South Tees Hospitals NHS
NHS Foundation Trust

Meeting / Committee:	Board of Directors	**Meeting Date:**	30 July 2013

This paper is for: (Only 1 column to be marked with x as appropriate)	Action/Decision x	Assurance	Information

Title:	Falls Report 2012/13

Purpose:	The purpose of this report is to inform the Board of Directors of the Trust performance and development work with regard to in patient falls.

Summary:	The paper provides information on: • The number and details of in patient falls reported within the Trust. • Current developments- local and national • Progress regarding the implementation of FallSafe across the Trust • Recommendations for future work

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Recommendation:	The Board of Directors is asked to consider and support the recommendations within the report.

Implications (mark with x in appropriate column(s)	Legal x	Financial x	Clinical x	Strategic	Risk & Assurance x

Falls Report
2012-2013

1. Introduction

A fall can be defined as “an event reported either by the faller or a witness resulting in the patient inadvertently coming to rest on the ground or at another lower level with or without loss of consciousness or injury that does not have a clear medical explanation such as acute myocardial infarction, epilepsy or cerebrovascular accident”.

Whilst the majority of falls are reported to result in no harm, even falls without physical injury can lead to loss of confidence, increased length of hospital stay and an increased likelihood of discharge to residential or nursing home care. In statistical terms:

- Over 280,000 patient falls are reported from hospitals and mental health (MH) units annually.
- The National Patient Safety Agency (NPSA) estimates that a thousand patients sustain a fracture as a result of falls in hospitals in England and Wales each year, including 530 fractured hips.
- The NPSA also reported 26 deaths directly attributed to falls within a one year period
- Healthcare costs associated with inpatient falls are estimated at a minimum of £92,000per year for the average acute trust

2. Background

Reducing falls within community and hospital environments is a high priority for the National Health Service. The NPSA and Patient Safety First identified key actions which should be undertaken within inpatient settings – these included accurate reporting, strategic commitment and multi-factorial assessment and intervention of all patients as key to reducing falls.

Working in collaboration with the local Primary Care Trusts a Falls Management Policy was agreed and launched in September 2006. The aim of the policy is to reduce, as far as reasonably practicable, the incidence of falls and fall related injuries for the population served. The policy includes a multifactorial falls risk assessment tool and care plan for staff to complete for all patients aged 65 years and over admitted to an inpatient area and offers guidance on interventions and referral pathways.

In order to equip staff with the knowledge and skills to follow the pathways a competency based training package was developed including a framework, workbook, training and resource file and educational sessions were delivered. Patient literature was also made available to all areas within the Trust and key places within the community: doctor’s surgeries, libraries etc.

A North East Regional Falls Task Group has been established since 2008 to share best practice and raise standards in falls and fracture prevention. The Trust has strong membership and has taken a pro-active approach to the group since its inception. A Regional Strategy has been developed identifying standards for all Health Trusts within the region to work towards to improve care. Guidelines for good practice have also been identified and the Trust has shown commitment to improve practice in line with this. The group is now developing into a Northern Falls Task Group.

3. Performance

Following full implementation of the falls management policy the Trust reduced the number of patient falls as demonstrated in figure 1.0 below. Please note however, that the data for 2012/13 also includes patient falls that occurred within the six community hospitals and the Rutson rehabilitation unit.

Figure 1.0 - Reported patient falls

Year	Catastrophic	Major	Moderate	Insignificant / Minor	Total
08/09	0	23	23	2457	**2503**
09/10	2	14	23	2130	**2169**
10/11	2	13	14	2113	**2142**
11/12	1	20	18	2034	**2073**
12/13	*3*	*24*	*30*	*2389*	***2446***

One of the most serious injuries sustained following a fall is a hip fracture, a serious injury that often leads to permanent disability and carries a high mortality rate of 30% within one year. Figure 2.0 below illustrates the number of fractures that our patients sustained following a fall during the last five years. Root cause analysis (RCA) is undertaken for all patients who sustain a fracture and recurring themes include patient confusion, lack of appropriate levels of observation, inappropriate or lack of patient footwear, patient choice, memory and /or reluctance to utilise the nurse call.

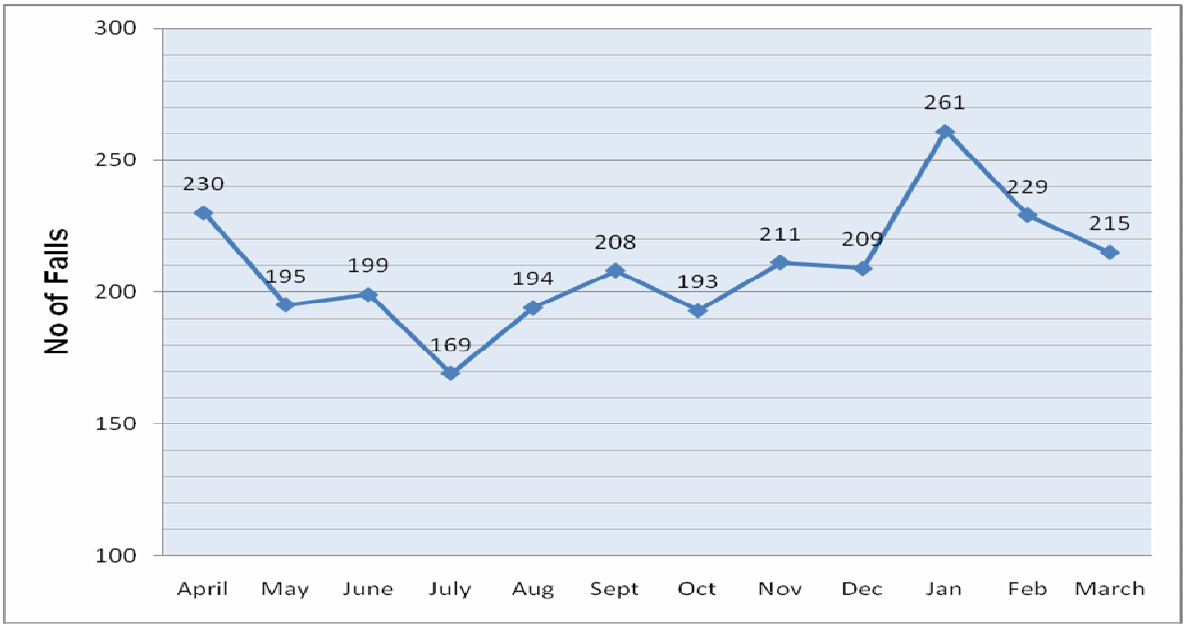
Figure 2.0 - Fractures

	08/09	**09/10**	**10/11**	**11/12**	**12/13**
Fractured Neck of Femur	24	14	11	18	27
Other Fractures	20	19	15	16	18
Total	**44**	**33**	**26**	**34**	**45**

Whilst the number of falls and the number of serious injuries sustained have increased, as previously stated the figures now include the community hospitals, where 10 fractures were sustained in 2012/13. These figures should also be considered along with the patient activity figures which confirm that the Trust saw 4,823 additional emergency admissions (81,404 – 86,227) and 2,475 additional elective patients (180,998 – 183,463) in 2012/13.

When reviewing the numbers of falls by month, the graph below (figure 3.0) clearly demonstrates that the highest number of falls ever recorded, occurred at a time when the Trust was under great pressure.

Figure 3.0 - Number of patient falls by month



Patient falls are reported via the datix system and the introduction of mandatory drop down fields provides further monitoring information represented in figure 4 below

Figure 4.0

	10/11	11/12	12/13
Risk Assessment completed	91%	97%	95%
First fall	80%	81%	75%
Fall from bed – bed rails in use	17%	16%	16%
Confused at time of fall	37%	41%	41%
Fall witnessed		18%	20%
Post fall observations recorded		97%	95%

These results raise the following issues

- 25% of patients fell more than once
- 84% of patients who fell from bed did not have bedrails in place, that may or may not have prevented a fall
- 41% of fallers were confused patients
- 5% of patients did not have observations recorded following their fall.

