1 Overview

About the West of England Academic Health Science Network

The West of England AHSN is delivering positive healthcare outcomes locally and nationally by driving the development and adoption of new innovations and making a meaningful contribution to the economy.

We are one of 15 AHSNs across England, established by NHS England in 2013 to spread innovation at pace and scale.

As the only bodies that connect NHS and academic organisations, the third sector and industry, we are catalysts that create the right conditions to facilitate change across whole health and social care economies, with a clear focus on improving outcomes for patients.

@WEAHSN www.weahsn.net and newsletter sign-up: http://www.weahsn.net/news-views/newsletter-sign-up/

About the South West Academic Health Science Network

The South West AHSN is driven by a core of experts, a company limited by guarantee, which empowers the members to make and share the best changes. We do this by supplying insights, skills, resources, access to funding and capacity to connect innovative solutions to needs.

The goal of the Network is to improve and sustain the healthcare system in Devon, Cornwall and the Isles of Scilly and Somerset for current and future generations of patients.

We prioritise finding solutions for problems which affect the largest numbers of patients and put the greatest stress on our healthcare system in the South West.

@sw_ahsn http://www.swahsn.com/

About the event

Following the previous work on falls in the south west of England, the two AHSNs were asked to support local organisations to collaborate to reduce harm from falls locally. The aims of the workshop were to:

- Further develop the collaborative approach to prevention and better management of falls
- Create a forum to share best practice and learn from each other
- Encourage networking of like-minded colleagues across the West of England and South West Academic Health Science Networks
- To embrace the Quality Improvement methodology to effect changes and drive improvement.
- To encourage organisations to develop their own plans and ideas on how to reduce harm from falls in their region.
2 Input from the room

86 attendees from 35 organisations were in the room with attendees from the West of England (51), South West (29) and Wessex (6) AHSN regions. There were a range of roles in the room including occupational therapists, physiotherapists, nurses, falls leads, rehabilitation nurses, falls specialists, and ward managers.

Helen Blanchard, Director of Nursing and Midwifery, Royal United Hospitals Bath NHS Foundation Trust opened the day and then attendees selected their own agenda of topics to discuss using Open Space methodology. Output notes as follows:

<table>
<thead>
<tr>
<th>Topic</th>
<th>Key points from group discussions</th>
<th>What next?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Commissioning/</td>
<td>Lack of system wide strategy</td>
<td>Share resources what’s happening? AHSN</td>
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<tr>
<td>falls strategy</td>
<td>How do we get buy in to develop?</td>
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<td></td>
<td>Pathway? Peninsular wide</td>
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<td>What priorities for CCG</td>
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<td>Community falls</td>
<td>Referrals from the ambulance service do not declare the referrals</td>
<td>Key information output:</td>
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<td>How do we identify patients who are at risk of falling even if they haven’t fallen yet?</td>
<td>What happened with…?</td>
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<td>Frequent fallers – are these identified between agencies</td>
<td>Where was it, e.g. bathroom</td>
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<td>Who is responsible for providing education?</td>
<td>What have you found? E.g.</td>
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<td></td>
<td>SPA for falls – MH records, community records</td>
<td>large meds list, postural job</td>
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<td></td>
<td>Clinical judgment should be used to identify referrals rather than scoring tools but what if there is not the experience to have clinical judgement? What guidance should be given?</td>
<td>North Somerset completed ambulance: RR pilot to respond to fallers. What was the outcome? Evaluation?</td>
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<td>Stumbling block in primary care – does the information get directed onto the correct person/team?</td>
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<td>How do we positively manage risk and ensure they are safe at home? How do we make this shared decision making?</td>
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</table>
| **Dementia falls prevention** | This is me – meaningful interaction for the individual  
Environment – kings fund audit, flooring, hip hop study, home rails/ handles  
Dementia care mapping ® – identify triggers  
Waling aids – coloured frames, visual awareness, colour coded, assistance required  
Pet therapy – pat dogs can be boring!  
Footwear – no slip slipper socks  
falls guidance – for patients/careers/relatives/expectations  
Johns campaign improved interaction  
Fear of falling – reduction in activity, isolation | Introduce or review pre-existing interventions  
Revamp and relaunch |
| **Dementia falls prevention (continued)** | Nutrition ‘finger foods’ general vs specific  
Handovers – safety briefing and board rounds  
Hip protectors – new evidence for reviews and increase tech  
Senior alarms – technical advances – proactive not reactive sensors  
Occupations activity – purposeful activity  
Nothing ventured, nothing gained – risk taking  
Comfort rounding and increasing observations – complete notes in patient areas  
Medication – reviews invest in pharmacy and involve in board rounds etc.  
Early planning to reduce length of stay | **Ideas:**  
Warning indicators to highlight  
**What next?**  
Review pre-existing interventions  
Revamp and relaunch |
| **Dementia inpatient management – DOLS / Safeguarding** | Maintaining reduction of falls  
Electronic monitoring of patient vital signs  
Link between DOLS – people remaining in their own space in an acute/ community hospital  
Conflict between ward routine and person centred care  
Mental capacity  
Conflict between pressure care/ falls prevention equipment  
Getting patients out of bed / structure and routine | **Ideas:**  
Automatic monitoring patient – falls prevention (pattern of obs)  
Enhanced recovery approach  
MCA and DOLS films (NHS England)  
**What's next:**  
Look at films DOLS and MCA |
| **Engagement of falls leads/ repeat falls** | Link in with Dementia Strategy Group  
Making data real – taking to the leads to share – reward taking to Board level  
Detail shared back  
Repeat falls – SWARM  
Definition of fall – to near miss | |
| **Engaging falls leads** | FAT: Falls action team  
Measurement is a gift – split into day and night, break it down, re-examine  
Example of looking at data to change practice e.g. time of breaks at night  
Toilet tagging  
Commode tagging  
Falls champions – topic of the quarter; all disciplines | |
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<td>Falls and frailty in the community</td>
<td>same multi-factorial risk assessment across organisation record sharing is key Falls champion meetings (reps from teams all grades) Eyes right Thomas Pocklington Trust Virtual wards to discuss patients known to many</td>
<td>Ideas: Use multi-factorial falls assessment Tools to Assessment risk “enhanced care tool in obs” Level of obs Time of day ABC chart Meaningful activity to promote mobility Pool activity level</td>
</tr>
<tr>
<td>Falls prevention with dementia and DOLS / safeguarding</td>
<td>Safe environment Safeguarding and DOLS Discharging from acute into care difficulty in acute hospitals assessing care and support needs prior to discharge Care planning and use of ABC charts</td>
<td>What’s next: Share information with group Multi fac. Risk Assessment Pool activity level Enhanced care tool (Levels 1 – 4) Look at NHS Protect site</td>
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<tr>
<td>FRAX and FRAT -- Joining things together</td>
<td>Two members same area not aware each other’s admission Admission ED fallers do they all get assessed with FRAX? No!</td>
<td>Survey all those here want arrangements (locally) for assessing fracture risk in patients that fall? (Ann Remmers)</td>
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<td>How do we identify frailty?</td>
<td>How do we identify frailty? Care homes – need to manage anxiety (residents and carers) – all residents are frail/ at risk of falls Telecare – prevent falls and manage falls Provide sensor mats, GPS track chair occupancy monitors Need medication review – pharmacist or doctor used Different names for frailty pathway from ED Pilots of Rockwood frailty scale Different models of “falls specialists” can be postcode lottery</td>
<td>Rural areas – unfulfilled packages of care How do we address safeguarding/ deprivation of liberty? What is the EFI being piloted by GPs? How do we stop patients falling between visits?</td>
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</table>
3. **Outcomes and next steps**

In the afternoon attendees worked on organisations action plans. As part of the evaluation attendees were asked what they would do as a result of today – with many committing to take actions back within their own organisations:

![Word cloud from attendee comments “As a result of today…”](image)

4. **What our participants said**

There was a 50% response rate and 91% of attendees said the overall rating of the event was “good” or “excellent”. Word cloud from comments “What worked well…”

![Word cloud from comments “What worked well…”](image)
Comments from attendees:

“Great to hear good practice from other organisations”

“Really interesting and diverse collection of ideas and projects”

“Informal approach was lovely”

“Good to have opportunity to plan way forward as a team”

As well as participation in the event, there were discussions on Twitter using #fallfree16

Dave Anderson @DaveThePhysio Mar 3 Really good ideas around falls safety at the @WEAHSN conference in Taunton. Just one from today. #fallfree16

Joanna Bates @paramedicjoanna Mar 3 Some fantastic conversations @weahsn #fallfree16 event. Making connections and sharing best practice.

SWASFT ECS @swasFT_ECS Mar 3 We're at @WEAHSN's #fallfree16 event in Taunton today with @paramedicjoanna discussing falls prevention & management

Kevin Hunter @pskevh Mar 3 Session 1 in 'fall' swing #fallfree16

Dave Evans @qi_dave Mar 3 Dementia falls prevention - sharing ideas and practice to reduce patient falls. #fallfree16

Other resources mentioned include Mrs Andrew's story https://youtu.be/Fj_9HG_TWEM

Thank you to everyone involved in the day!