LEADING BETTER VALUE CARE
Reducing harm from falls in hospital

NSW Falls Prevention Network Forum

Malcolm Green
31 May 2019

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CLINICAL EXCELLENCE COMMISSION

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SPECIALISTS IN SAFETY

PARTNERS IN IMPROVEMENT

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FALLS COLLABORATIVE

'Keeping older people safe in our care'

Aim

Reduce falls and serious harm from falls by 5% within 12 months

Inclusions: Age ≥70 years
Inpatients in a health service
Partial or assisted fall
Exclusions: Staff, visitors

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Appreciation for a System

"Every System is perfectly designed to deliver the results that it gets."

Psychology of change

Theory of Knowledge

Unwarranted Variation

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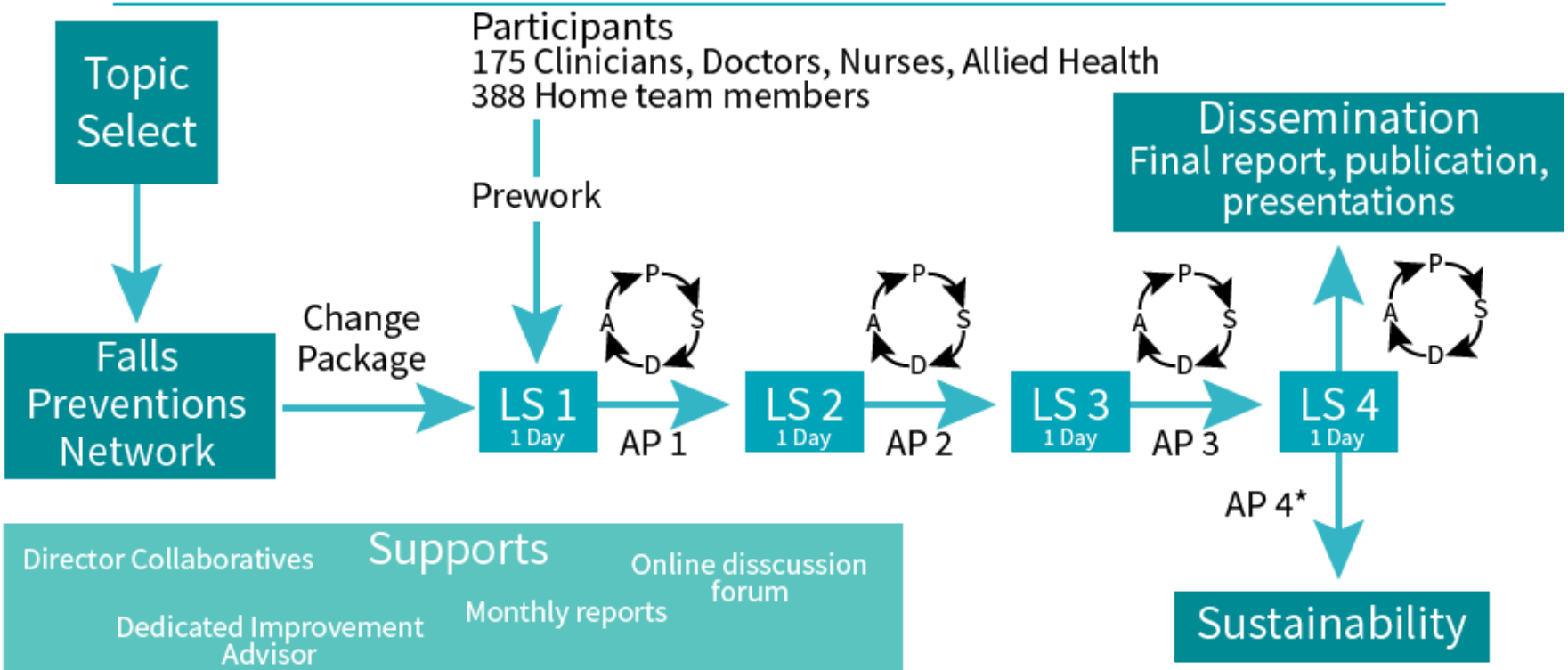
CEC Falls Collaborative

(18 Months Time Frame)



LS - Learning Session
AP - Action Period

*AP 4 continue reporting data as needed to document success

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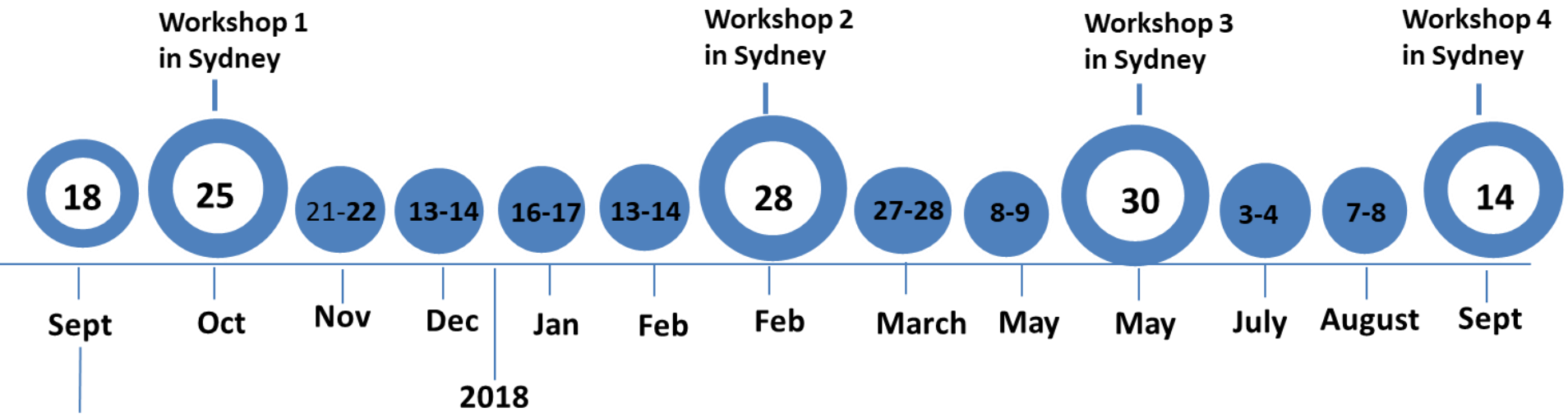