The graph below (figure 5.0) confirms that the lowest number of falls occurred during mealtimes and this mirrors the national picture. However the highest number of patient falls occurred between the hours of 12 midnight and 6 am.

Figure 5.0 - Time of patient falls

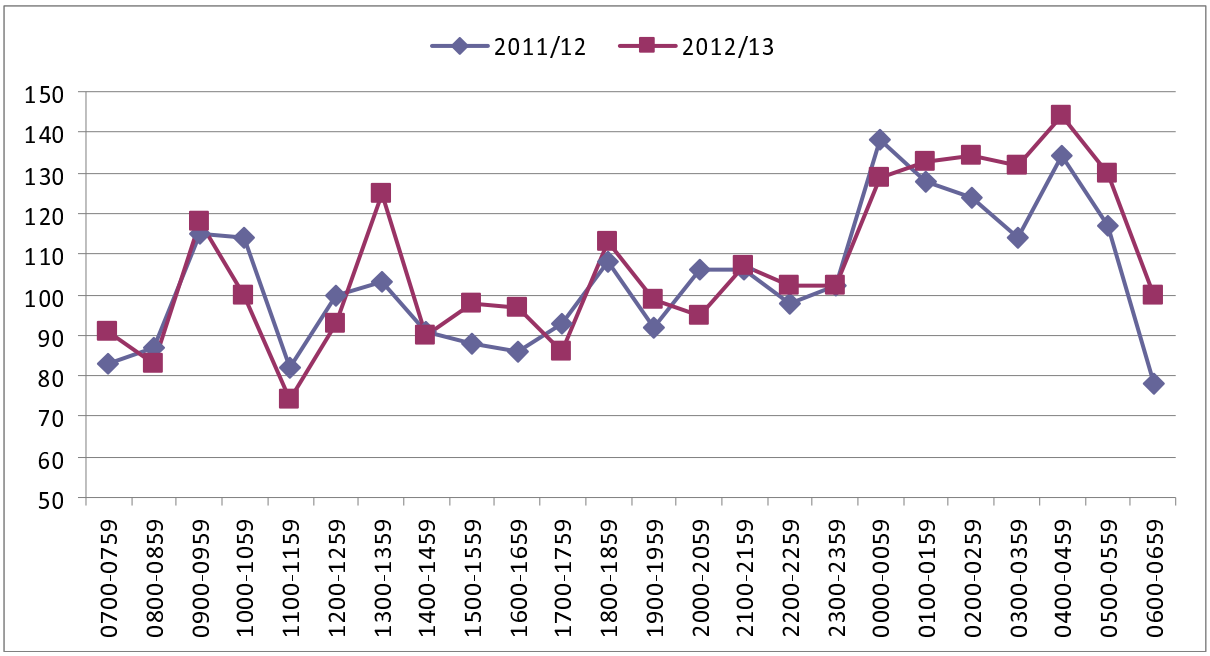


Figure 6.0 - Mode of falls 2011/13

Figure 6.0 confirms that the highest number of the falls reported occurred on a dry floor, with falls from bed being the second highest mode of fall. The reporting subcategories for fall on dry floor have recently been reviewed to improved future analysis.

