Preventive Strategies to Effectively Mitigate Children's Fall in the Inpatient Wards

Singapore Healthcare Management 2017

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Introduction

Falls represent a major public health problem around the world. Falls are the leading causes of unintentional injury to children and has been considerable concern during hospitalization. A large number of children fell with their parents in attendance and despite interventions, fall rate incidence did not improve significantly. Researches done by a renowned hospital overseas showed that 20% of falls were due to inadequate communication with caregivers, 13% were due to inadequate assessment of fall risk status and despite implementing fall risk assessment tools and educational initiatives, there has been no significant improvement in the rate of fall incidents. In KK Women's and Children's Hospital (KKH) the incidents of fall among paediatric patients showed an increasing trend since 2014 (Graph 1). According the American Nurses Association (2002), patient fall rates is one of the indicators that could be improved through nurse-led safety strategies or interventions. Thus, this project was initiated by the team of nurses with the aim of establishing a fall prevention program that effectively reduce fall incidents among children in the inpatient units of KKH.

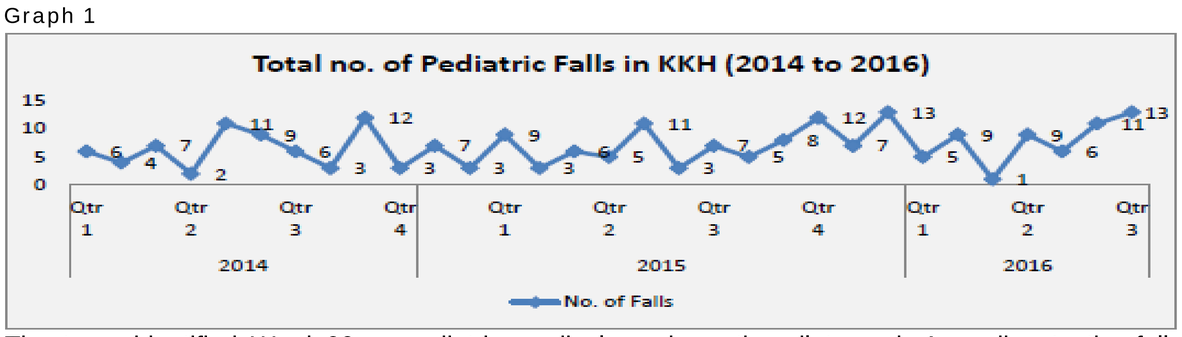
Aim

To establish fall prevention program that effectively reduce fall incidents among children in the inpatient units in KK Women's and Children's Hospital.

Methodology & Intervention

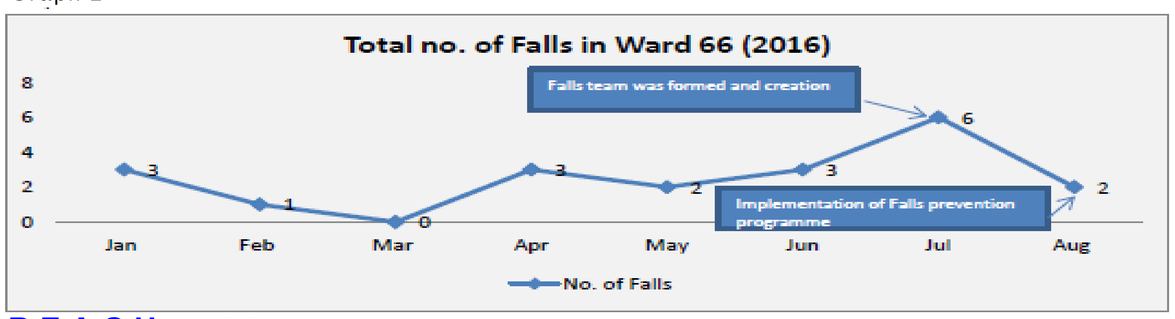
In July 2016, a fall team was formed and analysed the data on falls among paediatric patients in KKH from 2014-2016. As shown in graph 1, there is an increasing trend in patient's fall.

Graph 1



The team identified Ward 66,a paediatric medical ward, as the pilot ward. According to the fall incidents reported in the Risk Management System (RMS), there was a sharp increase in Ward 66 from Jan-Aug 2016. There were a total of 18 fall incidents as shown in Graph 2.

