Service Priorities and Programmes

Electronic Presentations

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Quality of Care Project (QOCP): Fall prevention in Surgical Department, United Christian Hospital (UCH)

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Introduction

Fall incident rate of surgical ward S7A was 0.92 per 1000 patient bed days in 2011. It was comparatively higher than our hospital fall rate 0.63 per 1000 patient bed days. As fall is one of the nursing quality indicators and fall-related injuries compromise the quality of health of patients as well as contribute substantial cost to hospital, it is important to implement appropriate and effective fall prevention strategies to reduce patient fall. Hence, QOCP in fall prevention in surgical ward was carried out in 2012.

Objectives

To reduce fall incident rate through implementation of the follow strategies – 1. To implement fall prevention measures. 2. To improve working process / Transform care at bedside to reduce nursing time.

Methodology

1. Fall incident data analysis - A retrospective review of fall incident reports and medical records from January 2011 to December 2011 was done. Baseline data such as Morse Fall Scale, age, incident time, activity during fall and fall mechanism were collected. In 2011, there were 7 fall incidents in ward S7A in the period of 0900 to 1700. Risk factors that contribute to fall incidents were then identified. 2. Conduct specific training program for a nursing supporting staff - A nursing supporting staff (PCAII) has been trained for the fall prevention project and assigned to work from 0900 to 1700. That staff carried out hourly round in ward, maintain safe environment, assist patients in basic and toilet needs, patient fall assessment checking and particularly providing fall prevention education and so on. 3. Improvement of work environment and procurement of fall prevention devices - Installation of tailor-made storage cabinets and wall-mounted gloves racks for easy access. Procurement of fall prevention devices including fall-alarm pads and beside chairs. 4. Provision of fall prevention education to frontline staff, patients and their carers.

Result

Result There is a decreasing trend of fall incident rate noted. Fall incident rate of surgical ward S7A was 0.83 per 1000 patient bed days in 2012 after implementing the

project for one year, while fall incident rate in 2011 was 0.92 per 1000 patient bed days. Besides, there was only one fall incident happened during the working hours (weekdays 0900-1700) with the additional nursing supporting staff in 2012, while there were 7 reported fall incidents at the same period in 2011. It is very encouraging to have such significant reduction of fall incident rate. Conclusion Team approach in upholding quality patient care is always important. With the additional resources, particularly for employing designated supporting staff, and the concerted effort of Hospital Fall Prevention Task Force, there was a significant result in reducing patient fall incident. Also, environment modifications and patient workflow revision initiated to save more nursing time for caring our patients were other strategies in fall prevention. Certainly, it is well worth to continue this patient safety project and promote to other wards in order to reduce fall incidents.