Northern Ireland Hospice

Falls Risk Management Programme

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Aims

- To set up a multidisciplinary group to devise means of managing and reducing patient falls within the Hospice in-patient unit

- To consider all aspects of patient care and also the environment in order to determine any associated risk factors and how best to prevent falls

Why do we need a Falls group in Hospice?

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- People aged 65 and older have the highest risk of falling with 30% of people older than 65 and 50% of people older than 80 falling at least once a year (NICE 2013)
- Falls are estimated to cost the NHS more than 2.3 billion per year
- Falls rarely have a single cause – often a combination of intrinsic and extrinsic factors
- Hospice every year provides specialist care for over 3,000 adults with life limiting conditions
- Patient safety is paramount - reduction and prevention of falls is essential

Common causes of falls in palliative care patients

- Malignant spinal cord compression
- Brain metastases
- Sepsis
- Medication
- Hypotension
- Myopathy
- Fatigue
- Visual impairment
- Co-existing disease eg.cardiac,TIA / stroke
- Parkinsons disease
- Metabolic abnormalities

- Additional:
  - Generalised weakness
  - De-functioning
  - Cognitive impairment
  - Previous history of falls

Habib F and Ward J 2015 Managing Falls in Palliative Care GM **45** 31-33

Costs of Falls for Patients

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- Loss of confidence
- Patient fear of further falls
- Anxiety
- Reduced mobility
- Loss of independence / increased dependency
- Injury
- Pain
- Extended length of stay

Objectives of Falls group

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- Complete a retrospective baseline audit and literature review
- Develop a comprehensive assessment tool to enable us to identify and modify falls risks
- Develop documentation for care after a fall
- Consider all aspects of care that could reduce/prevent falls- patient/family advice, footwear, foot care, eyesight, patient orientation, ward signage, falls prevention equipment, staff training and improved communication
- Heighten staff, patient and family awareness of risk factors and falls prevention
- Participate in national benchmarking

Methodology

- Multi disciplinary group set up in April 2014
  - Deputy ward manager / Consultant / Physiotherapist/ Occupational Therapist / Staff nurses /Health care assistants
- Completed retrospective baseline audit
- Comprehensive assessment tool devised - Moving and Handling and Falls Risk management
- New documentation devised for Care after a Fall

