**CONFERENCE SPEECH**

**FOR**

**IRIS BERRYHILL**

**HS 5/12- I have taken your attachments and have combined, interspersed and sectioned them into the four parts as we discussed (I didn’t think I should rewrite your data but I have added commentary where I thought appropriate to inspire thought from the audience). I did my best to delineate the 4 phases of the research and I accented the explanations of the acronym, PICOT so that each of the letters makes sense. In addition, I have noted where to take question/comment breaks from the audience. I’ve noted 4 places, and if this runs approximately 20 minutes of speaking time, then each Q/A would be approximately 2 1/2 minutes +/-.**

Hello everyone and thank you for giving me the opportunity to share the abstract I have written regarding senior citizens, patient safety, and most importantly, in hospital fall prevention. (**If there is anyone in particular you would like to acknowledge, do that here**). I’d like to take a moment to acknowledge \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ for recognizing the importance of this study and for suggesting that I relate my research and findings with you. There are a few key factors we must keep in mind.... the senior population is growing. According to reports, in 2015, the estimated population 65 years and older accounted for 14.9%. That proportion is expected to swell to **OVER** **22%** by 2050. While our aging population, for the most part, is better informed, is younger in spirit (in general), and can be more independent for longer, once an aging patient needs to be admitted to a hospital... for any reason, the “**fall factor**”... by that I mean the chance for accidents and injuries from patient falls is **WAY** too common. We have to find a way to educate the staff and to instill unprecedented levels of safety in order to minimize these unnecessary burdens. To take a line from Freud and adapt it, “Sometimes a fall is **NOT** just a fall.” It can wreak havoc on already stressed staff, it can cause premature deterioration of patient health and morale... and it can create stress both financially and administratively. I know.... it’s happened to someone very close to me. Positive and preventative action must be established and instituted. It’s been said that “Every accident is a notice that something is wrong with methods, materials, procedures. Investigate... then **ACT**.” Today our mission is to discuss that action.

I suppose you can say that my interest in this issue and my involvement in finding a resolution to reduce the number of incidents and the inherent damage they create, is **personal**. Many years ago, my 70 year old grandmother was admitted to the hospital for the first time in her life because of high fever and a bad cough. Her first night in the hospital she fell off the bed, sustained a severe head injury and a broken right hip. Even when her cough was healed, because of the head injury she endured, she was confused and was unable to care for herself. Subsequently, her health declined, and she eventually succumbed to her injuries **from the fall**. This incident and many other unnecessary falls in this age group increased my interest in fall prevention for the 65 and older hospitalized patients. This leads to this question “Are healthcare workers (nurses, patient care providers and doctors) doing enough to prevent falls for the older hospitalized patients?”

The Centers for Medicare and Medicaid Services estimate that by the year 2030, there will be **EIGHTY-ONE MILLION** people **over** the age of **SIXTY-FIVE**, and while the trend is to live longer, more fulfilling, and naturally more active lives, feeling “young at heart” can get us just so far. The National Council on Aging also states, “Falls are the leading cause of fatal injury and the most common cause of non-fatal trauma related hospital admissions among older adults. Falls result in more than 2.8 million injuries treated in emergency departments annually, including over **EIGHT HUNDRED THOUSAND** hospitalizations and more than **TWENTY SEVEN THOUSAND DEATHS.** Add to that the escalating rate of inpatient falls that occur in patients sixty-five years and older, and it’s plain to see that unless we take positive corrective measures, we are headed for a blatantly catastrophic scenario. In addition to the pain and suffering endured by the patients and their families, injuries like in patient falls cause inordinate expenditures of time, funds, supplies, Human Resources, and energy. Something must be done to address the issue and straighten out the situation before this gets **completely** out of hand.

There are many obvious reasons why I was intent on doing whatever possible to shine a light on this issue in order to discover a resolution and suggest implementation of effective, efficient procedures. I devised an acronym to help recognize and refer to the important elements of the study, and that is **PICOT.** It stands for the following:

**P ...** Inhospital **PATIENTS,** 65 years and older

I ... Standardized **ITEMIZED** fall prevention tool

**C.**.. **COMPARISON** to previous fall reports and studies

**O...** Decrease in the number of **OCCASIONS** in which falls occur

**T ... THREE months...** the timeline to be followed for the four point plan. (**Please clarify if the study was three or 4 months. My notes say 4 months and your power point mentioned Oct, Nov, Dec, and Jan- if 4 months, we will have to bold “TIMELINE” to represent the “T”**).

The project was structured to be conducted in four phases:

* **PHASE ONE.**.. Assessment
* **PHASE TWO** ... Planning
* **PHASE THREE** ... Implementation
* **PHASE FOUR** ... Evaluation.

