Optimizing the Role of Other Patient's Families in Injury Prevention in Fall Risk Patients

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Abstract:
There are still incidents of patients falling while undergoing treatment at health facilities, requiring us as officers to look for various prevention efforts, improve patient safety support facilities, and involve all patient caretakers' families to jointly care for patients around them who are at risk of falling. This study aims to see efforts to optimize the role of other families in preventing the risk of falling. This type of research is qualitative, involving eight main informants from the head of the room and eight additional informants from the families of waiting for patients at RSUD Dr. H. Koesnadi Bondowoso. This research was conducted from 26 February to 24 March 2023 by collecting data through unstructured interviews, in-depth observation, and documentation studies. The data obtained was verified by triangulation of sources and techniques. The conclusion shows that efforts to prevent the risk of falling by optimizing the role of the patient's family are very effective because the patient's family feels happy by paying attention to the presence of patients around them, especially those wearing yellow marker bracelets so that the presence of the waiting family besides paying attention to the patient's family can also take a role by paying attention to other patients surrounding.

INTRODUCTION

Patient safety is a system that makes patient care safer, including risk assessment, patient risk identification and management, accident reporting and analysis, the ability to learn from incidents and follow-up, and solutions to minimize risk and prevent injury caused by error or negligence action (Adhitama et al., 2023). Patient safety is a system in which hospitals make patient care safer to prevent injuries caused by errors due to acting or not taking the action that should be taken (Salawati, 2020). Patient safety is a top priority in health and nursing services and the most important aspect of quality management (Wianti et al., 2021). Patient safety mechanisms can be maximized with the help of the patient's family, which can improve the quality of service at the hospital (Afandi et al., 2023a; Afandi et al., 2023b).

Maintenance of Patient Safety, based on the Minister of Health (2017), States that every healthcare facility must implement patient safety. Patient safety is carried out by establishing a service system that applies patient safety standards, goals, and seven steps to patient safety. The service system in health facilities must also guarantee the implementation of safe patient care through Patient Safety Goals (SKP) efforts which include increasing patient identification, increasing effective communication, increasing drug administration safety, improving operating procedures, increasing infection prevention, and increasing injury prevention efforts, due to the risk

of falling. This Patient Safety target approach aims to minimize risks and prevent injury from carrying out an action or not taking the action that should be taken. So that this can affect performance in service, impacting the quality of work of nurses in service at clinics (Asmaningrum & Afandi, 2022).

A fall is an incident reported by a sufferer or eyewitness which results in a person suddenly lying down/sitting on a lower floor/place with or without loss of consciousness or injury (Purnamadyawati & Bachtiar, 2021). Falls are the second leading cause of unintentional injury deaths worldwide. Every year, an estimated 684,000 people die from falls globally, with more than 80% being in low- and middle-income countries (Sulistiyo et al., 2023). Incidents of falling patients impact physical injuries, including abrasions, lacerations, and bruises. Even in some severe cases falling can result in fractures, bleeding, and head injuries (Setyowati & Indasah, 2022).

Incidents of falling will certainly harm the patient or client, especially physically, which causes mild to severe injuries and even death and concerns the quality/quality of service from a hospital. So that all health workers must pay attention to the patient's condition by carrying out all fall risk prevention programs through various approaches to care, from the risk assessment of falls when the patient first enters the hospital to interventions in prevention (Lestari, 2021). Data at RSUD Dr. H. Koesnadi Bondowoso obtained data that in 2022 around 18% of patient safety incidents occurred with falls. The fall incident was included in the category of non-injury events at 78% and 25% as unexpected events. This is far from the standard Joint commission international (JCI) which states that it is hoped that it will not occur in hospital patient falls. This fall incident also occurred in almost all health facilities domestically and abroad. In the United States, incidents of falls in hospitals and health centers are reported as many as 1,000 patients per day. Of the 345,800 falls in the inpatient unit during the study, 315,817 people were reported to have experienced injuries (Boulding et al., 2014).

Family support is support from the family, which consists of verbal and nonverbal information or advice, real help, or actions given by family familiarity or obtained due to the presence of people who are supportive and have emotional benefits or behavioral effects on the recipient (Winarsih et al., 2020). Family members believe that supportive people will always be ready to provide the help, assistance needed, and advice in certain situations (Siregar et al., 2021). The effective function of the family aims to protect and provide psychosocial support for family members (Kurniyawan et al., 2022). This mechanism can lead to increased knowledge from patients and families, hoping it will reduce the incidence of patients falling into the room (Putri et al., 2022).

