Causes analysis and preventive measures for falls in patients hospitalized with cerebral infarction

MO Haiyan

Guangxi Zhuang Autonomous Region People's Hospital, Nanning Guangxi 530021, China

【**Abstract**】**Objective:** To analyze the causes of falls in patients hospitalized with cerebral infarction, thereby proposing targeted preventive measures. **Methods:** In this study, the clinical data of 100 cerebral infarction patients in our department were randomly selected and their falls during hospitalization were retrospectively reviewed. **Results:** Analysis of the causes of falls in patients hospitalized with cerebral infarction (CI)revealed a relatively strong association with age, muscle strength, educational level, and self-care ability. **Conclusion:** In order to prevent the occurrence of falls during hospitalization in patients with cerebral infarction, it is necessary to strengthen the daily management and strengthen health preaching in our department, while simultaneously developing targeted fall prevention measures in combination with a good quality management mode, to prevent the incidence of fall events during hospitalization in patients with cerebral infarction and improve the quality of care.

【**Key words**】Hospitalized patients with cerebral infarction;Falls;Reason;Preventive measure

Fall is a sudden or unintentional stop of the patient, falling to the ground or lower than the initial position[1], which is a sudden and involuntary body position change. Cerebral infarction is a common and frequently-occurring disease in middle-aged and elderly people, which can cause dysfunction of movement, sensation and balance, resulting in patients'slow response, unstable gait, and decreased balance function, significantly increasing the incidence of falls. Falling will not only cause physical injury, but also the psychological pressure caused by it can not be ignored. In addition, the fall of inpatients will also lead to the aggravation of the disease, the prolongation of hospital stay, the increase of economic burden, and the conflicts and even disputes between doctors and patients, nurses and patients. Moreover, patient safety is the basis of nursing quality, and fall is an important nursing quality control index, which can effectively prevent inpatient fall events, reduce the incidence of falls, reduce the severity of injuries, and maintain patient safety. Therefore, analyzing the risk factors of falls in patients with cerebral infarction and seeking effective nursing intervention measures have become one of the key points of nursing work in our department at present, and also an important indicator to evaluate the quality of nursing.

1 Data and methods

1.1 General information

In this study, 100 inpatients with cerebral infarction in our department were randomly selected and their clinical data during hospitalization were analyzed retrospectively. All patients were randomly divided into two groups,

with 50 patients in each group. According to the data analysis, the age was concentrated between 65 and 95 years old, with an average of 78 years old, including 60 males and 40 females. In addition, there were 40 patients under 80 years old, 60 patients over 80 years old and 60 patients under 90 years old;Education level: 27 primary school students, 55 junior high school students, 18 college students;Muscle strength: 18 people at level 0-1, 58 people at level 2-3, and 24 people at level 4-5;Self-care ability: 8 people are heavily dependent, 60 people are moderately dependent, 30 people are slightly dependent, and 2 people are not dependent. There was no significant difference between the two groups in terms of age and gender, educational background, muscle strength and self-care ability.

1.2 Research methods

All patients were divided into two groups, and different management modes were adopted for them. One group of patients is the control group, which adopts the conventional management mode, while the other group of patients is the observation group, which adopts fall prevention measures to manage them. Then record and analyze the probability of falling events of the two groups of patients, and conduct a questionnaire survey on the satisfaction of patients.

1.3 Reasons for patients falling

By investigating the clinical data of patients, we can find that the reasons for their falls are summarized as follows.

(1)Time factor falls occur in the morning and evening of the day, because patients will deal with some personal problems, such as physiological and dietary problems.

(2)Disease and its own factors: hemiplegia, cerebral ischemia and hypoxia caused by insufficient blood supply in cerebral infarction patients, resulting in sudden brain dysfunction, cognitive impairment, loss of consciousness and prone to fall. At the same time, older people are also prone to fall because of their old psychological state and their underestimation or overestimation of their own physical condition, and unpredictable factors, such as body fusion, holding breath during defecation, and rising or falling blood pressure.

