

# LEADING BETTER VALUE CARE



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VALUE CARE



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# LEADING BETTER VALUE CARE

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 **Falls in Hospitals | CEC**

 Management of Osteoarthritis – OACCP | ACI

 Osteoporotic Refracture Prevention – ORP | ACI

 Diabetes High Risk Foot Services – HRFS | ACI

 Diabetes Mellitus | ACI

 Chronic Heart Failure – CHF | ACI

 Chronic Obstructive Pulmonary Disease – COPD | ACI

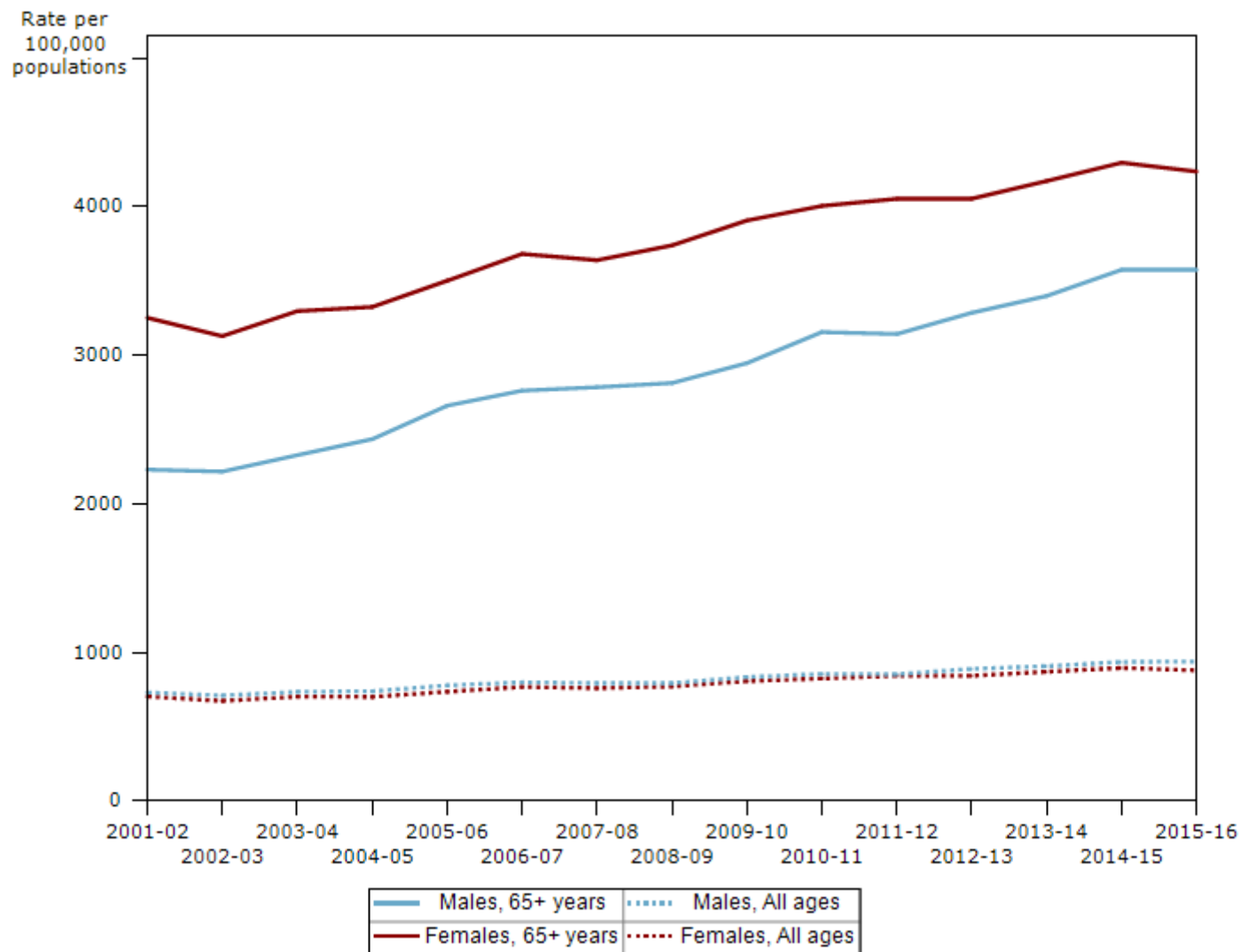
 Renal Supportive Care: End Stage Kidney Disease | ACI

