LEARNING FROM FALLS

SEPTEMBER 2022

IN THIS EDITION

The purpose of this Learning from Falls Newsletter, is to share information and key learning derived from incidents of inpatient falls across HSC Trusts, which have been identified from post fall reviews, Serious Adverse Incidents (SAIs) and Patient Experience, as shared with Care Opinion.

HSC Health and Social Care

HSC Public Health Agency

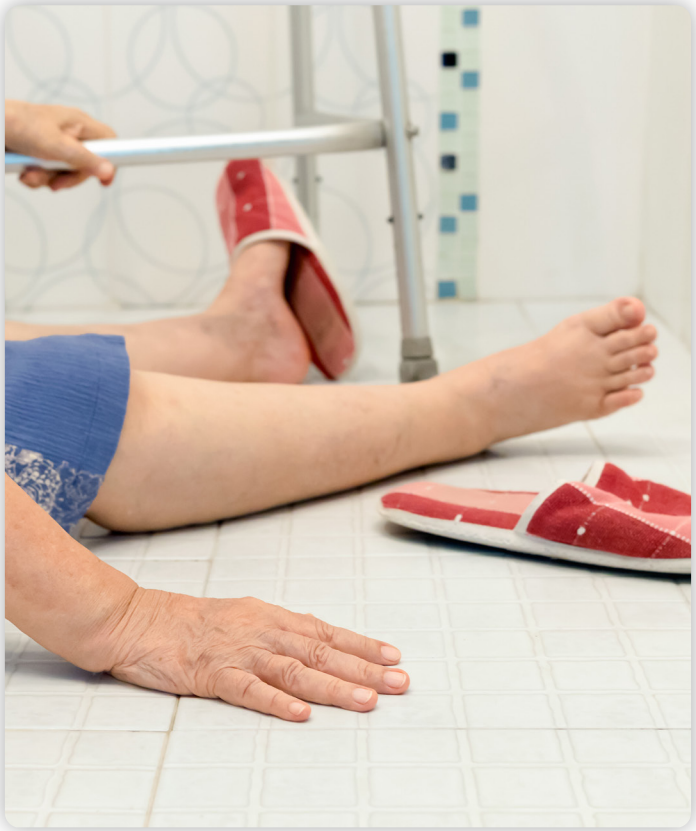
Falls and fractures in older people are a costly and often preventable health issue. Reducing falls and fractures is important for maintaining health, wellbeing and independence amongst older people.

