LBVC Falls Project

Implementing Post Fall Huddles while changing a culture towards Falls Prevention

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Leading Better Value Care Initiatives

During the 2017-2018 financial year, there were **8 LBVC initiatives** implemented across the state within NSW Health, aimed at improving the experience of care of the patient, within these 8 areas:

- Osteoarthritis
- At risk of osteoporotic re-fracture
- Diabetes
- at risk of diabetic foot complications
- Chronic heart failure
- COPD
- End-stage renal disease
- **over 70 yrs of age at high risk of falling in hospital**

Leading Better Value Care Falls Collaborative

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The Leading Better Value Care Falls Collaborative

= 47 teams across NSW, supported by the CEC,

to focus on evidence based interventions, individual patient risk assessment and response, to build highly reliable healthcare teams,

to drive improvements in care in regards to falls prevention and post fall management.

Goal of the LBVC Falls Collaborative:

to reduce falls and harm from falls by 5% in 12 mths

from baseline 2016-2017 data

In WNSW LHD there are 3 LBVC Falls teams:

- *Bathurst Medical ward (95% pts have a FRAMP completed within 24 hrs)*
- *Canowindra Soldiers Memorial Hospital (90% pts have a FRAMP completed within 24 hrs)*
- *Orange Older Person's Acute Mental Health Unit*

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Older Person's Acute (OPA)
Mental Health Inpatient Unit

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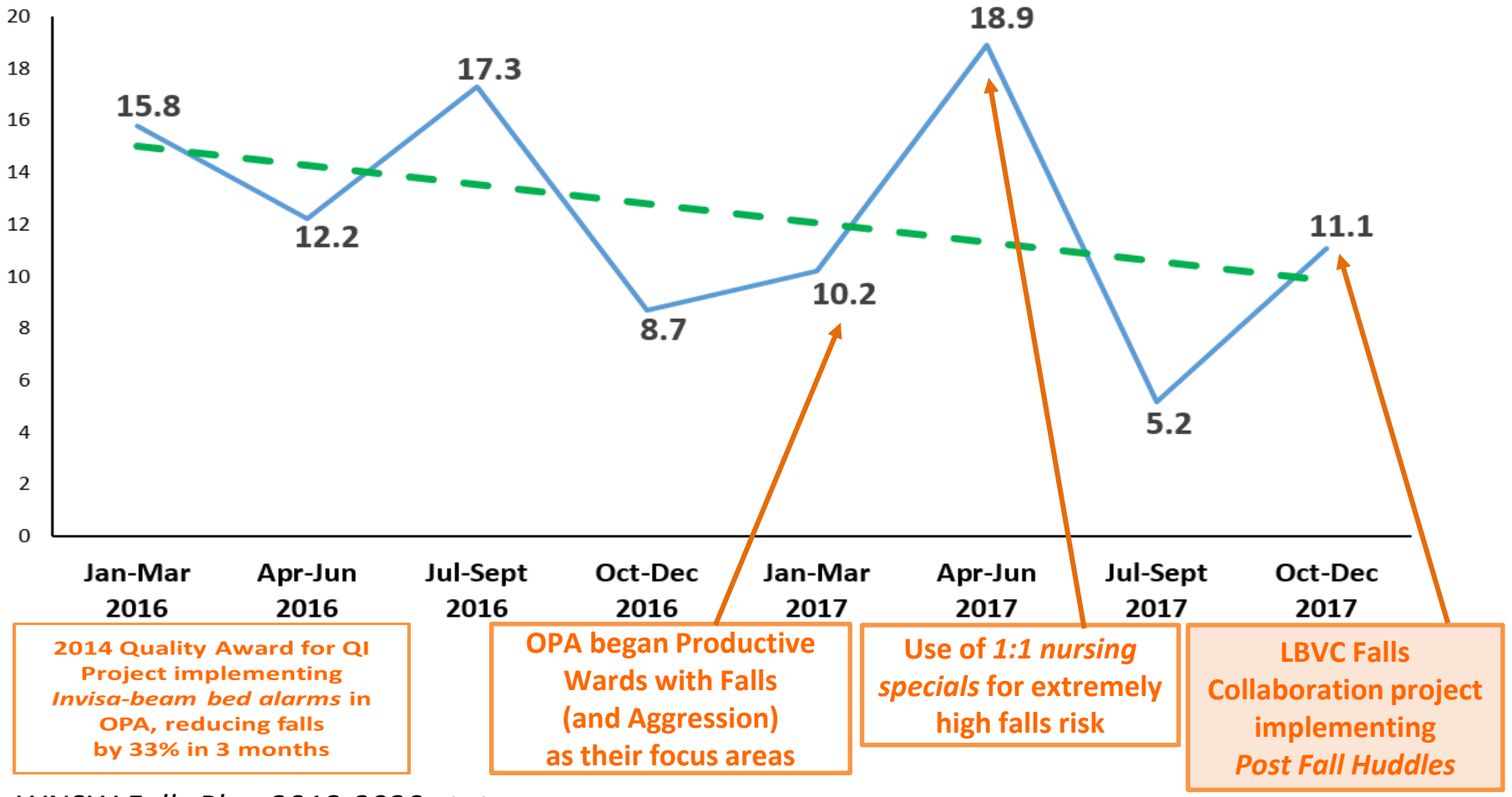
Background: OPA's patients mostly present with a high-very high falls risk

- our patients are **≥ 65 years (or have younger onset BPSD)**
- majority have had one **fall in the last 6/12** or presented to hospital with a fall
- mental state is at the least **agitated** (incl fearful, anxious) and often **confused and disorientated,** and intermittently aggressive
- **vision** an issue for most ≥ 65yrs eg cataracts, have glasses
- **toileting** issues common for our patients - frequency, incontinence and/or nocturia
- many **transfer with supervision or minor help** as are deconditioned and/or **fluctuate with their mobility**
- many **mobilise with a walking frame** (w/sticks not allowed on OPA)
- most are on at least one **Antipsychotic and/or Anti-depressant and/or a sedative** (eg manic and barely sleeping 2 hours)

Falls rate in OPA:

OPA's Quarterly Falls Rate (per 1000 occupied bed days) Jan 2016–Dec 2017



The WNSW Falls Plan 2018-2020 states:
"The Chief Executive Goals for 2018 identify that falls should ***be equal to or less than 1.7 per 1000 bed days in Acute & Procedural facilities and 4 per 1000 bed days in sub-acute & MPS facilities*** *as a Tier 1 goal."*

Falls: the problem in OPA

Staff heard saying,
"It's OPA, our patients fall."

- From January 2016 – December 2017 there were a total of **80 fall incidents in 36 patients**
- **16 of these 36 patients (44.4%) experienced 2 or more falls, with 8 of these people experiencing 4 or more falls**
- From July-Dec 2017, there were 12 falls incidents in OPA; 4 people fell once, and 4 people fell twice

  = 50% of those who fell in OPA July-Dec 2017, fell again

→ ***Post Fall Huddles*** *may have a vital role in* ***preventing repeat falls*** *in OPA*

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The aim of OPA's LBVC Falls project?

To reduce the number of falls in the Older Persons Acute (OPA) Mental Health Unit by 80% from March-August 2018, **through the implementation of Post Fall Huddles**

Inclusion criteria:

- every OPA inpatient, including those on trial leave at the time of their fall

Exclusion criteria:

- only if fall is a SAC1 incident[1]

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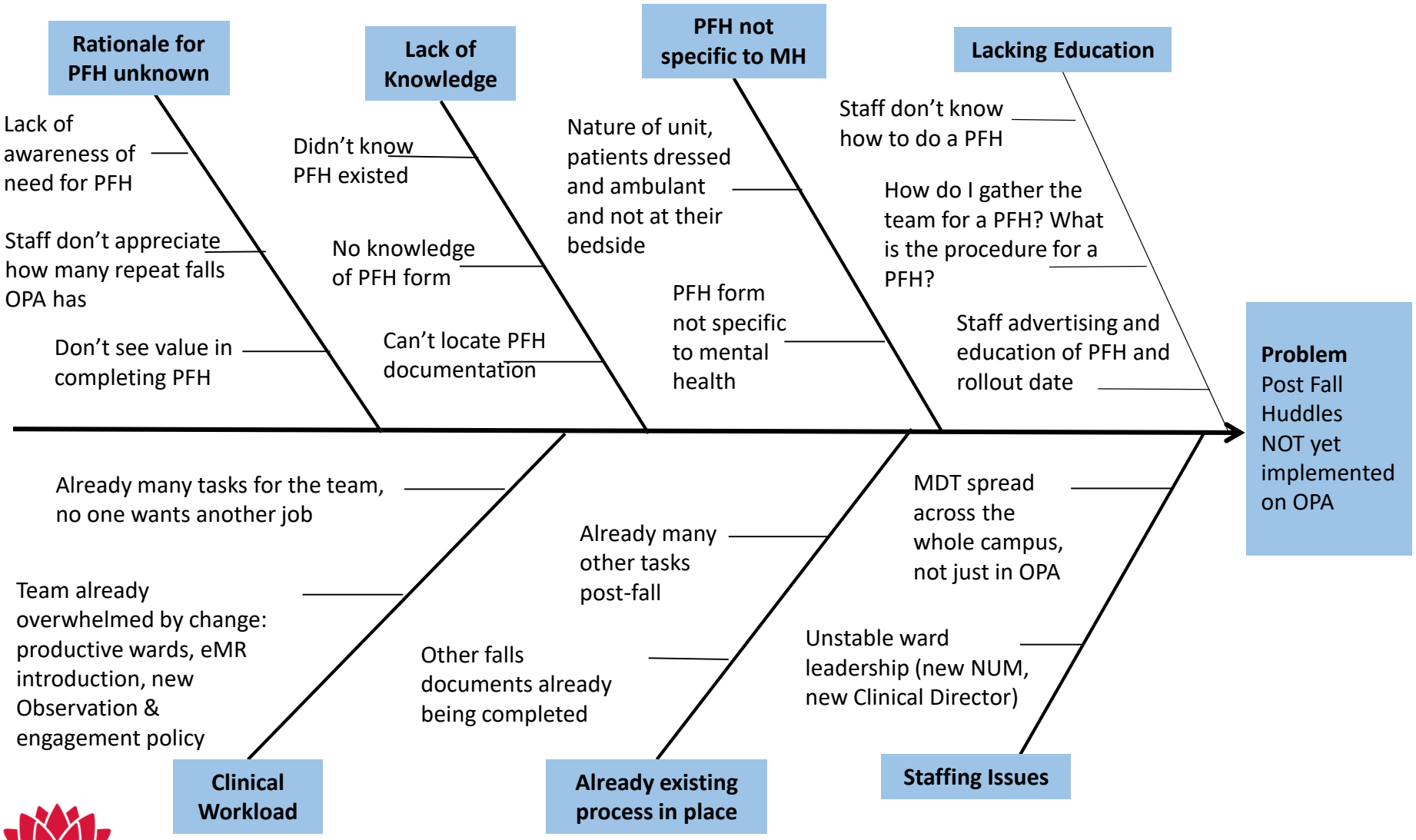
Fishbone (Cause & Effect) Diagram



