The Royal Wolverhampton NHS Trust	

Trust Board Report

Meeting Date:	23 September 2013
Title:	Falls Prevention
Executive Summary:	This report provides information around the progress of the organisation in relation to the prevention of falls and in particular those that cause harm
Action Requested:	For the Trust Board to note the report
Report of:	Chief Nursing Officer
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Resource Implications:	None
Public or Private:	Public
References:	Safety Thermometer 2011 Patient Safety Improvement Group
NHS Constitution:	In determining this matter, the committee should have regard to the core principles contained in the constitution of: • Equality of treatment and access to services • High standards of excellence and professionalism • Service user preferences • Cross community working • Best value • Accountability through local influence and scrutiny

1.0 Background

More than a third of people over 65 years of age fall each year, falls represent the most frequent and serious type of accident for this group. Falling can lead to reduction in quality of life, mortality and a risk of prolonged hospitalisation as well as destroying confidence, increasing isolation and reducing long term independence. Preventing and reducing the number of falls has become a national health priority.

The management of falls within the community is led through the Therapy department's Falls Prevention Team, based at West Park it outreaches into the community.

The organisation monitors both the number of falls by ward and the number of falls that cause harm. Harm is defined as fractures (excluding fingers and toes) and cerebral haemorrhage (NPSA 2011). Monitoring is done through a) incidence data and b) prevalence data submitted through the NHS Safety Thermometer.

2.0 The number of falls

2.1 Incidence data demonstrates that the increase in rate of falls per 1000 occupied bed days remains within 10% year on year (Table 1) and also below the target for acute falls despite the lack of a dedicated falls prevention team for the acute sector. Of note is the fact that falls that cause harm are not confined to the wards where patients fall most frequently. In 2012/13 there were 23 falls that caused harm, two resulting in death (Table 2)