# FALLS COLLABORATIVE

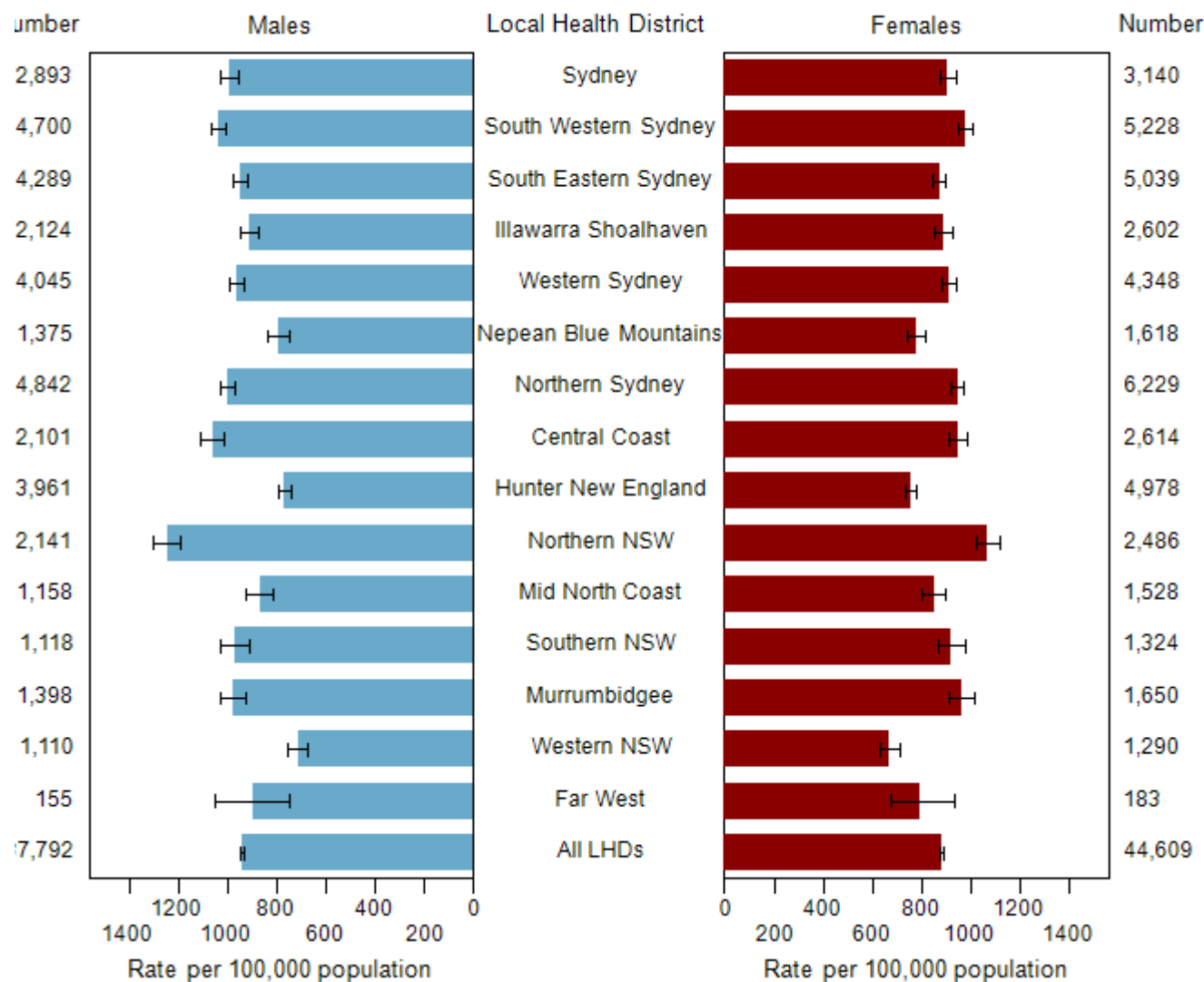
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- Significant harm to patients
- In 2016, there were 38 SAC1 and 458 SAC 2 falls across NSW
- Risk of harm from falls increases with:
  - Age
  - Medications
  - Reducing cognitive function
  - Functional decline
- Many falls are preventable
- NSW Falls prevention program for last 12 years
- Unwarranted variation in clinical practice and outcomes

