

# Reducing falls across older person mental health NHS wards using a collaborative approach

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## Introduction

As well as the individual impact, falls in older adults represent a substantial burden to the NHS. Falls in hospital inpatients are common, with reported rates ranging from 3 to 14 per 1,000 bed days in observational and intervention studies. Inpatient falls are one of the most frequently reported incidents in CTM UHB.

## Aim

The aim of the collaborative was to reduce the incidence of inpatient falls rate per 1,000 bed days within five Older Adults Mental Health Wards in CTM UHB and to support the reliable implementation of evidence-based multifactorial falls prevention assessments and interventions delivered as a care bundle.

## Methods

The Falls Collaborative was structured around 5 learning sessions with action periods between each session. Each ward participating was formed by a multidisciplinary team of people who were part of the daily work on the wards for falls prevention. Local teams were tasked with implementing specific changes to standardise the care provided for falls prevention based on the agreed actions on each learning session, and regularly measure its implementation using the AMat tool developed, this ensure the continuous and shared learning using PDSA cycles.

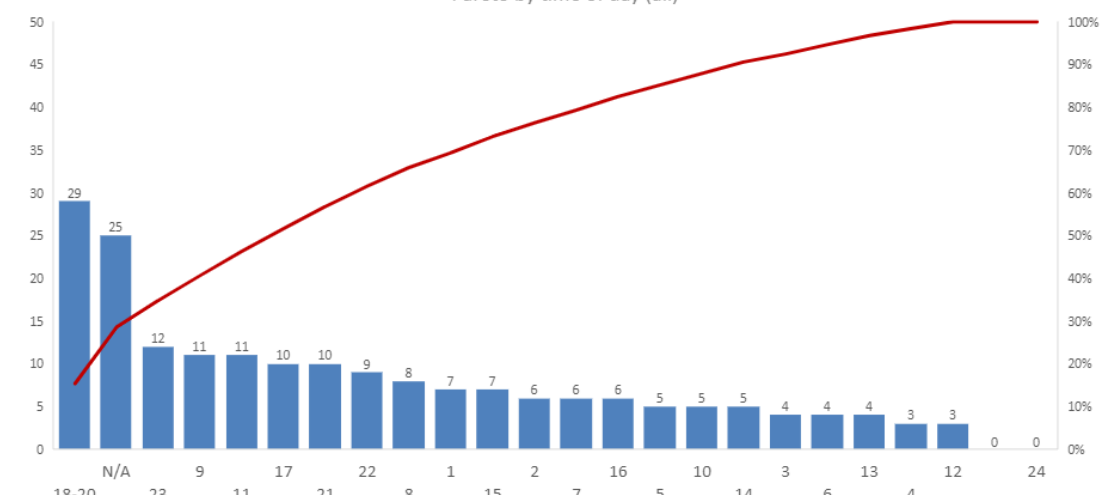


After each learning session, face to face meetings were scheduled by ICTM to visit local teams on the wards.

This approach ensured frontline staff felt supported throughout the project and allowed teams to have more focused discussions about their specific challenges, and that activities were carried out after each learning session. Local teams were tasked with implementing specific changes to standardise the care provided for falls prevention based on the agreed actions on each learning session, and regularly measure its implementation using the AMat tool developed.

