Oxford University Hospitals
NHS Foundation Trust

Cover Sheet

Trust Board Meeting in Public: Wednesday 28 September 2022

TB2022.070

Title:	**Learning from patient falls – making a difference**

Status:	**For Discussion**
History:	**A patient story and perspective is presented at each Trust Board**

Board Lead:	**Chief Nursing Officer**
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Confidential:	**No**
Key Purpose:	**Performance**

Executive Summary

1. The purpose of the paper is to
    - share the patient stories behind the incident investigations into patient falls
    - Introduce the work of the Harm Free Assurance Forum and specifically the Trust wide activity relating to falls prevention practice and learning from the harm associated with falls.
    - Describe the Trust wide falls prevention programme including the recruitment of a Trust-wide falls Patient safety practitioner role.
2. Falls are common in older people and can lead to severe harm, including hip fracture and even death. Preventing falls is important for maintaining the health, wellbeing, and independence of older people.
3. The National Audit of Inpatient Falls (NAIF) is a clinical audit that evaluates practice in falls prevention and management against evidence-based standards. The 2021 national audit of inpatient falls listed eight recommendations for nationwide practice change.
4. Raymond and Elsie's stories are shared from Trust investigations into their falls. The combined learning from the investigations was
    - Enhanced Care and Close Observation Policy:
        a. All members of the clinical team should know the details of each patient under the care of this policy with a clear understanding of their behaviour profile and personal risk action plan to reduce risk of them falling.
        b. The enhanced care and close observation policy should be widely publicised to maximise effective and appropriate utilisation in all clinical areas
    - Patient acuity: The combined acuity and dependency of all patients within a clinical area bears influence over the capacity and availability of nursing and support staff. Ensuring accurate analysis to inform staffing levels and skills
    - Falls assessment and risk management: Falls prevention evidence suggests that detailed risk assessments personal to the patient should lead to personalised action plans to reduce the risk of falling. Falls assessment completed on admission should involve the next of kin for a 'collateral history' where the patients' memory or cognition is impaired to the degree that they cannot provide an accurate account.
    - Post-fall management: Injuries sustained from falling are not always obvious and do not always manifest immediately. A systematic and comprehensive examination should be undertaken by a physician after

every fall. A ‘rule out’ approach should be adopted where an assumption of injury has occurred until proven otherwise by clinical examination, observation, or diagnostic procedures. A post-falls care plan should be completed to effectively communicate with the clinical team.

- Sleep and rest: The usual sleep-wake cycle is disrupted within the acute hospital environment, which can lead to fatigue, disorientation and delirium. These represent falls risks and should be factored into falls risk assessment and mitigation through measures, such as noise reduction, essential lighting only, and
- Ward/unit orientation: Patients should be orientated to the ward or clinical area to ensure they know the direct route to the nearest bathroom.
- Self-care in hospital: Eating and drinking to get better. Get up slowly and safely. Ask for help to go to the bathroom.
- Patient education - Patient and families should be given the falls-safe patient information booklet with a brief discussion on best practice to prevent in-hospital falls.
- Clinical documentation: Documentation is critical in-patient safety review. The opportunity to understand and learn from incidents is greatly improved by detailed documentation. Where is done contemporaneously, the accuracy is improved.
- Staff education: Falls assessment, risk management and after care is complex. A tailored and proportionate programme of education should be available to all staff with the option of calling upon falls’ prevention expertise to advice clinical areas.

5. The Trust’s Harm Free Assurance Forum (HFAF) focuses on four aspects of patient care. Hospital Acquired Pressure Ulcers, Nutrition, and hydration, Patient Falls and Patient frailty.
6. Trust investigative and learning activity relating to patient falls is reported to HFAF, Patient Safety and Effectiveness Committee, Integrated Assurance Committee, Trust Board, Clinical Governance Committee.
7. The next steps in falls preventions are to revise the current policy, improve the quality of informatics and reporting, enhance our educational resources and clinical preventions measures. The recruitment of Trust wide Falls patient safety practitioner and a patients safety partner (PSP) for HFAF in the second wave of PSP will be critical to delivering these ambitions.
8. **Recommendations:** The Trust Board is asked to note the contents of the paper.

Contents

Learning from patient falls – making a difference

1. Purpose

1.1. The purpose of the paper is to

- Share the patient stories behind two investigations into patient falls
- Introduce the work of the Harm Free Assurance Forum and specifically the Trust wide activity relating to learning from and reducing the number of patient falls
- Describe the Trust wide falls programme including the recruitment of a falls patient safety practitioner.

2. Background

2.1. Falls are common in older people and can lead to severe harm, such as hip fracture and even death.[1]. For this reason, it is imperative that all measures to prevent falls occurring under the care of OUH are in place.

2.2. 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. Sustaining a fall is more likely to occur in older age. This risk increases following the admission to hospital.

2.3. The causes of a fall are multifactorial and often involve more than one issue. These include:

- muscle weakness
- poor balance
- visual impairment
- polypharmacy – and the use of certain medicines
- environmental hazards
- some specific medical conditions, which might make a person more likely to fall

2.4. Falls prevention is based on assessing the personal risk factors of patients and putting measures in place to minimise the chance of a fall during a hospital stay or visit. These prevention measures are embedded within a Trust policy and range of clinical procedures, which are monitored and overseen by a Trust clinical lead for falls, a falls patient safety practitioner, and senior nurses within our clinical divisions.

