Falls in Care Homes Multiprofessional Fellowship Commission

Evaluation , Findings and Recommendations Report

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1 Project Overview

1.1 Background and Context

1.1.1 Each year around one third of people aged over 65 experience one or more falls, rising to 50% in those over 80. People living in care homes are three times more likely to experience a fall than people living in the community (British Geriatrics Society, 2020). A fall can result in suffering, disability, loss of independence and decline in quality of life, even when there is no injury. The prevention and management of falls and associated injuries is a policy driven priority for the NHS, Social Care and Voluntary sector, with data evidencing that falls is the greatest reason that East Midlands Ambulance Service (EMAS) get called out to care homes.

1.1.2 Across Nottinghamshire, there are 355 care homes: 91 nursing homes and 264 residential homes (homes without qualified nursing staff.) There are 198 'Ageing Well' care homes and 157 Learning Disability homes.

1.1.3 Residents in care homes are some of the frailest and most frequent users of healthcare systems.

1.1.4 Between May 2022 and April 2023 there were an average of 180 calls to East Midlands Ambulance Service (EMAS) per month from care homes whereby a fall had occurred, making falls in care homes the chief complaint.

1.1.5 Between May 2022 and March 2023 there were 511 falls related admissions from care homes in Nottingham and Nottinghamshire.

1.1.6 Additionally, it is recognised that these figures represent a small proportion of the actual falls that occur , with care homes managing many falls "in house"

1.1.7 When the data was scrutinised further it was evident that the majority of falls related calls came from a small number of homes.

1.1.8 The Enhanced Health in Care Homes Framework version 3 recognises that best practice for the prevention of falls in care homes is through the promotion of physical activity, strength, and balance.

1.1.9 To meet the arising and ongoing need recognised, Nottingham and Nottinghamshire ICB commissioned a Falls in Care Homes Fellowship Role. This role was commissioned for a 12-month period and had both operational objectives-to support those homes identified as the greatest in need, as well as strategic objectives- to support the system's overall approach and management to falls. It was envisaged that both these approaches would leave a lasting legacy of resources and learning to support future falls management service planning , whilst providing insight into the lived experiences and challenges of the Nottingham and Nottinghamshire care home sector workforce when working to prevent and manage falls in care homes.

1.1.10 Objectives for this role included:

- To provide specialist clinical advice, training, and expertise to care home providers and other key services.
- Confirm and develop intelligence surrounding the needs of falls prevention and management in care homes across Nottingham and Nottinghamshire.

- Review and analyse falls data, data collection and highlight areas of concern and good practice.
- Provide recommendations as to future service improvement outcomes and opportunities.
- Influence immediate quality improvement in the care homes where targeted work is undertaken.
- Develop trusted relationships with a small group of pre-selected care homes to better understand the lived experiences an challenges of falls prevention and management for the care home sector workforce.

1.2 Model for Delivery

1.2.1 The fellowship role was hosted by Nottinghamshire Healthcare NHS Trust with clinical supervision provided from the trusts consultant physiotherapist and falls lead.

1.2.2 Enhanced falls specialist support was offered to preselected care homes based upon quantitative data captured via the Systems Analytics and Intelligence Unit (SAIU) which included non-elective falls related admissions, self-reported falls frequencies and EMAS utilisation figures. This enhanced offer enabled the building of trusted relationships within the care sector and provided rich insight into the lived experiences and challenges of the workforce.

1.2.3 Strategic falls prevention and management support and the implementation of quality improvement projects was offered to the care home sector and system colleagues via monthly falls in care homes project workshops.

1.2.4 Both of these support offers enabled the role to confirm and develop intelligence surrounding the needs of falls prevention and management in care homes in Nottinghamshire through the collection of qualitative data to highlight areas of concern and good practice.

1.2.5 Regular feedback of findings was offered to the Integrated Care Board , Nottinghamshire Healthcare NHS Foundation Trust, and place-based partnerships across the Integrated Care System.

1.2.6 The fellowship findings have been offered to the ICB via this Evaluation , Findings and Recommendations Report produced to close the falls fellowship year.

1.2.7 Findings of the fellowship have enabled the production of the ICS Falls in Care Homes Best Practice Guidelines along with a number of legacy resources including:

- The Post Falls Guidelines for Care Homes with supporting documentation
- The Walking Safely and Staying Steady educational poster
- A suite of training resources including the intrinsic relationships between falls and dementia, nutrition, hydration , frailty, and falls.
- Further training resources developed include falls hotspot mapping and falls huddle training.
- Delivery of a Falls Awareness week promotional campaign that included 95 care home staff members across 38 care homes receiving online training, 32

shares of training content, 120 falls prevention pledges and 12 in person falls awareness events across the system.

1.3 Scope

1.3.1 Ten homes across the ICS were offered the enhanced falls support. The number of homes offered support was based upon time constraints of the fellowship but also enabled homes to be selected upon various intersections of data intelligence. Three homes were selected based upon the highest EMAS utilisation with a further three selected based upon their falls related non elective admissions . Two other homes were offered support due to these homes having the highest self-reported falls. Two homes were selected for the offer where it was suspected good practice was taking place- creating an opportunity to share good practice more widely.

1.3.3 Three homes declined the enhanced support offer. This was for various reasons which included a recent change in management , a recent investment by a home into a privately funded falls training package and a home that had moved into special measures and did not feel that they had capacity to ask staff to work through any additional changes in practice. The later home received support from the ICB quality assurance team.

1.3.4 The enhanced support offer included regular support visits to the homes by a clinical falls specialist who offered:

- Bespoke evidence-based training to staff
- Resident reviews with subsequent feedback and learning
- Implementation of nationally recognised Action Falls Training
- Ongoing support to homes to embed the Action Falls Approach
- Informal learning and one to one support through relationship building and visible leadership.
- Falls huddles inspired by the Patient Safety Incidence and Response Framework (PSIRF)- including structured open questions using the PSIRF ethos of compassionate leadership and systems learning.
- Advice and education to care home managers and leaders.

1.3.5 Qualitative data was captured during falls huddles, a care home survey , one to one conversations and during formal and informal training sessions offered to the ten homes receiving the enhanced support offer using a method of inductive thematic analysis.

1.3.6 All homes within the integrated care system were invited to be part of The Falls in Care Homes Project Workshops and subsequent quality improvement projects.

1.3.7 All system colleagues working within and with homes, whose role in some way involved falls prevention and management were invited to attend the falls in care homes project workshops.

1.3.8 Qualitative data was captured from falls in care homes through the transcription of online open forums and the use of inductive thematic analysis.

1.3.9 All homes were invited to be part of subsequent quality improvement projects and have been encouraged to embed finalised quality improvement work within their homes.

1.3.10 Targeted Quality improvement projects were devised based upon feedback during falls in care homes project workshops and members were supported to define gaps in current falls prevention interventions and implement quality improvement projects as a system wide collective.

1.4 Operational Assumptions

1.4.1 Care homes involved in the enhanced support offer will utilise knowledge, advice and education provided and embed this into daily practice thus improving falls prevention and management offer to residents in their care. This will include the use of a train the trainer model and also through receiving enhanced regular support from the falls in care homes multi-professional fellow.

1.4.2 The offer of resident reviews by a falls specialist as part of the enhanced falls support offer will create opportunities for learning, ensure robust risk assessments and action plans are in place and residents' risk of falls is mitigated as much as is possible . This will be realised using a train the trainer model , the creation of regular formal and informal learning opportunities and knowledge imparted on new staff during the induction process.

1.4.3 Care home staff that have received Action Falls Training will implement this method of evidence-based falls risk assessment and action taking across the home thus implementing robust falls risk assessments, mitigating risks where possible, enabling evidence-based interventions and supporting residents to utilise the multidisciplinary team proactively.

1.4.4 Regular visits to homes receiving enhanced support will support in the embedding of the action falls process and philosophy.

1.4.5 The offer of informal training and support through relationship building and visible leadership will support care home staff to receive manageable and meaningful bitesize training, which in turn will support a culture shift in the way falls are prevented and managed in care homes.

1.4.6 The facilitation of PSIRF inspired falls huddles will help to build confidence and empower staff through a compassionate, no blame approach to falls incidents- creating a shared ownership of falls incidents and facilitating a new approach to learning that feels inclusive and supportive. See appendix 4

1.5 Strategic Assumptions

1.5.1 Acting as an advisory to care home managers and leaders through system leadership workshops will enable strategic improvement of falls prevention and management across the sector by developing care home leaders who are aware of :

- Evidence-based falls prevention interventions
- How to appropriately respond and learn from falls incidents
- How to create a culture shift in how falls are prevented and managed.

1.5.2 Quality improvement projects realised through falls in care homes workshops will be implemented by care homes.

1.5.3 Care home staff who have received training will utilise knowledge gained to prevent and manage falls in the care homes by which they work, support other staff members to learn from their example and create a ripple of learning.

