LEARNING FROM FALLS

SEPTEMBER 2023

IN THIS EDITION

The purpose of this Learning from Falls Newsletter, is to share information and key learning derived from adverse incidents of inpatient falls across HSC Trusts, which have been identified from post fall reviews. HSC Trusts are required to undertake a post fall review and submit a Shared Learning Form to the Public Health Agency (PHA), for any fall that has resulted in moderate, major or catastrophic harm.

HSC Public Health Agency

A thematic analysis was carried of all submitted Shared Learning Forms by HSC Trusts between the dates 1st April 2022 and 31st March 2023, received by the closing date of the 26th May 2023. Key themes have been identified and results compared with the results from a similar analysis last year, covering the period 1st April 2021 to the 31st March 2022.

Falls and fractures in older people are a costly and often preventable health issue. Reducing falls and fractures is important for maintaining health, wellbeing and independence amongst older people.

A fall is defined as an event which causes a person to, unintentionally, rest on the ground or lower level, and is not a result of a major intrinsic event (such as a stroke) or overwhelming hazard. Having a fall can happen to anyone; it is an unfortunate but normal result of human anatomy. However, as people get older, they are more likely to fall over. Falls can become recurrent and result in injuries including head injuries and hip fractures. A fall can lead to pain, distress, loss of confidence and lost independence.

Patient falls have both human and financial costs. For individual patients, the consequences range from distress and loss of confidence, to injuries that can cause pain and suffering, loss of independence and occasionally death. The costs to NHS organisations include additional treatment, increased lengths of stay, complaints and, in some cases, litigation. Falls are a major cause of disability and mortality. In addition, falls frequently bring about a fear of falling which increases risk and reduces independence.

KEY FACT

Falls are among the top 5 most frequent Adverse Incidents reported across Health and Social Care Trusts.

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Causes of Falls

The causes of having a fall are multifactorial – a fall is the result of the interplay of multiple risk factors. These include:

- Balance problems and muscle weakness
- A long-term health condition, such as heart disease, dementia or low blood pressure, which can lead to dizziness and brief loss of consciousness
- Visual and or hearing impairment
- Cognitive impairment
- Frailty
- Polypharmacy - and the use of certain medicines. For more information on the role that medicines can play in falls, and the importance of medication review, click here.
- Environmental hazards and a number of specific conditions

https://www.rcn.org.uk/clinical-topics/older-people/falls

KEY FACT

Falls are a regional Key Performance Indicator for quality and safety across the HSC.

Risk Assessments and Plans of Care

Risk assessments and plans of care relating to falls prevention must be **updated by nursing staff:**

- Weekly if no fall or change to condition/risk has occurred
- When a patient has a fall or near miss
- When a patient is found and a fall is suspected (unwitnessed fall)
- When a patient's risk factors or medical condition changes
- On transfer to another care setting

KEY FACT

About 1/3 of people over 65 fall each year and this figure is higher in the over 75s.

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The Shared Learning Form

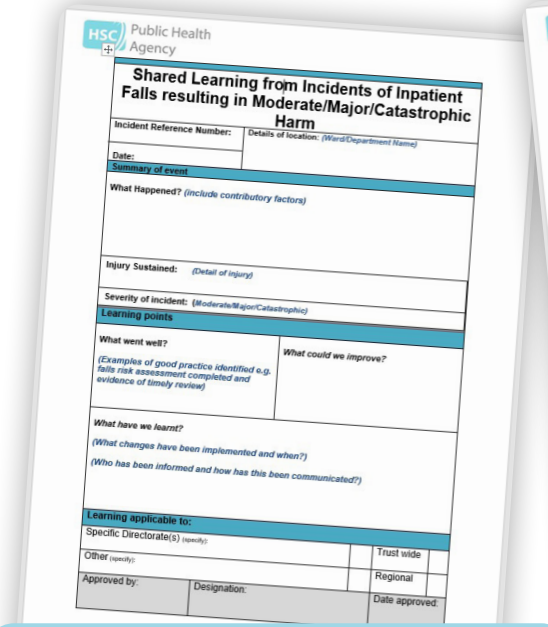
A **Shared Learning Form** is completed following a Post Fall Review to allow for **local learning** resulting in a change in practice and to reduce the incidence of future falls. For patients who fall in hospital, this form is then submitted to the PHA falls inbox falls.learning@hscni.net. This allows for a regional analysis of incidences where falls have occurred and for the sharing of this regional overview.