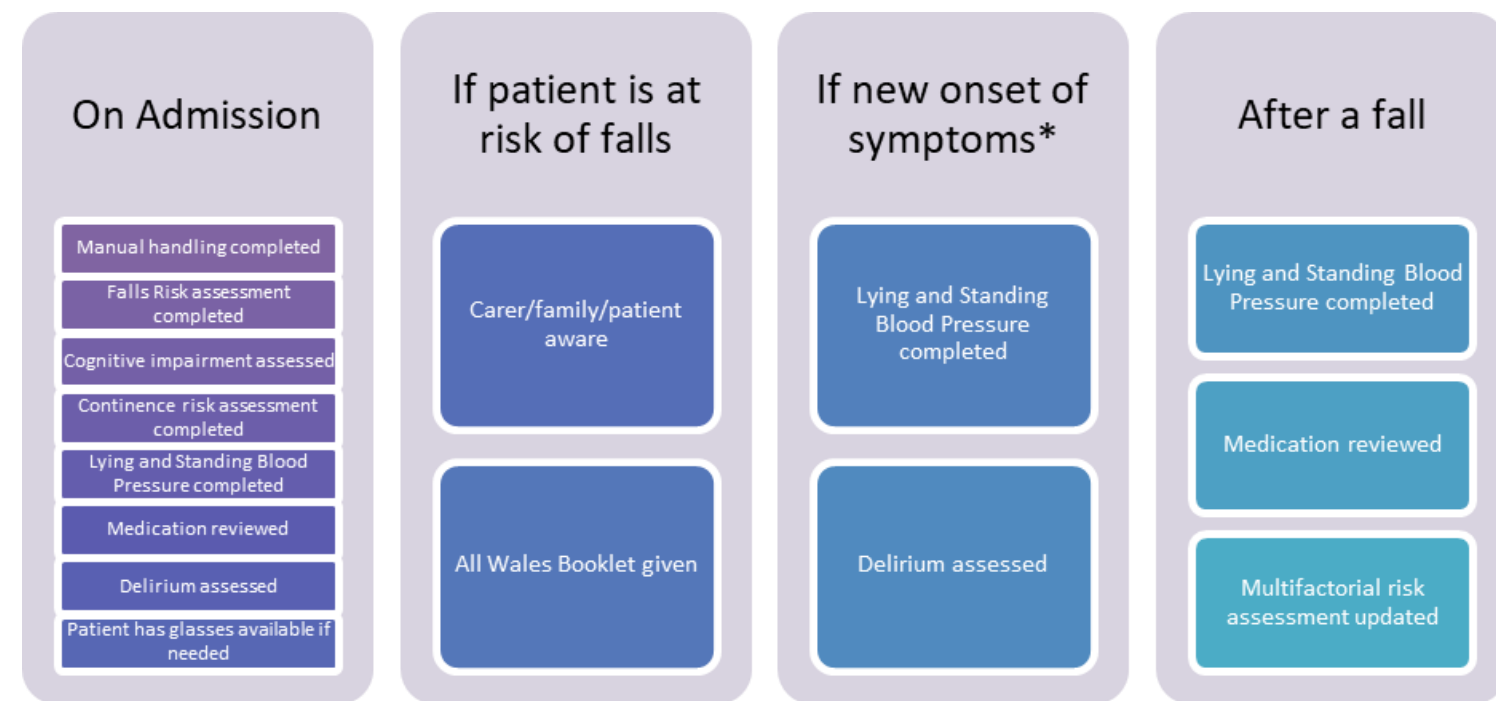
## Results

Pareto by time of day (all)



