

Winter 12-15-2016

Falls Program on an Acute Psychiatric Unit

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Inpatient Psychiatric Falls: A Look Inside

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Fall 2016

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STATEMENT OF PROBLEM & PURPOSE

Falls in hospitals and injuries related to falls are one of the biggest concerns for healthcare professionals in the United States. Not only can falls prolong a hospital stay but it can also bring about unwanted costs. Falls amongst psychiatric patients is an even greater challenge to address than fall amongst medical surgical patients due to the nature of the mental health disease process of these patients and “fall prevention is a pressing subject for research because injury from patients falls has become a disease burden” (Abraham, 2016a). In the metropolitan hospital psychiatric unit there has been a struggle to address the ongoing occurrence of falls and nurses have questioned the effectiveness of their Schmid Falls Risk Assessment tool in its ability to properly identify those at risk. This paper addresses general cost of falls among psychiatric patients, identifies successful interventions presented in literature that have addressed falls in psychiatric patients, conducts a root-cause analysis, and offers suggestions on how to decrease falls amongst this patient population.

RATIONALE

Hospital leadership identified a rising trend of falls amongst psychiatric patients, thus the leadership conducted a root-cause analysis to identify common causality themes. In the last fiscal year there were 45 falls among 28 patients on one of the acute psychiatric units. This brought about a call to action to look at why these falls were happening; it is the organization priority to look at, identify and address these falls, which is why a root-cause retrospective data analysis was conducted. The hospital falls task force provided demographic information on all of these 45 falls and provided access to the unit staff as well as medial records for further study.

Falls happen in all units in the hospital. But, in psychiatric units, falls are more frequent. Abraham states (2016a) “falls in psychiatric units are more frequent...because the expectation is for the patients to be out of bed, attending therapeutic groups and activities throughout the day” (p. 22). Psychiatric patients have an increased risk of falling due to the increased mobility among this population. But, before we discuss the risk factors for falls among psychiatric patients and the interventions used on a psychiatric inpatient unit, we must first define a fall.

According to the Agency for Healthcare Research and Quality (AHRQ) (2001) a fall is defined as “an unintentional coming to rest on the ground floor, or other lower level, but not as a result of syncope or overwhelming external force” (p. 281). In addition, Morse (2009a) further defines falls into three other subcategories: the first fall, called *anticipated physiological falls*, are falls that research has allowed us to be able to predict based on specific patients that are likely to fall due to specific risk factors. The second type of fall is the *accidental fall*. This kind of fall is defined as falls that only happen to those who do not score at risk for falling. The third type of fall is the *unanticipated physiological fall*. This kind of fall occurs when a person with none of the risk factors falls because of a seizure, because they felt faint, or because a knee suddenly gave out (p. 4). Table 1, below, further defines these types of falls. Later, we will be using these fall definitions to categorize and understand the falls happening on unit 7B.

Table 1.
Falls Definitions

ACCIDENTAL PHYSIOLOGICAL FALL

A fall that occurs unintentionally (e.g., slip, trip). Patients at risk for these falls cannot be identified prior to a fall and generally do not score at risk for falling on a predictive instrument or assessment.

ANTICIPATED PHYSIOLOGICAL FALL

A fall that occurs in patients whose risk factor score indicates the patient is at risk of falling. Controlled sliding down a wall to the ground or utilization of a physiologic structures is considered a fall.

UNANTICIPATED PHYSIOLOGICAL FALL

A fall that occurs when the physical cause of the fall is not reflected in the patient's assessed risk factors (e.g., seizure, syncope, knees gives out).

(SOURCE: Morse, 2009 and Trepanier & Hilsenbeck, 2014)

LITERATURE REVIEW

Now that we have defined a fall, we will look at why it is important to use appropriate fall risk assessment tools and what the literature tells us on how to prevent falls. According to an article written by Abraham (2016b), the “purpose of risk assessment instruments is to allow healthcare professionals to measure the patients’ intrinsic fall risk factors” (p.1), but hospital-based fall risk tools have proven to be ineffective in preventing falls because of the lack of “accuracy in identify individuals at fall risk” (p. 1). The Joint Commission (2016) shares that the best way to prevent falls from happening is using a risk assessment tool that is specific to the population being served. Morse (2016b) cautions that the improper use of a fall scales may even worsen a patient fall risk and injury to the patient (p. 75). Morse (2016b) shares that fall intervention programs consist of two parts: one, to identify those patients at fall risk, and two, to apply appropriate and specific interventions (p. 76). Fall risk assessments and interventions must reflect the specific needs of the population that is being served.

So what are the fall risk assessment(s) that have been proven effective in identifying those at risk for falling in the hospital and specifically in psychiatric units? Abraham (2016b) gives examples of these acclaimed evidence-based fall risk tools: the Hendrich II Fall Risk Model, the Morse Fall Scale, the Schmid Fall Risk, the Saint Thomas Risk Assessment tool for Falling Elderly Inpatients (STRATIFY), the Edmonson Psychiatric Fall Risk Assessment Tool

(EPFRAT), and the Wilson Simms Fall Risk Assessment Tool; the latter two are specific to psychiatric patients (p. 2).

