International Journal of Current Science Research and Review
ISSN: 2581-8341
Volume 07 Issue 08 August 2024
DOI: 10.47191/ijcsrr/V7-i8-68, Impact Factor: 7.943
IJCSRR @ 2024
www.ijcsrr.org

Evaluation of Prevention of Patients at Risk of Falls in Nurses in Inpatient Department: A Qualitative Case Study

Diana Helen Cantika[1], Bayu Anggileo Pramesona[2], Betta Kurniawan[3]
[1,2,3] Master of Public Health Program, Faculty of Medicine, Universitas Lampung
Jl. Soemantri Brodjonegoro 1, Bandar Lampung, 35145, Lampung, Indonesia

ABSTRACT: Patient safety is an essential component of quality health services. However, patient care still has shortcomings, especially in patient safety incidents such as patients being injured due to falls. This study aimed to evaluate the implementation of prevention for patients at risk of falling in nurses in the inpatient department in a hospital setting. This qualitative research with a case study approach was conducted from February to April 2024 in a government hospital in Lampung, Indonesia. A total of 20 informants consisting of 10 implementing nurses as the primary informants, one head of nursing, one secretary of the Committee for Improving Quality and Patient Safety, five heads of inpatient rooms, and three patients at risk of falling as supporting informants were recruited purposively. In-depth interviews, Focus Group Discussions, and observations were conducted for data collection. Thematic analysis was used for data analysis. The implementation of prevention of patients at risk of falling in nurses in the inpatient department has been employed in the form of providing facilities, facilities, and completeness of the assessment form for patients at risk of falling, and the existence of standard operational procedures on prevention of patients at risk of falling. However, some of the available facilities are damaged and must be repaired. In addition, some nurses still need to learn how to conduct a fall risk assessment. It is recommended that the director and hospital management immediately improve facilities to support the implementation of fall risk prevention and that there be regular training for all nurses related to filling out fall risk assessments in the hospital.

KEYWORDS: Evaluation, Nurses, Patient, Patient at fall risk, Prevention.

INTRODUCTION

The patient safety program is a system that ensures that hospitals make patient care or health services safer. Patient safety is related to patient care, incidents that can be avoided or should not have happened, and has been considered a discipline. However, the quality of service still has shortcomings in patient care, especially in patient safety incidents such as patients being injured due to falls. (Kementerian Kesehatan RI, 2015). Fall risk is an increased chance of falling that can cause physical injury. Fall risk is a patient at risk of falling, generally caused by environmental and physiological factors that can result in injury. The fall risk category is divided into three, namely low fall risk, moderate fall risk, and high fall risk. The cause of fall risk can be caused by intrinsic factors such as a history of previous falls, decreased visual acuity, behavior and walking posture, musculoskeletal system, mental status, acute illness, and chronic illness. Extrinsic factors include medication, bathroom, building design, floor surface conditions, and lack of lighting. The consequences of a fall incident can cause unexpected events such as lacerations, fractures, head injuries, bleeding to death, psychological trauma, prolonged treatment time, and increasing patient care costs due to using diagnostic equipment that is unnecessary, such as CT Scans, X-rays, and others. Injuries caused by falls are a common patient safety problem. Any patient of any age or physical ability, physiological changes due to medical conditions, medications, surgery, procedures, or diagnostic testing that may leave them weak or confused can be at risk of falling (Joint Commission International, 2015).

Patient falls are a global problem in hospitals experienced by almost all countries. Hundreds of thousands of patients fall in the United States each year, and 30-50% result in injury. Falls can impact the length of hospital stay and increase costs because injured patients who fall require additional care and sometimes prolonged hospitalization. Data shows that falls with injury can add 6.3 additional days of hospitalization, and the average cost incurred for falls with injury is approximately $14,000 (Joint Commission International, 2015). Another study in the United States found that falls occurred in as many as 315,817 in or an average of 3.56 falls/1000 occupied bed days, and there were 82,332 (26.1%) cases of falls resulting in injury or an average of 0.93/1000 (Bouldin et al, 2013). Another study in Australia stated that the incidence of hospitalization for the elderly continues to increase by 2.3% per year.

International Journal of Current Science Research and Review
ISSN: 2581-8341
Volume 07 Issue 08 August 2024
DOI: 10.47191/ijcsrr/V7-i8-68, Impact Factor: 7.943
IJCSRR @ 2024
www.ijcsrr.org

More than 27,000 falls resulted in injury to patients that occurred in the health service area or 3.0/1000. More falls were reported in public hospitals 4.0/1000 than in private hospitals, with 1.5/1000 occupied bed days (Stephenson et al, 2016).

The incidence of patient falls in Indonesia is also a problem in almost all hospitals based on data obtained in 2012, including the top three patient safety incidents; data from the report shows that there were 34 cases, or equivalent to 14% of incidents of falls in hospitals in Indonesia. Based on the report, it is known that the incidence of patient falls is still high compared to hospital accreditation standards, which stipulate that the incidence of patient falls must be at 0% or there will be no falls in the hospital. The minimum service standards also state no patient falls, as stated in KMK No. 129 of 2008. In addition, the prevention of patient falls is a mandatory national quality indicator set by the Ministry of the Republic of Indonesia (Kongres PERSI, 2012).

