Falls Prevention and Management
Final Internal Audit Report

October 2022

Hywel Dda University Health Board

GIG CYMRU NHS WALES
Partneriaeth Cydwasanaethau
Gwasanaethau Archwilio a Sicrwydd
Shared Services Partnership
Audit and Assurance Services

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Contents

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Auditors:	Ceri-Ann Corcoran, Principal Auditor
Executive sign-off:	Mandy Rayani, Director of Nursing, Quality and Patient Experience
Distribution:	Mandy Davies, Assistant Director of Nursing and Quality Improvement Sian Passey, Assistant Director of Nursing Karen Barker, Head of Nursing, Scheduled Care Claire Rawlinson, Quality Improvement Practitioner
Committee:	Audit & Risk Assurance Committee

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Acknowledgement
NHS Wales Audit and Assurance Services would like to acknowledge the time and co-operation given by management and staff during the course of this review.

Executive Summary

Purpose

The purpose of the audit is to review arrangements across the Health Board for the prevention of falls and the effective management of patients following a fall.

Overview

We have concluded **Reasonable** assurance on this area with one high priority matter arising relating to the completion of falls risk assessments. Sample testing identified instances where risk assessments had not been completed, or could not be evidenced as such.

We have also identified five medium priority matters arising relating to:

- The falls policy requires review and updating.
- Absence of a delivery plan and target completion date for the development of the falls strategy.
- Absence of a Health Board falls prevention and management training programme.
- Timeliness and completeness of falls incident investigations.
- Sharing of lessons learned across the Health Board.

Full detail is provided in section 2 of the report, with a summary of matters arising and recommendations in Appendix A.

Report Opinion

		Trend
Reasonable 	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved.	N/A

Assurance summary[1]

Objectives		Assurance
1	Falls Policy	Reasonable
2	Falls Risk Assessments	Limited
3	Falls Prevention	Reasonable
4	Staff Training	Reasonable
5	Falls Investigations & Shared Learning	Reasonable
6	Reporting of Falls Data	Substantial

[1]The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.

Key Matters Arising

		Objective	Control Design or Operation	Recommendation Priority
1	Falls Policy	1	Operation	Medium
2	Risk assessments	2	Operation	High
3	Falls Strategy Development	3	Design	Medium
4	Falls Prevention & Management Training	4	Design	Medium
5	Incident Investigation	5	Operation	Medium
6	Sharing of Lessons Learned	5	Design	Medium

1. Introduction

1.1 The National Institute of Health and Care Excellence (NICE) identifies that falls and fall-related injuries are a common and serious problem for older people and falls in hospital are the most common patient safety incidents reported. The human cost of falling includes distress, pain, injury, loss of confidence, loss of independence and mortality which also affects the family members and carers of people who fall. Falling has an impact on quality of life, health and healthcare costs and the Health Board recognises that the prevention of falls, and effective management of patients following a fall, is an important patient safety challenge for the Health Board, in common with all Health Boards.

1.2 This review seeks to provide the Health Board with assurance in relation to the arrangements for the prevention and management of patient falls.

1.3 The associated potential risks are:

- patient harm;
- reputational damage to the Health Board; and
- financial loss to the Health Board.

2. Detailed Audit Findings

Objective 1: There are adequate policies and procedures in place, detailing falls prevention processes and embedding the requirements of NICE CG161

2.1 To minimise falls and their impact on patients and staff the Health Board has adopted the National Institute of Health & Care Excellence (NICE) clinical guidance *Falls in Older People: Assessing Risk & Prevention (CG161)*. The guidance provides recommendations for the assessment and prevention of falls in older people for use by healthcare and other professionals and staff who care for older people who are at risk of falling.

2.2 Health Board Policy 401 *'Preventing Falls and Post Fall Care in Inpatient Areas Policy'* (the 'Falls Policy') was due for review in 2018. We were advised that this will be undertaken by the Adult Inpatient Falls Reduction Improvement Group (see also para 2.30).

