



## James A. Haley Veterans' Hospital: Preventing Injury Falls on Two Medical Nursing Units

Staff reviewed the previous 22 injury falls in acute care settings at the [James A. Haley Veterans' Hospital](#) in Tampa, Fla. The review showed that in a majority of the falls, the patient had mobility difficulties, toileting issues and/or a history of falls. Other common factors included altered mental status/confusion and use of certain kinds of drugs. In all but two incidents, the patient had multiple risk factors. The project was part of *Prevention of Hospital Falls* funded by the Robert Wood Johnson Foundation (RWJF) and managed by the Institute for Healthcare Improvement (IHI) in Boston, Mass.

Staff used the review results to guide implementation and testing of changes to prevent injury falls on two medical nursing units: 5-South and 7-North.

### Interventions

The two units tested the following:

- Safety *huddles* after a fall or a near miss. Staff discussed what happened, what should have happened and what could be done to prevent a future occurrence.
- The *teach back* technique to educate patients on why they are at increased risk for a fall injury. Staff asked at-risk patients to agree to call for help even if they thought they did not need it.
- Regular comfort, care and safety *rounds* to check on patients' conditions
- Precautions with patients at high risk for injury from fall. Staff applied the following precautions to patients with one or more specified risk conditions (including history of falls, osteoporosis and use of anticoagulants):
  - A room near the nurses' station
  - Chair and/or bed alarm
  - Bedside floor mat
  - Observation every hour via toileting and comfort rounding
  - Evaluation by an interdisciplinary team
  - Hip protectors for patients at risk for hip fracture

- Non-skid socks
- Visual identifiers of at-risk patients
- Consideration given to:
  - Moving the patient to a "low" bed, one that can be lowered to within inches of the floor
  - Providing a helmet for patients at risk of head injury

## Results

The goal was to reduce falls resulting in injury of moderate or greater severity to one or fewer falls per 10,000 patient days. The test period was June 2006–March 2007; the comparison baseline was October 2003–May 2006.

- Unit 5-South had no falls resulting in injury of moderate/greater severity, and so met the project goal.
- Unit 7-North did not meet the goal; it experienced one moderate/more serious fall during the project period, resulting in a rate of 1.69.
- The fall on 7-North was the only serious injury fall to occur in any of the hospital's acute care units during the test period. Reflecting that one fall, the hospital-wide rate for the study period was 0.30, thus meeting the project goal.
- Both pilot units and the hospital as a whole reduced injury fall rates (moderate and more serious) during the study period:
  - The 5-South rate dropped from about 1.5 to 0.0.
  - The 7-North rate dropped from about 4.5 to 1.69.
  - The hospital-wide acute care rate also declined—from just over 1.0 to 0.3.
- As of June 2007 the hospital had gone more than six months without a fall injury of moderate or greater severity. See Appendix 1 in [Program Results](#) for categories of fall injuries. (The 7-North fall occurred in late 2006.)

The hospital's team said the information and changes stemming from the project spread quickly to other units in the hospital and had promise of usefulness across the Veterans Health Administration (VHA).

## Afterward

In an interview in late 2009, Pat Quigley, Ph.D., M.P.H., director of the project and deputy director of the Patient Safety Center for VHA facilities in Florida and Puerto

Rico, said the 2006–2007 work did, in fact, have an impact beyond Haley. (Quigley was also a member of the IHI team.)

When the project started, the VHA was already a national leader in the use of hip pads to protect patients at risk for hip fracture from a fall, said Quigley. The RWJF project focused the VHA's attention on reducing fall injuries among other kinds of at-risk patients. "It was transforming."

As an example of new thinking, Quigley cited the bundling of three interventions for people at risk for hip injury: protective hip pads, a low bed and floor mats.

## **Bibliography**

### **Articles**

Quigley P, Hahm B, Collazo S, Gibson W, Janzen S, Powell-Cope G, Rice F, Sarduy I, Tyndall K and White S. "Reducing Moderate and Severe Injury from Falls in Two VA Acute Medical Surgical Units." *Journal of Nursing Care Quality*, 24(1): 33–41, 2009.