Regulation 28: REPORT TO PREVENT FUTURE DEATHS – reference KENNETH JOHN SWIFT

This report summarises the findings from an investigation into concerns raised by HM Coroner under regulation 28, and the actions taken to minimise future risk and harm.

Matters of concern:

1. Although assessed as being at risk of falls and despite being positioned in a bay that was close to the Nurses' Station in the Ward for better observation, Mr Swift was also recommended to have a falls sensor as he was observed by the Occupational Therapist and Physiotherapist trying to mobilise without supervision despite advice not to do so.

2. It was said in evidence that:
   No falls sensor was immediately available – Mr Swift was put on a 'waiting list' of 34 existing patients needing such equipment. The cost of chair sensor was said to be £60; of a bed sensor £90. The hospital was said to be in a tendering process to acquire such equipment. In the relevant Ward (AMU/AMB) 95% of the usual 30 patients (when full) at any one time would have been assessed at risk of falls.
   Four sensors have been acquired since Mr Swift's death for use at the present time in that Ward.

3. Such a mechanism may have made staff aware that Mr Swift, an elderly man known to be capable of confusion and already suffering from infection that could be aggravated by immobility if injured, was mobilising unsupervised.

4. That in this Ward at least there is the potential for future deaths resulting from, or the aggravation of, conditions by the consequences of falls in other patients.

Introduction/background:

Falls and falls related injuries are a common and serious problem for patients in hospital, particularly older patients. People aged 65 and older have an increased risk of falling and in the hospital setting, they are particularly vulnerable due to acute illness, chronic illness and the associated frailty and anxiety.

York Teaching Hospital NHS Foundation Trust has a policy which provides guidance to reduce the risk of patients falling in hospital. This policy provides a consistent approach to preventing falls in hospital, based on best practice and clinical evidence of effectiveness.

Some patients may continue to fall and incur harm even when best practice is followed. In such cases we try to ensure vigilant monitoring, re-assessment

and where necessary, modifications to the plan of care and actions to minimise the risk of harm.

All adult in-patients aged 65 and over should have a falls risk assessment completed within six hours of being admitted to hospital. People under 65 years of age who are judged by a clinician to be at higher risk of falling due to an underlying condition should also have the assessment completed. The assessment process will generate a list of preventative measures to be considered by staff completing the assessment. Preventative measures may include: provision of walking aids, review of night sedation, sight and hearing checks, provision of a low profile bed, non-slip footwear or sensor alarms.

The use of bed and chair sensors will not stop someone from falling but they should be considered where patients are unable to use a call bell and need assistance to mobilise. The sensors should be used as a mechanism to alert staff that a patient might be getting out of bed or standing from a chair, but they should only be used as a tool to help reduce the risk of someone falling and in association with close observation. They cannot be used in isolation and should be part of a package of interventions. Constant alarms on bed sensors can be very irritating for the patient and therefore they may not be suitable for confused patients. In the case of patients who are confused or who fail to follow advice the sensors may not be beneficial and a position on the ward which facilitates frequent observation by nursing staff may be more beneficial.

Response to matters of concern:

We have a multi-factorial electronic assessment tool which is used by the nursing staff to determine risk of falling and which preventative measures/interventions should be used to prevent or minimise the risk of falling and injury. The tool triggers recommendations based on individual risks.

The Physiotherapist on Ward AMB requested a falls sensor for Mr Swift and was unable to secure one. She reported to Sister on Ward AMB that the Medical Equipment Library had advised her that there was a waiting list of 34 patients for sensors. It is correct that at the time of the request there was not a sensor available for Mr Swift however our investigations with the Medical Equipment Library have failed to identify any occasion where more than five patients were awaiting a sensor at any one time and therefore we are unable to substantiate the information provided at the inquest.

Since 2014 we have purchased 55 falls sensors, including 10 in August 2016 but due to malfunction and lost parts we only had 30 sensors available across the Trust at the time of Mr Swift's assessment. Since August 2017 we have purchased an additional 30 complete sensor kits at a cost of £650 per kit and we are reviewing the demand and will purchase additional kits if necessary.

It is possible that the use of a falls sensor may have alerted staff more quickly to the fact that Mr Swift was mobilising unsupervised. However the evidence

in the literature (National Institute for Health and Care Excellence 2013) reports that the use of bed and bedside falls sensors as part of a single intervention does not reduce falls rates.

Our approach to preventing harm from falls follows the NICE guidelines (2013) which recommend that, for patients at risk of falling in hospital, a multi-factorial assessment and multi-factorial interventions should be considered and this did happen in Mr Swift's case.

Mr Swift was assessed as being at risk of falling whilst he was in hospital and to minimise the risk the following preventative measures were put in place:

- Footwear assessed for suitability
- Walking aids provided
- Bed provided near the toilet and nurses station
- ECG checked
- Blood glucose checked
- Referral made to physiotherapist and occupational therapist
- Lying and standing blood pressure checked
- Medications reviewed
- Condition of spectacles checked
- Plan to supervise the patient when walking to the toilet.

Following investigation into the circumstances of Mr Swift's fall and serious injury we have taken the following actions:

a. implemented process of escalation to Matron/ Patient Safety Team when sensor requests cannot be achieved
b. agreed new management system with the Equipment Library for the storage and supply of fall sensors to the clinical areas
c. introduced additional training for all staff including the Equipment Library Staff on the correct use of fall sensors
d. implemented process for auditing the use of sensors
e. implemented process for ensuring on going supply of sensors due to the short warranty of the pads
f. implemented tendering process to ensure value for money and efficiency of product
g. further promoting the use of multi-factorial interventions to reduce falls incidents and harm.

Evaluation of the actions above will be reported to the Falls Steering Group in December 2017.

Reference:

Falls (2013) NICE guideline CG161.

[redacted]
Deputy Director of Patient Safety

September 2017.