Don’t Fall for it!

Prince of Wales Hospital

and Community Health Service

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Case for Change

- POWH is a major tertiary teaching hospital and referral centre with a bed base of 450 and 41 inpatient units
- Increased in hospital-based falls and harm observed from 2021-2024

Themes 2021-2024

Framework & Objectives

- Framework: *individualised ward-based data, observational audits, staff feedback* to inform action plans
- Aims:

  Reduce the number of falls and harm from falls in 15 high-risk wards

  Improve patients' safe experience in hospital

Ward-Base Method: Facilitation

- **Who**: 15 high falls risk wards
- **How**: Facilitation & Education by CNC Comprehensive Care
    1) Ward-specific data, HS1/HS2 reports and IMS+ themes
    2) Observational audit findings
    3) Staff feedback “It was nice to be heard”
- **What Resulted**: Person-centred, individualised action plans on each ward

- **Governance**: newly formed steering committee ‘Reducing Comprehensive Care-related Harms’

Example Action Plans

Ward	Actions Implemented	Issues Identified
WARD	• Diuretic administration to 0800 • Create signage for bathrooms “Don’t Fall, Call” • All patients sat out of beds for mealtimes	
WARD	• Nursing staff focusing on falls prevention strategies specific to SPECIALITY	
	• Nurse in charge on night shift will monitor completion of risk screening • Weekly audit of FRAMP completion for 3 months • 9 new alarm mats ordered • Develop lanyard cards	
WARD	• Physio and OT will communicate to nurses post patients’ therapy if toileting, hydration or rest • Dinner Breaks staggered from 5pm for the 4 nurses and time is allocated	
WARD	• Security staff regular rounds 24Hrs • Fun/Colourful scrubs every shift • Pharmacist education • Structured and regular Diversional Activities • Delirium Experience sessions	
WARD	• Shower chairs ordered to increase access to equipment	
WARD	• Surgical Dresser manager to adjust time	
WARD	• Free of clutter and equipment – senior walkthrough • 4 B’s (bickies, blanket, bowels/bladder, bevvy)	
WARD	• Dashboard for predicting high risk consumers	
WARD	• Working with nurses and technicians to prevent falls	
WARD	• Starting medication Trial to see if reduction in delirium	

Hospital-Wide Method: Education

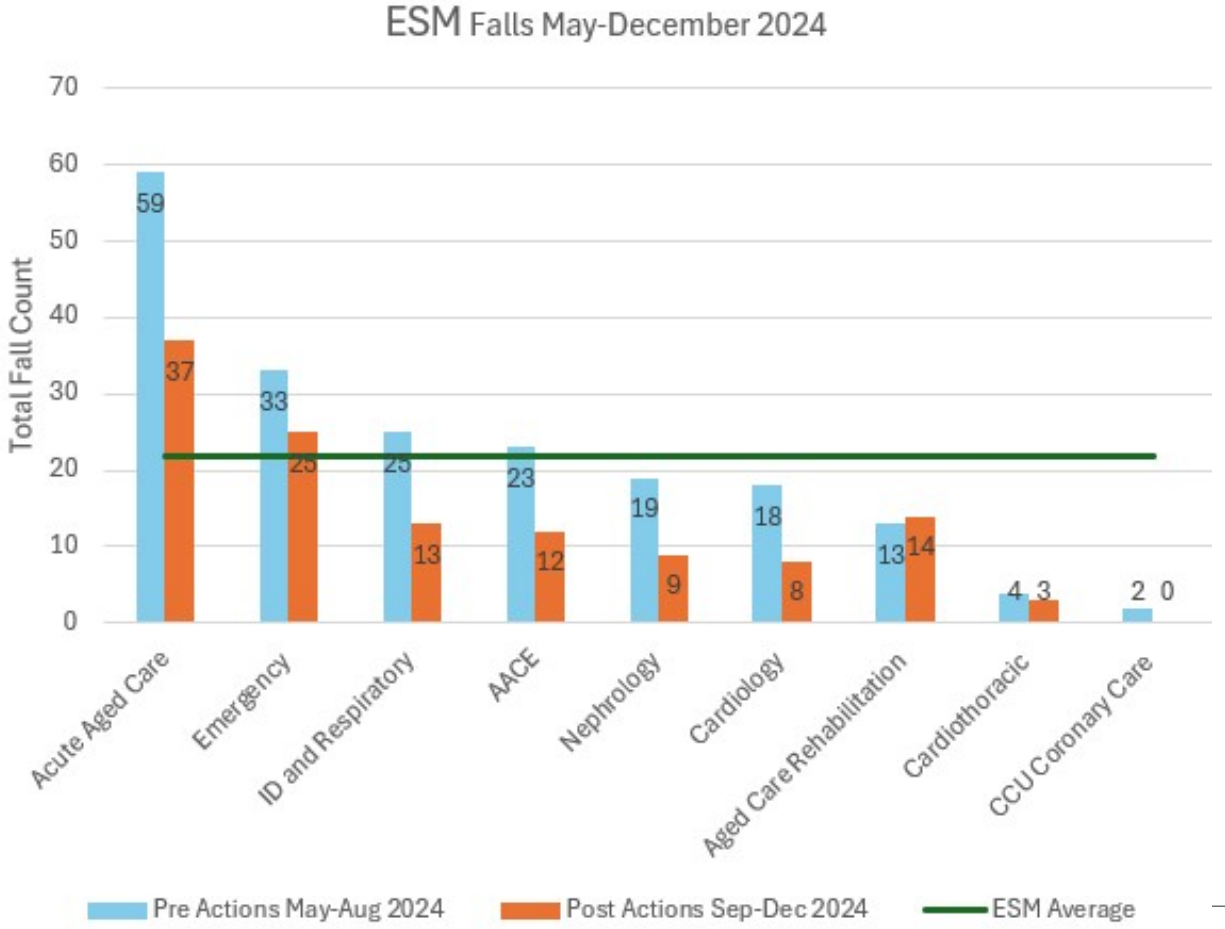
Modes of education:

- Cartoon character for staff attention and bedside education
- Formal grand rounds by visiting Professors speaking to multidisciplinary staff
- Fun education quizzes and competitions with prizes

Results

- Practice changes made by staff
- Reduction in falls and harm from falls:
  - 12 of the 15 wards, falls halved in total after implementation of falls-prevention action plans
- Patients felt safe:
  - In one ward, 90% of patients surveyed stated they ‘always’ felt a sense of safety on the ward

Results- Reduction in Total Falls



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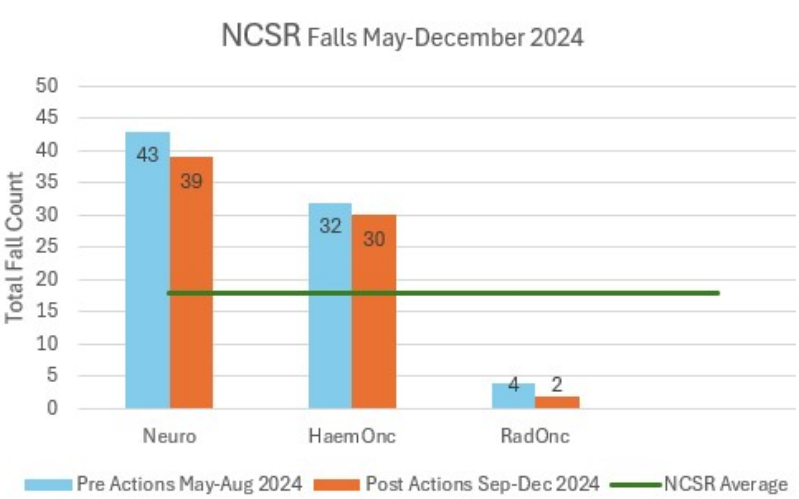