The information that follows is an analysis of the PHA Falls Inbox for the period 1st April 2022 to 31st March 2023, and includes inpatients and patients who have fallen in Emergency Departments.

KEY FACT

Falls make up half of the hospital admissions for accidental injury, especially hip fractures.

The new Regional Don't Fall Poster, developed by the PHA Inpatient Falls Prevention Group


Public Health Agency

Shared Learning from Incidents of Inpatient Falls resulting in Moderate/Major/Catastrophic Harm

Incident Reference Number:

Details of location: (Ward/Department Name)

Date:

Summary of event

What Happened? (include contributory factors)

Injury Sustained: (Detail of injury)

Severity of incident: (Moderate/Major/Catastrophic)

Learning points

What went well?

(Examples of good practice identified e.g. falls risk assessment completed and evidence of timely review)

What could we improve?

What have we learnt?

(What changes have been implemented and when?)

(Who has been informed and how has this been communicated?)

Learning applicable to:

Specific Directorate(s) (specify)

Other (specify)

Trust wide

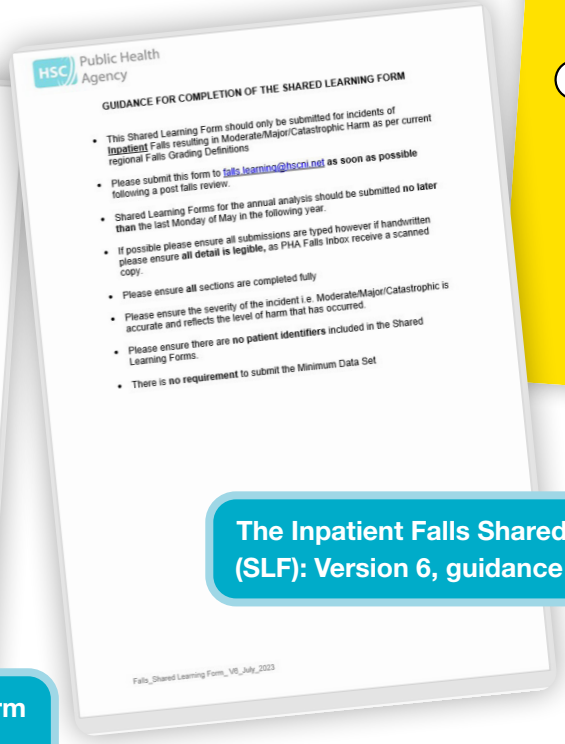
Regional

Approved by:

Designation:

Date approved:

The Inpatient Falls Shared Learning Form (SLF): Version 6, dated July 2023


Public Health Agency

GUIDANCE FOR COMPLETION OF THE SHARED LEARNING FORM

- This Shared Learning Form should only be submitted for incidents of Inpatient Falls resulting in Moderate/Major/Catastrophic Harm as per current regional Falls Grading Definitions
- Please submit this form to falls.learning@hscni.net as soon as possible following a post falls review.
- Shared Learning Forms for the annual analysis should be submitted no later than the last Monday of May in the following year.
- If possible please ensure all submissions are typed however if handwritten please ensure all detail is legible, as PHA Falls Inbox receive a scanned copy.
- Please ensure all sections are completed fully
- Please ensure the severity of the incident i.e. Moderate/Major/Catastrophic is accurate and reflects the level of harm that has occurred.
- Please ensure there are no patient identifiers included in the Shared Learning Forms.
- There is no requirement to submit the Minimum Data Set

Falls_Shared Learning Form_ V6_July_2023

The Inpatient Falls Shared Learning Form (SLF): Version 6, guidance documentation

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Key findings in relation to Inpatient Falls across HSC Trusts which resulted in Moderate/Major or Catastrophic Harm April 2022 to March 2023

- 156 falls reported this year (1st April 2022 to 31st March 2023) compared with 123 falls reported last year (1st April 2021 to 31st March 2022), a 27% increase
- There is less of a range between the number of shared learning templates submitted by Trusts, this year compared with last year, with NHSCT providing the largest number at 40 (32 last year), BHSCT 36 (38 last year), WHSCT 32 (15 last year), SHSCT 26 (8 last year) and SEHSCT 22 (30 last year).
- Analysis was carried out under 5 key themes 'What happened', 'What went well before the fall', 'What went well after the fall', What we could improve', 'What we have learned'.
- There was an increase in the amount of detail in the forms
- The majority of incidents reported were moderate, with 76, 63 were major, 5 were catastrophic, 8 did not complete the classification
- 5 catastrophic incidents were reported this year – the same number as last year
- Some forms submitted had incorrect grading of the Fall - The PHA Regional Inpatient Falls Group will be providing further clarity to the grading of falls and that should improve the grading of falls in the future

KEY FACT

20% of falls require medical intervention.

