Stockport NHS
NHS Foundation Trust

Implementation of a multi-factorial falls prevention programme to reduce falls

Nursing, Quality & Accountability Conference
2nd November 2011

Cathy Gibson
Assistant Risk Manager
Christine Gidley
Assistant Director of Nursing

Every patient matters

Stockport NHS
NHS Foundation Trust

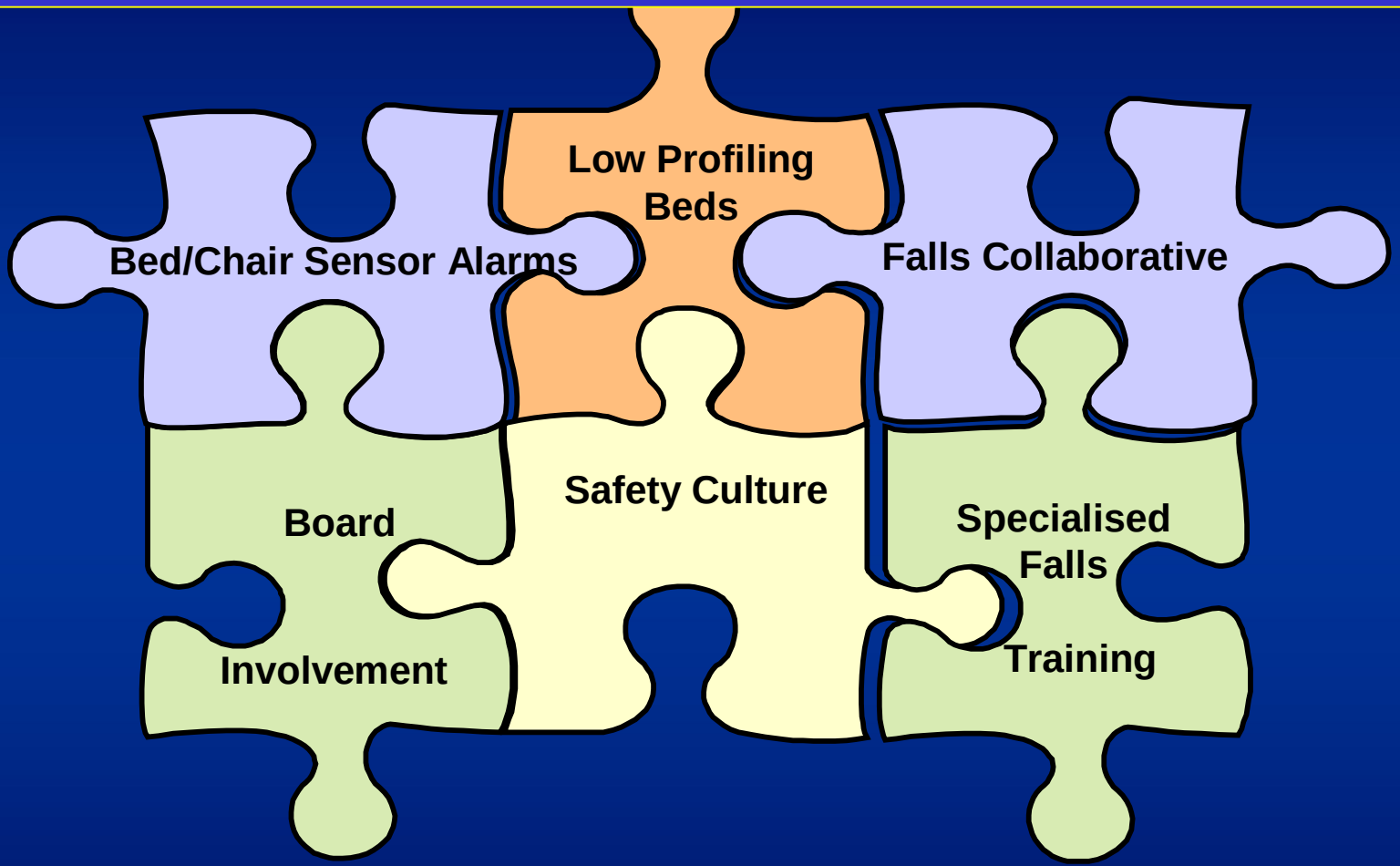
Winner of the 2010 Nursing Times Award – Patient Safety for the Implementation of a Multi-Factorial Falls Prevention Programme

Every patient matters

The Nature of the Project

Stockport NHS
NHS Foundation Trust

A multi-factorial falls prevention programme



Every patient matters

Why we undertook the project

Stockport NHS Foundation Trust

- Frequent occurrence (highest incidence)
- Cause of harm

Why we undertook the project

Stockport NHS Foundation Trust

"The very first requirement in a hospital is that it should do the sick no harm."