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
- Cognition
- Frailty
- Polypharmacy - and the use of certain medicines
- 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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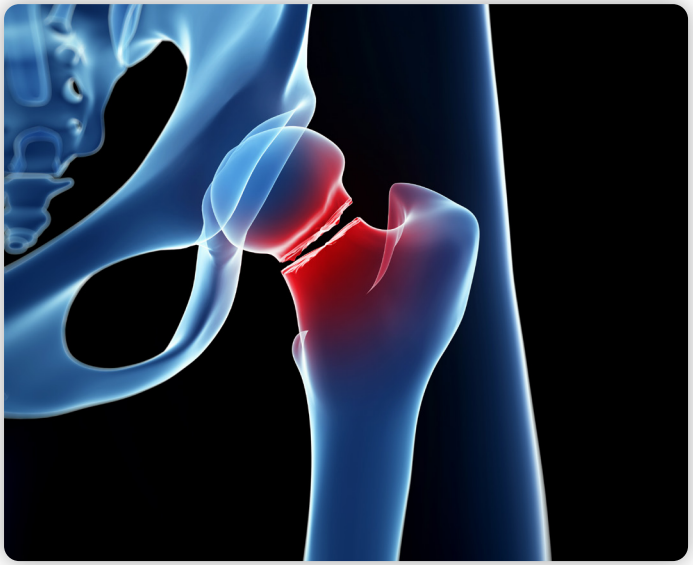
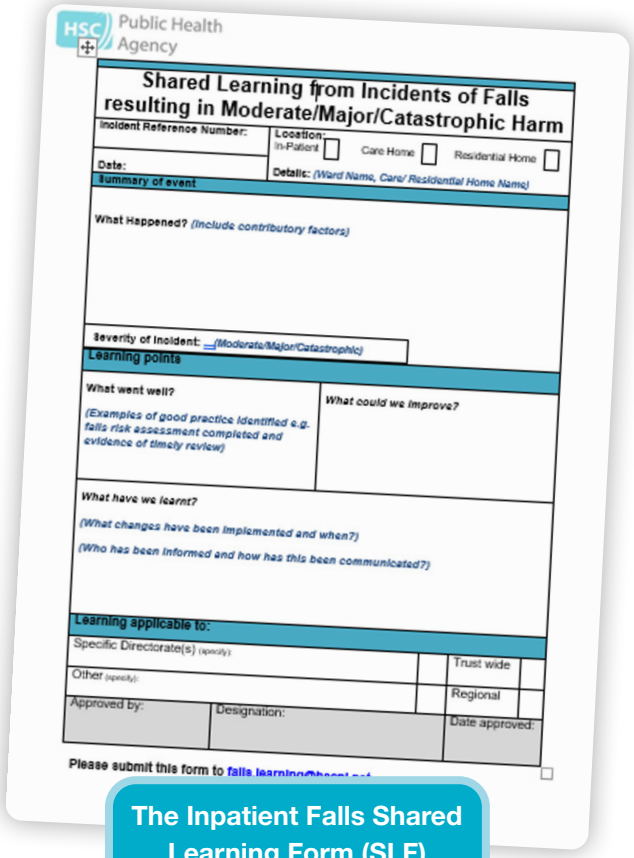
Thematic Analysis of Shared Learning Forms from Incidents of Inpatient Falls Resulting in Moderate / Major / Catastrophic Harm

HSC Trusts are no longer required to report inpatient falls that have resulted in moderate, major or catastrophic harm as a Serious Adverse Incident (SAI), unless serious care or service delivery issues are identified from the initial post fall review; instead inpatient falls are classed as **Adverse Incidents** and a timely Post Fall Review is completed internally. The aim of this is to allow for local learning resulting in a change in practice, to reduce the incidence of future falls.

A **Shared Learning Form** (SLF) following a Post Fall Review is then submitted to the PHA falls inbox falls.learning@hscni.net. This allows for a regional analysis of incidences were falls have occurred and for the sharing of this regional overview. The information that follows is an analysis of the PHA Falls Inbox in the period April 2021 to March 2022.





HSC Public Health Agency

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

Incident Reference Number: | Location: In-Patient ☐ Care Home ☐ Residential Home ☐

Date: | Details: (Ward Name, Care/ Residential Home Name)

Summary of event

What Happened? (Include contributory factors)

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) | Trust wide ☐

Other (specify) | Regional ☐

Approved by: | Designation: | Date approved:

Please submit this form to falls.learning@hscni.net

The Inpatient Falls Shared Learning Form (SLF)

KEY FACT

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

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Overview of Information Received April 2021-March 2022

- 109 falls reported April 2020-March 2021 compared to 123 reported in April 2021-March 2022
- 122 of the 123 Shared Learning Forms (SLFs) had all sections completed
- Number of SLFs submitted to PHA varies across Trusts; with 6.5% from the Southern, Belfast 31%, Northern 26%, SET 24.5%, and Western 12%*
- 5 catastrophic falls in April 2021-March 2022
- 71% of falls were unwitnessed
- 24.5% witnessed
- 4.5% were not clarified in the SLFs (templates), some of the witnessed inpatient falls were by patients, and some were while the patient was on 1:1 (16% of the witnessed falls).

*SHSCT did submit further SLFs outside the deadline for inclusion in this analysis

KEY FACT

20% of falls require medical intervention.

