LEARNING FROM FALLS

SEPTEMBER 2024

IN THIS EDITION

The purpose of this Learning from Falls Newsletter, is to share information and key learning from inpatient falls across Health and Social Care (HSC) Trusts', which are classified as Adverse Incidents identified from post fall reviews.

HSC Public Health Agency

Any inpatient fall that has resulted in moderate, major or catastrophic harm (see table 1 below) is reported to the Public Health Agency using the Shared Learning Form (SLF) following a post fall review.

Grading the severity of harm to a person from a fall incident can be challenging for reporters. The aim of the Falls Severity Grading Document is to provide additional guidance for staff when using the HSC regional risk matrix. Examples provided are not exhaustive nor should be substituted for clinical decisions and **each case should be dealt with on an individual basis.**

Table 1: FALLS Severity Grading of Injury: Moderate, Major and Catastrophic are reported using Shared Learning Forms

DOMAIN	MODERATE	MAJOR	CATASTROPHIC
PEOPLE (Impact on the Health/ Safety/ Welfare of any person affected: e.g. Patient/ Service User, Staff, Visitor, Contractor)	The fall has resulted in • Injuries causing ***semi-permanent harm/ disability***. (Consider physical/emotional injuries/trauma). • A full recovery is expected within one year. • Injuries have resulted in harm that requires a moderate increase in treatment and follow up • The person may require a prolonged length of hospital stay or care provision (between 5 and 14 days).	The fall has resulted in • long-term permanent harm/ permanent disability, i.e. the person is unlikely to regain their former level of independence. • The person may require an increased length of hospital stay/care provision (>14 days).	The fall has resulted in death • Falls resulting in death must be discussed with the coroner by the relevant medical practitioner. **OR** • The fall results in permanent harm/disability. This could be physical/emotional trauma which impacts on more than the person injured. If the fall resulted in death, details recorded on death certificate should be recorded on the Datix system, including coroner ref number, date and time of discussion and by whom.
EXAMPLES OF POSSIBLE INJURIES	Fracture to wrist/fingers/toes; facial fractures. Surgery may or may not be required where falls result in moderate harm.	Intracranial bleed, fracture of long bones, fractured neck of femur (intracapsular/ extracapsular), pelvis and ankle.	Spinal cord injuries, Catastrophic Brain Injuries. The person requires long term care/admission to a care facility beyond 1 year because of the fall.

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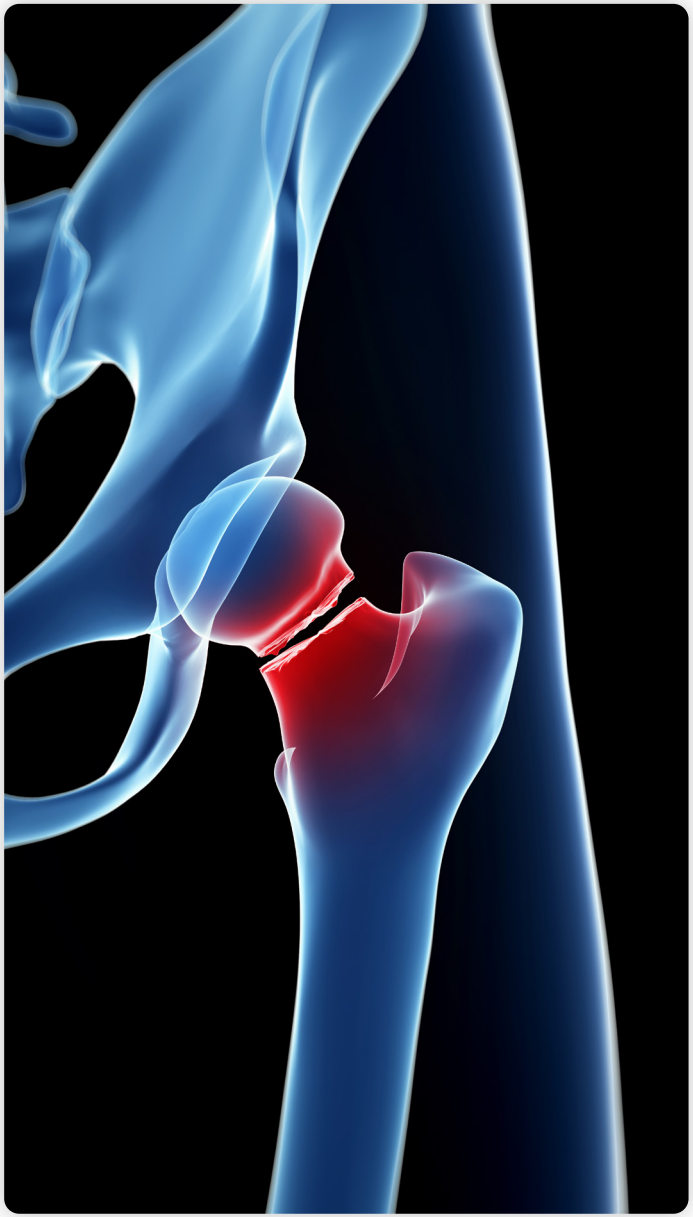
A thematic analysis was undertaken of all Shared Learning Forms submitted to the PHA between 1st April 2023 and 31st March 2024. These were received by the closing date of the 31st May 2024. This newsletter is developed and published during Falls Awareness Week in September 2024, therefore it is not possible to include Shared Learning Forms submitted after this date.

Key themes have been identified and results compared to the period 1st April 2022 to the 31st March 2023. The previous 2023 'Learning from Falls Newsletter' can be accessed at PHA Learning From Falls (September 2023) (hscni.net))

A fall is defined as an event, which results in a person coming to rest inadvertently on the ground or floor or other lower level (WHO, 2021). This includes near miss events where a person is assisted to the ground. Having a fall can happen to anyone; it is an unfortunate, but normal result of human anatomy. However, as people get older, they are more likely to fall over and falling can become a recurrent issue.

Patient falls have both human and financial costs. For individual patients, the consequences range from distress and loss of confidence, to injuries that can cause pain and suffering, loss of independence and occasionally death. The costs to NHS organisations include additional treatment, increased lengths of stay, complaints and, in some cases, litigation. In addition, falls frequently bring about a fear of falling which increases risk and reduces independence.



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Causes of Falls

A fall is the result of the interplay of multiple risk factors. These include:

- Balance problems and muscle weakness.
- A long-term health condition, such as heart disease, dementia or low blood pressure, which can lead to dizziness and brief loss of consciousness.
- Visual and/or hearing impairment.
- Cognitive impairment.
- Frailty.
- **Polypharmacy** – patients on FOUR or more medications are at greater risk of having a fall. **Regular medication reviews play an important part in falls prevention**.
- Environmental hazards and a number of specific conditions.

Additional information on falls in older people: Assessing risk and prevention NICE Clinical guideline [CG161] can be found at:
Falls in older people: assessing risk and prevention

Risk Assessments and Plans of Care

Risk assessments and plans of care relating to falls prevention must be **updated by nursing staff:**

- When a patient has a fall or near miss.
- When a patient is found and a fall is suspected (unwitnessed fall).
- When a patient's risk factors or medical condition changes.
- On transfer to another care setting.

KEY FACT

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. 1 (nice.org.uk)

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The Shared Learning Form

A **Shared Learning Form** is completed following a Post Fall Review to allow for **local learning** resulting in a change in practice and to reduce the incidence of future falls. For patients who fall in hospital, this form is then submitted to the PHA falls inbox falls.learning@hscni.net. This allows for a regional analysis of inpatient hospital falls which informs the annual Learning from Falls Newsletter produced by PHA. The information that follows is an analysis of the PHA Falls inbox for the period 1st April 2023 to 31st March 2024, reported by the 31st May 2024, and includes inpatients and patients who have fallen in Emergency Departments.

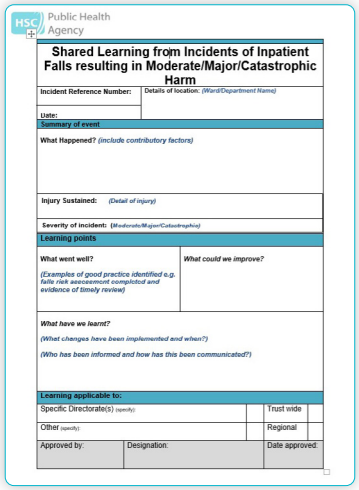
The Public Health Agency chairs a multidisciplinary Regional Inpatient Falls Prevention Group, which incorporates staff from all Trusts and was formed to set direction on falls prevention for adult inpatients. The Group provide advice, support and share regional learning as well as lead on the development of regional tools/pathways when appropriate, regarding falls prevention.

KEY FACT

Over 3 million people in the UK have osteoporosis and they are at much greater risk of fragility fractures.

KEY FACT

Falls are the leading cause of accidental death in Northern Ireland.


Public Health Agency

Shared Learning from Incidents of Inpatient Falls resulting in Moderate/Major/Catastrophic Harm

Incident Reference Number: | Details of location: *(Ward/Department Name)*

Date:

Summary of event

What Happened? *(include contributory factors)*

Injury Sustained: *(Detail of injury)*

Severity of incident: *(Moderate/Major/Catastrophic)*

Learning points

What went well? *(Examples of good practice identified e.g. falls risk assessment completed and evidence of timely review)*

What could we improve?

What have we learnt?

(What changes have been implemented and when?)

(Who has been informed and how has this been communicated?)

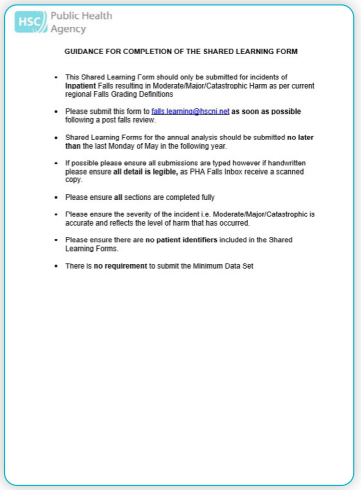
Learning applicable to:

Specific Directorate(s) *(specify)* | Trust wide

Other *(specify)* | Regional

Approved by: | Designation: | Date approved:

The Inpatient Falls Shared Learning Form (SLF): Version 6, dated July 2023


Public Health Agency

GUIDANCE FOR COMPLETION OF THE SHARED LEARNING FORM

- This Shared Learning Form should only be submitted for incidents of **inpatient** Falls resulting in Moderate/Major/Catastrophic Harm as per current regional Falls Grading Definitions
- Please submit this form to falls.learning@hscni.net **as soon as possible** following a post falls review.
- Shared Learning Forms for the annual analysis should be submitted **no later than** the last Monday of May in the following year.
- If possible please ensure all submissions are typed however if handwritten please ensure **all detail is legible,** as PHA Falls Inbox receive a scanned copy.
- Please ensure **all** sections are completed fully.
- Please ensure the severity of the incident i.e. Moderate/Major/Catastrophic is accurate and reflects the level of harm that has occurred.
- Please ensure there are **no patient identifiers** included in the Shared Learning Forms.
- There is **no requirement** to submit the Minimum Data Set

The Inpatient Falls Shared Learning Form (SLF): Version 6, guidance documentation

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In 2023 the Group developed a new regional **Falls Prevention in Hospital; Information for Patients and Visitors leaflet.** The purpose of this leaflet is to inform patients and their visitors of the steps they can take to reduce the incidence of falls. This leaflet works in tandem with the previously produced **Falls Poster,** which promotes the use of the Call Button, to reduce the incidence of patients inappropriately attempting to mobilise, without the required assistance of hospital staff.

Falls Prevention in Hospital; Information for Patients and Visitors leaflet

Falls Poster

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Key findings in relation to Inpatient Falls across HSC Trusts which resulted in Moderate/Major or Catastrophic Harm 1st April 2023 to 31st March 2024 (submitted to PHA by 31st May 2024)

- 148 falls reported this year (1st April 2023 to 31st March 2024) by the end of May 2024, compared with 156 falls reported last year (a 5% decrease) (See Table 2).

- Analysis was carried out under 5 key themes
  - **What happened?**
  - **What went well before the fall?**
  - **What went well after the fall?**
  - **What we could improve?**
  - **What we have learned?**

- The Safety, Quality and Innovation Team, PHA quality assured all forms submitted during the year on a weekly basis and returned any incomplete forms to the sender, for amendments and resubmission.

Reasons why forms were returned for resubmission included:

- A query regarding grading of the Fall[1].
- The form was not signed.
- Information was omitted.

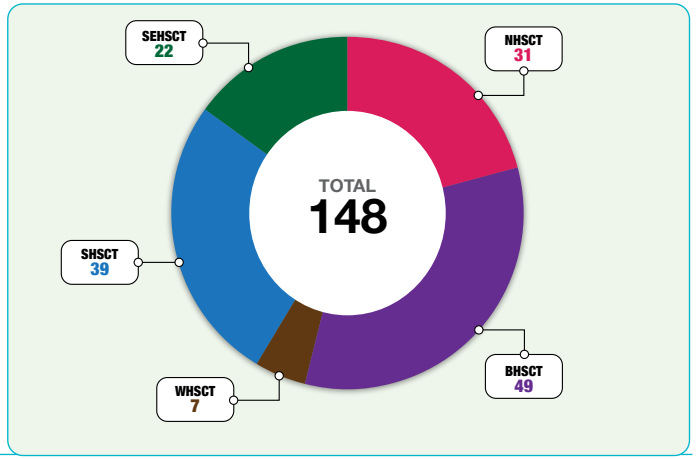
- **Classification of incidents:**
  - 8 catastrophic harm
  - 77 major harm
  - 63 moderate harm

- 8 catastrophic incidents were reported this year – 3 more than last year. It should be noted 2 of these this year were in the Emergency Department, whereas none were linked with ED last year.

TABLE 2: Number of Shared Learning Forms submitted per Trust

	April 22 - March 23	April 23 – March 24
NHSCT	40	31
BHSCT	36	49
WHSCT	32	7
SHSCT	26	39
SEHSCT	22	22
Total	156	148

CHART 1: Number of SLFs submitted per Trust (April 23-March 24)



1 Guidance regarding the grading of inpatient falls was updated and agreed by the Inpatient Regional Falls Group, which is chaired by the PHA and has representatives from the 5 HSC Trusts, this can be accessed at FALLS SEVERITY GRADING OF INJURY. APRIL 2024.pdf (hscni.net).

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Theme 1: What Happened?

Based on the information provided within the Shared Learning Forms (SLFs):

- **121 falls (82%) were unwitnessed.**
- **27 falls (18%) were witnessed.**

Of the patients who fell:

- 63% had a documented history of dementia, delirium or confusion, this was 61% last year.
- 56% had a documented history of falls.
- 43% were found on the floor compared to 51% last year.
- 52% got up without the required assistance (47% last year) with a further 12% declining assistance (11% last year).
- 21% felt dizzy when standing and fell, (20% last year), this was often when they tried to mobilise without assistance to use the bathroom or after being assisted to the bathroom and left alone to respect their dignity, the patient then tried to mobilise independently to leave the bathroom.
- 9.5% had sedation mentioned as a contributing factor, whereas this was noted in 4% last year.
- 7% slipped and fell (7% last year), often because of inappropriate footwear or no footwear.
- 5% were reported as falling while having a virus this included COVID, Norovirus or Flu, 4% were noted last year though it was only COVID mentioned.

Table 3: What Happened April 2023 to March 2024?

What Happened?	Number of Patients
Unwitnessed Fall	**121**
Witnessed Fall	**27**
Delirium, confusion, history of Dementia	**93**
History of Falls	**83**
Patient got up without asking for assistance	**77**
Found on floor	**63**
Lost balance/dizzy usually when toileting alone	**31**
Fell out of bed/climbed out of end of bed	**28**
Declined assistance	**18**
Patient on new sedation/pain relief	**14**
Patient slipped and Fell	**11**
Fell out of wheelchair/chair	**8**
Patient wearing TED stocking/no shoes	**8**
Patient had a virus COVID/NORO/Flu	**7**
Controlled fall assisted by staff	**5**

KEY FACT

Over 3 million people in the UK have osteoporosis and they are at much greater risk of fragility fractures. Fragility fractures are most common in bones of the spine, wrists and hips. Falls: applying All Our Health - GOV.UK (www.gov.uk

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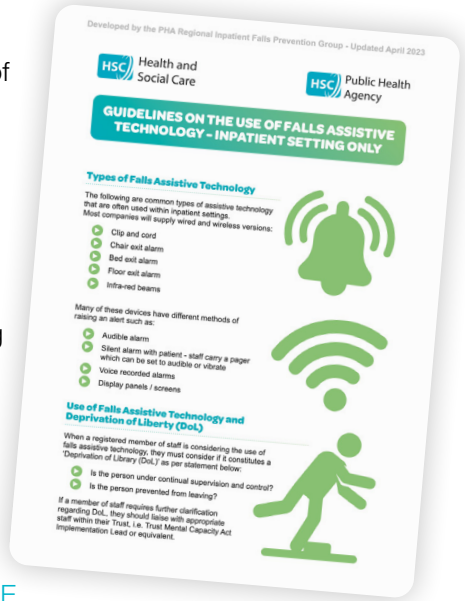
Theme 2: Learning Points - What went well?

What went well before the fall - examples of good practice:

Of the patients who fell:

- 62% (61% last year) had their bed rails and moving and handling assessments completed on admission.
- 60% had a falls assessment (59% last year) with this further broken down this year with 18% stating Falls Bundle A was complete and 15% stating Falls Bundle B was complete.
- 34% had a Lying and Standing Blood Pressure (30%, last year).
- 31% had an OT/Physiotherapy referral made (29% last year).
- 28% had a urinalysis (27% last year).
- 24% documented that the patient was advised to use the call bell (23% last year).
- 22% had a request made for 1:1 supervision, compared to to 17% last year.
- 22% had appropriate CNS observations (25% last year).
- 22% had a completed footwear assessment (21% last year).
- 21% of SLFs highlighted the use of assistive technology (19% last year), though in several cases it was also noted as being removed by the patient prior to falling and in another case it was **not working** giving **false reassurance** to staff. The guidelines can be accessed at GUIDELINES ON THE USE OF FALLS ASSISTIVE TECHNOLOGY - INPATIENT SETTING ONLY (hscni.net).


Developed by the PHA Regional Inpatient Falls Prevention Group - Updated April 2023

Health and Social Care

Public Health Agency

GUIDELINES ON THE USE OF FALLS ASSISTIVE TECHNOLOGY - INPATIENT SETTING ONLY

Types of Falls Assistive Technology

The following are common types of assistive technology that are often used within inpatient settings. Most companies will supply wired and wireless versions:

- Clip and cord
- Chair exit alarm
- Bed exit alarm
- Floor exit alarm
- Infra-red beams

Many of these devices have different methods of raising an alert such as:

- Audible alarm
- Silent alarm with patient - staff carry a pager which can be set to audible or vibrate
- Voice recorded alarms
- Display panels / screens

Use of Falls Assistive Technology and Deprivation of Liberty (DoL)

When a registered member of staff is considering the use of falls assistive technology, they must consider if it constitutes a 'Deprivation of Library (DoL)' as per statement below:

- Is the person under continual supervision and control?
- Is the person prevented from leaving?

If a member of staff requires further clarification regarding DoL, they should liaise with appropriate staff within their Trust, i.e. Trust Mental Capacity Act Implementation Lead or equivalent.

- 20% had a documented fear of falling assessment completed in full (32% last year).

****A full list can be seen in Table 4: It should be noted that significantly more of these patients may have had these assessments completed but it was not noted on the SLF.****

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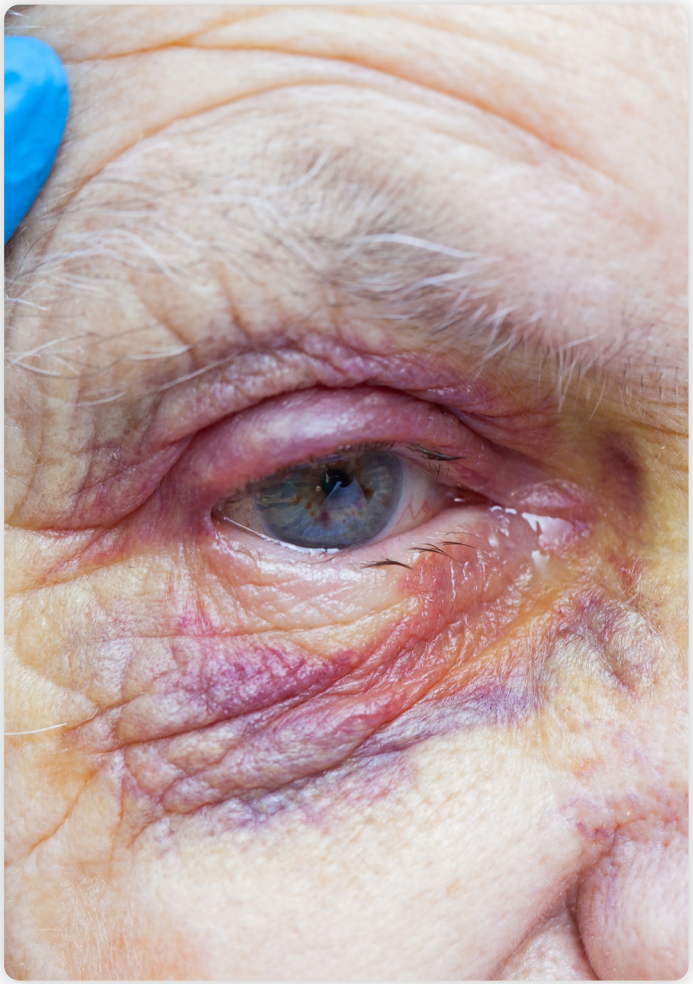
Table 4: What went well before the Fall? Examples of good practice

