



Royal College
of Physicians

Implementing FallSafe

Care bundles to
reduce inpatient falls

In partnership with



Royal College
of Nursing



avma
action *against* medical accidents

NHS
National Patient
Safety Agency

NHS
South Central

 The
Health
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Glossary

FallSafe care bundles	These were a specific measurable set of multifactorial assessments and interventions.
Full bundles	This refers to the stage of the FallSafe project when the staggered implementation was complete, and all the process measures were being collected.
Lying and standing blood pressure (L&S BP)	This is an assessment of whether blood pressure drops significantly when the patient stands (key to identifying a common cause of falls called orthostatic hypotension). Accurate L&S BP can only be taken with a manual sphygmomanometer.
Multifactorial (or multifaceted) assessment	This refers to a process of assessing patients for a range of risk factors that can lead to falls, such as impaired mobility, cognitive impairment, urine infection etc.
Multifactorial interventions	These are changes made to care or treatment that can modify the risk factor or manage it in such a way as to reduce the risk of it leading to falls.
Plan, do, study, act (PDSA)	This is a process for introducing changes in practice.
Process measures	These are measures of the delivery of care, for example how many patients have a call bell in reach.

Summary

Over 280,000 patient falls are reported every year from hospitals and mental health units. Falls can cause serious injury and increased healthcare costs.¹ Research has shown that falls can be reduced by 20–30% through multifactorial assessments and interventions.² The aim of these assessments and interventions is to identify and treat the underlying reasons for falls, such as muscle weakness, cardiovascular problems, dementia, delirium and medication. However, audits have found low levels of implementation of these assessments and interventions in UK hospitals.³

The FallSafe project was funded by the Health Foundation, and aimed to ‘close the gap’ between the evidence base for effective care and the care that patients actually receive.

The FallSafe project involved educating, inspiring and supporting 17 registered nurses from acute, rehabilitation and mental health wards (the FallSafe leads) to lead their local multidisciplinary teams in reliably delivering these assessments and interventions through a care bundle approach. A new element of the care bundles was introduced every four to eight weeks over nine months, and delivery of the full bundles was then sustained for six months. Compliance with the elements of the care bundles was measured each month. Outcomes were assessed by reported falls rates, which were adjusted by the proportion of staff who were certain that falls had been reported.

The FallSafe project has resulted in substantial improvements in the delivery of care, including a doubling of patients receiving assessment of lying and standing blood pressure; undergoing medication review; and being asked about fear of falling. In the first six months of full implementation, while reported falls rates increased by 12%, when under-reporting rates were factored in, we estimated that the project may have delivered around a 25% reduction in falls. We are currently analysing an additional six months’ worth of data and writing up our findings for a peer-reviewed journal.

One of the aims of the project was to share our learning across the NHS. We have developed this ‘FallSafe pack’ which contains our findings from the project, as well as everything that was used by the FallSafe leads to successfully implement and monitor the care bundles on their wards. Patient feedback on the care bundles is depicted in the wordcloud in Fig 1.



Fig 1 Wordcloud of feedback given to FallSafe leads by their patients

Learning from the FallSafe project

What we did in the FallSafe project
and how you can learn from this

Planning the project

Goals of the FallSafe project

FallSafe was a quality improvement project to study the introduction of care bundles designed to prevent inpatient falls in hospitals.

A care bundle is a list of actions (called elements) that need to be applied consistently to patients for whom they are appropriate. The actions are selected because they have been shown to be effective through research.

Our goal was to find out whether a nurse could influence others on the ward to embed care bundles for falls prevention into regular ward practice, using a quality improvement approach.

We sought to study and share the learning across the NHS with regard to:

- any difficulties that arose in the implementation of the care bundles and their elements
- the support and training that staff would need
- how successfully the care bundles were implemented.

The project was neither designed nor powered as research to demonstrate that this approach reduces falls, as the elements of the care bundles had already been shown to do this in the existing literature. The article ‘Preventing falls and fall-related injuries in hospitals’ from *Clinics in Geriatric Medicine* – reprinted in this pack – reviews this literature. That literature formed the basis of the FallSafe approach and, consequently, this article is referred to throughout this section of the guide.²

Recruitment of sites, wards and FallSafe leads

We wrote to the chief executives of all hospital trusts in the South Central Health Authority, inviting them to nominate wards to participate in the study, and 17 wards from 13 hospitals covering a range of specialties were selected to participate.

Key to the project was introducing changes from *within* the ward, as this was a common feature of successful projects, and was considered more likely to work than having change imposed by someone from outside the ward team.² We asked for an experienced, registered nurse to be nominated as FallSafe lead for each ward area. This sounds similar to the common system of link nurses, but we intended the FallSafe lead to have a more defined role in leading improvement, and to receive more extensive training in both quality improvement techniques and falls prevention, as well as peer support and access to expert advice. Our FallSafe leads were given a £2,000–£2,500 supplement to their salary, either as an honorarium or an incremental step for ‘acting up’, to create a contractual obligation to deliver and measure the elements of the care bundles and to carry out the extra work required for the project.

Equipment

The wards were each given a budget of up to £5,000 to spend on equipment that might be beneficial for falls prevention. The main items bought were ultralow beds, footwear, non-slip socks and manual sphygmomanometers, for the measurement of lying and standing blood pressure.

Peer group training and support for FallSafe leads

The FallSafe leads had three days of training on falls prevention and quality improvement at the beginning of the project. This was followed by a study day every four to eight weeks for around nine months: a total of

11 study days. These study days preceded the introduction of each new element of the care bundles on their wards. At each study day, the FallSafe leads had access to advice from a doctor for medical aspects of falls prevention, a falls nurse specialist, a physiotherapist, and quality improvement advisers. More detail on the training provided and how it could be replicated locally is provided on pages 19–21.

Other forms of support were available to the leads. There was a website containing background materials and documents. There was also a project manager providing a coordinating role, who recruited the sites, wards and FallSafe leads and the latter's replacements as necessary; organised and arranged the training days and materials; and collated the process data from each ward and their data on occupied bed days and reported falls. This is a role we envisage being performed by a hospital-wide or trust-wide leader with responsibility for FallSafe's introduction across your hospital.

For the 17 FallSafe leads, a very important source of support was the peer support they gained from each other at the training days. This included information-sharing (eg stockists of good slippers) and debating strategies for improvement (both in practical terms and regarding influencing colleagues). The great variation in not only the ward specialties, but also in the local culture and management styles they worked within, appeared to add to the richness of this community.

FallSafe leads and their ward teams

FallSafe leads were expected to form a core multidisciplinary ward team, including nurses, healthcare assistants, physiotherapists and occupational therapists. Following a study day, the FallSafe leads would return to their wards, share their learning with the multidisciplinary team, and plan the improvements.

In each hospital, a local consultant or general practitioner was asked to provide support and advice to the FallSafe leads, particularly with regard to medical aspects, such as medication reviews, diagnosis and management of delirium, and treatment of orthostatic hypotension.

Support from local management was also necessary to give the FallSafe leads time to carry out the project measurements, to attend study days and to deliver training to staff on their wards. The ward time spent on the project by the FallSafe leads was about 12 hours a month.

Delivering the FallSafe care bundles

The evidence for falls prevention in hospitals

The care bundles we used for FallSafe were developed from the elements of multifactorial interventions of successful falls prevention research trials (Fig 2).

One of the key messages from the research evidence was that, because the causes of falls are complex and multiple, interventions for reducing falls cannot be 'simple fixes', but instead need to have multiple elements.

The education provided to the FallSafe leads aimed to cover all the important elements while, to keep the number manageable within the timeframe of the project, only a certain number were introduced as process measures.

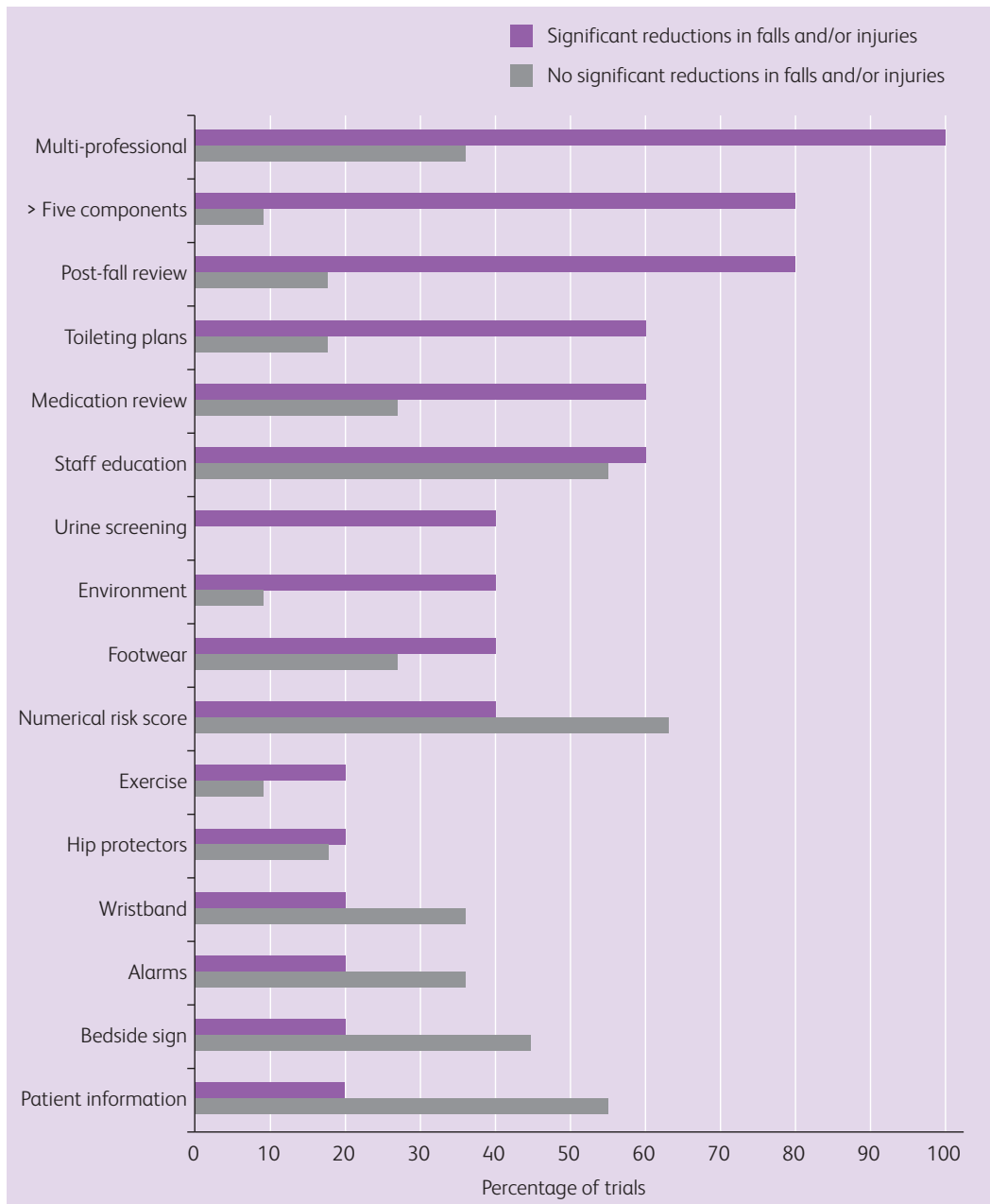


Fig 2 Elements within successful versus unsuccessful multifactorial trials²

The FallSafe care bundles

The elements of the FallSafe care bundles are outlined in boxes A and B. The elements address some of the underlying reasons for falls, such as muscle weakness, cardiovascular problems, dementia, delirium and medication. These are also detailed on the care bundles reference card included in the 'Further resources' section of this pack. The parts of the care bundles that were measured monthly as process measures are indicated with an asterisk*.

