Fall Reduction in Long-Term Hospital Setting
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**SETTING**

The quality improvement project took place at an 18-bed inpatient hospital located in the Midwest. The unit was developed in response to the demand of inpatient, acute, med surg beds and decrease of long-term care facility bed availability, forcing patients who are medically stable and do not require acute level med surg nursing to remain in the hospital setting while awaiting appropriate and safe discharge disposition.

**BACKGROUND**

Approximately 700,000 to 1,000,000 patients fall in the hospital each year (Falls, 2019). The Institute of Medicine report and the Centers for Medicare and Medicaid Services classified hospital falls as a never event and do not reimburse hospitals for the care relating to patient falls (Falls, 2019). Exploration and implementation of fall prevention interventions will ultimately provide patients with improved health outcomes and safety and promote practice and safety standards that healthcare organizations require.

**PROBLEM STATEMENT**

A total of 44 patient falls occurred in 2022. It was found that patient alarms were not being correctly applied, hooked up, or were malfunctioning in over 50% of the fall events. It was also found that nursing bedside report was not occurring on the unit and opportunities for alarm review and checks were being missed.

**IMPROVEMENT TEAM**

This quality improvement project was conducted with a team consisting of the CNI student, unit clinical manager, the professional development nurse, the quality improvement nurse, and ad hoc members.

**IMPROVEMENT METHOD**

The Plan-Do-Study-Act (PDSA) method is a way to test a change that is implemented. Going through the prescribed four steps guides the thinking process into breaking down the task into steps and then evaluating the outcome, improving on it, and testing again.

**BASELINE ASSESSMENT DATA**

- Forty-four patient falls occurred in 2022
- Highest number of falls occurred on Wednesdays between 5pm and 8pm
- More than half of the falls on the unit in 2022 were related to the use of alarms
- Eleven patient falls were related to alarms not being turned on, applied to the patient incorrectly, or not hooked to the unit alert system
- Other reasons for falls were identified as alarm equipment malfunction, alarm fatigue, and alarms not being used on patients

**LEARNINGS & LIMITATIONS**

**LEARNINGS**

- PDSA cycles not long enough – ideally 3 to 4 weeks to catch all stable staff
- Lower census = more manageable to round and do report
- CNAs leave early without checking in with nursing
- New alarms placed - not communicated to the team so not all know about alarm
- Alarms and call lights not being answered while trying to give report
- Some patients are not appropriate to do report at the bedside
- There is a need to set clear role expectations regarding BSR for RNs and CNAs

**LIMITATIONS**

- Rotating/float staff every day and every shift
- Challenges with consistently communicating education points with scheduling barriers, meeting cancelations, etc.
- Culture of unit not performing BSR and knowledge of patient population influencing and preventing practice of BSR as standard practice on the unit

**REFERENCES**

Please scan the QR Code for references, acknowledgments, and supplemental materials pertaining to project