Agenda item 12
Paper F

THE NEWCASTLE UPON TYNE HOSPITALS NHS FOUNDATION TRUST

COUNCIL OF GOVERNORS

SLIPS, TRIPS AND FALLS

Report Purpose:	
Decision / Approval	
Discussion	✓
Information	

Brief description of the item and any significant issues:
This paper provides the national context for the Trust's performance on slips, trips and falls in hospitals and sets out a series of actions and recommendations to further improve patient, visitor and staff safety and reduce the number of such incidents resulting in major harm / injury.

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SLIPS, TRIPS AND FALLS

1. INTRODUCTION

In 2007 the National Patient Safety Agency (NPSA) produced a document entitled "*Slips, Trips and Falls in Hospital*". The report aims to give NHS staff an understanding of the scale and consequence of patients falling in hospital and suggests interventions that, when used together can reduce falls and injuries.

The NPSA worked with other organisations to examine research evidence and information on falls in hospitals, including over 200,000 incidents reported to the NPSA's National Reporting Learning System (NRLS) from acute and community hospitals and mental health units in a one year period. Whilst 96% of incidents caused minor or no harm the report identifies the significance these events can have on patients confidence, consequential delays in discharge and loss of independence.

Although serious incidents represent only 4% of all reported falls incidents, it is estimated that over 500 people suffer hip fractures each year following a fall in hospital. The NRLS analysis of reports identified 26 deaths following falls in hospital.

The NPSA report (2007) examined the following in relation to falls; causes and circumstances of falls, the most vulnerable patients, learning from the circumstances of falls, assessment of patients for risk of falls, preventing falls and reducing injury, after a fall and cost benefits of preventing falls

In particular the report identified:

Causes and circumstances of falls

- A fall can be as a result of a single factor, for example a faint. However, most falls, particularly those in older people are the result of several interacting factors. The following factors appear to be the most significant to hospital patients; walking unsteadily, being confused, being incontinent or needing to use the toilet frequently, having fallen before and taking sedatives or sleeping tablets.
- Efforts to reduce falls and injuries need to involve a wide range of staff in particular, those from the following groups; nursing, medical, therapy, pharmacy, management and facilities services. The report concluded that staff from these areas need to work with patients and their carers to strike a balance between falls prevention and rehabilitation

Most vulnerable

- Hospital patients are at a greater risk of falling than those in the community as they may undergo surgery which affects mobility or memory, medication related contributory factors including sedation, pain relief, anaesthetic and

other medications. Older people are vulnerable and those with a history of falls are at a higher risk again.
- Analysis of incident reports show most falls are not witnessed by staff and even when they are, staff are unlikely to be able to prevent the fall. Thus concluding that constant observations of patients may neither be feasible or effective in preventing falls.

Learning from the circumstances of falls
- NHS organisations need to make sure reports from their local risk management systems are analysed to understand where, when and why their patients are most vulnerable to falls, the report includes an example of what to report about a fall.

Assessment of patients for risk of falls
- The NPSA found some hospitals were using falls risk scores without checking how well they over or under predicted falls in their patients. The report provides guidance and explains that a risk score is not an essential part of falls prevention. Looking directly at risk factors that can be changed or avoided may be more effective at preventing falls.

Preventing falls and reducing injury
A range of interventions, used together and tailored to the individual can be effective. Possible interventions include;

- reviewing medication associated with a risk of falling
- detecting and treating causes of delirium, cardiovascular illness, eyesight problems
- detecting and treating or managing incontinence or urgency
- providing safe footwear
- physiotherapy, exercise and walking aids.

Research evidence is unclear whether the above interventions are effective for patients suffering from dementia. Evidence is too limited to recommend either hip protectors or movement alarms in hospital.

Hospital environmental factors which were found to impact upon the risk of falls or injury include;

- flooring surface and pattern, and hardness or softness of flooring
- lighting, including sudden changes from dim to bright light
- the design of floor and hand rails
- layout of toilets and bathrooms
- the distance and space between hand holds, beds, chairs and toilets
- the line of sight for staff observing patients
- trip hazards, including steps, clutter and cables
- furniture and medical equipment.

After a fall
- Following a fall there is the opportunity to reduce the degree of harm by promptly detecting and treating injuries. The reason for the fall should also be ascertained and safety measures applied to reduce the risk of further

falls or injuries. For patients who fall more than once, each fall should trigger a review of whether further interventions could reduce the risk of further falls. The report recognises that some organisations have excellent advice on what should happen after a fall. However, the analysis of incident reports shows that after care could be improved upon for many patients.

Cost benefits of preventing falls

- The report estimates overall direct healthcare costs to the NHS from patient falls is £15 million per year. This represents a cost of £92,000 per anum for an 800 bed acute hospital Trust. Research studies estimate that a range of individually targeted interventions could produce an 18 per cent reduction in the number of falls. This would result in cost savings of £16,560 in an average acute hospital.

2. CURRENT POSITION

Falls consistently remain the most frequently reported incident type in the Trust.

Whilst data is collected within the Trust is collected using different criteria to that used by the NPSA and is subsequently not directly comparable. Trust incidents are graded on the level of harm caused therefore similarities can be drawn the Trust data collection category of severity and that of the NPSA's degrees of harm.

Table 1 illustrates that the level of harm caused within the category of incident graded as insignificant or minor within the Trust account for 95.3% of incidents. Similar to the NPSA results which indicate 96% of falls incidents cause minor of no harm (table 2).

Table 1- Trust incidents by severity - 2007

Insignificant	Minor	Moderate	Major	Catastrophic
60.4%	34.9%	3%	1.7%	0

The NPSA reported the following degrees of harm from fall incidents in acute hospitals

Table 2 – NPSA degrees of harm caused by fall incidents

No harm	Low Harm	Moderate harm	Severe harm	Death
66.5%	29.5%	3.3%	0.7%	<0.1%

The percentage of incidents resulting categorised as severe within the Trust 1.7%, is higher than the NPSA's severe harm statistic of 0.7%. Whilst the figures are not directly comparable, it does identify a potential cause for concern particularly as the figure appears to be rising within the Trust, during the same time period in 2006 major incidents accounted for 1.1% of all fall incidents.

Whilst there is work ongoing within the Trust around slips, trips and falls, as the NPSA suggests there is scope for improvement. Work currently ongoing includes:

- existence of a city-wide Falls Prevention Group
- availability of ad hoc training
- targeted awareness sessions for specific Directorates

- risk assessors in each Directorate
- formal incident reporting processes
- regular production of reports for the Trust Board
- availability of Guidance on Health and Safety website
- processes in place to follow up of falls
- falls incorporated into Essence of Care, data collection planned for April 2008
- existence of Trust Guidelines on Preventing Falls in Adult Inpatients (2005) including; assessment tools and a multifaceted plan of interventions form which includes clinical and environmental intervention, appropriate referral processes.

3. THE NEXT STEPS

Implement slips, trips and falls recommendations (appendix1) which will include:

- Essence of Care audit incorporating audit of falls
- The Falls Prevention Group to review falls risk assessment tool followed by subsequent launch of new tool.
- Formalised annual rolling programme of Falls Prevention Training
- Issue guidance on the completion of incident forms relating to falls
- Develop incident reporting through the launch of a web based system for incident reporting
- Falls to be tabled as an item on the patient experience and quality report
- Ensure falls are reported at quarterly performance reviews for all Directorates
- Falls incidents to be reported at Risk Management Group
- To develop a Trust Falls Prevention Group?-
- Audit of Trust guidelines in Practice
- Audit of documentation for 75 random patients who have had a fall reported.
- Further information regarding what to do after a patient has a had a fall to be added to current version of guidelines
- To undertake training needs analysis of risk assessors

Diane Palmer
Assistant Director – Quality
April 2008

Slips Trips and Falls – Recommendations, Current Position and Further Work
The Newcastle upon Tyne Hospitals NHS Foundation Trust

Recommendations (modified from the NPSA 2007)	**Current Position**	**Scope for Further Work**	**Action Plan**
1. Each patient at risk of falling should receive multifaceted clinical and environmental interventions that could reduce the risk.	• Trust Guidelines on Preventing Falls in Adult Inpatients (2005) state that the Newcastle Falls Risk Assessment should be completed for all adult inpatients, *(a minority of wards are exempt from this e.g. obstetrics, and Ward 9 Coronary Care Freeman Hospital, use an adapted version).* The Falls Risk Assessment identifies those at risk of falling. The current tool calculates a risk score, however, a tool has been developed which would fit in with the NPSA's recommendation that there should be a shift towards directly identifying and treating risk factors. • If the patient is 'at risk' then a care plan or a *'Plan of Interventions' Form* is completed. The latter is multifaceted and includes clinical and environmental interventions. • Falls Prevention Training is provided for staff on an ad hoc basis, as outlined in the Clinical Governance and Risk Department Training Prospectus.	• Further work required on Guidelines to incorporate NPSA recommendations. • The Falls Risk Group should review the recently developed tool. Following review the tool could be introduced into practice. • Audit required to determine whether all clinical areas follow the Trust Guidelines. • A formalised annual rolling programme of Falls Prevention Training is required.	• Audit of documentation for 75 random patients who have had a falls incident reported to be undertaken by CGARD by June 2008. • Incorporate awareness of Preventing falls in Adult Inpatients into cycle of Essence of Care planned audits 2008. • Formalised annual rolling programme of Falls Prevention Training in place by March 2008. • Look at local health education programmes such as nurse training or courses and ensure Falls Prevention Training is included.
2. Circumstances of all falls to be described completely	• Forms generally completed comprehensively (verbal feedback from	• CGARD planning to introduce web based system for incident	• To develop specific falls reporting tool as per NPSA guidance on

Appendix 1

Recommendations (modified from the NPSA 2007)	Current Position	Scope for Further Work	Action Plan
and meaningfully on local incident forms.	CGARD), however more space on form would facilitate better completion. • Details of injuries not always included.	reporting during 2008 which will allow for prompts and provide more space for details.	Datix web, including incorporating the use of triggers & web link to guidance. • Re-issue guidance on completion of Incident Forms. Position of web site for easy access. • Measure knowledge of Plan of Interventions in Essence of Care Audit 2008.
3. Analyse and use reports of falls to learn about contributing factors from ward to Board level.	• Regular Progress Reports are produced to update the Board on current status. • Work at Directorate level on this • Falls Nurse Specialist has done targeted awareness raising work for medical wards – wards 22, 23, 52 (RVI). Plans to roll out to wards 18 and 19 (RVI). • The Trust has recently participated in a National Audit of Falls & Bone Health.	• Reinforce responsibility for this at Directorate level. • Reinforce responsibility for analysis and use of reports at Sisters/Charge Nurse meetings. • Consult with staff to identify causal factors of unreported near misses. • Roll out results of National audit and execute subsequent action plan.	• To be monthly item on patient experience and quality Board Report from March 2008. • To ensure that Falls Incidents are reported at quarterly performance reviews for all Directorates. • Falls incidents to be reported at the Strategic Risk Management Group.
4. Create a Falls Prevention Group with the right members to act on both clinical and environmental risk factors.	• Nurse Consultant for Vulnerable Older Adults chairs city-wide Falls Prevention Group which is attended by Falls Nurse Specialist, Falls Consultants, Specialists from the Osteoporosis Services, Pharmacy representative, Occupational Health representative, Health & Safety representative, Physiotherapy representative. • Each Directorate has an identified Risk Assessor responsible for conducting local risk assessments. Risk Assessors	• Establish a Trust Group to focus on clinical and environmental risk factors. • Development of local environmental risk assessment tools. • Establish a team to carry out environmental falls risk assessments based on criteria provided by the NPSA & environmental factors identified	• To develop a Trust 'Falls Prevention Group'. • To undertake training needs analysis of risk assessors.

Recommendations (modified from the NPSA 2007)	Current Position	Scope for Further Work	Action Plan
	are provided support and guidance as required by the Trust's Health & Safety Department. • The Trust Health & Safety Department has a website which provides guidance on Slip, Trips and Falls. In addition, a staff booklet has been produced by the Department which identifies methods of reducing Slips, Trips & Falls.	through local incident analysis. • Establish public and patient links and incorporate their opinions into action plans developed by the Group.	
5. Base falls prevention policies on the evidence described in the NPSA Report entitled Slips Trips and Falls in Hospital.	• Trust Guidelines on Preventing falls in Adult Inpatients are in line with this report, with the exception of the falls tool.	• Scope for further work as outlined in point 1 • Ensure Guidelines use in practice • Raise awareness of guidelines	• Review date March 2008, lead by Nurse Consultant Clare Abley.
6. If using a falls risk score, understand to what degree it under or over predicts the chances of a patient falling.	• Trust Guidelines currently include the use of a "Falls Risk score." • Work is ongoing to develop a Falls checklist which does not include a scoring system. The new checklist will be launched for Trust wide use following the current review of the guidelines it's introduction will be supported by education sessions provided by the Falls team.	• Audit of completion of Falls Risk Assessment Form.	• Audit of documentation for 75 random patients who have had a falls incident reported to be undertaken by CGARD by June 2008. • Incorporate awareness of Preventing falls in Adult Inpatients into cycle of Essence of Care planned audits 2008.
7. Have appropriate guidance for staff on how to observe, investigate, care for and treat patients, staff and visitors who have fallen.	• Current Guidelines for patients include advice on referring on to the Newcastle Integrated Falls Service and also on diagnosis and treatment of osteoporosis. • Root Cause Analysis training available for staff with responsibilities for investigating adverse incidents.	• Further information on 'what to do after a fall' to be added when Guidelines on preventing falls are next updated (due for update in March 2008).	• Review date March 2008, lead by Nurse Consultant Clare Abley.

