

Quality Improvement project on "Improving Fall Risk Assessment & Documentation"

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INTRODUCTION

Unintentional falls are a common concern in healthcare settings, often resulting in significant harm such as fractures, head injuries, and other sentinel events. Recognizing the importance of fall prevention. Moreover, Effective fall risk assessment has been shown to reduce the incidence of falls and overall healthcare costs.

AIM STATEMENT

The objective of this study is to achieve a fall rate of zero per 1000 in-patient days by ensuring 100% compliance in fall risk assessment and documentation for all in-patients. Concurrently, to enhance the knowledge and proficiency of our nursing staff in conducting comprehensive fall risk assessments and maintaining accurate documentation.

REASON FOR IMPROVEMENT

Problem Statement

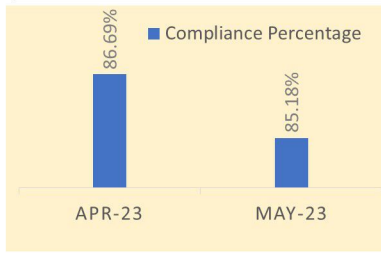
There are decrease in trend of complete documentation of nursing Fall risk assessment (85%) from April. 23 to May. 23

Why this is a problem?

- Incomplete history collection & fall risk assessment may lead to increase the **risk of patient fall**, which may further increase the rate of patient fall lead to adverse event including sentinel event.
- Can significantly increase the length of stay.
- Adverse Impact in patient satisfaction.

*Total Number of patient Admission/ Month

April	May	June	July	Aug	Sept
299	336	302	328	316	377



METHODOLOGY

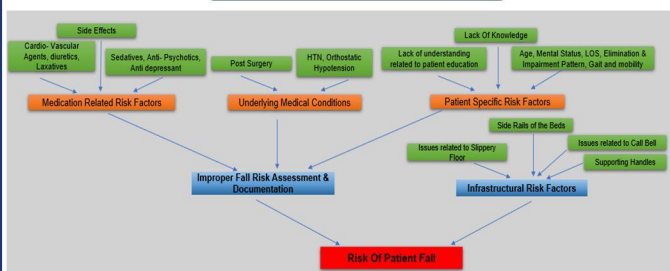
- ✓ Prospective Design was adopted.
- ✓ Benchmark: 100%
- ✓ Location: Fortis Hospital and Kidney Institute, Rashbehari
- ✓ Data Collection Method: Checklist
- ✓ Period: Apr- 23 to Sep-23
- ✓ Population Group: IPD Patients admitted in Fortis Hospital and Kidney Institute
- ✓ Sample Size: More than 15% of total Admission every month.
- ✓ Analysis Done in Excel

Number of Fall Risk Documentation compliance X100

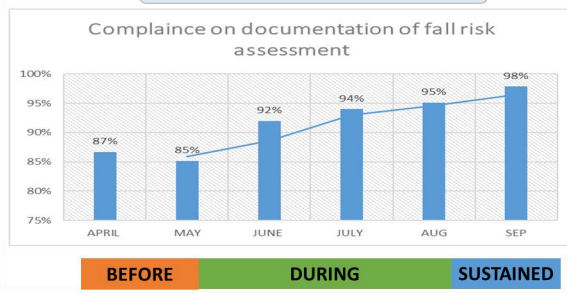
Total number of sample audited

DISCUSSIONS & FINDINGS

TREE DIAGRAMME



PERIODIC ANALYSIS



GAPS IN THE PROCESS FLOW

1. New patient admitted in the Dept.
2. Initial assessment including fall risk assessment was documented **incompletely on Admission.**
3. Fall risk assessment was performed but it was **not correlating with patient condition.**
4. Fall risk precautions were taken as per the fall risk assessment score.
5. Clutter Free Room Preparation done including arranging the Call bell within the reach of patient.
6. Fall risk assessment is completed & documented in every shift correlating with patient condition. (**Skipped in few instances**)
7. Patient & family members education was done.

RISK ANALYSIS BY SWIFT MATRIX

What if	Cause	Consequence	Current Protection	Probability	Consequences	Risk	Recommended Protective Measures	Probability (Mitigated)	Consequences (Mitigated)	Risk (Mitigated)
Infrastructural Risk Factors	Issues related to Slippery Floor Side Rails of the Beds Issues related to Call Bell Supporting Handles	Major	All Infrastructural Risk Factors are Minimized, New Call Bell System Introduced along with Escalation Matrix.	2	4	8	Infrastructure to be maintained as per protocol to mitigate the risk of the same, Patients are being accompanied by the attendant.	1	4	4
Improper Risk Assessment & Documentation	Fall risk assessment was not correlating with patient condition. Often missed out to categorize highly vulnerable patients. Lack of staff knowledge related to fall risk assessment & documentation.	Severe	Sampling Audit	3	5	15	QIP done to minimize the probability of the specific risk & Fall Risk Assessment to be done as per protocol.	1	5	5

CAUSE:	Cause #1 Improper history collection & assessment due to lack of knowledge regarding fall risk assessment tools and interventions to be taken.	Cause #2 Low Adherence to the standardized audit tool to assess patient fall.	Cause #3 Lack of knowledge regarding the action of certain drugs that may lead to fall.	Cause #4 Poor ISBAR hand over & communication with team.
PDSA CYCLE:	Change #1	Change #2	Change #3	Change #4
PLAN	Change?	Spot teaching to the particular staff. CNE training imparted, Role play done.	Apart from Training, all nurses are sensitized to mandatorily do the fall risk assessment following the standardized tool.	Training imparted regarding drugs mainly identification of the drugs that can contribute to increased risk of fall for e.g., Sedatives, Diuretics, Cardiovascular Agents etc.
	Predict	Along with Spot Teaching & Sensitization, Bed side handover are done under the supervision of senior nurses in the language that patient can understand,	Improved compliance on History collection & Documentation	Standardized tool are used in all the settings.
DO	Learn	Needs continuous training and sensitization	Audits needs to continue in order to ensure compliance.	Increase confidence level of all related stakeholders.
STUDY	Compare prediction	As Predicted	As Predicted	As Predicted
ACT	Adapt or Abandon Change	Adopted	Adopted	Adopted