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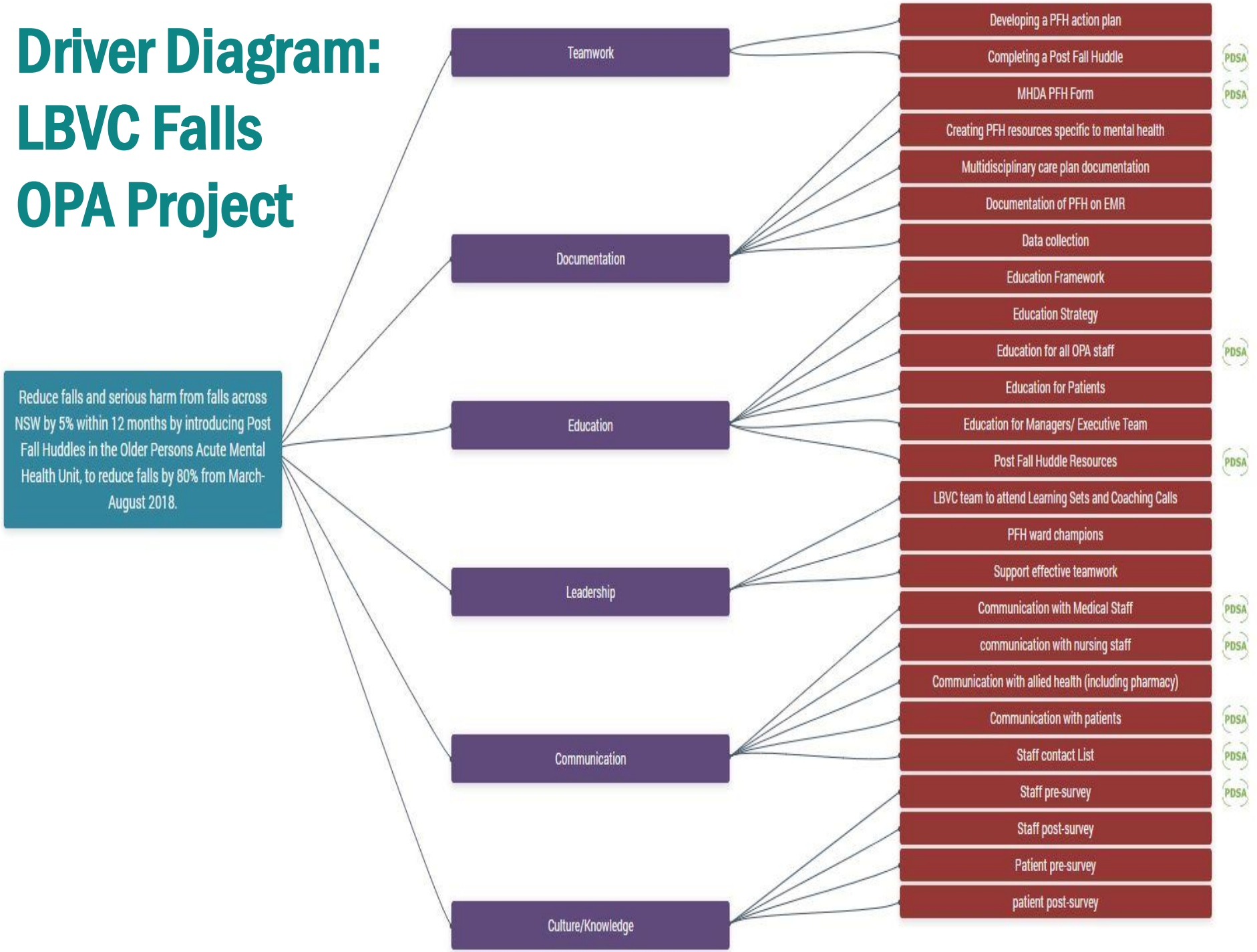
Driver Diagram: LBVC Falls OPA Project



PDSAs completed by Sept 2018

- **Post Fall Huddle procedure** developed via process mapping, a **simulated Post Fall Huddle** (on 12/2/18) and **x2 trial PFHs** w LBVC falls team conducted in March 2018
- Completed **pre-project surveys of staff and patients/carers** to gain baseline knowledge/lack of knowledge of Post Fall Huddles
- Developed an **OPA MDT contact list** so any staff member is able to arrange a Post Fall Huddle on OPA
- Designed a **mental-health specific Post Fall Huddle Form**
- **Educated all OPA staff** on Post Fall Huddles and how to co-ordinate and lead a PFH on OPA, with post-education surveys to assess understanding of PFH
- Developed **PFH educational and 'Days without Falls' posters** displayed in common areas

Process Map of Post Fall Huddle (PFH):

Patient has a fall

Post Fall procedure followed as per CEC Post Fall Guide

Patient has fall overnight 4pm-8am weekday (M-F)

ICS emails MDT contact list to alert **PFH needed 9:30am after MDT handover next working day**

Patient has fall working hours 8am-4:00pm Mon-Fri

Within 2 hours MDT is alerted to planned PFH

Patient has fall on wkend from 4pm Fri - 8am Mon or public holiday

ICS emails MDT contact list to alert **PFH needed 9:30am Monday after MDT handover**

Post Fall Huddle occurs

MDT (ICS, NUM, MO, RN, Pharmacist, OT, PT), person whom fell, person whom witnessed fall and carer (if possible) gather in the place where the fall occurred

Hard copy PFH form completed and PFH documented in eMR

Updated Care plan and clinical handover to reflect actions implemented
Discuss in morning handover
Review action plan in MDT Case review

OPA MDT Post Fall Huddle Contact Checklist

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Multidisciplinary Team Post Fall Huddle

