Falls in Hospital

Reducing falls and harm from falls – Older Persons Patient Safety

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NSW FALLS PREVENTION PROGRAM

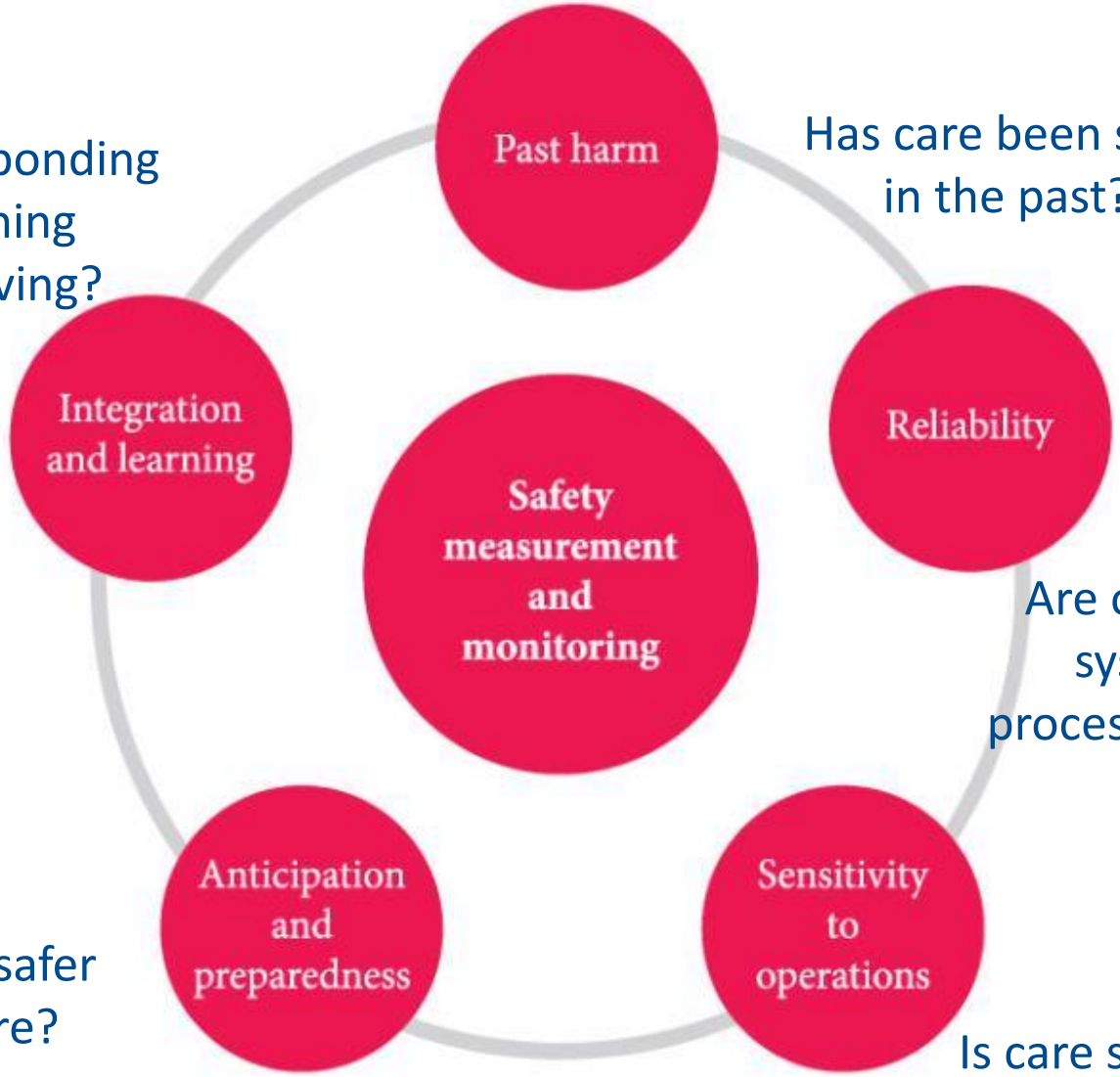
LEADING BETTER VALUE CARE

CLINICAL EXCELLENCE COMMISSION

Improving safety

Are we responding & learning & improving?

Has care been safe in the past?



Are our clinical systems & processes reliable?

Will care be safer in the future?

Is care safe today?

