Implementation of a Multifactorial Fall Prevention Protocol to Reduce Fall Rates in an Inpatient Psychiatric Unit

By

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Abstract

There is a continuous effort to reduce the number of falls that occur in hospitals across the world. Fall prevention strategies have evolved into standards of care in all aspects of healthcare. As such, fall rates continue to be an ongoing problem among various inpatient units. Patients in psychiatric facilities have comorbidities and healthcare needs, as do those in inpatient medical units, which contribute to their risk of falling while in the hospital. Much of the research is targeted toward fall rates and fall prevention strategies in medical units rather than in the psychiatric/mental health population. Unfortunately, there is limited information to support standardized fall prevention strategies that are specific to inpatient psychiatric units. Since falls that occur in inpatient psychiatric units are incorporated into the total numbers of falls within an organization, this pilot study evaluates the need for a multifactorial fall prevention protocol that is specific to psychiatric patients and the unit in which they are admitted. A pre-and-post intervention evaluation was conducted to determine the effectiveness of strategies developed to promote safety and prevent falls in an inpatient psychiatric unit.

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Chapter I: Introduction

Falls continue to be a healthcare issue that is consistently being addressed to meet national standards of safety and quality. In the United States alone 30% to 40% of patient safety issues are related to falls, and there is an overabundance of reported falls and data within medical units, yet there is a lack of reports to justify the high incidence of falls in psychiatric inpatient units (Abraham, 2016a).

By the year 2020, costs associated with patient falls are expected to reach approximately $43.8 billion dollars, and these values are the main reason why hospitals are held to a critical standard of preventing hospital-related injuries (Abraham, 2016a). Additionally, the National Database of Nursing Quality Indicators (NDNQI) is the leader in collecting data for quality and patient safety within hospitals around the nation. The NDNQI relates that since 2003, collection of data regarding falls has been obtained from Critical Care, medical-surgical units and step-down intensive care units; however, a new initiative in 2012 was to explore specific risk factors for falls in other areas of nursing including pediatrics, psychiatric and neonatal populations (Staggs, Davidson, Dunton, & Crosser, 2015). Despite the continuous battle to analyze causes of patient falls in general, the psychiatric population is falling behind in being part of the potential for change and improvement.

This project contributes to the limited current research on fall prevention programs specifically in psychiatric inpatient units. By identifying the areas of fall prevention practices that need improvement, implementation of a multi-factorial fall prevention program could incorporate initiatives adopted by other researchers' evidence while enhancing current unit practices to reduce the number of falls. Addressing safety and fall prevention measures for this

specific unit has been an ongoing process and the goal of eliminating falls is of benefit to not only the patient, but to the organization as well.

Background and Significance

Fall prevention programs are aimed to reduce the number of fall rates and the severity of potential injuries if any occur, which can be fatal or non-fatal (World Health Organization, 2017). Approximately 37.3 million falls that occur each year require some medical attention in healthcare (WHO, 2017). The Joint Commission on Accreditation of Healthcare Organizations deemed reducing the risk for patient harm relating to falls a goal, yet the incidences of falls continue to be problematic for many psychiatric institutions (Van Dyke, Singley, Speroni, & Daniel, 2014). Additionally, Abraham (2016a) relates the costs associated with injuries from patient falls is about $20 billion in the United States alone. Throughout the evidence, the risk factors for patient falls are clear. There seems to be a gap in the evidence regarding nursing and staff interventions to prevent falls and promote safety within a psychiatric unit setting.

As a nurse working within a medical inpatient setting and having many years of experience working in inpatient psychiatric hospitals, the author notes that purposeful or hourly rounding has become the standard of care for patients on medical floors but has had inconsistencies in maintaining a standard of care for the psychiatric population. The literature review by DaSilva (2017) corroborates the moderate strength in evidence that there is a lack of attention on rounding in a psychiatric setting. Further research is needed to determine best practices by staff in inpatient psychiatric units to reduce falls.

Needs Assessment

On a psychiatric unit in the Southeast United States that was used as the setting for this project, the fall incidence is rarely zero and the fall prevention measures in place have not been

adjusted or modified since opening the unit in 2012. The practices to safeguard against falls do not include the patient or other disciplines such as pharmacy or physical therapy. Additionally, the staff do not have any formal training on fall prevention practices other than the general hospital orientation that is not specific to the psychiatric population. Adding a multidisciplinary approach with staff and patient education and patient endorsement to fall prevention measures would address the areas that current practices are missing. Though fall rates are lower than other areas of the hospital, there is a need to review and improve current practices to reduce the incidence of falls.

Problem Statement

There is substantial evidence on fall-risk assessment tools, fall rates, costs associated with falls in the hospital, fall reduction approaches and overall adverse outcomes related to patients falling in medical units. There is limited evidence to support the severity of falls in a psychiatric setting, though equally essential and just as likely to occur as in a medical unit.

There are varying characteristics in patients admitted to a psychiatric unit that need to be explored and considered when addressing falls. These include psychiatric diagnoses, medical comorbidities, age, medication regimens, competency, cognitive status, environment, patient compliance and even staffing; these can all affect the incidents of patient falls (Abraham, 2016b). Considering the factors mentioned and knowing there are many other risks for falls in this population, one would assume that there would be more of a focus on preventing falls in inpatient psychiatric units, especially considering the impact of psychotropic medication on patient balance and mobility. In fact, there is a lack of evidence to support the use of fall risk assessments to assess risk due to psychotropic medications as well as mental health status. Including Pharmacy and Physical Therapy evaluations for collaboration in identifying fall risks

are rarely utilized in the units' current practices. Also lacking in evidence is the benefit of incorporating fall safety rounds to ensure all fall measures are in place and fall prevention education for psychiatric patients and staff. Preventing falls by utilizing specific tools or interventions are grossly studied in every other aspect of healthcare.

Additionally, there are many associated factors with patient falls, and it is very difficult to delineate the specific risks within the psychiatric population. For example, a 22-year-old psychiatric patient diagnosed with mood disorder or psychosis may potentiate acting out behaviors, falling, having pseudo-seizures or non-epileptic psychogenic episodes. This patient may also have a true diagnosed seizure disorder and may be taking benzodiazepines and anti-epileptic drugs in addition to mood stabilizing/psychotropic medications, which all significantly increase the patient's risk for falls. Because the patient may be young and considerably healthy from a physical standpoint, there may be a lack of fall prevention interventions in place. The complexities of a patients' mental health, moreover, may contribute to challenges in differentiating whether the patient had a true fall or if it was a behavioral issue. In comparison, a medical patient who is 95 years old with a history of dementia, osteoarthritis, and hypertension may be on three to five medications all of which increase their risk for falls. Due to the age and health conditions, it is possible the geriatric patient will be monitored more closely than the 22-year-old psychiatric patient. In this example, it is likely the medical patient has standard fall precautions in place already but these options are limited in a psychiatric setting.

Project Aim

The aim of this project is to evaluate the effectiveness and acceptability of an intervention designed to reduce the number of falls in the 25-bed inpatient psychiatric unit utilizing a multi-factorial approach including patient education and staff education on fall prevention, as well as

collaboration with multidisciplinary team members including pharmacy and physical therapy consultations.

Unit leadership at a 438-bed hospital in the South Eastern United States has identified an inconsistent trend per quarter in the number of falls among the psychiatric population. Many questions arise when evaluating patient fall rates in a psychiatric unit. Is there a gap in education among the staff on identifying falls? Is there a lack of resources that are not readily accessible to staff that educates them on the combination of risks associated with mental illness, medications and medical comorbidities? Is there a psychiatric specific intervention that can be utilized by nurses and staff to prevent patients from falling? Are Psychiatrists considering the potential side effects each of the psychotropic medications can elicit when taken concurrently Are the fall risk assessment tools used to identify a high fall risk patient not conducive to the psychiatric population? Would including a pharmacy and/or a physical therapy evaluation aid in identifying higher risk patients? Appendix G depicts the fall rates by quarter for 2017 and what has already been reported for quarter one of 2018. Quarters two and three in 2017 have the highest percentage of falls, so these two quarters will be used for data analysis in this study.

Objectives. The goals of the project include:

-To evaluate current rounding practices and its effects of fall prevention measures on overall fall rates in the inpatient psychiatric unit.

-To identify trends contributing to patient falls on the inpatient psychiatric unit using root cause analysis (RCA).

-To develop a falls/safety initiative comprised of a multidisciplinary approach in conjunction with hourly rounding by staff aimed at reduction of falls.

-To create educational tool for the psychiatric patient to be provided on admission requiring acknowledgment of receipt as an understanding of fall prevention measures. The clinical standard for patient education in healthcare already exists, fall prevention education is not a practice consistently being done.

-To implement educational competency for staff using theoretical frameworks to address patients' risk for falls, new processes for collaborative evaluations, and falls safety checklist to assist nurses and staff with fall prevention initiatives to reduce the number of falls.

Clinical Question

In a 25-bed inpatient psychiatric care unit, will implementing a multifactorial fall prevention protocol including staff and patient education reduce the number of falls over six months compared to 2017 fall rates?

Congruence of Organizations' Strategic Plan

The organizational plan is based on the premise of health promotion, upholding patient safety, exceeding standards of excellence, decreasing adverse events and maintaining the quality of care to all individuals. The psychiatric unit’s strategic plan includes promoting mental health needs of the implied population, maintaining safety, decreasing adverse events, ensuring standards of laws/rights and privacy of psychiatric patients are upheld.

The unit is a 25-bed inpatient psychiatric unit within a 438-bed acute care hospital located in the United States. The unit contains a shared-governance to share process-improvement strategies and involve staff in decision-making processes. Additionally, the organization intends to provide every individual group and individual psychotherapy, a medication assessment and offer educational groups for patients. While utilizing a multidisciplinary approach, staff aim to deliver compassionate care while maintaining safety,

comfort, and confidentiality. One of the main focuses of this behavioral health unit is to optimize the patient's experience focusing on their diagnosis to implement interventions targeted toward stabilization and aid in returning to optimal functioning. Therefore, the impetus for this fall prevention and safety initiative is consistent with the organization's strategic plan, mission, and values by promoting safety and communication between the patient, nurse, and staff as well as decrease potential adverse events while hospitalized.

It is never the intention of the organization to cause harm or contribute to it; however, the complexities surrounding a psychiatric patient pose potential risks for falling thereby contributing to injury, prolonged hospitalizations, increased costs, decreased health outcomes and more. Induction of a fall prevention safety initiative is needed to reduce the number of falls within this inpatient unit.

Chapter II: Review of Literature and Theoretical Framework

Review of Literature

The data related to falls in inpatient medical units are extensive, and depending on what the focus is, there is an abundance of information regarding factors associated with falls. For this project, literature was reviewed in inpatient medical units to depict the profound deficit in components attributing to falls and fall prevention strategies within psychiatric settings. There is also an abundance of information on geriatric psychiatric units but the unit in which the study will be conducted; patients are from age 18 and older. Though this is not a geriatric psychiatric unit, elderly patients do comprise the population, so the potential for falls is significant.

Gap in Literature

There are limited current data to illustrate the significance of nursing and multi-disciplinary involvement in the implementation of fall prevention and safety initiatives in acute psychiatric settings. Additionally, there is a lack of recent evidence regarding efficacious fall prevention strategies that coexist among psychiatric patients with the inclusion of comorbidities, polypharmacy, education for patients and staff as well as checklists to ensure each measure is in place. Therefore, the evidence synthesized will allow the reader to understand why a multi-disciplinary and multi-factorial approach to the development of this program is warranted.

Search Process

Various literature databases were used for the review of literature, including CINAHL (Cumulative Index to Nursing and Allied Health), Google scholar, Bradley University Online Library Database for peer reviewed journals, Ebscohost, PsycINFO, Wiley Online Library and Ovid. Key words for the searches included: Purposeful rounding in mental health, benefits of rounding in psychiatric settings, effects of rounding and adverse events, falls in inpatient

psychiatric units, rounding to improve patient outcomes, fall rates in psychiatric hospitals, risk factors for falls in psychiatric patients, fall prevention in psychiatric units, fall assessment tools in psychiatric units, and falls in mental health.

In searching for evidence of pharmacy involvement in the use of fall prevention in psychiatric patients since 2014, greater than 16,000 articles presented including results involving the geriatric or elderly population, nursing home reviews, polypharmacy contributing to falls in the elderly, psychotropics associated with hip fractures, emergency room assessments for falls and falls in acute care hospitals. Inclusion for this section of the review included dates after 2014, psychotropic medications co-occurring with other drug classifications increasing fall risks, and pharmacy collaboration or multi-disciplinary approaches as a measure for implementation of fall prevention strategies in psychiatric units. Thus, five articles within the specified inclusions are reviewed including one qualitative study on older adults (65 or older) and one article dated back to 2010 within this criterium for its substantial attribute to this study. Exclusion criteria were studies only focusing on geriatric populations or any area of clinical practice other than acute psychiatric inpatient units and studies conducted before 2014.

To depict the severity of falls in general, costs and general risk factors attributed to falls, assessing for falls in both medical and psychiatric units were searched resulting in over 300,000 articles. Data after 2014 on implementation of fall prevention strategies in inpatient psychiatric units and effects of rounding to decrease fall rates in inpatient psychiatric units were searched resulting in over 16, 000 articles. Of these articles, eight were selected for review based on their relevance to this study Exclusion criteria included articles that were not peer-reviewed and those that were dated before 2012 unless it was instrumental in adding to current literature. Inclusion criteria were fall rates in inpatient psychiatric units, analysis of fall risk factors specific to a

general psychiatric population (not medication related), rounding as an intervention to reduce falls, comparison of fall prevention programs (including fall risk assessment tools), peer-reviewed and data pertinent to this unit specific initiative.

Falls Related to Medications

In a significant quantitative analysis of incident reports between 2004 and 2010, over 154618 patient falls within academic medical centers were analyzed and found that the psychiatric population was considered one of the most at-risk populations (Williams, Szekendi & Thomas, 2014). Williams, Szekendi, & Thomas (2014) related that many of the psychiatric medications used contribute to falls by symptoms of hypotension, confusion, and dizziness while patients are ambulating as opposed to being in bed. One-third of psychiatric patient falls were found to be repeat falls, in which patients were three to five times more likely to be taking psychotropic medications (Williams et al., 2014). Additionally, the literature review by Abraham (2016c) distinctly identifies the lack of studies on psychiatric patient falls and depicts the specific factors associated with falls including psychotropic medications, mental status, patient behavior, medical comorbidities and even the lack of knowledge by physicians regarding complex medication regimens relating to falls.

