“You cannot change what you don't know”
Falls prevention at Bankstown-Lidcombe Hospital

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Project Team

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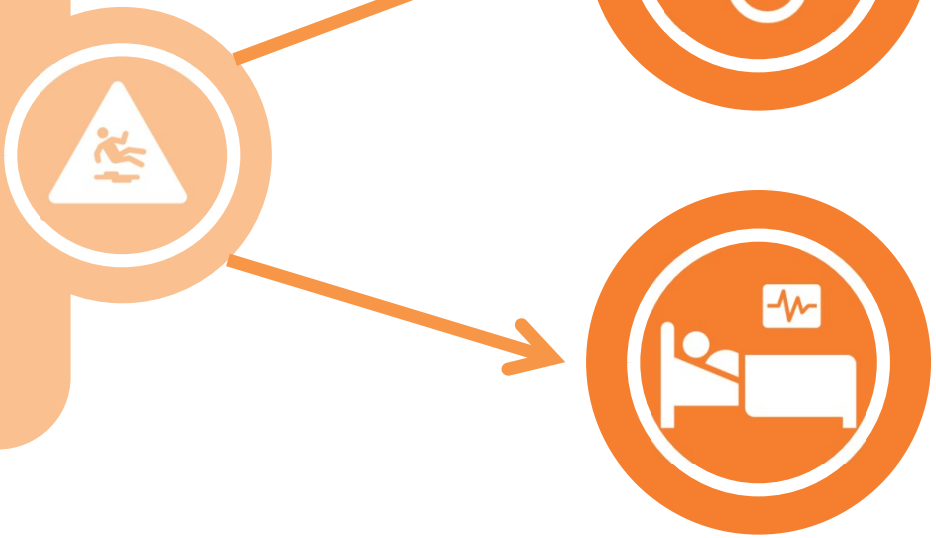
NUMs & CNEs

Raj Gujraz **SWSLHD Falls Prevention**

Why we started this project

292 Falls

(Oct 23 – Apr 24)



8 Harm Score 2

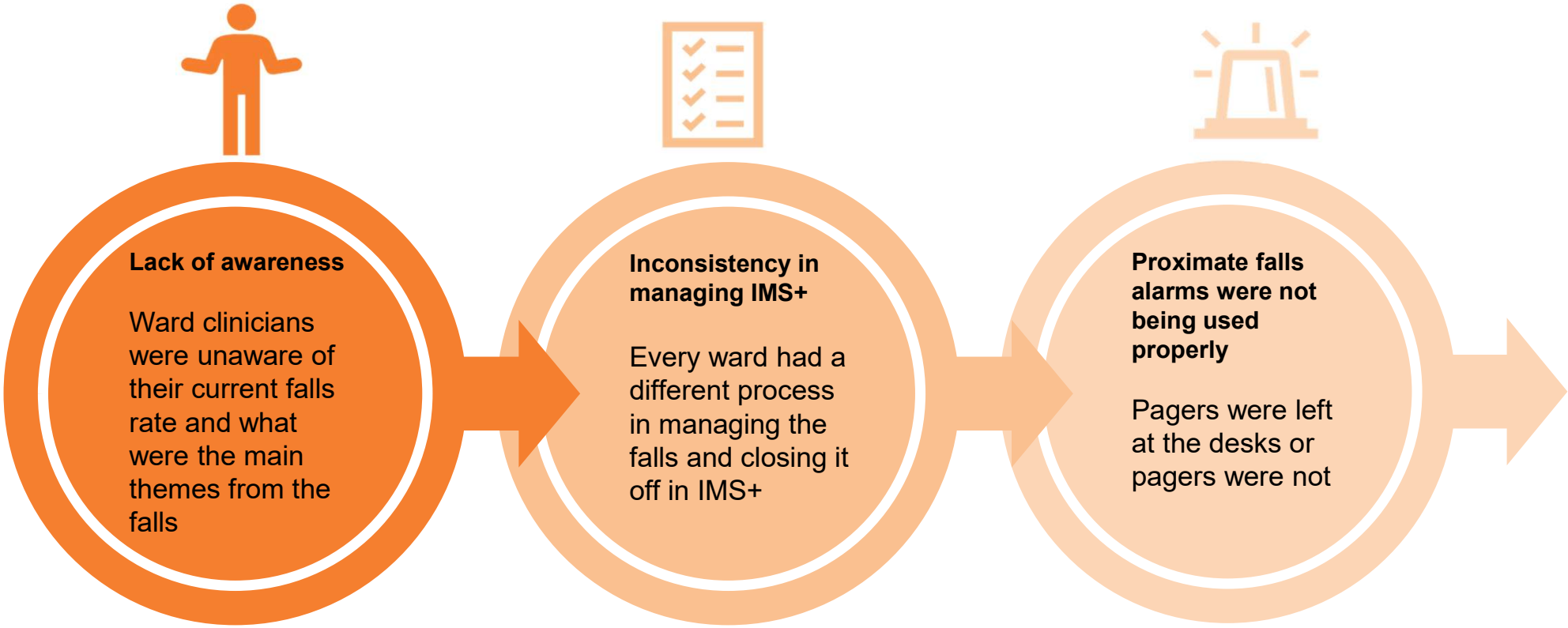
8 Falls resulting in major injury to patient (fracture and intracranial haemorrhage)