[1] Falls: applying All Our Health - GOV.UK (www.gov.uk)

2.5. The Trust subscribed to the National Audit of Inpatient Falls (NAIF)[2] , which is a clinical audit evaluating the of effectiveness of our inpatient falls prevention measures and management plans. The 2021 national audit of inpatient falls[3] has listed eight recommendations following the data audit during 2020. These recommendations are listed in Appendix 1.

2.6.

3. Patient and staff stories behind the incident investigations

Elsie

Elsie was first admitted to hospital in February 2022 following a fall at home where she sustained a hip fracture. She underwent a total hip replacement and subsequently became unwell in hospital contracting Coronavirus and hospital acquired pneumonia.

Upon the resolution of her acute care needs, Elsie was discharged to a HUB[4] bed to give her more time to recover before going home. Shortly after her discharge home she told her family that she was experiencing shortness of breath and they described a decline in her physical health. She was admitted again to hospital because of this. Elsie has a background of hypertension, Type 2 diabetes, and high cholesterol. She was assessed as having a clinical frailty score[5] of six, which means she has a moderate degree of frailty. This typically requires assistance in undertaking all outdoor activities and some support for activities of daily living inside the home. Elsie had been low in mood for a while, and she had been unwell, but she was alert and oriented and there were no concerns related to her cognitive function.

Elsie's family came to visit her in hospital and after they went home, she tried to move back into bed from her bedside chair. Unfortunately, Elsie fell to the floor whilst undertaking this manoeuvre. A visitor saw Elsie fall and alerted a nurse who came to examine her. It looked initially like Elsie had not sustained any injury and she didn't complain of any pain. The nurse asked for a medical review for Elsie, but this didn't happen.

Elsie told the nursing staff of the pain she felt the following day. The right hip X-ray showed a fracture of femur bone. She also had a CT scan of her head which didn't show any bleed. Elsie was referred to the Nuffield Orthopaedic Centre for surgery.

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[2] National Audit of Inpatient Falls (NAIF) | RCP London
[3] National Audit of Inpatient Falls Report Autumn 2021 | RCP London
[4] HUB beds are commissioned by the County Council. They are commissioned for a patient who is medically able to leave hospital but who isn't ready to return home. Patients continue to receive therapy support.
[5] Acute Frailty Network - Clinical Frailty Scale

A harm-free review meeting took place on 8th April 2022 to discuss this fall. This is a meeting attended by a multi-professional team to evaluate the cause of the fall, to verify the level of harm caused, decide the level of incident investigation, and identify the learning to support future falls prevention measures. The falls risk assessments undertaken for Elsie were accurate and had identified her previous falls. Her call bell and walking frame were within reach, , and she was wearing her grip socks. She had not previously attempted to mobilise on her own before and had always asked for assistance. The team found that Elsie was not reviewed by the medical team over night following her fall. She complained about pain the following day and so an X-ray was requested which identified the femoral fracture. Elsie's fall did not need to be reported as externally (RIDDOR[6)] as there were no environmental, Trust policy or practice contributions to the cause of her fall.

Raymond

Raymond was admitted to Horton General Hospital having been referred to the emergency department by his general practitioner with suspicion of a chest infection. He had had two courses of antibiotics in the community but was still unwell and feeling tired all the time.

Raymond and his wife lived independently at home and did not have a package of care in place. Raymond has stage 4 cancer, Type 2 diabetes, Hyperparathyroidism [7] and Osteoporosis [8].

On admission, Raymond was also found to have a urinary tract infection. Investigations revealed high blood sugar levels and ketones[9] present in his blood. He was started on a variable rate insulin regime using the Trust's guidance. He was also confused and with memory impairment.

He was transferred to the Emergency Assessment Unit (EAU) later that day under the care of the acute medical team. A falls risk assessment was completed within 6 hours of admission to EAU where it stated that Raymond had not had previous falls.

Raymond was mobile and independent on the unit, wearing his own shoes and had been able to use the call bell prior to the fall. However just after midnight, Raymond was found on the floor of the bay. He said that he had been trying to

[6] Dangerous occurrences - RIDDOR - HSE
[7] parathyroid glands in the neck, near the thyroid gland produce too much parathyroid hormone
[8] bone disease that develops when bone mineral density and bone mass decreases
[9] What are ketones? | Ketones in diet | Diabetes UK

walk to the patient opposite as he could not sleep, he wanted to ask them to ‘stop snoring’.

Raymond was examined by the on-call registrar physician, which revealed pain in his right hip. A right hip and pelvis Xray showed a fracture of the right hip.

Raymond’s case was discussed in the trauma multi-disciplinary team meeting and it was decided to manage his fracture without surgery. . This decision is usually taken when the fracture doesn’t result in displacement of the bones and can heal in place without the need for surgical fixation. Raymond was discharged to a HUB bed and was reviewed in trauma outpatients where a repeat x-ray of their right hip showed the fracture to be stable and healing in a good position.

In reviewing Raymond’s case, we learned that he had previously fallen at home, but this was not ascertained during our assessments; it was disclosed by his wife. Raymond had his own shoes, grip socks provided by the ward, a call bell in reach and had had a therapy assessment which concluded that he could mobilise independently without walking aids.

Raymond was able to walk unaided on admission and his wife told the team that he didn’t use a mobility aid at home. An assistant practitioner also discussed with Raymond about how prior to the fall, he had used urine bottles and a commode as they had declined to get out of bed due to feeling unwell and mobilising with the pumps and drip stands was difficult.

When the team investigated, the Matron for EAU spoke with Raymond to verify details of the fall; he confirmed that he had walked across the bay due to noise from another patient and said he had ‘tripped over their feet.’ He did not recall falling over any equipment.