Older Person Acute Inpatient Unit

Contact List

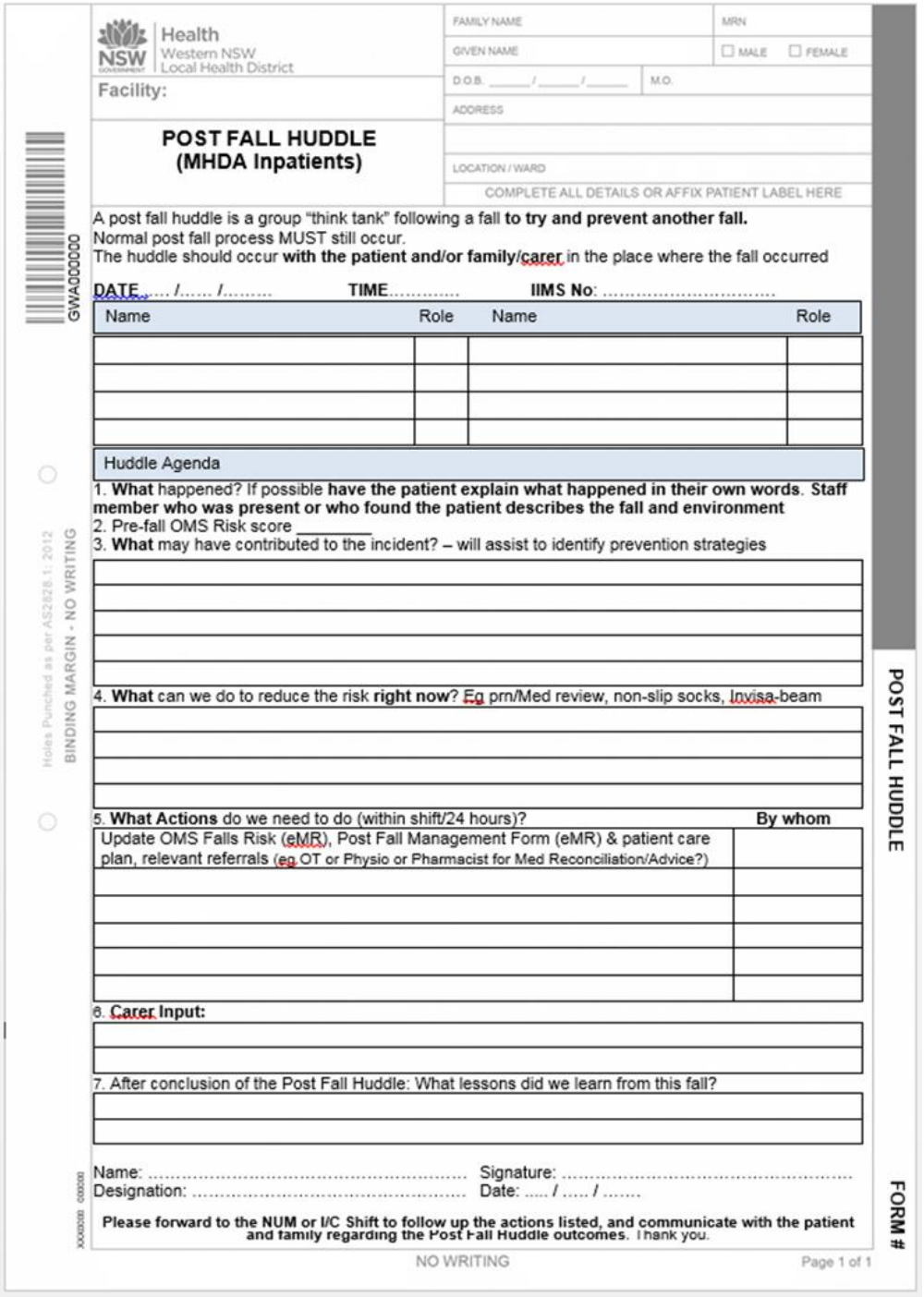
Patient Falls: Weekend (ICS to send email) organise MDT Huddle Monday morning 0930 hr (after morning clinical handover meeting)

Patient Falls: Monday to Friday NUM or ICS please organise Day of incident

Title	Name	Phone number/Email
NUM or ICS	NUM, ANUM or ICS	6369 7502
Psych Registrar		6369 7502
JMO		6369 7502
Physiotherapist	Emma	7240 or 0424 327 307 or email Emma.Wirth@health.nsw.gov.au
Pharmacist	Gabrielle	3743 or 0422 372 724 gabrielle.hansen@health.nsw.gov.au
Occupational Therapist	Melissa	7607 or 043 660 177 or email Melissa.Lane1@health.nsw.gov.au
MDT staff will complete Post Fall Huddle Form	Nominated Person attending Huddle to complete form	Post Fall Huddle: MDT will review fall from weekend next working day Weekdays – MDT Post Fall Huddle will be held during business hours Time to be organised within 2-3 hours post fall
Patient, Family, Carer or Person Responsible to be present for MDT Post Fall Huddle where possible	Family or Carer to be invited to MDT Post fall Huddle If unavailable ask for any recommendations they would like to contribute Give feedback from Huddle	Inform patient of Post Fall Huddle if they are mentally stable to attend/ discuss what happened with MDT, Interventions Management Plan

MHDA Inpatient Post Fall Huddle form:

- original PFH form developed by MPS sites
- form redeveloped to suit mental health, drug & alcohol inpatient units
- draft form then trialled and adjusted throughout first few months of project until consensus reached on final form



Health
Western NSW
Local Health District

Facility:

FAMILY NAME | MRN
GIVEN NAME | ☐ MALE ☐ FEMALE
D.O.B. ____/____/____ | M.O.
ADDRESS
LOCATION / WARD
COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

POST FALL HUDDLE
(MHDA Inpatients)

GWA000000

A post fall huddle is a group "think tank" following a fall **to try and prevent another fall.**
Normal post fall process MUST still occur.
The huddle should occur **with the patient and/or family/carer** in the place where the fall occurred

DATE..... /..... /..... TIME..... IIMS No: .....

Name	Role	Name	Role

Huddle Agenda

1. **What** happened? If possible **have the patient explain what happened in their own words. Staff member who was present or who found the patient describes the fall and environment**
2. Pre-fall OMS Risk score _____
3. **What** may have contributed to the incident? – will assist to identify prevention strategies

4. **What** can we do to reduce the risk **right now?** Eg prn/Med review, non-slip socks, Invisa-beam

5. **What Actions** do we need to do (within shift/24 hours)? **By whom**

Update OMS Falls Risk (eMR), Post Fall Management Form (eMR) & patient care plan, relevant referrals (eg OT or Physio or Pharmacist for Med Reconciliation/Advice?)	

