

Patient Safety Strategies: Evidence-based Practices for Fall Prevention



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About the Authors

Virginia Hall, DNP, MSN/Ed., RN, CNE, has been an associate professor for the online RNBSN degree program at Chamberlain University for the past 10 years. With more than 40 years of professional experience in nursing, Hall's background includes nursing instruction, management, emergency nursing, and patient safety. She has served for over 10 years in the long-term care arena, in a supervisory and nursing assistant educator role, in addition to being the director of nursing and administrator of two facilities. Hall is a member of the National League for Nursing and the Phi Pi Chapter of the Honor Society of Nursing, Sigma Theta Tau International. Additionally, she is an editorial reviewer for *Holistic Nursing*; has given numerous professional presentations in the areas of online learning, nursing education, and patient safety; and is a certified healthcare risk manager in the state of Florida.

Carole Eldridge, DNP, RN, CNE, NEA-BC, currently the vice president of post-licensure and graduate programs for Chamberlain University, has more than 40 years of experience in nursing and education, including experience in starting and managing healthcare companies.

Eldridge has opened and operated several Medicare and private-duty home health agencies, a hospice, a medical equipment company, and a healthcare publishing company, overseeing a four-state home care company as chief executive officer for several years. She served as vice president of resident and quality services for a nationwide assisted living company. Eldridge has written and published more than 60 training publications for unlicensed attendants in long-term care as well as textbook chapters and articles for professional journals.

Dedication

This book is dedicated to my family who give me strength to do my best and in memory of my late son, Jason, who I know is smiling down at me and cheering me on. —Virginia Hall

Nursing Education Instructional Guide

Patient Safety Strategies: Evidence-based Practices for Fall Prevention

Target audience

Nurse managers, assistant nurse managers, nurse leaders, nursing directors, VPs of nursing, chief nursing officers, charge nurses, patient care managers, ancillary services managers, staff educators, patient safety specialists

Statement of need

Patient falls are a fixture in The Joint Commission's list of top 10 sentinel events; in fact, they were the third most common sentinel event reported to the accreditor in 2016. Causes of falls range from inadequate assessment, medication or disease side effects, and environmental hazards to a lack of leadership or staff orientation—yet until now, there's never been a single guide on fall prevention initiatives.

Educational objectives

1. State a goal for performing an assessment
2. Explain why documentation is important
3. Describe the two phases of nursing assessment
4. Identify elements of the functional screen
5. Define a fall
6. Identify several nonmodifiable intrinsic fall risk factors
7. List examples of modifiable risk factors
8. List functional risk factor modifications
9. Describe recommendations for preventing falls in the cognitively impaired

10. List specific medical conditions responsible for falls that are often overlooked
11. Identify hospitalwide steps that may reduce the risk of falls
12. List modifiable risk factors that a good fall prevention program should address
13. Identify the three main elements of a fall prevention program
14. Identify elements that should be included in a multifactorial intervention program
15. Formulate questions to ask after a fall takes place in order to respond appropriately
16. Describe factors to consider when conducting a post-fall assessment of an unwitnessed fall
17. Identify three distinct information records that must be maintained for every fall
18. Identify four categories of pediatric falls

Faculty

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Accreditation/Designation statement

HCPPro is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center's Commission on Accreditation.

This educational activity for 3.0 contact hours is provided by HCPPro, a division of BLR.

Nursing contact hours for this activity are valid from November 1, 2017 to November 1, 2020.

Disclosure statements

The planners, presenters/authors, and contributors of this CNE activity have disclosed no relevant financial relationships with any commercial companies pertaining to this activity.

Instructions

In order to successfully complete this CNE activity and be eligible to receive your nursing contact hours for this activity, you are required to do the following:

Instructional Guide

1. Read the book: *Patient Safety Strategies: Evidence-based Practices for Fall Prevention*
2. Go online to www.hcpro.com/downloads/12626
3. Follow the CE Instructional Guide
4. Complete the exam and receive a passing score of 80% or higher
5. Complete and submit the evaluation
6. Provide your contact information at the end of the evaluation

A certificate will be emailed to you immediately following your submission of the evaluation and successful completion of the exam. Please retain this email for future reference.