4. The combined learning from the investigations

4.1. The investigation of both incidents revealed rich insights into how we can improve our falls prevention and management practice. The key learning points are set out below:

- Enhanced Care and Close Observation Policy:
    a. All members of the clinical team should know the details of each patient under the care of this policy with a clear understanding of their behaviour profile and personal risk action plan to reduce risk of them falling
    b. The enhanced care and close observation policy should be widely publicised to maximise effective and appropriate utilisation in all clinical areas
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and support staff. Ensuring accurate analysis to inform staffing levels and skills

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- Staff education: Falls assessment, risk management and after care is complex. A tailored and proportionate programme of education should be available to all staff with the option of calling upon falls prevention expertise to advice clinical areas.

5. Patient falls whilst in the care of the Trust.

5.1. During the previous 12 months, 2282 patients have fallen whilst in the Trust's care.

5.2. Of these, 1601 (70.2%) experienced no harm, 581 (25.5%) experienced minor harm, 28 (1.2%) experienced moderate harm, 20 (0.9%) patients experienced major harm and four people (0.2%) unfortunately died following their fall. There were 48 (2.0%) near miss events over this period.

5.3. Figure 1 below shows the number of patients falls reported each month by the level of harm.

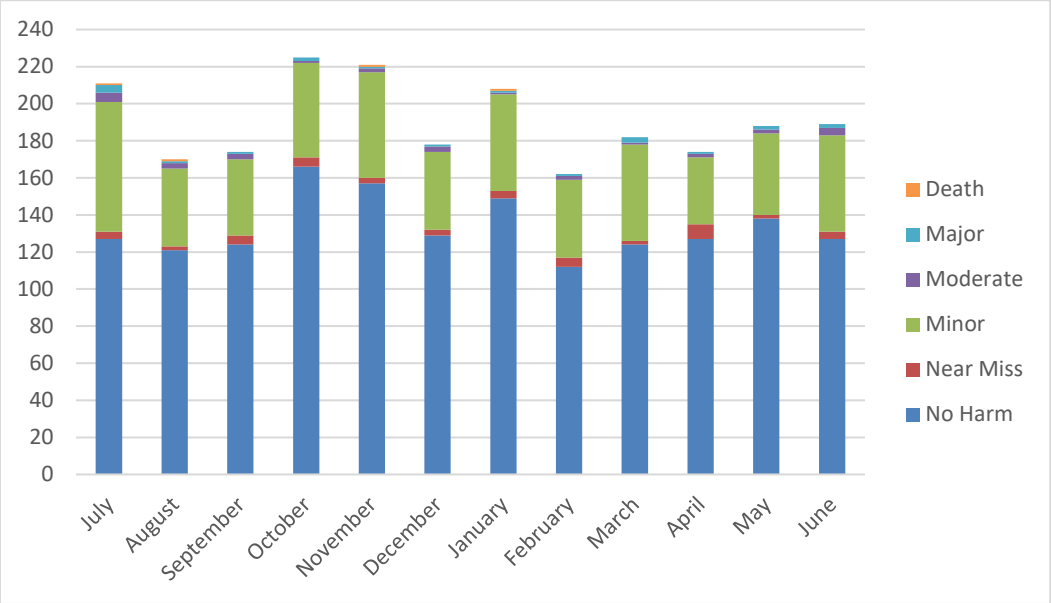

Figure 1: The number of patients' falls with harm

5.4. Figure 2 below shows the five main categories of falls between July 2021 and June 2022.

5.5. 778 patients fell without witnessed and were found on the floor, 343 fell form their wheelchair/ chair or commode, 243 fell from their bed, 257 fell whilst mobilising without assistance, and 149 fell in the bathroom/ shower or off the toilet.

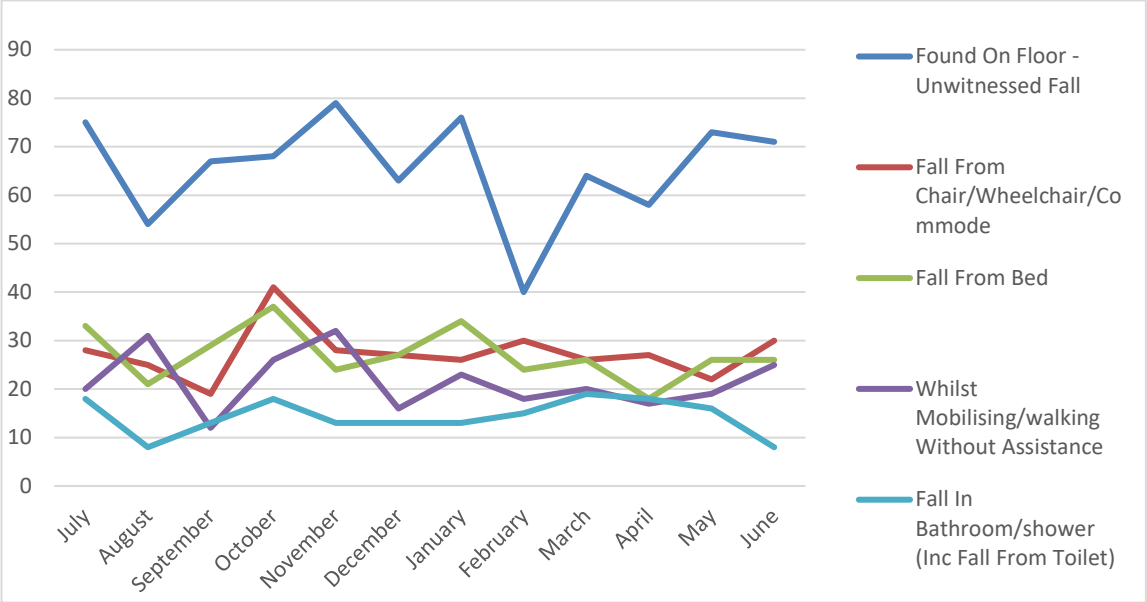

Figure 2: Main categories of falls between July 2021 and June 2022

5.6. There have been 12 complaints relating to falls this year. Two related to falling in hospital grounds and 10 patients fell in clinical settings (inpatient and diagnostic areas). Of the 10 patient falls in clinical settings, seven were unwitnessed and three witnessed. Table 1, below, gives a summary.

