Aiming to Prevent Falls in the Emergency Department

**Avoiding a Second Emergency: Preventing Falls in the Emergency Department**

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**Define Project**

The Emergency Department (ED) did not have a formal Fall Prevention program and patient falls were not uncommon, often resulting in injury. As a result of these falls, the Ambulatory Falls Team and the ED nurses determined a process for assessing patient fall risk as part of an overall improvement strategy designed to reduce falls. The Mayo Clinic Hospital Phoenix is one of 20 sites participating in the Ambulatory Falls Workgroup, which led to increased patient safety. This project was designed to improve falls prevention by developing a formal process to identify patients at risk for falls, with a focus on the ED. The project focused on evaluating the current process for identifying patients at risk for falls. This process would identify those patients likely to fall and tailor interventions to improve patient safety.

**Define Fall Prevention: Why is This Important?**

- Patients with a history of falls
- Confusion
- Medications
- Use of alcohol
- Non-functional bathroom
- Apprehensive

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**Project Measurement**

<table>
<thead>
<tr>
<th>Measure: Baseline 2012</th>
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<tbody>
<tr>
<td>Falls: 16 (6.1%)</td>
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<tr>
<td>Injuries: 6 (24%)</td>
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</tbody>
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**Analyze ED Patient Falls: Who’s at Risk?**

- **One Study of ED Patients: Falls/Year**
  - **Falls**: 2012: 16 Falls in the Mayo ED
  - **Injuries**: 6 (2.3%)

**Factors contributing to the gap**

- **The lack of a standardization of care for falls prevention**
- **Limited staff education on who is at risk for falls**
- **Lack of knowledge of ED staff of the amount of falls occurring**
- **The lack of knowledge of fall risk among patients and their families**
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**Measure: Baseline 2012**

Falls: 16 (6.1%)

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**Analyze Mayo ED: Why Patients Fall?**

- **Factors contributing to the gap**
  - **Limited staff education on who is at risk for falls**
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**Parameters contributing to the gap**

- **Limited staff education on who is at risk for falls**
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**Analyze the Project**

- **Factors contributing to the gap**
  - **Limited staff education on who is at risk for falls**
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**Improve: Communicate Risk**

- **Communication Risks**
  - **Project**
  - **Training**
  - **Simulation**
  - **Credibility**
  - **Standardization**

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**Improve: Intentional Rounding**

- **Intentional Rounding**
  - **Project**
  - **Training**
  - **Simulation**
  - **Credibility**
  - **Standardization**

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**Improve: October**

- **Fall Prevention**
  - **Project**
  - **Training**
  - **Simulation**
  - **Credibility**
  - **Standardization**

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**Improve: Private Rewards**

- **Private Rewards**
  - **Project**
  - **Training**
  - **Simulation**
  - **Credibility**
  - **Standardization**

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**Improve: Public Rewards**

- **Public Rewards**
  - **Project**
  - **Training**
  - **Simulation**
  - **Credibility**
  - **Standardization**

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**Control: Sustaining Improvement**

- **Sustaining Improvement**
  - **Project**
  - **Training**
  - **Simulation**
  - **Credibility**
  - **Standardization**

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**Define Fall Prevention: Why is This Important?**

- Patient safety is our primary concern
- Mortality risk
- Accreditation status
- Understanding
- Reinforcement
- Fall rate validity required

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**Define Project**

The Emergency Department (ED) did not have a formal Fall Prevention program and patient falls were not uncommon, often resulting in injury. As a result of these falls, the Ambulatory Falls Team and the ED nurses determined a process for assessing patient fall risk as part of an overall improvement strategy designed to reduce falls. The Mayo Clinic Hospital Phoenix is one of 20 sites participating in the Ambulatory Falls Workgroup, which led to increased patient safety. This project was designed to improve falls prevention by developing a formal process to identify patients at risk for falls, with a focus on the ED. The project focused on evaluating the current process for identifying patients at risk for falls. This process would identify those patients likely to fall and tailor interventions to improve patient safety.

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**Improve: Fall Packet**

- **Fall Packet**
  - **Project**
  - **Training**
  - **Simulation**
  - **Credibility**
  - **Standardization**

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**Improve: Private Rewards**

- **Private Rewards**
  - **Project**
  - **Training**
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**Improve: Public Rewards**

- **Public Rewards**
  - **Project**
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**Control: Sustaining Improvement**

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