## Project Title

Interprofessional Collaboration in the Form of a Huddle Among Multi-disciplinary Teams in Fall Prevention

## Project Lead and Members

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## Organisation(s) Involved

Outram Community Hospital

## Healthcare Family Group(s) Involved in this Project

Allied Health, Healthcare Administration, Medicine, Nursing

## Applicable Specialty or Discipline

Post-Acute & Continuing Care, Patient Safety and Quality, Physiotherapy, Nursing, Renal Medicine

## Project Period

Start date: Jun 2022

Completed date: Feb 2024

## Aims

Aim to decrease fall rate in both our pilot ward and the other scaled up ward by half with our fall huddle.

## Project Attachment

See poster appended/ below

## Background

See poster appended/ below

## Methods

See poster appended/ below

## Results

See poster appended/ below

## Conclusion

See poster appended/ below

## Project Category

Care & Process Redesign

Risk Management, Preventive Approach

## Keywords

Fall prevention, Risk Assessment, Huddle

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# Interprofessional Collaboration in the Form of a Huddle Among Multi-disciplinary Teams in Fall Prevention – a Quality Improvement Initiative in Outram Community Hospital.

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## Introduction/Background

Fall is the most common reported event in hospitals reporting system regardless of the patient's demographics with an event rate ranging from 1.3 to 8.9 per 1000 patient bed-days.

Falls have negative implications for patients, healthcare workers and hospital administrators with associations of higher patient morbidity, mortality, healthcare workers' distress, increased societal economic burden, institutional reputational and medicolegal risks.

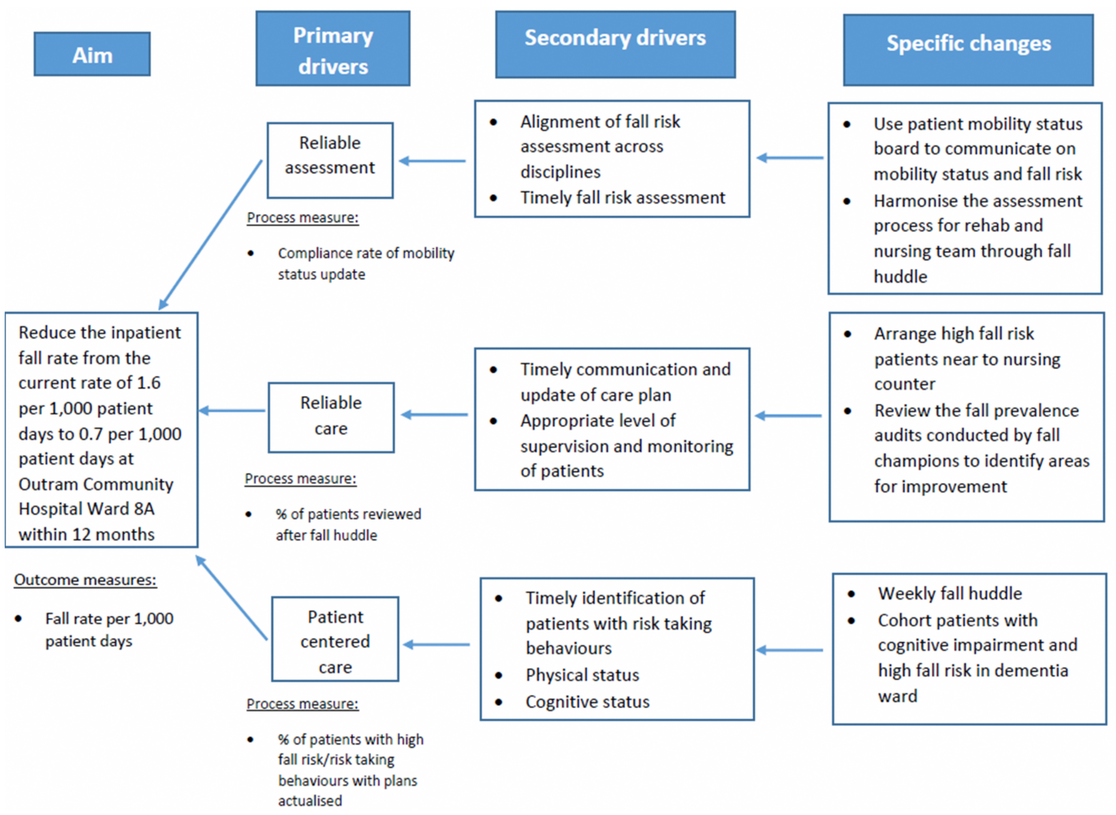
We describe a quality improvement initiative incorporating interprofessional collaboration huddle to reduce fall rate.

