Service Priorities and Programmes

Electronic Presentations

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Dream towards "Zero Fall Wards" in surgical unit

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Introduction

Fall injury is one of the common incidents in hospital; the consequence increases the length of stay, legal liability and burden to staff workload. This program using a retrospective approach to evaluate the past incidents to design a specific, strength based approach to improve this safety issue.

Objectives

1. Analyze fall prevention practice & fall incident reports to identify the area of improvement
2. Assess the staff knowledge on fall prevention program & how to using fall risk assessment form
3. Strengthen the good practice of fall prevention

Methodology

Mind-set, Skill-set & Tool-set model as guideline in this program.

- Analyze the result and address the root causes of past fall incidents.
- Evaluate current practice to identify the key area(s) of improvement and ways to changes.
- Re-design education materials to strengthen nurse training to identify high fall risk group. The "Fall Knowledge Test" as a tool to measure the different on knowledge.
- Ward practices & routine were modified to facilitate staff to identify high risk group. New tool "Scheduled Rounding Form" & "Ward Map" were designed.
- "Smart roommate" signage to strength relative / patient on fall prevention.
- Increasing use of alarm mat.
- Provide fall prevention pamphlet, "Tips for family and friends".

Result

Results:

After implemented the program for 6 months, the fall rate per 1,000 occupied bed days reduce for 33% (from 0.59 to 0.39). There were only 6 fall incident reported in past 6 month in 3 acute wards with 15,328 occupied bed days. When compare the “fall knowledge test” before and after the program, the staff understanding on how to prevent fall increase for least 20%.

Conclusion:

The program achieved positive results to reduce the fall rate by enhance the staff competence to using the assessment tool and modify the ward routine. For the ultimate goal of quality improvement program is to aim at “Zero Fall” ward. The system should encourage systematic reporting of adverse situation \ nearly fall case as to promote a culture of safety - a core part of everyone’s job. Moreover, to enhance systematic identifications of risks and establish efficient communication to share risk information and to co-ordinate improvement initiatives.