Falls are costly

The health service costs of a fall causing minor injuries are estimated at $600. A hip fracture causing a three-week stay in hospital is estimated to cost $47,000, and a hip fracture with complications and discharge to an aged residential care facility $135,000.¹

The direct costs of patient falls in hospitals for 2010–11 were between $3 million and $5 million.¹ However, figures from international studies and analysis of New Zealand data suggest the total resources used by falls are 2–2.5 times higher than the direct costs – which would mean the true cost could have been about $6–12 million per annum.²

Patient falls have human costs

Patient falls that result in harm are the most frequently reported adverse event in hospitals.

Of the 730 serious and sentinel events reported by district health boards (DHBs) in the two years 2010–12, 365 were patient falls, and of these 170 were associated with a hip fracture.³

We have a duty of care to prevent harm to patients in our care.

Older people are more likely to fall because of medical conditions (such as delirium, cardiac conditions, neurological conditions, muscular–skeletal conditions or side effects from medicines) or problems with balance, strength or mobility. Having poor eyesight or poor memory can increase an older person’s risk of falling, especially when they are in an unfamiliar environment.

The most serious injuries resulting from falls are fractures and head injuries, with hip fractures being the most common.

Of those who suffer a hip fracture, nearly 20 percent will die within a year, almost half will require long-term care and half will require help with daily living. Half of those who walked without help before fracturing a hip will no longer be able to walk independently in the year following the fracture.⁴

Fracturing a hip while in hospital can extend a person’s length of stay by over a month. The estimated cost for the additional time is conservatively $26,000.¹

A fall can be life-changing for an older person and his or her family/whānau.

Falls prolong or complicate hospital stays.

Case study – Hazel’s story

Hazel was in hospital for a scheduled hip replacement operation in September 2012, and was returning to her bed from the bathroom during the night, when her crutches slipped and she fell.

She cracked a bone in the hip she’d just had surgery on, and needed to have further surgery. This turned a week-long stay in hospital into a three-week stay and had a major impact on Hazel and her family.

Hazel says she wasn’t confident on the crutches she was given. “I think I would’ve been more comfortable with a walker, and I wouldn’t have had the fall.”

She says there needed to be better communication with her about whether she should have crutches or a walker, but also about her having to wait for staff to help her get back to bed.

The fall and extended hospital stay put pressure on her husband and their two children.

“I was upset, from being in pain, but also at not being with my family and I was worrying about how my husband was coping.”

Hazel says she has been well cared for by staff during her recovery and rehabilitation, but is still feeling the impact of her fall six months on.

“I have to do many things differently. I can no longer run, I still have a limp and I can’t ride my bike. Bending over and getting up are much harder now.”

Hazel’s fall might have been prevented if:

• her clinical assessment had ensured she was confident in using the mobility aid considered best suited to her physical ability
• there had been better communication about staff being available to assist Hazel at all times (especially at night) with her walking and assistance to get back to bed
• staff made sure that Hazel was aware that she could and should use the call button at any time, including the one in the bathroom.

What your organisation can do

• Put in place a falls prevention programme, that includes raising patient and family awareness about the impact of falling.
• Appoint falls prevention/harm reduction leaders and champions.
• Put in place clinical management systems to report, record and analyse falls – every incident is an opportunity for positive learning.
• Ensure staff complete falls prevention education programmes.
• Provide risk assessment and care planning tools.
• Put visual cues, such as patient display boards, in the bed area.

What you can do

• Make sure the environment is free of falls hazards and clutter.
• On admission, ask patients if they have fallen in the past 12 months.
• Undertake a risk assessment for each patient with his or her family/whānau and develop and implement a care plan with them.
• Communicate a patient’s falls risk and plan on handover, transfer and discharge.
• Reassess a patient’s falls risk after they have had a fall or if his or her condition changes.
• Teach patients and their families/whānau how to avoid falls.
• On discharge, refer patients to fracture prevention and exercise programmes, as appropriate.
• Report all falls.
• Take part in falls events analysis and audits.

ACC accepted approximately 2600 claims for in-patient falls in 2010–11.

Many falls are preventable, and steps can be taken to help prevent people from falling and to reduce the harm sustained if they fall.

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