Lavsa, Fabian, Saul, Corman and Coley (2010) were instrumental in adding to previous research in associating falls with medications specifically in adult psychiatric populations. Lavsa et al. (2010) conducted a retrospective case-control study including 774 documented falls while considering the complexities of psychiatric diagnoses as well as medical diagnoses contributing to side-effects and potentiating further risk for falls. The use of the atypical anti-psychotic drug Lithium for example was found to be a common drug in patients who had fallen but this drug had not been identified in other published studies as a risk factor for falls (Lavsa et al., 2010). The

adverse effects of many atypical antipsychotics are recognized for their effects on the central nervous system, such as symptoms of ataxia, muscle rigidity and vertigo (Lavsa et al., 2010). Each of these symptoms are assessed by the nurse during the fall risk assessment scoring identifying this patient as a high risk. Additionally, concurrent use of psychotropic medications and other classifications of drugs such as benzodiazepines were not analyzed as predictors of falls but, use of multiple cardiac medications were noted in many of the patients who had fallen (Lavsa et al., 2010). Many of the patients had also been prescribed either atypical antidepressants, sleep aides, benzodiazepines, alpha-blockers or anticonvulsants where other studies referenced had noted other classifications to have equal or greater significance to falls (Lavsa et al., 2010). Other predictors of falls in this study were diagnoses of dementia or Alzheimer's and medications such as laxatives or stool softeners which could be addressed in the modification of fall-risk assessment tools for psychiatric patients (Lavsa et al., 2010). Though this study is not current and is a retrospective design method, it offers valuable information to the current institution as there are not many studies evaluating such factors. It is evident that due to the complex combination of drugs prescribed to psychiatric patients, it may be a viable option to ensure pharmacy consultations are conducted on patients with multiple comorbidities and polypharmacy use as a strategy for identifying risks and preventing falls. This study corroborates the need for modification of current practices in psychiatric settings for the implementation of a falls and safety initiative conducive to this population.

Multidisciplinary Approaches

Wynaden, Tohotoa, Heslop, and Omari (2016) identified intrinsic and extrinsic factors of falls associated with health conditions requiring the use of multiple classifications of medications. Included in this study as an interdisciplinary approach were occupational therapists,

nurses and physiotherapists to identify specific triggers suggesting the use of multi-disciplinary assessment and management strategies to reduce falls (Wynaden et al. 2016).

Including patient input in the process of setting goals to promote their safety and well-being engages the patient and allows them to feel as if they are involved in their care (Agency for Healthcare Research and Quality, 2013). Hill, Etherton-Beer, & Haines (2013) conducted a pilot randomized control trial to determine if use of patient education materials such as a video and written material had any effect on perception of fall risks and prevention strategies. This study showed that patients responded well to the education, feeling more engaged and promoted healthy behaviors to prevent falls upon discharge (Hill, Etherton-Beer, & Haines, 2013). In a quasi-experimental study, patients who received video education showed more engagement and motivation to prevent falls compared to those patients who received only written education (Hill et al., 2009). Education seems to be a critical component of patients' understanding of fall risks and may increase their motivation to prevent falls.

Benefits of Rounding

Hourly rounding was implemented by the Studer Group (2006) as a best practice in an attempt to improve clinical outcomes within the hospital setting. These clinical outcomes included decreasing patient falls, improving patient satisfaction scores, preventing skin breakdown, minimizing call light frequency and overall improving the outcome of the patient. Their study demonstrated that over a six-week time frame, call light use reduced by 37.8%, patient satisfaction scores increased by 12 points, patient falls were reduced by 50%, and skin breakdown was decreased by 14% (Studer Group, 2006). Rounding has been shown to decrease negative adverse effects and negative patient outcomes, as well as promote positive patient and staff experiences (Fabry, 2015). Mandated rounding on medical units are the standard of care in

many hospitals across the country. From experience, variations in rounding exist, including hourly rounding, purposeful rounding, safety rounding, leadership rounding, multidisciplinary rounding, and intentional rounding. In addition to rounding, acronyms such as ICARE and 4 P's (which will be discussed later) that organizations choose to utilize to assist their staff in remembering critical components to address when rounding on patients in hopes of meeting patients' needs, promoting patient safety and satisfaction. Hourly rounding is not a new concept and has evolved since the 1980's in a hospital in Birmingham, Alabama (Lowe, 2015). Since its inception, rounding has developed into multiple variations and is now used across several other countries. Lowe (2015) described hourly rounding as a nurse-driven systematic approach that is evidence-based and a proactive means to meet the needs of each patient. Purposeful rounding implies rounding with a purpose, specifically communicating with the patient to address needs while ensuring safety, rather than simply observing them. Utilizing keywords to promote patient satisfaction, improve communication, and anticipate the needs of the patient before they ask is the goal (Lowe, 2015). Use of hourly and purposeful rounding will be examined further to understand the significance within psychiatric inpatient settings as it relates to patient falls and safety.

Rondinelli, Ecker, Crawford, Seelinger and Omery, (2012) conducted a qualitative study from 11 hospitals in Southern California using an action research design to identify the effectiveness of implementing a standardized way of performing purposeful or hourly rounds. Utilizing acronyms such as A-activity, B-bathroom, C-comfort, D-dietary, E-environment and the 4 P's acronym for pain, potty, position and personal belongings, a standardized rounding tool was created (Rondinelli et al., 2012). However, despite standardization of a purposeful rounding tool, Rondinelli et al. (2012) found that collaboration, formal staff education, and flexibility

surrounding revision of rounding tools to meet the needs of specific units is imperative for successful implementation. Additionally, Rondinelli and colleagues found that nursing leadership support and inclusion of staff feedback after implementation was necessary to be successful. In contrast, Fabry (2015) argued that staff should be made accountable for their rounding and that completing a piece of paper was not the way to measure it. Many of the researchers targeted how rounding decreases adverse events, improves patient satisfaction, decreases falls and promotes positive patient experiences. Incentivizing hospitals utilizing the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAPS) was developed in 2007 by the Studer group which is a consulting firm meant to explore and analyze the areas of patient care that are lacking and making sure these areas are addressed (Fabry, 2015). Per Fabry (2015), patients are seemingly more satisfied when staff is present, visible and readily available. Further, in a two-phase non-random sampling approach Nolan, Bradley, and Brimblecombe (2011) conducted a qualitative analysis of 92 mental health service users over 9 months to further understand the quality of care and experiences of psychiatric patients. They concluded that the patients viewed staff as too busy with other tasks such as documenting and observing rather than engaging and tending to the needs of the patients. Regardless of the structure of rounding, DaSilva (2017) acknowledged the lack of interactions between nurses and psychiatric patients despite much of evidence suggesting that rounding on medical units has shown many positive correlations to patient experiences.

In a nationwide study using a quasi-experimental design in 27 medical units across 14 hospitals as well as data collection from Pres Ganey Surveys, Meade, Bursell and Ketelsen, (2006) identified over six weeks that call light use and fall rates were significantly decreased with one-hour nursing rounds compared to two-hour rounding or no rounding at all. Meade and

colleagues utilized a pre- and- post-intervention analysis to rounding and conducted surveys one year after the study, finding that patient satisfaction scores were markedly increased with nurses performing hourly rounds. Though this study was not specific to a psychiatric population and had differing implications including call-light use, which is not always pertinent to psychiatric inpatient units, it was evident that the systematic approach utilized was beneficial and could be tailored to address falls and meet the needs of psychiatric patients. Mitchell, Lavenberg, Trotta, and Umscheid (2014) concluded in the systematic review of over 16 published articles that much of the research corroborated the use of hourly rounding tools in decreasing fall rates. Several studies documented how regular rounds by nurses and staff on inpatient units reduced falls and improved patient safety. However, there is currently a lack of structure and continuity regarding hourly and purposeful rounds specifically in inpatient psychiatric units.

DaSilva (2016) proposed the ICARE rounding tool from the theoretical framework of Sister M. Simone Roach, who pioneered The Theory of Caring and the Six C's of Caring for use in an inpatient psychiatric hospital. This ICARE rounding tool comprised of I-Introduce, C-Caring attributes of Roach's theory, A-Assessment, R-Reassure, E-Environment with scripted statements made to enhance communication with the patient and provide excellent care (DaSilva, 2016). DaSilva (2016) identified the weaknesses in the literature about rounding specifically with the psychiatric population. However, the investigator was unable to locate any studies involving replication of this model or tool. In comparison, Perez-Carter, (2017) reviewed a quality improvement initiative in a geriatric psychiatric unit including a different meaning of the acronym ICARE (I-Introduce, C-Check for Comfort, A-Ask/Assess, R-Reassure/Reorient, E-Environment) rounding tool. Perez-Carter (2017) related that the four "Ps" were included in this checklist which addressed the needs of the geriatric and dementia patients. What are the four

"Ps"? After implementation, a 70% reduction in falls was reported and increased staff satisfaction and patient safety were also improved (Perez-Carter, 2017). This model of ICARE is most conducive to the varying and sometimes complex needs of the psychiatric population.

Krepper et al., (2014) conducted a quasi-experimental study over six months study to determine if a structured process (SHaRP) for hourly rounds compared to less formal means of rounding where one staff member trained the others. They found that the SHaRP process made a significant difference in patient satisfaction and improved efficiencies within the hospital, but results were not necessarily advantageous. Regardless of the structure of rounding, DaSilva (2017) acknowledged the lack of interactions between nurses and psychiatric patients despite the majority of evidence suggesting that rounding on medical units has shown many positive correlations to patient experiences.

There is some evidence that suggests including staff in developing quality improvement projects such as rounding in hospitals not only contributes to the success of the program, but significantly reduces the number of falls. A pre-and post- intervention evaluation conducted by Morgan et al., (2016) related that though a staff-led intentional rounding program has many benefits and is particularly helpful in the reduction of falls, in the observation sample nurses were conducting their rounds but they were only documenting it about 50% of the time. The lack of documenting rounds could warrant additional research in finding out what barriers exist for successful implementation of rounding. Evaluation of current practices and including staff ideas on how to prevent falls may be a valuable insight in the development of this fall prevention initiative. Using the collection of data on benefits of each of the rounding tools mentioned, the development of this falls prevention and safety initiative can incorporate those pertinent strategies specific to this unit to enhance current processes.

Assessing for Falls

Abraham (2016a) conducted a two-part study to demarcate the perceptions of unit directors on addressing falls in inpatient psychiatric units. This review is instrumental in identifying that there is a lack of current data identifying specific risk factors for falls within the psychiatric population. However, a limitation existed within the study because only the perceptions of unit directors were considered. Regardless, the researchers attempted to gather data pertinent to falls, conducted a root cause analysis (RCA) and implemented a strategy utilizing a multi-factorial approach specific to the needs of the unit. Abraham (2016b) discussed different fall risk assessment tools and how each included different factors such as diagnosis, comorbidities, age, medications, history of falling, gait, judgment, orientation, and judgment. Abraham (2016b) pointed out that of the directors surveyed on intrinsic factors related to falls, gait was of the highest rated factors, prior falls was second, multiple medications were third, and comorbidities was the fourth most prominent risk of patient falls.

The Edmonson Psychiatric Fall Risk Assessment Tool (EPFRAT) includes nine factors specific to the psychiatric population, including malnutrition, sleep, medications, gait, diagnosis, elimination, prior history of falls, age and mental status (Edmonson, Robinson, & Hughes, 2011). The EPFRAT was developed and compared to the Morse Fall Scale showing only a minor difference in the specificity, resulting in the conclusion that further testing was needed to evaluate the reliability and validity of this tool (Edmonson, Robinson & Hughes, 2011). Abraham (2016d) reviewed and compared seven fall risk assessment tools, indicating that majority of the scales were not appropriate or useful for the psychiatric population. The exceptions were the EPFRAT and WSFRAT tools, both of which allowed for a thorough psychiatric fall assessment and the WSFRAT including the nurses' judgment in the score.

Clinical judgment is an important aspect of patient assessments and may prove just as beneficial as the tools used to predict falls (Abraham, 2016d).

Van Dyke et al. (2014) conducted a pilot study to identify which fall assessment tool is best suitable for the prevention of falls in a small psychiatric unit. Using the Wilson Sims Fall Risk Assessment tool (WSFRAT) and nursing judgment, conclusions were drawn that the WSFRAT allowed for more comprehensive nursing assessment, including use of psychotropic medications, gait or sensory problems, mental and physical status as well, such as if the patient is on a detox protocol (Van Dyke et al., 2014). The Hendrich II tool used as unit policy was noted not to be any more conducive to the psychiatric population. However, both the Hendrich II and WSFRAT tools were equal in identifying high and low risk for falls showing minimal improvement in the reduction of falls using either tool (Van Dyke et al., 2014).

Wynaden et al. (2016) further evaluated how effective the generic fall risk assessment tools were in identifying older patients risk for falls in an inpatient psychiatric unit. Wynaden and colleagues (2016) identified that these older adults have both complex mental health care and physical co-morbidity needs and should be considered a high-risk group for falls during their hospitalization. The themes identified in their analysis were noted to be limitations in using generic fall risk assessments tools, standardized tools not capturing assessment of fall risk patients, and causes of falls related to specific populations (Wynaden et al., 2016). Utilizing the information from this study added to the development of the tools used in this project. Collaboration among each multidisciplinary team member should be included in the safety of all patients and fall prevention should be no different.

In a very similar setting to the one used in this project Yates and Tart (2012) used a retrospective and comparative design over two years and analyzed falls within both medical and

psychiatric patients to examine characteristics of falls including age, gender, mental status, the severity of fall, types of falls, and compliance of fall prevention interventions. Staff was surveyed to evaluate the effectiveness of the fall prevention policy in place, and compliance of fall prevention interventions was identified by each the psychiatric and medical units (Yates & Tart, 2012). This study determined that most psychiatric patients who fell while admitted were under the age of 65, but there were also non-geriatric patients in the medical setting who fell of similar nature. This analysis delineated the differentiation of falls, types of injuries, ages and showed explicitly within the psychiatric population, patients were not wearing nonskid socks, their risk for falls was not identified on the chart, patient education was not completed, fall risk assessments were not done within 12 hours (Yates & Tart, 2012). Also, there were no medication profile reviews involved with the patients who had fallen (Yates and Tart, 2012). Each of these factors are to be evaluated when assessing the psychiatric patients risk for falls which can be instrumental in the development of this project plan.

