Western Health and Social Care Trust

QUALITY IMPROVEMENT PLAN (QIP) TARGETS QUARTERLY TRUST BOARD REPORT

FALLS

6 February 2025

PROGRESS TO DATE

Falls are a costly and often preventable health issue and continue to be the highest reported incident within the Trust. Reducing falls and injuries following a fall is important for maintaining health, wellbeing and independence amongst older people. Work is ongoing to raise awareness regarding preventing falls throughout the Trust. The Professional Nursing Team and the Falls Integrated Pathway Co-ordinator (FIPC) through the Trust Slips Trips and Falls Group, support this work and the development of a 3 year falls strategy. However, consideration needs to be given that one dedicated FIPC is not sufficient to meet the demands of the entire Trust in relation to falls.

Falls in Hospital Inpatient Settings

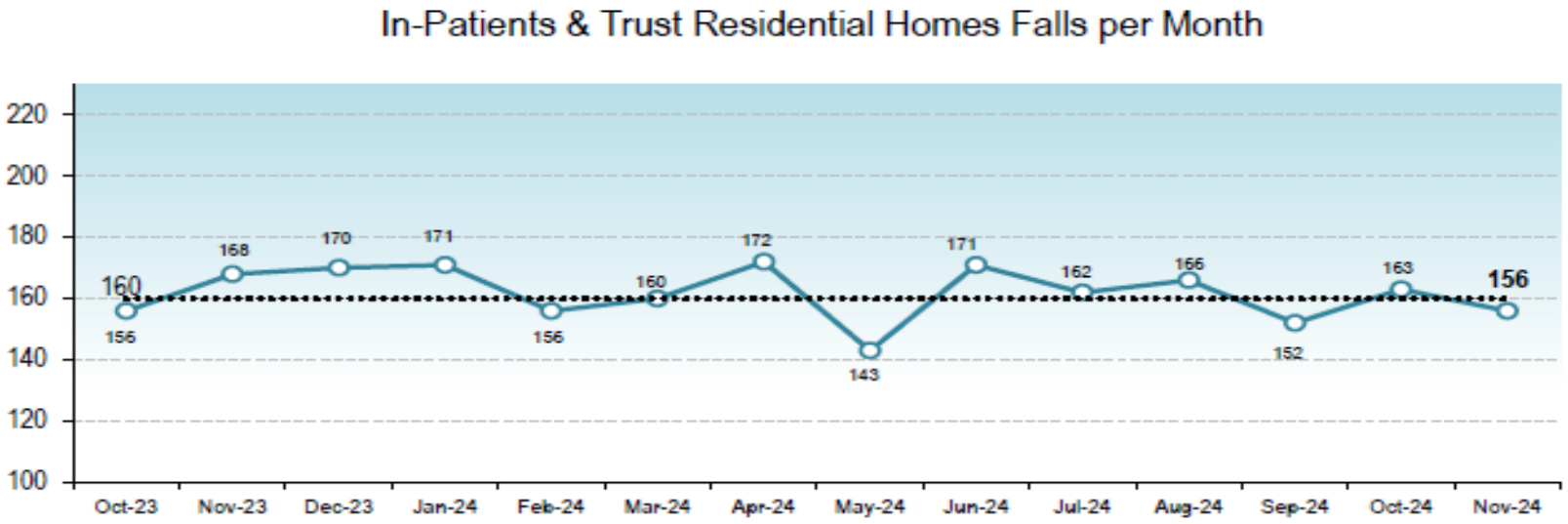
Reporting of falls occurring within inpatient settings continues to the PHA. In Quarter 3 there was a decrease in the number of falls reported from Trust acute inpatient settings with 416 falls reported in quarter 3 and there were an additional 55 falls in Trust residential Homes (total of 471 falls) compared with 499 falls reported in quarter 2. This is a slight decrease compared to the same quarter in 2023 when there were 480 falls reported.

The median number of falls reported from Trust inpatient settings in quarter 3 is 160, a slight increase from 156 in the previous year.

The increase in the median number of falls in inpatient settings may be associated with the increasing numbers of patients living with frailty and dementia or confusion admitted to hospital. Wards escalated beyond capacity are also experiencing challenges in securing staff to support patients who require enhanced care.

Patients are spending days in Emergency Departments before transfer to an acute hospital ward. This increases the risk of patient falls as patients become increasingly deconditioned whilst awaiting hospital admission.

Many patients admitted to hospital could benefit from rehabilitation in community prior to hospital admission. Currently there is a gap in the provision of timely community rehabilitation services to enable many older people or people living with disabilities to live full and independent lives. Patients admitted to hospital from community already have a history of falling, fear of falling or problems with their mobility when admitted to hospital. All of these factors in an unfamiliar hospital environment increase the risk of patients having a fall in hospital when they are acutely unwell.



The majority of inpatient falls reported were from Acute Hospital sites with 173 falls reported from the Altnagelvin site and 122 reported from SWAH. This is a decrease when compared with the Q3 in 2023. The majority of people who experience a fall in Trust inpatient settings fall once. However, there were 40 patients who fell twice and 24 patients who experienced 3 or more falls. The majority of people who experienced 3 or more falls had cognitive impairment.

Quarter	Rate per 1,000 bed days for No. of Falls	Rate per 1,000 bed days for No. of Falls resulting in harm (Moderate Major or Catastrophic)
Quarter 1 2020/21	**7.00**	**0.14**
Quarter 2 2020/21	**6.24**	**0.22**
Quarter 3 2020/21	**7.45**	**0.13**
Quarter 4 2020/21	**8.02**	**0.11**
Quarter 1 2021/22	**6.19**	**0.02**
Quarter 2 2021/22	**5.87**	**0.02**
Quarter 3 2021/22	**6.25**	**0.09**
Quarter 4 2021/22	**7.51**	**0.13**
Quarter 1 2022/23	**6.61**	**0.10**
Quarter 2 2022/23	**7.07**	**0.14**
Quarter 3 2022/23	**6.55**	**0.14**
Quarter 4 2022/23	**5.70**	**0.21**
Quarter 1 2023/24	**6.21**	**0.04**
Quarter 2 2023/24	**5.34**	**0.10**
Quarter 3 2023/24	**6.38**	**0.05**
Quarter 4 2023/24	**6.47**	**0.11**
***Quarter 1 2024/25**	**6.02**	**0.11**
Quarter 2 2024/25	**Not yet available**	**Not yet available**
Quarter 3 2024/25	**Not yet available**	**Not yet available**

*Bed day figures for Q1 2024/25 are provisional, therefore rates are subject to change.

From review of fall incidents reports, staff continue to experience challenges regarding the correct grading of fall incidents with injury sustained not always being clear on incident reports. Regionally, falls leads working with the Public Health Agency (PHA), who have produced guidance to support staff with the correct grading of fall incidents. Various staff forums across the organisation have received this information for sharing. This information is also available for staff to access on the Falls Integrated Pathway SharePoint site.

The Falls Integrated Pathway Co-ordinator (FIPC) continues to support new Ward Sisters / Charge Nurses with completing post falls reviews where fall incidents have resulted in moderate and above levels of harm within inpatient settings. Learning from fall incidents continues to inform improvement work both within the Trust and across the region. Within the Trust there is a positive incident reporting culture and a willingness to learn from incidents.

The number of patients experiencing a fall in the Emergency Department (ED), Altnagelvin Hospital, is significantly higher than the numbers experiencing a fall in the ED, South West Acute Hospital (SWAH). The reasons for this are multi-factorial and include environmental factors in addition to the departments being over-crowded and the general layout. The median number of falls occurring in the ED, SWAH, is 3 each month compared with 10.5 each month in ED, Altnagelvin .

The FIPC has worked collaboratively with Nurse Practice Educators across the Trust to increase staff awareness in relation to preventing falls in EDs. Staff training focused on the importance of patient risk assessment and care planning includng the different elements of the FallSafe Bundle. Staff are encouraged to use shared learning from incident reports to inform improvement work within the department. Information and resources to support people in community following ED attendance is shared with staff during awareness sessions with a view to ensuring secondary falls prevention is considered as part of discharge planning from EDs and ward settings.

Regionally, the FIPC working with colleagues have reviewed the minimum dataset for falls to support staff to identify learning from fall incidents in hospital settings. Following a recent meeting between the PHA and Assistant Directors regionally there were recommendations made in relation to further testing of the review process to include an audit of the dataset over a three-month period and provide feedback as part of PDSA cycle 2. Within the other Trusts the proposed regional minimum dataset document is currently completed with support from the Fallsafe Co-ordinators with some attaching it as a document into the Datix system. In the Western Trust post fall reviews are the responsibility of handlers and lead nurses to investigate their incidents for shared learning and the post fall review is built into the Datix system and due to limited resources the FIPC is unable to assist with this. Additional work needs to be completed to look at how this review can be progressed.

Within the past quarter the FIPC has attended a number of SEA and SAI round table meetings to support with the identification of learning and follow up actions required in response to learning identified from the incident.

Falls Audit

The Royal College of Physicians FallSafe care bundles are the recommended foundation for inpatient falls prevention. Trusts currently implement regionally agreed elements of the Fallsafe bundle and wards are audited on a monthly basis for compliance with the different elements of the fallsafe bundle together with the number of falls occurring on their wards each month.

Even though compliance with the different elements of the FallSafe bundle is 95% and it is good practice to implement the various elements of the FallSafe bundle, this does not correlate with the number of falls reported from different inpatient settings across the organisation. Wards with lower levels of compliance with the Fallsafe bundle audits do not necessarily have a higher incidence of falls happening in their areas. Conversely wards with high levels of compliance with the different elements of the Fallsafe bundle do not have the lowest incidence of falls. The different elements of the Fallsafe bundle are good practice and do help prevent falls however there are other factors outside which contribute to the increased incidence of falls e.g. high numbers of confused patients in wards either due to dementia or delirium in the majority of cases. These patients are acutely unwell and many are unsteady on their feet requiring close supervision or assistance for safe mobility. Many patients frequently attempt to mobilise independently and do not use their call bell to alert staff of their need for assistance. A number of wards have patients cared for in escalation spaces, which has been identified as a contributing factor in falls with some patients. Single occupancy wards and ward lay out make patient observation difficult in some wards and it is essential for staff to know these risks when patients are transferring between wards / departments as this informs where a patient may be best placed on a ward for staff observation.

