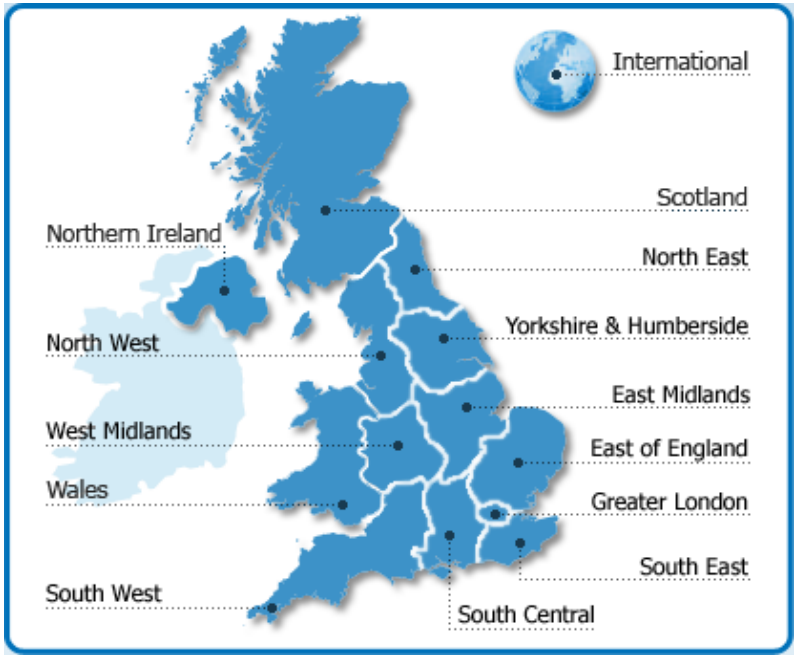
Falls prevention in health and social care: the UK perspective.

Julie Windsor Patient Safety Clinical Lead- Medical Specialties/ Older People.



The National Health Service (NHS) and population statistics



England population is 55 + million.

The NHS deals with over 1 million patients every 36 hours.

16+ million hospital admissions in 2015/16

18% of people were aged 65+

2.4% were aged 85+

People aged 60 and over projected increase from 14.9m in 2014 to 21.9m by 2039.

As part of this growth, the number of over-85s is estimated to more than double from 1.5 million in 2014 to 3.6 million by 2039

The National Health Service (NHS)

Service providers

- 209 clinical commissioning groups
- 135 acute non-specialist trusts
- 17 acute specialist trusts
- 54 mental health trusts
- 35 community providers
- 10 ambulance trusts
- 7,454 GP practices
- 853 for-profit and not-for-profit independent sector organisations

Clinical staff

- 106,430 doctors
- 285,893 nurses
- 132,673 scientific, therapeutic and technical staff
- 19,772 ambulance staff

Falls admissions.