Every patient matters

Why we undertook the project

Stockport NHS Foundation Trust

Extent of Problem

- Falls affect **60,000** people per year in the UK
- **14,000** deaths per year
- **2,300** people in the UK fall everyday
- **28 – 33 %** of the population over **65** years will fall every year
- **32 – 42%** of the population over **75** years will fall each year

Every patient matters

Why we undertook the project

Stockport NHS Foundation Trust

- Frequent occurrence (highest incidence)
- Cause of harm
- Poor patient experience
- Psychological impact on patient
- Impact on patient's family
- Cost

Why we undertook the project

Stockport NHS
NHS Foundation Trust

Economic Benefits

- Minor falls extend a patient's stay in hospital by **1 – 2** days
- **800** bed acute hospital - **£92K** per year (1,260 falls /annum)
- Direct healthcare costs **£15M** per year

No harm incident	**£41**
Low harm incident	**£66.50**
Mod / severe	**£324**
Fractures	**£2,289**
Hip fractures	**£3,981**

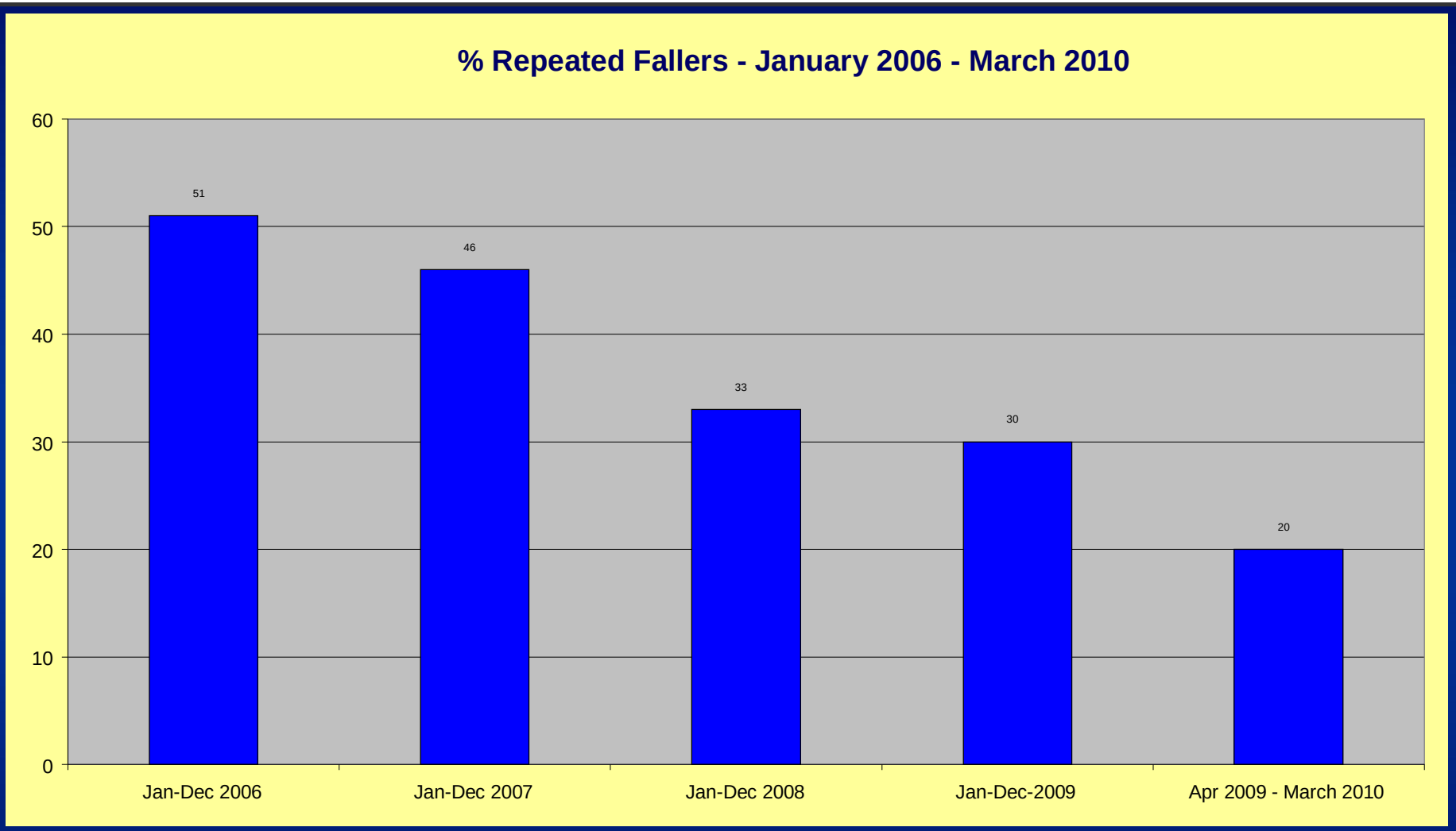
Why we undertook the project

Stockport NHS Foundation Trust

- Frequent occurrence (highest incidence)
- Cause of harm
- Poor patient experience
- Psychological impact on patient
- Impact on patient's family
- Cost
- Previous good work reducing repeat fallers

Why we undertook the project

Stockport NHS Foundation Trust



Every patient matters

How we prepared

Stockport NHS
NHS Foundation Trust

- Review of incident data
- Discussion at Risk / Falls Committee
- Preparation meetings
- Multidisciplinary discussions
- Business group and ward “buy in”
- Ward ownership
- Production of initial Driver Diagram
- Project planning & goal agreement