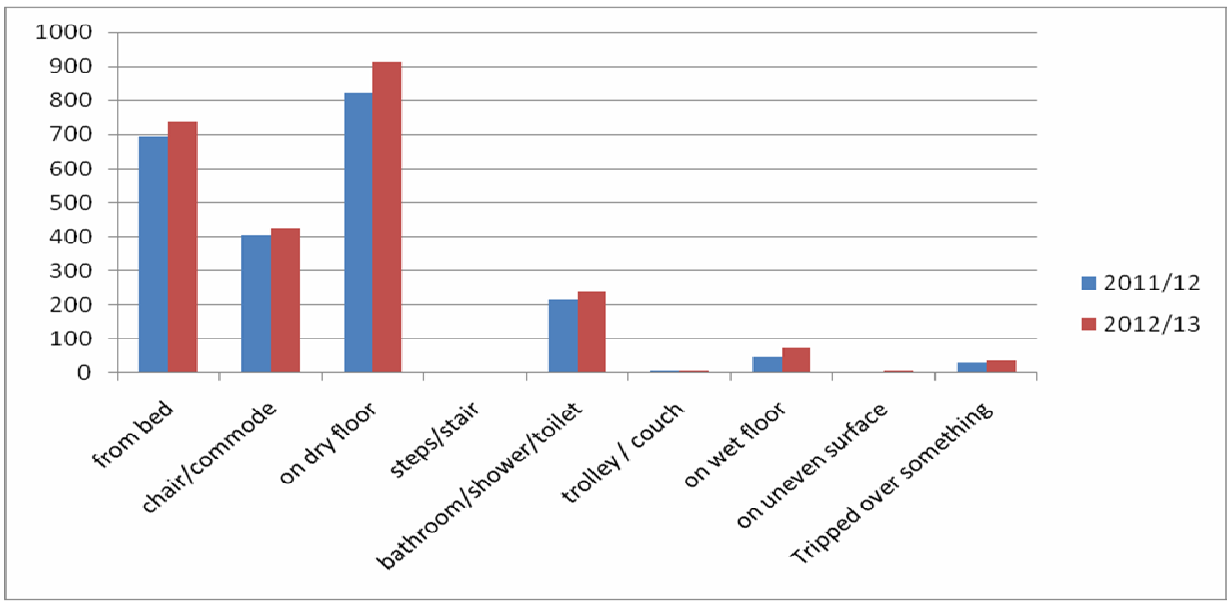


Figure 7.0 – Falls by time from admission

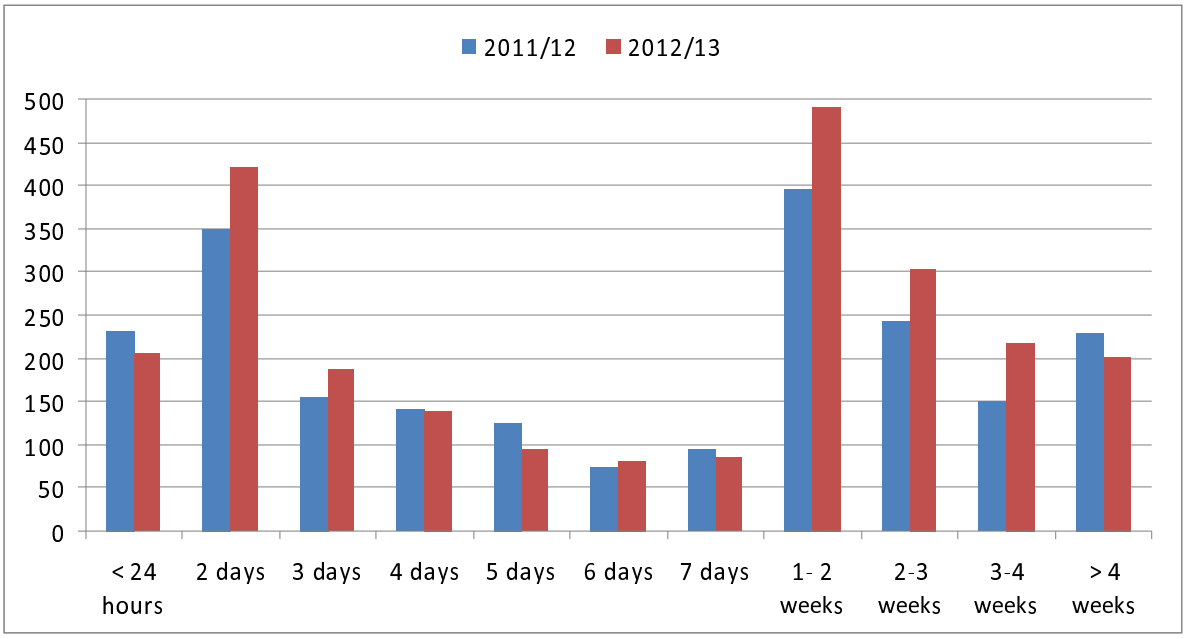


Figure 7.0 illustrates that the highest number of falls occur within 24-48 hours and this may warrant further investigation.

4. Current Developments

When discussing with nursing teams the high number of falls that occur at night, access to bedrails and hi-lo beds have been highlighted as difficult. The Trust has recently purchased 304 electric profiling beds and 10 specialist beds with integrated bedrails and 124 additional hi-lo beds.

Maintaining the safety of confused patients, particularly those who have dementia is challenging for ward teams. The Trust is committed to improving the care for these vulnerable patients and now has a team of staff dedicated to educating and increasing the ability of staff to provide safe care and environments for patients with dementia. In addition two Specialist nurses, who can support staff who are caring for patients with challenging behaviour, have been appointed in Acute Medicine.

The FallSafe project was a quality improvement project funded by the Health Foundation and delivered by the Royal College of Physicians Clinical Effectiveness Evaluation Unit in partnership with the South Central Strategic Health Authority. The project was overseen by a stakeholder steering group including the Royal College of Nursing, the National Patient Safety Agency and Action against Medical Accidents. The project ran from 2009-2102 and involved educating and supporting registered nurses to develop ward based multidisciplinary teams to deliver falls assessments and interventions through a care bundle approach.

The FallSafe project resulted in substantial improvements in care, including a doubling of patients receiving lying and standing blood pressure assessment, medication review and being asked about fear of falling. The Trust is committed to

rolling out FallSafe, in line with the other strong evidence base across all of its hospital wards.

In May this year the Trust submitted falls data to Quest prior to the first meeting of the Quest "falls circle" which was held in June. The data submitted from nine Trusts clearly highlighted the variation in the definition of a fall and how Trusts count and report patient falls. A new dataset with agreed definitions has been developed and the data exercise is being repeated. All documents relating to falls are being shared as are the last 10 RCAs in order to determine whether the themes are common across all Trusts.

