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Geraldton Hospital Falls Huddles

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September 19, 2019

Background

- Geraldton Hospital inpatient falls rates have steadily increased over the past three years (2015-2017)
- Recent research identified that inpatient teams where all members play an active role in falls risk reduction were successful in sustaining decreased falls rates
- Our primary aim was reducing inpatient falls which is recognised in the National Safety Quality Health Standard 5 - Comprehensive Care
- Implemented Pre and Post Fall Multidisciplinary Huddles for 6 month trial from 29 January to 26 July 2018
- Mixed general ward
- Trial successful and huddles continued
- Review of huddles March 2019

Procedure

- Multidisciplinary assessment and intervention
  - Doctor (consultant or registrar)
  - Pharmacist
  - Older Patients Initiative
  - Physiotherapist
  - Occupational Therapist
  - Primary Nurse and Wing Coordinator (if available)
- Falls Risk Assessment Management Plan (FRAMP) for facilitation of discussion and documentation

Procedure

- Patient selection process
  - Two patients per day Monday to Friday selected by Senior Physiotherapist or Older Patient's Initiative Clinician
    - Post-Fall Huddle – A patient who had an inpatient fall was given highest priority
    - Pre-Fall Huddle – High falls risk inpatient identified
  - The selected patients were identified on the Nurse Station communication whiteboard
- Meet at 14:15 and 14:30 outside patient's room
- Allied Health Professional to discuss with patient/carer falls prevention strategies immediately post huddle and sign the FRAMP
- If a patient falls despite having a huddle an additional post fall huddle occurs whereby the multidisciplinary team reviews the strategies in place to ensure they were appropriate and adhered to by staff

Promotion

- Inpatient nursing stand-up meetings
- Multidisciplinary discharge team meetings
- Allied Health team meetings
- Inpatient nursing in-services
- Patient Service Assistant in-services

Outcomes

Trial (2018) and review (2019) periods:

- Number of inpatient falls
- Number of huddles completed
- Number of inpatient falls post a pre-fall huddle
- FRAMP audit
- Staff survey on knowledge and perceived benefit of huddles at completion of trial

Additional measures during review:

- Time taken to collect disciplines
- Interventions recommended
- Interventions completed

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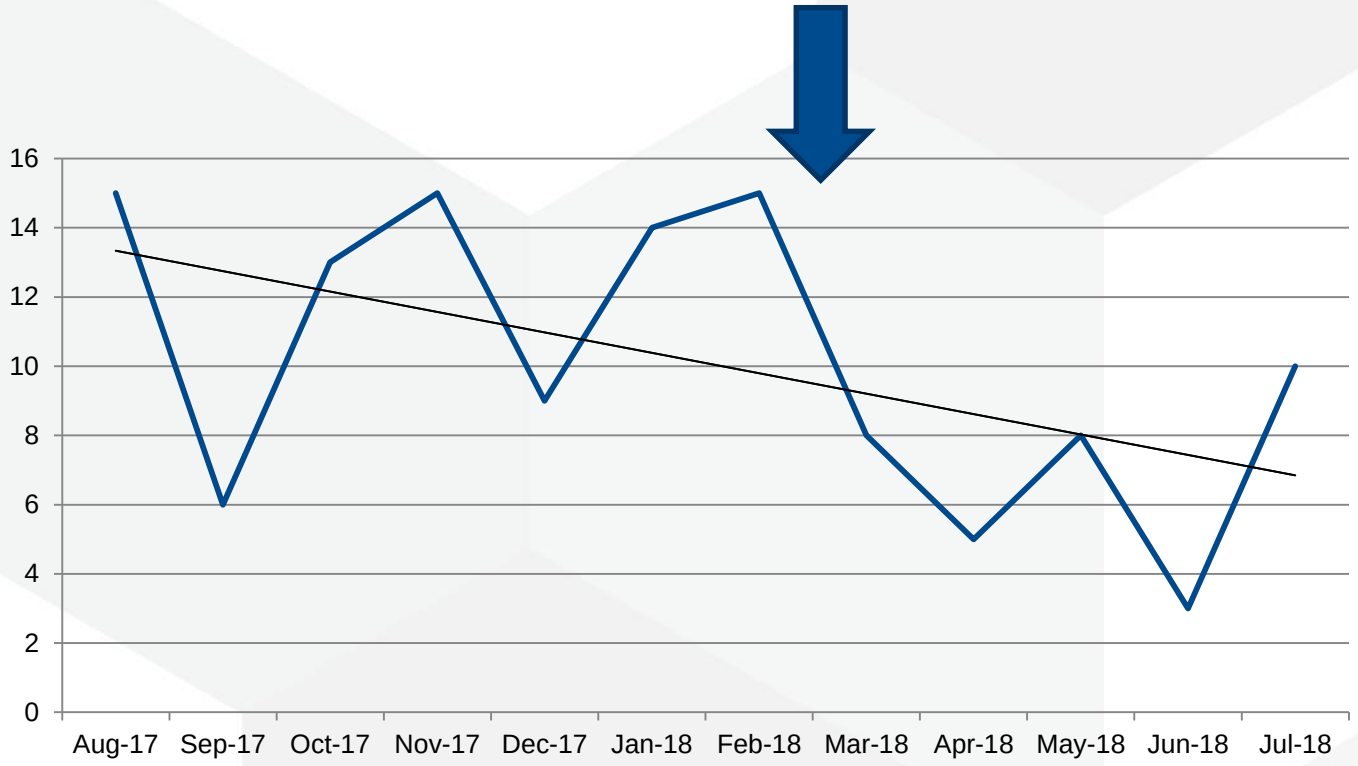
Trial Results

