Root Cause Analysis (RCA)
Patient FALLS
2022/18647

Patient Name: *****	NHS/Unit Number:******	Date of Birth: *****	Actual Injury: Other (provide details below) Side of body If any other injuries were sustained, detail them here: XXX XXX
Ward: XXX Division: Specialised Hospital Site: Royal Stoke Location where fall occurred: Bed Was the patient location appropriate for their speciality? Yes Date admitted to UHNM: XX XX-22 Time: Reason for admission: XXX XXX XXX	Date of Fall XX XX-22 Time of Fall: 1945 Datix ID Number: 279789 SI Ref Number: 277281 Date Datix reported: XX XX-22 Time:1016 Datix Harm Severity: Severe 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? Unknown patient did not use the call bell 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 at the meeting however Datix shows that the H&S team had documented NO pre falls panel No *(If No to Questions 1, 2, 3 and/or Yes to Question 4 RIDDOR reporting MUST be considered)*	
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 1 Was a STOP 5 hot debrief carried out?no If not, why not? Not embedded on ward	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? No

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 from bed. Bed rails were insitu. Not specified what position patient was found in but patient was found on the floor.

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

Patient was admitted on XX XX/22 with worseningXX XX. Patient had previously had a XX XX XX XX when due to being NBM, they were taken off their regular XX medication and put onXX XX XX. Following surgery, the XX was still prescribed and her regular XX medications were restarted which caused worsening XX and resulted in the admission. They did not have any falls during their stay with us until the fall on the XX XX but has had previous falls (which resulted in XX XX XX XX

GCS has been fluctuating between 14 & 15 during admission with us.

Prior to admission, patient was a resident in **********in an assessment bed following herXX 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 XX as to be used (XX) however due toXX XX, should have been assessed as XX and alternatives should have been considered. This has not been documented anywhere as a consideration.
  Patient did not have any footwear on at time of fall as patient was in bed prior to fall.
  Comfort round last documented at 1620 and stated patient was confused but that call bell was within reach. Based on knowledge of patient, I do not believe the patient would have used the call bell to ask for assistance as they have not done so to my knowledge during their time with us.
  Acuity on the ward has been high. Two staff nurses on the late shift due to careers leave (establishment of three) and one RN finished at 1930 leaving one RN to handover.
  Patient does have episodes of XX and it was documented patient was XX on the last comfort round at 1620. Last GCS recorded prior to the fall supports this as was assessed as GCS XX.

- **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)*

  Following the fall, patient was reviewed by SHO on call and was not for a CT head unless GCS changed or there was a focal deficit. However, CT head was ordered on XX XX and showedXX XX XX XX . Patient was assessed by Neurosurgery and not suitable for any intervention from them and for ward based care. Reviewed by physio therapy XX XX and not currently for any intervention as advised by medical team for patient to be nursed on bed with a 30 degree head tilt. XX and XX as advised by Stroke team stopped and XX prescribed forXX XX. PRNXX prescribed to keep systolic bp below XX. Oral intake poor so for potential enteral feeding if continues. Interval CT head imaging to monitorXX XX. A delay in physio therapy and the addition of interval scanning will result in a prolonged length of stay.

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? XX If Yes, was this accurately captured in the continence assessment? XX Was a continence plan of care in place? XX	If the patient is 65 years or over was a 6 CIT completed on admission? No If completed what was the score? 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? No	**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/2022 Time:1527	Yes	Yes	N/A	N/A	Yes	N/A	Understanding	X			Yes	N/A	use with care
								Sit to stand	X					
								Walking	X					
								Repositioning in bed	X					
XX	XX XX /2022 Time:2130	Yes	Yes	Yes	Yes	Yes	No	Understanding	X			Yes	both up	recommended
								Sit to stand	X					
								Walking	X					
								Repositioning in bed	X					

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? Yes - evidence that patient nursed in visable bed space	Was any equipment involved? E.g. trip hazards No	Please state any other factors? E.g. wet floor, lighting Comfort round states environment was clear	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? 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? No - this was captured on the daily bundles If yes was the call bell a) in reach N/A b) in working orderN/A If no was an alternative considered?No	Has a lying & standing blood pressure been recorded? No If not is a reason for not completing recorded in the care plan/ multifactorial assessment? unable to stand on admission - not reviewed once able to stand	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? Yes	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? N/A What footwear? Bare Feet Was the patient using hip protectors? N/A	Did the patient require a hearing aid? No If Yes were they in use? N/A Did the patient wear glasses? Yes Reading glasses If Yes were they in use? Unknown	Date & Time of the last comfort round? XX XX /2022 1620 If there was a significant gap from the last comfort round to the time of the fall why was this? Fall at 1945. No documentation as to why fall comfort round was missed	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? 2:4 (two one to ones, one RN finished at 1930) What is the ward's planned staffing establishment? 3:4 On the day of the fall – looking at safecare - what were the Care Hours per patient day /percentage acuity? Safecare not completed If short - how many care hours were short for the shift? Safecare not completed Were any other staff on the ward at the time of the fall (medical staff, AHPs……)? One on call registrar who found patient	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? Nursed in a high observational area prior to fall	Please enter last available results of the ward Falls audit: Does the ward / area have at least one active Falls Champion who is in date? SSN XX XX SQN XX XX booked for the refresher day in September 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) What percentage of staff have completed bedrails training in last 2 years (as recorded on ESR)? 94.4%

