Collaborative Approach to Decreasing Patient Falls in ECU Health Behavioral Health Unit

Michael Morledge, MD, MPH, Irene Pastis, MD, Angela Kallis, MD, Letecia Yelverton, BSN, RN, Tim Garriss, BA, COTA/L IV, CWT, Shelley Greene, OTR/L II, Rhonda Godwin, LRT/CTRS, Rhonda Walton, LCMHC, LRT/CTRS

Department of Psychiatry and Behavioral Medicine, Brody School of Medicine, East Carolina University, Greenville, North Carolina, USA

BACKGROUND

- A recent study on the incidence of falls in US hospitals found a fall rate of 8.55 per 1000 patient days and injurious fall rate of 1.97 per 1000 patient days on geriatric psychiatric units in general hospitals.
- This rate is significantly higher than for general adult psychiatric units in general hospitals. Psychiatric conditions and psychiatric medications are associated with an increased fall risk.
- Other clinical conditions including neurological disorders, neurocognitive impairments, visual/hearing impairments and gait/balance difficulties may also increase fall risk.
- The most common activities patients are engaged in during falls in psychiatric settings include getting up from a bed, chair or wheelchair; walking/running; bathroom-related; or behavior-related.
- Hospital fall prevention strategies target patient and family education, clinician education, environmental modifications, assistive devices, hospital systems, and medication reviews.

PROJECT AIM

- Our quality improvement project used a collaborative approach to reduce falls on the ECU Health Internal Medicine/Psychiatry (Geriatric) Inpatient Behavioral Health Unit.

PROJECT DESIGN/STRATEGY

- Our collaborative approach involved physicians, nursing, occupational therapy, and physical therapy, with significant support from allied health staff.

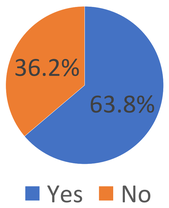
CHANGES MADE (PDSA CYCLES)

- After identifying patients with a moderate to high fall risk using Johns Hopkins Fall Risk Assessment Tool we provided patient education focusing on fall prevention as well as weekly in-person group exercises focusing on muscle strengthening. The goal of the interactive sessions was improved mobility and stability. The sessions were led by different disciplines including OT, PT and allied health. Assistive devices were provided as indicated.
- Physicians assigned to patients also performed daily medication review in collaboration with nursing.

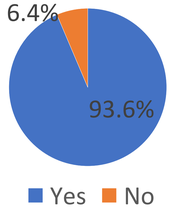
RESULTS/OUTCOMES

- Following these interventions patient feedback was overwhelmingly positive with patients reporting benefit.
- Data was insufficient to demonstrate reduced fall rate over period of time of study.

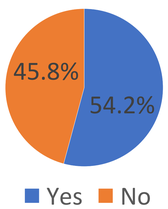
In the past 6 months have you fallen?



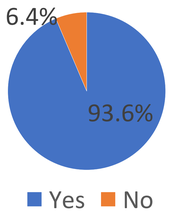
Did you find the educational session on preventing falls helpful?

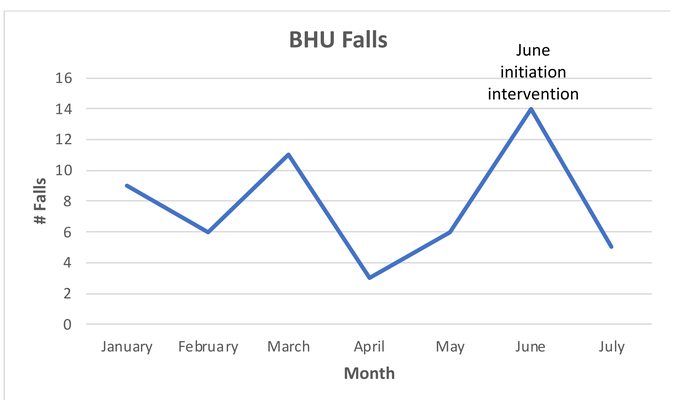


Do you worry about falling?



Do you feel like the exercises were helpful?





LESSONS LEARNED

- Our quality improvement project utilized a collaborative approach felt to be successful by patients and staff.
- Future research should include increased sample size, increased study length and standardized data recording in order to obtain data sufficient to demonstrate overall reduced fall rate.

NEXT STEPS

- Our collaborative approach to reduce falls could potentially be further expanded to other patient populations.

ACKNOWLEDGEMENTS

Thank you to Dr. Pastis and Dr. Kallis for their guidance and to the Behavioral Health Unit staff for all of their work on this quality improvement project.

Michael Morledge, MD, MPH
Department of Psychiatry and Behavioral Medicine
East Carolina University
Greenville, North Carolina 27834
210-355-0755
morledgem19@ecu.edu