Higher rate than SWSLHD

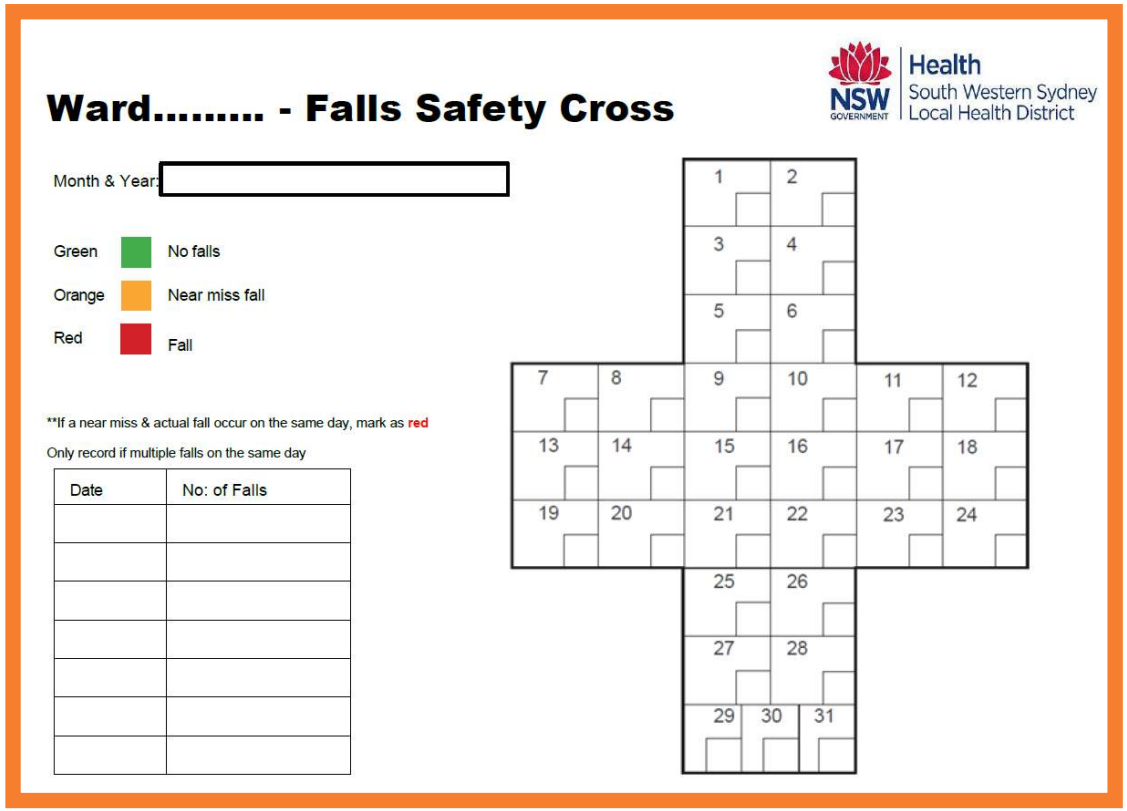
One Harm Score 1

1 Fall unfortunately resulting in death

A cluster review of all the falls incidents



Intervention: Falls Safety Cross



Ward..... - Falls Safety Cross

Health
South Western Sydney
Local Health District

Month & Year:

Green — No falls

Orange — Near miss fall

Red — Fall

**If a near miss & actual fall occur on the same day, mark as red

Only record if multiple falls on the same day

Date	No: of Falls

"You cannot change what you don't know"

- Simple visual display, increasing awareness and having falls at the forefront of our practice.
- Process is monitored by the BNK Falls Committee and reported every month.
- Since Implementation in May 2024. Wards have achieved >30 days without a fall.
- Crosses are used for 'Top 3 Risks' in each clinical area.

