‘Lets reflect on the fall’

(Qualitative findings)

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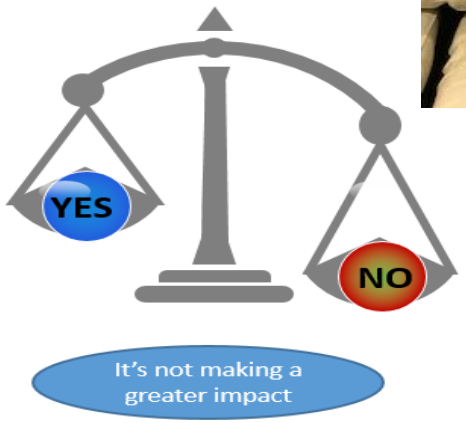
Despite of multiple falls prevention strategies, falls continue to be a huge challenge in the hospital setting…

We discussed the need to renew and expand our efforts to prevent falls and go beyond the standard falls prevention strategies.

Origin of Study one

Are the standard falls prevention strategies effective in preventing falls?



Background

- Falls prevention is a huge challenge in hospital.
- 40% of injuries in acute care are attributed to falls
- Falls lead to an increase in morbidity and mortality
- Little known about the perception of patients in hospital
- There is paucity of research around utilising reflective models for nurses and patients to prevent falls
- We have identified one study done in America called "a reflective accountability model for falls prevention

This is a new concept in Falls prevention. The Research team liked the utilisation of the reflective model in this study and wanted to implement this model in our clinical setting.

(Cameron et al., 2010)
(Ang,Mordiff and Wong 2011)

Falls Prevention Study

This is an action research study using multimethod with PDSA cycle

(Action research is a spiral process involving data collection to identify the gap, taking action, and analysis of the action focussing on the real problem).

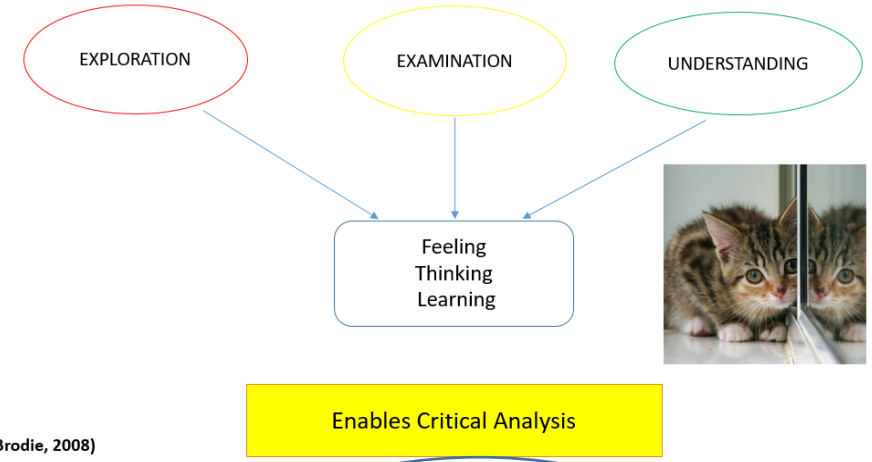
The study aim is to minimise falls on the participating wards by involving the staff and patients in taking action, through critical reflection on what has occurred, developing ideas about how things could be done differently, implementing these ideas and evaluate them to see what works in reducing the falls.

Objectives

- To engage staff in reflection on current practice around falls prevention
- To support patient reflection after a fall and look at how this could change nursing practices around falls prevention
- To work with staff to develop and implement falls prevention strategies based on the patient and staff reflections

Benefits of reflection in Falls prevention

Reflection facilitates:

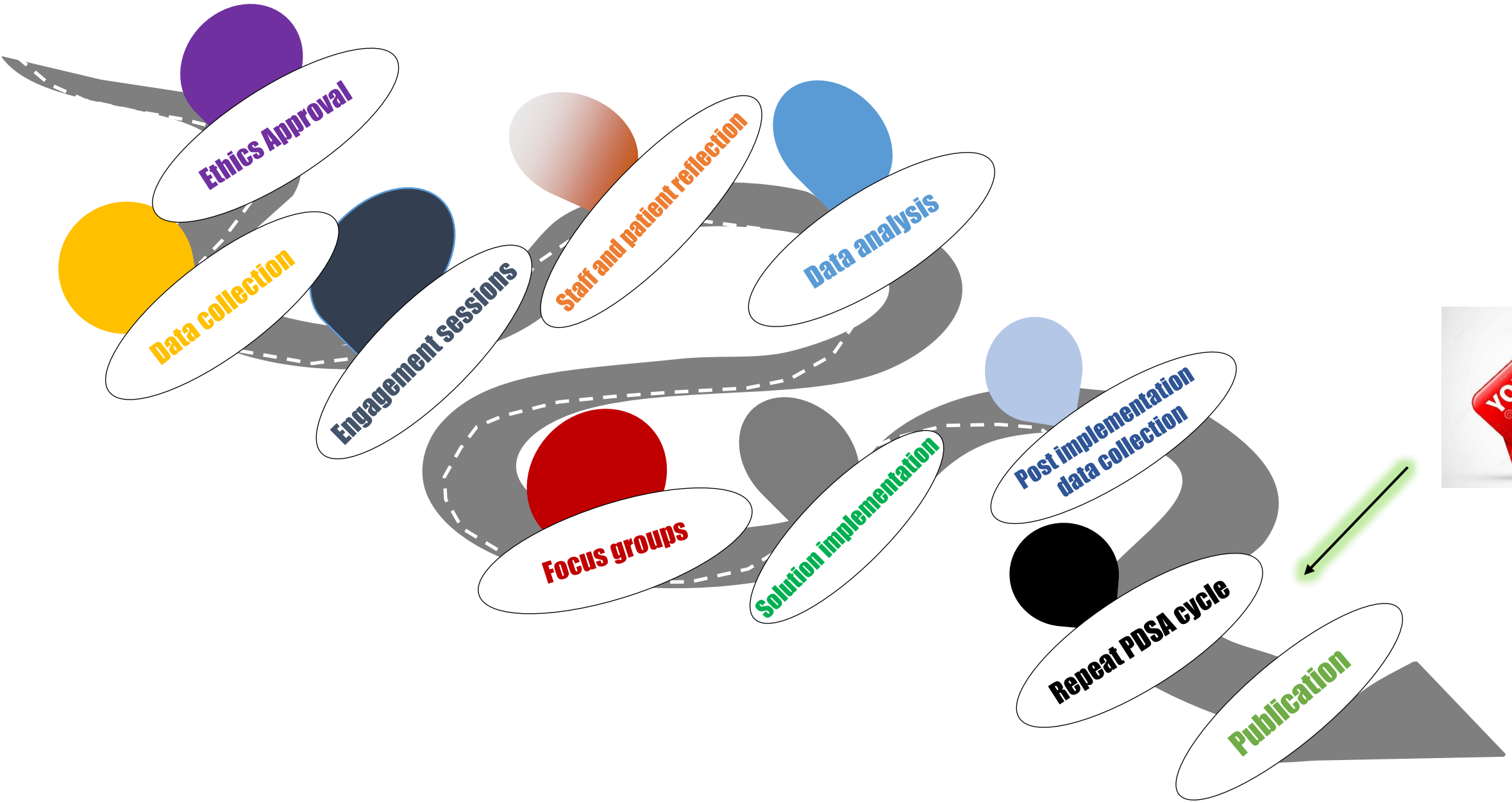


Enables Critical Analysis

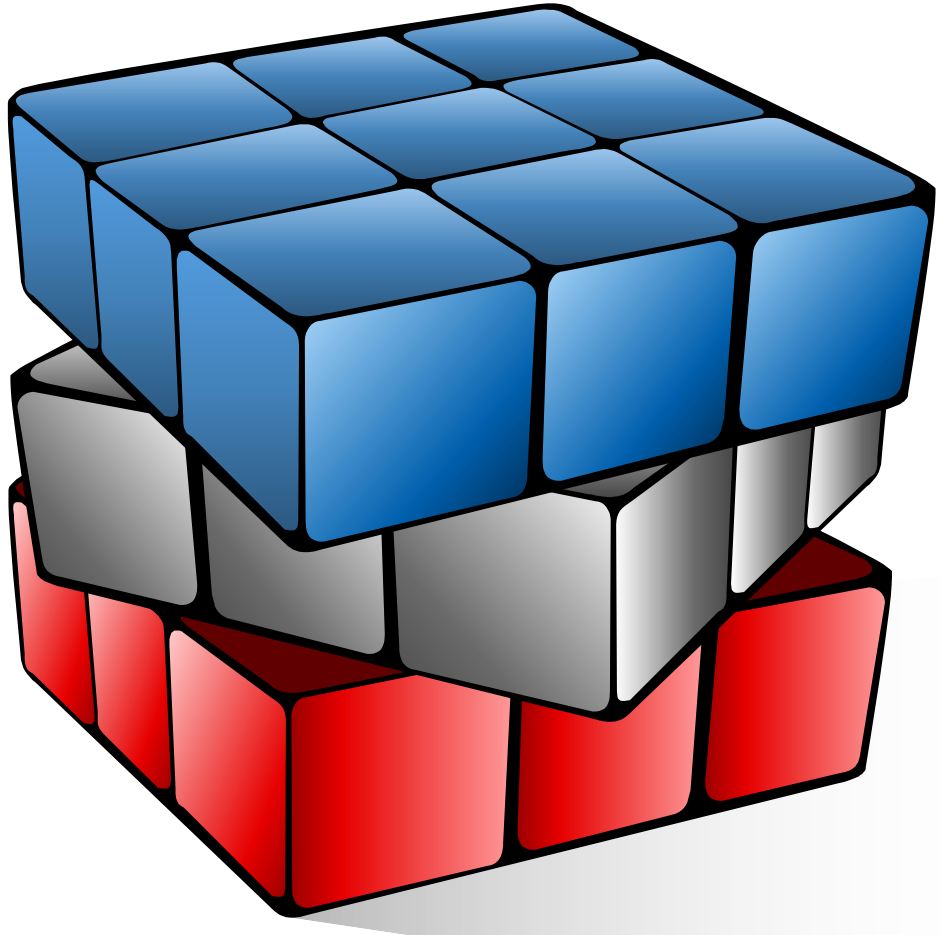
(Brodie, 2008)

This Research aims at **culture change** for which an action oriented approach through evidence is best suited as it engages people in looking at their own practices and enables them to create potential solution for the real problem - Falls

Falls prevention study - Journey



Phases of the study



Phase 1
Data Collection(quantitative)
Engagement Session

Phase 2
Staff Reflections
Patient stories

Phase 3
Feedback from Phase 2
Co Design the Solutions with the staff and implement the solution(Focus groups)

The PDSA cycle was repeated

I fell because…

I thought I will be fine

Outcomes of the fall

Patient reflections/stories/perceptions (n=24)

No one came for a long time

Things you could to for me (solutions)

Range of emotions

1. I fell because…

Weakness

"Weakness in the leg."
"My leg just went."
"I was actually on the edge of the bed and wanted to get the trolley, and the leg just went under me."
"I stood there and I was going to go to the toilet. I took one step with my weak leg and it gave out on me, and down I went."

Dizzy/Lightheaded

"I stood up and next minute, I am on the floor"
"... I stood up after I finished I felt as if I was going to faint."
"When I finished, I stood up to clean myself. Half did it and had felt dizzy then I went to the floor."

Trip and slips

"Maybe my legs getting caught in the underwear."
"I was on a drip and had to pee all the time, the night dress I had was slippery and I fell."

Impaired vision

"I am blind, I have a big bathroom at home and the toilet is next to it.
Its not the same here"

2. I thought I will be fine…(Independence)

"I had to go to the toilet, I have a weak bladder, I did not have a bottle there , I thought that I will be fine to go to the toilet myself"

"Yes, my husband gets very annoyed with me. I try to do things on my own…thought I should be ok"

"I had a look and thought that I should be able to do it easy. Did that as a child, I looked at the space where I could jump from, easy peasy. It doesn't work for me like that in real life".

"I thought I don't need help and thought I can do this and as it turned out - things went a bit wrong"

"I would get up and say nothing but, I admit it's my fault this time. I should have had someone here, but I thought I am ok to walk"

"As I said it would put you in an awful spot when you used to doing things, and you cannot anymore. I thought I will be fine but not really. Now I've got to press the button and don't feel like doing it"
"I have always been independent in my life, never asked help from anyone"