5. Progress this year

Following the introduction of the FallSafe project in September 2012 within the organisation our falls management strategy was reviewed in line with best practice and more up to date guidance. Achievements so far include:

- Review of the falls risk assessment tool to include most up to date evidence.
- Introduction of a risk assessment tool for patients under 65 years of age.
- Incorporation of a simple bedrails and hi-lo bed risk assessment within the falls risk assessment to ensure appropriate use of beds and equipment.
- Inclusion of Dementia CQUIN within falls assessment tool has assisted in the trust achieving compliance in terms of FAIR (Find, Assess and investigate, Refer) and meeting the CQUIN target.
- Update of the falls root cause analysis template to assist staff in the investigation of injurious falls.
- Update of falls subcategories on DATIX to improve analysis of falls data.
- Benchmarking against FallSafe evidence and subsequent development of an implementation plan (see pages 9/10).
- Revision of falls working group into Hospital Falls Strategy group with revised membership and terms of reference. Priorities for the group have been agreed in line with implementation plan.
- Identification of a FallSafe lead for each ward/ department with clear roles and responsibilities.
- FallSafe leads meetings held bimonthly to provide support and lead implementation of strategy group priorities.
- Implementation of RCP Falls e-learning programme as part of mandatory training (Slips, trips and falls level 2).
- Purchase of Hoverjack to enable appropriate lifting of patients following a fall and suspected injury which will assist the Trust in working towards full compliance with NPSA RRR 001 – Essential care after an inpatient fall.
- Purchase of Manga Camel's for the Community Hospitals to provide staff with a greater range of options to assist a patient up off the floor.
- Implementation of intentional rounding tool has helped to improve observations of patients at high risk of falls.
- Regular audit of identified elements of falls care bundles to confirm areas for improvement.

