VISOKA ZDRAVSTVENA ŠOLA V CELJU

DIPLOMSKO DELO

PREPREČEVANJE PADCEV PACIENTOV NA KIRURŠKEM ODDELKU

THE PREVENTION OF PATIENT FALLS IN SURGICAL UNITS

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POVZETEK

Uvod: Padci so najpogosteje zabeleženi neželeni dogodki, ki se zgodijo v bolnišničnem okolju. Da bi se izboljšali kakovost in varnost zdravstvene oskrbe pacientov, so med drugim potrebni preventivni ukrepi na področju preprečevanja oziroma zmanjšanja tveganja za padec pacientov. Z raziskavo smo želeli ugotoviti in opredeliti vzroke za padec ter na podlagi petletne analize padcev oblikovati model aktivnosti za njihovo preprečevanje.
Metoda: Uporabljeni so bili kvantitativna metoda raziskovanja, metoda deskripcije in tehnika analiziranja dokumentov. Za izvedbo raziskave smo uporabili kontrolno listo, s pomočjo katere smo analizirali prijave s podatki o padcih pacientov. Uporabljen je bil neslučajni, namenski vzorec, v katerega so bili vključeni pacienti, ki so padli v času hospitalizacije v obdobju 2012-2016 na kliničnem oddelku (v nadaljevanju KO) za travmatologijo v UKC Ljubljana. Od 204 prejetih dokumentov smo lahko analizirali 201 dokument, kar predstavlja 98,5-odstotno izvedbo vzorca. Pridobljeni podatki so bili obdelani s pomočjo programa Microsoft Excel in statističnega programa SPSS.
Rezultati: Rezultati so pokazali, da je padlo 54,2 % pacientov ženskega spola. Največji delež padlih pacientov je bil v starostni strukturi od 80 do 89 let (32,8 %). Večina pacientov je bila v analiziranem obdobju ocenjena kot ogroženi za padec (72,4 %), v letih 2015 in 2016, ko so bili na voljo podatki o višini ocene za ogroženost, prevladujejo pacienti z zmerno ogroženostjo za padec (47,8 %), sledijo pa jim pacienti z visoko ogroženostjo za padec (42,4 %). Kar 46,3 % pacientov je bilo pred padcem delno pokretnih in 42,8 % psihično orientiranih. V 55,5 % niso prejeli uspaval, narkotikov oziroma pomirjeval pred padcem. Kot preventivni ukrep so imeli pacienti v 61,5 % dvignjene zaščitne ograje, z delovanjem klicne naprave so bili seznanjeni v 88,3 %, fiksirani pa niso bili v 95,6 %. Od tega se jih je 47,2 % zgodilo v nočni izmeni, 73,1 % v bolniški sobi, najpogosteje pa so bili najdeni na tleh (34,8 %). Padec se je v 54,7 % končal brez poškodb, njihovo psihično stanje je ostalo nespremenjeno v 52,6 %. Takojšen pregled s strani zdravnika je bil izveden v 65 % primerih padlih pacientov.
Razprava in sklep: Ugotovili smo, da se število padlih pacientov z leti povečuje, kar je najverjetneje posledica doslednejšega beleženja vseh vrst padcev, staranja in komorbidnosti pacientov. Vsekakor bi bilo pomembno, da v bolnišnicah celovito pristopijo k preprečevanju padcev. Osnova zanj je prikazana v modelu, ki smo ga zasnovali na podlagi naših ugotovitev, ter zajema pogostejše ocenjevanje ogroženosti pacienta, stalno preverjanje razumevanja navodil, pogostejše obhode po bolniških sobah, ne nazadnje pa tudi uporabo senzorjev, ki nas opozarjajo na spremembe položaja pacienta v postelji. Zdravstvenemu osebju bomo morali omogočiti dodatno strokovno izobraževanje na področju uvajanja preventivnih ukrepov, ki bodo pripomogli k zmanjševanju oziroma preprečevanju padcev pacientov.

Ključne besede: zagotavljanje kakovosti, dejavniki tveganja, neželeni dogodki, padci pacientov

SUMMARY

Introduction: Falls are among the most frequently documented unwanted events that take place in hospital environments. In order to improve the quality and safety of patient health care some precautionary measures must be made in the prevention or reduction of risk in patient falls. With this research we wish to determine and identify possible causes of patient falls and, further on, on the basis of a five-year analysis of falls devise an activity model which would prevent them.
Method: Methods used were a quantitative research method, descriptive method and document analysis. For the purpose of the study we used a check list with the help of which we analyzed recorded patient falls. A non-random purpose sample of patients, who experienced a fall during their stay at the surgical unit (SU) of the trauma department of UKC Ljubljana during the years 2012-2016, was used. Of the 204 documents that were received we were able to analyze 201, representing 98.5% of the sample total. Information gained was then processed with the help of Microsoft Excel and the statistical analysis programme SPSS.
Results: Results have shown that 54.2% of female patients experienced a fall. The highest percentage of patients that have fallen was in the age group ranging from 80 to 89 years (32.8%). Most of the patients were, at the time of analysis, marked as at risk of falling (72.4%). In the years 2015 and 2016 when the data for the assessment of risk of falling was available, patients with a moderate risk of falling are at the forefront (47.8%), followed by patients with a high risk of falling (42.4%). Altogether 46.3% of all patients were partially walking prior to falling and 42.8% were mentally oriented, 55.5% were not given any sleeping remedies, narcotics, sedatives prior to falling. In 61.5% of the cases patients had elevated rails on their beds as a preventative measure. In 88.3% patients were familiar with the mechanics behind nurse call systems and 95.6% were not under medical restraints. Of these, 47.2% of the falls took place in the night shift, 73.1% in the patient room, but most frequently the patients were found on the floor (34.8%). In 54.7% of the cases the fall resulted in no injuries, while their mental state remained the same in 52.6% of the patients. An immediate check up by a physician was conducted in 65% of the fallen patients.
Discussion and conclusion: We have determined that the number of fallen patients is increasing which is most likely a result of more consistent recording of cases, aging and patient co-morbidity. It is of great importance that hospitals take a holistic approach to patient fall prevention. The grounds for such an approach are presented in the model that was designed on the basis of the findings of this study and it includes more frequent patient fall risk assessments, constant testing on whether the patient understood instructions, a greater frequency of patient room rounds, and lastly the use of movement sensitive sensors which would notify us on changes in the patient's bed position. Health workers must be provided with additional professional training in the field of introducing preventative measures that would help to diminish or prevent patient falls.

Keywords: Quality assurance, risk factors, unwanted events, patient falls.