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The Rotherham NHS Foundation Trust

The Falls Collaborative

'Reducing the incidence and severity of in-patient falls in reality'

Manchester :October 2010

Patricia Bain, Deputy Chief of Quality & Standards

Why this matters to us….

- **Falls are common nationally and locally**
  - 30% of all patient safety incidents (200,000 per annum in England and Wales despite gross underreporting and recording e.g. *Sari BMJ 2007)*

  Rotherham
  - *1200 fall incidents per year*

- **Harmful to our patients**
  - 20-30% lead to minor injury
  - 2-5% to moderate or serious injury
  - Cluster of serious incidents related to falls in 2008
  - No change in incidence, single intervention approaches

Why this matters to us?

- **Costly for our Trust**

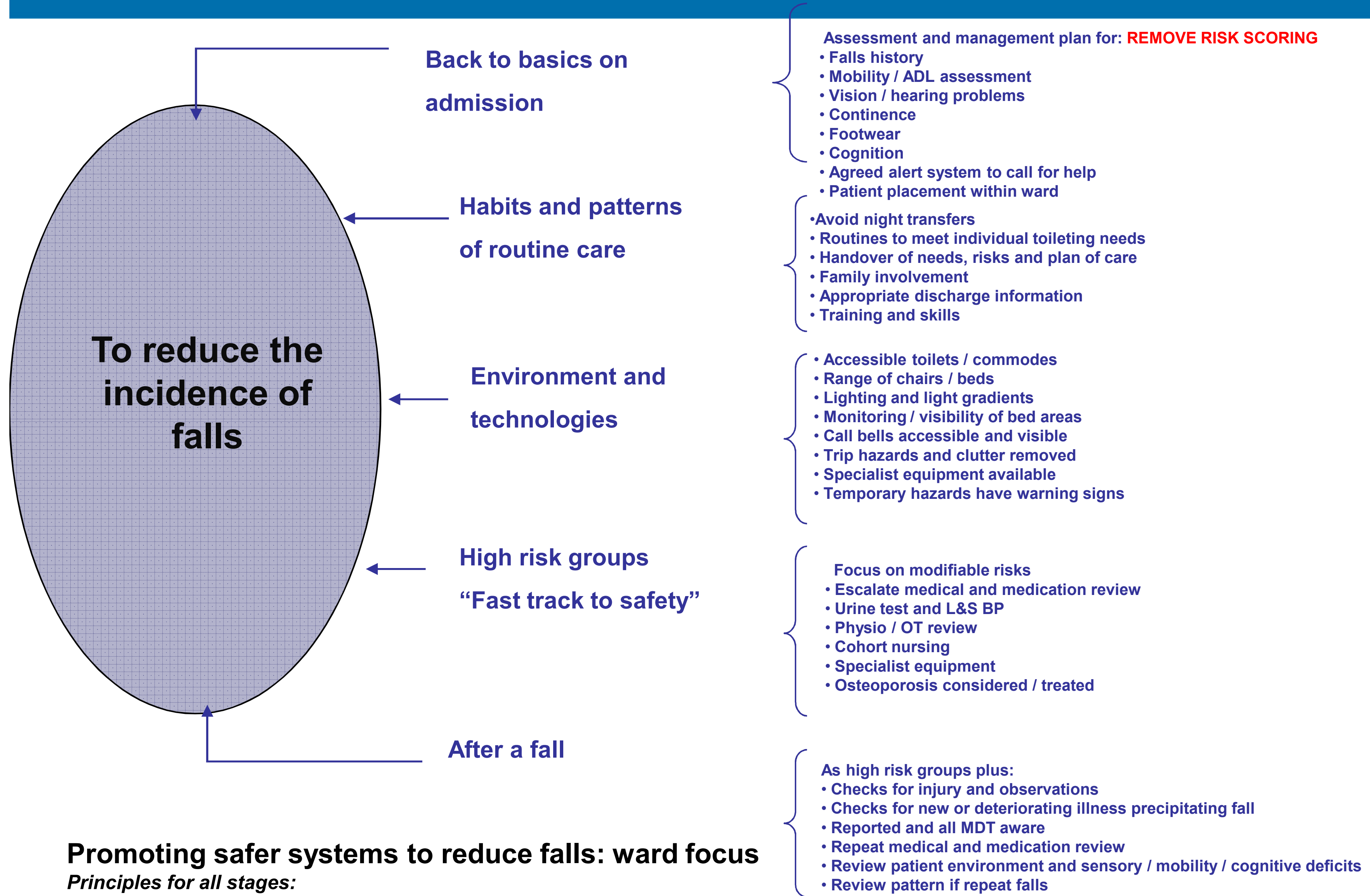
  - Length of stay, impaired rehab, discharge to long term care, opportunity costs. e.g. Inpatients sustaining Hip Fracture Mean LOS 46 days and very poor functional outcome (*Murray JAGS 2007*)

