1.0 BACKGROUND
Falls and Fall related injuries are a common and serious problem for older people (NICE CG 161, 2013). Hampshire Hospitals NHS Foundation Trust (HHFT) recognised in 2013 that rates of patient falls were higher than the national average. The National Patient Safety Agency (NPSA, 2010) suggested an average rate of inpatient falls of 5.6 per 1,000 bed days (BD).

2.0 IMPROVEMENT AIM
At HHFT we will reduce falls causing harm by 30% by December 2016

3.0 MEASURES
Outcome Measures
- Rate of falls per 1000 beds
- Rate of harm from falls per 1000 beds

Process Measures
- Staff trained
- Risk assessment and care planning compliance

Balancing measure
- Incident reporting rates

4.0 METHODOLOGY
- MDT work group developed
- Data gathering and analysis
- Fishbone analysis to understand the problem
- Driver diagrams to generate change ideas
- PDSA cycles to implement changes
- Audit of documentation and care

4.1 Fishbone analysis: suggesting multiple areas of falls prevention improvement needed

4.2 DRIVER DIAGRAM
Using learning from the Fallsafe project to develop change ideas

5.0 CHANGE IDEAS ACTIONED
- Falls Co-ordinator appointed July 2013
- Training programme in place Aug 2013
- (example PDSA cycles below)

6.0 RESULTS
From PDSA cycles improvements in training rates and risk assessment compliance.

6.1 Reduced rate of falls
Overall improvements achieved in standards of assessment, documentation and provision of care leading to reductions in rates of falls by 19% (to 6.34) against year 1, and continuing

6.2 Reduced harm
Significant 75% reduction (to 0.14) in falls with harm against year 1, and continuing

7.0 SUMMARY
It is possible to reduce falls with harm in an acute in-patient organisation by implementing multifactorial interventions and promoting engagement at all levels in a structured and sustainable way.

7.1 Lessons Learned
Implementation of a falls reduction strategy requires:
- A systematic approach
- Engagement at all levels
- Joint working with other groups within the organisation
- A continuous cycle of monitoring and learning
- Effective methods of sharing progress with staff

7.2 On-going developments
- Embedding post falls hot debriefs for all in-patient falls in high risk ward areas
- Investigating possible approaches to manage patients who fall frequently both as an in-patient or on discharge
- Provision of appropriate discharge information to patients and their carers and health and social care organisations in the community