Service Priorities and Programmes

Electronic Presentations

Convention ID: 79
Submitting author: Mr TAK LEUNG SZE-TO
Post title: Advanced Practice Nurse, Ruttonjee & Tang Shiu Kin Hospitals, HKEC

Patient Engagement on Fall Prevention

Lee A, Lei PO, Sze-to TL, Cheng TF
Acute Integrated Medical Services, Ruttonjee & Tang Shiu Kin Hospitals

Keywords:
Patient Engagement
Fall Prevention

Introduction

Patient fall is an event which results in the patient or a body part of the patient coming to rest inadvertently on the ground or other surface lower than the body (WHO, 2012). Although not all the fall-related injuries are fatal, some patients subsequently have decline in self-care ability, reduced mobility and self-confidence. Falls occur as a result of a complex interaction of risk factors. Beside an unsafe environment, patient with the condition of poor mobility, cognition, and limited vision prone to falls (Elderly Health Services, 2015). We assess our patients' condition, equipment and ward environment regularly to prevent falls. Recently, we investigated some fall incidents and found that underlying medical conditions such as neurological, cardiac or other disabling conditions, and side effects of medication were the possible causes of falls. Therefore, we have strengthened the patient engagement to tackle the problem with multiple resources since April 2015.

Objectives

1. To engage patients in participating in fall prevention 2. To minimize patients' fall rate in wards

Methodology

According to HKEC Guidelines on Fall Prevention (2014), patients with Morse Fall Scale ≧ 55 or are supplemented with clinical judgment are regarded as with high fall risk. Nurses should provide both Universal and Additional Fall Preventive Measures when they are admitted. On top of these, we tried to provide the following measures for high risk patients. 1. Neighbourhood Support A double-sided "Neighbourhood Support Reminder" is placed on the target's bedside table. The side facing the target shows "防止跌倒 不要離床" with an understandable cartoon. Combining with the explanation from nurses, it raises the awareness of patient at risk . The other side shows "如病人離床 請通知護士". Nurses invite some smart patients or relatives in the same cubicle as helpers. In case the target tries to climb out of bed, the opposite side neighbours can notify the nurses immediately. The fall incident can be prevented by utilizing the possible resources in the cubicle. 2. Educating Patients on Fall Prevention Our team have observed that some fall incidents are drug or disease related. Nurses educate the targets and their relatives on fall

prevention with a leaflet. We remind them some of the medications such as antihypertensive and hypnotic drugs may induce the effect such as postural hypotension and instability. We engage the patients in taking care of themselves and let them to play a proactive role of preventing falls.

Result

Results and Recommendations: The improvement project has been launched in A7 ward since April 2015 and implemented in other AIMS wards since August 2015. Patients are involved in fall prevention. Fall incident was stopped at the very beginning by the quick reminder from neighbours. The fall rate of comparable wards decreased by 11% by comparing 2Q-4Q of 2014 with the same period of 2015. However, we met some difficulties during the implementation. Some patients refused to put the "Neighbourhood Support Reminder" on the table and we could not recruit suitable neighbour in the cubicle sometimes. There was no guarantee for the neighbour to help us in all times. Therefore, the reminder serves as a supplementary mean and we should not neglect the basic preventive measures. Conclusions: Fall incident is made up of multiple factors. No single method is suitable for all settings. It is a good practice to review the trend of the fall incidents and mobilize all possible resources to minimize the fall rate.