(3)Environmental factors: hospital management, lack of auxiliary facilities in the ward bathroom, slippery floor, dark lighting, inappropriate shoes and socks, unreasonable placement of hospital bed articles, accumulation of articles in corridors and corridors, and dense personnel. Most of them occur in the bathroom, which is because the bathroom floor is slippery, dry and wet areas are not divided, and patients have poor muscle strength and slow behavior. In addition, it is a blind area of nursing, and it is impossible to directly care for patients.

(4)The patients with cerebral infarction due to drug factors are mostly elderly people, but the tolerance and sensitivity of elderly people to drugs are different from that of adults, and they are prone to adverse reactions. After medication, adverse reactions such as dizziness and hypotension may occur, which may lead to the risk of falling. In particular, sedative hypnotics, antipsychotics and narcotic analgesics are recognized as significant risk factors for falls[2].

(5)Nursing factors The hospital nursing staff are not enough to meet the needs of patients, and some medical staff have a weak sense of fall prevention and a weak sense of responsibility, which leads to not paying enough attention to patients'falls in daily nursing, and also leads to the incidence of falls.

1.4 Statistical analysis

In this study, the software SPSS19. 0 was used, and then the statistical data of patients were analyzed by x2. When p<0. 05, the statistical data of patients was statistically significant.

2 Results

Through the analysis of the comparative data of the two groups of patients, it can be found that after the adoption of fall prevention measures, the incidence of fall events of the patients in the observation group has been effectively reduced, far lower than 16%of the patients in the control group. The data difference between the two groups of patients is statistically significant, that is, p<0. 05. In addition, after the adoption of preventive measures, the satisfaction of the patients'families has also been effectively improved. The following is the specific statistical data:

Table 1 Comparative analysis of data of two groups of patients

Divide into groups	Number of patients	Reverse situation	Patient satisfaction
Observation group	**50**	0（0%）	96%
control group	**50**	8（16%）	68%
P		<0. 05	<0. 05

3 Discussion

In recent years, all of the""top 10 safety goals for patients""successively developed by the Chinese hospital association mentioned""preventing and reducing unintentional injuries such as patient falls"", and""preventing and reducing the occurrence of patient falls""was included in the implementing rules of the standards for the review of tertiary comprehensive hospitals as one of the important indicators for evaluating the safety management of hospitals at all levels. It was mentioned in the technical guideline for fall intervention in the elderly[3]published by our national health and Education Commission: the occurrence of falls is not unexpected, not too numerous, and is able to be prevented and controlled. While in fall safety management, nurses as direct executors and participants play a vital role in the development and implementation of measures for fall prevention[4]. Therefore, in order to prevent the occurrence of fall events during hospitalization of cerebral infarction patients, it is necessary to adopt corresponding effective preventive measures according to the occurrence cause of fall events in cerebral infarction patients, to ensure the safety of cerebral infarction patients during hospitalization, to provide high-quality medical services for patients, nursing staff must do the following preventive measures.

3. 1 fall risk assessment

Fall risk assessment in hospitalized patients is an effective and necessary countermeasure to prevent falls. So, a relevant scale was developed in each hospital, and in our department combined with the relevant scale of our hospital, dizziness and muscle weakness, for example, are very high-risk factors through a history of falls,

awareness, age (>70 years), sensation, vision, hearing, taking medications (including antihypertensives, hypoglycemic agents, tranquilizers, etc.), frequent urination and urination, balance disorders, and the ability to perform activities of daily living (mainly including grooming, dressing, shoe dressing, eating, toileting, etc.)Ambulation ability, and so on, a comprehensive assessment of the patient to assess the patient's high and low risk of falling through a quantitative outcome. For these high-risk patients with a score of≥4, health care workers should take more and more exhaustive care and be marked to elicit vigilance[5]. Assessment requirements: 1>ambulatory assessment should be performed within 24 hours of admission or transfer, at the time of surgery, and immediately after any change in condition (awareness, change in limb movement). 2. A total score≥4, i. e. , to be regarded as a high-risk row patient, is of high concern, and related protective measures must be performed;Patients and family members were informed and signed on the inform form, which was assessed once daily. 3 it is responsible for the nurses to carry out self-care and cognitive ability and other assessments, and to inform the patients about the scores and protective measures in a timely manner to strengthen the prevention awareness of the patients.

