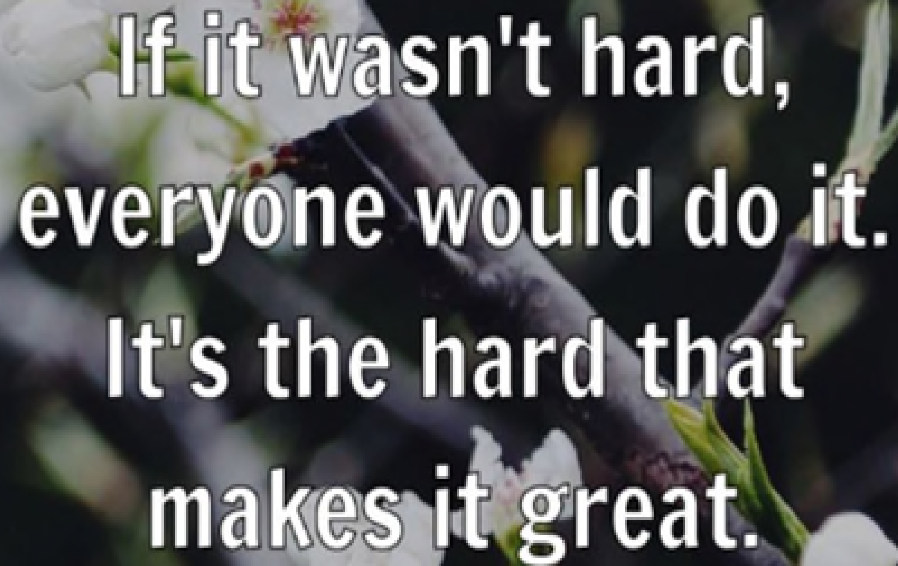
Fall Prevention

The Falling LEAF Program

CHI St. Joseph Flaget - Medical Surgical Unit

Project Leader: Paige Holt, BSN, RN

Project Team Members:
Jacki Olson, MSN, RN, MSCRN
Maria Lawson, RN


If it wasn't hard,
everyone would do it.
It's the hard that
makes it great.
Tom Hanks

It Was Time To Make a CHANGE!

In 2019 2 patient incidents resulted in major harm, both were results from falls.

Patient #1 was diagnosed with a cerebral hemorrhage

Patient #2 was diagnosed with bilateral wrist fractures

Action Needed

Engage the Medical Surgical Unit staff with initiation of fall prevention interventions to provide heightened awareness of Fall Prevention.

Motivate staff to participate in data collection and education surrounding the Fall PI Project by providing the "why" behind our efforts in decreasing falls and preventing patient injury falls.

Implement fall prevention interventions that are accessible, direct and patient centered on the Medical Surgical Unit at Flaget Hospital in an effort to reduce the number of patient falls and eliminate patient injury falls.

Contributing Factors

01	Alarm Management	• Bed and/or chair alarm NOT in use or NOT activated
02	Toileting	• Leaving patients unattended during toileting sessions
03	Patient Confusion	• Patients ambulating without calling for assistance
04	Incorrect Fall Risk Score	• Morse Fall Risk score NOT appropriately updated

Intervention: Alarm Use and Access

Chair alarms purchased for all patient rooms. Alarms were stored in bedside tables for easy access. Fall mats purchased for use with high fall risk patients in an effort to cushion a potential fall.

Intervention: Safe Toileting

The Falling LEAF Program was initiated to provide a visual fall risk tool for staff recognition prior to entering the patient's room. The Falling LEAF Program also implemented the practice of staff remaining with all confused, or high fall risk patients during toileting sessions.

The Falling LEAF Program

Patient Indications:

1. **Morse Fall Risk Score: >65**
2. **Confusion or Known Dementia**
3. **Non-Compliance with Fall Prevention Instructions**

Interventions:

- **Stay with Patient While Toileting**
- **Bed/Chair Alarm in Use**
- **Keep Room Door Open**
- **1-2 Assist with Activity**
- **Gait Belt with Ambulation/Transfers**
- **PT Evaluation Order Needed**

Patient Indications:

1. **Morse Fall Risk Score: 21-64**

Interventions:

- **Bed/chair alarm PRN**
- **Keep door open**
- **Gait belt use with ambulation**
- **1 assist**
- **Assistive device use PRN, walkers for all orthopedic patients**

Patient Indications:

1. **Morse Fall Risk Score: 0-20**

Interventions:

- **Saline/Hep Lock IV**
- **Stand by Assist**
- **Encourage to Use Call Light for Assistance**

Intervention: Visual Reminders

“Call Don’t Fall” ceiling tile signs installed above all patient beds. The ceiling tiles serve as a visual reminder for the patient to “call” for assistance before getting out of the bed.

Intervention: Fall Mats

Cushion impact from inevitable falls in an effort to prevent patient injury

Intervention: Accurate Fall Risk Score

Morse Fall Risk documentation mandated for nursing staff at 0800 and 2000 to auto prompt nursing to re-assess the patient’s fall risk status.

Data Collection:

What Did We Track?

1 **Random Audits**

Performed random audits of patient fall risk scores and LEAF utilization to ensure proper use of LEAF program.

2 **Fall Data Log**

Data log kept to track all patient falls. Data log included patient name, date and time of fall, injury status, fall risk score at time of fall, staff involved, and the situation surrounding fall.

3 **Unit Data Display**

Displayed number of patient falls, AND number of patient falls resulting in injury on the Medical Surgical Unit.

HOW
ARE
WE
DOING?

Definitions of Harm:

None: resulted in no signs or symptoms of injury as determined by post-fall evaluation (which may include x-ray or CT scan)

Minor: resulted in application of ice or dressing, cleaning of a wound, limb elevation, topical medication, pain, bruise or abrasion

Moderate: resulted in suturing, application of steri-strips or skin glue, splinting, or muscle/joint strain

Major: resulted in surgery, casting, traction, required consultation for neurological (basilar skull fracture, small subdural hematoma) or internal injury (rib fracture, small liver laceration), or patients with any type of fracture regardless of treatment, or patients who have coagulopathy who receive blood products as a result of a fall

Death: the patient died as a result of injuries sustained from the fall (not from physiologic events causing the fall)

FALLS DATA

YEAR	TOTAL	NO HARM	MINOR HARM	MODERATE HARM	MAJOR HARM
2019	16	9	5	0	2
2020	16	11	5	0	0
2021	20	18	1	1	0
2022	13	10	3	0	0

Let's celebrate!

QUESTIONS