ASQua
ASIAN SOCIETY FOR QUALITY IN HEALTH CARE

Topic 1

Completed Projects

on Engaging Patients for Patient Safety

Reducing Patient Harm from Falls through Enhanced Patient Engagement

Rajeena Selvi Karuppiah, Raja Nor Azlina, Dr. Rhema Sundram, Sulizawati Nain, Nurul Hani Shaari
Institut Jantung Negara, Malaysia

INSTITUT JANTUNG NEGARA
National Heart Institute

ABSTRACT

Patient falls in healthcare settings continue to be an issue of concern as these undesirable events could potentially result in injury, prolonged hospital stay and additional medical cost.

To address and overcome this vital patient safety issue, Institut Jantung Negara drew our focus on enhancing patient engagement as a proactive strategy to reduce falls and minimize associated harm.

A quality improvement initiative based on the Plan-Do-Study-Act approach was initiated with the aim to reduce patient harm (major and moderate) from falls for inpatients in the general wards by 20% by December 2022.

The project commenced in June 2022, and progress was made from January to June 2023.

A wide change concept linked to fall prevention with enhanced patient engagement, effective process and outcome measures did result in a sustained improvement in fall harm reduction.

CONTACT

Rajeena Selvi Karuppiah
Institut Jantung Negara
rajeena@ijn.com.my
+603 2600 6685
www.ijn.com.my

INTRODUCTION

Institut Jantung Negara, IJN in Malaysia is a JCI-accredited cardiac center committed to providing advanced standards in cardiovascular and thoracic care to adult and paediatric patients. Fall occurrence is a common undesirable event for patients in hospitals, particularly cardiac patients with comorbidities and multiple medications.

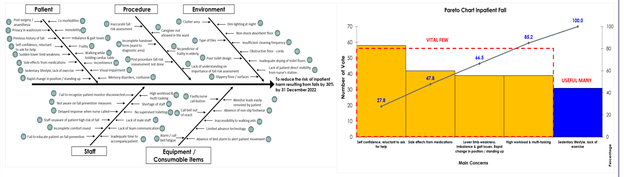
Preventing falls in the hospital and limiting patient harm resulting from falls is an ongoing challenge especially with the elderly cohort of patients. To reduce patient harm from falls, it was imperative to overcome key barriers that were identified and advance facilitators through improved patient engagement. With this in mind, a multi-department taskforce was formed comprising of representatives from Nursing, Quality, Pharmacy, Physiotherapy, Facilities & Housekeeping.

METHODS AND MATERIALS

A retrospective review of incident reports on inpatient falls reported by staff was retrieved from the online database for the duration of October 2021 to April 2022. Reports on falls of outpatients, visitors and staff were excluded. A total of 20 inpatient fall reports were registered. In summary,

- Location of falls: Toilet (n=10), bedside (n=6), walkaway (n=3), waiting area (n=2).
- Fall with injuries (n=11) while falls with no injury (n=9)
- Harm scale: Major injury (eg. intracranial bleeding, limb fracture) (n=4), minor injury (n=7).

A Plan-Do-Study-Act (PDSA) quality improvement was initiated to determine the underlying root causes and contributing factors through a fish-bone diagram and a Pareto chart was utilized to analyze the and narrow down the focus of areas for improvement. Specific corrective and preventive actions were implemented.



RESULTS

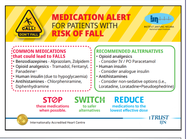
STRATEGY FOR CHANGE

1. Bed sensor alarms were placed to alert ward nurses for patients at high risk of falling.
2. Bedside Mobility Assessment Tool (BMAT) to assess patient's level of mobility.
3. Fall prevention measures education at the point of admission and following fall-reassessments.
4. Frequently scheduled comfort rounds to assist patients to the bathroom and fall warning posters on toilet doors.
5. Anti-slip floor treatment in all patient bathrooms.
6. Medication alert notifications for patients with risk of fall.
7. Engage and empower patients to actively participate in their own fall prevention.
8. Individualized risk assessment based on patient's medical history, medications, mobility level, and any prior incidents.
9. Earlier referral for Berg Balance Test (Change to day 2 from day 3)

MEASURABLE OUTCOMES

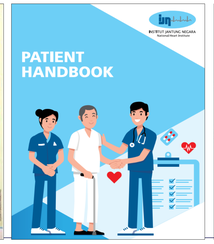
1. Reduction in Fall Rates: Implementation of patient engagement strategies led to a 14% reduction in patient falls within the first half year (January to June 2023). Inpatient fall with major and moderate harm reduced to zero incidents.
2. Increased Patient Involvement: Patients actively participated in their care plans, with >90% reporting a better understanding of fall prevention strategies.
3. Improved Safety Culture: Hospital staff reported a more comprehensive safety culture through our annual Survey on Patient Safety Culture, emphasizing fall prevention.





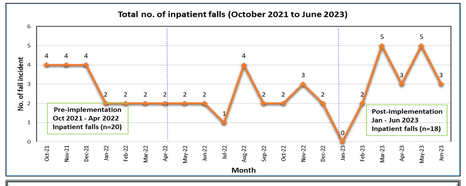




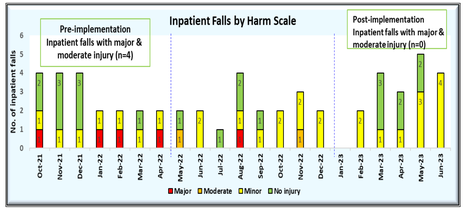




GRAPHS AND TABLES



- Inpatient fall incidents reduced from 20 incidents (October 2021 to April 2022) to 18 incidents (January to June 2023).



- Inpatient falls with Major and Moderate harm injuries reduced significantly from 4 incidents (October 2021 to April 2022) to 0 incident (January to June 2023).

DISCUSSION

A multimodal strategy through enhanced patient engagement is paramount to lessen patient harm from falls. This approach includes education, communication, shared decision-making, and a patient-centered care focus. This PDSA study demonstrates a statistically significant reduction in patient harm from hospital falls through multifaceted prevention strategies.

The likelihood of falls and other associated harm can be significantly decreased when patients are actively involved in their care and safety. Patients are more likely to succeed in improving their self-efficacy and level of knowledge on fall prevention when they actively participate in the learning process.

Further research and use of best practices in patient engagement is essential to achieve the desired outcomes.

CONCLUSION

The implemented interventions were clearly shown to be effective to reduce harm resulting from falls from 4 major fall incidents to zero incident in January to June 2023.
Overcoming barriers and promoting facilitators in patient engagement is crucial for reducing patient falls. Our project demonstrates that addressing these challenges can lead to a substantial decrease in patient harm from falls. When healthcare providers, patients, and their families work together, it makes the healthcare system safer and improves safety culture.

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