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# RUH Cohort Falls Report

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# Executive Summary

This is a report on the fall that occurred in Royal United Hospital (RUH) Ambulance Cohort Area (ACA):

This report is after the incident has been heard in coroners court. Therefore, it focuses on how we can learn from this event to ensure it does not happen again. It primarily consists of an evaluation of the current clinical guidelines and practices, and how we may be able to implement changes to improve our practice as a company.

## Summary:

Following the Joint Royal College Ambulance Liaison Committee (JRCALC) Guidelines, specifically, 'Falls and Trauma in the Older Adult' and 'Frailty' are inadequate to prevent a similar fall from occurring again in an ambulance cohort area. The falls risk assessment within these guidelines focuses on an in-depth holistic approach, with the aim of identifying patient specific mobility needs. It is not designed to highlight patients at immediate risk of falls in a hospital department. Therefore, for Bristol Ambulance, to help prevent further similar incidents, should consider several possible interventions, including:

- ❖ Adopting a falls risk assessment protocol similar to RUH's (Page 6). This rules patient in or out of a 'Falls Risk' Category, and highlights patients with colored blankets.
- ❖ Ensure commodes are available for patients who are at falls risk to limit their need to mobilise.
- ❖ Conduct a joint falls risk assessment with the Trust we provide cohorting for. This should be done as part of the set-up process to ensure shared understanding of how to best highlight and manage at-risk patients.
- ❖ Before staff begin work within a cohorting area they conduct company mandated training specific to falls risk and management.

For a detailed evaluation and implementation of the above please see below.

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## **JRCALC Guidelines:**

JRCALC Guidelines appear inadequate to assess falls risk in hospital. Below is an evaluation of the guidelines as they pertain to this incident. Excerpts are on page five.

### **Falls and Trauma in the Older Adult Guidelines:**

- The Scope of this Policy is for assessing patients who *have* fallen. This guideline is implicitly for pre-hospital falls. It emphasises two key areas: Major Trauma and Long lie.
- This guideline does not include a risk of falls assessment for in-hospital patients. The emphasis of the falls assessment is a holistic ‘multi-factoral’ approach - there is no threshold for who is a high, medium and low falls of risk.
- The guidelines indicate that it is down to the paramedics professional opinion, and that their opinion should be informed by risk factors and pertinent history such as section 4.4 and Appendix B below.
- Section 14.4 specifically highlights a mobility assessment, but this is well beyond the scope of ACA as it involves observing “postural stability, gait, stride length and sway” with the aim of identifying “slow tentative pace, loss of balance, short strides, shuffling, en-bloc turning, and inappropriate mobility use”. This would not be feasible in ACA due to volume of patients and work load of the clinician.
- Appendix B highlights an “*informal* assessment” of mobility in Functional, Mobility and Assessment.
- There are no guidelines for a practical and timely falls risk assessment in the context of ACA within JRCALCs ‘Falls and Trauma in the Older Adult’.

## JRCALC Guidelines Excerpts:

**4.4 Table 1 - Examples of Intrinsic and Extrinsic Risk Factors**

Intrinsic Risk Factors	Extrinsic Factors
<p><u>Effects of ageing:</u> Muscle weakness, Frailty, Urological conditions Gait &amp; balance problems, Poor vision and hearing, A fear of falling</p> <p><u>Acute and chronic conditions:</u> Arthritis Stroke Incontinence Dementia Parkinson's disease Musculoskeletal disease or previous injury, Sensory deficits Diabetes Postural hypotension Depression</p> <p><u>Medications:</u> Side effects (e.g. sedation or slowed reaction times) Drug interactions New or recently adjusted medications</p>	<p>Lack of handrails and grab bars, Poor stair design Poor lighting or glare Obstacles, clutter &amp; trip hazards Slippery or uneven</p>

