East London NHS
NHS Foundation Trust

Falls project
MHCOP
Leadenhall and Columbia wards

Project Background

- Falling is the leading cause of injury-related death in people over 75 in the UK. Falls in hospitals are the most commonly reported safety incidents, with an estimated number of around 282,000 patients falls in England each year (NICE, 2014).

- Inpatient falls are the most common cause of harm in the NHS. They cause distress, pain, injury, loss of confidence and anxiety for relatives, carers and hospital staff

- In the 2012-2013 financial year there were a total of 396 falls reported in the Trust. 144 of these resulted in harm. Using the DOH Opportunity Estimator this harm is estimated to have cost £32k to treat

Aim	Primary Drivers	Secondary Drivers	
Reduce falls by 20% by June 2015. Reduce falls resulting in moderate to severe harm by 20% by June 2015	Staffing	Staffing per shift; Skills mix on the ward; The use of 1:1s	
	Ward systems and activities	Review daily activities; Therapy / expert intervention	
	Education & training	Communicate risk and raise awareness at forums, staff meetings	Increase awareness of falls risks and prevention among service users and their families
		Transfers and manual handling	MFA
	Physical environment	Furniture ; Toilets; Rails/handles; Lighting; Doors; Corridors; Bedroom	Clothing that fits inc. appropriate footwear
		Access to outside space	Response times to falls
	Identifying risk factors and acting on them	Physical health needs e.g. hydration and continence	Using MFA reliably
			Review medication
		Individualised care planning and adapting interventions	Communicate risks
			Identify risk takers
	Using data	Reviewing trends and learn from incidents	Reporting incidents and linking reporting systems, Rio coding

Clothing that fits inc. appropriate footwear

- Assessing footwear and clothing on Admission – initial assessment
- Assessing footwear in relation to mobility and transfer ability – post admission OT assessment
- Provision of alternative footwear.

Using MFA reliably

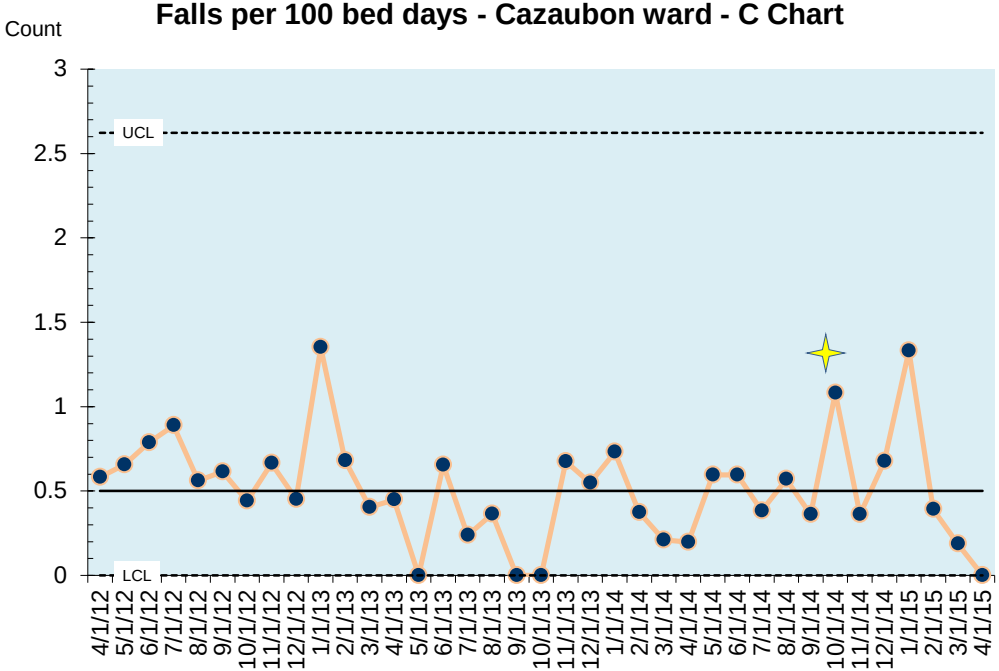
- Completion of the multifactorial assessment
- MDT review of assessment
- What happens once the MFA is completed
- Reviewing MFA post fall

