

# 3-Nation approach to reducing harm from falls

## Three nations come together to share evidence-based knowledge, translate that knowledge into practice and share learnings.

Join us for a free, exciting, world-class event that will include answering the following questions:

- An exchange of falls prevention ideas and experiences across '3 Nations' – what can we learn from each other?
- Patient safety opportunities through a falls lens – what are the successes and challenges?
- How can we grow our international falls prevention networks and partnerships to share ideas and learning?
- Falls prevention – it's a long game; how do we sustain the focus with the right culture, leadership and learning environment?

**Confirmed speakers (bios overleaf):**

- Dr Frances Healey, Deputy Director of Patient Safety, National Health Service (NHS) England
- Julie Windsor, Patient Safety Clinical Lead – Medical Specialties/Older People, NHS England
- Lorraine Lovitt, Lead, NSW Falls Prevention Program, Clinical Excellence Commission
- Sandy Blake, Clinical Lead, Reducing Harm from Falls programme, Health Quality & Safety Commission New Zealand
- Jon Buchan, Portfolio Manager, Maternal, Child and Youth Health, Whanganui District Health Board
- Carmela Petagna, Senior Portfolio Manager – Quality Improvement Programmes, Health Quality & Safety Commission New Zealand.

**Dates and venues:**

- Wednesday 13 September, Nordmeyer Theatre, Otago Medical School, Wellington Hospital
- Friday 15 September, Fisher & Paykel Centre, Auckland Hospital.

**Registration: Click here to register**

Seats are limited, so please get in quick. We reserve the right to limit registrations to ensure a multidisciplinary audience.

## Indicative agenda

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| 9.00–9.30am | Registration and morning tea |
| 9.30–9.40am | ***Welcome***<br>Local delegate |
| 9.40–10.40am | ***Patient safety struggles and successes – are there lessons we can apply to falls prevention?***<br>Dr Frances Healey<br>Deputy Director of Patient Safety<br>NHS England |
| 10.40–11.00am | Presentation from local delegate about local falls prevention project(s) |
| 11.00–12.00pm | ***Falls prevention in health and social care: the UK perspective***<br>Julie Windsor<br>Patient Safety Clinical Lead, Medical Specialties/Older People<br>NHS England |
| 12.00–12.30pm | Lunch |
| 12.30–1.15pm | ***Keeping older people safe in our care***<br>Lorraine Lovitt<br>Lead, NSW Falls Prevention Program<br>Clinical Excellence Commission, Australia |
| 1.15–1.45pm | ***Reducing harm from in-hospital falls in New Zealand***<br>Sandy Blake<br>Clinical Lead, Reducing Harm from Falls programme<br>Health Quality & Safety Commission New Zealand |
| 1.45–2.15pm | ***From falls to frailty assessment***<br>Jon Buchan<br>Portfolio Manager, Maternal, Child and Youth Health<br>Whanganui District Health Board New Zealand |
| 2.15–2.45pm | ***The next steps – reducing harm from all falls and fractures in New Zealand***<br>Carmela Petagna<br>Senior Portfolio Manager, Quality Improvement programmes<br>Health Quality & Safety Commission New Zealand |
| 2.45–3.30pm | ***Panel discussion***<br>Chair: Carmela Petagna<br>Panel: Dr Frances Healey, Julie Windsor, local delegate, Lorraine Lovitt, Sandy Blake, Jon Buchan |
| 3.30–4.00pm | ***Close***<br>Carmela Petagna and local delegate |

# Speaker information

## Dr Frances Healey

Frances is a registered general nurse and registered mental health nurse with a doctorate in hospital falls prevention.

Her clinical career encompasses frontline and senior nursing and management posts in acute hospitals, mental health units and community hospitals.

In her research roles, she designed and led successful research studies related to pressure ulcer prevention and falls prevention. Later, she collaborated on studies taking innovative approaches to mortality review, with methods adapted to review the care of older patients with frailty. She developed a pilot national clinical audit that was the first to include bedside observation of care as well as review of care records, and has led large-scale quality improvement (QI) projects, including FallSafe.

Frances has held a range of responsibilities related to improving the quality of investigation and learning from patient safety incidents, including delivery of a national programme focused on improving understanding of human error and root cause analysis investigation techniques. This mixed clinical, research, audit and QI background gave her expertise and an enduring interest in the pitfalls of measurement and assurance of patient safety.

For the past 14 years she has worked within national organisations in England with responsibilities for patient safety, and is currently Deputy Director of Patient Safety (Insight) in the national patient safety team at NHS Improvement. Her responsibilities include oversight of the teams who undertake clinical review of all nationally reported death and severe harm incidents, and who share findings through the NHS Improvement Patient Safety Alerting System.

## Julie Windsor

Julie is a registered general nurse and has a master's degree in gerontological practice. Her entire career has been within older people's services, both in acute hospital and community care.