The Hendrich II Fall Risk Model includes “assessments of elimination, dizziness, male gender, seizure medications, depression, cognitive status, and benzodiazepines” (Abraham, 2016b, p. 2). This assessment tool includes some of the risk factors for psychiatric patients, but does not include other issues like history of falls or medication combinations (Tsai, Radunel, Keller, 1998). *The Morse Fall Scale* is tailored for use in medical-surgical units, but this tool has not been validated for psychiatric inpatient patients (Abraham, 2016b, p. 2). Although some psychiatric units use this tool, intravenous (IV) therapy was part of the assessment tool, which is not commonly practiced in a psychiatric unit. Toileting, an important contributing factor for falls in psychiatric populations, was *not* assessed in this tool (Abraham, 2016b, p. 2). *The Schmid Fall Risk Model* assesses history of falls, mental status, mobility, and elimination. Although research has not indicated its use for psychiatric inpatients, these five factors included in this tool were appropriate to be assessed in the psychiatric population (Abraham, 2016b, p. 2). *The Saint Thomas Risk Assessment Tool for Falling Elderly Inpatients* (STRATIFY) is an initial predictor of patient falls for the geriatric population and only takes about a minute to complete; the factors assessed are agitation, history visual problems, elimination, and a combined mobility and transfer score (Abraham, 2016b, p. 2). Blair & Gruman (2006) argue that medication, which is not assessed with this tool, is an important risk factor for psychiatric patients.

The next two fall risk assessment tools are specific to the psychiatric inpatient population. The first is the Edmonson Psychiatric Fall Risk Assessment Tool (EPFRAT). This tool was found to have a higher sensitivity in assessing fall risk in the psychiatric inpatient population and “includes nine domains of assessment; the history of falls, sleep, nutrition, ambulation, diagnosis,

medication, elimination, mental status and age of patient” (Abraham, 2016b, p. 2). Furthermore, Abraham (2016b) notes that psychiatric patients have unique fall risk factors, which include malnutrition, poor judgment, sleep disturbances, psychosis, depression, agitation, anxiety, medication and ambulation (p.2). The second tool is the Wilson Sims Fall Risk Assessment Tool (WSFRAT). This tool is designed to be used by staff nurses and includes risk factors of “age, mental and physical status, elimination, impairments, gait, history of falls, specific medications, and detox protocol” (Abraham, 2016b, p.3). Abraham (2016b) created a table that compared these select fall risk assessment tools which has been simplified in Table 2 below.

Table 2. Comparison of Fall Risk Assessment Tools			
	Risk Assessment Tool	Population Targeted	Recommendation for Psych
1.	Wilson Sims Fall Risk Assessment Tool (WSFRAT)	Psych Population	Allows a comprehensive psychiatric fall assessment including clinical judgment.
2.	Edmonson Psychiatric Fall Risk Assessment Tool (EPFRAT)	Psych Population	Allows a comprehensive psychiatric fall assessment for psychiatric falls but doesn't include a field for nurses clinical judgment.
3.	Hendrich II Fall Risk Model	Acute Care Environments	Although the scale leaves out variables for psychiatric population, it is better than using proprietary risk assessment tools.
4.	Schmid Fall Risk Model	General Hospital	Although not indicated for psychiatric inpatient use, the factors measured are fair indicators of fall risk in the psychiatric population.

5.	Morse Fall Scale	Medical Surgical Units	A reliable scale for general hospital areas including adult psychotic patients but not for geropsychiatric patient population
6.	Saint Thomas Risk Assessment Tool for Falling Elderly Inpatients	Elderly Inpatients	Meds are not part of the assessment, which is a major factor for both general and geriatric psych patients

(SOURCE: Abraham, 2016)

The discussion of different fall assessment tools used provides an understanding why it is important to use a fall risk assessment tool that is specific for the psychiatric population.

Although the Schmid Fall Risk assessment tool used in all units at the hospital (including Psychiatrics), measure fair indicators for fall risk in the psychiatric population, it is questionable if this tool is appropriate, and if it is, are healthcare professionals using it properly? If not, would it be beneficial to change the assessment tool to either the EPFRAT or WSFRAT models?

To reiterate what Morse (2016b) said, we first must identify patients at risk and second apply the appropriate interventions (p. 76). So, what are these interventions for psychiatric fall risks? Trepanier & Hilsenbeck (2014) note that “once a patient has been identified at risk for a fall, the healthcare team must develop an individualized plan of care aimed at mitigating the risk factors and therefore decreasing risk of falls” and that “interventions are not the same for all patients” (p. 138). Successful interventions consist of using a standardized valid and reliable screening tools, implement hourly rounding and rounding during shift changes, offering educational materials for clinical staff, patients, and significant others, offering an individualized plan of care, and – if a patient is at risk for falls and has a history of falls within the last 12 months and is cognitively impaired – offer continuous observation (Trepanier & Hilsenbeck,

2014, p. 139). Other evidence-based interventions include ensuring a safe and clear environment. By removing or moving any objects that could cause a fall such as: trays for charting, patients' belongings, and IV poles, a safe environment can be achieved (Morse, 2009, p. 13). These interventions can be implemented for anyone who is at risk for falling. For those on a psychiatric unit, the healthcare team may also prevent falls by looking at the interactions of medication, altering medications to reduce patient confusion, using bed alarms to assist with patient monitoring, helping the patient to the toilet, or increasing patient surveillance (Morse, 2009, p. 14).

