Focus Groups to Identify Gaps in Fall Prevention Strategies

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Background

• Increased patient falls in early 2015 at a community hospital in southern California (U.S.A.)
• Team established
  • Patient safety manager
  • Nurse manager
  • Clinical educators (2)
  • University professor
  • Graduate students (2)
• Assessment of current hospital policies showed evidence-based practices

Purpose

To explore Registered Nurse (RN) and nursing assistant (NA) reflections on falls and fall prevention for hospitalized medical/surgical and critical care patients

To develop an action plan for improving fall prevention strategies

Methods

• 3 focus groups fall 2015
  • 2 for RNs
  • 1 for nursing assistants
• Recruitment: e-mails, flyers, invitations by nurse managers/educators
• Groups moderated by professor, facilitated by hospital clinical educator, graduate students
• Semi-structured interview guide
  • Fall experiences
  • Patients at risk of falling/injuries
  • Current fall prevention efforts
  • Areas of future improvement
• Notes evaluated during team meetings; action plan developed

Findings

• Most participants had experienced recent patient falls, could identify specific high fall/injury-risk patients… e.g.,
  • Altered mental status, older age
  • Taking specific medications
  • Post-operative status
  • Palliative care/chronic pain issues
  • Sequential compression devices on ambulatory patients

• Strategies to prevent falls/injuries
  • Shift report
  • Visual cues (armbands, wall signs, whiteboards)
  • Hourly rounds (among nurses only)
  • Bed alarms/foot mats
  • Lift team assistance

• Opportunities for improvement
  • Need for better communication
  • Greater staff time-in-rooms
  • Enhanced signage
  • Working smart to anticipate patient needs
  • Need to understand role of sitters/families
  • Knowledge deficits: alarms and specific policies

Evaluation

• Action plan to enhance fall prevention
  • Report findings to nurse leadership team
  • Clinical educators and nurse management to enhance awareness and reinforce existing policies
  • Present communication issues to Clinical Practice Council

• Staff reflections informed team of local gaps in fall prevention

• Highlighted difficulties in preventing falls in acute care given large numbers of at-risk patients

• Focus groups with frontline nursing staff are a great way of gathering pertinent information and realistic ideas for hospital fall prevention efforts

Participants

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>RNs (n = 9)</th>
<th>NAs (n = 11)*</th>
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</thead>
<tbody>
<tr>
<td>Gender (female)</td>
<td>8 (89%)</td>
<td>9 (81%)</td>
</tr>
<tr>
<td>Days (primary shift)</td>
<td>5 (56)</td>
<td>7 (64)</td>
</tr>
<tr>
<td>Employed full-time</td>
<td>8 (89)</td>
<td>9 (82)</td>
</tr>
<tr>
<td>Age (M, 40.0±27.4)</td>
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<tr>
<td>Years at hospital (M, 28.1±10.2)</td>
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<tr>
<td>Experienced at least one patient fall</td>
<td>9 (100)</td>
<td>7 (64)</td>
</tr>
<tr>
<td>Nursing education (1st degree)</td>
<td>ADN 4 (44)</td>
<td>ADN 1 (9)</td>
</tr>
<tr>
<td>Nursing education (highest)</td>
<td>ADN 8 (88)</td>
<td>RDN 2 (18)</td>
</tr>
<tr>
<td>Education (highest degree)</td>
<td>MS 3 (33)</td>
<td>MS 2 (18)</td>
</tr>
<tr>
<td>Certified as nursing assistant</td>
<td>0 (0)</td>
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</tbody>
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*One NA did not complete the demographic survey; there were 11 NAs in the focus group.