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Evidence-Based Fall Prevention Strategies for MU Healthcare

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Pediatric:
-Many pediatric falls go unreported (Schaffer et al., 2011)
-Be sure to document near miss falls and situational details of falls (developmental level, age, degree of injury, supervision, pharmacological factors) to identify patterns (Wenger & Dufek, 2013)
-Address the momentary nature of pediatric falls to create better predictors of pediatric falls and ultimately more detailed and improved fall prevention strategies (Wegner & Dufek, 2013)
-Hospitals can collaborate and share their data to create a more comprehensive understanding of pediatric falls (Kingston et al., 2010)

Critical Care:
-Major contributing factor to falls in the ICU: delirium (Mullin et al., 2011)
-Communicate safety issues, delirium, and narcotic pain control in shift report (Mullin et al., 2011)
-Increase staff compliance on fall prevention protocol, routinely round on patients, and show the patient how to use their call light each shift (Mullin et al., 2011)
-let the patient dangle before getting up and secure all tubes, cables, and bags when walking (Flanders et al., 2009).
-Incorporate the use of an ICU-specific fall assessment tool-the Tyndall Bailey Falls Risk Assessment Tool (Tyndall et al., 2020).

Emergency Department:
-Incorporate nurse judgment when assessing for fall risk using the KINDER-1 Fall Risk Assessment tool (Cook et al., 2020)
-Allowed nurse-driven high fall risk protocol that included video monitoring, bed alarms, and live observers (Cook et al., 2020)
-Assign a PT to the ED to perform gait assessments to determine patients at risk for falls (Goldberg et al., 2020)
-Have a pharmacist review current medications to determine if polypharmacy was a factor and provide recommendations for medication adjustments (Goldberg et al., 2020)
-Overall research shows Interdisciplinary approach is effective at reducing falls

Perioperative:
-Perioperative RNs should perform and document a thorough preoperative nursing assessment that includes a patient's risk for falling (Denholm, 2008)
Be especially vigilant during transport and transfer; use wheel locking mechanisms, side rails, and safety straps (Denholm, 2008)
-Priority nursing actions for preventing falls: controlling the environment (bed rails, clear pathways) and educating staff, patients, and families (Chaves et al., 2020)
-OR Postoperative Debrief Project found that debriefing enhanced OR safety culture and identified inefficiencies and adverse events; staff consistently participated in the meetings (Magill et al., 2017)

Does debriefing with interdisciplinary staff after a fall incident as compared to not debriefing reduce fall rates?

- Debriefing provides an opportunity for a fall safety team to encourage communication and involvement of frontline staff and raise situational awareness which help decrease risk for falls
- A successful huddle accurately confirms facts, allows immediate response, and facilitates communication and can be used as an effective learning tool
- Debriefing allows for rapid identification of factors that contributed to the fall and implementation of additional safety interventions if necessary
- Post-fall huddles lead to more positive perceptions of teamwork among staff and improve attitudes toward patient safety, enhancing safety culture (Magill et al., 2017)

Medical-Surgical:
-Utilize a post fall safety team responsible for responding to falls, completing the post-fall assessment checklist, making recommendations and tailoring interventions using TeamSTEPPS framework
-Use the 4 P's (Presage, Planning, Process and Product) to create standardized post-fall reporting
-Post-fall huddles should include specific details about the fall, questions to identify root causes of the fall, and questions about patient perspective of the fall. A leader who knows the patient population and is available should lead the huddle.
-Huddles should facilitate honesty and engagement with staff to encourage open discussion and allow feedback and concerns to be voiced

Psychiatric:
-Psychiatric patients have unique risk factors, such as altered mental state, psychoactive medications, and increased mobility within inpatient units.
-Focus on routine screening of modifiable risk factors (poor mobility, confusion, sedative medication or continence problems, etc.) and implement interventions that specifically target these risk factors.
-Non-adherence to fall prevention policies is the cause of many falls. Provide consistent, high quality education to staff regarding psychiatric falls to reduce fall rates.

Perinatal:
-Are fall risks for short amounts of time (such as until an epidural wears off) (Gaffey, 2015)
-Use the Egress Test to evaluate patients' readiness to begin ambulating (Gaffey, 2015)
-Engage the patient in fall prevention strategies (have patients sign a letter agreeing to use the call light when they need to get up) (Lockwood and Anderson, 2013)
-Baby drops can be reduced with the Newborn Fall Safety Bundle that includes education about drop risk factors, baby drop prevention posters in mothers' rooms, signed nurse-mother safety plans, hourly nurse rounding, Boppy pillow use to assist with positioning during feeds, intentionally discouraging co-sleeping, and debriefing after drops (Miner, 2019)

Recommendations for Practice: *MU Healthcare should identify leaders who have patient contact in each unit who are responsible for conducting post-fall debriefs and initiate a policy with a standardized debriefing tool to be used within a few hours of each fall.*

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