Perspectives of Inpatients With Cancer on Engagement in Fall Prevention

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PURPOSE: To explore perspectives of hospitalized adults with cancer regarding engagement in fall prevention plans. The primary aim was to discover new knowledge about patients' perspectives and improve the design of fall prevention strategies. A secondary aim was to compare fall-related perspectives of patients who had and who had not fallen.

PARTICIPANTS & SETTING: 30 inpatients with cancer at a teaching hospital in a statewide academic health system in the midwestern United States.

METHODOLOGIC APPROACH: A descriptive exploratory approach framed qualitative data collection through interviews with inpatients. Data were analyzed thematically.

FINDINGS: Themes reflected six perspectives related to engagement in fall prevention. A need to go to the bathroom triggered a two-step process in which participants decided whether to ask staff for assistance to mobilize and to wait for assistance to arrive. If necessary, participants would disengage from fall prevention plans and move to the bathroom without assistance to avoid incontinence, preserve privacy, and maintain independence in toileting. Factors influencing decisions were assessments of mobilization capacity and views of nurses' behaviors.

IMPLICATIONS FOR NURSING: Nurses can foster patient engagement in fall prevention by developing trusting, authentic relationships with at-risk patients, involving patients in assessing their own fall risk, and tailoring toileting plans to ensure continence.

KEYWORDS fall prevention; inpatient; cancer; hospitalization; qualitative

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Falls are a leading cause of injury during hospitalization worldwide, resulting in increased healthcare costs, morbidity, and mortality (World Health Organization, 2018; Zhang et al., 2017). Despite a plethora of evidence-based interventions for fall prevention, inpatients continue to fall and suffer harm at costs projected to reach $55 billion in 2020 in the United States (Centers for Disease Control and Prevention, n.d.; Joint Commission, 2015; Wildes et al., 2015). About 700,000 inpatient falls occur annually, with as many as 50% of these resulting in injuries (Kiyoshi-Teo et al., 2019; Zhang et al., 2017).

Inpatients with cancer are at high risk for falls, with about 25% falling during hospitalization (Knox, 2018; Wildes et al., 2016; Zhang et al., 2017). Fall-related factors for inpatients with cancer include neurologic and motor deficits, weakness and fatigue, rapid fluctuations in medical conditions, and equipment that hinders mobilization (Knox, 2018; Kuhlenschmidt et al., 2016; Wildes et al., 2015). More than 15 million people are living with cancer in the United States, with the number projected to rise to more than 20 million by 2026 (National Cancer Institute, 2018). The Oncology Nursing Society has prioritized research that addresses symptom burden and quality of life among patients with cancer (Von Ah et al., 2019). More research that supports quality of life and harm reduction in this growing population is needed to guide nursing care (Guerard et al., 2015; Joint Commission Center for Transforming Healthcare, n.d.).

A primary cause of falls among alert adult inpatients is nonengagement in fall prevention plans (Hill et al., 2016; Vonnes & Wolf, 2017). One factor widely identified in quantitative and qualitative studies as a barrier to engagement in fall prevention plans is inpatients' tendency to minimize their risk of falling

(Gettens et al., 2018; Kuhlenschmidt et al., 2016; Lim, Seow, et al., 2018; Twibell et al., 2015). Beyond exploring patients' perceived fall risk, little research has examined inpatients' perspectives related to engagement in fall prevention plans.

Qualitative research can advance the science of fall prevention by providing nurses with a better understanding of inpatients' experiences with fall prevention plans (Knox, 2018; Zhao & Kim, 2015). New knowledge about inpatients' perspectives can strengthen strategies for engagement in fall precautions and enhance patient safety (Joint Commission, 2016; Zecevic et al., 2017). Therefore, the purpose of this study was to explore perspectives about engagement in fall prevention plans among inpatients with cancer. A secondary aim was to compare fall-related perspectives between patients who had and who had not fallen during their current hospitalization.

Methods

Participants and Setting

The study was conducted at Indiana University Health Ball Memorial Hospital, a teaching hospital in a statewide academic health system, in Muncie. At the time of the study, in 2017–2018, more than 6,000 patients with a diagnosis of cancer received inpatient care at the target hospital each year, with cancer-related outpatient visits numbering more than 30,000. In addition, when the study began, fall rates for inpatients with cancer were above national benchmarks.