Results of baseline audit - Location of falls

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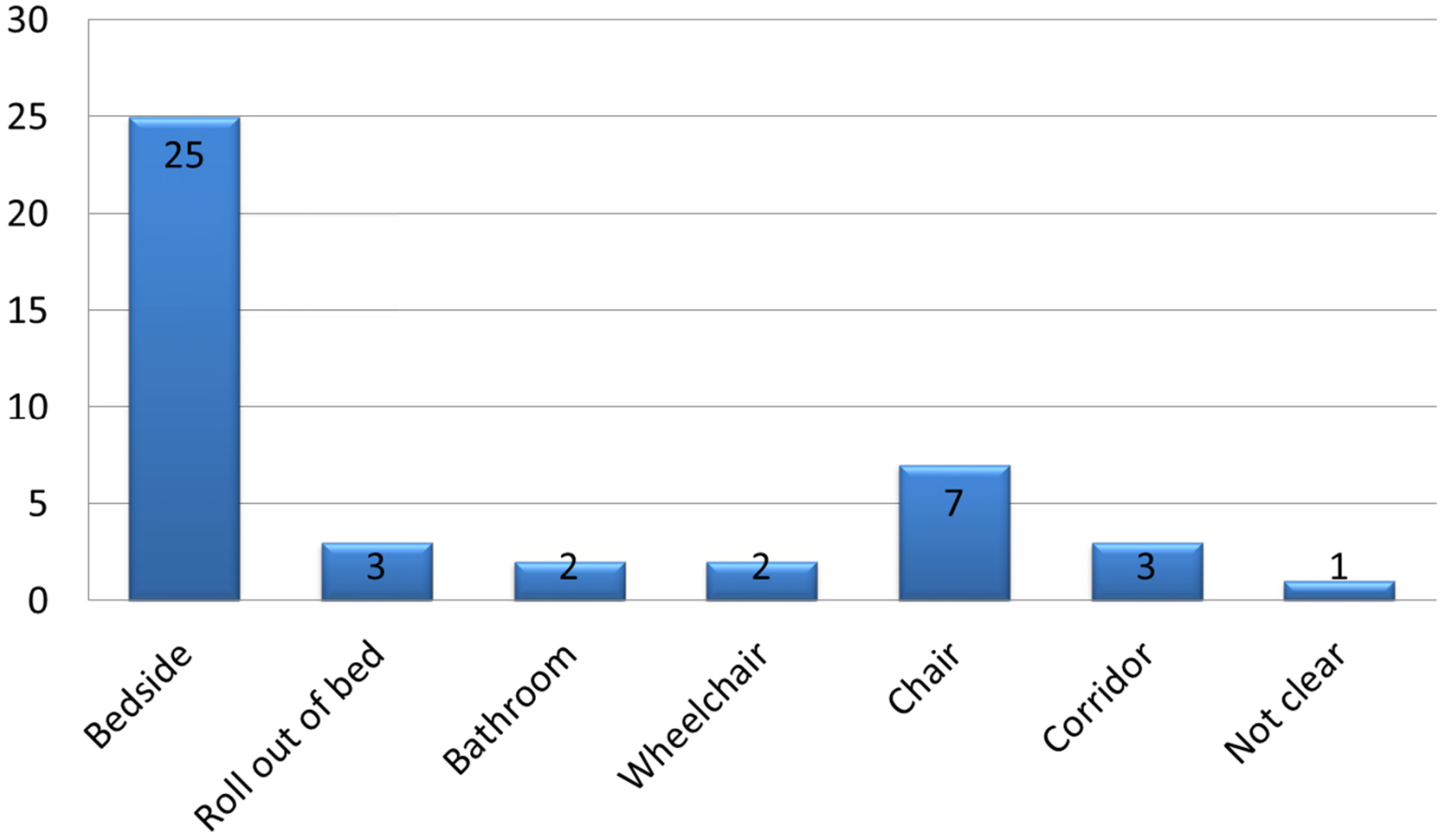