2.3 The Falls Policy is generally consistent with the principles of the NICE guidance and current practice across the Health Board. However, sample testing of risk assessments (see para 2.6 below) highlighted that the policy isn't clear about the falls risk assessment requirements for A&E and MIU patients and is silent on the requirement for a focused review of falls incidents assessed as moderate harm or greater.

2.4 Comparison with other Welsh Health Board policies also identified opportunities for improvement, including incorporating guidance on the actions to be taken on patient admission and stipulating timescales for completion, review, and update of the patient's Multifactorial Falls Risk Assessment (MFRA).

[Matter Arising 1]

Conclusion:

2.5 The Health Board policy for the prevention and management of falls was due for review in 2018 and this was ongoing at the time of audit. Whilst the policy is generally consistent with NICE guidance and current practice, opportunities to further enhance the policy were identified. We have therefore concluded **Reasonable** assurance for this objective.

Objective 2: Risk assessments have been completed where required, and appropriate action taken to reduce the risk of a fall

2.6 Current best practice in the NICE clinical guidance CG161 calls for completion of an MFRA for all inpatients aged over 65, or aged 50-64 who are clinically judged to be at risk. The MFRA focuses on manageable risk factors and incorporates a Falls Prevention Care Plan to identify actions to reduce the risk of falling. This requirement is appropriately reflected in the Falls Policy.

2.7 We sampled 15 falls incidents reported on Datix during the period April 2021 to June 2022 and sought to establish whether an MFRA (and incorporated Falls Prevention Care Plan) had been completed on patient admission, prior to the fall. Our sample comprised incidents across acute and community sites, and all were considered to require an MFRA due to age (in line with NICE guidance and the Falls Policy) or frailty.

- We were unable to ascertain whether an MFRA had been completed for four patients. No MFRA was provided for seven of the 15 sampled, although in three cases the incident investigation noted that an MFRA had been completed prior to the fall.
- Three of these four related to A&E or MIU patients where a fall occurred after admission. There were conflicting views among the Senior Nurse Managers as to whether an MFRA is required to be completed in these settings, although in one case a standalone Falls Prevention Care Plan had been completed.
- We were able to establish the admission date and assess the timeliness of MFRA completion in five cases, three of which were 17, 20 and 38 days respectively after admission. The Quality Improvement Practitioner for Falls advised that it should be completed within 6hours of admission / transfer to another clinical area. However, this is not reflected in the Falls Policy (see para 2.4).

[Matter Arising 2]

Conclusion:

2.8 Sample testing identified instances where an MFRA had not been completed or could not be evidenced as such, and highlighted ambiguity with regards to the MFRA requirements for A&E/MIU patients (see also para 2.3 above regarding policy requirements). Accordingly, we have concluded **Limited** assurance for this objective.

Objective 3: Action is being taken to reduce the risk of patient falls within the Health Board and holistic falls awareness and prevention activities have been considered across other settings including community care

2.9 Falls prevention is a key priority for the Health Board under *Strategic Objective 5 – Safe, Sustainable, Accessible & Kind Care* and aligns with the 'Healthier Mid and West Wales' health and care strategy which focusses on integrated working and community driven prevention.

2.10 The Quality Improvement & Practice Development Team have been tasked with producing, in conjunction with key stakeholders, a collaborative falls framework which aims to:

- promote falls prevention to reduce the number of avoidable falls in the community and in hospitals

- work collaboratively with relevant third sector and social care services
- ensure an equitable three county approach to community fall intervention
- develop a seamless transition for patients between hospital and home

2.11 A task and finish group, the Falls Prevention Strategy Steering Group, was established in October 2021 to provide direction and management in planning and developing the strategy. The Steering Group is accountable to the Quality, Safety and Experience Committee (QSEC) and supported by a number of working groups focussed on achieving a whole system approach to falls prevention.