Acknowledgement: Campbelltown & Braeside Hospital

Intervention: Checklist to manage falls incidents

1.	Was the Falls Risk Assessment and Management Plan (FRAMP) completed and accurate prior to the fall?	Y/N
2.	Was the fall risk assessment repeated after the inpatient fall incident?	Y/N
3.	Was the Management Plan (FRAMP) updated post fall?	Y/N
4.	Was a post fall management form completed (eMR ad hoc)?	Y/N
5.	Did a post fall safety huddle occur and was this documented in the clinical notes?	Y/N
6.	Was the patient in a closed supervision room? And was a nurse always present at all times?	Y/N
7.	Refer to SAGO chart. Post fall were the following observations completed hourly for the first 4 hours and then 4th hourly for a minimum of 24 hours: ☐ Blood pressure ☐ Heart rate ☐ Respiratory rate ☐ Temperature ☐ Oxygen saturations ☐ Pain score ☐ BGL (BGL required post fall, but only required hourly if clinically indicated) Please comment on any gaps in post fall observations:	Y/N
8.	Refer to the neurological observation chart. Post fall were the neurological observations completed hourly for the first 4 hours and then 4th hourly for a minimum of 24 hours? Post fall neurological observations are compulsory even if the patient did not hit their head.	Y/N
9.	Is there documented evidence that the patient was reviewed within 4hrs by a medical officer after the fall?	Y/N
10.	Has the post fall been communicated? (at clinical handover, change of shift risk huddle and patient care boards)	Y/N
11.	Was a review of environment factors attended post fall? (any clutter, mobility aids in reach, call bell in reach, bedrails down, bed at lowest height and bed brakes on)	Y/N

A standardised process to manage falls incidents in IMS+

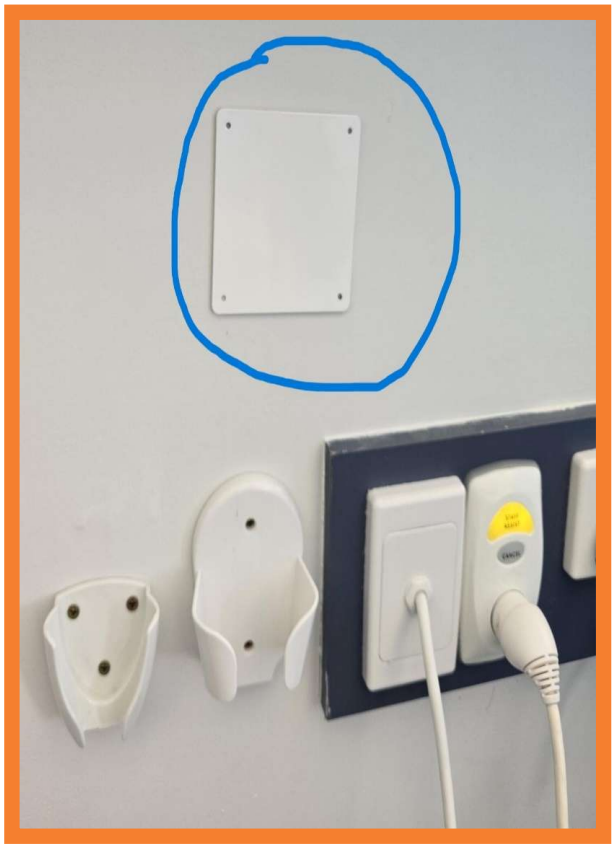
- Simple checklist for NUM and CNE to refer to when managing falls in IMS+ post fall.

Aim:

- Ensuring consistency with post fall management Identify emerging themes with policy compliance.
- Patient Safety Manager monitors compliance – NUMs attach the completed template when finalising the IMS+.

