CLINICAL EXCELLENCE COMMISSION

Monitoring and evaluation plan
Better Value Healthcare
Falls in Hospital

May 2017

Contents

Executive summary

The recent formation of a NSW Safety and Quality Council and the plan to develop a NSW Quality and Safety Framework will herald a move from volume to value based outcomes by addressing quality and safety issues and systems. Consistent with this strategic direction from NSW Health, and the Leading Better Value Care initiative, the CEC is supporting Local Health Districts (LHD) in their desire to move from implementing individual patient safety programs to developing integrated systems for safety and reliability. In shaping organisational culture, the role of clinical leadership and supporting frontline teams will be pivotal.

The NSW Health system aims to provide the safest and highest quality care for every patient. The CEC, over the last twelve years, has established many great initiatives and programs underpinned by a comprehensive purpose to provide leadership to the standardisation of safety and quality in NSW to improve outcomes for patients.

The current approach to falls in NSW has produced some variable patient outcomes across local health districts. Good practice is evident but in silos, not at scale.

Introduction

More than one in three people aged 65 or over fall at least once a year and many fall more often. The number of falls-related incidents in hospital is high and fall-related injuries impose a substantial burden on the health care system. They can lead to reduced quality of life, disability, reduced physical activity, social isolation, functional decline and even death.

Preventing patient falls and associated patient harm has been a national priority for many years, and is one of the ten health service standards that form the Australian Health Services Safety and Quality Accreditation Scheme endorsed by Australian Health Ministers in November 2010.

Due to the high prevalence of falls, the NSW Government has identified *Falls in Hospital* as a priority for NSW Health. Subsequently, *Falls in Hospital* has been included in the first tranche of initiatives in the NSW Better Value Healthcare Program. As a result, all Local Health Districts (LHD) are expected to have systematised and reliable safety and quality initiatives in place to reduce falls and harm from *Falls in Hospital* for patients over the age of 70 from 2017/18.

The Clinical Excellence Commission (CEC) NSW Falls Prevention Program will continue to support LHD to reduce falls and harm from *Falls in Hospital* for patients over the age of 70 as part of a broader Older Persons Patient Safety Program focusing on improving the quality and safety of care for frail elderly patients.

Workshop

This plan provides the framework for monitoring and evaluating (M&E) the *Falls in Hospital* initiative. It outlines the program, documents the key evaluation questions and provides a data matrix showing how each question will be answered. The development of this plan commenced with a full day program logic workshop held on 4 April 2017. The workshop comprised 14 people with representation from the Clinical Excellence Commission, Agency for Clinical Innovation, Senior Executive Staff including a Director of Clinical Governance, middle management staff including a NUM, NSW Falls coordinators and a group of senior interdisciplinary clinicians.

Workshop drivers

There already exists sufficient information to describe the broad program of work that is the NSW Falls Prevention Program, including the strategic direction of the program and associated leadership, staff engagement and improved clinical practice actions[1]. However budgetary drivers and an expectation of 'better value for health care' meant it was worth re-visiting the Falls Prevention Program to better articulate its rationale as well as how it expects to deliver value.

Background

Better Value Healthcare

In 2016, the NSW Ministry of Health (MoH) made a commitment to improving the health of people in NSW by shifting focus to value rather than volume. This resulted in the development of the NSW Better Value Health Care Program (BVHC), a state wide project incorporating specific initiatives aimed at improving the NSW Health system performance against The Institute of Healthcare Improvement (IHI) triple aim of improving patient and provider experience, population health outcomes, and system efficiency and effectiveness

BVHC involves the implementation of eight selected clinical programs in the 2017/18 financial year, with a goal of delivering improved clinical outcomes, patient experience and cost benefits. The NSW *Falls in Hospital* project is one of these initiatives and builds on the comprehensive work developed by the Clinical Excellence Commission's (CEC) NSW Falls Prevention Program.

