Te Hopai Trust: Falls Prevention Initiatives

The Te Hopai Trust 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 Te Hopai

Te Hopai includes three areas: a rest home, a hospital and a dementia unit. The falls project formally commenced in September 2013 after the quality and training manager attended the first learning set of the falls prevention initiative.

Te Hopai's approach

There was strong management support for the falls prevention initiatives.

The Te Hopai team initially focussed on improving the data they were collecting about falls.

- They adapted (with permission from Mercy Parklands) their high falls risk profile and summary forms. The new form included severity assessment codes (SAC) ratings which had not previously been used.
- SAC ratings allowed the severity of falls to be tracked. Targets were set for falls reductions in each SAC rating category.

> *" We previously defined falls as injury and non-injury. Adding in the SAC rates is helpful because different interventions are required for different types of falls and different types of fallers."*

- Residents in the frequent faller category have a high falls risk profile added to their file.
- Visual saftey crosses were developed for fall free days and displayed where they could be easily seen by staff. They have raised general awareness of falls.

> *"Its in your face every day"*

- Falls data into the mini-collaborative to be used in tracking and benchmarking.

Staff engagement was encouraged:

- Vouchers were given for percentage reductions in certain types of falls.
- Initiatives had to be practical and care givers had to see the merit in the initiative. The three areas have different challenges in considering initiatives to prevent falls.

Data were analysed and initiatives planned to respond to the risks identified.

Examples of Te Hopai's response to the falls data

Different initiatives were tried in each of the three areas of Te Hopai.

> *"Some of the things we tried worked in one area but not in another."*

- Changes to the rest home roster to have someone starting earlier in the morning.
- The addition of a recreation officer in the dementia unit at the weekends. By examining falls data the team identified that falls occurred in the weekends in the morning when caregivers were occupied helping

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

residents with personal cares. The addition of an extra staff member appears to be reducing the falls.

- The sunshine group - Increasing the sun exposure of residents to increase their vitamin D levels by increasing time outside. New garden furniture was purchased to help make the outdoors area look more attractive. Walks and stories outside were organised. Results are being monitored but initial data shows a reduction in falls.
- Vouchers are being used in a positive way for falls free days on the star chart to encourage staff engagement with falls prevention and increase their awareness.

Achievements

The falls reduction targets have been met or exceeded for each SAC rating.

> *"We know we have reduced our fall rates. We set targets at the end of last year….we wanted to reduce SAC 4 by 10% and SAC 3 by a quarter and halve our fracture rates (SAC 2) versus 2013. We are on target for SAC 4 and beating our targets for SCA 3 and 2."*

How the falls prevention mini-collaborative helped

- The learning sets provided opportunities to meet people from the different agencies

> *"It was good to meet people from the HQSC and work out how their roles and work could influence and improve our work here in aged residential care."*

- The learning sets and particularly the information about data

> *"Provided the foundation about how to do it."*
>
> *"I really liked the spreadsheet."*

- Using the spreadhseet and benchmarking against other facilities

> *"It's particularly useful and relevant to benchmark against local facilities that you know are the same as you…. We are all in the same DHB and have access to the same resources so we know we are similar."*

- New falls prevention initiatives have been set up using the The Plan-Do-Study-Act (PDSA) cycle. Initiatives are written up and the results reported. The PDSA concept was not new to the quality and training manager but the course provided new ideas.
- Taking part provided the opportunity to talk to others and hear what other aged care facility providers were doing.

> *"It's always good to brainstorm a little. You can get ideas from other people and they can get ideas from you".*
>
> *"The third one was useful as we werefeeding back after a long time and we had implemented ourr initiatives. We heard new ideas."*

- Collegiality and collaboration.

> *"There was definitely value, do it again! We need to work as whole team in aged residential care. We would like to have every older person in New Zealand living in a place they want to live in. Different facilities offer different things. We all have something different to offer. These groups break down barriers between us and encourage and enable us to share."*

Keeping going

Te Hopai will keep going with the falls prevention initiative they have in place. Monitoring falls is now part of business as usual.

> *"Yes, we will keep going…It is part of our quality planning for this year."*

The Te Hopai team are keen to keep using the spreadsheet and sending data in.