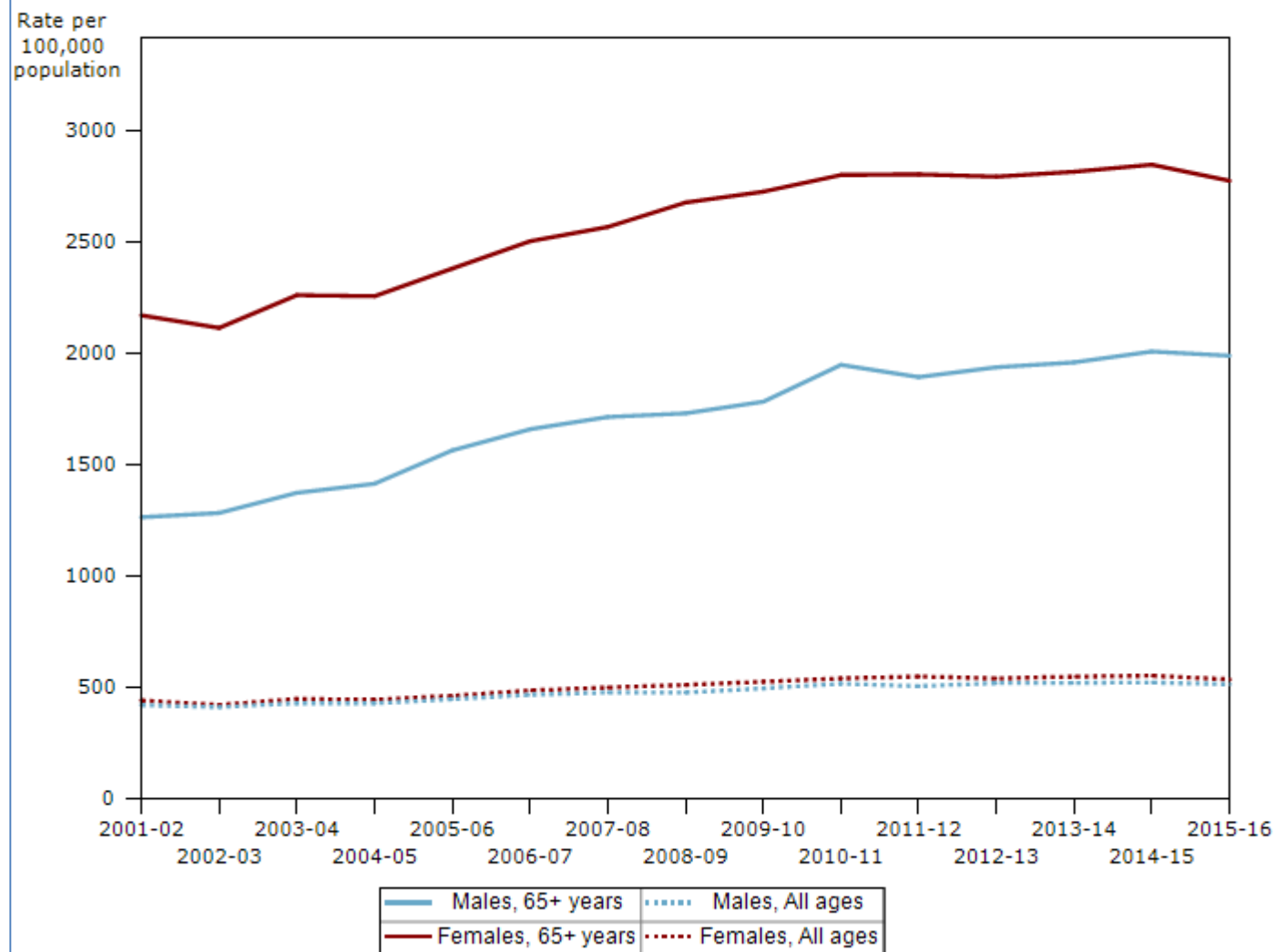
# Fall-related hospitalisations, persons of all ages and 65 years and over, NSW 2001-02 to 2015-16



