Falls and falls with harm driver diagram

What are we trying to achieve…	We need to ensure…	Delivered through…
To reduce the rate of all falls, and falls with harm by 10%, for adults in hospital, by March 2028	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
		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
	Effective and inclusive communication	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 at all levels to support a culture of safety	Leadership is visible, compassionate and inclusive
		Staff feel supported and valued
		Improved access to learn and develop
		Learning system for continuous improvement
	Promote safer mobility through safe, clinical and care processes	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

Primary driver

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	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)	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)

Primary driver
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

Primary driver

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	
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	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	

Primary driver

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 vision check	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			