Are Interprofessional Roundtable Debriefings Useful in Decreasing ED Fall Rates? Findings From a Quality-Improvement Project

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Problem: There are more than 1 million patient falls each year in the United States. Falls are known to be a sign of poor health, are a marker of decline in function, and are associated with high morbidity. The objective of this study was to determine the effectiveness of a Falls Roundtable intervention for reducing the rates of patient falls in an urban academic trauma center emergency department.

Methods: We implemented a Falls Roundtable performance-improvement debriefing intervention in a single urban academic emergency department. To evaluate this intervention, we conducted a retrospective analysis of patient fall events 13 months before and 14 months after implementation. We evaluated pre- and post-intervention differences in the total number of assisted falls, unassisted falls, and rate of falls.

Results: Despite a slowly improving trend in falls after the intervention, there was no statistically significant improvement in the number of assisted falls, number of unassisted falls, or rate of falls. The Falls Roundtable intervention was helpful in identifying many additional actionable improvement opportunities in the emergency department.

Implications for practice: The Falls Roundtable incident debriefing intervention alone does not appear to be an effective tool for falls prevention in the ED setting but may serve as an integral component of a multifaceted fall-reduction strategy.

Key words: Patient falls; Falls Roundtable; emergency nursing

According to the Agency for Healthcare Research and Quality, more than 1 million patient falls occur each year in the United States. Thirty percent of these falls result in injury, with 10% resulting in serious injuries such as fractures or head trauma.[1] Falls are associated with an increased hospital length of stay and often are associated with more infections, delirium, and other complications.[2] Twenty percent of patients with fall-related hip fractures die within 1 year of the fall. Fear of falling again can significantly alter a patient's quality of life. In addition, falls are a contributing factor in approximately 40% of admissions to skilled nursing facilities and long-term acute care hospitals.

In 2012, 2.4 million falls were treated in emergency departments, with more than 722,000 of these patients requiring hospitalization.[3] When injuries from all causes were taken into account, falls were one of the most common causes of injuries seen in ED encounters. Among patients with a diagnosis of a fall, the fall was the primary ED visit diagnosis in 20% (as opposed to a secondary or tertiary reason). As the population ages, the numbers of falls and ED visits for injuries from falls are expected to increase.[3]

The estimated annual direct medical costs of falls, adjusted for inflation, was $30 billion in 2012.[3] Falls are known to be a sign of poor health, as well as a marker of a decline in function, and to be associated with high morbidity, with most fractures among older fractures occurring as a result of falls.[4]

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Although falls are a major population-wide concern, falls within the confines of the hospital also need to be addressed. Effective October 1, 2008, the Medicare and Medicaid agencies no longer reimburse hospitals for costs associated with treating injuries incurred by patients who fall during a hospitalization.[5] With health care costs consistently on the rise, it is imperative that all hospital departments work to find effective solutions toward the achievable goal of having no patient falls.[6]

Methods

LOCAL PROBLEM

This practice-improvement project took place in an urban academic emergency department. The setting provides a breadth of specialized care for complex and time-critical conditions and is designated as an Advanced Comprehensive Stroke Center, Adult and Pediatric Burn Center, Certified Chest Pain Center, and American College of Surgeons Level I Trauma Center. It resides within a 751-bed hospital that experienced a 17% increase in inpatient discharges and outpatient encounters over the past 5 years. The emergency department experienced a 25% increase in volume in that 5-year period (from approximately 43,000 encounters to over 54,000 encounters) and operates with 23 critical care treatment rooms, 5 lower-acuity "fast-track" treatment rooms, 7 hallway treatment beds, and a 2-bay trauma resuscitation room.

Before implementation of the Morse fall risk scale in our emergency department, all patients were treated as high risk for falls. There were no specific clinician guidelines for determining which interventions should be implemented and which could be deferred. The decision was guided by the judgment of the emergency nurse or physician.

The Morse fall risk scale[7] was entered into the electronic medical record by the emergency nurse during the primary nursing assessment and was reassessed or updated whenever the patient's condition changed or as new information became available. The Morse scale is a tool that has been validated for use in the inpatient setting. One significant limitation for use of the Morse fall risk scale in the emergency department is that not all of the information is available or known at the time of assessment, potentially leading to under-triaging of a patient's true risk of a fall.

In December 2012 the Falls Roundtable intervention was introduced in our emergency department. The Falls Roundtable was an intervention that had been used in our acute care units for 2 years before implementation in the emergency department. The hospital achieved reductions in its rate of falls, with exemplar nursing units achieving fall-reduction rates of up to 56%. These results are consistent with previous findings that interprofessional communication is pivotal to providing a safe environment of care.[8] The objective of this study was to determine the effectiveness of the Falls Roundtable as a standalone performance-improvement tool for reducing the rate of falls in an urban academic trauma center emergency department.

FALLS ROUNDTABLE INTERVENTION

At our academic medical center, the inpatient units used the fall-reduction strategy known as the Falls Roundtable, which is a post-event interprofessional debriefing and discussion process. The Falls Roundtable is a weekly review session for all patient falls that occurred in the previous week. The interprofessional panel consists of 1 nursing quality outcomes coordinator, 2 acute care clinical nurse specialists, the director of acute care nursing services, 1 physical therapist, 1 education and development nurse, and 1 pharmacy resident. If the nurse or staff member responsible for the patient's care at the time of the fall was unable to attend, his or her appointment would be rescheduled or a phone conference line would be used so that he or she could provide the necessary information without having to be physically present. Most often, a unit manager or other staff member who was aware of the circumstances would also attend, but the goal was to always debrief the person who was caring for the patient at the time of the fall.

The circumstances of the fall were discussed by the staff member and the panel, including any noteworthy occurrences that took place before the fall. As applicable, the panel would ask specific questions necessary for data collection (Table 1) pertaining to patient injuries, activity at the time of the fall, the fall-prevention interventions that were in place, communication, medications or use of other substances, staffing levels, staff responsiveness, clinical judgment, use of patient handling and equipment, and other contributing factors in the opinion of the staff member.

The panel followed the same structured flow of questions with each debriefing. An answer for every necessary question was obtained each time, with simple branching logic used to determine whether a question was unnecessary. For example, if the fall occurred during hallway ambulation, questions about bed alarms and bedside commodes were not applicable.

Once all information had been obtained, the panel and staff member discussed the fall, the circumstances surrounding it, and the other possible contributing factors.

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