A The care bundle for all patients

- a history of previous falls* and of fear of falling* taken at the time of admission
- urinalysis during admission* (to consider the possibility of infection causing falls and delirium)
- avoidance of prescriptions of night sedation*
- ensuring that a call bell is in reach*
- ensuring that appropriate footwear is available and in use*
- immediate assessment for and provision of walking aids
- clear communication of mobility status
- personal items in reach
- no trip or slip hazards

B The care bundle for older and more vulnerable patients

Falls risk scores can be misleading and are not a necessary part of a hospital falls prevention policy.¹⁰

In the FallSafe project, the age threshold we used for the cognitive assessment was over 70 years, as a compromise between the local policies of the hospitals involved, which used varying age thresholds. National Institute for Health and Clinical Excellence (NICE) Clinical Guideline 21 defines older people as those aged 65 years or above, and hospitals introducing the FallSafe care bundles may wish to consider using 65 years as their threshold.

In the FallSafe project, all patients in wards for older people were counted as high-risk and received this bundle. For other wards we recommended that all patients with a history of falls or fear of falling, or who tried to walk alone although unsteady or unsafe,⁴ received it.

- a cognitive assessment (mini mental state examination (MMSE) or abbreviated mental test score (AMTS)) in all patients admitted aged >70yrs*
- testing for delirium (confusion assessment method (CAM)) in those at risk, as advised in NICE guidelines⁵
- bedrail risk–benefit assessment⁶ and/or consideration of ultralow beds
- visual assessment (a basic check of ability to recognise objects from the end of the bed as a screen for severe eyesight problems, and fuller assessment as required)
- lying and standing blood pressure* taken with a manual sphygmomanometer to check for orthostatic hypotension, and pulse taken by hand to check for arrhythmias
- medication review for medication that can increase the risk of falls*
- observation, including bed position on the ward, and toileting assessment and plan (tailored to needs rather than standard two-hourly)
- medical review of falls risk factors and assessment for osteoporosis
- screen for depression

Due to the limited duration of the project and the need not to overwhelm the FallSafe leads with the task of collecting data, only the elements marked with an asterisk were introduced and measured in all the FallSafe wards. The remaining elements were covered in the FallSafe leads' education and implemented on some wards. Any hospital wishing to implement the FallSafe approach should aim to introduce and measure these additional elements at a later stage when improvements in the delivery of the core elements (*) of the care bundles have been achieved and sustained.

You can read more about how to implement the FallSafe care bundles and measure them in the subsequent sections of this guide.

We had originally planned a further bundle for care after a fall, but we found that none of the hospitals involved had any clear guidelines for how to manage a patient who has had a fall. This led to our group developing the content of *Rapid response report: essential care after an inpatient fall*, which was disseminated by the National Patient Safety Agency (NPSA) to all hospitals in England and Wales to implement in 2011, and is included in the 'Further resources' section of this pack.⁷ The actions required in this should now be in place across the NHS.

Introducing the care bundles on the wards

After each study day, the FallSafe lead worked with colleagues on their ward to introduce that new element, starting by taking a baseline measurement of its delivery. Every month the FallSafe lead measured adherence to the elements implemented thus far, to see how reliably they were being delivered. This continued when all the measured elements (process measures) were in place using the 'FallSafe care bundles measurement grid' (pages 28–35). These data were collated centrally by the project manager, together with the reported falls and occupied bed days for those wards, and fed back to the wards as run charts so they could monitor their own progress (a FallSafe runchart spreadsheet is available at www.rcplondon.ac.uk/projects/fallsafe to help you produce these for your wards).

A variety of different stratagems were necessary to introduce these changes effectively, and the FallSafe leads were encouraged to use 'plan, do, study, act' (PDSA) cycles to help them determine how to make each element of the care bundles work best on their ward.⁸

An information sheet was produced for patients on what would be done to minimise falls during their hospital stay. Ward staff were able to go through this with the patient and family. These were adapted locally, and examples are available at www.rcplondon.ac.uk/projects/fallsafe.

The delivery of the care bundles

Fig 3 and Table 1 indicate the percentage of patients receiving each relevant element of the care bundles per month.

Overall there were some very encouraging signs over time, in terms of rising standards in every process measure as more participants adopted and incorporated the FallSafe approach. For example, night sedation (a potential cause of falls) was being given to only 13% of patients by the end of the project, in contrast to a major project in Australia, which succeeded in reducing this to only around 20% after two years of focused intervention.² By the end of the FallSafe project, 68% of patients were being asked about fear of falling, 50% were having their lying and standing blood pressure taken, and 78% had their urinalysis recorded. These figures are considerably higher than those being achieved in many hospitals and, in turn, means patients were receiving safer and more effective falls prevention care.³

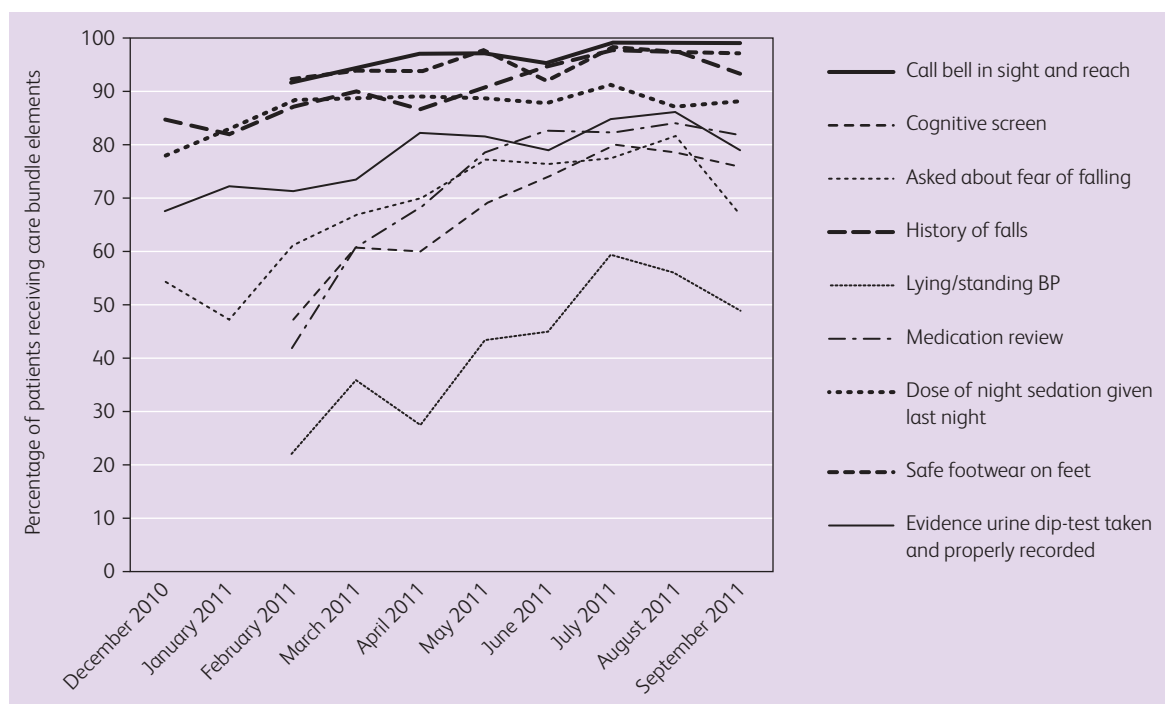


Fig 3 Adherence to the elements of the care bundles

	Before improvement started (baseline – %)	After full care bundles had been in place for 6 months (%)	% improvement
Call bell	91	98	78% reduction in the proportion of patients left without a call bell in reach
Cognitive screen	50	78	56% increase in the proportion of patients aged over 70 years assessed for confusion
Fear of falling	29	68	127% increase in the proportion of patients asked if they were worried about falling
History of falling	81	89	42% reduction in patients not asked about history of falling
Lying and standing BP	25	50	100% increase in patients with their L&S BP taken
Medication review	42	84	100% increase in patients with a medication review requested
Night sedation not given	78	87	41% reduction in patients given night sedation
Safe footwear	91	97	67% reduction in patients without safe footwear
Urinalysis	63	78	24% increase in ward tests of urine

Challenges along the way

Mental health wards

Inclusion of mental health care settings for older people was, to some extent, a 'leap in the dark' at project planning stages, as no published evidence exists for effective implementation of falls prevention strategies in this area. Some process measures were not relevant to their sector (eg call bells in reach, as so few patients had the capacity to understand and use a call bell).

However, the three FallSafe mental health wards for older people were successful in implementing all relevant elements of the care bundles, including those that might generally have been considered the sphere of general nurses rather than mental health nurses, such as lying and standing blood pressure. In reality, the patient groups of the mental health and the acute wards had many shared features. Many of the patients in mental health wards were aged over 75, and had multiple pathologies, which meant physical risk factors for falls were commonplace; while the majority of patients who fall in acute care have dementia or delirium in addition to physical illness.

Ward staffing

At the end of the two-year project, only nine of the 17 wards remained open and looking after the same patient specialty; and only nine FallSafe wards kept the same FallSafe lead throughout. On one ward, the FallSafe lead left and could not be replaced. On seven wards, the original FallSafe lead left and was replaced by a colleague. One ward had four FallSafe leads during the lifespan of the project, and there was inevitably a large knowledge gap while each replacement got up to speed. They also missed out on the earlier study days.

This rate of turnover was higher than we had anticipated, and a factor seemed to be that participation in the project built self-confidence and increased the likelihood of promotion. Because of this experience, we suggest that, from the outset, you aim to train a deputy for each FallSafe lead. Some FallSafe leads moved within their organisation, and when this is the case you should aim for them to continue to use the falls prevention and quality improvement skills and knowledge in their new role. If FallSafe leads do move on outside the organisation, you should aim to conduct an 'exit interview' to understand their reasons for leaving and any lessons for the recruitment and retention of future FallSafe leads.