Driver Diagram: Reducing Harm from In-patient Falls

Stockport NHS

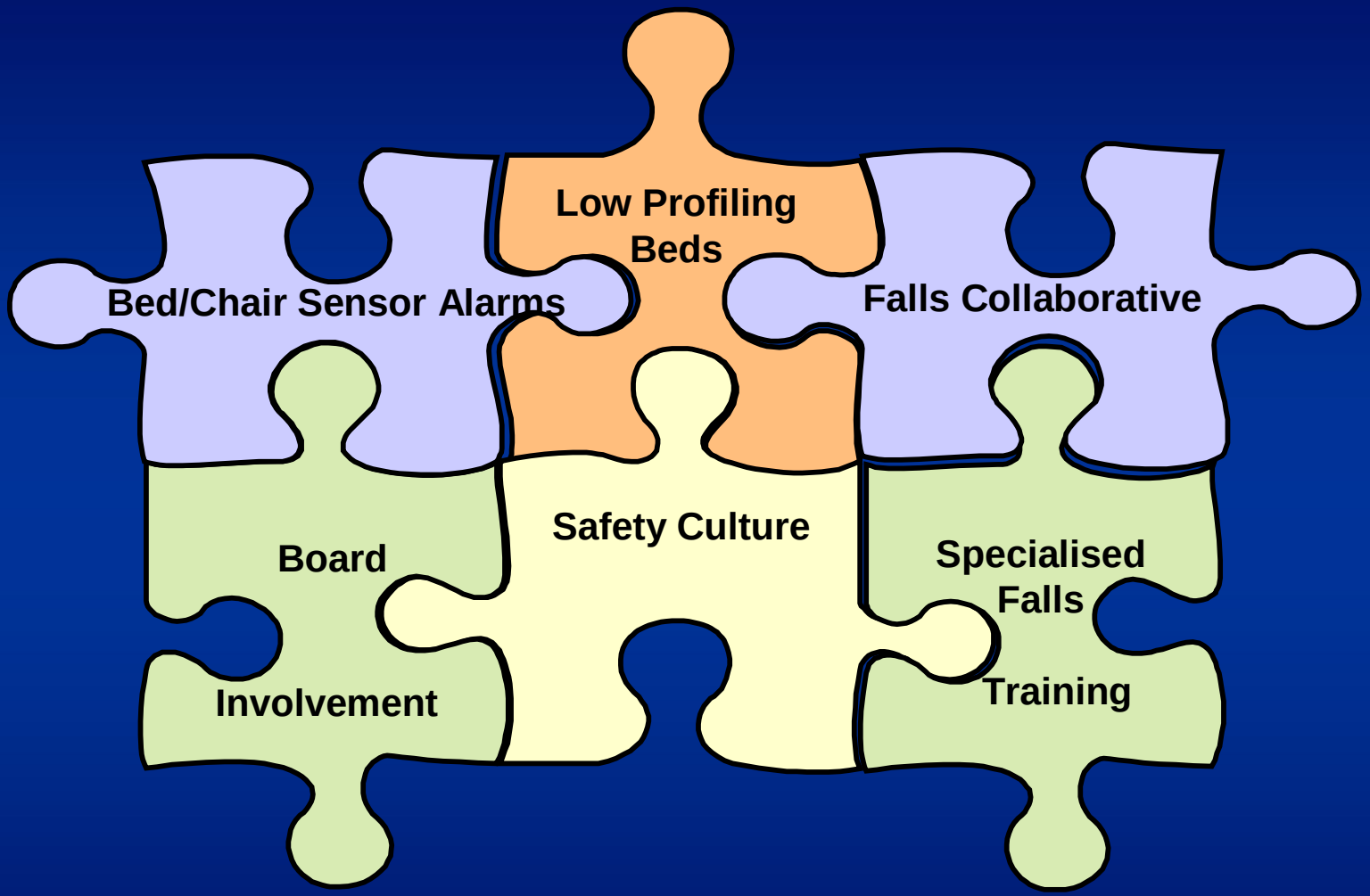
GOAL

Reduce patient falls by 25% while maintaining or improving the proportion who experience no harm

	Primary Drivers	Secondary Drivers
1	Every patient is assessed for risk of falls and appropriate, customised falls risk reduction care plan is initiated promptly and reliably.	•Trust using a standard, risk assessment tool. •Documentation is streamlined is possible •Falls care plan is reliably initiated at appropriate time •Update Trust falls policy & procedures (Flowchart).
2	A skilled, effective multidisciplinary team has clear roles and responsibilities, includes patient and family where appropriate, and communicates effetively.	•Roles and responsibilities of all stakeholders, including patient and family members, are understood by all. • Staff members have appropriate clinical training •Communicate falls risk at all handovers and transitions •Visual reminders of falls risk •Patients and family members receive information to help them prevent falls
3	Patients receive evidence based, customised treatment to reduce risk of falls.	•Equipment (low-profiling beds, sensors, bed rails, hip protectors) is available •Physiotherapy •Assess patients for : •Vision •Postural Hypotension •Mental health / Post op delirium •Continence •Home Visit (occupational therapy) •Review current available evidence based practice
4	Medication is managed to reduce falls risk.	•Process for stopping psychotropic medication •Medication Reviews •Calcium and Vitamin D •Anticoagulation •Sleep medication
5	The physical environment is free of fall hazards	•Walk around inspection including representative from estate to assess need and plan changes • Use Productive Ward techniques (LEAN) to remove clutter •Implement NW Guidance on Environmental Safety implemented •Footwear review • Empower patients and family to identify hazards