Patient falls are a challenge for healthcare facilities worldwide due to the high volume, risk, and costs involved. Hospitals face severe financial consequences if they do not have measures to prevent patient falls. Another study reported in 2012 at the Islamic Hospital UNISMA Malang obtained data that the incidence of patient falls was still ranked fourth of all unexpected events (Budiono, 2014). Data on patient safety incidents at Hospital X Kendari in 2012, namely patients falling from bed in 12 cases and in the bathroom in 3 cases (Pagala et al, 2017). Meanwhile, according to the report on patient safety incidents in 2018 at the Type B Teaching Hospital in Wates City, there were 11 incidents of patient falls out of 66 patient safety incidents, or there were 16.7% of incidents of patient falls from the total incidents in 2018 (Budi et al, 2019).

Based on the accreditation standards on patient safety targets in the sixth assessment element, it is determined that there must be regulations governing the prevention of patient injuries due to falls that require hospitals to carry out an assessment process for all inpatients and outpatients with conditions, diagnoses, and locations indicated as high risk of falling by the regulations. The hospital carries out the initial assessment process, follow-up assessment, and re-assessment of inpatients based on records of identified fall risks. Meanwhile, for inpatients, based on records of identified fall risks, steps are taken to reduce the risk of falls for patients from situations and locations that cause patients to fall (Sutoto et al, 2018).

Nursing staff are among the health workers who play an essential role in improving health and are the backbone of service facilities because their numbers are greater than those of other health workers. Nurses have a central role as caregivers, who are actively involved for 24 hours in providing nursing care to patients. Work guidelines guide nurses' behavior at work. In addition to standard operating procedures (SOP) and nursing care standards (SAK) as guidelines for nurses at work, nurse safety guidelines are needed to guide nurses to behave safely and securely at work. Therefore, safety protocols for nurses and patients must be followed and practiced correctly. Fatigue in nurses can affect wherever they work. In addition to causing work accidents, fatigue can cause nurses to make mistakes in work procedures. As a result, fatigue in nurses can harm patients, reducing the assessment of the health services provided, increasing the risk of errors, patient falls, injuries, irregular nursing care, poor communication, and lack of continuity in care (Sitorus, 2023).

Several studies have shown that hospital falls are often caused by nurses' non-compliance in implementing fall prevention protocols set as accreditation standards. One study proved that nurses who did not implement the initial assessment SOP 60% and 100% did not carry out a re-assessment in 2016 at the x Surabaya Hospital (Jati, 2018). Another study stated that the frequency of nurses who did not comply with implementing the SOP for the risk of patients falling was 60.4% nurses compared to nurses who complied with implementing the SOP for the risk of patients falling, which was 39.6% (Pagala et al, 2017). Strategies to improve nurse compliance in implementing patient fall prevention can be improved through several efforts, including monitoring nurse compliance, auditing and feedback on implementing patient fall prevention interventions, leadership, providing education to staff, and using information systems (Miake-Lye et al, 2013). However, although various strategies have been implemented, patient falls still occur frequently, especially in government hospitals. This study aims to evaluate the implementation of prevention of patients at risk of falling in nurses in inpatient installations in hospital settings.

METHODS

This qualitative research with a case study approach was conducted from February to April 2024 in a government hospital in Lampung, Indonesia. A total of 20 informants consisting of 10 implementing nurses as the primary informants, one head of nursing, one secretary of the quality improvement and patient safety committee, five heads of inpatient rooms, and three patients at risk of falling as supporting informants were recruited purposively. The inclusion criteria in this study were: 1) informants working as implementing nurses in inpatient installations with a minimum work period of 1 year, 2) having a minimum education of a Diploma,

International Journal of Current Science Research and Review
ISSN: 2581-8341
Volume 07 Issue 08 August 2024
DOI: 10.47191/ijcsrr/V7-i8-68, Impact Factor: 7.943
IJCSRR @ 2024
www.ijcsrr.org

and 3) patients with a moderate and high risk of falling status. The exclusion criteria include 1) informants who quit during the research process and 2) informants who were on leave, sick, or unable to attend when data collection was carried out. In-depth interviews, Focus Group Discussions, and observations were conducted for data collection. In-depth interviews in this study were conducted with informants face-to-face, including the Head of Nursing, Secretary of the quality improvement and patient safety committee, nurses, and patients at risk of falling as many as three people for 30-45 minutes per person. The researcher conducted interviews in the workroom and inpatient room in a calm atmosphere. Meanwhile, FGD was conducted in the hospital hall for about 50-60 minutes with five heads of rooms. The researcher also collected data through observation and documentation studies. Thematic analysis was used for data analysis.

RESULTS

1. Indepth Interviews

In-depth interviews were conducted with several informants, including the head of nursing, the secretary of the quality improvement and patient safety committee, frontline nurses, and patients at risk of falling. The following are the results of interviews conducted by researchers with informants.

