

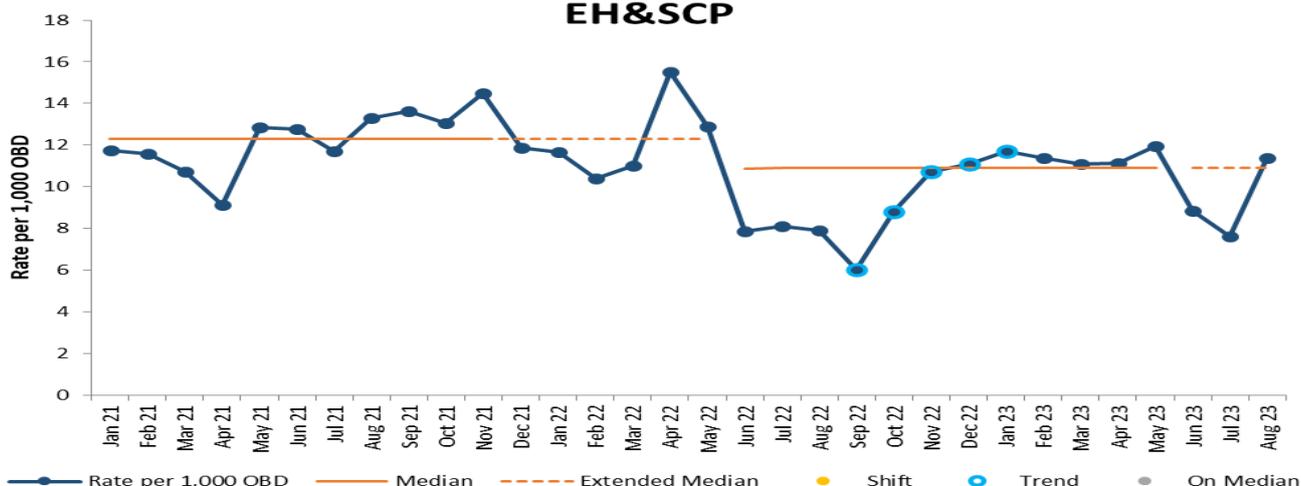
EH&SCP Falls Newsletter

Issue 3 August 23



Falls Awareness Week
#ThinkFalls #ActionOnFalls

**Monthly falls per 1,000 OBD
EH&SCP**



Falls Awareness Week

All Staff Update

'Let's talk Falls Lothian' is a new Teams channel to support Falls Awareness week which starts on 18th – 24th September.

There will be the opportunity to listen to lunch and learn sessions from Podiatry and Dietetics and how these link with Falls. It's also a forum to share all the great work that happens across Lothian to support and manage Falls.

You can access the Let's Talk Falls Teams Channel by clicking the link below. Make sure to join the Teams channel before Falls Awareness week so you don't miss the lunch and learn sessions.

[Let's Talk Falls Channel](#)



- Type **Lets Talk Falls** into intranet search and its top of the page
- **Mairi and Lorna** have updated the EH&SCP intranet site with falls awareness week materials and the updated risk poster



EH&SCP Falls Improvement Group

Members

Alison Glover - QI/Standards Lead & Co-Chair

Carrie McGill - OT Lead & Co-Chair

Meggan Hoy – SCN representing Rehab & MH

Kirsty MacFarlane – SCN representing Intermediate care

Samantha Wight – SCN representing HBCCC

Isla McGlashan –physiotherapy

Dr Tashfeen Chaudhry – Rehab

Dr Rosamund Ring - HBCCC Associate Specialist

Jacquie Brodie – QI and innovation, HBCCC/IC

Lorna Graham – Service Innovation nurse, Rehab

Philip Leung-Pharmacy

The above group meet quarterly in line with the NHS Lothian in patient delivery group, we review quarterly falls, feedback area improvements, share ideas from acute and other partnership areas and focus on any education gaps which are identified.