Table 1:
Number of Shared Learning Forms submitted per Trust April 2022 - March 2023

NHSCT	40
BHSCT	36
WHSCT	32
SHSCT	26
SEHSCT	22
Total	156

Chart 1:
Number of Templates submitted Per Trust for April 2022-March 2023

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Theme 1: What Happened?

Based on the information provided within the Shared Learning Forms (SLFs):

- 128 falls (82%) were unwitnessed
- 24 falls were witnessed (15%)
- 4 (2.5%) not stated, last year this was 4.5%
- 61.5% had a documented history of dementia, delirium or confusion, this was 53% last year
- 53% of the inpatients had a documented history of falls
- 51% were found on the floor compared to 47% last year
- 47% got up without the required assistance (38% last year) with a further 11% actively declined assistance (6.5% last year)
- 20% felt dizzy when standing and fell, (16% last year), this was often when they tried to mobilise without assistance to use the bathroom or after being assisted to the bathroom and left alone to respect their dignity, the patient then tried to mobilise independently to leave the bathroom
- 7% slipped and fell 7% (4% last year), often because of inappropriate footwear or no footwear
- 4% had started new sedation and this was seen as a contributing factor, whereas this was noted in 2% last year, one learning report noted the need to review the use of sedation at night as a learning outcome
- 4% were reported as falling while in isolation due to COVID, this may have occurred last year but wasn't noted

Table 2:

What happened April 2022 to March 2023?

What Happened?	Number of Patients
Unwitnessed Fall	128
Witnessed Fall	24
Delirium, confusion, history of Dementia	96
History of Falls	82
Found on floor	79
Patient got up without assistance and fell	74
Lost Balance	31
Fell out of bed/climbed out of end of bed	26
Declined Assistance	17
Fell out of Wheelchair/chair	12
Patient slipped and Fell	11
Patient on new sedation	7
Patient in isolation due to COVID	6
Section not completed	4
Tripped	3

KEY FACT

Over 3 million people in the UK have osteoporosis and they are at much greater risk of fragility fractures.

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Theme 2: Learning Points - What went well?

What went well before the fall - examples of good practice:

- 61% had their bed rails and moving and handling assessments completed on admission, (72% last year)
- 59% had a falls assessment (also 59% last year)
- 32% had a documented fear of falling assessment (13% last year)
- 30% had a Lying and Standing Blood Pressure noted as completed (20%, last year)
- 29% had an OT/Physiotherapy referral made (25% last year)
- 27% had a completed urinalysis (22% last year)
- 25% had appropriate CNS observations (26% last year)
- 23% documented that the patient advised to use the call bell (15.5% last year)
- 21% had a completed footwear assessment (17%, last year)
- 19% of reports highlighted the use of assistive technology, though in other cases it was also noted as being removed by the patient prior to falling and in another case, it was **not working** giving **false reassurance** to staff
- 17% had a request made for 1:1 supervision, as opposed to 16% last year, though sometimes a lack of staffing made it not possible to action this
- 6% mentioned the use of Fall Safe signage, this was 4% last year
- 4% of reports mentioned the patient was on the Delirium Pathway, this was not noted last year

It should be noted that significantly more of these patients may have had these assessments completed but it was not noted on the SLF.

Table 3:
What went well before the fall?
Examples of good practice

What went well? (Before the fall)	Number of patients
Moving handling/bed rails/completed/reviewed on admission	95
Falls Prevention Assessment completed	92
L/S BP completed and reviewed	47
Physio/OT referral/review	45
Urinalysis completed	40
CNS Observations	39
Patient advised to use call bell	36
Footwear Assessment completed on Admission	33
Fear of falling assessment	32
Assistive Technology used	30
1:1 supervision implemented	26
Fall safe signage displayed	9
Patient on delirium pathway	7

KEY FACT

Research has shown that falls can be reduced by 20-30% through multifactorial assessments and interventions.

