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Acknowledgements

Deborah Kenyon, Julia Gray, Chris Stanley, Frances Healey, Peter Oliver, John Clark, Sophie Jagatia, Deborah Lee, Daniel Havely, Charlotte Haynes, and participants in the 2004 - 2011 audits:

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Funding

This audit has been funded by the Greater Manchester Supra-district Clinical Audit Committee through contributions from primary care Trusts across Greater Manchester, Cheshire and Mersey.

The network event held on June 25th at Haigh Hall was sponsored by HQIP.
Endorsements

In 2009, the Northwest Prevention & Management of In-Patient Falls audit provided a great example of clinicians and audit teams working together across a region to pool resources in a valuable study. The importance of the subject was matched by the commitment and enthusiasm of the participants and clear improvements in care provision were demonstrated. The current report shows most of the participating Trusts have maintained or improved on their 2009 performance and makes clear recommendations on how Trusts can continue to improve the services they provide to some of their most vulnerable patients. These recommendations are valid for providers of acute services across the country.

The project is a clear demonstration of how Trusts can learn from each other, both in developing clinical audit skills and in improving services. This regional project has fed into the development of standards for the RCP national pilot audit of inpatient falls, commissioned by HQIP. This demonstrates the importance of regional projects, not just in improving regional services, but in setting the ball rolling for national improvements. I am happy to endorse the audit and congratulate the project team and the participating trusts on their success.

The last eight years of the Northwest Prevention & Management of In-Patient Falls audit encompass all that audit should be; groups of hospitals coming together with the aim of improving the care their patients receive, understanding their strengths and weaknesses, acting to address these, and sharing learning along the way. Throughout this period the NW audit has constantly ‘raised the bar’ for all of the participating hospitals, as the publication of new evidence and guidance led to new standards being included in the audit. It has demonstrated that highly reliable delivery is possible for some aspects of falls prevention, and where other aspects fall short, has greatly added to our understanding of why these are such a challenge in frontline practice; only through this understanding will we find the right strategies for improvement.

In this report the NW audit has a final achievement to claim; the recent pilot audit of inpatient falls [Royal College of Physicians, 2012] owed a great deal to the methods of the NW audit, and the precedent the NW audit had established was critical to securing funding to pilot a similar approach across the UK. Therefore everyone involved in the NW audit deserve congratulation, not only for the improvements to their patients’ care, but for the influence they have had beyond the Northwest.

ROBIN BURGESS
Chief Executive
HEALTHCARE QUALITY IMPROVEMENT PARTNERSHIP
September 2012

FRANCES HEALEY
Associate Director of Patient Safety
NHS COMMISSIONING BOARD
SPECIAL HEALTH AUTHORITY
September 2012
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Background

Supporting evidence of literature/theory

Following publication of Standard 6: Falls in the National Service Framework for Older People in 2001, concerns were raised by Dr David Bourne and Dr Gary Cook that little was being done by Northwest hospitals to proactively reduce the incidence of in-patient falls among the elderly. This led to a multi-site audit funded in 2004 and 2006 by the Greater Manchester Supra-district Audit Committee to determine the baseline level of practice in relation to:

- completion of falls assessments,
- re-assessment of falls risk where indicated,
- recommended actions or interventions for at-risk patients,
- and documented implementation of action(s).

The methodology changed in 2009 to collect more detailed information on the usage of falls tools, as well as to include a comprehensive service evaluation which reflected NHS LA and Patient Safety First guidance. These pro formas have since been used by other hospitals in Scotland, Isle of Man and the USA, as well as modified for UK mental health Trusts. Where possible, hospitals have been supported to implement local programmes of training, audits, and health/safety promotion to drive service developments in falls prevention. A patient expert has been involved since 2009; his statement of feedback on the 2011 audit can be found in FIGURE 47 on page 78.

AIMS AND OBJECTIVES

The aim of the project was to collect a baseline of information on falls prevention and management activities, support hospitals in implementing evidence-based assessments and interventions, and facilitate the provision of more equitable care for service users in the Northwest.

Our objectives were to show continued improvements in and continued development of falls prevention services through regular case note audits and organisational questionnaires based on the best available research.

RESEARCH SUMMARY

According to the National Service Framework (NSF) for Older People, falls are a major cause of disability and the leading cause of mortality due to injury in people aged over 75 years in the UK. Hip fracture is the most common serious injury related to falls in older people, resulting in an annual cost to the NHS of around £1.7 billion for England, and inpatient falls are thought to result in substantial morbidity and additional healthcare costs. As a result, falls prevention is a priority public health area. Standard 6 of the NSF for Older
People is “to reduce the number of falls which result in serious injury and ensure effective treatment and rehabilitation for those who have fallen”.

While falls within hospitals are common, research on in-patient falls is limited, with most previous falls-related research based in community settings only. Falls in hospitals affect between 13-32% of admitted patients, and rates from 2.9-13 falls per 1000 bed days have been reported. Up to 30% of falls in hospital are thought to result in injury. Additional health and financial costs are also incurred due to longer patient stays in hospital, surgery, psychological problems, and limiting the activities of daily living. In-patient falls can lead to patient complaints and litigation which can in turn lower staff morale.

BEST PRACTICE GUIDANCE

An effective falls prevention strategy is tailored to the needs of the individual, rather than a generic programme aimed at all older patients. It starts with identifying those most at risk of falling and co-ordinating appropriate preventative action. Falls risk assessment tools in hospitals have resulted in minor reductions in inpatient falls and, at worst, no reduction on harmful falls, whereas falls prevention programmes, which include both risk assessments and interventions, are thought to reduce the incidence of falls by 15-30%.

SUMMARY OF METHODOLOGY

In 2004 & 2006, Trusts completed prospective audits in May of 60 patients aged 65 and over who were in hospital for at least three days in orthopaedic, elderly, general medicine, or surgery wards.

In 2009 & 2011, Trusts completed an organisational questionnaire and retrospectively reviewed case notes of patients aged 65 and over. These patients were discharged or deceased in May after being in-patient for at least three days from orthopaedic, elderly, general medical, or surgical wards. The sample decreased from 80 in 2009 to 60 patients in 2011 as statistical tests indicated the smaller sample would still yield significant results.

PREVIOUS FINDINGS

The 2004 audit showed that many hospitals were not yet using standardised tools, that tools were often poorly completed, and that patients with a high number of risk factors were not always being documented as being high risk. Nevertheless, those patients who were assessed using a tool had more interventions provided.

The 2006 audit showed that most hospitals had implemented standardised tools and that those patients assessed using a tool had even more interventions provided than in 2004. Re-assessments also improved, suggesting that falls tools were becoming more established in
practice.

The 2009 audit identified continued gaps for assessing certain modifiable risk factors, such as lying & standing blood pressure, cognition, and medication reviews. Provision of care was becoming more equitable across the region, services were receiving more support, and the usage of a tool had a more positive effect on the provision of interventions than a patient’s level of risk.

**TRAINING**

The 2009 audit found that training programmes lacked important and updated content (and some Trusts lacked a training programme at all). Establishing falls prevention training programmes which are based on latest information from expert research will have a significant impact on the services provided. For example, it is not enough to check a patient’s eyesight by merely making sure they have their glasses, but many staff still consider this sufficient for falls prevention. Similarly, taking lying & standing blood pressure using a specific, validated technique provides more reliable information about orthostatic hypotension than the self-modified techniques actually performed on many wards.

The research is clear that a multi-factorial approach to falls prevention has an impact in reducing falls. But all approaches must ensure staff have the knowledge and the confidence to assess correctly and appropriately -- saving time and resources. Falls prevention covers so many aspects of hospital provision. It is an excellent opportunity to increase productivity by improving workforce competencies.

Recent research on the impact of patient anxiety on falls risk has shown that it is as important as physiological risk factors. “A fall prevention programme should focus on reducing the consequences of falling and on promoting self-efficacy and activity” (Faes, 2010). But, more than simply staff educating a patient, peer learning is a more effective ‘fear of falling’ support strategy. It may not be practical to organise group support in hospital; however, this acute episode may be the only chance to refer the patient before they experience a harmful fall (with its expensive consequences). Brief interventions would not only reduce their fear of falling but also address greater issues of well-being, such as mental health and physical activity.

Kim Delbaere’s research “showed that per-
ceived and physiological fall risk were both independent predictors of future falls” (2010) — it is just as important to identify how patients feel about their risk of falling as identifying other modifiable risk factors. Having both heightened anxiety and an unrealistic understanding of one’s physiological capabilities can result in more falls.

FALLS TOOLS

When the in-patient falls audit began in 2004, many of the eight Trusts were not using a falls tool. In 2009, all Trusts were using a falls tool such as FRASE, MORSE, or Stratify. Few had updated their tool in several years, and even fewer had implemented the 2007 guidance from the NPSA. At least eight Trusts also used a standard elderly admission screening tool.

The 2009 audit revealed that most acute Trusts relied on outdated and un-validated tools. Where tools were modified and updated, most still did not reflect best practice and new research.

David Oliver and Frances Healey (2009) suggest that “Numerical risk prediction tools are not a vital part of falls prevention in hospitals — routine screening for modifiable falls risk factors ... may be more effective.” Indeed, the 2009 audit results showed that simply assessing a patient resulted in more targeted assessments and interventions than allocating actions to a patient’s risk level. But, the majority of tools used by Northwest hospitals today still stratify a patient’s risk.

FIGURE 3 — Selection of guidance used by the audit

<table>
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<tr>
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<tr>
<td>2001</td>
<td>NSF For Older People, Standard Six: Falls</td>
</tr>
<tr>
<td>2004</td>
<td>NICE, Clinical Guideline 21 — Falls</td>
</tr>
<tr>
<td>2007</td>
<td>NPSA, ‘Slips, Trips And Falls In Hospitals’</td>
</tr>
<tr>
<td>2009</td>
<td>Patient Safety First, ‘How-To Guide for Reducing Harm from Falls’</td>
</tr>
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</table>
Methodology

The 2011 audit included a case note review audit, a service evaluation, and a post-falls audit.

Case Note Review Audit

The case note review audit measured Northwest acute Trusts against standards for assessment and care of modifiable risk factors for falls. 60 patients were sampled per acute Trust who met the audit criteria (total sample: 844):

- 65 years and older
- from medicine, care of the elderly, orthopaedic and surgery wards
- who were discharged or deceased in May 2011
- after a stay in hospital of at least three days.

The 2011 audit was designed to be comparable to the 2009 audit, in order to measure care following quality improvements in these areas.

Information analysts or Clinical Audit teams generated a list of patients who fit the criteria. Patients were either sampled from this list or sorted into four lists according to the treatment specialty: medicine, care of the elderly, orthopaedics and surgery.

Data was collected by multi-disciplinary clinical teams and audit staff at each acute Trust using a paper pro forma, which they then entered into an Excel database. The audit coordinator reviewed and cleaned the data for inclusion in the regional database, with the Trusts approval. Summary tables and charts were provided once all data had been submitted and checked.

Service Evaluation

Each participating organisation was also invited to submit a service evaluation questionnaire, which evaluated their falls prevention service and activities (total sample: 12 acute Trusts). Many sections requested the optional submission of evidence. Section 8 also involved an audit of up to 10 nurses in each Trust (total sample: 56).

Questionnaires were posted or emailed to the audit coordinator, and administrative staff entered the data into an Excel database.

Post-Falls Audit

The post-falls audit measured Northwest acute Trusts against standards for the management of falls in hospital. The first 10 unwitnessed falls starting October 14, 2011 were audited per Trust, at least one week post-fall. Trusts also had the option to collect an additional 10 falls with moderate (or more severe) injury, to provide further qualitative evidence of their post-fall protocols. This optional sample was not included in the analysis for this report, as too few Trusts collected this additional data.

Data was collected by staff at each acute Trust using a paper pro forma, which they then entered into an Excel database. Eleven acute Trusts participated in the post-fall audit (total sample: 99).
Limitations

The scope of the falls audit was limited primarily by the Trusts’ ability to collect data. Some Trusts had only a couple data collectors; other Trusts had a large team of staff involved. Although the 2009 audit sample of 80 was achievable for most Trusts, lowering this sample to 60 reduced the burden on all Trusts without decreasing the significance of the findings. This decision was made in consultation with a local statistician, after reviewing the 2009 audit results.

Despite the reduced sample size, most Trusts failed to meet the deadlines for data collection. The project timeline was able to accommodate these extensions, but this delay has come at a price: the final report has been published over a year following the period audited (May 2011).

At the beginning of the 2009 audit, the coordinator met with each participating Trust to explain the methodology, criteria and pro formas. Because most of these details remained the same in 2011, the coordinator only met with participating Trusts on request. In hindsight, all Trusts would have benefited from meeting with the coordinator again, especially those Trusts which relied on new data collectors.

Traditional audits review clinical practice against clearly defined standards; however, it is widely acknowledged that few such standards exist for falls prevention. The original audit in 2004 examined many areas of falls prevention in order to contribute to the production of relevant standards for preventing in-patient falls. The 2011 audit refines these proposed standards, as Trust policies and pathways continue to converge over time.

The 2011 case note audit pro forma draft was developed within a steering group. It was finalised after a conference attended by most participating Trusts, incorporating their feedback.

WHERE FALLS RISK IS CONCERNED, THE HOSPITAL STAY OF A SINGLE PATIENT IS A HUGE SAMPLE ON ITS OWN.

Because of the limited resources at each Trust, it was not feasible to design a pro forma which examined each modifiable risk factor in detail for each patient, over his entire hospital stay. A patient’s condition (and thus his risk factors) can change considerably over time, and it is not practical to quantify whether a Trust effectively assessed and cared for each patient’s modifiable risk factors over time. This sort of analysis is more effectively and reliably performed in the context of post-fall incident review — a qualitative, in depth analysis of a small sample. As such, the Northwest falls audit only asks whether a patient was provided an assessment or intervention at least once during their hospital stay.

This is the minimum amount of detail possible for Trusts to collect which is still useful, as the audit results establish a baseline which can be easily monitored through future case note audits.
Standards

The standards measured in each audit cycle changed to reflect new evidence.

In the 2004 audit, Trusts examined whether:

- a falls tool was completed appropriately,
- patients were provided with a care plan and re-assessed at appropriate intervals
- an operational falls service was set up with an appropriate complement of staff
- an environmental audit tool and action plan was in place

In the 2006 audit, Trusts reviewed the same, but looked more closely at the modifiable risk factors contained within the tools. The 2009 audit changed significantly to reflect a considerable jump in available evidence, as well as consultation with Frances Healey (National Patient Safety Agency) and Dr David Oliver (Department of Health). Standards became more specific and measurable.

CASE NOTE REVIEW

The 2011 audit saw further refinement of these standards (see FIGURE 4, same page), again reflecting new research which reiterated NPSA’s guidance from 2007. The main change was a more realistic deadline (‘by the end of the first full day following admission’ compared to ‘within 24 hours of admission’) that would be easier for Trusts to audit in the future. This involved no changes to the pro forma, which collects actual dates. 2009 data was re-analysed using the 2011 standards using the updated analytical workbook in Excel.

Collecting dates and causes of re-assessments proved time-consuming, so the re-assessment standard was dropped from the 2009 case note audit in favour of collecting more details on modifiable risk factors.

There are a number of reasons why a particular assessment might not be possible for all patients at any given time, but Trusts should still document these attempts for 100% of their patients. It is good practice (and good risk management) and will protect staff if investigated by the coroner or a regulatory agency.

SERVICE EVALUATION

The service evaluation became more comprehensive in 2009, thanks to Patient Safety First guidance, and Trusts were asked to report on:

FIGURE 4 — Standard & Criteria for 2011 Case Note Review

100% of patients (65+) should receive an assessment of falls risk factors by the end of the first full day following admission containing at least:

- History of Falls
- In-patient Fall
- Gait/mobility
- Anxiety about falls

ALSO CONSIDER:

- Cognition/mental state
- Medication
• Falls tools
• Actions on admission
• Multidisciplinary falls group
• Training
• Local safety audits and policies
• Falls incident database

In 2011, two additional sections were added to the questionnaire:

• Post-fall protocol
• Lying & standing blood pressure

The post-fall protocol section measured acute Trusts against the post-fall audit standards which are covered in the next section. The lying and standing blood pressure section involved assessing the knowledge of a small sample of registered nurses on the wards.

POST-FALLS AUDIT

The standards for the post-fall audit reflect the NPSA rapid response report RRR0001 on post-fall management, which details that all Trusts should have a protocol in place that meets NICE standards for the assessment and management of injury. A link to the full list of standards is listed in the References (p43).