Our last meeting was August 23, below are topics we continue to discuss and work on

- ⇒ Identification of high areas of falls and harm providing data breakdown and support with improvement. Currently 2 areas in scope for support.
 - ⇒ Identification of falls priorities from monthly and 6 monthly assurance.
 - ⇒ Developing a resource pack and inventory for falls aids and equipment.
 - ⇒ Create a multifactorial risk poster
 - ⇒ Post Falls guidance poster
 - ⇒ Updated terms of reference
 - ⇒ Represent EH&SCP on other falls groups
 - ⇒ Kirsty sits on the NHS Lothian falls Education Group
 - ⇒ Alison sits on the Falls Data group
-



A Hello from Belinda Wilson, Falls Programme Manager

In December 2022, I took up the role of Falls Programme Manager which is a Lothian wide role, and I will be working on developing the Lothian Falls prevention and management strategy. My background is in project management, and leadership and I have worked on a wide variety of programmes including digital transformation, wellbeing and most recently the East Region Recruitment Service.

Part of my new role will be to review and improve accessibility of Falls educational resources for all health and social care staff and following a Lothian wide staff survey that provided feedback on what staff need, we are currently developing a new Falls platform to support staff in their day-to-day roles. Our public facing Falls internet page is under development with a new landing page to support people with falls prevention information in their local communities and our strategy work has recently commenced with a brain storming event to lay the groundwork for the Lothian Falls strategy.

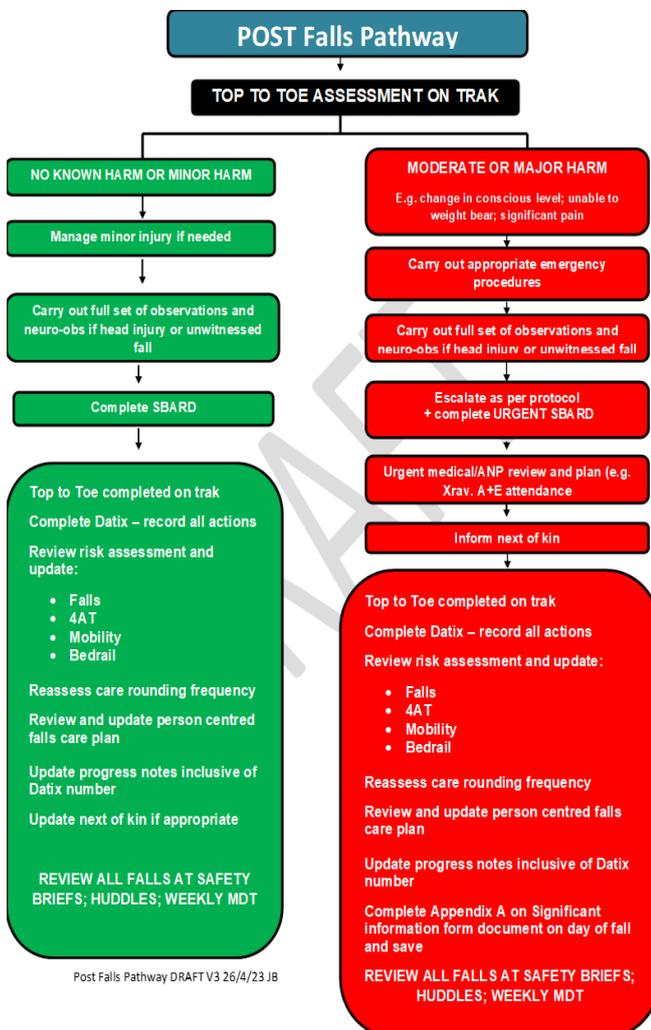
POST FALLS GUIDANCE

Why?

- We identified a lack of knowledge from staff feedback and assurance data.
- NHS Lothian post falls clinical pathway last updated 2014.

