Preventing falls among older people with mental health problems

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A trust has developed a protocol that has led to a significant drop in falls leading to a fracture among older people with mental health problems. Fiona Chaâbane reports.

At Sussex Partnership NHS Trust (formerly West Sussex Health and Social Care NHS Trust), we have introduced an evidence-based protocol for the prevention and management of falls among older people with mental health problems. Since the protocol's introduction throughout older people's mental health services in October 2003, the incidence of falls leading to a fracture in this patient group has dropped substantially.

The consequences of falls for this care group can be life-changing and life-limiting[1]. Falls are common in older people with dementia and often occur when neurological and physiological changes impair the person's ability to maintain their own safety and wellbeing[2]. Memory failure and other cognitive deficits make engagement in preventive or rehabilitative programmes difficult and often unproductive, and cooperating with best-practice advice and remedial interventions may not be achievable due to the level of dependency and related disabilities. The impact of a fracture of, for example, neck of femur, could, at worst, prove fatal; at best, it means extensive rehabilitation and increased dependency, and makes the prospect of returning home to live independently more remote, so that placement in a residential or nursing care home may be the only option. The risks for this very vulnerable patient group have been significantly reduced by the implementation of the protocol through the trust's clinical governance framework and through practice development.

An increased risk of falls

The trust undertook phased closure of a large psychiatric institution, enabling inpatient and day-patient services for older people with mental health problems to be provided in smaller, local and purpose-built or adapted units. The first phase of patient transfers occurred in the summer of 2000 to a unit in Bognor Regis. This group of patients included those with advanced dementia receiving continuing care, and those with varying degrees of dementia admitted from the community for assessment. The former group of patients had been in hospital on a long-term basis, some for many years, and the latter group were expected to be discharged back to their community once their condition had been assessed and their needs stabilised. The unit (which has since closed) had 27 beds, 20 for continuing care and seven for short-stay assessment, and initially ran at approximately 65% occupancy. Within a few months it became apparent that the incidence of falls leading to a fracture, usually neck of femur, was higher than elsewhere in the trust and therefore a major risk to health and wellbeing.

Anecdotal evidence led me to approach the clinical audit committee, and the clinical audit coordinator and I drew together incident-reporting figures and presented our findings to the clinical audit and clinical governance committees.

Clinical audit work showed that patients were significantly more likely to sustain a fracture in the Bognor Regis unit than in comparable ward settings elsewhere in the trust. Within six months, seven patients had fallen and fractured their neck of femur. In 18 months, 10 neck of femur fractures and one wrist fracture were seen. In a similar care group facility in the trust, with 62 beds, there were six fractures in 12 months, a different unit had no fractures in another 12-month period.

A number of factors needed to be investigated and taken into consideration in calculating the increased risk to patients in the new unit, including changes to nursing practices and levels of medical support, different levels of observation and intervention, different flooring types and more compact care environments.

An extensive review of falls leading to a fracture investigated all common factors and antecedents, including: the time of day of the incident; where it occurred; staff on duty; concurrent events; patient's overall mood level and cognitive ability; medication regimes (including the use of "as required" medication); the patient's physical health, level of mobility and self-care prior to the fall; the conclusions of the most recent medical review, working or actual diagnosis and overall plan of care; risk assessments and rating scales; and sleep/behaviour patterns. Many of the patients who sustained a fracture did not regain independent mobility and, for some, the effects of surgery, rehabilitation, pain, recovery and increased dependency had a detrimental effect on the illness for which they were originally admitted to hospital and worsened cognitive function. The only correlation between the events themselves and these factors was that all patients sustaining a fracture were suffering from dementia of a moderate to severe degree, and all had fallen to the floor.

Staff assessment and intervention

It was very apparent from this detailed case and incident review that staff were not always intervening proactively or delivering a range of assessments or interventions to those who were either at risk of falls because of their age, health and diagnosis, or who were admitted because their condition involved behaviour which was causing falls at home. Although written records demonstrated awareness and some insight regarding the falls risks, little beyond sporadic one-to-one supervision was offered to reduce risks. Considering that the occurrence of falls is part of the diagnostic criteria for some forms of dementia, and that some of the medications used may increase the potential for falls[3], this needed to be addressed.

It seemed clear that the risk of falling needed to be assessed at the start of hospital care so that it could be managed where possible from that time, rather than reactively, after a fall. A trawl of falls-risk assessments identified an abundance of works that related to older people, but very little was relevant to older people with cognitive problems or mental health issues. The ability of these patients to engage in risk reduction programmes, falls prevention strategies and health promotion was often limited or impractical.

