PATIENT SAFETY & CLINICAL RISK SUB-COMMITTEE	Date: Agenda Item:
REPORT TITLE:	Patient Falls Annual Report
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REPORT DISCUSSED PREVIOUSLY: (name of sub-committee/group & date)	Falls Strategic Group

Action Required:		
Approval (√)	**Discussion (√)**	**Assurance (√)**

Summary of Key Issues

This report provides information and assurance about progress with the Trust's fall prevention and management strategy in 2013/2014. In summary:

1. Identifies trends for falls in 2013/14 and 2012/13.
2. Number of falls reported has increased due to improved reporting (datix implementation) and raised awareness, from 1019 to 1094 however falls with harm have decreased from 330 to 301
3. There have been 0 deaths within 72 hours of fall, a much improved picture from 12/13. Nine deaths within four months of a traumatic fall have been reported, equivalent to 12/13; 24 serious harm falls have been reported, a decrease from 12/13.
4. Identifies key activities implemented in 2013/14
5. Provides evidence of progress made and actions taken
6. Identifies key areas for consideration 2014/15

In 2013/14

- No harm falls are more consistently reported: 10% increase from previous year
- 2012/13 objectives were met
- There is targeted strategy to managing falls based on understanding of the Trust falls risks which has promoted change to ways of working and the culture and understanding of patient falls. The development of the weekly Falls Board has improved and enhanced staff engagement.

Relationship to Trust Strategic Objectives & Assurance Framework:

SO1: Safe -Deliver safe services and be in the top 20% against our peers
SO3: Caring – Ensure patients are cared for and feel cared about

Corporate Impact Assessment:	
Legal and regulatory implications	Yes
Financial implications	Yes
Patient Experience/Engagement	Yes
Risk & Performance Management	Yes
NHS Constitution/Equality & Diversity/Communication	Yes

Attachments:

1. Executive Summary

In 2013/2014 there is evidence of a decrease in the trend of falls with harm (8.7%) although overall the number of falls reported indicates a rise (1019 12/13 to 1094 13/14). It must be noted that reporting of no harm falls has improved significantly showing a 10% rise. This is a positive step which was expected as a result of a greater focus on falls and allows the Trust to learn lessons in a proactive way thus reducing the number of falls with harm and repeat fallers.

Strategies implemented in latter part of 2013 are now being embedded within clinical practice and are affecting an improvement in how the Trust manages patient falls it is anticipated that this will result in a further reduction of patient falls in 2014/15. If the current trend of a 2% reduction in falls per month continues a 25% reduction in falls by quarter 4, 14/15 will be achieved.

In 2013/14 there were 1095 reported falls of which 301 resulted in harm; 19 were considered to be major harm. This can be compared to 2012/13; 1019 falls of which 330 resulted in harm; 15 were major harm

In 2013/14 the key objectives for falls management were

1. To better understand the Trust's patient fall profile.

2. To develop a realistic strategy to manage patient falls within the Trust.

3. To determine how the Trust compared nationally.

All these key objectives were met and the work undertaken throughout the year has resulted in a more cohesive, open and targeted approach to management of falls. As a result of the work undertaken to better understand the Trust falls profile it was noted that reporting of falls rose as staff awareness and understanding improved.

The Quality Account stated that the Trust would reduce patient falls by 50% this was not met. This can be attributed to a number of factors, of which increased awareness, better reporting and increasing patient acuity and volume (the addition of Copthorne/Charlwood/Escalation areas/Hazelwood) are significant.

Patient falls are graded as a 16 risk 13/14 on the Trust risk register this is a reduction from 20 12/13. As targeted solutions are embedded into practice and falls with harm reduce further it is anticipated that the risk rating will decrease further.

Key issues:

There have been a number of initiatives to manage patient falls implemented in 2013/14

1. Development of the Falls Prevention Strategy - this enabled the trust to have clear plan and framework for the patient falls within the Trust identifying 6 key areas for action.

