

**QUALITY IMPROVEMENT PLAN (QIP) TARGETS
QUARTERLY TRUST BOARD REPORT**

FALLS

5 February 2026

PROGRESS TO DATE

Falls are a costly and often preventable health issue and continue to be the highest reported incident within the Trust. Reducing falls and injuries following a fall is important for maintaining health, wellbeing and independence amongst older people. Work is ongoing to raise awareness regarding preventing falls throughout the Trust. The Professional Nursing Team and the Falls Integrated Pathway Co-ordinator (FIPC) through the Trust Slips Trips and Falls Group, support this work and the development of a 3-year falls strategy. However, consideration needs to be given, as one dedicated FIPC is not sufficient to meet the demands of the entire Trust in relation to falls.

Falls in Hospital Inpatient Settings

Reporting of falls occurring within inpatient settings continues to the Public Health Agency (PHA). In Quarter 3 (September to November 2025) there were 512 falls reported on the Trust datix system from Trust residential homes and hospital inpatient settings. Of these 467 were from hospital inpatient settings and 45 were from Trust residential homes. This was a slight increase from the 510 falls reported in Q2 and a significant increase when compared with the same quarter in 2024 when there were 471 falls reported from Trust residential homes and hospital inpatient settings.

The median number of falls reported from Trust inpatient settings in Q3 is 169, an increase from 160 in 2024 and 156 in 2023. The increase in the median number of falls in inpatient settings may be associated with the increasing numbers of patients living with frailty and dementia or confusion admitted to hospital. Wards escalated beyond capacity are experiencing staffing challenges, which includes securing staff to support patients who require enhanced care.

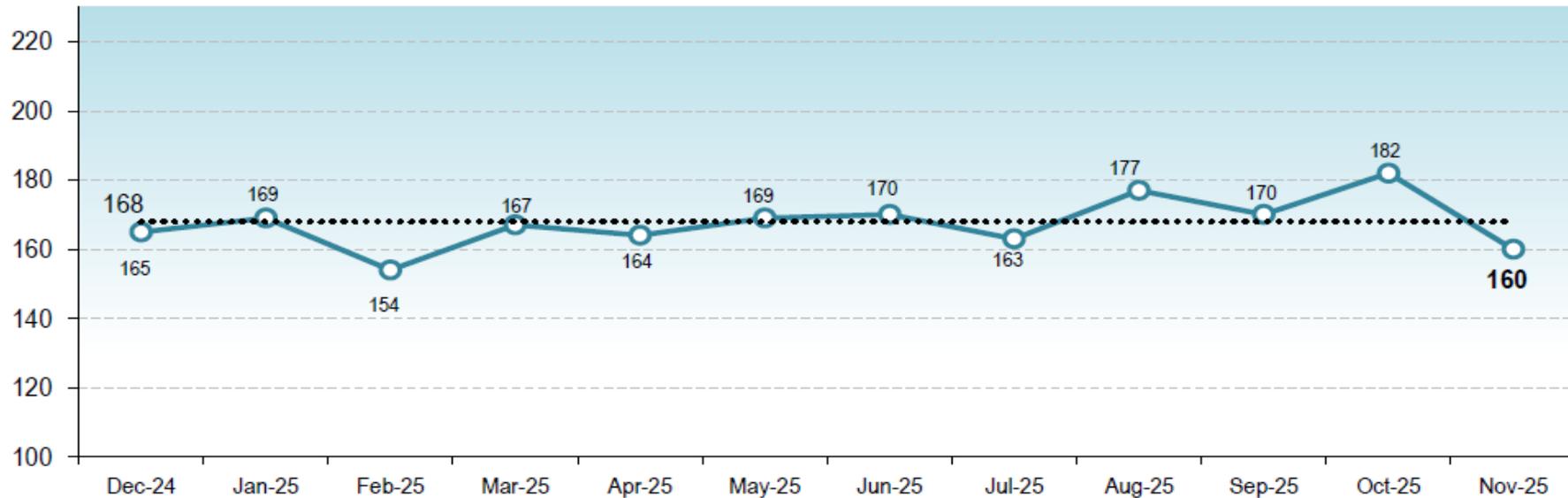
Patients are spending days in Emergency Departments (EDs) before transfer to an acute hospital ward. This increases the risk of patient falls as patients become increasingly deconditioned whilst awaiting hospital admission.