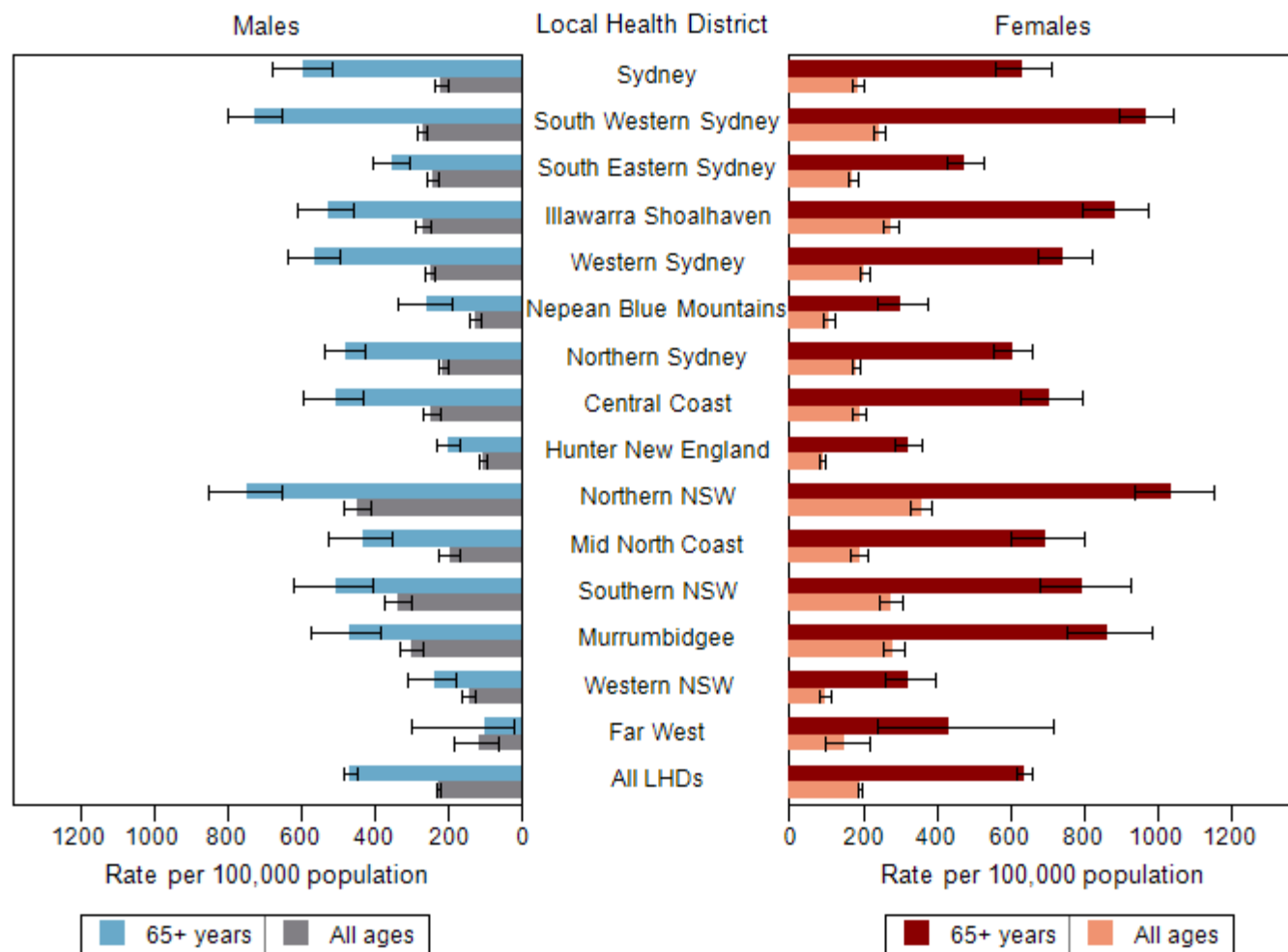
# Fall-related hospitalisations by Local Health District, persons aged: All ages, NSW 2015-16



Fall-related injury hospitalisations, persons of all ages and 65 and over,  
Hospital stay: Overnight stay, NSW 2001-02 to 2015-16



