



Queensland Government
Queensland Health

FALLS PREVENTION

CHOOSE TO SEE



CHOOSE TO ACT

Urszula Dolecka, Physiotherapist

13/11/ 2008

CHOOSE TO SEE – CHOOSE TO ACT





CHOOSE TO SEE – CHOOSE TO ACT

- ▶ **It is a falls prevention education program for health care workers**
 - ▶ **It enhances any existing programs**
 - ▶ **It was developed in October 2007 as an immediate response to a significant increase in number of falls in a clinical area of an acute hospital**
 - ▶ **It is based on principles of adult learning**
 - ▶ **It is interactive and area specific but the concept is easy to implement in any clinical area with a minimum effort**
- ▶ **It is about changing attitudes, accepting responsibility and being focused on patient needs and safety**
- ▶ **It is about common sense, trust and empowerment**



CHOOSE TO SEE – CHOOSE TO ACT

- ▶ **Following escalation of falls - we started to ask the following questions:**
 - ▶ **Why falls continue to happen in our area despite of all efforts?**
 - ▶ **Is there something wrong with preventive procedures, protocols and guidelines?**
 - ▶ **Is there something wrong about the way we do our jobs?**



If we only could:

- ▶ Analyse all falls and act upon the recommendations
 - ▶ Change procedures
 - ▶ Enlarge patients' rooms
 - ▶ Provide one to one assistance for high risk patients
- ▶ **But it was impossible since we had limited resources and had to act almost overnight**
- ▶ We decided to **“stop, look and listen”** - and “see” what was really happening
 - ▶ Unexpected reports started to come on daily basis

CHOOSE TO SEE – CHOOSE TO ACT



- ▶ **Two staff members in the room**
- ▶ **Anything wrong with this situation?**
- ▶ **No response until prompted by a bypassing observer**
- ▶ **Had staff chosen “not to see” because patients do this so often and it doesn't always result in a fall?**

Not every unsafe task will finish with a fall but the price to find out is too big!

During our “journey”

- ▶ We stopped a number of falls, but unfortunately also witnessed some
- ▶ We came up with following observations:
 - ▶ Most of patients had Falls Risk Assessment done and had “Falls Risks” signs above the bed - we were not “seeing” them or acting differently because of them
 - ▶ Many falls were likely to happen in the presence of or in the view of Nursing Staff or other health care workers – two parallel worlds
 - ▶ Many falls happened around the bedside - the risk was easy to predict
 - ▶ We had seen risky behaviour - where others had not

Good idea but ...



The program aimed to help staff members to:

- ▶ Better identify risky behaviours or situations
- ▶ Feel empowered to choose to see and to choose to respond
- ▶ Develop a deeper sense of responsibility for all patients and not just for their own
- ▶ Become more observant and aware of their work environment and its limitations
- ▶ We were supported strongly by Nursing Clinical Facilitators and NUMs

To make it relevant and practical:

- ▶ **We re-enacted and photographed most commonly observed risky situations**
- ▶ **Developed worksheets and handouts**
- ▶ **Designed a session (approx 30 min duration) that involved:**
 - ▶ **Open discussion and analysis of 2 scenarios**
 - ▶ **Re-enactment of most common situations at the bedside**
 - ▶ **Discussion about preventive measures and responses**
 - ▶ **Hands on experience of risk – eg to feel how slippery commonly used compression stockings are**
- ▶ **Finally:**
 - ▶ **Conducted education sessions for current NS and more sessions later in the year for newly recruited staff members**

CHOOSE TO SEE – CHOOSE TO ACT



What this behavior tells us about the patient?

What actions should be taken?

CHOOSE TO SEE – CHOOSE TO ACT



What can happen next?

What should be done immediately?

Please, list the preventive measures:

CHOOSE TO SEE – CHOOSE TO ACT

▶ In the program we acknowledge that:

- ▶ Acutely ill patients (particularly elderly) may have limited insight into safety and if not assisted on time, they will attempt very unsafe tasks
- ▶ Due to limited resources we cannot always be with every patient, but hospitals are full of staff members constantly moving around – they can **choose to see and choose to act**
- ▶ Not all falls could be prevented but every one should be a lesson
- ▶ Most of falls have warning signs and they should not be ignored

CHOOSE TO SEE – CHOOSE TO ACT

- ▶ **The program aims to convey the message that:**
 - ▶ If patients look unsafe ➡ they are unsafe
 - ▶ **Intuition** is not a “black magic” – it is something that comes from knowledge and experience and we should trust ourselves
 - ▶ We can not afford to ignore what we see
 - ▶ Preventing falls is a team effort but every staff member’s responsibility
 - ▶ In relation to safety, all patients are ours

Disturbing findings

- ▶ **Through discussions with participants and analysis of scenarios we found that staff members:**
 - ▶ **Generally feel uncomfortable to interfere with work of others, particularly, when more senior or permanent staff members are involved**
 - ▶ **Believe that they are too busy with their own workload**
 - ▶ **Think that responding will cause more work and will divert them from their own duties**
 - ▶ **Are afraid of being perceived as troublemakers**

Responses

- ▶ **“She is doing this all the time”**
- ▶ **“I just corrected her”**
- ▶ **“I can see that”**
- ▶ **“ I can’t look after him all the time, I have another 3 patients”**

**FILLING IN AN INCIDENT REPORT
TAKES LONGER THAN
STOPPING A FALL**

Evaluation

- ▶ **Almost impossible to ascertain how much the program reduced the number of falls – at the same time some other initiatives were implemented**

Clinical Area (80 beds)	Sep/Oct 2007	Nov/Dec 2007
No of falls reported	44	22

- ▶ **Positive responses and open discussions during and after sessions**
- ▶ **More appropriate responses in post session worksheets**

CHOOSE TO SEE – CHOOSE TO ACT

- ▶ **Where from here?**
- ▶ **Continue the program with NS**
- ▶ **Target support staff**
- ▶ **Introduce the concept into corporate induction program**
- ▶ **Keep it practical and relevant !!!**

CHOOSE TO SEE – CHOOSE TO ACT
SHE COMES TO HOSPITAL TO GET BETTER