1.5.4 The delivery of a system wide falls awareness campaign by workshop members will help to reduce falls in care homes through raising awareness of falls risks; and supporting staff to better understand how to mitigate identified risks.

1.5.5 Encouraging staff to complete falls prevention pledges will support a *falls is everyone's business* ethos empowering staff to know that their personal contribution, regardless of role will make a difference.

1.5.6 Quality improvement resources developed by Falls in Care Homes Workshops will support care homes across the system to better prevent and manage falls.

1.6 Operational Interdependencies

1.6.1 The delivery of the enhanced falls support was dependent on workforce engagement facilitated through the development of strong trusted relationships with the Falls in Care Homes Fellow; and care homes having an appetite for quality improvement with a willingness to create space for learning and development.

1.7 Strategic Interdependencies

1.7.1 Engagement in Care Home Project Workshops was dependent on organisations supporting staff to attend and get involved in the delivery of quality improvement projects.

1.7.2 The utilisation of quality improvement work was dependent on the care homes appetite for improvement. ICS quality assurance teams and care home multidisciplinary teams also needed to be aware of the quality improvement projects and being willing to promote the embedding of these within homes by which they interface.

1.8 Key Issues and Risks Identified

Risk/ Issue	Mitigations
Risk of training not being embedded within care homes involved in the enhanced support offer due to high staff turnover.	Regular visits and visible leadership from fellow to embed and create sustainability over time, offering ongoing training and support to new staff members
Risk of lack of engagement due to a nervousness of struggling homes to be open about falls incidents and skills and training gaps.	The building of trusted relationships with homes over time, through gentle, curious enquiry, affiliative, collaborative, and compassionate leadership
Poor attendance to project workshops due to time limitations and organisations not giving staff protected time to attend.	System wide promotion of project workshops to the care home sector and system stakeholders ensuring benefits of attendance are mutually beneficial.
Care Home sector and wider stakeholders do not support implementation of quality improvement work.	Supporting workshop members to devise and own quality improvement work to support engagement and dissemination.
Sampling bias of Qualitative data capture by fellow.	Employ objective method of inductive thematic analysis and include peer debriefing of themes and codes

2. Project Delivery

2..1 The aim of the enhanced support offer was for 10 homes to receive specialist, evidence-based falls prevention and management support for 12 months. Due to the time required to fairly select homes, engage and confirm their commitment to the offer , work with the homes did not start until February 2024. Due to a lack of initial engagement from two homes, two alternative homes were selected and offered enhanced support for six months. This led to 8 homes receiving 11 months of enhanced support and two homes receiving six months of support.

2.2 The aim for the Falls in Care Homes Project Workshops was to deliver system wide falls support through quality improvement projects to the care home sector and supporting services over a 12-month period. Workshops began in February following a period of planning, promotion, and engagement with 11 months of strategic support and intervention offered.

2.3 Monthly highlight reports and update meetings were provided for the full 12 months of the fellowship.

2.4 Homes who declined the offer of enhanced support, or disengaged with the offer after a period of time gave various reasons for this. These included a change in care home management structure, homes going into special measures and homes who had recently invested in external falls prevention and management training.

3. Impact

3.1 Impact Summary

Evaluation method	Parameters	Impact Summary
Qualitative data	Inductive thematic analysis of data derived from project workshops, care home only open forums, care home surveys and PSIRF inspired falls huddles.	Qualitative data collected provided insight and context of current quantitative data and real-life experiences of preventing and managing falls for the care home sector workforce. This led to the production of this findings report submitted to the ICB , and the development of the Falls in Care Homes Best Practice Guidelines for Nottingham and Nottinghamshire. Key pieces of Falls QI work have also been produced, disseminated, and embedded across the ICS care home sector.
Quantitative data collection	Taken from the ICB SAIU portal and using three intersections of data including : Self-reported falls rates EMAS see and treat figures Non elective admissions	Quantitative data was able to detect positive and significant impacts on EMAS see and treat and figures , treat and covey figures and secondary care non-elective admissions .
Enhanced falls support offer	Engagement and support offer journal Transcriptions of informal one to one and group conversations Care home surveys	Findings report submission to ICB Development of the Falls in Care Homes Best Practice Guidelines for Nottingham and Nottinghamshire.

3.2 Qualitative Data Collection

3.2.1 Qualitative data was obtained via a process of inductive thematic analysis using transcripts of system wide project workshops, care home only open forums, PSIRF informed falls huddles, care home surveys and during informal conversations and training opportunities.

3.2.2 Data collected has enabled key findings of lived experiences, challenges, good practice, and insight within the area of falls prevention and management in care homes.

3.2.3 This has enabled the production of this findings report and The Falls in care Homes Best Practice Guidelines for Nottingham and Nottinghamshire.

3.2.4 The Falls in Care Homes Best Practice Guidelines are designed to offer support and guidance to the care home sector and staff supporting care homes in how best to prevent and manage falls in Care Homes. A copy of these can be found via Care Sector Health Resources – useful information for Care Staff- NHS Nottingham and Nottinghamshire ICB

3.3 Quantitative Data Collection

3.3.1 Quantitative data was obtained from the ICB Systems Analytics and Intelligence Unit (SAIU) from the five homes who demonstrated consistent engagement with the enhanced falls support offer.
3.3.2 Three intersections of data were scrutinised including EMAS see and treat figures , EMAS see and convey figures , secondary care (falls related) non-elective admissions and care home self-reported falls rates.

3.4 Enhanced Operational Falls Support Offer

3.4.1 The enhanced falls support offer was successfully delivered to 10 homes (with a change in two homes during the 12-month period). This enabled qualitative data collection and subsequent write up of findings and best practice and the delivery of specialist, bespoke training, development, and quality improvement to a select number of homes experiencing the highest falls rates.

3.5 Strategic Falls Support and Intervention

3.5.1 System wide leadership was successfully offered to care homes and supporting services across the integrated care system. This enabled the development a supportive community of practice where quality gaps were identified and mitigated through quality improvement work and implementation.

4. Findings and Analysis

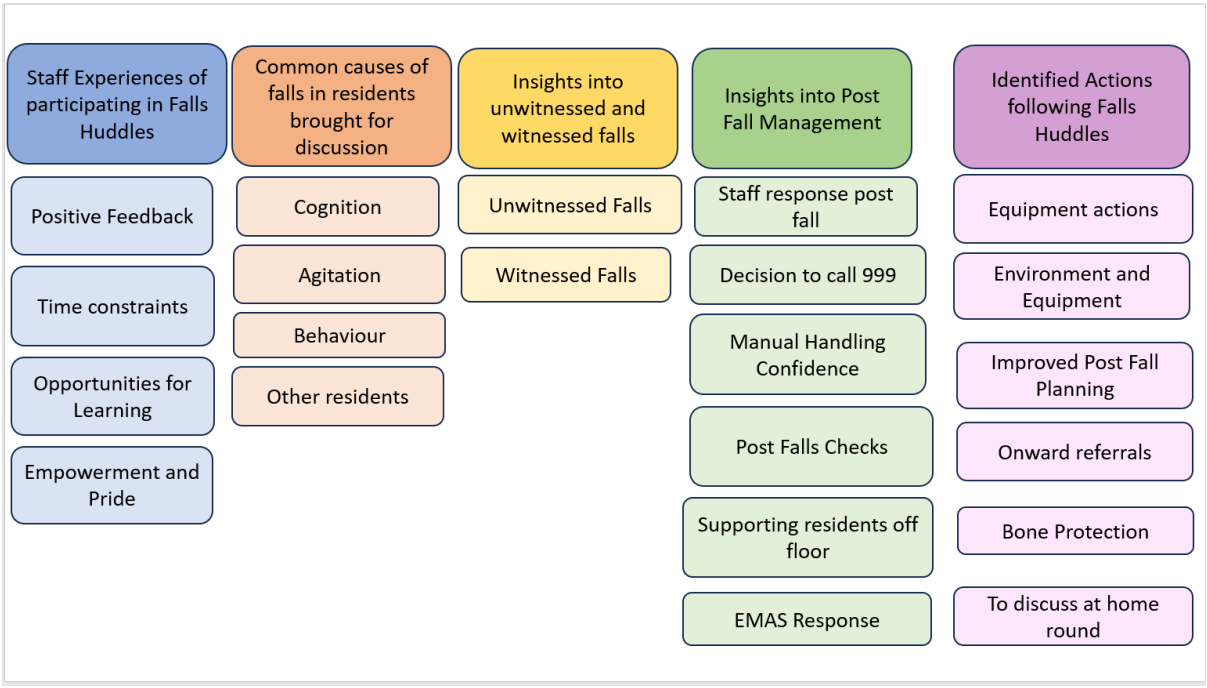
4.1 Qualitative Data collected from PSIRF inspired Falls Huddles

4.1.1 A Falls Huddle is a facilitated debrief following a falls related incident. These were inspired by the NHS Patient Safety Incident and Response Framework (PSIRF) and aligned to the principles of this. PSIRF inspired falls huddles were embedded within the enhanced support offer to 10 care homes.
4.1.2 Falls huddles created an opportunity to capture themes and trends associated with challenges and lived experiences of the care home workforce working to prevent and manage falls in care homes.
4.1.3 Each falls huddle involved a series of open questions put to staff members and included:

- What happened leading up to the fall?
- What did we do well?
- What have we learnt from this fall?
- What are our actions going forwards?

