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Performance Evaluation of Nursing Staff in the Prevention of Injury: Focus in Patient Fall and Medication Error in a Provincial Hospital

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ABSTRACT

Patient falls and medication errors remain the leading causes of preventable harm in hospitals, especially in resource- limited provincial settings where nurses serve as the primary safety barrier. This study evaluated the performance of nursing staff in preventing physical injuries, specifically patient falls and medication errors, in a provincial hospital in MIMAROPA, Philippines. Using a quantitative descriptive-correlational design and total enumeration sampling, data were collected from 56 registered nurses using a validated, 4-point Likert scale questionnaire and analyzed using frequency, percentage, weighted mean, standard deviation, and chi-square test. Results showed that respondents were predominantly young, bachelor's degree holders, and had less than five years of service. Nurses consistently performed safety practices, with an overall mean of 3.71 (Always Performed) for fall prevention and 3.81 (Always Performed) for medication safety. Weakest practices included assistance during mobility and distraction control during drug administration. Educational attainment, length of service, and training attendance showed significant relationships with performance ($p<0.05$). The study concludes that while nursing performance is generally strong, critical gaps persist due to workload, interruptions and reporting barriers. It is recommended that hospital management optimize staffing, conduct targeted competency training, enforce 'Quiet Zones', and implement a non- punitive reporting system to further strengthen patient safety and quality care.

Keywords: *Nursing Staff, Patient Safety, nursing performance evaluation, patient falls prevention and medication error prevention, provincial Hospitals*

INTRODUCTION

Patient safety is a core pillar of quality healthcare and a primary duty of nurses, who serve as the frontline defense against preventable harm. Globally, the World Health Organization (2023) notes that over half of patient injuries are avoidable, with patient falls and medication errors being the most common adverse events. In the Philippines, Department of Health Administrative Order No.2020-0007, the Philippine Nursing Act, and Commission on Higher Education standards all mandate safe care, yet incidents persist due to workload, poor communication, and limited resources, challenges felt most acutely in provincial hospitals. While performance evaluation identifies practice strengths and gaps, related studies in these settings remain scarce. This study assesses nursing performance in preventing falls and medication errors in a provincial hospital to generate evidence for targeted interventions, training, and policies that strengthen patient safety and quality of care.

Statement of the Problem

This study sought to answer the following questions;

1. What is the demographic profile of the respondents in terms of:
    1.1 age group
    1.2 educational attainment
    1.3 years of experience
    1.4 designation and
    1.5 relevant training attended
2. What is the level of performance of nursing staff in the prevention of patient fall?
3. What is the level of performance of nursing staff in the prevention of medication errors?
4. Is there a significant relationship between the demographic profile of the nursing staff and their performance in preventing physical injuries such as falls and medication errors?
5. Based on the findings, what safety policy that includes targeted recommendations based on the identified gaps and relationships can be proposed?

Scope and Limitation

The study focuses on one provincial hospital in MIMAROPA Region IVB, which caters predominantly to low- income patients and operates under conditions of limited resources. The research involves 56 eligible staff nurses across clinical areas; nurses working as admin staff are not included, as well as staff nurses who were on leave at the time of the study. It focuses on two specific domains of patient safety and not the institution's overall safety performance. The findings may not fully be generalizable to private hospitals, large tertiary medical centers, or facilities with substantially different resource availability and workforce demographics.

