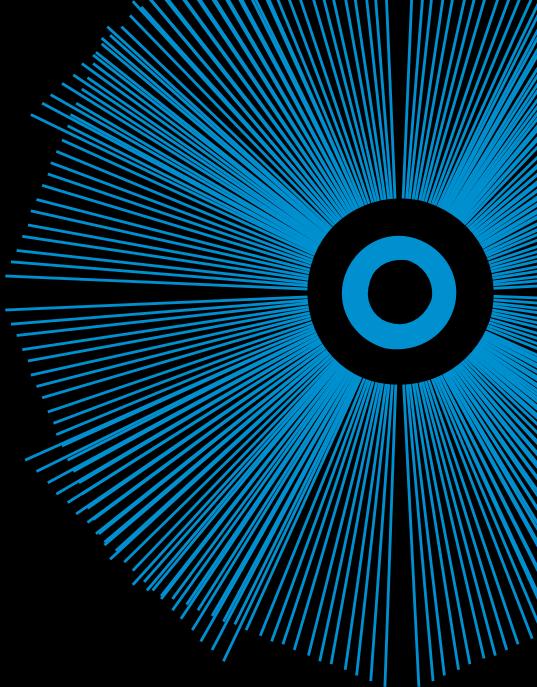




Shine



Shine 2012 final report

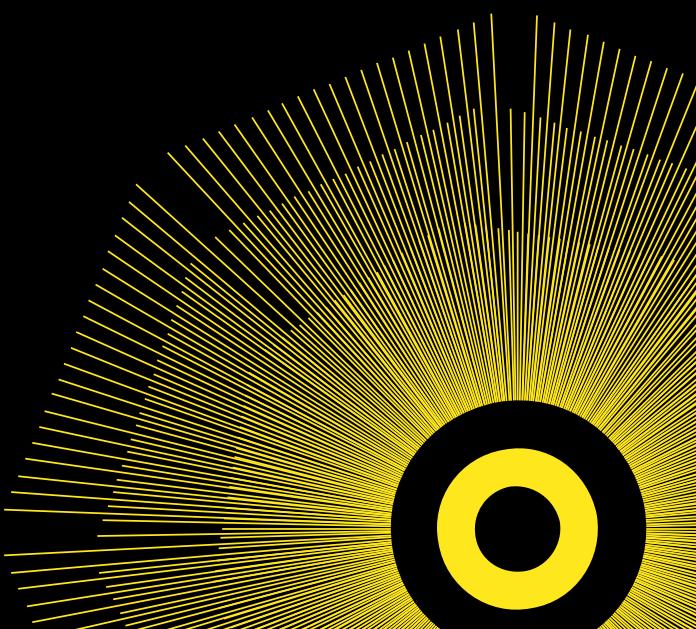
NOHARM

Normalizing Orthostatic Hypotension and
Reducing Medication

Stockport NHS Foundation Trust

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Project title: NOHARM (normalising orthostatic hypotension and reducing medication)

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Abstract



Evidence suggests that 18% of hospital admissions (aged 65+) experience orthostatic hypotension -- a drop in blood pressure when standing -- which greatly increases their risk of falls and cardiovascular events. With age, this percentage rises significantly.

Currently 17.7% of Stockport's population is aged 65 or over (JSNA, 2011), a total of 51,400 people, over 6700 being 85+ years and is projected to rise. Approximately 30% of this population will fall at least once in the next year. Evidence suggests that three times this number of falls will go unreported. It is also recognised that about 50% of the people who had a fall are at risk of having another fall within 12 months' time.

There are a number of modifiable risk factors in falls prevention work (such as safe footwear), yet hospitals continue to struggle with assessing and treating orthostatic hypotension; it has not received the same attention. Through a national pilot audit, a regional audit, and qualitative interviews with hospital staff, we have found considerable barriers to effectively managing orthostatic hypotension.

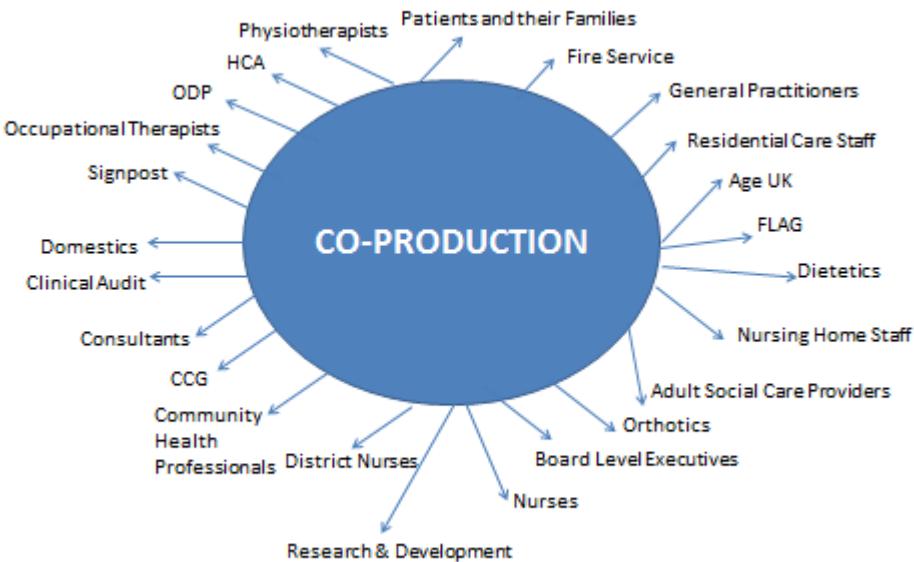
Stockport NHS Foundation Trust have undertaken a quality improvement project to design an orthostatic hypotension pathway (Lying and standing blood pressure assessment) using a

combination of co-production and Plan-Do-Study-Act (PDSA) methods. The project ran from January 2013 through to end of March 2014. The first two months (stage one) was used to provide a framework for the project including all practical aspects including office base, telephones and equipment. The steering group and project groups were also recruited during this period, and the evidence based teams, that is, the ward staff, pharmacists and therapists that worked in the target areas were briefed. Patients were informed of the project when they became inpatients. It was planned that the next four months (stage two) would be used to introduce the first pathway document and develop it as a result of feedback from the evidence based teams. The third stage of the project spanned four months and looked at how effective the developed pathway worked in the clinical areas, what effect it had on patients' safety and care and ease of use by staff members. The final stage (last 4 months of the project) consisted of evaluation and write up of the project.

The pathway for orthostatic hypotension will have far-reaching effects because it jointly addresses several big gaps in falls prevention: medication reviews, communication with patients and between providers, and cognitive assessments. The pathway involves training, assessments, and interventions for orthostatic hypotension, as well as improved discharge information for patients, families, carers, and GPs.

