Illawarra Shoalhaven Local Health District

“Peas in a Pod” A collaborative approach to reducing falls at Coledale Hospital.

LBVC CEC Falls In Hospital Collaborative

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Falls Forum
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AIM STATEMENT

The “Peas in a Pod” project is collaborative across clinical and non-clinical teams and encompasses inspiration, education, and supporting the staff to deliver multifactorial interventions through a care bundle approach.

Our aim is to reduce falls at Coledale Hospital by 30% in 12 months, thereby,

“Keeping older people safe in our care”
EVIDENCE FOR THERE BEING A PROBLEM WORTH SOLVING

Falls By Location on Rehab Ward

- Bedside 62%
- Bathroom Related 35%
- Other 4%
EVIDENCE FOR THERE BEING A PROBLEM WORTH SOLVING

Falls on Rehab Ward According to Time Band

Falls According to Time Band

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EVIDENCE FOR THERE BEING A PROBLEM WORTH SOLVING

Falls Coledale 2016-2017

[Graph showing a trend with peaks and troughs from July 2016 to June 2017]

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NSW GOVERNMENT
STRATEGIES IMPLEMENTED

- Staff Education
- Patient Care and Communication Boards
- Ways of Working "PODS"
- Clinical Handover and SIER Rounding
- Safety and Communication Huddles
- Intentional Rounding
- Environmental (e.g., Night Lights)
STRATEGIES IMPLEMENTED

- Ways of Working
  - Team nursing / Model of Care
  - PODs
- Communication and Collaboration
  - Intentional Rounding - All Staff
  - Culture change around safety
  - Patient Care and Communication Boards
- Environment
  - Night lights, glow in the dark tape
  - Call buzzer placement
  - Sensor mats
OUTCOME

Falls rate per 1000 OBD Feb-17 to Jul-18

Falls per 1000 Beddays

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STRATEGIES FOR SHARING/ SUSTAINABILITY

- **Start with one initiative** after multi-voting etc. and prioritising this, but be flexible to where the project will take you.
  - Started with intentional rounding but our biggest successes have been changing our ways of working, improving communication and collaboration (involving all staff) and really addressing environmental concerns.

- **Understanding ways of working**
  - For e.g. wards need to think of how many times a non-nurse is going into a room.
  - Continued education and orientation of new staff members (clinical, and non-clinical teams) for current culture and practices to remain
  - These staff are invaluable and willing to assist in the prevention of falls.
  - Consistent leadership of team (key staff across disciplines)
  - **Safety huddles** were instrumental in maintaining sustainability of the project using ongoing communication.
LESSONS LEARNT

- **Culture change** and staffing practice is very difficult to measure and requires time.
- **Staff Open Forums** - were important in providing open and safe space for staff to give feedback and discuss different practices and ways of working.
- All staff involved in the process - **becomes a way of working for everyone.** The biggest success has been that every staff member on site is always available regardless of position.
- **Test small** - rules of 5 was helpful - we used 1 nurse, 1 shift, 1 bedroom, same 4-patients - to test several PDSA’s.
- **Safety Huddle** - very useful and gave a forum everyday across all clinical and non-clinical workforce streams for project updates and changes being implemented.
- Reminding staff why we are doing this and the impact and objective falls rate and severity of harm from injuries and call buzzer data to show impact to practice and falls prevention.