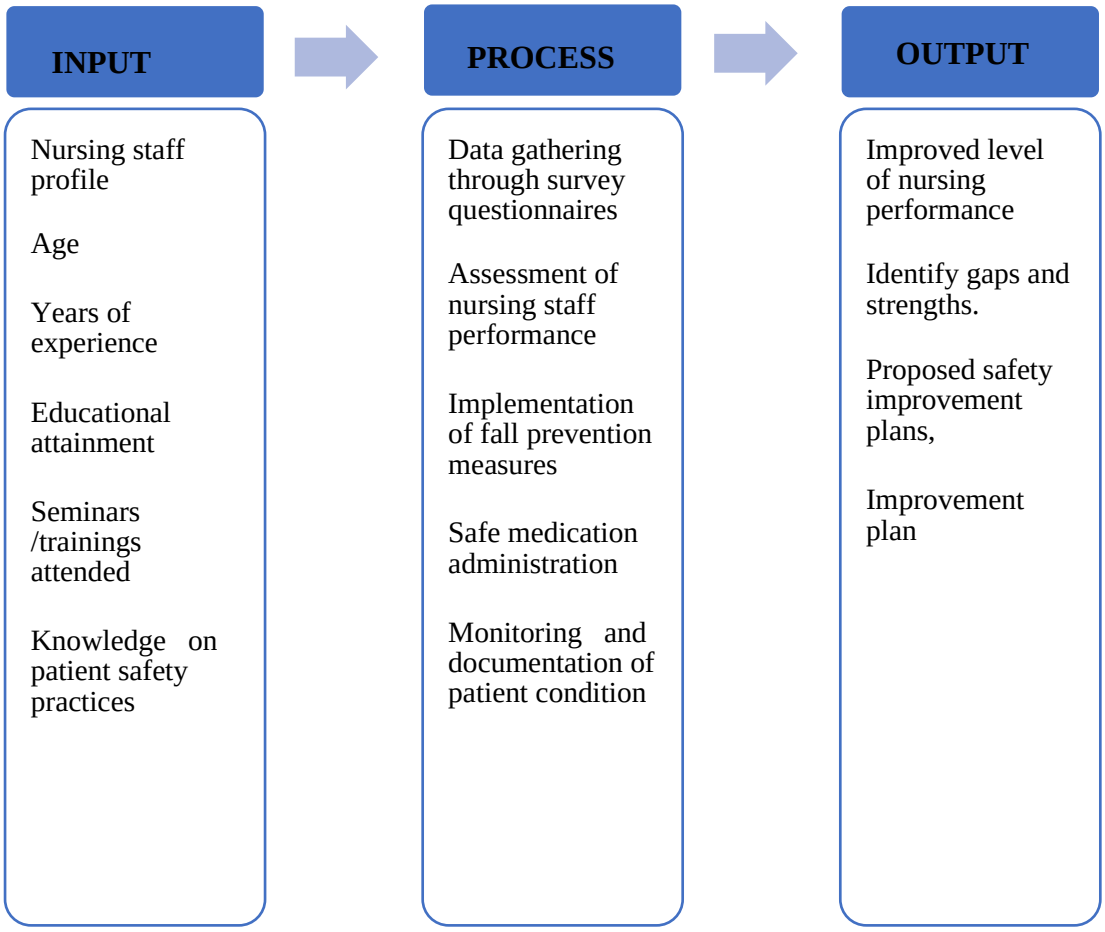
Review of Related Literature

Patient falls and medication errors continue to be among the leading preventable causes of patient harm in healthcare facilities. Research indicates that ongoing performance evaluation, continuous training, competency assessment, and compliance with established patient safety protocols improve nurses' ability to prevent these adverse events. Regular monitoring of nursing practice enhances the quality of care and supports safer clinical outcomes. These findings emphasize the importance of evaluating nursing staff performance in promoting patient safety and preventing physical injuries in provincial hospitals (Morris et al.,2022)

Theoretical Framework

The study is grounded in Donabedian's Structure -Process-Outcome Model (1966/2016). Structure refers to resources, staffing, policies, tools, and facilities. Process covers nursing actions such as fall prevention and safe medication practices, which are measured in this study. Outcome denotes patient results, specifically prevention of falls and medication errors. The model posits that good structures enable safe processes, which in turn produce better patient safety outcomes and provide the basis for evaluating performance and designing the SAFE-CARE improvement program.

Conceptual Framework



Methodology

Research Design

This study used a quantitative descriptive correlational approach to evaluate the performance of nursing staff in a provincial hospital regarding the prevention of physical injuries with particular emphasis on patient falls and medication errors. The research design is appropriate because it enables the researcher to collect and analyze numerical data to describe nurses' current performance.

Research Steps

The research process began by securing ethical clearance from the Ethics Review Board and obtaining formal permission from the provincial hospital administration to conduct the study. Once institutional approval was granted, the researcher conducted an orientation and explained the purpose of the study, the voluntary nature of participation, and strict confidentiality protocols. After securing informed consent from the participants, the

questionnaires will then be distributed and retrieved upon completion. The collected responses will then be checked, organized, encoded, and prepared for statistical analysis.

Data Collection and Sample Collection

Data collection was gathered using a structured, expert-validated Likert-scale questionnaire that covers demographic information of the respondents and assessment of the level of performance of nursing staff in preventing patient falls and medication errors. The completed surveys were collected, checked for completeness, and securely stored to undergo analysis.

Data Analysis Methods

The data gathered were analyzed using frequency and percentage to summarize the respondents' demographic characteristics. The weighted mean will determine the overall performance of nursing staff, while the standard deviation will assess the consistency or variability of the responses. The chi-square test of independence will be used to determine whether there is a significant relationship between the respondents' demographic characteristics and their level of performance in preventing patient falls and medication errors. The hypothesis will be tested at a 0.0.5 level of significance.

Study Limitation and Ethical Consideration

The study strictly observed ethical standards by securing informed consent from all participants, ensuring voluntary participation, and allowing withdrawal at any time without penalty. Ethical standards were strictly upheld through formal clearance from the Ethics Review Board.

Results and Discussion

In both safety domains, falls and medication safety, a consistent pattern emerged: basic, fast, routine steps are always done, while complex, time-consuming, high-impact safeguards are only often done. Performance satisfies basic DOH requirements but is not excellent, providing a strong basis for the proposed SAFE CARE PROGRAM, which targets prevention of medication error and patient falls by improving system, culture, and practice application, not just knowledge.

Conclusions

The study concludes that nursing staff in the provincial hospital are young, qualified, and mostly junior in service; basic, routine safety practices are consistently done, while time-consuming, complex, high-impact safeguards are only often performed, revealing a clear knowledge -practice gap.

Recommendations

Based on the findings and conclusions of the study, the hospital administration should adopt and implement the SAFE CARE Program to prevent medication errors and patient falls. Improve resource support, institutionalize a Just Culture for safe reporting, and provide continuous training, especially for junior nurses. For Quality Assurance, update patient safety

policies and evaluation tools to focus on critical safeguards and integrate these indicators into regular quality monitoring and DOH/ Philhealth accreditation reports. For Nursing Service to strictly enforce the weakest practices by streamlining workflows and conducting regular bedside coaching to close the knowledge gap.

Acknowledgement

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AI Declaration

AI-supported tools helped with the structure in creating this article. No AI tools were used to collect, analyze, or interpret data. All authors are credited for *their academic contributions.*

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