Recommendations (modified from the NPSA 2007)	Current Position	Scope for Further Work	Action Plan
	• Health & Safety processes in place for follow up of staff & visitor falls. • Clinical Governance and Risk Department has processes in place for the follow up of patient incidents.		

Clare Abley
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Supported by
Elaine Coghill – Senior Nurse, Service Improvement
Pam Reeve – Senior Sister, Falls and Syncope Service
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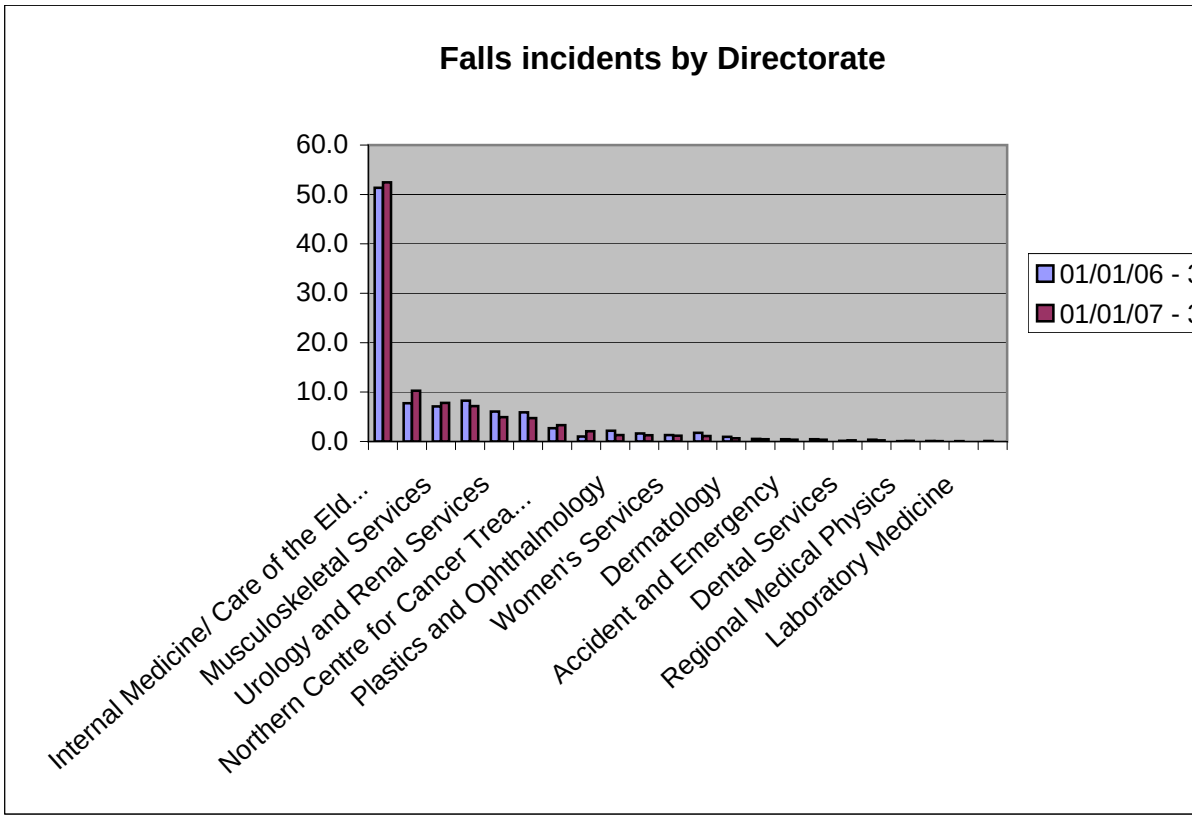
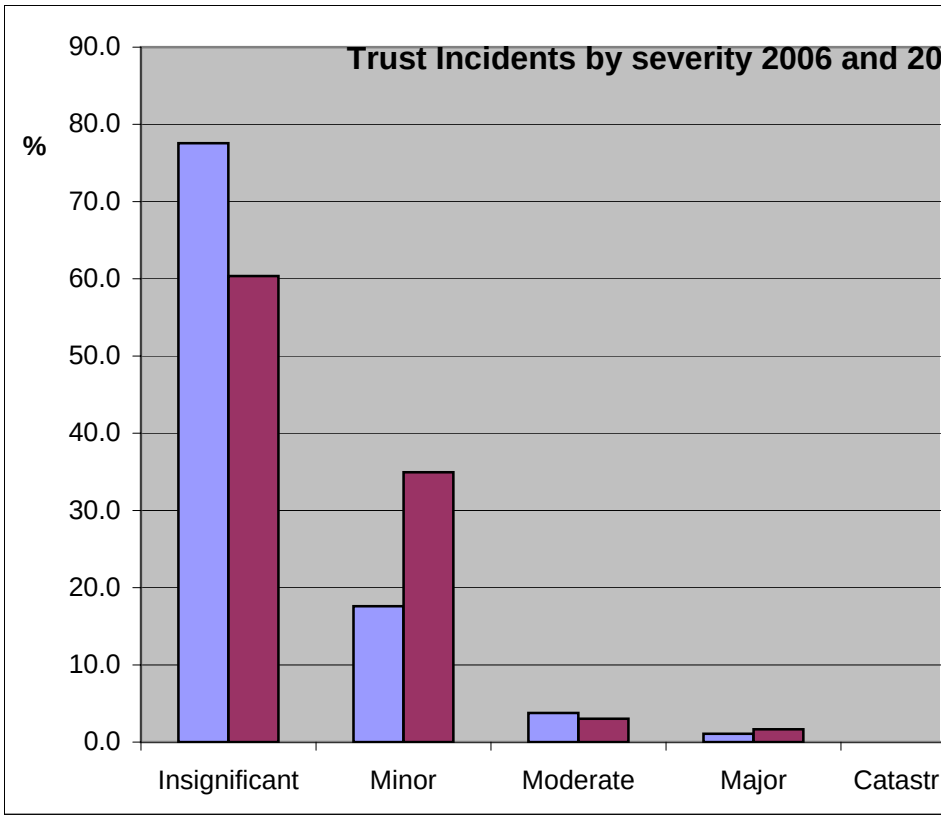
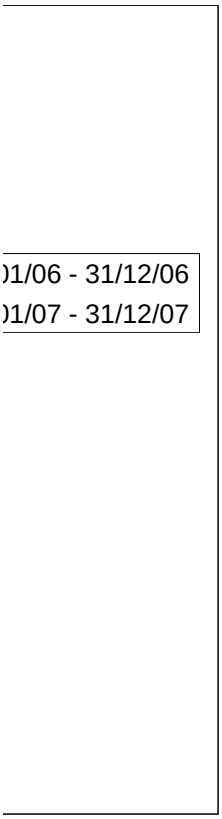
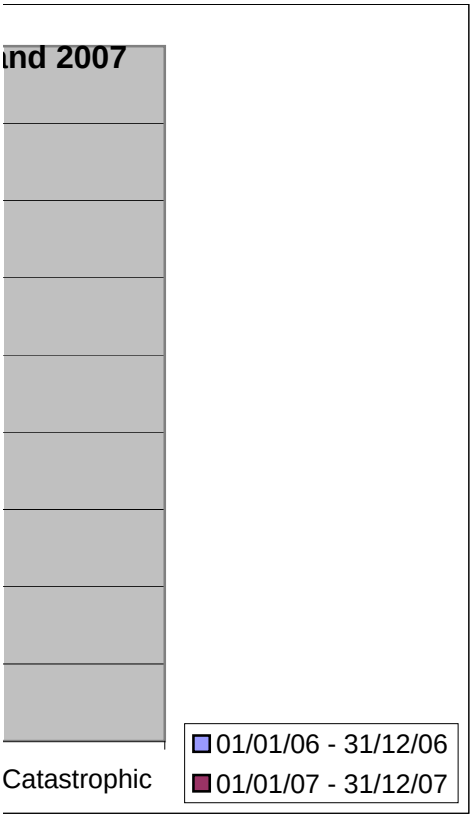
Karen Collingwood – Clinical Effectiveness Advisor


Falls incidents by Directorate
60.0
50.0
40.0
30.0
20.0
10.0
0.0
01/01/06 -
01/01/07 -
Internal Medicine/ Care of the Eld...
Musculoskeletal Services
Urology and Renal Services
Northern Centre for Cancer Trea...
Plastics and Ophthalmology
Women's Services
Dermatology
Accident and Emergency
Dental Services
Regional Medical Physics
Laboratory Medicine


Trust Incidents by severity 2006 and 20
%
90.0
80.0
70.0
60.0
50.0
40.0
30.0
20.0
10.0
0.0
Insignificant
Minor
Moderate
Major
Catastr


01/06 - 31/12/06
01/07 - 31/12/07


nd 2007
Catastrophic
01/01/06 - 31/12/06
01/01/07 - 31/12/07