Fergusson Rest Home and Hospital: Falls Prevention Initiatives

Fergusson Rest Home and Hospital 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 Fergusson Rest Home and Hospital

Fergusson Rest Home and Hospital, part of the BUPA Group, is located in central Upper Hutt. Fergusson provides rest home, hospital and day care and care through a secure dementia unit.

The falls prevention initiative came along at the right time for the Fergusson team:

> *"...we had almost reached that optimum level – we didn't know what else to do. We have checked medications, checked the environment so when this collaborative came it was very timely. It gave us new ideas."*

The manager and three team members attended the first Learning Set. Four team members shared attendance at the other two learning sets. The aim was to involve team members from the rest home, hospital and dementia unit.

> *"It really helps having a group across the different areas and different shifts – something that works in the rest home might not work in the hospital."*

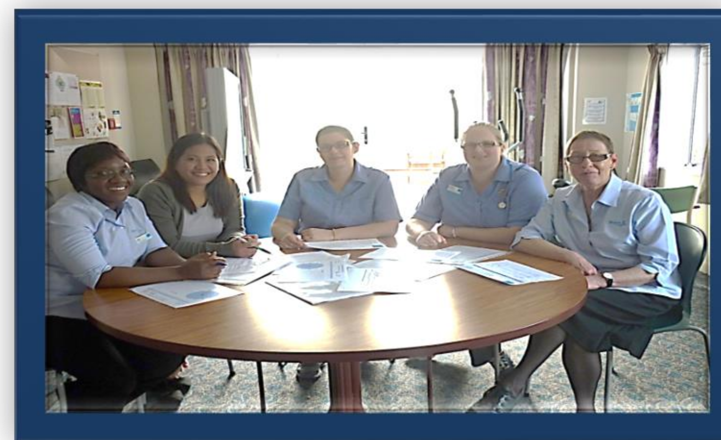
The plan was to:

> *"Start small with a few individuals. If it worked with them then expand it to the rest of the facility."*

The Fergusson team also worked closely with the quality improvement advisor before and during the falls prevention mini-collaborative.

Fergusson's approach

Fergusson's approach was based on team work. The team who went to the Learning Sets formed a falls prevention committee and worked together to collect data, look at where falls were occurring and make plans for falls prevention.



The Fergusson Falls Prevention team

The team mapped falls and developed a falls calendar and falls crosses. Data about falls were being collected before the falls prevention initiative but since

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

taking part more detail is being collected and the information shared more widely.

> *"We did the map and recorded where and at what time falls happened. We noticed a trend."*

The Committee meets regularly and records minutes and has a folder where all the ideas and information about what happens are collated.

> *"We do minutes each meeting and identify what we have been doing in each area. Plan for the next couple of months. Whoever represented that area [of the facility] would then carry the plans through."*

Committee members take the information back to their areas of the facility and share the information and involve the wider team.

> *"In a big facility like this we need to think about how to get the information out. We would take it to the handover meeting. Everyone was on board. We sell the idea to the different areas. We talked about it in the staff meetings."*

> *"The major thing we did was making everyone aware, getting everyone involved in the process. The calendar, identifying the ones at risk of falls."*

> *"With the staff we attached the graphs to the meeting minutes. Staff look at them while they are having lunch and see this is where we were and look at where we are and what's been happening."*

Examples of Fergusson's responses

Fergusson's responses included a combination of facility-wide responses and interventions for individual residents.

> *"In the rest home rearranging the bedroom furniture was effective in reducing falls for some frequent fallers."*

Making sure everyone was aware of the residents at risk of falling by talking about them during handover and clearly identifying them by decorating their walkers and using ID tags on the walkers.

> *"We used ID tags and decorated the walkers. We let everyone know who the residents should be – they see the walker and look for the person. Everyone knows even the cleaner. If you see a high risk resident you walk along with them."*

Changing the sensor pads the facility used – they were rolling at the edges causing tripping.