Table 1:
Number of Shared Learning Forms (templates) submitted per Trust April 2021-March 2022

NHSCT	32
BHSCT	38
WHSCT	15
SHSCT	8
SEHSCT	30
Total	123

Chart 1:
Number of Shared Learning Forms (templates) submitted per Trust April 2021-March 2022

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Theme 1: What Happened to the Patient?

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

- 56% of the inpatients had a documented history of falls
- 53% of inpatients had a documented history of dementia, delirium or confusion
- 47% of inpatients were found on the floor. SLFs document that 18% fell out of bed, on some occasions out the bottom of the bed
- 12% of inpatients slipped out of a wheelchair or hospital chair
- 16% of inpatients lost their balance while standing

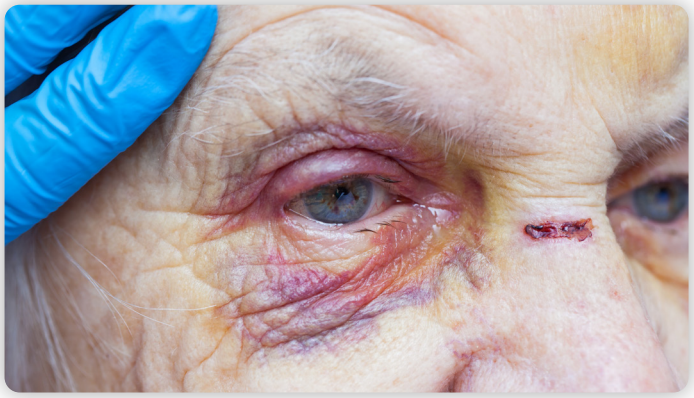
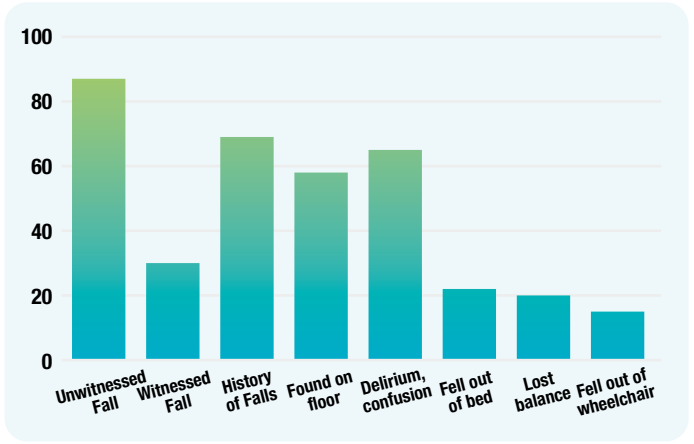


Table 2:
What happened to the patient?

What happened to the patient?	Number of patients
Unwitnessed Fall	87
Witnessed Fall	30
History of Falls	69
Found on floor	58
Delirium, confusion, history of Dementia	65
Fell out of bed / climbed out of end of bed	22
Lost Balance	20
Fell out of Wheelchair / chair	15
Declined Assistance	8
Tripped on lip of door / item on floor / trousers fell down	5
Patient got up without assistance and fell	10
Patient slipped and fell	5
Patient on new sedation	3
Section not completed	1

Chart 2:
What happened to the patient?



N.B: See table for full detail

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 best practice:

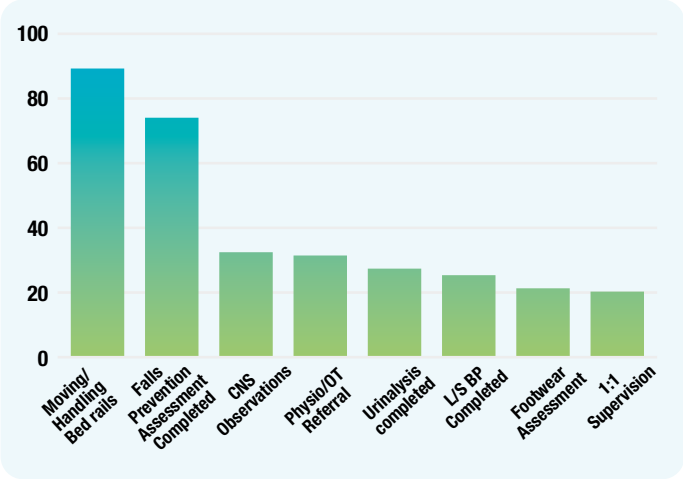
- 72% of inpatients had a bed rails and moving and handling assessment completed on admission
- 59% of inpatients had a falls assessment completed
- Other examples of good practice commonly reported were:
  - CNS observations completed in 26% of inpatients
  - OT/Physiotherapy referrals 25%
  - Urinalysis completed in 22% of inpatients
  - Lying and standing blood pressure in 20% of inpatients
  - Footwear assessment in 17% of inpatients
  - 1:1 supervision implemented in 16%
  - Patient advised to use the call bell 15.5%
  - Fear of falling assessed 13%
  - Fall safe signage was displayed 4%

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?

What went well? (Before the fall)	Number of patients
Moving handling / bed rails completed / reviewed on admission	88
Falls Prevention Assessment completed	73
CNS Observations	32
Physio / OT referral / review	31
Urinalysis completed	27
Footwear Assessment completed on Admission	21
1:1 supervision implemented	20
L/S BP completed and reviewed by medical team	25
Patient advised to use call bell	19
Fear of falling assessment	16
Fall safe signage displayed	5

Chart 3:
What went well before the fall?



NB: See table for full detail.

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What went well <u>after</u> the fall…
Examples of best practice:

- Informing next of kin (55%)
- Medical assessment completed (54.5%)
- Updated bedrails assessment (50%)
- Updated moving and handling assessment (44%)
- Updated falls assessment (43%)
- Timely assistance given (41%)
- Falls team notified (31%)
- The patient was moved to 1:1 or 2:1 supervision (30%)
- Cognitive assessment completed (26%)
- Risk of fracture identified prior to moving the patient (21%).
- Call bell being within reach (15%)
- All details of the fall plan updated (12%)
- Good record keeping (6.5%)

KEY FACT

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

KEY FACT

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

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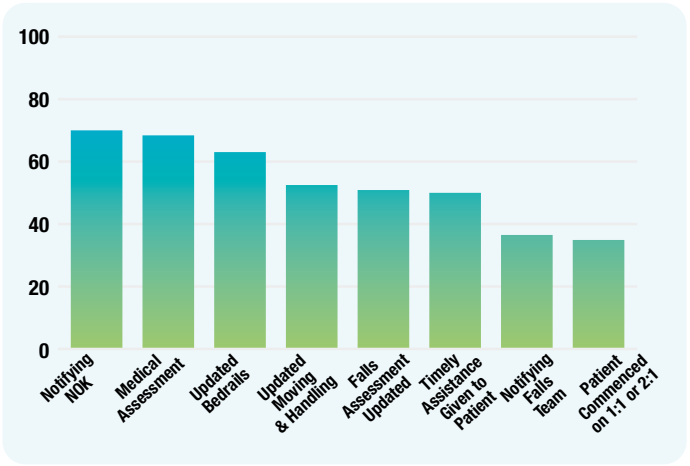
Table 4:
What went well <u>after</u> the fall?
Examples of best practice

What went well after the fall?	Number of patients
Notifying NOK	68
Medical assessment completed post fall	67
Updated Bedrails Assessment	62
Updated Moving and Handling Risk assessment completed	54
Falls Assessment updated	53
Timely Assistance given to Patient	50
Notifying Falls Team	38
Patient moved on to 1:1 or 2:1 supervision	37
CNS Assessment	34
Possibility of fracture identified before mobilising the patient	26
Cognitive Assessment completed	32
Call Bell was in reach	19
All details of the fall, outcome and plan were noted	15
Good record keeping	8