The population for this study was cognitively alert adults diagnosed with cancer who were at risk for falls. Inclusion criteria for the purposive sample were as follows:

- Inpatient on a non–critical care unit in the target hospital
- Diagnosis of cancer for the present hospital admission
- Ability to speak, read, and understand English
- Not pregnant
- Ability to hear adequately to participate in conversation
- Assessed by RN assigned to the patient's care as medically stable and able to be interviewed
- Assessed as at risk for falls by the primary nurse and the researcher using the hospitalwide fall risk assessment tool, the Johns Hopkins Fall Risk Assessment Tool (Poe et al., 2007)
- Cognitively alert and oriented as assessed by the primary nurse
- Not receiving hospice or end-of-life care

Exclusion criteria included the following:

- Medical diagnosis of dementia, delirium, or confusion
- Medical instability
- Enrollment in another research study or trial

The sampling plan stratified participants into two groups: (a) those who had fallen or had had a near-fall between the time of hospital admission and study enrollment and (b) those who had not fallen between the time of hospital admission and study enrollment. A fall was defined as an event in which a person came to rest inadvertently on the ground, floor, or other lower level (Williams et al., 2015). A near-fall was described as an event in which a patient was positioned to imminently begin a descent to a lower surface, had staff not intervened. The sampling plan called for participant recruitment until data were saturated, with an anticipated sample size of 12–15 inpatients in each of the two groups.

Methodologic Approach

The current study took a qualitative descriptive exploratory approach (Sutherland, 2017). No theoretical framework was defined for the study to not bias the research team's conceptions of the data (Polit & Beck, 2018). The study was approved by the institutional review board of the target hospital, which was affiliated with the university where two members of the research team worked (K.R.T. and D.S.).

Data were collected from 2015 to 2016 using a semistructured interview guide (see Figure 1). Interview questions first validated whether or not participants had been told they were at risk for falls and instructed about the fall prevention plan. The remaining interview questions sought to understand participants' thoughts, feelings, and intentions regarding the fall prevention plan, in an effort to explore their engagement with or willingness to engage in precautions recommended by the staff. The questions were drawn from a review of the literature, the research team's clinical experience, and items on quantitative instrumentation tested by this research team in earlier studies (Incollingo, 2016; Spradlin et al., 2016; Twibell et al., 2015). The questions were reviewed and revised by clinical experts in fall prevention and by academicians with experience in qualitative research. The interview questions were pilot tested with eight inpatients who were at risk for falls. The inpatients answered each question readily and verified that the questions were clear and fairly easy to answer.

One researcher (K.R.T.) conducted 85% of the interviews. Another member of the research team (A.M.S.) completed the additional interviews. The researchers were unknown to the participants and uninvolved in their care. The researcher shared study information with patients who met the sampling criteria and, if they were interested, conducted the informed consent process. Overall, 38 patients were approached about the study and 30 participated, for a participation rate of 79%. Patients who declined to participate in the current study cited fatigue as the primary reason; discomfort was also cited as a reason not to participate.

Interviews occurred at the patient's bedside when no others were present in the room. The interviewer developed a rapport with participants to put them at ease, as recommended by Turner (2010). Interviews ranged in length from 7 to 20 minutes. Interviews were audio recorded and transcribed by the interviewer. Demographic and clinical data were gathered from the electronic health record.

When data saturation was reached, three members of the research team (K.R.T., D.S., and P.A.) completed individual analyses of the data. Saturation of data occurs when no new ideas or themes are emerging from the data and the data are of sufficient quality and quantity (Fusch & Ness, 2015; Lowe et al., 2018). Because participants in the current study responded to the same interview questions and one researcher conducted most of the interviews, the researcher was able to track the emergence of new ideas. By the time enrollment reached 15 in each sample group, the interviews did not seem to be generating any new ideas. The other two researchers on the analysis team verified that no new thematic content had emerged from the previous four interviews and that the data set contained sufficiently rich and thick information to address the aims of the study. Enrollment in the study then concluded.

Before beginning the analysis process, the three researchers on the analysis team declared personal biases about the sample or fall prevention during hospitalization. Biases could threaten the objectivity of the data analysis (Cypress, 2017). Biases acknowledged by the analysis team included the following:

- Inpatients who have a diagnosis of cancer will be afraid of falling and will follow fall precautions.
- Participants may not be honest about their fall-related perceptions.
- Participants will be concerned about mobilizing to the bathroom during hospitalization.
- Participants may be too sick to articulate details in the research interview.

