

## 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?**

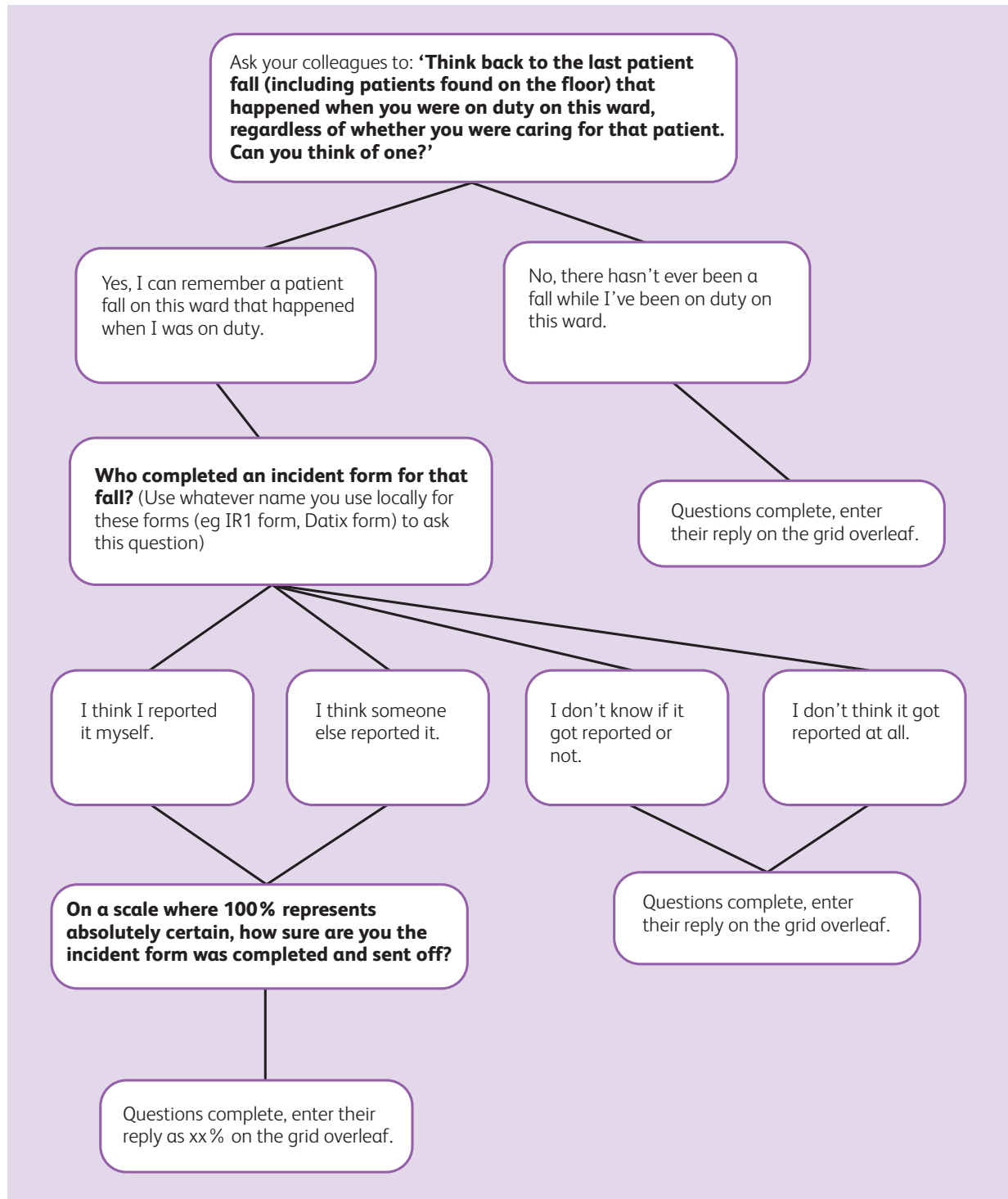
Just verbally asking the questions on the flowchart questionnaire on page 25 should be the quickest method for collecting the information, taking no more than a minute. You can then enter respondents' answers in the grid on page 26.

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](http://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 ( <b>confident reported</b> )	41/82 (50%)	53/78 (68%)			
Total who were 50–98% certain that they or a colleague had reported the last fall ( <b>possibly reported</b> )	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 ( <b>unlikely to have been reported</b> )	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%.