Project Title

To reduce fall incidence in Orthopaedics Ward 5A in Hospital Ampang

Group Members

Nama	Jawatan
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Dr Jasmin Bujang	Pegawai Perubatan Unit Kualiti
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En Mustafa Kamal Abd Rahim	Ketua Jururawat Wad 5A
Pn Nor Anisa Zainudin	Jururawat Terlatih Wad 5A
Pn Nor Rabiatutadawiah Mohd Hatta	Jururawat Terlatih Wad 5A

OUTLINE OF PROBLEM

PROBLEM IDENTIFIED/ PROBLEM LISTING

- Incidence of Fall
- Thrombophlebitis
- Cancelation of operation
- Bed sores
- Blood transfusion error

PRIORITISATION OF PROBLEM

Problem	S	M	A	R	T	Score
To reduce the incidence of inpatient fall in Hospital Ampang	15	15	10	15	15	**70**
To reduce the incidence of thrombophlebitis among patients in Hospital Ampang	5	15	5	15	15	**55**
To reduce the rate of cancelation for operation among patients in Hospital Ampang	10	15	5	5	5	**40**
To reduce the incidence of pressure sore among patients in Hospital Ampang	10	15	10	15	15	**65**
To reduce theIncidence of Blood Transfusion Error among patients in Hospital Ampang	15	15	15	5	5	**55**

Group members: 5	Score	1	2	3
		Low	Moderate	High

Reason For Choosing

Seriousness	• Increase hospital stay • Increase cost of hospitalization ie medication, investigation, intervention etc • Increase mortality rate
Measurable	Fall incidence is measurable through incident reporting
Appropriate	Patient fall is an issue that requires urgent attention and immediate action due to lack of availability of method to seek assistance by patients.
Remedial	• Improving nursing care through EPEEP observation programme • Increasing knowledge and awareness on fall prevention
Timeliness	To reduce incidence of patient fall within a year with a 3 monthly review

SERIOUSNESS

Falls are the second leading cause of unintentional injury deaths worldwide. In Malaysia, falls among elderly incidence are between 15-34%

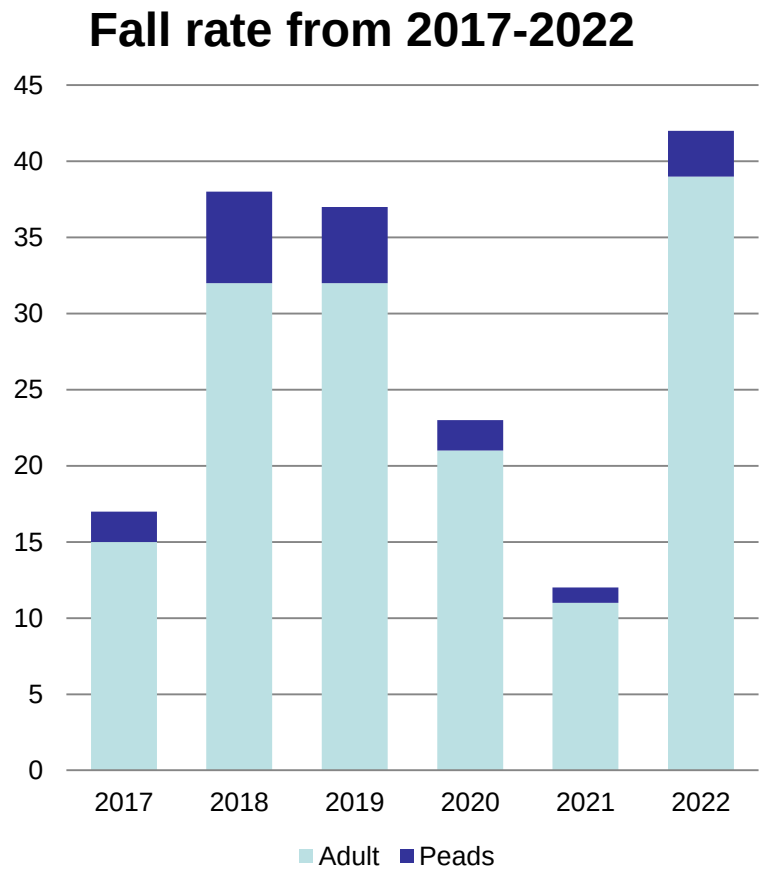
Each year ~684000 individuals die from falls globally from low to middle-income countries

