Healthcare Improvement Scotland

Falls Networking day 30 May 2018

# NHS Tayside

EVERY PERSON EVERY TIME SCOTTISH PATIENT SAFETY PROGRAMME 2008-2018 Ten years of improving safety

## Who or what prompted this work? How did you build will?

- Falls Lead P&K, Medicine Directorate and Senior Practice Development
- Commitment to reduce falls and falls with harm
- Learning from adverse incidents
- Establish range of tools/interventions to support improvements and share
- Empower clinical staff to continuously test ideas to improve

## What activities or tests of change have been successful in reducing falls or falls with harm?

- Ward Falls Champions coached through data and provide leadership
- Falls Improvement groups – continuous cycle of testing, learning, feedback and sharing ideas
- Using a 'pick and mix' approach appropriate to the ward setting.

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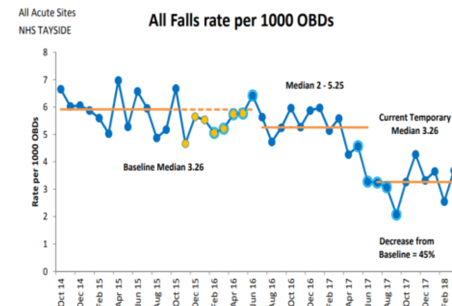
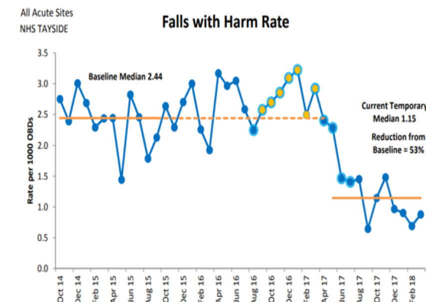
## What 3 things have been critical to your success?

1. Falls Documentation incorporating
    - Falls Risk Assessment
    - Falls History on admission
    - Personalised Treatment Intervention plan with triggers
    - Post fall reflection




2. Educational resources in varied formats




3. P&K HSCP/Acute Medicine Falls Champions and Falls groups provide leadership and QI support, review and analyse data, consider service user needs, environment and empower MDT to consider further improvements.

# Specific Falls Documentation

- Care plan (handwritten, individualised), triggers for interventions (not exhaustive). Exemplar produced.
- Bed rail decision making tool incorporated
- Post fall review provides at a glance history/trends of falls sustained.
- Introduction of combining this with process measure around identifying if care plan interventions are evident in practice – measuring practice not just documentation.

**Falls Risk assessment – 2 questions**

WRITE OR ATTACH LABEL
Surname............ Sex..........
Forename..........
DOB and CHI..........

HOSPITAL..........
WARD..........

NHS Tayside

Falls Risk Assessment

The following 3 questions must be completed with ALL patients, within 24 hours of admission.
Re-assessment required if patient condition changes.
(Please document Yes/No below)

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 1 | History of falls prior to admission? (if yes, complete falls history & falls prevention action plan) | | | | | | |
| 2 | Falls(s) since admission? (if yes, complete hospital falls history & falls prevention action plan) | | | | | | |
| 3 | Additional falls risk factors for this patient? E.g. Patient tries to walk alone but unsteady/unsafe, learning disabilities, parkinson's, CVA, cognitive impairment, acute confusional state, continence issues, visual impairment, medication (night sedation), surgery, seizures/epilepsy, fear of falling etc. (if yes, complete falls prevention action plan) Please state: walks alone but unsafe, cognitive impairment | | | | | | |
| Date | | | | | | | |
| Time | | | | | | | |
| Initial | | | | | | | |

Document your assessment of the risk factors to support your decision making around interventions

Falls History: (to be completed within 48 hours of admission)

Falls history assessment: (Date & Time of last fall prior to admission)
Estimated date and time of the last fall? Date .......... Time of Day..........
First fall? Yes ☐ No ☐ Recurrent falls? Yes ☐ No ☐ Number of falls within the last year?..........
Any warning immediately prior to any falls? Yes ☐ No ☐
Palpitation ☐ Dizziness ☐ Alcohol ☐ Loss of Consciousness ☐
Slip/Trip ☐ Environmental hazards ☐ Associated movement ☐
Explanation about fall/previous falls: (where, when, why) Activity at time of fall? (Please describe)
(consider if fall/injury could be non accidental)