## Goal/Objective

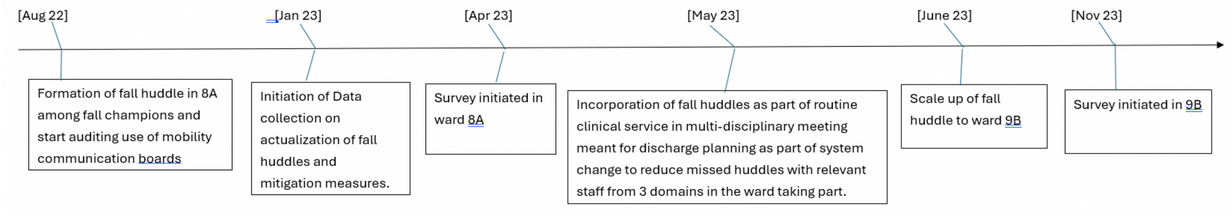
We aim to decrease fall rate in both our pilot ward and the other scaled up ward by half with our fall huddle.

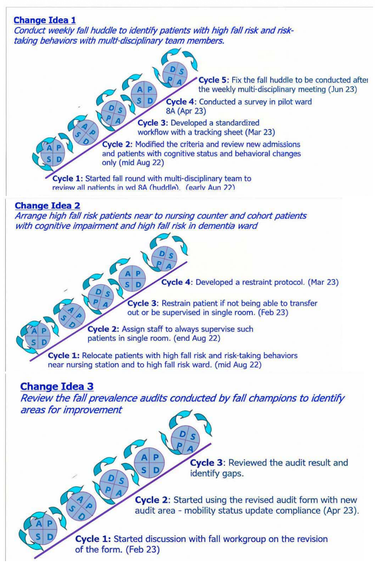
## Problem Analysis

Based on ground feedback, there are three main drivers for fall risks as illustrated below: 1) reliability in fall risk assessment 2) ensuring actualization of care plans for fall mitigation measures 3) creation of care paths for special groups of patients with inherently high fall risk




## Implementation Plan



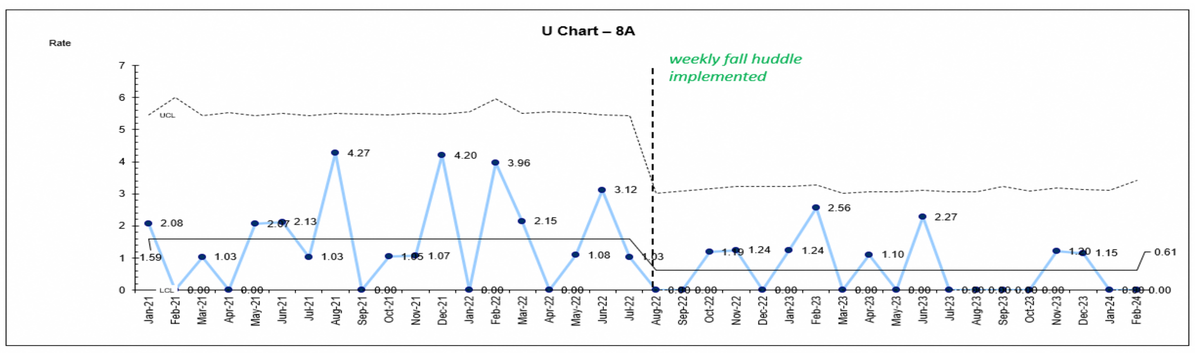

Weekly fall huddle was initiated in Ward 8A in August 22 due to the need for regular reliability in fall risk assessment and communication of fall risks among interprofessional domains of nursing, medical and allied health rather than the traditional method of fragmented assessment of fall risk on admission with differing risk of fall. Multiple PDSA were conducted (Change idea 1) with the final model of huddle incorporating into weekly multidisciplinary meetings meant for discharge planning with attendance by physiotherapist x 1, occupational therapist x 1, medical doctors (1 junior and 1 senior at least), nursing team who look after the patients. The huddle focused on newly admitted patients since the last huddle and those who have new medical conditions predisposing to increased fall risk since the last huddle.

