Reduction in Falls on Ward 32

Theme | PSIRF Trust Priority

Produced by | Helen Williams and Gemma Styles

Case Study Date | 24/01/2025

REASON WHY?

Following a serious incident in 2020 where a patient on ward 32 fell and died as a result of his injuries. The staff on the ward have made significant improvements to aspects of care around prevention and treatment of people who are at risk of falls.

SMART AIM

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

To reduce the number of falls with moderate harm or above on ward 32 by 50 % by December 2024

PLAN

- The initial plan was to ensure that all porters had the correct training on moving and handling patients as well as awareness of where information is held about the mobility status of the patient.
- The porters also developed a checklist so that they would ask about mobility status , including if patients needed to escorted.
- The team, already reasonably good at risk assessment developed these skills and started to cohort patients who were at a higher risk of falls than the rest of the patients (who are all at risk) .
- They made sure to utilise the yellow slipper socks for patients who did not have access to suitable footwear.

DO

All porters now use the check list, not just for ward 32, but also for other areas to help make certain that patients with mobility problems get the right level of support that is required.

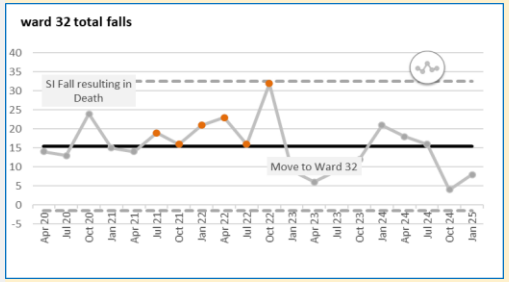
Patients make use of the yellow slipper socks. The ward discussed the potential infection control issues and decided, on balance that the risk of falling was higher than the risk of infection.

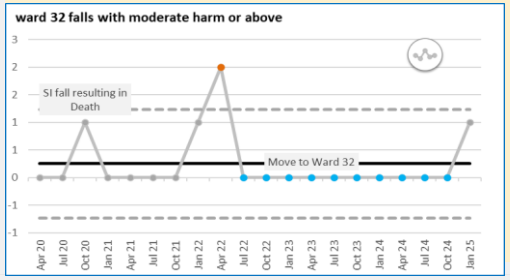
The cohorting means that higher staffing levels can be allocated to the patients who are at most risk, if they are all in one bay. It also allows for activities to be held in the bay.

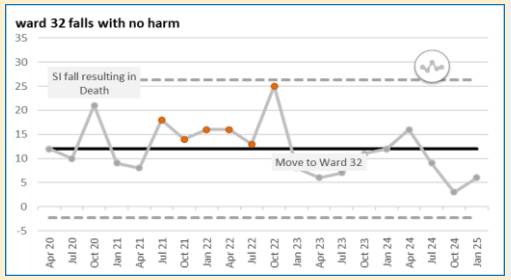
The team take patients outside in the summer and all patients are seen within 24 hours of their operation by a therapist.

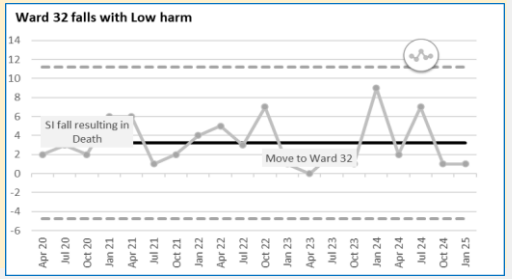
STUDY

The total number of falls has reduced over time, particularly when the unit moved to a new ward space. Interestingly what we also see is that the falls that do happen are now far more likely to result in no harm rather than low harm. There have only been 4 incidents where moderate harm or above has been caused since the death in 2020. There has been an overall reduction in falls between 21/22 and 23/24 of **34%** and a reduction of falls with moderate harm and above of **66.7%**









ACT

The team will **Adopt** all of the changes made so far.

Next Steps

To consider where future improvements can be made in areas such as lying and standing blood pressure and neuro obs.

To discuss as a team the possible reintroduction of a checklist board that includes medication, footwear and eyewear/hearing aids as well as walking aids, as an aide memoir to staff.

There is a recognised issue with the floor, as it can look like water to patients who have cognitive issues, however this is currently outside of the wards ability to change.

ACKNOWLEDGEMENTS & REFERENCES | **All staff on ward 32 and the support from the Dementia team, and IPC.**