4.1.4 Coding of all direct anonymised quotes offered during falls huddles was created to establish overall themes. The coding can be viewed in appendix 1. Identified themes and codes can be viewed at point 4.1.5.

4.1.5 Falls Huddles Identified Themes and Codes



4.1.6 Falls huddles were positively received by care home staff and were recognised as key opportunities for learning following falls incidents. Staff reported feelings of empowerment and pride following the falls huddle process. Time constraints were identified by staff as a potential barrier to implementation.

4.1.7 Falls huddles were able to show that the type of falls that staff needed support with most involved falls relating to reduced cognition, agitation, and behaviour.

4.1.8 Falls Huddles were able to provide insights and opportunities for learning from both witnessed and unwitnessed falls incidents.

4.1.9 Topics raised for discussion at falls huddles included staffs post fall actions, decisions to call 999, confidence issues relating to manual handling, post falls checks, supporting residents from the floor and EMAS responses.

4.1.10 Numerous actions relating to equipment checks , environmental adaptations , post fall plans and risk mitigation , onward referrals, queries relating to bone protection and planning for proactive home round discussions were derived from the falls huddle process.

4.1.11 Findings from falls huddles suggest :

- Care homes require further support in the areas of managing cognitively impaired residents who may also be showing signs of agitation and / or issues relating to behaviour- which are in turn causing falls.
- Residents displaying cognitive and behavioural issues predispose other residents to falls.

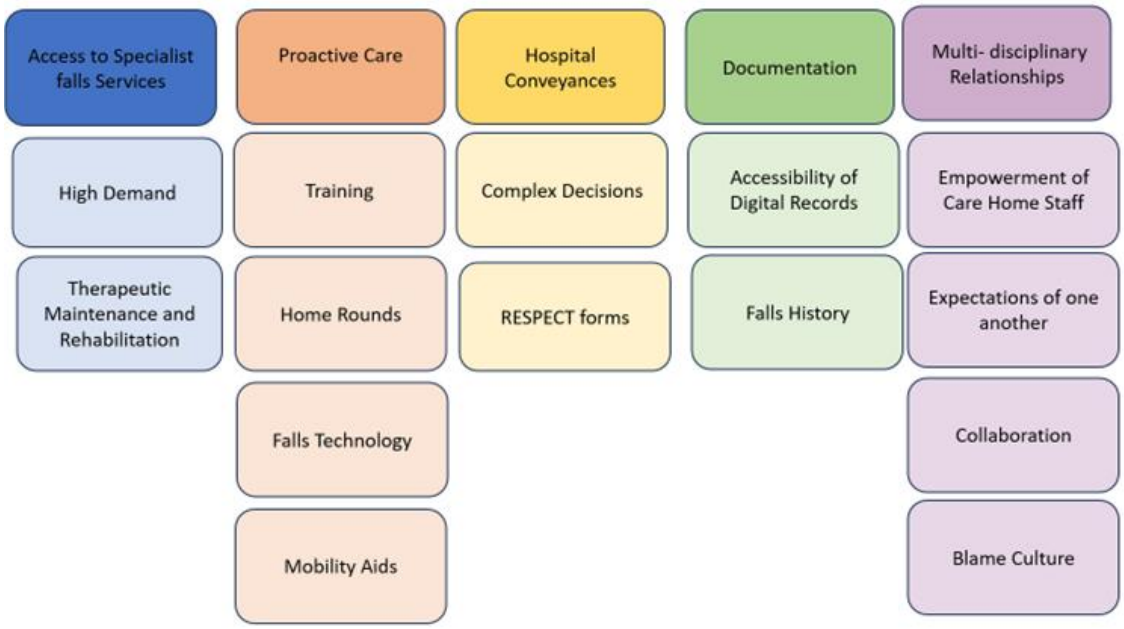
- Discussing both witnessed and unwitnessed falls can provide insights and opportunities for learning.
- Falls huddles were particularly useful in facilitating opportunities for learning in post fall management.
- Areas for further investment and support should focus on supporting homes to respond with confidence in decision making involving when to seek external and appropriate support, post falls checks and supporting residents up from the floor.
- Discussions about EMAS responses suggested an appropriate clinical response but at times highlighted incidences where care home staff felt unsupported and blamed.

4.2 Qualitative Data Collected from Falls in Care Homes Workshops and Care Home Only Open Forums.

4.2.1 Online Falls in Care Home Workshops and Care Home Only Forums were delivered throughout the year and provided the foundation to the system wide falls intervention offer provided.

4.2.2 Participants were asked to talk freely about their experiences, challenges and areas of good practice when working to prevent and manage falls in care homes. Feedback was organised into codes and themes and can be viewed at 4.2.3.

4.2.3 Themes and Codes derived from System Wide Falls in Care Home Workshops and Care Home Only Open Forums



4.2.4 Areas of concern for workshop members included difficulty accessing specialist falls support services due to high demand and the recognition that there is a significant need for therapeutic maintenance and rehabilitation for residents following falls.

4.2.5 Members indicated that further investment and support is required to offer:

- Subject specific training as well as generalised falls prevention training

- Further support to homes to ensure proactive use of home rounds in relation to residents who are at risk of and experiencing falls
- Proactive use of falls prevention technology
- Specific training on the correct use, fitting of and safety checking of mobility aids.

4.2.6 There was system wide recognition that the decision to convey a resident to hospital is often very complex and this limits confidence of care home staff to lead on this decision making- process despite them often being best placed to advocate at times when the resident may not be able to do this for themselves.
4.2.7 RESPECT forms can support this complex decision-making process for residents who have this in place. RESPECT forms should directly stipulate the residents wishes around conveyance to hospital should they have an injurious fall, including a head injury or fracture.
4.2.8 There are currently issues relating to the accessibility of digital records by multi-disciplinary team members supporting homes to prevent and manage falls. This includes inability to access laptops and tablet devices and falls history often not being housed in one specific part of the care plan – causing difficulty in the identification of falls themes and patterns.
4.2.9 Successful multi-disciplinary relationships are paramount to the prevention and management of falls in care homes and where these are found improved falls prevention strategies are in place.
4.2.10 Multidisciplinary teams should place specific consideration on how to build relationships with care home staff (as well as care home managers) which enable staff to feel empowered to lead on complex decision making about falls prevention and management.
4.2.11 There is significant evidence of a blame culture within care homes relating to falls prevention and management. This can be amplified by the approach taken by visiting healthcare professionals when enquiring and advising on falls related issues. In turn this has been shown to disempower care home staff from using their own clinical knowledge and reasoning to prevent and manage future falls.
4.2.12 There needs to be further focus and emphasis on the importance of cross organisation collaboration relating to falls prevention and management with homes feeling empowered to be equal partners in decision making processes.
4.2.13 Further clarity on one another's roles and responsibilities around falls prevention and management is required to ensure a cohesive robust falls prevention and management plan for residents.

4.3 Quantitative Data collected from the Systems Analytics and Intelligence Unit

4.3.1 Data collected was able to demonstrate a 22 % reduction in EMAS see and treat figures in homes receiving the enhanced falls support offer compared to a 17% increase for the rest of the care home sector in Nottingham and Nottinghamshire, over the same period of time.
4.3.2 Data was able to show a 35% reduction in EMAS treat and convey figures in homes receiving the enhanced falls support offer compared to a 13% increase for the rest of the care home sector in Nottingham and Nottinghamshire, over the same period of time.

4.3.3 Non elective falls related admissions were shown to be significantly reduced in homes who remained consistently engaged in the enhanced falls support when their individual falls rates were compared to the previous 12 months.
4.3.4 One home demonstrated no significant difference in falls related non elective admissions compared to the previous 12 months.
4.3.5 One home saw an increase in non-elective admissions. This is a home which has a floor of NHS funded assessment beds. The manager of this care home reports over 80% of hospital admissions are falls related and involving residents staying in NHS funded beds, commonly known as pathway 2 beds. The majority of these falls are said to occur within the first 24 hours after admission to the home.
4.3.6 Data showed an overall reduction of 19% in non-elective admissions in residents who have a falls history compared to a 7% increase in residents with a falls history living in all other Nottingham and Nottinghamshire Care Homes over the same period of time.
4.3.7 All homes with the exception of one did not consistently complete self-return forms which include monthly falls rates . This meant this data was unable to be scrutinised.

4.4 Qualitative Data collected from Enhanced Care Homes Surveys

4.4.1 Surveys were sent to all homes that participated with the enhanced falls support offer.
4.4.2 Homes reported:

- To be pleased with the easy access for help and advice the enhanced support was able to offer.
- Falls rates to have reduced.
- They would like the enhanced falls support offer to continue
- having one person to go to regarding concerns around falls helped build confidence in staff to highlight concerns and training needs
- Building a rapport and trust with staff improved confidence in skills and abilities to prevent and manage falls.
- An improved understanding of falls prevention.
- Improved ability of care homes teams to work together on falls prevention strategies
- They will utilise the knowledge gained once the fellowship ends

5. Conclusion

5.1The importance of trusted relationships between the care home sector and the multidisciplinary team was fond to be the most significant theme generated within all of the qualitative data captured. This theme also featured heavily in anecdotal feedback via 1-1 conversations with professionals across the care home sector and wider system. Specifically clear expectations of system partners at every level across organisations was seen to have the most significant impact on overall falls prevention and management.

5.2 Lack of trusted relationships was shown to often lead to tensions between the care home sector and visiting professionals from both falls specialist services and EMAS in particular- which in turn leads to reduced confidence and disempowerment of care home staff to take proactive and appropriate actions to prevent falls.

5.3 Care home staff regularly report a blame culture around falls within their own organisation which is often exacerbated by the response and interactions involving visiting health professionals.

5.4 Much work is required to facilitate better relationships and understand the needs and expectations of care home staff and the wider multi-disciplinary team within the area of falls prevention and management.

5.5 Care homes engage well with a consistent enhanced falls support offer, and report improvement within the areas of

- Knowledge and understanding of falls prevention
- Awareness of training needs
- Proactive identification of falls risk and subsequent actions
- Awareness of areas requiring improvement to the current falls management approach
- Improved confidence of care home staff to seek and act upon advice

5.6 Care homes who consistently engage in an enhanced falls support-as set out in this report - see a significant reduction in EMAS see and treat utilisation **suggesting a significant improvement in non-appropriate EMAS utilisation.**

5.7 Care Homes who consistently engage in an enhanced falls support offer-as set out in this report- see a reduction in EMAS see and convey figures. The Enhanced Health in Care Homes Framework advises that 40% of admissions from care homes are said to be falls related and so this would **suggest a reduction in the impact of falls experienced by residents in these homes.**

5.8 The majority of care homes who consistently engage in an enhanced falls support offer- as set out in this report see a significant reduction in falls related non elective admissions and non-elective admissions of residents who have a previous falls history **suggesting reduced demand on secondary care and a reduced impact of falls experienced .**

5.9 Care homes in Nottingham and Nottinghamshire are typically poor at reporting their falls rates to the ICB despite this being a contractual requirement . In addition, significant variation in how cares homes define a fall has been observed throughout the fellowship work. **This brings into question the validity of current care home self-reported falls data held by the SAIU.**

5.10 Falls huddles were found to be positively received by care homes who described these as opportunities to learn following falls related incidents. Feedback related to falls huddles was resoundingly positive with care home staff commonly reporting feelings of pride and empowerment and clearer understanding of the actions required to prevent future falls. Previous research has shown that empowering staff and creating a sense of pride amongst staff groups increases quality of care and supports in the retention of staff[1] suggesting that falls huddles support in improved care quality and staff retention.

5.11 Training of care homes in the Falls Huddle Approach was successfully offered to 37 care homes across the ICS.

5.12 Falls huddles were able to provide significant insight into the types of falls care homes feel they most require support with. These were all related to cognition, behaviour and agitation with staff reporting these are the most challenging cohort of residents in terms of falls prevention and management.

5.13 Feedback from care homes did include some concerns around having the time to complete falls huddles following falls related incidents.

5.14 Falls huddles were proven to enable qualitative data capture providing improved insight and context relating to falls in care homes.

5.15 Using a series of structured open questioning by the falls huddle facilitator enabled the voice of care home staff to be heard and understood during findings analysis. This along with the PSIRF ethos of gentle and compassionate enquiry was positively received and enabled rich insight and learning.

5.16 Providing reassurance to care home staff that information collected would be anonymised reassured staff and enabled them to speak freely, offering rich and meaningful insights into the challenges, learning and quality improvement needs.

5.17 Falls Huddles were found to be appropriate for developing insight and learning opportunities for both witnessed and unwitnessed falls occurring within care homes.

5. 18 Care Homes chose to use the falls huddle opportunity to discuss:

- Complex decision making around when or when not to call 999,
- Challenges and concerns relating to manual handling- in particular supporting residents to get up off the floor
- Post falls checks and the general response by the care home following a fall

5.19 Falls huddles were shown to be a space for the identification and delegation of actions for a resident who has experienced a fall suggesting falls huddles created space for proactive steps to be devised in order to prevent future falls.

5.20 Falls huddles were shown to support care home staff in taking actions associated with mobility equipment, environment, post fall protocol and planning, onward referrals, bone health and planning for home rounds.

5.21 System wide Falls in Care Homes Project Workshops were found to successfully facilitate the identification of quality improvement needs across the care home sector and provide a platform for the development of and embedding of quality improvement work.

5.22 System colleagues who attended workshops felt reassured that their comments would be anonymised enabling them to talk freely about the challenges and needs.

5.23 Key areas for concern for workshop members included difficulty accessing specialist falls services due to high demand and recognised that there remains a very high need for these services for residents who require rehabilitation and support to maintain their balance, strength, function, and independence. Factors which all contribute to mitigating a person's falls risk.

5.24 Workshop members shared that residents are being screened by care homes teams prior to being referred to specialist falls services.

5.25 Qualitative findings suggest a need for subject specific falls prevention and management training to accompany generalised falls prevention and management training. In particular this should focus on the intrinsic relationships between dementia, frailty, hydration, nutrition, and falls.

5.26 Whilst there has previously been investment into improving the proactive nature of care home rounds, qualitative data from system workshops suggests homes require further support in planning for home rounds- with a particular focus on identifying residents at risk of falls in addition to residents who have already fallen.

5.27 Quality improvement themes relating to the proactive use of falls technology were also identified during system workshops.

5.28 Qualitative data from workshops identified specific training needs relating to the safe use of mobility equipment.

5.29 Care staff have highlighted concerns relating to long waits for therapy teams to assess for and then provide simple mobility aids such as walking frames and sticks causing significant falls risks in the process.

5.30 Workshop findings suggest that decisions relating to the calling for an ambulance and around conveying residents to hospital is an area of significant concern and reduced confidence for the care home sector.

5.31 It was widely acknowledged during workshop forums that RESPECT forms can support the decision-making process relating to the conveyances of residents following falls for those that have them. There was an identified need for RESPECT forms to stipulate specifically about a residents wishes following and injurious falls – including incidences involving head injuries or fractures. Based upon qualitative data capture this is not commonly seen within the RESPECT form documentation currently.

5.32 Accessibility of digital records and in particular digitalised falls history was a common theme raised by visiting professionals. This included limited access to laptops and digital devices whilst in the home, and the falls history of a resident being housed within different parts of the digital care plan. In turn this limits insight and support offered to the resident in terms of falls prevention and management interventions.

1. Woodward, A. and Rushton, A. 2023 Empowerment of care home staff through effective collaboration with healthcare 109-117(37) 1

6. Reflections on the role

6.1 The commission of the multiprofessional falls in care homes fellowship has been successful in meeting its defined objectives of

- Providing enhanced falls support to a small group of care homes,
- System wide falls specialist intervention to the care home sector
- Developing qualitative insight into challenges and experiences of the care home sector in relation to preventing and managing falls in care homes.

6.2 The role has required strategic system leadership from a clinician with a significant experience of falls prevention and management to coordinate and deliver implementation of enhanced falls support offers, system wide quality improvement and collection of qualitative insights.

6.3 It is acknowledged that when this fellowship ends there will be a gap in this offer, and a pause in the gathering of qualitative insight required to support future quality improvement work- within the area of falls prevention and management in care homes.

7. Recommendations

7.1 The Integrated Care Board (ICB) and system stakeholders must consider how the enhanced support offer described in this report can be embedded within services designed to support care homes to better prevent and manage falls.

7.2 Based upon quantitative data findings , it is recommended that an enhanced falls support offer-similar to the one described in this report is provided to preselected homes within the Nottingham and Nottinghamshire Integrated Care system who:

- Have disproportionately high EMAS see and treat figures compared to falls related non elective admissions.
- High EMAS see and convey figures
- High falls related non elective admission rates

7.3 Despite monthly falls reporting to be a contractual requirement for care homes , falls are not being consistently reported by the majority of care homes across the ICS. Further investigation into the reasons for this is required in order to increase care home self-reported falls rates.

7.4 The care home sector reports a nervousness relating to being transparent about falls rates - due ot the impact this may have on the home as a business. The falls self-reporting forms are also said to take around 30 minutes to complete. These two factors should be factored into any further initiatives developed to increase self-reporting falls rates by the care home sector.

7.5 To improve opportunities for quantitative insight into falls in care homes (via the SAIU) it is recommended that EMAS reporting includes specific intersections of data detailing falls related see and treat and see and convey figures.

7.6 It is recommended to the (ICB) and system partners that homes are supported to adopt falls huddles as a process of reflection and learning following a falls related incident- in a similar way to how NHS organisations are being supported to implement this approach using The Patient Safety Incident and Response Framework. Support will need to include training on the concept of falls huddles and how to facilitate these effectively.

7.7 In addition to generalised falls prevention and management training subject specific training is also recommended to be offered to care homes. This should include training on Dementia and Agitation, Nutrition, Hydration and Frailty and how these conditions contribute to falls. Please refer to the Falls in care Homes Best Practice Guidelines for further information https://notts.icb.nhs.uk/care-home-staff-information/

7.8 Nationally recognised ACTION Falls training for care homes which includes falls risk assessment training and appropriate action taking is also recommended for all care homes across Nottingham and Nottinghamshire.

7.9 It is recommended that the ICB consider how falls training may be offered across the sector including oversight of falls training offered and ways of incentivised in addition to this being a contractual requirement. In addition, the ICB should work to gain oversight of falls training offered and received, including the quality of training offered.

7.10 Future training for care home staff should include developing leadership skills to empower and develop confidence in staff to work as collaborative and equal partners with the multidisciplinary team. In turn this will improve proactive working and ensure those advocating for care home residents are the people who know them best. In turn this will reduce and better manage falls in care homes.

7.11 Residents who are experiencing agitation, behavioural issues or reduced cognition have been shown to cause falls for other residents. How residents relate to one another and live together should be considered in falls risk assessments and falls risk mitigations.

7.12 The ICB should consider the offer of future fellowships to gather a deep and rich understanding of quality improvement needs. This work has been particularly successful in building trusted relationships and developing quality improvement work collaboratively with the workforce.

7.13 Further training for care homes should include opportunities for informal learning and reflection as well as more structured training sessions. Staff have reported to find learning through visible leadership and informal conversation particularly effective.

7.14 The ICB and system partners are recommended to implement strategic intervention and support via future Care Home Project Workshops to successfully identify and implement future quality improvement work.

7.15 Specialist Falls services need to remain accessible to care home residents experiencing falls , ensuring they are offering the same service to care home residents compared to people of a similar age residing in their own homes. The ICB needs clear oversight of this specialist falls offer to mitigate the risk of care inequalities and ensure high quality evidence-based interventions.

7.16 Further work is required from all system partners to define what is included in a generalised falls support offer- which all services are expected to provide and how this differs to a specialist falls support offer. This will help to manage multidisciplinary expectations of one another and support in the building of trusted relationships- where falls are seen as a shared problem. This will also help to ensure specialist falls support is offered to those residents who require it.

7.17 Falls prevention and management support- offered by specialist falls services should include evidence-based resistance exercises, advice on the prevention and management of

sarcopenia and postural stability training. Once intervention ends care homes should be supported to understand how to support the resident to sustain strength and balance to prevent future falls. Advice provided should be person centred and include communication to the home and wider multidisciplinary team on the actions required to mitigate identified falls risks.

7.18 Referrals to specialist falls services are often screened by care home teams for suitability. It is recommended that the ICB have oversight of this screening process to ensure staff have the skills to make this judgement safely and appropriately This will help to prevent an inequality of service provision for care home residents when compared to people of a similar age and health condition living in their own home.

7.19 Falls technology should be used more proactively to prevent falls. In particular to gain insight into falls risks and build falls history information of individual residents. This should be considered during future funding opportunities relating to falls prevention technologies.

7.20 To reduce long waits for basic mobility aids such as walking sticks and walking frames- which in turn causes many falls , it is recommended that the ICB considers ways to reduce this risk. This could be achieved through working directly with the care home sector and equipment providers to potentially enable care homes to be trained in the fitting of and ordering of simple mobility equipment via their own equipment provider contracts. This could potentially be piloted with a small number of homes initially.

7.21 ReSPECT forms should stipulate the specific wishes of residents who may have a injurious fall including sustained fractures and head injuries. It is recommended that the ICB and stakeholders consider falls specific scenarios in further ReSPECT training for the care home sector . Quality monitoring of ReSPECT forms to ensure these include falls specific information is also required.

7.22 It is recommended that care home providers formulate falls histories in one section of a care plan and that provider organisations and care homes work together to overcome accessibility issues. This was trialled during the fellowship whereby a Nottinghamshire Healthcare computer was granted access to the care homes digital care record via their own log in details whilst on the premises. This is easier to achieve when digital records are housed via an external website.

7.23 It is recommended that the ICB and wider stakeholders may be able to facilitate spaces for collaborative learning and reflection following falls incidents across organisational boundaries. It is hypothesised that this will support the care home sector to feel that they are equal partners and have shared ownership of falls prevention and management strategies. It is predicted that this will also reduce inappropriate referrals to specialist falls services.

7. 24 It is acknowledged that as the Falls in Care Homes Fellowship ends there will be a gap in enhanced support to homes experiencing very high falls rates; and strategic falls intervention for care homes across the Nottingham and Nottinghamshire Integrated Care System. It is

recommended that the ICB and system partners consider how this gap will be filled to ensure ongoing falls prevention and management support is appropriately offered to care homes.

8. Appendix 1 Coding Template for Falls Huddles – Qualitative Data Capture

Code	Description	Direct Quote from Transcript
Positive Feedback	Reported Feelings of staff involved that participated in at least one falls huddle	"Really helpful" "Reassuring " "I enjoyed that " "The team are happy to trial the falls huddle approach "
Time Constraints	Staff shared concerned with time required to complete a falls huddle.	"It is a good tool, but we don't have time to do this straight after a fall due to limited staffing numbers and time constraints". "This could work (the falls huddle approach) if we are given 10 minutes protected time in staff meetings". "Good to have protected time to reflect and make plans"
Feelings of Empowerment and Pride	Staff shared significant feedback that falls huddles helped them to feel empowered and proud of their work.	"We are doing well to prevent falls " "Builds confidence in what we are already doing to prevent a fall " "We feel proud of our falls prevention plan " "We have clear identified actions " "Reassuring, confidence building " "Supportive"
Opportunities for Learning	Staff shared comments about falls huddles being an opportunity for learning about falls	"Good for learning and for making actions to go in the weekly home rounds on Thursday". "Makes you think "
Agitation	Agitation was reported to be a significant factor present in many of the falls discussed.	"The resident was observed to be agitated and walking around the lounge (prior to the fall)" "Another resident entered the room and attempted ot take the residents zimmer frame. This caused the resident to become agitated." "The resident was very agitated at this time and was provided with lots of reassurance"
Behaviour	It was noted that a resident's behaviour and choices can increase the risk of a fall.	"The resident attempting to get out of bed independently to go to the bathroom. This resident lacks capacity and so is unaware of risks of falls if they mobilise without supervision " "The resident is being left in bed for too long in the morning – longer than he wishes and the resident is then not waiting for assistance before getting out of bed to use the toilet". "The resident is anxious and was rushing to tea". "The resident had gradually positioned themselves onto the edge of the chair and then slipped onto the floor". "Lack of insight is impacting on behaviour". "The resident is declining to spend time in communal areas and so reduced supervision available".
Cognition	Staff regular fed back during falls huddles that a deterioration in cognition was a common factor in the incidence of falls and that deterioration of cognition was also linked with a deterioration in physical ability.	"Staff have noticed a gradual deterioration in cognition and physical abilities over past few months " "Gradual decline in cognition and mobility noted". "Due to reduced cognition resident leans back in chair and doesn't sit with back to chair". "Resident will not tolerate the placing of pillows and cushions to support positioning due to decreased cognition and agitation"
Unwitnessed Falls	Most of the falls discussed during the fall's huddles were unwitnessed with the majority of these falls happening when the residents were unsupervised in the lounge or their bedrooms.	"This was a very busy time for the home and all staff had temporarily left the lounge to support other residents to move into the area". "If staff had been present the resident may not have fallen". "The resident was in her own room unsupervised by a staff member". "The resident was found on the floor laughing by her chair". "The resident was found by staff member on the floor with her zimmer frame on the floor next to her". "The resident was found by a member of the catering team who alerted other staff members quickly". "There were no staff member in the lounge when the resident fell". "Reduced staffing levels and time constraints contributing factor". "The aim to have member of staff in lounge supervising residents at all times". "Staff were not aware that another resident had entered the room". "The resident wad left unattended in lounge". "The fall was unwitnessed, and staff were alerted by the sensor matt "