The analysis team invited other members of the research team to inspect the thematic schema and review the audit trail of decisions in light of these biases to ensure that decisions about themes were not slanted toward the researchers' expectations of what participants might say in the interview (Noble & Smith, 2015).

The three researchers analyzed separately the data from the participants who had fallen and the data from the participants who had not fallen. Following the Braun and Clarke (2006) methodology for thematic analysis, researchers first read all interview transcripts in one setting, read them more slowly a second time to mark key ideas, and read them a third time to generate codes for each unit of meaning in the transcripts. Similar codes clustered together in categories and were labeled as themes or subthemes. Lastly, researchers read the data a fourth time to determine if the themes explained all the data. The three researchers then convened to share individual analyses of data. Sharing of categories, themes, and

FIGURE 1. Interview Guide to Elicit Inpatient Perspectives on Fall Prevention

- Has your nurse or physician told you that you might fall while here in the hospital? If so, what are your thoughts about their words?
- Has your health team given you instructions on how to prevent falls while you are here?
- What do you think or feel about the instructions the staff have given you to keep you safe from falling?
- To what extent do you intend to follow the fall prevention plan the nurses have described for you?
- What thoughts or feelings would keep you from following the fall prevention plan?
- What thoughts or feelings would prompt you to follow the fall prevention plan?
- When a nurse has asked you not to get up alone but you want to get up alone, how do you decide what to do?
- To what extent are you afraid of falling while here in the hospital?
- How confident are you that you can move around on your own while here in the hospital and not fall?
- If you did fall while here in the hospital, what might happen to you?
- If you have fallen since you have been here in the hospital, tell me about that. How did it happen, and what were you thinking and feeling? What was most important to you in that moment when you were deciding what to do about getting out of bed?

subthemes occurred by writing key phrases and words on large pieces of paper on a conference room wall.

In comparing themes from the two groups of participants (those who had fallen and those who had not fallen), no differences were noted in broad themes. Slight differences in the labels for the themes and subthemes were evident but were quickly resolved in dialogue among researchers on the analysis team. The researchers agreed that the thematic schemata for the two groups were very similar. For the remainder of the analysis, data from both groups were combined.

After researchers agreed on the themes that represented the entire data set, they reflected on the findings and determined that no themes were missing, incomplete, or overstated. The three researchers weighed the importance of each theme numerically, with 1 being unimportant to engagement in fall prevention plans and 10 being highly important. A weighting of importance, known in some disciplines as sentiment analysis, was intended to capture the fervency with which a theme was described, the centrality of the theme to the data, and the extent to which a theme was intertwined in the totality of the data (Dedoose, 2012; Denecke & Deng, 2015; Georgiou et al., 2015). The research team expected that weighing the importance of the themes would enrich the analysis by ensuring that all themes were not considered of equal relevance in describing the data. The weights assigned by the three researchers were averaged to determine the mean weightings for each theme.

Researchers ensured that the study met criteria for rigor in qualitative methods (Cope, 2014). For the criterion of dependability, three researchers reached independent consensus on themes and subthemes. To document credibility, researchers created audit trails to provide transparency about decision making. To maintain reflexivity, researchers welcomed feedback about the possible influence of biases on the analysis process. To bolster transferability, researchers enlisted three clinical experts in inpatient care and fall prevention to review the themes and verify that the schemata were congruent with typical experiences of inpatients. Researchers offered direct quotes from the data to support themes and enhance confirmability. Authenticity, defined as the extent to which researchers captured the emotions of participants' experiences (Polit & Beck, 2018), was supported by researchers' weightings of the importance of the themes.

TABLE 1. Sample Characteristics (N = 30)

Characteristic	n
Cancer type	
Breast	6
Leukemia	4
Colon	3
Lung	3
Genitourinary	2
Lymphoma	2
Metastatic/multiple sites	2
Oral/larynx	2
Skin	2
Adrenal	1
Bone	1
Thyroid	1
Missing data	1
Fall in previous year	
No	16
Yes	14
Risk of fall[a]	
Moderate	18
High	12

[a] Fall risk was determined with the Johns Hopkins Fall Risk Assessment Tool. Moderate risk is indicated with a score of 6–13, whereas high risk is indicated with a score of greater than 13.