Purpose for mobilising when fall occured

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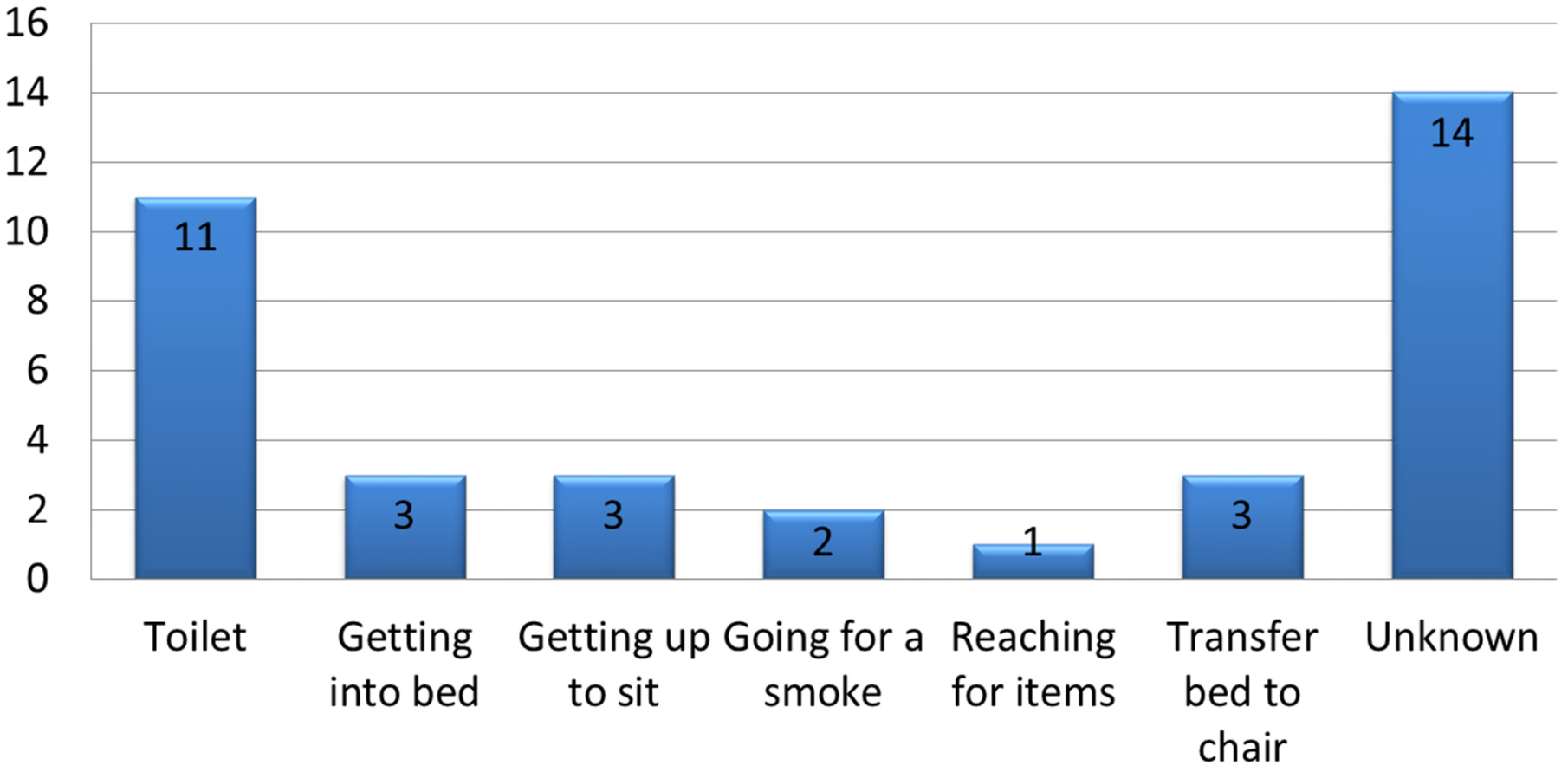

