REDUCING PATIENT FALLS

INTRODUCTION:

Falls are a serious healthcare issue and can cause injury and even death. However many a times falls are Preventable. Fall prevention has therefore been recognized as an important area for research and intervention. Due to the prevalence of falls in hospitals around the world, the Joint Commission International (JCI), World Health Organization (WHO), and other agencies have made fall prevention a priority in ensuring patient safety.

RATIONALE:

Falls are a common cause of morbidity and the leading cause of nonfatal injuries and trauma-related hospitalizations. Falls occur in all types of healthcare institutions and to all patient populations. In hospitals, falls consistently make up the largest single category of reported incidents. The goal of this study is to analyse the number of hospital falls and actions taken by the hospital to decrease the number and severity of inpatient falls and to assess the high risk patient group and to recommend suggestions to decrease the falls among them.

OBJECTIVE:

1.Analysis of patient falls and fall prevention programs.
2.To assess the reasons resulting patient falls.
3.To assess high risk patient groups in various age.

METHODOLOGY:

*Type of study: Retrospective / Non interventional study.

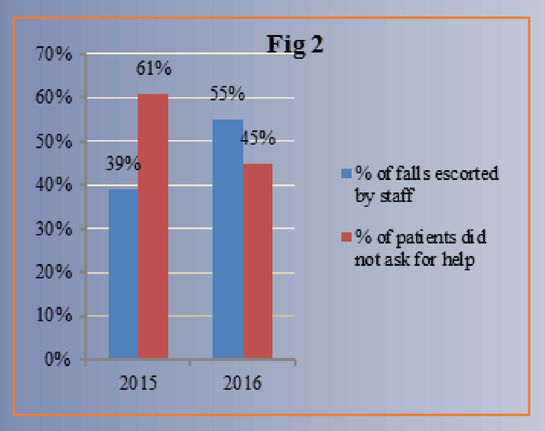
*Sample population: The study is conducted among the in patients (Jan'2015– Dec'2016)

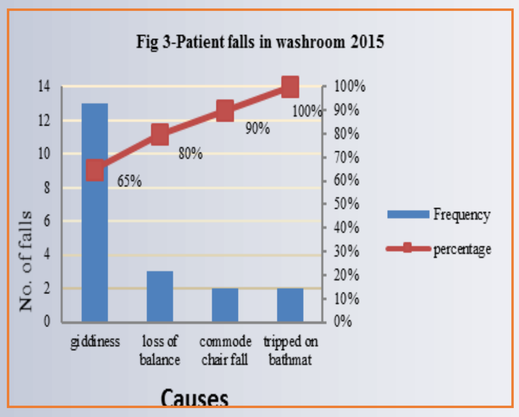
*Study design and Sample size - Secondary data (Quantitative), 71 in patients.

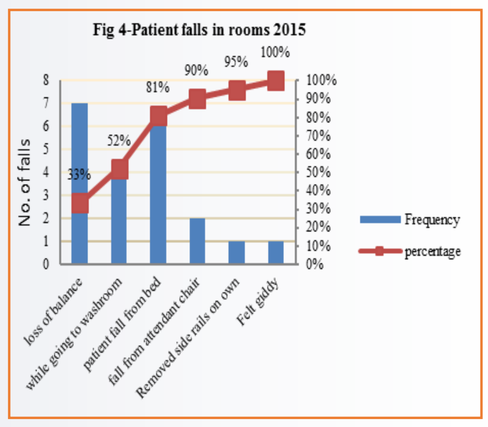
*Data analysis- dUsing tables, bar graphs, fish bone analysis and pareto analysis.

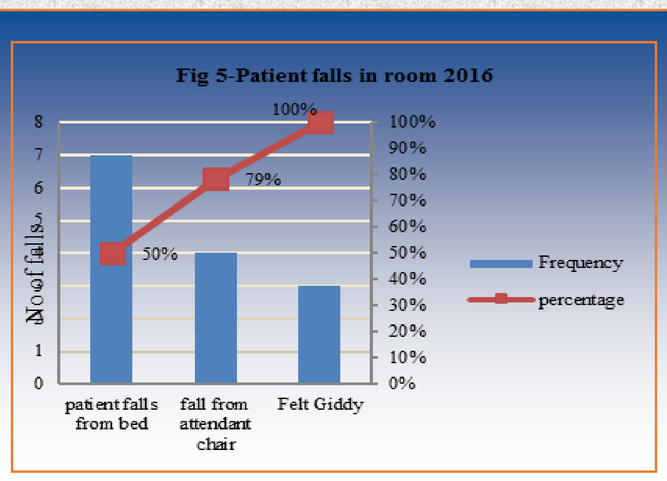
FINDINGS:

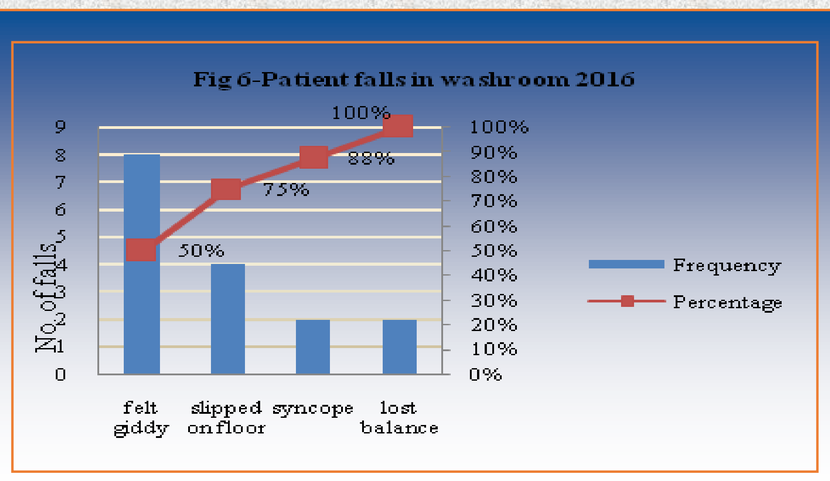
Falls	Falls in the room	Falls in the bathrooms	Total falls
2015	21 (51%)	20 (49%)	41
2016	14 (47%)	16 (53%)	30

