The Evolution of the Falls Bundle

Medication
Mobility
Exercise
Diet
Safety
- Personal
- Environmental

→

Multi
Factorial
Falls
Risk
Assessment
Tool

→ Acute

Medication
Orthostatic Hypotension
Mobility

→ OPS

Medication
Orthostatic Hypotension
Mobility
Exercise
Diet
Safety
- Personal
- Environmental

Compliance Non compliance

WARD/OPS/HOME: DATE: TIME:

Building a Better Health Service | Seirbhís Sláinte Nios Fearr á Forbairt
National Quality Improvement Team

Has the Patient received:	Patient 1	Patient 2	Patient 3	Patient 4	Patient 5	Total %
Medication:						
1) Have high risk medications for falls been identified and newly prescribed during inpatient stay?						
2) If so, has rationale for prescribing been identified?						
Orthostatic Hypotension:						

Compliance Non compliance

WARD/OPS/HOME: 1 DATE: 12/11/2019 TIME:

Has the Patient received:	Patient 1	Patient 2	Patient 3	Patient 4	Patient 5	Total %
Medication:						
1) Have high risk medications for falls been identified and newly prescribed during inpatient stay?	√	√	√	√	X	80%
2) If so, has rationale for prescribing been identified?	√	√	√	√	X	80%
Orthostatic Hypotension:						
1) Has the patient been assessed for orthostatic hypotension?	√	√	√	√	X	80%
2) Has lying and standing blood pressure been recorded at least once?	√	√	√	√	X	80%
Mobility:						
1) Has the patient's mobility needs been established at the time of assessment?	√	√	√	√	X	80%
2) Have mobility aids been left in accessible areas?	√	√	X	√	X	60%
3) If the patient has a walking aid at home, has this been provided within 24 hours?	X	√	X	√	X	40%
Compliance/Non Compliance	☹	☺	☹	☺	☹	
Total	0%	100%	0%	100%	0%	40%

Comments: Record here when a deliberate change was introduced and/or an event took place. Use this information to annotate your run charts.

SAFETY - Personal

SAFETY - Environment

Risk Factor	Active Problem			Consider the following:	Date & Time
Memory/Mood	Patient/carer report or staff note known history of Cognitive Impairment/ Dementia	☐ No	☐ Yes	If Yes, consider the following: Care plan reflects needs with supervision/assistance with ADLs ☐	
	Evidence of Delirium (e.g. 4 AT score 4 or more)	☐ No	☐ Yes	Inform Medical Team of Delirium for review ☐	
Visual Impairment	Patient report / staff note vision impairment at admission	☐ No	☐ Yes	If Yes, consider the following: Ensure glasses or visual aids are available/reachable & clean ☐	
Access to Toilet					
Footwear					
Night-time Risk					
Environment Screen					

Date: _____

Falls Prevention Screen
(Acute Hospital)

Date: _____ Time: _____ Initials: _____

Patient Details:

If Yes to any of these please complete the **Multi-factorial Falls Risk Assessment** below on this patient

(Tick as applicable) ✓

- *Is the patient 65 years or older?* ☐ Yes ☐ No
- Is the patient 50 - 64 years old **AND** ☐ Yes ☐ No
  - *Had a fall in the past year / admitted with a fall OR* ☐ Yes ☐ No
  - *Help / supervision needed to transfer / walk OR* ☐ Yes ☐ No
  - *Has a fear of falling OR* ☐ Yes ☐ No
  - *A medical condition that, in your judgement, would increase a fall risk; such as stroke, amputee, etc* ☐ Yes ☐ No
- *Is the patient aged under 50 years AND had a fall in the past year / admitted with a fall?* ☐ Yes ☐ No