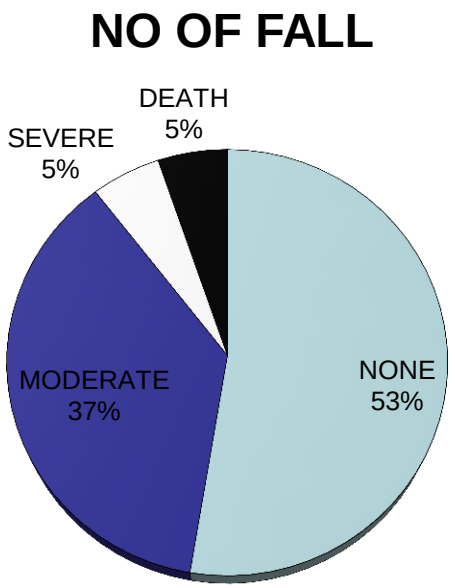
37.3 million of falls are severe, requiring medical attentions, each year

The average cost of fall per patient of 65 years old and older is approximately $1049 *** (in Australia)**-> to get numbers in Hospital Ampang

Source : World Health Organization, 2021

FALL RATE IN HOSPITAL AMPANG





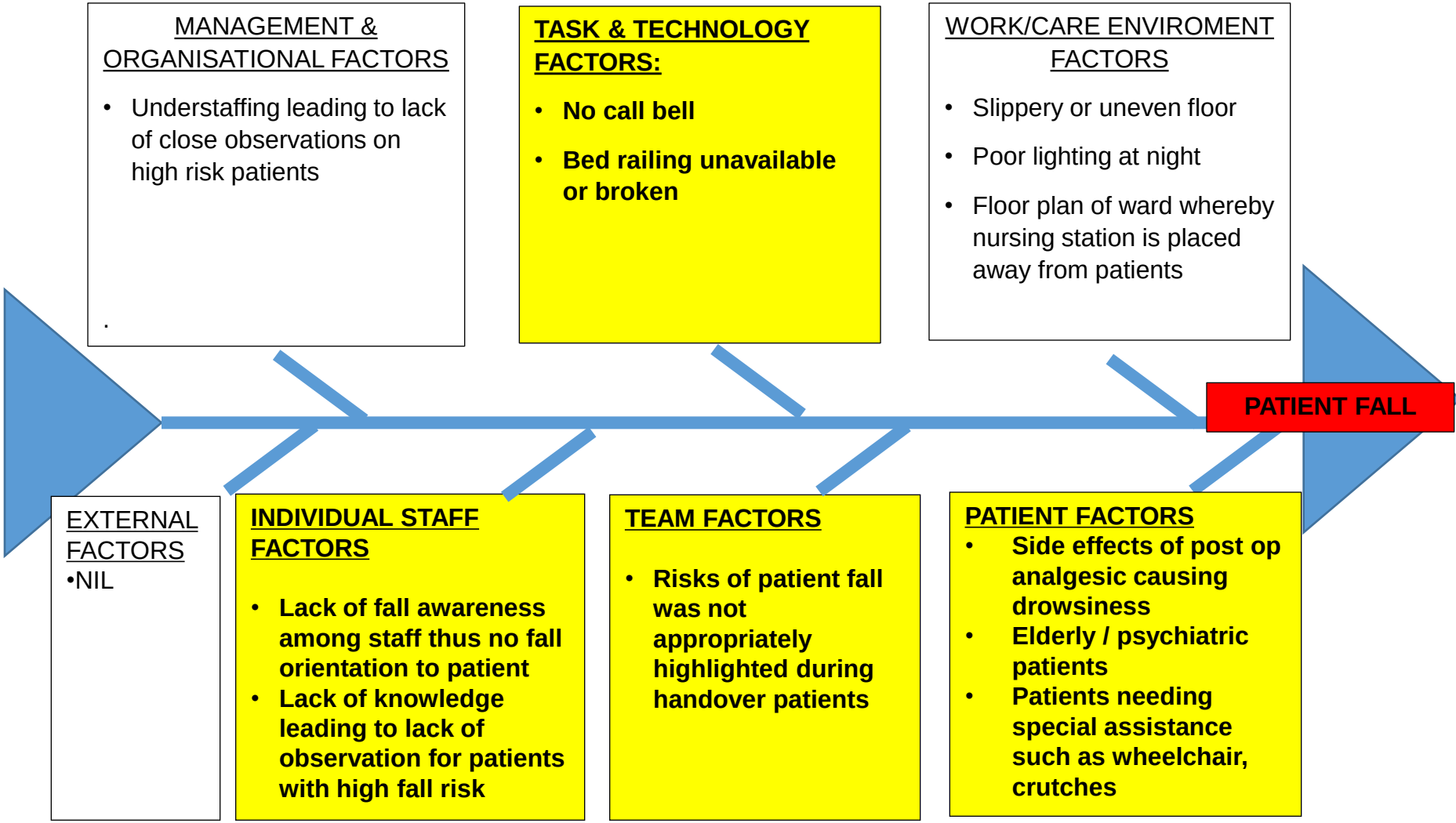
PROBLEM STATEMENT

- What : incidence of patient fall
- Who : Inpatients
- When : during admission
- Where : Orthopaedic & Surgical Wards (5A, 5B, 5C & 5D)
- Why : patient safety is compromised
- How : despite SOP is in place for proper monitoring and fall prevention, but % of fall rate still increased.

PROBLEM STATEMENT

Patient fall is a common and devastating incidence as it compromises patient safety as well as reflecting the quality of care of the facilities. Published figures quote a prevalence of 28-35% in the community and in acute care hospitals, the incidence of reported falls varies from 0.6-13 falls per 1000 patient days. There is a myriad of reasons of why fall happens and it is of vital importance to find out why in order to reduce patient fall rate. Among the possible causes of fall in Hospital Ampang are the lack of observation and lack of call bells in the ward. Thereby, by doing a QA Project in this we hope to explore the possible factors as well as coming up with possible remedial measures to overcome this problem.

