CYLCHLYTHYR IECHYD CYMRU

Dyddiad Cyhoeddi: 6 Ebrill 2016

Llywodraeth Cymru
Welsh Government

STATWS: CYDYMFFURFIO

CATEGORI: Llythyr Prif Swyddog Nyrsio / Prif Swyddog Meddygol Gweithredol

Teitl:

Egwyddorion, Fframwaith a Dangosyddion Cenedlaethol: Codymau Cleifion Mewnol sy'n Oedolion

Dyddiad Dod i ben / Dyddiad yr Adolygiad:

D/B

I'w weithredu gan:

Byrddau ac Ymddiriedolaethau Iechyd

Angen gweithredu erbyn:

Ar unwaith

Anfonwr:

Yr Athro Jean White, Prif Swyddog Nyrsio / Dr Chris Jones, Prif Swyddog Meddygol Gweithredol

Enw(au) Cyswllt GIGC Llywodraeth Cymru :

Martin Semple, Cyfarwyddiaeth Nyrsio, Grŵp Iechyd a Gwasanaethau Cymdeithasol, Llywodraeth Cymru, Parc Cathays 2, CF10 3NQ; 02920 823198

Dogfennau amgaeedig:

Egwyddorion, Fframwaith a Dangosyddion Cenedlaethol: Codymau Cleifion Mewnol sy'n Oedolion

Cyflwyniad

Codymau yw'r digwyddiadau clinigol yr adroddir amdanynt amlaf ymysg cleifion sy'n oedolion, ac maent yn her sylweddol i'r GIG yng Nghymru o ran diogelwch cleifion. Adroddir am fwy na 240,000 mewn ysbytai acíwt ac ymddiriedolaethau iechyd meddwl yng Nghymru a Lloegr bob blwyddyn (sef dros 600 y dydd)[1]. Gall effeithiau codymau amrywio o ddim niwed o gwbl i anaf difrifol a marwolaeth. Fodd bynnag, gall hyd yn oed y codymau hynny, nad ydynt yn arwain at niwed difrifol, achosi llawer iawn o ofid, yn enwedig i bobl sy'n oedrannus a/neu eiddil, gan arwain at ganlyniadau sy'n bygwth annibyniaeth yr unigolyn. Gan fod oedran cyfartalog cleifion yn codi mae nifer y codymau sy'n gysylltiedig â digwyddiadau difrifol yn cynyddu; felly, mae'n amserol i sicrhau bod y mesurau diogelu angenrheidiol yn eu lle ac yn cael eu cyflawni, er mwyn lleihau nifer y codymau ar draws yr holl fyrddau iechyd yng Nghymru.

Bydd codymau difrifol yn anochel yn ymestyn hyd yr amser y bydd angen i glaf aros mewn ysbyty a gallant arwain at anabledd parhaol a lleihad yn annibyniaeth y claf. Yn 2007, amcangyfrifwyd bod cost uniongyrchol codymau cleifion i'r GIG yng Nghymru a Lloegr dros £15 miliwn y flwyddyn[2]. Bydd costau yn fwy erbyn hyn a bydd cost ychwanegol gofal iechyd, yn ystod ac yn dilyn rhyddhau o'r ysbyty, yn cynyddu'r ffigur hwn yn sylweddol.

Mae ymchwil wedi dangos y gall ymyriadau lluosog, a gyflawnir gan dimau amlddisgyblaethol ac sydd wedi eu teilwrio i'r claf unigol, leihau codymau o 20-30%. Mae'r ymyriadau hyn yn neilltuol o bwysig i gleifion â dementia neu ddeliriwm, sydd mewn perygl mawr o gael codymau mewn ysbyty.

Er mai ar godymau cleifion mewnol y mae'r cylchlythyr hwn yn canolbwyntio, dylai byrddau ac ymddiriedolaethau iechyd barhau i ystyried gweithgareddau cyfannol ar gyfer codi ymwybyddiaeth o godymau ac atal codymau ar draws lleoliadau eraill, gan gynnwys gofal sylfaenol a chymunedol.

[1]Coleg Brenhinol y Meddygon. *National audit of inpatient falls Audit report* 2015. Llundain: RCP, 2015.
[2] Asiantaeth Genedlaethol Diogelwch Cleifion. *Slips trips and falls in hospital.* Llundain: NPSA, 2007

Pwrpas y Cylchlythyr hwn yw:

- Lledaenu dogfen 'Egwyddorion, fframwaith a dangosyddion cenedlaethol: codymau cleifion mewnol sy'n oedolion'

- Hybu adolygu meddyginiaethau cleifion sydd wedi syrthio neu mewn perygl o gael codwm a thynnu sylw gweithwyr iechyd proffesiynol at ddogfennau canllaw sydd ar gael gan Grŵp Strategaeth Meddyginiaethau Cymru Gyfan ynghylch polyfferylliaeth a defnyddio therapi bisffosffonad drwy'r geg, tymor hir, yn ddiogel.

- Atgoffa byrddau ac ymddiriedolaethau iechyd beth yw'r gofynion o ran adrodd am godymau a digwyddiadau difrifol wrth Lywodraeth Cymru.

- Atgoffa byrddau ac ymddiriedolaethau iechyd y disgwylir iddynt ddefnyddio'r Safon Iechyd a Gofal ar gyfer atal codymau.

- Tynnu sylw at raglen Archwilio Codymau a Thoresgyrn Brau (FFFAP), a cheisio cael byrddau ac ymddiriedolaethau iechyd i weithredu a sicrhau eu bod yn cydymffurfio.

Mae'n ofynnol i fyrddau ac ymddiriedolaethau iechyd wneud y canlynol:

- Nodi a gweithredu'r holl ofynion yn y Cylchlythyr hwn
- Prif Weithredwyr i ymateb i'r cylch adrodd a eglurwyd yn y ddogfen Egwyddorion, Fframwaith a Dangosyddion Cenedlaethol: Codymau Cleifion Mewnol sy'n Oedolion
- Enwi arweinydd gweithredol a chlinigol sy'n atebol am ddiogelwch cleifion mewnol mewn perthynas â chodymau ac atal codymau
- Enwi a hysbysu Llywodraeth Cymru am fforwm bwrdd/ymddiriedolaeth iechyd sy'n gyfrifol am sicrhau bod gofynion y Cylchlythyr hwn yn cael eu gweithredu
- Dylai byrddau ac ymddiriedolaethau iechyd anfon manylion arweinwyr codymau a fforymau codymau i MajorHealthConditions@wales.gsi.gov.uk ddim hwyrach na 31 Mai 2016.

Egwyddorion, Fframwaith a Dangosyddion Cenedlaethol: Codymau Cleifion Mewnol sy'n Oedolion

(Dosberthir gyda'r Cylchlythyr hwn)

Sefydlwyd Grŵp Cymru Gyfan, yn cynnwys cynrychiolwyr arweinwyr amlddisgyblaethol codymau mewn byrddau ac ymddiriedolaethau iechyd a chynrychiolwyr Llywodraeth Cymru, ym mis Mehefin 2013 er mwyn datblygu casgliad o ddangosyddion cenedlaethol ar gyfer codymau cleifion mewnol sy'n oedolion. Bydd y dangosyddion yn darparu dull safonedig o ymdrin â chodymau cleifion mewnol a chasglu data, fydd yn cyfrannu at ddeall codymau'n well.