Further research on interventions to prevent falls on psychiatric units also requires institutional coordination. Preventing patient falls requires "a planned and coordinated effort. In an institution, this means involving all staff, from the highest levels of administration to housekeeping. It includes all health professionals, but especially nursing, medicine, pharmacy and physiotherapy" (Morse, 2009, p. 15). Among the psychiatric population not only does fall prevention require institutional coordination, but also an understanding that risk status can change quickly; risk assessment and reassessment must be ongoing. "...The effects of psychotropic medications and/or psychiatric symptomatology or simply being in a new environment can alter the risk profile" (Blair & Gruman, 2006, p. 353). To summarize, successful interventions for reducing falls among a psychiatric population consist of using a reliable screening tool, implementing scheduled rounding, offering educational materials to staff, patient and family, individualizing the plan of care, offering continuing observation and assistance, ensuring a safe and clean environment, looking at drug-to-drug interactions, altering medications, using bed alarms, coordinating institutionalized care and ensuring continuous reassessment of fall risk.

COST ANALYSIS

According to the Center for Disease Control and Prevention (2015) hospital cost for falls to Medicare alone totaled to over \$31 billion a year; Abraham (2016) argues that “the projection for fall-related expenses may reach \$43.8 billion yearly by 2020” (p. 22). Furthermore the Joint Commission (2015) shared there are “hundreds of thousands of patients fall in hospitals (a year), with 30-50% resulting in injury” (p. 1), and the average cost for a single fall with an injury is about \$14,000 (p. 1). Additionally, falls without injury cost the hospital an additional \$3,500 a year (Wu, Keeler, Rubenstein, Maglione, & Shekelle, 2010). If we input these numbers with the number of falls on the psychiatric unit being observed, that means that the cost for 41 falls on this unit would range from \$143,500 to \$574,000 during their 2015/2016 fiscal year.

PROJECT OVERVIEW

There are four main goals of this root-cause retrospective data analysis. The first is to look at how nurses on the acute care psychiatric unit assess and intervene with patients who are at risk for falling. The second goal is to get an understanding of how the unit (as a whole) approaches fall risk patients. The third goal is to review all 45 charts for those patients who fell and to evaluate the effectiveness of the Schmid Falls Risk Model and to get an understanding of any trends seen among these patients. The fourth goal of our project is to offer evidence-based suggestions on how to improve the unit’s fall assessment and interventions based on our root-cause analysis. Our objective is to help management, staff, and leadership better understand their strengths around preventing falls and also to provide our evidence of gaps in care around assessment, intervention, communication and education.

METHODOLOGY

Our project will consist of five different parts: A retrospective data analysis, a review of unusual occurrence reports, RN assessment observations, RN interviews, and patient interviews. Our focus is to first get an understanding of how falls assessments and intervention are conducted and second, to see where we can find any gaps in care and how we can improve fall protocol. We will first review the charts of the 45 incidences of falls in the 2015/2016 fiscal year. The purpose of this is to evaluate the effectiveness of the Schmid tool in identifying fall risk and to see if there were any commonalities or trends to discover among these patients. A chart review of falls can indicate various assessments and interventions that have worked and ones that have not. The second component of our project will be a review of unusual occurrence reports; this will allow us to see how nursing staff and other healthcare professionals address patients that have fallen. The purpose of this to identify any patterns relating previous falls at ZSFG Hospital. Reviewing the unusual occurrence reports also allows us to see details of each fall and may uncover useful information about the incident.

The third part of our project will consist of RN assessment observations and RN interviews. The reason we want to observe RN assessments is to evaluate the use of the Schmid tool by nurses and identify possible barriers to proper assessment and interventions for fall risk patients. In addition, we will be interviewing the RNs to gather information around how they assess patients on ambulation, elimination as well as asking what interventions they use for those patients who are a fall risk. These interviews will reveal which interventions are commonly used among the RNs and will also reveal any inconsistencies among staff. Appendix A includes a list of question that we asked the interviewed RNs; the results section of this paper will discuss our findings. The final part of this project will consist of patient interviews. Conducting patient interviews allows us to gather information on the patients' understandings of their own fall risk,

if there is any. These interviews also allow us to see if the nurses spoke to the patients regarding their fall risk. Appendix B will have the list of questions we asked the patients and the results section of this paper will discuss our findings.

EXPECTED RESULTS

From this project we are expecting to understand key components that are pertinent to falls; we expect to understand the outcome of patient falls, to learn about the effectiveness of current interventions, and to identify any gaps in care. We are also expecting to learn about this domain, and how it affects long-term outcomes among psychiatric patients. A conclusion that might emerge from this project might be the true effectiveness of the Schmid tool in identifying fall risk. We also expect to identify barriers that might exist in completing proper assessments and interventions for fall risk patients. Finally, we hope to understand how staff communicates with each other regarding falls risk patients.

