Reducing harm from falls in acute, mental health & community hospitals; what does & doesn’t work

All participants lines are muted to reduce background noise
Falls interventions: Where should we invest our efforts?

Julie Windsor
Patient Safety Lead Older People and Falls.
National Advice & Guidance Team

8th June 2015
What I’m going to cover.

- Update on national falls and harms data
- How and why falls occur
- Prevention strategies and evidence review
- Resources
To start with then...

Definition of a fall:

- *Unexpected event in which a person comes to the ground or other lower level with or without loss of consciousness*”

(World Health Organisation/Lamb 2005)
But not like this....
More like this…
Falls… The facts

Generally not accidental but result of complex interplay between

- Functional decline (normal aging process)
- Medical decline
- Social factors
- The environment
Falls.. The figures.

- Leading cause of death through injury for 75+
- 30% of people age 65 and over will fall every year increasing to 50% of those age 80 and over
- 60% of those who fall once will fall again in the same year
- Incidence in Care Homes and hospital $\times 2-3$ (dementia & delirium)
- IP Hip fracture mortality = 3 in 10
- Return to pre fracture independence = 1 in 10
Physical effects of falls

- Fractures
- Immobility
- Incontinence
- Cuts and bruises
- Pneumonia / chest inf
- Hypothermia
- Death
- Head Injury
- Pressure Ulcers
- Dehydration
Psychological effects of falls

- Increased dependency
- Emotional distress
- Loss of control
- Social isolation
- Fear of falling
- Carer stress
- Loss of confidence
- Anxiety/depression
- Embarrassment
- Low self esteem
Why do older people fall?

- Weak muscles/ unsteadiness
- Slowed reactions- musculoskeletal/neurological
- Foot problems
- Vision & hearing
- Continence
- Dizziness/ blackouts/ cardiac syncope/ low BP
- Pain
- Cognition/ memory loss / delirium
- Fear of falling
- Acute illness
- Medication
There's no shortage of falls policies and guidance …..!

DoH Quality & Outcomes Framework, NHS, Adult Social Care, Public Health
NICE GG 81 Hip#
NICE Hip # QS 16
NICE 161 Falls
NICE Falls QS 86
NICE TA’s 204, 160,161
CQUIN # prevention. Dementia
Comprehensive Spending Review
NHS Operating Framework
Best Practice Tariff Hip #
Prevention Package Older People
Musculoskeletal Services Framework

Active for Life’
NSF Older People
Commissioning Toolkit Falls & Fracture Prevention
RCP National Falls & # Audit
BGS/AGS Falls Guideline
Blue Book ( hip#)
Silver Book ( urgent Care)
NPSA Slips, Trips & Falls in Hospital
NPSA RRR post fall response
NPSA Safer Practice Notice (Bedrails)
MHRA Use of Bedrails guidance
NPSA How To Guide – Reducing Harm from Falls
RCN ‘Lets Talk about Restraint’
No wonder it seems daunting!
And so are the numbers…..

Acute and Community Hospitals.

<table>
<thead>
<tr>
<th>PD09 Degree of harm (severity)</th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>No Harm</td>
<td>170,655</td>
<td>168,479</td>
<td>167,475</td>
<td>164,750</td>
<td>671,359</td>
</tr>
<tr>
<td>Low</td>
<td>64,121</td>
<td>64,669</td>
<td>61,484</td>
<td>57,984</td>
<td>248,258</td>
</tr>
<tr>
<td>Moderate</td>
<td>6,922</td>
<td>7,017</td>
<td>6,389</td>
<td>5,274</td>
<td>25,602</td>
</tr>
<tr>
<td>Severe</td>
<td>874</td>
<td>1,024</td>
<td>1,070</td>
<td>1,113</td>
<td>4,081</td>
</tr>
<tr>
<td>Death</td>
<td>118</td>
<td>105</td>
<td>120</td>
<td>150</td>
<td>493</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>242,690</strong></td>
<td><strong>241,294</strong></td>
<td><strong>236,538</strong></td>
<td><strong>229,271</strong></td>
<td><strong>949,793</strong></td>
</tr>
</tbody>
</table>
### Mental Health Hospitals.

<table>
<thead>
<tr>
<th>PD09 Degree of harm (severity)</th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>No Harm</td>
<td>18,370</td>
<td>17,241</td>
<td>17,093</td>
<td>16,120</td>
<td>68,824</td>
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<tr>
<td>Low</td>
<td>12,935</td>
<td>12,160</td>
<td>11,207</td>
<td>10,682</td>
<td>46,984</td>
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<tr>
<td>Moderate</td>
<td>1,425</td>
<td>1,368</td>
<td>1,431</td>
<td>1,292</td>
<td>5,516</td>
</tr>
<tr>
<td>Severe</td>
<td>92</td>
<td>107</td>
<td>134</td>
<td>105</td>
<td>438</td>
</tr>
<tr>
<td>Death</td>
<td>13</td>
<td>10</td>
<td>7</td>
<td>13</td>
<td>43</td>
</tr>
<tr>
<td>Total</td>
<td>32,835</td>
<td>30,886</td>
<td>29,872</td>
<td>28,212</td>
<td>121,805</td>
</tr>
</tbody>
</table>
Age of patients reported to have fallen in hospital

Breakdown by age of falls in acute clusters

% of all reported acute falls

0% 2% 4% 6% 8% 10% 12% 14% 16% 18%

Age group

Types of moderate and severe falls harms

- Fractured hip (proximal femur): 61%
- Upper limb fracture (humerus, Colles, etc.): 24%
- Lower limb fracture (excluding hip): 5%
- Pelvic fracture (pubic rami): 5%
- Other fracture (rib, skull etc.): 2%
- Digit (finger, thumb, toes): 2%
- Fracture confirmed but site unclear: 5%
What does severe harm look like?
Who should we assess?

✓ All patients aged **65** years or older

✓ Patients aged **50 to 64** years who are identified by a clinician as being at higher risk of falling e.g.

  - Sensory impairment
  - Dementia
  - Fall
  - Stroke
  - Syncope,
  - Delirium
  - Gait disturbances
NICE CG161 recommendations

× Do not use risk prediction tools esp those that assign a numerical score or hierarchy of risk.
× Do not offer “one size fits all” blanket interventions.
✓ Do use individual **multifactorial assessment**.
✓ Do use **multifactorial intervention plans**.
✓ Do provide relevant oral and written information about individual falls risk factors & bedrail use
Multifactorial assessment should include

- cognitive impairment esp delirium
- continence problems
- falls history (causes, consequences, & fear of falling)
- footwear that is unsuitable or missing
- health problems that affect falls risk
- medication review
- postural instability, mobility and/or balance problems
- syncope syndrome
- visual impairment
A bit about measurement.....

What does it mean?
Triangulated data over time is important = the whole picture.

- Falls incidence
- Falls rate per 1000 OCBD
- Moderate & severe number and rate
- Multiple fallers per specialty
- Falls by patients with diagnosis of dementia
- Falls involving bedrails
- Complaints involving falls
- Safety thermometer can help individual wards with QI improvements but has limitations
More like this....
Not like this!
Interventions for which there is poor or little research evidence.

Clinics in Geriatric Medicine (26 4 645-692)
www.england.nhs.uk
Evidence for interventions

Interventions for preventing falls in older people living in the community

Published: 24 September 2013

As people get older, they may fall more often for a variety of reasons including problems with balance, poor vision, and dementia. Up to 30% may fall in a year. Although one in five falls may require medical attention, loss

17 hospital trials but no clear strategy for successful interventions
Complex problems in complex settings require complex solutions
Alert signs + Low beds + Alarms + Walking aid in reach + Toilet regime + Toilet supervision

= Nursing interventions **not** as part as MDT intervention **did not** reduce falls or injuries.

But interesting unintended finding....
What does work then?

MDT FallSafe care bundles can reduce falls by 25%

www.rcplondon.ac.uk
FallSafe: The care bundles

**Bundle A (all patients)**

- History of falls and fear of falling on admission.
- Urinalysis (?infection)
- Avoid new night sedation
- Ensure call bell in reach (not psychiatry)
- Ensure appropriate footwear available and in use
- **Bedrails**: assessment of risks and benefits
- Immediate assessment for walking aids
- Clear communication of mobility status
- Personal items in reach
- No slip or trip hazards

**Bundle B (those at risk of falls)**

- Cognitive assessment.
- Bedrail risk assessment.
- Appropriate bed in use and in appropriate place.
- Visual Assessment.
- Lying and standing BP
- Pulse checked manually.
- Medication review.
- Medical review and bone health.
- Observation and toileting plan
- Delirium & depression screen.
Where can we make difference?