Review medication

- Review as part of MFA
- Identify high risk medications

Reporting incidents – a way of developing practice

- Datix prompts
- Identifying standards
- Reviewing incidents
- Identifying trends


Falls per 100 bed days - Cazaubon ward - C Chart
Count
UCL
LCL
3
2.5
2
1.5
1
0.5
0
4/1/12
5/1/12
6/1/12
7/1/12
8/1/12
9/1/12
10/1/12
11/1/12
12/1/12
1/1/13
2/1/13
3/1/13
4/1/13
5/1/13
6/1/13
7/1/13
8/1/13
9/1/13
10/1/13
11/1/13
12/1/13
1/1/14
2/1/14
3/1/14
4/1/14
5/1/14
6/1/14
7/1/14
8/1/14
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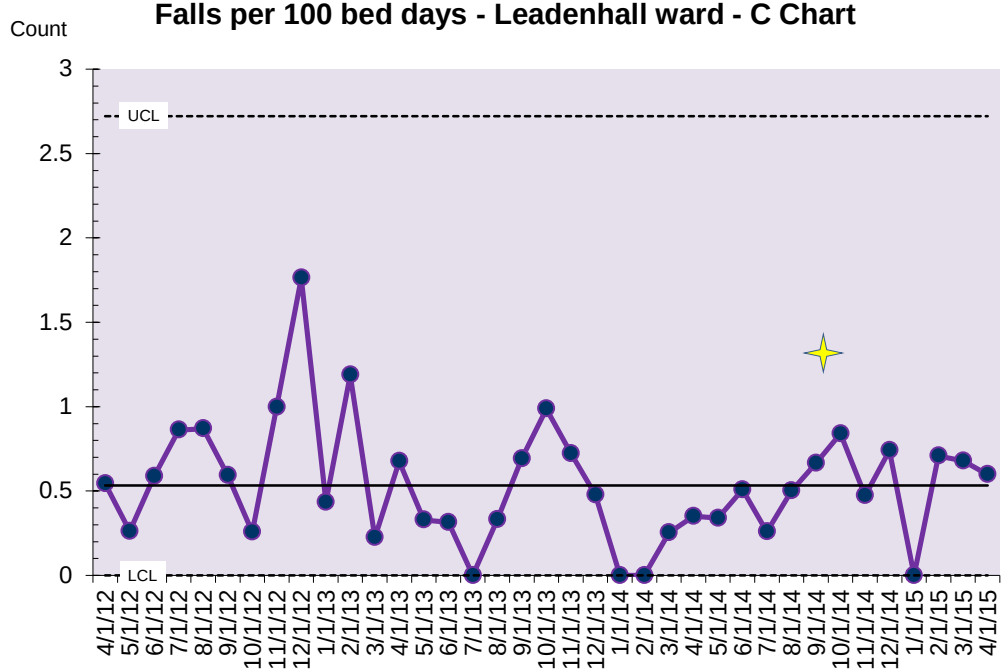
1/1/15
2/1/15
3/1/15
4/1/15


