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A collaboration between Nursing and Midwifery

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Working Together

Excellence

Inclusive

Kind

Embracing Change

How did our journey begin?

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Introduction

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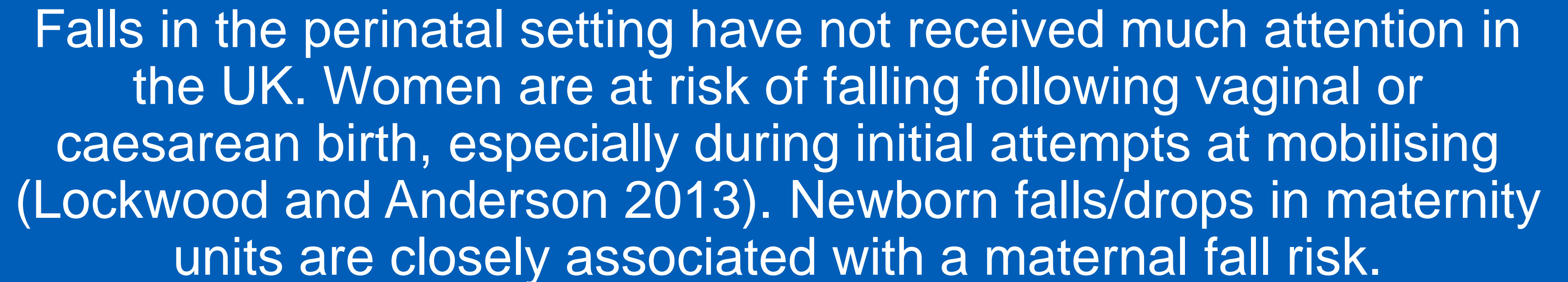

Falls in the perinatal setting have not received much attention in the UK. Women are at risk of falling following vaginal or caesarean birth, especially during initial attempts at mobilising (Lockwood and Anderson 2013). Newborn falls/drops in maternity units are closely associated with a maternal fall risk.

Traditional falls risk assessments do not address the unique characteristics experienced by women in the immediate post partum period, and indeed to the risks of the baby being dropped.

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Falls Prevention - Nursing

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Multifactorial Risk Assessment for adult inpatients

- Based on National Guidance
- Many elements remain relevant to maternity patients but are they enough?
- Do they identify the risk?
- Do our maternity staff have the relevant knowledge?

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Falls Prevention - Midwifery

Multifactorial Risk Assessment

Assumptions:

Young, Fit and Healthy

Risk within Maternity for Falls is low

Reality:

Maternity patients can have pre existing medical conditions making them a falls risk.

The birth may have involved complications

Noisy, unfamiliar environment

Exhaustion

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Falls Prevention is everyone’s Business

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Review

Maternity falls were difficult to review as they did not fit the standard Falls prevention policy.

Through reviewing themes of Maternal inpatient falls it was evident that the falls assessment needed to be specific.

Staff Comments

Training specific to maternity patients would be better as opposed to training with nurses as focus would be on elderly

Maternity specific prevention is a good idea

A bespoke maternity falls policy would be useful

This can be quite common due to events like blood loss, effects of opiates

Specific Care Plan In Maternity!

Specific Risk Factors in Maternity!

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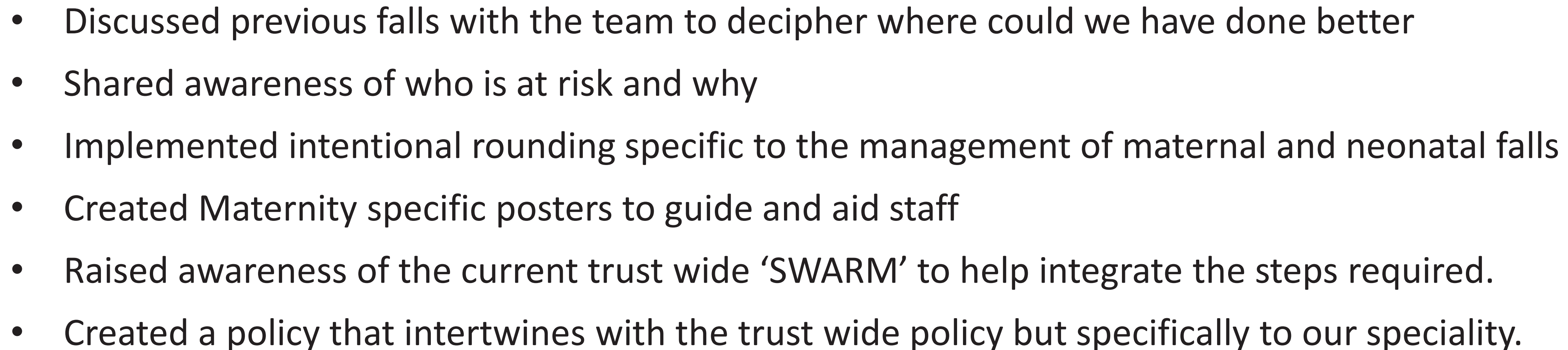
Awareness

Through raising awareness alone over the last year we have had no preventable falls on the inpatient Maternity Ward.