Identifying orthostatic hypotension improves patient safety through reducing falls and unnecessary medications. Patients (along with their families and carers) are supported to become active partners in their own care, especially those diagnosed with dementia and delirium. With more engagement and higher quality assessments, staff can work more effectively and efficiently: less paperwork, quicker pathways, and fewer incidents.

A co-production method brought together staff, patients, families and carers to identify important 'touchpoints' between the key stakeholders and generate solutions to improve experiences and outcomes. The project involved twenty four different department and agencies at any one time.



A number of audits, interviews and surveys were carried out and summarised and/or presented back to the evidence based teams for review and response at monthly team meetings. Testable modifications were implemented using a PDSA: planning the change, and implementing the change, observing the impact, and identifying further changes.

This gathered evidence has been invaluable in ensuring the pathway is usable, effective and delivers demonstrable improvements to the service provided to patients. We have, however struggled to demonstrate a reduction in overall length of stay for patients because the patient's admission is coded and stored electronically. A patient who has come into ED (emergency department) after a fall is more likely to have the condition causing the fall to be recorded rather than the fall itself; therefore comparable data is difficult to come by.

The project has had several positive effects on the service provided to patients, Interaction between staff and patients has increased, and according to patient feedback, patients feel more involved in their own care. Patients and their families/carers are now encouraged to take an active part in managing Orthostatic Hypotension. Staff has found the pathway easy to use, and a senior nurse in one area commented that it provides a clear framework for assessment and early intervention for patients.

The Outcomes

Stockport is an ideal testing site, as our population match England's economic and social statistics. The Hospital base is a District and General hospital with 800 inpatient beds and a large community service covering a diverse area. The Project took place on two wards with a high number of older patients.

Test wards

Test ward 1 (E2) is a 35 bedded acute elderly care ward with a quick turnover of patients. Patients are nursed in 6 bedded bays with registered nurses allocated to oversee 2 bays. There is a central nurse's station in the middle of the ward. Patient falls had been consistently high in previous audit of incident reporting. The reported falls in the period August 2011 to March 2012 were 82 of those 2 resulted in fractures, 19 resulted in minor physical injury and 61 either a 'near miss' or no resulting injury.

Test ward 2 (M4) is a 27 bedded unit for patients with a Fractured Neck of Femur who are admitted directly from ED (Emergency Department). The ward has 4 bedded bays and a nurse's station in each of the bays. Patients have a high number of offending medications that is, those medications known to be a contributing factor in labile blood pressure or causing dizziness. The reported falls in the period August 2011 to March 2012 there were 37 reported falls of those 1 resulted in significant injury, 7 resulted in minor physical injury, the remaining 29 either a 'near miss' or no resulting injury.

A third acute elderly care ward (E3) with a previously high number of reported falls had the same observation and audit but with no intervention and acted as a comparison control ward. The reported falls for the period August 2011 to March 2012 were 80 of those 2 resulted in a fracture, 18 resulted in minor physical injury and the remaining 60 either a 'near miss' or no resulting injury.

We can demonstrate that the patient populations are comparable prior to admissions in terms of falls history with the following table. Each ward had a sample of twenty patients audited over a four month period using nursing admission documentation (**Figure 1**).

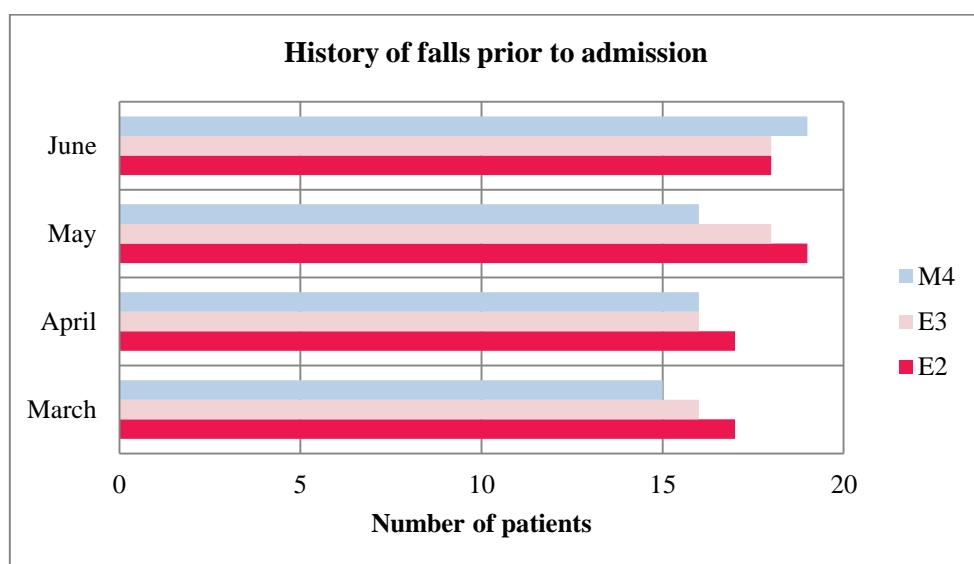


Figure 1

The project used a co-production methodology promoted by the NHS Institute (NHS Institute for Innovation and Improvement 2013), so patients and staff worked together in evidence based teams to share experiences and identify important ‘touchpoints’ where the pathway could improve.

The project team decided after a literature search on three criteria that would automatically trigger the need for a postural BP assessment; a history of falls (fall that was not a slip or trip in the last twelve months), a history of dizziness on standing from a lying or sitting position and those aged 75 years or over.

The falls risk tool that was already in use identified patients as being low, medium or high risk through a series of questions and those patients in the medium or high category should have a postural BP assessment (lying and standing blood pressure assessment). An initial audit of 24 people over 75 years old showed that 18 (75%) met one of the other two criteria, either dizziness on standing or history of falls. Of these 18 people only three had undergone a postural BP. Two out of the three patients had evidence of a postural drop and one person had medical intervention. A very simple document was introduced that required only the BP measurements to be entered. (**Appendix 1**).

There were two evidence based teams running concurrently: one based around the ward (patients, nurses, HCAs, doctors) and one based around the e-discharge system (junior doctors and pharmacists). Patient notes, electronic systems; discharge information, medication reviews including any changes made, and referral letters were used to measure compliance with the pathway protocols, as this information is generated and saved electronically making this information easy to access with correct permissions. Monthly surveys using a data gathering system was undertaken sampling 20 patients from each area (**Appendix 2**). We also used existing data that is collected for other use, for instance incident reporting and patient satisfaction surveys. The hospital informatics team were able to provide further information useful to the data collection.