NURSING RELEVANCE

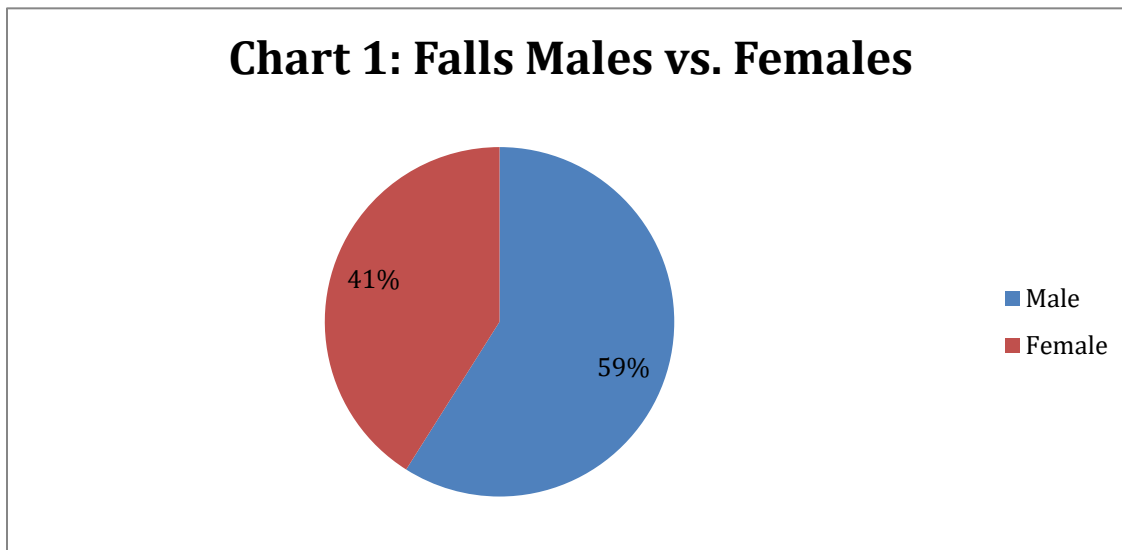
So why is all of this relevant for RNs? According to the Quality and Safety Education for Nurses (QSEN) (2016) project RNs should “have the knowledge, skills and attitudes necessary to continuously improve the quality and safety of the healthcare system within which they work” (para. 1). As nurses, we must understand the environment we work in and be able to evaluate and reevaluate our practice to better serve our patient population; what may work for one patient may not work for another. Furthermore the QSEN (2016) project shares that one of the competencies for nurses is patient-centered care where we as nurses “recognize the patient as the source of control and full partner in providing compassionate and coordinated care based on respect for patient’s preferences, values and needs” (para. 5). *Needs* is the key word in this statement, as every patient has their own specific needs – especially with it comes to preventing falls.

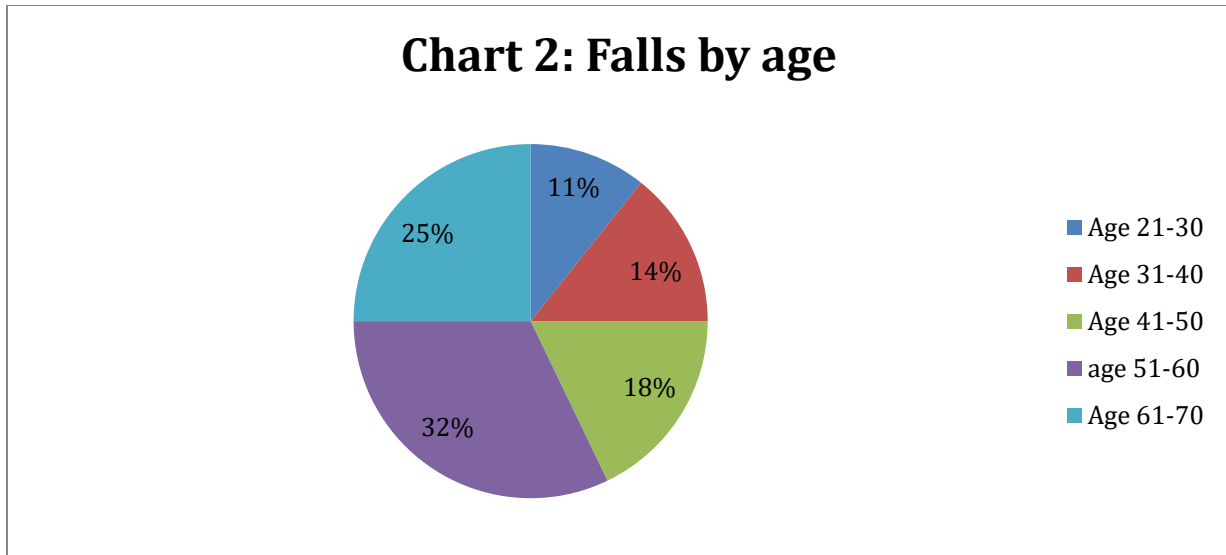
Focusing on patient-centered care not only takes into account the safety of individualized care, but also reminds the nurse that as RNs we are patient advocates, and this can only be fulfilled through patient-centered care.