Mae gwaith y Grŵp wedi cynnwys adolygu'r sylfaen o dystiolaeth sydd wedi ei chrynhoi o fewn y ddogfen. Mae'r ddogfen yn darparu'r canlynol ar gyfer byrddau ac ymddiriedolaethau iechyd:

- Fframwaith ar gyfer asesu unigolyn
- Meini prawf cenedlaethol ar gyfer asesiad amlffactoraidd
- Meini prawf cenedlaethol ar gyfer ymyriad amlffactoraidd
- Casgliad cenedlaethol o ddangosyddion ar gyfer Cymru
- Meysydd data cenedlaethol safonedig ar gyfer adrodd am godymau
- Hybu 'Gwella Ansawdd Gyda'n Gilydd lefel Arian' lleol

Camau gweithredu ar gyfer byrddau ac ymddiriedolaethau iechyd:

Mewn ymateb i'r ddogfen hon, disgwylir i fyrddau ac ymddiriedolaethau iechyd wneud y canlynol:

- Lledaenu'r ddogfen newydd sy'n dwyn y teitl '*Egwyddorion, fframwaith a dangosyddion cenedlaethol: codymau cleifion mewnol sy'n oedolion'* ymhlith staff clinigol a staff llywodraethu clinigol
- Ystyried a gweithredu'r arweiniad ar asesu ac ymyrryd mewn cysylltiad ag atal a rheoli codymau
- Defnyddio'r dangosyddion cenedlaethol gros, y tynnir sylw atynt yn y ddogfen, i adrodd am godymau drwy system Datix

Rhagnodi Addas

Fel y trafodwyd yn gynharach, gall codymau arwain at anafiadau difrifol gan gynnwys toresgyrn. Mae arwyddocâd y codymau mwyaf difrifol hyn yn waeth i bobl hŷn, yn nhermau'r gofal y bydd arnynt ei angen a'r symudedd a'r annibyniaeth y byddant efallai yn eu colli. Mae swyddogaeth rhagnodi priodol yn bwysig o ran atal codymau a lleihau'r perygl o dorri asgwrn.

Adolygu Meddyginiaethau

Dylid ystyried adolygu meddyginiaethau fel rhan o asesiad amlffactoraidd cleifion sydd mewn perygl o syrthio.

Mae'n hysbys bod rhai meddyginiaethau yn gysylltiedig â mwy o risg o gael codwm. Dylid adolygu a yw meddyginiaethau yn dal yn addas yn achos pob claf sydd wedi syrthio neu sydd mewn perygl o gael codwm.

Rhydd dogfen Grŵp Strategaeth Meddyginiaethau Cymru Gyfan (AMWSG), sy'n dwyn y teitl *Polypharmacy Guidance for Prescribing,* wybodaeth bellach ar adolygu meddyginiaeth ac yn enwedig meddyginiaethau sy'n gysylltiedig â chodymau.

Rhagnodi ar gyfer Pobl sydd mewn Perygl Mawr o Doresgyrn Osteoporotig

Bydd y dewis priodol o therapi yn dibynnu ar amrywiaeth o ffactorau. Rhydd dogfen AWMSG, sy'n dwyn y teitl *Guidance to Support the Safe Use of Long-term Oral Bisphosphonate Therapy*, gyngor ynglŷn â rhagnodi bisffosffonadau drwy'r geg yn briodol, eu gweini a'u hadolygu; ac amgylchiadau lle dylid gofyn am gyngor arbenigol ynghylch dewisiadau eraill o driniaeth (pigiad bisffosffonad, raloxifene, strontium ranelate, denosumab neu teriparatide).

Camau gweithredu ar gyfer byrddau ac ymddiriedolaethau iechyd:

- Sicrhau bod trefniadau yn eu lle ar gyfer adolygu priodoldeb rhagnodi meddyginiaethau yr ydym yn gwybod eu bod yn cynyddu'r perygl o godymau mewn cleifion sydd wedi cael codwm neu mewn perygl o syrthio;
- Sicrhau bod cleifion sydd mewn perygl mawr o dorasgwrn osteoporotig yn cael cynnig therapi addas yn unol ag arweiniad AWMSG.

Safonau Iechyd a Gofal, Adrodd am Ddigwyddiadau Difrifol, a Rhaglen Archwilio Codymau a Thoresgyrn Brau.

Safonau Iechyd a Gofal

http://gov.wales/docs/dhss/publications/150402standardsen.pdf

Y Safonau Iechyd a Gofal sy'n ffurfio conglfaen y system gyffredinol o sicrhau ansawdd yn y GIG yng Nghymru. Mae'r Safonau Iechyd a Gofal yn darparu fframwaith y gellir ei ddefnyddio i ganfod cryfderau a thynnu sylw at feysydd i'w gwella. Fe'u bwriadwyd i gael eu defnyddio mewn ymarfer o ddydd i ddydd er mwyn annog lefel gyson o ansawdd a diogelwch ar draws yr holl wasanaethau a hybu ymarfer effeithiol a chyson, cyfredol. Mae arweiniad i gyd-fynd â'r rhain wedi ei gyhoeddi ar E-Lawlyfr Llywodraethu GIG Cymru.

Mae Safon Iechyd a Gofal 2.3 yn ymwneud ag atal codymau. Mae'r safon yn ymwneud â lleihau'r perygl i bobl syrthio ac mae'n hybu asesu ystod o ffactorau y gwyddom eu bod yn cynyddu'r perygl o syrthio, yn ogystal â phwysigrwydd datblygu cynlluniau gofal unigol gyda'r nod o atal unigolion rhag cael codymau ac felly leihau niwed ac anabledd. Mae'n bwysig i fyrddau ac ymddiriedolaethau iechyd fesur eu perfformiad presennol yn erbyn y safon ac wedyn cymryd y camau angenrheidiol i sicrhau bod y safon yn cael ei chyrraedd.

Mae'r Fframwaith a ddiweddarwyd ar gyfer Sicrhau Profiad Defnyddwyr Gwasanaeth (2015) (http://gov.wales/docs/dhss/publications/151231whc061en.pdf), sy'n cysylltu â'r safonau, yn gymorth i sicrhau bod pobl yn cael argraffiadau cyntaf a pharhaol sy'n gadarnhaol, eu bod yn derbyn gofal mewn amgylcheddau diogel, cefnogol a iachusol, a'u bod yn deall ac yn cymryd rhan yn eu gofal.

Adrodd am Ddigwyddiadau Difrifol Cysylltiedig â Chodymau

http://www.wales.nhs.uk/sites3/docopen.cfm?orgid=932&id=170588

Mae arweiniad *Gweithio i Wella* yn disgrifio'r trefniadau i adrodd am bryderon sy'n ddigwyddiadau difrifol o safbwynt diogelwch cleifion (y cyfeirir atynt yn yr adran hon fel digwyddiadau difrifol). Mae diffiniad digwyddiad difrifol yn cael ei egluro yn y ddogfen.

Rhydd yr arweiniad enghreifftiau o ddigwyddiadau difrifol y mae'n rhaid adrodd amdanynt wrth Lywodraeth Cymru; mae enghreifftiau'n cynnwys codymau cleifion sy'n cyfrannu at niwed enbyd a marwolaeth.

Mae'r nifer o godymau cleifion yr adroddir amdanynt drwy'r system hon yn cynyddu. Fodd bynnag, oddi wrth y data a roddir, gellir casglu nad yw'r holl fyrddau ac ymddiriedolaethau iechyd yn adrodd am godymau cleifion mor gyson ag y disgwylid.

Rhaglen Archwilio Codymau a Thoresgyrn Brau (FFFAP)

Rhaglen archwilio glinigol genedlaethol yw Rhaglen Archwilio Codymau a Thoresgyrn Brau (FFFAP) a drefnir gan Goleg Brenhinol y Meddygon. Cynlluniwyd y rhaglen i archwilio'r gofal y mae cleifion â thoresgyrn brau a chodymau cleifion mewnol yn ei dderbyn yn yr ysbyty a hyrwyddo gwelliant yn ansawdd y gofal.

Mae'r rhaglen archwilio'n cynnwys tair ffrwd waith a'r rhain yw:

Archwiliad Cenedlaethol o Godymau Cleifion Mewnol

https://www.rcplondon.ac.uk/projects/falls-workstream-national-audit-inpatient-falls

Cronfa Ddata Genedlaethol ar gyfer Torasgwrn y Glun (NHFD)

http://www.nhfd.co.uk/nhfd/nhfd2015reportPR1.pdf

Cronfa Ddata Gwasanaeth Cyswllt Toresgyrn (FLS-DB)

https://www.rcplondon.ac.uk/node/1520

Rhydd yr archwiliadau hyn ddata pwysig y dylai byrddau ac ymddiriedolaethau iechyd fod yn ei ddefnyddio i adolygu ac i fod yn sail i arferion fydd yn gwella gofal a diogelwch cleifion. Gellir gweld yr adroddiadau diweddaraf drwy ddefnyddio'r dolenni cyswllt a ddarparwyd.

I'w nodi - Cryfhau'r trefniadau ar gyfer monitro pa mor dda y mae byrddau / ymddiriedolaethau iechyd yn gweithredu canfyddiadau ac argymhellion archwiliadau. Bydd Pwyllgor Ymgynghorol Archwilio Clinigol ac Adolygu Canlyniadau Cenedlaethol Llywodraeth Cymru dan gadeiryddiaeth yr Athro Peter Barrett-Lee yn cynnal hapwiriadau rheolaidd o archwiliadau unigol o fis Mawrth.

2016 ymlaen. Yr archwiliadau cyntaf i gael eu hadolygu fydd archwiliad cenedlaethol torasgwrn y glun a'r archwiliad codymau a gyhoeddodd adroddiadau yn 2015.

Camau gweithredu ar gyfer byrddau ac ymddiriedolaethau iechyd:

- Byrddau ac ymddiriedolaethau iechyd i asesu yn erbyn Safon Iechyd a Gofal 2.3 ar gyfer atal codymau a darparu sicrwydd eu bod yn cydymffurfio drwy eu systemau sicrhau ansawdd gan gynnwys i'r bwrdd
- Sicrhau yr adroddir yn brydlon am bob digwyddiad difrifol yn unol ag arweiniad *Gweithio i Wella*
- Adolygu canfyddiadau a gweithredu argymhellion rhaglen archwilio FFFAP gyda'r bwriad o wella'r canlyniadau ar gyfer diogelwch cleifion, a ddangosir drwy berfformiad gwell mewn canlyniadau archwiliadau

Principles, framework and national indicators: adult in-patient falls

Endorsed by

British Geriatric Society Cymru/Wales Falls Special Interest Group

TABLE OF CONTENTS

MEMBERSHIP

Development Group:

Chair	Denise Shanahan-	Cardiff and Vale UHB (nursing)
Vice Chair	Paul Labourne-	Powys Teaching Health Board (nursing)
Swapna Alexander-		Betsi Cadwaladr UHB (medical)
Debbie Davies -		Cwm Taf UHB (therapies- WTAC)
Sarah Jones-		Public Health Wales
Alison Lewis -		Aneurin Bevan UHB (nursing)
Anya Pinhorn-		Powys Teaching Health Board (medical)
Iain Roberts -		Public Health Wales (service improvement)
Amanda Ryan -		Cardiff and Vale UHB (nursing)
Helen Tyler -		Velindre NHS Trust (therapies)
Gill Webber -		Hywel Dda UHB (nursing)
Beverly Wilding-		Cwm Taf UHB (nursing)

Contributors:

Sian Bolton-	Public Health Wales
Alyson Charnock-	Abertawe Bro Morgannwg UHB (nursing)
Helen Griffiths-	Abertawe Bro Morgannwg UHB (nursing)
Anne Owens-	NHS Wales Informatics Service
Sean Page-	Betsi Cadwaladr UHB (nursing)
Mandy Tyler-	Aneurin Bevan UHB (therapies)
Natalie Vanderlinden-	Hywel Dda UHB - Assistant Director of Therapies & Health Science (Director of Therapies & Health Science Representative)
Maureen Wolfe-	Betsi Cadwaladr UHB (nursing)
Nicola Job-Davies	Royal College of Nursing

SITUATION

The Chief Nursing Officer for Wales directed, under the Free to Lead Free to Care Post Implementation Group, a Working Group to develop a suite of national indicators for adult in-patient falls.

The All-Wales Group, including representation from other falls multi-disciplinary work streams and leads, has met since June 2013 and this paper sets out the recommendations to date.

The Indicators are evidence-based and designed to be captured and reported via the national e-datix system. Full benefits of reporting will require data integration.

BACKGROUND

Falls are the most frequently reported adult in-patient clinical incident. There is no standardised reporting mechanism of in-patient falls within or across Wales. The adverse effects of falls range from no physical harm to catastrophic injury and death with psychological sequelae common.

Extensive work has been undertaken in Wales by the 1000 Lives Falls Community Collaborative demonstrating the benefits of a standardised approach. As the Collaborative has focused on community falls, the Chief Nursing Officer for Wales recognised that a standardised approach for in-patient falls will bring benefits to better understand in-patient falls and the response. It should be recognised that the evidence base for community falls and in-patient falls assessments and interventions differ significantly.

The strategic drivers include UK (1, 2, 3, 4, 5) and Welsh priorities (6, 7, 8) which seek to report on falls, mitigate risks of falls and reduce harm from falls.

---

[1] NPSA Slips Trips and Falls in hospital, 2007

[2] Cochrane Collaboration, 2012

[3] NICE CG 161, 2013

[4] NPSA RR01, 2011

[5] RCP Recommendations from the falls and bone health audit and

[6] Burden of Injury

[7] NSF for Older People, 2003

[8] Health and Care Standards 2015

ASSESSMENT

The first task of the Chair of the Group was to establish membership and together with the Vice Chair, invitations were sent to each Health Board and Trust and Public Health Wales (PHW).

At the first meeting 23rd June 2013, the membership was discussed and other representatives invited to broaden this membership. The Terms of Reference were agreed through face to face meetings and e-communication. With the challenges of All Wales working face to face, consultation on issues was undertaken through e-communication where applicable. Underpinning key principles, for example, promoting individualised care, and recognising the risk of unintended consequences were agreed.

The evidence-base was reviewed and summarised and a matrix developed. The evidence base for stratification of risk using falls risk prediction tools is not valid for in-patients and should not be used. A multi-factorial assessment (MFA) to modify risks as part of patient centred multi-factorial interventions (MFI) is recommended.

A one day workshop, facilitated by PHW was held on 6th December 2013. The aim was to firmly place the person at the centre of practice and was modelled on a patient scenario. The agreed outputs from the meeting were the framework for individual assessment, national criteria for Multi-Factorial Assessment (MFA), national criteria for Multi-Factorial Intervention (MFI) along with proposed gross indicators and national fields for reporting (datix), and Improving Quality Together (IQT) Silver examples. These have since been refined as the framework for individual assessment. A review of physical harm vs. immobility and glossary of terms have also been prepared.

Psychological harm, particularly fear of falling is a commonly recognised effect which may result in self-limiting behaviour, but the assessment of this is beyond the scope of this set of Indicators.

RECOMMENDATIONS

That the Free to Lead Free to Care post implementation steering group is asked to note the following:

- Membership
- Terms of reference
- Underpinning principles
- Evidence base

And consider and approve the following:

- Framework for individual assessment
- National criteria for Multi-factorial assessment (MFA)
- National criteria for Multi-factorial Intervention (MFI)
- Proposed national indicators for Wales (number of falls, number of people who have fallen 2 times or more, number of people who have fallen, level of harm)
- The adoption of standardised national datix fields for falls reporting
- To promote local 'Improving Quality Together Silver'

And consider and approve the following recommended next steps:

- Develop standardised national datix fields for falls reporting (these ultimately could be used for a falls information data set for research purposes)
- Development of a national reporting system for in-patient falls
- A national group to review the data, trends, injuries and compliance with mitigation
- Develop a data repository of anonymised falls data that can be interrogated as a research tool

Underpinning Key Principles:

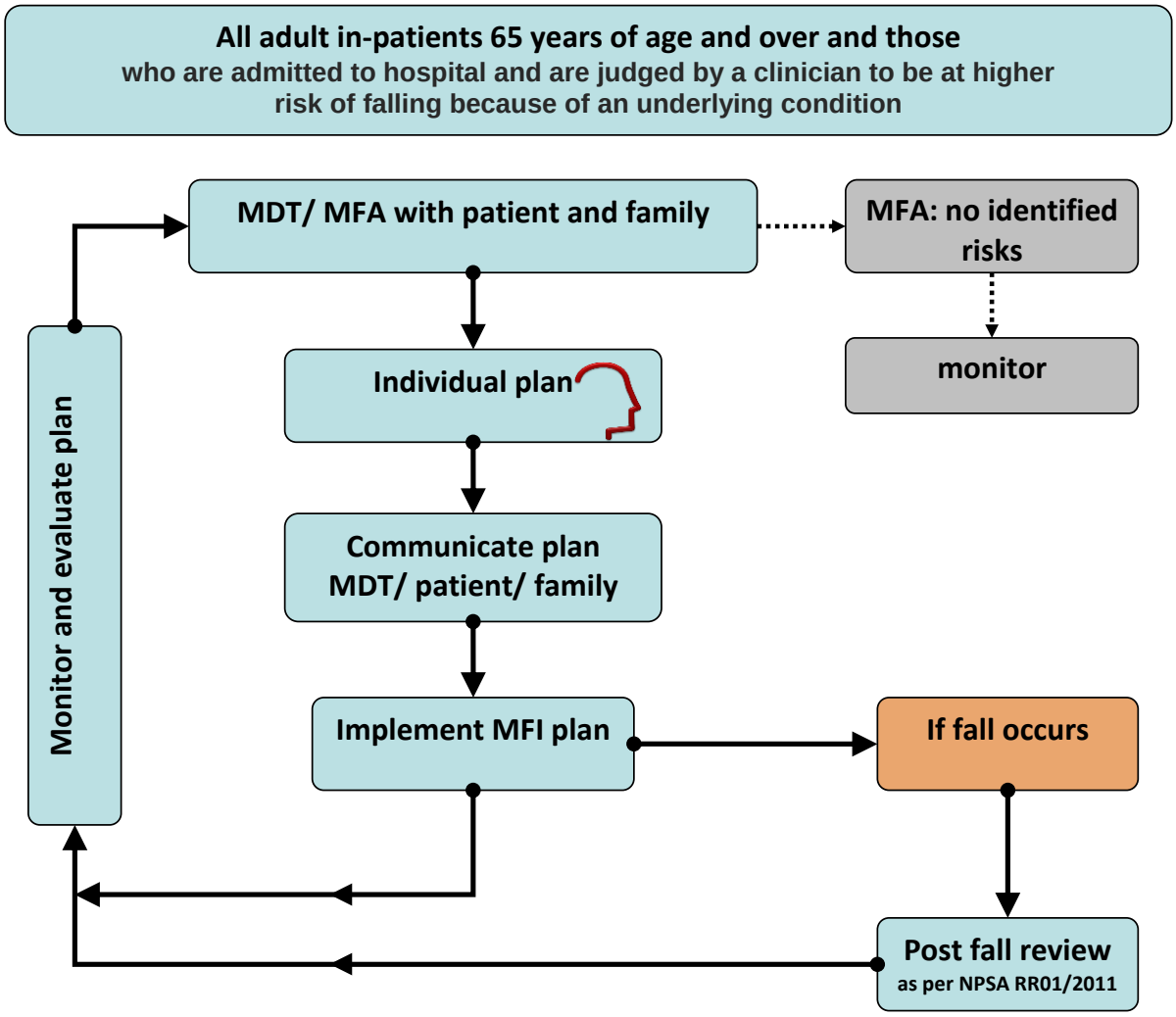
FRAMEWORK FOR INDIVIDUAL ASSESSMENT

Abbreviations:

MDT- Multi Disciplinary Team

MFA - Multi-Factorial Assessment

MFI - Multi-Factorial Interventions



NATIONAL CRITERIA FOR MULTI-FACTORIAL ASSESSMENT AND INTERVENTIONS

National Criteria for Multi-Factorial Assessment (MFA)

Initial assessment to be documented for any patient in hospital with intention to assess or admit for greater than 6 hours (excluding day case activity).

- Multi-Factorial Assessment (MFA) must include:
  - Falls history* and bone health
  - Cognitive impairment* and delirium review
    - dementia, confusion, ability to maintain own safe environment
  - Physiological assessment and examination
    - e.g. lying and standing BP, cardiac, delirium screen if appropriate
  - Medication* review
  - Gait and balance (postural instability, mobility problems and/ or balance problems*)
  - Sensory deficits
    - Vision*, hearing, numbness
  - Toileting* and non verbal indicators of need
  - Foot wear* and foot health

  * Aligns to National Institute for Health and Care Excellence Clinical Guideline 161
- Re-assessment is mandatory:
  - On transfer to different area
  - With change in condition
  - Following a fall

- **Ongoing** proportionate and timely multidisciplinary assessment
- **Ongoing** appropriate review of the multi-factorial assessment

National Criteria for Multi-Factorial Intervention (MFI)

- Individualised person centred care and intervention plan following MFA
    - Commenced immediately following initial assessment
    - Progress of interventions and specialist assessments documented in clinical notes
- Multidisciplinary review of Multi-factorial assessment
- Environment
    - Position on ward
    - Position on ward in relation to toilet
- Equipment
    - Ultra low bed use/ availability
    - Use of bedrails
    - Alerts (movement senor equipment)

- Evidence of post fall protocol informed by NPSA RRR & and NICE clinical guidance
- Post fall multidisciplinary debrief/ safety round
- Undertake a post fall review for all patients and always undertake a root cause analysis investigation if a patient has come to harm.
- Incorporate not duplicate national and local pathways

    e.g. nutrition and hydration, continence bundle, delirium guidelines, dementia, pain assessment

PROPOSED INDICATORS

Gross Indicators:

Number of falls

Number of patients who have fallen

Number of patients who have fallen 2 or more times

Harm from fall

- Level of harm
- Type of physical harm (e.g. no physical harm, laceration, bruising, fracture neck of femur, spinal fracture, other fracture, head injury, death)

Local Indicators:

Investigation into injury from fall to include:

- Evidence of multi-factorial assessment undertaken
- Evidence of multi-factorial interventions implemented to mitigate modifiable factors
- Holistic assessment considering the '4Ps' principle[9] to identify increased dependency and need:
  - **Previous:** The patient's general circumstances, lifestyle and events leading up to the admission
  - **Present:** The patient's current condition
  - **Predict:** The factors likely to impact on completing a successful discharge for this patient
  - **Prevent:** The actions required to overcome problems and prepare the patient for discharge
- Post fall multidisciplinary debrief date
- Length of stay
  - This includes total length of stay from admission recorded in days
  - If less than 24 hours record in hours / minutes
  - Time in hours or days since transfer to a different clinical area/environment

[9] 'Passing the Baton - A Practical Guide to Effective Discharge Planning' available at: http://www.wales.nhs.uk/sitesplus/829/page/36467

PROPOSED NATIONAL DATIX FIELDS

To support drill down locally which can be used to support 'Improving Quality Together' Silver and provide a national research database

Date of admission	date
Date of fall	date
Time of fall	time
If fall with 24hrs of admission, how many hours since admission?	time
Area of ward fall took place (pick list)	choice

- room of bed
  - cubicle/ single room
  - shared 2-3
  - shared 4-6 beds
  - shared ≥7 beds
- corridor
  - toilet
  - ensuite
  - shared
- bathroom

Fall witnessed? (Yes/ No)	yes/ no
Staff on duty at time of fall:	

- RN — number
- HCSW — number
  - (consider others)

Fall from height (pick list)	choice

- over raised bed rail
- from trolley
- down steps
- other height

Does patient have diagnosis of dementia (Yes/No)	yes/ no
Does patient have cognitive impairment or delirium (Yes/No)	yes/ no

CONSIDERATION OF UNINTENDED CONSEQUENCES

Falls Versus Immobility: The Unintended Consequences

Risk averse cultures in in-patient settings that attempt to reduce the incidence of falls may cause unintended undesirable consequences potentially more harmful to the patient than a fall.

Covinsky *et al.* (2003) state, 'Bed rest, or inactivity associated with hospitalisation or disease state, poses a significant threat to muscle tissue and functional capacity. In older adults, physical inactivity during hospitalisation is almost an accepted part of the inpatient experience, yet clearly contributes to a host of negative outcomes'. It follows that adverse change in musculature for older people will increase their risk of falls.

Bed-based hospital care is common, especially in acute hospitals. The periods of the day when a person is in bed may form part of the overall falls risk reduction strategy. Similarly, patients who are sitting out in a chair may only be encouraged to move within specific parameters e.g. only if they call for assistance. The consequences of reducing a person's mobility either intentionally or unintentionally need to be fully understood and balanced against the risk of a harmful fall.

Even people who are fully capable of activity and at very little risk of fall do not move around in hospital as much as they would at home. Older people are even less likely to move around. In addition to the specific reason for admission, factors such as pain, disorientation, anxiety, the right clothing, or simply not knowing if it is *allowed* will reduce the amount of physical activity an older person undertakes in hospital. Changes to daily routines, e.g. breakfast in bed, use of wheelchair to be taken to the bathroom or not getting dressed, will have a significant impact on an older person's musculature.

Younger healthy individuals who are immobilized will lose up to 5% of their muscle strength each day (*de Morton et al., 2007*), with nearly half their muscle strength being lost within 3 – 5 weeks. Unfortunately, the loss of muscle bulk and the rate of loss for older people is much greater. Within a week of a hospital admission an older person who is nursed in bed may become as much as 50% weaker. The loss of muscle strength in older people results in a far more significant loss in function compared to their younger counterparts. Older people are 7 times more likely to develop severe limitations to their mobility as a consequence of this muscle loss compared to younger people. 63% of our very elderly patients (≥90 yrs) will lose their basic functional ability during a hospital stay (*Covinsky et al., 2003*).

Furthermore, older people often present to hospital with pre-existing Sarcopenia. Sarcopenia is an age-related, multi-factorial process that is phenotypically characterised by the loss of muscle mass. It has been described as low muscle mass and low muscle function (*Cruz-Jentoft et al., 2010*) and becomes increasing common with advancing age in older people. It is estimated that 1:20 people over 65 yr olds and 1:2 in those over 80 will develop sarcopenia. Whilst the onset of sarcopenia is insidious, its progression is greatly accelerated by and primarily attributed to physical inactivity. Sarcopenia is exacerbated by poor protein intake and low levels of vitamin D and is not isolated to traditional frail elderly but is also seen in older obese people who may be less active with a poor diet.

Aside from the affect on muscles, reduced mobility may results in other unintended consequences such as, decreased endurance, osteoporosis, joint contractures, and cardiovascular complications e.g. increased heart rate, decreased cardiac reserve, orthostatic hypotension and venous thrombosis. Even in small measures these factors will further increase the risk or the harm from falls.

Older people in hospital are therefore extremely vulnerable to the negative effects of reduced mobility and exercise.

Maintaining an activity level that prevents the decline in muscle loss should be factored into any falls prevention strategy. Weight bearing activities such as transfers and walking should form part of the fundamental care for an older person in hospital. The physiotherapist will be able to advise specific exercises (ideally resistance exercises) to support the care and rehabilitation programme.

Whilst exercise and activity can reverse the effects of muscle weakness recovery from muscle weakness is slower than the rate of loss with only 6% gain a week in those exercising at 65% - 70% capacity (*Dittmier and Teasell, 1993*). Unsurprisingly the rate is slower again in older people. The ability of an older person to recover muscle bulk and strength may take many months. To reduce their risk of falls, older people need to exercise regularly, totaling at least 50 hours over minimum of 12 weeks.

As a general rule, for every day an older person is in bed it may take up to 6-7 days of significant activity to regain the loss. For many older people the loss may be irretrievable.

Summary

Measures to reduce a person's risk of fall whilst in hospital may perversely result in iatrogenic harm resulting in short or long term unintended consequences.

With advancing age, it becomes increasingly likely that even a brief, clinically mandated period of rest could initiate a serious decline in muscle strength and functional capacity, i.e., a "tipping point" from which some may not fully recover (*English & Paddon-Jones, 2010*). Therefore, maintaining a level of mobility or physical activity for people who fall or are at risk of falls is a fundamental level of care that must be actively considered by the multidisiciplinary team and can be enhanced by specific physiotherapy exercises.

Professor Bernard Isaacs, the renowned Geriatrician quotes:

> *Sudden death from over-activity is much feared and rarely seen.*
> *Sudden death from under-activity is little feared and much seen.*

Author: Debbie Davies (Physiotherapist) MSc., MCSP on behalf of Welsh Therapies Advisory Committee

REFERENCES

Covinsky, K. E., Palmer, R. M., Fortinsky, R. H., Counsell, S. R., Stewart, A. L., Kresevic, D., Burant, C. J. and Landefeld, C. S. (2003) Loss of Independence in Activities of Daily Living in Older Adults Hospitalized with Medical Illnesses: Increased Vulnerability with Age. *Journal of the American Geriatrics Society*. 51: 451–458.