Multi-factorial Falls Risk Assessment

Interventions Required should be incorporated in the main nursing care plan

	Risk Factor	Active Problem - High risk medications prescribed during in-patient stay			Consider the following:	Date & Time
MEDICATION	Identification of high risk medications for falls	Benzodiazepines; hypnotics/anxiolytics	☐ No	☐ Yes	If Yes, consider the following: Liaise with the prescriber regarding new high risk medications prescribed ☐	
		Antipsychotics	☐ No	☐ Yes	Liaise with the pharmacist regarding high risk medications prescribed ☐	
		Antidepressants	☐ No	☐ Yes	Evidence for prescribing rationale completed: (See Psychotropic Prescribing Algorithm) ☐ No ☐ Yes	
OH ORTHOSTATIC HYPOTENSION	Cardio-vascular	Lying and standing blood pressure reading indicates probable orthostatic hypotension	☐ No	☐ Yes	If Yes, consider the following: Consult Medical Team ☐	
		Patient reports feeling dizzy / lightheaded / fainting episodes or loss of consciousness within the last year	☐ No	☐ Yes	Review of antihypertensives and / or diuretics ☐	
MOBILITY	Mobility Needs	Patient's admission to hospital is a result of a fall	☐ No	☐ Yes	If Yes, consider the following: Refer to Physiotherapy ☐	
		Patient had a fall in last 12 months	☐ No	☐ Yes	Ensure patient's walking aid is available and accessible ☐	
		Patient reports fear of falling	☐ No	☐ Yes	Refer to Occupational Therapy ☐	
		Patient reports or staff note unsteady gait - require assistance /supervision to mobilise	☐ No	☐ Yes	Provide patient with Falls Prevention Leaflet ☐	
		Does the patient require assistance to stand	☐ No	☐ Yes	Ensure Call Bell is within easy reach and advise patient re use of same ☐	

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The situation we are facing

- An estimated 60,000 people over 65 require for medical attention for a fall each year. (TILDA 2017)

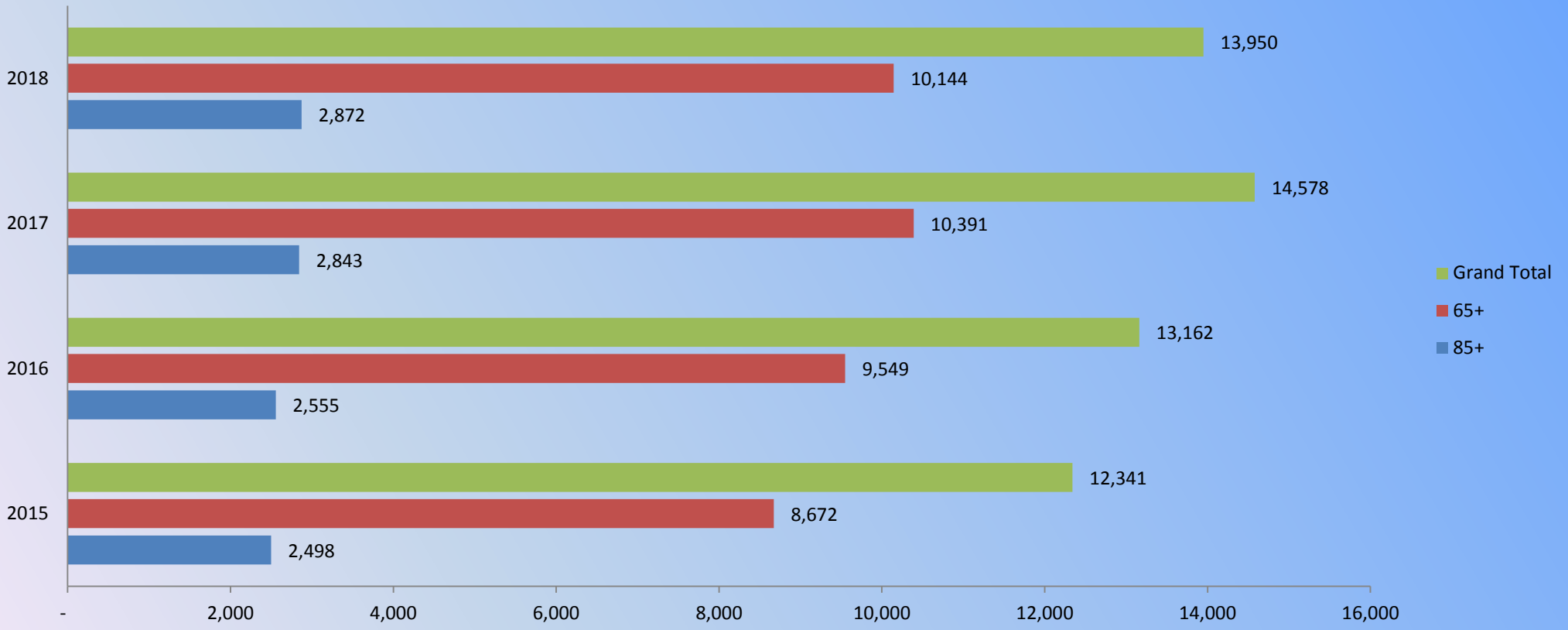
- Low falls (< 2metres) are the leading cause of injury, accounting for 81% of major trauma presentations in people aged ≥ 65 years (NOCA Major Trauma Audit 2017) which is an increase of 4% over the previous year figure.

