SPSP Acute Adult Programme Falls Reduction Change Package

Improvement Hub
Enabling health and
social care improvement

Introduction

Welcome to the falls reduction change package

The aim of the falls change package is to provide evidence-based guidance to support the delivery of falls reduction for patients in acute hospital settings. A change package consists of a number of high-level outcomes supported by activities that when tested and implemented, bring about improvement. It brings together what is known about best practices and processes based on evidence from literature, research, and the experiences of others.

Why have we developed this change package?

This change package is for acute hospital teams participating in falls improvement work. It will support teams to use quality improvement methods to improve falls reduction in their service.

How it was developed?

This change package was co-designed and co-produced with clinical and quality improvement experts from NHS boards. The clinical experts were from a range of disciplines such as nursing, including Excellence in Care Leads, physiotherapy, occupational therapy and medicine. A Falls Expert Reference Group (ERG) was convened in October 2020 with representation from across NHS Scotland. A benefit of working in a virtual space was the inclusion and contribution from colleagues in remote, rural and island NHS boards.

Contents and how to use the package

What is included in this change package?

- Driver diagram
- Change ideas
- Guides, tools and signposts to the supporting evidence and examples of good practice, and
- Guidance to support measurement

Guidance on using this change package

This change package is a resource to support NHS boards with falls improvement work to reduce falls. It is not expected for teams to work simultaneously on all aspects of the driver diagram. It is designed to assist teams in the identification of areas for improvement relevant to their local context. The change ideas and measures are not exhaustive and it is expected that teams will develop their own to support their identified areas for improvement. We would encourage teams to seek support from their local quality improvement teams in the development of additional measures if required.

Using this package

This is an interactive document, if you click on the primary/secondary driver it will take you to additional information including tools and resources relating to that driver. At the top of each page of the secondary drivers, there is an arrow and home button . The arrow button will take you back to the primary driver page and the home button will take you to the main Driver Diagram page.

Project aim

Setting a project aim

All quality improvement projects should have an aim that is: **S**pecific, **T**ime bound, **A**ligned to the NHS board's objectives and **N**umeric (STAN).

The national aims for the SPSP Falls Improvement Programme are:

- Reduce inpatient falls by 20%
- Reduce inpatient falls with harm by 30%

by March 2024.

NHS boards are encouraged to set their own local aims specific to their context.

National Aim:

- reduce all falls by 20%
- reduce falls with harm by 30%

by Mar 2024

Local Aim:

- reduce all falls by ….
- reduce falls with harm by ….

by Mar 2024

Driver diagram and change ideas

What is a driver diagram?

A driver diagram visually presents an organisation or teams' theory of how an improvement goal will be achieved. It articulates which parts of the system need to change, in which way, and includes ideas of how to make this happen. It is used to help plan improvement projects and ensure team engagement.

The primary drivers are the key components of the system that need to change to deliver the aim. The secondary drivers are the processes that influence the primary drivers. Changing the processes outlined in the secondary drivers should change the primary drivers and deliver the aim.

Change ideas

Change ideas are specific practical changes the project team can make to alter the processes in the secondary drivers.
The following pages provide a list of change ideas for the early recognition and response for the prevention of falls. They are grouped by the primary driver that they influence. Project teams should select change ideas to implement. A range of change ideas will be needed to ensure there are changes to all primary drivers.

This change package does not contain an exhaustive list of change ideas. Project teams can also generate their own change ideas that will help drive change in the secondary drivers. One way of generating ideas is to use the question "How might we?" For example, "How might we engage with patients and their families to improve the experience of care when in hospital?"

2023 Falls Reduction Driver Diagram

What are we trying to achieve…	We need to ensure…	Which requires…
National Aim: • reduce all falls by 20% • reduce falls with harm by 30% by Mar 2024	Person centred care*	Patient and family inclusion and involvement* Individualised assessment Targeted evidence based falls risk interventions Regular review of falls risk interventions
	Promote safer mobility	Patient / family / carer involvement* Maintain a safe environment Meaningful activity Maximise opportunities for supported positive risk taking
Local Aim: • reduce all falls by …. • reduce falls with harm by …. by Mar 2024	Multidisciplinary Team intervention and communication*	Management of communication in different situations* Communication between primary and secondary care Multidisciplinary falls risk assessment and intervention
	Leadership to support a culture of safety*	Psychological safety* Staff wellbeing* Safe staffing* System for learning*

Essentials of Safe Care

Primary Driver
Person centred care

Secondary drivers	Change ideas				
Patient and family inclusion and involvement	Provision of person centred visiting	Conversation with patient / family about falls history	Provide falls risk and safer mobility information to patient / family	What matters to you conversations to inform patient care	
Individualised assessment	Implementation of agreed tool for early identification of frailty *	Implementation of agreed tool for early identification of delirium *	Standard comprehensive assessment with multifactorial interventions	Local policy and procedure to support commencement of enhanced obs/1:1	Monitor patterns of behavior
Targeted evidence based falls risk interventions	Timely CGA	Implementation of agreed tool to manage delirium *	Delivery of person centred care planning documentation		
Regular review	Daily review of person centred care plan	Post-fall review and care plan updated	Structured ward round	Local policy and procedure to support review of and stopping enhanced obs/1:1	