Cruz-Jentoft A.J., *et al*. (2010) Sarcopenia: European consensus on definition and diagnosis: Report of the European Working Group on Sarcopenia in Older People. *Age Ageing.* 39: 412-23

de Morton N., Keating J.L., Jeffs K. *Exercise for acutely hospitalised older medical patients*. Cochrane Database of Systematic Reviews 2007, Issue 1.

Dittmier D.K. and Teasell R. (1993) Complications of Immobilisation and bed rest. *Canadian Family Physician*. Vol. 39 pages 1428 - 1437

Isaacs, B. (1992) *The Challenge of Geriatric Medicine*. Oxford: Oxford University Press.

English, K.L. and Paddon-Jones, D. (2010) Protecting muscle mass and function in older adults during bed rest. *Current Opinion in Clinical Nutrition and Metabolic Care*. 13(1): 34-39. Available @ http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3276215/#R8

Post In-patient Fall Root Cause Analysis Template				
Datix reference:				
Patient Name:		**NHS number:**		
Investigating Officer	*Name:*	*Role:*		
	Signature:			
Date of Fall:				
Date Completed:				
Is there evidence of an initial multi-factorial assessment? *(For any patient in hospital with intention to assess or admit for greater than 6 hours)*			Yes	No
If **No** please complete a 5 Whys assessment.				
Is there evidence of appropriate review of the multi-factorial assessment?			Yes	No
If **No** please complete a 5 Whys assessment.				
Did the patient receive appropriate prophylactic interventions? *(For example: observable bed, intentional rounds as planned, was close supervision in place if planned)*			Yes	No
If **No** please complete a 5 Whys assessment.				
Were there any further factors or interventions that could have been considered? (*Were all MFI's actively being implemented appropriately at the time of the fall as highlighted by the multidisciplinary MFA and was the MFA to the standard expected)*			Yes	No
If **No** please complete a 5 Whys assessment.				
Did appropriate immediate post fall actions / interventions take place? *(Was the standard of treatment to the standard expected*)			Yes	No
If **No** please complete a 5 Whys assessment.				
What actions / learning can we gain from this fall?				
What is the plan for disseminating the learning?				

SUGGESTIONS FOR IMPROVING QUALITY TOGETHER

Improving Quality Together Silver:

- National indicators local reports: knowing the local position
- National data fields/local reports : where, when , who etc (use clinical dashboard)
- Co-production and patient engagement and involvement in their plan
- MFA implementation
- MFI implementation
- Learning derived from RCA
- Improvement tools:
    - Safety cross
    - Heat/ measles map
    - Pattern and trend analysis
    - Intentional rounds
    - Gate record of each fall intervention/ falls averting action has taken place
- Environmental assessment
    - Hand grab rails (contrast)
    - Toilet seat (contrast)
    - Floor coverings (carpets, non slip and contrast)
    - Toilet door (Stirling university / RNIB resources)
- Culture
    - Active understanding of verbal and non verbal requests of when a patient may wish to use the toilet

GLOSSARY OF TERMS

Acute Setting
A setting with onsite availability of the full range of diagnostic and therapeutic capabilities needed to diagnose and treat acute physical illnesses.

Assessment
An initial and ongoing process of identifying risk factors.

Bone health
A history of the number of fractures and sites; any bone scans or medication prescribed to protect bone health and concordance with this.

Carer
Where the term 'carer' is used, this refers to unpaid carers, not paid carers such as care workers.

Cognitive impairment
A term used to describe a condition involving problems with cognitive function that is their mental abilities such as thinking, knowing and remembering.

Datix
A risk management database used to record adverse events via incident reporting and supports concerns, claims and inquest processes.

Delirium
A clinical syndrome characterised by disturbed consciousness, cognitive function or perception, which has an acute onset and fluctuating course (previously called 'acute confusional state'). Hyperactive delirium is subtype of delirium characterised by people who have heightened arousal and can be restless, agitated and aggressive. Hypoactive delirium is subtype of delirium characterised by people who become withdrawn, quiet and sleepy.

Dementia
A progressive and largely irreversible clinical syndrome that is characterised by a widespread impairment of mental function.

Fall
'An event whereby an individual comes to rest on the ground or another lower level with or without loss of consciousness' (AGS/BGS 2001).

Falls history
A history of the number of falls in the last year including the mechanism of fall, likely cause and any resultant fractures informed by the patient, carer or family, care setting and medical notes.

Gait and balance
Gait is a term to describe the manner and style of walking. Balance, in relation to the upright posture, often refers to unsteadiness, when walking, where the regular pattern of walking is disturbed. It may also indicate a lack of co-ordination when transferring from one position to another.

Injurious fall
A fall resulting in a fracture or soft tissue damage.

Level of harm
1 None, 2 low, 3 moderate, 4 severe and 5 death as per the All Wales grading of concerns framework: Putting Things Right.

Mitigation
The elimination or reduction of the frequency, magnitude, or severity of exposure to risks, or minimisation of the potential impact of a threat or warning.
http://www.businessdictionary.com/definition/mitigation.html

Multidisciplinary
More than one healthcare professional from different disciplines.

Multi-factorial assessment
An assessment with multiple components that aims to identify a person's risk factors for falling.

Multi-factorial intervention
An intervention with multiple components that aims to address the risk factors for falling that are identified in a person's Multi-Factorial assessment. This may include a more in-depth or specialist assessment.

Non-acute setting
A setting focused on recovery and rehabilitation, symptom control or palliative care.

Older people
Older people are people aged 65 years and older.

Putting Things Right
Guidance produced for the NHS in Wales to enable responsible bodies to effectively handle concerns according to the requirements set out in the National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011 ("the Regulations").

Root cause analysis
A systematic investigation to identify how and why patient safety incidents happen. Analysis is used to identify areas for change and to develop recommendations which deliver safer care for patients.

Targeted
Interventions that are aimed at modifying a particular risk factor or factors.

Type of Physical harm
An assessment of obvious physical harm such as no physical harm, bruising, laceration, fracture, fracture neck of femur, spinal fracture, other fracture, head injury, death.

Unwitnessed fall
An individual has fallen but the mechanism of the fall was not witnessed. The patient is frequently found on the floor.

EVIDENCE BASE SUMMARY

Evidence Matrix	reduce/ prevent number of falls	reduce harm from falls	number of osteoporotic #	MFA	MFI	rehabilitation	Vitamin D	Physio/ exercise/ gait & balance	presence/ absence of carpet in sub acute hospitals	low bed use to reduce falls	sensor alarms to reduce falls	Symbol/ wrist band .	staff training/ guideline implementation	knowledge intervention for patient	falls risk scoring tools	hip protectors	provide oral and written information to patient and family	/environmental checks improvement	/post fall must be reviewed post fall protocol	policy & training on use of bedrails	Intentional rounding	serious injury screening	Delirium	Dementia care: voidance of prescribing antipsychotic medication for patients with	unintended/ perverse consequences	critical incident analysis	ensure relevant information is shared a cross service
NSF OP WAG (2003)	☑		☑	☑		☑																				☑	
Cochrane Collaboration (2012)	☑			☑	☑		☑	☑	☑	☒		☑	☒	☑		☑	☑								☑		
NICE (2013)	☑		☑	☑	☑	☑									☒		☑	☑						☑			
NPSA Slips Trips and Falls in hospital (2007)				☑	☑						☒	☒			☒	☒		☑	☑				☑				☑
Cochrane Collaboration (2012)										☒	☒																
NPSA Using bedrails safely and effectively (2007)																				☑							
NPSA RR01 (2011)				☑	☑													☑	☑								
FallSafe Care Bundles (2011)		☑		☑	☑																						
Safety First 'How to' guide for Reducing Harm from falls		☑													☒				☑				☑	☑	☑	☑	

