Root Cause Analysis (RCA)
Patient FALLS

Patient Name: ***********	NHS/Unit Number: **********	Date of Birth:***********	Actual Injury: Other (provide details below) Side of body left side If any other injuries were sustained, detail them here: Fracture to left humerus
Ward: 126; Neurology 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-23 Time: 0824 Reason for admission: Unsteadiness and increase frequency of seizures	Date of Fall XX XX-23 Time of Fall: 0145 Datix ID Number: 291583 SI Ref Number: 291583 Date Datix reported: XX XX-23 Time:0622 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? Click Here 2. If assistance with mobility was required was the risk assessment being followed? Click Here 3. If patient fell from bed were bedrails used as indicated by the bed rail assessment? Click Here 4. Were there any environmental factors involved in the fall (e.g. cables, wet floors, brakes not deployed…..)? Click Here Is this incident RIDDOR reportable? 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: ************	Patient Consultant: XX XX 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?no If not, why not? Unsure	Was the patient withdrawing from drugs or alcohol? No Does the patient smoke? No If so, did the patient have NRT Click Here Prescribed/referral to Smoking Cessation? Click Here 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** (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)

  Un-witnessed fall. Patient was found lying on the floor by the door to his pod. Patient was XX but XX and XX immediately post fall. Bed rails insitu

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

  Patient presented to ED XX XX/23 at XX following a fall which resulted in XX XX. He had no XX XX expect a XX XX XX XX. Patient has a history of XX following XX in XX XX and was recently discharged (XX XX 23) following an increase in XX XX due to previous XX XX XX XX/XX XX: XX XX XX following XX: ED noted XX XX believed to be due to XX and XX and XX XX XX . On admission to neurology ward, patient was assessed as being a falls risk but not assessed as being 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 in use as assessed on XX as to be used (XX) however comfort round prior to fall stated bed rails were in use. Patient also did not call bell for assistance (comfort round at 0000 stated call bell within reach) as believed the nurses were all on strike and he was left alone. He believed because it was quiet and there was low lighting so could not see anybody. He got up to investigate, lost his balance and put his arms out to catch his fall to prevent himself hitting his head on the door frame of the pod.
  Comfort round at 0000 also states patients was wearing own well-fitting slippers.

- **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)*

  XX of XX XX was ordered as pt was complaining of XX and found to have a XX XX XX XX XX . The patient has been seen by the XXXX and discussed with the spinal team for the use of a XX. Patient has been seen by therapy teams and where prior to admission had XX XX XX XX XX , the patient would now benefit with XX XX XX.

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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? No If Yes, was this accurately captured in the continence assessment? N/A	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
126	XX XX/2023 Time:0824	Yes	Yes	No	No	Yes	Yes	Understanding X Sit to stand X Walking X Repositioning in bed X	Was a continence plan of care in place? N/A	If the patient is 65 years or over was a 4AT completed on admission? No If completed what was the score? Was the patient known to have dementia/ cognitive impairment? Yes	Yes	both up	not recommended
	Click here Time:	Click Here	Click Here	Click Here	Click Here	Click Here	Click Here	Understanding Sit to stand Walking Repositioning in bed			Click Here	Click Here	Click Here

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Falls Interventions Use the risk assessment book and care plan for evidence										
Was a falls alert symbol displayed at the patient's bedside? No	Is there evidence that positioning of the patient in the ward environment had been considered? Unknown	Was any equipment involved? E.g. trip hazards	Please state any other factors? E.g. wet floor, lighting	Was an Ultra-low bed considered? unknown Is there evidence of this Unknown Were crash mats used with the low bed? N/A	Has a falls medication review been carried out? Yes - evidence in medical notes	Did the patient show signs of an acute new confusion? Was a delirium screen (4AT) carried out? No 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 If yes was the call bell a) in reach Yes b) in working orderYes If no was an alternative considered?Click Here	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? Yes	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? No Referred post falls 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 OBJ/2023 0000 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? Click Here	What was the staffing on the shift when the patient fell? 2 RNs 4 HCAs What is the ward's planned staffing establishment? 3 RNs and 3 HCAs On the day of the fall – looking at safecare - what were the Care Hours per patient day /percentage acuity? 132.7% If short - how many care hours were short for the shift? 17.3 Were any other staff on the ward at the time of the fall (medical staff, AHPs………)? NA; night shift	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? No	Please enter last available results of the ward Falls audit: 88.89% Does the ward / area have at least one active Falls Champion who is in date? Two; *********** How many staff have completed falls training locally? Is training added to eroster as a skill? (Any paper records to be scanned and added to Datix) Not to e-rostering but kept in falls training record book What percentage of staff have completed bedrails training in last 2 years (as recorded on ESR)? 100%

