B.A.C.K to B.A.S.I.C.S: A Fall Prevention Bundle

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B.A.C.K. to B.A.S.I.C.S: a Fall Prevention Bundle

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BACKGROUND

Patient falls while in an inpatient setting can have serious consequences, among which include injury to the patient as well as length of stay at the hospital (Ang et al., 2012). How can hospital staff decrease the likelihood that a patient will fall during their stay at the hospital? A recent increase in falls on RHC has pushed the floor over their FY16 goal for fall prevention among patient falls. The BTB guideline remains in place on RHC, but staff (RNs and TPs) are unaware of it or are only aware of part of the acronym. The BTB guideline remains in place on RHC, but staff (RNs and TPs) are unaware of it or are only aware of part of the acronym.

B.A.C.K. to B.A.S.I.C.S.

What does B.A.C.K. to B.A.S.I.C.S stand for?

- B: Bed check criteria and trial periods
- A: Ambulation
- C: Change in status
- K: Keep alert
- I: Inspect the room
- S: Stay with the patient
- C: Communicate and educate
- S: Supply patient with needs at the bedside

PROJECT PURPOSE

- Assess current BTB criteria for evidence based practice, change criteria if necessary and assess barriers to BTB use/implementation.
- Assess and compare fall rates on RHC and determine what, if any, fall interventions were in place when the patient fell.
- In staff RNs and TPs to education about the B.A.C.K. to B.A.S.I.C.S.” result in more appropriate use of fall risk interventions to reduce falls?

METHODS

- Pre-education survey for staff RNs and TPs.
- BTB criteria education via a PowerPoint on TLC.
- Discuss BTB criteria during daily safety huddle.
- Review of fall data on RHC during June and September.
- Assessment of fall prevention methods in place during those patient falls.
- Consultation to the bed check representative.

RESULTS and OUTCOMES

After reviewing the evidence available, the current BTB criteria was found to be based in evidence.

Based on the survey responses, staff RNs and TPs:
- Often felt a bed check was available when needed
- Often ambulated their patients at least daily
- Often rounded according to RHC rounding guidelines
- Always stayed with the patient while toileting
- Always communicated the patient’s activity level during change of shift
- Often communicated the patient’s fall risk to the patient
- Often communicated the patient’s fall risk to the RN at change of shift
- Often communicated the patient’s fall risk to the TP at change of shift
- Often communicated the fall risk interventions already in place to the RN and TP caring for that patient.

Additionally the surveys showed that the most common reasons cited by RNs and TPs to initiate a bed check were:
- Impulsiveness, fall history, mental status change/confusion, new medication, call bell non-compliance and high fall score.

The surveys also showed that the most common reason cited by RNs and TPs not to initiate a bed check were:
- Alert and oriented/independent/steady gait, no new medication, appropriate use of call bell and low fall score.

CONCLUSIONS and RECOMMENDATIONS

- A survey, although anonymous, may not be the best method to collect data.
- Based on fall data collection in September (1 fall):
  - Staff RNs and TPs on RHC are either not following the fall prevention policy or are not charting the fall interventions that are in place.
  - Education about the definition of the fall prevention indicators found in EPIC is needed to ensure proper charting.
- More research will need to be done to assess the effectiveness of the movement of the bed check from the patient’s sacrum to under their shoulders.
- More education is needed to assess the effectiveness of BTB as a fall prevention bundle.

REFERENCES


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