

Tailoring Interventions in Reducing Rate of Falls in a Psychiatric Inpatient Unit

Karissa Padilla MSN, RN, RN-BC, Melinda Jenkins Ph.D., FNP, and Sallie Porter DNP, Ph.D., APN, RN-BC, CPNP

Background and Problem

National Database of Nursing Quality Indicators: psychiatric units experience 13 – 25 total number of falls per 1,000 patient days compared to four falls in a medical-surgical area per 1,000 days (Abraham, 2016)

- 700,000 – 1,000,000 reported inpatients falls each year (AHRQ, 2013)
- One-third of falls lead to fracture and head trauma (AHRQ, 2019)
- By 2020, cost of fall injuries will reach \$67.7 billion (CDC, 2014)
- Increased LOS, liability, and additional healthcare costs (Bouldin et al., 2013)

CMS do not reimburse hospitals for injuries related to falls since October 2008 (Abraham, 2016; Bouldin et. al., 2013; CMS, 2014)

Challenges in Psychiatry:

- adherence to plan of care,
- lack of patient engagement, and
- lack of research studies (Abraham, 2016)

Aim

Principal aim is to decrease the rate of falls in a psychiatric inpatient hospital using the evidence-based Tailoring Interventions for Patient Safety (TIPS) program

- Evidence-based practice to prevent falls by using a fall risk screening tool and a tailored fall prevention program which address patient's risk factors (Dykes et al., 2018)

Methodology

- QI project in a 133-bed psychiatric hospital
- Provided in-person education and hands-on training of the Fall TIPS program to the 103-nursing staff: electronic medical record (EMR) TIPS documentation of the Morse fall assessment, tailored-interventions, and patient education
- Project timeline: Oct. 2019 to Feb. 2020
- Data source was de-identified falls rate per 1,000 patient days from Jan. 2018 to Feb. 2020

Contact Information

Karissa Padilla, MSN, RN, RN-BC
Karissa.Padilla@rutgers.edu

Patient Name: _____ Date: _____	
<div> Increased Risk of Harm If You Fall <input type="checkbox"/> </div>	Fall Interventions (Circle selection based on color) <div> <div> Communicate Recent Fall and/or Risk of Harm </div> <div> Walking Aids </div> </div>
Fall Risks (Check all that apply) <div> <div> History of Falls <input type="checkbox"/> </div> <div> Medication Side Effects <input type="checkbox"/> </div> <div> Walking Aid <input type="checkbox"/> </div> <div> IV Pole or Equipment <input type="checkbox"/> </div> <div> Unsteady Walk <input type="checkbox"/> </div> <div> May Forget or Choose Not to Call <input type="checkbox"/> </div> </div>	<div> IV Assistance When Walking </div> <div> Toileting Schedule: Every _____ hours </div> <div> Bed Alarm On </div> <div> Assistance Out of Bed </div>

Fall Prevention Information	
Your nurse has evaluated you and identified that you have a high risk for falling while in the hospital.	
Why are you at risk for falling?	
1. You are in an unfamiliar environment. 2. You are not feeling well.	
How can we work together to prevent you from falling while you are in the hospital?	
Tell your nurse about recent falls.	You have a high chance of getting hurt if you fall.
Call for help to get out of bed. You need someone to assist you. Make sure to use your walking aid while ambulating.	Call for help to get out of bed. You need someone to assist you.
The bed alarm/chair is on to remind you and your care team that you need help to get up.	Your doctor has put you on bed rest. Please call when you need help.
Call for help with toileting. Your care team will help you to the bathroom.	FALL RISK
Yellow Fall Risk wristband.	

Results

- Though post-intervention only started October 2019, the overall falls incidents **decreased by 14%** from 149 in 2018 to 128 in 2019
- The findings showed a **decrease in the falls rate** with the Fall TIPS program compared to pre-intervention from Sept. 2019 to post-intervention from Feb. 2020:
 - Falls rate per 1,000 pt. days: 4.73 to 1.46
 - Falls with injury per 1,000 pt. days: 1.18 to 0.58
- A Mann-Whitney U test of falls rate pre-intervention from Jan. 2018 to Sept. 2019 and post-intervention from Oct. 2019 to Feb. 2020
- Although there is **no statistical significance** of falls rates in using Fall TIPS, the data is trending towards significance.
 - Falls rate per 1,000 pt days: $U(N_{\text{Fall standard}} = 21, N_{\text{Fall TIPS}} = 5,) = 33, z = -1.27, p = 0.21$
 - Falls w/injury rate per 1,000 pt days: $U(N_{\text{Fall standard}} = 21, N_{\text{Fall TIPS}} = 5,) = 30, z = -1.47, p = 0.14$

