**Reduction rate on a dementia assessment ward: can small changes make a difference?**


*a.c.goncalves@soton.ac.uk*

**Aim:** To reduce the rate of falls in Brooker Organic (Older Person’s Mental Health ward)

**Objectives:**
1. To collect data on incidence of falls and description of events that may have contributed to a fall based on the incident reports
2. To actively engage ward staff throughout the project
3. To implement sustainable changes to practice to consistently reduce the rate of falls on the ward.

**Actions taken:**
*Review of incident reports* to find patterns in the location of falls and determine lessons learnt from previous falls. In addition, several *staff engagement* initiatives were conducted, where staff were asked about causes for falls and what could be done to reduce the rate of falls on the ward. These initiatives informed the following actions:

- The **date of the last fall** is now written **every day on top of the patient clinical notes**;
- **Prompts to facilitate a detailed post falls review** were included in the **weekly multi-disciplinary ward round paperwork**.

**Measures and Outcomes: Statistical Process Control “U” chart**

- **Changes implemented:** week 24
- **UCL 0.104**
- **LCL 0.038**
- **Center Line 0.0506**
- **Falls rate per day**
- **Weeks in 2017**

Actions were sustained and adopted on staff initiative in another part of the ward.

The rate of falls was reduced from 3.80 to 1.76 falls per 100 occupied bed days.

**Conclusions**

- Changes to practice and improvements in care can be implemented and sustained when 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.