		"Staff found the resident on the floor in the bedroom". "If the resident was given constant supervision this would take away some of this residents independence". "Found by staff member."
Witnessed Falls	Some falls brought to falls huddle for discussion were witnessed. All of these falls occurred when residents were mobilising either independently or with supervision.	"Resident was mobilising independently in dining room". "The resident went to sit on chair which was slightly further back that the resident had realised and as a result lost balance and fell " "The second fall was when resident was mobilising to bathroom with carer and became incontinent of urine. The resident then slipped on the urine and fell to the floor backwards".
Other residents	There was some feedback at falls huddles that suggests other residents can be a contributing factor to falls.	"There then proceeded to be an argument between the two residents over the frame with residents pulling the frame away from one another". "On arrival another resident was also in the room and was encouraged successfully to leave the area "
Environment and Equipment	There was significant discussion around environment and equipment both in respect to it being used ot prevent a fall and also not being used due to issues relating to deprivation of liberty and risk of injury. There was also some acknowledgement that clutter present in rooms made post fall care difficult initially.	"There was a senor matt in place which is good". "There was some equipment and clutter in the room which made it difficult to access the resident on the floor initially". "Sensor matt alerts staff" "The laundry trolley was moved to create more space". "The resident was found on floor having slipped off bed each time". "We are using sensor matts (to prevent falls) " "A crash matt not appropriate as resident can walk and this would pose as a falls risk". "Bed rails not appropriate as residents attempting to get out of bed independently meaning that the bed rails would be a high risk of injury". "Not appropriate for tilting chair as this would be a deprivation of liberty".
Post Falls Checks	There was significant reflection on checks carried out by staff following a falls incident. Feedback suggests that post fall a duty nurse or senior carer is called to lead on post falls checks. This could reflect some reduced confidence or training gap in other staff members or related more to organisational policy. Feedback during huddles was consistently suggesting that teams have good confidence in their abilities to spot serious injury and escalate or manage falls "in house" although clinical reasoning to support this was not always articulated during huddles. There was also variation in the type of checks completed post fall between different homes and sometimes feedback during huddles was vague in terms of what specific checks were/ should be	"The nurse on duty was called who check resident over " "The checks included for head injury, pain and broken bones " "We checked the resident was safe and free of injury before moving her". "Good at determining injury and safety and managing the fall in house". "The nurse on duty completed visual checks, neuro checks and set of observations before staff were able to agree that the resident was not injured " "We were able to reason quickly that the resident could be supported onto their feet safely which reduced the impact of this fall and meant we did not need to call 999 or UCR". "Senior staff member attended". "Checked for injuries including signs of fracture or bang to head " "The resident was deemed to be free of injury but did not use istumble app or take obs " "We have a good method for checking for injury." "Obs were taken and were normal". "UCR and 999 was not used as staff felt this was not required". "Senior carer checked for bruising, head injury, external rotation /shortening of lower lib, facial expression and general demeanour". "Observed by three members of staff who checked resident for bruising, cuts, externally rotated lower limb or shortening before assisting resident to feet " "Staff acknowledge that they could have called 999 or UCR if an injury or medical emergency was presented or if they felt that they could not support the resident safely onto their feet". "Staff were able to demonstrate good skills at identifying fractured neck of femur quickly "

	completed. Variation in checks completed.	
Staff Response post Fall	There was significant feedback from staff who attended falls huddles that they felt they were mechanisms in place within the home that allowed them to respond quickly when a resident experienced a fall. An additional theme was that many staff reported that they felt there was a sense of teamwork and staff realising the importance of remaining calm. There was also evidence of staff working together to determine whether UCR or 999 was appropriate following a fall.	"Emergency buzzer pressed immediately, and staff responded quickly " "Emergency buzzer pressed " "Staff stayed calm which was really helpful " "As a team we responded quickly " "Staff reacted quickly and worked as a team to support the resident and each other" "We remained with the resident and provided reassurance and debrief afterwards " "Staff responded quickly and worked well together " "Staff demonstrated good communication with one another " "Staff remained calm, and this helped to keep the resident calm " "Staff showed kindness and compassion to the resident and each other during a stressful time". "We work well together as a team to support residents through an incident". "Staff responded very quickly " "We considered most appropriate response as a team". "We agreed together that there was no need for UCR or 999 " "We clinically reasoned that 999/UCR or 111 support was not required and we could manage the fall in house". "Quick response from staff " "Staff responded quickly and identified the issue quickly due to knowing resident well "
Decision to call 999	Whilst it was not always clear what post fall checks were completed staff were consistently confident in knowing that residents in severe pain or with an externally rotated lower limb should receive support from 999.	"Resident in severe pain " "External rotation of lower limb present "
EMAS response	There was some positive feedback relating to EMAS response time and treatment identified.	"The ambulance arrived within 20 minutes " "The paramedic prescribed IV oromorph" "The Paramedic used lifting equipment to transfer resident to a stretcher"
Reduced Confidence in MH Techniques	There was some uncertainty and reduced confidence n manual handling techniques shared in falls huddles relating specifically to post fall management.	"We are unsure of the best method for getting the resident up off the floor and need training regarding this". "We are not clear how best to physically support resident back onto their feet".
Non-use of equipment to support residents from the floor.	There was significant evidence form discussions during falls huddles that the use of equipment to lift residents from the floor was not used. Staff often reported that they felt this would cause more distress or agitation. It was not always clear on methods used to assist people although supporting residents quickly to their feet was valued highly by staff members to prevent long lies on the floor.	"We got the resident to push down onto the carers hands to stand " "Due to decreased cognition staff felt that the use of a stand aid or hoist would not be appropriate and would cause distress". "We were able to reason quickly that the resident could be supported onto their feet safely which reduced the impact of this fall and meant we did not need to call 999 or UCR" "The resident was supported to stand with light assistance of three staff members which enabled the resident to get off the floor quickly within 10 minutes of the fall occurring and reduced the psychological and physiological impact of the fall". "A decision was made not to use the hoist as this was felt by staff to be something which would cause further agitation and therefore become unsafe". "The resident was deemed to be uninjured and so was assisted up from the floor by being encouraged to slide onto her bottom and then pull herself up by her wheeled zimmer frame that was weighed down by two staff members". "This was deemed as the least stressful method of getting this resident up off the floor who becomes increasingly agitated if a hoist or lifting equipment was used". "Staff then assisted the resident back onto their feet by two care staff"
To discuss at home round	An action that came from a falls huddle was to	"Incident to be highlighted for discussion and MDT support at next home round ".

	discuss the resident at home round.	
Improved Post Falls Planning	There was some evidence of falls huddles supporting teams to improve their post falls plans for individuals and as an organisation	"Better post falls protocol is required " "Most appropriate way for resident to be supported off the floor after a non-injurious fall to be added to the care plan".
Improved ways of Managing Agitation	There was evidence that improved management of agitation was identified as a way of mitigating future falls risks	"We now have a plan in place and documented that when resident is in her room her door is closed".
Plans for Increased Monitoring	One of the most common identified actions post falls huddle was to implement increased monitoring through the use of sensor-based technology or face to face supervision and checks.	"Sensor matt now in situ to alert staff to uninvited residents " "Completing 15-minute checks " "Encourage resident to spend more time in communal areas". "Increase supervision" "There is a need to provide constant supervision when mobilising". "Two hourly checks overnight" "1 hourly checks overnight" "Provide constant monitoring in dining room during the day". "Night staff to offer toileting support at 7 am" "Day shift to support resident to get out of bed and be offered toileting support first". "Practice close supervision with all mobility and transfers" "Resident is now supported in the living room during the day"
Bone Protection	The importance of establishing whether residents were on bone protecting medication was a regular action following falls huddles.	"Check resident on bone protection at next home round" "Need to query whether this resident should be on bone protecting medication". "Check resident is on bone protection"
Onward Referrals	Falls huddles were shown to be an opportunity to identify the need for onward referrals to falls teams	"Referral to community physio for lower limb strengthening exercises". "Physio referral – to be marked as priority due to fractured neck of femur".
Equipment Actions	There were some identified actions relating to equipment identified	"Bed to be lowered to minimise risk of injury (but not right to the floor as resident can get up independently and if too low could be seen as a deprivation of liberty)" "Ensure sensor matt is in situ in room overnight". "Sensor matt in room has been implemented". "Implement chair sensor"

