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Health Quality & Safety Commission New Zealand

Kupu Taurangi Hauora o Aotearoa

National Patient Safety Campaign

Learning session one
What does the evidence/data say

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Health Quality & Safety Commission

Areas to cover

- Impact of falls - a reminder
- Falls and ARC - challenges and opportunities
- What does an effective falls risk assessment tool and care plan look like?
- What does the evidence say?

Did you know?

- Falls in NZ public hospitals result in two persons a week fracturing their hip
- For every person who falls in hospital and fractures their hip, five fall in aged residential care and fracture their hip
- Falls with serious harm often occur when the person is going to, or returning from the toilet/bathroom (hospital and in aged residential care)

Some more facts

- 50% of the serious and sentinel events reported by DHBs in 2010-12 were patient falls
- 75% of in-hospital falls with serious harm reported in 2011/12 were in the 75+ age group
- If you are over 80 years old, you are 9 times more likely to be admitted to hospital following a fall
- Falling is one of the top reasons why a person moves into residential aged care
- The direct costs of in-hospital falls for 2010-11 is estimated between **$3-5 million**

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Older people and falls

Of the elderly with hip fractures

- 50% had had a previous fracture
- 25% have dementia
- 50% will require help with activities of daily living in the first year after hip fracture
- 50% who walked unaided prior to their fracture will no longer be able to walk independently
- 50% will require long-term care
- 20% will be dead in one year