2. Introduction of specific lead for patient falls – this gave a centralised over view of the falls within the Trust.

3. Introduction of equipment to manage risk for example crash mats, low beds, chair raisers and one way slides

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4. Review and re-launch of the Trust falls groups including the development of a weekly Falls Board to ensure lessons learnt were shared throughout the Trust and assisted with the inception and dissemination of new initiatives and strategies.

5. Introduction of targeted audits to monitor patient falls - these gave a clearer view of the effectiveness of falls prevention strategies and informed future actions.

6. Introduction of monthly falls clinic required by NHSLA, NICE and CQC.

7. Introduction of a falls ward round which facilitates targeted individualised plans of care.

8. Falls prevention training initiated for clinicians - improved understanding of falls management and consistency in embedding NICE guidelines. Doctors trained in 2012/13 (20); 2013/14 (112). Nurses, AHP's, NA's all receive training on the MAST programme.

9. Divisional Monthly Reports are now made available for analysis, action and monitoring. This provides the senior divisional teams with the opportunity to identify trends within their specialities and amend their actions plans accordingly with the support of the falls team.

10. Review of reporting systems – ensured a clearer view of the Trust falls and enabled structured approach to achieving Trust falls Strategy

11. Review of the inpatient Falls Pathway - bought the pathway in line with current NICE guidelines

12. Introduction of referral system for inpatients at risk of falling provided specialist resource and advice.

Audits undertaken have indicated that these initiatives have resulted in a raised awareness of falls and subsequently have promoted a change in culture and an increased understanding of individual accountability for the safety of the Trust patients. Falls with harm are escalated more promptly and any injuries manifesting later but linked to the fall are escalated. This practice provides a rich source of learning and has encouraged a culture of openness around falls and their management and the opportunity to develop new ways of working.

Recommendations :

That the PSRC approve the report and agree the key objectives for 2014/15

1. Reduce inpatient falls by 25% in year from 1095 to 822.

2. Review Falls Strategy and improve the use of targeted falls solutions to manage patient's fall risk

3. Embed the use of

- Stop and wait
- Forget- me- knot timers
- Postural BP guidance
- Post fall checks and use of the Abbey pain scale and SBAR to report falls
- Doctor's post fall sticker

4. Develop falls pathway within ED/AMU/SAU in line with NICE guidance to minimise unnecessary admission to hospital due to falls at home. Improving links and working with primary care partners

5. Audit and revisit the falls pathway with the new Consultant Nurse for Falls and Patient Safety.

6. Expand falls team remit to include CSS and therapists.

7. Develop system for identifying patients who are at risk of falling so that staff are alerted on any subsequent re admission within the year.

8. Continue to explore, evaluate falls prevention strategies and consider implementation with SaSH falls prevention strategy such as sensor alarms

9. Improve and develop a proactive system for the review and investigation of falls incidents. Introduce After Action review

10. Continue to work with the CCG and National forum for falls to develop standards for falls

management including defining avoidable and unavoidable falls , benchmarking standards and the development of falls KPI's

Report be submitted to the Safety and Quality Committee for assurance

2. Falls Trends

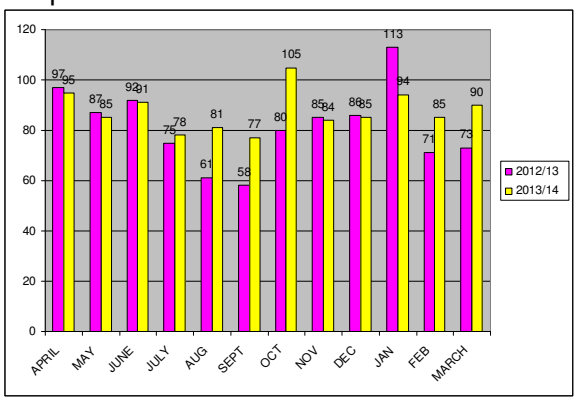
Falls trends for 2013/14 have been compared to trends for 2012/13.

