INPATIENT FALLS
PREVENTION STRATEGY
2013/14
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1. **INTRODUCTION**

Patient falls have both human cost and financial cost. For individual patients the consequences can range from distress and loss of confidence, to injuries that cause pain and suffering, loss of independence and occasionally death.

Patients relatives and hospital staff can feel anxious and guilt.

The cost for NHS organisations includes additional treatment, increased length of stay, complaints and in some cases, litigation.

Preventing patients from falling is a particular challenge in acute hospital settings. There will always be a risk of falls in hospital given the nature of the patients that are admitted, and the injuries that may be sustained are not trivial. However, there is a lot that can be done to reduce the risk of falls and minimise harm, whilst at the same time allowing patient’s freedom and mobilization during their stay. NPSA (2007)

The reasons why patients fall are complex and influenced by contributing factors such as physical illness, mental health, medication and age, as well as other environmental factors.

Efforts to reduce falls and injuries need to involve a wide range of staff and in particular those working in nursing, medical, therapy and pharmacy.

2. **VISION**

The Trust aims to reduce the number of all reported inpatient falls by 14% at year end of 2013/14 and reduce the number of harms caused by a fall and fragility.

This will support our new Vision: “to be recognised as the safest and most caring NHS Trust in the UK” and via Our Values: Care for People, Listen and Improve, Work Together and Do the Right Thing.

A baseline will be calculated by the total number of falls per 1000 bed days and the number of falls causing harm per 1000 bed days at end of 2012/13.

The Strategy outlines best practice approaches for preventing falls in the hospital including implementing standard falls prevention strategies; identifying falls risk; and implementing falls and injury prevention interventions. Falls prevention programs are most likely to be successful when all these components are implemented.
3. MULTIFACTORIAL ASSESSMENT

All adult inpatients on the acute wards will be risk assessed within 24 hours of admission using The Falls risk assessment adapted from the Falls risk assessment for the elderly (FRASE). For patients who are identified at risk, which is scoring above ‘8’, should have a falls prevention care plan implemented that reflects the ‘multifactorial assessment and intervention’.

All patients over the age of 65 years admitted to the Accident & Emergency department major’s side due to having a fall will have a falls risk assessment, trolley rail assessment and falls prevention care plan commenced if at risk on admission.

This will identify risk factors and where possible should be acted upon, including fast access to mobility assessment and walking aids, identifying medical causes of falls, and treating urinary incontinence or urgency.

All adult inpatients will have a bedrail risk assessment.

To ensure this happens across all inpatient wards it will be monitored through the Trusts Nursing Quality Assurance System (NQAS).

A falls category has been created which spot checks 10 patients’ records each month. Within the falls category there are questions checking that the patient has had a falls risk assessment, a bed rail assessment and a falls prevention care plan implemented if the patient is at risk. Checks are also made to ensure that the patient has been reassessed as and when required i.e. a minimum of weekly, following a fall and any change in the patient’s condition. The NQAS results are expected to achieve above 90% to obtain a green status.

The falls risk assessment will be validated during the financial year through the creation of an audit tool to ensure the prediction tool is accurate, reviews of numerical falls risk assessments suggest there is a likelihood of such tools missing some patients’ or identifying a patient as a likely faller when they are not. (Patient Safety First 2009)

4. TRAINING

All acute adult inpatient wards will have a Falls key trainer who will be responsible for championing falls prevention and ensuring all staff receives a mandatory falls awareness session every 2 years. The ward manager will ensure the falls champion attends an annual update.
The key trainer will ensure all staff with the support of the ward manager and the practice development teams (PDT) are aware of:-

- Displaying a yellow triangle at the bedside of all medium and high risk patients, this will alert all multidisciplinary staff to assist the patient should they try to get up without help.
- Champion best practice
- Challenge poor practice
- Cascade any new innovations to the team e.g. Falls safe project
- Carry out any audits related to falls prevention and cascade results to the team with the support of the ward manager

All Falls key trainer study days and updates will be advertised via the Trust Training Prospectus which is known as STEPS TO EXCELLENCE.

The PDT team will provide falls awareness sessions within the ward areas at the request of the ward manager to support key trainers. The Mandatory falls awareness sessions consists of key elements of successful Falls prevention and takes between 45min – 1 hour maximum.

All occupational and physiotherapy staff should have a key trainers within the department to cascade mandatory falls awareness session training and any new innovations/alerts in relation to falls.

The Trust Falls clinical lead (Consultant Geriatrician) will provide education to junior doctors on a rolling teaching programme. This will be delivered at the grand round at least once every 4 months.

5. HEALTH PROFESSIONAL RESPONSIBILITES

All health professionals should be involved in falls prevention.

