Preventing Patient Falls in Hospitals and Nursing Homes

Posted on September 17, 2018

Introduction

Falls in nursing homes and hospitals become a reason for serious injuries in adults. About 2.8 million people are admitted to hospitals each year due to fall injuries. They are the reason for about 95% of hip bone fractures in adults and result in severe brain damage when patients fall to the ground and have head injuries. Usually, patients who are above fifty years of age or develop motor function disabilities have an increased risk of falls in hospitals. The case can be more severe if the patient is suffering from less bone density issues like osteoporosis or osteoarthritis. The issue is critical due to its nature and the statistics that show an increased death rate due to falls in the past few years. Due to these adverse effects, there is a need for optimized methods of fall prevention in a hospital environment. Various studies have been concluded to minimize the risk of falls and their subsequent chronic effects. This paper will review two research studies that were conducted to evaluate the risk of falls and methods of prevention. It will also provide a potential solution to solve the problem and minimize the risks (Centers for Disease Control and Prevention, 2016; Breimaier, Halfens, & Lohrmann, 2015).

Discussion

The purpose of this paper is to provide a potential evidence-based solution for falls in nursing homes. The information we found from the research studies will be used to develop a solution and minimize risks (Breimaier, Halfens, & Lohrmann, 2015; Duarte et al., 2018).

Problem Effects

The problem of falls in nursing practice causes adverse effects on nurses and other healthcare professionals. A nurse, while delivering care to the patient, has to make sure that none of her actions become a cause of physical or mental stress for the patient. While transporting a patient on a stretcher, with the help of a walker or wheelchair, if a patient falls, it reflects poor nursing care provided by the nurse. It results in decreasing nurses' confidence and trust in physicians on her. Falling from beds because of the absence of safety rails becomes a cause of death in most patients. It has been observed that most patients who do not get assistance walking to or from the washroom or getting out of bed have the highest risk of falls. Nurses, while delivering care to such patients, have to guide them about how they can be safe from falling risks and physically help them in walking. Some

patients who are unconscious or unable to move by themselves rely more on nurses to transport them to the hospital. Nurses face more problems in delivering care to these patients as they are totally dependent on external care. These patients need care when traveling and getting out of bed, as well as additional support while they sleep, to avoid chances of rolling over and falling. In the next paragraphs, we will discuss two types of research that aim to prevent fall risks and methods of safety implementation (Breimaier, Halfens, & Lohrmann, 2015).

Professional Literature & Resources

- The effectiveness of multifaceted and tailored strategies to implement a fall-prevention guideline into acute care nursing practice: a before-and-after, mixed-method study using a participatory action research approach

This research, which was carried out in an Austrian university teaching hospital, was aimed at finding an evidence-based solution to the patient's fall problem. It includes multifeatured and specially designed strategies for the implementation of fall prevention programs in a specialized hospital environment. The strategy was focused on the before and after measures in fall cases. The study was done by interviewing the nursing staff dealing with the ophthalmology and accident department, and their understanding of the issue and their suggested measures were assessed. For the application of the method, the standard Consolidated Framework for Implementation Research (CFIR) was used to organize and evaluate all the necessary features of the program and schedule the implementation process. Because of the growing need for advanced methods for fall prevention, the effectiveness of present programs for fall prevention, and currently, active strategies for the problem were included in the research to develop an evidence-based plan (Breimaier, Halfens, & Lohrmann, 2015).

The research process started by informing the nursing and healthcare staff about the program to ensure effective data collection. Both departments were assigned a team head, and they were asked to discuss the issue and develop strategies to solve the problem. After the discussion, they were asked to provide their analysis and plan of prevention. The multifaceted approach resulted in improved knowledge of the staff, though their strategies and methods were already effective and practical (Breimaier, Halfens, & Lohrmann, 2015).

The results of the research increased nurses' knowledge about fall prevention methods. This significant increase in knowledge resulted in better delivery of nursing care by these nurses and their procedures regarding patient information about the risks of falls. The program provided them with recommendations in their daily practice and suggested measures to take to prevent falls and how they should perform if such incident happens (Breimaier, Halfens, & Lohrmann, 2015).

- Feasibility of using risk prompts to prevent falls, dehydration, and pulmonary aspiration in nursing homes: a clinical study protocol

This study aimed to formulate the process of written guidelines and signs to inform people about the

risk of falls, a decrease in water level in the body, and risks of pulmonary aspiration. This study used a strategy of informing patients about the importance of these risks and their bad effects. The study was meant to target each of the three risks together and increase patient knowledge about the issue with the help of verbal and written descriptions (Duarte et al., 2018).

The study used the intervention method of nursing home members and acknowledged the importance of these three risks. The study used wristbands and wall signs to inform patients about the importance of these risks. These methods resulted in increasing patients' knowledge about the issues and what they can do to avoid these problems (Duarte et al., 2018).

Potential Solution

Based on the research findings of these two studies, we can formulate our fall prevention plan. This plan will include the inspiring methods from these studies and our personal knowledge of the problem (Breimaier, Halfens, & Lohrmann, 2015; Duarte et al., 2018).

Implementation

The plan will need the help of nursing staff,f who will be given knowledge about the issue and its risk factors. They will be informed about the new strategies to prevent fall problems and how they can effectively implement the strategy in their practice. The plan will include intervention for the patients in nursing homes. This intervention will inform them about ways they can prevent the problem and when they need professional help. The program will use graphical guidelines and reminders for the patients to remind them about the safety precautions to avoid falling. The safety measures will include caution signs, cleaning of floors, safety bars on walkthroughs and beds, and enough light in corridors and rooms. Further research is needed to improve strategies for fall prevention and intervention of nurses and patients to minimize the potential problem (Breimaier, Halfens, & Lohrmann, 2015; Duarte et al., 2018).

Conclusion

The problem of falling in a hospital environment has been a cause of many chronic injuries and deaths in the past decade. Therefore, there is a need for an advanced strategy to avoid this problem in healthcare institutions. Various research studies have been conducted to increase knowledge about the issue and minimize its occurrence in hospitals. This paper will enable nurses and patients to learn the methods of rectifying the problem and improve their knowledge about the risks and how they can use safety equipment to avoid falling from beds or stretchers or slipping from the floor (Centers for Disease Control and Prevention, 2016; Breimaier, Halfens, & Lohrmann, 2015; Duarte et al., 2018).

References

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