Table 1. Results of interviews with informants (n = 10)

Question	Quotes	Conclusion
What are the risk factors for falls in hospitalized patients?	**Head of Nursing Department** *"More from the patient's factors such as advanced age, history of previous falls, muscle weakness, balance problems, reduced vision, postural hypotension, chronic medical conditions such as arthritis, diabetes, stroke, Parkinson's. External factors from the patient are the lack of handrails on the stairs and inappropriate stair design".* **Secretary of the committee for improving quality and patient safety** *"So far, what has happened is a result of factors from the patient himself, such as weakness in the muscles, especially the leg muscles".* **Frontline nurses** *"This factor is usually found in elderly patients, where the reflexes of an elderly person will decrease compared to previous ages so that it will be difficult to balance themselves when they are about to fall and the use of slippery or too high footwear when walking can also cause a person or patient to fall." (Informant 1)* *"Like the balance factor, it is found in patients with neurological disorders, arthritis, and certain types of treatment." (Informant 4)*	The results of the interview showed that cases of patients falling were more likely to occur due to factors such as elderly patients, previous history of falls, muscle weakness, balance problems, reduced vision, postural hypotension, chronic medical conditions such as arthritis, diabetes, stroke, Parkinson's, incontinence, and dementia, as well as the patient's worry or fear of falling incidents. At the same time, external factors from the patient include the lack of handrails on the stairs and inappropriate stair design.
How do nurses in hospitals prevent falls in outpatients? What are the results so far?	**Head of Nursing Department** *"Each bed has a side rail. Then, for each room, there is also a handle. The bathroom also has a handle; the floor is smooth. If mopping is being done, there must be a safety triangle".*	The interview results showed that standardization in the inpatient room already exists; the standardization applied is that there is no history of patient falls. Nurses on duty must prevent

International Journal of Current Science Research and Review
ISSN: 2581-8341
Volume 07 Issue 08 August 2024
DOI: 10.47191/ijcsrr/V7-i8-68, Impact Factor: 7.943
IJCSRR @ 2024
www.ijcsrr.org

Question	Quotes	Conclusion
	Secretary of the committee for improving quality and patient safety *"The handrail for the bathroom is already there, and the floor is also not slippery, then the cloth restraint in our place is also already there, the fall risk sticker is already there, the sticker must be attached to the patient's bed specifically for patients with a high risk of falling is also already there. We conduct a fall risk assessment when the patient first comes in. We have also done it."* **Frontline nurses** *"As a nurse, of course, when I receive a patient, I will immediately conduct a fall risk assessment within 1x24 hours, then when I conduct a fall risk assessment using Morse fall, there will be criteria and a score, then each score will indicate high risk, medium risk, and low risk" (Informant 2)* *"For fall risk, most are labeled high fall risk because most patients are post-operative. Then, for the bed side rails, all are there, even though our beds are still old.* *"Our floor is uneven, the type of ceramic is also slippery, and there are no non-slip sandal facilities for patients...." (Informant 3)* *"The nurse also gave me instructions not to move here and there so I do not fall" (Patient 1)*	the risk of falling for each patient being treated. Prevention is done by installing side rails and handrails in the treatment room and bathroom; the floor is made non-slippery. Cleaning staff install safety triangles or markers for slippery floor conditions when mopping.
Is there leadership support to prevent falls in hospitalized patients? What form of support, if any?	**Head of Nursing Department** "*This support is in the form of recommendations to nurses to conduct a fall risk assessment on each new patient and is carried out as an initial step in the procedure for preventing the risk of falling in patients."* **Secretary of the committee for improving quality and patient safety** "*Especially for the assessment of fall risk in new patients entering the treatment room, it is carried out within 1x24 hours so that preventive measures can be taken immediately based on the level of risk."* **Frontline nurses** *"The leadership always supports the prevention of incidents of falls in hospitalized patients. First, we help the patient, and then we review whether any direct consequences occur to the patient. After that, documentation, recording and then we discuss it with officers or fellow employees on the ward, then if we look for the core of the problem" (Informant 8)*	The interview results showed that the leadership supports the prevention of falls in hospitalized patients by providing SOPs, and nurses are expected to understand and implement them properly. First aid provided by nurses, if a patient falls, is to help the patient stand or sit and report to the patient safety target team, then re-assess the impact of the fall, and then carry out treatment or action if injured.

International Journal of Current Science Research and Review
ISSN: 2581-8341
Volume 07 Issue 08 August 2024
DOI: 10.47191/ijcsrr/V7-i8-68, Impact Factor: 7.943
IJCSRR @ 2024
www.ijcsrr.org

Question	Quotes	Conclusion
	"Maybe not everyone understands, especially for nurses who are new and have not been exposed to patient safety training." (Informant 6)	
What obstacles and challenges do health workers face to prevent falls in hospitalized patients?	**Head of Nursing Department** *"There are indeed constraints on facilities and infrastructure and also limited staffing. In addition to that, it is also the same as other rooms; we do not have facilities for patient bells and non-slip sandals."* **Secretary of the committee for improving quality and patient safety** *"To implement the risk of falling, there is a step for patients to get up and down, so we lack one step in each room. For other facilities, such as beds, the ones below often have problems with the side rails. As for the triangles installed on the bed, we initially had difficulty finding triangles for the patient's bed".* **Frontline nurses** *"For the assessment, God willing, we have done everything because, indeed, the form and so on have been provided by the hospital; the only obstacle in our place is because of the high mobility, new nurses who have not been trained in Patient Safety Training so they also do not understand. Then there is still a third of the beds in our place that do not have side rails" (Informant 9)* *"So for the patient room, there is already a footrest, and for the inhibiting factor, it is in the facilities, especially in the building. .... For other factors, there is a shortage of personnel, especially on the night shift." (Informant 10)*	The interview results showed that nurses tried to take preventive measures against fall risks, but they still experienced obstacles in their implementation. The obstacles experienced were related to the lack of supporting facilities and the lack of nursing staff, especially for night shifts. Some things that support nurses include several treatment rooms having diversional therapy and a fall risk prevention implementation form.
How is the monitoring and evaluation process in efforts to prevent patient falls in hospitals?	**Head of Nursing Department** *"The monitoring and evaluation process in efforts to prevent patients from falling in hospitals is always carried out"* **Secretary of the committee for improving quality and patient safety** "*Prevention is carried out based on SOP, a format is available for use by nurses and other officers, making it easier to implement prevention of the risk of patients falling".* **Frontline nurses** *"There is monitoring carried out by the leadership, not only nurses and patients but all those who are there from parking, to maybe cleaning services are also given education" (Informant 7)* *"Monitoring is carried out so that prevention of the risk of falling*	The interview results showed that nurses had a good perception regarding implementing fall risk prevention. Perception is a process in which a person selects, organizes, and interprets sensory stimuli into meaningful information about their work environment. Nurses understand that the risk of falling can be prevented by implementing reasonable hospital procedures. Nurses understand that every new

International Journal of Current Science Research and Review
ISSN: 2581-8341
Volume 07 Issue 08 August 2024
DOI: 10.47191/ijcsrr/V7-i8-68, Impact Factor: 7.943
IJCSRR @ 2024
www.ijcsrr.org

Question	Quotes	Conclusion
	becomes a shared responsibility because it indicates patient safety in the hospital. Primarily, we nurses are also responsible". (Informant 5)	patient must be assessed to determine their fall risk level. The patient's fall risk level is assessed using the Morse Fall Scale. The hospital also provides labels that nurses can use to indicate the patient's fall risk level and to conduct monitoring and evaluation.
Is there a standard operating procedure for managing fallen patients in this hospital?	**Head of Nursing Department** "*What we do first is help the patient, then we review whether any direct consequences occur to the patient. Maybe there are wounds, and so on; after that is handled, we re-educate the patient and family so that it does not happen again, then the third thing that follows is we evaluate what caused the fall, after that, maybe it is continued to documentation, recording and then we discuss it with the officers or fellow employees on the ward, then if we look for the core of the problem, if that is not possible, maybe we will also convey it to the patient safety target team*" **Secretary of the committee for improving quality and patient safety** *"There is an SOP: patients who fall are given treatment according to their condition, then the patient and family are re-educated so that no more falls occur. Incidents of patient falls are reported to the person in charge of the room to be made a written report as documentation, and the results are reported to the patient safety target team within 24 hours after the patient falls."* **Frontline nurses** *"Of course, there is an SOP in this hospital; immediately conduct a fall risk assessment within 1x 24 hours. Conducting a fall risk assessment using Morse fall, there will be criteria for each score, and each score will indicate high risk, medium risk, and low risk. Then, the task as a nurse, when it is final or has been calculated, is to enter the criteria, which is then education is carried out according to the findings of the Morse fall score". (Informant 1)* *"If a fall occurs after handling a patient, re-educate the patient and family so that no more falls occur; we nurses on duty at that time who encounter the fall incident will report to the person in charge of the room who handles the fall risk. later, after the report is made a written report and later reported to the patient safety target team that handles it, the reporting time is 1 x 24 hours" (Informant 4)*	The interview results showed that there is an SOP in preventing the risk of falling, and nurses are expected to understand and implement it well. First aid provided by nurses, if a patient falls, is to help the patient stand or sit and report to the patient safety target team, then re-assess the impact of the fall, and then carry out treatment/action if injured. The assessment results are documented as a form of evaluation so that it does not happen again in the same patient or other patients with the same condition. Nurses provide re-education to patients and families so that they can help in preventing the risk of falling. Nurses conduct an evaluation related to the cause of the patient falling; the results are documented and discussed with other officers, and the evaluation results are submitted to the patient safety team for follow-up.

