Falls in hospitals
The ten biggest challenges we all face, and new ideas for tackling them

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Assessment tools

Delirium

Dementia
<table>
<thead>
<tr>
<th>Reference</th>
<th>Title</th>
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<tbody>
<tr>
<td>NICE CG 161 2013</td>
<td>Falls in older people clinical guideline update Appendix E Evidence tables</td>
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<tr>
<td>Myakie-Lye et al. 2013</td>
<td>Inpatient Fall Prevention Programs as a Patient Safety Strategy: A Systematic Review</td>
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<tr>
<td>Cameron et al. 2012</td>
<td>Interventions for preventing falls in older people in care facilities and hospitals.</td>
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<td>Spoelstra et al. 2012</td>
<td>Falls prevention strategies: an integrative review</td>
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<tr>
<td>Oliver, Healey et al. 2010</td>
<td>Preventing falls and fall-related injuries in hospital</td>
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<tr>
<td>Oliver et al. 2007</td>
<td>Strategies to prevent falls and fractures in hospitals and care homes: systematic review and meta-analyses.</td>
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<td>Coussement et al. 2008</td>
<td>Interventions for preventing falls in acute- and chronic-care hospitals: a systematic review and meta-analysis.</td>
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</tbody>
</table>
The 'How to' Guide for Reducing harm from falls

Let's talk about restraint

Rights, risks and responsibility

A National Audit of Falls in Hospitals:
Report of the 2011 pilot
Patients’ risk of falling in hospital

“Do not use fall risk prediction tools to predict inpatients’ risk of falling in hospital”

“Regard all inpatients aged 65 years or older as being at risk of falling in hospital”

* Plus inpatients aged 50 to 64 years (if clinical judgement that underlying condition could cause falls)
Idea 1: Think intervention and work backwards

“Who would benefit most from this particular intervention?”

More reading with hyperlinks to other resources

http://britishgeriatricssociety.wordpress.com/2013/05/16/all-down-to-numbers/
Are they safe to walk alone?

Willing and able to ask for help?

NO PROBLEM!

BE THERE BEFORE THEY TRY!
“Ensure that aspects of the inpatient environment that could affect patients’ risk of falling are systematically identified and addressed.”

Including:

- flooring
- lighting
- furniture
- fittings such as hand holds
Idea 2: Use the skills of your occupational therapists to look at fittings, flooring and lighting in your toilets as if they were conducting a home hazard assessment, and order minor works to improve the environment.
Challenge 3: Privacy and dignity or safety first?
“A MAN MAY BE DOWN
BUT HE’S NEVER
OUT!”
HOME SERVICE FUND CAMPAIGN
SALVATION ARMY
MAY 19-26
1919

Life is brighter after GUINNESS
“GUINNESS IS GOOD FOR YOU”
Idea 3: Ask your patients if they want you to stay with them, wait outside, or go right away. If they can no longer express preferences, ask family/friends about their attitudes to privacy.
Multifactorial assessment may include:

- continence problems
- cognitive impairment
- falls history (causes, consequences, & fear of falling)
- footwear that is unsuitable or missing
- health problems that affect falls risk
- medication
- postural instability, mobility and/or balance problems
- syncope syndrome
- visual impairment
High levels of dementia and delirium in inpatient fallers

- 88% had mobility problems
- 65% were cognitively impaired
- 65% had bone health problems
- 58% had continence problems/urgency
- 49% culprit medication
- 42% had orthostatic ↓BP/cardiovascular
- 37% impaired vision
- 36% had delirium

Royal College of Physicians 2012 Clinical Effectiveness and Evaluation Unit Report of the 2011 inpatient falls pilot audit www.rcplondon.ac.uk based on case note review of 447 patients in 46 hospitals who fell in September 2011 – data drawn from those where assessment was not omitted, so potentially skewed
Anytown Hospital
Falls prevention policy
Idea 4: In your policies and care plans and guidance, focus on cognitively impaired patients as the norm, with interventions for cognitively intact patients as the exception.
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### Risk factors in hospital fallers

