HSC Public Health Agency

HSC Health and Social Care Board

# PREVENTION OF FALLS RESULTING IN MODERATE TO SEVERE HARM.

# EVALUATION OF NEW PROCESS REPORT

**November 2018**

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## Methodology

## Trusts' Responses

In relation to the question "What are the main mechanisms by which this programme has worked?"

### WHSCT

Commitment from all levels of multi-disciplinary staff.

Regional focus and improvement work already started. Falls

Prevention group and the falls learning group

### NHSCT

Having a falls coordinator to oversee the implementation of the programme.

Having a process to follow regarding completion of investigations.

### SEHSCT

There is awareness that Falls prevention is a key priority to preventing harm to patients.

Communication and focus of resources

### BHSCT

It has worked as a fall safe coordinator was appointed in 2016 who drove the project forward

the coordinator had a vast amount of experience in improvement projects and was able to transfer these skills to embed the project.

by the fall safe coordinator raising awareness, educating, inspiting and supporting staff this project has been embedded in the Trust and is now high on the quality improvement agenda

### SHSCT

Training has been provided to staff, on the elements of the falls prevention bundle.

Audit of the falls prevention bundle with feedback and improvement action plans.

Feedback of the falls data on the walking stick and from datix has informed staff of numbers of falls and how implementation of the bundle has impacted on falls.
Shared learning.

# Conclusions

**This evaluation has clearly demonstrated an improvement in the**
**-Timeliness**
**-Learning**
**-Reporting**
**Of all falls incidents resulting in moderate to major/catastrophic.**

Further to this evaluation it is recommended that the PHA take action to further embed the new process across all HSC trust areas.

Overall a number of key improvements were noted in relation to the new process

**Positive feedback was received from the Trusts.**

Falls prevention will continue to be a regional priority

Further focus is required to embed this process across all trust areas including commissioned services (residential and nursing homes).

There has been a significant reduction in reported SAIs/SEAs over the past two years and falls are now reported as incidents in a timely way, by the appropriate staff.

There has been a reduction in the regional falls rates resulting in moderate to major/catastrophic harm per 1000 bed days

The responses from all the methodologies used identified a number of areas for improvement and these have been incorporated into the recommendations.

# Recommendations

## Recommendations already actioned

- The definition of what constitutes a fall should be clearly documented and communicated to all Trusts.
- PHA in collaboration with the HSC Trusts should review the current timeframes for undertaking a post fall review for ongoing applicability and achievability.
- The PHA in collaboration with HSC Trusts should review the current requirements for grading/reporting of falls and consider bringing the definitions into line with those already contained within DATIX.

## Recommendations and areas for potential development

- The PHA should review the pilot and take action to further embed the new process.
- Further work is required to ensure the process is spread and embedded in all areas within Trusts including commissioned services (nursing and residential homes).
- Reporting on regional themes and learning should be populated and disseminated regionally.
- Training for Falls prevention across all Trusts should be evaluated and a consistent approach considered.
- This model should be considered for other SAIs e.g. Prisons or suicide incidents.

## 1.0 INTRODUCTION

This Report provides an evaluation of the new process for reporting of falls resulting in moderate to severe harm which was introduced in April 2016 (see appendix 1). It has given consideration to the findings from internal audit reports which were carried out both regionally and within individual Trusts and examines the findings from a, *Regional Learning Event on Falls Prevention - a multidisciplinary approach*, which was held on 30th March 2017. In addition analysis from feedback forms completed by all HSC Trusts and secondary data pertaining to all Trusts was used as part of the evaluation.

A Regional In-Patient Falls Prevention Group, led by the PHA, had been established (April 2013) to provide multidisciplinary advice and support across the HSC in preventing harm to patients who fall whilst in hospital and share regional learning across Northern Ireland. It focuses on sustainable strategies for falls prevention and management across Trusts and is the group overseeing this evaluation process.

This report describes the background, the aims of the improvement work, measures identified, outcomes and the challenges encountered by the Regional In-Patient Falls Prevention Group as well as presenting the results achieved. It also makes recommendations for further work to improve falls prevention, reporting and the learning process across the region.

## 2.0 BACKGROUND

In December 2015 a thematic review was published which analysed and identified the numbers and types of Serious Adverse Incidents (SAIs) relating to patients with a fall resulting in moderate to severe harm and reported as an SAI, across all programmes of care.

The purpose of this report was to identify recurrent themes within the reported SAIs, to consider any regional learning and whether any further actions were required to reduce/prevent reoccurrence of these incidents. This review provided a detailed analysis of SAIs relating to where a patient with a fall resulting in moderate to severe harm and reported as an SAI, had occurred. A review of all the relevant SAIs reported, within HSC was carried out across all programmes of care for the period of 6 months, 1 October 2013 to 31 March 2014.

From the conclusions of this review it was clear that there was a need to learn from these investigations and use them to inform future quality improvement work. The findings of this review indicate that there are multi-faceted reasons for falls resulting in fractures and it has to be acknowledged that not all of them are preventable. It was clear from the review that whilst a huge amount of work had been undertaken by Trusts and Designated Review Officers (DROs) in managing these SAIs, this had not

identified a lot of new learning. Donaldson[1] reported that lack of consistently high standards of investigation and action planning are barriers to effective risk reduction within health and social care organisations. He also identified another barrier to be the limited degree to which front line staff are involved in discussing and seeking solutions to things that have gone wrong. Further to this thematic review a proposed new way forward was conducted for a year's period.

This new approach recommended that front line multidisciplinary staff were key to post falls review of these incidents. It was agreed that Trusts would manage falls resulting in moderate to severe injury as adverse incidents and undertake a Post Falls Review internally, unless there were particular issues or identified learning that need to be investigated through the SAI process. The aim was that all falls resulting in moderate to serious harm would be reviewed locally by Trusts on a quarterly basis and reported in through the Regional In-Patient Falls Prevention Group to identify learning, themes and trends.

The Regional In-Patient Falls Prevention Group adopted a regional approach to the management of patient falls across Trusts in N.I. and worked towards the standardisation of a regional post falls review document and post falls minimum dataset (see appendix 2) for use in all settings in line with best practice. This project commenced in April 2016, for the period of two years with view to evaluating following this in June 2018 to see if it is more effective than the previous process.

