

Falls and Pressure Injuries Collaborative Learning Session 3

Hospital name: Counties Manukau DHB

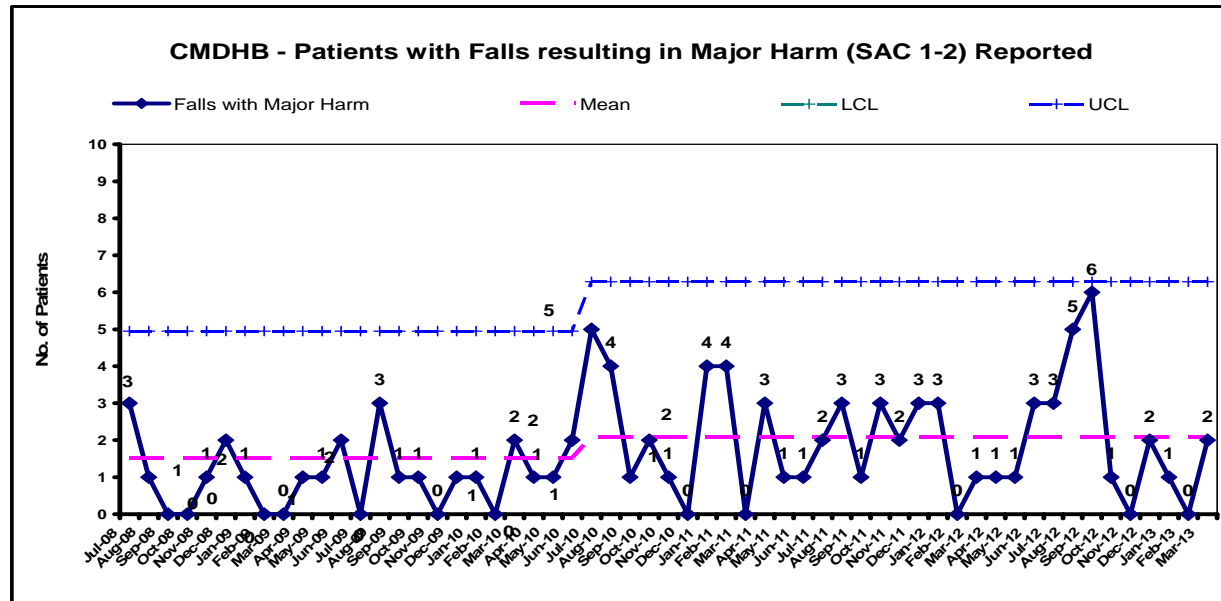
Presenters: Reducing Serious Harm from Falls

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Key problem

Approximately 90 falls occur every month in our DHB

- 30 of those patients are harmed when they fall
- Approximately 2 serious harm from falls happen every month



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Aim of this innovation

- Reduce serious harm (SAC 1 & 2) from patient falls by 20 % December 2013 and achieve zero serious harm from falls by 1st June 2014
- Accurate and timely identification of patients at risk of falling



Root causes of baseline data

- Locally created falls risk assessments failed to accurately and consistently identify patients at high risk of falls, or harm from falls
- Falls risk assessments were poorly and inconsistently implemented across the DHB
- Inadequate fall prevention strategies for patients at risk
- Falls were poorly reported via the Incident Reporting Systems (IRS)



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Key changes implemented

- Standardised and validated risk assessment tool (Morse) introduced
- ALL patients to have a risk assessment completed within 6 hours of admission
- Standardised falls prevention strategies linked to risk assessment implemented

COUNTIES MANUKAU HEALTH BOARD

MORSE FALL RISK ASSESSMENT

History of Falls: No (20) / Yes (25)

Secondary Diagnosis: No (0) / Yes (15)

IV Infusion: No (0) / Yes (15)