Other Workshops being held in 2018

8th March M LHD - NSW Falls Prevention Network Rural Falls Forum – Wagga Wagga

11th May - NSW Falls Prevention Network/Program Annual Forum – Wesley Centre, Pitt St, Sydney

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FALLS CHANGE PACKAGE

Falls Collaborative Driver Diagram

The Problem:
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

SMART Aim: Reduce falls and serious harm from falls by 5% within 12 months

Outcome Measure:
How much: Decrease rate of falls with harm by 5% by 30 June 2018.

Inclusions: Age ≥ 70 years
Inpatients in a health service
Partial and assisted falls
Exclusions: Staff, visitors.

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Primary Drivers	Secondary Drivers
Recognition of patient at risk and plan of care	Fall Risk Screening tool (OMSS) Fall Risk and Assessment Management Plan (FRAMP) completion Cognitive screening Delirium screening Orthostatic hypotension screening and monitoring Issues with toileting Identification of visual issues Re-screening on change of patient condition, transfer to ward Post fall management Completion of care plan
Medication Management	Medication review Medication reconciliation Reduction of the inappropriate use night sedation
Intentional Rounding	Patient Environment Toileting Pain management Patient positioning
Safe mobilisation	Mobility assessment Appropriate equipment Skilled Nurse / AHP Environmental review

FALLS CHANGE PACKAGE

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Primary Drivers	Secondary Drivers
Teamwork	Safety Huddles
	Post Fall Huddles
	Multidisciplinary Team Rounds
Documentation	Screen documentation
	FRAMP documentation
	Multidisciplinary Care plan documentation
Education	Education Framework
	Education Strategy
	Education for Nurses
	Education for Allied Health
	Resources and tools
	Education for Pharmacists
	Education for Medical Officers
Leadership	Executive walk-arounds attendance
	QI Coaching attendance
	QI Collaborative attendance
	Provide a supportive environment to raise concerns
	Prioritise the service focus
	Support effective teamwork
Communication	Communication Framework
	Communication Strategy
	Communication ward to Board
	Communication with Senior Clinicians
	Communication with junior medical officers , nurses & AH
	Communication with patients
Culture	Staff pre-survey
	Staff post-survey

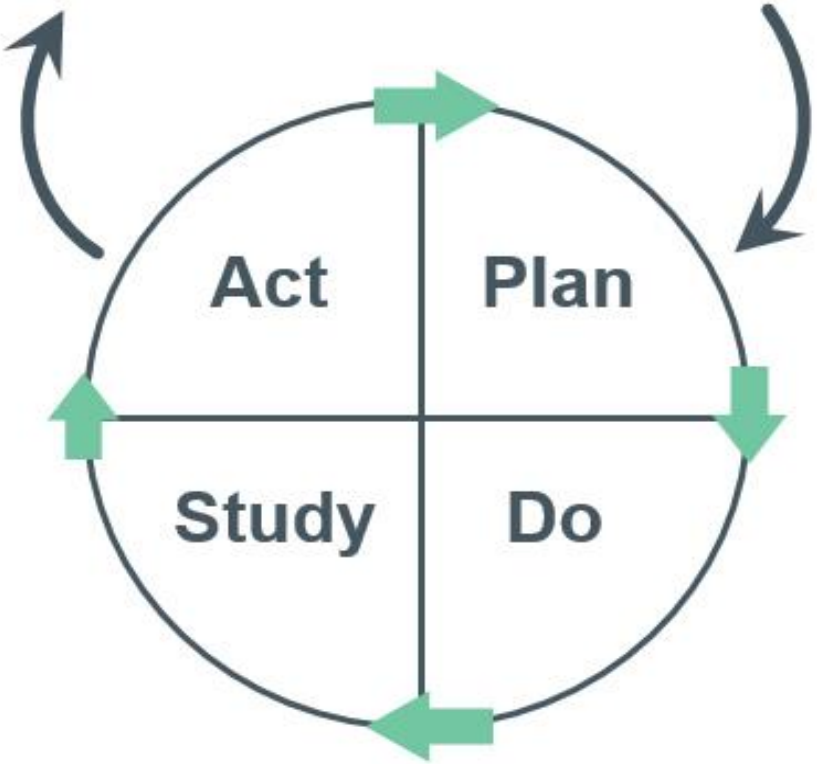
Model for Improvement

What are we trying to accomplish?

How will we know that a change is an improvement?

What change can we make that will result in improvement?