- Hip fractures - 3,608 people over the age of 60 were admitted to Irish hospitals with hip fracture in 2017. (Irish Hip Fracture Database)

- The number of hospitalisations for hip fractures is projected to triple from 4301 in 2014 to 12,709 in 2046 (Kelly et al, 2018)

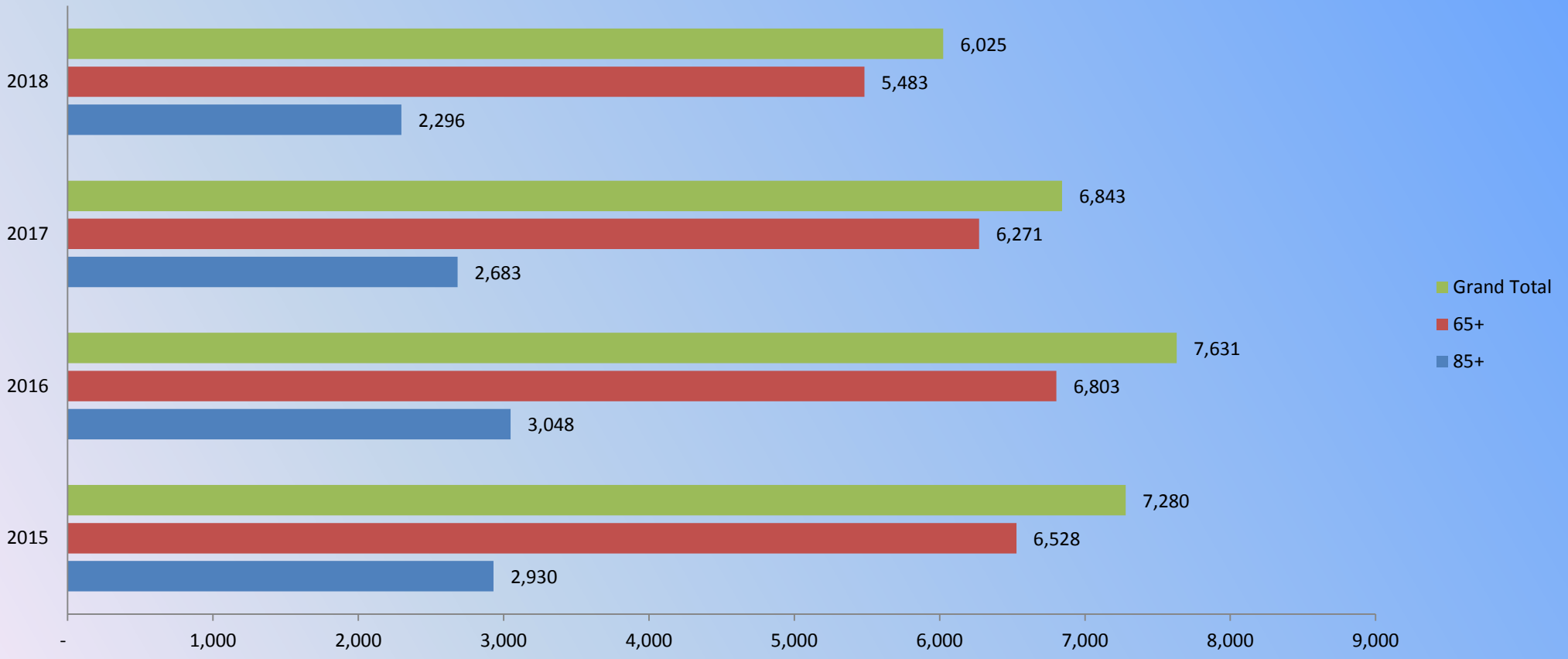
- 168 people aged 65+ died from fall related incidents in 2017. (CSO)

