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Quality Improvement: Preventing Falls in the ED

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Problem & Aim Statement

- **Problem:** Lack of standardized approach to assess for patients at risk of falls

- **Aim:** To identify patients that are at risk of falls in the ED and to implement timely fall prevention interventions

Milestones

- July, 2015 to present
  - Literature review
- October, 2015
  - Goal: To increase completion of tool
  - Chart audits and staff survey
  - Modified the original falls sticker

The Original Tool

FALL RISK ASSESSMENT

Here because of a fall? ☐ YES ☐ NO
Altered mental status? ☐ YES ☐ NO if yes – check appropriate finding:
☐ confusion ☐ disoriented ☐ intoxicated ☐ sedated
Impaired gait? ☐ YES ☐ NO
Recent fall (last 3 months) ☐ YES ☐ NO
Mobility assisted device used? ☐ YES ☐ NO
Frequent elimination (bowel/bladder)? ☐ YES ☐ NO

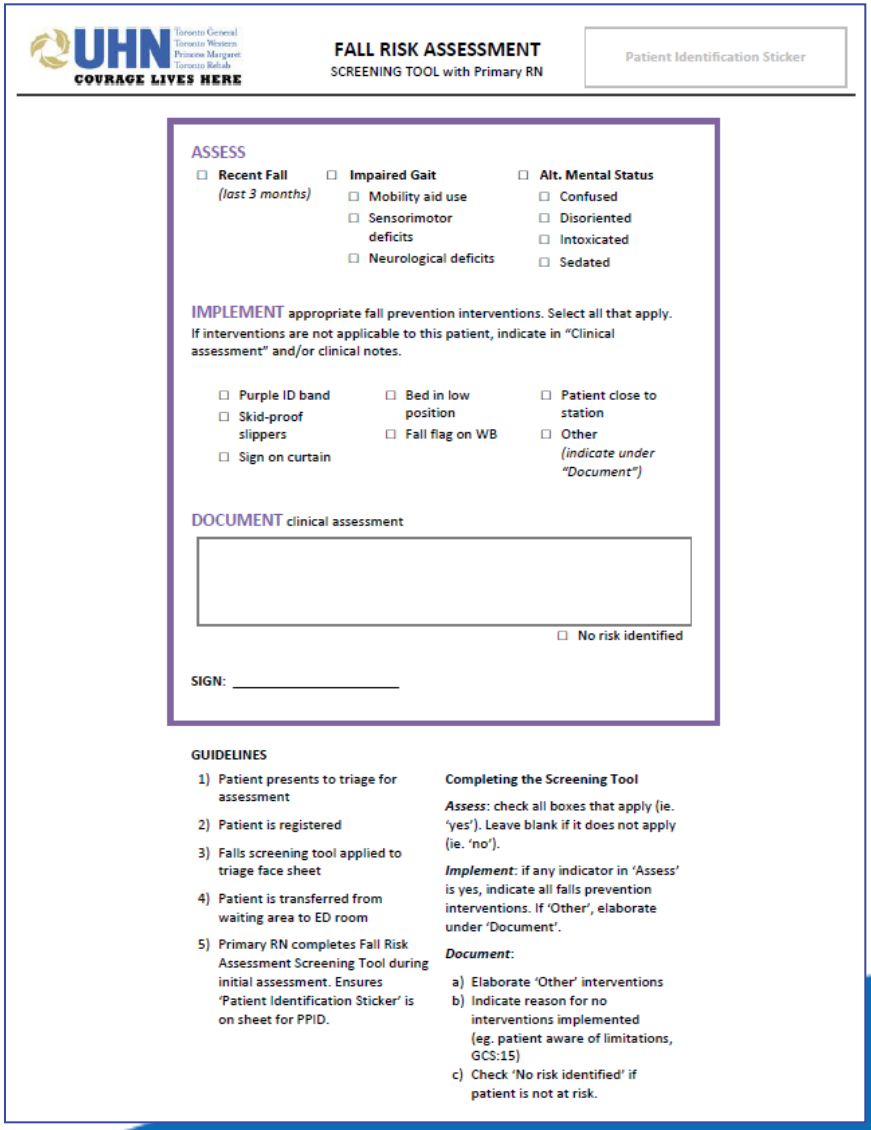
IF YES TO ANY OF THE ABOVE PATIENT IS AT RISK FOR FALLS
☐ **purple ID band**

☐ sign on door/bed ☐ skid proof slippers ☐ fall flag on WB
☐ bed in low position ☐ patient close to nursing station

