Airedale NHS Foundation Trust
Board of Directors: 27 September 2012
Title: The Management and Prevention of Slips, Trips and Falls for Hospital Inpatients and Community Services: Current Position
Author: Debra Fairley, Deputy Director of Nursing

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Background

The management and prevention of slips, trips and falls for hospital inpatients and those patients cared for within community services remains a key priority for improvement for Airedale NHS Foundation Trust (ANHSFT). This was described in detail in the Trust's *Quality Account* (2011/12).

This paper provides an update for Executive Assurance Group on the current position (as of 21.8.12) with regard to:

- Current initiatives aimed at the management and prevention of slips, trips and falls and;
- The number of falls reported on the new monthly *Quality and Safety Dashboard*, with particular regard to the Board's concerns about the number of inpatient falls.

Current status

The falls rate (for hospital inpatients only) has been previously reported in the Trust's *Quality Account* (2011/12) and is summarised below:

Fiscal Year	Falls	Bed Days	Falls Per Thousand Bed Days
2011/12	1100	101078	**10.9**
2010/11	1201	123529	**9.7**
2009/10	1089	127983	**8.5**

Despite our continued focus on reducing the number of falls, disappointingly, the *falls rate* has shown a steady increase. There are several key points to note when considering this:

- Adverse incident form (AEF) reporting - including falls reporting - has improved significantly over the last few years as demonstrated by trend analysis with an increase in reported 'no harm' and 'low harm' incidents of which falls is included. Earlier data, therefore may not have been an accurate representation of the actual number of slips, trips and falls.

- The Trust actively encourages the reporting of *all* slips, trips and falls, no matter how minor – the number of falls resulting in serious injury is therefore of significant importance. During Quarter 1 (2012/13) there was only one patient who sustained a fracture/significant injury as a result of a fall – compared to 10 patients for the same time period in 2011/12[1].

- The number of inpatient falls has reduced to **1100** (reported in 2011/12) from **1201** (in 2010/11). However the falls rate has increased due to the decrease in the number of bed days during the same period.

[1] The number of fractures/significant injuries occurring as a result of a fall ranged from 4 to 10 – total 27 – during 2011/12 – information source – Trust Board paper April 2012.

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Current position Quarter 1 - 2012 (information source: monthly *Quality and Safety Dashboard*)

Falls					April	May	June
Acute Hospital Inpatient Falls	<75	≥ 75	TK	Number per month	68	82	82[2]
Community Inpatient Falls [Castleberg]	≤5	≥6	TK	Number per month	6	8	8
Community Service Falls	≤1	≥2	TK	Number per month	1	1	0
Falls by Fracture	≤2	≥3	TK	Number per month	0	0	1[3]

Points to note with reference to the dashboard

- The 'red flag' is not an alert: ≥ 75 represents an improvement measure (to reduce the number of falls each month by 10 per cent). A more appropriate alert for hospital inpatients (excluding Castleberg) is around **87** falls per month – this is based on the average number of falls per month that occurred during 2011/12 (which was 87 – range 64 to 125: information source *Nurse Sensitive Indicators: Monthly Report* - April 2012).

- With regard to Castleberg Hospital and community services – there was insufficient falls and incident data prior to the transfer of community services against which to identify an alert or indeed a measure of improvement. Consequently, the improvement measure set out above is based on a 'best guess' until AEF reporting and data analysis are more robust. AEF reporting in the community is steadily improving – this is reflected by the increase in submission of AEFs and, information presented to the SI Assurance Panel meetings.

- The number of significant injuries (e.g. head injury, severe laceration) as a result of a fall also needs to be included in the dashboard – this will be amended accordingly

Key Initiatives in 2011/12

These were set out in the *Quality Account* and are summarised as follows:

- The Trust's *Falls Policy* was revised and approved by the Trust's Quality and Safety Operational Group.

- A new falls assessment form was implemented alongside an individualised care plan.

- The Trust's safeguarding team and the patient safety manager meet on a weekly basis to review all AEFs related to falls which result in significant injury.

- A root cause analysis is undertaken for all falls resulting in significant harm. All action plans are reviewed at the Trusts' Falls Assurance Panel meetings.

[2] This may change due to reconciliation of AEF and once the data has been verified at the end of each quarter.
[3] This was a fracture neck of femur

- A patient information leaflet on falls has been produced for patients, carers and visitor (presently in draft). This explains what can be done to reduce the risk of a patient falling whilst in hospital.

- Eleven floor-level beds were purchased for patients who are at high risk of falling out of bed.

- All wards have been supplied with bed and chair alarms for high risk patients.

- A process for reporting falls which result in significant harm has been developed.

- In November 2011, the Trust participated in a national falls clinical audit organised by the Royal College of Physicians; we await recommendations.

- The Trust continues to contribute to the district-wide Bradford and Airedale Integrated Falls and Bone Health Strategy Group.

- A pathway for staff to follow when a patient falls has been developed in line with the National Patient Safety Agency alert *Essential Care after an Inpatient Fall* (2011).

- The Institute for Innovation and Improvement's (2009) *High Impact Actions for Nursing and Midwifery* has been used as a framework for falls prevention work.

- Footwear can be obtained for patients from the *"Dignity Room"* to help reduce the likelihood of an inpatient fall and support patient safety.

<u>Improvement measures to be undertaken in 2012/13</u>

A risk assessment setting out the risk of falling and harm for hospital impatients is reported on the Trust's risk register (risk is 9) and has been since July 2011 – the risk was previously reported at 15. Existing improvement measures and those planned for 2012/2013 are set out below:

- The falls leaflet will be reviewed by the Trust's Readers Panel, prior to implementation.

- Community staff are now members of the Trust's Falls Steering Group.

- Monitoring mechanisms continue to be reviewed and strengthened. A live database is presently being developed for those falls which result in significant harm in order to enable further learning and prevention.

- The benefits of cushioned flooring for 'high risk' wards continues to be explored.

- An annual bed rails audit will be repeated and recommendations acted upon.

- Falls are discussed at the Trust's Safeguarding Strategic Group and is also incorporated into safeguarding adults training.

- Further work is presently being undertaken to examine the circumstances surrounding those 'patients that are found on the floor'.

- Intentional rounding has now been implemented within all inpatient wards, which includes a falls assessment risk.

- Monitoring of falls (both within the hospital and community) is now reported in the monthly *Safety Thermometer Survey* – which is part of the national CQUIN scheme.

- The Trust will take part in the *Training and Action for Patient Safety* (TAPS) programme commencing 7th September 21012, which will focus on a number of high risk areas - including falls.

- A significant amount of work is well underway to enhance/develop pathways for patients suffering from dementia. This work focuses on reducing the length of hospital stay and rates of admission – falls practitioners within community services will be involved in pathway development.

Summary

The Trust continues with its work to reduce the number of hospital inpatient falls, particularly those that result in serious harm. Systems and processes are being embedded within community settings as we seek to understand the nature of falls within the community. Monitoring and reporting to the Board will continue via the monthly *Quality and Safety Dashboard*.