EASTERN MAINE MEDICAL CENTER - EMHS MEMBER

Background

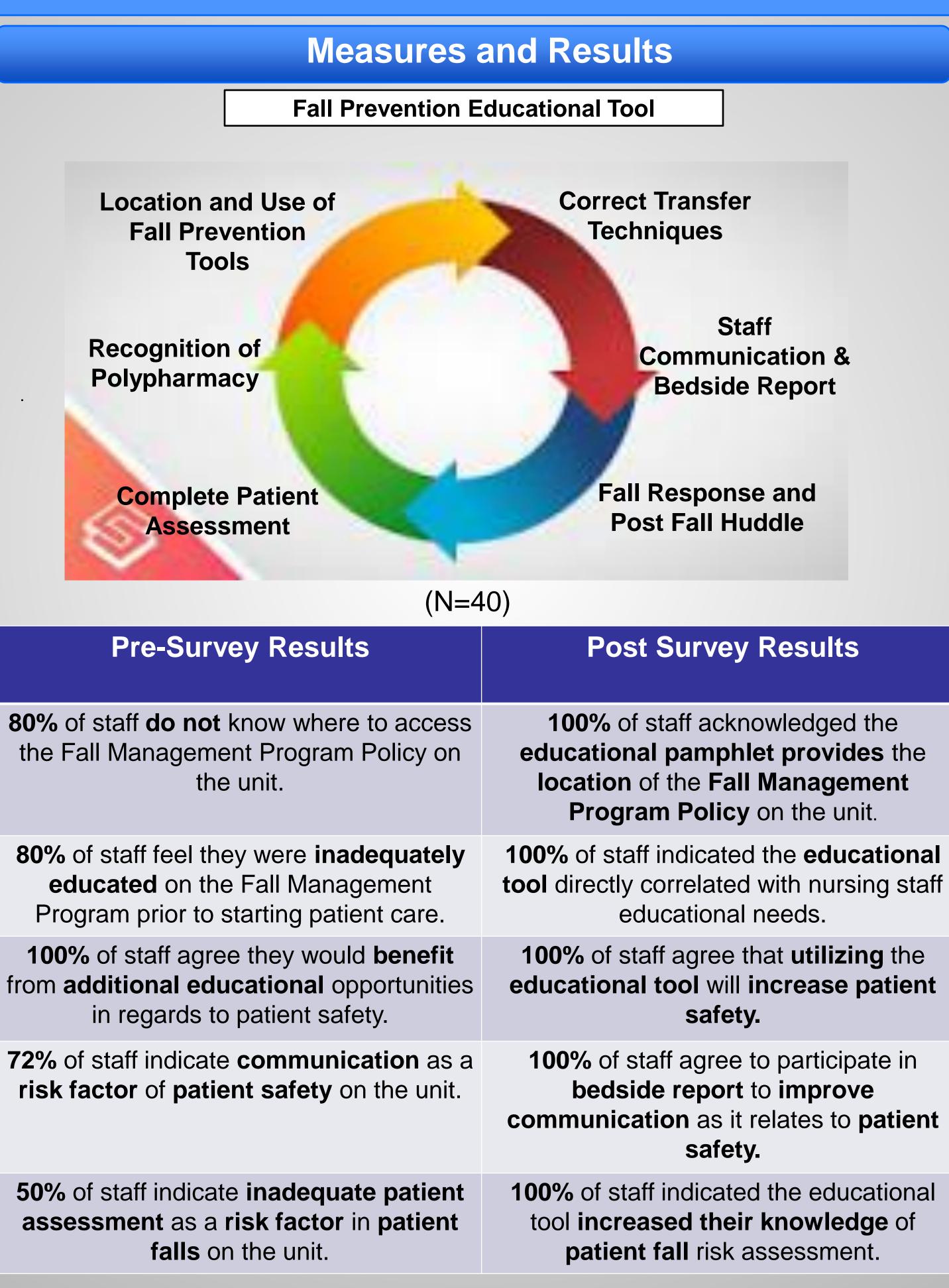
- 30-50% of patient falls in a hospital result in injury.
- Patients who experience a fall in a hospital increase their length of stay by 6.3 days on average.
- The average cost of a fall with injury is \$14,000.
- The Joint Commission cites communication failures and inadequate staff training and education as significant risk factors contributing to falls.
- Continuing education for health care providers is recognized as the most effective tool in preventing patient falls in the health care setting.

Practice Change

Increase nursing staff knowledge of fall prevention tools and promote patient safety through staff education.

Methods

- Administered anonymous paper pre-surveys to nursing staff.
- Presented educational content to nursing staff via email and staff mailboxes.
- Anonymous post-surveys were administered directly after the educational pamphlet was received by nursing staff.



Education: Will Providing Nursing Staff with Fall Prevention Education Improve Patient Safety?

Samantha Madore, RN, Kara Voisine, RN BSN, Tyler McCormick, RN



Summary/Discussion In order for this educational pamphlet to be successfully implemented we needed to: Assess nursing staffs knowledge related to patient safety and fall prevention. Implement the tool with nursing staff. Evaluate and interpret the post survey results. Encourage new and current nursing staff to utilize educational tool provided. Some feedback we heard during our education for the staff was: "Education only works for people willing to learn." • "High acuity with inadequate staffing is the number one risk factor related to patient falls." "Lack of communication puts patients at risk." "Outdated equipment are hazardous to patient safety." Conclusion Patient safety in hospital settings can be increased with targeted education as related to fall prevention. The nursing staff on Grant 6 strongly support continuing education, patient safety and the need to raise awareness surrounding negative outcomes as related to patient falls. Preventing falls and fall-related injuries in health care facilities. (2015). The Joint Commission: Sentinel Event Alert, (55), 1-5. Retrieved May 1, 2018, from https://www.jointcommission.org/assets/1/18/SEA_55.pdf Hendrich, A. L., RN, PhD. (2017, June 12). Falls. Retrieved May 1, 2018, from https://psnet.ahrq.gov/primers/primer/40/falls Falls. (2016, March 14). Retrieved May 1, 2018, from https://www.ecri.org/components/HRC/Pages/SafSec2.aspx?tab=2