Pwyllgor Ansawdd, Diogelwch a Phrofiad/ Quality, Safety and Experience Committee

DYDDIAD Y CYFARFOD: DATE OF MEETING:	11 AUGUST 2026
TEITL YR ADRODDIAD: TITLE OF REPORT:	Inpatient Falls Assurance Report
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Sharon Daniel - Executive Director of Nursing, Quality and Patient Experience
SWYDDOG ADRODD: REPORTING OFFICER:	Anna Chiffi - Assistant Director of Nursing, Quality and Patient Safety

Pwrpas yr Adroddiad (dewiswch fel yn addas) **Purpose of the Report** (select as appropriate)
Er Sicrwydd/ For Assurance

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

This report provides the Quality, Safety and Experience Committee (QSEC) with an annual update on the work of the Inpatient Falls Group, now transitioning towards a system-wide Safer Mobilisation Group, to strengthen strategic leadership, oversight and assurance across the whole care pathway. The report is presented to enable QSEC to take assurance on current performance, improvement activity and governance, and to support the next phase of system-wide transformation.

Whilst improvement activity is well established and examples of positive practice are evident, ongoing variation in compliance, workforce pressures and patient complexity continue to present risks that require focused action during 2026/27.

Cefndir / Background

The Inpatient Falls Group has operated throughout 2025/26 as the principal forum for oversight of falls prevention, management and learning. Chairing the Group transitioned to Assistant Director of Nursing – Patient Safety & Quality in April 2025, providing senior clinical leadership and clear accountability for delivery and assurance.

Over the course of the year, the Group has evolved from a predominantly inpatient-focused model towards a whole-system safer mobilisation approach, reflecting national direction and local learning.

The revised Terms of Reference establish the Group as providing strategic leadership, system-wide oversight and robust assurance, with a clear emphasis on prevention, early intervention, and reduction of deconditioning-related harm.

The Group's scope now extends across the full patient pathway, including community, acute, rehabilitation, long-term care and chronic disease management, ensuring a consistent and integrated approach to falls prevention and mobilisation.

Minutes across the reporting period demonstrate a progressive shift in focus, including:

- Recognition of duplication and the need to align with deconditioning programmes
- Agreement to broaden to a system safer mobilisation model
- Increased emphasis on multi-professional and system-wide engagement

This transition reflects both internal audit requirements and a growing understanding that inpatient falls are intrinsically linked to system-wide factors including frailty, dementia, hydration, infection and functional decline.

Asesiad / Assessment

The Health Board continues to report incidents of inpatient falls as a recurrent patient safety concern, with consistent themes identified across all sites throughout the year. Review of local intelligence and meeting discussions demonstrates increasing maturity in the organisation's ability to identify, understand and respond to contributory factors; however, variation in practice persists.

The Group has identified four recurring risks requiring continued oversight:

- Variation in completion and quality of Multifactorial Falls Risk Assessments (MFRA), across clinical areas.
- Increasing patient acuity, frailty and cognitive impairment resulting in higher falls risk.
- Workforce pressures affecting enhanced observation and supervision of vulnerable patients.
- Environmental and equipment factors, particularly during periods of escalation, boarding and flow pressure.

Whilst the Health Board continues to experience inpatient falls, there is increasing evidence of a more mature and systematic approach to prevention, scrutiny and learning. Key improvements over the reporting period include the establishment of falls learning panels, enhanced thematic review processes, increased scrutiny of contributory factors and stronger alignment with deconditioning, frailty and hydration programmes. These developments have enabled a more proactive identification of risk and targeted intervention at site level.

However, whilst governance arrangements have strengthened, available intelligence demonstrates that the principal challenge remains the consistent implementation of preventative measures at ward level. The most significant opportunities for improvement continue to relate to compliance with MFRA's post-fall reviews, documentation standards,

supervision of high-risk patients and responsive interventions for patients with cognitive impairment and delirium.

Consequently, assurance can be taken from the strengthening of systems and oversight arrangements; however, further work is required to demonstrate sustained reduction in falls incidence and variation across services.

Encouragingly, the Group has demonstrated increasing system-wide learning and improvement capability. The establishment of falls learning panels, structured audit processes, and quality improvement (QI) initiatives has enabled more consistent identification of themes and targeted interventions. There is also evidence of innovation and local improvement, including deconditioning initiatives, hydration programmes, and environmental adaptations.

