My Safety Plan

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BACKGROUND

- Through discussions we discovered that the three different units represented within our group, although having different patient populations, all of them were at risk for falls.
- Current practice was use of “My Safety Plan” contract with every admission to reduce falls. We discovered the knowledge of the safety plan was inconsistent.
- We questioned why some units were using the “My Safety Plan” as a part of the admission process for every patient and others were not?
- Did the units currently using the “My Safety Plan” (which is a contract) have lower rates of falls?

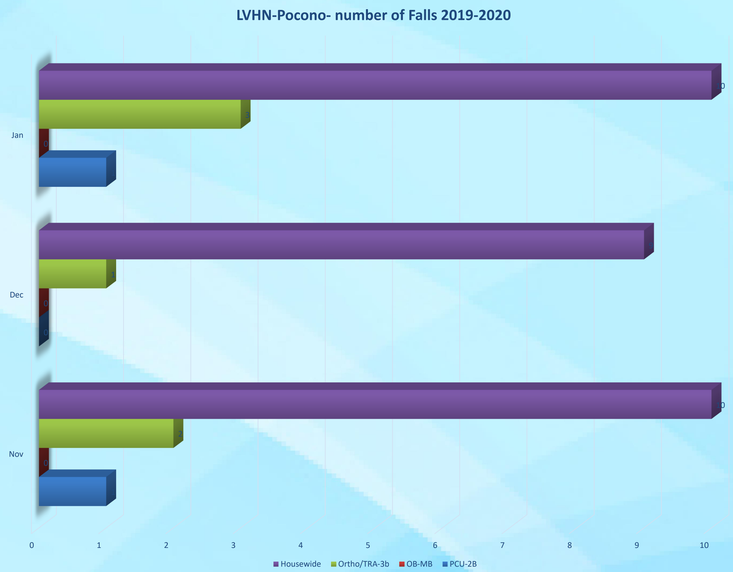
P I C O

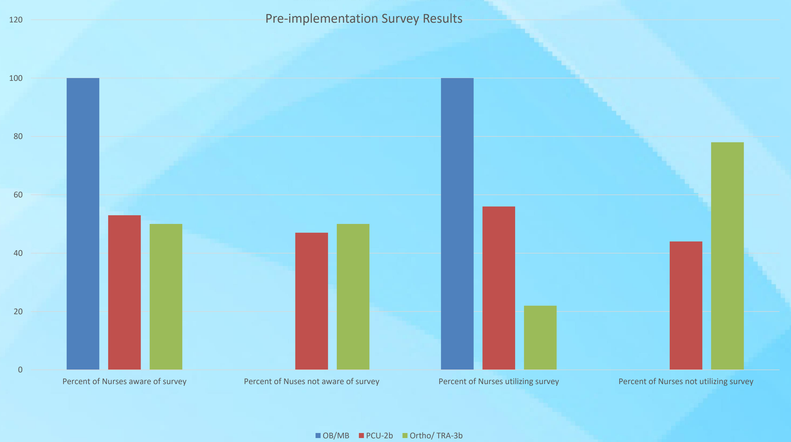
- **P: Staff Nurses**
- **I: “My Safety Plan” contract**
- **C: Units not using “My Safety Plan”**
- **O: Will using “My Safety Plan” contract affect fall rates**

EVIDENCE

- In “impact of fall prevention on nurse and care of fall risk patients” management was involved with engaging the nurses to care about the falls and holding them accountable with educating themselves and their patients, which lead the nurses to start using the fall reduction policy they had in place and being consistent in hopes of not getting reprimanded and seeing quality care for their patients. We had hope to use this in our practice with leadership involvement supporting the discussion and re-education on the “My safety Plan” we have now. There was some short falling with inconsistent support from upper leadership and no accountability if it was not used for each patient like was done in this research.(King, Pecanac, Krupp, Liebzeit & Mahoney, 2016)
- “Fall risk and prevention agreement: patient family involvement” this article utilized a contract similar to ours with a demographic similar to 2B and 3B patients. They focused using the contract with the patients and their family members which in turn would help the patients understand and hold themselves accountable to their own safety and engage them in the process. As well allowing the family members to understand the priority in keeping their “loved ones” safe. We took this and tried implementing it on our floors in regards to the patients whom may have had cognitive delays in truly understanding the contract and what it meant. So involving the family would help during visitation and encouraging the patients to utilize the fall prevention system we use at Pocono now. “Call do not fall”, the bed/chair alarms and assistance to the bathroom. (Vonnes &Wolf, 2017)
- “Preventing patient falls” discussed finding the root cause for falls at that particular hospital/unit. It lead our discussion to denote that all of our patients had the common factor of medications and fluid imbalances which can lead to falls no matter the dx and age group of the patient demographic. We noted that every patient would benefit from an explanation that they are signing the “my safety plan” with the explanation of what made them a fall risk. This was more effective on the patient whom did not suffer from any cognitive delays e.g. dementia or delirium. Patients having the understanding of their medications and fluid shifts and the effects on them helped them to be more complaint in calling and waiting for assistance and reaffirming all of their belongings were in reach and up holding their end of the contract before their nurse left their room. (Wiklund, Dwyer & Davis, 2016)

OUTCOMES





We implemented utilizing the survey through Dec. and Jan., and the charts above show the outcome of falls through the implementation.

- OB was utilizing the plan before this and had a consistent 100% utilization rate compared to the other units.
- 2B/PCU did have a decrease in falls compared to 3B/ortho-Tra through the 3 months once implementation went into effect. They had consistent leadership and staff throughout the two months of implementation.
- 3B/Ortho-TRA did have a slight decrease from Nov-Dec but the rates rose in Jan. Which during that time there was change in leadership and staff was altered by new nurses joining the team, having inconsistent training. Management did not consistently help reinforce the use of “my safety plan” and there was no consequence for not using it.
- This was all compared to the entire hospital “housewide” to see where the floors rated in contribution to the falls for the hospital.

IMPLEMENTATION

- Pre-implementation survey: Distributed to determine if the “My Safety Plan” contracts were or were not being utilized on each unit
- Making the “My Safety Plan” contract known about and available to staff. With the help of management, making the “My Safety Plan” a mandatory part of the admission process for all patients.
- Setting up reminders around the units for the staff to reinforce the components of the “My Safety Plan” contract. Ex. Notes on WOWs, Copy of the signed contract at patient bedside and reminders set up on the EPIC brain

NEXT STEPS

- Moving forward we will reinforce the “ My Safety Plan “ with our revised admission folders. We are currently switching to a new LVHN folder to be given to each patient on admission and included in the folder is a “My Safety Plan”.
- With the retraining on using the new admission folders, the “My Safety Plan” will be automatically implemented during each and every admission.
- With the help of management this could be reinforced and become a staple in our admission process.
- Along side the above process, having a consistent leadership and staff will be beneficial, which at this point all three units now have.

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