3. 2 strengthen associated preaching of falls

Health education can effectively reduce the incidence of falls, so health care workers should prescribe high-risk patients and family members at the time of admission, during hospitalization, at discharge, without hearing, and strengthen the preaching many times, so that they have safety awareness for preventing falls and grasp relevant interventions. (1)On admission, patients, families, chaperones, etc. were introduced to the room environment and safety measures, and the patients, families, chaperones were instructed on how to use the call bell. Factors, methods and dangers and precautions for fall prevention are informed, and a specialist fall prevention/fall bed promotional manual is issued. (2)Place items commonly used by patients where accompanying hands are available, such as walkers, water cups, paper towels, other items as much as possible in the cabinet, and shift the edge of the bed with potential obstacles, such as chairs, chaperones, etc. (3)The patient was instructed to move gently, the range of motion should not be too large and be uninformative, instructed not to get out of bed unauthorized, do not leave the ward at will, use AIDS and a call bell if necessary, wear appropriate pants, and wear no slip shoes. Sitting should be performed when wearing hosiery, shoes, pants, and shifting body position with slow motion, following the three-step curve principle, such as lying flat for 30 s, sitting up for 30 s, standing for 30 s and walking again, when there is dizziness, should rest in bed, lock your feet, and ensure safety. (4)When the patient is restless or unconscious, ask to keep her accompanied, increase her alertness, pull the column up, and restrain if necessary to prevent falling into the bed.

3. 3 valuing records

Patients were scored according to their high-risk factors for falls after admission based on their fall history, age, state of consciousness, mobility of extremities, vision, and medication taking. 4 points belonged to patients at high risk of falling, placing an anti fall warning board at the head of the bed, and the responsible nurse assessed them daily, recorded on the responsible nurse nursing work record sheet, and noted on the nursing record sheet all measures taken to protect the patient, such as the bed bar, 24-hour chaperoning, With assistance when

getting up, et al. For patients who fall during hospitalization, the time, place, cause, management, and consequences of occurrence should be promptly recorded, and the discussion focused, lessons learned, and precautions should be provided. In case of contingencies and prompt debriefing, the Department convened a nursing safety meeting to discuss the reason for analysis and propose effective rectification measures, Fill out the nursing adverse event upper statement within the specified time above the nursing quality management committee (includes the occurrence of things after, the situation of the patient, the specific experience and consequences, the parties'knowledge about the matter, Department discussion, cause analysis, corrective action, nursing quality committee discussion feedback, and implementation validation of corrective action). Nursing quality management board dedicated personnel from the reported situation to the ward learned the situation by talking to the responsible nurse and patient, from which the cause of the patient's fall was analyzed, and the ward was instructed to take effective protective measures to prevent the recurrence of falls.

3. 4 enhance detail management to focus management on patients at high risk for falls

Increase the frequency of patrols during multiple time periods during which patients fall, placing items commonly used by high-risk patients at random as desirable;Valuing improvements in the environment;If the ward layout is reasonable and safe, the room has adequate lighting, the floor is kept dry, and sliding pads may also be paved. Corridor, stairs, toilet and bathroom with banister, and lighting. Do good psychological care and strengthen preaching, while extending the preaching of fall prevention to various places in the hospital, and produce a striking""careful slip down""warning card to be placed in the corridor of the ward;Posting""preventing falls by ten knows""and""high risk individuals for falling to fall beds""promotional images outside the bathroom door of the patient room;Welcome prompts such as""please use the caller""posted at the bedside of the bed, ""please return to the home for fall prevention after the bedside shaker is used, ""and""pull both bedridden bars while lying still""were posted and emphasized to guide use.