Areas identified for improvement in relation to compliance with the FallSafe bundle performance include identifying patients with a fear of falling, urinalysis and measurement of lying and standing blood pressure. The audit also highlights improvement in identifying patients with a history of falls in the past 12 months as well as avoiding the prescription and administration of new night sedation needs to be an ongoing focus for staff.

Key Performance Indicators (KPIs) are discussed with Nursing Assistant Directors and Lead Nurses / Midwives through the Accountability and Assurance meeting. Discussions focus on identifying themes and the learning whilst reviewing the exception reports / action plans in place to ensure the issues are appropriately managed and improvement occurs.

The Senior Lead Nurse for Assurance and Quality continues to work alongside the PHA and regional colleagues to review and update current KPIs which includes the Falls Bundle and are developing a regional guidance document. This will accompany the Falls Bundle audit and support staff with KPI audits.

The FIPC continues to support regional work streams for Encompass, to ensure falls documentation is within the Encompass system. Data is currently being validated by the live Encompass Trusts for the adult inpatient KPIs to provide assurances of the data.

The Encompass system will link with patient flow boards and an already established icon will enable staff to see at a glance, which patients are at higher risk of having a fall.

The Trust continues to work collaboratively with the Healthy Living Centres to deliver the Stepping on Strength and Balance programmes across the Trust. Within the past quarter, Trust staff supported the delivery of five programmes. There were 150 people invited to attend, and one 103 people attended the programmes.

The Care Home Support Team continues to support Independent Sector Care Homes with the delivery of falls training. Falls improvement work across three independent sector care homes with the development of fall champion roles over the past year has been extended to include a further three care homes this year.

The Social Work Teams within Primary Care have worked collaboratively with the Falls Integrated Pathway Co-ordinator and a number of Statutory, community and voluntary agencies to deliver Health and Well-being Events to support people at risk of falls. The event in Foyle Arena held for the third year had 120 people attend. Omagh Leisure Centre hosted the event for the first time this year with 36 members of the public in attendance. The PHA has provided funding to support the delivery of another falls event in Enniskillen in February.

Staff from Health Improvement and the FIPC continued to deliver Falls Awareness sessions to a number of community groups in the past quarter, sharing information on pathways and booklet resources to support with prevention.

Since the falls awareness survey moved from the survey monkey platform to Microsoft Teams platform, 39 people have complete the survey which they can use to develop their own action plan to reduce their risk of falling.

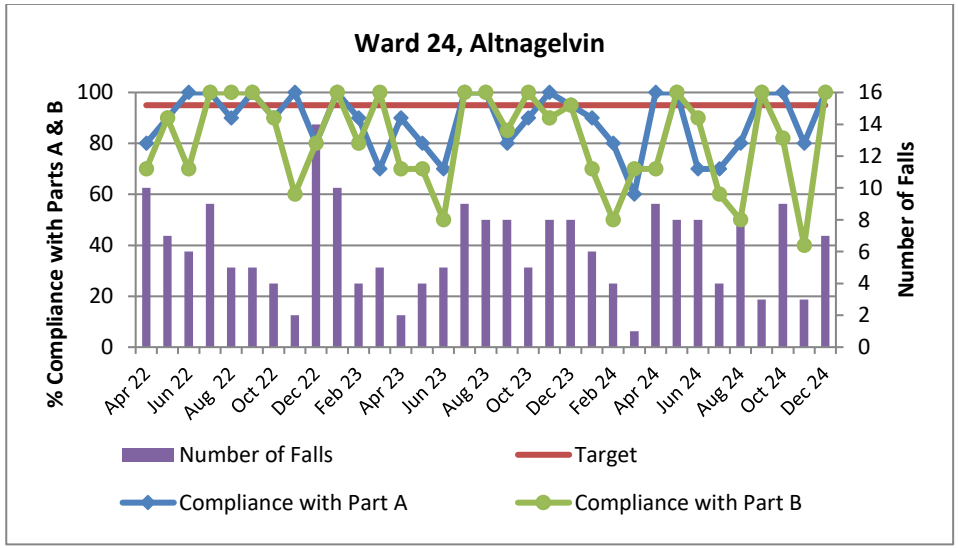
Health Improvement and Trust Communications continue to support with the sharing of falls prevention messaging through Trust social media channels. The post on medicines and falls shared during fall awareness week had 2.7K views, 12 shares and 12 reactions. A recent post shared during the recent icy spell had 102 reactions, 53 comments and 134 shares.

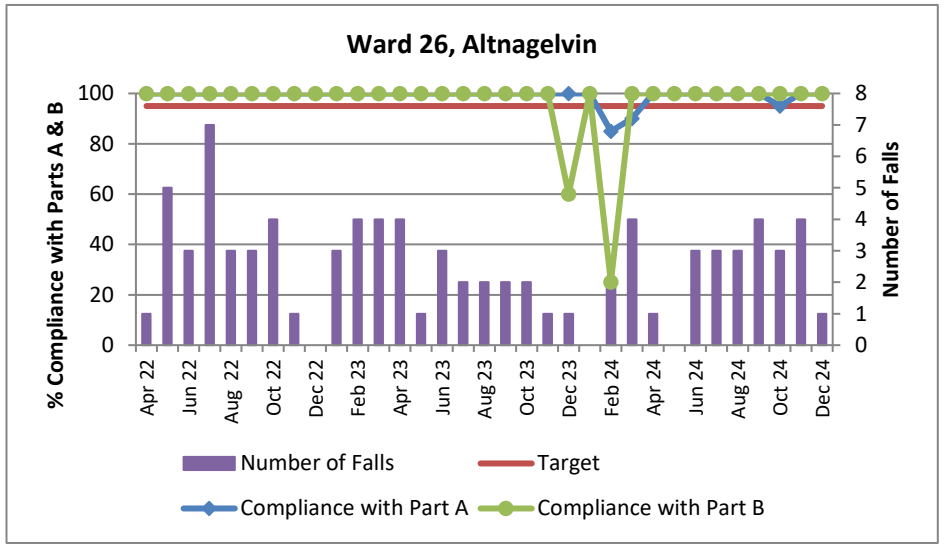
Patients and carers continue to share their experience of services received through care opinion with seven stories shared and responded to within the past quarter. Themes emerging are used to feedback to staff though different Trust meetings and the Falls Integrated Pathway uses the information to inform staff training and improvement work.

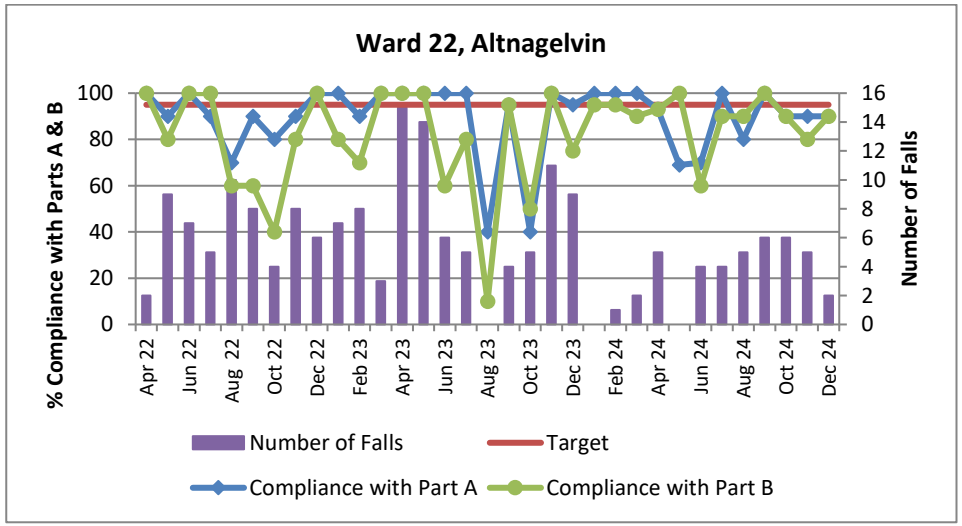
The overall Trust compliance with the Fallsafe Bundle for December 2024 was 95% for both Part A and Part B. The run charts overleaf outline compliance with the Fallsafe bundle for each adult inpatient ward.

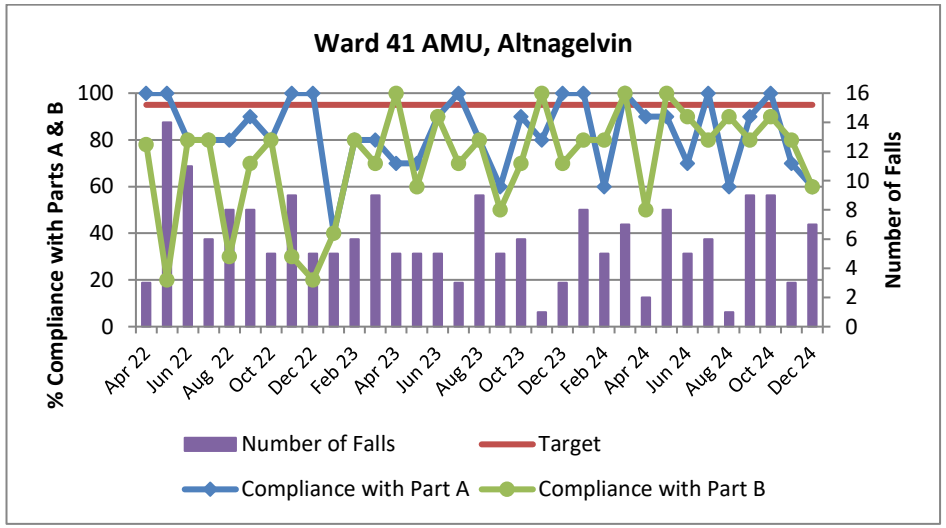
FallSafe Bundle (Parts A & B)