NPSA the How to guide: reducing harm from falls in mental health inpatient settings		☑													☒				☑				☑	☑	☑	☑	
RCP Falling standards, broken promises (2010)		☑	☑	☑	☑	☑		☑											☑			☑	☑				
Kings College London																		☑			☑						
Intentional Rounding: a position paper (2012)																					☒						
Implementing failsafe (2012)				☑	☑						☒	☒					☒		☑								
AGS/BGS Clinical Practice Guideline (2010)				☑	☑		☑	☑										☑						☑			
Nursing Executive Centre (2009)		☑		☑	☑																	☑					
Fundamentals of Care	☑					☑																					
Safetylit.org search																											

KEY

☑ empirical evidence	no clear evidence either way
☑ evidence based practice recommendations	☑ practice guidelines - practice based evidence
☑ second stage assessment	☒ no evidence
☑ some evidence as part of MFI but not for individual interventions	☒ not recommended as practice based intervention

Indicator Specification Form

Performance Measure ID:	
Performance Measure Name:	Total Number of Adult in-Patient Falls Per Calendar Month

Description:
This is the total number of adult in-patient falls that have occurred in hospital during the calendar month

A fall is defined as 'An event whereby an individual comes to rest on the ground or another lower level with or without loss of consciousness' (AGS/BGS 2001)

In-patient setting is defined as in hospital with intention to assess or admit for greater than 6 hours excluding day case activity

Strategic Fit:
National Service Framework for Older People
The NHS '1,000 Lives Multiagency Community Falls Collaborative
Prudent Health Care
Improving Quality Together
Health and Care Standards

Operational Fit:
Reduction in hospital morbidity and mortality
Reduced organisational cost

Known Standards:
Assessment and prevention of falls in older people NICE Clinical Guidance 161 2013
Rapid Response Report NPSA/2011/RRR001: essential care after an inpatient fall

Reporting Format:
Ability to display results in a graph and table by single clinical area, a locally defined group of clinical areas, hospital and Health Board

Total number of falls on the y axis of the graph and name of the month on the x axis

Interpretation:
This is the total number of patient falls that have occurred in an inpatient setting during the calendar month

This is a single count and can only be interpreted as part of trend information for that given area

Calculation: total number

Numerator:	
Denominator:	
Data Source:	Each fall is individually entered into Datix as the incident occurs
Data Collection Frequency:	As fall occurs
Target:	There is no target

Fitness for Purpose:
The results of data capture for this indicator will be reviewed in December 2015 to ensure it is satisfying information requirements in respect of falls

This is an area specific trend analysis to provide initiation and base line for improvement work

Testing/Pilot:
Powys tHB

Information Governance:
Anonymised data with ability for ward staff to see patient details

Commercial Considerations:
None

Impact Assessment:
No extra time is required

Implementation Plan:
This indicator is currently collected

Maintenance:
The sponsor of this indicator is Chief Nursing Officer for Wales via Welsh Nursing and Midwifery Committee and Welsh Therapies Advisory Committee

A full review of this indicator will be undertaken in (eg June 2016) or earlier if deemed necessary

Performance Measure ID:	
Performance Measure Name:	Number of individual adult in-patients who have fallen 2 or more times

Description:
This is the number of individual adult in-patients who have fallen 2 or more times in the calendar month (for the previous 12 month period)

A fall is defined as 'An event whereby an individual comes to rest on the ground or another lower level with or without loss of consciousness' (AGS/BGS 2001)

In-patient setting is defined as in hospital with intention to assess or admit for greater than 6 hours excluding day case activity

Strategic Fit:
National Service Framework for Older People
The NHS '1,000 Lives plus' Multiagency Community Falls Collaborative
Prudent health Care
Improving Quality Together
Health and Care Standards

Operational Fit:
Reduction in hospital morbidity and mortality
Reduced organisational cost

Known Standards:
Assessment and prevention of falls in older people NICE Clinical Guidance 161 2013
Rapid Response Report NPSA/2011/RRR001: essential care after an inpatient fall

Reporting Format:
Trend graph for each area / service / locality/ individual patient as part of Integrated Governance Reports extracted from Datix

Interpretation:
This is a single count and can only be interpreted as part of trend information for that given area- for service improvement

Calculation:
None

Numerator:	
Denominator:	
Data Source:	Datix
Data Collection Frequency:	At the point of each fall within Datix
Target:	None

Fitness for Purpose:
This is a area specific trend analysis to provide initiation and base line for improvement work

Information Governance: Anonymised data with ability for ward staff to see patient details (research possibilities)
Commercial Considerations: Datix
Impact Assessment: Already collecting the data for this – therefore low impact Reduction in hospital morbidity and mortality related to falls Reduced organisational cost Reduced potential increases in length of stay
Implementation Plan: Information is currently collected – number of individual patients who fall rather than number of falls requires extraction The main focus is HB reporting however there is requirement for monthly All Wales reports to be collated
Maintenance: The sponsor of this indicator is Chief Nursing Officer via Welsh Nursing and Midwifery Committee and Welsh Therapies Advisory Committee A full review of this indicator will be undertaken in (eg June 2016) or earlier if deemed necessary

Performance Measure ID:	
Performance Measure Name:	Number of individual adult in-patients who have fallen
Description: This is the number of individual patients who have fallen in the calendar month in an in-patient setting (for the previous 12 month period) A fall is defined as 'An event whereby an individual comes to rest on the ground or another lower level with or without loss of consciousness' (AGS/BGS 2001) In-patient setting is defined as in hospital with intention to assess or admit for greater than 6 hours excluding day case activity	
Strategic Fit: National Service Framework for Older People The NHS '1,000 Lives plus' Multiagency Community Falls Collaborative Prudent health Care Improving Quality Together Health and Care Standards	
Operational Fit: Reduction in hospital morbidity and mortality Reduced organisational cost	
Known Standards: Assessment and prevention of falls in older people NICE Clinical Guidance 161 2013 Rapid Response Report NPSA/2011/RRR001: essential care after an inpatient fall	
Reporting Format: Trend graph for each area / service / locality/ individual patient as part of Integrated Governance Reports extracted from Datix	
Interpretation: This is a single count and can only be interpreted as part of trend information for that given area- for service improvement	
Calculation: None	
Numerator:	
Denominator:	
Data Source:	Datix
Data Collection Frequency:	At the point of each fall within Datix
Target:	None

Fitness for Purpose: This is a area specific trend analysis to provide initiation and base line for improvement work
Testing/Pilot: Powys tHB
Information Governance: Anonymised data with ability for ward staff to see patient details (research possibilities)
Commercial Considerations: Datix
Impact Assessment: Already collecting the data for this – therefore low impact Reduction in hospital morbidity and mortality related to falls Reduced organisational cost Reduced potential increases in length of stay
Implementation Plan: Information is currently collected – number of individual patients who fall rather than number of falls requires extraction. The main focus is HB reporting however there is requirement for monthly All Wales reports to be collated
Maintenance: The sponsor of this indicator is Chief Nursing Officer via Welsh Nursing and Midwifery Committee and Welsh Therapies Advisory Committee A full review of this indicator will be undertaken in (eg June 2016) or earlier if deemed necessary