Month	Number of complaints	Location of fall
July	1	Hospital Grounds
August	2	Hospital Grounds. Clinical Setting
September	1	Clinical Setting
October	1	Clinical Setting
December	2	Clinical Setting. Clinical Setting
February	2	Clinical Setting. Clinical Setting
March	1	Clinical Setting
April	1	Clinical Setting
June	1	Clinical Setting

Table 1: Complaints relating to patient Falls

5.7. These complaints were triangulated with other incidents and patient experience at the weekly Trust, Inquests, Complaints, Claims, Serious Incidents and Safeguarding triangulation meeting (ICCSIS). This meeting escalates any concerns following the triangulation to the weekly Trust Serious Incident Group (SIG).

6. The Harm Free Assurance Forum.

6.1. The Trust's Harm Free Assurance Forum (HFAF) is chaired by the Chief Nursing Officer.

6.2. It is a multidisciplinary forum and focuses on four aspects of patient care.

- Hospital Acquired Pressure Ulcers
- Nutrition and hydration
- Patient Falls
- Patient frailty

6.3. The Terms of Reference for the Forum are shown in Appendix 2.

6.4. The Forum contributes to the Trust's investigation, analysis and change in practice following patient safety incidents by

- reviewing harms related to the above to identify themes, learning and service improvement actions/outcomes.
- discussing and seeking assurance from action plans following Divisional and Serious investigations related to the above.
- monitoring progress of improvement work programmes detailed by the Divisions
- engaging in partnership practice across health and social care for patients at risk, particularly discharge practice and communication across boundaries.
- monitoring training levels of eligible staff according to need as systems allow
- communicating risks and investigations to Clinical Governance Committee

6.5. The Forum reports into

- Patient Safety and Effectiveness Committee (PSEC) and Clinical Governance Committee ahead of Trust Board each quarter
- an annual report to Trust Board on progress against improvement action plans.

6.6. The HFAF is particularly important for falls since it represents an opportunity for a multi-professional team to evaluate the harm from falls within the monthly period, but also on a longitudinal basis. This enables the group to link the emergent learning from incident review with the strategic ambitions to prevention falls and minimise the harm from falls.

7. Trust wide falls prevention programme

7.1. The Trust's clinical lead for falls prevention, falls education and safety resources, and divisional nursing and education colleagues work collaboratively to oversee falls education, harm prevention measures, informatics and reporting, performance evaluation through internal and external audit, and fidelity to falls policy and best practice.

7.2. Falls informatics and reporting : Reporting of falls and harm data is vital in providing internal and external assurance of the quality and safety of our clinical care. Historically, falls reporting has been limited to descriptive data, which does not fully capture measures of variation in practice and harm. A full review of falls informatics and reporting is being undertaken to address this issue. Current reporting includes the number of patient falls and themes into IAC and Trust Board. Please see Appendix 3 for the August Falls report within the Trust Integrated Performance Report for Integrated Assurance Committee on 10th August 2022.

7.3. Education and training: After a period of hiatus, a revised online falls prevention e-learning package has been procured and is being implemented to improve the opportunities for falls education. This will be complimented by the recruitment of a falls patient safety practitioner role, who will have expertise in falls prevention and will be a crucial resource for the Trust

7.4. Falls prevention measures: Participation in the national audit of inpatient falls has identified areas for improvement in terms of optimising our falls prevention measures, such as availability of walking frames, specific clinical assessments, and understanding the extent to which under reporting may occurs.

7.5. Falls prevention policy and process: The falls prevention and management policy is currently under review by a multiagency group seeking to produce a modern and fit for purpose policy that

8. Next steps

8.1. A Patient Safety Partner (PSP) will be recruited to join the Harm Free Assurance Forum in the second phase of PSP implementation in April 2023. This is part of the wider implementation of Patient Safety Partners across the Trust[10]. This will help the falls programme by providing an external view through the lens of patients and their families and influencing future change in practice through user-experience design principles.

[10] NHS England » The NHS Patient Safety Strategy

8.2. Implement the patient information produced by the NAIF in conjunction with Carers Oxfordshire, Age UK, and Dementia Oxfordshire. This is shown in Appendices 4 - 8.

8.3. Update Falls policy, and as part of this

- Falls Safe: At a Glance. Appendix 4.
- Review EPR to ensure all exemplar practice is included and streamlined to maximise safety

8.4. Safety message to include revised Fall Safe: At a Glance. This being led by the Deputy Director of nursing for SUWON.

9. Conclusion

9.1. This paper has shared the experience of patient stories behind the investigations into patient falls.

9.2. Alongside this, the Trust's overall patient safety and clinical governance activity has been described to demonstrate how the learning from these incidents leads to change in practice to reduce and minimise patient harm from falls.