Injury sustained

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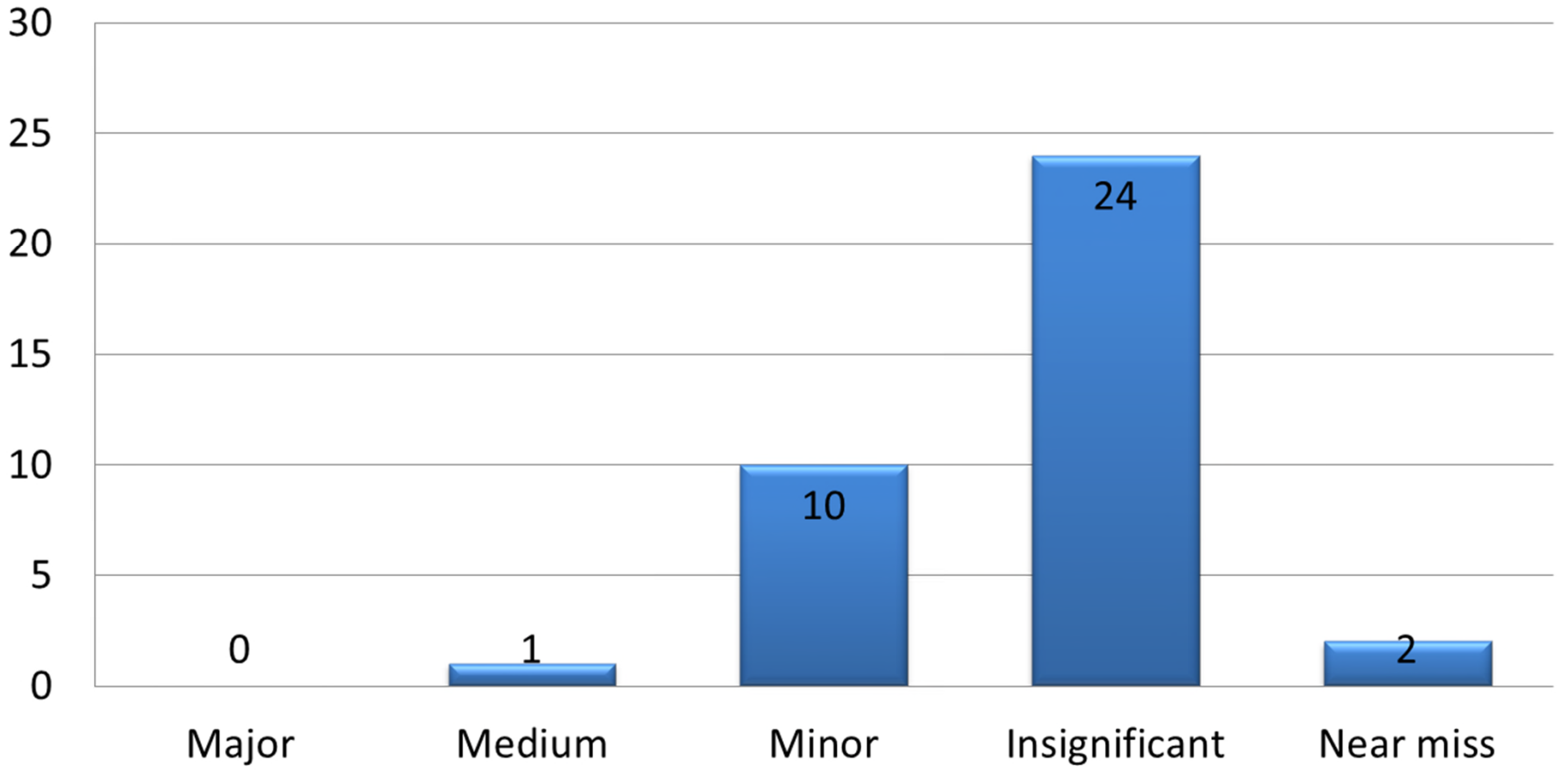
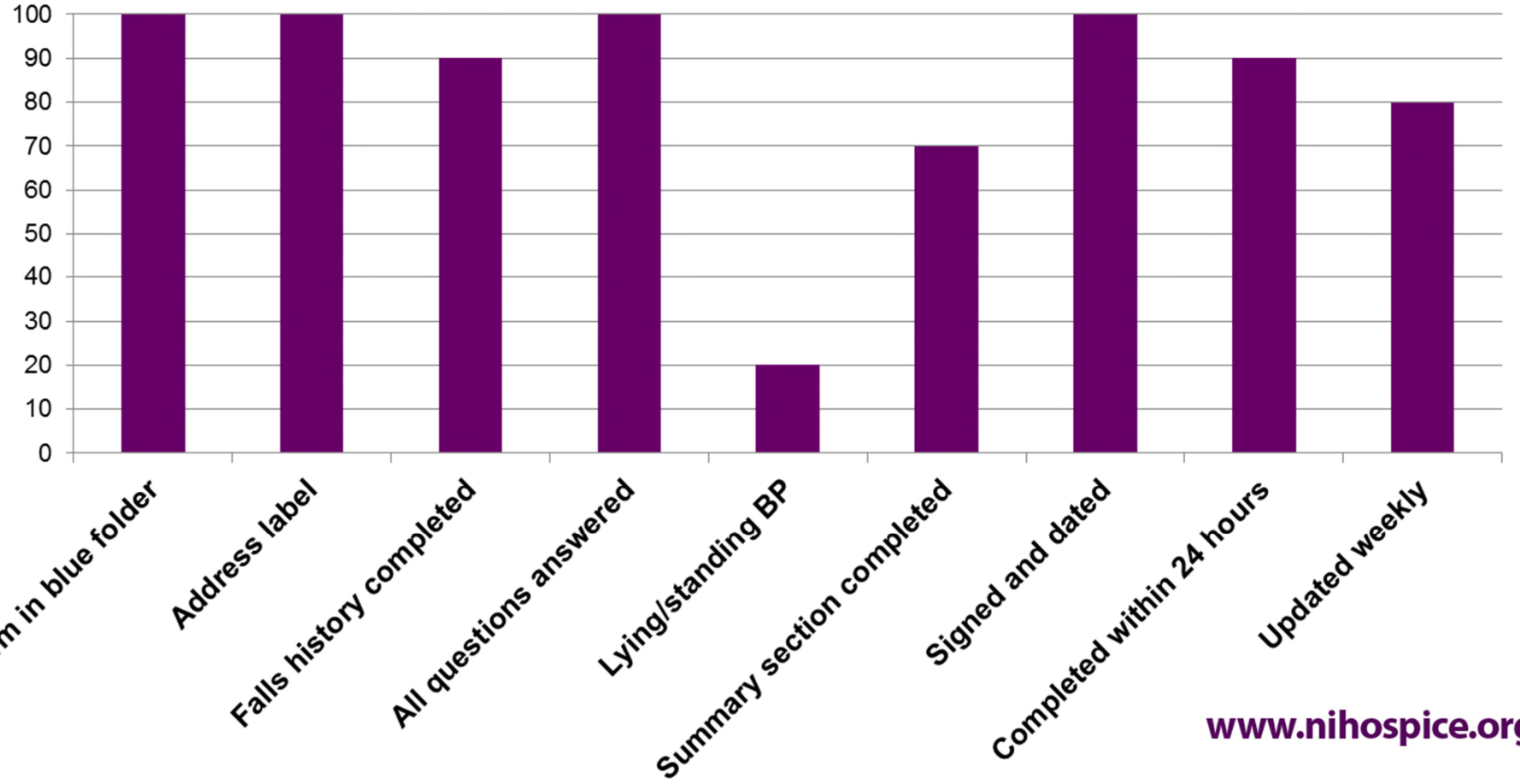