Performance Measure ID:	
Performance Measure Name:	Number of adult in-patient falls - Harm

Description:

This indicator comprises of the total number of adult in-patient falls that have occurred in an adult in-patient setting during the calendar month, captured in the following categories in the Datix system:

- 0 No Harm
- 1 Minor harm resulting in minimal intervention or treatment
- 2 Minor harm resulting in minor intervention or treatment
- 3 Moderate harm
- 4 major harm
- 5 Catastrophic harm resulting in death or permanent harm

Include descriptors: bruise, skin tear, fracture (type and location e.g. Left fracture neck of femur or lumbar spinal fracture), head injury

Consider – is there an assessment done, were interventions to reduce risk planned and implemented

A fall is defined as 'An event whereby an individual comes to rest on the ground or another lower level with or without loss of consciousness' (AGS/BGS 2001)

In-patient setting is defined as in hospital with intention to assess or admit for greater than 6 hours excluding day case activity

Strategic Fit:

National Service Framework for Older People
The NHS '1,000 Lives plus' Multiagency Falls Collaborative
Prudent health Care
Improving Quality Together
Health and Care Standards

Operational Fit:

Reduction in hospital morbidity and mortality
Reduced organisational cost

Known Standards:

Assessment and prevention of falls in older people NICE Clinical Guidance 161 2013
Rapid Response Report NPSA/2011/RRR001: essential care after an inpatient fall

Reporting Format:

Ability to display results in a single graph and table by single clinical area, a locally defined group of clinical areas, hospital and Health Board

Monthly trend graph for each area through Care Metrics and area / service / locality as part of

Integrated Governance Reports extracted from Datix

Interpretation:
This indicator provides information regarding the numbers of adult in-patient falls which result in obvious physical harm

This is a single count and can only be interpreted as part of trend information for that given area

Calculation:
This is to be undertaken through data extract from Datix and total validated against total number of falls reported over same time period

Numerator:	Number of falls by category of harm
Denominator:	Total number of falls
Data Source:	The total number of inpatient falls recorded in Datix within a calendar month
Data Collection Frequency:	At the point of each fall within Datix
Target:	No target for trend analysis

Fitness for Purpose:

The results of data capture for this indicator will be reviewed in June 2016 to ensure it is satisfying information requirements in respect of falls

This is a area specific trend analysis to provide initiation and base line for improvement work

Testing/Pilot:
Powys tHB

Information Governance:
Anonymised data with ability for ward staff to see patient details

Commercial Considerations:
Datix

Impact Assessment:
Development of minimum data set
Development of datix user interface
Development of reporting systems

Implementation Plan:
Information Department tested reporting from Datix June- December 2014 and on-going

Recording of mitigation tested through PDSA within Powys tHB- mitigation difficult to capture using datix

Maintenance:
The sponsor of this indicator is Chief Nursing Officer for Wales via Welsh Nursing and Midwifery Committee and Welsh Therapies Advisory Committee

A full review of this indicator will be undertaken in (eg January 2016) or earlier if deemed necessary

Free to Lead; Free to Care:

Adult In-patient Falls Working Group

Terms of Reference

INTRODUCTION

As part of the All Wales Nursing and Midwifery Dashboard work the Chief Nursing Officer for Wales has directed that a National Indicator is developed for falls. Due to the different strands of work being undertaken across on Wales on falls it has been agreed that a working group under the Free to Lead Free to Care initiative is established to bring together the different strands of work and develop a National adult in-patient Falls Indicator/s

PURPOSE

The purpose of the All Wales Falls Working Group is:

- Produce Key Principles to underpin work.
- To review the existing evidence and best practice assessment tools relating to adult in-patient falls to inform the development of national in-patient falls indicators in order to manage falls effectively
- To make a recommendation to the Free to Lead Free to Care Steering Group by 31st March 2014 that all organisations:
  - Adopt best practice tools / standards
  - Implement appropriate indicators applied and measured nationally that benefit patients through providing intelligence to sustainably improve practice and to apply best practice standards
  - Incorporate the evidence/ best practice and indicator understanding into Health Professional Education

DELEGATED POWERS AND AUTHORITY

- The working group will work under the delegated authority of the Chief Nursing Officer and is authorised to undertake this programme of work.
- The working group will work to the timescales set by the Chief Nursing Officer.
- The working group will make recommendations to the Chief Nursing Officer through the Free to Lead; Free to Care Post Implementation Steering Group.
- Recommendations will be based on a review of existing evidence and will meet national and international standards:
  - National Institute for Health and Clinical Excellence
  - Cochrane Collaboration

  - National Patient Safety Agency
  - Royal College of Physicians
  - Profound
  - *1000 Lives*
- The working group will demonstrate that it has taken into account Equality and human rights principles and ensure that recommendations meet the requirements of adult patients who share one or more protected characteristics as set out in the Equality Act 2010 via an Equality Impact Assessment.
- The working group may establish sub-groups or task and finish groups to carry out on its behalf specific aspects of its business.

MEMBERSHIP	
Chair	Consultant Nurse for Older Vulnerable Adults, Cardiff and Vale
Vice Chair	Assistant Nurse Director of Nursing, Powys
Members	Representative from 1000 Lives Falls Collaborative
	Physician with a specialist interest in falls
	Representative of Public Health
	Lead practitioner in the Care of People with dementia
	Welsh Therapy Advisory Committee representative
	Representative from each of the Health Boards and Trusts in Wales
Secretary	Provided by Cardiff and Vale University Health Board
By invitation	The Working Group Chair may extend invitations to attend meetings if specifically required.

Member Appointments

The membership of the Working Group shall be determined by a combination of nomination from the Professional Body or Organisation or based on the recommendation of the Working Group.

Appointed members shall hold office for the period of the work required.

Support to Committee Members

The Working Group Secretary, on behalf of the Chair, shall:

- Arrange meetings and venues as directed;
- Take notes of the meetings and develop action sheets;
- Organise for draft notes and action log to be circulated within one week of the meeting being held.

WORKING GROUP MEETINGS

There will be 2 meetings of the Working Group to enable the first submission to the Free to Lead Free to Care Steering Group by September 2013 therefore work will be undertaken by e-mail as well as formal meetings.

Quorum: At least five members must be present to ensure the quorum of the group.

Frequency of Meetings: as work indicates, with 2 meetings held prior to submission of the first report to the All Wales Free to Lead; Free to Care Implementation Board September 2013.

Attendance: All members are expected to attend meetings or via Video Conference and this will be available for each meeting of the group.

REPORTING AND ASSURANCE ARRANGEMENTS

The Working Group Chair shall:

- Report to each meeting of All Wales Free to Lead; Free to Care Post Implementation Steering Group. This includes verbal updates on activity, the submission of working group minutes and written reports, as well as the presentation of a final report and recommendation;
- Bring to the Post Implementation Steering Group specific attention any significant matters under consideration by the Working Group;

REVIEW

These terms of reference and operating arrangements shall be reviewed quarterly by the Working Group with reference to the Implementation Board.

DATE OF ACCEPTING THE TERMS OF REFERENCE AND APPROVAL

Date: *Updated 01.04.14*

Chair of Working Group signature: *D. Shanahan*