Improving Staff Knowledge of Their Patients' Fall Risk through the Use of Visual Tools

Shannon King BSN, RN
Lehigh Valley Health Network

Tina Marsteller BSN, RN
Lehigh Valley Health Network

Courtney Sniscak BSN, RN
Lehigh Valley Health Network

Maria Zarzecki BSN, RN
Lehigh Valley Health Network

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Published In/Presented At
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Inpatient falls continue to occur throughout the network.

It is necessary to continue to improve fall prevention measures.

- Falls negatively affect patient outcomes and can increase patient’s length of stay.
In inpatient adults, how do visual icons displaying fall risk compared to verbalizing patients’ Hendrich II fall score improve staff knowledge of their patients’ fall risk?

- **P**: Inpatient adults
- **I**: Visual fall risk aid (fall risk icons to supplement communication boards)
- **C**: Hendrich II fall score
- **O**: Improve staff knowledge of patients’ fall risk
TRIGGER?

Knowledge vs. Problem

- Problem-based trigger
  - Noted patient-specific fall risk factors not always communicated during nursing handoff
  - Hendrich II score mentioned, but what does that number mean for each of our patients?
EVIDENCE

- **Search engines**
  - CINAHL
  - Pub Med
  - Ebsco host

- **Discuss the key words**
  - Fall risk
  - Communication
  - Visual tools
  - Handoff
Fall risk scores are not a necessary part of fall prevention guideline (Delgelau et al., 2012)

Best practice for fall reduction (Oliver et al.)
- risk assessment, visual identification of individuals at high risk for falls, fall risk factor directed interventions, standardized multifactoral education including visual tools for staff family and patients

The use of visual icons that corresponds to individual patients’ fall risk as a part of a fall prevention took kit has been shown to be an effective measure in preventing falls (Dykes et al.)
Strategies for effective nursing handoff communication (Reisenberg, Leitzsch, & Cunningham, 2010).

- Guidelines, policies/procedures
- Tools for consistency
- Resources/Education to reinforce handoff skills
Icons used to depict fall risk status have been validated in a previous study by nursing staff (Hurley et al., 2009)
Current Practice at LVHN

- **Policy: PATIENT CARE SERVICES – FALL PRECAUTIONS**
  - Communicate patient’s risk for falls i.e. using door frame Fall Alert magnet, Fall precaution labels, Patient Transport Communication sheet [NSG-270], and methods of handoff communication.
  - Visual tools utilized (ie. Yellow non-skid socks) to identify patients at risk for falls, but not in handoff communication.
IMPLEMENTATION

1. Process Indicators and Outcomes
2. Baseline Data
3. Design (EBP) Guideline(s)/Process
4. Implemented EBP on Pilot Units
5. Evaluation (Post data) of Process & Outcomes
6. Modifications to the Practice Guideline
7. Network Implementation
Practice Change
Make It Happen
RESULTS

- **Key Findings**
  - **Control unit**
    - 86% of oncoming nurses stated fall risk and patient specific risk factors discussed during handoff
    - Risk factors listed: impaired mobility (lift out of bed, assist of 1 or 2, walker, unsteady, hip fracture), dizziness, history of falls, fall score, medications, confusion, & surgery
    - Confidence: 0% not at all confident, 22% somewhat confident, 14% neutral or extremely confident, 50% confident

- **Next steps**
Implications for LVHN
Lessons Learned
References

- Oliver, D., Daly, F., Martin, F. C., McMurdo, M. E. T. Risk factors and risk assessment tools for falls in hospital in-patients: a systematic review
- Dykes et al. Fall Prevention in Acute Care Hospitals: A Randomized Trial
Strategic Dissemination of Results

- PLAN for DISSEMINATION
Make It Happen

- Questions/Comments:

Contact Information: