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A Quality Improvement Study Concerning the Safety of Patients in the Acute Hospital Setting with Emphasis on Minimizing Patient Falls and Injuries by Implementing Staff Education and Reminders

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A Quality Improvement Study Concerning the Safety of Patients in the Acute Care Hospital Setting
with Emphasis on Minimizing Patient Falls and Injuries by Implementing Staff Education and
Reminders.

An honors thesis/project in partial fulfillment
of the requirements for the degree of
Honors Baccalaureate in Nursing

By

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Honors Nursing Students

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University of Arkansas

This honors undergraduate thesis/project is approved for recommendation to the College of Education and Health Professions Honors Council.

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Abstract:

Background: Patient falls in the hospital have continued to be a major avoidable problem in the acute care hospital setting. These falls can lead to negative patient outcomes as well as an increase in cost for the hospital.

Aim: The aim of this quality improvement project is to determine if an educational intervention and posting of fall prevention posters in the cardiology units impacts the fall rates and fall index.

Setting: The cardiac units of Washington Regional Medical Center.

Participants: The cardiac nursing staff as well as all patients who fell on this floor between the months of April through September during the years of 2013 and 2014.

Methods: A “Hospital Survey on Patient Safety” was completed by staff on the cardiology units to gather baseline knowledge on how nursing staff felt about patient safety overall on their units. Staff education was then implemented on ways to decrease patient falls during mandatory staff meetings on the cardiac units in April 2014. Fall prevention posters were posted in all 60 patient rooms, staff break rooms and bathrooms. Post Huddle Fall Sheets, a report used routinely by the nursing staff, were used to collect data on falls both pre and post implementation of staff education and poster placement. The pre period was from April to September of 2013 and the post period was from April to September of 2014.

Results: Overall implementation of staff education and fall prevention reminder posters had no statistical significance on the incidence of falls. The fall index data showed that the total number of falls decreased on all units, 3 South, West and East, during the month of April after interventions were implemented. Three East had a decrease in falls during all months between April and September; whereas, 3 South and West had no statistical significant decrease in falls.

Conclusion: In summary, more consistent and continuous staff education concerning fall prevention needs to be implemented into the acute care setting. Interventions must be more invasive and multifaceted to make an impact on falls.

Introduction:

Patient falls are a national problem when it comes to safety in the acute care setting. Patients who fall typically have longer stays in the hospital. Falls are avoidable. “Patient falls, a measure of hospital quality, constitute serious problems in acute care hospitals, which may result in hospitals not being reimbursed for fall-related costs” (Dykes, Carroll, McColgan, Hurley, Lipsitz, Colombo, & Middleton, 2011, pg. 446). The most common causes of falls include: patient’s items not within reach, the path to the bathroom is not clear, and patients are under the influence of medications that put them at risk. It has been estimated that nearly half of hospitalized patients in the acute care setting fall, with 50% of those patients sustaining injuries that cause extended hospital stays. The spectrum of injuries resulting from falls can be as minimal as bruising, or more serious as with “fractured bones and even cause death” (Swartzell, Fulton, & Friesth, 2013, pg. 180). Patient falls typically occur in their room when patients are trying to change position, getting up to chair, or making a trip to the restroom. It has been estimated that at least 33% of falls can be prevented (Abreau, Mendes, Monteiro, & Santos, 2012). Moreover, Medicare/Medicaid will not reimburse hospitals for fall related injuries that occur in the acute care setting. Falls are costly not only to the patient, but the hospital (Ganz, Huang, Saliba & al., 2013). Falls are a high priority for everyone who works in the health care setting. Numerous products and procedures have been developed to assist in fall prevention such as bed alarms, where staff can hear the audible alarm when patients attempt to get up. Another fall prevention procedure is ensuring a clear footpath is kept between the patient’s bed and the restroom to help avoid falls. Falls can be minimized with very little extra effort from the staff in the acute care setting, which would benefit patients, nurses and the hospital.

According to Rowe (2013), “Evidence suggests that staff education is one of the most important factors in the success of a falls reduction program” (pg. 98). It is important for staff to be current on the risk factors for patient falls and what can be done throughout the day to prevent falls.

Updates and reinforcement of education on hospital policy and new ways to prevent patient falls is also an important management issue (Rowe, 2013).

It has been identified by the hospital administration at Washington Regional Medical Center (WRMC) that patient safety related to falls is an ongoing priority. This quality improvement project will specifically focus on the falls of the cardiology units.

Aims:

The aim of this quality improvement project is to determine if an educational intervention and posting of fall prevention posters in the cardiology units impacts the fall rates and fall index.

Methods:

This study was conducted following approval of the University of Arkansas' Institutional Review Board and the WRMC Quality Improvement Department. All patient information was de-identified in compliance with guidelines of the Health Insurance Portability and Accountability Act (HIPAA). Fall statistics for the cardiology units was obtained from the "Post Fall Huddle" form (Appendix B), which lists falls by tally number only.

Nurses working on the cardiology units were asked to complete a "Hospital Survey on Patient Safety" (Appendix A). Twenty surveys were distributed with eleven surveys returned, for a 55% return rate. Survey data revealed an average of 3-5 patient falls reported per nurse in the last year. The survey also gathered information about nurse perceptions concerning patient safety overall on the cardiology units. Baseline patient fall data occurring on the cardiology units from April 2013 to September 2013 was then evaluated. An education presentation on fall prevention was presented at the cardiology units staff meetings in April 2014. An educational handout was given to staff which provided information on specific patient fall statistics by unit, provided "SAFE" posters listing methods to prevent falls, and the importance of preventing falls to both the patient and the hospital (Appendix D). The "SAFE" reminder posters were posted in all 60 patient rooms, employee

bathrooms and break rooms on the cardiology units (Appendix C). Data from the “Post Fall Huddle” form on falls from April 2014 to September of 2014 was used to compare with our baseline data (Appendix B).

Results:

This project resulted in institutional changes to the acute care setting through education and placement of fall prevention posters on the cardiac unit. A fall index, number of patient falls X 1,000/ number of patient days, was used to interpret the data collected. After implementation, the fall index from 3 East between 2013 and 2014 showed a decrease in falls during the months of April through September (Table 1). The fall index for 3 South showed a decrease in falls during the month of April and no falls during the month of June (Table 2). The fall index for 3 West showed a decrease in the amount of falls for the months of April and August and no falls during July (Table 3). Overall, all three units experienced a decrease in falls according to the fall index data during the month of April, which was soon after implementation of staff education and reminder posters.

Three East had a decrease in falls during all months between April and September; whereas, 3 South and West had no statistical significant decrease in falls.

Table 1: Fall Index from 3 East 2013 versus 2014

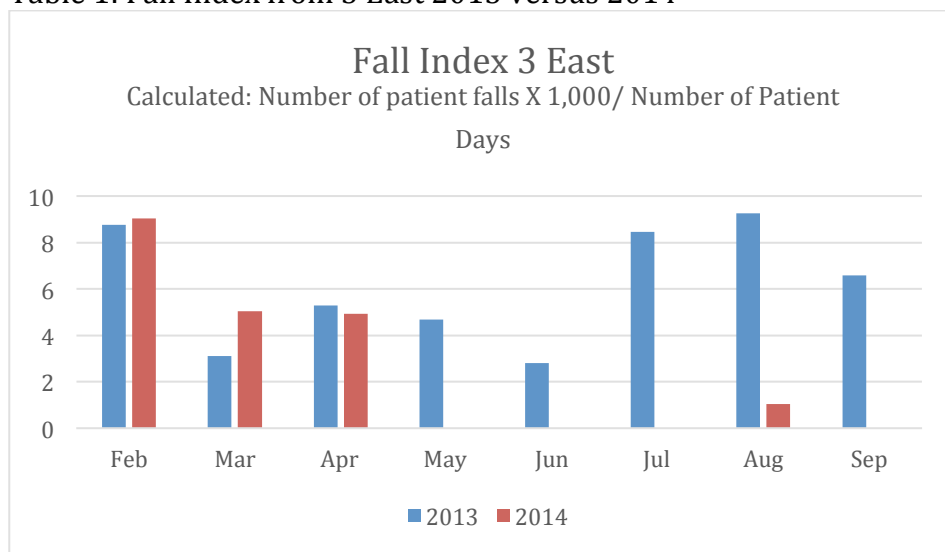


Table 2: Fall Index from 3 South 2013 versus 2014

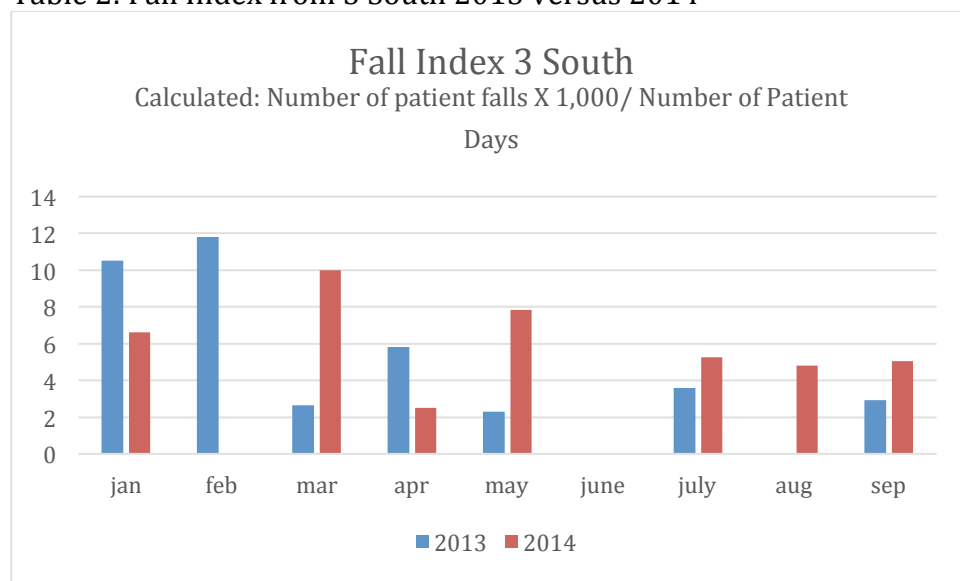
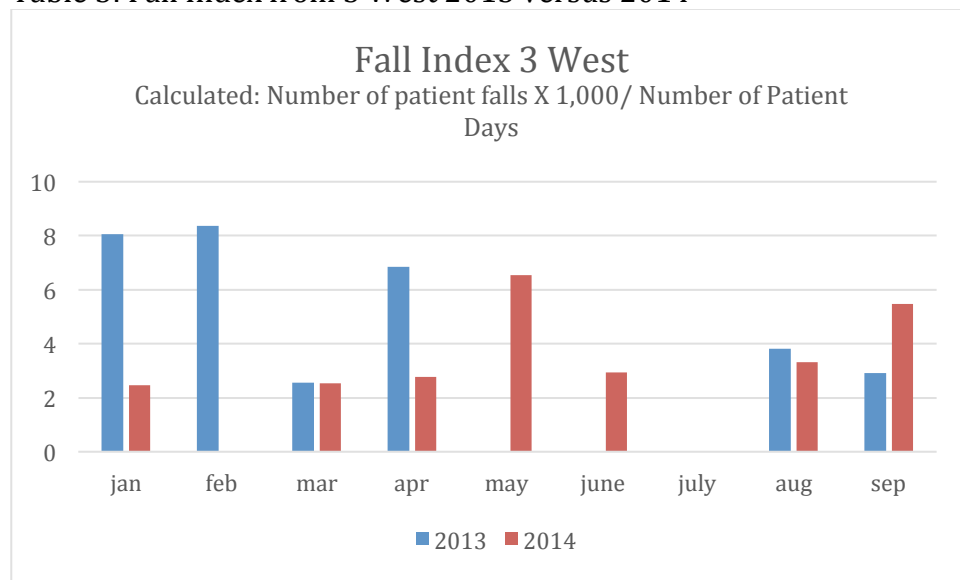


Table 3: Fall Index from 3 West 2013 versus 2014



Discussion:

Overall, there was not a statistical significance difference between fall rates pre- and post-educational intervention and following posting of fall reminder posters on the units. There is more to be done regarding fall prevention, and other options should be explored in order to help reduce the number of falls in the acute care setting.

According to the literature, there is substantial evidence to support the need for interventions; however, this study showed the intervention of education and staff reminders was not enough to prevent patient falls. Further investigations are recommended to determine ways to decrease patient falls. It has been established that patients on medical units, like the units used in this study, are more likely to have patient falls as these patients have complex diagnoses but are still mobile. This places these patients at a greater risk than patients in other units where mobility isn't a factor (Bouldin, Andresen, & Shorr, 2013). Previously studies have shown there is an increased risk for the patients on the medical units to fall, and the risk factors involved are so numerous that a single intervention is not adequate in addressing the incidence of falls.

According to Dykes et al. (2011), "Older adults have a five fold risk in comparison to the younger population to fall" (pg. 439). The cardiology unit used in this study cares primarily for patients 65 years of age or older. It has also been established that one intervention is not typically enough to effect the incidence of falls in the acute care setting; therefore, in moving forward, a multifaceted intervention should be explored to decrease the occurrence of falls (Dykes, et al., 2011).

Another very common contributor to patient falls is the promptness of call light response as well as hourly rounding. Providing motivation for nurses to complete hourly rounding consistently as well as having motivated ancillary nursing staff to promptly answer call lights could limit or at least decrease the incidence of falls. According to the literature, a common problem health care entities and

administrators encounter is the struggle to get the entire staff to buy into these principles (Huey-Ming, & Chang-Yi, 2009).

Limitations:

Falls have been a confounding factor in the healthcare setting for decades, and it has been found that minimal interventions have not made any serious impact on falls (Morgan, Mathison, Rice, & Clemmer, 1985). For quality improvement projects to make a difference, healthcare professionals are going to have to make radical changes in practices. This study identified limitations that researchers should consider as they attempt to decrease falls in the acute care setting.

These limitations include: one staff education opportunity did not make a statistically significant difference, staff education lacked consistent follow up, and the reminders remained in the same place for the entirety of the project. Rather than presenting the staff education in a staff meeting, it might have been more beneficial to present the education in a seminar format for all the nurses on the units to attend. Had the information been reviewed at all monthly staff meetings, the nurses would have had a more constant reminder of the studies goal and the implementations made. The nurses then would have potentially been more motivated toward continual practice of fall interventions and subsequently a decrease in the incidence of falls could have occurred.

An improvement that could be made would be to change the location of the posters and have multiple formats to present the information. When the workplace is consistently the same, it is easy to overlook aspects of the environment. Had the posters been moved, it would have been more likely to keep the nurses attention, therefore more effectively remind them. Another limitation identified was the lack of family and patient inclusion in this attempt to decrease falls. If there were a way to reach the patient with the intervention techniques, they would be more aware and more likely to follow the best practices to prevent falls. They may also hold their nurse to the best practice procedures to prevent falls. Ways to reach the patient could be to have a handout waiting for them on the bedside table upon

admission or to play a fall prevention educational video on the hospital's television channel making the patient more aware.

A statistic that was not measured for this study was the patient's mental condition and their knowledge of own limitations. It is important to note contributing factors to falls like a patient's level of consciousness and presence of delirium. Unfortunately, in the acute care setting nurses frequently have patient loads with more than one patient with an altered level of consciousness or delirium making it difficult to monitor each patient intensely (Tzeng, 2010).

In order to encourage compliance with the study, potential fall audits could have been performed to see if interventions were implemented. Had potential fall audits been implemented, the nursing staff may have been more encouraged to prevent falls from occurring. Had there been more of a researcher presence on the floor, the education could have been made more specific to the needs of that unit. Overall, changes that should be considered going forward are continued education throughout the project's timeline.

Conclusion

In theory, staff education and fall prevention reminder posters should decrease the incidence of falls. In practicality, the acute care setting is stressful and busy, and the healthcare staff is distracted, which prevents falls from being the priority. In going forward, the suggestion would be to incorporate multifaceted interventions for fall prevention in the acute care setting.

References

- Abreau, C., Mendes, A., Monteiro, J., & Santos, F. R. (2012). Falls in hospital settings: a longitudinal study. *Revista Latino-Americana de Enfermagem*, 20(3), 597-603. Retrieved December 04, 2014, from http://www.scielo.br/scielo.php?script=sci_arttext&pid=S0104-11692012000300023&lng=en&tlng=en. 10.1590/S0104-11692012000300023.
- Bouldin, E., Andresen, E., & Shorr, R. (2013). Falls Among Adult Patients Hospitalized in the United States: Prevalence and trends. *Journal of Patient Safety*, 9(1), 13-17. Retrieved November 17, 2014, from <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3572247/#!po=50.0000>
- Dykes, P., Carroll, D., McColgan, K., Hurley, A., Lipsitz, S., Colombo, L., & ... Middleton, B. (2011). Scales for assessing self-efficacy of nurses and assistants for preventing falls. *Journal Of Advanced Nursing*, 67(2), 438-449. doi:10.1111/j.1365-2648.2010.05501.x
- Ganz, D. A., Huang, C., Saliba, D., & al., e. (2013, January). *Preventing falls in hospitals: A toolkit for improving quality of care*. Retrieved from Agency for Healthcare Research and Quality: <http://www.ahrq.gov/professionals/systems/hospital/fallpxtoolkit/fallpxtoolkit.pdf>
- Huey-Ming, T., & Chang-Yi, Y. (2009). Relationship between call light use and response time and inpatient falls in acute care settings. *Journal Of Clinical Nursing*, 18(23), 3333-3341. doi:10.1111/j.1365-2702.2009.02916.x
- Morgan, V. R., Mathison, J. H., Rice, J. C., & Clemmer, D. I. (1985). Hospital Falls: A persistent problem. *American Journal Of Public Health*, 75(7), 775-777.
- Rowe, Jimmy. (2013) "Preventing Patient Falls: What are the factors in hospital settings that help reduce and prevent inpatient falls?". *Home Health Care Management & Practice*, 25(7), 98-103.
- Swartzell, K. L., Fulton, J. S., & Friesth, B. M. (2013). Relationship Between Occurrence of Falls and Fall-Risk Scores in an Acute Care Setting Using the Hendrich II Fall Risk Model. *MEDSURG Nursing*, 22(3), 180-187.

Tzeng, H. (2010). Inpatient falls in adult acute care settings: Influence of patients mental status.

Journal Of Advanced Nursing, 66(8), 1741-1746. doi:10.1111/j.1365-2648.2010.05343.x

Appendix A

Hospital Survey on Patient Safety

Instructions

This survey asks for your opinions about patient safety issues, medical error, and event reporting in your hospital and will take about 10 to 15 minutes to complete.

If you do not wish to answer a question, or if a question does not apply to you, you may leave your answer blank.

- An **“event”** is defined as any type of error, mistake, incident, accident, or deviation, regardless of whether or not it results in patient harm.
- **“Patient safety”** is defined as the avoidance and prevention of patient injuries or adverse events resulting from the processes of health care delivery.

SECTION A: Your Work Area/Unit

In this survey, think of your “unit” as the work area, department, or clinical area of the hospital where you spend most of your work time or provide most of your clinical services.

What is your primary work area or unit in this hospital? Select ONE answer.

- | | | |
|--|--|--|
| <input type="checkbox"/> a. Many different hospital units/No specific unit | <input type="checkbox"/> h. Psychiatry/mental health | <input type="checkbox"/> n. Other, please specify:
<div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div> |
| <input type="checkbox"/> b. Medicine (non-surgical) | <input type="checkbox"/> i. Rehabilitation | |
| <input type="checkbox"/> c. Surgery | <input type="checkbox"/> j. Pharmacy | |
| <input type="checkbox"/> d. Obstetrics | <input type="checkbox"/> k. Laboratory | |
| <input type="checkbox"/> e. Pediatrics | <input type="checkbox"/> l. Radiology | |
| <input type="checkbox"/> f. Emergency department | <input type="checkbox"/> m. Anesthesiology | |
| <input type="checkbox"/> g. Intensive care unit (any type) | | |

Please indicate your agreement or disagreement with the following statements about your work area/unit.

	Strongly Disagree	Disagree	Neither	Agree	Strongly Agree
Think about your hospital work area/unit...	▼	▼	▼	▼	▼
1. People support one another in this unit	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
2. We have enough staff to handle the workload	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅

- 3. When a lot of work needs to be done quickly, we work together as a team to get the work done ₁ ₂ ₃ ₄ ₅
- 4. In this unit, people treat each other with respect ₁ ₂ ₃ ₄ ₅
- 5. Staff in this unit work longer hours than is best for patient care ₁ ₂ ₃ ₄ ₅

SECTION A: Your Work Area/Unit (continued)

Think about your hospital work area/unit...	Strongly Disagree ▼	Disagree ▼	Neither ▼	Agree ▼	Strongly Agree ▼
6. We are actively doing things to improve patient safety	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
7. We use more agency/temporary staff than is best for patient care	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
8. Staff feel like their mistakes are held against them	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
9. Mistakes have led to positive changes here	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
10. It is just by chance that more serious mistakes don't happen around here	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
11. When one area in this unit gets really busy, others help out	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
12. When an event is reported, it feels like the person is being written up, not the problem	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
13. After we make changes to improve patient safety, we evaluate their effectiveness	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
14. We work in "crisis mode" trying to do too much, too quickly	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
15. Patient safety is never sacrificed to get more work done	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
16. Staff worry that mistakes they make are kept in their personnel file	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
17. We have patient safety problems in this unit	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
18. Our procedures and systems are good at preventing errors from happening	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅

SECTION B: Your Supervisor/Manager

Please indicate your agreement or disagreement with the following statements about your immediate supervisor/manager or person to whom you directly report.

	Strongly Disagree ▼	Disagree ▼	Neither ▼	Agree ▼	Strongly Agree ▼
1. My supervisor/manager says a good word when he/she sees a job done according to established patient safety	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅

procedures

- | | | | | | |
|--|---------------------------------------|---------------------------------------|---------------------------------------|---------------------------------------|---------------------------------------|
| 2. My supervisor/manager seriously considers staff suggestions for improving patient safety | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₃ | <input type="checkbox"/> ₄ | <input type="checkbox"/> ₅ |
| 3. Whenever pressure builds up, my supervisor/manager wants us to work faster, even if it means taking shortcuts | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₃ | <input type="checkbox"/> ₄ | <input type="checkbox"/> ₅ |
| 4. My supervisor/manager overlooks patient safety problems that happen over and over | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₃ | <input type="checkbox"/> ₄ | <input type="checkbox"/> ₅ |

SECTION C: Communications

How often do the following things happen in your work area/unit?

- | | Never
▼ | Rarely
▼ | Some-
times
▼ | Most
of the
time
▼ | Always
▼ |
|---|---------------------------------------|---------------------------------------|---------------------------------------|---------------------------------------|---------------------------------------|
| Think about your hospital work area/unit... | | | | | |
| 1. We are given feedback about changes put into place based on event reports | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₃ | <input type="checkbox"/> ₄ | <input type="checkbox"/> ₅ |
| 2. Staff will freely speak up if they see something that may negatively affect patient care | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₃ | <input type="checkbox"/> ₄ | <input type="checkbox"/> ₅ |
| 3. We are informed about errors that happen in this unit | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₃ | <input type="checkbox"/> ₄ | <input type="checkbox"/> ₅ |
| 4. Staff feel free to question the decisions or actions of those with more authority | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₃ | <input type="checkbox"/> ₄ | <input type="checkbox"/> ₅ |
| 5. In this unit, we discuss ways to prevent errors from happening again | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₃ | <input type="checkbox"/> ₄ | <input type="checkbox"/> ₅ |
| 6. Staff are afraid to ask questions when something does not seem right | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₃ | <input type="checkbox"/> ₄ | <input type="checkbox"/> ₅ |

SECTION D: Frequency of Events Reported

In your hospital work area/unit, when the following mistakes happen, how often are they reported?

- | | Never
▼ | Rarely
▼ | Some-
times
▼ | Most
of the
time
▼ | Always
▼ |
|--|---------------------------------------|---------------------------------------|---------------------------------------|---------------------------------------|---------------------------------------|
| 1. When a mistake is made, but is <u>caught and corrected before affecting the patient</u> , how often is this reported? | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₃ | <input type="checkbox"/> ₄ | <input type="checkbox"/> ₅ |
| 2. When a mistake is made, but has <u>no potential to harm the patient</u> , how often is this reported? | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₃ | <input type="checkbox"/> ₄ | <input type="checkbox"/> ₅ |
| 3. When a mistake is made that <u>could harm the patient</u> , but does not, how often is this reported? | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₃ | <input type="checkbox"/> ₄ | <input type="checkbox"/> ₅ |

SECTION E: Patient Safety Grade

Please give your work area/unit in this hospital an overall grade on patient safety.