In summary, the instrumental findings to the effects of both psychiatric and medical classifications of drugs with fall rates among the adult psychiatric population warrant further review of interventions to decrease falls. Additional interventions to promote patient safety such as hourly rounding by nursing staff to ensure their needs are met and collaboration with physical therapists to evaluate the patients physical status allow for a thorough assessment of the patients physical and emotional needs. Pharmacy involvement for patients on multiple medications could be beneficial in establishing a safe regimen of complex medications. Finally, involving the patient in fall prevention strategies as well as standardizing processes for communication and education among employees are of the effective tools shown to be beneficial. Additional

considerations include the variations in fall risk assessment tools specific to the psychiatric population.

Theoretical Framework

Understanding current unit practices, as well as goals for the organization regarding patient safety, is vital to initiating change and ensuring methods remain consistent. Utilizing theoretical frameworks adds significant value to promoting modifications within not only an organization but also specific units. Mitchell (2013) noted that change is necessary to show progression in healthcare, but there are many factors to consider when implementing changes; consequently, the lack of a structured process can pose a risk for failure. Inclusion for the use of frameworks included the development of organizational changes as well as the most influential theories for policy, environmental, cultural and procedural changes. Thus, organizational change, culture models, as well as Lewin's change theories were utilized as a mixed-theory approach to ensure the organization, leadership, and staff are considered pre- and post-implementation to maintain the success of the program.

Edgar Schein. The evaluation of a needed change in process or structure must be carefully analyzed before developing a well-articulated organizational change (Batras, Duff & Smith, 2016). Organizational change theories, as well as organizational culture, can be beneficial in fostering health promotion strategies (Batras, et al., 2016). Edgar Schein had a pivotal influence on organizational culture developing Schein's Organizational Culture Model, which includes artifacts typically involving processes in an organization, values, and goals of the organizational structure, and assumptions of the culture that constitute the organizational sector (Schein, 1988). Cultural evolution is a force to be considered when planning an organizational change as biases may alter the changing environment (Schein, 1988). With Schein's theoretical

framework, managing a culture within the organization involves identifying what could potentially occur if no change is made by unfreezing current systems, using viable people that are adept to the new planned culture to eradicate dysfunction and maintain the leaders who are proficient within the system while eliminating those who are not (Schein, 1988). Ultimately, the use of positive and influential champions in the implementation process and culture development to ensure success may be of benefit (Batras, Duff & Smith, 2016).

Kurt Lewin. Kurt Lewin was instrumental in developing a three-staged model consisting of unfreezing current practices, changing to the desired process and then refreezing once the changes are optimal (Cummings, Bridgman, & Brown, 2016). Lewin is respected for his theory and foundation of the ‘unfreeze-change-refreeze' model while other theorists have built on his theory developing their empirical research and conclusions. Edgar Schein nobly credits Lewin's work as the main foundation in change management where other theorists discredit Lewin's theory by implying his change theory has evolved only because of the work of other theorists and that Lewin did not actually publish the term ‘refreeze' within his literature (Cummings, Bridgman, & Brown, 2016). Despite the varying opinions of other scholars, the investigator will focus specifically on the three-staged model set by the majority of current literature of the pioneer Kurt Lewin as well as Edgar Schein's organizational culture model.

Changing as three steps or ‘CATS' is of Lewin's seemingly simplistic approach to the development of the three-staged-model considered ‘paradigm' for the management change (Cummings, Bridgman, & Brown, 2016). Moreover, to understand the backbone for CATS, some would argue that the evolution of Lewin's historical theories in field theory, action research and group dynamics should be appreciated as a whole rather than individually as they are contributory to understanding the complexities of change (Batras, Duff, & Smith, 2016).

Evaluating what constitutes the change within the organizational structure, policies, staff, management and behavioral observations of individuals in a group setting are key components to Lewin's field theory and are needed for any planned change (Batras, Duff, & Smith, 2016). While incorporating groups behavior and attitude toward the need for a change, Lewin then used this theory for the development of action research and the creation of the CATS model (Batras, Duff & Smith, 2016). After participation and support from groups within the hospital, management can incorporate these ideas to begin the process of changing current practices. Unfreezing current practices involves preparing the organization for the change and assessing the values in which its constituents hold (Mehrolhassani and Emami, 2013).

The change. Cultivating Schein's theory, the investigator and unit managers will be able to evaluate current organizational practices and culture to dictate the realm of possibilities for improving patient safety within the psychiatric unit. The culture of the group is evolving to include individuals who are hoping to improve current issues in practice and promote positive health outcomes for patients. The exception of few nurses who are resistant to change and dislike new processes, the potential for this much-needed change is plausible. Schein (1988) relates that innovative modifications within an optimistic organization will be proactive and manageable making setting new goals, values, structures and processes tolerable. Schein (2010) identifies resistance to change as a force of human nature. However, this typical response is necessary during the unfreezing stage of making a change. Motivating learning as well as decreasing the learners' anxiety about the change are principles that leaders may consider during the transformative process (Schein, 2010). Once staff is informed of the plans for change and buy-in is obtained, the falls/safety initiative will be presented. A systematically planned approach to changing current practices will articulate the importance of improving patient safety and

reducing the number of falls within the unit. Mitchell (2013) discusses that innovative practices of a collaborative effort in implementing change will need frequent updates and modifications; however, use of a change theory may decrease potential barriers thereby improving overall success.

Relevance to clinical question. After careful evaluation of the organization culture and unfreezing current practices, the next phase in Lewin's model is moving toward the change (Batras, Duff & Smith, 2016). In this sector, change involves implementing the clear strategies to prevent falls. Staff would require training and competencies to ensure accountability. Each safety initiative would be mapped out and enforced to be followed through by leadership, management or project champions. After the new process has been in place the final step in Lewin's theory of change is to refreeze new practices (Mitchell, 2013).

Chapter III: Methodology

Needs Assessment

Due to the gap in literature that exists regarding prevention of falls in inpatient psychiatric units, fall rates are an ongoing issue. The Agency for Healthcare Research and Quality (2013) relates that falls in hospitals are between 700,000 and 1,000,000 people resulting in injuries, deaths or prolonged hospitalizations. Preventing falls in hospitals is a goal of The Joint Commission (TJC) and the Centers for Medicare & Medicaid Services (CMS) have identified falls as a preventable "never event" (Joint Commission Center for Transforming Healthcare, 2018). The number of falls within this inpatient psychiatric unit continues to be a problem. Implementation of this falls/safety initiative could potentially improve the rate of falls, improve communication among team members and patients, promote therapeutic environments and safety, decrease costs associated with prolonged hospitalizations due to falls, and promote positive patient outcomes overall.

Project Design

Pre- and post- intervention design is that of a quality improvement pilot study.

Setting. Located within a 438-bed acute care hospital in central Florida, the unit chosen for this pilot study is a 25-bed acute inpatient psychiatric unit that had a total of 3,044 admissions between the years of 2018 and 2019. This unit was selected due to the persistent need for improvement in the clinical areas identified but with regard to the reduction of fall rates**.** To provide a clinical picture of the unit and current practices, the standard practices and policies of the unit will be discussed. In this psychiatric setting, rounds or observation checks are conducted every fifteen minutes by a mental health technician (MHT) identifying each patient and documenting exactly where the patient is within the unit (bathroom, room, dining room) and

what activity he or she is doing (See Appendix A). Hourly rounding is done by the nurse to validate the patient is safe (not harming himself or herself) and to ensure all needs are being met. The nurse is to document on an hourly rounding log the engagement with the patient as well as any complaints, concerns, questions or needs that may arise during their stay. If a patient is identified as a fall risk, the patient receives a yellow pair of non-skid socks, a yellow wristband, a sign that hangs outside of the door picturing a falling leaf and the rounding sheet is printed on yellow paper. Precautions including fall, suicide, elopement (which is a patient who attempts to leave the unit unauthorized), and others noted are to be checked off at the top of the form based on the nurses' assessment of the patient. If the patient is elderly, in a wheelchair, needs assistance in and out of bed or to the bathroom, a battery operated cordless chair alarm is placed under the patient, which alarms if they try to get up. There are three hospital rooms within the psychiatric unit specified for "medical patients" which consists of a private room, a hospital bed that can be moved up and down but is primarily locked so the patient cannot move it, and a camera so the patient can be visualized from the nurses' station. All other 22 beds are in a double occupancy room with a psychiatric care bed that is bolted to the ground and immobile. The patients have a mattress, one pillow, a fitted sheet and blankets. There is a bed near the window and a bed near the bathroom. One staff member is assigned to the Q15 minute rounds board (See Appendix A), and their only job is to do their safety checks. Nurses do purposeful hourly rounding on their own assigned patients. Purposeful hourly rounding is a new initiative to this unit, so a tracking form is being utilized and tracked by management for compliance. In addition to these rounds, a nurse is assigned to perform safety checks with the technician assigned to the Q15 minute rounds every two hours. There are typically three staff nurses assigned and one charge nurse assigned (who has a patient assignment). On average, each nurse has anywhere

from 5-8 patients on any given day depending on census and staffing. Meditech is the electronic health record system utilized to document psychological and nursing physical assessments as well as fall risk screenings. Prior to implementation of this project, the fall risk screening tool utilized by the organization and incorporated in the electronic charting system was the Morse Fall Scale (MFS) which will be further discussed to depict guidelines for establishing patients at highest risk for falls (See Appendix E). There is a dining room and two considerably smaller group rooms, all of which contain weighted chairs and stationary tables so they cannot be used as weapons. The amount of furniture plus up to 25 patients make it very difficult for wheelchairs to get through.

In a psychiatric unit where independence is promoted, the patients are expected to participate in unit activities, therapeutic groups and remain out of their room to prevent social isolation; ambulatory patients are considered an equal fall risk to those who are not ambulatory. Fall risk assessments are conducted on each patient each shift. However, the fall risk assessment tool is not particularly conducive to the psychiatric population. The interventions recommended for ensuring the patient's bed is in a low position and intravenous therapy interventions do not apply in the psychiatric setting. The unit policy is if the patient requires the use of an ambulatory aid, the patient uses a wheelchair to either push themselves around or push it in place of a walker. Abraham (2016b) relates that many of the fall risk assessment tools only include patient-specific factors and do not consider other contributory risks such as the unfamiliar environment, staffing, and lack of assistive devices. The MFS assesses:

1. History of falling
2. Secondary diagnosis (incontinence, hypotension, sensory impairments)
3. Ambulatory aid, (crutches/cane/walker/furniture), none, bedrest, nurse assist

4. Intravenous therapy heparin lock

5. Gait (normal/weak/impaired)

6. Mental status, oriented to own ability overestimates/forgets limitations.

Prior to implementation of this project, any patient with a Morse Fall Score greater than 45 was considered a high risk for falls and per organizational standard, a yellow triangle fall risk sign is placed outside the patients' door to alert staff of the fall risk. The use of MFS was the preferred standard method for identifying high fall risk patients and was used during this study to ensure consistency. It should be mentioned that since the implementation of this project, the organization no longer requires the nurse to document on the MFS for each patient but for the purpose of continuity, the MFS remained a guide for nurses to ensure patients were adequately screened.

Population/Sample. The unit is a 25-bed acute inpatient psychiatric facility. Admission and exclusion criteria include (See Appendix H) adults over the age of 18 with an acute psychiatric diagnosis warranting admission either on a voluntary basis or an involuntary basis. Involuntary admissions would follow the Baker Act law and would be initiated by a law enforcement officer or healthcare professional initiating a hold for 72 hours for evaluation by a psychiatrist. The policy for medical clearance criteria for patients deemed clinically appropriate for this unit is seen in Appendix B. Inclusion criteria for data collection included reports of falls as documented in the incident reporting system. Since the MFS was used at the time of implementation of this study, the defining factors of a fall were used as depicted by Janice Morse herself. Morse (2009) articulated the three variations in falls to include anticipated physiological falls (frailty/aging related), unanticipated physiological falls (dizziness, seizures, buckling knees) and accidental falls (trip, loss of balance). The organizational policy includes these three

variations of falls in their types of falls with the addition of an intentional falls which are behaviorally motivated and are not to be classified unless the other types of falls have been ruled out. For this study, the investigator excluded evaluation of potential physiological causes of each documented fall as this was not the focus at that time.

Tools and Instruments. This study utilized descriptive statistics with a trend analysis of data comparing pre-intervention fall rates and post-intervention fall rates. First, baseline data were obtained and the need for improvement in fall rates had been established. Staff recognized trends with certain psychiatrists ordering a large amount of sedating medications prompting the request for pharmacy consultations for polypharmacy patients. Staff also believed that admission criteria for accepting only medically cleared patients who are independent and ambulatory varied and depended on the nurse assessing the patient and the nurse calling report to provide information about the patient in hopes to place the patient in a bed (See Appendix B and Appendix H). Since there are multiple components that could potentially alter patient fall risks, a retrospective data collection and analysis was completed to identify specific trends of those patients who have fallen which were documented in the incident reporting system and is tracked by hospital administration and statistics provided to unit management. The data was collected from the two quarters of which there were the greatest number of falls being quarters two and three (April through September in 2017), (See Appendix G). Analyzing these data allowed the investigator to identify what trends existed so this multifactorial protocol could target these areas. Due to multiple causes and risk factors that could potentiate a fall, any incident report that was entered into the system and documented as a fall was used. The Agency for Healthcare Research and Quality (2013) suggests measuring falls with injury to obtain an injurious fall rate as well as to decipher the hospitals definition of a fall to gain precise numbers. Organizational

policy has a standardized fall definition of: “an unplanned decent to the floor; assisted or unassisted, with or without injury, regardless of patient age or cause of event”. Over a few years, the unit has only had one fall that was considered with injury, so injurious falls were not isolated in the data obtained for this project. Patient specific data including age, diagnosis, location of fall, time of fall, time of admission, last MFS score, number of medications administered that increase risk of falls as identified in the MFS, use of fall prevention interventions documented by the nurse, day shift versus night shift, and prior history of falls documented were areas the project mentor and investigator deemed appropriate for this initiative. The project mentor and investigator deemed the criteria statistically important to complete a trend analysis and subsequently was able to demonstrate graphically. Additionally, other factors found to be helpful in recognizing weak areas on the unit such as timing of falls (as in meal times, after medication passes, after admission etc.) or trends in the staff working though not the purpose of this study, are found to provide valuable information to unit management for further process improvement. Data was collected by the project mentor who has been provided much of the information as statistics without patient identifiers from the quality and safety department as well as corporate for use in quality improvement. This data was entered in a run chart by the investigator for thorough analysis.