S1.0 100% of acute Trusts should have a legible and accessible post-fall protocol which manages care according to NPSA and NICE guidance.

S2.0 Staff at 100% of acute Trusts should have access to specialist equipment for handling patients with fractures.

S3.0 100% of acute Trusts should use a 15-point Glasgow Coma Scale which triggers urgent medical review according to NICE guidance.

S4.0 100% of patients who experienced a fall, where head injury has occurred or cannot be excluded (e.g. unwitnessed falls) should be observed according to the following frequency and duration:

• Perform and record observations on a half-hourly basis until GCS = 15.
• When GCS = 15, minimum frequency of observations is:
  o half-hourly for 2 hours
  o then 1-hourly for 4 hours
  o then 2-hourly thereafter.

FIGURE 5 — Criteria for rushed imaging standard (S5.0) in the 2011 Post-Fall Audit

- GCS < 13 when first assessed
- GCS < 15 when assessed 2 hours after the injury
- Suspected open or depressed skull fracture
- Sign of fracture at skull base (haemotympanum, ‘panda’ eyes, cerebrospinal fluid leakage from ears or nose, Battle’s sign)
- Post-traumatic seizure
- Focal neurological deficit
- > 1 episode of vomiting
- Coagulopathy (history of bleeding, clotting disorder, current treatment with warfarin) PLUS amnesia or loss of consciousness since the injury

Standards

13
• If patient deteriorates to GCS < 15 after initial 2-hour period, revert to half-hourly observations and follow original schedule.

$5.0 \quad 100\%$ of patients who meet any of the criteria in FIGURE 5 (p13) should have imaging and results analysed within 1 hour of request being received by radiology department.

$6.0 \quad 100\%$ of patients with suspected or actual head injury (and their families/carers) should be made aware of:

• the possibility of long-term symptoms and disabilities following head injury.

• the existence of services that they could contact should they experience long-term problems following head injury.

$7.0 \quad 100\%$ of patients should be triaged post-fall according to best practice guidance (Manchester Triage System for falls) and assessed by a doctor within the following timings:

• **IMMEDIATE** (0 MINUTES)
• **VERY URGENT** (16 MINUTES)
• **URGENT** (60 MINUTES)
• **STANDARD** (120 MINUTES)
• **NON-URGENT** (240 MINUTES)

More details about these standards can be found by reviewing the NPSA Rapid Response Alert, RRR0001 (References, p43).

**COMPARING AGAINST THE STANDARDS**

The Highlighted Results section (p44) features significant and interesting results, many of which measure Trusts against existing or proposed standards.
Performance against Standards

This section summarises 2011 audit results against the standards. Please see Standards (p12) for a full list of standards and Highlighted Results (p44) for samples by Trust and a full description of audit results against these standards. Summary data by Trust, including service evaluation results, is available in a separate document (Appendices, Part I and II).

### CASE NOTE REVIEW AUDIT STANDARDS

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**KEY:** BLUE = ASSESSED 100% OF PATIENTS BY END OF FIRST FULL DAY FOLLOWING ADMISSION, GREEN = ASSESSED 90% - 99% OF PATIENTS BY END OF FIRST FULL DAY FOLLOWING ADMISSION, AND RED = ASSESSED LESS THAN 90% OF PATIENTS BY END OF FIRST FULL DAY FOLLOWING ADMISSION.

### POST-FALL AUDIT STANDARDS

<table>
<thead>
<tr>
<th></th>
<th>AINTREE*</th>
<th>CHESTER*</th>
<th>EAST LANC*</th>
<th>LEIGHTON*</th>
<th>PENNINE*</th>
<th>SOUTHPORT*</th>
<th>STRK*</th>
<th>STOCKPORT*</th>
<th>UPŠR*</th>
<th>WIGAN*</th>
<th>WIRRAL*</th>
<th>LANC TEACH</th>
</tr>
</thead>
<tbody>
<tr>
<td>Post-fall protocol is legible and accessible to ward staff</td>
<td>Y</td>
<td>DID NOT ANSWER</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td></td>
<td></td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Specialist equipment for moving patients with fracture</td>
<td>Y</td>
<td>DID NOT ANSWER</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td></td>
<td></td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>15-point Glasgow Coma Scale triggers medical review</td>
<td>Y</td>
<td>DID NOT ANSWER</td>
<td>Y</td>
<td>N</td>
<td>Y</td>
<td>N</td>
<td>Y</td>
<td>Y</td>
<td></td>
<td></td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Neurological observations for head injury</td>
<td>OUT OF TOTAL SAMPLE (99 PATIENTS): 5%</td>
<td>NO DATA</td>
<td></td>
<td>NO DATA</td>
<td></td>
<td>NO DATA</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rushed imaging</td>
<td>OUT OF 27 PATIENTS: 0 PATIENTS</td>
<td>NO DATA</td>
<td></td>
<td>NO DATA</td>
<td></td>
<td>NO DATA</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Head injury advice</td>
<td>OUT OF 11 PATIENTS: 2 PATIENTS</td>
<td>NO DATA</td>
<td></td>
<td>NO DATA</td>
<td></td>
<td>NO DATA</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical review timings</td>
<td>OUT OF TOTAL SAMPLE (99 PATIENTS): 36%</td>
<td>NO DATA</td>
<td></td>
<td>NO DATA</td>
<td></td>
<td>NO DATA</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**KEY:** *= 11 TRUSTS THAT SUBMITTED DATA. BLUE = MET STANDARD, RED = DID NOT MEET STANDARD, AND BLACK = NO DATA.
2011 Audit Findings

How audit results improve quality of services or patient care

The audit findings are split according to the three sections of the 2011 audit: case note review, service evaluation, and post-fall audit. More detailed charts are available in Highlighted Results on page 44. In the last section, acute Trusts action plans following the 2009 audit have been compared against their 2011 audit results.

CASE NOTE REVIEW RESULTS

Fifteen acute Trusts audited up to 60 patients who were discharged in May 2011 (total sample: 844) in a case note review of falls assessments and interventions. Most Trusts maintained or improved performance from the 2009 audit (see FIGURE 6, same page, and FIGURE 20, p51). In 2011, ten out of fifteen acute Trusts assessed at least 80% of their patients using a falls tool by the end of the first full day following admission (see FIGURE 19, p50); however no Trust met the standard of 100%.

Since the 2004 audit, Trusts have been steadily improving their assessments of patients falls history, gait/mobility and cognition (see FIGURE 21, p52). Overall, assessment of patient anxiety has improved slightly but still lags significantly behind the other main risk factors (see FIGURE 31, p62).

In 2011, nine out of fifteen acute Trusts assessed the falls history of at least 90% of their patients by the end of the first full day following admission (see FIGURE 22, p53). Nearly all Trusts showed improvements from the 2009 audit for this risk factor (see FIGURE 23, p54).

FIGURE 6 — Assessment of patients’ risk of falling (at least once during the hospital stay) as reported in the 2004, 2006, 2009, and 2011 audits

In 2011, six out of fifteen acute Trusts assessed the gait/mobility of at least 90% of their patients by the end of the first full day following admission (see FIGURE 26, p57). This increases to eleven acute Trusts if the bar is lowered to 80%. Nearly all Trusts showed improvements from the 2009 audit for this risk factor (see FIGURE 27, p58).

In 2011, six out of fifteen acute Trusts assessed the cognition of at least 90% of their patients by the end of the first full day following admission (see FIGURE 28, p59). This increases to eight acute Trusts if the bar is lowered to 80%. All but one Trust showed improvements from the 2009 audit for this risk factor (see FIGURE 29, p60).

The biggest improvers (Macclesfield, Aintree, Stockport, Wigan) have shown how appointing
new clinical falls leads and improving the quality of documentation can increase the number of assessments and interventions. We can also learn from those Trusts who have experienced challenges in the last few years (Tameside, Wirral). Organisational changes, loss of consultant and nurse falls leads, and new audit teams all impact on falls prevention programmes. Implementing new tools takes time, and performance may decline as staff adjust to and improve the new way of working.

Those Trusts who have consistently participated in the Northwest in-patient falls audit have seen bigger improvements [see FIGURE 17, p48]. Is this a reflection of the time, resources, motivation, or education of participating Trusts? Regardless of the reason, it is clear that Trusts new to the audit (and/or falls prevention) can quickly make considerable improvements (see FIGURE 24, p55) by addressing the key areas other Trusts already do well (see FIGURE 7, same page). A good area to start is the assessment of falls history, which Trusts should be assessing in 100% of their patients. Any Trust who assessed less than 90% of their patients should take immediate action to improve their practice (see FIGURE 25, p56). See FIGURE 37 (p68) and FIGURE 38 (p69) for the full ranked lists of assessments and interventions, respectively. Note that no standards exist at this time for the assessment of risk factors such as hearing or lying and standing blood pressure.

SERVICE EVALUATION RESULTS

An identical service evaluation pro forma was used in 2009 and 2011 (with exception of two new sections) and therefore is directly comparable. Two Trusts completed only section one and ten Trusts completed the entire questionnaire. Six Trusts did the optional audit of nurse knowledge, in section eight. A full summary of 2011 service evaluation results is available in a separate document: Appendices, Part II.

Section 1: Falls Tools

Twelve Trusts completed this section on their falls tools that were in use during or after the May 2011 audit. Many of those Trusts are still using published tools (such as FRASE or STRATIFY). Though all twelve Trusts reported modifying the tool internally, only three Trusts incorporated NPSA guidance from 2007. All but one tool resulted in a risk score. Three tools divided patients into ‘at risk’ or ‘not at risk’ categories. Nine tools stratified patients into multiple risk groups (e.g. low, medium, or high).
Eight of the twelve Trusts did not validate their tools for sensitivity and specificity. This is especially concerning, as the content of these tools varies considerably between Trusts, even where the same base tool was used (e.g. FRASE or STRATIFY).

Falls tool content varies considerably between Trusts, but all tools should cover the core questions recommended by NPSA guidance: falls history, in-patient falls, unsteady gait, and anxiety about falls. Trusts should also consider integrating their falls tool with a cognitive assessment and a prompt for reviewing medication.

All twelve Trusts reported having a tool which identified modifiable risk factors and prompted assessment of gait. Three of the twelve Trusts had tools which did not ask about falls history. Four of the twelve Trusts had tools which did not record falls during admission. Two of the twelve Trusts had tools which did not check cognitive states. Eight of the twelve Trusts had tools which did not ask patients about fear of falling, whereas four Trusts had tools which did not advise falls education is provided to the patient, relative or carer.

Trusts should consider how patients are reassessed, as falls risk can change significantly over time, as patient condition changes or a patient is transferred to a new ward. One of the twelve Trusts did not prompt reassessments at all, another Trust did not prompt reassessments after an in-patient fall or a ward transfer, and a third Trust did not prompt reassessments after a ward transfer. Only five of the twelve Trusts prompted reassessments after a pre-determined period has passed (usually a week).

Trusts should consider how they prompt post-fall assessments and what these assessments cover (cardiovascular, neurological and musculoskeletal). Five of the twelve Trusts did not prompt an immediate injury assessment after each fall. This is a decrease from 2009, when eleven of thirteen Trusts did not prompt an immediate injury assessment after each fall (see FIGURE 8, same page). Of those seven Trusts that did prompt an assessment, one Trust did not include a cardiovascular assessment (such as lying & standing blood pressure).

In order to promote efficiency and productivity, Trusts should consider integrating their falls tool with other relevant pathways for elderly patients. All but one of the twelve Trusts had a tool which was integrated with bed rails guidance. Three of the twelve Trusts had tools which were not integrated with moving and handling. Six of the twelve Trusts had tools which were integrated with the management of medicines, continence, agitation, delirium detection, dementia, and bone health. Three of the twelve Trusts had tools which were not integrated with most associated pathways or tools. Only one of the twelve

---

FIGURE 8 — Falls tools which prompt an immediate injury assessment after each fall

![Percentage of Sample](chart)

<table>
<thead>
<tr>
<th>Year</th>
<th>Number of Trusts</th>
</tr>
</thead>
<tbody>
<tr>
<td>2009</td>
<td>13</td>
</tr>
<tr>
<td>2011</td>
<td>12</td>
</tr>
<tr>
<td>Best Practice Standard</td>
<td>100%</td>
</tr>
</tbody>
</table>

2011 Audit Findings
Trusts had a tool which prompted home visit referrals. Two Trusts had a tool which prompted social care assessments and equipment referrals.

Section 2: Actions on Admission

Ten Trusts completed the rest of the service evaluation questionnaire. Most of those ten Trusts performed the key tasks on admission: asking a patient for his falls history, checking gait/balance, assessing cognition, ensuring call bell is within reach, minimising environmental hazards, and providing accessible footwear, aids and adjustable beds.

Four out of ten Trusts did not provide current information on in-patient falls to patients on admission. Information was usually displayed for taking or for reference on the wards.

All ten Trusts reported that patients have access to a physiotherapist, occupational therapist or mobility aids, but five Trusts had no system in place to ensure access within 24 hours. One of the ten Trusts did not have access to a mental health liaison nurse or psychiatric team, and eight of the remaining nine Trusts had no system in place to ensure access to these professionals within 24 hours.

All ten Trusts had a pharmacist who reviews medications of all patients. The triggers for these reviews varied significantly between Trusts (e.g. within 24 hours of admission, on discharge, after a ward transfer, after a change in condition, after a pre-determined time period has passed, or after an in-patient fall). Trusts should consider establishing a protocol for medication reviews which is responsive to a patient’s change in risk.

Section 3: Multi-disciplinary falls group

All ten Trusts now had a falls group that specifically addresses in-patient falls. Nine Trusts reported that this group met between three to twelve times in the twelve months prior to survey completion.

FIGURE 9 – Number of Trusts who had staff from the following groups attend at least half of the falls group meetings in the last twelve months prior to survey completion

<table>
<thead>
<tr>
<th>NUMBER OF TRUSTS (OUT OF TEN)</th>
</tr>
</thead>
<tbody>
<tr>
<td>10 ALLIED HEALTH PROFESSIONALS</td>
</tr>
<tr>
<td>9 NURSES</td>
</tr>
<tr>
<td>9 DOCTORS</td>
</tr>
<tr>
<td>9 GOVERNANCE/RISK</td>
</tr>
<tr>
<td>7 PRIMARY CARE</td>
</tr>
<tr>
<td>6 PHARMACISTS</td>
</tr>
<tr>
<td>4 HEALTHCARE ASSISTANTS</td>
</tr>
<tr>
<td>4 EXECUTIVE</td>
</tr>
<tr>
<td>3 TRAINING &amp; DEVELOPMENT</td>
</tr>
<tr>
<td>2 ESTATES/FACILITIES</td>
</tr>
<tr>
<td>1 PATIENT REPRESENTATIVE</td>
</tr>
<tr>
<td>0 PORTERS</td>
</tr>
<tr>
<td>0 SOCIAL CARE</td>
</tr>
</tbody>
</table>

Allied health professionals attended at least half the meetings in the last twelve months prior to survey completion in all ten Trusts (see FIGURE 9, same page). Multi-disciplinary falls group should, at a minimum, be attended by allied health professionals, nurses, doctors, and governance/risk. Three of the ten Trusts were missing at least one of the latter key groups (e.g. no one in this group attended more than half the meetings in the last twelve months prior to survey completion).

Groups should also include pharmacists and
healthcare assistants. Four of the ten Trusts did not have pharmacists that attended at least half of the meetings, and six Trusts did not have healthcare assistants that attended at least half of the meetings.

No groups included porters or social care. Only one Trust included a patient representative. Two included estates, and four included members of the executive board.

All ten Trusts had a falls lead consultant. Two of the ten Trusts did not have a falls coordinator, falls lead nurse, or falls lead executive appointed. Only three of the ten Trusts had a falls lead in estates. Details about what responsibilities these staff have can be found in a separate document: Appendices, Part II.

**Section 4: Training**

Education is even more important than a falls tool, and all Trusts should have a comprehensive, relevant and updated programme for their staff. Out of the ten Trusts, one did not have a training programme for falls prevention, management and reporting. Of those nine Trusts that did have a training programme, all required the attendance of nurses and healthcare assistants. Three Trusts required the attendance of all relevant internal staff groups. One Trust did not require the attendance of doctors, and two Trusts did not require the attendance of allied health professionals or governance/risk. Four Trusts did not require the attendance of pharmacists.

