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# Fall Prevention in the Non-Conforming Elderly Patients on an ACE Unit

University Medical Center of Princeton at Plainsboro

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PODIUM PRESENTER:
Allison M Healy, BSN, RN-BC, Senior Care Coordinator, Clinical Resource Nurse
Andrew Aupperle – Nursing Assistant, ACE Unit

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## University Medical Center of Princeton at Plainsboro

- University Medical Center of Princeton (UMCP) is a unit of Princeton HealthCare System (PHCS),a not-for-profit healthcare system in central New Jersey
- UMCP has been a leading teaching hospital for more than 40 years
- In May of 2012, UMCP relocated its facility from the heart of Princeton (established in 1919) to a brand new facility, miles up the road
- 250 bed patient tower with attached diagnostic and treatment building
- Outpatient services are located in the adjacent five-story MAP building, which includes imaging, a surgery center, a lab and a sleep center

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## University Medical Center of Princeton at Plainsboro

- NICHE Exemplar Status - 2011
- Magnet Designation - 2012
- Jim Craigie Center for Joint Replacement earned The Joint Commission's Gold Seal of Approval® for hip and knee replacements – 2015
- The Acute Rehabilitation Unit at UMCP has earned three-year accreditation from the Commission on Accreditation of Rehabilitation Facilities (CARF) – 2016
- *U.S. News & World Report* recognized UMCP as a Best Regional Hospital in Central New Jersey, ranking at No. 8 statewide and No. 18 in the entire New York metropolitan region

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## Geriatric Education and Support at UMCP

- Senior Care ED with goals to reduce/eliminate: falls, hospital-induced delirium, skin breakdown, sensory deprivation/overstimulation, decrease triage times and improve communication among caregivers
- 20 ANCC Geriatric Certified Nurses
- 40 GRN's
- 22 Geriatric Patient Care Associates
- Geriatric Education Day
- Geriatric Certification Review Courses
- Virtual Dementia Tour®
- Alzheimer Caregiver Support Group



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## The Acute Care of the Elderly Unit at UMCP

- 24 bed unit with private rooms
- Geriatric recliners in each room
- Adequate lighting, hand rails and non skid flooring
- Large 42 inch flat screen TV/ pillow speakers
- Nurse to patient ratio 1:6
- Nursing Assistant to patient ratio 1:8 + rounder
- Safe patient handling equipment readily available
- Weekly pet therapy, music therapy and art therapy
- Assistive eating devices available at RN's discretion MWF interdisciplinary rounds

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## Standardized Fall Prevention Measures on the ACE Unit

- John Hopkins Fall Risk Assessment
- Colored socks to identify fall risk patients
- Yellow wrist band
- Activation of bed/personal alarms
- Magnet outside patient door for fall risk identifier

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## Fall Prevention Intervention Guidelines by Risk Category

| Low Fall Risk | Moderate Fall Risk | High Fall Risk |
|---|---|---|
| Fall Risk Score: 0-5 Points | Fall Risk Score: 6-13 Points<br>Color Code: YELLOW | Fall Risk Score: >13 Points<br>Color Code: RED |
| Maintain safe unit environment including:<br>• Removing excess equipment/supplies/furniture from rooms and hallways<br>• Clean all spills immediately<br><br>Basic safety interventions<br>• Orient patient to surroundings, including location of bathroom, use of bed, and location of call system<br>• Keep bed in lowest position<br>• Keep no more than 3 side rails up<br>• Secure locks on beds, stretchers, Geri-chairs, and wheelchairs<br>• Keep floors obstacle free<br>• Place frequently needed objects within reach<br>• Encourage patient to call for assistance<br>• Display special instructions for vision and hearing impaired individuals<br>• Use properly fitting nonskid footwear | Implement measures listed under low risk score and<br><br>• Yellow nonskid footwear<br>• Yellow ID band<br>• Red light Q-wire activation<br>• Activation of personal or bed alarm<br>• Bed Alarm/Personal alarm signage<br>• Supervise/assist bedside sitting, personal hygiene, and toileting as appropriate<br>• Reorient confused/patients as necessary<br>• Establish elimination schedule, including use of bedside commode<br><br>Evaluate need for the following:<br>• PT/OT consult if patient has had a history of falls or is unstable on feet | Implement measures listed under low/moderate risk and:<br>• Red nonskid footwear<br>• Remain with patient while toileting<br>• Observe q 60 minutes<br>• Moderate/High Bed alarm sensitivity setting<br><br>Evaluate need for the following:<br>• Move patient to room with best visual access to nurse<br>• 1:1 sitter |



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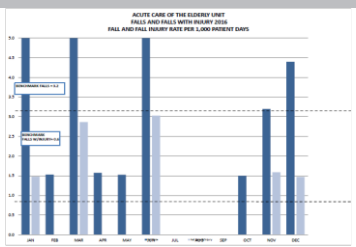




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## The Non-Conforming Elderly Patient

A patient admitted to the ACE Unit whose John Hopkins Fall Assessment score has deemed them either a moderate or high fall risk, yet is non compliant with UMCP's and the ACE Unit's fall precaution measures. This patient or family usually refuses personal and bed alarms although staff may feel the patient is unsteady or unsafe to ambulate independently.