Results

A majority of participants were women and at a moderate-to-high risk for falls (see Table 1). The Johns Hopkins Fall Risk Assessment Tool was used to determine fall risk; a moderate risk for fall is indicated with a score of 6–13, whereas a high risk for fall is indicated with a score of greater than 13. In the current sample, the score range was 7–19, with a mean of 13.2. The mean age of participants was 65.4 years, with a range of 26–92 years. One-fifth of the sample was aged younger than 57 years. Almost all participants (n = 27) were taking narcotic medications, and 2 were taking anticoagulants. Of the participants who had not fallen between the time of hospital admission and study enrollment, five had fallen in the past year. Of participants who had either fallen (n = 10) or who had had a near-fall (n = 5) between the time of hospital admission and study enrollment, 13 had fallen in the past year. All participants confirmed that they had received instructions to not mobilize without assistance.

Six themes emerged: need to get out of bed, deciding to ask for help, I know myself and these surroundings, the possibility of falling, waiting, and

relationship with nurses. Quotations representative of each theme are presented in Figure 2.

Need to Get Out of Bed

The first theme, need to get out of bed, was described by nearly three-fourths of the sample and was weighted in importance by researchers as 9 on the scale from 1–10. Participants described the inner conflict they experienced when they wanted to get out of bed independently but the fall prevention plan cautioned them to not mobilize without assistance. This perspective was mentioned early in the interviews and provided a context for describing other themes. This theme was associated with verbal and nonverbal expressions of mild-to-moderate anger. Two subthemes clustered within this theme: need to go to the bathroom and need to move around.

Most often, participants' need to get out of bed related to going "to the bathroom" for toileting purposes. Participants commented firmly, frequently, and intensely about the importance of mobilizing quickly and independently to the bathroom. Self-toileting is a developmental task that is learned in early life, and forgoing private management of one's own toileting needs seemed unacceptable and shaming to adult participants in this study. In addition, participants claimed that avoiding incontinence is "what matters most." Participants expressed irritation about choosing between being incontinent when help did not arrive in time and being "in trouble" for disregarding the prevention plan if they mobilized without help. Both options were described as "unacceptable" and "what happens to someone in childhood, not as a fully functioning adult," reflecting a sense of shame related to "disrespect" by nursing staff. Participants viewed getting to the bathroom as a non-negotiable "driver," even if in variance with the prevention plan.

Other reasons to get out of bed were to stretch, build strength, and maintain functional capacity. Although- cited as necessary to participants in this study, getting out of bed to move around was a less intense need compared to going to the bathroom for toileting purposes.

Deciding to Ask for Help

The second theme captured participants' perspectives about requesting assistance from nursing staff to mobilize, per the fall prevention plan. Participants described this theme as occurring most commonly when they needed to self-toilet. Three-fourths of participants described cognitions associated with deciding "to call," which meant using a bedside call button to send a message to staff that assistance was needed. More than half of those who described this theme expressed reluctance to call for assistance. This theme was weighted as 8 on the scale of 1–10.

I Know Myself and These Surroundings

The third theme reflected participants' deliberate, three-faceted assessment process that aimed to determine structures in the hospital room that participants could "hold on to" while mobilizing, evaluate their own ability to mobilize safely and independently in the moment, and elicit their personal values that influenced decisions about engaging in fall prevention plans. Participants' self-assessment typically occurred when participants were deciding whether to call for assistance to mobilize. Three subthemes were knowing me in the moment, knowing me as a person, and knowing this room. This theme was weighted as 9 on the scale of 1–10.

The Possibility of Falling

A fourth theme reflected participants' perspectives about what would happen if they fell. No participants mentioned an increased vulnerability to falling because of having cancer; no participants even said the word "cancer." The first of two subthemes, falling is not a concern, captured the perspectives of a majority of participants who did not believe they would fall or that they would experience negative consequences if they fell. In the second subtheme, that would hurt, a small number of participants described the consequences of falling as "bad" and "painful." Three participants articulated a negative outcome from a previous fall that prompted changes in their fall-related engagement. The researchers weighted this theme as 8 on the scale of 1–10.