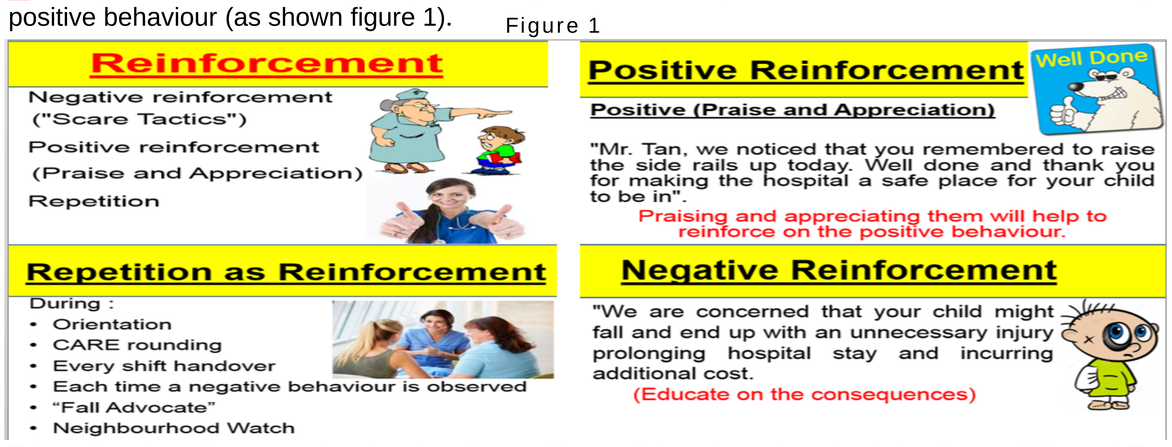
Graph 2



R-E-A-C-H stands for:

Reinforcement – use of positive/negative and repetitive reinforcement to encourage positive behaviour (as shown figure 1).

Figure 1



Education includes use of safety brochures (figure 2a), orientation checklist (figure 2b), and Fall Pictorial Chart (figure 2c)

Figure 2a: Fall Precaution Brochure

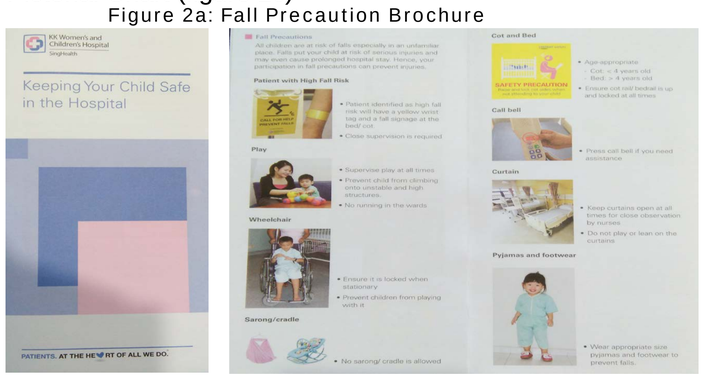


Figure 2b: Orientation Checklist

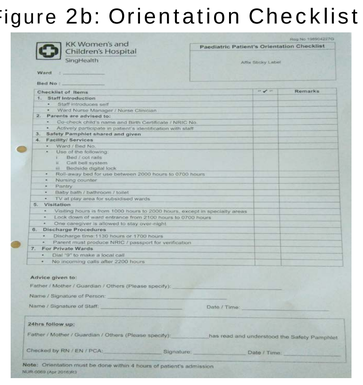
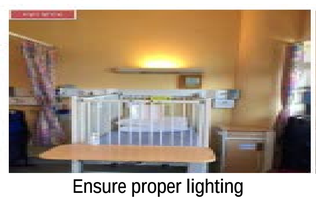


Figure 2c: Fall Precaution Pictorial Guide

Assessment of the environment includes 2-hourly nurse rounding, keeping environment free from obstacles, ensuring proper lightings, and pull-back of curtains.


2-hourly Nurse Rounding


Keep environment free from obstacles


Ensure proper lighting


Pull back curtains

Communication between healthcare professionals and parents is key in creating a safe environment for the children to be in. We have adopted the CUS model in helping us to achieve effective communication with the parents. We can use words such as, "I am Concerned, I am Uncomfortable, and this is a Safety tissue" (as shown in figure 3). There is a video created to demonstrate the use of CUS model and was played during roadshows, CEO-CMB forum and Fall Precaution Awareness Week.

