Decreasing Falls

[Name of the Writer]

[Name of the Institution]

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One thing that is not being given enough concentration and effort is that how the fall prevention is supposed to be carried out at the healthcare organizations. One of the reasons that there is lack of attention towards the given subject is due to the fact that there are not many people who are aware of the fact that what sort of impact falls are going to have over the healthcare output of the organization as well as the patient safety. At the same time, the healthcare organizations are quite sceptical when it comes to determining the effects of the fall and how they are bound to have an impact over the long-term health of different stakeholders. The other thing that is quite important that what are some of the strategies that can be implemented in the organization so that such incidents are avoided in the organization.

# Goal of the Project

 This project is going to look at the host of the various strategies that can be used by the healthcare organizations to make sure that how falls are supposed to be decreased in the organization. Not only that, it also goes a long way towards making sure that how the falls are going to be brought down as well as making sure that the staff is also made aware of the impact of the fall and how it affects the organization one way or the another. Preventing hospital falls and injuries requires knowledge of fall and injury circumstances. Our objectives were to determine whether reported fall circumstances differ among hospitals and to identify predictors of fall-related injury.

# Long Term Objectives of the Project

 As the goals of the project are clear now, following are some of the underlying objectives that are going to be achieved during the course of the project.

* Identification of some of the ways that can be implemented to make sure that the fall care processes are being identified and how educational and quality improvement tools can be used at the workplace
* Furthermore, coming up with the ways through which the patient, families and the organization come with the strategies to mitigate such incidents at the workplace
* Development of an interdisciplinary fall reduction mechanism whose idea is going to be to make sure that how fall incidents are going to be controlled in the organization

# Literature Review

 There is considerable literature that tends to point towards the fact that how mitigation strategies can be developed at the level of the healthcare institute and what role healthcare stakeholders can play to make sure that the reduction of such issues can be carried out at the first place. The initiative that is being taken by the healthcare organizations these days is called the STEADI initiative. The idea behind this initiative is to make sure that the multi factor approach is being developed to make sure that the fall prevention mechanism can be developed at the first place. The idea is to make sure that the correct screening method has to be determined for the fall management. Not only that, effort is also needed to be made to make sure that the screening of the fall risk is done in the manner that the assessment of the risk factors is being done at the level of the organization in the manner that the considerable leeway has to be there in terms of how fall management is going to be done. The other aspect of the STEADI initiative is to make sure that there has to be evidence-based interventions to make sure that the fall risk that is being faced by the stakeholder is being taken care off at the given moment of time. The fall research screening is something that is also needed to be carried out at the level of the healthcare centres to make sure that the prevalence of such incidents is being avoided all the time. For instance, the researchers have been able to find the underlying evidence that how the older adults who are in the position to make sure that the FPOC assessment is being done in the right manner. The odds of the fall are another thing that has to be kept in mind. Specially in the case where the likelihood is on the lower side where the fall prevalence is going to be having a significant injury to the person who is affected by the fall at any particular point of time. Thus, risk management is something that is needed to be carried out by the healthcare workers all the time. These days, it is quite common among hospitals and the healthcare centres to come up with their own effort to reduce the prevalence of such incidents. The first thing that is needed to be done is to ensure that what are some of the workplace hazards and the identification of such incidents has to be done. Lighting up the workplace and adherence to OSHA standards in the long run is bound to go long way towards improving such situation. System wise changes as per literature evidence is something that has to be done to stop the prevalence of such incidents.

# Methodology

 The methodology that is going to be used during the course of this research would be based on the premise that how the objectives of the research that are spelled out earlier can be achieved. The idea must be to make sure that the secondary sources and literature reviews are read about and some insight is being developed regarding how this whole process of falls being avoided and the intervention is going to be used is going to be done. The sources that are going to be used in this research would be primarily based on the texts that I would be obtaining from my school library. Some other articles are going to be taken from the scholarly websites. The nature of the research is that the secondary resources are going to be used quite extensively so effort is going to be made to make sure that validity is being provided to the research.

# Resources Used During the Project

 The technical resource that is going to be used during the course of this project is going to be about making sure that the focus is carried out towards the potential solutions so different scholarly libraries are going to be used. The secondary research as well as going by the past interventions would be the way forward when coming up with ways through which the falls are going to be detected and level of control is going to be brought at the workplace. Some solutions are quite easy to install, and the idea would be look at the solutions that fit with the underlying ideology of the organization. Retrospective cohort study. Adverse event data on falls were compared according to hospital characteristics. Logistic regression was used to determine adjusted odds ratios (aORs) with 95% confidence intervals (CIs) for risk factors for fall-related injury. Some fall characteristics differed by hospital type. Further research is necessary to determine whether differences reflect true differences or merely differences in reporting practices. Fall prevention programs should target falls involving older patients, unassisted falls, and falls that occur in the patient's bathroom and in patient care areas outside of the patient's room to reduce injuries.

**References**

Bouldin, E. D., Andresen, E. M., Dunton, N. E., Simon, M., Waters, T. M., Liu, M., ... & Shorr, R. I. (2013). Falls among adult patients hospitalized in the United States: prevalence and trends. *Journal of patient safety*, *9*(1), 13.

Coussement, J., De Paepe, L., Schwendimann, R., Denhaerynck, K., Dejaeger, E., & Milisen, K. (2018). Interventions for preventing falls in acute‐and chronic‐care hospitals: a systematic review and meta‐analysis. *Journal of the American Geriatrics society*, *56*(1), 29-36.

Krauss, M. J., Nguyen, S. L., Dunagan, W. C., Birge, S., Costantinou, E., Johnson, S., ... & Fraser, V. J. (2017). Circumstances of patient falls and injuries in 9 hospitals in a midwestern healthcare system. *Infection Control & Hospital Epidemiology*, *28*(5), 544-550.

Mahoney, J. E. (2018). Immobility and falls. *Clinics in geriatric medicine*, *14*(4), 699-726.

Oliver, D., Healey, F., & Haines, T. P. (2017). Preventing falls and fall-related injuries in hospitals. *Clinics in geriatric medicine*, *26*(4), 645-692.