THE IMPLEMENTATION OF THE SWARM HUDDLES FRAMEWORK FOR INPATIENT FALLS

A quality improvement initiative implemented for patients considered at a high risk of falls to primarily aid prevention and as a safety review following an inpatient fall.

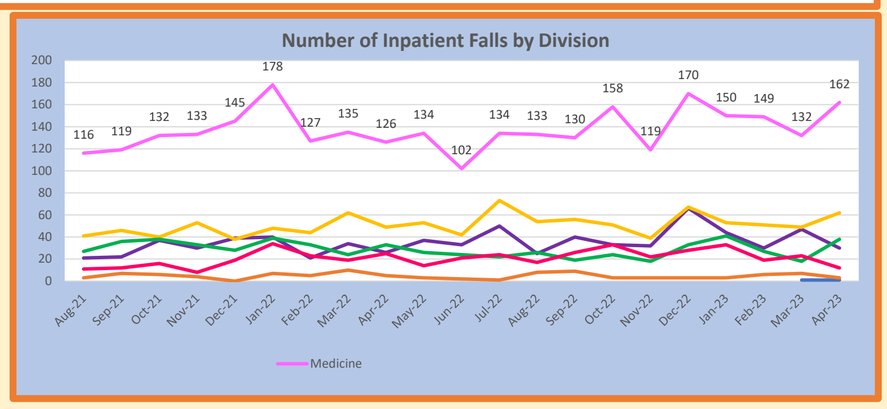
BACKGROUND

Inpatient falls are a key performance indicator with regards to the quality and patient safety agenda.

The number of falls within the Medicine Division has consistently remained high between 130-160 falls per month since August 2021 and is the highest amongst all other Divisions.

From reviews and undertaking serious incident investigations reoccurring themes of poorly completed falls assessment, not timely or evidencing preventative measures and lack of multidisciplinary team engagement has been identified.

A pre pilot audit was undertaken on the MFRA and compliance to the NICE Clinical Guideline Falls in Older People: Assessing Risk and Prevention (CG161). This again evidenced poor and untimely completion. Staff questionnaires were completed prior to the pilot which showed a lack of knowledge regarding the role of the MDT in falls prevention.



AIMS OF THE SWARM PROJECT

The aim of the Swarm Project framework was to ensure that falls prevention via risk assessment and effective risk reduction strategies was implemented fully and as a multidisciplinary team, for high-risk individuals, in order to create a safer environment and reduce harm. In doing so, to improve the compliance of the Multifactorial Falls Risk Assessment (MFRA) and interventions in its entirety, timely completion and implementation of risk reducing strategies and where able to reduce the number of inpatient falls for people who are considered high risk.

By developing swarm huddles (patient safety meetings) with key multidisciplinary members and key processes, ensured there was an MDT approach and improved risk assessments to reduce the risk of falls (pre swarm) where able and to ensure in the event of a fall there was timely reassessment and actions to prevent reoccurrence (post swarm).

Following a patient safety incident the swarm approach has been evidenced within some literature and by NHS England 2021, however there is no available literature in using this approach as a preventative measure to patient safety incidents.

The aim was to ensure the Swarm huddle meetings were attended by the key multidisciplinary team members to jointly complete the MFRA and implement risk reducing interventions. Target: more than 95% of patients included in the PDSA.

- Improve the quality of the MFRA assessment ensuring all risks are considered and an individualised action plan is developed and actioned. Target > 95%
- Improve the timeliness of the MFRA assessment completed by setting a two-hour guidance for the Swarm huddles to take place. This will achieve well within the six hours ward admission target set by the Prevention and Management of Adult Inpatient Falls policy (2021). Target 95 % noting that a Swarm huddle MFRA completion will not be achievable currently for patients admitted or who fall out of working hours.
- Ensure that over 80% of patients are discussed by the multidisciplinary team.

