

ABOVE, BEYOND, AND OVER THE SIDE RAILS: EVALUATING THE NEW MEMORIAL EMERGENCY DEPARTMENT FALL–RISK-ASSESSMENT TOOL

Authors: Robin A. Scott, ND, MS, RN, CEN, CNS, Kathleen S. Oman, PhD, RN, FAEN, FAAN, Kathleen Flarity, DNP, PhD, RN, CEN, CFRN, FAEN, and Jennifer L. Comer, BSN, RN, CEN, Aurora, CO

Contribution to Emergency Nursing Practice

- Validation of a previously published ED specific fall-risk-assessment tool.
- Identify strengths and barriers to implementation of the fall-risk-assessment tool.
- Identify fall-risk-assessment tool topics that need further definition.

Abstract

Introduction: Patient falls are a significant issue in hospitalized patients and financially costly to hospitals. The Joint Commission requires that patients be assessed for fall risk and interventions in place to mitigate the risk of falls. It is imperative to have a patient population/setting specific fall risk assessment tool to identify patients at risk for falling. The purpose of this study was to evaluate the reliability and validity of the 2013 Memorial ED Fall Risk Assessment tool (MEDFRAT) specifically designed for the ED population.

Method: A two-phase prospective design was used for this study. Phase one determined the interrater reliability of the

MEDFRAT. Phase two assessed the validity of the MEDFRAT in an emergency department (ED) within a 600-bed academic/teaching institution; Level II Trauma Center with >100,000 annual patient visits.

Results: The Memorial ED Fall Risk Assessment Tool was validated in this ED setting. The tool demonstrated positive interrater reliability ($k=0.701$) and when implemented with a falls prevention strategy and staff education demonstrated a 48% decrease in ED fall rate (0.57 falls/1000 patient visits) post implementation during the study period.

Discussion: The MEDFRAT, an evidenced based ED-specific fall risk tool was implemented on the basis of the risk factors consistently identified in the literature: prior fall history, impaired mobility, altered mental status, altered elimination, and the use of sedative medication. The Memorial ED Fall Risk Assessment Tool demonstrated to be a valid tool for this hospital system.

Keywords: Patient Safety; Falls; Assessment Score

Robin A. Scott is Clinical Nurse Specialist for Emergency and Trauma Services, University of Colorado Hospital, Aurora, CO.

Kathleen S. Oman is Chair in Pediatric Nursing, Children's Hospital Colorado, and Professor, University of Colorado Denver, College of Nursing, Aurora, CO.

Kathleen Flarity is Research Nurse Scientist, University of Colorado Health, Aurora, CO, and Mobilization Assistant to the Chief of the Air Force Nurse Corps, Washington, DC.

Jennifer L. Comer is Charge Nurse Emergency Department, University of Colorado Hospital, Aurora, CO.

For correspondence, write: Robin A. Scott, ND, MS, RN, CEN, CNS, 12605 E. 16th Avenue, Mail Stop F756, Aurora, CO 80045.; E-mail: Robin.scott@uchealth.org.

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Introduction

Patient falls are common adverse events reported in the health care setting and are a significant source of morbidity and mortality.^{1–5} Although multiple initiatives and mandates have been implemented across the health care industry to eliminate hospital falls, patients still fall. The Agency for Healthcare Research and Quality (AHRQ) estimates that there are between 700,000 and 1 million patient falls each year, and approximately one third are classified as preventable.⁴ Patient fall rates are considered a nurse-sensitive indicator; a patient fall, as defined by the National Database for Nursing Quality Indicators (NDNQI), is an

unplanned descent to the floor (to include landing on a surface on which “you would not expect to find the patient”), with or without injury to the patient. Because patient falls lead to the development of comorbidities, further injury, and extended lengths of stay, the Joint Commission made fall prevention a National Patient Safety Goal in 2005. The Joint Commission now requires that all patients be assessed for fall risk and further mandates that fall-prevention interventions be put into place to decrease the risk of patient falls.¹

