Fall and injury prevention

There are many literature reviews related to quality improvement/ evidence-based practice on reducing falls in the healthcare settings. Three databases were search; namely: EBSCOhost, ProQuest, and SAGE Premier. Five articles were reviewed; and the following four articles were included in the review of the literature: Fall Safety Bundle (Campbell, 2016), Evaluation of Hospital-Based Fall Prevention Program (Ringquist, 2013), Preventing Patient Falls (Rowe, 2012), and Falls Among Older People (Wang & Wollin, 2004).

The Centers for Medicare and Medicaid Services (CMS) report thousands of falls in hospitals each year. The CMS does not reimburse hospitals for fall related injuries, costing healthcare organizations millions of dollars each year (Campbell, 2016). Falls can result in injury, reduce quality of life, prolong hospital stay, lifelong disabilities, and even death especially among people who are 65 years plus. Almost 50 % of elderly people with fracture that results from falls, either from home or in the healthcare settings, do not regain their pre-fall standard of ambulation due to dislocation and damaged of the musculoskeletal system.

Fracture in any form negatively affects the quality of life in various ways such as: decreasing mobility, independence, and increasing mortality (Wang & Wollin, 2004). I will argue that, most if not all healthcare facilities have policy manuals that clearly outline procedures and strategies to reduce falls among all patient regardless of their age. However; strict compliance with the protocols that are known to be evidence- based to reduce falls, are not comply to, or are being ignored by healthcare staff members, patients, caregivers, and evenfamilymembers.

Falls have been defined as unintentional descents to the floor that may or may not be assisted by another person (Rowe, 2012). There are many factors that can cause a patient to fall while in a healthcare setting such as: side effects of medications- especially cardiac and neurological medications, physiological changes like age, immobility, poor oxygenation, wet floor, patient trips over an electrical cord, and patient trying to get into the bathroom in poor lighting. Also, patient suffering fromdementiaand other diseases that affect the normal functioning of the brain, like Parkinson's disease, multiple sclerosis is at increased risk of fall. Most patient falls occurs during the first days of hospitalization; therefore, it is important that all patients are assess on a continues basis to identify the potential of risk for falling (Rowe, 2012).

The aim of the Fall Safety Bundle literature review on falls in healthcare settings, was to create an evidence-based fall safety for use by healthcare providers and as anacademicframework to increase healthcare provider's consciousness and knowledge for prevention of falls and fall-related injuries in healthcare settings (Campbell, 2016, p. 5). The evidence suggests that healthcare organizations that have put into effect or execute a fall safety bundle to prevent potential falls in the healthcare settings, have reported a drastic decrease of the number of patient falls as well as a decrease in major injuries based on recorded statistics over a decade.

The research and literature review favor the use of a package that includes: " screens for fall risk patients on admission; a screening tool for fall related injury risk factors and history upon admission; a complete assessment of any anticipated physiological falls and risk for serious injury from a fall"

(Campbell, 2016, p. 43). I will argue also that, Communicationamong healthcare providers, patient, caregivers, and family members regarding customized strategies and intervention to prevent injuries from falls and other related problems is very important and must be included in the package.

A fall safety committee identified seven standard parameters or variables which were deemed necessary in the prevention of falls. They included: a stationary means of communication with patients and other healthcare providers such as a patient communication whiteboard in the patient's room, answering to call lights promptly, assisting patients in ensuring toileting safety, importance of patient/family teaching, a safe handoff communication form among staff members, standardized availability and use of fall prevention equipment like non-skid hospital stocks.

Daily morning meeting at the nurse's station prior to a morning shift, and post falls meeting are both evidence-based practices that have been proven to increase nurse's awareness for fall risk patients. These meetings are important because, effective communication, delegation, and collaboration through information sharing with other members in the healthcare team such as physical therapy, will enhanced a safeenvironmentthat will prevent potential falls.

In a literature review based on a program that was implemented at the University of Illinois to evaluate falls prevention in hospital, an online learning courses was offered to all staff members who interacted with clients. A specific time frame was given to the healthcare providers to

complete the learning course. Another face- to face teaching took place on the floor and was directed at the effective scoring of the MORSE FALL SCALE. Statistics of the Morse fall scale shows a significant difference between preintervention and postintervention.

According to the literature review by Ringquist (2013), there " Were 328 patient falls during the year prior to implementation of the fall prevention program, the year after the initial implementation phase, there were 278 patient falls" (Ringquist, 2013, p. 104). This means 50 less incidence of falls was reported per year following the execution of fall prevention plan in the healthcare organization. This reduction in fall is significant not only to the patients who did not fall, but also for the hospital because it decreases the potential for liability. Also, it saves the hospital millions of dollars since the Center for Medicare Services no longer reimburse hospitals or other healthcare settings for falls related injuries.