Figure 1: Triple aim of LBVC

The BVHC initiatives will be implemented by each Local Health District (LHD) and be incorporated into LHD Roadmaps and Service Level Agreements for monitoring with the purpose of informing local quality improvements. A comprehensive impact evaluation will occur after initiative stabilisation within each LHD with the purpose of assessing the impact of the initiative in terms of the triple aim to inform decisions around the value of the initiative. This document provides the implementation strategies and evaluation approaches to monitoring and impact that will guide BVHC assessments. This document should be read in conjunction with the *Falls in Hospital: preventing falls and harm from falls'* (CEC, Snapshot January 2017); *'NSW Falls Prevention Program – Leading Better Value Care: Falls in Hospital Implementation Plan'* (CEC, January 2017*);* documents.

[1] *CEC NSW Falls Prevention Program Nov 2010: Revised 2016*. Adapted from Making Safety of Patients Everyone's Priority (Patient Safety First NHS UK); *'Falls in hospital: preventing falls and harm from falls'* (CEC, Snapshot January 2017); *'NSW Falls Prevention Program – Leading Better Value Care: Falls in Hospital Implementation Plan'* (CEC, January 2017*); Better Value Health: Overview of Falls in Hospital approach'* (Adapted from: Implementing FallSafe© Royal College of Physicians 2012) Draft March 2017.

NSW Falls Prevention Program

The CEC NSW Falls Prevention Program has provided co-ordination to implement information and resources in line with the NSW Falls Policy PD2011_029: *Prevention of Falls and Harm from Falls* among Older People 2011 - 2015, the NSW Falls Prevention Program aims to:

- Reduce the incidence and severity of falls
- Reduce the social, psychological and economic impact of falls among older people, families and carers.

The policy describes actions that take place in three key domains: health promotion, NSW Health clinical services and NSW Health residential aged care services (multi-purpose services and State government residential aged care facilities).

The current key drivers of the NSW Falls Prevention Program are:

- Implementation of the Australian Commission on Quality and Safety in Health Care (ACSQHC) 2009, Falls Best Practice Guidelines for Hospital, Community Care and Residential Care
- The ACSQHC National Safety and Quality Health Service Standards (NSQHSS): Standard 10: *Preventing Falls and Harm from Falls*. This Standard has focused the CEC work to provide guidance and resources re falls across all ages in many settings including Paediatrics, Maternity and Mental Health settings both within the hospital and community care.
- NSW Government Healthy Ageing Strategy.

The framework to progress the implementation includes:
The CEC provides state-wide leadership, co-ordination and collaboration working with NSW Local Health District Falls Co-ordinators and LHD with falls plan implementation; co-ordination of the NSW Falls Prevention Network ; liaison and partnering with key research groups and NHMRC research trials, collaboration with NSW Ambulance and ACI Networks (Aged Health and Musculoskeletal in particular). The NSW Falls Policy Advisory Group has previously developed a broad draft of strategic directions for ongoing for future work.

Patient cohort

The patient cohort for the *Falls in Hospital* initiative are those aged 70 years and over in an acute setting. Of particular interest are those patient groups with a high risk of falling comprising patients with cognitive decline, delirium and dementia, with poor balance and strength and those requiring assistance with personal care needs, and those with where medications increase risk of a fall or fall injury.

Primary audience

The evaluation will be governed by the CEC Executive providing information on progress of the program improvement processes within each LHD and early clinical outcomes. This will be used to guide future changes to the *Falls in Hospital* program and to inform the NSW Health system on the effectiveness of the initiative.

The MoH Better Value Healthcare Committee and the LHD will be included as a secondary audience for reporting requirements.

Evaluation purpose

Purpose

The NSW Government is committed to evaluation to ensure a sound evidence base for program improvement. Evaluation results can contribute significantly to appropriate investment strategies and future policies and program direction. The purpose of the *Falls in Hospital* monitoring and evaluation plan is to:

- Assess the implementation, delivery and service improvements for *Falls in Hospital* to determine success factors and barriers for optimising the program
- Measure the implications and impacts of activities
- Define data sources and frequency plan
- Assess the impact of *Falls in Hospitals* for patients over the age of 70 in terms of expected and unexpected outcomes, efficiencies, effectiveness and sustainability.

