make it better

Reducing Harm from Inpatient Falls – A journey not a sprint

Hospital Falls Prevention Steering Group

Canterbury District Health Board
Te Poari Hauora ō Waitaha

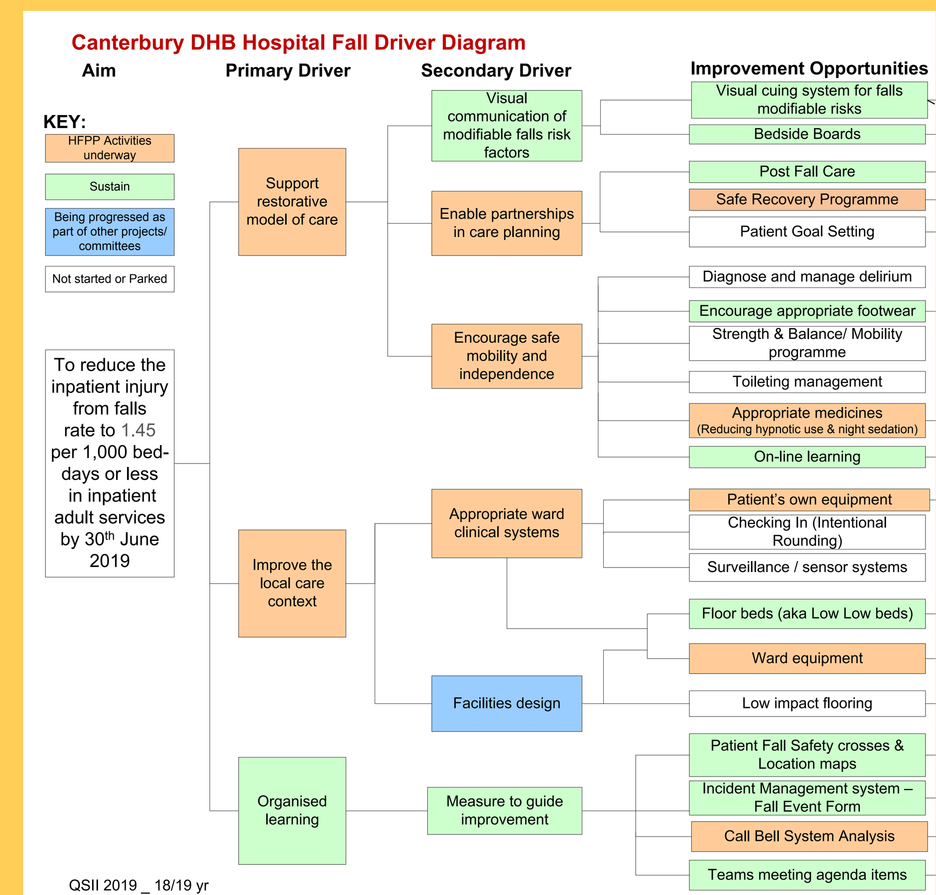
October 2019

Aim

Reducing inpatient harm from falls.
Targets revised annually based on data and predicted impact of initiatives.

Background

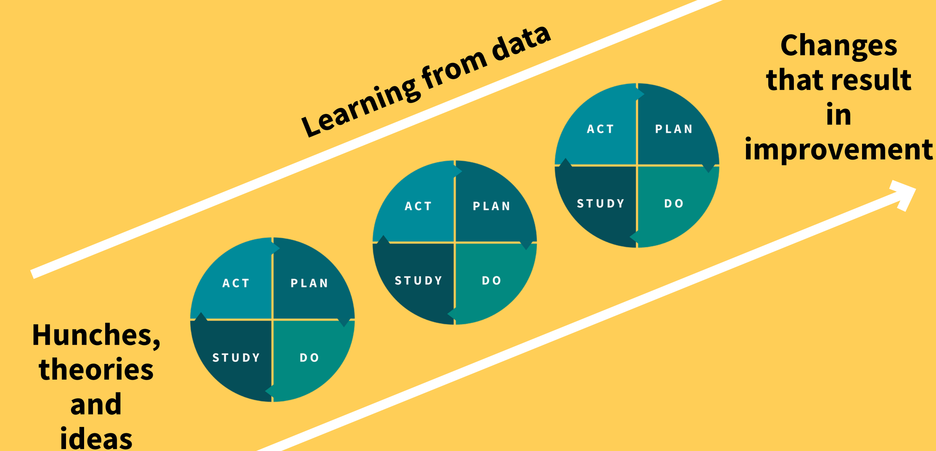
A Hospital Falls Prevention Steering Group (HFPSG) was set up in 2013 to identify and oversee key priorities to reduce both the number of falls and the harm from falls. Divisional Fall Prevention Committees work closely with the HFPSG on organisation wide improvements as well as progressing local initiatives.



Method

Process Improvement model applied to projects to implement a sustainable, systematic and combined approach to a wide range of improvement initiatives.

Active Consumer representation is embedded on the Hospital Fall Prevention Steering Group and improvement work streams. Bedside Boards, staff resources, and standardised patient information has been co-designed with consumers and clinical staff.