What Went Well Before the Fall	Number of Patients
Moving handling/bed rails/completed/reviewed on admission	92
Patient given Falls Risk Assessment	89
L/S BP completed and reviewed	51
Physio/OT referral/review	46
Urinalysis assessment completed	42
Patient advised to use call bell	36
CNS Observations	33
Footwear assessment completed on admission	33
1:1 supervision implemented/requested	32
Assistive technology used	31
Fear of Falling assessment	29
Falls Bundle A completed in full on admission	26
Falls Bundle B completed in full on admission	22
Fall safe signage displayed	14
Patient on delirium pathway	14
Patient communication issues, identified and addressed	11
Patient on close observation	11
Falls prevention booklet shared and discussed	9

KEY FACT

All falls cannot be prevented without unacceptable restrictions to patients' independence, dignity and privacy.



KEY FACT

Research has shown that falls can be reduced by 20-30% through multifactorial assessments and interventions.

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What went well after the fall: examples of good practice

Of the patients who fell:

- Informing next of kin was included in 69% of Shared Learning Form responses (66% last year).
- Timely assistance was provided to the patient who had fallen in 60% (54% last year), with the identification of a possible fracture before mobilising in 49% (45% last year).
- A medical assessment was noted as completed in 53% (52% last year).
- An updated bedrails assessment was documented in 43% (41% last year).
- Updated falls assessment in 39% (39% last year).
- Updated moving and handling assessment in 33% (39% last year).
- CNS assessment was completed in 29% (28% last year).
- A cognitive assessment was completed in 28% (24% last year).
- Analgesia given in 22%.

- The call bell (button) being left within reach of the patient was mentioned in 21% (17% last year). This increase may have been assisted by the use of the 'Call Don't Fall' poster, developed last year by the Inpatient Regional Falls Group, PHA Don't Fall Poster - Final.pdf (hscni.net).
- Falls Team notified in 18% (11% last year).
- 18% mentioned having medication reviewed either before or after the fall.

****A full list can be seen in Table 5: It should be noted that significantly more of these patients may have had these assessments completed but it was not noted on the SLF.****

KEY FACT

Older people may remain in hospital for a number of weeks as a result of a fall, and at any one time older people recovering from hip fracture require over 3,600 hospital beds in England, Wales and Northern Ireland.

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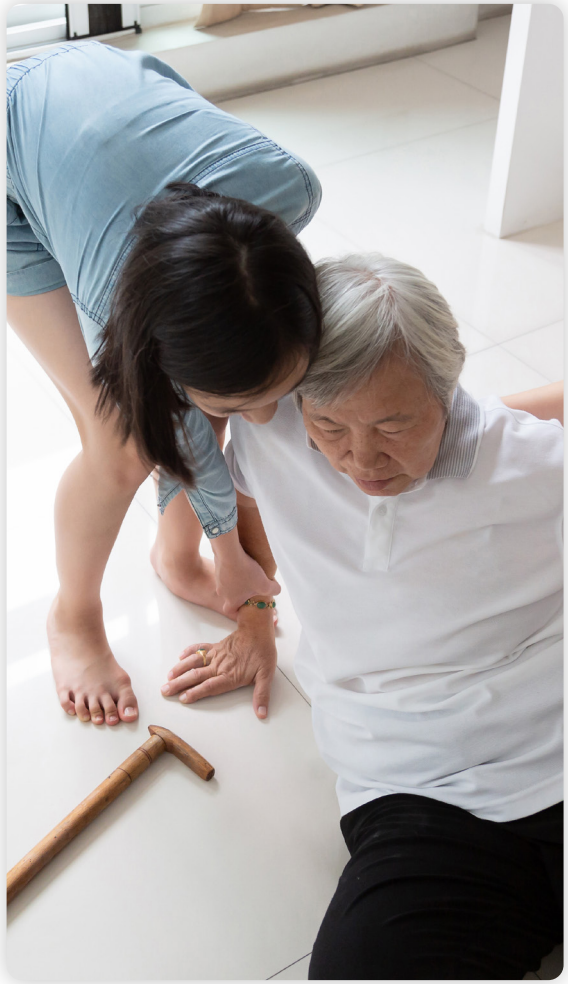
Table 5: What went well after the Fall? Examples of good practice

What Went Well After the Fall?	Number of Patients
Notifying NOK	102
Timely Assistance given to Patient	89
Evidence of Pace	79
Possibility of fracture identified before mobilising the patient	72
Updated Bedrails Assessment	63
Falls Assessment updated	58
Updated Moving and Handling Risk assessment completed	49
CNS Assessment and Observation	43
Cognitive assessment completed either pre or post fall	41
Analgesia given	32
Call Bell was in reach	31
Evidence of PACE	27
Medication review completed either pre or post fall	27
Notifying Falls Team/Fall Safe co-ordinator	26
Patient moved on to 1:1/2:1 supervision/requested	25
Timely specialist advice sought	19
Post fall patient commenced on EPCO	17
Patient bed observed from station	17
NEWS 2 score noted	15
Good record keeping	11
Health and Safety notified	4
Eyesight tested by optometrist/referred	3



KEY FACT

Around 50% of falls are preventable.

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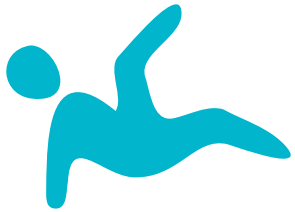
Theme 3: What Could We Improve?

Based on the information provided with the Shared Learning Forms (SLFs), of the patients who fell:

- 58% identified issues with **fully and accurately completed documentation** (56% last year). The most common issue was omission, were there was a lack of documentation showing an assessment had been updated in line with Trust policy.
- 45% highlighted issues with the falls risk assessment (48% last year):
  - not documented fully
  - not reviewed as per Trust guidelines
  - not updated after the fall
- 42% highlighted issues with the CNS Assessment not being completed according to Trust Policy (49% last year).
- In 40% of cases, the Moving and Handling Care Assessment either needed updating or the patient should have been on a moving and handling care plan (41% last year).
- In 36% the patient was either not assessed for harm (spinal damage/fracture) before being moved from the floor, or this was not adequately documented (38% last year).
- 26% of notes did not document the **standing element** of the lying and standing blood pressure or record why it could not be taken (28% last year).
- 26% of notes did not document the cognitive assessment being completed in line with the Trust guidelines (27.5% last year).
- 20% noted that assistive technology should have been considered/available or used to help prevent the fall (16% last year).
- 19% of notes had either poorly documented verbal or written guidance to patients on the risk of falling in hospital (20.5% last year).
- 19% of returned forms noted issues with regards to the medical assessments post fall i.e. not being completed, not using the correct form or issues with the fall's algorithm (20.5% last year).
- 18% mentioned issues with the patient's footwear assessment, either not assessed or poorly assessed, with issues being identified but not being actioned.

For the full list of areas, 'What could we Improve' please see Table 6.



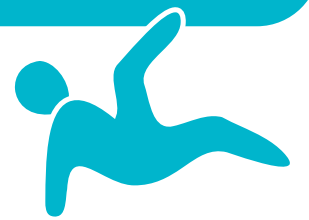


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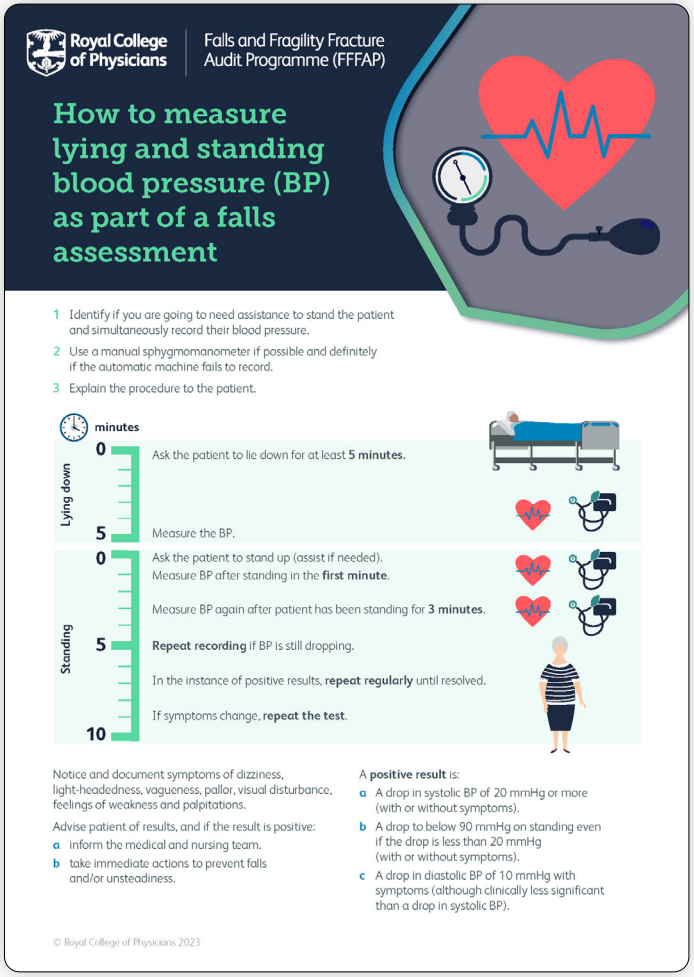
Table 6: What could we improve?

What could we improve?	Number of Patients
Poor terminology/completion of notes/updating notes	86
Fall risk assessments not completed/reviewed/ updated in timely manner	67
CNS assessment post fall not in line with policy	62
Moving and Handling Care Monitoring assessment needs updated/should have been on MH care plan	59
Issues with regards to documentation of the patients assessment for spinal injury prior to moving after the fall	53
Cognitive assessment should be completed/ updated	39
Standing Blood Pressure not completed on falls assessment and no reason provided for omission.	38
Did not use/consider Assistive Technology/or it was broken	29
Medical assessment post fall/falls algorithm/ incorrect form/not completed	28
There was no or poorly documented verbal/ written advice provided to the patient about the risk of falling in hospital	28
Patients footwear was not assessed/poorly completed	26
To remind all patients to use call bell and ensure it is documented	19
Urinalysis not performed/documented	19
Update Datix report for all incidents of falls	18
Short staffing on ward/extremely pressured including ED	17
Bed rail usage reviewed post fall/no rationale	17
Improvement in communication, reporting and actioned in a timely manner	14
Use Close Observation Form	14

How to Measure Lying and Standing Blood Pressure as part of a Falls Assessment.