Evaluation design

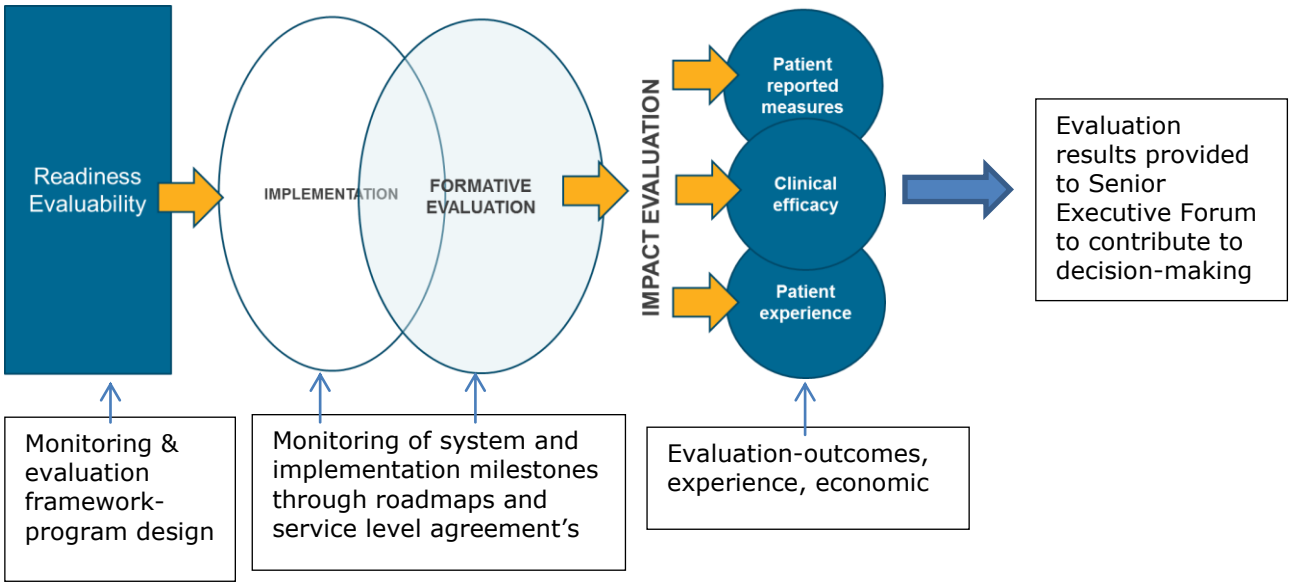
The evaluation has been designed to have three main stages and reporting streams. This is to effectively align all measures to the specific purpose of monitoring and evaluation. This M&E plan will define data requirements and collection systems to measure program progress and impact. There are three measurement levels aligned to guide the program through implementation milestones through to end of program outcomes and broader goals.
These three levels include:

- Program/project roadmaps between the MOH and LHDs
- Service level agreements between MOH and LHDs
- Impact evaluation conducted by the Pillars

The measurement alignment within the M&E framework will enable:

- Oversight of program delivery against anticipated milestones to identify and manage unexpected deviations (monitoring via roadmaps and service level agreements).
- A clear structure and methodology for the state-wide end of program impact evaluation to guide investment, disinvestment and future improvements

Figure 2: Monitoring and evaluation approach for LBVC programs



Parameters

For the purposes of the LBVC *Falls in Hospital* the focus for monitoring and evaluation will be within hospital settings for patients over the age of 70 years.
The NSW Falls Prevention Program has responsibilities for the wider program of work in community and health related residential aged care settings and acute hospitals which will continue to support the requirement for LHD to meet the National Accreditation, ACSQHC National Standard 10: *Preventing Falls and Harm from Falls.* This will not be included in the evaluation plan.

Evaluation foci

Assumptions

The assumptions or risks are noted and will be tested during the evaluation so as to understand the potential facilitators and barriers to change occurring as expected.