9. Appendix 2 Coding Template for System Workshops – Qualitative Data Capture

Code	Description	Quotes from Transcript
Empowerment of Care Home Staff	Care home staff feeling empowered to make informed decisions relating to falls prevention and management.	"There is something about empowering the care home isn't there to feel that they can sort of take some ownership". "There's maybe some work that needs to be done around building confidence". "I think we find erm whether its due to knowledge I don't what its due to but sometimes there isn't the ownership of falls prevention at a care home level". "Some feel like they have to ask for permission which they don't". "So, from my experience homes that have really good relationships with their care homes team do less of these referrals and feel more confident in putting in interventions". "I'm afraid it's not always the case that the best relationships mean that care homes can think for themselves. I'm afraid sometimes it is actually the opposite". "The care homes that we are in and out of unfortunately rely on us quite a lot and they don't always think for themselves". "I think it is just that you know we are in and out of care homes a lot and unfortunately that creates reliance rather than empowerment". "Safeguarding told us to refer even if it's just one fall and even if all the things we would put in place are in place already". "I think there is this myth around safeguarding tell us to refer so that's why we are referring".
Blame Culture	Blame culture following a falls related incident.	"There are those homes that will do referrals for the same person that's had lots of input already because they are worried that if they don't, they are going to be penalised". "We get lots of care homes saying that they will refer every single fall into the falls team to cover themselves". "There is a reluctance in terms of who makes that decision of actually we are not going to do a CT on this person, so again is it appropriate for somebody to be conveyed in an ambulance when they could be potentially seen by outpatients the following day rather than sitting in A&E for 10 hours?" "Yeah, and I think everyone is afraid. So the paramedic is thinking if there is a bleed and I don't take them in for scanning what backing have people got that the decision made was OK?" "They are so worried that if they don't do that (admit resident) and then say there is a bleed on the brain and the patient dies they will be held accountable for that, but yet they feel guilty because they are supposed to be advocating for these residents and they know what these residents' wishes are".
Collaboration	The importance of equal collaboration between care home staff and the wider multidisciplinary team.	"We are really pleased to be part of this project " "I think it is really important to remember that although we can give care homes more training it's also quite an isolated place to be so those with better relationships and support do feel more confident". "So those with better relationships and support do feel more confident and that is something that I feel is important to highlight". "Homes don't have the same sort of resource and backing as we have where we can ask multiple members of the team whereas they don't have access in the same way to the multidisciplinary discussion on their own".
Training	Falls prevention training for the care home sector.	"Some of it is likely to entail training that we might end up needing to sort of highlight". "Training is not actually in the contract, falls training so there are very different levels of training that care homes have erm some are more confident than others with putting in preventative measures." "Just to let you know falls training will be in the care homes contract from April 2024 for all nursing and residential homes". "The main thing I notice is training for the carers and the care home for what they know about the falls and how they can prevent it." "The turnover in care homes feels like you get staff trained up and then they move, and you get a whole new set".

		"Obviously agency use is another big issue, and I am also seeing reduced care homes staffing levels after the covid (in relation to training)".
RESPECT forms.	The need for detailed, high quality RESPECT forms which refer to falls related incidents.	"A few of the homes have mentioned RESPECT forms and say that these are fantastic when filled in properly and when it is very clear about what that residents' feelings about care is and what their issues are". "There have been a few examples where care homes called EMAS because somebody sustained a head injury and they know the resident doesn't want to be admitted to hospital, family doesn't want the resident to be admitted to hospital, conversations have been had not to go to hospital". "Some more work maybe needs to be done around you know if somebody does fall and hits their head what is the value of sending someone to ED for a CT scan to say they have got a bleed to then send them home. So that is a theme that we do have and is quite a cause of conflict".
Complex decisions	Complicated decision-making process following a falls related incident.	"They are sometimes finding that they you know, there are differences between EMAS because EMAS feel that they have got the responsibility if the person dies so I am trying to word this very sensitively, but you know there might be some training needs across the system about the care homes do know their residents the best". "They can have decisions documented in all sorts of places that aren't RESPECT forms you know families know their residents and residents know themselves best too so yes we've got professional accountability but a lot of the time these people are quite vulnerable , frail and they have made their wishes very clear about what they would like to happen and sometimes as a system we don't always listen to that" "Care homes have said to me that they feel that say there is a resident who really doesn't want to go into hospital the way that they have interpreted the guidance that they have got is that regardless of that regardless of that patients wises, if there is a head injury that they are effectively obliged to send them into hospital to be checked". "There is a bit of a mis match between what they say and how the guidance maybe reads or how the guidance is interpreted so I suppose there is some scope for maybe having more conversations with the care homes and help them understand that guidance and how it is meant to be interpreted". "What backing have people got that the decision made was, OK?" "What documented support have people got for that (decision not to admit) and understandably if people die then people are very fearful of being criticised and blamed for that, so you know I get it" "Care homes do, a lot of them really try to advocate for that resident to try and stop them going into hospital but they don't always have the evidence to back it up because it is overnight or at a weekend where the usual GP is not there, so I don't know if that's worth flagging".
Home Rounds	Proactive case finding during weekly care home rounds.	"A positive thing that we have started doing around therapy referrals and identifying people at risk of falls is identifying that within the care home rounds". "So, we are encouraging the care homes to come forward at that point for people that are having increased falls and then we can go in and look at falls assessments as part of that holistic assessment". "We will go through the guide to action for falls we will go through some falls mapping trying to look for trends and things like that and going through those preventative measures for falls". "I think certainly yeah erm if we can pick up those referrals via that weekly MDT meeting and weekly home round there will be a request go through to either the GP or somebody else for a falls assessment or physio input".
Expectations of one another	Expectations of the care home and wider multidisciplinary team have of one another.	"I think that they see that's it's our role to put things in place". "When we go out and give advice to reduce falls often it's not actually followed". "So, we get the same people coming back time and time again because they have followed the advice previously given". "Care homes are often saying that they cannot meet that need and the resident needs one to one which the patient doesn't require".

		"If you say his patient is not to be left unattended or need eye line supervision -straight away their answer, is we do not provide 1-1". "They will refer basically for assessments that they should be able to do themselves". "We've got a lot of issues and concerns with the management of falls in care homes". "Any fall that anyone has in a care home the erm care home put it through and they say we've got to it's a tick box exercise for us we've got to put those through". "If there are physical issues going on like infection then they will suddenly have a couple of falls and that's not to say they need to be referred but they are not sometimes screening out of physical issues. You will go in and ask; have you spoke to the GP? No." "Can't you speak to the GP about you know whether its pain, whether it is infection like that and therefore it feels like we are the first line and therefore we are telling them to phone the GP erm rather than the GP maybe being the first contact rather than us". "What we have done is erm developed a non-injurious falls screening tool erm so we will phone the care home and it will screen out whether somebody has tripped over someone's frame they are up and about they are walking as normal there's no actual concerns and there is actually not a need for a physio to necessarily erm come in". "You see those referrals go through (to community therapy) with very little information on them it's kind of almost a knee jerk reaction to say we need to do this."
Falls History	Documentation detailing falls history to enable holistic multifactorial falls assessment.	"One of the challenges we find is the amount of information you've got when you look at somebody's care notes around the falls and the unwitnessed falls and things and the times and where they have occurred and things, to be honest a lot of the care homes are getting better with that but yeah that can still be a bit of an issue". "I haven't got a full sense yet of you know for those homes who have got a digital social care record does that help professionals to work with them because the information that home has got is more standardised, is more up to date".
Falls Technology	The use of technology to prevent and manage falls.	"There is loads of falls tech out there erm some that just tell you that someone has fallen over but then more sort of sophisticated ones that are looking at activity over a period of hours or days that build up intelligence and can prompt care providers that they might need to make a referral to a health care professional or that you know such and such person is getting up at two o'clock in the morning and they wasn't doing that before" "What I don't really understand at the moment is how many care homes have invested in that kind of technology". "It would be interesting if we could look at that as we go maybe over the next kind of few months and see whether there is any best practice in the digital sort of arena that supports the care pathways, I just think it would be interesting to have a look at that"
Accessibility of Digital Records	Accessibility of digital information during a falls assessment.	"With the digital ones you have to find a member of staff that can then log you on to their computer which is probably in the manager's office which is probably in use with meetings going on so it can sometimes be more difficult to find the information". "Sometimes when I have gone to homes when there has been maybe newer staff or agency staff, they haven't always been able to access the digital records when I have needed them". "You shouldn't need to be running around asking them for files, you should be able to have sort of access to it"
Mobility Aids	Ensuring mobility aids are in good working order and appropriate for an individual resident.	"And the basic things like checking the patients frame for example".

		"There is no one checking the ferrules of the frame and it is worn out and the metal is coming through and when somebody is walking and that is when we get the falls". "I provide a frame that is then used by other residents there is no name or anything and the patients frame is too low or too high".
High demand	High demand for specialist falls services for care home residents.	"Our waiting lists are absolutely huge " "We've got very few resources in which to cope with the influx of referrals". "We are inundated by non-injurious falls". "The therapy referrals that are going through to therapy obviously there is quite a long waiting time". "Sometimes we will get out there and they will have had two (falls) and not have anymore because they were unwell, and it happened and then the illness resides, and they are absolutely fine" "We are not able really to do the preventative work that we need to do because we are constantly firefighting". "We can't do the kind of work that really, we all know will prevent people falling".
Therapeutic Maintenance and Rehabilitation.	Opportunities for care home residents at risk of falls to receive specialist support for physical maintenance and rehabilitation.	"Going through those preventative measures for falls and then we make sort of a shared decision around whether we are going to refer through to therapy whether we feel that will be of benefit really". "Most of the care homes don't have an activities coordinator erm so we can't provide an exercise for every day of a weekly or twice weekly " "If they have an activity coordinator, they can do some providing I give some exercise they can then do all of that exercise". "For example, someone has been discharged from hospital following a fracture, following a fractured neck of femur or something like that there is information on the discharge letter to say they need to be seen by therapy in secondary care but no real plan". "No real indication of what that person's physical function is on discharge so that leaves the care homes a little bit like should we doing this or should we be doing that in terms of rehab and things like that". "It leaves care homes in a bit of a what do we do? Are we still going to be using a hoist for example? There is nothing to say what their physical function is " "And obviously with the service pressures within community it will say therapist to see in the future but in terms of deconditioning and things like that you don't get any plan or no pan at all".

