Implementation of unified patient safety system (safe mobilization of fragile patients: SMFP) in cluster hospitals

Hong Kong East Cluster

Keywords:
Fragile patients are at risk of fall, limbs fracture and skin breakdown during transfer, mobilization and ambulation. Implementation of unified patient safety system (safe mobilization of fragile patients: SMFP) in cluster hospitals facilitate communication among medical (doctors, nurses, therapists) and non-medical staff (health care assistants, porters, ambulance men etc.) in preventing these injuries.

Introduction
Fragile patients are at risk of fall, limbs fracture and skin breakdown during transfer, mobilization and ambulation. To facilitate communication among medical (doctors, nurses, therapists) and non-medical staff (health care assistants, porters, ambulance men etc.) in preventing these injuries, a new system of patients' risk assessment, alert signage display and patient care protocol was designed and pilot tested in 2011 in 3 wards (O&T/RHTSK; O&T & MED/TWEH). The system was then modified and further tested in 2013 with SJH joining. In 2014, the system was promulgated in 39 wards in 6 hospitals within HKEC.

Objectives
A survey was done to evaluate whether the (1) system appropriately reflects the importance of safe mobilization of fragile patients; (2) system is systematic and well-organized; (3) workload required was appropriate; (4) alert signage enhances understanding on patients' specific needs; (5) staff regularly read the alert signage before mobilizing patients; (6) system can improve team communication and enhance patient safety; (7) staff agree the system should be implemented across HKEC.

Methodology
1651 questionnaires were distributed to staff in the 39 wards and hospital supporting
teams in the 6 hospitals from 19-20 January 2015.

**Result**
The return rate was 52.4%. 52% and 30% of staff were positive and neutral to the 7 questions respectively. Staff who were not the usual patients' careers but need to take care of them temporarily (e.g. endoscopy/ x-ray department nurses, ambulance men, central portering and ward supporting staff) welcomed the SMFP system most. Despite the positive response, 16.7% staff did not regularly read the alert signage before mobilizing patients. 36% nurses in wards with high patient turnover reported increased workload in repeated patient assessment and alert signage update. The SMFP system is effective in improving team communication and enhancing patient safety; and was accepted by majority of staff who agree to implement this unified patients' risk alert system across HKEC. Sufficient staff training, briefing, engagement and feedback collection are essential in winning staff acceptance. Nonetheless, extra workload of ward nurses should be addressed.