NIMS Data – No. of incidents that occurred relating to 'Slips, Trips and Falls‘ involving 'Patient' or 'Service User' – Hospital Groups



There was a total of **54,031** incidents between 2015-2018. Many of these incidents were categorised under negligible, minor and moderate. However, **105** were major/extreme.

NIMS Data – No. of incidents that occurred relating to 'Slips, Trips and Falls involving 'Service User' in Residential Care Centres for Older People



There was a total of **27,779** incidents between 2015-2018. Many of these incidents were categorised under negligible, minor and moderate. However, **48** were major/extreme.

Inpatient falls – the big picture

- Each year almost 3,000 falls in hospital in England result in hip fracture or brain injury, typically subdural haematoma. ? Data for Ireland
- Costs for patients are high in terms distress, pain, injury, loss of confidence, loss of independence and mortality, and costly in terms of increased length of stay to assess, investigate or treat even modest injury.
- A fall in hospital often affects plans for a patient to return home or to their usual place of care as it impacts on the older person's confidence and the confidence of their family and carers.
- An economic analysis commissioned by NHS Improvement estimated that the overall cost of reported inpatient falls (including the cost of extra treatment, length of stay and litigation) as £630 million annually.
- Likely that proportional costs in Ireland may be similar

Patient Characteristics	All Known		Male		Female	
	n	%	n	%	n	%
Number of falls	1790	100.0	928	51.8	862	48.2
Hospital						
Academic	1303	72.8	697	75.1	606	70.3
Community	434	24.2	212	22.8	222	25.8
Ambulatory care	53	3.0	19	2.0	34	3.9
Fall risk assessment prior to fall						
Very high	178	9.9	113	12.2	65	7.5
High	857	47.9	483	52.0	374	43.4
Moderate	71	4.0	37	4.0	34	3.9
Low	286	16.0	109	11.7	177	20.5
Not documented	398	22.2	186	20.0	212	24.6
Restraints present						
Yes	12	0.7	8	0.9	4	0.5
No/not documented	1778	99.3	920	99.1	858	99.5
Activity at time of fall						
Bed	310	17.3	168	18.1	142	16.5
Chair	152	8.5	93	10.0	59	6.8
Shower	37	2.1	14	1.5	23	2.7
Stretcher	47	2.6	26	2.8	21	2.4
Toilet	311	17.4	147	15.8	164	19.0
Transfer	1111	62.1	579	62.4	532	61.7
Wheelchair	36	2.0	20	2.2	16	1.9
Not documented	128	7.2	54	5.8	74	8.6
Prior fall documented						
Yes	395	22.1	221	23.8	174	20.2
No	1395	77.9	707	76.2	688	79.8
Fall prevention protocols implemented at time of fall						
Yes	1314	73.4	706	76.1	608	70.5
No/not documented	476	26.6	222	23.9	254	29.5
Result of fall						
Altered mental status	26	1.5	16	1.7	10	1.2
Head trauma	81	4.5	49	5.3	32	3.7
Limb weakness	34	1.9	23	2.5	11	1.3
Loss of consciousness	15	0.8	11	1.2	4	0.5
None documented	1653	92.3	843	90.8	810	94.0

