Root Cause Analysis (RCA) Patient FALLS			
Patient Name: *****	NHS/Unit Number: *****	Date of Birth: *****	Actual Injury: Fractured clavicle Side of body left side If any other injuries were sustained, detail them here: XX XX XX
Ward: XX Division: Specialised Hospital Site: Royal Stoke Location where fall occurred: Bay Was the patient location appropriate for their speciality? Yes	Date admitted to UHNM: XX XX-22 Time:12:31 Reason for admission: Admitted due to altered behaviour and witnessed seizure x6 Date of Fall XX XX-22 Time of Fall: 09:00	Datix ID Number: REF263774 SI Ref Number: ID266270 Date Datix reported: 28-Feb-22 Time: Datix Harm Severity: Moderate Harm	**TO BE COMPLETED BY QUALITY TEAM FOLLOWING CONFIRMATION AT PANEL** Is this incident RIDDOR reportable? Yes
Date RCA completed: XX XX/2022 RCA completed by: **********	Patient Consultant********** Consultant Signature for sign off of RCA: Date signed:	History of Falls: Yes Number of Falls this admission 2 Was a STOP 5 hot debrief carried out?yes If not, why not? Safetyhuddle	Was the patient withdrawing from drugs or alcohol? No Does the patient smoke? No If so, did the patient have NRT N/A Prescribed/referral to Smoking Cessation? N/A Was the patient smoking when they fell? No Was the NRT given? N/A

DO NOT USE NAMES PAST THIS PAGE

Summary of Incident

Include a timeline of all areas involved in the patients care, from admission to discharge & describe what the patient was doing at the time of the fall/s including key events

Was the fall witnessed: No - not witnessed by a member of staff

Please include details under each of the headings below:

- **Circumstances of the fall –**

Patient attended a & e on XX XX 2022 due to XX and was transferred toXX on the XXth. On theXX XX, she was transferred to ward XX before being transferred to wardXX Neurology under the care XX XX on XX XX 2022. On theXX XX , she was discharged with a diagnosis of XX and Patient had an un-witnessed fall on theXX XX. Patient was lying on the bed with call bell in reach and bedsides up in a four bed bay prior to the fall.

Patient had un-witnessed fall while nursed in the four bed bay, bedrails were insitu and call bell within reach. Patient was left settled on the bed following assistance with bedside wash, Staff walked past and saw patient lying on the floor on the right side.

- **Background** *(include the patient's presenting condition, treatment plan, previous history of falls, cognitive impairment etc):*

Patient presented with XX XX XX and XX XX alongsideXX XX.
Patient's medical history: XX, XX, XX.
Patient was at risk of falls and had one previous fall on the XX XX/22
Patient had a MCA completed that stated patient lacked capacity at that time. DOLS was put in place as patient wasXX XX XX XX.

- **Description of identified Contributory factors/ Underlying causes of the fall:**

Red slipper socks were already insitu, patient had call bell within reach but did not use. Patient has XX XX from admission. Patient previously XX and despite that, wasn't move to a higher visible area and nor falls sensor or low bed with crash mat was considered.

- **What treatment was required as a result of this fall and how did it affect the patient's length of stay/discharge**

Reviewed by Dr immediately. XX XX, XX XX taken, XX performed once on the bed, discussed with XXthey were happy for patient to be hoisted off the floor as they had done full assessment of lower limbs and patient was moving her legs independently and Dr had no concerns re: XX XX. Once patient was comfortable on the bed XX XX were sent.
Xray XX XX shows XX XX XX of XX XX .
No clinical suspicion of XX on review after fall this morning, and patient was able to move her XX XX.
Radiographs reviewed by XX XX . XX XX . No XX XX . No obvious XX
Advised to manage conservatively with a XX XX for XX XX with XX XX review following this.
Unlikely suitable for XX XX due to XX.
PT input for XX XX .

Admission		Falls Core Questions & Multifactorial assessment & interventions				Manual Handling				Continence	6 CIT	Bed rails		
		Were the falls core questions completed within 6 hours of admission?	Was a positive response given to any of the core questions?	If there was a positive answer to core questions was the multifactorial assessment & interventions completed	Has the Multifactorial assessment & interventions been reviewed/ added to during the patients admission?	Was a mobility assessment on admission completed?	Was the mobility assessment reviewed if the patient's condition changed, the patient moved wards or a fall occurred?	What was the patients mobility status at the time of the fall? Enter codes for: understanding, sit to stand, walking and reposition in bed		Did the patient have a continence problem? No Catheterised If Yes, was this accurately captured in the continence assessment? N/A Was a continence plan of care in place? N/A	If the patient is 65 years or over was a 6 CIT completed on admission? N/A Documented: Unable to complete due to patient's condition. If completed what was the score? Unable to obtain Was the patient known to have dementia/ cognitive impairment? Yes	Was a bedrails assessment completed within 6 hours of admission? Yes Was the Bedrail Assessment reviewed on transfer, a minimum of weekly or if any changes in condition or fall occurred?	If the patient fell from the bed what position were the bed rails in?	State the Matrix outcome
210	XX XX/2022 Time: 18:17	Yes	Yes	Yes	Yes	Yes	N/A	Understanding	X			Yes	N/A	recommended
								Sit to stand	X					
								Walking	X					
								Repositioning in bed	X					
218	03/02/2022 Time: 14:50	No	No	No	No	No	No Completed only on XX XX /22	Understanding	X			No	both up	use with care on XX XX not updated since
								Sit to stand	X					
								Walking	X					
								Repositioning in bed	X					

