NHS Improvement

Patient safety struggles and successes – are there lessons we can apply to falls prevention?

Dr Frances Healey, RN, PhD, Deputy Director of Patient Safety (Insight)

September 2017

Aiming to cover

NHS Improvement

- Some patient safety culture
- Some ideas from Charles Vincent
- Some ideas from Don Berwick

Note that:

- I will touch on areas Julie will cover in more depth
- Some chances to share with your neighbour

NHS
Improvement

LIVE STRONGER FOR LONGER
PREVENT FALLS & FRACTURES

Three Nation Approach To Reducing Harm From Falls

We’ve moved beyond narrow definitions of safety….

NHS Improvement

“…avoiding injuries to patients from the care that is intended to help them”
- Institute of Medicine

*“The simplest definition of patient safety is **the prevention of errors and adverse effects** to patients associated with health care.”*

– WHO website

*“Patient safety ….is concerned with errors of commission (doing the wrong thing) and **errors of omission (failure to do the right thing)** and is **inextricably linked with the other aspects of quality** (effectiveness and patient experience)”*

- NHS Improvement

Royal College of Physicians | Setting higher standards

A National Aud

Report of the 2

Preventable deaths due to problems in care in English acute hospitals: a retrospective case record review study

Helen Hogan, Frances Healey, Graham Neale, Richard Thomson, Charles Vincent, Nick Black

Learning from preventable deaths: exploring case record reviewers' narratives using change analysis

Helen Hogan, Frances Healey, Graham Neale, Richard Thomson, Nick Black and Charles Vincent

Using targeted risk factor reduction to prevent falls in older in-patients: a randomised controlled trial

Frances Healey, Andrew Monro, Angela Cockram, Vicki Adams, David Heseltine

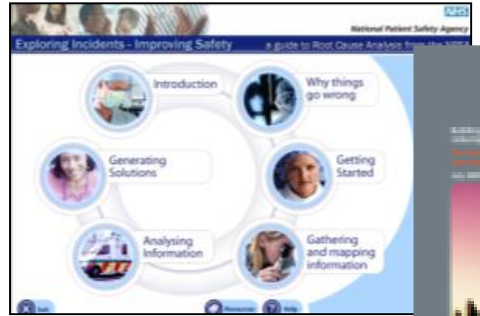
SYSTEMATIC REVIEW

The effect of bedrails on falls and injury: a systematic review of clinical studies

Frances Healey, David Oliver, Alison Milne, James B Connelly

Royal College of Physicians

Why FallSafe?
Care bundles to reduce inpatient falls



Slips, trips and falls in hospital

PSO/3

NICE

Falls: assessment and prev
falls in older people

PATIENT SAFETY FIRST

The 'How to' Guide for
Reducing harm from falls

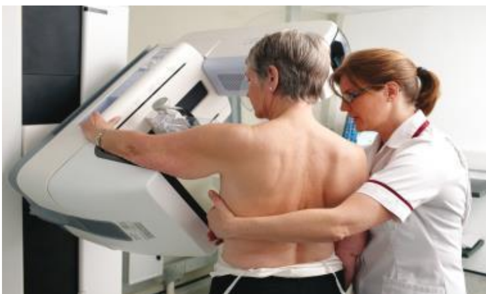
http://britishgeriatricssociety.wordpress.com/2013/12/19/fallsafe-are-culture-clashes-good-for-us/

Safer Healthcare – strategies for the real world (free e-book)

Ultra-safe

Adaptive

Ultra-adaptive

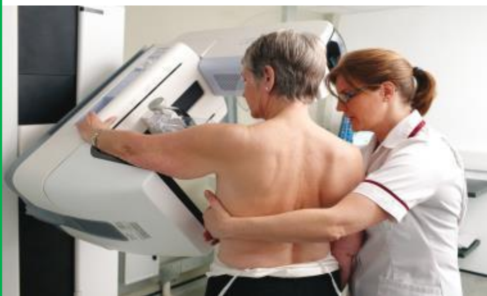


http://cgd.swissre.com/risk_dialogue_magazine/Safety_management/A_continuum_of_safety_models.html

Ultra-safe (uniformity + reliability)

NHS Improvement

Ultra-safe



Adaptive

Ultra-adaptive

Adaptive

NHS Improvement

Ultra-safe	Adaptive	Ultra-adaptive

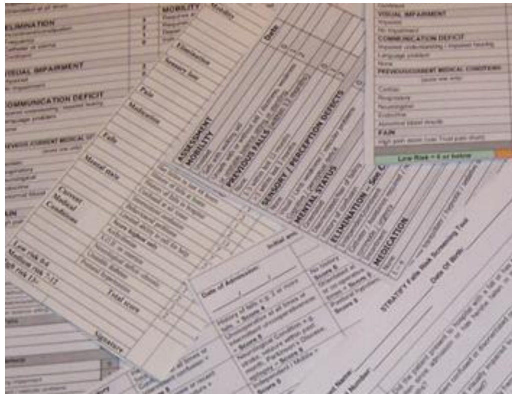
Ultra-adaptive (heroic)

NHS Improvement

Ultra-safe	Adaptive	Ultra-adaptive

Falls risk assessment

Falls risk prediction scores (numbers)



Ultra-safe

Prompts to consider manageable risk factors

Medication. Check for medication associated with falls risk, e.g. anti-depressants, sleeping tablets, sedation, anti-psychotics. Ask doctor to review (do not stop abruptly).	On temazepam 10mg nocte for some years – to review at ward round.
MDT. Ensure medical staff, physiotherapist, OT, social worker, etc aware of the patient's risk, frequency, nature, seriousness of falls (local protocol or pathway would cover expected actions by MDT members, e.g. mini-mental, osteoporosis check, mobility aid review).	SHO aware. Physio referral sent 3/2/07. OT referral sent 3/2/07. Noted on discharge plan.
Footwear. Check footwear for secure fit, non-slip sole, no trailing laces. Ask relatives to supply safer replacement or supply new slippers from ward store. Consider slipper socks in bed for patients at risk of falling at night.	Backless slippers – not safe. Daughter cannot get replacement until Saturday. Provided with new slippers from ward store.
Place. Nurse in most appropriate place on ward for their needs, e.g. close to nurses' station, close to toilet, quietest area (considering other patients' needs as well).	In Bay 3 nearest toilet and within earshot of nurses' station.
Lighting. Consider lighting best for patient, e.g. bedside lamp left on	Will have overhead lamp on low overnight.

