Fast Track to Fall Prevention
Product + Process = Prevention
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The Stryker Fall Prevention Program combines technology, education, and partnership to help hospitals minimize the risk of falls. Our program provides a systematic means to educate clinical staff on the conditions that can lead to a fall incident, along with evidence-based processes and technologies designed to help reduce the risk of patient falls. The program provides methods to assess and address patient risk factors in an effort to minimize the risk of falls during hospitalization and after discharge.1

Fall Prevention Program

- Fall Prevention Workbook featuring the latest evidence-based information on patient fall prevention
- Staff education including product and process training
- Complimentary Fall Prevention Online CEU Program
- Fall audit tool
- Sample post-fall huddle tool

Expected Outcomes and Results1,2,3

Effective inpatient fall prevention programs are multifaceted and require multiple efforts from the entire health care organization to successfully prevent inpatient falls. When caregivers follow evidence-based behaviors and procedures, which include the appropriate use of bed technology, the following results are achievable:

- Safety: Lower incidence of patient falls
- Satisfaction: Increase in perception of care (HCAHPS)
- Efficiency: Increase in caregiver compliance, satisfaction, and engagement
- Protection: Improved financial results related to risk avoidance and nonreimbursable hospital-acquired conditions

Falls in the Emergency Department4

Stryker realizes that falls are not only an inpatient issue and that they also occur in the emergency department (ED). Frequently, EDs are crowded places where events happen quickly and often with unpredictability. There is a great potential for patients to fall in such environments. Hospital falls are recognized as an important patient safety issue and are the most common adverse reportable event.

- What are your fall prevention best practices? (Please check all that apply)
  - Yellow arm band
  - Yellow socks
  - Yellow blanket
  - Sign on door
  - Sign in room
  - Sign on census board at nurses station
  - Bed exit alarm
  - What bed exit zone is recommended?__________
  - Low bed height
  - Brake set
  - How many side rails should be up? (Per policy)__________
  - Call light within reach
  - Are beds integrated into the nurse call system?
  - Clutter-free environment
  - Hourly rounding
  - Place high fall-risk patients close to nurses’ station
  - Post-fall huddles
  - Fall prevention devices (floor mats, hip protectors, helmets)
  - Other

- What is the definition of a fall in your facility?

- Who does your facility report their falls to? (NDNQI, CALNOC, etc?)

- What fall risk-assessment tool does your facility use?
  - Morse
  - Hendrich
  - Schmid
  - Johns Hopkins
  - KINDER1 (for ED)
  - Other

- What unit that has the highest fall rates in your facility?__________

- Who is the director/manager of that unit?__________

- What are your fall rates for the past year or 6 months? (Per 1000 patient days)__________
• Where are most of your falls happening?
  - Bathroom related
  - Bed related
  - In the room
  - In the hall
  - Procedure
  - Transport
  - Other

• Do you have a Falls Committee?
  - Yes
  - No

• Who is represented on your Falls Committee?
  - Nursing administration
  - Nurse managers
  - Nurse educators
  - Nursing staff
  - CNAs/PCTs
  - Risk management/patient safety officer/quality
  - PT/OT
  - Transportation department
  - Pharmacy
  - Biomed/engineering
  - EVS
  - Dietary
  - Materials management
  - Other

• What kind of beds do you have in your facility?

• Does your facility use low beds?
  - Yes
  - No

• Do you rent them or own them?
SAMPLE POST-FALL HUDDLE TOOL

- The post-fall huddle tool should be completed within 1 hour of a fall.
- Capturing the data immediately is more efficient in capturing all the data.
- The post-fall huddle can include the nurse, patient, family members, techs/CNA’s, pharmacy, nurse manager, PT, OT, and other departments involved in the care of the patient.

SITUATION

Date of fall: __________________________ Time of fall: __________________________

Witnessed or unwatched: ____________________________ By whom: ____________________________

Assisted or unassisted: ____________________________ By whom: ____________________________

Location of fall (bed, chair, bathroom, hall, procedure): __________________________

What was the patient doing prior to the fall?

- Accidental
- Anticipated/Physiological
- Unanticipated/Physiological
- Intentional

Was the patient a high fall risk prior to the fall?  Yes  No  Score: __________________________

What type of risk-assessment tool was used? __________________________

Has the patient fallen previously during this stay?  Yes  No

What is the fall risk score after the fall? __________________________

Was there a sitter in the room?  Yes  No  Was the patient restrained?  Yes  No

When was the last time the patient was rounded on? __________________________

What items were checked during rounds?

- Pain
- Potty Time: __________________________
- Position
- Possessions

HISTORY

Diagnosis prior to the fall: __________________________

Was patient oriented prior to the fall? __________________________

Abnormal labs prior to the fall: __________________________

Was the patient at high risk for injury (ABCS)?  Age 85+  Brittle bones  Coagulation

- Post-op surgery

Bed/chair alarm on: Yes  No

Patient/family given fall prevention education prior to the fall: Yes  No

ASSESSMENT

Pain level after fall: __________________________ Location of pain: __________________________

Injury after fall:  Yes  No

Change in LOC:  Yes  No

VS prior to fall: BP: ______  HR: ______  RESP RATE: ______  TEMP: ______

O2 Saturation: ______

VS after fall: BP: ______  HR: ______  RESP RATE: ______  TEMP: ______

O2 Saturation: ______

Glasgow Coma Scale: ______

ANALYSIS AND ACTION

Was MD notified?  Yes  No

Date and Time MD notified: __________________________

Orders: __________________________

Was Pharmacy notified?  Yes  No

What is the follow-up plan?

What is being done to prevent a fall by this patient in the future?

- Low bed
- Bed/chair alarm
- 1:1
- Patient/family education
- Staff education
- PT/OT consults
- Pharmacy re-evaluation of medications
- Other: __________________________

What protocol or system problems occurred that need to be communicated to other units or disciplines? __________________________

PARTICIPANTS OF POST-FALL HUDDLE

- Patient
- Family
- Primary RN
- Charge RN
- PCT/CNA
- Nurse Manager
- House Supervisor
- PT/OT/PTA
- Pharmacy
- Physician
- Quality Improvement/Patient Safety/Risk Management
- Other
REFERENCES:


