The Royal Wolverhampton NHS Trust	

Trust Board Report

Meeting Date:	28 January 2012
Title:	Falls Prevention
Executive Summary:	This report provides an update regarding the progress of the organisation in relation to prevention of falls following the last report to Board in June 2012
Action Requested:	The Board to note the report
Report of:	Chief Nursing Officer
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Resource Implications:	None.
Public or Private: **(with reasons if private)**	Public session
References: **(e.g. from/to other committees)**	Falls Prevention Committee Preventing Harm, Improving Safety
Appendices/ **References/** **Background Reading**	DoH Prevention Package for Older People (2009) Royal College of Physicians FallsSafe Project 2011
NHS Constitution: **(How it impacts on any decision-making)**	In determining this matter, the Board 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

Background Details	
1.0	Falls are recognised as the leading cause of accident related mortality in older people, half of those with a hip fracture, suffered as a result of a fall, never regain their former level of function; one in five die within 3 months (Age UK 2012).
2.0	**Falls resource at RWT:** ***2.1 Falls policy, risk assessment and care bundles***: Considerable work has been done in training staff to risk assess and use the falls bundle. This is now implemented across the Trust. Audit has demonstrated good compliance with risk assessment and bundles by nurses and poor completion by therapy and medical staff. Therapists expect anyone at risk of a fall to be automatically referred to their service and rely on this to be done verbally from the nurses. The medical staff are also expected to be alerted by the nursing staff to complete the review of culprit medicines however evidence suggests this is not done. The Trust follows a falls policy that uses comprehensive national guidelines including NICE, High Impact Actions and the RCP FallsSafe project all aimed at reducing the risk of falls and preventing harm. If a patient sustains a fall that is unwitnessed, for instance a patient is found on the floor, they may have hit their head so a series of interventions mandated by the NPSA 'Essential care after an inpatient fall' are followed, the purpose of this is to detect for cerebral bleeding or fracture. The essential care following an unwitnessed fall includes; neurological observations, medical review, diagnostic imaging if further review to confirm absence of fractures or cerebral bleeding. ***2.2 Falls prevention staff***: Following TCS the therapy department now manage the Falls Prevention service (therapy staff) who in reach into people's homes. The referrals patterns are 70% referral of patients from GPs and 30% from the RWT. The physiotherapy department run a 7 day service to ensure patients have appropriate aids and advice on falls prevention. Changes to nursing practice, where nurses base themselves in the bays, mean they are observing patients more and has demonstrated increased confidence from the patients. ***2.3 Equipment:*** There are 56 HiLo beds in the |Trust each tagged and can be located and used as necessary, more use of these are proposed. Sensors and alarms: Evidence suggests these are not as useful as was expected with frequent breakdown and confusion from both staff and patients as to their use. ***2.4 Falls Committee*** RWT has a multisciplinary falls committee, with public health (now local authority) involvement. The public health lead has written a strategy to encompass falls prevention within the home setting and whilst clearly this will support improved care outside of the hospitals and educate the public in falls prevention it does not support falls prevention in hospital. Following TCS,
3.0	**Monitoring falls** The Trust monitors numbers of falls (per 1000 bed days) through incidence reporting at the Quality and Safety Committee. Falls assessment is monitored through audit, which is completed twice a year, and monitors the completion of falls assessment and the falls care bundle which is put in place if a patient is found to be at risk of falls. When a patient suffers a fall resulting in serious harm, a root cause analysis is completed and presented at the CNO weekly accountability meeting. Falls assessment, bundle and post fall care

are reviewed along with other aspects of care.

3.1 Reduction in falls

The Trust has gradually reduced the number of falls per 1000 bed days (Table 1) since September, similarly improvements have been seen in risk assessment on admission or when the patient's condition changes. However during December this was slightly raised by 0.5% per 1000 bed days. Following review of root cause analysis on falls with serious harm there is a trend of increased falls at night and in areas with outbreaks of C. Difficile and Norovirus which contribute to nurses spending more time behind curtains. A business case has been submitted to the CCG to increase night time staffing in order to help improve safety and care at night and will be addressed urgently pending review by the CCG.

In November and increasingly in December we have seen numbers of falls unusually increase in Beynon Short Stay and Gynaecology where we are having increasing numbers of patients outlied pre discharge for bed capacity reasons.