Adaptive

Nursing Times.net

EDITOR'S COMMENT

"It's time to change the culture of the NHS

HOME | NURSING PRACTICE | NURSING TIMES LEARNING | OPINION | STUDENT NURS

Practice comment

Nursing by numbers: nurses must use clinical judgement to assess risk

12 April, 2010

Risk assessment tools may over or underpredict risk. It is essential to understand their limitations and have confidence in our own clinical judgement, says Frances Healey

Last year my co-author and I concluded that tools claiming to predict patients' likelihood of falling as "high" or "low" do not work well, with little evidence they are any more effective than nurses' judgement (Oliver and Healey, 2009). In this week's Practice Review, Professors Griffiths and Jill

http://britishgeriatricssociety.wordpress.com/2013/05/16/all-down-to-numbers/

NHS Improvement

- Miss A was a retired ballet teacher aged 79
- Admitted after a series of emergency calls following falls at home. Ambulance staff say her speech was slurred and think she may have been drinking.
- Has a spectacular black eye, but no other injuries.
- Brings in a carrier bag with a range of prescribed medication, sleeping tablets, and herbal remedies
- Appears very unsteady on her feet but refuses to relinquish her steel-tipped ebony walking stick for a frame
- Will ring for help before mobilising, but considers three seconds too long to wait, and so sets off without staff
- Deflects any attempts to formally assess her memory or self-care skills; *'maybe tomorrow, darling, I'm just too tired'.*
- Is extremely thin but says she always has been, rejects everything on the menu except toast

Improvement

Prevailing Theories Will Not Work

- The workforce is not trying hard enough – lean on them
- Incentives will fix it – Rig payment to force changes
- Regulations will fix it – Tighten controls - Enforce goals
- Measurement is a primary driver – Measure and report
- Formal experiments will point the way – Use RCT's
- More technologies will solve it – Build stuff
- "If only professionals could seize the controls..."
- Require spread

NOT.....	INSTEAD...
"Try Harder"	"We Are in This Together"
"Pay for Performance"	"Pride and Joy in Work"
"Follow the Rules"	"Use Principles...Modify as Needed"
"Measure and Report"	"Measure to Learn"
"Randomized Trials"	"Focused Empiricism"
"More"	"Less"
"Doctors Rule"	"Only a Team Can Succeed"
"Do What Worked Before"	"Customize Every Step"

NHS Improvement

Past approaches	Don’s proposals
The workforce is not trying hard enough – set targets & penalties	**It’s a shared challenge**
Incentives will fix it – change the payment system to incentivise	Pride and joy in the work
Regulation will fix it – create rules, inspect and enforce	Principles not detailed procedures
Measurement drives improvement – measure more	Measurement informs improvement – measure less
RCTs will show the way – make research & systematic review more rigorous	Evaluate real-life interventions and realistic evidence synthesis
Technology holds the answer	People hold the answer (and technology helps them)
Clinical (medical?) leadership is the key	We need the team (the whole team)
Require spread – it worked for them, don’t reinvent the wheel	Own and adapt

Sanctions succeeded? MRSA

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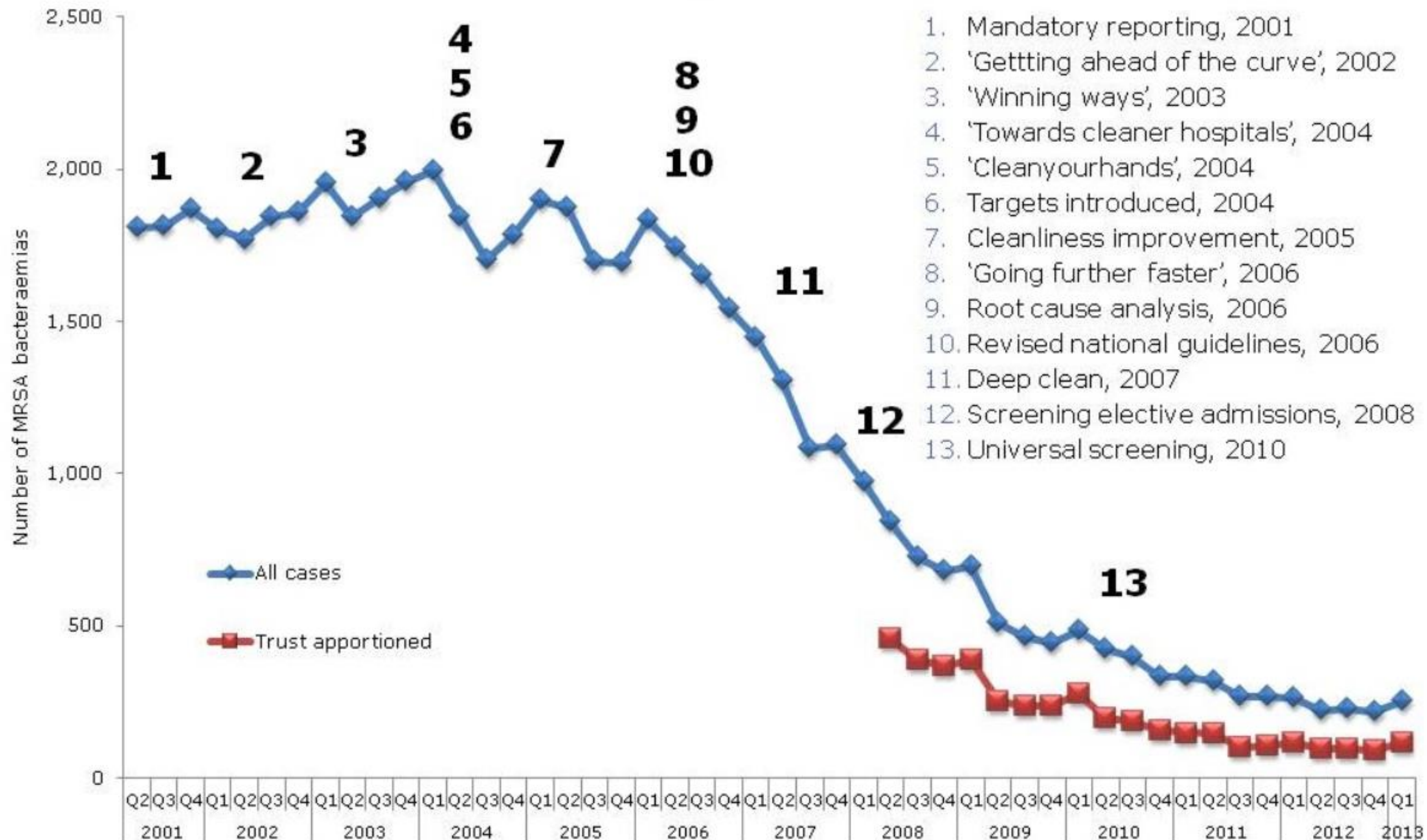
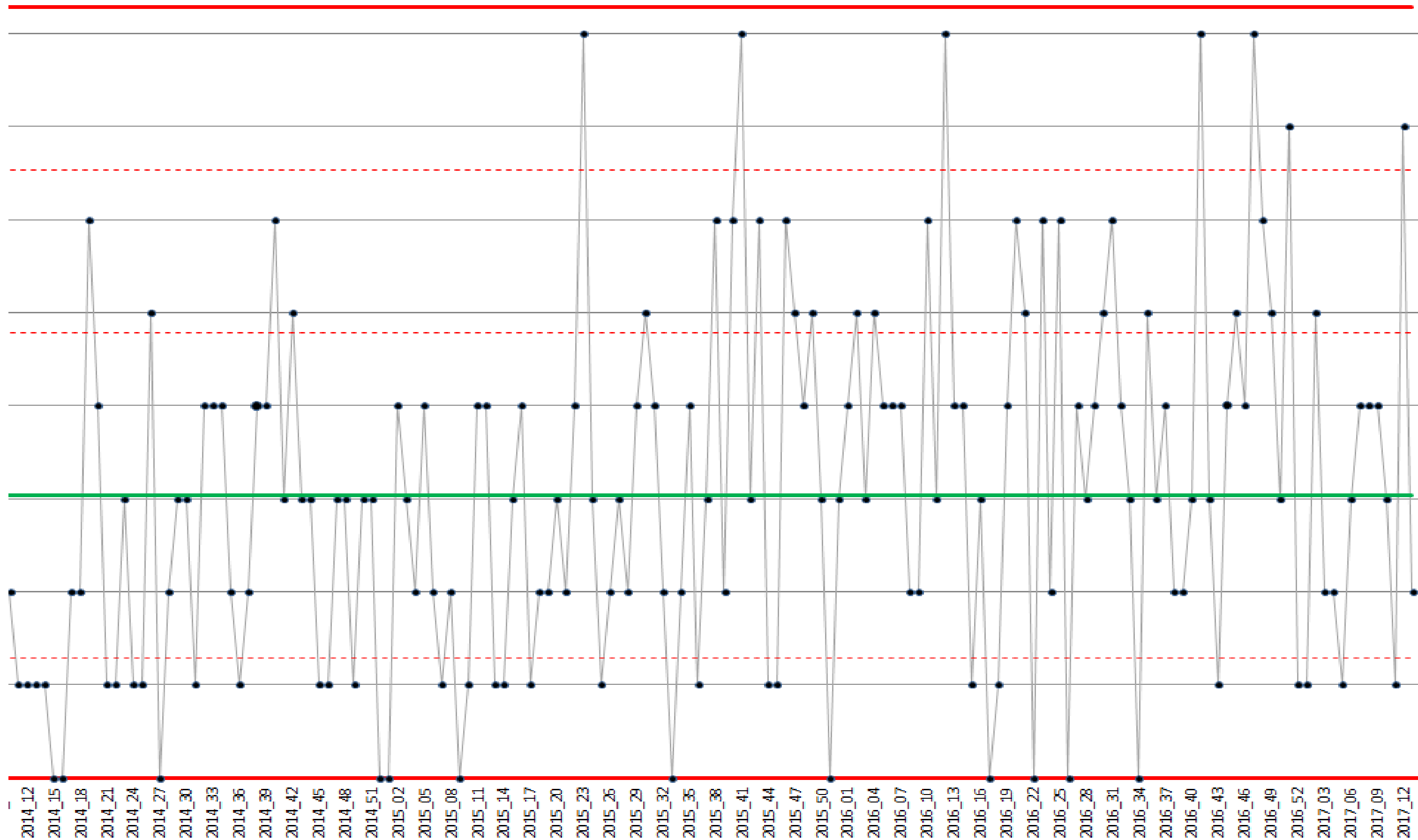


