South Eastern Health and Social Care Trust

Information Governance

10 January 2024 **Our Ref:** RFI 55268

Dear

Freedom of Information Act 2000
Information in Relation to In Patient Fall Prevention

I am writing to confirm that the South Eastern Health & Social Care Trust (the Trust) has now completed its search for information relating to the above, which you requested on 8 December 2023.

A response to each of the questions raised has been provided by the Primary Care & Older People Directorate and is attached in Appendix A.

If you are unhappy as to how this request has been handled, you have the right to seek a review within the Trust in the first instance. You should write to the Information Governance Department, Lough House, Ards Community Hospital (informationgovernance@setrust.hscni.net) within two months of the date of this response and your complaint will be considered and a response provided, within 20 working days of receipt.

If, after receiving a response, you remain unhappy, you can refer your complaint to the Information Commissioner at The Information Commissioner's Office –Northern Ireland, 3rd Floor, 14 Cromac Place, Belfast, BT7 2JB. It is important to note that if you refer any matter to the Information Commissioner, you will need to show evidence of having gone through the Trust's internal review procedure to try to resolve the matter with the Trust in the first instance.

If you have any queries about this letter, please do not hesitate to contact me. Please remember to quote the reference number above in any future communications.

Yours sincerely

_____

Caroline Degans
Information Governance Officer

Q1. What are the current In-Patient Fall Prevention Solutions Used?

A1. In-Patient Falls Prevention Solutions delivered within the Trust include:

The Falls Prevention and Management Service support and educate ward-based staff on the completion of the regionally agreed evidenced based FallSafe Bundles, A & B. Bundle A carried out on all patients admitted and bundle B for patients deemed a higher risk of falls, as per criteria in the bundle document. This is a Multifactorial Falls Assessment carried out on admission and reviewed by ward-based staff if patient's medical condition changes, a fall or near miss occurs, change in medication, transfer to another ward/care setting, otherwise weekly.

Ward based staff are educated on and supported with completion of the patient Moving and Handling, Bed Rails and Fall risk assessments on patient admission and review as per above triggers.

Further Falls Prevention Solutions include education at generic staff training and Multi-Disciplinary Team (MDT) Falls Champion sessions (which is a network of in-patient link clinicians with an interest in falls prevention).

The FallSafe bundles outline all the ward based environment checks to maximise safety and guidance on what to do if the patient is deemed a high falls risk. For example, patient placed nearer to/in view of nursing station for enhanced supervision, accessing and using assistive technology, adequate lighting, safe clear immediate environment, appropriate footwear and supervision/assistance with transfers/mobility, engaging in meaningful activity (referral to wider MDT).

Monthly Falls Awareness training to new Nursing and Midwifery colleagues as part of their comprehensive induction is delivered in conjunction with and organised by the Nursing Admin Team.

Timely Post Fall Incident reviews as per Regional and Public Health Agency (PHA) guidance and timeframes are completed collaboratively by the Acute Falls Team, Ward manager and Directorate Governance Lead for any fall resulting in moderate, major or catastrophic outcome following the PHA and regionally agreed Minimum Data Set and Shared Learning of the incident themes templates. Consistent, timely and broad sharing of the learning gained form the reviews is another falls prevention solution undertaken within the Trust.

Ongoing quality improvement work with the aim of Falls Prevention are:

- Think Yellow Emergency Department (ED) pilot - using a yellow blanket as a visual cue for staff that the patient is of increased falls risk, which is

provided following completion of triage using a 5-point questionnaire score.

- The recently collaboratively produced (Regional Falls Collaborative Group and PHA) 'Call don't Fall' poster as a visual cue to patients to use their call bell for assistance and reduce unsupervised mobility where appropriate.

- Some pilot work led by Safe and Effective Care Nursing colleagues with the aim of falls prevention is the Enhanced Patient Observation Charting (EPOC), which is a regionally developed risk assessment tool for supporting patients presenting with distressed behaviours, which are of concern for themselves and/or others, which was being carried out in the Ulster Hospital.

Q2. What are the current In-Patient Fall Detection Solutions Used?

A2. Ward based staff observational rounds as per patient's individual needs, identified by regularly reviewed and updated risk assessments and communication/documentation of same.

Q3. What Bed Exit Solutions are currently in use for In-Patient Care

A3. Bed Exit Solutions within the Ulster Hospital (UHD) In-Patient Ward Block single rooms include infrared beams installed to notify staff if a patient has got out of bed/up from a chair. These are not available in the other Trust in-patient sites.

Falls Prevention Team are currently leading an assistive technology pilot with phase 1 in the Ulster Hospital completed with positive preliminary results. Phase 2 is being planned for Lagan Valley and Downe Hospitals across a diverse range of ward specialities to give broad evidence of their efficacy of use in multiple in-patient settings.

The products used are from RambleGuard. The hope is that trust wide and regional standardisation of assistive technology endorsement will be gained from this work. This is an agenda item at our Regional Falls Collaborative group.

Q4. If any fall prevention / detection solutions are used, how do they alert to a fall / potential fall?

A4. The beam technology as well as the RambleGuard products discussed above provide an audible output. The RambleGuard detection handsets are mobile and can be on a staff member's person throughout their shift. The beam technology detection of fall/mobility output is at the Nursing Station

hardware, as well as a loud audible output both to the patient and the wider ward setting.

Q5. How many falls (Per year) were recorded in the last 5 year?

Q6. How many, if any resulted in patient deaths?

A5&6 Please see Table 1 below for the number of falls/deaths in an acute in-patient setting.

Table 1

Year	Number of In-Patient Falls	Number of In-Patient Deaths
2018	2611	<5
2019	2626	<5
2020	2646	<5
2021	2673	<5
2022	3110	<5
2023	2851	<5

Q7. How many have resulted in litigation?

A7. Please see Table 2 below for the number of in-patient falls that have resulted in litigation.

Table 2

Year	Number of In-Patient Falls which have resulted in Litigation
2018	Nil
2019	<5
2020	<5
2021	<5
2022	<5

Please note where numbers in individual cells are 1-4, within Table 1 & 2, in line with Trust policy, it is given as <5, to reduce any risk of identification of individual patients.

Q8. Are you currently following a fall prevention strategy?

A8. The Trust is currently following a fall prevention strategy which is the Falls and Osteoporosis Strategy 2021-2024.

Q9. Which team is responsible for In-Patient fall prevention?

A9. In-Patient Falls Prevention is addressed and managed by the Acute Falls Lead and Falls Coordinator, who strategically lead through implementation of best practice via support, education, Quality Improvement work and completion of timely Post Fall Incident reviews, as per Regional and PHA guidance and timeframes. This is enhanced by close links with all teams and directorates, with close collaborative working with Trust's Safe and Effective Care Team and Health and Safety.