Acknowledgement: SESLHD St George Hospital

Intervention: Falls Proximate Alarms

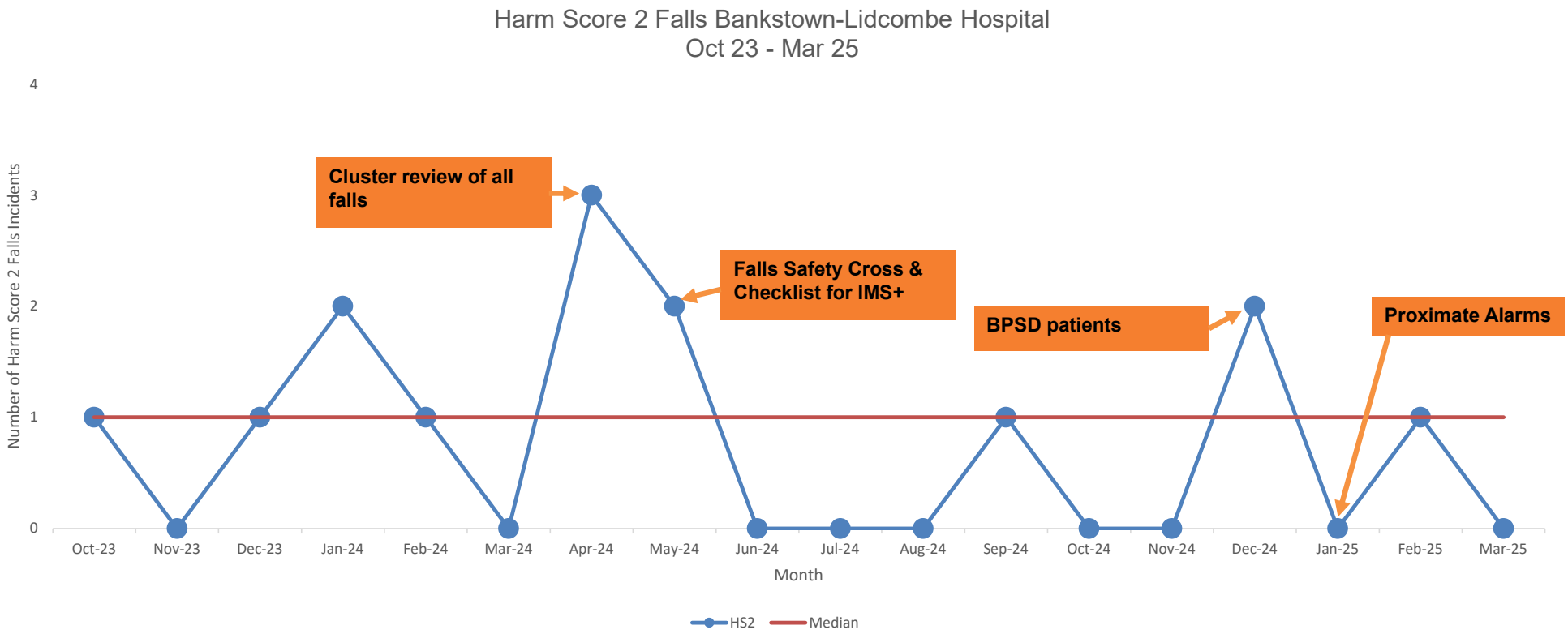


Proximate Alarm connected to the Call Bell system

- Simplify the process of connecting the falls alarm to the call bell system like Bowral, Campbelltown and Liverpool.
- There was no mounting to attach proximate adaptor. So, we had to engineer a metal plate can be mounted to the wall.
- All wards are fully functional, with the roll-out of the alarms started in Jan 2025.

Acknowledgement: Bowral, Campbelltown & Liverpool Hospitals

Outcomes


Harm Score 2 Falls Bankstown-Lidcombe Hospital
Oct 23 - Mar 25
Number of Harm Score 2 Falls Incidents
0
1
2
3
4
Cluster review of all falls
Falls Safety Cross & Checklist for IMS+
BPSD patients
Proximate Alarms
Oct-23
Nov-23
Dec-23
Jan-24
Feb-24
Mar-24
Apr-24
May-24
Jun-24
Jul-24
Aug-24
Sep-24
Oct-24
Nov-24
Dec-24
Jan-25
Feb-25
Mar-25
Month
HS2
Median

Outcomes – Days Without Falls

Ward 3C – 95 consecutive days without any falls
Ward 2B – 60 consecutive days without any falls
Ward 2C – 55 consecutive days without any falls

Learning Points

“Not re-inventing the wheel”

Explore what has currently been done elsewhere and how to adapt it to your model of care.

- Falls Safety Cross (Campbelltown & Braeside Hospitals)
- IMS+ Checklist (St George Hospital)
- Proximate Alarm connected to the call bell system (Bowral, Campbelltown & Liverpool Hospitals)

“Keep it simple for safety”

The falls safety cross is a simple concept but yet very easy to engage clinician.

The falls safety cross has also incidentally make the wards more competitive - competing with other to see who can achieve the most days in between a fall.

Questions