International Journal of Current Science Research and Review
ISSN: 2581-8341
Volume 07 Issue 08 August 2024
DOI: 10.47191/ijcsrr/V7-i8-68, Impact Factor: 7.943
IJCSRR @ 2024
www.ijcsrr.org

Question	Quotes	Conclusion
	"The nurse also gave me directions not to fall during treatment" (Patient 2) *"The nurse gave directions so that unwanted things such as falls do not happen" (Patient 3)*	
How is the socialization, and is there any training related to the policy of preventing patients at risk of falling in this hospital?	**Head of Nursing Department** *"Re-socialization is needed; maybe the evaluation is not only in the form of re-socialization but also a provision of pre-test and post-test and evaluation."* **Secretary of the committee for improving quality and patient safety** *"Training related to the policy of preventing patients at risk of falling has been carried out for nurses".* **Frontline nurses** *"Training related to the policy of preventing patients at risk of falling is essential for nurses." (Informant 2)* *"I think training related to the policy of preventing patients at risk of falling in this hospital needs to be carried out. Hospital facilities also need to be improved because there are still damaged facilities that do not meet safety and security standards." (Informant 6)*	Training related to the policy of preventing patients at risk of falling at this hospital has been carried out so that the human resources of nurses will be better. Quality human resources are first in providing services, training is fulfilled, and education is also fulfilled.
What is the reporting process for adverse events, especially patient falls, at this hospital?	**Head of Nursing Department** *"If an incident occurs in the hospital, it must be followed up immediately (prevented/handled) to reduce the impact/unexpected consequences. After being followed up, immediately make an incident report by filling out the Incident Report Form at the end of working hours/shift to the immediate superior. (No later than 2 x 24 hours); do not delay the report. After completing the report, please submit it to the reporter's immediate superior. (The immediate superior is agreed upon according to the Management's decision: Supervisor/Head of Section/Installation/Department/ Unit, Head of the Medical Committee). The immediate superior will check the report and perform risk grading on the reported incident."* **Secretary of the committee for improving quality and patient safety** *"In practice, if a patient safety incident occurs, the hospital patient safety team follows the patient safety incident handling flow as follows: (1) every incident must be reported internally to the Patient Safety Team within a maximum of 2x24 (two times twenty-four) hours using a report format, (2) The hospital patient safety team verifies the report to ensure the truth of the incident, (3) after*	The interview results showed that reporting would begin the learning process to prevent the same incident from happening again. An incident reporting system was created in the hospital, including policies, reporting flows, reporting forms, and reporting procedures that must be socialized to all health workers. The reported incidents have occurred, have the potential to occur, or are close to occurring.

International Journal of Current Science Research and Review
ISSN: 2581-8341
Volume 07 Issue 08 August 2024
DOI: 10.47191/ijcsrr/V7-i8-68, Impact Factor: 7.943
IJCSRR @ 2024
www.ijcsrr.org

Question	Quotes	Conclusion
	verifying the report, the hospital patient safety team investigates the form of interviews and document examinations, (4) based on the results of the investigation, the patient safety team determines the degree of the incident (grading) and conducts a Root Cause Analysis using standard methods to determine the root of the problem, (5) The patient safety team must provide patient safety recommendations to the head of the health care facility based on the results of the Root Cause Analysis."	
	Frontline nurses *"All officers in each unit have been given socialization about reporting patient safety incidents. It is just that the understanding and sense of responsibility of each officer are different, especially if there is much work and too many report forms to fill out; they feel that it is an additional burden". (Informant 7)*	
	"Reporting of patient safety incidents based on the Hospital Patient Safety Committee is done internally and externally. Internal reporting is a report on incidents that occur in the hospital environment. External reporting is done from the hospital to the Hospital Patient Safety Committee. The results of reporting safety incidents are used for decision-making and learning. For the decision making to be right on target, an evaluation of patient safety incident reporting is needed." (Informant 3)	

2. *Focus Group Discussion* (FGD)

The results of the Focus Group Discussion (FGD) conducted by the researcher followed by the head of the inpatient room were conducted to find alternative solutions to the obstacles found during interviews, observations, documentation searches, and confirmation related to problems found during the research, including the completeness of supporting facilities for the implementation of prevention of patients at risk of falling, the completeness of SOPs for prevention of patients at risk of falling, implementation and documentation of prevention of patients at risk of falling.

Table 2. Focus Group Discussion Result

Question	*Coding*	*Selective Coding*
Are the supporting facilities incomplete in implementing prevention of patients at risk of falling?	1. Procurement of supporting facilities and infrastructure for the implementation of patient fall prevention is carried out before the implementation of the 2023 hospital accreditation assessment	Improving facilities and infrastructure to improve the quality of hospital health services
How complete is the SOP for the daily assessment form?	2. Patients treated in class 3 rooms are educated regarding non-slip footwear because management has been unable to budget for it.	Evaluation and monitoring in improving the quality of hospital services
How is the implementation and documentation?	SOP and daily assessment forms for patients at risk of falling will be evaluated and revised	

International Journal of Current Science Research and Review
ISSN: 2581-8341
Volume 07 Issue 08 August 2024
DOI: 10.47191/ijcsrr/V7-i8-68, Impact Factor: 7.943
IJCSRR @ 2024
www.ijcsrr.org

The results of the FGD conducted have produced alternative solutions related to the completeness of facilities and infrastructure in implementing prevention of patients at risk of falling in hospitals, including including the need for bracelets, safe beds, and fenced stretchers in the 2023 hospital budget, while for the availability of non-slip footwear for class 3 inpatients, the hospital will provide more education to both patients and their families, it was stated in previous studies that reducing the incidence of patient falls by providing education to patients and their families gave meaningful results.