Falls per 100 bed days - Leadenhall ward - C Chart
Count
UCL
LCL
3
2.5
2
1.5
1
0.5
0
4/1/12
5/1/12
6/1/12
7/1/12
8/1/12
9/1/12
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1/1/13
2/1/13
3/1/13
4/1/13
5/1/13
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7/1/13
8/1/13
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10/1/13
11/1/13
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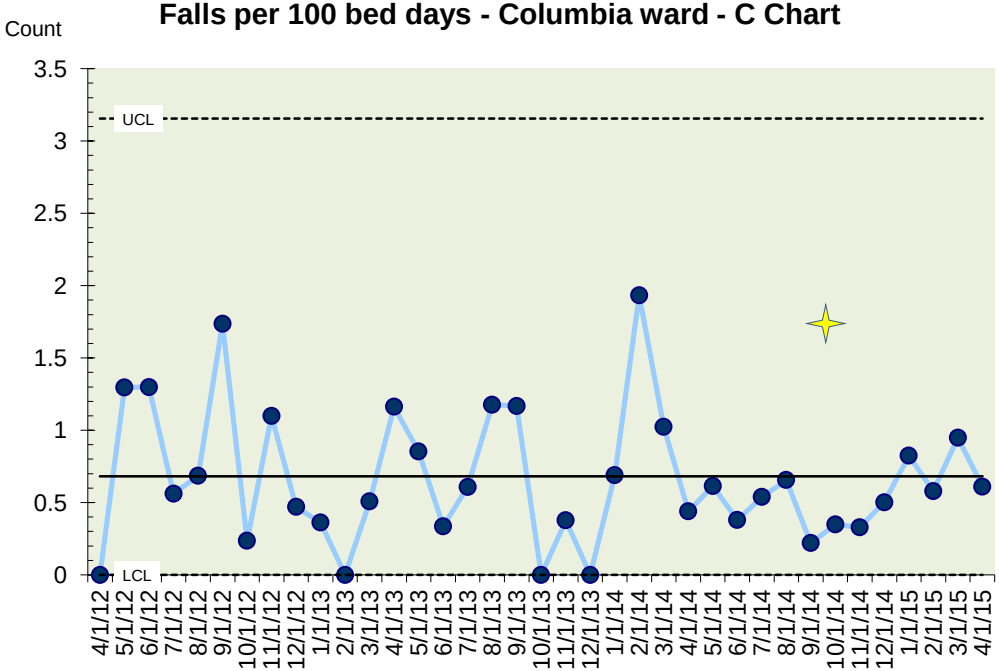
1/1/15
2/1/15
3/1/15
4/1/15