Writing our own protocol

Frustrated by this lack of appropriate risk assessments, I was set the challenge by my manager to "write your own" – so I did. I involved the clinical governance committee/clinical audit department and nursing groups, and sought the opinion of staff including physiotherapists, doctors and community mental health teams. I took it to wards and discussed it with staff, and trialled it on patients with the staff who care for them.

The outcome was a protocol aimed at the entire workforce (from portering/facilities staff to consultant), containing a risk assessment section[4]. This enabled staff to identify, from the time of admission, a risk level for each patient in addition to guided interventions to attempt to reduce the risk or, where this was not possible, to ensure that it was recorded, reviewed and addressed comprehensively within the person's overall plan of care and management. All staff who were able to influence the risks were required to do so.

Implementing a risk rating scale needed to be handled sensitively and tailored to the operational processes within the service. Risk assessment already has a high profile within mental healthcare. A wide range of rating measures were already in place regarding, for example, a person's propensity for self-harm or their ability to take care of themselves. The introduction of a further risk assessment needed to be managed tactfully and to have the full support of clinical staff for it to succeed. Staff needed to be assured that new paperwork had clinical relevance and credibility, would benefit patient care and be user-friendly. The work was therefore based upon the "SMART" process of objective setting (specific, measurable, attainable, relevant and timely), and involved ward staff from the outset.

Content of the protocol

The first part of the protocol makes recommendations for clinical and facilities staff, raising awareness of fundamental concepts of care of older people among the latter. For example, the need to keep walkways clear and attend to spills on the floor immediately was not always apparent to some staff in relation to a patient's cognitive impairment or sensory difficulties. Changes to practice include separating off areas for cleaning with mechanical obstacles, rather than politely asking patients to avoid the area or not walk across recently washed and still wet floors, or expecting those with a wide range of impairments to recognise standard hazard signs for what they are. A significant teaching component has aimed to ensure effective implementation of the protocol, and consultation with staff during its development has made ownership of risk reduction and practice changes more likely.

Next, the protocol contains an indicator of higher-risk periods for patients, for example after medication changes (withdrawal, cessation or increase), or during staff handover periods and at night time, and outlines the potential consequences of a fall for a patient.

After this, the protocol sets out actions to be taken in the event of a fall and if a fracture is suspected. It then sets out a risk assessment scale, with 12 areas to be rated, including the patient's diagnosis, ability to comprehend and to cooperate with care interventions, medication regime, physical health and level of mobility.

Guidance on interventions to be considered and actions to be taken are recommended, based on the patient's "low", "moderate" or "high/significant" score. Interventions for higher risk include more frequent risk assessment and medical/multidisciplinary review, engagement with physiotherapy services, use of aids and equipment (including hip protectors) and consideration for prophylactic use of calcium/vitamin D supplementation – particularly relevant for the continuing-care group, who may not have had a great deal of exposure to sunlight or physical exercise during their years of inpatient care.

The development of the risk assessment scale involved rating patients – 48 patients from short- and long-stay facilities were rated and 30 rerated twice over time to aid development of a scale that was both reflective of risks and user-friendly. The associated teaching and discussion that accompanied this work raised the profile of falls risk in this setting and the need for this assessment to be used in combination with others and in relation to the patient's very individual needs.

Results so far

The protocol was implemented across all older people's mental health service inpatient areas in October 2003, and an audit of 142 sets of clinical records the following year made 10 recommendations for practice change, all of which were implemented by the summer of 2005. These recommendations included that:

- the use of calcium/vitamin D supplementation should be reviewed and its use encouraged in high-risk groups, including continuing-care patients;
- a patient's risk of falls should be regularly reviewed in multidisciplinary meetings, and referrals to other services made where appropriate; and
- the protocol be introduced to all bank and agency staff at induction.

To date, the fracture rate remains low and falls have also been significantly reduced. Since the protocol's introduction, there have been 12 fractures in older people's mental health services up to the beginning of March 2007. The protocol has been reviewed and updated in response to operational changes and national guidance. The falls-risk assessment is now used throughout a patient's period of hospitalisation, and staff intervene proactively to attempt to reduce falls and their impact as much as possible. Other trusts, including primary care trusts (PCTs), have contacted us regarding using or adapting the risk assessment, and three trusts have said they have implemented it. Our local PCT has developed it within local nursing/residential homes for this client group.

In a patient group that may not be able to access self-help opportunities or engage with falls prevention strategies, this protocol has significantly reduced the risk of a fracture resulting from a fall. However, it needs to be constantly reviewed and its implementation monitored, to prevent it becoming a paper exercise without clinical relevance. HCRR

References

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