Falls Care Review and Learning Standard Operating Procedure (SOP)

For use following an adult fall in conjunction with the Adult Inpatient Falls Safety and Management Policy (B15/2014)

This SOP sets out the overall requirements and standardises the approach for all staff involved in the Falls Care Review and Learning process for adult patients.

This SOP will support falls safety and the promotion of harm free care by:

- Reviewing falls incidents
- Identifying themes and trends
- Demonstrating learning from falls incidents to support a reduction in falls

This SOP applies only to staff that have a role in reviewing falls incidents in clinical areas:

- The Multidisciplinary Team
- Deputy / Ward Sisters or Charge Nurses
- Matrons
- Heads / Deputy Heads of Nursing (HoN/DHoN)

All falls incidents must be reviewed within 24 hours of fall, Monday to Friday and within 72 hours at weekends/bank holidays to ensure pre and post fall care has been delivered as set out in the Adult Inpatient Falls Safety and Management Policy (B15/2014)

The Fall Safety Team will provide training to the Ward Sisters/Matrons via their professional nurse forums and will provide training for new Ward Sisters & Charge Nurses as part of their local induction on request

Monitoring and Audit Criteria

Key Performance Indicator	Method of Assessment	Frequency	Lead
Monitor number of falls and learning identified from incident	Data from CMG Care Review and Learning – Falls	Quarterly	CMG Falls Leads / Patient Experience

The majority of level 3 and above harms are from inpatient settings. However this SOP is applicable to all adult patients that fall within the organisation

Guidance to Complete Falls Care Review and Learning

IMMEDIATE - Nurse in charge of the ward / clinical area at the time of the fall

- Investigate and share immediate learning following fall with clinical team and the next shift, to maintain patient safety and reduce chances of further harm

WITHIN 24 HOURS MONDAY TO FRIDAY / 72 HOURS WEEKENDS/BANK HOLIDAYS - Ward Sister / Charge Nurse completing Falls Care Review and Learning, in consultation with Matron

- Discussion with patient if possible
- Meet Duty of Candour requirements
- Discussion with any witnesses to the fall
- Review Datix incident form (add name as the investigator), all nursing / medical and Nerve Centre documentation. Ensure information is accurate and level of harm/outcome code updated
- Review falls screening and ensure completed at relevant times
- Review falls care plan to ensure personalised and reflects patient's individual needs. Is there evidence Enhanced Falls Reduction Measures in place post fall?
- Identify learning to share with clinical team to support falls safety and promote harm free care

MONTHLY - Ward Sister / Matron

- Complete monthly Ward Falls Care Review and Learning and send to HoN / DHoN prior to monthly CMG Falls Care Review and Learning meeting

MONTHLY - Heads of Nursing / Deputy Heads of Nursing

- Hold monthly CMG Falls Care Review and Learning meeting to discuss falls incidents
- Identify areas to be invited to face to face Falls Care and Learning Review meetings; including areas with a level three harm or above, high volumes of falls or where a patient has three or more inpatient falls where there were learning identified
- Send a CMG summary to Fall Safety Team by the agreed date

Falls Care Review and Learning Standard Operating Procedure
Approved by: Policy and Guideline Committee
Issue Date: August 2023 (v3) **Review Date:** June 2026
Lead: Corporate Fall Safety Lead

Falls Care Review and Learning Standard Operating Procedure (SOP)

Level 3 Harm Flow Chart - *Process to be followed in all incidents where a patient falls and sustains a level 3 harm*

Patient identified as sustaining a level 3 harm from a fall – Nurse in Charge implements initial learning to ensure immediate safety for patient

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Ward Sister / Matron investigate circumstances around fall within 24 hours Monday-Friday / 72 hours weekend and bank holiday and take all immediate actions identified
Head / Deputy Head of Nursing to escalate to Deputy Chief Nurse, Assistant Chief Nurse and Corporate Fall Safety Lead immediately

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Results of initial investigation of incident including timeline of events sent to Head / Deputy Head of Nursing within timeframe identified above

Ward Sister / Matron implement changes from initial investigation, ensuring extensive communication across the MDT

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Fall Safety Lead to confirm Independent Chair for the investigation, within 72 hours of being notified of fall. Host CMG to provide with all relevant information

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Within 4 weeks of incident host CMG Head / Deputy Head of Nursing to arrange MDT meeting to establish key learning points

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Final report signed off by Head / Deputy Head of Nursing and Independent Chair within 2 weeks of the MDT

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Final report to be discussed at the next CMG Quality and Safety Board for final sign off

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Corporate Falls Safety Team to assemble and circulate learning points within 2 weeks of receiving final report