All falls are reported via Datix incident reporting system. Before April 2013 the categorisation of patient falls was very broad and did not allow for targeted solutions to be developed or a clear understanding of what the falls risks were. The coding of patient falls has been reviewed to give a clearer understanding of the overall falls risks. This enhanced process has identified the need to develop systems and more targeted strategies to manage specific falls risks.

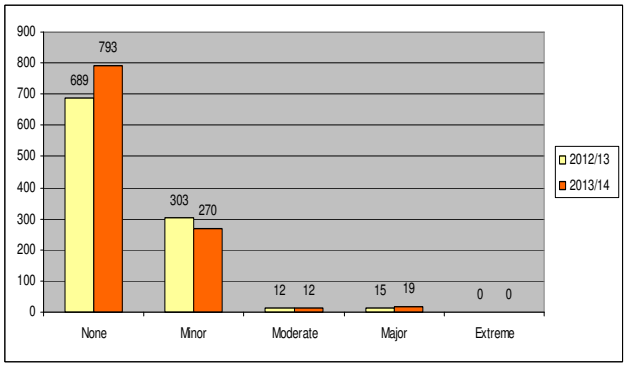
The reporting of patient falls has improved particularly falls which are un-witnessed and as can be seen there is less fluctuation in the number of reported falls monthly giving great assurance that falls are being reported more consistently (graph 1).

The percentage of falls with harm has decreased as no harm falls are now better reported. The apparent rise of falls with major harm is due to the changes in the parameters for considering an SI. (graph 2)

Graph 1

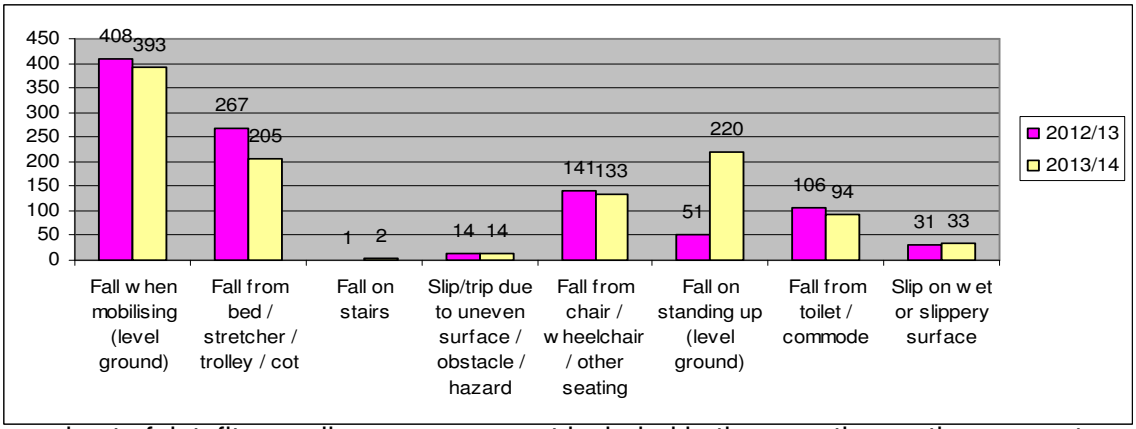


Graph 2



There is more consistent use of targeted patient falls management strategies being implemented based on the patient's type of falls risk rather than putting in management or preventative measures after the patient has fallen. Most notably 'falls from bed' have decreased since implementation of 40 low beds. (graph3)

Graph 3



Falls which are due to faint, fit, or collapse are now not included in the reporting as they are not considered true falls, this is constant with our neighbouring trusts. The NRLS still requires them to be recorded however and therefore they are documented on Datix for upload purposes only.

Consideration is being given to including a code of 'managed descent or controlled fall'. These type of falls result in no harm and are anticipated, they invariably occur during supervised rehabilitation or

when the patient is standing or mobilising under supervision. In this case the staff have a plan in place should the patient start to fall during care.