ASSESSMENT COMPLETED BY:_____

Milestones

- January, 2016
  - Single-paged handout checklist
  - Staff education and real-time feedback



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FALL RISK ASSESSMENT
SCREENING TOOL with Primary RN

Patient Identification Sticker

ASSESS

- ☐ **Recent Fall** *(last 3 months)*
- ☐ **Impaired Gait**
  - ☐ Mobility aid use
  - ☐ Sensorimotor deficits
  - ☐ Neurological deficits
- ☐ **Alt. Mental Status**
  - ☐ Confused
  - ☐ Disoriented
  - ☐ Intoxicated
  - ☐ Sedated

IMPLEMENT appropriate fall prevention interventions. Select all that apply. If interventions are not applicable to this patient, indicate in "Clinical assessment" and/or clinical notes.

- ☐ Purple ID band
- ☐ Skid-proof slippers
- ☐ Sign on curtain
- ☐ Bed in low position
- ☐ Fall flag on WB
- ☐ Patient close to station
- ☐ Other *(indicate under "Document")*

DOCUMENT clinical assessment

☐ No risk identified

SIGN: _____

GUIDELINES

1) Patient presents to triage for assessment
2) Patient is registered
3) Falls screening tool applied to triage face sheet
4) Patient is transferred from waiting area to ED room
5) Primary RN completes Fall Risk Assessment Screening Tool during initial assessment. Ensures 'Patient Identification Sticker' is on sheet for PPID.

Completing the Screening Tool

Assess: check all boxes that apply (ie. 'yes'). Leave blank if it does not apply (ie. 'no').

Implement: if any indicator in 'Assess' is yes, indicate all falls prevention interventions. If 'Other', elaborate under 'Document'.

Document:

a) Elaborate 'Other' interventions
b) Indicate reason for no interventions implemented (eg. patient aware of limitations, GCS:15)
c) Check 'No risk identified' if patient is not at risk.

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Milestones

- February, 2016
  - Chart audits
  - New sticker format
  - Staff education and real-time feedback
- March, 2016
  - Final chart audit
  - Positive feedback from staff

The NEW Falls Screening Tool

ASSESS

- ☐ **Recent Fall** *(last 3 months)*
- ☐ **Impaired Gait**
  - ☐ Mobility aid use
  - ☐ Sensorimotor deficits
  - ☐ Neurological deficits
- ☐ **Mental Status**
  - ☐ Confused
  - ☐ Disoriented
  - ☐ Intoxicated
  - ☐ Sedated
- ☐ **NO RISK IDENTIFIED**

IMPLEMENT appropriate fall prevention interventions.

- ☐ Purple ID band
- ☐ Skid-proof slippers
- ☐ Fall flag on WB
- ☐ Bed in low position
- ☐ Close to nursing station
- ☐ Sign on curtain
- ☐ Other *(indicate under "Document" or clinical notes)*

DOCUMENT clinical assessment

DATE/TIME: _____ **RN SIGNATURE:** _____

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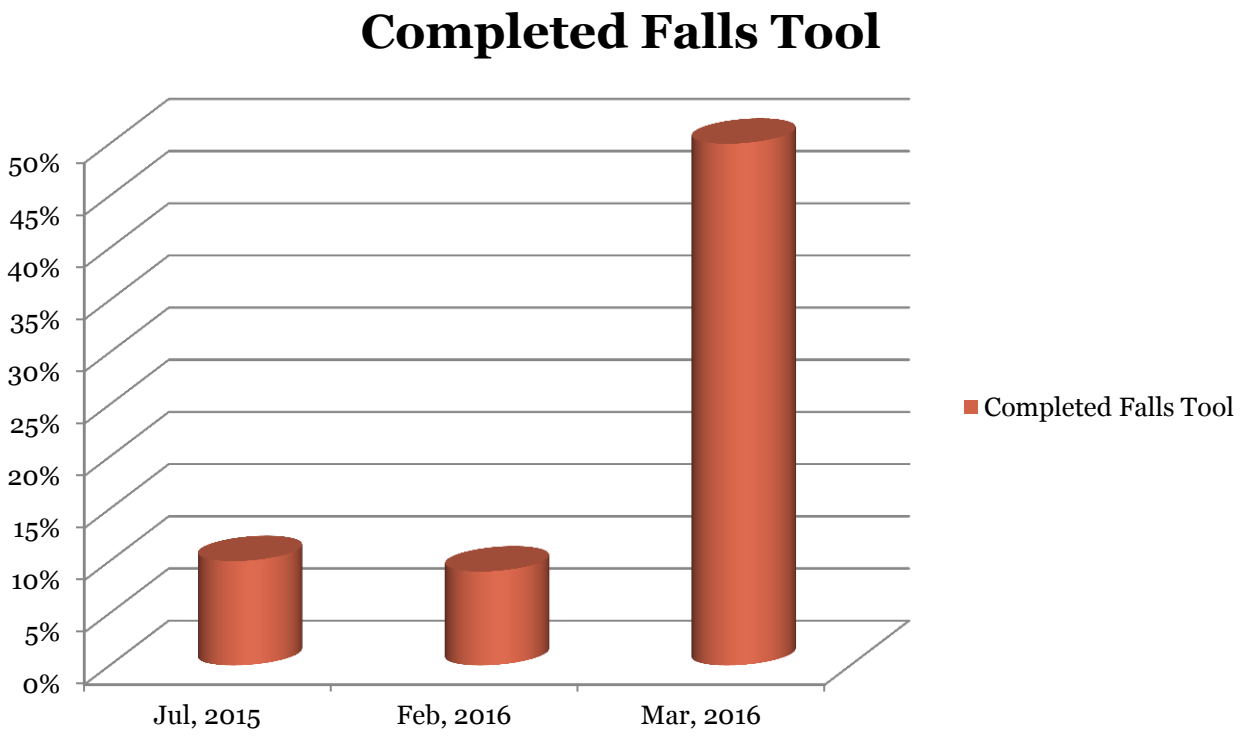
Compliance