IMMEDIATE - The investigation undertaken by the Ward Sister / Matron is important to ensure immediate safety and should include:

- All falls to be investigated as on page 1
- The Ward Sister / Matron should then share learning identified at ward huddles for at least seven days to ensure all staff are aware

WITHIN 8 WEEKS - MDT Falls Care Review and Learning Meeting (Chaired by Independent HoN / DHoN)

- Meeting focused upon learning and support - no blame
- Rotating Independent Chair to provide objectivity and shared learning. Rota to be held and allocated by Falls Safety Lead
- Attendance – minimum requirements; Independent Chair, CMG Head/Deputy Head of Nursing, Matron, Medical representative, Adult Safeguarding. Ward Manager. Attendance as required from Junior Medical Staff, Staff Nurse, Health Care Assistant, Therapy staff, Pharmacy, etc.
- Complete investigation template with actions and learning identified

CMG

- Return completed report following sign off at CMG Quality and Safety Board to Fall Safety Team.

Corporate Falls Safety Team

- Compile high level learning points from all level 3
- The Falls Steering Group will ask for assurance from CMG's that all learning points are completed quarterly

The majority of level 3 and above harms are from inpatient settings. However this SOP is applicable to all adult patients that fall within the organisation

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Falls Care Review and Learning Standard Operating Procedure (SOP)

Level 4 & 5 Harm Flow Chart - *Process to be followed in all incidents where a patient falls and sustains a level 4 & 5 harm (these will be investigated under the Incident policy and uploaded onto StEIS in line with the National Patient Safety guidance and the National Reporting and Learning System)*

Patient identified as sustaining level 4 or 5 harm from a fall – Nurse in Charge implements initial learning to ensure immediate safety for patient

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Ward Sister / Matron investigate circumstances around fall within 24 hours Monday-Friday / 72 hours weekend and bank holiday and take all immediate actions identified
Head / Deputy Head of Nursing to escalate to Deputy Chief Nurse, Assistant Chief Nurse, Corporate Falls Safety Lead and Head of Patient Safety immediately

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Results of initial investigation including timeline of events sent to Head / Deputy Head of Nursing and allocated Patient Safety Team oversight lead on 72 hours report within timeframe identified above

Ward Sister / Matron implement changes from initial investigation, ensuring extensive communication across the MDT

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Fall Safety Lead to confirm Independent Chair for the investigation, within 72 hours of being notified of fall. Host CMG to provide with all relevant information

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Within 4 weeks of incident host CMG Head/Deputy Head of Nursing to arrange MDT meeting to establish key learning points with allocated Patient Safety Lead present (meeting to be recorded)

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Within 2 weeks of meeting, Ward manager/Matron to make amendment to report and send to Patient Safety Team

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Patient Safety Team to review report and finalise within 1 week

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CMG Head/Deputy Head of Nursing/Independent Chair to sign off within 1 week and return to Patient Safety Lead

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Final sign off by Deputy Chief Nurse within 1 week. CMG to send out final report to patient or family.

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Corporate Falls Safety Team to assemble and circulate learning points within 2 weeks of receiving final report.

The majority of level 3 and above harms are from inpatient settings. However this SOP is applicable to all adult patients that fall within the organisation

IMMEDIATE - The investigation undertaken by the Ward Sister / Matron is important to ensure immediate safety and should include:

- All falls to be investigated as on page 1
- The Ward Manager / Matron should then share learning identified at ward huddles for at least seven days to ensure all staff are aware

WITHIN 10 WEEKS - MDT Falls Care Review and Learning Meeting (Chaired by Independent HoN / DHoN)

- Meeting focused upon learning and support - no blame
- Rotating Independent Chair to provide objectivity and shared learning. Rota to be held and allocated by Falls Safety Lead.
- Attendance – minimum requirements; Independent Chair, CMG Head/Deputy Head of Nursing, Matron, Medical representative, Adult Safeguarding, Patient Safety Lead, Ward Manager. Attendance as required from Junior Medical Staff, Staff Nurse, Health Care Assistant, Therapy staff, Pharmacy, etc.
- Complete SI specific Investigation Template and Learning Points
- Allocated Patient Safety Lead will provide oversight of report completion by Independent Chair and CMG Head/Deputy Head of Nursing sign off process
- Return completed report following sign off by Deputy Chief Nurse to Fall Safety Lead

Corporate Falls Safety Team

- Compile high level learning points
- The Falls Steering Group will ask for assurance from CMG's that all learning points are completed quarterly

Patient Safety Team

- Dissemination and sharing of report as per usual SI process within organisation
- Follow SI actions through to completion
- Any overdue SI actions will be presented at Adverse Events Committee and CMG Performance Review Meetings

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