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The high impact actions for nursing and midwifery 3: staying safe, preventing falls

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Even if there is no injury, falls can lead to a loss of confidence and independence. Reducing the number of falls sustained by older people in NHS care is a priority

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Abstract

Ward L et al (2010) The high impact actions for nursing and midwifery 3: staying safe, preventing falls. *Nursing Times*; 106; 29, early online publication.

The National Patient Safety Agency reported 152,000 falls in England and Wales in acute hospitals in 2009, 26,000 in mental health trusts and 28,000 in community hospitals. The number of falls is forecast to rise in line with increasing numbers of older and frail people with more complex health needs. Many of these falls are preventable and the challenge for the NHS is to improve patient safety at the same time as protecting independence and their right to make informed choices.

Keywords High impact actions, Falls, Risk assessment

Introduction

The average rate of falls in 2008 was 5.4 incidents per 1,000 bed days (NPSA, 2009). This equates to 30 falls per week in an 800 bed acute trust. Associated healthcare costs are estimated at a minimum of £92,000 per year for an average acute trust. That makes the annual healthcare cost for treating falls in England and Wales more than £15 million.

More important than the financial costs are the physical and psychological costs to the patient. Falls can result in a loss of confidence or independence, which, in turn, may lead to a need for increased or extended support from the NHS. This article, the third in our series on high impact actions for nursing and midwifery, looks at some of the approaches that organisations are taking to reduce the number of patient falls and help elderly and frail people to remain safe.

What can nurses do?

Falls prevention is a complex area and no single approach will work in all cases. Keeping patients safe and preventing falls must take into account individual needs and the different environmental factors associated with different settings - for example, home, care home or hospital.

There are many proven techniques to reduce the incidence of falls, including exercise programmes, identification bracelets, alarm systems and risk assessments. Nurses have a vital role in helping to co-ordinate appropriate interventions in response to individual patient risk and in looking at the contextual factors (things specific to the organisation and groups of patients) that may affect the risk of patients falling.

Examining the reasons for falls may produce secondary benefits. Nutrition and hydration may improve, as may continence, privacy and dignity. If patients are more mobile, they are less likely to develop pressure ulcers. Reducing falls by 18% through multifaceted interventions means an average 800 bed acute hospital trust could, potentially, save £16,500 a year - this does not include savings associated with a reduced need for care after discharge from hospital, or reduced litigation costs.

A sobering statistic for anyone who considers falls to be a minor problem is the average litigation cost faced by hospitals. Based on data gathered between 1995 and 2005 (Oliver et al, 2008), the average payment was £12,945. Just under two thirds of claims made by patients (60.5%) resulted in payment.

The Essential Collection (see box above/below etc) includes four case studies from different settings, each of which has succeeded in addressing the issue of falls.

Case study 1: Alarms to protect at-risk patients

In April 2009, East Kent Hospitals University Foundation Trust introduced sensor alarms on three wards with high incidence of patients falling. The weighted alarms would alert nurses when patients got out of bed unaided, and were used for patients identified as being at high risk of falls, following a risk assessment when they were admitted to hospital.

The project team used two different approaches to measure the alarm's effectiveness. On two wards, they used the sensors, backed up by preventive care mechanisms, screening tools and falls reporting. On the third ward, Bethersden Ward, the care package was enhanced by other interventions, including a low level bed, a supply of hip protectors, intensive training and a dedicated falls "champion".

The sensors were also introduced on a neurology ward for patients with conditions like Parkinson's disease and multiple sclerosis. At all times, staff were careful to balance peace of mind against respect for patient dignity and privacy. A new online reporting system for falls will provide real-time data and faster response times. It will be used to identify risk areas so that appropriate interventions can be deployed.

Impact of the initiative

On Bethersden Ward, the enhanced care package has helped to reduce the rate of falls by more than 60% within six months. This reduction has been sustained, indicating that falls prevention strategies have become embedded into routine care. Use of the alarm system as a single intervention on the two other wards did not reduce the incidence of falls. This suggests that preventing falls requires multiple, linked interventions.

An additional benefit was that the sensors reduced the need for "specials" - nurses who can sit with the most vulnerable patients. As well as being an added cost, these nurses can be difficult to recruit and patients may regard them as an invasion of their privacy. As a result of this project, the trust reduced its costs by £16,037 compared with the period before the work started.

Case study 2: A specialist falls matron targets high intensity users

Blackpool Primary Care Trust cares for a high proportion of older people, and spent around £50,000 a month in ambulance call-outs to people who had fallen. Half of these people did not need clinical treatment, simply reassurance and assistance in getting up. The PCT set out to reduce the number of falls among very high intensity users. The idea was to pre-empt and prevent falls by providing support via a community falls matron.

