Patient safety initiatives in the hospital setting essay sample

Health & Medicine, Hospital

Introduction

Patient safety is described by the US Institute of Medicine as “ the freedom from accidental injury due to medical care or from medical error” (Mansour, 2012). With that being said, patient safety has long been a major issue for hospitals. In the past many patients have been injured during hospital stays, some being injured severely with death being the result. With the growing trend of lawsuits, hospitals were becoming more and more vulnerable to financial liability when patients were injured on their grounds. No one wants to be responsible for the injury or death of another individual. This is why many hospitals have begun doing their own independent research as well as looking at the research from other patient safety organizations.

Patient safety goals are being put into place by organizations such as The Joint Commission, as well as falls reduction campaigns being implemented by the individual hospitals. While regulatory agencies like The Joint Commission require hospitals to identify who is at risk for a fall, and gives minimum standards to go by, it is up to the individual hospital to go beyond these required interventions to reduce the risk of a fall occurring within their facilities. Some ideas to prevent falls include the implementation of a new Clinical Nurse Leader position, purposeful hourly rounding, as well as sensors for beds to ensure they are in the low position.

Topic

One of the first ways to prevent falls in patients is to identify who is at risk. According to the United States Department of Veteran Affairs, the major

intrinsic, or physiology-based, risk factors for falls include; altered elimination, cognitive impairment, sensory deficits, altered or limited mobility/gait, and impaired balance (2009). Contributing to these risk factors are, for example, medications that act on the central nervous, circulatory, digestive, or urinary systems; age-related conditions that affect sensory organs; history or fear of falling; and fluid and/or electrolyte imbalances (United States Department of Veteran Affairs, 2009).

For most hospitals, there is a list of questions that nurses are asked used in documenting about patients on a daily basis to determine the ever changing status some patients have while hospitalized. These questions make up what is called The Morse Falls Scale. A Morse Falls Scale must be done each day, and with any condition change, to determine a patients risk for falling. The Department of Veteran Affairs also states " A score of 0-24 indicates no risk for falls. A score of 25-50 suggests a low risk for a fall while a score of greater than 51 indicates a high risk of falling"(2009).

To determine the score a person will have several questions must be asked such as: Does the patient have an IV? Is the IV a saline locked or does it have medications infusing? Has the patient fallen in the last three months? How does the patient ambulate? Are they on bedrest, use the nurse to assist, do they have a weak gait, or do they have an impaired gait? Are they taking diuretics/sedatives/tranquilizers? Is the patient over the age of 70? Are they oriented to their own ability or do they forget their limitations? (2009). Answering the aforementioned questions may seem tedious and like busy work however it is very important in the implementation of effective

interventions for at risk patients. Now that you have identified who is at risk and how at risk they are, it is imperative to quickly implement the necessary interventions to prevent those at risk from becoming a statistic and more importantly keep them safe from harm. Even those individuals, who are alert, oriented and are at a low risk for falls should still have preventative measures taken to prevent an accidental fall.

One of the leading causes for falls in this group is from hospital staff not lowering the bed down after attending to a patient. Also it is important to keep the patients call button within reach at all times, and educate the patient to call for assistance when needing to get up. Make sure the patient has all of their possessions within reach. For some it might be advisable to turn on a night light at night. For even alert patients, waking up in the middle of the night in a strange place can lead to a fall. Non-skid slippers are another way to prevent falls. Make sure your patients are wearing those any time they are out of bed. Side rails at the head of the hospital bed must be kept up on any patient who is hospitalized, but especially on those patients who are over 65 years of age or those receiving narcotics or sedatives (2009). Patients who are at a slightly increased risk for a fall should have the same interventions taken to protect them as a person with a low risk, but additional interventions are also needed.

Rounding on patients is supremely important for many reasons, one of which is decreasing falls. (Tucker, Bieber, Attlesey-Pries, Olsen & Dierkhising, 2012). It is usually during these rounding times you will find noncompliance within patients of this category. If you go into a room and find a patient who

is at moderate risk up and out of bed, reeducation is required and in some cases it may be beneficial to turn on the bed alarm to prevent them from getting up again without assistance. It is important to use judgment here when deciding to implement the bed alarm or not (National Guideline Clearinghouse, n. d.). Take into consideration things such as are they hooked up to a central line, suction, is there a chest tube? Typically when patients insist on getting up without help and have various kinds of tubing hooked to them it is recommended to implement the bed alarm for their safety (National Guideline Clearinghouse, n. d.).

Patients who are at a high risk for falls should have all previously discussed interventions taken along with additional interventions, such as having signs posted so all staff knows that a patient is at risk for a fall. A yellow arm band should also be placed on the patient to alert all staff of the patients risk for falls. There is also no question that these individuals should have a bed alarm activated. If possible it’s always a good idea to have these patients close to the nurses’ station (National Guideline Clearinghouse, n. d.). Having them closer to the nurses’ station improves the response time for when or if the bed alarm does go off. Having patients closer to the desk also given the staff a better opportunity to more closely monitor the patient. When it is not an option for a patient to be moved closer to the nurse station, it may be advisable for the patient to have a one to one sitter.