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What went well <u>after</u> the fall: examples of good practice

- Informing next of kin 66% (55% last year)
- Timely assistance provided to the patient who had fallen in 54% (41% last year), with the identification of a possible fracture before mobilising in 42% (21% last year)
- A medical assessment was noted as completed in 52% (54% last year)
- An updated bedrails assessment was documented in 41% (50% last year)
- Updated moving and handling assessment in 39% (44% last year)
- Updated falls assessment in 39% (43% last year)
- CNS assessment was completed in 28% (28% last year)
- A cognitive assessment completed in 24% (26% last year)
- The patient moved to 1:1 or 2:1 care in 18% (30% last year)
- The call bell (button) being left within reach of the patient was mentioned in 17% (15% last year)
- Falls Team notified in 11%

KEY FACT

All falls cannot be prevented without unacceptable restrictions to patients' independence, dignity and privacy.

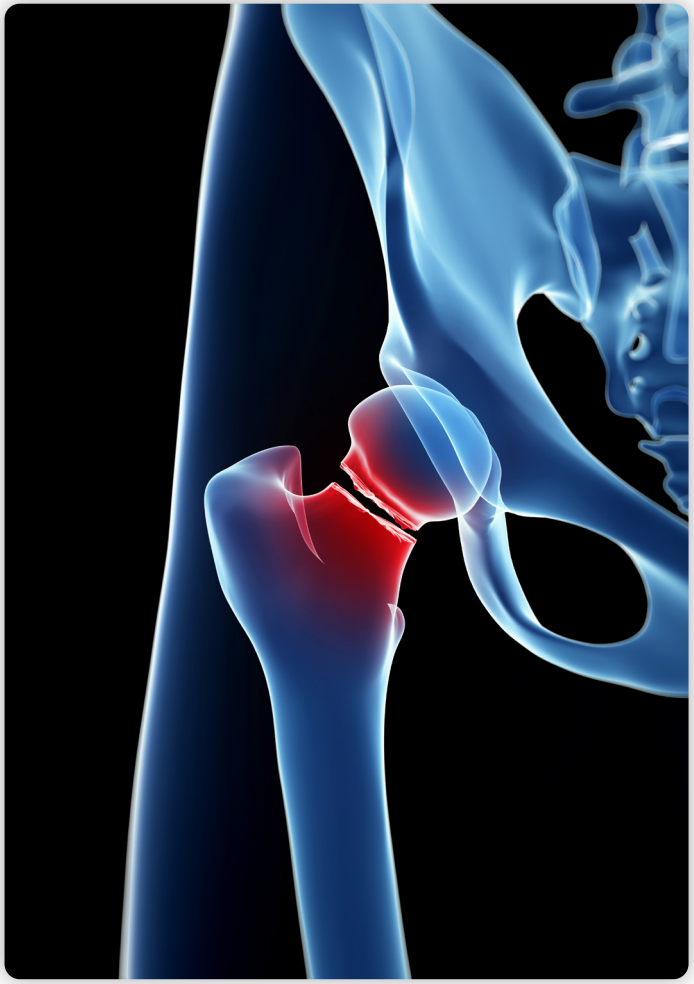

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Table 4:
What went well <u>after</u> the fall?
Examples of best practice

What went well after the fall?	Number of patients
Notifying NOK	103
Timely Assistance given to Patient	84
Medical assessment completed post fall	81
Possibility of fracture identified before mobilising the patient	65
Updated Bedrails Assessment	64
Falls Assessment updated	61
Updated Moving and Handling Risk assessment completed	61
CNS Assessment	44
Cognitive Assessment completed	38
Analgesia given	35
Patient moved on to 1:1 or 2:1 supervision	28
All details of the fall, outcome and plan were noted	28
Call Bell was in reach	26
Notifying Falls Team	18
Timely specialist advice sought	17
Medication review completed either pre or post fall	16
Patient observed from station	11
Falls Safety Cross completed	9
Good note taking	9
NEWS score noted	9
Eyesite tested by optometrist/referred	2
Post fall patient commenced on EPCO	1

KEY FACT

Hip fractures alone account for 1.8 million hospital bed days and £1.9 billion in hospital costs every year, excluding the high cost of social care.

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Theme 3: What Could We Improve?

