Royal College of Physicians

Why FallSafe?

Care bundles to reduce inpatient falls

In partnership with:

Royal College of Nursing

British Geriatrics Society

avma action against medical accidents

NHS South of England

NHS National Patient Safety Agency

The Health Foundation Inspiring Improvement

FallSafe was a quality improvement project that helped frontline staff to deliver evidence-based falls prevention. This approach can increase patient safety and satisfaction and build staff confidence.

A case study

The following case study demonstrates why it was necessary to set up the FallSafe project, and illustrates the kind of problems that the new quality improvement approach aims to resolve. Most hospital staff will remember a patient similar to the one outlined in the following account.

A lady in her 80s was admitted with a cough productive of sputum, and increasing shortness of breath. She had clinical and radiological signs of pneumonia. She was dehydrated and had low blood pressure. She was treated with intravenous fluids and antibiotics. The day after admission, she woke and wanted to go to the toilet. She tried to get up by herself, but slipped and fell. She was found to have a broken hip, but an operation had to be delayed because of her pneumonia. She had an operation five days later, and initially did well, but then had a further episode of pneumonia with delirium. After this, she became immobile. Four weeks later, following a further episode of pneumonia, she died.

At her inquest, it was discovered that she had had three falls in the month prior to admission. The coroner asked why no-one had found this out. Her daughter said she had been increasingly confused in the two days before admission. An assessment by her GP three months earlier had shown signs of dementia. She usually walked with a frame, but this had not been brought in with her, and no-one had thought to obtain one for her. She had got out of bed in her bare feet, and slipped on a polished floor. She had been taking multiple antihypertensive medications, which had been continued in hospital despite her dehydration and low blood pressure.

The coroner asked, had her nurses been aware of her history of falling and her confusion, would they have carried out a bed rail assessment, and nursed her differently.

What does the FallSafe approach involve?

The FallSafe project, funded by the Health Foundation, aimed to 'close the gap' between the evidence base for effective care and the care that patients actually receive.

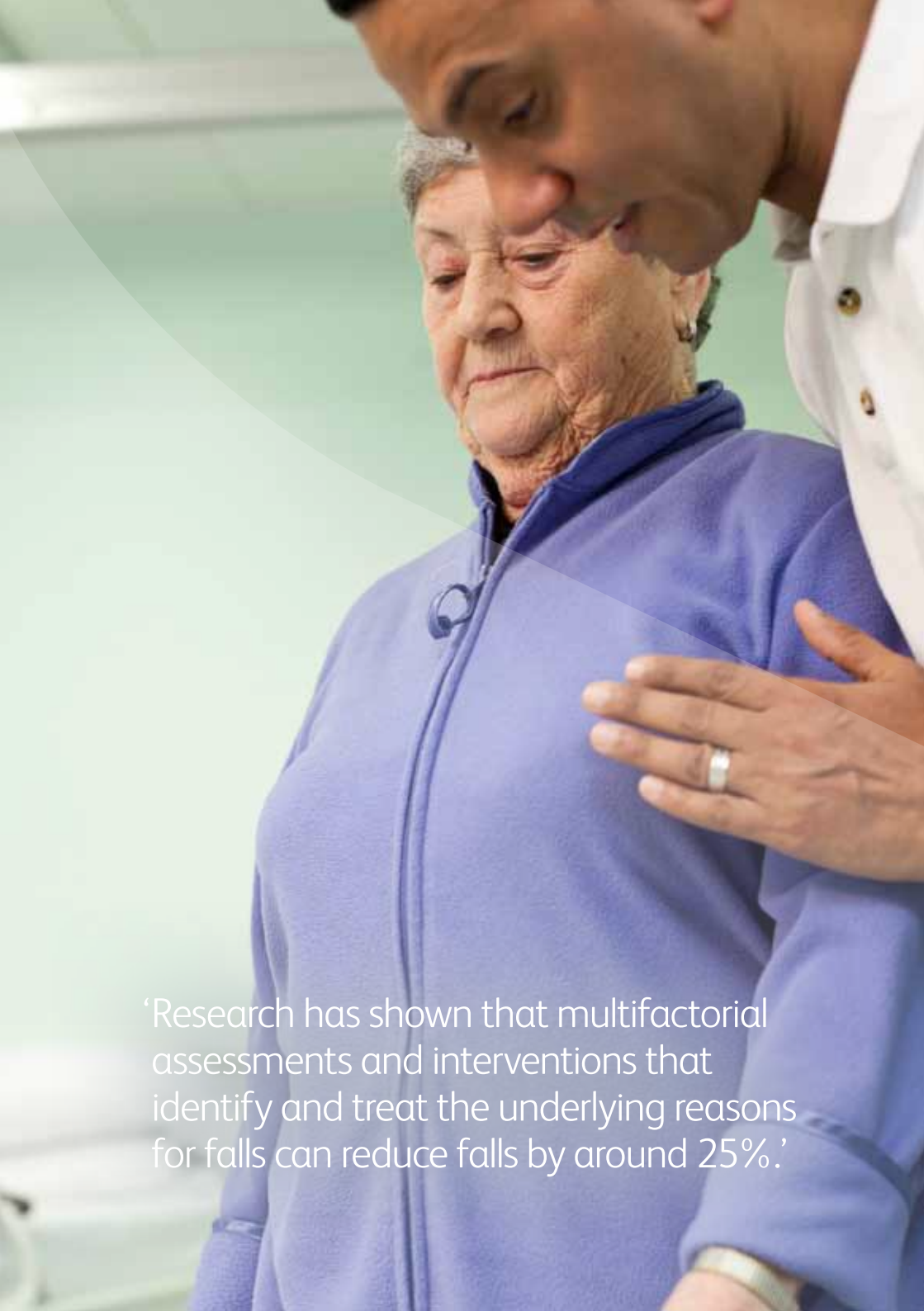
Research has shown that multifactorial assessments and interventions that identify and treat the underlying reasons for falls can reduce falls by around 25%. Reasons include muscle weakness, cardiovascular problems, dementia, delirium, toileting and medication. But national audits have shown that worryingly few patients who would benefit from these assessments and interventions are actually receiving them.

