



Service Priorities and Programmes Electronic Presentations

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Enhancement Program on Prevention of Patient Fall

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Hourly Patrol Rounding with visual aid

Modified Fall Risk Assessment Form

Modified Fall Risk Assessment Form

Introduction

Patient safety is the major focus area in health care system but patient falls are the most frequently reported adverse event in hospitals (Kline, Davis & Thom, 2011). Although some of patient falls cannot be predicted, we could strengthen our staffs' alertness and build up our relatives and patients' awareness on the risk of fall.

Objectives

Increase staffs alertness, both nursing and supporting staff, on prevention of patient fall Increase relatives and patients' awareness regarding risk of fall by engaging them in the program Decrease patient fall incident rate

Methodology

A Workgroup has been set up since Feb 2012 with bottom up approach to enhance communication and implementation of Enhancement Program in the Department. Monthly Fall Calendar and Hourly Patrol Rounding, based on the concept of visual management, have been designed and rolled out in all Surgical Wards. Fall Risk Assessment Form and Care Plan have been modified to facilitate the compliance of daily assessment. In-patient Post Fall Assessment Form has been incorporated into the CMS for efficacy of documentation. Staffs share the roles and responsibilities on the Program. All patients are being assessed on admission and to be reviewed daily on the risk of fall. Fall prevention leaflets are being distributed to patients and relatives upon admission.

Result

This program was being implemented in Surgical Wards since March 2012. 3 internal audits had been conducted in 2012 with the following results: The overall compliance rate on prevention of patient fall increased from 79% to 94% The

satisfaction rate of nurses increased from 63% to 87.5% The satisfaction rate of supporting staff decreased from 87% to 71.4% However, after clarification and reinforcement the concept of prevention of patient fall, the satisfaction rate of supporting staff rebounded from 64% to 71.4% in the second audit. The satisfaction rate of patients increased from 79% to 94% The fall rate decreased drastically from 0.68 to 0.40 The Severity Index of fall incidents was low: 1-2.

Conclusion Patient Fall is a common risk factor causing patient injury but could be prevented. The Enhancement Program demonstrates excellent outcomes on prevention of patient fall. Yet, without staffs commitment, and engagement of relatives and patients, the program could not be successfully implemented.