NOTE

This book and associated exam are intended for individual use only. If you would like to provide this continuing education exam to other members of your nursing staff, please contact our customer service department at 800-650-6787 to place your order. The exam fee schedule is as follows:

Exam quantity	Fee
1	\$0
2–25	\$15 per person
26–50	\$12 per person
51–100	\$8 per person
101+	\$5 per person

1

Introduction to Fall Prevention

The Problem

Patient falls are a leading cause of serious injury in hospitals and all healthcare settings and are one of the most expensive adverse events in healthcare facilities (Trepanier & Hilsenbeck, 2014). Falls are considered a sentinel event by The Joint Commission and account for a significant number of injuries due to inadequate caregiver communication; frailty; incomplete assessment, reassessment, and training of new staff; inadequate staffing levels; malfunction or misuse of equipment; and insufficient education of patients and their families. As discussed by Greenleaf Brown (2016), polypharmacy, defined as taking four to five or more medications, increases the chance of a significant fall with injury in the elderly population. Falls and those with injury continue to be a complex problem, and many hospitals have had success with reductions in significant injuries; however, hospitals have not been able to sustain significant improvement in the number of falls (Di Giacomo-Geffers, 2016).

The data is alarming: Falls are the largest single category of reported incidents in hospitals. Di Giacomo-Geffers (2016) notes that the Agency for Healthcare Research and Quality estimates that up to 1 million patients fall in healthcare facilities each year. Patient falls are often cited as the most frequent cause of harm for patients, and they are the leading cause of nonfatal injuries and trauma-related hospitalizations in the United States. More than half of patient falls with injuries reported to The Joint Commission since 2009 have ended in death (Di Giacomo-Geffers, 2016). Bergen et al. (2016) reported the following in the *Morbidity and Mortality Weekly Report (MMWR)*: “During 2014, approximately 27,000 older adults died because of falls; 2.8 million were treated in emergency departments for fall-related injuries, and approximately 800,000 of these patients were subsequently hospitalized (Para. 1).”

The Joint Commission, established in 1951, is a nonprofit organization that accredits and provides certification to organizations that demonstrate high quality in performance related to patient care. In 2002, The Joint Commission identified and established National Patient Safety Goals (NPSG) to focus attention on patient safety risks. These goals prioritize patient safety risks and determine the best

CHAPTER 1

interventions in dealing with them. The goals and interventions are then presented in a manner specific to the setting (The Joint Commission, 2016).

In 2008, one of The Joint Commission's patient safety goals was a requirement that hospitals reduce the risk of patient harm as a result of falls. The Joint Commission looks for documentation pertaining to this requirement when surveying a hospital, including an individualized care plan for each patient. The goal also states that hospitals must implement a fall reduction program that includes an evaluation of the program's effectiveness, because of the potential adverse consequences associated with patient falls. There is no single fall prevention program that works for all patients in every healthcare setting. A successful multifaceted program analyzes how and where falls happen, targets the unit where falls are most frequent, varies program elements to fit patients' needs, ensures that reporting the circumstances of patient falls is nonpunitive, assesses every patient for fall risk, and reeducates staff periodically. In addition to a comprehensive fall prevention program, a predictive, multidisciplinary assessment of fall risk of patients at admission, including their history of falls, depression, dizziness or vertigo, confusion or dementia, and cognitive impairment, is essential to the delivery of optimal patient care.

Since 2008, much work has taken place in the form of fall prevention programs. Hourly rounding with reduction and/or elimination of chemical and physical restraints, fall-risk identifiers, recognition of high-risk groups, sensor alarms, and many other interventions have been put into place. Fall risk has multifactorial causes, and everyone in the healthcare facility has an obligation to be alert to this patient safety danger. Interventions must be patient-specific. Patients need to be participants and engaged in their own care. Patients and their families must be involved in their fall prevention plans, and in some cases, contracts or agreements are signed by patients stating that they will abide by the measures in place to avoid the risk of falls, with and without serious injuries. For example, a patient contract may state that it's their responsibility to call for help when they need to get up to go to the restroom. Another example is in a nursing home setting, where patients may roll off the bed. Beds placed low and close to the floor and cushioned floor mats may prevent injury. Although it may not be possible to avoid falls altogether, patients and their caregivers can assist in avoiding falls with significant injury. When interventions are directed at causes identified in patient falls and falls with injury, improvements in patient care and safety and avoidance of injury are possible.

Patient falls are considered never events, which are defined by the Centers for Medicare & Medicaid Services (CMS) as an incident that is preventable and should not occur while a person is in a healthcare facility (CMS 2008). With the passage of the Deficit Reduction Act of 2005 and the implementation of

the Final Rule in October 2008, CMS stopped paying hospitals for the additional cost of care resulting from hospital-acquired conditions, which includes falls and traumas (Palmer et al., 2013). Under this policy, hospitals cease to be compensated for the treatment of “reasonably preventable” conditions required during patient stays, including injuries from patient falls. This can result in a significant loss of revenue to organizations.