National Benchmarking: Falls - 2015

Harm	NIH number YTD	National ave number YTD
None	28	34.5
Low	16	19.5
Moderate	0	0.9
Severe	0	0
Death	0	0
Total	44	55

Changes implemented

- Moving and Handling and Falls Risk Management assessment tool – completed on admission and updated regularly – kept at patient bedside for ease of access. Documentation audited



Changes implemented

- Care after a fall documentation
- Patient poster designed and displayed in every room
- Insert leaflet designed for inclusion in patient admission pack
- Falls prevention equipment purchased and multi disciplinary training session provided
  (attended by staff covering 9 disciplines)

Staff poster

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Falls awareness and prevention

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Moving and Handling Assessment:
This is to be completed on the patients admission. Must be updated regularly and if patient has a fall. It should be kept in the blue folder at the patients bedside at all times.

Falls alert wristbands:
The yellow wrist bands are for those patients identified to be at high risk of falling and should be immediately assisted if found up walking unaided.

Ramblegard:
Ensure the equipment is stored flat at all times. Bed pads are for use on Pentaflex mattresses and bed strips are for use on air mattresses. The sensor pads are marked A–D, please ensure the corresponding monitor, bed pad and seat pad are used together (eg. monitor A, bed pad A and seat pad A). Also ensure the bed pad and seat pad are switched on and batteries are in the monitor. The bed strips are used with monitor E – please do not remove the adhesive strip from the bed strip as it is very difficult to remove from mattress cover. Please ensure if the seat pad is being placed under the top seat cover of a riser recliner that it is removed prior to the chair being deep cleaned.
When working with a patient please take the monitor in with you as it will continue to bleep as the patient moves/is repositioned.

Bed area:
Please ensure the bed space is clutter free and no leads/wires visible as a trip hazard.
Ensure all spills are cleaned up immediately.

Eyesight:
If a patient wears glasses ensure they are worn as necessary.
If a patient requires an updated eye test or change to glasses prescription there is an optician who is able to come to the IPU - details with OT/Physio.

Footwear:
Ensure slippers and shoes are supportive and well fitting with a non slip sole.
If a patient has difficulty wearing standard footwear there is a supply of Kerrapeds in sizes S/M/L/XL in the clinical room. If Kerrapeds are provided please ensure a replacement pair are ordered to ensure stock is maintained.

A chiropodist is available on the IPU – dates available in ward office.
A guide to purchasing correct footwear for swollen feet is available from OT/Physio.

Please speak with a member of the Falls group if you need any further information - Jennifer Allen, Ashley Courtney, Sarah Irwin, Alan McPherson, Karen O'Hare, Martin Smyth or Gillian Walker.

Mobility aid:
Ensure the correct walking aid is used as provided by Physio.
Provide instruction as patient requires – encourage them to take their time and to concentrate on task – limit distractions and obstacles.
If using a rollator/4 wheeled walking aid ensure it is fully opened and brakes used as appropriate.