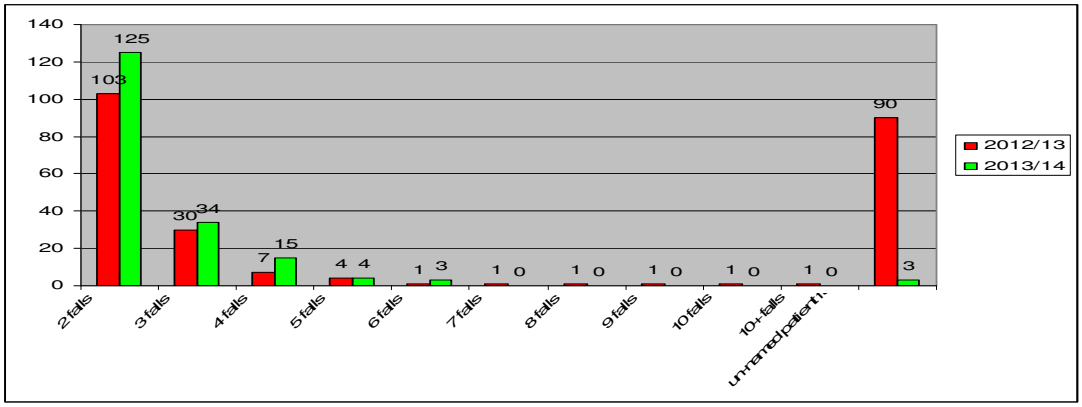
A review of the falls on standing and mobilising (604) was undertaken. Of these (112) were no harm falls classified as a managed descent. Benchmarking against other Trusts shows that many do not report this type of fall, however the NRLS still defines these as a fall and requires them to be reported thus the trust complies with that requirement.

Falls on standing and mobilisation continue to be the cause of a high number of falls. Audit of these falls indicates the root causes are:

- Unstable/unsteady or confused patients mobilising without assistance or supervision
- Patients mobilising without the identified walking aid as not available or out of reach
- Inappropriate or poor fitting foot wear or foot wear out of reach

As a result: the Stop and wait, Forget- me- knot timers and Postural BP guidance have been developed. Audits on foot wear, TED stockings with treads and provision and use of walking aids is planned for 2014/15 so that these specific areas can be targeted for improvement.

3 Patients Experiencing 2 or more falls



Patient falls being reported without the patients name are decreasing there were 3 in 2013/14 as opposed to 94 in the previous year. This is as result of the training undertaken by the risk department on the MAST training days and allows the Trust to identify repeat fallers.

Patients who experience more than two falls have risen slightly from 103 12/13 to125 13/14 as a result of the above. The maximum number of falls experienced by one patient in 2013/14 was 6 falls as opposed to an excess of 10 in 2012/13. It is notable that 73% of the patients had their second fall within 24 hours on being transferred from the ED/AMU/SAU. The 21 patients experiencing 4 of more falls were found to have had more than 2 ward moves and experienced at least 1 fall following each transfer. Working together with other initiatives in the Trust to ensure that patients are admitted to the right bed and are maintained on that ward for the length of their stay will help to reduce this statistic.

Of the 125 patients who had their first fall within ED, AMU or SAU departments 47% had that fall within 12 hours of admission. Of the patients who experienced two or more falls 60% had a history of multiple falls prior to admission or were admitted due to a fall at home.

3.1 Falls per 1000 bed days

	National average	2013/14	2012/13
Falls per 1000 Beddays	4.8	5.79	6.0
Falls with Harm per 1000 Beddays	1.0	1.58	2.92

Falls with harm per 1000 bed days are improving bench marking against other Trusts show that although still higher than average there has been a significant improvement

4. **SI Declared** (see Appendix 1 for list of SI's declared and description)

In 12/13 15 SI's were declared however there were 14 incidence of harm not declared as SI's which under the new reporting now would meet the criteria. SI's for 13/14 (24) are detailed in Appendix 1.

