Fall Prevention: Leadership Strategies to Translate Evidence into Acute Care Practice

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Introduction and Purpose

Falls are a leading harm event during hospitalization, resulting in increased health care costs, injury, and death. In early 2021, on an acute care unit in a large Indiana hospital, evidence-based standard work was in place to prevent falls. Yet staff did not consistently complete the standardized processes, and the number of falls remained above benchmark.

The primary aim of the initiative was to trial novel approaches based on implementation science to engage clinical nurses in fully adopting evidence-based standard work. A secondary aim was to provide the unit manager and clinical nurses an opportunity to expand their leadership competencies while addressing a high-priority gap in the provision of safe care.

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Methods

Design/Setting: Quality Improvement on a 25-bed intermediate critical care unit primarily for adult cardiac patients.

Intervention/Implementation: The unit manager developed a three-pronged plan based on principles of implementation science.

A.. Engaged the administrative director for the hospital's high-acuity units to join in meeting individually with every clinical nurse and unlicensed team member, reviewing falls data and discussing standard work for fall prevention as a top priority and a criterion for satisfactory job performance.

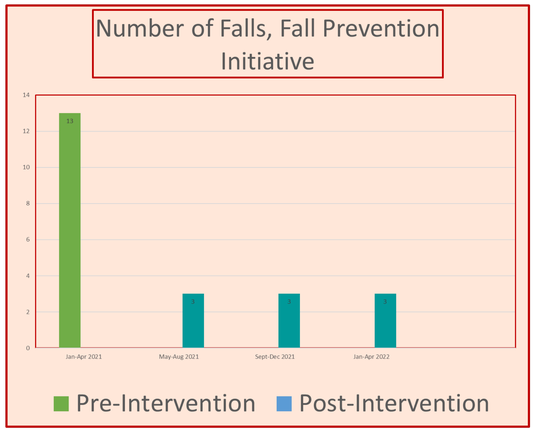
B. Empowered clinical nurses to select strategies for implementing standard work. Team members revamped the format of the daily safety huddle to include how to tailor the evidence to fit each at-risk patient.

C. Designed a visual management tool, the Falls Reward Board, to remind team members to complete standard work and track the number of days with no falls. Various increments of days were labeled with a sealed envelope. When the unit reached an incremental day with no patient falls, a nurse opened a card. Every team member received the reward on the card, such as ice cream sundaes, a popcorn bar, and gift cards/tickets.

Outcome Measure: Number of falls/month

Results

- The number of falls on the unit decreased from 13 to 3 in the first four months post-implementation.



- Clinical nurses were spokespersons for the initiative to hospital-wide groups. Morale and teamwork among the nurses improved as they worked together to reach ever-higher levels of rewards.
- The manager and clinical nurses expanded leadership in communication, relationship-building, knowledge of health care delivery, and professionalism.

Conclusions/Implications

Tailored approaches based on implementation science were successful in improving team engagement in evidence-based practice and reducing falls. Lessons learned included recognition of the high value of (a) drawing on an administrative voice to create urgency in implementation; (b) empowering clinical nurses to own the translation of research into practice; (c) designing visual tools to shape staff behaviors; and (d) repeating one-on-one education with team members every six months.