



NSW Falls Prevention Program update
May 2017

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Leading Better Value Care Better Health Care Initiatives



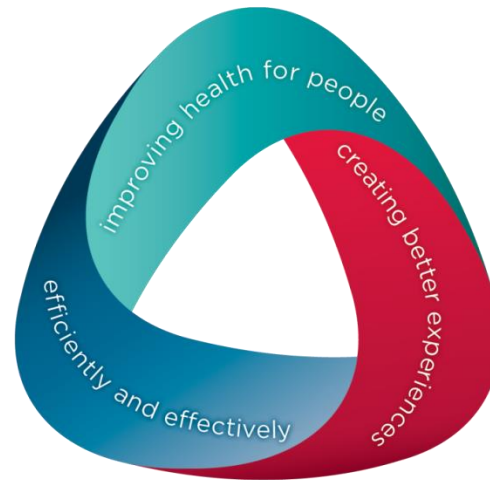
adding value to care

<http://www.eih.health.nsw.gov.au/bvh>

Clinical Excellence Commission Better Health Care Initiative Falls in Hospital



Clinical Excellence Commission Falls in hospital



Keeping Older People Safe in Our Care



Falls in Hospital

Keeping Older People Safe in Our Care

- *Regardless of the reason for admission* many older people are vulnerable to a fall, pressure injury, delirium during inpatient stays
- Systematic risk screening and evidence-based care can reduce risk
- Discharge planning should include ongoing preventative care

Keeping Older People Safe in Our Care

Improvement in the care of older people requires:

- **Leaders** to support staff in driving improvements, oversee governance and monitoring systems
- **Expert leads** (nursing, medical and allied health) to support strategic interventions
- **Falls Prevention is *everyone's* business** [®] - everyone has a role to play



Review of IIMS data

- Most falls occur at the bedside and in bathroom /during toileting
- High number of falls are unwitnessed and occur during the day
- Many patients are **confused and have poor mobility**
- Numbers of patients with serious injury such as head injury are increasing.

Key Performance Indicator for Falls in hospital

- **Fall-related injuries in hospital for patients aged 70 and older (per 1,000 bed days)**
(resulting in intracranial injury, fractured neck of femur or other fracture)
- Program Logic and Evaluation Plan
- Road Map developed at CEC and then with LHDs



Collaboration and working in teams

Improving clinical practice

- patients who are confused are immediately a *high fall risk*:
cognition and delirium screens are to be completed
- patients with *delirium* is a medical emergency: clinical review
- provide care for people with dementia and or delirium and delirium pathway
- **mobilise patients safely** -develop staff skills and confidence
- **monitor use of: antipsychotics, antidepressants, sedatives/hypnotics, or opioids** - reduce use of night sedation and benzodiazepines





Improving staff communication

- ***Post fall care and post fall huddle*** implement post fall huddles and revised plan of care to support improvements in safety in real-time
- ***Clinical handover and ward safety huddles*** identify high risk patients (fall, cognition, delirium, mobilising issues) and ensure that interventions are in place

Improving the physical environment including the use of appropriate equipment to enhance safe care for patients & staff



IIMS to IMS +

- Falls data set revised
- Simplified notification
- Pilot in M LHD – June 2017

CEC Data Monitoring

- Looking for reduction in serious injury
- Clinical Reporting System for state-wide & LHD falls data monitoring – LHD access
- QlikView for IIMS Data – LHD access



April 2017

APRIL FALLS MONTH

Moving right to stay upright



Moving right to stay upright

Harms of bed rest:

- Reduced muscle strength (even after a few days)

Patients at a higher risk of:

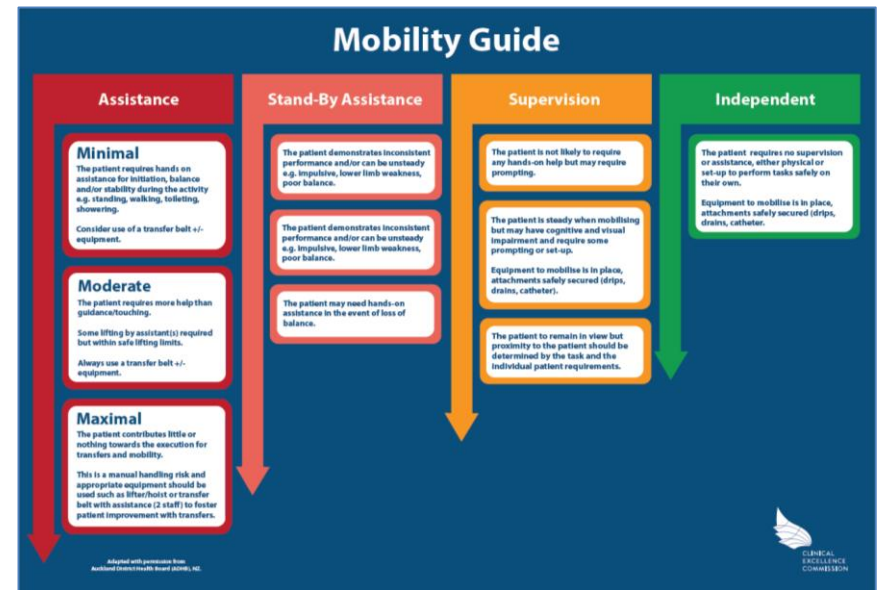
- delirium
- pressure ulcers
- falls
- incontinence
- thrombosis
- chest infections and
- increased length of stay

'END PJ Paralysis':

Nottingham University Hospital social media campaign

New Resources – safe mobilisation guide

COMING



Acknowledgement SES LHD

EAT... DRINK... MOVE...

Help your patients to

STAY ACTIVE!

And feel better in hospital

**Equipment**

- Provide walking aids and equipment for each patient who needs it.
- Label with the patient's name and avoid sharing to help with infection control.
- Position the walking aid where the patient can reach it easily.

Mobility Charts

- Ward staff to use manual handling and falls assessments to record mobility needs and update based on therapy assessment. Therapists to use mobility chart to record additional mobility needs and assistance required.
- Ask Therapy staff for advice if unsure. Therapy staff will add to & update charts for patients they are involved with, but do not need to review all patients.
- Display the chart clearly above the patient's bed so all staff know how to help and encourage each patient mobilise.
- Make sure patients know how important it is to mobilise, how to be active and independent on the ward, and how to get the help they need to do so.

Ward Staff

- Promote independent function & mobility
- Encourage patients to get up and get dressed in their own clothes
- Encourage patients who can, to mobilise around the ward
 - ✓ Walk to the bathroom or toilet
 - ✓ Walk to the food trolley to choose their food
 - ✓ Walk to the door to say hello or good bye to their visitors

Relatives

- Encourage relatives to bring in the patient's own clothes, walking aids, footwear.
- If safe to do so, relatives can walk with patients during their visit.

- Initial nursing simple assessment of mobility & fall risk on admission
- Promote mobility- walking to bathroom & toilet, take short walks during the day
- Encourage patients to be up & in their own clothing
- Communicate mobility requirements

REFERENCES

Fighting pyjama paralysis in hospital wards

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The Tension Between Promoting Mobility and Preventing Falls in the Hospital: Growdon, M; Shorr, R; Innouye S. JAMA Intern Med. Published online April 24, 2017. doi:10.1001/jamainternmed.2017.0840

Constructing definitions of safety risks while nurses care for hospitalised older people: Secondary analysis of qualitative data

Sherry Dahlke , Wendy A. Hall, Jennifer Baumbusch:

(Int J Older People Nurs 2017; 1–10 wileyonlinelibrary.com/journal/opn)

Take home message

- We all have a role to play in

Keeping Older People Safe in Our Care

- Looking for clinical improvement in how we provide this care and work together
- Acknowledgement the great work already underway across NSW



Thank you

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<http://www.cec.health.nsw.gov.au/patient-safety-programs/adult-patient-safety/falls-prevention>

www.cec.health.nsw.gov.au