The project team used all gathered information provided by the evidence based teams through observation, interview and comments on feedback sheets to make changes in the pathway

development. The group feedback sessions held once a month were instrumental in most of the changes to the pathway; this qualitative data was invaluable to our learning.



Changes as a result of the qualitative data;

- Pathway printed on bright yellow paper for easy recognition
- Introduction of process flow chart
- Addition of staff/patient interaction sheet
- Introduction of Pharmacy stickers
- Removal of staff/patient interaction sheet from pathway and placed on all BP machines to cut down on printing cost.
- Rewording on pathway to make it generic rather than specific to Acute or community, medicine or surgery.

We ended the second stage of the project with the final pathway (**Appendix 3**).

The evidence based teams were instrumental in gathering experience from patients on the wards. We joined forces with the patient experience team to further survey patients regarding their overall thoughts around the interaction with staff during the BP assessments.

We ran two large co-production workshops designed to look at the impact of a traumatic injury resulting from a fall has on an individual. The multi-disciplinary delegates including members of the public were split into six groups, each group with a diverse mix of skill, knowledge and experience. The groups then had to come up with the last member of their group – a person of their own creation – the groups fed back a portrait, a complete social, employment, physical, emotional and family story for their ‘new member’.

The multi-disciplinary groups then took their ‘person’ through a series of life events; the first was taking steps to ensure a healthy lifestyle. Each group was then given a scenario that involved a traumatic fall in a variety of circumstance that required hospitalisation; the groups were directed to look at gold standard care in an acute setting. Finally the groups had to revisit their person’s life after discharge, looking at how the person they first introduced to the room had changed physically and emotionally. The first workshop feedback was 100% positive and it was agreed that it was, although fairly traumatic for some delegates, an excellent opportunity to refocus on why we offer care to people. Every member of the workshop had something valuable to contribute.

The second workshop also included very senior managers both from the Acute and Community settings, NHS Governors, the CCG and representatives from a Nation chain of Gyms. This workshop was equally as successful and a lot of firm contacts were made.



IMPACT workshop May 2013

We wanted to know if the innovation was successful and asked the following questions;

Have we improved outcomes?

The quantitative data has shown that the pathway has provided a framework for early assessment (within six hours of admission to ward) and intervention (medication review within 24 hours of assessment) for patients who meet one of the criteria due to the robust instruction flow chart (**Figure 2**). Patients no longer have to wait for a decision to assess postural BP by a Doctor at some stage in the patient's stay.

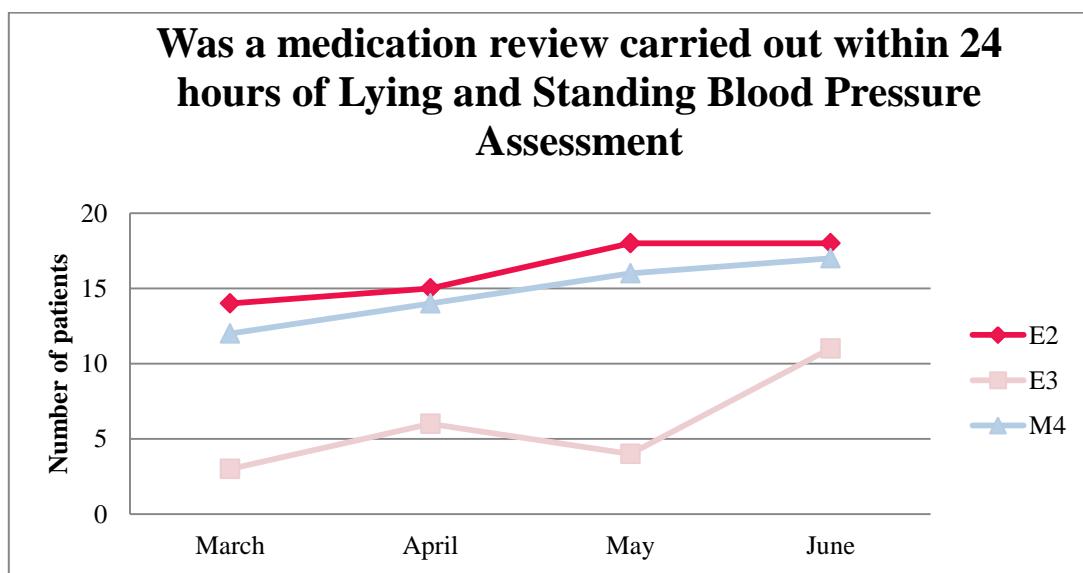


Figure 2

The qualitative data tells us that those patients who do not have a cognitive impairment feel more secure about falls after the interaction and encouragement to take an active part in their own care. Patients with dementia or a delirium are assessed in a timely manner and this helps to address the inequality in health screening for people with a dementia or delirium (Department of Health 2008) (**Figure 3**).

We have shown that we have identified and treated more people with postural hypotension than ever before; however, it has been difficult to show an overall reduction in falls as the present incident recording includes 'near misses'. With an increasing average age of patient the wards still experience a similar number of falls. There has been a reduction in the number of falls resulting in major and moderate injury but we are unable to separate non injurious falls from 'near miss' falls making it difficult to differentiate. The falls training for all clinical staff now includes the importance of incident reporting and the trust has seen a rise in the occurrence of falls incidents being reported electronically. The trust falls policy has now been updated to include the requirement of lying and standing blood pressure assessments if the patient meets one of the criteria (**Appendix 4**).