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



NB: See table for full detail

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):

- Almost half of the SLFs (49%) state issues with nursing documentation, whereas only 6.5% had reported good documentation, with a further 12% noting all details of the fall, outcome and plan, as being completed well.
- In relation to documentation, the more common issue was omission, were there was a lack of documentation showing an assessment had been updated in line with Trust policy or why an assessment could not be performed.
- Of the 60 reports highlighting **incomplete documentation**:
  - 58 highlighted issues in relation to an incomplete falls risk assessment
  - 51 highlighted incomplete moving and handling
  - 37 highlighted no lying and standing BP
  - 33 no cognitive assessments
  - 32 no documentation in relation to bed rail usage post-fall
  - 31 highlighted lack of assessment prior to moving the patient
  - 29 noted poor documentation regarding the verbal or written advice given to patients regarding falls
  - 24 highlighted lack of updating Datix or the lack of information on Datix
  - 23 highlighted a lack of CNS assessments
  - 22 highlighted a lack of footwear assessments.
  - 17 SLFs indicated urinalysis results not noted
  - 16 noted next of kin not being informed.

For the full list of areas that could be improved 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	60
Fall risk assessments not completed/reviewed or updated	58
There was no / poor documented verbal or written advice given to the patient about the risk of falling while in hospital	29
Moving and handling assessment needs updated	51
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	31
No lying and standing BP on falls assessment documented and reason not given	37
CNS assessment post fall/not in line with policy	23
Bed rail usage post fall	32
Update Datix report for all incidents of falls	24
Cognitive assessment should be completed/updated	33
CNS Observation must be completed	34
Patients footwear was not assessed	22
TED stockings without footwear / no footwear	11
Improvement in communication, reporting and action taken in a timely manner	11

What could we improve?	Number of patients
Ensure NOK is informed / documented	16
Medical assessment post fall / falls algorithm not completed	15
Urinalysis not recorded	17
Remind all patients to use call bell/ wear glasses / not documented	15
Ensure nursing staff made aware of falls risk at Safety Brief	13
Record Blood Glucose post fall	13
Staff to Complete 'Fear of Falling' assessment	8
1:1 staffing ineffective	9
Use Close Observation Form	5
Patient should have been on 1:1 / but not assessed / did not have available staff and did not ask family.	8
Sensor would have alerted staff before fall	5
Staffing issues on ward	5
Investigation info including X-rays faster turnaround / available for post fall review	6
Patient without 1:1 when it was needed	5
Additional Physio input needed	3

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Theme 4: What Have We Learnt?

Shared Learning Forms (SLFs) submitted to PHA clearly indicate that HSC Trusts have systems in place to learn from falls, with 76% stating they use Patient Safety Forums, staff newsletters or staff briefings to share the learning. Other methods of sharing learning are falls notice boards or posters (15%), ensuring staff have access to the most up to date Trust Fall policies (11%) and auditing areas identified as an issue in incident reports (9%), such as documentation in relation to patients who have fallen.

The main learning is that risk assessments need to be completed when there is any change in the patient's status and this needs to be correctly documented, which was identified in 48% of SLFs.

Other learning includes the ongoing need for falls prevention training or updates (33%) and that staff need to be encouraged to attend these.

All patients over 65 should have a lying and standing blood pressure assessment and if this is not possible it needs to be documented (20%). Staff need to utilise the resources available to them such as low entry beds and monitors (19.5%), and also consider other assistive technology (18%). The sharing of information promptly was identified in

19% of cases and informing the falls prevention champions or identify new champions was identified in 17% of SLFs. It should be documented that patients have been advised to use the call bell (18%).