Waiting

The fifth theme captured participants' perspectives on what it was like to engage in the fall prevention plan by asking for assistance and then waiting for help to arrive. The experience of waiting was a particularly unpleasant aspect of engaging in the fall prevention plan and engendered anger, frustration, and potential shame if they did not "make it in time" to the bathroom. All but one participant asserted that they would mobilize on their own rather than wait so long that they became incontinent. Delays in responses to calls for assistance seemed to discourage participants from calling for help in the future. Waiting was a major deterrent to engagement in fall prevention in this

FIGURE 2. Themes Representing the Perspectives of Inpatients With Cancer Related to Fall Prevention Plan Engagement

Need to Get Out of Bed

Language of participants to describe the experience of needing to mobilize within the constraints of a fall prevention plan

- Need to go to the bathroom
  - "When I have to go to the bathroom, I just get up and go. I don't want to call anyone. I don't want any help. I just want to go to the bathroom and get back to sleep."
  - "Having to go to the bathroom is a driver. It puts me in immediate motion."
  - "If I have to go to the bathroom, I'll get up and go. Don't cross me about that. Don't get between me and the bathroom, or I will rebel."
- Need to move around
  - "I have to keep moving. I can't just lie around and get weak."
  - "I have to get back to normal. I have to get up and function. I can't let anyone take away my independence."

Deciding to Ask for Help

Language of participants reflective of the choice to call or to not call for assistance to mobilize

- "I have to decide many times a day if I am going to call or not. It depends."
- "To ask for help is to admit defeat. I'll never call."
- "I'm here in the hospital to get help, so if they tell me to call, I will."
- "I have to call. I have to play by their rules, but I don't like it."
- "The nurses get all worked up about calling, more than I do because I'm not going to fall and I'm not going to call them."
- "Look at all this stuff. Slippers. Armband. Signs and notes on the walls. Side rails. Belts. It's hard to ignore, so I guess I will call."

I Know Myself and These Surroundings

Language of participants to describe a process of self-assessment of their capacity to mobilize, their personal values and characteristics salient to engagement in fall prevention plans, and the hospital room environment

- Knowing me in the moment
  - "I sit on the side of the bed, and, if I feel alright, I won't call. I'll go ahead and get up."
  - "I'll call if I feel dizzy or weak. If not, I'll just get moving."
  - "I was really surprised when I fell yesterday. I was sure I could make [it] there and back."
  - "I know what I can do safely. Every day is different. I just know."
- Knowing me as a person
  - "I know I need privacy. At my age, I deserve that. I can't go to the bathroom with someone looking at me."
  - "I'm proud. I don't ask for help."
  - "I'm vain, I guess. I will not be using a bedpan."
  - "I'm not a needy person. I take care of others. I don't want others to take care of me."
  - "I know I'm vulnerable, but I'm not helpless. I can do things for myself."
- Knowing this room
  - "This room is small, and the bathroom is not far."
  - "This room is not much different than home. I just look and see what I can hold on to."
  - "I can move around just fine at home, and I can do it here."

The Possibility of Falling

Language of participants when expressing what would happen if they fell while hospitalized

- Falling is not a concern
  - "I never think about falling. That's an odd idea."
  - "Some might fall, but I will not."
  - "I wasn't hurt that much when I fell. It wasn't that bad."
  - "Falling is just part of life. I fall all the time at home, sometimes 3 times a day."
- That would hurt
  - "Oh, I am sure falling would hurt just terrible, and I'd be in here longer."
  - "It would really hurt to fall in this place."
  - "Since my stroke last week, I have to be more careful. I don't want to fall and break a hip."

Waiting

Language of participants to describe what it was like to engage in the fall prevention plan by asking for assistance, then waiting for help to arrive

- "I'll call for help, but I'm not waiting very long. No one wants to soil themselves."
- "I'll press the call button to let them know I am going to the bathroom, if they want to catch up with me."
- "It irritates me to do what they ask and call for help, and then I wait and wait and no one comes. My getting to the bathroom is more important than their safety plan."
- "Waiting is hard. It is not good."

Relationship With Nurses

Language of participants describing the nurse–patient relationship within the context of the fall prevention plan

- "Some nurses care [about] how I am doing, and some don't. Some only care about me landing on the floor. They talk about it all the time. I just let them talk."
- "I ignore the nurses and keep going to the bathroom because they do not understand that it's urgent. I try not to let their nagging get on my nerves."
- "I know the nurses care about my safety. They are wonderful here."
- "I don't want to bother the nurses. They are too busy. Moving around is something I can do on my own."
- "There's no reason to call. They can't get here in time."
- "When they have enough help, I'll call before getting up on my own."
- "I don't want to get in trouble from the nurses. But getting to the bathroom is what matters most."
- "I don't want the nurses to get in trouble if I fall."
- "I hope they don't get mad at me, but when you have to go, you have to go."
- "It's like they hold you prisoner in here. You can't even move."

sample. This theme was weighted as 9 on the scale of 1–10.