  - Cost to our Trust annually between £400-600,000
  – May be subject to **external inspection/performance targets**

- **Worrying for staff and relatives**
  – Complaints, coroners inquests, litigation, guilt, anxiety, "*someone must be to blame*" "*place of safety*" "*something must be done*"
  – Perceptions

The Nature of the Project

- Whole systems approach, multiple interventions
- Evidence Based and Innovation
- Measured, benefits realisation
- Resourced : £5000 per ward, free slippers
- Multi disciplinary
- Collaborative: staff, patients, SHA, PCT, University, other Trusts
- Realistic Evaluation



Promoting safer systems to reduce falls: ward focus

Principles for all stages:

- ***Leadership at all levels***
- ***Measurement and reporting***

Realistic Evaluation

- Looks at ***why*** an intervention works, to complement the ***whether*** it has worked.
- Undertaken by talking to staff and asking them why they think patients fall, and a literature review.
- Created 5 additional areas for in-depth review

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Context, Mechanism, Outcomes

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	CMO	Data collection
1	Engaging relatives in the falls prevention programme	•Interviews with staff •Interviews with relatives
2	The appropriate use of bedrails	•Review of assessment and bedrail documentation •Interview staff •Observation of practice
3	Aggression, dementia, and gender	•Available data on patients with dementia •Interviews with staff •Documentary analysis to determine falls prevention action
4	Effectiveness of medication review	•Survey, interview with all professions •Available data relating to patient medication
5	Responding to call bells	•Interviews/surveys of patients •Survey/interview ward staff about capacity to