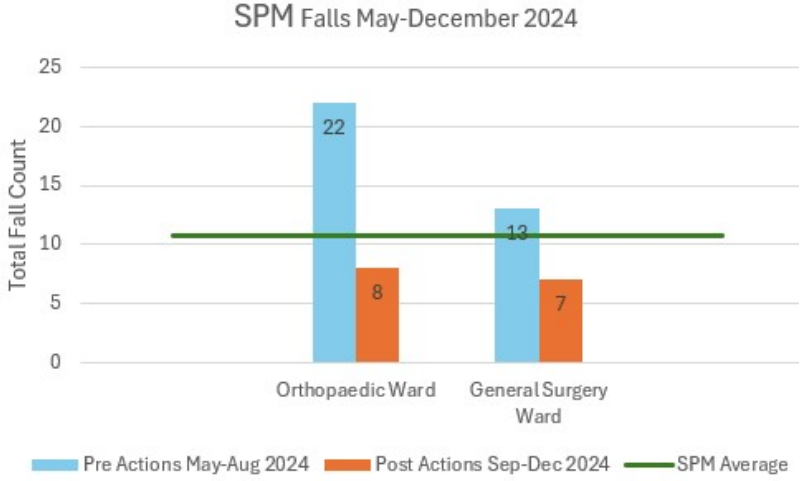
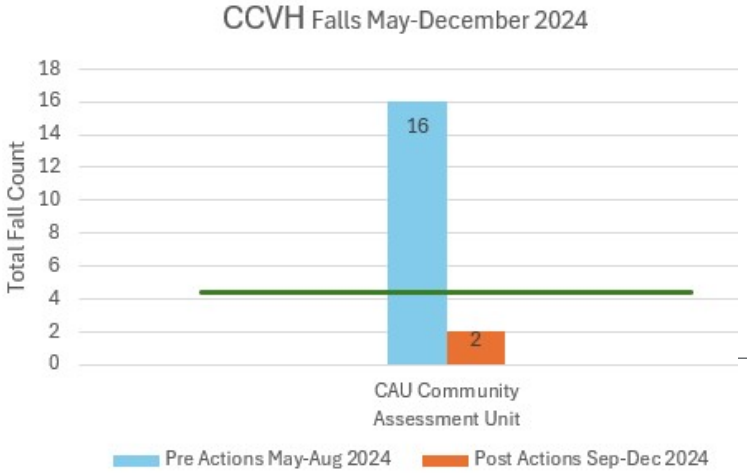
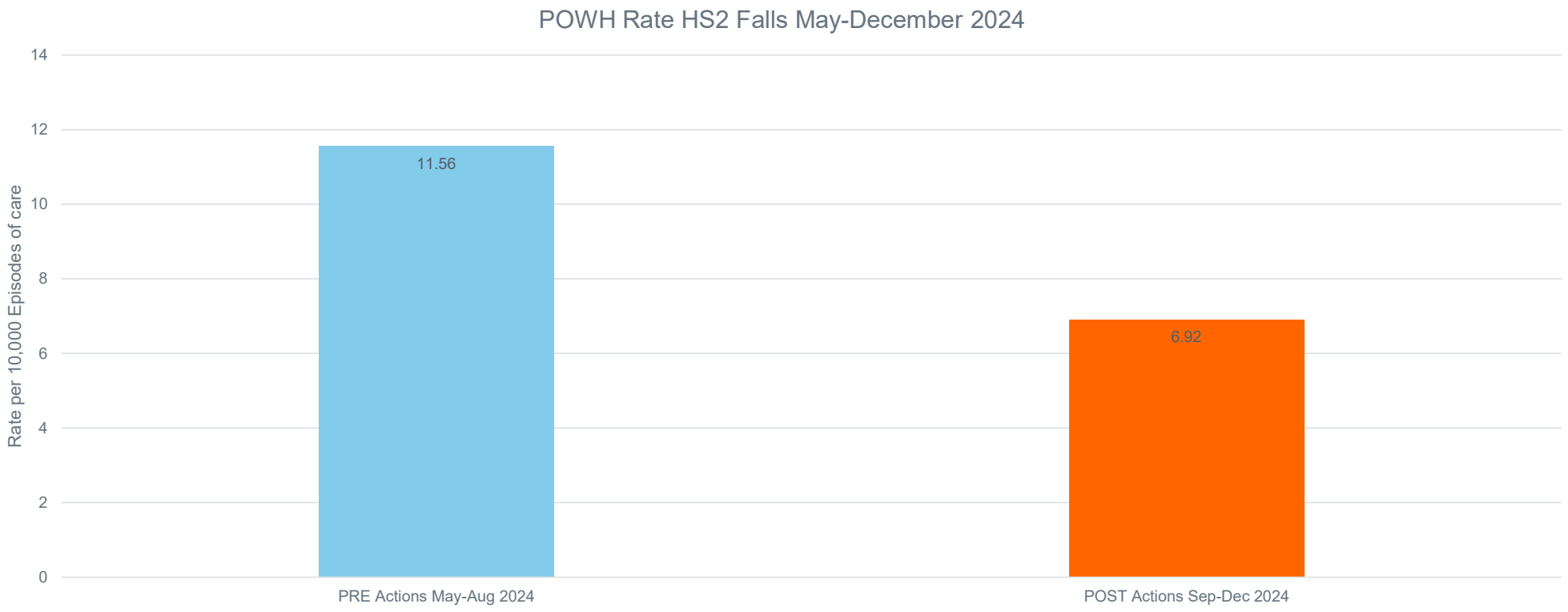






Results- Reduction in Harm from Falls



Lessons Learnt

1. Person-centred/contextualised action plans at a ward level
2. Executive sponsorship and reinforcing sponsors
3. MDT and Patient Safety
4. Ward staff are experts
5. CNC Comprehensive Care role
6. Timeline and accountability of milestones
7. Scalable and can be expanded to other hospital acquired complications

Future Plans/ Sustainability

- Clinical Leads Program
- Ward staff trained to review data
- Reducing Comprehensive care-related Harms Steering Committee