Based on the information provided within the Shared Learning Forms (SLFs):

- 56% of forms identified issues with **fully and accurately completed documentation** (49% last year), the most common issue was omission, were there was a lack of documentation showing an assessment had been updated in line with Trust policy
- 49% highlighted issues with the CNS Assessment not being completed according to Trust Policy
- 48% highlighted issues with the falls risk assessment
  - the assessment was not documented fully
  - it was not reviewed as per Trust guidelines
  - it was not updated after the fall
- In 45% (41% last year) of cases, the Moving and Handling Care Assessment either needed updating or the patient should have been on a moving and handling care plan
- In 38% (25% last year) the patient was either not assessed for harm (spinal damage/fracture) before being moved from the floor, or this was not adequately documented
- 28% of notes (30% last year), **did not document the lying and standing blood pressure** or document why it could not be taken
- 27.5% (27% last year) of notes did not document the cognitive assessment being completed in line with the Trust guidelines
- 20.5% (23.5% last year) of notes had either poorly documented verbal or written guidance to patients around advice given on the risk of falling in hospital

  The Regional Inpatient Falls Prevention Group PHA, are currently working on the development and design of a new HSC Inpatient Falls Prevention Advice leaflet for patients and visitors
- 20.5% (12% last year) of returned forms noted issues with regards the medical assessments post fall i.e. not being completed, not using the correct form or issues with the fall's algorithm
- 19% (18% last year) mentioned issues with the patient's footwear assessment, either not assessed or poorly assessed, with issues being identified, but not then being actioned
- 16% (4% last year), noted that assistive technology should have been considered or used to help prevent the fall

For the **full list of areas** we could improve please see **Table 5.**

KEY FACT

Older people may remain in hospital for a number of weeks as a result of a fall, and at any one-time older people recovering from hip fracture require over 3,600 hospital beds in England, Wales and Northern Ireland.

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Table 5:
What could we improve?

What could we improve?	Number of patients
Poor terminology/documentation/Updating notes	87
CNS assessment post fall/not in line with policy	76
Fall risk assessments not completed/reviewed or updated	75
Moving and Handling assessment needs updated	71
The patient was not assessed for harm/spinal fracture/ injury before moving them from floor/Major trauma not involved if C-spine damage expected/not noted	60
No lying and standing BP on falls assessment documented and reason not given	44
Cognitive assessment should be completed/updated	43
There was no/poor documented verbal or written advice given to the patient about the risk of falling while in hospital	32
Medical assessment post fall/falls algorithm not completed	32
Patients footwear was not assessed	30
Bed rail usage post fall	32
CNS Observation must be completed	34
Did not use/consider Falls Assistive Technologies	25
Urinalysis not recorded	22
Staffing issues on ward	21
Remind all patients to use call bell/wear glasses not documented	20

What could we improve?	Number of patients
Bedrail usage reviewed post fall/no rational	19
Update Datix report for all incidents of falls	19
Record Blood Glucose post fall	18
Use Close Observation Form	17
Improvement in communication, reporting and action taken in a timely manner	16
Staff to Complete 'Fear of Falling' assessment	12
Patient should have been on 1:1/but not assessed/did not have available staff and did not ask family.	11
1:1 staffing requested but not available	9
The FallSafe coordinator was not informed of incident	8
Ensure NOK is informed/documented	7
Patient placed in side room without 1:1 or adequate checks	7
Investigation info including X-rays faster turnaround/ available for post fall review	6
Posey/Protab Alarm detached	5
Ensure access to walking aid if had previously	4
post falls update NEWS2 as well as PARIS	2
Ensure nursing staff made aware of falls risk at safety brief	2
Dementia Champions not/undocumented as used	1
Consider use of EPCO	1
Improve admission doc/to include history falling/fear falling	1
Assistive tech used but didn't work	1

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Theme 4: What Have We Learnt?

Trusts have systems in place to learn from falls, with 74% (75.5% last year) stating they use Patient Safety Forums, staff newsletter or staff briefings to share the learning. Other methods of sharing learning were broken down into:

- The creation of a falls notice board or posters
- The use of the boards or signage to identify patients at risk
- Ensuring staff have access to the most up to date trust fall policies
- Auditing areas identified as an issue in incident reports such as nursing assessment completion or bed rails usage

KEY FACT

90% of hip fractures are caused by a fall.

A variety of additional systems have been introduced at Trust level to help reduce falls with:

- 4 forms referring to the use or provision of training on the Cohort Baton scheme
- 2 forms referred to the use of a sticker on notes to highlight high risk patients
- 2 forms referred to the roll out of Reminiscence Interactive Therapy Activity systems (RITA)
- 1 refers to an SQE project taking place on the ward to reduce falls
- A further 3 forms (1 form last year) identified the need for staff training on, or use of the Dementia tool

KEY FACT

Around 50% of falls are preventable.

