Service Priorities and Programmes

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**The reporting and monitoring of fall incidents as a tool in improving fall prevention in hospital**

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**Introduction**

Prevention of hospital fall incidents is global challenge for hospital risk management. Patients admitted to different specialty wards have different clinical and caring needs, and frailty level. However, they may have similar risk factors as far as falls prevention is concerned.

**Objectives**

To demonstrate a co-ordinated fall assessment service is effective in improving fall prevention in hospital.

**Methodology**

We collected and analysed the reports of inpatients falls from 2011. The fall incidents happened in adult inpatient wards, that reported through Advanced incidents Reporting System (AIRS) were recruited. The Fall Assessment Service Team (FAST) reviewed the reports and the hospital case notes, and documented the fall incidents systematically. FAST would also assess the patients and provide inputs for fall prevention.

**Result**

Following the pilot project in 2011, a standardised data set for fall risk assessment was formulated. In 2012, 232 adult inpatients falls incidents in our hospital were analysed systematically. The common risk factors of falls, the activities at the time of the falls, the mechanism of the falls and the interventions were recorded. We held regular meetings to disseminate our findings and suggestions to the ward nurse coordinators. We had implemented an exercise to incorporate the promotion of continence care as the strategy for hospital fall prevention from 2012. The projects continued in 2013. In the latest analysis, the total number of inpatients falls was reduced from 232 in 2012 to 214 in 2013. After correcting for the patient-bed days, the fall rate was reduced from 0.74 per thousand patient bed days in 2012, to 0.65 in the year of 2013. The trend of reducing inpatients fall rate could be observed over all age group. The encouraging results were most obvious in the two biggest specialties as far as the patient-bed days were concerned, namely medical and surgical wards. The fall rate of medical wards was reduced from 0.85 to 0.74. The fall rate of surgical

wards was reduced from 0.75 to 0.57. The most common activity associated with hospital fall was toileting. The most common mechanism and risk factor identified for fall was lower limb weakness. Conclusion: The interactive approach between the reporting side of the ward staff and the data analysing side of FAST, is effective in delivering generic and specific fall prevention strategies, as evidenced by the reduction of inpatient fall rate of our hospital.