Evaluation of Current Emergency Department Fall Risk Assessment Tools: Is An Emergency Department Specific Fall Risk Assessment Tool Needed?

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Abstract

Problem: The ability to accurately and quickly identify patients at high risk for falls at the point of entry into the emergency department is the most important step in fall prevention and avoiding harm. Using an inpatient falls risk assessment tool is not adequately identifying patients at risk in the emergency department setting. Multiple factors contribute to falls and are not included in the risk assessment tool. The purpose of the study was to determine if the false risk assessment tool used in the Emergency Department (ED) adequately identifies a patient at risk for falling.

Methods: This study used a snowball sampling method via Facebook with a link to Survey Monkey.

Results: Of the 72 nurses who completed the survey, 34.7% of the nurses thought the survey was not appropriate for the evaluation of falls in the emergency department. Even though this may not seem like many, of those 72 nurses, 47.2% of them would prefer a simpler tool. When asked what population of patients the fall risk assessment tool did not appropriately screen for, responses included intoxicated, pediatric, infants, substance abuse, dizziness, vertigo, and unconscious patients.

Implication for Practice: After reviewing the literature, it would be beneficial to develop an ED fall risk assessment tool that is specific to the patient population in the emergency department. A possible future study would be to implement an ED specific fall risk assessment tool and determine the effectiveness of the risk assessment tool on predicting patient falls.

Key Words: Falls, Fall risk tool, Emergency room specific falls tool

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Degree Name
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First Supervisor
Christine Neslon-Tuttle

Second Supervisor
Heather McGrane-Minton

Keywords
Falls, Fall risk tool, risk assessment tool, Emergency, emergency department, emergency

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(PRACTICE IMPROVEMENT)

Authors: Carrie A. Brown RN, CMSRN

Rochester, NY

Contributions to Emergency Nursing Practice

-Nurses can quickly and appropriately identify patients at risk for falls and initiate fall interventions early.

- This survey identified almost half of nurses surveyed would prefer a simpler tool.

- As fall risk assessment tools are required to be completed in emergency departments, a modified assessment tool specific for emergency departments will allow nursing practice to focus on fall reducing interventions.

Abstract

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Introduction

Falls account for more than 20.3 million visits to the emergency department (ED) annually.¹ According to the Agency for Healthcare Research and Quality, there are more than 1 million patient falls each year in the United States.¹ Patient falls represent nearly 40% of inpatient incident reports and occur during 7% of hospital admissions.² Most of the injuries related to falls are minor, such as abrasions, lacerations, or hematomas, but approximately 3% result in fractures.²

Due to the frequency of falls in the hospital and their associated morbidity and mortality, hospitals are required to have procedures or policies in place to prevent falls. The increased frequency of falls leads to protocols in place to improve patient safety and fall prevention. The Joint Commission (JC) has made fall prevention a national patient safety goal.² The JC mandates patients to be assessed for risk of falling and reassessment of fall risk throughout a patient stay in the hospital.

Unfortunately, the risk assessment tool used hospital wide is not reliable in identifying patients at high risk of falling in the ED. Most emergency departments do not have a standard emergency department falls risk assessment tool. Inpatient fall risk assessments can be too cumbersome, long, and not appropriate to assess the patient population with such a high turnover in an ED. Patients are also not being screened properly, risk assessments are not completed, and interventions are not in place prior to patient falls.² In order to promote patient safety, an individualized emergency fall risk assessment tool must be developed. Prior research indicates the Hendrich II Fall Risk Model is a valid instrument to identify high-risk patients in the inpatient environment.² When using this instrument in the ED, nurses were only able to predict one-third of the patient falls using the get up and go test, which was not always able to be
performed in the ED due to the high acuity and turnover of patients.²

The Timed Up and Go Test is a 15-second test to determine the mobility of patients and can be performed by the bedside nurse. This test is unable to screen patients at high risk and conditions that affect gait. This test is also not appropriate in EDs at high capacity.³ Functional mobility screens in the ED can be predictive of a patient’s fear of falling. Fear of falling is directly related to the patient’s decreased activity level, and decreased activity levels can lead to patient falls.

An ED-specific risk assessment tool, the Memorial ED Falls Risk Assessment Tool can be administered rapidly by nurses, is specific to emergency nursing, and has been validated for use in the ED. However, with this tool there was a discrepancy in both under and over assigning patient fall risk. Nurses were also failing to reevaluate the fall risk as a patient’s condition changes and leads to noncompliance with fall interventions.⁴

These studies revealed different factors that contribute to falls. Collecting information in attempt to recognize a trend or pattern to falls is important in fall prevention. Identifying a trend can lead to implementing a change in practice. Since the majority of falls occur in the patients' room,² it is important to keep the curtains open and patients in sight. Inappropriate footwear has consistently been shown to contribute to falls.² It is important to have non-skid socks to reduce the risk of falls. Studies have also shown that older adults with more comorbidities have an increased fall risk.² In the majority of falls in this study, patients had bad vision, poor leg strength, and had taken over four medications.⁶ Having such risk factors placed patients at an increased risk for falls. Since men are more likely to die from falls, it may be beneficial to include a gender specific tool in the falls risk assessment.⁷ Lastly, these studies have shown that intoxication also plays role in the majority of falls. All of these risk factors support the need for
an ED specific tool.

