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To reduce falls by 50% for patient who overestimate their ability in Ward 46 and Ward 47 within 6 months

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Background of the problem

Patients who are identified as high fall risk are in more prone to a fall if they also overestimate their ability. These group of patient do not ask for assistance when they move around in the ward especially if it is an unfamiliar surrounding. At times, they sustained a fall in the ward which could led to severe consequences such as fractures or head injuries. This will increase their hospitalization stay and incur unnecessary cost .

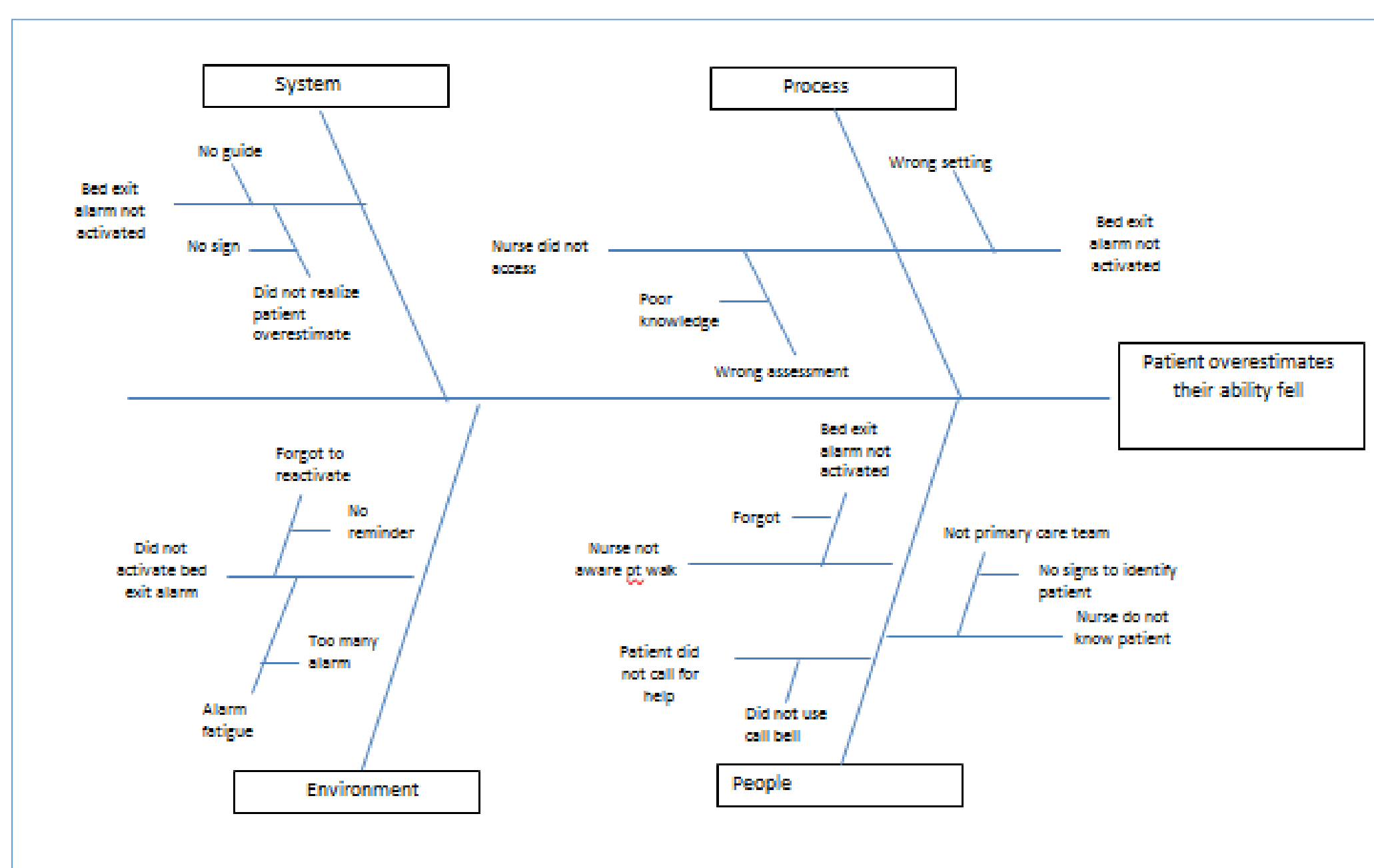
Currently, there are signage and identifiers for patient who are moderate/high risk for fall and appropriate initiatives will be carried out to prevent falls. Also with the hospital has implemented bed exit alarms, however the fall rates did not improve. As such, the fall precaution initiatives are not utilize to its full potential.