6. **Carer Input:**

7. After conclusion of the Post Fall Huddle: What lessons did we learn from this fall?

Name: ..... Signature: .....
Designation: ..... Date: ..... / ..... / .....

Please forward to the NUM or I/C Shift to follow up the actions listed, and communicate with the patient and family regarding the Post Fall Huddle outcomes. Thank you.

NO WRITING

Page 1 of 1

Holes Punched as per AS2828.1: 2012
BINDING MARGIN - NO WRITING

POST FALL HUDDLE
FORM #

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MHDA Inpatient PFH form (top half)

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Western NSW
Local Health District

Facility:

POST FALL HUDDLE
(MHDA Inpatients)

FAMILY NAME | MRN
GIVEN NAME | ☐ MALE ☐ FEMALE
D.O.B. _____/_____/_____ | M.O.
ADDRESS
LOCATION / WARD
COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

GWA000000

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2. Pre-fall OMS Risk score _____
3. **What** may have contributed to the incident? – will assist to identify prevention strategies

r AS2828.1: 2012
N - NO WRITING

MHDA Inpatient PFH form (lower half)

Holes Punch BINDING M

4. **What** can we do to reduce the risk **right now**? Eg prn/Med review, non-slip socks, Invisa-beam

5. **What Actions** do we need to do (within shift/24 hours)?

	By whom
Update OMS Falls Risk (eMR), Post Fall Management Form (eMR) & patient care plan, relevant referrals (eg OT or Physio or Pharmacist for Med Reconciliation/Advice?)	

6. **Carer Input:**

7. After conclusion of the Post Fall Huddle: What lessons did we learn from this fall?

Name: …… Signature: ……
Designation: …… Date: ..... / ….. / …….

Please forward to the NUM or I/C Shift to follow up the actions listed, and communicate with the patient and family regarding the Post Fall Huddle outcomes. Thank you.

OST FALL HUDDLE

FORM #

XXX0000 000000

NO WRITING

Simulated PFH conducted 12/2/18

Education of staff, patients and carers

HAVE YOU HEARD OF A

POST FALL HUDDLE?

A fall can occur on our unit because of any number of factors, including medication changes, delirium, cognitive deficits, unfamiliar environment and unsteady mobility.

In our unit, we have commenced Post Fall Huddles.

A **Post Fall Huddle** occurs after a person has fallen, once they have been reviewed by their treating team and stabilised.

A **Post Fall Huddle** includes the person who fell, their family and/or carer (if possible), the staff member/s present at the time of the fall, a Doctor, Nurse Unit Manager or Nursing team leader, Pharmacist, Occupational Therapist and Physiotherapist, gathering in or near the place where the fall occurred.

A **Post Fall Huddle** is a multidisciplinary team discussion to clarify the **reasons why the fall may have occurred** and any **actions that can be taken to try and prevent a further fall**.

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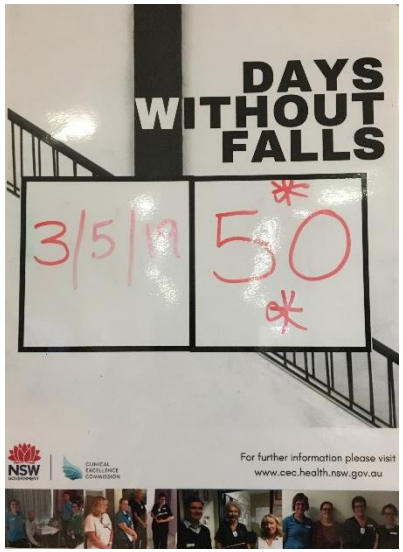
PFH education posters placed in common areas

Face-to-face and powerpoint education sessions completed by all OPA MDT staff (in-hours and after-hours staff)

‘Days without Falls’ communicated regularly to staff, patients and carers, with milestone ‘Days Without Falls’ celebrated