**Individualised Falls Intervention Plan**

Falls Prevention Action Plan

The following nursing interventions may address some of the falls risk factors. They are however NOT exhaustive and staff should use their clinical reasoning/professional judgement when determining falls risk interventions.
**Please state all actions taken from the list of interventions below.**

| Interventions: | Initial Plan | Update on Transfer |
|---|---|---|
| **Environmental:**<br>• Nurse in most appropriate place on ward for their needs e.g. easily observable area, near toilet etc.<br>• Area hazard free, personal belongings within easy reach<br>• Call system working/within reach at all times (where available)<br>• Adequate lighting at all times particularly overnight.<br>• Check infusion stands facilitate mobility.<br>• Use of sound/movement monitors (if available)<br>• Select suitable seating (appropriate height, comfort)<br>• Consider one-way glide sheet for chair<br>• Frequently re-orientate confused patients | | |
| **Vision/Hearing**<br>• Ensure correct glasses worn/within easy reach and clean.<br>• Determine if patient can recognize objects from the end of the bed - if concerns, refer to medical staff for visual acuity assessment<br>• Consider hearing implications, hearing aid working etc. | | |
| **Lying and Standing Blood Pressure:**<br>• Check and record. If deficit exists, inform medical staff and continue to check twice daily for at least 72 hours.<br>• Advice patient on slow movement from sitting/lying to standing. | | |
| **Mobility:**<br>• Follow mobility risk assessment/care plan.<br>• Consider referral to Physiotherapy and/or OT<br>• If patient requires walking aid is it within easy reach? | | |
| **Medication:**<br>• Request Medical staff or Pharmaceutical review. | | |
| **Delirium (Acute Confusional State)**<br>• Treat causes of delirium, refer to delirium guidelines | | |

**Includes bed rail risk/decision tool**

| | | |
|---|---|---|
| **Medication:**<br>• Request Medical staff or Pharmaceutical review. | | |
| **Delirium (Acute Confusional State)**<br>• Treat causes of delirium, refer to delirium guidelines | | |
| **Toileting:**<br>• Assess continence. If urine frequency, ward test urine.<br>• Plan routine/frequent toileting.<br>• Consider a commode for night time toileting.<br>• Consider full continence assessment and refer to continence service if indicated. | | |
| **Footwear/Clothing**<br>• Encourage patient to wear shoes not slippers.<br>• Check footwear for secure fit, non-slip sole. Ask relatives to supply safer replacements.<br>• Consider referral to podiatry in line with podiatry algorithm<br>• Suitability and appropriateness of clothing e.g. length | | |
| **Bed and bedrails:**<br>Bedrails can be used<br>• Re assess the risks each shift using the decision support table Fig 1 and record on the traffic light | | |
| **Bed and bedrails:**<br>Mitigation of risk AMBER<br>In cases where bedrails are used with care, some of these interventions should be considered:<br>• Using the extra low height facility of the Enterprise beds at all times when the patient is not being attended to<br>• Placement of the patient's call bell within easy reach and provision of visual and verbal reminders to use the call bell when necessary<br>• Position patient in an area which allows increased observation | | |

**Falls history whilst in hospital**

Hospital Falls History

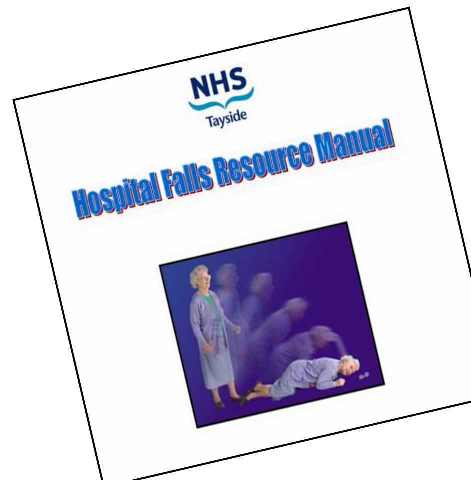
To be completed for all patients who have had a fall during current admission. This information should be included within an electronic incident report within Datix.

| | | | |
|---|---|---|---|
| Date/Time (of Fall) | | | |
| Incident reference number | | | |
| What was the patient attempting to do at the time of the fall? | | | |
| Location of fall: | | | |
| What possible causes of the fall can be identified (also ask patient)? | | | |
| What falls prevention strategies were in place at the time of the fall? e.g., nurse call to hand, correct footwear worn | | | |
| Essential care following a fall protocol followed Y/N If no, why not? | | | |
| Immediate Action Taken: (Including First Aid) | | | |
| Medical staff informed and patient reviewed: Y/N | | | |
| Complete/update and review Falls Prevention Action Plan and update Falls Safety Cross. | | | |
| Relatives informed? Y/N | | | |

INPATIENT FALL
Date: Time: Location:
Medical Team/H@N Informed ☐
Neurological Observations ☐
Datix Completed ☐
Verifier:
Falls Care Plan Updated ☐
NOK Contacted / Document Discussion ☐

# Education

- All staff complete Learnpro falls module
- Hospital Falls Manual
- In-patient falls guidance
- Falls 'champions' trained to deliver face-to-face sessions/handout
- Datix guidance




## NHS Tayside

## In-Patient Falls Guidance

Contents


1. Introduction
2. Definition of a Fall
3. Definition of a Fall with harm
4. Consequences of a Fall
5. Osteopororsis
6. Falls Risk Assessment and Falls Prevention Action Plan
7. Safety precautions for ALL patients
8. Management of a Fall
9. Recording and Reporting Falls
10. Information leaflets
11. Education
12. Posters
13. Improvement Ideas


These guidelines are a shortened version of the NHS Tayside Hospital Falls Manual. This manual and the NHS Tayside Learnpro Falls module provides more detailed information about falls and falls risk management.

