

ABSTRACT TITLE:

No One Walks Alone Fall Reduction Program. An innovative approach to falls
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Background: Despite inpatient fall reduction efforts across the country, there has not been a significant difference in overall fall rates. Within the first five months of data collection it was found that a Medical/Surgical department had 17 patient falls including 2 with injuries. The Hospital Falls committee began contacting similar sized organizations who demonstrated optimal fall rates and found an innovative approach.

Purpose: The purpose of this project was to reduce inpatient falls by implementing a program entitled **No One Walks Alone** (NOWA) in the medical/surgical department.

Methods: The Falls committee determined that previous approaches to falls were not working. Fall reduction approaches that many other hospitals used and nurses were accustomed to using were completely eliminated. The new NOWA program was introduced and included the following elements:

- Activation of chair and bed alarms on **all patients**.
- Staff accompanied patients into the bathroom and remained with them.
- Staff were responsible for assisting patients in and out of bed and accompanied patients as they ambulated in the hallway.
- Patients admitted after a fall at home; highly impulsive patients; patients with altered mental status and alcohol/drug withdrawal were flagged as 'watchers' and discussed in the shift-change safety huddle.
- NOWA letter presented to every patient and family member.
- Emphasis placed on the significance of hourly rounding.

An innovative video and agreement that it was everyone's responsibility to help keep patients safe, moved the initiative forward.

Results: Pre NOWA implementation: 20 falls and 2 with injury (over 7 months), post NOWA implementation: 7 falls and 0 with injury (over 7 months) for a 65% reduction in falls per the raw data. From a pre and post look at falls per 1000 patient days: 2.4 falls/1000 pt days vs 1.05 falls/1000 pt days. From this perspective, there was a 56.25% decrease in falls/1000 pt days from pre NOWA to post NOWA.

Conclusion: The implementation of NOWA demonstrated a reduction in falls >50%. Staff became more engaged with the process and, as per anecdotal evidence, began spending more quality time with their patients as they walked with them. A quantitative survey will be sent out to all staff after the patient video is implemented and tested for three months.

Gaps realized were the patient engagement (development of the patient NOWA Video to be reviewed on admission) and accountability for hourly rounding (developing a scanner method for hourly rounding

documentation). Both gaps will be measured using the electronic data available within each computer system.