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Using a regional initiative to improve falls prevention resulted in the development of champions who ensure falls avoidance is a priority on wards

A care bundle approach to falls prevention

In this article...

- Why FallSafe works
- The contents of a falls prevention care bundle
- What falls champions do

Authors
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Abstract

Falls cause harm and distress to NHS inpatients every year. One hospital’s implementation of a regional FallSafe project has increased the use of evidence-based measures to prevent falls. The project relied on a network of falls champions, who were nurses or healthcare assistants who taught and inspired their colleagues to implement care bundles.

More than 200,000 patient falls are reported annually in acute hospitals (National Patient Safety Agency, 2010). Between 2008-09, 777 falls in NHS settings caused severe harm, and 68 contributed directly to patient death (NPSA, 2010).

As well as the distress and anger experienced by patients and their families, there is a huge financial cost associated with unplanned care and treatment necessitated by falls. The social and psychological costs associated with loss of confidence, fear of falling and consequent social isolation are also significant (Salkeld et al, 2000).

The FallSafe project
Our aim was to introduce FallSafe, an initiative in which falls prevention interventions are rigorously applied in care bundles, into a an acute hospital across several wards and specialties. The original FallSafe project was run at 16 sites in the south central region in 2010-2012, funded by the Health Foundation and delivered by the Royal College of Physicians.

FallSafe lead nurses were supported to inspire ward colleagues and multidisciplinary teams to introduce and sustain an evidence-based falls prevention care bundle. The project resulted in a measurable improvement in falls-related care and suggested a 25% reduction in falls (Royal College of Physicians, 2012).

Introducing FallSafe in the trust
Effective change management is essential to organisational development. Teasdale (1992) suggests six strategies to embody into planning change:
- Create ownership and involvement;
- Create a positive environment;
- Identify the need for change with staff;
- Work with staff on an action plan;
- Communicate the changes;
- Anticipate conflicts and resistance.

All these strategies were used.

As part of Portsmouth’s falls strategy implementation and in the light of emerging FallSafe project results, many of the care bundle elements had already been introduced and were included in the trust’s falls prevention and care plan (Portsmouth Hospitals Trust, 2012). This plan is expected to be used routinely for all inpatients identified as being at risk of falling on admission or during their stay.

Before starting work on wards, the falls specialist nurse met senior management and news of the project was disseminated via the local falls network. A project coordinator was appointed to drive the implementation and a band 5 clinical educator was
Nursing Practice

Innovation

seconded for two days a week to support training in care bundle elements.

Fourteen wards were chosen, with specialties, including trauma and orthopaedics, medicine, surgery, oncology, medicine for older people, rehabilitation and stroke.

Each ward identified a FallSafe champion nurse or healthcare assistant to lead the work, plus a deputy where possible to provide support. All champions were expected to complete the falls prevention e-learning materials produced for the original FallSafe project, and to encourage their ward colleagues to do so as well.

The project was launched with a study day, and study days took place at monthly intervals over the six-month implementation period. Each included an opportunity for the falls champions to share experiences, successes, challenges and the many inventive ideas they developed to overcome barriers. There was also teaching from consultants and therapists who were an important part of the wider falls team.

At each study day, the FallSafe champions were given a pack containing a summary of the work needed over the next month plus data collection sheets. They then introduced the bundle elements to their ward, ensured colleagues were competent to carry them out then audited each element to test the extent to which it was being implemented. This was achieved using a plan, do, study, act (PDSA) approach. Champions undertook a range of initiatives that included, putting prompt sheets into nursing notes, creating posters and asking for a column for mobility status to be added to handover sheets, as well as using ward meetings.

One study day included a session on personality types. This had a terrific impact on all participants, who engaged well with the session. Beginning to understand how personality influences the ability to communicate with others and how their personality governed their response helped staff see how they might vary their approach. This was particularly valuable to champions who were finding it difficult to persuade others to engage. Comments received included: “The session was enlightening – made me evaluate what type of learner I am and, by doing that, it made me rethink how I get messages across to people.”