Sanctions failed?
(Surgical Never Events)

NHS
Improvement



A shared challenge

NHS Improvement

The Five Year Forward View

The health and wellbeing gap

The care and quality gap

The funding and efficiency gap

A sustainable NHS that continues to be tax-funded, free at the point of use and that is fully equipped to meet the evolving needs of its patients, now and in the future.

'Baby Boomers'	'Generation X'	'Generation Y'	'Generation Z'
1946-1964	1965-1980	1981-1994	1995-2010
Motivated and hard working; define self-worth by work and accomplishments.	Practical self-starters, but work-life balance important.	Ambitious, with high career expectations; need mentorship and reassurance.	Highly innovative, but will expect to be informed. Personal freedom is essential.
25% of the NHS workforce	40% of the NHS workforce	35% of the NHS workforce	<5% of the NHS workforce

Jones K, Warren A, Davies A. 2015. *Mind the Gap: Exploring the needs of early career nurses and midwives in the workplace.* Summary report from

NHS Improvement

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Rewards succeeded: AMR

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News story

Helping GPs to cut antibiotic prescriptions by 2.6m in just one year

Our national Patient Safety Team has helped GPs in the NHS to reduce how often patients are being prescribed antibiotics unnecessarily, cutting the number of prescriptions down by over 2.6 million in one year alone.

The team worked with Public Health England and NHS England to set goals and share data on antibiotic prescribing to encourage improvements across the country.

The result: we've seen an overall reduction in antibiotic prescriptions of 7.3% in just one year. This significantly exceeds the 1% reduction target set for the NHS to reduce the use of antibiotics for infections where they are not usually required or for conditions where antibiotics don't work.

> **Dr Mike Durkin, National Director for Patient Safety at NHS Improvement, said:**
>
> "This fantastic result achieved in just one year is testament to the huge efforts of GPs, pharmacists and local commissioners. Healthcare staff across the country should be congratulated for this, and our Patient Safety Team will continue to work with them and with our partners at Public Health England and NHS England to bring these figures down even further."

Rewards confused the picture: Safety Thermometer and pressure ulcers

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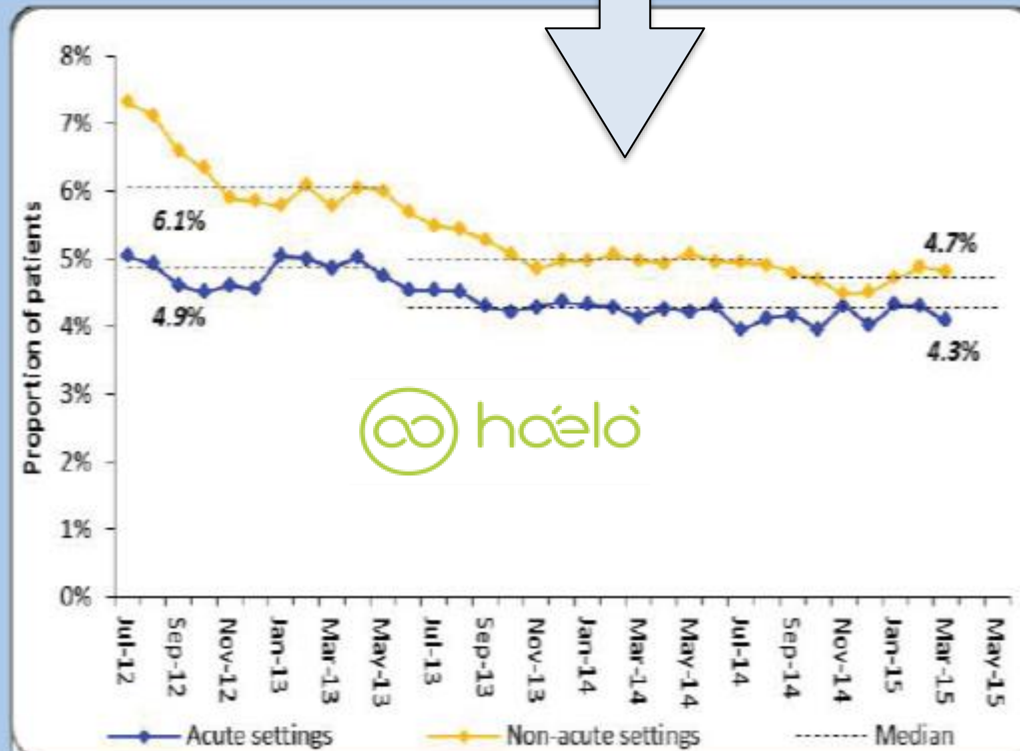
SAFETY THERMOMETER
(pressure ulcers grade 2+ prevalence)
48% captured -TVS skin survey suggests 'true' figure in acute settings **7.1%** late 2014