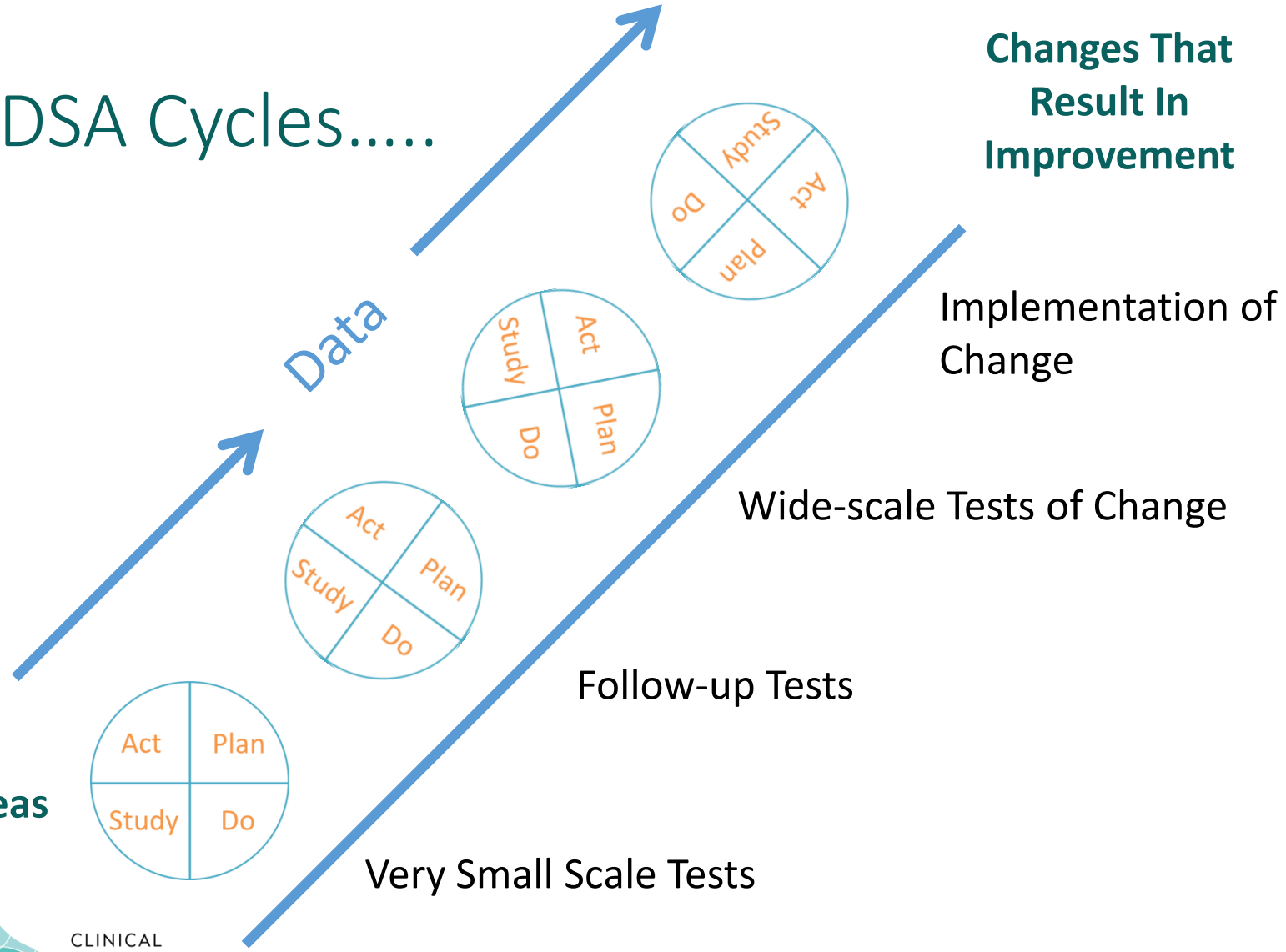
Thinking



Doing & Learning

PLAN DO STUDY ACT

Many PDSA Cycles.....



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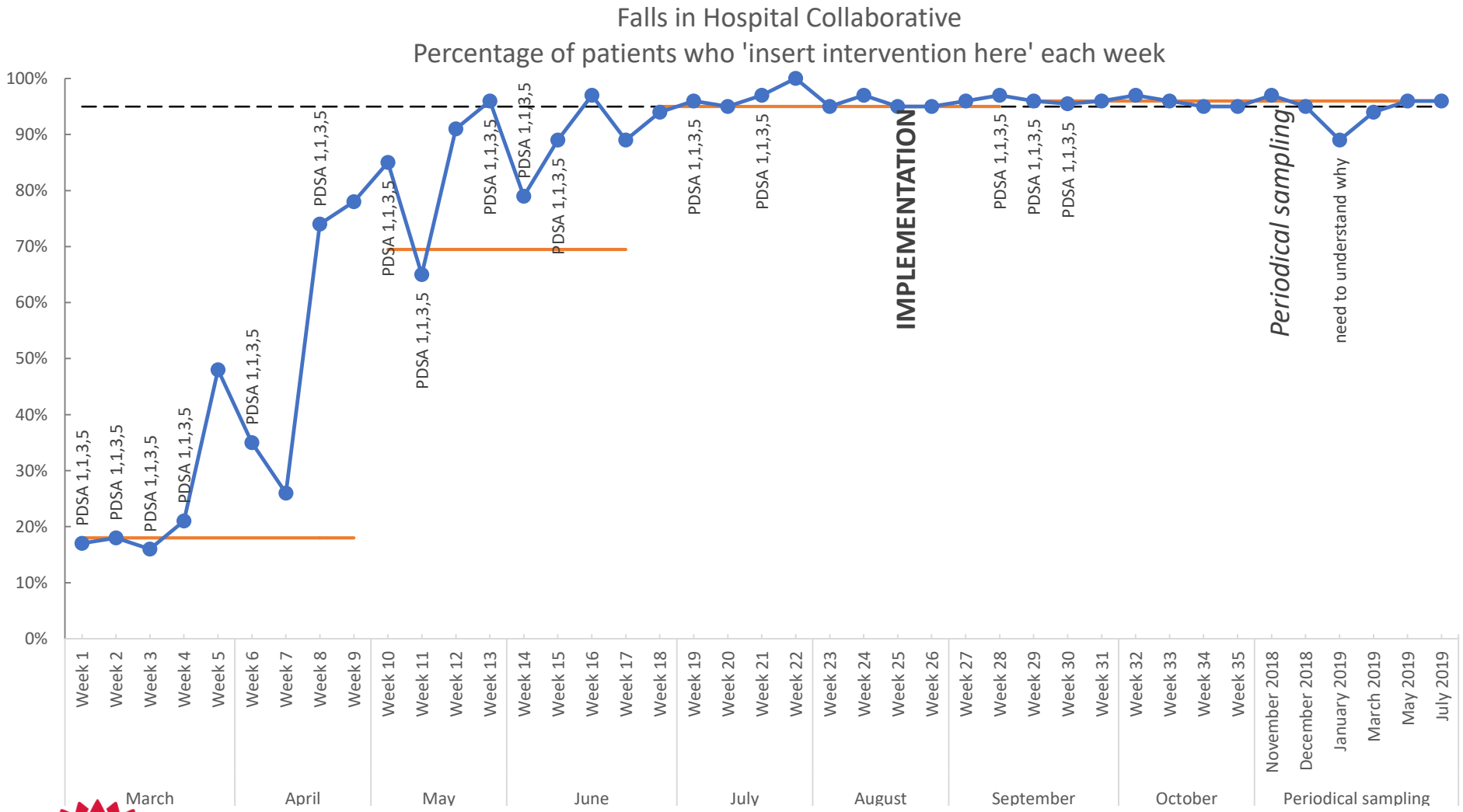
CONTINUOUS RUN CHART