What and who the project involved : The Methodology

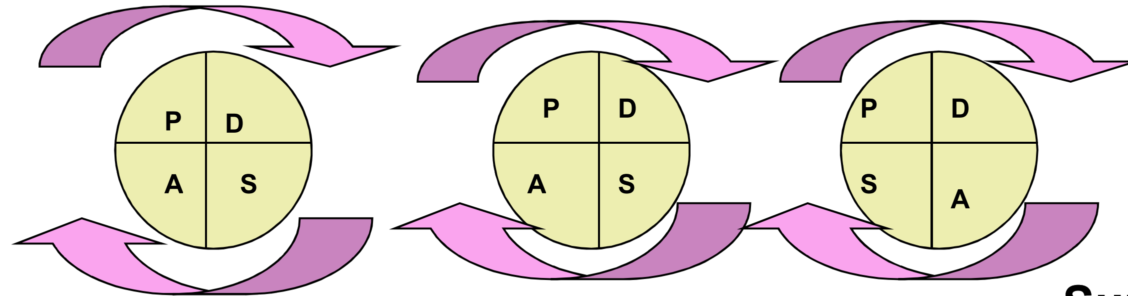
Select the topic

Set goals and Measures

Recruit team

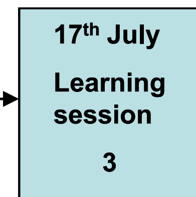
Dec08/Jan 09

Action Periods



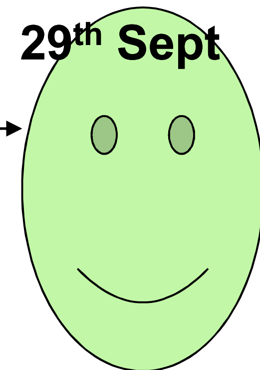
Launch

Feb 09



Summit

29th Sept



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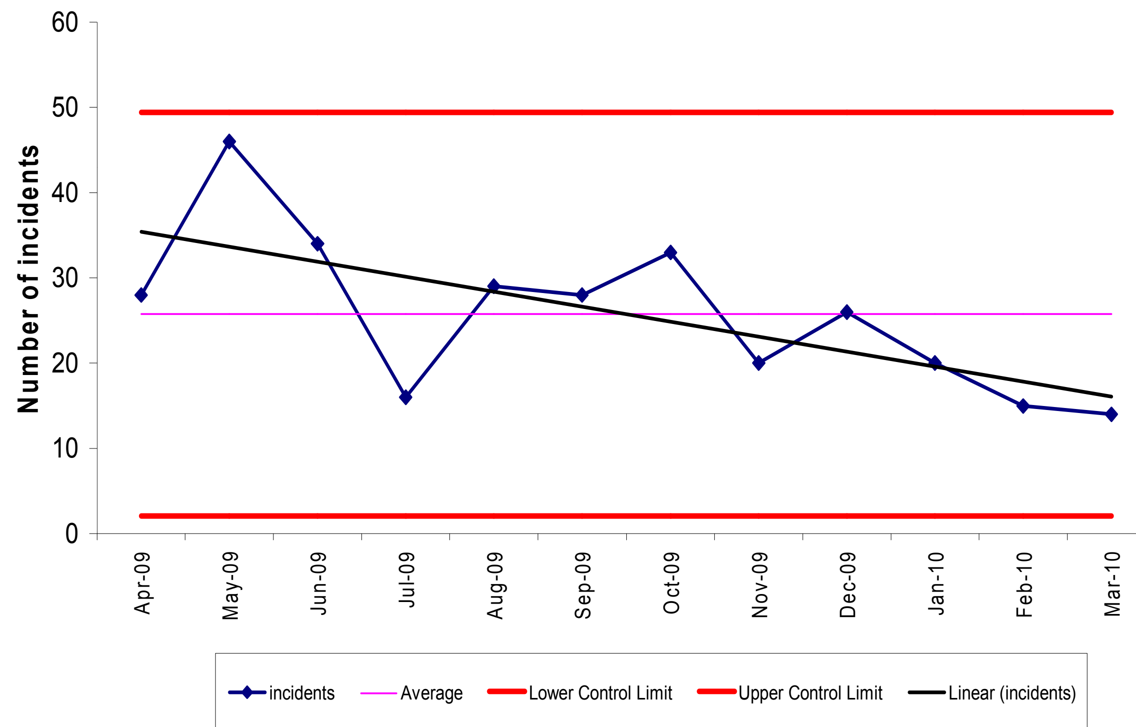
In-patient Falls Collaborative

Priority 2: Achievements of Staff : HSJ Nominated Award



Outcomes of the project

- Reduction falls Trust wide average 40% from height, 10% same level = 230 less falls per year
- Cost savings £383,000 per year
- 75% increase in timeliness of neuro-observations
- Call bell maintenance reduced
- Bed rails use improved and bed procurement risk focused
- Slippers provided for all who needed them

Survey data

- Patient and Staff Survey significant improvement
- Awareness increased, perceptions changed

Realistic evaluation Dementia : ranked scores	Score
Staff training on supporting people with dementia	287
Consider specialist unit	187
A range of different communication aids ….. to help communicate the need to give personal care and support	176
Access to mental health services for guidance on tailoring more patient specific support	167
Dementia practice guidelines	143
A pen portrait by the bedside……	137
More use of low beds	134
The employment of a mental health nurse on the wards	127
A patient diary	97