Post Falls Care					
Was a post falls proforma completed? Yes If not, why not? What version was used? Sept 2019 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? Yes How was the patient moved from the fall? Unknown	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? Yes Where required, were observations completed in line with trust policy? No Please state frequency of obs & for how long? **26/9** 20:24 20:26 21:09 XX 22:14 XX **27/9** 05:46 XX 11:08 12:42 XX 21:43 **28/9** 10:13 XX 17:15 XX 23:24	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? No If not, why not?
What investigations were requested as a result of the fall (include a date, time & results for each): CT head requested XX XX12:36 and completed XX XX 09:48. Result date XX XX12:56 Comparison made with previous CT dated XX XX 22. Movement artefact limiting in its quality despite 2 attempts. XX XX XX XX XX XX XX XX XX XX XX XX. There is XX XX XX and XX XX of the XXandXX XX XX XX XX XX XX. Small focus of XX XX identified within the region of the XX XX of theXX XX XX XX , however movement artefact limits assessment of exact location. No features suggestive of XX currently. Multiple\XX XX XX , XX of which are XX and xx are XX from previous CT and appear XX e. No new infarct identified elsewhere.					

Long-standing XX XX XX is unchanged. Background XX XX XX XX andXX XX XX XX . No significant XX XX XX XX or XX XX within the limitations of movement artefact. NormalXX, XxandXX XX.

Impression:
-XX XX XX XX along the XX XX and XX XX XX with Xx XX ofXX XX XX . Possible smallXX XX XX XX .
-XX XX XX XX . XX source to be considered.

CT head requested XX XX13:03 and completed XX XX 20:11. Result date XX XX 11:01

Plain CT Head:

Comparison is made to CT head datedXX XX .22.
There are gener\XX XX XX . XX XX XX changes XX XX XX XX XX and XX XX XX. Similar overall appearances to the Xx XX XX andXX XX XX XX .XX XX XX XX XX XX .
No newXX XX XX XX XX . Persistent XXof the XX XX of theXX XX XX , no evidence ofXX XX. No newXX XX , XXor other XX orXX.
The orbits, sinuses, bones, and soft tissues are unremarkable.

Conclusion:
- NoXX XX XX.

CT head requested XX10:12 and completed XX07:27. Result date XX10:10

Comparison made with previous imaging dating back to
XX XX/22.

Generalised XX XX withXX XX XX XX XX XX XX. Patent XXandXX. XX XX XX changes from previousXX XX. Overall stable appearance of XX XX XX XX involving the XX XX and the Xx XX with XX XX of the Xx XX XX and XX XX of theXX XX XX . XX XX XX iXX are again noted.
NoXX XX XX . NoXX XX, noXX. No compXX XX. No XX XX
Unremarkable appearance of the XX XX andXX XX XX, XX,Xx andXX.

Conclusion: Overall stable appearance of XX XX XX XX XX involving the XX XX and XX XX XX XX XX Xxand Xx of the XX XX of theXX 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): • **Drs aware and medical review within a time manner** • **Falls symbol by bedside** • **Patient in a high observational area** • **Duty of candour completed in a timely manner** **Immediate actions taken at the time (include any actions identified in the STOP 5 hot debrief if one was completed):** Reviewed by medical team Observations taken One to one in place	**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:** Risk assessment not reviewed Lying and standing bp not completed Comfort rounds not up to date **Post fall:** Policy for completion of neuro observations not followed. Delay in CT scan STOP 5 hot debrief not completed Datix not completed as per policy
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?)
 	
• Poor mobility on admission
• Fluctuating confusion
  • High number of one to one patients
  • Inadequate footwear
  • Patient unable to use call bell
  •
	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. STOP 5 hot debriefs to be completed
	
	2. All qualified staff to undergo falls training with PDN
	
	3. Consultants/ registrar to fully complete pro forma review

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: ********** Who was informed of the fall: ********** Date and time of discussion: XX XX 2022 XX 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	**********	Xx2022	Completed XX2022
	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	Completed XX XX by **********
				Within 14 days of panel	Completed XX XX /22 **********
	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	**********	XX2023	63% currently received updated falls training from falls champions and PDN
	Completion of observations following fall	Fall training refresher	**********	XX2023	63% currently received updated falls training from falls champions and PDN
	Completion of Datix following fall	Falls training refresher Reflective learning for those involved in incident	**********	XX2023	All staff made aware following incident and as part of the falls training
	Use of falls symbols	Housekeeper to update patient boards daily	**********	XX XX/22	Completed

	Assessments reviewed weekly	Proud to care audits weekly and to be discussed with staff when not updated	**********	XX2022	Weekly audit
	Ensure lying and standing blood pressure is taken when patient is able to stand	Senior nursing team to arrange education for the team	**********	XX2023	Weekly audit
	Ensure 6CIT is completed on patients that are 65 years old and over	Senior nursing team to arrange education for the team	**********	XX2023	Weekly audit
	Ensure 4AT is completed if delirium is suspected	Senior nursing team to arrange education for the team	**********	XXh 2023	Weekly audit
	Ensure neurological observations are completed for a full 24 hours following an unwitnessed fall or a fall with a head injury	Senior nursing team to arrange education for the team	**********	XX2023	Weekly audit
	Ensure patient own footwear is being worn where possible	Senior nursing team to arrange education for the team	**********	XX2023	Weekly audit
	Ensure falls bundle prescriptions are completed daily	Senior nursing team to arrange education for the team	**********	Xx2023	Weekly audit
	Ensure falls bundles are completed 2 hourly along with comfort rounds	Senior nursing team to arrange education for the team	**********	Xx2023	Weekly audit
	Although the bed rail assessment had been completed please re-assess if patients cognition changes	Senior nursing team to arrange education for the team	**********	Xx2023	Weekly audit
	Ensure safecare is completed to identify any shortfalls in stafing	Senior nursing team to arrange education for the team	**********	Xx2023	Weekly audit