Fall Prevention

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Fall Prevention

The main goal of this paper is to present an evidence-based proposal project. One of the most costly adverse events in health care provision is falls and in particular falls with injuries. Even though it is practically impossible to prevent falls from occurring, it is possible to accurately assess an individual's risk level for falls. Through the use of Hester Davis Scale for Falls Risk Assessment (HDS), we can actually reduce the rate of falls, especially the rate of falls with injuries. In a collaborative effort with the Hester Davis team to implement the HDS, The Residences of United Home Care ALF located at West Kendall area, Miami, Florida intends to see a decrease in all falls with particular emphasis on falls with injury. In this paper, we will discuss the implementation plan, present supportive evidence-based literature and give more information on the topic, as required.

Problem Description

A fall can be described as unexpected contact with a lower surface. Falls remains a major priority initiative in the field of healthcare. According to the Agency for Healthcare Research and Quality (AHRQ) (2015) falls have serious implications regardless of the setting, particularly for the elderly individuals. The Centers for Disease Control and Prevention (2016) states that out of five falls one

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have shown that in-patient multifaceted programs effectively decrease falls (Corbacho et al., 2018). In another study, they identify themes that are linked to the successful implementation of fall prevention programs: leadership support, education and training, creation of a multidisciplinary team, and a change of individual attitudes in relation to falls (Miake-Lye, Hempel, Ganz, and Shekelle, 2013)

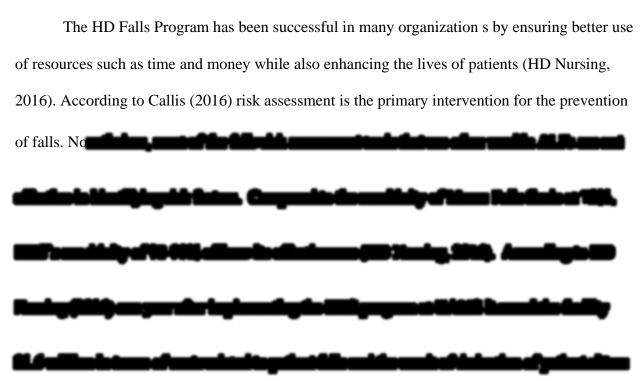
Recent studies

The risk assessment of falls in considered essential for any fall prevention program because they help in identifying individuals who are at risk (Leep Hunderfund, Sweeney, Mandrekar, Johnson, & Britton, 2011). The scale that is currently being used was not accurately identifying at risk residents. The Hester Davis Scale has been assessed and endorsed for implementation in clinical practice (Hester and Davis, 2013). It recommends interventions in the plan of care to help in reducing the potentiality for falls and reducing the risk of injury from falls. Some of the interventions in the scale are bed alarms, chair alarms, fall mats, and rounding of residents. By adhering to the recommendations in the plan of care, not only will the rate of residents fall decrease, the risk of injury from falls will also go down. Evidently, the population in this setting has changed and there is a need to shift from the falls bundle that is currently being utilized.

Description of the Proposed Solution

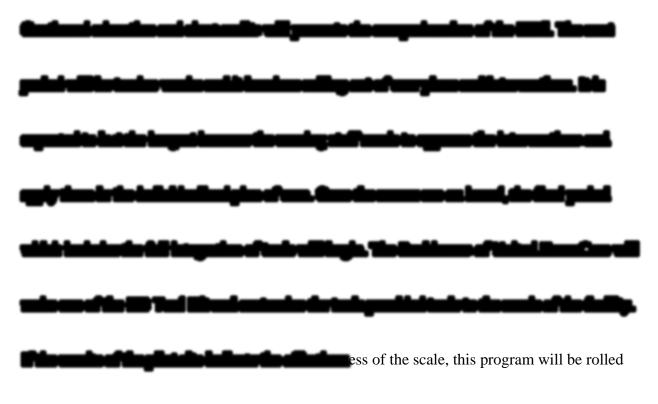
Falls can be prevented through a strategic plan that involves the inter-professional multidisciplinary teams and avails the needed tools. The main goal of the care team is ensuring residents' safety. The proposed solution for this problem is to implement, compare, and evaluate the efficacy of both scales in clinical practice applying one scale (falls bundle) to 1st and 2nd floors and the other scale (HPS) to the 3rd and 4th floors to compare and evaluate which scale would better at reducing falls and the risk of injury from falls in this 155-suite ALF.