Data collection

There were two groups of care bundle elements. Bundle A (Box 1) was applied to all inpatients and bundle B (Box 2) to those identified as being at risk of falling.

Before the bundles were introduced, falls champions were asked to collect baseline data for bundle A for 20 patients on their ward. Sets of three bundle elements were introduced over periods of between two weeks and one month, after which data on the newly introduced elements was collected. After all of bundle A had been introduced, baseline data for bundle B was collected. Elements from the bundle were then introduced and data collected in the same way as for bundle A.

Results

Quantitative results from the measured audit of care bundle elements are shown in Tables 1 and 2. Data was collected between 1 January and 31 May 2013. Overall, there was an improvement in implementation.

Qualitative outcomes

The falls champions developed innovative ideas to improve ward culture around falls prevention among all staff:

- Wards developed laminated sheets or used whiteboards to show individual patients’ mobility requirements so all those caring for them could see at a glance what help might be needed. Some wards used the purple colour scheme from the FallSafe resource pack (RCP, 2012) in poster information for patients and visitors.
- One champion drafted a traffic light guide for medications that increase fall risk. After consultation with the pharmacy department, this was developed into a chart that could go in the drug trolley.
- Another champion designed a guide sheet to be kept within the cover of the nursing notes folder to prompt and guide to the relevant pages of the nursing care booklet.
- One ward negotiated the provision of two walking frames that patients could use out of hours when there is no physiotherapy cover.

Challenges for champions

Some significant issues made it challenging for some wards to implement the care bundles. Several champions found that the timing of drug rounds, the frequency of ward rounds and the ability to identify the therapists and junior doctors attached to their wards affected how successful they were in communicating on introducing bundle elements. This was particularly an issue when action from the team was needed with, for example, medication reviews, avoiding night sedation and communicating the results of lying and standing blood pressure. This problem was particularly acute if the falls champion nurse worked mainly nights or the ward duty system was based on 12-hour shifts.

The striking improvement in cognitive screening reflects the concurrent hospital-wide introduction of a Commissioning for Quality and Innovation (CQUIN) target for dementia. This illustrates the benefits of identifying and carrying out actions that will draw attention to aspects of care that are relevant to a patient group, in this case those with dementia. Tackling all issues relating to dementia through the CQUIN automatically included specific falls issues.

It is pleasing to see that many of the interventions that rely on good essential nursing care scored highly. However, there
Many ward managers were sympathetic and imaginative in supporting falls champions, rostering so they could attend study days and encouraging them to use ward meetings and handovers to communicate FallSafe information. Making time to do the FallSafe work, which involved data collection as well as designing communications materials for staff and patients, proved very difficult for some champions.

Overall, it seems the ability to manage time and prioritise falls had a greater impact than money. There was little evidence that more money would have motivated people to behave differently. For FallSafe to work in any setting, staff needs to understand that implementation will be time well spent. Fewer falls means less unplanned work and fewer procedures – a good outcome for both patients and staff.

**Recommendations**

The quality of falls prevention initiatives in hospital wards could be improved if a rolling programme of auditing the care bundle elements could be incorporated into routine patient safety audits. Nursing documentation could be reviewed to streamline the recording of falls-related information.

Encouraging falls champions to share information from falls reporting with ward managers and the rest of the ward team might raise awareness of times of day or places where falls are frequent.

**Conclusion**

A care bundle approach to falls prevention can be implemented with sustained effort and commitment from multidisciplinary ward teams that include nurses, doctors, therapist, pharmacists, catering and domestic staff.

It is best driven by a nominated member of the nursing team with a strong personality and leadership attributes who is able to inspire and motivate others, and who recognises several teaching and communication styles will be required. Service development, however patient focused, can fall without effective leadership.