Literature Review

Fall-risk tools help staff quantitatively assess patients for fall risk and apply fall interventions.⁵ There is a growing body of evidence regarding inpatient fall-risk tools and fall mitigation but limited ED data. Of the 48 fall-risk assessment tools identified in the literature, the reliability and validity of the tool was established in only 10, and only 1 tool was designed specifically for the emergency department.^{4,5} In addition, both Cochrane Reviews and the Joanna Briggs Institute (JBI) cited a lack of Level I and II evidence to support prevention of falls in the acute-care setting and even less evidence in the ED setting.⁶ Poe concluded that there was no single tool that could be used effectively across different populations/settings.² Many of the more commonly used fall-assessment tools were developed and used in the 1990s including Hendrich II, 1995; Morse, 1999; and Conley, 1999.⁷⁻⁹ However, these fall-risk-assessment tools were specifically designed for—and implemented in—the inpatient population.

An important consideration is selecting an assessment tool that is valid for the patient population.¹ Fall-risk-assessment tools used in the inpatient setting may not adequately identify the risk factors of ED patients. Although the concept of assessing inpatients for falls started more than 30 years ago, the ED fall-assessment process is still in its infancy.⁵ Terrell evaluated the Hendrich II scale in the ED setting and found that the results did not reliably predict those patients who were at a high risk of falling in the ED environment.³ In addition, Flarity evaluated the Conley Scale in the emergency department; this study also concluded that an ED-specific fall-risk-assessment scoring tool was needed.⁵ The ED, because of its rapid pace and emergent nature, poses particular challenges for fall-risk assessments and fall-prevention efforts. Although inpatient units have certain standardized practices, the frequently fluid nature of ED care can make it especially challenging to assess risk for falls. For example, intoxicated patients should not be asked to stand and walk from a chair as assessed in the “Get Up and Go” test. These factors usually lead to the

incorrect or incomplete use of inpatient assessment tools in the ED setting. In the inpatient setting, a number of common factors have been identified in patients who fall: cognitive impairment, male gender, compromised mobility, sedating medications, and the process of toileting. Male patients above the age of 65 had the highest rate of falls in the inpatient setting.¹⁰⁻¹² Although these factors also apply to patients in the emergency department, other factors—such as intoxication, sedating medications, and trauma—are not accounted for in most inpatient tools.

A 2017 systematic review of fall assessment and prevention found that fall assessments should be patient centered instead of being generalized to all adult patients. The authors concluded that fall-prevention programs that target specific subsets of patients would be more effective in preventing falls.¹³ The ED population varies by region, day, and even hour-to-hour, and, as such, is a special patient subset unto itself. There is limited evidence to describe who falls in the emergency department. A retrospective study by McErlan and Hughes in 2016 concluded that the ED patients who fell were younger than in other settings and were more likely to have ingested alcohol or recreational substances.¹² They further identified that sedating medication (either administered in the emergency department or before) was identified as a risk factor for falling in 73.9% of the patients who fell in the emergency department. Flarity’s 2013 study recognized that the ED patient fall-risk population is different from the inpatient setting; the mean age was 46 years and 44 (40%) of the patients who fell were intoxicated; of the 44 intoxicated patients, 8 had additional risk factors including sedating medications ($n = 4$ [3.6%]), illicit drugs ($n = 2$ [1.82%]), and alcohol-related seizures ($n = 3$ [1.82%]).³ There is an impact on patient safety risk when ED patients at risk for falls are under triaged. Inaccurate fall-risk scores can lead to lack of fall-prevention interventions being used with ED patients. Also, there is a fiscal impact when patients are over-triaged (ie, incorrectly identified as a fall risk when they are not) by requiring additional nursing time and fall-prevention resources. This highlights the importance and necessity of an ED-specific fall-risk-assessment tool.

Methods

AIM AND RESEARCH QUESTION

In March of 2013, the Memorial ED Fall Risk Assessment Score (MEDFRAT) was published.⁵ The MEDFRAT was created at a hospital within our health system, and, in May of 2013, the new fall-risk assessment was distributed system-wide during an upgrade to the electronic health record (EHR)

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