FallSafe Audits

The FallSafe leads have undertaken several audits including an “under reporting” audit, lying and standing blood pressure audit and a full care bundle audit. It is pleasing to note that 100% ward staff interviewed (10 staff on 20 wards) were confident that they themselves or a colleague reported the last patient fall that they were aware of on their ward

A full care bundle audit was undertaken (325 patients) in October 2012 and the results are demonstrated below:

Figure 8 – **Care bundle audit results**

Bell in sight and reach?	91%
Safe footwear on feet?	63%
Asked about history of falls?	97%
Asked about fear of falling?	89%
Urinalysis performed?	60%
Avoided night sedation last night? (‘Yes’ = not given, ‘No’ = given)	85%
Cognitive screen?	57%
Lying and standing BP recorded?	40%
Full medication review requested?	71%
Received all relevant bundle elements?	**24%**

Whilst many of the elements score highly only 24% of patients received all elements of the care bundle.

Since completion of the audit the group has worked with the charitable funds organiser to launch the silver slipper campaign and a trial is planned to supply slipper socks to patients who do not have access to safe slippers. Incorporation of the Abbreviated Mental Test Score (AMTS) within the new falls risk assessment has increased the percentage of patients who undergo a cognitive screen to 98%. Staff do feel that the opportunity to undertake a lying and standing blood pressure has been affected for elective patients who are admitted on the day of surgery via theatre, and this will be considered when reviewing the falls pathway.

Conclusion

The causes of falls are complex and older hospital patients are particularly likely to be vulnerable to falling through medical conditions including delirium, cardiac, neurological or musculo-skeletal conditions, and side-effects from medications, or problems with their balance, strength or mobility. Factors such as poor eyesight and

poor memory create greater risks when someone is out of their normal environment on a hospital ward. However patient safety has to be balanced with independence, rehabilitation, privacy and dignity – a patient who is not allowed to walk alone will soon become a patient who cannot walk alone.

Disappointingly the number of falls and the number of fractures sustained has increased however, as previously stated, 2012/13 data includes the community hospitals and the Trust treated an additional 7298 patients within the year. As in previous years falls at night and falls from bed have remained an issue which will hopefully improve following the purchase of new beds. The challenges in caring for confused patients will continue to increase and training and support is required for all staff. In addition, the use of therapeutic volunteers is soon to be piloted.

The purchase of flat lifting equipment will assist staff to recover patients who may have sustained a serious injury from the floor. Whilst staff training in the use of the equipment has commenced the process requires further discussion within the organisation.

Recommendations

- Continue to work towards full implementation of FallSafe but this will require firm commitment from all wards.
- Work with Quest falls circle to benchmark data and share best practice
- Complete review of falls management policy and patient pathway
- Explore opportunities for funding in-patient falls specialist nurse or physiotherapist
- Ensure that any trials are co-coordinated via the strategy group so that evaluations are shared and lessons learnt.
- Develop strategies to educate / enfranchise patients and their carers to assist with falls prevention.
- To implement actions from Rapid Response Report NPSA /2011 / RRR001 – essential care after an inpatient fall.