The HPS was created at the University of Arkansas Medical Center (UAMS) over a period of four years by Dr. Amy Hester and Dees Davis. It is based on three core principles: predict, prevent, and sustain. As a predictor, the HDS is utilized in the assessment of patients based on several criteria facilitating individualized care plans. In prevention, the HDS provides specific interventions that enable the identification of the risk factors of a patient based on assessment. Through education and training the HDS Tool Kit can be used to sustain falls.



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out in the four floors.

The successful implementation of the HDS program will not only enhance the quality of care at the facility, it will also improve skills and competencies of the nursing staff. A change in the model of falls risk assessment and interventions enhance the efficiency of processes. Chair alarms, bed alarms, and fall mats will be rolled out to all floors within the ALD and stored safely. The program is entirely centered on the residents and it will ensure the provision of quality, patient-centered, safe care.

Literature that Supports the Project

Fall preventions remain a major priority for assisted living facilities across the United States. While it might not be possible to reduce the fall rate to zero, it is important to minimize the potentiality of falls. Falls are the most frequently reported adverse effect in health facilities. According to Mitchell ((2015), about 30-50% of adverse events related to falls result in injuries. The ideal situation would be the elimination of falls but even with all the provided tools, it looks

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like the process of preventing falls is not effective. Instead of concentrating on patients at risk of falls, healthcare professionals need to pay close attention to the risk of injury if a fall occurs. This merit safeguards the residents and protects them from injury. The Hester Davis Scale for Falls Risk Assessment is one of the tools that have helped in the identification of patients who are at risk of falls.

Searching for reliable and appropriate literature is time consuming but it is the only way to complete an evidence-based project. The nursing databases that were used for the literature search were PubMed, CINAHL, and COCHRANE. The keywords that were utilized during the search process include "Amy Hester, Dee Davis", "Fall Risk Assessment", "Fall Risk Scale", "Fall Prevention" and "Fall interventions."

In her article, Dupins (2014) presents her conversation with the creators of HDS, Hester and Davis. Both of them work at the UAMS and they have developed a tool for the assessment of falls and the risk of patients falls. According to Dupins (2016), the implementation of the HDS program at UAMS reduced the rate of falls by 11%,, lowered the falls with injuries by 60%, and are still instigating improvements. Through the enhancements in the processes of fall prevention they were able to save the hospital \$1.27 million in fall-related costs, and they also saved \$330,000in sitter costs (Dupins, 2016).

In another article, Cummins (2015) supports the adoption of the HDS at UMMC. They began using the HDS in 2012 and they developed individualized care plans based on the nurses' documentation. UMMC had received a rating of 10 by the Centers for Medicare and Medicaid Services on severe patient complications based on data from the previous two years. They made a decision to proactively and aggressively work towards the reduction of falls incidence using the HDS. Cummins (2015) reports that since the adoption of HDS at the hospital had led to a

massive decrease in falls with injury. The University of Mississippi Medical Center chose to use this scale since it evidence-based and it has been proven through research.