# Fall-related injury hospitalisations by Local Health District, Hospital stay: Day only stay, NSW 2015-16

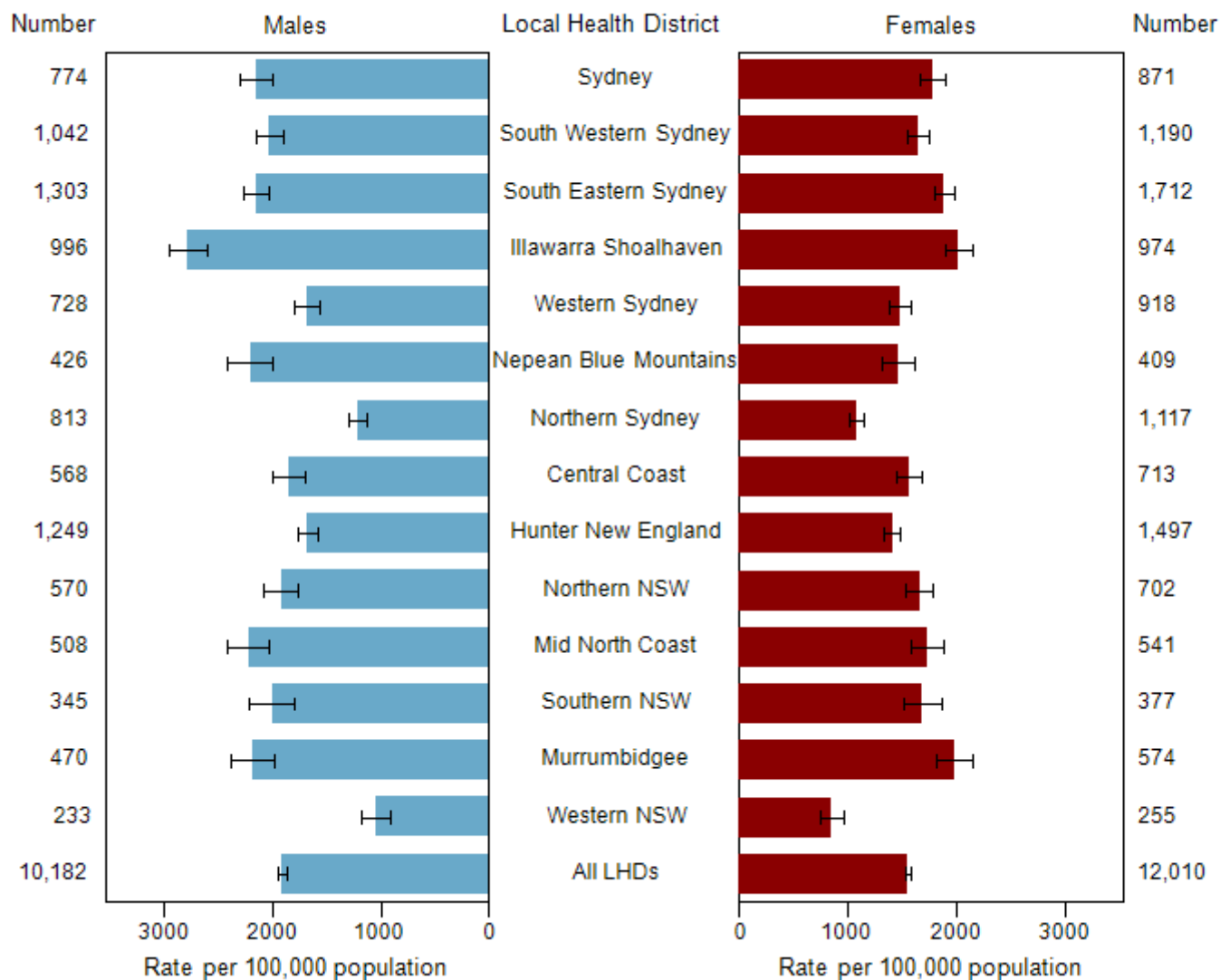


Dementia as a Principal diagnosis or Comorbidity, hospitalisations by age, persons aged 65 and over,  
NSW 2001-02 to 2015-16





Dementia as a principal diagnosis or as a comorbidity,  
hospitalisations by Local Health District, persons aged 65 and over, NSW 2015-16



# FALLS COLLABORATIVE

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*‘Keeping older people safe in our care’*