Project Plan

The impetus for this project has multiple implications: First, a Root Cause Analysis (RCA) was conducted of fall rates within the 25-bed psychiatric unit for the 6-months in 2017 of which the highest percentage of falls. From these data, the investigator identified statistics on trends and specific risk factors most notably found within the 6-month time frame. Subsequently,

many of the falls that occurred were within the first 24 hours of the patients admission to the unit indicating a need for change in processes surrounding this time frame.

The second and largest implication was to develop a multi-disciplinary approach to enhance current fall prevention strategies. This step consisted of changes to collaborative involvement of pharmacy and physical therapy evaluations. Polypharmacy patients or those considered high risk for falls by the nurse received a consultation to pharmacy for review of medications that increase risk of falling. The pharmacist and nurse would then discuss an option for alternatives to present to the attending psychiatrist or medical physician. Unfortunately, as expected, the physicians were not receptive to suggested changes despite their knowledge of increasing the patients fall risk. The second component to the multi-disciplinary approach was physical therapy involvement. A physical therapy consultation was initiated by the nurse for patients found to have a recent fall history or de-conditioning (as assessed by the nurse) to obtain professional recommendations on the patients' mobility and functional status. These collaborations were justified by department managers as clinically appropriate services to provide to patients. Also included in the multi-disciplinary approach was enforcing the hourly rounding by nurses as this was a fairly new requirement for this unit upon initiation of the project.

The components of the intervention were to streamline a falls and safety education training for staff and formal educational material on fall prevention for patients as this had not been standardized previously. Staff were required to attend an hour-long competency training on fall prevention and safety initiatives that were being implemented with this project. This was to ensure all staff members understood the expectations of the new fall prevention protocols for all patients especially those considered high fall risks as well as to promote accountability. This

training was mandatory and given to all new employees. Upon admission to the unit, each patient was asked to sign an agreement (See Appendix K) that laid out the fall prevention strategies and explained the unit's goal to promote safety. The patient was also given a professional brochure that the investigator developed regarding fall prevention and safety strategies while admitted (See Appendix L). The patient was also screened for falls by a nurse within 30 minutes of admission/arrival to the unit. If the patient was identified as a moderate to high fall risk or was unsteady on his or her feet, the patient was given yellow skid-free socks, a yellow wristband and a fall magnet was placed on the door. The Q15 minute rounds form was then initiated on a yellow form rather than a standard white one. Prior to initiation, these unit practices were inconsistently occurring. As a final measure, a checklist was created, laminated and placed at each computer for nurses to utilize. The checklist included all of the aforementioned steps and key components in this initiative to ensure consistency. There was no unit policy in place regarding fall prevention and safety interventions that involved education for the patient upon admission. The current policy regarding admission guidelines when the patient arrives is shown in Appendix C. There is mention of receiving a patient handbook, but the current policy does not include a discussion of specific fall prevention strategies.

The fourth and final implication of this project is to monitor fall rates post-intervention to evaluate the effectiveness of these fall prevention strategies. Wynaden et al., (2016) substantiated the need for a multi-disciplinary approach to preventing falls. Including specific measures in the psychological assessment and fall risk assessment such as cognition, functionality, mental state, behavior, medications, and comorbidities are of the most critical factors to be addressed (Wynaden, et al., 2016). For the project, nurses conducted functional screenings (See Appendix F) that aided in identifying those patients that require more assistance ambulating, eating or

toileting. A falls and safety checklist were added to be checked off for each patient upon admission. If the patient is a fall risk the boxes appropriate to each patient would need to be completed by the nurse (See Appendix I).

Outcomes. To obtain buy-in from staff, formal education was completed prior to implementation of the project**.** Staff and patient education were an essential component to ensure sustainability and success of the project. The investigator successfully held multiple mandatory meetings for all staff to be trained on the new initiative. All components of the multifactorial fall prevention protocol were organized and made easily accessible to staff, placed in a binder named the Fall Prevention Protocol at the nurses' station. All staff members were required to complete the training prior to the implementation date. Following the meetings with staff, the investigator worked with the unit secretary to laminate checklists, edit and submit educational brochure and falls/safety agreements to not only the unit leadership, but also to the organizations forms committee to be professionally edited and approved to be printed in bulk. Once approval was made at each level, the unit secretary diligently worked to create admission packets for patients that included the new forms and material. The unit secretary was responsible for re-ordering the forms and ensuring the unit had adequate stock of each of them. After implementation had begun, a midway evaluation was done by the investigator on an informal basis rounding on nurses and MHT's to gather feedback, suggestions or possible modifications. The investigator identified that one factor that required reminding of nurses, and that factor was making use of the checklist, hourly rounding and documenting that the rounding and education was done. After the conclusion of the project intervention, the investigator and project mentor obtained data on fall rates using the same information used for baseline data collection. The data were synthesized and discussed to evaluate the need for an amendment to the unit policies. Charge nurses and unit

management were responsible for ensuring the interventions were being completed. Individual staff variables and patient compliance to the aforementioned interventions were all considered in the barriers to the success of this protocol. Descriptive statistics was used for quantitative analysis of data.

Evaluation and sustainability plan. At three months post intervention, the initiative was evaluated by gaining staff feedback and insights as to what was going well and what could be improved. The investigator conducted random observations of the interventions to evaluate if staff were actually using them. There was no formal auditing since the investigator is an employee of this unit. The fall and safety agreements as well as the fall prevention brochure were placed in every admission packet for staff to review with patients upon admission. Consultations to physical therapy and pharmacy were then evaluated to determine if there was an increase in the number of consults placed. Fall prevention measures and the use of the protocol were reinforced at monthly staff meetings.

Time frame. Implementation of this project began immediately after approval. Staff education occurred from April 16th, 2018 through April 30th, 2018. After every employee was briefed on the new initiatives, the forms created were added to admission packets and the checklist posted at each computer station. The effective date was May 1st, 2018 and conclusion of project was December 31st, 2018. A timeline of dates for implementation and data collection/review are presented in Appendix J.

Data Analysis Post Intervention

Descriptive statistics with trend analysis was used to analyze the results of the study. Investigator and project mentor reviewed the data collected. The investigator then compiled

results similar to the baseline data collection methods which were graphically analyzed to evaluate trends. Run charts were used for quantitative data analysis.

Ethical Issues

Ethics/IRB Approval: Names were not used to assure privacy was maintained. Protection of patients' rights and welfare to ensure privacy and confidentiality was maintained. Pre-existing data with no personally identifiable information was utilized therefore the investigator was exempt from obtaining approval from the Institutional Review Board (IRB) or Committee on the Use of Human Subjects in Research (CUHSR). The project was a mandatory part of employment on the unit, so consent was not appropriate.

Chapter IV: Organizational Assessment & Cost-Effective Analysis

Organizational Assessment

The organization supports a safe and injury free culture and is continuously evaluating ways to reduce errors or improve patient outcomes. The Agency for Healthcare Research and Quality (2013) points out in their plan for reducing patient falls in hospitals that the organization should have a sense of urgency for this change, understand and support why the change is needed. On a unit level, staff are accustomed to organizational changes that promote safety and positive patient outcomes. The unit management and director required this initiative be adopted into practice and has since been the new standard of care regarding fall prevention strategies.

Staff were expected to be hesitant of the new changes brought on by this initiative. Since the protocol was inevitable, however, staff seemed less resistant knowing that management was providing support. Additionally, the resources given to the staff such as the checklist and not having to spend extraneous efforts in adding forms to the admission packets not only helped maintain consistency, but ensured that they were reviewed with the patient as part of the routine paperwork. Patient compliance did play a considerable role in signing the patient agreement and to some extent wearing the yellow socks and wristband. However, staff were seemingly more consistent in implementing the interventions knowing that this data was going to be tracked.

Risks/Unintended Consequences

There were no known risks identified with the development of this protocol. As expected, there did seem to be a disregard by psychiatrists for pharmacy input when involved in decision making for polypharmacy patients. Also, pharmacists explained that they are not as confident in manipulating psychiatric medications in conjunction with other high-risk drugs previously mentioned. As a result, there were not many consults placed to pharmacy. Additionally, after

implementation of the protocol, a change in documentation requirements by the organization eliminated the use of the Morse Fall Scale to identify a patient who was considered moderate to high fall risk. The new assessment for falls required "nursing judgement" and the nurse was simply asked if they felt the patient was a high fall risk and if so, were fall prevention interventions in place for that patient. This indicates that the previously required use of the MFS in psychiatric patients was not conducive to assessing this population.

Interprofessional Collaboration

The Agency for Healthcare Research and Quality (2013) suggest devising a tool identifying responsibilities of each staff member so every employee knows their roles in the fall prevention initiative; however, this tool is specific to medical floors where IV's, post-operative patients, and total care patients are involved. As a result, the use of this multifactorial fall prevention protocol was devised with the various roles involved in the inpatient psychiatric unit. All staff were responsible for the safety of all patients. Subsequently, the policy for on patient safety were reviewed at staff meetings and the investigator led training. The tools used in this initiative were developed with the AHRQ recommendations of specifying interventions for the mental health population.

Physical therapy consultations had a marked increase and all patients who were considered to be a high fall risk were evaluated and monitored by the physical therapy team. This enhanced communication among departments and physical therapy staff were more comfortable coming to the mental health unit to work with our patients with minimal resistance.

Budget

Staff are permitted a specified number of hours per year for education and training therefore, no additional costs were incurred by the unit to train on this fall and safety initiative.

There are ultimately no costs associated with this project as the unit director was able to obtain statistical data on fall rates pre and post intervention and results were analyzed independently without the use of additional personnel or statisticians.

Chapter V: Results

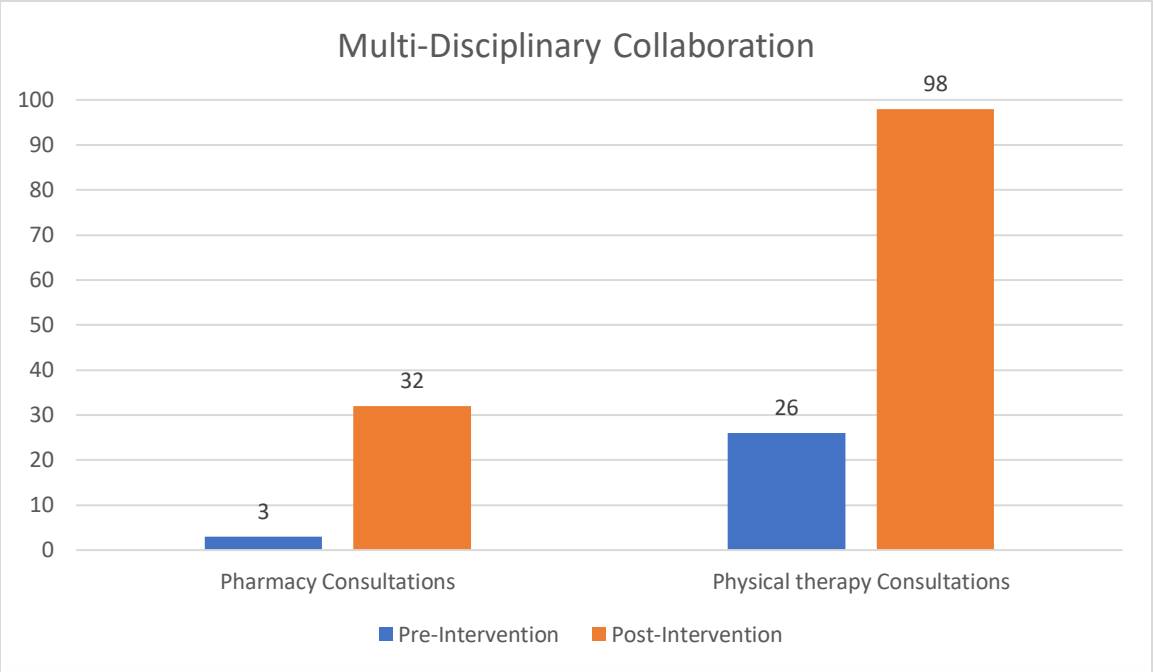
Analysis of Implementation Process

This project was multifactorial with an overall goal to reduce the number of falls in an inpatient psychiatric unit. Additionally, the goals of streamlining a safety and fall prevention protocol were achieved. Each step of the implementation process was met without difficulty. Evaluation of the pre-implementation fall rates are what led to the development of the evidence-based interventions that were utilized in this study. Involving pharmacy, physical therapy, rounding by nurses and identifying patients using yellow socks, yellow wrist band and a magnet outside their door are what were inconsistently being done before this initiative. The use of the Morse Fall Scale was the major component of this project that the nurses on the floor continued to use, but were no longer required by the organization.

