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Patients' perspectives of falling while in an acute care hospital and suggestions for prevention

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Abstract

Patient falls and falls with injury are the largest category of reportable incidents and a significant problem in hospitals. Patients are an important part of fall prevention; therefore, we asked patients who have fallen about reason for fall and how falls could be prevented. There were two categories for falls: the need to toilet coupled with loss of balance and unexpected weakness. Patients asked to be included in fall risk communication and asked to be part of the team to prevent them from falling. Nurses need to share a consistent and clear message that they are there for patient safety.

Patient falls and falls with injury are the largest category of reportable incidents and a significant problem in hospitals. Falls are devastating to patients, family members, providers, and the health care system, with 34% of falls leading to injury (Fischer et al., 2005). Recently, Center for Medicare Services (2008) and many state Medicaid agencies announced that there would be no further reimbursement to hospitals for costs associated with treating injuries incurred by patients who fall while hospitalized.

There are few studies on fall prevention programs in hospitals, and results have been inconclusive (Krauss et al., 2008; Schwendimann, Buhler, DeGeest, & Milisen, 2006). With known societal and now financial impact, there is an impetus to seek and test strategies for fall prevention. Although an important part of fall prevention, there is little known from the patients themselves about their fall experience and their suggestions to prevent falls while hospitalized. Therefore, the purposes of this study were to explore the patient's experience of a fall and to gather information on ways of preventing falls in acute care hospitals.

1. Background

Several studies have been done to explore perceptions of falls and fall prevention in independent older adults. When surveyed, older adults suggested that their balance, inattention, and medical conditions were the most frequent personal reasons for falls, although weather and surface hazards were also mentioned (Zecevic, Salmon, Speechley, & Vandervoort, 2006). Yardley, Donovan-Hall, Francis, and Todd (2006) asked older

independent adults their views regarding advice about fall prevention. These adults denied any communication about fall prevention, although some admitted to receiving information about home modifications. The researchers suggested that advice should focus on the positive benefits of engaging in fall prevention. Older adults qualified fall prevention advice as common sense and that advice was for others, not them. Other fall prevention researchers found that older women were not willing to face their risk of falling and often rejected fall prevention advice because they saw it as a threat to their autonomy and identity (McInnes & Askie, 2004).

Kong, Lee, Mackenzie, and Lee (2002) explored the psychosocial consequences of falls from the perspective of older Chinese adults who had experienced a recent fall at home or while in a hospital. The researchers found that falls were perceived to be unpredictable and therefore not preventable by these adults, although only three participants were in the hospital when they fell. We could locate no studies specifically conducted in an acute care hospital of patients who had fallen.

2. Methods

Because patients' perspectives regarding the inpatient fall experience offer unique views and directions for fall prevention, these experiences were explored in a qualitative descriptive study. Both institutional review board's approval and hospital compliance office agreement were obtained to interview patients who had fallen within 48 hours of their fall while an inpatient in an acute care hospital.

2.1. Procedure

The potential participants were referred to the investigators by the nurse who had firsthand knowledge of the patient and the fall. The nurse confirmed that the patient would be willing to speak to the investigators about their fall. The investigators provided a brochure that described the study, the risks and benefits, and maintenance of confidentiality and then obtained informed consent. Interviews were conducted at the patient's bedside using a semistructured interview guide developed by the investigators. Participants were asked to describe their experience of falling, speak of their injury, share whether or not they were informed about being at risk of falls, and their thoughts on methods of fall prevention during hospitalization. The tape-recorded interviews lasted between 15 and 45 minutes.

2.2. Sample

The sample consisted of nine participants referred to the investigators by nurses. To be eligible, the potential participant had to have fallen within 48 hours, was cognitively intact, and capable of sharing and communicating the experience of their fall in English.

The sample consisted of two men and seven women ranging in age from 24 to 78 years, with a mean of 61.2 years. There were family members present at three interviews. The average length of stay preceding the day of fall was 14 days, with a range of 1 to 47 days. Reasons for hospitalization were pneumonia, amputation, lymphoma, and a variety of neurological disorders. There were six participants who had fallen in the past.

2.3. Data analysis

The interviews were transcribed verbatim, reviewed and corrected for transcription accuracy and removal or masking of any names, and converted into NVivo (QSR International Pty Ltd, Bundoora, Australia) for coding and support of analysis. We used a two-person consensus for the analysis. We open coded text to capture meanings in the data, compared codes with each other, and performed selective coding to identify core categories. We then

used a process of debriefing among researchers and engagement with the raw data and codes and employed field and reflective notes to assure reliability and validity (Miles & Huberman, 1994).

3. Results

Two categories were identified that explained why participants in this study fell: the need to toilet coupled with loss of balance and unexpected weakness. No participant suffered an injury requiring treatment or a longer length of hospital stay. Participants identified strategies that they believed would enhance fall prevention during an acute care hospitalization.