Injuries Sustained following Traumatic Fall

	2013		2014	
	SI's	Major Falls which would now be SI's	SI's	*denotes one patient who sustained both fractures during the one episode ** all four fractures were experienced by the same patient during one episode.
Fractured NOF	13	2	14	
Peri-prosthetic fracture		2	1	
Fractured pubic rami		4	*2	
Head injury	2	4	3	
Fractured humerus/ shoulder		1	*1	
Facial fractures		1	**4	
Fractured ankle	0	0	1	
Fractured ondontoid peg	0	0	1	

Known Deaths following Traumatic Fall

	Known death within 72 hours of fall	**Known death within 4 months of fall**	**Declared as SI**	**Coroners inquest**	**Referred to coroner by Trust**
2012/13	2	9	7	10	9 (1 By SGH)
2013/14	0	9	9	9	9

The analysis of Falls SI's has provided greater assurance that all falls resulting in serious harm are reported this is the first time this type of data review has been undertaken.

Trends Identified from SI investigation

i. Delayed or no assessment undertaken of patients risk of falling- ED has incorporated a falls risk assessment into their paper work/MAST training has been enhanced/Matrons audit regularly during Friday Focus.
ii. Unable to evidence falls solutions in place due to incomplete pathway - pathway has been adapted to ease the documentation of strategies used.
iii. Failure to follow the post fall protocol or inappropriate post fall pick up system used.- guidance and training is being provided on the how to check a patient effectively to help determine the appropriate recovery solution. In addition the message 'if in doubt then flat lift' is being reinforced.
iv. Quality, timeliness and effectiveness of post fall review by clinicians - training for FY1, FY2, staff grade and physician assistants is being developed and rolled out. Information for induction pack has been written and a doctors sticker is being piloted
v. Postural blood pressures not being done- a postural Bp protocol is being developed.

Positive lessons learnt

Staff implemented training effectively and well following a patient fall in a department which does not experience many patient falls (three in two years)

Staff are using the stretcher attachments more frequently where appropriate to recover a patient post fall

Proactive consideration of falls prevention and management strategies are evident

3. Training

For 2013/14 compliance for falls management training is reported by Education & Training as 40% (302 staff) however the falls team do not recognise the detail within the report as correct for qualified nurses HCA's and AHP and believe that many more staff have attended as the training is part of the MAST package. The data for 2012/13 is not available

Patient falls management training is part of the MAST training program, the yearly training content is determined by gaps identified through audit and SI investigations and any new changes implemented as a result.

4. Audit

Falls pathway audit (undertaken annually all patient areas)
Summary of findings

The Trust is compliant with key process for inpatient falls management for the majority of falls however improvement and further embedding of the process is required.

Awareness of the falls prevention lead post and how to contact them has improved following the roll out of the updated pathway as there is a prompt within the paperwork for referring patients as needed.

Low bed use (undertaken annually all low beds in use)

Overall the audit indicates that 30 low beds were used with patients at risk of falling who did not have a subsequent fall. Whereas in 9 cases they were only requested after the first fall. In 4 of these patients the falls beds were not used effectively and potentially use of low bed increased the likely hood of the patients who fell on standing.

There is need for further implementation of low beds but there is an equal need for training and education in the effective use of an ultra low bed in a targeted planned management strategy for a patient at risk of falls.

Blue pillow slips (under taken annually all patient areas)
This audit showed that the pillow slips are not used consistently and that there are not enough in circulation for this to be used effectively. Consideration is being given to replacing the identifier with an alternative. It is recognised that a patient at risk of falls will be identified with the use of the interactive white boards

4.1 Specific Audits planned for 2014/15 in addition to standard audits

An audit on the availability and number of walking aids available.
This will be a snap shot audit undertaken on three separate dates. Once reviewed by therapy staff a patient is issued with the appropriate type of walking aid. There have been reported incidents of:

- The walking aid being 'tidied' away form the patients bed area.

- Relatives/ patients being discouraged from bringing in the walking aid on the basis of lack of space or potential for the walking aid to be lost.
- Aids being shared between patients
- Therapists being asked not provided more than two aids per bay area.

Physiotherapist staff will be undertaking an audit of the physiotherapy post fall reviews to determine what actions need to be considered to improve compliance with this aspect of the post falls protocol and pathway.

An audit of the foot wear of patients will be undertaken looking at the use and fit of the slipper socks.

