

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



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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



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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



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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



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**Essentials of Safe Care*

Primary Driver

Person centred care



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Secondary drivers

Patient and family
inclusion and
involvement

Individualised
assessment

Targeted evidence
based falls risk
interventions

Regular review

Change ideas

Provision of person
centred visiting

Implementation of
agreed tool for early
identification of frailty
*

Timely CGA

Daily review of
person centred care
plan

Conversation with
patient / family
about falls history

Implementation of
agreed tool for early
identification of
delirium *

Implementation of
agreed tool to
manage delirium *

Post-fall review and
care plan updated

Provide falls risk and
safer mobility
information to
patient / family

Standard comprehensive
assessment with
multifactorial
interventions

Delivery of person
centred care
planning
documentation

Structured ward
round

What matters to you
conversations to
inform patient care

Local policy and
procedure to support
commencement of
enhanced obs/1:1

Local policy and
procedure to support
review of and
stopping enhanced
obs/1:1

Monitor patterns
of behavior

**Use of reliable tools*

Person centred care



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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](https://www.crd.york.ac.uk/CRDWeb/ShowRecord.asp?ID=12012011211&ID=12012011211) [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](https://academic.oup.com/intqhc/article/27/3/175/2357330) [online] 2015; 27(3):175-182. <https://academic.oup.com/intqhc/article/27/3/175/2357330>
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Tools and Resources:

- Healthcare Improvement Scotland. [Virtual Visiting](https://www.hisengage.scot/virtual-visiting) [online]. 2020; <https://www.hisengage.scot/virtual-visiting>
- Hyslop B. ['Not safe for discharge'? Words, Values, and Person-Centred Care](https://academic.oup.com/ageing/article/49/3/334/5685757) [online] 2020; <https://academic.oup.com/ageing/article/49/3/334/5685757>
- NHS Education for Scotland. [The Health Literacy Place, Tools and Techniques](https://www.healthliteracyplace.org.uk/toolkit/techniques/) [online] 2021; <https://www.healthliteracyplace.org.uk/toolkit/techniques/>
- NHS England. [Always Events - Co-production using the Always Events® quality improvement methodology](https://www.england.nhs.uk/always-events/) [online] 2021; <https://www.england.nhs.uk/always-events/>
- Picker. [A toolkit for Improving Compassionate Care](https://picker.org/how-we-can-help/care-experience-tools/improving-compassionate-care/) [online] 2017; <https://picker.org/how-we-can-help/care-experience-tools/improving-compassionate-care/>
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- Scottish Government. [Coronavirus \(COVID-19\): Hospital Visiting Guidance](https://www.gov.scot/publications/coronavirus-covid-19-hospital-visiting-guidance/) [online] 2022; <https://www.gov.scot/publications/coronavirus-covid-19-hospital-visiting-guidance/>
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- What Matters to you?. [What Matters to you?](https://wmtty.world/) [online] 2020; <https://wmtty.world/>

Person centred care



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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](https://pubmed.ncbi.nlm.nih.gov/29595933/) [online] 2018; <https://pubmed.ncbi.nlm.nih.gov/29595933/>
- Healthcare Improvement Scotland. [SIGN: Risk reduction and management of delirium](https://www.sign.ac.uk/sign-157-delirium) [online] 2019; <https://www.sign.ac.uk/sign-157-delirium>
- Keuseman R, Miller D. [A hospitalist's role in preventing patient falls](https://www.tandfonline.com/doi/abs/10.1080/21548331.2020.1724473?journalCode=hop20) [online] 2020; (16);15. <https://www.tandfonline.com/doi/abs/10.1080/21548331.2020.1724473?journalCode=hop20>
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- Royal College of Physicians. [FallSafe resources - original](http://www.rcplondon.ac.uk/guidelines-policy/fallsafe-resources-original) [online] 2018; <http://www.rcplondon.ac.uk/guidelines-policy/fallsafe-resources-original>
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- World Falls Guidelines. [World falls guidelines](https://worldfallsguidelines.com/) [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](https://www.bgs.org.uk/resources/resource-series/silver-book-ii) [online] 2021; <https://www.bgs.org.uk/resources/resource-series/silver-book-ii>
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- Healthcare Improvement Scotland [ihub Frailty Resources](https://ihub.scot/improvement-programmes/acute-adult/older-people-in-acute-care/frailty-at-the-front-door/) [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](https://www.researchgate.net/publication/340298479_The_Newcastle_Model) In [James IA, Jackman L. Understanding Behaviour in Dementia that Challenges](https://www.researchgate.net/publication/340298479_The_Newcastle_Model) (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](http://www.rcplondon.ac.uk/guidelines-policy/acute-care-toolkit-3-acute-care-older-people-living-frailty) [online] 2020; [https://www.rcplondon.ac.uk/guidelines-policy/acute-care-toolkit-3-acute-care-older-people-living-frailty](http://www.rcplondon.ac.uk/guidelines-policy/acute-care-toolkit-3-acute-care-older-people-living-frailty)
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**Use of reliable tools*

