How to get falls e-learning fixed into your organisational training strategy: advice for falls leads.

Encouraging staff to access falls training via elearning means that you can reach large numbers of staff for basic training freeing up valuable face - to - face time for more specialist/ bespoke falls teaching. FallSafe: Preventing falls in hospital (aimed mainly at nursing staff) and CareFall (aimed mainly at medical staff) are available via the Health Education England E-learning for Healthcare (elfh) platform https://www.e-lfh.org.uk/programmes/preventing-falls-in-hospital-fallsafe-carefall/

Anyone can do these free courses if they have an elfh account. Organisations/Trusts may have an elfh account which can be linked to the Electronic Staff Record (ESR) system. If you would like to register and enrol large numbers of staff within your organisation for access onto the Preventing Falls in Hospital: Fallsafe/Carefall programme, please contact elfh directly. If you are not an NHS organisation, access may be possible via the Open Athens portal.

Whatever platform you are using, leaving it up to staff to find it and put it in their own learning record means that busy clinicians struggle to do this however keen they are even if your organisation makes it a requirement to do the training. It's better to 'fix' the training into your Trust education strategy via ESR so it's easy to access and staff are automatically reminded when it is due. Training compliance will also be easier to monitor as all staff by profession can be linked to the correct platform.

Follow these steps to 'fix' falls training into your organisation.

1. Most organisations will want to know how up-to- date staff are with their training which can help with understanding why some areas or staff groups may perform better than others. This may be relevant if an area starts to have more falls than usual, and enquiry may reveal staff out of date or not done their falls prevention training. Knowing the numbers of staff offered and then undertaking training can be very useful also for internal and external auditing (e.g. National Audit of Inpatient Falls). Your Trust Learning & Development / ESR Learning Support Lead should be able to provide reports of staff training status by ward/ dept etc.

   The way forward is to get the training included as part of your organisational learning strategy; let's say for example, induction, essential skills updates, or mandatory training programmes. Formalising the training in the strategy would include building it into the Trust business continuity plan which would consider potential impact if training not accessible for some reason (cyber security concern, escalation of reduced staffing, pandemic response etc).

2. Fixing the courses into your organisation requires a basic understanding of how training & development works in your hospital. Each Trust will have a training & development/ educational lead and you may even have an e-learning lead especially if a big Trust. The lead

for education may not necessarily be responsible for medical, nursing and AHP staff so be sure to check and make sure you speak to all relevant people as they will be the key to making this happen.

3. Mandatory training schedules will be locally agreed by your Trust and will differ depending on the specialty, professional group and possibly grade of staff. Falls training is not considered to be statuary training (i.e. required by statute or law) but most trusts would offer falls training as part of mandatory training for many groups of staff including a health & safety slips, trips, falls version for non-clinical staff. Such schedules are typically made up of a mixture of eLearning and face to face training. Find out or 'map' who does what, where and when then identify where your falls e-learning needs to go.

4. Once you have mapped out who does what it's possible to have the falls courses linked to the electronic competency/ training matrix for any group of staff. For example, you may want all the registered nurses in elderly care to do the course within 6 months of joining the organisation with a repeat at 3 years, but it wouldn't be relevant for midwifery or paediatric staff. Special considerations may also be needed for staff who redeploy in times of escalation or surge for example from theatre to wards.

5. You will also need to think how you get existing staff to do the course and if your organisation has a mandatory clinical skills or patient safety update this may be the route in. Your learning and development lead will be able to help you work this out as most likely it will need to be negotiated by specialty and by staff group.

6. You may think it relevant for all medical staff to have the CareFall course in their induction therefore it only needs to be done once. You may also wish that all FY1 and 2 junior doctors do the training in their induction, remember these are likely not permanent staff so may need to be treated differently in terms of induction training to other new joiners who are. Then there's the rest the existing medical staff to think about… talk to your medical education lead and medical falls lead to get a plan together.

7. You may have other groups of clinical staff such as allied health professional or military personnel who access different learning systems or platforms who will also need to be thought about, so talking to their educational and falls lead will be important too.

8. Either way, you need to talk to your learning and development leads to get a plan! It will take a bit of energy to get it all set up, but it needs only to be done once. Then you can focus on 'demand led' bespoke falls training tailored to special staff groups or topics rather than allocating a lot of time to basic training.

This guidance prepared by Julie Windsor, Patient Safety Clinical Lead Older People and Medical Specialties. NHS England & Improvement. December 2014, revised March 2022 with support and contributions from South Tyneside and Sunderland NHSFT, East Kent Hospitals University NHSFT, St Georges University Hospitals NHSFT.