IMPLEMENTATION OF A SAFETY HUDDLE FOR FALLS AND NEAR MISS FALLS

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Camden Rehabilitation Unit

- 20 Bed Sub Acute Unit
- Complex Fracture NOF’s, CVA, General Deconditioned Patients
- Average Length of Stay approximately 24 days
Safety Huddle

- NUM Led Multidisciplinary review of a Fall or Near Miss
- Involving Team and the patient
- Incidents / Near Misses are identified
- Documentation of Incident / Near Miss and the Recommendations / Plan
Principles of the Safety Huddle

- Prepare the patient (NUM)
- Introduction
- Description of the Fall / near fall by the patient
- Apologise
- Brainstorm with the team and the patient
- Document Plan
- Handover
Documentation

- Heading Safety Huddle and Incident
- Who is present
- Description of Incident “using patients own words” if possible
- Plan / Recommendations
Safety Huddle Documentation

Safety Huddle:

Date: 23/5/2014 Time: 0835hrs

Incident or Near Miss (please circle)

Date of Incident or Near Miss: 23/5/2014 0025hrs

Present:

Present: [Name] / [Pt's Daughter] / [Others]

NUM or T/L: [Name]

Medical Staff: [Name]

Nursing Staff: [Name]

Allied Health: [Name]/[ST]

Findings and Recommended Actions below in progress notes:

Incident Description - Fall overnight at 0025hrs:

Patient described "tried to go to toilet, light was off in bathroom, I couldn't see the clock" did not use rollator frame - "I got out of bed between the bed rail and the end of the bed, the bed rails were up."

Apology provided to the patient.

Recommendations:

1. Falls alarm 24/7 magnet style clothing alarm patient and daughter agreeable.
2. Bathroom door adjac with light on - patient then able to see clock.
3. Rollator frame positioned at gap at the end of the bed on toilet side.
4. Urinal on bedside tray close to patient (this was in place on the right of the fall)
5. Buzzer in reach (was in place)
6. Formal physio review.

[Signature] (Lane room)
Safety Huddle in Action
Results

Zero patients have had a repeat fall since the implementation of the Safety Huddle. (October 2013 to May 10th 2015)

2012 – 2 patients had repeat falls
2013 – 2 patient had repeat falls
Results

Camden Rehabilitation Unit
Falls Per Year 2011 to 2014

Year to date for 2015 – 5 Falls to 8th May 2015.
Pre Safety Huddle

Pre-huddle (2011-2013)
Mean: 4.2 (SD: 3.0) Range: 0-12.9

Number of falls per 1000 bed days

Oct Nov Dec Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb
Post Safety Huddle

Number of falls per 1000 bed days

- Post-huddle (2013-2015)
  - Mean: 2.5 (SD: 1.7)
  - Range: 0-5.4
Recommendations

- Not one strategy works to prevent falls always a combination.
- Camden Rehabilitation Unit common falls prevention strategies.
Clothing Style Magnet Alarm
Clothing Style Magnet Alarm
Chair / Bed Sensor Style Alarm
Chair / Bed Sensor Alarm
Infrared Beam Style Alarms
Beds
Safety Huddle Examples

- Patient in toilet – overbalanced fell from toilet, nurse just outside toilet giving privacy but was checking regularly

- Safety Huddle held – Patient was attempting to wipe self, lost balance and fell to floor

Options discussed, patient happy to have constant supervision in toilet and shower, and due to extreme risk agreed to soft helmet.
Unusual Fall

- Developmentally delayed patient, parent staying on ward with patient, assisting with care.
- Parent attempted to transfer patient
- Parent lowered patient to floor no injury sustained.
- Safety huddle was held
- Obvious recommendations post Safety Huddle ie Wait for assistance
These were the socks the patient was wearing.
Safety Huddles for other incidents
Safety Huddles for other incidents
The Salt Bottles

Mersyndol
Relaxo Gin (herbal medication used for sedation and calmative)
Phenergan
Patient Self Medicating

- Staff Specialist, Registrar, RMO, NUM and patient present for safety huddle
- Patient apologised for “doing the wrong thing”
- Dangers of self medicating discussed with patient
- Promised staff that he would not take any more
- Existing tablets removed with patients consent
Safety Huddle Conclusion