2.12 This includes a series of workshops with engagement from acute, community, voluntary and third sectors to evaluate the need for falls prevention work; consider existing falls prevention activity within the Health Board; identify actions to improve existing falls prevention arrangements; and agree the priorities for strategy development. The outcome of these workshops is due to be reported at the next Steering Group meeting.

2.13 The Quality Improvement Practitioner for Falls advised that a baseline assessment exercise has recently been completed to assess current practice across the Health Board and establish the extent to which service areas are meeting guidance around falls prevention and management. Feedback is currently being evaluated and the outcome will be used to inform a gap analysis to identify required improvements and areas of focus for the Strategy.

2.14 Development of the Strategy commenced in 2021 and we acknowledge that progress has been impacted by service pressures. There is no delivery plan in place identifying key milestones or timescales for completion, although progress is reported bi-annually to QSEC as part of the Quality & Safety Assurance Report with the most recent update provided in June 2022.

[Matter arising 3]

Conclusion:

2.15 Whilst work on developing the strategy is progressing with updates reported to QSEC, there is no delivery plan in place identifying key milestones or timescales for completion. We have therefore concluded **Reasonable** assurance for this objective.

Objective 4: Staff are appropriately trained to assess risks and identify hazards

2.16 The Falls Policy states that staff must access relevant training to ensure that they have the required competencies to comply with their responsibility in implementing the policy and associated procedures.

2.17 We observed examples of ad hoc training (such as training in completion of the MFRAs) and a series of 'away days' conducted by the Quality Improvement & Practice Development Team for newly qualified nursing staff in Prince Phillip Hospital, which included a focus on falls. However, there is no formal Health Board-

wide training programme for falls prevention and management. **[Matter Arising 4]**

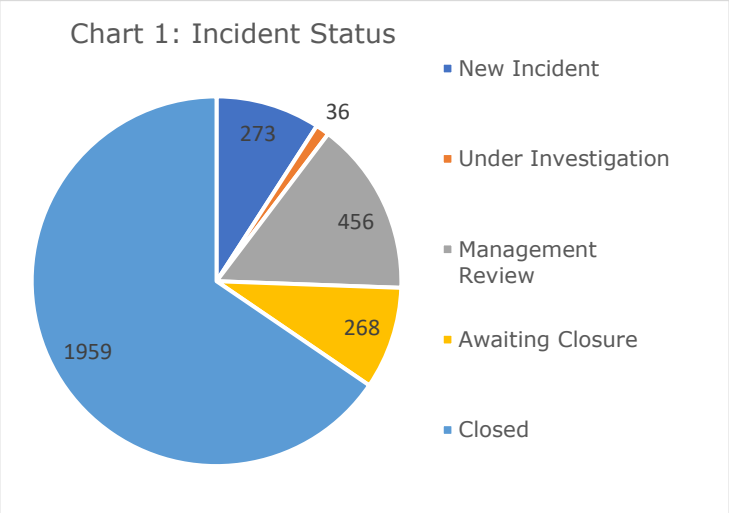
Conclusion:

2.18 We have concluded **Reasonable** assurance for this objective on the basis that whilst there is no Health Board-wide training programme for falls prevention and management, the design of the MFRA assists and guides staff in the identification and mitigation of falls risk.