BUBBLE CHART

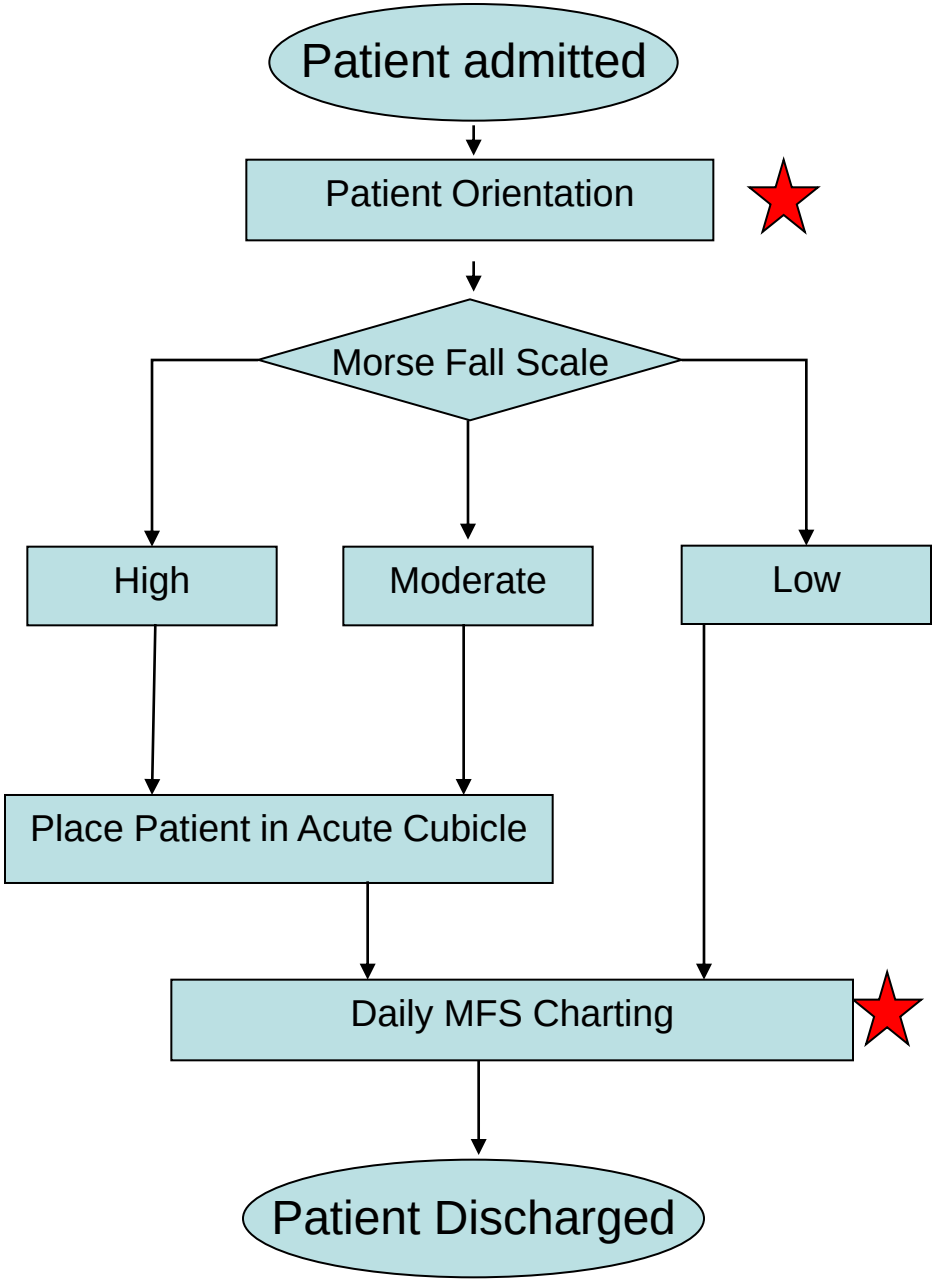

MANAGEMENT & ORGANISATIONAL FACTORS
• Understaffing leading to lack of close observations on high risk patients
.
TASK & TECHNOLOGY FACTORS:
• No call bell
• Bed railing unavailable or broken
WORK/CARE ENVIROMENT FACTORS
• Slippery or uneven floor
• Poor lighting at night
• Floor plan of ward whereby nursing station is placed away from patients
PATIENT FALL
EXTERNAL FACTORS
•NIL
INDIVIDUAL STAFF FACTORS
• Lack of fall awareness among staff thus no fall orientation to patient
• Lack of knowledge leading to lack of observation for patients with high fall risk
TEAM FACTORS
• Risks of patient fall was not appropriately highlighted during handover patients
PATIENT FACTORS
• Side effects of post op analgesic causing drowsiness
• Elderly / psychiatric patients
• Patients needing special assistance such as wheelchair, crutches

OBJECTIVE

- GENERAL OBJECTIVE
  - to reduce incidence of patient fall amongst patient admitted in Hospital Ampang
- SPECIFIC OBJECTIVE
  - To determine the percentage of patient fall.
  - To identify factors contributing to patient fall.
  - To formulate strategies and to implement possible remedial action.
  - To evaluate effectiveness of remedial measures implemented.

KEY MEASURES FOR IMPROVEMENT

Process of care



MODEL OF GOOD CARE

Process	Criteria	Standard
Patient Orientation & Morse Fall Scale Stratification	1. To conduct training and educate nursing staff on Fall Prevention	100%