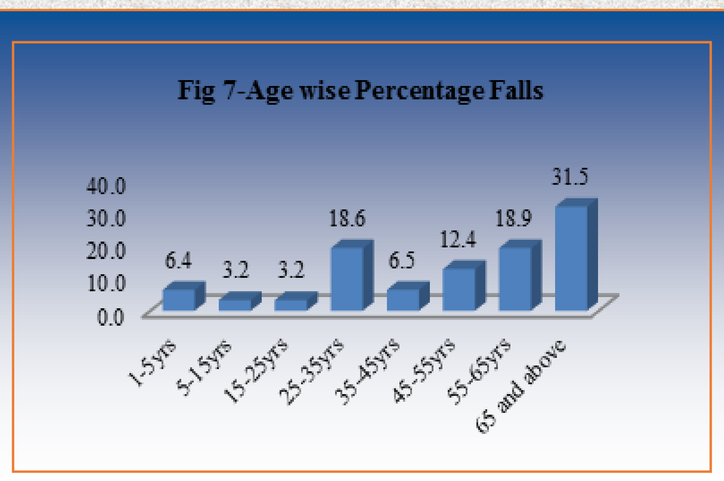








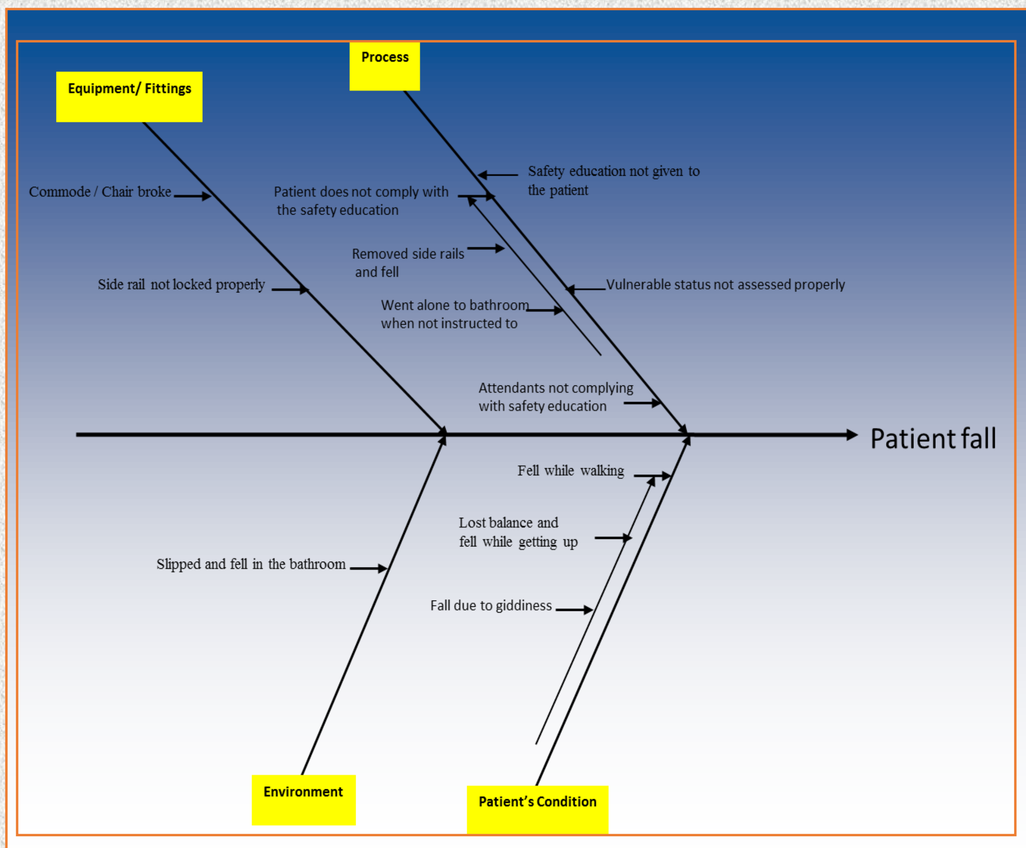




KEY FINDINGS:

1.Falls in the rooms were reduced from 21 in 2015 to 14 in 2016 and the falls in the bathroom was reduced from 20 in 2015 to 16 in 2016. (Ref Fig-1)
2.In 2015 out of the 41 total falls 39% of the patients were escorted by the staff and 61% patients did not call for help. (Fig-2)
3.In 2016 out of the 30 total falls 55% of the patients were escorted by the staff and 45% patients did not ask for help. (Fig-2)
4.In 2015 80% of the washroom falls were due to giddiness and loss of balance. (Fig-3)
5.In 2016 75% of the washroom falls were due to giddiness and slipped on floor. (Fig-6)
6.In 2015 81% of the falls inside the rooms were due of loss of balance ,while going to the washroom and fall from bed (Fig-4)
7.In 2016 79% of the falls were due to patient falls from bed and fall from attendant chair. (Fig-5)
8.When the falls were analyzed according to the age of the patients, the highest risk group of patients were 65 above i.e. 31.5% (Fig 7)

As per the findings it is clear that the factors differ with each fall, following are the actions taken by the hospital regarding the same.



Fall reason	No of falls	Action taken
Loss of balance	12	Monitoring of vitals on regular intervals, purple wrist bands tied on such patients.
While going to washroom	4	Keeping the floor dry & usage of wet floor signage
Fall from attendant chair	6	Patient attendant made to sign on the document after fall education impacted by the nurse.
Removed side rails on own	1	Posters for safety put up across the patient rest rooms and launch of audio visuals on patient falls to sensitize the patients.
Felt giddy	25	List of drugs which results in patient falls is updated and training intensified to the staff for patient safety.
Commode chair broke	2	Engineer department is responsible for such falls, proper explanation asked for such incidents and regular maintenance is done.
Tripped on bathmat	2	Change of non slip bathmats
Syncope	2	Training was given to nurses and housekeepers to manage patient deterioration.
Slipped on floor	4	Anti-skid application on bathroom floors.
Patient fall from bed	13	Regular visit to the patient rooms to see if the bed rails are down and Falls Prevention Flipcharts in different languages (English, Hindi and Arabic) being used as a tool by the nursing for education of patients.

RECOMMENDATIONS FOR HIGH RISK PATIENTS:

1.Train them to use appropriate assistive device such as cane or walker.
2.Provide professionally supervised balance and gait training and muscle strengthening exercise within the hospital.
3.Provide wrist bands with censors to the elderly patients which will alert near by staff that the patient is attempting to leave the bed.
4.Removal of foot rugs , change to safer footwear ,use of lightening at night and addition of stair rails.
5. Install bed side alarms and on the floor which will start ringing when the fall will occur.

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