421,800

2.7 % increase from 2012-13

Hospital Episode Statistics 2013-14

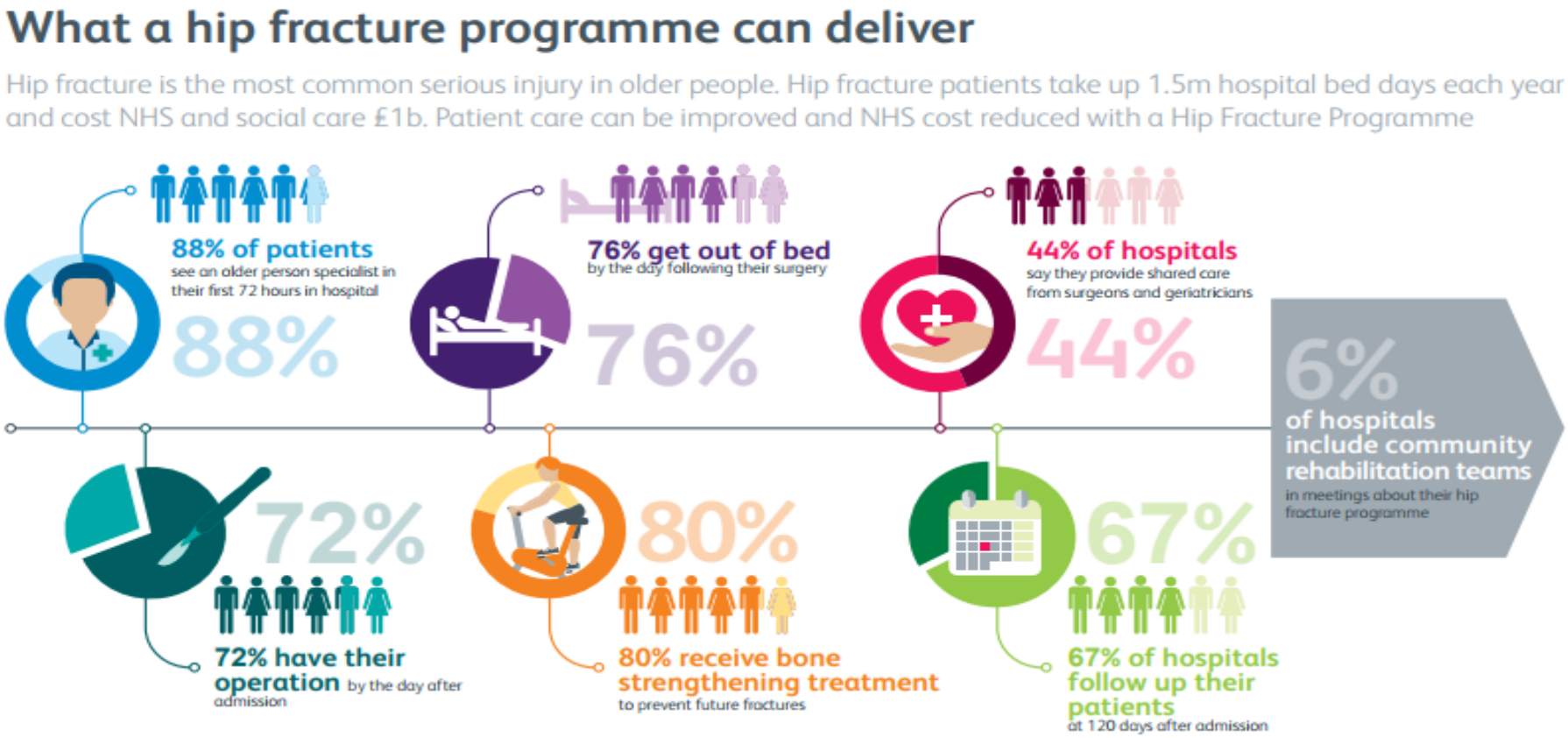
12,000 hip fracture

4,000 at any one time

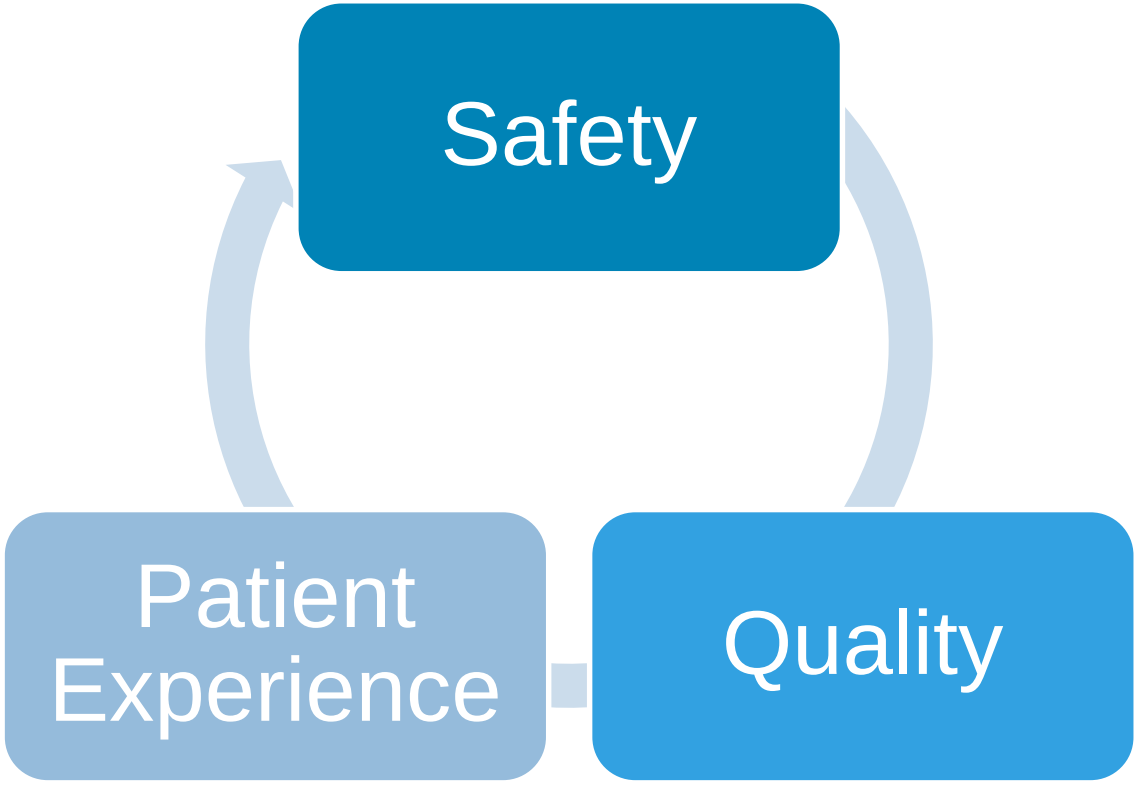
Mean LOS 19 days

3.9 % (2,511) were inpatient at the time of the fracture

Models of ortho/geriatric collaboration has transformed care.



Improving falls prevention in hospital



National Reporting & Learning System. Inpatient reported falls

Acute & Community hospitals

England						
PD09 Degree of harm (severity)	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**
No Harm	170,669	168,615	167,567	166,919	165,598	158,418
Low	64,122	64,726	61,536	58,919	56,783	54,224
Moderate	6,922	7,022	6,424	5,339	4,911	4,020
Severe	874	1,023	1,057	1,123	1,214	1,219
Death	118	106	120	147	147	127
Total	**242,705**	**241,492**	**236,704**	**232,447**	**228,653**	**218,008**

National Reporting & Learning System. Inpatient reported falls

Mental health hospitals

England						
PD09 Degree of harm (severity)	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**
No Harm	18,370	17,244	17,114	16,219	16,983	16,681
Low	12,937	12,160	11,217	10,787	9,846	9,059
Moderate	1,425	1,368	1,433	1,309	1,167	1,056
Severe	92	107	133	109	105	101
Death	13	11	7	14	9	7
Total	**32,837**	**30,890**	**29,904**	**28,438**	**28,110**	**26,904**

Drivers for improvement…..

There's no shortage of falls policies and guidance …..!

DoH Quality & Outcomes Framework, NHS, Adult Social Care, Public Health
NICE CG 81& QS 16 Hip#
NICE CG 161 & QS 86 Falls
NICE CG 176 & QS 74 Head Injury
NICE NG5 Medicines Optimisation
NICE TA's 204, 160,161
CQUIN's # prevention & dementia
Comprehensive Spending Review
NHS Operating Framework
Best Practice Tariff Hip #
DH Prevention Package Older People
Musculoskeletal Services Framework
RCN ' Lets Talk about Restraint'
Occ Ther Practice Guideline (Falls)

GMS contract 2017/18
Falls and fractures: consensus statement and resources pack for commissioners 2017
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

No wonder it seems daunting !

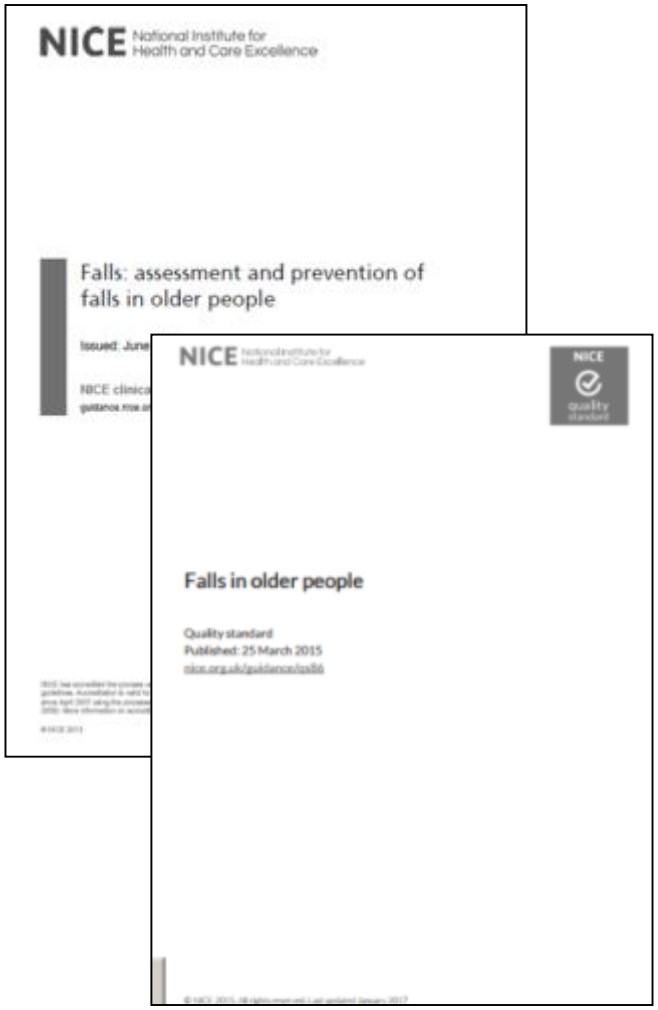
Some interventions can be quick & free though …

Who should we assess?

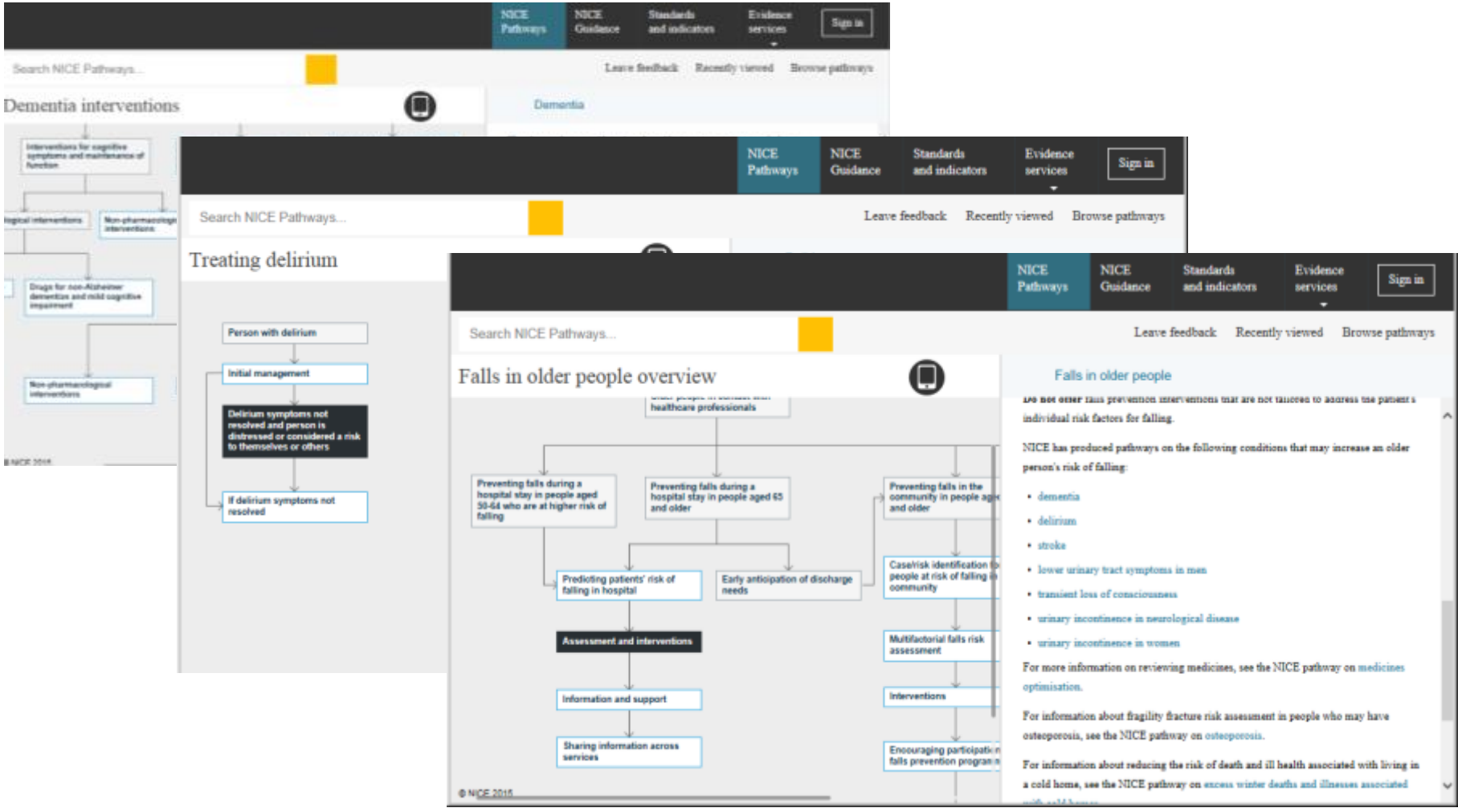
- ✓ All patients aged 65 years or older
- ✓ Patients aged 50 to 64 years who are identified by a clinician as being at higher risk of falling e.g.
- ✓ After a fall in hospital!