Anderson, AIJM 2016

QI Collaborative
Multi-factorial Falls Risk Assessment Tool (Acute Hospital)

What’s needed to start

Multidisciplinary falls steering group with wide membership representing all relevant professional groups. This is essential for ‘sign up’ as the proposed changes will affect all staff groups across nearly all specialties where patients over 65 are admitted.

Removal of falls risk screening tool and its replacement with MDT falls assessment for all patients over 65. Any tool that screens patients over 65 ‘in’ or ‘out’ of an inpatient falls pathway or assigns a hierarchy of risk (low/moderate/high) needs to be replaced with an **multifactorial falls risk assessment for all patients aged 65 and over** that is also applicable to patients aged 50 to 64 with an underlying condition likely to put them at risk of falling.

Why MFRA approach?

- NICE Guidance and others have counselled strongly against screening people for falls ‘risk’ as being either high-risk / low-risk
- Evidence from international settings is strongly pushing in direction of access for all > 65 to comprehensive assessment and selected patients 50-65
- The fundamental question arises as to how this feasibly happens
- Opportunity within the QI collaborative to test this

Falls Prevention Screen
(Acute Hospital)

Date: _____ Time: _____ Initials: _____

Patient Details:

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(Tick as applicable) ✓

Is the patient 65 years or older?	☐ Yes ☐ No
Is the patient 50 - 64 years old **AND**	☐ Yes ☐ No
Had a fall in the past year / admitted with a fall OR	☐ Yes ☐ No
• *Help / supervision needed to transfer / walk OR*	☐ Yes ☐ No
• *Has a fear of falling OR*	☐ Yes ☐ No
• *A medical condition that, in your judgement, would increase a fall risk; such as stroke, amputee, etc*	☐ Yes ☐ No
Is the patient aged under 50 years AND had a fall in the past year / admitted with a fall?	☐ Yes ☐ No

Multi-factorial Falls Risk Assessment

Interventions Required should be incorporated in the main nursing care plan

MEDICATION

Risk Factor

Identification of high risk medications for falls

Active Problem - High risk medications prescribed during in-patient stay

Benzodiazepines; hypnotics/anxiolytics	☐ No	☐ Yes
Antipsychotics	☐ No	☐ Yes
Antidepressants	☐ No	☐ Yes

If Yes , consider the following

Consider the following:

- Liaise with the prescriber regarding new high risk medications prescribed ☐
- Liaise with the pharmacist regarding high risk medications prescribed ☐
- Evidence for prescribing rationale completed: (See Psychotropic Prescribing Algorithm) ☐ No ☐ Yes

Date & Time

OH ORTHOSTATIC HYPOTENSION

Cardio-vascular

Lying and standing blood pressure reading indicates probable orthostatic hypotension	☐ No	☐ Yes
Patient reports feeling dizzy / lightheaded / fainting episodes or loss of consciousness within the last year	☐ No	☐ Yes

If Yes , consider the following

- Consult Medical Team ☐
- Review of antihypertensives and / or diuretics ☐

Date & Time

MOBILITY

Mobility Needs

Patient's admission to hospital is a result of a fall	☐ No	☐ Yes
Patient had a fall in last 12 months	☐ No	☐ Yes
Patient reports fear of falling	☐ No	☐ Yes
Patient reports or staff note unsteady gait - require assistance /supervision to mobilise	☐ No	☐ Yes
Does the patient require assistance to stand	☐ No	☐ Yes