4.0 Hospital Falls data

The number of falls per 1000 bed days is illustrated in Table 1

Table 1

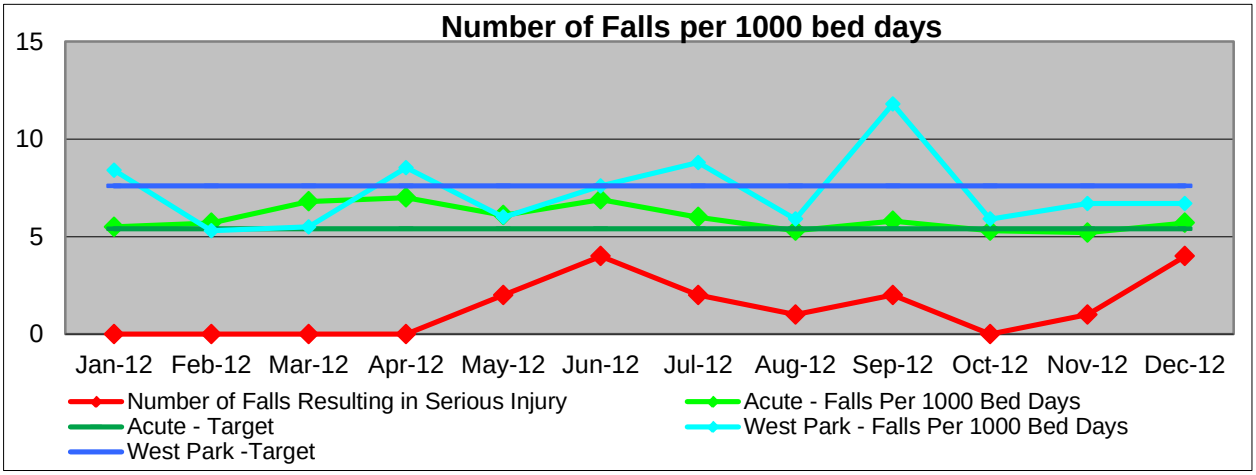


Table 2 demonstrates the reduction rates of falls over time compared to set targets but an increase in numbers of serious falls in December.

Table 2 **Falls reduction ratios: NXH and WPH**

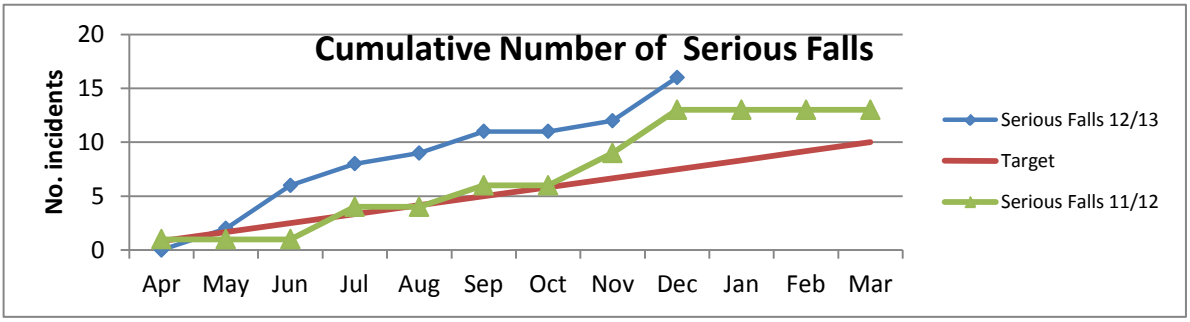
	July 12	Aug 12	Sep-12	Oct-12	Nov-12	Dec-12
Acute - Target per occupied bed days	<5.4	<5.4	<5.4	<5.4	<5.4	<5.4
Acute - Number of falls per occupied bed	6	5.3	5.8	5.3	5.2	5.7
West Park- Target per occupied bed days	7.6	7.6	7.6	7.6	7.6	7.6
West Park - Number of falls per occupied bed	8.8	5.9	11.8	5.9	6.7	6.7
Number of falls resulting in serious injury	2	1	2	0	1	4

5.0

Falls that cause serious harm (cerebral bleed of fracture)

In December we saw an increase in numbers of serious falls, two of which occurred as a direct result of patients left unattended during the night shift when staff were attending to other patients with *C.Diff*. Table 3 demonstrates the cumulative number of falls causing serious harm (bleed or fracture)

Table 3



6.0

Summary

The Trust is working hard to continue the trend of a reduction in falls and those resulting in serious injury which are scrutinised by the accountability meeting. There are high levels of falls risk assessment and use of the bundle by nurses however changes need to be considered to involve therapist and medical review.

7.0

Next steps

In order to move forward the Falls Committee now need to consider the following:

Determine the most effective preventative measures to reduce the risk of falls in hospital and ensure they are used across the Trust for those most at risk of falling

Devise an integrated pathway across the health economy for those who fall or are at risk of falls in hospital through to the balance and safety exercise groups planned by the public health/local authority

Review the scope and service of the community based falls prevention service: Question if this resource should be used differently in the short term (12 – 18 months)

Provide a 'traffic light' card to alert medical staff to the prescribing issues with culprit drugs.

Ensure all wards move to bay nursing as a consistent method of reducing harm to patients and increasing public confidence with high visibility

References

Age UK (2012) Later Life in the United Kingdom www.ageuk.org.uk/Documents/EN - GB/Factsheets/Later_Life_uk_factsheet.pdf?trk=true