BACKGROUND AND OBJECTIVES

• 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 and gait, balance, and visual/hearing deficits 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.

RESULTS/OUTCOMES

• Following these interventions patient feedback was overwhelmingly positive with patient impressions that they benefited.

• Data was insufficient to demonstrate reduced fall rate over period of time of study.

CONCLUSIONS

• Our quality improvement project utilized a collaborative approach felt to be successful by patients and staff.

• Future research should include longer time period with larger sample size and standardized data recording in order to obtain data sufficient to demonstrate reduced fall rate.

• An improved intervention could also include increased frequency of structured exercise sessions, possibly even daily.

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

REFERENCES


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