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Preventing Falls By Improved Surveillance.

Abstract

In hospitals, falls and medication errors are the highest number of incidents reported. Over 40% of patients with specific problems such as stroke experience one or more falls during their hospitalisation¹.

A three year Falls Prevention Project is underway at Bayside Health in Melbourne. This project spans three hospital sites (The Alfred, Caulfield General Medical Centre (CGMC) and Sandringham and District Hospital), where the patient populations vary, as do work practices and cultures from ward to ward and hospital to hospital. After extensive literature review, collaboration with other hospitals and internal discussions, a multistrategy falls prevention programme was chosen. There are three outstanding features amongst the information that is reported about our patients that fall: the fall is frequently unwitnessed, it often occurs in the setting of need to toilet and confusion or decreased cognition/mental capacity is a very common attribute amongst these patients that fall.

Increased surveillance has become a prime strategy in managing these patients and preventing falls by anticipating any problems and correcting them before they occur. Increased observation is the key to the proposed Falls Prevention Strategy. Operation Observation-Falls Prevention Strategy (O.O.F.P.S.) is the name of the innovation that is being implemented and trialed in a CGMC sub-acute aged care ward. This aims to change nursing practice so that nurses are able to observe patients for greater periods of time during the course of their shift by modifying long established practices related to nurse documentation; nursing handover; patient hygiene practices; staff meal breaks and patient eating times and creation of a high observation bay. This innovation will result in direct and indirect savings and increased patient safety and satisfaction as a result of greater nurse presence.

At CGMC already, prior to the OOFPS project, falls per 1,000 occupied bed days (OBD) fell from 12.0 to 7.4 (a 38.3% reduction) when comparing the six month period for the first six months of 2001 (pre-implementation) to the last six months of 2002 (6 – 12 months post-implementation of the Falls Strategy). Serious falls fell from 0.44 per 1,000 OBD to 0.28 (a 36.4% reduction). Even further reductions are anticipated with the progressive implementation of other initiatives such as improved night time surveillance.

This presentation will outline details of our findings to date in more detail, including the work practice and infrastructure changes and other falls prevention issues, such as incident analysis of serious incidents. Lessons to date and future plans for these organisations will be discussed.

¹ NARI. 'An Analysis of Research on Preventing Falls and Falls Injury in Older People: Acute Care Settings.' Report to the Commonwealth Department of Health and Aged Care Injury Prevention Section. August 2000.

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