A trust introduced a comprehensive falls strategy. It gives nurses more time to spend caring for hospital patients to reduce the risk of falls.

Making time for nurses to reduce patient falls

In this article...
- Steps that can be taken to give nurses more patient time
- How freeing up nursing time can reduce the risk of falls
- Factors that contribute to reducing falls

Keywords: Falls/Electronic health records/Prevention

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Alarms can indicate when at-risk patients leave their bed or chair and may need help

5 key points

1 Patient falls in hospital can result in delayed discharges, increased complications and increased costs for providers

2 In the US, as many as 20% of hospital patients fall at least once during their stay

3 One-to-one nursing care can reduce the likelihood of patients at-risk

4 Equipment is available that can help to prevent falls and reduce the consequences if a fall does happen

5 Steps can be taken to reduce nurses’ paperwork, such as introducing an electronic notes system

In 2007, Nursing Times published an article explaining the National Patient Safety Agency (NPSA) report on falls in hospital (Hairon, 2007). The report put forward a range of interventions, suggesting they would result in an 18% reduction in the number of falls in NHS establishments. The same report estimated the cost of such falls to be round £15 million a year. Since then, the numbers of falls in NHS establishments has remained high.

There are more than 250,000 falls and 1,000 fractures reported each year from hospitals in England alone (Royal College of Physicians, 2012). Patient falls in hospital care settings are a serious problem and can result in complications that delay discharge, decrease patients’ ability to function and increase healthcare costs. Falls can also alter patients’ perception of safety and wellbeing, making them less able or willing to participate in activities of daily living and rehabilitation due to fear of falling again.

Of the 208,338 falls reported in acute organisations between October 2008 and September 2009, the NPSA (2010) recorded the following degree of harm:
- No harm – 143,591;
- Low harm – 57,306;
- Moderate – 6,596;
- Severe – 777;
- Death – 68.

Box 1 defines each category.

Patient falls in hospitals are a serious problem and can cause long delays in their recovery. One-to-one nursing reduces the number of serious falls that occur, but nursing staff are often busy with routine clerical duties and do not have time to sit with patients constantly. Electronic health records make these clerical duties quicker to complete, giving nurses more time to spend with patients and reducing the likelihood of serious falls occurring. This article describes the steps taken by The Walton Centre to reduce falls and provides an evaluation of the programme.

The Walton Centre

The Walton Centre is the only standalone neurosciences trust in the UK. Over the last two years it has focused on reducing inpatient falls using several approaches; these have brought about a 57% reduction in falls with harm between 2011–12 and 2012–13. The trust has seen reducing falls with harm as an area where considerable improvement to patient outcomes and experiences can be made.

Background and external review

In 2010, The Walton Centre started using quality-metrics scorecards to record patient falls on individual wards. This information was then fed back to the board
of directors every month and at ward level to every ward nurse manager. At the same time, a falls steering group was developed to look at the cause of each fall and how to raise falls awareness. There has been little research specifically into neuroscience patients and falls but we believe the complexities and cognitive problems experienced by our patients are a contributing factor to the number of falls in the trust.

In May 2011, the director of nursing requested an external review by the NPSA of internal falls policies and procedures. The review concluded the trust had a vulnerable patient group and an almost unique service and had to revise its approach. Several recommendations were made that included reviewing the falls risk assessment, which was deemed too lengthy, as well as the trust’s falls care plan. Recommendations also included rewriting the slips, trips and falls policy and giving staff additional falls prevention training.

All recommendations were put into an action plan and presented to the trust’s governance, risk and quality committee.

There was a clear improvement in reducing falls after the recommendations were implemented (Fig 1).

Recent trends
The trust started to reduce the total numbers of falls between 2010-11 and 2011-12, and there was a significant reduction in all falls with harm in 2012-13 (Table 1). The number of reported falls increased between 2011-12 and 2012-13, but this is thought to be due to an increased awareness across the trust in reporting clinical incidents.

Training
In addition to implementing the NPSA’s recommendations, the trust created a quality matron post to focus on improving patient safety and falls prevention. This was created so one person could take the lead in this area.

The falls training programme was reviewed, refreshed and relaunched to include information on the consequences of patients falling, different types of patient falls, statistics, interventions, treatment, prevention equipment, and the roles and responsibilities of staff. Initially delivered only to nursing staff, the programme is now attended by all clinical staff, including consultants. By 2011-12, 99% of trust staff had done the training.

