365 Days of No Falls with Injuries

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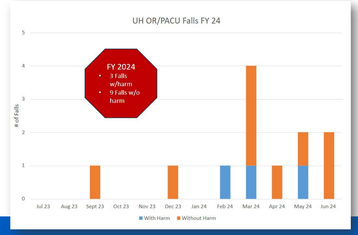
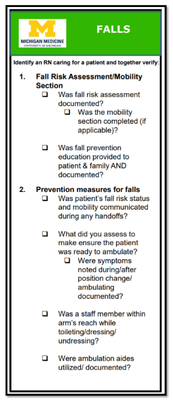
Background and Significance

Patient falls are considered critical safety events in the perianesthesia setting. In Fiscal Year (FY) 2023, our University Hospital (UH) PACU recorded 12 falls, 3 of which resulted in injury. In FY 2024, there were 4 falls, and 2 resulted in injury. Recognizing the need for improvement, our unit adopted enhanced fall prevention strategies aiming for "zero falls with harm."



Objectives

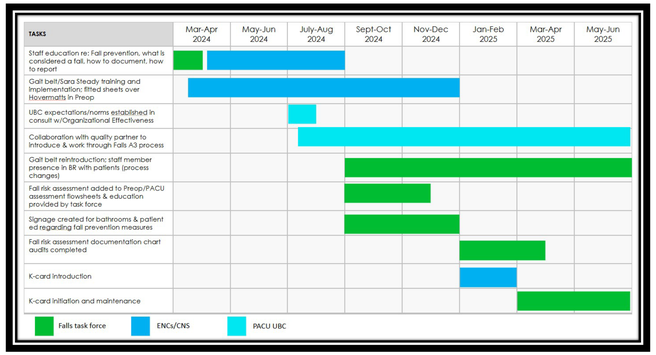
To reduce the incidence of falls and falls with injury in the PACU. Reduce the risk of falls while maintaining the highest possible level of mobility while ensuring patient privacy and respect. UH PACU would like to go 365 days with no falls with harm.



Implementation

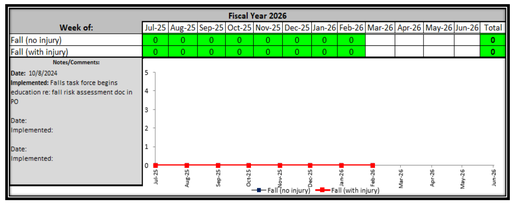
Our UH PACU Unit Based Committee used the A3 problem-solving approach and collected staff feedback via surveys to identify root causes, notably a lack of awareness of updated fall policies. Interventions included:

- Targeted staff education on fall prevention policies, emphasizing the "within arms' reach" toileting approach
- Patient education in Preop on postoperative fall risk prevention/interventions
- Installation of clear signage in patient bathrooms
- Obtaining 2 Sara Steady devices for the unit
- Introduction of wipeable gait belts
- Utilization of LPNs to focus on safe patient handling
- Recognizing and reinforcing safe practices through a "You Have Been Caught Being Safe" initiative that included a t-shirt
- Moving Preop fall risk assessment rows in Epic flowsheet for better visibility
- Regular communication via monthly emails
- Implementation of Fall Rounding



Successful Practice

Following these interventions, the PACU achieved 365 consecutive days with zero falls resulting in injury.



Implications

This project demonstrates that a data-driven, A3 problem-solving approach can successfully eliminate falls with injury in the PACU. Sustained focus on education, clear policy communication, and patient engagement advances perianesthesia safety culture and may serve as a model for similar clinical settings.

References

Joint Commission (2026). *Sentinel event policy*. Comprehensive Accreditation Manual for Hospitals. https://www.jointcommission.org/en-us/knowledge-library/support-center/standards-interpretation/sentinel-event-policy-and-procedures

University of Michigan Health (2024). *UMH patient fall prevention policy (*62-11-017). https://michmed-clinical.policystat.com/policy/16575495/latest

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