  - Sensory impairment
  - Dementia
  - Fall
  - Stroke
  - Syncope,
  - Delirium
  - Gait disturbances

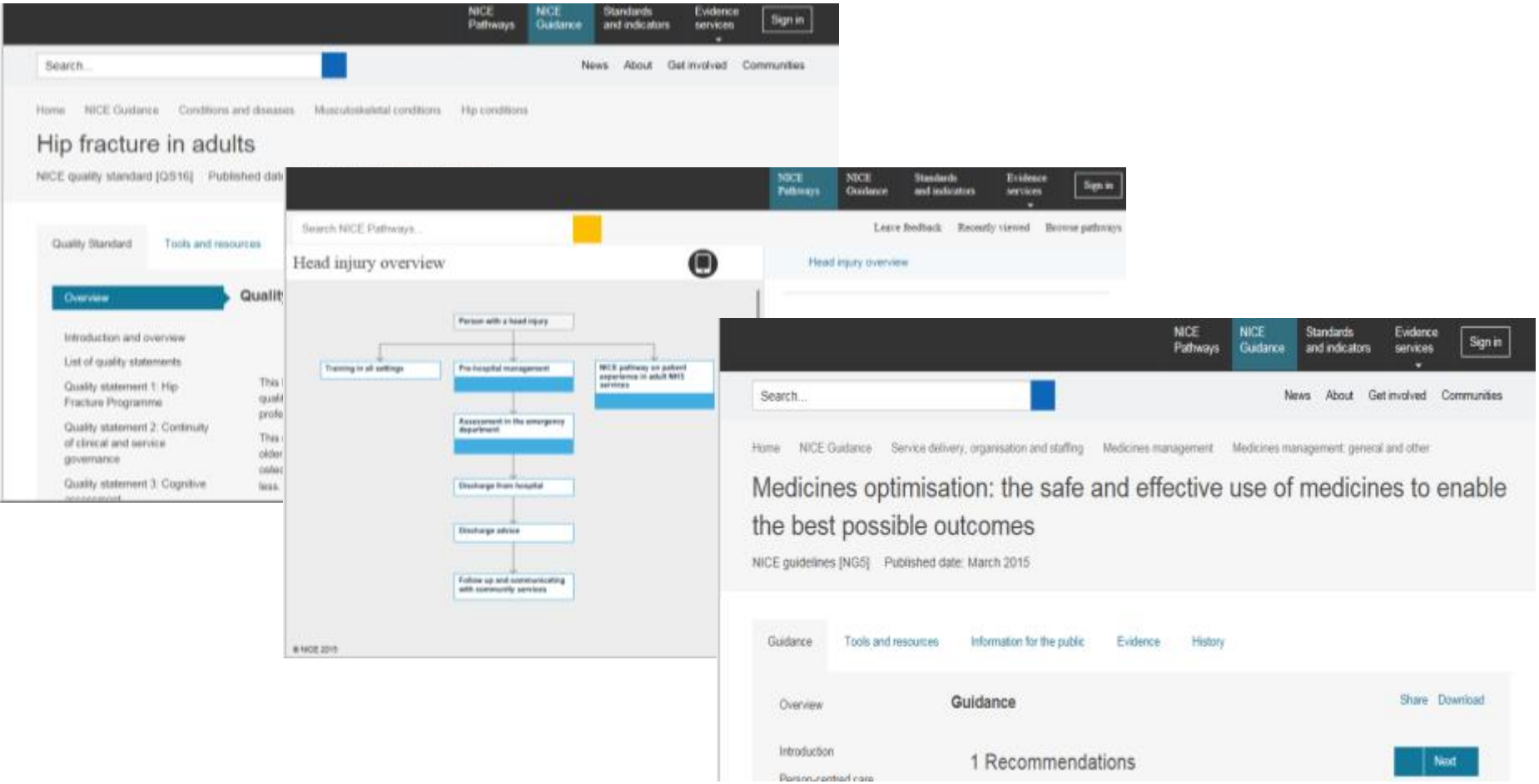
- ✓ Offer individualised risk assessment and intervention plan



Related NICE Guidelines- not seeing things in isolation (prevention)

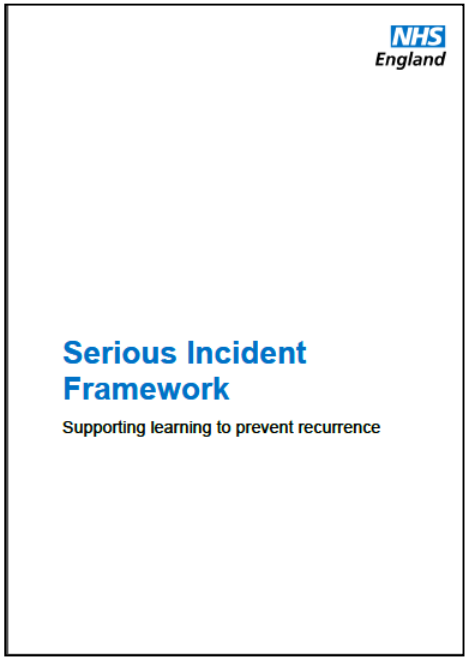


Related NICE Guidelines- not seeing things in isolation (sequelae)

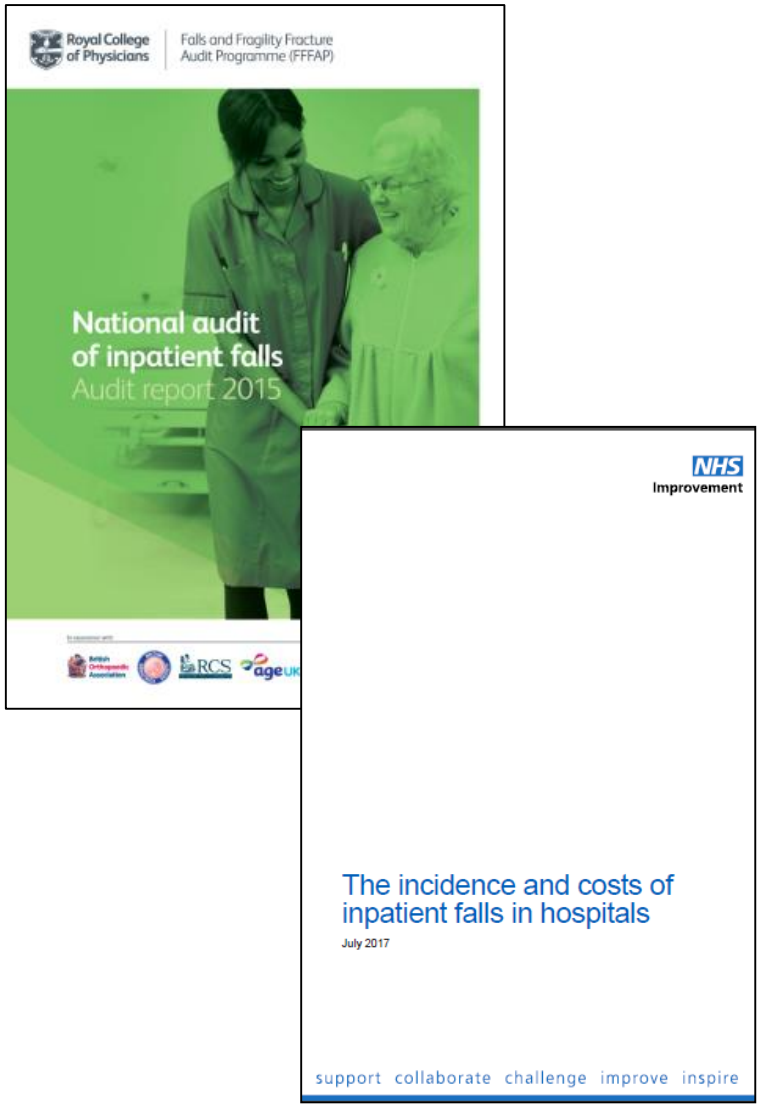


What about investigations?

