

Stop And Check

A Falls Reduction And Prevention Strategy On An Inpatient Nephrology/Neurology/Medicine Unit

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Introduction

During 2006, it was identified that patient falls on the Nephrology/Neurology/Medicine unit (2B) were increasing. An organized and structured plan to identify patients at greatest risk was required as well as the implementation of strategies to help reduce and/or prevent falls. An evaluation process was also required to determine the effectiveness of the strategies implemented.

Process

A core group of front-line nurses from Unit 2B met to review our patient safety and satisfaction statistical data. Patient falls were identified as an area in which the nurses believed we could develop and implement an initiative which would help identify patients at greatest risk and improve patient safety.

Stop and Check was born!

Identification Of Patients At Risk For Falls

Identification of patients at greatest risk can be determined by any member of the interdisciplinary team. The criterion used includes:

- Clinical judgment
- Diagnosis, including but not limited to:
 - Dementia
 - Delirium
 - Confusion
 - Agitation
 - Visual Impairment
 - Neurological deficits (CVA, TIA)
 - Physical Impairment
- Age is not a determining factor

Implementation

A visual prompt "Stop and Check" sign is used to identify the room and patient location. Any member of the interdisciplinary team can identify a patient at risk. They then place the Stop and Check sign on the doorway, and above the patient bed in a semi- or ward room, to identify that a patient at risk of falling is in that room. This visual prompt was designed as a proto-type by front-line nurses using wood, paint and Velcro.

An education rollout to the interdisciplinary team was developed outlining the specifics of the strategy, the signage, where and when to apply it, and the responsibilities of each team member.

Implementation - cont.

Whenever a member of the interdisciplinary team pass a doorway where the Stop and Check sign is in place, they are required to visually observe the patient to ensure that the patient is safe.

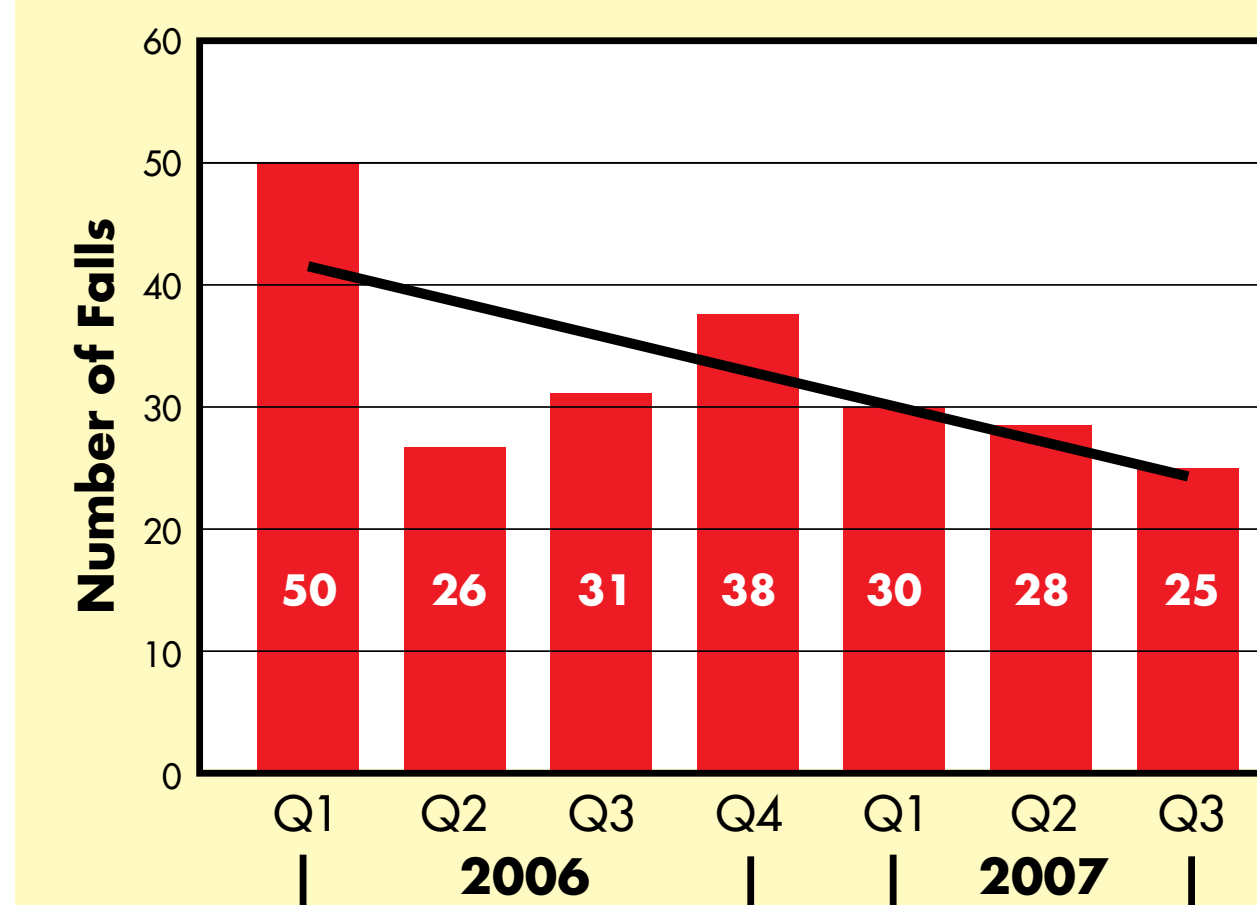
Fall minimization techniques are also employed (low rise beds, landing mats, relocation for increased observation, etc.).

Falls are tracked through the Risk MonitorPro® safety event reporting system using the category - Safety Precautions in place at the time of the fall.

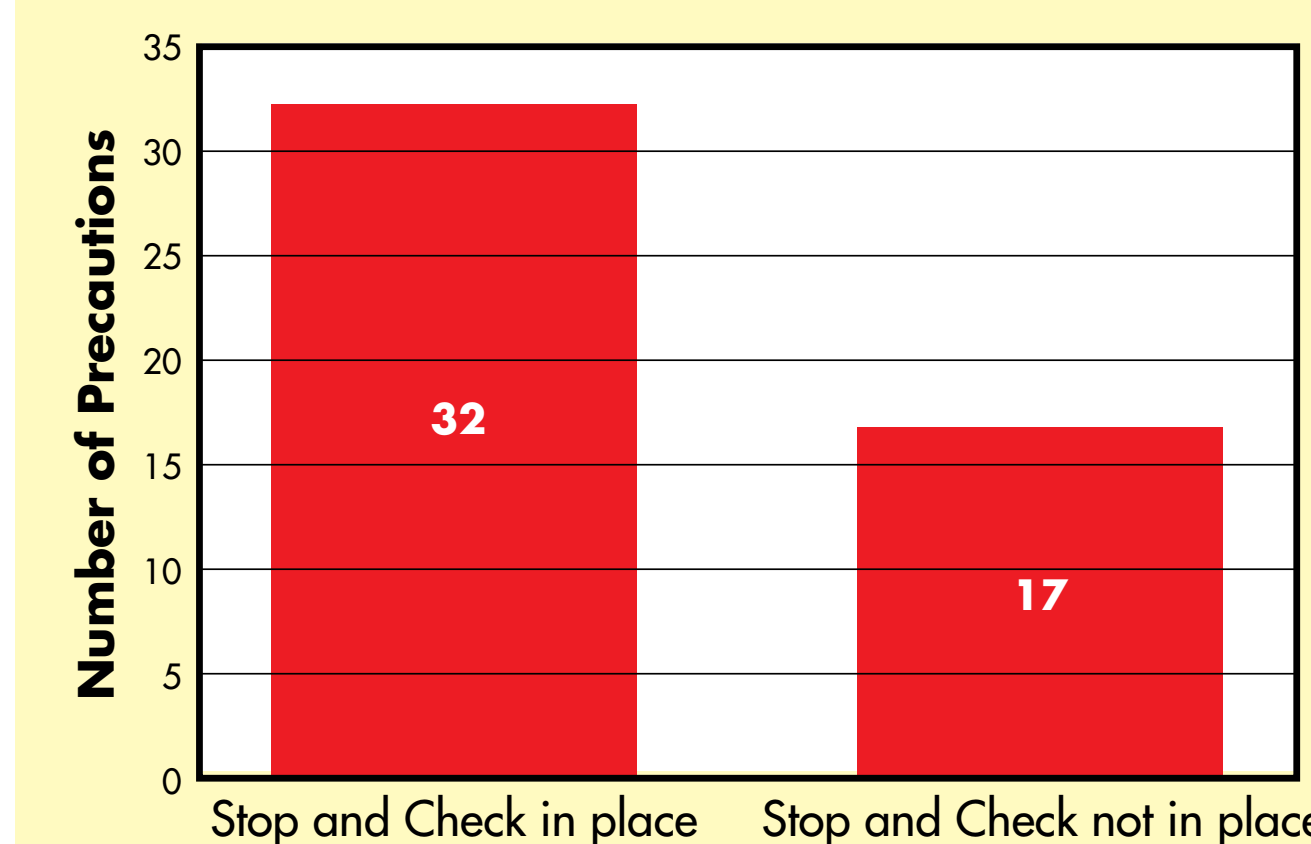
Evaluation And Comments

This strategy has increased the knowledge of fall management techniques on the unit as it was developed and implemented by front-line nurses. Since the implementation of the Stop and Check signage, there has been an increased awareness that fall prevention is the responsibility of all members of the team.

Families have reported decreased anxiety knowing that there are many eyes watching the patient to prevent or reduce falls.



Statistical data reviewed monthly/quarterly and shared with the team has supported the strategy initiative in showing that falls from the first quarter 2006 compared to the first quarter 2007 declined by 40%.



Data is also reviewed from Risk MonitorPro® using the category "Safety Precautions in Place at Time of Fall". The categories "Stop and Check in Place" and "Stop and Check not in Place" were added to our data collection in March 2007 to reflect the use of the initiative. Each fall is reviewed to determine if the initiative had been used correctly and if there was/is anything else we can do to decrease falls.

While Stop and Check increases awareness for the risk of patient falls, it will not prevent patient falls. Fall severity is tracked through Risk MonitorPro®. While most falls are Level 2 (Minor), there were three Level 3 (Serious) falls in 2006 and only one in 2007. In this case, it was a repeat fall resulting in a fractured hip and prolonged hospitalization. Stop and Check, as well as all other fall prevention initiatives had been in place throughout.

Severity Levels for Safety Events

Level 0 - Departmental

Departmentally identified issue that is not directly patient-related (e.g. inventory or process issue; narcotic count discrepancies; expired inventory).

Level 1 - Near Miss

A safety event that almost or could have happened that would have potentially caused harm, loss or damage to a patient/visitor. There was no impact on the patient/visitor. (e.g. a mislabelled specimen identified before being processed).