Bone Care 2020: Osteoporosis NZ

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Fear of falling

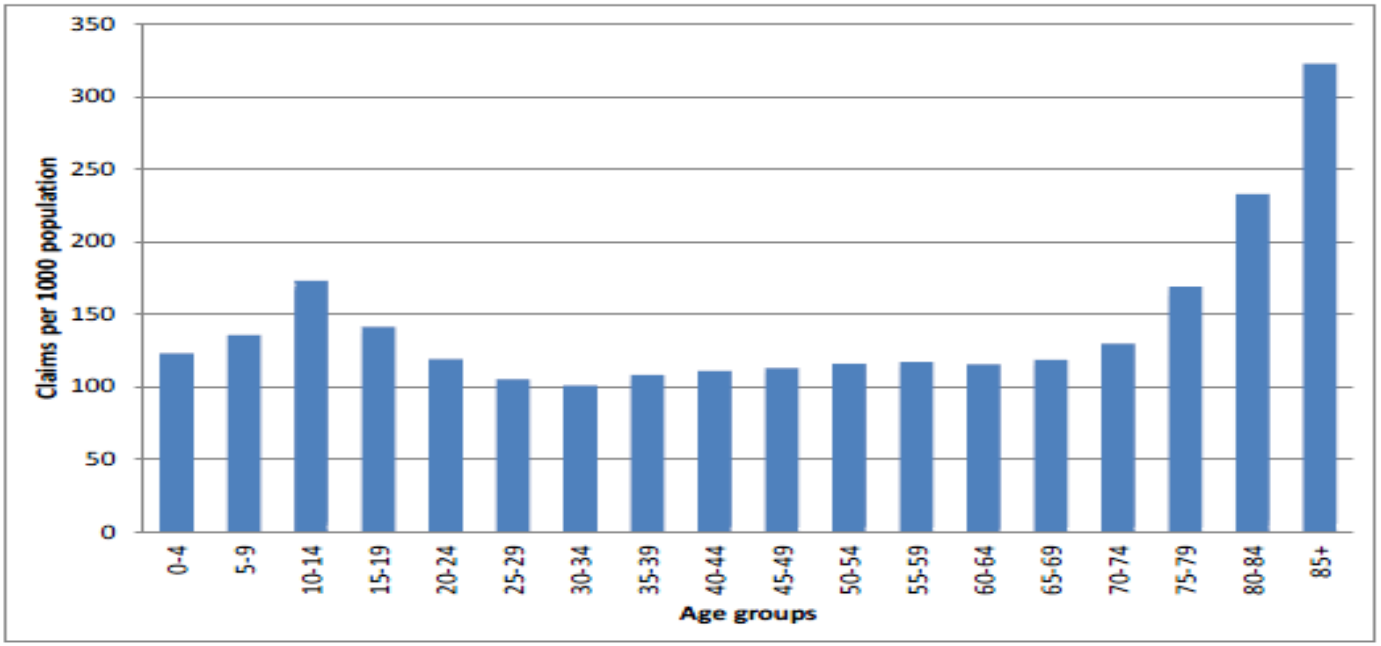
Consumer stories confirm the research –

- A fall creates a vicious cycle - older people stop walking, driving and socialising
- Increasing risk of further fall through loss of muscle tone, balance and confidence

Excessive fear of falling can lead to needless restriction in participation in physical and social activities, resulting in physical de-conditioning, poor quality of life, social isolation, depression, and psychological distress (Delbaere et al 2011).

The age when harm from falls increase

Figure 3 Fall-related ACC claims by age 2010-11



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New ACC claims

(represents harm requiring treatment)

New accepted claims for falls for ARC 2010-2011

10,500 falls in ARC represent a rate of:

- 18 per 1000 based on the total population aged 65+ (pop -586,000)
- 40 per 1000 based on the total population aged 75+ (pop-261,000).

Jean-Pierre de Raad, NZIER

What do you believe?

- The majority of falls with harm are **not preventable** in residential aged care
- **Restraint** has its place in falls prevention (lap belt, rails)
- **Vitamin D** does not really make a difference
- **Exercise** is unsafe when we don't have a physiotherapist to supervise
- Hip protectors, non slip socks, alarms are not proven and are too costly anyway

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The challenges

- A resident who is not allowed to walk alone rapidly becomes a resident who cannot walk alone
- Average length of stay in aged residential care is 14 months (independence and residents' rights versus managing the risk)
- Acuity is high, and the expectation we manage inhouse
- We have to meet accreditation /certification expectations
- The workforce is largely an unregulated workforce
- Capacity to address the problem of falls
- InterRai – how does it fit?
- What we do must not cost us more.

A recent ‘Toolkit’ says

- Falls prevention must be balanced with the need to mobilise patients
- It may be tempting to leave patients/residents in bed to prevent falls, but they need to walk to maintain their strength and to avoid the complications of bed rest
  (Preventing Falls in Hospitals: A toolkit for improving quality of care)
- Falls prevention needs to be customised. Each resident has a different set of risk factors, so care must address residents’ unique needs

What does the evidence say about

Risk assessment

- Falls risk prediction tools are not recommended
- Must use clinical judgment (use our eyes and ears and brain)
- Involve the resident and family and listen to them
- Identify actual individual risk factors
- Risk factors identified **must** inform care plan
- Certain questions must be asked
- Must reassess if patient falls or condition changes

The burden of knowledge creates the accountability to act

What does the evidence say about

Falls care plan

- Must include resident and family
- Clinical judgment is key, the tool supports rather than dictates
- About addressing a person's own risk factors- individualised
- Set of cares that are for all whether at risk or not, (universal precautions)
- Guide lines help
- Tick lists are not supported - better to write the individual strategies

The evidence also says

- Prescribe Vitamin D
- Introduce strength and balance exercises that are safe for the individual
- Maintain an uncluttered/safe environment
- Put in place an individualised care plan that addresses the residents' risk factors.

This programme aims to reduce the harm that people can suffer if they fall and hurt themselves - especially older people receiving care, whether in hospital, residential care, or in their own home.

At the end of the day we have to be able to put our hands on our hearts and say "we have truly done our best to keep the patient safe from falling".

Sandy Blake, Director of Nursing, Whanganui DHB, and Clinical Lead for the Reducing Harm From Falls Programme

Open for better care: falls resources

10 Topics in reducing harm from falls

Preventing falls in hospitals - a tool kit for improving quality of care

News

Falls audiovisuals

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Preventing falls in an aged residential care facility

Staying on your feet in the community

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