I want to point out something before I begin to break down the study. I once heard this quote from a business executive, only, when you really think of the message, it applies to the medical field and the patient/caregiver dynamic.... even more so. Because of that, I have taken the liberty to “adjust” some words to suit our mission. “A **patient** is the most important visitor on our premises. He is not dependent on us... **WE** are **DEPENDENT** on **HIM**. He is not an interruption in our work. He is the **PURPOSE** of it. He is **NOT** an outsider in our facility. He is **PART** of it. We are **NOT** doing him a favor by serving him. He is doing **US** a favor by giving us the **OPPORTUNITY** to do so.” If, ironically, this passage seems to overstate, considering the crisis we face that inspired this study, I think the first step that needs to occur is for all of us to really listen to those words, consider the commitment we have made to the profession and the patient, and reconfirm our purpose and our pledge to serve **ALL** who enter our hospital grounds. We all know that at times nursing can be overwhelming, but we are literally responsible for people’s **LIVES**. We must treat every patient in any situation with empathy, attention, and appropriate care, because one day, we don’t know who might be unsafe in that bed.... our own parent... our child or friend, or possibly even **US**... each patient deserves the attention and care we would expect for ourselves.

**PHASE ONE: ASSESSMENT**

At the community hospital in South Florida where the project was completed, the problem with the current fall prevention program was the nurse’s lack of adherence to the current fall protocol, which was the Modified Hendrich Fall Risk Model (Bolt & Greenberg 2007). The lapse in compliance to the protocol resulted in an increase in the patient fall rate. This upward trend was a growing concern for the patients, nurses and administration. The objectives of the project was to implement evidence-based changes to the fall prevention program at the hospital to decrease the fall rate, increase patient safety and educating the nurses on new fall prevention measures.

In-hospital fall prevention measures for the elderly are not only a national issue but also an international concern for the healthcare industry (Dykes et al., 2010). Hospitalization of the patient 65 and older in unfamiliar surroundings has increased their risk of falling and fall-related injuries. The fear of falling by the elderly, chronic illness and the functional decline has also led to a spiraling downfall of reduced mobility and increase of falls (Dykes et al., 2010). A single fall could result in severe injuries (Dykes), which would be devastating to the patients, families and nurses. It would also increase the patient’s hospital stay for more than six days (Burcher, 2013). Patient falls remain a concern to the healthcare community and especially in the acute care hospitals. It affects the patient’s family dynamics by increasing the cost of care and sometimes changes the leadership role. It is also one of the most challenging patient safety concerns for hospitalized patients 65 and older. This project identified the need for innovations to reduce the incidence of falls for the elderly hospitalized patients.

**\*\*\* Are there any comments or questions so far? We can spend a few minutes to clarify before we continue.**

**PHASE TWO: PLANNING**

The project examined the Modified Hendrick Fall Risk Model used at the hospital, the nurse’s compliance to the fall protocol, their knowledge of fall prevention and fall assessment skills. The goal of the project was to decrease the number of falls at the community hospital and to implement new measures to prevent the reoccurrence of patient falls. In-hospital falls among the elderly patients have serious long-term effects, including severe pain, limited movement to the affected areas and a change in lifestyle (Oliver et al., 2009). Inpatient falls also have a significant effect on the credibility of the healthcare facility in the community which affects patient admissions and the financial viability of the facility.

The AHRQ (2013) reported that more than 700,000 people are hospitalized each year because of injuries sustained from falls of which some of them resulted in head injuries. These head injuries increased the days spent in the hospital to more than five with some of the injuries resulting in the death of the patient (AHRQ, 2013). Some of the injuries sustained from falls may not be head injuries but because the patient is elderly with fragile bones, the injury sustained would be more severe to the patient and costly to the hospital than if a similar fall injury was sustained by a 25-year-old patient in good health (AHRQ, 2013). Traumatic events wreak havoc more insidiously than just the obvious initial damage. Traumas like falls can easily take its toll on patient confidence, morale, and the overall healing and rehabilitation process, depending on the fragility of the patient’s overall original mental and physical stability.

Fall injuries obtained by patients over the age of 65 resulted in premature death, loss of mobility and their independence (AHRQ, 2013). The loss of function for the fall victim causes an unexpected financial hardship and emotional distress to the patients and their families. When the patients are discharged with a disability obtained from an in-hospital fall, the long term care and financial burden is not only on the patients but also on the taxpayers for their lifetime support (AHRQ, 2013). The care of the elderly fall injured patient with a disability most likely would be transferred to a nursing home or rehabilitation facility of which the cost would be paid by government-sponsored Medicare insurance (AHRQ, 2013).

Even though Medicare absorbs approximately 78% of the cost of falls, which is $34 billion annually (AHRQ, 2013), ... and keep in mind that rate of incidence as well as costs in general have increased dramatically, Medicare does not pay hospitals for the extra cost incurred from in-hospital falls (Butcher, 2013). In some hospitals, there are more than ten falls in a month, and 80% of those falls are patients over the age of 65 (AHRQ, 2013). Therefore, it is imperative that a thorough analysis of each fall incident of the elderly be completed and an evaluation of the fall prevention measures used to determine the effectiveness and to identify improvement opportunities at the hospital.