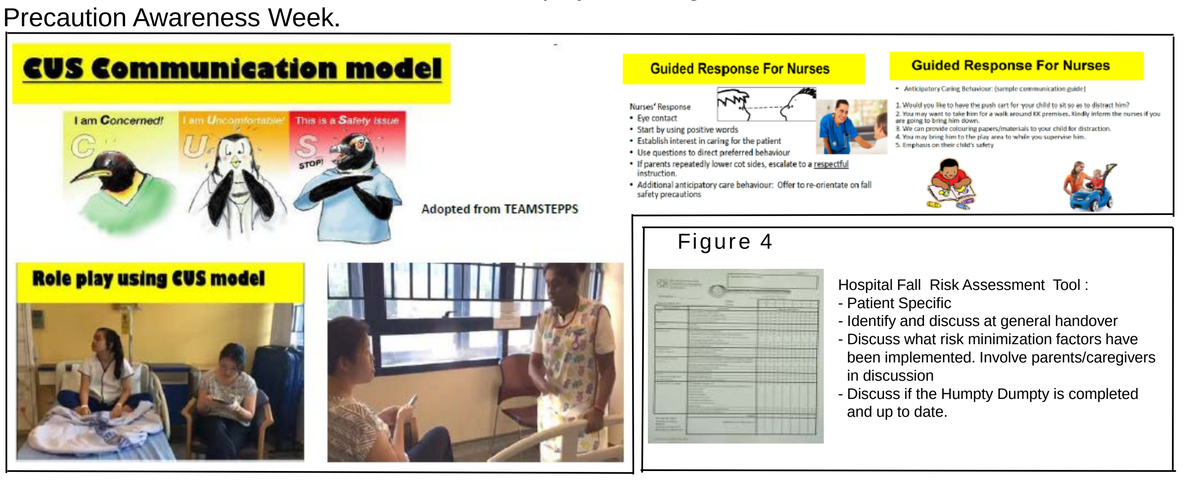


Figure 4

Hospital Fall Risk Assessment Tool :
- Patient Specific
- Identify and discuss at general handover
- Discuss what risk minimization factors have been implemented. Involve parents/caregivers in discussion
- Discuss if the Humpty Dumpty is completed and up to date.

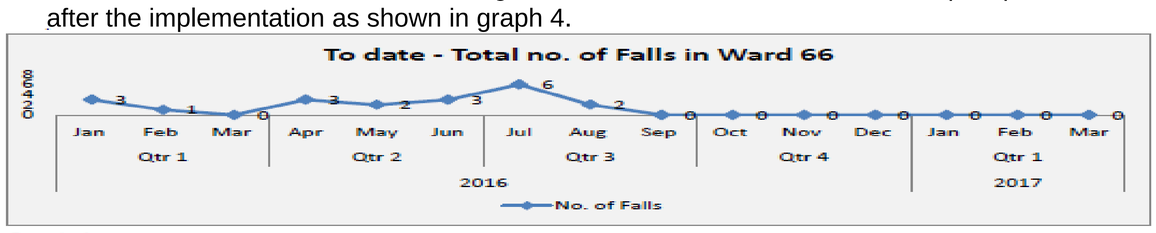
The team created a sample communication reference guide for nurses entitled "Guided Response for Nurses". These guides include how nurses' response during conversation with patients, anticipatory caring behaviour based on 5 different case scenarios: Cot/Bed rails; Visitor chairs; Roll Away bed; Running in the ward; and Pram.

Hospital Fall Assessment Tool – the HUMPTY DUMPTY Scale (Figure 4) was used to assess the risk of fall and the appropriate measures to be initiated.

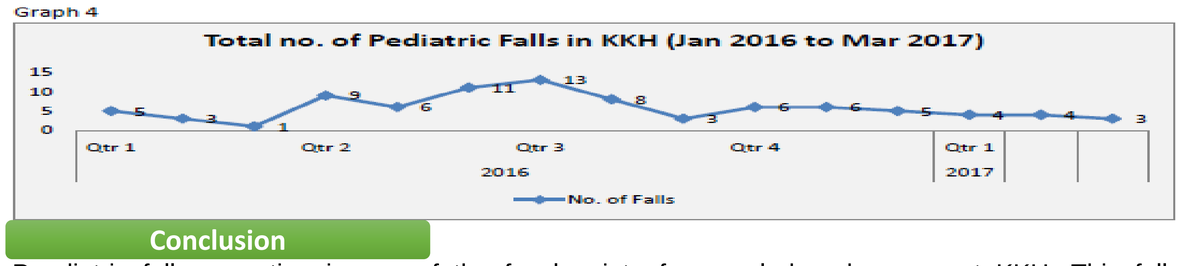
Result

After the implementation of R-E-A-C-H, there was a proactive prevention of fall in Ward 66. There was no reported fall incident from September 2016 to April 2017 as reflected in the department's synergy board. Knowing the root cause of falls enabled the team to create strategies tailored to the specific group of patients and the stakeholders inputs has provided a holistic approach to the problem. The initiation of the fall prevention strategies has reaped the following benefits:

1) Achieved zero patient falls after the implementation of the programme from August 2016 up to present as shown in graph 3.
2) The success of this new initiative was spread and implemented across the entire inpatient wards in the Children's tower and there is a significant reduction in the number of hospital paediatric falls after the implementation as shown in graph 4.



Graph 4



Conclusion

Paediatric fall prevention is one of the focal point of nurse led endeavours at KKH. This fall prevention program has been implemented, tested and proven to be an effective tool in the prevention of unintentional injury due to falls in ward 66. The project was spread throughout the entire Paediatric Wards and after its implementation, there was a significant decrease in the number of falls in KKH (as shown in Graph 4).