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Fall Prevention in the Greenwich Hospital Emergency Department

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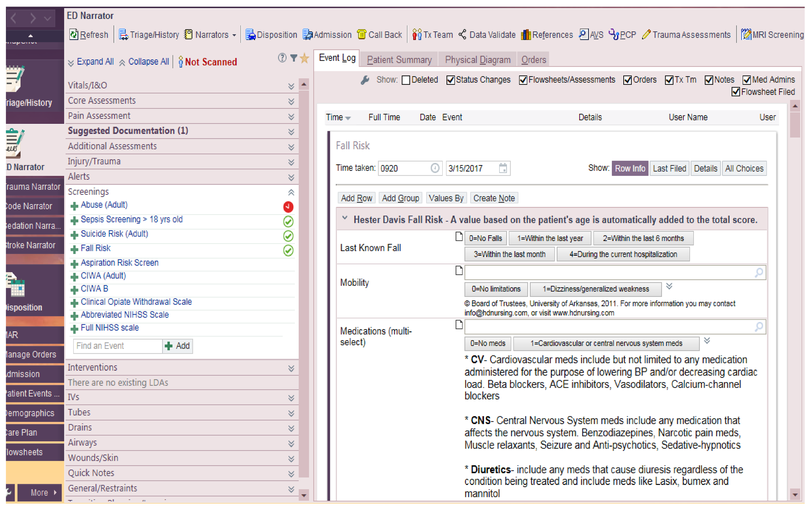
Background:

Falls are an occurrence in all parts of a hospital, but in the Emergency Department, they can happen all the time. “Between 700,000 and 1 million patients suffer a fall – an unplanned descent to the floor with or without injury – in U.S. hospitals each year, according to the Agency for Healthcare Research and Quality” (Butcher, 2013). In the Emergency Department, there is a constant and face paced environment which can be over stimulating for patients. Also, for the nurses caring for these patient, there is not always an important focus on falls since it is not a priority

Goal:

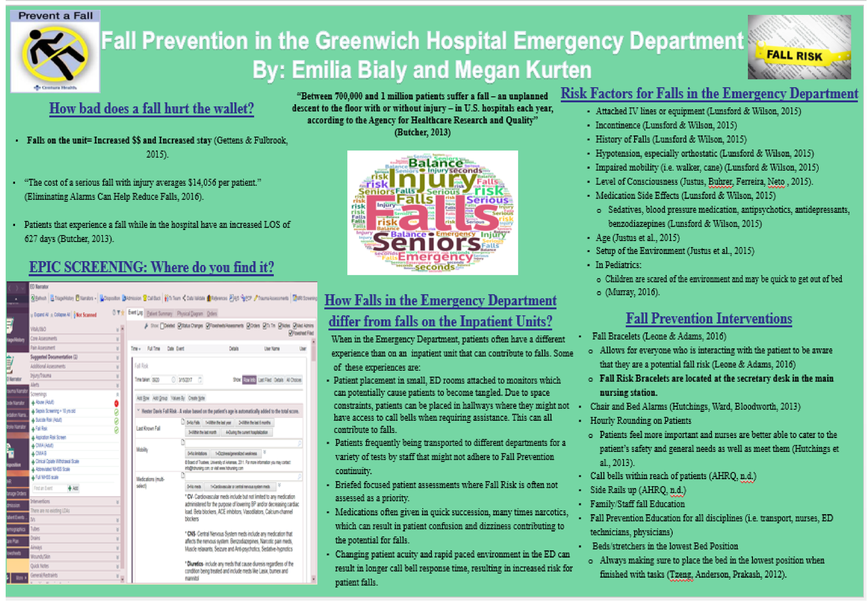
- Work with the nurses on the unit to determine problems related to falls
- Research ways to prevent falls and work to implement them on the unit
- Reduce the incidence of falls on the unit

EPIC Screening Tool and Fall Risk Score:



Implementation of Project:

- Worked on the unit, observed the stigma of falls and the nursing role related to fall prevention
- Worked with the nurses on the Fall Committee for the Emergency Department
- Worked to make fall bracelets more readily available within triage for when patients first arrive as well as within nursing stations
- Presentation of final poster to nursing staff at RN Monthly Staff Meeting.