What we learned

- Perceptions can be changed
- Its challenging for everyone
- Maintaining momentum and MDT input is difficult
- Collaboration, whole systems approach works on many levels
- We cannot compromise the autonomy, independence, rehabilitation, dignity of older patients : A unit with no falls is doing no rehab”
- Not to pretend that the numbers and skills of nurses on wards for disabled, patients suffering dementia symptoms, aggressive and frail patients has nothing to do with patient safety, dignity or quality

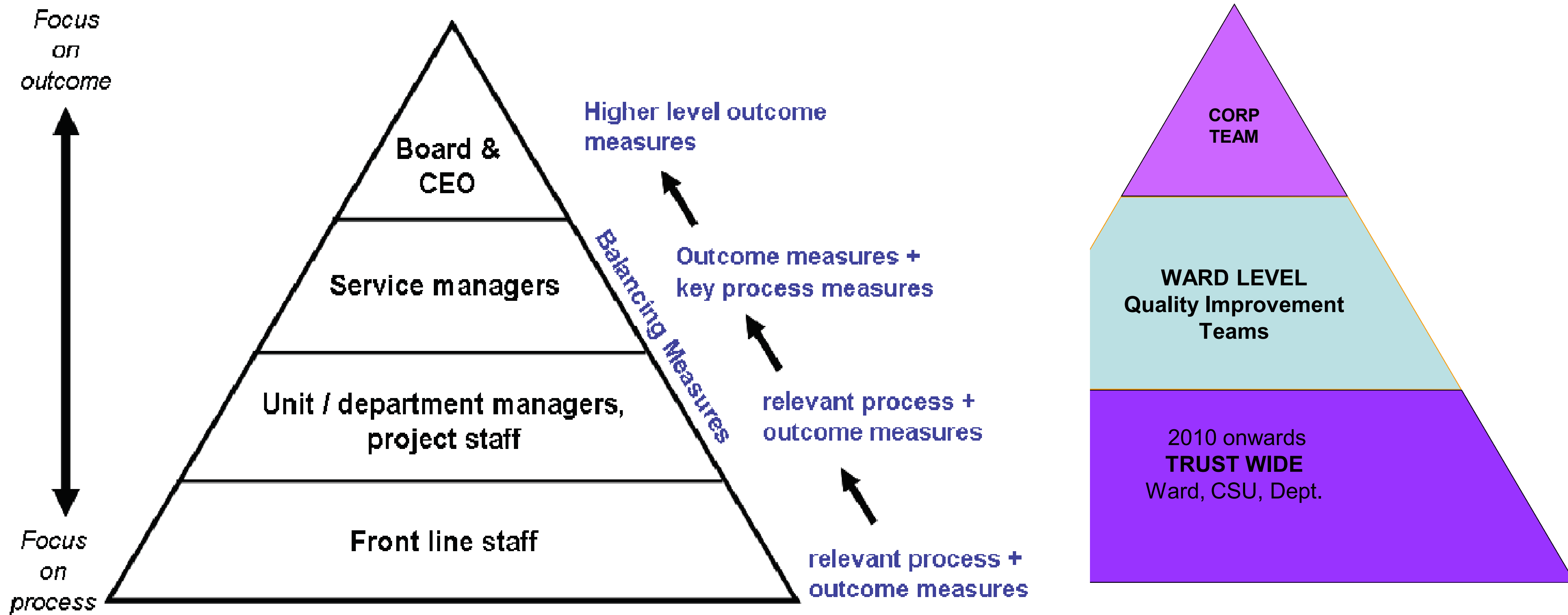
Ongoing implementation: Trust wide

- Purchasing for safety: Low/high beds, call bells, slippers
- Bed rails and environmental assessments
- Re-design of Assessment Forms
- Engagement in Medication Review
- Neuro-observation training
- Eye sight testing service
- Alternative level of care for patients suffering symptoms of dementia
- Training Quality Improvement Teams
- Health community approach
- Dissemination, regional, national

Sustainable improvement, owned by all

Reporting and Monitoring Structures

Quality Improvement Teams



- Quality Improvement Teams trained and on all wards
- Annual programme of work agreed
- Ward to Board reporting and monitoring framework

Any Questions