Trust Standard Operating Procedure

Plymouth Hospitals NHS
NHS Trust

Policy for the Prevention and Management of Patient Falls in Hospital (Children)

Date	Version
January 2017	**2.0**

Purpose

This policy provides guidance for clinical staff, managers and Patient Safety team in the prevention and management of patient falls of children in hospital to:

- Promote staff awareness so that the risks to patient Slips, Trips and Falls are minimised.
- Reduce the likelihood of harm to patients through falls and ensure any patient who does fall in hospital is managed safely and appropriately.
- Ensure that patient falls are managed across the Trust in line with national standards and guidance.

The appendices of this policy provide the clinical tools and documentation needed to promote patient safety regarding risks of falls.

This document should be read in conjunction with the Procedure for Assessing and Managing Health and Safety Risks and Tool for Assessing Risk in the Workplace.

Who should read this document?

All staff working in clinical areas and patient safety

Key messages

- Patient falls are a common patient safety incident reported both at Trust level and nationally (National Patient Safety Agency 2007).
- A fall in hospital has a huge impact on patients – increased length of stay in hospital, decline in general health, serious illness or even death.
- Prevention of patient falls is important - the key to this being to identify and minimise the risk factors for falls in patients in hospital.

Accountabilities

Production	Matron Acute Paediatrics
Review and approval	Paediatric Clinical Governance Group
Ratification	Executive Director Of Nursing
Dissemination	Matron Acute Paediatrics
Compliance	Matron Acute Paediatrics

Links to other policies and procedures

- Procedure for Assessing and Managing Health and Safety Risks
- Tool for Assessing Risk in the Workplace.
- Incident Management Standard Operating Procedure
- Moving and Handling Standard Operating Procedure
- Workforce Induction and Training Policy

Version History

1.0	August 2012	Developed to link in with the Prevention and management of

		patient falls in hospital (adult) Standard Operating Procedure.
2.0	January 2017	SOP Revision

Last Approval	Due for Review
January 17	March 2020

PHNT is committed to creating a fully inclusive and accessible service.

Making equality and diversity an integral part of the business will enable us to enhance the services we deliver and better meet the needs of patients and staff.

We will treat people with dignity and respect, actively promote equality and diversity, and eliminate all forms of discrimination regardless of (but not limited to) age, disability, gender reassignment, race, religion or belief, sex, sexual orientation, marriage/civil partnership and pregnancy/ maternity.

An electronic version of this document is available on the Trust Documents Network Share Folder (G:\TrustDocuments). Larger text, Braille and Audio versions can be made available upon request.

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Plymouth Hospitals NHS
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Standard Operating Procedure

Prevention and management of patient falls in hospital (Children/Young People)

1 Purpose and Scope

Plymouth Hospitals NHS Trust recognises that patient falls are a common and potentially harmful event for individuals - nationally they account for 40% of patient safety incidents in adults. Many falls that occur in children/adolescents are a part of normal childhood development. Nursing staff will need to be aware that some children/young people whose developmental stage makes them unable to protect their own safety, i.e.

- those with reduced consciousness through medication, head injury etc.
- and those with restricted mobility

These patients will need to have the risk minimised to ensure their safety. With a focus on patient safety, the Trust is committed to reducing the number of patient falls and in particular the number of falls resulting in serious injury.

There will always be a risk of falls in hospital, given the nature of patients and the clinical environments in which care is given. However, there is much to be done to reduce the risk of falls and minimise the harm. The Trust focus on prevention of patient falls, requires clinical teams to identify those patients who are at high risk of falling in hospital – this SOP includes measures to take for the management of falls incidents, to ensure a full review, appropriate preventative measures taken and accurate recording of incidents.

Note – Actions to take for the prevention of slips, trips and falls for adult patients and for staff, visitors and the public are contained in separate Standard Operating Procedures.

1.2 Definitions

A fall is defined as an unexpected, involuntary loss of balance by which a person comes to rest at a lower or ground level.

