#the EoSC
#spsp247

Creating the Conditions for Safe Care

When 2 worlds collaborate it all “falls” into place

SPSP National Learning Event
27th September 2022

When 2 Worlds Collide – it all 'Falls' into Place

Healthcare Improvement Scotland | Every Person Every Time Scottish Patient Safety Programme

Stephanie Frearson
Acute QI Lead

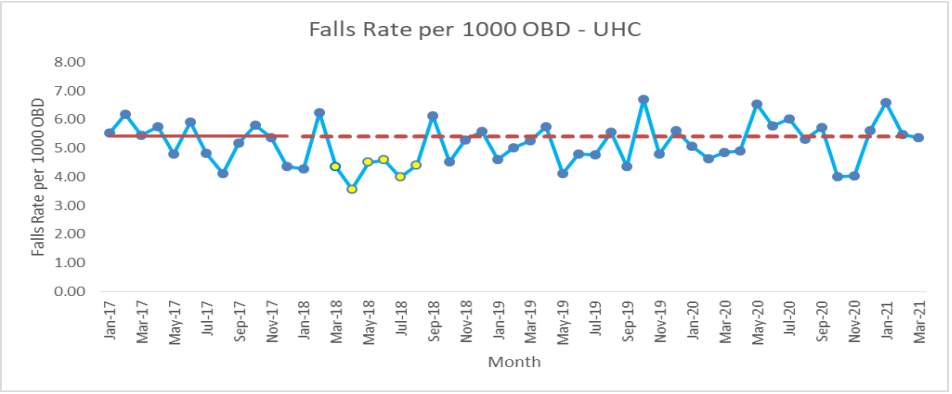
Jen Pennycook
Chief Nurse – Excellence in Care and Professional Development

Our purpose

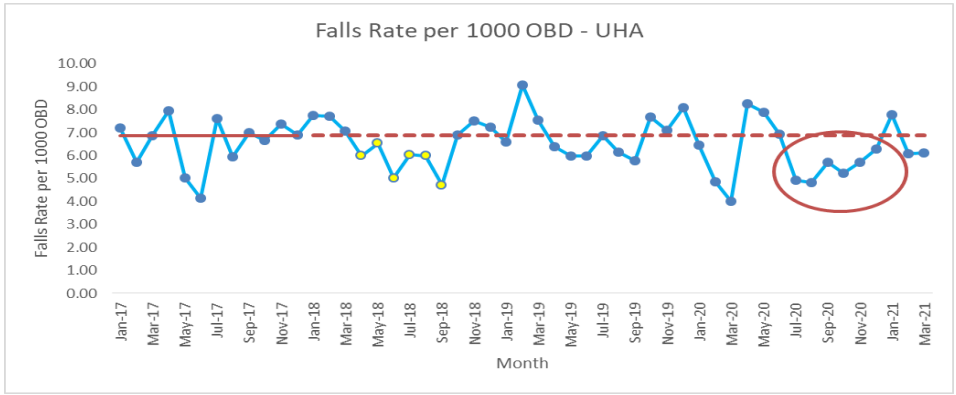
Working together to achieve the healthiest life possible for everyone in Ayrshire and Arran

NHS Ayrshire & Arran

Our Why?



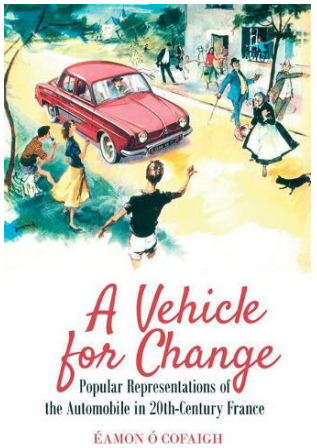
- No change in rate/median for several years
- No dedicated support for Fall Improvement
- No clear vision/plan
- Will to try something different



Our Vision

Slightly Different
Falls Coordinator Role

- Sit within the QI team
- Dedicated support to 'red' areas
- Use of data for improvement
- Improve processes (falls review/AERG)



'Our vision is to provide a consistent and collaborative approach to falls prevention and management to improve patient experience and outcomes.'