Multi Factorial Falls Programme

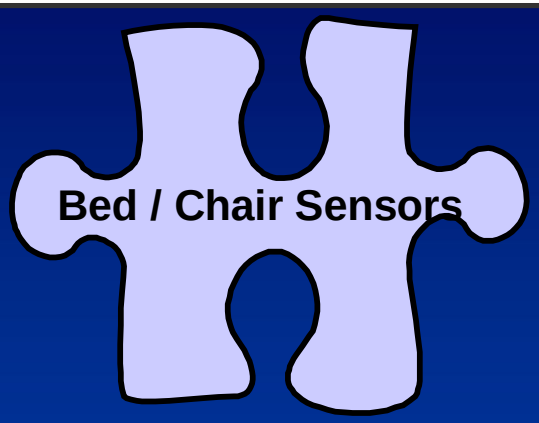
Stockport NHS Foundation Trust



Every patient matters

Bed / Chair Sensor Alarms

Stockport NHS
NHS Foundation Trust

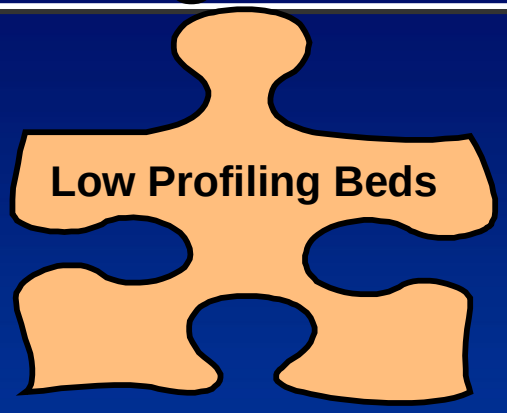


- **Bed/Chair Sensor Alarms trialled & purchased for all high risk**
- **Close working with Procurement Department**
- **Use of innovative new technologies to improve patient comfort & safety**
- **Flow Chart and Procedure Developed**
- **Training Programme implemented**
- **Rapid Response to alarms**

Every patient matters

Low Profiling Beds

Stockport NHS Foundation Trust



- Low Profiling Beds trialled & number now purchased for patients at high risk
- Flow Chart and Procedure Developed
- Training Programme implemented/Ongoing Refresher Training
- Monitored usage through agreed procedures

Every patient matters

Falls Collaborative

Stockport NHS
NHS Foundation Trust

- "Learning Ward"
- PDSA Cycles
- Electronic Handover / Safety Briefing
- Toileting – high risk falls patients
- Notice board
- Communication with Families
- Review of Medication
- Footwear
- Observation – computers & telephone
- Changes to Bathroom Areas – relocation of toilet roll holders

Specialised Falls Training

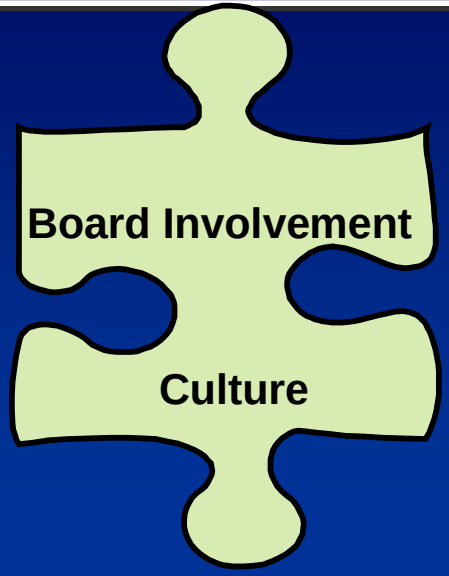
Stockport NHS Foundation Trust

- Training Package developed by Risk Management Department and delivered to high risk wards
- Training delivered both on wards and in classrooms.
- Content Covers completion of Falls Risk Assessment / Care Plan & Initiatives.
- Over 1500 staff have attended this training at all levels (Nurses and AHP's) – ongoing.

Every patient matters

Board Involvement / Culture

Stockport NHS Foundation Trust



- Executive Safety Ward "Walk Rounds" conducted
- Quality Reports produced monthly presented to the Board of Directors
- Falls Group – bi-monthly and multi-disciplinary
- Corporate Falls Report – presented and reviewed bi-monthly
- Ward Safety Notice boards
- Nursing Care Indicators – undertaken monthly

