Releasing Time to Care
The Productive Ward

Falls Prevention
New Zealand module

Version 3.0
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# Releasing time to care: The Productive Ward – falls prevention: New Zealand module

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Health Quality & Safety Commission New Zealand  
www.hqsc.govt.nz/contact-us/

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Every day in New Zealand, according to the Accident Compensation Corporation (ACC):

- 1170 people make a claim following a fall
- 120 people sustain a fracture or dislocation from a fall; of those, 14 sustain a hip fracture
- 5 people fall while at a medical treatment site
- 97 people will require ongoing rehabilitation to return back to full independence after their fall
- more than one person dies as a result of a fall.¹

The good news is that many falls are preventable.

This module will help you identify and reduce the risk of falls and harm from falls for people in your care. Preventing falls requires more than simply identifying a falls risk; it requires evidence-based interventions for each person at risk. This needs to be supported by a well-functioning multidisciplinary team, with robust processes, clear communication, integrated care planning, accurate documentation and a culture of safety.

The reduction of falls will reduce pain, suffering and harm for those in your care. It will reduce the burden of care placed on family/whānau members and carers. Preventing falls will also reduce admissions and length of stay in hospital, meaning resources can be applied to other patients who need care.
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**What is the New Zealand falls module?**

The New Zealand adaptation of The Productive Ward module, for falls prevention, has been led by the national Reducing Harm from Falls Programme at the Health Quality & Safety Commission (the Commission). The Commission’s *Open for better care* campaign focus for 2015 was ‘Stand Up to Falls’, recognising that falls prevention is everyone’s business. It is the responsibility of each and every health care worker to be alert to falls risks.

This module will help clinicians to focus on the problem of falls and provide support to prevent falls and harm from falls within the clinical environment. A fall is ‘any unintentional change in position where the person ends up on the floor, ground, or other lower level; including falls that occur while being assisted by others’.2

**Why do this module?**

- Falls reduce quality of life for people in our care, their families/whānau and carers. Falls also add considerable costs to our health system.

- Around 30 percent of patients who have a fall develop a fear of falling. As a result, they no longer perform daily activities they had the ability to perform prior to the fall. This restriction of activity may lead to a loss of lower limb strength, a further reduction in mobility, physical function and social isolation.3 Most people who fall never totally regain the same level of independence and confidence they had prior to their fall.

- Falls can cause serious injuries. The most common injuries that require hospitalisation are:
  - fractured femur including hip fracture
  - shoulder, arm and wrist fractures
  - intracranial injuries
  - leg and ankle fractures.4
For older adults, there is a five to eight-fold increased risk of death during the first three months after a fracture.\textsuperscript{5}

While harm from falls is often devastating for those who have fallen, the fall also causes stress and anxiety for families and support people. This often results in loss of worktime and income as extra time is needed to care for the older person who has fallen.

Falls generate significant costs for the health system. Falls requiring ongoing treatment and rehabilitation cost New Zealand approximately $420 million in 2013–14, and this has been increasing every year on average by $27 million.\textsuperscript{1}

Falls that do not result in injury can still impact in a loss of confidence, which in turn may lead to loss of mobility and independence, and social isolation.

**What the module covers**

- Tools and processes to support falls prevention and management from admission through to discharge.

**What it does not cover**

- Screening and assessment tools (covered in the Commission’s website, Reducing Harm from Falls section www.hqsc.govt.nz/our-programmes/reducing-harm-from-falls.)
- Management of incidents.
Learning objectives

The team will:

- understand how to prepare for the module
- understand how to use a ‘measles’ map and other data sources to identify the incidence of falls, including high risk areas and times
- understand the concept of cost/benefit analysis
- define standardised work and understand how it increases quality
- develop audits as a positive activity that help sustain falls prevention processes
- identify the factors that will contribute to the success of the module
- learn about the Commission’s Reducing Harm from Falls programme and the evidence-based resources and tools available on its website (www.hqsc.govt.nz/our-programmes/reducing-harm-from-falls).
What tools will I need?

The Tools referenced in this adapted module link back to the Releasing Time to Care (The Productive Ward) and can be located at www.qualitasconsortium.com.