**Doctors** should target ‘culprit medication’ in all patients, especially avoiding new prescriptions of night sedation. A Medication review should be carried out with modification/withdrawal of medication that can increase the risk of falling on patients on admission and again following a fall. Each ward should have the Falls safe guidance sheet on medication published by the Royal College of Physicians (RCP 2012) as a resource on the ward.

**Doctors** have a duty post fall to carry out a full medical physical examination of the patient and a review of the medication. An examination should also be carried out for medical causes of falls.
**Therapy staff** should provide fast access to assessment and walking aids. Additionally particularly in rehab settings with longer lengths of stay, sustained programmes of patient education and strength and balance training.

**Pharmacy** staff should also be carrying out a reconciliation of all patients’ medications on admission and advising doctors of possible culprit medication.

**Ward Managers** should ensure that there is a process in place to carry out a **RCA** following a second fall and feedback any learning the rest of the team and colleagues through the Quality Framework meeting.

**Registered Nurses**

- Are responsible for completing the initial falls risk assessment within 24 hour of admission on all inpatients and initiate interventions to reduce the risk. To commence the Falls Prevention Care Plan if the score indicates that the patient is a medium or high risk.

- A falls yellow triangle **must** be placed both at the bedside and on the patient status at a glance board to raise awareness of all patients that are medium/high risk of falls.

- Attend mandatory falls training bi-annually, applying information learnt or accessing support as required from their ward manager/matron.

- Certain patients may require a **temporary** period of enhanced level of observation following a risk assessment, to maintain patient safety while the level of risk is managed, in this instance the registered nurse should use the one to one guidance to risk assess the patient and if required escalate to the ward manager and matron for authorisation. This must reviewed every **24 hours**.

**All Staff**

- The roles and responsibilities of all levels of staff to maintain a safe environment, undertake formal risk assessment and take action to reduce risk are described in the MSFT Health and Safety policy and are outlined in individual job descriptions.

- All employees have a responsibility to report Adverse Incidents involving slips, trips and falls.

- All clinical staff has a responsibility to follow the post-fall protocol when a patient has fallen.
6. USER & CARER INVOLVEMENT

Nurses and other caregivers should where possible encourage carers when possible to:-

- Stay with the patient, especially if they are confused or unable to call for assistance to get out of bed. The presence of a loved one can be comforting and reassuring to the patient.

- Encourage to bring in familiar objects from home to make the patient feel more comfortable in the unfamiliar hospital environment.

- Bring in activities that the patient enjoys at home that could prevent restlessness such as simple games, puzzles or reading materials.

- If the patient normally wears glasses, a hearing aid, a walking frame or other devices at home, make sure these are available in the hospital.

- For patients with confusion the About Me Tool should be completed fully by a family member/carer.

- Safe footwear should be requested to bring into hospital as soon as possible

The Patient information leaflet: - Falls prevention and advice whilst in hospital should be given to all at risk patients or their family/care where appropriate.

7. IMPROVING RECOGNITION AND UNDERSTANDING OF DEMENTIA

People with Alzheimer's and other types of dementia tend to be at a high risk of falling. They are more than three times more likely to fracture their hip when they fall, which leads to surgery and immobility. The rate of death following a hip fracture for those with Alzheimer's is also increased. Thus, fall prevention for people with dementia is critical. (Heerema 2012)

One way to reduce falls in people with dementia is to understand why they fall, if we can identify what makes some one more likely to fall we can try to anticipate needs and decrease falls. There are many causes:-

- Physical weakness, gait changes and poor balance, fatigue, restlessness

- Visual misconception, boredom, loneliness

- Clutter

- Discomfort or pain
• Medication side effects
• Hunger, thirst, a need to use the toilet

One of this year's National Commissioning for quality innovation (CQUIN) is improving dementia care, including sustained improvement in Finding people with dementia, Assessing and Investigating their symptoms and Referring for support (FAIR)

The Trust will be screening all patients over the age of 65 years of age and those with a positive result will be referred onto the dementia nurses for further advice on care.

All patients admitted to the Trust with a communication difficulty or confusion will have the About Me Tool completed, this form will help the staff to care for the patient in an individualised way as it clearly states the patient’s likes, dislikes interests etc.

A programme of Dementia care training is planned throughout the year. The aim is for a minimum of 25% of trained and untrained nursing staff from the acute inpatient wards this will include new staff commencing within the Trust to attend a Dementia workshops. Also scheduled throughout the year are Dementia briefing sessions, it is expected a minimum of 40% of porters, receptionists and radiology staff to attend by the end of the year.

