Therapeutic Nursing Interventions for Falls

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Introduction

Healthcare facilities face many concerning challenges regarding the delivery of patient care within a safe environment. Over the years, healthcare has experienced drastic changes to improve patient outcomes and have adequate customer service. I currently work at Riverside Rehabilitation Institute (RRI). This 50-private-patient-room facility has an interdisciplinary treatment team consisting of a physiatrist, physicians, rehabilitation nurses, physical, occupational, recreational therapists, speech-language pathologists, neuropsychologists, dieticians, case managers, internal medicine resident partners, and other support staff" (Riverside, 2020). RRI is partnered with Select Medical and includes a 3,600 square-foot therapy gym, four side gymnasiums, and an outdoor ambulation path.

The majority of the patient population consists of an aging community with complicated conditions, and for the reason they are being admitted (such as a stroke, neurological disorder, traumatic brain injury, orthopaedic trauma, spinal cord injury, or amputation). The average nurses take care of six to seven patients during a 12-hour shift. Therapeutic services are given throughout the day, while nightshift nurses take care of patients and perform necessary wound care. Because the facility is an acute rehabilitation clinic, one of the biggest concerns healthcare workers and patients face is the possibility of a fall. Falls are a common issue across many healthcare facilities,

**Clinical Problem**

Falls are a common issue that has been plaguing many hospital facilities. "Accidental falls are among the most common incidents reports in hospitals, complicating approximately 2% of hospital stays (Bouldin, 2013)." It highlights how United States hospitals have an average of 3.3 to 11.5 falls per 1,000 patient stays. Our facility defines a fall as "an unexpected loss of balance, leading to an individual making contact with a lower surface" (Riverside, 2020). It can prolong hospital stays, resulting in further injury, higher financial costs, and possibly death. While falls happen more frequently among older adults and children, it can occur in any age group. Many factors contribute to falls, such as age, injury, a hazardous environment, medications, unsafe transfer and ambulatory techniques, and patients uneducated about their current condition(s). Despite facilities attempting to meet safety goals and integrating comprehensive strategies, falls happen frequently.

Our community assessment tool for 2020 highlighted key facts pertaining to our falls. Most patients at our facility consist of the elderly population (adults older than 65), have had a stroke or a neurological deficit, poor vision, a surgical procedure, an amputation, or are taking an average of 15 medications per day. The average patient stays for two weeks. With the facility involving rehabilitation, patients are more ambulatory and are encouraged to be independent. Ever since I have started in May, we have had a patient fall once per week. It is rare for us to break ten days in a row without any falls. Most falls occur during the day, in the patient's room, and on weekends when most patients do not have therapy sessions. Also, staffing ratios are lower on weekends compared to weekdays. This increases a more unsafe environment and results in forgetfulness due to a busy work environment (not turning the bed alarm on, leaving patients alone in the bathroom, not placing fall mats, leaving the room cluttered due to assisting another patient, etc.). Despite staff trying to follow safety guidelines, using the whiteboard, and educating patients about requesting assistance, many patients are forgetful and attempt independence.

**Current Clinical Practice**

Our facility believes in utilizing a universal fall prevention program to promote safety and independence. The universal fall prevention program is cited from the Agency for Healthcare Research and Quality (AHRQ) website. According to AHRQ, the facility must balance fall prevention with other priorities and mobilize for the patient. Patients are being admitted for different reasons, and a fall is a secondary diagnosis. For example, a patient may have had a stroke, resulting in a fall at home. Fall prevention is interdisciplinary, meaning nurses, therapists, physicians, families, patients, environmental services, physicians, and mid-level practitioners need to cooperate and communicate to prevent falls. Communication is imperative and should be shared with the interdisciplinary team through online charting and using the whiteboard. Should a fall occur, post-fall procedures must be conducted and explained in a debrief in hopes of preventing future falls. Lastly, fall prevention should be customizable due to patients having different backgrounds.

Despite these universal formal mechanisms for fall prevention, we achieve these goals in fall prevention differently. Everyone receives online training modules for their critical role when they start, but only the nurses, certified nursing assistants (CNAs), and therapists obtain fall prevention training. The fall prevention training modules include promoting a clutter-free environment, encouraging hourly rounding, making sure the bed alarm is on, leaving the bed low, using fall mats, placing a seat belt on the patient when they are in their wheelchair, evaluating the proposed transfer status when assisting the patient, keeping the bed/chair alarm on when the patient is on them, raising the side rails up, leaving doors open for the confused patient, having sitters, and keeping well-lit room (AHRQ).

Before patients arrive at the facility, nurses receive reports from the other facility and ask about the current condition, one of which is the transfer status and use of any walking aids. All patients receive a fall risk band and a "Call, Don't Fall" form to sign, implying an agreement to call for assistance before leaving the bed and are appropriately educated on fall prevention. Therapy evaluates the transfer and ambulation status after the day they arrive. Unless the patient alert and oriented to their ability or the nurse received a report about their transfer status, the patient is typically placed in bed. When patients are admitted, the nurse may ask the paramedic howFor charting purposes, the Moore’s Falls Risk Assessment is used once per shift to examine the patient’s safety status. In nursing, the whiteboard is a universal communication system that facilitates the status of the patient. At RRI, the whiteboard communicates who is taking care of the patient, swallow status, vision and hearing aids, transfer and ambulation status, discharge time, and persons to call if the patient cannot make decisions. It is updated daily, depending on how much progress the patient has made in their therapy sessions. We also have colored magnets that are placed next to the bathroom to highlight whether the patient can be left alone (green), should be watched while waiting outside (yellow), or have someone present while the patient is in the restroom (red). Color-coded fall signs are also placed inside the patient's room to notify everyone what he/she should bear in mind when moving the patient. Should a patient fall, an incident report is completed, and a phone call is made to the attending physician and family members.