In many cases families will be more than willing to stay with a patient to help make sure they do not get out of bed without assistance. If this is not possible a hospital staff member, usually a nurse assistant, will need to stay

with the patient. Most all hospitals have moved away from using restraints. The liability had become too great for hospitals and staff to continue such a practice. As previously alluded to one important tool most facilities have adopted is hourly rounding. Studies have shown that by hourly rounding and addressing the 4 P's, which are pain, potty, position, and possessions, reduces the amount of falls that occur in an inpatient setting (Ford, 2010). It is also a great way to make the patient feel safe. According to the research done by Beverly Ford in 2010, patients who see that someone from the faculty is coming in to their room each hour to check on them feels that they are being taken care of and safe. More often than not a patient will avoid using the call bell because they do not want to bother their nurse. (Tucker, et al., 2012). Particularly with these patients it is important to see them as often as possible and at a minimum once an hour.

Studies have shown that one factor in reducing the risk of falls is to have the bed in the lowest position when leaving the room. (Tzerg, Prakash, Brehob, Devecsery, Anderson, Yin.,, 2012). Studies have also shown that 26. 5% of patients who fell during a hospital stay fell from their beds. 3. 6% fell over the bed rails, footboards, or headboards. (Tzerg et al., 2012). If the bed is raised from the lowest position it dramatically increases a patient's chance for falling. According to research done in 2012 by Tzerg, et al, the appropriate height of a hospital bed in the horizontal position is the patients' knee height. For women the average keen height is 19. 49 inches and in men it is 21. 3 inches. (Tzerg et al, 2012). There is also research to suggest that a

bed height sensor should be placed on all hospital beds to ensure that a bed is not left in the up position.

Many hospitals have started implementing a new nursing position that helps bridge the gap between nurses with a heavy patient load and the patient who needs closer monitoring. According research The Clinical Nurse Lead (CNL) position has been created at the encouragement of several agencies such as The Joint Commission and Accreditation of Healthcare Organizations. (Stanly, Gannon, Gabuant, Hartranft, Adams, Mayes, Shouse, Edwards, Burch, 2008). In the Fall of 2006 the first CNLs graduated from 12 different masters nursing programs across the united states. “ With a heightened awareness these new graduates went out into the workforce to improve healthcare quality and patient safety, national indicators have been identified and they are being used to determine the quality of care being provided to patients” (Stanly, et al., 2008). While not the answer to improved patient safety, studies have shown that implementing the position, especially on surgical units has improved the level of care received by patients while hospitalized (Stanly, et al., 2008).

There is no question that falls more often occur in the older population. Medicare has taken a huge interest in this factor and many questions are now being asked. Some of the questions being asked involve things such as what were the risk factors leading up to the incident, how did the incident occurred, what interventions were taken to prevent, and what was the response time after it occurred? (Liang, Mackey., 2011). Because of the association of falls with mortality and disability, especially in the elderly,

several studies have investigated the incidence of falls and the associated risk factors. In 2011 research done by Liang and Mackey reported The Centers for Disease Control and Prevention estimation of approximately one third of people 65 years of age and older fall each year, with many of those falls taking place in hospital settings.

In October 2008, the Centers for Medicare and Medicaid stopped reimbursing for hospital-acquired conditions, or events, that should never occur during hospitalization (Liang, Mackey., 2011). The guiding premise on why these " never events" should not occur is because there is a sufficient evidence base to prevent those events (Liang, Mackey., 2011). If a patient experiences one of these events during their hospitalization, the hospital will not be reimbursed for the treatment costs associated with the event if the patient's insurance is provided through Medicare or Medicaid. With the already serious losses most hospitals take each year, they simply cannot afford to have more revenue lost. This pay-for-performance initiative includes some patient outcomes that are considered to be nursing-sensitive, for example, injuries from falls. This phenomenon of hospitals not receiving reimbursement based on patient outcomes is a relatively new phenomenon for nurses in acute care. This is why hospitals are being serious and taking a hard stands on patients' safety while in their care.

Summary

While there is defiantly a trend toward improvement to increase patient safety while hospitalized, it is obvious that there is still a long way to go.

Nurses more than ever are using their role as a patient advocate to find new and insightful way to reduce risks for falls. Implementing falls precautions before there is a fall is one of the best ways to avoid an incident. Keeping beds in low position reduces the risk for the alert and oriented patients to fall. Implementing unit standards, researching and revising things that needs to be addressed are highly important for patient safety initiatives to be effective with a hospital setting. Continued research is also needed. Hospitals and patient acuity are both changing almost on a daily basis. It is up to those in the medical profession to avoid becoming stagnant and continue to grow in an effort to protect our patients from harm.

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