Healthcare Improvement Scotland

Scottish Patient Safety Programme

Falls

Measurement Framework

October 2026

NHS SCOTLAND

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1. How to use this Measurement Framework

Measurement is an essential part of improvement. It helps teams understand if the changes they are implementing are leading to better outcomes and improved care. This framework provides an overview of the three types of measurement used in improvement and outlines the data that participating teams are required to submit as part of the SPSP Falls programme. It also describes the measures associated with the SPSP Falls change package and provides guidance on how to collect, analyse and display data effectively.

The readiness for change toolkit can be used alongside this framework to help teams assess whether the conditions for change are in place, understand current practice against the Essentials of Safe Care, and identify priority areas for improvement. This can support teams in selecting and implementing the changes that are most likely to have the greatest impact in their local context.

This framework should be used in conjunction with the SPSP Falls driver diagram and change package. It is applicable to inpatient services including community hospitals. Measures are aligned to the relevant secondary drivers within the Essentials of Safe Care.

To learn more about measurement click on the link: The Improvement Journey - Measurement (TURAS)

1.1 Why measure

This measurement framework is intended to measure the impact of key changes that you want to make.

Measurement helps you to:

- recognise the variation that exists within your system and processes
- work out whether your changes are making an improvement, and
- help tell your improvement story.

To learn more about measurement, please see Measurement at the QI Zone on Turas.

1.2 Choosing measures

An improvement project should have a small family of measures that track the progress of the project over time. These should include:

- **Outcome measures**: to tell an NHS board, site or team whether the changes it is making are helping to achieve their stated aim. For example, measuring the rate of falls per 1000 occupied bed days over time.
- **Process measures**: to help the team understand whether key actions needed to achieve their local improvement aim are happening reliably. For example, the number of patients with completed falls risk assessments. Learning from these measures can help inform tests of change.
- **Balancing measures**: to understand possible unintended consequences of the work elsewhere in the system. For example, staff experience.

Outcome measures are routinely collected through the SPSP Adults in Hospital programme for national reporting.

Participating teams are expected to submit outcome data on falls and falls with harm quarterly. From January 2027, NHS boards will be encouraged to submit at least one process measure alongside their outcome measures.

Participating NHS boards should select process and balancing measures that help them understand whether the changes they are making are leading to improvement. Boards may choose to use measures from this framework, or develop additional measures tailored to their local context. We encourage teams to seek local quality improvement support to develop alternative measures if required.

To learn more about measures click on the link: Developing your measures (TURAS)

1.3 How to measure

When planning your data collection consider:

- What data will you collect?
- Who will collect the data?
- When will you collect the data?
- How will you collect/ record the data?
- Any local information governance and /or clinical governance procedures you should follow.

To learn more about data collection click on the link: Data collection (TURAS)

1.4 Sampling

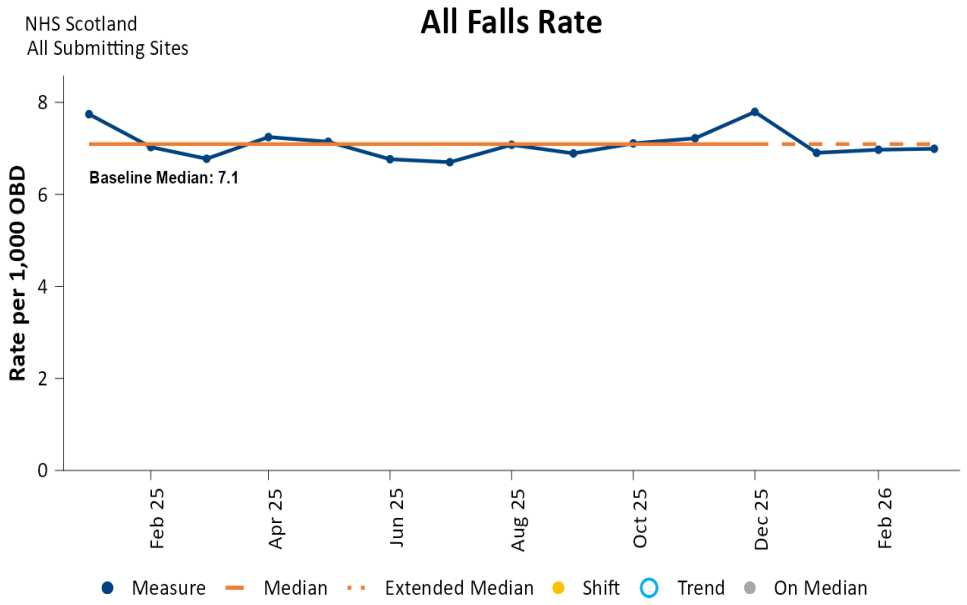
Measuring for improvement relies on small sample sizes, often referred to as 'just enough' data to learn from. When it is not possible to access a larger amount of data, it is suggested that a random selection of 5 records per week, giving 20 records per month, will gather enough data.