"....policy turbulence a major influence"



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BMJ Open 2016;6:e011886 doi:10.1136/bmjopen-2016-011886

Health services research

Multimethod study of a large-scale programme to improve patient safety using a harm-free care approach

Maxine Power[1], Liz Brewster[2], Gareth Parry[3], Ailsa Brotherton[1], Joel Minion[4], Piotr Ozieranski[5], Sarah McNicol[6], Abigail Harrison[1], Mary Dixon-Woods[7]

+ Author Affiliations

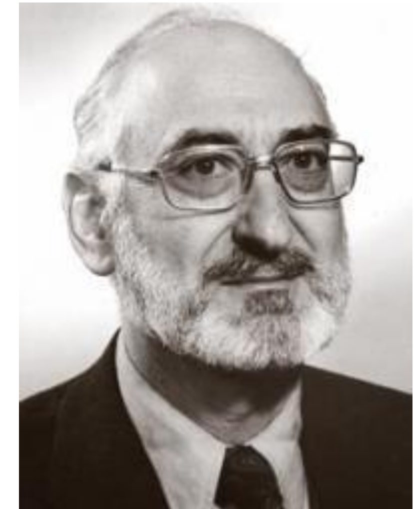
Correspondence to
Professor Mary Dixon-Woods; md753@medschl.cam.ac.uk

Received 11 March 2016
Revised 7 July 2016
Accepted 15 July 2016
Published 22 September 2016

"...at the core of [healthcare] are two human beings who have agreed to be in a relationship where one is trying to help relieve the suffering of another, which is love."

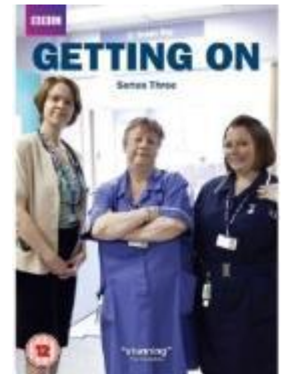
Don Berwick 'Money-driven medicine' 2010

"Systems awareness and systems design are important for health professionals, but they are not enough…..ultimately, the secret of quality is love."



Professor Avedis Donabedian

Love isn't always easy….



Joy or more everyday thankfulness?

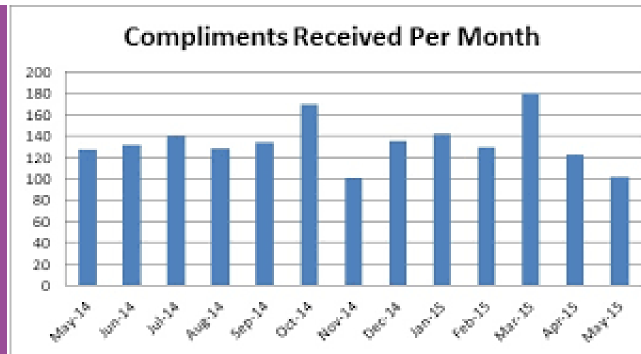
VIEWPOINT

OPEN ACCESS

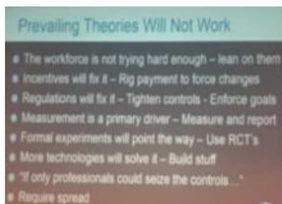
Positive deviance: a different approach to achieving patient safety

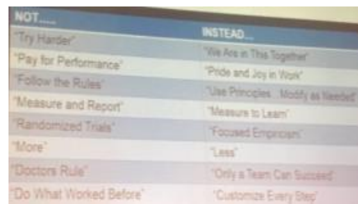
Rebecca Lawton,[1,2] Natalie Taylor,[2,3] Robyn Clay-Williams,[3] Jeffrey Braithwaite[3]

"The consistent delivery of well-executed safe care under typically difficult circumstances tends to go unrecognised"



A particular challenge for falls prevention?





NHS Improvement

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Require spread – it worked for them, don't reinvent the wheel	Own and adapt

'Inadequate' Hinchingbrooke hospital to be put in special measures

Care Quality Commission publishes scathing report revealing catalogue of serious failings at privately run hospital

Hinchingbrooke hospital in Cambridgeshire. Photograph: Terry Harris/Rex Features

Hinchingbrooke hospital will be placed into special measures after a report by the Care Quality Commission (CQC) revealed a catalogue of serious failings at the privately run hospital, including in its A&E unit, which put patients in danger and delayed their pain relief.

Virginia Mason is denied full accreditation after lapses

Originally published June 21, 2016 at 2:44 pm | *Updated June 22, 2016 at 12:29 pm*

1 of 3 *The Virginia Mason Medical Center complex, on Seattle's First Hill, was visited May 20 by the Joint Commission, which inspects hospitals. (Greg Gilbert/The Seattle Times)*

Virginia Mason Medical Center in Seattle was found out of compliance in nearly 30 areas during a surprise visit in May by the Joint Commission, a nonprofit group that accredits hospitals across the nation

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NHS Improvement

NHS Improvement

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More measures ≠ better measures

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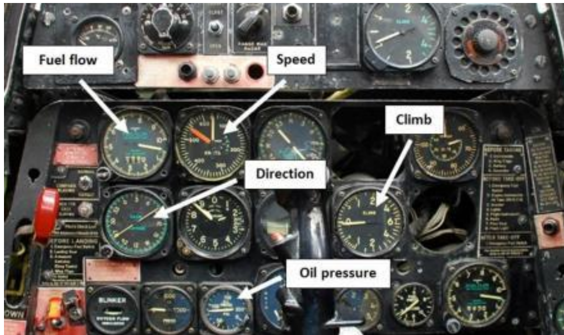
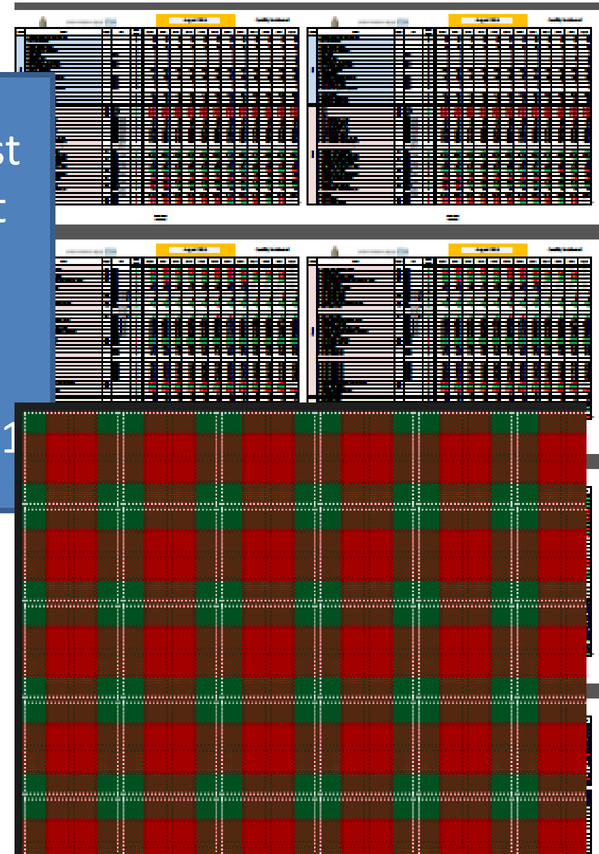


Anytown trust board report

Quality Dashboard pages 270-381



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Perspective

Restoring Trust in VA Health Care

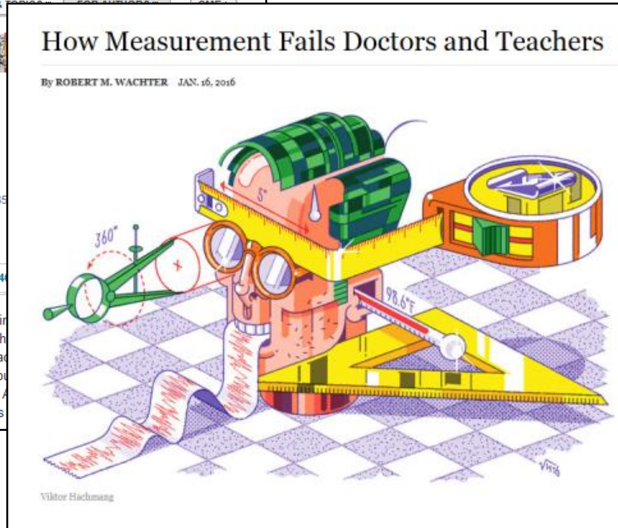
Kenneth W. Kizer, M.D., M.P.H., and Ashish K. Jha, M.D., M.P.H.

N Engl J Med 2014; 371:295-297 | July 24, 2014 | DOI: 10.1056/NEJMp140685

Comments open through July 30, 2014

Article | References | Citing Articles (2) | Comments (4

It has been nearly 20 years since the Veterans Health Admir
that oversees the Department of Veterans Affairs (VA) health
sweeping reforms that markedly improved quality, boosted ac
Recent revelations about long wait times for veterans compou
administrators make it clear that reforms are again needed. A
of wait-time data at more than 40 facilities indicate a serious



How Measurement Fails Doctors and Teachers

By ROBERT M. WACHTER JAN. 16, 2016

Viktor Hachmang

NHS Improvement

Measurement effort & time compared to improvement effort & time?

"If you're not measuring, how will you know if you're improving?"

Does everything have to be measured?

Pause for a quick conversation with your neighbour:

- Think of an aspect of healthcare that you believe has improved since your career began
- Even though not measured, could you convince a reasonable judge & jury that improvement has occurred?

We don't always need a statistician …

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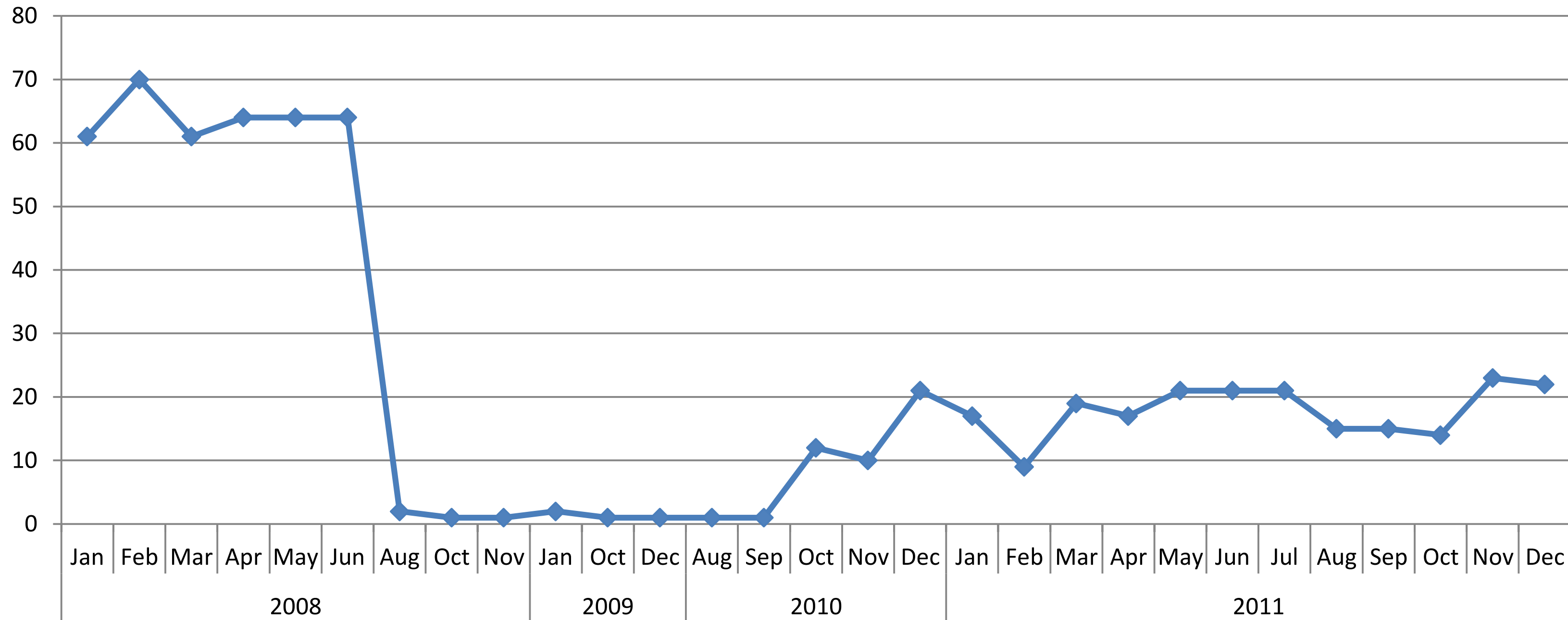

