Fall prevention program – addressing individual patient needs
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Introduction
Post-fall review, adopted the “fresh pair of eyes” principle has been commenced since September 2012 in Queen Mary Hospital. A Nursing Officer (NO) / Ward Manager (WM) of the Quality and Safety (Q&S) Department examines individual fall incident and gathers data for planning the effective fall reduction strategies / fall management.

Objectives
1. To examine the fall incidents case by case at patients' and relatives’ point of view; 2. To identify areas for improvement on fall prevention and fall management; 3. To set reference and guide for other cluster hospitals in implementing fall reduction strategies/fall management plans.

Methodology
Upon receiving fall incidents via the Advanced Incident Reporting System (AIRS), the NO/WM, Q&S went to wards for checking of the fall-related documentation, visiting and communicating with the patients or patients’ relatives for exploring the contributing risk factors of every fall incident. The NO/WM, Q&S discussed the on-hand post-fall review information with the ward in-charge/ ward manager for immediate improvements, if required. The NO/WM, Q&S would further enhance fall prevention education to the patient/patient’s relative. The collected data was further analysed. Results and effective falls reduction strategies were shared in Cluster Patient Safety Committee meeting.

Result
1. Post fall documentation review increased from 61% in 4Q2012 to 84% in 3Q2014. 2. Post fall patient/patient’s relative interviews increased from 61% in 4Q2012 to 70% in 3Q2014. 3. Highlights of the fall incidents are: 3.1 70.32% were related to overestimation of their own abilities and did not call help (increased by 33.96% when compared with 36.36% in 2012/13); 3.2 61.1% were documented as “not at risk” on initial fall risk assessment; 3.3 45% were related to toileting (increased by 6.12% when compared with 38.88% in 2012/13); 3.4 6.34% were related to kick off fever or sudden onset of high fever of more than 38.3°C. 4. Fall risk strategies were implemented.