

Falls and falls with harm driver diagram

What are we trying to achieve...

National Aim:

To reduce the rate of all falls, and falls with harm by 10%, for adults in hospital, by March 2028

We need to ensure...

A people-led approach to the planning and delivery of safe care

Effective and inclusive communication

Leadership at all levels to support a culture of safety

Promote safer mobility through safe, clinical and care processes

Which requires...

People and professionals are equal partners in shared decision making throughout the hospital stay

People, families, carers, and staff are systematically listened to, and concerns are acted upon

Individualised assessment and safer mobility interventions that are regularly reviewed

Care and support is planned to meet the needs of the people

Communication tailored to individual needs and preferences

People and teams feel safe and able to speak up

Multi-disciplinary team collaboration and communication throughout persons' journey

Leadership is visible, compassionate and inclusive

Staff feel supported and valued

Improved access to learn and develop

Learning system for continuous improvement

Appropriate safe staffing levels and skill mix

Promotion of self- management, deconditioning, and reconditioning strategies

The provision of an engaging and safe environment

Promote and support people to engage in personalised meaningful activity

Maximise opportunities for positive risk taking

A people-led approach to the planning and delivery of safe care

People and professionals are equal partners in shared decision-making throughout the hospital stay

Person-centred visiting

Provide falls risk and safer mobility information to patient, families and carers

'What matters to you' conversations to inform patient care

Use of 'I can' boards

People, families, carers, and staff are systematically listened to, and concerns are acted upon

Engage with people, families and carers to gather falls history then document and act upon any concerns

Identify concerns about falling using tools like the Short Falls Efficacy Scale (FES-I)

Individualised assessment and safer mobility interventions that are regularly reviewed

Individualised prescribed mobility plans with visual exercise prompts

Use of Clinical Frailty Scoring (CFS) for early identification of frailty on admission (Frailty)

Use the 4AT for early identification of delirium

Regular assessment of unmet needs e.g. stress or distress

Care and support is planned to meet the needs of people

Early initiation of Comprehensive Geriatric Assessment (CGA) (Frailty)

Completion of person-centred care planning documentation reviewed following any changes

Ward round includes; falls risk review, update of management plans and standardised medication review

Post-fall MDT review and updated care plan

Decision support tool and local guidance for enhanced observations or 1:1 (starting, reviewing and stopping)

Effective and inclusive communication

Communication tailored to individual needs and preferences

Timely provision of falls information in accessible formats, including translation, interpretation and British Sign Language

ED handover to inpatient ward includes falls relevant risks and history from pre-hospital care and ED, for example, fall at home with a long lie

Visual guides on safe and suitable footwear for patients and families

People and teams feel safe and able to speak up

Opportunity for teams and staff to report and reflect on the learning from falls

Joint primary and secondary care groups to share learning from falls reporting

Staff using ward safety briefs and ward huddles as an opportunity to highlight falls related safety issues

Multidisciplinary collaboration and communication throughout a person's journey

Timely access to the skills of a multidisciplinary team
For example:-

- Regular review of food, fluid, and nutrition / dietetic input
- Continence assessments and intervention
- Goal setting from admission with Physiotherapy and Occupational Therapy colleagues
- Appropriate footwear / podiatry input
- Vision or hearing support
- Pharmacy review

(this list is not exhaustive)

Involvement of falls coordinators in improvement work, where possible

Inpatient falls and frailty status included in Immediate Discharge Letter

Referral or signposting to community falls resources and/or fracture liaison service as appropriate

Leadership at all levels to support a culture of safety

Leadership is visible
compassionate and
inclusive

Leadership demonstrating
compassionate leadership
behaviours and reflection

Leaders identify
opportunities to share
areas of good practice and
spread improvement

Regular leadership safety
walk rounds to include
falls improvement
conversations (EOSC)

Staff feel supported and
valued

Invite, listen to and act on
the experience, questions
and ideas of staff to
improve care

Local processes to
celebrate success

Use of standardised
feedback tools e.g.,
iMatter

Process and safe space to
access senior support
to reflect and debrief after
falls incidents

Everyone has the
opportunity to learn and
develop

Relevant falls TURAS
module is completed and
kept up to date

Staff have access to
learning around backward
chaining for fall to standing

Staff have up-to-date
moving and handling
training (CORE)

Protected time for staff to
prioritise falls education
and simulation to
support learning e.g. MDT
simulation card game

Learning system for
continuous improvement

Use quality improvement
support to help teams
prioritise improvements
based on feedback and
incidents

Access to local and / or
national falls learning
system for all staff

Local governance process
to review falls data, share
good practice and agree
areas for improvement

Promote safer mobility through safe, clinical and care processes

Appropriate safe staffing levels and skill mix

Process to use staffing level tools alongside the professional judgement tool, as part of the common staffing method to inform workforce planning

Processes to assess, mitigate and escalate staffing risks that may impact the provision of safe and high-quality care

7-day AHP input available for people experiencing falls and frailty

Involvement of activity coordinators and volunteers in line with local policy

Promotion of self-management, deconditioning, and reconditioning strategies

Use of personal outcomes discussions for goal setting and treatment planning

Family involvement in therapy sessions

Deconditioning and reconditioning education with patient, family and carers

Signposting or referral to community resources e.g. strength and balance exercise programmes and leisure classes

Digital access for prescribed exercise programmes

Group based exercise/activity programmes, where environment allows

The provision of an engaging and safe environment

Workstation positions for close observation of people at risk of falls

Bed rail assessment to inform plan of care and appropriate use of adjustable height beds

Appropriate use of technology enabled care in line with local policy e.g. use of bed sensors to establish patterns of activity

Easy access to fluids

Use of 'call don't fall' initiatives where appropriate

Seats placed around the ward for patients to rest

Promote and support people to engage in personalised meaningful activity

Use of personal activity diaries

Monitor patterns of movement and behaviour, using locally agreed tools

Support individualised routines for personal care and dressing

Polypharmacy reviews, for example use of [7 steps](#)

Bedside vision check

Assess and treat orthostatic hypotension

Provision of de-caffeinated drinks

Maximise opportunities for supported positive risk taking

Falls risk assessment completed at the front door to support safe waiting

Discuss positive risk taking around mobility, including safe provision of mobility equipment out of hours

Locally agreed approach to a comprehensive falls risk assessment with multifactorial interventions like standardised medication review