KEY FACT

Falls make up half of the hospital admissions for accidental injury, especially hip fractures.

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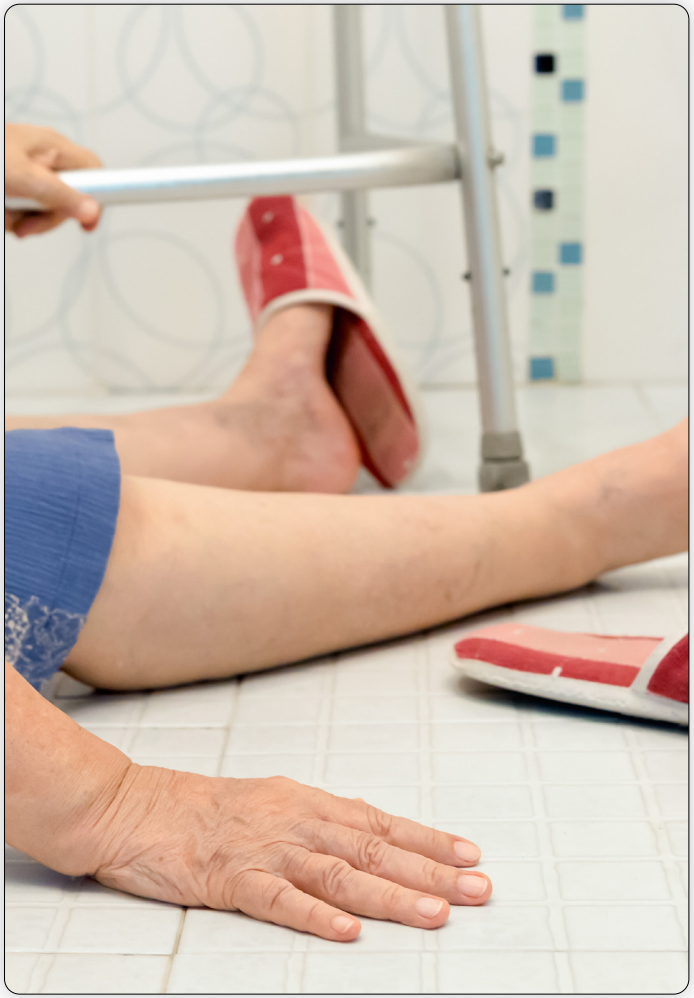
What could we improve?	Number of Patients
Record Blood Glucose post fall	14
Falls Bundle B not completed	13
Ensure NOK are informed/documented	11
Patient drowsy due to sedative or pain control medication	11
Alarm detached/cord too long	9
Consider use of Enhanced Patient Observation/ not completed	9
Falls leaflet not provided	9
Staff to complete 'Fear of Falling' assessment and action it	9
Patient should have been on 1:1 but not assessed	8
The Fall Safe Coordinator was not informed of incident	7
Faster turnaround of investigations including X-rays and CT Scans	7
Range of falls prevention interventions not considered	6
Lower bed not considered/eProcurement issues	5
Patient not on dementia care pathway	5
Ensure nursing staff made aware of falls risk at safety brief	5
1:1 staffing requested but not available	5
Ensure access to walking aid if had previously	5
Post falls update NEWS2	4



KEY FACT

Falls are a regional Key Performance Indicator for quality and safety across HSC.

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Theme 4: What Have We Learnt?

Trusts have systems in place to learn from falls:

- 80% outline their process for sharing learning from falls, this includes:
  - 47% stating 'Learning from injurious falls will be themed each quarter, and shared at the 'patient safety quality network' meeting for further dissemination and improvement within individual Directorates'.
  - A further 33% 'Learning from injurious falls will be reported on each month and presented at the Senior Nursing and Midwifery Team meeting for further dissemination and improvement within individual Directorates'.
- 69% state the systems they have in place for sharing on the ward:
  - 54% stating 'Areas identified for improvement will be disseminated to staff within the ward, at safety briefings and ward handovers'
  - 15% stating 'Ward manager will discuss this incident and the review process at the next ward meeting with ward staff. Both areas of good practice and areas for improvement will be discussed'.
- 54% state an action plan will be completed:
  - 33% stating 'Ward Manager will complete an action plan and identify who is responsible for each action and the time frame for each
  - 21% stating 'Ward Manager and Assistant Clinical Service Manager will complete an action plan and attach it to the incident on Datixweb.'

Specific areas of Training identified included:

- 15% state staff to attend the falls awareness training sessions via zoom over the next few months.
- 15% state staff to ensure moving and handling training is up-to-date and/or complete refresher training.
- 1% state 'all staff to be reminded of responsibilities in regards to professional standards of practice, codes of conduct and expected competencies as outlined by their governing body i.e. NMC, RCN, HCPC, GMC etc'.
- With Encompass being introduced in the SE Trust, 11% of forms stated, 'staff are encouraged to escalate issues with Encompass to their Ward Manager urgently and seek guidance and support from Acute Falls Prevention service when appropriate.'