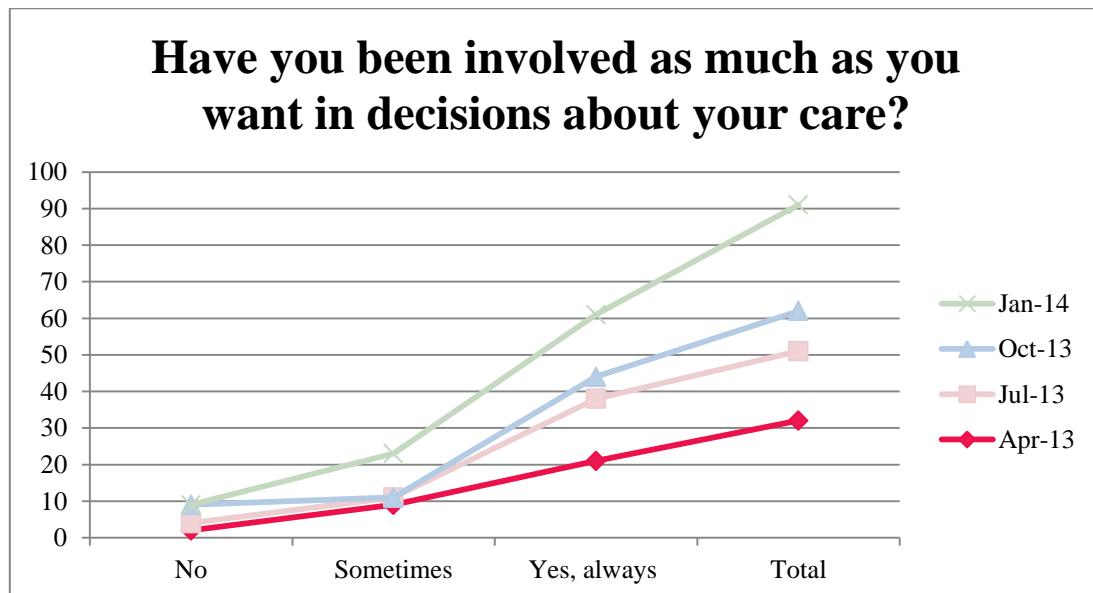


Figure 3

No	Yes to some extent	Yes, definitely	Total	
2	9	21	32	Apr-13
2	2	17	19	Jul-13
5	0	6	11	Oct-13
0	12	17	29	Jan-14

Has the pathway improved the experience and knowledge of patients, hospital staff, care homes and GP'S?

When we undertook a patient survey we found that the level of engagement that patients felt with staff had increased over the course of the project (**Figure 4**).

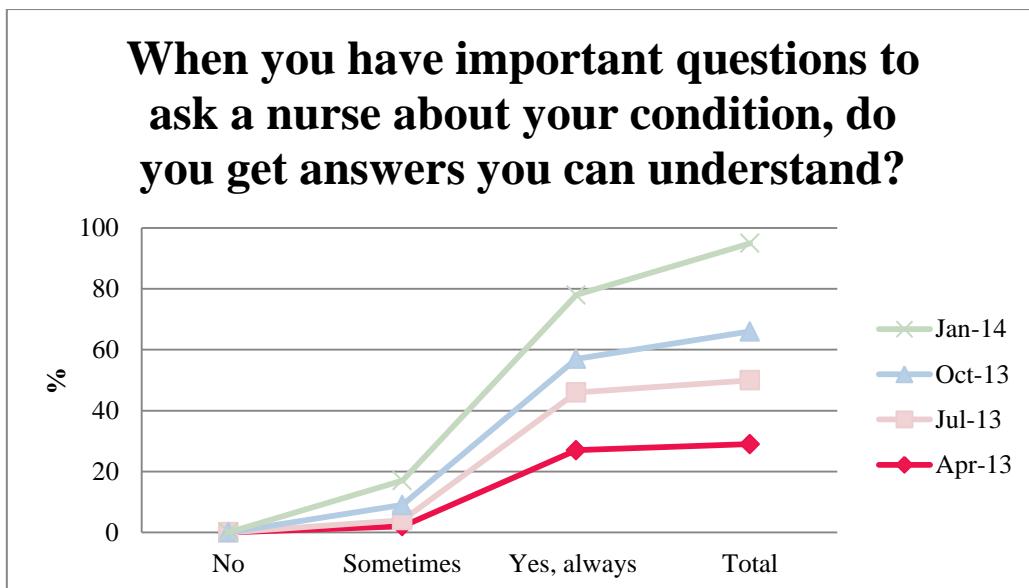


Figure 4

No	Sometimes	Yes, always	Total	
0	2	27	29	Apr-13
0	2	19	21	Jul-13
0	5	11	16	Oct-13
0	8	21	29	Jan-14

Using a staff survey as evidence we can show that in September 2013 staff is now using the pathway on a regular basis, interacting with patients and offering advice on the physical management of Postural Hypotension compared to March 2013 (**Figure 5**).

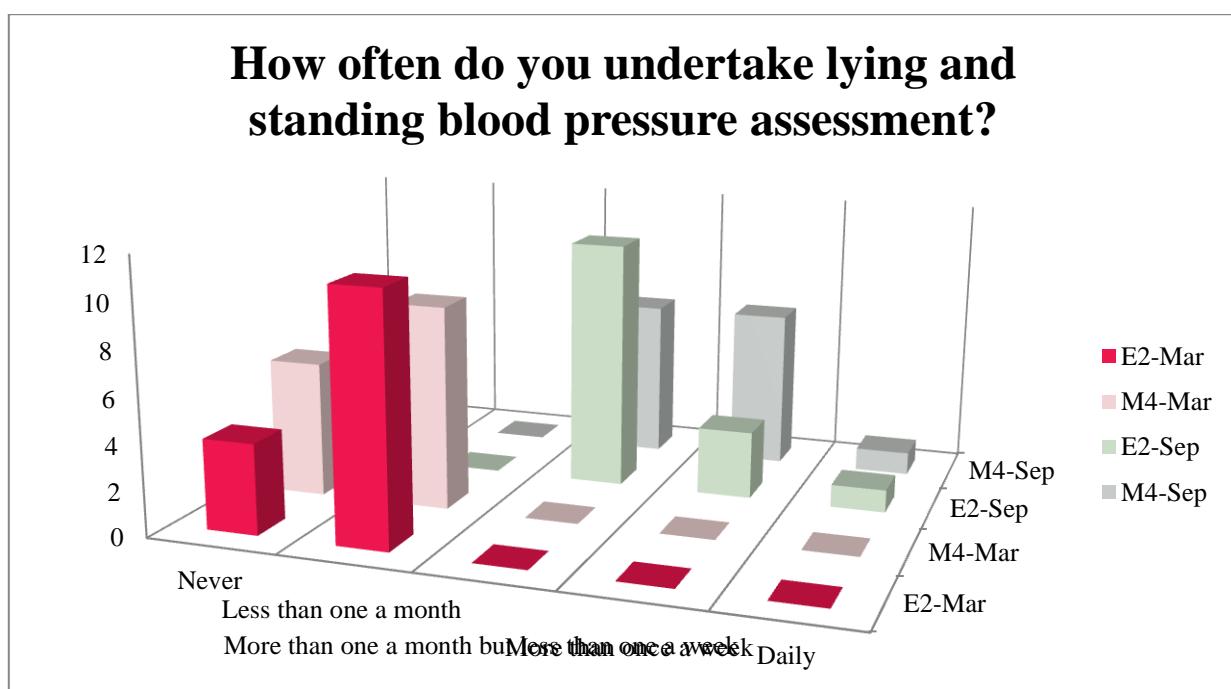


Figure 5

A sample of electronic discharge letters from the acute hospital setting to patients' own General Practitioners shows a high number (84%) are outlining the diagnosis of postural hypotension and requesting community follow up.