This chart shows reported falls per month in a 500 bed hospital – the high point of scale is 80, bottom is zero

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60% certain last fall was reported

77% certain last fall was reported

16
14
12
10
8
6
4
2
0

Feb-10 Mar-10 Apr-10 May-... Jun-10 Jul-10 Aug-10 Sep-10 Oct-10 Nov-10 Dec-10 Jan-11 Feb-11 Mar-11 Apr-11 May-... Jun-11 Jul-11 Aug-11 Sep-11 Oct-11 Nov-11 Dec-11 Jan-12

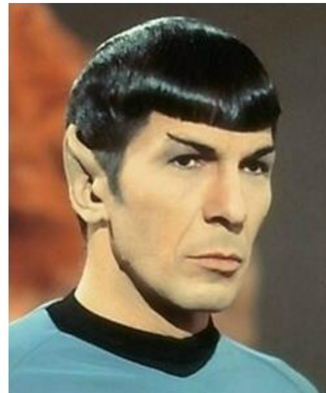
- **Frequent data or accurate data can be a trade-off**
- **Not so much 'good enough' as 'do you know how good it is?' – because you can't measure changes in quality if you are concurrently improving data quality and completeness**

NHS
Improvement

More on measurement…

Culture and behaviour in the English National Health Service: overview of lessons from a large multimethod study

Mary Dixon-Woods,[1] Richard Baker,[1] Kathryn Charles,[2] Jeremy Dawson,[3] Gabi Jerzembek,[4] Graham Martin,[1] Imelda McCarthy,[4] Lorna McKee,[5] Joel Minion,[1] Piotr Ozieranski,[6] Janet Willars,[1] Patricia Wilkie,[7] Michael West[8]



https://www.slideshare.net/DrFrancesHealey/2015-july06-psc-frances-healey-ps-data-or-ps-intelligence-30-mins

NHS Improvement

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Inpatient intervention: Forest plots (multifactorial interventions)

Acute Setting

Falls – incidence rate ratio

Study or Subgroup	log[Rate Ratio]	SE	Weight	Rate Ratio IV, Random, 95% CI
1.1.1 Randomised trials				
Cumming (acute)	0.0583	0.2655	48.8%	1.06 [0.63, 1.78]
Dykes 2010	-0.5978	0.2454	51.2%	0.55 [0.34, 0.89]
Subtotal (95% CI)			**100.0%**	**0.76 [0.40, 1.44]**
Heterogeneity: Tau² = 0.15; Chi² = 3.29, df = 1 (P = 0.07); I² = 70%				
Test for overall effect: Z = 0.85 (P = 0.40)				
1.1.2 Controlled Pre/Post				
Koh 2009	-0.2357	0.1665	100.0%	0.79 [0.57, 1.09]
Subtotal (95% CI)			**100.0%**	**0.79 [0.57, 1.09]**
Heterogeneity: Not applicable				
Test for overall effect: Z = 1.42 (P = 0.16)				
1.1.3 Other non random				
Brandis 1999	-0.0726	0.0897	23.1%	0.93 [0.78, 1.11]
Krauss 2008	-0.3011	0.1703	14.0%	0.74 [0.53, 1.03]
Lieu 1997	-0.844	0.2189	10.3%	0.43 [0.28, 0.66]
Mitchell 1996	-0.5621	0.2636	7.9%	0.57 [0.34, 0.96]
Rainville 1984	0	0.2692	7.7%	1.00 [0.59, 1.69]
Schwendimann 2006b	-0.3147	0.2247	10.0%	0.73 [0.47, 1.13]
Von Renteln-Kruse 2007	-0.1985	0.0593	27.0%	0.82 [0.73, 0.92]
Subtotal (95% CI)			**100.0%**	**0.76 [0.64, 0.90]**
Heterogeneity: Tau² = 0.02; Chi² = 13.67, df = 6 (P = 0.03); I² = 56%				
Test for overall effect: Z = 3.20 (P = 0.001)				

NICE 2013

Adaptive

Ultra-safe

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

Adaptive

NHS Improvement

Age and Ageing Advance Access published December 8, 2013

Age and Ageing 2013; 0: 1–7
doi: 10.1093/ageing/aft190

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Falls prevention in hospitals and mental health units: an extended evaluation of the FallSafe quality improvement project

Frances Healey[1], Derek Lowe[2], Adam Darowski[3], Julie Windsor[4], Jonathan Treml[5], Lisa Byrne[6], Janet Husk[2], Jill Phipps[7]

[1]NHS England, London, UK
[2]Royal College of Physicians, London, UK
[3]Oxford Radcliffe Hospitals, Oxford, UK
[4]Portsmouth Hospitals NHS Trust, Portsmouth, UK
[5]University Hospitals Birmingham, Birmingham, UK
[6]Great Ormond Street Hospital, London, UK
[7]Southern Health, Southampton, UK

Halving broken hips in public hospitals – the Aotearoa New Zealand experience

Health Quality & Safety Commission New Zealand

www.hqsc.govt.nz
newzealand.govt.nz

The problem

Two patients in our public hospitals fall and broke their hip every week in 2012. By 2016, that number has nearly halved.

The results

Reductions in harm from falls and value for money

The approach

The Health Quality & Safety Commission's role

An integrated and sustainable approach

The future

The future involves:

- keeping the evidence up to date
- ensuring sustainability and spread
- continuing to promote – maintaining the annual 'April Falls' events
- continuing a broader 'health of older people' focus with other agencies and across sectors.

NHS Improvement

Ultra-safe

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

But without the rigour of RCT design and execution would the negative results have been believed?

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

Another example of realistic evidence synthesis: do bedrails increase the risk of falls & injury?

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AFTER REDUCTION:	**Falls (% change)**	Injuries (% change)	Serious inj. (number)	**Statistically significant?**
Si,1999	***+61%***	*No change*	*+1*	***Yes (falls↑)***
Hoffman, 2003	*-7%*	*-2%*	*+1*	*No*
Capezuti, 2007	**↓ *46% int.*** **↓ *38% cont.***	~ ~	*2 → 1* *7 → 4*	*No sig difs*
Brown,1997	***+118%***	~	~	***Yes (falls↑)***
Hanger, 1999	***+25%***	*+3%*	*+1**	***Yes (falls↑)***

Healey et al. 2008 Age and Ageing 33(4) 390-394

NHS Improvement

MENTAL STATE				
	Patient is confused and disorientated	Use bedrails with care	Bedrails NOT recommended	Bedrails NOT recommended
	Patient is drowsy	Bedrails recommended	Use bedrails with care	Bedrails NOT recommended
	Patient is orientated and alert	Bedrails recommended	Bedrails recommended	Bedrails NOT recommended
	Patient is unconscious	Bedrails recommended	N/A	N/A
		Patient is very immobile (bedfast or hoist dependant)	**Patient can mobilise, but only with help from staff**	**Patient can mobilise without help from staff**
		MOBILITY		

NHS
Improvement

Mrs Green is very frail, has poor hearing and eyesight, and limited mobility that means she can manage only a few steps with a walking frame, and probably has at least moderately impaired memory. She has been getting out of bed at night to use the toilet without calling the nurses but has nearly fallen on the way, and her husband is desperately worried she will fall. He asks the team to put bedrails on the bed. He knows she is unlikely to get around or over the bedrails because of her frailty so will have to call the nurses when wanting to get out of bed. Mrs Green agrees with her husband but the nurses are unsure if she has really understood.

Pause for a quick conversation with your neighbour:

- **What would you do?**

MENTAL STATE				
	Patient is confused and disorientated	Use bedrails with care	Bedrails NOT recommended	Bedrails NOT recommended
	Patient is drowsy	Bedrails recommended	Use bedrails with care	Bedrails NOT recommended
	Patient is orientated and alert	Bedrails recommended	Bedrails recommended	Bedrails NOT recommended
	Patient is unconscious	Bedrails recommended	N/A	N/A
		Patient is very immobile (bedfast or hoist dependant)	Patient can mobilise, but only with help from staff	Patient can mobilise without help from staff
		MOBILITY		

Adaptive

OPINION

Nursin' USA - Why do UK nurses consider restraints unacceptable?

19 June, 2010

Our resident American nurse Sara Morgan wonders why the UK, with such a focus on patient safety, considers even minimal restraint unacceptable?

Physically restraining fellow human beings is a practice generally frowned upon. Restraints are reserved for criminals, those suspected of being criminals and particularly adventurous fancy-dress costumes. In healthcare, we are (thankfully) long past the days when psychiatric or unruly medical patients were tied to their beds, the wall or each other as a way of maintaining order. Many activities that we nurses effortlessly navigate on a daily basis such as patients complaining, declining medication or questioning a doctor's decision, were previously grounds for the application of restraints. Isn't it fantastic that we have evolved beyond such crude methods of interacting with patients?

But...

We have an enormous problem with patient falls. We've all seen the statistics: thousands of falls per year, resulting in hundreds of injuries, fractures and even deaths. According

RELATED ARTICLES

- UK nurses do care deeply about patient safety – which i why they don't use restrainin vests
  13 July 2010
- Last offices neglected in over half of hospital deaths
  11 May 2010

OPINION

UK nurses do care deeply about patient safety – which is why they don't use restraining vests

13 July, 2010

Frances Healey on the use of restraint vests and why the UK is lucky to have avoided introducing them.

- This article is in response to Nursin' USA - Why do UK nurses consider restraints unacceptable?

The consequences of a fall in hospital can be severe, and the risk of falls and injury are a great cause of anxiety to nurses who want to keep their patients safe. But advocating that nurses in the UK should copy their American counterparts by tying patients to their beds or chairs with restraining vests is not the way forward. The Royal College of Nursing in their guidance on restraint (RCN, 2008) state that *"Vest, belt or cuff devices specifically designed to stop people getting out of beds or chairs are in relatively common use in hospital and care home settings in many countries outside the UK, including in Europe, the USA and Australia. These devices are not acceptable in the UK."*

RELATED ARTICLES

- Nursin' USA - Why do UK nurses consider restraints unacceptable?
  19 June 2010
- Antipsychotic use in dementi
  16 November 2009

NHS Improvement

Past approaches	Don's proposals
The workforce is not trying hard enough – fix targets and penalties	It's a shared challenge
Incentives will fix it – change the payment system to incentivise	Pride and joy in the work
Regulation will fix it – create rules, inspect and enforce	Principles not detailed procedures
Measurement drives improvement – measure more	Measurement informs improvement – measure less
RCTs will show the way – make research & systematic review more rigorous	Evaluate real-life interventions and realistic evidence synthesis
Technology holds the answer	**People hold the answer (and technology helps them)**
Clinical (medical?) leadership is the key	We need the team (the whole team)
Require spread – it worked for them, don't reinvent the wheel	Own and adapt

" .... the alarm was brilliant – after we'd been using it for a few days he didn't even try to stand up any more."

Ward sister, overheard at a conference

NHS Improvement

The safe use of ultra low beds | Signal

Reference number	1309
Issue date	14 February 2011
Type	Signal

This Signal is about using ultra low beds safely and appropriately.

A sample incident reads:

"Patient has rolled off High/Low bed with crash mat in place and bed at lowest height. Banged his head on the bottom corner of the locker. Cut to right of head bleeding profusely .Wound covered by dressing pads with pressure to staunch flow……."

Ultra low beds can help to prevent harm from falls - particularly for patients with delirium who are at risk of falling out of bed, but who cannot be given bedrails as they might try to climb over them (see NPSA bedrail guidance). However, ultra low beds need to be used safely and appropriately.

A search of the National Reporting and Learning System (NRLS) database of all incidents reported from 1 November 2003 to 24 June 2010 identified a series of patient safety incidents related to the use of ultra low beds. These included:

- injuries from floor-level furniture or fittings such as radiators, pipes, or lockers (including one serious burn);
- ultra low beds placed close to a wall but not flush with it, creating potential for asphyxial entrapment if the patient slipped between the side of the mattress and the wall (see MHRA bedrail guidance);
- ultra low beds left at working height in error, leading to falls from height
- patients who appeared to have tripped over crash mats used beside the ultra low bed (including three fractured hips).

Some reports suggested ultra low beds were seen as a universal falls prevention solution and were therefore provided inappropriately for mobile patients (see RCN restraint guidance). Additionally, some reports suggested that ultra low beds had been used with bedrails raised, negating their purpose.

It is important to note that even when ultra low beds were used correctly in the lowest position, some patients still sustained serious injuries. These included fractured hip and intracranial injury. As a result, it is important that even falls from ultra low beds are taken seriously (see the Rapid Response Report, *Essential care after an inpatient fall*).

Local guidance, training and specialist advice should be provided to help staff to use ultra low beds as safely and appropriately as possible.
Please contact us with your initiatives to reduce risks in these areas.

NHS Improvement

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NHS Improvement

Stepping On © Clemson & Swann

Halving broken hips in public hospitals – the Aotearoa New Zealand experience

Royal College of Physicians | Falls and Fragility Fracture Audit Programme (FFFAP)

National audit of inpatient falls
Audit report 2015

active & HEALTHY

NHS Improvement

The whole team….

Can I ask who is in the room today?

Pause for a quick conversation with your neighbour:

- Tell them about a time a colleague not from your own discipline, or a patient’s family/whanau, or patient taught you something you use in falls prevention

NHS Improvement

Past approaches	Don's proposals
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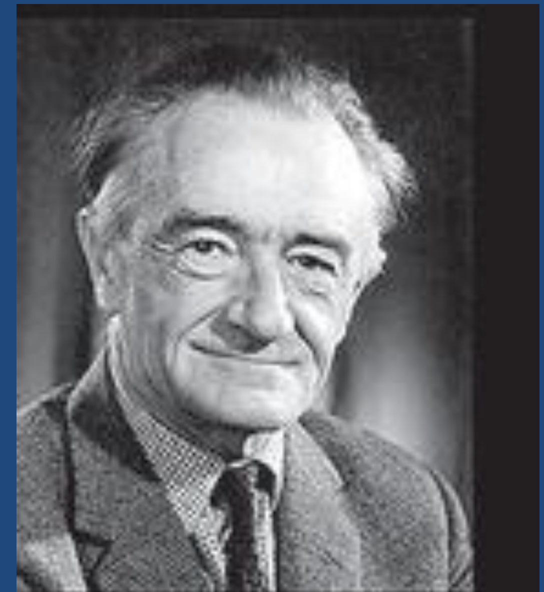
THE
COCHRANE
LIBRARY



“The results at that stage showed a slight numerical advantage for those who had been treated at home. It was of course completely insignificant statistically.

“I rather wickedly compiled two reports, one reversing the numbers of deaths on the two sides of the trial. As we were going into committee, in the anteroom, I showed some cardiologists the results……..

"……they were vociferous in their abuse: `Archie', they said, `we always thought you were unethical. You must stop the trial at once…'

"I let them have their say for some time and then apologised and gave them the true results, challenging them to say, as vehemently, that coronary care units should be stopped immediately.

"There was dead silence and I felt rather sick because they were, after all, my medical colleagues."

Professor Archibald Cochrane & Max Blythe *One Man's Medicine* (1989) p.211

Cognitive dissonance

- We have a strong need for our personal beliefs and our personal actions to chime
- The discomfort we feel when they don't is 'cognitive dissonance'
- Usually a force for good – creating our own 'wheel' means we move heaven and earth to make it turn
- Sometimes a negative - if we believe we are part of effective, motivated, caring teams, who have introduced a well thought-out change, it is very hard to also simultaneously believe:
  - We haven't achieved real improvements in safety
  - We might be less safe than peers

http://britishgeriatricssociety.wordpress.com/2013/05/16/all-down-to-numbers/

ED checklists – steady spread example

NHS Improvement

Emergency Department Safety Checklist

Patient Label here...

Date__________ Time Booked in__________

	Action	Time	Initials	Comments
1st hour completion time :	Assessment/Triage			
	Vital signs measured + NEWS recorded			
	ECG recorded (within 10 minutes)			
	*ECG reviewed by Dr (within 30 minutes - **time** on ECG)*			
	Undressed and gown			
	Wristband			
	Pain score assessed			
	Analgesia administered (if appropriate)			
	Infection control screening			
	Sepsis suspected (Temp < 36° or > 38°C, HR > 90 or RR > 20)			
	IV access + care plan			
	Blood tests			
	Imaging (Stroke, # NOF within 1 hour)			
	Specific Pathway Triggered (see box 1)			
	PFC informs CST - specialty bed required			
	Pathway commenced (e.g. Stroke, DKA, NOF, GI bleed, Sepsis)			
2nd hour completion time :	Vital signs measured + NEWS recorded			
	Pain score assessed			
	Analgesia administered (if necessary)			
	Next of kin aware			
	Patient has dementia (*This is me* commenced)			
	Refreshments offered (if not NBM)			
	Pressure Area Care:			
	Assessment undertaken			
	Care plan commenced (as appropriate)			
	Patient good to go:			
	Patient ready for transfer			
	Specialty bed confirmed			
3rd hour completion time :	Vital signs measured + NEWS recorded			
	Pain score assessed			
	Analgesia administered (if necessary)			
	Refreshments offered (if not NBM)			
	Review by senior doctor			
	Regular medication administered (if appropriate)			
4th hour completion time :	Vital signs measured + NEWS Recorded			
	Pain score assessed			
	Analgesia administered (if necessary)			
	Refreshments offered (if not NBM)			
	Regular medication administered (if appropriate)			
Referrals & Pathway/Speciality Triggers if required	Adult safeguarding referral			**Box 1 - Specialty Bed Trigger:**
	Child cause for concern referral			
	Mental health matrix completed			Stroke/TIA □ Stroke Unit (B504)
	Mental Health referral			Upper GI Bleed □ Ward 11 (B404) or MAU (A300)
	Domestic or sexual violence Yes / No			DKA □ MAU (A300) or ITU/HDU
	IDSVA referral			NIV □ Respiratory (A522) or MAU (A300)
	Paddington Alcohol Test Yes / No			Chest Drain □ MAU (A300), Respiratory (A522) or BHI/700
	Referral to Alcohol Clinical Nurse Specialist			# NOF □ T&O (A609)
	Referral to Drug Clinical Nurse Specialist			Tracheostomy □ Ward 700, A522 or ITU/HDU/CICU)

Authors: Jason Lugg & Hayley Thomas (November 2014)

The Emergency Department Safety Checklist

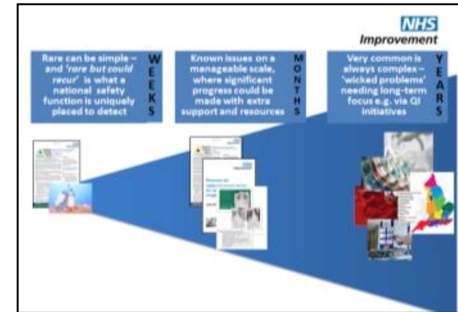
Improving safety and reliability in overcrowded urgent care systems across the West of England

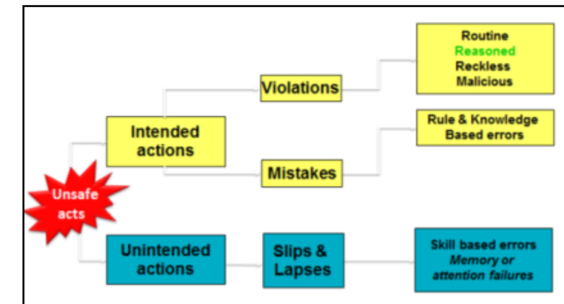
SHINE 2014 Final report at http://www.weahsn.net/wpcontent/uploads/EDCL2016_A7_01.docx

We have learned from experience

NHS Improvement

- Mindful of size of the challenge
- Error wisdom to avoid 'solutionitis'
- Balance systems & frontline
- Including through our 'ask why' videos





https://improvement.nhs.uk/resources/patient-safety-alerts/

NHS Improvement

Conscientiousness…..

Research is pointing to *conscientiousness* as the one-trait-to-rule-them-all in terms of future success, both career-wise and personal.

"It would actually be nice if there were some negative things that went along with conscientiousness," Roberts told me. "But at this point it's emerging as one of the primary dimensions of successful functioning across the lifespan. It really goes cradle to grave in terms of how people do."

http://amp.timeinc.net/time/3136568/science-points-to-the-single-most-valuable-personality-trait/?source=dam

Thank you

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