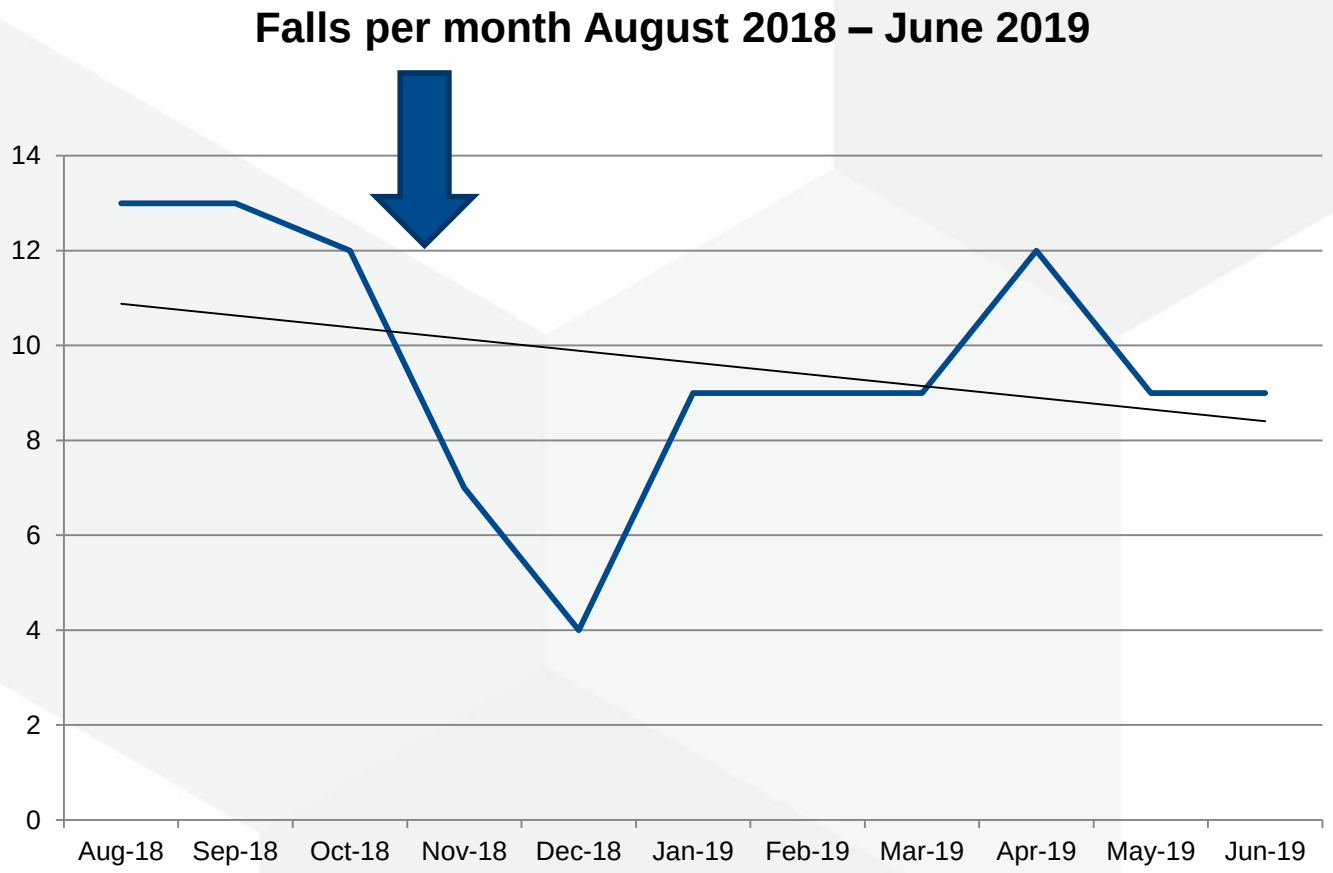
Falls Incidents

August 2017 – January 2018	February 2018 – July 2018
68	35

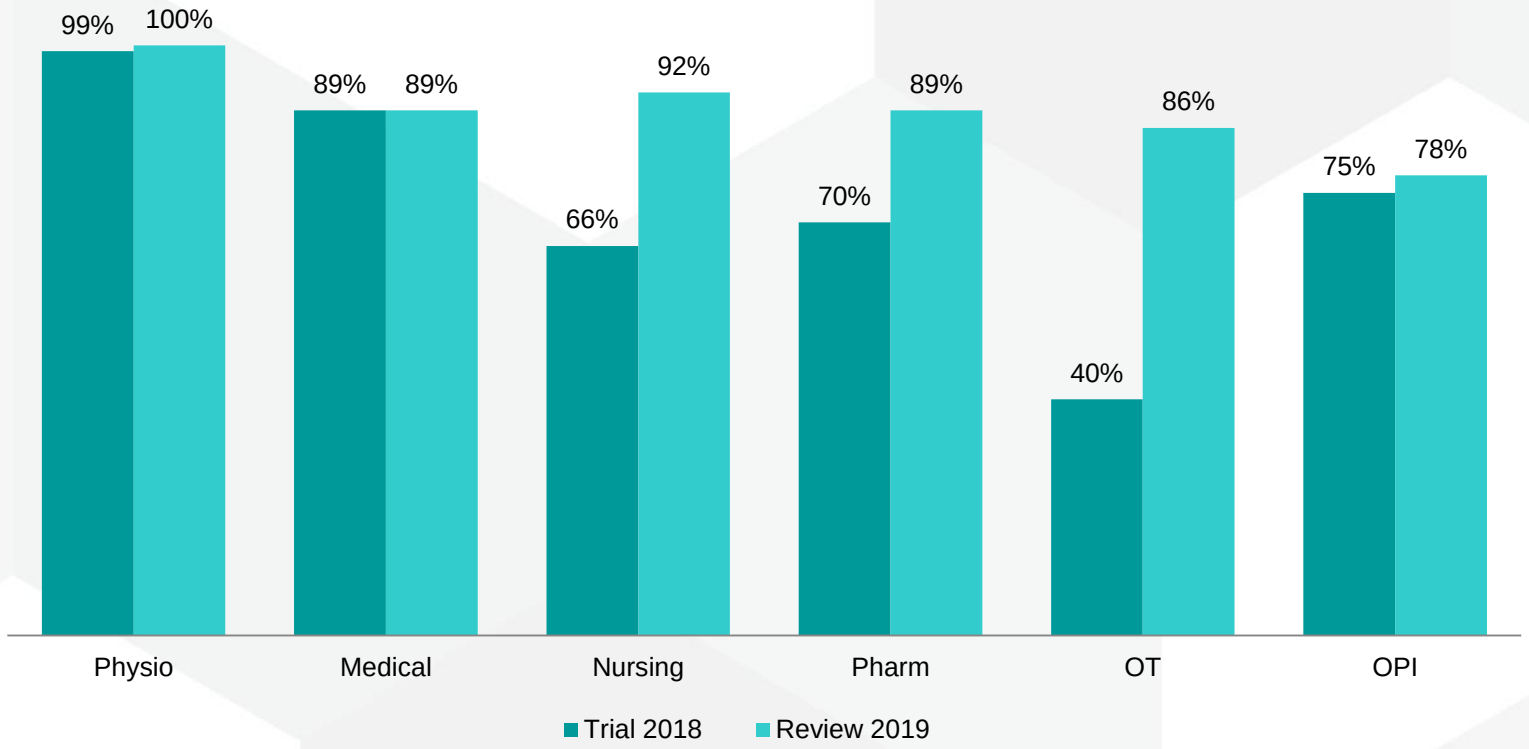