One recurring comment made by the FallSafe leads was that their role in training and supporting the other members of their team to carry out falls prevention was almost impossible when the ward was using high levels of temporary staff, or had a high staff turnover and unfilled vacancies. If you have any wards in that situation, we would suggest that the staffing situation needs to be stabilised before any attempt is made to introduce the FallSafe approach. If you do introduce FallSafe to a ward with high turnover or temporary management, you should be prepared to give the FallSafe lead additional support and more time to educate their colleagues.

Medication review

The care bundles had to consist of elements that a nurse could initiate. In terms of medication review, this entailed asking a doctor to review the medication chart. However, as most doctors would not have sufficient specialist knowledge about the effects of medication on the risk of falls to carry out this task confidently, a review of the published literature was undertaken and guidelines produced on what medications were particularly implicated in causing falls. This work was undertaken by the John Radcliffe Hospital, Oxford, jointly by a consultant geriatrician (FallSafe clinical lead), a cardiologist and a clinical pharmacologist. The FallSafe leads were then able to present these guidelines to the doctor attending their ward and ask for a

patient's medications to be reviewed in the light of them. You can find a copy of these guidelines, *Medicines and falls in hospital*,⁹ in the 'Further resources' section of this pack.

Impact of the FallSafe approach on patient care

Safe and effective care

There were substantial improvements in the delivery of the elements of the care bundles outlined above. This meant that many more patients received the individual assessments and care that are essential to preventing falls in hospital.

Transformed attitudes

The project demonstrated that, with the right levels of training and support, it is possible for a nurse to lead the introduction of falls prevention using a quality improvement approach, in a way that embeds changes in practice that reduce falls on a ward.

By the end of the project, FallSafe leads reflected that attitudes to falls prevention on their wards had been 'transformed', from passive acceptance of falls, to active engagement in falls prevention.

Improved falls reporting and reduced falls

It is difficult to count accurately the number of falls that occur on a ward. There is inconsistency in what staff consider to be a fall, and reporting is variable. Any focus on falls, including quality improvement initiatives, tends to increase the number of reported falls on a ward. The percentage of unreported falls needs to be identified before any improvement work is undertaken, and should also be measured on an ongoing basis thereafter. This way, any variation can be taken into account when assessing the number of falls actually reported, and their rise or decline.

To establish this, we asked ten nurses on each FallSafe ward whether they were certain that the last fall that had occurred had been reported, both at the beginning of the study, and again when the care bundles had been implemented ('FallSafe measurement of under-reporting', pages 24–27). We found that increasing falls awareness had led to an increase in the completeness of the reporting of falls on the ward. Prior to the FallSafe initiative, only 56% of staff were confident that the last fall they could recall had been reported; this rose to 85% once the FallSafe initiative was in place.

For the intervention wards, taking these levels of under-reporting and the falls rates per thousand occupied bed days (both at baseline and post-FallSafe implementation) we were able to estimate that falls may have reduced by around 25% on the FallSafe wards, which is in line with the evidence from the literature.² We are currently analysing an additional six months' worth of falls data and writing up our results for a peer-reviewed journal.

Healthcare costs and quality improvements for patients

A current estimate of the cost of healthcare treatment for inpatient falls is between £200,000 and £500,000 per annum per medium-sized acute hospital. If these estimates are correct, a 25% reduction in falls would deliver annual savings of £50,000 to £125,000. But realising these cost savings, in terms of staff time and occupied beds, is likely to be problematic, given the wide distribution of falls across a range of units and the relative rarity of falls resulting in severe injury (less than 1% of the total).

Although, in purely financial terms, the healthcare costs of falls are only a small fraction of a percentage of hospital income and expenditure, the costs to a hospital's reputation, patient and carer confidence, and social

care costs, can be significant. Adopting the FallSafe approach can not only prevent falls but can give patients and carers confidence that the hospital is doing all that it can to prevent them.

Meeting targets

Most hospitals in England have Commissioning Quality and Innovation (CQUIN) targets based on reducing inpatient falls with their primary care trust. These can be very challenging to achieve, as the baseline of reported falls is unlikely to be accurate. As we demonstrated through the FallSafe project, as staff interest in falls prevention grows, so does the completeness of falls reporting.

Other CQUIN targets are based on completion of numerical risk scores, which may direct staff efforts to the wrong patients (see the Patient Safety First 'How to' guide in this pack for more information) and fail to lead on to interventions to prevent falls.¹⁰

The FallSafe care bundles allow an opportunity for the CQUIN mechanism to be used positively. Setting targets based on levels of adherence to the care bundles across the organisation is likely to be a more effective use of CQUIN, as it is one that benefits patients.

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www.drugsandfalls.com
- 10 Patient Safety First. *The 'how to' guide to reducing harm from falls*. London: NPSA, 2009.†

† Document cited is available in this pack

Implementing FallSafe in your organisation

The steps for senior management and FallSafe leads to take to replicate the FallSafe approach and the training programme for those leads.

Overview of the FallSafe approach

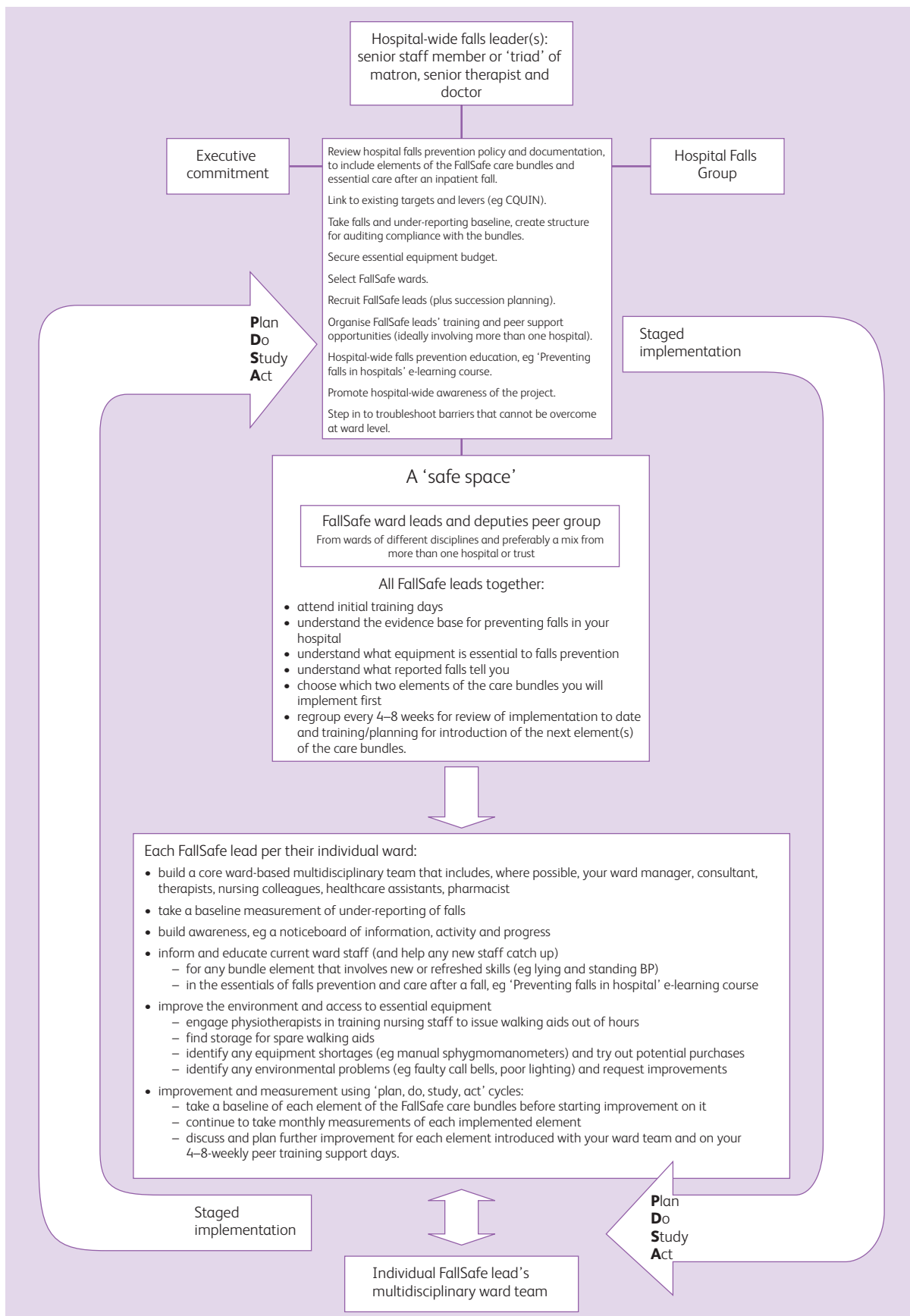


Fig 4 Overview of the FallSafe approach

Steps for senior management

Steps	Hints and tips
Get executive and non-executive commitment to introduce the FallSafe approach	It is easy for falls prevention to become one of a number of initiatives competing for staff and managerial time. Only if the topic is given impetus by senior staff in the organisation is there any realistic chance of making it happen. Hopefully you already have a director and a non-executive director with a particular interest in falls prevention involved; if not, you need to engage them. An enthusiast from your hospital board will help the project along as it faces the inevitable headwinds, and will assist in securing the necessary resources.
Use your hospital's falls prevention group	<p>You need a wide range of staff involved in any falls prevention efforts. As part of your patient safety and clinical governance structures, your hospital should already have a multidisciplinary group that coordinates policy and practice for falls prevention. If not, the Patient Safety First 'How to' guide in this pack provides advice on how to set one up and who to include.</p> <p>Your hospital's falls prevention group will need to mandate the use of the care bundles as the new standard of care, and make any necessary changes to policies. They will need to ensure participation from different departments and to coordinate its introduction and long-term sustainability across your organisation.</p> <p>Of course you may have reasons to adapt the FallSafe care bundles locally, but if you do this, stay evidence-based: reliable delivery of an ineffective intervention won't help patients.</p>
Involve patients and their carers	Hopefully you already have patient and carer representatives on your organisation's falls prevention group; if not, aim to recruit them.
Identify relevant targets	Link into any local motivation. For example, do you have a CQUIN target for falls prevention? Are falls rates reported in your quality accounts?
Identify a leader (or leaders) to drive and coordinate adoption of the FallSafe approach across the whole hospital	A falls coordinator or specialist nurse would be ideal if you already have one, or consider a 'triad' of a matron, senior therapist and doctor. The leader(s) will be key to leading and coordinating the delivery of the FallSafe approach across the wards of the hospital, recruiting and supervising the ward-based FallSafe leads, organising their training, and troubleshooting problems at a higher level. Falls prevention is unlikely to succeed without someone fulfilling this essential role between the wards and the hospital's executive and falls groups. However, don't change this into a top-down initiative: the essential part of FallSafe was that improvement at ward level was led from <i>within</i> the ward team.
Understand what reported falls can tell you	<p>Your local incident reporting system can be a goldmine – but you have to work at extracting the gold.</p> <p>Numbers per month will not mean much, and numbers per ward will mainly tell you which wards have the most frail, older patients more vulnerable to falling. Instead, aim to summarise who fell (eg patient age), where they fell, at what times, and what injuries they sustained, etc. Do you know how many of your fallers are confused, and how many fall more than once?</p> <p>The hospital-wide falls leader should read the free-text description of at least 50 reported falls so that they can develop an overview of what the most common causes might be (although this might show that falls are not currently well described and this needs improvement too). This information might help you to prioritise which elements of the FallSafe approach you want to implement first and which wards need to be your first priority.</p>