- Main function is for learning
- Need to be MDT otherwise missing vital contributions… and engagement!
- Should usually include patients and families.
- Focus on what happened rather than avoidable or not = distracting.
- All severe injury not necessarily SI's
- Should not be an industry in themselves!
- Think about different models of investigation e.g. cluster



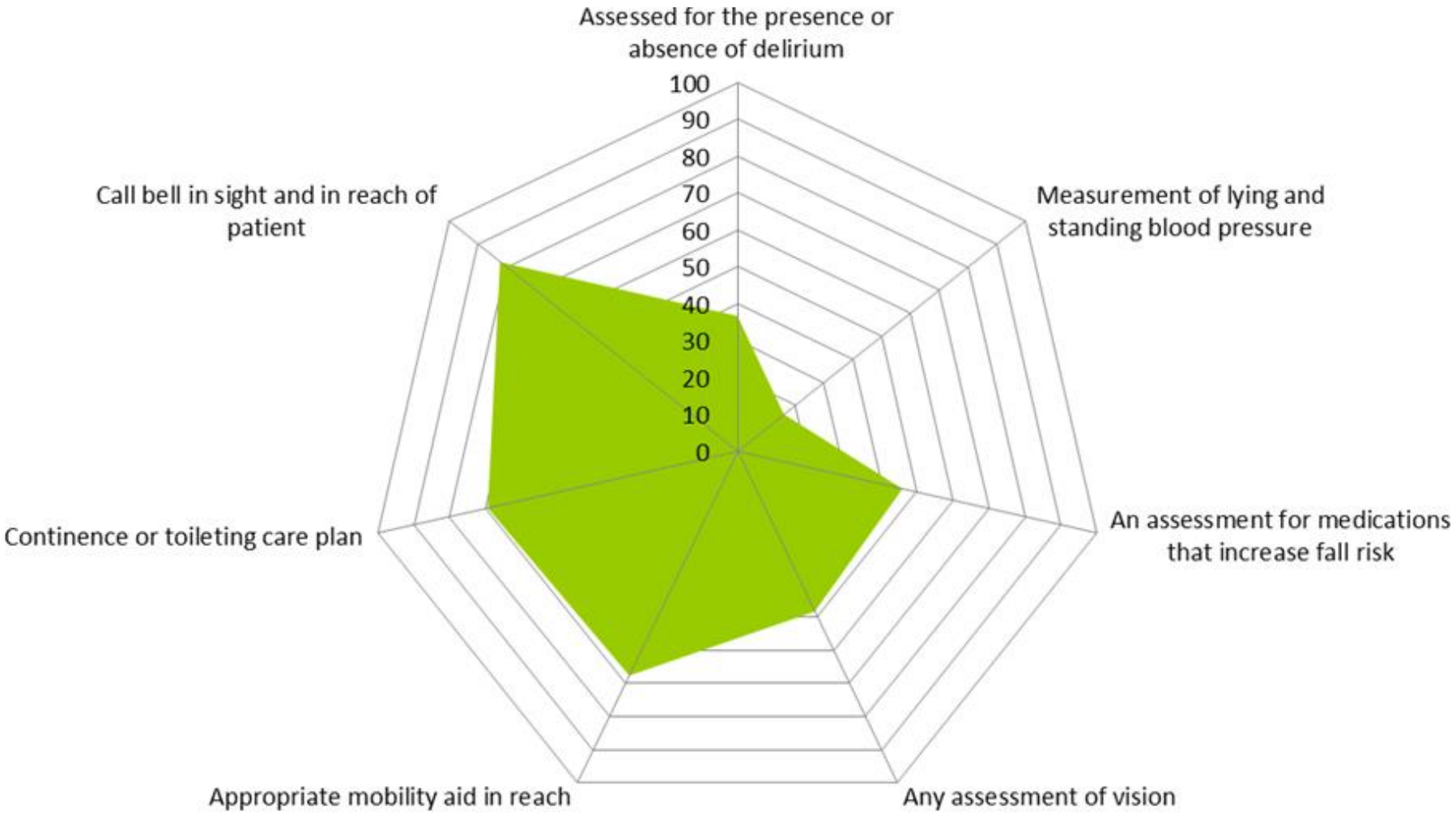
In patient falls; patient and financial cost



- Over 600 falls reported per day to the NRLS in England and Wales (>250,000 a year)
  - 5,059 Moderate harm
  - 1,367 Severe harm
  - >2500 hip fractures occur in hospital (4.2%)
  - 143 deaths

- Not all falls result in injury but affect confidence, increase anxiety & reduce mobility
- estimated overall cost of £630 million approximately 25% of the £2.3 billion total costs of falls estimated by NICE

Key clinical data: national audit 2016 results. 2017 will report in Oct .



Key recommendations for Trusts and LHB's

- ✓ Falls steering group
- ✓ Falls multidisciplinary working group
- ✓ Audit bed rail use
- ✓ Review multifactorial falls risk assessments (MFRAs)
- ❖ Do **NOT** use a fall risk prediction tool

Helpful resources: Blood pressure (1)

All patients aged over 65 should have a lying and standing blood pressure performed as soon as practicable

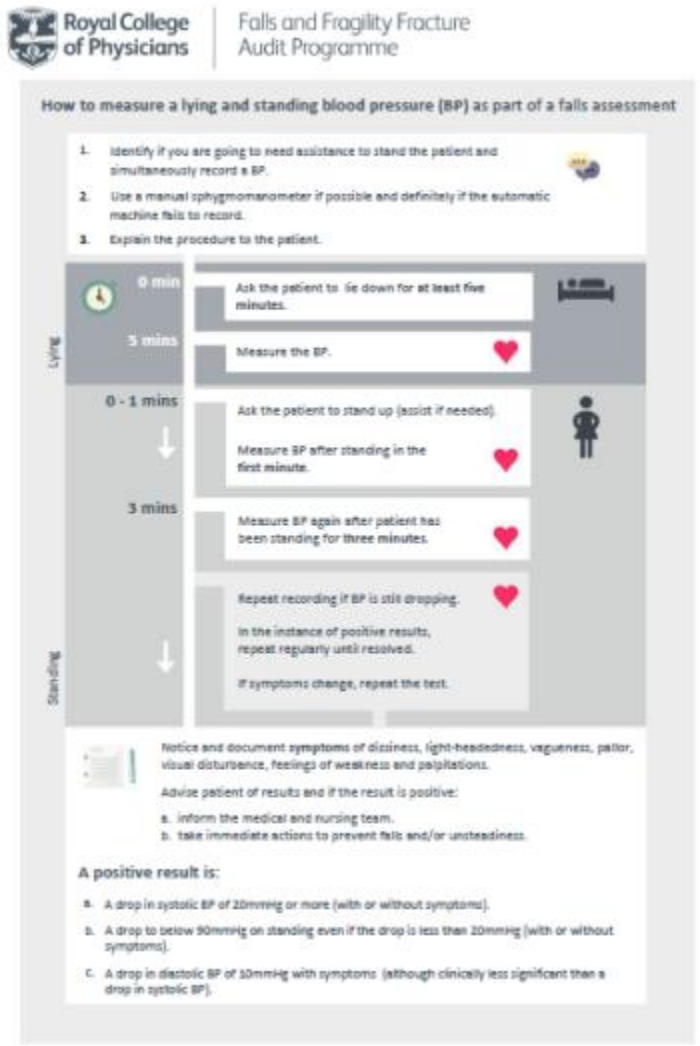
(national audit 2015)

https://www.rcplondon.ac.uk/projects/outputs/measurement-lying-and-standing-blood-pressure-brief-guide-clinical-staff

http://www.e-lfh.org.uk/programmes/preventing-falls/

Windsor J et al (2016)Orthostatic hypotension 1: effect of orthostatic hypotension on falls risk. Nursing Times; 112: 43/44, 11-13.

