Paper title

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Information regarding the level of risk a patient has for falling can be conveyed in many ways such as in a report from one nurse to another, as part of the assessment, a diagnosis, in the daily safety briefing, and as recorded in the electronic health record (EHR). Incorporating technology into the workflow can help prevent falls and improve patient safety. "Workflow is the sequence of physical and mental tasks performed by various people within and between work environments" (U.S. Department of Health & Human Services, n.d.). Falls are dangerous, bringing further complications and injury to patients. This paper describes the present way information is conveyed from admission onward regarding a patient's risk for fall and explores areas where improvement can occur.

Explanation of Flowchart

A patient came to the emergency room and admitted to the hospital. Depending on diagnosis and emergency healthcare staff involved with the patient a determination is made regarding the patient's risk for falling. If the patient's diagnosis is fall, change in mental status, or ambulatory dysfunction the patient is automatically classified being at high risk for falling. In this case patient interventions to prevent falls should be initiated in the emergency room by the nurse caring for the patient. When admitting this patient, it is evident the patient is at high risk for falling.

The patient with a different diagnosis is not considered a falls risk until information is gained to status otherwise. When admitting this patient to the floor, the nurse has no knowledge of the degree of risk for falling, unless the ER nurse has completed a falls risk assessment of the patient. Emergency nurses have access to the falls risk assessment but rarely complete this assessment if it is not related to the patient's admitting diagnosis. "There is evidence in the falls

prevention research literature which suggests that in excess of 50% of potential falls relating to older adults are avoided as a result of ongoing falls prevention interventions" (Hamm, Money, Atwal & Paraskevopoulos, 2016, p.319).

When a patient arrives on the floor, the present instructions for the admitting nurse are to review the patient's medications, complete a database, and assessment, all done within the within the patient's EHR. While reviewing medications and completing the database, determining the patient's orientation is quickly assessed. If a patient is not entirely oriented, they are then determined to be at risk for falls. At this time the nurse initiates the falls risk protocol or delegates this task to the clinical assistant. The protocol includes yellow socks and blanket, alarms for the bed and chair, as well as placing a falls risk sign outside the room. The nurse also must choose a care plan for the patient called "risk/actual for fall" in the electronic health record. If the patient is fully oriented they are not considered at risk for falling at this time, unless previously determined.

As the process of admission continues the nurse completes the full assessment. The nurse then charts on the patient in the electronic health record using a modified Morse Falls Risk assessment tool to determine if the patient is at risk for falling. The needed information to complete the falls risk is a history of falls, secondary diagnosis, ambulatory aid, IV or attached equipment, and orientation. A score generates from the assessment questions. With a score more than or equal to 45, the falls risk protocol is put into place if less than 45 the patient is not at risk for falling. At this time if the patient scores 45 or higher the care plan "risk/actual for fall" is automatically entered into the care plan segment of the electronic health record.

Once the patient is on the floor, the policy states the falls risk assessment tool should be completed once daily until discharge occurs, if there is a change in mental status, or the patient

falls. Conveying of the patient's the risk of falling is done at bedside report to the oncoming nurse. Education to the patient regarding the risk of falling is completed by the day shift nurse when reviewing the daily care plan. Charting in the electronic health record documents the assessment, teaching, and outcomes of the falls risk/prevention.

The Metric

Metrix used to calculate the falls is measured by how many falls occur within a 1000 patient hospitalization day, if the falls prevention protocol was in place at the time of the fall, and outcomes of the fall. Falls are reported through an event reporting system and reviewed by management and the Falls Council.

The Falls Council includes floor nurses, managers, clinical nurse leaders, and nursing assistants. They track, initiate, and adapt the fall protocol taking into consideration evidence-based practices and the measured outcomes from our falls prevention protocol. "Although many tools to accomplish workflow redesign are available, the best method is the one that compliments the organization and supports the work of clinicians" (McGonigle & Mastrian, 2015, p.241). Having nurses and nursing assistants as part of the Falls Council ensures clinicians have a say in the workflow. Improvements can be made in the workflow of falls prevention.