A specific example of local innovation is the decaffeinated drinks project at Bronglais Hospital (BGH), which has been implemented as part of a wider focus on hydration, nutrition and deconditioning. The initiative has explored reducing caffeine intake and increasing access to alternative and fortified fluids, with early indications suggesting improved hydration, reduced agitation in cognitively impaired patients, and a positive impact on overall patient stability. While attribution to falls reduction alone remains complex due to concurrent interventions, the project demonstrates the value of a multifactorial, person-centred approach to falls prevention, and highlights the potential for system-wide learning and scaling subject to further evaluation.

Importantly, the Group is increasingly drawing together system-wide intelligence, including incident data, audit findings and patient experience, to inform improvement priorities and reduce variation.

Total Number of falls across the care group with no harm to catastrophic harm

The graph above presents the total number of reported falls across the Care Group. Numbers have remained relatively stable over the reporting period, with the majority resulting in no or low harm. While incidents resulting in moderate, severe or catastrophic harm remain infrequent, all such events are reviewed to identify contributory factors, ensure appropriate mitigating actions are implemented, and inform ongoing improvements in safer mobilisation and falls prevention practices. The overall trend highlights the importance of maintaining a strong focus on preventative interventions, risk assessment, and learning from incidents to minimise patient harm. The transition to a safer mobilisation model represents a significant strengthening of approach. This reframes falls not as isolated events within

inpatient care, instead as a system outcome requiring coordinated prevention, early intervention, rehabilitation and recovery.

From a Safe, Timely, Effective, Efficient, Equitable and Person Centred (STEEEP) perspective:

Domain	Rating	Narrative
Safe	Amber	Robust governance and learning structures established; falls-related harm remains a significant patient safety risk.
Timely	Amber	Variation persists in early identification of risk and timely preventative interventions.
Effective	Amber	Improvement initiatives are established but not yet consistently embedded across all sites.
Efficient	Green	Duplication has reduced through alignment with deconditioning and wider improvement programmes.
Equitable	Red	Variation in practice and outcomes remains evident across sites and services.
Person-centred	Amber	Increasing focus on mobilisation, frailty and dementia care; further embedding required.

The Group is also increasingly focused on high-risk populations, including frail adults and people living with dementia, ensuring their needs are explicitly recognised within pathway design and care delivery. Priorities for 2026/2027 include:

1. Full implementation of the transition to a System-Wide Safer Mobilisation Group.
2. Improvement in compliance with MFRA and post-fall review standards.
3. Reduction in variation across sites through standardised audit and assurance processes.
4. Strengthened integration with frailty, dementia, delirium, hydration and deconditioning programmes.
5. Development of outcome measures to monitor falls incidence, harm severity and patient experience more effectively.
6. Increased patient and family involvement in falls prevention improvement work.

Overall, the Health Board should take moderate assurance that governance, leadership and system-wide oversight arrangements are strengthening and that significant progress has been made in transitioning from a traditional inpatient falls model to a broader safer mobilisation approach. However, recurrent themes relating to workforce capacity, patient frailty, cognitive impairment and variation in clinical practice continue to limit the pace of improvement. The priorities identified for 2026/27 are intended to strengthen implementation, improve consistency and support a measurable reduction in falls-related harm across the Health Board.

Argymhelliad / Recommendation

The Committee is asked to:

- Receive assurance from the strengthening of governance, system-wide oversight and improvement activity, including implementation of the Safer Mobilisation Group and the transition to a fully integrated, prevention-focused approach to reducing falls-related harm.
- Note the ongoing risks relating to variation in clinical practice, workforce capacity and compliance with key assessment and documentation requirements.