- Governance processes will be established to support local accountability for improvements
- LHD executive, facility service managers and clinicians agree that there is a case for change and that improvements are required
- LHDs will identify and support clinical leaders and Interdisciplinary Teams required to drive local practice changes
- LHDs will review workforce capacity and support staff to provide best care
- LHDs will continue to meet requirements of the National Accreditation ACSQHC National Standard10: *Preventing Falls and Harm from Falls*

Risks

The following table outlines potential risks of the program and assesses the likeliness of those risks occurring. The risks are derived from the key assumptions of the program and are included where mitigation strategies have not been developed and included in the core program. It is advised that the risks are monitored through the evaluation governance structures.

Key Assumptions from theory of change (focus on the linkages and word in the positive). We assume that...	What evidence do we have to support this (e.g. scholarly literature, evaluations, observations)	How likely is it that this assumption is wrong?			How serious a risk to achievement of the end of program outcome?			Investigate this assumption further?
		Low	Med	High	Low	Med	High	Yes? How?
1. Governance processes will be established to support local accountability for improvements	LHD Falls or equivalent Committees in place and reporting to Quality Committees as a requirement to meet National Accreditation Standard	x					x	
2. LHD executive, facility service managers and clinicians agree that there is a case for change and that improvements are required	Local IMS data re numbers of falls and injury Patient Stories, experience and feedback Audits of clinical care HIE data (Clinical Reporting System)	x					x	
3. LHDs will identify and support clinical leaders and Interdisciplinary Teams (IDT) required to drive local practice changes	There is evidence that LHDs support systems and clinical leaders as well as Interdisciplinary Teams to drive local changes	x					x	
4. LHDs will review workforce capacity and	LHDs undertake a process to build capacity within existing		x				x	

Key Assumptions from theory of change (focus on the linkages and word in the positive). We assume that...	What evidence do we have to support this (e.g. scholarly literature, evaluations, observations)	How likely is it that this assumption is wrong?			How serious a risk to achievement of the end of program outcome?			Investigate this assumption further?
		Low	Med	High	Low	Med	High	Yes? How?
support staff to provide best care	workforce							
5. LHDs will continue to meet requirements of the National Accreditation ACSQHC National Standard10: Preventing Falls and Harm from Falls	There is evidence that LHDs have met the ACSQHC National Standard10: Preventing Falls and Harm from Falls	x				x		

Guiding principles

Principles for the program were identified throughout the Program Logic workshop. These are not outcomes but rather 'ways in which we go about our program'. There was not structured process for identifying principles; rather they were captured as they arose.

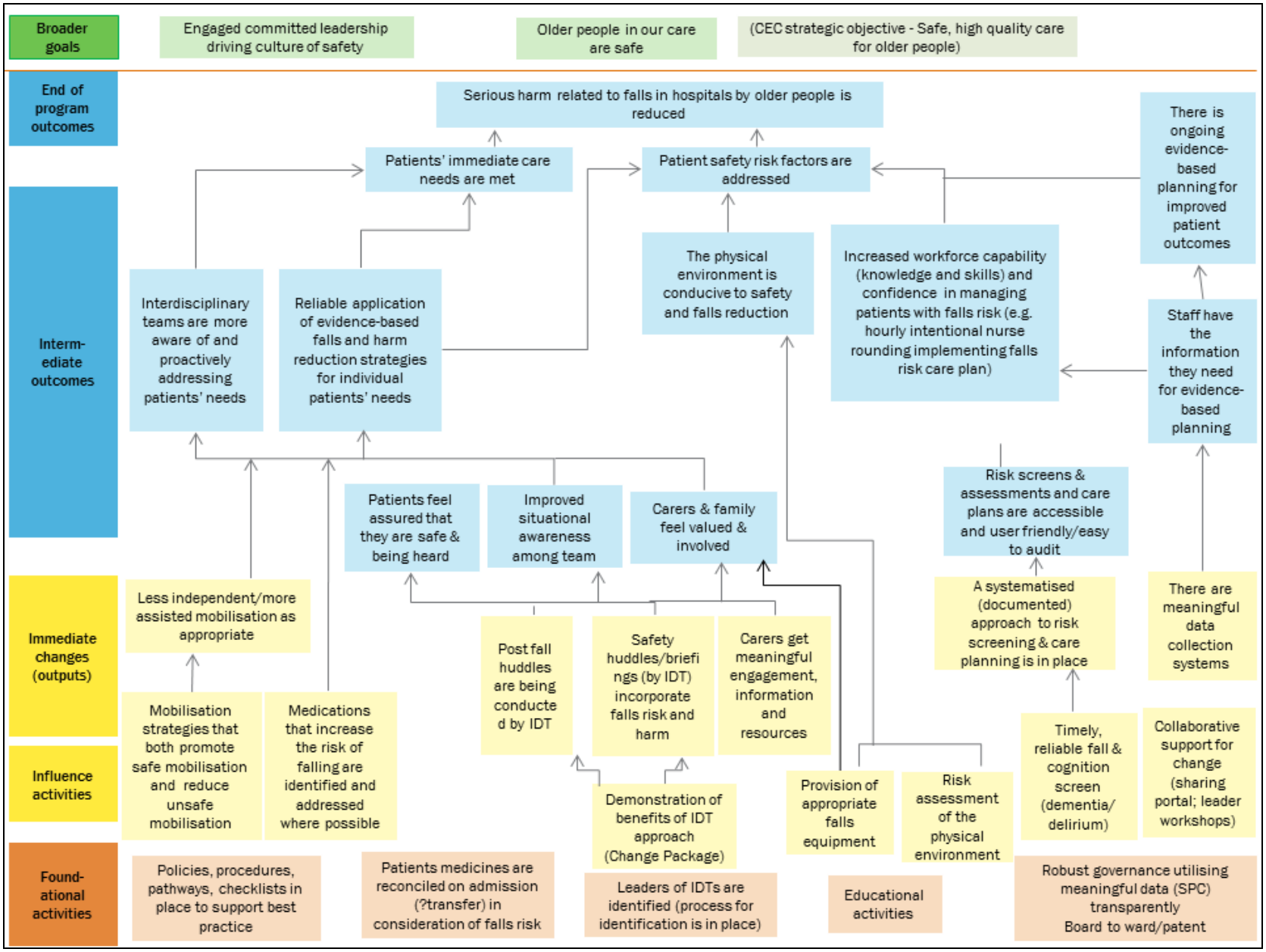
They included:

- Cognitive impairment is prioritised for management for falls prevention
- Shared decision making (with families)
- Person-centred approach to falls prevention
- Holistic approach to falls prevention
- Overlaying the principles is the vision that engaged and committed leadership believes that falls reduction is realistic and achievable and helps shape the culture required to improve patient care.

Program logic

The program logic outlines the major components in the design of the *Falls in Hospital* program - and depicts the causal linkages to the change processes required for the program to achieve desired outcomes. As such it provides a foundation to guide monitoring and evaluation in order to track progress. The logic should be viewed from bottom to top.

There are five streams of change in the program logic demonstrating how essential each of these components are in the management of older people at risk of falling. In general terms, the program logic denotes the key streams in the program comprising patients, systems and staff.
The program logic map is in diagram overleaf and the narrative (program theory) underpinning this is included in the next section.


Broader goals
Engaged committed leadership driving culture of safety
Older people in our care are safe
(CEC strategic objective - Safe, high quality care for older people)
End of program outcomes
Serious harm related to falls in hospitals by older people is reduced
Interm-ediate outcomes
Patients' immediate care needs are met
Patient safety risk factors are addressed
There is ongoing evidence-based planning for improved patient outcomes
Interdisciplinary teams are more aware of and proactively addressing patients' needs
Reliable application of evidence-based falls and harm reduction strategies for individual patients' needs
The physical environment is conducive to safety and falls reduction
Increased workforce capability (knowledge and skills) and confidence in managing patients with falls risk (e.g. hourly intentional nurse rounding implementing falls risk care plan)
Staff have the information they need for evidence-based planning
Patients feel assured that they are safe & being heard
Improved situational awareness among team
Carers & family feel valued & involved
Risk screens & assessments and care plans are accessible and user friendly/easy to audit
Immediate changes (outputs)
Less independent/more assisted mobilisation as appropriate
Post fall huddles are being conducte d by IDT
Safety huddles/briefi ngs (by IDT) incorporate falls risk and harm
Carers get meaningful engagement, information and resources
A systematised (documented) approach to risk screening & care planning is in place
There are meaningful data collection systems
Influence activities
Mobilisation strategies that both promote safe mobilisation and reduce unsafe mobilisation
Medications that increase the risk of falling are identified and addressed where possible
Demonstration of benefits of IDT approach (Change Package)
Provision of appropriate falls equipment
Risk assessment of the physical environment
Timely, reliable fall & cognition screen (dementia/ delirium)
Collaborative support for change (sharing portal; leader workshops)
Found-ational activities
Policies, procedures, pathways, checklists in place to support best practice
Patients medicines are reconciled on admission (?transfer) in consideration of falls risk
Leaders of IDTs are identified (process for identification is in place)
Educational activities
Robust governance utilising meaningful data (SPC) transparently Board to ward/patent

Narrative description

The model shows that the key broader goal of the Falls Prevention Program is that 'Older people in our care are safe'. This is strongly aligned with the CEC strategic objective[2] of 'Safe, high quality care for older people'. The Falls Prevention Program is expected to contribute to this broader goal by **reducing the serious harm related to** falls in Hospital **by older people.**
The model shows that the serious harm related to falls in Hospital will be reduced if two things are in place: **patients' immediate care needs (for example, toileting) are being met**; and **patient safety risk factors are being addressed**.
The *Falls in Hospital* program – includes several key strategies for ensuring that patients immediate care needs are being met and their safety risk factors are addressed, including:

- Mobilisation strategies
- Medication reconciliation strategies
- An interdisciplinary team (IDT) approach
- Risk screens that includes Cognition and Delirium screening and care planning
- Risk assessment of the physical environment
- Meaningful data collection systems

The expected outcomes of these strategies and their contribution to meeting patients' immediate needs and addressing patient safety risk factors are outlined below.
If mobilisation strategies are in place, then there will be **more assisted mobilisation and less independent mobilisation amongst those for whom independent mobilisation is a risk.**

If medications that increase the risk of falling are identified and addressed, then **the risk of medication-induced falls is reduced**.

The demonstration of the benefits of an Inter Disciplinary Team (IDT) approach (change package) should see **safety huddles/briefings** and **post-fall safety huddles conducted by IDTs explicitly incorporating the consideration of falls risk and harm**. Together, this would provide IDTs with **an improved situational awareness** and enable more effective and appropriate prevention responses. Underpinning the success of this is that there is engaged, committed leadership that believes falls reduction is realistic/achievable, and drives a culture of improvement. This is seen as key to overcoming the core identified problem of a less than ideal safety culture.

Improved medication management, mobilisation strategies, the implementation of safety huddles/briefings and post-fall huddles incorporating falls risk and harm collectively will enable staff **to be more aware of and to proactively address patients' needs**, as well as **reliably applying evidence-based falls and harm reduction strategies.**

Reliable screening of cognition, delirium and fall risk and harm would see **a systematised (documented) approach to risk screening and care planning in place**. The risk assessment of the physical environment and the timely, provision of appropriate falls equipment, would see **a physical environment conducive to safety and falls prevention**.

[2] CEC Strategic Plan: http://www.cec.health.nsw.gov.au/about/our-strategy

Collaborative support for change (through sharing portal and collaborative workshops/forum) would further strengthen workforce capability and confidence in managing falls risk, as would meaningful data systems that provide staff with the information they need for evidence-based planning (EBP), and thereby enable **ongoing evidence based practice for improving patient outcomes**.