Analysis of Project Outcome Data

During the initial phases of the project planning stage, pre-existing data on fall analysis of the inpatient psychiatric unit were evaluated to determine what interventions should be included in this multifactorial approach to prevent falls. It was found that the greatest number of falls occurred shortly after the times that medications are routinely administered. This warranted the component of involving pharmacy consultations for polypharmacy patients. Polypharmacy included patients on more than two psychotropic medications and more than two or three medications for medical reasons such as pain, hypertension or other chronic illnesses. Additionally, unit leadership identified the lack of physical therapy consultations placed for patients who had limited mobility, weakness, or medical comorbidities that increase their risk for falls. As a result, physical therapy consultations were included in the multifactorial approach to reduce falls. The data simply included the number of consults placed by nurses for the years

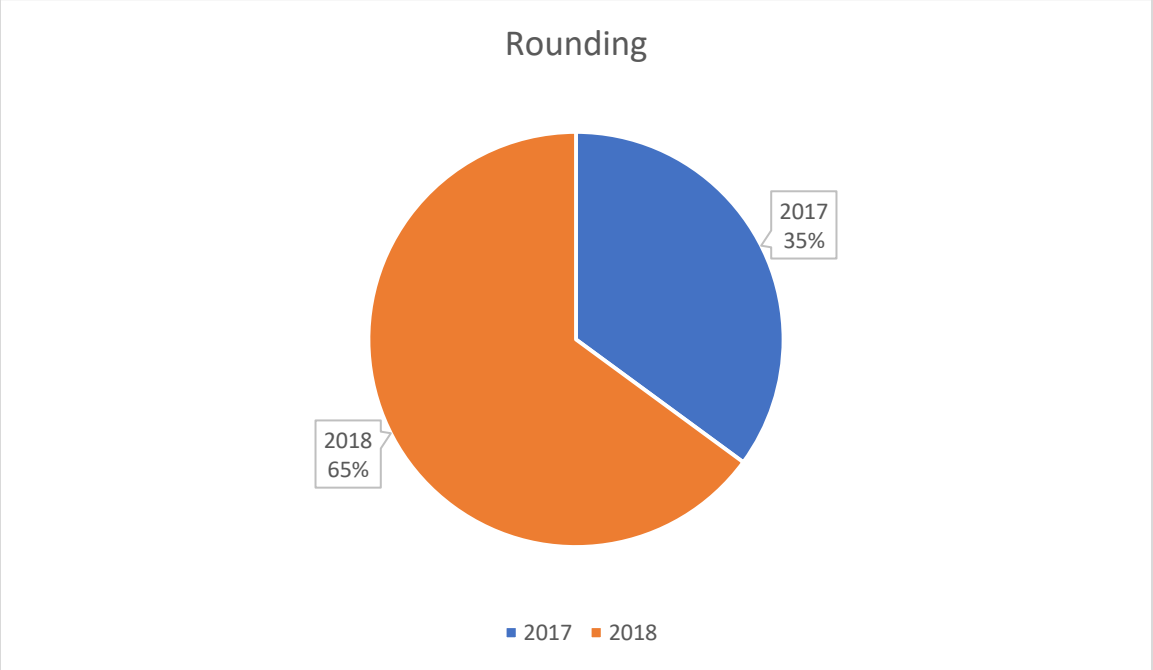
2017 and 2018. There was an increase of pharmacy consultations placed by nurses from 3 in 2017 to 32 in 2018. In 2017 there was a total of 26 physical therapy consultations placed by nurses and in 2018 there were 98. These data do not delineate if the consults were fall risk specific but overall numbers of the consults for the unit indicating compliance by the nurses for the intervention.



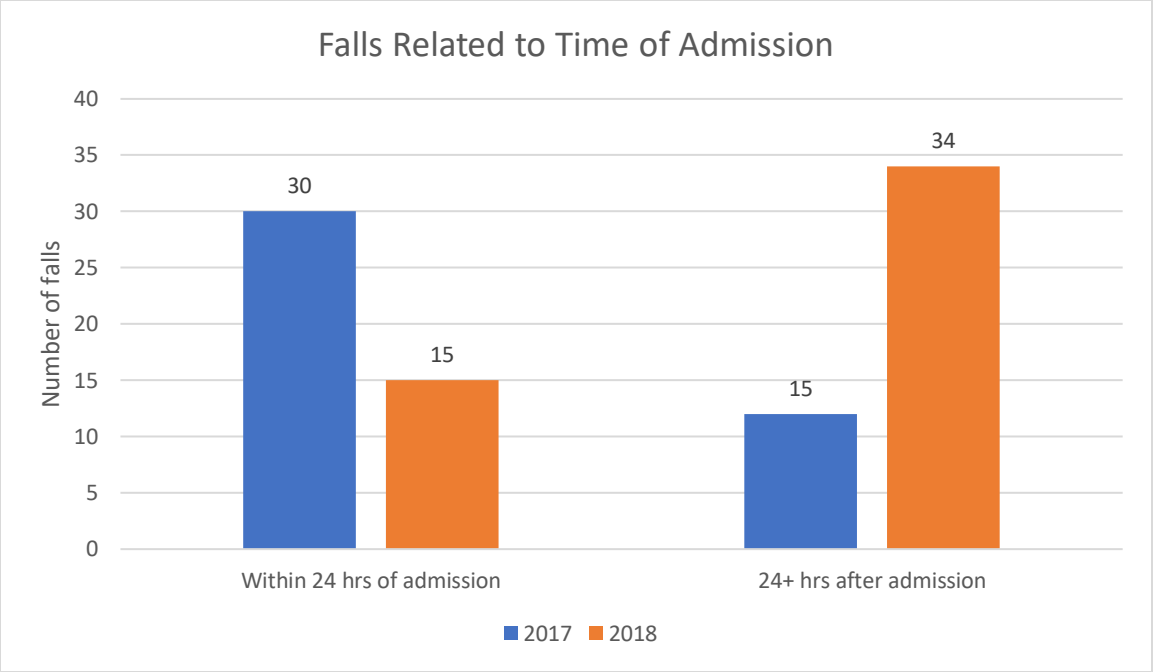
Staff and patient education were another component that was imperative to the success of this study. Staff education was completed with 100% compliance as this was a mandatory requirement. Patient education varied due to patient compliance and acuity of illness. The data for patient education compliance was not analyzed due to the use of pre-existing data and the focus being only on fall rates pre-and post-intervention. However, a formal patient agreement and patient brochure were developed for the sole purpose of this project and have since been inducted into unit practices (See Appendices K and L).

Hourly rounding by nurses was also at an increased rate when data was analyzed comparing 2017 and 2018. Though these percentages are for the overall year, there is a 30%

increase in nurse rounding which would require further analysis of specific quarters to determine if this study was significant to this improvement.



Finally, the significant piece of data that was utilized for training purposes was found to be the timing of when patients fall in association with their time of arrival to the unit. Subsequently, the staff training reinforced the need to facilitate fall interventions immediately when the patient arrived on the unit and required a nurse to assess the patient upon arrival. A new standard has since become implemented that require a nurse and technician to greet the patient before they step foot on the floor. This allows the nurse to quickly assess the patient and communicate the need for fall prevention interventions such as a yellow wrist band, yellow socks, a yellow Q 15-minute observation sheet and a magnet placed outside their door. The number of falls within 24 hours of admission and those 24 or more hours after admission were tracked for 2017 and 2018. Since inception of this intervention, 2018 had a significant drop of 50% reduction in fall rates within 24 hours of admission. However, fall rates increased after 24 hours of admission.



A final implication for this study was to determine if the fall risk assessment and functional screening completed by the nurse was beneficial in reducing the rate of falls for patients. The checklist that was incorporated in the study was specific to this unit and eventually was inducted into routine practice that it was no longer needed after staff became familiar with the tool. Additionally, the Morse Fall Scale (MFS) was eliminated from the routine assessment in the integrated electronic health record documented by the nurse. The nurse was required to assess if the patient was a fall risk and if fall prevention strategies (whatever the unit deems appropriate) were in place. Therefore, this statistical data was not utilized to contribute to the strength of the study.

Chapter VI: Discussion

Findings

To determine if a multifactorial fall prevention and safety protocol was effective in reducing fall rates, a root cause analysis (RCA) was conducted of the 25-bed inpatient psychiatric unit. Within this RCA, the investigator utilized data from the 6-months in which there were the highest number of falls in 2017. Utilizing evidence-based research, the use of a collaborative involvement with pharmacy and physical therapy, hourly rounding, standardized education for patients and staff, and the use of a fall prevention brochure and agreement signed by patients were implemented. After implementation of these interventions over a 6-month time frame, fall rates were then monitored. A checklist was created for the nursing staff to ensure they were utilizing each of the interventions in this study. Fall rate averages were calculated per 1000 occupied bed days by quarter. Quarters two and three (May 1st through November 1st) from 2017 and 2018 were compared. For 2017 quarters two and three, there were a total of 23 falls and 20 falls for 2018 for the same quarters indicating an overall 2 percent reduction in fall rates for these quarters (See Appendix M). Not included in this data for maintaining the integrity of the statistical data reporting period is that for quarters one and four, fall rates were actually higher in 2018 than in 2017 making the overall fall rates for 2018 greater than 2017.

Limitations or Deviations from Project Plan

Limitations to this study include the variations of patient compliance in patient education, patient competency status and lack of psychiatrists' desire to collaborate with pharmacy recommendations. Additional limitations regarding the overall number of falls is the inability to differentiate the falls that were considered behavioral and those that were deemed true ground level falls. There may be a considerable decrease in the overall number of falls for this unit had

these been delineated. Additionally, there were multiple components used in this study so a further limitation would be the multifactorial approach that possibly hinders analysis of one area of fall rates. Final limitations include the lack of using a psychiatric specific fall risk scale.

Implications

The implications of this pilot study may be of benefit to future researchers within nursing practice, leadership, hospital administrators and multidisciplinary advocates for patient safety and fall prevention of the psychiatric population. The significance of multifactorial components that are involved with fall rates in this inpatient psychiatric unit identify the need for multidisciplinary interventions, collaboration among various members of the healthcare team and that falls are of significant concern in the psychiatric population. This study further identifies the need for analyzing variables contributing to a fall within this population and that number of falls incorporated into the organizations overall fall rate may skew the results of those falls occurring in inpatient medical units due to behavioral falls. Perhaps a specified tool could be helpful in discriminating intentional or behavioral falls commonly seen from regular ground level falls. Finally, hospital administrators may consider standardizing staff and patient education for psychiatric units to promote patient safety and incorporate multifactorial interventions to prevent falls specific to unit policy and procedures.

The outcomes of this study expand on the limited research that is available on fall prevention strategies, interventions and approaches in the inpatient psychiatric setting. It is evident that multivariate components need to be included and that a standardized approach to fall prevention is not conducive to the psychiatric population. Reducing the number of falls is of benefit not only to the patient but to the organization, unit staff and leadership team. It is of

utmost importance to implement fall prevention strategies and develop a protocol that is specified for each unit to maintain safety and prevent falls.

Future Research

Recommendations could include further investigation on the reduction of length of stays, nurse satisfaction and retention rates, patient satisfaction scores, timing of falls, fall rates based on event codes inputted into the event reporting system, as well as fall rates by age. Each of these components were included in the overall fall rates for this study thereby limiting the strength of evidence. Furthermore, future researchers may consider utilizing a staff led approach for the development of fall prevention strategies. The abundance of factors including biological (age, sex, race), medical conditions, physical condition, visual or hearing impairments, psychiatric diagnoses, number of medications and external/environmental risk factors are all variables that may be considered. Nurse perception of fall risk assessments of patients, nursing duties, staffing and patient acuity are other variables that may be included in future research.

Significance to Nursing Practice

Nurses have a due diligence to the patients we care for. This multifactorial fall prevention protocol utilized evidenced-based practices to promote the safety and well-being of psychiatric patients by focusing on strategies to reduce the number of falls in an inpatient psychiatric unit. The nurse assessing the patient promoted advocacy for fall prevention and increased their awareness of risks contributing to falls. Collaboration with technicians, pharmacists, physical therapists and psychiatrists was enhanced due to this study increasing the awareness of the patients' condition to members of the health care team.

Health Policy

Unit policy for psychiatric inpatient fall prevention strategies are evolving into standards of practice with this study being the foundation for its premise. The leadership team of the inpatient psychiatric unit have identified the importance of a unit specific fall prevention protocol and have taken the results to the organizations fall prevention committee. Thus, a fall prevention committee for only psychiatric units across the organization on divisional basis is in the developmental stages. As a whole, the committees have the potential to promote a positive change for psychiatric patient safety by identifying the need for isolating fall prevention strategies from those of the general medical world.

VII: Conclusion

Value of Project to Health Care and Practice

This project reveals the multifaceted components that are involved with maintaining patient safety and the complex variables associated with fall prevention strategies in an inpatient psychiatric setting. It is also evident that fall prevention strategies should be specific to the targeted population and interventions should be adjusted accordingly. Collaboration among unit staff, nurses, physicians, pharmacists, physical therapy and patient involvement in fall prevention strategies and education among both patients and staff should be proposed as a standard of care within the psychiatric population. It should also be noted that falls considered to be behavioral should be further investigated to differentiate these numbers from the organizations total number of falls. Additionally, further research should be conducted in standardizing fall scales that are specific to the psychiatric patient involving their medical comorbidities, psychiatric conditions, competency status and number of psychotropic and medical medications that increase their risk for falls. In-depth analysis of each of these factors may warrant a change in the future of statistics surrounding fall rates in inpatient psychiatric units. Furthermore, analysis of unit specific multifactorial fall prevention strategies should be conducted to contribute to the lack of research in this area.

DNP Essentials

DNP essential I: *Scientific Underpinnings for Practice*- was met by utilizing nursing theories to promote the delivery of health care. Additionally, the evaluation of health care practices to promote safety and patient outcomes by contributing to the prevention of falls helped meet this DNP essential.

DNP essential II: *Organizational Systems Leadership for Quality Improvement and Systems Thinking*- was met by identifying a target population that required a change to promote the health outcomes of patients. The investigator utilized organizational standards and maintaining the effectiveness of costs while involving practices that were already considered standards of care for the organization and by leadership to implement fall prevention strategies.

Plan for Dissemination

DNP essential III: *Clinical Scholarship and Analytical Methods for Evidence-Based Practice*- was met through elaborate research and analysis of previous evidence-based fall prevention protocols that were shown to be efficacious in the reduction of fall rates.

DNP Essential IV: *Information Systems/Technology and Patient Care Technology for the Improvement and Transformation of Health care*- was met by investigating previous electronic health record documentation requirements for fall risk scores done by the nurse, analyzing the information systems used by the organization and by the unit and how it contributes to patient outcomes and delivery of care. Contributed to the elimination of the use of the Morse Fall Scale that was previously required for nursing documentation as this was not conducive to the psychiatric population.

DNP Essential V: *Health Care Policy for Advocacy in Health Care*- the investigator met this essential by designing a policy that coincides with the organizational standards to promote patient safety and well-being. The implementation of a standardized unit protocol for fall prevention strategies is now in place and has the potential to progress to other institutions within the organization.

DNP Essential VI: *Interprofessional Collaboration for Improving Patient and Population Health Outcomes*- this essential was met by streamlining interprofessional communication

surrounding patient centered care to promote safety and collaborate on risk factors that could increase the patients risk for falling as evident by the increase in consultations placed to interdisciplinary team members.