SWARM APPROACH

Like Bees, Staff 'Swarm' To The Site Of The Incident To Determine Its Causes And How To Prevent It Recurring.
The Swarm Is Carried Out In A Blame-free Environment And While The Incident Is Still Fresh In Every One's Mind. This Helps Build A More Accurate Picture Of The Organisational And Human Factors Involved, And Allows Staff To Suggest Improvements That Can Be Made Immediately (LI ET AL, 2015)

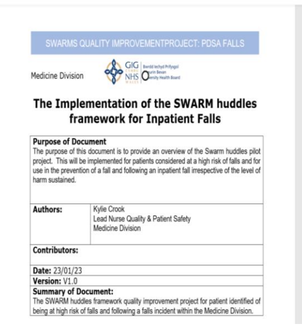
AN EFFECTIVE SWARM:

- Encourages Candour By Reassuring Participants That They Are In A Blame free Environment
- Introduces Participants To Each Other To Create Familiarity And Respect;
- Reviews The Facts; Discusses What Happened, As Well As How And Why It Happened;
- Proposes Actions And Assigns Task Leaders With Specific Duties And Deadlines.

PLANNING

A First meeting was held with Divisional Leads to obtain engagement and to obtain consensus of using the swarm approach prior to a fall incident (pre swarm) as well as following incident (post swarm) and agreement obtained.

A pilot ward identified for a two-month period. Meetings held with ward team and local MDT, Including Task and finish groups meetings leading up to the start date of 3rd April 23
A 'Implementation of the SWARM huddles framework for Inpatient Falls (PDSA), Pre and post huddle flow charts and swarm meeting process documentation developed by the SN QPS.


SWARMS QUALITY IMPROVEMENTPROJECT: PDSA FALLS

Medicine Division

The Implementation of the SWARM huddles framework for Inpatient Falls

Purpose of Document	The purpose of this document is to provide an overview of the Swarm huddles pilot project. This will be implemented for patients considered at a high risk of falls and for use in the prevention of a fall and following an inpatient fall irrespective of the level of harm sustained.
Authors:	Kylie Crook Lead Nurse Quality & Patient Safety Medicine Division
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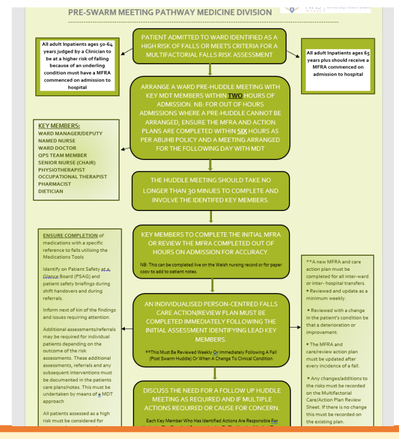
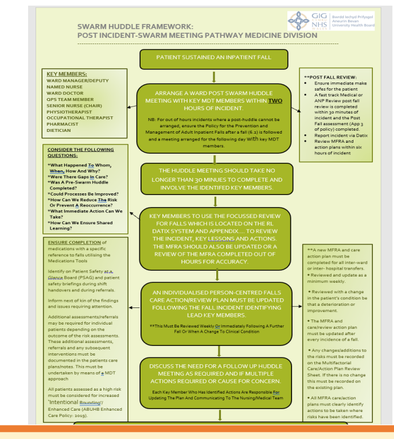
Summary of Document:	The SWARM huddles framework quality improvement project for patient identified of being at high risk of falls and following a falls incident within the Medicine Division.





DATA COLLECTION

Quantitative Measures:

- Prior to the commencement of the pilot Swarms project, baseline data was collected using a newly developed Falls MFRA audit form. Currently there is no specific data collection on the MFRA available to utilise. This was used to measure current compliance and by which to measure the impact of the PDSA and understand if a change for improvement.
- Baseline data from the RL Datix incident reporting system for the pilot ward, on the number of inpatients falls was obtained. This was also used to compare the number of inpatient falls during the project pilot.

Qualitative Measures:

- Prior to the commencement of the pilot Swarm project, baseline qualitative data was collected by providing staff members a questionnaire to complete on their knowledge, previous experience of the Swarm framework, the project processes and their perspective on the benefits and barriers to the framework.
- Following implementation of the project, and after each Swarm huddle meeting, the MDT was asked to complete a staff questionnaire.
- This asked specific questions as to the meeting processes, attendance, any interruptions, barriers and if they have found the meeting beneficial in identifying, assessing, and actioning preventative measures of falls risk, for the case under review and if not the reason why.

