Ten years of improving safety

Falls case studies

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#ACFALLS2018 #SPSP10

Reducing falls and falls with harm – board case studies:

- ❑ Understand the factors that have contributed to success
- ❑ Share learning
- ❑ Revise the falls driver diagram and change package

EVERY PERSON 24/7 EVERY TIME
SCOTTISH PATIENT SAFETY PROGRAMME 2008-2018

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Themes and findings

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“Actually learning why the person fell in the first place, and putting interventions in, individualised and customised to that person to prevent it happening again”.

“You should be able to glance at the patient and see visually that things are in place”

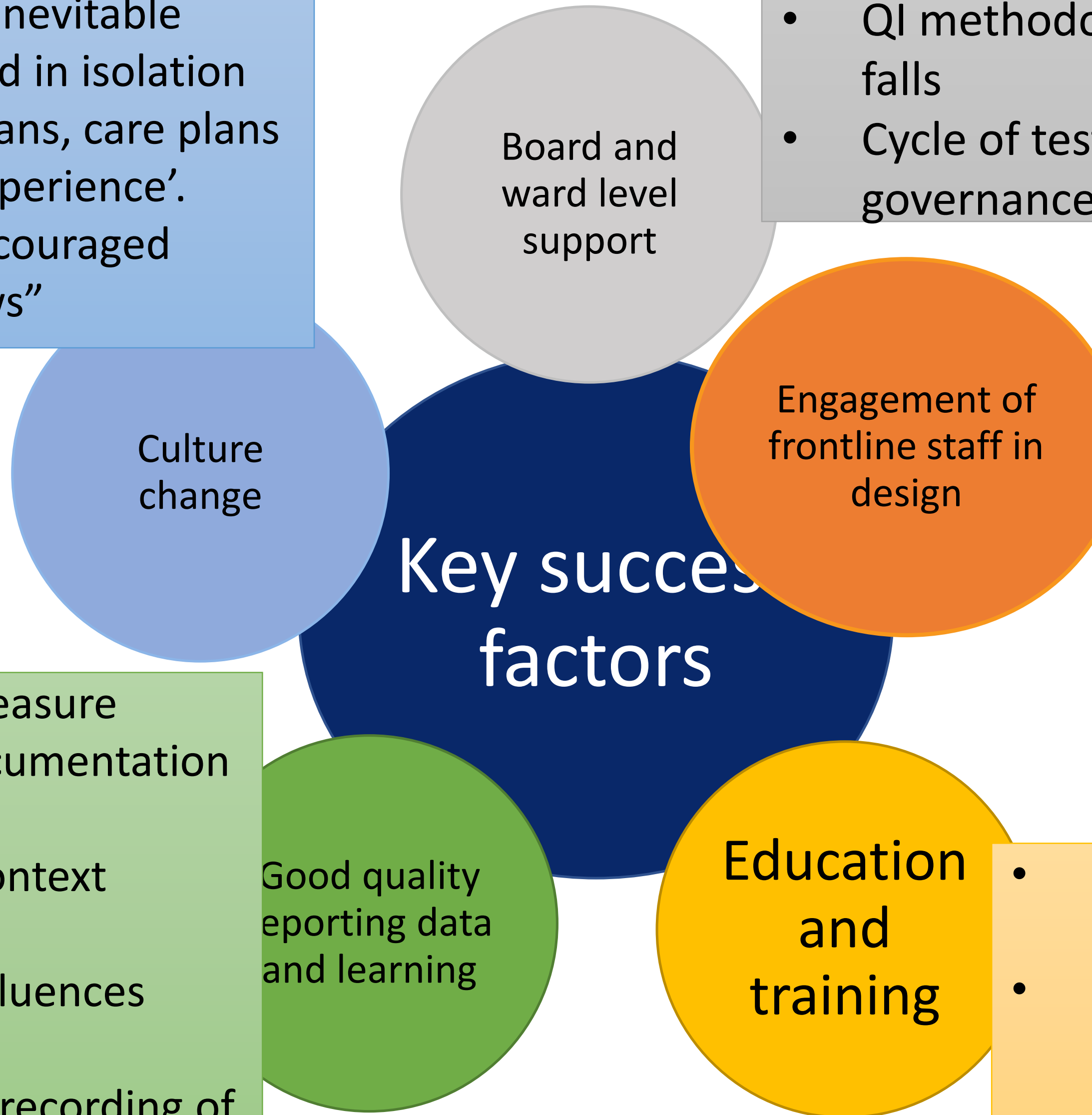
“You can’t look at falls in isolation. It’s just a piece of the jigsaw. It’s about looking at the safety culture in the hospital huddle, the safety brief and the team huddles and how the ward functions. It is really about the leadership in the ward, it really does count”

“It’s about staff getting used to having these conversations with each other and with patients, and getting used to thinking about whether the care plan is in place at the bedside.”

“Having a chief nurse who gives you permission to try something new - it makes a massive difference”.

- Catalyst for change
- Multi-professional issue
- Falls and harm are not inevitable
- Falls can't be considered in isolation
- Bundles are not care plans, care plans are not always 'lived experience'.
- Questioning culture encouraged
- "Serious success reviews"

- Organisational priority
- Hospital wide awareness and learning
- Clear aim using data and patient stories
- QI methodology and support to understand causes of falls
- Cycle of testing, learning and data review with clinical governance, falls groups, frailty networks



- Staff at all levels empowered
- Teams choose interventions for testing based on local context, data, clinical judgement and individual patients
- Assessment & care planning redesigned and individualised
- Care interventions aligned with clinical conditions and activities to improve and maximise mobility & functioning

- Process measures - measure practice not solely documentation compliance
- Teams develop own context specific measures
- Learning from data influences tests of change
- Coaching for accurate recording of falls and falls with harm

- Coaching to individualise risk assessment and care planning
- Education linked to conditions & health needs: delirium, hypotension, continence care, medicines
- Patient & family involvement

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Driver diagram

Outcome		Primary drivers
Reduce falls and falls with harm through: **•Individualised risk assessment and care planning based on people's clinical conditions and health needs and their care setting.** **•An approach that promotes mobilisation and meaningful activity to enhance cognitive and physical functioning.**		**Board and ward level support for improvement**
		Person centred care which is aligned with underlying health conditions and clinical needs
		Effective team working to maintain a safe environment
		Promote mobilisation and meaningful activity
		Education and QI support, using data to drive improvement