The training programmes all covered the use of in-patient falls tools, accessing or offering safe footwear, and assessment of effective call bell use. All but one Trust also covered accessing alternative beds and bed/chair alarms. Other topics covered (such as bed rails guidance and post-fall assessment) varied by Trust. Two Trusts did not review professional guidance (such as NPSA 2007) in their training. More details can be found in a separate document: Appendices, Part II.

Only three Trusts delivered the training as e-learning. Most used ward-based learning. One Trust relied on classroom-based learning only.

Two Trusts did not have a training target, though all Trusts tracked attendance rates. Only five Trusts performed a falls training needs analysis in the last twelve months (prior to survey completion).

**FIGURE 10 — Trust audit activity related to falls in the last twelve months (prior to survey completion)**

<table>
<thead>
<tr>
<th>TRUST RANK</th>
<th>1, 2, 3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
</tr>
</thead>
<tbody>
<tr>
<td>CALL BELL</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ENVIRONMENT</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>BED/CHAIRS</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
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<td></td>
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<tr>
<td>TOILETS</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>INFORMATION*</td>
<td>Y</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>FOOTWEAR</td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>WALKING AIDS AND POSSESSIONS</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

* Provided to patients, relatives or carers

**Section 5: Local audits and policies**

Three Trusts audited all of the fourteen suggested topics related to in-patient falls, in the last twelve months (prior to survey comple-
A further three Trusts audited at least eleven suggested topics. Three Trusts audited three or less topics. Four Trusts did not perform a local audit on patients aged 65+ with dementia and/or cognitive problems in the last twelve months (prior to survey completion).

The most popular topic to audit was ‘call bell is to hand’ and the least popular topics were ‘walking aids are to hand’ and ‘possessions are to hand’ (see FIGURE 10, p20). All ten Trusts addressed the results of the audits through action plans, business cases, or strategies.

The executive board at all ten Trusts set annual targets for reducing harm from falls and required all falls were reported. The schedule of patient safety themed board walkarounds varied amongst Trusts from twice yearly to more than weekly. Harmful falls (including root-cause analyses) were reviewed by boards at least quarterly in six Trusts in the last twelve months (prior to survey completion). Three Trusts had boards which reviewed falls audit compliance only once in the last twelve months (prior to survey completion).

All ten Trusts had a significant number of policies covering areas related to in-patient falls. The most popular policies included bed rails guidance, moving and handling, and maintaining privacy/dignity (all Trusts). The least popular policies included bone health management, orthogeriatric liaison referrals, and delirium detection and management (four to five Trusts). More details about the lengthy list of policies are listed in a separate document: Appendices, Part II.

**Section 6: Falls incident database**

All ten Trusts maintained a database which included all reported falls incidents. Harm was defined primarily by the severity grading recommended by the national reporting and learning system (NRLS), except one Trust which used the global trigger tool (GTT) only.

All ten Trusts performed root cause analyses for all serious or harmful incidents and identified location trends or ‘hot spots’, but three Trusts did not calculate the rate of harmful falls per 1000 occupied bed days. Trusts should give careful consideration to how they review falls incidents and interview patients wherever possible.

**FIGURE 11 — Where the ten Trusts report falls data**

All ten Trusts submitted falls incidents to the NRLS (at least monthly) and most had a select group of staff (such as a falls group or patient safety team) who reviewed harmful falls and falls audit compliance (though the frequency of these reviews varied from twice to weekly or more). Important falls data were more likely to be reported to a select group of staff than the public (see FIGURE 11, same page). Falls audit compliance should be included, as a minimum, in the Trusts’ annual quality report,
which is available to the public.

Section 7: Post-fall protocol

Please see POST-FALL AUDIT RESULTS for more information about this section of the service evaluation.

Section 8: Orthostatic hypotension

Five out of nine Trusts reported that they had a form for assessing and recording lying and standing blood pressure. Only two Trusts trained staff in how to measure it, however.

As part of the service evaluation, Trusts were asked to survey the knowledge of orthostatic hypotension in ten registered nurses on the wards. Out of 56 nurses in six Trusts, 61% knew when to assess lying and standing blood pressure (e.g. prolonged bed rest, elderly, or history of light-headedness or falls). Only 46% of the 56 knew how to measure lying and standing blood pressure and when to suspect orthostatic hypotension. 75% of the 56 knew to adjust or discontinue medication and 61% of the 56 knew to advise patients to stand up more slowly, sit at edge of bed or adopt a ‘squat position’ before mobilising. Only 41% of the 56 knew that regular fluid intake was important, however, and few nurses knew the importance of counter-pressure documents and physical therapy.

No nurses knew how to clench muscles in the upper body and breathe, such that the flow of blood out of the upper extremities slowed. No nurses knew that eating smaller meals may also help reduce symptoms. Out of the ten possible interventions, 20% of the 56 nurses knew four to six, 27% knew three, 20% knew two, and 23% knew one. 11% of the 56 nurses knew none. The average number of interventions known by the 56 nurses at any given Trust ranged from 1 to 4.

POST-FALL AUDIT RESULTS

The 2011 audit was the first year to explore post-fall management in detail. Acute Trusts were measured against eight standards set by the NPSA rapid release report (RRR0001) and corresponding NICE guidance such as Head Injury (see References, p43). Acute Trusts were asked to take immediate action (by July 14, 2011), but many acknowledged this deadline was not possible, due to the complexity of the topic and the barriers to changing practice.

The pro forma for collecting data reflected this complexity. Data was collected starting October 14, 2011, to give Trusts even more time to implement changes. By the end of the service evaluation submission period, 100% of the ten acute Trusts reported having a legible and accessible post-fall protocol on the wards, which prompted staff to inform relatives (or keyworkers), recorded the frequency and duration of neurological observations (where

FIGURE 12 – Neurological observations for patients with an unwitnessed fall
relevant), and recorded clinical observations to detect any potential new acute illness that caused the fall or to detect any harm from the fall (see FIGURE 41, p72).

Only one out of ten Trusts did not have access to specialist equipment for handling patients with fractures. Three out of ten Trusts had Glasgow Coma Scales which did not trigger urgent medical reviews.

Although most Trusts have these protocols in place, all Trusts have considerable work ahead in educating their staff on best practice guidance. At least 95% of the post-fall audit sample (99 patients) did not meet the standard set by NICE for neurological observations post-fall (see FIGURE 12, p22). Half of these were due to incorrect timings of observations and half were due to no observations recorded at all (see FIGURE 42, p73). All patients with unwitnessed falls should be treated as though they might be injured until observations confirm otherwise.

No patient met the standard for rushed imaging for suspected head injury. Of those 27 patients who met the criteria (see FIGURE 5, p13), 22% had imaging reviews which did not meet the standard timing, 26% had imaging reviews but did not have timings documented, and 52% had no imaging at all (see FIGURE 43, p74). Only two out of eleven patients with actual or suspected head injury had care which met the standard set by NICE for providing advice following a head injury (see FIGURE 44, p75).

All patients who are injured in hospital should be provided care similar to that of an emergency department. 36% of the 99 patients had care which met the standard set by NICE for timing medical assessments post-fall. 33% of the 99 had timings which did not meet the standard, and 31% of the 99 had no timings documented at all (see FIGURE 45, p76).

According to the Manchester Triage System for falls, patients should be triaged into five categories and receive assessments within a time appropriate to their category. Patients in the post-fall audit were triaged according to reported details about their illness (most significantly, GCS scores and other signs of head injury). 20 patients were VERY URGENT (to be assessed within 16 minutes), 18 patients were URGENT (to be assessed within an hour), and 61 patients were STANDARD (to be assessed within 2 hours).

FIGURE 13 — Percentage of patients in each triage group whose medical review post-fall met the standard timings

![Percentage of Sample](chart)

Only five of the VERY URGENT patients were assessed according to standard. Six of the URGENT patients and 25 of the STANDARD patients met the standard (see FIGURE 13, same page). A similar proportion was missing dates in each category (see FIGURE 46, p77). It is concerning that the most critical patients are least likely to have care which meets best
practice standards. Acute Trusts should ensure staff are correctly and consistently triaging patients who receive an injury in hospital, documenting when medical assessments are performed and reviewing any incident to ensure best practice guidance is being followed.

DID TRUSTS MEET THEIR OBJECTIVES?

At the final network event in 2009, most participating Trusts prepared and presented an action plan. These action plans have been reviewed against their audit results for 2011. Please see the appendices for a more comprehensive summary of 2011 audit results by Trust. 2009 audit results are available in the previously published report (see References, p43). Only those results which relate to Trust action plans are reported in this section. Both 2009 and 2011 audit results have been analysed using the 2011 analytical workbook and should be directly comparable using the 2011 standards. If comparable results are not available, only 2011 results are shared.

Countess of Chester Hospital NHS FT’s objective was to improve assessments and care for modifiable risk factors. From the 2009 to 2011 audits, they improved significantly in assessments for alternative beds (29% to 45%), bed rails (64% to 80%), polypharmacy (83% to 98%), and eyesight (18% to 32%).

They established a group to review audit results and plan improvements. For future audits, they will ensure that personnel have access to the complete medical record. They hoped to see improved timings of cognitive assessments, which increased from 90% (2009) to 97% (2011) of patients assessed by the end of the first full day following admission. Although they hoped to increase the

The Countess of Chester Hospital is a 600 bedded acute site, which provides services to the local population covering Western Cheshire, Ellesmere Port, Neston and North Wales.

Goals from 2009 report:
- Improve timings of cognitive assessments to within 24 hours
- Research potential options to improve recording of eyesight and hearing
- Improve capture of lying and standing blood pressure for medium and high risk patients on admission
- Further rollout of the assessment of the risk of osteoporosis

Actions taken:
- Implementation of the DAME (Drugs, Age, Medicine, Environment) falls assessment tool to capture this information
- Emphasis on highlighting the use of the falls assessment tool following refinement
- Continuing falls prevention education
- Osteoporosis specialist nurse in post
- Dedicated falls clinic run by orthogeriatrician
- All patients admitted as the result of a fall seen by orthogeriatrician and osteoporosis nurse

Statement submitted by Countess of Chester Hospital NHS FT September 2012
number of medium or high risk patients who have had lying & standing blood pressure measured, Chester saw only a modest increase from 4% (2009) to 9% (2011).

East Cheshire NHS Trust’s objective was to improve education and training for all clinical staff. In 2009, they had a training programme which was required for most staff but the curriculum did not cover many critical areas of falls prevention. In response, they organised additional training by manual handling coordinators, and the clinical risk manager attended ward meetings.

A second objective was to ensure all patients who have fallen or at risk of falling are identified. They established a rolling programme of clinical audits, monitored by their quality and safety board. Ward managers develop action plans which are monitored by matrons. As a result, the number of patients assessed by the end of the first full day following admission increased from 44% (2009) to 78% (2011).

A third objective was to ensure that all patients who have fallen are offered appropriate interventions with the aim of preventing further falls. They revised and trialled a new falls care plan form, and matrons monitored incident reports to ensure appropriate action was taken. New equipment such as glide and lock sheets was also ordered. From the 2009 to 2011 audits, more patients were provided with alternative beds (7% to 43%), bed rail plans (6% to 28%), and moving/handling plans (61% to 78%).

St Helens and Knowsley Teaching Hospitals NHS Trust’s objective was to improve their falls service. They hoped to maintain their good performance and to improve identification and support for continence, cognition and hearing/vision. From the 2009 to 2011 audits, they saw a modest increase in assessments for eyesight (3% to 10%) and hearing (1% to 8%). Interventions for eyesight also increased from 1% (2009) to 17% (2011).

Significantly more patients in 2011 received a cognitive assessment by the end of the first full day following admission compared to 2009 (33% to 63%). The number of patients being assessed for continence increased nominally from 28% (2009) to 30% (2011).

St Helens and Knowsley provided more bed rails plans in 2011 (63%) compared to 2009 (46%). They also reported providing all patients with an alternative bed in 2011, compared to 8% in 2009.

Finally, they hoped to improve the patient experience. In 2011, significantly more patients had their anxiety about falling assessed by the end of the first full day following admission (32%) compared to 2009 (4%). More patients had their falls care plans discussed.
with them in 2011 (35%) compared to 2009 (22%).

Wrightington, Wigan and Leigh NHS FT’s objective was to raise awareness within the Trust, bringing cultural changes such as urinalyses, lying & standing BP, and cognitive assessments (AMT) for all patients. Urinalyses increased from 31% (2009) to 44% (2011), but lying & standing blood pressure had only a nominal increase from 5% (2009) to 7% (2011). 95% of patients in 2011 had a cognitive assessment by the end of the first full day following admission, compared to 85% in 2009. The audits did not record whether this assessment was using AMT, however.

From 2009 to 2011, Wigan also saw significant improvements in bed rail assessments (28% to 98%), continence (33% to 100%), and alternative beds (5% to 61%), likely a result of their new multifactorial falls risk reduction plan which integrates assessment and intervention for all patients (on admission, post-fall, and after a change in ward or condition). They also:

- organised multi-disciplinary teams to pilot the new tool,
- trained ward teams on new tool, new incident maps and falls service referrals, and
- improved bedrail assessments and access to beds with bedrails

They hoped to see polypharmacy reviewed within 24 hours of admission, completed post-fall incident forms, and improved access to electronic patient records. Only 56% of patients had a risk/benefit review of their medication in 2011, however.

Wigan also hoped to increase discussions about falls care with patients. In 2011, 32% of patients had their anxiety about falling reviewed by the end of the first full day following admission, compared to 0% in 2009. Discussions with patients about care plans only increased nominally, from 46% (2009) to 51% (2011).

Following the 2009 audits the falls group focused on monitoring trends and utilised tools such as ward maps, safety cross and developed a root cause analysis tool. The Trust has seen a significant and sustained reduction in falls over the last 3 years.

The falls group has focused on the trend analysis, completion of assessments and care plans and further work is now being undertaken to review the falls assessment tool.

Southport and Ormskirk NHS Hospitals Trust had three objectives:

- Monitor trends of falls
- Establish effectiveness of falls risk assessments, and
- Develop staff training and improve awareness.

They hoped to see, through regular reviews of the Trust’s data, a decrease in the number of
falls, an increase in referral to falls services, and improved compliance with the falls policy.

As reported in the service evaluation questionnaires for 2009 and 2011, a select group of staff (such as a falls group) increased their reviews harmful falls from once (2009) to monthly (2011). They reported that their falls tool (implemented in 2008) had not yet been validated for sensitivity and specificity.

In 2009, they had a falls prevention training programme which required the attendance of most staff. The curriculum, however, lacked a significant amount of critical content. This increased significantly in 2011, though it is still lacking integration with medicines management, bed rails guidance, continence management, and post-fall injury management.

Mid-Cheshire Hospitals NHS FT’s objective was to improve screening for use of bedrails. They had a risk balance tool integrated with their falls tool (FRASE) and hoped to re-launch the bedrail policy and set a target with the Trust’s falls leads. The current pro forma would be adapted to record when bedrails were in use and why. They hoped to see a reduction in incidents where the use of bedrails would have prevented the fall. Correspondingly, the number of patients with a bed rail assessment increased from 27% (2009) to 63% (2011). Those receiving a bed rail plan increased from 21% (2009) to 58% (2011).

A second objective was to improve the number of patients who had lying & standing blood pressure measured. Previous to 2009, it was only recorded if requested by medical staff. They planned to set a new target with Trust falls leads. However, lying & standing blood pressure assessments decreased nominally from 6% (2009) to 5% (2011).

A third objective was to increase the number of patients receiving a medication review, particularly those on psychotropic medications. Previous to 2009, patients were assessed on an ad hoc basis (due in part to reduced numbers of pharmacists). They planned to train nursing staff to request medication reviews post-fall and if patient is on psychotropic medications. They investigated the inclusion of a trigger once the incident report form went electronic. Reassuringly, the number of patients receiving a risk/benefit review of their medication in 2011 was 93%.

A fourth objective was to investigate methods for improving documentation of patient involvement in falls care plans. They intended to identify gaps in current documentation which will be reviewed and actioned by the falls group. They hoped to see improvements in the completion of their documentation at the next audit. Although no patients had their anxiety about falling assessed in 2011, 18%
discussed their falls care plan with the medical team, increasing from 9% in 2009.

Further improvements included an increase in continence assessments (49% in 2009 to 78% in 2011). Less patients received an alternative bed in 2011 (3%) compared to 2009 (22%).

University Hospital of South Manchester NHS FT prepared a SWOT (Strengths, Weaknesses, Opportunities and Threats) analysis which identified the following opportunities for action:

- Medication reviews of falls
- Lying & standing blood pressure

They planned to roll out their new falls tool in more wards, which includes considerable promotion and training. This would be monitored by the Trust’s falls group and the executive lead for safety and quality. They planned to audit the quantity, cost and distribution of psychotropic medications to inform the promotion and structure of medication reviews.