Relationship With Nurses

Content of the sixth theme focused on the participants' perceptions of nurses and the nurse–patient relationship within the context of the fall prevention plan. This theme was weighted as 8 on the scale of 1–10. The data depicted the fall prevention plan as a source of tension in the nurse–patient relationship. More than half of the participants in the current study mentioned the nurse's role in fall prevention. Some described nurses as positive, caring, and interested in keeping patients safe. Others blamed nurses, in an irritated tone, for the "unwanted and belittling" fall prevention plan; another description of the shame participants perceived was related to nurses "not trusting me to get myself to the bathroom." Participants spoke about nurses' lack of caring when they "enforced" the plan. Participants thought nurses did not understand the primacy of toileting and that normal aging can make waiting to urinate or defecate uncomfortable or impossible. In addition, having a staff member stay in the bathroom to ensure that a patient does not fall was viewed as childish, embarrassing, and an affront to an adult's independence. One participant expressed with intensity the private nature of toileting and the power of the nurse–patient relationship to engage patients in harm reduction:

> I can sense if a nurse respects me and really cares about me or not. If they don't, I'm not going to ask them to help me go to the bathroom. That's an intimate activity. I may not want a specific nurse with me.

Participants expressed guilt and concern that "trouble" with nurses might arise if they did not follow the prevention plan. However, participants asserted that their needs and self-knowledge were more accurate and more important than engaging in the fall prevention plan and that they were willing to tolerate dissonance with nurses, if necessary, to avoid incontinence.

Almost half of the participants reported that nurses were "too busy" to come quickly when called. Participants reasoned that they could "help" the staff by mobilizing on their own and not bothering them by calling for help.

Discussion

This qualitative study is the first to explore engagement in fall prevention plans among inpatients with varying cancer diagnoses across the adult lifespan. When reflecting on the extent to which they were engaging in fall prevention precautions, participants first expressed resistance to engagement when they needed to mobilize for toileting purposes. The overall data suggested five reasons that participants may resist asking for assistance to mobilize to the bathroom:

- They did not want anyone helping them with a private activity.
- It was hard to wait for help to arrive when toileting was an urgent matter.
- Participants thought they could mobilize to the bathroom independently and without falling.
- Nurses were too busy to help.
- Participants did not want to request assistance from nurses who were not perceived as caring.

Participants clearly stated that they would disregard fall prevention precautions and get up without help to avoid incontinence. Continence mattered most. Similarly, prior research has indicated that inpatients prioritized toileting above fall precautions, which may explain, in part, why the majority of inpatient falls are related to toileting (Lim, Ang, et al., 2018; Radecki et al., 2018; Zhao & Kim, 2015).

Data in this study strongly reflected inpatients' negative emotions related to nurse-driven fall prevention plans, in contrast to other studies in which participants viewed such plans positively, as ways of keeping patients safe (Gettens et al., 2018; Radecki et al., 2018; Shuman et al., 2016). Participants in the current study described feeling shame associated with being labeled at risk for falls and, therefore, requiring a fall prevention plan, losing independence when mobilizing, and potentially experiencing incontinence if staff did not arrive quickly to assist. Shame is a painful human emotion—one that humans fear and try to avoid (Daniels & Robinson, 2019). Shame often manifests as angry responses or social withdrawal, as conceptualized by Scheff and Retzinger (1991) and as expressed by participants in the current study. When participants experienced shame and anger related to the fall prevention plan, engagement in the plan was less likely.

The data in the current study reflected a two-step decision-making process that participants initiated when they needed to get out of bed. The first decision point was whether to call for help. The leading reason to call for help was that the nurses told participants to request assistance and participants wanted to cooperate. Two primary reasons not to call for assistance were the perceptions that participants could mobilize

independently and nurses were too busy to assist. Similarly, prior research has documented the inverse relationships between inpatients' perceived confidence to mobilize and the likelihood of requesting assistance to mobilize (Lim, Ang, et al., 2018; Twibell et al., 2015). The dilemma of maintaining functional independence and yet following "the rules" of fall prevention also has been documented in other studies (Hill et al., 2016; Radecki et al., 2018; Shuman et al., 2016).

