Fall Prevention Initiatives in Dementia Care

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ABSTRACT
As a tertiary level urban tertiary geriatric psychiatry program in a metropolitan area, patients who are admitted come from a variety of settings and present with a wide range of problems including frequent falls. The unit based quality improvement committee of our shared governance organization, is responsible for responding to quality improvement data by developing appropriate initiatives to improve nursing practice and patient care. Incidents of patient fall reached as high as 38 per month necessitating staff to take on fall prevention for quality improvement. A Fall Prevention/Restraint Task Force (FRPTF) was created to examine existing problems and practice patterns related to fall prevention and restraint use. The guiding principal for the task force was to train staff on evidence-based strategies to decrease fall incidents. Initiatives, including application of person-centered care, creation of intensive-bed monitoring rooms and restraint-free fall prevention strategies proved successful in decreasing fall incidents to less than 5 per month.

BACKGROUND
The Geriatric Psychiatry program, located in the Johnston R. Bowman Health Center at Rush University Medical Center, evaluates and treats older adults with acute mental illness and problematic adjustments in later life. Although a majority of the patients are 62 and older, younger patients with dementia and increased functional abilities are also admitted. As a tertiary referral center, many patients admitted to the unit not only have behavioral problems but also have complex medical co-morbidities that greatly increase their risk for falls. With incidents of patient falls reaching as high as 18 in a month, the unit-based quality improvement committee chose to aggressively address this issue. One of the major outcomes was the creation of a Fall/Restraint Prevention Task Force (FRPTF), comprised of the Unit Director, Clinical Nurse Coordinator (CNC) and staff nurses. Its responsibility was to examine existing problems related to falls, evaluate current practices and implement restraint-free fall prevention strategies.

PROCESS
Recognizing that falls are only symptoms of a problem, members of the FRPTF knew that reducing falls can be a daunting undertaking. It requires keen assessment, careful interventions and interdisciplinary participation to succeed. Falls are generally related to any one or a combination of these factors: patient characteristics (e.g. behaviors, history of falls, medical complications), environment, and treatment (e.g. medication use and procedures). The FRPTF wanted to determine what could be done to strengthen current effective practices and initiate innovative strategies for fall prevention.

PERSON-CENTERED CARE
Falls due to intrinsic factors, those which are related to the patient himself, are often driven by poor vision, gait disturbances, etc.) However, for patients with dementia, many of the problems that are commonly addressed such as pain and the need to urinate, are otherwise expressed behaviorally. Incongruous behavior problems, such as agitation can increase a patient’s risk for falls especially when combined with decreased cognitive ability and/or mobility. Therefore, understanding the language of behavior becomes an integral part in fall prevention among patients with dementia.

In addition to the standard of care used for fall prevention (see Exhibit 2) within the medical center, the FRPTF introduced these initiatives to modify the environment and provide a safer and more relaxing atmosphere.
• Discontinue use of light and background music was utilized to provide a soothing ambiance.
• The medication dispensing system was moved out of the central patient area.
• Wireless phones were provided to nursing staff to decrease stimulation in milieu.
• Low beds (see Exhibit 3) with bed alarms and soft floor mats on the sides were used.
• A bed exit remote monitoring area, free of furniture, was created for close observation of patients who have a higher risk of falls or being restrained physically due to behavior or medical reasons.
• Staffing pattern of day and evening shifts was redesigned to provide a full-time night shift nurse for these rooms.
• The FRPTF decided to transition use of low beds and intense monitoring rooms. See Exhibits 4 and 5.

TREATMENT FACTORS
Fall prevention requires an interdisciplinary approach tailored to individual risk factors. For better understanding of the relationship between medical and psychiatric issues, each patient is assigned a psychiatrist and an internist, both of whom are specialized in geriatric care. Consultants from other specialties are also available when needed. A thorough medication review and modification of medications ups and especially with psychotropics is done. Physical and occupational therapy for rehabilitation is provided when indicated. Nursing care plans were strengthened to clearly articulate interventions that are unique to each individual. If possible, formal and informal caregivers are included in interdisciplinary team meetings to discuss effective measures for continuity of care. These measures are further reinforced in discharge instructions.

In conclusion, we recognize that there is no single intervention that can effectively prevent a fall. Therefore, we recommend that because falls are multifactorial in nature, a strong fall prevention program should have an interdisciplinary approach and tailored to each individual need. It requires commitment and persistent hard work from all staff members to succeed. But seeing the results of our efforts, we felt empowered and satisfied knowing that we made a difference and possibly saved someone’s life. And so, our journey continues.