



Research Article

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Using a Multidisciplinary Approach to Reduce Falls in an Inpatient Setting

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Abstract

Falls are the leading cause of fatal and non-fatal injuries in the elderly. According to the National Institute for Health and Care Excellence (NICE) guidelines, patients over 65 are at risk of falling due to comorbidities, poor health conditions, frailty, increased medication use, and decreased mental alertness [1]. The selected site currently has a fall rate of 2.52 falls per 1,000 patient days which exceeds their goal of 2.15 falls per 1,000 patient days. Consistent communication, including nurse leader engagement in daily huddles, review, distribution of fall data, and family engagement is integral to fall prevention (King et al., 2018). This DNP quality improvement project was implemented at a local community hospital in Tuscaloosa, Alabama. The implemented project included the use of a standardized nurse leader daily huddle form and a Patient/Family Fall Prevention Agreement Contract. The target population was all the patients admitted to the designated medical-surgical unit. The nursing staff to participate in the project included the nurse leader, RN's and PCA's assigned to the unit during the implementation period. Three major focus areas were identified for the interventions: lack of nurse-patient communication, lack of consistency, and lack of patient/family engagement. The overall goal was to enhance nurse-patient communication, perform mutual goal settings and take actions to achieve those goals together.

Keywords: Communication; fall; fall risk; Patient engagement; Prevention

Introduction

The most reported never event in hospitals is patient falls. The Joint Commission defines a never event or sentinel events as any event that results in temporary harm, permanent harm, or death to a patient (The Joint Commission, 2022). They are the leading cause of injury and death among the elderly. Falls are among the twenty-eight never events that occur in hospitals. However, 28%-35% of elderly patients fall annually, with 6-16% occurring during hospital admissions. Nearly one in four falls result in an injury, while at least 10% result in a severe injury [2]. According to the National Institute for Health and Care Excellence (NICE) guidelines, patients over 65

are at risk of falling due to comorbidities, poor health conditions, frailty, increased medication use, and decreased mental alertness [1].

Even those falls that do not result in a severe injury can compromise healthcare resources and place an economic burden on organizations through increased lengths of stay, medical costs, and litigation. In 2008, the Centers for Medicare & Medicaid Services (CMS) halted hospital reimbursement for fall-related injuries and increased lengths of stay. This new regulation forced hospitals to institute various fall prevention strategies [2].

PICOT Question

In hospitalized adult patients >65 years of age, does the use of a nurse-led multidisciplinary approach reduce falls in an inpatient setting?

Research Questions

The research questions for this study were:

- Did consistent nurse-patient communication assist with fall rate reductions?
- Did consistent patient-family engagement assist with fall rate reductions?
- Did the nurse-led implementation of a fall contract help reduce the fall rates?

Purpose

The project aims to promote a multidisciplinary approach to creating a culture of safety that is vigilant in preventing falls through consistent and standardized communication and patient and family engagement.

Theoretical Framework

The theoretical framework used to guide this project was King's Attainment Goal Theory. King's Goal Attainment Theory focuses on practice guidelines that assist nurses in developing nurse-patient relationships that encourage patients to maintain reasonable health goals. The nurse and patient communicate initially during the interaction phase, and in the transaction phase, they set goals that promote patient safety and decrease falls. King's Theory of Goal Attainment will become an integral part of the implementation plan for this DNP project, as the nurse leader led daily huddles and the patient and family fall prevention agreements consistently become a part of the unit's standard work.

Relevance to Nursing Practice

King's Theory of Goal Attainment proposes: (1) if perceptual interaction accuracy is present in nurse-patient interactions, the transactions will occur; (2) if the nurse and patient make the transaction, the goal will be achieved; and (3) if the goal is achieved, satisfaction will occur, and (4) if a nurse communicates appropriate information to the patient, mutual goal-setting and goal achievement will occur. Inpatient falls are preventable when the associated risk factors have been adequately identified. These risk factors are commonly identified using a fall risk assessment tool such as the Morse Fall Scale, Hendrich's High-Risk Fall Model, and the St. Thomas assessment tool in falling elderly inpatients (STRATIFY). Predictors of a patient's fall risk include the type or number of medications administered, mobility level, elimination

patterns, and previous history of falling. The Morse Fall score is used in hospitalized patients to assess whether the individual is at low, moderate, or high risk for falling. The score is based on the following risk factors: history of falling, the number of comorbidities, need for ambulatory aids, and intravenous lines in use, gait, and mental status [3].

As applicable as tools like the Morse Fall Scale predict a patient's risk for falling, they are only the initial phase in fall prevention. Focus on standard work in nursing care is also critical in preventing falls in the inpatient setting. For example, assessing risk factors such as type and time of medication administration, early ambulance, and proactively addressing toileting needs are areas of standard nursing care that predict an individual's risk for falling [3].

Once an assessment of the patient's predictability for the risk of falling is completed, the following steps include communicating the patient's risk to the care team and ensuring that the proper resources are in place to prevent the individual from falling and injuring themselves. Documentation in the electronic medical record allows the care team to view and follow the plan of care aimed at fall prevention. Communicating the patient's risk for falling is pertinent information that must be included during the shift report and when transferring a patient from one area to another. Fall alert/prevention signage, bracelets, and footwear will also be integral in fall prevention. Additional fall prevention measures to consider are bed exit alarms, video monitoring, 1:1 sitter, low beds, and fall mats [4,5].

Acknowledgment

None.

Conflict of Interest

No conflict of interest.

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