NSW Falls Prevention Program update
May 2017

Lorraine Lovitt
Clinical Excellence Commission
Lead, NSW Falls Prevention Program
Leading Better Value Care
Better Health Care Initiatives

adding value to care


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
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

Acknowledgement SES LHD
• 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

Helen Reilly Therapy Lead, and Professional Lead for Dietetics, Heart of England NHS Foundation Trust
REFERENCES

_Fighting pyjama paralysis in hospital wards_
David Oliver  (consultant in geriatrics and acute general medicine)
BMJ 2017;357:j2096 doi: 10.1136/bmj.j2096 (Published 2017 May 02)

_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

Lorraine Lovitt, Lead NSW Fall Prevention Program
E: lorraine.lovitt@health.nsw.gov.au


www.cec.health.nsw.gov.au