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Fall 12-4-2019

### Reduce Patient Falls at Skilled Nursing Facility

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#### Recommended Citation

Patel, Jalpa, "Reduce Patient Falls at Skilled Nursing Facility" (2019). *DNP Qualifying Manuscripts*. 25.  
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## 1 Abstract

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

17

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

## 20 **Reduce Patient Falls at Skilled Nursing Facility**

21 In this competitive world, healthcare is based on the quality of care and  
22 patient safety. Patient falls, and related injuries have become one of the most  
23 concerning healthcare problems affecting the safety and quality of patient care. In  
24 2019, falls in the elderly patient population and related injuries became a concern  
25 for the chosen skilled nursing facility (SNF) facility. The facility offers long-term  
26 and short-term patient care for Medicare, Medicaid, and private pay patients. The  
27 majority of the population admitted to this SNF is 50 years of age and above. The  
28 facility census depends on the facility's quality, safety, and patient satisfaction  
29 ratings. The average admission to this SNF is three to five patients per day, with  
30 an average daily census of 100 to 120. According to Dulal's (2017) theoretical  
31 research from 653 nursing homes, the Centers for Medicare and Medicaid  
32 Services' (CMS) three essential aspects of quality care are health inspection  
33 ratings, quality measures ratings, and staff ratings. Knowing the identified three  
34 critical aspects of quality care can help this SNF improve. The facility must  
35 address patient falls and related injuries by developing prevention strategies.

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

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

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

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

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

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

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

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

86         The fall assessment screening questions were created by the DNP student  
87 (project lead) and the SNF Director of Nursing based on their critical nursing  
88 judgement from past nursing experiences and observations from various past  
89 work facilities who also struggled with the patient fall issue. Some of the fall  
90 screening questions were also influenced by Bergen, Stevens, and Burns (2016)  
91 article (see Appendix B). Bergen et al. (2016) noted that 28.7% of older adults  
92 reported falling, and an estimated 29 million reported falls resulted in injuries in  
93 2014. Bergren et al. also found that healthcare providers have a vital role in fall  
94 prevention by screening adults for fall risk by assessing their mobility needs and  
95 reviewing the high-risk medications that are linked to falls.

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

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

110           According to Francis-Coad et al. (2018), staff participation in educational  
111 classes helps them gain knowledge and alertness for fall prevention through  
112 sharing and connecting. The fall prevention project emphasized educating the  
113 nurses to use the fall screening assessment tool, effective bedside nursing  
114 communication, and increasing the level of safety knowledge. Zubkoff et al.  
115 (2016) reported that involving the nursing leadership team in gathering data from  
116 the unit and making rounds encouraged nursing staff to more strictly follow the  
117 new interventions. In order to reduce patient falls, it is imperative to look at the  
118 problem, understand the problem, and approach the problem with evidence-based  
119 interventions.

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

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



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## Appendix A: Monthly Patient Falls Data

<b>Performance Measure</b>	Jan 2019	Feb 2019	March 2019	April 2019	May 2019	June 2019	July 2019	Aug 2019	Sep 2019	Oct 2019	Nov 2019	Dec 2019
<b># Patient Falls at SNF</b>	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**

