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RCP GUIDANCE ON GAINING INSIGHTS FROM INPATIENT FALLS

The way that providers respond to patient safety incidents is changing. The new Patient Safety Incident Response Framework (PSIRF) will be piloted across England in 2020/2021 with the aim of rolling it out nationally in 2022. An introductory version of the framework can be found here: https://improvement.nhs.uk/resources/patient-safety-incident-response-framework/

Our guidance on how to respond to inpatient falls has been developed to support the new PSIRF. This includes the language used to describe and define responses to incidents as well as the suggested methods. The PSIRF will recommend more proactive and focused investigations, with alternative methods such as "hot debriefs" and "after action reviews" being used for some incidents. In PSIRF, patient safety incident investigations (PSII) will focus on key safety concerns and be led by a suitably qualified investigator. PSIIs into falls with severe harm may be warranted locally and decisions based on the actual and potential impact of incident, the likelihood of recurrence and the potential for learning.

Organisations that are not early adopters to PSIRF must continue to follow the serious incident framework. However, following that framework, does not preclude using hot debriefs following all falls and after-action reviews following falls with severe harm, including inpatient femoral fracture (IFF) as we have suggested below.

Principles and behaviours encouraged by PSIRF include openness and transparency, engaging with patients, a just culture and continuous learning and improvement. While the PSIRF will not become mainstream until 2022, these principles have underpinned the recommendations for gaining insights from inpatient falls.

Purpose

The purpose of this guidance is to reduce the variability in how organisations respond to falls with severe harm including IFFs. Multi-disciplinary exploration of such falls using standardised questions will replace detailed written reports and root cause analyses. Care should be taken to avoid the process becoming a "tick box exercise". It should not be used to attribute blame, avoidability, preventability, liability or predictability.

Purpose of the hot debrief

- To ensure the patient and those involved in the patient's care are given an opportunity to provide their account of the fall
- To collect information about the circumstances surrounding the fall to inform an after-action review
- To improve record keeping relating to the fall
- To support data collection for the National Audit of Inpatient Falls (NAIF).

In association with

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Purpose of the after-action review

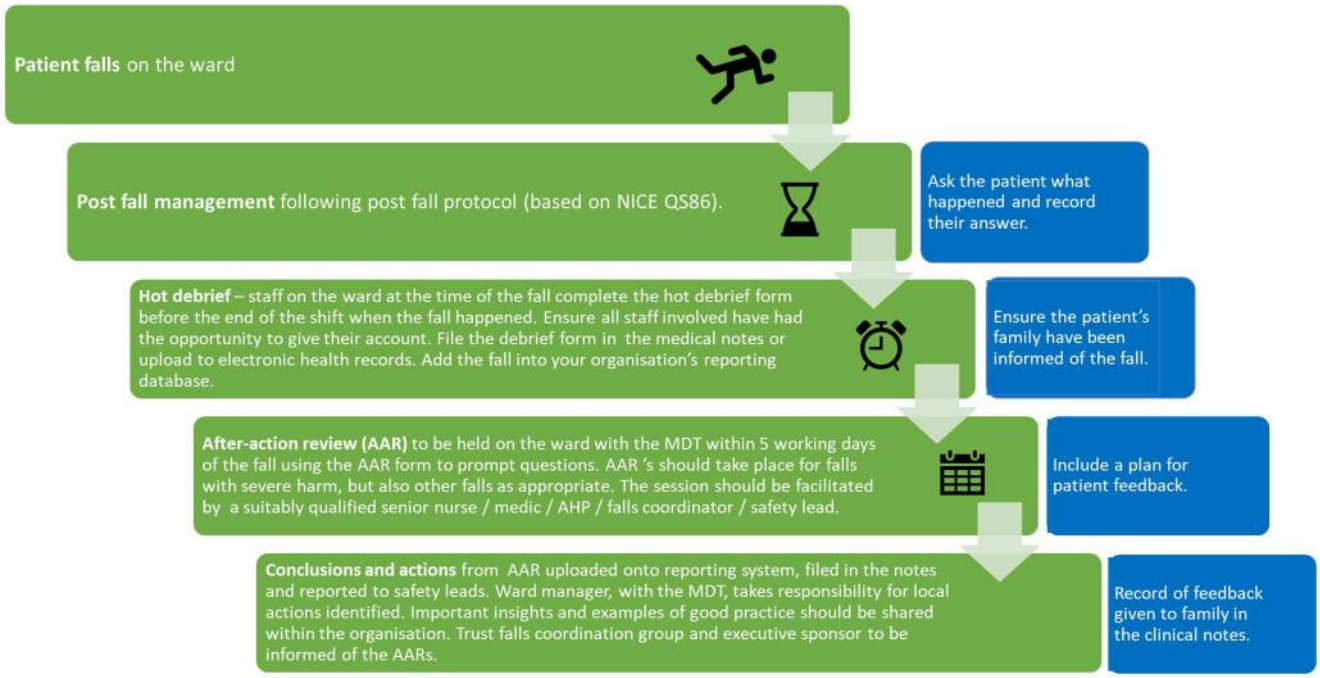
- For the multi-disciplinary team to participate in open discussion about the circumstances leading up to and the management of the fall (with severe harm of IFF).
- To develop insights into how patient safety might be improved as a result of this discussion.
- To share the outcome of discussions more widely to allow others within the organisation to benefit from the insights.
- To be used to identify patterns that might deem this to be an organisational priority for investigation and to provide an information base to support a PSII.

Language

In line with the PSIRF, using terms such as serious incident review, investigation or root cause analysis is discouraged. Instead it is proposed that insights from inpatient falls are gained from debriefs, reviews and if indicated specific and focused PSII investigations undertaken by appropriately qualified individuals.

Timing

The process of gaining insight from inpatient falls needs to start as soon as the patient is safe and stabilised. The process begins with a hot debrief, enacted within the same shift as the fall. A multi-disciplinary team MDT facilitated after-action review (if indicated) should take place within 5 working days of the fall.



Involvement

Gaining insight from inpatient falls needs to be very strongly multi-disciplinary and include nurses, doctors, and therapists as well as pharmacists, dieticians, HCAs and domestic staff.

The after-action review findings should be shared within the organisation, sharing examples of good practice, backed up with evidence of efficacy.

After-action review findings should be discussed at executive sponsored fall-focused patient safety meetings.

The patient should be provided with feedback following the after-action meeting. This feedback should be both via conversation (meeting or telephone call) and in writing.

Documentation

Documentation should be minimised and include:

- hot debrief template
- after-action review template.