The pathway is now being used in intermediate care which bridges the gap between acute hospital settings and either patient's own home or a Nursing/Residential home. A small sample audit shows that the assessments are being completed but some work needs to be done on document completion to meet NHS LA (National Health Service Litigation Authority) standards (**Figure 7**).

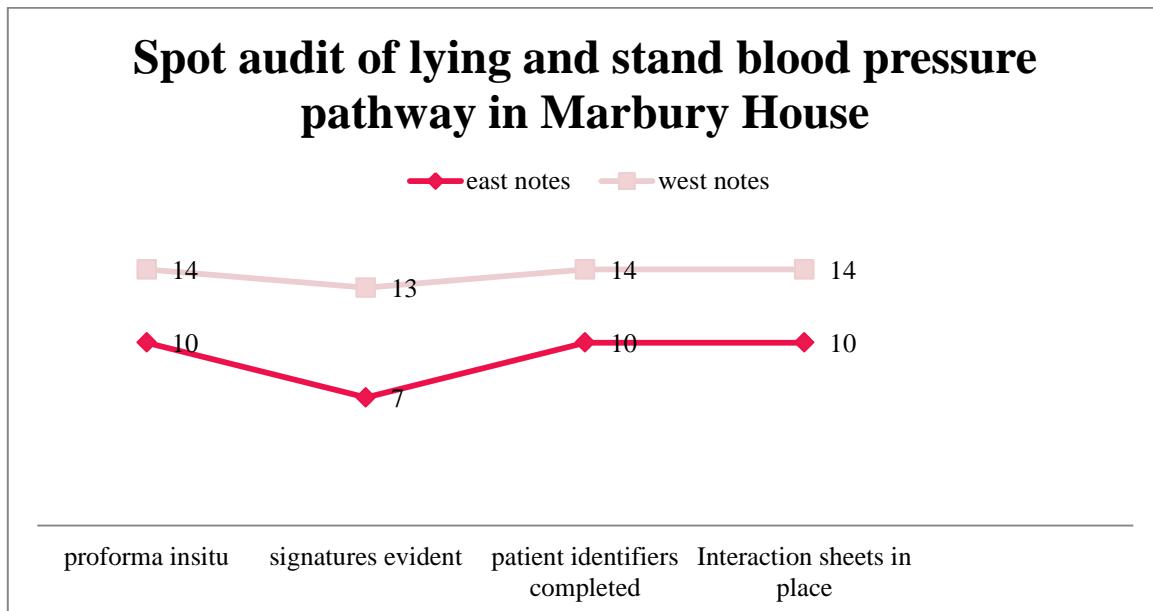


Figure 7

Has the pathway improved the effectiveness of medication reviews and management of Postural Hypotension?

The information gathered from the EPMA (Electronic Prescribing Medicines Administration) system and a manual patient notes search shows that of the sample audited on the target wards 60% of patients on M4 had a medication review within 24 hours of admission to the ward in March when the pathway was first introduced. This figure however is consistent with previous months and before the introduction of the pathway. Four months later the percentage of patients with a medication review within 24 hours increased to 85% and twelve months later is 83%.

The other target ward (E2) shows a similar pattern with a consistent increase from the beginning of the project while the 'control' ward has no clear pattern but did show an increase in later months; however this could be due to information contamination as the same team of clinicians could sometimes work across the target and control ward.

Has the project improved efficiency through clearer responsibilities and communication?

The pathway has improved efficiency by:-

- Giving a clear timeline for actions
- Having clear instructions for its use
- Streamlining into existing nursing documentation

The pathway has improved the recognition of responsibility by:-

- Outlining a standard for assessment
- Gives clear instructions regarding who to inform and action they should take
- Defines the roles of Doctors, Pharmacists and Nursing staff
- Gives guidance of professionals who will/may be involved in the pathway.

The pathway has improved communication by:-

- Offering a communication/instruction sheet to be used by staff when assessing a patients postural BP.
- The pathway acts as a framework that enables the pathway document to act as a 'single point of truth' A health professional looking at the pathway will know which colleagues from different disciplines have had input into that patient's care and treatment

Learning from the project



Workshop May 2013

The project has been a huge catalyst for change in the way we approach projects within the Quality improvement team. The success arising from coproduction meetings and workshops has had a big impact upon the way we look at joined up working. The project, in the end, involved twenty five different departments and agencies all with positive contributions.

We have developed close links with the Adult Social Care Directorate and some private care companies who joined our working groups on a regular basis and in turn asked us to be involved in a community collaborative looking at health and social care issues. These links help to ensure that we have a balanced view of what was happening outside the acute sector. This again has forged strong links with other projects because we are now used to working together as a group rather than independently, with this whole health economy working we are now able to pool resources, expertise

and experience which in turn increases the positive impact upon falls within community and acute settings.

The ward teams worked very differently; on reflection it was apparent that the ward management styles were very different. On one of the test wards the manager delegated the deputy ward manager to take the lead running the evidence based teams, this person showed herself to be a participative leader who encouraged her team to actively participate but led the decision making process, engaging and motivating her team. This ward was proactive and the feedback was always timely and plentiful, attendance at the project group meetings was 100%.

The second ward is led by a manager who has input into on the ward everything and spreads herself very thinly to cover all her responsibilities. This ward, while using the pathways during all the cycles of the PDSA, were not as enthusiastic as the other ward and this was reflected in the minimal feedback given to the project group, attendance was disjointed and rarely was a deputy delegated to represent. It appeared that little or no guidance was offered to group members and decision-making was left up to group members, it often leads to poorly defined roles and a lack of motivation. This was further emphasised during an informal interview with a team member.

On reflection, the project manager felt that possibly there was not enough time spent on the wards driving the project forward. It was felt at the time that in order to really measure the pathways effectiveness as a standalone, self-explanatory document that limited time would be spent coaching staff in its use. One ward flourished under this approach whilst the other struggled somewhat.

The real learning from this is not to assume that clear communication with colleagues ensure the job gets done. There are many reasons why colleagues may not hear or understand what others are saying. That is because each person's readiness to hear depends on many factors.

If we were to do this over again we would carefully consider three components: the audience, what is said and when it is said.

For example, it is widely recognised that the first step in managing change is building awareness around the need for change and creating a desire among others. Therefore, initial communications should be designed to create awareness around the business reasons for change and the risk of not changing. Likewise, at each step in the process, communications should be designed to share the right messages at the right time.