3. 5 direct medication correctly

Patients taking sedative and hypnotic drugs should be advised not to get out of bed when they are not fully awake, and those taking antihypertensive and diuretic drugs should follow their medication without disturbing the medication, and be aware of reactions after the medication. The efficacy of medication and its side effects in patients were evaluated. Patients were instructed to take their medication correctly as directed, to try to administer the medication at bedtime while using sedative hypnotics, to toilet before medication, to minimize activity after medication, and to have lighting at night or urination at the bedside.

3. 6 clear responsibility for nurse safety management responsibilities

(1)The head of the bed was plugged with a""fall prevention""identifier. (2)Patients who were at high risk of falling were included in the handoffs, to do the handoffs well, and to focus on handoffs, the duty personnel did the heart. (3)Patients in out-patient examination, to do out assessment and record, when critically ill patients go out, health care accompanied, take rescue medicine. With pitail stand while flat car, secure belt when wheelchair, chaakhar when stop, ensure safety etc. (4)Psychological care is strengthened for patients with an aged psychological state and the ability to under-or overestimate their physical state, and is communicated

multiple times before effective preaching.

Conclusion: falls are important in prevention: it is crucial to properly assess patients, take effective measures, create a suitable environment, while enhancing safety education for patients, families and caregivers, and increase the importance that caregivers place on falls in patients hospitalized with pre cerebral infarction. Proper assessment of a patient's high risk of falls is an effective and necessary countermeasure to prevent falls. Studies have found[6]that patients who have experienced a fall have an increased probability of another in-hospital fall. Therefore, it is important to make the assessment of patients seriously first: nurses must not only understand the patient's life habits, psychological conditions, but also fully understand the patient's condition, can distinguish the high-risk group, for patients with a history of falls, do centrality, and strengthen the tour of the patient to understand the patient's need. Take hand off shift carefully and record it in nursing record. In addition, there are differences in patient age and cultural level in clinical nursing, such that one cannot understand or misinterpret what nurses mean, but also when nurses are busy, require constant marking of fall prone patients or require patients to remember all the preaching unrealities. So using the warning card welcoming prompts while performing the relevant precautions to make patients feel the nurse welcoming service, such as""please use a caller""at the head of each bed by inserting a humanized warning card, the orange heart-shaped""caution activity""signage[7], on the patient's head card will make it easy for the nurse or patient's family to see, serve as someone to monitor, and provide help in a timely manner to reduce the incidence of falls. Improving the quality of care, improving patient satisfaction, and reducing the rate of falls also maintained the doctor-patient relationship.

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脑梗死住院患者跌倒的原因分析与预防措施

莫海燕

广西壮族自治区人民医院，广西南宁 530021

【摘要】目的：对于脑梗死住院患者跌倒原因进行分析，从而提出针对性的预防措施。方法：在本次研究中，随机选取我科 100 例脑梗死患者的临床资料，对其住院期间的跌倒情况进行回顾性分析。结果：通过对脑梗死住院患者的跌倒原因进行分析可以发现，其和脑梗死患者的年龄、肌力、文化程度以及自理能力等具有较为紧密的联系。结论：为了防止脑梗死患者住院期间出现跌倒情况，需要加强我科的日常管理，加强健康宣教，同时结合优质管理模式制定针对性的预防跌倒措施，防止脑梗死患者住院期间跌倒事件的发生率，提高护理质量。