### Appendix B: Falls Assessment Checklist

Falls History	As per section 5 of Guidelines
Cardiovascular	Consider cardiac arrhythmias, TLoC and postural hypotension (NB: postural hypotension may be affected by drugs, disease or age-related deterioration of autonomic nervous system) – see section 6
Neurological	Consider delirium – refer to the Confusion Assessment Method within the SWASFT <i>Frailty</i> clinical guideline (section 4)
Functional, Mobility and Gait Assessments	Record an informal assessment of mobility – see section 14. Consider footwear and availability and appropriateness of mobility aids. Assess frailty and consider referral for a Comprehensive Geriatric Assessment – refer to the SWASFT <i>Frailty</i> clinical guideline (section 2)Is the patient able to undertake basic Activities of Daily Living (ADLs)?:Personal hygiene e.g. bathing, grooming, maintaining continence Dressing Eating Transferring/mobility
GI/GU	Assess alcohol intake – see section 9Consider nutritional intake and dehydration. Assess urgency or frequency of urination and any symptoms indicative of a urinary tract infection. Nocturia may be linked to sleep disturbance, poor lighting, not using mobility aids or disorientation
Sensory Disturbance	Ask if the patient noted loss of vision or increase glare from lights, particularly at night. Enquire whether an eye test has recently been undertaken and if glasses are worn or requiredAsk if the patient has noticed diminished hearing, requires hearing aids and if they are working adequately. Consider if a hearing test may be required
Muscoskeletal	Undertake a c-spine assessment – see section 3. Assess for signs of head injury – see section 10 and NICE <i>Head Injury</i> guidance. Assess joints and muscles for pain, swelling and deformity; both acute and gradual onset. Consider low muscle mass and sarcopenia. Undertake a skin assessment for pressure ulcers and high risk areas – refer to SWASFT <i>Pressure Ulcers</i> clinical guideline

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## **Frailty Guidelines:**

- The Frailty Guidelines do not have a defined Scope. They provide reference material, assessment aides and clinical management recommendations.
- No specific falls risk assessment is included in the JRCALC Frailty guidelines.
- The core message is assessing a patient compared to their normal base line. Assessment is focused on the injuries from the fall and long lie effects, and use of the Rockwood Frailty Score.
- The guidelines overlap considerably with 'Falls and Trauma in Older Adults'
- Functional Assessment in Section 5. Table 5.7 details the FRESH model, but it is essentially another holistic history gathering tool but is specific to frailty and activities of daily living.
- There are no guidelines for a practical and timely falls risk assessment in the context of ACA within JRCALCs 'Frailty Guidelines.

## **Ambulance Hospital Handovers Guidelines:**

- Within 'Ambulance Hospital Handovers' guideline Appendix 7 details the remit of cohorting. The guideline primarily focuses on when a cohorting area would be created due to surges in demand and how this would be decided and staffed.
- It does not appear to directly apply to a permanent cohorting area, however, the RUH ACA appears to meet the standards of this guideline when it comes to the responsibility and actions of BA staff e.g regular observations, assisting with personal care and escalating deteriorating patients. A falls risk assessment is not detailed anywhere in the guidelines.

# Hospital Falls Risk Assessment

<u>Patient Demographic Label</u>	 <b>Royal United Hospitals Bath</b> NHS Foundation Trust
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## Emergency Department- Falls Risk Assessment Tool

