Root Cause Analysis (RCA)
Patient FALLS

Patient Name: XXXXXXX	NHS/Unit Number: ****	Date of Birth: ****	Actual Injury: Other (provide details below) Side of body XX Minimally XX XX XX XX at the XX XX XX XX XX XX XX
Ward: XX Division: Medical Hospital Site: Royal Stoke Location where fall occurred: Bay Was the patient location appropriate for their speciality? Yes Date admitted to UHNM: XX XX-23 Time:20:42 Reason for admission: confusion/aggressiveness	Date of Fall: XX XX-23 Time of Fall: 03.45 Datix ID Number: 305889 SI Ref Number: 2023/12983 Date Datix reported: XX -23 Time: 04.34 Datix Harm Severity: Moderate Harm	**TO BE COMPLETED BY QUALITY TEAM FOLLOWING CONFIRMATION AT PANEL** 1. Were all risk assessments completed in line with trust policy? Yes 2. If assistance with mobility was required was the risk assessment being followed? N/A patient did not use the call bell to ask for assistance Click Here 3. If patient fell from bed were bedrails used as indicated by the bed rail assessment? Yes 4. Were there any environmental factors involved in the fall (e.g. cables, wet floors, brakes not deployed…..)? No Is this incident RIDDOR reportable? Health and safety were not present at the panel, however the progress notes on Datix state that this has been RIDDOR reported to the HSE Click Here *(If No to Questions 1, 2, 3 and/or Yes to Question 4 RIDDOR reporting MUST be considered)*	
Date RCA completed: XX XX/2023 RCA completed by: XXXX	Patient Consultant: XXXXX Consultant Signature for sign off of RCA: Date signed:	History of Falls: No Number of Falls this admission 1 Was a STOP 5 hot debrief carried out?no If not, why not? Being introduced on the wards	Was the patient withdrawing from drugs or alcohol? No Does the patient smoke? No If so, did the patient have NRT No 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: Yes - witnessed by a member of staff

Please include details under each of the headings below:

- **Circumstances of the fall** (e.g. witnessed, un-witnessed, immediate cause e.g. patient fell from the bed with the bed rails insitu, mechanism of injury, precise position and location patient was found) At 03.45 the pt got up from bed unaided then subsequently slipped on XX XX, following an episode of XX. This was a witnessed pt fall. Pt assessed for signs of injury, nil noted. Pt reviewed by the dr, post falls proforma completed by doctor and nurse. Subsequent XX of theXX XX shows a **XX XX XX XX XX XX at the XX XX XX XX XX XX XX.**

- **Background** *(include the patient's presenting condition, treatment plan, previous history of falls, cognitive impairment etc):*
  Patient admitted to Ward XX due to XX XX and XX XX.
  Past medical history of XX, XX, XX XX, XX XX, XX, XX XX

- **Description of identified Contributory factors/ Underlying causes of the fall:** (e.g, bed rails assessment was not followed and bed rails were in the incorrect position, patient was not wearing suitable footwear, patient did not use the call bell, Acuity on the ward at the time of the fall was high)
  Bed rails assessment completed XX XX which indicated a code of XX. This is to use bed rails with care and consider alternatives. Patient due to XX XX did not ring the call bell which was to hand. Acuity high on the ward on the night of the fall with four 1:1 pts and three nursing assistants which would be considered suboptimal for the number of 1:1's.

- **What treatment was required as a result of this fall and how did it affect the patient's length of stay/discharge** *(surgery, physio, mortality, impact on ADLs)*
  Post fall pt assessed for signs of injury nil noted. Pt reviewed and the post falls proforma completed by the dr and nurse. XX XX pt complained of XX XX XX when XX with the therapies assistant. A XX was requested of the XX XX which showed the afore mentioned XX. Pt is now awaiting a XX XX. Case discussed with the orthopaedic registrar on-call who has advised to keep the pt in a XX XX XX. Secondly advised the patient can mobilise but with no weight bearing on the XX XX. The pt is currently aside from this XX for discharge and is on treatment for a XX so having discussed this with the consultant she does not feel this injury will significantly impact the length of the stay for the pt.

Admission		Falls Core Questions & Multifactorial assessment & interventions				Manual Handling				Continence	6 CIT/4AT	Bed rails		
Ward / Area	Date and time of admission Ward/ Area	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? Yes If Yes, was this accurately captured in the continence assessment? No Was a continence plan of care in place? No	If the patient is 65 years or over was a 6 CIT completed on admission? No If completed what was the score?	**Was the Bedrail Assessment completed on admission and 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
XX	XX XX/2023 Time: 10:17hrs	Yes	Yes	No	Yes	Yes	Yes	Understanding	X		If the patient is 65 years or over was a 4AT completed on admission? No If completed what was the score?	Yes	both down	use with care
								Sit to stand	X					
								Walking	X					
								Repositioning in bed	X					
	Click here Time:	Click Here	Click Here	Click Here	Click Here	Click Here	Click Here	Understanding			Was the patient known to have dementia/ cognitive impairment? Yes	Click Here	Click Here	Click Here
								Sit to stand						
								Walking						
								Repositioning in bed						

Falls Interventions Use the risk assessment book and care plan for evidence										
Was a falls alert symbol displayed at the patient's bedside? Yes and captured in patient risk assessment book	Is there evidence that positioning of the patient in the ward environment had been considered? No	Was any equipment involved? E.g. trip hazards No	Please state any other factors? E.g. wet floor, lighting The pt slipped on her urine	Was an Ultra-low bed considered? No- - not considered Is there evidence of this No evidence recorded Were crash mats used with the low bed? No	Has a falls medication review been carried out? Unknown	Did the patient show signs of an acute new confusion? Was a delirium screen (4AT) carried out? N/A If 'Yes' provide details of additional checks/interventions made:	Was the patient able to use the call bell? Yes - this was captured on the daily bundles Was the call bell a) in reach Yes b) in working orderYes If no was an alternative considered?N/A	Has a lying & standing blood pressure been recorded? No If not is a reason for not completing recorded in the care plan/ multifactorial assessment? No	Do the falls bundles have fully completed and signed prescriptions of care every day? No	Are falls bundles completed 2 hourly? No

Mobility		Other Factors			Staffing – THIS SECTION MUST BE COMPLETED IN FULL		Audits and Training
Was the patient referred to Physiotherapy/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 at the time of the fall?	If patient was using own walking aid had it been checked for suitability by the therapy team? N/A Was the patient wearing appropriate footwear? Yes What footwear? Own Slippers 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? XX XX/2023 02.30hrs If there was a significant gap from the last comfort round to the time of the fall why was this?	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? 3:3 What is the ward's planned staffing establishment? Yes but 3:3 was insufficient as four 1:1 pts On the day of the fall – looking at safecare - what were the Care Hours per patient day /percentage acuity? Not completed If short - how many care hours were short for the shift? Were any other staff on the ward at the time of the fall (medical staff, AHPs…No……)?	Was the patient in a cohorted bay? No Was 1:1 staffing considered necessary? Yes If yes was 1:1 provided? No If not available was this escalated (include details of how/who it was escalated to)? Short staffed escalated by the NIC to site Were any other safety measures put in place? Staff advised to datix all shifts where staffing is suboptimal noted	Please enter last available results of the ward Falls audit: Unknown Does the ward / area have at least one active Falls Champion who is in date? Nominated staff member who is awaiting to attend the Falls Champion training How many staff have completed falls training locally? Nil Is training added to eroster as a skill? No (Any paper records to be scanned and added to Datix) What percentage of staff have completed bedrails training in last 2 years (as recorded on ESR)? 95.8% completed as part of induction

N/A - aid not required						on the datix submitted for this fall Datixed regularly by myself when working outside our establishment numbers and high acuity	

Post Falls Care

Was a post falls proforma completed? Yes If not, why not? What version was used? Sept 2009 Version 5 Did the patient require pain relief? no Was the Abbey pain tool used if the patient had a cognitive impairment? n/a What was given and when? n/a Drug: Date/Time:	Was the patient checked by a trained nurse &/or Doctor for injury prior to moving? Yes How was the patient moved from the fall? assistance from staff	If an injury was suspected was the patient flat lifted using the hover jack? N/A Was this documented in the patient's notes? N/A If injury suspected and hover jack not used why was this? Was there any delay in obtaining the hover jack? no Detail of the any delay:	If the fall was un-witnessed or a head injury sustained were neuro obs carried out? N/A Where required, were observations completed in line with trust policy? N/A Please state frequency of obs & for how long? N/A	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?

What investigations were requested as a result of the fall (include a date, time & results for each): Xx

requested by the consultant on XX XX, XX reported on XX XX

Conclusions	
Good practice identified (e.g. risk assessment completed and updated appropriately, suitable footwear worn, call bell in reach, patient cohorted and fall witnessed): **Post falls proforma completed by doctor and nurse in line with trust policy.** **Falls symbol above the patient's bed and the fall prevention leaflet** **Immediate actions taken at the time (include any actions identified in the STOP 5 hot debrief if one was completed): Doctor and nurse review post fall and the falls proforma completed. Pt is now being nursed in the cohort bay post fall.**	**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: Falls risk assessment incomplete** **Lying and standing BP not completed before the fall** **Not all risk assessment completed** **Post fall: Risk assessments not updated post fall**
Root Causes	

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. Pt was XX, and XX XX XX XX as result of this. Unfortunately, due to short-staffing a 1:1 was unavailable.	**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.* Lying and stand BP not recorded on admission Frequency of observations not in line with trust policy.

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)? Yes	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: XX Who was informed of the fall: XX Date and time of discussion: XX XX/2023 14.00hrs 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? Yes If not, why not?

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	Ward Manager / RCA Presenter	06/07/23	Completed
	Duty of Candour requirements	Share the outcome of the investigation with the patient/family, as appropriate and provide the opportunity for discussion	Ward Manager / RCA Presenter	Within 10 days of incident	XX XX/2023
				Within 14 days of panel	XX XX/2023
	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*

	Staff to make sure the falls risk assessment is updated post fall in the risk assessment booklet	Staff to complete documentation	Ward Manager Admitting nurse	On-going and monitored by ward manager	XX XX/2023
	Staff to make sure that the fall leaflet is given to the NOK	Leaflets to be given to the next of kin on admission	Ward Manager Admitting nurse	On-going and monitored by ward manager	XX XX/2023
	Staff to ensure that lying and standing BP is recorded on admission Staff to ensure all 6 CIT and 4AT is completed on admission	Lying and standing BP to be recorded 6 CIT and 4 AT to be completed on admission	Ward Manager Admitting nurse	On-going and monitored by ward manager	Updated at daily huddle
	Staff to make sure that the falls risk is clearly documented in the risk assessment booklet	Staff to complete documentation	Ward Manager Admitting nurse	On-going and monitored by ward manager	XX XX/2023
	The frequency of post falls observations to be undertaken as per trust policy	Staff to record observations in accordance with policy	Ward Manager Admitting nurse	On-going and monitored by ward manager	XX XX/2023
	Ensure falls bundle prescriptions are completed daily	Staff Education	Senior Nursing Team	XX 2023	XX Xx/2023
	Ensure falls bundles are completed 2 hourly along with comfort rounds	Staff Education	Senior Nursing Team	XX 2023	XX xx9/2023
	Ensure a STOP % Hot Debrief Tool is used following a fall	Staff Education	Senior Nursing Team	XX 2023	XX Xx/2023
	Ensure the multifactorial risk assessment is completed when the core questions have been positive	Staff Education	Senior Nursing Team	XX 2023	XX XX/2023
	Ensure if the patient is confused and therefore not able to use the call bell then an alternative measure has been put into place	Staff Education	Senior Nursing Team	XX2023	XX XX/2023