<table>
<thead>
<tr>
<th>Hospital inpatients</th>
<th>Odds Ratio (95% CI)</th>
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<tr>
<td>History of falls</td>
<td>2.85 (1.14–7.15)</td>
</tr>
<tr>
<td>Sedatives</td>
<td>1.89 (1.37–2.60)</td>
</tr>
<tr>
<td>Antidepressants (yes vs. no)</td>
<td>1.98 (1.00–3.94)</td>
</tr>
<tr>
<td>Cognitive impairment</td>
<td>1.52 (1.18–1.94)</td>
</tr>
<tr>
<td>Age (for 5 years increase)</td>
<td>1.04 (1.01–1.06)</td>
</tr>
</tbody>
</table>

### Risk factors for injury in hospital fallers

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<thead>
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<th>Hospital inpatients</th>
<th>Odds Ratio (95% CI)</th>
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<tr>
<td>SRRIs (yes vs. no)</td>
<td>1.84 (1.04-2.67)</td>
</tr>
<tr>
<td>2+ antipsychotic</td>
<td>3.26 (1.20-8.90)</td>
</tr>
<tr>
<td>Opiate</td>
<td>1.59 (1.14-2.20)</td>
</tr>
<tr>
<td>Diuretic</td>
<td>1.53 (1.03-2.26)</td>
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</table>

Reducing sedative medication reduces falls rates

<table>
<thead>
<tr>
<th>Study</th>
<th>Effect on medication use</th>
<th>Falls</th>
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<tr>
<td>Haumschild et al. 2003</td>
<td>Through ward visits by pharmacists, significantly reduced prescribing rate of “culprit” medication</td>
<td>Reduced by 47% (p&lt;0.05)</td>
</tr>
<tr>
<td>Peterson et al. 2005</td>
<td>Through computerised medication ordering system alerts, significant reductions in prescriptions of neuroleptics and sedatives</td>
<td>Reduced by 55% (p &lt;0.001)</td>
</tr>
<tr>
<td>Healey et al. 2013</td>
<td>Through educating nurses to influence colleagues as part of multifactorial intervention, reduced night sedation from 34% to 10% of patients</td>
<td>Reduced by 25% (p&lt;0.01)</td>
</tr>
</tbody>
</table>
Idea 5: Use pharmacy accounts to monitor initiatives to drive down your levels of sedative use
Multifactorial assessment may include:

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Do we really encourage mobility?

- Older hospital patients in the USA who could mobilise averaged 332 steps a day (about 20 steps each waking hour).
- Mobile pre-discharge older patients in UK spent 25 minutes a day standing or walking; most times when they walked, they walked less than 20 steps.
- “……[these patients] had a lack of opportunity to mobilise rather than a lack of ability to mobilise”

Fisher et al, 2012 factors that differentiate level of ambulation in hospitalised older adults  Age & Ageing 41 (1) 107-111
Roberts et al. 2012 Measuring activity in older inpatients  Age & Ageing research letters Feb 1 2012
“....... the alarm was brilliant – after we’d been using it for a few days he didn’t even try to stand up any more.”

Ward sister, overheard at a conference
“Ultralow bed ordered to ensure he cannot get to his feet without nurses.”

The safe use of ultra low beds | Signal

Reference number 1309
Issue date 14 February 2011
Type Signal

This Signal is about using ultra low beds safely and appropriately.

A simple incident reads:

“Patient has rolled off High/Low bed with crash mat in place and bed at lowest height. Banged his head on the bottom corner of the locker. Cut to right side of head bleeding profusely. Wound covered by dressing pads with pressure to staunch flow.”

Ultra low beds can help to prevent harm from falls - particularly for patients with delirium who are at risk of falling out of bed, but who cannot be given bedrails as they might try to climb over them (see NHS bed rail guidance). However, ultra low beds need to be used safely and appropriately.

