Falls collaborative at Pilgrim

We strive to ensure the best possible care for our patients while in our hospitals. One of our current priorities is to reduce inpatient falls which can cause injury and prolonged recovery.

To achieve this, a small team of senior and experienced clinical staff at Pilgrim hospital consisting of a consultant, matron, nurse consultant and site duty manager, are working with allied health professionals including physiotherapists and occupational therapists on a falls prevention pilot.

Together they have joined a national improvement team dedicated to reducing falls, which includes many trusts from across the country.

Wards 3B and 6B who are piloting this work, aim to reduce falls by 30% and reduce the rate of falls from harm (moderate, severe and death) by 20%, and of course improve the experiences of our patients.

Inpatient falls are the most commonly reported patient safety incident; with more than a quarter of a million falls in acute and community hospitals and mental health units in England reported to the National Reporting and Learning System (NRLS) annually.

Falls are a major concern for patient safety and a marker of care quality. A significant number of falls result in death or severe or moderate injury. The falls prevention programme aims to reduce harm from falls by:

- Raising awareness of relevant resources
- Supporting local leaders and frontline staff to reliably implement best practice
- Support commissioning bodies to plan and monitor services for safer care
- Creating a ‘virtuous circle’ of local and national learning from reported falls incidents
- Developing materials for staff education.

Wards 3B and 6B at Pilgrim Hospital are piloting methods to reduce falls including identifying high risk patients and putting measures in place to mitigate the risk of falls occurring. On these wards, patients who are identified as at risk of falling are issued with a fall safe leaflet explaining the use of the yellow wristband they are asked to wear. They are then given a yellow wristband, yellow non-slip socks and a yellow magnet above their bed.

A falls prevention workbook has been designed to drive the training for falls prevention on both wards. This will improve the education and knowledge of staff on these wards of patients at risk and the multifactorial reasons they fall.

Medication reviews are also taking place to increase the awareness of culprit medications relevant to the cause of falling to include occupational therapists and physiotherapists. The aim of his is to reduce falls through medication cause. A sticker will be placed in the notes of patients for medication review.

Work is also ongoing to increase the compliance of lying and standing blood pressure which is to be taken of patients as a clear indicator in the potential for patients having a fall. This training is being given to staff from both wards in a 20 minute rolling session with a plan to be rolled out across the Trust.

Every Thursday patients who have fallen in the last 7 days are reviewed to assess where the fall took place (looking at environmental factors), what happened to cause the fall and forward any proposed actions to stop a further fall to assure that all assessments are completed.

Further initiatives to be introduced including implementing a system where live assessments of patients who have fallen are reviewed within 30 minutes of the fall to assure correct process is followed by a Swarm team. Physiotherapists are also looking to deliver a short training package on the assessment for a walking aid for out of hours as it has been identified there is a delay in getting patients a walking aid out of hours which in turn can increase the potential for an inpatient fall.

The pilot finishes in June 2017 with a celebration event to be held in London in October, and we'll share findings and lessons learnt with other wards and hospitals.

Picture: The falls collaboration team, Pilgrim Hospital.