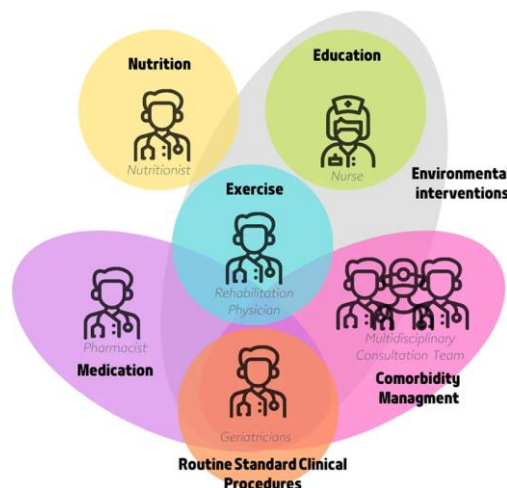


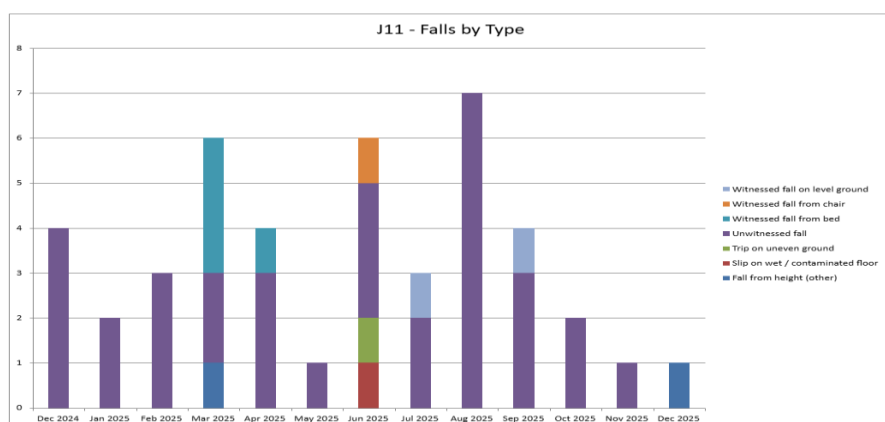
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Background: Ward J11 experienced a rise in inpatient falls following a shift from respiratory to older people's medicine, contributing to consistently high monthly fall numbers. Despite enhanced care, wellbeing initiatives, audits and safety huddles, incidents did not reduce, highlighting the need for a multifactorial approach addressing medication risk and cross-disciplinary collaboration.

Method: The use of Leeds Improvement Method (LIM) was used to develop PDSA cycles for this test of change, starting with Genba's to understand the problem and utilising available data sets to assess the KPI baseline and instigate nursing-led tests of change which progressed to collaborating with pharmacy to develop standard work for inpatient medication reviews. The new process included routine medication reviews for all new admissions, leading to the creation of standard work to ensure consistent MDT review processes. Proactive identification of medications contributing to inpatient falls created a more robust mistake proofing concept improving from end of line to successive checks. This contributed to not only the timely communication of potential harm via safety huddles and MDT meetings but also, empowered staff to have more involvement in individual patients care prior to a fall happening.



Results: Medication reviews led to a reduction in falls from six incidents per month to one within the first month (J11 Datix Incidents 2025), with improvements sustained for three consecutive months. Additional benefits included improved MDT collaboration, earlier identification of high-risk patients, reduced reliance on enhanced care, increased staff autonomy and higher morale across the ward team.



Intervention implemented August 2025.

Conclusion:

Implementation of multifactorial interventions to reduce inpatient falls using all members of the multidisciplinary team alongside strong communication can contribute to a reduction in inpatient falls. This intervention leads to an increase in patient safety and overall patient experience.

Reference: NHS England (2021) Patient Safety Alert: Falls Prevention. NHS England. Available at: [https://www.england.nhs.uk/patient-safety/patient-safety-improvement-programmes/Leeds Teaching Hospitals NHS Trust](https://www.england.nhs.uk/patient-safety/patient-safety-improvement-programmes/Leeds%20Teaching%20Hospitals%20NHS%20Trust) (2023) The Leeds Improvement Method. LHT. Available at: [https://www.leedsth.nhs.uk/about/the-leeds-way/leeds-improvement-method/Oliver D et al. \(2007\) 'Strategies to prevent falls and fractures in hospitals and care homes', BMJ, 334:82. Available at: View BMJ article \[bmj.com\]National Institute for Health and Care Excellence \(2025\) Falls: assessment and prevention in older people \(NG249\). NICE. Available at: View NICE guideline NG249 \[nice.org.uk\]Royal Pharmaceutical Society \(2013\) Medicines optimisation: helping patients to make the most of medicines. RPS. Available at: <https://www.rpharms.com/Portals/0/RPS%20document%20library/Open%20access/Policy/helping-patients-make-the-most-of-their-medicines.pdf>](https://www.leedsth.nhs.uk/about/the-leeds-way/leeds-improvement-method/Oliver%20D%20et%20al.%20(2007)%20'Strategies%20to%20prevent%20falls%20and%20fractures%20in%20hospitals%20and%20care%20homes'%20BMJ%20334:82.%20Available%20at:%20View%20BMJ%20article%20[bmj.com]National%20Institute%20for%20Health%20and%20Care%20Excellence%20(2025)%20Falls:%20assessment%20and%20prevention%20in%20older%20people%20(NG249).%20NICE.%20Available%20at:%20View%20NICE%20guideline%20NG249%20[nice.org.uk]Royal%20Pharmaceutical%20Society%20(2013)%20Medicines%20optimisation:%20helping%20patients%20to%20make%20the%20most%20of%20medicines.%20RPS.%20Available%20at:%20https://www.rpharms.com/Portals/0/RPS%20document%20library/Open%20access/Policy/helping-patients-make-the-most-of-their-medicines.pdf)