What we did

- Created a draft pathway based on datix classification
- Intended to be more about documentation post fall and not clinical guideline
- Pilot in 2 wards
- Asked for feedback from various groups including NHS Lothian falls education group



Feedback

- Liked visual
- Helpful to know the documentation to complete post fall
- Clinical guidelines need to be clearer
- Some staff may not know what classification it is, so might be better to have injury and non injury?
- Discussion around escalation post fall

Thoughts

- Change the title to focus on documentation
- Work with NHS Lothian education group to develop a standardised pathway for NHS Lothian

NEXT STEPS

- Discuss at next falls delivery group in December
- Work with Belinda Wilson and education team
- 2 members of EH&SCP staff are on the education group and will feedback
- Re-design focusing on documentation

UPDATED MULTIFACTORIAL RISK POSTER

Please share with staff in your areas



Falls Awareness Week
#ThinkFalls #ActionOnFalls

#ThinkFalls #ActionOnFalls CONSIDER THE RISKS

HISTORY OF FALLS

- Recent falls
- Lack of confidence
- Clinical concerns
- Falls risk assessment
- Safety brief
- At a glance board
- Family/carers/friends input
- Discuss at MDT
- Ward placement
- Action findings

SENSORY IMPAIRMENT

- Glasses check
- Hearing aid check
- Hazard free environment
- Reduce environmental noise
- Adequate Lighting
- Audiology/Optician referral

DIZZINESS & FAINTING

- Lying and standing BP
- Medical review
- Pharmacist review
- Fluid intake
- Mobility support

BLADDER & BOWEL

- BASIC tool if there is a worsening problem
- Infection
- Toileting regime
- Continence products
- Access to the toilet
- Medication review
- Bladder & bowel referral

NIGHT PATTERNS

- Normal night pattern
- Adequate night lights
- Reduce clutter
- Bed height (profiling beds)
- Bedrail review
- Personal items within easy reach
- Mobility aids within easy reach
- Observations frequency
- Calm environment
- Medication review
- Falls alarm

FEET & FOOTWEAR

- Loss of sensation in feet
- Pain in feet
- Appropriate footwear
- Well fitting footwear
- Podiatrist referral
- Orthotic referral

BALANCE AND MOBILITY

- Communication with physiotherapist/OT and/or medical staff
- Unsteadiness
- Mobility aids to transfer
- Mobility aids to keep moving
- Mobility aids in easy reach
- Mobility aids in good working order
- Brakes on the bed
- Correct position of bed and chair
- Items within easy reach
- Promote daily physical activity

COGNITIVE IMPAIRMENT

- Environmental
- Infection
- Malnutrition
- Pain control
- Dehydration
- Constipation
- Risk assessments (4AT)
- MDT review
- Previous patterns (WMTY/GTKM)
- Falls alarms
- Meaningful activity
- Visual orientation clues

DELIRIUM

- "SQID" : Single question in delirium
Is this person more confused than normal?
Ask the question to a friend, relative
- 4AT
- Medical review
- TIME bundle
- Environment
- Risk assessments review
- Effective communication
- Appropriate observations
- Review supervision

FOOD, FLUID & NUTRITION

- Weight loss
- Loss of appetite
- Risk assessments -MUST, Nutritional profile
- Hydration
- Food and/or fluid chart
- Dietetic referral

OSTEOPOROSIS

- Known diagnosis
- Risk review
- Medication review
- Dietary supplements

MEDICATION

- Medication review
- Side effects of drug changes
- Identified drugs that cause sedation, hypotension, bradycardia, tachycardia or periods of asystole

