CASE STUDY

Quality Improvement Program Results in Decreased Bed-Related Falls in Medical/Surgical Clinical Setting

Kristy Alfano MSN, RN, NE-BC; Suzann Fay BSN, RN-BC; Pamela Rice, MSN, RN

INTRODUCTION

Evidence-based fall prevention continuous quality improvement (CQI) programs are an important aspect of patient safety. Accidental falls are associated with injury, increased morbidity and mortality, and increased length of stay and costs.[1-3] A hospital in New York identified the need for bed standardization and re-education to enhance fall prevention efforts. The following case history describes the success of this CQI initiative.

METHODS

Clinical Setting: This QI initiative took place on a 28-bed telemetry unit.

QI Timeline:

January 2017:
- Vendor fair held to select new beds
- Hospital decides to launch no falls challenge with telemetry unit as they had highest fall risk in the system.
- Opportunity for bed standardization identified to ensure staff were educated on the appropriate use of technology and risk-stratified fall prevention protocols.
- Root cause analysis revealed patients who were post-procedure and post-anesthesia needed high-risk stratified interventions for fall prevention.
- Root cause analysis revealed the primary location for falls occurred in the bathroom.

February 2017: Bed in-servicing conducted

March 2017: No Falls Challenge initiated

April 2017: Falls workshops held and evidence-based education provided to nursing staff on fall prevention and reinforcement of protocols.

May 2017: Literature review conducted to assess evidence-based research on fall prevention to update policy

October 2017: Falls policy updated with updated risk-stratified interventions

Intervention: Bed standardization * with risk-stratified interventions and re-education.

Fall Prevention Interventions:
- The policies and procedures for fall prevention remained the same throughout the CQI initiative, including but not limited to: ensuring beds were in low height, appropriate use of technology (iBed Awareness), application of fall bracelets and socks.
- Fall prevention interventions were audited for compliance throughout the CQI initiative. Lack of compliance was followed up immediately by nurse manager.
- Patients were educated on the need for toileting assistance when considered at risk for falls.
- All patients, regardless of risk, had iBed awareness turned on.
- All patients at risk of a fall were placed in Zone 2 for bed alarm sensitivity.
- Nursing Assistants helped ensure technology was appropriately configured to help maintain compliance with risk-stratified fall interventions.

Education: Evidence-based fall prevention education** was provided on best practices for fall prevention.

Communications: The results of the QI initiative were communicated to staff by the nursing manager during a weekly wrap-up email. In the event of a fall, all staff were e-mailed describing the scenario. A real-time post fall huddle was conducted with timely follow up for all people involved. In addition, a count of falls and updated statistics were provided on an ongoing basis on white boards in the break room.

*S3® Med/Surg Bed configured to include Chaperone® Bed Exit with Zone Control® Bed Exit Technology and iBed® Awareness

**Stryker account manager/clinical team partnered with the facility team on delivery of education.

MKT-EXT-001 17 MAR 2018 Rev A

METHODS CONTINUED

Leadership Support and Collaboration: This CQI initiative garnered strong leadership support. Team collaboration was emphasized as an important element of this process improvement project. A strong focus was placed on the need for collaboration between RNs and Nursing Assistants to work together as a team and determine roles for the initiative.

RESULTS

This QI initiative was successful and resulted in 115 days without a bed-related fall on a 28-bed telemetry unit.

CLINICAL IMPLICATIONS

- This QI initiative resulted in an enhanced clinical culture focused on patient safety.
- Strong leadership was essential to the success of this initiative.
- Ongoing CQI efforts continue to build on the success of this initiative.

REFERENCES

1. The Joint Commission. Sentinel Event Alert. Issue 55. Preventing falls and fall-related injuries in health care facilities. Available at: https://www.jointcommission.org/assets/1/18/SEA_55.pdf
2. Shekelle PG, et al: Making health care safer II: An updated critical analysis of the evidence for patient safety practices. Comparative effectiveness review No. 211. (Prepared by the Southern California-RAND Evidencebased Practice Center under Contract No. 290-2007- 10062-I.) AHRQ Publication No. 13-E001-EF. Rockville, Maryland: Agency for Healthcare Research and Quality, 2013. 7.
3. Wong C, et al: The Cost of Serious Fall-Related Injuries at Three Midwestern Hospitals. The Joint Commission Journal on Quality and Patient Safety, 2011;37(2).

This case history was developed by MedBio Publications LLC, which was in turn funded by Stryker Corporation.
The authors maintained total editorial control over the content of this document.