KEY FACT

20% of falls require medical intervention.

KEY FACT

90% of hip fractures are caused by a fall.

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A variety of additional actions have been taken at Trust level to help reduce falls which include:

- The falls Prevention in Hospital; Information for Patients and Visitors Leaflet to be provided to all patients.
- Display the Call Bell Poster and encourage patients to use it prior to mobilising.
- The use of falls signage/a board above the bed.
- In the SHSCT the use of falls stickers was mentioned on 2 forms.
- All bank and agency to be informed of falls staff.
- Ordering additional falls equipment.
- Ward manager to ensure all staff know where to find flat-lifting equipment on their site.
- Staff are to read and sign they have read the Falls folder.

Staff learning included:

- Updating risk assessments in line with the Trust policy and this should be correctly documented.
- Documenting the patients **lying and standing** blood pressure, and if this is not possible then document why.
- Documenting factually in the patient records and Datix.
- Communicating and relaying information promptly.
- The importance of documenting and using appropriate post fall equipment.
- The importance of Medical staff being aware of post falls pathway.
- Ensuring X-ray delays are followed up by medical staff.
- Recognising family may need assistance if taking a patient off the ward.
- The importance of reminding the patient to use the **call bell** and documenting the patient has been informed.
- Ensuring where appropriate the use of **assistive technology** has been considered.
- Ensuring completion of the cognitive screening by Medical or OT staff in line with Trust policy.
- Notifying the ward Falls Prevention Champions or Fall Safe Co-ordinators of the fall incident.
- Not to use wheelchairs as a form of permanent seating.

The Emergency Department

Key learning points:

- Overcrowding increases the risk of falls.
- If a patient is confused consider support from the family.
- The need for 1:1 staffing in Emergency Departments for high risk patients.

KEY FACT

Falls are among the top 5 most frequent Adverse Incidents reported across Health and Social Care Trusts.

LEARNING FROM FALLS

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TABLE 7: What we have learnt?

What we have learnt?	Number of Shared Learning Forms
Areas identified for improvement will be disseminated to staff within the ward, at safety briefings and ward handovers	80
Learning from injurious falls will be themed each quarter, and shared at the 'patient safety quality network' meeting for further dissemination and improvement within individual Directorates	70
Learning from injurious falls will be reported on each month and presented at the Senior Nursing and Midwifery Team meeting for further dissemination and improvement within individual Directorates	49
Ward Manager will complete an action plan and identify who is responsible for each action and the time frame for each	49
Ward Manager and Assistant Clinical Service Manager will complete an action plan and attach it to the incident on DatixWeb	31
Ward manager will discuss this incident and the review process at the next ward meeting with ward staff. Both areas of good practice and areas for improvement will be discussed	22
Staff to attend the falls awareness training sessions via zoom over the next few months	22
Staff to ensure moving and handling training is up to date and/or complete refresher training	22
Staff are encouraged to escalate issues with Encompass to their Ward Manager urgently and seek guidance and support from Acute Falls Prevention service when appropriate	17
All staff to be reminded of responsibilities in regards to professional standards of practice, codes of conduct and expected competencies as outlined by their governing body i.e. NMC, RCN, HCPC, GMC etc	17
All staff to read and sign they have read the Falls folder	7
Risk assessments should be updated in line with Trust policy including if there is any change in patient's status and correctly documented	7
Importance of using/documenting appropriate post fall lifting equipment	6
Falls leaflet to be provided to all patients	6
Overcrowding of wards/ED increases the risks of falls	5
All patients above the age of 65 should have a Lying/Standing blood pressure recorded at the time of admission and if not then reason why noted	5

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What we have learnt?	Number of Shared Learning Forms
Remind all patients to use call bell and document	5
The importance of communication and relaying information promptly	4
Family may need assistance if taking patient off ward	4
Use of Falls signage/board above bed	3
Medical staff need to be aware of post falls pathway	2
Use fall stickers on notes (SHSCT)	2
Wheelchairs not to be used for seating	1
All bank and agency informed of Falls protocol	1
Ward manager to ensure all staff know where to find flat-lifting equipment on their site	1
X-ray delays need followed up by medical staff	1
Falls equipment ordered	1

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Conclusion

This Falls Newsletter 2023-2024 is launched to coincide with national Falls Awareness Week from **Monday 16th September to Friday 20th September**. This Newsletter provides an overview of the key themes identified from inpatient falls, which were classified as Adverse Incidents, in the period April 2023 to March 2024.

Only Shared Learning Forms submitted to the Safety, Quality and Innovation Team, PHA, by the 31st May 2024 have been analysed and it is recognised forms may be submitted after that date.

This thematic analysis provides rich patient safety information in relation to falls prevention strategies for HSC Trusts to consider going forward; whilst recognising that so much good practice is also reflected in the key findings.

Please disseminate this Newsletter widely across your Organisation and share at Team Meetings/Safety Briefings, to support improvements in practice in relation to inpatient Falls Prevention Strategies.

KEY FACT

All falls cannot be prevented without unacceptable restrictions to patients' independence, dignity and privacy.

If you have any comments or questions related to Learning From... Falls please get in contact by email at falls.learning@hscni.net

References

- Keeping mobile and preventing falls
- AGE UK
- RCN
- RCN Falls

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