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REDUCING THE NUMBER OF FALLS AMONG PSYCHIATRY INPATIENT HOSPITAL SULTAN HAJI AHMAD SHAH (HOSHAS), TEMERLOH

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Selection of Opportunities for Improvement

Falls are common among psychiatry inpatients worldwide. Psychiatry in HOSHAS faces a similar problem, the trend of fall is alarmingly increasing from 9% in the year 2019 to 18% in 2020.

Falls are multifactorial. The most common factors are the adverse effects of neuroleptic medications, medical co-morbidities, unsafe environment and even the psychiatry disorder itself, which may impair the patient's cognition for hazard recognition. Failure in fall risk detection, poor supervision of patients at high risk and failure to use suitable measures was also associated with higher risk of falls.

Falling could cause serious injuries, mortality, hinders the recovery and decreases the quality of life of the patient. It also portrays the organisation negatively and incur the financial burden.

Psychiatry patients require unique fall preventive measures and it is still lacking not only in Malaysia but also worldwide. With a specific intervention tailored to these risk factors, the incident of fall can be significantly reduced.

Thus, this study will focus on reducing fall among Psychiatry inpatients HoSHAS. The specific objectives of this study are:

1. To determine the magnitude of fall.
2. To determine possible contributing factors of fall.
3. To implement remedial measures based on the factors identified.
4. To evaluate effectiveness of the remedial measures conducted.

Key Measures for Improvement

Indicator	Formula	Standard
Percentage of fall among psychiatry inpatient	$\frac{\text{Number of fall in Kenanga 9 in a year}}{\text{Number of fall in HOSHAS in a year}} \times 100\%$	< 5%

Process of Gathering Information

1st phase March-April 2021
Pre-remedial study: Study the magnitude and contributing factors

2nd phase May 2021-March 2022
Remedial measures

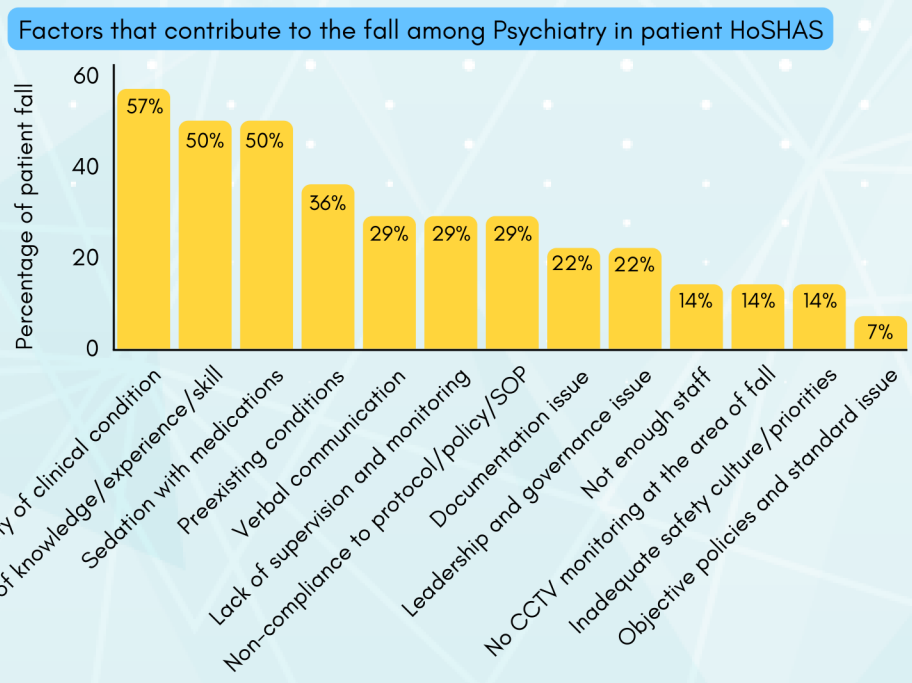
3rd phase April 2022
Post-remedial study: Aimed to study the result after the remedial measures

Inclusion criteria: all psychiatry inpatients.