PROBLEM DESCRIPTION

The purpose of this study was to determine the most appropriate fall risk assessment tool to precisely identify a person at risk in the variable environment of an ED. The target population of this study includes nurses over the age of 18 from any ED. There is no exclusion criterion for length of employment. The current study will determine if the risk assessment tool used hospital wide is reliable in identifying patients at high risk of falling in the ED. Results will be used for quality improvement.

Methods

STUDY DESIGN

The sample of ED nurses was obtained using snowball sampling via Facebook. A link to the Survey Monkey survey was posted and shared on Facebook. Data collected was strictly anonymous, had no individual identifying markers, and no mention of at which institution the nurse works. Data included the rate of patient turnover in the ED and if the hospital's acuity was affecting nurses completing fall assessments. The data was used to better understand nursing compliance when completing a fall assessment and ease of completing the tool. This study received Institutional Review Board approval from the author's academic institution prior to initiation of study procedures.

SAMPLE AND SETTING

Nurses employed in the EDs completed the survey online. Participants were from a variety of emergency department settings ranging from level 1 trauma centers to non-designated trauma centers, such as small rural hospitals. Inclusion criteria included nurses employed in EDs, age 18 and over, and participants must have access to Facebook to be recruited into the study.
PROCEDURES

Data was collected from April 4, 2017 through August 4, 2017. The study population included emergency nurses. Emergency nurses were asked to complete a 10-question survey regarding the falls risk assessment tool used in the ED they are employed. Questions included patient population, census, level trauma center, which tool is used, tool compliance, policy for tool use at facility, ease of tool use, appropriateness for patient population, preference for a simpler tool, and an open-ended question regarding which populations of patients in the ED they felt were not considered in the tool.

ETHICAL CONSIDERATIONS

The Institutional Review Board granted exempt status to this Quality Improvement Project. The study author reported no conflicts of interest, and there was no outside sources of funding. All survey data submitted was confidential and anonymous with no identifying markers.

DATA ANALYSIS

Data was exported from SurveyMonkey to an Excel spreadsheet. Individual responses were summarized for each question answered using descriptive statistics. All analyses were conducted in SPSS version 23.

Results

A total of 72 emergency nurses competed the survey and majority of nurses were in adult (n, %) and pediatric (n, %) emergency departments seeing between 100-200+ patients a day. Whether or not they knew which fall risk assessment tool being used, 72.2% of the nurses reported completing a fall risk assessment tool on all patients they encounter. Of the 72 nurses, 62.5% were required by the facility to complete documentation on fall risk. Forty-two nurses (58.3%) felt that the tool they are currently using is easy and quick to complete, forty-seven
(65.3%) felt it was a valid tool to use for the emergency room population, and nearly half the nurses would prefer a simpler tool.

**Discussion**

This study investigated fall risk assessment tools among nurses working in an ED. Results indicated that nurses reported an ability to complete the assessment based on the acuity, census, and ease of the assessment tool. Most of the time the facility required nurses to complete the assessment on all patients all of the time, whereas some surveyed only completed assessments on at risk patients.

While most of the nurses in this sample reported that the tool was already simple and easy to complete, nearly half of the nurses indicated they would prefer a simpler tool. Whether this is due to the number of patients they see in a day or whether they were able to think and reflect about the answer given in the prior question, emergency nurses are overwhelmed with the number of patients and the tasks they are given to complete by their institution. If a quick and focused fall risk assessment tool is specific for the emergency population, it will more likely improve nursing compliance and judgment on determining at-risk patients.

**Limitations**

This study had several limitations. First, the sample size was small but relative to the length of time the survey was conducted. Some of the survey questions could have been asked in a different way so that more of the responses would be answered. For example, 50 participants did not indicate the level trauma center designated for their ED. We are unable to determine if the participants were unaware of the level trauma center or if the question was worded in a way they were unsure of what was being asked.

Another limitation is determining if the participants are actually completing the fall risk
assessment tool on patients. For example, if the nurses are overwhelmed, are they not completing the risk assessment tool? It is unknown if the facility requires nurses to complete the tool prior to disposition. The only way of knowing if the assessments are being completed is to audit charts for compliance.

**Implications for Emergency Nursing**

The implementation of an ED fall risk assessment tool would be beneficial for nurses to be clear, concise, and easy to complete to improve evaluations of patients at risk for falls. The tool needs to be appropriately designed for at-risk patients by including children and patients that may be identified at risk by alcohol intoxication.

**Conclusion**

This study examined the use of a fall risk assessment tool users in various EDs. Nearly half of nurses who participated indicated they would prefer a simpler tool when assessing patients' fall risk. Determining which aspects are essential to identifying patients at risk can lead nurses to quickly identify and initiate interventions to prevent falling. Increasing staff awareness as well as compliance in completing fall risk assessments can lead to better outcomes and potentially preventing falls in the ED. Finally, placing emphasis on recognition, completion, and initiation of interventions can encourage nurses to make fall reduction efforts a priority in reducing harm. Future research should examine the outcomes of having an emergency room specific fall risk assessment tool. By implementing this tool, research should be done to determine the effectiveness of the risk assessment tool on predicting patient falls.
REFERENCES


3.2. Redmond, WA

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