Training in relation to trying to prevent patients falling with a diagnosis of dementia will also be cascaded through the Falls Key trainer study days and Falls awareness sessions.

8. THE TRUST WILL IMPROVE ITS RECOGNITION AND TREATMENT OF DELERIUM

Delirium is a recent and usually fluctuating change in a person’s awareness, often shown as disorientation or confusion, or through difficulties with memory. It can often be triggered by an infection, operation or a new drug. It can affect up to 1 in 3 hospital patients in the UK, but is potentially preventable in about a third of these cases. Delirium can lead to longer stays in hospital, bed pressure sores, and may increase the risks of dementia and death. However, the condition is poorly recognised in UK hospitals and long-term care, and preventative methods are generally not in place. (NICE 2010)

Improving the recognition of undiagnosed delirium may lead to sustainable and successful fall prevention programs. Detection of impairments in mental status can assist staff to create individualised patient care plans. Knowledge about which patients are at risk for injury
from delirium and falls can lead to improvements in patient safety, functioning, and quality of life.

All inpatient ward areas should have delirium posters for doctors and nurses to refer to; these posters describe signs and symptoms and recommended treatments. The poster also shows the confusion assessment method (CAM) which is used to confirm diagnosis.

The Trust currently has no formal delirium guidelines to refer to, therefore local Trust delirium guideline needs to be developed within the next 6 months by the Trusts clinical dementia lead.

9. DELIVERING A SAFE ENVIRONMENT

Many aspects of the hospital environment may have an impact on the risk of falls and injury.

These include:-

- Flooring surface, including any unevenness, and how slippery a surface is when wet or dry. Flooring density how soft or hard it is to land on. Flooring pattern can create an illusion of slopes or steps for patients with dementia or impaired sight.
- Lighting, including sudden changes from dim to bright lighting and the position of switches
- The design of doors, handrails, toilets and bathrooms
- The distance between handholds, beds and chairs and toilets
- The line of sight for staff observing patients
- Trip hazards, including steps, clutter and cables
- Furniture , medical devices including beds, trolleys, bedrails, commodes and wheelchairs and ensuring stability if patients lean on them

(NPSA 2007)

All ward managers will ensure that they reliably deliver the basics of a safe environment, including avoiding clutter, addressing trip or slip hazards promptly.

All nursing staff will ensure that call bells are within reach for patients able to use one, and providing safe footwear to patients who have none. The ward manager will ensure that there is a supply of slipper socks
which will be used until safe footwear can be provided by the patient’s family.

The ward manager will ensure continual maintenance/Improvement of the ward environment along with all other nursing staff– especially good even lighting, stable and comfortable furniture, clear signposting (especially of toilets) and hand holds/rest seats.

All staff within the Trust have a responsibility when in a patient area that the areas are hazard free and patient safety is paramount at all times.

10. REDUCING THE RISK OF HARM FROM FALLS

Patients beds should not be set on a high setting, a fall from height can cause increased risk and severity of injury. The bed setting should be at a height that patients can easily get off the bed and mobilise if able.

Bedrails if recommended should be kept in a raised position at all times except when care is being delivered. This includes at meal times.

When a serious injury occurs as a result of an inpatient fall, safe manual handling and prompt assessment and treatment is critical to the patient’s chances of making a full recovery. All wards should have ‘The Essential care post fall protocol’ at the nurses’ station. This clearly states requirements for physical assessment after a fall including which physiological observations at what intervals and for how long. This is mandatory following a Rapid Response alert (Jun 2011) from the NPSA which aims to ensure that local protocols and systems help staff to consistently achieve this. After a fall has occurred the initial focus has to be on rapidly identifying and treating any resultant injury, in addition to this they need to identify and treat any new physical cause, because in a hospital setting a fall can be an ominous sign of a change in their underlying illness (for example a further myocardial infarction, or an extension of a stroke).

It is also extremely important that any fall triggers a review, to identify what further actions might be taken to prevent the patient falling again, and for learning that might prevent other patients falling.

Ultra low beds can help to prevent harm from falls - particularly for patients with delirium who are at risk of falling out of bed, but who cannot be given bedrails as they might try to climb over them (see NPSA bedrail guidance). The Trust has a number of ultra low beds, but often there are
not enough. This has been incorporated into the bed replacement programme. However, ultra low beds need to be used safely and appropriately. A search of the National Reporting and Learning System (NRLS) database of all incidents reported from 1 November 2003 to 24 June 2010 identified a series of patient safety incidents related to the use of ultra low beds.

