Fall Accountability Care Program.

Jenny Huang BSN, RN  
*Lehigh Valley Health Network, jenny.huang@lvhn.org*

Kelly Menendez BSN, RN  
*Lehigh Valley Health Network, kelly.menendez@lvhn.org*

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Despite multiple fall interventions in place, such as bed alarms, chair alarms, fall-risk bracelets, yellow non-skid socks, hi-low bed with fall matts, and patient instructions, falls are increasingly prevalent on medical-surgical units. (Hoke & Guarracino, 2016).

The LVH post-fall huddles are attended by staff working at that time. The subsequent safety report is then reviewed by unit leadership. Staff not working the day of the fall do not have the learning opportunity afforded by the huddle and review of safety report.

Goal is to increase awareness by all unit staff of each fall’s root causes.

Results

The LVH post-fall huddles are attended by staff working at that time. The subsequent safety report is then reviewed by unit leadership. Staff not working the day of the fall do not have the learning opportunity afforded by the huddle and review of safety report.

What fall prevention interventions were in place at the time of the fall?

Post-fall reflection survey was requested to be completed by each RN who experienced a patient fall and then sent to all unit staff within 3 days.

Reflection Survey questions:
1. Provide a detailed description of what occurred, including actions taken post fall. Did the patient incur injuries?
2. What factors placed the patient at an increased risk of falling? (i.e. medications, clutter in the room, unsteady gait, mews score/ vs, fall risk score)
3. What factors placed the patient at an increased risk of falling?
4. What are some opportunities for learning?
5. From your Nursing perspective, what did you take away from this fall/what will you change in your Nursing practice for the future?

Post-interventions – Fall Awareness Survey re-administered to unit staff.

Implementation process began Oct-Dec. Patient falls decreased on both TSU and 6B after implementation of the survey. Data shows a correlation between survey responses and reduced falls, not causation. Data was not controlled for differences in population over time or between units.

Results – Staff Awareness

16 of 25 RNs felt learning details about fall events from their peer was beneficial.

4 RNs reported changing practice based on learnings from the Reflection Survey questions. The primary practice change related to not toileting alone and establishing a frequent toileting schedule.

Conclusion

Leadership support is essential for staff accountability to complete the Reflection Survey questions and send to peers.

References


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