Falling Leaf Program: Implementing a fall prevention program

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Why?

We noticed a recent increase in falls and fall-related injuries at our building. We wanted to better understand the mechanisms of the falls and implement a comprehensive, interdisciplinary fall prevention program.

Data

March 2016: 29 falls, 21 residents, 8 repeat offenders*
April 2016: 40 falls, 29 residents, 13 repeat offenders*

*Repeat offenders refers to residents who sustained more than one fall in a one month span

What is the Falling Leaf Program?

A program developed by Carolyn Spradlin as an adaptation to the Falling Star Program. The identified problem with the Falling Star Program is that is identifies patients at any risk of falls and results in a large number of patients in the program thus decreasing the effectiveness. The Falling Leaf Program identifies the residents that are at *highest* risk of falls. The program works to monitor these specific residents and determine the underlying reasons for these falls. A visual symbol of a leaf is placed outside the patient's door and is used as a way for team members to intervene more quickly and better meet their needs.

How is it implemented:

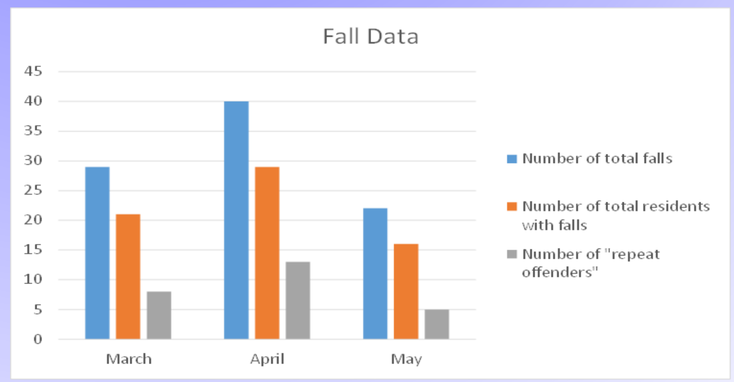
- Spacing out Falling Leaf residents amongst CNAs
- Reassessment of residents on effectiveness of interventions
- Nursing staff identified causes of falls: toileting needs, ADL routines, timing of medications, environmental hazards, etc.
- Visual symbol means all staff members check in on resident when passing room to make sure all needs have been met.

Initial Findings:

- Over 50% of falls during PM/NOC shifts
- Majority of falls related to toileting needs and unsupervised transfers
- Many falls occur within first week of admission
- 28/99 residents were identified as "high risk" and placed on the Falling Leaf Program in beginning of May

Results after one month of program:

May 2016: 22 falls, 16 residents, 5 repeat offenders.
After one month of implementation, there was a decrease in the number of falls, number of residents falling, and number of repeat offenders.
Of the 22 falls in May, 14 were sustained by Falling Leaf Program participants indicating a need for further interventions in this population.
Only 3 Falling Leaf Program participants had more than 1 fall in May demonstrating some effectiveness of our program in decreasing the number of falls of these "high risk" individuals.



Conclusion:

The implementation of this program at our facility is still in its early stages as we continue to work out any issues that arise. Some of our initial future plans include weekly reviews to assess for residents that can be removed from the program as well as any additional identified high fall risk residents who need to be added to the program. Additionally, we have recently started involving our pharmacy representative in fall meetings to assist with medication reviews to further decrease potential falls.