Source: Vincent C, Burnett S, Carthey J. *The measurement and monitoring of safety.* The Health Foundation, 2012. www.health.org.uk/publications/the-measurement-and-monitoring-of-safety

Why Falls in Hospital for older persons?

- Significant harm to patients
- Many falls are preventable
- Risk of harm from falls increases with
  - Age and co-morbidities
  - Medications
  - Reducing cognitive function
- In 2016, there were 38 SAC1 and 458 SAC2 falls across NSW
- NSW Falls prevention program for last 12 years
- Remains unwarranted variation in clinical practice and outcomes
- Aim 5% reduction in hospital fall related serious harm in ≥70 years

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Leadership and Culture all levels

- **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

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Falls in Hospital

- Multi-factorial risk screen and assessment
- Multi-factorial and multi-disciplinary interventions
- Patient/families/carers engagement
- Comprehensive documentation – eMR enabler

CEC improvement collaborative

- 12 month Statewide Quality Improvement Collaborative
- 3 one day learning sets over 12 months
- Multidisciplinary teams
- Focus on key interventions – change package
- Coach teams 1:1
- Quality Improvement Database System (QIDS)
- Data to inform/drive continuous improvement

Interventions

- Reliably identify patients at risk of falls and implement interventions
- Cognitive screening: recognise and treat delirium
- Safe mobilisation strategies and increased mobility
- Medications: review, reconciliation, reduction:
  - **antipsychotics, anti-hypertensives, antidepressants, sedatives/hypnotics, opioids**
- Intentional rounding
- Safety huddles and Post fall huddles
- Multidisciplinary management

Evaluation of Falls in Hospital

- Triple aim
  - health of the public (outcomes)
  - improved patient and staff experience
  - efficiency and effectiveness of care

- Hospital falls leading to intracranial injury, fractured neck of femur or other fracture per 1000 occupied bed days

CEC support

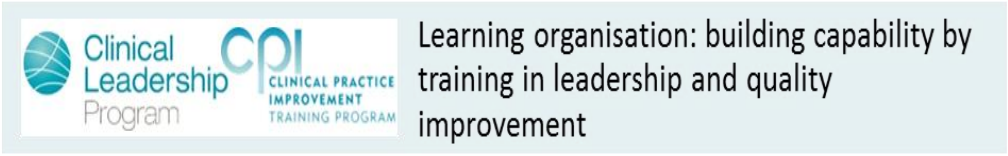
- Quality Improvement Collaborative learning sets
  - 25 October 2017
  - 28 February 2018
  - 30 May 2018

- Coaching support for nominated teams from LHD between workshops and LHD/SHN visits to work with clinical teams

- Two rural falls forums
  - Mid North Coast LHD – Kempsey – Friday 10 November
  - Murrumbidgee LHD – February 2018

Supporting Learning Systems

Safety & Quality

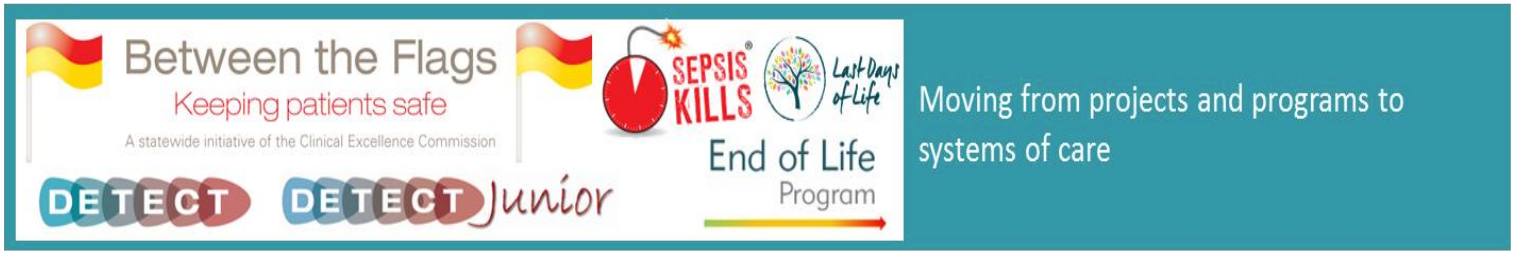


Learning organisation: building capability by training in leadership and quality improvement

Real time data for improvement

Development of high reliability patient care teams to improve culture

Ward based essentials of safety



Moving from projects and programs to systems of care

Statewide systems for incident monitoring and intelligence

FALLS PREVENTION

- Overview
- Leading Better Value Care
- Falls Prevention for Hospitals
- Paediatric Falls Prevention
- Falls Prevention in Other Settings
- Information for Patients
- Related Reports & Publications
- 2017 April Falls Resources
- NSW Falls Prevention Network

CONTACT US

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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 is scheduled for Wednesday 25 October 2017 with additional dates in February and May 2018.