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<td>National Minimum Dataset (NMDS)</td>
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<td>Falls quality and safety markers</td>
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<td>process and outcome achievements</td>
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<td>Local audit results</td>
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<td>Health Roundtable data, falls</td>
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<td>debrief forms, etc.</td>
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<td>Website Resources</td>
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Creating your module baseline and keeping track of progress

This module has its own 10-point checklist to help you identify your position before you begin and show your progress.

Remember… it is important to have your baseline measurement and regular measurements over a period of time.

An example of the 10-point checklist for falls prevention, and a blank template, can be found at the end of this document.
How will we do this in our unit?

The six-phase process

1. Prepare
   - decide who will be involved
   - talk to staff, patients and carers
   - take photos and video of environment
   - gather data including incident reports

2. Assess
   - review the photos and video of environment
   - analyse patient and staff experience
   - analyse incidents related to falls
   - compare best practice with current practice

3. Diagnose

4. Plan
   - review the description of good falls prevention (print off the ‘10 topics’ from the Commission website for staff to read)
   - brainstorm and identify changes to the process
   - prioritise what you wish to change

5. Treat

6. Evaluate
   - review data and incidents
   - consider and respond to patient and staff feedback
   - consider further opportunities for improvement

- determine the test period
- inform all staff
- implement strategies
- gather data regularly
Prepare
**Prepare**

**Step 1: Decide who will be involved and contribute:**
- Staff including nursing, medical and allied health physiotherapists, occupational therapists, health care assistants, allied health assistants, volunteers and families/whānau and carers.

**Step 2: Talk to staff:**
Use Tool 5 (interviews).
For example:
- Do staff believe falls are preventable?
- What is the general feeling towards falls prevention in the unit/department?
- What is the level of commitment to falls prevention?
- Do staff understand the impact of falls on patients and families/whānau?
- Are there any barriers to reporting falls?
- What do staff think will help prevent falls in their unit?

**Step 3: Talk to patients and carers:**
Use Tool 5 (interviews).
For example:
- What is the patient’s experience – what do they think will stop them from falling?
- What is the carer's/family's experience – what do they think would stop their family member from falling?
- Are staff available to help you/the patient with mobilising when required?
- Did you/the patient receive information about preventing falls?
Gather information from hospital, for example, using Commission patient experience surveys:

- If your DHB uses other patient experience surveys, gather any results relating to falls and falls prevention.
- Ask your consumer engagement liaison (or equivalent) for any feedback they have received from patients and families/whānau.
- Look back over the past year and identify any complaints related to falls.
- View the Commission’s falls quality and safety markers regarding completion of falls assessments and individualised care planning.

**Step 4: Take photographs and videos:**

Use Tools 6 and 7:

- Take photographs of the work/patient area. Pay particular attention to the environment, for example, clutter, walkways, toilets and bathrooms, equipment, drips and drains, and accessibility of call bells.
- Film the whole area to obtain a dynamic view of patients mobilising.

**Step 5: Gather data/reports:**

Incidence of falls at unit/department/service level:

- Source incident management system data from the last 12 months.
- Collect current incidence of falls using safety crosses (refer to p25).
- Using incident reporting system and/or safety cross data, plot fall locations and times in your area using a ‘measles’ map (refer to p26).
- Source the most recent documentation and results of any audits, Commission quality and safety markers, patient experience data, Health Roundtable data, unit-based falls audit data.

**Step 6: Collect best practice and evidence-based guidance on falls prevention:**

- from the Commission’s Reducing Harm from Falls website
- from ACC’s website
- from your local falls prevention champions
- from those people coordinating the Fracture Liaison Services within your hospital.

Gather time of falls data. Video the environment at the time of day that is the most problematic.
**Prepare – milestone checklist**

*Move on to ‘Assess’ only if you have completed ALL of the items on these checklists*

| 1. Decide who will be involved. | ✓ |
| 2. Talk to staff. | ✓ |
| 3. Talk to patients and carers and gather patient feedback. | ✓ |
| 4. Take photographs and videos. | ✓ |
| 5. Gather data and reports. | ✓ |

Make sure all staff involved are aware of plans and progress. Discuss the initiative as a part of department meetings and use the communication strategies detailed in the other Productive Ward modules.
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<th>Effective teamwork checklist</th>
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<td>5. Did the team focus on the area/process, not individuals?</td>
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Assess
Assess

Information from your photographs/videos (Tools 6 and 7):

Review the videos and photographs you have taken to assess your current state and identify areas of concern.

