

Privacy or Safety: What is BEST practice to keep patient's from falling?

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ABSTRACT

According to Morse (1997, p.2), "falls are the second leading cause of death in the United States; 75% occur in the elderly population." Hendrich (2006) states that more than half of all falls occur when patients try to get to the toilet while exiting the bed, and a regular toileting schedule for patients identified as high risk due to impaired mobility or drug side effects will reduce falls in most acute care hospitals. This evaluation was conducted for the purpose of determining if the intervention, a "no toileting alone" protocol, reduced falls with patients identified as high risk (greater than 51 on the Morse Fall Scale (MFS)) for the study units following the implementation of the "no toileting alone" protocol. The questions that guided the evaluation were:

1. Does use of a "not toileting alone" protocol decrease the total number of falls and fall rates of patients identified as high risk on the MFS?
2. Is the severity and injury of a fall pre-protocol greater than post-protocol?

PURPOSE

The purpose/goal of this presentation is to show that a "no toileting alone" protocol works to reduce patient falls in those patient's who are at high risk for falling. In order to accomplish this a true collaborative approach was implemented between the DNP and multiple other professions within the hospital. A partnership was formed with patient's, families and bedside caregivers to understand the importance and reasons why assisting with toileting and being within arms reach of the patient was necessary while using the bathroom. Bedside caregivers included physicians, nurses and nursing assistants. This collaborative program is transforming our fall program and improving the safety of our patients.

OBJECTIVES

- By the end of this presentation the participant will be able to:
- ❖ Define the significant factors related to falls in high risk patients.
 - ❖ Identify how a "no toileting alone" protocol decreases falls and falls with injury
 - ❖ List the components of the "no toileting alone" protocol

METHODS

A retrospective analysis will be conducted, using a cross-sectional review design. The research was conducted in a 437 bed not-for-profit Midwest healthcare setting. The two protocol units where the "no toileting alone" protocol was introduced included a 26 bed medical unit and a 34 bed surgical unit. Data will be analyzed using archived fall incident reports for patients identified as high fall risk (> 51 MFS) from Feb 2012 thru Jan 2013 for the pre-protocol data and Feb 2013 thru Jan 2014 for the post protocol data of de-identified patients who fell. The rate of falls per 1000 patient days was calculated at the unit level for both pre-protocol (n=9) and post-protocol units (n=2) for the evaluation period starting Feb 2012 through Feb 2014. The "no toileting alone" protocol was introduced in Feb 2013. The inpatient sample size included 78 inpatients that fell from Feb 2012 to Feb 2014. Descriptive statistics collected included age, gender, Morse Fall Score, Total Length of stay (LOS) and LOS post fall.

The "no toileting alone" protocol consisted of completing a fall partnership agreement with the patient and family, referencing signs placed above the patient's bed on the ceiling reminding them to call for assistance before getting out of bed, utilizing bed alarms and chair alarms to alert staff when patients were attempting to get out of bed alone and put high fall risk patients on an every 2 hour toileting schedule. The most important part of the protocol was that staff were to remain within an arms length of the patient or have the patient in visual sight. Staff were extensively educated on all of these interventions related to the "no toileting alone" protocol.



RESULTS

The analyses of the data were divided into pre and post protocol groups

1. Does a "no toileting alone" protocol decrease the total number of falls and fall rates of patients identified as high risk on the MFS??"

Data from eleven units were used to calculate the pre protocol fall rates. A pre protocol fall rate (n = 11) showed a mean value of 3.6211 (Figure 1).

Parametric (T-tests) and non-parametric (Wilcoxon rank sum) statistical tests were conducted on the sample units (n = 2) where the "no toileting alone" protocol was applied. In addition, analysis of pre and post fall rates of the two units was carried out. The post protocol rate (n = 2) showed a mean of 1.970 (Figure 2). There was a lack of variability due to the small sample. The Wilcoxon rank sum test demonstrated a one tailed (indicating an expectation the post protocol rates will fall) (p = 0.0783). Although greater than the significance .05 level it was close. Results of this inquiry demonstrate that although not statistically significant at the .05 level the total numbers of falls and fall rates did decrease.