3. It was a long time (long time)

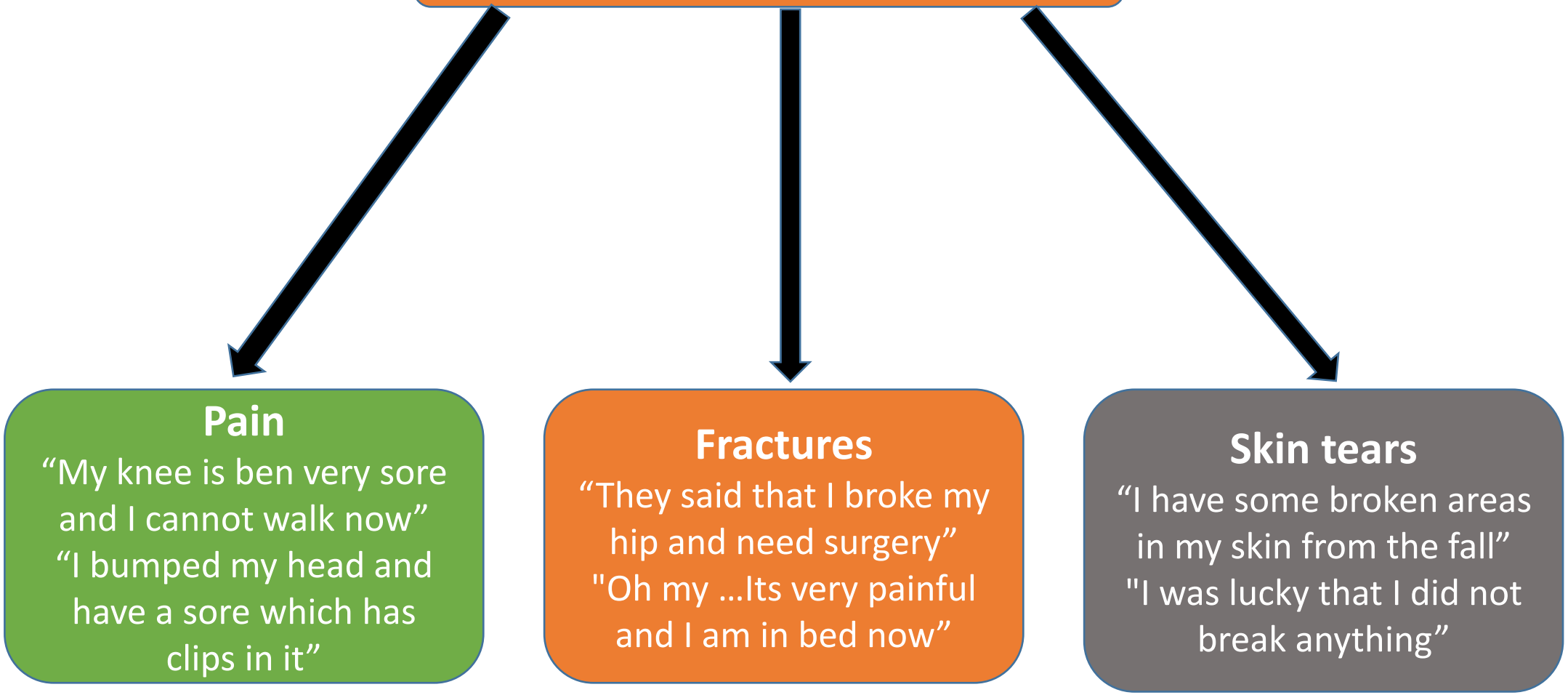
“They left me in the toilet for a long time, The thing is that when I collapsed, I had to scream, because as I said they came in just in the nick of the time”.

“I rang the bell to go to the toilet , no one came for a long time”

“I was sitting in the toilet for a long time, no one came, I thought I will go out myself…”

“I was asked to sit in the chair, I sat for a long time, my back was sore, and I had to lie down, I moved myself from the chair to the ground and lay flat on the ground”

4. Outcomes of the fall



5. Range of emotions

6. You can avoid falls by doing this(solutions)

1. “I wish someone was there” (supervision)

“**Maybe they (nurses), need to be there for the patients**”

“I was lying on the floor for 10 -15 min, **I wish someone was there**”

“Yeah, I went to the toilet on the chair, the nurse left me on the chair, and said not to move, if you want me, call. Anyway, she had gone**….maybe she could have been there waiting for me**”

“**Need someone standing outside the door,** and check to make sure you are ok, so they can help”

“There wasn’t anyone there when I called, **I thought someone will be there to help**”

6. You can avoid falls by doing this(solutions)

2. “This needs to be a safe place” (environment)

“**Non slippery floors** in hospital” “Bathroom floors are wet and is slippery”

“May be the floor needs to be **non-slippery,** like the one’s in the kids park”

“There **needs to be a bar** which you can hold on to when you are getting up from the toilet and going to the sink to wash your hands”

“ **Need a clock** in the bathroom”

“Avoid keeping too many **things around the bed** so that we can walk easily”

6. You can avoid falls by doing this(solutions)

3. “Tell me how to avoid falls in hospital” (Education)

“Maybe **telling us what to do** coming on to the ward will be the way to go”

“**They told me to press the buzzer**. But I did not know which one was the buzzer ”

“**No falls education was given to me**. Maybe that can be bought into it. I don’t know…….”

