EAST KENT HOSPITALS UNIVERSITY NHS FOUNDATION TRUST

REPORT TO: **BOARD OF DIRECTORS – 29 AUGUST 2014**

SUBJECT: **IN PATIENT FALLS AND PREVENTION**

REPORT FROM: **LEAD NURSE FOR FALLS AND OSTEOPOROSIS**

PURPOSE: **For information and discussion**

1. INTRODUCTION:

All inpatient falls within EKHUFT are reported using the Datix WEB online system. The reporting form has been designed to identify specific risk factors for falls and to enable the reporter to record the interventions undertaken to prevent falls and injuries. The incident report is automatically sent to the Falls Prevention Nursing Team to:

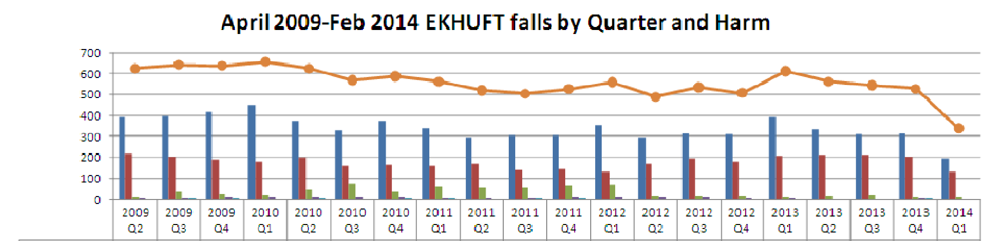
1. Clarify the severity of any injuries;
2. Identify quickly any falls causing fractures or serious head injuries and enable the Root Cause Analysis to be initiated;
3. Identify patients who require specialist assessment and interventions;
4. Highlight need for equipment to prevent or reduce potential harm;
5. Enable a patient alert on the 'Special Register' on Patient Administration System to be set up to increase awareness of the patient's risk during the admission and any future admissions.

Falls resulting in a fracture or serious head injury will be investigated by Root Cause Analysis or After Incident Action Review. These are facilitated by the Falls Prevention Team.

2. SUMMARY:

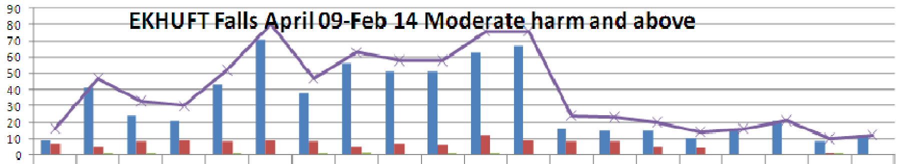
There has been a steady decrease in falls rates in EKHUFT since 2009. However, in 2013-2014 rates of falls increased (Table 1). Injurious falls graded moderate and above decreased despite a small increase in the number of fractures and serious head injuries (Table 2).

Table 1



	2009 Q2	2009 Q3	2009 Q4	2010 Q1	2010 Q2	2010 Q3	2010 Q4	2011 Q1	2011 Q2	2011 Q3	2011 Q4	2012 Q1	2012 Q2	2012 Q3	2012 Q4	2013 Q1	2013 Q2	2013 Q3	2013 Q4	2014 Q1
None	392	394	415	450	373	328	374	339	293	304	306	351	295	316	309	391	335	310	314	195
Low	216	201	189	177	199	160	166	159	169	141	144	131	170	195	178	206	211	212	203	130
Moderate	9	41	24	21	43	71	38	56	51	51	63	67	16	15	15	10	16	21	8	12
Severe	7	5	8	9	8	9	8	5	7	6	12	9	8	8	5	4	0	0	1	0
Death	0	1	1	0	1	0	1	2	0	1	1	0	0	0	0	0	0	0	1	0
Totals:	624	642	637	657	624	568	587	561	520	503	526	558	489	534	507	611	562	543	527	337

