Let's Reflect on the Fall

Team Members
Vanathy David
Joanne McLoughlin
Miriam Nonu
Denise Edgar

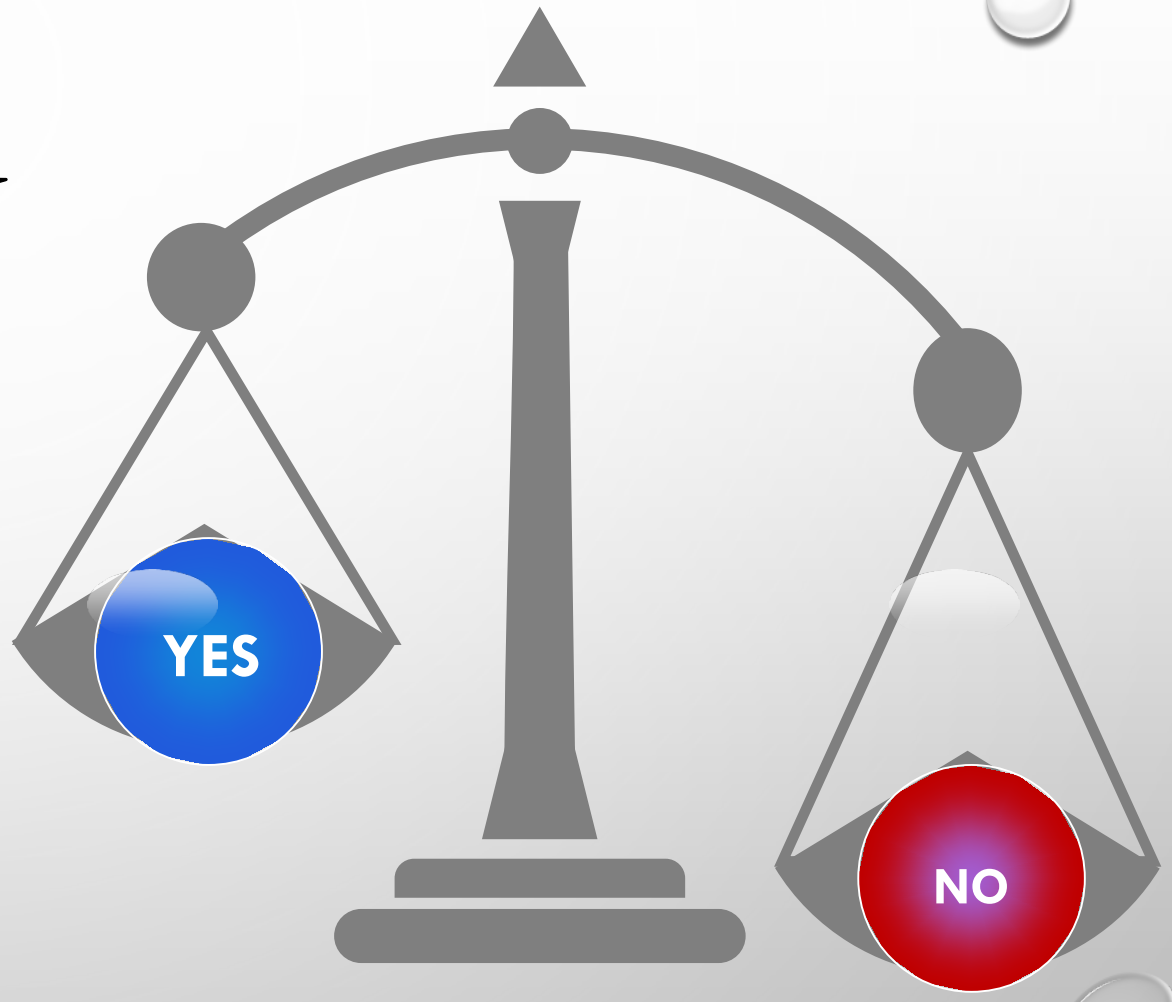
Supervisors
Prof Valerie Wilson
Prof Victoria Traynor

Background

Are the standard falls prevention strategies effective in preventing falls?

Despite of multiple falls prevention strategies, falls continue to be a huge challenge in the hospital setting…

We discussed the need to renew and expand our efforts to prevent falls and go beyond the standard falls prevention strategies.



It's not making a greater impact

(Cameron et al., 2010)

PROJECT 'AIM'

AIM

To decrease the number of falls on three participating wards at Wollongong hospital by the use of reflection by staff and patients

Objectives

- To Increase the compliance with falls best practice guidelines and implementation of strategies
- To explore whether staff engagement, with the chosen self-reflective model, supports the utilisation of the falls prevention strategies in participating wards
- To identify the impact of patient reflection after a fall and its influence on change in nursing practices around falls prevention
- To co design solution with the staff on the pilot wards

RESULT OF LITERATURE SEARCH

- There is paucity of research around utilising reflective models for nurses and patients to prevent falls
- We have identified one study done in America called “a reflective accountability model for falls prevention”
- The study utilised a reflective model to evaluate on each fall from staff and patients' perspective
- The implementation of this study along with a few other strategies have showed significant impact on preventing falls and related injuries on the pilot ward.

