Princess Margaret. “Working on AT&R opens your eyes to what the nurses do there – they are fantastic and so dedicated.”

She hadn’t worked with dementia patients before, so being in the dementia unit was “a steep learning curve” but worthwhile.

Gibb said it was wonderful for RNs to have the opportunity to gain experience caring for older people in other parts of the health system.

“The GAP is unique in that it brings together nurses from different employers, from aged residential care and DHB settings, and gives them the opportunity to gain experience and valuable networks across the health system.” It aimed to increase the visibility of aged-care nursing as a specialty and as an area with “exciting career possibilities”, which would help recruit and retain nurses in geronotology.

Feedback from participants showed the opportunity to rotate to other settings, then return to their own area with new knowledge and experience, had increased their confidence and given them a sense of excitement about aged-care nursing, Gibb said.

Initial evaluation of the scheme showed nurses who had completed GAP were already stepping up to take on clinical leadership and educator roles in their workplaces, she said. An example is Gene Ruiz, who completed the first GAP programme and, as clinical manager at Bishop Selwyn Lifecare, is now preceptor at that site for this year’s GAP nurses on rotation there. Ruiz said a major benefit of GAP was staff who worked in acute care and in residential settings were able to experience how the system worked in each and get to know staff they normally only spoke to on the phone.

Five nurses finished the first GAP (one of the six who started withdrew), and a second intake of nine nurses started the second programme in May this year.

Gibb said, as well as selecting a good group of nurses to participate, it was important the right aged-care employers were involved too. They needed to have enough staff to do without one of their RNs, who was away on rotation for 24 weeks, and to be able to provide the education and support needed by the new RN on placement.

A formal evaluation of the scheme is now underway. •

Falls prevention tailored to suit individual residents

By Jan Jackson

In 2011, the incidence of falls at the Ferguson Rest Home and Hospital in Upper Hutt was very high and above key performance indicators for the dementia and hospital area.

Clinical manager Joy Tlapi and I set a goal to reduce the incidence of falls by 25 per cent for both areas by August 2012. Several interventions were put in place, but by August 2012, the hospital reported 70 falls compared to 79 in 2011; the dementia unit 71 compared to 48 in 2011. Clearly, we needed to do more.

At the beginning of 2013, staff at Ferguson still aimed to reduce the incidence of falls and the harm they caused. We decided to enrol in the Health Quality and Safety Commission’s collaborative programme. Run in conjunction with the Accident Compensation Corporation and the three Greater Wellington district health boards (DHBs) – Wairarapa, Hutt Valley and Capital and Coast – this pilot programme aimed to strengthen the falls prevention programmes in the region’s aged residential care (ARC) facilities, and so improve care.

During the 10-month programme, each organisation learnt from the others, and shared knowledge to enhance better care for the elderly, with a long-term aim of replicating this in other areas of concern, eg pressure injuries and medication errors.

Ferguson staff attended three workshops, the first in September 2013. This included an examination of falls statistics, the model used to reduce falls, measures for quality

Resident June Chalmers, with caregiver Rachel O'Connell, who is a member of the falls team. Chalmers’ walker has an orange tag, indicating she needs help with walking.
improvement, how to use the data and ideas for managing the programme in our own facility.

The second workshop in February this year involved each organisation sharing changes that had been tested in its facilities, a discussion on how InterRai data could help with reducing falls, and lessons from the “First do no harm” collaborative and commitment to the next steps.

**Identify residents of concern**
The third workshop was held in June. Again, changes tested in facilities were shared, InterRai data was discussed, along with the psychologic factors involved in making changes and the next steps to take.

As a result of the workshops, Fergusonson Rest Home and Hospital set up a falls committee of six staff representing the hospital, rest home and dementia unit. The goal of each representative was to identify residents of concern and strategies to help minimise the risk of falls, as well as harm from falls. The committee met monthly, with the core agenda being to review incidents for the facility and per area, to set goals for specific residents or systems, and to share falls statistics.