Less commonly raised learning points include the importance of ensuring the next of kin is informed (15%), ensuring the most at risk patients are visible from the nursing station (11%), appropriate medication post fall (11%), a falls care plan should have been implemented (9%), all risk assessments must be completed within 6 hours of admission (9%), all staff need to complete Datix training (6%) and all patients undergo a medical review post a fall (5%). The complete list can be seen in **Table 6.**

KEY FACT

Around 50% of falls are preventable.

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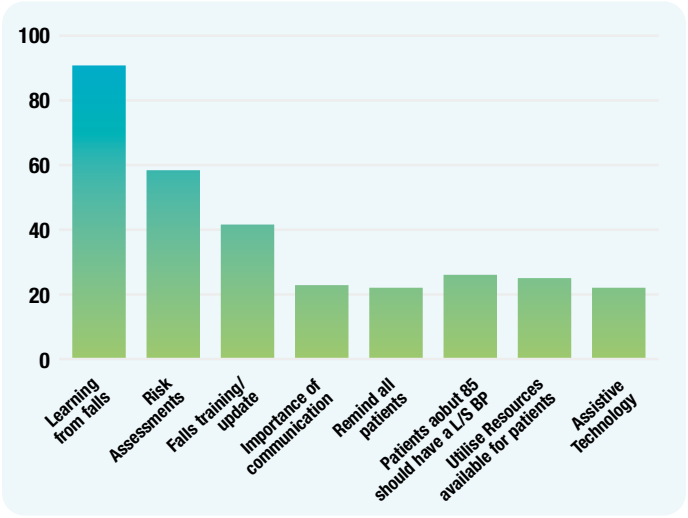
Chart 5:
What have we learnt?



NB: See table for full detail.

Table 6:
What have we learnt?

What have we learnt?	Number of patients
Learning from falls shared: at the 'patient safety quality network' / staff briefing / newsletter	93
Risk assessments should be repeated if there is any change in patient's status and correctly documented	59
Falls training / update sessions to be provided / staff encouraged to attend	41
The importance of communication and relaying information promptly	23
Remind all patients to use call bell and document	22
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	25
To remind staff to utilise resources available for patients who are high risk of falling. E.g. monitor or low entry beds	24
Assistive Technology should have been considered and always connected up	22
Importance of notifying family / NOK / and documenting	18
Inform ward fall prevention champions / identify new champions	21
Falls notice board/posters to be created	18
Appropriate pain medication post fall	13
A Falls care plan should have been implemented	12
Ensure at risk Patients most visible from Nurse Stations	13
Audit of note taking for 1 week / 10 patients who fell	11
Ensure Staff have access to updated Trust falls policies	13
All risk assessments must be completed within 6 hours of admission	11
Medical staff need to review patients post fall	6
Ensure all staff have completed Datix training	7
Close Observation form needs to be completed re supervision	3
Dementia tool needs to be used / staff trained	1

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Learning From Falls that have been classified as a Serious Adverse Incident

An inpatient fall can be categorised as a **Serious Adverse Incident (SAI)** if the subsequent internal review identifies:

- Serious care or service delivery issues in the treatment.
- Learning that needs to be reviewed through the serious adverse incident process.

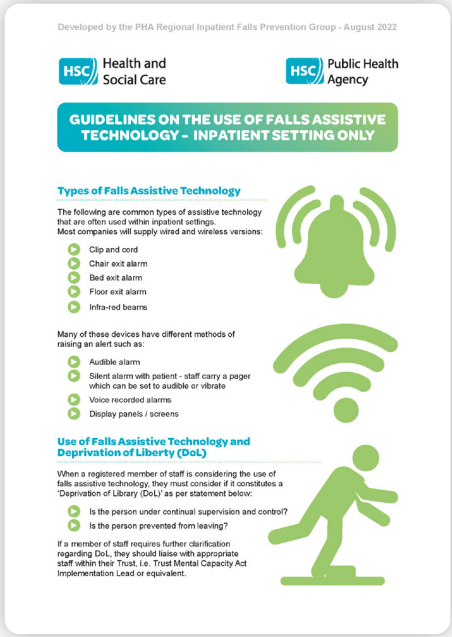
What follows is a brief outline of three SAIs to identify learning specifically relating to falls. A brief description of each of the cases and key learning identified through the local serious adverse incident review has been described below.