Table 1

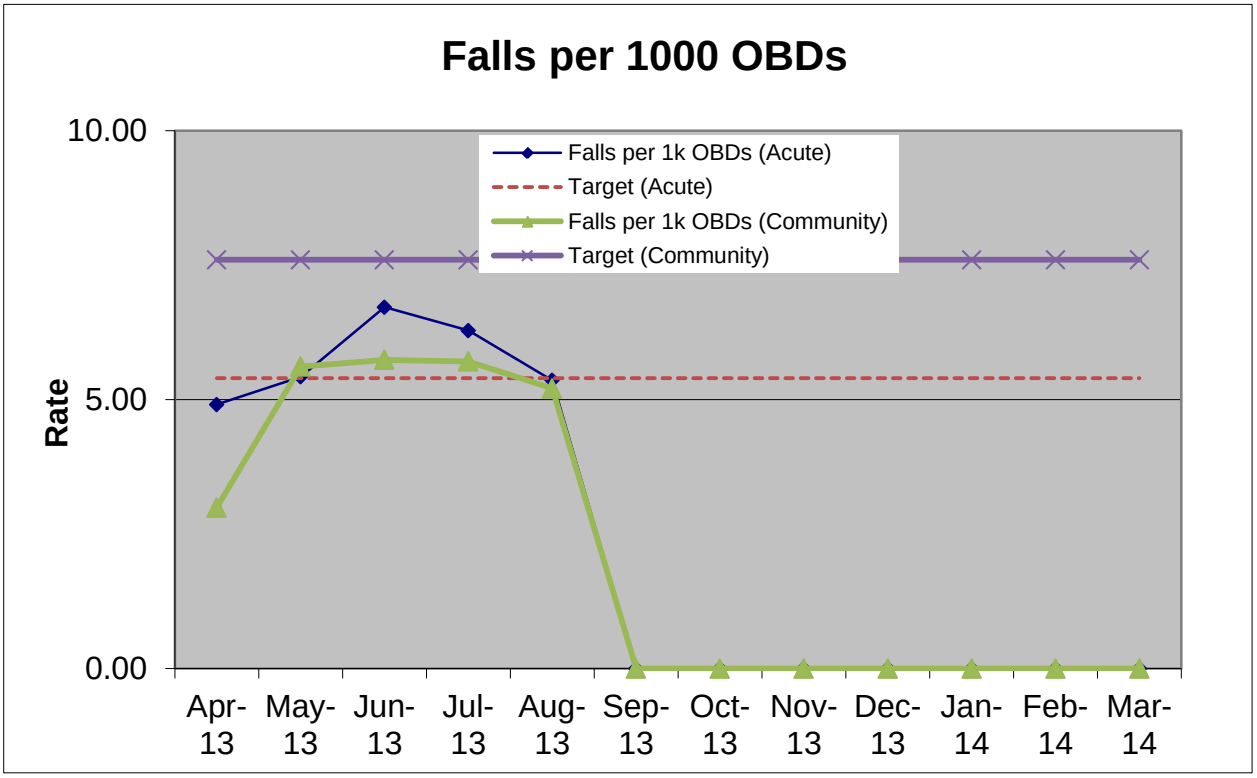

Table 2

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Serious Falls 13/14	5	9	11	15	19							
Serious Falls 12/13	0	2	6	8	9	11	11	12	16	16	20	23
Serious Falls 11/12	1	1	1	4	4	6	6	9	13	13	13	13

2.2 Discussions with the Local Area Team (LAT) have demonstrated the Trust is not out of kilter with the rest of region and a themed analysis of all falls causing harm undertaken by the Trust and the Clinical Commissioning Group supported this. However the reduction of harm and improving safety remains our priority and the organisation continues to explore different ways of managing the risks associated with falling.

3.0 Improvements to date

3.1 **Risk assessment** - Between 95 – 100% of patient continue to have a falls risk assessment completed within 6 hours of admission to the ward. This triggers the need for a falls care bundle. Changes to audit processes demonstrate medical review is taking place at point of admission when the patient is clerked. This has brought into question the need or value of having a multidisciplinary falls bundle because on audit it was found the medical staff were required to document their findings in two places which is pointless duplication.

3.2 **Care Bundle** -The falls 'care bundle' was first introduced in 2011 as part of phase one Creating Best Practice, the 'bundle' approach to care is firmly embedded within practice now and a review of the falls bundle, including input by the medical team is underway ensuring the aspects of the national FallsSafe programme (Royal College of Physicians) are endorsed. This is being led through the Creating Best Practice programme as part of improving practice. Issues that the medical staff do not complete the bundle have been discounted as incorrect because medical staff automatically clerk and analyse the risk of falls by taking a thorough cardiovascular review. This is clearly documented in the medical records but is not always apparent within the falls bundle so audit tools have been changed to reflect this.

3.3 **NICE** - A review of the NICE guidance in August 2013 has revealed the Trust is 96% compliant, the remaining 4% is due to environmental factors outside of our control. However through the Environment Group we now ensure any new refurbishments or build encompass best practice for dementia friendly and FallsSafe initiatives.

3.4 **Bay/Tag Nursing** - Supporting FallsSafe and evidenced with success from our wards where falls have reduced, is the use of 'tag' and bay nursing. This will be endorsed across the Trust as the best practice is rolled out.

3.5 **Post falls care** - Improvements to the use of post falls care has supported earlier identification of injuries as has the correct use of bed rails which whilst supporting patients from falling out of bed, can be harmful if used with a patient who is confused and tries to climb over them.

3.6 **Accountability** - Scrutiny of the root cause of falls with harm takes place at every accountability meeting held weekly. Findings from this have demonstrated the need for more 'high visibility' beds however if bay nursing is working well all patients should remain visible. This is however unachievable

at night when there are far fewer nurses on duty. The workforce review supports changes to increase night time staffing in an attempt to redress this problem.

4.0 Moving forward

4.1 The Trust has gained financial support to run a falls reduction team consisting of a falls lead therapist and a small team of therapy assistants for 12 months who will provide intensive mobility practice on wards to focus on patients standing up and sitting down – 30% of fallers are known to get up in order to use the lavatory. The lead will also run a planned programme of formal training for all nursing staff.

4.2 Continue to focus on remediation (training, education, constructive challenge and environmental review) at the weekly accountability meetings

4.3 Incorporate the FallsSafe programme into the falls bundle

4.4 Focus on reducing the rate of falls per faller (over 50% of patients who were harmed had fallen before)

4.5 Continue to embed intentional rounding, tag and bay nursing and cohort of fallers to improve supervision.

4.6 Agree and set metrics for the Trust to achieve as part of the improvement programme Creating Best Practice (reduce the rate of harm caused per 1000 bed days by 10%, reduce the ratio of repeat falls for fallers).

5.0 Monitoring

Monitoring of progress will be achieved through the Creating Best Practice work stream and will be reported back through the Patient Safety Improvement Group quarterly.