



England

# Post Falls Responses

NHS England Patient Safety update

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# Background

## Suboptimal aftercare following a hospital fall with serious injury first identified by National Patient Safety Agency in [2011](#)

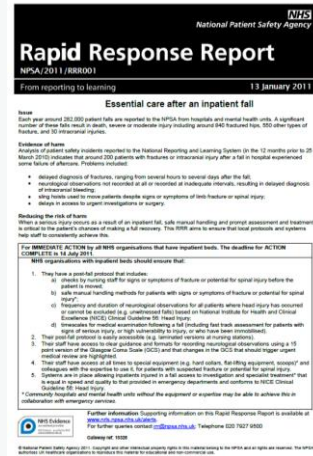
### Review of pt safety reports had found:

- Delayed diagnosis of fractures and intracranial bleeds
- Absent or inadequate post fall monitoring (esp neuro obs)
- Sling hoists used despite symptoms of lower limb # or spinal injury
- Delays in access to urgent investigations or surgery

### Trusts asked to put in place post fall protocols that included:

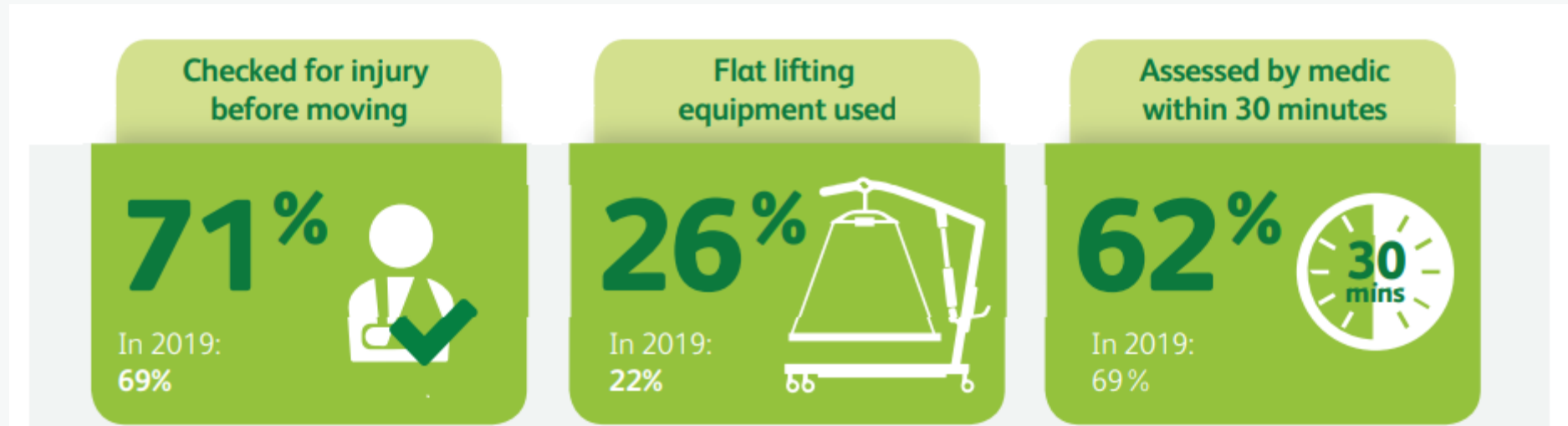
- Checks for injury before moving patient
- Safe manual handling methods + equipment
- Align frequency and duration of neuro obs with [NICE HI guidance](#)
- Timescales for medical examination
- Access to Investigations and treatment equal in speed and quality to that in ED

Accredited by NICE & informed [Quality Standard 86](#) 'Falls in older people' in 2015



# Enduring issue ...audit indicates improvement is difficult

The National Audit of Inpatient Falls (NAIF) found improvement needed for femoral fracture care against NAIF Key Performance Indicators [NAIF Autumn 2021 report](#) and [NICE Quality Standard 86](#) ... specifically immediate care following the fall... significantly worse than out-patient peers.

