Defying Gravity: Fall Prevention Quality Improvement Project

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Purpose/Aims

This project aims to reduce patient falls in a pediatric inpatient hospital setting by identifying and addressing system gaps, delivering targeted staff education, and fostering multidisciplinary collaboration.

Background

- In March 2025, an increase in inpatient falls led to a hospital-wide containment period.
- In response, a fall prevention nurse team was created to identify gaps, provide targeted education and lead improvement efforts.
- Initial surveys of 101 nurses revealed that while 91% reported using the teach-back method of education as part of their practice with patients and families, only 36.6% reported they always use this method, and 19.8% reported feeling very comfortable doing so.
- A gap analysis revealed inconsistent understanding of hourly rounding practices—only 39% of 101 nurses said they performed hourly rounds and prioritized individualized risk education strategies.
- Direct observations revealed nurses were not performing teach-back methodology correctly with many caregivers unable to verbalize fall prevention strategies despite documentation.
- This highlighted the need for education tools, staff training, and centralized communication strategies.

Purposeful Rounding

THE 5P'S OF PURPOSEFUL ROUNDING
HOURLY HIGH FALL RISK CHECKLIST

Path
- ✓ Environment clear of clutter
- ✓ Unused equipment removed

Position
- ✓ Checked if the patient is comfortable
- ✓ Repositioned if needed
- ✓ Bed in lowest position, locked with side-rails up

Potty
- ✓ Asked if patient needed to use the restroom
- ✓ Assisted with toileting as needed
- ✓ Assessed if bedside commode is needed
- ✓ Ensured urinal/bedpan within reach if needed

Possessions
- ✓ Call light within reach
- ✓ Phone/iPad, water, personal belongings within reach
- ✓ Non-slip footwear accessible

Parents
- ✓ Encouraged to call for help instead of assisting patient alone if needed
- ✓ Instructed parent to check in with nurse prior to leaving bedside
- ✓ Questions answered and concerns addressed

REACH OUT FOR SUPPORT

children's health

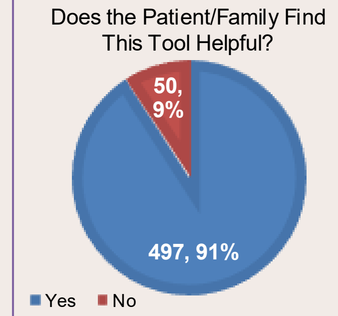
children's health

my fall safety plan

Today, I could fall because...
- I take medicines that may make me dizzy
- I am feeling wobbly or confused
- I had surgery or a procedure
- I am connected to fluids
- I am at risk for seizures

When I need to use the bathroom or get out of bed, I need:
- A gait belt
- A wheelchair
- A walker
- A shower chair
- A bedside commode
- An adult to stand next to me
- 1 care team member to help
- 2 care team members to help

I will:
- Call for help before getting out of bed
- Wear non-skid socks or shoes
- Keep the floors clear of clutter
- Keep the bed locked in the lowest position with the side rails up
- Let my care team know if I will be by myself



Methodology

- To address these gaps, the fall prevention team partnered with a teach-back expert to become champions in effective teach-back techniques.
- Educational materials were utilized, developed and distributed in response to feedback. Interactive "Safety Sips" in-services, including games and real-time role-play, were held to increase engagement.
- The fall prevention team rounded with 287 nurses and (when available) each nurse's patients and families. 82% of the nurses observed had attended in-services with our HAC team.
- To clarify expectations for rounding, the team developed the "5P's of Purposeful Rounding," a mnemonic integrated into staff education, posted in unit work areas, and discussed in huddles.
- Additionally, a laminated "My Fall Safety Plan" was piloted on several Acute Care Service (ACS) units. This tool was placed in patient rooms and updated collaboratively by nursing, PCTs, and PT/OT to reflect customized safety strategies. This tool enhances patient- and family-centered care through creation of a shared, visual plan that is reviewed each shift and tailored throughout the hospital stay.

Outcomes

- Of the 241 nurses observed post-education, 94% demonstrated correct teach-back use.
- Caregiver understanding also improved: 91% (497/547) of families surveyed at the bedside reported that the "My Fall Safety Plan" helped them understand and participate in fall prevention.
- Educational tools, including the "5P's of Purposeful Rounding" and the "My Fall Safety Plan", have become part of nursing practice across ACS, supporting sustained culture change and improving communication between staff, patients, and families.
- Purposeful rounding practices were formally integrated into Epic documentation, ensuring sustainability and promoting real-time visibility of individualized interventions.
- Following implementation, the 2025 monthly ACS fall rate decreased from 0.81 (March) to 0.0 (December) falls with injury per 1,000 inpatient days.
- In 2024, our average ACS yearly fall rate was 0.75. After the implementation of the "My Fall Safety Plan" in 2025, our average ACS yearly fall rate was 0.60.
- The "My Fall Safety Plan" tool has expanded to six of eight ACS units and has become a part of standard, daily practice.
- The fall prevention RN role has proven successful and has now been created as an official "HAC Force" of nurses with in-person coverage throughout ACS 5 days a week and is projected to expand to night shift.

Implications for Practice

Implementing targeted education and multidisciplinary collaboration to address system gaps can reduce fall rates in pediatric inpatient settings. This strategy promotes a commitment to safety, enhances staff awareness, and supports consistent use of evidence-based practice. These interventions may serve as a model for other pediatric facilities seeking to improve patient safety outcomes.

Grateful acknowledgements to the following: Hanna Boehm, BSN, RN, CPN ; Kristin Pallone BSN, RN, CPN, MSN; Tracey Porter BSN, RN; and Christina Smith DNP, APRN, ACCNS-P, CPN, EBP-CH for supporting this project.

References QR: