Trust Policy

Plymouth Hospitals NHS
NHS Trust

Prevention and Management of Patient Falls in Hospital (Adults) Policy

Date	Version
October 2015	2.0

Purpose

This policy provides guidance for Plymouth Hospitals NHS Trust staff in the prevention and management of patient falls in hospital to:

- Promote staff awareness so that the risk of an inpatient fall is minimised.
- Reduce the likelihood of harm to patients through falls and ensure any patient who does fall in hospital is managed safely and in accordance with Trust guidance.
- 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 may have a huge impact on patients – Sometimes leading to reduced independence, increased length of hospital stay, 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	Falls Working Group
Review and approval	Clinical Effectiveness group
Ratification	Medical Director
Dissemination	Falls Working Group
Compliance	Falls Working Group and Quality Assurance Committee

Links to other policies and procedures

- Health & Safety Policies and Procedures referred to on Trust Documents
- Preventing slips, trips and falls Standard Operating Procedure
- Incident Management Policy
- Serious Incidents Requiring Investigation Policy
- Moving and Handling Standard Operating Procedure
- Workforce Induction and Training Policy

Version History		
1.0	August 2012	Developed to replace the previous Falls Framework which encompassed the prevention and management of both patient and staff related slips trips and falls.
2.0	November 2015	Review & Revision of Version 1.0

Last Approval	Due for Review
November 2015	September 2018 (Earlier if guidance changes)

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.

CONTENTS

Plymouth Hospitals NHS
NHS Trust

Prevention and Management of Patient Falls in Hospital (Adults)

1 Purpose and Scope

Plymouth Hospitals NHS Trust recognises that patient falls are a common and potentially harmful event for individuals – Nationally, falls are the most commonly reported safety incident.

The impact of a patient fall can vary from being left shaken and losing confidence in mobility to serious fractures or bleeds, which may even lead to death. The Trust is committed to reducing the number of patient falls and in particular the number of falls that cause harm to our patients.

There will always be a risk of falls in hospital, given the clinical condition of patients and the environment in which care is given. The Trust focus on safety includes prevention of patient falls and harm from falls. It requires Clinical Teams to identify those patients who are at high risk of falling in hospital and take appropriate preventative measures. This Policy should be read in conjunction with the Falls Resource Folder available on every ward. Key contents from the Falls Resource Folder are included in this Policy as Appendices. It also includes measures to take for the management of falls incidents to ensure a full review of the fall and accurate recording of incidents.

Note – Actions to be taken for the prevention of slips, trips and falls for staff, visitors and the public is contained in a separate Standard Operating Procedure

1.2 Definitions

A **Fall** is defined as "… an event which results in a person coming to rest inadvertently on the ground, floor or lower level." (*Ref: WHO Falls Fact Sheet 344 Oct 2012*)

Hazard – Something that has the potential to cause harm or loss

Risk – The likelihood of harm or loss occurring in defined circumstances

Falls and fall-related injuries are a common and serious problem for older people. People aged 65 and older have the highest risk of falling with 30% of people older than 65 and 50% of people older than 80 falling at least once a year.

The human cost of falling includes distress, pain, injury, loss of confidence, loss of independence and mortality. Falling also affects the family members and carers of people who fall. Falls are estimated to cost the NHS more than £2.3 billion per year. Therefore falling has an impact on quality of life, health and Healthcare costs. (NICE 2013)

Rates of falls in hospital are measured and benchmarked nationally. All falls within PHNT should be reported through the Trust Incident Reporting System (Datix).

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 and 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 an outpatient, admission, surgery or longer stay in hospital	*"Fracture to wrist"* *"Taken to the 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

- Responsible 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.

Care Groups

- Ensure that moderate incidents relating to falls are appropriately managed within the service lines, supported by the Care Group Quality Managers as necessary. Report findings of investigation into falls classified as moderate that result in a fracture to the Health and Safety Team who report to the HSE.

- Review the risks relating to patient falls

- In conjunction, the Falls Team review incidents relating to falls across the Care Group and subsequent investigations looking for themes and trends to identify changes to practice and learning that might prevent other patients from falling in similar circumstances.

- Ensure duty of candour has been undertaken for all moderate harm incidents within the Service Lines

Service Lines

- Responsible for ensuring that all Wards/Departments maintain updated Environmental Risk Assessments to promote patient safety.

- Review local risks identified regarding patient falls and ensure that appropriate action is taken to manage these and where mitigating actions are not controlled at Service Line level, escalate to Care Group Level

- Ensure that all Ward/Departmental Managers fulfil responsibilities for patient care, staff training and ward equipment related to prevention of falls and falls management

- Responsibility for their incidents' management, especially moderate incidents
- Responsibility to ensure they have (and be able to demonstrate they have) assurance that Duty of Candour is completed and Health and Safety have been informed of the findings of all falls resulting in fracture.

- In conjunction with the Falls Team; review falls incidents to identify themes and to ensure lessons learned from incidents and are shared with the aim of preventing other patients from falling in similar circumstances,

Ward/Department Managers

- Responsible for undertaking environmental risk assessment utilising Workplace Safe Environment Safety Audit (including Slips, Trips & Falls (Staff & Others) of the clinical area and highlighting specific risks to patient falls (see Workplace Safe Environment Safety Audit (including Slips, Trips & Falls (Staff & Others)

- Take action to remove hazards and reduce the risk of slips, trips and falls

- Responsible for ensuring that staff are appropriately trained in the management of patients at risk of falls, to minimise the risk of falls on the ward or department environments.

- Ensure new staff have attended induction and have been given the opportunity to become familiar with their working environment.

- Oversee and promote the assessment of all patients at risk of falls in the clinical area for which they are responsible.

- Ensure that a Falls Risk and Care Plan (appendix 1) is completed for any patient aged over 65 (or younger if clinically relevant). Identifying a patient's INDIVIDUAL risk factors and taking steps to keep the patient safe and reduce likelihood of a fall during their time in hospital.

  For example :

    - Highlight patients who are at high risk of falls through patient safety brief at the beginning of each shift & ensure an appropriate intentional care record prescription is made and fulfilled. (appendix 2)

- Ensure that patients who are deemed to be a high risk of falls are in an appropriate bed space where there is the maximum amount of observation available & use a falls symbol on patient's bedhead. (appendix 3)

- Ensure that all appropriate measures are in place to reduce the likelihood of a fall. Including use of equipment such as low profile beds and sensor cushions. If bed rails are deemed appropriate complete the risk assessment (appendix 4)

- Promote high standards of patient care with regard to falls risk and falls management.

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

- Investigate incidents of patient falls:

    - Ensuring duty of candour has been undertaken where necessary.

    - Conduct a detailed investigation exploring the reasons for the fall and that any actions resulting from the investigation are implemented and lessons learned are shared with the help of the Patient Safety Team across the Trust.

All Clinical Staff

- All clinical staff who are involved in a patient's care should be aware of the patient's individual risk of falls and take steps to keep the patient safe. AHP and medical staff should liaise with the patient's nursing team to identify and, where possible, reduce the likelihood of a fall.
    - For example physiotherapists will provide advice on mobilising a patient, medical staff will review medications and assess the patient for delirium.

- Follow Health & Safety guidance to maintain a safe clinical/working area,
    - For example ensuring the bed space is free of clutter & spills are mopped up immediately.

- Work together as a MDT to promote patient independence with mobility and reduce risks of falls in hospital.

- Undertake mandatory training in manual handling and ensure the patient's Manual Handling Assessment is up-to-date.

- Provide information to the patient (and relatives where possible) on steps they can take to reduce their risk of falling whilst an inpatient.

- Report any incident fall through the Datix Reporting System and document in the patient's clinical records.

- Take responsibility for ensuring the post fall guidance is followed this includes completion by the reviewing doctor of a post fall assessment sticker in the patient's notes. Record actions implemented to reduce the likelihood of a further fall. (appendix 5/6)

The Multi-Professional Falls Working Group

- Leads on the development of falls prevention and falls management initiatives across the Trust

- Receive reports on falls, in particular those resulting in harm, reviewing the effectiveness of improvement measures, and making recommendations to support safe practice across all disciplines: nursing, medical and allied health professionals

- Support the work of the Falls Nurse.

- Actively promote the message that falls prevention involves the MDT and is not the sole remit of the nursing body.

Falls Nurse

- Contributes to and supports the Trust's falls working group to promote evidence based falls prevention strategies.
- Take a lead role in the development of appropriate evidence based assessment and screening tools related to patient falls
- Provide specialist education, training and advice to Trust staff.
- Provide support to clinical areas to help them maintain patient safety with regard to patient falls.
- Review reported incidents of patient falls in hospital and work with Matrons and Ward Managers where there are high numbers of falls.
- Review all falls resulting in serious injury and ensure appropriate remedial measures are taken and that lessons learned are shared across the Trust.
- Contribute to national audits of clinical practice related to patient falls.
- Undertake audits within the Trust to ensure compliance with falls prevention strategies and identify areas for improvement.

The Patient Safety Team

- Promote a positive safety culture within Plymouth Hospitals NHS Trust
- Promote shared learning across the organisation
- Support Trust projects relating to patient safety
- Support the Falls Team to monitor incident themes, and review with the falls working group, to ensure all opportunities for improvement are incorporated into the ongoing falls reduction work.
- Review, with the Falls Working Group, that measures taken are having an impact on falls reduction.
- Work with the wider quality governance team to disseminate learning across the organisation in conjunction with nursing and medical colleagues.

The Risk and Incident Team

- Ensure the Trust risk register is appropriately reviewed to reflect the risks relating to patient falls; to ensure that appropriate actions are taken/planned to mitigate the risks to patients
- Ensure duty of candour has been completed for all serious incidents

- Manage any serious incidents relating to falls in line with the Serious Incidents Requiring Investigation Policy.
- Ensure all serious incidents have robust investigation using root cause analysis methodology
- Conduct assurance visits to wards/departments to review whether actions resulting from a serious incident investigation have taken place, and that evidence is available to demonstrate the actions taken.
- Support staff involved in investigations in line with the supporting staff policy
- Identify and share learning
- Report to the Health and Safety Team any falls, including those classed as moderate, that result in a fracture.

Health and Safety Team

- Review Datix Incidents
- Review Datix Risk Register
- Liaise with the Risk & Incident Team in relation to serious and moderate patient falls incidents.
- Report monthly to the Health & Safety Committee
- Report patient falls to the HSE where this falls under the RIDDOR requirements
- Provide guidance in relation to health and safety matters utilising the green Health & Safety/COSHH folder
- Receive completed Workplace Safe Environment Safety Audits from each individual Ward/Department
- Provide 1:1 advice and guidance as requested
- Maintain a Health & Safety page on Staff Net with advice, guidance and references to legislation
- Receive reports on falls, in particular those resulting in harm, reviewing the effectiveness of improvement measures, and making recommendations to support safe practice across all disciplines: nursing, medical and allied health professionals
- Support the work of the falls nurse.

3 Strategies to prevent patient falls in hospital

The Trust's primary consideration is to reduce the number of patient falls and minimise the injury sustained from any fall in hospital.

Every ward has a falls resource folder which contains information aimed to educate staff on the common reasons for falls and what actions can be taken to reduce the risk of patient falls.

Of particular importance:

- The need to identify a patient's individual risks, for example poor vision, memory impairment, impaired balance, fear of falling. The care plan should focus on managing those risks to reduce the likelihood of a fall.
- Involvement of the MDT to help prevent patient falls.

- Good use of communications and visual clues to highlight those patients most at risk of falling.

4 Management of patients 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 the patient's condition following a fall. Prompt escalation if changes to the patient's conscious level trigger urgent medical review, use of appropriate equipment to safely move patients who are suspected to have suffered serious injury following a fall i.e. scoop stretcher.

The care of a patient who has fallen is detailed in appendix 5/6

Of particular importance:

- Initial assessment - Using an ABCDE approach.
- Safe transfer of a patient found on the floor using the scoop if lower limb, pubi rami or vertebral fracture(s) are suspected.
- Vital signs monitoring, including neurological observations, as indicated by the guidance
- Medical review of the patient should be undertaken – Immediately if serious injury is suspected and within 4 hours for all other falls. This review should seek to identify the cause for the fall in order that preventative measures can be taken to reduce further falls. A falls sticker should be placed in the hospital notes and completed by the doctor called to assess the patient.
- Nursing staff should review and update the falls, manual handling and intentional rounding documentation and add the patient to the ward safety brief.
- Duty of candour needs to be completed in line with the Serious Incident requiring Investigation policy
- Next of kin / relatives to be informed of fall in line with the patient's wishes or where the patient is deemed not to have capacity…
- Any patient fall must be recorded in the clinical record and reported via Datix reporting system.

5 Staff Training

The importance of training in relation to the management of patient risk of 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 service level through performance management.

Small group teaching in falls prevention strategies can be arranged by contacting the falls nurse.

6 Monitoring and Assurance

The Falls Working Group meets monthly and monitors progress against the falls reduction action plan

The reducing harm from falls project reports to the quality improvement committee each month

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 Director of Nursing and disseminated to nursing teams through the NMAB. 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 falls working group. Any such changes will be ratified by the Director of Nursing and will be reported retrospectively, to the NMAB.

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. For non-significant amendments, informal consultation will be restricted to the falls working group with input from other individuals as required who are directly affected by the proposed changes

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

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

Royal College of Physicians (2012) Implementing FallSafe - care bundles to reduce inpatient falls

NICE clinical guideline 161

Useful resources are available at

http://www.patientsafetyfirst.nhs.uk

http://www.npsa.nhs.uk

http://www.hse.gov.uk

Dissemination Plan	Appendix 7

Core Information	
Document Title	Prevention and Management of Patient Falls in Hospital (Adults) Policy
Date Finalised	November 2015
Dissemination Lead	Falls Working Group
Previous document in use?	Yes
Action to retrieve old copies.	To be managed by Document Controller - removal of old documents from StaffNET

Dissemination Plan

Recipient(s)	When	How	Responsibility	Progress update
All staff	August 2016	Vital Signs	Document Control	

Review and Approval Checklist		Appendix 8
Review		
Title	Is the title clear and unambiguous?	Yes
	Is it clear whether the document is a policy, procedure, protocol, framework, APN or SOP?	Yes
	Does the style & format comply?	Yes
Rationale	Are reasons for development of the document stated?	Yes
Development Process	Is the method described in brief?	Yes
	Are people involved in the development identified?	Yes
	Has a reasonable attempt has been made to ensure relevant expertise has been used?	Yes
	Is there evidence of consultation with stakeholders and users?	Yes
Content	Is the objective of the document clear?	Yes
	Is the target population clear and unambiguous?	Yes
	Are the intended outcomes described?	Yes
	Are the statements clear and unambiguous?	Yes
Evidence Base	Is the type of evidence to support the document identified explicitly?	Yes
	Are key references cited and in full?	Yes
	Are supporting documents referenced?	Yes
Approval	Does the document identify which committee/group will review it?	Yes
	If appropriate have the joint Human Resources/staff side committee (or equivalent) approved the document?	N/A
	Does the document identify which Executive Director will ratify it?	Yes
Dissemination & Implementation	Is there an outline/plan to identify how this will be done?	Yes
	Does the plan include the necessary training/support to ensure compliance?	Yes
Document Control	Does the document identify where it will be held?	Yes
	Have archiving arrangements for superseded documents been addressed?	Yes
Monitoring Compliance & Effectiveness	Are there measurable standards or KPIs to support the monitoring of compliance with and effectiveness of the document?	Yes
	Is there a plan to review or audit compliance with the document?	Yes
Review Date	Is the review date identified?	Yes
	Is the frequency of review identified? If so is it acceptable?	Yes
Overall Responsibility	Is it clear who will be responsible for co-ordinating the dissemination, implementation and review of the document?	Yes

Equalities and Human Rights Impact Assessment	Appendix 9

Core Information	
Manager	Steven Shearman
Care Group	Medicine
Date	October 2016
Title	Prevention and Management of Patient Falls in Hospital (Adults) Policy
What are the aims, objectives & projected outcomes?	This policy provides guidance for Plymouth Hospitals NHS Trust staff in the prevention and management of patient falls in hospital to: □ Promote staff awareness so that the risk of an inpatient fall is minimised. □ Reduce the likelihood of harm to patients through falls and ensure any patient who does fall in hospital is managed safely and in accordance with Trust guidance. □ 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**

Scope of the assessment
This impact assessment considers all protected characteristics

Collecting data	
Race	Where English is the patient's/relative's second language, care will be taken to ensure that information regarding how to reduce the risk of falls is given in a way that is clearly understood, including the use of interpreters where appropriate.
Religion	It is not anticipated that there will be any impact associated with religion but this will be monitored via Datix and any patient feedback received
Disability	This policy may impact positively on those patient who are at a greater risk of falling due to their disability. Where the disability affects the communication skills of the patient care will be taken to ensure that information regarding how to reduce the risk of falls is given in a way that is clearly understood, including the use of interpreters where appropriate.
Sex	It is not anticipated that there will be any impact associated with sex but this will be monitored via Datix and any patient feedback received
Gender Identity	It is not anticipated that there will be any impact associated with gender identity but this will be monitored via Datix and any patient feedback received
Sexual Orientation	It is not anticipated that there will be any impact associated with sexual orientation but this will be monitored via Datix and any patient feedback received
Age	This policy will impact positively on those older patients who are at a greater risk of falling.

Socio-Economic	It is not anticipated that there will be any impact associated with socio-economic group but this will be monitored via Datix and any patient feedback received
Human Rights	It is not anticipated that there will be any impact associated with human rights but this will be monitored via Datix and any patient feedback received
What are the overall trends/patterns in the above data?	There will be a positive impact for some older patients and some patients with a disability. When information is given to patients regarding how to reduce the risk of falling, care is required to ensure that the information is given in a way that is clearly understood
Specific issues and data gaps that may need to be addressed through consultation or further research	

Involving and consulting stakeholders	
Internal involvement and consultation	Steve, can you fill in these consultation sections please?
External involvement and consultation	
Overall assessment and analysis of the evidence	Some positive impacts have been identified for older patients and those with a disability. Feedback and Datix will be used to identify if other impacts arise

Action Plan

Action	Owner	Risks	Completion Date	Progress update
Review of Datix and patient feedback to identify any impacts arising	Steve Shearman		ongoing	