Target: To continue to monitor and improve compliance with the Fallsafe Bundle, to improve prevention of falls









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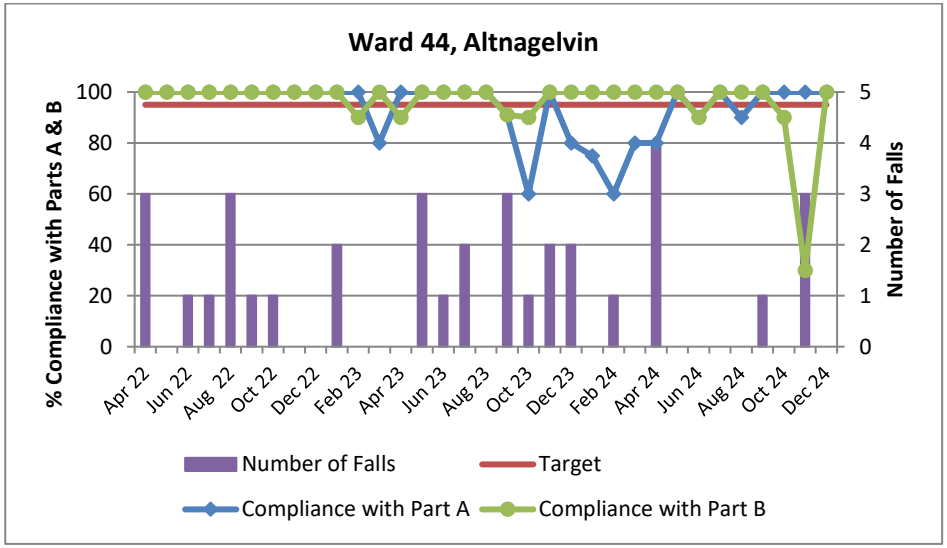

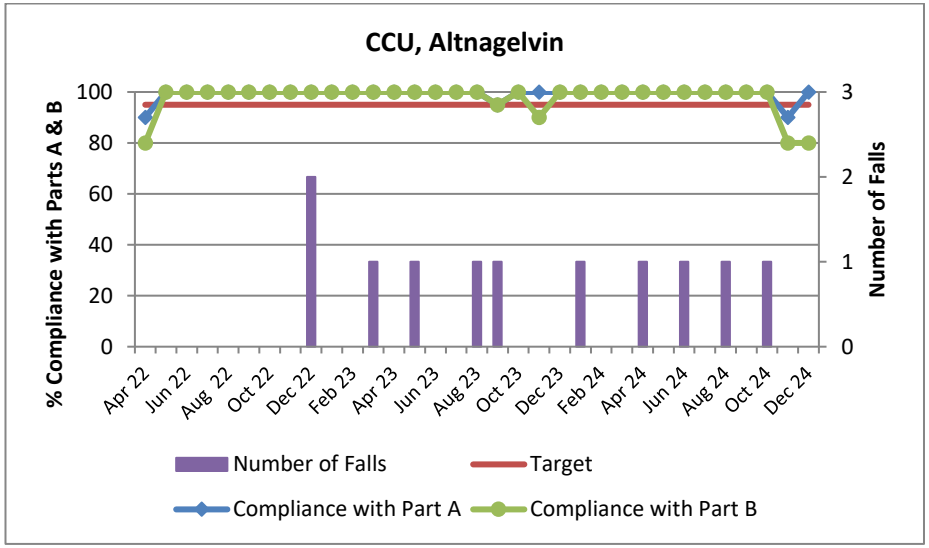

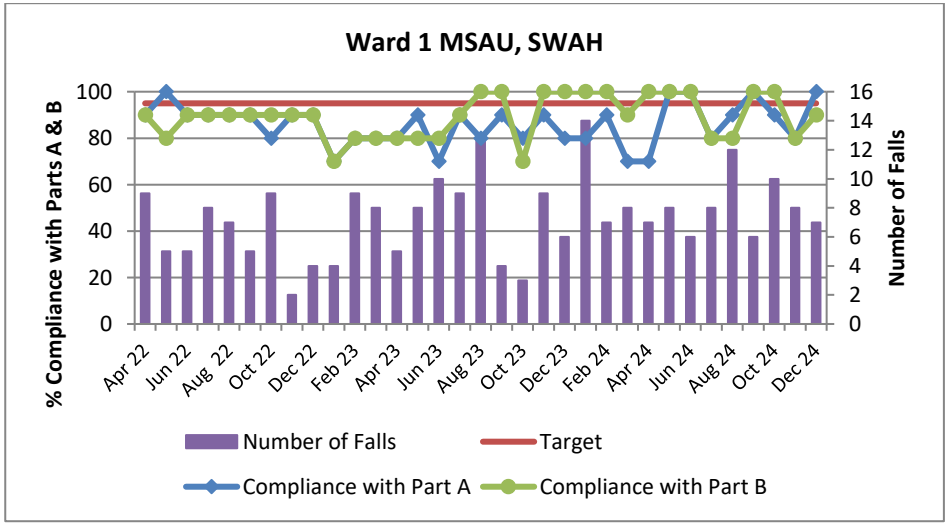

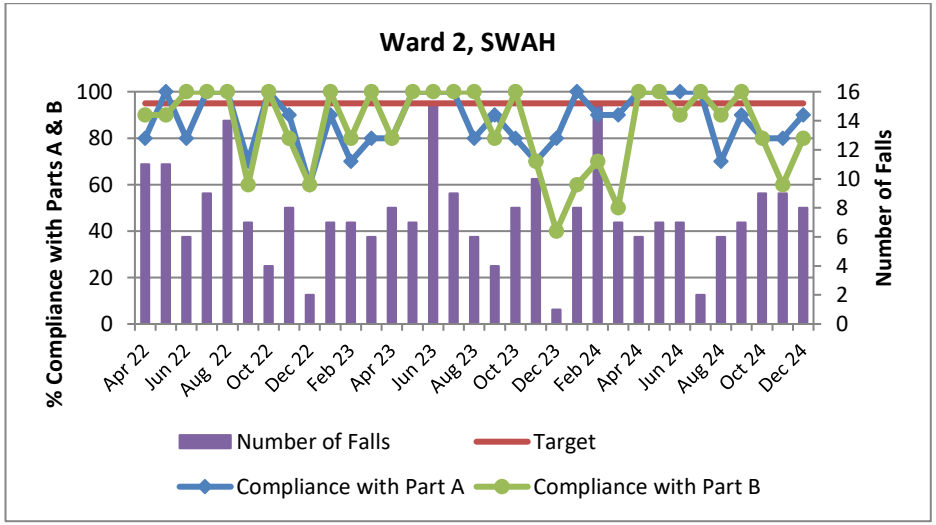

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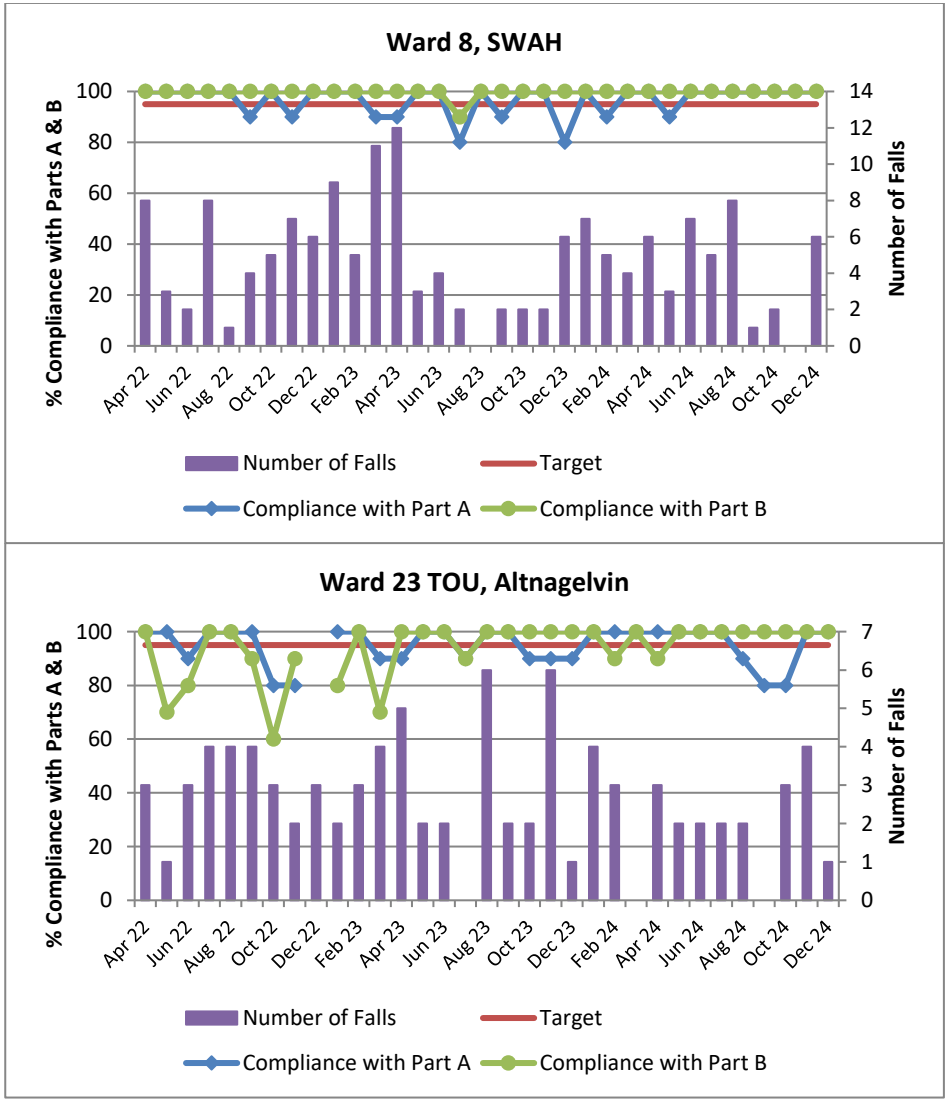

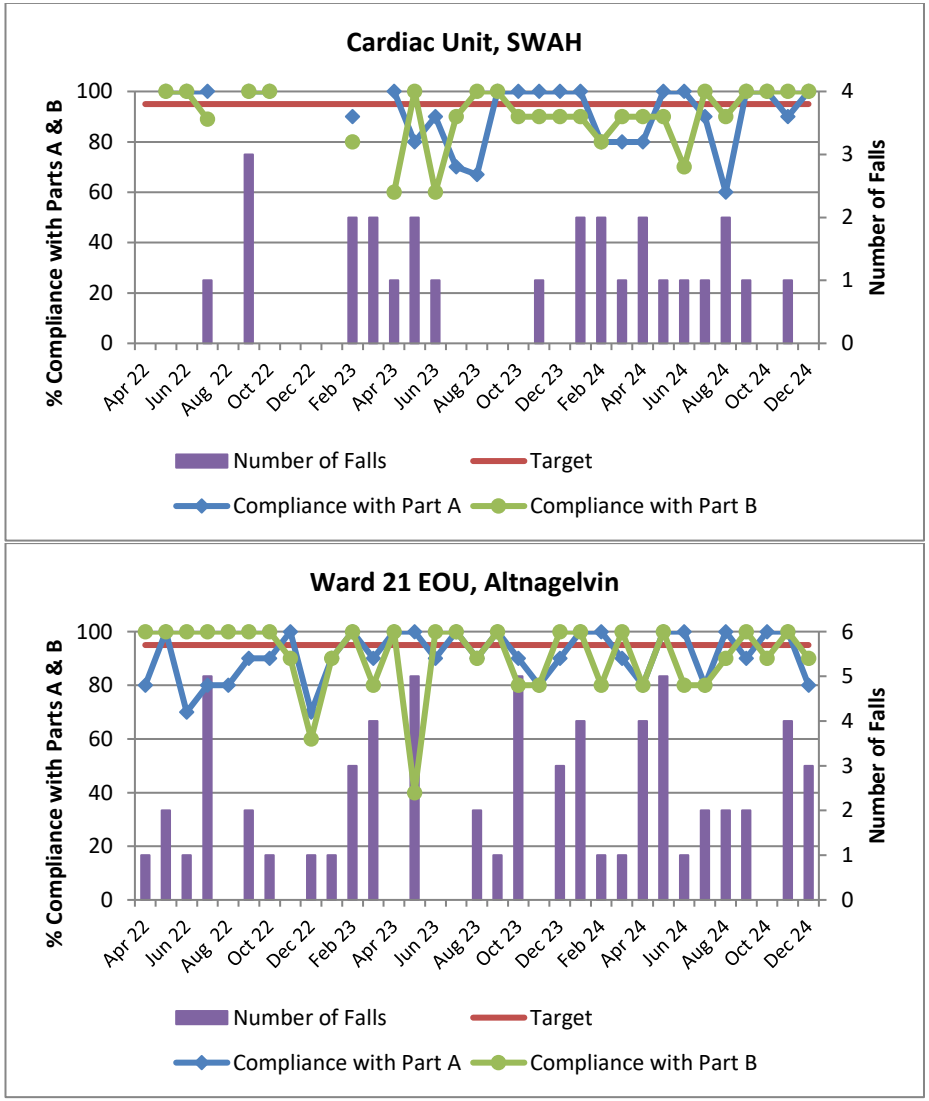

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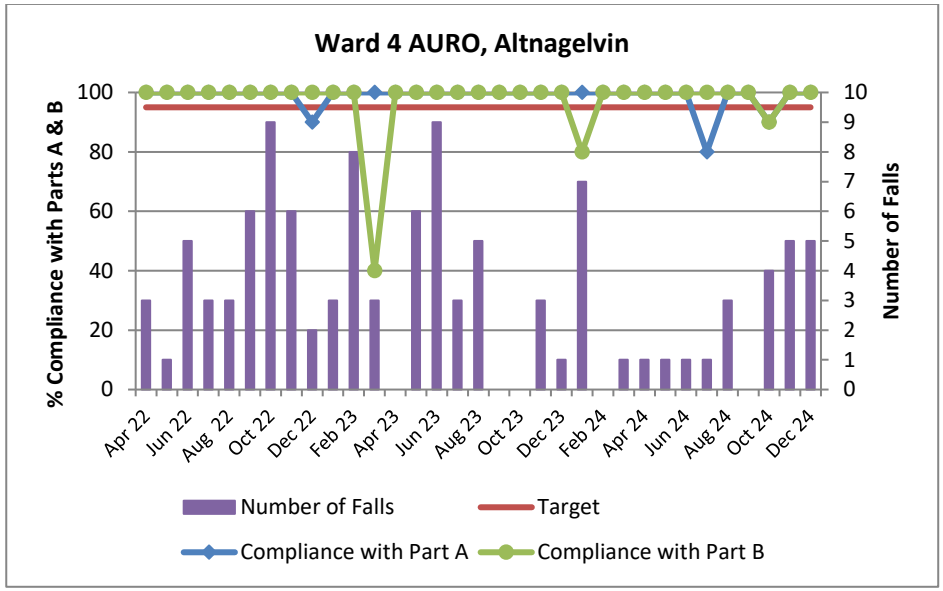

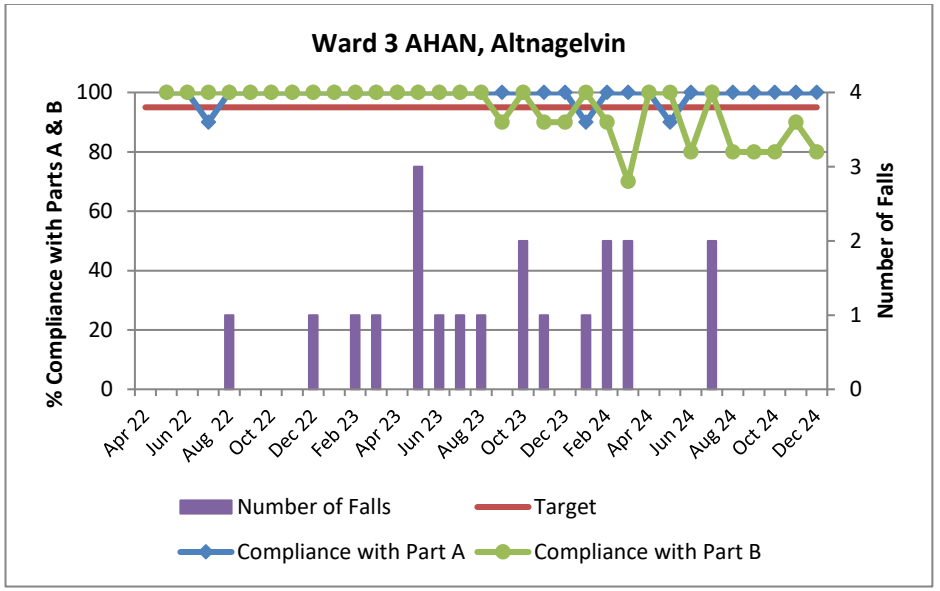

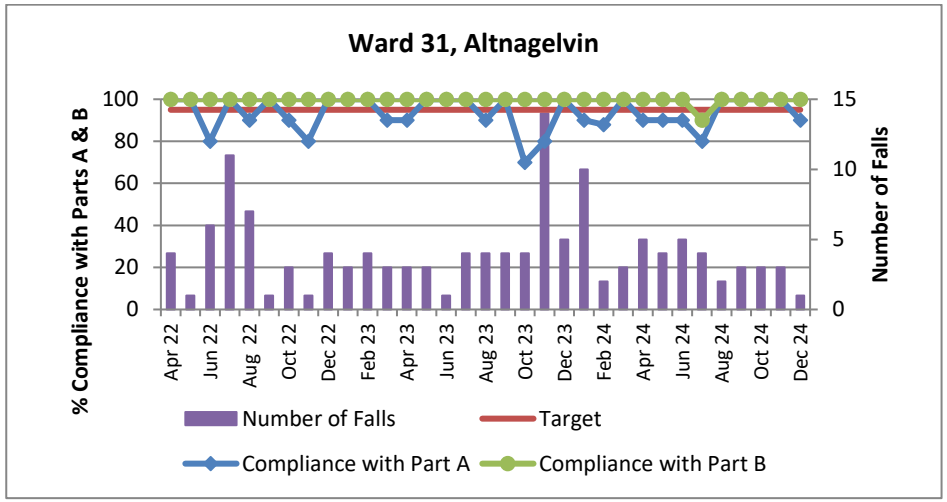

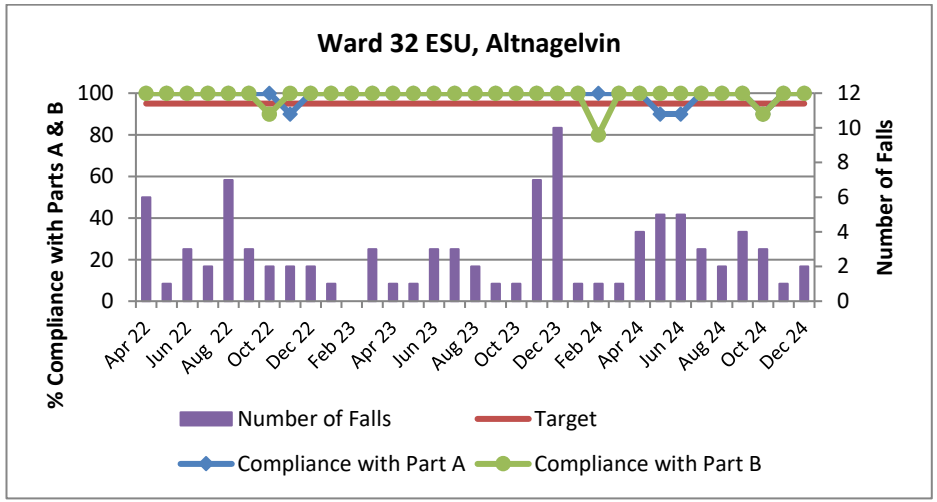

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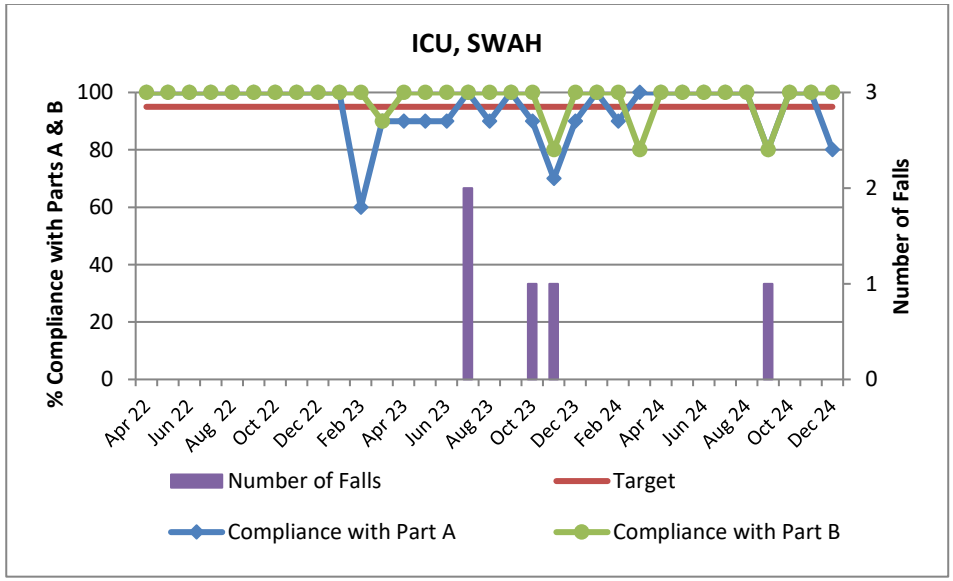

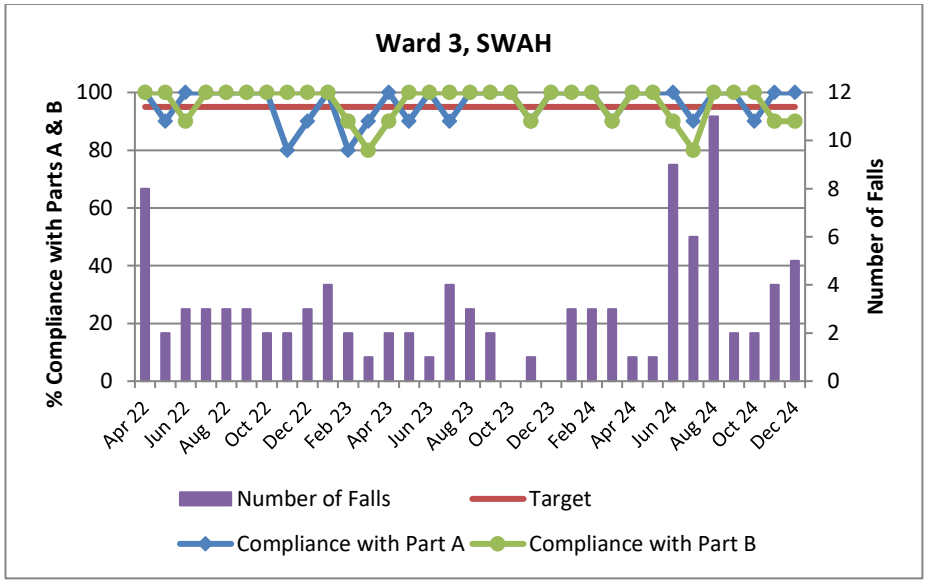

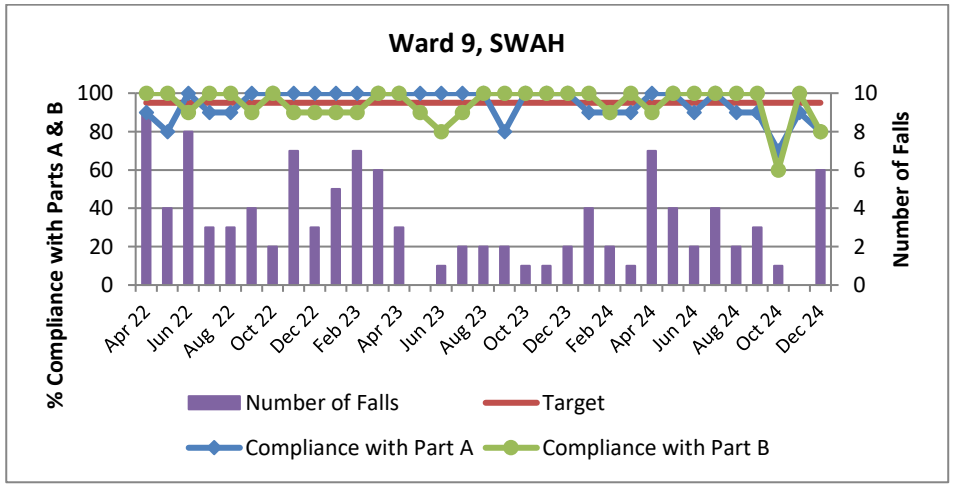

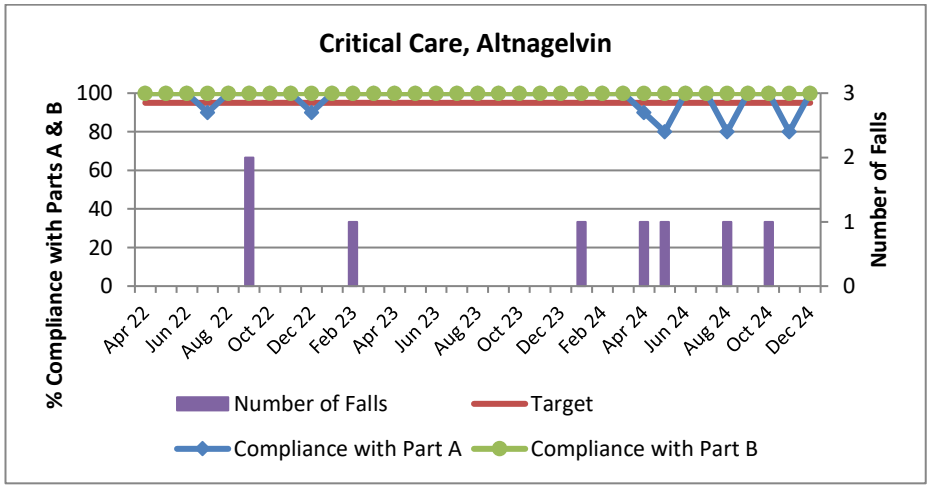

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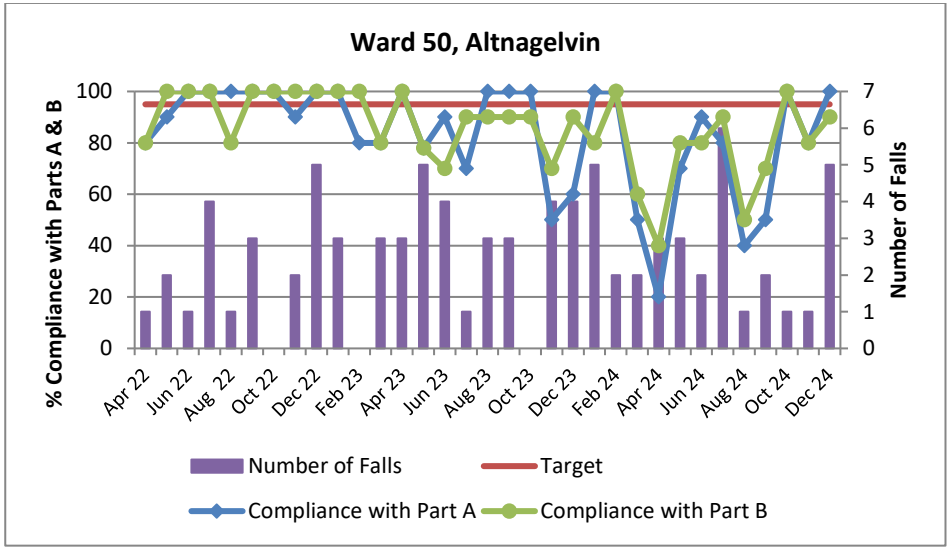

