Policy for the Prevention and Management of Adult Inpatients Falling in Hospital Settings

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Policy for the Prevention and Management of Adult Inpatients Falling in Hospital Settings

Key Messages

- This policy applies to all healthcare professionals /care staff (including bank, agency and locum staff) working in all inpatient hospital settings who are involved in the direct care, treatment and provision of services to adult patients who are at risk of falling.

- All adult in-patients should have a falls risk assessment completed by healthcare professionals with the appropriate training and skills, within 24 hours of admission and their care should be documented in their healthcare record. All in-patient falls must be assessed and managed according to the policy and procedure to ensure any injury is promptly identified and treated.

- A maternity in-patient will be identified as at risk of falls on an individual basis following assessment as per admission protocol

- All relevant departments should have systems in place to ensure that this policy and procedure are effectively implemented in their area. Local ward and service teams shall monitor the implementation of aspects of this policy and procedure, and the results measured against the Scottish Patient Safety Programme Care Bundle using the Quality Improvement Data System (QiDS), plus information from local audits and adverse events.

- This policy and procedure are available on the Intranet:- http://intranet.lothian.scot.nhs.uk/NHSLothian/Healthcare/ClinicalGuidance/Pages/ClinicalGuidance-1.aspx

Minimum Implementation Standards

Good Practice for Managers

- All line managers should have local dissemination and implementation plans in place to ensure all staff are familiar and adhere to all aspects of this policy.

Good Practice for Employees

- Has read the policy (or selected excerpts) and considered what it means for him or her, in terms of how to conduct his or her duties
- Has undertaken the e-learning module “Falls Prevention for Adult In-patients” which is essential training to support the implementation of the policy. Please contact the falls coordinator for further information.
- Has altered working practices as expected by the policy

1. Why do we have this Policy?

1.1 Falls are a common problem in hospitals and are associated with significant morbidity and mortality. Hospital inpatients, particularly older people are at increased risk of falls, largely because of their co morbidities rather than by virtue of advanced age alone.

1.2 This policy and the associated procedure support the need to reduce the risk of falls for in-patients in hospital and improve patient experience and outcome of care.

1.3 NHS Lothian also has a NHS Lothian Preventing Slips, Trips and Falls Policy, which covers the general need to identify and manage the risks of slips, trips and falls in our premises. By successfully implementing that policy, this will help reduce the risk of patients falling too.

1.4 Many of the general principles and approaches described in this policy are appropriate for community patients but for further information, this policy should be read in conjunction with The Prevention and Management of Falls in the Community: A Framework for Action for Scotland 2014/15, the NHS Lothian Falls Prevention and Bone Health Strategy 2011-2016, and the referral pathway for older patients discharged from the emergency department after a fall.

2. Policy Statement

2.1 NHS Lothian shall provide safe, person-centred care in a manner that is fully consistent with the Delivery Framework for Adult Rehabilitation: Prevention of Falls in Older People (HDL 2007) 13), the Scottish Patient Safety Programme for Acute Adults, Healthcare Improvement Scotland's 9 points of care priorities, and Standard 11 of Healthcare Improvement Scotland's Care of Older People in Hospitals Standard (June 2015), in order to reduce the risk of falls in its hospitals.

2.2 NHS Lothian shall implement this policy by providing a framework which supports a multidisciplinary and co-ordinated approach to falls prevention and management within hospitals in NHS Lothian. Healthcare Improvement Scotland (HIS) supports NHS Lothian to deliver evidence based, safe, effective, high quality person-centred care for falls prevention and management.

3. Policy Scope

3.1 This policy applies to all healthcare professionals /care staff (including bank, agency and locum staff) working in all inpatient hospital settings who are involved in the direct care, treatment and provision of services to adult patients who are at risk of falling. A maternity in-patient will be identified as at risk of falls on an individual basis following assessment as per admission protocol.

4. Roles & Responsibilities:

4.1 Executive Director Nursing, Midwifery and Allied Health Professionals

The Director of Nursing, Midwifery and Allied Health Professionals has delegated responsibility on behalf of the Chief Executive for leading on the implementation of the policy and procedure.

4.2 Medical Directors, Associate Nurses Director and Allied Health Professional Lead

4.2.1 Senior Clinical Managers are responsible for the operational implementation of the policy and procedure within their clinical areas

4.2.2 Ensure that the findings from audit of falls risk assessments and learning points from Significant Adverse Event reports are reviewed and have improvement plans. That the findings and improvement plans are communicated to the service, Board and Healthcare Improvement Scotland via the Scottish Patient Safety Programme

4.3 Clinical Managers

4.4.1 The clinical manager identifies which staff in his or her area the policy and procedure applies to and can direct staff to where to access on the intranet

4.4.2 The clinical manager has systems in place to provide assurance to him or her that the policy and procedure is being implemented as intended in their area of responsibility.

4.4.3 Ensuring that the findings from audit of risk assessments and learning points from Adverse Event reports are reviewed and communicated to the service, Site Directors and Senior Managers, and inform improvement plans.

4.4.4 All ward managers must ensure that a review of all falls assessments and care planning are audited and reviewed for compliance on a monthly basis via Quality Improvement data System (QiDS) and this is monitored via clinical and management structures.

