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WELSH HEALTH CIRCULAR

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Llywodraeth Cymru
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STATUS: COMPLIANCE

CATEGORY: Chief Nursing Officer /Acting Chief Medical Officer Letter

Title: Principles, Framework and National Indicators: Adult In-Patient Falls

Date of Expiry / Review:

N/A

For Action by:

Health boards and trusts

Action required by:

Immediately

Sender:

Prof Jean White, Chief Nursing Officer / Dr Chris Jones, Acting Chief Medical Officer

DHSS Welsh Government Contact(s) :

Martin Semple, Nursing Directorate, Health and Social Services Group, Welsh Government, Cathays Park 2, CF10 3NQ; 02920 823198

Enclosure(s): Principles, Framework and National Indicators: Adult In-Patient Falls

Introduction

Falls are the most frequently reported adult in-patient clinical incident and are a significant patient safety challenge for the NHS in Wales. There are more than 240,000 reported in acute hospitals and mental health trusts in England and Wales every year (that is over 600 a day)[1]. The effects of falls can range from no harm to serious injury and death. However, even those falls that do not result in serious harm can cause a great deal of distress, particularly for those who are elderly and/or frail, resulting in consequences that can threaten an individual's independence. As the average age of patients is rising the number of falls related to serious incidents is increasing, it is therefore timely to ensure the necessary safeguards are in place and being carried out to minimise the number of falls across all health boards in Wales.

Serious falls will inevitably prolong the length of time a patient is required to stay in hospital and may lead to permanent disability and reduction in a patient's independence. In 2007, the direct cost of patient falls for the NHS in Wales and England was estimated to be more than £15 million a year[2]. Costs will be greater now and the additional cost of healthcare during and following discharge from hospital will increase this figure significantly.

Research has shown that multiple interventions, performed by multidisciplinary teams and tailored to the individual patient, can reduce falls by 20–30%. These interventions are particularly important for patients with dementia or delirium, who are at high risk of falls in hospital.

Whilst this circular focuses on in-patient falls, health boards and trusts should continue to consider holistic falls awareness and prevention activities across other settings, including primary and community care.

[1]Royal College of Physicians. National audit of inpatient falls Audit report 2015**.** London: RCP, 2015.
[2] National Patient Safety Agency. *Slips trips and falls in hospital.* London: NPSA, 2007

The purpose of this Welsh Health Circular is to:

- Disseminate the 'Principles, framework and national indicators: adult in-patient falls' document
- Promote medication review in patients who have fallen or are at risk of falls and bring health professionals attention to the availability of the All Wales Medicines Strategy Groups' guidance documents about polypharmacy and the safe use of long-term oral bisphosphonate therapy
- Remind health boards and trusts of the requirements for reporting falls as serious incidents to the Welsh Government
- Remind health boards and trusts of the expectation to use the Health and Care Standard for falls prevention
- Highlight the Falls and Fragility Fracture Audit Programme (FFFAP), and seek action and assurance of compliance from health boards and trusts.

Health boards and trusts are required to:

- Note and action requirements throughout this WHC
- Chief Executives to respond to the reporting cycle set out in Principles, Framework and National Indicators: Adult In-Patient Falls document
- Identify an executive and clinical lead accountable for in-patient safety in relation to falls and falls prevention
- Identify and inform Welsh Government of the health board/trust forum responsible for ensuring the requirements of this WHC are implemented
- Health boards and trusts should send details of falls leads and falls fora to MajorHealthConditions@wales.gsi.gov.uk no later than 31 May 2016.

Principles, Framework and National Indicators: Adult In-Patient Falls

(Distributed with this WHC)

An all-Wales Group comprising of representatives from health boards and trusts falls multidisciplinary leads and Welsh Government was established in June 2013 to develop a suite of national indicators for adult in-patient falls. The indicators will provide a standardised approach for in-patient falls and data collection that will bring benefits to a better understanding of falls.

The work of the group has included a review of the evidence-base which has been summarised within the document. The document provides health boards and trusts with the following:

- Framework for individual assessment
- National criteria for multi-factorial assessment
- National criteria for multi-factorial intervention
- A national set of indicators for Wales
- Standardised national data fields for falls reporting
- Promotion of local 'Improving Quality Together Silver'

Actions for health boards and trusts:

In response to this publication, health boards and trusts are required to:

- Disseminate the new document entitled *Principles, framework and national indicators: adult in-patient falls* to clinical staff and clinical governance staff
- Consider and implement the guidance on assessment and intervention related to falls prevention and management
- Use the gross national indicators highlighted in the document to report falls via the Datix system

Appropriate Prescribing

As discussed earlier, falls may result in serious injuries including broken bones. The significance of these more serious falls is amplified for older people in terms of the care they require and the potential loss of mobility and independence. Appropriate prescribing has an important role in both preventing falls and reducing fracture risk.

Medication Review

Medication review should be considered as part of a multifactorial assessment in patients at risk of falling.

Some medicines are known to be associated with an increased risk of falls. The ongoing appropriateness of medicines should be reviewed in all patients who have fallen or are at risk of falls.

The All Wales Medicines Strategy Group (AMWSG) document entitled Polypharmacy Guidance for Prescribing provides further information on medication review and medicines particularly associated with falls.

Prescribing for People at High Risk of Osteoporotic Fractures

The appropriate choice of therapy will depend on a range of factors. The AWMSG document entitled Guidance to Support the Safe Use of Long-term Oral Bisphosphonate Therapy provides advice on the appropriate prescribing, administration and review of oral bisphosphonates; and circumstances in which specialist advice on alternative treatment options (injectable bisphosphonates, raloxifene, strontium ranelate, denosumab or teriparatide) should be sought.

Actions for health boards and trusts:

- To ensure arrangements are in place to review the appropriateness of prescribing medicines which are known to increase the risk of falls in patients who have fallen or are at risk of falls
- To ensure patients at high risk of osteoporotic fractures are offered

	appropriate therapy to reduce risk in accordance with AWMSG guidance.

Health and Care Standards, Serious Incidents Reporting, and Falls and Fragility Fracture Audit Programme

Health and Care Standards

http://gov.wales/docs/dhss/publications/150402standardsen.pdf

The Health and Care Standards form the cornerstone of the overall quality assurance system within the NHS in Wales. The Health and Care Standards provide a framework which can be used to identify strengths and highlight areas for improvement. They are designed to be used in day to day practice to encourage a consistent level of quality and safety across all services and to promote up-to-date effective and consistent practice. Accompanying supporting guidance is published on the NHS Wales Governance e-Manual.

Health and Care Standard 2.3 relates to falls prevention. The standard is about minimising the risk of people falling and promotes the assessment of a range of factors which are known to increase the risk of falling, as well as the importance of developing individual care plans which aim to prevent individuals from falling thus reducing harm and disability. It is important that health boards and trusts identify their current performance against the standard and then take the necessary steps to ensure the standard is met.

The updated Framework for Assuring Service User Experience (2015) (http://gov.wales/docs/dhss/publications/151231whc061en.pdf) which links to the standards helps to ensure that people have positive first and lasting impressions, that they receive care in safe, supportive and healing environments, and that they understand and are involved in their care.

Reporting of Falls Related Serious Incidents

http://www.wales.nhs.uk/sites3/docopen.cfm?orgid=932&id=170588

The Putting Things Right guidance describes the reporting arrangements of concerns which are patient safety serious incidents (referred to as serious incidents in this section). The definition of a serious incident is set out in the document.

The guidance provides examples of serious incidents that must be reported to Welsh Government, examples include patient falls that contribute to severe harm and death.

The number of patient falls being reported through this system is increasing. However, from the data provided, it can be assumed that not all health boards and trusts are reporting patient falls as routinely as expected.

Falls and Fragility Fracture Audit Programme (FFFAP)

Falls and Fragility Fracture Audit Programme (FFFAP) is a national clinical audit programme organised by the Royal College of Physicians. The programme is designed to audit the care that patients with fragility fractures and inpatient falls receive in hospital and to facilitate quality improvement.

The audit programme comprises of three work streams, these are:

National Audit of In-patient Falls

https://www.rcplondon.ac.uk/projects/falls-workstream-national-audit-inpatient-falls

National Hip Fracture Database (NHFD)

http://www.nhfd.co.uk/nhfd/nhfd2015reportPR1.pdf

Fracture Liaison Service Database (FLS-DB)

https://www.rcplondon.ac.uk/node/1520

These audits provide important data that health boards and trusts should be using to review and inform practices that will improve the care and safety of patients. Latest reports can be accessed using the links provided.

To note - to strengthen the arrangements for monitoring how well health boards / trusts are taking forward the findings and recommendations from audits, the Welsh Government National Clinical Audit & Outcome Review Advisory Committee chaired by Prof. Peter Barrett-Lee will be undertaking a regular spot check of individual audits from March 2016 onwards. The first audits to be reviewed will be the national hip fracture audit and the falls audit which both published reports in 2015.

Actions for health boards and trusts:

- Health boards and trusts to assess against the Health and Care Standard 2.3 for falls prevention and provide assurance of compliance via their quality assurance systems including to the board
- To ensure all serious incidents are reported in a timely manner in accordance with the Putting Things Right guidance
- To review findings and implement the recommendations from the FFFAP audit programme with the intention of improving outcomes for patient safety, demonstrated by improved performance in audit results

Principles, framework and national indicators: adult in-patient falls

Endorsed by

British Geriatric Society Cymru/Wales Falls Special Interest Group

TABLE OF CONTENTS

MEMBERSHIP

Development Group:

Chair	Denise Shanahan-	Cardiff and Vale UHB (nursing)
Vice Chair	Paul Labourne-	Powys Teaching Health Board (nursing)
Swapna Alexander-		Betsi Cadwaladr UHB (medical)
Debbie Davies -		Cwm Taf UHB (therapies- WTAC)
Sarah Jones-		Public Health Wales
Alison Lewis -		Aneurin Bevan UHB (nursing)
Anya Pinhorn-		Powys Teaching Health Board (medical)
Iain Roberts -		Public Health Wales (service improvement)
Amanda Ryan -		Cardiff and Vale UHB (nursing)
Helen Tyler -		Velindre NHS Trust (therapies)
Gill Webber -		Hywel Dda UHB (nursing)
Beverly Wilding-		Cwm Taf UHB (nursing)

Contributors:

Sian Bolton-	Public Health Wales
Alyson Charnock-	Abertawe Bro Morgannwg UHB (nursing)
Helen Griffiths-	Abertawe Bro Morgannwg UHB (nursing)
Anne Owens-	NHS Wales Informatics Service
Sean Page-	Betsi Cadwaladr UHB (nursing)
Mandy Tyler-	Aneurin Bevan UHB (therapies)
Natalie Vanderlinden-	Hywel Dda UHB - Assistant Director of Therapies & Health Science (Director of Therapies & Health Science Representative)
Maureen Wolfe-	Betsi Cadwaladr UHB (nursing)
Nicola Job-Davies	Royal College of Nursing

SITUATION

The Chief Nursing Officer for Wales directed, under the Free to Lead Free to Care Post Implementation Group, a Working Group to develop a suite of national indicators for adult in-patient falls.

The All-Wales Group, including representation from other falls multi-disciplinary work streams and leads, has met since June 2013 and this paper sets out the recommendations to date.

The Indicators are evidence-based and designed to be captured and reported via the national e-datix system. Full benefits of reporting will require data integration.

BACKGROUND

Falls are the most frequently reported adult in-patient clinical incident. There is no standardised reporting mechanism of in-patient falls within or across Wales. The adverse effects of falls range from no physical harm to catastrophic injury and death with psychological sequelae common.

Extensive work has been undertaken in Wales by the 1000 Lives Falls Community Collaborative demonstrating the benefits of a standardised approach. As the Collaborative has focused on community falls, the Chief Nursing Officer for Wales recognised that a standardised approach for in-patient falls will bring benefits to better understand in-patient falls and the response. It should be recognised that the evidence base for community falls and in-patient falls assessments and interventions differ significantly.

The strategic drivers include UK (1, 2, 3, 4, 5) and Welsh priorities (6, 7, 8) which seek to report on falls, mitigate risks of falls and reduce harm from falls.

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[1] NPSA Slips Trips and Falls in hospital, 2007

[2] Cochrane Collaboration, 2012

[3] NICE CG 161, 2013

[4] NPSA RR01, 2011

[5] RCP Recommendations from the falls and bone health audit and

[6] Burden of Injury

[7] NSF for Older People, 2003

[8] Health and Care Standards 2015

ASSESSMENT

The first task of the Chair of the Group was to establish membership and together with the Vice Chair, invitations were sent to each Health Board and Trust and Public Health Wales (PHW).

At the first meeting 23rd June 2013, the membership was discussed and other representatives invited to broaden this membership. The Terms of Reference were agreed through face to face meetings and e-communication. With the challenges of All Wales working face to face, consultation on issues was undertaken through e-communication where applicable. Underpinning key principles, for example, promoting individualised care, and recognising the risk of unintended consequences were agreed.

The evidence-base was reviewed and summarised and a matrix developed. The evidence base for stratification of risk using falls risk prediction tools is not valid for in-patients and should not be used. A multi-factorial assessment (MFA) to modify risks as part of patient centred multi-factorial interventions (MFI) is recommended.

A one day workshop, facilitated by PHW was held on 6th December 2013. The aim was to firmly place the person at the centre of practice and was modelled on a patient scenario. The agreed outputs from the meeting were the framework for individual assessment, national criteria for Multi-Factorial Assessment (MFA), national criteria for Multi-Factorial Intervention (MFI) along with proposed gross indicators and national fields for reporting (datix), and Improving Quality Together (IQT) Silver examples. These have since been refined as the framework for individual assessment. A review of physical harm vs. immobility and glossary of terms have also been prepared.

Psychological harm, particularly fear of falling is a commonly recognised effect which may result in self-limiting behaviour, but the assessment of this is beyond the scope of this set of Indicators.

RECOMMENDATIONS

That the Free to Lead Free to Care post implementation steering group is asked to note the following:

- Membership
- Terms of reference
- Underpinning principles
- Evidence base

And consider and approve the following:

- Framework for individual assessment
- National criteria for Multi-factorial assessment (MFA)
- National criteria for Multi-factorial Intervention (MFI)
- Proposed national indicators for Wales (number of falls, number of people who have fallen 2 times or more, number of people who have fallen, level of harm)
- The adoption of standardised national datix fields for falls reporting
- To promote local 'Improving Quality Together Silver'

And consider and approve the following recommended next steps:

- Develop standardised national datix fields for falls reporting (these ultimately could be used for a falls information data set for research purposes)
- Development of a national reporting system for in-patient falls
- A national group to review the data, trends, injuries and compliance with mitigation
- Develop a data repository of anonymised falls data that can be interrogated as a research tool

Underpinning Key Principles:

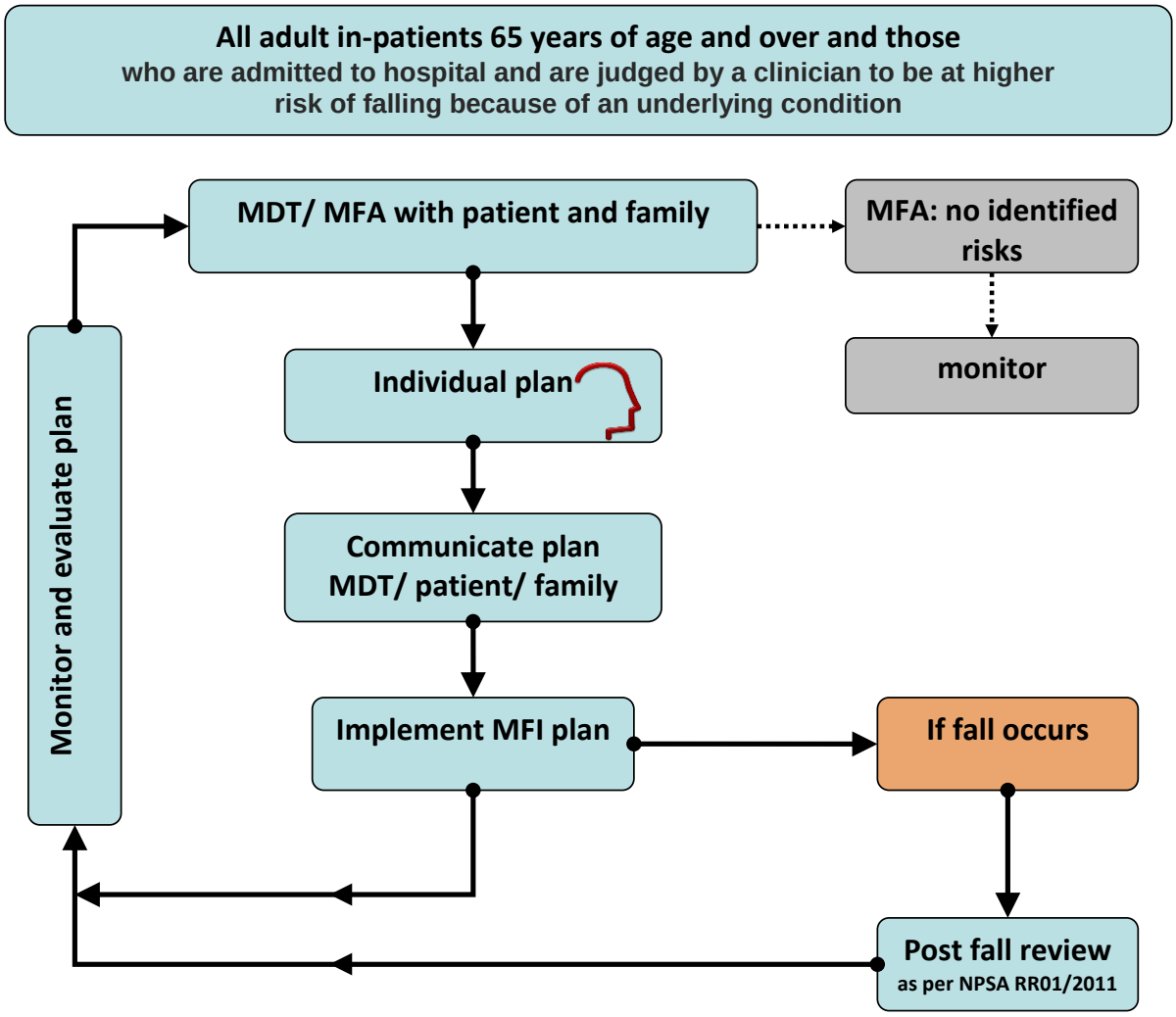
FRAMEWORK FOR INDIVIDUAL ASSESSMENT

Abbreviations:

MDT- Multi Disciplinary Team

MFA - Multi-Factorial Assessment

MFI - Multi-Factorial Interventions



NATIONAL CRITERIA FOR MULTI-FACTORIAL ASSESSMENT AND INTERVENTIONS

National Criteria for Multi-Factorial Assessment (MFA)

Initial assessment to be documented for any patient in hospital with intention to assess or admit for greater than 6 hours (excluding day case activity).

- Multi-Factorial Assessment (MFA) must include:
  - Falls history* and bone health
  - Cognitive impairment* and delirium review
    - dementia, confusion, ability to maintain own safe environment
  - Physiological assessment and examination
    - e.g. lying and standing BP, cardiac, delirium screen if appropriate
  - Medication* review
  - Gait and balance (postural instability, mobility problems and/ or balance problems*)
  - Sensory deficits
    - Vision*, hearing, numbness
  - Toileting* and non verbal indicators of need
  - Foot wear* and foot health

  * Aligns to National Institute for Health and Care Excellence Clinical Guideline 161
- Re-assessment is mandatory:
  - On transfer to different area
  - With change in condition
  - Following a fall

- **Ongoing** proportionate and timely multidisciplinary assessment
- **Ongoing** appropriate review of the multi-factorial assessment

National Criteria for Multi-Factorial Intervention (MFI)

- Individualised person centred care and intervention plan following MFA
    - Commenced immediately following initial assessment
    - Progress of interventions and specialist assessments documented in clinical notes
- Multidisciplinary review of Multi-factorial assessment
- Environment
    - Position on ward
    - Position on ward in relation to toilet
- Equipment
    - Ultra low bed use/ availability
    - Use of bedrails
    - Alerts (movement senor equipment)

- Evidence of post fall protocol informed by NPSA RRR & and NICE clinical guidance
- Post fall multidisciplinary debrief/ safety round
- Undertake a post fall review for all patients and always undertake a root cause analysis investigation if a patient has come to harm.
- Incorporate not duplicate national and local pathways

    e.g. nutrition and hydration, continence bundle, delirium guidelines, dementia, pain assessment

PROPOSED INDICATORS

Gross Indicators:

Number of falls

Number of patients who have fallen

Number of patients who have fallen 2 or more times

Harm from fall

- Level of harm
- Type of physical harm (e.g. no physical harm, laceration, bruising, fracture neck of femur, spinal fracture, other fracture, head injury, death)

Local Indicators:

Investigation into injury from fall to include:

- Evidence of multi-factorial assessment undertaken
- Evidence of multi-factorial interventions implemented to mitigate modifiable factors
- Holistic assessment considering the '4Ps' principle[9] to identify increased dependency and need:
  - **Previous:** The patient's general circumstances, lifestyle and events leading up to the admission
  - **Present:** The patient's current condition
  - **Predict:** The factors likely to impact on completing a successful discharge for this patient
  - **Prevent:** The actions required to overcome problems and prepare the patient for discharge
- Post fall multidisciplinary debrief date
- Length of stay
  - This includes total length of stay from admission recorded in days
  - If less than 24 hours record in hours / minutes
  - Time in hours or days since transfer to a different clinical area/environment

[9] 'Passing the Baton - A Practical Guide to Effective Discharge Planning' available at: http://www.wales.nhs.uk/sitesplus/829/page/36467

PROPOSED NATIONAL DATIX FIELDS

To support drill down locally which can be used to support 'Improving Quality Together' Silver and provide a national research database

Date of admission	date
Date of fall	date
Time of fall	time
If fall with 24hrs of admission, how many hours since admission?	time
Area of ward fall took place (pick list)	choice

- room of bed
  - cubicle/ single room
  - shared 2-3
  - shared 4-6 beds
  - shared ≥7 beds
- corridor
  - toilet
  - ensuite
  - shared
- bathroom

Fall witnessed? (Yes/ No)	yes/ no
Staff on duty at time of fall:	

- RN — number
- HCSW — number
  - (consider others)

Fall from height (pick list)	choice

- over raised bed rail
- from trolley
- down steps
- other height

Does patient have diagnosis of dementia (Yes/No)	yes/ no
Does patient have cognitive impairment or delirium (Yes/No)	yes/ no

CONSIDERATION OF UNINTENDED CONSEQUENCES

Falls Versus Immobility: The Unintended Consequences

Risk averse cultures in in-patient settings that attempt to reduce the incidence of falls may cause unintended undesirable consequences potentially more harmful to the patient than a fall.

Covinsky *et al.* (2003) state, 'Bed rest, or inactivity associated with hospitalisation or disease state, poses a significant threat to muscle tissue and functional capacity. In older adults, physical inactivity during hospitalisation is almost an accepted part of the inpatient experience, yet clearly contributes to a host of negative outcomes'. It follows that adverse change in musculature for older people will increase their risk of falls.

Bed-based hospital care is common, especially in acute hospitals. The periods of the day when a person is in bed may form part of the overall falls risk reduction strategy. Similarly, patients who are sitting out in a chair may only be encouraged to move within specific parameters e.g. only if they call for assistance. The consequences of reducing a person's mobility either intentionally or unintentionally need to be fully understood and balanced against the risk of a harmful fall.

Even people who are fully capable of activity and at very little risk of fall do not move around in hospital as much as they would at home. Older people are even less likely to move around. In addition to the specific reason for admission, factors such as pain, disorientation, anxiety, the right clothing, or simply not knowing if it is *allowed* will reduce the amount of physical activity an older person undertakes in hospital. Changes to daily routines, e.g. breakfast in bed, use of wheelchair to be taken to the bathroom or not getting dressed, will have a significant impact on an older person's musculature.

Younger healthy individuals who are immobilized will lose up to 5% of their muscle strength each day (*de Morton et al., 2007*), with nearly half their muscle strength being lost within 3 – 5 weeks. Unfortunately, the loss of muscle bulk and the rate of loss for older people is much greater. Within a week of a hospital admission an older person who is nursed in bed may become as much as 50% weaker. The loss of muscle strength in older people results in a far more significant loss in function compared to their younger counterparts. Older people are 7 times more likely to develop severe limitations to their mobility as a consequence of this muscle loss compared to younger people. 63% of our very elderly patients (≥90 yrs) will lose their basic functional ability during a hospital stay (*Covinsky et al., 2003*).

Furthermore, older people often present to hospital with pre-existing Sarcopenia. Sarcopenia is an age-related, multi-factorial process that is phenotypically characterised by the loss of muscle mass. It has been described as low muscle mass and low muscle function (*Cruz-Jentoft et al., 2010*) and becomes increasing common with advancing age in older people. It is estimated that 1:20 people over 65 yr olds and 1:2 in those over 80 will develop sarcopenia. Whilst the onset of sarcopenia is insidious, its progression is greatly accelerated by and primarily attributed to physical inactivity. Sarcopenia is exacerbated by poor protein intake and low levels of vitamin D and is not isolated to traditional frail elderly but is also seen in older obese people who may be less active with a poor diet.

Aside from the affect on muscles, reduced mobility may results in other unintended consequences such as, decreased endurance, osteoporosis, joint contractures, and cardiovascular complications e.g. increased heart rate, decreased cardiac reserve, orthostatic hypotension and venous thrombosis. Even in small measures these factors will further increase the risk or the harm from falls.

Older people in hospital are therefore extremely vulnerable to the negative effects of reduced mobility and exercise.

Maintaining an activity level that prevents the decline in muscle loss should be factored into any falls prevention strategy. Weight bearing activities such as transfers and walking should form part of the fundamental care for an older person in hospital. The physiotherapist will be able to advise specific exercises (ideally resistance exercises) to support the care and rehabilitation programme.

Whilst exercise and activity can reverse the effects of muscle weakness recovery from muscle weakness is slower than the rate of loss with only 6% gain a week in those exercising at 65% - 70% capacity (*Dittmier and Teasell, 1993*). Unsurprisingly the rate is slower again in older people. The ability of an older person to recover muscle bulk and strength may take many months. To reduce their risk of falls, older people need to exercise regularly, totaling at least 50 hours over minimum of 12 weeks.

As a general rule, for every day an older person is in bed it may take up to 6-7 days of significant activity to regain the loss. For many older people the loss may be irretrievable.

Summary

Measures to reduce a person's risk of fall whilst in hospital may perversely result in iatrogenic harm resulting in short or long term unintended consequences.

With advancing age, it becomes increasingly likely that even a brief, clinically mandated period of rest could initiate a serious decline in muscle strength and functional capacity, i.e., a "tipping point" from which some may not fully recover (*English & Paddon-Jones, 2010*). Therefore, maintaining a level of mobility or physical activity for people who fall or are at risk of falls is a fundamental level of care that must be actively considered by the multidisiciplinary team and can be enhanced by specific physiotherapy exercises.

Professor Bernard Isaacs, the renowned Geriatrician quotes:

> *Sudden death from over-activity is much feared and rarely seen.*
> *Sudden death from under-activity is little feared and much seen.*

Author: Debbie Davies (Physiotherapist) MSc., MCSP on behalf of Welsh Therapies Advisory Committee

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Post In-patient Fall Root Cause Analysis Template				
Datix reference:				
Patient Name:		**NHS number:**		
Investigating Officer	*Name:*	*Role:*		
	Signature:			
Date of Fall:				
Date Completed:				
Is there evidence of an initial multi-factorial assessment? *(For any patient in hospital with intention to assess or admit for greater than 6 hours)*			Yes	No
If **No** please complete a 5 Whys assessment.				
Is there evidence of appropriate review of the multi-factorial assessment?			Yes	No
If **No** please complete a 5 Whys assessment.				
Did the patient receive appropriate prophylactic interventions? *(For example: observable bed, intentional rounds as planned, was close supervision in place if planned)*			Yes	No
If **No** please complete a 5 Whys assessment.				
Were there any further factors or interventions that could have been considered? (*Were all MFI's actively being implemented appropriately at the time of the fall as highlighted by the multidisciplinary MFA and was the MFA to the standard expected)*			Yes	No
If **No** please complete a 5 Whys assessment.				
Did appropriate immediate post fall actions / interventions take place? *(Was the standard of treatment to the standard expected*)			Yes	No
If **No** please complete a 5 Whys assessment.				
What actions / learning can we gain from this fall?				
What is the plan for disseminating the learning?				

SUGGESTIONS FOR IMPROVING QUALITY TOGETHER

Improving Quality Together Silver:

- National indicators local reports: knowing the local position
- National data fields/local reports : where, when , who etc (use clinical dashboard)
- Co-production and patient engagement and involvement in their plan
- MFA implementation
- MFI implementation
- Learning derived from RCA
- Improvement tools:
    - Safety cross
    - Heat/ measles map
    - Pattern and trend analysis
    - Intentional rounds
    - Gate record of each fall intervention/ falls averting action has taken place
- Environmental assessment
    - Hand grab rails (contrast)
    - Toilet seat (contrast)
    - Floor coverings (carpets, non slip and contrast)
    - Toilet door (Stirling university / RNIB resources)
- Culture
    - Active understanding of verbal and non verbal requests of when a patient may wish to use the toilet

GLOSSARY OF TERMS

Acute Setting
A setting with onsite availability of the full range of diagnostic and therapeutic capabilities needed to diagnose and treat acute physical illnesses.

Assessment
An initial and ongoing process of identifying risk factors.

Bone health
A history of the number of fractures and sites; any bone scans or medication prescribed to protect bone health and concordance with this.

Carer
Where the term 'carer' is used, this refers to unpaid carers, not paid carers such as care workers.

Cognitive impairment
A term used to describe a condition involving problems with cognitive function that is their mental abilities such as thinking, knowing and remembering.

Datix
A risk management database used to record adverse events via incident reporting and supports concerns, claims and inquest processes.

Delirium
A clinical syndrome characterised by disturbed consciousness, cognitive function or perception, which has an acute onset and fluctuating course (previously called 'acute confusional state'). Hyperactive delirium is subtype of delirium characterised by people who have heightened arousal and can be restless, agitated and aggressive. Hypoactive delirium is subtype of delirium characterised by people who become withdrawn, quiet and sleepy.

Dementia
A progressive and largely irreversible clinical syndrome that is characterised by a widespread impairment of mental function.

Fall
'An event whereby an individual comes to rest on the ground or another lower level with or without loss of consciousness' (AGS/BGS 2001).

Falls history
A history of the number of falls in the last year including the mechanism of fall, likely cause and any resultant fractures informed by the patient, carer or family, care setting and medical notes.

Gait and balance
Gait is a term to describe the manner and style of walking. Balance, in relation to the upright posture, often refers to unsteadiness, when walking, where the regular pattern of walking is disturbed. It may also indicate a lack of co-ordination when transferring from one position to another.

Injurious fall
A fall resulting in a fracture or soft tissue damage.

Level of harm
1 None, 2 low, 3 moderate, 4 severe and 5 death as per the All Wales grading of concerns framework: Putting Things Right.

Mitigation
The elimination or reduction of the frequency, magnitude, or severity of exposure to risks, or minimisation of the potential impact of a threat or warning.
http://www.businessdictionary.com/definition/mitigation.html

Multidisciplinary
More than one healthcare professional from different disciplines.

Multi-factorial assessment
An assessment with multiple components that aims to identify a person's risk factors for falling.

Multi-factorial intervention
An intervention with multiple components that aims to address the risk factors for falling that are identified in a person's Multi-Factorial assessment. This may include a more in-depth or specialist assessment.

Non-acute setting
A setting focused on recovery and rehabilitation, symptom control or palliative care.

Older people
Older people are people aged 65 years and older.

Putting Things Right
Guidance produced for the NHS in Wales to enable responsible bodies to effectively handle concerns according to the requirements set out in the National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011 ("the Regulations").

Root cause analysis
A systematic investigation to identify how and why patient safety incidents happen. Analysis is used to identify areas for change and to develop recommendations which deliver safer care for patients.

Targeted
Interventions that are aimed at modifying a particular risk factor or factors.

Type of Physical harm
An assessment of obvious physical harm such as no physical harm, bruising, laceration, fracture, fracture neck of femur, spinal fracture, other fracture, head injury, death.

Unwitnessed fall
An individual has fallen but the mechanism of the fall was not witnessed. The patient is frequently found on the floor.

EVIDENCE BASE SUMMARY

Evidence Matrix	reduce/ prevent number of falls	reduce harm from falls	number of osteoporotic #	MFA	MFI	rehabilitation	Vitamin D	Physio/ exercise/ gait & balance	presence/ absence of carpet in sub acute hospitals	low bed use to reduce falls	sensor alarms to reduce falls	Symbol/ wrist band .	staff training/ guideline implementation	knowledge intervention for patient	falls risk scoring tools	hip protectors	provide oral and written information to patient and family	/environmental checks improvement	/post fall must be reviewed post fall protocol	policy & training on use of bedrails	Intentional rounding	serious injury screening	Delirium	Dementia care: voidance of prescribing antipsychotic medication for patients with	unintended/ perverse consequences	critical incident analysis	ensure relevant information is shared a cross service
NSF OP WAG (2003)	☑		☑	☑		☑																				☑	
Cochrane Collaboration (2012)	☑			☑	☑		☑	☑	☑	☒		☑	☒	☑		☑	☑								☑		
NICE (2013)	☑		☑	☑	☑	☑									☒		☑	☑						☑			
NPSA Slips Trips and Falls in hospital (2007)				☑	☑						☒	☒			☒	☒		☑	☑				☑				☑
Cochrane Collaboration (2012)										☒	☒																
NPSA Using bedrails safely and effectively (2007)																				☑							
NPSA RR01 (2011)				☑	☑													☑	☑								
FallSafe Care Bundles (2011)		☑		☑	☑																						
Safety First 'How to' guide for Reducing Harm from falls		☑													☒				☑				☑	☑	☑	☑	

NPSA the How to guide: reducing harm from falls in mental health inpatient settings		☑													☒				☑				☑	☑	☑	☑	
RCP Falling standards, broken promises (2010)		☑	☑	☑	☑	☑		☑											☑			☑	☑				
Kings College London																		☑			☑						
Intentional Rounding: a position paper (2012)																					☒						
Implementing failsafe (2012)				☑	☑						☒	☒					☒		☑								
AGS/BGS Clinical Practice Guideline (2010)				☑	☑		☑	☑										☑						☑			
Nursing Executive Centre (2009)		☑		☑	☑																	☑					
Fundamentals of Care	☑					☑																					
Safetylit.org search																											

KEY

☑ empirical evidence	no clear evidence either way
☑ evidence based practice recommendations	☑ practice guidelines - practice based evidence
☑ second stage assessment	☒ no evidence
☑ some evidence as part of MFI but not for individual interventions	☒ not recommended as practice based intervention

Indicator Specification Form

Performance Measure ID:	
Performance Measure Name:	Total Number of Adult in-Patient Falls Per Calendar Month

Description:
This is the total number of adult in-patient falls that have occurred in hospital during the calendar month

A fall is defined as 'An event whereby an individual comes to rest on the ground or another lower level with or without loss of consciousness' (AGS/BGS 2001)

In-patient setting is defined as in hospital with intention to assess or admit for greater than 6 hours excluding day case activity

Strategic Fit:
National Service Framework for Older People
The NHS '1,000 Lives Multiagency Community Falls Collaborative
Prudent Health Care
Improving Quality Together
Health and Care Standards

Operational Fit:
Reduction in hospital morbidity and mortality
Reduced organisational cost

Known Standards:
Assessment and prevention of falls in older people NICE Clinical Guidance 161 2013
Rapid Response Report NPSA/2011/RRR001: essential care after an inpatient fall

Reporting Format:
Ability to display results in a graph and table by single clinical area, a locally defined group of clinical areas, hospital and Health Board

Total number of falls on the y axis of the graph and name of the month on the x axis

Interpretation:
This is the total number of patient falls that have occurred in an inpatient setting during the calendar month

This is a single count and can only be interpreted as part of trend information for that given area

Calculation: total number

Numerator:	
Denominator:	
Data Source:	Each fall is individually entered into Datix as the incident occurs
Data Collection Frequency:	As fall occurs
Target:	There is no target

Fitness for Purpose:
The results of data capture for this indicator will be reviewed in December 2015 to ensure it is satisfying information requirements in respect of falls

This is an area specific trend analysis to provide initiation and base line for improvement work

Testing/Pilot:
Powys tHB

Information Governance:
Anonymised data with ability for ward staff to see patient details

Commercial Considerations:
None

Impact Assessment:
No extra time is required

Implementation Plan:
This indicator is currently collected

Maintenance:
The sponsor of this indicator is Chief Nursing Officer for Wales via Welsh Nursing and Midwifery Committee and Welsh Therapies Advisory Committee

A full review of this indicator will be undertaken in (eg June 2016) or earlier if deemed necessary

Performance Measure ID:	
Performance Measure Name:	Number of individual adult in-patients who have fallen 2 or more times

Description:
This is the number of individual adult in-patients who have fallen 2 or more times in the calendar month (for the previous 12 month period)

A fall is defined as 'An event whereby an individual comes to rest on the ground or another lower level with or without loss of consciousness' (AGS/BGS 2001)

In-patient setting is defined as in hospital with intention to assess or admit for greater than 6 hours excluding day case activity

Strategic Fit:
National Service Framework for Older People
The NHS '1,000 Lives plus' Multiagency Community Falls Collaborative
Prudent health Care
Improving Quality Together
Health and Care Standards

Operational Fit:
Reduction in hospital morbidity and mortality
Reduced organisational cost

Known Standards:
Assessment and prevention of falls in older people NICE Clinical Guidance 161 2013
Rapid Response Report NPSA/2011/RRR001: essential care after an inpatient fall

Reporting Format:
Trend graph for each area / service / locality/ individual patient as part of Integrated Governance Reports extracted from Datix

Interpretation:
This is a single count and can only be interpreted as part of trend information for that given area- for service improvement

Calculation:
None

Numerator:	
Denominator:	
Data Source:	Datix
Data Collection Frequency:	At the point of each fall within Datix
Target:	None

Fitness for Purpose:
This is a area specific trend analysis to provide initiation and base line for improvement work

Information Governance: Anonymised data with ability for ward staff to see patient details (research possibilities)
Commercial Considerations: Datix
Impact Assessment: Already collecting the data for this – therefore low impact Reduction in hospital morbidity and mortality related to falls Reduced organisational cost Reduced potential increases in length of stay
Implementation Plan: Information is currently collected – number of individual patients who fall rather than number of falls requires extraction The main focus is HB reporting however there is requirement for monthly All Wales reports to be collated
Maintenance: The sponsor of this indicator is Chief Nursing Officer via Welsh Nursing and Midwifery Committee and Welsh Therapies Advisory Committee A full review of this indicator will be undertaken in (eg June 2016) or earlier if deemed necessary

Performance Measure ID:	
Performance Measure Name:	Number of individual adult in-patients who have fallen
Description: This is the number of individual patients who have fallen in the calendar month in an in-patient setting (for the previous 12 month period) A fall is defined as 'An event whereby an individual comes to rest on the ground or another lower level with or without loss of consciousness' (AGS/BGS 2001) In-patient setting is defined as in hospital with intention to assess or admit for greater than 6 hours excluding day case activity	
Strategic Fit: National Service Framework for Older People The NHS '1,000 Lives plus' Multiagency Community Falls Collaborative Prudent health Care Improving Quality Together Health and Care Standards	
Operational Fit: Reduction in hospital morbidity and mortality Reduced organisational cost	
Known Standards: Assessment and prevention of falls in older people NICE Clinical Guidance 161 2013 Rapid Response Report NPSA/2011/RRR001: essential care after an inpatient fall	
Reporting Format: Trend graph for each area / service / locality/ individual patient as part of Integrated Governance Reports extracted from Datix	
Interpretation: This is a single count and can only be interpreted as part of trend information for that given area- for service improvement	
Calculation: None	
Numerator:	
Denominator:	
Data Source:	Datix
Data Collection Frequency:	At the point of each fall within Datix
Target:	None

Fitness for Purpose: This is a area specific trend analysis to provide initiation and base line for improvement work
Testing/Pilot: Powys tHB
Information Governance: Anonymised data with ability for ward staff to see patient details (research possibilities)
Commercial Considerations: Datix
Impact Assessment: Already collecting the data for this – therefore low impact Reduction in hospital morbidity and mortality related to falls Reduced organisational cost Reduced potential increases in length of stay
Implementation Plan: Information is currently collected – number of individual patients who fall rather than number of falls requires extraction. The main focus is HB reporting however there is requirement for monthly All Wales reports to be collated
Maintenance: The sponsor of this indicator is Chief Nursing Officer via Welsh Nursing and Midwifery Committee and Welsh Therapies Advisory Committee A full review of this indicator will be undertaken in (eg June 2016) or earlier if deemed necessary

Performance Measure ID:	
Performance Measure Name:	Number of adult in-patient falls - Harm

Description:

This indicator comprises of the total number of adult in-patient falls that have occurred in an adult in-patient setting during the calendar month, captured in the following categories in the Datix system:

- 0 No Harm
- 1 Minor harm resulting in minimal intervention or treatment
- 2 Minor harm resulting in minor intervention or treatment
- 3 Moderate harm
- 4 major harm
- 5 Catastrophic harm resulting in death or permanent harm

Include descriptors: bruise, skin tear, fracture (type and location e.g. Left fracture neck of femur or lumbar spinal fracture), head injury

Consider – is there an assessment done, were interventions to reduce risk planned and implemented

A fall is defined as 'An event whereby an individual comes to rest on the ground or another lower level with or without loss of consciousness' (AGS/BGS 2001)

In-patient setting is defined as in hospital with intention to assess or admit for greater than 6 hours excluding day case activity

Strategic Fit:

National Service Framework for Older People
The NHS '1,000 Lives plus' Multiagency Falls Collaborative
Prudent health Care
Improving Quality Together
Health and Care Standards

Operational Fit:

Reduction in hospital morbidity and mortality
Reduced organisational cost

Known Standards:

Assessment and prevention of falls in older people NICE Clinical Guidance 161 2013
Rapid Response Report NPSA/2011/RRR001: essential care after an inpatient fall

Reporting Format:

Ability to display results in a single graph and table by single clinical area, a locally defined group of clinical areas, hospital and Health Board

Monthly trend graph for each area through Care Metrics and area / service / locality as part of

Integrated Governance Reports extracted from Datix

Interpretation:
This indicator provides information regarding the numbers of adult in-patient falls which result in obvious physical harm

This is a single count and can only be interpreted as part of trend information for that given area

Calculation:
This is to be undertaken through data extract from Datix and total validated against total number of falls reported over same time period

Numerator:	Number of falls by category of harm
Denominator:	Total number of falls
Data Source:	The total number of inpatient falls recorded in Datix within a calendar month
Data Collection Frequency:	At the point of each fall within Datix
Target:	No target for trend analysis

Fitness for Purpose:

The results of data capture for this indicator will be reviewed in June 2016 to ensure it is satisfying information requirements in respect of falls

This is a area specific trend analysis to provide initiation and base line for improvement work

Testing/Pilot:
Powys tHB

Information Governance:
Anonymised data with ability for ward staff to see patient details

Commercial Considerations:
Datix

Impact Assessment:
Development of minimum data set
Development of datix user interface
Development of reporting systems

Implementation Plan:
Information Department tested reporting from Datix June- December 2014 and on-going

Recording of mitigation tested through PDSA within Powys tHB- mitigation difficult to capture using datix

Maintenance:
The sponsor of this indicator is Chief Nursing Officer for Wales via Welsh Nursing and Midwifery Committee and Welsh Therapies Advisory Committee

A full review of this indicator will be undertaken in (eg January 2016) or earlier if deemed necessary

Free to Lead; Free to Care:

Adult In-patient Falls Working Group

Terms of Reference

INTRODUCTION

As part of the All Wales Nursing and Midwifery Dashboard work the Chief Nursing Officer for Wales has directed that a National Indicator is developed for falls. Due to the different strands of work being undertaken across on Wales on falls it has been agreed that a working group under the Free to Lead Free to Care initiative is established to bring together the different strands of work and develop a National adult in-patient Falls Indicator/s

PURPOSE

The purpose of the All Wales Falls Working Group is:

- Produce Key Principles to underpin work.
- To review the existing evidence and best practice assessment tools relating to adult in-patient falls to inform the development of national in-patient falls indicators in order to manage falls effectively
- To make a recommendation to the Free to Lead Free to Care Steering Group by 31st March 2014 that all organisations:
  - Adopt best practice tools / standards
  - Implement appropriate indicators applied and measured nationally that benefit patients through providing intelligence to sustainably improve practice and to apply best practice standards
  - Incorporate the evidence/ best practice and indicator understanding into Health Professional Education

DELEGATED POWERS AND AUTHORITY

- The working group will work under the delegated authority of the Chief Nursing Officer and is authorised to undertake this programme of work.
- The working group will work to the timescales set by the Chief Nursing Officer.
- The working group will make recommendations to the Chief Nursing Officer through the Free to Lead; Free to Care Post Implementation Steering Group.
- Recommendations will be based on a review of existing evidence and will meet national and international standards:
  - National Institute for Health and Clinical Excellence
  - Cochrane Collaboration

  - National Patient Safety Agency
  - Royal College of Physicians
  - Profound
  - *1000 Lives*
- The working group will demonstrate that it has taken into account Equality and human rights principles and ensure that recommendations meet the requirements of adult patients who share one or more protected characteristics as set out in the Equality Act 2010 via an Equality Impact Assessment.
- The working group may establish sub-groups or task and finish groups to carry out on its behalf specific aspects of its business.

MEMBERSHIP	
Chair	Consultant Nurse for Older Vulnerable Adults, Cardiff and Vale
Vice Chair	Assistant Nurse Director of Nursing, Powys
Members	Representative from 1000 Lives Falls Collaborative
	Physician with a specialist interest in falls
	Representative of Public Health
	Lead practitioner in the Care of People with dementia
	Welsh Therapy Advisory Committee representative
	Representative from each of the Health Boards and Trusts in Wales
Secretary	Provided by Cardiff and Vale University Health Board
By invitation	The Working Group Chair may extend invitations to attend meetings if specifically required.

Member Appointments

The membership of the Working Group shall be determined by a combination of nomination from the Professional Body or Organisation or based on the recommendation of the Working Group.

Appointed members shall hold office for the period of the work required.

Support to Committee Members

The Working Group Secretary, on behalf of the Chair, shall:

- Arrange meetings and venues as directed;
- Take notes of the meetings and develop action sheets;
- Organise for draft notes and action log to be circulated within one week of the meeting being held.

WORKING GROUP MEETINGS

There will be 2 meetings of the Working Group to enable the first submission to the Free to Lead Free to Care Steering Group by September 2013 therefore work will be undertaken by e-mail as well as formal meetings.

Quorum: At least five members must be present to ensure the quorum of the group.

Frequency of Meetings: as work indicates, with 2 meetings held prior to submission of the first report to the All Wales Free to Lead; Free to Care Implementation Board September 2013.

Attendance: All members are expected to attend meetings or via Video Conference and this will be available for each meeting of the group.

REPORTING AND ASSURANCE ARRANGEMENTS

The Working Group Chair shall:

- Report to each meeting of All Wales Free to Lead; Free to Care Post Implementation Steering Group. This includes verbal updates on activity, the submission of working group minutes and written reports, as well as the presentation of a final report and recommendation;
- Bring to the Post Implementation Steering Group specific attention any significant matters under consideration by the Working Group;

REVIEW

These terms of reference and operating arrangements shall be reviewed quarterly by the Working Group with reference to the Implementation Board.

DATE OF ACCEPTING THE TERMS OF REFERENCE AND APPROVAL

Date: *Updated 01.04.14*

Chair of Working Group signature: *D. Shanahan*