

PREDICTING PATIENTS AT RISK FOR FALLING IN THE EMERGENCY DEPARTMENT

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PURPOSE AND RATIONALE:

The dynamic, high-stimulus environment of the emergency department coupled with the potential for a rapid change in patient condition requires a comprehensive fall screening tool which can be administered quickly and accurately in the outpatient setting. In 2009, HH ED reported a total of 40 patient falls. This translates into 0.4 falls per 1000 patient visits and was the third highest number of falls in one area. This prompted in depth chart reviews of the falls that occurred in the emergency department. We found 63% of the falls took place within the first 3 hours of the patients ED stay and most were due to attempts to reach the toilet. We also found 25% of the patients who fell were not identified as a fall risk when screened with our fall risk assessment tool at the time of arrival. It is worth noting the 38% of the falls occurred in patients under the influence of alcohol or illegal substances. Some of these patients were not identified as a fall risk at triage when using our traditional fall risk assessment.

RESEARCH QUESTIONS

Can a Modified Fall Risk Assessment Tool improve the identification of fall risk patients in the ED and therefore decrease ED fall rates?

Would increasing the frequency of fall risk screening on patients in the ED prevent more falls by identifying patients with a change in condition?

SYNTHESIS OF REVIEW OF LITERATURE

Many studies have been done on falls experienced by inpatients, but very few on patient falls in the Emergency Department (ED). Of the 2 studies found in the literature on ED falls, both were retrospective descriptions of the type of patient who fell. Both concluded that standard fall risk assessment tools validated for the inpatient population may not be sensitive for the ED population. Dukes et al (1990) Terrell et al (2009)

METHODS AND PROCEDURES

A Modified Fall Risk Assessment was designed to include patients under the influence of alcohol or illegal substances. Registered nurses will be educated on the Modified Fall Risk Assessment Tool and the related interventions. Each patient will be assessed at triage for risk of fall status. If not at risk for falling (score of 0), the patient will be reassessed at least 2 hours after the initial nursing assessment is completed post triage, at change of condition or after an intervention which may impact his fall risk status. Once an emergency department patient is deemed a fall risk, he will always be considered at risk for falling for the remainder of the ED stay. The fall prevention protocol will be instituted, which includes identification of the patient as a fall risk with a green bracelet and triangle, exit alarms and frequent checks. Fall risk patients are instructed to call for assistance with toileting and ambulation. The number of falls pre and post intervention (use of modified fall risk tool) will be compared. The number and profile of patients who change from a non fall status at triage to a fall risk status during their ED stay will be explored.

RESULTS:

Data will be collected from September 1, 2010 through October 1, 2010. We anticipate that this will allow for at least five thousand patient visits in which to evaluate the fall screening tool.

DISCUSSION/APPLICATION TO PRACTICE:

It has been discussed for decades among healthcare providers that patient falls and fall related injuries are a major patient safety issue. Being able to accurately identify patients at risk for falling at the point of entry will be the first step toward preventing patient harm and possibly avoiding a prolonged hospital stay or significant injury. Incorporating fall risk assessment into the emergency nursing practice will provide a much needed step toward patient centered nursing.

Dukes, I.K., Grant, M.K., Pathakji, G.S. (1990) Accidents in the accident and emergency department. Arch Emerg Med; 7: 122-4.

Terrell, K., Weaver, C., Giles, B., and Ross, M. (2009) ED patient falls and resulting injuries. Journal of Emergency Nursing, 35: 89-92.

