**Service Priorities and Programmes**

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**Submitting author:** Dr Mei Cheung WONG
**Post title:** Associate Consultant, UCH, KEC

# A review of inpatient fall incidents of psychogeriatric patients and measures for fall prevention in the United Christian Hospital

*Wong MMC (1), Pang PF(1)*
*(1) Department of Psychiatry, United Christian Hospital*

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## Introduction

In view of the rise in fall rate, we would like to look for factors associated with psychogeraitrics (PG) inpatient falls to improve our fall prevention program. The Morse Fall Scale (MFS) is used in all wards of the United Christian Hospital (UCH) but a fall risk assessment targeting inpatient psychiatric patients is justified.

## Objectives

A pilot study comparing two fall risk assessment tools was done and the adherence to specific fall preventive measures were audited.

## Methodology

A retrospective review was done for all fall involving psychogeriatric inpatients in psychiatric ward of UCH in 2016. Scores of MFS and Wilson Sims Fall Risk Assessment Tool (WSFRAT) were compared for thirty consecutive inpatients. They were then compared with the modified version of the Functional Ambulation Classification (MFAC). Detection of postural hypotension and mobility assessment upon admission were audited.

## Result

93 psycho-geriatric patients were admitted in 2016. There were a total of twelve inpatient falls reported which involved eleven elderly patients. Two-third of the falls involved patients with dementia. Over half of the patients fell on the way to the bathroom and most happened during the night shift when the staffing level was low. The WSFRAT was able to pick up all high risk cases assessed by the MFS but not the other way around. The classification of high fall risk by WSFRAT also matched perfectly with the MFAC. Thirteen patients were involved in the audit and it was found that twelve of them (92.3%) had their supine and erect blood pressure measured on the day of admission. One patient was found to have substantial drop in blood pressure on standing and appropriate measure had been taken for this patient. All patients had been assessed by physiotherapist within three days of admission and mobility aids were readily available if they required one.
Patients with dementia had poor safety awareness and had poor adherence to safety

measures suggested to them. Use of bed exit alarms and bed pan is encouraged. Close supervision is important in the prevention of falls. There was good adherence to the detection of postural hypotension and patients' mobility was also assessed promptly with walking aids readily available if needed. The WSFRAT which is a fall risk assessment targeting psychiatric patients had been piloted in PG patients and an extra proportion of at risk patients are able to benefit from additional fall risk interventions if it is used instead.