- Slip - to slide accidentally causing the person to lose their balance. This is either corrected or causes a person to fall
- Trip - To stumble accidentally over an obstacle, causing the person to lose their balance. This is either corrected or causes a person to fall

- A place at Height – where a person could be injured falling from it, even if it is at or below ground level
- Hazard – Something that has the potential to cause harm or loss
- Risk – The likelihood of harm or loss occurring in defined circumstances

Hospital patients are at greater risk of falls than those in the community - due to a range of patient-related issues but also the extrinsic factors of the environment. Falls rates in hospital are measured and benchmarked nationally: Falls reported in hospital per 1,000 bed days range from 3 – 14 with an average rate of 4.8 per 1,000 bed days (Plymouth Hospitals current falls per 1,000 bed days is 3.98 per 1000 days). There have only been 4 falls in 2016 within the paediatric service line.

1.3 Definitions of the degree of harm

Degrees of harm following a patient fall, have been set out by the National Patient Safety Agency:

Term	Definition ref patient falls	Examples of falls injury reports
No harm	No harm to patient	*"No apparent harm"* *"No complaints of pain, no visible bruising"*
Low harm	Harm that required first aid, minor treatment or extra observation or medication	*"Shaken and upset"* *"Graze to hand"* *"Small cut on finger"*
Moderate harm	Harm requiring follow-up review as outpatient, admission, surgery or longer stay in hospital	*"Fracture to wrist"* *"Taken to Emergency Department for suturing"* *"Fractured pubic rami, requiring bed-rest"*
Severe harm	Permanent harm sustained or disability as a result of the fall	*"Confirmed fracture neck of femur"*
Death	Death as a direct result of the fall	*"GCS lowered……patient intubated and sedated for transfer to critical*

		care… patient died same day"

NPSA (2007)

2 Key Duties

Medical Director and Director of Nursing

- Board Members with responsibility for Patient Safety within the Trust
- Overall responsibility for the standards of patient care in hospital
- Overall responsibility for the safe clinical environment in which care is delivered.

Matrons/Heads of Service

- Responsible for ensuring all wards/departments maintain updated environmental risk assessments to promote patient safety where appropriate (See Appendix 1).
- Review risks identified regarding patient falls and ensure appropriate actions are taken to manage these.
- Ensure all ward/department managers fulfil responsibilities for patient care, staff training and ward equipment related to falls management.
- Review with ward/department managers incidents of falls, to identify trends and patterns and take appropriate action to ensure lessons are learned from incidents.

Ward/Department Managers

- Responsible for undertaking environmental risk assessment of the clinical area and highlighting specific risks to patient falls (see Appendix 1).
- Take action to remove hazards and reduce the risk of slips, trips and falls.
- Responsible for ensuring that staff are appropriately trained in basic health and safety competencies and the management of patients at risk of falls.
- Ensure new staff receive adequate levels of induction, are aware of their environment and the processes that are conducted within it.
- Maintain high standards of patient care with regard to falls risk and falls management.
- Monitor levels of falls in children/young people and conduct a yearly audit on falls risk assessments.

- Responsible for ensuring that clinical staff report accurately any patient fall, slip or trip - both in the clinical records and through the Trust Datix incident reporting system.

- Investigate incidents of patient falls - ensuring appropriate reporting has been undertaken, review actions taken to address patient injuries and lessons learned from incident.

The Patient Safety Team

- Promote patient safety and support Trust work towards improving patient safety.

- Ensure the Trust Risk Register is appropriately reviewed to reflect the risks regarding patient falls accurately; to ensure that appropriate actions are taken/planned to mitigate the risks to patients.

- Review incident reports to ensure they are appropriately managed in accordance with Procedure for Managing Incidents.

- Monitor incidents, complaints and claims related to patient slips, trips and falls, reporting the output of this monitoring together with identifications of any learning and recommendations for action to the Falls Working Group, Ward managers and Matrons.

- Ensure any patients fall incident under RIDDOR is reported in a timely manner to the Health and Safety Team and also ensure that falls leading to serious injury are appropriately managed and reported via the serious Untoward Incident processes.