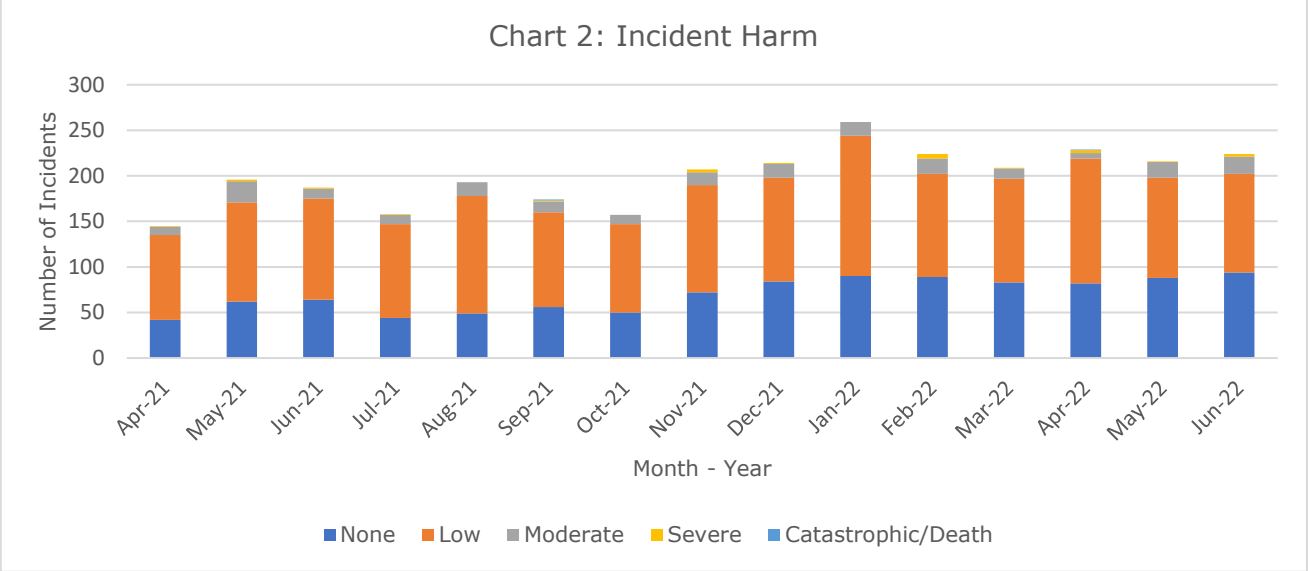
Objective 5: Falls incidents are investigated and monitored to identify themes and trends, with action taken to address issues identified and lessons learned shared across the health board

At a Glance - Falls Incident Data

2.19 Analysis of all inpatient and community falls incidents reported during the period 1 April 2021 – 30 June 2022 identified a total of 2992 incidents, 35% of which remain open at August 2022.



2.20 Most incidents (92%) were assessed as resulting in 'no' or 'low' harm, with 8% resulting in 'moderate' or 'severe' harm. There were two incidents assessed as 'catastrophic/death' during the period.



2.21 The conclusion and lessons learned fields on Datix has been completed (to identify learning or confirm none) for 98% of incidents either closed or awaiting closure.

Sample Testing of Falls Incidents

2.22 For the sample of 15 falls incidents reviewed at objective 2, all but one had been investigated, although in eight cases the investigation was initiated more than 30 days after the incident, with two in particular taking 84 and 36 days respectively. The incident awaiting investigation was reported in December 2021 and graded as 'moderate harm'. **[Matter Arising 5]**

2.23 The 2020 National Audit of Inpatient Falls (NAIF) recommended that all inpatient falls resulting in hip fracture be reported as 'severe harm' regardless of circumstance and outcome. This applied to three in our sample, all of which had been appropriately reported.

2.24 Datix requires completion of a 'focused review' for falls incidents resulting in 'moderate harm' (or greater). This includes a series of falls-specific questions around the MFRA (including whether it had been implemented as planned and updated following the fall), falls prevention activities and post fall management. This review had been fully completed for eight of the 14 investigated incidents (all 'moderate', 'severe' or 'catastrophic' harm), and partially completed (only confirming that an MFRA was in place at the time of the fall) for a further three. **[Matter Arising 5]**

Monitoring by the Quality Improvement Practitioner

2.25 The Quality Improvement Practitioner monitors the number of falls incidents on a monthly basis to identify and engage with 'hot spot' areas to support them in reducing falls incidents, for example through targeted informal training and the identification of a 'Falls Champions' to drive improvements. A high-level overview of engagement activity is provided bi-annually to QSEC in the Quality & Safety Assurance Report.

