| AGENDA ITEM |
|---|
| 6.2.1 |

**QUALITY & SAFETY COMMITTEE**

# SLIP, TRIP OR FALL IMPROVEMENT PLAN BRIEFING PAPER

| | |
|---|---|
| **Date of meeting** | 24th May 2022 |
| **FOI Status** | Open/Public |
| **If closed please indicate reason** | Not Applicable - Public Report |
| **Prepared by** | Debbie Bennion, Deputy Executive Nurse Director |
| **Presented by** | Greg Dix, Executive Director of Nursing & Midwifery |
| **Approving Executive Sponsor** | Executive Director of Nursing |
| **Report purpose** | FOR NOTING |

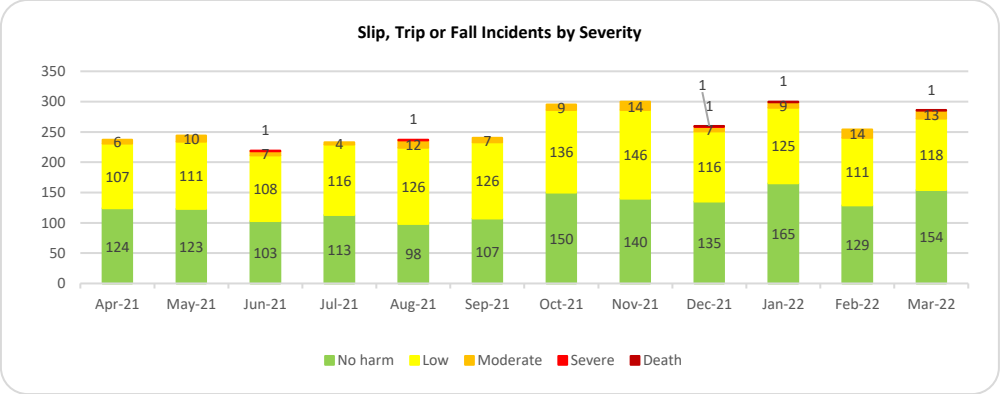
| **Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/group)** | | |
|---|---|---|
| **Committee/Group/Individuals** | **Date** | **Outcome** |
| (Insert Name) | (DD/MM/YYYY) | Choose an item. |

| **ACRONYMS** | |
|---|---|
| CTMUHB | Cwm Taf Morgannwg University Health Board |
| ILG | Integrated Locality Group |

## 1. SITUATION/BACKGROUND

This report has been developed to inform the Quality & Safety Committee of the current position of incidents relating to patient slip, trip or falls and the planned quality improvement focus for 2022/23.

Between the 01.04.2021 and 31.03.2022, a total number of 22,037 patient safety incidents were reported. Of these, 3105 were reported under the category of slip, trip or fall. Slip, trip or fall incidents are Cwm Taf Morgannwg University Health Board's (CTMUHB) second highest reporting category after pressure damage, accounting for 14% of the incidents reported during 2021/2022. The trend for slip, trip or fall incidents for 2021/2022 is reflected in the chart below:



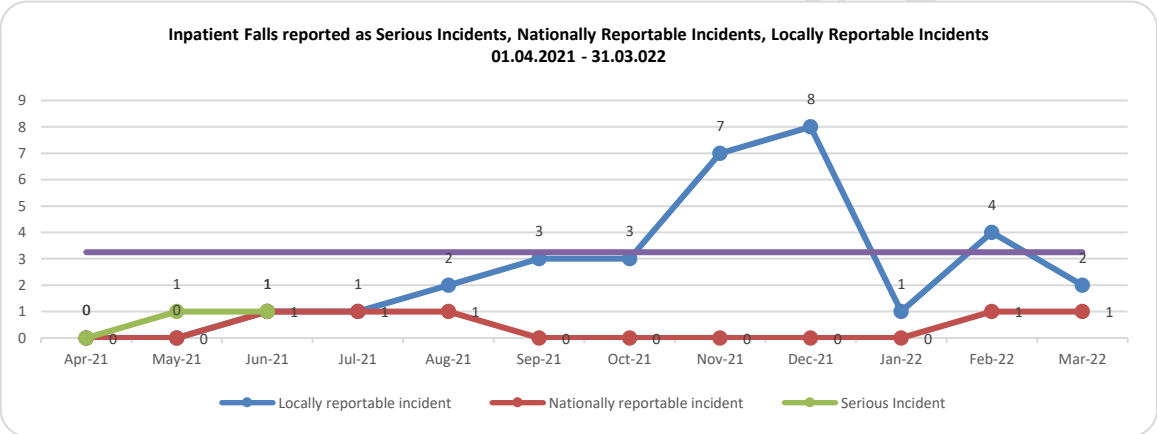

It should be noted that the initial harm/grading on reporting may be subject to change once investigated. Of the slip, trip or fall incidents reported during 2021/2022, 96% are reported as resulting in no or low harm. A breakdown of the severity of incidents on reporting is provided in the table below:

| Severity | Total |
|---|---|
| No harm | 1541 |
| Low | 1446 |
| Moderate | 112 |
| Severe | 3 |
| Death | 3 |
| **Total** | **3105** |

Between the 01.04.2021 and 14.06.2021, **two** slip, trip or fall incidents were reported to the Delivery Unit as Serious Incidents. Following the implementation of the revised NHS Wales National Incident Reporting Policy on 14.06.2021, the terminology and criteria for reporting was changed from Serious Incidents to Nationally Reportable Incidents. From 14.06.2021 to 31.03.2022, the Datix system has recorded five Nationally Reportable Incidents however, one of these was an incident created as a "test" for the Datix system; therefore there were **four** Nationally Reportable Incidents reported to the Welsh Government/Delivery Unit. The Datix team are

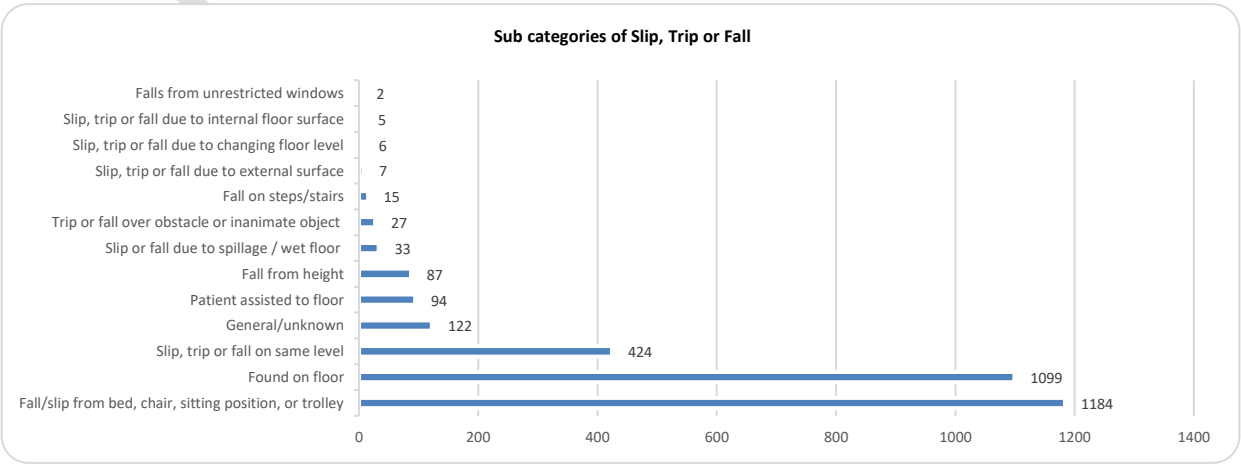
currently undertaking a data cleansing and checking exercise to ensure all "test" incidents are excluded on aggregate reporting.

As part of the transition to the National Reportable Incident Framework, the Health Board introduced Locally Reportable Incidents (incidents that would previously been reported under the serious incident criteria). Under this arrangement, 32 slip, trip or fall incidents were reported internally in 2021/2022. The Health Board has taken this approach to ensure oversight of "make safes" and care reviews; it also enables monitoring and improvements to be tracked. The trend in relation to serious incidents, nationally reportable incidents and locally reportable incidents is highlighted in the chart below:

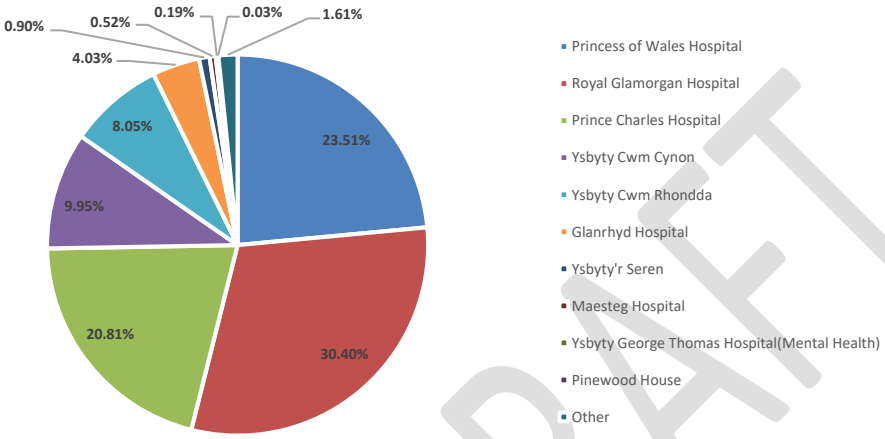



Of the 3105, incidents reported for 2021/2022, 38.1% (1184) were reported under the sub-category of "fall/slip from bed, chair, sitting position, or trolley" and 35.4% (1099) under "found on floor" i.e. an unwitnessed fall . A breakdown of all sub-categories reported under slip, trip or fall is highlighted in the chart below.

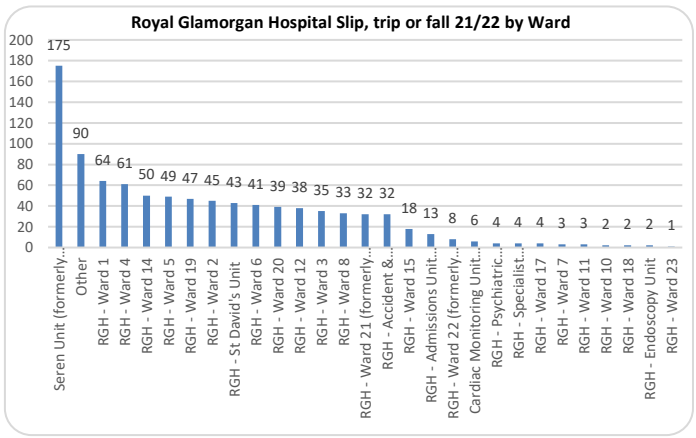
Please note the 2 falls categorized as "falls from unrestricted windows" have been erroneously categorized as such, these falls were not from an unrestricted window; the patients had fallen in a bathroom setting. The incident forms are currently being amended to reflect this, once actioned there will be 0 falls categorised in this sub category.

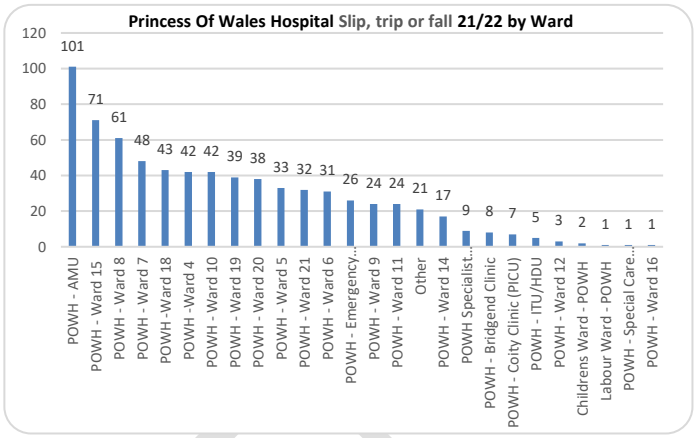


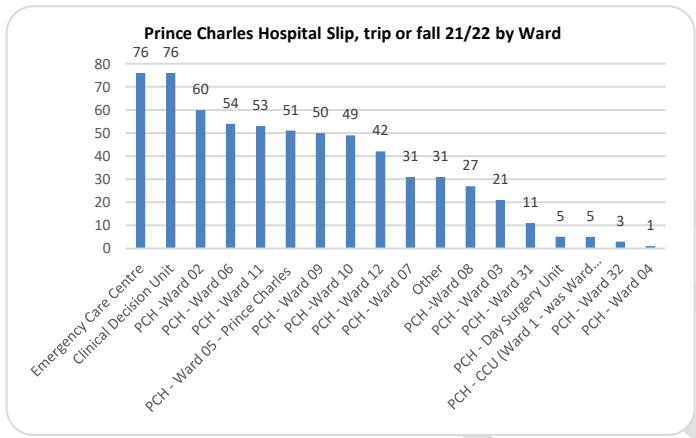
During 2021/2022, the highest number of slip, trip or fall were reported as occurring at the Royal Glamorgan Hospital (30.4%). A full breakdown of the incidents reported by Unit for 2021/2022 is provided in the chart below:

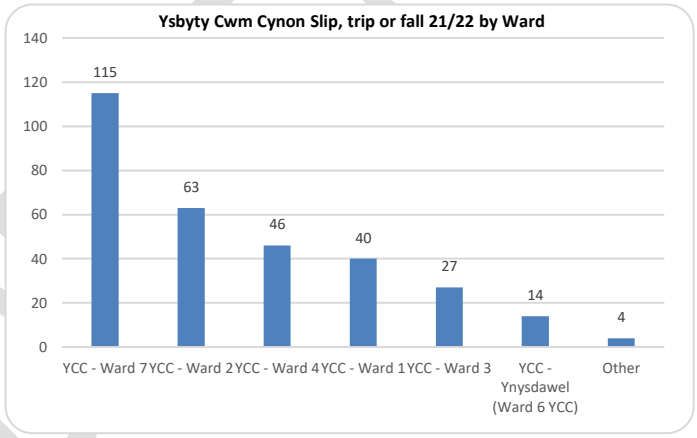


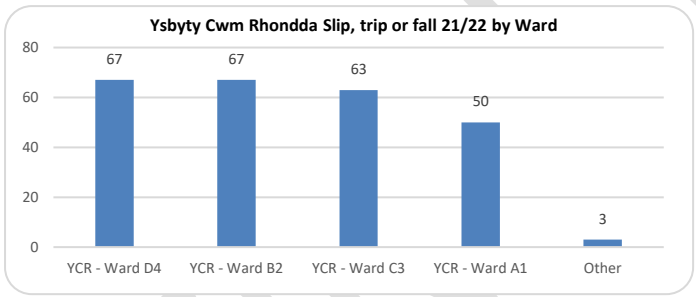
A breakdown of the locations by site for slip, trip or fall for 21/22 by each hospital site is provided below:

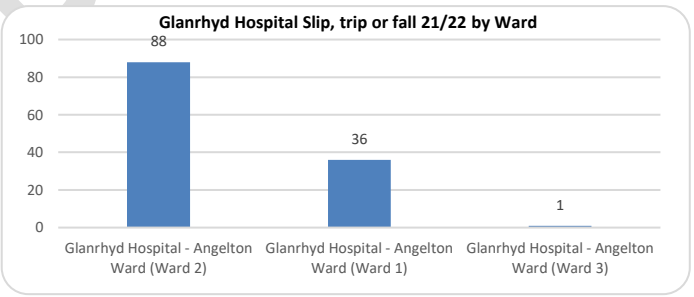


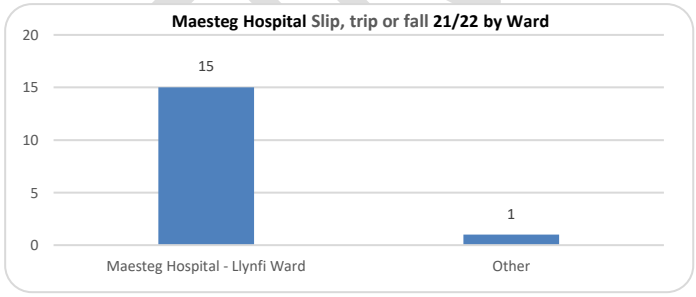



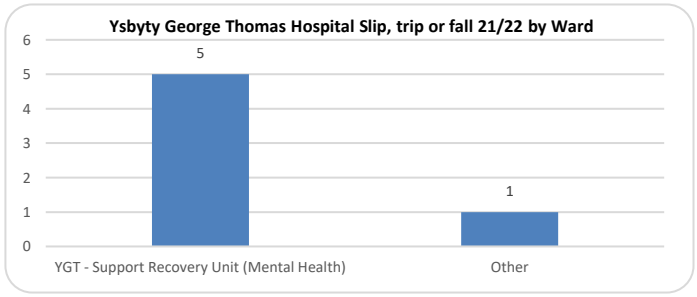



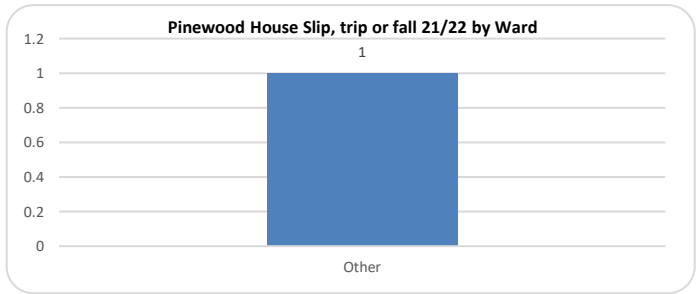



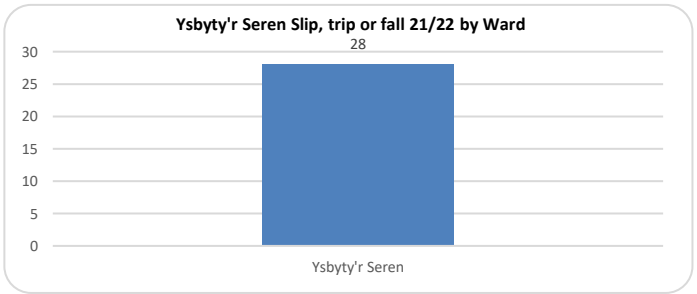



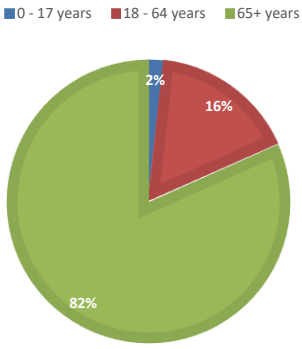



Of the inpatient falls reported, the highest number of incidents is reported in the 65+ age band, which is highlighted in the chart below:




## 2. SPECIFIC MATTERS FOR CONSIDERATION BY THIS MEETING (ASSESSMENT)

### 2.1 High Reporting areas:

**Bridgend Integrated Locality Group (ILG)**

**Princess of Wales Hospital – Acute Medical Assessment Unit**

The Head of Nursing has reported on a number of factors that are potentially influencing the increased number of falls reported in this unit, these include:

- The length of stay on this ward, has increased over the last 6 months, ranging from 3 days to a few weeks.
- The "Frailty at the front door model" now has 15 beds where patients remain for prolonged lengths of time often admitted with delirium and dementia.
- The current environment is difficult to observe patients
- There has been & remains a high use of bank and agency Registered Nursing.

The nursing teams are undertaking a series of actions to reduce the number of falls in this department, these include a raised awareness amongst all staff around the importance of completion of documentation and individualised care planning. A practice educator is now working alongside the teams on the unit to provide bespoke education for staff within AMU based on the results of two recent audits (available on the AMaT system).

All reported falls undergo a Falls scrutiny multi-disciplinary panel who scrutinise all documentation and provide lessons learnt for sharing.

### Glan Rhyd - Angelton Clinic – Ward 2

The nursing teams have reported at their internal performance review, analysis of the high number of falls links with "sun downing". In order to mitigate the risk of falls in this area the teams have taken the following approach:

- The ward nursing establishment has been temporarily increased to allow for one to one observation of patients at extremely high risk of falls (it is of note this ward has a high use of temporary staffing within their establishment.)
- Room sensors have been upgraded to provide early warning of a patient potentially falling with work ongoing in terms of exploring further technology to enable the reduction of falls
- Prescribing practices are being analysed by a specialist mental health pharmacist to understand in more detail the relationship between prescribing practices and patient falls.
- The central patient safety team have been supporting the area with small tests of change such as patient care rounding.

## Rhondda Taf Integrated Locality Group (ILG)

### Royal Glamorgan Hospital - Seren Ward

The high incidence of falls on Seren ward is fully recognised within the ILG, and is a matter of close scrutiny through their monthly Quality Safety Risk & Experience process.

The client group on this ward are almost universally effected by multiple risk factors that are a concern in relation to falls management and which exacerbate the risk when clustered, i.e. mentally disordered; often frail: with limited capacity: mainly ambulant with poor engagement in measures to minimise risk e.g. footwear choice, monitored activity.

The unit has instituted a falls scrutiny panel that is modelled on the community hospitals model (following shared learning) with the support of the governance team. On review, a high standard of risk assessment and identification has been noted with the processes within Seren ward commended for their rigor both generally and following falls. Further improvement of process and outcomes is anticipated through the imminent appointment of an Advanced Nurse Practitioner with a focus on Older Persons Mental Health, including both physical and mental health co-morbidities.

## Merthyr Cynon Integrated Locality Group (ILG)

### Prince Charles Hospital

The ILG report that the management of inpatient falls is a key priority with weekly monitoring undertaken; a dashboard is available for the Senior Nurse Team, who in turn share and discuss with their wider teams. Falls data including actions are key to the bi monthly quality, safety, risk and

patient experience meetings, quarterly Senior Nurse Business meetings as well as the individual ward and department meetings. Any key trends identified for learning are discussed in detail at the monthly Focus Group, a forum where they operationalise the governance agenda.

The patient safety huddle each morning at 08:00 hours-"Safe to Start" is attended by all Ward Managers across the PCH site whereby the patient safety and quality agenda is discussed and falls are key. It is during this meeting acuity is reviewed including all patients requiring 1:1 nursing and cohort observation are discussed and staffing is aligned to the areas at greatest risk. There is an audit trail of all decisions undertaken during this meeting.

The Lead Nurse for Scheduled Care is the lead on the All Wales Falls Group and is integral to quality improvement work across the site.

**Emergency Room & Clinical Decisions Unit (CDU)**

The Head of Nursing has reported on a number of actions the teams are taking forward in order to reduce the number of falls within these units which include:

All falls when investigated are referred for review at Fall Scrutiny Panel to determine whether unavoidable/avoidable with identified lessons learned. Band 7 and Senior Nurse in attendance.

Purposeful Senior Nurse Documentation reviews are undertaken during the shift with the Band 7 (supernumerary) rounding to assess clinical areas on an hourly basis during core hours 8-4pm. During these periods staff are reminded to ensure falls risk assessments are completed with appropriate interventions/care planning implemented accordingly with prompt escalation of concerns to the nurse in charge and/or Senior Nurse.

Start of shift safety briefings are undertaken to identify any patient at risk of falls to ensure they are nursed in an appropriate observable area with appropriate level of nurse intervention/support.

**CDU**

It is of note the environment in CDU is extremely challenging as the layout makes observation of patients difficult (there are 12 individual cubicles which have limited visibility and three four bedded bays).

The senior nurse and ward manager are based on the unit and are undertaking observations in the area several times a day. This provides assurance that patients care needs in all areas are being addressed.

Intentional Rounding has been introduced and is ongoing, this encourages staff to identify any safety concerns regarding the patient. Those patients who have higher care needs including a higher risk of falls are provided

with increased supervision or a move to an area with improved visibility using this set proforma.

All patient falls are reviewed at a weekly scrutiny panel with Band 5 registered nurses being encouraged and given time to attend to ensure any learning identified is shared with the whole team.

The senior nurse is currently working with Improvement Cymru (MDT approach) piloting Human Factor Training that will support the quality improvement work around patient care and safety.

**Ysbyty Cwm Cynon**
**Ward 7**

Ward 7 YCC is a 15 bedded Specialist Dementia Ward, and is a stand-alone Mental Health Ward within YCC. The nature of the patient group is generally moderate to advanced Dementia; due to their lack of capacity and cognitive impairment, patients are not able to keep themselves safe against falls by adhering to a prescribed care plan as the nature of their condition remain unpredictable.

The Mental Health Service Group have reported that all falls resulting in moderate harm or above are reported via the Quality, Safety and Risk Group internally and overseen with the ILG Governance Team. A Falls Panel is in place whereby all falls resulting in moderate harm or above are scrutinised by a multi-disciplinary team comprising of a nurse, therapist and advanced nurse practitioner .

This unit, like many similar units has identified "sun downing" as a time of increased falls, the team has increased their non-funded establishment temporarily to provide an additional twilight HCSW shift to support higher level supervision at this time.

The unit does continue to use 1:1 support (supervision) as identified in individual care plans but continue to strive to move away from this when possible in order to promote mobility and least restrictive practice. Patients are generally not "nursed" in bed but in the communal areas of the ward and the unit now operates a natural waking system on the ward which has proved to reduce levels of agitation and anxiety in the mornings.

## 2.2 Falls Scrutiny Panels and investigation/ improvement methodology

The Quality Improvement team, central patient safety team and the corporate nursing team continue to support the Integrated Locality teams in a targeted approach to reducing inpatient falls. However, it has been recognised there is a need for a CTMUHB wide Falls Prevention and Management Group to be established (please see section 2.3 for further details).

### 2.2.1 Falls Scrutiny Panels

Bridgend ILG have regular, robust multidisciplinary team falls panels, which include representation from a medic, physiotherapist, occupational therapist, pharmacist and nurse. The other ILG's are moving towards this model with the support of the central patient safety team.