IMPLEMENTATION

The Swarm pilot project commenced on the 3rd April 2023 on one medical ward in Ysbyty Ystrad Fawr Hospital.
The project run for two months incorporating the Pre-Swarms huddles in the first month before introducing the post swarm huddles in the second month.
The swarm huddle meetings incorporated key multidisciplinary team members and was chaired initially by the Senior Nurse for Quality and Patient Safety for the Medicine Division and Ward Manager for the ward, following a meeting agenda. The aim that meetings lasted no longer than 30 minutes.

A poster developed to advertise the pilot project.
Baseline data collection, MFRA audit and staff questionnaires were disseminated and completed prior to commencement.
Familiarisation with swam documents for meetings: meeting agenda, at a glance forms
A pilot project meeting was completed after the first month with stakeholders to discuss any key concerns.
The Quality and Patient Safety Team will support the pilot implementation and attend the Swarm huddle meetings as able and be available to support with immediate concerns.

KEY FINDINGS

- Full data analysis ongoing currently.
- Pilot period ended 5th June 2023 but ongoing swarms
- 'Time to complete' was the main identified barrier before starting the pilot.
- Pre- Audit showed MFRA's not being completed timely or fully with actions.
- 67 patients received a pre-swarm huddle
- 3 falls during this period of pre swarmed patients and who received a post swarm.
- One patient boarded, all patients understanding of actions but non-compliant. All preventative actions/MFRA in place.
- Swarms meetings taking approx. 10 mins to complete and not the anticipated 30 mins.
- Excellent support from physiotherapy & nursing.
- OT and discharge liaison started to join of own accord.
- Generally good attendance by medical team.
- Pharmacy input decreased over period due to staffing. Raised to Divisional pharmacist who is keen to support.
- Swarms being held over weekends/BH's
- One nurse had been non-clinical and was available to support coordination of meetings.
- MFRA's in place and completed prior to meetings with occasional exception with agency staff on duty out of hours.
- At a glance forms in medical notes with key staff to lead was generally completed.

'We feel decision making is now an MDT approach.'

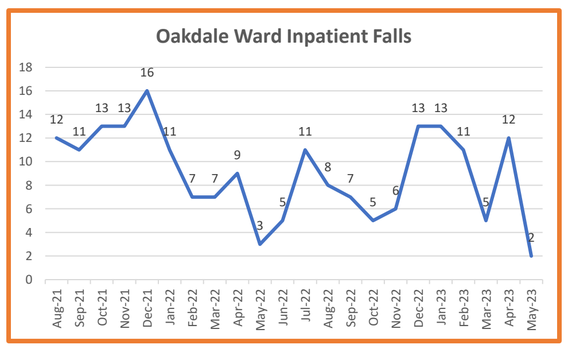
Staff feedback:

- Very positive and has led to other therapists on other wards enquiring when this process will start on their wards
- Therapists have sought MFRA training as a result.
- All key members have stated they have seen an improvement in standards of documentation and MFRA
- Evidence of excellent teamwork as an MDT.
- Each discipline taking a role as chair of the meetings, moving away from nurse led.
- Creativity in team developing a bee sticker to identify patients on PSAG board that have been swarmed.

'Awareness of risk assessments has improved, and we are working better as a team..'

WHAT WE LEARNT & NEXT STEPS

- Identifying challenges and barriers ensuring the engagement of the key members was paramount. Preparation and communication was integral to the process with clear leadership from a QPS lead and team and ward manager.
- Involving all key members in the swarm meetings taking turns in chairing improved engagement. This aided the ward staff to take ownership of the project to ensure sustainability.
- Improved standards across all inpatient documentation not only MFRA assessment.
- SWARM huddles decreased the number of inpatient falls within the clinical area from 12 cases per month to 2 cases in which all preventative measures had been implemented.



- Next pilot wards identified and commence roll out August.
- Planned to create electronic versions for ease of analysis.
- Next pilot wards identified.
- Plan to roll out across all sites.
- Commence a value -based healthcare project.