During the past two year from April 2016 to present day, all falls resulting in moderate to severe harm are reviewed locally by Trusts as near to the incident happening as possible; and on a quarterly basis are reported to the Regional In-Patient Falls Prevention Group to identify learning, themes and trends. This group is working towards adopting a regional approach to the management of patient falls across Trusts in N.I. Work continues on the standardisation of a regional post falls review documentation and post falls assessment tool for use in all settings in line with best practice.

The identified themes will inform the quality improvement work in falls prevention through the Regional In-Patient Falls Prevention Group. Elements within the 'Fallsafe' bundle link directly with the themes arising from the thematic review and confirm the opportunity to use this to address the factors contributing to harm.

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[1] The Donaldson Report: (December 2014), 'The Right Time, The Right Place'; an expert examination of the application of health and social care governance arrangements for ensuring the quality of care provision in Northern Ireland.

## 3.0 EVALUATION OVERVIEW

### 3.1 Aim: To measure the impact of the programme of work relating to prevention of falls. This Includes:

- Post falls review to be carried out within 72 hours of the incident being discovered (5 working days at bank holidays).
- Completion of minimum dataset post fall.
- Completion of falls shared learning template.
- To identify any gaps or potential areas for improvement in the falls prevention programme or where things need to be changed.

### 3.2 Objectives

- Are there tangible improvements in the reporting process and timeliness of response following the incidents?
- Identify any gaps and how are these evidenced?
- As a result of Falls work programme who has benefitted/or not and why?
- In what context did this programme work and why?
- What are the main mechanisms by which this programme worked?
- If this programme has worked what (measureable) outcomes have we seen as a result?
- What has been the impact on strategic priorities?
- Where should we focus next?

### 3.3 Timeframes

- Evaluation to cover period from 1 April 2016 – 31 March 2018

## 4.0 METHODOLOGY

This evaluation will be analysed using feedback from the following key areas;

- **Analysis of secondary data which includes**:
  - Trust learning submissions from their falls incidents resulting in moderate to severe harm
  - Any SEA/SAI reports submitted relating to falls resulting in moderate to severe harm.
  - The falls data submitted quarterly on SharePoint relating to numbers of falls resulting in moderate to severe harm.

- **Analysis of returned Evaluation Forms from Each Trust which included the following:**
  - Composition of the falls team for both hospital and community.
  - Regional and Trust strategies for falls prevention
  - The new regional falls work programme from April 2016
  - Any further Trust information which may be relevant to the ongoing work relating to falls prevention

- **Analysis of each organisation's internal Audit Report (including the PHA and 5 HSC trust reports).**
  - In accordance with the 2016/17 annual audit plan, BSO Internal Audit carried out an audit of learning from Serious Adverse Incidents (SAIs) and from falls within the PHA and within the 5 HSC trusts.
  - This audit was carried out during January and February 2017, and included audit of the new pilot process for the investigation learning and reporting of moderate to severe harm from falls. At the time of the audit this had been rolled out across all Trusts.
  - Internal Audit conducted a regional audit of the management of falls across all 5 Trusts during this time period; including the operation of the PHA pilot. It was agreed to consider the findings from these audits as part of the wider evaluation process.

- **Analysis of CEC regional learning event**
  - A Multidisciplinary Falls Prevention learning event was held on Thursday 30th March 2017 and was facilitated by the Clinical Education Centre (CEC). This event shared professional developments in relation to the prevention and management of falls and its objectives were to:
    - Outline the regional perspective with regards to the Falls Prevention strategy including the impact and factors in relation to falls
    - Opportunity to share current practice and innovation with regards to the multidisciplinary approach to Falls Prevention and the implementation of the Falls Safe Bundle
    - Explore opportunities for a regional educational approach in relation to Falls Prevention for Nursing and Allied Health Professionals
  - It was agreed by the Regional In-Patient Falls Prevention Group that feedback from this event should be considered as part of the wider evaluation of the new falls process and wider consideration for improvements.

## 5.0 ANALYSIS

### 5.1 Secondary Data

#### 5.1.1 Learning submissions

The reasons why patients fall are complex and have numerous contributing factors such as physical illness, mental health, medication, age and environmental factors.

From the learning submissions this evaluation identifies similar themes to those that had been previously highlighted in the regional thematic review[2], however many improvements were also noted as a result of the introduction of the new Falls process. Each individual case resulting in moderate to severe harm had an investigation performed (appendix 3) which identified the following:

- What happened?
- What went well?
- What if anything could we improve?
- What have we learnt? (Locally – and any Regional Learning)

All Trusts confirmed in their feedback that they now manage falls resulting in moderate to severe injury as adverse incidents and undertake a Post Falls Review internally, unless there are particular issues or identified learning that need to be investigated through the SAI process. Whilst all Trusts have spread this process to include commissioned services (nursing and residential homes), there are still inconsistencies in the reporting of these. Further work is required to ensure the process is spread and embedded in all areas within Trusts. In the majority of cases reported the post falls review was carried out however there were challenges to meeting the agreed target of within 72 hours of the incident being discovered (5 working days at bank holidays). It was agreed to review the time frames for ongoing applicability and achievability.

#### 5.1.2 SEA/SAI reports and Falls Data

[2] PHA THEMATIC REVIEW 'Report on the Regional Review of Patients with a fall resulting in Moderate to Severe Harm and reported as an SAI': December 2015

There were 14 cases reported and investigated as SEA – level one for 2016/17 and 15 cases reported and investigated as SEA – level one for 2017/18, this has significantly reduced from the previous two years (see table one).

**Table 1**

| Reporting Organisation | 2014/15 | 2015/16 | 2016/17 | 2017/18 | TOTAL |
|---|---|---|---|---|---|
| BHSCT | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] |
| NHSCT | 58 | [illegible] | [illegible] | [illegible] | [illegible] |
| SEHSCT | [illegible] | 12 | [illegible] | [illegible] | [illegible] |
| SHSCT | 58 | 45 | [illegible] | [illegible] | [illegible] |
| WHSCT | 12 | 14 | [illegible] | 5 | [illegible] |
| **Total** | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] |

**Source: HSCB Datix (14.06.18)**

Trusts have alluded to the fact that the new process, has led to more timely learning being identified by the appropriate staff i.e. the staff who are looking after the patient and are aware of environmental factors etc. All 5 HSC Trusts confirmed they have processes in place to share the local learning identified in their shared learning templates. In addition the learning from all incidents (both SEAs and adverse incidents) is collated and shared at the Regional In-Patient Falls Prevention Group. It is recognised that a more robust method for reporting on regional themes and learning should be developed and disseminated regionally.

### 5.2 Analysis of Trust Evaluation Feedback

All Trusts were asked for feedback on the following:

- The new regional falls work programme from April 2016 – March 2018.
- Any further trust information which may be relevant to the ongoing work relating to falls prevention.

Overall the Trusts' responses in relation to the new falls evaluation process were positive. The following questions were asked in the Trusts' questionnaires (see appendix 4) and they are followed by each Trusts individual response.

### 5.2.1 Tangible improvements

**WHSCT**

*Grading of falls incidents has significantly improved with focused training and awareness in this area therefore more appropriately focusing falls review where needed. This is evidenced through incidents reporting of falls to PHA of moderate and above.*

**SEHSCT**

*We believe this process supported by the launch of the updated policy has improved communication in the Trust; we are still working towards embedding the process. Greater awareness evidenced in improvements in the KPI compliance and use of Falls Prevention as focus of the week in wards (as required)*

**SHSCT**

*Local Patient Safety Falls data – wards using the safety cross (27 wards) falls by bed days show a falls reduction over the last 3 months – this is a validated process within adult acute, non-acute and mental health inpatient ward areas where falls patient safety work has been focused and audit processes implemented.*
*Patient Safety Falls Data in Q2 17/18 shows a reduction of almost 20% compared to Q1 17/18*
*There is general ongoing awareness of falls prevention within the Trust.*

**NHSCT**

*Staff though training and questions on Datixweb are more aware of the need to report falls that result in a moderate to severe injury to the Falls Prevention Team. They are also more aware of the importance of learning and improving practice following investigations of an injurious falls – action plans are now completed following injurious falls and implemented by Ward Sisters.*
*Trust has achieved a reduction in the number of moderate to severe falls. There has been an increase in awareness of the severity of injury. This can be evidenced through data that is forwarded via the shared point.*

**BHSCT**

*Improvements are clear in the data. This is collected from the datix system. The fall safe project has led to raising staff, patient and carer awareness, engagement and education. Governance and Quality managers are now informed of a fall that is graded moderate or above.*

### 5.2.2 Identification of gaps

**WHSCT**

*The quality of learning identified is improving but monthly reviews of completed templates indicate further review is often required. Additional awareness sessions for the ward sisters are planned.*

**SET**

*Nothing identified at present but there is a focus on the wards which have moved to our new build to identify any impact single rooms have on the rate of falls.*

**SHSCT**

*The Trust is reviewing and formalising falls training and including it in mandatory training every 3 years.*

**BHSCT**

*Reporting of falls across each directorate was inconsistent in the past however, this has improved. Currently we are not sure of gaps.*

**NHSCT**

*Each Directorate decides if an incident should be reported as an SAI, and this should happen within 72 hours. The Division will use the falls investigation report to help make this decision. As investigations are not always completed within the 72 hour timeframe, a decision regarding an SAI has to be made prior to the falls team completing an investigation.*

### 5.2.3 Level of engagement in the programme.

**WHSCT**

Ward sisters are broadly engaged in the process. Patients/users engagement has not been prioritised at this stage.

**BHSCT**

There are 62 wards engaged in the programme in the Trust across 5 sites. This includes management, staff and patients of each ward.

**NHSCT**

Engagement with the process is at all levels. The following staff receives a completed investigation report:-

- Assistant Director of Nursing and Assistant Director for relevant directorate
- Head of Governance and Governance Manager for Directorate
- Health & Safety Officer
- Ward Sister
- Assistant General Manager and Divisional Nurse for Directorate

Patient / families are informed by the senior manager that an investigation is being completed regarding the incident, and upon completion the report is discussed with the patients / family.

**SEHSCT**

We held a workshop in June and we have enrolled a number of falls champions

**SHSCT**

Engagement is good within the Trust with good clinical and nursing engagement. There is good management support

### 5.2.4 Identification of challenges and enablers

**WHSCT**

**Challenges** - Delay in appointment in falls co-ordinator. Other competing priorities for staff at all levels. Commitment from all levels of multi-disciplinary staff.
**Enablers –** Regional focus and Improvement work already started. Falls Prevention group and the falls learning review group.

**SEHSCT**

**Challenges** - communication, you think you have done it, however there is always something that slips through the net.

The **enablers** will be the network of champions

**BHSCT**

**Challenges: -**
- The lack of resources given to deliver this project.
- This project is one of many quality initiatives to drive within the Trust.
- 1 Fall safe coordinator delivering to a vast number of ward areas across 5 sites in the Trust
- Engagement of staff within ward areas
- Level of engagement from medical colleagues

**Enablers: -**
- Good support from the Trust Falls Forum group to deliver the project
- Peer support provided to Fall safe coordinator

**SHSCT**

**Challenges:-** Operational pressures remain a challenge in the ability to deliver this programme

**Enablers:-** Dedicated post

**NHSCT**

**Challenges:-** Availability of staff to complete the investigation within the current timeframe

### 5.2.5 Beneficiaries

**WHSCT**

Delay in appointment in falls co-ordinator. Other competing priorities for staff at all levels. Commitment from all levels of multi-disciplinary staff.

Regional focus and Improvement work already started. Falls Prevention group and the falls learning review group.

**NHSCT**

Staff - investigation reports identify learning / areas for improvement regarding practice. Service users - will benefit as knowledge and standards of care regarding falls prevention and management are increased through service improvement.

The organisation - reduced number of falls resulting in moderate to severe injury

**BHSCT**

- Patients, carers and staff have all benefitted from this work.
- This is clear from the reduction of the number and severity of falls within the Trust.
- Some feedback from patients, carers and staff:
- They did not realise how important their footwear was while in hospital and how proper fitting slippers could reduce their risk of a fall.
- Some staff could not believe how something as simple as ensuring the patient's table is always within reach could reduce the risk of a fall.

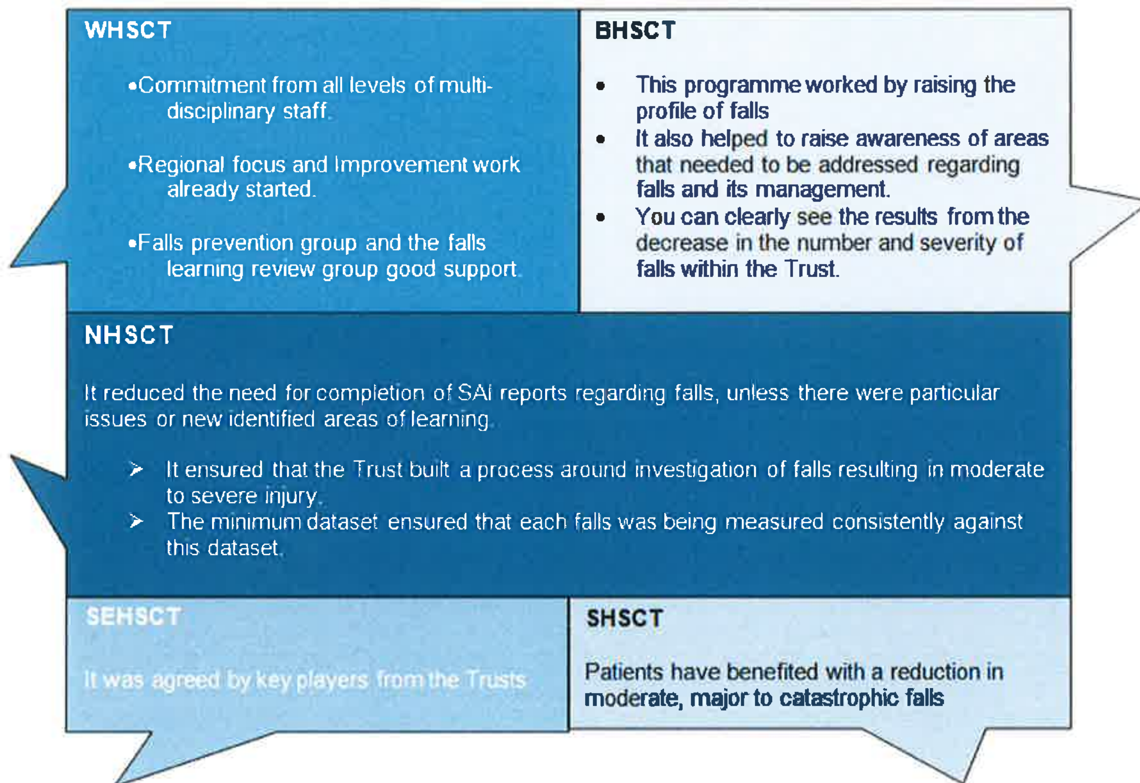
**SEHSCT**

Staff and patients

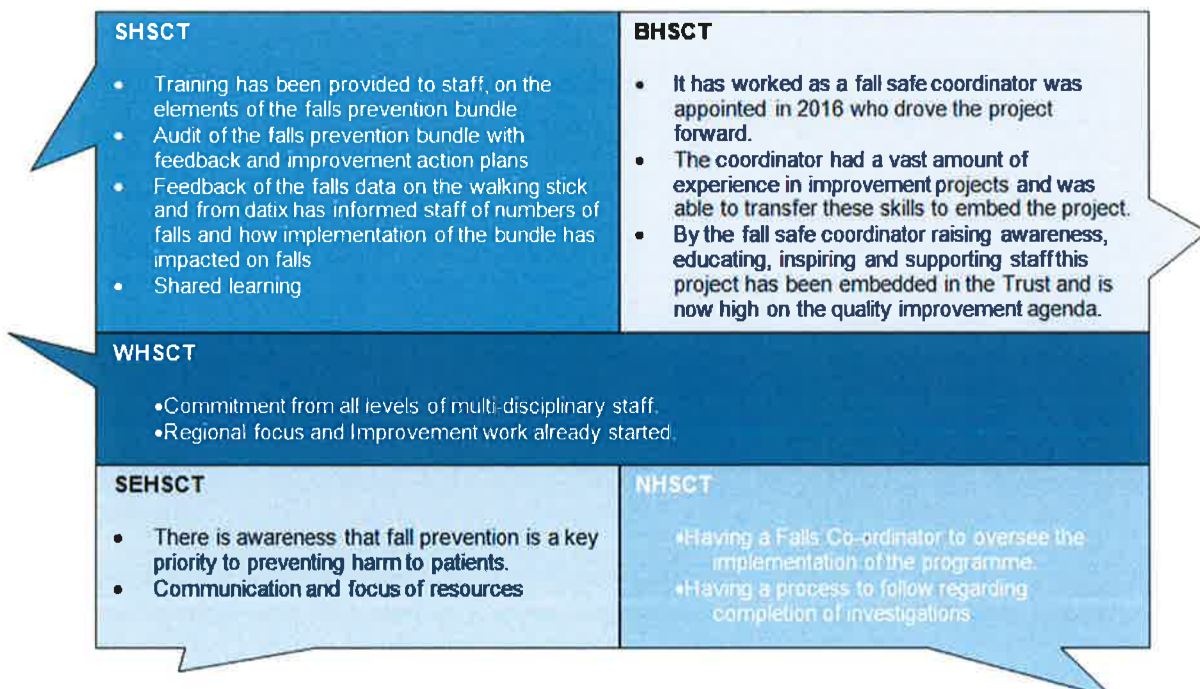
**SHSCT**

Patients have benefited with a reduction in all falls and injurious falls

### 5.2.6 Why did it work?




### 5.2.7 Identification of mechanisms enabling it to work



### 5.2.7 Impact on strategic priorities

### 5.2.8 Analysis of Overall Responses from Returned Evaluation Reports

Trust responses to the new process have been generally positive. Trusts have indicated that:

- There have been improvements in grading of falls incidents and in the awareness regarding the falls programme.
- There has been increased consideration for falls training across the Trusts but an indication that this could be improved if a regional e-learning training tool was developed.
- While there has been improved communication identified with senior teams, ward managers and ward staff there appears to be challenges in relation to patient/user engagement.
- Some Trusts identified lack of to deliver the programme in a timely way.
- The development of peer support and falls champions has been a positive support to the Falls Safe Coordinator. This works well as it ensure falls management doesn't become person dependant.
- All Trusts have indicated that patients have benefited by this new process and all Trusts have noted a percentage reduction in falls resulting in moderate to major/catastrophic injury.
- The commitment from all levels of multi-disciplinary staff is evident and most Trusts commended the regional focus on falls prevention.

### 5.2.10 Analysis of each organisation's internal Audit Report (including the PHA and 5 HSC trust reports).

In accordance with the 2016/17 annual audit plan, BSO Internal Audit carried out an audit of learning from Serious Adverse Incidents (SAIs) and from falls within the PHA and within the 5 HSC trusts. This audit was carried out during January and February 2017, and included audit of the new pilot process for the investigation learning and reporting of moderate to severe harm from falls. At the time of the audit this had been rolled out across all Trusts. Internal Audit conducted a regional audit of the management of falls across all 5 Trusts during this time period; including the operation of the PHA pilot. It was agreed to consider the findings from these audits as part of the wider evaluation process.

The main findings from the BSO audits have mostly been addressed by the Regional Falls Group and have complemented the new process for reporting falls. These recommendations included:

| Recommendation | Action |
| --- | --- |
| The definition of what constitutes a fall should be clearly documented and communicated to all Trusts. | In relation to the Falls definition, the Regional In-Patient Falls Prevention Group have agreed the WHO definition ***"Falls are commonly defined as inadvertently coming to rest on the ground, floor or other lower level, excluding intentional change in position to rest in furniture, wall or other objects".*** |

| Recommendation | Action |
| --- | --- |
| PHA should review the current timeframes for undertaking a post fall review for ongoing applicability and achievability. | The Regional In-Patient Falls Prevention Group recognised the challenges with the tight time frames and have agreed to extend the Post falls review to be carried out within10 days, this will be formalised on completion of evaluation |

| Recommendation | Action |
| --- | --- |
| PHA should review the current requirements for grading / reporting of falls and consider bringing the definitions into line with those already contained within DATIX. | The Regional In-Patient Falls Prevention Group have agreed to using the regional DATIX Risk Matrix to categorise falls which changed from moderate to severe/death to moderate, major and catastrophic. |

| Recommendation | Action |
| --- | --- |
| The PHA reviews the pilot and take action to further embed it. | This will be addressed as part of the new falls reporting process |

| Recommendation | Action |
| --- | --- |
| Reporting on regional themes and learning should be populated and disseminated regionally. | Whilst this is carried out both locally as part of the Trusts' processes and regionally via the Regional In-Patient Falls Prevention Group, other methods of learning from the falls process to date will be considered and as a first step a Falls learning section will be added to the Learning Matters newsletter and consideration given to a regional falls learning event in early 2019. |

## 5.3 Analysis of CEC regional learning event

A Multidisciplinary Falls Prevention learning event was held on Thursday 30th March 2017. This event facilitated professional development in relation to the prevention and management of falls and its objectives were to:

- Outline the regional perspective with regards to the Falls Prevention strategy including the impact and factors in relation to falls
- Opportunity to share current practice and innovation with regards to the multidisciplinary approach to Falls Prevention and the implementation of the Falls Safe Bundle
- Explore opportunities for a regional educational approach in relation to Falls Prevention for Nursing and Allied Health Professionals

It was agreed by the Regional In-Patient Falls Prevention Group that feedback from this event should be considered as part of the wider evaluation of the new falls process and wider consideration for improvements. The event was evaluated positively and the feedback commended the work currently being carried out in inpatient settings. There was also positive feedback regarding the good Multi-disciplinary relationships both in Trusts and regionally. There were many examples of what is currently working well within Trusts (see appendix) such as the falls pathway, the MDT falls clinics, the use of safety briefing to identify patients at risk of Falls and improvements in reporting. Many challenges were also identified (see appendix xx) these include for example: - wider approach to falls prevention to

extend to community, nursing homes etc., review of all reporting systems and coding. Potential solutions were recommended around areas such as communication, partnership approach being used across all services and planned approach to discharge. There was also recognition that a holistic approach to education on falls prevention would be very useful and some recommendations were made regarding this for consideration.

## 6.0 OUTCOMES

As part of the evaluation process to measure the effectiveness of the new reporting project, the Regional In-Patient Falls Prevention Group agreed to monitor the rates from the reports on the incidents of falls resulting in moderate or major/catastrophic harm per 1,000 bed days."

The 2016/17 & 2017/18 Commissioning Plan requirement states:

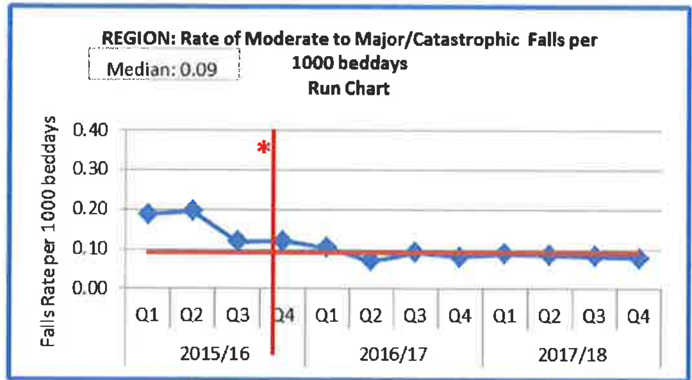
"Trusts will monitor and provide reports on the number of incidents of falls, those which cause moderate or major/catastrophic harm and the rate per 1,000 bed days."

Falls incidents are monitored and information submitted to the HSCT and PHA on a quarterly basis. A core function of the Public Health Agency (PHA) is to provide leadership and support to health and social care providers in improving the quality of services delivered to service users.

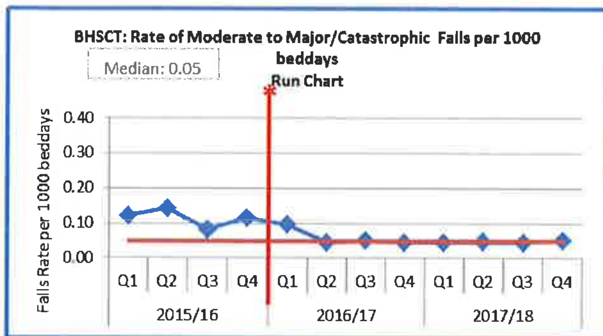
HSC Trusts routinely report to the PHA/HSCB and Department of Health (DoH), the numbers and rates of falls incidents classified as causing moderate to major/catastrophic harm. The results from this will be analysis to see if there is a correlation between the new process and the reduction of rates of falls resulting in moderate or major/catastrophic harm per 1,000 bed days.

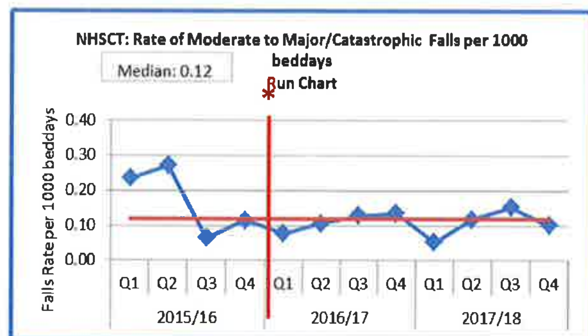
In addition as an outcome measure Trusts were asked 'if this programme has worked what (measureable) outcomes have we seen as a result', the feedback from this question will also be considered.

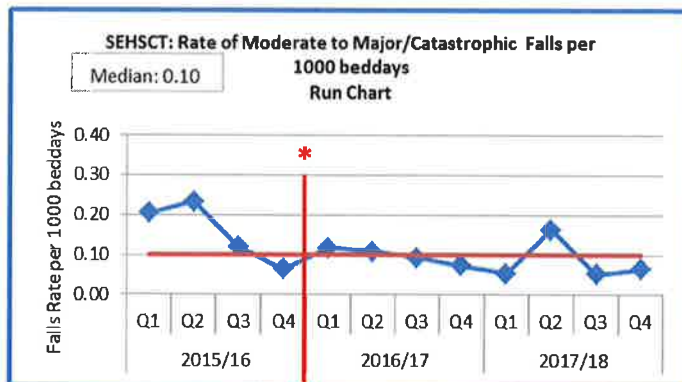
The following graphs show the total rate of falls per 1,000 occupied bed days (from April 2015 to March 2018) which resulted in harm of a moderate/major/catastrophic nature.

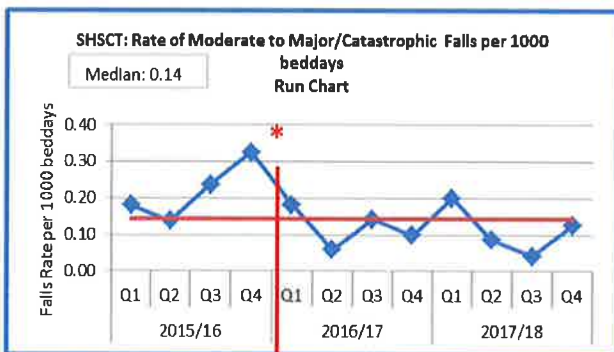


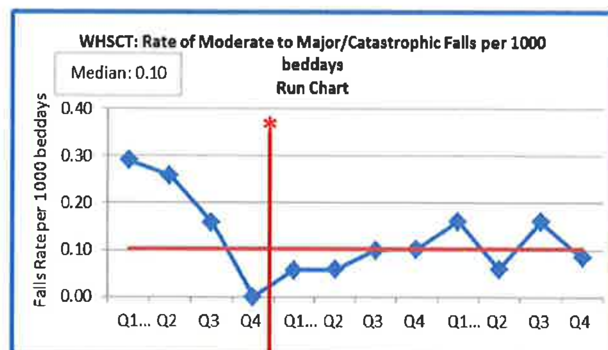

* Please note this is the date that the new process commenced.



### 6.1 Analysis of the rates of falls which resulted in a moderate/major/ catastrophic nature.

Regionally, the 2016/18 annual Trust range of falls rates resulting in moderate to major/catastrophic harm reported was between 0.08 to 0.11 per 1000 bed days.

**Since the new process commenced there has been a reduction in falls rates (see graphs above). All Trusts have shown a downward pattern with aspects in variation in their reporting.**

It should be noted that this initiative uses incident rates to compare improvement over time, but not for the purpose of comparison between Trusts as it is recognised that differences in the ways that organisations collect data and the patients that they care for, and the services they provide, all mean that direct comparisons are not possible.

In addition Trusts were asked **'if this programme has worked what (measureable) outcomes have we seen as a result'** Trusts responses were as follows:

**BHSCT**

A decrease in the number and severity of falls within the Trust.

Within the Trust we have a highly skilled and knowledgeable workforce with over 800 staff educated in the fall safe programme.Staff are more proactive in wanting to reduce the risk of patients falling in their areas. One example of this is the use of a sign being used in elderly care to identify those patients at risk of a fall and those who have fallen while in hospital.

**NHSCT**

- Reduction in the number of falls resulting in a moderate to severe injury.
- Consistent approach to the investigation of falls that result in a moderate to severe injury.
- Accountability by directorate for implementation of action plan relating to learning identified

**SHSCT**

Local Patient Safety Falls data – wards using the safety cross (27 wards) falls by bed days show a falls reduction over the last 3 months – this is a validated process within adult acute, non-acute and mental health inpatient ward areas where falls patient safety work has been focused and audit processes implemented.

Patient Safety Falls Data in Q2 17/18 shows a reduction of almost 20% compared to Q1 17/18

**SET**

Improvements in the KPI compliance overall

**WHSCT**

More accurate reporting of moderate and above falls and focus on review to include learning for sharing.

### 6.2 Analysis of Trusts' Responses relating to Measureable Outcomes

The consensus from the Trusts' in relation to measureable outcomes was largely positive. They alluded to the fact that as a result of introducing this process there is timelier reviewing of the incidents. Previously Trusts would have been reported as SAIs which would have taken on average 12 to 16 weeks to complete

Now the majority of falls incidents are reviewed and action taken on average with 10 working days. Four of the five Trusts referred to the reduction of falls resulting to moderate to major/catastrophic harm. The NHSCT reported a more consistent approach to the investigation of falls.The WHSCT indicated they had a more accurate reporting system which focuses on learning for sharing. BHSCT suggested that their staff are more proactive in wanting to reduce the risk of falls and they focus on education and training of staff to achieve this. There is a process in each of the Trusts to share timely local learning and the learning from all incidents reported are collated and shared through the Regional In-Patient Falls Prevention Group.

## 7.0 CONCLUSIONS

This evaluation has clearly demonstrated an improvement in the timeliness, learning and reporting of falls incidents resulting in moderate to major/catastrophic harm. A key part of the evaluation process was to measure the impact of the programme of work relating to prevention of falls. This included analysing secondary data, gathering information on Trust views on the new processes used, taking account the feedback from the PHA and Trusts internal audit report and reviewing the feedback from the CEC regional learning event.

Overall a number of key improvements were noted in relation to the new process and overall positive feedback was received from the Trusts. The responses from all the methodologies used identified a number of areas for improvement and these have been incorporated into the recommendations. Following this evaluation it is recommended that the PHA embed the new process across all HSC Trust areas, unless there are particular issues or identified learning that need to be investigated through the SAI process.

Falls prevention will continue to be a regional priority and further focus is required to embed this process across all trust areas including commissioned services (residential and nursing homes). There has been a significant reduction in reported SAIs/SEAs over the past two years and falls are now reported as incidents in a timely way, by the appropriate staff. The reduction in regional falls rates resulting in moderate to major/catastrophic harm per 1000 bed days is testament to the hard work and commitment given by all Trusts towards falls prevention and testing and spreading the new process, to ensure falls learning is captured as near to the event as possible by the staff who know the patient and environment the incident occurred.

## 8.0 RECOMMENDATIONS

Recommendations that have already been Actioned

| Recommendation | Action |
|---|---|
| The definition of what constitutes a fall should be clearly documented and communicated to all Trusts. | In relation to the Falls definition, the Regional In-Patients Falls Prevention Group have agreed the WHO definition "Falls are commonly defined as inadvertently coming to rest on the ground, floor or other lower level, excluding intentional change in position to rest in furniture, wall or other objects". |
| PHA in collaboration with the HSC Trusts should review the current timeframes for undertaking a post fall review for ongoing applicability and achievability. | The Regional In-Patient Falls Prevention Group recognised the challenges with the tight time frames and have agreed to extend the Post falls review to be carried out within10 days, this will be formalised on completion of evaluation. |
| The PHA in collaboration with HSC Trusts should review the current requirements for grading/reporting of falls and consider bringing the definitions into line with those already contained within DATIX. | The Regional In-Patient Falls Prevention Group have agreed to using the regional DATIX Risk Matrix to categorise falls which changed from moderate to severe/death to moderate, major and catastrophic. |

## Recommendations and Areas for Potential Development

| Recommendation | Action |
| --- | --- |
| The PHA should review the pilot and take action to further embed the new process. | This will be addressed as part of the new falls reporting process |
| Further work is required to ensure the process is spread and embedded in all areas within Trusts including commissioned services (nursing and residential homes). | This will be addressed through the Regional Commissioned Services Falls group. |
| Reporting on regional themes and learning should be populated and disseminated regionally. | In addition to current sharing of learning, other methods of learning from the falls process will be considered and as a first step a Falls learning section will be added to the Learning Matters newsletter and consideration will be given to a Regional falls learning event in early 2019. |
| Training for Falls prevention across all Trusts should be evaluated and a consistent approach considered. | PHA will work with CEC to undertake a scoping exercise and collate details of all the Falls Prevention Education and Training Programmes/opportunities that are currently available to HSC staff, in an effort to establish a regional overview of what is available and potentially highlight any duplication/gaps in current training. Development and/or extension of current face to face programmes will be considered in addition to introducing a regional e-learning training tool. |
| This model should be considered for other SAIs e.g. Prisons or suicide incidents. | This will be addressed through the relevant specialist SAI group(s). |

## Appendix one

Public Health
Agency

**Management of Falls – Draft Process – 1 April 2016 – 31 March 2018**

1. Trusts will manage falls resulting in moderate to severe harm as Adverse Incidents, unless there are particular issues or identified learning that needs to be investigated through the Serious Adverse Incident process, e.g. if the subsequent internal review identifies significant contributory lapses in patient care.

2. At the Regional Falls Group meeting it was agreed that from 1 April – 30 June 2016 Trusts would monitor and test their own internal structures and undertake a Post Falls Review internally, as they do currently.

3. From 1 July 2016 there will be an agreed minimum dataset to commence a Regional Post Falls Review.

4. As part of the Post Falls Review the following four questions will be incorporated:

   - What happened?
   - What went well?
   - What if anything could we improve?
   - What have we learnt? (Locally – and any Regional Learning)

DRAFT

## Appendix 2

Public Health Agency

QUALITY 2020

### Minimum Data Set for Post Falls Review

(Falls resulting in Moderate to Severe Harm)

| | |
|---|---|
| **This is the Minimum Data Set for HSC Trust Post Falls Review as agreed by the Regional Inpatient Falls Prevention Group.**<br>**A post falls review should be carried out within 72 hours of the incident being discovered (5 working days at bank holidays)** | |
| **Date Dataset agreed: 14/06/2016** | |
| **Demographics & further information** | |
| Date of Post Fall Review | **Agreed** |
| Lead Reviewer Name | **Agreed** |
| Lead Reviewer Designation | **Agreed** |
| Lead Reviewer Contact Tel No. | **Agreed** |
| Patient Name | **Agreed** |
| Patient D.O.B. | **Agreed** |
| Gender | **Agreed** |
| Hospital No./H&C No. | **Agreed** |
| Consultant / GP | **Agreed** |
| Ward/Dept/Location of fall | **Agreed** |
| Date and time of admission | **Agreed** |
| Reason for admission | **Agreed** |
| Diagnosis on admission | **Agreed** |
| Date & Time of Incident | **Agreed** |
| Incident Reference No. | **Agreed** |
| Type of injury (include investigations/ x-rays performed) | **Agreed** |
| **Assessment** | |
| Was a falls assessment carried out within 6 hours of admission?<br>Include Date and Time of Assessment | **Agreed** |
| If assessment was performed what was the outcome of assessment (action required/taken)? | **Agreed** |
| Elements of Falls Bundle – Part A & Part B completed: (Y/N)<br>**Falls Bundle Part A**<br>• Asked about history of falls in past 12 months<br>• Asked about fear of falls<br>• Urinalysis performed – if applicable<br>• Avoidance of new prescription of night sedation<br>• Call bell in sight and reach and did patient understand how to use this?<br>• Safe footwear on feet at time of incident<br>• Immediate assessment and provision of walking aids and referral if applicable<br>• Clear communication regarding mobility status | **Agreed** |