【关键词】脑梗死住院患者；跌倒；原因；预防措施

跌倒是病人突然或非故意的停顿，倒于地面或倒于比初始位置更低的地方[1]，是一种突发的、不自主的体位改变。脑梗死是中老年人的常见病、多发病，可引起运动、感觉和平衡等功能障碍，导致病人反应迟钝、步态不稳、平衡功能下降，明显增加了跌倒事件的发生率。跌倒不仅会造成生理伤害，由此产生的心理压力也不容忽视。除此之外，住院患者的跌倒还会导致病情加重、延长住院时间、增加经济负担，引发医患、护患矛盾甚至纠纷。况且，患者安全是护理质量的基础，跌倒是一项重要的护理质控指标，有效防范住院患者跌倒事件，降低跌倒发生率，减少伤害严重度，以维护患者安全。因此，分析脑梗死患者发生跌倒的危险因素，寻求有效的护理干预措施，已成为目前我科护理工作的重点之一，也是评价护理质量的重要指标。

1 资料和方法

1.1 一般资料

在本次研究中，随机选取了我科 100 例脑梗死住院患者，对其住院期间的临床资料进行了回顾性的分析。将所有患者随机均分为两组，每组患者人数为 50 人，根据数据分析可以得知: 年龄集中在 65 到 95 岁之间，平均达了 78 岁，其中男性 60 例，女性 40 例，此外年龄 80 岁以下 40 人，80 岁以上，90 岁以下的患者 60 人；文化程度，小学 27 人，初中 55 人，大学 18 人；肌力，0-1 级 18 人，2-3 级 58 人，4-5 级 24 人；自理能力，重度依赖 8 人，中度依赖 60 人，轻度依赖 30 人，无需依赖 2 人。且两组患者在年龄和性别、学历、肌力，自理能力等方面的差异不具有统计学意义。

1.2 研究方法

将全患者均分为两组，分别对其采取不同的管理模式。其中一组患者为对照组，采取常规的管理模式，而另一组患者为观察组，采用跌倒预防措施来对其进行管理。然后对两组患者的跌倒事件发生几率进行记录和分析，并对患者的满意度进行问卷调查研究。

1.3 患者跌倒的原因

通过对患者临床资料进行调查可以发现，其跌倒的原因总结如下几点。

（1）时间因素跌倒事件发生在一天中的早晚两个时间段，因为这时患者会处理一些个人问题，如生理及饮食问题等。

（2）疾病及自身因素 脑梗死病人出现偏瘫、脑供血不足致大脑缺血缺氧，使患者突然发生脑功能失调，认知能力障碍，出现意识丧失而易发生跌倒。同时年龄偏大，因不服老的心理状态和对自己身体状况估计不足或过于高估自己的能力也是易跌倒因素，不可预知的因素，如体位聚变，排便时摒气，血压升高或下降等。

（3）环境因素医院管理，病室卫生间缺少辅助设施，地面过滑，照明过暗，鞋袜不合适，病床物品摆放不合理，楼道、走廊物品堆积，人员密集等。最多发生在卫生间，这是因为卫生间地面滑，未分干湿区域，加上患者肌力差，行为缓慢，此外它是个护理的一个盲区，无法对患者进行直接护理。

（4）药物因素脑梗死患者多是老年人，然老年人对药物的耐受性和敏感性与成年人不同，容易发生不良反应。用药后可能产生眩晕、低血压等不良反应，易发生跌倒的危险。特别是镇静催眠药、抗精神病药和麻醉镇痛药，被公认为是跌倒的显著危险因素[2]。

（5）护理因素医院护理人员不足以满足患者的需求，加上部分医护人员的跌倒预防意识不强，责任心弱，导致在日常护理中对患者跌倒不够重视，也导致了跌倒的发生率。

1.4 统计学分析

在本次研究中，采用的是软件 SPSS19. 0，然后通过 x2 对患者的统计数据进行分析，当 p<0. 05 时表示患者的统计数据具有统计学意义。

2 结果

通过对两组患者的对比数据进行分析可以发现，在采用跌倒预防措施之后，观察组的患者跌倒事件的发生几率得到了有效的降低，远远低于对照组患者的 16%，两组患者的数据差异有统计学意义，即 p<0. 05，此外，采用预防措施之后，患者家属的满意度也得到了有效的提高，下面是具体的统计数据：

