

Evaluation of the Falls Specialist Officer Pilot Project

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Queensland **Stay On Your Feet**[®]

Executive Summary

Issue addressed

Falls are the most commonly reported adverse event in Queensland hospitals. During 2006-07, over 10,000 falls were reported in Queensland Health facilities (Queensland Health 2008). Falls rates in hospital vary according to patient populations, with estimates ranging from 3 to 18 falls per 1,000 bed days (Haines *et al.* 2008a). These hospital-acquired falls can result in harm, longer recovery times, increased length of hospital stay and mortality, all of which increase the burden on the health care system. This pilot project was designed to evaluate the role of Falls Specialist Officers (FSO) working in hospitals to deliver education, training and support to frontline staff on best practice strategies for falls prevention. The project aims were to build staff awareness, competency and attitudes towards falls prevention, and reduce the rate of falls and fall injuries.

The intervention

For this project, two FSOs were placed in three south-east Queensland metropolitan hospitals, jointly funded project by the Patient Safety and Quality Improvement Service (formerly known as the Patient Safety Centre) and the participating Health Service Districts. During the 12-month project, the FSOs raised awareness on best practice strategies for falls prevention, developed and delivered tailored training and education to all frontline staff across 11 wards, and facilitated broad hospital engagement in falls prevention activities.

Methods

This report details the findings of the project evaluation, using data collected pre- and post-project. The levels of compliance with best practice safety actions in falls prevention were examined using compliance audits, and safety attitudes towards falls prevention were assessed using a standardised safety climate instrument. The rate of reported falls and coded injurious falls were examined during the 12-month periods pre-, during and post-program, collected from hospital incident reporting systems and coded admitted patient data.

Results

Staff compliance with best practice strategies for falls prevention varied considerably pre-project, and significant improvements in compliance were demonstrated post-project. There was a 19-57% increase in the use of falls risk screening strategies (complete, correct, documented and completed within 24 hours; $p < 0.05$); and a 7-32% increase in environmental safety actions (appropriate bed height, bed-brakes locked, access to call bell, clutter-free environment; $p < 0.05$). Small improvements in safety attitudes were reported post-project, particularly for the "learning from mistakes" dimension, which suggests that staff were willing to learn from mistakes and make positive changes. Two dimensions remained problematic post-project: "unit recognition and support" and "provision of safe care". As such, additional strategies are required to build stronger teamwork for falls prevention, facilitate open and blame-free communication, and promote recognition and rewards for safe actions.

There was, however, no reduction in the rate of reported falls or coded injurious falls. There are a number of factors which may explain this finding: increased incident reporting behaviour, which is an indicator of teams with a positive safety culture; the limited evidence whether improving compliance with best practice strategies for falls prevention is effective in preventing falls; and the intervention period may have been too short to show an effect. In addition, the study did not modify existing falls risk tools or assessed whether falls prevention intervention strategies were implemented appropriately.

Conclusion

The tailored education program developed and delivered by FSOs was effective in enhancing staff competencies in best practice strategies for falls prevention, as well as improving compliance behaviour and staff attitudes towards falls prevention. However, given there was no reduction in the rate of reported falls or coded injurious falls, further investigation with the addition of strategies targeted towards patient education and risk factor interventions is warranted.

Where to from here?

The opportunities from this project are that momentum has been built for preventing falls in Queensland hospitals. At a hospital level, local investment is essential to maintain the focus on ongoing education and enhancement of safety culture towards

falls prevention. This project demonstrated that the FSO role working in hospitals can be an effective mechanism in which to drive these initiatives. At a state level, Queensland Health should consider the development of a suite of standardised tools and training resources to ensure the consistency of falls prevention education. These approaches are required to provide the necessary top-down and bottom-up approach to target all hospital staff and management, and develop and sustain effective falls prevention initiatives across Queensland Health facilities. In all, valuable information was obtained from this project about the future needs within hospitals and other Queensland Health facilities, to ensure the continued development of falls prevention education and training, which can inform future Queensland Health policy and other strategic planning processes.