Examine the current environment – concentrate on making an accurate assessment of what is currently happening and recording issues (not solutions) on sticky notes.

Look for:

- how bed areas are prepared prior to patients mobilising and if they are free from hazards
- whether patient’s items and assistance aids are within reach, for example, mobility aids, call bell
- any interruptions or distractions during mobilisation
- uncluttered corridors, free of trolleys and other equipment so that patients can access the handrails.

At this stage resist the urge to come up with solutions to problems you have identified.

Don’t look at individual practice, look at the environment unless there is a safety issue to address.
Incidents and data:
Review and evaluate 12 months of incident management system data and your safety cross results.
- Using the ‘measles’ map described on p26, take note of any patterns of falls occurring, such as around bed areas, bathrooms or where lighting may be poor. Review the times falls occur and assess whether there is any difference between day and night.
- How many falls are occurring?

Review and evaluate recent DHB/Health Roundtable data or equivalent and/or other unit-based falls audit data:
- How many patients have documented falls risk assessments and management plans?

Note findings from falls incident analysis and consider contributing factors that lead to falls, such as patients experiencing periods of prolonged/repeated fasting or medication side effects.

Review best practice and current research:
- Collate all the information from your review and evaluation.
- Identify and understand differences between your service’s current falls prevention practice and best practice.
- Understand your patient population – how many have cognitive impairment or have fallen before?

Patient and carer experience:
- Are there any themes related to falls prevention that are of concern to patients and carers?
- How many patients and carers are provided with falls prevention information? For example: on admission the patient pamphlet for staying safe in hospital; on discharge the ACC Home Safety Checklist or other local falls prevention information? Resources can be found at: www.hqsc.govt.nz and www.acc.co.nz.
- How many patients feedback that they:
  » received assistance to mobilise
  » can reach their mobility aid
  » can reach their call bell
  » have been given advice of footwear to wear in hospital?
Staff experience:

- Have staff identified themes related to falls prevention?
- Are there identified gaps in falls prevention knowledge?
- Is information about falls prevention communicated to staff?
- What are the barriers to reporting falls?

Summarise on a flipchart or equivalent the themes, frustrations and issues identified from all the feedback and experiences of staff, patients and carers regarding patient falls and associated issues.

Don’t forget to invite members of the multidisciplinary team to comment.
## Assess – milestone checklist

*Move on to ‘Diagnose’ only if you have completed ALL of the items on these checklists*

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<th>Tick if completed</th>
<th>1. Review photographs and videos.</th>
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<td></td>
<td>2. Analyse incidents and contributing factors related to falls.</td>
<td>Yes/No</td>
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<td></td>
<td>3. Create ‘measles’ map of falls incidents.</td>
<td>Yes/No</td>
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<td></td>
<td>4. Review best practice and current research.</td>
<td>Yes/No</td>
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<td>5. Analyse patient, carer and staff experiences.</td>
<td>Yes/No</td>
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Make sure all members of the multidisciplinary team, including all shifts, are aware of progress.
Diagnose
Before creating your ‘new design’ for falls prevention, work through the following examples of falls prevention improvements with your team.

Not all of these examples will apply to your specific environment. Some examples include information and education for your patient and their families/whānau to consider when they return home. If there are a lot of changes you need to make, consider implementing a few at a time so the change effort does not become overwhelming.
Consider what ‘good’ looks like:
Ideas that have worked. Example 1:

Raising awareness of falls incidents

The incidence of falls can reduce by increasing staff and patient awareness.

Safety crosses illustrate the incidence of falls in a highly visual way. Visual management reminds staff about the size of the problem and encourages them to ask questions.