Communication planning, therefore, begins with a careful analysis of the audiences, key messages and the timing for those messages. As a project Manager it is important to a communication plan that addresses the needs of front-line employees, supervisors and executives. Each audience has particular needs for information based on their role in the implementation of the change.

One area that could have been improved upon was engaging the junior doctors in the pathway, specifically asking for community follow up on the e-discharge system. This area was the responsibility of two consultant geriatricians, one of whom has direct teaching duties. It was unfortunate that the teaching style of this person was to begin a session and see where it went rather than stick to a prescribed lesson plan so often the subject of the lying and standing blood pressure pathway was not discussed. This deficit in learning was discussed on several occasions each time with an undertaking to address the issue and the project group looked at different ways to send out the message to junior doctors, including face to face meetings and written information. In the end we had to rely on nurses educating them and encouraging their participation.

A second challenge was a lack of senior support in one business group, this made it very difficult to roll out the pathway across the Trust and huge efforts had to be made to work around the problem as it became obvious that we were unable to work with the problem. This setback could have been

significant in the delay of the roll out beyond the target wards but the project manager presented to other senior members of staff and engaged the business groups by showing the success of the pathway and making it a talking point in several different forums in order to ensure the project stayed current. This approach worked well and support was given by the business group and the roll out continued.

The pathway for orthostatic hypotension will have far-reaching effects because it jointly addresses several big gaps in falls prevention: medication reviews, communication with patients and between providers, and cognitive assessments. The pathway involves training, assessments, and interventions for orthostatic hypotension, as well as improved discharge information for patients, families, carers, and GPs.

Identifying orthostatic hypotension improves patient safety through reducing falls and unnecessary medications. Patients (along with their families and carers) are supported to become active partners in their own care, especially those diagnosed with dementia and delirium.

With more engagement and higher quality assessments, staff can work more effectively and efficiently: less paperwork, quicker pathways, and fewer incidents.

The project has really taught us that we need to have trust in ourselves and our colleagues to truly buy into PDSA and undertake the changes and overcome the barriers that this can bring. However, if we were to do anything different it would be looking at individual's responsibilities; personality and response to challenge and change is what makes us unique and it is easy for the creative, enthusiastic and often loudest to take the lead when the more reflective, measured members of the team need to be heard.

It is easy to see why often projects take the easier option and are driven in a very prescriptive way with carefully controlled design. Following the evolving pathway has been interesting and challenging, both personal and strategically.

Plans for sustainability and spread

We have planned a strategy for sustainability beyond the end of the project:

- The pathway has now been included in the existing Standard Operating Procedures for admitting patients; it has also been outlined in the admission policy.
- There is an existing audit carried out periodically to ensure compliance with NHS LA requirements.
- There is a recurring training programme on falls' documentation carried out by the Risk Team within the Trust and the pathway is included in this.
- It has been included in the core training that all new Healthcare Assistants joining the Trust undergo.

- The pathway documentation and its use will be embedded into the audit programme that is undertaken by junior doctors as part of their development. The audit will take place in six months' time and the results used to determine any further changes that may need to be made.
- The project is also included in the Trust's 'lessons learned' initiative linked with the CQUIN for 2014/15.
- The CCG have committed to looking at future funding for community falls clinics where the pathway will be integral to the assessment of patients.

During the course of the project we have met many different people who have expressed an interest in the pathway; we are committed to sharing our findings with them and will form an active partnership with any interested parties.

Cost Impact

- **Financial Summary**

During the planning stages of the NOHARM project it was recognised that the cost saving, if any, would be minimal and the real benefit would be to the care services provided to patients. The greatest benefit has been that patients now receive their investigations (BP) in a timely manner enabling Drs to diagnose orthostatic hypotension earlier and review medication.

The financial benefits, however, are difficult to quantify as reducing length of stay in hospital has not been evidenced because of the diverse co morbidities experienced by patients who have been admitted due to a fall. It was identified that there would be a cost saving through medication review, however in reality individuals' medication often has been changed to a less offending drug rather than stopping the drug altogether. A very high number of the patients undergoing the lying and standing blood pressure assessment have some form of dementia, which can be a costly disease in terms of medication.

There was a concerted effort to design the pathway so that it has the least pages possible and is generic across all disciplines to cut down on printing costs. Beyond the end of the project each business group will incur the cost of printing further pathways and pharmacy stickers.

We hosted two large workshops with a cost of catering and room hire that was not originally budgeted for, but the benefit that the workshops brought in terms of moving the co-production and partnership working forward was worth the spend.

Collecting data in varying forms was difficult and it was identified that collecting data electronically would have been easier, there was an initial outlay to purchase iPads to enable this process, the major benefit will be to reduce time manually collecting data and then having to manually input onto a spreadsheet. This meant that more time could be spent on other aspects of the project.

There was no financial impact on the ward budgets during the project. Towards the end it was identified that the wards would have benefitted from more "Dynamaps" - blood pressure taking machines, as both test wards had a high number of pts and lying and standing BP's were not being done in a timely manner as machines were in use.

Some patients had difficulty standing for their BP and a further piece of equipment was identified by ARJO called the "STEDDY", this supports patients to stand and would have been invaluable during the project. The Trust had agreed to fund this equipment.

The initial project bid requested funding for a project assistant however at the beginning of the project it was agreed that it would be more valuable to appoint a person who has assisted on projects previously so we appointed a higher grade doing less hours. This person was invaluable as she also had worked on our falls collaborative project in the past so had a vast amount of knowledge and experience so for further projects this would be a recommendation.

The NOHARM project steering group included a Business Accountant who monitored all spend and reported back to the Steering group on a quarterly basis.

Salaries were backfilled for the time that was spent on meetings, workshops and training but this had been budgeted in the original proposal and the financial summary shows the project was on target with the forecasted spend.

Appendices

- 1. First Lying and Standing Blood Pressure Document**
- 2. Final Lying and Standing blood Pressure Pathway document**
- 3. Example of audit questions**
- 4. Trust Falls risk assessment including pathway**
- 5. Resources**

Appendix one



Lying and Standing Blood Pressure

Name	
DOB	
Hospital Num	
Consultant	
Ward	

	Lying BP (for 5 mins)	Standing BP 1 min	Standing BP 3min	Standing BP 5 min	Circle Y/N
Date	BP Pulse				Dizzy/ lightheaded Y/N
Date	BP Pulse				Dizzy/ lightheaded Y/N

Lying and standing blood pressure only needs recording once- unless requested.