Helpful resources: Blood pressure (2)



Helpful resources: Vision Check tool.

Pilot across 16 hospitals (acute & community) by range of nurses, doctors, therapists, support workers….. AND patients!

Downloadable from RCP website

Or, for hard copies contact:FLSDB@rcplondon.ac.uk

Levers for improvement…..

CQC Inspection guidance:
Anywhere Hospital National Audit of Inpatient Falls

	Metric	CQC Key Question	2015[2] Report	National Aggregate (England)	National Aspirational Standard	Audit's rating	
53 cases	Case Ascertainment All patients	Well led	Not reported for this audit			n/a	
	Does the trust have a multi-disciplinary working group specifically for falls prevention where data on falls and falls resulting in harm, severe harm and death per 1,000 OBDS is discussed at most or all the meetings.?	Effective	**Yes**	n/a	yes	n/a	
	Proportion of patients who had a vision assessment	Safe	**53.3%**	48.3%	100%	Between 50 and 79%	
	Proportion of patients who had a lying and standing blood pressure assessment	Safe	**22.4%**	16.1%	100%	Less than 50%	
	Proportion of patients assessed for the presence or absence of delirium	Safe	**85.6%**	35.6%	100%*	More than 80%	
	Proportion of patients with appropriate mobility aid in reach	Responsive	**83.7%**	68%	100%	More than 80%	

Anticipated date of next update is mm/yy

1 Xxx 1x- Xxx 1x
2 May 15

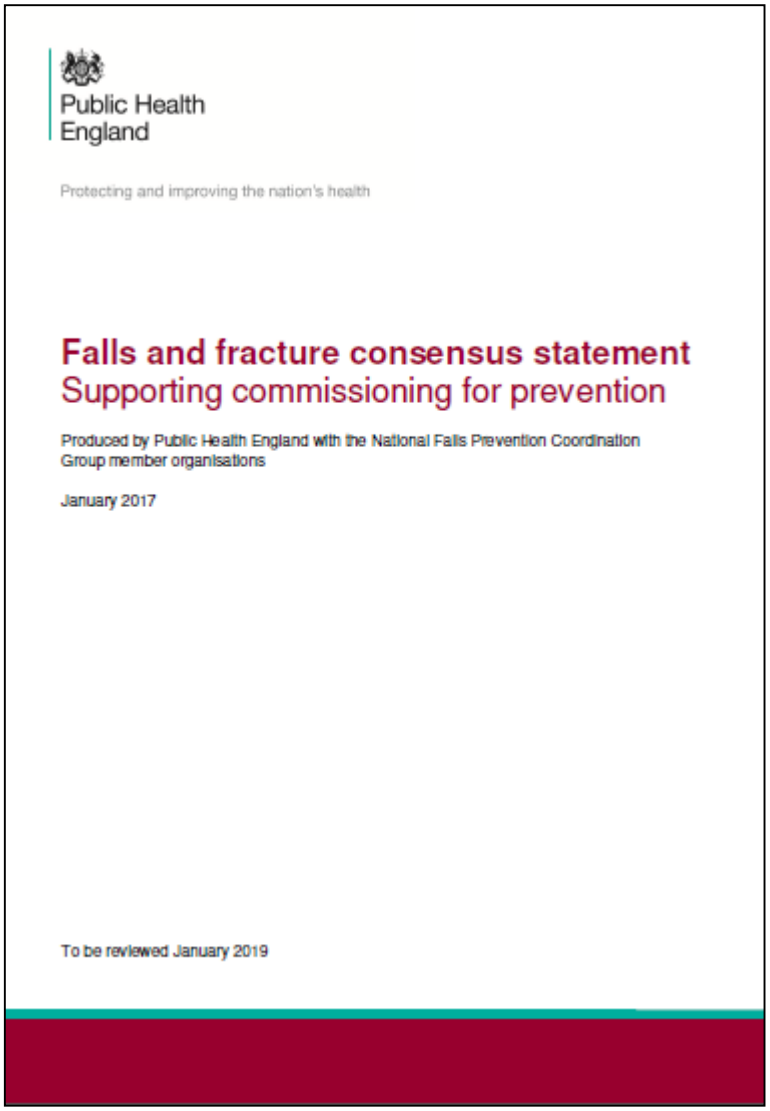
* NICE Clinical Guideline

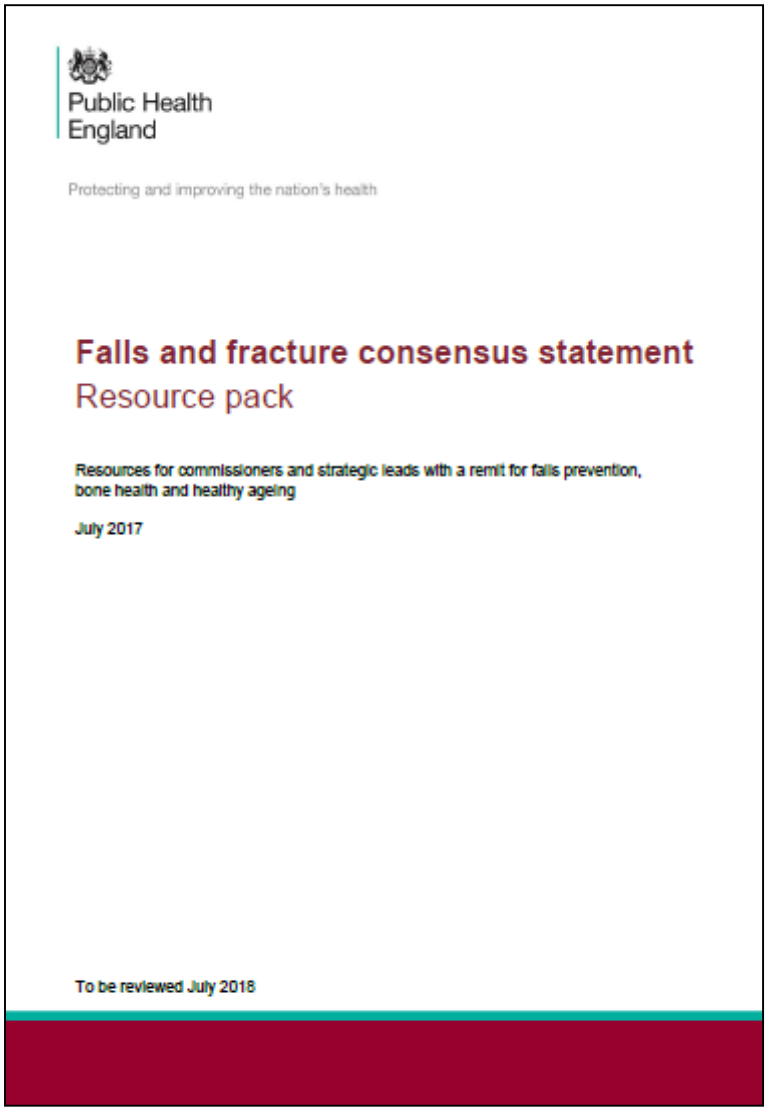
2017/18 GMS CONTRACT

'…..patients identified as living with severe frailty, the practice will deliver a clinical review'

- ✓ ***provide annual medication review***
- ✓ ***discuss if fallen in the last 12 months***
- ✓ ***provide any other clinically relevant interventions.***

Support for commissioners.