Plan and Test

Healthcare Improvement Scotland

Scottish Patient Safety Programme: Essentials of Safe Care – Prioritisation Matrix

The prioritisation tool will help you identify the 'change ideas' in the Essentials of Safe Care (EoSC) that will strengthen your existing patient safety work and/or highlight gaps that you need to address.

Primary Driver/Aim:

Change idea:

Please apply appropriate ratings to the following indicators:

1. Scale: Maximum % of target stakeholders affected	10%	25%	50%	80%	100%
Rating	1	2	3	4	5

2. Impact: Organisational culture of safe, consistent, person centred care	Prevents	Limits	Supports	Promotes	Achieves
Rating	1	2	3	4	5

3. Improvement: To stakeholder experience

Using a collaborative approach to reducing incidence of Falls with Acute Hospital Setting

NHS Ayrshire & Arran

Aim

Within NHS Ayrshire and Arran we plan to use a collaborative approach by integrating Falls and QI expertise to reduce the incidence of Falls by 20% in identified 'high risk' (red) areas in both acute hospital settings by Dec 2022

Measures of success:

Reduce no of Falls
Reduce no of Falls with Harm

Increase days between Falls/FWH in hospitals

Increase compliance with initial/repeat risk assessment

Increase staff understanding of QI methodology

Primary Drivers

Focus on
Improved
Clinical Outcomes

Focus on
Using quality improvement (QI) methodology and local data to identify and drive improvement

Focus on
Improving our Infrastructure and culture

Secondary Drivers

- Identification of risk
- Risk Assessment
- Post Falls review (MDT)
- Training Education

- Agree local Improvement plan
- Communicate process and outcome measures to clinical staff and management teams
- Ongoing education and training for staff to ensure staff knowledge and understanding of QI methodology and data for improvement

- Clinical teams are supported by FC and QI team to reduce the incidence of Falls.
- learning from falls reviews is used to inform improvement plans
- Named executive sponsorship and clinical leadership to review outcomes and support improvement work.
- Clear collaboration and integration with other improvement/assurance programmes e.g EIC

Change Ideas for Testing

Develop a shared vision to reduce Falls.

Develop a clear local aim for reducing Falls.

Revisit use of safety briefs/SBAR Handovers or capturing risk

Falls Training/Champions

Develop learning need analysis tool

Promote formal and informal learning opportunities to educate staff about QI methodology

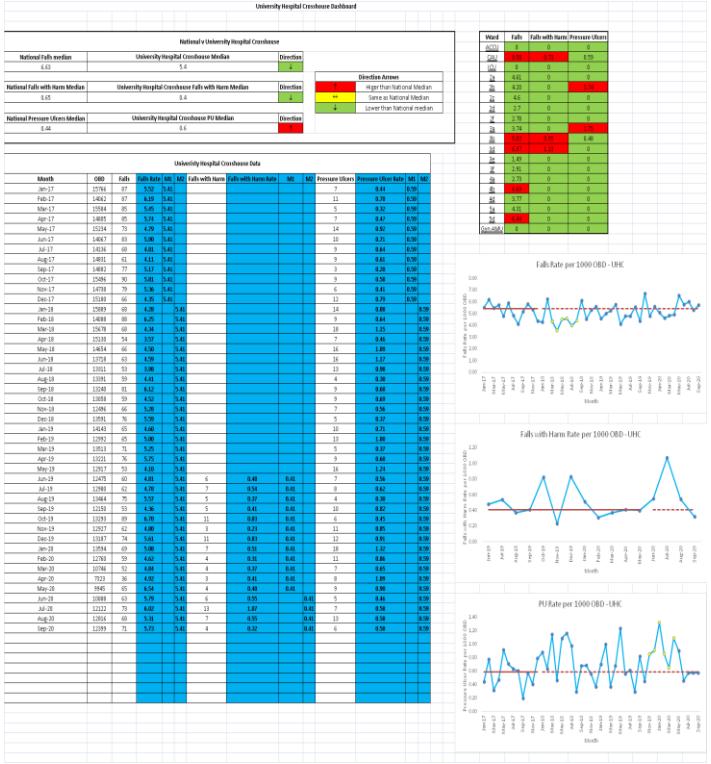
Use language that everyone can understand

