Service Priorities and Programmes

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Unanticipated fall in an acute medical ward can be prevented with team communication

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Introduction

A fall is an event which results in a person coming to rest inadvertently on the ground or floor or other lower level, it may be accidental, anticipated physiological, unanticipated physiological, or intentional falls. Fall-related injuries may be fatal or non-fatal.
Morse Fall scale (MFS) is used widely in acute care settings. Above 45 MFS score would be identified as high risk of fall. MFS is used on every in-patient admissions, relevant preventive measures would be applied to those with > 45 MFS score. However, unanticipated fall still happened, that is whose with < 45 MFS score. In year 2014 to 2016, there were totally 22 cases of fall reported in an acute medical ward, 31.8% were unanticipated fall. Unanticipated fall may occur because of many reasons. We have piloted a continuous quality improvement (CQI) program to reduce fall.

Objectives

- To enhance nursing knowledge to assess fall risk, including unanticipated one.
- To strengthen communication between nurses and supporting staff.
- To enhance staff awareness in modifying a patient's fall risk status.
- To reduce fall incidence.

Methodology

This CQI program was conducted in a medical ward from October to December 2016. Those having a high fall risk would be alerted, by posting up a magnetic bed number signage at the entrance of each cubicle, as well as at the bedside. This enhancement communication tools, will be updated at the beginning of each shift and after reviewing. Those patients with low risk in MFS will also be included into fall prevention measures. Moreover, one patient one call bell was provided and checked by supporting staff every shift.

Result

There was no fall incident obtained within the implement period. Nurses' awareness and knowledge in assessing fall risk was enhanced. The simple tool promotes a good communication between nurses and supporting staff, and their attention and

awareness in prevention of patient fall gained in our ward. The most important is reinforcing alertness in caring culture with team approach.