If any question is answered 'YES' – put yellow blanket & socks on patient				
Questions	Yes	No	Actions (If required)	Additional information
Has the patient fallen prior to, or since admission into the department?			» Place in observable bay <input type="checkbox"/> » Place nurse call bell <input type="checkbox"/> » Provide non-slip socks <input type="checkbox"/>	
Is the patient over 65 years of age?			» If any other risk identified follow actions above <input type="checkbox"/>	
Is the systolic BP less than 90mm/hg or is there a drop of more than 20mm/hg on lying and standing BP?			» Clinician Assessment <input type="checkbox"/> » IV fluid if no contra-indications <input type="checkbox"/>	
Any reason to believe that the patient is cognitively impaired (long or short term) or may be suffering with delirium?			» Place in observable cubicle <input type="checkbox"/> » Manage cause if indicated <input type="checkbox"/> » Consider enhanced care <input type="checkbox"/>	
Is the patient taking any medications that may increase the risk of falling?  E.g. Morphine pre-hospital etc.			» Review patients regular medications <input type="checkbox"/> » Review any medications administered during episode of care. <input type="checkbox"/>	
Does the patient have any issues with their eyesight or hearing?			» Glasses in reach <input type="checkbox"/> » Belongings in reach <input type="checkbox"/>	
Is the patient anxious about falling? Have any relatives/carers expressed any concerns?				
Does the patient require any assistance to mobilise? (Have they brought any mobility aids with them?)			» Provide nurse call bell <input type="checkbox"/> » Ensure use of mobility aids <input type="checkbox"/> » Identify number of staff required to assist to mobilise. <input type="checkbox"/>	
Are there any other risks factors that may increase the risk of falls?  E.g. Incontinence, head injury, poorly controlled pain, intoxicated, postictal etc.			» Place in observable cubicle <input type="checkbox"/> » Pain assessment & management <input type="checkbox"/> » Note on First Net – Falls Risk <input type="checkbox"/>	
<u>Name of Assessor:</u>		<u>Signature:</u>		<u>Date:</u>

When patient is moved into a different area in FD, this assessment is to be reviewed.

### Summary:

This is the ED Falls Risk Assessment. The tool is based on the clinician asking questions of the patient based on several elements of the NICE guidelines. This appears to work on the basis that if the patient hits just one of the 'holistic' risk factors, they are considered at risk and are highlighted with a yellow blanket and yellow socks. This Risk Assessment appears to be quite a sensitive tool, to highlight any patient at risk, no matter how small. It is worth noting on reflection that the triage



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nurse who took the handover omitted this risk assessment. It is unclear if this was an oversight or on purpose. If this was completed this would have helped to highlight the patient who fell.

## **NICE Guidelines:**

The NICE Guidelines CG-161 'Falls in Older People: Assessment and Prevention' were last updated after a 'Surveillance' period in 2019. This guideline does include guidance for falls in hospital.

### **1.1.2 Multifactorial falls risk assessment**

1.1.2.1 Older people who present for medical attention because of a fall, or report recurrent falls in the past year, or demonstrate abnormalities of gait and/or balance should be offered a [multifactorial falls risk assessment](#). This assessment should be performed by a healthcare professional with appropriate skills and experience, normally in the setting of a specialist falls service. This assessment should be part of an individualised, [multifactorial intervention](#). [2004]

1.1.2.2 [Multifactorial assessment](#) may include the following:

- identification of falls history
- assessment of gait, balance and mobility, and muscle weakness
- assessment of osteoporosis risk
- assessment of the older person's perceived functional ability and fear relating to falling
- assessment of visual impairment
- assessment of cognitive impairment and neurological examination
- assessment of urinary incontinence
- assessment of home hazards
- cardiovascular examination and medication review. [2004]

## **1.2 Preventing falls in older people during a hospital stay**

### **1.2.1 Predicting patients' risk of falling in hospital**

1.2.1.1 Do not use fall [risk prediction tools](#) to predict inpatients' risk of falling in hospital. [new 2013]

1.2.1.2 Regard the following groups of inpatients as being at risk of falling in hospital and manage their care according to recommendations 1.2.2.1 to 1.2.3.2:

- all patients aged 65 years or older
- patients aged 50 to 64 years who are judged by a clinician to be at higher risk of falling because of an underlying condition. [new 2013]

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## 1.2.2 Assessment and interventions

1.2.2.1 Ensure that aspects of the inpatient environment (including flooring, lighting, furniture and fittings such as hand holds) that could affect patients' risk of falling are systematically identified and

1.2.2 Assessment and interventions **2013]**

1.2.2.2 For patients at risk of falling in hospital (see recommendation 1.2.1.2), consider a [multifactorial assessment](#) and a [multifactorial intervention](#). **[new 2013]**

1.2.2.3 Ensure that any [multifactorial assessment](#) identifies the patient's individual risk factors for falling in hospital that can be treated, improved or managed during their expected stay. These may include:

- cognitive impairment
- continence problems
- falls history, including causes and consequences (such as injury and fear of falling)
- footwear that is unsuitable or missing
- health problems that may increase their risk of falling
- medication
- postural instability, mobility problems and/or balance problems
- syncope syndrome
- visual impairment. **[new 2013]**

### Summary:

NICE Guidelines recommend a multifactorial assessment for risk of falls. They specifically do not recommend 'Fall Risk Prediction Tools' such as the Morse Fall Scale or St.Thomas Risk Assessment Tool for Falling in the Elderly (STRATIFY) due to the apparent low sensitivity and specificity. Recommendations go on to explain that the multi factorial falls assessment should be carried 'normally in the setting of a falls specialist service (1.1.2.1)'.

These guidelines, like the JRCALC, help to provide a detailed picture of a patients overall capability but appear ill equipped to identify a patient who is at immediate risk of falls in ACA.



## The Investigation:

Reviewing the investigation, it appears that not all pertinent details were reported. Below is a list of questions that could have been informative in our future interventions. If any falls do occur in future similar questions should be asked in any subsequent investigation for BA to better learn and improve. Furthermore, it may be best to consider phone call or face to face interview for incidents that lead to patient harm to ensure as much detail is gathered as possible.

Question	Use
<p>1) Is there any extrinsic cause for the fall?</p> <p>a) Was the floor slippery?</p> <p>b) Did the patient have appropriate foot wear?</p> <p>c) Were any trip hazards present?</p> <p>d) Does the patient normally use mobility aids</p>	<p>If we could identify extrinsic causes we could seek to limit these in patient areas</p> <p>D) The patient was scored as Rockwood Frailty 3 (by the medical team) and 5 (by the surgical team) while in hospital. We do not know what the pre-hospital team scored the patient as we do not have access to those records. It appears the patients mobility was challenging to assess for multiple clinicians. Regardless a Rockwood 5 involves the patient requiring mobility aids – were these available? Were they brought into the department</p>
<p>2) Why did the Emergency Department not complete their Falls Risk Assessment?</p>	<p>This can help us to understand our gaps in communication and team-working with the ED department.</p>
<p>3) Were there any other falls in ACA or ED recently?</p>	<p>Were there any similar falls in ACA or ED? If there were, were they adequately reported? If there were unreported falls, this could represent a blind spot in our Patient Safety and Quality Improvement processes.</p>
<p>4) What was the broader context of the fall?</p> <p>a) What else was happening in the immediate area at the time?</p> <p>b) Why was the clinician away from the area?</p>	<p>All of these would help us to accurately map what was happening when the fall occurred and we could more directly address issues that contributed to the circumstances of the fall</p>

<p>c) Did the clinician take hand over directly? If so, was the patient highlighted as a falls risk in handover?</p> <p>d) Was the patient seen by a hospital clinician prior to the fall?</p>	
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**The System of Care:**

To better appreciate the context that this fall occurred within I created an AcciMap and a Human Factors Analysis and Classification System (HFACS) (Appendix One) of the event from the information available.

This helped to reveal the broader systems implication in the matter. Specifically:

- 1) There was ambiguity over who was ultimately responsible for ACA from a policy perspective
- 2) The dynamic work demands made patients and staff more vulnerable to this type of incident.
- 3) The human factors involved in ACA are significantly different from typical ambulance queuing.

**Point One:**

Within ACA there was ambiguity surrounding who has ultimate responsibility for the patients in the ACA. Policy states that the hospital has overall responsibility but that this is delegated to ambulance clinicians for observations, personal care and hydration.

The work-as-prescribed in policy is that the ACA is in an extension/projection of an ambulance queuing in the car park. However, the work-as-done in practice within the Emergency Department was that the patients were assessed, and treated by hospital clinicians as if they were in-patients. To highlight this, plenty of the interventions that took place in ACA would not take place in ambulances but only in ACA e.g catheterization. Over time as this ambiguity continued this likely created a blind spot for ambulance and hospital staff alike as both parties may assume that that the other had completed work/risk-assessments/tasks for the patients when neither have. This could have contributed to the fact that the patient was triaged by an ED nurse and was not labelled a falls risk, despite the patient hitting several markers on the RUH risk assessment tool.