### 2.2.2 All Wales Falls Investigation Tool

The Delivery Unit and Once for Wales Datix team have confirmed plans for an All Wales Falls Investigation Tool to be launched, which will align with a similar tool which is in place for pressure damage investigation. The introduction of a robust investigation tool which will be used across all ILG's will aid consistency and support a clear outcome from panel, with agreed level of harm and whether the fall was avoidable or unavoidable.

## 2.3 CTMUHB wide Falls Prevention and Management Group

This group will support the Quality & Safety Committee's role and function in its responsibility for ensuring the quality and safety of healthcare in relation to the prevention, assessment and management of falls in line with Health Care Standard 2.2.

The terms of reference for this multidisciplinary group have been drafted and an initial meeting is planned for June 2022.

The group will:

- Provide a means for the multidisciplinary representation of the three Integrated Locality Groups, patient safety team (s), corporate nursing team, safeguarding and quality improvement team to work to develop a robust quality improvement programme**,** which will be a vehicle for reducing the incidence of avoidable harm from falls.

- Monitor progress via an annual plan of work which will include the creation and launch of CTMUHB Falls Strategy, the monitoring of compliance with NICE guidance and any national audits (e.g. fracture neck of femur audits) and the review of the CTMUHB Inpatient falls policy (due for review in September 2022)**.**

- Monitor all aspects of the "Putting Things Right policy" and any Safeguarding concerns as applicable to a patient who has sustained a slip, trip or fall within our health care setting; this will allow the patient experience and any financial penalties in terms of redress and claims to feature at the forefront of any improvement work

Whilst there is a need to focus on inpatient falls, it is recognised that there is an urgent need to work with our partner agencies for example Welsh Ambulance Service, Fire service and third sector teams to reduce the number of slips, trips, falls that occur in our community settings which often

result in admission to hospital. This will feature heavily in the proposed CTMUHB Falls Strategy and form part of the Falls Prevention and Management Group agenda.

This Falls Prevention and Management Group will assist the Quality and Safety Committee in measuring the success of quality improvement goals by sharing learning and best practice and identifying trends which should be taken into account in improving and escalating risks.

The progress of the "Falls Prevention and Management Group" will be evaluated at their monthly meetings and report on a quarterly basis to the Quality & Safety Committee.

## 3. KEY RISKS/MATTERS FOR ESCALATION TO BOARD/COMMITTEE

Any fall has a potentially harmful effect on patients, whether this is in terms of their psychological wellbeing or physical harm.

There is a need to continue to work to reduce the number of avoidable falls which occur in our health care settings. Whilst there is evidence of considerable activity throughout every ILG in terms of falls prevention in order to reduce the incidence of falls; it is recognised that the establishment of a Health Board wide Falls Prevention and Management group will allow good practice & learning from incidents to be shared on a more formal basis.

Current falls data provides information on numbers of falls, categorisation of harm and demographic factors, however the ability to provide data on "falls per 1000 bed days" would allow us greater clarity on falls numbers, context, benchmarking, and comparison and inform improvement targets. Our performance management colleagues are developing more sophisticated metrics to assist with our prevention and improvement strategy.

Leadership, sharing good practice and developing an improvement strategy across the health board will be key to an equitable, person centred approach to a reduction in incidence and prevalence.

## 4. IMPACT ASSESSMENT

| | |
|---|---|
| **Quality/Safety/Patient Experience implications** | Yes (Please see detail below) |
| | |
| **Related Health and Care standard(s)** | Safe Care |
| | If more than one Healthcare Standard applies please list below: |

| | |
|---|---|
| **Equality Impact Assessment (EIA) completed - Please note EIAs are required for <u>all</u> new, changed or withdrawn policies and services.** | No (Include further detail below) |
| | N/A |
| **Legal implications / impact** | There are no specific legal implications related to the activity outlined in this report. |
| | |
| **Resource (Capital/Revenue £/Workforce) implications / Impact** | There is no direct impact on resources as a result of the activity outlined in this report. |
| | |
| **Link to Strategic Goals** | Improving Care |

## 5. RECOMMENDATION

5.1 The Quality and Safety Committee is asked to **NOTE** the CTMUHB review of the incidence and prevalence of patient falls and the plans to develop a pan organisational ambition and strategy to prevent avoidable falls and prevent harm from falls.