Working together

NHS Improvement

Public Health England

Protecting and improving the nation's health

National Falls Prevention Coordination Group member organisations

Falls and fracture consensus statement

Supporting commissioning for prevention

Many new initiatives joining safety check opportunities with falls services and health & social care

3 year programme looking at partnership working across health, social care, independent & voluntary sector

Public health falls and fracture programmes and services

STEADY On! Lancashire County Council

Bristol Community Health

About Our Services Patients & Carers Community GP Area News

Home > Our Services > Strength and balance classes

Strength and balance classes

Open Access Protocol

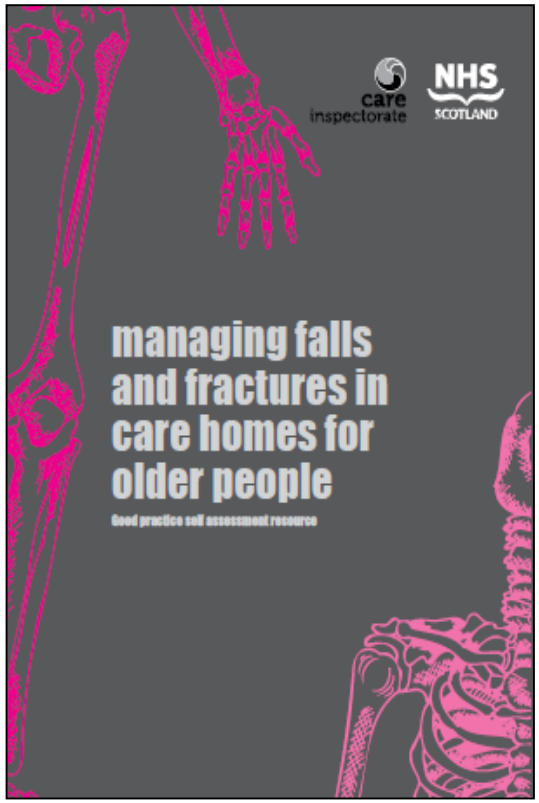
BMJ Open

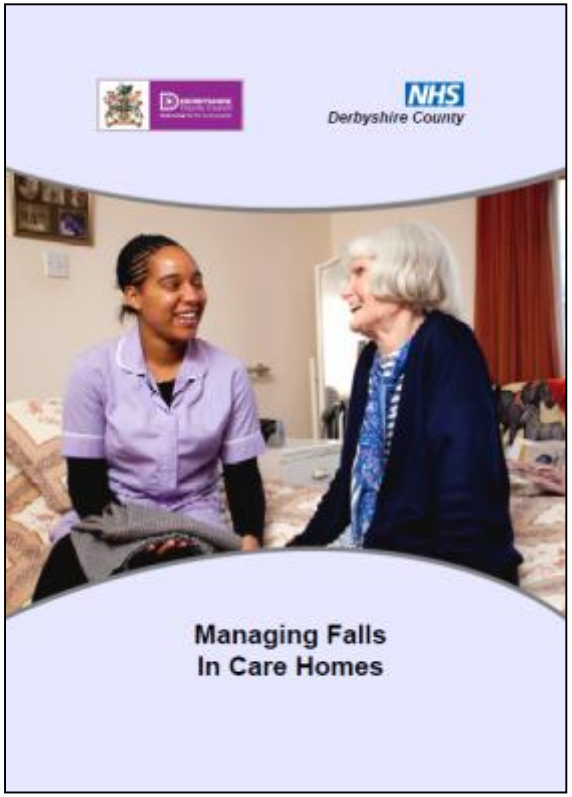
A cluster randomised controlled trial of advice, exercise or multifactorial assessment to prevent falls and fractures in community-dwelling older adults: protocol for the prevention of falls injury trial (PreFIT)

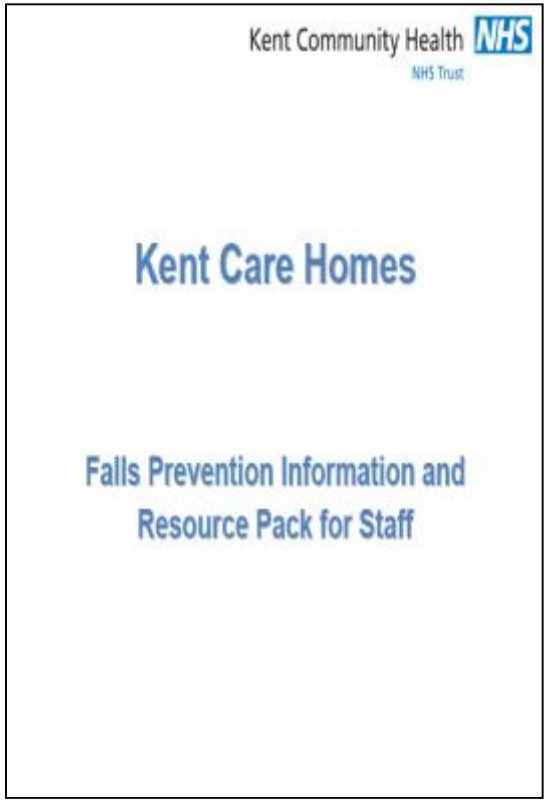
Julie Bruce,[1] Ranjit Lall,[1] Emma J Withers,[1] Susanne Finnegan,[1] Martin Underwood,[1] Claire Hulme,[2] Ray Sheridan,[3] Dawn A Skelton,[4] Finbarr Martin,[5] Sarah E Lamb,[1,6] on behalf of PreFIT Study Group

FallsFree4Life
FREE FALLS PREVENTION SERVICE

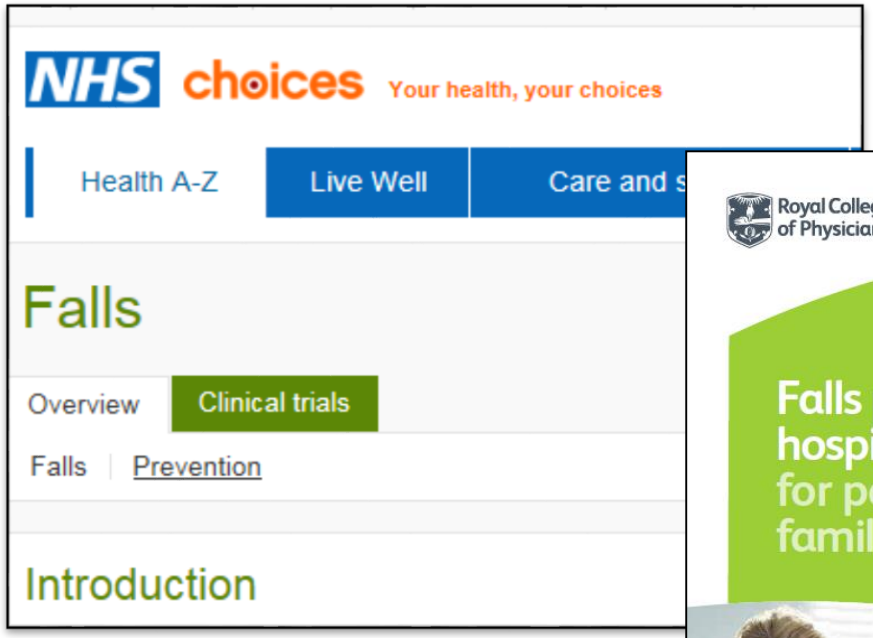
Resources for Care Homes.

