Innovative Approach to Decreasing Patient Falls on an ICU Stepdown  
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**Problem:** A 39 Bed ICU Stepdown area was exceeding the NDNQI benchmark for patient falls.

**Evidence:** Although the literature review showed a limited number of studies regarding the use of Low Beds to prevent falls, the BedSafe program from the Veterans Administration’s Sunshine Network showed promising results.

**Strategy:** Due to a sustained trend in patient falls on this high acuity area, a unit based Fall Team was formed to identify strategies to decrease the rate of falls to below the NDNQI benchmark. The team examined the data, current practice on the floor, and staff compliance to the current fall reduction plan. Information was obtained from local “best practice” hospitals, regarding interventions to reduce falls. The Fall Team reviewed recommendations from the hospitals and current literature and developed a Process Improvement Plan.

**Practice Change:** All patients are screened for risk of falling. High Fall Risk patients receive a yellow armband and yellow non-slip socks. A “Fall Risk” sign is placed at the head of the bed, and a yellow magnet is placed at the doorway of the room. The Fall Team added the following practices: patients determined to be “high fall risk”, or at the discretion of the nurse, the nurse will order a Low Bed for the patient, implement the Bed Exit alarm, and complete hourly rounding.

**Results:** For seven consecutive quarters, the average rate of falls was eleven per quarter at an average rate of 4.1 falls per 1000 patient days, which exceeded the averaged NDNQI benchmark of 3.19 falls per 1000 patient days. After implementation of the low bed approach, the fall rate has dropped to an average of one per month for a Q4 2010 rate of 0.98 falls per 1000 patient days, falling far below the Q4 2010 NDNQI benchmark of 3.2 falls per 1000 patient day. Every fall is examined by the team to determine if the fall could have been prevented and results are posted in the unit.

**Recommendation:** Due to the success of the program, it has been expanded housewide to include all adult inpatient areas.

**Lessons Learned:** Although previous interventions were effective in other hospitals, they were unsuccessful on the Cardiac Stepdown unit. The combination of Low Beds, Bed Exit alarms, and frequent rounding has shown success that hopefully will be duplicated throughout the hospital.

**Bibliography:**