The FallSafe project involved educating, inspiring and supporting registered nurses (the FallSafe leads), from a range of acute, rehabilitation and mental health wards, to lead their local multidisciplinary teams in delivering these assessments and interventions through a care bundle approach. Our care bundles comprised nine components, with a new component introduced every six to eight weeks over the course of nine months.

The approach of FallSafe was unique in several ways:

- Each FallSafe lead was given enough **education** and support to make them a confident and knowledgeable specialist within their ward team.
- The basic **equipment** they needed was available.
- The care bundle was implemented in **stages** rather than all at once, so improvements became manageable rather than overwhelming.
- How well the bundle was being delivered was **measured** at least every month. The results were used to learn and improve, not to criticise or blame.
- FallSafe leads were encouraged to be **adaptable** and to deliver improvements in ways that suited their patients and their teams.
- A **community** was created where leads could exchange ideas within and across hospitals and other specialities.

You can read more detail in the *Implementing FallSafe* guide in this pack which is also available to download from: **www.rcplondon.ac.uk/projects/fallsafe**



‘Research has shown that multifactorial assessments and interventions that identify and treat the underlying reasons for falls can reduce falls by around 25%.’

But we do all that anyway!

Many hospitals have link nurses, but they often have limited education on falls prevention, and are typically charged with communicating with the nursing team rather than leading improvement across professional boundaries.

Many of the care bundle components we used in FallSafe are already in hospitals' policies and protocols, but they are not being delivered to patients nearly as often as they should be.

The participating wards in the FallSafe project saw significant increases in how well they delivered the essentials of falls prevention. Here are a few examples:

> The number of patients without a call bell in reach **was reduced by 78%**.
> **Twice as many** requests for medication reviews were made.
> The number of patients who did not have safe footwear **was reduced by 67%**.
> **Twice as many** patients had their lying and standing blood pressure checked manually.
> There was a **56% increase** in patients being assessed for signs of confusion.
> More than **twice as many** patients were asked if they were worried that they might fall.
> There was a **41% decrease** in the number of patients given night sedation.

Unless your hospital is reliably delivering the essentials of falls prevention to all the patients who need them, you could benefit from the FallSafe approach.

Did falls reduce?

Falls rates vary dramatically between different types of ward, from month to month, and between winter and summer. It is easy to mistake this variability for dramatic improvements in falls prevention. For example, falls rates are often 30% lower in summer than in winter, and falls rates on individual wards or small departments will often vary by as much as 80% between one month and the next. Additionally, not all falls are reported, and increasing knowledge and awareness of falls prevention can lead to improved reporting, which can hide any change in the underlying falls rate.

In the FallSafe project we tried to overcome these common mistakes by using a formal assessment of under-reporting, and comparing falls rates for the same seasons. After six months of the care bundle being fully in place, we estimated that falls may have been reduced by around 25%, which is the same success rate as that obtained by the research studies on which the FallSafe care bundle was based. We are currently collecting data from an additional six months and writing up our findings for publication in a peer-reviewed journal.

But we don't have any resources ...

Everything we used for the FallSafe project is available to you in this pack or to download from **www.rcplondon.ac.uk/projects/fallsafe**. This includes a guide containing tried and tested formats for collecting monthly measurements and an e-learning course on falls risks and their prevention, that could make delivering effective education much easier. Staff we have shared these with see them as very practical and easily transferable.

But falls are not a simple problem with a simple fix. The patients most vulnerable to falling have a complex mix of risk factors and need skilled and knowledgeable care. So we can't promise that falls prevention can be delivered for free. Someone said to us:

I'd like to do FallSafe in my hospital, but we won't be able to release staff for any training and they don't have the time to collect any measurements – will it still work?

The answer is almost certainly no. But if you carry on doing what you've always done, you'll carry on getting the results you always have. In almost every hospital, falls are the most common patient safety incident, with over 1,000 falls a year in a typical 600-bed hospital.

With the costs of those falls estimated at around £500,000 for an average acute hospital and targets for the Commissioning for Quality and Innovation (CQUIN) payment framework often related to reductions in falls rates, there are plenty of financial incentives to invest in falls prevention. Over and above these incentives, the FallSafe leads received positive feedback from patients, which is summed up in the graphic below.

Don't just 'do something' to prevent falls...

...do something that works!

FallSafe was a quality improvement project, that helped frontline staff to reliably deliver evidence-based falls prevention. This approach can increase patient safety and satisfaction and build staff confidence.

We wish you success in all your falls prevention endeavours.

Dr Adam Darowski
Associate director
Clinical Effectiveness and Evaluation Unit, RCP

Dr Frances Healey
Clinical associate
Clinical Effectiveness and Evaluation Unit, RCP

Janet Husk
Programme manager
Clinical Effectiveness and Evaluation Unit, RCP

Royal College of Physicians, 11 St Andrews Place, Regent's Park, London NW1 4LE.

Clinical Effectiveness and Evaluation Unit
Tel: +44 (0)20 3075 1347
Email: fbhop@rcplondon.ac.uk

www.rcplondon.ac.uk/projects/fallsafe

Royal College of Physicians