Despite this, only 33% of patients had a risk/benefit review of medication in 2011. The number of patients who had lying and standing blood pressure measured (although higher than many Trusts) also decreased from 14% (2009) to 8% (2011).

Another opportunity was hospital-provided footwear. They planned to minimise foam footwear use and trial alternative footwear. This would be monitored by the Trust safety committee and by the finance team. Other opportunities included improving the assessment of hearing which resulted in proposed changes to the falls tool.

Significantly more patients had their assessments, as a result of the new falls tool. Eye-sight assessments increased from 8% (2009) to 83% (2011) and hearing assessments increased from 3% (2009) to 72% (2011). Bed rail assessments also increased from 49% (2009) to 85% (2011), and continence assessments increased from 76% (2009) to 100% (2011).

Fewer patients were provided with urinalyses, decreasing from 60% (2009) to 33% (2011). Fewer patients were also provided with an alternative bed, decreasing from 54% (2009) to 17% (2011) of all audited case notes.

UHSM also planned to: trial pressure alert sensors, update training to target different staff roles, develop clinical competencies (e.g. bedrail usage), perform regularly PDSA environmental audits (e.g. access to call bell, footwear), and investigate an e-learning training package. UHSM’s audit activity in 2009 was exemplary, and little has changed in 2011. Similarly, their training programme in 2009 covered all core concepts and
was required for most staff. This continued in 2011.

Stockport NHS FT’s objective was to review and improve their assessment of patients. Correspondingly, 93% of patients in 2011 had their falls history assessed by the end of the first full day following admission, compared to 76% in 2009. This trend continued for gait/mobility assessments (88% in 2009 to 97% in 2011). The number of patients who had their anxiety about falling reviewed also increased from 4% (2009) to 22% (2011). Finally, more patients received continence assessments in 2011 (83%) than 2009 (63%).

Stockport participated in collaborative work in reducing harm from falls on four wards and hoped this would increase the measurement of lying & standing blood pressure. Although they assess for orthostatic hypotension more than most Trusts, they only saw a nominal increase from 11% (2009) to 13% (2011).

They planned to re-launch a bed rail procedure and review the location of the falls tools within the care pathway to improve the completion of documentation. More patients were assessed for bed rails in 2011 (43%) compared to 2009 (20%).

To improve cognition assessments, they organised further audits on delirium and integrated the confusion assessment method (CAM) into the admission policy. Cognitive assessments increased from 48% in 2009 to 58% in 2011.

Stockport also intended to review the current practice of urinalysis in light of the antibiotic policy. Less patients received a urinalysis in 2011 (23%) compared to 2009 (39%).

Lancashire Teaching Hospitals NHS FT prepared an action plan at the end of the 2009 audit which stated that they had implemented a new assessment tool that covered falls, moving/handling and bed rails. Correspondingly, the assessment of bed rails increased from 53% (2009) to 77% (2011).

They intended to assess all patients on admission using this new tool and improve the assessment of osteoporosis, hearing, eyesight and fear of falling. Nominally less patients were assessed for osteoporosis in 2011 (3%) compared to 2009 (9%). Assessments for hearing and eyesight were also low in 2011 (3% and 2% respectively) compared to 2009 (35% and 41% respectively). Significantly more patients had their fear of falling assessed in 2011 (72%) compared to 2009 (45%).

They also hoped to assess all patients on ad-
mission for lying & standing blood pressure (except for those unable to stand independently for one minute), but this decreased nominally from 4% (2009) to 0% (2011).

They intended to improve the consultation of patients regarding their care plans. This decreased from 24% (2009) to 3% (2011).

Lancashire Teaching also planned to minimise ward transfers and to consider referrals to appropriate clinics on discharge. The number of patients with no ward transfers decreased from 65% (2009) to 48% (2011). Those with two or more ward transfers increased from 2% (2009) to 20% (2011).

Finally, they hoped to improve falls data collection and communication with ward staff.

Two Trusts from the 2011 audit did not participate in 2009: Royal Bolton Hospital NHS FT and Pennine Acute Hospitals NHS Trust. Therefore, it is not possible to reflect on any objectives set prior to the 2011 audit.

Other Trusts participated in the 2009 audit, but did not present their action plans at the final network event: Aintree University Hospitals NHS FT, Tameside Hospital NHS FT, and Wirral University Teaching Hospital NHS FT. Therefore, it is not possible to reflect on any objectives set after the 2009 audit. Wirral University Teaching Hospital NHS FT has since reported that they had developed an action plan following the 2009 audit but were unable to attend the network event to present it.

Overall, Aintree University Hospitals NHS FT saw significant improvements from 2009 to 2011 as a result of newly appointed leads in

A comparison of the results of the 2011 audit with those of the previous audit in 2009, showed an improvement in reviews of gait/mobility, falls risk, anxiety about falls, eyesight, medication, continence and bedrails, while checks of hearing and mobility/moving and handling had remained the same. It was, however, disappointing to note that there had been a decrease in reviews of first history of falls, lying and standing blood pressure and osteoporosis. The latter could be explained by the withdrawal of funding for the Osteoporosis Specialist Nurse.

New documentation to assess falls risk and identify appropriate interventions, where necessary, was developed at the Trust in 2011. This was later included in the nursing documentation, but was not fully embedded in practice at the time of the audit. Further raising of awareness has since taken place and the audit findings will be disseminated widely to reinforce this.

Despite the decline in performance in these areas, the number of all falls has shown a steady decrease during 2012, as have the number of serious falls leading to harm. A ‘Stop the Line’ process to investigate harmful falls quickly has been successfully implemented recently and the Safety Express Group has introduced many falls prevention measures. An action plan will be developed to address the concerns raised by the audit findings and will be monitored by the Trust Falls Steering Group.

Statement submitted by Wirral University Teaching Hospital NHS Trust September 2012
falls prevention. Tameside Hospital NHS FT lost their falls leads (consultant and coordinator) and, without appointing new leads, continued to struggle in 2011 with the same gaps. Wirral University Teaching Hospital NHS FT saw a decline in performance in 2011 as a result of transitioning to a new tool and electronic system. They also had a new audit team.

Other Trusts participated in the 2009 audit and presented at the final network event, but did not participate in the 2011 audit: Salford Royal NHS FT and Central Manchester University Hospitals NHS FT. Therefore, it is not possible to reflect on whether they met their objectives as their performance in 2011 is unknown.

Trafford Healthcare NHS Trust participated but did not present at the final network event in 2009. They have since been merged into Central Manchester University Hospitals NHS FT. Their performance in 2011 is unknown.
Trust Action Plans

How Trusts are responding to audit results

In response to the audits, Trusts developed action plans which included changes such as:

- Redesign of the falls tool
- Appointment of falls leads
- Multi-disciplinary falls groups
- Improved documentation
- Improved promotion of falls prevention
- Updates to policies on or related to falls
- New assessments, care plans or tools for modifiable risk factors
- Improved training of staff
- Increased participation in local and national research and audit projects
- Increased amount of local or environmental audits

The audits have also enabled staff to:

- Increase engagement with their boards and staff,
- Present business cases for changes in the provision of their services,
- Prepare quality evidence for coroner’s court or regulatory investigations, and
- Build their confidence through networking with other hospitals and national experts.

2011 ACTION PLANS

Once Trusts received the validated data and regional summary, they were invited to prepare a presentation at the final network event. In 2011, Trusts could choose between two templates: a SMART action plan or a SWOT analysis. Trusts examined their performance against their 2009 action plans and 2011 audit results, sharing what worked (or not) at the network event on 25 June 2012. These presentations can be found in a separate document: Appendices, Part I.

Aintree University Hospitals NHS FT’s goals were to ensure the initial assessments were done in a timely fashion and that modifiable risk factors were assessed. Since 2009, they changed their documentation. They also had new staff working on the audit.

Although pleased to see considerable improvements in their assessments, they identified several opportunities, such as linking objectives to other Trust targets (dementia strategy) and electronic documentation.

East Lancashire Hospitals NHS Trust participated for the first time in 2011. They identified several opportunities:
- Commissioner-led support of falls prevention programmes in the community and fracture liaison services
- Falls champions sharing information
- Improved inter-disciplinary working
- Integration with dementia strategy and CQUIN
- Increased involvement of orthogeriatrics

Lancashire Teaching Hospitals NHS FT’s goals were to:

- promote the usage of their falls tool (integrated with moving & handling and bedrail assessments),
- increase the number of patients with lying & standing blood pressure measured
- improve the documentation of patient involvement, and
- improve the falls referral on discharge (for continuity of care).

Through a regular programme of audits, they hope to see that all patients identified as at risk have an appropriate plan of care which includes urinalysis and assessment of vision and hearing on admission. They also hope to have root cause analyses on all injuries following a fall. Finally, they hope to see improved education and training for all staff and improved documentation (forms and policies).

East Cheshire NHS Trust’s goals were to improve assessment processes and care planning. Although pleased to see considerable improvements, they identified several opportunities to reduce falls and improve patient experience, increase pharmacy reviews and reduce the number of ward transfers:

- Integration with community business unit,
- Executive engagement and focus on falls prevention,
- Participation in ‘Safety Thermometer’,
- Integration with other Trust projects (e.g. dementia strategy, development of acute elderly care unit), and
- Introduction of Datix incident reporting.

The draft report is quite comprehensive. Although it is our first participation, going through the reports of previous Audit we noted considerable improvement in the performance of the participating Trusts and would strongly recommend repeating the audit if possible.

Our participation in the North West In-Patient Falls Audit has highlighted areas for potential improvement and stimulated us into applying measures to enhance our falls prevention and management services. We received very good support and guidance by Katherine in completion of the audit. However, it would be helpful if the audit pro-forma could be simpler and include questions highlighting outcomes of the falls services. To reduce the likelihood of qualitative differences among data collectors it would be helpful to have more clearly defined criteria for visual assessments, etc.

Statement submitted by East Lancashire Hospitals NHS Trust September 2012
Mid-Cheshire Hospitals NHS FT’s goals were to improve bedrail screening, increase recording of lying & standing blood pressure, increase review of medications (especially psychotrophic) and improve documentation of interventions. The new documentation (updated to include lying & standing blood pressure) was implemented just after the 2011 audit and ward-based pharmacists have been given the responsibility of reviewing medication (particularly after falls). They identified a number of opportunities, such as:

- Implementation of a FallSafe project,
- Online falls reporting
- Development of a falls fracture clinic,
- Physiotherapy to hold falls prevention classes, and
- Appointment of a non-hip fracture nurse.

Mid-Cheshire Hospitals NHS FT submitted a statement following their review of the draft 2011 audit report, which can be seen on page 34.

St Helens & Knowsley Hospitals NHS Trust’s goals were to evaluate their progress since 2009. They performed a detailed service review, revised falls service provision (including policies, tools, care plans and training), and increased liaison with primary care and emergency care colleagues. They identified a number of opportunities such as a regular programme of audits (local, regional and national), national quality improvement pro-

Mid-Cheshire Hospitals NHS FT’s Current Practise

- Monthly monitoring tool to cover 3 wards of 10 patients each to look at distribution of Falls Prevention information to patients, completion of intervention plans and number of staff receiving training, etc. (all wards will therefore be monitored once every six months).
- Falls workshop on Oct 3rd to highlight audit results.
- Consultant Orthogeriatrician highlighting need for doctors to standardise post fall review via audit day.
- Post fall nursing documentation now completed online via questionnaire. Direct link to pharmacy lead who will advise relevant ward pharmacists to review medication.
- Monthly report to all wards re: number of falls in their area and target for following month (with 10% reduction built-in)
- Annual Falls and Bone Health audit (first audit with new documentation) shows 71% of inpatients had a recorded bone health score.
- Collaboration with local council to produce home hazard display boards and updated falls prevention leaflets.
- Quarterly production of FaB newsletter (Falls and Bone Health) to inform all staff of latest local developments.

Mid-Cheshire Hospitals NHS FT’s Future Plans

- Night Nurse Practitioners (who undertake initial review of all patient falls overnight) will document four trigger questions: med review, L/S BP, urinalysis and change in medical condition prior to fall. It is hoped that this will then filter through into everyday practice.
- Introduction of FallSafe project onto 5 wards.
- Bedside eye tests by nurses.
- Hazard Hot Spot posters being developed to cover the bed area, the toilet area and the patient.
- Collaboration with Occupational Therapy dept to produce early home environmental assessment sheets which can be completed by relatives to identify potential problems or need to undertake a formal home visit prior to discharge.
Stockport NHS FT’s goals were to check improvement since the 2009 and to re-focus work regarding falls at the Trust, taking into account NW Falls audit recommendations. They updated and re-launched their bedrails policy, updated and improved the access of their falls tool, included lying & standing blood pressure in their tools and training, and implemented FRAX. They identified a number of opportunities, such as:

- Establishing a new harm-free care committee,
- Safety Thermometer survey,
- Falls collaborative on high risk wards,
- More focussed work on modifiable risk factors, and
- Corporate objective to reduce number of falls and harm rates.

University Hospital of South Manchester NHS FT’s goals were to compare their progress against the previous audit results and to improve their standards in assessing modifiable risk factors, performing medication reviews, and measuring lying & standing blood pressure. The new falls tool was slowly introduced across the Trust. Training was updated to reinforce measurement of lying & standing blood pressure, and a number of initiatives were piloted to formalise risk/benefit reviews of medication.

Although pleased to see improvements, they identified a number of opportunities, such as:

- A full-time falls service facilitator
- Introduction of a ward-based ‘falls champion’ (FallSafe), and
- E-learning training package (RCP).

University Hospital of South Manchester NHS FT submitted a statement following the re-

University Hospital of South Manchester NHS FT’s plans for the future, based on the SWOT analysis provided at the feedback session in June 2012, are to:

- Promote executive buy-in to the Falls management strategy in the Trust.
  The executive lead for Falls has recently moved under the nursing directorate. A scoping exercise is to be undertaken led by the Chief Nurse in Sept 2012 to review the projects being undertaken in the Trust such as the falls strategy.
- Prioritise what we do in relation to the results from the NW Falls audit and evidence from recent FallSafe study.
  In relation to increasing education on falls management and disseminating that knowledge, we intend to review the training of lying and standing blood pressure recording, re-visit the work undertaken on risk/benefit medication reviews, re-visit the Footwear project, integrate falls strategy with other trust strategies (e.g. Dementia), link in with work on “intentional rounding” and re-view the root cause analysis process relating to Falls.

Statement submitted by University Hospital of South Manchester NHS FT September 2012
view of the draft 2011 audit report, which can be seen on page 35.

Tameside Hospital NHS FT’s goals were to benchmark the Trust against the 2009 results. A focus group was established to develop an action plan and new falls documentation. A Trust-wide patient safety falls programme was implemented, as well as root-cause analysis investigations of falls and a regular programme of audits.

Subsequent audits have shown encouraging results after the falls documentation was revised and launched in November 2011. Falls documentation will be audited monthly and non-compliance managed. Admission documentation has been revised and will be implemented in July 2012. They hope to see improvements in vision, hearing and cognitive assessments in the next audits.

Wrightington, Wigan and Leigh NHS FT’s goals were to compare their progress against previous audit results. Falls will be reported on Datix and more rigorously analysed by the falls scrutiny committee through root cause analyses and other modelling techniques. A rapid response team for post-fall management was appointed. They hope to see improvements in assessments, bed management (aka reduced ward transfers), training and education, as well as better address bone health.

OTHER ACUTE TRUSTS

The following acute Trusts did not present on June 25th but did submit objectives following their review of the draft 2011 audit report.

Countess of Chester Hospital NHS FT intends to continue the work identified from their 2009 objectives to aid effective falls prevention and risk assessment. Their 2009 objectives and actions are provided in a statement on page 24.

Southport and Ormskirk NHS Trust’s objectives and actions are provided in a statement below.

Further staff education will be undertaken to ensure effective use of the tool once implemented. The falls care plan has been reviewed and now includes questions around history of falls and patients fears and anxieties. There are also prompts for completion of lying and standing blood pressure. Staff training will be reviewed further to include all of the recommendations for this 2011 report.

A falls incident database has been developed to enable an in-depth analysis of patient falls and the trends. This will be implemented in the coming months.

All falls are reported at ward and departmental level and within the Trust risk management committee. We are currently reviewing this process and are doing so in conjunction with harm free care implementation.