SUMMARY REPORT/RESULTS

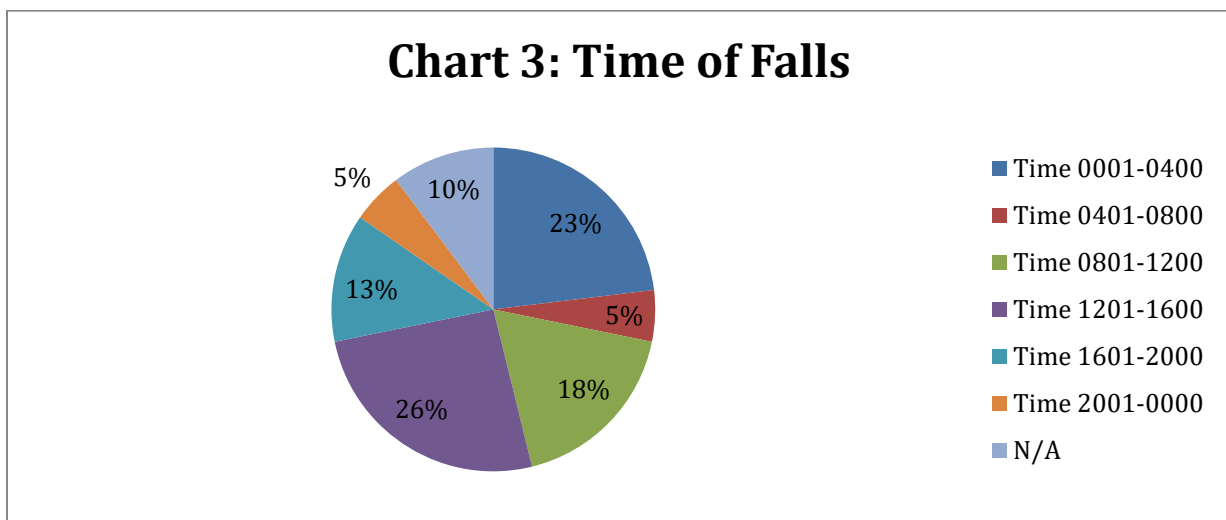
Retrospective Data Analysis & Unusual Occurrence Reports

In this section we will go into detail about the findings we discovered from our retrospective data analysis and unusual occurrence report. The first section will discuss what we found among the retrospective analysis of the 45 falls in the past 2015/2016 fiscal year. Below are some demographic data for this population:

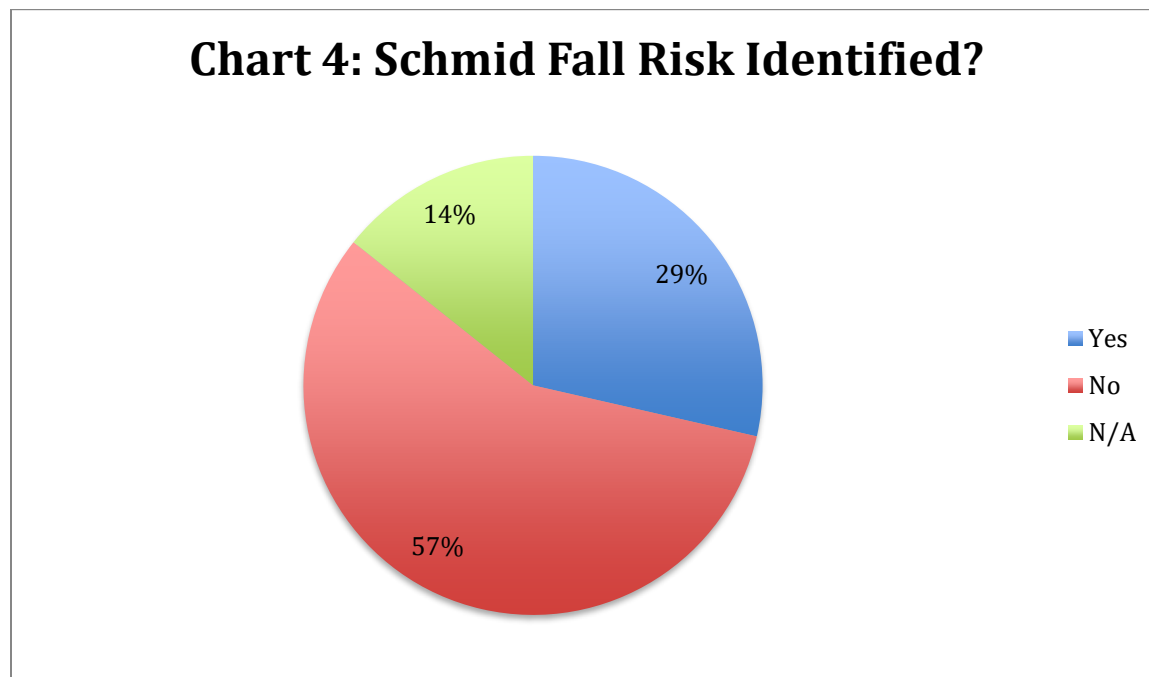




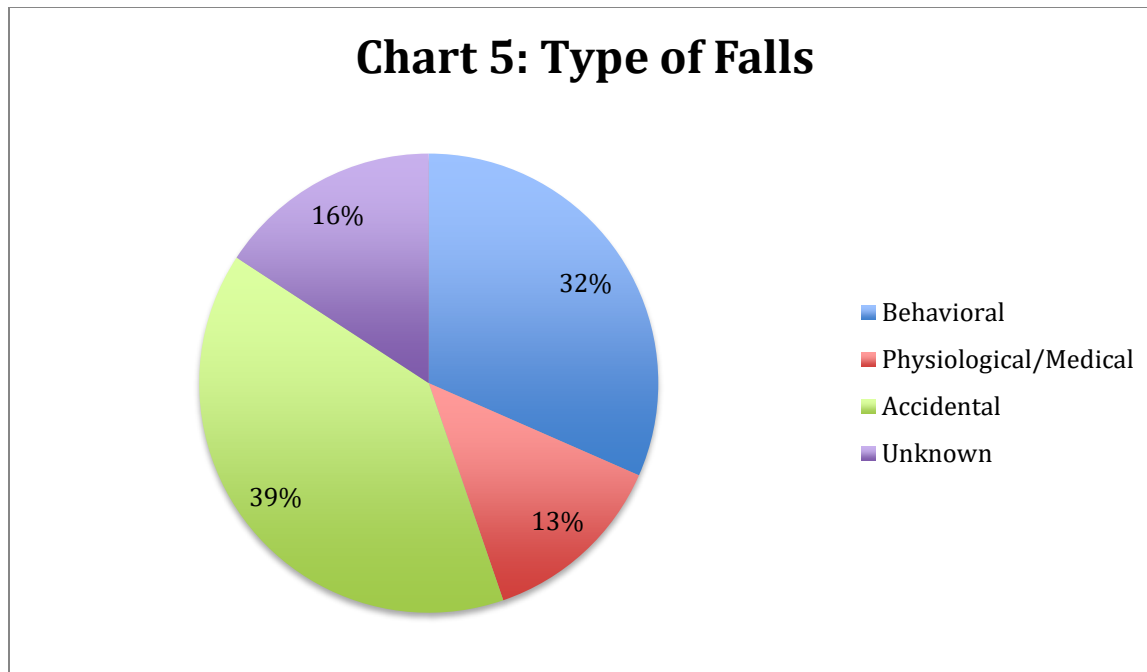
From this data we see that out of the 45 falls that happened, 59% were among males and 41% were among females. When we compare falls between age groups, we see that the age group that fell the most was the group between the ages of 51 and 60. Knowing that males fall more than females and that patients between the ages of 51-60 are falling over a higher rates than those in other age groups can help us tailor fall interventions for these populations. Chart 3, below, gives falls based on times; it is important to note that most of the falls occurred between early morning (0001-0400) and mid afternoon (1201-1600).



Our retrospective data analysis also gave us information on if the Schmid Fall Risk scale actually scored those that fell to be at risk; Chart 4 shows this data:

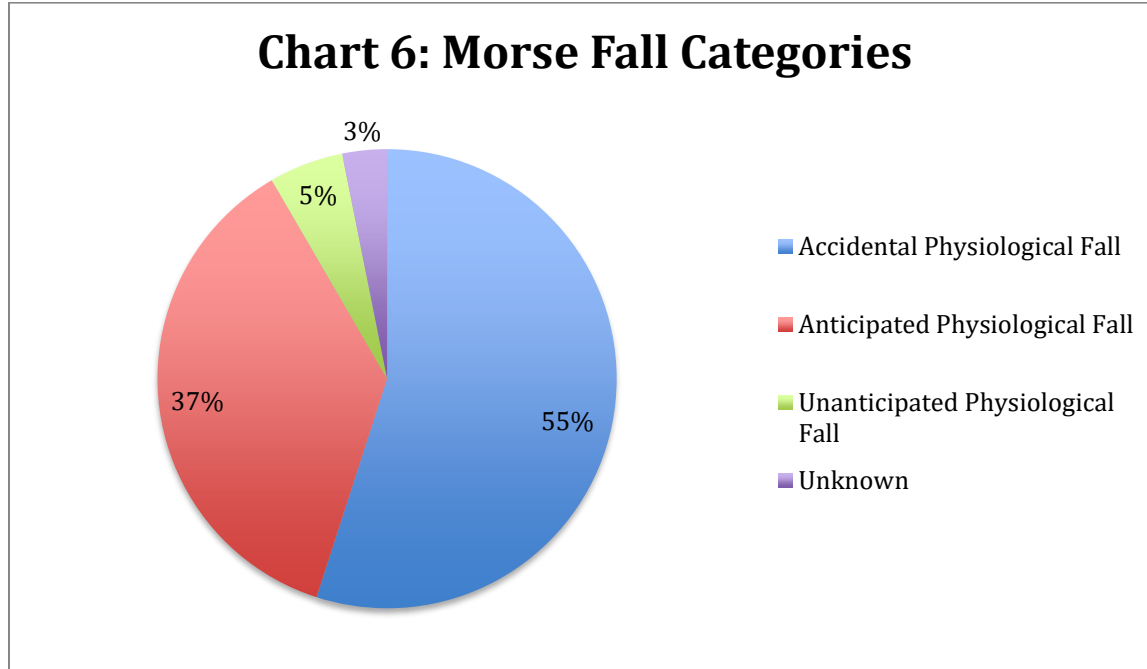


Among the 45 falls that had occurred in the 2015/2016 fiscal year, 57% of those that fell did not have a Schmid score that identified them as fall risk. Only 29% of the patients that fell actually scored as a fall risk on the Schmid scale. For 14% of the patients that fell, there was no data available in the chart about their Schmid score. This is a significant find and leads us to a few conclusions. The data shows us that the Schmid Falls Risk Model may not appropriate for this target demographic, or that the Schmid assessment is not being conducted properly. We learned more about the falls themselves through our analysis of the unusual occurrence reports. On unit 7B, the falls are categorized into three categories: accidental, physiological/medical, and behavioral. Accidental falls are those that are caused by tripping or falling; physiological or medical falls are caused by medication or a physiological process; behavioral falls are caused by patients that act out towards staff, other patients, or themselves (i.e. swinging or kicking). Chart 5, below, shows this data:



Most of the falls – 39% – are categorized as accidental falls. Some examples of the reasons for these falls are “falling off toilet”, falling “from a spill on a floor”, “tripping on shoes”, and “falling while urinating”. 32% of the falls were behavioral falls, the second most common type of fall. Some reasons for these falls were “falling when trying to kick and punch staff”, “getting dressed”, “on purpose”, and “getting out of wheelchair”. Finally the last category, physiological & medical falls, were about 13% of the falls that happened during the 2015/2016 fiscal year. Reasons for these falls ranged from “collapsing and blood pressure was 84/61”, patient was “walking and starting to run and tripped”, and “patient felt dizzy”. One thing these falls did not note was *if* these patients were at risk for falling, *did* the patient that had a “behavioral fall” have risk at all? This is important to understand because patients with and without identified risks would likely need different interventions.

In the next section we will categorize these falls based off of Morse (2016) definitions of falls:



What the Morse fall definitions do is categorize these falls based off of risk rather than cause. Table 1, on page 3-4, provides the definition of these categories of falls. This chart shows 55% of the falls that happened on the unit observed were accidental physiological falls. These falls happened among a group of people that did not score at risk for falls, even though they may have fallen for the same reasons as others who *were* at risk. This information will guide our conclusion section of this paper and will help frame our discussion of what we can do to better to provide interventions for patients that are falling, but not scoring at risk for falling.

RN Interviews

In this next section we will go over the information we collected from our RN interviews about falls. During these interviews we asked 13 nurses on unit the same seven questions. Appendix A includes the list of questions that we asked the nurses. From this information we discovered some interesting things. The first question, *How do you assess orientation and neuro status?*, had a majority of nurses agreeing on how to assess for this: 10 out of 13 nurses stated

they check for assessment and orientation times 3 (A&Ox3). This assessment asks the patient for person (who they are), place (where they are), and time (what day/time is it). The next question was, *How do you identify the level of patient mobility?* A majority of nurses (11) stated they watched the patient's gait, watched them walk, and observed how the patients got out of bed. Four RNs shared a common theme by saying that they look in the chart, and two other nurses shared that they obtain this information from shift report. Some nurses did more than just one of these interventions. For example, one nurse said that they watched the patient, looked in the chart and got this information in report; what is noted here is the common response gotten by most nurses. Another question asked was, *How do you identify patient elimination patterns?* Six nurses responded by saying that they ask the patient, and five shared they watch the patient during their bathroom visit. Two agreed that they got the level of patient mobility in report and by looking in the chart. The reason we asked these first three questions is because there seemed to be a pattern of falls around patient mobility and elimination.

In addition, we asked, *How do you come to know the patient's history of previous falls?* The reason we wanted to ask this question is to get an idea of where nurses were getting information on a patient's fall history. The nurses' responses were mixed. Nine responded by saying they look at the patient's initial assessment from Psych Emergency Services (PES). In the Psychiatric Emergency Service (PES) unit they conduct a Schmid Assessment and pass this information on to the nurses in the acute psychiatric unit. Four nurses said that they ask the patient if they had fallen in the past. The question that had the most varied responses was, *When you identify a patient who is a fall risk, what do you do next?* There were 14 different interventions identified in the interviews with the RNs: five shared that they tell the doctor, four stated that they try and initiate a one-on-one with the patient, one stated that they educate the

patient of their fall risk, one said that there is “not much you can do”, one stated that they conducted a Schmid Assessment, three shared that they use a yellow falling star and three shared that they check if the patient is wearing non-skid socks. Responses to this question have identified an inconsistency in interventions used; there was no uniformity of understanding how to implement fall interventions for those at risk. To reduce falls, the unit may want to consider doing an RN retraining on falls policy and protocols. If a nurse responded by saying they “activated falls protocol,” we asked them what that meant. Two nurses said that they would be more vigilant in watching the patient, three said that they would initiate a 1-on-1, and four stated that they would do room safety checks.