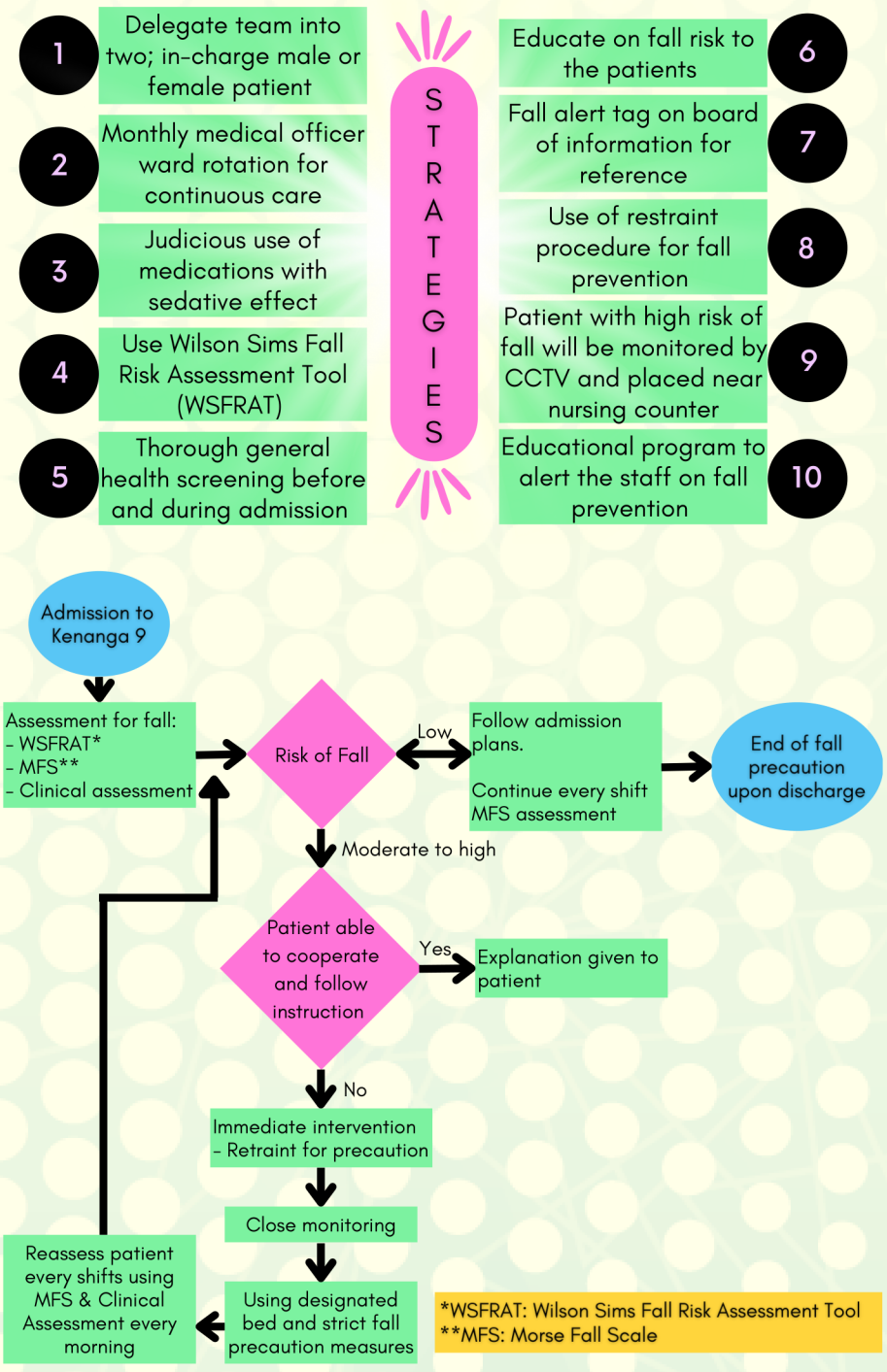
Exclusion criteria: Patient who fell due to possible medical related complications such as seizures, loss of consciousness, paralysis, cardiac arrest or intentional fall due to suicide attempt or tantrum.