Many patients admitted to hospital are reporting difficulties accessing GP services when unwell. Delays in ambulance response times following a fall can result in some people experiencing a long lie. This can result in onward transportation to hospital for further medical assessment due to risks associated with a long lie following a fall.

Many older people could benefit from rehabilitation in community prior to hospital admission. Currently there is a gap in the provision of timely community rehabilitation services to enable many older people or people living with disabilities to live full and independent lives.

There are high numbers of older people in acute hospital wards and emergency departments experiencing delays in transfers of care to community or care home settings. This increases risk of hospital acquired infections and contributes to hospital acquired deconditioning, both of which contribute to increased dependency levels, increased demand for care in the community, increasing levels of frailty and associated falls.

In-Patients & Trust Residential Homes Falls per Month



The majority of inpatient falls reported were from Acute Hospital sites with 202 falls reported from the Altnagelvin Hospital site and 163 reported from South West Acute Hospital (SWAH). This is an increase when compared with Q3 in 2024. The majority of people who experience a fall in Trust inpatient settings fall once (423 patients). However, there were 20 patients who fell twice and 2 patients who experienced 3 falls and 4 patients fell five or more times within hospital inpatient settings.

In Q3, 10 patients sustained injuries resulting in moderate and above levels of harm; this is a reduction from 12 reported in Q3 2024.

40% of incidents reported where patients sustained injuries resulting in moderate / above levels of harm following a fall occurred in Altnagelvin Hospital's ED. This ED is experiencing many challenges with high demand and a lack of appropriate space for treating patients. Many patients requiring admission to hospital are remaining in the ED for several days before transfer to a ward setting. Between June 2024 and November 2025, there were 183 falls reported from Altnagelvin Hospital's ED. During the same period, SWAH ED reported 70 falls.

Challenges in relation to patient flow from hospital wards to community care settings increase the risk of hospital acquired infections and deconditioning which in turn increases risk of patient falls.

Several patients, medically optimised for hospital discharge have experienced recurrent falls within acute hospital care settings.

Table 1. Rate of falls per thousand bed days.

Quarter	Rate per 1,000 bed days for No. of Falls	Rate per 1,000 bed days for No. of Falls resulting in harm (Moderate Major or Catastrophic)
Quarter 1 2020/21	7.00	0.14
Quarter 2 2020/21	6.24	0.22
Quarter 3 2020/21	7.45	0.13
Quarter 4 2020/21	8.02	0.11
Quarter 1 2021/22	6.19	0.02
Quarter 2 2021/22	5.87	0.02
Quarter 3 2021/22	6.25	0.09
Quarter 4 2021/22	7.51	0.13
Quarter 1 2022/23	6.61	0.10
Quarter 2 2022/23	7.07	0.14
Quarter 3 2022/23	6.55	0.14
Quarter 4 2022/23	5.70	0.21
Quarter 1 2023/24	6.21	0.04
Quarter 2 2023/24	5.34	0.10
Quarter 3 2023/24	6.38	0.05
Quarter 4 2023/24	6.47	0.11
Quarter 1 2024/25	6.02	0.11

Unfortunately, there are no further figures to add to table 1, as there is no data on the PHA site after Q1 2024/25.

Within the Trust there is a positive incident reporting culture in relation to fall incidents and a willingness to learn from incidents. However, there are ongoing challenges in relation to the correct grading of fall incidents where a fall has resulted in patient harm.

Regionally, falls leads working with the PHA, have re-shared guidance to support staff with the correct grading of fall incidents. In September, the PHA shared the guidance on the correct grading of fall incidents in the Regional Learning from Falls Newsletter.