This is a new concept in Falls prevention. The Research team liked the utilisation of the reflective model in this study and wanted to implement this model in our clinical setting.

(HOKE AND GUARRACINA, 2016)

OUR STUDY

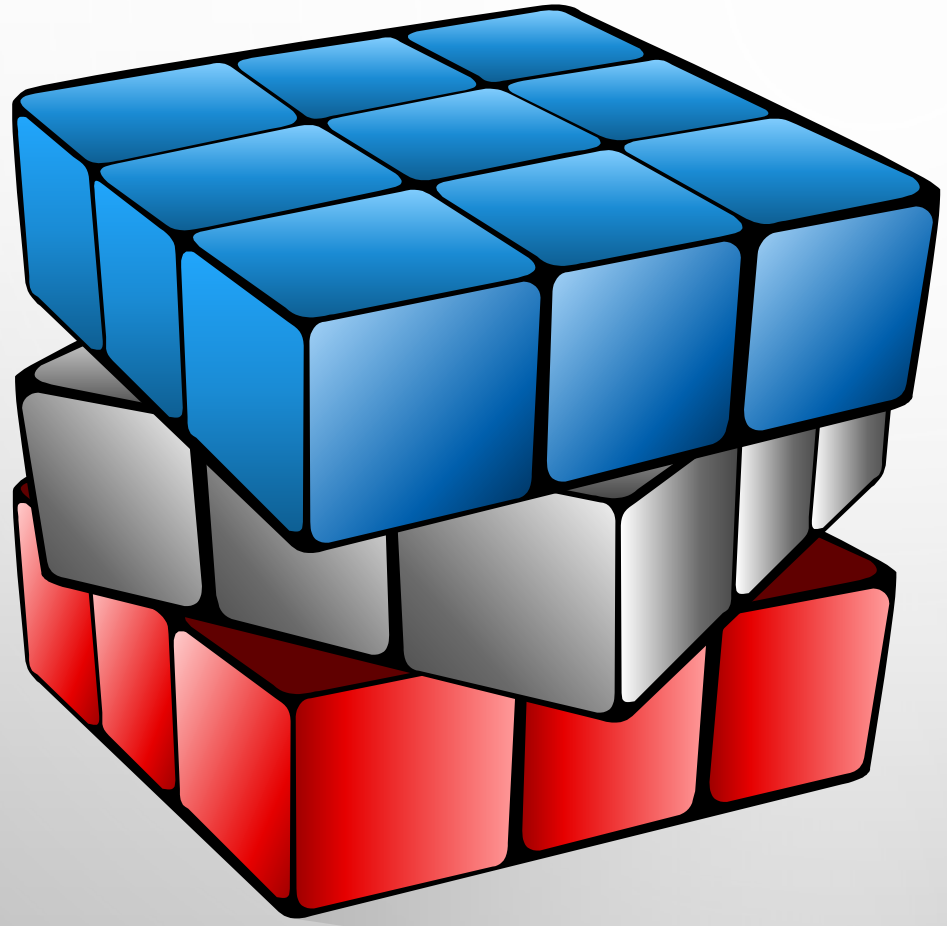
This is a mixed method study using an action research approach following a PDSA model

(Action research is a spiral process involving data collection to identify the gap, taking action and analysis of the action focussing on the real problem)

In this Project, we aim to minimise the falls and related injuries by involving the staff and patients in taking action through critical reflection on what has occurred, developing ideas about how things could be done differently, implement these ideas and evaluate them to see what works in reducing the falls.

This Research aims at **culture change** for which an action oriented approach through evidence is best suited as it engages people in looking at their own practices and enables them to create potential solution for the real problem - Falls

PHASES OF THE STUDY



Phase 1

Data Collection
Engagement Session

Phase 2

Staff Reflections
Patient stories

Phase 3

Feedback from Phase 2
Co Design the Solutions with the staff

RESULTS

WARD A

Pre-Intervention	Intervention	Post Intervention
April - 8	July -7	Oct- 6
May- 9	Aug- 8	Nov- 8
June -6	Sept- 5	Dec- 6
Total = 23	**Total = 20**	**Total = 20**