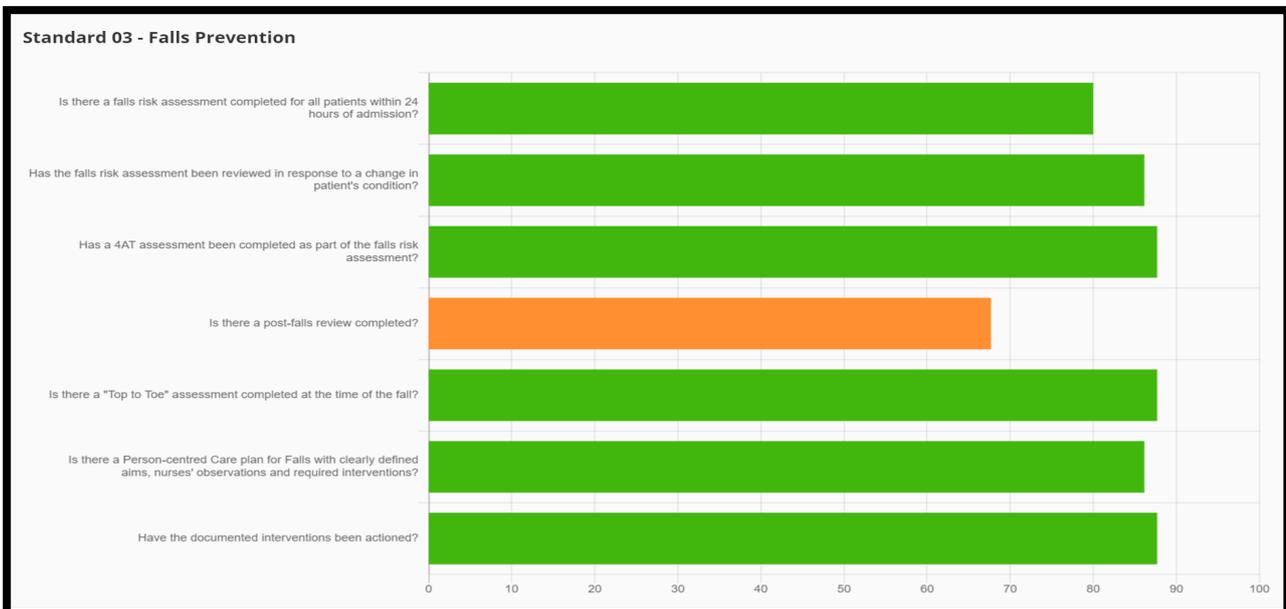


Falls Assurance

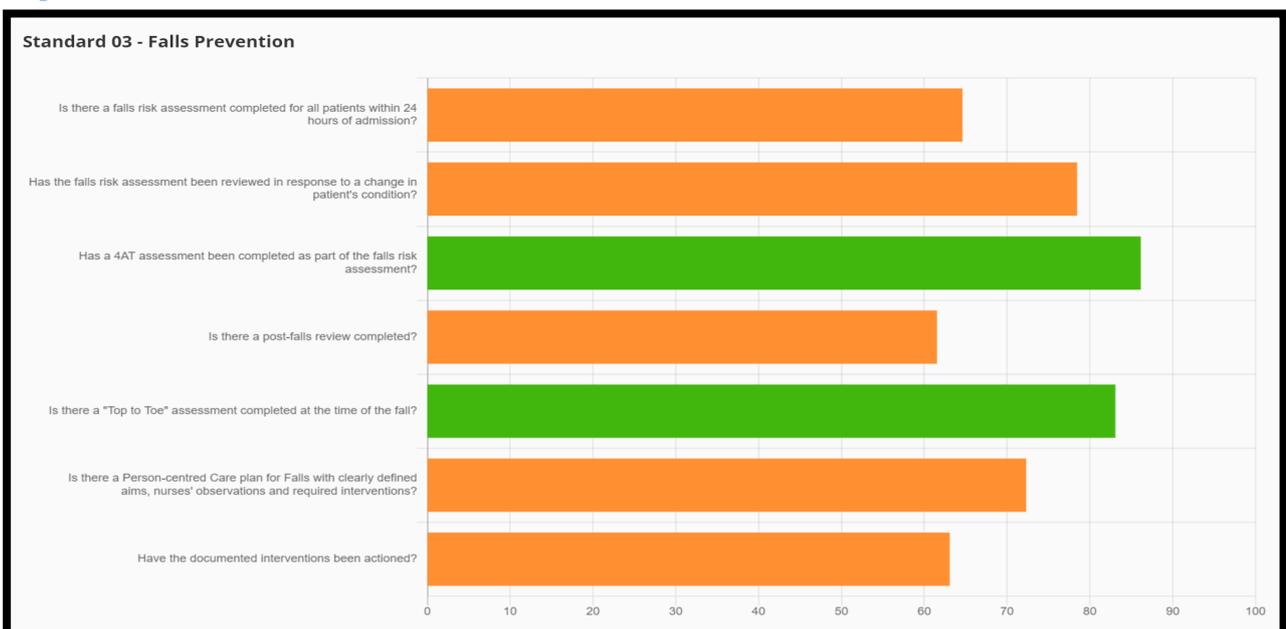
LACAS Comparison Standard 3 Falls Prevention