In the Indiana Regional Medical Center (IRMC) policy manual, fall is defined as an unplanned, assisted or unassisted decent to the floor either with or without injuries to the patient/resident/client either witnessed or unwitnessed (IRMC policy manual, 2017). In the IRMC policy manual it is theresponsibilityof all healthcare workers to ensure that the environment is conducive for patient safety, as such safety is to be the top priority of all team members.

Staff members should recognize that all clients are to be considered at risk for falls and to continue appropriate intervention to prevent falls. To accurately assess, identify and institute evidence-based interventions with

patients who are at risk for falling at IRMC, " all adult patients admitted to the Intensive Care Unit, 7 Telemetry, 6 Medical, 4 Surgical, BehavioralHealthService, and Rehabilitation Services will be assessed for falling by using the MORSE fall assessment and will be assessed for risk of injury" (IRMC policy manual, 2017).

On admission at IRMC, a registered nurse (RN) will assess patient for presence of fall risk factors, complete the initial MORSE fall and risk for injury assessment and determine level of risk. If the patient is determined to be high risk to fall, the admission RN will ensure that the fall sticker which is yellow, is placed on the patient's wrist, yellow slippers are placed on the patient or tied to the foot of the bed, a white board in the patient's room is updated, chair/bed alarm is activated. If a family member is available, he/she can be consulted for individualized fall prevention interventions.

Patients at risks for falls will not be left unattended in the bathroom during activities of daily living (ADLs). Ongoing assessment will be completed every shift or with each handoff of care by either an RN or LPN. If there is a fall, a post fall assessment is completed immediately. The RN is responsible for establishing and revising the individual plan of care related to safety and fall prevention by editing text on process intervention screen.

In the IRMC policy manual, general fall prevention interventions are outlined as follows:

Toileting: staff will remain within arm's length away of all high risk fall patients during toileting and until returned to a monitoring process; toilet all high risk falls patients prior to administering pain medications; toilet all high-

risk patients prior to the end of shift change. Alarms and visual identification: apply yellow slippers and bracelet; chair and bed alarms are activated when in use. Communication: update whiteboard with high risk fall status; include high risk fall updates in handoff communication or shift report; consider placing patient in a chair next to nurse's station; Safety and staffing: evaluate medications for potential side effects or poly-pharmacy; consider need for physical or chemical restraint if patient is in danger of harming self or others; assess need to reassign staff to seat with the patient; all patient transfers will use gait belt (IRMC policy manual, 2017, p. 8).

Data collected from the 4 Surgical floors, in comparison to the hospital policy shows partial compliance with the protocols that are clearly outlined in the hospital policy. The following findings were observed during the data collection. I noticed a patient who need an assist of one for ambulation was transferred to the toilet without the use of a gait belt; a patient was lying in bed and the call bell was not within reach of the patient; some of the rooms with double beds were cluttered which can pose a hazard to patient when they need to use the toilet.

Comparison of the literature reviews on strategies to prevent falls and the policy manual at IRMC, shows some significant variance in strategies and interventions to prevent falls. A multi-agency approach to fall prevention programs is the strategy that most healthcare agencies are pursuing (Wang; Wollin, 2004); whereas, at IRMC the quality department in conjunction with unit managers are responsible in conducting an ongoing safety rounds to ensure the environment remain hazard-free- thus preventing falls. Some healthcare organizations have developed creative ideas such as putting

posters on falls along the hallway, internal television programs in patient's rooms that explains strategies to prevent falls, whereas, at IRMC, those approaches and strategies to prevent falls are not practice.

Recommendations based on literature synthesis that are aim at reducing falls in the healthcare settings include more effective communication strategies within the hospital environment. The traditional one on one walking rounds is not use often, and it is a great means to assess patients who are at risk for fall in real-time. A different communication technique is the installation of whiteboards in the luncheon, staff locker rooms, and at the nurse's station.

The presence of these whiteboards at strategic locations, will quickly and easily attract the attention of staff members- thus making them to be aware and be alert of those patients who are at risk for fall. A constant update of these whiteboards and walking rounds to check on patients will ensure safety- thus preventing falls. IRMC and many healthcare organizations have begun using benchmarking -the process of measuring products, practices, and services against best performing organizations (Marquis ; Huston, 2017, p. 614).