Utilizing a Psychiatric Based Fall Scale on an Inpatient Behavioral Health Unit to Reduce Falls

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Background and Significance: Falls occur more frequently on psychiatric units than on medical surgical units (Lee, Mills & Watts, 2013) This is due to: side effects of psychotropic medications (specifically newly prescribed medications), altered state of consciousness due to psychosis, hallucinations &/or delusions and fall scales that do not adequately assess the risk of falls in this population. The John Hopkins fall risk assessment tool (JHFRAT) used on the inpatient behavioral health unit (BHU) was created for medical surgical units and is not adequate in assessing risk for falls in this population.

Clinical Question: Will use of the Wilson Sims fall risk assessment tool (a psychiatric based fall risk assessment) better identify people at risk for falls on the BHU? Will this in turn reduce falls on the BHU?

Evidence: A literature review was conducted to decide on a new fall risk assessment tool for the BHU. The Wilson-Sims Fall risk assessment tool (WSFRAT) was determined to be the best fit as it originates on a behavioral health unit, considers the effects of medication and detox, and allows for RN clinical judgement regarding fall risk of the patient.

Once the WSFRAT was decided on, 100 adult psychiatric patients were assessed for risk for falls using both the JHFRAT and the WSFRAT. Of the 100 patients assessed, 18 were found to be considered high risk for falls on the WSFRAT but only low or moderate risk on the JHFRAT. All patients who scored high fall risk on the JHFRAT were considered a high fall risk on the WSFRAT. This data shows that 18% or a portion of the psychiatric population is being missed when assessed for fall risk using the JHFRAT.

Intervention Implementation: The clinical informatics team built the WSFRAT in the EMR (Electronic Medical Record). All RNs on the BHU were provided one on one education on how to use the WSFRAT by a nurse educator. An email was also sent out with instructions on how to utilize WSFRAT.

Evaluation: Fall data was collected from 4 quarters prior to implementation and one quarter post implementation. It is our intention to collect 4 quarters of data post implementation to determine if this change was effective in reducing falls on the BHU.

Results: The average number of falls per 1000 patient hours last year (prior to implementation of WSFRAT) was 3.85. The average number of falls per 1000 patient hours last quarter (post implementation) was 2.88.

Significance/Conclusion: The decrease in number of falls per 1000 patient hours post implementation shows that the WSFRAT was effective in decreasing the number of falls on the inpatient BHU.