April 2018

Public Health Agency

QUALITY 2020

## Minimum Data Set for Post Falls Review

(Falls resulting in Moderate to Severe Harm)

| | |
|---|---|
| • Personal items within reach<br>• No slips or trips hazards<br>**Falls Bundle Part B**<br>• Cognitive screening<br>• Lying and standing blood pressure record<br>• Full Medication review requested<br>• Bedrails risk assessment | |
| Is this the patients first fall (this admission)? If no – give number of falls this admission including dates and times of day/night | **Agreed** |
| Was the patient assessed for urinary continence/ frequency/ urgency? | **Agreed** |
| Any additional contributory factors – e.g. environment, staffing issues, patients clinical condition, previous medical history | **Agreed** |
| Do you have documented evidence when the patient's falls assessment / care plan, bed rail & manual handling assessments were last reviewed before the fall:<br>• whenever their condition changed (e.g. deteriorating health, or development of confusion<br>• Following an incident or fall<br>• Transfer to another ward | **Agreed** |
| Was the fall witnessed? If yes - by whom?<br>(Staff - provide name and designation/ relative/other patient etc.) | **Agreed** |
| Was a body check completed prior to moving patient post fall? | **Agreed** |
| What was the immediate post fall management in terms of how the patient moved? | **Agreed** |
| Was a falls action plan instigated/reviewed following this fall? | **Agreed** |
| Was the incident discussed with patients next of kin? – informed of incident & explanation given – when and to whom? | **Agreed** |
| If appropriate, do you have documented evidence that the patient was given written/verbal advice on falls prevention? – Prior to falling as well as after - if so date & time given to patient | **Agreed** |
| Multi-disciplinary team meeting required? | **Agreed** |
| Has a Post Falls Assessment been completed by medical staff? – date, time & medical staff name | **Agreed** |
| Was medical treatment plan implemented? If so, provide details | **Agreed** |
| Was the Post Falls Protocol / Process Followed? If no – ensure elements are identified within the shared learning template | **Agreed** |
| Following your review of care provided, what do you think were the contributory factors to the falls incident? | **Agreed** |

**On completion of the Post Falls Review a shared learning template should be sent to:**

**falls.learning@hscni.net**

April 2018

Appendix 3

**Evaluation of the Falls In-Patient Programme**

| **Section one**<br><br>**please can you complete the following details relating to your Trust Area** | | |
|---|---|---|
| **Name of person Completing the Evaluation** | | |
| **Name of Trust** | | |
| **COMPOSITION OF FALLS TEAMS FOR THE FOLLOWING AREAS:** | **Numbers of Staff** | **Grade of Staff** |
| **Hospital** | | |
| **Community** | | |

| | | |
|---|---|---|
| **A & E (if different to above)** | | |
| **Do you have a Trust Falls Group if so what is the composition of this** | | |
| **Have you Terms of reference for this group and if yes would it be possible to share** | | |

**Section Two**

**Please complete this evaluation based mainly on the regional and local strategies for falls prevention - however if you have any further comments relating to any other stage in the Regional Inpatient Falls Process previously feel free to add them to the comments at the end.**

| Question | Comment |
|---|---|
| **Falls are a regional Quality and Safety priority in Northern Ireland.** | |

| Question | Response |
| --- | --- |
| **How does falls prevention compare with other patient safety priorities in your Trust?** | |
| **What do you think about the current falls prevention strategies in your Trust?** | |
| **Do your Trust strategies Align with the Regional Plan**<br><br>**If no do you have plans to address this – please give details** | |
| **Do you have a Multi-disciplinary Team approach to Falls Prevention and Management – please give details** | |

**Section 3**

**Please complete this evaluation based mainly on the work programme from April 2016 (attached with e-mail) - however if you have any further comments relating to any other stage in the Regional Inpatient Falls Process previously feel free to add them to the comments at the end.**

| Question | Comment |
| --- | --- |
| **Can you confirm that you are analysing and reporting falls resulting in moderate to severe harm as part of your ongoing trust arrangements and only where necessary as a SAI?** | |
| **Are you using the regionally agreed post falls review minimum data set**<br>**Is this working?** | |
| **Are you using the shared learning template?**<br><br>**How is this working?** | |
| **Are you using the shared learning template within the time frames?**<br><br>**(72 hours post falls or within** | |

| | |
|---|---|
| **5 working days)**<br><br>**How is this working?** | |
| **Are there any tangible improvements in relation to falls prevention since the introduction of the new process on 1st April 2016?**<br><br>**Identify any improvements and how these are evidenced?** | |
| **Identify any gaps and how these are evidenced?** | |
| **What is the level of engagement in the programme?**<br><br>**Include management, staff and patients/user.** | |

| | |
|---|---|
| **Please give details.** | |
| **What were the challenges and enablers in delivering the programme of work?**<br><br>**Please give details.** | |
| **As a result of Falls work programme who has benefitted/or not and why?**<br><br>**Please give details** | |
| **In what context did this programme work and why?**<br><br>**Please give details.** | |
| **What are the main mechanisms by which this programme has work?** | |

| | |
|---|---|
| **Please give details** | |
| **If this programme has worked what (measurable) outcomes have we seen as a result?**<br><br>**Please give details** | |
| **What has been the impact on strategic priorities?**<br><br>**Please give details** | |
| **Where should we focus next?** | |
| **Any further comment which you feel should be included in the Evaluation which may not have been considered?** | |
| **Section Four**<br><br>**Further Trust Information - please can you complete the following details relating to your Trust Area** | |

***Whilst this section is not part of the Evaluation it is important information which will inform other ongoing work relating to Falls prevention.***

| Question | Comment |
|---|---|
| **Can you outline the process for your referral/falls pathway in the Hospital**<br><br>**(Can you share a copy of this)** | |
| **Can you outline the process for your referral/falls pathway in the Community**<br><br>**(Can you share a copy of this)** | |
| **Do you hold strength and balance classes with you Trust** | |
| **What is the length and content of the programme ?** | |

| **How often are these provided?** | |
|---|---|
| **Can you indicate the number who've attended?** | |

**Thank-you for taking the time to complete this evaluation form and also the other information requested. Once completed please return to mary.mcelroy@hscni.net and copy it also to lynne.mcgee@hscni.net**