continued

Steps	Hints and tips
Have a budget to overcome barriers to implementation	<p>You'll also need to prepare similar information at ward level, rather than hospital level, for your FallSafe leads so that they and their individual wards can understand their own priorities.</p> <p>You don't have to spend a fortune on equipment, but the basics of footwear supply, manual sphygmomanometers, and access to at least one ultralow bed for each ward are essential. If you don't already have these, there is no point beginning to measure aspects of care that will be impossible for the wards to deliver. You should work on securing a budget. However, if possible, don't go ahead with your purchases until your FallSafe leads can be involved in trying out and choosing the best equipment for their patients.</p>
Look for a local partner organisation who are also aiming to implement the FallSafe approach	<p>Making this a joint effort with a neighbouring hospital or hospitals opens staff up to new practice, and means you can share the training of the FallSafe leads. Having more than one organisation working together helps to keep peer support sessions for FallSafe leads a 'safe space', separate from any line management or performance management.</p> <p>We found that bringing together staff from acute or rehabilitation hospitals and mental health units was particularly helpful, as they had complementary skills that they could share with each other. The patients most vulnerable to falling in all of these settings often have a complex mix of physical illness and mental health needs.</p>
Make the 'Preventing falls in hospitals' e-learning accessible	<p>In England, you can do this via the Electronic Staff Record and, in Wales, via Learning@NHSWales. Or you could upload the CD version in this pack to your intranet.</p> <p>With the support of resources, glossary, nurse viewpoints and clinical videos, this interactive course aims to give you the knowledge you need to prevent falls and to help your patients stay safe and independent. It covers patient risk factors (cardiovascular, balance, confusion, bone health, medication, vision and toileting), environmental risk factors (patient environment, special equipment and special observation), and what to do after a fall. It concludes with a case-study-based exam which produces a certificate for those who pass.</p> <p>The e-learning course is designed for registered nurses, but other staff groups may also find it useful. It will underpin any training for the FallSafe leads and they can ensure that their ward colleagues also complete the course.</p>
Choose your first FallSafe wards	<p>Trying to implement FallSafe on every ward all at once in a large hospital would be a big challenge and study days for large numbers of FallSafe leads would be unmanageable. To create study days where everybody feels engaged, you probably need to keep to no more than 20 in each peer group. Choose a representative mix of ward types rather than focusing on one specialty. The variety of patient groups and staff backgrounds will make it easier to come up with different ways to overcome implementation challenges.</p> <p>If a ward has a high level of vacancies, or no current ward manager, aim to wait until these issues are resolved before trying to implement FallSafe.</p>
Recruit your FallSafe leads	<p>FallSafe leads need to be ward-based, and not working solely nights or solely office hours. The ward manager may wish to take the lead on falls, but rarely has the time to dedicate to the detail of the FallSafe approach because of their other responsibilities. We found that staff nurses who had at least two years' post-registration experience, or were deputy sisters / charge nurses, were ideal.</p> <p>We offered an honorarium or 'acting-up' uplift in salary, equivalent to a single increment for a year of active improvement effort. This was very cost-effective in terms of the good will it generated: the FallSafe leads put in far more extra time and effort</p>

continued

Steps	Hints and tips
	<p>than this would have cost to backfill. If you can't do that, aim to do everything you can to make this a formalised and desirable role that is not 'just another link nurse'. Assign a proper job title, badges, commitment to release for training, and explain advantages for future promotion, etc.</p> <p>If all else fails and staff get reluctantly volunteered rather than volunteering, don't worry; not all our FallSafe leads were enthusiasts at the beginning, but they were all enthusiasts by the end!</p> <p>The FallSafe lead requires training and peer support. They also need time to devote to influencing and training ward colleagues, improving practice, and collecting measurements. Our FallSafe leads estimated the time needed to be about three hours a week.</p>
<p>Start succession planning</p>	<p>If your hospital has a high turnover of nurses, recruitment (and training) of new FallSafe leads will be fairly constant. The confidence of our FallSafe leads flourished, and the evidence they were able to demonstrate of leading improvements on their wards helped some of them secure promotion. You will therefore need to consider including deputy FallSafe leads to share in the training and improvement efforts, and to be ready to take over.</p>
<p>Make essential changes to documentation</p>	<p>You may not need to carry out a wholesale review and revision of policy and documentation, as FallSafe is about the reliable delivery of things that should already be in most policies.</p> <p>But your core admission documentation does need to trigger questions about history of falls and fear of falling. Phrasing is important: reasonable questions to ask every inpatient are: 'any recent falls, slips, trips or faints?'; 'any dizzy spells or worries that you might fall?'. You may also need to provide new falls prevention care plans that highlight specific elements of the FallSafe care bundles and lead through to actions taken (there is an example in the Patient Safety First 'How to' guide included in this pack). You may also need additional templates to guide staff in making cognitive assessments or making better decisions on the risks and benefits of bedrails; we have examples in this pack you might want to use. Be prepared for these to need adaptation in the light of experience. For the elements of the FallSafe care bundles that involve passing requests between staff groups, providing pre-printed labels or rubber stamps can make life easier. For example, some of the original FallSafe wards used a rubber stamp (as illustrated below) to request a review of a medication that could increase falls risk, or used stickers to inform physiotherapists of new patients with a history of falling.</p> <div data-bbox="475 1608 1037 1798" style="border: 1px solid black; padding: 5px; margin: 10px 0;"> <p>Falls medication review to reduce CVS and CNS drugs</p> <p>Requested by..... Date</p> <p>Reviewed by..... Date</p> </div> <p>Revising paperwork does not only have to mean adding things; there may be some things you can take out of your current paperwork. For example, some hospitals still use numerical scores, which can be unreliable (you can read more in the Patient Safety First 'How to' guide included in this pack).</p> <p>It is important that paperwork should be kept to a useful minimum. Several elements of the FallSafe care bundles rely on observing the care delivered to the patient rather</p>

continued

Steps	Hints and tips
	<p>than checking documentation. After all, writing 'call bell in reach' on a care plan doesn't guarantee it has happened.</p> <p>The FallSafe project helped to develop the National Patient Safety Agency guidance on <i>Essential care after an inpatient fall</i>, enclosed in the 'Further resources' section of this pack. Make sure this is built into your local documentation.</p>
Plan access to walking aids out of normal hours	<p>Patients who could require a walking aid for support need to be assessed and have one provided immediately.</p> <p>In many hospitals there are no systems in place outside office hours to supply a walking aid to patients who have been admitted as emergencies, even if the patient usually has one at home. Therapy and nursing staff need to come together and agree a practical way of meeting patients' needs at all times.</p> <p>The way forward may need to be agreed at hospital level, but the issues of nurse training, walking aid provision and storage may need to be resolved ward by ward.</p>
Communicating and promoting FallSafe to the whole hospital	<p>If you are introducing FallSafe in all your wards, you'll want all your staff to be kept informed of new developments. Even if you start with a smaller group of wards, it's important to keep the rest of your hospital updated. You will need to think through how you can do this – for example, staff newsletters, briefing sessions, staff canteen posters, or messages on ward computer screensavers.</p>
Educating everyone who has a part to play	<p>Training needs have to be determined for different staff groups and a plan made for how this training is to be delivered. The FallSafe leads will be important for informally educating all types of staff on their ward, but the hospital's overall training plan needs to be considered as well.</p> <p>Medical staff may need education in the diagnosis and management of delirium, and of syncope and pre-syncope in causing falls. They need to be aware of the role of medication in causing falls, including medication-related hypotension and orthostatic hypotension, and the role of sedatives and antidepressants. They need to learn what changes they should make to prescriptions. Pharmacists may help in this role, flagging up culprit medications and advising on alternatives with fewer side effects, etc.</p> <p>Porters, catering, cleaning and other support staff also need to be involved, as they commonly find themselves in situations where an unsteady patient is trying to get up, or is walking around unsafely, and they need to be able to respond appropriately.</p> <p>Physiotherapists play a key role in assessing gait and balance problems, rehabilitation, and in the provision of walking aids. They need to train nurses on how to assess for such an aid and how to obtain one in the periods when no physiotherapist is available.</p> <p>Occupational therapists can assist with strategies to manage the activities of daily living without risking a fall.</p>
Plan your study days	<p>See the later section on FallSafe lead training on pages 19–21 for hints and tips on how to do this and what to include, and how the content of the study days is linked to the staged introduction of the elements of the care bundles.</p> <p>Think of your initial study days as the launch of your FallSafe project; aim to generate excitement and enthusiasm as well as knowledge and skills. Give the FallSafe leads time to get to know and respect each other's knowledge and talents. The more motivated, supported and knowledgeable the FallSafe leads are, the more that enthusiasm will reach down to the wards and the care bundles will be reliably delivered.</p> <p>You may want to ask your FallSafe leads to complete the 'Preventing falls in hospitals' e-learning course before their first study day, or to use it after the initial study days to reinforce their learning. Remember the course is available online and on the CD in this pack.</p>

Steps for FallSafe leads

The following steps are for the FallSafe leads to carry out after they have received the initial two- or three-day training, with the schedule of study days at four- to eight-week intervals used as review points. They will need central backing from a hospital-wide leader, falls group and the senior executive to make a real difference.

Steps	Hints and tips
Build a core multi-disciplinary ward team	<p>Ask the therapists, nursing colleagues, healthcare assistants, pharmacists and medical staff who work on your ward to get involved. Remember the FallSafe approach is a multidisciplinary approach, not a nursing initiative: the FallSafe Lead is an improvement facilitator for all their colleagues, not just fellow nurses.</p> <p>In discussions with the FallSafe leads towards the end of the project, when asked what they would do differently next time, nearly all said that they would focus more on forming a team within their ward at the very beginning of the project.</p> <p>So that most shifts have someone working on them who has an interest in falls, several registered nurses need to be involved within this core ward team. It's good to include healthcare assistants too, as they are particularly useful in delivering the bedside fundamentals of falls prevention. Many find that this is something in which they can play a prominent role, and find it to be a very satisfying part of their work.</p>
Share your new knowledge	<p>Encourage as many colleagues as possible to carry out the 'Preventing falls in hospitals' e-learning, available online and on the CD in this pack. Take informal and formal opportunities to teach your ward colleagues to amplify and personalise that learning, and to make it ward-specific.</p>
Promote FallSafe within your ward	<p>Getting all staff who work on a FallSafe ward to know about FallSafe is a key task for the FallSafe lead, and we don't have any perfect solutions. Communication within the ward was a major challenge highlighted by our FallSafe leads. Large, busy wards with a high turnover of patients and staff, and areas that employed many agency staff, had particular problems with communication. We know that work emails were not used by many staff, and notices in the staffroom tended to become part of the wallpaper rather than read, while communication books were sometimes regularly written in but rarely read. One suggestion is to put messages on the ward computer screensaver, and most of our FallSafe leads used everyday opportunities like handovers, ward rounds and coffee breaks to communicate with colleagues.</p>
Understand what reported falls can tell you	<p>In the section above, we've suggested that the hospital-wide falls leader gives each FallSafe lead a comprehensive report of their falls, taken from the hospital incident reporting system. The FallSafe lead needs to discuss it with their core team of ward colleagues.</p> <p>Do your peak times for falls match any particular routines or workload pressures on your ward? Are there 'hotspots' where more patients fall and, if so, why might that be? We'd suggest that you read free-text descriptions of at least 20 reported falls from your ward so you can develop an overview of what the most common problems were in the past.</p> <p>Get to know the department that deals with risk management, so they can tailor the falls reports they produce for your ward to your needs.</p>
Identify, report and have addressed any missing equipment or environmental hazards	<p>It's unfair (and doomed to failure) to ask ward staff to measure call bells in reach when they have grumbled for years about the lack of call bells in a dayroom, or to expect them to be enthusiastic about falls prevention when the floor is uneven and awaiting repair. FallSafe leads need to identify, report and have addressed any essential improvements or repairs needed on their ward, and any missing equipment.</p>

continued

Steps	Hints and tips
	<p>In the 'Steps for senior managers' section, we've said that each FallSafe lead will need footwear supplies, manual sphygmomanometers, and, ideally, access to ultralow beds for patients who cannot be kept safe in a normal hospital bed. If these are going to be purchased for the first time, expect to be involved in trying out and testing them. Our FallSafe leads purchased slipper socks with all-round treads for patients who were too forgetful to put slippers on when they got out of bed, and 'proper slippers' for patients who had nobody to bring them safer footwear from home.</p>
<p>Choose your first one or two bundle elements</p>	<p>Stepped implementation of the elements of the care bundles is an important part of the FallSafe approach. Changes should be introduced gradually, letting people get used to one change before another is introduced. The order of implementation, however, really isn't important. We suggest that, in your peer group of FallSafe leads, you decide together where you all want to get started. All working on improvement of the same elements of the care bundles at the same time will help you to share your successes and challenges. For your first efforts at improvement, we'd suggest one care bundle element that is already routine but may not be reliable (eg call bell in reach), and one that involves some new skills or training.</p>
<p>Take baseline measurements for these care bundle elements</p>	<p>Use the 'FallSafe care bundles measurement' grid and helnotes on pages 28–35. You can also download Word versions of these for local adaptation from www.rcplondon.ac.uk/projects/fallsafe.</p>
<p>Take baseline measures of under-reporting from ten staff on every FallSafe ward</p>	<p>Not all falls get reported, and it's important to get an honest understanding of how many falls might not be getting reported on your wards. As the FallSafe lead, you should collect this information from your ward as you are more likely to get honest answers than senior managers. Use the 'FallSafe measurement of under-reporting' helnotes and grid we provide in this guide to assess levels of under-reporting (pages 24–27). You'll repeat this later, and that will help you to assess changes in the rate of reported falls.</p>
<p>Repeat your care bundle measurements every month</p>	<p>Do everything you can at ward level to carry out 'plan, do, study, act' cycles for further improvements. Ask staff's opinions and try to use their advice and ideas to make them feel valued and to give them some ownership of the project as well. Also explain why they are doing things. Why we do cognitive testing? Who do you tell? What do you do about a low score?</p> <p>Wearing a work uniform when collecting data may bring with it problems, as patients and colleagues do not recognise that you are not to be disturbed; our FallSafe leads recommend doing it out of uniform.</p>
<p>Introduce one or two further elements of the care bundles after each study day</p>	<p>Use each peer group study day to seek extra help and advice where your local improvement efforts are hitting barriers or challenges, and be prepared to share the secrets of your success with other FallSafe leads. Then use what you have learned on the day to prepare to add a new element of the care bundles, including taking a baseline measurement before you start.</p>
<p>Repeat the under-reporting measure about every four months</p>	<p>Use the 'FallSafe measurement of under-reporting' helnotes and grid on pages 24–27 to assess levels of under-reporting.</p>
<p>Don't expect to see a visible change in falls numbers ward by ward or month by month</p>	<p>It would be great if you did, but there will be a lot of random variation month to month; don't be disheartened if you don't see changes. We don't expect them to be visible until your hospital looks at whole-hospital rates of falls per 1,000 bed days for a calendar year, and factors in any changes in how completely falls are reported.</p>
<p>Don't give up!</p>	<p>There will always be people resistant to change and you need to be ready to accept this and not get downhearted.</p>

Education and development programme for FallSafe leads

This is an outline of the training and development support we gave to the FallSafe leads. The key content of all these sessions is reflected in the CD e-learning resource provided with this pack. The e-learning also provides links to extra resources you can use to deliver more in-depth training. In addition to the CD, you can access this e-learning via the NHS Electronic Staff Record in England and via Learning@NHSWales in Wales.

You will have staff in your own or neighbouring hospitals who can deliver similar training: senior nurses, therapists, pharmacists, geriatricians or psychogeriatricians, with either general expertise in falls prevention or expertise in particular topics like delirium or dementia. You are likely to have some staff in your hospital who could provide sessions on quality improvement theory, and your more experienced and respected managers and clinicians will be able to facilitate sessions on managing change, leadership, and engaging different staff groups.

We started with three days of training to cover the most important aspects of hospital falls prevention and quality improvement. Brief presentations were alternated with discussion, sharing of knowledge, and opportunities to apply the learning to patient case studies.

Initial study days	
Clinical knowledge	<ul style="list-style-type: none"> Falls prevention evidence overview – the basics of individual (intrinsic) risk factors and environmental (extrinsic) risk factors Understanding the limitations of falls risk scores Equipment risks and benefits (ultralow beds and alarms) Essential care after an inpatient fall
Quality improvement	<ul style="list-style-type: none"> Inspiration for improvement Overview of quality improvement
Other	<ul style="list-style-type: none"> The patient/carer experience Roles and responsibilities (including agreeing the two elements of the care bundles to be introduced first) Engaging others and building a local team Incident reporting and learning from your reported falls
'Homework'	<ul style="list-style-type: none"> Mapping patient journeys to identify any environmental hazards (pages 37–38) Discussing and agreeing new equipment with ward team Taking baseline measures of the under-reporting of falls (pages 24–27) and the first two care bundle elements (pages 28–35)

Then eight further study days took place at four- to eight-week intervals over the following year, and were linked to the staged introduction of the care bundle elements. On each of these days we introduced one or two new elements of the care bundles.

A typical study day would look like this:

Sharing the learning (progress review)

Process measures for the elements of the care bundles already underway would be shared, including celebrating successes and overcoming challenges. Individual plans for delivering these more reliably would be informed by the peer and expert advice provided in these discussions.

Coffee break

Introducing a new element of the care bundles (or sometimes two or three linked elements)

Presentation and group work to understand an aspect of falls prevention in more depth, to learn and practise any associated clinical skill, and to understand how to collect the new measurement(s). Over the eight days we covered the topics outlined below.

	Education	Clinical skill	Measurement
1	Cardiovascular causes (including the importance of hearing the patient's experience of falling to identify cardiovascular causes and the impact of the fall on their confidence)	<ul style="list-style-type: none"> taking a falls history fear of falling lying/standing blood pressure hand-taken pulse to check for arrhythmias 	<ul style="list-style-type: none"> asked about falls asked about fear of falls lying/standing BP
2	Continence, toileting and special observation	<ul style="list-style-type: none"> individualised toileting plans urinalysis 	<ul style="list-style-type: none"> urinalysis
3	Dementia, delirium and depression	<ul style="list-style-type: none"> cognitive screening: abbreviated mental test score (AMTS, page 36 for FallSafe format) delirium screening: confusion assessment method (CAM, see 'Further resources' section of this pack) 	<ul style="list-style-type: none"> cognitive screening (AMTS)
4	Gait, balance, footwear and bone health	<ul style="list-style-type: none"> selecting and adjusting temporary mobility aids 	<ul style="list-style-type: none"> safe footwear
5	Environmental safety and vision	<ul style="list-style-type: none"> basic visual assessment 	<ul style="list-style-type: none"> call bell in reach
6	Equipment risks and benefits (ultralow beds and alarms) and bedrail risks and benefits (useful tools in the 'Further resources' section of this pack)	<ul style="list-style-type: none"> bedrail assessment 	–
7	Culprit medication	–	<ul style="list-style-type: none"> no new night sedation medication review (<i>Medicines and falls in hospital</i> available in the 'Further resources' section of this pack, to assist this request of doctors)
8	After a fall, including root cause analysis	<ul style="list-style-type: none"> neurological observations 	–

There is no right order for any of these, as they all interconnect to some degree. For example, delirium can be linked back to urinalysis, as urinary tract infections can be a cause of delirium; and environmental safety included how the environment affected patients with dementia.

continued

Sharing the learning (progress review) – continued**Lunch****Quality improvement**

Sessions related to quality improvement were included on most of the study days. We started off with some of the basics of quality improvement science, such as ‘plan, do, study, act’ cycles and run charts, but these sessions gradually became more tailored to issues that were challenging the group, eg breaking down professional boundaries, team working, leadership styles, engaging other professional groups, engaging patients and carers, etc.

Coffee**Planning next steps**

An open discussion on how to start introducing the new elements of the care bundles in each FallSafe ward (including taking a baseline measurement of those elements before starting improvement efforts).

While each FallSafe ward started introducing each element of the care bundles at the same time, they faced very different challenges implementing them, so would often be at different stages of embedding them in practice when they regrouped for later study days. For example, when it came to lying and standing blood pressure, some FallSafe wards already had most of the skills and equipment they needed, but others had to try out and purchase manual sphygmomanometers and train staff to use the equipment before they could start to introduce it into routine clinical practice. This variation was helpful, as there were usually at least one or two FallSafe leads ‘ahead of the game’ on particular elements, who could give advice to their peers, but it did mean that flexibility had to be built into the programme of study days.

Our study days lasted about five hours as we had to allow for travel from a large geographical area, so it might be feasible to deliver a similar programme with two initial study days and eight half-days. But try not to compress too much in: informal networking and the chance to obtain fresh ideas and perspectives on obstacles faced were much valued by the FallSafe leads.