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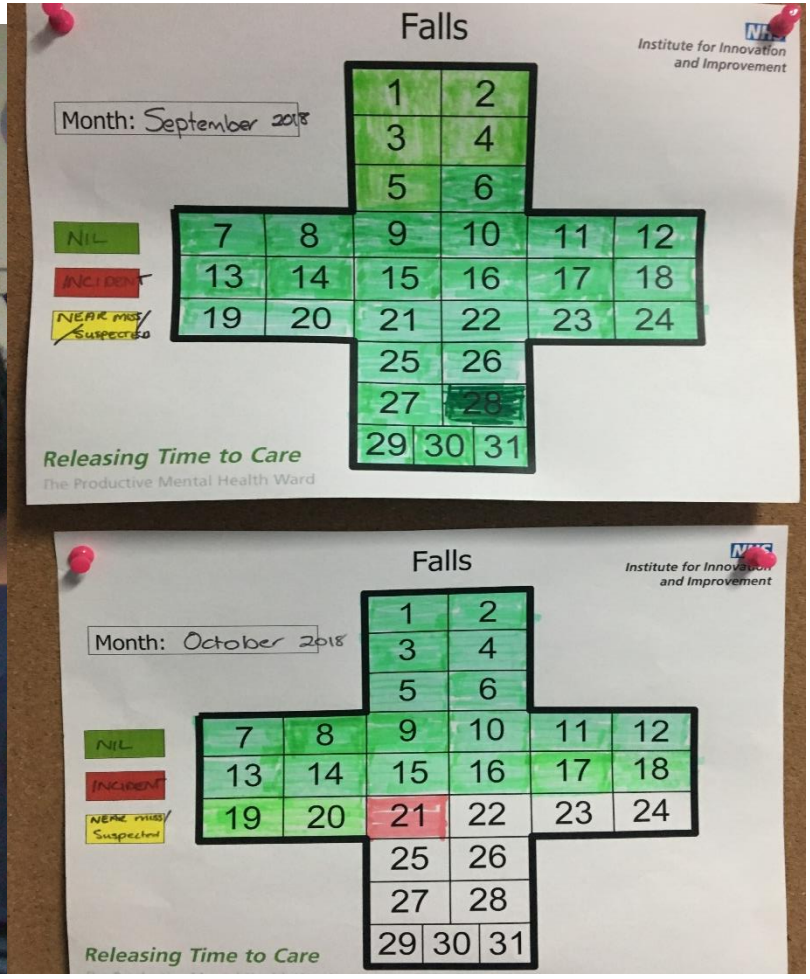
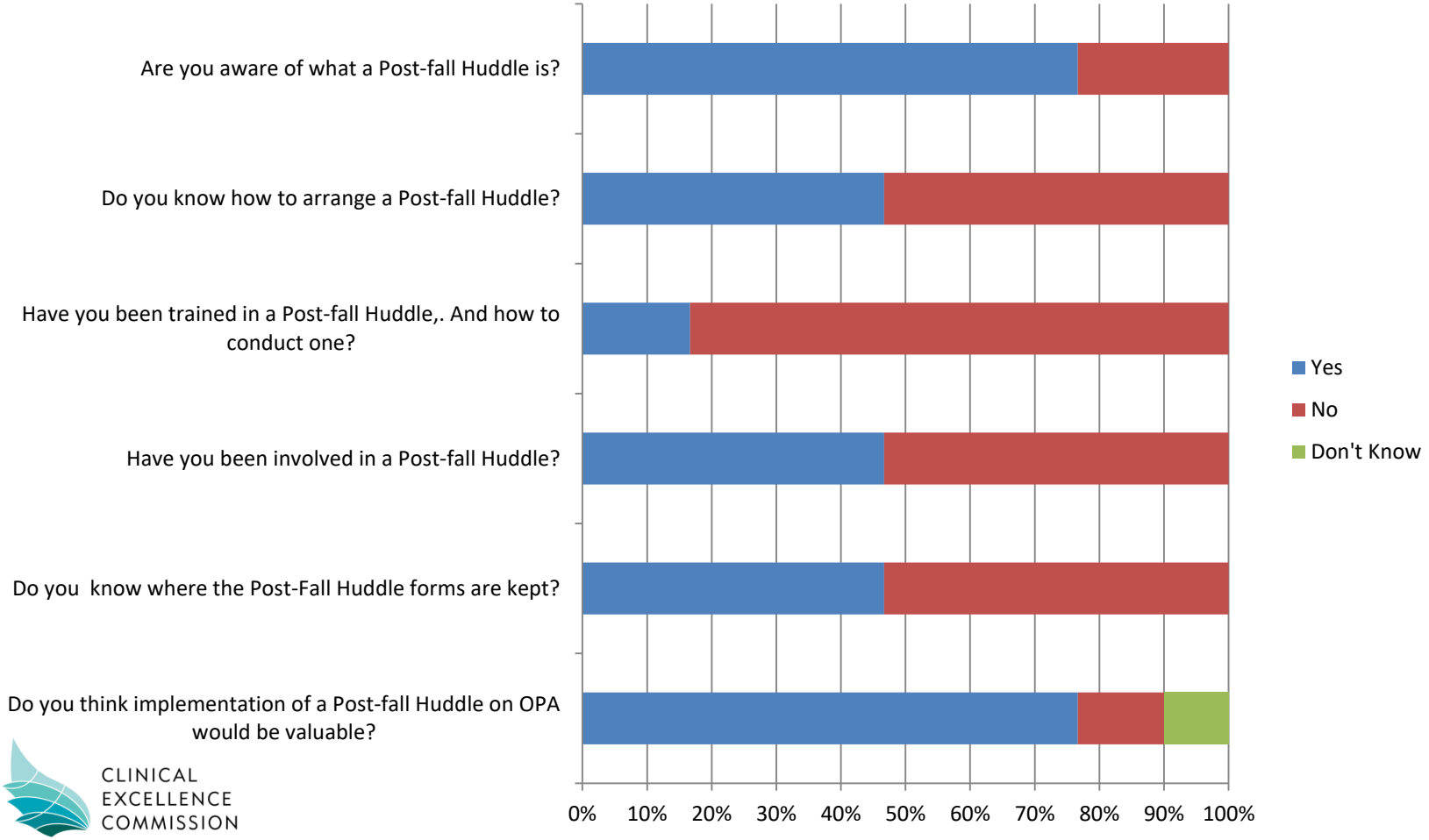
LBVC Falls project promoted use of monthly ‘Safety Crosses’, clearly communicating Falls IIMS, alongside updated falls run charts promoting increased discussion in staff hub



So, have all these completed PDSAs made any difference?

Measures: *Pre-project* staff survey results (30)