Lothian Accreditation and Care Assurance Standards (LACAS) are completed 6 monthly by SCN/DCN for each ward. These questions review local compliance and identify areas for improvement. The summary incorporates datix and Person Centred Assurance (PCAT) data. The graph below is for all EH&SCP In-patient beds.

Cycle 5 July 23



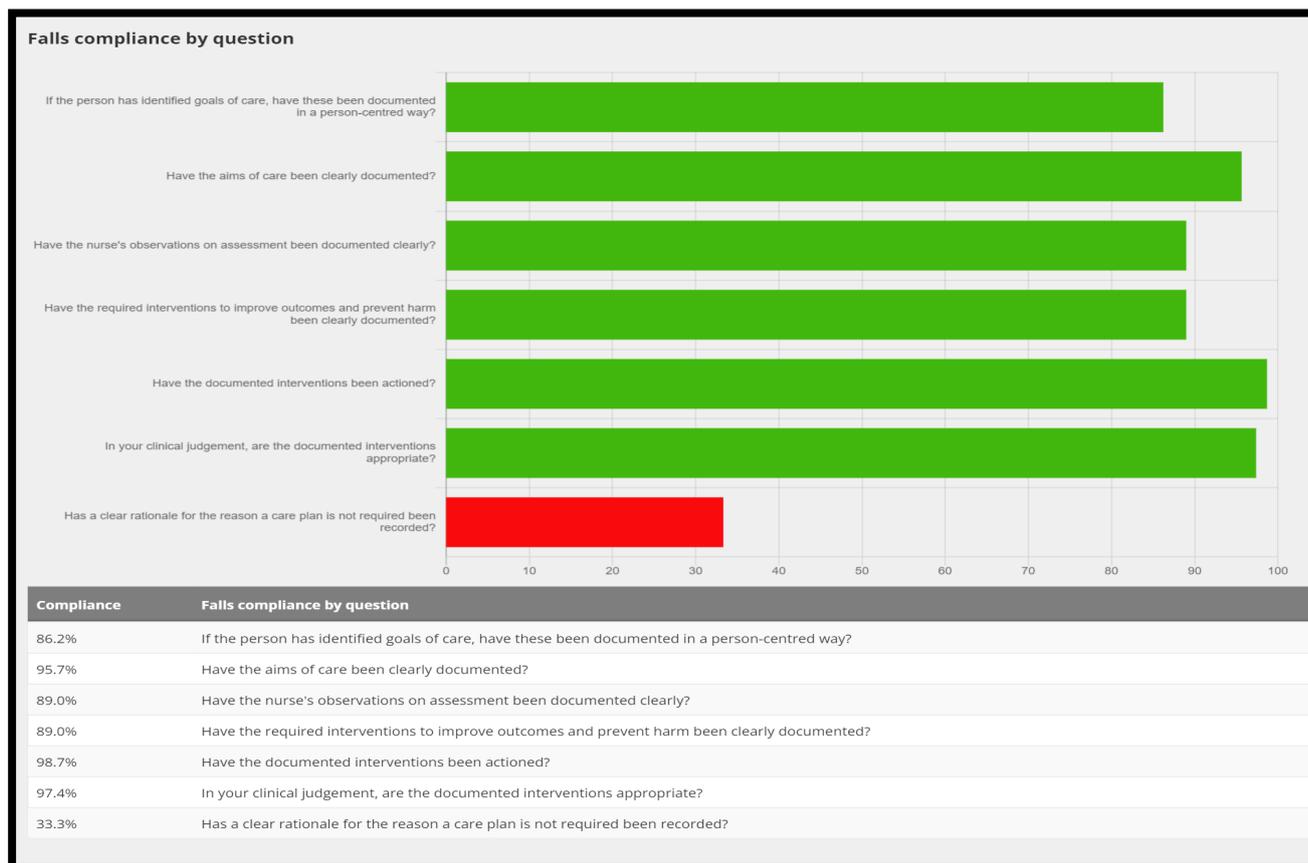
Cycle 4 Dec 22





PCAT Data January - July 23

Person Centred Assurance Tool (PCAT) is completed monthly by the SCN or DCN. 5 patients records will be reviewed, falls is one of the assurance questions.

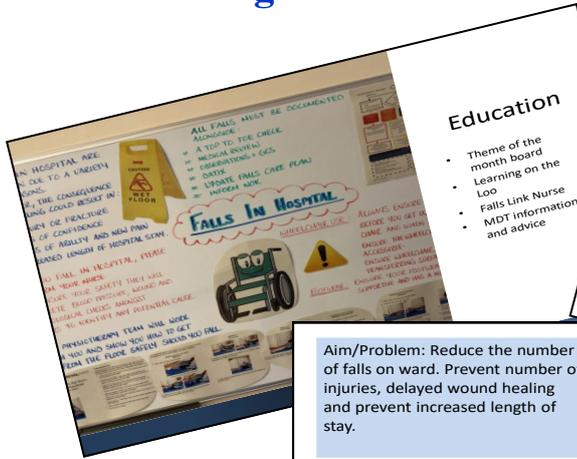


Governance

- * Quarterly meetings HBCCC/REHAB
 - * Harms Data
 - * SAE
- * Falls Improvement Group EH&SCP
- * SCN 1:1



Deputy Charge Nurse Improvement Workshop Change Ideas



Learning on the Loo

Learning on the Loo

Patient Falls

Falls are a common problem in hospitals and are associated with significant morbidity and mortality. Hospital inpatients, particularly older people are at increased risk of falls, largely because of their co-morbidities. Younger patients may be at risk of falling during their hospital stay e.g. when under effects of anaesthesia or medication. Consequences of hospital falls include injury, depression, and loss of confidence. Loss of functional ability and increased length of stay which can be devastating for the individual. A small number of patients die each year in hospital as a direct result of a fall and falls are a source of complaints that can relate to the injuries sustained.

All patients who fall must have:

- DATIX completed
- NOK informed
- Reassessment of falls care plan