Incidents of falls in patients during treatment at the hospital occur because the patient/family does not comply with the directions (fall risk education) from the treating staff. This mechanism has been discussed in the nurse's handover between shifts, hoping to reduce the incidence of patient falls (Rifai et al., 2020). Here it is important to optimize the role of other patient families to pay attention to patients around them who wear a yellow fall risk bracelet through education as a provision for additional knowledge and skills, so they don't feel hesitant to be involved in caring for patients at risk of falling around them. This is important because the patient's family is close to many patients. Apart from taking care of them and helping the patient next to them, they also remind them to be careful in mobilizing or can even prohibit patients/families from falling at risk when they do not comply with the officer's directions. This is supported by information from several families who conveyed that it was inconvenient to advise other patients at risk of falling who were not their family; other families did not understand what to do if the patient next to them wore a yellow fall risk marker bracelet. According to the phenomena, this study aims to see efforts to optimize the role of other families in preventing the risk of falling.

METHOD

This study is qualitative research with a descriptive approach with the primary informants consisting of eight pavilion heads of RSUD, Dr. H. Koesnadi Bondowoso, and ten additional informants comprised of two Patient Sub Committee members and eight family members—methods of data collection by unstructured interviews, in-depth observation, and document review. The data were then analyzed using the Miles and Huberman method. This research was carried out for one month, from 26 February to 24 March 2023, in the inpatient room of RSUD Dr. H. Koesnadi Bondowoso.

The instrument in this study was the researcher himself, using interview guides, questionnaires, observation sheets, recording devices (cell phones), cameras, and stationery. The data obtained from the primary informants were then analyzed, as well as triangulation. In the validity of the data, the researcher uses three triangulations, namely source and technique triangulation.

RESULT

Characteristics of Informants

In collecting data, it was found that eight pavilion heads of RSUD Dr. H. Koesnadi Bondowoso as the primary informant, and ten additional informants consisting of 2 members of the Patient Safety Sub Committee and eight family members following are the characteristics of the informants in this research.

Table 1. Characteristics of Informants

Characteristics	Key Informants (8)	Additional Informants (8)	Information
Age	40 - 50 years	40 - 50 years	All main and additional informants obtained during interviews were in the age range of 40-50 years
Gender	Male = 4 Female = 4	Male = 5 Female = 3	There are no obstacles related to gender when collecting data (interviews)
Education	Bachelor of Nursing	Middle school = 3, High school = 5	There are no obstacles related to education level when collecting data (interviews)
Language	Indonesia	Indonesia, Java, Madura	There were no language-related obstacles during data collection (interviews)

Efforts to Prevent Injury in Patients at Risk of Falling

From interview data, observation, and documentation, it can be described how efforts to prevent injury to patients at risk of falling in several rooms/pavilions of RSUD dr. H. Koesnadi Bondowoso.

Table 1. Efforts to Prevent Injury in Patients at Risk of Falling

Characteristics	Standard	Reality	Information
PIC Quality/Patient Safety	1 PIC/ Room	1 PIC/ Room	There are several rooms, with new PICs changing, not yet optimal in implementing patient safety programs
Availability of Fall Risk Bracelet (Yellow)	Ready Stok	There are several rooms that are out	The room did not immediately ask for supplies to meet the supply
Non-Slippery Floor	There are no slippery floors	There are still lots of slippery floor areas	Slippery floors are found starting from the room, terrace, and access to the bathroom
Hand Holding	There must be	Some rooms not all parts have handrails	The less spacious patient room is a complicating factor for installing handrails
Bathroom position	Close to the patient's bed	Some of the rooms where the bathrooms are located are a bit far from the patient's bed	Patient rooms that are less spacious do not allow a bathroom in one room or close to the patient's bed
Nurse/Midwife Office Position	Close to the patient's TT Can monitor patients	Several rooms where the officer's office is located are a bit far from the patient's bed and it is difficult to monitor the patient directly	The layout of the physical building has not been designed for officers' offices to be close to bed patients and can monitor patients instantly
Patient room CCTV	There must be	Not all patient rooms have CCTV	CCTV is only installed on the terrace access road, not yet leading to patient observation
Patient Motion Sensor	There must be	There isn't any yet	Still submitting according to the budget for procurement
Patient Bell (Nurse Call)	There must be	Only a few rooms have patient bells	Not all rooms have a bell installed near the patient
Wheelchair Availability	A must have, and easy to access	Some rooms lack wheelchairs	There are very limited number of wheelchairs per room and are often used to transport patients to other rooms/support examinations

DISCUSSION

Patient's Family as Fall Prevention Agent

In a program to optimize the role of other patient families in preventing injuries in patients at risk of falling through education regarding preventive measures according to what is stated in the fall risk assessment format in the medical record file. This is corroborated by the results of research conducted by Timur et al. (2020), which stated that it is necessary to optimize all parts in

preventing potential falls in patients, starting with the compliance of officers in implementing all efforts according to procedures.