Falls per month August 2017 – July 2018



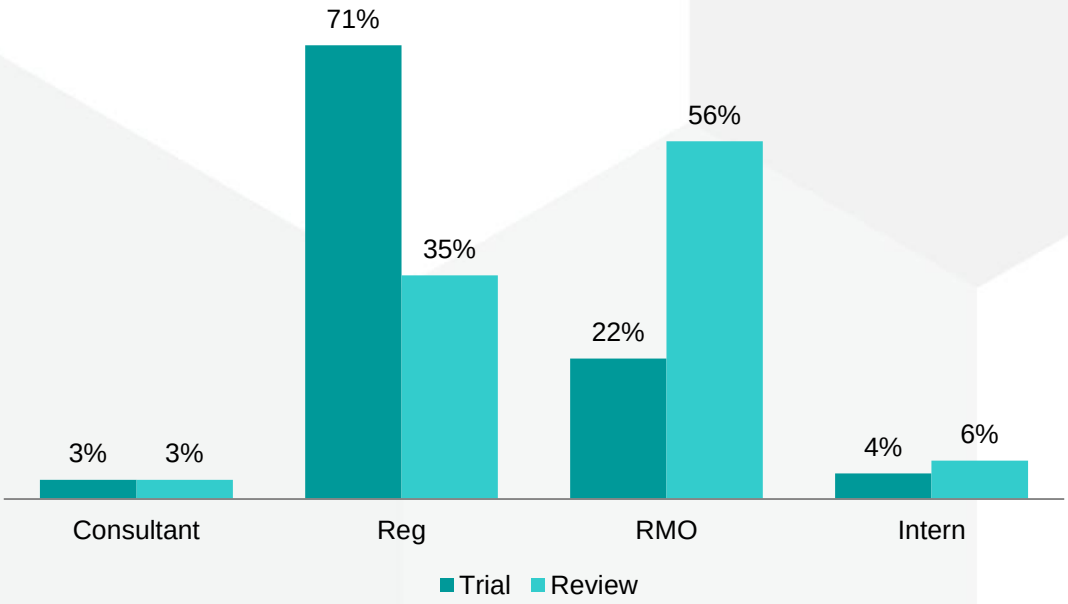
Post Trial Fall Rates



Discipline Attendance



Medical Attendance



It took an average of **3.25 minutes** to chase up all of the attendees. Maximum amount of time spent was **12 minutes**