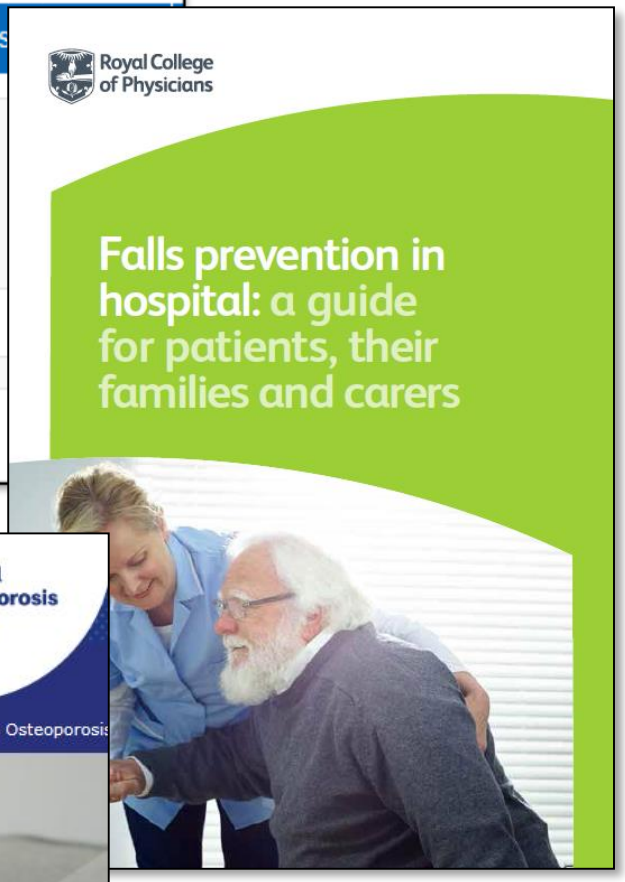


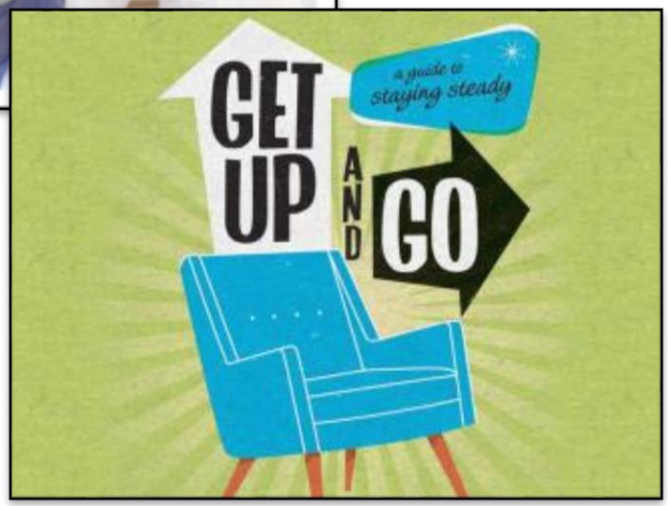


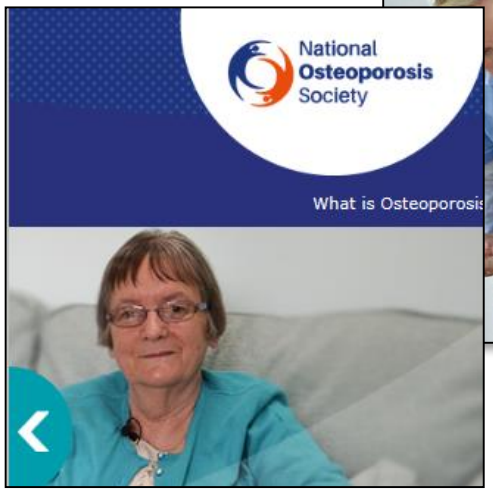


Resources for patients and carers









NHSI Falls Collaborative

Based on national audit indicators

Main purpose to:

- Reduce incidence of falls and harm
- Encourage increase in quality of reporting to support learning
- Increase quality of interventions
- Reduce variance in adherence to evidence based approaches
- 19 acute, MH & Comm trusts

East Midlands

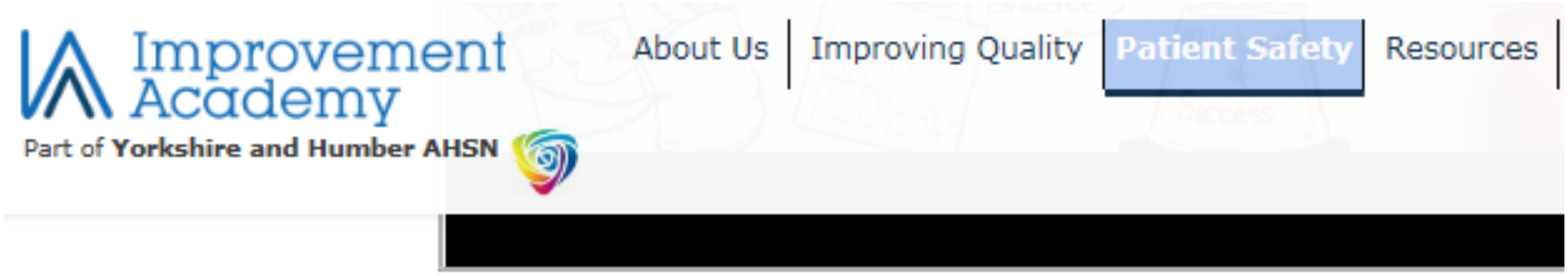
Site name	Percentage score							Sparkline indicator						
	Delirium	BP	Medication	Vision	Mobility aid	Continence CP	Call bell	Delirium	BP	Medication	Vision	Mobility aid	Continence CP	Call bell
Chesterfield Royal (CHE)	7.4	26.9	57.7	25.0	100.0	100.0	96.6							
Grantham And District General Hospital (GRA)	66.7	50.0	33.3	100.0	100.0	100.0	100.0							
Kettering General Hospital (KGH)	19.2	16.7	41.7	53.8	61.1	76.9	96.3							
King's Mill Hospital (KMH)	48.3	30.8	36.0	60.0	85.7	92.3	100.0							
Leicester Royal Infirmary (LER)	39.1	20.0	36.4	17.9	58.3	46.7	81.5							
Lincoln County Hospital (LIN)	46.4	15.0	42.3	96.7	73.3	70.0	76.7							
Northampton General Hospital (NTH)	50.0	6.7	40.7	27.6	36.4	72.7	81.5							
Nottingham City Hospital (CHN)	60.7	12.0	30.8	33.3	73.3	50.0	88.5							
Pilgrim Hospital (PIL)	66.7	10.5	79.2	85.7	93.3	85.7	96.6							
Royal Derby Hospital (DER)	15.0	33.3	39.3	39.3	78.6	60.0	84.6							
University Hospital Queens Medical Centre (UHN)	71.4	35.0	96.6	55.2	85.0	88.2	82.1							

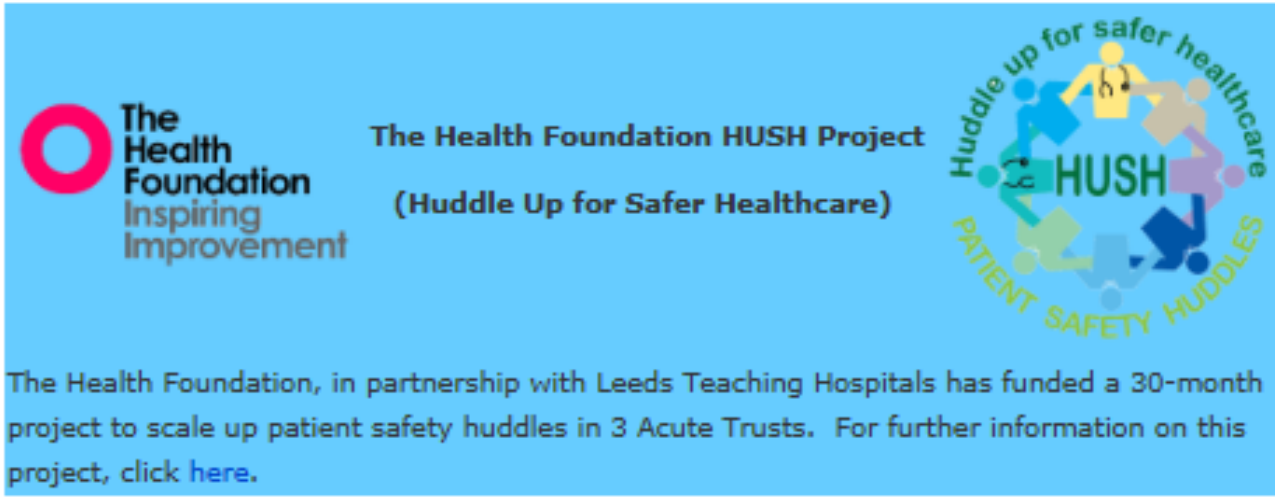
Complex problems in complex settings require complex solutions… where to focus efforts

Every older person is different. Don't try to answer the question 'What will stop older people falling' and just repeatedly ask 'What might stop *this* person falling?'.