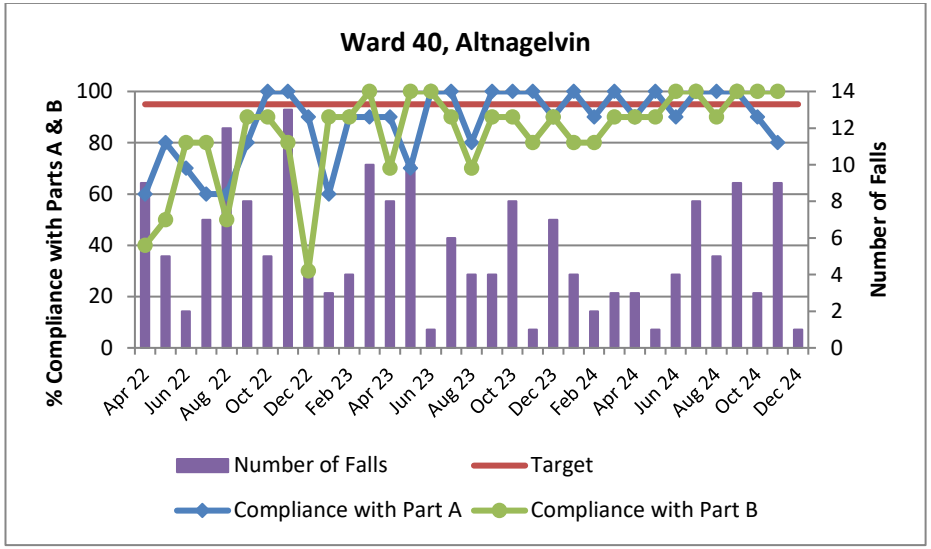

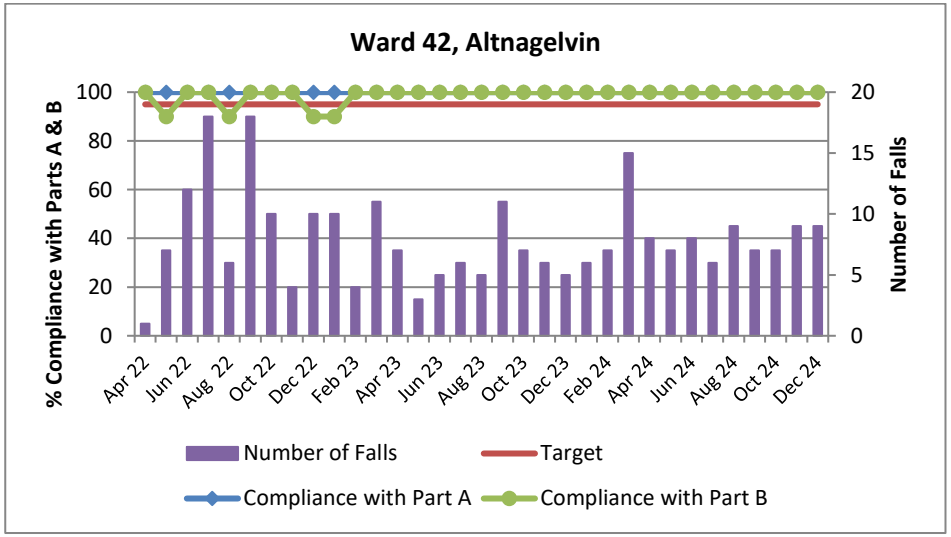

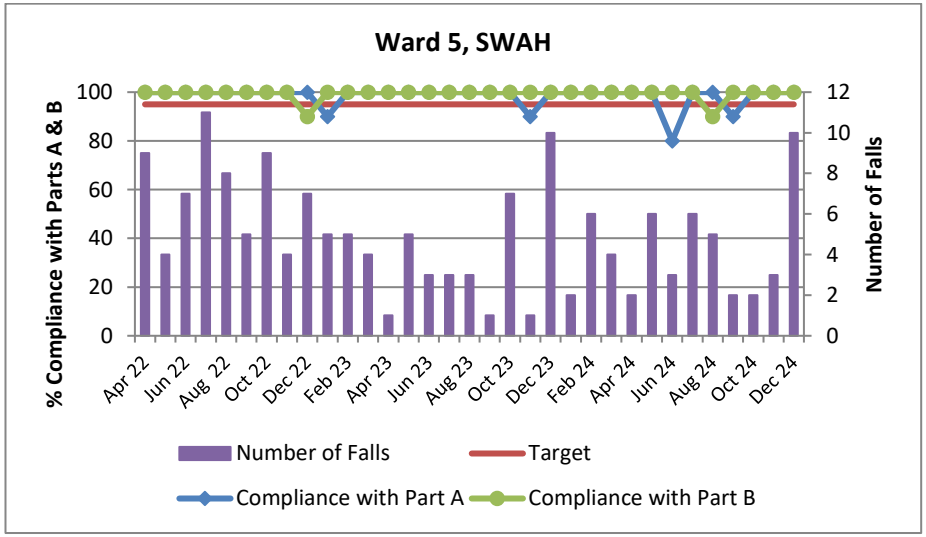

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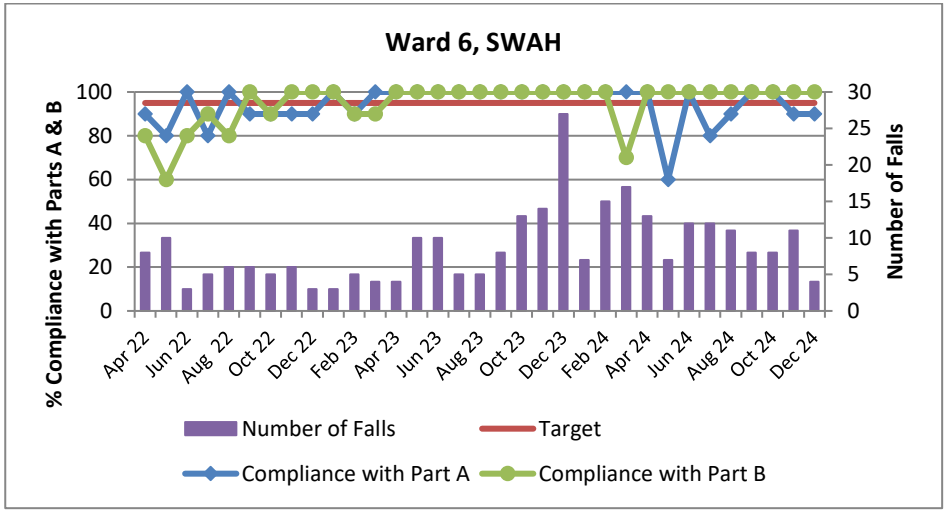

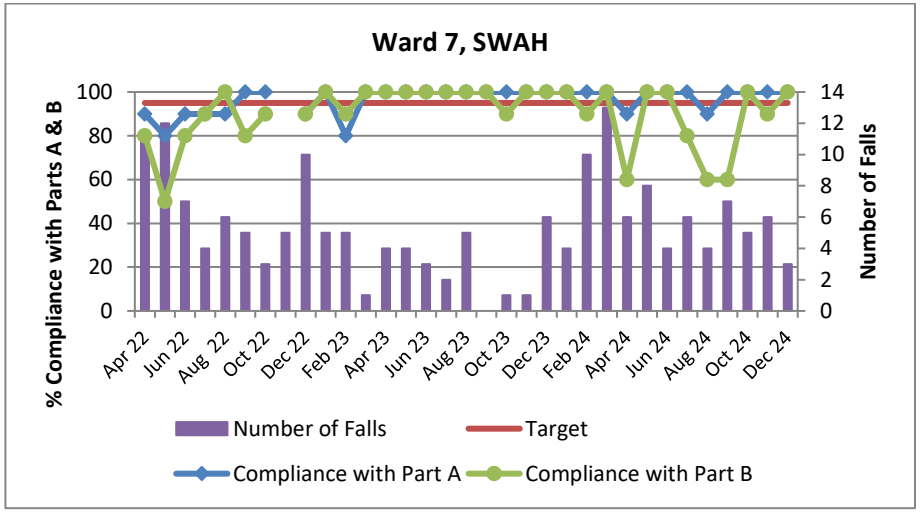

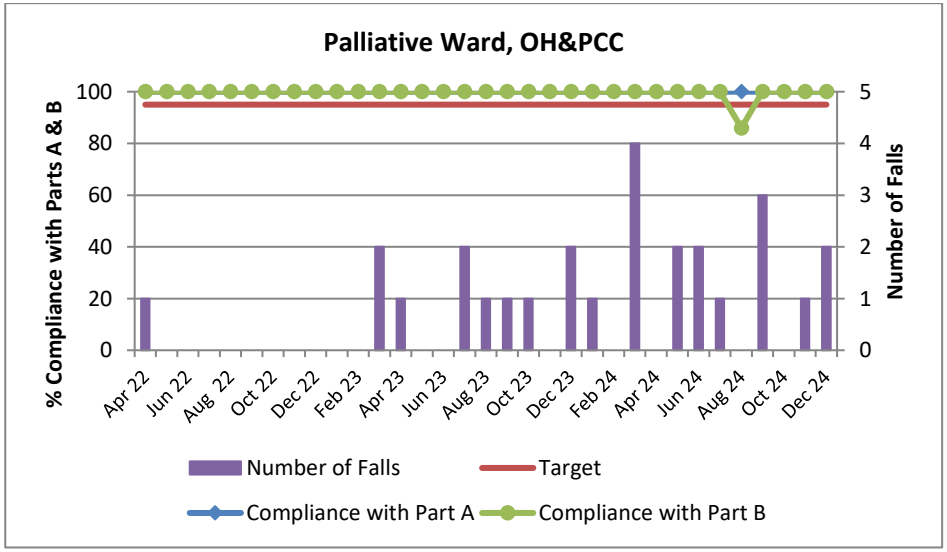

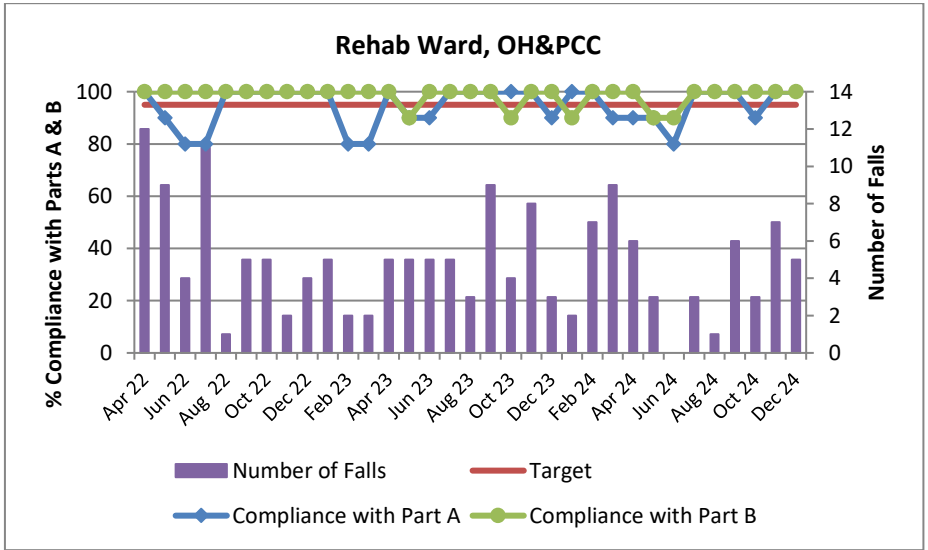

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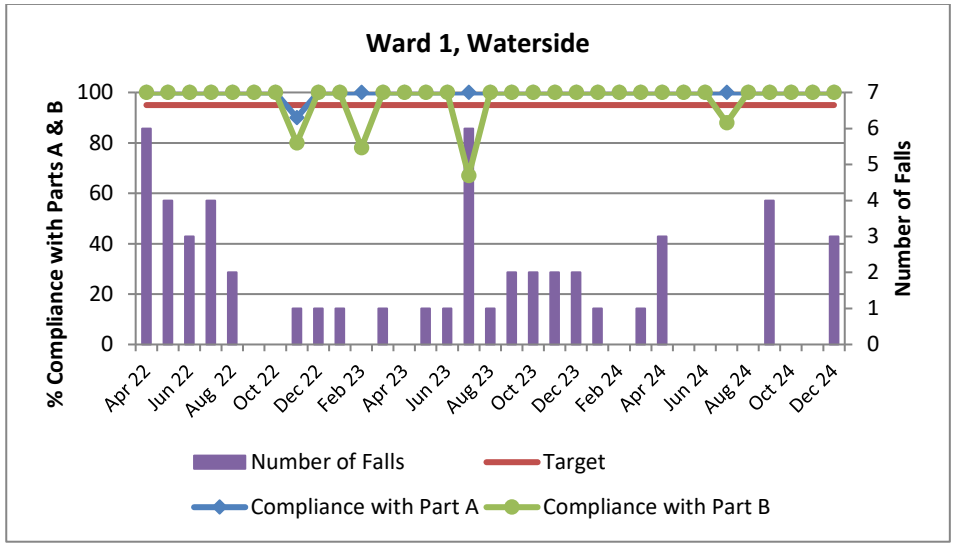