The FIPC has re-shared the guidance on the correct grading of fall incidents across different staff forums within the Trust to ensure this information reaches clinical staff. This information is also available for staff to access on the Falls Integrated Pathway SharePoint site.

The FIPC continues to support new Ward Sisters / Charge Nurses upon request with completing post falls reviews where fall incidents have resulted in moderate and above levels of harm within inpatient settings.

Various Trust forums share learning from fall incidents resulting in moderate and above levels of harm with staff. Staff have been encouraged to use shared learning from incident reports to inform improvement work within their areas. Shared learning informs falls improvement work both within the Trust and across the region.

The PHA does a thematic analysis of shared learning from incidents resulting in moderate and above levels of patient harm from across the region. Themes emerging are included in the learning from falls newsletter and used to inform regional falls improvement work plans.

The FIPC supports a number of regional work-streams including the Regional Inpatient Falls group chaired by the PHA; the Safer Mobility work including a regional task and finish group set up to review existing information and resources in relation to falls. The FIPC is chairing the Regional Encompass optimisation meetings. This group consists of falls leads regionally and a workflow analyst from encompass. They are reviewing existing documentation in relation to falls within the encompass digital system, introduced in May 2025. Changes made aim to support staff in the delivery of safe patient care whilst meeting best practice guidelines.

Amendments have been made to the inpatient falls risk assessment document to make it more accessible and user friendly for staff whilst reducing duplication. Work is ongoing on the production of tip sheets for staff in relation to locating and completing inpatient falls risk assessment documentation and other flow sheets used to support staff caring for patients at risk of falling.

Falls Audit

Whilst some areas have had improvements in performance in relation to Key Performance Indicators (KPIs), there are a number of areas where there is a need for improvement in relation to the revised KPIs for falls.

Within the encompass digital system there is an Inpatient KPI dashboard with falls metrics. The data in this dashboard is still in validation and therefore information in the dashboard cannot be used as official statistics at this time.

Regionally the Royal College of Physicians FallSafe care bundle audits have been replaced by revised KPIs for falls. Since September 2025, wards who would have previously completed the FallSafe Bundle within the Trust have been asked to manually audit 5 charts per month until the digital report build is complete to audit compliance and provide assurance using the revised KPI tool.

The FIPC has worked collaboratively with falls leads for inpatient settings across the region to produce a regional training resource for Nursing Staff working in Adult inpatient settings. The Regional training relates to the revised KPIs for falls. Work is ongoing towards having the training approved for regional use and accessible to all staff through the HSC learn platform.

Wards reporting the highest number of fall incidents between June 2024 and November 2025 continue to be wards where there are single occupancy rooms where the majority of patients are elderly, acutely unwell, living with high levels of frailty including cognitive impairment. Many acute care of the elderly wards are escalated beyond capacity as a number of patients await care in the community. This has been identified as a contributing factor in some fall incidents.

Many of the patients in these settings are confused, unsteady on their feet and require close supervision or assistance for safe mobility. Some attempt to mobilise independently and do not use their call bell to alert staff of their need for assistance.

Single occupancy wards, escalation spaces, ward / department lay outs combined with staffing challenges make patient observation difficult in some wards. It is essential for staff to know these risks when patients are transferring between wards / departments to support patient safety measures in the provision of care.

Since the introduction of the digital health care system, changes in ICT systems and the removal of PHA funding for the ED Project Worker role, there have been challenges in obtaining the information relating to ED attendances following a fall. Work is ongoing to explore how the digital system can support with the delivery of this information.

The FIPC visited wards during falls awareness week to share falls prevention information packs with wards. Different staff forums shared the information packs with staff. As part of regional work, the FIPC will be working with the PHA, Service Users and regional colleagues to review existing information and resources with a view to streamlining existing resources and developing regional resources within a task and finish group.

