

Analysis of Patient Falls in Acute Care Settings

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Patient falls are both costly and dangerous to both patients and health systems. Since the aging patient population has led to more frequent patient falls in the acute care setting, hospitals must change to combat the higher frequency of accidental falls (Kobayashi et al., 2017). *Safety* is the primary QSEN competency covered by addressing the occurrence of patient falls (QSEN Institute, 2020). Reduction of patient falls is essential for health systems because it increases patient safety, reduces patient length of stay, and lessens the number of resources used by the hospital.

Literature Review

Incidence and Characteristics of Accidental Falls in Hospitalizations

In acute and long-term care settings, patient falls have always been an issue that needs more focus and correction. The aging of the average patient population has led to an increase in annual falls for most acute and chronic care facilities (Kobayashi et al., 2017). From April 2015 to March 2016, Nagoya University Hospital in Nagoya, Japan, admitted 49,059 patients to their medical services (Kobayashi et al., 2017). Of those 49,059 patients, 826 fell while admitted to the hospital (Kobayashi et al., 2017). That is a patient fall percentage of 1.7%. Of the 826 falls, 67% occurred in patients' rooms, setting a clear focus for action (Kobayashi et al., 2017). The primary commonalities between the falls were lower staffing, slipper usage, and improper marking of patient likelihood to fall (Kobayashi et al., 2017). Unsurprisingly, Nagoya University Hospital found that the fall rates decreased when they increased staff in specific areas where falls were most likely (Kobayashi et al., 2017). Staffing should be a primary focus point to decrease falls.

Additionally, when the patient wore slippers, there were increased adverse event rates when the patient fell (Kobayashi et al., 2017). Slippers should be discouraged, and patients

should wear athletic shoes or nonslip socks when in the hospital. Lastly, the hospital switched wristbands that ranked the likelihood that the patient would fall based on their fall scale (Kobayashi et al., 2017). The ranking wristbands ensured that staff knew that the patient was likely to fall and that the staff could pay more attention to that patient, decreasing the fall rates (Kobayashi et al., 2017). Falls propose a massive risk to patient safety and often cause harm to patients in many acute and long-term facilities. Limiting falls directly relates to the QSEN competency of safety because it will improve patient safety in hospitals and other facilities (QSEN Institute, 2020).

Prevention of Falls in Hospitals

Most hospitals report patient falls as their facility's most common safety event (Morris & O'Riordan, 2017). Although not all falls are preventable, approximately twenty to thirty percent could be prevented by assessing risks and taking measures to limit or get rid of the risks (Morris & O'Riordan, 2017). Taking measures to reduce falls is essential, considering the adverse event rate (Morris & O'Riordan, 2017). Approximately 30-50% of in-hospital falls have some form of physical injury, and a bone fracture occurs in approximately 1-3% of in-hospital falls (Morris & O'Riordan, 2017). However, the mental injury rate is incalculable but prominent (Morris & O'Riordan, 2017). For example, in-hospital falls increase the length of the hospital stay, increasing the patient's mental stress (Morris & O'Riordan, 2017). Additionally, future fear of falling will also affect the patient and might make the patient less likely to provide self-care, such as showering (Morris & O'Riordan, 2017). The most significant risk factor for falls is advanced age (Morris & O'Riordan, 2017). Because of that, nursing staff should ensure hourly rounding, if not more often, to ensure that older patients are cared for adequately. Limiting falls

in the hospital is related to the QSEN competency of safety because, as stated above, falls have lasting damage both physically and psychologically to many patients (QSEN Institute, 2020).

Inpatient Fall Prevention from the Patient's Perspective: A Qualitative Study

Most in-hospital fall prevention programs are developed and led by clinicians (Radecki et al., 2018). However, taking patient advice about preventing falls is essential to promoting long-term, successful change (Radecki et al., 2018). Patients often see faults in healthcare that staff might not see because patients are the ones receiving care (Radecki et al., 2018). Researchers asked three questions regarding patients' perception of their likelihood of falling (Radecki et al., 2018). The questions are about their perceived likelihood of falling, how the patient sees the usefulness of the anti-fall preventions, and barriers to effective fall prevention (Radecki et al., 2018). After the researchers asked these questions, they concluded that staff relationships with the patient could prevent falls (Radecki et al., 2018). Suppose the nursing staff develops a patient-centered relationship with the patient. In that case, this will allow for a better understanding of the patient's needs and aid in creating a more personalized fall prevention plan (Radecki et al., 2018). Fall prevention and a patient-centered relationship are essential aspects of the QSEN competency of safety (QSEN Institute, 2020).

Patient-Level and Organizational-Level Factors Influencing In-Hospital Falls

In a hospital setting, falls are one of the most prevalent issues faced by healthcare organizations and clients. Fall prevention is essential to ensure patient safety. A fall could cause a patient to be hospitalized longer, have slower healing, and lead to a more significant financial burden on the hospital and the patient. Risk factors for falls can include both patient and hospital factors. Some patient risk factors include age, medical conditions, impaired mobility, and medications (Kim et al., 2022). Older age and medical conditions that affect neurovascular

systems can lead to a greater risk of falling. Both risk factors can lead to impaired mobility and the need for more medications to treat the patients' conditions. Most of these are nonmodifiable risk factors.