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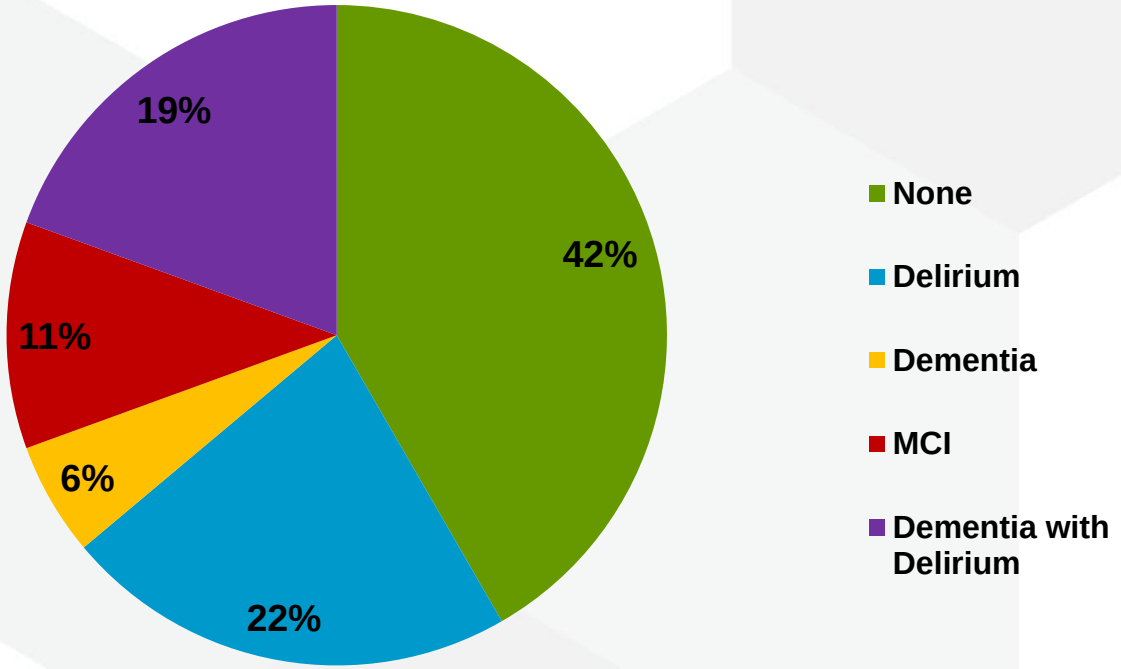
Average age of patients receiving huddle

80

Patients with Cognitive Impairment (review)



Falls Rates

- Trial Period
  - 94% of patients that received a pre fall huddle did not have an inpatient fall
- Review Period
  - 93% of patients that received a pre fall huddle did not have an inpatient fall

- Investigation into those that fell found that the referrals and interventions identified from the pre fall huddle were not always completed

Staff survey from trial period

- 70% strongly agreed and 30% agreed in the value of the huddles
- All staff strongly agreed or agreed that their falls prevention knowledge improved and 82% changed their clinical practice as a result

"The falls huddles have been a great initiative – educating nursing staff and medical staff and patients"

"The huddles have been a useful tool in identifying falls risk patients and planning or interventions for their care, as well as involving the whole multidisciplinary team"

Benefits

- Reduction of falls
- Facilitation of MDT discussion
- Discipline specific accountability
- Increased falls awareness and prevention strategies both patients/carer and staff
- Initiative was showcased during ACHS Assessment April 2019 and was commended in the final report by several assessors, assisting us to meet the Comprehensive Care, Communicating for Safety and Medication Safety Standards

Where to from here

- Consumer engagement during the huddles
- Ongoing focus on implementation of huddle interventions
- Capturing high risk patients earlier in their admission
  - Potentially increasing number of huddles as required day to day
- Sticker for documentation in the progress notes

Questions?

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Acknowledgements and References

Acknowledgments

- Shannon Mullikin, Quality Coordinator Geraldton
- Geraldton Hospital Inpatient Team

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