Case One: An older patient attended the ED with pleuritic chest pain and shortness of breath. The patient was reviewed by the cardiology team and was considered not suitable for transfer, for Percutaneous Coronary Intervention. The patient was treated for atrial fibrillation (AF) and acute pulmonary oedema, with intravenous frusemide, morphine and metoprolol and was subsequently transferred to the Coronary Care Unit. The patient deteriorated and treatment options were discussed with family and a ceiling of care agreed with a DNACPR (Do not attempt Cardiopulmonary Resuscitation) put in place.

Nursing staff documented that the patient was alert and orientated however the patient's family reported they had been confused at home during the night. The patient would not attempt to get out of bed without assistance. That evening the patient was found lying on the floor beside their bed. A CT brain scan was completed which showed widespread subarachnoid haemorrhage and subdural haematoma. The Regional neurosurgical team were contacted; however, the patient was not suitable for surgical intervention. The patient died one week later.

KEY LEARNING IDENTIFIED DURING THE SAI REVIEW:

- Consideration must be given to the patient's placement within the ward, to enable closer observation.
- Consideration should have been given with regards the use of a low bed and potential use of Falls Assistive Technology.
- There was communication with family. However, the review highlights the need for clear communication, with staff being mindful of the use of terminology.


Developed by the PHA Regional Inpatient Falls Prevention Group - August 2022

HSC Health and Social Care

HSC Public Health Agency

GUIDELINES ON THE USE OF FALLS ASSISTIVE TECHNOLOGY – INPATIENT SETTING ONLY

Types of Falls Assistive Technology

The following are common types of assistive technology that are often used within inpatient settings. Most companies will supply wired and wireless versions:

- Clip and cord
- Chair exit alarm
- Bed exit alarm
- Floor exit alarm
- Infra-red beams

Many of these devices have different methods of raising an alert such as:

- Audible alarm
- Silent alarm with patient - staff carry a pager which can be set to audible or vibrate
- Voice recorded alarms
- Display panels / screens

Use of Falls Assistive Technology and Deprivation of Liberty (DoL)

When a registered member of staff is considering the use of falls assistive technology, they must consider if it constitutes a "Deprivation of Library (DoL)" as per statement below:

- Is the person under continual supervision and control?
- Is the person prevented from leaving?

If a member of staff requires further clarification regarding DoL, they should liaise with appropriate staff within their Trust, i.e. Trust Mental Capacity Act Implementation Lead or equivalent.

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Case Two: The patient had a fall returning from the bathroom while on the ward and sustained a right humeral fracture and undisplaced fracture of their right sub-trochanteric upper femur, extending to the base of the greater trochanter. The patient also sustained an un-displaced fracture of the right pubic rami and later passed away.

KEY LEARNING IDENTIFIED DURING THE SAI REVIEW:

- All nursing documentation, including risk assessments to be updated within 24hours of transfer to another ward. Need for registered nurse signature to confirm that assessment has been reviewed or no change to existing assessment.
- Clarity is required in relation to what is meant by close supervision / minimal assistance of 1, assistance of 1 when mobilising.
- Nurses to record lying and standing Blood Pressure in patients who are at risk of falls. If patient is unable to have procedure carried out this should be recorded in the nursing record.
- Older Person's Assessment Liaison Practitioner (OPALS) to record if no assessment completed and the reason for not assessing mobility, rather than state appears to be at functional baseline.

