Interprofessional Falls Prevention Program
Fairview Lodge

Introduction

Building a culture that supports IP practice is the responsibility of the organization's leadership. IP collaboration reflects the requirements of high quality, resident-centred practice, including mutual respect, trust and open communication between team members.

Building a culture of safety is the responsibility of every individual in the organization. Improving resident safety is a major priority in healthcare delivery and vital to resident well-being and family confidence. Resident safety spans all disciplines and is therefore an excellent fit for IP practice.

A collaborative team approach is essential when a resident's safety needs are multiple and complex. Errors are often the result of systemic miscommunication in a hierarchical, multi-professional organization with a wide scope of practice. Engaging non-regulated health care professionals in IP initiatives will help in overcoming some barriers that influence the delivery of effective and efficient resident-centred care.

Falls are a major safety issue in LTC. The opportunity to implement a collaborative falls prevention program in the LTC setting should lead to positive outcomes in terms of the 'triple-aim' focus for healthcare transformation as it will impact on population health, experience of care, and cost per person.

Actions

An Interprofessional Falls Prevention Steering Committee was struck in September.

Members included:

- Resident Care Coordinator
- Manager, Nursing Practice
- Registered Nurse
- Registered Practical Nurses (2)
- Personal Support Workers (2)
- Documentation RPN
- Physiotherapist
- Adjuvant
- Recreation Programmer
- Administrator (ex-officio)

The team members were educated in the CPSI framework and team building.

A falls prevention program emphasizing IP collaboration principles will be rolled out to care staff, families and residents. Implementation will take place unit by unit over the course of 4 months (Sept – Dec). Utilizing in-house facilitators assisted in building institutional capacity.

Historical data on falls, 'found on floor', and injury relating to falls was collected via a review of the 'Nursing Monthly Indicators' sheets and our 'General Incident' notification statistics. This historical data was collected one year prior to program implementation and monthly following rollout. This is aggregate data with no client identifiers.

Resident Safety audits were developed and implemented by the committee.

The execution of the Program and tools and qualitative/anecdotal impact of experience for each committee member was evaluated.

The impact of program on the number of falls within the home will be evaluated once fully implemented.

Results

Measurable Outcomes Goals:

Within three months of implementation of the collaborative falls prevention program on the unit there will be:

- a reduction in the number of falls; FOF
- a reduction in the number of transfers to hospital resulting from residents FOF or having experienced a witnessed or un-witnessed fall.

Other outcomes that will not be specifically measured, but are predicted to change will be:

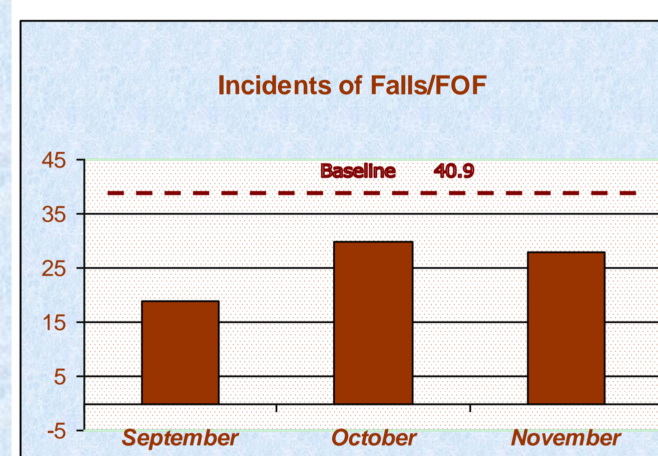
- increase in quality of worklife in terms of increased level of expertise/confidence
- positive change in role and perceived value of other disciplines