Patients should lay as flat as possible for 5minutes

Appendix Two

Lying and Standing Blood Pressure Pathway

Name:
Date of Birth:
Hospital Number:
Community Patient Identifier:
Consultant:

- This pathway should be used in conjunction with the falls risk assessment if the patient triggers one or more of the following criteria;
 - a. Over seventy five years old
 - b. Has a history of falls
 - c. Has a history of dizziness on standing
- The first lying and standing blood pressure assessment should be carried out either within the first 24 hours after admission (non-surgical patients) or for surgical patients within 24 hours of mobilising post-op.
- The assessment is to be carried out by a health care professional trained in the taking of lying and standing blood pressure.
- The comments box should be used to record any variance.
- Assistance may be needed to enable the person to stand, this must be recorded.
- All results should be made known to the clinician in charge of the patient's care.
- The second assessment, if required, should be undertaken forty eight hours after a medication change.
- There are further assessment records to be used at clinicians' discretion.

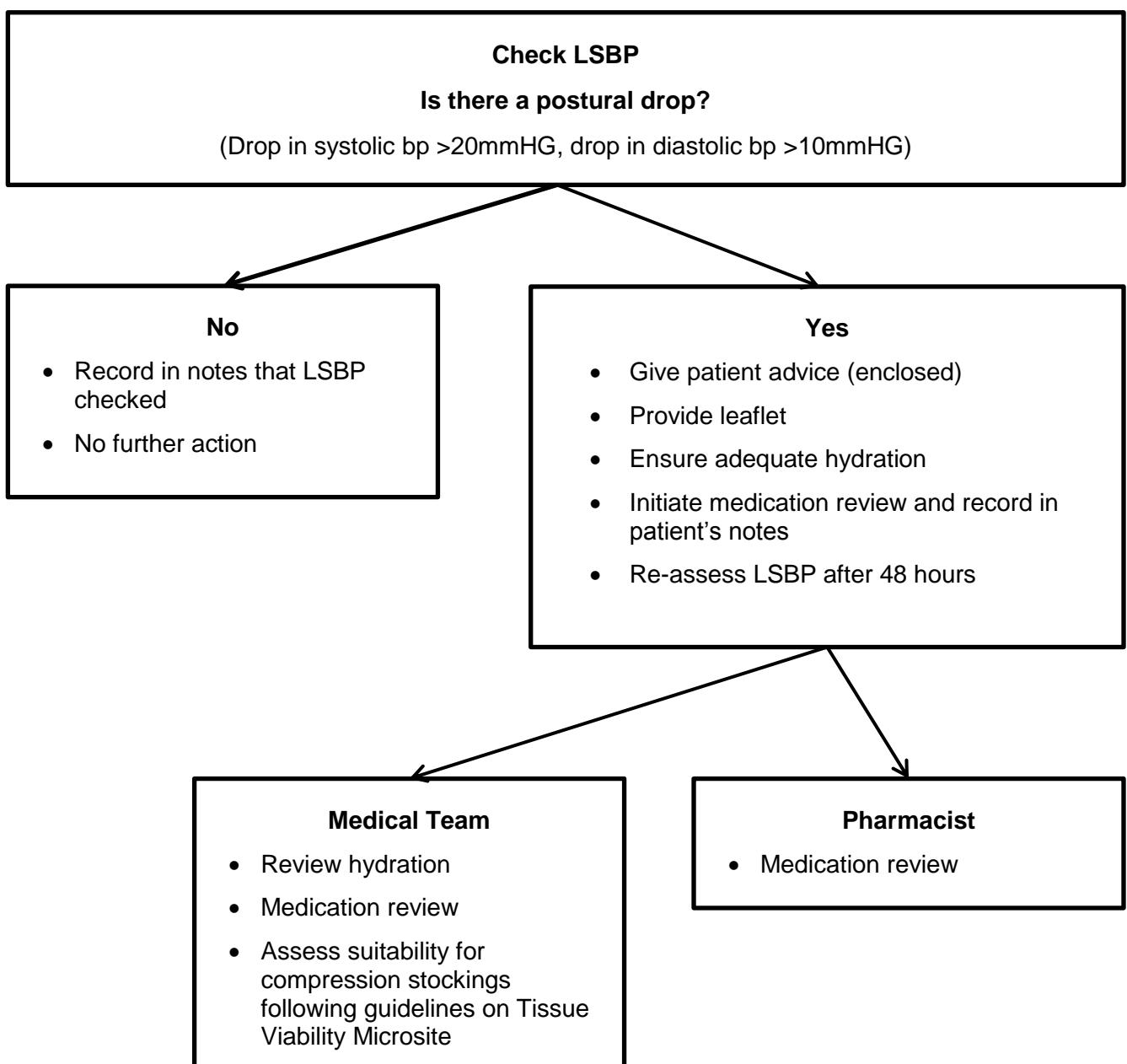
Medication and Therapist stickers

- There are sticker entry points to be used by therapists and pharmacists after a review or contact has been made.
- This sticker entry point is to flag up that a contact has been made and that entries should be read in patient's notes.
- It is not an expectation that notes are to be made in the pathway; however there is a small text box for anything thought relevant.

Colleague Sheets

These sheets are provided for colleagues from any other agency who may wish to record their contact with the individual.

Indications	Procedure
<ul style="list-style-type: none"> • All patients over 75 • History of falls • Symptoms of postural dizziness 	<ul style="list-style-type: none"> • Patient to have been lying down for at least 5 minutes • Measure lying blood pressure on a straight arm • Ask patient to stand • Measure blood pressure immediately after standing and then again at three and five minutes • Record results on chart • If patient unable to stand or comply inform doctor



Patient Name: Id Number:

ORTHOSTATIC HYPOTENSION ASSESSMENT

	Date		Lying BP (after 5 mins)	Standing BP On Standing	Standing BP 3min	Standing BP 5 min	Dizzy / Light- headed (circle)	Postural Drop	Sign, Print Name & Designation
1 st assessment		L	BP				Yes / No		
2 nd assessment		R	Pulse				Yes / No		
Variance									

	Date		Lying BP (after 5 mins)	Standing BP On Standing	Standing BP 3min	Standing BP 5 min	Dizzy / Light- headed (circle)	Postural Drop	Sign, Print Name & Designation
		L	BP				Yes / No		
		R	Pulse				Yes / No		
Variance									

Patient Name: Id Number:

Lying and Standing Blood Pressure Pathway

Medication review sticker	
Physio review sticker	
Occupational Therapy review sticker	
Dietetics	
Speech and Language Therapy	

Appendix Three

■ Reducing Falls & Unnecessary Medication Through An Orthostatic Hypotension Pathway ■

Casenote Number

--	--	--	--	--	--

Patient Age

--	--	--

Ward

	E2		M4
--	----	--	----

Was fall risk assessment completed?

Yes No

Has the patient got a LSBP pathway in their notes?