Attention must be paid to how people are treated and motivated (McClenahan, 1999) because "the strength of the NHS lies within its staff, whose skills, expertise and dedication underpins all that it does" (Department of Health, 2000).

**References**

- Portsmouth Hospitals Trust (2012) Policy for the Prevention and Management of Adult in-patients at Risk of Falling or Who Have Already Fallen. tinyurl.com/porthoosp-falls
- Royal College of Physicians (2012) Implementing FallSafe: Care Bundles to Reduce In-patient Falls. www.rcplondon.ac.uk/resources/falls-prevention-resources

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**TABLE 1. CARE BUNDLE A: CHANGE FROM BASELINE AFTER IMPLEMENTATION**

<table>
<thead>
<tr>
<th>Bundle element question</th>
<th>% yes at baseline</th>
<th>% yes when in place</th>
<th>% change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Call bell in sight/reach?</td>
<td>90</td>
<td>92</td>
<td>2.0</td>
</tr>
<tr>
<td>Safe footwear available?</td>
<td>87</td>
<td>92</td>
<td>6.4</td>
</tr>
<tr>
<td>Falls history taken?</td>
<td>67</td>
<td>80</td>
<td>19.4</td>
</tr>
<tr>
<td>Asked about fear of falling?</td>
<td>47</td>
<td>59</td>
<td>25.8</td>
</tr>
<tr>
<td>Urinalysis performed?</td>
<td>44</td>
<td>55</td>
<td>25.3</td>
</tr>
<tr>
<td>Night sedation avoided?</td>
<td>86</td>
<td>92</td>
<td>7.4</td>
</tr>
<tr>
<td>Assessed for walking aids?</td>
<td>83</td>
<td>91</td>
<td>9.1</td>
</tr>
<tr>
<td>Mobility status communicated?</td>
<td>82</td>
<td>89</td>
<td>9</td>
</tr>
<tr>
<td>Walking aids available?</td>
<td>76</td>
<td>83</td>
<td>9</td>
</tr>
<tr>
<td>Personal items in reach?</td>
<td>95</td>
<td>96</td>
<td>1.5</td>
</tr>
<tr>
<td>No visible slip or trip hazards?</td>
<td>95</td>
<td>95</td>
<td>0.1</td>
</tr>
</tbody>
</table>

The mean relative change was 10.4%.

**TABLE 2. CARE BUNDLE B: CHANGE FROM BASELINE AFTER IMPLEMENTATION**

<table>
<thead>
<tr>
<th>Bundle element question</th>
<th>% yes at baseline</th>
<th>% yes when in place</th>
<th>% change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cognitive assessment completed?</td>
<td>46</td>
<td>76</td>
<td>64.8</td>
</tr>
<tr>
<td>Bedrail assessment completed?</td>
<td>94</td>
<td>100</td>
<td>6.1</td>
</tr>
<tr>
<td>Appropriate bed?</td>
<td>97</td>
<td>100</td>
<td>6.1</td>
</tr>
<tr>
<td>Basic visual assessment completed?</td>
<td>90</td>
<td>93</td>
<td>3.3</td>
</tr>
<tr>
<td>Lying and standing BP recorded?</td>
<td>41</td>
<td>52</td>
<td>26.5</td>
</tr>
<tr>
<td>Pulse checked manually?</td>
<td>60</td>
<td>50</td>
<td>-16.6</td>
</tr>
<tr>
<td>Medication reviewed?</td>
<td>76</td>
<td>85</td>
<td>11.8</td>
</tr>
<tr>
<td>Medical review of falls risk factors/ osteoporosis?</td>
<td>68</td>
<td>58</td>
<td>-15.6</td>
</tr>
<tr>
<td>Toileting assessment/plan?</td>
<td>95</td>
<td>96</td>
<td>1.7</td>
</tr>
<tr>
<td>Appropriate bed position?</td>
<td>97</td>
<td>98</td>
<td>0.2</td>
</tr>
</tbody>
</table>

The mean relative change was 8.5%.