“Maybe give **something to read** about how to avoid a fall in hospital”

“**Maybe a poster** in the toilet door to remind us oldies”

6. You can avoid falls by doing this(solutions)

4. “Listen to me” (active listening and communication)

“Maybe they need to **listen to people**. What they want to do…….”

“I know I am not the only one, but maybe **I should've had the pan in bed**. I was very tired. I can see this coming”

“**Listen to me what I want to do then, tell me about what I should do”**

“I did not want to have a shower, I told the nurse that I am not up to it, she was very nice but maybe they **need to listen to what we want to do”**

"I know they are trying their best, and I know that I am not the only one here in trouble, but maybe when a person is so weak, they **should have considered given a pad in bed”**

6. You can avoid falls by doing this(solutions)

5. “This is what I need”

“They don't have the **non-slip socks**, I had to wait until they brought one. I was patiently waiting but some others would have gone to the toilet by then without waiting for the nurse”

“Make sure everything is ready for the patients before taking them to toilet”

“My **shoes** were at home and my husband did not bring them here”

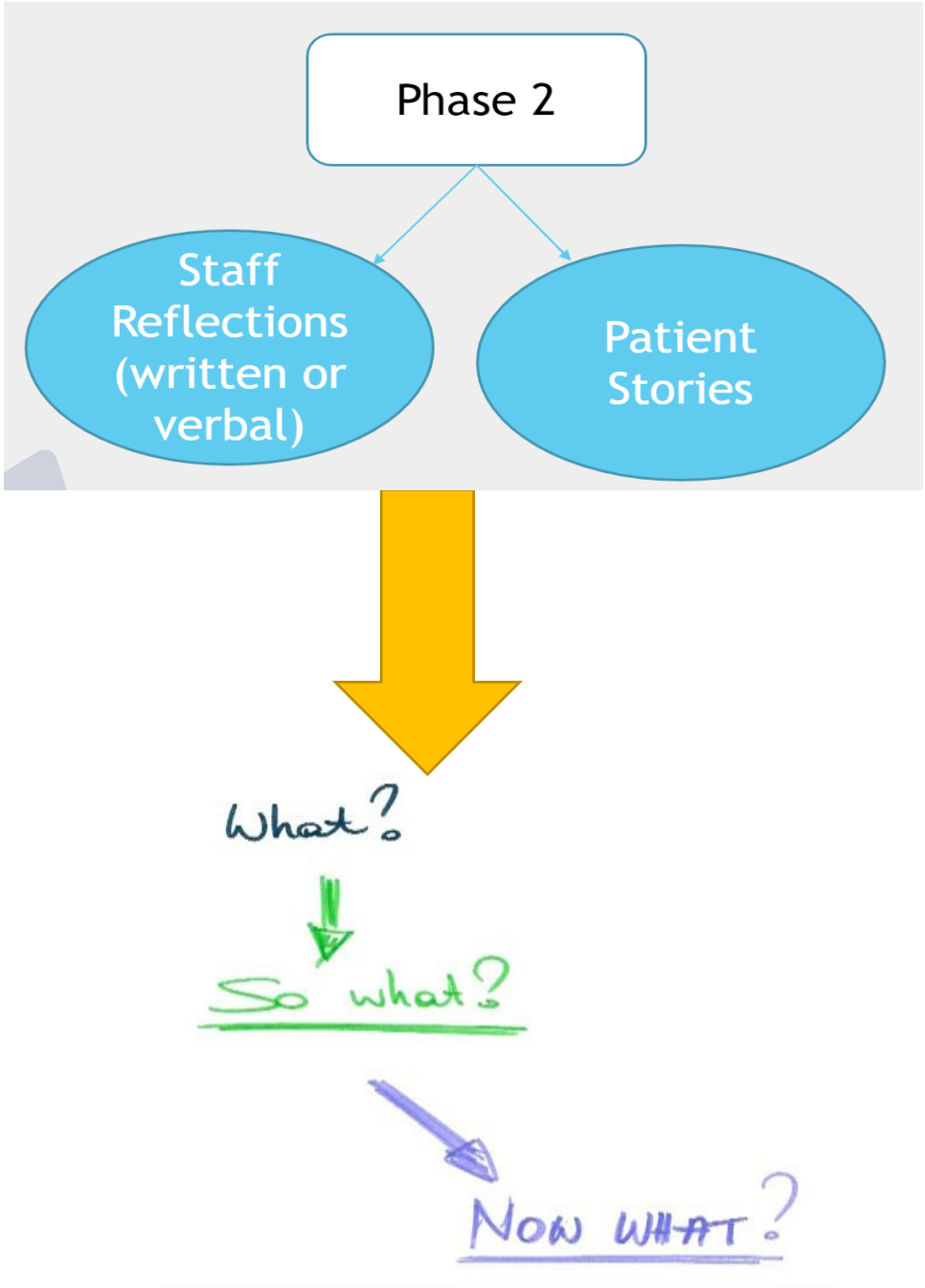
“Lost my **glasses**, I cannot see without them. I wish had my glasses so that I could see where I am going”