9.3. The Trust wide falls programme has been described, including measures to prevent falls, improve reporting and informatics, and the recruitment of a Trust wide falls patient safety practitioner role. This post will strengthen the Trust's focused activity to learn from and reduce patient harm.

9.4. The planned recruitment of a patient safety partner has been shared.

10. Recommendations

- The Trust Board is asked to note the contents of the report.

Appendix 1:

National Audit of Inpatient Falls Report Autumn 2021: Key recommendations

Data quality	Clinical leads should assess the extent of the gap between actual and reported falls in your trust or health board if more than 10% of inpatient femoral fractures (IFFs) are recorded in NAIF as not attributable to a fall. Higher proportions of IFFs not attributed to a fall suggest under-reporting.
Clinical Teams	Clinical leads should implement quality multi-factorial risk assessments (MFRAs) in all ward types, as inpatient falls can happen anywhere.
	Senior leaders and clinical teams should run at least one quality improvement (QI) project per year aimed at improving the quality of MFRA and to ensure care plans are followed.
	Falls leads and clinical teams should use QI methods to address poor performance against NICE Quality Standard 86 statements 4, 5 and 6 (NAIF KPIs 2, 3 and 4). **4: Checks for injury after an inpatient fall.** **5: Safe manual handling after an inpatient fall.** **6: Medical examination after an inpatient fall** Timely and effective post-fall management improves outcomes for patients.
	Clinical teams should administer analgesia as soon as a provisional diagnosis of IFF is made, aiming for within 30 minutes of the fall.
	Senior leaders should review patients who have experienced delays in starting femoral fracture management in inpatient settings to identify where systems and processes can be improved to avoid delays.
Dissemination	Falls leads and senior leaders should review NAIF reports and online real-time data for your trust in quarterly meetings of multidisciplinary team (MDT) falls working groups, so that these can be drivers for local QI projects.
Leadership and resources	Senior leaders should include time for participation in NAIF and related QI activities in job specifications and plans for falls leads/practitioners/coordinators

Appendix 2

HARM FREE ASSURANCE FORUM (HFAF)

Terms of Reference

1. Authority

1.1 The OUH HFAF is a strategic group chaired by the Chief Nursing Officer. The terms of reference shall be set out as below, subject to amendment according to changes in national guidance or local policy.

2. Purpose of Group

2.1 To review and discuss harms related to hospital acquired pressure ulceration, falls, nutrition and/or frailty.
2.2 Identify themes, learning and service improvement actions/outcomes.
2.3 To review and close action plans from Divisional and Serious Investigations related to the above to identify thematic learning opportunities for wider engagement
2.4 To monitor progress and supported the development of Divisional action plans
2.5 To monitor training levels of eligible staff according to need related to the above, as systems allow
2.6 To communicate risks, actions and mitigation from reviews of care quarterly to Patient Safety Effectiveness Committee (PSEC), Clinical Governance Committee (CGC) and Board.
2.7 Information will be held on a shared drive (MS Teams) to allow for equal access.

3. Core Membership

3.1 The membership of the group shall be:

Chief Nursing Officer (Chair)	Head of Therapies
Central Patient Safety Team	Lead Dietitian
Divisional Directors of Nurses and Midwifery/Deputies	Senior Accreditation and Regulation Manager
Nurse Consultant, Tissue Viability	Falls Prevention Practice Educator
Consultant Podiatrist	Director of Nursing - Education
Divisional Representation – CGRP and/or Matrons	Clinical Commissioning Group, Quality Manager
Medical Representative – TBC	
Safeguarding Team	Chief Nurse Informatics Officer

4. Attendance and Quorum

4.1 A quorum for any meeting of the Group shall be attendance by:
- Chief Nursing Officer or nominated deputy
- Four additional members of the group

4.2 Members are expected to send a nominated deputy to cover any periods of absence. The attendance of the deputy should be notified in advance and the deputy must be briefed and authorised to act on behalf of the member.

4.3 All Divisions must be represented

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5. Frequency of meetings

5.1 Meetings of the OUH HFAF shall be held monthly.

5.2 The meetings will be for the duration of 90 minutes.

6. Specific Duties

6.1 To review harms related to the above to identify themes, learning and service improvement actions/outcomes.

6.2 To discuss and seek assurance from action plans following Divisional and Serious investigations related to the above.

6.3 To monitor progress of improvement work programmes detailed by the Divisions

6.4 To engage in partnership practice across health and social care for patients at risk, particularly discharge practice and communication across boundaries.