- NEWS / GCS and repeat as necessary
- Top to toe completion
- Medical review
- Risk factors for falls completed
- Hygiene, Histo, etc.

Aim/Problem: Reduce the number of falls on ward. Prevent number of injuries, delayed wound healing and prevent increased length of stay.

Measures: Datix reporting reduces. Length of stay in bed days reduced. Number of transfers back to RIE for fall related injuries reduced.

Change ideas: Improved education and awareness of falls for all members of MDT. Ensure accurate post falls care for those that do fall to ensure all injuries are cared for appropriately. Obtain patient feedback regarding ways to prevent falls on ward.

Model for Improvement

- What are we trying to accomplish? **Aim**
- How will we know that our change is an improvement? **Measure**
- What changes can we make that will result in improvement? **Change Ideas**

Act Plan Study Do

Type of Measures

- Qualitative Measure**
Focuses on subjective information like emotions, experiences and satisfaction e.g. questionnaires, focus groups
- Quantitative Measure**
Describes objective information that can be expressed with numbers, graphs, charts etc.

Calum Dickson
Sutherland Ward

Project Idea for Fillieside ward, Findlay House

Aim/Problem: Falls/falls prevention. Often patients in intermediate care experience a fall(s) during their course of rehabilitation due to a variety of factors. This in turn can hinder their rehab progress, experience setbacks, extend their hospital stay and affect what their potential long term goals are. Aim was to examine potential ways in reducing the amount of falls and improving patient care.

