A high number of patients were admitted to a ward with mobility problems owing to a history of alcohol misuse. A sister led a project to reduce the incidence of falls.

Preventing falls in patients with alcohol problems

In this article...

- The impact of falls
- How one ward reduced the falls rate
- Engaging staff in methods of prevention

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Abstract

Falls in hospital are common, resulting in injury and anxiety to patients, and large costs to NHS organisations.

Around 3,500 falls are reported in Nottingham University Hospitals Trust every year. This means almost 10 every day; 40–50% of these result in a physical injury and 50 hip fractures are reported every year.

Risk of falls
On our gastrointestinal-medical ward we have high numbers of patients admitted with mobility problems due to a history of alcohol misuse. We also have patients who are confused due to infections and other unknown causes. When given the annual falls data at directorate meetings my ward was always the highest. Along with other staff, I had become complacent about the fact that our patients fall; sometimes four or five times or more during an admission.

Falls awareness
We joined the trust’s Releasing Time to Care: Productive Ward project in September 2008 (see tinyurl.com/Prod-ward-release). We have a performance board visible to patients, relatives and ward staff, which shows the number of falls on the ward.

I set the targets for the safety crosses on the ward. The targets for MRSA, C difficile and ward-acquired pressure ulcers were zero. However, falls were a different matter; looking back at how many we had each month, I decided to aim for a weekly target of a maximum of four falls. Although this may seem a lot, we were seeing much more than that: on average 30–40 a month.

Engaging staff
I introduced ward “time out” days instead of ward meetings, which had previously been held during the working day and were poorly attended. Every three months I hold two time out days so all staff can attend and receive the same training and updates.

Productive Ward means each week I have to look at the safety crosses and where we have not achieved our targets. A missed target then becomes the ward’s focus for the next week. A written document with the latest issues/problems and an action plan on how to improve is placed on the Productive Ward board. It is also put in the ward diary for the nurse in charge to read out to staff during handover.

We knew we had a target group of patients who were frequent fallers because they are detoxing from alcohol dependence. I therefore arranged for a task group to meet to look at ways to improve staff awareness of alcohol-dependent patients. This group consisted of a hepatologist, the ward sister, a deputy sister, a staff nurse, a care support worker and a member of the trust’s alcohol liaison team.

We have made the following changes:

- All falls scores are highlighted on our daily ward handover notes and discussed during the ward handover;
- We ask transferring wards to tell us patients’ falls score before transfer, which means we can look at which bed space is the most suitable and start bed moving if needed;
- We consider one-to-one nursing of high-risk patients.

Evaluating interventions
I was soon able to see that we were doing well in terms of reducing falls. Fig 1 shows a downhill trend year after year. This showed staff that even though we still had months with a higher rate of falls than others, the overall trend was good.

Conclusion
Having spent the last few years with the challenge of reducing falls, my advice to other nurse leaders is to realise the importance of getting all team members involved in making change.