Person centred care

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](https://www.cochranelibrary.com/cdsr/doi/10.1002/14651858.CD010523.pub2/full) [online] 2015;(3); <https://www.cochranelibrary.com/cdsr/doi/10.1002/14651858.CD010523.pub2/full>
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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](https://bmjopenquality.bmj.com/content/7/3/e000200.info) [online] 2018; 7:(200); <https://bmjopenquality.bmj.com/content/7/3/e000200.info>
- Healthcare Improvement Scotland [ihub SPSP Acute Adult - Falls Resources](https://ihub.scot/improvement-programmes/acute-adult/spsp-acute-adult-collaborative-1/additional-programme-information-falls/) [online]; <https://ihub.scot/improvement-programmes/acute-adult/spsp-acute-adult-collaborative-1/additional-programme-information-falls/>
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- NHS Education for Scotland. [Realistic Medicine Module](https://learn.nes.nhs.scot/18350/realistic-medicine) [online]; <https://learn.nes.nhs.scot/18350/realistic-medicine>
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- The 4AT. [Guide to delirium care: detection, treatment, and prevention — 4AT - RAPID CLINICAL TEST FOR DELIRIUM \(the4at.com\)](https://www.the4at.com/deliriumguide/#top) [online] 2022; <https://www.the4at.com/deliriumguide/#top>

Person centred care



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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](https://www.healthcareimprovementscotland.org/our_work/standards_and_guidelines/stnds/opah_standards.aspx) [online] 2015; https://www.healthcareimprovementscotland.org/our_work/standards_and_guidelines/stnds/opah_standards.aspx
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Tools and Resources:

- Clinical Excellence Commission [Structured Ward Rounds – Patricia’s Story](https://www.youtube.com/watch?v=fExIkV5jIU) [online YouTube] 2015; <https://www.youtube.com/watch?v=fExIkV5jIU>
- Royal College of Physicians [Modern Ward Rounds](https://www.rcplondon.ac.uk/projects/outputs/modern-ward-rounds) [online] 2021; <https://www.rcplondon.ac.uk/projects/outputs/modern-ward-rounds>

Primary Driver

Promote safer mobility



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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/care
rs



Evidence and Guidelines:

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- 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>
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Tools and Resources:

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- Healthcare Improvement Scotland [What Matters to You](#) [online] 2021; <https://wmt.y.world/>
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- 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, Elsevier (4edn) (Free book chapter) [online] 2021; <https://ihub.scot/media/9706/arora-dolan-2021-avoiding-deconditioning-chapter.pdf>

Promote safer mobility



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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](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6148705/) [online] 2018; 2018(9); <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6148705/>
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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](https://academic.oup.com/ageing/article/47/6/818/5054440) [online] 2018; <https://academic.oup.com/ageing/article/47/6/818/5054440>
- Royal College of Physicians. [Fall Safe Resources – Bed Rail Assessment](https://www.rcplondon.ac.uk/guidelines-policy/fallsafe-resources-original) [online] 2022; <https://www.rcplondon.ac.uk/guidelines-policy/fallsafe-resources-original>
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Promote safer mobility



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Meaningful activity

Planned activity
delivered by use of
volunteers

Risk enablement to
encourage patient
mobility

Group based
exercise/activity
programmes



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- 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/>
- McNally 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, McNally 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



Healthcare
Improvement
Scotland



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](https://agsjournals.onlinelibrary.wiley.com/action/downloadSupplement?doi=10.1111%2Fjgs.15595&file=jgs15595-sup-0002-supinfo.pdf) American Geriatric Society [online] 2018; <https://agsjournals.onlinelibrary.wiley.com/action/downloadSupplement?doi=10.1111%2Fjgs.15595&file=jgs15595-sup-0002-supinfo.pdf>
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- NIHR Older People & Frailty Policy Research Unit. [COVID-19 Technology for Strength and Balance](https://www.opfpru.nihr.ac.uk/our-research/covid-19-research/technology-for-strength-and-balance/) [online] 2021; <https://www.opfpru.nihr.ac.uk/our-research/covid-19-research/technology-for-strength-and-balance/>
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Tools and Resources:

- [End PJ Paralysis](https://endpjaralysis.org/) [online] 2020; <https://endpjaralysis.org/>
- Faculty of Sport and Exercise Medicine UK. [Moving Medicine](https://movingmedicine.ac.uk/) [online] 2021; <https://movingmedicine.ac.uk/>
- NHS England [East of England's Deconditioning Games](https://www.england.nhs.uk/east-of-england/east-of-englands-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](https://www.csp.org.uk/news/2019-08-15-east-kent-trust-rolls-out-i-can-scheme-help-mobilise-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