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No							

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Post Falls Care					
Was a post falls proforma completed? Yes If not, why not? What version was used? Version 5 Did the patient require pain relief? No Was the Abbey pain tool used if the patient had a cognitive impairment? No What was given and when? Drug: Date/Time:	Was the patient checked by a trained nurse &/or Doctor for injury prior to moving? Unknown How was the patient moved from the fall? Unknown	If an injury was suspected was the patient flat lifted using the hover jack? Unknown Was this documented in the patient's notes? unknown If injury suspected and hover jack not used why was this? Was there any delay in obtaining the hover jack? unknown Detail of the any delay:	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? 6hrly	Was the patient seen by a doctor or nurse practitioner within 4 hours of the fall or sooner if required? Unknown If not, why not? Falls proforma completed but no time. Entry on iportal at 0519 Is their assessment recorded on the post falls proforma? Yes If not, is the assessment following the fall documented in the medical notes? Yes	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? No If not, why not? Detailed medication review not completed or acknowledge informed GP on d/c letter
What investigations were requested as a result of the fall (include a date, time & results for each): XX to left shoulder XXXX/23 at 0522 XX XX XX : Comparison to previous of XX XX XX XX XX XX XX XX XX. XX XX unremarkable, the XX XX remains within the XX XX XX XX of the left XX XX Unremarkable XX XX XX to XX XX XX XX/23 at 0929 XX XX XX : Comparison made imaging acquired earlier today. The XX XX remains within the XX XX. No evidence of XX. No new XX XX identified. XX XX XX XX/23 at 0958					

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Comparison made with previous imaging. Generalised XX XX with XX XX XX XX XX XX XX. XX XX and XX. Established XX XX involving the Xx XX, XX and XX XX . Previous XX XX and XX XX XX XX are noted. Expected XX of theXX XX and XX XX. No XX XX XX. No XX XX XX. No XXXX, no XX XX, no XX. No XX XX. NoXX XX , XX appearance of the XX XX and XX XX XX, XX, XX and XX XX.
Conclusion: No XX XX XX identified.

Consultant Review:
There is XX XX of XX XX shown in the XX XX XX XX XX most likely in keeping with a XX XX . This remains unchanged when compared to previous. The XX XX and the remainder of the XX XX remain unchanged when compared to the preceding CT examination with XX XX XX XX XX.

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Conclusions

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Good practice identified (e.g. risk assessment completed and updated appropriately, suitable footwear worn, call bell in reach, patient cohorted and fall witnessed):

- **Duty of candour completed in a timely manner**
- **Call bell within reach**
- **Core falls questions answered on admission**
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Immediate actions taken at the time (include any actions identified in the STOP 5 hot debrief if one was completed):

Observations taken

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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:
Lying and standing bp not recorded
Multifactorial falls assessment not completed
Bed rail matrix not followed
Falls alert not in place
6-cit or 4At not completed

Post fall:
Neuro observations not completed as per policy
All falls reassessments not completed
Lying and standing Bp not recorded
Consultant review not completed fully
STOP 5 hot debrief not taken place

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<td>Root Causes</td>
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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. XX XX 2. Patient was XX at time of fall (felt XX and XX XX XX XX XX) 3. 6-cit not completed on admission which may have highlighted fluctuating confusion	**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. Falls symbol not is use 2. Bed rail matrix not followed 3. Stop 5 hot debrief not completed

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)? No	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 /2023 1500 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:	

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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	***********	XX XX/2023	
	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	XX XX /2023 completed and sent to NOK and patient
				Within 14 days of panel	
	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*
	Use of STOP 5 hot debrief	Fall training refresher	**************	XX 2023	100% of staff received falls training over last 12 months. Also discussed in ward meeting.
	Assessments reviewed weekly and post falls	Proud to care audits weekly and to be discussed with staff when not updated	***************	XX 2023	Completed; part of NIC checklist for prompting of review of assessments following a fall. Proud to care audits completed
	High observational area	Due to layout of ward, there is not an area of high observation. Staff are now basing themselves within each bay (or just outside) to ensure all patients are observed to reduce falls	*****************	XX 2023	Completed; all staff are aware of the change and feel basing themselves in one bay is beneficial in

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					reducing falls and also increasing patient care.
	Ensure lying and standing blood pressure completed at every admission	Staff now have a nominated senior nurse who meet monthly and discuss issues within the ward. A complete admission is also gone through with them to ensure they are aware of their responsibilities.	*****************	XX 2023	On-going but initial meeting completed
	Use of falls symbols	Housekeeper to update patient boards daily	*****************	XX 2023	Completed

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