The Trust became an integrated care organisation in April 2011. This will enhance the relationships between the falls teams across the community and acute Trust and ensure a seamless pathway for patients and standardisation of services, assessment tools and resulting care and interventions.

Part 2 of the Statement submitted by Southport and Ormskirk NHS Trust September 2012
Safer Care through QIPP

How the audit supports the quality, innovation, productivity, and prevention agenda

Falls prevention is covered by the Safe Care workstream in the QIPP programme [aka Safety Express] led by Maxine Power (Salford NHS FT), which has generated the quality improvement product ‘Safety Thermometer.’ This is now part of the Commissioning for Quality and Innovation payment scheme (CQUIN).

Productivity means doing the right things at the right time. The 2009 audit looked specifically at the efficiency of falls prevention through the collection of data on falls re-assessments (dates, triggers, outcomes). The 2009 and 2011 results indicate a significant opportunity for improving efficiency through reducing unnecessary assessments and improving communication between providers.

For example, a number of Trusts set an objective to reduce the number of urinalyses (to prevent unnecessary prescriptions for antibiotics) following the 2009 audit. The 2011 audit revealed significant reductions in the provision of urinalyses for these Trusts.

The Northwest inpatient falls audit has supported acute Trusts through their individual quality improvement cycles. Feedback following the audit networking events has been highly positive, with Trusts citing how they have adopted ideas from other Trusts or learned from each other’s improvement programmes.

The 2011 audit also demonstrates the impact that clear leadership has on developing a productive service.

Those Trusts who lost their falls leads saw a decline in performance (aka audit results that did not meet objectives set by the individual Trust).

Similarly, those Trusts who were in the process of adopting a new falls tool also saw declines in their performance, despite having a history of strong leadership. Support and involvement from the entire Trust is needed to manage changes of such a large scale.
Saving Costs

How the audit supports value for money

Improving quality is a major component of bridging the English NHS funding gap. Trusts are asked to make savings of 6% or more.

The NHS Institute for Innovation and Improvement estimates that around £4.5 billion could be saved if acute Trust’s adopted best clinical practices (such as implementing the Pro- ductive series or reducing lengths of stay). Jim Easton, Director of Efficiency and Improvement at the Department of Health, stresses the importance of auditing practice to understand where we are and where we should go from there, in making quality improvements.

NATIONAL STANDARDS

Implementing NICE standards could save the NHS £600 million and reducing inpatient falls could save £15 million. Although no current standards exist for in-patient falls, a working group at NICE is currently updating these standards for publication in the next year. In the meantime, the Northwest audit of in-patient falls has helped identify practical and relevant standards for Trusts to use in local and national audits. These have been incorporated into the Royal College of Physicians’ proposed national audit of in-patient falls.

CLINICAL GOVERNANCE

The audit has identified opportunities for cost-saving which will inform commissioning new patient pathways. As part of the quality improvement process, Trusts tackle variations in practice which have huge cost implications, such as the prescription of psychotropics. The previous audit reports raised important questions about the number and quality of medication reviews, and this continues to be relevant in 2011. There are significant opportunities to reduce unnecessary medications, improve patients’ quality of life, and reduce both in-patient and community based falls.

For example, most Trusts struggle to assess orthostatic hypotension through measuring lying & standing blood pressure [see FIGURE 34, p65]. Orthostatic hypotension is managed primarily through reducing unnecessary or harmful medications, which would save the NHS money. But it is not straightforward to assess for orthostatic hypotension in a frail, acutely unwell elderly patient on a busy ward. Further innovative work is needed which addresses this critical area. The successful Trust will see rewards in both efficiency and engagement.
Conclusion

Summary of findings

Prior to the NPSA report on slips, trips and falls in 2007, there was no clear direction for falls prevention in hospitals. The first audit in 2004 was based on limited research by the audit leads, who proposed an audit to learn more about what is being done in their hospitals. The evidence showed that patients were not routinely assessed or provided interventions appropriately.

By repeating the audit, Trusts learned that difficult areas are difficult for everyone. As a whole, participating hospitals performed better with each audit cycle. Even the quality of action plans has improved over time, as acute Trusts set more realistic targets.

But everyone must remain on their guard — falls prevention services are highly sensitive to transition such as loss of falls leads, new electronic systems or tools, and a change in board leadership.

The audit has been difficult and time-consuming for everyone involved. Falls prevention is not an ideal audit topic as there are few agreed standards and many limitations. Despite this, participation and involvement from Northwest acute Trusts has increased over time. The audit has been adopted in hospital sites around the world, including mental health units. Clinical staff remain committed to improving services despite the challenging audit design and the limited research.

The Royal College of Physicians has completed

the pilot of a proposed national audit of inpatient falls, which incorporates learnings from the Northwest audit with the latest research. Northwest acute Trusts should expect to top the charts if they continue their hard work. Most English hospitals have minimal experience auditing falls at this scale and are eager to learn from the Northwest.

RECOMMENDATIONS

Based on the 2011 audit results, we have a number of recommendations for Northwest acute Trusts:

- Update and validate falls tools
- Establish a succession plan
- Improve multi-disciplinary education
- Increase patient involvement
- Review patients’ medications
- Promote post-fall management

These recommendations should also be useful to other acute providers in England and further afield.
Update your tools

Despite increasing guidance on what makes a falls tool effective, some Northwest acute Trusts are still using older tools which rely on stratifying patients into low, medium or high risk based on computed scores (see FIGURE 16, p47). Research suggests that these types of tools are less effective and possibly even harmful (Oliver, 2009).

The level of assessments for falls risk has remained stable from 2009, but the proportion of patients who are considered ‘at risk’ has increased (see FIGURE 18, p49). Furthermore, there are significant differences in the number of ‘low’ and ‘high’ risk patients at each hospital.

FIGURE 14 — Patient’s risk level as reported in the 2004, 2006, 2009, and 2011 audits

In light of criticisms of numerical risk prediction tools (Oliver, 2009), Trusts should consider whether a non-numerical tool would fit better into their falls prevention programme. NPSA recommends a care plan which allows for personalised and comprehensive assessments for all patients who have a history of falls, unsteady gait, or fear of falling.

The 2009 audit showed how the use of a tool resulted in significantly more assessments and interventions for the patient. As the transition to a new tool takes considerable time and investment, consider making changes in small steps. Choose a quality improvement process which promotes engagement with staff, as ultimately the success of the tool depends on them.

Validate your tools

A perfect falls tool would correctly identify all patients who were at risk of falling (sensitivity) and all patients NOT at risk of falling (specificity). Any deviation from this ideal would mean an increase in harm or a decrease in efficiency. It is important, therefore, that all hospitals validate their tools for sensitivity and specificity within their hospital population.

Despite clear guidance on tool validation from Patient Safety First (October 2010), Northwest acute Trusts are still using un-validated tools (See FIGURE 16, p47).

With unvalidated stratification of patients, there is a serious and potentially harmful inequity in the provision of interventions to patients. Those Trusts who regularly validate their tools have confidence that their patients are receiving appropriate and necessary care to prevent harmful falls. Validating your tools will increase the efficiency of your work and protect your Trust against litigation.

Establish a succession plan

The falls prevention programme is only as good as the people who are involved in it.
Larger multi-disciplinary teams that involve several staff from each professional group have proven to be better at weathering the current transitions in leadership. It is absolutely essential to establish a succession plan and share the specialist knowledge amongst staff.

**Conclusion**

**Improve your education**

A tool is only as good as the staff members that use it. The 2011 audit has shown considerable opportunities for improving the education of staff. Although most Trusts had a falls training programme which was required for most key staff members (see FIGURE 39, p70) and covered many core concepts (see FIGURE 40, p71), there appear to be significant qualitative differences within and between hospitals in how staff defined an adequate assessment or intervention for modifiable risk factors.

For example, some data collectors for the 2011 audit believed that ticking a box to record that a patient wore glasses is an adequate assessment of eyesight. Many Trusts reported that medication was reviewed during the patient’s stay, but no Trust had documented evidence that these medication reviews considered a patient’s risk of falling.

Out of 56 nurses from six acute Trusts, only 45% knew how to measure lying and standing blood pressure (see FIGURE 36, p67). This is despite many Trusts having instructive tools, guidance and training programmes for lying and standing blood pressure.

There are natural differences between Trusts, such as the provision of assessing urine for infections or providing prophylactic treatment of osteoporosis. It is important that Trusts collect evidence that their practice matches their policies through clinical audit, but also that their policies are appropriate for their population.

**Increase patient involvement**

The gaps found in 2004 are still gaps in 2011, and the common thread between all of these ‘difficult to reach’ areas (See FIGURE 35, p66) may be patient involvement. The latest quality improvement methods (such as FallSafe) are proficient at identifying leaders and educating staff. But a good proportion of preventing falls depends on healthy and productive communication between staff and patients. This is especially a challenge for those wards with a high proportion of patients with dementia or delirium.

Recent research has shown that a patient’s anxiety about falling is an independent risk factor and should be assessed and treated appropriately through brief interventions, prescriptions or referrals to mental health services. In 2011, 74% of patients were not assessed for anxiety about falling, which is an increase from 71% in the 2009 audit (see FIGURE 21, p52). In 2011, two acute Trusts assessed at least 70% of their patients for anxiety about falling.
iety about falls, as a result of updating their falls tools and implementing the changes across the Trust (see FIGURE 30, p61). Some acute Trusts have improved more quickly than others (see FIGURE 32, p63).

If Trusts want to see further improvements in their falls service, they will need to tackle this challenging area with a rigorous programme that focuses on engaging with patients. Consider working in partnership with community providers or engaging in national or regional quality improvement programmes.

**Review patients’ medications**

In the 2011 case note review, 94% of patients had an increased falls risk due to certain medications, which can increase other risk factors such as delirium or orthostatic hypotension. With such a high percentage, there is little reason not to review the medications of all patients, but only 47% of those with heightened risk did (see FIGURE 33, p64). Acute Trusts should establish a programme of medication reviews led by pharmacists and consultants, which considers a patient's risk of falls. Where appropriate, patients’ medications should be reduced or altered to reduce their risk of falls.

**Promote post-fall management**

If a patient falls next to the toilet on a ward, she should receive the same high quality care as the patient who fell on the street. The 2011 post-fall audit has shown how significant these gaps are for patients who experience potentially injurious falls in hospital. It is not possible to prevent all falls, but it is possible to provide excellent post-fall management.

Acute Trusts should consider adopting a triage system for responding to falls in hospital, which efficiently and effectively assesses for injury and identifies necessary interventions. Liaise with colleagues in emergency departments to share skills with ward-based staff.

**FUTURE WORK**

The Northwest inpatient falls audit has enabled acute Trusts to make considerable improvements to their practice. They will continue to evaluate these developments through a regular programme of local audits. The Royal College of Physicians has recently completed a successful pilot of a national audit of inpatient falls, which draws heavily on the Northwest audit. As such, there are no plans to seek funding for another cycle of the regional audit.

However, Trusts would benefit from the support of a clinical network which continued to foster their shared goals in improving patient safety in hospitals. More work is needed to evaluate quality improvements, especially in post-fall management, medicines management, orthostatic hypotension and management of dementia/delirium.
References


Connor G. Fall risk assessment scale for the elderly F.R.A.S.E. Nursing Development Unit, General Hospital, Tullamore, 1996.


45. FIGURE 16 - FALLS TOOLS IN USE DURING THE MAY 2011 AUDIT
48. FIGURE 17 - PERCENTAGE OF PATIENTS ASSESSED FOR FALLS RISK BY YEAR
49. FIGURE 18 - PROPORTION OF PATIENTS CONSIDERED ‘AT RISK’ OF FALLING
50. FIGURE 19 - PERCENTAGE OF PATIENTS ASSESSED FOR FALLS RISK BY TRUST
51. FIGURE 20 - CHANGE IN PERCENTAGE OF PATIENTS ASSESSED FOR FALLS RISK BY THE END OF THE FIRST FULL DAY FOLLOWING ADMISSION BY TRUST
52. FIGURE 21 - AVERAGE PERCENTAGE OF PATIENTS RECEIVING NO ASSESSMENTS OF FALLS HISTORY, GAIT/MOBILITY, COGNITION, OR ANXIETY ABOUT FALLS BY YEAR
53. FIGURE 22 - PERCENTAGE OF PATIENTS ASSESSED FOR HISTORY OF FALLS BY TRUST
54. FIGURE 23 - CHANGE IN PERCENTAGE OF PATIENTS WHO HAD AN ASSESSMENT OF FALLS HISTORY BY THE END OF THE FIRST FULL DAY FOLLOWING ADMISSION (SORTED BY 2011 PERCENTAGES)
55. FIGURE 24 - AVERAGE PERCENTAGE OF PATIENTS WHO WERE NOT ASSESSED FOR HISTORY OF FALLS (PLUS RANGE)
56. FIGURE 25 - AVERAGE PERCENTAGE OF PATIENTS WHO WERE NOT ASSESSED FOR HISTORY OF FALLS (PLUS RANGE) BY TRUST
57. FIGURE 26 - PERCENTAGE OF PATIENTS ASSESSED FOR GAIT/MOBILITY BY TRUST
58. FIGURE 27 - CHANGE IN PERCENTAGE OF PATIENTS WHO HAD AN ASSESSMENT OF GAIT/MOBILITY BY THE END OF THE FIRST FULL DAY FOLLOWING ADMISSION (SORTED BY 2011 PERCENTAGES)
59. FIGURE 28 - PERCENTAGE OF PATIENTS ASSESSED FOR COGNITION BY TRUST
60. FIGURE 29 - CHANGE IN PERCENTAGE OF PATIENTS WHO HAD AN ASSESSMENT OF COGNITION BY THE END OF THE FIRST FULL DAY FOLLOWING ADMISSION (SORTED BY 2011 PERCENTAGES)
61. FIGURE 30 - PERCENTAGE OF PATIENTS WHO HAD THEIR ANXIETY OF FALLS ASSESSED
62. FIGURE 31 - CHANGE IN PERCENTAGE OF PATIENTS WHO HAD THEIR ANXIETY OF FALLS ASSESSED
63. FIGURE 32 - CHANGE IN PERCENTAGE OF PATIENTS WHO HAD AN ASSESSMENT OF PATIENT ANXIETY ABOUT FALLS BY THE END OF THE FIRST FULL DAY FOLLOWING ADMISSION (SORTED BY 2011 PERCENTAGES)
64. FIGURE 33 - MEDICATION REVIEWS
65. FIGURE 34 - ORTHOSTATIC HYPOTENSION
66. FIGURE 35 - PERCENTAGE OF PATIENTS WHO RECEIVED AN ASSESSMENT OF MEDICATION, EYESIGHT OR ORTHOSTATIC HYPOTENSION IN 2004 AND 2011 (SORTED BY 2011)
67. FIGURE 36 - NURSE KNOWLEDGE OF LYING AND STANDING BLOOD PRESSURE
68. FIGURE 37 - RANKING OF ASSESSMENTS BY THEIR OVERALL PERCENTAGE OF PROVISION
69. FIGURE 38 - RANKING OF INTERVENTIONS BY THEIR OVERALL PERCENTAGE OF PROVISION
70. FIGURE 39 - TRAINING PROGRAMME ATTENDANCE
71. FIGURE 40 - TRAINING PROGRAMME CURRICULUM
72. FIGURE 41 - EVALUATION OF POST-FALL MANAGEMENT SERVICE
73. FIGURE 42 - NUMBER OF PATIENTS WITH AN UNWITNESSSED FALL MEETING STANDARDS FOR NEUROLOGICAL OBSERVATIONS
74. FIGURE 43 - NUMBER OF PATIENTS MEETING STANDARD FOR RUSHED IMAGING FOR SUSPECTED HEAD INJURY
75. FIGURE 44 - NUMBER OF PATIENTS WITH SUSPECTED OR ACTUAL HEAD INJURY MEETING STANDARD FOR ADVICE PROVIDED
76. FIGURE 45 - NUMBER OF PATIENTS MEETING STANDARD FOR TIMINGS OF MEDICAL ASSESSMENT FOLLOWING FALL
77. FIGURE 46 - NUMBER OF PATIENTS MEETING STANDARD FOR TIMINGS OF MEDICAL ASSESSMENT FOLLOWING FALL
78. FIGURE 47 - STATEMENT OF FEEDBACK FROM THE EXPERT PATIENT
The most interesting and significant audit results are reported in tables and figures in four or five self-described sub-sections: CONTEXT, DATA, STANDARD, IMPLICATIONS and RECOMMENDATIONS. Additionally, a STATEMENT OF FEEDBACK from the patient expert is presented. A full summary of audit results can be found in separate documents (Appendices Part I and II).