Mission Statement

To reduce falls by 50% for patient who overestimate their ability in Ward 46 and Ward 47 within 6 months

Analysis of problem

The team used the cause and effect diagram to identify the root causes.



Using the prioritization matrix, the final root causes were identified:

- 1.No guideline for activating bed exit alarm
- 2.No sign to identify patient as overestimate ability
- 3.Forgot to reactivate bed exit alarm
- 4.Wrong bed alarm setting

Interventions / Initiatives

Based on the root causes, the team brainstormed the following initiatives

PDSA 1

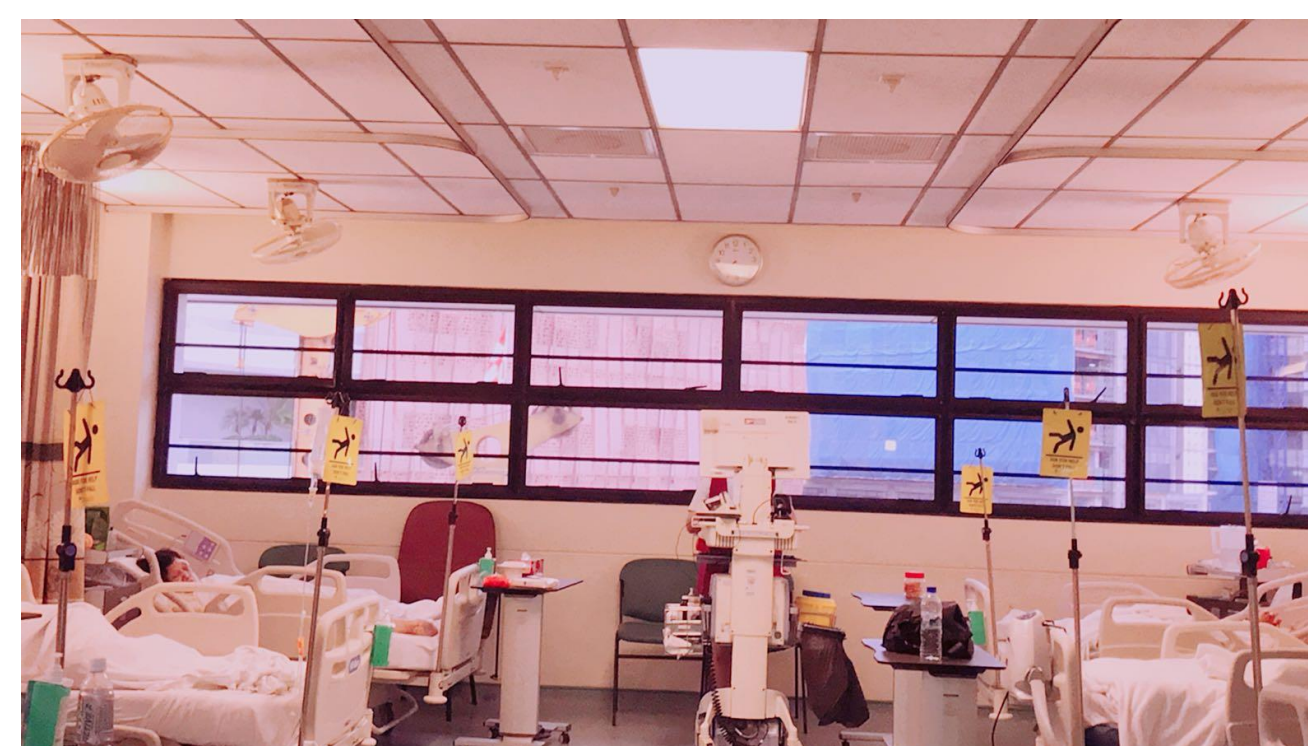
Create guideline of activating bed exit alarm