*Note: Safety crosses can be used to measure any aspect around falls and falls prevention.*

**Safety cross**

Simply draw a calendar in the shape of a cross. It is designed to attract the eye. For example:

- Green indicates no incident in the chosen area.
- Yellow indicates a near miss.
- Red indicates an incident has occurred.
Ideas that have worked. Example 1 continued...

Safety crosses, used in conjunction with a plan of the area (‘measles’ map), identifies areas where falls occur and highlights areas where the risk of falling is higher.

Measles map

- Every time an incident occurs a red dot highlights the exact location, and a different-coloured dot indicates a near miss (unsteady but did not fall – near miss events remind us of the risk).
- Annotate the time on the dot to identify any patterns related to time of day.
- Over time a cluster may appear which will highlight to the team more detailed work is required in the high risk area.
- Recording the incident form number on the dot will also allow easy tracking of details if a cluster is identified.
Consider what ‘good’ looks like:
Ideas that have worked. Example 2:

Education and feedback to staff

- Education and feedback sessions have helped staff gain a greater understanding of the issues around falls prevention and become an active part of the solution.
- The education and feedback sessions included real cases as well as reporting on falls rates in the unit. These sessions provided a forum where achievements could be celebrated and staff members were recognised for appropriate use of best practice safety actions.

One study has shown education significantly increased compliance for various screening and environmental strategies:

- Risk assessment screening (from 59 percent to 79 percent, a 20 percent improvement).
- Risk assessment screening correctly completed and documented (from 57 percent to 80 percent, a 23 percent improvement).
- Risk assessment screening completed within 24 hours of admission (from 25 percent to 81 percent, a 56 percent improvement).
- Bed height at appropriate level (from 50 percent to 79 percent, a 29 percent improvement).
- Clutter-free environment (from 71 percent to 81 percent, a 10 percent improvement).
Consider what ‘good’ looks like:

Ideas that have worked. Example 3:

Create a ‘clutter-free’ bed space

Sometimes patient bed spaces become so cluttered that mobility aids cannot be reached and paths to toilets, bathrooms and public areas become difficult to navigate.

If you identify issues with clutter on your ward, consider how this can be improved to ensure there is a place for everything and everything is in its place.
Building knowledge

Falls prevention is a national priority. The Commission promotes that ‘falls prevention is everyone’s business’. All staff have a responsibility to know about falls prevention and to include the patient and their family/whānau in assessment and care planning.

Clinicians should actively engage with their patients and families/whānau to raise awareness of the importance of falls prevention, not only in hospital but also when they return home.

Easy access to evidence-based tools and resources, to maintain knowledge, helps to ensure the care provided is individualised to the patient’s risk factors.

Tools to help include:
- falls risk assessments
- falls care plans
- local policies and procedures
- falls audit templates
- staff education and resources
- signage for patient room, for example, Commission falls signalling system for mobilising safely (www.hqsc.govt.nz/our-programmes/reducing-harm-from-falls/projects/signalling-system)

Consider what ‘good’ looks like:

Ideas that have worked. Example 4:

- education pamphlets for patients and family/whānau
- the Commission’s ’10 Topics’
- ACC resources.
Consider what ‘good’ looks like:
Ideas that have worked. Example 5:

Medication

Some medicines may increase the risk of a person falling and suffering fall-related injuries.

The goal in reviewing and modifying medicine use by older people is to avoid unnecessary prescribing and avoid harm from medications.

Medication reviews must involve the older person and family/whānau.

In particular, medicine reviews should focus on those medicines that affect:

- blood pressure, gait/movement
- cognition and elimination
- levels of drowsiness.

When prescribing and administering medication, staff should discuss the associated risks with the patient and family/whānau.

For example, if a patient is starting or changing blood pressure medication, blood pressure and levels of dizziness must be monitored regularly.

Refer to Topic 8 for further information.
**Ideas that have worked. Example 5 continued…**

**Vitamin D**

While most people get sufficient vitamin D from sun exposure and dietary sources, this is not always the case for the older adult. Prescribed vitamin D supplements are thought to prevent falls by improving muscle strength and psychomotor performance in older people who are at risk of vitamin D deficiency.

