

A SUCCESSFUL ED FALL RISK PROGRAM USING THE KINDER 1 FALL RISK ASSESSMENT TOOL



Authors: Ann B. Townsend, DrNP, RN, ANP-C, CNS-C, CEN, Marisol Valle-Ortiz, DrNP, RN, PNP, NEA-BC, and Tracy Sansweet, BSN, RN, CEN, Woodbury and Bridgeton, NJ, Philadelphia, PA

CE Earn Up to 8.5 CE Hours. See page 554.

Problem: Emergency nurses did not perform falls risk assessments routinely on our ED patients; the instrument used was aimed at inpatients. We identified a need to revise fall assessment practices specific to our emergency department. The purpose of the performance improvement project was to reduce ED falls and evaluate the use of an ED-specific fall risk tool, the KINDER 1 Fall Risk Assessment. The plan was to establish fall risk assessment practices at point of ED entry and to decrease total falls.

Methods: We retrospectively reviewed ED fall data for each quarter of 2013, which included risk assessments scores, the total number of falls, and the circumstances of each fall. Using Kotter's framework to guide a successful change process, we implemented the KINDER 1 to assess fall risk.

Results: During the first 4 weeks of the project, 937 patients (27%) were identified as high risk for falls using the KINDER 1. During the

subsequent 3 quarters, the total number of falls decreased; reported falls without injuries dropped from 0.21 to 0.07 per 1000 patients, and falls with injuries were reduced from 0.21 to 0.0 per 1000 patients.

Implications for Practice: The results of this project represented a valuable step toward achieving our goal to keep ED patients safe from injuries as a result of falls. The findings add to the body of nursing knowledge on the application of clinical-based performance improvement projects to improve patient outcomes and to provide data on the use of the KINDER 1 tool, which has not been extensively tested.

Keywords: Accidental fall; ED patients; Fall risk tool; ED fall prevention; KINDER 1

Nearly 1 million patients fall each year during a hospitalization, and as many as one third of falls in hospitals are preventable using fall risk interventions that focus on individual and environmental risk.¹ Reliable and valid fall risk assessment tools, such as the Hendrich II Fall Risk Model (HFRM) and the Morse Falls Scale (MFS), have been used

successfully in inpatient settings.²⁻⁴ Nonetheless, specific fall risk assessment tools for screening ED patients need to be developed and validated.² Although both the HFRM and the MFS are highly specific tools for assessing inpatient falls, their application to the ED patient population has not been established.²

To be consistent with the inpatient tool adopted in our hospital in Southern New Jersey, the ED leadership team had used the HFRM as the sole ED fall risk assessment tool. The HFRM was built into the electronic medical record (EMR), to be completed upon admission by the nursing staff. To evaluate the use of the HFRM retrospectively in the emergency department, we retrieved 2013 quarterly data for fall risk prevention procedures in adult ED patients. We found that no final fall risk scores had been entered into the database, which indicated that the tool had not been sufficiently completed by our emergency nurses to enter a total score.

Purpose

As part of an ED safety performance initiative and in response to a patient fall incident that resulted in an injury, the ED leadership team designed a change process that was delivered as a fall risk project improvement, as shown in

Ann B. Townsend, *Member, New Jersey ENA Chapter*; is former ED Resource Nurse, Inspira Medical Center, Woodbury, NJ, and Assistant Professor of Nursing, School of Nursing and Health Sciences, LaSalle University, Philadelphia, PA.

Marisol Valle-Ortiz, *Member, New Jersey ENA Chapter*, is former ED Nursing Director, Inspira Medical Center, Woodbury, NJ, and Interim Nurse Leader Consultant.

Tracy Sansweet, *Member, New Jersey ENA Chapter*, is former Clinical System Analyst, Emergency Department, Inspira Medical Center, Woodbury, NJ, and Systems Analyst II, Information Services, Inspira Health Network, Bridgeton, NJ.

For correspondence, write: Ann B. Townsend, DrNP, RN, ANP-C, CNS-C, CEN, School of Nursing and Health Sciences, LaSalle University, 1900 West Olney Ave, Philadelphia, PA 19141-1199; E-mail: townsend@lasalle.edu.

J Emerg Nurs 2016;42:492-7.