10. Appendix 3 Enhanced Falls Support offer to Care Homes Surveys

Enhanced Falls Support to Care Homes

Survey

1.From your point of view what's been your top 3 highlights of this project, what's worked and why?

- Our team working together to find ways to ensure all falls are being monitored and staff are being more observant
- That we managed to create the fall snapshot so now we are finding out ways to reduce falls which before was not noticed
- The findings from the falls huddle we did, as this is something we would have never done before in such detail

2.What been your homes greatest learning?

- It has been the fact that now when a fall happens people look more in depth as to what the reason could have been, rather than assuming an infection is there more things are being looked at such as correct shoes etc, although this was something we did before but was more from a nurse/management investigation point of view, now the carers are also taking this on board and are communicating with us straight away if someone's shoes don't fit or are broken etc.

3.How did this work in practice for you? Can you share a resident's story of how this has worked in practice.

- We had a resident who had a fall so we used the falls snapshot to tick off the findings, it was during this time that we noticed the slippers had worn on one side meaning their balance was not great which could of resulted in the fall, the slippers was then replaced.
- Also another resident who does not normally fall had a fall and because of the new tools we now have in place from this study we was able to determine that he had a chest infection and get him the correct medication he needs to make him better.

4.This project was only funded for a year so it's coming to an end in its current guise – what would you like to happen next?

- It would be nice to see if there was a way for a follow up every so often to see if all the work that has been put in place is still being used as it is easy to keep on top of the things we have in place when you know you will be having meetings to discuss findings ect, so would be a shame when this project finishes if all the hard work stops or gets forgotten about as it will not be spoken about/mentioned without the meetings in place. (I hope this makes sense)

Enhanced Falls Support to Care Homes

Survey

1.From your point of view what's been your top 3 highlights of this project, what's worked and why?

Training was delivered well

Falls reduced due to training

Victoria was very supportive of staff and supported them to look at new fall's preventions

Victoria gave staff confidence

2.What been your homes greatest learning?

Falls prevention

3.How did this work in practice for you? Can you share a resident's story of how this has worked in practice.

We had a resident that had a lot of falls. After review with Victoria and support she gave staff on how to prevent falls this resident as not had any further falls.

4.This project was only funded for a year so it's coming to an end in its current guise – what would you like to happen next?

Staff to continue to use the training that was shown regarding falls prevention and ensure falls that can be prevented are prevented.

Enhanced Falls Support to Care Homes

Survey

1.From your point of view what's been your top 3 highlights of this project, what's worked and why?

The ease of access for help and advice, the information that I have received and also the writes ups. As a care home we depend on services such as the falls team, the Support and advice Victoria has given me has help me to reduce falls, it has also help in a safeguarding matter as I have written up and information given on falls, and this was looked at really well .

The biggest and most important thing Victoria was able to build trust with my staff they got to know her , talk to her get advice and do falls huddles so this in turn was better for the manager as I didn't need to go through myself, they could raise something with her or ask their own advice and get the help needed. Having trust in professionals is very important for both staff and residents and having a familiar face help put them as ease and confidence that they are getting all the help and support needed.

2.What been your homes greatest learning?

Mine has been the continues support before this it was refer to the falls team and wait for month and month sometime residents falling or declining more in between, with the support for Victoria it has been quick and clear , helping with falls the right equipment or changing of equipment , the excellent documentation .

3.How did this work in practice for you? Can you share a resident's story of how this has worked in practice.

I can share may with you

One was the resident family member that said we was not going anything regarding his wife falling and rolling out of bed , lucky Victoria was in that day and offered support and advice and made sure we had all in please a safeguarding was raised by the family but because we had the quick assessment and the detail of the assessment it was close straight away that day and there was no concern.

I had 2 residents that wasn't walking correctly with frames Victoria noticed it was the frame they had and ordered new ones, and this has helped a lot.

Another was a resident falling and family raising concerns Victoria was able to give them peace of mind with her knowledge and support that that all we had in please was enough.

Without the above I probably would have been safeguarded and not had the help and support quickly that I have needed.

4.This project was only funded for a year so it's coming to an end in its current guise – what would you like to happen next?

I would like to see it continue or what support that I have in place I am sorry, but the falls team previously wasn't quick enough referrals could take month and month with falls continuing

With this project I have received the help and support I needed quickly for my service users and once it ends, I have concerns of how long referring to previous fall teams and documentation that is needed before referral sometime resulting and feature or bad falls.

This project I fell has help me and my care home and my residents stay as safe as possible but also trying to prevent falls or putting things in places to make sure things do not escalate further.

Victoria has also been present on ward round and is known to the care home team so having a network where everyone else and talks to each other is a massive help to me and my care home. I cannot stress enough that taking away these such service have a massive impact on care homes.

Would this project be considered integrated into previous falls teams team and making one bit team where we can get the help and advice we need really quick and clear and the documentation to back this up and then like with my care home have input in ward round with other health professionals so that service users and care homes get the help and support they need and family are more reassured that things are being done.

I also like that I had one person that I could email or call for help and advice making it quicker and easier instead of call a GP do they need a refer, why do they need a refer , evidence etc and sometime no getting the help quick enough resulting in injuries. Some has a fall I was able to refer to Victoria , get help her come and assess get all in place .

For example, if I need help and you can google this I would have to refer through a GP and evidence a lot is it needed what in place etc . with this project I was able to say email Victoria say I have a service user that had a falls or is a falls risk because of this and a date and time of a visit would be sorted, and I get the help and advice I need quickly.

Enhanced Falls Support to Care Homes

Survey

1.From your point of view what's been your top 3 highlights of this project, what's worked and why?

It made you relook in to how and why falls were occurred. It gave the home a feeling that everyone was involved, and it highlighted what else could be done with a bit of support.

2.What been your homes greatest learning?

To realise how much we were already doing.

3.How did this work in practice for you? Can you share a resident's story of how this has worked in practice. It worked to help us look at alternatives for an individual and it has enabled him to have a little more freedom.

4.This project was only funded for a year so it's coming to an end in its current guise – what would you like to happen next?

I think this should be a roll out programme for someone may be on the PIC team to take up

11. Appendix 4 PSIRF Inspired Falls Huddle Template

For further information on the Patient Safety Incident and Response Framework please visit:

https://www.england.nhs.uk/patient-safety/patient-safety-insight/incident-response-framework/

FALL HUDDLE TEMPLATE

RESIDENT:
DATE AND TIME OF FALL:
EXACT LOCATION OF FALL:
DATE AND TIME OF HUDDLE:

Describe what happened before the fall:

Describe what happened at the time of the fall:

Describe what happened after the fall:

What went well?

What did not go well?

What have we learnt from this fall?

What are our actions following this falls huddle?

12. Appendix 5 Methodology of qualitative data capture

Inductive thematic analysis was used within this fellowship to capture , analyse, and recognise patterns within qualitative data in a systematic and objective way . The use of inductive thematic analysis enabled insights to be derived from the qualitative data received allowing themes to emerge directly from the data. It was important to use this type of thematic analysis opposed to deductive thematic analysis to ensure themes came directly from the data set and were influenced as little as possible by the author. . This approach also enables analysis to remain closely connected to the data enabling nuanced and novel insights It is hoped that this has l allowed for richness and depth of insight into the perspectives of care home staff and multidisciplinary teams members providing a comprehensive understanding of experiences and viewpoints.

The method by which inductive thematic analysis is completed is also known to be straightforward and transparent meaning the method can be applied consistently and rigorously which helps to enhance the validity of the findings. Deriving themes directly form the qualitative data provided also enables complex perspectives to be coded and themed easily providing simple ways of demonstrating complicated perspectives, thoughts, and experiences clearly.

As inductive thematic analysis is not tied to a specific theoretical framework there is a risk that subjectivity may play a role in both coding and theme identification and therefore peer review of coding and themes took place. This helped to control against unconscious bias from the author. Personal and critical reflexivity was also used throughout the qualitative data capture facilitated by regular clinical and managerial supervision from Nottinghamshire Healthcare Trust Falls Lead as well as strategic oversight from the Nottinghamshire Integrated Care Boards Enhanced Health in Care Homes Lead.