**HOW TO READ THE FIGURES**

Each table/figure has an individual key which explains how to read the table/figure. Note that the sample for each question may vary insignificantly from the final sample for each Trust as blanks were excluded by question only. The case note audit sample per Trust is presented on page 45. The post-fall audit data is not reported by Trust due to the reduced sample.

**HOW TO INTERPRET THE FIGURES**

Please review this data in context of the Trust’s presentations and action plans. Please also note that the data reported is from May 2011 and therefore may differ from current Trust practice. Where possible, data from previous audits is reported alongside the 2011 audit results.

**2011 CASE NOTE AUDIT SAMPLE**

Trusts were asked to sample sixty patients.
A minimum sample of forty was accepted for inclusion in the final regional analysis and report.

<table>
<thead>
<tr>
<th></th>
<th>2011 CASE NOTE REVIEW AUDIT SAMPLE</th>
</tr>
</thead>
<tbody>
<tr>
<td>TOTAL</td>
<td>844</td>
</tr>
<tr>
<td>SOUTHPORT</td>
<td>63</td>
</tr>
<tr>
<td>TAMESIDE</td>
<td>61</td>
</tr>
<tr>
<td>CHESTER</td>
<td>60</td>
</tr>
<tr>
<td>LANC TEACH</td>
<td>60</td>
</tr>
<tr>
<td>LEIGHTON</td>
<td>60</td>
</tr>
<tr>
<td>STHK</td>
<td>60</td>
</tr>
<tr>
<td>STOCKPORT</td>
<td>60</td>
</tr>
<tr>
<td>UHSM</td>
<td>60</td>
</tr>
<tr>
<td>AINTREE</td>
<td>59</td>
</tr>
<tr>
<td>WIRRAL</td>
<td>59</td>
</tr>
<tr>
<td>PENNINE</td>
<td>59</td>
</tr>
<tr>
<td>BOLTON</td>
<td>55</td>
</tr>
<tr>
<td>EAST LANC</td>
<td>47</td>
</tr>
<tr>
<td>WIGAN</td>
<td>41</td>
</tr>
<tr>
<td>MACC</td>
<td>40</td>
</tr>
</tbody>
</table>

Highlighted Results 45
Unless otherwise stated, the percentage for each question is out of the above sample for each Trust. Note that there may be valid clinical reasons for why certain assessments or interventions are not provided. As such, there are no standards set for the provision of assessments and care for modifiable risk factors. Only ‘YES’ percentages are provided, to give some indication of provision. It is up to individual Trusts to monitor and investigate these trends through local, topic-specific audits.

2011 POST-FALL AUDIT SAMPLE

Trusts were asked to sample ten patients with unwitnessed falls. Due to the small sample, data was only reported regionally.

<table>
<thead>
<tr>
<th>Trust</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>AINTREE</td>
<td>10</td>
</tr>
<tr>
<td>CHESTER</td>
<td>10</td>
</tr>
<tr>
<td>EAST LANC</td>
<td>10</td>
</tr>
<tr>
<td>SOUTHPORT</td>
<td>10</td>
</tr>
<tr>
<td>STHK</td>
<td>10</td>
</tr>
<tr>
<td>STOCKPORT</td>
<td>10</td>
</tr>
<tr>
<td>UHSM</td>
<td>10</td>
</tr>
<tr>
<td>WIRRAL</td>
<td>10</td>
</tr>
<tr>
<td>LEIGHTON</td>
<td>7</td>
</tr>
<tr>
<td>PENNINE</td>
<td>6</td>
</tr>
<tr>
<td>WIGAN</td>
<td>6</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>109</strong></td>
</tr>
</tbody>
</table>

2011 SERVICE EVALUATION SAMPLE

Twelve acute Trusts participated in the service evaluation, but not all Trusts answered all sections or questions. Data is reported qualitatively, with exception of a small ward-based audit of nurse knowledge of orthostatic hypotension. Please see Appendices, Part II (a separate document) for a summary of the results by Trust.
**FIGURE 16 - FALLS TOOLS IN USE DURING THE MAY 2011 AUDIT**

**CONTEXT**

In the service evaluation, acute Trusts reported on falls tools in use in May 2011: where the tool was from, what date the version was adopted, what the tool’s outcomes were (stratification, score), and whether the tool was validated locally.

**DATA**

<table>
<thead>
<tr>
<th>TRUST</th>
<th>VERSION IN USE SINCE</th>
<th>OUTCOME STRATIFICATION</th>
<th>OUTCOME SCORE</th>
<th>VALIDATION</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>TOOLS BASED ON FRASE</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MID-CHERHIRE</td>
<td>2006</td>
<td>MULTIPLE RISK GROUPS</td>
<td>SCORE</td>
<td>NOT VALIDATED</td>
</tr>
<tr>
<td>AINTREE</td>
<td>2006</td>
<td>MULTIPLE RISK GROUPS</td>
<td>SCORE</td>
<td>NOT VALIDATED</td>
</tr>
<tr>
<td>STOCKPORT</td>
<td>2004</td>
<td>MULTIPLE RISK GROUPS</td>
<td>SCORE</td>
<td>VALIDATED</td>
</tr>
<tr>
<td>STHK</td>
<td>2009</td>
<td>TWO RISK GROUPS</td>
<td>SCORE</td>
<td>VALIDATED</td>
</tr>
<tr>
<td><strong>TOOLS BASED ON STRATIFY</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PENNINE</td>
<td>2010</td>
<td>TWO RISK GROUPS</td>
<td>SCORE</td>
<td>VALIDATED</td>
</tr>
<tr>
<td>WIRRAL</td>
<td>2000</td>
<td></td>
<td>SCORE</td>
<td>NOT VALIDATED</td>
</tr>
<tr>
<td>WIGAN</td>
<td>2005</td>
<td>MULTIPLE RISK GROUPS</td>
<td>SCORE</td>
<td>NOT VALIDATED</td>
</tr>
<tr>
<td><strong>TOOLS BASED ON NPSA 2007</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>LANC TEACH</td>
<td>2010</td>
<td>MULTIPLE RISK GROUPS</td>
<td>SCORE</td>
<td>NOT VALIDATED</td>
</tr>
<tr>
<td>SOUTHPORT</td>
<td>2008</td>
<td>MULTIPLE RISK GROUPS</td>
<td>SCORE</td>
<td>NOT VALIDATED</td>
</tr>
<tr>
<td>UHSM</td>
<td>2010</td>
<td>NO RISK GROUPS</td>
<td>NO SCORE</td>
<td>NOT VALIDATED</td>
</tr>
<tr>
<td><strong>TOOLS DEVELOPED INTERNALLY</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CHESTER</td>
<td>2007</td>
<td>MULTIPLE RISK GROUPS</td>
<td>SCORE</td>
<td>NOT VALIDATED</td>
</tr>
<tr>
<td>EAST LANC</td>
<td>2010</td>
<td>MULTIPLE RISK GROUPS</td>
<td>SCORE</td>
<td>VALIDATED</td>
</tr>
</tbody>
</table>

Key: **BLUE** indicates data which meets best practice standards.

**IMPLICATIONS**

Many Trusts have not updated their tools to reflect the latest guidance and research (NPSA, 2007). Only three Trusts have validated their tool in a local population.

**RECOMMENDATIONS**

Avoid using a tool which provides a numerical score, but especially one which stratifies patients into multiple risk groups. Implement changes gradually and plan for a transition of at least two years. Validate your tools using guidance from Patient Safety First (2010).
**FIGURE 17 - PERCENTAGE OF PATIENTS ASSESSED FOR FALLS RISK BY YEAR**

**CONTEXT**

In the case note audit, acute Trusts collected data on whether patients were assessed using a falls tool.

**DATA**

![Percentage of Sample chart]

<table>
<thead>
<tr>
<th>Year</th>
<th>Percentage</th>
<th>Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>2004 (7 Trusts)</td>
<td>53%</td>
<td>0% to 92%</td>
</tr>
<tr>
<td>2006 (9 Trusts)</td>
<td>63%</td>
<td>10% to 95%</td>
</tr>
<tr>
<td>2009 (14 Trusts)</td>
<td>87%</td>
<td>60% to 99%</td>
</tr>
<tr>
<td>2011 (15 Trusts)</td>
<td>89%</td>
<td>57% to 100%</td>
</tr>
<tr>
<td>2011* (11 Trusts)</td>
<td>92%</td>
<td>67% to 100%</td>
</tr>
<tr>
<td>Best Practice Standard</td>
<td>100%</td>
<td></td>
</tr>
</tbody>
</table>

Key: 2011* indicates data only from the eleven hospitals who participated in both 2009 and 2011.

**IMPLICATIONS**

In 2004, most patients were not assessed for falls risk because many Trusts had not yet adopted a falls tool. Over time, more Trusts started using a falls tool and more patients were assessed.

**RECOMMENDATIONS**

Trusts should continue to monitor how many patients receive a falls risk assessment, in order to reduce inequity and meet the best practice standard.
FIGURE 18 - PROPORTION OF PATIENTS CONSIDERED ‘AT RISK’ OF FALLING

CONTEXT

In the case note audit, acute Trusts collected data on what a patient’s risk level was (‘at risk’ or ‘not at risk’). In 2009 and 2011, those Trusts that used multiple risk groups were asked to define ‘at risk’ as any risk level which indicated a need for further assessments or interventions.

DATA

![Percentage of Sample Assessed for Falls Risk](image)

- **2004 (7 Trusts)**: 73.6% at risk, 26.4% not at risk
- **2006 (9 Trusts)**: 52.5% at risk, 47.5% not at risk
- **2009 (14 Trusts)**: 58.6% at risk, 41.4% not at risk
- **2011 (15 Trusts)**: 82.6% at risk, 17.4% not at risk

IMPLICATIONS

In 2004, few patients were assessed using a tool. The high proportion of ‘at risk’ patients is most likely due to bias in the sample, as patients with higher risk were more likely to be identified and provided further assessments.

In 2011, the proportion of patients considered ‘at risk’ jumped significantly. This is due to a change in culture regarding the definition of ‘at risk’.

RECOMMENDATIONS

Trusts should adopt and promote a single definition of ‘at risk’ and involve risk managers in ward-based training programmes.
FIGURE 19 - PERCENTAGE OF PATIENTS ASSESSED FOR FALLS RISK BY TRUST

CONTEXT

In the case note audit, acute Trusts collected data on whether patients were assessed using a falls tool. This data was reported by Trust and for the total sample.

PROPOSED STANDARD

100% of patients should be assessed using a validated falls tool by the end of the first full day following admission.

DATA

[Graph showing percentage of patients assessed for falls risk by trust]

IMPLICATIONS

Most Trusts have sustained levels of assessments above the proposed standard.

RECOMMENDATIONS

Those Trusts who are performing below the proposed standard should consider improving the timing and completion of their falls tools through internal promotion and training.
FIGURE 20 - CHANGE IN PERCENTAGE OF PATIENTS ASSESSED FOR FALLS RISK BY THE END OF THE FIRST FULL DAY FOLLOWING ADMISSION BY TRUST

CONTEXT

In the 2009 and 2011 case note audits, acute Trusts collected data on whether patients were assessed using a falls tool by the end of the first full day following admission. The percentage in 2009 was subtracted from the percentage in 2011 for those Trusts who participated in both years.

DATA

IMPLICATIONS

Most Trusts have sustained or improved their percentage of assessments by the end of the first full day following admission. Those Trusts with a decline have reported significant changes in leadership, tools or audit teams.

RECOMMENDATIONS

All Trusts should consider how changes might affect patient safety. Be prepared to assertively promote new tools for at least two years. Include falls prevention in any transition plan for changes in leadership.
**FIGURE 21 - AVERAGE PERCENTAGE OF PATIENTS RECEIVING NO ASSESSMENTS OF FALLS HISTORY, GAIT/MOBILITY, COGNITION, OR ANXIETY ABOUT FALLS BY YEAR**

**CONTEXT**

In the 2004, 2006, 2009 and 2011 case note audits, acute Trusts collected data on whether patients’ falls history was recorded in the notes (usually in a falls tool). In 2009 and 2011, acute Trusts also collected data on whether cognition, gait/mobility and patient anxiety about falls was assessed.

Patient anxiety about falling is a modifiable risk factor for falling, independent from a patient’s gait/mobility. Anxiety causes unnecessary distress to patients, who may inappropriately limit their physical activities and increase their falls risk.

**DATA**

![Graph showing percentage of patients receiving no assessments over years]

**IMPLICATIONS**

Overall, Trusts have improved their assessments of three key modifiable risk factors but are poor at assessing and caring for patient’s anxiety about falls.

**RECOMMENDATIONS**

Hospitals should include patient anxiety in their falls tool and consider any barriers to providing care (such as patient education, brief interventions, or referrals).
FIGURE 22 - PERCENTAGE OF PATIENTS ASSESSED FOR HISTORY OF FALLS BY TRUST

CONTEXT

In the 2004, 2006, 2009 and 2011 audits, acute Trusts collected data on whether patients’ falls history was documented, usually in a falls tool. This data was reported by Trust and for the total sample.

PROPOSED STANDARD

100% of patients should have their falls history assessed by the end of the first full day following admission.

DATA

<table>
<thead>
<tr>
<th>Percentage of Sample (2011)</th>
</tr>
</thead>
<tbody>
<tr>
<td>0%</td>
</tr>
<tr>
<td>-----</td>
</tr>
<tr>
<td>BEST PRACTICE STANDARD</td>
</tr>
<tr>
<td>WIGAN</td>
</tr>
<tr>
<td>CHESTER</td>
</tr>
<tr>
<td>LEIGHTON</td>
</tr>
<tr>
<td>LANC TEACH</td>
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<tr>
<td>STOCKPORT</td>
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<tr>
<td>UHSM</td>
</tr>
<tr>
<td>BOLTON</td>
</tr>
<tr>
<td>AINTREE</td>
</tr>
<tr>
<td>STHK</td>
</tr>
<tr>
<td>2011 (TOTAL SAMPLE)</td>
</tr>
<tr>
<td>MACC</td>
</tr>
<tr>
<td>SOUTHPORT</td>
</tr>
<tr>
<td>WIRRAL</td>
</tr>
<tr>
<td>PENNINE</td>
</tr>
<tr>
<td>EAST LANC</td>
</tr>
<tr>
<td>TAMMISE</td>
</tr>
</tbody>
</table>

■ BY END OF FIRST FULL DAY FOLLOWING ADMISSION
■ ON THE SECOND FULL DAY OR LATER

IMPLICATIONS

Many acute Trusts assessed over 90% of their sample, which is an excellent result. There is room for improvement, however, especially in the timing of assessments (ORANGE).

RECOMMENDATIONS

Trusts should aim to assess history of falls in 100% of their patients, documenting if assessment was not possible and why.
FIGURE 23 – CHANGE IN PERCENTAGE OF PATIENTS WHO HAD AN ASSESSMENT OF FALLS HISTORY BY THE END OF THE FIRST FULL DAY FOLLOWING ADMISSION (SORTED BY 2011 PERCENTAGES)

CONTEXT

In the 2009 and 2011 audits, acute Trusts collected data on whether patients’ falls history was documented, usually in the general nursing notes. The change in percentage from 2009 to 2011 was reported by Trust.

DATA

Percentage of Sample (2011)

<table>
<thead>
<tr>
<th></th>
<th>0%</th>
<th>20%</th>
<th>40%</th>
<th>60%</th>
<th>80%</th>
<th>100%</th>
</tr>
</thead>
<tbody>
<tr>
<td>WIGAN</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CHESTER</td>
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<td>LEIGHTON</td>
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<tr>
<td>LANC TEACH</td>
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<td>STOCKPORT</td>
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<td>AINTREE</td>
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<tr>
<td>MACC</td>
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<td></td>
</tr>
<tr>
<td>WIRRAL</td>
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<td></td>
</tr>
<tr>
<td>TAMESIDE</td>
<td></td>
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<td></td>
<td></td>
</tr>
</tbody>
</table>

KEY: The DARK BLUE | line indicates the percentage of patients in 2011. The GREEN ▶ bar indicates the gain in percentage from 2009. The PINK ◀ bar indicates the loss in percentage from 2009.

IMPLICATIONS

Many acute Trusts improved since 2009, which is an excellent result. Changes of less than 10% are unlikely to be significant.

RECOMMENDATIONS

Trusts should monitor any trends in falls history assessments through a programme of regular audits, to identify any significant changes.
FIGURE 24 - AVERAGE PERCENTAGE OF PATIENTS WHO WERE NOT ASSESSED FOR HISTORY OF FALLS (PLUS RANGE)

CONTEXT

In the 2004, 2006, 2009 and 2011 audits, acute Trusts collected data on whether patients’ falls history was documented, usually in a falls tool. This data was summarised by Trust and the average of these figures reported.

DATA

2009 was a difficult year for a few acute Trusts, but most of the ‘lost ground’ was recovered by the 2011 audit.

RECOMMENDATIONS

Acute Trusts should aim to assess history of falls in 100% of their patients, documenting if assessment was not possible and why.
**FIGURE 25 - AVERAGE PERCENTAGE OF PATIENTS WHO WERE NOT ASSESSED FOR HISTORY OF FALLS (PLUS RANGE) BY TRUST**

**CONTEXT**

In the 2004, 2006, 2009 and 2011 audits, acute Trusts collected data on whether patients’ falls history was documented, usually in a falls tool. This data was summarised by Trust and the difference in maximum and minimum value per Trust was calculated.

**DATA**

<table>
<thead>
<tr>
<th>TRUST</th>
<th>2004</th>
<th>2006</th>
<th>2009</th>
<th>2011</th>
<th>MAX - MIN</th>
</tr>
</thead>
<tbody>
<tr>
<td>MRI</td>
<td>79%</td>
<td>33%</td>
<td>9%</td>
<td>70%</td>
<td></td>
</tr>
<tr>
<td>AINTREE</td>
<td></td>
<td>57%</td>
<td>4%</td>
<td>53%</td>
<td></td>
</tr>
<tr>
<td>WIRRAL</td>
<td>60%</td>
<td>32%</td>
<td>18%</td>
<td>22%</td>
<td>41%</td>
</tr>
<tr>
<td>STOCKPORT</td>
<td>48%</td>
<td>35%</td>
<td>21%</td>
<td>7%</td>
<td>41%</td>
</tr>
<tr>
<td>WIGAN</td>
<td>33%</td>
<td>8%</td>
<td>0%</td>
<td>33%</td>
<td></td>
</tr>
<tr>
<td>MACC</td>
<td>32%</td>
<td>46%</td>
<td>16%</td>
<td>30%</td>
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</tr>
<tr>
<td>TRAFFORD</td>
<td>44%</td>
<td>25%</td>
<td>15%</td>
<td>29%</td>
<td></td>
</tr>
<tr>
<td>TAMESIDE</td>
<td>33%</td>
<td>17%</td>
<td>42%</td>
<td>28%</td>
<td>25%</td>
</tr>
<tr>
<td>PENNINE</td>
<td>50%</td>
<td></td>
<td>25%</td>
<td>25%</td>
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</tr>
<tr>
<td>UHSN</td>
<td>17%</td>
<td>3%</td>
<td>5%</td>
<td>0%</td>
<td>17%</td>
</tr>
<tr>
<td>BOLTON</td>
<td>20%</td>
<td></td>
<td></td>
<td>4%</td>
<td>16%</td>
</tr>
<tr>
<td>LANC TEACH</td>
<td>8%</td>
<td>2%</td>
<td></td>
<td>7%</td>
<td></td>
</tr>
<tr>
<td>LEIGHTON</td>
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<td>0%</td>
<td></td>
<td>5%</td>
<td></td>
</tr>
<tr>
<td>CHESTER</td>
<td>5%</td>
<td>2%</td>
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<td>3%</td>
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<tr>
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<td>-8%</td>
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<td>SOUTHPORT</td>
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<td>22%</td>
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<tr>
<td>EAST LANC</td>
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<td>29%</td>
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<tr>
<td>SALFORD</td>
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<td></td>
<td></td>
<td>1%</td>
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</tbody>
</table>

**KEY:** BLUE indicates data which meets best practice standard. RED indicates those Trusts who assess less than 90% of their sample.

**IMPLICATIONS**

Most Trusts experienced improvements over time. Any changes within 10% are unlikely to be significant, but Trusts should measure regularly and respond quickly to any concerning trends.

**RECOMMENDATIONS**

All acute Trusts who assess less than 90% of their sample for falls history (last measurable figure is in RED) should take immediate action to improve their practice.
FIGURE 26 - PERCENTAGE OF PATIENTS ASSESSED FOR GAIT/MOBILITY BY TRUST

CONTEXT

In the 2004, 2006, 2009 and 2011 audits, acute Trusts collected data on whether patients’ gait/mobility was documented, usually in the general nursing notes. This data was reported by Trust and for the total sample.

PROPOSED STANDARD

100% of patients should have their gait/mobility assessed by the end of the first full day following admission.

DATA

<table>
<thead>
<tr>
<th>Percentage of Sample (2011)</th>
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<tbody>
<tr>
<td>0%</td>
</tr>
<tr>
<td>BEST PRACTICE STANDARD</td>
</tr>
<tr>
<td>WIGAN</td>
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<tr>
<td>CHESTER</td>
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<tr>
<td>STOCKPORT</td>
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<td>UHSM</td>
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<tr>
<td>LANC TEACH</td>
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<td>LEIGHTON</td>
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<td>BOLTON</td>
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<tr>
<td>AINTREE</td>
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<tr>
<td>2011 (TOTAL SAMPLE)</td>
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<td>SOUTHPORT</td>
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<td>PENNINE</td>
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<td>STHK</td>
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<td>STHK</td>
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<tr>
<td>MACC</td>
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<tr>
<td>EAST LANC</td>
</tr>
<tr>
<td>WIRRAL</td>
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<tr>
<td>TAMESIDE</td>
</tr>
</tbody>
</table>

- BY END OF FIRST FULL DAY FOLLOWING ADMISSION
- ON THE SECOND FULL DAY OR LATER

IMPLICATIONS

Many acute Trusts assessed 85% of their sample, which is a good result. There is room for improvement, however, especially in the timing of assessments (ORANGE).

RECOMMENDATIONS

Trusts should aim to assess gait/mobility in 100% of their patients and ensure this information is recorded and used appropriately in a falls tool.
FIGURE 27 — CHANGE IN PERCENTAGE OF PATIENTS WHO HAD AN ASSESSMENT OF GAIT/MOBILITY BY THE END OF THE FIRST FULL DAY FOLLOWING ADMISSION (SORTED BY 2011 PERCENTAGES)

CONTEXT

In the 2009 and 2011 audits, acute Trusts collected data on whether patients’ gait/mobility was documented, usually in the general nursing notes. The change in percentage from 2009 to 2011 was reported by Trust.

DATA

**Percentage of Sample (2011)**

![Diagram showing percentage of sample (2011) for various locations.](image)

**KEY:** The **DARK BLUE** line indicates the percentage of patients in 2011. The **GREEN** bar indicates the gain in percentage from 2009. The **PINK** bar indicates the loss in percentage from 2009.

**IMPLICATIONS**

Many acute Trusts improved since 2009, which is an excellent result. Changes of less than 10% are unlikely to be significant.

**RECOMMENDATIONS**

Trusts should monitor any trends in gait/mobility assessments through a programme of regular audits, to identify any significant changes.
FIGURE 28 - PERCENTAGE OF PATIENTS ASSESSED FOR COGNITION BY TRUST

CONTEXT

In the 2004, 2006, 2009 and 2011 audits, acute Trusts collected data on whether patients’ cognitive or mental state was documented, usually in the general nursing or medical notes. This data was reported by Trust and for the total sample.

PROPOSED STANDARD

100% of patients should have their cognition assessed by the end of the first full day following admission.

DATA

<table>
<thead>
<tr>
<th>Percentage of Sample (2011)</th>
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<tbody>
<tr>
<td>0%</td>
</tr>
</tbody>
</table>

- BEST PRACTICE STANDARD
- CHESTER
- BOLTON
- WIGAN
- LANC TEACH
- LEIGHTON
- UHSM
- SOUTHPORT
- AINTREE
- 2011 (TOTAL SAMPLE)
- PENNINE
- EAST LANC
- MACC
- STHK
- Wirral
- STOCKPORT
- TAMESIDE

- □ BY END OF FIRST FULL DAY FOLLOWING ADMISSION
- □ ON THE SECOND FULL DAY OR LATER

IMPLICATIONS

Many acute Trusts assessed 85% of their sample, which is a good result. There is room for improvement, however, especially in the timing of assessments (ORANGE).

RECOMMENDATIONS

Trusts should aim to informally assess cognition in 100% of their patients and ensure this information is recorded and used appropriately in a falls tool. Trusts should have robust and inclusive pathways which consider the needs of patients with dementia and delirium.
FIGURE 29 — CHANGE IN PERCENTAGE OF PATIENTS WHO HAD AN ASSESSMENT OF COGNITION BY THE END OF THE FIRST FULL DAY FOLLOWING ADMISSION (SORTED BY 2011 PERCENTAGES)

CONTEXT

In the 2009 and 2011 audits, acute Trusts collected data on whether patients’ cognitive state was documented, usually in the general nursing notes. The change in percentage from 2009 to 2011 was reported by Trust.

DATA

Percentage of Sample (2011)

<table>
<thead>
<tr>
<th>0%</th>
<th>20%</th>
<th>40%</th>
<th>60%</th>
<th>80%</th>
<th>100%</th>
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</thead>
<tbody>
<tr>
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<td>WIGAN</td>
<td>LANC TEACH</td>
<td>LEIGHTON</td>
<td>UHSM</td>
<td>AINTREE</td>
</tr>
<tr>
<td>MACC</td>
<td>STHK</td>
<td>WIRRAL</td>
<td>STOCKPORT</td>
<td>TAMESIDE</td>
<td></td>
</tr>
</tbody>
</table>

KEY: The **DARK BLUE** | line indicates the percentage of patients in 2011. The **GREEN** ▶ bar indicates the gain in percentage from 2009. The **PINK** ◄ bar indicates the loss in percentage from 2009.

IMPLICATIONS

Many acute Trusts improved since 2009, which is an excellent result. Changes of less than 10% are unlikely to be significant.

RECOMMENDATIONS

Trusts should monitor any trends in cognition assessments through a programme of regular audits, to identify any significant changes.
FIGURE 30 - PERCENTAGE OF PATIENTS WHO HAD THEIR ANXIETY OF FALLS ASSESSED

CONTEXT

In the 2009 and 2011 audit, acute Trusts collected data on whether patients were asked if they felt anxious about falling.

DATA

![Percentage of Sample (2011)]

- **BEST PRACTICE STANDARD**
  - UHSM: 100%
  - LANC TEACH: 72%
  - LANC: 33%
  - WIGAN: 37%
  - STHK: 32%
  - WIRRAL: 29%
  - 2011 ALL: 22%
  - STOCKPORT: 13%
  - CHESTER: 11%
  - EAST LANC: 3%
  - SOUTHPORT: 1%
  - BOLTON: 1%
  - TAMESIDE: 1%
  - AINTREE: 1%
  - PENNINE: 1%
  - LEIGHTON: 1%

**TREND**

- **BY END OF FIRST FULL DAY FOLLOWING ADMISSION**
- **ON THE SECOND FULL DAY OR LATER**

IMPLICATIONS

Most acute Trusts do not routinely assess a patient’s anxiety about falling.

RECOMMENDATIONS

Acute Trusts should assess anxiety about falls alongside falls history, gait/mobility and cognition for every patient (65+). These assessments should be integrated with care, such as patient education, brief interventions or referrals for psychological support.
FIGURE 31 - CHANGE IN PERCENTAGE OF PATIENTS WHO HAD THEIR ANXIETY OF FALLS ASSESSED

**CONTEXT**

In the 2009 and 2011 audit, acute Trusts collected data on whether patients were asked if they felt anxious about falling. For those acute Trusts who participated in both audit cycles, the 2009 figure was subtracted from the 2011 figure.

**DATA**

![Bar chart showing percentage change in anxiety assessment](chart.png)

**IMPLICATIONS**

Most acute Trusts have significantly improved from 2009 to 2011. More improvement is needed for all Trusts.

**RECOMMENDATIONS**

Acute Trusts should assess anxiety about falls alongside falls history, gait/mobility and cognition for every patient (65+). These assessments should be integrated with care, such as patient education, brief interventions or referrals for psychological support.
FIGURE 32 – CHANGE IN PERCENTAGE OF PATIENTS WHO HAD AN ASSESSMENT OF PATIENT ANXIETY ABOUT FALLS BY THE END OF THE FIRST FULL DAY FOLLOWING ADMISSION (SORTED BY 2011 PERCENTAGES)

CONTEXT

In the 2009 and 2011 audits, acute Trusts collected data on whether patients’ anxiety about falls was documented, usually in the general nursing notes. The change in percentage from 2009 to 2011 was reported by Trust.

DATA

<table>
<thead>
<tr>
<th>Percentage of Sample (2011)</th>
</tr>
</thead>
<tbody>
<tr>
<td>0%</td>
</tr>
</tbody>
</table>

UHSM
LANC TEACH
MACC
WIGAN
STHK
WIRRAL
STOCKPORT
CHESTER
TAMESIDE
AINTREE
LEIGHTON

KEY: The **DARK BLUE** line indicates the percentage of patients in 2011. The **GREEN** bar indicates the gain in percentage from 2009. The **PINK** bar indicates the loss in percentage from 2009.

IMPLICATIONS

Many acute Trusts improved since 2009, which is an excellent result, though there is still room for considerable improvement. Changes of less than 10% are unlikely to be significant.

RECOMMENDATIONS

Trusts should monitor any trends in assessment of patient anxiety about falls through a programme of regular audits, to identify any significant changes.
**FIGURE 33 - MEDICATION REVIEWS**

**CONTEXT**

In the 2011 audit, acute Trusts collected data on whether patients were taking medications during their hospital stay which increased their falls risk (such as increased sedation or orthostatic hypotension).

**PROPOSED STANDARD**

100% of patients should receive a medication review with their falls risk in mind.

**DATA**

- 94% of patients had an increased falls risk due to medications
- 100% should have had their medication reviewed
- 47% of those with increased risk had their medication reviewed
- 64% of those with medication reviewed had medication changed

**IMPLICATIONS**

Most of the sample were on medications which increased their risk of falls. These medications may be unnecessary or even harmful. Less than half of these patients received a medication review, and even those patients that do have a review may not meet best practice standards. Qualitative interviews have highlighted the reviews’ lack of structure and the poor communication between professionals.

**RECOMMENDATIONS**

Acute Trusts should review medication guidance produced by FallSafe and ensure pharmacists and GPs are involved in any programme to increase the number and quality of medication reviews, to ensure any changes are sustainable and cost-effective. Keep committed to the changes, as changing culture may take several years.
FIGURE 34 - ORTHOSTATIC HYPOTENSION

CONTEXT

In the 2009 and 2011 audit, acute Trusts collected data on whether patients were assessed for orthostatic hypotension and provided interventions where necessary. In the 2004, 2006, and 2011 audits, acute Trusts also collected data on whether patients showed signs of orthostatic hypotension.

DATA

The low percentage of patients with orthostatic hypotension reflects the poor provision of quality assessments in hospital. Research suggests that a minimum of 18% of patients (65+) in hospital have orthostatic hypotension.

IMPLICATIONS

RECOMMENDATIONS

Acute Trusts should identify local barriers to accurately and appropriately measuring lying & standing blood pressure in patients (65+) who have a history of falls.
FIGURE 35 – PERCENTAGE OF PATIENTS WHO RECEIVED AN ASSESSMENT OF MEDICATION, EYESIGHT OR ORTHOSTATIC HYPOTENSION IN 2004 AND 2011 (SORTED BY 2011)

CONTEXT

In the 2004 audit, acute Trusts found that most patients did not have a proper assessment of medication, eyesight, or orthostatic hypotension. This was re-assessed in the 2011 audit.

DATA

```
<table>
<thead>
<tr>
<th>Risk Factor</th>
<th>2004</th>
<th>2011</th>
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<tbody>
<tr>
<td>Medication review</td>
<td>25%</td>
<td>44%</td>
</tr>
<tr>
<td>Eye test</td>
<td>3%</td>
<td>25%</td>
</tr>
<tr>
<td>Lying and standing BP</td>
<td>10%</td>
<td>8%</td>
</tr>
</tbody>
</table>
```

IMPLICATIONS

Only marginal improvements have been made in assessing these risk factors.