Conclusion

A decrease in the patient falls rate is beginning to become apparent. The changes made to systems such as the reporting process has improved understanding of the Trust patient's falls risk enabling the Trust to implement targeted strategies. It is notable that following the implementation of the low beds there was a decrease in falls from bed. By raising awareness and implementing strategies such structured ward rounds for ward visits it has been possible to target areas with a high falls rate and considered area based actions.

There have been a number of initiatives to manage patient falls implemented in 2013/14 as result of the clearer understanding. The initiatives have resulted in raising the awareness of falls and are encouraging a change in culture.

The Trust broadened the parameters for considering which falls with harm to raise as a serious incidents resulting in rich source of learning improving the culture of openness and development

Although there appears to have been apparent rise in falls these are being reported and falls with harm per 1000 bed days have significantly improved. It is apparent that ongoing work is required to continue this down ward trend however the Trust is now evidencing increased effectiveness in the management and prevention of inpatient falls. The Trust is more now proactively managing patient falls risk rather reactively.

The Trust is compliant with existing NICE guidelines for the management of inpatient slips trips and falls. Additionally the Trust is progressing well to meet additionally requirements and is improving falls management work in conjunction with healthcare partners.

Appendix 1 SI declared in year

ID	Location	Incident date	Description
51994	NEW	07/03/2014	Steis 2014/9199 Extension of fracture About 20 seconds after the patient has been checked by HCA on duty, we heard a loud sound and found patient on the floor. Un-witnessed fall. Patient sustained fracture of right leg.
47944	AMU	08/08/2013	Steis 2013/23823 Patient found sitting on the floor by the bed side. She denies any injury at the time of incident. X-ray showed fractured 'neck of femur' NOF.
50794	ANGIO	09/01/2014	Steis 2014/3338 Patient ready to go home and waiting to be collected by discharge lounge. Patient tried to get herself up out of the chair to use toilet and stumbled and fell forwards landing on her right hand side. Patient complaining of pain in right arm/shoulder and right leg. Patient taken for X-Ray of arm and leg - right humerus (upper arm) is fractured.
51915	AMU	04/03/2014	Steis 2014/8312 Patient had an unfitness fall, hit her head and sustained a small cut, bruised knee and pain in her right hip. X-ray hip showed fractured pubic rami, x-ray knee showed old fracture and CT head NAD. hip x-ray fractured pubic rami
46909	TILGAT	15/06/2013	Steis 2014/8229 Patient was found on the floor. He was walking around the bed and he reported to us that suddenly felt weak in his left leg and his legs just went. Doctor on call was present and checked the patient. Update 11.03.2014: Review of notes on receipt of complaint determined fall on 17/05/2013 unreported on incident reporting system. Opinion requested of approx age of fracture from image taken on 16/06/2013. Fracture approx one month old.
52135	ED	13/03/2014	Steis 2014/9211 Patient was visiting her husband who's also an inpatient. Patient was sitting in a wheelchair and had an unfitness fall. Sustained laceration on left side of face and was helped by 2 staff members to go back to wheelchair. Complaining of left hip pain.Fracture of left NOF.
48924	MEAD	05/10/2013	Steis 2013/30273 Fall with fracture of NOF. I was in Bay 2 when I heard a banging noise in Bay 3. I saw patient in 3D lying awkwardly on the floor near to his bed and he was asking for help (he wanted to go to the toilet and he didn't press the bell). I immediately called the staff nurse SR6 (assisting personal care) and the 'sister' came after 1 minute from Abinger Ward ('sister' was helping the staff nurse there doing drugs). Side rails 1 up and 1 down. Patient normally independent to walk with zimmer frame.