> *"The new mats don't require any mat over. You learn from what you do."*

Other approaches were tried for individuals

> *"Toileting before they go to bed. It started to work."*

> *"One resident was falling frequently and the sensor mats were not working. We decided to sit outside the door at night to keep her safe. Then we could hear when she was moving around."*

Achievements

As well as reducing the number of falls, the Fergusson team have really enjoyed taking part in the initiative.

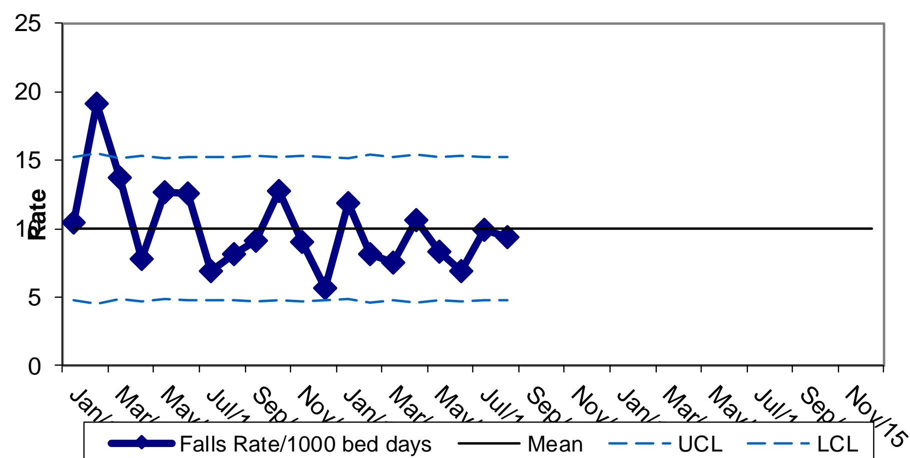
> *"The good thing is the enthusiasm that was coming out of the whole group."*

The manager thought that job satisfaction had improved and working together to prevent falls had:

> *"Moulded the team together to work as a team."*

The team take pride in reducing the number of falls:

> *"No one is going to fall on our shift"*



An example of Fergusson's achievements in one part of the facility

How the falls prevention mini-collaborative helped

The team found the Learning Sets and most of the material quite helpful. What they gained most from was:

- Meeting with staff from other facilities to share ideas.

  "What we did find helpful was when the teams were sharing as to what they were doing at the different facilities….we managed to copy a lot of things…the techniques being used all over Wellington."

- The quality improvement facilitator working with them to graph their falls data

  "She took all our stats and made sense out of them. Put them on a graph to look at what times falls were prevalent and she did a site map and looked at where the falls were happening. She had a lot of information and she can suggest straightaway – what if you do it like this. Good having someone to do this. She sees it – dealing with it all the time."

The format of one-day sessions worked well as it meant the sessions were not too long and there was time for networking. The team would have liked more time in the third session to hear other facilities talk about their achievements.

> *"Allow more time for the sharing time – that is the most interesting of the lot. That was really good when they all presented about what they had done but they had limited time for that."*

Keeping going

The team will keep going and expand what they are doing to other residents because:

> *"We still have that passion of keeping our residents safe. It is still there even though we have finished the study days."*

The team also plans to extend the quality improvement approach to other topics:

> *"We are hoping that what we learnt will flow across to other areas. E.g. pressure injuries, medication errors could easily fit into such a system."*

Having an ongoing way to share ideas would be helpful. The team suggested a website of email exchange of ideas. Continuing to have someone to go to such as a quality improvement advisor would be an advantage.

> *"We need someone for questions – an out of the box thinker…we need outside views.*

Tips from Fergusson:

Involve the whole team : *"Bringing all of the different areas together – it worked really well."*

Have a clear target: *"" If you really have a target like us – reduce harm from falls and falls rate so you set aside time for that."*