If Yes , consider the following

- Refer Physiotherapy ☐
- Ensure patient's walking aid is available and accessible ☐
- Refer Occupational Therapy ☐
- Provide patient with Falls Prevention Leaflet ☐
- Ensure Call Bell is within easy reach and advise patient re use of same ☐

Date & Time

	Risk Factor	Active Problem				Consider the following:		Date & Time
SAFETY - Personal	 Memory/Mood	Patient/carer report or staff note known history of Cognitive Impairment/ Dementia	☐ No	☐ Yes	If Yes , consider the following	Care plan reflects needs with supervision/assistance with ADLs	☐	
		Evidence of Delirium (e.g. 4 AT score 4 or more)	☐ No	☐ Yes		Inform Medical Team of Delirium for review	☐	
	 Visual Impairment	Patient report / staff note vision impairment at admission	☐ No	☐ Yes	If Yes , consider the following	Ensure glasses or visual aids are available/reachable & clean	☐	
	 Access to Toilet	Patient needs assistance mobilising to toilet	☐ No	☐ Yes	If Yes , consider the following	Consider care plan needs for assistance with toileting	☐	
						Ensure accessible Call Bell is in place	☐	
	 Footwear	Inappropriate Footwear	☐ No	☐ Yes	If Yes , consider the following	Request alternative suitable footwear	☐	
						Supply alternative safe footwear if available	☐	
SAFETY - Environment	 Night-time Risk	Patient gets up during the night	☐ No	☐ Yes	If Yes , consider the following	Consider night-time toileting needs	☐	
						Consider the need for observation/supervision	☐	
						Ensure accessible Call Bell is in place	☐	
	 Environment Screen	Inadequate Lighting	☐ No	☐ Yes	If Yes , consider the following	Ensure adequate lighting in place	☐	
		Call Bell not in place	☐ No	☐ Yes		Ensure environment is clutter free	☐	
		Trip Hazards	☐ No	☐ Yes		Partner with Older Persons Council for Walkability Study in your area	☐	

[An alarm device does not replace regular visual checking of the patient who is at risk of falling]

Date: _____ Time: _____ Initials: _____

Refer to local Falls Prevention / Management Policy

MFRA implementation reflects best practice

- Composite of comprehensive assessment with a series of prompts where specific issues have been identified
- That assessment typically being carried out initially as part of nursing assessment / care plan
- Some may already be in place
- We specifically are looking to highlight good practice –
  - high risk drug prescribing,
  - orthostatic hypotension and
  - mobility baseline (reflects recent UK NHS C-QUIN approach)
- But these three areas in themselves won't address falls in absence of sustained attention to other areas of MFRA

MFRA Guidance – Acute Hospital

- Specific Guidance developed in relation to the key areas, will be focussed on during subsequent talks
- Separate Guidance for MFRA for residential care in development- will include additional elements around mobility, diet and exercise
- All areas relevant , compliance initially focussed on 3 key areas

Points to emphasise- Medication Use

- Really promoting appropriate use of high risk medications…and more importantly appropriate avoidance of new prescribing
- Want to avoid ‘new prescribing’ where this might be appropriate
- If already on same long-term, is there an ongoing clinical indication
- What reason being used for prescribing
- Link with NCEC guidance from National Dementia Office re non-pharmacological management of non-cognitive symptoms in BPSD in dementia (launching Dec 5th)