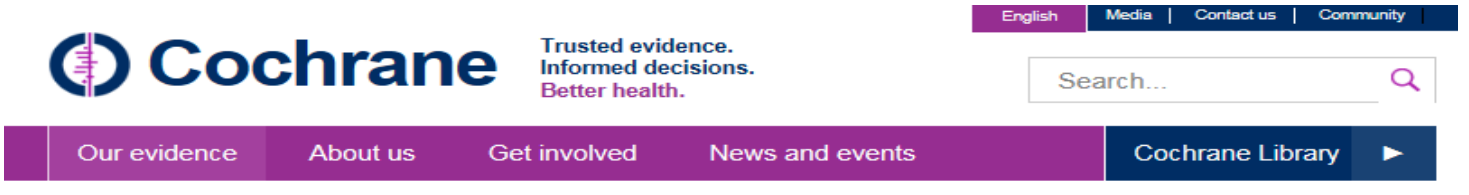
Frances Healey RN PhD

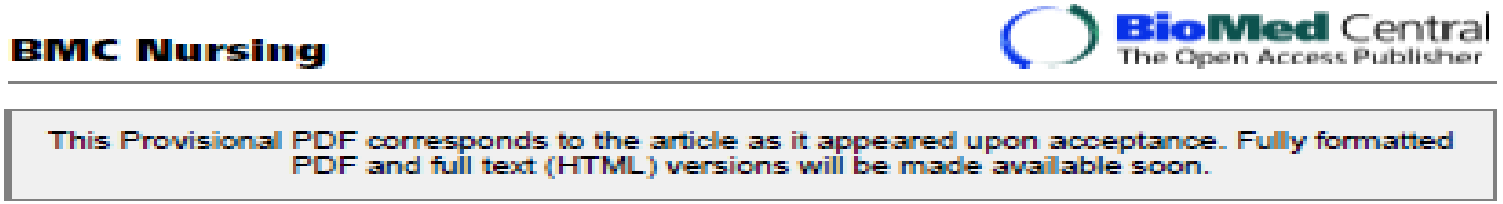
Some emerging evidence though



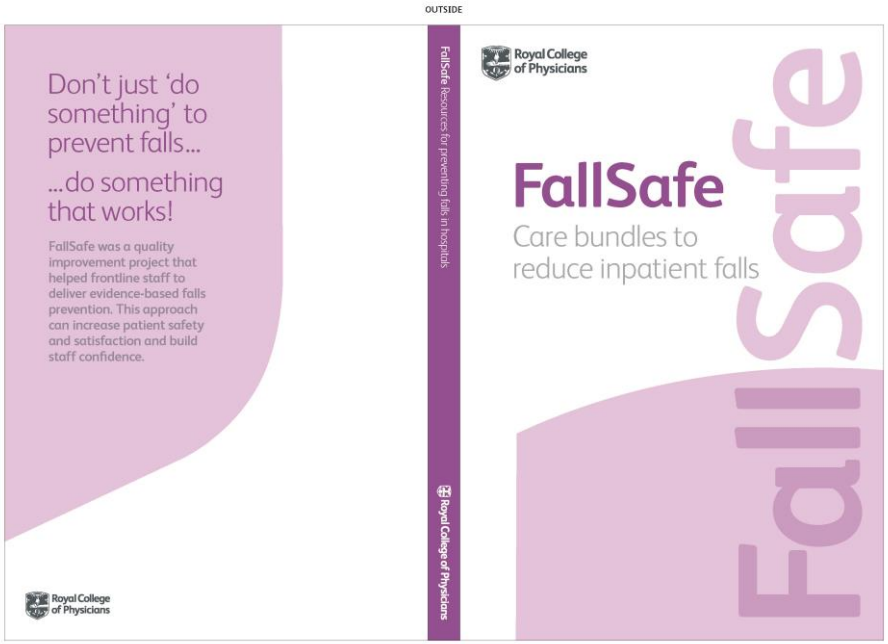


Evidence – systematic reviews





What works in hospitals



MDT FallSafe care bundles using quality improvement model can reduce falls by 25%

www.rcplondon.ac.uk

Healey F, Lowe D, Darowski A et al. Falls prevention in hospitals and mental health units: an extended evaluation of the FallSafe quality improvement project. *Age Ageing* 2014;43: 484-91. doi:10.1093/ageing/aft190

And what doesn't….

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.

http://www.anzfallsprevention.org/conference-wrap-up/

Barker A et al 2016 6-Pack programme to decrease falls injuries in acute hospitals: cluster randomised controlled trial. *BMJ* 2016;352:h6781

Effectiveness at large scale

40% reduction in hip fracture 3 year study across all hospitals

Increased multicomponent falls assessments

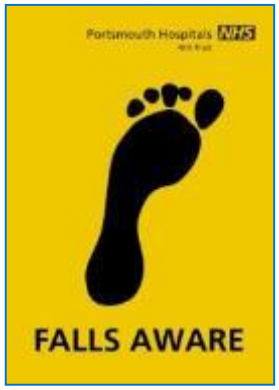
Reduced hip fractures

Increased **multifactorial individualised** interventions

Supported by nationwide systematic and comprehensive public health and primary care campaign

Jones S et al (2016) Reducing harm from falls. New Zealand Medical Journal N Vol 129 No 1446 p 89-103.

Single interventions for which there is currently poor or little research evidence for efficacy



Oliver D, Healey F, Haines T (2010) Preventing falls and falls related injuries in hospital *Clinics in Geriatric Medicine* (26 4 645-692)

Staff Education

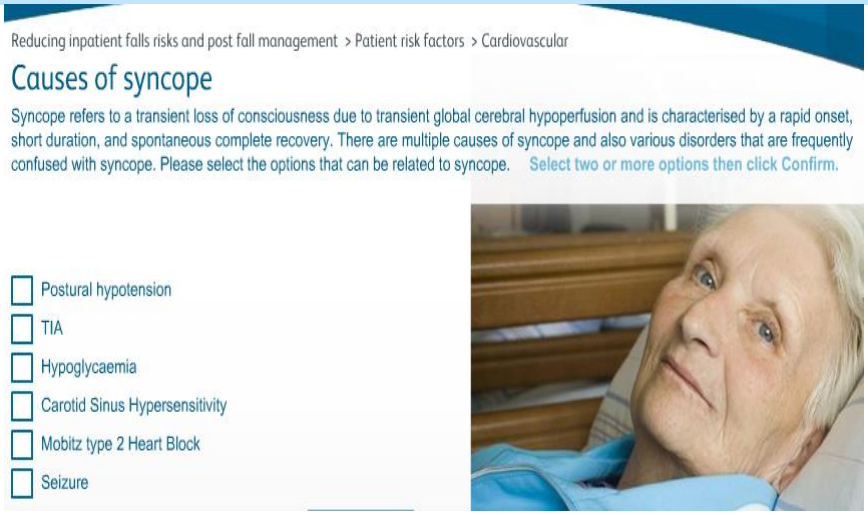
http://www.laterlifetraining.co.uk/

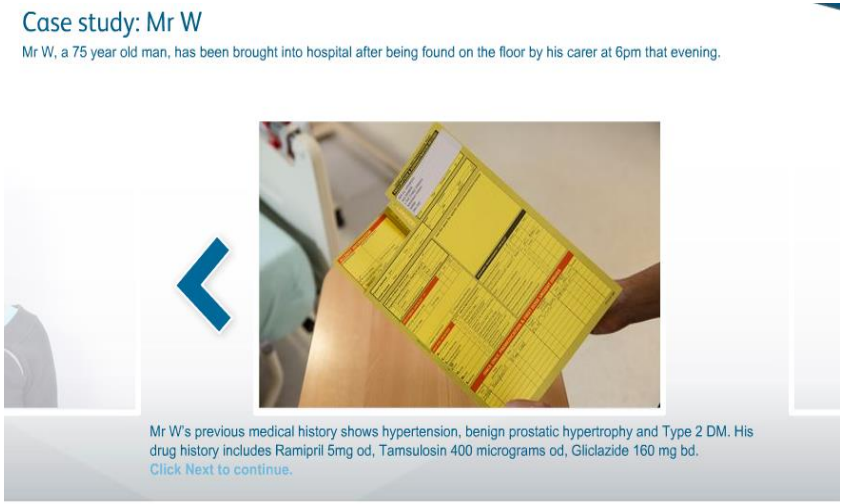
http://www.e-lfh.org.uk/programmes/preventing-falls/

E-learning for nurses.

E-learning for doctors.

http://www.e-lfh.org.uk/programmes/preventing-falls/





Thanks for listening ….Any questions?

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