



Service Priorities and Programmes Electronic Presentations

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Enhancement prevention of injurious fall of palliative care unit

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Introduction

Injurious fall in hospital may lead to serious consequences including deteriorated physical ability and adverse psychological effects to patient; increased hospital stay and utilization, hence may raise the operational cost of caring (Tseng & Yin, 2013; Cameron et al, 2012). This is an ongoing project following 2013 CQI on fall prevention of palliative care unit in Shatin Hospital, with marked decrease in fall cases number. However, reviewing the fall data of 2014, there was increased numbers of injurious falls with relatively high severity index was observed. Nearly 70% of falls incidents were related to patients' needs of elimination, especially using commode. Moreover, ineffective communication among multidisciplinary staff regarding patients' condition changes was also noted in the review. Therefore, multifactorial interventions for injurious fall prevention were implemented to minimize the numbers and the severity of injurious fall incident.

Objectives

1. To facilitate staff to familiar with fall prevention strategies, including institutional, environmental & equipment-related, and personnel support-related interventions.
2. To strengthen multidisciplinary communication regarding the patients' physical condition changes that may contribute to the risk of fall.
3. To promote the use of injurious fall prevention devices

Methodology

1. Institutional interventions
 - A. Shared previous fall data analysis in order to enhance the exchange of knowledge and experience among multidisciplinary staff.
 - B. Arranged patrolman during the time of handover.
 - C. Implemented pilot scheme of using enhanced absorbency napkin to minimizing the time of patients being unattended, during napkin round especially at night shift.
2. Environment and equipment-related interventions
 - A. New movement monitor system with remote flashlight was installed for the patients in isolation room.
 - B. To apply movement monitor alarms for patients identified with fall risk.
 - C. Remove bedside commode immediately after every single use.
 - D. Encourage fall risk patient to use hip protector and head saver
3. Personnel support-related interventions
 - A. Educated staff to fulfill patients' elimination needs with priority.
 - B. Improved multidisciplinary

communication and assessment regarding the fall risk, ability of using bedside commode and postural dizziness of patients. C. Nurses reinforced fall prevention education and provide leaflets to relatives of patients in risk. D. Reinforced nurse education to encourage fall risk patients to use injury preventive devices E. Strengthened the routine practice to offer preventive devices to fall risk patient

Result

1. Staffs are familiar with the fall prevention strategies, change of routine and workflow become regular practice. 2. Multidisciplinary communication was enhanced by information sharing of fall cases. In addition, communication regarding the condition change of patients, with documentation in patient record and verbal handover, becomes team practice 3. Staffs promotion in using the injury prevention devices was observed to be increased.