Falls per 100 bed days - Columbia ward - C Chart
Count
UCL
LCL
3.5
3
2.5
2
1.5
1
0.5
0
4/1/12
5/1/12
6/1/12
7/1/12
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1/1/13
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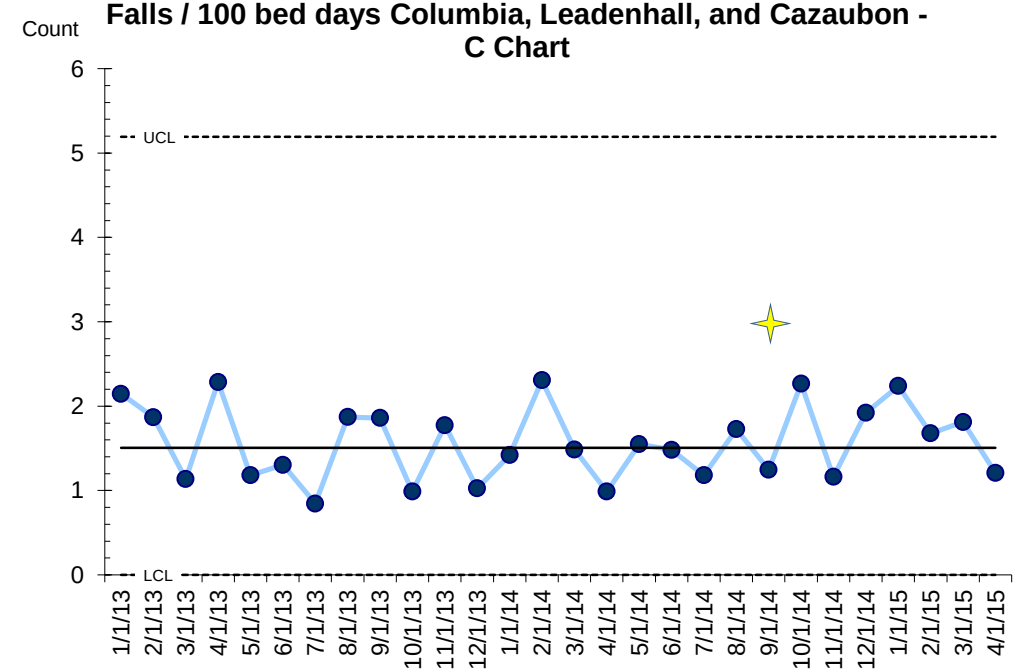
Falls / 100 bed days Columbia, Leadenhall, and Cazaubon - C Chart
Count
UCL
LCL
6
5
4
3
2
1
0
1/1/13
2/1/13
3/1/13
4/1/13
5/1/13
6/1/13
7/1/13
8/1/13
9/1/13
