Falls

- In this video we have seen an incident where a patient has fallen in hospital.
- NHS Resolution has been notified of **377 claims** where a patient has fallen in hospital in the past two years*. The total value of these claims is **£33 Million.**
- Sadly **75** of these incidents resulted in the death of a patient. A further **207** patients sustained fractures as a result of falling.

*Data correct as of 31/07/2019. Includes claims where the incident date was 2017/18 or 2018/19 and Incident Description contains the term “fell” and/or “fall”. (575 claims) These claims were then manually sorted to remove incidents that did not relate to falls in hospital (e.g. removal of fallopian tube) (Final number 377 claims)

Falls

- The causes of falls that result in claims vary but include these themes:
  - Call bells being left out of reach (as seen in Alan's story)
  - Risk assessments not being completed or followed
  - Inadequate supervision
  - Accidents involving equipment.
- Here are some examples of claims that have been settled:
  - Patient fell from their bed during the night, suffering a fractured femur and then sadly died. **Total cost of claim £19,500**
  - Falls risk was not identified on admission, patient fell on ward and sustained a fracture to the cheek. **Total cost of claim £6,288**
  - Patient pressed the call button numerous times as they needed to go to the toilet. No nurse arrived. The patient then attempted to stand from the bed and fell, resulting in a serious fracture to their right leg. **Total cost of claim £31,000**

Falls

- Do you have experience of a patient falling within your ward/department?
- Was it possible to identify the reasons why that person fell and was this information shared with you and your colleagues?
- Was there a plan made to prevent similar incidents occurring in future and did this work?

Supporting patients and their family following an incident

- In Alan's story we saw how staff supported and communicated with Alan and his daughter following his fall.
- After an incident the following actions are statutory, regulatory and professional requirements, but also the right and fair way to support staff, patients and their families
  - Making a meaningful apology as soon possible
  - Communicating openly and clearly with patients and their families
  - Keeping people informed throughout an incident and investigation

Supporting patients and their family following an incident

Research carried out by NHS Resolution showed that the way in which patients and their families are treated following an incident can be a factor in the motivation to pursue a claim, these themes include:

- No explanation provided or a long delay in providing one
- Not receiving an apology, or receiving one of poor quality
- A belief that their healthcare provider did not undertake any actions to investigate the incident in the first instance
- Not being given the opportunity to discuss the findings of an investigation
- No reassurance that actions were taken that would prevent the same incident happening again

Reference. Behavioural insights into patient motivation to make a claim for clinical negligence
https://resolution.nhs.uk/resources/behavioural-insights-into-patient-motivation-to-make-a-claim-for-clinical-negligence/

Supporting patients and their family following an incident

Imagine that Alan's story had taken place within your ward/department and consider the following questions

- What would happen to the nurse involved in the incident?
- What do you think would be the main concerns that Alan and his daughter have following the fall?
- If you were going to have a difficult conversation with a patient or relative how would you ensure that you were well prepared and supported?

Individual responsibility and learning

- NHS Resolution's Being Fair publication explores the balance of fairness, justice, learning – and taking responsibility for action
- In this video we have seen how a team (ward staff) respond to an incident and commit to learning, but what are your thoughts about the individual role and responsibility of the staff nurse (David)?
- From what you saw do you think that David recognised his role in the incident?
- Would you feel confident that David had identified and acted upon individual learning points to prevent another similar incident?
- Think about your own organisation, what support and control measures are in place that would support individuals like David to learn from incidents and develop their practice?

Reference. Did you know? Being Fair https://resolution.nhs.uk/resources/being-fair/