Key issues and evaluation questions

The key issues that underpin the broader NSW Falls Prevention Program and the new iteration of the *Falls in Hospital* Program comprise:

- There needs to be an approach to care that is both interdisciplinary and multidisciplinary (team-based)
    - It is not a 'nursing' issue alone
- An understanding of individual patients' needs to be at the core of an interdisciplinary approach
    - This includes a shared (whole-of-team) understanding of what the specific goal is for each patient developed in consultation with patient family/carer
- The issues relating to patients falling in hospital are complex and individualised interventions can only contribute to reduction in preventable falls
    - Not all falls are preventable therefore, a major objective of the program is to reduce harm and the severity of any injuries sustained by a fall
- Cognitive impairment including delirium is the key driver for falls in residential aged care and a key driver in hospitals given the ageing population and shift to spending end-of-life stages in hospital
    - There are larger numbers of acutely ill people in hospitals, who are older and cognitively impaired and who either have, or at risk of developing, a delirium
- There has been an erosion in clinical inquiry in clinical practice
    - Clinical judgement could be strengthened by moving away from reliance on a risk score and compliance to a broader understanding of safety and managing older people at risk and a broader understanding of how improvement science could create more reliability for care of older people
- The 'value' in 'better value care' prioritises quality over cost - older people in our care are valued and staff have appropriate skills and capacity to provide the care that is required.
- It has been identified that when there is leadership and a process of change where staff feel part of a team and work together to prevent falls - there is a reduction in the number of falls - they 'get it'
- The 'change package' needs to be 'reliable' (able to be rolled out in a consistent manner regardless of location) – from an improvement standpoint we would seek to look to customise the change package depending on individual clinical areas.

Key evaluation questions

The key evaluation questions, derived from the program logic are:

KEQ	Evaluation component	Reporting process
To what extent have system improvements been implemented?	Monitoring	Roadmaps
What are the factors of success and barriers to effective program implementation?	Monitoring	Roadmaps and local improvement plans
Has there been a reduction in harm?	Monitoring	Service Level Agreements
What has been the impact of the program?	Impact	Evaluation report

Data plan

The following table provides the data matrix for the M&E through examination of the key evaluation questions, the methods and data sources. Data collection timing has not yet been assigned other than baseline, ongoing and end of program (denoting when the program has been in place long enough to be settled).

Key evaluation question	Evaluation component	Evaluation method	Data source	Baseline	Ongoing	End - settled
To what extent have system improvements been implemented?	Monitoring	Monitoring of: • Governance structures • Accreditation status • Medication reconciliation • Screening – cognition and delirium • Safe Mobilisation • Huddles / safety briefings • Post Fall Huddles	Document review, (accreditation, pathways, policies) Monitoring of systems in place for quality improvement (CEC Clinical Reporting System) Possible self-assessment of change package components at a local level	To be assessed at baseline	Yes	Information from Roadmaps to be provided for impact evaluation
What are the factors of success and barriers to effective program implementation?	Monitoring	Knowledge, attitude behaviour and practice (KABP) of staff assessed Education	Staff questionnaires - Potential for pre, post and 6 month after any training activities # of people completing training	To be assessed at baseline, at conclusion of implementation and training	Yes	Information from Roadmaps to be provided for impact evaluation
Has there been a reduction in harm?	Monitoring	A fall occurring in health service area	Admitted Patient Data Collection - Number of separations with: (1) diagnosis	To be assessed at baseline	Yes	Information from

