ABSTRACT

According to Morse (1997, p.2), “falls are the second leading cause of death in the United States; 75% occur in the elderly population.” Hendrich (2006) states that more than half of all falls occur when patients try to get to the toilet while exiting the bed, and a regular toileting schedule for patients identified as high risk due to impaired mobility or drug side effects will reduce falls in most acute care hospitals. This evaluation was conducted for the purpose of determining if the intervention, a “no toileting alone” protocol, reduced falls with patients identified as high risk (greater than 5 on the Morse Fall Scale (MFS)) for the study units following the implementation of the “no toileting alone” protocol. The questions that guided the evaluation were:

1. Does use of a “no toileting alone” protocol decrease the total number of falls and fall rates of patients identified as high risk on the MFS?
2. Is the severity and injury of a fall pre-protocol greater than post-protocol?

METHODS

A retrospective analysis will be conducted, using a cross-sectional review design. The research was conducted in a 437 bed not-for-profit Midwest healthcare setting. The two protocol units where the “no toileting alone” protocol was introduced included a 26 bed medical unit and a 34 bed surgical unit. Data will be analyzed using archival fall incident reports for patients identified as high fall risk (> 51 MFS) from Feb 2012 thru Jan 2013 for the pre-protocol data and Feb 2013 thru Jan 2014 for the post protocol data of de-identified patients who fell. The rate of falls per 1000 patient days was calculated at the unit level for both pre-protocol (n=9) and post-protocol units (n=2) for the evaluation period starting Feb 2012 through Feb 2014. The “no toileting alone” protocol was introduced in Feb 2013. The inpatient sample size included 78 inpatients that fell from Feb 2012 to Feb 2014. Descriptive statistics collected included age, gender, Morse Fall Score, Total Length of stay (LOS) and LOS post fall.

The “no toileting alone” protocol consisted of completing a fall partnership agreement with the patient and family, referencing signs placed above the patient’s bed on the ceiling reminding them to call for assistance before getting out of bed, utilizing bed alarms and chair alarms to alert staff when patients were attempting to get out of bed alone and put high fall risk patients on an every 2 hour toileting schedule. The most important part of the protocol was that staff were to remain within an arms length of the patient or have the patient in visual sight. Staff were extensively educated on all of these interventions related to the “no toileting alone” protocol.

RESULTS

The analyses of the data were divided into pre and post protocol groups.

1. Does a “no toileting alone” protocol decrease the total number of falls and fall rates of patients identified as high risk on the MFS?

Data from eleven units were used to calculate the pre protocol fall rates. A pre protocol fall rate (n = 11) showed a mean value of 3.6211 (Figure 1). Parametric (T-tests) and non-parametric (Wilcoxon rank sum) statistical tests were conducted on the sample units (n = 2) where the “no toileting alone” protocol was applied. In addition, analysis of pre and post fall rates of the two units was carried out. The post protocol rate (n = 2) showed a mean of 1.970 (Figure 2). There was a lack of variability due to the small sample. The Wilcoxon rank sum test demonstrated a one tailed (indicating an expectation the post protocol rates will fall) (p = 0.0783). Although greater than the significance .05 level it was close. Results of this inquiry demonstrate that although not statistically significant at the .05 level the total numbers of falls and fall rates did decrease.

OBJECTIVES

By the end of this presentation the participant will be able to:

- Define the significant factors related to falls in high risk patients.
- Identify how a “no toileting alone” protocol decreases falls and falls with injury.
- List the components of the “no toileting alone” protocol.

REFERENCES


Table 1 Descriptive Statistics