Develop role of FC within QI team

Dedicated 'named' QI support

Develop shared learning platform to inform improvement plans

Our How



Led by data

Use data for improvement

QI Team Alignment to CNMs

NHS Ayrshire & Arran

The Aim

- Improve understanding/ownership of Data
- Encourage use of BI platform
- More Collaborative working relationship

The Ask

- I hour per month (SCN/CNM)
- Agree day/time that suits
- If SCN unavailable – appoint deputy

The Outcome

- Provide assurance around falls/PU/other harms
- Ability to use data for improvement
- Support your 1:1's with CNM

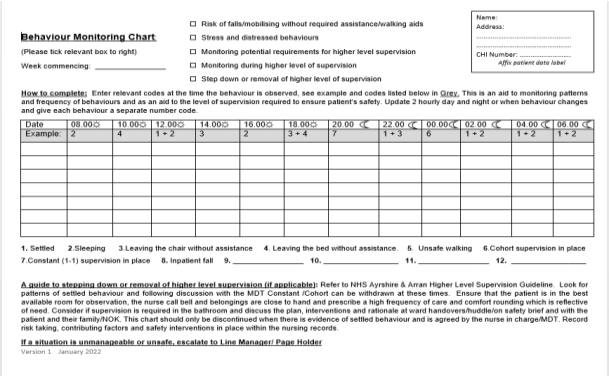
Collaborative working

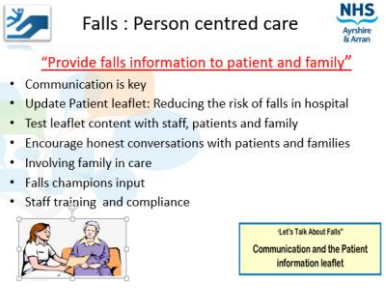
Implement and Embed

Collaborative Approach - QI/Falls Coordinator

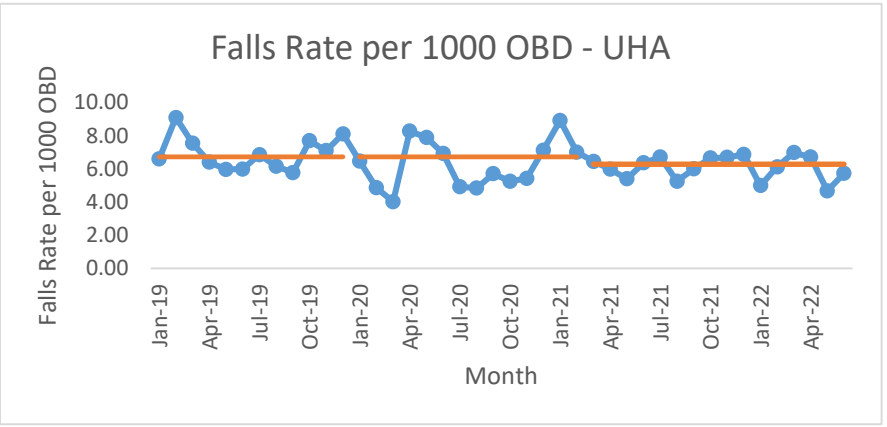
Use of QI tools/methodology
Data to monitor falls count/themes

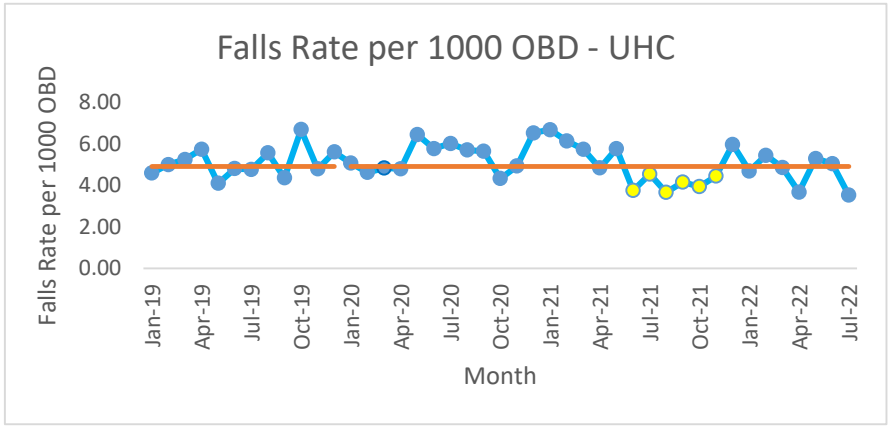
Improved and meaningful changes in clinical practice

