Healthcare Improvement Scotland | SCOTTISH PATIENT SAFETY PROGRAMME | EVERY PERSON EVERY TIME

NHS Greater Glasgow and Clyde

NHS GGC Falls Reduction Storyboard

Creating the Conditions
Creating Conditions
- 10 Test sites participating across all 4 Acute Sectors
- Set up Acute Falls Improvement group to drive forward improvement which bi-monthly
- Improvement work on data quality

Aim
Developing Aims
To reduce falls and unavoidable falls with harm by 10% by Sep 2023

Testing Changes
Testing Changes
Following benchmarking exercise the following change ideas were identified

Change ideas

- **Staff Education**
  - Inclusion of Active Wards principles into link worker training and new CAS standards
  - Running of Senior Staff and HCSW development days
  - Focus on all wards producing a Falls Information board
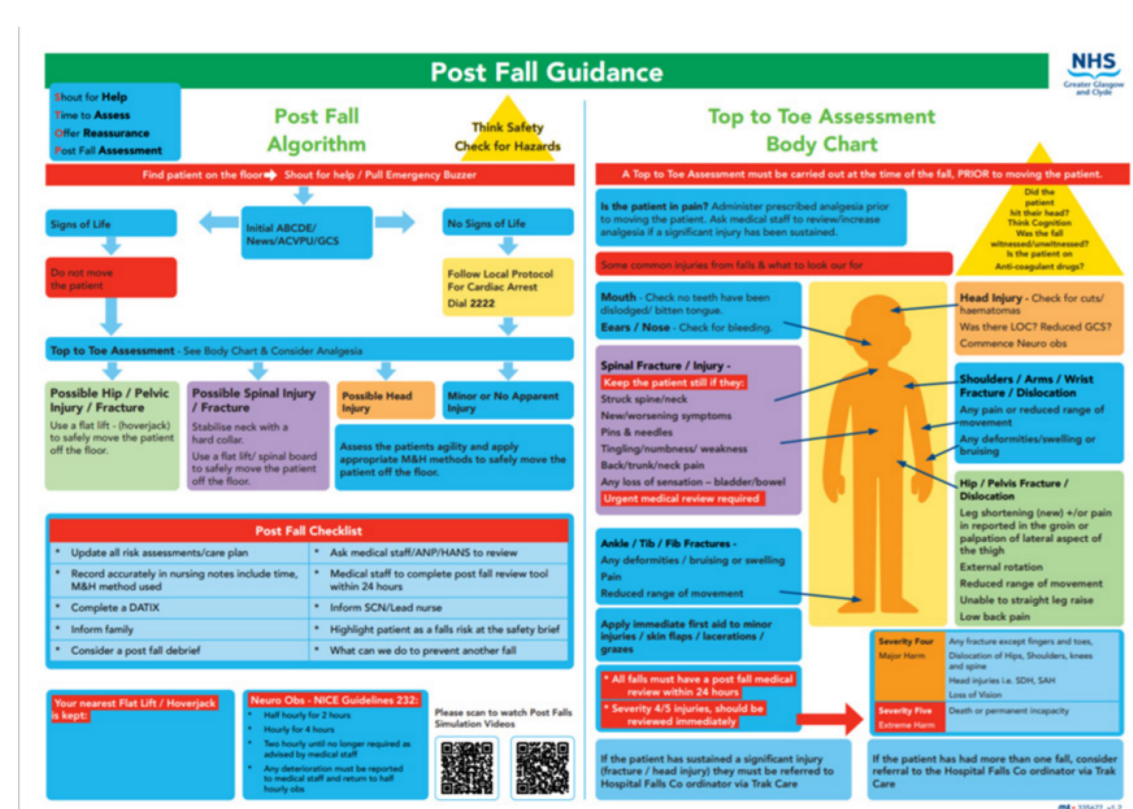 - Formation of new MDT Clinical Inpatient Falls Guidelines and New board Falls Strategy

  Guidelines for the Prevention and Management of In-patient Falls – Adults Aged 16 and Over

  Staying Safe, Strong and Steady

- **Patient/Family information**
  - Coproduced new falls information leaflet with feedback from staff and patients/family members

- **Post fall Resources**
  - Debrief tool - Coproduced with clinical staff and linked to staff welfare resources
  - Post Falls checklist sticker
  - Post Falls guidance poster with embedded simulation videos

- Use of Yellow Visual Cuing Kits

- Stay in the Bay " – improving cohort nursing and encouraging meaningful activity

Next Steps
- Continue with Acute Improvement Group
- Focus on reducing Rate of Falls with Harm – working on investigation processes and sharing of learning
- Align improvement priorities to key drivers within new Falls Strategy

