FALLING RATES OR FALLING FLAT?

Can a multi-factorial assessment and interventional programme decrease inpatient falls in an Elderly Care ward?

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BACKGROUND:
- Each year approximately 282,000 inpatient falls are reported to the National Patient Safety Agency (NPSA), making them the most common patient safety incident reported.
- A significant number of falls result in death, or moderate to severe injury.1
- Research has shown that falls can be reduced by 18 – 31% through multi-factorial assessment and intervention.2
- If a fall cannot be prevented, the patient should receive a prompt and effective response to achieve the best possible recovery and avoidance of further falls.

AIMS:
- To reduce the inpatient fall rate in an Elderly Care ward by 20%.
- To improve the quality of care provided to patients who fall.

METHOD:
- Ward 22, a nineteen-bedded unit, and one of four Elderly Care wards at the Ulster Hospital, Northern Ireland, was selected as an improvement project.
- A baseline audit was undertaken in November 2011 by reviewing incident report forms to establish the number of falls in 2010 patient bed days for Ward 22 (n = 1000). The baseline falls rate was calculated as 14.70 falls / 1000 bed days for November 2010 – October 2011 (Graph 1).
- A multi-disciplinary team with Clinical Lead was established and, using a sequence of plan – do – study – act learning cycle, a Falls Care Plan, Falls Walking Stick Poster, bedside alarms and post-fall management guidelines were introduced. Feedback sessions with ward staff were organised subsequent to each intervention.
- The initial intervention was the introduction of a multi-factorial falls assessment and care plan in December 2011: a form to be completed by nursing staff, the first part documenting risk factors and the second identifies areas of increased risk, enabling adoption of care to prevent falls (Figure 1).
- A feedback session with nursing staff was organised in January 2012 regarding the use of Falls Care Plan for all patients.
- Completion of the newly introduced Falls Care Plan was monitored monthly to improve compliance and a 3 month re-audit for November 2011 – January 2012 was conducted to assess initial impact.
- A ‘Falls Walking Stick’ poster was introduced in February 2012 as a visual incentive to aid and encourage nursing staff. Completed as a daily basis, the poster highlights if a fall occurred on a particular day and allows estimation regarding number, location, or reason for the fall (Figure 2).
- A feedback session with nursing staff was held in March 2012 to discuss use of the Falls Walking Stick poster.
- A 6 month re-audit of the inpatient falls rate was conducted in April 2012, following the introduction of both interventions.
- Bedside alarms were made available on the ward in May 2012, with selection of appropriate patients through MDT assessment.
- Trust guidelines to aid medical and nursing staff in post-fall management, focusing on head, neck and pelvic/hip injuries, were introduced in May 2012 as part of the project (Figure 3).
- A 10 month re-audit was conducted in November 2012 to assess the on-going effects of the above interventions (Graph 2).
- A 1 year re-audit is planned when data is available.

RESULTS:
- Positive feedback was obtained from staff regarding the Falls Care Plan, as this identified patients at-risk of falls and enabled adoption of care to suit individuals’ needs.
- Monthly monitoring regarding completion of the Falls Care Plan helped achieve a compliance rate of 88%. The audit also highlighted up to 83% of patients were considered high risk for falls.
- Nursing staff felt the ‘Falls Walking Stick’ was a good visual reminder of progress and provided incentive to continue.
- There was also positive feedback regarding the post-fall assessments in subjectively improving quality of care after a fall.
- A 10 month re-audit calculated the inpatient falls rate as 11.12 falls / 1000 patient bed days from November 2011 – August 2012, a reduction of 27.6% over the current study period (Graph 2).

CONCLUSIONS:
- Falls are the most common patient safety incident reported, frequently resulting in moderate to severe injury, thus reduction of falls and adequate post fall management is of critical importance.
- This study has demonstrated good compliance with a multi-factorial falls assessment and care plan using a ‘Falls Walking Stick’ poster, as well as positive feedback from staff regarding usage.
- The inpatient falls rate decreased by 17.6% over 10 months; still to attain our initial goal of a 30% reduction in the inpatient falls rate, we intend to continue implementing and monitoring the changes described, with further re-audits as required.

NEXT STEPS:
- Obtain data for a full calendar year, November 2011 – October 2012, and calculate the falls rate for a 1 year re-audit.
- Compare the 1 year re-audit falls rate for Ward 22 with inpatient falls rates for the other Elderly Care wards, where the same extended patient safety incident reduction programme has been implemented.
- Expand the interventions to the other Elderly Care wards and re-audit the inpatient falls rate.
- Hand ownership of the project to nursing staff in the long-term to maintain and improve inpatient falls rate.