Overview of the FallSafe implementation across South Tees

(adapted from the FallSafe implementation document to reflect South Tees approach)

Executive board
Overall monitoring

Overall monitoring

Hospital wide falls leaders
Senior Nurse for Trauma
Clinical Lead for Falls
Elderly care Consultant

Planning, monitoring and feedback to executive board

Hospital falls strategy group
Clinical Matrons
AHP lead
Clinical leads
Patient and carer representative

- Responsible for falls prevention policy and documentation
- Link to existing targets and levers (eg CQUIN)
- Analysis of falls data – monitor for changes and investigate/act accordingly
- Agree and update action plan to improve implementation
- Recruit and monitor FallSafe leads
- Organise FallSafe leads training and peer support opportunities across the trust
- Promote hospital wide awareness of the project
- Monitor implementation of e-learning programme
- Step in to troubleshoot barriers that cannot be overcome at ward level
- Monitor equipment availability
- Act on new evidence/ alerts timely

FallSafe leads working group
FallSafe lead and deputies from each ward from each ward

- Initial training day
- E-learning programme completion
- Analysis of baseline audit
- Analysis of quarterly re-audit
- Review action plan to improve implementation
- Review of any RCA/SUI
- Monitor and analyse falls on ward level
- Feedback progress on each ward/ highlight issues
- Regroup every quarter for review and updates

FallSafe on their ward

- Promote FallSafe project on the ward
- Identify multi-disciplinary support team
- Complete audit as required
- Promote e-learning programme
- Be point of contact for each ward
- Implement changes as agreed within the group and by Falls Strategy group
- Inform and educate staff on the ward
- Be source of knowledge and support on the ward
- Share learning from working group training session

Implementation plan 30/06/13

(monitor against "Steps for Senior Management and FallSafe leads")

Element	Evidence	Actions required
Executive and non executive commitment to FallSafe	Complete with annual report and thematic analysis	Nil
Hospital falls prevention group	Established. Meeting quarterly	Completed
Involve patients and their carers	RCA are fed back to relatives	Ensure feedback trust wide. Patient advice booklet review Patient views/experiences after a fall Work with dementia team
Identify relevant targets	Regional targets	To be agreed
Identify leader/leads to drive an coordinate	Senior nurse for trauma and Clinical lead for Falls identified with elderly care consultant support	Nil
Understand what reported falls can tell you	Annual report in place PCH monthly report in place Falls data at ward level – KPI's are in staff rooms	Quarterly report to be developed with DATIX FallSafe leads to read falls description – gap in capacity to complete
Have a budget to overcome barriers to implementation	To work within existing budgets at present	Nil
Look for partner organisation who are also implementing FallSafe	Link with regional falls group – strong links already in place	Work with Quest Falls Circle
Make the 'Preventing falls in hospitals' e-learning accessible	Agreed as mandatory across the trust. Available on NMLS Accessibility at community hospitals addressed	Quarterly report on numbers completed
Choose your first FallSafe wards	Hospital wide implementation due to amount of previous work completed	
Recruit your FallSafe leads	Flyer sent out to ward managers Database of staff in place	To monitor attendance/participation.
Start succession planning		On hold
Make essential changes to documentation (to include care bundles)	Tool updated and being piloted. Planned roll out 01/10/12	Review of falls policy (including bed rails) needs finalising Review Matrons KPI's in line with new policy
Plan access to walking aids out of hours	Seven day working for physiotherapists in some areas Competencies developed for nurses in others	Need gap analysis – some wards have 7 day service Audit of problem ?access of equipment ? case managers
Communicating and promoting FallSafe to the whole hospital	Study day flyer sent out Poster for all areas Talking point	Staff briefing article Use of intranet/internet
Educating everyone who has a part to play	e-learning programme agreed SHO induction training Preceptorship training	Discuss with Hospital Strategy group – training matrix to be agreed Consider slips, trips and falls for all in CMAT Liaise with training leads
Plan your study days	Initial day planned (including suggested topics on page 19) Dates for future sessions agreed (as part of FallSafe working group)	Using baseline audits to plan topics
Steps for FallSafe leads	Introduced at initial training day and future sessions	
Audit implementation	Baseline audit agreed and to be repeated every quarter	Monitor tool and update as required