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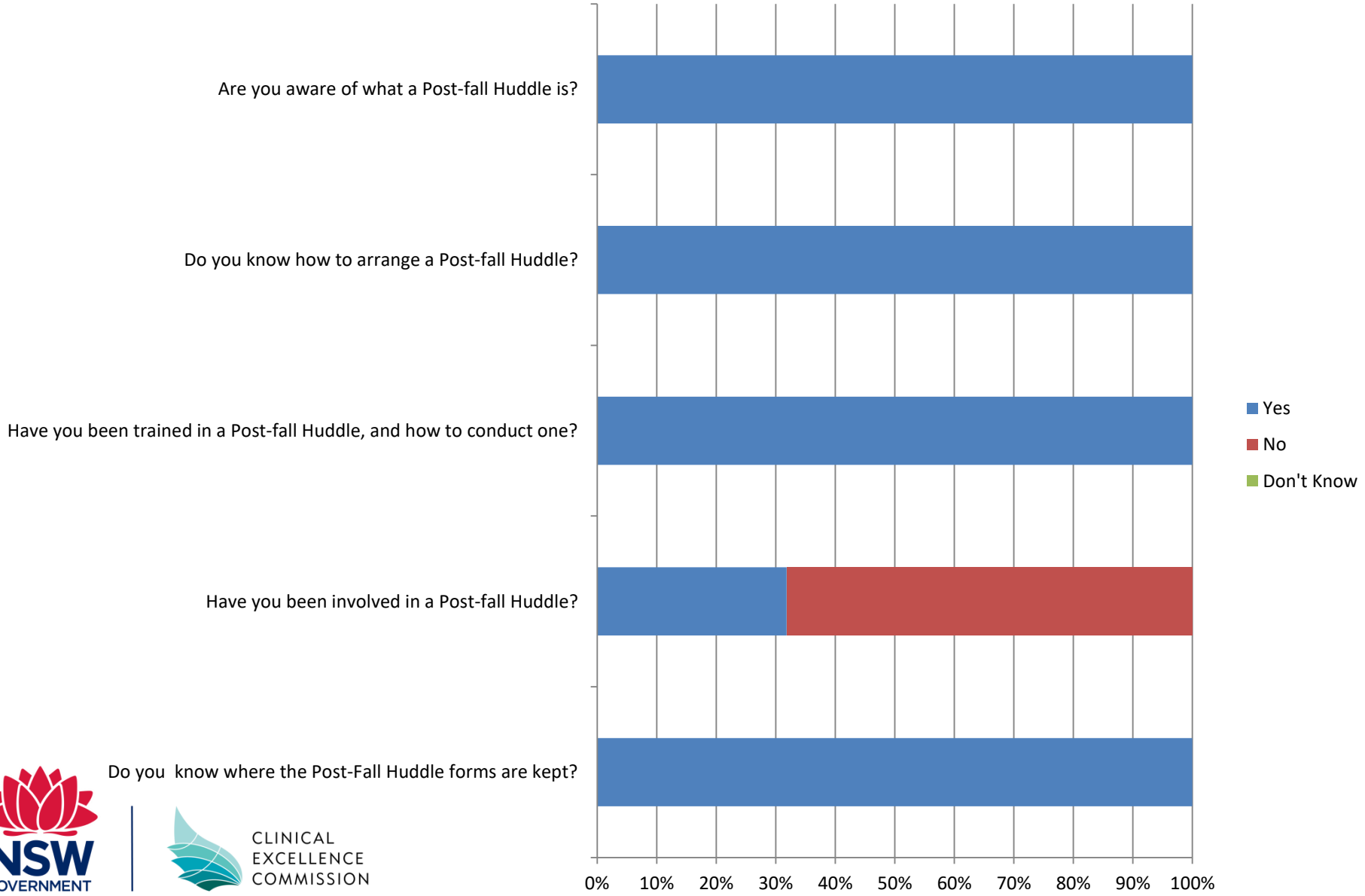
Measures: *Post-education* staff survey (22)



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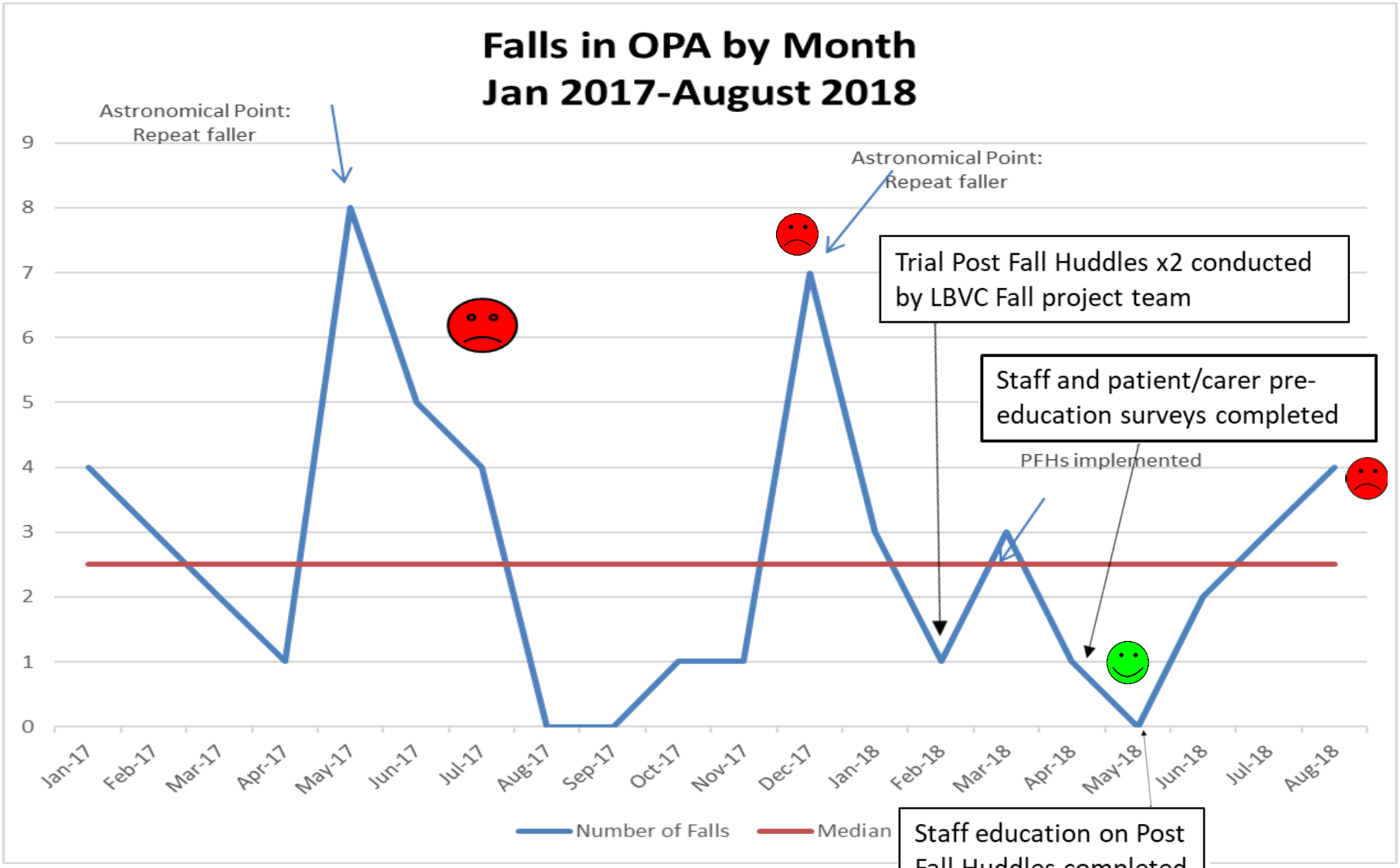
Results: Run chart #Falls IIMS in OPA up until LBVC Falls final workshop Sept 2018