Sometimes there are missed opportunities for fall prevention in the hospital because of the lack of a complete fall assessment on admission and the use of a standardized fall protocol to identify the risk factors for falls (TJC, 2015). The implementation of a comprehensive fall assessment should be focused on the individual patient and should be performed on admission to the facility. The fall assessment should include the patient’s age, cognitive status, functional ability (TJC, 2015) history of previous falls and medication regimen. This information supports the nurse to formulate a fall prevention plan for the patient. The patient fall prevention plan should be family focused, and family members should be aware of the fall prevention strategies that are in place. The family should also be encouraged to participate in the safety of their family member while he or she is hospitalized.

* **A there any more questions at this point?**

**PHASE THREE: IMPLEMENTATION**

Education is a key factor in fall prevention for the elderly. Healthcare facilities should provide fall prevention education and training for the staff using a validated tool that is standardized for fall prevention. The complexity of fall prevention requires considerable knowledge of the cultural, ethical, legal, political (TJC, 2015), and safety considerations in the implementation of a falls prevention protocol. The fear of falling by patients who have sustained previous injuries from falls restricts their social life and therefore limits their activities (AHRQ). In addition, once again, possibly stating the obvious, a system of checks and balances must be implemented in order to further insure adherence to the protocol.

The implementation of fall prevention programs by facilities that educate both patients, families and nurses have reduced the number of patient falls and increased the safety of the facility. Studies have shown that inpatient falls occurred in the acute care hospitals in approximately 1.9 to 3 percent of hospitalization, and the patient fall range exceeds the fall prevention goal of Healthy People 2010; of reducing falls among the 65 and older population to not exceeding 34 per 100,000 (Currie, 2008). Even though there might be underlying conditions which could be contributing factors in patient falls, the trauma resulting from the fall would most likely be the cause of the patient’s morbidity and possibly mortality (Currie, 2008).

(**Please add specific procedures taken in your study**). While the study We conducted was at a small community hospital, we followed and tested procedures that included cautioning staff regarding patient viability by posting notices on the patient’s door, possibly adding floor mats or cushioning to mitigate any falls that might occur, checking positioning of bed rails, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

* **Before we continue, is there anything you would like to ask or say?**

**PHASE FOUR: EVALUATION**

In-hospital fall injuries of the elderly population is an ongoing issue and even though stringent measures were initiated by some hospitals there has being no real solution to the problem. The contributing factors for patient falls remained the same and in some instances fall protocols continued to be ignored. Education on fall prevention measures, and more rigorous interventions are needed to decrease the fall rate and increase patient safety. Managing the patient’s underlying risk for falls and the environment could be the primary strategies in fall prevention.

Clearly this is an ongoing project, but it is one in which I am vested professionally, personally, and intellectually. When my grandmother was admitted to the hospital with that high fever, she was in unfamiliar surroundings, in a strange bed, and in poor physical condition. Because of that, one major step we must always keep in mind is to have **EMPATHY**. This dialogue is overdue. The only way we will advance as a community of caring, effective professionals, is to do just that... be skilled, observant, and vigilant in our care/response procedural stimulus. To paraphrase Dr. Freud, “Sometimes a patient chart is **just a patient chart.**” (**Wait for the laugh**). That chart is just a piece of paper on a clip board. There is a living, breathing, fragile human being represented by that chart, and as nursing professionals, we took a vow to care for and heal those who come under our care. It is **critical** ... no pun intended... (**Wait for the laugh**) that we maintain our focus on **HEALING** regardless of age, state of mind, or physical fragility. Being SIXTY FIVE years of age is not a death sentence, nor should it be. ....Far from it.... People are admitted into hospitals for a variety of reasons and none of those admissions warrant their conditions to be exacerbated by needless traumas like in hospital falls. It’s been said, “The point is that being able to demonstrate ‘due diligence’ is not about devising or having a policy, or a system, or a heap of procedures and checklists at hand, it’s about **taking the action** and **doing the thing** based on that list of **viable preventative actions**.” While it may seem like more work initially, the all around potential savings to cost, patient confidence, professional care, morale, and general systemic stress would ultimately be salvaged.

It is my intention, through honoring the memory of my grandmother, that we all stop, think, and formulate the procedures that need to be created and managed in order to reel in this growing issue. ... and then we must **TAKE ACTION** and **FOLLOW THE PLAN**. Any **thing**... procedure... improvement, requires thought and **action**.... and community discourse. It has been my purpose to bring this to light so that the incidence of crisis is reduced. I am thankful for your participation. Together we will make strides to improve the conditions and ultimately general viability for **all** patient safety. Thank you all!!