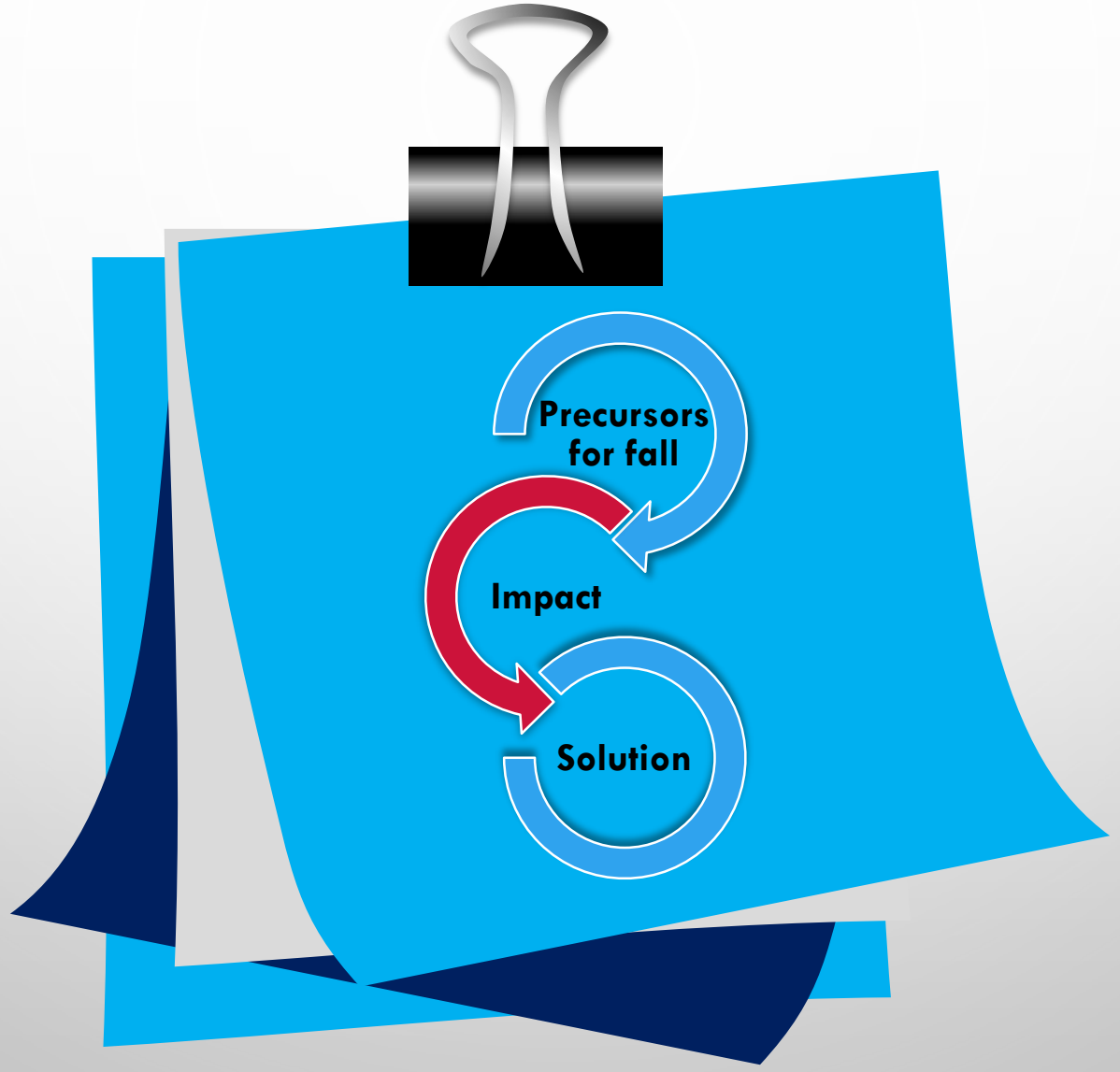
WARD B

Pre-Intervention	Intervention	Post Intervention
April - 3	July -2	Oct- 2
May- 10	Aug- 4	Nov- 6
June -6	Sept- 4	Dec- 4
Total = 19	**Total = 10**	**Total = 12**

WARD C

Pre-Intervention	Intervention	Post Intervention
April - 2	July -2	Oct- 2
May- 5	Aug- 4	Nov- 3
June -2	Sept- 3	Dec- 3
Total = 9	**Total = 9**	**Total = 8**

THEMES- QUALITATIVE DATA



QUALITATIVE DATA

Precursors for falls

Causes of the fall can be patient or staff related factors. Patient related can be underlying medical issues, perception and non-compliance. For staffing it can be lack of supervision and perception

Quotes

"I stood there and I was going to go to the toilet. I took one step with my weak leg and it gave out on me and down I went"

"*Well* the charge sister put me in a chair and after I was showered, you have to sit in the chair until lunch and this chair was very uncomfortable"

Impact

Physical Impact – injuries

Emotional Impact – anger, upset, loss of independence, feeling silly, frustrated, overwhelmed and fear

Quotes

"I didn't quite make it… and then of course that always upsets me when I have a fall."

"She had skin abrasion on the right buttock and inner thigh"

"After the fall, I thought I was going to kick the bucket"

Solutions

Patient and Staff offered some potential solutions to prevent future falls

Quotes

"may be the floor needs to be non-slippery like the one's in the kids park.."

"in my opinion the fall could have been prevented if he was specialled/closely monitored with an improved number of staffing"

Successes so for….

- This project has won the ROSCARS award for the best nursing and midwifery project in 2018.
- Oral and Poster presentations in the Multiple conferences.

CONCLUSION

- Currently, we are feeding back the data from staff reflection and patient stories
- We will be unpacking the data in the focus group and exploring the solutions through staff engagement.
- Solutions will be implemented on the individual wards in collaboration with the staff and the managers.
- The whole PDSA will be repeated again


THANK
YOU