Use of reliable tools

Person centred care

Patient and family inclusion and involvement

Provision of person centred visiting

Conversation with patient / family about falls history

Provide falls risk and safer mobility information to patient/ family

What matters to you conversations to inform patient care

Evidence and Guidelines:

- Ciufo D, Hader R, Holly C. University of York. A Comprehensive Systematic Review of Visitation Models in Adult Critical Care Units within the Context of Patient and Family-Centred Care [online] 2011; 9(4):362-387. https://www.crd.york.ac.uk/CRDWeb/ShowRecord.asp?ID=12012011211&ID=12012011211
- Luxford K, Axam A, Hasnip F et al. Improving Clinician Carer Communication for Safer Hospital Care: Study of 'TOP 5' Strategy Patients with Dementia [online] 2015; 27(3):175-182. https://academic.oup.com/intqhc/article/27/3/175/2357330
- Morris ME, Webster K, Jones C, Hill A-M, Haines T, et al. Interventions to reduce falls in hospitals: a systematic review and meta-analysis [online] 2022; 1;51(5). https://pubmed.ncbi.nlm.nih.gov/35524748/
- Scottish Government. Practicing Realistic Medicine: Chief Medical Officer for Scotland annual report [online] 2018; https://www.gov.scot/publications/practising-realistic-medicine/

Tools and Resources:

- Healthcare Improvement Scotland. Virtual Visiting [online]. 2020; https://www.hisengage.scot/virtual-visiting
- Hyslop B. 'Not safe for discharge'? Words, Values, and Person-Centred Care [online] 2020; https://academic.oup.com/ageing/article/49/3/334/5685757
- NHS Education for Scotland. The Health Literacy Place, Tools and Techniques [online] 2021; https://www.healthliteracyplace.org.uk/toolkit/techniques/
- NHS England. Always Events - Co-production using the Always Events® quality improvement methodology [online] 2021; https://www.england.nhs.uk/always-events/
- Picker. A toolkit for Improving Compassionate Care [online] 2017; https://picker.org/how-we-can-help/care-experience-tools/improving-compassionate-care/
- Scottish Government. Shared Decision Making in Realistic Medicine: What Works [online] 2019; https://www.gov.scot/publications/works-support-promote-shared-decision-making-synthesis-recent-evidence/pages/1/
- Scottish Government. Coronavirus (COVID-19): Hospital Visiting Guidance [online] 2022; https://www.gov.scot/publications/coronavirus-covid-19-hospital-visiting-guidance/
- Social Care Institute for Excellence. Care Planning, Involvement and Person-Centred Care [online]. 2017; https://www.scie.org.uk/mca/practice/care-planning/person-centred-care
- What Matters to you?. What Matters to you? [online] 2020; https://wmty.world/

Person centred care

Healthcare Improvement Scotland | Every Person Every Time 24/7 Scottish Patient Safety Programme

Individualised assessment | Implementation of agreed tool for early identification of frailty * | Implementation of agreed tool for early identification of delirium * | Standard comprehensive assessment with multifactorial interventions | Monitor patterns of behaviour | Local policy and procedure to support commencement of enhanced obs/1:1

Evidence and Guidelines:

- Graham C, Kasbauer S, Cooper R, King J, Sizmur S, et al. Health Services and Delivery Research. An Evaluation of a Near Real-time Survey for Improving Patients' Experiences of the Relational Aspects of Care [online] 2018; https://pubmed.ncbi.nlm.nih.gov/29595933/
- Healthcare Improvement Scotland. SIGN: Risk reduction and management of delirium [online] 2019; https://www.sign.ac.uk/sign-157-delirium
- Keuseman R, Miller D. A hospitalist's role in preventing patient falls [online] 2020; (16);15. https://www.tandfonline.com/doi/abs/10.1080/21548331.2020.1724473?journalCode=ihop20
- NICE. Comprehensive Geriatric Assessment NICE Quality standard QS136 [online] 2016; https://www.nice.org.uk/guidance/QS136/chapter/Quality-statement-2-Comprehensive-geriatric-assessment
- Royal College of Physicians. FallSafe resources - original [online] 2018; http://www.rcplondon.ac.uk/guidelines-policy/fallsafe-resources-original
- Tieges Z, Maclullich AMJ, Anand A, Brookes C, Cassarino M, et al. Diagnostic accuracy of the 4AT for delirium detection in older adults: systematic review and meta-analysis [online] 2021; 50(3):733-743 https://pubmed.ncbi.nlm.nih.gov/33951145
- World Falls Guidelines. World falls guidelines [online] 2022; https://worldfallsguidelines.com/

Tools and Resources:

- Afezolli D, Akpan A, Ardagh M, Arendts G, Banerjee J, et al. Silver book II in Holistic Assessment of Older People [online] 2021; https://www.bgs.org.uk/resources/resource-series/silver-book-ii
- Dalhousie University. Geriatric Medicine Research: Clinical Frailty Scale [online] 2005; https://www.dal.ca/sites/gmr/our-tools/clinical-frailty-scale.html
- Healthcare Improvement Scotland ihub Delirium Resources [online]; https://ihub.scot/improvement-programmes/acute-adult/older-people-in-acute-care/delirium/
- Healthcare Improvement Scotland ihub Frailty Resources [online]; https://ihub.scot/improvement-programmes/acute-adult/older-people-in-acute-care/frailty-at-the-front-door/
- James IA, Jackman L. Chapter 10 The Newcastle Model In James IA, Jackman L. Understanding Behaviour in Dementia that Challenges (2nd edn.). 2017. Jessica Kingsley Publishers. [online] https://www.researchgate.net/publication/340298479_The_Newcastle_Model
- Royal College of Physicians Acute Care Toolkit 3: Acute Care for Older People Living with Frailty [online] 2020; https://www.rcplondon.ac.uk/guidelines-policy/acute-care-toolkit-3-acute-care-older-people-living-frailty
- The 4at. Rapid Clinical Test for Delirium [online] 2022; https://www.the4at.com/

Use of reliable tools

Person centred care

Healthcare Improvement Scotland | Scottish Patient Safety Programme

Targeted evidence based falls risk interventions

Timely CGA

Implementation of agreed tool to manage delirium *

Delivery of person centred care planning documentation

Evidence and Guidelines:

- Coulter A, Entwistle V, Eccles A, Ryan S, Shepperd S et al. Personalised Care Planning for Adults with Chronic or Long-term Health Conditions [online] 2015:(3); https://www.cochranelibrary.com/cdsr/doi/10.1002/14651858.CD010523.pub2/full
- Ellis G, Gardner M, Tsiachristas A, Langhorne P, Burke O et al. Comprehensive Geriatric Assessment Older Adults Admitted to Hospital [online] 2017;(9); https://www.cochrane.org/CD006211/EPOC_comprehensive-geriatric-assessment-older-adults-admitted-hospital
- Healthcare Improvement Scotland SIGN: Management of Osteoporosis and the Prevention of Fragility Fractures [online] 2021; https://www.sign.ac.uk/our-guidelines/management-of-osteoporosis-and-the-prevention-of-fragility-fractures/
- Healthcare Improvement Scotland Care of Older People in Hospital Standards [online] 2015; https://www.healthcareimprovementscotland.org/our_work/standards_and_guidelines/stnds/opah_standards.aspx
- Sillner A, Holle C, Rudolph J. The Overlap Between Falls and Delirium in Hospitalized Older Adults: A Systematic Review [online] 2019; 35(2):221-236. https://pubmed.ncbi.nlm.nih.gov/30929884/
- World falls guidelines [online] 2022; https://worldfallsguidelines.com/

Tools and Resources:

- Bauernfreund Y, Butler M, Ragavan S, Sampson EL. TIME to think about delirium: improving detection and management on the acute medical unit [online] 2018; 7:(200); https://bmjopenquality.bmj.com/content/7/3/e000200.info
- Healthcare Improvement Scotland ihub SPSP Acute Adult - Falls Resources [online]; https://ihub.scot/improvement-programmes/acute-adult/spsp-acute-adult-collaborative-1/additional-programme-information-falls/
- My Home Life Scotland. Caring Conversations [online] 2021; https://myhomelife.uws.ac.uk/scotland/caring-conversations/
- NHS Education for Scotland. Realistic Medicine Module [online]; https://learn.nes.nhs.scot/18350/realistic-medicine
- NHS Education for Scotland Enhancing Person-centred Care [online]; https://www.effectivepractitioner.nes.scot.nhs.uk/clinical-practice/enhancing-person-centred-care.aspx
- Royal College of Physicians. Bedside Vision Check for Falls Prevention [online] 2017; https://www.rcplondon.ac.uk/projects/outputs/bedside-vision-check-falls-prevention-assessment-tool
- The 4AT. Guide to delirium care: detection, treatment, and prevention — 4AT - RAPID CLINICAL TEST FOR DELIRIUM (the4at.com) [online] 2022; https://www.the4at.com/deliriumguide/#top

***Use of reliable tools**

Person centred care

Regular review | Daily review of person centred care planning documentation | Post-fall review and care plan updated | Structured ward round | Local policy and procedure to support review of and stopping enhanced obs/1:1

Evidence and Guidelines:

- Healthcare Improvement Scotland Care of Older People in Hospital Standards [online] 2015; https://www.healthcareimprovementscotland.org/our_work/standards_and_guidelines/stnds/opah_standards.aspx
- NICE Guideline Chapter 28 Structured Ward Rounds [online] 2017; https://www.nice.org.uk/guidance/ng94/documents/draft-guideline-28
- Royal College of Physicians FallSafe resources - original [online] 2018; http://www.rcplondon.ac.uk/guidelines-policy/fallsafe-resources-original
- Royal College of Physicians Supporting best and safe practice in post-fall management in inpatient settings [online] 2022; https://www.rcplondon.ac.uk/projects/outputs/supporting-best-and-safe-practice-post-fall-management-inpatient-settings
- World Falls Guidelines. World falls guidelines [online] 2022; https://worldfallsguidelines.com/

Tools and Resources:

- Clinical Excellence Commission Structured Ward Rounds – Patricia's Story [online YouTube] 2015; https://www.youtube.com/watch?v=fExlkV5jlUI
- Royal College of Physicians Modern Ward Rounds [online] 2021; https://www.rcplondon.ac.uk/projects/outputs/modern-ward-rounds