It has been reported in New Zealand amongst adults aged 75 and over:

- 6.6 percent show vitamin D deficiency
- 29.5 percent have vitamin D levels below the recommended level (29.5 percent).\(^8\)

Consider how you will discuss Vitamin D prescribing in your unit.

Ref: ACC\(^9\) and Topic 7.\(^7\)
Intentional rounding is a strategy to consider in preventing falls. Rounding may involve checking if patients:

- would like assistance to go to the toilet
- have mobility aids within reach
- are in pain
- have a clutter-free bed area
- can reach their call bell.

It has been reported that patients say:

- they receive a lot more attention from the team when rounding is in place
- they use their call bell less as they trust that a staff member will return
- they are less likely to attempt to go to the bathroom unaided, as assistance will be offered on the round.
Consider what ‘good’ looks like:
Ideas that have worked. Example 7:

Exercise programmes

Certain types of exercises are known to help prevent falls by improving balance, lower body muscle strength and cognitive function.

Balance exercises are key. In general, effective programmes also include lower body muscle strengthening exercises.

Know what appropriate strength and balance exercise classes are available for older people in your region, and what the referral processes are.

Ensure the doctor or physio advises the patient/family/whānau on what exercises are safe and appropriate for them.

The Otago Exercise Programme which was developed in New Zealand is internationally recognised as an effective, evidence based physical activity programme focused on falls prevention for people aged over 80.

Trials showed that the programme reduced falls and falls injury by up to 35 percent.10

Several exercise programmes are detailed in the Commission’s Topic 9.7
Consider what ‘good’ looks like:

Ideas that have worked. Example 8:

ACC – Standing up to falls

Many falls can be prevented by taking positive steps to reduce the chances of falling.

Everyone’s home is different, so it pays to be aware of how the patient’s family/whānau can make the home safer.

ACC’s ‘Standing up to falls’ booklet gives people information and checklists of what they can do to protect themselves to maintain their independence. It covers aspects of health, behaviour and environment at home and in the community.11

All of ACC’s falls prevention programmes and tools are available at www.acc.co.nz/preventing-injuries/athome/older-people/information-for-olderpeople/PI00029

Giving the checklist to patients and families/whānau helps them make their home a safer place.
Focus on Reducing Harm from Falls each year – link with April Falls

April Falls is now a regular feature of the New Zealand landscape.

Each year April is a falls focus month and provides the catalyst for services to work locally, regionally or nationally to promote falls prevention initiatives.

April Falls raises awareness and educates patients, residents, carers, staff and the community on ways to stay active, healthy and prevent falls.¹²

Health care facilities are encouraged to conduct an event or a series of events during the month. Suggested activities include displays, competitions, staff education and other fun, educational and innovative events.

What is your ward/unit going to do to mark April Falls?

Think about focusing on a particular intervention, test it, collect results, and assess what difference it made. If positive improvement is noted, this may well be able to be implemented across other areas.
Diagnose – milestone checklist

Move to ‘Plan’ only if you have completed ALL of the items on these checklists

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<td>1. Carefully work through the examples with the team.</td>
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<td>2. Openly and honestly discuss each example.</td>
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<td>3. Consider the examples against your own environment.</td>
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<td>4. Ask staff for new ideas, possibly building on the examples shown.</td>
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Plan
Plan
It’s all about the preparation…

Your emphasis, when creating your new falls prevention strategy, should be clarity of roles, engaging the whole multidisciplinary team and partnering with patients and families/whānau.

Planning and design could incorporate processes, environment, and engagement with patients.

Pictured Right: An example of system and process change: Risk assessment tools and individualised care plan developed by Whanganui DHB.
Create your ‘new design’...

Complete your ‘new design’ for falls prevention and injury reduction by reviewing examples of ‘what good looks like’ and generating practical ideas which can be established and sustained in the unit.

The multidisciplinary team should be involved in the discussion around the new design.
Create your plan for the implementation of your newly designed process

Use Tool 11 (cost/benefit analysis) to create your implementation plan.

Display the plan by putting a completed module action planner sheet (Tool 12) in a prominent position in the area.

Assess impact against cost, e.g., setting up costs little but has major impact.
The completed module action planner should now contain a prioritised list of everything that needs to be done to create your falls prevention approach for the department/service.