Fig. 1

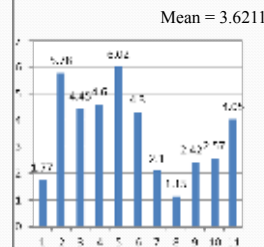


Fig. 2

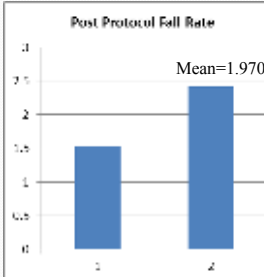


Table 1 Descriptive Statistics

Characteristic	Unit	Pre-Protocol		Post-Protocol	
		Mean	SD	Mean	SD
Age	1	70	12.20	74	10.00
Age	2	70	10.42	74	10.00
Morse Fall Score	1	52	12.12	51	10.00
Morse Fall Score	2	50	11.11	51	10.00
LOS	1	10	10.00	10	10.00
LOS	2	10	10.00	10	10.00
LOS	3	10	10.00	10	10.00
LOS	4	10	10.00	10	10.00
LOS	5	10	10.00	10	10.00
LOS	6	10	10.00	10	10.00
LOS	7	10	10.00	10	10.00
LOS	8	10	10.00	10	10.00
LOS	9	10	10.00	10	10.00
LOS	10	10	10.00	10	10.00
LOS	11	10	10.00	10	10.00
LOS	12	10	10.00	10	10.00
LOS	13	10	10.00	10	10.00
LOS	14	10	10.00	10	10.00
LOS	15	10	10.00	10	10.00
LOS	16	10	10.00	10	10.00
LOS	17	10	10.00	10	10.00
LOS	18	10	10.00	10	10.00
LOS	19	10	10.00	10	10.00
LOS	20	10	10.00	10	10.00
LOS	21	10	10.00	10	10.00
LOS	22	10	10.00	10	10.00
LOS	23	10	10.00	10	10.00
LOS	24	10	10.00	10	10.00
LOS	25	10	10.00	10	10.00
LOS	26	10	10.00	10	10.00
LOS	27	10	10.00	10	10.00
LOS	28	10	10.00	10	10.00
LOS	29	10	10.00	10	10.00
LOS	30	10	10.00	10	10.00
LOS	31	10	10.00	10	10.00
LOS	32	10	10.00	10	10.00
LOS	33	10	10.00	10	10.00
LOS	34	10	10.00	10	10.00
LOS	35	10	10.00	10	10.00
LOS	36	10	10.00	10	10.00
LOS	37	10	10.00	10	10.00
LOS	38	10	10.00	10	10.00
LOS	39	10	10.00	10	10.00
LOS	40	10	10.00	10	10.00
LOS	41	10	10.00	10	10.00
LOS	42	10	10.00	10	10.00
LOS	43	10	10.00	10	10.00
LOS	44	10	10.00	10	10.00
LOS	45	10	10.00	10	10.00
LOS	46	10	10.00	10	10.00
LOS	47	10	10.00	10	10.00
LOS	48	10	10.00	10	10.00
LOS	49	10	10.00	10	10.00
LOS	50	10	10.00	10	10.00
LOS	51	10	10.00	10	10.00
LOS	52	10	10.00	10	10.00
LOS	53	10	10.00	10	10.00
LOS	54	10	10.00	10	10.00
LOS	55	10	10.00	10	10.00
LOS	56	10	10.00	10	10.00
LOS	57	10	10.00	10	10.00
LOS	58	10	10.00	10	10.00
LOS	59	10	10.00	10	10.00
LOS	60	10	10.00	10	10.00
LOS	61	10	10.00	10	10.00
LOS	62	10	10.00	10	10.00
LOS	63	10	10.00	10	10.00
LOS	64	10	10.00	10	10.00
LOS	65	10	10.00	10	10.00
LOS	66	10	10.00	10	10.00
LOS	67	10	10.00	10	10.00
LOS	68	10	10.00	10	10.00
LOS	69	10	10.00	10	10.00
LOS	70	10	10.00	10	10.00
LOS	71	10	10.00	10	10.00
LOS	72	10	10.00	10	10.00
LOS	73	10	10.00	10	10.00
LOS	74	10	10.00	10	10.00
LOS	75	10	10.00	10	10.00
LOS	76	10	10.00	10	10.00
LOS	77	10	10.00	10	10.00
LOS	78	10	10.00	10	10.00
LOS	79	10	10.00	10	10.00
LOS	80	10	10.00	10	10.00
LOS	81	10	10.00	10	10.00
LOS	82	10	10.00	10	10.00
LOS	83	10	10.00	10	10.00
LOS	84	10	10.00	10	10.00
LOS	85	10	10.00	10	10.00
LOS	86	10	10.00	10	10.00
LOS	87	10	10.00	10	10.00
LOS	88	10	10.00	10	10.00
LOS	89	10	10.00	10	10.00
LOS	90	10	10.00	10	10.00
LOS	91	10	10.00	10	10.00
LOS	92	10	10.00	10	10.00
LOS	93	10	10.00	10	10.00
LOS	94	10	10.00	10	10.00
LOS	95	10	10.00	10	10.00
LOS	96	10	10.00	10	10.00
LOS	97	10	10.00	10	10.00
LOS	98	10	10.00	10	10.00
LOS	99	10	10.00	10	10.00
LOS	100	10	10.00	10	10.00

CLINICAL IMPLICATIONS

The impact of a "no toileting alone" protocol did not demonstrate statistical significance but did demonstrate clinical significance to this inquiry. The clinical significance of a decrease in the number of falls and the overall fall rates for the post-protocol units was significant in terms of program outcomes. This pilot gives further reason to study the impacts of a "no toileting alone" protocol with a larger sample population. These results support the findings that toileting was one major factor related to inpatient falls and that a "no toileting alone" protocol may be critical to fall prevention (Hendrich, 2006; Sullivan & Bandros, 1999, and Alcee & Mather, 2000). The findings of this study underline the importance of assuring patient safety while toileting.

Nurses must acknowledge the importance to patient safety for remaining with high fall risk patients while toileting and recognize this is an important intervention for fall prevention. It is prudent to conduct further study to establish a relationship between toileting alone and the "no toileting alone" protocol. Strategies must be identified to allow for nurses to remain with patients assessed at high fall risk while accommodating the needs of the other patients they are responsible for. Until there is greater understanding for rationale preventing nurses from staying with patients while toileting the true benefits of a "no toileting alone" protocol will not be fully realized?

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