**Point Two:**

During background research into this event, I discussed ACA with several other paramedics who had worked there previously. Many of them describe several issues with the dynamic nature of the department.

Often hospital clinicians would see, assess, manage, or move patients without the clinician being aware. This would happen because the paramedic was the clinician in charge as well as the liaison with ED and so would regularly be required to walk away from ACA to contact different sections of

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the ED. While they were gone the ACA situation would change and this could create blind spots for patient specific needs.

Secondly, the paramedics describe a slow drift overtime of what the ACA was accepting. Over time as HALOS and charge nurses got accustomed to the ACA, they would need to adapt to the demands of the day and use ACA in ways it was not intended to, which pushed ACA outside of its Scope. Examples include HALOs asking ACA to briefly care for patients who were not suitable so crews could go home on time, or so other patients could be moved through the department. However, many times the brief period became extended to several hours. One case involved a patient who required BiPAP being placed in ACA. When the paramedic alerted the charge nurse they were told that this was not appropriate but there was no other space in the ED at this time and that they needed to 'just keep a close eye' on the patient.

This type of incident was not an isolated event. These incidents were raised to the ED staff as per the ACA policy, however, these were rarely done in writing, often verbally on the day. This likely prevented any one individual keeping track how often there were near misses in ACA due to its accidental and improvised misuse.

### **Point Three**

From mapping the ACA system of care it is clear that the human factors involved are significantly different from typical ambulance work and typical ambulance queuing; multiple patients on hospital beds, often requiring protracted clinical and personal care. Furthermore, the typical ambulance staff to patient ratio is two to one, in ACA it can be a range up to three to seven. Reviewing the guidelines it appears inadequate to simply map current pre-hospital policies on to in-hospital patients regardless of the fact the pre-hospital clinicians are the ones caring for patients.

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## **Recommendation:**

### **Falls Risk Assessment Tool:**

As described the ergonomics and human factors involved in ACA are clearly different from a typical ambulance patient interaction. The type of holistic risk assessment recommended by JRCALC cannot be reliably implemented in a clinical context like ACA. This recommended assessment is in-depth and necessarily time consuming, and would be unrealistic to implement in an ACA context due to ACA's dynamic nature and high turnover of patients. We should therefore look to implement an adapted Falls Risk Assessment.

As a starting place **we should consider employing the risk assessment already used in RUH ED.** This is a tool that BA could look to adapt and employ to highlight at risk patients as it uses several markers from the holistic approach to rule falls risk in or out for a given patient. In practice this will need to be implemented in conjunction with local trusts and adapted accordingly.

### **ACA Risk Assessment:**

There is no documented falls risk assessment of ACA before its implementation. A pre-emptive in-depth risk assessment would have likely identified the gap between pre-hospital in-hospital falls risk and an intervention could have been enacted. For example, we could integrate with the current RUH policy and procedures. Therefore, **in future we should conduct a falls risk assessment and intervention strategy before implementing a cohorting area.**

Additionally, **ready access to commodes may have been identified as a possible intervention to limit the risk of falls and should be considered in future cohort areas.**