6.5 To monitor training levels of eligible staff according to need as systems allow

6.6 To communicate risks and investigations to Clinical Governance Committee

7. Standing Agenda

7.1 Review of activity against Improvement action plans

7.2 Divisional and SIRI Action Plan closure updates and themes

7.3 Review of Incidents, investigations and outcomes for practice change and wider learning.

7.4 Highlight reports on improvement outcomes.

7.5 Monthly reports of clinical incidents

8. Reporting arrangements

8.1 Reporting into PSEC and Clinical Governance Committee ahead of Trust Board each quarter

8.2 The Chief Nursing Officer will present an annual report to Trust Board on progress against improvement action plans.

9. Review

9.1 The Terms of Reference of the group shall be reviewed annually

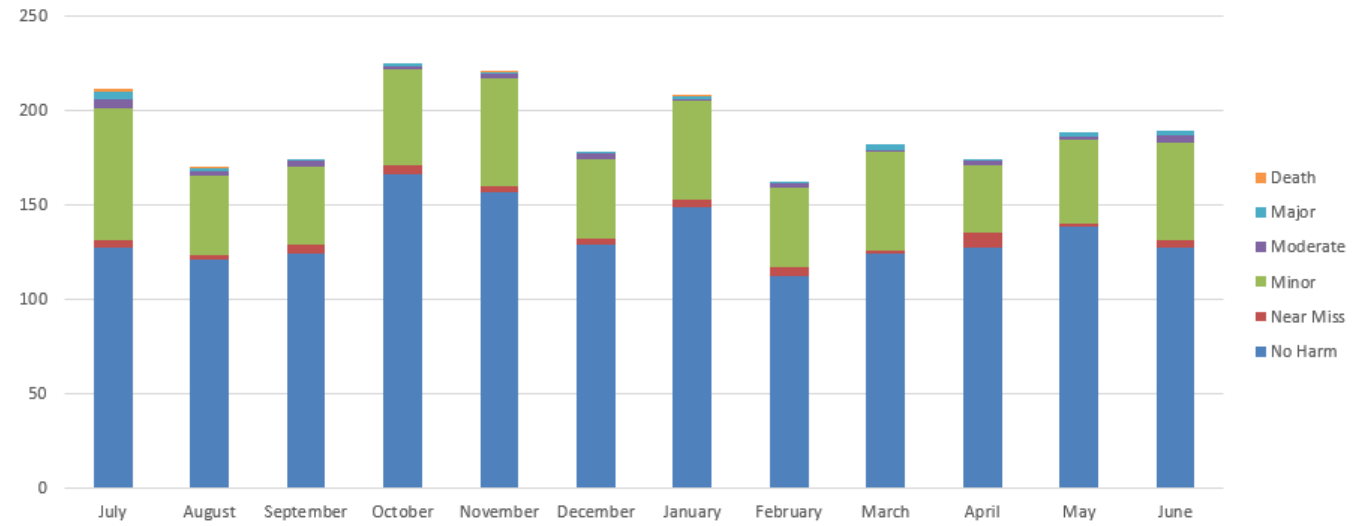
Authors: Sam Foster, Chief Nursing Officer/ Ria Betteridge, Nurse Consultant
Reviewed Feb 2022

Appendix 3 (Slide1)

Harm from falls report June 2022

Oxford University Hospitals NHS Foundation Trust

The chart below shows all patient reported falls by the level of actual harm between July 2021 – June 2022



June 2022 summary: There were 189 falls reported in June, which is comparable to May (188). This total is equivalent to the rolling average of 190.2 reported falls per month but is 10% higher than the total falls for this time last year of 173 (2021/22 performance data is affected by the coronavirus pandemic). Falls resulting in harm (minor and above) accounted for 58 (30.7%) of all falls this month, which is higher than May's performance (48, 25.5%). There were six falls resulting in higher severity harm levels (6/189, 3.2%): Moderate - 4 and Major – 2.

Harm level	June 2021*	June 2022
No harm	126	127 (↑)
Near miss	0	4 (-)
Minor	44	52 (↑)
Moderate	2	4 (↓)
Major	0	2 (↓)
Death	0	0 (-)
Total falls	172	189 (↑)

June performance: annual comparison 2021* vs 2022

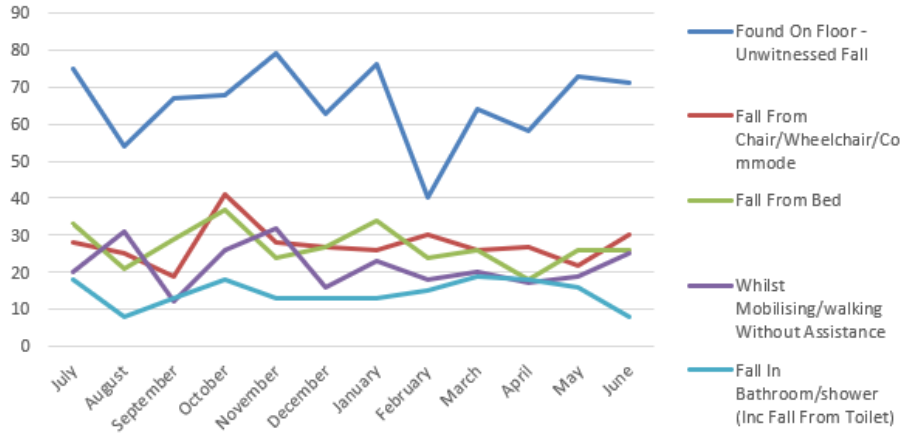
Learning | Respect | Delivery | Excellence | Compassion | Improvement *performance affected by CoVID-19

Appendix 3 (Slide 2)

Harm from falls report June 2022

Oxford University Hospitals NHS Foundation Trust

Top five categories of falls - rolling 12-month period: July 2021 to June 2022



Top five categories of falls June 2022

Previous month comparison

Category	May	Jun
Unwitnessed Fall – found on floor	73	71(↓)
Fall From Chair / Wheelchair/Commode	22	30 (↑)
Fall from bed	26	26 (-)
Fall whilst mobilising/ walking without assistance	19	25 (↑)
Fall in bathroom/shower/ from toilet	16	8 (↓)

ANALYSIS:

The number of reported falls in June is comparable to the previous month, but the proportion with harm (minor and above) and higher severity levels of harm is higher by 5.1% and 1% respectively. This is accounted for by a rise in falls with minor harm and a small rise in falls with moderate harm.

IDENTIFIED THEMES:

- Comparable number of total falls reported over the last quarter
- Increase in proportion of falls with harm and higher severity harm in June compared to May

ACTIONS:

- Review the six incidents of moderate harm and above at the next HFAG to identify lessons and actions to translate into clinical practice improvement.