2. Observation Results

The results of this study, with a case study design, show that the researcher observed the implementation of prevention for patients at risk of falling in the treatment room. The researcher conducted a documentation search related to the implementation of prevention of patients at risk of falling, including medical records, standard operating procedures, and policies made by the patient safety team. The results of the observations made by the researcher on the implementation of prevention of patients at risk of falling and documentation of prevention of patients at risk of falling for inpatients from the inpatient room of as many as 28 people.

Table 3. Results of observations on the number of inpatients based on the patient's origin of admission

Origin of patient admission to hospital	Frequency	Percentage (%)
Inpatient department	28	33

Observation of the implementation of prevention of patients at risk of falling for the initial assessment of inpatients, as many as 28 people (33%) underwent daily assessments in the inpatient room.

Table 4. Results of observations on the number of inpatients who underwent initial and daily fall assessments

Fall risk assessment	Frequency	Percentage (%)
Initial assessment	223	79
Repeated assessment	59	21

The results of facility observations in the context of implementing prevention of patients at risk of falling carried out in the treatment room showed that there were still beds that could not be adjusted in height and did not have safety rails in class 3 ward and class 3 ward patients did not receive non-slip footwear while being treated in the hospital.

Table 5. Observation results related to hospital facilities

Observed aspects	Yes	No	Note
Exit signs are present and visible	√		
The hallway or corridor is free from obstructions	√		
Equipment, tables, and chairs are sturdy, neat, and securely locked	√		
Equipment, tables, and chairs are by the needs of the related unit	√		
The bed height adjuster is installed correctly and not loose		√	In Class 3 wards, there are still beds that need to be more safe.
Door handles are secure and easy to reach	√		
All lights work properly	√		
Floors are clean, dry, and free of obstructions	√		
Floors are level and free of holes or breaks in tiles	√		
The Bell/call button is easily accessible	√		
The bed is in a low position	√		
Bedside table within reach	√		
Light switch within reach	√		

International Journal of Current Science Research and Review
ISSN: 2581-8341
Volume 07 Issue 08 August 2024
DOI: 10.47191/ijcsrr/V7-i8-68, Impact Factor: 7.943
IJCSRR @ 2024
www.ijcsrr.org

During observations regarding the number of beds in this study, researchers found that 26 beds were less safe or did not have fences, while 74 beds were fenced and safe.

Table 6. Number of beds in inpatient department

Bed condition	Frequency	Percentage (%)
Safe/compliant	74	74
Not safe/not compliant	26	26

DISCUSSION

The results obtained by researchers are patient factors that concern inpatient nurses in this study related to the risk of patients falling, including previous history of falls, cognitive or psychological disorders, age >65 years, gender, length of hospitalization, osteoporosis, and musculoskeletal disorders. This is the fact that anticipatory risk factors must be sought to prevent patients from falling; factors related to the patient's condition include previous history of falls, incontinence, cognitive/psychological disorders, age >65 years, gender, length of hospitalization, osteoporosis, poor health status, musculoskeletal disorders.

Implementation of prevention of patients at risk of falling needs to see the supporting facilities and infrastructure of the hospital managers. Researchers use the checklist to observe the facilities and infrastructure. The results of the observations conducted, researchers still found 26 beds that were unsafe or not equipped with bed safety rails, three unsafe stretchers in the emergency installation, footwear for class 3 patients was not available, and yellow fall risk marker bracelets were often empty in the emergency installation. These results do not follow Pohan (2017), who stated that there are risk factors that can be anticipated and must be sought to prevent patients from falling; environmental factors and facilities include Wet/slippery floors, messy rooms, poor lighting, inadequate handrails, loose cables, slippery/inappropriate footwear, low toilet seats, wheelchairs and beds, prolonged hospitalization, unsafe equipment, beds left in a high position.

The initial assessment process carried out by nurses still needs to be optimal. It can be seen from the documentation that the initial assessment process for patients at risk of falling was not carried out during the emergency installation. This was also found in a study conducted by Suparma (2015), which showed that the safety of patients at risk of falling based on SOP was not 100% implemented in the emergency installation of Panti Rini Kalasan Hospital, Sleman. In fact, this is not in accordance with the Regulation of the Minister of Health of the Republic of Indonesia (2011), Hospital patient safety is a system where hospitals make patient care safer which includes risk assessment, identification and management of matters related to patient risk, reporting and analysis of incidents, the ability to learn from incidents and their follow-up and implementation of solutions to minimize the emergence of risks and prevent injuries caused by errors due to carrying out an action or not taking action that should be taken, the failure to carry out an initial assessment in the emergency installation was discovered through interviews with implementing nurses because they received less socialization regarding the initial assessment of patients at risk of falling in the emergency installation, this is in accordance with the research of Kilateng, et al (2015) which stated a moderate level of relationship between nurses' knowledge of patient safety and preventive measures for patients at risk of falling at Maria Waloda Maramis Airmadidi Hospital.