表 1 两组患者的数据对比分析

分组	患者人数	倒发生情况	患者的满意度
观察组	**50**	0（0%）	96%
对照组	**50**	8（16%）	68%
P		<0. 05	<0. 05

3 讨论

近几年，中国医院协会陆续制定的“患者十大安全目标”中均提到“防范与减少患者跌倒等意外伤害”，并将“防范与减少患者跌倒的发生”列入《三级综合医院评审标准实施细则》中，作为评价各级医院安全管理的重要指标之一。我国卫计委公布《老年人跌倒干预技术指南》[3]中提到：跌倒的发生并非意外，并非防不胜防，是能够预防和控制的。而在跌倒安全管理中，护士作为直接执行者和参与者，对跌倒预防的措施制定和实施起着至关重要的作用[4]。因此，为了防止脑梗死患者住院期间跌倒事件的发生，需要根据脑梗死患者跌倒事件的发生原因来采取相应的有效预防措施，保证脑梗死患者住院期间的安全性，为患者提供高质量的医疗服务，护理人员要做好下面的预防措施。

3. 1 跌倒危险性评估

对住院患者进行跌倒危险性评估，是预防跌倒有效且必要的对策。所以，各各医院制定出了相关量表，我科结合本院相关量表，把头晕，肌无力例为极高危因素，通过跌倒史、意识、年龄（>70 岁），感觉、视觉、听觉，服用药物（包括降压药、降糖药、镇静安眠药等），排尿排便频繁，平衡障碍，日常生活活动能力（主要包括梳洗、穿衣、穿鞋、进食、如厕等方面）、行走能力等等方面，对患者进行全面的评估，以通过量化的结果来评估患者跌倒的危险性高低。对≥4 分的这些高危患者，医护人员应予更多更详尽的照顾，并做好标记，引起警惕[5]。评估要求：1、患者入院或转入 24 小时内、手术时及病情改变（意识、肢体活动改变）立即进行动态评估。2、总分≥4，即视为高危行患者，高度关注，须执行相关防护措施；告知患者及家属并在告知书上签字，每天评估一次。3 责任护士进行自理及认知能力等评估，并及时将评估的分值、防护措施告知患方，强化患方防范意识。

3. 2 加强跌倒的相关宣教

健康教育能够有效降低跌倒的发生率，因此医护人员要在入院时、住院期间、出院时向高危患者及家属进行宣教，对不听讲的，更要多次加强宣教，使得他们具有预防跌倒的安全意识，掌握相关干预措施。（1）入院时向患者、家属、陪护等介绍病室环境及安全措施，指导患者、家属、陪护如何使用呼叫铃。告知预防跌倒的因素、方法和危险性及注意事项，并发放专科预防跌倒/坠床宣传手册。（2）将患者常使用的物品放置在随手可得处，如助行器、水杯、纸巾，其他物品尽量放于柜内，挪移床边有潜在的障碍物，如椅子、陪护床等。（3）指导患者动作轻柔，运动幅度不宜过大，无人陪同时，嘱不要擅自下床，不要随意离开病房，必要时用辅助工具及按呼叫铃，穿合适的衣裤，穿防滑鞋子。穿脱袜子、鞋、裤子时应坐着进行，变换体位时动作宜慢，遵循三步曲原则，如平躺 30 秒，坐起 30 秒，站立 30 秒再行走，当有头晕不适时，应卧床休息，锁好床脚，确保安全。（4）患者躁动不安或意识不清时，嘱留陪人，提高警觉，将床栏拉起，必要时约束，以防坠床。

