“I Feel Fine”: Fall Preventative Measures in the Post Anesthesia Care Unit (PACU)

Team Leader: Rusela DeSilva MSN RN CAPA CPAN
Cedars Sinai Medical Center, Los Angeles, California

Team Members: Tesha Seabra MSN RN CPAN, Lini Thomas MSN RN CCRN CNRN,
Dawn Sullivan MSN RN CCRN, Joey Yap BSN RN CPAN, Siobhan McCourt BSN RN CCRN,
Joan Riswold BSN RN CPAN, Robin Reidy MSN RN CCRN

Background Information: Falls are linked to prolonged hospital stay, increased discharge to
nursing homes, and higher health care expenditure. MIDAS reports indicated four patient falls
occurred in the Post Anesthesia Care Unit (PACU) area from January 2017 to October 2017. 1
out of 4 falls resulted in patient injury, requiring a surgical intervention. A post fall focus study
revealed that the falls happened while patients used the bathroom or ambulated to the
bathroom. In all fall cases in the PACU, patients have expressed “I feel fine”.

Objectives of Project: The purpose of the study was to eliminate the patient falls in the PACU
by adapting and modifying the Cedars Sinai Medical Center (CSMC) fall prevention measures to
the PACU setting.

Process of Implementation: The CSMC fall preventions measures which included hourly
rounding, yellow fall risk identification package, bed alarms, fall video, self-releasing belt,
patient/family education, and staying with the patient in the bathroom were reviewed. ‘PACU
specific fall prevention measures’ were created by eliminating the measures that were not
applicable to the setting. The measures adopted focused on yellow fall risk identification and
managing patient expectation at the point of intake in Preop through patient education that
the nurse will accompany and stay with the patient in the bathroom. Standard practices with
having patients sit and dangle for a few minutes prior to standing and ambulating were
reinforced. The PACU staff were educated on the ‘PACU specific fall prevention measures,’ and
the project was implemented in November 2017. In the instances where patient refused to
have the staff stay in the bathroom, bathroom call light was provided, PACU staff stood outside
the bathroom door, and patient’s refusal was documented in the electronic medical record.

Statement of Successful Practice: There were zero falls reported in the post-implementation
phase after the adoption of the ‘PACU specific fall prevention measures.’

Implications for Advancing the Practice of Perianesthesia Nursing: Modifying and curtailing
the hospital fall prevention measures to the PACU setting and focusing on the steps that apply
to the setting have helped in decreasing the patient falls. The project needs to be continued
and data collected for a longer period to monitor and ensure that the results are sustainable.