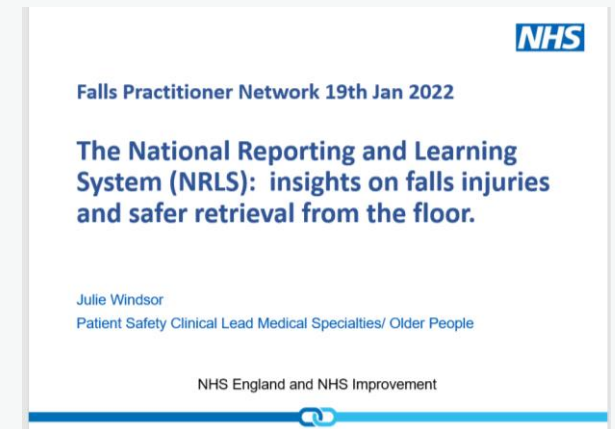


# Time for a rethink

## Inpatient falls safety reports – adding detail & context

Why search the National Reporting and Learning System (NRLS) again?

- Reports provide rich ‘first person’ narrative data (staff voice)
- Can offer additional contextual insight/ tells the story to support and/or drive quality improvement work.
- Can be particularly helpful for complex ‘wicked’ problems to illuminate areas for closer focus.



# Vignettes of actual reports often more powerful than numbers to make the case

...and discussion with staff more helpful to understand the issues

## Discussion/ thinking points (1)



### ED dept practice .... same on a ward?

*'Pt found on floor by trolley ... No LOC - Wound on forehead - ++ bleeding ... ED consultant, ED reg, ops man and additional nurses present. Pt log rolled c to get pt back onto trolley. Trauma mattress i moved to maj 9 for closer observation ... Pla and spine.'*

### Different acute hospitals – different approach

*'Patient reviewed by medical team. Trauma t called. Lifted onto bed with assistance of 6 u secured in blocks and tape. Patient CT head intercranial haemorrhage.'*

## Discussion/ thinking points (2)



### Difficult to get flat lifting equipment into tight spaces

*'Unable to get lift into sideroom'*

#### Solution ?

*'... right leg shortened and rotated ... manoeuvred out on a slide sheet ... scooped off the floor with assistanc bed.'*

### Equipment supply/ storage/ provision

*Lack of equipment can force staff into unlicensed use c*

*'moved back on to bed using Marsden weight board as greater than waiting for Hoverjack to become available*

*'Unable to locate hoverjack'*

#### Solution?

*HCA contacted porters to bring hoverjack'*

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## Discussion/ thinking points (3)

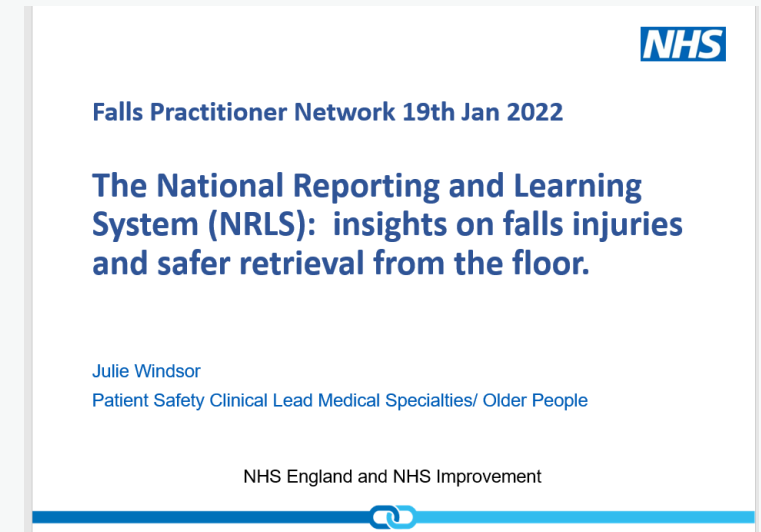


### Assessment can be incredibly difficult though – rapid deterioration

*'unwitnessed fall 21.15, alert and oriented, stated had banged head ... stood up with minimal assistance, news-1 and gcs-15, seen by doctor at around 23.20 ... ct head ... deteriorated news 6 and gcs to 9 ... exceedingly large acute left - sided subdural haemorrhage with significant mass effect and midline shift.'*