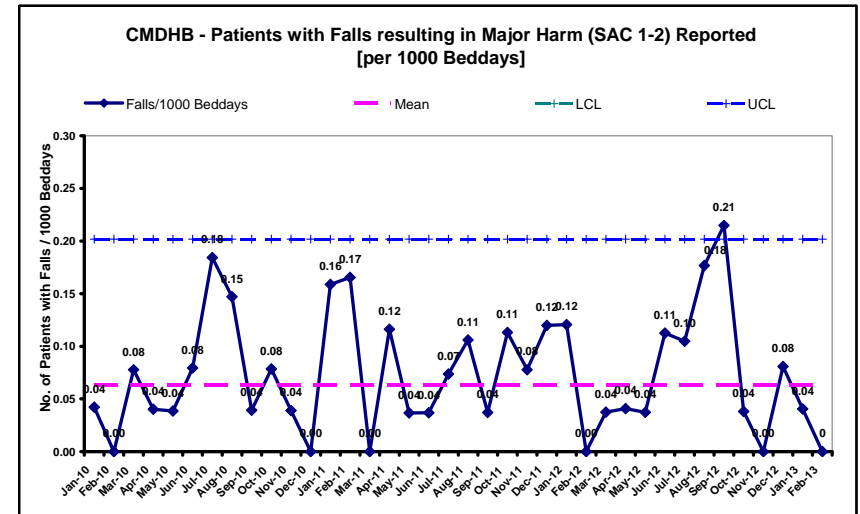
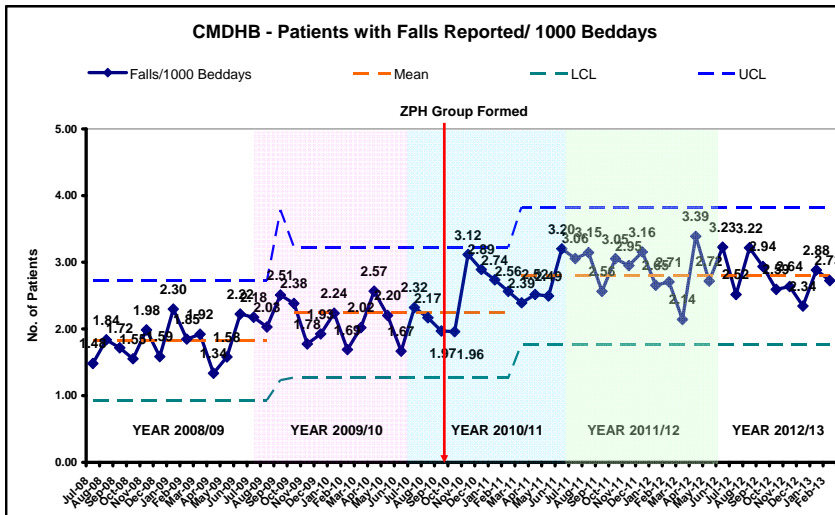
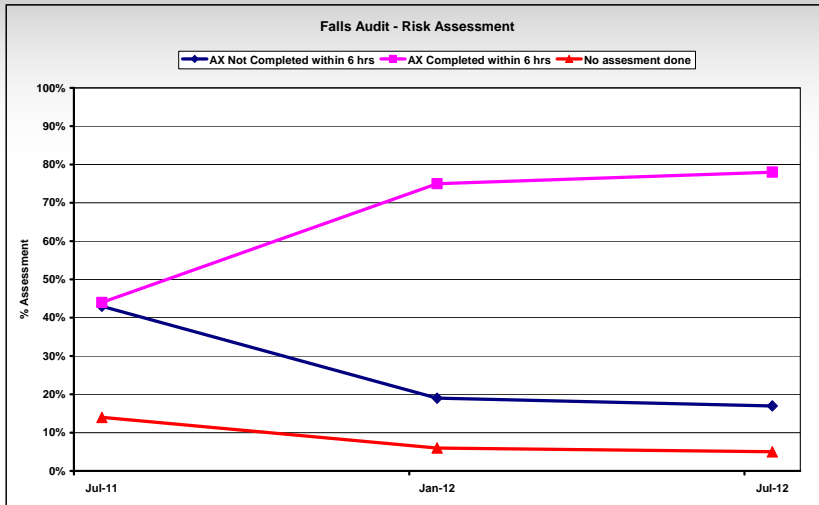
Gait / Transferring: Independent (20) / Needs Assistance (10)