2.26 At the time of fieldwork, the Team had reviewed falls incidents data for Prince Philip and Glangwili hospitals to June 2022, and Bronglais and Withybush hospitals to August 2022. Focus is prioritised on sites with the highest falls incidents (i.e. acute sites) and therefore excludes community settings, although the Quality Improvement Practitioner cited examples where engagement had been requested by and provided to community hospitals.

Sharing of Lessons Learned

2.27 Scrutiny & Assurance Meetings are held for each acute site (with community representation) to monitor and scrutinise inpatient falls, identifying causal factors and sharing learning to prevent recurrence. The outcomes of these meetings feed into the Directorate Quality, Safety & Experience (QSE) Groups, with minutes of the Scheduled Care QSE Group evidencing discussion around falls.

2.28 Directorate QSE Groups also receive an incidents report from the Patient Safety & Assurance Team. This provides substantial detail allowing for the identification of

themes and trends, including an analysis by service area and a breakdown of 'accident, injury' incidents (including falls) by cause.

2.29 Directorate QSE Groups report by exception to the Operational Quality, Safety & Experience Sub-Committee (OQSESC). Review of OQSESC minutes/papers did not identify any reporting in relation to falls or lessons learned. Consequently, there is no evidence that lessons learned are being shared across the Health Board, beyond the Directorate QSE Groups.

2.30 The Adult Inpatient Falls Reduction Improvement Group was resurrected in April 2022 following temporary suspension during Covid-19. Terms of Reference are yet to be drafted so we were unable to confirm the purpose, duties and membership of the Group, which has not met since the April 2022 due to unavoidable absence of the lead. We understand that this is now resolved, with the Group due to reconvene imminently.

[Matter Arising 6]

Conclusion:

2.31 We have concluded **Reasonable** assurance for this objective. Sample testing identified instances where fall incidents had not been investigated promptly, and the focused review was incomplete. Whilst there is evidence of scrutiny and lessons learned at Directorate level, there is no evidence that this learning is being shared across the wider Health Board. There is opportunity to address this gap through the Adult Inpatient Falls Reduction Improvement Group.

Objective 6: There is regular reporting and scrutiny of falls data at an appropriate forum.

2.32 The Quality, Safety & Experience Committee (QSEC) is responsible for providing assurance to the Board that lessons are learned from patient safety incidents. Patient safety incident statistics are reported to QSEC via the Quality and Safety Assurance (QS&A) reports on a bi-monthly basis, with a more detailed update on falls presented every six months.

2.33 The QS&A report to the June 2022 meeting provided an update on the falls improvement work, including the development of the Falls Strategy, and cited examples of how the Quality Improvement & Practice Development Team have engaged in falls improvement activity with wards in Glangwili and Prince Philip hospitals.

Conclusion:

2.34 Noting the above, we have concluded **Substantial** assurance for this objective.

Appendix A: Management Action Plan

Matter Arising 1: Falls Policy (Operation)	**Impact**
Health Board Policy 401 *'Preventing Falls and Post Fall Care in Inpatient Areas Policy'* (the 'Falls Policy') was due for review in 2018. We were advised that this will be undertaken by Adult Inpatient Falls Reduction Improvement Group but has been delayed due to service pressures and staff absence. The Falls Policy is generally consistent with the principles of the NICE guidance and current practice across the Health Board. However, sample testing of risk assessments highlighted that the policy isn't clear about the multifactorial falls risk assessment (MFRA) requirements for A&E and MIU patients and is silent on the requirement for a focused review of falls incidents assessed as moderate harm or greater. Comparison with other Welsh Health Board policies also identified opportunities for improvement, including incorporating guidance on the actions to be taken on patient admission and stipulating timescales for completion, review, and update of the patient's MFRA.	Potential risk of: • Staff are not aware of and therefore are non-compliant with falls prevention and management requirements, potentially resulting in recurrent incidents and patient harm.