MODEL OF GOOD CARE

Process	Criteria	Standard
Daily MFS Charting	1. To conduct training and educate nursing staff on EPEEP method	100%
	2. To do EPEEP Observation	
	- ENVIRONMENT	100%
	- Introduce Self (every shift)	
	- Ensure bed railing is up (2hourly)	
	- Bed is levelled/lowered (2hourly)	
	- Ensure things are within patient's reach (2hourly)	
	- POSITION	100%
	- To enquire patient's position is comfortable (2hourly)	
	- To change position if required/ every 2 hourly if bed bound patients	
	- Inspect patients condition (2hourly)	
	- PAIN	100%
	- Pain score (during vitals signs taking)	
	- Check IV line (during vital signs taking)	100%
	- ELIMINATION	
	- Ask and help patient if need to PU/BO (during vital signs taking)	
	- To change diaper if needed (during vital signs taking)	
	- PLAN	100%
	- Ask if patient needs anything else (during vital signs taking)	

INDICATOR & STANDARD

- Indicator:

Percentage of Patient Fall

- Formula:

To use current standard

- Standard:

PROCESS OF GATHERING INFORMATION

METHODOLOGY

Study Design	**Cross Sectional Study**
Study Period	**1 year**
Study Sample	**Patients admitted to Ward 5A**
Sample Size	**All patients admitted to Ward 5A**
Inclusion Criteria	**All patients admitted to Ward 5A**
Exclusion Criteria	**Fall due to events such as seizures, loss of consciousness, paralysis or cardiac arrest and due to external forces** **Intentional fall due to suicidal attempts**

