Churtonleigh Lifecare: Falls Prevention Initiatives

Churtonleigh Lifecare participated in the Aged Related Residential Care mini-collaborative[1] to reduce harm from falls. The collaborative was established by the Health Quality and Safety Commission in conjunction with the Accident Compensation Corporation and three Wellington based district health boards.

About Churtonleigh Lifecare

Churtonleigh is part of the Ultimate Care Group. It is a hospital and rest home level facility with 34 beds, located in Churton Park, Wellington. Churtonleigh Lifecare prides itself on residents being *'as independent or as cared for'* as they choose.

Churtonleigh Lifecare's approach

There was strong management support for the falls prevention initiatives and four of the Churtonleigh team went to the Learning Set sessions: Two registered nurses and two healthcare assistants. Attending the sessions and working on falls prevention initiatives as a team was really helpful as

> *"We could talk about things afterwards"*
>
> *"It was good to have each other's support when we were asking staff to do extra work"*
>
> *"We often work on different shifts so we are there for people to ask us questions"*

Talking about falls prevention to the wider team was a key part of Churtonleigh's approach. The four who attended the Learning Sets put together a poster about what they had learnt. Encouraging other staff was seen as very importantand the team focussed on encouraging staff, letting them know what was happening and thanking staff for their extra efforts.

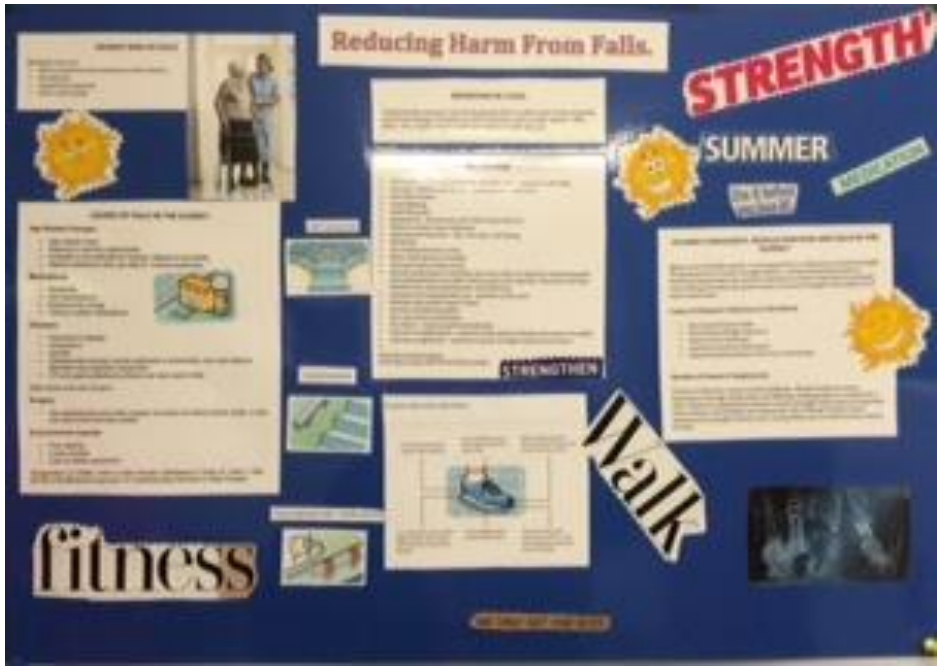


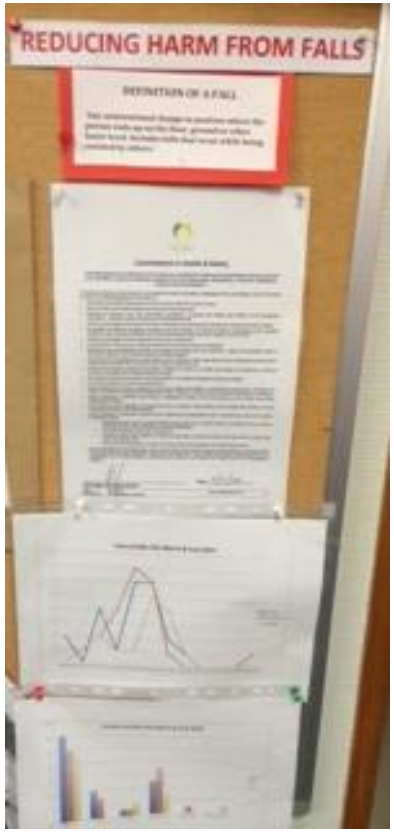
Figure 1: Churtonleigh's falls prevention poster

The team started analysing the monthly falls data and graphing it. Data were sent to the quality improvement facilitator to be used to benchmark the Wellington facilities. Although Churtonleigh already collected falls data, the team thought that by them also collecting data using clocks and maps they

[1] http://www.hqsc.govt.nz/our-programmes/reducing-harm-from-falls/projects/arrc-mini-collaborative/

could *"focus on what is happening"* and be *"more specific with the times and locations….It is good to have that."*

Examples of Churtonleigh Lifecare's responses



Graphs were put on the wall as well as falls crosses. The falls crosses were looked at more by the wider team than the graphs. The team put in place a number of Plan-Do-Study-Act (PDSA) cycles.

- Responding to data that identified a peak from 3 to 7 in the afternoon by developing an afternoon diversion therapy programme which has been successful at reducing the peak.
- Responding to clusters of falls that identified a frequent faller. The team tried and assessed different approaches such as diversion therapy, bells, sensor mats for individuals.
- Initiatives for residents such as charting vitamin D and encouraging hip protectors for new residents.

Achievements

- The graphs showed reductions in the falls rate. The PDSA cycle is being used to look at the results of different initiatives.

Tip from the Churtonleigh team: It is helpful to have a clear goal for your PDSA cycle – your time frame and what you are aiming for. Be very specific. Explain to people what you are doing and why. If you have a clear goal you can see if it has been met or not.

How the falls prevention mini-collaborative helped

The team found the Learning Sets "really helpful". They took the learnings back to Churtonleigh and did the recommended work between learning sets.

The first learning set was helpful in providing information about the graphs but would have been possibly more useful for nurse managers. But with help with excel the team has found the graphs useful.

The visit by the quality improvement facilitator was

> *"Very supporting, gave us ideas, encouraged us to keep going and motivated us."*

The team found the PDSA cycle really helpful.

> *"Not something we can use just for falls…we can use it for something else..we now know what to do."*

In the third Learning Set session they would have liked more time to be spent in the going over care plans in detail. They had come prepared with their care plan for a resident who falls frequently.

> *"I was looking forward to it…It would have been really useful to go into that in detail."*

Keeping going

The team plan to keep going. Cluster groups would be good but initial attempts to develop them have not worked. They hope to meet with other Ultimate Care facilities to work together.

> *"Sometimes we get a bit stuck and wonder if anyone else has some ideas about how to help this frequent faller…we got ideas from the other facilities."*