These included: • injuries from floor-level furniture or fittings such as radiators, pipes, or lockers (including one serious burn); • ultra low beds placed close to a wall but not flush with it, creating potential for asphyxial entrapment if the patient slipped between the side of the mattress and the wall (see MHRA bedrail guidance); • ultra low beds left at working height in error, leading to falls from height • patients who appeared to have tripped over crash mats used beside the ultra low bed (including three fractured hips). (NPSA 2011)

Some reports suggested ultra low beds were seen as a universal falls prevention solution and were therefore provided inappropriately for mobile patients (see RCN restraint guidance). Additionally, some reports suggested that ultra low beds had been used with bedrails raised, negating their purpose.

All of the above is cascaded through the Falls training programme.

11. QUALITY GOVERNANCE ARRANGEMENTS

The number of falls and harm from falls will be monitored monthly by the nominated lead for falls and the Governance Department.

The number of falls by ward and harm from falls will be reported monthly to the Quality & Safety Committee (QASC) along with any recommendations or initiatives being undertaken. The number of falls incidents will be monitored through the divisional governance groups, any concerns of specific wards should be addressed by the matron. The divisional governance groups will also be challenged by a identified member of the corporate nursing team, on what actions are being taken should there be a rise in falls in an area.

The falls steering group will analyse data provided by the Governance manager on a bi monthly basis to identify any trends from falls. This with any actions will be shared with the relevant area.

High incident wards will have the area where a fall occurred plotted on a map of the ward, (measles charts) this will identify if there are any areas
within the ward that are a high risk area for patients. Ideally the chart will carried out over a 3-6 month period to obtain a true reflection of where the incidents happen. These will again be shared with the managers of the areas the QASC and the Falls Steering Group. Where possible within the limitations of the single sex accommodation guidance, high incident areas will not be used for patients at risk of falling.

All falls will have an actual impact of harm recorded when reported on the incident system. The grading is the same as the NPSA:-

1. **No harm:** Impact prevented – any patient safety incident that had the potential to cause harm but was prevented, resulting in no harm to people receiving NHS-funded care.

   Impact not prevented – any patient safety incident that ran to completion but no harm occurred to people receiving NHS-funded care.

2. **Low:** Any patient safety incident that required extra observation or minor treatment and caused minimal harm, to one or more persons receiving NHS-funded care.

3. **Moderate:** Any patient safety incident that resulted in a moderate increase in treatment and which caused significant but not permanent harm, to one or more persons receiving NHS-funded care.

4. **Severe:** Any patient safety incident that appears to have resulted in permanent harm to one or more persons receiving NHS-funded care.

5. **Death:** Any patient safety incident that directly resulted in the death of one or more persons receiving NHS-funded care. (NPSA 2011)

Any fall with an actual impact harm level of **grade 4** will have a route cause analysis carried out by the ward manager. This will then be presented at the Falls Steering Group to enable any learning from the fall to be shared, as well as learning being shared with the staff from the area that the incident has occurred. Ward managers from other areas will share any learning with their staff through their usual communications channels. Falls RCA is also on the agenda of the Quality framework group, this again helps ward managers network and share learning with each other. Any falls with impact harm level of 5 will become a serious incident (SI) and the SI procedure will be initiated.
12. FALLS STEERING GROUP

The steering group will meet alternate months or a minimum of 6 times annually. The group will report into the Quality & Safety Group which reports to the Board. This steering group is a multi agency, multi-disciplinary group; initiatives to reduce the harm from falls are unlikely to succeed if they are seen as only relevant to nurses and physiotherapists.

In addition, links with social and primary care are important for joining up hospital falls prevention with initiatives in the community. As the group progresses through the year the community falls prevention team for the community will be invited to the meeting.

The group should as a minimum include representatives from these professional groups / departments:

The Falls lead (Elderly care consultant)

Practice Development Team

Governance Manager

Physiotherapist/occupational therapist

Ward Manager

Dementia Nurse/OT

The Falls Steering group will analyse trend reports provided by the Governance team, any areas that highlight concerns will have a review by the nominated falls lead from corporate nursing. This will involve looking at falls prevention initiatives within the area, training requirements, staffing levels and audit results. An action plan can then be created by the ward manager /matron on these recommendations.

The group will also request information from governance related to high incident areas i.e. circumstances of falls times, what the fall was from etc.

The falls group will review falls RCA carried out on any patients sustaining an injury of grade 4 harm.

The falls steering group will monitor the number of falls by per 1000 bed days along with harm caused by a fall, to monitor if on target to meet the key performance indicator of a 14 % reduction.
13. REFERENCES

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Patient Safety First 2009 The 'How to' guide to reducing harm from falls National Patient Safety Agency: London.

Royal College of Physicians 2012. Implementing Falls safe Care bundles to reduce inpatients falls