Mobility		Other Factors			Staffing – THIS SECTION MUST BE COMPLETED IN FULL			Audits and Training
Was the patient referred to Physiotherapy Yes & Occupational Therapy? Yes If the patient requires a walking aid is this recorded on the mobility assessment? N/A - no mobility aid requried Were any walking aids being used appropriately	Was the patient wearing appropriate footwear? Yes What footwear? Slipper Socks Was the patient using hip protectors? No	Did the patient require a hearing aid? No If Yes were they in use? N/A Did the patient wear glasses? No If Yes were they in use? N/A	Date & Time of the last comfort round? /20XX XX 22 6:00 If there was a significant gap from the last comfort round to the time of the fall why was this? NA	If at risk of falling, were staff members informed of this during hand over? Yes	What was the staffing on the shift when the patient fell? 3/4 What is the ward's planned staffing establishment? 3/4 On the day of the fall what were the Care Hours per patient day /percentage acuity? 121.3%	How many staff were on the ward at the time of the fall? Please include therapy and medical staff. 10 staff members	Was the patient in a cohorted bay? No Was 1:1 staffing considered necessary? No If yes was 1:1 provided? N/A If not available was this escalated (include details of how/who it was escalated to)? Were any other safety measures put in place? **Patient moved to a high observation area post fall**	Please enter last available results of the ward Falls audit: 80/81 on April Does the ward / area have at least one active Falls Champion who is in date? yes How many staff have completed falls training locally? 1x RN completed train the trainer course, unclear how many staff have completed falls training. Is training added to eroster as a skill? Not documented on eroster (Any paper records to be scanned and added to Datix) no

at the time of the fall? N/A - aid not required								What percentage of staff have completed bedrails training in last 2 years (as recorded on ESR) ? 100%

Post Falls Care					
Was a post falls proforma used? Yes If not, why not? What version was used? Version 5 Did the patient require pain relief? yes Was the Abbey pain tool used if the patient had a cognitive impairment? No What was given and when? Drug: XX XX Date/Time: XX XX/22 12:30/21:45 XX XX/22 02:30 XX XX/22 9:30 XX XX/22 9:35	Was the patient checked by a trained nurse &/or Doctor for injury prior to moving? Yes How was the patient moved from the fall? hoist	If an injury was suspected was the patient flat lifted using the hover jack? N/A Was this documented in the patient's notes? Yes If injury suspected and hover jack not used why was this? Doctor reviewed patient andXX XX XX XX XX . Was there any delay in obtaining the hover jack? no Detail of the any delay: N/A	If the fall was un-witnessed or a head injury sustained were neuro obs carried out? No Where required, were observations completed in line with trust policy? No Please state frequency of obs & for how long? No XX XX recorded on vital pac post falls.	Was the patient seen by a doctor or nurse practitioner within 4 hours of the fall or sooner if required? Yes If not, why not? Is their assessment recorded on the post falls proforma? Yes If not, is the assessment following the fall documented in the medical notes? N/A	Has the consultant (blue) section of the post falls proforma been completed? Yes If not, why not? Has each of the sections been acknowledged and actions taken recorded? Yes If not, why not? N/A
What investigations were requested as a result of the fall (include a date, time & results for each): XX XX - XX XX /2022 9:30am result- XX XX XX - XX XX/2022 21:05 result- XX XX XX XX XX XX /2022 09:39. Result- XX XX XX shows Xx XX XX of XX XX . XX- XX XX/2022 immediately after fall. Result- XX XX XX- XX XX/2022- 10:30. Result- XX XX, XX XX , XX XX, XX XX, XX XX, XX XX, XX XX, XX XX, XX XX XX, XX XX , XX XX, XX XX, XX XX, XX XX, XX XX, XX XX XX XX - XX XX /2022 immediately post fall. Result XX XX					

<table>
<tr><th colspan="2">Conclusions</th></tr>
<tr><td>Good practice identified (e.g. risk assessment completed and updated appropriately, suitable footwear worn, call bell in reach, patient cohorted and fall witnessed):

• Adult Falls Core Questions, Falls Multifactorial assessment and Interventions completed on admission.
• Documented on falls prevention bundle call bell in reach
• Family updated immediately after fall and through admission
• Consultant section of the post falls proforma completed

Immediate actions taken at the time (include any actions identified in the STOP 5 hot debrief if one was completed):
XX recorded
XX XX recorded
Assessed for XX
Reviewed by doctor
XX shortly after fall.</td><td>Deviations from policy/process/actions pre and post fall:
(e.g. risk assessments not completed on admission/transfer, hover jack not used where injury was suspected, policy for neurological observations following unwitnessed fall was not followed, lying and standing blood pressure was not completed, falls pro-forma was incomplete…)

Pre fall:
Bedrails & falls assessments not reassessed following ward transfer or completed weekly as per policy.
Not considered moving to a higher observation area post first fall
Low bed not considered following first fall.

Post fall:
Neurological observations not carried out as per trust policy and not recorded on vital pac.
Lying and standing blood pressure not done.
Falls risk assessment and bed rails not reassessed post fall.</td></tr>
<tr><td>Root Causes</td><td></td></tr>
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These are the most fundamental, underlying causes contributing to the incident that must be addressed as learning and actions. Root causes should be meaningful (not sound bites such as communication failure) and there should be a clear link by analysis, between root CAUSE and EFFECT on the patient. If unsure, ask the 5 whys…. (Why did the fall occur? Why was that? Why was that? Why was that? Why was that?) 1. Patient had a previous fall on the XX XX/22 and improving viability was not considered. 2. Low bed with crash matts no considered/documented	**Additional points of learning:** *These are points of learning that may not have actually contributed to the fall e.g. the use of a falls symbols was not recorded in the patient risk assessment book, and therefore require actions to improve future practice.* 1. Mobility assessment not reviewed after patient moved ward. 2. Bedrail Assessment not reviewed on transfer and not completed weekly. 3. Falls symbol not displayed and not documented in falls prevention bundle

Duty of Candour	
Was the patient and/or family member been informed of the patient's risk of falling (evidenced in the care plan that the falls prevention leaflet has been given)? unknown	Is there clear documented evidence of discussions with the patient and/or family explaining the circumstances of the fall, injury sustained and that there is an investigation underway? Yes **If not this must be actioned as Duty of Candour is a legal requirement and must be completed within 10 days of identification of the incident.** Who held the discussion: ********** Who was informed of the fall: XX Date and time of discussion: XX XX /2022 14:00 Do the patient and/or NOK wish to receive the outcome (final DOC) following the investigation? Yes Has the Falls Duty of Candour card be given or sent to the NOK? No If not, why not? Staff unaware of use Date 10 day notification sent: XX XX .2022 Date final report / outcome sent: XX XX .2022
The space below is for any other supporting information:	

RCA Action Plan

The recommendations and learning identified from investigation should also be added to the collated Ward improvement plan
Ensure that Actions are SMART (Specific, Measurable, Achievable, Realistic and Timely)
Identify within your actions how learning is to be shared with staff

Completion Guidance	Improvement/area of concern	Action	By whom	Date to be achieved	Update
Mandatory actions for all falls	Share the outcome of the investigation and learning with all staff directly involved in the incident & staff where the incident occurred	Share the report & lessons learned with all ward / department staff e.g. staff meetings, Safety Huddles, newsletters	**********	19/05/2022	Learning from RCA poster given to staff and signed
	Duty of Candour requirements	Share the outcome of the investigation with the patient/family, as appropriate and provide the opportunity for discussion	**********	Within 10 days of incident	Patient's XX ********** had an initial meeting on the XX XX/22 where information about the fall, futures interventions, and investigation were disclosed. Duty of Candour to be sent ASAP
				Within 14 days of panel	XX XX/2022
	For Example: *Lack of staff awareness in relation to falls prevention*	*1. Display numbers of falls by month on run chart* *2. Falls champion to deliver falls awareness session to all staff 2 yearly in line with trust policy* *3. Share learning and themes from recent falls* *4. Use Falls Safety Cross*	*Named person*	*xx/xx/xx*	*1. Date completed* *2. 50% of staff completed by *date** *3. Date completed* *4. Updated daily*
	Ensure all risk assessments are updated on transfer to the ward and a minimum of weekly	Falls Champion to arrange refresher training and start with 1:1 falls awareness sessions with staff.	**********	XX 2022	Discussed in fall training 63% currently received updated falls training with falls champions and PDN
	For patients with falls risk factor ensure consideration is given to visibility, enhanced observations, low bed and that a multifactorial assessment is completed to evidence actions in place	Staff education and awareness	**********	XX 2022	Discussed in fall training 63% currently received updated falls training with falls champions and PDN
	Neurological observations to be completed in line with policy for falls with known head injury/unwitnessed falls	Staff education and awareness	**********	Xx 2022	Discussed in fall training 50% of staff completed XX XX/22
	Medical team to ensure fall is included in discharge letter	Discussion with medical team	**********	XX 2022	To be discussed at next consultant meeting;

					emailed for invite (awaiting date)