The Costs and Risks

Risk factors for falls are difficult to avoid with the increasing elderly population. Falls and falls with significant injury continue to be a threat to patients’ safety and are a financial threat to healthcare facilities. Medicare costs for falls have totaled \$31.3 billion and more per year. The older population is expected to rise to 55% by 2030. According to the adjusted statistics, it is expected that there will be 48.8 million falls and 11.9 million fall injuries by 2030 (Bergen et al., 2014).

The number of older adults is increasing, with 10,000 Americans turning age 65 each day, and according to the Centers for Disease Control and Prevention (CDC), an older adult falls every second of the day (2016). The financial repercussions and adverse consequences (including fracture, head injury, depression, and fear of falling) associated with patient falls are among the most serious risk management issues that hospitals face. Additionally, on average, an elderly hospitalized patient who falls incurs additional expenses of more than \$14,000 and stays 6.3 days longer in the hospital than originally planned (The Joint Commission, 2015).

Across many industries, plaintiffs’ attorneys and insurance companies examine several factors when considering the potential for liability. Businesses that are susceptible to lawsuits and insurance claims typically have the following characteristics in common:

1. They provide services that are potentially dangerous and could cause harmful mistakes
2. They are subject to intense scrutiny by state and federal regulatory agencies, the public, and the media
3. They feature complex, interdependent systems supported by multiple processes and disciplines

Acute care facilities feature each of these characteristics. Plaintiffs’ attorneys can view hospitals as a source of potentially significant financial compensation, and insurance carriers can see the industry as a source of significant potential losses.

The Goals

The 2017 NPSGs apply to the nearly 21,000 accredited healthcare organizations and programs in the United States, including ambulatory care and surgery centers, office-based surgery sites, assisted living facilities, behavioral healthcare settings, home healthcare environments, nursing homes, laboratories, and hospitals. The Joint Commission first introduced its NPSGs in an effort to improve patient safety. Each goal contains a set of evidence-based, specific requirements that identify opportunities for reducing risk to patients by pinpointing potential problems in critical aspects of care. Each year, The Joint Commission solicits feedback from healthcare professionals who review the current NPSGs and make recommendations based on each goal's relevance, priority, clarity, ability to measure compliance, time needed to implement, and cost of implementation.

As mentioned, The Joint Commission safety advisors are continuously monitoring patient safety initiatives and in 2017 are looking to ensure evidence of a well-developed and evaluated evidence-based fall prevention program, with multidisciplinary commitment. Organizations are required to articulate a clear fall prevention program, discuss fall and injury rates, and show clear evidence of review of fall prevention interventions and changes made to further enhance fall prevention. All accredited organizations are surveyed for implementation of the goals and requirements. Surveyors look for evidence of implementation, review relevant documentation, and question leadership about how consistently the organization implements action into a care plan and what level of monitoring occurs after it implements each goal.

The Solution

There is no one-size-fits-all solution to the problem of falling. There is, however, a single main goal that every healthcare provider should work toward: prevention. Although it may not be possible to prevent every fall, most falls are preventable. Each fall prevented is one less potential injury, fracture, head trauma, or death. The goal of this book is to help healthcare providers learn how to prevent as many falls as possible, thereby preserving the mobility, quality of life, and independence of patients.

The Nurses' Role in Fall Prevention

Fall prevention includes multidisciplinary and multicomponent interventions. Quigley and White (2013) suggest that routine and predictable behaviors are important and that fall prevention programs

that include fall risk assessment and reassessment post falls are necessary to prevent reoccurrence and promote needed changes in intervention and/or treatment. An environment that promotes a safe culture contributes to patient safety and quality within the organization. Nurses have an important responsibility to seek to reduce falls by exhibiting leadership in promoting strong nursing process, interventions, and continuous evaluations. A strong interest in open communication among the disciplinary team that involves collaboration and cooperation among all the disciplines is necessary to reduce communication errors and promote patient safety. Nurses must continually seek new interventions that are evidence-based and always mindful of patients and families, environmental conditions, physical limitations, and increased risk for falls in all settings. Complete and accurate documentation is necessary to communicate thoroughly to all members of the healthcare team and all interested third parties.

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Patient falls ranked third as one of the top 10 of sentinel events reported to The Joint Commission in 2016. Causes of falls range from inadequate assessment, medication, disease entities, and environmental hazards to a lack of leadership or staff orientation and until now, there's never been a single guide on fall prevention initiatives.

This book is a step-by-step guide of how to set up a successful and sustainable evidence-based multidisciplinary falls prevention program to protect patients as well as keeping proper documentation in order to avoid possible litigation.

This book will help staff understand:

- How to identify risk factors that lead to falls using a multidisciplinary approach.
- Proper response, documentation, and follow-up assessment procedures to a fall.

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