A quality improvement project to improve assessment and documentation following inpatient falls

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Introduction & Aims

- Inpatient falls are a common cause of avoidable harm in hospital and care settings
- Majority of falls assessments undertaken by junior members of medical team and frequently performed out-of-hours when there is less senior advice available
- At our trust, there is no specific guidance on what constitutes a gold standard medical post falls assessment
- Poor falls assessment → adverse outcomes for the patient, including:
  - Delayed diagnosis of fracture/bleed
  - Recurrence of falls when modifiable risk factors not addressed
  - Delay in recognising a medical precipitant of the fall

Standards

Post-falls assessments should take place for every fall in hospital. They should be clearly documented in medical notes and include[1,2]:

- Circumstances of fall
- Consideration of a medical precipitant for the fall
- Medication review including anticoagulation status
- Consideration of the need for CT Brain and for other imaging e.g. hip x-ray

Cycle 1 – Pre-intervention

27 falls assessments from 3 elderly care wards from Nov20 – Jan21.

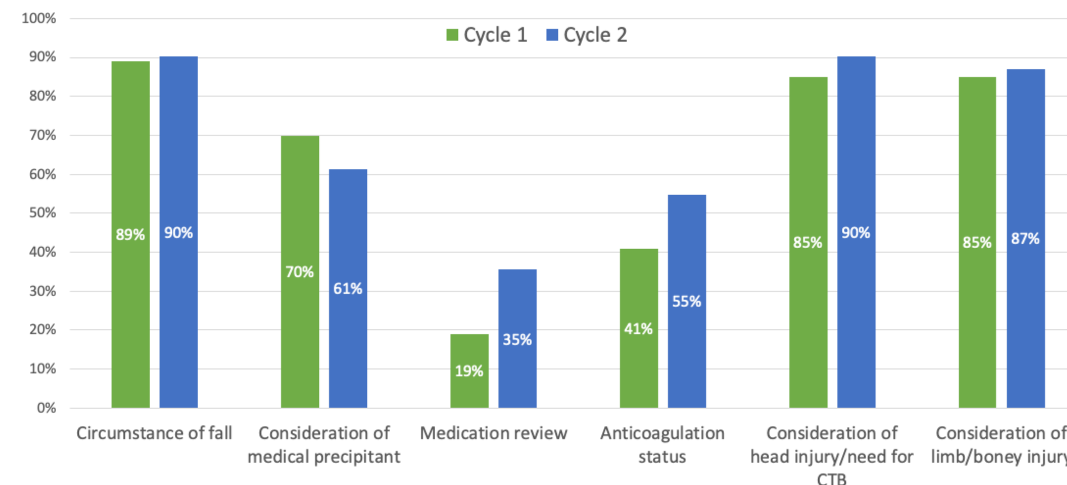
Data extracted from Datix reports and electronic health records

Cycle 2 – Post-intervention

31 falls assessments from 3 elderly care wards from Feb22 – May22.

Proforma used in 8/31 assessments:

- Use associated with day staff on their base ward
- When proforma was used, 100% of domains were fulfilled



Intervention

Falls assessment proforma "cut and paste"

Events of fall:
Time of fall
Circumstances of fall (pre/during/post, collateral)
Are there any medical precipitants of fall (including postural hypotension)
Are there any pharmacological precipitants of fall (e.g. antihypertensives, hypnotics/sedatives)

Examination/bedside investigation:
BM
ECG
Lying/standing BP
GCS
Is patient delirious:
Findings of basic systems examination including brief neurological exam:
Skeletal survey:
1. Long bone examination (inc. shoulder and hip):
2. Head/Spinal examination

Impression:
Delirium: yes/no (consider causes as per Delirium card)
Acute medical precipitants:
Falls risk factors:
Injuries sustained:

Plan: (delete as appropriate)
Is the delirium bundle required?

Is CT Head Required?
(1) Consider if head injury or possible head injury and
  (a) Suspected skull fracture
  (b) New confusion or GCS ≤13
  (c) Post traumatic seizure or vomiting or new focal neurological deficit
  (d) Patients receiving DOACs or untreated hereditary or acquired bleeding disorders or thrombocytopenia (platelet count < 100 x109/l)
(2) Until CT performed or if no CT ordered consider nursing neuro-obs

Are X-Rays required? (clinical boney injury/pain) (See post fall lanyard card for ordering radiology)

Medication changes including analgesia or anticoagulation/antihypertensives review

Conclusions and Future Work

- Medical documentation lacks standardisation
- The "cut and paste" proforma was not universally used by trainees
- Possible barriers to the use of this proforma include time, awareness, and poor distribution
- Future QIP cycles should focus on:
  - Implementation of falls proforma as a template in our electronic health record system
  - Involvement of MDT in post-falls documentation and falls prevention plan

1. NICE QS 86. Falls in Older People. Available: https://www.nice.org.uk/guidance/qs86
2. BMJ Best Practice. Assessment of falls in the elderly. Available: https://bestpractice.bmj.com/topics/en-gb/880

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