ISSN 2475-529X

Short Article

Journal of Nursing & Healthcare

Decreasing Falls through Shared Governance

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Submitted: 10 Jan 2021; **Accepted**: 25 Jan 2021; **Published**: 31 Jan 2021

Citation: *Harry Walk (2021) Decreasing Falls through Shared Governance, Journal of Nursing & Healthcare, 6 (1) : 1-2.*

Abstract

In October 2018, at the unit based forum meeting, clinical nurses evaluated patient fall rates and noticed an increase in patient falls in the Q3 2018. The Q3 2018 fall rate was 6.20. Then nurses analyzed each fall including reviewing CCTV to determine possible causes. One of the falls was due to a slip in the shower. The shower floor was tiled and became slippery when wet. Additional falls occurred in the hallway of the unit and possible causes included reality distortion, unsteady gait due to age, medications, and physical condition. In some cases they noticed the CCTV did not capture a fall because there was no camera in that section of the hallway. The clinical nurses discussed this information with the Clinical Manager, at the November 2018 staff meeting. They suggested re-surfacing the floor to prevent slipping, additional cameras mounted in the hallways, and a second monitor at the other nurses station in an effort to prevent patient falls. After implementing these interventions along with CCTV monitoring the fall rate for Q1 2020 was 2.07 and Q2 2020 was 2.66. Through shared governance, evidence based practice implementation and environment of care enhancements the fall rate decreased by 40%.

On a 34 bed adult inpatient psychiatric unit comprehensive care is provided in a wellness and recovery oriented environment. Care is provided to resolve the psychiatric emergency that precipitated an admission, rapidly restore a patient to pre-crisis level of functioning, and discharge them with the least restrictive forms of treatment. An individualized interdisciplinary treatment plan is developed and may include medication management, electroconvulsive therapy, therapeutic milieu, structured group activities, and family or community meetings.

Problem

Clinical nurses on 1 Pines evaluate unit level patient safety data on a regular basis during staff and unit based forum (UBF) meetings. Patient falls is one indicator that evaluated. Regulatory and accreditation requirements for 1Pines include monitoring unit hallways every 15 minutes for patient safety. To assist with monitoring closed-circuit television cameras (CCTV) are installed and a monitor is placed at one of the two nurses' station. One staff member is required to monitor the hallways every 15 minutes for staff and patient safety. Staff can review footage taken from the CCTV to analyze falls.

In October 2018 at their UBF meeting, clinical nurses evaluated patient fall rates and noticed an increase in patient falls in the Q3 2018. The Q3 2018 fall rate was 6.20. They analyzed each fall including reviewing CCTV to determine possible causes. One of the falls was due to a slip in the shower. The shower floor was tiled and became slippery when wet. Other falls occurred in the hallway of the unit and possible causes included reality distortion, unsteady gait due to age, medications, and physical condition. In some cases they noticed the CCTV did not capture a fall because there was no camera in that section of the hallway. The clinical nurses discussed this information with Clinical Manager, at the November 2018 staff meeting. They suggested re-surfacing the floor to prevent slipping, additional cameras mounted in the hallways, and a second monitor at the other nurses station in an effort to prevent patient falls.

Intervention

In Q1 2019, the clinical manager requested the Security department to evaluate best locations and need for additional CCTV cameras and a monitor. Security installed a second monitor in the back nurses' station for CCTV system and additional cameras so that all hallways were visible. The clinical manager reviewed literature to identify fall prevention strategies in behavioral health and patient bathrooms. The literature identified increased grip on bathroom flooring assists in decreasing falls in patient bathrooms. Walk developed a plan to resurface shower floor. Shower floor resurfacing completed by maintenance department. In Q2 2019, the clinical manager and professional practice and development coor-

dinator developed a staff competency for monitoring the CCTV. In Q3 2019, the coordinator administered competency and validation tool to staff for monitoring the CCTV. In Q4 2019, in addition to the CCTV a staff member was assigned to physically monitor hallways every 15 minutes. When staff completed their 15 minute rounds, they were assigned to monitor the CCTV.

Outcome

After implementing these interventions along with CCTV monitoring the fall rate for Q1 2020 was 2.07 and Q2 2020 was 2.66. Through shared governance, evidence based practice implementation and environment of care enhancements the fall rate decreased by 40%.