The team began by identifying the very high intensity users as people with one or more long-term conditions who had fallen twice or more over the last 12 months. This amounted to 350 people with a range of conditions including COPD and heart failure. The community falls team, headed by a falls matron, carried out holistic risk assessments with individual patients and then developed a patient-centred service to reduce the risk of falls. It is part of a wider team that includes occupational therapists, physiotherapists, chiropodists and others, as well as a local social enterprise that provides telehealth and telecare. The community falls matron delivers training for anyone working with vulnerable older people, including the acute trust, social services and the local council.

Impact of the initiative

The community falls matron carries out around 10 falls visits a week. Patients feel reassured and better cared for and the number of hospital admissions has gone down. Figures show that approximately six hospital admissions are prevented every month, equating to a cost saving of around £18,000 per month. The latest matron analysis statistics show that 83 admissions have been deflected to date and £243,000 saved. Once assessed, 50-75% of patients do not experience another fall within three months of the initial visit. Three years on from the project launch, patient satisfaction surveys are glowing. Calculations relating to return on investment show that for every £1 spent, the community falls matron programme generates £2.69 of benefits.

Case study 3: Distraction therapy for patients with dementia

In acute settings, patients with dementia often become more confused, feel displaced, have high anxiety levels and wander around the ward. The Tiptree Box consists of familiar, everyday items and a café-style table where patients can sit safely and not be confined to their bedside. It was introduced onto the acute wards of the Colchester Hospital University Foundation Trust to help to prevent falls in people with dementia.

A team at the hospital, led by Tiptree Ward sister, began studying research into distraction therapy for patients displaying classic "sundowning" behaviour, where they become more agitated and confused in the early evening. They came up with the idea of giving these patients a box of tactile, familiar objects at this time of day to provide a sense of safety and make them more likely to remain sitting in a chair, where they would be safe and comfortable. The team compiled boxes for nine separate areas, including accident and emergency, the emergency assessment unit, trauma and orthopaedics.

Impact of the initiative

The Tiptree Box won first prize in the Health Enterprise East Bright Ideas Competition 2007. The stress levels of staff and patients have come down and the toolkit has reduced the number of patients who are described as "difficult to care for". Staff feel they have more time to care and do not feel like security guards following patients who are wandering. Patients are more co-operative in taking their medication and the café areas have become more communal, so individuals feel less isolated.

The idea came from nurses and was simple and cost-effective to implement. Consequently, it has been enthusiastically received. The box provides a positive way for staff to manage a potentially challenging group of patients.

Case study 4: A checklist observation tool

Ipswich Hospital Trust recorded 2,051 patient falls in 2008-09, costing more than £131,000. The trust set a target to reduce falls by 25%. Using its experience of Leading Improvement in Patient Safety and The Productive Ward programme, the project team developed a checklist-based observation tool to prevent falls in high risk patients. There are seven simple steps:

1. Hydration - making sure patients have something to drink;

2. Checking toilet needs;

3. Patients having the right footwear;

4. De-cluttering the area;

5. Making sure patients can reach what they needs, such as the call bell;

6. Making sure bedrails are correctly fitted;

7. Patient having an appropriate walking aid, if applicable.

Nurses use the checklist regularly throughout the day.

Impact of the initiative

Initially, there was some resistance to the idea of "yet another piece of paper", but attitudes towards the tool changed when the fall rate dropped dramatically. The pilot project demonstrated a reduction of nearly two thirds within the first three months of implementation on a complex elderly care ward.

The tool has significantly reduced the number of falls, improved patient safety and released staff time. Fewer slips, trips and falls have resulted in less need for reactive management by staff. Staff morale has increased and patients say they feel more confident and are using their nurse call buzzers less. For every £1 spent on the seven simple steps programme, £6.24 of benefits have been generated. This does not take into account the additional quality benefits that have not been monetised.

The Essential Collection

The Essential Collection, plus literature reviews for each HIA, are available for download on the NHS Institute website, which also contains an opportunity estimator to enable you to calculate potential savings, and a range of tools and resources. Go to: *www.institute.nhs.uk/hiawww.institute.nhs.uk/hia*

What are the best sources of information?

- *Slips Trips and Falls in Hospital Guidelines*
- *The assessment and prevention of falls in older people*
- *Prevention of Falls Network Europe*
- *Patient Safety First - The How to Guide for Reducing Harm from Falls*
- Oliver D et al (2007) *Strategies to prevent falls and fractures in hospitals and care homes and effect of cognitive impairment: systematic review and meta-analyses*. *British Medical Journal*; 324: 82.
- Age UK (formerly Help the Aged and Age Concern): *Ways to make tasks easier around the home*
- Becker C et al (2003) Effectiveness of a multifaceted intervention on falls in nursing home residents.**J***ournal of the American Geriatrics Society*; 51: 3, 306-313.

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