NHS South of England

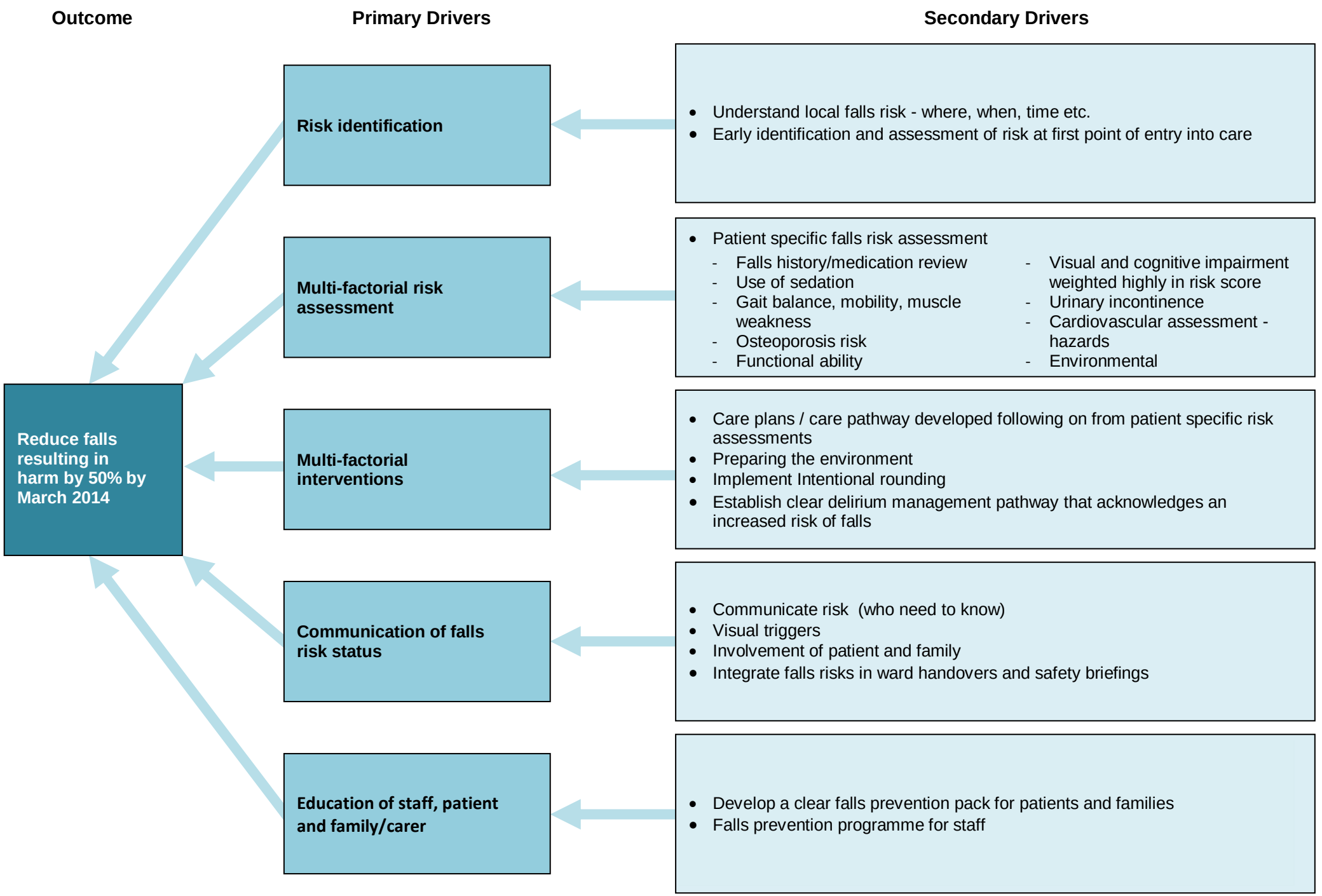
South of England Improving Safety in Mental Health Collaborative

Falls Prevention

Driver Diagram and Change Package

A driver diagram is used to conceptualize an issue and to determine its system components which will then create a pathway to achieve the goal. Primary drivers are system components which will contribute to moving the primary outcome. Secondary drivers are elements of the associated primary driver. They contain change concepts that can be used to create projects that will affect the primary driver.

Adapted from Annette Bartley Consulting Limited, North Bristol NHS Trust, Royal Devon and Exeter Foundation NHS Trust and the South West Quality and Patient Safety Improvement Programme


Outcome
Primary Drivers
Secondary Drivers
Reduce falls resulting in harm by 50% by March 2014
Risk identification
Understand local falls risk - where, when, time etc.
Early identification and assessment of risk at first point of entry into care
Multi-factorial risk assessment
Patient specific falls risk assessment
Falls history/medication review
Use of sedation
Gait balance, mobility, muscle weakness
Osteoporosis risk
Functional ability
Visual and cognitive impairment weighted highly in risk score
Urinary incontinence
Cardiovascular assessment - hazards
Environmental
Multi-factorial interventions
Care plans / care pathway developed following on from patient specific risk assessments
Preparing the environment
Implement Intentional rounding
Establish clear delirium management pathway that acknowledges an increased risk of falls
Communication of falls risk status
Communicate risk (who need to know)
Visual triggers
Involvement of patient and family
Integrate falls risks in ward handovers and safety briefings
Education of staff, patient and family/carer
Develop a clear falls prevention pack for patients and families
Falls prevention programme for staff

Secondary Drivers	Key change concepts and change ideas for PDSA testing
• Understand local falls risk	• Analyse falls by time of day, patient's age range, type of patients, condition, locations, severity / harm • Early identification and assessment of risk at first point of entry into care • Develop falls pathway
• Patient specific falls risk assessment	• Risk assessment documentation, specify review dates • Develop clarity about frequency and type of observations and actions to be recorded post fall
• Care plans developed from patient specific risk assessments	• Multidisciplinary input into care plans, review frequency • Medical review • Medication review / patient compliance / withdrawal / night sedation usage • Vision assessment • Review provision and assessment of safe footwear for patients • Distraction/diversion boxes to support confusion • Functional assessment • Promote use of mobility / standing aids • Cohort high risk patients where appropriate in hospital / care home settings
• Preparing the environment	• Changes of lighting levels at night • Non placement of commodes at bedside overnight • Trip hazards, flooring, space / clutter • Review availability of bed mounted drip stands to reduce trip hazards • Availability of call bells / pendent alarms • Use of high/low beds / crash mats • Use of telecare • Reduce inappropriate use of bedrails • Patient signage e.g. to toilets, poster campaign to encourage patients to call for help to return from the toilet, visibility of toilet seats (contrast colour) • Availability of chairs for resting
• Intentional rounding	• Consider frequency • Modify checklist to appropriate situation • Educate carer's in own environment • Consider telephone checks • Implement hourly intentional rounding for high risk patients in inpatient settings • Use of specialling
• Communicate risk (who needs to know)	• Use of visual cues at bedside, handovers & safety briefings • Use of labels in clinical notes to alert doctors/pharmacists about falls risk to prompt medication review • Develop communication flows into community and primary care about falls risk on discharge or transition points
• Involvement of patient and family	• Communication between care team and patient and family uses language that the patient/family can understand • Patient and family participate in care at the level the patient chooses and understands risk • When care goes wrong, there is a policy of transparency which supports open communication and apology to the patient/family

Secondary Drivers	Key change concepts and change ideas for PDSA testing
• Integrate falls risks in ward handovers and safety briefings	• Institute safety briefings and focus on patients with increased risk of injury • Standardise clinical communication and handovers using standard handover template SBAR format (situation, background, assessment, recommendation)
• Develop a clear falls prevention pack for patients and families	• Develop posters for high risk areas • Develop patient & carer information leaflets
• Falls prevention programme for staff	• Develop training facility / resource / programme for use with high risk areas • Deliver falls prevention training to all clinical staff at induction • Develop link nurses / champions in each clinical area to ensure interventions and documentation in place • Run charts / safety crosses for each clinical area so staff can monitor falls reduction • Run charts to monitor progress, including regular cycle of observational and documentation audit for ongoing assurance of reliability of risk assessment process and any planned interventions.