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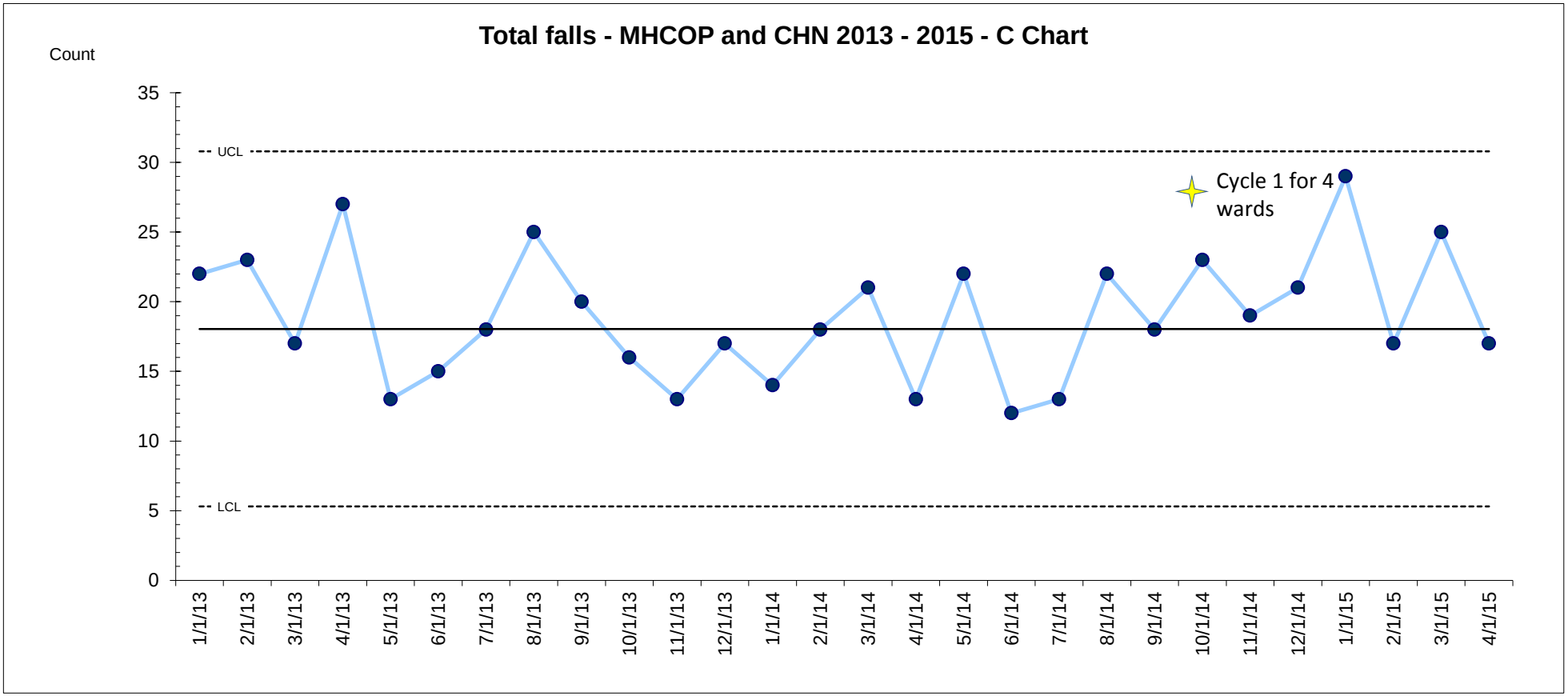
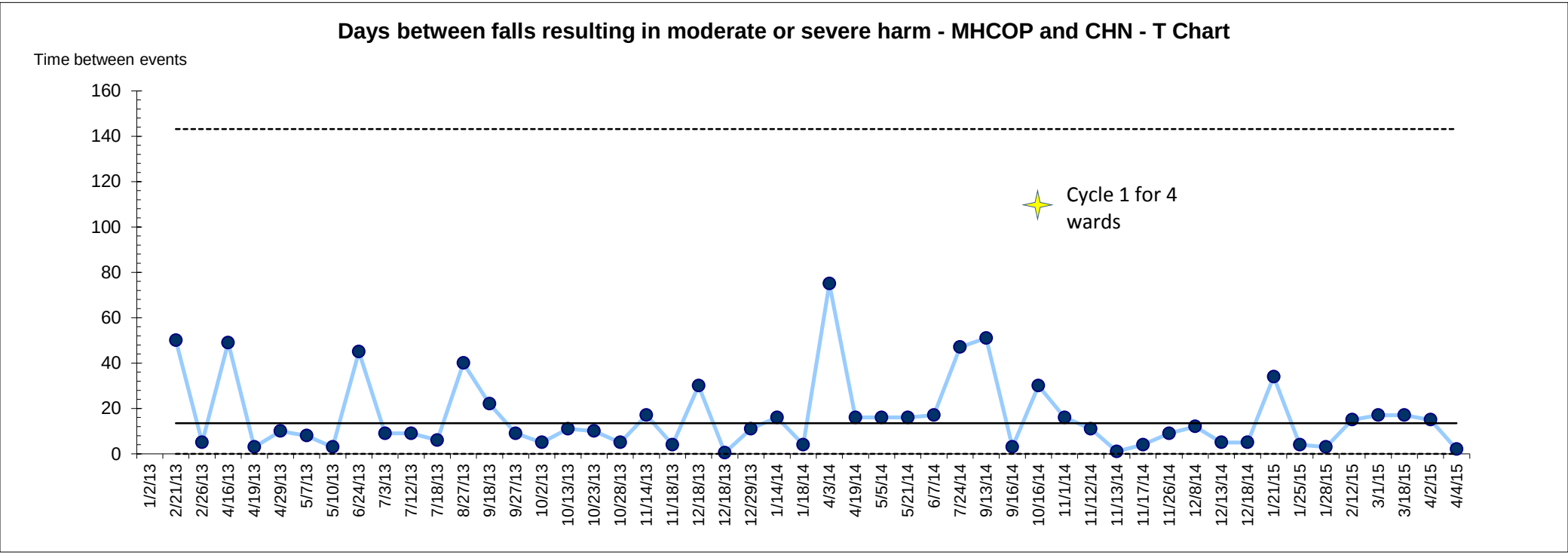
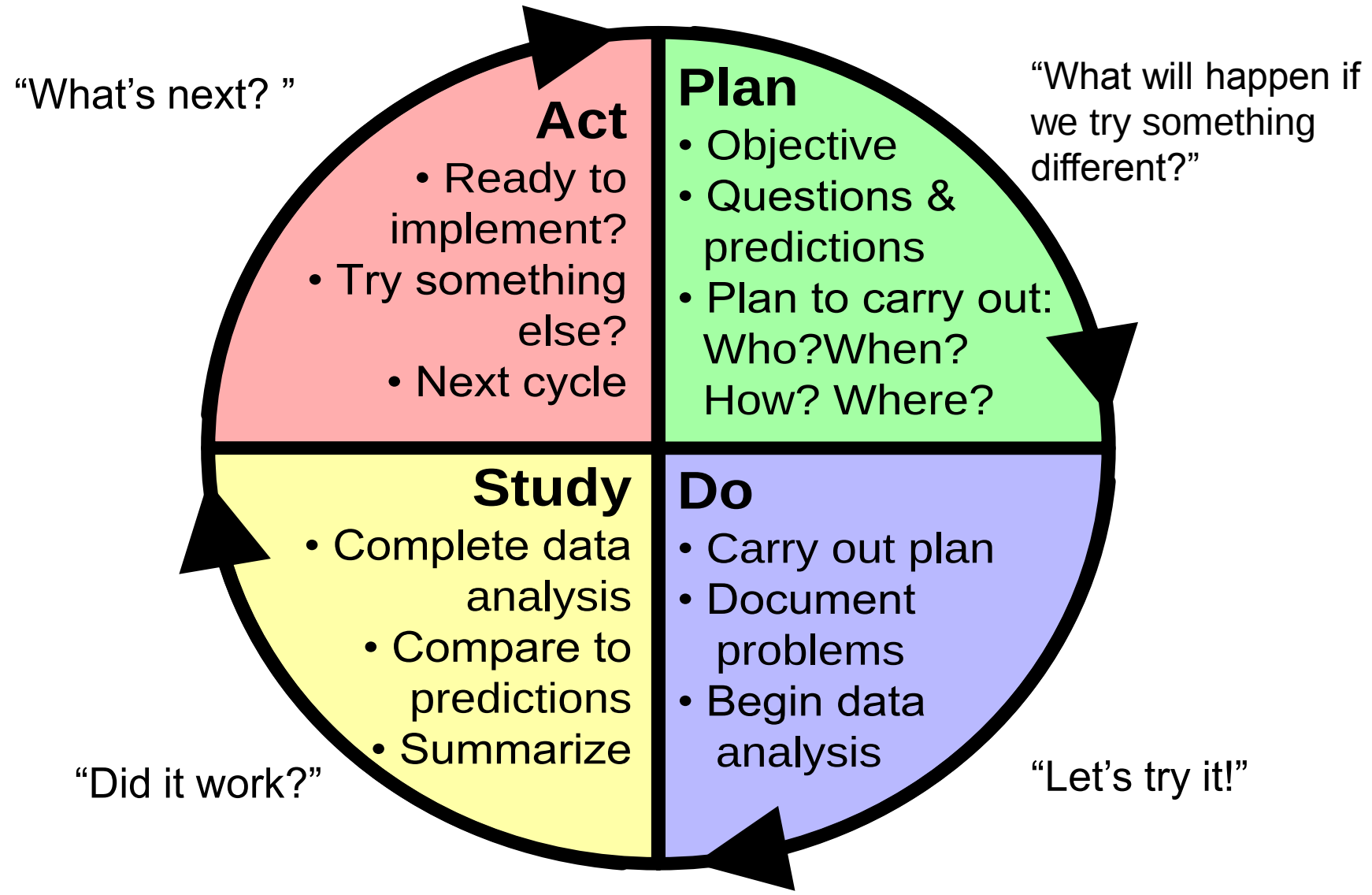
Reduce the Total Number of Falls by 20% by June 2015 (to an average of 14.4)