Measures: Examining datixes to see possible trends such as times of days/nights where falls often happen, where they happened and determine if there was a specific reason which may have caused the fall such as toiletry needs, delirium, pain.

Change Ideas: The implementation of measures to reduce falls such as a safety huddle at the start of each shift to highlight to staff any patients of concern, placement of staff overnight in each corridor, purchase and replacement of falls alarms, putting more focus on continence issues, implementing non caffeinated drinks after a certain time.

Model for Improvement

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Act Plan Study Do

Qualitative Measure
Focuses on subjective information like emotions, experiences and satisfaction e.g. questionnaires, focus groups.

Quantitative Measure
Describes objective information that can be expressed with numbers, graphs, charts etc.

Aim (overall goal for this project) To reduce and prevent the amount of falls in patients.

Change Idea Examining the factors around patients experiencing a fall and looking at ways to prevent these.

PSQA objective: Describe the objective for this PSQA cycle

Plan
The objective is to gather information around falls by looking at datixes and finding trends or patterns as to why patients are falling. With this information then looking at ways that the ward can change or improve.

Do
When the new measures are implemented and relayed to the team, hopefully begin to see why specific patients may be falling and putting in strategies to prevent further falls such as falls alarm, room placement within the ward, BASICS continence assessment and seeing if anything that may be a factor in a patient having a fall may be prevented.

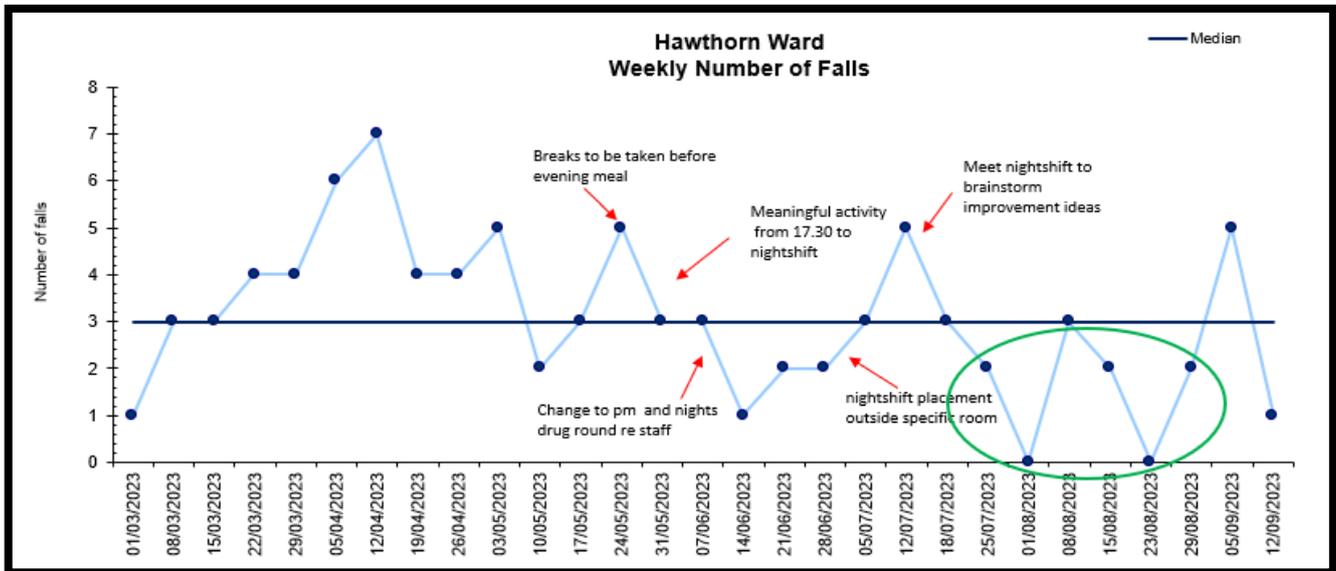
Study
Falls have begun to decrease but still much room for improvement which is ongoing. Suggest involvement was placement of staff on night shift at each corridor to hear and act swiftly if alarm triggered or movement was heard.