4.4 Quality Improvement Support Team

4.3.1 Provides improvement advice and supports helping local and service teams analyse data/information to inform local improvement plans

4.3.2 Support data systems such as QiDS to inform improvement planning.

4.3.3 Adverse event management support and advice including the provision of Datix on which all falls should be recorded. See below link to Adverse Event Management Policy and Procedure:
Adverse Event Management Policy
Adverse Event Management Procedure

4.4.4 Within the team are Falls Co-ordinators who support clinical staff where falls are identified as a high priority to develop improvement plans and apply improvement methodology including training/education and specialty clinical support.

4.5 All Staff

4.5.1 All staff involved in the direct care of the patient are expected to follow the procedures and systems that have been put in place to implement the policy.

4.5.2 Follow all policies and procedures designed to ensure safer ways of working including actions to prevent slips, trips and falls.

4.5.3 Report any hazards or concerns relating to falls prevention and management to their line manager.

5 Associated Procedures and Guidelines:

5.1 Further guidelines for the Identification and Assessment of patients at risk of falls, Management of adult inpatients at risk of falls in the hospital setting, and Managing patients with delirium (acute confusion) and dementia guidelines are available within the Procedure for the Prevention and Management of Adult Inpatients Falling in Hospital Settings.

5.2 NHS Lothian has agreed to use the National Guidelines developed by consultation across NHS Scotland and Healthcare Improvement Scotland. The Acute Adult Programme advises the use of Care Bundles from the
Prevention of Falls Driver Diagram and Change Package

5.3 All adult patients should have the falls bundle for inpatients commenced as soon as possible on admission and at least within 24 hours of admission to the ward or department. **See link above for further details**

6. Management of an in-patient fall within a Hospital Setting

6.1 Post-fall care must be in accordance with the National Guidelines and falls bundle. The first priority is to ensure the needs of people affected by the fall are attended to, including any urgent clinical care which may reduce the harmful impact. If there are steps that can be taken immediately to reduce the risk of recurrence, then these should be implemented.

6.2 It is the responsibility of all staff to report and record all falls and near-misses on the Datix system, in line with the Adverse Event Management Policy.

6.3 All ward managers must ensure that a review of the fall and lessons learned are shared with the ward team and includes the patient and their relatives (with patient permission).

6.4 There are some in-patient falls, which need to be reported under RIDDOR to the HSE. Clear guidance on this can be found on the link below:-
http://intranet.lothian.scot.nhs.uk/Directory/HealthandSafety/Reference%20Library/RIDDOR/Pages/default.aspx

For any queries regarding RIDDOR please contact the Health and Safety Service - details on intranet or on link below:-
Corporate > A-Z> Health & Safety > HS Contact Details

7. Evidence Base

7.1 Published evidence supports multidisciplinary assessment of falls risk factors and targeted interventions to reduce or reverse these risks. There is a small body of evidence from randomised controlled trials in older people in a variety of hospital settings which supports this

7.2 More recently the patient safety literature supports a methodology using high impact actions to prevent falls in a hospital setting which may be effective in reducing harm rather than overall falls rates. There are no long term studies of these interventions as yet to support them in terms of sustainability.

National Institute for Health and Clinical Excellence. *Falls: assessment and prevention of falls in older people. Clinical guideline 161 (2013*) Available at: www.nice.org.uk/guidance/CG21/Guidance/pdf/English

National Patient Safety Agency *Slips, trips and falls in hospital*, London, 2007 NPSA www.npsa.nhs.uk

Department of Health. *The National Service Framework for Older People. (2001)*

Cameron, I.D. et al., 2010. Interventions for preventing falls in older people in nursing care facilities and hospitals (Review). Cochrane Database of Systematic Reviews

NHS Quality Improvement Scotland (2010) Up and About pathways for the prevention and management of falls and fragility fractures, Edinburgh: NHS QIS

Scottish Executive. Coordinated, integrated and fit for purpose. A delivery framework for adult rehabilitation in Scotland. 2007

Royal College of Physicians (2012) Implementing fallsafe: Care bundles to reduce inpatient falls London
https://www.rcplondon.ac.uk/projects/falls-prevention-hospital

8 Monitoring and Learning

Element to be monitored	How	Frequency	Reporting to
Reliable Care • Bundle Compliance from falls risk assessment to post-fall assessment • Compliance with AE procedure - Datix	• Quality Improvement Data System • TRAK Boxi reports • Local audits • Observation • Datix Dashboards • Data generated from improvement plans in areas of high priority • Complaints • Thematic learning at ward and service area level	Monthly	• Ward staff • Service Team • Clinical Management Group • Acute Hospitals Committee • Through SPSP to Healthcare Governance • Board Quality & Performance report
Outcome Measure • Rate of falls resulting in significant harm or death per 1,000 occupied bed days	Datix Reporting System Monthly Site Reports	Monthly Monthly	Healthcare Governance Committee/CMG Site Directors/Chief Nurses/Clinical Directors

9. Review of policy

This policy will be audited via the Quality Improvement Department using both the Healthcare Improvement Scotland Acute Adult Programme, Prevention of falls audit and the Quality Improvement Data System measures. This is a compliance measure of falls assessment, prevention and management.

This policy will be reviewed and revised every 3 years or as a result of any changes in legislation.