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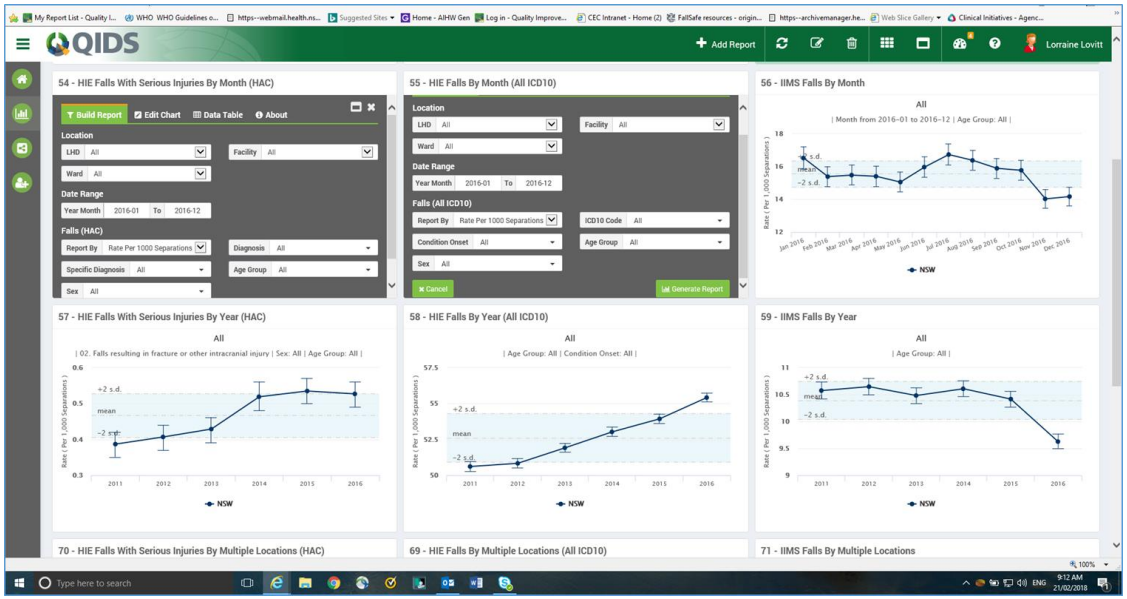
SERIOUS HARM FROM FALLS

- 11/40 teams have not had a SAC 1 or 2 for > 390 days (duration of the Collaborative)

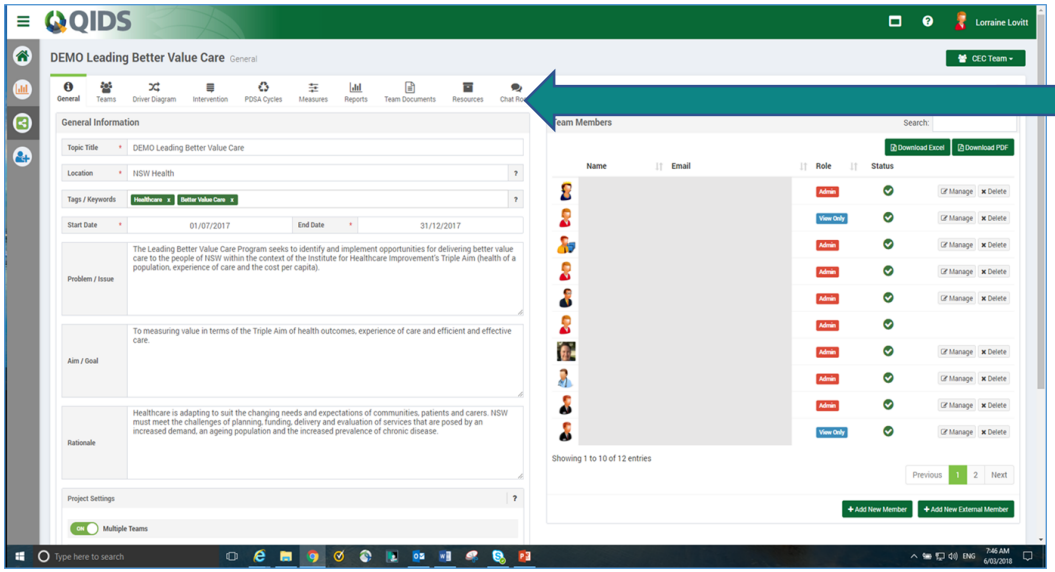
- 26/40 teams have not had a SAC 1 or 2 for > 100 days

