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.
Setting a project aim

All quality improvement projects should have an aim that is: Specific, Time bound, Aligned to the NHS board’s objectives and Numeric (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
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...

**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

## We need to ensure...

<table>
<thead>
<tr>
<th>Make Sure</th>
<th>What to make sure of</th>
<th>Why</th>
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</thead>
<tbody>
<tr>
<td><strong>Person centred care</strong></td>
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<tr>
<td><strong>Promote safer mobility</strong></td>
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<tr>
<td><strong>Multidisciplinary Team intervention and communication</strong></td>
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<tr>
<td><strong>Leadership to support a culture of safety</strong></td>
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## Which requires...

<table>
<thead>
<tr>
<th>Essential</th>
<th>Why</th>
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<tbody>
<tr>
<td>Patient and family inclusion and involvement*</td>
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<tr>
<td>Individualised assessment</td>
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<tr>
<td>Targeted evidence based falls risk interventions</td>
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<tr>
<td>Regular review of falls risk interventions</td>
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<tr>
<td>Patient / family / carer involvement*</td>
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<tr>
<td>Maintain a safe environment</td>
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<tr>
<td>Meaningful activity</td>
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<tr>
<td>Maximise opportunities for supported positive risk taking</td>
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<tr>
<td>Management of communication in different situations*</td>
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<td>Communication between primary and secondary care</td>
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<td>Multidisciplinary falls risk assessment and intervention</td>
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<tr>
<td>Psychological safety*</td>
<td></td>
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<tr>
<td>Staff wellbeing*</td>
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<td>Safe staffing*</td>
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<tr>
<td>System for learning*</td>
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</table>

*Essentials of Safe Care*
## Primary Driver
Person centred care

### Secondary drivers

<table>
<thead>
<tr>
<th>Patient and family inclusion and involvement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individualised assessment</td>
</tr>
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</tr>
<tr>
<td>Regular review</td>
</tr>
</tbody>
</table>

### Change ideas

<table>
<thead>
<tr>
<th>Provision of person centred visiting</th>
<th>Conversation with patient / family about falls history</th>
<th>Provide falls risk and safer mobility information to patient / family</th>
<th>What matters to you conversations to inform patient care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Implementation of agreed tool for early identification of frailty *</td>
<td>Implementation of agreed tool for early identification of delirium *</td>
<td>Standard comprehensive assessment with multifactorial interventions</td>
<td>Local policy and procedure to support commencement of enhanced obs/1:1</td>
</tr>
<tr>
<td>Timely CGA</td>
<td>Implementation of agreed tool to manage delirium *</td>
<td>Delivery of person centred care planning documentation</td>
<td>Monitor patterns of behavior</td>
</tr>
<tr>
<td>Daily review of person centred care plan</td>
<td>Post-fall review and care plan updated</td>
<td>Structured ward round</td>
<td>Local policy and procedure to support review of and stopping enhanced obs/1:1</td>
</tr>
</tbody>
</table>

*Use of reliable tools*
Evidence and Guidelines:


Tools and Resources:

### Tools and Resources:


### Evidence and Guidelines:

- Royal College of Physicians. *FallSafe resources - original* [online] 2018; http://www.rcplondon.ac.uk/guidelines-policy/fallsafe-resources-original
**Evidence and Guidelines:**

- World falls guidelines [online] 2022; https://worldfallsguidelines.com/

**Tools and Resources:**

- Bauernfriend 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/
- 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

Evidence and Guidelines:

- Royal College of Physicians FallSafe resources - original [online] 2018; http://www.rcplondon.ac.uk/guidelines-policy/fallsafe-resources-original

Tools and Resources:

- Royal College of Physicians Modern Ward Rounds [online] 2021; https://www.rcplondon.ac.uk/projects/outputs/modern-ward-rounds
### Primary Driver
#### Promote safer mobility

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

- 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:

- Health Service 360 The Last 1000 days [online] 2022
- Realistic Medicine. Shared decision making, reducing harm, waste and tackling unwarranted variation [online] 2023; https://www.realisticmedicine.scot/

Promote safer mobility

What matters to you conversations to inform patient care

Personal outcomes discussions

Family involvement in therapy sessions

Promote ‘reconditioning’ with patient/family/carers
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/

Tools and Resources:

• Royal College of Physicians. Fall Safe Resources – Bed Rail Assessment [online] 2022; https://www.rcplondon.ac.uk/guidelines-policy/fallsafe-resources-original
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:


Tools and Resources:

- Care Inspectorate Care about Physical Activity [online]; http://www.capa.scot/
- Faculty of Sport and Exercise Medicine UK. Moving Medicine [online] 2021; https://movingmedicine.ac.uk/
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:


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

*Use of reliable tools*
Multidisciplinary Team intervention and communication

Evidence and Guidelines:


Tools and Resources:

- 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

*Use of reliable tools

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

Highlight falls related safety issues during hospital huddles
Multidisciplinary Team intervention and communication

Evidence and Guidelines:

Tools and Resources:
Multidisciplinary Team intervention and communication

Evidence and Guidelines:

- 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://managameds.scot.nhs.uk/for-healthcare-professionals/7-steps/#:~:text=7%20Steps%201%20Step%201%3A%20What%20matters%20to,ands%20able%20to%20take%20drug%20therapy%20at%20tended%3F
- 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

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

Evidence and Guidelines:

- Institute of Healthcare Improvement. Three ways to create psychological safety by Amy Edmondson [online] [video] 2022; https://www.youtube.com/watch?v=jbLjdFqrUNs

Tools and Resources:

- Edmondson A The importance of psychological safety [online] [video] 2021; https://www.youtube.com/watch?v=eP6guvr0U0
Leadership to support a culture of safety

**Evidence and Guidelines:**


**Tools and Resources:**

Leadership to support a culture of safety

Evidence and Guidelines:


Tools and Resources:


• Learning from Excellence A Call to Learn from What Works Well [online]; https://learningfromexcellence.com/

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:


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
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](https://www.ihub.scot).
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