Yes No

Is the front page filled out correctly?

Yes No

Is patient name and unit number on every page?

Yes No

Has first LSBP assessment been carried out?

Yes No

If not:

Was it attempted and recorded as unsuccessful?

Yes No

Was there a postural drop?

Yes No

If so:

Was a medication review requested?

Yes No

If yes:

Was a medication review carried out?

Yes No

Was a medication review completed within 48 hours of request?

Yes No

If so:

Was medication changed?

Yes No

Was a repeat lying and standing blood pressure done?

Yes No

Were the flow chart tick boxes completed?

Yes No

■ DRAFT ■

Appendix Four

FALLS RISK ASSESSMENT INCLUDING BED RAILS

To be completed for all Adult In-Patients as per the Trust In-Patients Falls Standard Operating Procedure

Patient Name:	Date of Admission:
Hospital No.	NHS No.

Falls Risk Assessment:

If answer to any of the Screen Questions below are YES, complete the bed rails risk assessment form below, and Falls Risk Care Plan on the back of this form. To be re-assessed on transfer to another ward (within 6 hours), if clinical condition changes, after a fall, or weekly if no changes.

If answers are NO, to be re-assessed on transfer to another ward (within 6 hours), if clinical condition changes, after a fall, or weekly if no changes.

Falls Risk Assessment must be completed for all Adult In-Patients within 6 hours of admission and on transfer from another area. Bed Rails Risk Assessment to be completed if any answers to the screen questions below are Yes.	Ward:	Ward:	Ward:	Ward:
	Initial Assessment Date/Time:	Review Assessment Date/Time:	Review Assessment Date/Time:	Review Assessment Date/Time:
Screen Questions:				
History of Falls before Admission? (within the last 12 months prior to admission)	Yes / No	Yes / No	Yes / No	Yes / No
Falls since Admission?	Yes / No	Yes / No	Yes / No	Yes / No
Tries to Walk Alone but Unsteady / Unsafe?	Yes / No	Yes / No	Yes / No	Yes / No
Patient or Relatives anxious about Falls?	Yes / No	Yes / No	Yes / No	Yes / No
Print Name, Signature and Grade of Nurse Completing Assessment:				

Bed Rails Assessment:

Mental State	Mobility		
	Patient is very Immobile (bedfast or hoist-dependent)	Patient is neither independent nor immobile	Patient can mobilise without help from staff
Patient is confused and disorientated?	Use Bed Rails	Bed Rails <u>NOT</u> Recommended	Bed Rails <u>NOT</u> Recommended
Patient is drowsy?	Bed Rails Recommended	Use Bed Rails	Bed Rails <u>NOT</u> Recommended
Patient is orientated and alert?	Bed Rails Recommended	Bed Rails Recommended	Bed Rails <u>NOT</u> Recommended
Patient is unconscious?	Bed Rails Recommended	N/A	N/A

Taken from the National Patient Safety Agency's Safer Practice Notice 'Using Bed Rails Safely and Effectively'

- Use the risk matrix in combination with nursing judgement.

- Patients with capacity can make their own decisions about bed rails use.
- Patients with visual impairment may be more vulnerable to falling from bed.
- Patients with involuntary movements (e.g. spasms) may be more vulnerable to falling from bed. If bed rails are used, may need padded covers.
- Ensure you know how to fit bed rails correctly, including assessing any potential entrapment gaps.

Are Bed Rails required?								
Yes	No	Date	Time	Rationale	Signature	Review Date	Bumpers Used	

FALLS RISK CARE PLAN

Patient Name:	Hospital No.		
NHS No.	Ward:		
Patient's Problem: Is at risk of falls	Problem Number:		
Short Term Goal	To reduce risk of patient falling	Long Term Goal	To keep patient harm free

<u>Nursing Interventions</u> Assess against criteria below State Yes – criteria in situ State No – not needed or required	Ward:	Ward:	Ward:	Ward:
	Initial Assessment Date/Time:	Review Assessment Date/Time:	Review Assessment Date/Time:	Review Assessment Date/Time:
Ensure the patient's call bell is within reach and patient understands how to use it.				
Ensure their footwear is well-fitting and non-slip (<i>if not, refer to slipper project, where applicable</i>).				
If the patient is on night sedation, ensure this is reviewed on admission.				
Does the patient need to be moved to the most appropriate place on ward? State where				
Falls Leaflet to be given to patient or family (<i>on first assessment</i>)				
Apply a yellow wrist band.				
Display a falls hazard sign above the bed and indicate on electronic handover.				
Is a bed/chair sensor alarm required?				

(refer to SOP/Flow Chart)				
Is a low profiling bed / electric bed required to reduce falls from height? (refer to SOP/Flow Chart)				
If the patient's falls are associated with the need to use toilet, offer toileting every 2 hours (refer to <i>intentional rounding document</i>).				
Has a bed rails assessment been completed? Are they required?				
Lying and Standing Blood Pressure to be undertaken as per pathway if the patient triggers one or more of the following criteria: a. Over seventy five years old b. Has a history of falls c. Has a history of dizziness on standing				
Additional Comments				
Date Care Plan Discontinued:				
Print Name, Signature and Grade of Nurse completing Assessment / Care Plan				

Appendix 5: Resources from the project

Please attach any leaflets, posters, presentations, media coverage, blogs etc you feel would be beneficial to share with others

Cash for project aiming to drop number of falls

STEPPING Hill is leading the way in helping to reduce the number of patients injured in falls through a new research project. Bosses at the Hospital have been awarded £75,000 from the national Health Foundation charity to investigate falls. They are looking at ways to reduce them and unnecessary medication for people with orthostatic hypotension – a condition which can cause people to feel dizzy and fall when they stand up. Falls are a nationwide problem, costing the NHS around £15m a year – and around £100,000 to Stepping Hill. If the new 15-month project is successful, its findings will be shared with hospitals across the NHS. Stepping Hill is the only hospital in the north west to receive funding through the scheme. Iain Rogers, nurse and project leader at Stepping Hill, said: "Receiving injuries from falling over is one of the biggest problems in hospitals today, particularly among older patients. "With this project we hope to have a real impact in reducing these numbers, which would be great news for patients, not just at Stepping Hill, but across the country."

Stockport Express Jan 2013



High Peak Radio.msg

High Peak Radio Interview

Feb 2013

- 'The Role of Co-Production in Improvement'
Blog written by the Project Manager and published on The Health Foundation website
- Article in the Stockport Health Watch Magazine June 2013
- Several mentions in the Stockport NHS Foundation Trust team briefs
- Highlighted in the Annual Shared Leadership presentation 2013