Recommendations		**Priority**
1.1a	Review and update the policy to ensure it accurately reflects current practice for the prevention and management of falls.	**Medium**
1.1b	Consider re-launching the updated policy with an awareness campaign to ensure all clinical staff are au fait with the requirements	

Agreed Management Action		**Target Date**	**Responsible Officer**
1.1a	In-patient falls group set up and Task & Finish group established to update Falls Policy.	31 December 2022	Head of Nursing, Scheduled Care
1.1b	Falls policy following completion to be ratified through relevant Goverance committees. Relaunch following approval	28 February 2023	Head of Nursing, Scheduled Care

Matter Arising 2: Risk Assessments (Operation)	**Impact**
Sample testing of falls incidents identified instances where there was no evidence that an MFRA had been completed, and in some cases whilst an MFRA was in place, it had been completed up to 38 days after patient admission. We were advised that the MFRA should be completed within 6 hours of admission, although this is not reflected in the Falls Policy (see Matter Arising 1).	Potential risk of: • Failure to identify and mitigate falls risks, potentially resulting in recurrent falls incidents and patient harm • Financial loss and reputational damage arising from redress incidents and negligence claims

	Recommendations	**Priority**
2.1a	An MFRA must be completed for all eligible patients (as identified in the NICE guidance and Health Board Falls Policy) within 6 hours of admission.	**High**
2.1b	Consider implementing independent checking controls to ensure the existence and quality of MFRAs, particularly in falls 'hot spots'. This control has been observed at other Welsh Health Boards.	

	Agreed Management Action	**Target Date**	**Responsible Officer**
2.1a	Staff reminded of the importance of completing the MFRA on admission in line with guidance. Through professional forums, Practice Development Nurses on sites and monitored through site scrutiny meetings	31 December 2022	HoN each site / Quality Improvement and Practice Development Teams
2.1b	Spot check audits of MFRA quality and forms to be undertaken quarterly and actions fed back to relevant sites. Action to be monitored through PNMF The audit findings will be included as an agenda item to enable discussion with the Heads of Nursing and the Executive Director of Nursing will write to Senior Nurse Management Team members to highlight the findings and necessary actions.	31 January 2023	Quality Improvement and Practice Development Teams

Matter Arising 3: Development of the Falls Strategy (Design)			**Impact**
Development of the Strategy commenced in 2021 and we acknowledge that progress has been impacted by service pressures. There is no delivery plan in place identifying key milestones or timescales for completion, although progress is reported bi-annually to QSEC as part of the Quality & Safety Assurance Report with the most recent update provided in June 2022.			Potential risk of: • inadequate falls prevention activity, potentially resulting in recurrent falls and patient harm.
Recommendations			**Priority**
3.1	Develop a delivery plan for the Falls Strategy identifying key milestones and timescales for completion. This should form the basis of progress monitoring to QSEC.		**Medium**
Agreed Management Action		**Target Date**	**Responsible Officer**
3.1	Delivery plan will be developed in line with frailty work which is being taken forward via Transforming Urgent and Emergency care programme	30 April 2023	Assistant Director of Nursing for Quality Improvements/ Director for Transforming Urgent Care Programme Board

Matter Arising 4: Falls Prevention & Management Training (Design)			**Impact**
There is no Health Board-wide training programme for falls prevention and management.			Potential risk of: • Staff are not aware of and therefore are non-compliant with falls prevention and management requirements, potentially resulting in recurrent incidents and patient harm.
Recommendations			**Priority**
4.1	Develop and implement a falls prevention and management training programme. This should form part of the Health Board's Falls Strategy.		**Medium**
Agreed Management Action		**Target Date**	**Responsible Officer**
4.1	Quality Improvement Practitioner (falls lead). Is working with the national falls task force to identify an e-learning training package. Once training package is ratified then it will be aligned to our internal falls strategy.	30 April 2023	Quality improvement Practitioner