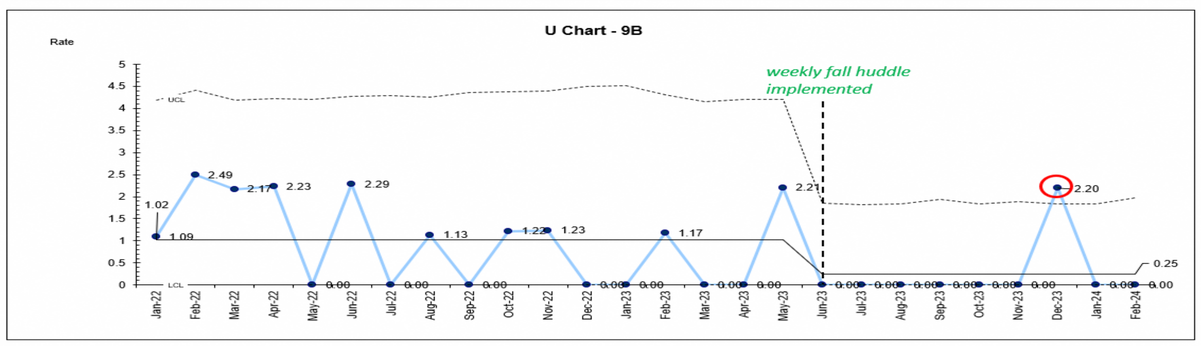
From the huddle, mitigation measures were brainstormed with realization of 2 main observations (change idea 2) 1) there are unique building design considerations that contribute to fall risk 2) need for care protocols for patients with neurocognitive disorders with behavioural issues until individualized treatment can be instituted e.g. initiation of restraint protocols.`

We also conducted audits on the actualization of the fall huddles and the mitigation measures discussed in Jan 23 (change idea 3) to ensure fidelity to intervention as shown in the timeline. As a way to improve visibility of a patient's fall risk and functional status to everyone working in the ward, the use of mobility boards at patient's headboard was audited to identify areas for improvement.

Feedback from the ground in 8A was sought in Apr 23. With success in 8A (see fig in results), the huddle was scaled up to Ward 9B in Jun 23 with same methodology for implementation.

## Benefits/Results




Mean fall rate fell by half in Ward 8A and by more than half in Ward 9B after the huddle were scaled up as shown in the U-charts above.
The astronomical point in Ward 9B in Dec 23 was due to leave of absence of the team senior doctor who is the fall champion in the ward and points to the importance of collective leadership in improvement efforts.
The above U-charts fulfilled rule no. 4 in interpretation of control charts where presence of 2 out of 3 successive points below the centreline i.e. zone A, more than 2 sigmas away from centreline signal special cause of effect, pointing to the huddle as the reason why the fall rate is decreasing.
This is especially so in Jul 23 for Ward 8A when the huddle was incorporated into routine multi-disciplinary meeting after ground feedback rather than as an existence on its own, leading to better actualization of the fall huddle.

## Sustainability & Reflections

Relying on single dimensional assessment of fall risk is inadequate and ineffective.
Interprofessional communication and collaboration is effective in reducing fall rate in institutions which are caring for older adults. This is especially so where the institutions main business model involves active rehabilitation of older adults.
For the improvement efforts to be effective, it is important to incorporate ground feedback to PDSA cycles and change methodology of improvement initiative.
With the initial data of improvement, it remains to be seen if the institution fall rate can be reduced when the initiative is scaled up to the rest of the wards in OCH.