1.5 Presenting data

Run charts are an excellent way to present your data to help you to understand what is happening in your service. They are used to distinguish between random variation (variation that affects all processes, people and outcomes equally) and non-random variation, which could be due to the changes you have introduced.

The SPSP Adults in Hospital Team will issue a toolkit for outcome measures and process measures to NHS boards participating in the SPSP Adults in Hospital programme.

To learn more about presenting your data, please see Presenting data at the QI zone on TURAS.



2 Falls Measures

Participating NHS boards should select a small family of measures that support their local improvement work. For falls, **two measures are** routinely submitted through the SPSP Adults in Hospital national reporting process alongside narrative progress reporting. **From January 2027**, NHS boards will be encouraged to submit at least **one process measure** alongside their outcome measure. Additional process and balancing measures may be selected to support local improvement priorities.

<table>
<tr><td colspan="2">Readiness for change and identifying opportunities for improvement
Readiness for change assessment tool
Engagement with adverse events team and/or regular case note review to identify opportunities for improvement</td></tr>
<tr><td>Outcome Measures</td><td>Inpatient Falls
Inpatient Falls with Harm</td></tr>
<tr><td>Process Measures</td><td>A people-led approach to the planning and delivery of safe care
Completed falls risk assessments with evidence of patient / family / carer involvement
Completed 4AT
Delirium response
Effective and inclusive communication
Percentage MDT representation at daily ward meeting (for example ward huddle) where falls are discussed
Referrals to community falls resources and/or fracture liaison service
Leadership at all levels to support a culture of safety
Falls with harm - evidence of shared learning with clinical teams
Promote safer mobility through safe, clinical and care processes
Completed falls risk assessment on admission to clinical area as per local policy
Evidence of physiotherapy and/or occupational therapy interventions delivered for patients identified as appropriate
Post-fall review with an intervention plan at ward level within 24 hours of the fall
Completed medication review on admission to clinical area and/or following an inpatient fall</td></tr>
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Balancing Measures	• Patient, family and carer experience • Staff experience

2.1 Outcome Measures

Concept / Measure Name	What / How to measure	Data collection and reporting
Inpatient Falls Rate of inpatient falls per 1,000 Occupied Bed Days (OBD)	A fall is defined as: **An event which results in a person coming to a rest unintentionally on the ground or floor or other lower level.** For more detail please see the our Falls Definition webpage. **Numerator:** The total number of inpatient falls for month. **Denominator:** The total number of acute occupied bed days for the same time period. **Rate:** (numerator ÷ denominator) x 1000 Gives the number of falls per 1000 acute occupied bed days (OBDs). **Inclusion criteria:** • controlled falls • falls due to an environmental cause. **Exclusion criteria:** • falls as a result of external force from another person or intentional falls. • falls in paediatrics, maternity, mental health, outpatients, day case procedures and emergency departments.* **Note:** Falls following a medical event can be included or excluded from reporting based on the clinical context and judgement of the event reporter/reviewer.	**Data source:** As per incident management system or local data collection tool. **Reporting frequency:** Monthly data points reported quarterly. **Type of chart:** Run chart **For rare events:** Data can be visualised locally as days between.

Concept / Measure Name	What / How to measure	Data collection and reporting
	* Emergency Department (ED) attendances are not classified as inpatient episodes and do not generate occupied bed days. For local measurement of falls in the ED a denominator such as 'attendances to Emergency Department accepted for admission' could be used as an alternative.	

Concept / Measure Name	What / How to measure	Data collection and reporting
Inpatient Falls with Harm Rate of inpatient falls with harm per 1,000 Occupied Bed Days (OBD)	Falls assessed as 'category 1' harms- descriptor 'major 4' and 'extreme 5' using the falls definition risk matrix should be included in falls with harm reporting to SPSP. **Numerator:** The total number of inpatient falls with harm assessed as Category 1 (major 4 and extreme 5) on the National Adverse Events Framework per month. **Denominator:** The total number of occupied bed days for the same time period. **Rate:** (numerator ÷ denominator) x 1000 **Exclusions:** falls with harm assessed as Category 2 or 3, or falls with harm in paediatrics, maternity, mental health, outpatients, day case procedures and emergency departments.* * Emergency Department (ED) attendances are not classified as inpatient episodes and do not generate occupied bed days. For local measurement of falls with harm in the ED a denominator such as 'attendances to Emergency Department accepted for admission' could be used as an alternative.	**Data source:** As per incident management system or local data collection tool. **Reporting frequency:** Monthly data points reported quarterly. **Type of chart:** Run chart **Rare events:** Data can be visualised locally as days between.

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

Concept / Measure Name	What / How to measure	Data collection and reporting
Completed falls risk assessments with evidence of patient / family / carer involvement **Goal**: Process reliability at 95% or greater.	Person centred care planning places people using health services as equal partners in planning their care. **Numerator:** Number of admissions with a completed falls risk assessment with evidence of patient, family, or carer involvement. **Denominator:** Number of records examined. **Percentage:** (numerator ÷ denominator) x 100	**Data source:** Sample five patients weekly per ward / department or include all patients if numbers less than 20 per month. **Reporting frequency:** Monthly sample of 20, eg sample 5 per week. **Type of chart:** Run chart

Concept / Measure Name	What / How to measure	Data collection and reporting
Completed 4AT Percentage (%) compliance with 4AT screening **Goal**: Process reliability at 95% or greater	A new onset of delirium or confusion is a clinical condition that can indicate that a patient has deteriorated and is unwell. Delirium is a risk factor for falls. The 4AT tool is designed to be used by any health professional at first contact with the patient, and at other times when delirium is suspected. **Numerator:** Total number of patients with a completed 4AT score as per locally defined delirium screening criteria. **Denominator:** The total number of patients who meet locally defined delirium screening criteria. **Percentage compliance:** (numerator ÷ denominator) x 100 **Inclusion criteria:** All patients who meet the locally defined delirium screening criteria.	**Data Source:** Local agreed documentation for 4AT, medical or nursing notes. Identify patients who meet the locally defined delirium screening criteria, then review a sample of five patients per week per ward/department. If fewer than 20 eligible patients are identified in a month, review all eligible patients. **Reporting frequency:** Monthly **Type of chart:** Run chart

Concept / Measure Name	What / How to measure	Data collection and reporting
Delirium response Percentage compliance with TIME bundle implementation within 2 hours for patients with 4AT score of ≥ 4 **Goal:** Process reliability at 95% or greater	All patients identified as experiencing delirium with should have the TIME bundle for delirium management implemented within 2 hours of 4AT score of ≥ 4. • **T**hink, exclude and treat possible triggers • **I**nvestigate and intervene for possible underlying causes • **M**anagement plan initiated • **E**ngage and explore in discussion with the family **Numerator:** The total number of patients with a 4AT score of ≥ 4 who have evidence of the 4 elements of the TIME bundle documented within 2 hours of the trigger score **Denominator:** The total number of patients in the sample. **Percentage compliance:** (numerator ÷ denominator) x 100 **Inclusion criteria:** Patients with a new confusion, who have been screened and have 4AT score of ≥4.	**Primary data source:** The patient's medical and nursing notes including NEWS2 and 4AT or TIME chart as per local documentation. Sample five patients weekly per ward / department with a 4AT score of ≥4 or include all patients if numbers less than 20 per month. **Reporting frequency:** Monthly **Type of chart:** Run chart

Effective and Inclusive Communication

Concept / Measure Name	What / How to measure	Data collection and reporting
Percentage MDT representation at daily ward meeting (for example ward huddle) where falls are discussed **Goal**: 90% MDT representation	Daily ward meetings like huddles are a way of involving the wider MDT team in identifying, sharing and addressing safety issues on the ward. **Numerator:** Number of disciplines at ward meeting/huddle. **Denominator:** Optimum number of disciplines represented (as agreed locally) who could attend ward meeting/huddle. For example, the denominator would be five if it was agreed that there should be five disciplines at the ward meeting/huddle, for example: • physiotherapist • occupational therapist • nurse • dietitian • geriatrician **Percentage:** (numerator ÷ denominator) x 100	**Data source:** Head count per discipline at a ward meeting or huddle. **Reporting frequency:** Weekly data reportedly monthly. **Type of chart:** Run chart

Concept / Measure Name	What / How to measure	Data collection and reporting
Referrals to community falls resources and/or fracture liaison service Percentage of patients who received a referral to community falls resources and/or fracture liaison service **Goal**: Process reliability at 95% or greater	Referrals to community falls resources can be a key part of discharge planning for effective post discharge support and recovery. **Numerator:** Number of patients referred to community falls resources and/or fracture liaison service **Denominator:** Total number of patients eligible for referral to community falls resources and/or fracture liaison service as per local referral criteria **Percentage:** (numerator ÷ denominator) x 100	**Data source:** Review of a sample of patient notes to determine whether patients received a referral to community falls prevention resources and/or a Fracture Liaison Service **Reporting frequency:** Weekly data reportedly monthly. **Type of chart:** Run chart

Leadership at all levels to support a culture of safety

Concept / Measure Name	What / How to measure	Data collection and reporting
Falls with harm - evidence of shared learning with clinical teams Percentage of falls with harm reviews with evidence of shared learning	Supports the shared learning with clinical staff delivering care to patients. Evidence of organisational learning. **Numerator:** Number of falls with harm where learning is recorded and shared with clinical teams **Denominator:** Number of falls with harm (level of harm- per local agreement) **Percentage:** (numerator ÷ denominator) x 100	**Data source:** Local incident management system. **Reporting frequency:** Monthly **Type of chart:** Run chart

Promote safer mobility through safe, clinical and care processes

Concept / Measure Name	What / How to measure	Data collection and reporting
Completed falls risk assessment on admission to clinical area as per local policy Percentage (%) of records with a falls risk assessment **Goal**: Process reliability at 95% or greater	Timely multifactorial risk assessment can support identification of risks and inform person centred care planning designed to promote safer mobility and reduce falls. **Numerator:** Number of admissions with completed falls risk assessment on admission to clinical area as per local policy. **Denominator:** Number of admission records examined. **Percentage:** (numerator ÷ denominator) x 100	**Data source:** Sample five patients weekly per ward / department or include all patients if numbers less than 20 per month. **Reporting frequency:** Monthly sample of 20 e.g. sample 5 per week. **Type of chart:** Run chart

Concept / Measure Name	What / How to measure	Data collection and reporting
Evidence of physiotherapy and/or occupational therapy interventions delivered for patients identified as appropriate Percentage (%) of records with evidence of physiotherapy and / or occupational therapy interventions delivered **Goal**: Process reliability at 95% or greater	Access to physiotherapy and occupational therapy interventions that support safer mobility are important to reducing falls. **Numerator:** Number of patients identified as at risk of falls who have evidence of physiotherapy / occupational therapy interventions delivered. **Denominator:** Total number of patients identified as at risk of falls **Percentage:** (numerator ÷ denominator) x 100 Further investigation into quality, frequency, duration or effectiveness of therapy interventions could be explored locally if relevant to the focus of the improvement activity.	**Data source:** Sample of patients identified as at risk of falls. **Reporting frequency:** Monthly sample of 20 e.g. sample 5 per week. **Type of chart:** Run chart

Concept / Measure Name	What / How to measure	Data collection and reporting
Post-fall review with an intervention plan at ward level within 24 hours of the fall Percentage of post-fall review with an intervention plan completed within 24 hours of the fall **Goal**: Process reliability at 95% or greater	To complete a post-fall review and intervention plan. Promotes shared learning. **Numerator:** Number of post-fall reviews with an intervention plan completed within 24 hours of the fall **Denominator:** Number of falls (as defined by local incident management system) **Percentage:** (numerator ÷ denominator) x 100	**Data source:** Local incident management system **Reporting frequency:** Monthly **Type of chart:** Run chart

Concept / Measure Name	What / How to measure	Data collection and reporting
Completed medication review on admission to clinical area and / or following an inpatient fall Percentage (%) of records with completed medication review on admission to clinical area and/or following an inpatient fall **Goal**: Process reliability at 95% or greater	Patients who are taking five or more medications have an increased risk of falls. Some medications are known to increase the risk of falls. **Numerator:** Number of admissions with completed medication review on admission to clinical area and/or following an inpatient fall. **Denominator:** Number of records examined. **Percentage** (numerator ÷ denominator) x 100	**Data source:** Sample 20 patients each month (5 per week). **Reporting frequency:** Monthly **Type of chart:** Run chart

2.3 Balancing Measures

Concept / Measure Name	What / How to measure	Data source
Patient, family and carer experience Qualitative measure	Patient, family, carer experiences of interventions to promote safer mobility and reduce falls within the clinical environment. Refer to SPSP Essentials of Safe Care.	Conversations with people, families, and carers. Care opinion, local service user feedback mechanisms, informal and formal complaint processes.

Concept / Measure Name	What / How to measure	Data source
Staff experience Qualitative measure	Staff experience and perceptions of falls reduction and safety within their clinical environment. Refer to SPSP Essentials of Safe Care	Local falls engagement opportunities e.g. staff engagement in falls networks or sharing at MDTs.

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