DNP Essential VII: *Clinical Prevention and Population Health for Improving the Nation's Health*- was met by integrating evidence-based prevention strategies to promote health by preventing falls as indicated by the World Health Organizations goals to reduce fall rates and prevent mortality.

DNP Essential VIII: *Advanced Nursing Practice*- was met by developing and completing training for all employees including unit management, on fall prevention strategies, development of patient educational brochure, patient agreement and standardizing a protocol that is conducive to the inpatient psychiatric unit based on unit statistics. Practices were then evaluated and monitored which contributed to the overall success of the scientifically based intervention. This essential was also met by encouraging other nurses to become involved in the unit and organizations fall prevention committee to promote change and improve nursing practice.

Plan for Dissemination

A PowerPoint presentation will be presented to the Bradley University dissemination team in hopes to address the need for a multifactorial fall prevention protocol as well as the results of this study.

Attainment of Personal and Professional Goals

It is important that psychiatric patients do not get forgotten in the realm of patient safety and this project has emphasized that patient safety and promotion of health outcomes is a passion and priority of future practice. Overcoming many barriers in completing this project have geared the investigator for what previously seemed like the inevitable. Communicating with

organizational leaders including the Chief Nursing Officer, directors of pharmacy and physical therapy as well as patient safety officers have helped the investigator see that patient safety is the common goal of all regardless of title. Finally, research and education are a distinct component to completing this project. This has fulfilled a goal of the investigator and conducting further studies in the promotion of health within the psychiatric population.

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Appendix A: Q-15 Minute Check

Patient observation for: Date:

☐ Suicidal Ideation ☐ Self Injury ☐ Assaultive/Aggression ☐ Elopement ☐ Fall
☐ Detoxification W/D ☐ Seizure ☐ Psychosis ☐ Other: _____

PATIENT LABEL

Precaution level every 15 minutes unless ordered: ☐ Continuous 1:1 ☐ Within line of eyesight

Location Codes:
1= In Room **2=** Bathroom **3=** Sun Room **4=** Hallway **5=** Dining Room **6=** Activity Room
7= Conference Room **8=** Off Unit **9=** Medication Window **10=** Seclusion (use other form)

Behavior Codes:
A= Agitated/restless **B=** In Bed Awake **C=** Confused / Disoriented **D=** Crying **E=** Eating **F=** Watching TV
G= Attending Group **H=** Hygiene/Shower **I=** Isolative **J=** Standing **K=** Pacing **L=** With Peers **M=** Meeting
N= Nurses Station **O=**With Staff **P=** Phone **Q=** Quiet/Calm **R=** Reading **S=** Sleeping/Note Chest Rising
T= Threatening/Violent **V=** With Visitors **W=** Walking **X=** Sitting **Y=** Other: _____

Time	Code	MHT	RN	Time	Code	MHT	RN	Time	Code	MHT	RN	Time	Code	MHT	RN
00:00				06:00				12:00				18:00			
00:15				06:15				12:15				18:15			
00:30				06:30				12:30				18:30			
00:45				06:45				12:45				18:45			
01:00				07:00				13:00				19:00			
01:15				07:15				13:15				19:15			
01:30				07:30				13:30				19:30			
01:45				07:45				13:45				19:45			
02:00				08:00				14:00				20:00			
02:15				08:15				14:15				20:15			
02:30				08:30				14:30				20:30			
02:45				08:45				14:45				20:45			
03:00				09:00				15:00				21:00			
03:15				09:15				15:15				21:15			
03:30				09:30				15:30				21:30			
03:45				09:45				15:45				21:45			
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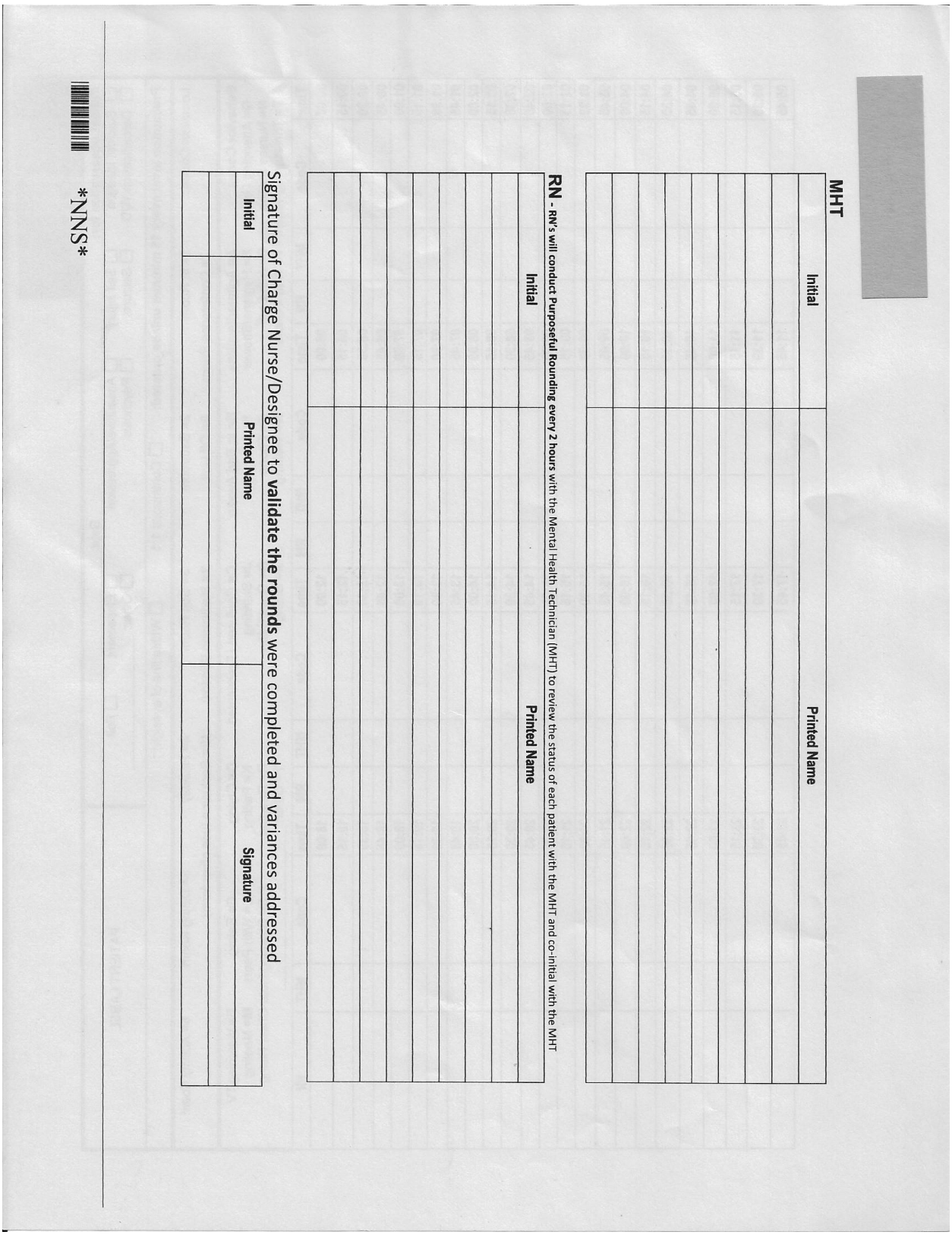
04:45				10:45				16:45				22:45			
05:00				11:00				17:00				23:00			
05:15				11:15				17:15				23:15			
05:30				11:30				17:30				23:30			
05:45				11:45				17:45				23:45			

NNS

Appendix A: Q-15 Minute Check



MHT

Initial	Printed Name

RN - **RN's will conduct Purposeful Rounding every 2 hours** with the Mental Health Technician (MHT) to review the status of each patient with the MHT and co-initial with the MHT

Initial	Printed Name

Signature of Charge Nurse/Designee to **validate the rounds** were completed and variances addressed

Initial	Printed Name	Signature

NNS

Appendix B: Medical Clearance Guidelines

[redacted]

OoDepartment: Behavioral Health Unit	**Policy:** BH- Medical Clearance Guidelines
Owner (Position Assigned Responsibility): Behavioral Health Director	**Folder:** Department – Behavioral Health Unit
Approvals	**Number:** 2.656.060
Department: Behavioral Health Manager: 12/22/14	**Effective Date:** 7/6/15
Committee:	**Issue Date:** 8/2014
Administrative Officer: Associate Chief Nursing Officer: 4/19/15	**Reviewed Date(s):** 8/17/16, 8/30/17
Medical Staff Dept. (if required):	**Revised Date(s):** 12/22/14
Quality Council: 6/5/15	**Retired:**
Medical Executive Committee: 6/25/15	
Board of Trustees: 7/6/15	
Policies describing procedures/treatments are general guidelines to aid the professional in exercising his or her judgment in rendering patient care.	

SCOPE:
All patients on the Behavioral Health Unit at [redacted] Hospital

PURPOSE:
To provide guidance for a medical screening process for patients who may be in need of admission to the Behavioral Health Unit.

DEFINITIONS:
N/A

POLICY:
It should be noted that the parameters listed below are to be used as guidelines for physicians and staff to determine if a patient may be admitted to the [redacted] Hospital inpatient Behavioral Health Unit. Values outside the ranges indicated below should be addressed or explained in order to be considered for inpatient admission. These values are not intended as a substitute for the emergency physician or psychiatrist to determine medical stability but as a reference for referral of a patient to an inpatient psychiatric unit.

PROCEDURE:

1. Physicians are requested to differentiate patients with an acute medical need versus an acute psychiatric need when making a referral to the inpatient Behavioral Health Unit.

2. The medical clearance criteria listed below is not all inclusive but shall serve as a guideline for the physician involved in evaluating the medical appropriateness of a patient who is being considered for admission to the Behavioral Health Unit.

3. Exceptions to the criteria in regards to the lab values, assessments and reports listed below may be on an individual basis after thorough review by the Admitting Physician.

4. Consultations with the consulting medical physician may also be sought to support the decision making process regarding medical appropriateness for admission to the Behavioral Health Unit.

Appendix B: Medical Clearance Guidelines

Vital Signs:

- Heart Rate: greater than 50, less than 140.
- Respiratory Rate: greater than 12, less than 24.
- Systolic BP: greater than 90, less than 180. (Low B/P may be a patient's baseline. MD can make the decision to order a lactic acid level to rule out sepsis)
- Diastolic BP: greater than 50, less than 110.
- Temperature: less than 100.4
- Oxygen Saturation: not acutely less than 92% on room air. (May be lower for a patient with COPD. ABGs may be ordered to ensure a normal reading and ph.)

Basic screening for patients presenting with psychiatric symptoms and being referred for inpatient admission:

- Complete Blood Count (CBC) without differential (unless otherwise indicated)
- Complete Metabolic Panel (CMP)
- Urinalysis (if indicated for urinary symptoms, or geriatric patients with new onset of altered mental status)

Other screens as indicated by clinical presentation:

- Blood Alcohol Level (not a determinate of admission. Cognitive capacity and the ability to participate in the therapeutic milieu must be made available such as the patient's ability to ambulate safely, speak clearly as well as eat and drink fluids.)
- Urine Drug Screen
- Urine pregnancy test for females less than 50 years of age without hysterectomy
- Acetaminophen / Aspirin in the non-toxic range in cases of reported or suspected overdose
- For elevated Aspirin levels a 4- hour retest with decreasing levels and treatment started when indicated.
- Acetaminophen should be trending down and verified by a 4 hour test result before being accepted for admission.
- Send drug levels for current treatment medications as indicated (Lithium, Depakote, etc.) This will not hold up admit or transfer to the Behavioral Health Unit. (not a determinate of admission).
- TSH
- Plain CT Scan of the head for patients presenting with psychosis with no previous history.
- INR for persons on anticoagulant therapy.

Abnormal lab values:

Abnormal values may not necessarily prevent admission but should be addressed and explained prior to referral for psychiatric admission. In some cases it will be necessary to begin treatment and monitor for the values to improve prior to being accepted to a psychiatric unit. While these values may serve as a guideline, the decision to admit will depend on the accepting psychiatrist and the ability of the Behavioral Health Unit to safely meet the needs of each patient.

Normal expected ranges:

- WBC: greater than 2.5, less than 15
- Hemoglobin: greater than 8
- Potassium: greater than 3.0 – less than 5.3

Appendix B: Medical Clearance Guidelines

[redacted]

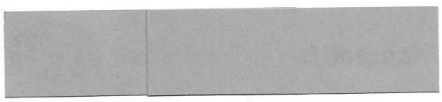
- Lithium level: less than 1.7
- Glucose: less than 300

SCREENING FOR PREGNANT PATIENTS:

- Pregnant patients who present for a psychiatric condition should be screened for any obstetric complications or distress.
- Patient who are over 20 weeks gestation may be admitted to the Behavioral Health Unit if an obstetrician has been following the patient and will continue to provide ongoing consultation.
- Patients over 20 weeks gestation without an obstetrician for consultation may not be admitted to the Behavioral Health Unit.

REFERENCES:

Appendix C: Admission Process



Department: Behavioral Health	**Policy:** Admission Process
Owner (Position Assigned Responsibility): Behavioral Health Director	**Folder:**
Approvals	**Number:** 656.0008
Department:	**Effective Date:** 11/11
Committee:	**Issue Date:** 11/11
Administrative Officer: 1/31/13	**Reviewed Date(s):** 8/30/17
Medical Staff Dept. (if required): 2/07/13, 8/15/16	**Revised Date(s):** 1/31/13, 8/13/16
Quality Council: N/A	**Retired:**
Medical Executive Committee: N/A	
Board of Trustees: N/A	
Policies describing procedures/treatments are general guidelines to aid the professional in exercising his or her judgment in rendering patient care.	

SCOPE: Patients who are admitted to the Behavioral Health Unit

PURPOSE: To ensure that patient's rights are properly maintained and to ensure that patients are uniformly and properly admitted to the inpatient behavioral health unit.

DEFINITIONS: (ED) Emergency Department

POLICY: Admission assessments will be completed by RN within 8 hours upon admission to the inpatient unit.