Nursing Role/Responsibilities:

- Use fall bracelets and fall score for each patient. Also letting all individuals interacting with the patient their fall risk
- Use of chair/bed alarms, side rails up, call bell in reach, bed in the lowest position
- Work to prevent falls and advocate for patient safety

Patient-Centered Care:

- Patients are at constant risk for falls when in the Emergency Department
- Changing patient acuity and rapid paced environment sometimes results in longer call bell response, there are multiple monitors and lines attached to the patient
  - This can cause the patient to move on their own and get caught up, leading to a fall
- Patients that experience a fall while in the hospital have an increased LOS of 627 days (Butcher, 2013).
- Hourly rounding on patients so that they feel important and nurses are better able to cater to the patient’s safety and general needs as well as meet them (Hutchings et al., 2013).

Evaluation:

- Once the board was presented with the unit and then discussed, we examined how the fall rate could be affected.
- The last fall had been 35 days and most recently it is now 12
- With the addition of the board, the fall rate should decrease

Conclusion:

All patients are at risk for falls whenever they come into the hospital and especially when they are in the Emergency Department. Preventing falls is about first seeing the risk factors in patients and make sure to identify them to everyone caring for that patient. With collaborative efforts by medical personnel, the number of days since a fall can be seen in do better over time.

References

Ben Natan, M., Heyman, N., & Ben Israel, J. (2016). Identifying Risk Factors for Elder Falls in Geriatric Rehabilitation in Israel. *Rehabilitation Nursing*, *41*(1), 54-59. doi:10.1002/rnj.170

Butcher, L. (2013). The No-Fall Zone. Retrieved from http://www.hhnmag.com/articles/6404-Hospitals-work-to-prevent-patient-falls

Clipart Kid (2016). Retrieved from http://www.clipartkid.com/elderly-fall-risk-cliparts/

Eliminating Alarms Can Help Reduce Falls. (2016). Healthcare Risk Management, 30(11), 124-126.

Gettens, S., & Fulbrook, P. (2015). Fear of falling: association between the Modified Falls Efficacy Scale, in-hospital falls and hospital length of stay. Journal Of Evaluation In Clinical Practice, 21(1), 43-50. doi:10.1111/jep.12226

Hutchings, M., Ward, P., & Bloodworth, K. (2013). 'Caring around the clock': a new approach to intentional rounding. Nursing Management - UK, 20(5), 24-30.

Justus Buhrer Ferreira Neto, C., Schaia Rocha, A., Schmidt, L., Pailo de Almeida, F., Carvalho Dutra, J., & Dagmar da Rocha, M. (2015). Risk assessment of patient falls while taking medications ordered in a teaching hospital. Revista Brasileira De Enfermagem, 68(2), 278-283. doi:10.1590/0034-7167.2015680217i

Klymko, K. (2016). Video Monitoring: A Room with a View, or a Window to Challenges in Falls Prevention Research? MEDSURG Nursing, 25(5), 329-333.

Leone, R. M., & Adams, R. J. (2016). Safety Standards: Implementing Fall Prevention Interventions and Sustaining Lower Fall Rates by Promoting the Culture of Safety on an Inpatient Rehabilitation Unit. Rehabilitation Nursing, 41(1), 26-32. doi:10.1002/rnj.250

Lunsford, B., Wilson, L. (2015). Assessing your patients' risk for falling. Retrieved from https://www.americannursetoday.com/assessing-patients-risk-falling/

Murray, E. (2016). Quality Improvement. Implementing a Pediatric Fall Prevention Policy and Program. Pediatric Nursing, 42(5), 256-259.

Pinterest (n.d.) Retrieved from https://www.pinterest.com/pin/123215739776208662/

Saleh, B. S., Nusair, H., AL Zubadi, N., Al Shloul, S., & Saleh, U. (2011). The nursing rounds system: Effect of patient's call light use, bed sores, fall and satisfaction level. International Journal Of Nursing Practice, 17(3), 299-303. doi:10.1111/j.1440-172X.2011.01938.x

Tzeng, H., Yin, C., Anderson, A., & Prakash, A. (2012). Nursing Staff's Awareness of Keeping Beds in the Lowest Position to Prevent Falls and Fall Injuries In an Adult Acute Surgical Inpatient Care Setting. MEDSURG Nursing, 21(5), 271-274.

Visiting Angels. (2017). Retrieved from https://www.njseniorcare.com/wp-content/uploads/2015/10/Fall-risk-word-cloud.png