Amcanion: (rhaid cwblhau) **Objectives: (must be completed)**	
Cyfeirnod Cylch Gorchwyl y Pwyllgor: Committee ToR Reference:	3.8 Provide assurance to the Board that current and emerging clinical risks are identified and robust management plans are in place and any learning from concerns is applied to these risks as part of this management.
Cyfeirnod Cofrestr Risg Datix, Teitl a Sgôr Risg Cyfredol: Datix Risk Register Reference and Score:	
Parthau Ansawdd: Domains of Quality Quality and Engagement Act (sharepoint.com)	7. All apply
Galluogwyr Ansawdd: Enablers of Quality: Quality and Engagement Act (sharepoint.com)	5. Whole systems persepctive
Amcanion Strategol y BIP: UHB Strategic Objectives:	3. Great care
Nodau Cynllunio 2026/27 Planning Goals 2026/27	6. Safe, Timely, High Quality Care
Hypergyswllt i Amcanion Llesiant HDdUHB 2026 Hyperlink to HDdUHB Well-being Objectives 2026	10. Not Applicable

Model Cymdeithasol ar gyfer Iechyd a Llesiant: (wedi'i gwblhau ar gyfer newid strategol a/neu newidiadau sylweddol i wasanaethau) A Social Model for Health and Wellbeing: (*complete for strategic change and/or significant service changes)*	5. A more preventative approach, including earlier identification and intervention, will be taken to support people to maintain and improve their health and wellbeing.
Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	Contained within the body of the report
Rhestr Termau: Glossary of Terms:	Contained within the body of the report
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y cyfarfod hwn: Parties / Committees consulted prior to this meeting:	Inpatient Falls Group

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: Financial / Service:	Not applicable
Ansawdd / Gofal Claf: Quality / Patient Care:	Contained within the report
Gweithlu: Workforce:	Not applicable
Tegwch Iechyd: Health Equity:	Not applicable
Risg: Risk:	Not applicable
Cyfreithiol: Legal:	Not applicable
Enw Da: Reputational:	Not applicable
Gyfrinachedd: Privacy:	Not applicable

