

Abstract Title: Post-Implementation Analysis of a Revised Fall Prevention Program at a Magnet Community Hospital

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Research Questions: Have psychiatric and medical patient fall rates been influenced by revised fall prevention program interventions? Are nursing staff knowledgeable about the revised interventions and if so how effective do they think the revisions have been?

Background: National Patient Safety Goal 9, “reduce the risk of harm resulting from patient falls” (The Joint Commission, 2008), has focused attention on fall injury prevention for a number of years. More recently, awareness of this patient safety issue has been heightened due to The Centers for Medicare and Medicaid Services’ payment reforms for ‘never events’ (2008). As acute care facilities review their fall prevention policy and procedures and staff education, it is prudent to gather and analyze hospital-specific data to inform these processes.

Sample: Fall data (95 occurrences) was gathered from adult psychiatric and medical patients hospitalized from 10/01/06 through 09/30/07. A total of 160 hospital staff members responded to an anonymous survey regarding awareness and effectiveness of fall prevention interventions.

Methods: Donabedian’s Model of Healthcare Quality utilizing structure, process, and outcomes (Polit & Beck, 2004) served as the framework to guide the research, i.e. continual policy analysis (structure) and nursing interventions (process) should positively impact and improve overall patient safety with regard to patient falls and fall-associated injuries (outcomes). The study design was comparative and correlational. Patient chart and risk management reports were reviewed retrospectively for fall type, severity of injury, mental status, age and gender of patients who fell. Data analysis included descriptive and inferential statistics. Since nurses and nursing assistants are required to complete fall prevention education annually, an electronic survey was developed and distributed housewide to evaluate staff awareness of the revised fall interventions.

Results: In a prior study (Yates, Kulcsar & Tart, 2007), data revealed psychiatric inpatients fell more often than medical patients. Following fall prevention program revisions, the converse was true. In a comparison analysis, the psychiatric fall rate decreased from 7.97 (2005-06) to 5.09 (2006-07), and a 2.8-fold reduction in their injury fall rate was seen. Between the two time periods, the medical fall rate rose 48.83% and the injury fall rate increased 2.4-fold. Non-adherence to fall policy interventions, e.g. failure to use bed exit alarms, nonskid gripper socks and lack of patient medication profile review potentially contributed to the medical phenomenon. Nurses and nursing assistants reported that nonskid gripper socks (95%) and Posey® Sitter Select devices (72%) were helpful in preventing patient falls.

Implications for Practice: To enhance awareness, increase accountability and continue to improve patient safety, these results have been disseminated to staff and the Fall Prevention Committee, which has taken action on shortcomings exposed by the study. Hourly rounding, by nurses and nursing assistants, has since been piloted on two inpatient service areas to evaluate its effectiveness in reducing patient falls. Plans are underway to pilot hourly rounding housewide to address not only inpatient falls, but pain, skin integrity and patient satisfaction as well.

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Yates K, Kulcsar A, Tart RC. *Evaluation of psychiatric and medical patient falls to inform and guide revision of a community hospital fall prevention program.* Poster presentation: 8th Annual Evidence-Based Practice Conference: Translating Research Into Best Practice With Vulnerable Populations, Phoenix, AZ. Presented February 22, 2007.