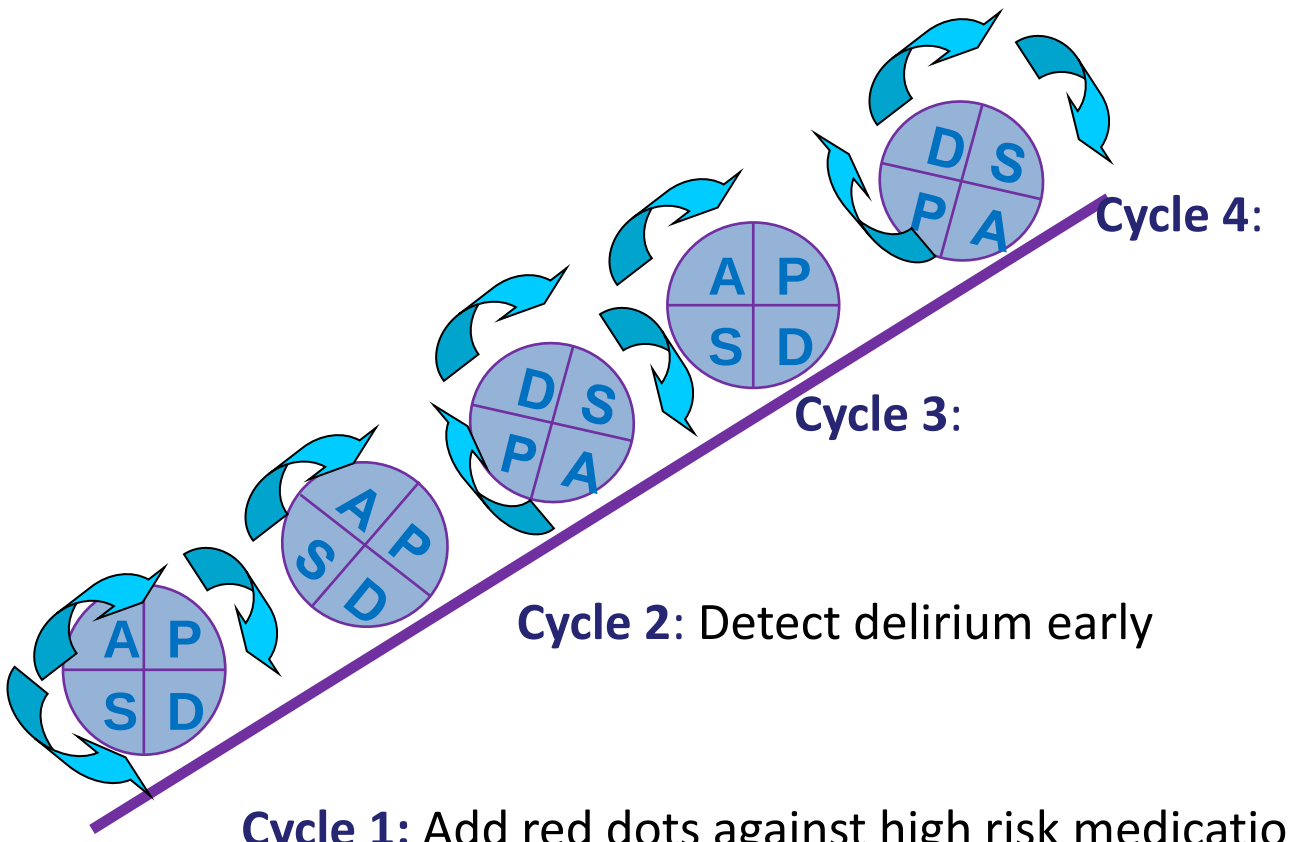
Increase the Number of Days Between Falls Resulting in Moderate to Severe Harm by 20% by June 2015 (to an average of 16.08)



