

Implementing a Fall Prevention Protocol to Reduce Fall Rates Among Inpatients With Cancer

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BACKGROUND: Globally in healthcare delivery, inpatient falls and fall-related injuries contribute to unsafe patient care environments. On two inpatient oncology units, the frequency of patient falls had increased, despite the use of a fall screening tool.

OBJECTIVES: This project aimed to determine whether implementing the Agency for Healthcare Research and Quality (AHRQ) 3B Scheduled Rounding Protocol would reduce the average daily fall rate and number of fall-related injuries on two adult inpatient oncology units.

METHODS: This quantitative, quasi-experimental quality improvement project evaluated the implementation of the AHRQ protocol to reduce the average fall rate and number of fall-related injuries for adult patients with cancer.

FINDINGS: The average daily fall rate decreased following implementation of the AHRQ protocol, indicating clinical significance. This project's results suggest that implementing a standard fall prevention protocol can reduce the rate of patient falls.

KEYWORDS

fall prevention; patient falls; inpatient care; fall risk assessment; safety

DIGITAL OBJECT IDENTIFIER

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PATIENT FALLS DURING HOSPITALIZATION ARE A SERIOUS clinical issue that can lead to adverse outcomes, including an increased risk of morbidity and mortality from associated injuries. According to the World Health Organization (2021), a fall is an event in which a person negligently comes to rest on the ground or a lower surface or level. The National Database of Nursing Quality Indicators defines a fall as “an unplanned descent to the floor with or without injury to the patient” (Agency for Healthcare Research and Quality [AHRQ], 2013). About 30%–50% of patient falls result in major injuries such as fractures (Morris & O’Riordan, 2017). Patient falls are also a leading cause of accidental death for older adults during hospitalization (Glasper, 2019). AHRQ (2019) reported that annually as many as one million patients may experience a fall during hospitalization, and about one-third of these falls may lead to severe injuries. Although older adults are more prone to fatal falls, adult inpatients with cancer are also likely to experience fatal falls (Shah, 2020; Tsai et al., 2017).

In 2016 in the United States, falls among hospitalized patients aged 65 years or older accounted for about 30,000 deaths (Burns & Kakara, 2018). About one-third of falls that occur in hospitals result in injury, and the cost associated with fatal falls is estimated to be \$754 million annually (Centers for Disease Control and Prevention [CDC], 2023b). In healthcare facilities, serious injuries or deaths because of falls are treated as “never events,” which are events with serious consequences that are preventable if clinicians follow safety recommendations (AHRQ, 2019). The Centers for Medicare and Medicaid Services does not compensate or refund healthcare institutions for additional costs related to patient falls (AHRQ, 2019). In 2015 in the United States, more than \$50 billion was spent on medical costs related to patient falls (CDC, 2023a).

In the United States, the death rate from patient falls has risen, with an estimated 30% increase from 2007 to 2016 (Burns & Kakara, 2018). At this rate, by 2030, deaths from patient falls in the United States are expected to increase at a rate of seven falls per hour (National Council on Aging, 2023). When a patient falls, the chance of another fall occurring is doubled, putting patients at higher risk for future falls (CDC, 2023a).

As a strategy to reduce patient falls, fall assessment tools, such as the Morse Fall Scale, have been designed to detect and predict fall risk in hospitals so that clinicians can implement appropriate measures to prevent patient falls (Morse, 2009). However, based on studies to date focused on reducing patient falls, the use of fall risk assessment tools, such as the Morse Fall Scale, among clinicians has not been established (Strini et al., 2021). Clinicians