DATA COLLECTION METHOD

NO	FACTORS	WHAT	WHEN	WHERE	WHO	HOW
1	**Individual Fx** Lack of fall awareness among staff thus no fall orientation to patient Lack of knowledge leading to lack of observation for patients with high fall risk	To conduct training and educate nursing staff on Fall Prevention and EPEEP method	3 Monthly	Ward 5A	Nursing Staff Ward 5A	Attendance List Survey on Staff Knowledge
2	**Task & Technology Fx** No call bell Bed railing unavailable or broken **Patient Factors**	To do EPEEP Observation To conduct Audit on compliance to EPEEP Observation	Every day Every 3 months	Ward 5A Ward 5A	All Patients Nursing Staff Ward 5A	Borang Pemantauan EPEEP Survey on Patient's Perspective Observational Audit on Practice & Audit on Documentation of EPEEP

DATA COLLECTION METHOD

NO	FACTORS	WHAT	WHEN	WHERE	WHO	HOW
3	**Team Factors** Risks of patient fall was not appropriately highlighted during handover patients **Patient Factors**	Proper handover between nursing shift for patients with high risk of fall	Every day	Ward 5A, 5B, 5C & 5D	Nursing Staff Quality Unit	Audit on documentation in nursing report

DATA COLLECTION FORM

(if any)

	Nama Pesakit:	MRN:						Wad/Katil No:						DOA:											
No.	Semakan kad menunggu pesakit (waris) Nama :	Tarikh:.....												Tarikh:.....											
	Masa	6-8	8-10	10-12	12-2	2-4	4-6	6-8	8-10	10-12	12-2	2-4	4-6	6-8	8-10	10-12	12-2	2-4	4-6	6-8	8-10	10-12	12-2	2-4	4-6
		am	am	am	pm	pm	pm	pm	pm	pm	am	am	am	am	am	am	pm	pm	pm	pm	pm	pm	pm	am	am	am
1)	**E : Environment**																								
	a) Perkenalkan diri																								
	b) Pagar katil dinaikkan																								
	c) Katil dilaraskan/ direndahkan																								
	d) Mengalih peralatan untuk mudah dicapai pesakit Eg: Loker/cardaic table/call bell/ bakul sampah dan lain-lain																								
2)	**P:Position**																								
	a)Tanya adakah baringan pesakit selesa. -Bantu jika perlu & ubah kedudukan bantal																								
	b)Mengubah posisi baringan 2 jam sekali (Braden scale ≤ 16)																								
	c)Memeriksa keadaan kulit pesakit keseluruhan																								
3)	**P:Pain**																								
	a) Bertanya skor tahap pesakit																								
	b)Periksa IV line ***																								
4)	**E:Elimination**																								
	a) Tanya & bantu pesakit untuk PU/BO																								
	b) Menukar lampin pakai buang.																								
5)	**P:Plan**																								
	a)Tanya jika ada apa-apa lagi yang pesakit perlukan Eg : Masalah semasa pesakit/keperluan lain																								
	Nama jururawat yang bertugas																								
	Disemak oleh																								

Jika berkenaan

Tandakan (/) dalam petak berkenaan jika telah dilaksanakan

Sasaran:Setiap pesakit perlu dibuat nursing round secara holistik dengan model EPPEP. (Nasihat risiko jatuh difokuskan)

Masa lawatan Jururawat:2 Jam sekali dan 1 jam sebelum tamat shint

MINISTRY OF HEALTH MALAYSIA
PATIENT SAFETY INCIDENT REPORTING FORM

*Borang boleh diisi dalam **Bahasa Malaysia***

DATE OF REPORTING: ___ / ___ / _____

SECTION A: TO BE COMPLETED BY THE REPORTER OF THE INCIDENT

INCIDENT DESCRIPTION (Please fill in the blanks)

1.	**NAME OF FACILITY/ INSTITUTION**		**PATIENT'S NAME**	
2.	**DATE OF INCIDENT**	☐☐ / ☐☐ / ☐☐☐☐	**IF UNCERTAIN** APPROXIMATE DATE: ___ /___ /___	
3.	**TIME OF INCIDENT**	☐☐ : ☐☐ AM/ PM	**IF UNCERTAIN** APPROXIMATE TIME: ___: ___ AM /PM	
4.	**PATIENT'S RN/ OTHER INDENTIFICATION NUMBER** : _____ **AGE:** _____ **ETHNIC:** _____ **GENDER** : MALE / FEMALE / UNKNOWN (please circle) **STATUS** : ALIVE / DECEASED **LANGUAGE BARRIER**: YES / NO **DIAGNOSIS** : _____			

5. **TYPE OF PATIENT** (please tick one)