- As per chart audits

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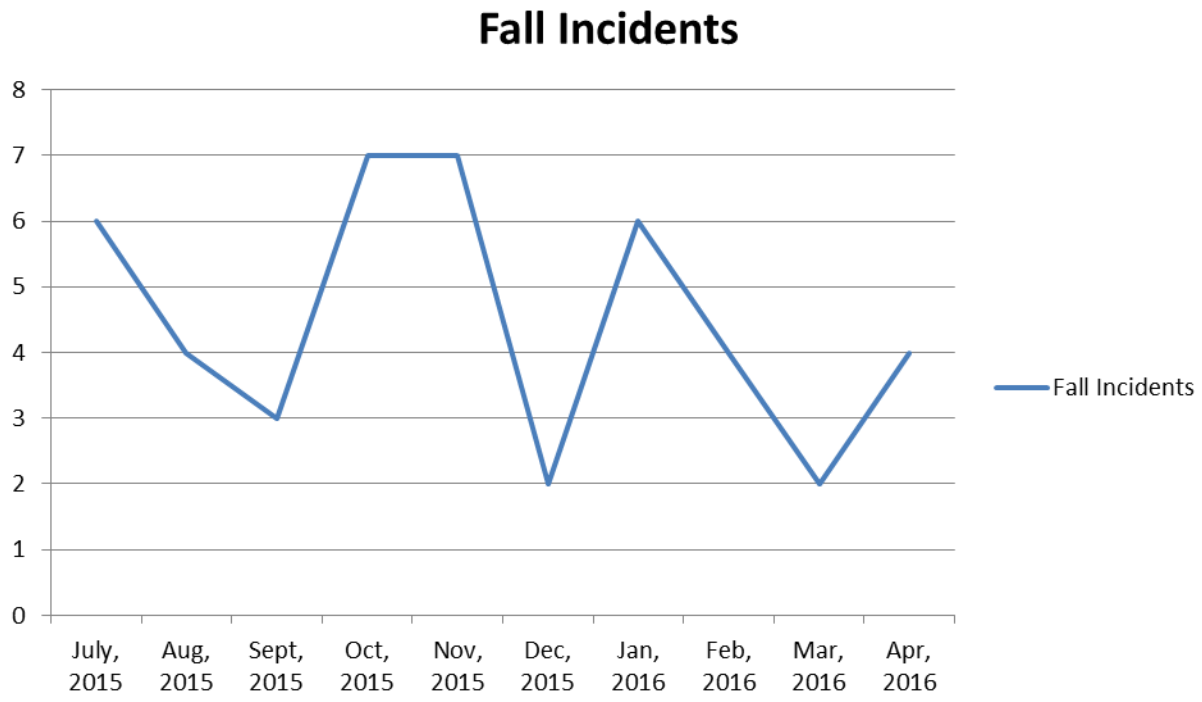
Falls Incidents



- At TWH ED

Next Steps…

- Staff education and reminders
- Nurse champions
- Constructive feedback and Reflective practice