Learning | Respect | Delivery | Excellence | Compassion | Improvement

Appendix 4

Oxford University Hospitals NHS
NHS Foundation Trust

Appendix 2: Falls Prevention Policy "At a Glance"

What are the key points?

- **All Falls**, irrespective of how they have happened or impact on patient must be reported on **Datix.**
- **Risk Assessment:** Risk of developing pressure damage to be **assessed within 6 hours** of admission to your clinical area and if the patient's condition changes. Reassessment should be undertaken weekly at a minimum.
- Check that an **appropriate care plan** is documented that addresses the individual patient's risks.
- Check the patient has **suitable equipment for the bed and chair.**
- Ensure patients **"at risk"** have an Intentional Rounding schedule.
- Review individual patient information each shift.
- Ensure patients are given an information leaflet and explanation as to their risk and the care advised. Document that this has been completed.
- Speak to colleagues and the **multidisciplinary team** for advice or help if necessary.
- Ward managers are responsible for completion of monthly **audit** of compliance with the Policy.
- Keep yourself updated on Falls prevention and management via the e-learning module on e-LMS.

Where can I find more information?
Prevention and Management of Adult Inpatient Falls on the Policies intranet
FallSafe and Falls Prevention intranet page
or
Contact the Falls Prevention Team at Falls.prevention@ouh.nhs.uk

Appendix 5

How should your hospital prevent and respond to falls during your stay?

Did you know that over

2,000

people over the age of 60 fell and fractured their hip while staying in hospital in England and Wales in 2020?

The patient and carer panel, who advise the Falls and Fragility Fracture Audit Programme (FFFAP) chose the **three most important findings** of the most recent report to help you understand what your hospital should be doing to prevent falls and to respond to a fall if it does happen.

How can falls be prevented?

People who may be at risk of falling should receive an assessment that looks at factors known to increase the risk of falling, so the hospital can address these risk factors.

The hospital should assess six key factors:

- Vision
- Blood pressure
- Medication
- Mobility (including walking aids)
- Continence
- Delirium

What should happen after a fall?

Immediately after a fall happens, the hospital should do the following:

1. Check for and identify injury before moving the person from the floor.
2. Move the person safely from the floor using a recommended technique.
3. Make sure assessment by a medical professional takes place within 30 minutes of the fall.

How can I help to improve care in hospital?

Hospitals are required to make improvements to their services. They often have a patient and public involvement group who advise them on patient feedback.

Anyone who is able to provide constructive feedback and suggestions for hospitals to improve the care they provide should consider joining the patient and public involvement group.

Royal College of Physicians | National Audit of Inpatient Falls (NAIF)

For more information on the content of this resource, you can refer to our Autumn 2021 annual report.

Compare your local healthcare provider's performance against others using our charts.

For further explanation on any of the terms above, you can refer to the FFFAP glossary.

Appendix 6

https://youtu.be/WE9AqW66OGc

Appendix 7

Royal College of Physicians | National Audit of Inpatient Falls (NAIF)

What is your hospital doing to prevent falls?

This resource is aimed at those who are looking to influence and improve the care and management of patients who have fallen in an inpatient setting. This might include anyone: patients, relatives or carers, who would like information to support conversations with care providers, commissioners, governors and non-executive directors. Falls are the most frequently reported incident affecting hospital inpatients, with 247,000 falls occurring in inpatient settings each year in England alone.

The actions below are designed to help you find out whether your hospital is meeting recommended targets and to raise areas in need of improvement with the board of governors, commissioners or other group.

You can ask the hospital Patient Advice and Liaison Service to help you find the right person to speak to about this.

Recommendation: **All trusts and health boards should register with, and participate in, the National Audit of Inpatient Falls (NAIF).**

77%

Audit result: 77% of all eligible organisations participated.

Action

Find out if your local hospital is **participating in the audit** by viewing the State of the Nation reports for **England** and **Wales** on the Royal College of Physicians' website.

Recommendation: **There should be committed members at board level who have a responsibility for falls.**

90%

Audit result: 90% of organisations had someone in an executive role with responsibility for falls.

Action

Find out if there is an **executive director and a non-executive director with responsibility** for falls who sit on the board at your trust or health board.

Recommendation: **The trust or health board should have a patient safety group that meets to discuss falls at least four times a year.**

87%

Audit result: 87% of organisations said they had a patient safety group that met to discuss falls at least four times a year.

Action

Ask your local trust or health board if they have a patient safety group and how often they meet, and if falls is always on their agenda.

Recommendation: **Patients who usually need a walking aid such as a stick or walking frame should be provided with one as soon as possible on admission to hospital.**

56%

Audit result: 56% of organisations had a policy to provide patients with a walking aid on admission to hospital, for those who usually needed one.

Action

Ask if your hospital has a policy to **provide walking aids** to people who need them as soon as they are admitted and that the aids are available 7 days a week.

Based on data from the National Audit of Inpatient Falls, published 12 March 2020. Find out more about preventing falls in hospital. Publication review date: March 2023

Appendix 8

Royal College of Physicians | National Audit of Inpatient Falls (NAIF)

How does your hospital deal with inpatient falls?

This resource is aimed at those who are looking to influence and improve the care and management of patients who have fallen in an inpatient setting. This might include anyone: patients, relatives or carers, who would like information to support conversations with care providers, commissioners, governors and non-executive directors.