Primary Driver
Promote safer mobility

Secondary drivers	Change ideas			
Patient / family / carer involvement	What matters to you conversations to inform patient care	Personal outcomes discussions	Family involvement in therapy sessions	Promote 'reconditioning' with patient / family / carers
Maintain a safe environment	Work station positions for close observation of people at risk of falls	Seats placed around the ward for patients to rest	Bed rail assessment to inform plan of care	Test 'call don't fall' initiatives
Meaningful activity	Planned activity delivered by use of volunteers	Risk enablement to encourage patient mobility	Group based exercise/activity programmes	
Maximise opportunities for supported positive risk taking	Activities displayed around ward e.g. sit to stands at bed space	Communication of patient mobility needs e.g I Can	Daily plan for patients to get up and dressed	Individualised prescribed mobility plans with visual exercise prompts

Promote safer mobility

Patient / family / carer involvement | What matters to you conversations to inform patient care | Personal outcomes discussions | Family involvement in therapy sessions | Promote 'reconditioning' with patient/family/carers

Evidence and Guidelines:

- Avanecean D, Calliste D, Contreras T, Yeogyeong L, Fitzpatrick. Effectiveness of Patient-centered Interventions on Falls in the Acute Care Setting Compared to Usual Care: A Systematic Review [online] 2017; 15(12); https://journals.lww.com/jbisrir/Abstract/2017/12000/Effectiveness_of_patient_centered_interventions_on.14.aspx
- Harvey J A, Chastin S FM, Skelton D. What Happened to my Legs when I Broke my Arm [online] 2018; 5(3): 252-258. http://www.aimspress.com/article/10.3934/medsci.2018.3.252
- Liu B, Moore J, Ummukulthum A, Wai-Hin C, Khan S, et al. Outcomes of Mobilisation of Vulnerable Elders in Ontario (MOVE ON): A Multisite Interrupted Time Series Evaluation of an Implementation Intervention to Increase Patient Mobilisation [online] 2018; 47(1) 112-119; https://academic.oup.com/ageing/article/47/1/112/3970847
- Rossiter C, Levett-Jones T, Pich J. The Impact of Person-centred Care on Patient Safety: An Umbrella Review of Systematic Reviews [online] 2020; 109:103658; https://pubmed.ncbi.nlm.nih.gov/32593882/#:~:text=The%20selected%20reviews%20examined%20the%20impact%20of%20person-centred,often%20demonstrating%20limited%20evidence%20of%20impact%20on%20safety.
- The Royal Health Foundation Person Centred Care: from Ideas to Action [online] 2014; https://www.health.org.uk/publications/person-centred-care-from-ideas-to-action

Tools and Resources:

- British Geriatrics Society. Deconditioning information for providers of services for older people and the public [online] 2022; https://www.bgs.org.uk/resources/deconditioning-information-for-providers-of-services-for-older-people-and-the-public
- Healthcare Improvement Scotland What Matters to You [online] 2021; https://wmty.world/
- Health Service 360 The Last 1000 days [online] 2022
- Moving Medicine. Hospital Associated Deconditioning - Moving Medicine [online] 2022; https://movingmedicine.ac.uk/consultation-guides/condition/adult/hospital-associated-deconditioning-2/
- Realistic Medicine. Shared decision making, reducing harm, waste and tackling unwarranted variation [online] 2023; https://www.realisticmedicine.scot/
- Royal College of Physicians. Falls Prevention in Hospital: a Guide for Patients, their Families and Carers [online] 2016; https://www.rcplondon.ac.uk/projects/outputs/falls-prevention-hospital-guide-patients-their-families-and-carers
- Arora A, Dolan B. (2021) Avoiding Deconditioning in O'Hanlon S, Smith M (Eds) A comprehensive guide to rehabilitation. London, Elseiver (4edn) (Free book chapter) [online] 2021; https://ihub.scot/media/9706/arora-dolan-2021-avoiding-deconditioning-chapter.pdf

Promote safer mobility

Maintain a safe environment

Work station positions for close observation of people at risk of falls

Seats placed around the ward for patients to rest

Bed rail assessment to inform plan of care

Test 'call don't fall' initiatives

Evidence and Guidelines:

- Cameron ID, Dyer SD, Panagoda CE, Murray GR, Hill K, et al. Interventions for Preventing Falls in Older People in Care Facilities and Hospitals [online] 2018; 2018(9); https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6148705/
- Hartung B, Lalonde M. The Use of Non-slip Socks to Prevent Falls among Hospitalized Older Adults: A Literature Review [online] 2017; 38(5):412-416. https://pubmed.ncbi.nlm.nih.gov/28285830/
- Brewer B, Carley K, Reminga J, Benham-Hutchins M, Effken J A. Nursing Unit Design, Nursing Staff Communication Networks, and Patient Falls: Are they Related? HERD; [online] 2018; 11(4): 82-94 https://journals.sagepub.com/doi/full/10.1177/1937586718779223
- Royal College of Physicians and Clinical Medicine. Morris R, O'Riordan S. Prevention of Falls in Hospital [online] 2017; 17(4): 360–362. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6297656/#__ffn_sectitle

Tools and Resources:

- Ali U M, Judge A, Foster C, Brooke A, James K, et al. Do Portable Nursing Stations within Bays of Hospital Wards Reduce the Rate of Inpatient Falls [online] 2018; https://academic.oup.com/ageing/article/47/6/818/5054440
- Royal College of Physicians. Fall Safe Resources – Bed Rail Assessment [online] 2022; https://www.rcplondon.ac.uk/guidelines-policy/fallsafe-resources-original
- UK Government Bed Rails: Management and Safe Use [online] 2021; https://www.gov.uk/guidance/bed-rails-management-and-safe-use

Promote safer mobility

Meaningful activity

Planned activity delivered by use of volunteers

Risk enablement to encourage patient mobility

Group based exercise/activity programmes

Evidence and Guidelines:

- Liu B, Moore J, Ummukulthum A, Wai-Hin C, Khan S, et al. Outcomes of Mobilisation of Vulnerable Elders in Ontario (MOVE ON): A Multisite Interrupted Time Series Evaluation of an Implementation Intervention to Increase Patient Mobilisation [online] 2018; 47(1) 112-119; https://academic.oup.com/ageing/article/47/1/112/3970847
- Royal College of Occupational Therapists Occupational Therapy in the Prevention and Management of Falls in Adults [online] 2020; https://www.rcot.co.uk/practice-resources/rcot-practice-guidelines/falls
- Thomas E, Battaglia G, Patti A, Brusa J, Leonardi V, et al. Physical Activity Programs for Balance and Fall Prevention in Elderly: A systematic Review [online] 2019; 98(27):pe16218; https://journals.lww.com/md-journal/Fulltext/2019/07050/Physical_activity_programs_for_balance_and_fall.47.aspx
- Tricco A, Thomas SM, Veroniki AA, et al. Comparisons of Interventions for Preventing Falls in Older Adults: A Systematic Review and Meta-analysis [online] 2017; 318(17):1687-1699. https://jamanetwork.com/journals/jama/fullarticle/2661578

Tools and Resources

- Care Inspectorate Care about Physical Activity [online]; http://www.capa.scot/
- McInally L, Black F. Using Activity Passports to Support People to Improve their Health and Wellbeing [online] 2018; https://www.careopinion.org.uk/blogposts/753/thinkactivity---using-activity-passports-to-s
- Care Opinion, McInally L. Improving Patient Activity in Hospital [online] 2017; https://www.careopinion.org.uk/blogposts/646/improving-patient-activity-in-hospital
- Faculty of Sport and Exercise Medicine UK. Moving Medicine [online] 2021; https://movingmedicine.ac.uk/
- Public Health England, UK Government. Active Hospitals [online] 2020; https://www.gov.uk/government/case-studies/active-hospitals
- The King's Fund The Role of Volunteers in the NHS [online] 2018; https://www.kingsfund.org.uk/publications/role-volunteers-nhs-views-front-line
- The King's Fund Volunteering in Health and Care [online] 2013; https://www.kingsfund.org.uk/publications/volunteering-health-and-care

Promote safer mobility

Maximise opportunities for supported positive risk taking

Activities displayed around ward
e.g. sit to stand at bed space

Communication of patient mobility needs
e.g. I Can

Daily plan for patients to get up and dressed

Individualised prescribed mobility plans with visual exercise prompts

Evidence and Guidelines:

- Wald HL, Ramaswamy R, Perskin MH, Roberts L, Bogaisky M, Suen W, Mikhailovich. The Case for Mobility Assessment in Hospitalized Older Adults American Geriatric Society [online] 2018; https://agsjournals.onlinelibrary.wiley.com/action/downloadSupplement?doi=10.1111%2Fjgs.15595&file=jgs15595-sup-0002-supinfo.pdf
- Hartung B, Lalonde M. The Use of Non-slip Socks to Prevent Falls among Hospitalized Older Adults: A Literature Review [online] 2017; 38(5):412-416. https://pubmed.ncbi.nlm.nih.gov/28285830/
- NIHR Older People & Frailty Policy Research Unit. COVID-19 Technology for Strength and Balance [online] 2021; https://www.opfpru.nihr.ac.uk/our-research/covid-19-research/technology-for-strength-and-balance/
- Taylor N, Harding K, Dennett A, Febrey S, Warmoth K, et al. Behaviour change interventions to increase physical activity in hospitalised patients: a systematic review, meta-analysis and meta-regression [online] 2022; 51(1):afab154; https://pubmed.ncbi.nlm.nih.gov/34304267/

Tools and Resources:

- End PJ Paralysis [online] 2020; https://endpjparalysis.org/
- Faculty of Sport and Exercise Medicine UK. Moving Medicine [online] 2021; https://movingmedicine.ac.uk/
- NHS England East of England's Deconditioning Games [online]; https://www.england.nhs.uk/east-of-england/east-of-englands-deconditioning-games/
- The Chartered Society of Physiotherapy East Kent trust rolls-out 'I can' scheme to help mobilise and empower patients [online] 2019; https://www.csp.org.uk/news/2019-08-15-east-kent-trust-rolls-out-i-can-scheme-help-mobilise-empower-patients

