

Questions



Answers about the

QSMs

What are quality and safety markers?

Quality and Safety Markers are a way of tracking change in practice in the areas covered by the national patient safety campaign 'Open for better care'. They estimate the effect of changed practice by looking at outcomes which are measured by harm to patients and cost to the health system.

What are the quality and safety markers for falls prevention?

The markers have two parts: **process** (certain care practices known to be effective) and **outcomes** (what happens with patients and the health system)

The **process measures** for falls are

- percentage of patients aged 75+ (55+ for Maori and Pacific populations) who received a falls risk assessment – the aim is that 90% have a risk assessment
- percentage of patients assessed to be at risk who received an individualized care plan – the aim is that all who are at risk have care planned that will address their particular risk factors.

The **outcome measures** for falls are

- older patients who fall in hospital and suffer a hip fracture
- the additional bed days and cost associated with these events.

Why consider processes of care and not just focus on outcomes?

It may take a couple of years of sustained effort to make changes in culture and practice that will show up in reduced fall rates in hospitals¹. So we need to choose care processes known to be effective in preventing falls and monitor that they are being implemented consistently - it's about doing the right thing while older people are in our care.

Why is hip fracture the outcome measure?

Other outcomes such as the number of patient falls or falls resulting in some injury (30% - 51% of falls²) seem to be possibilities until you look at the wide variability in reporting.

Hip fracture is an injury that will not generally be missed. It is a definite diagnosis and a serious event which is required to be reported to the Commission as a Serious and Sentinel Event. It is possible to check hip fracture events occurring after admission from the National Minimum Data Set. The pattern since 2010 in New Zealand's public hospitals is that every week, two patients fall and fracture their hip³.

Hip fractures represent about 1.1% - 2% of all falls-related injuries sustained by inpatients² - hip fractures are the tip of the iceberg. When we reduce the number of falls in hospitals we reduce the possibility of fall-related hip fractures. Conversely, if the rate of hip fractures goes down, we can infer that the rate of falls and other injuries has also.

What if we improve our care processes and we don't see an improvement in our falls rate?

This may point to issues which need further attention:

- it may be that while risk assessments and care plans are done, the right questions were not asked to really identify and address the risks of individual patients
- or documentation of the risk assessment and care plan may be good but the patient is not actually getting the planned care.

What are the results of the June 2013 baseline audit?

The baseline results for falls QSMs are [here](#). The QSM data will be collected quarterly in each DHB, based on a sample of 130 cases. The worked example (next page) comparing the QSM results in two wards will help you think about what your DHB's results mean.

¹ Healey F, Darowski A. 2012. Older patients and falls in hospital. *Clinical Risk* 18(5): 170–6.

² Oliver D, Healey F, Haines TP. 2010. Preventing falls and fall-related injuries in hospitals. *Clinics in Geriatric Medicine* 26(4), 645–692.

³ Health Quality & Safety Commission. 2013. *Making our hospitals safer – Serious and Sentinel Events 2011/2012*. Wellington: Health Quality & Safety Commission.

A worked example

THE STORY OF WARD X AND WARD Y

Both Ward X and Ward Y have had 100 patients aged 75+ admitted this month.

- In both wards, all of these patients were risk assessed, and the results of the assessments were documented.

However, what happened after the risk assessment was a bit different in each of the two wards...

In Ward X

- 98% of these patients had an individualized care plan (i.e. specific interventions or supports in the plan of care which would address their particular risk of falling)
- 2% of these patients had nothing in their care plan addressing their particular risk of falling.

In Ward Y

- 7% of these patients had an individualized care plan (i.e. specific interventions or supports in the plan of care which would address their particular risk of falling)
- 93% of these patients had nothing in their care plan addressing their particular risk of falling.

WHAT WE CAN SAY OR QUESTION

We can say that both the wards have hit the target for risk assessment.

great!

We can say

either 2% had *no risk* for falls

or 2% are at risk but we've misjudged it because we didn't actually put a care plan in place

probably right

We can say

either 93% had *no risk* for falls

or 93% are at risk but we've misjudged it because we didn't actually put a care plan in place

probably NOT right

we should look at it

Which ward needs to think about improving the number of patients getting specific interventions and supports for their falls risks in their care plan?

