LEADING BETTER VALUE CARE
Reducing harm from falls in hospital

NSW Falls Prevention Network Forum
IS LHD

Lorraine Lovitt
24 August 2018
"We need to shift the paradigm from volume to value driven care." Elizabeth Koff, Secretary, @NSWHealth
#NSWHealthInnovation
What is the size of the problem?

- In 2016, 38 patients died in NSW public hospitals (SAC1) following a fall-related incident, and
- There were 458 fall-related incidents (SAC 2) with serious harm
- Risk of harm from falls increases with:
  - Age
  - Medications
  - Reducing cognitive function
  - Functional decline
- Many falls are preventable
MRS DEAN’S STORY

The patient, their family and carers at the centre of care

Christine Ewin sharing her story of the journey with her mother Mrs Dean
Niccola Follett (SNSWLHD Falls Prevention Coordinator)

https://www.youtube.com/watch?v=37YI_Xnz6e4
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
Build will to do what it takes to change a new system

Share ideas for improvement

Support execution of the ideas
What are we trying to accomplish?
How will we know that a change is an improvement?
What change can we make that will result in improvement?

BTS Focus =
- Testing a change
- Implementing a change

MODEL FOR IMPROVEMENT

Aktivieren
Planen
Studieren
Vergleichen

Helps to develop the aim and measures
Helps to develop a change ie the ‘Change Package’
Many PDSA Cycles.....

Hunches, Theories, Ideas

Very Small Scale Tests

Follow-up Tests

Wide-scale Tests of Change

Implementation of Change

Changes That Result In Improvement

Data

PLAN DO STUDY ACT
FALLS COLLABORATIVE

‘Keeping older people safe in our care’

Aim
Reduce falls and serious harm from falls by 5% within 12 months (June 2018)

Inclusions: Age ≥70 years
Inpatients in a health service
Partial or assisted fall

Exclusions: Staff, visitors
Falls in Hospital
Timeline 2017/18

- Workshop 1: 18 Sept
- Workshop 2: 28 Feb
- Workshop 3: 30 May
- Workshop 4: 14 Sept
- Coaching Calls: 7-8 Aug

Other Workshops being held in 2018:
- 8th March: M LHD - NSW Falls Prevention Network Rural Falls Forum – Wagga Wagga
- 11th May: NSW Falls Prevention Network/Program Annual Forum – Wesley Centre, Pitt St, Sydney

Tri Nations Falls Expert Workshop: 21-22 Nov, 13-14 Dec, 16-17 Jan, 13-14 Feb, 27-28 March, 8-9 May, 3-4 July, 7-8 August, 3-4 September
FALLS COLLABORATIVE

Evidenced based change package

Risk identification and management
Cognitive impairment - dementia/delirium
Mobility - safe mobilisation
Medication review - reconciliation and reduction
Rounding - care needs/toileting plan
Multi-disciplinary team collaboration
Post falls, safety huddles and clinical handover
CEC NSW Falls Program
LBVC Falls in hospital
Resources

LEADING BETTER VALUE CARE

FALLS PREVENTION

- Introduction
- Risk Identification & Management
- Cognition & Delirium Screen
- Orthostatic Hypotension Screening
- Medication Management
- Intentional Rounding
- Safe Mobilisation
- Teamwork
- Education
- Communication
- Falls Prevention Program Home

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LEADING BETTER VALUE CARE

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.

Leading Better Value Care (LBVC) seeks to identify and implement opportunities for delivering value based care to the people of NSW. As part of the program, the CEC is using the Institute for Healthcare Improvement (IHI) collaborative methodology to help reduce serious harm from falls in hospitals; and to improve the safety of older persons.

The aim is to achieve a 5 per cent reduction in falls occurring in a health service area resulting in intracranial injury, fractured neck of femur or other fracture as a rate per 1000 occupied bed days by 30 June 2018.

The Falls in Hospital Quality Improvement Collaborative is comprised of three one day learning sessions with ongoing monthly coaching sessions provided to the teams in between the learning sessions to support the implementation of evidence based interventions. The first learning set was held in October 2017 with additional learning sets on 28 February and 30 May 2018.

Falls in Hospital (short version)
Leading Better Value Care

YouTube video [high resolution]

Length 2:13

Added Aug 2017
QUALITY IMPROVEMENT TOOLS

The Clinical Excellence Commission provides a range of tools and resources to support NSW Health staff to improve the quality of care for our patients. The tools and resources include graphs, charts, diagrams and mapping tools designed to help you plot the data around your intended quality improvement initiative.

By using these tools and resources throughout your Quality Improvement initiative, you and your team can gain a better understanding of the underlying problems that are causing the issue, gain insight as to how best to go about the improvement and develop an effective strategy to complete your project.

Each tool includes background information and instructions on how and when it should be used. Accompanying templates (Excel or Power Point) have been developed and are available for staff to download and use with their own data. Links to instructional videos have also been included for most tools, to further assist in the explanation of the resource.

You can select the tools and resources from the menu on the left hand side of this page.

FEEDBACK

We welcome your feedback on the usefulness and relevance of the individual tools. If you've got any ideas or suggestions on how we can improve these resources, please take a moment to complete the evaluation survey found at the bottom of each of the individual tools' page.

If you are after additional information or tools, please email the CEC Quality Improvement Academy Staff at CEC-QI@health.nsw.gov.au

QUALITY IMPROVEMENT DATA SYSTEM (QIDS)

Monitor falls data

LHD team activity

Resources
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 ≥ 70 years
Inpatients in a health service
Partial and assisted falls
Exclusions: Staff, visitors.

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
Falls Collaborative Driver Diagram

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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
CONTINUOUS RUN CHART

Falls in Hospital Collaborative
Percentage of patients who 'insert intervention here' each week

95% reliability

IMPLEMENTATION

Periodical sampling

need to understand why

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

Week 1 Week 2 Week 3 Week 4 Week 5 Week 6 Week 7 Week 8 Week 9 Week 10 Week 11 Week 12 Week 13 Week 14 Week 15 Week 16 Week 17 Week 18 Week 19 Week 20 Week 21 Week 22 Week 23 Week 24 Week 25 Week 26 Week 27 Week 28 Week 29 Week 30 Week 31 Week 32 Week 33 Week 34 Week 35

March April May June July August September October Periodical sampling

NSW Government
CLINICAL EXCELLENCE COMMISSION
FALLS COLLABORATIVE

Learning Set 1 - 25 October 2017

46 teams across NSW

Introduction to QI and the Falls Change Package
FALLS COLLABORATIVE

Learning Set 2 - 28 February 2018

42 teams across NSW

Human factors, reliability and storyboards
FALLS COLLABORATIVE

Learning Set 3 - 30 May 2018

41 teams across NSW

Data, communication and leadership
OUTCOME DATA

No of falls with harm per quarter in NSW

UCL = 113.124
CL = 85.400

Count

jan-mar 16 apr-june 16 jul-sep 16 oct-dec 16 jan-mar 17 apr-june 17 jul-sep 17 oct-dec 17 jan-mar 18 apr-june 18
ELIZABETH KOFF (SECRETARY MoH) opening the day
Executive sponsors invited to support teams
Focus on spread and sustainability
Celebrating success
NEXT STEPS

Learning Set 4 - 14 September 2018

• Focus on spread and sustainability

Evaluation of the collaborative (state level)

LHD teams

• spread and sustainability plan
QUESTIONS?