Mental Status: Normal (10) / Abnormal (15)

Total Score: 0-20 (Low Risk), 21-24 (Medium Risk), 25-44 (High Risk)

Score 0 - 24		Score 25 - 44		Score 45+	
Universal Precautions Orientate patient to ward, bed area and how to use call bell Patient must wear firm supportive footwear or non slip socks Bathroom should be uncluttered and appropriate equipment in place Keep ward area and passages clear and uncluttered Remove unnecessary objects from patient's bedside	History of falling Orientate patient to ward, bed area and how to use call bell Document risk and interventions required in care plan Bed in low position Use night light in patient's bed space	Secondary diagnosis Refer to pharmacist for medication review as required Instruct patient in medication (name/dose, side effects, and interactions with food/other medications where appropriate)	Gait - decreased mobility - decreased balance Call bell within reach Patient must wear firm and supportive footwear or non slip socks Refer to Physiotherapy if required Mobility aid as required Keep ward and passages clear and uncluttered Remove any unnecessary objects from patient's bedside Communicate with colleagues about how much assistance is required for mobilising and transferring Nurse on H-Ca or Ultra-low bed if required Personal items within reach	Ambulatory aid Educate patient on what they can do independently Give patient falls and pressure prevention pamphlets	IV Infusion Call bell within reach Remind patient about physical limitations
Mental status <input type="checkbox"/> post-operative delirium <input type="checkbox"/> dementia	Universal Precautions Orientate patient to ward, bed area and how to use call bell Falls alert sticker on head of bed Alert next to name on whiteboard and/or WMS Fall alert notice on wall above bed Document risk and interventions required in care plan Bed in low position Put bed up against the wall Use night light in patient's bed space Check patient as regularly as conditions require Note on WMS (whiteboard at bedside) how patient is to mobilise (i.e. with assistance, with supervision) Complete use of Risk Prevention	Gait Call bell within reach Patient must wear firm and supportive footwear or non slip socks Refer to Physiotherapy if required Mobility aid as required Assist/supervise unsteady patients when mobilising and transferring Communicate with colleagues about how much assistance is required for mobilising and transferring Keep ward and passages clear and uncluttered Remove any unnecessary objects from patient's bedside Personal items within reach Keep patient's bed in low position Put bed against the wall if required Regular testing as appropriate Educate patient on what they can do independently Give patient falls and pressure prevention pamphlets Inform patient and family of falls prevention strategies Call bell within reach	Mental status Nurse in position of high visibility Orientate patient to place and time at each contact	IV Infusion Call bell within reach Remind patient about physical limitations	Mental status Nurse in position of high visibility Pharmacy to review medication Complete Delirium Screening-CAM Nurse in position of high visibility Pharmacy to review medication Orientate patient to place and time at each contact Encourage family to be with patient if appropriate Do not leave patient alone in bathroom Toileting routine if appropriate Consider use of Bed Chair Alarm

Outcomes so far



What we have learnt



Do's:

- Get accurate data (not easy initially)
- Focus interventions on those at most risk of harm should they fall (ABC)
- Updates & results visible
- Build actions into processes that already work – for example assessment tools into admission packages or care plans.
- **Try to be resilient**



Don'ts:

- Present falls solely as a nursing problem
- Judge quality of care on crude falls rates
- Focus on falls prevention at the expense of autonomy and rehab
- Panic if falls rates are slow to drop over the first few years
- Forget – it is not about ticking boxes, it is about 'real' falls prevention interventions
- Be too caught up with benchmarking



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Putting learning into future actions by:



- Improving the accuracy of risk assessment:
 - Scenario based training (s)
 - User friendlier Morse tool (s)
 - ABC to identify patients at risk of harm from falls (s)
- Targeted falls prevention interventions implemented
 - Clearer interventions linked to patients falls risk factors (s)
 - Embedded with care plan (s)
 - Utilise IT systems
- NB (s) = started PDSA cycles on these areas



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