Some items may involve a change in working practice for your staff, for example, ensuring patients are assessed using evidence-based falls assessment tools.

It is important to summarise the new working practices in a ‘standard operating procedure’ so staff have a clear understanding of the change and how it affects their daily work tasks. This can be on a flip chart or in an A4 document.

This is a simple exercise that clearly communicates the new way of working. It has the added benefit of helping to set the standard for new staff along with the existing staff who will be delivering the care.
Example ‘standard operating procedure’ for falls prevention

For all patients admitted to the unit:

1. Assess:
   • Screen and assess all patients’ falls risk within 24 hours of admission (or as per local procedure).
   • Review the patient’s environment each shift to ensure:
     » clutter-free bedspace and walkways
     » mobility aids, call bells and tray tables are within reach.

2. Plan:
   • Document a falls prevention and management plan for all patients within 24 hours of admission (or as local procedure).
   • Identify all patients at risk of falling at point of care and shift handover.
   • Discharge planning.

3. Implement:
   • Action individualised falls prevention and management strategies for all patients.
   • Implement the post-fall review or action plan for all patients who have fallen.

4. Report:
   • Report all falls including falls without harm.

5. Evaluate:
   • Analyse all falls and incorporate lessons learnt and recommendations into future prevention strategies.
Plan – milestone checklist

Move to ‘Treat’ only if you have completed ALL of the items on these checklists

<table>
<thead>
<tr>
<th>1. Consider examples of ideas that have worked.</th>
<th>Tick if completed</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. Create a new falls prevention approach for the unit.</td>
<td></td>
</tr>
<tr>
<td>3. Document the new approach as an agreed ‘standard operating procedure’.</td>
<td></td>
</tr>
</tbody>
</table>

Make sure all members of the multidisciplinary team, including all nursing shifts, are aware of progress. This could be accomplished as a discussion at shift handover.

<table>
<thead>
<tr>
<th>Effective teamwork checklist</th>
<th>Tick if YES</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Did all of the multidisciplinary team participate?</td>
<td></td>
</tr>
<tr>
<td>2. Was the discussion open and honest?</td>
<td></td>
</tr>
<tr>
<td>3. Were the hard questions discussed and answers agreed by all?</td>
<td></td>
</tr>
<tr>
<td>4. Did the team remain focused on the task?</td>
<td></td>
</tr>
<tr>
<td>5. Did the team focus on the area/process, not individuals?</td>
<td></td>
</tr>
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</table>
Treat – go do it!
**Treat**

**Before the test starts:**
- Determine period for the test, for example, ‘We will test the new falls prevention approach for three months’.
- Test should be long enough to record failures, but short enough to be able to change and retest.
- Set the start and end dates – and communicate them.
- Inform all staff personally where possible, and also post notices detailing the process you have gone through and the ‘standard operating procedure’ to be tested.
- Agree on the collection method, and who will do it.
- Agree the way to collect clinical incident data, and who will do it.

**What are we testing?**
- Does everyone understand what the new process is?

**During the test:**
- Get daily feedback from staff and patients on how they feel the new process is working.
- Take ‘after’ photos and videos during the test period.
- Invite visitors from senior management to view the new process and ask for their comments on a suggestions board.

**Collect data to show change/improvement, for example:**
- monitor the incidence of falls using safety crosses and measles maps
- monitor the number of patients with documented:
  - screening and falls risk assessments completed within 24 hours of admission (or as per service admission policy)
  - falls management plans (individualised to patient risks) completed within 24 hours of admission (or as per service admission policy).
**Treat – milestone checklist**

*Move to ‘Evaluate’ only if you have completed ALL of the items on these checklists*

<p>| | |</p>
<table>
<thead>
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<tbody>
<tr>
<td><strong>Tick if completed</strong></td>
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</tr>
<tr>
<td>1. Test period defined.</td>
<td></td>
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<tr>
<td>2. All staff informed.</td>
<td></td>
</tr>
<tr>
<td>3. Try out (test) the new falls prevention strategies.</td>
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<tr>
<td>4. Film the department/service and compare to ‘before’ videos.</td>
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<tr>
<td>5. Get staff, patient and family/whānau feedback on the new strategy.</td>
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<tr>
<td>6. Collect data.</td>
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</table>

**Effective teamwork checklist**

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Make sure all members of the multidisciplinary team, including all nursing/midwifery shifts, are aware of progress.
Evaluate
Step 1: Collect information

A. Review the data:
Reassess performance against the following:
• Have falls and injuries from falls decreased as a result of the greater focus on falls prevention?
• Has the number of documented screening, risk assessment and falls management plans increased?