Health and Safety Team

- Provide guidance on the prevention of slips, trips and falls.
- Promote health and safety awareness including slips, trips and falls (quarterly newsletters, special events as opportunities present, departmental visits at least one per area per year, etc.).
- Produce reports to the Health and Safety Committee and others (typically a Department or Group) on slips, trips and falls prevention activity.
- Review the effectiveness of slips, trips and falls prevention activity.

Working with the Multi-professional Falls Working group

- To work with the Multi-professional Falls Working group to look at and review the Falls Reduction plan in respect of children and young people and elements of the High Impact Action for Falls to promote prevention measures in place to prevent and reduce slips, trips and falls.

- Lead on the development of further falls prevention and falls management

initiatives across the Trust to include children and adolescents.

- Receive reports on slips, trips and falls, commenting on the effectiveness of improvement measures, and making recommendations to support safe practice.

All Clinical Staff

- Undertake timely and regular risk assessments of patients to identify those at risk of falls.
- Ensure appropriate care plans in place to manage risks of patient falls, ensure safe patient handling and minimise slip, trips and fall risk factors.
- Follow Health & Safety guidance to maintain a safe clinical/working area.
- Work in multi-professional way to promote patient independence with mobility and reduce risks of falls in hospital.
- Undertake mandatory training in Manual Handling, patient handling risk assessments, use of manual handling equipment and falls prevention.
- Ensure patients and relatives are made aware of any risks of falls for patients and where appropriate relatives are involved in the falls care plan.
- Use appropriate equipment to promote safe moving and handling of patients and reduce risks of falls.
- Report any incident of slip, trip or fall - ensuring appropriate care is afforded to patients who fall in hospital. Reporting should be through Datix reporting system and documented in the patient's clinical records.
- Escalate any concerns regarding factors contributing to falls risks within the clinical area - ensure appropriate measures are taken to promote patient safety.
- Where there are concerns of a safeguarding nature this should be discussed with the senior nurse/safeguarding team.

3 Arrangements to Prevent Patient Slips, Trips and Falls in Hospital

The Trust's primary consideration is to reduce the occurrence of patient slips, trips or falls and minimise the injury sustained from any fall in hospital

In the Paediatric Service Line, whilst the amount of falls is significantly reduced, ongoing assessments still need to be carried out through the use of :

- Individualised care plans should be available for all children and take account of their developmental stage, mobility, emotional, psychological and any cognitive impairment.
- Environmental assessments – ensuring that the flooring and infrastructure are appropriate to the age of the child/young person.
- Equipment and footwear - a range of equipment to reduce falls risks in hospital; including bed rails, movement sensors, footwear. 1:4 falls incidents in hospital involve a patient falling from height (usually from bed). Low-profile beds are available across the Trust, for those patients at high risk of falls from bed, for whom bed rails or other prevention measures are not appropriate/effective.
- Generic assessments on each admission to ensure that the care plans are regularly updated and fit for the needs of the patient.

Guidance on falls prevention stresses the need for a multi-faceted approach to interventions to reduce patient falls. Falls risk assessments are most useful in identifying the different factors contributing to the falls risk, rather than giving a total score to define the risk. It is therefore important that the falls risk assessment includes consideration of the wide range of factors which could be contributing to the patient's falls risk - some of which will be intrinsic to the individual patient, others will be specific to the clinical environment.

The assessment of Children and Young people identified as at risk of falls in hospital should also include -

Cognitive function

Mental health status

Visual assessment

Level of developmental delay

Medication reviews

4 Management of Children and Young People who fall in hospital

National guidance on essential care following a patient fall in hospital is given by the NPSA (2011). This includes assessment, examination and monitoring of patient condition following a fall, escalation if changes to the patient's conscious levels trigger urgent medical review, availability of appropriate equipment to safely move patients who are suspected to have suffered serious injury following a fall and access to prompt/speedy investigation and specialist treatment for patients who have suffered a fall.