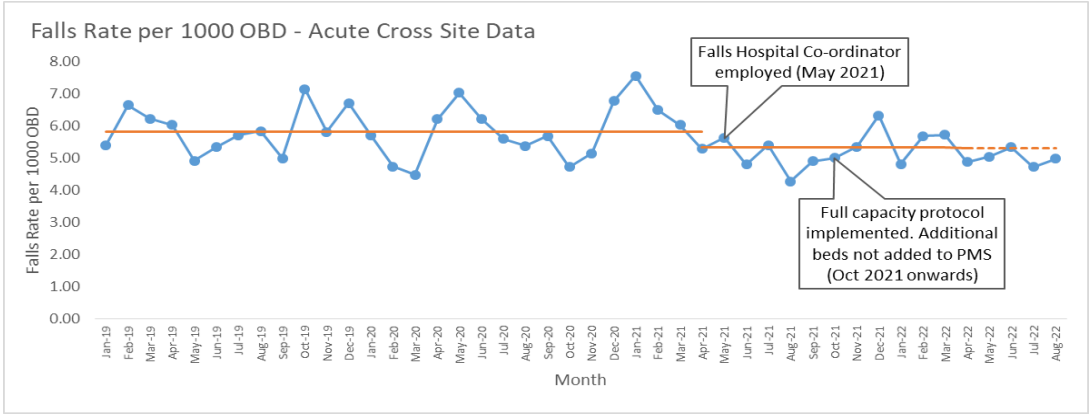




Measurement for Improvement







Our NHSAA Learning System

Supporting our Local Network

Daily/Weekly huddles

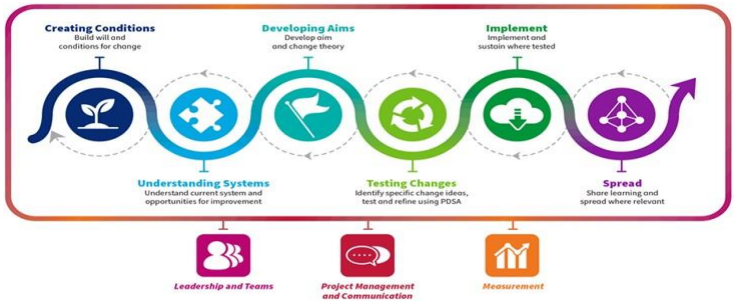
Dedicated QI support to wards

Sharing Data

Monthly data surveillance meetings(QI team/FC)

Monthly QI/CNM/SCN meetings

Monthly AND meetings

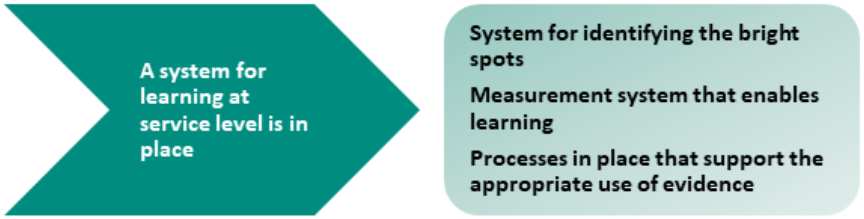


Sharing Evidence/Success

Chief nurse meetings -

Case studies/reflective summaries

Much more than just a falls Co-ordinator!