B. Talk to staff:
• Has the whole multidisciplinary team engaged in this process?
• Are staff more aware of the risks and consequences of falls and injury from falls? Have attitudes changed towards falls prevention?
• What is the general feeling towards falls prevention on the unit?
• Do staff demonstrate and report:
  » increased knowledge around falls prevention?
  » more commitment to falls prevention?
• Are staff reporting all falls?

C. Capture patient experience:
• If you have taken a patient experience/consumer feedback snapshot, then repeat the exercise.
• Which changes have had the most impact?
• Are more patients who require assistance with mobilising receiving assistance when they need it?
• Are more patients receiving information about preventing falls?
• Are patients/families/whānau aware of their falls prevention plan?
• Are patients/families/whānau asked about what they think will help them?
Step 2

Decide where there are still opportunities for improvement and if there are additional changes that can be made to the area, for example, go back to discussions and videos, and repeat the process.

The Commissions video “Preventing Falls in Hospital” is a good resource to stimulate thinking:
**Evaluate – milestone checklist**

<table>
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<tbody>
<tr>
<td>1.</td>
<td>Analyse feedback from staff, patients and families/whānau about the new processes and record comments.</td>
</tr>
<tr>
<td>2.</td>
<td>Analyse falls rate before and after the new process.</td>
</tr>
<tr>
<td>3.</td>
<td>Communicate success!</td>
</tr>
</tbody>
</table>

Make sure all members of the multidisciplinary team including all nursing shifts are aware of progress.

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**Effective teamwork checklist**

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# How do I sustain improvement?

| Monitor and audit continually | • Continue to monitor falls risk assessment rates.  
| | • Continue to monitor completion of care plans (individualised to patient risks).  
| | • Continue to monitor falls and falls with harm incidents.  
| Ensure leadership attention | • Ensure monthly falls are reviewed and discussed with the nursing manager or equivalent line manager.  
| | • Ensure audit results are discussed with staff at least once a month at unit meetings.  
| | • Ensure changes/improvements and challenges are brought to the attention of senior leaders in your organisation.  
| Do not stop improving | • Encourage staff to continue to find new and better ways of doing things – it is not about doing this once and then applying standard operating procedures, but about continuous improvement.  

*Audits are not just for accreditation or certification*
Learning objectives complete?

Six objectives were set at the beginning of this module.

Test how successfully these objectives have been met by asking five multidisciplinary team members (of differing levels and disciplines) the questions in the following grid. Ask the questions in the first column and make an assessment against the answer guidelines in the second.

The results of this assessment are for use in improving the facilitation of this module and are not a reflection of staff aptitude or performance.

If all five team members’ responses broadly fit with the answer guidelines then the learning objectives of the module have been met.

Note the objectives where the learning has only been partly met and think about how you can change the way you approach the module next time so the responses are fully met.

