Hospital Related Falls

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 Hospital related falls are frequent among elderly patients and result in devastating complications. According to epidemiologic studies, the rate of hospital-related falls is three to five per 1,000 bed-days. The data that suggest the existence of hospital falls is the report of the healthcare Research and Quality Agency, which states that about one million patients fall each year. Most of the hospital falls lead to severe injuries such as head trauma, internal bleeding, andfractures. Also, other falls that do not cause injuries can cause severeproblems to patients, for example, anxiety and distress,members of patient’s families, and hospital staff. The agency reports that we can reduce hospital falls by maintaining the safety of patients and helping them to recover their mental and physical health. The objective of this paper is to analyze various sources on hospital-related falls, the appropriate quality improvement process and quality improvement tools.

**Analysis of the Existing Data**

 Abreu and his colleagues carried out a longitudinal study to determine the prevalence of hospital falls, their impacts, causes, and interventions that may help to prevent them. The researchers argued that hospital falls affect the healthy lifestyles of patients, and it is among the major causes of deaths among the elderly(Abreu, Mendes, Monteiro& Santos, 2012). The findings of their research indicated that there is an increase in the number of falls each year. Most of the falls occur in the morning and at night. In the morning, many activities such as waking up, hygiene, tests, and rehabilitation take placeand they coincide with the daily routines of patients leading to situations that are prone to falls. Shifts in the afternoon and at night may lead to confusion among patients. These shifts have fewer activities, and the number of care providers reduces;thus, the frequency of surveillance among patients decreases(Abreu, Mendes, Monteiro& Santos, 2012). Some of the interventions to prevent hospital falls include reports, analysis, and reorganization procedures as they will enhance the safety of patients. Another intervention is encouraging nurses to record all incidents of hospital falls and introduce strategies like risk assessment scales and event monitoring.

 In another study, the researchers found that the risk factors for hospital falls are antidepressant, antiepileptic, hypnotic, and antipsychotic drugs (de Groot, Al‐Fattal&Sandven, 2019). Other factors are balance, age of the patient, and sex. The balance was the most significant risk factors for falls. Factors that lead to poor balance may consist of lower extremity functions, muscle activation patterns, and gait speed. Also, Najafpour, Yaseri, and Arab conducted a study to examine the most significant risk factors of hospital-related falls. Their findings were that longer hospital stays, use of chemotherapy drugs, anticonvulsants, and sedatives, balance, cancer, and urinary incontinences were the most important factors.

They recommended that nurses should consider medication history and patient-related factors to prevent hospital falls (Najafpour, Godarzi, Arab &Yaseri, 2019). Lipschuetz asserts that many hospitals have put efforts to prevent falls among patients during hospitalization. These efforts are based on key risk factors such as toileting, falls history, mobility, and medication therapy. Also, falls increase the economic burden per patients due to injuries. According to Morris and O’Riordan, hospital falls lead to loss of confidence, prolonged stays in the hospital and recovery delays(Morris &O’Riordan, 2017). They suggest that some of the effective measures of reducing falls are using spectacles, minimizing clutter, and hearing aids.

**Quality Improvement Process**

 Plan Do Study Act or the model for improvement is a great quality improvement process for reducing hospital falls. This model employs various cycles that test changes, which may improve the problem. The model involves four stages, which include planning, doing, studying, and acting. The four stages guide the process of thinking and break down the task into phases then evaluates the outcome, improve it, and test it again. Plan Do Study Act model or the model for improvement is a simple process but it is powerful in accelerating quality improvement. The fundamental concerns for this model include the aim that the healthcare wants to achieve, measuring the process and outcome, identifying the changes that will lead to improvement, and what healthcare intends to test.

 The quality improvement tool for quality improvement plan will include the use of a run chart, which involves plotting data against time to establish patterns or trends. Run charts are useful because they show how the process trends or patterns are running. The model for improvement process is beneficial for dealing with hospital falls because it creates flexibility. The testing stage allows for adaptation to changes in the local conditions even in challenging and new environments. It is impossible to determine the effects of a change before its implementation therefore, testing an idea in small scales will facilitate its implementation in larger scales. It also identifies side effects because an action may have opposite reactions. Using this model will indicate if it is essential to address the side effects thus, minimizing costs and risks.

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