Case Three: The patient was day 7 post left hip surgery (Enoxaparin 40mg at night) and conservative management of a fractured left humerus following a fall at home. At midnight the patient was found lying on the floor with a laceration to their head which was actively bleeding. The patient was assessed and deemed safe to transfer back into bed. The head wound was cleaned, dressed and steri-strips were applied. Post head injury Glasgow Coma Scale (GCS) observations commenced at 15-minute intervals. Initially the GCS was 15/15 and it was noted that patient was alert and coherent. Less than 2 hours later the head wound began bleeding heavily and a pressure dressing was applied, patient became unresponsive GCS 3/15 and NEWS 8.

A CT scan of the brain showed a large right-sided subdural bleed with midline shift. The scan result and the patient's condition were discussed with the Regional Neurosurgical team who advised the patient was unsuitable for intervention. On discussion with the family a DNACPR was put in place and the patient died a short time later.

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KEY LEARNING IDENTIFIED DURING THE SAI REVIEW:

- The patient had a Falls Assessment completed on admission which noted having a call buzzer within their reach, bedrails to be in-situ and the area around the bed to be kept clutter free. All these falls prevention measures were in place at the time of the fall. The patient was not able to mobilise independently in and out of bed.
- It is uncertain to the exact cause of the fall which was unwitnessed, but it is likely based on patients account that they may have fallen as a result of mobilising without assistance to the bathroom. The falls preventive steps were in place at the time with the exception of footwear, which would have required assistance of staff to put on.
- On review of the post fall episode, the Inpatient Post Fall Medical Algorithm was followed appropriately.
- Although it would not have altered the outcome for the patient, the incident highlights how a significant injury can result from a relatively minor fall, particularly in a vulnerable group and reinforces the need for careful assessment, continued observation and adherence to the post falls protocol.

KEY FACT

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

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Care Opinion

Care Opinion
What's your story?

After a fall at work I attended CAH ED due to head injury. I want to compliment all the staff I came in contact with in the department, the care and support I received was professional and of the highest standard.

I had occasion to be referred to Daisy Hill ED recently following a fall and I cannot begin to explain the professional attention that I received from Dr Anil and Sr Geraldine. The dignity and kindness I was afforded was outstanding and for this I am very thankful and deeply appreciative. Further referral for X-ray, MRI and Spinal Specialists was so efficient with follow up from ED Dr's and Dr Anil was greatly appreciated; a truly great service provided by fantastic people. Thank you all.

My mother stayed in ward 1a. We both found the staff upbeat, approachable and friendly. I was given regular updates on her general condition and rehabilitation. My main thanks go to the physios, Ryan and George in particular, who were friendly, supportive and encouraging. Mum is now back to what she was prior to her fall. I can also see her mood is getting better too. Thanks, from the family for your professionalism and dedication so clearly seen in your work, especially Aneka who was Mum's named nurse.

"Following a fall, I was seen at ED Antrim Area Hospital. I had an x-ray, diagnosis, plaster fitted, blood tests done and results checked in a timely manner for such a busy department. I was also seen at fracture clinic at Whiteabbey Hospital out patients department. I cannot speak highly enough about their organisational skills. In both departments I was treated with respect and kindness, and I know the treatment I received was delivered safely."

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Summary

This Learning from Falls Newsletter provides an overview of the key themes identified from inpatient falls which were classified as Adverse Incidents, in the period April 2021 to March 2022 and shared with the PHA Safety/Quality/Experience 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 best practice is also reflected in the key findings.

Key learning has also been shared in relation to inpatient falls that have been classified as Serious Adverse Incidents which can provide areas of focus for improvement. The patient experience of falls has been highlighted through the sharing of feedback provided on the Care Opinion platform. This Learning From Falls Newsletter will support embedding Regional Learning in relation to inpatient falls and be used to support initiatives for quality improvement in relation to falls prevention across HSC Trust inpatient settings.

KEY FACT

90% of hip fractures are caused by a fall.

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

Additional Reading

- **Wider impacts of COVID-19 on physical activity, deconditioning and falls in older adults. (n.d.). [online] Available at: www.gov.uk/government/publications/covid-19-wider-impacts-on-people-aged-65-and-over.**

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