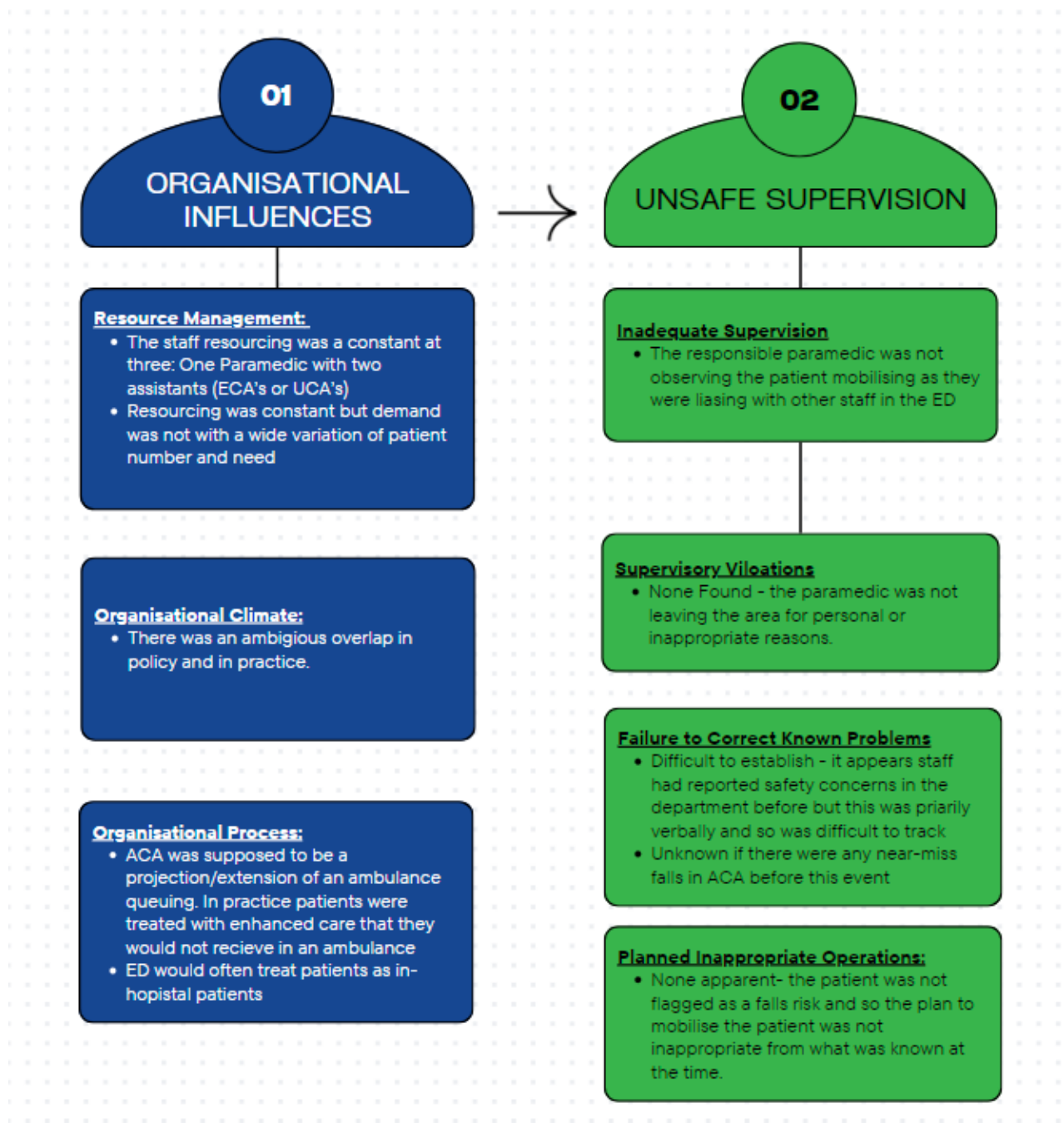
A key consideration in this incident it that the current guidelines are not sufficient to assess what is needed in ACA. What is need is a quick assessment of their immediate risk of falls. The holistic approach is brilliant for assessing there over all needs and for identifying how a multi-disciplinary