QUALITY IMPROVEMENT DATA SYSTEM



Monitor falls data

LHD team activity



Resources

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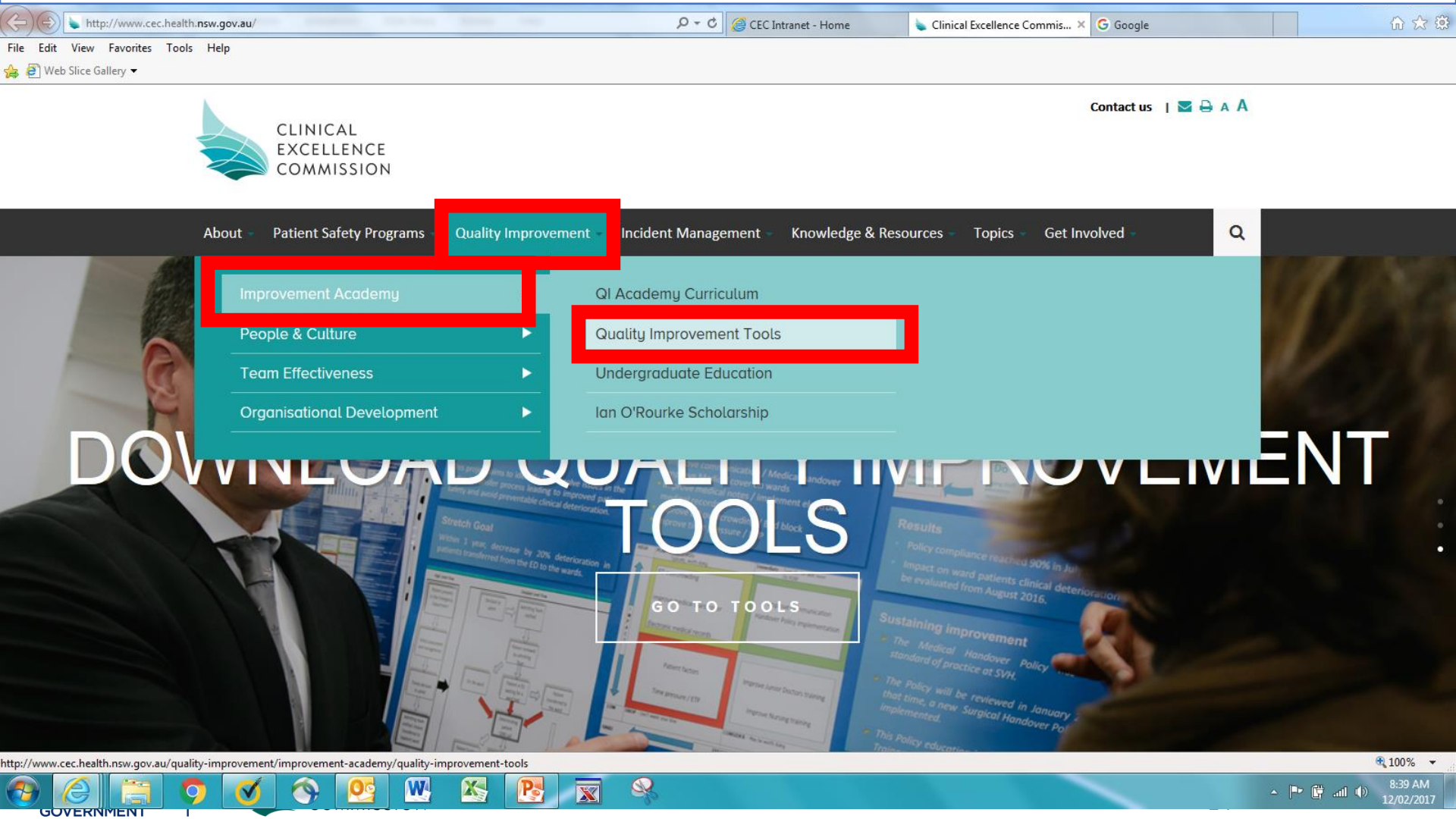
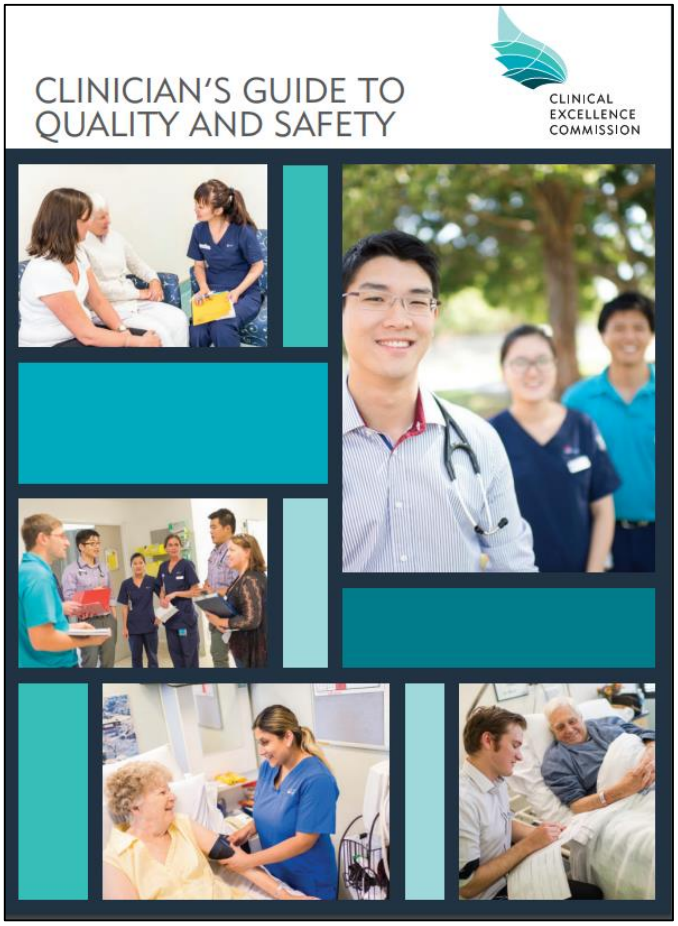
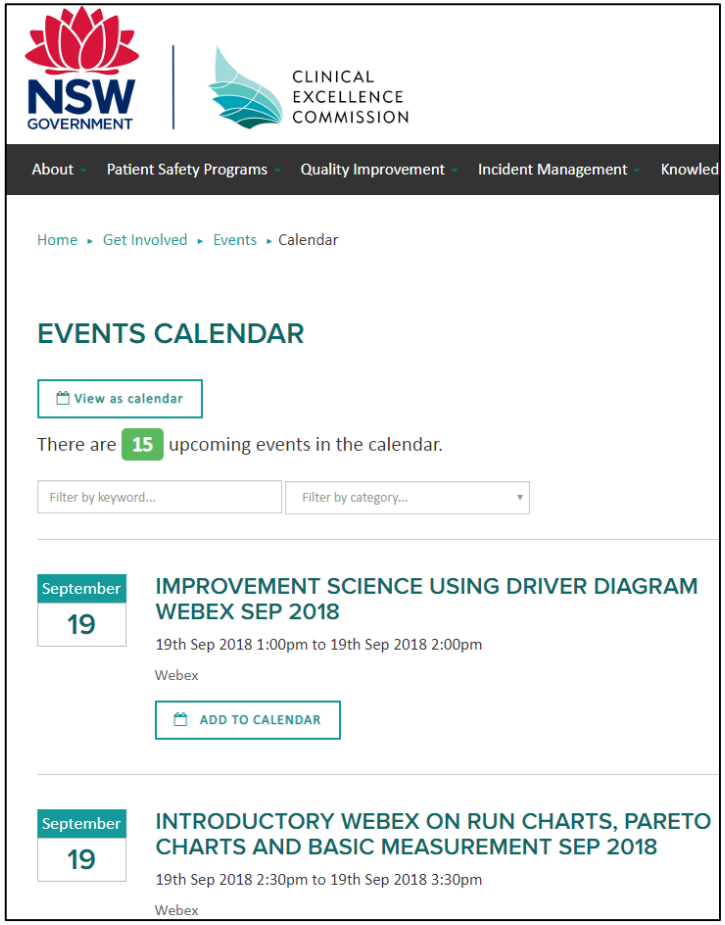
CEC Quality Tools Web Site www.cec.health.nsw.gov.au

