focus on FALLS

connecting people working in falls prevention

open FOR BETTER CARE
Hāpai ake te toiora

Issue 5 September 2016

Welcome to *Focus on Falls* – a quarterly publication for everyone interested in understanding and preventing falls in older people. Reducing Harm from Falls is the name and the broad aim of the national programme led by the Health Quality & Safety Commission, working in partnership with key organisations such as the Accident Compensation Corporation (ACC), the Ministry of Health and district health boards (DHBs).

Please pass it on!

Sandy Blake, Clinical Lead

INSIDE

- A major investment in falls prevention from ACC
- Findings from the Reducing Harm from Falls programme evaluation
- A patient's perspective
- Just-in: Evidence-based publications and resources

LET'S HEAR FROM YOU

Sign up to be on the mailing list. We love to get your questions and feedback. Let us know what you think of *Focus on Falls*, what you'd like to hear about in the future, or tell us about your improvement story. Please contact Gabrielle Nicholson – Senior Project Manager (**gabrielle.nicholson@hqsc.govt.nz**). If you are new to *Focus on Falls*, **previous issues** are available on the Commission website.

Quick Question

How does leadership help to reduce harm from falls?

ANSWER ON PAGE 6

ACC invests $30.5m to reduce falls and fractures for older New Zealanders

An investment of $30.5 million over four years by ACC, to support new and existing initiatives aimed at preventing falls and resulting injuries, has been welcomed by ACC Minister Hon Nikki Kaye and Minister for Seniors Hon Maggie Barry.

Both Ministers visited Auckland City Hospital on 12 July 2016 to celebrate the investment and visit an older persons' health ward.

'ACC's investment will boost work being done by local health organisations and community partners to provide better services for those at risk of falls and those who've been injured in a fall,' says Ms Kaye.

'This is one of the most significant investments ACC has made as it continues to ramp up its injury prevention work.'

The investment will help fund access to:

- in-home and community-based strength and balance programmes
- fracture liaison services, to identify and treat those at risk of osteoporosis and further fractures
- assessment and management of visual acuity and environmental hazards in the home
- medication review for people taking multiple medicines
- vitamin D prescribing in age-related residential care
- integrated services across primary and secondary care (including supported hospital discharge), to provide seamless pathways in the falls and fracture system.

'This is a great example of ACC working collaboratively with partners, including DHBs, the Health Quality & Safety Commission and the Ministry of Health, to enhance the reach and effectiveness of its injury prevention work,' says Ms Kaye.

The **full article is available** on the Commission website.

Findings from the Reducing Harm from Falls programme evaluation

A summative evaluation of the national Reducing Harm from Falls programme was conducted by Synergia Ltd between November 2015 and May 2016, and the final report is now available on the **Commission's website**.

The evaluation noted a number of improvements:

- There was a marked reduction in falls – 67 fewer fractured neck of femur to end December 2015.
- Assessment of older patients for falls risk, and having an associated individualised care plan (in hospital), increased to 92 percent.

Consumers are actively engaged in programme activity and there has been an increased awareness of harm from falls, falls self-management and the importance of avoiding a fall.

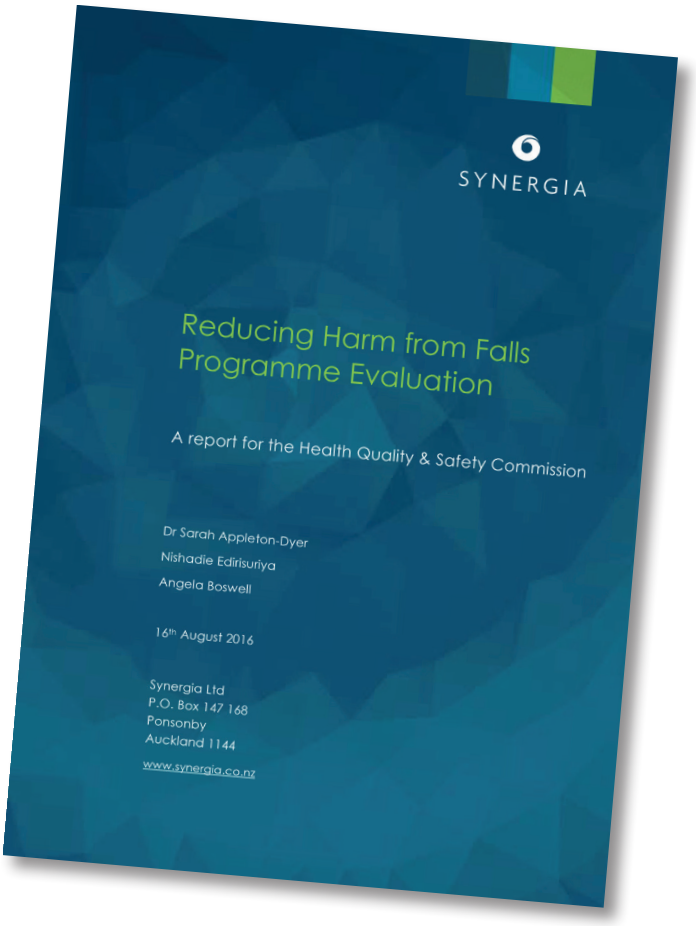
Sector benefits include:

- putting the spotlight on falls: increasing awareness, knowledge and priority of falls prevention
- building sector capability through an evidence base, education and training, and promoting quality improvement
- sector leadership at national, regional and local levels
- data monitoring to track and promote engagement.

Stakeholders are generally confident of the sustainability of activities and outcomes, particularly in hospitals. Table 1 shows the factors noted in the report in relation to sustainability.

Key stakeholders noted future improvements could be made by increasing:

- emphasis on reducing harm from falls outside hospitals
- funding for the primary prevention of falls
- quality improvement capability across DHBs



- use of technology to engage more staff in workshops, eg, webinars
- cohesion and collaboration between regional networks.

The report highlighted the value of the Commission continuing to have a leadership role, supporting other agencies to engage (outside hospitals), providing evidence-based resources, building quality improvement capability, and developing and maintaining the quality and safety markers. The role of ACC and the Ministry of Health in supporting an increased focus on falls prevention in the community was also highlighted.

Table 1: Factors noted in the report in relation to sustainability

Supporting factors	Challenges to sustainability
Data monitoring and use	Limited human and financial resources
Staff training and education	Falls prevention is unsystematic in some settings
Organisational support	
Strategies are now 'business as usual'	

A patient's perspective

One Upper Hutt resident is well aware of the slogan 'falls prevention is everyone's business'.

Seventy-nine-year-old Yvonne Price broke her ankle in a fall on 23 December 2015, after slipping on an unsecured mat at her daughter's house. Mrs Price lives in a cottage on the property she shares with her daughter and son-in-law.

'I was watering the plants on the deck of my daughter's house,' she says.

'I ran out of water and was going back into the kitchen. I stepped on a new mat on the deck and it slid. I ended up lying on the ground with my foot at an odd angle.'

Her first problem was finding a way to call for help. Because she couldn't stand, she had to 'bottom shuffle' to her daughter's office, where she could reach the phone. She rang an ambulance and sat on the floor, waiting for it to arrive.

'When I got to the emergency department, they tried three times to put the break together, but it didn't work. So I had to have an operation under general anaesthetic. I ended up with three pieces of metal in my ankle. I was in hospital for nearly three weeks.'

Mrs Price says the worst part was not being able to walk for so long. 'I had to use a walking frame to get around in hospital and for the first six weeks I was home. In fact, all I could do was hop – but I got quite good at it!'

She is still wearing a moon boot, awaiting the all-clear from specialists.

As well as losing her ability to move freely and independently, and needing to rely on friends, family and neighbours to drive her to appointments and check-ups, Mrs Price lost her family Christmas.

'Christmas didn't happen. Not for me. I had visitors in hospital on Christmas Day, but it wasn't the same.'

Mrs Price says she had removed falls hazards from her house after being warned about them by her brother – but the errant outdoor mat belonging to someone else was her undoing.

ACC has a simple checklist to help identify hazards in the home: **ACC falls checklist for the home**. See also the checklist ***Stay independent: Are you at risk of falling?***

Simple things to keep yourself safe around the home include checking you have non-slip rugs or they are secured to the floor, keeping cords and wires away from walkways or taped down, and ensuring stairs and walkways are well lit with easy-to-grip handrails.

The **full article is available** on the Commission website.

Yvonne Price

Applying '10 priorities for an integrated approach' to my mum's story – Liz Price

In **Topic 10 An integrated approach to falls in older people: what is your part?** we suggested looking at a patient journey to see if an integrated approach might have prevented a fall and/or reduced harm. There's an example of how the story could have been different in **Issue 1** of *Focus on Falls*.

We asked Liz Price, Director of Communications at the Commission to do the same assessment of service integration for her mother's fall.

'In December 2015, my mother tripped over a mat on our deck and broke her ankle. She was 79 and had no known falls risk factors. The fall was due to a loose mat that was a clear falls hazard. It is possible that some strength and balance exercises would have helped her stop her fall altogether, or have made it less serious.

'The two things we would have done differently in hindsight? To sign mum up to some strength and balance exercises, and not have a loose mat.

'She was in hospital for three weeks, including over Christmas. The care was very good. Our only criticism was not being made aware of the home support available for her once she left hospital. If I hadn't known to ask, we wouldn't have received any. As it turned out, mum got a few hours' home help every week for three months, which was extremely helpful.'

Just in: Evidence-based publications and resources

So many studies... and still the same messages

Since we published a review of recent evidence in December 2015 (***Focus on Falls* issue 4**), there have been thousands of articles published in peer-reviewed journals. Using the search term 'falls older people' in Google Scholar for articles published in the first half of 2016 showed about 22,200 results. Titles range from the sublime to the not-so-ridiculous, as we found in a random stab at results: **To fall is human: falls, gait, and balance in older adults** and **Oh the weather outside is frightful: Severe injury secondary to falls while installing residential Christmas lights**.

Not so randomly, this section presents selected publications from 297 found with the same search terms for the same time period in PubMed. Overall, the research questions and findings focus on the core issues covered in the **10 Topics in reducing harm from falls**, and confirm **10 priorities for stakeholder action** identified by the falls programme.

In selecting material 'just in' for this issue we continue themes in relation to preventing falls in the community:

- the need for an **integrated approach** across all sectors to promote and support safety outdoors and at home
- provision of **effective exercise programmes**
- promotion of appropriate **physical activity for older people**.

Preventing falls in the community

'State of the art' review

Highlights of a **'state of the art' review** in the *British Medical Journal* on preventing falls in older people in the community are available in this **PDF**. **Rapid responses** (*BMJ* letters to the editor) include a note on benign paroxysmal positional vertigo (which incidentally references the London Neuroscience Strategic Clinical Network **resource and video guides** on the diagnosis and management of dizziness in adults) and a lively debate on vitamin D. The review concludes that the most effective way to reduce falls and associated health care costs among older people in the community is 'exercise based and tailored interventions'. This is the emphasis in the **Stay independent toolkit for clinicians**. The *BMJ* review also reinforces the **Ask, assess, act** process – in particular, asking older patients if they have fallen in the last year and asking about difficulties with walking or balance.

Falls outdoors

An emergency department-based **study** (**PDF**) of risk factors for severe injury following indoor and outdoor falls in geriatric patients found that males falling outdoors were younger than those falling indoors. They fell most commonly during daily activity, followed by during sports and leisure activity. However, while engaging in leisure-time physical activity is protective for falls in **older age** (**PDF**) and **middle age** (**PDF**), fall-prevention strategies are still needed in for those who are active in this way.

While recurring falls in community-dwelling older people should prompt questions about declining functional ability (and possibly trigger **comprehensive geriatric assessment**), 'location changes the inference' according to an earlier **study** (**PDF**) finding that recurrent outdoor falls are associated with generally good health. Since less healthy people tend to stay indoors, the authors suggest that asking about the amount of time an older person is spending indoors and outdoors is important in both assessment of frailty and falls history-taking.

The concept of 'environmental supportiveness' (the extent to which the environment supports or hinders physical activity) is highlighted in an **article** (**PDF**) describing the development of an audit checklist to assess outdoor falls risk. A walk-along interview approach was used, in which older people who'd had a fall in the previous year walked a familiar route and highlighted areas they felt were particularly positive or negative in terms of contributing to falling or fear of falling. It was recommended that identified hazards were reported to the local council via **www.fixmystreet.com** – the New Zealand equivalent is **fixmystreet.org.nz**.

Pedestrian injuries (8 percent) and deaths (29 percent) are shown in this **infographic on road trauma** from New South Wales. The New Zealand Transport Authority's ***Pedestrian Planning and Design Guide*** (**PDF**) defines the older pedestrian as one '... who may be physically or cognitively less able than others due to aging'. Since approximately 75 percent of hospital admissions resulting from a same-level fall in the road environment are older people (see Figure 3.7, pages 3–9 in the guide), pedestrian safety is part of an **integrated approach to falls in older people**. Relevant sections in the guide are:

3.9 Why people don't walk

3.11 Falls, slips, trips and stumbles

11.3 On-site assessment of walkability.

It's worth mentioning again a New Zealand programme to reduce hazard-related falls in people aged 75 and over with significant visual impairment, known as the **VIP trial** (**PDF**). The programme's success in reducing falls both at home and *away* from home is discussed in this **article** (**PDF**). The team suggests that individualised advice for the home environment from a trained occupational therapist for this high-risk group enabled behaviour change that supported safe mobilisation in other environments.