FallSafe templates

FallSafe measurement of under-reporting

FallSafe care bundles measurement

FallSafe AMTS recording format

FallSafe mapping the patient journey

FallSafe measurement of under-reporting

Why are we asking for this to be done?

Research suggests that some falls in hospitals go unreported. However, once a project on falls is underway, reporting tends to improve. This can mean that things look like they are getting worse when actually they are getting better. Asking colleagues about how they reported previous falls on the ward, before and during the lifetime of the initiative, helps to distinguish increases in reporting from real increases in falls.

When do I need to collect this information?

As soon as possible, and it must be before you start trying to make improvements to falls prevention. Collection will need to be repeated every three or four months thereafter.

Who should I collect the information from?

Starting from an agreed date every three or four months, we want you to collect the information from the first ten qualified nurses on the ward who you see at handovers. This should mean you get staff working days and nights. Don't pick and choose the staff who are more willing – they won't give you a picture of what the typical staff member would do. Include bank, agency and 'borrowed' nurses, if there are any working on the ward. In wards with many qualified nurses, you may be able to ask all ten qualified nurses in a single shift; in smaller wards, it may be a few days before you've encountered ten such nurses.

How should I collect the information?

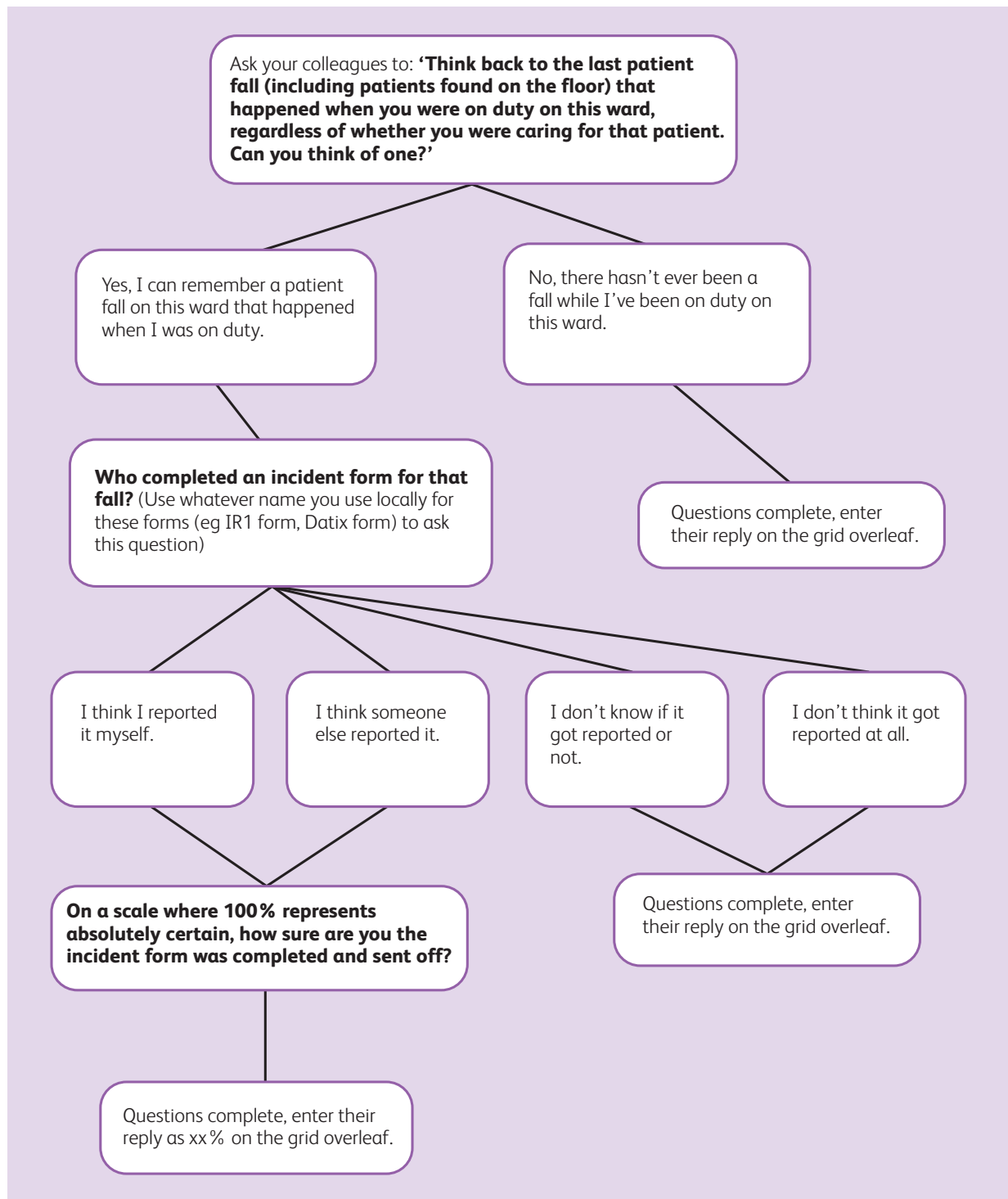
Just verbally asking the questions on the flowchart questionnaire on page 25 should be the quickest method for collecting the information, taking no more than a minute. You can then enter respondents' answers in the grid on page 26.

To help you measure your falls reporting, the following pages provide:

- an under-reporting flow chart questionnaire
- an example of a completed under-reporting measurement grid
- a grid you can photocopy and use to collect your results
- helpnotes on collating your responses.

This document is available as an MS Word document for you to adapt from www.rcplondon.ac.uk/projects/fallsafe.

FallSafe measurement of under-reporting questionnaire



FallSafe measurement of under-reporting grid

Example

	Nurse 1	Nurse 2	Nurse 3	Nurse 4	Nurse 5	Nurse 6	Nurse 7	Nurse 8	Nurse 9	Nurse 10
No patient falls have happened while this nurse was on duty on this ward.	✓						✓			
They are not sure who reported the last patient fall on this ward that they were aware of.				✓						
They don't think the last patient fall on this ward that they were aware of got reported on an incident form.					✓					
They personally reported the last patient fall on this ward that they are aware of (how certain %).		100%	99%							
They believe someone else reported the last fall on this ward that they are aware of (how certain %).						100%		50%	75%	99%

Fill in your results here

	Nurse 1	Nurse 2	Nurse 3	Nurse 4	Nurse 5	Nurse 6	Nurse 7	Nurse 8	Nurse 9	Nurse 10
No patient falls have happened while this nurse was on duty on this ward.										
They are not sure who reported the last patient fall on this ward that they were aware of.										
They don't think the last patient fall on this ward that they were aware of got reported on an incident form.										
They personally reported the last patient fall on this ward that they are aware of (how certain %).										
They believe someone else reported the last fall on this ward that they are aware of (how certain %).										

Information collected between (date) and (date)

Name of FallSafe lead: Name of project ward/unit:

FallSafe measurement of under-reporting collation helnotes

Any changes in under-reporting should only be analysed across *all* your FallSafe wards: the numbers of staff asked per ward will be small and relate to only one recent fall and, at that level, trends could be misleading.

To collate your responses, disregard any staff who cannot recall a fall.

Summarise your other results like this:

Example

Under-reporting summary	April 2012	July 2012	Month and year	Month and year	Month and year
Total number of staff who recalled a recent fall	82	78			
Total who were 99–100% certain that they or a colleague had reported the last fall (confident reported)	41/82 (50%)	53/78 (68%)			
Total who were 50–98% certain that they or a colleague had reported the last fall (possibly reported)	20/82 (24%)	21/78 (27%)			
Total who were 0–49% certain that they or a colleague had reported it, or who are not sure who reported the last fall, or don't think it got reported at all (unlikely to have been reported)	21/82 (26%)	14/78 (18%)			

Use these results as a context for any changes in rates of reported falls, for example:

Between April 2012 and July 2012 the rate of reported falls in Anytown Hospital increased from 5.0 falls per 100 bed days to 5.5 falls per 100 bed days (an increase of 10%). In the same period, the proportion of staff who were confident that the last fall had been reported increased from 50% to 68%. This suggests that the increase in the reported falls is likely to be related to an increase in how completely falls are reported. Because the percentage increase in the completeness of reporting exceeds the increase in reported falls, it suggests that the underlying 'true' falls rates may actually be decreasing.

Between April 2012 and July 2012 the rate of reported falls in Anytown Hospital decreased from 5.0 falls per 100 bed days to 4.5 falls per 100 bed days (a decrease of 10%). In the same period, the proportion of staff who were confident that the last fall had been reported increased from 50% to 68%. This suggests that the decrease in reported falls reflects a real reduction in the 'true' falls rate rather than any deterioration in the completeness of the reporting of falls. Because the percentage increase in the completeness of reporting exceeds the decrease in reported falls, it suggests that the underlying 'true' falls rates may have decreased by more than 10%.

FallSafe care bundles measurement

Q When do I need to collect this information?

A Monthly, ideally around the same date each month.

Q Who should I collect the information from?

A We want you to collect it by observing and checking the notes of 20 patients on your ward (or all patients if you have fewer than 20). They don't have to be 'new' patients since you last took the measures. To avoid any temptation to 'hand-pick' your patients:

- if you are on a small ward, collect it from the twenty patients that come first in handovers
- if your ward has two teams, take the first ten patients from each team, and so on if you have three teams, etc.

Q How should I collect the information?

A Through some quick bedside observation at a time of day when most of your patients who are well enough would be out of bed, and through checking the notes at any time. **Remember the check doesn't just apply to nursing notes;** you might well find a cognitive screen completed in a doctor's notes and a history of falling in the occupational therapist's notes. So any notes that are easily accessible on the ward should be checked (but not notes that are held in a separate place, eg the therapist's office).

To help you measure compliance with the care bundles, the following pages provide:

- an example of a completed measurement grid
- a grid you can photocopy and use to collect your measures
- helpnotes on completing the measurement grid.

This document is available as an MS Word file for you to download and adapt from www.rcplondon.ac.uk/projects/fallsafe. A 'FallSafe runchart spreadsheet' is also available from that webpage to assist you in analysing your results.

