The Effect of Visual Cues on Fall Risk on an Inpatient Psychiatric Unit

The Problem
An inpatient psychiatry unit presents unique challenges to hospital fall prevention, since patients are typically mobile on the unit. Monthly monitoring of patient falls showed a steady increase in our 12 month rolling total number of falls beginning in January 2014.

Aim/Goal
Our goal was to decrease the number of patient falls on the inpatient psychiatry unit.

The Team
Amanda Tjonahen, RN, Psychiatry
Michele Urban, RN, Psychiatry
Gregory Ludlow, Ed.D., Psychiatry

The Interventions
- Conducted in-depth analyses of our fall data to identify patterns and trends;
- Met with nurses and mental health associates to obtain input on why they thought patients were falling more frequently;
- Identified inability to identify patients at fall risk when patients were outside their rooms as an issue;
- Trialed at-risk patients wearing red slipper socks; and
- Monitored red slipper sock usage.

The Results/Progress to Date
In-depth analyses of our fall data did not identify any patterns or trends in patient falls. However, unit staff found it difficult to identify at risk patients when they were moving around the unit or away from their rooms. The red slipper socks provided staff with a visual cue allowing them to more easily identify patients at risk for a fall.

Lessons Learned
The slipper socks are only effective if the patients wear the socks when moving around the unit.

Next Steps/What Should Happen Next
- Continue to monitor the usage of the red slipper socks
- Conduct ongoing analyses of patient falls to determine additional areas for improvement
- Identify other problems that might benefit from the use of visual cues

For more information, contact:
Amanda Tjonahen, RN, Unit-based Educator/
atjonahe@bidmc.harvard.edu