The second decision point participants described when needing to get out of bed was how long to wait for help to arrive after calling for assistance. Participants viewed requesting help and waiting for help as distinctly different decisions. Participants were more willing to call for help than they were to wait very long for help to arrive. Prior research also has revealed inpatients' inclination to not wait long for help to arrive and identified waiting as a major barrier to following falls precautions (Hill et al., 2016; Radecki et al., 2018).

The data suggested that when participants made decisions to call for help or to wait, they self-assessed their capacity for independent mobilization in the moment and identified structures in the room "to hold on to" for steadiness. In a prior study of inpatients with hematologic cancer, Knox (2018) also noted patients' moment-by-moment self-evaluation of their own capacity for independent mobilization. Identifying structures "to hold on to" is a strategy that patients have reported in another study as well (Radecki et al., 2018). However, patients may not be able to judge what structures in a hospital room are safe for steadying oneself.

Although all participants in the current study had a diagnosis of cancer, this diagnosis was rarely mentioned in the interviews and did not seem to influence participants' engagement in fall prevention. Two-thirds of the participants in this study had experienced falls. In contrast to other studies (Scarlett et al., 2019; Shuman et al., 2016), the majority of participants in the current study did not express a fear of falling, were confident that they could mobilize independently, and did not view falling as a major concern. Knox (2018) found similar cognitions in a comparable sample of patients with cancer who did not see themselves as terminally ill. Participants in the current study may have been in what Knox (2018) described as a restitution phase (Frank, 2013) in which they anticipated returning to an accepted level of wellness following hospitalization. Therefore, acknowledging any risk for instability, weakness, or dependence was counter to their desired wellness trajectory. To affirm patients' commitment to maintaining independence and a high quality of life, nurses can sensitively present fall prevention plans as a temporary precaution that prevents injury and supports patients' goal of independence on discharge.

The findings of the current study emphasized that the nurse–patient relationship is a factor in patient engagement in fall prevention precautions. Participants suggested that they would be more likely to follow nurses' recommendations for safety and harm prevention if nurses cared about them as individuals. Nurses have a responsibility to structure a trusting relationship that facilitates engagement in all aspects of care, particularly safety plans. Koloroutis and Trout (2012) offer guidelines for creating therapeutic relationships with patients through skilled communication and specific relational approaches. As more research is conducted to illuminate the power of the nurse–patient relationship, healthcare professionals can recognize that getting to know patients as individuals and caring about them holistically is not just something that is nice to do if time allows but rather is necessary to enhance engagement in safety plans and excellent patient outcomes.

No differences in thematic content were found between participants who had and who had not fallen. The similarities in themes across the two groups may be attributable, in part, to a lack of distinct differentiation between the groups. Participants in one group had not fallen between the time of hospital admission and study enrollment (n = 15). Participants in the other group had either fallen (n = 10) or had had a near-fall (n = 5) between the time of hospital admission and study enrollment. The near-fall participants did not actually land on a lower surface, so there was no impact or risk of injury. The viewpoints of patients who had had a near-fall may have been more similar to the viewpoints of those who had not fallen, therefore blurring group distinctions. Alternately, the severity of any of the falls, past or present, could have been mild and may not have created much concern for safety among the group that had fallen. Patients who fall every day without concern may share perspectives similar to those who have not fallen.

Limitations

This study was conducted at a single hospital serving a population with limited racial diversity. More than 90% of inpatients at the target hospital were White. In addition, few young or middle-aged adult inpatients were assessed as at risk for falls; as a result, the data for this study primarily represent inpatients

aged older than 57 years. A replication of this study in samples with racial and ethnic diversity and including younger adults could extend the transferability of these findings.

Although researchers took steps to enhance the rigor of the study, the resulting themes may have been influenced by the researchers' biases or the wording of the interview questions. Contrary to researchers' biases that participants would be afraid of falling and generally compliant with fall precautions, the majority of participants in this study did not express fear of falling or a strong intention to engage in fall precautions because of fear. Results of the data analysis did reflect participants' concern about restrictions on independent toileting, which was one of the researchers' biases. An inspection of the audit trail did not reveal bias in the analysis; the data clearly and repeatedly reflected toileting concerns across multiple participants. The congruence of the themes with the findings of other similar studies suggests that the results may have adequate rigor and may be transferable to similar clinical settings and samples.

Implications for Nursing

The current study's results hold clear implications for clinical practice. Patients with cancer who are not receiving end-of-life care may resist engagement in fall prevention plans if independent mobilization for toileting is restricted. The findings of this study suggest three approaches to enhance engagement in fall prevention, all within the scope of autonomous nursing practice.