PROCEDURE:

A. Upon admission the RN will complete a physical assessment ensuring patients are treated with dignity, respect, and provided with maximum level of privacy.
   a. The physical assessment will be carried out in the presence of another assigned staff member.
   b. The patient needs to be observed without clothing or undergarments holding the patient gown in front of the patient for privacy. The assessment will identify any bruising, scrapes, wounds, or other such integumentary issues that may be present.
   c. The assessment will ensure that the patient has no contraband on his/her person. In the event a cavity search is determined to be necessary – it must be ordered AND completed by a physician with an RN present during the entire process.

B. RN will complete the Nursing Admission Assessment that includes health history, a brief psychosocial, vital signs, Suicide Safety screen, Personal Safety Plan and Medication Reconciliation.

C. Admission paperwork to include consent for treatment will be completed upon admission or as soon as patient is able. The patient will be informed of their rights and provided with a copy of those rights (CF-MH 3103- Rights of Persons in Mental Health Facilities and Programs). Behavioral Health staff will explain the rights and how the patient may report violations of those rights.

Appendix C: Admission Process

[redacted]

Notice of Right to Petition for Writ of Habeas Corpus or for Redress of Grievances

D. The admitting / attending psychiatrist will be notified NO LATER than one hour of the patient's arrival on the behavioral health unit. The RN will indicate if the patient is in need of smoking cessation aids, obtain a meal order, and identify any physical issues or outstanding medical issues that were noted during the RN assessment and obtain orders as necessary. The RN will review the Suicide Assessment with the psychiatrist and obtain an order for Level of Observation.
E. All patient belongings will be itemized on the Patient Belongings Inventory. Valuables will be inventoried and placed in the behavioral health unit's safe and Valuables Envelope tag attached to the Belongings Inventory.
F. The patient will be asked who, if anyone, they would like notified of his/her admission to the behavioral health unit.
G. The patient will be provided with a Patient Handbook and orientated to the unit including introduction to staff members and roommate (if indicated and feasible).
H. The patient will have a History and Physical Exam (review of systems) by a licensed individual practitioner (LIP) as approved in the Medical Staff Bylaws of [redacted] Hospital within 24 hours of admission.
    a. The History and Physical Exam for patients admitted to the inpatient Behavioral Health Center will include the additional requirement of an assessment and documentation of the 12 Cranial Nerves.
I. The patient will have an Initial Psychiatric Exam completed by an LIP as approved by the Medical Staff Bylaws of [redacted] Hospital no later than 24 hours post admission to the Behavioral Health Center.

DEFINITIONS:
"History and Physical Exam" – Must meet the minimum required elements as defined by policy 1.840.034 titled "Medical Records – Required Content"

RELATED POLICIES

REFERENCES:
The Joint Commission

Appendix D: Fall Risk Screening Tool

Behavioral Health Fall Risk Screening Tool Assessment:

Get up and go test result:	☐	Multiple attempts success	☐ Can rise in single movement	☐	Success push up 1 attempt	☐	Unable to rise w/o assist
Pt has 3 or more meds in drug classes known to be indicator of fall risk:			☐ Yes	☐	No		
Factors that place patient at risk of fall/injury:	☐	None	☐ Anti-coagulation	☐	Sedation	☐	Slow reaction time
	☐	Hx of fall with injury	☐ Orthostatic hypotension	☐	Sensory impairment	☐	Osteoporosis hx/current

Morse Fall Scale

History of Falling: _____
- 0 = No Falls within the past 3 months
- 25 = Has fallen during this hospitalization OR Has immediate history of falls within the past 3 months

Secondary Diagnosis: _____ 0=
Only 1 active medical diagnosis
- 25= More than 1 medical Diagnosis for current admission OR taking Medications from these classifications: Anti-Seizure, Anti-Anxiety, Psychotropics, Sedative/Hypnotic, Narcotic Analgesics, Anti-Fever, Insulin/Oral Hyperglycemics, Laxatives, Diuretics, or Analgesics.

Ambulatory Aid: _____
- 0= None/Bedrest/Nurse Assist – walks without a walking aid or uses a wheelchair, or is on bedrest and does not get up at all
- 15= Crutches/Cane/Walker – uses crutches, cane or walker
- 30= Furniture – walks clutching onto furniture for support

IV/Saline Lock: _____
- 0= Does not have IV, (saline) lock or is not attached to equipment
- 20= Has an IV, Saline Lock or is Attached to equipment

Gait: _____
- 0= Walks with head erect, arms swing freely at side, striding without hesitation OR on bedrest
- 10= Stooped but able to lift head without losing balance, if furniture required, uses as guide, light touch
- 20= Difficulty rising from chair, head down, watches ground while walking, Cannot walk without assistance, grabs furniture

Mental Status: _____
- 0= If mental status is normal. (Oriented to own ability)
- 15= If considered to overestimate his/her abilities or is forgetful of limitations

FALL RISK Score: *(total of the above scores)* Total Score: _____

*** Use Total Score to Complete Fall Risk Level Interventions on next page.
- No Risk:(Score 0)
- Low Risk: (Score 1-24)
- Moderate Risk: (Score 25-45)
- High Risk: (Score 46-125)

(See next page for interventions)

Appendix E: Fall Risk Interventions

FALL RISK INTERVENTIONS:

No Risk:(Score 0) (No additional interventions are needed based on Fall Risk Scale)

Low Risk: (Score 1-24) ◻ Yes ◻ No

- ◻ Non-slip/skid NON-YELLOW sock
- ◻ Bed should be in low and locked position
- ◻ Fall status communicated with all hand offs
- ◻ Remove excess equipment/supplies/furniture from room
- ◻ Secure excess electrical and telephone wires
- ◻ Clean all spills in patient room and hall immediately. Use wet floor sign.
- ◻ Secure locks on beds, stretchers, and wheelchairs
- ◻ Keep floors clutter/obstacle free - maintain clear path for toileting
- ◻ Place call light and frequently used objects within reach
- ◻ Educate patient/family on call light use
- ◻ Proper use of assistive devices i.e. grab bars
- ◻ Assure adequate lighting, especially at night
- ◻ Patient Education

All of the above selected interventions are implemented? ◻ Yes ◻ No

If No Why: _____

Moderate Risk: (Score 26-45) ◻ Yes ◻ No

(INCLUDES LOW AND MODERATE RISK INTERVENTIONS)

- ◻ Bed should be in low and locked position
- ◻ Fall status communicated with all hand offs
- ◻ Remove excess equipment/supplies/furniture from room
- ◻ Secure excess electrical and telephone wires
- ◻ Clean all spills in patient room and hall immediately. Use wet floor sign.
- ◻ Secure locks on beds, stretchers, and wheelchairs
- ◻ Keep floors clutter/obstacle free - maintain clear path for toileting
- ◻ Place call light and frequently used objects within reach
- ◻ Educate patient/family on call light use
- ◻ Proper use of assistive devices i.e. grab bars
- ◻ Assure adequate lighting, especially at night
- ◻ Patient Education
- ◻ Yellow armband and yellow no-slip/skid socks are on
- ◻ Consider consult to pharmacy
- ◻ Consider consult to physical therapy
- ◻ Not left unattended when assisting with toileting/hygiene

All of the above selected interventions are implemented: ◻ Yes ◻ No

If No Why: _____

Appendix E

High Risk: (Score 46-125) ▫ Yes ▫ No

(INCLUDES LOW, MODERATE AND HIGH RISK INTERVENTIONS)

- ▫ Bed should be in low and locked position
- ▫ Fall status communicated with all hand offs
- ▫ Remove excess equipment/supplies/furniture from room
- ▫ Secure excess electrical and telephone wires
- ▫ Clean all spills in patient room and hall immediately. Use wet floor sign.
- ▫ Secure locks on beds, stretchers, and wheelchairs
- ▫ Keep floors clutter/obstacle free - maintain clear path for toileting
- ▫ Place call light and frequently used objects within reach
- ▫ Proper use of assistive devices i.e. grab bars
- ▫ Assure adequate lighting, especially at night
- ▫ Patient Education and educate patient/family on call light use
- ▫ Yellow armband and yellow no-slip/skid socks are on
- ▫ Consider consult to pharmacy
- ▫ Consider consult to physical therapy
- ▫ Not left unattended when assisting with toileting/hygiene
- ▫ Fall Risk sign on door
- ▫ Side rails, bed alarm and video monitoring should be used per policy
- ▫ Use of sitters and/or restrictive devices per policy
- ▫ Use of a matt, hip protectors or helmet to prevent injury

All of the above selected interventions are implemented: ▫ Yes ▫ No

If NO, Why: _____

Functional Screening:

Functional Assessment WDP: ☐ Yes ☐ No

West Florida Division
Computer Downtime - BH: ADMISSION ASSESSMENT AND HISTORY
PERMANENT CHART COPY *BA* Rev 01-16

BA

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PATIENT LABEL

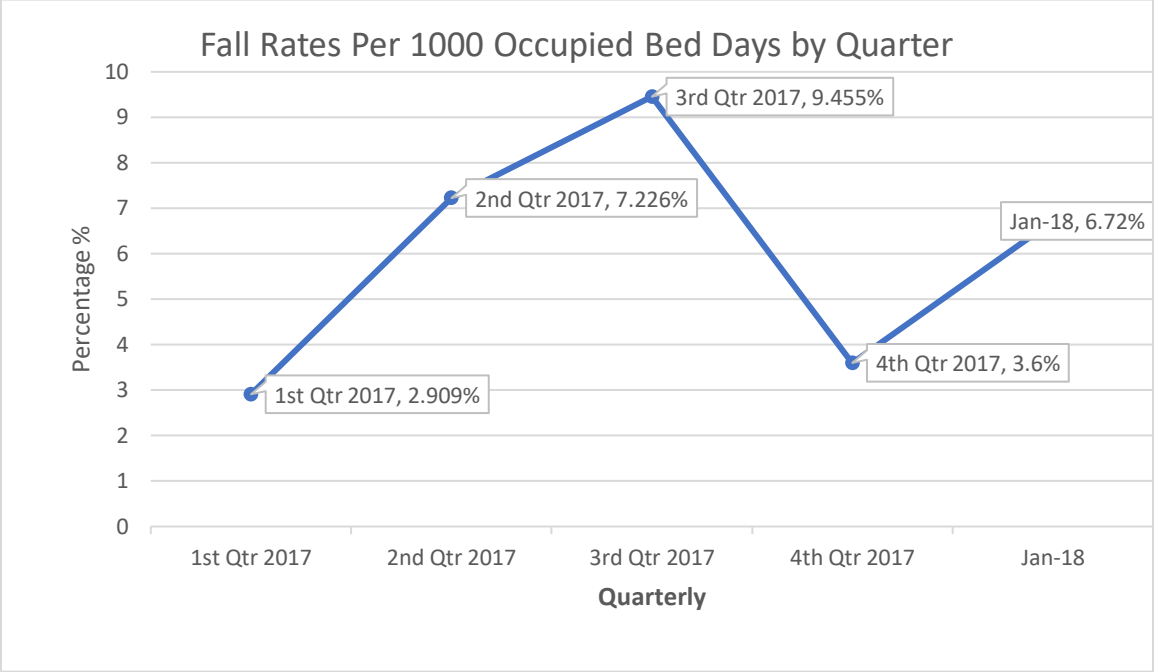
Appendix F: Functional Screening

Functional Screening:

Functional Assessment WDP:	☐	Yes		☐	No			
ADL/functional level:	☐	Dependent	☐	Independent	☐	Needs assist		
Bathing performance level:	☐	Dependent	☐	Independent	☐	Needs assist		
Assist to eat:	☐	Dependent	☐	Independent	☐	Needs assist		
Mobility activity:	☐	Total assist	☐	Ambulation independently	☐	Ambulates with walker	☐	Requires wheelchair
Toileting:	☐	Dependent	☐	Independent	☐	Needs assist		

Functional comment: _____

Appendix G: Fall Rates Pre-Intervention



Appendix G. Data provided by corporate not including patient specifics of with or without injury. These are falls documented and reported which were then compared to other Behavioral Health Units within the Divisional Organization. There is no delineation of repeat falls, falls with or without injury. Percentages are calculated by the total number of falls per quarter, how many beds were occupied during that time are totaled and divided by the number of falls. Per quarter: Total occupied beds/Total falls=fall rate.

Appendix H: Admission Criteria

Department: Behavioral Health	**Policy:** Admission and Exclusion Criteria
Owner (Position Assigned Responsibility):	**Folder:**
Approvals	**Number:** 656.0003
Department: Behavioral Health Unit (BHU)	**Effective Date:** 5/02/12
Committee: 4/26/12	**Issue Date:** 11/11
Administrative Officer: 5/02/12	**Reviewed Date(s):** 4/26/12
Medical Staff Dept. (if required): 02/08/2017	**Revised Date(s):** 02/08/2017
Quality Council: N/A	**Retired:**
Medical Executive Committee: N/A	
Board of Trustees: N/A	
Policies describing procedures/treatments are general guidelines to aid the professional in exercising his or her judgment in rendering patient care.	

SCOPE:
Patients referred for admission to Behavioral Health Unit.

PURPOSE:
To ensure that criteria for admission to the Behavioral Health inpatient unit is consistent and applied uniformly to all potential patients.

DEFINITIONS:
N/A

POLICY:
All patients admitted to the inpatient behavioral health program will be:

1. Male or Female
2. 18 years of age or older
3. Will be admitted either under a Baker Act Voluntary status (BAx40) or under Baker Act Involuntary status (BAx52)
4. Will meet admission criteria as outlined, will display a severity of illness and have the potential to benefit from the active treatment.
5. Will not meet the criteria for Exclusion from admission.