FallSafe care bundles measurement grid

Example	Sample of 20 patients (or all patients if ward has fewer than 20 patients)																				Totals (‘Yes’ plus ‘N/A’ out of total, eg 10 ‘Yes’ + 5 ‘N/A’ = 15/20). Please refer to helpnotes.
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	
Use to track patient names/initials/bed number/room number if you need to	FH	AB	ST	YH	LT	YT	TY	UP	KL	MJ	NM	HK	LT	FR	GT	HY	DE	ES	FR	TT	
All 20 patients	If small ward with fewer than 20 patients write total here																				
Observe: Call bell in sight and reach?	Y	N	N/A	Y	Y	Y	Y	Y	N/A	Y	Y	Y	Y	N	Y	Y	N/A	N	Y	Y	17/20
Observe: Safe footwear on feet?	Y	Y	N/A	Y	Y	Y	Y	Y	N	Y	Y	Y	Y	N	Y	Y	N/A	N/A	Y	N	17/20
Notes: Asked about history of falls?	Y	Y	N/A	Y	Y	Y	Y	Y	N	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	19/20
Notes: Asked about fear of falling?	N	N	N/A	Y	N	N	Y	N/A	N/A	N	Y	N	N	N	N/A	N/A	N	Y	Y	Y	11/20
Notes: Urinalysis performed?	Y	Y	Y	Y	N	Y	Y	Y	N	Y	Y	Y	Y	N	Y	Y	Y	Y	Y	Y	16/20
Drug card: Avoided night sedation last night? (‘Yes’ = not given, ‘No’ = given)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	N	Y	Y	Y	Y	Y	N	Y	Y	18/20
For any of the 20 patients aged 70+†	Number of patients aged 70+																				13
Notes: Cognitive screen?	Y	N	N/A	N/A	N/A	N/A	N/A	Y	N/A	Y	Y	Y	Y	N	Y	N/A	N/A	N	Y	Y	17/20
For any of the 20 patients who are ‘higher risk’‡	Number of higher risk patients																				8
Charts: Lying and standing BP recorded?	Y	Y	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Y	Y	N	N	N/A	N/A	N/A	N/A	N/A	Y	N/A	18/20
Notes: Full medication review requested?	Y	Y	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Y	Y	Y	Y	Y	N/A	N/A	N/A	N/A	Y	N/A	19/20
Received all relevant bundle elements?	N	N	Y	Y	N	N	Y	Y	N	N	Y	N	N	N	N	Y	N	N	Y	N	7/20

† The FallSafe project used ‘over 70 years’ as the cut-off age, as a compromise between the policies of the hospitals involved: some considered cognition assessment appropriate for all patients over 65, others for all over 75.
‡ In the project, all patients on older peoples’ wards were counted as high risk; on other wards only some were. Follow your local policy, but also always consider patients with a history of falls or fear of falling as high risk.

FallSafe care bundles measurement grid

Ward	Sample of 20 patients (or all patients if ward has fewer than 20 patients)																				Totals (‘Yes’ plus ‘N/A’ out of total, eg 10 ‘Yes’ + 5 ‘N/A’ = 15/20). Please refer to helpnotes.
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	
Date																					
Use to track patient names/initials/bed number/room number if you need to																					
All 20 patients	If small ward with fewer than 20 patients write total here																				
Observe: Call bell in sight and reach?																					
Observe: Safe footwear on feet?																					
Notes: Asked about history of falls?																					
Notes: Asked about fear of falling?																					
Notes: Urinalysis performed?																					
Drug card: Avoided night sedation last night? (‘Yes’ = not given, ‘No’ = given)																					
For any of the 20 patients aged 70+†	Number of patients aged 70+																				
Notes: Cognitive screen?																					
For any of the 20 patients who are ‘higher risk’‡	Number of higher risk patients																				
Charts: Lying and standing BP recorded?																					
Notes: Full medication review requested?																					
Received all relevant bundle elements?																					

† The FallSafe project used ‘over 70 years’ as the cut-off age, as a compromise between the policies of the hospitals involved; some considered cognition assessment appropriate for all patients over 65, others for all over 75.
 ‡ In the project, all patients on older peoples’ wards were counted as high risk; on other wards only some were. Follow your local policy, but also always consider patients with a history of falls or fear of falling as high risk.

FallSafe care bundles measurement helpnotes

Observe: call bell in sight and reach?

Dementia units without a call bell system, as they have too few patients who are able to use call bells, can skip this measure.

Collect the information by walking around and observing your patients.

The measure applies to anywhere patients are sitting or lying at the time you undertake the observation.

Hopefully 'Yes' is self-explanatory.

'N/A' can be used for any patient too ill or too confused to use a bell, for patients walking around at the time, for patients with a staff member caring for them hands-on at the time, and for patients in the toilet (as too intrusive to check).

If you have patients in beds, chairs or day rooms where no bells can be made to reach, these count as 'No'; think about doing something to fix this.

Observe: safe footwear on feet?

Take this observation at a time when most of your patients, who are well enough, are likely to be out of bed. Collect by walking around and observing your patients.

'N/A' can be used for any patient in bed and under the covers, any hoist-dependent patient, and any patient who has been offered safe footwear but *refuses* to wear it (not just forgets to wear it).

'No' should be recorded if a patient has:

- bare feet
- socks only (but all-round treaded non-slip socks are ok)
- anti-embolism stockings only
- bandages or dressings only
- shoes or slippers that are visibly too big
- shoes or slippers that are visibly too small
- lace-up shoes without laces, or with trailing laces
- shoes or slippers worn with squashed backs
- novelty slippers
- backless shoes or slippers, except for very confidently mobile patients
- foam disposable slippers, except for very confidently mobile patients
- high-heeled shoes, except for very confidently mobile patients.

Anything else should be good enough footwear to count as 'Yes'. For mobile patients sitting or resting on the bed but too polite to wear their shoes/slippers on the bed, you can count 'Yes' as long as they have safe shoes/slippers within easy reach (not shut away in a cupboard).

Notes: asked about history of falls?

Check the patient's records in all the places where you might reasonably expect this to be recorded given your local paperwork (eg falls assessment form, documentation on sections on problems with mobility), but don't feel you have to read their entire case notes. It doesn't matter what area of notes (nursing, medical, physiotherapy or occupational therapy notes) or who asked the questions – nurse, doctor or physiotherapist or occupational therapist are equally fine – as long as it is in case notes that are accessible to all the team.

If you have a patient to whom asking the question would be inappropriate – eg a patient who is unconscious or dying – you can count as 'N/A'. If the patient is unable to answer – eg unconscious or severe dementia – and there is no carer to ask (neither on admission nor visiting later), you can count as 'N/A'.

Otherwise 'Yes'/'No' should be self-explanatory (remember 'Yes'/'No' refers to whether the patient was asked, not whether their answer is yes or no). Even for younger fairly healthy patients, if the question is phrased as 'any falls or faints?', it is appropriate and useful for planning their care.

Notes: asked about fear of falling?

We refer to this measure as 'fear of falling', but in practice you should use words like anxieties or worries. Check their notes in all the places where you might reasonably expect this to be recorded given your local paperwork (eg falls assessment form, documentation on sections on problems with mobility), but don't feel you have to read their entire case notes. It doesn't matter who asked the questions – nurse, doctor, physiotherapist or occupational therapist are equally fine – as long as it is in case notes that are accessible to all the team.

If you have a patient to whom asking the question would be inappropriate – eg a patient who is unconscious or dying – you can count as 'N/A'. If the patient is unable to answer – eg unconscious or severe dementia – and there is no carer to ask (neither on admission nor visiting later), you can count as 'N/A'.

Otherwise 'Yes'/'No' should be self-explanatory (remember 'Yes'/'No' refers to whether the patient was asked, not whether their answer is yes or no). Even for younger fairly healthy patients, if the question is phrased as 'any dizzy spells or worries you might fall?', it is appropriate and useful for planning their care.

Notes: urinalysis performed?

You can record as 'Yes' for a patient if urinalysis has been recorded at least once during their inpatient stay. If you have a long stay unit and the recording interval doesn't feel often enough for your unit, you may wish to set a local rule, eg urinalysis at least once in the last month.

Check the patient's records in all the places where you might reasonably expect this to be recorded given your local paperwork: nursing admission proforma or bedside observation charts perhaps. If you can't find it with a reasonably good look-through, you can count as 'No'. If it was that hidden, it probably wouldn't be acted on anyway.

To count as 'Yes', the urinalysis result would need to be recorded as at least pH number plus 'NAD' or 'nil found,' or if any abnormalities are detected that these are noted.

If the records note that they tried *more than once* to get a sample but failed, you can count as 'N/A'.

Drug card: given night sedation last night?

Note: What we are aiming for is *no* new night sedation prescribed (unless there were very good clinical reasons to do so), but to make data collection more straightforward, we are only asking you to count night sedation doses given.

This means you don't have to look back to find out what night sedation the patient was taking at home. If you are making a difference and discouraging colleagues from prescribing new night sedation (or from administering *pro re nata* (PRN) night sedation), we'd expect this to show up in a reduced number of doses given. If your team was already very good at avoiding this, we'd expect your numbers to at least stay steady and not increase. But there is no 'right number' of doses given.

Check the patient's drug card and look for doses of night sedation given on the night time drug round the night before (usually 22:00 doses in most hospitals). Remember to look for stat or PRN doses as well as those regularly prescribed. Remember which drugs are considered sedatives:

- temazepam etc (all other -azepam except clonazepam)
- chlordiazepoxide (*don't* count if it is being used for alcohol withdrawal)
- zopiclone, zolpidem
- trazodone (*don't* count if the patient has a diagnosis of depression and trazodone is being used to treat depression)
- amitriptyline (*don't* count if being used to treat depression or a small dose to reduce overnight urinary frequency or if being used as part of pain relief).

Count as 'N/A' any patients who have *not* been on the ward for at least one night or who are *not* able/allowed to take oral medication.

Notes: cognitive screen completed?

You only have to collect this for patients in your sample of 20 patients who are aged over 70 years.[†]

Any format of cognitive screen is ok (eg abbreviated mental test score (AMTS)), mini-mental state examination (MMSE) etc), either ones that are already in standard use in your hospital or, as part of your improvement work, you might introduce the FallSafe AMTS template included in this guide (page 36).

Check the patient's records in all the places where you might reasonably expect this to be recorded given your local paperwork, but don't feel you have to read their entire case notes. It doesn't matter what area of notes (nursing, medical, physiotherapist or occupational therapist notes) or who asked the questions – nurse, doctor or physiotherapist or occupational therapist are equally fine – as long as it is in case notes that are accessible to all the team. A good place to look is the doctor's admission notes; they may record just the total score rather than the detail, eg 'AMTS 7/10', but that will still count as 'Yes'.

You can count as 'N/A' if the patient is unable to answer – eg unconscious, aphasic or non-verbal. Also count as 'N/A' if they don't have good spoken English and no translator is available. Just being very confused wouldn't be a reason to put 'N/A'. You can still try, and record as 0/10 if that is all they can do.

Otherwise, 'Yes'/'No' should be self-explanatory.

[†] This was the age threshold we used in the FallSafe project as a compromise between local policies with different age thresholds. NICE Clinical Guideline 21 defines older people as those aged 65 years or above, and hospitals introducing the FallSafe care bundles may wish to consider using 65 years as the threshold.

Charts: lying and standing blood pressure recorded?

You only have to collect this for patients in your sample of 20 patients who are at 'higher risk' of falls.

In the FallSafe project, all patients in wards for older people were counted as high risk; on other wards only some were. Follow your local policy, but also always consider patients with a history of falls or fear of falling as high risk.