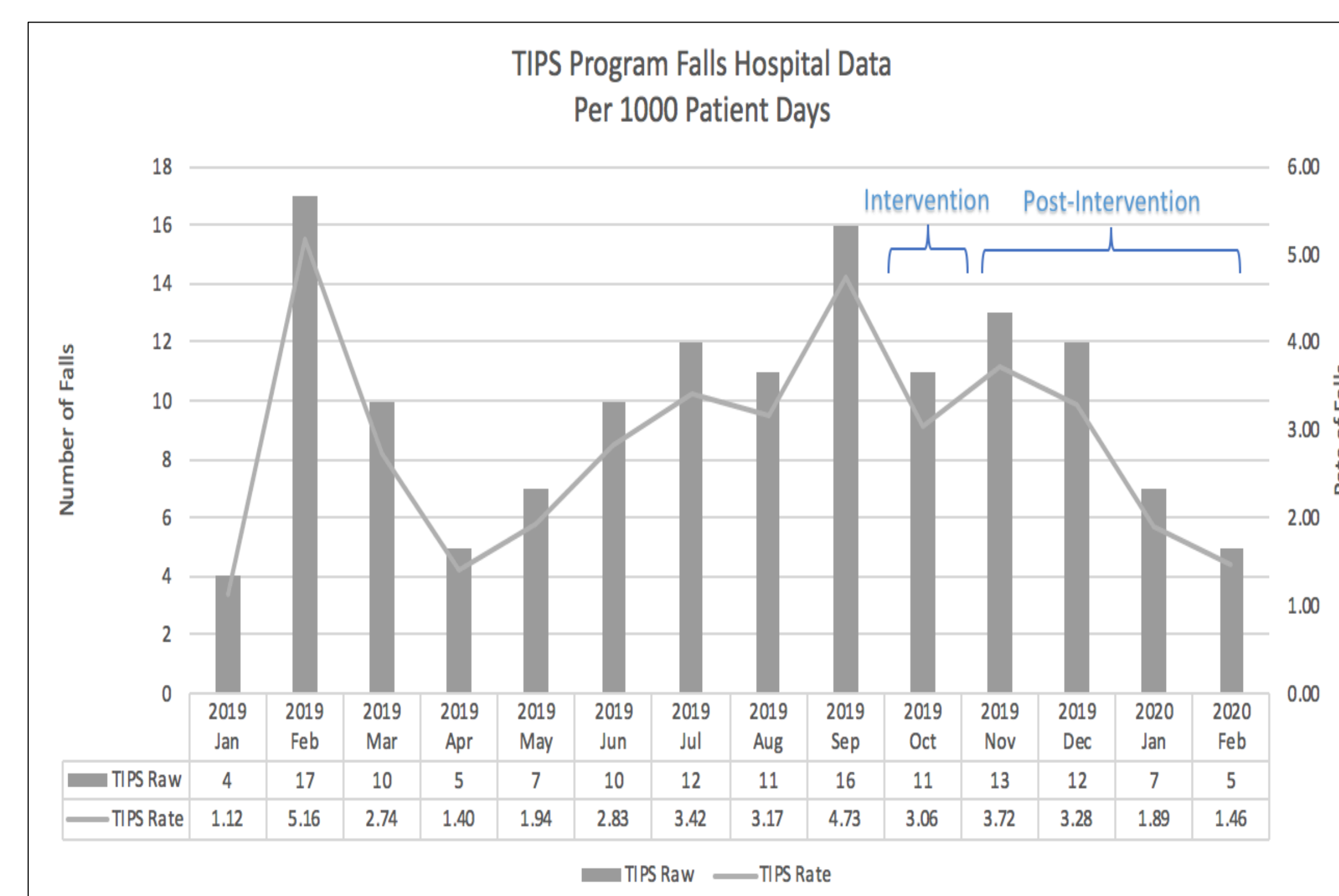


Figure 1
TIPS Program Falls Hospital Data (Jan. 2019 – Feb. 2020)

