Background

At local hospitals:

• 70 falls in 2 units in 2013
• Over 1/2 of the falls were “anticipated”
• One resulted in major injury to a patient
• More than 2/3 occurred while toileting and getting out of bed

• Both local hospitals participate in the Collaborative Alliance for Nursing Outcomes (CALNOC)
Purpose

- To determine the effectiveness of the No One Walks Alone fall prevention program at Hospital A and Hospital B
- This program is part of an on-going study of a national system wide implementation of NOWA
Objectives

• To implement the program in a new Hospital (A) and two units of an existing Hospital (B), to determine efficacy
• To reduce the number of patient falls to zero
• To require all hospital employees follow guidelines set by No One Walks Alone (NOWA)
• To implement nurse hourly rounds to ensure patient safety
• To assume every patient is a fall risk regardless of diagnosis
Methods

• Portions of the program began in December for Hospital A, with the full roll-out beginning March 3\textsuperscript{rd}. Hospital B began with a roll-out on two specific units March 18\textsuperscript{th}.

• Staff were trained using PowerPoint slides and an Epic Healthstream model.

• Continued system data collection by monitoring fall rates over a one month trial period after the start of implementation on March 3\textsuperscript{rd} and 18\textsuperscript{th}.

• All falls are recorded by individual units throughout the hospital.

• Results will be compared with fall rates before implementation of program.
*Policies of the fall program began to be implemented in December 2013, but were not fully implemented until March 3rd, 2014*
Inpatient Falls Hospital B

- Reported Falls
- Falls with Injury

Month, Year:
- Jan, 2013
- Feb, 2013
- Mar, 2013
- Apr, 2013
- May, 2013
- Jun, 2013
- Jul, 2013
- Aug, 2013
- Sep, 2013
- Oct, 2013
- Nov, 2013
- Dec, 2013
- Jan, 2014
- Feb, 2014
- Mar, 2014
- Apr, 2014
Results

• Current data suggests a decrease in fall rates from both hospitals after implementation
• Since full implementation there have been a reported six falls, three of which were when the patient was being assisted
• Study is limited to one month of data
• Results appear to show a decrease in fall rates, however, long term data is needed to determine statistical significance
Recommendations

• Continue monitoring to assess long term effectiveness of the program
• Address patient refusal rates; modified plans may be needed for specialized units such as pediatrics or family birth
• Ongoing interpretation of data to examine the most effective methods of the program in preventing falls
• Implementation of the program hospital-wide in Hospital B
Reference

Authors

James Rollandi, SN
Kirsten Roush, SN
Anna Tran, SN
Emiko Yamaguchi, SN