Key evaluation question	Evaluation component	Evaluation method	Data source	Baseline	Ongoing	End - settled
		resulting in intracranial injury, fractured neck of femur or other fracture as a rate per 1000 occupied bed days. Number and review of IMS falls data	code of intracranial injury, fractured neck of femur or other fractures in any diagnosis field and an external cause code of fall and a condition onset flag of '1' OR (2) diagnosis code of intracranial injury, fractured neck of femur and other fractures in any diagnosis field and an external cause code of fall and a condition onset flag of '9' and a place of occurrence code of 'Health service area'. Falls in Hospital are identified using the following algorithm: • injuries resulting in intracranial injury, fractured neck of femur or other fracture with ICD10-AM diagnosis codes, and recorded in any diagnosis field, AND • external cause code for falls (ICD-10-AM: W01x, W03, W04, W05, W061, W062, W063, W064, W066, W068, W069, W07x, W08x, W10x, W130, W131, W132, W135, W138, W139, W18x, W19) recorded in field immediate following diagnosis field, AND condition onset flag of the above external cause code of '1' (condition arising during the episode of hospitalisation).			Roadmaps to be provided for impact evaluation

Key evaluation question	Evaluation component	Evaluation method	Data source	Baseline	Ongoing	End - settled
			• if the condition onset flag of the above external cause code is not recorded ('9'), the ICD10-AM code for place of occurrence which is immediately following the external cause code (or, if coded, immediately following the external cause code and an activity code from U50 – U73) must be 'Y92.22' (=health service area) IMS reported falls stratified /age and falls resulting in injury & SAC level			
What has been the impact of the program?	Impact	Patient Reported Measures Patient and Carer Experience Staff experience Patient outcomes: Assessment of patient outcomes (LOS, complexity, severity of injury, mortality, morbidity, discharge destination) compared with counterfactual of risk stratified patients	Measures yet to be defined – may include validated Falls tools such as Fear of Falling e.g. iconFES app (Falls Efficacy Scale) Questionnaires Questionnaires Admitted Patient Data Collection Potentially in the future, PREMs and PROMs CEC Clinical Reporting system Economic appraisal – Business as usual	Yes	no	Yes

Key evaluation question	Evaluation component	Evaluation method	Data source	Baseline	Ongoing	End - settled
		that did not fall Falls per 1000/bed days Program efficiency	projections – potentially using patient outcomes and counterfactual. To include return on investment calculations.			

Governance

Governance accountability process

The Governance committee will be the Clinical Excellence Commission Senior Management Team (SMT).

Responsibility for evaluation

Local Health Districts will be responsible for completing Roadmaps and reporting against key performance agreements in Service Level Agreements.

Impact evaluation will occur at a state level by the CEC.

Communication and dissemination

Roadmaps and SLA reports to be submitted to MoH as required.

Impact evaluation results will be presented to LHDs and progress communicated to LHDs, reporting to Clinical Excellence Commission SMT and the MoH Better Value Healthcare Steering Committee.

Evaluation will also be discussed at LHD performance meetings.

Codes of behaviour

This evaluation comprises the delivery of human services and potentially confidential information. The evaluation will be conducted in an ethical manner and any individual records will be destroyed at the end of the evaluation.
The evaluation will be conducted in compliance with Australasian Evaluation Society (AES) *Code of Conduct* that can be accessed at http://www.aes.asn.au/images/stories/files/About/Documents%20-%20ongoing/AES%20Guidlines10.pdf and the National Health and Medical Research Council (NHMRC) *National Statement on Ethical Conduct of Human Research* accessed at http://www.nhmrc.gov.au/_files_nhmrc/publications/attachments/e72.pdf

Timelines

Impact evaluation in 2 years from commencement of initiative at LHD

Attachments

A series of tools will be developed as each stage of evaluation progresses. These will be attached to the evaluation plan as they become available.

References

1. CEC NSW Falls Prevention Program Nov 2010: Revised 2016. Adapted from Making Safety of Patients Everyone's Priority (Patient Safety First NHS UK); 'Falls in hospital: preventing falls and harm from falls' (CEC, Snapshot January 2017); 'NSW Falls Prevention Program – Leading Better Value Care: Falls in Hospital Implementation Plan' (CEC, January 2017); Better Value Health: Overview of Falls in Hospital approach' (Adapted from: Implementing FallSafe© Royal College of Physicians 2012) Draft March 2017.

2. CEC Strategic Plan: http://www.cec.health.nsw.gov.au/about/our-strategy

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