Falls prevention is everybody's business

Patient/family partnership

Consistent process and practice

April to Nov. 2015

- ✓ Standardised Visual Cues for Safe Mobility across all divisions, focus moves from assessment to enabling safe mobility
- ✓ Bedside Boards incorporating safe mobility plans
- ✓ Bedside handover starts

July 2015

- ✓ Better access to data and trends for local areas

November 2015

- ✓ Standardised Post Fall Care process – team approach to preventing falls

April to June 2016

- ✓ 'Help us keep everybody safe' Visitors poster

June 2016

- ✓ Move to new purpose built facility for Older Persons Health and Rehabilitation
- ✓ Patient information standardised

July 2016 to June 2018

- ✓ Bathroom safety section added to Older Persons Health & Rehab
- ✓ Intentional rounding/regular toileting plans introduced to some areas

April 2018

- ✓ Appropriate footwear guideline reinforced using footwear

July 2018 to present

- ✓ Analysis of characteristics and trends in falls
- ✓ Sharing of learnings from serious event reviews

September 2018

- ✓ Refocus and consolidation

November 2018

- ✓ SI Fall Prevention package released

April 2019

- ✓ Restorative Care model (Get up Get dressed Get moving) rolled out – supports bringing in of own walking aides and safe footwear

August 2019

- ✓ CDHB video on the way we do things in our hospitals for staff education/ Ongoing improvements to bedside boards in Acute setting

April 2015

Continuous testing, consulting, refining and evaluating

July 2018

Focus moves to embedding, sustaining, evaluating

Patients say "it's great to know the names of the team looking after me"

Staff say "it's great to discuss patients' safe mobility plans with them so they can safely mobilise around the hospital"

Consultants say "it's so good to see people get up, get dressed and get moving"

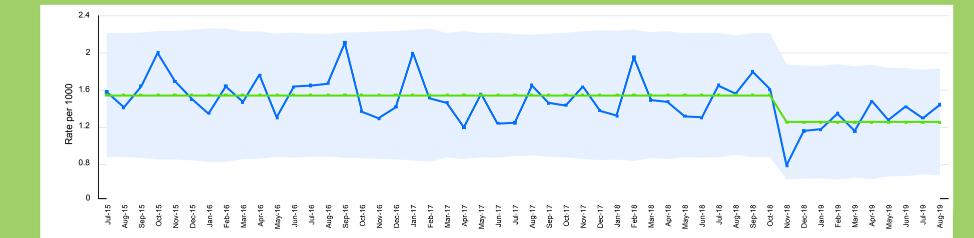
Spread and sustainability

- ✓ Multi- disciplinary consultation at different levels
- ✓ Divisional Falls committees reporting in to the Steering Group
- ✓ Improving incident data capture
- ✓ Clear documentation and messaging,
- ✓ Defined roles and responsibilities for execution
- ✓ Supported strong leadership at all levels to ensure the sustainability.
- ✓ Annual April Falls Campaign used to show case initiatives

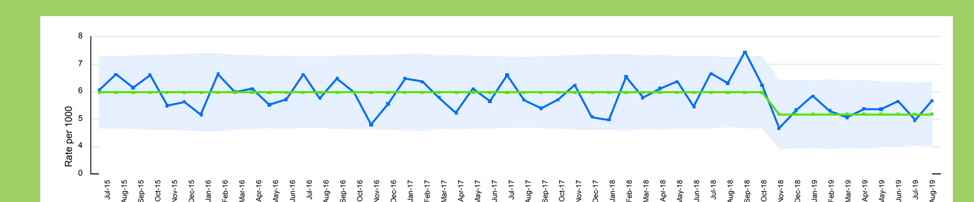
Results

- ✓ Statistically significant reduction in inpatient falls rate and Inpatient injury from falls rate achieved in July 2019.

Inpatient falls resulting in injury – all Canterbury DHB facilities



Total inpatient falls in hospital – all Canterbury DHB facilities



- ✓ Inpatient fall measures rates reduced year on year

Outcome Measures	15/16 yr	16/17 yr	17/18 yr	18/19 yr
Inpatient falls per 1,000 bed days	5.98	5.91	5.84	5.79
Inpatient Falls resulting in injury per 1,000 bed days *(Target in brackets)*	1.58	1.54	1.47 *(1.49)*	1.37 *(1.45)*
Numerator – Inpatient falls	2,123	2,116	2,112	2,152
Numerator – Inpatient falls resulting in injury	563	552	532	508
Denominator	358,508	358,163	362,366	372,796

** Inpatient falls measures introduced. Data retrospectively updated from 1 July 2015 onwards*

Challenges and lessons learnt

- ✓ Outcome measures take a long time to show impact
- ✓ Must be beneficial to patient and add value to clinician's day or it won't happen.
- ✓ Feedback cycle – regular data on progress at ward level important
- ✓ Communication is a constant challenge – many opportunities offered but few wards maximised
- ✓ System-wide constant change challenging