Aims and Hypothesis

To audit events of falls on a dementia assessment ward with an aim to identify triggers and record the processes which followed event of fall. We worked with a hypothesis that inpatient falls can be prevented if risk of fall is identified early in the assessment process along with possible triggers and causes.

Background:

Falls on hospital wards with elderly inpatients are an ongoing concern as it can cause unnecessary suffering to patient, may result in fractures and can increase their length of stay in hospital.

This audit was carried out as part of a quality improvement project LIPS (Leading Improvement in Patient Safety). Our project was designed to study triggers, causes and reasons of falls on dementia wards. Following the audits we aim to draft a pathway with an aim to reduce number of falls and improve quality of the inpatient stay on the wards. We are working as a multidisciplinary team which include a ST5 psychiatry registrar, deputy ward manager, occupational therapist and a nursing assistant.

Results

Total number of 16 patients were present on the ward at any given time during the audit timeframe. 21 falls events were recorded in the three month period of audit involving 11 patients. 7 falls happened while patients were on one to one observations to prevent falls. Most common area of falls were the day room and lounge area of the ward where 9 out of 21 falls happened. Most fall happened when patients were trying to get out of furniture (n=9) or walking (n=8). Only 13 out of 21 falls events were documented in next ward round discussion and only one person was referred to physiotherapist following the fall.

Methods

We audited three monthly electronic data records from September 2014 to November 2014 for all the inpatients on a female dementia ward of University Hospital Llandough which is part of Cardiff & Vale University Health Board.

We carefully identified incidents of falls and recorded the location, events leading to falls, possible triggers and consequences of each fall event. We also compared the actions following falls with the local falls protocol.

Conclusions

Local policies for falls on the wards are in place and regularly reviewed however not always followed. There is room for improvements and a multidisciplinary approach is required to help prevent recurrent falls. One to one observation to prevent falls is shown to reduce number of falls on the ward but does not always prevent falls. Audit on two further wards is planned which will be followed by guidance and action plan with an aim to reduce number of falls on the wards.