The 'revised' minimum dataset developed by the Regional Falls Collaborative, is used to identify shared learning from fall incidents within in patient settings. It is implemented in 4 of the 5 Trust across the region. The Western Trust has not adopted the 'revised' minimum

dataset at this time. The Trust continues to use the previously agreed minimum dataset within the post-fall review section of datix to investigate fall incidents resulting in moderate and above levels of harm for shared learning.

The 'revised' minimum dataset document is lengthy and to complete the document would put additional demands on ward managers and lead nurse time. Unlike other Trusts across the region, the Western Trust does not have a funded resource to support with post fall reviews. To implement the 'revised' minimum dataset adds duplication of effort and additional paperwork to nursing workloads.

The FIPC continues to support regional work streams for encompass optimisation and encompass Benefits, to ensure the falls documentation supports staff in the delivery of safe patient care. Work is ongoing in relation to producing tip sheets for staff using the encompass system.

Work is also ongoing with the Senior Project Officer from encompass in relation to the benefits of encompass in relation to preventing falls. This encompass benefit is undergoing a regional challenge.

Trust staff continue to work collaboratively with the Healthy Living Centres to deliver the Stepping on Strength and Balance programmes across the Trust. Between September and November 2025, there were five programmes.

There were five follow on OTAGO programmes delivered by the Healthy Living Centres between September and November across Trust areas with 79 people attending. A follow on OTAGO programme in Limavady will commence in January 2026.

The Care Home Support Team continues to support Independent Sector Care Homes with the delivery of falls training. Falls improvement work across 3 independent sector care homes with the development of fall champion roles over the past year has been extended to include a further 3 care homes this year.

The FIPC continues to meet with care home managers and social workers to discuss residents who are having recurrent falls. Themes emerging inform recommendations in relation to resident care, staffing, training needs and ways of working.

The FIPC has delivered Falls Awareness Sessions and shared information resources with a number of community groups.

During Positive Aging month, the FIPC worked collaboratively with the Head of Service for Intermediate Care and staff from the Intermediate Care service to deliver an information event in Foyle Arena.

The FIPC has recently been receiving requests for assistance from Northern Ireland Fire & Rescue Service following fire safety checks. Without additional investment in staffing, there is not capacity within the existing Falls Integrated Pathway staffing resource to provide a follow up service to these referrals.

The falls awareness questionnaire to support with earlier intervention through self-assessment continues to be encouraged. People access the questionnaire through a QR or short URL code. The questions and information support with self-assessment, providing information to help develop an action plan, which will support them to stay independent for longer. The questionnaire has the potential to support with identifying people in the general population who could benefit from follow up at a falls prevention service if this was available within the Trust.

Health Improvement staff have delivered the 10 contracted falls awareness sessions for 2025-26 and are delivering additional sessions upon request. Feedback from Falls Awareness sessions delivered by Health Improvement and the FIPC has been very positive with people attending reporting increased confidence to reduce their risk of falling by making changes to their home environment and planning to increase levels of physical activity.

The majority of people attending these sessions are not achieving the *World Health Organisation guidelines on physical activity and sedentary behaviour*. The guidelines recommend 150-300 minutes of moderate-intensity or 75-150 minutes of vigorous-intensity physical activity for adults. Additionally, the guidelines recommend regular muscle-strengthening activity for all age groups and the reduction in sedentary behaviours across all age groups and abilities.

Health Improvement and Trust Communications continued to support with the sharing of falls prevention messaging through Trust social media channels.

Patients and carers continue to share their experience of services received through care opinion with seven stories shared through the Care Opinion website.

None of the stories criticised services received, however improvements to waiting times between ED and admission to a ward setting was a theme emerging from stories shared. Stories were shared from a range of service areas included the emergency department, acute hospital wards, and minor injuries units.

Themes emerging on care opinion are shared with staff through different Trust meetings.

The Falls Integrated Pathway uses the information to inform staff training and improvement work.

The FallSafe Bundle was not used post the introduction of the encompass digital system on 8th May 2025