Managing Falls

Implementation of a three-intervention initiative to improve quality of care for patients with cancer

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BACKGROUND: All healthcare institutions prioritize falls as a major safety issue. Falls are of particular concern on inpatient oncology units where patients are substantially at risk for injury related to falls.

OBJECTIVES: This article describes a multifaceted fall-prevention initiative that can be implemented on oncology units using evidence-based interventions in the key areas of communication, toileting, and hourly rounding. The Visual Rounding Tool for communication around hourly rounding and proactive toileting is also introduced.

METHODS: Based on a root cause analysis and literature review, the inpatient oncology unit–based committee launched a three-intervention initiative, carried out during three consecutive months, to address patient falls.

FINDINGS: Fall rates decreased using the three-intervention initiative. Systematic improvement in processes enabled an increased occurrence of communication between nurses and assistive personnel, increased use of the Visual Rounding Tool for proactive toileting and hourly rounding, and a significant but short-lived decrease in call light use.

KEYWORDS
fall prevention; fall risk; communication; quality of care; toileting; rounding

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ALL HEALTHCARE INSTITUTIONS PRIORITIZE FALLS as a major safety issue that is managed by nurses daily. This is confirmed by the National Database of Nursing Quality Indicators (NDNQI, 2019), which identifies falls as a nursing quality indicator. Patients with cancer are at an increased risk for injury because of anemia, thrombocytopenia, and bone fragility from metastatic disease (Toomey & Friedman, 2014), and the effects of cancer treatment may impair functional status and increase the risk for falls. Patient advocacy is necessary because patients are often not aware of their fall risk even when they have had a previous fall (Tucker et al., 2019). Fall prevention is a vital nursing intervention that requires constant, intentional, and diligent actions for continued management. Although researchers and clinicians have searched for the best interventions, there is not one answer to the falls dilemma. Falling is a complex problem that must be solved with a multifaceted solution. This article describes the background, methods, and implementation of a multifaceted falls initiative. Unique features of the structured implementation plan for communication, toileting, and nurse rounding are shared, and the results and impacts of this three-intervention initiative are discussed.

Background

The acute care inpatient oncology unit at Michigan Medicine in Ann Arbor experienced spikes in monthly fall rates that were higher than standard goals set institutionally and nationally. The foundation for the three-intervention falls initiative included continuous education and awareness for staff and patients. Lean methods, based on the Toyota model, are used in health care to examine the efficiency of processes and resources to determine value for the customer (Lawal et al., 2014). During the initiative, lean principles, such as root cause analysis, standard work, and process behavior charts, were used. The unit-based committee (UBC) and a continuous improvement specialist gathered data and conducted a root cause analysis related to patient falls. Three root causes were identified: (a) RNs were not providing consistent reports to unlicensed assistive personnel (UAPs), (b) most patients who fell were on their way to and from the bathroom, and (c) hourly rounding was inconsistently practiced. After the root causes were identified, the UBC team brainstormed countermeasures, and members of the UBC completed a literature review to identify best practices. In the literature, RN–UAP communication,