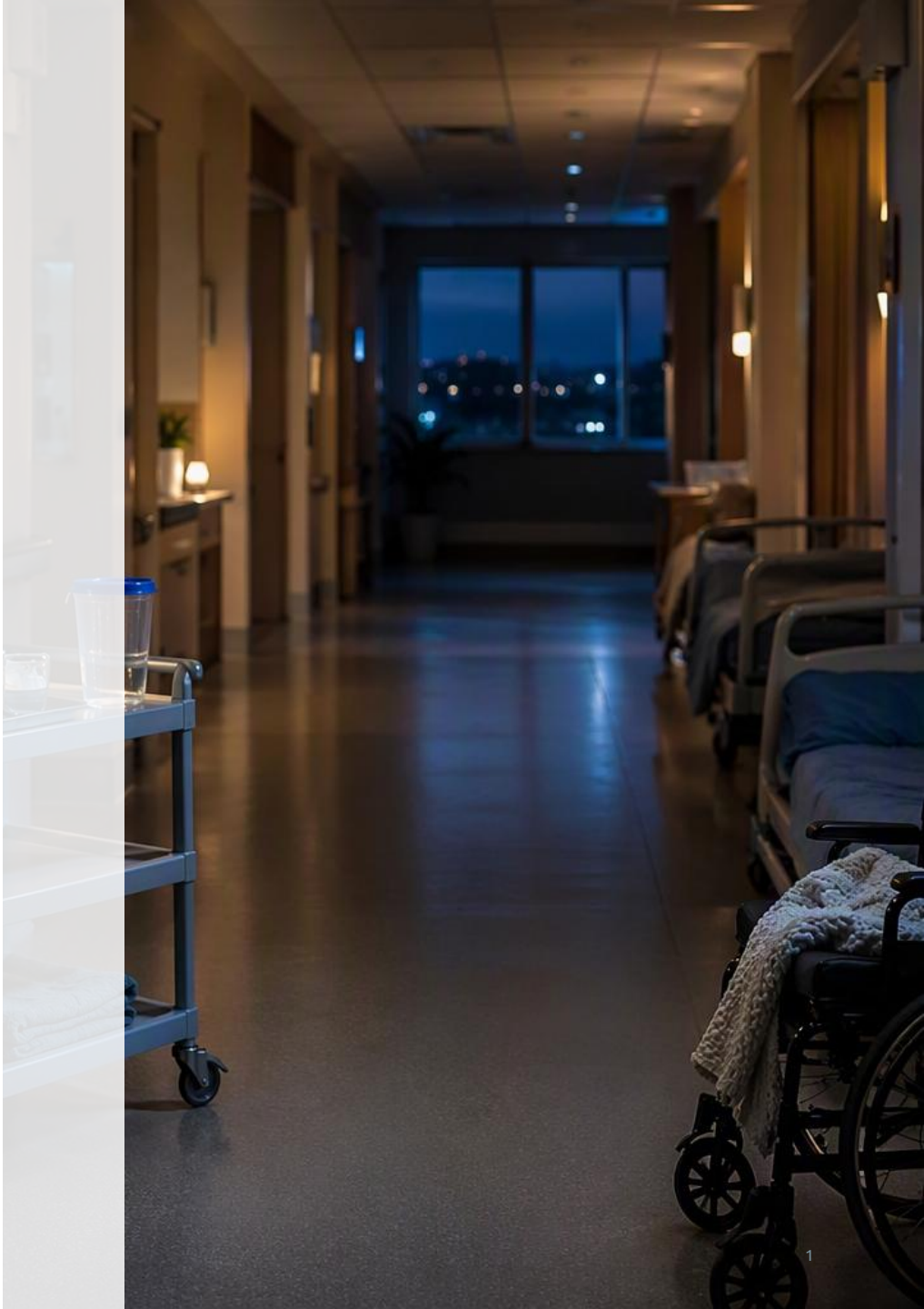
Cydraddoldeb: Equality:	Not applicable

Patient story

Decaffeinated drinks project

Bronglais General Hospital

A composite patient story showing how a clinically initiated change, informed by an emerging evidence base, offers decaffeinated drinks as the default option while preserving patient choice.



Draft narrative for governance, quality improvement and patient experience discussion | clinically initiated project

Meet “Mrs E”

A composite, anonymised patient story reflecting a clinically initiated project, informed by emerging ev

Mrs E is admitted to Bronglais following a fall at home. On admission, she is offered decaffeinated tea and coffee as the default option, with caffeinated drinks still available if preferred or clinically appropriate.

This project was clinically initiated by staff in response to emerging evidence around caffeine, nocturia, sleep, agitation and falls risk.

> *“Being offered decaf as the default made it easier, and I still had a choice.*

Purpose: person-centred care

Lens: comfort, safety, dignity

What mattered to the patient

The story starts with clinical curiosity, emerging evidence and a consistent default offer

Why staff initiated the project

- Clinical staff identified emerging evidence linking caffeine reduction with reduced bladder irritation/nocturia, improved sleep and potential falls prevention benefits.
- The project was therefore framed as proactive quality improvement, rather than a response to a single patient request.
- Decaffeinated drinks were offered as the default, with patient choice and personalised clinical judgement maintained.
- Staff used the admission and falls-risk conversation to consider caffeine intake as one modifiable factor within wider safer mobilisation work.

Key point: the project is clinically led and evidence-informed, with decaf as the default and choice preserved.

The clinically initiated change

Decaffeinated drinks offered as the default, informed by emerging evidence and clinical judgement

Project approach

- Clinical staff initiate the default decaf offer as part of a proactive safety and quality improvement project.
- Use seven drinks rounds per day as the routine delivery point, with caffeinated drinks available if requested or clinically indicated.
- Promote hydration and fortified options where clinically appropriate.
- Discuss caffeine intake when completing the falls risk assessment on admission.

Clinically initiated

Default decaf, choice maintained

What changed for Mrs E

Patient experience benefits aligned to safer mobilisation and hydration

Comfort

The default offer was clinically led rather than dependent on Mrs E knowing to ask.

Dignity

Staff explained the rationale and preserved Mrs E’s individual choice.

Confidence

She felt reassured that the team were thinking proactively about night-time comfort and safety.