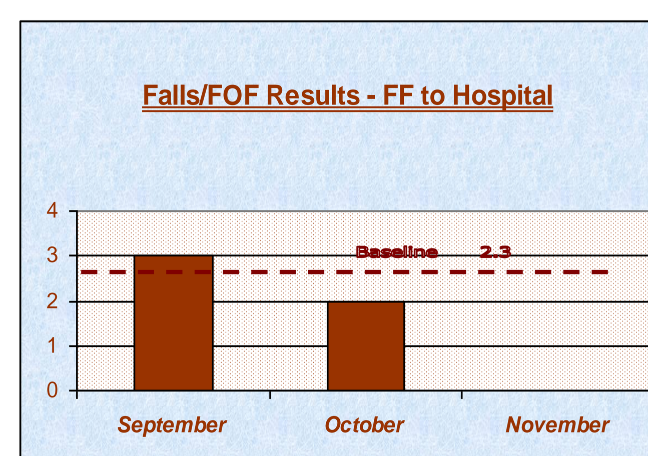
The Falls Prevention Education program was rolled out as a 4 hr session for registered staff and committee members and as a 2 hr session for other direct care providers (PSWs, adjuvants, recreation programmers, etc). As of December 31/09 – 76% complete.

Awareness building has begun – article in our resident newsletter, presentation to resident council and family council.

For the three months ending November 30/09, there was an overall reduction in the incidents of falls/FOF as well as a reduction in transfer to hospital as a result of fall/FOF.

These findings, while positive were measured very early in the program implementation and could be confounded by a number of other factors. The results need to be sustained over a longer period in order to be valid.





Challenges

- Time constraints – for front line committee member to attend meetings as well as getting time to complete assigned audits
- Differing levels of knowledge, understanding about the continuous quality improvement process and auditing amongst committee members
- Documentation inaccuracies – reinstruction of registered staff was needed in some cases to use the correct focus button when documenting so that all fall/FOF incidents would be picked up in reports
- Turnover of physiotherapist membership
- Copy write issues – Falls Risk Assessment Tool (FRAT)
- Programming issues – adding the FRAT to our documentation software then instructing staff as to how to use the tool

Lessons Learned

Spending extra time at the kick-off is worth it!

Our committee met for a ½ day to clarify and agree upon the mandate, roles and responsibilities of the committee members and how they can each contribute. We also spent time discussing the IP approach and CQI measurement and evaluation tools.

Don't reinvent the wheel.

We opted to use the FRAT – already validated and reliable tool for measuring risk. We also closely followed the *RNAO Best Practice Guideline for Prevention of Falls and Fall Injuries in the Older Adult* and just tailored it to meet our needs.

Use technology – if you don't ask, you don't know what is possible.

We worked closely with CIS and our software vendor to put the FRAT onto our documentation system (work in progress). Once that is completed, we will have the opportunity to review the FRAT online and to make necessary recommendations/changes to care plans directly. As well, immediately upon completion of the FRAT, a notification will go out to appropriate staff to advise of any resident at high risk for falls so that proactive measures can be put in place.

Because of shift work, we rotated meeting dates and times so that we could maximize opportunities to attend the meetings.

New Evidence/Best Practices

While there were no best practices identified as a result of this project, we were able to reinforce the *RNAO Best Practice Guideline for Prevention of Falls and Fall Injuries in the Older Adult.*

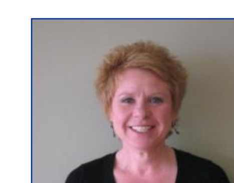
The team also found using the FRAT tool which has been tested as reliable and valid in assessing risk of fall moved the team forward at a faster rate than we would have been able had we had to develop and test our own assessment tools.

Next Steps

The work of the Interprofessional Falls Prevention Committee will continue – high risk rounds will be conducted and all resident incidents of fall/FOF will be thoroughly reviewed to ensure corrective action has been taken and to identify any trends.

The interprofessional approach to the provision of care to our residents will be emphasized in any future program roll out as well as in any non-clinical program as part of change management strategy as the same principles of buy-in, better decision making, increased employee engagement, enhanced quality of worklife, etc. apply.

Contact Information



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