Maupuia Lifecare: Falls Prevention Initiatives

Maupuia 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 Maupuia Lifecare

Maupuia Lifecare, part of the Ultimate Care Group, provides rest home and hospital care. It is located in Maupuia, Wellington.

The facility manager, the clinical nurse leader and two registered nurses went to some or all of the sessions. The team who went to the meetings came back and shared the information with others at the facility.

Maupuia's approach

Maupuia already collected data about falls as part of a set of clinical indicators. Attending the falls prevention sessions helped the team to look at the falls data more systematically and to develop responses to minimise falls. Separating falls out from other clinical indicators helped the team to focus on falls prevention.

> *"We now have a separate meeting just for falls. So we can really focus on it. In a quality meting there are lots of things to discuss."*

Involving the whole team was seen by the manager as very important:

> *"As much as possible I consult the staff member because they are on the floor and they know what to do. I was able to explain that this is not just for me – you will also benefit. I involve them and I now ask them what are we going to do now we know this is the problem? What is your suggestion – how can we prevent this happening?"*

The team collects information about all falls and uses SAC ratings. They identify the time and place of falls, what happened and who was on duty. On a daily basis the information is recorded by the nurses onto a falls cross. The falls cross is displayed at the nursing station and on the walls in the corridors.

> *"The falls cross gives us the information at a glance."*

At the end of the month the manager graphs the data using the spreadsheet developed for the falls prevention initiative. The graph is discussed at the falls

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

prevention meeting where the team establish causes and plan preventive action.

Examples of Maupuia's responses

Collecting the falls data and displaying information on the falls calendar was one of the important facility wide initiatives that resulted from the falls prevention initiative.

The team also made some changes after analysing the reasons for falls. For example:

- The team found that one fall occurred when a resident was struggling with a heavy door. A privacy curtain was installed in the toilet cubicle so the door didn't need to be used.
- Examples of preventing falls by individual residents included changing toileting regimes, looking at patterns in the falls and monitoring presidents more carefully at the times they are prone to falls. Sensor mats help by letting the team know when someone is getting up.

> *"The others that went share their ideas. New ideas to share with my team is toileting them regularly. That's why some of them get up. Also having someone on the floor all of the time. Some of them think they can do it. Keep an eye on them."*

Achievements

As well as reducing the numbers of falls, having the falls data has helped the team with their audits.

The number of falls has been reduced by increasing staff awareness of falls and looking at when falls are happening.

> *"Before starting this we had recurrent falls. When we started with the location monitoring and the calendar it has really reduced the falls. We could see the patterns and especially the times."*

Although there had been an initial reduction of falls the team had noticed a recent increase that may have been due to an increase in falling by one resident. Reducing falls is an ongoing challenge with the need to continuously monitor the reasons why falls are happening and respond.

> *"It is too early to evaluate our progress. It gets frustrating for us – we thought we were ahead of everything already but this month the stats are high – we are now trying to think of other ideas and preventative action."*

Reducing falls has become the responsibility of the whole team:

> *"Everybody is part of the programme."*

> *"We look at the calendar. I don't like to have any fall on my shift. No-one likes to have their name there if there is a fall. It's a competition not to have my name there and not to have a fall on my shift. I feel good if I go home and there is not a fall on my shift."*

The falls calendars for individuals are also being used by families and by GPs when they visit:

> *"Some of the families and the GP know about the calendar. When the GP comes he always has a look at the calendar. Some of the families give positive feedback and like to see that we are monitoring them – they know that we are doing something for the residents to minimise falls."*

How the falls prevention mini-collaborative helped

The team were positive about the value of attending the falls prevention sessions.

> *"They have done a great job. They are very helpful."*

Attending the sessions helped the team to document what they were doing and to be more systematic about putting in place initiatives and seeing how they worked. The process for making the graphs using the spreadsheet was:

"Simple and user friendly."

Sharing experiences was valuable.

"We were very interested- we already had falls prevention. It was collaborative so you hear from different facilities what they do and they share ideas."

"Our two nurses that went said they learnt a lot and they shared what we are doing. They were very proud to present to them what we have done."

Potential improvements to the Learning Sets include the option of visiting each facility first to find out what they are already doing and then building on that in the sessions.

Keeping going

The Maupuia team will keep going:

"We will keep doing it. We will continue to carry on with the programme. It has been a guide for us. Quality is about ideas from each and every one. We were pleased that other facilities were happy to share what they had done."

The team have already extended the quality improvement approach to medication error and have plans to extend further to monitoring infection.

"Yes, we have learned a lot – the evidence is in the folder. It was worthwhile- we will do it again. We have started it already with medication error."

"We could do it to areas such as infection. This is very good at least we have a guide now we have the format and we could do it in another area. The safety calendar is also being applied to medication errors. We had a high rate – learned from the falls calendar and instead of falls it is medication error."

A way to keep sharing ideas with other facilities would be welcomed:

"We can do it ourselves but it would be good to get fresh ideas from others. Other facilities might be doing something better. Blogs might work. Discussion sites on the internet."