Areas of Improvement

There are many areas which need improvement when conveying information regarding the falls risk of patients. Once a patient is assessed as a falls risk there should be a notification which shows a red "Falls" sign in the electronic record. "Often, however, this underlying design conflicts with the needs of clinicians, who must see a wide range of information in formats that allow quick review" (Koppel & Kreda, 2010, p. 9). Completion of the falls risk assessment should take place when the patient is in the emergency room and the protocol should then be put

into place once the patient is determined to be at risk for falling. There have been incidences where a patient is brought up from the emergency room by transport and placed in their room without notification to the nurse receiving the patient. Enacting the protocol in the ER, the patient would have yellow socks and blanket indicating to the transport staff the patient is at risk for falling. Having a red "Falls" flag advising all the staff from the floor secretary to the clinical assistants, the patient is at risk for falling. ER nurses have access to the falls risk assessment tool in their electronic assessment, and it should be utilized to help prevent falls.

Another area of improvement utilizing technology will be placing a falls diagnosis on the patients' electronic health record if the patient has fallen recently. It would then be part of the electronic record and help by giving the floor nurse a heads up that the patient has had a previous fall. Emanuele (as cited in Huser, Rasmussen, Oberg, & Starren, 2011) suggested:

> *Work-flow-enabled EHR system*, which can communicate bi-directionally with a Workflow Management System…send EHR event notifications to the work-flow engine and display in the EHR system tasks and alerts generated by the workflow engine. (p.19)

Also, since completion of the electronic patient database is before the patient assessment, it would be wise to consider the falls risk assessment be part of the database and if positive for risk of falls it could generate a falls risk care plan and intervention in the nurse's patient assessment.

Finally, I suggest the patient falls risk score as a requirement each shift rather than daily. Many patients who are not at risk for falls during the day shift, become falls risks at night. This risk is missed by only requiring the fall assessment daily.

Conclusion

Using the workflow of conveying falls risk information has encouraged thinking and planning with the use of technology beyond the current protocol to prevent falls and increase the

safety of patients. There are many new technologies used to enhance nursing care and workflow. Technology can help convey and alert healthcare workers of relevant information regarding patients. According to Choi, Lawler, Boenecke, Ponatoski, & Zimring (2011), Fall-prevention models can assist hospital staff with the development of a balanced fall prevention plan including technology to prevent falls and fall-related injuries" (p.2522). It is important to be aware of and step back to evaluate the process making sure the technology is effectively being used to improve patient care and outcomes. Technology can alert nurses that a patient is at risk for falling by having a positive falls risk score, and it can convey this finding by placing a record of the score on the patient's electronic health record.

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Conveying Fall Risk Information

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                              ┌──────────────────────┐
                              │   Pt in ER Admitted  │
                              └──────────────────────┘
                ┌──────────────────────────┴──────────────────────────┐
                ▼                                                       ▼
     ┌────────────────────┐                                  ┌────────────────────┐
     │ Pt. dx             │                                  │  Other dx          │
     │ falls/CMS/         │                                  │                    │
     │ ambulatory         │                                  │                    │
     │ dysfunction        │                                  └────────────────────┘
     └────────────────────┘                                           │
                │                                                      ▼
                │                                         ┌────────────────────┐
                │                                         │ Floor RN           │
                │                                         │ calls ER           │
                │                                         │ RN for             │
                │                                         │ report             │
                │                                         └────────────────────┘
                ▼                                                  │
          ┌──────────┐        ┌───────────────────────┐           │
          │ +Falls   │◄───────│ Pt. not fully oriented │◄──────────┤
          │ Risk     │◄───────└───────────────────────┘           │
          └──────────┘                        ┌───────────────────────┐
                │                              │  Pt. fully oriented   │
                │                              └───────────────────────┘
                │                                          │
                │                                          ▼
                │                                      ╲ - Falls ╱
                │                                       ╲  Risk ╱
                │                                        ╲     ╱
                │                                         ╲   ╱
                │                                          ▼
                │                         ┌──────────────────────────────┐
                │                         │ RN completes admission        │
                │                         │ (med review, data base, and   │
                │                         │ assessment)                   │
                │                         └──────────────────────────────┘
                │                            │                    │
                ▼                            ▼                    ▼
     ┌────────────────────┐           ┌──────────┐          ╲ - Falls ╱
     │ CA/RN              │◄──────────│ +        │           ╲  Risk ╱
     │ Apply falls        │           │ Fall     │            ╲     ╱
     │ risk               │           │ Risk     │             ╲   ╱
     │ interventions      │           └──────────┘              ▼
     └────────────────────┘                │                    │
                │                           │                    │
                └───────────────┬──────────┴────────────────────┘
                                ▼
            ┌──────────────────────────────────────────┐
            │       Assess Daily for Risk of Fall       │
            └──────────────────────────────────────────┘
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