What have we done?



- Discussed previous falls with the team to decipher where could we have done better
- Shared awareness of who is at risk and why
- Implemented intentional rounding specific to the management of maternal and neonatal falls
- Created Maternity specific posters to guide and aid staff
- Raised awareness of the current trust wide ‘SWARM’ to help integrate the steps required.
- Created a policy that intertwines with the trust wide policy but specifically to our speciality.

START

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BACK TO BASICS

IS YOUR PATIENT A FALLS RISK?

FALLS PREVENTION

THINGS TO CONSIDER

- Risk assessment
- L/S BP recorded for all falls risk
- Care plan
- Assess neonatal falls risk
- Yellow wristband applied
- Call Bell within reach
- Safe footwear - yellow socks and/or slippers
- History of falls
- Ensure bed space is tidy
- Offer assistance to mobilise
- Cognitive impairment
- Mobility assessment
- Full medication review
- Reassess weekly, after a fall or change in patient condition

BACK TO BASICS - FALLS PREVENTION

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- **Risk Assessment** – identify if a patient is at risk of falls and why. Remember to explain to the patient why they are at risk of falls and explain the measures that can be taken to prevent falls. Must be completed within 6 hours of admission to the ward and remember to complete the risk assessment weekly, after a fall, or if a patient's condition changes.

- **Lying & Standing blood pressure** – If a patient has an undiagnosed postural drop, this can increase their risk of falls. If you identify a drop in blood pressure from lying to standing, ensure you inform a Doctor so the right action can be taken.

- **Care plan** – this highlights the falls prevention measures we need to put in place and allows you to document these. Remember to individualise this so it meets the needs of the patient – everyone is different.

- **Bed Space** - The environment needs to be maintained to promote safe mobilisation around the bed space. Ensure all belongings are positioned so that the risk of trips or falls is minimised.

- **Yellow wristband** – this helps us all to visually identify if a patient is at risk of falls and offer them assistance if needed.

- **Call bell within reach** – ensure patients know how to use this and where it is at all times. Communicate to patients the importance of using the call bell if they need help.

- **Safe footwear/yellow non-slip socks** – check the patient's footwear – do they fit well, will they come off easily? If a patient does not have appropriate footwear, offer them the yellow non-slip socks and ensure they are the correct size.

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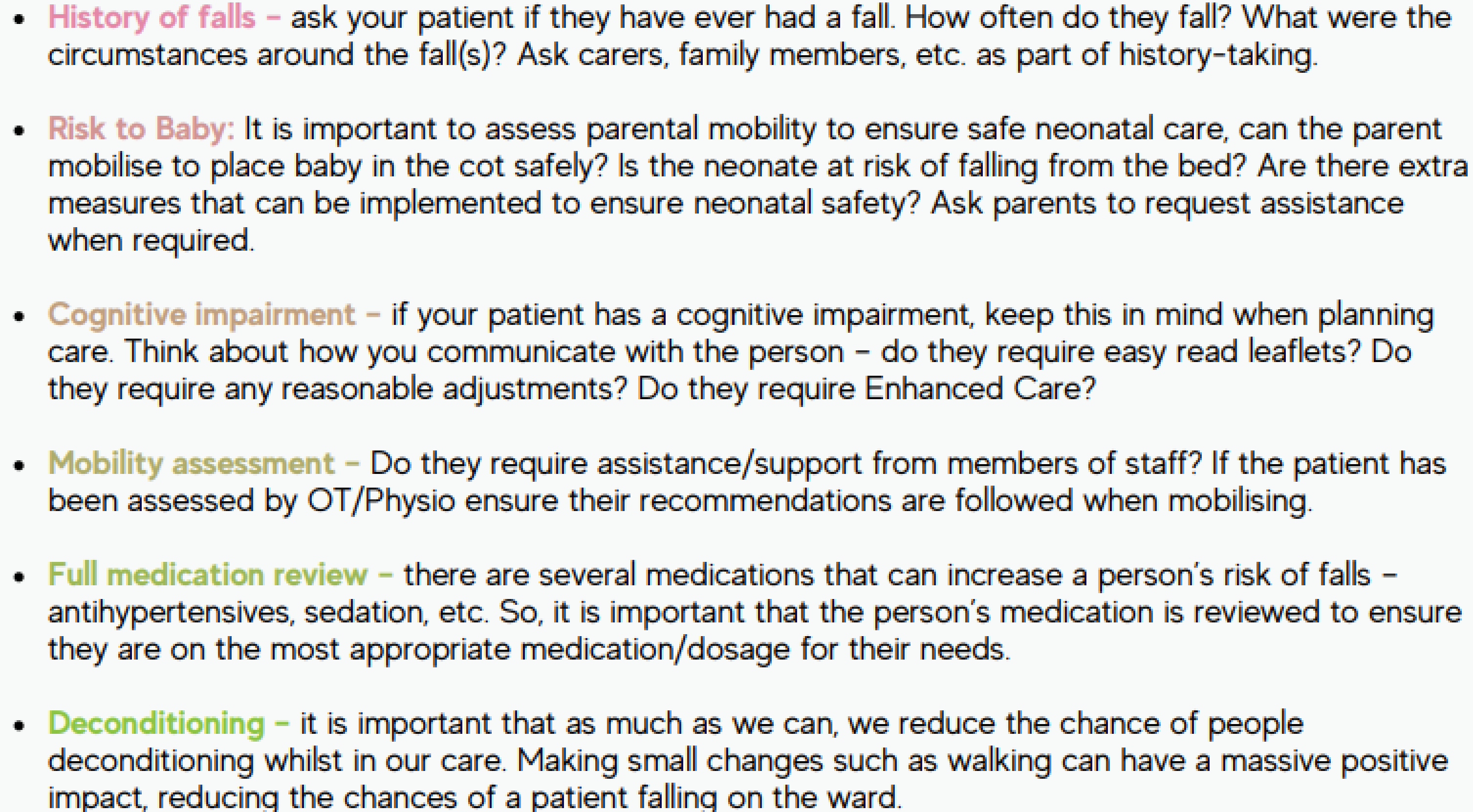