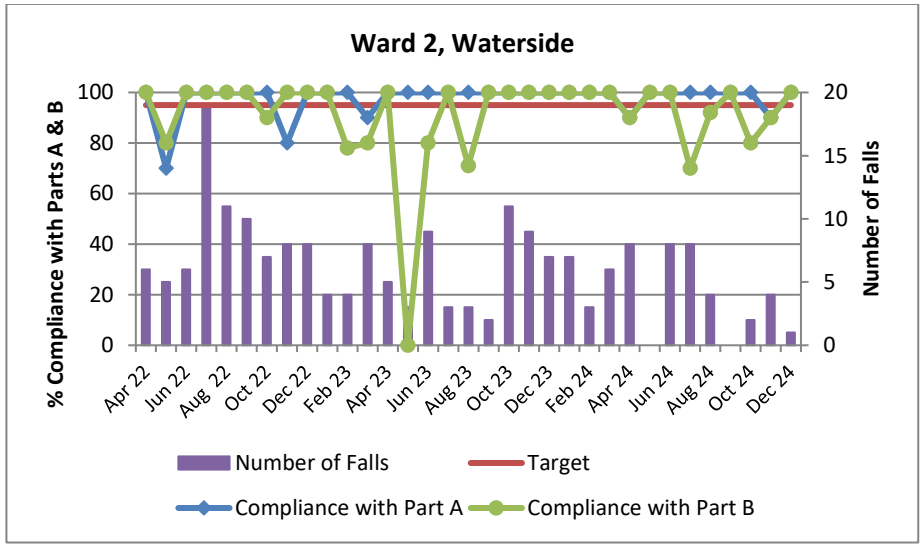

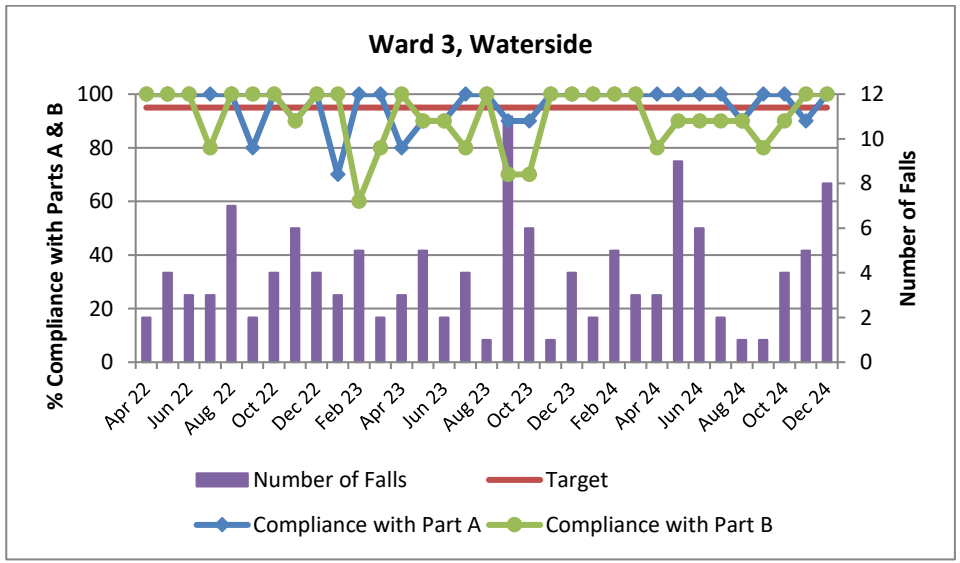

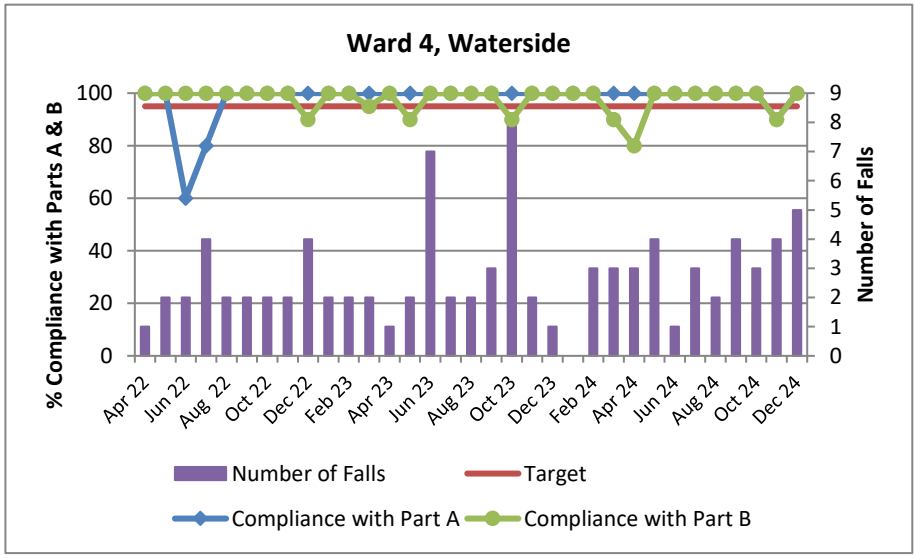

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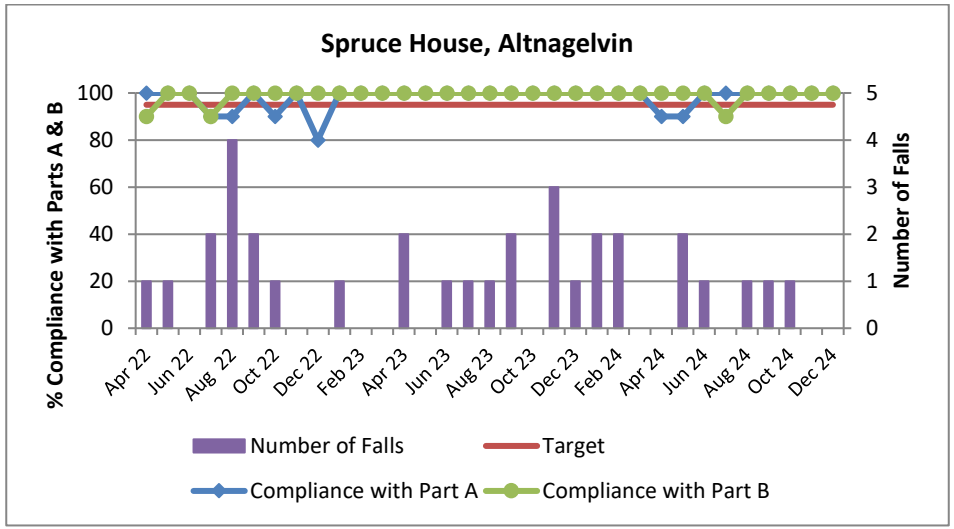