Available online 6 May 2016
0099-1767

Copyright © 2016 Emergency Nurses Association. Published by Elsevier Inc.
<http://dx.doi.org/10.1016/j.jen.2016.03.028>

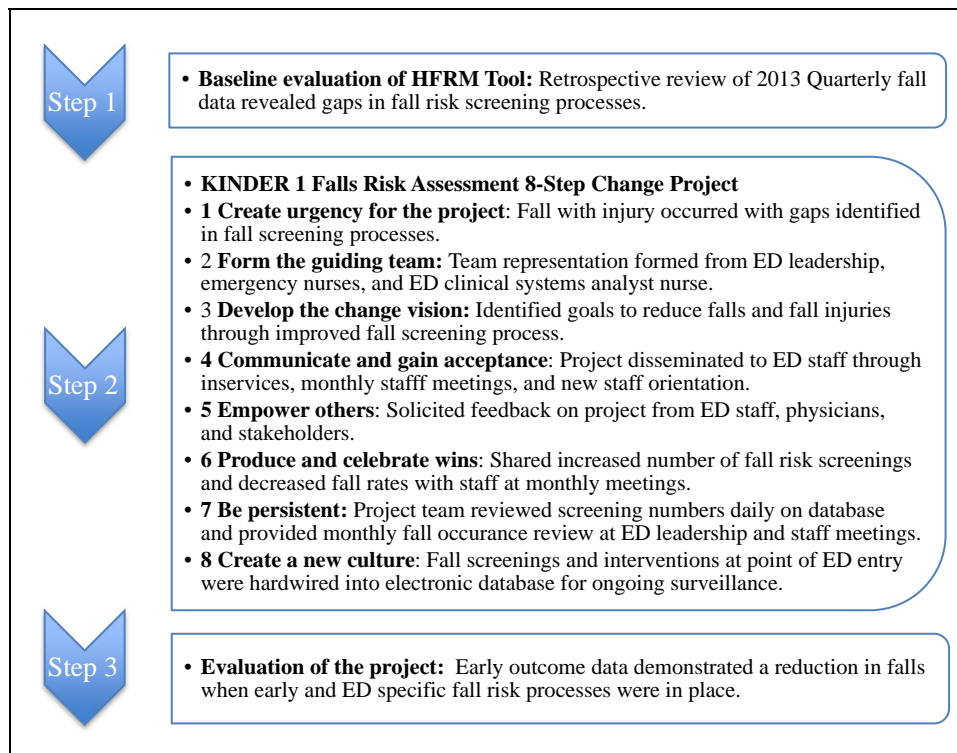


FIGURE 1

Improvement flow process steps, based on data from Kotter et al.⁶ *HFRM*, Hendrich II Fall Risk Model.

Figure 1. The purpose of this project was to reduce ED falls by implementing a fall reduction plan and an ED-specific fall risk assessment tool, the KINDER 1 Fall Risk Assessment.⁵ Our vision for implementing the Fall Risk Assessment Program was to improve the overall quality and safety of care in the emergency department by decreasing falls. We used Kotter's 8 steps of change as a framework⁶ to establish fall risk assessment practices at the point of ED patient entry and to compare outcome data after implementation of the fall risk performance improvement project with retrospective falls data prior to project inception.

Relevant Literature

During the review of our fall risk process, the HFRM⁴ was evaluated as the fall risk tool for ED use. The HFRM, developed by nurses in 2003, aimed to assess fall risk in inpatient settings. The patient is scored on the presence of the following 8 risk factors: (1) confusion, disorientation, and impulsivity receives a score of 4, whether a chronic or

an acute condition; (2) symptomatic depression is scored at 2 points; (3) altered urinary or fecal elimination is assigned a score of 1 for incontinence, frequency, or nocturia; (4) dizziness or vertigo is given a score of 1, unless previously recorded in the history; (5) male gender is scored as 1 point; (6) antiepileptic medications are given a score of 2 for administration, dose changes, or discontinuation; (7) benzodiazepine medications are scored as 1 point; and (8) inability to rise from a seated position to a standing one has a range of points from 0 to 4, based on performance.⁴ Each category is summed for a total score to predict the risk for falls; a score of 5 points to a maximum score of 16 points indicates a high risk for falls.⁴ When compared with other fall risk tools, such as the MFS and the St Thomas's Risk Assessment tool in falling elderly inpatients (STRATIFY), the HFRM performed with greater predictive validity, sensitivity, and specificity³; however, the HFRM may not reliably predict ED patient falls.²

In contrast, the KINDER 1 Fall Risk Assessment Tool was designed by emergency nurses to identify adult patients at risk for falls starting at the point of entry or triage.⁵ The KINDER 1 identified risk factors unique to ED patient falls

Download English Version:

<https://daneshyari.com/en/article/5563255>

Download Persian Version:

<https://daneshyari.com/article/5563255>

[Daneshyari.com](https://daneshyari.com)