In their article, Miake-Lye, Hempel, Ganz, and Shekelle, (2013) addressed the problem of falls in acute care settings. The study found out that the use of multifaceted interventions can decrease the risk of falls by up to 30%. Some of their recommendations include patient risk assessments, signage, patients and staff education, non-skid footwear, and wristband alerts (Miake-Lye, Hempel, Cando Cando

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The Floor Administrators will be initially trained on appropriate documentation in the HDS and the proper inventions outlined in the care plans. A training program that can be used on a computer has been set up in the facility's website. The staff members are asked to review the available evidence and the floor administrators will move around the floors to help the staff with training. The staff members have been familiarized with the fall mats and chair alarm, they know where they are stored, and they have been trained on when and how to use them.

All falls in the ASL will be monitored by the IT professional who will create spreadsheets that outline information about the causes of a fall. In the event of a fall, the Risk Management and the Improvement Advisor will monitor the StatIt reports. The two reports are shared and discussed among the main stakeholders during the weekly videoconference meetings. By training the Floor Administrators, we hope to mitigate any barriers that may arise in the course of implementation. The weekly videoconference meetings provide a venue for addressing possible challenges or barriers and the Hester Davis team will provide guidance on how to handle them.

The implementation plan is feasible. At the same time, there are increased costs linked to the involvement of floor administrators. These are individuals whose services are vital and for every minute that they spend training rather that working on the floor is viewed as additional fees. Since they are in charge of the floors and they play a significant role in the process, their fees and hours linked to the training have been pre-approved. In this paper, we present a practice of the change project. Hence, using the information that will be acquired in the course of the process, the small tests of change will be re-examined and changes will be implemented based on the gathered information. To ensure the sustenance of the changes in the facility, a dashboard will be created on the website to check if everyone in the floor is using the HDS for documentation. It will also allow the managers to gain insights into the process and the proper documentation of falls.

Change Model

The successful implementation of any change project in an organization requires one to refer to a change theory or model. For the purpose of this paper, we will use the Iowa Model, which is an evidence-based practice model to explain the change process. This change model starts with a trigger, which can be problem focused or knowledge focused. Just like any other change model, an evaluation of the outcomes will be performed and the information will be disseminated. The Iowa

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Evaluation Plan

The process of evaluation consists of data collection methods, examining the outcome measures in relation to the goals of the project, identifying how the outcomes will be measured

with regards to reliability, validity, and applicability, and outlining the implications for practice and future research.

One needs to gather data and information in order to determine if an intervention is working. An accurate data collection method is essential to maintain the integrity of the research. In this project, both qualitative and quantitative data will be collected. This is referred to as mixed method approach. Quantitative data in measuring falls with will be obtained from the risk assessment program whereas the electronic health record will provide both qualitative and quantitative data. The qualitative data will be in the form of the interventions utilized in the plan of care. The fall risk scores of the residents will provide quantitative data.

The objectives of the project must be measured to establish if the intended outcomes are accomplished. To appropriately measure the outcomes of a project, there is a need to formulate questions to address the outcomes that are desired. In our project, one would want to know if the interventions resulted to a reduction in rates of falls as well as rates of fall-related injury, thereby promoting patient safety (Joint Commission, 2011). The other measurement that will have to be addressed is whether the appropriate interventions have been used with reference to the resident's fall risk score.

The appraisal phase involves the determination of reliability, validity, and applicability. According to Heale, and Twycross (2015), reliability is the likelihood of a study reporting something that is reproducible. Continuous used of the HDS and correlated tools will provide the reliability. Validity is defined as the degree to which the study findings are likely to be unbiased. This information was documented with close supervision thus the information is free from bias. The StatIt report and calnoc data will be used to determine the validity. Applicability is the degree to which the results are likely to have an impact of practice. It will be determined through continued used and positive outcomes.

In this research, we found out that when the HDS is used properly it can be used to accurate determine a resident's risk for falls. If the HDS is successfully implemented, the tool will be rolled out to all the floors in the ASL. This should decrease the rate of falls and falls with injury thus enhancing patient safety. The HDS is still work in progress and it continues to be restructured and there is a research team exclusively devoted to further studies. The team will continue monitoring the usage and viability of the HDS.

Conclusion

References

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