Every patient matters

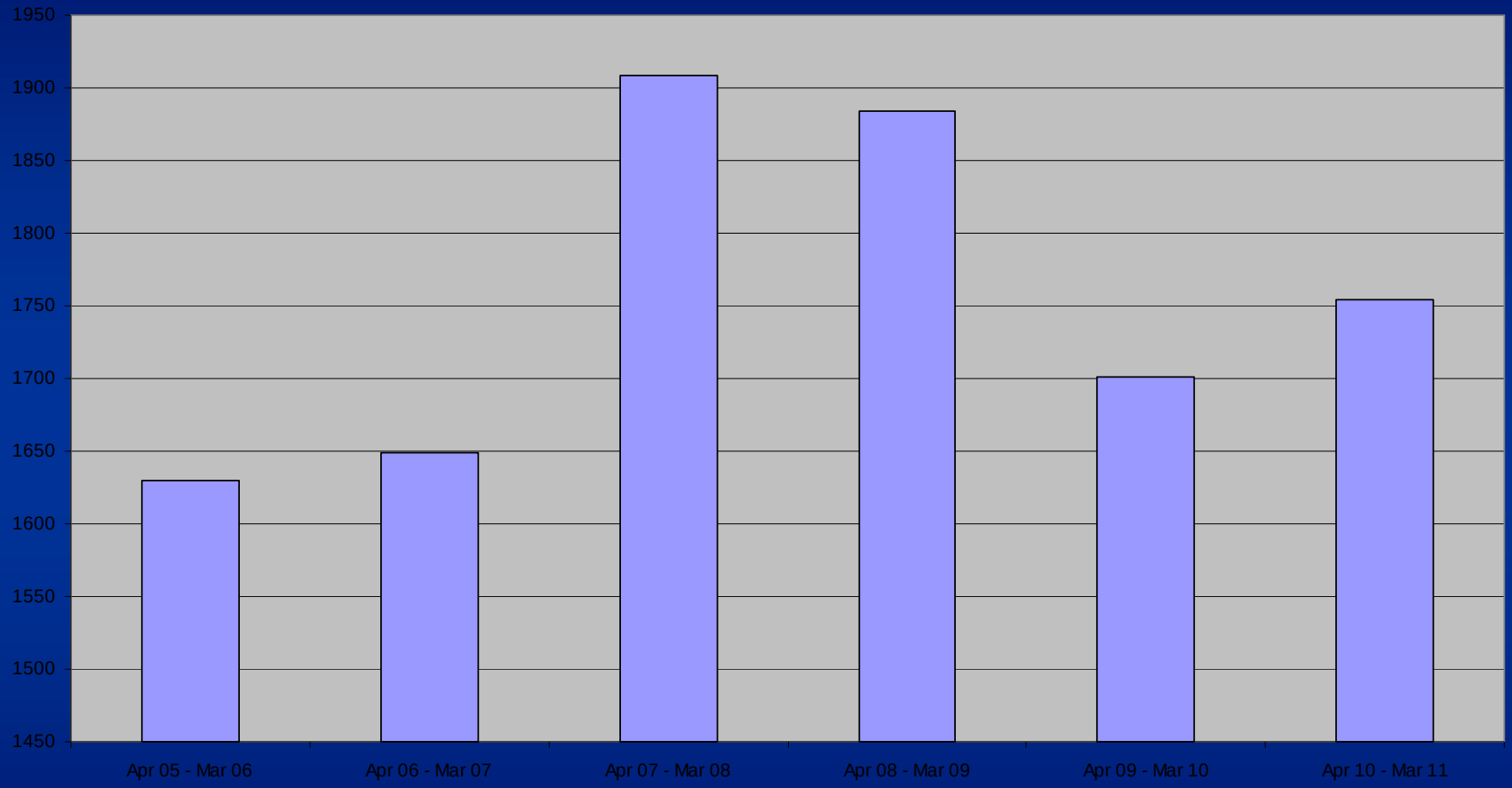
The Outcomes

Stockport NHS
NHS Foundation Trust

Every patient matters

Number of Falls

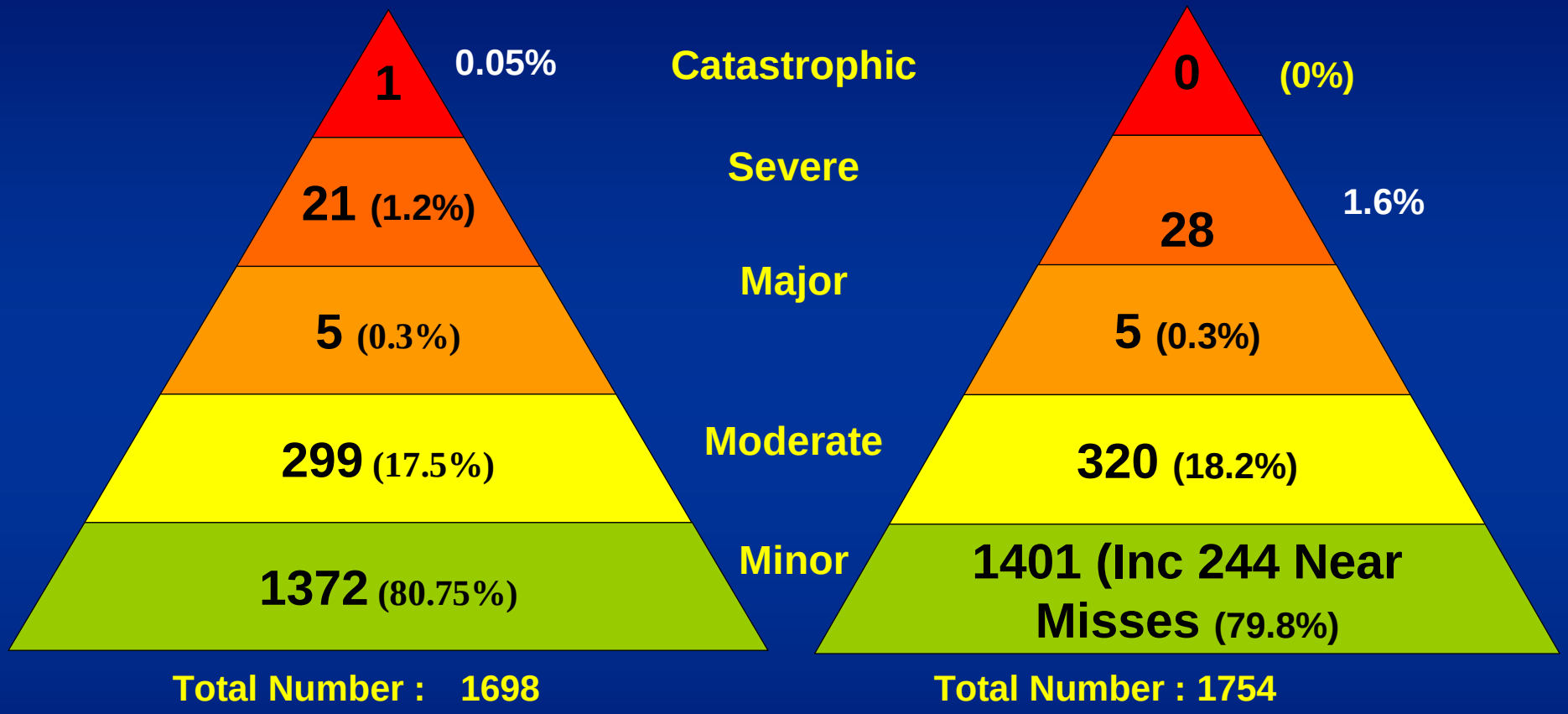
April 2005 – March 2011



Every patient matters

The Outcomes

Stockport NHS
NHS Foundation Trust

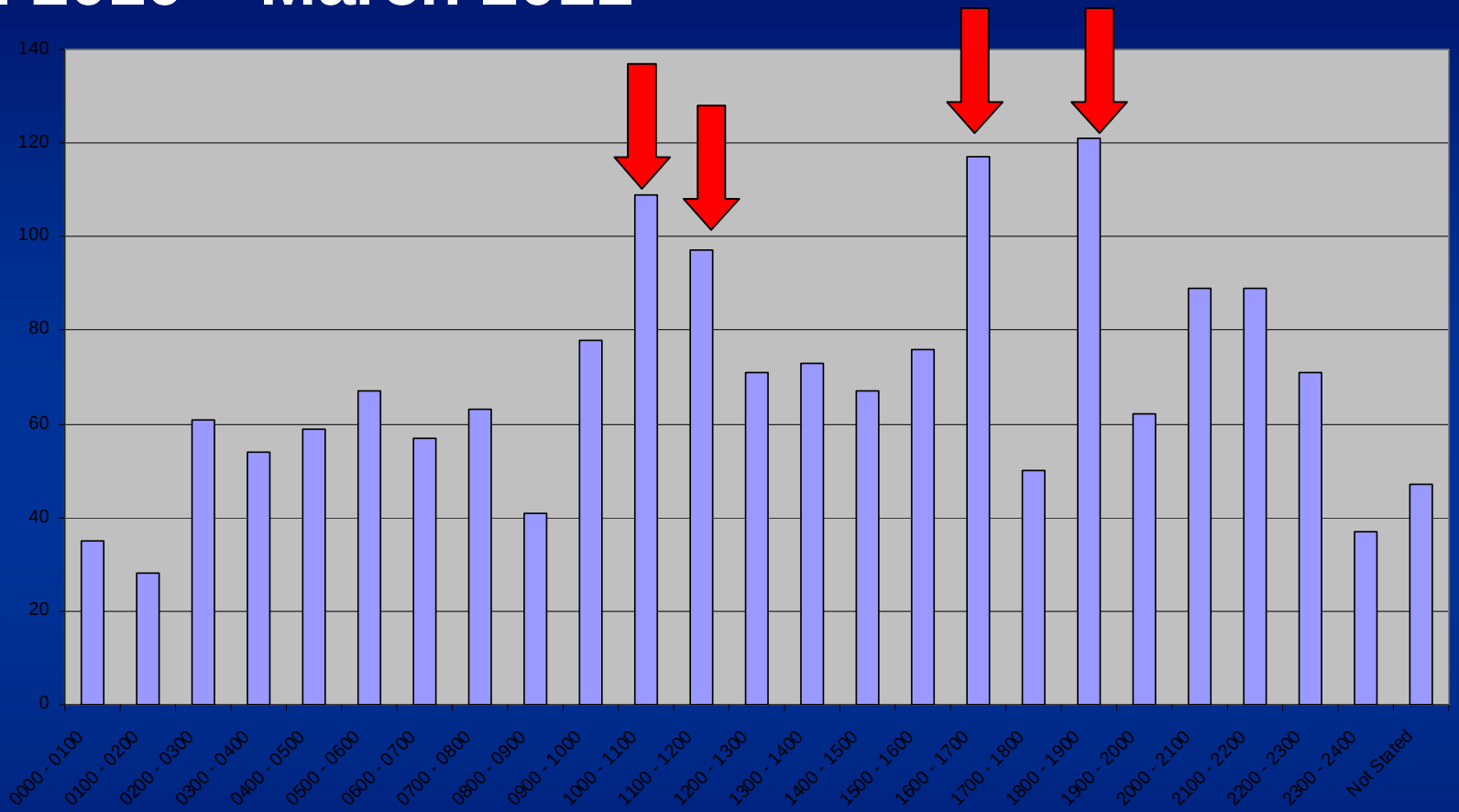


Every patient matters

Time of Day When Fall Occurred

Stockport NHS
NHS Foundation Trust

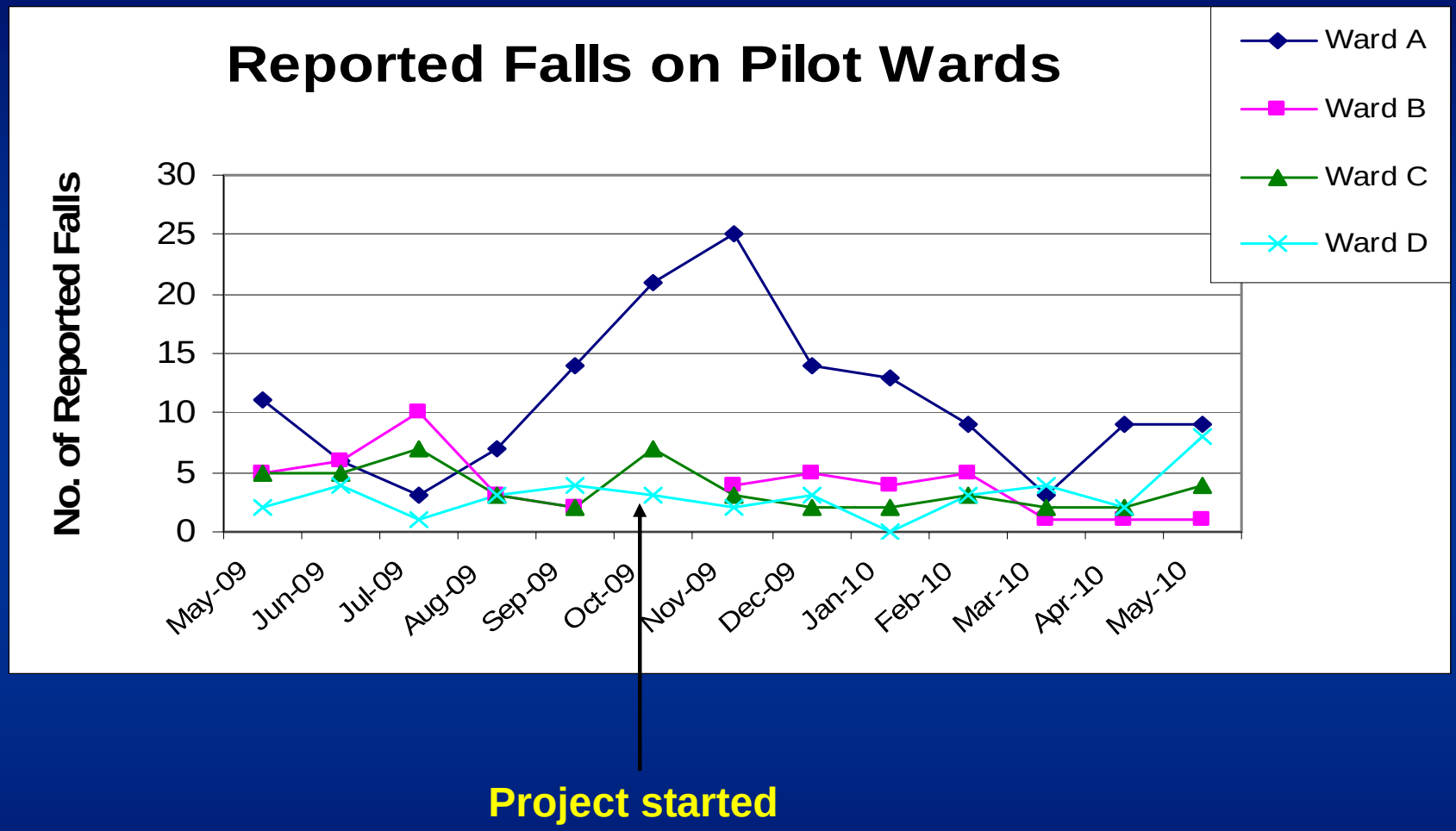
April 2010 – March 2011



Every patient matters

The Outcomes

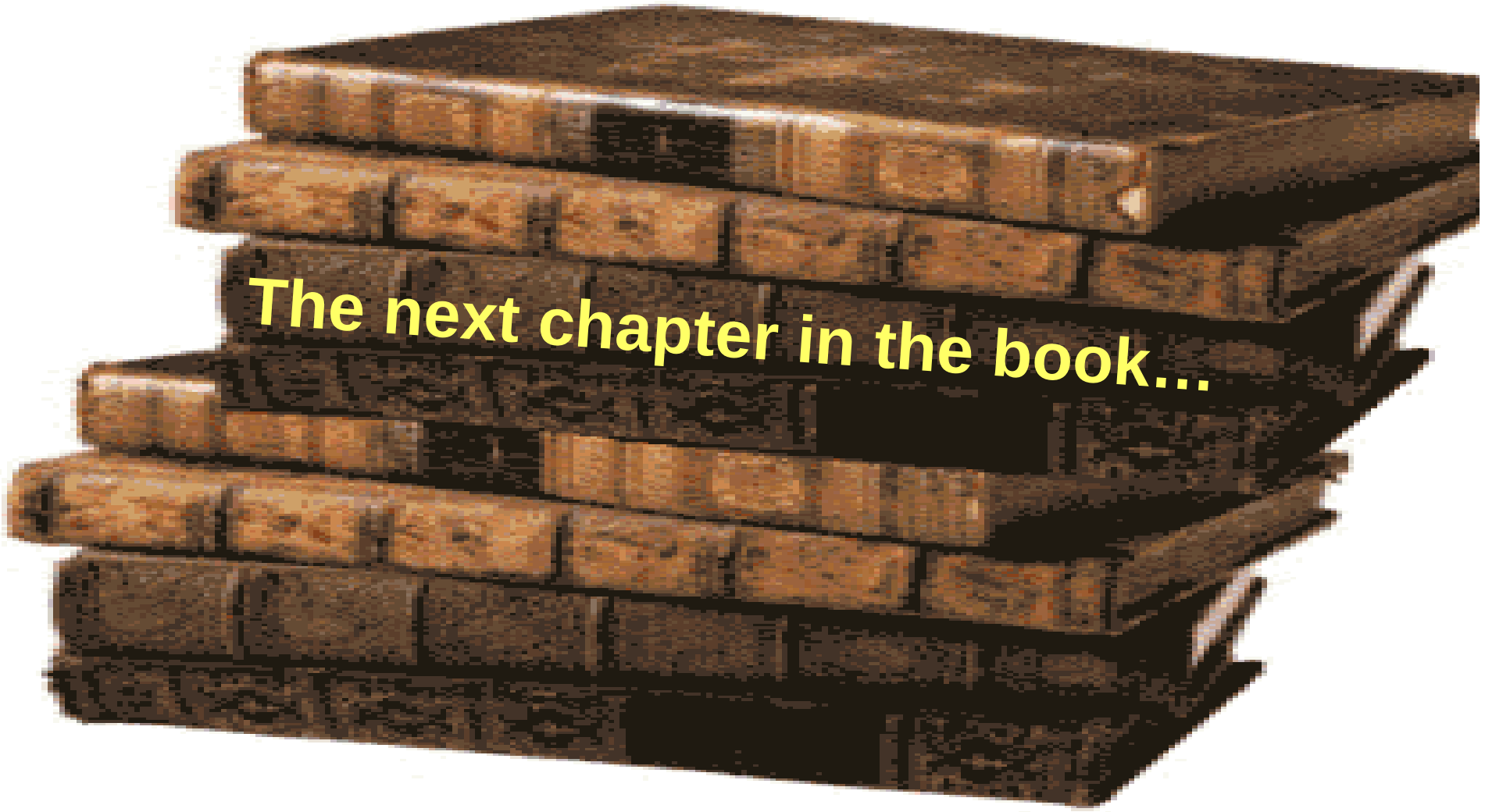
Stockport NHS
NHS Foundation Trust



Every patient matters

Further Developments

Stockport NHS
NHS Foundation Trust



Further Developments

- Falls Collaborative completion and roll-out of successful changes
- Implement appropriate actions from North West Falls Audit – eyesight, continence, lying & standing BP etc.