Points to emphasise- Orthostatic Hypotension

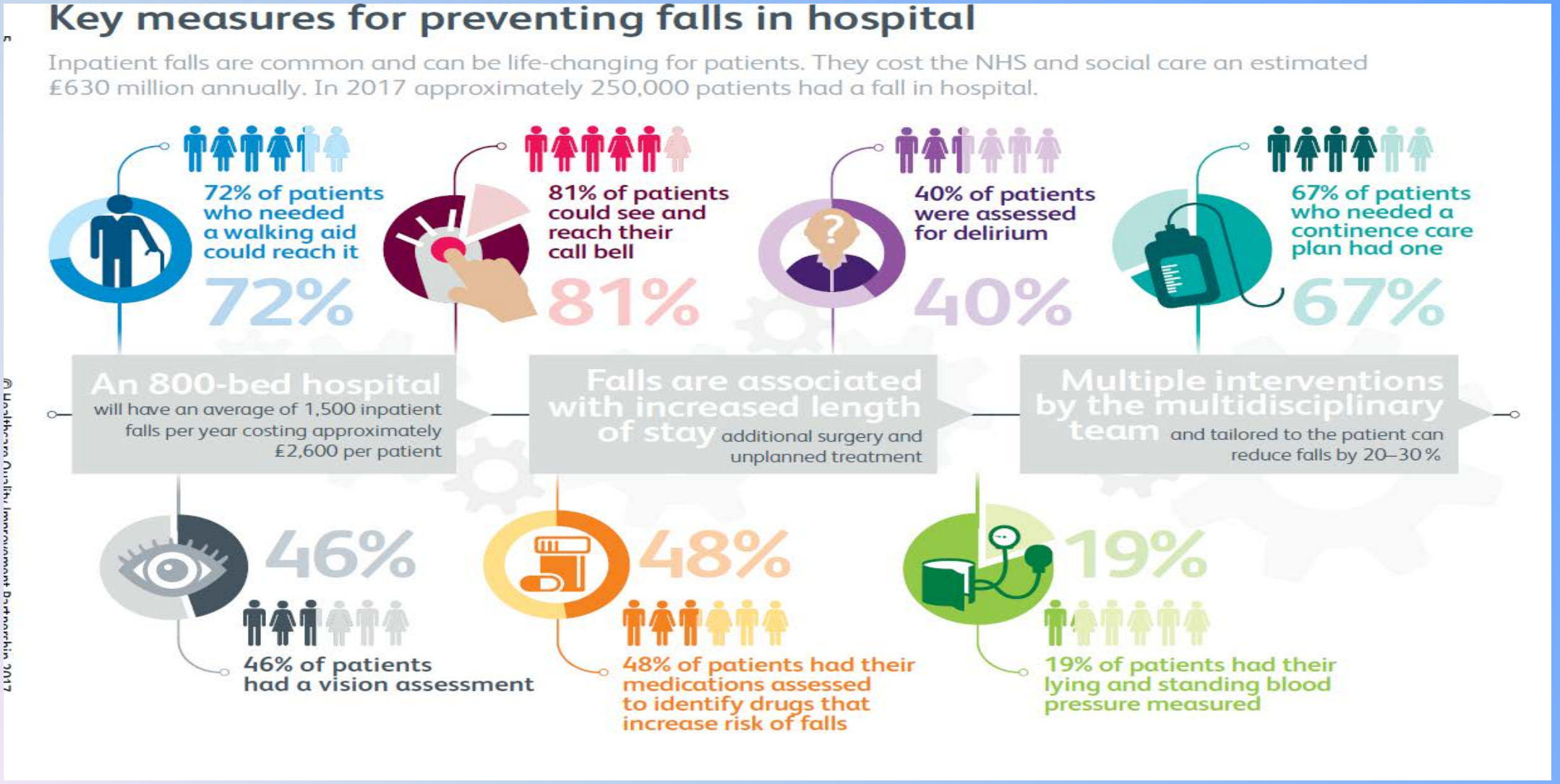
- Use of validated measurement
- Who’s doing and why?
- ? Follow on actions from same and how this will be managed

Points to emphasise- Mobility

- Using a high level approach to identify mobility needs
- Teams will then need to work on those aspects that reflect referral pathways, access to equipment / assistance

Cognition/ Toileting/ Vision/ Environment

- If Delirium / Dementia improvement work ongoing in care setting, ? Opportunity to link with falls
- Toileting- 45% of inpatient falls occur in toilet / bathroom (Tzeng, 2010)



National Audit Inpatient Falls, NHS, 2017