Primary Driver
Multidisciplinary Team intervention and communication

Secondary drivers	Change ideas					
Management of communication in different situations	Highlight falls related safety issues during hospital huddles	Ward safety briefs to highlight issues and concerns	Use of standardised communication tools * to reduce risk with transitions of care			
Communication between primary and secondary care	Test mechanisms for all inpatient falls communicated via Immediate Discharge Letter	Standardised handover from ambulance to hospital	Joint primary and secondary care falls groups			
Multidisciplinary Team falls risk assessment and intervention	Multidisciplinary Team standard comprehensive assessment	Multidisciplinary Team multifactorial interventions	Polypharmacy reviews e.g. adopt 7 steps	Multidisciplinary Team ward huddles	Assess concerns about falling *	Assess and treat orthostatic hypotension

Use of reliable tools

Multidisciplinary Team intervention and communication

Healthcare Improvement Scotland | Scottish Patient Safety Programme

Management of communication in different situations

Highlight falls related safety issues during hospital huddles

Ward safety briefs to highlight issues and concerns

Use of standardised communication tools * to reduce risk with transitions of care

Evidence and Guidelines:

- Jones K, Crowe J, Allen J, Skinner A, High R, et al. The Impact of Post-fall Huddles on Repeat Fall Rates and Perceptions of Safety Culture: A Quasi-experimental Evaluation of a Patient Safety Demonstration Project [online] 2019, 19:650; https://bmchealthservres.biomedcentral.com/articles/10.1186/s12913-019-4453-y
- Muller M, Jurgens, J, Redaelli M, Klingberg K, Hautz WE, et al. Impact of the Communication and Patient Hand-off Tool SBAR on Patient Safety: A Systematic Review [online] 2018; 8:e022202; https://bmjopen.bmj.com/content/bmjopen/8/8/e022202.full.pdf
- Nagrecha R, Sing Rait J, McNairn K. Weekend Handover: Improving Patient Safety During Weekend Services [online] 2020; 56:77-81; https://www.sciencedirect.com/science/article/pii/S2049080120301412#:~:text=Weekend%20handovers%20are%20a%20valuable%20tool%20to%20increase,one%20of%20the%20most%20high-risk%20processes%20within%20medicine.
- Royal College of Physicians. Supporting best and safe practice in post-fall management in inpatient settings [online] 2022; https://www.rcplondon.ac.uk/projects/outputs/supporting-best-and-safe-practice-post-fall-management-inpatient-settings
- Ryan S, Ward M, Vaughan D, Murray B, Zena M, et al. Do Safety Briefings Improve Patient Safety in the Acute Hospital Setting? A Systematic Review [online] 2019; 75(10); 2051-2259; https://onlinelibrary.wiley.com/doi/full/10.1111/jan.13984

Tools and Resources:

- 1000 Lives Plus, NHS Wales Tools for Improvement - Improving Clinical Communication Using SBAR [online] 2011; https://documents.pub/document/improving-clinical-communication-using-sbar-1000-lives-plus.html?page=1
- East London NHS Foundation Trust SBAR - Situation-Background-Assessment-Recommendation [online] 2008; https://qi.elft.nhs.uk/resource/sbar-situation-background-assessment-recommendation/
- Institute for Healthcare Improvement Safety Briefings [online]; https://www.ihi.org/resources/Pages/Changes/ConductSafetyBriefings.aspx
- Institute for Healthcare Improvement Huddles [online]; https://www.ihi.org/resources/Pages/Tools/Huddles.aspx
- NHS Education Scotland QI Tools – SBAR [online] 2022; https://learn.nes.nhs.scot/3408/quality-improvement-zone/qi-tools/sbar

***Use of reliable tools**

Multidisciplinary Team intervention and communication

Communication between primary and secondary care

Test mechanisms for all inpatient falls communicated via Immediate Discharge Letter

Standardised handover from ambulance to hospital

Joint primary and secondary care falls groups

Evidence and Guidelines:

- Healthcare Improvement Scotland. SIGN – The SIGN Discharge Document [online] 2012; https://www.sign.ac.uk/media/1066/sign128.pdf

Tools and Resources:

- NHS Health Scotland Up and About [online] 2019; https://www.healthscotland.com/uploads/documents/23464-Up%20and%20about-Taking%20positive%20steps%20to%20avoid%20trip%20and%20falls-April%202019-English.pdf
- Social Care Institute for Excellence. Delivering integrated care: the role of the multidisciplinary team [online] 2022; https://www.scie.org.uk/integrated-care/workforce/role-multidisciplinary-team

Multidisciplinary Team intervention and communication

Healthcare Improvement Scotland | Scottish Patient Safety Programme

Multidisciplinary Team falls risk assessment and intervention | Multidisciplinary Team standard comprehensive assessment | Multidisciplinary Team multifactorial interventions | Polypharmacy reviews e.g. adopt 7 steps | Multidisciplinary Team ward huddles | Assess concerns about falling * | Assess and treat orthostatic hypotension

Evidence and Guidelines:

- Delbaere K, Close JCT, Mikolaizak, S, Sachdev PS, Brodaty H, et al. The Falls Efficacy Scale International (FES-I): A comprehensive longitudinal validation study. Age and Ageing [online] 2010; 39(2): 210-216; https://academic.oup.com/ageing/article/39/2/210/40898
- Frith J. The association of orthostatic hypotension with falls—an end to the debate? Age and Ageing [online] 2017; 46(4)540-541; https://academic.oup.com/ageing/article/46/4/540/3748456
- Hartog LC, Schrijnders D, Landman GWD, Groenier K, Kleefstra N, et al. Is orthostatic hypotension related to falling? A meta-analysis of individual patient data of prospective observational studies Age and Ageing [online] 2017; 46(4):568-575; https://academic.oup.com/ageing/article/46/4/568/3052927
- RCPCH Implementing Multidisciplinary Ward Safety Huddles To Improve Situation Awareness [online] 2019; https://qicentral.rcpch.ac.uk/resources/safety/implementing-multidisciplinary-ward-safety-huddles-to-improve-situation-awareness-the-royal-free-hospital-experience/
- World falls guidelines [online] 2022; https://worldfallsguidelines.com/