Falls in Hospital (short version)
Leading Better Value Care

YouTube video (high resolution)

Length 2:13

Added Aug 2017

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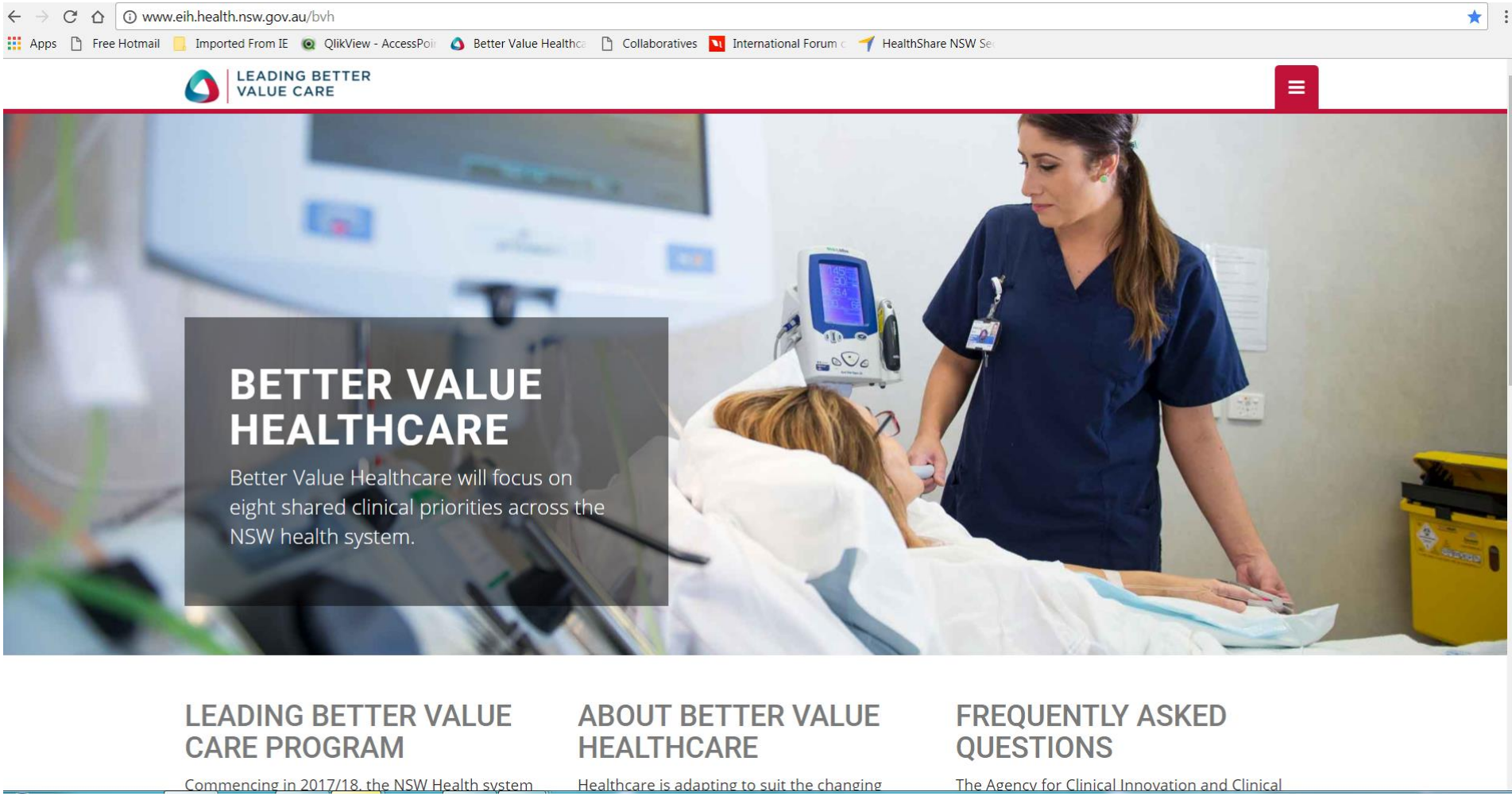
More information…..



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Thank you

For further information:

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