If you are introducing FallSafe to any wards that do not care for mainly older patients, we would suggest that you tailor the helpnotes to your local policy here, bearing in mind the advice in the Patient Safety First 'How to' guide that numerical risk scores are not a reliable method of identifying more vulnerable patients, and numerical risk scores that have not been validated in your hospital's patient population should not be used. Alternative approaches are discussed in that 'How to' guide but, as a minimum, you must always consider patients with a history of falls or fear of falling as high risk.

We'd expect the lying and standing blood pressure to be recorded on observation charts.

You can count as 'N/A' if the patient is unable to stand / too ill to stand / unable to cooperate with staff.

Otherwise, 'Yes'/'No' should be self-explanatory.

Notes: full medication review requested?

You only have to collect this for patients in your sample of 20 patients who are at 'higher risk' of falls.

In the FallSafe project, all patients in wards for older people were counted as high risk, on other wards only some were. Follow your local policy, but also always consider patients with a history of falls or fear of falling as high risk.

If you are introducing FallSafe to any wards that do not care for mainly older patients, we would suggest that you tailor the helpnotes to your local policy here, bearing in mind the advice in the Patient Safety First 'How to' guide that numerical risk scores are not a reliable method of identifying more vulnerable patients, and numerical risk scores that have not been validated in your hospital's patient population should not be used. Alternative approaches are discussed in that 'How to' guide but, as a minimum, you must always consider patients with a history of falls or fear of falling as high risk.

You are measuring that the *request* has been made, not the response. Check the patient's records in all the places where you might reasonably expect this to be recorded, given your local paperwork, but don't feel you have to read their entire case notes. The logical place for nurses to write the request or to stick a request label is in the current section of the medical notes, where it should be seen at the next doctors' round or MDT meeting.

You can count as 'N/A' if the patient is on no medication at all.

Otherwise, 'Yes'/'No' should be self-explanatory.

Received all relevant care bundle elements (column totals)

This is completed after you've checked all the individual measures. Look down the column for each patient. If all the boxes have a 'Yes' or 'N/A' in them, you will put a 'Yes' here. Any 'No' in the column, even if it is just one 'No' among several measures that were 'Yes', means you have to put 'No' here. Patients with a 'Yes' will have received all the key elements of falls prevention that they needed.

Run charts on compliance with the elements of the care bundles

For our formal evaluation of the FallSafe project, we discarded all patients with 'N/A' from analysis, but you do not need to do this for tracking your monthly progress. The mathematics are much easier if you total the care bundles as we have shown in the example grid. This is because, except on very small wards, you always have a denominator of 20, regardless of the proportion of older or 'higher-risk' patients on each ward to produce percentages from and track your results.

The 'FallSafe runchart spreadsheet' will help you to produce run charts of your progress on each element of the care bundles and is available for you to download from www.rcplondon.ac.uk/projects/fallsafe.

The Royal College of Physicians has not obtained permission to reproduce the AMTS recording format for online use. Please see the print version of this document for the AMTS recording format.

FallSafe mapping the patient journey

- 1 Choose a patient on your ward who goes to the bathroom without the aid of a nurse/carer.
- 2 Start the mapping from the patient's bed using the prompts below.
- 3 Bear in mind the patient's level of mobility.

Using the example provided overleaf, keep a record of:

- obstructions
- time of day
- possible falls risks encountered
- changes needed to the ward.

Prompts

- **Mobility factors:** Bear in mind the patient's level of mobility. Does the patient have immediate access to suitable walking equipment and/or suitable slippers? Are the patient's glasses in reach?
- **Patient's personal area:** Is the area free of clutter? Has the bed got open space around it for the patient to manoeuvre?
- **Flooring:** Suitably non-slip? Are there any visible spills or unevenness?
- **Lighting:** Is the route well lit? Consider the same route at day and night.
- **Signage:** Is it clear where the nearest toilet is?
- **Nurses visible:** Are there any nurses around who could help if the patient were to fall?
- **Toilet facility:** Is the door heavy? Is there enough room for a mobility frame? Are there adequate hand rails?

FallSafe mapping the patient journey

Example



The FallSafe Pack

Essential reading accompanying this
Implementing FallSafe guide

1. About FallSafe

In addition to this *Implementing FallSafe* guide, the pack includes:

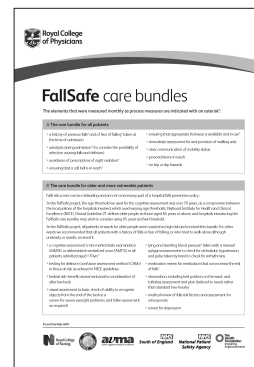
a. Why FallSafe?

An A5 booklet that concisely explains what the FallSafe initiative is, why it is important and why colleagues should get involved.



b. FallSafe care bundles reference card

A handy double-sided A4 card detailing the elements of the FallSafe care bundles in the 'Further resources' section of the pack.



Additional copies of these documents, including the FallSafe templates in this guide are available for you to download from www.rcplondon.ac.uk/projects/fallsafe

2. RCP/NHS Preventing Falls in Hospitals e-learning course



Produced under the auspices of FallSafe, this interactive course gives you the knowledge you need to prevent falls and to help your patients stay safe and independent.

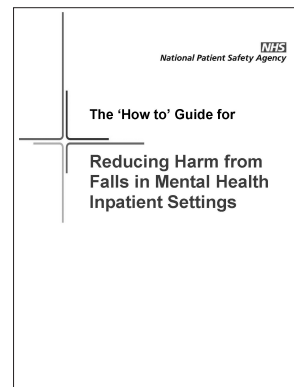
It has been developed primarily for registered nurses working in acute or community hospitals, but any staff member with an interest in falls prevention is welcome and encouraged to use it.

With the support of resources, glossary, nurse viewpoints and clinical videos, this e-learning course covers patient risk factors (cardiovascular, balance, confusion, bone health, medication, vision and toileting); environmental risk factors (patient environment,

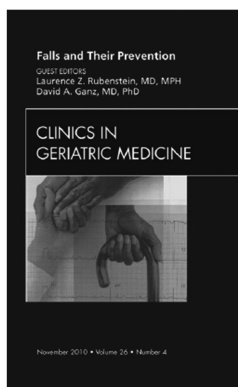
special equipment and special observation) and what to do after a fall. It concludes with a case-study based exam.

A CD version is included in your pack that you can upload to your intranet. But we would recommend you access it online, in England via the NHS Electronic Staff Record, or in Wales via Learning@NHS Wales.

3. Patient Safety First, *The 'How to' guide for reducing harm from falls*



This 'How to' guide gives a broad background to the problem of falls in hospital, and to using a quality improvement approach to systematically introduce evidence based care bundles for falls prevention. It is most useful for reference by the hospital-wide leaders of falls prevention, especially those in nursing, quality improvement or risk management roles. In addition to the copy that accompanies this guide, you can download further copies from www.patientsafetyfirst.nhs.uk or www.rcplondon.ac.uk/projects/fallsafe.



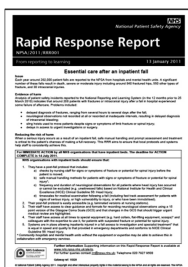
4. Oliver et al. Falls and their prevention. *Clin Geriatr Med* 2010;26(4)645–92

This gives a detailed overview of the evidence for falls prevention and its implications for clinical practice, especially the differences between successful and unsuccessful initiatives. It is most useful for reference, especially for clinical staff with a special interest in falls, including falls nurse specialists and geriatricians.

Also available online at [www.geriatric.theclinics.com/article/S0749-0690\(10\)00053-4/abstract](http://www.geriatric.theclinics.com/article/S0749-0690(10)00053-4/abstract)

5. 'Further resources':

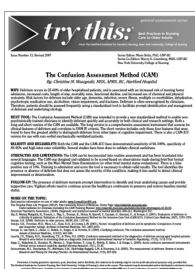
Included in the 'Further resources' section of this pack as single inserts are:



a. National Patient Safety Agency. *Essential care after an inpatient fall. Rapid response report.* London: NPSA, 2011.

Useful reference for hospital-wide leaders of falls prevention, with links to additional resources, including neurological observation charts.

Additional copies can be downloaded from www.nrls.npsa.nhs.uk/alerts or www.rcplondon.ac.uk/projects/fallsafe



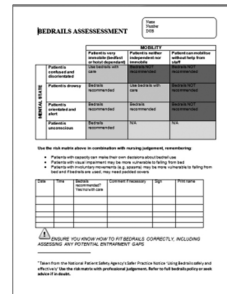
b. Confusion assessment method

This provides a short summary of delirium and why the confusion assessment method is important and is intended for frontline nurses and doctors.

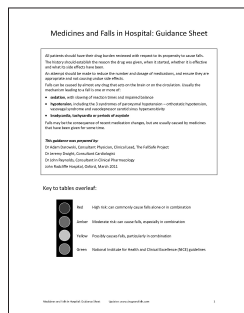
Additional copies can be downloaded from [http://consultgerirn.org/uploads/File/Confusion%20Assessment%20Method%20\(CAM\).pdf](http://consultgerirn.org/uploads/File/Confusion%20Assessment%20Method%20(CAM).pdf)

c. Resources for preventing falls from bed

Useful reference documents for hospital-wide leaders of falls prevention, for dissemination to wards and departments for frontline nurses to refer to. They are all accessible via www.nrls.npsa.nhs.uk/alerts or www.rcplondon.ac.uk/projects/fallsafe



- i. NPSA Safer practice notice, 'Using bedrails safely and effectively'
- ii. MHRA poster, 'Safe use of bedrails'
- iii. NPSA bedrails assessment template
- iv. NPSA SIGNAL, 'The safe use of ultralow beds'



d. Darowski A, Dwight J, Reynolds J. Medicines and falls in hospital. Oxford: John Radcliffe Hospital, 2011.

A traffic light guide to the evidence regarding medication and falls to assist medication review in hospital.

This Guidance is Endorsed by the British Geriatrics Society (BGS).

Updates: www.drugsandfalls.com

FallSafe partners

Lead organisation

Royal College of Physicians London (RCP)

Partner organisations

South Central Strategic Health Authority, now South of England NHS
 National Patient Safety Agency (NPSA)
 Royal College of Nursing (RCN)
 Action against Medical Accidents (AvMA)
 British Geriatrics Society (BGS)

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The Health Foundation, Closing the Gap through Clinical Communities Programme

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For analysis of the data

Derek Lowe MSc CStat medical statistician working with the Clinical Effectiveness and Evaluation Unit, RCP

Thank you to all the staff in the South Central SHA whose support helped towards the success of the FallSafe project.

Don't just 'do something' to prevent falls... ...do something that works!

FallSafe was a quality improvement project that helped frontline staff to deliver evidence-based falls prevention. This approach can increase patient safety and satisfaction and build staff confidence.

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**Royal College
of Physicians**