Tools and Resources:

- Gibbon J, Frith J. PHSI Orthostatic Hypotension: a pragmatic guide to diagnosis and treatment Drug Ther Bull. [online]; https://dtb.bmj.com/content/58/11/166.long
- NHS Scotland 7 steps to appropriate polypharmacy NHS Scotland [online] 2022; https://managemeds.scot.nhs.uk/for-healthcare-professionals/7-steps/#:~:text=7%20Steps%201%20Step%201%3A%20What%20matters%20to,and%20able%20to%20take%20drug%20therapy%20as%20intended%3F
- Royal College of Occupational Therapists Occupational Therapy in the Prevention and Management of Falls in Adults [online] 2020; https://www.rcot.co.uk/practice-resources/rcot-practice-guidelines/falls
- Royal College of Physicians Measurement of lying and standing blood pressure: A brief guide for clinical staff [online] 2017; https://www.rcplondon.ac.uk/projects/outputs/measurement-lying-and-standing-blood-pressure-brief-guide-clinical-staff
- The Chartered Society of Physiotherapy Clinical Update: Preventing Falls in Hospital [online] 2017; https://www.csp.org.uk/frontline/article/clinical-update-preventing-falls-hospital
- The University of Manchester Falls Efficacy Scale International [online] 2006; https://sites.manchester.ac.uk/fes-i/

Use of reliable tools

Primary Driver
Leadership to support a culture of safety

Secondary drivers	Change ideas			
Psychological safety	Structured 1:1 time	Process to access senior support and discussion	Structured hospital huddles to raise concerns	
Staff wellbeing	Listening to the workforce and identifying areas for improvements	Test ideas for improvements in a timely manner	Celebrate success	Use of standardised feedback tools e.g. iMatter
Safe staffing	Staff education and awareness	Mechanism for effective rostering	Process for mitigation of staffing shortfalls	Process to escalate staffing shortfalls which impact on safe delivery of care
System for learning	Post-falls staff debrief	Quality improvement and measurement support	Involvement of falls coordinators in improvement work	Establish local falls groups with MDT representation

Leadership to support a culture of safety

Psychological safety

Structured 1:1 time

Process to access senior support and discussion

Structured hospital huddles to raise concerns

Evidence and Guidelines:

- Grailey KE, Murray E, Reader T, Brett SJ. The presence and potential impact of psychological safety in the healthcare setting: an evidence synthesis. BMC Health Services Research [online] 2021;21(1):773; https://bmchealthservres.biomedcentral.com/articles/10.1186/s12913-021-06740-6
- Institute of Healthcare Improvement. Three ways to create psychological safety by Amy Edmondson [online] [video] 2022; https://www.youtube.com/watch?v=jbLjdFqrUNs
- O'Donovan R, McAuliffe E. A systematic review of factors that enable psychological safety in healthcare teams Int J Qual Health Care [online] 2020; (4):240-250; https://academic.oup.com/intqhc/article/32/4/240/5813852

Tools and Resources:

- Edmondson A The importance of psychological safety [online] [video] 2021; https://www.youtube.com/watch?v=eP6guvRt0U0
- Healthcare Improvement Scotland Leadership Walk-rounds and Safety Conversations [online]; https://ihub.scot/project-toolkits/safety-principles/safety-principles/leadership-and-culture-principle/leadership-walk-rounds-and-safety-conversations/
- Healthcare Improvement Scotland Essentials of Safe Care, Readiness for Change Assessment & Prioritisation Tool [online] 2021; https://ihub.scot/media/8197/20210308-eosc-readiness-tool-v012.pdf
- Institute for Healthcare Improvement Why Is Psychological Safety So Important in Health Care? [online] 2022; http://www.ihi.org/education/IHIOpenSchool/resources/Pages/AudioandVideo/Amy-Edmondson-Why-Is-Psychological-Safety-So-Important-in-Health-Care.aspx - new reference
- West M, Eckert R, Collins B, Chowla R. Caring to change: how compassionate leadership can stimulate innovation in health care [online] 2017; https://www.kingsfund.org.uk/sites/default/files/field/field_publication_file/Caring_to_change_Kings_Fund_May_2017.pdf

Leadership to support a culture of safety

Staff wellbeing

Listening to the workforce and identifying areas for improvements

Test ideas for improvements in a timely manner

Celebrate success

Use of standardised feedback tools e.g. imatter

Evidence and Guidelines:

- NHS Education for Scotland National Trauma Training Programme [online] 2020; https://www.nes.scot.nhs.uk/news/the-national-trauma-training-programme-nttp/
- Perlo j, Balik B, Swensen S, Kabcenell A, Landsman J, et al. Institute for Healthcare Improvement Framework for Improving Joy in Work [online] 2017; https://www.ihi.org/resources/Pages/IHIWhitePapers/Framework-Improving-Joy-in-Work.aspx