- | | | | | |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| A | B | C | D | E |
| Excellent | Very Good | Acceptable | Poor | Failing |

SECTION F: Your Hospital

Please indicate your agreement or disagreement with the following statements about your hospital.

Think about your hospital...	Strongly Disagree ▼	Disagree ▼	Neither ▼	Agree ▼	Strongly Agree ▼
1. Hospital management provides a work climate that promotes patient safety	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
2. Hospital units do not coordinate well with each other	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
3. Things “fall between the cracks” when transferring patients from one unit to another	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
4. There is good cooperation among hospital units that need to work together	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅

SECTION F: Your Hospital (continued)

Think about your hospital...	Strongly Disagree ▼	Disagree ▼	Neither ▼	Agree ▼	Strongly Agree ▼
5. Important patient care information is often lost during shift changes	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
6. It is often unpleasant to work with staff from other hospital units	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
7. Problems often occur in the exchange of information across hospital units	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
8. The actions of hospital management show that patient safety is a top priority	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
9. Hospital management seems interested in patient safety only after an adverse event happens	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
10. Hospital units work well together to provide the best care for patients	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
11. Shift changes are problematic for patients in this hospital	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅

SECTION G: Number of Events Reported

In the past 12 months, how many event reports have you filled out and submitted?

- | | |
|--|--|
| <input type="checkbox"/> a. No event reports | <input type="checkbox"/> d. 6 to 10 event reports |
| <input type="checkbox"/> b. 1 to 2 event reports | <input type="checkbox"/> e. 11 to 20 event reports |
| <input type="checkbox"/> c. 3 to 5 event reports | <input type="checkbox"/> f. 21 event reports or more |

SECTION H: Background Information

This information will help in the analysis of the survey results.

1. How long have you worked in this hospital?

- | | |
|--|--|
| <input type="checkbox"/> a. Less than 1 year | <input type="checkbox"/> d. 11 to 15 years |
|--|--|

- b. 1 to 5 years
- c. 6 to 10 years
- e. 16 to 20 years
- f. 21 years or more

2. How long have you worked in your current hospital work area/unit?

- a. Less than 1 year
- b. 1 to 5 years
- c. 6 to 10 years
- d. 11 to 15 years
- e. 16 to 20 years
- f. 21 years or more

3. Typically, how many hours per week do you work in this hospital?

- a. Less than 20 hours per week
- b. 20 to 39 hours per week
- c. 40 to 59 hours per week
- d. 60 to 79 hours per week
- e. 80 to 99 hours per week
- f. 100 hours per week or more

SECTION H: Background Information (continued)

4. What is your staff position in this hospital? Select ONE answer that best describes your staff position.

- a. Registered Nurse
- b. Physician Assistant/Nurse Practitioner
- c. LVN/LPN
- d. Patient Care Asst/Hospital Aide/Care Partner
- e. Attending/Staff Physician
- f. Resident Physician/Physician in Training
- g. Pharmacist
- h. Dietician
- i. Unit Assistant/Clerk/Secretary
- j. Respiratory Therapist
- k. Physical, Occupational, or Speech Therapist
- l. Technician (e.g., EKG, Lab, Radiology)
- m. Administration/Management
- n. Other, please specify:

5. In your staff position, do you typically have direct interaction or contact with patients?

- a. YES, I typically have direct interaction or contact with patients.
- b. NO, I typically do NOT have direct interaction or contact with patients.

6. How long have you worked in your current specialty or profession?

- a. Less than 1 year
- b. 1 to 5 years
- c. 6 to 10 years
- d. 11 to 15 years
- e. 16 to 20 years
- f. 21 years or more

SECTION I: Your Comments

Please feel free to write any comments about patient safety, error, or event reporting in your hospital.

THANK YOU FOR COMPLETING THIS SURVEY.

Appendix B

PATIENT STICKER HERE



DO NOT COPY. DO NOT INCLUDE IN MEDICAL RECORD.