Transfers:
When standing always encourage a patient to push up from chair/bed – never to pull up on their walking aid.
When sitting down encourage patient to step back until they feel the chair at the back of their legs and to feel behind for the chair before easing themself down.

Before leaving a patient:
Ensure call button is within reach and encourage patient to call for any assistance required.
Ensure overbed table is within easy reach with all required items eg. glasses, mobile phone, TV remote, water jug and glass.
Ensure bed area is clutter free with no trip hazards.

Staff Newsletter

Falls Group Newsletter – August 2015

Falls Risk Management Tool – Must be completed on the patients admission and kept at all times in the patients blue bedside folder.

Care immediately after a fall – Must be completed at the time of a fall. Please ensure that following a fall the patients moving and handling update is completed and also the bed rail assessment if appropriate.

Falls Awareness week – We will be holding a **Hospice Falls awareness week** beginning **17th September**. There will be an information stand and display for patients and relatives and also for staff.

Recent falls on ward – In June and July there were 2 falls due to patients over reaching to get their buzzer and items on their locker and a further 2 falls due to patients reaching to get equipment near bedside –stedy and wheelchair. **Before leaving a patient can all staff please ensure their buzzer and personal items are close at hand and any equipment such as commode/stedy/wheelchair are out of view so patient is not tempted to try and get up unaided.**

Falls alert wristbands – The yellow wrist bands are for those patients identified to be at **high risk** of falling and should be immediately assisted if found up walking unaided.

Foot care –Kerrapeds are available in S/M/L/XL in the clinical room. When provided please ensure a replacement pair are ordered to ensure stock is maintained. If a patient needs to see a chiropodist, Charmaine will be available in the IPU on the following dates – **1st, 9th & 17th Sept**

Ramblegard – Bed strips, bed and seat pads are located in the clinical treatment room – they must be stored flat to prevent damage. Instructions on use and extra batteries are also stored with the equipment. When working with a patient please take the monitor in with you as it will continue to bleep as the patient moves/is repositioned.

If Ramblegard misalarming:

- Check pad is correctly positioned (may be better positioned under hips rather than shoulders)
- Check pad has not got caught or nipped in bed frame
- Check seat pad has not been left on chair which visitors are using
- Check monitor is taken to bedside when staff working with the patient
- Check batteries do not need replaced

The Falls group would like to ensure there is a team approach in the management and prevention of falls. We value everyones support and would ask that if anyone has any suggestions, comments or recommendations that they speak to any of the group – Jennifer Allen, Ashley Courtney, Sarah Irwin, Alan McPherson, Karen O'Hare, Martin Smyth or Gillian Walker.

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Changes implemented

- Stock of Kerraped footwear now available in sizes S/M/L/XL for patients who are unable to wear standard footwear

- Yellow alert wrist bands introduced to highlight patients at high risk of falling

- Patient information packs
- Falls awareness week
- Purchase of orientation clock

Links with artist in residence to design dementia friendly ward signage to promote patient orientation

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Ongoing work

- Ongoing regular staff newsletters
- Review and update staff falls poster
- Regular audit of documentation
- New Falls policy
- Design E-learning module as part of staff mandatory training
- Change of chiropody service within Hospice so that priority given to in-patient unit
- Ongoing promotion of Falls awareness week
- Link with artist in residence re: patient bedside sign
- Re-assessment of new Hospice environment