A number of quality initiatives were implemented.

Some residents’ rooms were re-arranged to position beds closer to en suites. Daily walking schedules were instigated for mobile hospital residents – 10 at present. Exercise classes were started, with input from the physiotherapist. We reviewed our toileting regime for some residents. The GP reviewed medications. Levels of care were reassessed and hospital residents were provided with mattress overlays. Tags were attached to walkers, identifying residents who needed help with walking and who were at high risk of falls. Hip protector pants for mobile residents at risk of falls were ordered.

A number of environmental changes were also made, eg mapping falls per area and at what times, and chairs being placed in the dementia unit hallways to break residents’ long walks from the dining room to the lounge or rooms. Mirrors were strategically placed to help increase visibility in the dementia unit and address the blind spots. Part of the courtyard area was resurfaced and the courtyard itself landscaped to remove hazards. New improved sensor mats were ordered and placed beside the beds of at-risk residents. Staff were given intense training. Better discussions took place on shift handovers to identify residents of concern, and graphs showing incident rates were displayed, with incidents discussed at meetings.

Lessons from other facilities helped us introduce new ideas to try with our residents. The main lesson has been looking out at the residents as individuals and having interventions tailor-made to their needs. Re-evaluating and trying other strategies has also been a great strength in managing to support residents of concern.

The many interventions put in place in the dementia area are reflected in statistics. In August 2013, 129 falls were reported in the dementia unit. By August this year, this had reduced to 82 falls.

**Reducing falls is an ongoing challenge and very much depends on the changing acuity of our residents.**

The falls committee now meets bi-monthly, reviewing any incidents and falls statistics, with the aim of continuing to reduce harm for the residents in our care. However, reducing falls is an ongoing challenge and very much depends on the changing acuity of our residents. But the programme has given us all a passion for reducing the risk of falls and has involved our staff well. Not only do we want to protect our residents from the pain, discomfort and loss of confidence associated with falls, we also want to avoid adding to the workload of our registered nurses, who are the ones responsible for writing up falls reports and doing the follow-up assessments. They are already working to full capacity, so if we can avoid adding to their workload, this benefits everyone.

The programme has been so successful at Fergusonson Rest Home and Hospital that our provider organisation Bupa is developing a similar project in its other facilities nationally.

**Jan Jackson, RN, is the care manager of the Fergusonson Rest Home and Hospital, Upper Hutt.**

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**Wairarapa med**

By Fred Wheeler

The primary aim of the Government’s health of older people strategy is to develop an integrated approach to health and disability support services responsive to older people’s changing needs. Older people should be able to access services at the right time, in the right place and from the right provider. The strategy also supports initiatives that encourage positive ageing in the community.

Medication management is a major health risk and cost for older people, especially those taking multiple medications. Good processes are needed to keep people safe at home, while also avoiding preventable presentations to the emergency department (ED) and subsequent admissions to acute wards. Knowing medication is safely managed at home also facilitates early discharge, and may delay the need to move to an aged residential care (ARC) facility.

The Wairarapa District Health Board’s (DHB) community nursing services has developed an initiative – the medication run (med-run) programme – which is contributing to helping older people to be safer in their own homes. The service, which is unique to our district, is delivered by health-care support workers (HCSWs), who, in turn, are supported by the district nursing team.

**Rural population**

Wairarapa DHB serves a largely rural population of around 42,000, 16.5 per cent of whom are aged over 65 (four per cent higher than the national average). This figure is expected to increase to 30 per cent by 2026. The capacity for psycho-geriatric care in the community is also limited.

The Masterton med-run service was established nearly five years ago in response to an identified need, and was built into the district nursing service. While non-DHB home support services provide a valuable service for many clients, recruitment, training and retention of staff can be a problem, especially when dealing with clients with complex needs who may need services once a day, seven days a week.

To function well, the med-run service required guaranteed registered nurse (RN) cover, providing consistent supervision of home-support workers and their clients.

The initial client load quickly rose from four