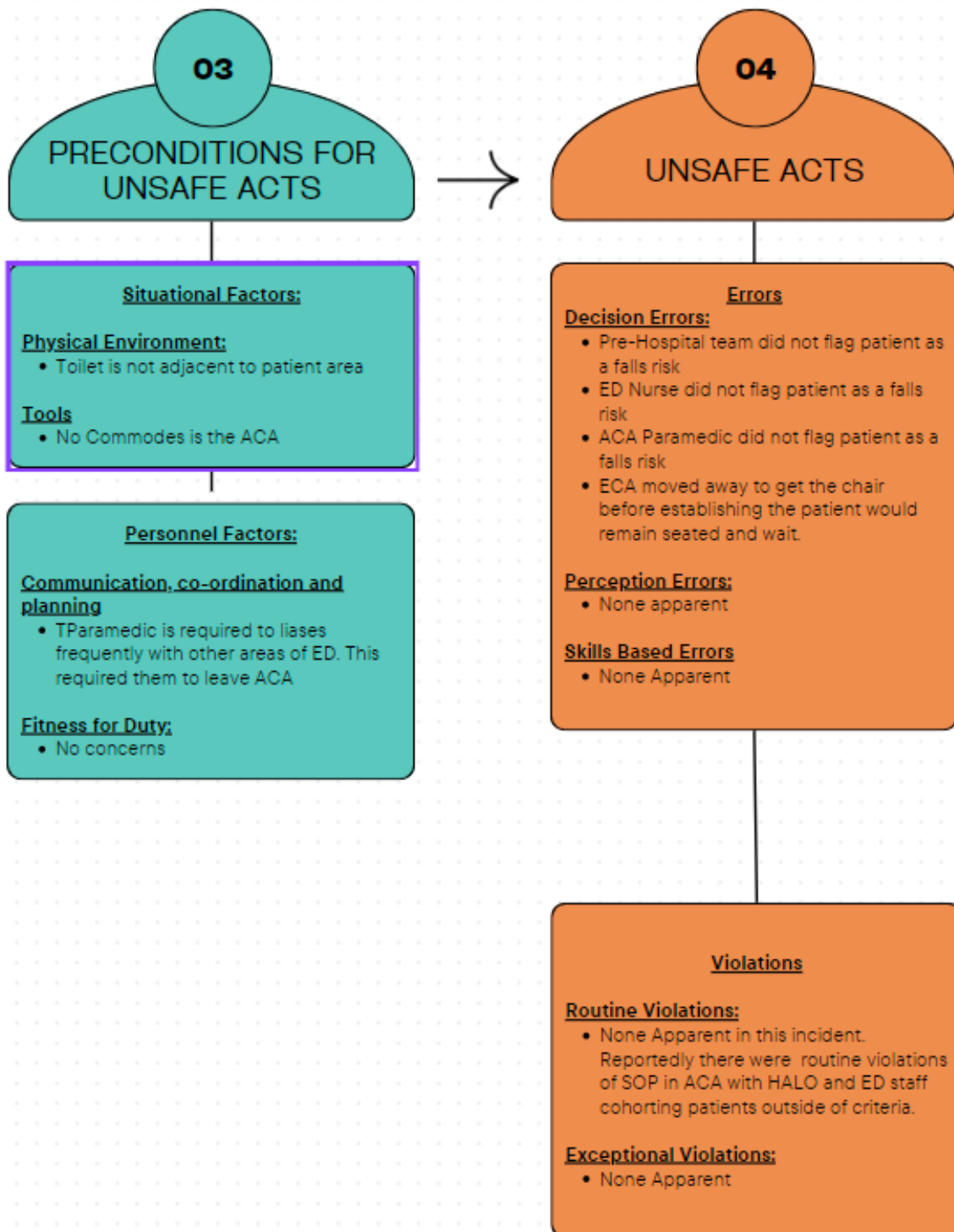
team can help the patient. They are not sufficient to ascertain the patients level of falls risk in the ACA area.

## Appendix One:



## HFACS for ACA:







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## Appendix Two:

### Pertinent Coroners Statements

“The paramedic working within the cohort area did not complete a falls risk assessment in accordance with the JRCALC guidelines following the admission of a patient who had just had a fall at home. “

“The other two ambulance staff did not seem to understand that Mr Cruse was a falls risk, they did not consider that he was at a greater risk of falls and did not consider that any further action should have been considered or taken.”

“An investigation took place but the staff did not identify any learning and did not undertake the case study to help them identify such patients in the future. Bristol Ambulance Emergency Medical Services still run some cohort areas alongside South Western Ambulance NHS Foundation Trust, and continue to convey patients to hospital. The evidence given on behalf of this organisation did not provide reassurance that this is a matter which the ambulance service have adequately addressed. There is a real concern that ambulance staff throughout the organisation may not be adequately trained in recognising and dealing with patients who have had a fall or falls”