First, nurses can pursue the development of a trusting nurse–patient relationship to encourage engagement in fall prevention precautions. Nurses can convey compassion and caring while creating opportunities to dialogue with patients about their perceptions of the fall prevention plan. To help diffuse tension in the nurse–patient relationship prompted by a fall prevention plan, nurses can learn about a patient's life beyond their diagnosis and course of hospitalization. Nurses can acknowledge in discussions the common feelings of shame, fear, and anger related to fall prevention plans. Nurses can express empathy and mitigate shame by sharing short personal stories about times they felt embarrassed and angry. Nurses can acknowledge in conversation how hard it is to engage in the fall prevention plan by waiting. Honest nurse–patient dialogue that includes the articulation of strong emotions can foster authentic relationships and may help patients express their negative feelings and think more clearly about engagement in fall precautions. Most importantly, nurses can develop therapeutic relationships with patients that actively involve the patient and family in safety planning (Stern & Sarkar, 2017).

KNOWLEDGE TRANSLATION

- Mobilizing to the bathroom in a timely manner is more important to many patients than engaging in the fall prevention plan.
- Nurses can prioritize building a trusting relationship with patients at risk for falls and seek to understand their perspectives; when patients believe that nurses care about them as individuals, patients may be more likely to engage in safety plans.
- Nurses and patients can collaboratively assess fall risk and share fall-related perspectives to tailor strategies and education to reduce falls.

Once a collaborative relationship is progressing, a second nursing approach is to partner with patients and families to develop a personalized fall prevention plan (Lim, Ang, et al., 2018; Primeau et al., 2017; Radecki et al., 2018). Nurses can collaborate with patients to interweave evidence-based interventions into an individualized plan that enhances patient ownership, valuing, and engagement. Consensus is growing that a collaborative fall risk factor assessment in real time with patients can help them understand nurses' rationale for precautions and give nurses more insight into patients' self-knowledge (Kuhlenschmidt et al., 2016; Radecki et al., 2018). In addition, based on the findings of the current study, nurses can discuss patients' in-the-moment assessments and emphasize how quickly one's physiological stability can shift with postural changes and how one's cognitive clarity to self-assess could be blurred by medications and medical conditions.

Fall prevention education for patients with cancer may be best conveyed in a warm, conversational manner personalized to the patient and sensitive to patients' fall-related perceptions. Video-based education can be helpful in depicting compelling stories of patients like themselves who made good choices to call for help to keep from falling.

Third, the findings of this study suggest that nurses cannot disregard the high value that patients place on maintaining continence. A tailored, collaborative plan is needed to facilitate timely toileting. Hourly rounding is one evidence-based strategy that can ensure that patients have assistance to the bathroom as often as every hour, before their need

is urgent (Goldsack et al., 2015). Nurses can inquire about patients' usual pattern of getting up to go to the bathroom at night and support a similar schedule. Nurses may partner with patients to agree on how many minutes they are willing to wait. Positive reinforcement for waiting may help patients decide to call and wait for help the next time. If technology allows nurses to communicate with patients who are waiting, nurses can let patients know when help can be expected to arrive at the bedside. When assisting a patient who is angry about losing independence in mobilizing, staff can allow the patient to do as much as possible on their own while the staff respectfully observe closely and intervene when necessary. As a trusting nurse–patient relationship deepens, nurses may initiate sensitive conversations that reframe incontinence as preferable over falling. Nurses can acknowledge that incontinence and falling can be shaming; however, incontinence does not hold a risk for injury that could be deleterious and life-changing for patients hospitalized with a diagnosis of cancer.

Conclusion

Hospitalized adults with cancer described six perspectives related to engagement in fall prevention plans. The results can guide nurses in designing and coordinating safety plans tailored to the patient's perspective. This study suggests that independent and timely toileting is what matters most to patients with cancer. Patients prioritize continence over prevention plans and will mobilize to the bathroom without help, if necessary. In addition, the findings of this study elevate nurses' awareness of the negative emotions that inpatients may experience related to fall prevention and the discomfort of waiting for help to arrive.

Future research can replicate this study in more diverse settings. A specific focus for further qualitative research is an explication of the elements of nurses' behavior that are viewed as caring and that facilitate engagement in fall prevention plans. Tailored fall prevention plans based on an understanding of the experiences of inpatients with cancer can elevate engagement and mitigate harm in this vulnerable inpatient population.

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