Malatest International

Sprott House: Falls Prevention Initiatives

Sprott House 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 Sprott House

Sprott House is a registered charity located in Karori, Wellington. Sprott House offers independent living, rest home and secure dementia care.

The general manager wanted the team to participate in the falls prevention Learning Sets. All three Learning Sets were attended by the manager of the dementia unit (also the resident safety officer) and the second set was also attended by the quality manager.

Sprott House's approach to falls prevention

Following the first Learning Set the Sprott House team started to map falls. Previously they had completed incident reports and sent in reports about the numbers of falls. Attending the first Learning Set gave them the idea of falls mapping.

> *"From the first month I could identify clusters and see where the falls were happening the most – and it was in the living area. [Previously] I didn't put the connections together…."*

Now each month:

> *"We map and we use a different colour each month so we can look at trends as well. If a resident is frequently falling in a place we can look at that place and see if there is anything wrong with the lighting etc."*

The Sprott House team now also uses a falls clock to look at the times falls are happening and where staff are at those times. Identifying when falls are taking place has meant that for some residents high risk times have been identified, such as meal times when staff are busier.

> *"We ask families to come in at the times that are high risk for falls – families have always been really good. It's just about working together."*

Involving staff in quality initiatives is essential. Information about falls is communicated to staff.

> *"Managers get the falls map and clock each month. Every meeting I have with the staff I take that. Copies go up in the staff rooms as well. All the staff are now well informed as well."*

> *"It's very important to staff to keep their residents safe. I let staff know how many falls we have had and what we are doing."*

Staff are also involved in finding solutions.

> *"Staff are very good at identifying risk and if someone's mobility changes. They come with ideas. They are on the floor and they know what works."*

Many of the potential solutions for individual residents were already in place before the falls prevention initiative. For example sensor beams, hip protectors. Information about individual residents is documented in the care

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

plans and staff have the responsibility to ensure that recommendations are followed. The safety officer would have also liked to have more information about care planning included in the Learning Sets.

The new approach to falls prevention has led to facility-wide approaches and:

> "Allowed every one of us to be more accountable."

> *"Before we were not really thinking about what staff were doing, why residents were falling at a particular time…it helps to look at someone globally."*

The emphasis at Sprott House is about collaboration and finding positive solutions. For this reason they prefer not to use the falls crosses because of the potential risks of making individual staff feel responsible for what is the responsibility of the whole team.

> *"It's not just my problem or the facilities problem. It's our problem and we need to be problem solving together."*

How the falls prevention initiative helped

The most valuable aspect of the falls prevention initiative was the opportunity to meet people from other facilities and the practical advice provided by one of the speakers.

> *"It's been interesting to see what other homes have done. Some things they are doing we took away because they were causing falls. … It's been good to get together with other people."*

Collecting data about falls using the falls calendar and falls clocks had helped to make a difference.

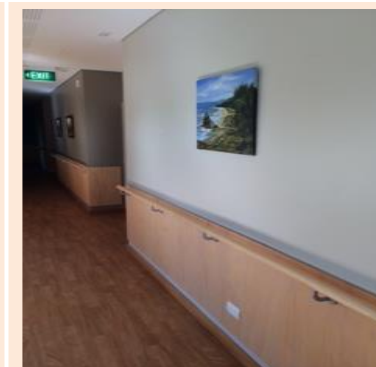
> *"Quality is more about following through in the statistics and thinking about what we can do. We are thinking more now – it's not just a bit of paper we fill in. we are thinking more now about the follow through. Why and we what we could put in place."*

Having the data also made it easier to go to managers and suggest new initiatives.

> *"Having the data makes it easier to go to your managers – you can explain the evidence."*

Having agencies such as ACC and the Health Quality and Safety Commission involved was useful.

> *"You felt these people care and other people are trying to look at and prevent falls. It allowed me to think about things that are out there that we don't know about."*

An example of one of Sprott House's falls prevention initiatives	
We noticed that people were trying to hold on to the lip of the wooden panels. Dementia affects their perceptions. ACC funded hand rails in the unit as a result of the falls prevention unit. The residents immediately started using them. The number falls dropped but has come up again with new residents. We are continuing to look at that.	

Keeping going

The falls mapping and falls clocks will continue – they have become part of the regular monthly reporting cycle. In addition the safety officer is planning to develop criteria for falls and new incident reporting forms that will include severity assessment criteria (SAC) ratings. Although meeting with staff from other facilities had been valuable it was unlikely these meetings would continue without someone external organising them.