POST FALL HUDDLE

Date		Room or Location		Time of last patient contact	
Time		Fall Score at time of fall			

Contributing Factors to the Fall:

Bed Alarm not on	Bed in high position	Obstacles in path	Chair wheels not locked
Tripped	Slipped	Wet floor	Ambulating without assistance
Legs "gave out"	Patient equipment	Bed wheels not locked	Toileting without assistance
Other (state reason):			

What fall precautions were in place that did not prevent the fall:

Bed alarm on	Call light in reach	2 hr comfort rounds	Able to use call light
Bed in low position	Pathways clear	Non-skid footwear	Night light in use
Bed wheels locked	Adequate lighting	Commode at bedside	Mattress placed on floor
Non-exit side rails up	Personal items in reach		Chair alarm on
Oriented to surroundings	Furniture/equip placed to facilitate mobility		Chair wheels locked
Patient instructed to call for assistance	Gait belt used, if appropriate		

Documentation shows appropriate interventions with patient change in condition: Yes No

Care Plan modified with condition change Yes No

Hourly rounds done and documented each hour? Yes No

Last time offered toileting? _____

When was the patient last offered fluids? (if applicable) _____

What fall precautions were put in place to prevent future falls:

Bed alarm on	Call light in reach	2 hr comfort rounds	Able to use call light
Bed in low position	Pathways clear	Non-skid footwear	Night light in use
Bed wheels locked	Adequate lighting	Commode at bedside	Mattress placed on floor
Non-exit side rails up	Personal items in reach		Chair alarm on
Oriented to surroundings	Furniture/equip placed to facilitate mobility		Chair wheels locked
Patient instructed to call for assistance	Gait belt used, if appropriate		Enclosed Bed

Members Present:

Appendix C

Skid socks on.



All items within reach.

(call light, personal belongings)

Footpath clear of obstacles.

Ensure all needs are met.

Appendix D

Fall Prevention Staff Education

Definition of a fall:

- ❖ An adult fall is defined as any unplanned descent to the floor with or without injury to the patient.
- ❖ A pediatric fall is defined as any unplanned descent to the floor with or without injury to the patient as developmentally appropriate.

Why is it important?

- ❖ Patient's who fall typically have longer stays in the hospital.
- ❖ Falls are avoidable and preventable.
- ❖ Falls lead to injuries as minimal as bruising to fractured bones or even death.
- ❖ Falls are costly to not only the patient, but the hospital.
- ❖ Medicare and Medicaid will not reimburse hospitals if a patient sustains an injury in the hospital due to a fall.

Prior to leaving the patient's room all staff will ensure fall prevention interventions are in place, these include:

- Leave the bed in lowest position with wheels locked
- Bed alarm on
- Patient is wearing non-skid footwear
- Leave upper bed rails raised, and lower rail on the non-exit side raised
- Clear the pathway to the bathroom/bedside commode/ urinal
- Remind the patient to ask for assistance before getting out of bed
- Move the bedside table within patient's reach
- Keep personal items (glasses, hearing aid, etc.) within reach

Our project:

We will be posting fall prevention reminder posters in all patient rooms, staff bathrooms and break rooms. We hope that these will provide staff as well as families and visitors with simple reminders of things that can easily be done to prevent falls. We are comparing falls from the past year, 2013, to the falls of 2014. We are hoping that the "reminder posters" put in place will decrease the number of falls. Any feedback from the nursing staff would be much appreciated. You can contact us at lmalexan@uark.edu or sabrock@uark.edu.

Resources:

Washington Regional Policies and Procedures. Policy #WRMS-CS5.06

Dykes, P., Carroll, D., McColgan, K., Hurley, A., Lipsitz, S., Colombo, L., & ... Middleton, B. (2011). Scales for assessing self-efficacy of nurses and assistants for preventing falls. *Journal Of Advanced Nursing*, 67(2), 438-449. doi:10.1111/j.1365-2648.2010.05501.x

Ganz, D. A., Huang, C., Saliba, D., & al., e. (2013, January). *Preventing falls in hospitals: A toolkit for improving quality of care*. Retrieved from Agency for Healthcare Research and Quality: <http://www.ahrq.gov/professionals/systems/hospital/fallpxtoolkit/fallpxtoolkit.pdf>