Building a new Hospice for future generations

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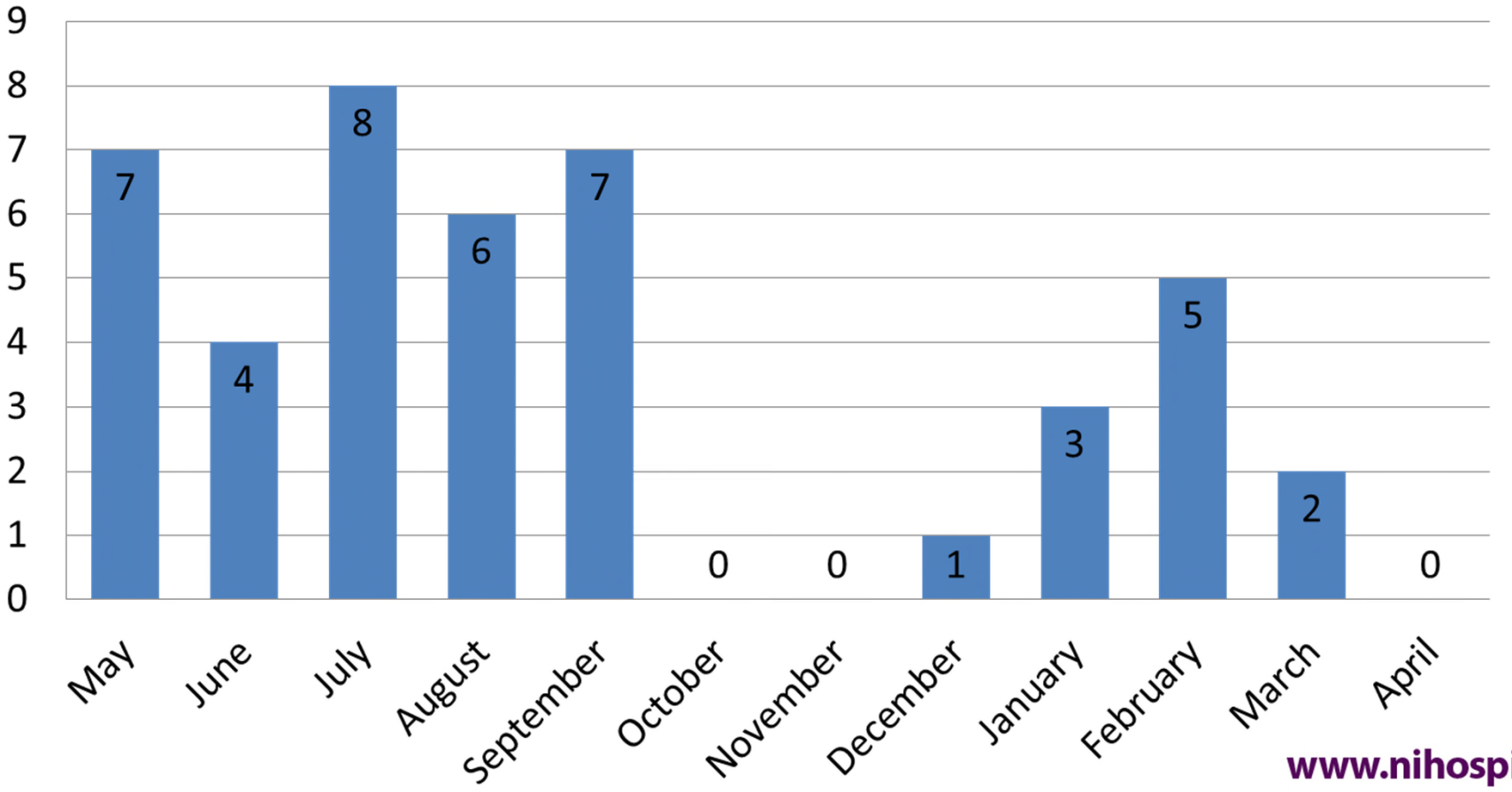
Conclusion

- Overall reduction in falls: May 2014 – April 2015



Conclusion

- Increased awareness among staff, patients and families of falls risk factors and prevention of falls
- Improved documentation
- Improved patient orientation within the ward due to improved dementia friendly signage
- **Successful implementation –** due to a **multi disciplinary quality improvement approach** has led to a more patient centred, holistic approach to care with **overall improved patient safety**

References

- Chartered Society of Physiotherapists and College of Occupational Therapy 2000 Falls audit pack – guideline for the collaborative, rehabilitative management of elderly people who have fallen
- College of OT 2015 OT in the prevention and management of falls on adults – practice guidelines
- Habib F and Ward J 2015 Managing Falls in Palliative Care GM **45** 31-33
- Help the Hospices 2010 Falls toolkit for prevention and management
- NICE 2013 Falls: assessment and prevention of falls in older people
- NICE 2015 Falls in Older People: overview
- Royal College of Physicians 2012 Implementing Fall Safe – Care bundles to reduce inpatient falls