Safety

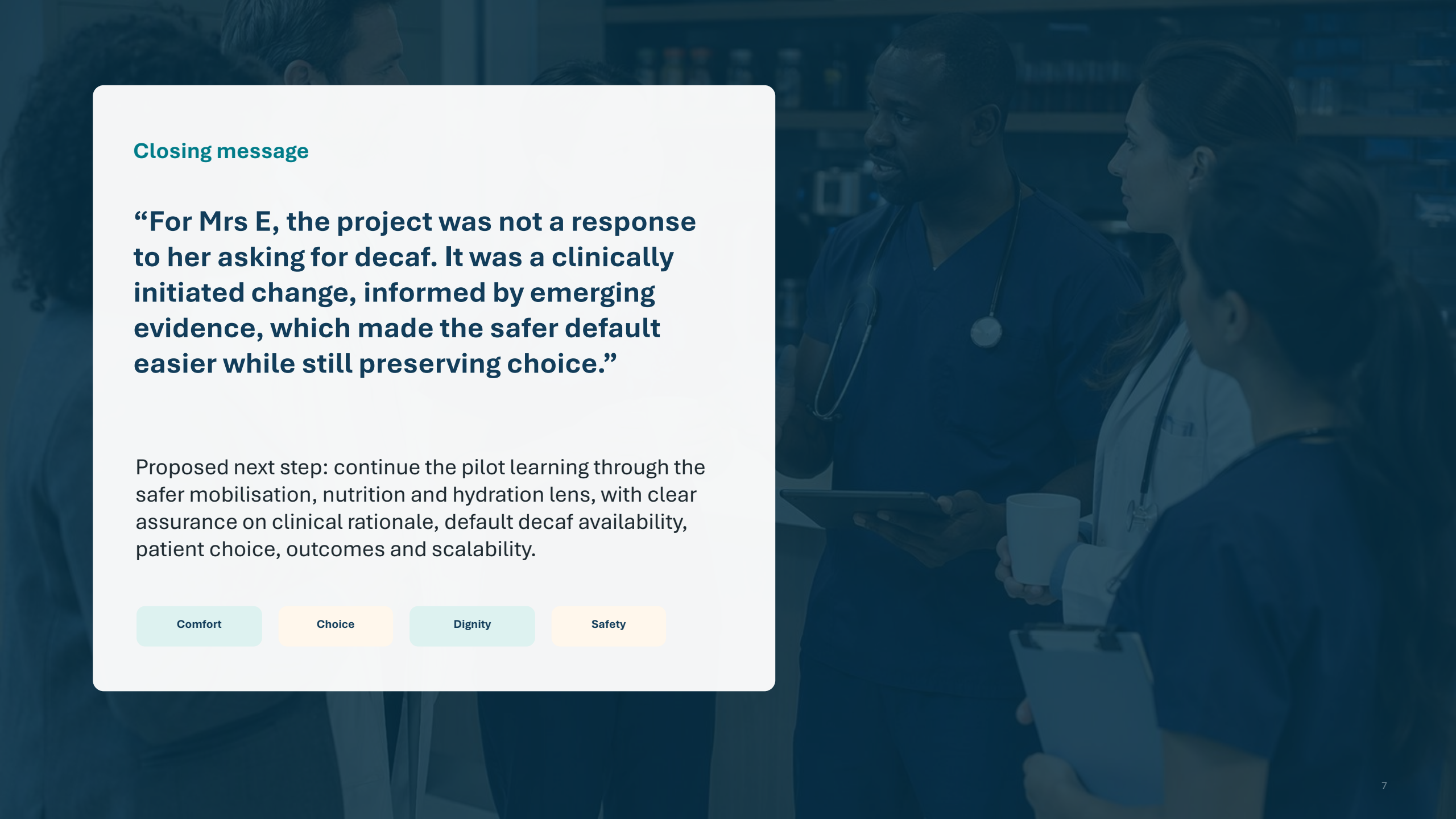
The conversation linked hydration, continence, sleep and safer mobilisation as part of wider falls prevention.

Assurance and learning

How to evidence, govern and scale a clinically led improvement

Next Steps

- Confirm consistent availability of decaffeinated drinks as the default option across clinical areas.
- Capture staff and patient feedback on acceptability, choice, comfort and implementation barriers.
- Monitor relevant safety signals alongside other falls and safer mobilisation interventions, recognising attribution will be multifactorial.
- Clarify supply, cost and operational constraints with facilities and catering colleagues.
- Define when caffeinated drinks remain the right personalised or clinically indicated choice.



Closing message

“For Mrs E, the project was not a response to her asking for decaf. It was a clinically initiated change, informed by emerging evidence, which made the safer default easier while still preserving choice.”

Proposed next step: continue the pilot learning through the safer mobilisation, nutrition and hydration lens, with clear assurance on clinical rationale, default decaf availability, patient choice, outcomes and scalability.

Comfort | Choice | Dignity | Safety