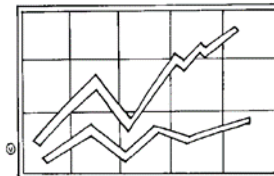
Healthcare Improvement Scotland

Falls Networking day 30 May 2018
NHS Fife

Scottish Patient Safety Programme 2008-2018 — Every person, every time — Ten years of improving safety

Who or what prompted this work? How did you build will?

- Recognition of patient harm from falls → 8 falls/day & 1 #/8 days
- Specific event that led to a complaint
- Acknowledgement that change was required



→ Executive Led Call to Action – Shared problem : Shared Solution

→ Carer story illustrating the <u>personal affects of falls, harm and loss</u>

What activities or tests of change have been successful in reducing falls or falls with harm?

- **Falls pathway** – Risk assess, care plan & post falls care: prevent further falls
- **Systems approach linked to frailty** - Falls, frailty screening, dementia, poly pharmacy, built environment & high volume pathways.
- Education / Training / Awareness Raising with **all** staff
- Clear reporting providing **data for improvement**
- Introduction of **Falls Champions**
- Frailty screening at the Front Door

Healthcare Improvement Scotland

Falls Networking day 30 May 2018
NHS Fife

SCOTTISH PATIENT SAFETY PROGRAMME 2008-2018
EVERY PERSON 24/7 EVERY TIME
Ten years of improving safety

What 3 things have been critical to your success?

- **Executive Leadership and Support**

The reduction of inpatient falls was called out as the primary strategic priority for Quality & Safety in NHS Fife 2014/15

- **Collaborative Learning and Ella's Story**

Ella's personal engagement as well as sharing Ella's story with staff to illustrate the personal and human side of falls has had a powerful and lasting impact.
NHS Fife Falls & Bone Health learn pro module
Collaborative learning with QI focus – OPC / Falls Collaborative
Inpatient and Community Falls Group –> NHS Fife Frailty MCCN
NEW! Frailty competencies – staff development pathway

- **Data and Reporting / Dashboard**

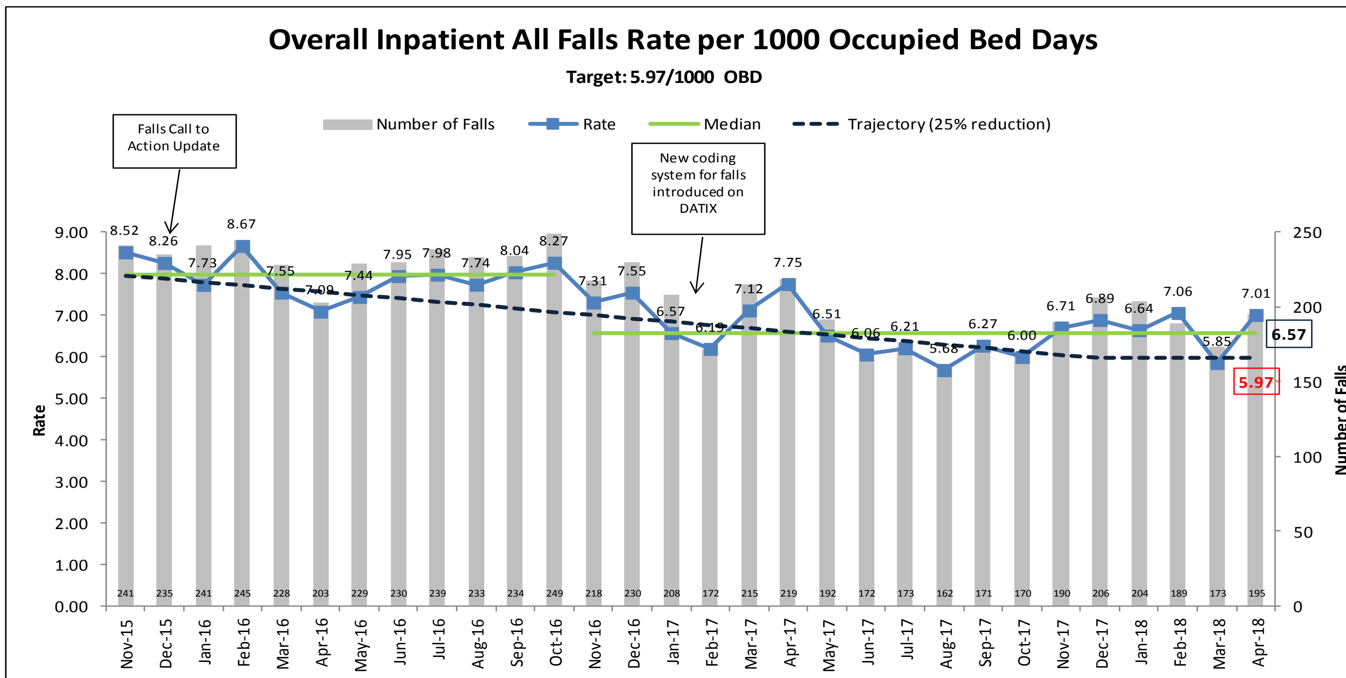
Clear data for each clinical area then aggregated at department, division and organisation level – telling a story and giving teams ownership of their own data and improvement with support

Healthcare Improvement Scotland

EVERY PERSON EVERY TIME SCOTTISH PATIENT SAFETY PROGRAMME 2008-2018

Ten years of improving safety

Where are we now – Total Falls Rate per 1000 occupied bed days



Healthcare Improvement Scotland

SCOTTISH PATIENT SAFETY PROGRAMME 2008-2018
EVERY PERSON EVERY TIME
Ten years of improving safety

Total Falls with Harm Rate per 1000 occupied bed days