Healthcare
Improvement
Scotland



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



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](https://bmchealthservres.biomedcentral.com/articles/10.1186/s12913-019-4453-y) [online] 2019; 19:650; <https://bmchealthservres.biomedcentral.com/articles/10.1186/s12913-019-4453-y>
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Tools and Resources:

- 1000 Lives Plus, NHS Wales [Tools for Improvement - Improving Clinical Communication Using SBAR](https://documents.pub/document/improving-clinical-communication-using-sbar-1000-lives-plus.html?page=1) [online] 2011; <https://documents.pub/document/improving-clinical-communication-using-sbar-1000-lives-plus.html?page=1>
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- Institute for Healthcare Improvement [Huddles](https://www.ihl.org/resources/Pages/Tools/Huddles.aspx) [online]; <https://www.ihl.org/resources/Pages/Tools/Huddles.aspx>
- NHS Education Scotland [QI Tools – SBAR](https://learn.nes.nhs.scot/3408/quality-improvement-zone/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



Healthcare
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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](https://www.sign.ac.uk/media/1066/sign128.pdf) [online] 2012; <https://www.sign.ac.uk/media/1066/sign128.pdf>

Tools and Resources:

- NHS Health Scotland [Up and About](https://www.healthscotland.com/uploads/documents/23464-Up%20and%20about-Taking%20positive%20steps%20to%20avoid%20trip%20and%20falls-April%202019-English.pdf) [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](https://www.scie.org.uk/integrated-care/workforce/role-multidisciplinary-team) [online] 2022; <https://www.scie.org.uk/integrated-care/workforce/role-multidisciplinary-team>

Multidisciplinary Team intervention and communication



Healthcare
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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>
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- [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>
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- 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



Healthcare
Improvement
Scotland



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



Healthcare
Improvement
Scotland



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](https://bmchealthservres.biomedcentral.com/articles/10.1186/s12913-021-06740-6). 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](https://www.youtube.com/watch?v=jbLjdFqrUNs) [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](https://academic.oup.com/intqhc/article/32/4/240/5813852) 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](https://www.youtube.com/watch?v=eP6guvRt0U0) [online] [video] 2021; <https://www.youtube.com/watch?v=eP6guvRt0U0>
- Healthcare Improvement Scotland [Leadership Walk-rounds and Safety Conversations](https://ihub.scot/project-toolkits/safety-principles/safety-principles/leadership-and-culture-principle/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](https://ihub.scot/media/8197/20210308-eosc-readiness-tool-v012.pdf) [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?](http://www.ihl.org/education/IHIOpenSchool/resources/Pages/AudioandVideo/Amy-Edmondson-Why-Is-Psychological-Safety-So-Important-in-Health-Care.aspx) [online] 2022; <http://www.ihl.org/education/IHIOpenSchool/resources/Pages/AudioandVideo/Amy-Edmondson-Why-Is-Psychological-Safety-So-Important-in-Health-Care.aspx> - new reference
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Leadership to support a culture of safety



Healthcare
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Scotland



Staff wellbeing

Listening to the
workforce and
identifying areas for
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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](https://www.nes.scot.nhs.uk/news/the-national-trauma-training-programme-nttp/) [online] 2020; <https://www.nes.scot.nhs.uk/news/the-national-trauma-training-programme-nttp/>
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Tools and Resources:

- NHS Education for Scotland and Healthcare Improvement Scotland ihub [Ready to Lead: Lesson 7 – Celebrating Success webpage](https://ihub.scot/project-toolkits/ready-to-lead/ready-to-lead/lesson-7-celebrating-success/) [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](https://wellbeinghub.scot/) [online]; <https://wellbeinghub.scot/>
- Picker Institute Europe [Understanding staff wellbeing, its impact on patient experience and healthcare quality](https://picker.org/research_insights/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](https://news.sssc.uk.com/news/coaching-for-wellbeing) [online]; <https://news.sssc.uk.com/news/coaching-for-wellbeing>

Leadership to support a culture of safety



Healthcare
Improvement
Scotland



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



Healthcare
Improvement
Scotland



System for learning

Post-falls staff
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Quality improvement
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Involvement of falls
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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](https://bmchealthservres.biomedcentral.com/articles/10.1186/s12913-019-4453-y) [online] 2019; 19:650; <https://bmchealthservres.biomedcentral.com/articles/10.1186/s12913-019-4453-y>
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- <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](https://learningfromexcellence.com/) [online]; <https://learningfromexcellence.com/>
- NHS Education for Scotland [Achieving Sustainable Change](https://learn.nes.nhs.scot/60970) [online]; <https://learn.nes.nhs.scot/60970>
- The Health Foundation [Quality Improvement Made Simple, What Everyone Should Know about Health Care Quality Improvement](https://www.health.org.uk/sites/default/files/QualityImprovementMadeSimple.pdf) [online] 2021; <https://www.health.org.uk/sites/default/files/QualityImprovementMadeSimple.pdf>



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](#).

Contact details



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