



## Original article

## Inpatient fall prevention from the patient's perspective: A qualitative study

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## ABSTRACT

**Aim:** The aim of this study was to describe the patient's perspective of fall prevention in an acute care setting to aid in the design of patient centered strategies.

**Background:** Falls are one of the most common adverse events in hospitals and can lead to preventable patient harm, increased length of stay, and increased healthcare costs. There is a need to understand fall risk and prevention from the patients' perspectives; however, research in this area is limited.

**Methods:** To understand the patient perspective, semi-structured interviews were conducted with twelve patients at an academic healthcare center.

**Results:** Qualitative analysis revealed three major themes: (1) how I see myself, (2) how I see the interventions; and (3) how I see us. The theme "How I see myself" describes patients' beliefs of their own fall risk and includes the sub-themes of awareness, acceptance/rejection, implications, emotions, and personal plan. Interventions, such as fall alarms, are illustrated in the theme "How I see the interventions" and includes the subthemes what I see and hear and usefulness of equipment. Finally, "How I see us" describes barriers to participating in the fall prevention plan.

**Conclusions:** Most fall prevention programs favor clinician-led plan development and implementation. Patient fall assessments needs to shift from being clinician-centric to patient-centric. Nurses must develop relationships with patients to facilitate understanding of their needs. Developing these truly patient-centered programs may reduce the over-reliance on bed alarms and allow for implementation of strategies aimed to mitigate modifiable risk factors leading to falls.

## 1. Introduction

Falls and falls with injury are one of the most commonly reported adverse events in hospitals. In the United States, approximately 700,000 to 1,000,000 patients fall annually during their hospitalization and up to half of these falls result in an injury (Agency for Healthcare Research and Quality [AHRQ], 2013). Falls may prolong length of stay and contribute to morbidity, making fall prevention a priority for hospitals (Miake-Lye, Hempel, Ganz, & Shekelle, 2013).

Fall prevention is complex, with single interventions lacking efficacy compared to multimodal approaches (Cameron et al., 2012). Evidence based practice operates where clinical judgment, scientific evidence and patients' values and preferences converge (Melynk & Fineout-Overholt, 2015). Effective fall prevention therefore requires a partnership between the patient and staff that respects and includes the patient's view. Therefore, the need to study and describe the patient's perspective exists in tandem with the need to investigate processes and

interventions aimed to decrease falls.

While previous studies have explored patients' perspectives of fall prevention programs in a community setting, less evidence describes this subject in the acute care setting (Chen et al., 2016; McMahon, Talley, & Wyman, 2011; Pohl et al., 2015). Shuman et al., (2016) interviewed fifteen hospitalized patients to understand their perceptions of fall risk and fall prevention interventions. They found that "communication and level of engagement influenced patient perceptions" suggesting healthcare providers need to include the patient in fall prevention (Shuman et al., 2016, p. 84). However, this study did not explore patients' perceptions of specific interventions or equipment that is often included in fall prevention programs. Additionally, the study did not explore patient barriers to participation in fall prevention strategies while in the hospital.

Patients want to be active participants in their fall prevention plan (Carroll, Dykes, & Hurley, 2010). Furthermore, patients value the ability to tailor the approach to meet their individualized needs (Haines

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& McPhail, 2011). When patient preference is ignored, patients may feel their autonomy is threatened (Haines & McPhail, 2011). Weingart et al., (2011) surveyed patients discharged from the hospital to describe the association between patient participation in care and the quality and safety of care. The study identified an inverse relationship between participation and adverse events (Weingart et al., 2011). Including patients in their care may therefore decrease the risk of adverse events, such as falls.

The aim of this study was to describe the patient's perspective of fall prevention in an acute care setting to aid in the design of patient-centered strategies.

## 2. Methods

A qualitative study was designed to describe the patient's perspective of their own fall risk and of the fall prevention interventions implemented by nursing staff. The study was reviewed and approved by the local Institutional Review Board (protocol #1407636143).

### 2.1. Setting

The study was conducted in a large, urban, tertiary care, academic health center in the Midwest. The facility has been designated as a Magnet Hospital for excellence in nursing services and high-quality clinical outcomes for patients. Participants were selected from non-intensive care inpatient units. The facility screens all inpatients for fall risk on admission and every shift. In addition to universal fall risk prevention measures, additional interventions are matched to patient specific etiology to mitigate fall risk. Interviews took place over a period of seven weeks starting October 2014. Data collection was interrupted for a period of five months due to personal leave and was completed in March 2016.