The care of a patient who has fallen must include:

- Initial patient safety - assessment of injuries, maintenance and assessment of patient airway, breathing and circulation.
- Move patient back to bed, once it is deemed safe to move them - following manual handling assessment of situation. If necessary, the patient should be assessed for injuries at the site of fall if there are serious injuries suspected.
- Vital observations/neurological observations should be recorded and repeated as necessary and noted on an age specific observation chart.
- Medical review of the patient should be undertaken - timing of this will depend on nature of fall and suspected injuries.
- Review of patient risks of further falls should be documented and the care plan reviewed and updated.
- Parents/carers should be informed of fall and outcome to patient.
- Patient falls should be recorded in the clinical record and reported via Datix reporting system. Serious harm to patients should be escalated through the Trust Serious Untoward Incident procedures -for reporting and investigation.

See Appendix 2 for details and flow-charts of actions to be taken following patient fall.

5 Staff Training

The importance of training in relation to the management of patient risk of slips, trips and falls is recognised by the Trust. The training needs of staff have therefore been identified and included within the Training Needs Analysis documented in the Workforce Induction and Training Policy.

Training will be delivered as part of the Trust's mandatory and update training programme which must be completed on an annual basis through e-learning or the distance learning programme. Compliance with mandatory training completion is monitored at Directorate level through Performance management.

Ongoing awareness will be highlighted through monthly governance meetings and regular team meetings where incidents will be discussed, learning shared from the incidents and actions taken to mitigate risks.

6 Monitoring and Assurance

Compliance with this procedure will be reviewed on a yearly basis by the Paediatric matron by auditing a sample of notes. The notes to be reviewed will be identified via incidents reported on Datix. Departmental meeting minutes will

also be reviewed to ensure that appropriate action was taken in response to the findings of environmental risk assessments or in response to any incidents. The review of meeting minutes will also review the action taken to raise awareness about preventing and reducing slips, trips and falls.

The outcome of this review will be reported to the Safe Care Group. Action plans to address any issues arising will be developed and implemented by the Paediatric Matron with progress monitored by the Safe Care Group.

Monitoring the delivery of mandatory training will be managed in accordance with the Workforce Induction and Training Policy.

7 Document Ratification Process

The design and process of review and revision of this procedural document will comply with The Development and Management of Trust Wide Documents.

The review period for this document is set as three years from the date it was last ratified, or earlier if developments within or external to the Trust indicate the need for a significant revision to the procedures described.

This document will be approved by the Paediatric Clinical Governance Group and ratified by the Director of Nursing and disseminated to paediatric nursing teams by Matron. It will be available to all staff through Trust Documents.

Non-significant amendments to this document may be made under delegated authority from the Director of Nursing, by the nominated author**..** Any such changes will be ratified by the Director of Nursing and will be reported retrospectively, to Clinical Governance Group**.**

Significant reviews and revisions to this document will include a consultation with Ward/departments, Patient Safety Team, Health and Safety Team and Health and Safety Committee.

Dissemination and implementation

Following approval and ratification, this clinical policy will be published in the Trust's formal documents library and all staff will be notified through the Trust's normal notification process, currently the 'Vital Signs' electronic newsletter.

Document control arrangements will be in accordance with The Development and Management of Trust Wide Documents.

The document author(s) will be responsible for agreeing the training requirements associated with the newly ratified document with the Director of Workforce and Organisational Development, and for working with the Trust's training function, if required, to arrange for the required training to be delivered.

8 Reference material

National Patient Safety Agency (2007) - Slips, Trips and falls in hospital

Chief Nursing Officer (2009) High Impact Actions for nurses and midwives

National Patient safety Agency (2011) Essential Care after an inpatient fall NPSA/2011/RRR001

Useful resources are available at**:**

http://www.patientsafetyfirst.nhs.uk
http://www.npsa.nhs.uk
http://www.hse.gov.uk

Slips, Trip & Falls - General Assessment Checklist — **Appendix 1**

Purpose: *The purpose of this checklist is to assist Managers in identifying hazards when completing a slip, trip and falls risk assessments. (Note - The "Patients Falls Assessment Tool" should be used to determine the risk of an individual patient falling.). Falls Risks include Work involving the use of step stools, step ladders, trestles etc as a means of access will require an additional assessment of risk i.e. work at heights risk assessment*

