Reduction of Injuries Related to Falls on Transitional Care Unit FY2005

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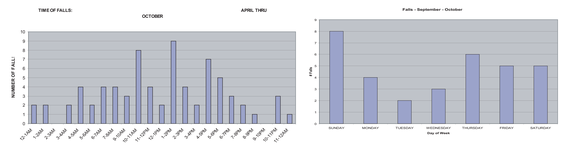
Problems Identified

~ Increased fall rate: 6.5 to 15 by 2nd quarter FY 05
~ Benchmark was 5.5 VA National Fall Rate
~ Several serious injuries within short time
~ Increased number of other hospital staff assigned to cover (floated)

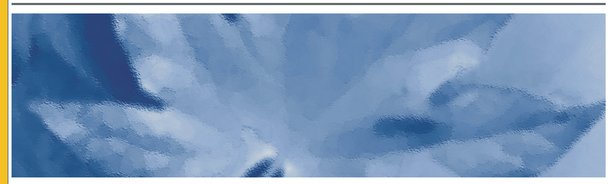
Process to Identify Causes

~ Aggregate RCA on TCU falls-included frontline staff
~ Single RCA
~ Brainstorming with Geriatric Leadership and frontline staff
~ Online literature research

Drill Down



Studied upward trends compared to staffing patterns:
~ Staff call-ins, days off
~ Looked at historical data on time of falls and days of the week
~ Noted sufficient increases with falls when acute care staff was assigned to TCU
~ Identified inconsistent approaches from acute to long term care with residents identified at risk for falls



Action Plan

~ Revised Fall Prevention Plan included leadership approval of 24 adjustable height beds
~ Changes in staff assignment sheet to highlight residents at risk for falls
~ Communication book for each team
~ Changing the mix of staff on 12-8 shift
~ Re-education of incontinence program
~ Re-education of the Morse Fall Scale
~ Staff education on using "who, what, where, when and how" when reporting a fall
~ Hospital-Wide Fall Prevention Program
~ Post fall note in electronic medical record

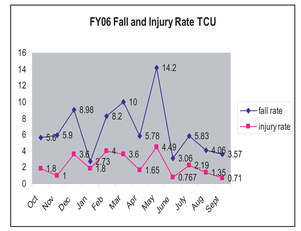
Lending Eyes and Ears Against Falls

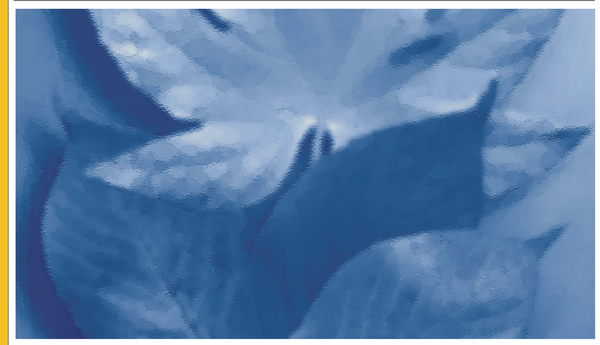
~ LEEAF
~ Hospital-wide program- all wards
~ Residents/patients are assessed with the Morse Fall Scale to determine if at risk for falls on admission, transfer and when they do have a fall
~ Pts who are a fall risk are identified with a green ID band
~ A laminated leaf is placed on the outside of the patient's room to alert all staff, the patient is at risk of falling
~ Signs are in patient's rooms alerting visitors to help prevent falls

~ Beds can be lowered to 6 inches located on TCU and on acute care units
~ Personal alarms to alert staff
~ Landing strip mats to cushion a fall.

Great Results

~ Decreased number of falls on the 12-8 shift
~ Decreased fall rate and injury rate for FY06
~ No serious injuries related to falls for FY06





Efforts Don't Stop

Still rolling out increased awareness:
~ E-mails to staff on general safety tips
~ Purchased Bedfellow Positioning Pillows
~ Increased pharmacy input to avoid falls
~ Hospital-wide Fall Prevention Education Days presented by Fall Prevention Team members
~ Assessing resident/patient bathrooms including lighting : bathroom is our number one location for falls FY06

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