SPSP Acute Adult Programme Falls Change Package

Improvement Hub
Enabling health and
social care improvement

Introduction

Welcome to the falls change package

The aim of the falls change package is to provide evidence-based guidance to support the delivery of falls prevention 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. 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

We have made this 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 SPSP Acute Adult Falls are:

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

by September 2023.

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 Sep 2023

Local Aim:

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

by Sep 2023

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 to patient deteriorating. 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?"

2021 Falls Prevention Driver Diagram

Healthcare Improvement Scotland | Every Person Every Time SCOTTISH PATIENT SAFETY PROGRAMME

What are we trying to achieve…

National Aim:

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

by Sep 2023

Local Aim:

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

by Sep 2023

We need to ensure…

- Person centred care*
- Promote mobilisation
- Multidisciplinary Team intervention and communication*
- Organisational safety culture*

Which requires…

- Patient and family inclusion and involvement*
- Individualised assessment
- Targeted evidence based falls risk interventions
- Regular review
- Patient / family / carer involvement*
- Maintain a safe environment
- Meaningful activity
- Maximise opportunities for supported positive risk taking
- Management of communication in different situations*
- Use of standardised communication tools*
- Communication between primary and secondary care
- Multidisciplinary falls risk assessment and intervention
- 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	Person centred visiting	Conversation with patient / family about falls history	Provide falls risk information to patient / family	
Individualised assessment	Timely initial falls risk assessment	Early identification of delirium	Early identification of frailty (CGA)	Monitor patterns of behavior
Targeted evidence based falls risk interventions	Person centred care planning documentation	Risk based care rounding (or equivalent)	Daily review of person centred care planning documentation	
Regular review	Structured ward round	Post-fall review		

Person centred care

Patient and family inclusion and involvement

Person centred visiting

Conversation with patient / family about falls history

Provide falls risk information to patient/ family

Evidence and Guidelines:

A Comprehensive Systematic Review of Visitation Models in Adult Critical Care Units within the Context of Patient and Family-Centred Care University of York, 2011, Ciufo D, et al.

Practicing Realistic Medicine Scottish Government, 2018

Improving Clinician Carer Communication for Safer Hospital Care: Study of 'TOP 5' Strategy Patients with Dementia Luxford et al, 2015

Tools and Resources:

Shared Decision Making in Realistic Medicine: What Works Scottish Government, 2019

Care Planning, Involvement and Person-Centred Care Social Care Institute for Excellence, 2017

What Matters to you? 2020

Always Events NHS UK

Virtual Visiting HIS, Healthcare Improvement Scotland, 2020

'Not safe for discharge'? Words, Values, and Person-Centred Care Hyslop, 2020

The Health Literacy Place, Tools and Techniques NHS Education for Scotland, 2021

Coronavirus (COVID-19): Hospital Visiting Guidance Scottish Government, 2020

Person centred care

Healthcare Improvement Scotland

SCOTTISH PATIENT SAFETY PROGRAMME

Individualised assessment | Timely initial falls risk assessment | Early identification of delirium | Early identification of frailty (CGA) | Monitor patterns of behavior

Evidence and Guidelines:

Comprehensive Geriatric Assessment NICE Quality standard QS136, 2016

An Evaluation of a Near Real-time Survey for Improving Patients' Experiences of the Relational Aspects of Care Health Services and Delivery Research, 2018, Graham C, et al.

Comprehensive Geriatric Assessment Older Adults Admitted Hospital Cochrane Database of Systematic Reviews, 2017, Ellis G et al.

Falls in older people: assessing risk and prevention NICE Clinical guideline CG161, 2013

Preventing falls in older people during a hospital stay NICE Clinical guideline CG 161, 2013

SIGN: Risk reduction and management of delirium Healthcare Improvement Scotland, 2019

Falls in older people NICE Quality standard, 2015

Rapid Clinical Test for Delirium The 4AT

A hospitalist's role in preventing patient falls Keuseman & Miller, 2020

Tools and Resources:

ihub Delirium Resources Healthcare Improvement Scotland

ihub Frailty Resources Healthcare Improvement Scotland

Newcastle Model Understanding Behaviour in Dementia that Challenges - James and Gibbons (pp.148-167) 2019, James

Silver book II in Holistic Assessment of Older People British Geriatric Society, 2021, Bianca Buurman, et al.