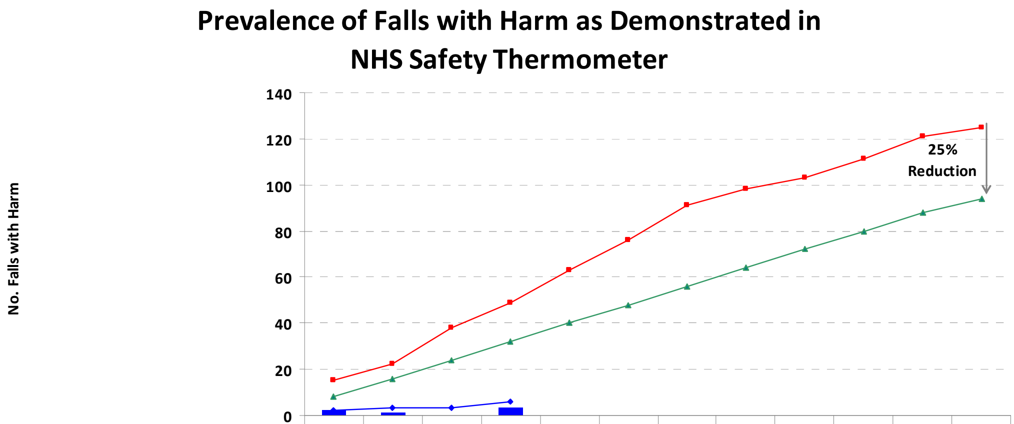
Table 2



	2009 Q2	2009 Q3	2009 Q4	2010 Q1	2010 Q2	2010 Q3	2010 Q4	2011 Q1	2011 Q2	2011 Q3	2011 Q4	2012 Q1	2012 Q2	2012 Q3	2012 Q4	2013 Q1	2013 Q2	2013 Q3	2013 Q4	2014 Q1
Moderate	9	41	24	21	43	71	38	56	51	51	63	67	16	15	15	10	16	21	8	12
Severe	7	5	8	9	8	9	8	5	7	6	12	9	8	8	5	4	0	0	1	0
Death	0	1	1	0	1	0	1	2	0	1	1	0	0	0	0	0	0	0	1	0
Totals:	16	47	33	30	52	80	47	63	58	58	76	76	24	23	20	14	16	21	10	12

3. SAFETY THERMOMETER

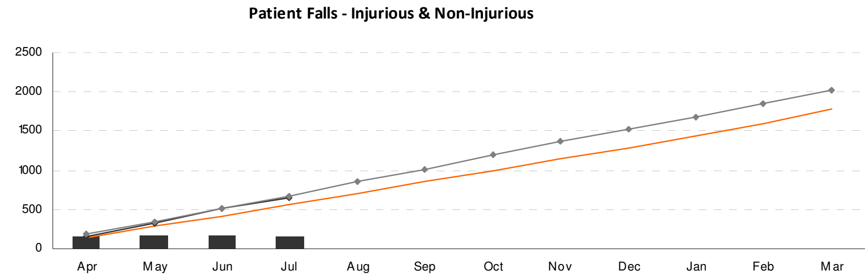
In 2013-2014 the Trust was identified as having a higher than average rate of falls according to the Safety Thermometer. This alerted the Trust to ensure that the data collected was validated as peer review indicated that data was not collected as a prevalence audit. The data is now validated by the Falls Team and the prevalence of falls is well below trajectory.



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Falls with Harm 2014/15	2	1	0	3								
Falls with Harm 2014/15_Cum	2	3	3	6								
Falls with Harm 2014/15 Trajectory	8	16	24	32	40	48	56	64	72	80	88	94
Falls With Harm 2013/14_Cum	15	22	38	49	63	76	91	98	103	111	121	125

4. CURRENT SITUATION

There were 152 in patient falls in July compared with 176 in June. Three of these resulted in fractures, 1 to the wrist and 2 to the hip. Two fractures occurred at QEH and these were both deemed unavoidable. The further fracture occurred at WHH and is awaiting a RCA meeting to clarify the circumstances. The wards with the most falls were CDU at WHH (17), Cambridge M2 (13), Richard Stevens Stoke Unit (9) and Treble (8).



	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
2014/15	158	172	176	152								
2014/15 Cum	158	330	506	658								
2013/14 Cum	193	349	514	673	852	1015	1201	1365	1530	1683	1854	2020
Trajectory Cum	140	284	408	567	707	860	991	1148	1283	1445	1601	1788

Actions

In June the Falls Prevention Team raised concern regarding the number of falls at William Harvey Hospital resulting in fractures and serious head injuries. Although the total number of falls is similar to that at the other sites, the number of fractures and head injuries was disproportionately high in the first quarter of this year. A meta analysis of these incidents was undertaken and core contributory factors were identified. These include:

1. Sub standard assessment
2. Lack of equipment to prevent harm
3. Delayed discharge
4. Delayed escalation of delirium and deterioration

An action plan is currently being developed which will include core elements to form actions from all falls related RCAs. To support the wards at WHH a member of the Falls Prevention Nursing Team has been deployed for a 3 month interim period. Support will include undertaking base line audits with ward teams, developing action plans, education and training, and evaluating the effectiveness of these measures.

5. NATIONAL GUIDELINES

NICE Guidelines

In June 2013 an updated guideline for the Prevention of Falls in Older People was issues which included prevention of falls in hospital. This discouraged use of predictive screening tools and recommended that all patients over 65 and younger patients with a clinical risk of falling should undergo a routine assessment and have an intervention plan. This required a significant change in practice and a piece of work was undertaken with the ward based Falls Link Workers to ensure they devised an assessment tool which was easy to use. The result is the Falls Risk Assessment and Care Plan and an updated Bed Rails Risk Assessment. Compliance with be audited in October as part of the annual audit and CQuIN for reduction of falls.

This piece of work is a good example of engagement of staff and not disconnecting them from the production of a tool they will have to complete.

6.BENCHMARKING WITH OTHER TRUSTS

There has not been a local Falls Network for many years. Furthermore, benchmarking is very difficult given the uniqueness of EKHUFT. However, the Falls Prevention Team strived to set up a Southern England Falls Collaborative and the first meeting was held in May. The purpose of this collaborative will be to:

- Benchmark data
- Support network

- Raise concern
- Contribute nationally to the falls agenda
- Develop services
- Trial equipment
- Undertake research

7. EQUIPMENT

The Trust has invested heavily in equipment over the past 5 years. However, it has recognised the need for more low level beds and a business case has been submitted. Prevalon non slip cushions are about to be trialed on a stroke unit to prevent slips from chairs in patients without core strength. Equipment routinely used includes:

- Low level beds
- Sensor alarms
- Crash mats
- Hip protectors