Level 2 - Minor

A safety event causes minor or no permanent physical injury, reaction or damage to a patient/visitor (e.g. mislabelled specimen processed; left knee x-rayed when a right hip was ordered; a fall resulting in no or minimal injury).

Level 3 - Serious

A safety event that causes stress, anxiety or an unexpected permanent outcome to a patient/visitor and requires further investigation or treatment (e.g. mislabelled specimen processed & a treatment provided that was not required).

Level 4 - Catastrophic

A safety event that causes an unexpected negative outcome, excessive anxiety or stress, permanent loss, disability, death or mis-diagnosis (e.g. wrong operation is performed; patient dies or has permanent loss of function (sensory, motor, physiological)).

Future Implications

Development of a formalized standard screening assessment tool and policies and procedures for an Inpatient "Stop and Check: Falls Prevention/Reduction Program" — currently under development by an interdisciplinary Falls Prevention Committee.

Develop and produce a Stop and Check sign which is durable and meets Infection Control guidelines and can be mass produced for use across the hospital.

Roll-out the Stop and Check Program across the hospital.

Continued education for the interdisciplinary team, patients and families.

On-going review and analysis of statistical data through Risk MonitorPro®. Stop and Check sign is in place, they are required to visually observe the patient to ensure that the patient is safe.

Fall minimization techniques are also employed (low rise beds, landing mats, relocation for increased observation, etc.).

Falls are tracked through the Risk MonitorPro® safety event reporting system using the category — Safety Precautions in place at the time of the fall.

We wish to thank the staff and interdisciplinary team from 2B for their on-going commitment and support to patient safety and this initiative and to the staff in Quality & Risk Management for their assistance with data collection and evaluation.