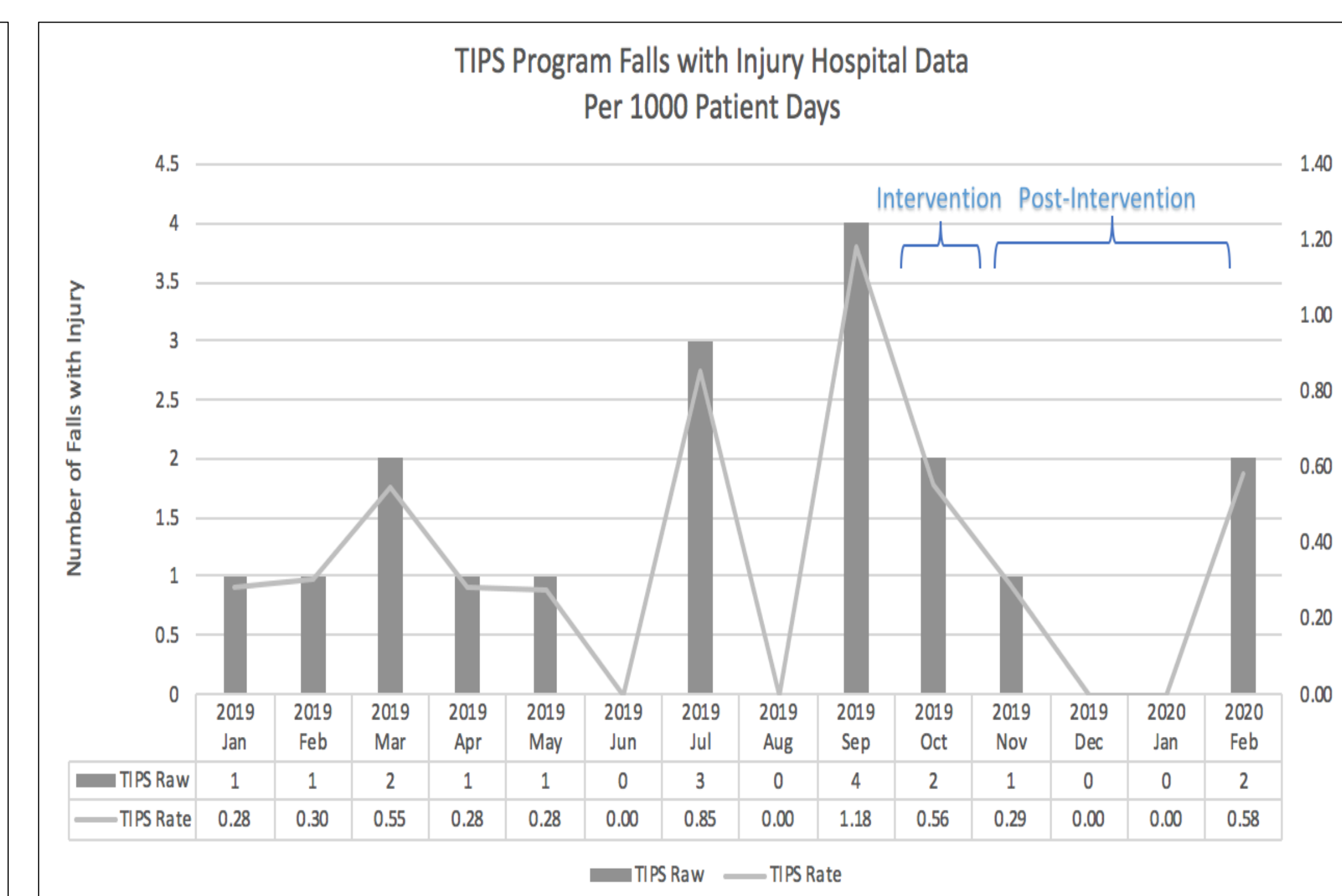


Figure 2
TIPS Program Falls w/ Injury Hospital Data (Jan. 2019 – Feb. 2020)

Discussion

- TIPS program showed a downward trend in the rate of falls and falls with injury
- Inpatient falls in psychiatric hospitals can be addressed and reduced using the Fall TIPS by continuously assessing the fall risk factors, tailoring interventions, and patient education

Discussion

- Universal fall precautions and fall risk injury assessment should be assessed
- Involving staff, patient, and family in fall prevention plan of care

Implications

- Clinical Practice: Communicating risk assessment, interventions, and education
- Healthcare Policy: Incorporated the TIPS program in the Fall Prevention Policy
- Quality and Safety: Continuous review of fall incidents, monthly tracking of data, and audits to ensure compliance
- Education: Educating the nursing staff and consistent patient and family education
- Economic Implications: Cost-savings
- Dissemination: Poster presentation within the hospital and university and publication submission
- Sustainability: Standard of care in Nursing practice and policy; monitoring of falls data; and continuous involvement of nursing staff and management

Conclusion

- Although not statistically significant, it assisted with the trending down of the falls rate by educating nurses in identifying risk factors, tailoring interventions using the EMR documentation/poster and educating patients

Reference List

Abraham, S. (2016). Factors Contributing to Psychiatric Patient Falls. *Journal of Community Medicine and Health Education*, 6(2), 1-10.

AHRQ. (2013). Preventing falls in hospitals toolkit to improve quality of care. Retrieved February 16, 2019, from <http://www.ahrq.gov/professionals/systems/hospital/fallpxtoolkit/fallpxtoolkit.pdf>

AHRQ. (2019). Falls. Retrieved February 16, 2019 from <https://psnet.ahrq.gov/primers/primer/40/Falls>

Dykes, P. C., Carroll, D. L., Hurley, A., Lipsitz, S., Benoit, A., Chang, F., . . . Middleton, B. (2010). Fall prevention in acute care hospitals: a randomized trial. *Journal of the American Medical Association*, 304(17), 1912-1918.