☐	INPATIENT	☐	DAY CARE
☐	OUTPATIENT	☐	OTHERS: SPECIFY .....
☐	A&E		

LOCATION/ WARD / CLINIC : _____

DEPARTMENT(S) INVOLVED (please tick)

☐	MEDICAL	☐	O&G	☐	ONCOLOGY
☐	SURGICAL	☐	PHARMACY	☐	GERIATRIC
☐	ORTHOPAEDIC	☐	RADIOLOGY & IMAGING	☐	REHABILITATION
☐	PAEDIATRIC	☐	A&E	☐	ICU/ CCU
☐	LABORATORY	☐	PSYCHIATRY		
☐	OTHERS: SPECIFY _____				

6. **TYPE OF INCIDENT** (please tick one) ☐ **Actual** ☐ **Near Miss**

Examples of incidents that need to be reported: (Note that this list is not exhaustive)

☐	i.	Wrong surgery/procedure –wrong site, side or patient
☐	ii.	Unintended retained foreign body in patient after an operation/procedure
☐	iii.	Error in transfusion of blood/blood products
☐	vi.	Medication error (please fill in MERS form as well)
☐	v.	Patient fall in the facility
☐	vi.	Obstetric related incidents
☐	vii.	Adverse outcome of clinical procedure
☐	viii.	Pre-hospital care and ambulance service related incident
☐	ix.	Radiotherapy related incident
☐	x.	Patient suicide / attempted suicide
☐	xi.	Patient discharged to wrong family members / next-of -kin
☐	xii.	Assault/ battery of patient
☐	xiii.	Unanticipated Fire – Fire, flame, or unanticipated smoke, heat, or flashes occurring in the facility
☐	xiv.	**Others type of incident** : _____

7. **BRIEF DESCRIPTION OF WHAT HAPPENED** (Please fill in the blanks)
The description should explain what happen prior and during the incident and how it occurred. Do include any additional information which you think may lead to the incident.

PATIENT OUTCOME (please tick one) **& IMMEDIATE ACTION – ONLY FOR ACTUAL INCIDENT**

8. **OUTCOME OF INCIDENT**	☐	NONE
	☐	MILD
	☐	MODERATE
	☐	SEVERE
	☐	DEATH
	☐	CURRENTLY CANNOT BE DETERMINED
9. **IMMEDIATE ACTION FOLLOWING INCIDENT**		

REPORTED BY

10. **DESIGNATION**: (please tick one)

☐	NURSE	☐	SPECIALIST
☐	HOUSE OFFICER	☐	PHARMACIST
☐	MEDICAL OFFICER	☐	OTHERS:

SIGNATURE OF REPORTER:

NAME:
DATE:

Note: As part of good leadership and clinical governance, please inform the incident to your Head of Department(s) immediately.

SECTION B : TO BE COMPLETED BY THE RISK MANAGER/ QUALITY MANAGER OF HOSPITAL

1. **ACTION TAKEN:** *Mandatory Root Cause Analysis:* *1) Incident with Severe or Death outcome* *2) Other incident/near miss based on the Risk Manager/ Quality Manager assessment* *3) Directive from State Health Department / Ministry.*	(Please tick) ☐ "PRESCRIPTION SLIP" ☐ MONITOR THE TREND FIRST ☐ RCA ☐ MIRCA (Multi-incident Root Cause Analysis) Additional comments :
2. **e-IR SUBMITTED?** Please submit to e-IR **within 5 days** from the date of the incident.	Date of Submission: _____-_____-_____
3. **RISK MANAGER/ QUALITY MANAGER OF HOSPITAL**	(please fill in the blanks) NAME: SIGNATURE: DESIGNATION: DATE:

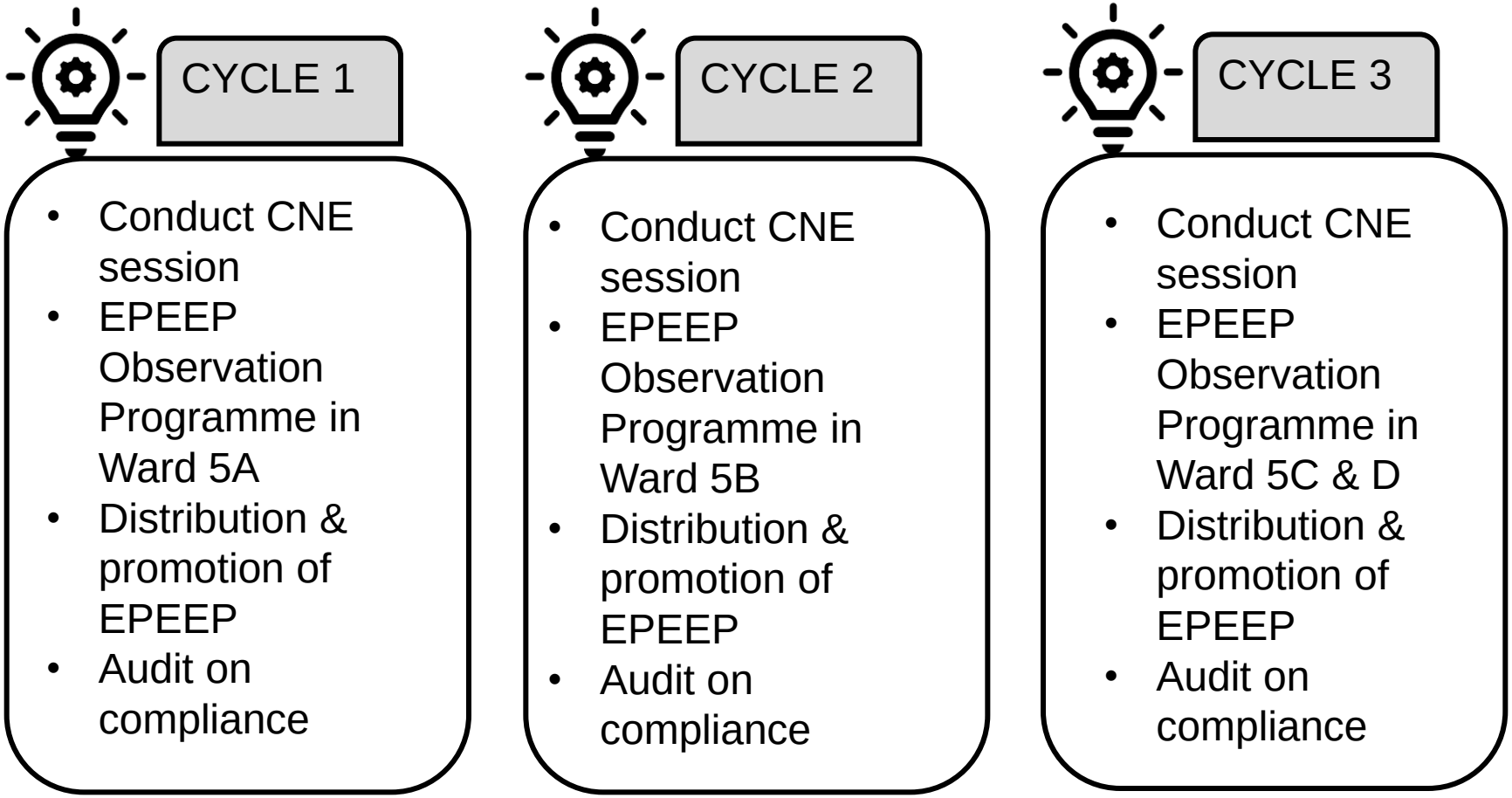
Data processing

Analysis & interpretation

Strategy for change

The goal to reduce rate of patient fall is achievable by implementing measures to prevent fall such as EPEEP programme (Explain, Pain/Position, Elimination/Toilet, Environment and Plan to return).

EPEEP programme is carried out by implementing a method of observation and nursing care whereby it involves rounds at each cubicle by nursing staff in a 2 hour interval to address patients need in order to reduce chances of fall