The PDSA Cycle



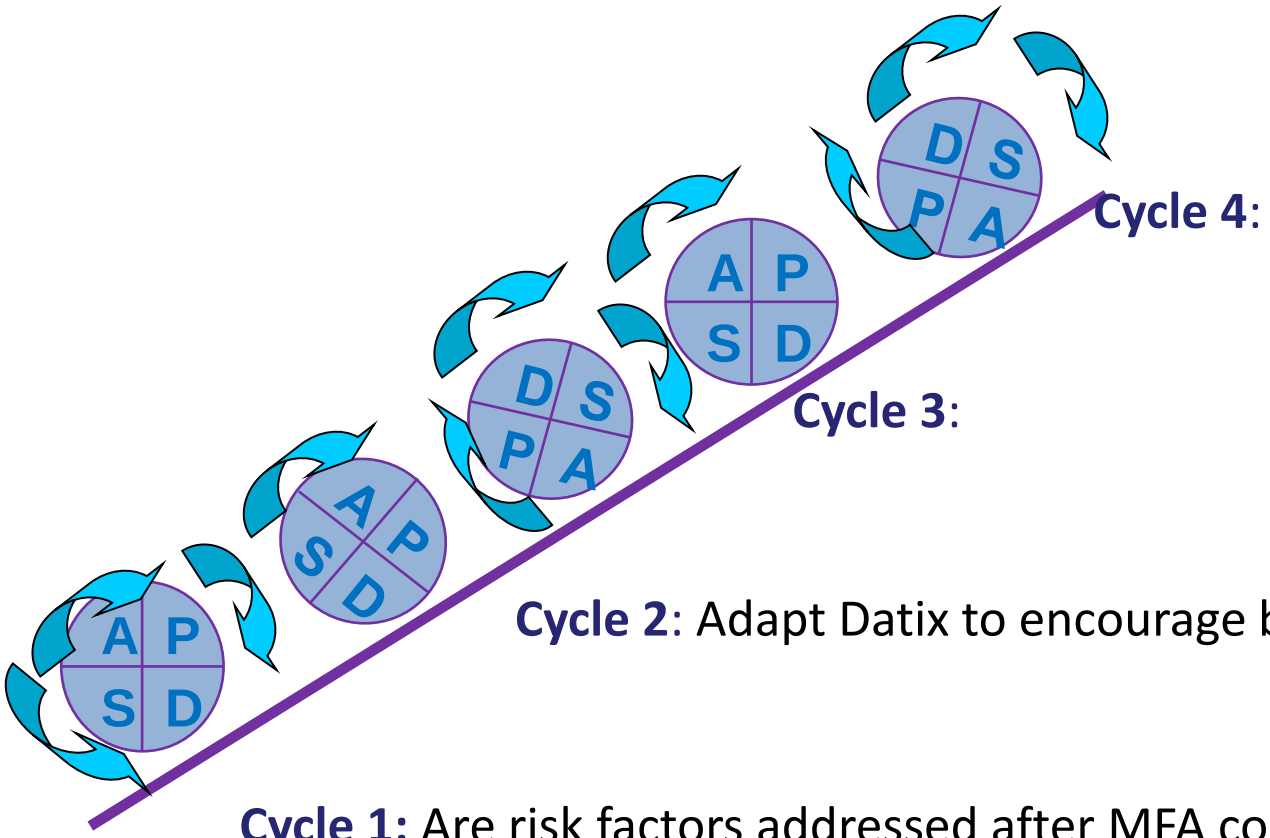
Columbia – checklist for admission pack on use of PRN



Cycle 1: Add red dots against high risk medication to impact on prescribing practices.

Action: ZD to laminate falls posters and display on Columbia Ward
Action: Consider a change idea around working with families
Action: Ward staff to offer all service users a full glass of water at medication times

Leadenhall – reviewing impact of MFA on risk factors



Cycle 4:

Cycle 3:

Cycle 2: Adapt Datix to encourage best practice learning

Cycle 1: Are risk factors addressed after MFA completed? We want to identify if risk factors are addressed and if this impacts on falls in the first 7 days of admission.

Action: AC to circulate the findings of the falls Audit that is currently in progress (after 24th April)
Action: AC to find out if ELFT can benchmark against another Trust
Action: AC to develop falls training for service users
Action: Ward staff to offer all service users a full glass of water at medication times

Next development

- Assessing for delirium