http://www.cec.health.nsw.gov.au/quality-improvement/improvement-academy/quality-improvement-tools



QI ACADEMY





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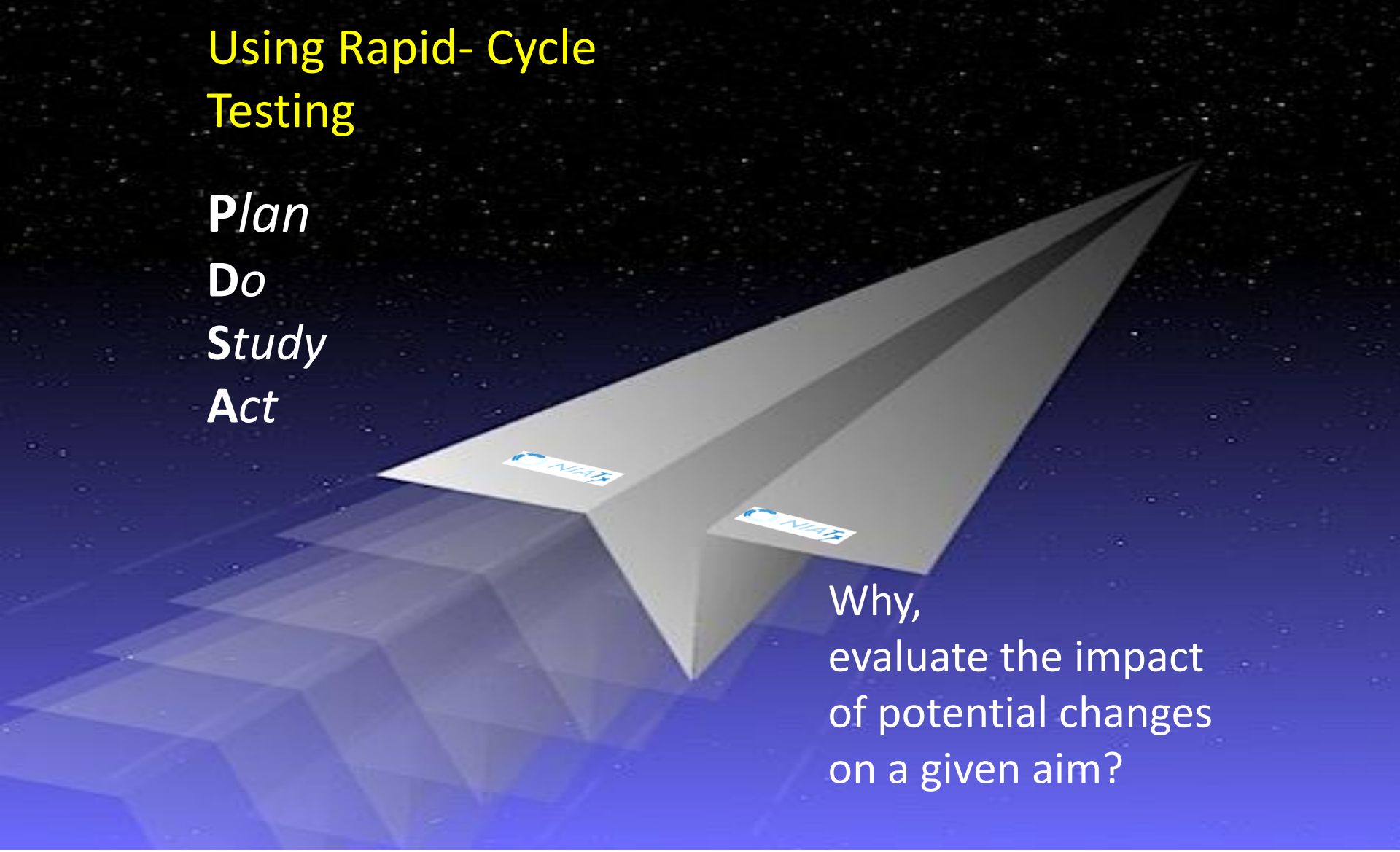
Using Rapid- Cycle Testing

P*lan*

D*o*

S*tudy*

A*ct*



Why,
evaluate the impact of potential changes on a given aim?

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Your Aim & Measures

- **AIM**

– Improve the performance of a paper aeroplane to maximize the distance it flies and the accuracy of the flight

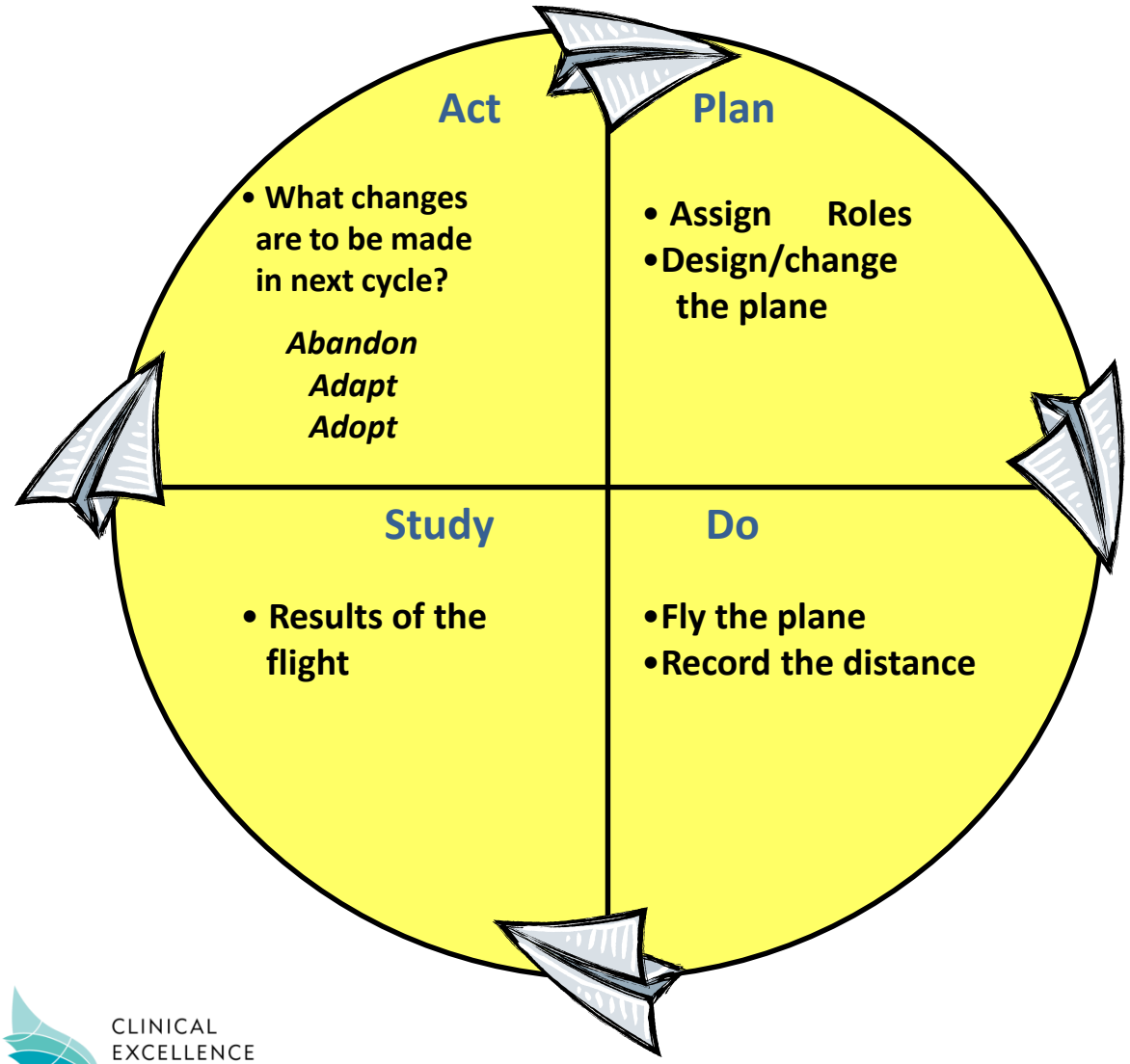
- **M e a s u r e s**

– Distance in meters

– Accuracy of the landing (total landing points)