Acute Care Toolkit 3: Acute Care for Older People Living with Frailty Royal College of Physicians

Person centred care

Healthcare Improvement Scotland

SCOTTISH PATIENT SAFETY PROGRAMME

Targeted evidence based falls risk interventions

Person centred care planning documentation

Risk based care rounding (or equivalent)

Daily review of person centred care planning documentation

Evidence and Guidelines:

Personalised Care Planning for Adults with Chronic or Long-term Health Conditions Cochrane, 2015, Angela Coulter, et al.
Falls in Older People: Assessing Risk and Prevention NICE Clinical Guideline CG161, 2013
Preventing Falls in Older People During a Hospital Stay NICE Clinical guideline CG161, 2013
SIGN: Management of Osteoporosis and the Prevention of Fragility Fractures Healthcare Improvement Scotland, 2021
Care of Older People in Hospital Standards Healthcare Improvement Scotland, 2015
A Hospitalist's Role in Preventing Patient Falls Keuseman & Miller, 2020
Interventions for Preventing Falls in Older People in Care Facilities and Hospitals Cameron et al, 2018

Tools and Resources:

ihub SPSP Acute Adult - Falls Resources
Healthcare Improvement Scotland
Realistic Medicine Module NHS Education for Scotland
Caring Conversations My Home Life Scotland, 2021

Enhancing Person-centred Care NHS Education for Scotland
Bedside Vision Check for Falls Prevention Royal College of Physicians
Managing Falls and Fractures in Care Homes for Older People Care Inspectorate

Person centred care

Regular review

Structured ward round

Post-fall review

Evidence and Guidelines :

Falls in Older People NICE Quality standard, 2015

Care of Older People in Hospital Standards Healthcare Improvement Scotland, 2015

Chapter 28 Structured Ward Rounds NICE Guideline, 2017

Tools and Resources:

Modern Ward Rounds Royal College of Physicians

CEC - Structured Ward Rounds – Patricia's Story YouTube, 2015

Rapid response report: Essential care after an inpatient fall (rcplondon.ac.uk) National Patient Safety Agency

Primary Driver
Promote mobilisation

Secondary drivers	Change ideas				
Patient / family / carer involvement	Test 'What matters to you?'	Personal outcomes discussions	Family involvement in therapy sessions		
Maintain a safe environment	Desks in bay with staff member presence	Seats placed around the ward for patients to rest	Bed rail assessment to inform plan of care		
Meaningful activity	Use of volunteers	Risk enablement to encourage patient mobility	Group based exercise programmes	Structure staff and ward activity	
Maximise opportunities for supported positive risk taking	Posters of activities 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 mobilisation

Patient / family / carer involvement

Test 'What matters to you?'

Personal outcomes discussions

Family involvement in therapy sessions

Evidence and Guidelines:

The Health Foundation: Person Centred Care from Ideas to Action Royal Health Foundation, 2014

Effectiveness of Patient-centered Interventions on Falls in the Acute Care Setting Compared to Usual Care: A Systematic Review Avanecean et al, 2017

Outcomes of Mobilisation of Vulnerable Elders in Ontario (MOVE ON): A Multisite Interrupted Time Series Evaluation of an Implementation Intervention to Increase Patient Mobilisation Liu et al, 2018

The Impact of Person-centred Care on Patient Safety: An Umbrella Review of Systematic Reviews Rossiter et al, 2020

Tools and Resources:

Falls Prevention in Hospital: a Guide for Patients, their Families and Carers Royal College of Physicians, 2016

What Matters to You Healthcare Improvement Scotland, 2021

What Happened to my Legs when I Broke my Arm Aims Medical Science, Harvey JA, et al, 2018

CollaboRATE Tool to Measure Impact of Shared Decision Making Glyn Elwyn

Promote mobilisation

Maintain a safe environment

Desks in bay with staff member presence

Seats placed around the ward for patients to rest

Bed rail assessment to inform plan of care

Evidence and Guidelines:

Prevention of Falls in Hospital Clinical Medicine, 2017, Morris & O'Riordan

The Use of Non-slip Socks to Prevent Falls among Hospitalized Older Adults: A Literature Review Geriatric Nursing, Hartung & Lalonde, 2017

Interventions for Preventing Falls in Older People in Care Facilities and Hospitals Cochrane Database of Systematic Reviews, 2018

Nursing Unit Design, Nursing Staff Communication Networks, and Patient Falls: Are they Related? HERD, Brewer et al, 2018

Tools and Resources:

Bed Rails: Management and Safe Use UK Government, 2021

RCP: Fall Safe Resources – Bed Rail Assessment Royal College of Physicians

Do Portable Nursing Stations within Bays of Hospital Wards Reduce the Rate of Inpatient Falls Age & Ageing, Ali et al, 2018

Promote mobilisation

Meaningful activity | Use of volunteers | Risk enablement to encourage patient mobility | Group based exercise programmes | Structure staff and ward activity

Evidence and Guidelines:

A toolkit for Improving Compassionate Care Picker, 2017
Occupational Therapy in the Prevention and Management of Falls in Adults Royal College of Occupational Therapists, 2020
Physical Activity Programs for Balance and Fall Prevention in Elderly: A systematic Review Medicine, Thomas et al, 2019
Comparisons of Interventions for Preventing Falls in Older Adults: A Systematic Review and Meta-analysis JAMA, Tricco et al, 2017
Outcomes of Mobilisation of Vulnerable Elders in Ontario (MOVE ON): A Multisite Interrupted Time Series Evaluation of an Implementation Intervention to Increase Patient Mobilisation Age & Ageing, Liu et al, 2018

Tools and Resources

The Role of Volunteers in the NHS The King's Fund, 2018
Volunteering in Health and Care The King's Fund, 2013
Active Hospitals Public Health England, 2020
Moving Medicine Faculty of Sport and Exercise Medicine UK, 2021
Care about Physical Activity Care Inspectorate
Using Activity Passports to Support People to Improve their Health and Wellbeing Care Opinion, McInally L, 2018
Improving Patient Activity in Hospital Care Opinion, McInally L, 2017

Promote mobilisation

Maximise opportunities for supported positive risk taking

Posters of activities 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:

Preventing Falls in Older People During a Hospital Stay NICE Clinical guideline CG161, 2013
COVID-19 Technology for Strength and Balance NIHR Older People & Frailty Policy Research Unit
Falls Management Exercise (FaME) Implementation Toolkit NIHR Applied Research Collaboration East Midlands, 2021
The Use of Non-slip Socks to Prevent Falls Among Hospitalized Older Adults: A Literature Review Geriatric Nursing, Hartung & Lalonde, 2017

Tools and Resources:

Later Life Training Return on Investment – FaME (PSI) and Otago – Cost Effective Interventions for Falls Webinar
End PJ Paralysis 2020
Moving Medicine Faculty of Sport and Exercise Medicine UK, 2021
Safety Briefings Institute for Healthcare Improvement
Huddles Institute for Healthcare Improvement

Primary Driver
Multidisciplinary Team intervention and communication

Secondary drivers	Change ideas		
Management of communication in different situations	Hospital huddles	Ward safety briefs	
Use of standardised communication tools	Structured communication (SBAR)		
Communication between primary and secondary care	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 falls risk assessment	Multidisciplinary Team falls risk interventions	Multidisciplinary Team ward huddles

Multidisciplinary team intervention and communication

Management of communication in different situations

Hospital huddles

Ward safety briefs

Evidence and Guidelines:

CEL 19 (2013) - Patient Safety Essentials and Safety Priorities Scottish Government, 2013

Do Safety Briefings Improve Patient Safety in the Acute Hospital Setting? A Systematic Review Journal of Advance Nursing, Ryan et al, 2019

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 BMC Health Services Research, Jones et al, 2019

Tools and Resources:

Safety Briefings Institute for Healthcare Improvement

Huddles Institute for Healthcare Improvement

Multidisciplinary Team intervention and communication

Use of standardised communication tools

Structured communication (SBAR)

Evidence and Guidelines:

Weekend Handover: Improving Patient Safety During Weekend Services Annals of Medicine & Surgery, 2020, Rajvi Nagrecha, et al.

Impact of the Communication and Patient Hand-off Tool SBAR on Patient Safety: A Systematic Review BMJ Open, 2018, Müller M, et al.

Tools and Resources:

QI Tools - SBAR NHS Education Scotland

SBAR - Situation-Background-Assessment-Recommendation East London NHS Foundation Trust

Tools for Improvement - Improving Clinical Communication Using SBAR 1000 Lives Plus, NHS Wales

Multidisciplinary Team intervention and communication

Communication between primary and secondary care

Immediate discharge letter

Standardised handover from ambulance to hospital

Joint primary and secondary care falls groups

Evidence and Guidelines:

SIGN – The SIGN Discharge Document Healthcare Improvement Scotland, 2012

Tools and Resources:

Up and About NHS Health Scotland

National Falls and Fracture Prevention Strategy 2019-2024 Draft Scottish Government, 2019

Multidisciplinary Team intervention and communication

Healthcare Improvement Scotland

SCOTTISH PATIENT SAFETY PROGRAMME

Multidisciplinary Team falls risk assessment and intervention

Multidisciplinary Team falls risk assessment

Multidisciplinary Team falls risk interventions

Multidisciplinary Team ward huddles

Evidence and Guidelines:

Falls in Older People: Assessing Risk and Prevention NICE Clinical Guideline CG 161, 2013

Preventing Falls in Older People During a Hospital Stay NICE Clinical Guideline CG 161, 2013