Questions

& Answers about the QSMs

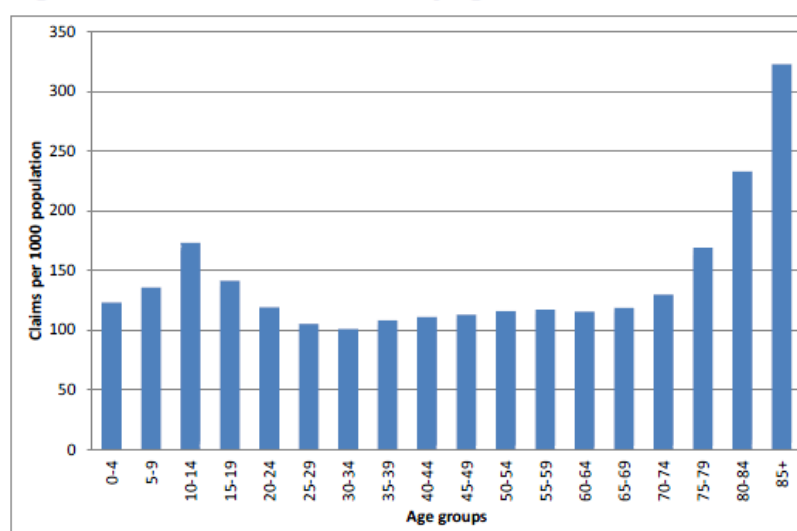
Why only audit whether patients 75 years and over got a risk assessment and individualized plan of care?

For practical measurement purposes, a line has to be drawn somewhere. For instance, at 65 years and over is likely to yield an unmanageable number for audit, at 85 years and over, a number too small to be useful. However, we know that about 75 per cent of inpatient falls with serious harm were in the 75 plus age group in 2011/12⁴

Support for age 75 as a cut off point can be found in an analysis of the rate of falling and falls-related injury rates in community-dwelling people – rates are doubled for those aged 75 years and over compared to the rate at 65 and over.⁵

This graph of fall-related ACC claims by age 2010-11⁶ also lends support for taking 75 years as the point at which rate of falls increases significantly.

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



Finally, analysis of new accepted claims for falls coded as occurring in age-related residential care (ARC) in 2010-2011 indicates that for the ARC population, falls rates are more than doubled at 75 years and over:

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+ (586,000)
- 40 per 1000 based on the total population aged 75+ (261,000).⁷

⁴ Health Quality & Safety Commission analysis of National Minimum Data Set 2011/12 data.

⁵ Rubenstein LZ. 2006. Falls in older people: epidemiology, risk factors and strategies for prevention. *Age and Ageing* 35-S2:ii37-ii41.

⁶ De Raad JP. 2012. *Towards a value proposition... scoping the cost of falls*. Wellington: New Zealand Institute of Economic Research. Figure 3 Fall-related ACC claims by age 2010-11, page 6.

⁷ Per figures in advice by email 25/09/12 from Jean-Pierre de Raad, NZIER to Shelley Jones, Programme Coordinator, Reducing Harm from Falls, Health Quality & Safety Commission.

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QSMs

Why is it 55 years and over for Māori and Pacific peoples?

However, age 75 as a cut off point *misses* older Māori and Pacific people, where a shorter life expectancy means that risk assessments should be considered at an earlier age point. The Expert Advisory Group's proposal for the age point 55 years and over for Māori is supported by findings in the Ministry of Health's publication *Tatau Kura Tangata: Health of Older Māori Chart Book 2011*⁸. This age point was strongly supported by Te Roopu Māori (the network providing clinical and expert advice to the Board and Chief Executive of the Commission)⁹.

For the two top unintentional injury mortality categories (falls and motor vehicle traffic accidents) hospitalisations and mortality rates are significantly higher in Māori than non-Māori in the age groups 50-64 years and 65 years and over⁶.

Further, because Māori over the age of 50 have poorer health outcomes and a higher burden of chronic illness than non-Māori of the same age, and are more likely to be exposed to risk factors for poor health⁶, it can be assumed that underlying conditions contributing to falls risk factors appear earlier and disproportionately.

The significantly higher incidence of cardiovascular disease, diabetes, and respiratory illness among Pacific peoples than other ethnic groups¹⁰ also suggests that underlying conditions contributing to falls risk factors appear earlier and disproportionately in Pacific peoples.

It is worth noting disparities for Pacific peoples in stroke, which is the largest cause of adult disability in New Zealand, and an important underlying condition to consider in falls risk factors: incidence (measured in hospital admissions) is increasing disproportionately among Pacific peoples, who are three times more likely than Europeans to be dependent 12 months after suffering a stroke¹¹.

What other questions do you have?

Please email any further questions about the QSMs for the falls programme to info@hqsc.govt.nz so we can consider adding them to this resource.

⁸ Ministry of Health. 2011. *Tatau Kura Tangata: Health of Older Māori Chart Book 2011*. Wellington: Ministry of Health.

⁹ At a meeting in August 2012.

¹⁰ Statistics New Zealand and Ministry of Pacific Island Affairs (2011). Health and Pacific peoples in New Zealand. Wellington: Statistics New Zealand and Ministry of Pacific Island Affairs. Downloaded from www.stats.govt.nz/browse_for_stats/people_and_communities/pacific_peoples/pacific-progress-health.aspx

¹¹ Stroke Foundation of New Zealand and New Zealand Guidelines Group. 2010. *Clinical Guidelines for Stroke Management 2010*. Wellington: Stroke Foundation of New Zealand.