Making the Right Call for Falls: Evaluating the Efficacy of a Multi-Faceted Trust Wide Approach to Improving Patient Safety Post Falls

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Abstract : Introduction: Inpatient falls are the most commonly reported patient safety incidents, and carry a significant burden on resources, morbidity, and mortality. Ensuring adequate post falls management of patients by staff is therefore paramount to maintaining patient safety especially in out of hours and resource stretched settings. Aims: This quality improvement project aims to improve the current practice of falls management at Guys St Thomas Hospital, London as compared to our 2016 Quality Improvement Project findings. Furthermore, it looks to increase current junior doctors confidence in managing falls and their use of new guidance protocols. Methods: Multifaceted Interventions implemented included: the development of new trust wide guidelines detailing management pathways for patients post falls, available for intranet access. Furthermore, the production of 2000 lanyard cards distributed amongst junior doctors and staff which summarised these guidelines. Additionally, a 'safety signal' email was sent from the Trust chief medical officer to all staff raising awareness of falls and the guidelines. Formal falls teaching was also implemented for new doctors at induction. Using an established incident database, 189 consecutive falls in 2017were retrospectively analysed electronically to assess and compared to the variables measured in 2016 post interventions. A separate serious incident database was used to analyse 50 falls from May 2015 to March 2018 to ascertain the statistical significance of the impact of our interventions on serious incidents. A similar questionnaire for the 2017 cohort of foundation year one (FY1) doctors was performed and compared to 2016 results. Results: Questionnaire data demonstrated improved awareness and utility of guidelines and increased confidence as well as an increase in training. 97% of FY1 trainees felt that the interventions had increased their awareness of the impact of falls on patients in the trust. Data from the incident database demonstrated the time to review patients post fall had decreased from an average of 130 to 86 minutes. Improvement was also demonstrated in the reduced time to order and schedule X-ray and CT imaging, 3 and 5 hours respectively. Data from the serious incident database show that 'the time from fall until harm was detected' was statistically significantly lower ($P = 0.044$) post intervention. We also showed the incidence of significant delays in detecting harm (> 10 hours) reduced post intervention. Conclusions: Our interventions have helped to significantly reduce the average time to assess, order and schedule appropriate imaging post falls. Delays of over ten hours to detect serious injuries after falls were commonplace; since the intervention, their frequency has markedly reduced. We suggest this will lead to identifying patient harm sooner, reduced clinical incidents relating to falls and thus improve overall patient safety. Our interventions have also helped increase clinical staff confidence, management, and awareness of falls in the trust. Next steps include expanding teaching sessions, improving multidisciplinary team involvement to aid this improvement.

Keywords : patient safety, quality improvement, serious incidents, falls, clinical care

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