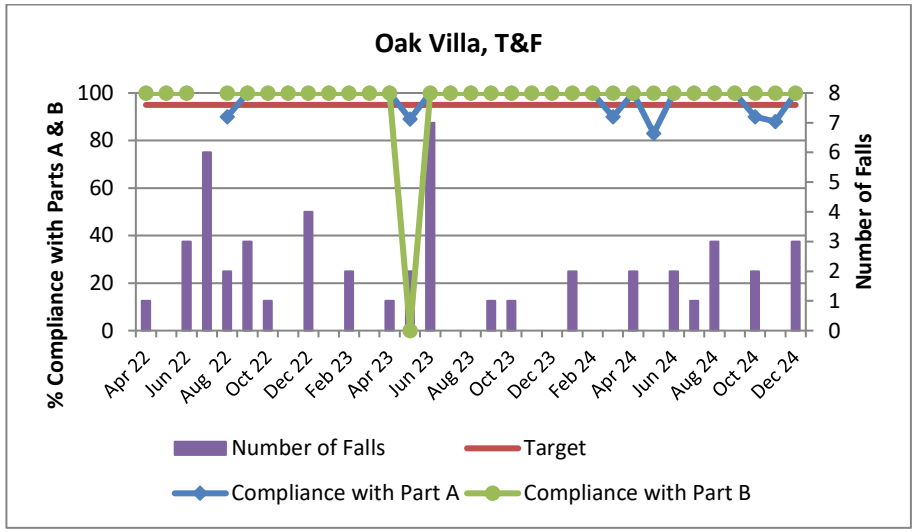

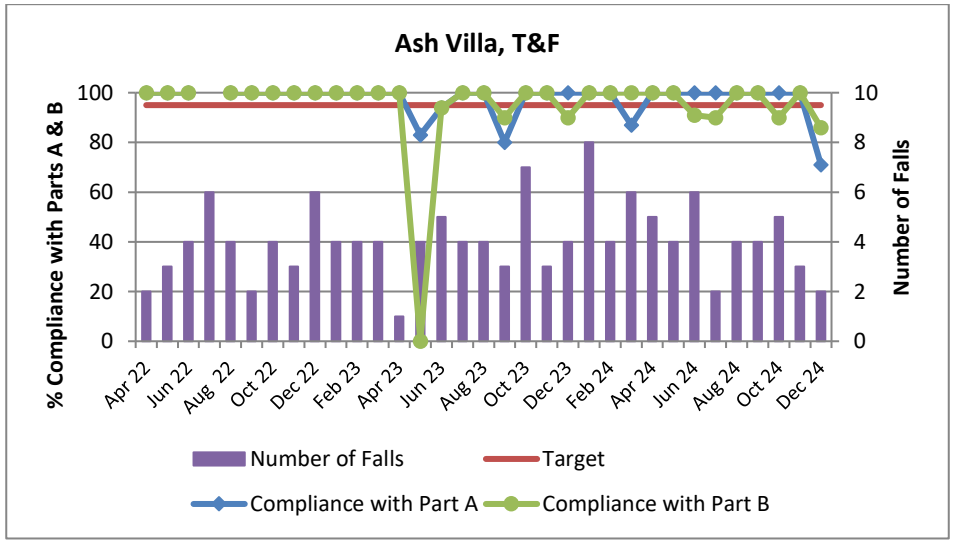

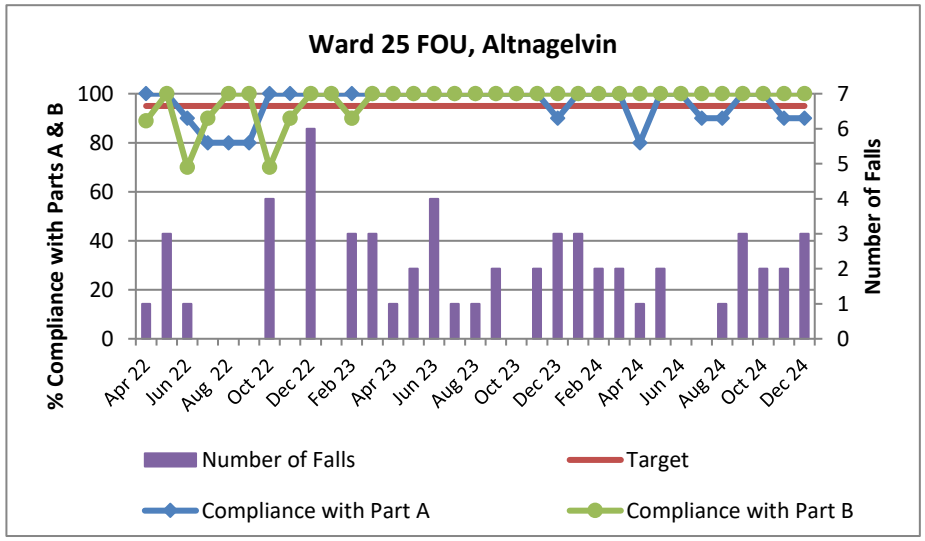

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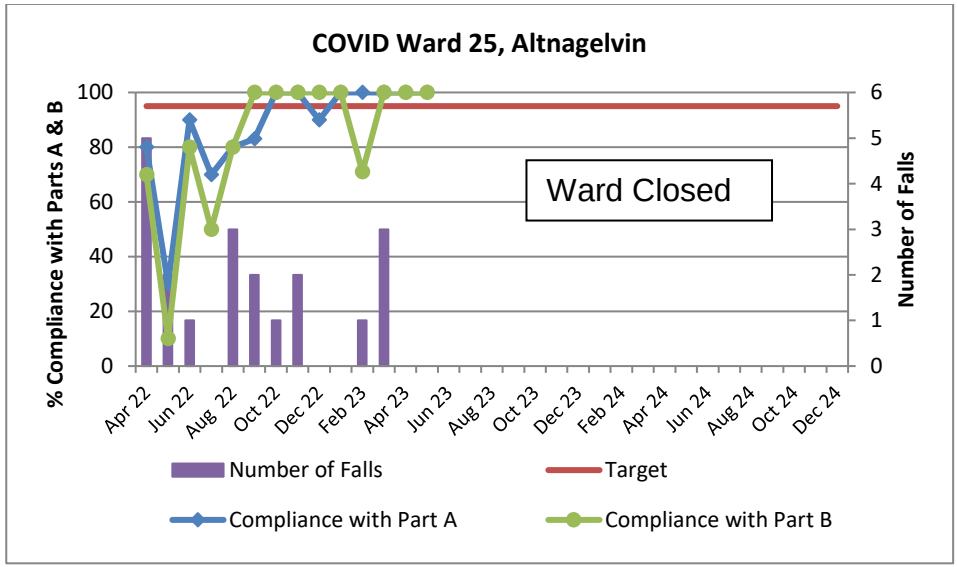

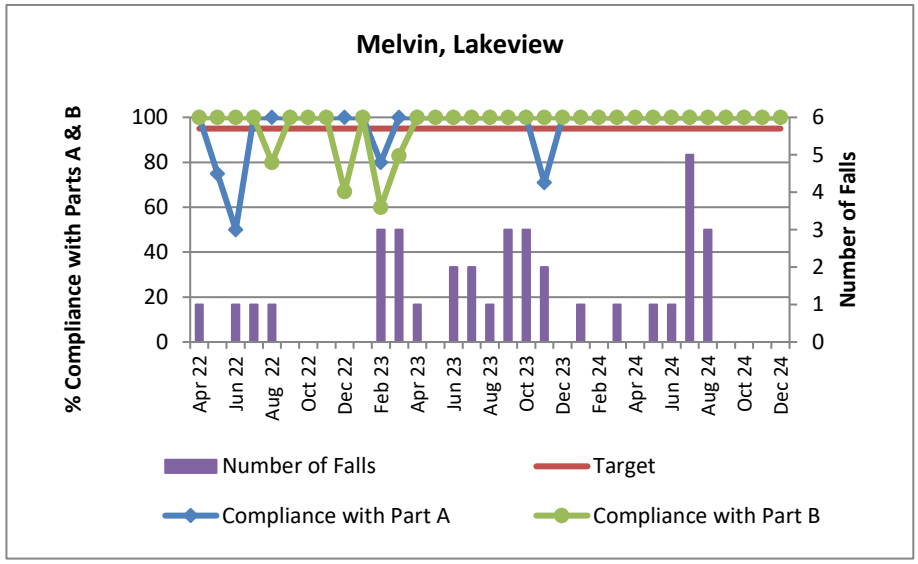

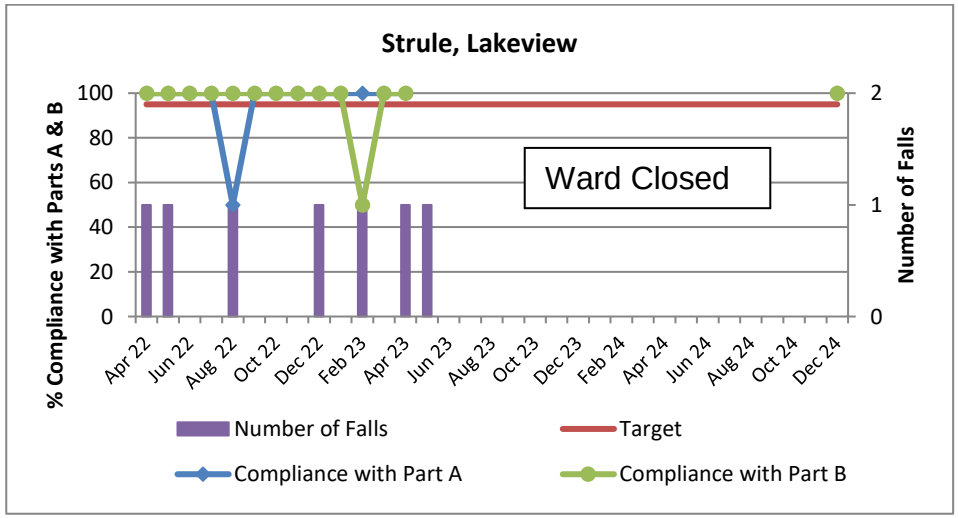

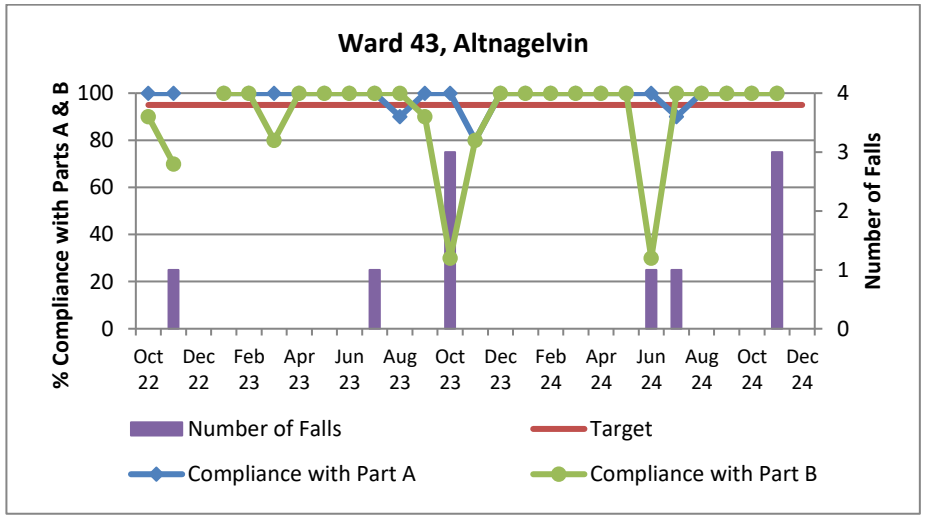

FallSafe Bundle (Parts A & B)
Target: To continue to monitor and improve compliance with the Fallsafe Bundle, to improve prevention of falls