Reducing falls rate on a dementia assessment ward: can small changes make a difference?

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Abstract

Aim: to reduce the rate of falls in Brooker Organic

Objectives: To collect data on falls incidence and description events of every fall based on the incident reports; to actively engage ward staff throughout the project; to implement sustainable changes to practice to consistently reduce the rate of falls on the ward.

Methods: the review of post-falls incident reports alongside staff engagement activities informed the implementation of two changes to practice on the ward: (1) ward staff were instructed to write the date of the last fall on top of every patient clinical notes on a daily basis; and (2) prompts to facilitate a detailed post falls review were added to the weekly ward round paperwork. A statistical process control chart was used to monitor the rate of falls 6 months before and after the implementation of these changes to practice.

Results: these two strategies were implemented in June 2017. By July 2017, all patients had the date of their last fall recorded in their clinical notes. This was reviewed in March 2018 and adherence to this strategy remained 100%. Further, it had been expanded on spontaneous staff initiative to another ward. Falls continue to be discussed on weekly ward rounds. The statistical process control chart showed a reduction in the rate of falls from 3.80 to 1.76 per 100 occupied bed days.

Conclusion: changes to practice and improvements in care can be successfully implemented and sustained when frontline staff are empowered to make decisions based on routinely collected clinical data. The increased awareness of falls amongst staff and prompt multi-disciplinary reviews post falls may have contributed to a reduction in the rate of falls on the ward.

More information

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Contributors

Author: **Ana Carolina, Vieira Goncalves**