- Increased usage of key performance indicators

Further Developments

Stockport NHS
NHS Foundation Trust

- Continue with:
  - implementation of Patient Safety First / High Impact Actions
  - and improve Nursing Care Indicator results
  - participation in audits (external/internal)
- Review Patient Information Leaflet.
- Complete roll out of Bed/Chair Sensor Alarms to all wards

Moving Forward 2011-2012

Stockport NHS Foundation Trust

The Journey Continues !

Every patient matters

Moving Forward

Stockport NHS
NHS Foundation Trust

Complete Falls Risk Assessment and Care Plan

Has patient got good supporting shoes/slippers?

Yes

No

Refer via Tel. 0161 480 1211 or
e-mail : Information Needed:
Name, DOB, Ward, Home Address & Phone Number, Slipper Size, Payment Details

Visit will be arranged for next available working day

Visit made with slippers supplied
Follow up visit arranged for discharge – if date not known contact details left with patient/ward staff to inform project once arranged

Two week follow up (if desired). If contact has not been made a follow up call will be made to arrange home visit.

Home Visit
Accident Prevention Assessment conducted, where appropriate referrals to additional support services will be made
CASE CLOSED

SLIPPER PROJECT WITH AGE UK STOCKPORT

Every patient matters

Moving Forward

Stockport NHS
NHS Foundation Trust

- **Back to Basics Campaign (Falls)** :

STUMBLE

- **Slippers**
- **Toileting**
- **Use Assessment Tool**
- **Medication**
- **Blood Pressure**
- **ALert**
- **Environment**

Moving Forward

Stockport NHS
NHS Foundation Trust

- **Implementation of the NPSA National Alert – Essential Care after an Inpatient Fall**
- **Development of Root Cause Analysis Section – Falls in the Patient Safety Investigation Report for serious incidents.**
- **New Corporate Objective for 2011-2012 to reduce number of major to catastrophic falls by 10%**
- **Focus on reducing harm from falls – looking particularly at severe and catastrophic falls.**

Moving Forward

- **Participation in Safety Express National Project (reducing falls, pressure sores, VTE and Urinary Infections/Catheters)**

- **Falls Learning Days**
- **Plan, Do, Study, Act (PDSA) Cycles**
- **WebEx Sessions**

Moving Forward

Stockport NHS
NHS Foundation Trust

Winner!

Safety Express Project

Whole Health Economy Engagement

October 2011

Every patient matters

Moving Forward

Stockport NHS Foundation Trust

- Equipment
- Ask the Patients – History of Falling
- Medication Reviews
- Full Audit – Falls – Random Selection of Wards – six monthly
- Exercise
- Updating of Falls Standard Operating Procedure/Falls Risk Assessment Form

ANY QUESTIONS!!

Thank You