Always concerned about things that mattered to older people, she first became aware of the 'falls problem' while the clinical manager of a day hospital in 1996, when she co-led the setting up of the region's first multi-professional falls clinic.

After a few years working as a district falls coordinator setting up falls services across health and social care boundaries, in 2008 she returned to her first love, acute hospital care, and set about improving falls prevention in a 2000-bed district general hospital.

She was co-designer of the successful FallSafe and CareFall projects and a member of the NICE 161 (Falls) Clinical Guideline Development Group. She is currently a steering group member of the National Falls and Fracture Audit Programme (Inpatient Falls) and a member of the National Falls Prevention Coordination Group.

Julie has been, and still is a clinical advisor to several falls studies and a clinical reviewer for the National Institute for Health Research. Her particular interest is the built environment and patient safety technologies.

Julie took up the Patient Safety Clinical Lead – Medical Specialities/Older People post with the NHS's Patient Safety National Advice and Guidance Team in 2014, where her key tasks are to:

- provide specialist clinical advice and insight concerning safety issues related to older people
- advise national (and international) policy/clinical interventions audits and guidance
- identify topics, engage stakeholders and develop national safety alerts or other appropriate responses.

## Lorraine Lovitt

Lorraine has is a registered nurse with postgraduate qualifications in gerontology and considerable experience in aged care (management, consultation and coordination) in both community and acute care settings and with the residential aged care sector.

During her career she has worked at the NSW Department of Health developing a discharge policy, and initiated the development and implementation of the NSW health program 'ComPacks' (a community facilitated discharge initiative).

Lorraine worked on the NSW Government Dementia Strategy, and supported the implementation of key initiatives to support improved care for people with dementia. Currently Lorraine is Lead, NSW Falls Prevention Program at the Clinical Excellence Commission (CEC). The CEC has a key role in building capacity for quality and safety improvement in health services in NSW. In her role Lorraine is working to support improved care for older people as they engage with NSW health services.

Lorraine is a long-term director of Twilight Aged Care (a residential aged care provider) and is a graduate of the Australian Institute of Company Directors. Lorraine is motivated to ensure people in our care are supported to continue to live their lives well and with dignity.

## Sandy Blake

Sandy has been the Clinical Lead for the New Zealand Health Quality & Safety Commission's national Reducing Harm from Falls programme since its inception in 2013. In December 2016 the programme's success was profiled and celebrated in the *New Zealand Medical Journal*. The article highlighted a sector-wide commitment to preventing falls-related harm and a 40 percent reduction in falls resulting in a broken hip in public hospitals since December 2014. The article noted that New Zealand appears to be the first country to achieve this on a national scale.

She is also the Director of Nursing, Patient Safety and Quality, at Whanganui District Health Board (DHB), where she leads the DHB's patient safety programme with particular focus on nurse-sensitive indicators of care and adverse event management.

Sandy has led the development and implementation of a frailty nursing assessment tool using TrendCare (a nurse acuity tool) as the hosting platform. During 2004–09 Sandy was state-wide nursing director of patient safety for Queensland Health.

## Jon Buchan

Jon graduated as a registered general nurse from the University of Plymouth in 1998 and rapidly developed an interest in emergency nursing. This lead to completion of a diploma in paediatric nursing from Southampton University.

A move from England to Whanganui in 2004 gave Jon the opportunity to introduce electronic acuity-based patient assessments into Whanganui DHB. This tool enabled a long-held passion for evidence-based practice to be applied and utilised as a basis for ensuring appropriate nursing resources.

The Health Quality & Safety Commission's Reducing Harm from Falls programme brought focus onto the lack of a consistent assessment for falls risk and offered the opportunity to develop evidence-based electronic falls assessment.

Although now based within Service and Business Planning as Portfolio Manager for Maternal, Child and Youth Health, Jon has maintained active participation in utilisation of electronic systems to add value to the health system and patient programmes. To date, these include Care Capacity Demand Management Allied Health, electronic assessments and quality improvement strategies.

## Carmela Petagna

Carmela is a Senior Portfolio Manager at the Health Quality & Safety Commission New Zealand and has been with the organisation for six years.

She is responsible for leading and managing a number of national quality improvement programmes, each at varying stages of development and implementation. These include medication safety, pressure injuries prevention and management, and emerging work in the primary care and aged residential care sectors. Carmela has managed the Commission's national Reducing Harm from Falls programme since its inception in 2013 and is delighted with the success of the programme in reducing in-hospital falls resulting in a fractured neck of femur (by 40 percent over the life of the programme).

Carmela works across the health and disability sector, with public and private service providers, and clinical leaders and other health professionals from diverse sectors and backgrounds. Strong collaborative relationships and connections are developed, which are critical for the success of the Commission's programmes.

She ensures the Commission's programme teams work and partner with stakeholders to ensure projects are well integrated and can demonstrate improved patient care and outcomes.