Act
Further staff training and consistent implementation of measures will help improve fall prevention on the ward.

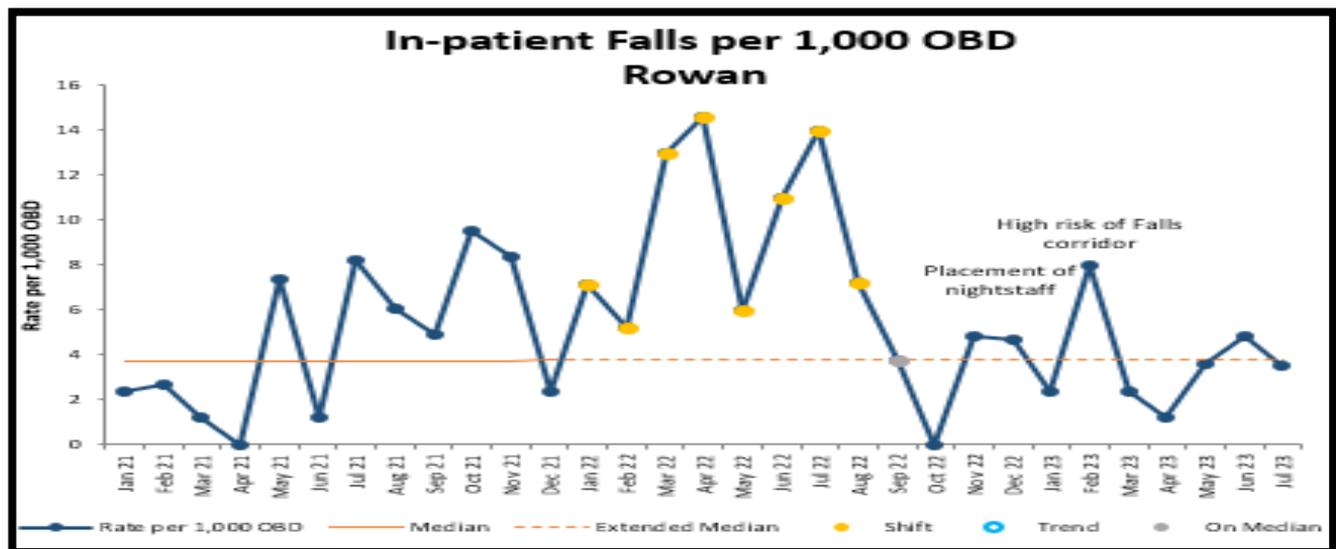
Stephen Lawless
Fillieside Ward

Adapted by kind permission of kentchft.qi@nhs.net

LOCAL IMPROVEMENTS



Lots of great work going on in Hawthorn included in the chart above. Focusing on improvement around the times of high falls. The team are now looking at tests of change around falls on nightshift.



Rowan Test of Change

Placement of patient at high risk of falls together in one corridor.

- Falls reduced
- Less noise in relation to alarms



Physiotherapy

Band 2 study day was recently held for the Unit as part of Physio teaching regarding education around falls and positioning when mobilising a patient and also, where possible, joint sessions with new staff and CSW's on the ward when starting to mobilise patients on the ward, so physio can feedback to them on their positioning with the patient. This was in response to discovering that several falls has occurred when patients were being walked on the ward by new members of staff, particularly those who have not worked in inpatient settings before, not fully understanding where to position themselves to provide 'assistance' or 'supervision' and so were often following with a wheelchair rather than walk beside them.

Occupational Therapy and Medical collaboration

The above group within intermediate care would like to better understand patients concerns about falling when they are admitted, looking at interventions to reduce these concerns and measuring if these concerns are reduced. This may involve testing an new tool to measure these concerns. This is at an early stage of QI planning so watch this space.