If some of the objectives are not met, or are only partly met, think about how you can change the way you approach the module next time so the objectives are fully met. It sometimes helps to re-read the module and reflect on the experiences in implementing the module first time round.
<table>
<thead>
<tr>
<th>Question (ask the team member)</th>
<th>Answers for outcome achieved</th>
</tr>
</thead>
</table>
| Describe the things you need to do in the prepare stage of the module. | • Find policy and falls prevention resources.  
• Find out patient experience/consumer feedback.  
• Talk to staff.  
• Assess incident data.  
• Video and photograph the process.  
• Collect falls data. |
| How can a measles map and data from other sources enhance your understanding of falls in your unit? | • A measles map can identify any clusters of locations and times that are high risk for falls.  
• Safety crosses can be used to identify the overall incidence of falls. |
| Why use a cost/benefit analysis and how does it work? | • Helps the team prioritise improvements.  
• Provides grid where you put ideas in boxes relating to cost and benefit.  
• Aim to do the low cost, high benefit ideas first. |
| Define standard work and how it is used in the falls prevention module to increase quality. | • Important tool for communicating.  
• Key to sustaining new falls prevention initiatives.  
• Agreed by the team, not by an individual.  
• Acknowledges best evidence actions. |
<table>
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| What are the key points to remember about falls prevention audits? | • Ensures people are carrying out the new falls prevention process.  
• Should be quick.  
• Based on the best evidenced standard created by the team.  
• Never stop using audits.                                                                                       |
| What factors contribute to the success of falls prevention programmes? | • Increasing awareness of the incidence, risk and outcome of falls.  
• Engaging all staff, patients and carers in developing and implementing falls prevention strategies.  
• Agreeing as a team on the standard operating procedure for falls prevention.  
• Linking improvement to effort and acknowledging the team’s hard work.  
• Collecting and displaying data that demonstrates improvement.  
• Being guided by best evidence.                                                                                 |
# 10-point checklist for falls prevention

Example:

<table>
<thead>
<tr>
<th>Before starting</th>
<th>After 4 weeks</th>
<th>After 12 weeks</th>
<th>After 6 months</th>
</tr>
</thead>
<tbody>
<tr>
<td>The grid opposite allows you to measure your performance against the 10-point checklist for this module.</td>
<td>Shade in the boxes according to your achievement of the measure. Your progress is clearly visible.</td>
<td>Continue to monitor monthly.</td>
<td></td>
</tr>
</tbody>
</table>
# 10-point checklist for falls prevention

<table>
<thead>
<tr>
<th></th>
<th>Before starting</th>
<th>After 4 weeks</th>
<th>After 12 weeks</th>
<th>After 6 months</th>
</tr>
</thead>
<tbody>
<tr>
<td>Falls prevention is a priority in the department/service.</td>
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</tr>
<tr>
<td>All patients are screened for risk of falling, at risk patients are assessed within 24 hours of admission to the area (or as per your admission policy or relevant organisation policy). Care plan is developed following risk assessment.</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Patient falls risk is communicated in notes, at handover, on unit rounds, to the multidisciplinary team, the patients and their families/whānau/carers.</td>
<td></td>
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</tr>
<tr>
<td>All patients’ falls risks are reassessed if condition changes, medication changes, upon transfer to another unit or otherwise weekly.</td>
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</tr>
<tr>
<td>The environment is kept clear and tidy with a place for everything and everything in its place.</td>
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</tr>
<tr>
<td>Staff provide assistance with mobilising as required.</td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Visitors/carers provide assistance with mobilising as required.</td>
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<td></td>
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</tr>
<tr>
<td>All members of the team are aware of the number of falls and the action plan to reduce the number of incidents.</td>
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</tr>
<tr>
<td>Falls risk assessment and care planning audits are conducted every month to ensure the falls prevention process is followed correctly and documented in patients’ charts.</td>
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</tr>
<tr>
<td>Patients and families/whānau are involved in discussions about falls risk and prevention.</td>
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<td></td>
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</tr>
</tbody>
</table>


9. ACC, Vitamin prescribing criteria 2008 (ACC4697) and Why Vitamin D is important (ACC6774).


Acknowledgements

Thank you to all staff from the following organisations who have contributed to, or made possible, the adaptation of the module to the New Zealand context:

- Health Quality & Safety Commission
- Waikato DHB – Older Persons and Rehabilitation, Quality and Patient Safety, and Director of Nursing and Midwifery
- Accident Compensation Corporation
- The Ministry of Health
For more information visit www.hqsc.govt.nz/our-programmes/reducing-harm-from-falls/

Productive Series Representative: Ministry of Health, Quality and Productivity.

This module has been customised for New Zealand through the national Reducing Harm from Falls programme, led by the Health Quality & Safety Commission New Zealand. It is designed to guide clinical staff in falls prevention quality improvement work. It will also help providers meet the New Zealand Health and Disability Standard 8134.1.2008.