As we all know, prevention of the risk of falling is a common concern in health facilities involving health workers, patients, and waiting families. This collaboration is expected to reduce the incidence of patient falls, where officers try to create a safe environment where patients understand their condition, which is prone to falling. The family can help, accompany, and supervise patients with family relations (own family) and others around them.

Of course, in the beginning, there needs to be education for the family so they can understand what efforts can be taken to prevent potential falls in their own family who are patients or other patients around them. This is in accordance with the information submitted by the main informant.

"Yes, of course, we also involve the patient's family in preventing the risk of falling because we as officers do not see patients directly 24 hours." (PJ)
"At the beginning, we tell the family if the patient is at risk of falling so that his role is also to accompany and report to if something is needed." (NH)

In addition, the family whom the officers had given education felt pleased because they understood more about what factors could cause patients to fall so that they could anticipate them. Providing education at the outset by officers to families can also make families more open if other patient families pay attention and feel happy if they can also give advice and supervise other patients around them, especially patients who wear yellow marker bracelets. Additional informants convey this from the patient's family below.

"We feel very happy after being explained fall prevention. We as a family can pay attention to each other with patients around us so they don't fall." (YL)
"If I see a patient wearing a yellow wristband, even if it's not my family, it's also paying attention. Sometimes his family needs help, for example, when he wants to go to the bathroom or when his family wants to eat. So, we can help each other." (RZ)

Cooperation between officers and the patient's family is very effective in preventing the risk of falling, this can be seen in the recapitulation of patient safety incident reports which show a significant reduction in the incidence of patient falls. This condition is reinforced by the information submitted by members of the Patient Safety Subcommittee that by cooperating with families who are waiting for patients after being given education related to fall risk prevention, it is felt to be very effective because the families who are waiting near the patient can also pay attention to the condition of the patients around them, especially those who are at risk of falling or attached with a yellow wristband. The family feels they have a role when giving advice or helping surrounding patients at risk of falling. They are seen between families chatting with other families and discussing efforts to prevent falls in patients around them. This is also corroborated by suggestions from research by Gunarni & Aziz (2021), which state the importance of periodic evaluation of fall risk prevention programs to see the effectiveness of their implementation. The above opinion is supplemented by the research conducted by Aprilian (2021) that the evaluation results that led to recommendations can be the basis for further development and improvement.

In the future program Preventing the risk of falling patients must be dominant as the central authority of the treating officer by completing all infrastructure and rearranging the patient's room/bed position with the officer's office. This is in accordance with the statement of hospital

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stakeholders during the FGD, which stated that in the future, they would try to design a room arrangement so that patients can be easily observed from the nurse's office and equipped with monitoring support equipment. In addition to the arrangement of the room and the completeness of supporting facilities for the prevention of fall risk, it is also necessary to analyze the number of workloads of officers that can be used as a reference for the compliance of officers in providing care that is oriented towards patient safety, especially the risk of falling. This is in accordance with the results of research conducted by Yuliatin & Susilaningsih (2020) stated that the heavier the workload of nurses, the poorer the implementation of health education. Hospital management needs to analyze nurse workload objectively to minimize obstacles in implementing health education. Optimal health education, including fall risk prevention mastery, can be effectively implemented.

CONCLUSION

Efforts to prevent the risk of falling are one of the real efforts of creating services that guarantee patient safety. Implementing fall risk prevention is very effective for health workers by involving patients and families who are waiting. Education about preventing the risk of falling for the waiting patient's family provides the benefit of the family understanding more about the causative factors and what efforts can be made. The role of the family in preventing the risk of falling in patients around them is very effective in causing incidents of patient falls. Families feel very happy because they have additional knowledge about fall prevention and pay attention to each other's patients around them.

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CONFLICT OF INTEREST

There is no conflict of interest in this article.

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