## Case Study

A.S. -a 85 y/o man who lives at home with his wife and leads a very active lifestyle and was known to still do taxes for many clients, although retired. A.S was admitted to the ACE Unit late in the evening for a lower GI bleed. Past Medical history consists of atrial fibrillation, hypertension and BPH. Upon arrival to the unit A.S was alert and oriented to person, place and time, vital signs with in normal limits and hemoglobin was stable at 12.4. Admitting physicians assessed patient. Patient was made NPO, fluids were started, Coumadin was stopped and a GI Consult was placed. A.S had a John Hopkins score of 6 (moderate fall risk) and expressed to nursing staff that he did not want the bed alarm to be put on. At 4am the wife of A.S came to the nurse's station asking for help. A.S was found on the bathroom floor with evidence of a large bloody bowel movement. A rapid response was initiated. A.S had a laceration to his forehead and his left pupil was fixed and dilated. A.S. had not received any opiates, laxatives or psychotropic medication in the last 8 hours. The MRI of the brain determined that the patient had multiple embolic CVA's. The patient was transferred to the Critical Care Unit. 8 days later A.S. passed away with his family at his bedside.





# INTERVENTIONS





ACE leadership in collaboration with PI had to brainstorm and investigate why patients were falling so frequently

We found that most falls were
- Non- conforming patients
- Patients admitted with GI bleed
- Falls out of Geri Recliner

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## Leadership Interventions

- Patients are no longer able to refuse bed alarms with a JHFR score of 6 or greater and if so must sign out AMA
- Patients are to be in bed by 11pm and can no longer sleep in the recliner
- Any patient admitted with a GI Bleed must sign the educational form with RN



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**Fall Education for patients with a Gastrointestinal Bleed**

We are committed to maintaining patient safety. Our approach to reduce falls and injuries is comprehensive and based on research and evidence. Some of our fall prevention measures include hourly rounding, bedside report, bed/chair alarms, physical therapy and identification of high fall risk patients.

**What is a Gastrointestinal Bleed?**

Gastrointestinal (GI) bleeding refers to any bleeding that starts in the gastrointestinal tract. Bleeding may come from any site along the GI tract, but is often divided into:

- Upper GI bleeding: The upper GI tract includes the esophagus (the tube from the mouth to the stomach), stomach, and first part of the small intestine.
- Lower GI bleeding: The lower GI tract includes much of the small intestine, large intestine or bowels, rectum, and anus.

**What you may experience as a result of a Gastrointestinal Bleed that could place you at risk for falling:**

| | Date | Patient Signature | RN Signature |
|---|---|---|---|
| ➢ **Low Blood Pressure** –Sometimes with blood loss, it is possible for your blood pressure to drop. You may feel dizzy or light headed. It is safe for you to always call for assistance when getting out of bed. | _____ | _____ _____ | |
| ➢ **Anemia** – With sudden blood loss, your hemoglobin (your body's ability to carry oxygen) may drop. This is called anemia. Anemia can make you feel tired, cold, deep, and irritable. You may be short of breath or have a headache. | _____ | _____ _____ | |
| ➢ **Dehydration** – Anemia can make you feel dizzy and light headed. You may be short of breath or have a headache. | _____ | _____ _____ | |
| ➢ **Delirium** – a confused mental state that is sudden in onset. It is most often temporary and causes changes in level of alertness, awareness, behavior and impairs your judgment. | _____ | _____ _____ | |
| ➢ **Possibility of being "NPO" for a procedure** | _____ | _____ _____ | |



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## Falls Calendar

- Used to encourage staff to keep the unit fall free
- A visual aide for patients and families to emphasize that the unit is dedicated to keeping falls to a minimum
- Adds a sense of pride with how many days the unit has been fall free

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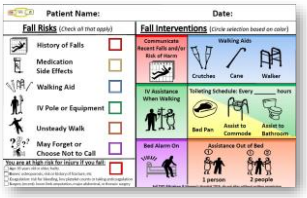
## TIPS Board

Tailoring Interventions for Patient Safety (TIPS) is a tool created by Patricia C. Dykes PhD, RN, FAAN, FACMI at Brigham & Women's Hospital. The tool was created to engage patients in fall prevention efforts



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## Recliner Usage

- Patients are highly encouraged to sit in the recliner during the day to increase mobility and orientation
- After 11pm, patients are asked to return to bed for the remainder of the night for safety and adequate rest
- Hill-rom beds have a chair setting if patient is insistent in sitting in a chair position

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## Unit Base Falls Committee

- Monthly meeting consisting of staff members from the ACE Unit to discuss:
  - New fall prevention initiatives that could be implemented
  - Discussion regarding details from the previous falls
  - Suggestions or concerns regarding existing fall prevention measures
- Meets after the monthly hospital wide Falls Committee meeting
- Committee reports back minutes to the ACE Unit leadership



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## Other Fall Prevention Tools

- NICHE Volunteers
- Ambulating Patients Regularly
- Purposeful Rounding
- Bedside Report

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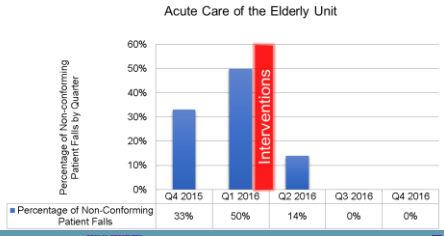

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## Year to Date

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