Targeted Multiple Intervention and Tailoring Interventions for Patient Safety (TIPS) Fall Prevention

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Background

- In the US, there are 700,000 to 1,000,000 inpatient fall occurrences each year.[1]
- Approximately 30-50% of inpatient falls cause serious injury resulting in physical, psychological, and financial consequences including pain, additional procedures, and prolonged hospital stays.[2]
- 80% of inpatient falls are preventable with appropriate fall prevention interventions.[3]
- An orthopedic acute care unit reported 14 falls during the 12 months period prior to implementation, with 6 of those occurring in the 3-months.

Objectives

The purpose of this quality improvement (QI) project is to reduce fall occurrences using Targeted Multiple Interventions and Tailoring Interventions for Patient Safety (TIPS) fall prevention strategies.

Short-Term Goals

- 80% of nurses will complete the Fall TIPS poster and use the poster to educate and engage patients.
- 60% of patients and families who participate in the fall TIPS will verbalize their fall risks and tailored interventions.
- Falls will decrease by 25% when compared to the three-month period prior to implementation.

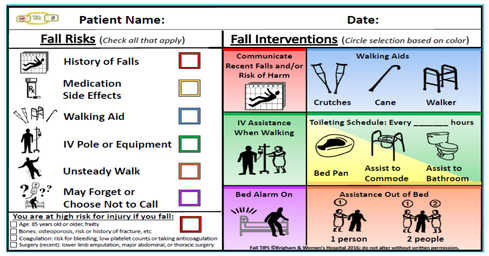
Long-term Goals

- Annual unit falls rate will decrease by 50% compared to the previous twelve months.

Methods

- This QI project was conducted over 11 weeks in an adult orthopedics acute care unit of a large urban medical center.
- Four change champions were identified from day and night shift.
- 91% of staff members received Fall TIPS education and training.
- Patients' and staffs' fall knowledge survey completed pre- and post-implementation.
- Nurses used the Fall TIPS poster as a communication and patient education tool to trigger patient engagement.
- Change champions completed 264 audits to measure nurse's compliance and patient engagement in the Fall TIPS fall prevention process.
- Audit data analyzed using a run chart.
- Change champions offered remedial education to nurses as needed after each audit.
- Huddle time and shared governance meetings were used to increase awareness and compliance rates.
- Bi-weekly progress report were shared with staff.

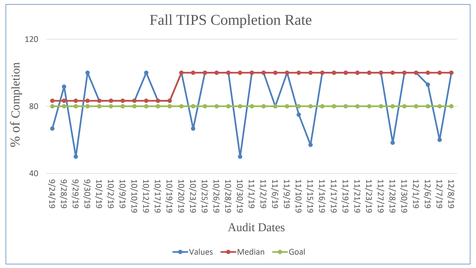
Fall TIPS Poster

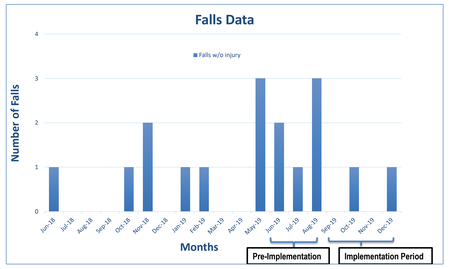


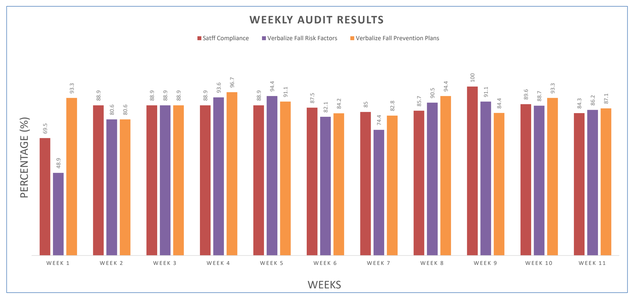
Results

- Patient's fall risks and prevention knowledge significantly improved.
  - Ability to identify fall *Risks* (Pre-mean 3.5; Post-mean 4.3, p=0.001).
  - Ability to identify fall *Preventions* (Pre-mean 3.9; Post- mean 4.5, p=0.001).
- Staffs' fall prevention knowledge improved by 4% (78% to 82%) after education.
- Nurses' compliance and patient engagement.
  - Mean staff compliance rate *87.1%* (Goal 80%).
  - *83.3%* of patients were able to verbalize their fall risks (Goal 60%).
  - *88.8%* of patients were able to verbalize fall prevention plans (Goal 60%).
- There were 2 fall occurrences during the implementation period. The number falls reduced by *66.7%* (Goal 25%) compared to the past three months prior to the implementation.

Figures







Discussion

- The purpose of this project was to reduce falls with effective fall communication and patient engagement.
- The project improved communication between staff, patient/family, and other caregivers.
- Staff adherence to the protocol greatly impacted patient safety.
- The results indicate the Fall TIPS engagement process increased patients' knowledge in the fall risk and prevention plans.
- Program barriers include lack of awareness, forgetfulness, lack of motivation, and resistance to change.
- Data sharing, individual feedback, reminders, and huddle time discussions were effective strategies to overcome these barriers.
- Project outcomes were consistent with conclusions found in the literature reviewed.

Conclusions

- Inpatient falls have significant consequences. Most falls are preventable with appropriate fall interventions.
- The overall results signify the effectiveness of the fall prevention practice.
- Poster completion and patient engagement are key for successful patient outcomes.
- Change champions and charge nurses play a significant role in reminding staff complete the Fall TIPS intervention every shift to sustain the effectiveness of the intervention.

References

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3. France, D., Slayton, J., Moore, S., Domenico, H., Matthews, J., Steaban, R. L., & Choma, N. (2017). Adverse events: A multicomponent fall prevention strategy reduces falls at an academic medical center. *The Joint Commission Journal On Quality And Patient Safety*, *43*460-470. doi:10.1016/j.jcjq.2017.04.006.

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