The patient reassessment process in this study has been implemented; this is by the provisions of the Indonesian Minister of Health Regulation (2011) that hospitals implement an initial assessment process for patients for fall risk and reassess patients if there is an indication of a change in condition or treatment and others. The assessment that can be given, according to Maryam, Nurrachmah, and Hastono (2019) identifies risk factors, assesses balance and gait to assess whether adult patients are at risk of falling or not, can use the Morse fall scale assessment, initial assessment for pediatric patients who are at risk of falling in the hospital can use the Humpty dumpty scale. In addition to assessing patients at risk of falling, interventions have been carried out for patients considered at risk based on the initial assessment by nurses. This can be supported by the availability of standard operating procedures for reducing the risk of falling; in pediatric patients, there are interventions, namely low-risk and high-risk standards; for reducing the risk of falling in adult patients, there are interventions, namely standard falls and high-risk falls. These results are by general prevention that can be given to all risk categories that patients have, including orienting the patient's room, positioning the bed as low as possible, locked wheels, installing both sides of the bed rails properly, tidying room, personal items within reach (telephone, drinking water, glasses), adequate lighting (adjust to patient needs), assistive devices within reach (sticks, crutches), monitoring the effects of medications and providing education on preventing falls to patients and families (Pohan, 2017).

International Journal of Current Science Research and Review
ISSN: 2581-8341
Volume 07 Issue 08 August 2024
DOI: 10.47191/ijcsrr/V7-i8-68, Impact Factor: 7.943
IJCSRR @ 2024
www.ijcsrr.org

The hospital that was the location of this study has also implemented monitoring steps to reduce injuries due to patients falling, although not optimally. Johnson. et al. (2014), who conducted a training and socialization program aimed at increasing nurses' knowledge, showed results in increased compliance in preventing patient falls. Daily assessment of patients at risk of falling is carried out if the patient is at risk of falling at the initial assessment of the patient being admitted to the hospital. The hospital needs to regularly monitor and evaluate the success of reducing injuries due to falls and related impacts. Documenting and following up immediately after a patient falls aims to protect the patient from getting worse by Filling out an incident report immediately; the development of the patient's condition and the patient's assessor after falling must be included in the medical record, the doctor reassesses the patient after falling to find out if there is a more severe injury to the patient, evaluating with the field related to preventing patients at risk of falling to determine interventions that are appropriate to the patient's condition, providing information to each section and nurse on duty that the patient has fallen and is at risk of falling again. The Indonesian Minister of Health Regulation (2011) states that incident reporting is carried out after analysis and obtaining recommendations and solutions from the hospital patient safety team to reduce incidents and correct the system to improve patient safety and not to blame people (non-blaming).

The hospital management has implemented policies or procedures developed to reduce the risk of patient injury due to falls; this is evidenced by the issuance of the Director's Decree Number 400 / .7.3.10 / SKP / VI / 2023 concerning Patient Safety Targets. Unwanted events are supported by management in the context of implementing prevention for patients at risk of falling; as stated in the Indonesian Minister of Health Regulation (2011), hospitals develop an approach to reduce the risk of patients from injury due to falls. Joint Commission International (2016) states that the risk of patient harm from falls should be reduced (reducing the risk of patients being injured due to falls). Hospitals develop an approach to reduce the risk of patient injury due to falls. Barriers in the implementation of prevention of patients at risk of falling at the research location obtained through the results of observations of the implementers of prevention of patients at risk of falling, interviews with informants, documentation tracing, and focus group discussions it is known that the completeness of the SOP and the initial assessment of patients at risk of falling in the emergency installation has not been carried out. The importance of initial assessment in the emergency installation because, according to the Ministry of Health of the Republic of Indonesia (2016), the emergency unit is a unit that is vulnerable to patient safety because the hospital emergency unit has the task of organizing temporary medical care and nursing care services as well as emergency surgical services, for patients who come with medical emergencies. The emergency unit can also reflect hospital services that generally accept patients with characteristics that require fast and appropriate assistance, and incidents related to patient safety are not infrequent. The hospital implements an initial assessment process for patients at risk of falling and reassesses patients if there is an indication of a change in condition or treatment, among others. The hospital makes policies and procedures developed to reduce the risk of patient injury due to falls in the hospital (Regulation of the Minister of Health of the Republic of Indonesia, 2011).

Hospital management is expected to be able to provide more education regarding patient safety targets which include reducing the risk of patients falling to nurses, especially emergency nurses, because during the study, there was no initial assessment of patients from the emergency department for inpatient care, incomplete SOPs will be immediately evaluated and revised by the patient safety team, this is by research conducted by Sugeng et al (2014) that the less than the optimal implementation of the patient management program with a risk of falling in hospitals is influenced by supervision factors and the preparation of SOPs in the implementation of prevention of patients at risk of falling. The quality of health services related to the implementation of prevention of patients at risk of falling, the results of research conducted through observation of suggestions, facilities, implementation of prevention of patients at risk of falling, interviews conducted with informants, and documentation regarding policies and implementation of prevention of patients at risk of falling then focus group discussions obtained results regarding obstacles in the implementation of prevention of patients at risk of falling and alternative solutions to the obstacles obtained, this is done in order to improve the quality of health services related to the implementation of prevention of patients at risk of falling. This is by Wiyono (2020). Quality is an effort carried out continuously, systematically, objectively, and in an integrated manner in determining problems. Causes of health service quality problems are based on established standards, determining and implementing problem-solving methods according to available capabilities, assessing the results achieved, and compiling suggestions for follow-up actions to improve service quality further.