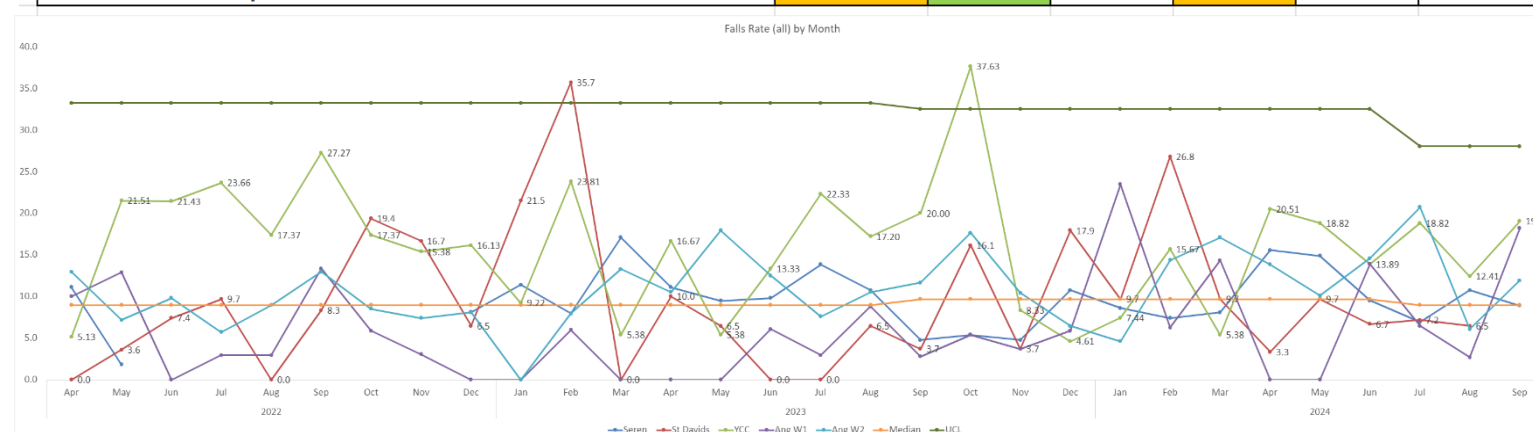
When stratifying the number of falls happening by time of day, there was an increased number of falls between 18-20 hrs.

Moreover, the care bundle for falls prevention was measured before and after, and the five participating wards were successful in implementing all the relevant process measures to be completed.



Although the collaborative didn't evidence a reduction in falls, it was evident a stabilization of the falls prevention process with more data points gathering beside the median. Two participating wards did in fact evidence a reduction in the number of falls reported before and after (ward 1 and ward 3). There was an astronomical point in October 2023, which was related to shortage in staffing levels across the 5 sites. Moreover, the care bundle for falls prevention was measured before and after, and the five participating wards were successful in implementing all the relevant process measures.

Data from	All Wards	Ward 1	Ward 2	Ward 3	Ward 4	Ward 5
Total occupied bed days before	24440	5775	3592	4809	3652	6612
Total occupied bed days after	22744	5122	3539	4577	3996	5510
Total reported falls before	239	54	36	73	12	64
Total reported falls after	255	48	37	69	33	68
Total reported falls with harm before	18	5	0	8	1	6
Total reported falls with harm after	18	2	0	8	3	7
Total reported falls per 1000 BD before	10	10	9	15	3	10
Total reported falls per 1000 BD after	11	9	11	14	8	13
Rate ratio of all reported falls after : before	0.93	1.12	0.97	1.05	0.36	0.94
Rate ratio of reported falls with harm after : before	1	2.5	0	1	0.33	0.85



A small survey was sent out at the end of the first year (30% response rate), where every answer was either 'Agree' or 'Strongly Agree' every positive statements. The topics covered throughout the collaborative were relevant, the sessions were well organised and easy to follow, the objectives of the collaborative were met, all of their voices were heard, they were able to contribute, data presented was relevant and easy to understand, guests who presented at the collaborative were great additions to the agenda, their ward felt supported throughout the collaborative and senior decision makers were visible and facilitated the collaborative.

## Discussion

It is evident that continued work is required to ensure an improved level of safety is maintained and having the care bundle available on AMat could contribute to its visibility and subsequent spread to other areas. Due to interest gained by this project, there is an interest to develop a similar collaborative focusing on falls and pressure ulcer prevention across all settings.

## Conclusions

The falls collaborative project has resulted in substantial improvements in care, including an increase of patients receiving lying and standing blood pressure assessment, medication review and delirium assessments. Whilst reported falls rates stayed the same for the five wards, when each ward individually was factored in, we saw a reduction in two wards and estimated that the increase in falls for the remaining of three wards was related to a previous state of underreporting, considering the numbers stayed levelled throughout the collaborative.