49855	GOD	19/11/2013	Steis 2013/35092 Fall with fracture of NOF Patient reported that he was trying to get up to go to the toilet and become unsteady and fell.
45898	LEI	21/04/2013	Steis 2013/21576 Patient sat in chair and decided to mobilise, unsupervised, with his zimmer frame. He was able to walk to the middle of the bay but then he fell to the floor. Update 24.7.13: Pt deteriorated and died - declared as SI - pt's death is subject to coroner's inquest.
48347	NEW	01/09/2013	Steis 2013/25906 FALL WITH FRACTURE Patient lost balance and fell. Patient sustained fracture of left hip.
48697	NUT	23/09/2013	Steis 2013/28119 Patient went to the toilet and on returning to her room she fell by her bed. The nurse heard patient calling and found her on the floor. Patient sustained fracture to right hip.
46961	TAND	18/06/2013	Steis 2013/19686 Fall with fracture. Patient was lying on her side on the floor when seen by the staff nurses and doctor.
50588	TAND	26/12/2013	Steis 2014/2558 At approx 18:00h, patient was being assisted from commode to chair by 2 members of staff, using her zimmer frame when she was lowered to her knees. Patient assisted to sit down on her bottom, called for help and transferred to bed. No signs or complains of pain. Patient was checked for injuries and assisted to her feet and into the chair, reviewed by doctor, X-Ray 2 days later showed fractured ankle.
48364	HAZEL	02/09/2013	Steis 2013/26111 Fall - Hazelwood fractured neck of femur (NOF) Patient was found on the floor in the corridor opposite to the toilet near to nurses station - an unfitness fall. X-ray revealed fracture of left hip.
49565	MEAD	06/11/2013	Steis 2014/15979 Patient was found on the floor next to his bed, urine on the floor. Patient alert and communicating. Unfitness fall. No obvious injuries seen. Felt a lump on the back of his head. Doctor made aware immediately. Falls protocol commenced stat.
52374	LEI	25/03/2014	Steis 2014/11759 Pt got up from bed, walked unaided across bay. He fell down as due to Parkinson's and dementia can be very unsteady on his feet. This morning (26th) patient complained of pain. X-Ray ordered and revealed fractured 'neck of femur'.
46696	CAPEL	04/06/2013	Steis 2013/17522 Patient fell after standing up from his bed and slipped to the floor. Patient is at high risk of falls and has advanced dementia.

51147	GOD	25/01/2014	Steis 2014/5005 Patient went to toilet. While coming back to her bed, she said that she felt dizzy and that she fell to the floor. No external injury noted. Patient complained of pain to right shoulder. Patient sustained fracture of the right clavical and hip.
52044	ABING	09/03/2014	Steis 2014/9176 Patient confused. Patient found on the floor. Transferred to bed. Complained of pain on the left hip. Did neuro observations. Doctor informed. Fractured NOF.
46521	BLETCH	24/05/2013	STEIS 2013/15881 While behind curtains attending to patient in the next bed, we heard a bang and came out to find patient on the floor, bleeding from left cheek bone and nose. Applied cold pack in an effort to stop bleeding. Observations checked. He was assisted to stand up and walk to his bed. Patient is confused.
50459	TILGAT	21/12/2013	Steis 2014/539I heard patient call out from bay c. Patient found on the floor facing down to the side of the bed in front of the chair. Post falls protocol actioned. Observations taken. Pain relief offered. HCA and staff nurse assisted patient to bed. Doctor informed. Neurological observations actioned. Patient sustained a fracture of left pubic rami.
51003	HOLM	19/01/2014	Steis 2014/3341 Patient came out from the room calling for help. I ran towards the patient. Before I arrived to patient she lost her balance, fell on the floor and became unresponsive. Patient sustained a skin tear to left elbow. Cardiac arrest call put out CT head showed significant acute on chronic sub dural collection.
48902	BLETCH	04/10/2013	Steis 2013/29253 Fall resulting in fractured NOF. Patient went to the toilet with assistance of health care assistant (HCA) and lost his balance hitting the wall with his shoulder and sliding down to the floor. The patient explained that the HCA was with him to the door to the toilet and then he said he could manage. He had his walking stick with him.
45747	NUT	13/04/2013	Steis 2013/12006 PATIENT FALL According to patient, she slipped whilst sitting on the stool. No injury observed. Patient hasn't complained of pain.