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Staff training was a key part of learning identified, with staff being encouraged to attend:

- Falls update training in 38% (33% last year)
- PACE training in 4.5%
- DATIX training in 4.5% (5.5% last year)
- Cohort Baton training
  PACE and Cohort Baton were not mentioned last year in this section
- Risk assessments need to be completed when there is any change in the patient's status and this needs to be correctly documented
- The need to document the patients **lying and standing** blood pressure, and if this is not possible then document why
- The importance of documenting factually in the nursing notes and Datix in 23%
- Reminding the patient to use the **call bell** and documenting this
- The use of **assistive technology** should have been considered in 16.5% (18% last year)
- Failure to complete or document the completion of the cognitive screening by Medical or OT staff was mentioned in 14% of cases
- The need to inform ward falls prevention champions or fall safe co-ordinators

The Emergency Department

Learning included:

- Overcrowding increases the risk of falls
- A need to consider the role of a patient's family in helping with confused patients in 2 cases
- The need for 1:1 staffing in Emergency Departments in 1 case

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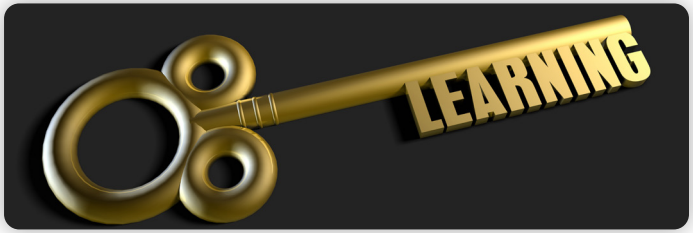
Table 6:



What have we learnt?	Number of patients
Learning from falls shared: at the 'patient safety quality network'/staff briefing/newsletter	116
Risk assessments should be repeated if there is any change in patient's status and correctly documented	73
Falls training/update sessions to be provided/staff encouraged to attend	59
Action plan completed (but not included with report)	40
importance of using/documenting appropriate post fall lifting equipment	37
importance of documenting factually in nursing notes and datix	36
All patients above the age of 65 should have a Lying/Standing blood pressure, recorded at the time of admission and if not then reason why noted	31
Remind all patients to use call bell and document	29
To remind staff to utilise resources available for patients who are high risk of falling. E.g. monitor or low entry beds.	28
Assistive Technology should have been considered/always connected up	26
Medical/OT staff need to complete cognitive screening	22
The importance of communication and relaying information promptly	15
Inform ward fall prevention champions/identify new champions	11
Appropriate pain medication post fall	11
Falls notice board/posters to be created	9
Encourage ward to use falls signage/Board to identify patients at risk of falls	9
Overcrowding of wards/ED increases the risks of falls	9
Audit to ensure completion of nursing assessments/Bed rail usage	8
Ensure Staff have access to updated Trust falls policies	8
All risk assessments must be completed within 6 hours of admission.	8
Ensure at risk Patients most visible from Nurse Stations	7
Ensure all staff have completed Datix training	7
Encourage staff to attend PACE training update.	7
Close Observation form needs to be completed re supervision	5
Dementia tool needs to be used/staff trained	3
A Falls care plan should have been implemented	3
RITA to be rolled out	2
Importance of notifying family/NOK/and documenting	2
Role for family with confused patients in ED	2
Use or training on Cohort Batton scheme	4
Use fall stickers on notes	2
Importance of reporting if patient later in pain post fall	1
Falls co-ordinators to develop CNS observation post fall for nurse	1
SQE project taking place in this ward to improve falls prevention	1
Need for 1:1 staff ED	1
Family may need assistance if taking patient of ward	1

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Conclusion

This Learning from Falls Newsletter September 2023 provides an overview of the key themes identified from inpatient falls which were classified as Adverse Incidents, in the period April 2022 to March 2023 and shared with the PHA, Safety, Quality and Innovation Team. This thematic analysis provides rich patient safety information in relation to falls prevention strategies for HSC Trusts to consider going forward; whilst recognising that so much good practice is also reflected in the key findings.

Please disseminate this Newsletter widely across your Organisation and share at Team Meetings/Safety Briefings, to support improvements in practice in relation to inpatient Falls Prevention Strategies.

KEY FACT

Falls are the leading cause of accidental death in Northern Ireland.

Coming soon, Regional Inpatient Falls Prevention Information booklet for Patients and Visitors

If you have any comments or questions related to Learning From... Falls please get in contact by email at falls.learning@hscni.net

References

- https://www.nidirect.gov.uk/articles/keeping-mobile-and-preventing-falls
- AGE UK
- RCN
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