“I had to go because I have a weak bladder, I did not have the **bottle** next to me, the girl took the bottle to empty and forgot to bring to back, I had to quickly get there. So thought instead of pressing the buzzer and waiting I will go”

Patient wish list

- Listen to me
- Inform me
- Give me opportunity to prevent my falls (footwear, glass etc)
- Offer me a safe environment
- Interact with me
- Maintain my autonomy within safe limits
- Be with me

Staff reflections



It was out of my control

Fall could have been prevented

Range of emotions

was out of my control

“All prevention strategies were in place, but it was **out of our control**.”

“We were **short staffed on that day** and the ward was **very hectic.** I was the only senior staff, I had to have multiple hats... It was an unwitnessed fall... I could have not prevented it"

“I have done whatever I could do...**everything was in place**...”

“Patient had non-slip socks, was in high vis room, FRAMP was in place... but he still fell... I **could not prevent him from falling**”

Fall could have been prevented

"**Need a floating nurse** when we are very busy.."

'If I had known that he is **high risk** for falls, **I would have prioritised** this patient first"

"Patient was left in the toilet and requested to press the buzzer…maybe I **should not have left her alone**, but I had to attend another patient who was sick.."

"I should've **given her a commode chair** as she was feeling dizzy..."

"Next **time I will not leave my patient in the toilet by herself**... I will ask my colleague to look after if I am caught up..."

Range of emotions

“I feel sorry for the patients who fall... they hurt themselves quite badly... and I feel for them as they are stuck in hospital for a long time after a fall…”

“Iam tired and exhausted, angry about myself that my patient fell…”

“I felt horrible... Iam a big advocate for patient safety... I feel so bad that I left my patient to fall on my shift..”

“I felt terrible when I found him on the floor, I was very upset and cried when I went home..."

Interview with the leadership team

- “There **was more awareness** on the ward around falls prevention because the project was going on and the staff were consciously reflection on the fall”
- “I think one of the staff recognised that, after a fall we potentially have to **move the quiet room somewhere different**, but still close enough where you can still call out someone if you need any help. I think from that intervention, the telephone was placed in the quite room…”
- “Oh yeah.. the clutter before in the quiet room we had the bedside table, after a fall where the patient tried to grab something from the bedside cupboard, we took the bedside table away and now we've got **the long cupboards next to the patient”**
- “Staff **are mindful of clutter** on the ward and making initiatives to clear the corridors... reflection helps awareness..”
- “The staff that are **involved in reflection also do other reflective things**, that seems to be their personality, something they are comfortable with…they try to implement the lessons learned”
- “Some of the things I’ve noticed is that **documentation around falls,** from some of the individuals involved has improved quite significantly”

Interview with the leadership team (continued)

Nurses back into the rooms, point of care and WOWs in rooms

Huddles – **mentioned the high risk patients**

High vis room, falls room , hourly rounding – use of toileting tool, NUM rounding

All these strategies have improved the falls rate and practice around falls

More preventative measures to prevent fall

Through the reflection they utilised the point of care model

Some staff previously and more now – aware low low beds, high risk, **increase documentation**

FRAMP in action – majority of staff doing it

Reinforcement **– more familiar with strategies post fall care increased**

Sunflower **(delirium management)**

Orientation package – falls included

3 lots of breaks – **change in break time**

Personal reflections

- Increased awareness around falls prevention strategies
- Observations showed implementation that the strategies were actually implemented.
- The strategies were also sustained
- Increased compliance with risk assessment and management plan
- Increased confidence around fall prevention practices
- Comfortable to reflect on the falls incident and explore solutions to prevent future incidents

Thank You!