Recommendation: **After a fall, patients should be checked for injury before they are moved.**

45%

Audit result: Of those patients who sustained a hip fracture while they were in hospital, 45% were checked before they were moved..

Actions

- Ask what procedure your hospital uses to **check patients for signs of injury** after they have fallen.
- Find out how many patients with hip fracture were checked in this way before they were moved by **asking to see your trust's NAIF report.**

Recommendation: **After a fall resulting in suspected fracture or spinal injury, patients should be moved from the floor using a safe lifting method.**

20%

Audit result: 20% of patients who sustained a hip fracture while in hospital were moved using a safe lifting method.

Actions

- Find out whether your trust or health board has **flat lifting equipment** on all sites.
- Find out how many patients with hip fracture were moved using flat lifting equipment by **asking to see your trust's NAIF report.**

Recommendation: **Patients should be assessed by a doctor within 30 minutes of a fall where serious injury is suspected (NB If on a site without a full-time doctor, an ambulance should be called).**

54%

Audit result: 54% of patients who had a hip fracture while in hospital were assessed by a doctor within 30 minutes of a fall, where serious injury was suspected.

Action

Find out how many patients with hip fracture were **seen by a doctor within 30 minutes of the fall** by asking to see your trust or health board's NAIF report.

Recommendation: **The level of harm recorded in reporting systems following an inpatient hip fracture should be severe.**

67%

Audit result: For 67% of patients with inpatient hip fracture, severe harm was recorded.

Actions

- Find out if your trust or health board has a policy that ensures all falls that result in inpatient hip fracture are **reported as severe harm**, regardless of the circumstances of the fall.
- You can also **ask to see your NAIF trust report** to find out what proportion of falls with hip fracture were reported as resulting in severe harm.

Based on data from the National Audit of Inpatient Falls, published 12 March 2020. Find out more about preventing falls in hospital. Publication review date: March 2023

The Flesch-Kincaid grade level for this document is 9.3, equivalent to a UK reading age of 10–13 years.

Appendix 9

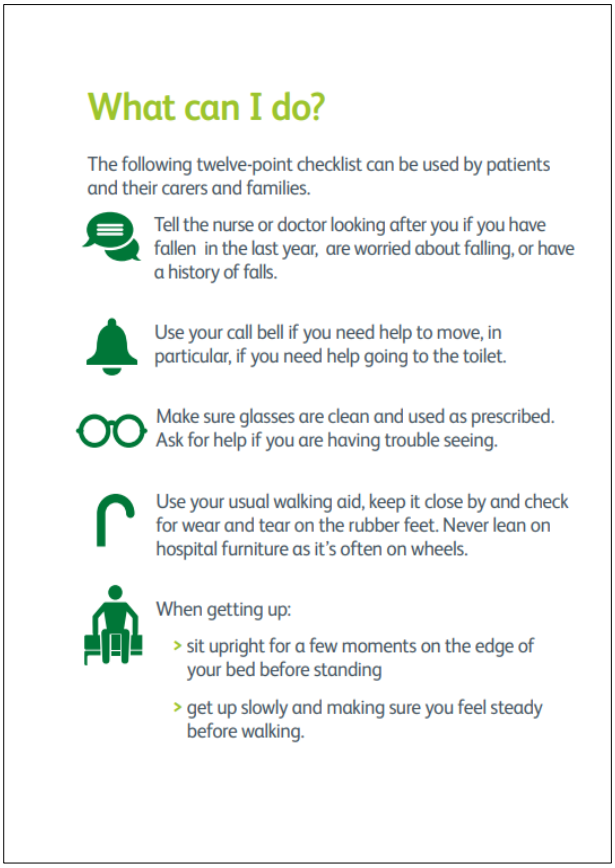
Falls prevention in hospital: a guide for patients, their families, and carers

Falls prevention in hospital: a guide for patients, their families and carers has been designed to help prevent serious injury and unnecessary cost to the NHS caused by older people tripping or falling when they are in hospital.

This guide provides jargon free information on the care patients can expect to receive in hospital, as well as advice on how to be alert to potential dangers and what to do to avoid them. It sets out a check list of simple measures that, when undertaken, can minimise the risk of falling or tripping.

Advice in the checklist includes:

- Tips on exercises to improve circulation when getting out of bed or before standing
- How to use walking aids in hospital safely
- Ensuring the bedside environment is uncluttered and vision glasses and walking aids are to hand when standing



What can I do?

The following twelve-point checklist can be used by patients and their carers and families.

Tell the nurse or doctor looking after you if you have fallen in the last year, are worried about falling, or have a history of falls.

Use your call bell if you need help to move, in particular, if you need help going to the toilet.

Make sure glasses are clean and used as prescribed. Ask for help if you are having trouble seeing.

Use your usual walking aid, keep it close by and check for wear and tear on the rubber feet. Never lean on hospital furniture as it's often on wheels.

When getting up:

> sit upright for a few moments on the edge of your bed before standing

> get up slowly and making sure you feel steady before walking.

Do some simple leg exercises before getting up from your bed or chair:

> point your toes and release a few times

> tighten the muscles in your calves and then release them

> move your legs up and down if you can, to get the circulation going.

If you feel dizzy – stop, sit down, and let the ward staff know.

Drink regularly and eat well.

Be familiar with your bedside environment. Ask for clutter to be moved if your path isn't clear.

Make sure your shoes or slippers fit well, grip well and cannot fall off.

Take care in the bathroom and toilet. Ask for help if you need assistance.

It is also important to make sure that you receive a falls risk assessment – see 'What should hospitals be doing?' (p 12) for more information.