Understanding your system
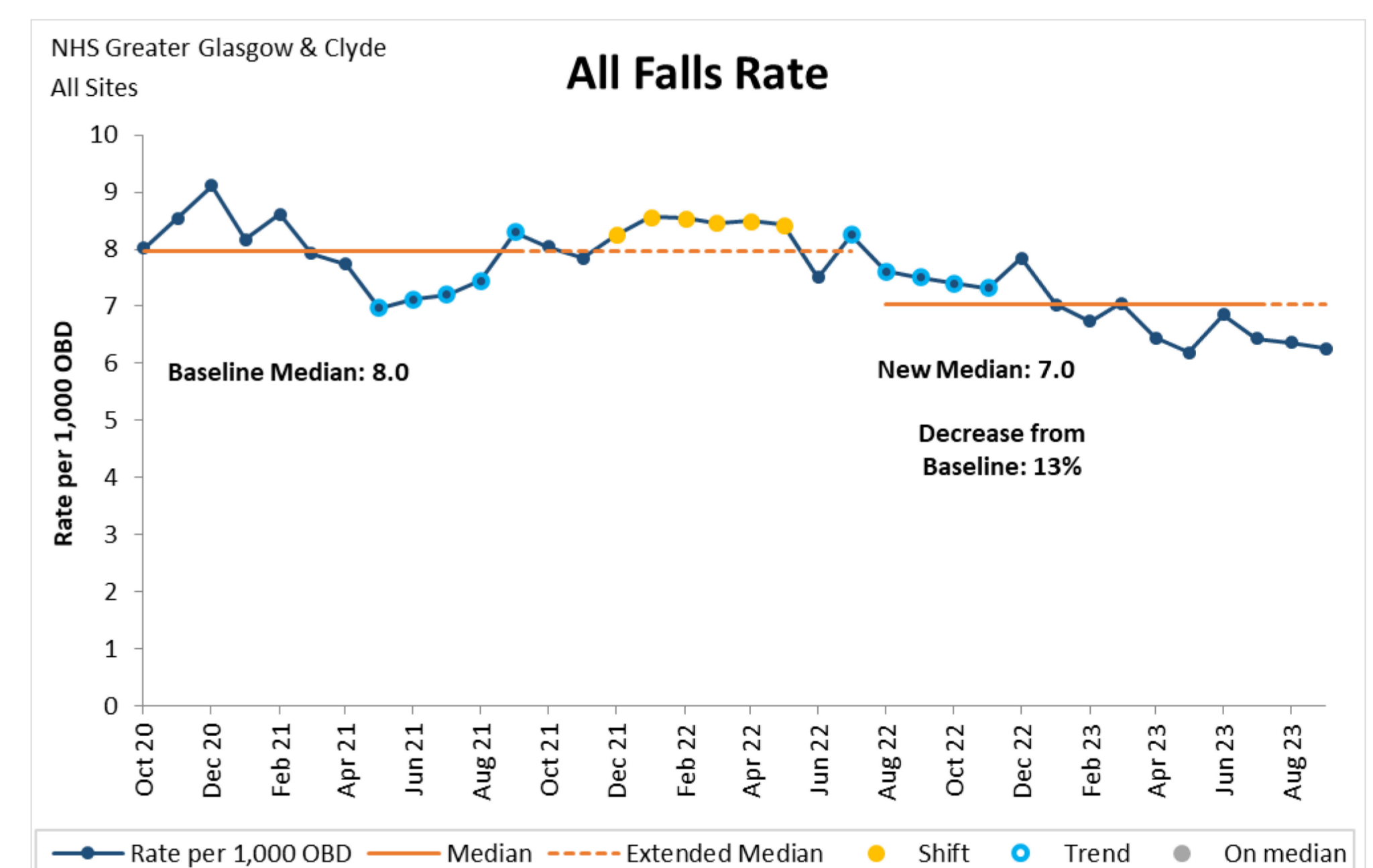**Understanding Systems**
Carried out initial meetings with the MDT on selected wards. Discussed Driver Diagram and identified areas for targeted improvement. Results can be seen below.

Areas of identified improvement

Individualised Assessment | Targeted evidence based falls risk interventions | Patient/family information and involvement | Regular review
Secondary Driver

Areas of identified improvement

Meaningful Activity | Maximise opportunities for supported positive risk taking | Patient/family/carer involvement | Maintain a safe environment
Secondary Driver

Areas of identified improvement

Management of communication in different situations | Use of standardised communication tools
Secondary Driver

Areas of identified improvement

System for Learning | Safe Staffing | Management of communication in different settings | Staff Wellbeing
Secondary Driver

Data
Measurement
We have achieved a sustained reduction in our rate of falls as per chart below.

NHS Greater Glasgow & Clyde All Sites

All Falls Rate

Rate per 1,000 OBD

Baseline Median: 8.0

New Median: 7.0

Decrease from Baseline: 13%

Rate per 1,000 OBD | Median | Extended Median | Shift | Trend | On median

Implementation and spread
Implement
- Focus on "Once for GGC" Approach to aid consistency
- Use of updated Intranet Falls Page and communication strategies
- Encourage QI capacity across all teams working to reduce falls

Project Management and Communication | **Leadership and Teams**

Enablers for success
- Coproduction of resources
- Raising awareness using multiple communication channels
- An improvement focus on the learning from falls investigations

Challenges we encountered
- Clinical staff engagement
- Financial constraints
- Falls Team clinical pressures

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