Aim: Reduce falls and serious harm from falls by 5% within 12 months

(ACSQHC: Hospital Acquired Complications List: serious falls - #nof, other #s and head injury)

Inclusions: Age  $\geq 70$  years

Inpatients in a health service

All falls which result in a person coming to rest inadvertently on the ground or floor or lower level, including partial or assisted falls

Exclusions: Staff, visitors

# FALLS COLLABORATIVE

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- 12 month Statewide Quality Improvement Collaborative
- 3 one day learning sets over 12 months
- Multidisciplinary clinical teams
- Focus on key interventions – change package
- Monthly 1:1 coaching for teams
- Link LHD/SHN teams and NSW Falls Co-ordinators
- Quality Improvement Database System (QIDS)
- Hospital team data to drive continuous improvement

# *Keeping Older People Safe in Our Care*

## *Leadership and culture*

- **Boards:** leading through strategic direction, governance, risk management, financial and quality and safety
- **Executive:** building capability and supporting frontline teams in improvement
- **Expert clinical/improvement leads and teams:** nursing, medical and allied health improve clinical processes
- **All ward staff:** practice reliable falls prevention/care



# FALLS COLLABORATIVE

Patient/family  
carer at the  
centre of care



Christine Ewin  
sharing her story  
with Niccola Follett  
(Falls Co-ordinator)  
about her journey  
with her mother  
Mrs Dean

# Key Strategies

- ***Delirium/Dementia:*** systems in place to screen and manage Promoting resources from the ACI networks, and the ACSQHC.
- ***Mobility:*** Systems in place to mobilise patients safely. CEC safe mobilisation resources.
- ***Medications*** – review, reconciliation and reduce, where feasible: antipsychotics, antidepressants, sedatives/hypnotics, opioids and others. CEC Medication reconciliation toolkit.
- ***Intentional rounding and multidisciplinary team rounds:*** CEC In Safe Hands and team effectiveness assistance.
- ***Huddles and clinical handover:*** proactive, regular ward/hospital huddles as well as post fall huddles. CEC safety and post fall huddle knowledge and tools.

# FALLS CHANGE PACKAGE

## Falls Collaborative Driver Diagram

### The Problem:

In 2016, 38 patients died in NSW public hospitals following a fall-related incident. In addition, there were 458 fall-related incidents resulting in serious patient harm

**SMART Aim:** Reduce falls and serious harm from falls by 5% within 12 months

### **Outcome Measure:**

**How much:** Decrease rate of falls with harm by 5% by 30 June 2018.

*Inclusions: Age  $\geq 70$  years  
Inpatients in a health service  
Partial and assisted falls*

*Exclusions: Staff, visitors.*



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## Primary Drivers

Recognition of patient at risk and plan of care

Medication Management

Intentional Rounding

Safe mobilisation

## Secondary Drivers

Fall Risk Screening tool (OMSS)

Fall Risk and Assessment Management Plan (FRAMP) completion

Cognitive screening

Delirium screening

Orthostatic hypotension screening and monitoring

Issues with toileting

Identification of visual issues

Re-screening on change of patient condition, transfer to ward

Post fall management

Completion of care plan

Medication review

Medication reconciliation

Reduction of the inappropriate use night sedation

Patient Environment

Toileting

Pain management

Patient positioning

Mobility assessment

Appropriate equipment

Skilled Nurse / AHP

Environmental review

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## Primary Drivers

Teamwork

Documentation

Education

Leadership

Communication

Culture

## Secondary Drivers

Safety Huddles

Post Fall Huddles

Multidisciplinary Team Rounds

Screen documentation

FRAMP documentation

Multidisciplinary Care plan documentation

Education Framework

Education Strategy

Education for Nurses

Education for Allied Health

Resources and tools

Education for Pharmacists

Education for Medical Officers

Executive walk-arounds attendance

QI Coaching attendance

QI Collaborative attendance

Provide a supportive environment to raise concerns

Prioritise the service focus

Support effective teamwork

Communication Framework

Communication Strategy

Communication ward to Board

Communication with Senior Clinicians

Communication with junior medical officers, nurses & AH

Communication with patients

Staff pre-survey

Staff post-survey



# FALLS COLLABORATIVE

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Learning Set 1 – 25 October 2017

46 teams across NSW

