Patient Centered Falls Prevention

Theme | Patient Safety

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SaTH Improvement Hub

The Shrewsbury and Telford Hospital NHS Trust

REASON WHY?

Patients falling over in hospital can result in injury, prolonged length of stay, deconditioning and reduced clinical outcomes. All patients are different and need different levels of support to help keep them safe.

SMART AIM

S SPECIFIC M MEASUREABLE A ACHIEVABLE R RELEVANT T TIME-BOUND

To reduce the risk of patient A falling over in hospital by the end of his stay as evidenced by the number of falls

PLAN

Patient A is a 77-year-old gentleman with an acquired brain injury and as such was forgetting that he needed support to get out of bed whilst he was in hospital. On admission Patient A used a stick to get around but was unsteady on his feet and had had numerous falls at home, making him a high risk of falling in hospital as well.

He was in hospital with CDIFF and therefore was getting out of bed to go to the toilet. This had resulted in one fall and one near miss.

The ward manager planned to talk to the gentleman and his wife to work out a way to help Patient A remember not to get up without asking for assistance first .

DO

The ward manager had a discussion with the patient and his wife about what might help.

Patient A decided that a sign telling him to use his call bell would be useful. He pointed out where it should be placed on the wall so he could see it.

He decided on a large poster that would read Gary (the ward manager) says call for a nurse before you get up. Gary did query if it should have his wife's name on it, but Patient A's wife claimed that he never listened to her and it would have to have the name of someone in authority otherwise he would ignore it.

Two posters were put on the wall , one in front and one to the side of patient A.

STUDY

The day after the intervention Patient A reported that the posters had prevented him moving without assistance multiple times.

In the following week he had one fall. This was after someone (unknown) had taken the posters down without discussion with the ward manager. Patient A didn't remember who had removed them. They have since been replaced.

ACT

To **ADOPT** discussions with patients that are at high risk of falls or other patient safety issues in order to co produce effective personalised solutions.

The removal of the poster, whilst unfortunately resulting in patient A having a fall (he was uninjured) did highlight the efficacy of this simple technique and with Patient A's permission the posters were put back on the wall.

ACKNOWLEDGEMENTS & REFERENCES | Many thanks to Ward 9 and Patient A who has allowed the production of this poster.