Tools used for data collection:
1. Incident reports of falls (2018 - 2020)
2. Census of falls
3. Hospital Information System (HIS)
4. Morse Fall Scale
5. Wilson Sims Fall Risk Assessment Tool

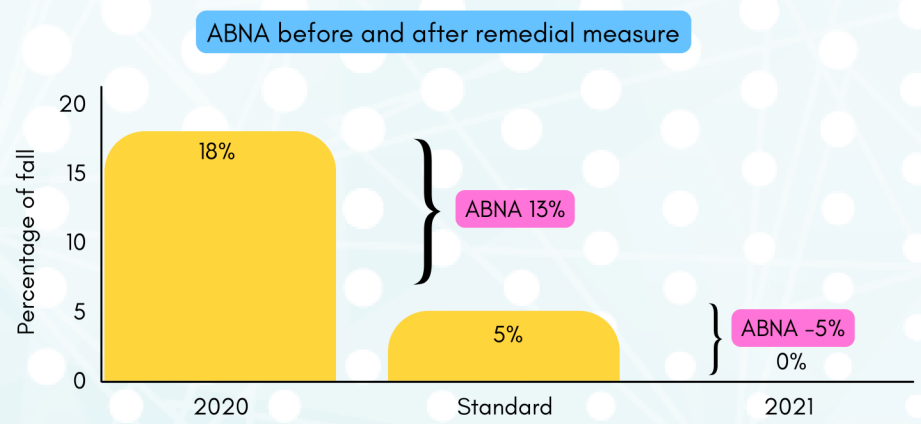
Analysis and Interpretation



Strategies for Change



Effect of Change



The Next Step

From this study, there was a high prevalence of fall among Psychiatry inpatients and was found to be multifactorial. Reduction in patient falls can be accomplished using a multifactorial assessment with tailored intervention. Fall risk assessment tools have been very helpful for paramedics in identifying patients at risk. Paramedics can be patient's advocates by advising safer options. It's evident in this study that fall is preventable when the responsibility is taken from all levels of organisation from paramedics to specialists.

The concept of intervention can be replicated to other centres. In future the measures will be continued and we recommend further improvement with implementing a different colour attire as a reminder of patient's status to assist in identifying patient risk for fall.

References

1. Abraham, S. (2016). Looking for a psychiatric fall risk assessment tool. Ann Psychiatry Ment Health, 4(2), 1061.
2. Kerzman, H., Chetrit, A., Brin, L., & Toren, O. (2004). Characteristics of falls in hospitalized patients.Journal of advanced nursing, 47(2). 223-229.https://doi.org/10.1111/j.1365-2648.2004.03080.x
3. Xu, C., & Xie, H. (2015). Institute of Mental Health, Singapore. Nursing, 5, 5102.
4. Turner, K., Bjarnadottir, R., Jo, A., Repique, R. J. R., Thomas, J., Green, J. F., & Staggs, V. S. (2020). Patient falls and injuries in US psychiatric care: Incidence and trends. Psychiatric services, 71(9), 899-905.c
5. StudyCorgi. (2021, December 16). Falls Prevention in Sedated Psychiatric Patients. Retrievedfrom https://studycorgi.com/falls-prevention-in-sedated-psychiatric-patients/
6. Patient Safety Unit. Guidelines on Implementation Incident Reporting and Learning System 2.0 for Ministry of Health Malaysia Hospitals [Malaysia Ministry of Health Web site]. 2017. Available at http://patientsafety.moh. gov.my. Accessed January 15, 2021.
7. Marshall B, Giuliani D, Kolodziej J, O Hagan G, Pradhanang L (2020). Assessing Patient Fall Risk on Psychiatric Units: A Comparison of Three Fall Risk Scales. Iris J of Nur & Car. 2(4).IJNC.MS.ID.000545.
8. Morse J. M. (2006). The safety of safety research: the case of patient fall research. The Canadian journal of nursing research = Revue canadienne de recherche en sciences infirmieres, 38(2), 73-88.
9. Wilson, S.C.,Fettes, S., Sims(2014), K. Gravity. It's not a suggestion—It's the law! The development of the Wilson Sims Psychiatric Fall. Risk Assessment. J. Am. Psychiatr. Nurses Assoc, 20, 83.

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