CONCLUSION

The implementation of prevention of patients at risk of falling for nurses in inpatient installations has been carried out in the form of providing facilities, facilities, and completeness of the assessment form for patients at risk of falling, and the existence of

International Journal of Current Science Research and Review
ISSN: 2581-8341
Volume 07 Issue 08 August 2024
DOI: 10.47191/ijcsrr/V7-i8-68, Impact Factor: 7.943
IJCSRR @ 2024
www.ijcsrr.org

standard operational procedures on the prevention of patients at risk of falling. However, some of the available facilities are damaged and must be repaired. In addition, there are still some nurses who do not know how to conduct an assessment of patients at risk of falling. It is recommended to the Director and management of the hospital to immediately improve the facilities to support the implementation of prevention of patients at risk of falling, and there needs to be regular training for all nurses related to filling out the assessment of patients at risk of falling in the hospital.

REFERENCES

1. Ardani dan Muh. (2018). Diskusi refleksi kasus meningkatkan kepatuhan perawat terhadap penerapan standar prosedur operasional pencegahan risiko jatuh. JHeS (Journal of Health Studies) 2 (2) https://doi.org/10.31101/jhes.471, 16–22 .
2. Bouldin et al. (2013). Falls among Adult Patients Hospitalized in the United States: Prevalence and Trends. Patient Saf Vol.9 (1), 13-17.
3. Budi et al. (2019). Keakuratan Rekam Medis Berdasarkan Laporan Insiden Pasien Jatuh di Rumah Sakit. Prosiding Call For Paper SMIKNAS, Program Studi D3 Rekam Medik dan Informasi Kesehatan Universitas Duta Bangsa Surakarta Tahun 2019, 51-58.
4. Budiono. (2014). Pelaksanaan Program Manajemen Pasien dengan Risiko Jatuh di Rumah Sakit. Jurnal Kedokteran Brawijaya 28 (1), 78-83.
5. Cahyono. (2012). Membangun Budaya Keselamatan Pasien dalam Praktik Kedokteran. Jogyakarta: Kanisius.
6. Cosway, Stevens dan Panesar. (2012). Clinical leadership: A role for students? British Journal of Hospital Medicine. Vol.73 No.1, 50-51.
7. Jati. (2018). Kepatuhan Perawat Melaksanakan Standar Prosedur Operasioinal Pencegahan Pasien Jatuh Berdasarkan Faktor Demografi dan Motivasi. Jurnal Ilmiah Kesehatan Media Husada 6 (2), 225-264.
8. Johnston dan Magnan. (2019). Using a fall prevention checklist to reduce hospital falls: Results of a quality improvement project. American Journal of Nursing, 43-49.
9. Joint Commission International. (2015). Comprehensive Accreditation Manual for Hospitals : The Patient Safety Systems Chapter. New York: The Join Commission.
10. Kementerian Kesehatan RI. (2015). Pedoman Pelaporan IKP. Jakarta: KPPRS.
11. Kongres PERSI. (2012). Laporan Peta Nasional Insiden Keselamatan Pasien. Jakarta: PERSI.
12. Miake-Lye et al. (2013). Inpatient Fall Prevention Programs as a Patient Safety Strategy: A Systematic Review. Annals of Internal Medicine 158 (5), 390-396.
13. Najihah. (2018). Budaya Keselamatan Pasien dan Insiden Keselamatan Pasien di Rumah Sakit. Islam Nurse, 1-8.
14. Pagala et al. (2017). Perilaku kepatuhan perawat Melaksanakan SOP terhadap Kejadian Keselamatan Pasien di Rumah Sakit X di Kendari. Jurnal Promosi Kesehatan Indonesia July 17, 32.
15. RSUD dr. H. Bob Bazar SKM. (2023). Program Manajemen Fasilitas dan Keselamatan Rumah Sakit Umum Daerah dr. H. Bob Bazar, SKM Kabupaten Lampung Selatan Tahun 2023. Lampung: RSUD dr. H. Bob Bazar SKM.
16. Sitorus. (2023). Risiko Psikososial Dalam Kinerja Perawat. The Indonesian Journal of Health Science, Vol. 9, No. 1., 25.
17. Stephenson et al. (2016). Prevention of falls in acute hospital settings: A multi-site audit and best practice implementation project. International Journal for Quality in Health Care, 28 (1) https://doi.org/10.1093/intqhc/mzv113, 92–98.
18. Sutoto et al. (2018). Standar Nasional Akreditasi Rumah Sakit. Jakarta: Standar Akreditasi Rumah Sakit.
19. Timur. (2020). Sistem Informasi Pencegahan Pasien Jatuh (Sipenja) Untuk Meningkatkan Kepatuhan Perawat Dalam Pencegahan Pasien Jatuh : Pilot Study. Jurnal Ilmiah Kesehatan Vol XIII, No II, 69.

Cite this Article: Diana Helen Cantika, Bayu Anggileo Pramesona, Betta Kurniawan (2024). Evaluation of Prevention of Patients at Risk of Falls in Nurses in Inpatient Department: A Qualitative Case Study International Journal of Current Science Research and Review, 7(8), 6568-6579