Falls results March 2018-May 2019:

- a total of 19 falls *(well below the 80 falls incidents that occurred in 2016-2017)*

- 1 repeat "faller" had 3 falls, a 2nd repeat "faller" had 2 falls

  = 2/16 fallers were repeat fallers = ~12% of "fallers"

  = 5/19 falls being repeat falls = 26% of falls *(not 50%)*

- There have been no falls more serious than SAC3

- 1 fall in each of April/June/Oct/Nov/Dec 2018

- **0 falls in May/Sept 2018, Jan/Feb/April 2019**

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And we have seen a change in culture towards falls prevention in OPA

- OPA staff no longer accept that “OPA patients fall”
- staff, patients and carers have a greater awareness of the falls rate in OPA and the role that everyone has in preventing falls, including a greater enthusiasm for being a part of ongoing QI projects in OPA
- the ‘Days Without Falls’ posters in the patient common area and beside the entrance to OPA, ensure all have falls prevention on the forefront of their minds whilst in OPA

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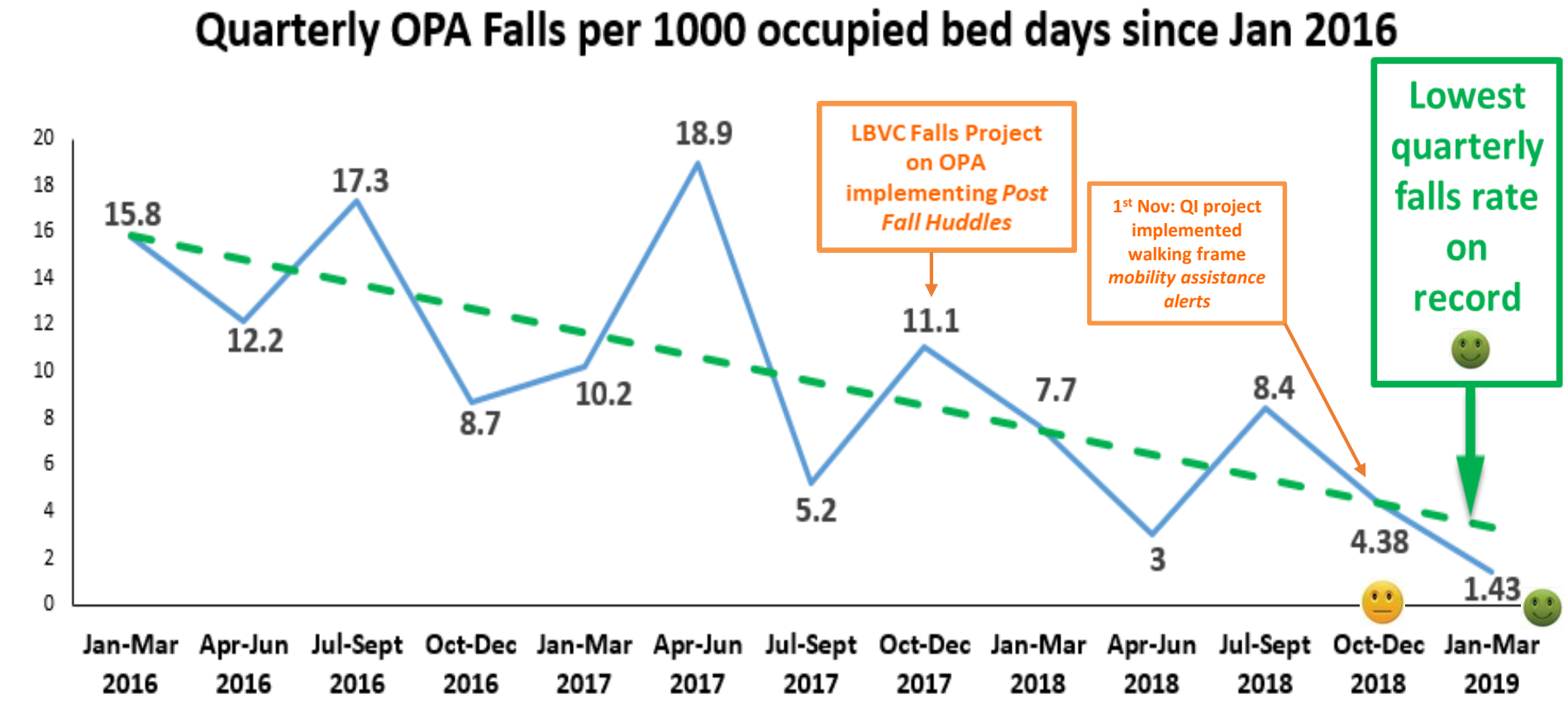
… and our data is now reflecting this

Results: On Monday 4 March 2019 we celebrated a record 75 days without a fall

... and we actually made it to a record 85 days!

Results: OPA Falls Rate lowest on record!



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Thank you


75
days
75
days
without a fall
Great work OPA!
DAYS WITHOUT FALLS
4/3/19 75
75
days
without a fall
Great work OPA!
75
days
without a fall
Great work OPA!
THINGS WE DO ON OLDER PERSONS ACUTE WARD
75