A ‘Shift’ in Practice: Reducing Falls in an Elderly Mental Health Ward

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Older adults with cognitive impairment have a higher risk of falls, with annual incidence of around 60-80%, at least twice that of cognitively intact older adults. We created an ethos that recurrent falls should not be an accepted occurrence by exploring the relationship between cognitive impairment and falls risk. Incident analysis and inspection reporting highlighted a requirement for specific teaching around early warning systems, identifying the deteriorating patient, falls prevention and management. The environment was altered to provide a more homely setting for patients who required care in hospital. A 36% reduction in the number of falls has been achieved, with statistical analysis providing support that change ideas relating to reducing anxiety are the primary contributory factor.

**Method**

Pareto charts were the primary diagnostic tool used for collecting baseline data. The adverse event reporting system (Datix) was used to provide the count of falls each week and each month. Monthly ward meetings allowed for ongoing diagnostics of the current process and appreciation of a system, along with supporting and building local capacity for improvement and access to, and balance of, improvement support.

**Results**

A shift in practice has been achieved with a reduction of 36%. Special cause variation appeared when the activity coordinator left post; staff experience concurred with this as the primary contributing factor. Although many falls have been prevented diagnostics consistently demonstrate that a new admission can contribute to 50% of the monthly falls until staff are able to risk assess and manage interventions that are person-centered.

**Process Change**

Change ideas have predominantly focused on three primary drivers: recognition and assessment, increasing staff’s knowledge on falls and adapting the environment, by providing a more homely setting.

**Conclusions**

This project has been person-centered, improving patient care and overall experience of being an in-patient. It has had great engagement from the clinical team while they have been operationally challenged with the demands of a busy ward. Focusing on intrinsic factors has increased engagement and support. The overall reduction in falls has been achieved. The benefit of focusing on agitation and confusion has allowed bespoke interventions for a cohort of patients who are most likely to fall.

**Key Learning Points**

- Harvesting the great thinking staff have and supporting them to take the steps to change
- To enhance the patient assessment, capacity and consent was as important as falls and management of the deteriorating patient
- To empower staff you need to provide them with time and headspace, providing training for staff on how to complete top toe assessments while in the company of the falls specialist

**Achievements**

- Successfully building momentum, capacity and courage to try QI and capturing and sustaining this enthusiasm and commitment
- Making the ward a more homely setting
- Fostered good working relationships between Quality Improvement, falls specialist and secondary care community hospital
- Setting up a falls action group to review progress and share learning

Although still within the top 30, at number 27, Glenlee has had 99 falls within the last 12-month period compared with 187 originally

**Key Reference Materials**

- National Falls Bundle
- Scottish Patient Safety Programme

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