Tools and Resources:

- NHS Education for Scotland and Healthcare Improvement Scotland ihub Ready to Lead: Lesson 7 – Celebrating Success webpage [online] [video] 2021; https://ihub.scot/project-toolkits/ready-to-lead/ready-to-lead/lesson-7-celebrating-success/
- National Wellbeing Hub National Wellbeing Hub for Health and Social Care Staff [online]; https://wellbeinghub.scot/
- Picker Institute Europe Understanding staff wellbeing, its impact on patient experience and healthcare quality [online] 2015; https://picker.org/research_insights/staff-wellbeing-its-impact-on-patient-experience-and-healthcare-quality/
- The Scottish Social Service Council Coaching for Wellbeing Resources [online]; https://news.sssc.uk.com/news/coaching-for-wellbeing

Leadership to support a culture of safety

Safe staffing | Staff education and awareness | Mechanism for effective rostering | Process for mitigation of staffing shortfalls | Process to escalate staffing shortfalls which impact on safe delivery of care

Evidence and Guidelines:

- Griffiths P, Recio-Saucedo, Dall'Ora C, Briggs J, Maruotti A, et al. The Association Between Nurse Staffing and Omissions in Nursing Care: A Systematic Review Journal of Advanced Nursing. [online] 2018; 74(7): 1474–1487; https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6033178/
- Shekelle PG Nurse-Patient Ratios as a Patient Safety Strategy: A Systematic Review Ann Intern Med.[online] 2013; 158(5):2:404-409; https://www.acpjournals.org/doi/10.7326/0003-4819-158-5-201303051-00007?url_ver=Z39.88-2003&rfr_id=ori:rid:crossref.org&rfr_dat=cr_pub++0pubmed&

Tools and Resources:

- Healthcare Improvement Scotland Staffing Workload Tools [online]; https://www.healthcareimprovementscotland.org/our_work/patient_safety/healthcare_staffing_programme/staffing_workload_tools.aspx
- Healthcare Improvement Scotland Safe Staffing [online]; https://ihub.scot/improvement-programmes/scottish-patient-safety-programme-spsp/essentials-of-safe-care/safe-clinical-and-care-processes/safe-staffing/
- Learning from Excellence A Call to Learn from What Works Well [online]; https://learningfromexcellence.com/
- NHS England Safe Sustainable and Productive Staffing [online]; https://www.england.nhs.uk/wp-content/uploads/2021/05/safe-staffing-adult-in-patient.pdf

Leadership to support a culture of safety

System for learning | Post-falls staff debrief | Quality improvement and measurement support | Involvement of falls coordinators in improvement work | Establish local falls groups with MDT representation

Evidence and Guidelines:

- Jones KJ, Crowe J, Allen JA. et al. The Impact of Post-Fall Huddles on Repeat Fall Rates and Perceptions of Safety Culture: A Quasi-Experimental Evaluation of a Patient Safety Demonstration Project [online] 2019; 19:650; https://bmchealthservres.biomedcentral.com/articles/10.1186/s12913-019-4453-y
- Leonard M, Frankel A. How Can Leaders Influence a Safety Culture? The Health Foundation. [online] 2012;
- Morris ME, Webster K, Jones C, Hill A-M, Haines T, et al. Interventions to reduce falls in hospitals: a systematic review and meta-analysis [online] 2022; 51(5):afac077; https://pubmed.ncbi.nlm.nih.gov/35524748/
- Sujan M. An Organisation Without a Memory: A Qualitative Study of Hospital Staff Perceptions on Reporting and Organisational Learning for Patient Safety Reliability Engineering & System Safety [online] 2015; 144:45-52; https://www.sciencedirect.com/science/article/pii/S095183201500201X
- https://www.health.org.uk/sites/default/files/HowCanLeadersInfluenceASafetyCulture.pdf
- The Health Foundation Measuring Safety Culture [online] 2011; https://www.health.org.uk/sites/default/files/MeasuringSafetyCulture.pdf
- Vincent C, Burnett S, Carthey J. The Measuring and Monitoring of Safety The Health Foundation [online] 2013; https://www.health.org.uk/publications/the-measurement-and-monitoring-of-safety

Tools and Resources:

- Learning from Excellence A call to learn from what works well [online]; https://learningfromexcellence.com/
- NHS Education for Scotland Achieving Sustainable Change [online]; https://learn.nes.nhs.scot/60970
- The Health Foundation Quality Improvement Made Simple, What Everyone Should Know about Health Care Quality Improvement [online] 2021; https://www.health.org.uk/sites/default/files/QualityImprovementMadeSimple.pdf

Measurement

Measurement is an essential part of improvement as it helps the project team understand if the changes they are making are leading to improved care. Below you will see an outline of three types of measures used in improvement and a link to the measurement framework.

Outcome measures
Outcome measures are used to understand if the changes are resulting in improvements towards the aim.

Process measures
Process measures demonstrate that change ideas are improving the underlying processes that contribute towards falls prevention.

Balancing measures
Balancing measures are used to determine if the changes are affecting things elsewhere in the system (unintended consequences).

More detailed information can be found in the measurement framework on the ihub website.

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