RECOMMENDATIONS

Acute Trusts are recommended to implement a quality improvement programme which addresses these risk factors, such as FallSafe.
FIGURE 36 – NURSE KNOWLEDGE OF LYING AND STANDING BLOOD PRESSURE

CONTEXT

In the service evaluation, six acute Trusts did a small audit of nurse knowledge of lying and standing blood pressure. 56 nurses were asked when to assess (prolonged bed rest, 75 years or older, diabetes, history of light-headedness or falls), how to assess (blood pressure drop of at least 20 mmHg systolic or 10 mmHg diastolic, patient reported light-headedness), and how to treat orthostatic hypotension (usually a change in medications).

DATA

THE AVERAGE NUMBER OF INTERVENTIONS KNOWN BY THE NURSES (OUT OF A POSSIBLE NINE)

- 61% NURSES KNEW WHEN TO ASSESS L&S BP
- 45% NURSES KNEW HOW TO ASSESS L&S BP
- 52% NURSES KNEW HOW PATIENTS WITH OH SHOULD MOBILISE

THE NUMBER OF NURSES WHO COULD ADVISE PATIENTS ON HOW TO USE THEIR MUSCLES TO REDUCE OH

IMPLICATIONS

Many Trusts delegate responsibility for taking blood pressure to health care assistants, who may receive minimal or no training in measuring and reporting lying & standing blood pressure. It is critically important that all nurses have a basic understanding of when, how and why to take lying & standing blood pressure.

RECOMMENDATIONS

Consider developing an orthostatic hypotension pathway and implementing an education programme. Consult guidance such as FallSafe or other Trust policies (like Nottingham University Hospital NHS Trust’s falls policy).
FIGURE 37 — RANKING OF ASSESSMENTS BY THEIR OVERALL PERCENTAGE OF PROVISION

CONTEXT

In the 2011 audits, acute Trusts collected data on whether a patient was provided with assessments for falls, usually in a falls tool. This data was summarised and the percentage of the total audit sample reported.

DATA

<table>
<thead>
<tr>
<th>Assessment / Investigation</th>
<th>Percentage of Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>HISTORY OF FALLS (BY THE END OF THE FIRST FULL DAY FOLLOWING ADMISSION)</td>
<td>84%</td>
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<tr>
<td>CONTINENCE</td>
<td>82%</td>
</tr>
<tr>
<td>GAIT/MOBILITY (BY THE END OF THE FIRST FULL DAY FOLLOWING ADMISSION)</td>
<td>82%</td>
</tr>
<tr>
<td>FALLS RISK (BY THE END OF THE FIRST FULL DAY FOLLOWING ADMISSION)</td>
<td>80%</td>
</tr>
<tr>
<td>COGNITION (BY THE END OF THE FIRST FULL DAY FOLLOWING ADMISSION)</td>
<td>80%</td>
</tr>
<tr>
<td>REVIEWED BY A PHYSIOTHERAPIST</td>
<td>65%</td>
</tr>
<tr>
<td>BED RAILS</td>
<td>55%</td>
</tr>
<tr>
<td>URINALYSIS</td>
<td>49%</td>
</tr>
<tr>
<td>RISK/BENEFIT REVIEW OF ALL MEDICATION</td>
<td>44%</td>
</tr>
<tr>
<td>ALTERNATIVE BEDS</td>
<td>33%</td>
</tr>
<tr>
<td>HEARING</td>
<td>30%</td>
</tr>
<tr>
<td>EYESIGHT</td>
<td>25%</td>
</tr>
<tr>
<td>ANXIETY ABOUT FALLS (BY THE END OF THE FIRST FULL DAY FOLLOWING ADMISSION)</td>
<td>22%</td>
</tr>
<tr>
<td>FURTHER INVESTIGATIONS FOR INFECTIONS WERE PERFORMED</td>
<td>14%</td>
</tr>
<tr>
<td>LYING AND STANDING BLOOD PRESSURE</td>
<td>8%</td>
</tr>
<tr>
<td>OSTEOPOROSIS</td>
<td>6%</td>
</tr>
</tbody>
</table>

IMPLICATIONS

Most Trusts do well at assessing history of falls, continence and gait/mobility. Less than half of the sample received a risk/benefit review of their medication and fewer still were assessed for significant risk factors, such as anxiety about falls or osteoporosis.

RECOMMENDATIONS

Acute Trusts should focus first on improving those areas which other Trusts do well before tackling the more difficult areas.
FIGURE 38 – RANKING OF INTERVENTIONS BY THEIR OVERALL PERCENTAGE OF PROVISION

CONTEXT
In the 2011 audits, acute Trusts collected data on whether a patient was provided with interventions for falls, usually in a falls tool. This data was summarised and the percentage of the total audit sample reported. Note that there may be valid reasons for a patient not to have an intervention; acute Trusts should consult research to identify whether reported levels of provision are of concern.

DATA

<table>
<thead>
<tr>
<th>Intervention</th>
<th>Percentage of Patients</th>
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</thead>
<tbody>
<tr>
<td>MOVING/HANDLING PLAN</td>
<td>59%</td>
</tr>
<tr>
<td>FALLS CARE PLAN AGREED WITH PATIENT, RELATIVE OR CARER</td>
<td>35%</td>
</tr>
<tr>
<td>BED RAIL PLAN</td>
<td>32%</td>
</tr>
<tr>
<td>CONTINENCE</td>
<td>31%</td>
</tr>
<tr>
<td>CHANGE IN MEDICATIONS</td>
<td>30%</td>
</tr>
<tr>
<td>CATHETERISATION</td>
<td>23%</td>
</tr>
<tr>
<td>TREATED FOR THE INFECTION</td>
<td>16%</td>
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<tr>
<td>ADVICE ON TOILET PLANNING</td>
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<td>ALTERNATIVE BED</td>
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<tr>
<td>EYESIGHT</td>
<td>13%</td>
</tr>
<tr>
<td>HEARING</td>
<td>6%</td>
</tr>
<tr>
<td>ADVICE ON HOW TO PREVENT SYMPTOMS OF ORTHOSTATIC HYPOTENSION</td>
<td>2%</td>
</tr>
</tbody>
</table>

IMPLICATIONS
Only a small percentage of patients (relatives or carers) are involved in their falls care plan. Very few patients are provided with advice on preventing symptoms of orthostatic hypotension, whereas research suggests this figure should be at least 18%.

RECOMMENDATIONS
Acute Trusts should consider trying innovative ways of identifying those patients who may benefit from interventions to prevent falls, especially where prevalence rates is significantly below reported rates. Acute Trusts should also consider participating in research projects to better understand the prevalence and need for less known risk factors.
## Figure 39 – Training Programme Attendance

### Context

In the service evaluation, acute Trusts reported on their falls training programmes: whether they had one and who was required to attend.

### Data

<table>
<thead>
<tr>
<th>Number</th>
<th>East Lanc</th>
<th>UHSM</th>
<th>Southport</th>
<th>Aintree</th>
<th>STMK</th>
<th>LANC Teach</th>
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<td>Y</td>
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<td>Y</td>
<td>Y</td>
<td>Y</td>
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<tr>
<td></td>
<td><strong>Does your trust have a “falls prevention, management, and reporting” training program?</strong></td>
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<td>Y</td>
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<td><strong>Is training required for the following?</strong></td>
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<td>Y</td>
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<td><strong>Nurses</strong></td>
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<th>LANC Teach</th>
<th>Stockport</th>
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<td>Y</td>
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<td>Y</td>
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<td>Y</td>
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<tr>
<td></td>
<td><strong>Allied health professionals (e.g. physiotherapist, occupational therapist, dietician)</strong></td>
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### Implications

Only five out of the ten Trusts require training for the six key professional groups.

### Recommendations

Consider developing targeted training for specific professional groups, such as medication reviews for pharmacists or environmental safety for estates. Share expertise with partner organisations.
FIGURE 40 – TRAINING PROGRAMME CURRICULUM

CONTEXT

In the service evaluation, acute Trusts reported on the curriculum of their falls training programmes. Note that some concepts may be covered by other training programmes and not integrated with the falls training programme. A select number of concepts are reported here. See the summary data tables in Appendix, Part II, for the full list.

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<th>Assessment of effective call bell use</th>
<th>Accessing or offering alternative beds/chairs</th>
<th>Medicine(s) management (including sedatives)</th>
<th>Use of the incident reporting system</th>
<th>Bed rails guidance</th>
<th>Continence management</th>
<th>Post-fall injury/medical assessment</th>
<th>Moving and handling</th>
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Key: BLACK (?) indicates missing data.

IMPLICATIONS

Two Trusts had curriculum which covered all key concepts. Three Trusts covered all but one key concept. One Trust had significant gaps in coverage.

RECOMMENDATIONS

Consider how falls training is integrated into other areas of professional development, to improve the usefulness to staff.
Figure 41 — Evaluation of Post-Fall Management Service

**Context**

In the service evaluation, acute Trusts reported on the legibility, accessibility and content of their post-fall protocol on the wards and their staff’s ability to access specialist equipment.

**Standards**

1. 100% of acute Trusts should have a legible and accessible post-fall protocol which manages care according to NPSA and NICE guidance.
2. Staff at 100% of acute Trusts should have access to specialist equipment for handling patients with fractures.
3. 100% of acute Trusts should use a 15-point Glasgow Coma Scale which triggers urgent medical review according to NICE guidance.

**Data**

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<tr>
<th>Trusts Reported Having a Legible and Accessible Post-Fall Protocol on the Wards Which:</th>
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<th>Promoted Staff to Inform Relatives, Keyworker</th>
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<tr>
<td>Prompted frequency and duration of neurological observations (for patients with visible or reported head injury or where head injury cannot be excluded)</td>
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<th>Recorded Clinical Observations to Detect Any Potential New Acute Illness That Caused the Fall and to Detect Any Harm from the Fall</th>
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1. Acute Trust did not have access to specialist equipment for handling patients with fractures.
2. Promoted staff to inform relatives, keyworker.

**Implications**

All Trusts reported following the first standard, which is an excellent result. Several Trusts have not yet complied with the other two standards.

**Recommendations**

Trusts should ensure all staff have access to and know how to use specialist equipment for handling patients. All Glasgow Coma Scales should trigger urgent medical review according to NICE guidance.
**Figure 42 — Number of Patients with an Unwitnessed Fall Meeting Standards for Neurological Observations**

**Context**

In the 2011 post-falls audit, acute Trusts collected data on whether patients with unwitnessed falls were treated according to best practice guidance for post-fall management.

**Standard**

100% of patients who experienced a fall, where head injury has occurred or cannot be excluded (e.g. unwitnessed falls) should be observed according to the following frequency and duration:

- Perform and record observations on a half-hourly basis until GCS = 15.
- When GCS = 15, minimum frequency of observations is:
  - half-hourly for 2 hours
  - then 1-hourly for 4 hours
  - then 2-hourly thereafter.
- If patient deteriorates to GCS < 15 after initial 2-hour period, revert to half-hourly observations and follow original schedule.

**Data**

95% of the sample did not meet the standard set by NICE for neurological observations post-fall.

**Implications**

95% of the sample did not meet the standard set by NICE for neurological observations post-fall.

**Recommendations**

Acute Trusts should ensure staff are aware of NICE guidance and document all observations.
FIGURE 43 – NUMBER OF PATIENTS MEETING STANDARD FOR RUSHED IMAGING FOR SUSPECTED HEAD INJURY

CONTEXT

In the 2011 post-falls audit, acute Trusts collected data on whether patients with unwitnessed falls were treated according to best practice guidance for post-fall management. 27 met the criteria:

- GCS < 13 when first assessed
- GCS < 15 when assessed 2 hours after the injury
- Suspected open or depressed skull fracture
- Sign of fracture at skull base (haemotympanum, ‘panda’ eyes, cerebrospinal fluid leakage from ears or nose, Battle’s sign)
- Post-traumatic seizure
- Focal neurological deficit
- > 1 episode of vomiting
- Coagulopathy (history of bleeding, clotting disorder, current treatment with warfarin) PLUS amnesia or loss of consciousness since the injury

STANDARD

100% of patients who meet any of the criteria above should have imaging and results analysed within 1 hour of request being received by radiology department.

DATA

STANDARD MET, 0
STANDARD NOT MET, 6
NO IMAGING, 14
TIME NOT DOCUMENTED, 7

IMPLICATIONS

None of the sample met the standard set by NICE for review of imaging post-fall.

RECOMMENDATIONS

Acute Trusts should ensure staff are aware of NICE guidance and document referrals and reviews.
FIGURE 44 – NUMBER OF PATIENTS WITH SUSPECTED OR ACTUAL HEAD INJURY MEETING STANDARD FOR ADVICE PROVIDED

CONTEXT

In the 2011 post-falls audit, acute Trusts collected data on whether patients with unwitnessed falls were treated according to best practice guidance for post-fall management. 11 patients had suspected or actual head injury.

STANDARD

100% of patients with suspected or actual head injury (and their families/carers) should be made aware of:

- the possibility of long-term symptoms and disabilities following head injury.
- the existence of services that they could contact should they experience long-term problems following head injury.

DATA

IMPLICATIONS

Only two patients had care which met the standard set by NICE for providing advice post-head injury.

RECOMMENDATIONS

Acute Trusts should ensure staff are aware of NICE guidance and document referrals and reviews.
FIGURE 45 – NUMBER OF PATIENTS MEETING STANDARD FOR TIMINGS OF MEDICAL ASSESSMENT FOLLOWING FALL

CONTEXT

In the 2011 post-falls audit, acute Trusts collected data on whether patients with unwitnessed falls were treated according to best practice guidance for post-fall management.

STANDARD

100% of patients should be triaged post-fall according to best practice guidance (Manchester Triage System for falls) and assessed by a doctor within the recommended timings.

DATA

- **STANDARD MET, 36**
- **MISSING DATES, 30**
- **STANDARD NOT MET, 33**

IMPLICATIONS

36% of patients had care which met the standard set by NICE for timing medical assessments post-fall.

RECOMMENDATIONS

Acute Trusts should ensure staff are aware of NICE guidance and document reviews.
FIGURE 46 – NUMBER OF PATIENTS MEETING STANDARD FOR TIMINGS OF MEDICAL ASSESSMENT FOLLOWING FALL

**CONTEXT**

In the 2011 post-falls audit, acute Trusts collected data on whether patients with unwitnessed falls were treated according to best practice guidance for post-fall management.

**STANDARD**

100% of patients should be triaged post-fall according to best practice guidance (Manchester Triage System for falls) and assessed by a doctor within the following timings:

- **RED** – IMMEDIATE (0 MINUTES)
- **ORANGE** – VERY URGENT (16 MINUTES)
- **YELLOW** – URGENT (60 MINUTES)
- **GREEN** – STANDARD (120 MINUTES)
- **BLUE** – NON-URGENT (240 MINUTES)

**DATA**

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<td><strong>ORANGE (16 MINUTES)</strong> - 20 PATIENTS</td>
<td>25% (5)</td>
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<td><strong>YELLOW (1 HOUR)</strong> - 18 PATIENTS</td>
<td>33% (6)</td>
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<td><strong>GREEN (2 HOURS)</strong> - 61 PATIENTS</td>
<td>41% (25)</td>
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**KEY:** The overlay indicates the percentage of patients meeting the standard within each level.

**IMPLICATIONS**

More critical patients were less likely to have care which met best practice standards.

**RECOMMENDATIONS**

Acute Trusts should ensure staff are correctly and consistently triaging patients with unwitnessed falls, documenting when medical assessments are performed, and reviewing any incident to ensure best practice guidance is being followed.
FIGURE 47 – STATEMENT OF FEEDBACK FROM THE EXPERT PATIENT

CONTEXT

An expert patient, John Andrew Clark, was appointed to review the 2011 audit results, attend the final network conference and feedback on the report. This was the second audit cycle in which John has participated. He provided a final statement of feedback.

STATEMENT OF FEEDBACK

I took home the following points:

i) The quality of response seems to depend on the person in charge in each Trust and the importance attached to it by the hospital Trust in question.

ii) There is a vast potential for early detection of possible falls in outpatient departments which is only just beginning to show.

iii) Lying and standing blood pressure tests need a lot more attention.

iv) Medication issues and how they affect balance need more attention, and GPs need to be included in this somehow.

v) Tests need to be standardised and applied more rigorously across the board for ‘potentially at risk’ patients - otherwise progress will not be maintained or shown to progress.

vi) Training and awareness need to be improved; the ‘checking glasses’ anecdote [in lieu of an eyesight test] was revealing.

IMPLICATIONS

John raises important points which should be considered alongside individual Trust results. Trust culture is difficult to measure, but it has consequences for the experience and safety of patients.

RECOMMENDATIONS

Acute Trusts will need to work more closely with GPs to ensure that care transitions appropriately between hospitals and community environments.