Falls in the home

New Zealand epidemiological and cost data were used in modelling work in a **cost utility and equity analysis** (**PDF**), finding that home safety assessment and modification (HSAM) is highly cost effective in reducing injurious falls in older people. Since HSAM is even more cost effective when targeted to those with previous injurious falls, the authors suggest prioritising this group.

With reference to this analysis, a related **blog** argues for not only the cost effectiveness of home safety and modification as an intervention, but also the efficiencies of scale in a national government-led programme. The blog outlines implications for policy and health service provider decisions at a local level, and also suggests actions 'citizens not waiting for government' could take through non-government organisations and personal home safety (eg, by using **ACC's home safety checklist**).

Speaking of citizens and preventing falls in the community, there's evidence of the value to society of individuals stepping up to this challenge in the **Queen's Service Medal awarded to Margaret Dando** for services to senior citizens. Specifically, for helping '... senior citizens of Otago to retain mobility, avoid social isolation, and have a much greater quality of life through her dedicated delivery of the **Steady As You Go** (SAYGo), community based strength and balance exercise programme'. Margaret's work with Age Concern Otago and the peer-led SAYGo programme are featured in the video **Staying on your feet in the community**.

Updates on exercise to prevent falls

A Cochrane **systematic review and meta-analysis** (**PDF**) on exercise for reducing fear of falling in older community-dwellers acknowledges that exercise is effective in reducing falls, but its effect on reducing fear of falling is unclear. The authors conclude that exercise interventions probably reduce fear of falling to a small or moderate degree, but the effect beyond the end of the intervention is unclear. As an alternative to exercise interventions for fear of falling, a randomised controlled trial (RCT) implemented a home-based cognitive behavioral programme to manage concerns about falls in community-dwelling, frail, older people. The **study** (**PDF**) found that at 12 months the intervention group showed significantly lower levels of concern, activity reduction, disability and indoor falls compared with the control group. However, there was no significant difference between the two groups in the total number of falls.

Professor Cathie Sherrington's presentation 'Exercise for falls prevention: evidence update and implementation challenges' (**PDF**) at the **2016 NSW Falls Prevention Network Forum** is effectively a preview of an upcoming review updating exercise and falls prevention. The presentation – given as the Pam Albany guest lecture – is **available from the NSW Network via YouTube** (skip to the presentation's introduction at 07:36 minutes).

Muscle anabolics as a pharmacologic alternative to progressive resistance training for strengthening muscle to prevent falls and fractures is discussed in this **review**. One of the authors, Professor Stephen Lord, discusses **myostatin antibody** as another pharmacologic alternative in his presentation 'Falls prevention research update' (**PDF**) at the **NSW Forum**. This presentation is also **available from the NSW Network via YouTube** (skip to the presentation's introduction at 49:40 minutes). Also in the presentation: discussion of rivastigmine for gait stability in Parkinson's disease, a review of current perspectives on vitamin D and falls, and systematic review evidence for step training.

Exercise interventions for frail older people are discussed in a **systematic review** (**PDF**) of RCTs. A New Zealand **RCT** investigating the effect of vibration training on functional ability and falls risk as an innovative approach for inpatients in a rehabilitation unit found some beneficial effect.

Physical activity in older age to promote healthy ageing – including mental health – is covered in two reviews. The first is a **literature review** (**PDF**) updating epidemiological evidence, prevalence and interventions promoting active ageing and arguing for innovative population-level efforts to address physical inactivity, prevent loss of muscle strength and maintain balance in older people. An **editorial perspective** on this review puts it in the context of prevention and health promotion 'at every age and into the oldest ages... [to] amplify capabilities and wellbeing to the end of life'. The second **review** argues that while a population-level approach is needed, at the individual level, older people's involvement in physical activity may be influenced by encouragement and support from health professionals, family or friends; availability of low-cost and enjoyable activities; and improving self-efficacy

through successful performance of an activity in a safe environment (**SAYGo**, anyone?).

