Working with SHAs case study: Taking action to prevent patient falls

Overview

In 2009, North Bristol NHS Trust took up the challenge to create and champion their own toolkit to prevent patient falls. The process has effectively reduced falls and helped to raise staff awareness of the issues of quality and safety in the hospital.

Project details

In 2009, the nursing director and the lead clinician for elderly care began working together to decrease patient falls in the hospital. With the active engagement of a number of clinicians, they began to develop the tools and guidance hospital staff would need to improve in this area.

The complete toolkit was tested, then made available to all staff on the hospital IT system.

The toolkit included guidance on:

- essential care
- reducing harm from falls
- what to do after a fall in hospital
- the use of bed rails
- nursing competencies.

It included a number of practical tools, including:

- a presentation on reducing harm from falls
- a risk assessment tool
- intentional rounding technique for falls . This is a process where the nurse visits each patient at regular intervals and performs certain tasks for them and assessments for example, checking they have a call bell or need the toilet.
- adult bed rail risk assessment tool
- a leaflet and poster
- lists and codes for equipment
- a list of ward champions
- the falls audit report.

Each ward’s champions work to raise awareness and reduce falls in their area. The easily accessible resources mean they have all the necessary tools to monitor and influence staff behaviour and embed improvement.

Impact

Along the way the hospital has been measuring its progress. Initially the number of reported falls increased. This was expected, as the project raised awareness and reporting. The number of falls is now decreasing. In one ward where staff have embraced the intentional rounding for falls technique, falls have reduced by 50%. Student nurses are also using the technique as a prompt to increase contact with patients. It is helping them develop their interpersonal skills and the added interaction is well received by patients and their families.

Learning

The majority of falls are avoidable. This project has enabled the trust to learn about, and take seriously, what causes patients to fall and to realise that they can be prevented by being proactive. By conducting intentional rounding and keeping an audit of the steps that have been taken with a patient, if a fall occurs all the evidence is in hand to see whether that fall could have been avoided.

Some additional and surprising learning has arisen from the issue of falls by patient with cognitive disorders, such as dementia. There were a high number of falls in the toilet areas for these patients.

By investigating issues affecting dementia patients the team was able to address environmental issues such as changing the all-white colour scheme, which makes it more difficult for patients to orientate themselves. Patients were struggling to differentiate objects and surfaces, becoming confused, unsteady and falling. With this learning they have been able to ensure that the hospital the trust is building will be equipped with contrasting toilets. This will make the environment much easier to navigate and help prevent patients from falling.