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Reduce Patient Falls at Skilled Nursing Facility

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Abstract

Falls and related injuries are becoming a massive concern for healthcare systems. Preventing falls should be the top priority for healthcare organizations. Since the risk of falling cannot be eliminated, implementing a plan that addresses fall prevention strategies can significantly reduce the number of falls. This article explores evidence-based practice (EBP) interventions in order to prevent elderly patient falls in a skilled nursing facility (SNF). The EBP research interventions, such as fall screening tools used for patient assessment, safety education classes for staff, bedside nursing communication exchange, and daily nursing leadership rounds, can have a vital effect on patient and staff safety. The fall prevention interventions were implemented in 2019 for a fall reduction project at a 120-bed SNF located in the San Francisco Bay area. The goal was to reduce fall incidents by 50% and increase safety knowledge among the staff by 50% within one year of the Centers for Medicare & Medicaid Services state survey window. The ongoing project outcome data show dramatically reduced inpatient falls and increased safety knowledge among the staff.

Keywords: patient safety, falls, skilled nursing facility, fall assessment tools, safety education, and bedside communication.

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In this competitive world, healthcare is based on the quality of care and patient safety. Patient falls, and related injuries have become one of the most concerning healthcare problems affecting the safety and quality of patient care. In 2019, falls in the elderly patient population and related injuries became a concern for the chosen skilled nursing facility (SNF) facility. The facility offers long-term and short-term patient care for Medicare, Medicaid, and private pay patients. The majority of the population admitted to this SNF is 50 years of age and above. The facility census depends on the facility's quality, safety, and patient satisfaction ratings. The average admission to this SNF is three to five patients per day, with an average daily census of 100 to 120. According to Dulal's (2017) theoretical research from 653 nursing homes, the Centers for Medicare and Medicaid Services' (CMS) three essential aspects of quality care are health inspection ratings, quality measures ratings, and staff ratings. Knowing the identified three critical aspects of quality care can help this SNF improve. The facility must address patient falls and related injuries by developing prevention strategies.

According to Limona (2009), 63% of nonfatal, unintentional injuries are the result of falls; 50% of traumatic head injuries are caused by unintentional falls; and 95% of hip fractures are caused by falls. Limona further explained that many factors contribute to patient falls, but mainly, it is because of a failure to use a fall screening tool and a lack of safety knowledge by staff. The evidence-based

research by Kim (2016) showed that interventions focused on establishing a fall screening tool for patient assessment and shift-to-shift reports at the bedside improved patient quality of care. This article will discuss and summarize the chosen evidence-based fall prevention interventions that were successful at the identified SNF by utilizing the *c*hange theory framework (Lippitt, Watson, & Westley, 1958).

Falls are considered a burden on patients, nurses, and organizations. After interviewing staff and patients regarding patient safety, it was found that the deficiency of patient safety information and lack of detailed patient assessment by staff led to a majority of falls in the identified SNF. According to Roigk, Becker, Schulz, & Rapp (2018), elderly patients are at high risk for falls, with two falls per resident in a year due to impaired mobility. Patient safety is critical in healthcare, and maintaining safety needs should be highly prioritized.

According to Sharif, Al-Harbi, Al-Shihabi, Al-Daour, and Sharif (2018), most falls are related to a lack of safety knowledge and the lack of use of a fall risk screening tool during the patient assessment. The SNF data, before a fall prevention practice improvement project, showed approximately two to four patient falls daily, with minor to significant injuries (see Appendix A). Appendix A shows the total number of patients' falls per month in the chosen SNF that were collected from the facility incident report data. The 2019 state survey report of the facility showed a deficiency in patient safety and an increase in patient falls. The

variables that play a role in achieving the planned goals are effective nursing bedside communication, the fall screening assessment tool use, and increased staff safety knowledge.

According to Mardis et al. (2017), there was a 29% statistically significant improvement with patient safety when shift-to-shift nursing communication occurred at the bedside. Mardis et al. described that many root cause analyses of patient harm incidents were caused by nursing communication errors. Nursing communication can help to minimize the patient safety error if the communication occurs promptly. The nursing staff at SNF were educated on the importance of bedside nursing communication and encouraged to follow these practices daily. The nursing leadership made rounds during shift exchange to ensure nurses performed effective bedside nursing communication by exchanging patient safety knowledge. Many fall incidents and patient harm can be avoided if bedside nursing communication occurs correctly and efficiently (Mardis et al., 2017).