SLIP HAZARDS	**Hazard Found** (√)	**TRIP HAZARDS**	**Hazard Found** (√)	**FALLS RISKS** Take account of controls already in place	**Hazard Found** (√)
Spills / splashes of liquids / solids		Loose tiles/floor boards carpets/mats		**Patients & Visitors**	
Wet floors (following cleaning)		Uneven outdoor surfaces		Falls from chair, etc	
Wet floors (other than cleaning)		Holes / cracks / potholes		Confused mental state	
Unsuitable footwear		Bumps / ridges / protruding nails		Physical weakness / disability / lack of or no handrails	
Loose mats – on polished floors not non-slip		Changes in surface level – stairs, steps or slopes		Poor lighting	
Rain, sleet, snow		Cables / leads across walking areas		**Fall Hazards for staff, contractors**	
Change from wet to dry surfaces (footwear still wet)		Location of electrical/telephone sockets		Unguarded openings, skylights, roof edges	
Unsuitable floor surface/covering		Obstructions i.e. items stored on floor		Working from access platform	
Dusty/Dirty floors		Low wall and floor fixtures		Accessing high level storage	
Sloping surfaces		Items stored in passage ways		Sloping surfaces / floors	
		Difficult access		Unsuitable access method	
		Poor or unsuitable lighting			

Other Slip & Trip Hazards or Falls Risks (Describe each one identified)

Assessment undertaken by →	Name :	Job Title:	Signature:	Date:

Appendix 2

Care of Patient following a fall in hospital

1. Ensure patient is safe before being moved.

A physical examination of the patient must take place, complete a full ABCD style assessment, with the results documented in the patient record:-

A - Airway

B – Breathing

C – Circulation

D – Disability with regards to neurological state and consciousness levels

E – Exposure and risks of hypothermia

2. Check for signs/symptoms of fracture/ spinal injury before patient is moved -

3. Ensure safe manual handling methods for patients with signs and symptoms of fracture or potential for spinal injury by obtaining the Pegasus trolley and scoop stretcher, or the spinal board, through request from the Porters - ensuring the specialist equipment is used by appropriately trained staff.

4. Medical advice and review must be sought even when extrinsic factors can be associated with the fall, in order to rule out patho-physiological factors. All children should have a medical review documented in the medical notes.

5. Neurological observations for patients where head injury has occurred or cannot be excluded - these must performed and recorded on a half hourly basis until Glasgow Coma Scale (GCS) equal to 15, or returns to level normal for the patient;

Minimum frequency of observations half-hourly for 2 hours

Then 1 hourly for 4 hours

Then 2 hourly thereafter.

Those patients with GCS of less than 15 should be reviewed by medical team for consideration of need for CT scan

(National institute for Health and Clinical Excellence (NICE) Clinical Guideline 56: Head

injury).

6. Any changes in the GCS should trigger urgent medical review

The patient must be re-assessed in light of a change in circumstances and medical review undertaken

7. Document the circumstances surrounding the fall in the patient record and a Falls Alert Sticker placed in the hospital notes. All patients who fall in hospital should be reviewed by the clinical team; reassessment of risks of falls should be documented.

8. Incident report (Datix) must be completed as soon as possible following the fall. Key information should be included;

Time and place of incident

Activity being undertaken at time of fall

Circumstances surrounding the fall (e.g. patient hurrying to the toilet)

Degree or severity of harm - this may need to be reviewed as degree of harm becomes clearer

Staffing levels and skill mix at time of fall

Strategies in place prior to fall and non-compliance to strategies already in place.

Strategies to be put in place following the fall, in order to reduce the chance of further falls.

9. Ensure timely contact for Parent or Next of Kin, to advise of patient fall and changes to the person's condition, prognosis, treatment (consider time of day and extent of injury, if surgery is required or ward transfer needed) **Give next of kin parent advice/information leaflet on head injury**