- Based on the current Morse Fall Scale Score, if the patient score 'Yes' for overestimate ability or have a history of fall, bed exit alarm must be activated at Stage 2

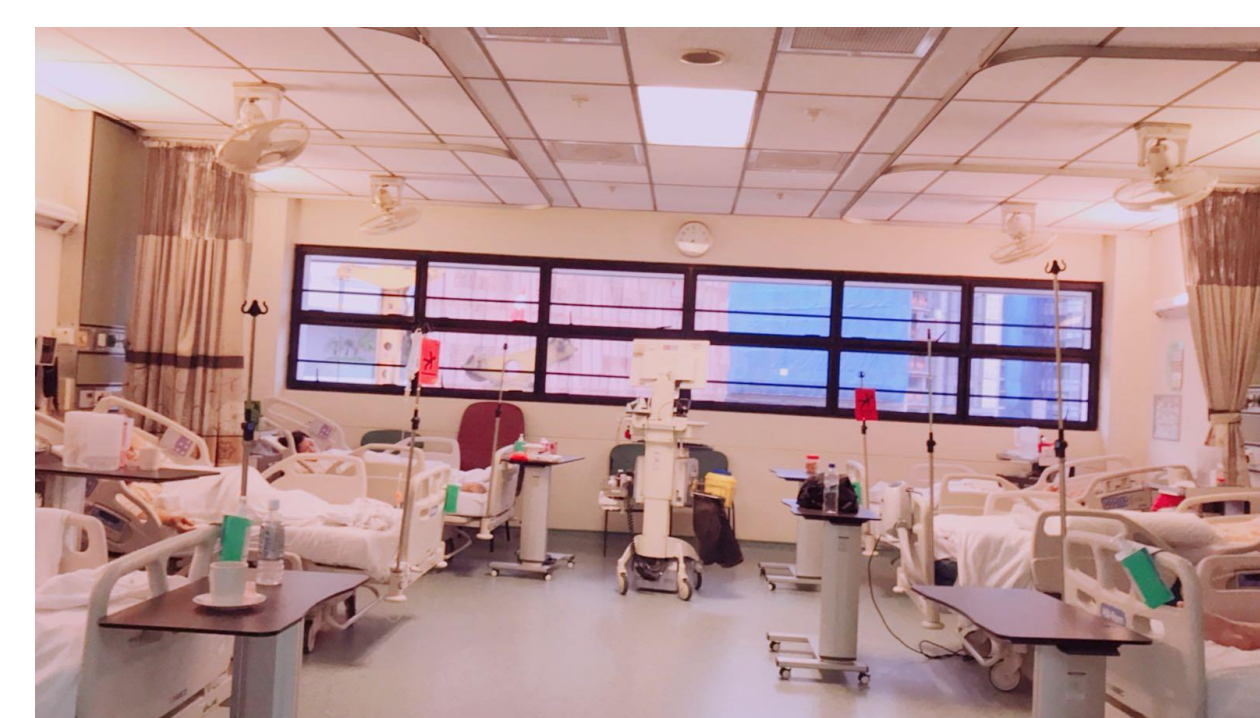
PDSA 2

Signage for patient overestimate ability and reminder to activate bed exit alarm

- Review current fall signage and streamline to one fall signage
- Red fall signage will only be used for patient who overestimate their own ability and had history of fall