1. Introduction

Patient falls are the highest reported incident in hospital settings. In 2016, there were 3673 falls (1020 with harm) recorded on Datix in Tayside hospital in-patients settings. Some of these falls will have resulted in death, severe or moderate injury creating a significant financial burden to the organisation as well as distress to patients, their families and staff.

P&K Hospital Falls Education Handout

Educational handout

GUIDANCE FOR COMPLETING DATIX FOLLOWING AN INPATIENT FALL

REPORTER
Complete all your details as the reporter.

VERIFIER
Select a verifier from your area (normally Charge Nurse or Senior Charge Nurse)

EVENT DETAILS

- Event title: can simply be 'fall'
- Event category: select 'slip, trip or fall (in-patients) - *a pop up box appears to describe the things that meet the requirements for a fall with harm, it states;*
  'Harm will be where another secondary care intervention is necessary (steri-strip, suture, and/or management of dislocation, fracture, head injury, death), and/or a patient has fallen and received harm or injury requiring radiological investigation (x-ray, ultrasound, MRI or CT) with a confirmed harm'
- Sub category: select any relevant details from the list
- Outcomes/interventions: choose from the list, remembering the details from the pop up box
- Anyone harmed: anything selected apart from 'none of the above' in the previous field, select 'yes' or for none of the above 'no'. **N.B. the need for an x-ray/scan/diagnostic alone is not sufficient, an injury must be confirmed. Minor injuries, e.g., swelling/bruise/abrasion, can be described later in the Datix report and in the nursing record.**
- All falls are an adverse event
- Complete details of location and time and date of the fall
- Circumstances: use free text to provide a full description of the event including where patient was found; include bay, location, time, position, lighting; what the patient was doing at the time and if there were any witnesses, were they using walking aid? Wearing footwear? Have glasses on? Was patient confused? Was fall avoidable/unavoidable? Provide information about number of staff on duty and their location at that time. How was patient retrieved from the floor? Provide information about preventative measures already in place e.g. buzzer in reach, night lights available, correct footwear and walking aids
- Immediate Action: use free text to record your response. These may include, use of essential care after patient fall protocol, informing Doctor/HAN of the event using SBAR handover, updating falls care plan and falls history as required, updating falls cross, sharing information regarding fall at safety briefing, informing family and provide falls information leaflet, reviewing/implementing interventions, ensuring nursing record is updated with falls details and any resulting actions
- Complete out of hours and doctor involvement questions

FALLS IN-PATIENT SECTION

- Protocol followed: select 'yes' or 'no'
- Any other factors: Consider value of including relevant information on reason for patients hospital admission, patients previous falls history, patients cognitive state e.g. confused/alert, patients understanding of their level of

MOBILITY ASSISTANCE GUIDANCE

| | |
|---|---|
| FBH | Full Body Hoist for transfers |
| STANDING HOIST | Standing hoist for transfers |
| TRANSFERS ONLY | A2 Transferring through 90 degrees with physical assistance of 2 staff with / without mobility aid<br>A1 Transferring through 90 degrees with physical assistance with / without mobility aid |
| MOBILITY AID | GF – Gutter Frame<br>TWW – Tri Wheel Walker<br>WZF – Wheeled Zimmer Frame<br>EC – Elbow Crutch<br>W/S – Walking Stick |
| A1 - ASSISTANCE OF 1 | Physical Assistance of 1 staff ( may need to move frame if used ) |
| A2 - ASSISTANCE OF 2 | Physical Assistance of 2 staff ( may need to move frame if used ) |
| CLOSE SUPERVISION | Supervision by member of staff positioned behind the patient close enough to be able to correct patient |
| DISTANT SUPERVISION | Patient can mobilise by themselves but with a member of staff in ward area |

# Falls Bundle

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- Created Tayside Falls Bundle which identifies if care plan interventions are evident in practice not just documentation.
- Currently collected manually in some areas

**Falls Care Bundle**

| Ward/Department: | | | Date: | | | | |
|---|---|---|---|---|---|---|---|
| **Criterion** | **Evidence** | **patient 1** | **patient 2** | **patient 3** | **patient 4** | **patient 5** | |
| All patients have had a multifactorial assessment and all risks relating to falls are documented | Documentation | | | | | | |
| Patients identified as being at risk of falls have documented interventions in response to each of those risks | Documentation | | | | | | |
| Evidence of interventions to respond to falls risks are evident at the patient's bedside at the time of measuring | Observation | | | | | | |
| Evidence that a post fall review has been completed and the falls treatment plan updated with appropriate interventions | Documentation | | | | | | |
| % Compliance | | 0% | 0% | 0% | 0% | 0% | |
| | | | | | | **Overall Compliance** | **0%** |