Flight

PDSA Cycle for Improvement



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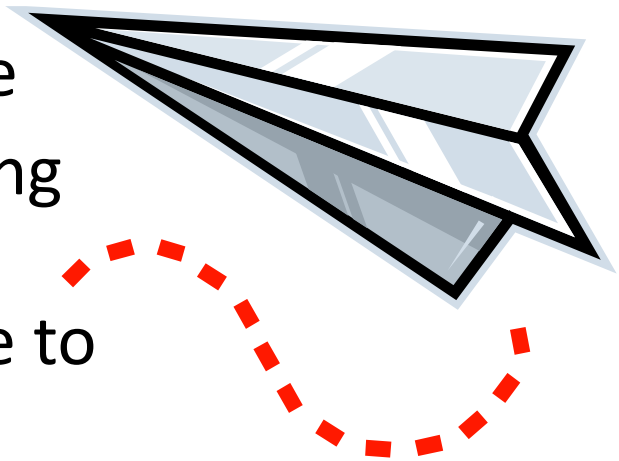
Flight

PDSA Cycle for Improvement

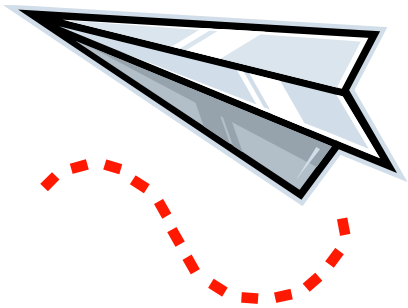
Rules



- Only one design change per PDSA cycle
- Each team designs and commits to flying only one plane
- All planes must have wings and be able to fly
- Each design is flown by each of the three pilots
- In order to fly you must get clearance from the air traffic controller

PDSA Cycle *Flight* for Improvement

- Assign the following roles
  - Team Lead
  - Pilots x 3
  - Data collection/scribe
  - Design Team
- Decide on a Name for your TEAM
- Design and build a paper airplane for distance



Flight One Collect Your Baseline DATA

- Pilot 1, 2 and 3 will fly the plane and record the data;

Repeat

- Rapid Cycle: More cycles = more data = more chances to improve

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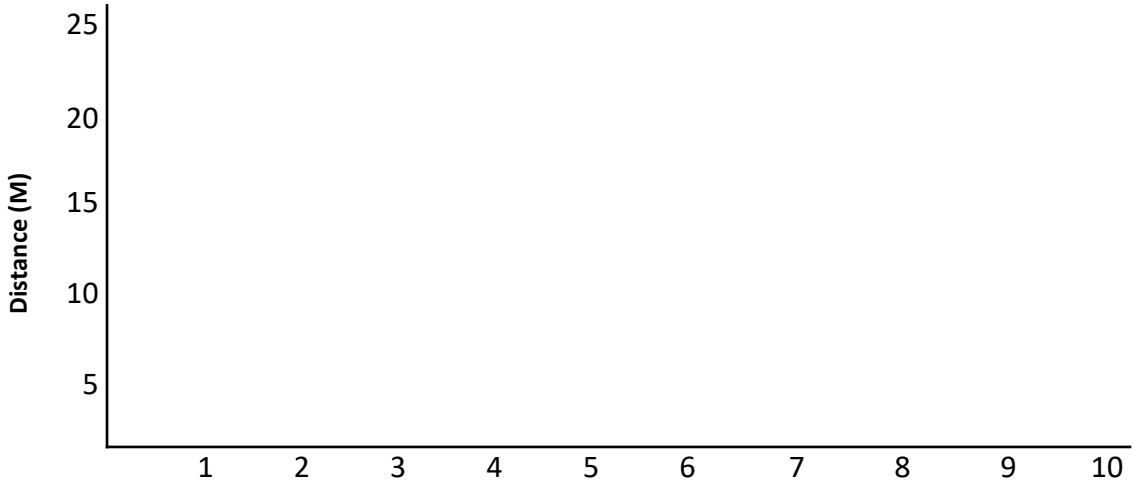
What is your theory?

PDSA Tracker

#	Plan		Do	Study	Act
#	What questions? Theories?	Prediction	What do you see? How Long?	How did what you see match prediction?	What now? Adopt, adapt, abandon?
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					

Data Collection on a Run Chart



PDSA Test Cycle

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PDSA Tracker

#	Plan		Do	Study	Act
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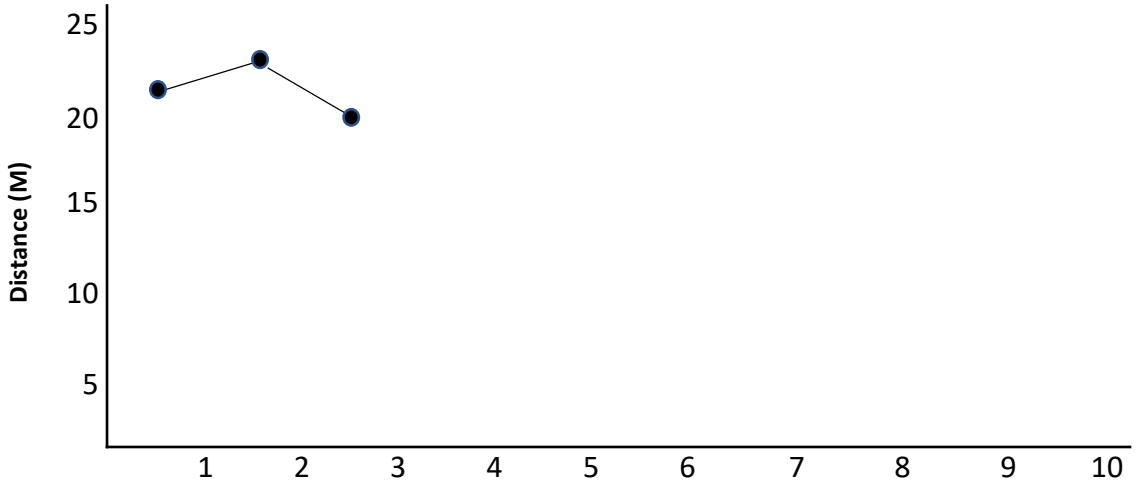

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Let's Play!

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Discussion

What did you learn about rapid-cycle change projects?