Developed:

Leadership in Falls prevention and reduction
- underpinned by QI methodology

Falls 'dashboard' – captures information
– tracks improvement
– application of QI tools

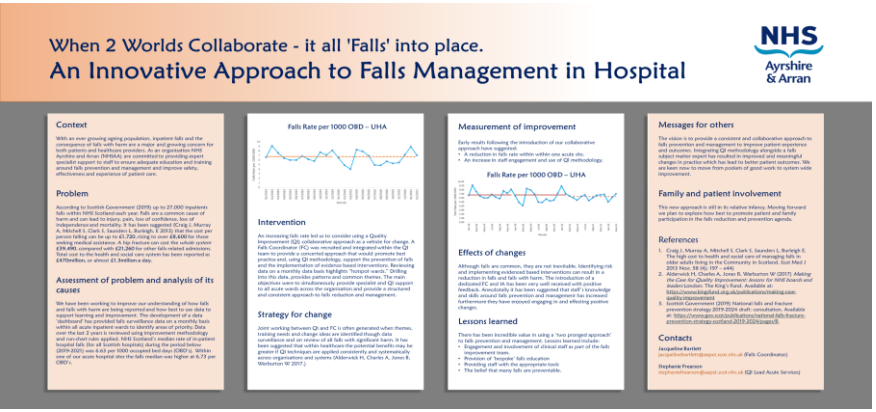
Falls education programme
Improved process around:

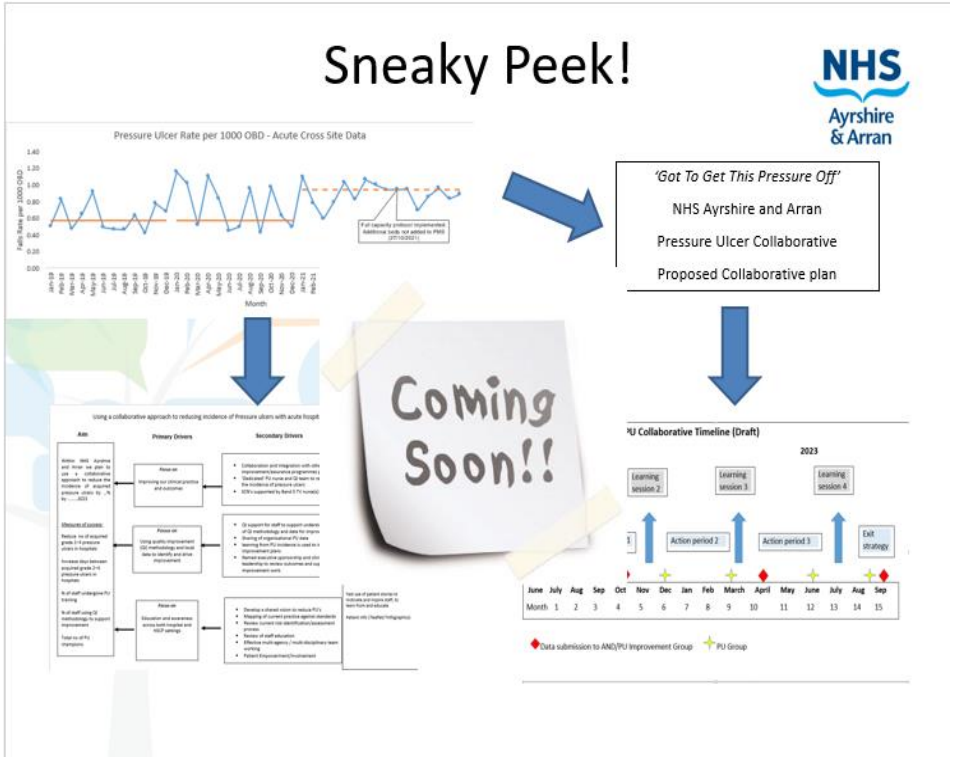
- Reporting,
- Staff wellbeing
- Communication

Sharing our Story/Success

Healthcare Improvement Scotland

Every Person Every Time – Scottish Patient Safety Programme





Thank you

Any Questions?

Jen.pennycook2@aapct.scot.nhs.uk
Stephanie.Frearson@aapct.scot.nhs.uk