- Very Positive from a Managers perspective
- Feel a sense of treating incidents seriously
- Great for IIMS Management
- Honest, transparent approach to when something goes wrong
- A comfortable way to offer an apology to the patient
- To date it is reducing repeat incidents

**CORE Values** Collaboration / Openness / Respect and Empowerment
The Future

- Safety Huddle used routinely for all incidents
- Plans to Evaluate patient and staff satisfaction
- Ethics approval currently underway to formally evaluate satisfaction
- Publish Results with assistance from the Centre for Applied Nursing Research (CANR)
The Future Continued

- Preparation and development of an educational DVD for staff and other facilities on performing a Safety Huddle, and providing examples.
- Preparation of educational patient video clip on Safety Huddles as part of the orientation for patients on the ward.
- Recently Implemented on another ward at Camden, with interest from other Hospitals.
April Falls Day 2015
The Impact of Safety Huddles on Reducing Inpatient Falls in a Rehabilitation Unit

Context

A safety huddle (post-fall huddle) was implemented in a 20-bed general rehabilitation ward of a public hospital located in South Western Sydney, New South Wales, Australia.

The huddle consisted of a multidisciplinary group meeting with the patient and, where possible, their carer.

Problem

Inpatient falls are one of the most common patient safety incidents reported in rehabilitation wards[1], and can result in serious adverse patient outcomes, including permanent (physical disability and occasionally death)[2].

However, limited research has focused on including patients and their carer within a multidisciplinary approach to fall prevention, following a fall, or new fall event in rehabilitation settings.

Assessment of Problem and Analysis of Its Causes

Monthly quality assurance data indicated that despite appropriate fall risk assessment and implementing a falls risk management plan, some patients were experiencing repeat falls.

In consultation with the Local Health District falls committee, the Nurse Unit Manager (NUM) considered a solution that focused on a multidisciplinary and patient-centred approach was the most appropriate method to improve falls management in a rehabilitation setting.

Intervention

Using a participatory action research approach, falls prevention strategies were developed with the patient and their carer who partnered with staff in implementing the agreed interventions.

After determining the need for emergency care and acting accordingly, where possible the post-fall huddle meeting was convened within 1 hour of the fall event.

The following process was implemented:

1. The Nurse Unit Manager (NUM) reviewed the case of the Post-Fall Huddle Team Leader.
2. Nursing, medical and allied health staff participated in the safety huddle. The patient and carer (where possible) were also involved.
3. Staff gave an account of the occurrence of the incident.
4. The team confirmed or verified any actions from the fall event, and interventions for preventing a repeat fall were discussed by the huddle team in consultation with the patient and their carer. This process was documented (Figure 1) in the patient's file.
5. Based on analysis of the fall event, the appropriate changes modified the fall prevention plan to include interventions to prevent a repeat fall from occurring.
6. Communication of the patient's fall prevention plan occurs during handover reports.
    After the post-fall huddle, the NUM followed-up with staff and patient to ensure interventions were implemented to prevent a repeat fall occurring. The NUM also assessed any questions or concerns voiced by the patient or carer.

Study design

A participatory action research approach.

The primary outcome was the number of repeat falls and the secondary outcome was the number of falls per 1,000 occupied bed days (OBSD).

Strategy for Change

The proposal to introduce a safety huddle was presented to nursing, allied health and medical staff during the ward’s regular monthly team meeting. All staff were supportive of the proposal and eager to see the implementation of the Safety Huddle program.

Measurement of Improvement

Repeat falls and the number of falls per 1,000 OBSD in the rehabilitation unit were measured over a 10-month period (October 2013 to September 2014).

Although the overall monthly fall rates were lower, varying from 0 to 7 falls per month, the rate of repeat falls was reduced. See Figure 1.

Effects of Changes

The standardised approach of a post-fall safety huddle, including the clear documentation, resulted in my patients experiencing a repeat fall.

The approach was very well received by the multidisciplinary team and patient, particularly the participatory approach for managing fall risk.

Lessons Learnt

Safety huddles can be embedded as part of routine clinical practice to reduce repeat falls in a rehabilitation setting.

Message for Others

Safety huddles are effective in reducing repeat incident report falls in a rehabilitation setting. It is borne a multidisciplinary and patient-centred approach to patient safety incidents (e.g., medication incidents, pressure ulcer development).

References


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