Matter Arising 5: Falls Incidents (Operation)	**Impact**
Sample testing of 15 falls incidents identified that all but one had been investigated, although in eight cases the investigation was initiated more than 30 days after the incident, with two in particular taking 84 and 36 days respectively. The incident awaiting investigation was reported in December 2021 and graded as 'moderate harm'. Datix requires completion of a 'focused review' for falls incidents resulting in 'moderate harm'. This includes a series of falls-specific questions around the MFRA (including whether it had been implemented as planned and updated following the fall), falls prevention activities and post fall management. This review had been fully completed for eight of the 14 investigated incidents (all 'moderate', 'severe' or 'catastrophic' harm), and partially completed (only confirming that an MFRA was in place at the time of the fall) for a further three.	Potential risk of: • Poor quality incident investigation impacting on learning • Failure to identify and mitigate falls risks, potentially resulting in recurrent falls incidents and patient harm • Financial loss and reputational damage arising from redress incidents and negligence claims

Recommendations		**Priority**
5.1	Monitoring/review of falls incidents to identify those not investigated in a timely manner and non-compliance with the requirement for focused review. Issues identified should be addressed with the responsible individual(s), with action taken for repeated non-compliance where appropriate.	**Medium**

Agreed Management Action		**Target Date**	**Responsible Officer**
5.1	Scrutiny meetings to be reviewed and Terms of reference will be updated to include monitoring of falls incidents and quality of the investigation. Action identified to be reviewed at each meeting	31 January 2023	Quality Improvement Practitioner

Matter Arising 6: Sharing of Lessons Learned (Design)	**Impact**
Whilst there is evidence of shared learning at Directorate level via scrutiny and QSE Groups, there is no evidence that this learning is shared across the wider Health Board.	Potential risk of: • Poor quality incident investigation impacting on learning • Failure to identify and mitigate falls risks, potentially resulting in recurrent falls incidents and patient harm • Financial loss and reputational damage arising from redress incidents and negligence claims

Recommendations		**Priority**
6.1	Review existing governance arrangements for falls prevention and management and identify an appropriate forum for Health Board-wide sharing of lessons learned.	**Medium**

Agreed Management Action		**Target Date**	**Responsible Officer**
6.1	The Goverance arrangements will be considered via the In-patient falls group and discussed with Assistant Director of Assurance and Risk	31 December 2022	Assistant Director of Nursing for Quality, Assurance & Professional Regulation

Appendix B: Assurance opinion and action plan risk rating

Audit Assurance Ratings

We define the following levels of assurance that governance, risk management and internal control within the area under review are suitable designed and applied effectively:

	**Substantial assurance**	Few matters require attention and are compliance or advisory in nature. **Low impact** on residual risk exposure.
	**Reasonable assurance**	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved.
	**Limited assurance**	More significant matters require management attention. **Moderate impact** on residual risk exposure until resolved.
	**No assurance**	Action is required to address the whole control framework in this area. **High impact** on residual risk exposure until resolved.
	**Assurance not applicable**	Given to reviews and support provided to management which form part of the internal audit plan, to which the assurance definitions are not appropriate. These reviews are still relevant to the evidence base upon which the overall opinion is formed.

Prioritisation of Recommendations

We categorise our recommendations according to their level of priority as follows:

Priority level	Explanation	Management action
High	Poor system design OR widespread non-compliance. Significant risk to achievement of a system objective OR evidence present of material loss, error or misstatement.	Immediate*
Medium	Minor weakness in system design OR limited non-compliance. Some risk to achievement of a system objective.	Within one month*
Low	Potential to enhance system design to improve efficiency or effectiveness of controls. Generally issues of good practice for management consideration.	Within three months*

* Unless a more appropriate timescale is identified/agreed at the assignment.

NHS Wales Shared Services Partnership
4-5 Charnwood Court
Heol Billingsley
Parc Nantgarw
Cardiff
CF15 7QZ

Website: Audit & Assurance Services - NHS Wales Shared Services Partnership