Overall, **key messages** are that while evidence indicates which exercise interventions are effective in which groups in which circumstances, they must be tailored to the individual older person's needs, capabilities, motivation and interests. And as many older people reject the idea they are at risk of falling, promotion of exercise programmes should emphasise the positive benefits for health, wellbeing and independence. Ideally, older people are involved in physical activity for the love of it, according to an **editorial comment** on a **systematic review and meta-synthesis of qualitative studies** of independent older people's experiences of non-clinical physical activity. Focusing on physical activity as something that has relevant short-term benefits while being fun, sociable and achievable is recommended for increasing engagement.

A **special article** (**PDF**) on narrowing the research-to-practice gap and enhancing integration of clinical and community practice also reiterates the message that at local and community levels, basing exercise programmes on evidence helps ensure their effectiveness and the best **return on investment**.

Quick Question

How does leadership help to reduce harm from falls?

ANSWER

My experience as Clinical Lead for the Commission's Reducing Harm from Falls programme has taught me that, as an individual clinical leader, I cannot influence change and make a difference on my own.

It takes a team of leaders at all levels of health organisations to do what is needed – a team that is grounded in the needs of the patient, family and whānau right through to senior managers and the board chair.

Each role has an important contribution to make, playing to their **own set of unique skills, strengths and knowledge**. Leaders can influence what is prioritised across an organisation, locality and region. It is important there is a common understanding of what we are trying to achieve and alignment with national priorities.

The success of any combined effort depends on leaders understanding the impact of falls and using their influence in 'their world' to make the right changes to reduce harm experienced by those in our care.

Taking a system view and having knowledge of the overall national strategy is helpful, but more importantly the key is for leaders across the system to implement strategies which are **guided by evidence**. This must be **translated into practice** to reduce falls and fall-related harm for older people. Leaders have a key role in assisting with this translation.

The Reducing Harm from Falls programme has been well led by a small programme team at the Commission, and guided by an **expert group of advisors**. Working closely with the sector, this partnership has provided the evidence, knowledge and leadership to allow the sector to understand the seriousness of the falls problem. It has put a spotlight on the problem to help raise it as a priority area of focus.

The sector has been provided with tools, evidence and the advice it needs to care safely for our older people at risk of falling or those who have fallen and suffered harm. We often say there is no 'magic bullet' to reduce harm from falls, yet many of the programme's activities **have helped make a difference**.

Evidence, and providing resources, is not enough. Many clinicians I speak to say they have not yet read the falls programme's series of evidence-based resources, the '**10 Topics**'. The topics identify **10 key priorities** to consider when addressing falls prevention and challenge our thinking.

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Local clinical leaders need to embed such resources into their education programmes, especially for those engaged in caring for older patients. The knowledge and evidence base needs to be referred to constantly by leaders so there is a common language, understanding and validation for change.

Clinical practice is often driven by personal experience, beliefs and values, and the experience of our peers. By sharing and showcasing good examples and providing exposure for local leaders to learn from, we can change peoples' beliefs and encourage them to follow and explore a different way.

One platform that supports leaders and emerging leaders with a passion for falls prevention is the network of local and regional integrated falls groups. These groups collaborate, lead and drive falls prevention initiatives across a range of care settings. An example of this approach in action is the DHBs in each region collaborating to agree on a common theme for April Falls, which has now become an annual event. Regional leadership, networks and collaboration are a key step towards a sustainable model of reducing harm from falls. Collaboration works best if the person doing the leading is known, inclusive, credible and respected by their peers.

National efforts have been supported by three visiting international experts and leaders on falls prevention (**Dr Frances Healey**, **Professor Lindy Clemson** and **Dr Anne-Marie Hill**). They have conducted workshops nationally and shared their learnings, which has built further capability in local falls prevention leadership.

The quality of the partnership that senior managers within the Commission, ACC and the Ministry of Health form is important for delivering consistent messages to the sector. This is enhanced by the partnerships extending to local and regional groups, and clinical leaders who can broker and influence the changes that may need to occur.

Strategically these centrally led organisations have opportunities to inform and influence board chairs and chief executives who themselves have overall accountability for the culture, safety and the standard of care delivered.

We have a better chance of achieving sustained reductions in falls and harm from falls if all leaders within the health system **put the patient and their family/whānau at the centre** and understand the important part they each play in this area of high patient harm.

Significant and sustained improvement has been achieved and this must be sustained. Falls prevention is everyone's business, and as leaders we have a duty to make sure this remains a priority.

Sandy Blake
Clinical Lead

Health Quality & Safety Commission New Zealand
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