### 2.2. Participants

Inclusion criteria for participation included patients who met the following criteria: a Glasgow Coma Scale of 15, free of cognitive deficits, English speakers, a Johns Hopkins Fall Risk Assessment Tool (JHFRAT) score of  $\geq 6$ , admitted to a non-intensive care unit (ICU), a unit length of stay  $> 24$  h, in a private room for confidentiality, and be  $\geq 18$  years of age. Patients that fell during the current hospitalization were excluded. The JHFRAT screens for known fall risk factors including age, fall history, elimination, medication usage, patient care equipment that tethers, cognition, and mobility status (Poe, Cvach, Dawson, Straus, & Hill, 2007). The tool calculates a total score that corresponds to a fall risk level: 0–5 is considered low risk, 6–13 is moderate risk, and  $> 13$  is considered high risk for falling (Poe et al., 2007).

The lead investigator (BR), a Clinical Nurse Specialist (CNS), was responsible for data collection. On selected days, the investigator asked the unit charge nurse for a list of patients with JHFRAT scores  $\geq 6$  (patients considered at least at moderate risk of falling). Guided by this list, the investigator reviewed each patient's chart to screen for exclusion criteria, as well as to independently verify the fall risk score. For the units that had more than one patient eligible on a given day, all names were written on a piece of paper and then drawn out of a cup to decrease bias.

### 2.3. Data collection

Each participant was provided a study information sheet describing the study and measures to ensure confidentiality. Verbal consent was received to take part in the interview and participants were assigned a unique participant code. All interviews were conducted by the lead investigator. A sign was placed on the patient's door requesting that no healthcare workers enter the room during the interview. Interviews

**Table 1**  
Patient interview guide.

1. Are you aware that you have been identified as a "fall risk" by the nursing staff?
2. What does that mean to you to be identified as a "fall risk"?
3. When the nurse explained you were a fall risk, did it make sense to you?
4. How do you feel about being identified as a "fall risk"?
5. Do you believe you are a fall risk? Why or why not?
6. What do you believe the nurses are doing to help prevent you from falling?
7. What do you do to prevent you from falling while here in the hospital?
8. Do you feel like you and your nurse share the same fall prevention plan?
9. What are your thoughts and feelings on the usefulness of the interventions we use to keep you from falling?
10. What keeps you from following the fall prevention plan?

were audiotaped and conducted in the patient's private room using a standardized open-ended interview approach (Turner, 2010). The interview guide was developed by the investigators with input from local and national experts in fall prevention. The guide was designed to elicit patient awareness/perceptions of fall risk and prevention interventions. Interviews were transcribed verbatim and checked for accuracy. The interview guide is shown in Table 1.

### 2.4. Data analysis

After five interviews were completed, the lead investigator reviewed transcripts to identify themes. Thereafter, data was reviewed after every two interviews until data saturation was reached. After ten interviews, no new themes emerged. To verify saturation, two more interviews were conducted. As no new themes emerged, data collection was stopped.

Transcript analysis was guided by constant comparative methods (Kolb, 2012). During open coding, the team, which consisted of a CNS and a physician, read all transcripts repeatedly to gain a general understanding of the data. The team individually analyzed the transcripts for emerging themes. Together, the team iteratively refined the themes to reflect meanings in the data. During focused coding, the team individually organized initial themes into major themes. The team then met to compare and discuss until consensus was reached. Throughout the analysis process, investigators practiced reflexivity and examined negative cases that might lend to alternative explanations of the data.

## 3. Findings

### 3.1. Demographics

A total of twelve patients participated in the study, including 7 men and 5 women. Ages ranged from 38 to 89 years, with a mean of 65.2 years. At the time of the interview, three patients were hospitalized in medical progressive care units, three were on medical units and six were on surgical units. Prior to hospitalization, 11 patients were living independently without assistance while one was living with a caregiver and required assistance. Admitting diagnoses included pneumonia, atrial fibrillation, chronic obstructive pulmonary disease, falls, and urological surgery. The average JHFRAT fall risk score was 9 with a range of 6–14. Table 2 provides patient characteristics including fall risk factors. Of the 12 patients, three were considered an automatic high fall risk because of a history of more than one fall within the six months before admission. The average length of stay was 5 days (range 1–11 days).

Interviews took an average of six and a half minutes with a range of 2.8 min to 16.8 min. Family members were present during one interview.

Qualitative analysis revealed three major themes that were consolidated as follows from the patient's viewpoint: (1) How I see myself, (2) How I see the interventions, and (3) How I see us.

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