A search of the National Reporting and Learning System (NRSL) database of all incidents reported from 1 November 2003 to 24 June 2010 identified a series of patient safety incidents related to the use of ultra low beds. These included:

• Injuries from floor-level furniture or fittings such as radiators, pipes, or lockers (including one serious burn);
• ultra low beds placed close to a wall but not flush with it, creating potential for asphyxial entrapment if the patient slipped between the side of the mattress and the wall (see NHSLA bed rail guidance);
• ultra low beds left at working height, leading to falls from height;
• patients who appeared to have tripped over crash mats used beside the ultra low bed (including three fractured hips).

Some reports suggested ultra low beds were seen as a universal falls prevention solution and were therefore provided inappropriately for mobile patients (see RCN restraint guidance). Additionally, some reports suggested that ultra low beds had been used with bedrails raised, negating their purpose.

It is important to note that even when ultra low beds were used correctly in the lowest position, some patients still sustained serious injuries. These included fractured hip and intracranial injury. As a result, it is important that even falls from ultra low beds are taken seriously (see the Rapid Response Report, Essential care after an Inpatient fall).

Local guidance, training and specialist advice should be provided to help staff to use ultra low beds safely and appropriately as possible.

Please contact us with your initiatives to reduce risks in these areas.

http://www.nrls.npsa.nhs.uk/resources/?EntryId45=94850
“.... if we can get the intentional rounding right none of our patients will ever have to get out of their chairs except for the toilet.”

Snelling 2013 ‘Ethical and professional concerns in research utilisation: Intentional rounding’ Nursing Ethics 1–14
Idea 6: Take the early and frequent mobilisation of medical patients as seriously as we take the early and frequent mobilisation of surgical and trauma patients.
Multifactorial intervention

“ Ensure that any multifactorial intervention:

• promptly addresses the patient’s individual risk factors

• takes into account whether the risk factors can be treated, improved or managed during the patient’s expected stay

Do not offer falls prevention interventions that are not tailored to address the patient’s individual risk factors for falling.”
Are we a 24/7 service?

- 35% on all wards
- 30% on most wards
- 26% on one or some wards
- 9% not on any wards

NHS England
Idea 7: Bring together medical, therapy and nursing staff to find practical solutions that deliver everyday rather than weekday remobilisation & falls expertise
Information for patients should include:

- Explaining about the patient's individual risk factors for falling in hospital.
- Showing the patient how to use the nurse call system and encouraging them to use it when they need help.
- Informing family members and carers about when and how to raise and lower bed rails.
- Providing consistent messages about when a patient should ask for help before getting up or moving about.
- Helping the patient to engage in any multifactorial intervention aimed at addressing their individual risk factors.
The call buzzer and me

“Just buzz if you need anything.” That is the all too familiar sentence from a nurse as they leave your room in hospital. You hear that instantly recognisable sound of the call bells almost engrained in the air when you walk on to a ward. (It is less apparent on a really well run ward in my experience.)

I have spent the equivalent of nearly four months of my life as an in-patient, yet I have probably only ever pressed my buzzer maybe five times.

Why my reluctance to ask for help?

- It feels painfully symbolic of my loss of independence
- I know how busy the staff are and feel guilty
- I sense staff disapprove of patients who buzz too often and fear the reaction of whoever responds
I will always remember the first time I ever pressed my buzzer in hospital. It was a couple of days into my admission to the Gynaecology Unit and I woke up with excruciating abdominal pain. I was in proper agony. The reaction I received from the staff nurse was one of indifference. **I think this experience has conditioned me to be an infrequent buzzer.**
Idea 8: When it comes to encouraging patients to use the call buzzer, it’s not what we say, but what we do, that matters.
Challenge 9: extreme falls vulnerability requiring one-to-one observation
Idea 9: Make specialising special

- Training with recognised skills and status
- Teach personal resilience and coping skills
- Rotation and rest periods
- Access to diversion materials
- Consider permanent cohort observation rooms
I could easily have gone on …..

- Bedrails; neither routine use nor total elimination
- Falls aftercare; illness and injury detection
- What reported falls trends (don’t) tell us
- Visual impairment
- Recognise and celebrate success
Idea 10: Make haste slowly and do less but do it well

Absolutely must do

Probably should do if possible

Would like to do one day
I can’t promise you that you can prevent every fall
I can promise there is always something more we can do to prevent falls

Thank you for listening

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