The last question we asked only to seven nurses was, *Do you think the unit’s fall policy and protocol is adequate for your unit? If not, do you have any suggestions?* Five agreed that it was adequate, one said “no”, and another nurse said that they did not know the policy and protocol for falls. The one that said “no” stated that their patients are too sedated and the nurse miss the change in status for the patient that can put patients at risk for falls.

Throughout our interviews with the nurses we noticed a great variety of answers, but those that stood out the most were the ones regarding interventions that RNs used for patients who were at risk for falling. To have a successful falls prevention policy and protocol in place, nurses must follow a consistent process. The inconsistent answers and interventions points to gaps in the delivery of care. Another thing to note was when a few nurses stated they would use a falling star or use non-slip yellow socks for those patients at risk. We assessed the unit to see if these interventions were being used and found neither the falling star or yellow non-skid socks. We believe we can conclude that the falls protocol is not clear for the nurses on the unit. We also

believe that falls among psychiatric patients are much more challenging to address due to the nature of the psychiatric diagnosis and expectations that the patients on the unit will be mobile. i

Redesign of Process

While conducting our root-cause analysis project we came across challenges that forced us to change our initial plan of action. We initially wanted to see how the RNs on the unit used the Schmid Fall Risk Assessment during shift change, however due to the nature of the unit we found that the nurses do not use the Schmid Assessment on every shift assessment. Instead, we found that the Schmid Assessment was done during the initial intake assessment in PES and not during each shift change. This forced us to eliminate this part of the project. Furthermore, we originally wanted to interview patients on the unit regarding their mobility, elimination patterns and fall risk assessment. However, staff instructed us that interviewing patients in this unit would be challenging due to their psychiatric diagnosis, therefore we removed patient interviews from our project.

IMPLEMENTATION/RECOMMENDATION

Based on our literature review and our root-cause analysis we have concluded a few things about fall assessment, interventions, and the Schmid Fall Risk Model. First, it is clear from the RN interviews that the nurses are inconsistent in assessing and implementing interventions for fall risk patients. Most of the interviewed nurses did not know what the Schmid Fall Risk Tool was, so the first step would be to have an in-service with the nurses to get a baseline of their understanding of the tool. During this in-service there will be a discussion on where to access the unit's fall policy and protocol for those that do not know where it is. During the in-service there should also be time for the nurses to share their understanding, frustration, and suggestions around fall risk patients with management and leadership. This discussion will

allow management to allow their staff to share their thoughts and ideas about the unit. After this in-service there can be more specific training on where gaps in care are, starting with interventions used for fall risk patients. Staff education would consist of fall intervention for those with mobility challenges, elimination challenges, and behavioral challenges. Nurses need to be retrained on how to implement fall interventions and how to properly assess patients for fall risk.

Another recommendation would be to implement a more effect fall risk evaluation tool. From our retrospective data analysis we know the Schmid Fall Risk Model failed to identify 57% of the individuals who fell. Our suggestion would be to implement the Wilson-Sims Fall Risk Assessment Tool. The literature and research identifies this tool as the best one for psychiatric units because it allows a comprehensive psychiatric fall assessment that includes clinical nursing judgment. This would be a bigger project because not only does this require training for nurses, but also a change in protocol to the PES unit staff.

EVALUATION

If we implemented a training program for the nurses and a new assessment tool to assess for falls, we must be able to evaluate the effectiveness of the training and the assessment tool. Our evaluation would be ongoing and consist; we must look over time to see if the numbers of falls decreased on the unit when compared to the previous year. We must evaluate, on a regular basis, nurses' understanding of the new Wilson-Sims Tool. We would need to ask, *What are the challenges with the new tool; what is useful about it?* We will a year later, after implementing these changes, assess how they assess falls. To keep a sustainable plan for our recommendation we must re-evaluate the tools that we implemented, done on a fiscal yearly basis.

CONCLUSION

In conclusion, one of the greatest lessons learned was that to get anything done there must be support from all communities in the hospital including leadership, management, staff, and patients. We also realized that when a unit does not have electronic medical records, the research portion of a project is greatly slowed down. In order to achieve higher levels of change, those that are trying to implement those changes must collect as much data as possible. This provides objective reasoning behind proposed change. The majority of the efforts of this study centered on collecting and analyzing the data and resources available on this unit. We have concluded that the Schmid Tool and through RN interviews that there are gaps in care and an inconsistency with fall assessment. Discovering the cause of the problem was essential for future project implementation, and that goal was accomplished. In the end, the greatest learning from this project is that if management, leadership and staff can even begin to think about making a change than this was a successful process, and a beginning of much larger change ahead.

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Appendix A

RN Interview Questions

1. How do you assess orientation and neuro status?
2. How do you identify the level of patient mobility?
3. How do you identify patient elimination patterns?
4. How do you come to know the patients' history of previous falls?
5. When you identify a patient who is a fall risk, what do you do next?
6. IF one says to "*activate falls protocol*", what does that mean?
7. Do you think the unit's fall policy and protocol is adequate for your unit? If not, do you have any recommendation?