3. 3 重视记录

患者入院后根据跌倒史、年龄、意识状态、肢体活动情况、视力、服药情况等进行跌倒高危因素进行评分，4 分属于高危跌倒患者，在床头放防跌警示牌，责任护士每天评估，记在责任护士护理工作记录本上，并在护理记录单上记下保护患者所采取的一切措施，如上床栏，24 小时陪护，起床时有人搀扶等。对住院期间跌倒的患者应及时记录发生的时间、地点、原因、处理及后果，集中进行讨论，吸取教训，加以防范。一旦发生意外事件，及时汇报，科室召开护理安全会讨论分析原因，提出有效的整改措施，在规定时间内填写《护理不良事件上报表》上报护理质量管理委员会 (包括事情发生经过、患者情况、具体经过及后果，当事人对此事的认识，科室讨论，原因分析，纠正措施，护理质量委员会讨论反馈意见，纠正措施实施验证)。护理质量管理委员会专职人员根据报告的情况到病房通过与责任护士和患方交谈了解情况，从中分析患者跌倒的原因，指导病房采取有效的防护措施防止跌倒再次发生。

3. 4 加强细节管理，重点管理高危跌倒的患者

增加患者跌倒多发时间段的巡视频次，将高危患者常用的物品放置于随手可取处；重视环境的改善；如病房布局合理、安全，房间有充足的照明，保持地面干燥，也可铺设防滑垫。病区的走廊、楼梯、厕所及浴室设扶手，并有照明灯。做好心理护理，加强宣教，同时将防跌倒的宣教扩展到院内各个场所，制作醒目“小心滑倒”警示牌放在病房的走廊；在个个病室的卫生间门外张贴“预防跌倒十知道”和“跌倒坠床的高危人群”宣传图片；在病床的床头张贴“请使用呼叫器”、床尾张贴“请将病床摇把使用后回归原处

防跌倒”、“卧床时请拉两侧床栏”等的温馨提示并强调指导使用。

3. 5 正确指导用药

对服镇静、安眠药的患者，劝其未完全清醒时勿下床活动，服降压、利尿药的患者，应遵医嘱服药，勿乱用药，并注意用药后的反应。评估患者用药效果及其副作用。教会患者正确按医嘱服药，使用镇静催眠药时尽量睡前给药，用药前入厕，用药后尽量减少活动，夜起要有照明或者床边排尿。

3. 6 明确责任护士安全管理职责

（1）床头插“预防跌倒”标识。（2）高危跌倒的患者列入交接班内容，做好交接班，并重点交接，值班人员做到心中有数。（3）外出检查的患者，要做好外出评估并记录，危重患者外出时，医护陪同，带上抢救药品。用平车时立护栏，轮椅时系安全带，停下来时刹好车，确保安全等。（4）对因不服老的心理状态和对自己身体状况估计不足或过于高估自己的能力的患者加强心理护理，并多次沟通后再做有效宣教。

结论：跌倒重在预防：正确评估患者，采取有效措施，创造适合环境、同时加强对患者、家属及护理人员的安全教育，提高护理人员对于预脑梗死住院患者跌倒的重视程度等至关重要。正确评估病人跌倒的高危性是预防跌倒的有效和必要对策。有研究发现[6]，曾经发生过跌倒的病人，其再次发生住院期间跌倒的概率增加。因此，首先认真做好患者的评估工作很重要：护士不仅要了解病人的生活习惯，心理状况，并且要充分了解病人的病情，能分辨高危人群，对有发生跌倒史的病人，做到心中有数，加强巡视病人，了解患者的需要。认真做好交接班，并在护理记录上记录。此外，临床护理中患者年龄、文化层次存在差异，因此存在听不懂或误解护士的意思，也存在护士工作繁忙，要求时刻盯住易跌倒患者或要求患者记住所有的宣教不现实。所以在执行相关预防措施的同时使用警示牌温馨提示，让患者感受到护士温馨的服务，如在每个病床的床头贴“请使用呼叫器”，如在病人的床头卡上插上人性化的警示牌——橙色心形“谨慎活动”标牌[7]，使护士或患者家属都会随时看到，起到人人监督，及时提供帮助，以减少跌倒的发生率。提高护理质量、提高患者满意度，降低跌倒率的同时也维护了医患关系。

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