= Delirium

A life-threatening and potentially preventable clinical condition.

- Drugs – prescribed, over-the-counter, illicit?
- Alcohol intoxication or withdrawal
- Metabolic disorders
- Focal brain lesions
- Infections

www.england.nhs.uk
Urinary Incontinence

15% of hospital falls are linked to toilet or commode use

- Stress incontinence
- Sensory urgency
- Motor urgency
- Reflex incontinence
- Sepsis
- BPH
- Syncope
- Constipation
- Diarrhoea
- Retention
Visual/sensory impairment

- Specs
- Bi/varifocals
- Hearing aids
- Glaucoma
- Retinopathy
- Hemianopea
- Cataracts
Eye disease prevalence

Following admission with hip fracture 45% of older people were found to have moderate to severe visual impairment problems (Grue et al 2009).

In a study of acute medical wards 50% were found to have impaired vision, 40% needed new glasses, 37% had cataracts (Jack 1995).
Appropriate footwear..... Very important!

- Check feet
- Neuropathies
- Get footwear sorted
Keeping mobile is v. important for muscle tone

- Get patient up!

- Risk of de-conditioning increased postural instability

- Also has knock on effects for ‘normalisation’ also hydration, nutrition, PU and HAI prevention
Balance/ gait/ mobility problems/ muscle weakness

- Get up & Go test
- Walk & Talk
- Early provision of correct walking aid (and do not tidy away!)
NICE Quality Standard 86 2014
Care after an inpatient fall

Have a post-fall protocol specifying:

- Checks for injury before moving
- When to call an ambulance (if care home / community hospital)
- Safe manual handling if fracture
- Observations
- Timescales for medical review
- Post fall review of circumstances
- Reporting requirements
- Referral for specialist assessment
Why are patients with dementia more likely to fall? (1)

- Balance impairments correlates with memory and naming deficits
- Gait – patterns/slower/inability to use aid
- Medications esp neuroleptic, antipsychotic, sedatives
- Behavioural disorders
- Decreased ability to verbalise what is wrong
- Wandering/exhaustion Interpretation of surroundings different (floors, curtains, lighting, sounds).

Bunn et al (2014) Preventing falls among older people with mental health problems: a systematic review

Why are patients with dementia more likely to fall? (2)

- Reduced dual task performance e.g. walk & talk
- Alterations to sleep/wake cycle
- Malnutrition/dehydration
- Deconditioning
- Decreased attention to comorbid pathologies
- (No) fear of falling
- ↓ muscle mass, Vit D, Vit B12 = increased risk of fracture
Environmental considerations

- Poor lighting esp on stairs
- Low temperature
- Wet, slippery, uneven floor surfaces
- Chairs & beds too high/low/unstable
- Inappropriate/ unsafe walking aids
- Unsafe/ absent equipment e.g handrails
Some hazard modification is free!
Staff Education

preventing falls

Falls are the commonest cause of injury in hospitals. This course is about helping to prevent them.

- Patient risk factors 55 mins
- Environmental risk factors 25 mins
- After a fall 10 mins
- Check your knowledge

CareFall

Reducing inpatient falls and post fall management

This course is about helping you identify and manage risk factors.

- Introduction 10 mins
- Risk factors for falls
- Patient risk factors 30 mins
- Environmental risk factors 8 mins
- After a fall 13 mins

www.england.nhs.uk
E-learning for nurses.

For example, the aid shows you that if the patient is very immobile (bedbound or tube-dependent), bedrails are recommended in most cases, but should be used with care if the patient is also confused and disoriented.

You may also need to consider other factors such as poor vision and the risk of restless patients getting bruises or sores from the bedrails.

If you use bedrails, make sure you understand your local guidance on selecting suitable patients.

Click Next to continue.
Resources for patients and carers

Falls

Overview  Clinical trials
Falls  Prevention

Introduction

www.england.nhs.uk
National Inpatient Falls Audit

- 172 Acute Trusts taking part

- Organisational, clinical & bedside (observational) components based on NICE 161

- Early reports suggest improvements needed!
To conclude:

What's the most important falls intervention? .......YOU!

Thanks for listening ....Any questions?

jwindsor@nhs.net

www.england.nhs.uk