3.1. Reasons for falling

The loss of balance in the context of an urgent need to reach the bathroom was identified as the most common reason for falling. Participants described their pressing need to use the bathroom that clouded their memory of their physical limitations and prevented them from taking the time to attain physical balance. One participant described his known low blood pressure early in the morning. At home, he usually would sit on the side of his bed before standing, but while in the hospital, his urge for the bathroom and the use of a sleeping medication 6 hours earlier fogged his memory:

I think I just had to go, so I stood up. I got very dizzy... and then my whole body went numb....I just reached for the floor and landed on my hip.

After being transferred from another facility for management of a stroke, a participant needed to get to the bathroom. Focused on the bathroom need and not on the reason for being hospitalized, he stood up and described falling as, "I crumbled like a piece of paper."

Other participants described being involved in an activity that they had never had a problem performing previously. A participant, on her sixth or seventh lap of an ambulation schedule which she had performed daily, fell on her 47th day of hospitalization.

In fact, I just lost my footing. I cannot describe it any other way...it could have been...the soles of my shoes...it could have been that I just brushed by something or it could have been the neuropathy....

Additional reasons given for their falls included not getting enough physical therapy and not having necessary items within reach (in this case, the brace she needed was not in reach when she needed to get to the bathroom). Another participant stated that he rang for help a number of times, but when no one came, he attempted to get to the bathroom on his own.

3.2. Patient activities to reduce falls

When asked what they could do to prevent themselves from falling, participants identified the need to be involved in their own activity assessment by asking themselves, "Before I get up, I need to think." Taking the time to stop and think allowed participants to be more thoughtful about their abilities. Pausing reduced a hurrying manner, carelessness, and denial about the risk of falling. Some participants stated that they did not think that they would be as weak as they were, whereas others "forgot" about their deficits because of illness and surgery.

I was trying to get the photo album to show pictures, and for some reason, when I got to the edge of the bed, I thought I still had my leg. So, I went to put pressure on my leg, and there was nothing. I am not used to it being amputated.

Participants did note the request from their nurses to call them before they get out of the bed and the chair or go to the bathroom. "I am supposed to call for help...but I don't want to bother them [the nurses]." One participant was provided her call light but on the side where she had weakness, so she was unable to put her call light on when she needed assistance. Another participant stated,

Luckily, I was close enough to the bed to reach my call light...it [call light] didn't slip away as it usually does in the night, it slips down, you know, and then I can't reach it.

Most participants expressed the emotional obstacle of not calling for assistance because they did not want to be a bother to the nurse. The physical obstacle of actually having a device to call for assistance and being able to wait for a person responding to their need for assistance were also deterrents to their fall prevention.

Most participants mentioned that they were not aware of their risk of falling, and those who were told of their risk received inconsistent messages regarding their risk from different nurses. Participants wanted to be informed and told of why they were at risk and what specific activities the nurse wanted them to do to reduce their risk and the role of the health care team in their fall prevention.

Participants recognized that having an appropriate assistive device and safe footwear is important for fall prevention. A number of participants had been admitted urgently and did not have their walkers with them. This required the health care provider to request one for use during hospitalization.

I use a walker at home...to get to the bathroom. The nurses want me to use the commode, but I prefer going to the bathroom because it is giving me extra exercise.

Three participants used hospital slippers because of the gripper material on the bottom, whereas another who had been hospitalized for a significant length of time sought expert option on appropriate footwear from a physical therapist. Clear paths to the bathroom and better lighting were mentioned as changes to the hospital environment to improve fall prevention.

3.3. Nursing activities to reduce falls

A clear message from participants in this study is their need to feel that asking for assistance with getting up out of bed, walking, and going to the bathroom or into a chair is not bothering the nurse. Four participants mentioned that they were told to call for help. Nurses should emphasize that calling for help is not bothering them. It is not a question of whether or not patients can get out of bed by themselves; it is the nurses' work to keep patients safe. Patients need to know that not only does the nurse not mind coming to help them, even if they are busy, but also that the nurse wants to come and help. Helping patients is a priority for the nurse whether or not they appear to be busy. No patient should ever feel the same as one participant said, "I feel like I called the nurse enough. You know I don't want to be a bother."

3.4. Implications for nursing practice

The major reasons for falling from the patients' perspective are the need to toilet coupled with loss of balance and unexpected weakness; both reasons appear amenable to nursing interventions to prevent falls, although patients believed that some of these falls were not preventable. Because patients expressed reluctance to call for help from the nurse because they thought the nurses appeared too busy, the message has to be given to, heard by, and acted upon by patients and their families. All nurses need to share and deliver a clear and

consistent message that they are there for patients and to provide a safe environment, including providing prompt responses to meet patient needs.

A comprehensive assessment of the patient's history of falls (six of nine participants in this study had previously fallen) should be the first step on the continuum of communication of fall risk (Morse, 1997). Other areas to assess are comorbidities, gait, mental status, and need for (as well as availability of) ambulatory aids. A plan of care can be generated from this assessment that is tailored to specific nursing interventions to overcome explicit fall risks. The plan then needs to be communicated to nursing assistants and all members of the multidisciplinary health care team, and a clear message from the patients is to include the patient and their family in this communication. A successful communication of this plan at the point of care is a pivotal part of a nurse-led fall prevention program.

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