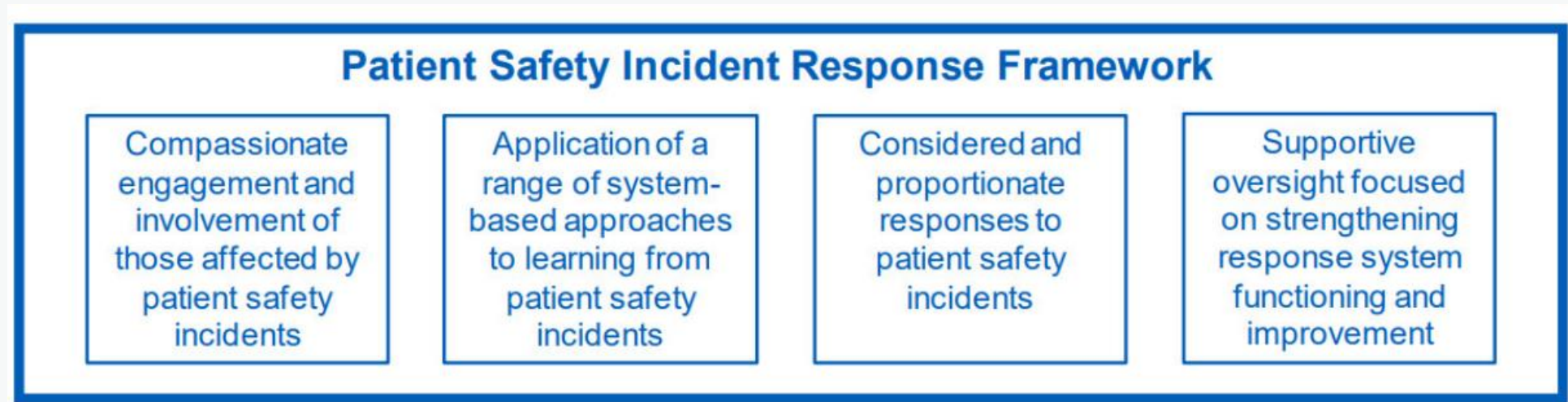
# Summary of findings and discussion

- Scant detail in reports could be affecting ability to answer audit questions.
- Reports often don't describe what clinical assessments are carried out prior to moving.
- Reports often seem to indicate that staff are unclear what assessments are required.
- Prominent issue is that nursing staff outside of ED's often do not have first aid skills.
- Many reports do not describe immediate care of injury e.g. analgesia etc even when significant injury suspected.
- Access to and training in the use of appropriate flat lifting equipment appears to remain challenging
- Findings shared with RCP/NAIF to inform next stages of recommendation and guidance work



# Other drivers for change on the horizon

## PSIRF



- Opportunity to rethink and restructure approaches to immediate post fall management in line with other post fall review responses.
- Move away from old SI Framework

# Always evolving and learning

**Emerging risk- Immobilisation of C-Spine in pt's with existing spinal disease and suspected spine trauma- variation in guidance & variation in practice**

## **Extract from a reported incident**

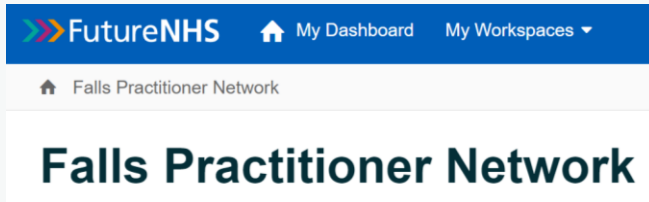
*'.....C spine - tender centrally throughout. Complaining of pain down left arm ED cons concludes; Immobilise for trauma CT - unlikely to tolerate collar, blocks ok. ED Con aware that patient has chronic painful neck and DISH (does not have Ankylosing Spondylitis) Asks nursing staff to transfer to trauma board for scan*

*Pt moved to trauma board- no collar fitted for comfort*

*Call from CT radiologist at approx. 0715 - significant c spine fractures on scan  
Went to reassess patient - on trauma board having been to CT scan Blocks in place, tolerating Complaining of reduced power in arms - feel like they are 'dead'*



# Guidance unclear & not kept pace with current clinical practice



Staff are concerned about practice variation and lack of clarity in the guidance

**NHS England Patient Safety** undertaking deep dive search of NRLS/ LFPSE

[Falls Practitioner Network - FutureNHS Collaboration Platform](#)



Updating their guidance



? Other actions, by who?, ? tie in with RCP NAIF as audit scope extends

**Work in progress.....**

# Thank you

**Now straight on to Julie Whitney**

Please write your questions in the Q&A panel and we'll answer at the end