Appendix H: Admission Criteria

PROCEDURE:

ADMISSION CRITERIA	EXCLUSIONARY CRITERIA
For admission, at least one of the following conditions are met (without the co-existing presence of an exclusionary criterion):	Patients who **are not** acceptable for admission:
Suicidal ideation or attempt – previous 48 hours	Total care patients, bedridden and immobile patients.
Physically aggressive threats or actions that pose an imminent risk of harm to self or others due to a treatable primary psychiatric condition, and safely manageable within the resources and capabilities of facility and staff	The patient has a prior history of violent behavior or poor impulse control and is beyond the resources and subsequent capabilities of the staff and environment to contain and manage.
Inability to care for self, due to a primary treatable psychiatric condition, and the patient's associated needs are manageable within the resources and capabilities of the facility and staff.	Intellectually or Developmentally Delayed / Dementia patients unless the reason for admission is to treat a mental illness that meets admission criteria with reasonable expectation the patient can participate in and benefit from active treatment and engage in the therapeutic milieu. Psychiatric admission for behavioral issues related to IDD / Dementia is not appropriate.
Patient's history of illness per prior hospitalization or through a current therapeutic relationship with a psychiatrist demonstrates ability for the patient to be treated within the resources and capacity of the hospital.	Patients who have an acute, unstabilized medical condition, in addition to psychiatric problems; acute critical lab values.
Inappropriateness or failure at outpatient level of a treatable primary psychiatric condition.	Require custodial care.
Significant impairment in social, familial, or occupational relations.	Forensic cases.
Need for psychiatric management and pharmaceutical stabilization that cannot be safely completed in an outpatient setting.	Pregnant patients who are not considered medically stable, under current OB care, or acutely psychotic experiencing delusions about being in labor.
18 years of age or older	Patients requiring any type of Med/Surgical consults / treatment unavailable at receiving psychiatric facility.
Meets InterQual criteria for acute inpatient stabilization	Patients with feeding tubes, pice lines, IV's

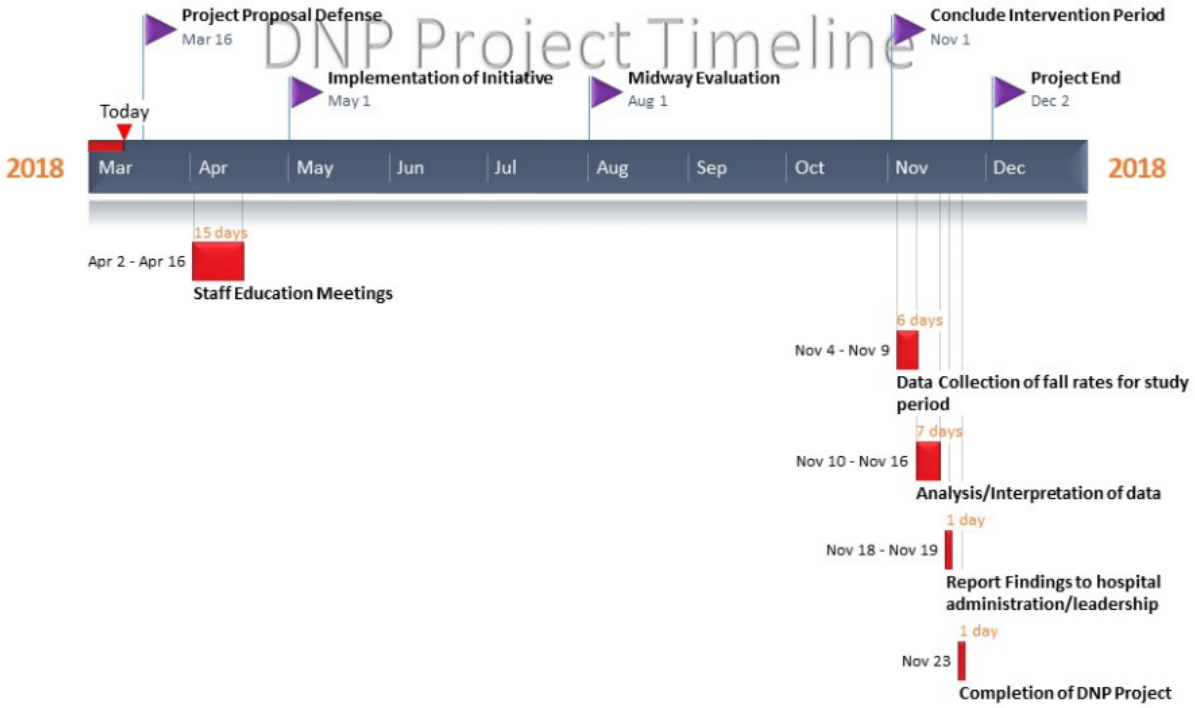
RELATED POLICIES / ATTACHMENTS: None
REFERENCES: Centers for Medicare and Medicaid Services; Conditions of Participation

Appendix I: Falls Checklist

First 30 Minutes on Unit		**Within 4 hours of Admission**		**Shift to Shift**	
☐	Admission Fall Eval done by RN during skin assessment upon arrival to unit	☐	Interview pt, determine risk for falls based on medical hx, medications and PRIOR HISTORY of falls	☐	SBAR-Communicate pts at risk for falls
☐	RN to inform MHT of fall risk. A YELLOW Q15 min. sheet should be started	☐	RN Admission assessment documented in Meditech. RN admission note includes risk for falls	☐	Chart checks to include interventions are in place
☐	If ANY fall risk, immediately place yellow band, yellow socks and a fall magnet outside pts door	☐	Morse Fall Scale documented (should include initiation of interventions as stated in MFS)	☐	Re-evaluate medications and need for consults during admission
☐	Educate pt of falls/safety initiative and prevention.	☐	Physician orders received and placed into Meditech	☐	Reinforce education with patient each shift. DOCUMENT EDUCATION
☐	Have pt sign understanding agreement	☐	Order PT evaluation if pt is deconditioned, weak or if medically justified	☐	DOCUMENT interventions in place
☐	Moderate to High Fall risks should be evaluated for rooms nearest nurses' station	☐	Consult Pharmacy for polypharmacy review	☐	Ensure YELLOW Q15 min. sheet is used for next shift.

Upon receiving report, the nurse should ask the reporting RN if the pt is considered a fall risk. Use judgement (Low, Moderate or High). Any recent OD, administration of emergency treatment order (ETO) due to behavior or obvious medical necessity would warrant a room closest to the nurses' station or a private camera room with a hospital bed. The charge RN, staff and unit secretary should work together to determine the best room available and re-assign rooms if possible, BEFORE the patient arrives on the unit.

Appendix J: DNP Project Timeline



Appendix K: Fall/Safety Agreement

FALL/SAFETY AGREEMENT

Welcome to the Behavioral Unit:

It's our privilege to serve you in the hospital. While you're here, our first concern is your safety and well-being. Your nurse will ask you questions about your medical history, physical status and current medications to determine if you are considered a fall risk. It is possible that your physician may prescribe you medications that could increase your risk for falls. Also, you are in a new environment and we want to make sure you are aware of your surroundings. After the assessment is made, you may be asked to wear a yellow wristband, yellow non-skid socks and will have a fall risk sign placed outside your door. **We are here to make sure you are safe so here's what we are asking from you while you're here!**

ASK FOR HELP!

If you are feeling dizzy, weak or like you may need assistance going to the bathroom or getting out of bed, let us know. We will be rounding every 15 minutes. Make sure to communicate your needs with any of the staff.

SIT BEFORE YOU STAND/STAND UP SLOW

Sitting up after lying for a long period of time may cause dizziness. Please sit for a few minutes to allow your blood pressure to get to a normal state. We don't want you to fall by standing up too fast. If you are taking a new medication or waking up in the middle of the night, please sit before you stand and stand up slowly. Most important, ASK FOR HELP.

COMMUNICATE WITH STAFF

Your safety is our goal. Please let us know if you are feeling dizzy, lightheaded, and weak, fatigued or if you have problems with your bones, joints or muscles so we can be sure to assist you when needed.

PATIENT RESPONSIBILITIES

- If feeling dizzy/lightheaded, I agree to ask for help EVERY TIME I need to get out of bed or go to the bathroom.
- I will communicate with staff if I'm feeling dizzy, lightheaded, weak or like I'm going to fall.
- I agree to wear the yellow wrist band and yellow socks if deemed necessary by my Nurse/Physician.
- I will sit before abruptly standing and will stand up slowly to make sure I do not faint or get dizzy.
- My nurse may move my room closer to the nurses station if considered a higher fall risk.

PLEASE CHECK ONE:

☐ I agree to comply with these fall prevention measures for my safety to prevent potential falls.
☐ I decline the fall prevention measures that are available for my safety to prevent potential falls.

Patient/Proxy Signature:_____ Date:_____

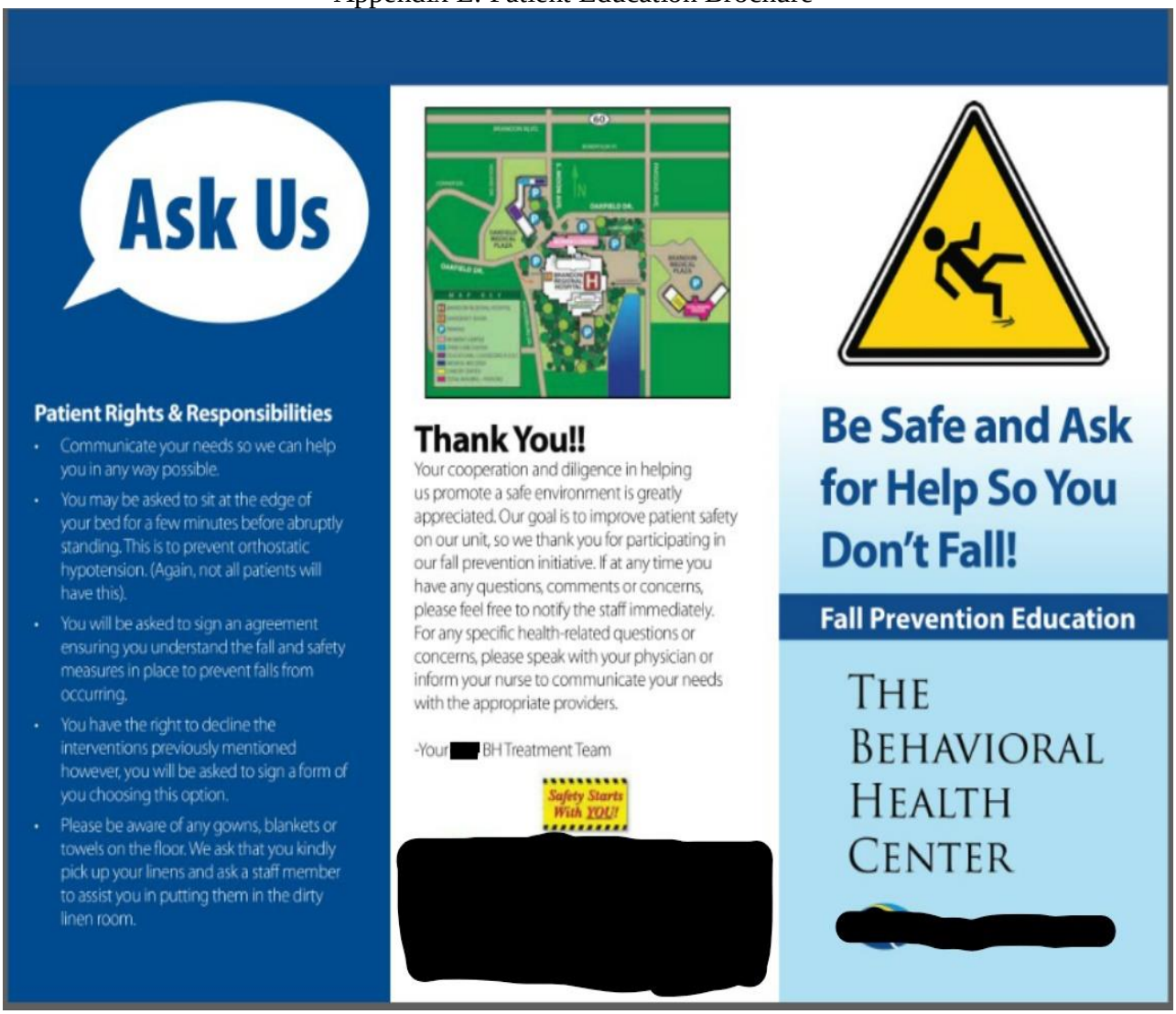
Witness Signature/Title:_____ Date:_____

[redacted]

Patient Identification/Label

BRH02818 Fall Safety Agreement (Rev.04/2018) Page 1 of 1

Appendix L: Patient Education Brochure



Patient education brochure (front)

Appendix L: Patient Education Brochure

Our Mission and Goal

Patient safety is our main goal and your health is a priority. Since many factors can contribute to someone falling, we want you to be aware of what these are so you can help us prevent falls from happening.

If you have a history of falling, weakness, seizures, regularly take multiple medications, dizziness, confusion or have a medical condition effecting your ability to walk or use the bathroom independently, notify the staff immediately. A fall risk assessment will be completed by your nurse on arrival to our unit and these risk factors will be addressed. Please note: If you do have any of these risk factors, your nurse will determine the appropriate intervention for you to ensure your safety is maintained.

This brochure reviews helpful pointers for patients to ensure a safe, therapeutic and falls free environment!

Accidents Happen!

In the unusual event that an accidental spill occurs, please inform the staff immediately so we can assist in cleaning it up. Slipping on a spill is likely to occur and could increase the risk of injury to you or other patients. Be mindful of your surroundings and always wear the non-skid socks provided to you upon arrival. Also, the bathroom floor will get wet when you shower! Please ask for towels or pads which are available to absorb the water and can help prevent slipping. If you need assistance in the shower, please let us know.

Medications effect everyone differently

Though we do not anticipate any side effects from medications, your physician and nurse can review potential side effects of certain medications that may increase the risk for dizziness and falls. It's a good idea to discuss this with your provider when you are told about starting a new medication. Also, certain combinations of medications can increase dizziness and possibly orthostatic hypotension. This occurs when standing too fast resulting in a drop-in blood pressure. Please discuss any medication-related concerns with your nurse or physician.

Communicate your needs

Please inform the staff of any physical limitations, weakness, joint or mobility issues so we can individualize your treatment plan to prevent falls. You know your body best!

Why the Yellow Wrist Band, Yellow Socks and Magnet?

Majority of the patients in the hospital are considered a risk for falls due to this being a new environment, medications or health-related conditions increasing the risk for falls.

- We ask that you comply with wearing the yellow socks and yellow wrist band that have been provided.
- A magnet will be placed outside your door to help identify those patients the staff have identified as a fall risk.
- Every patient is different and not all patients have the same risk factors. This is at the discretion of your nurse and physician.
- If you need a new pair of socks, we will be happy to provide you with a new pair, just ASK!

Patient education brochure (back)

Appendix M: Fall Rate Comparison