The informal mechanisms, though useful, have some flaws. First, all healthcare workers should receive online training for fall prevention to understand its importance. There is also a lack of in-person transfer technique classes hosted by therapy teams catered to new hires. The unit can be overwhelming, resulting in nurses forgetting to make appropriate changes to the environment to prevent falls (set bed alarm, lower bed, etc.). Another issue I see is how all the patient rooms lack a gait belt. The devices can reduce patient falls and back injuries for healthcare workers. While the bathrooms and whiteboards' safety sign is significant, the fall signs are not placed conveniently in a location where everyone will notice them. Many nurses forget to ask questions related to ambulation during a handoff or admission. Many nurses refer to the whiteboard for assistance as it is an invaluable communication tool. While useful, the whiteboard can have outdated information based on the patient’s current condition. The "Call Don't Fall" form does not 100% guarantee compliance from the patient. Again, most patients are 65+ years in age, with most having short-term memory loss and episodes of forgetfulness. The listed mechanisms have good intentions, but many require adjustments to execute the long-term plan efficiently.

**Clinical Interventions**

I would propose a few suggestions in hopes the number of falls reduces over the coming months. The first I would suggest would be to have all new hires go through the online fall prevention training class while the healthcare team members receive an in-service fall prevention class. Again, only the nursing, occupational, and physical therapy teams perform the fall prevention strategies listed earlier. It would be more beneficial if speech therapy, environmental services, and the physicians involved in care use the fall prevention training modules. An evidence-based article created by Jacquez (2016) suggests how communication from active participants with an understanding of fall prevention promotes a safer environment. That means co-workers would better understand transfer status, set bed alarms, increase awareness if the patient can be left alone, and more. Whiteboards should also be used more frequently by other staff. Another study conducted by Goyal et al. (2020) interpreted how nurses used the whiteboard most often to communicate with patients and family members. Also, 60% of the patients involved in the study understood the whiteboard's purpose and found a small amount of physicians using it. Nurses can orient patients and family members to the whiteboard's purpose while the facility can encourage the physician(s) to use them more frequently.

Despite the hourly rounding and use of the Morse Fall Scale, accidents still occur at RRI. I think we can either implement the Hester Davis Scale (HDS) or replace the Morse Fall Scale. It covers nine factors that contribute to falls: age, last known fall, mobility, toileting, mental status, communication/sensory, behavior, medication, and volume/electrolyte status. While the Morse Fall Scale covers a history of falls within the last three months, the secondary diagnosis, the use of ambulatory aids, IV/Heparin lock, transfer status, and mental status. While the Morse Fall Scale is more simplistic, the Hester Davis Scale (HDS) is more in-depth (Philip, 2019). Both can be used in conjunction, though a thesis shows it not having a significant impact on inpatient falls (Payne, 2020) and recommending them to be more streamlined to improve the falls skills' user interface.

Another intervention that can improve communication among staff regarding fall prevention is the use of gait belts. Cost-effective and affordable, gait belts have been clinically shown to reduce injury for both parties by promoting assisted (or controlled) falls (Venema, 2019). Despite having ambulatory aids already in the patient’s room, an uncontrolled fall can still occur and cause fatal injuries. A gait belt should be placed in every patient’s bedroom.

The last intervention I would like to recommend is improving the fall debriefings. At the beginning of any shift with a new fall, the supervisor goes over the one patient who fell and makes recommendations for that specific person. *The Joint Commission* notes how all falls should be categorized so similar incidents can be prevented (Alert, 2015). Data should be examined to study what went right and what went wrong. The errors can be discussed and resolved via education or modification to avoid future falls. Titler et al. (2016) utilized evidence-based fall prevention interventions, which targeted patients highly susceptible to falls. Three community hospitals were examined, highlighting how communicating with all staff, using the Adoption and Practice Scales via research findings and previous mistakes. There was a decline in fall rates three months before and after interventions were given.

**Conclusion**

Falls are a serious and common issue within all healthcare facilities. Despite utilizing the best evidence-based practice for reducing them, falls still occur. A wide variety of intrinsic and extrinsic factors contribute to an individual's risk for falls. Understandably, a fall is most likely bound to happen within an acute rehabilitation facility, but that is not excusable for the number of falls that have occurred on the one-floor unit. Implementing the HDS could be beneficial, but it should be researched before disregarding the Morse Fall Scale, a system that has been in use for the last year. Education should be used in-person and online for healthcare workers who engage with patients daily. Strategies like using and updating the whiteboard more often, educating patients and families, and placing signs in more convenient spots can also decrease the chance of falls. Lastly, individual falls should be examined and cataloged, highlighting what went right and wrong. The lessons learned from each fall can trigger interventions that may prevent future falls.

Resources

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