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Barriers

- Staffing
- Nursing and Midwifery teams historically did not work together to share learning.
- Staff misconceptions
- ‘Women do not fall in Maternity they faint!’
- Digital barrier – maternity falls is not a national guideline

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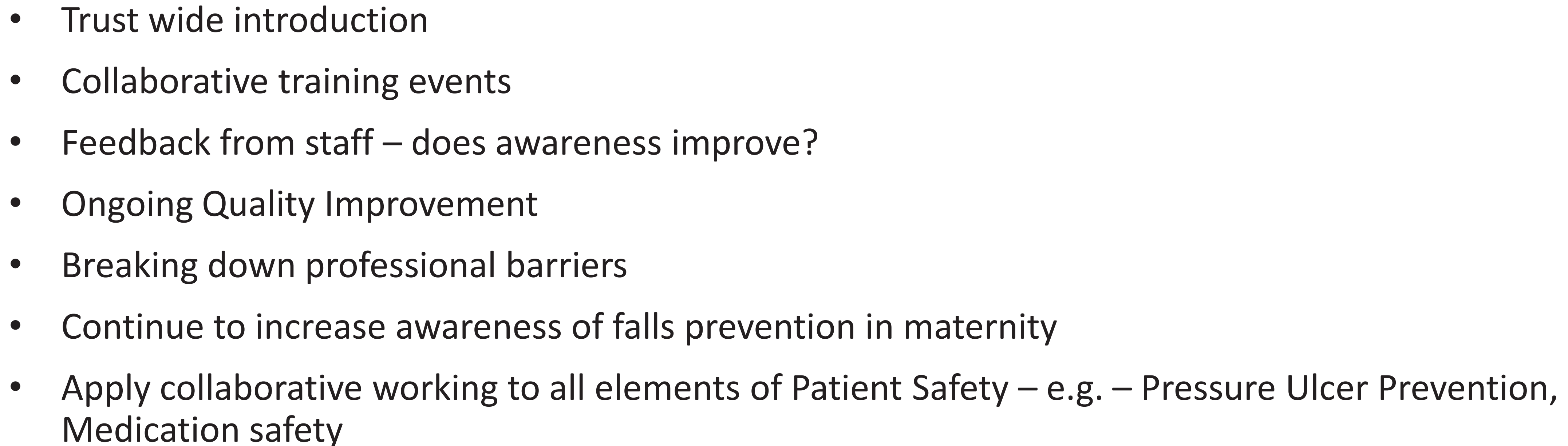
Next Steps



- Trust wide introduction
- Collaborative training events
- Feedback from staff – does awareness improve?
- Ongoing Quality Improvement
- Breaking down professional barriers
- Continue to increase awareness of falls prevention in maternity
- Apply collaborative working to all elements of Patient Safety – e.g. – Pressure Ulcer Prevention, Medication safety

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We are only at the beginning!

Thank You