Implementing Multidisciplinary Ward Safety Huddles To Improve Situation Awareness QI Central, RCPCH, 2019

Tools and Resources:

ihub Delirium Resources Healthcare Improvement Scotland

ihub Frailty Resources Healthcare Improvement Scotland

Clinical Update: Preventing Falls in Hospital Chartered Society of Physiotherapy, 2017

Occupational Therapy in the Prevention and Management of Falls in Adults Royal College of Occupational Therapists, 2020

Primary Driver
Organisational safety culture

Secondary drivers	Change ideas				
Psychological safety	Compassionate leadership at all levels	Collective leadership approach	Structured 1:1 time	Visible supportive leadership	
Staff wellbeing	Listening to the workforce and identifying areas for improvements	Test ideas for improvements in a timely manner	Celebrate success		
Safe staffing	Staff education and awareness	Effective rostering	Real-time staff risk assessment	Mitigation	Escalation
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	

Organisational safety culture

Psychological safety

Compassionate leadership at all levels

Collective leadership approach

Structured 1:1 time

Visible supportive leadership

Evidence and Guidelines:

Managing the Risk of Learning: Psychological Safety in Work Teams Edmondson AC, 2002
The 4 Stages of Psychological Safety: Defining the Path to Inclusion and Innovation Clark TR, 2020
How Can Leaders Influence a Safety Culture? Health Foundation, Leonard M & Frankel A, 2012
CEL 19 Patient Safety Essentials and Safety Priorities Scottish Government, 2013

Tools and Resources:

Leadership Walk-rounds and Safety Conversations Healthcare Improvement Scotland
Safety Culture Discussion Tool NHS Education for Scotland
The Importance of Psychological safety – Edmondson YouTube, 2020
Essentials of Safe Care, Readiness for Change Assessment & Prioritisation Tool Healthcare Improvement Scotland, 2021

Organisational safety culture

Staff wellbeing

Listening to the workforce and identifying areas for improvements

Test ideas for improvements in a timely manner

Celebrate success

Evidence and Guidelines:

Framework for Improving Joy in Work Institute for Healthcare Improvement, 2017

National Trauma Training Programme Project Lift, 2020

Tools and Resources:

National Wellbeing Hub for Health and Social Care Staff Healthier Scotland

Coaching for Wellbeing Resources The Scottish Social Service Council

3 Things You Can Learn From Marriott About Taking Care Of Employees Forbes, Gibbons, 2020

Upside Down Management Timpson, 2021

Understanding staff wellbeing Picker Institute Europe, Paparella G, 2015

Organisational safety culture

Healthcare Improvement Scotland | Scottish Patient Safety Programme

Safe staffing | Staff education and awareness | Effective rostering | Real-time staff risk assessment | Mitigation | Escalation

Evidence and Guidelines:

The Association Between Nurse Staffing and Omissions in Nursing Care: A Systematic Review J Adv Nurs, 2018, Griffiths P. et al.

Nurse-Patient Ratios as a Patient Safety Strategy: A Systematic Review Annals of Internal Medicine, Shekelle PG, 2013

Tools and Resources:

Safe Sustainable and Productive Staffing Case Studies NHS England

Staffing Workload Tools Healthcare Improvement Scotland

Safe Staffing Healthcare Improvement Scotland

A Call to Learn from What Works Well Learning from Excellence

Organisational safety culture

Healthcare Improvement Scotland | Every Person Every Time | Scottish Patient Safety Programme

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:

An Organisation Without a Memory: A Qualitative Study of Hospital Staff Perceptions on Reporting and Organisational Learning for Patient Safety Reliability Engineering & System Safety, Sujan M, 2015

How Can Leaders Influence a Safety Culture? The Health Foundation, 2012

Measuring Safety Culture The Health Foundation, 2011

The Measuring and Monitoring of Safety The Health Foundation, 2013

The 'How to' Guide for Reducing Harm from Falls Patient Safety First, 2009

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 BMC Health Services Research, Jones et al, 2019

Tools and Resources:

A call to Learn from what Works Well Learning from Excellence

Achieving Sustainable Change NHS Education for Scotland

Quality Improvement Made Simple, What Everyone Should Know about Health Care Quality Improvement The Health Foundation, 2021

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.

Contact details

his.acutecare@nhs.scot

@SPSP_AcuteAdult @ihubscot

#spsp247 #spspFalls

Edinburgh Office

Gyle Square

1 South Gyle Crescent

Edinburgh

EH12 9EB

0131 623 4300

Glasgow Office

Delta House

50 West Nile Street

Glasgow

G1 2NP

0141 225 6999