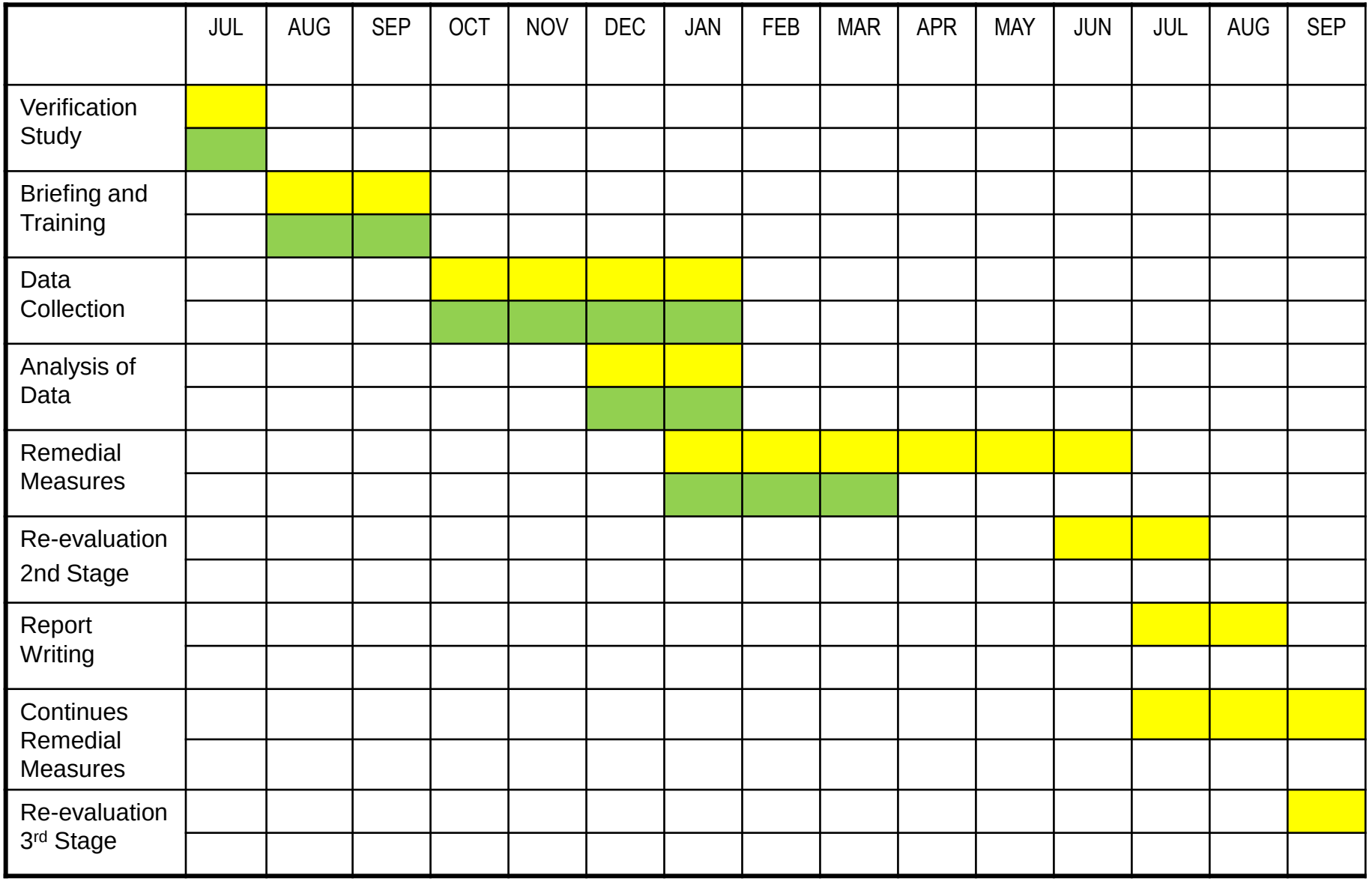

CYCLE 1
Conduct CNE session
EPEEP Observation Programme in Ward 5A
Distribution & promotion of EPEEP
Audit on compliance
CYCLE 2
Conduct CNE session
EPEEP Observation Programme in Ward 5B
Distribution & promotion of EPEEP
Audit on compliance
CYCLE 3
Conduct CNE session
EPEEP Observation Programme in Ward 5C & D
Distribution & promotion of EPEEP
Audit on compliance

Effect of change

The next step

Effect of Change

GANTT CHART


JUL
AUG
SEP
OCT
NOV
DEC
JAN
FEB
MAR
APR
MAY
JUN
JUL
AUG
SEP
Verification Study
Briefing and Training
Data Collection
Analysis of Data
Remedial Measures
Re-evaluation 2nd Stage
Report Writing
Continues Remedial Measures
Re-evaluation 3rd Stage

LITERATURE REVIEW

- Ng, S.C.; Ooi, K.L Improving care through EPEEP nurse rounding in Singapore tertiary hospital. International Journal of Evidence-Based Healthcare 12(3):p 210, September 2014.
- Tinneti ME, Doucette J, Claus E et al. Risk factors for serious injury during falls by older persons in community. J Am Geriatr Soc. 1995;43(11) : 1214-21
- Koh SSL, Manias E, Hutchinson AM, Johnston L. Fall incidence and fall prevention practices at acute care hospitals in Singapore: a retrospective audit. J Eval Clin Pract. 2007; 13(5):722-7

THANK YOU