Hospitals play an essential role in the management and prevention of falls. Some risk factors from the hospital side include the competency of the nurse staff, the appropriate number of nurses on duty to care for patients effectively, and having adequate technology in place to monitor patients at risk for falling (Kim et al., 2022). Adequate technology to prevent patients from falling includes monitors or bed and chair alarms and wearable devices. Patients with more extended nurse care had a lower risk of falling; therefore, adequate nursing staff is vital. New graduate nurses who do not have the clinical knowledge to be aware of all potential risk factors to prevent a fall may not provide the quality of care needed to prevent falls (Kim et al., 2022). Since this is a problem, it is crucial to provide hospitals with diverse nursing staff with ranges of experience to provide the best nursing care. Since patient risk factors are nonmodifiable, focusing on the hospital factors that can lead to falls is essential. Quality and Safety for Nurses' safety competency minimizes harm to patients and providers by the individual's involved performance and by having effective methods, processes, and technology (QSEN Institute, 2020). Through the competency of safety, hospitals should focus on providing appropriate staff and training and having adequate technology in place to prevent patient falls in the hospital.

Clinical Effects of Outpatient Health Education on Fall Prevention and Self-Health

Management of Elderly Patients with Chronic Diseases

One out of three people over 65 experiences a fall each year. Falls put high financial stress on the patients and their families since they lead to injuries and death (Wu et al., 2022). Patients with chronic illnesses are at the highest risk of experiencing falls (Wu et al., 2022). The

at-risk patients with chronic illness need proper education to lower their fall risk. This study divided 102 patients with chronic illnesses into two groups, the first receiving routine nursing care and the second receiving health education and guidance along with routine healthcare (Wu et al., 2022). The health education and guidance included individual rehabilitation programs and weekly phone calls from nurses. The researchers studied whether health education and nursing guidance improved the patient's risk of falls. The results showed that the group receiving the additional health education and guidance benefited from the group receiving only routine nursing (Wu et al., 2022). Some of the benefits noted include an increase in fall prevention knowledge, a better self-care ability, a better quality of life, and improved satisfaction with the nursing they received (Wu et al., 2022). Client health education and rehabilitation are essential to preventing and lowering the risk of falls. These outcomes can educate patients in both the outpatient and inpatient setting. When clients are educated about potential hazards and aware of their physical limitations, their risk of falling is lower. The rehabilitation can strengthen the clients and increase their mobility, reducing fall risk. Health education and rehabilitation regarding falls correlate to the QSEN competency of safety because it uses appropriate strategies to limit the patient's harm resulting from a fall (QSEN Institute, 2020). Through proper education, patients will have a lower risk of injury and death from falls.

Case Study

Limiting falls is a goal essential to every care setting. Whether ambulatory, acute, long-term, or any other setting, falls pose a risk to patients and should be managed accordingly. On a medical-surgical floor at a clinical site, a patient fell during the rotation. The patient had on slip-resistant socks and was a known fall risk. However, a fall still occurred. After the staff asked the

patient about the events leading up to the fall, they found that the patient's call light had been going off, and the staff was busy. Because the staff was busy, they did not respond promptly to the call light, and the patient got up alone to use the restroom. Two changes can come from this situation. First, increased staff could help eliminate this problem of being too busy during the shift. More staff would ensure that staff is better attending to patient needs. Second, a ranked wristband system would better help staff focus on patients at significant risk of falls. Under the current fall system, any patient considered a fall risk gets the same wristband even though some patients are at a much greater risk for falls. Under a ranked system, there would be multiple levels of fall risks, and therefore, staff could appropriately divide their attention. No healthcare system made this change. However, healthcare centers should consider these changes to increase patient safety due to the costliness of falls on patients and healthcare systems.

Synthesis

Practice:

Nurses can implement interventions to prevent falls in the acute care setting in various ways. The primary interventions in preventing falls are increasing staffing and making others aware of patients' fall risks with wristbands. The study at Nagoya University Hospital proved that falls declined when staff increased in the areas where falls were likely to occur (Kobayashi et al., 2017). Another safety measure put into practice at this hospital was patients wearing wristbands based on their fall risk. If patients have wristbands, staff can pay close attention to these patients, and this could decrease the fall rates (Kobayashi et al., 2017).

Education:

Since falls are a recurring problem in the acute care setting, teaching must be improved to reduce accidental falls. Nurses and patients can play a role in the prevention of falls. Nurses should know what risk factors and comorbidities place patients at a higher risk of falling. Some risk factors that place patients at a higher risk of falling include advanced age, chronic illness, and impaired mobility. Another way nurses can prevent falls is by knowing potential hazards. Patients can play a part in preventing falls by being educated, aware of their physical limitations, and knowing when to ask for help. When nurses get the proper education, they can properly educate their patients.

Research:

The priorities for further study include the prevention of falls through intervention and education. Future studies should compare interventions that prevent falls to determine a standard of care that consistently shows a decline in fall rates. Educating patients and staff on potential hazards and risk factors can lower fall rates in the acute care setting. Incorporating fall risk evaluation and prevention education into the admission process can help lower fall rates and decrease the number of injuries and deaths that occur from falls.

Conclusion

Falls pose a significant risk to patients in acute, long-term, and almost all care settings. Staff and healthcare systems must reduce falls to increase patient safety. Falls can have a lasting effect on a patient's physical and mental health. Patient falls are costly not only to patients but also to the healthcare facility, and because of those reasons, facilities must take action to reduce them.

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