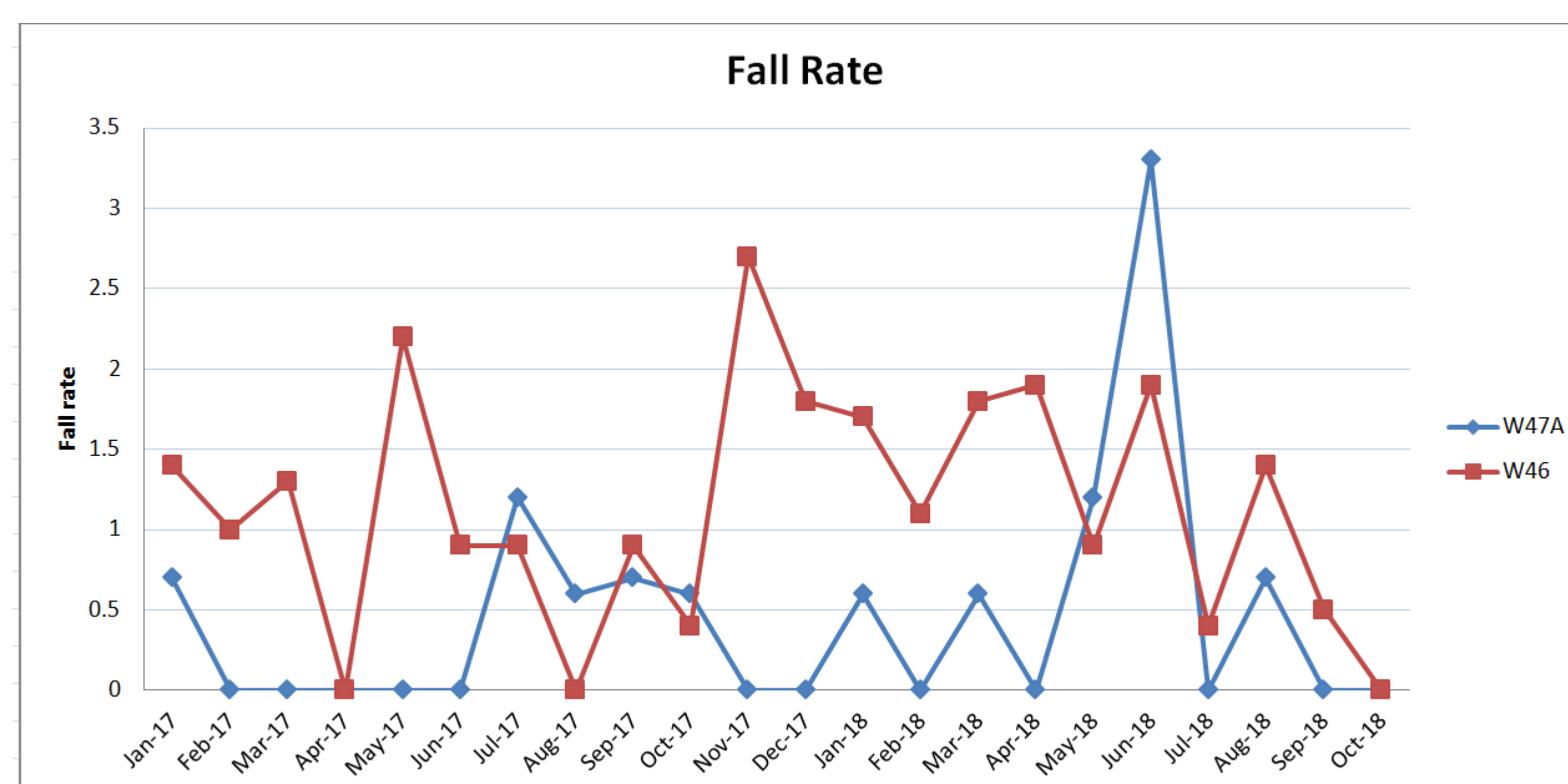
Before: 2 different fall signage in the ward



After: Red fall signage only for patient who overestimate ability

Result

After implementing PDSA 1 & 2, the fall rate did not have any significant improvement



Survey and feedback was obtained from the nurses. The mission was not achieved due to the following reasons:

- 1.Require effort from the nurses to keep track of the signage on the bed especially in wards with high patient turnover
- 2.Staff forget to place signage after identifying that patient overestimate ability

Conclusion

Although the mission was not achieved, the team believed that an alert to remind nurses that patient overestimate ability should be build. The team will work with Nursing Quality and source for other alternatives