At the SNF, the fall screening assessment tool was also part of the fall prevention interventions. Each newly admitted patient was screened with a fall screening assessment tool. Knowing the patient's mental status, previous fall-related history, age, underlying chronic medication use, mobility level, ability to call for help, and recent surgery information were used to assess the patient upon admission (see Appendix B). The fall risk information from the fall assessment screening tool can make nurses more aware of making critical decisions for

patient safety. The critical decision to prevent patients from falling involves using bed alarms, putting elderly patients close to the nursing station, making hourly rounds for visual checks and needs, and closely monitoring safety needs.

The fall assessment screening questions were created by the DNP student (project lead) and the SNF Director of Nursing based on their critical nursing judgement from past nursing experiences and observations from various past work facilities who also struggled with the patient fall issue. Some of the fall screening questions were also influenced by Bergen, Stevens, and Burns (2016) article (see Appendix B). Bergen et al. (2016) noted that 28.7% of older adults reported falling, and an estimated 29 million reported falls resulted in injuries in 2014. Bergren et al. also found that healthcare providers have a vital role in fall prevention by screening adults for fall risk by assessing their mobility needs and reviewing the high-risk medications that are linked to falls.

The third intervention, staff education on improving patient safety, included formal training, one-on-one coaching, and monthly nursing in-service meetings to achieve the desired fall reduction goal. Approximately 30 to 35 full-time and five on-call nursing staff received training to increase the level of awareness regarding patient safety and healthcare regulation to reduce the number of patients falls and related injuries. The facility incident tracking data tool showed significantly reduced patient falls and an increase in the level of safety knowledge among staff (see Appendix C). The level of staff safety understanding

is a crucial factor for work ethics and related patient outcomes. The unsafe patient care by healthcare workers raises serious questions about quality, safety, compassion, attitude, knowledge, and communication within healthcare industries. The knowledge and education components of this intervention plan place a significant emphasis on identifying and implementing the necessary measures to prevent falls.

According to Francis-Coad et al. (2018), staff participation in educational classes helps them gain knowledge and alertness for fall prevention through sharing and connecting. The fall prevention project emphasized educating the nurses to use the fall screening assessment tool, effective bedside nursing communication, and increasing the level of safety knowledge. Zubkoff et al. (2016) reported that involving the nursing leadership team in gathering data from the unit and making rounds encouraged nursing staff to more strictly follow the new interventions. In order to reduce patient falls, it is imperative to look at the problem, understand the problem, and approach the problem with evidence-based interventions.

In conclusion, a fall can occur anywhere, and it can significantly reduce the ability of an adult to remain independent. Many factors in healthcare raise questions about patient safety, so it is essential to understand those factors in order to establish evidence-based project planning. The ratio of falls in the elderly patient population and related injuries are still increasing daily, regardless of 24/7

staff observation. Assessing patients for fall risk, understanding the importance of safety, and addressing the barriers for improvement are fundamental aspects of this fall prevention project. After implementing the fall screening assessment tool and bedside nursing communication exchange and providing staff education training at the SNF, the interventions had a significant impact on the patient safety outcome. The facility safety incident data show the dramatic decrease in the number of patient falls. The number of falls decreased by 40 to 45% since the EBP interventions were applied in April 2019. The final goal is to achieve a 50% reduction in the number of patients' falls and a 50% increase in staff knowledge on patient safety by December 2020. The ethical considerations and patient and staff confidentiality were strictly followed.

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Appendix A**:** Monthly Patient Falls Data

Performance Measure	Jan 2019	Feb 2019	March 2019	April 2019	May 2019	June 2019	July 2019	Aug 2019	Sep 2019	Oct 2019	Nov 2019	Dec 2019
# Patient Falls at SNF	36	34	38	32	31	25	23	18	20	16	18	

Appendix B: Fall Assessment Screening Tool

To identify "high risk", "moderate risk", & "low risk" fall patients upon admission.

The higher number of YES, the higher risk for fall.

Patient has any recent history of falls?		YES	NO
Patient age greater than 60yrs?		YES	NO
Patient with recent surgery, fractures, or generalized weakness?		YES	NO
Patient alert, oriented: name, place, time & location, verbally responsive, or confused?		YES	NO
Patient able to call for help when needed?		YES	NO
Patient on any high-risk medications	Blood thinner, Blood pressure, Diabetic controls, Laxatives, Diuretics	YES	NO
	Narcotics pain meds	YES	NO
	Psychotropic meds: Sedatives, Hypnotics	YES	NO
Patient with any medical condition that cause urgency or frequent use of bathroom?		YES	NO

Appendix C: Fall Prevention Project Outcome Tracking

Table 2