Additional staff
A paper outlining the need for more nurses to allow for one-to-one nursing care was presented to the board of directors in November 2011. This was approved and 15 additional nurses were recruited. However, the number of patients thought to be at risk of falling varies from shift to shift, making it difficult to ensure the right number of nurses is always available. This often resulted in using bank and agency nurses to free up permanent staff so they could provide one-to-one nursing care.

In 2012 the clinicians remodelled the nursing wards to reflect their subspecialty, including a dedicated spinal ward, vascular ward, neurology and neuro-oncology ward. Nursing numbers are based on the acuity of specialty for each of these. An additional 29-bed ward was opened and a further nursing review undertaken with a view to increasing the number of nursing staff across all inpatient wards.

This review revealed a need to remove ward managers from nursing establishments to allow them to support staff and better coordinate their wards. The number of nurses per shift was also increased to reflect patient need and, combined with the opening of the new ward, more than 70 whole-time equivalent posts were created. Five advanced nurse practitioner (ANP) roles were also created to clinically lead each subspecialty. This has led to improved subspecialty training and a more seamless pathway for patients who have access to the ANP from admission to discharge.

Close observation or one-to-one supervision
Following the review, the trust produced a one-to-one observations standard operating procedure for patients at risk of falls. This is usually provided by a nurse who will stay within close proximity of the patient and endeavour to reduce the chance of falls. However, the nurse may not be able to physically intervene to prevent the fall.

Close observation raises issues of privacy and dignity, although these can be avoided through good communication with the patient, family and all members of the care team. One-to-one does not mean giving no privacy – for example, in the toilet or bathroom – staff can stay in close proximity but use other methods to offer privacy, such as facing away from the patient or using curtains if available.

Falls equipment
Yellow alert bands
Any patient identified as being at high risk of falls is given a yellow alert band so staff from all departments are able to recognise this risk immediately. Staff can then take action to prevent a fall; this may include assisting at-risk patients back to their bed space or ward if they are on their own. The yellow alert band acts as a communication tool between staff across departments.

**BOX 1. FALL CATEGORIES**

The National Patient Safety Agency (2010) categorises slips, trips and falls according to their severity:
- **No harm** – requiring first-aid treatment or just extra observation, for example bruises and grazes
- **Low harm** – requiring hospital treatment or a prolonged length of stay but from which a full recovery is expected, for example fractured clavicle, laceration needing suturing
- **Moderate harm** – requiring hospital treatment or a prolonged length of stay but from which a full recovery is expected, for example fractured clavicle, laceration needing suturing
- **Severe harm** – causing a permanent disability, for example brain injury, hip fractures where patients are unlikely to recover their former level of independence
- **Death** – directly due to the fall

**FIG 1. TOTAL FALLS AND FALL WITH HARM 2011**
Alarms and monitors
Fall alarms and mobility monitors were introduced as an extra resource to reduce falls risk. These indicate, by alarm or voice, when high-risk patients try to get out of their bed or chair releasing pressure from a sensor pad on which patients sit. This system is not suitable for all high-risk patients, including those willing and able to ask for help or those who would fall immediately on standing.

Ultra-low profiling bed
Ultra-low beds do not reduce the risk of a fall but can help prevent harm if one occurs. Particularly useful for patients who are confused and trying to get out of bed, they can be lowered to a height of <30cm and used with impact (crash) mats.

E-patient
In 2012 nurses reported spending more and more time on paperwork and less with patients. The director of nursing, quality matron and IT department met to discuss nursing staff needs and, as a result, e-patient was developed and launched. This allows nurses to complete all their nursing risk assessments using an iPad at the patient’s bedside. Care plans automatically calculate risk-assessment scores and refer to the appropriate member of the multidisciplinary team if the score triggers a certain point. This reduces the time nurses need to fill out forms, fax and telephone as part of the referral process. E-patient has increased the time nursing staff can spend with patients; patient feedback has been positive.

Conclusion
Several studies have shown the benefits of using electronic health record (EHR) systems in hospitals. Generally, such systems improve nursing documentation, reduce medication errors and make nurses feel more satisfied with their work environments. One study found nurses working in an EHR environment were less likely to report poor patient safety compared with peers in non-EHR environments (Agency for Healthcare Research and Quality, 2012).

The steps described in this article all contribute to improving patient safety by reducing the risk of falls. One of the principles of nursing practice, principle C, states that nurses and nursing staff should manage risk, be vigilant about risk, and help to keep everyone safe in the places in which they receive healthcare (Royal College of Nursing, 2012). NT

References

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