REDUCING HARM FROM FALLS

THE NEW ZEALAND STORY

PRESENTED BY:

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HQSC, New Zealand

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Whanganui DHB

HEALTH QUALITY & SAFETY COMMISSION NEW ZEALAND
Kupu Taurangi Hauora o Aotearoa

WHANGANUI DISTRICT HEALTH BOARD
Te Poari Hauora o Whanganui

WHO WE ARE

HEALTH QUALITY & SAFETY COMMISSION NEW ZEALAND
Kupu Taurangi Hauora o Aotearoa

Carmela Petagna

Senior Portfolio Manager

HQSC, New Zealand

WHANGANUI DISTRICT HEALTH BOARD
Te Poari Hauora o Whanganui

Sandy Blake RN

HQSC Clinical Lead for the National Reducing Harm from Falls Programme and WDHB Director of Nursing, Patient Safety & Quality

Whanganui DHB, New Zealand

ABOUT NEW ZEALAND

PARTNERSHIPS & COMMON PURPOSE

ALIGNED TO THE NEW ZEALAND TRIPLE AIM

NEW ZEALAND'S HEALTH SYSTEM

District health boards (DHBs) are responsible for providing or funding the provision of health services in their district.

HEALTH QUALITY & SAFETY COMMISSION

HEALTH QUALITY & SAFETY COMMISSION NEW ZEALAND

Kupu Taurangi Hauora o Aotearoa

Under the New Zealand Public Health & Disability Amendment Act 2010 the Commission is charged with:

- providing advice to the Minister of Health on how quality and safety in health and disability support services may be improved
- leading and coordinating improvements in safety and quality in health care
- identifying key health and safety indicators (such as events resulting in injury or death) to inform and monitor improvements in safety and quality
- reporting publicly on safety and quality, including performance against national indicators
- sharing knowledge about and advocating for safety and quality.

'We are responsible for assisting providers across the whole health and disability sector – private and public – to improve service safety and quality and therefore outcomes for all who use these services in New Zealand.' - *Professor Alan Merry, Chair*

CATALYST FOR CHANGE

ESTABLISHING INFRASTRUCTURE

- National Expert Advisor Group
- National Clinical Lead
- Regional and local Falls Leads
- Alliances (Patient Safety Campaign)
- From the 'board' to the 'ward'

PROJECT PLAN

THE FIVE E's:

ENQUIRE

ENGAGE

ENACT

EMPOWER

EVALUATE

PROGRAMME AIMS

HOSPITAL SETTINGS

Outcome measures:

- Nationally a reduction in fall-related hip fractures (10-30%) in hospital settings by 30 June 2015
- Reduced fall-related additional occupied bed days and associated costs

Process measures:

- 90% of older in-patients receive a risk assessment & individualised care plan addressing identified risks

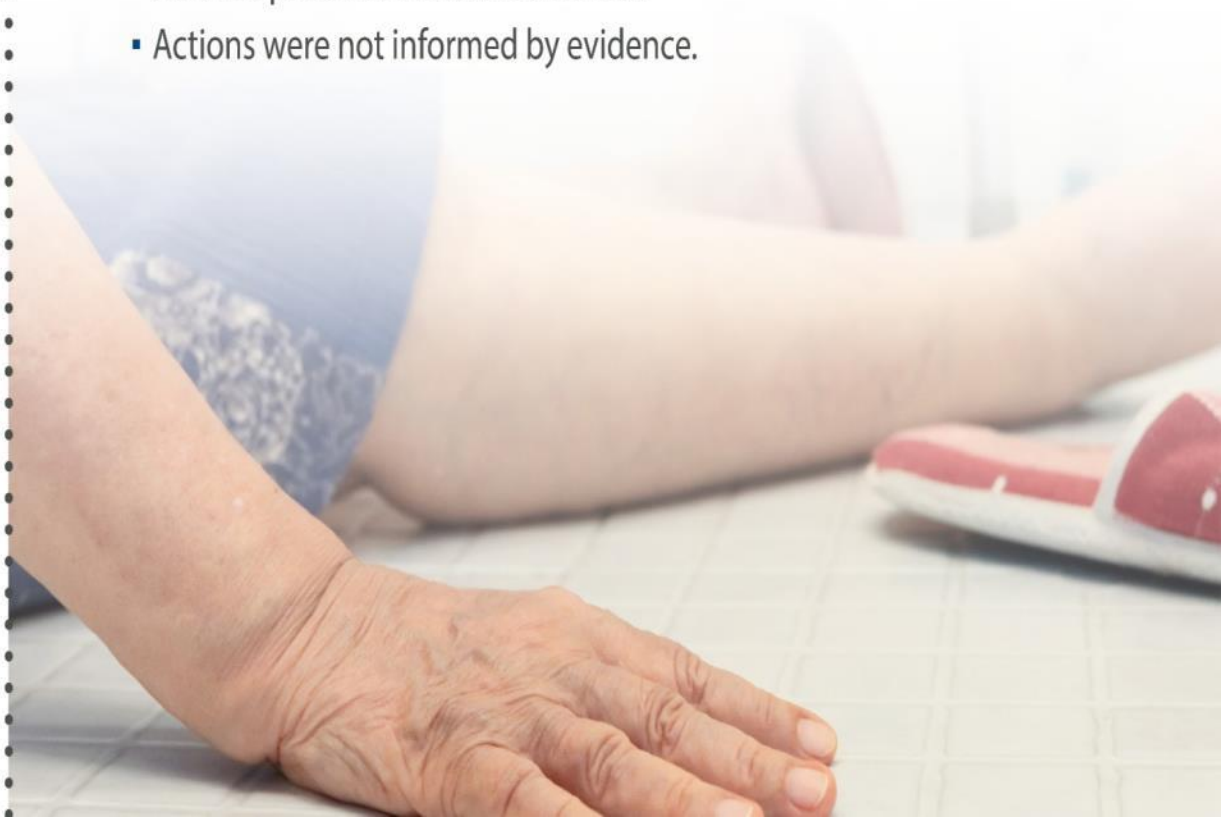
- Prevent falls and reduce harm from falls in hospital acute care settings
- Reduce harm from falls and promote safe mobilising in aged residential care settings
- Promote falls prevention strategies in home based care settings and in the community (includes population health approach)
- Promote evidence-based best practice to build capacity & capability for improvement and system change

WE IDENTIFIED GAPS

HOSPITAL

A stocktake across the acute setting revealed the following approach to falls prevention:

- No standardisation - every place and every ward is different.
- All used predictive risk assessments.
- Actions were not informed by evidence.



THE PROBLEM & CONTRIBUTING FACTORS

THE PROBLEM:

Increased rates of fractured hips in public hospitals.

CONTRIBUTING FACTORS

- A lack of leadership/ownership of the problem.
- Little knowledge of the evidence.
- No national guidance.
- Feeling of overwhelming hopelessness & inevitability.

METHODOLOGY

IT WAS:

- adaptive
- incremental
- organic and agile
- individualised

IT WAS NOT:

- a bundle
- prescriptive
- a collaborative (formal)
- generic - one size fits all.

KEY FOCUS AREAS

CARE PLANNING

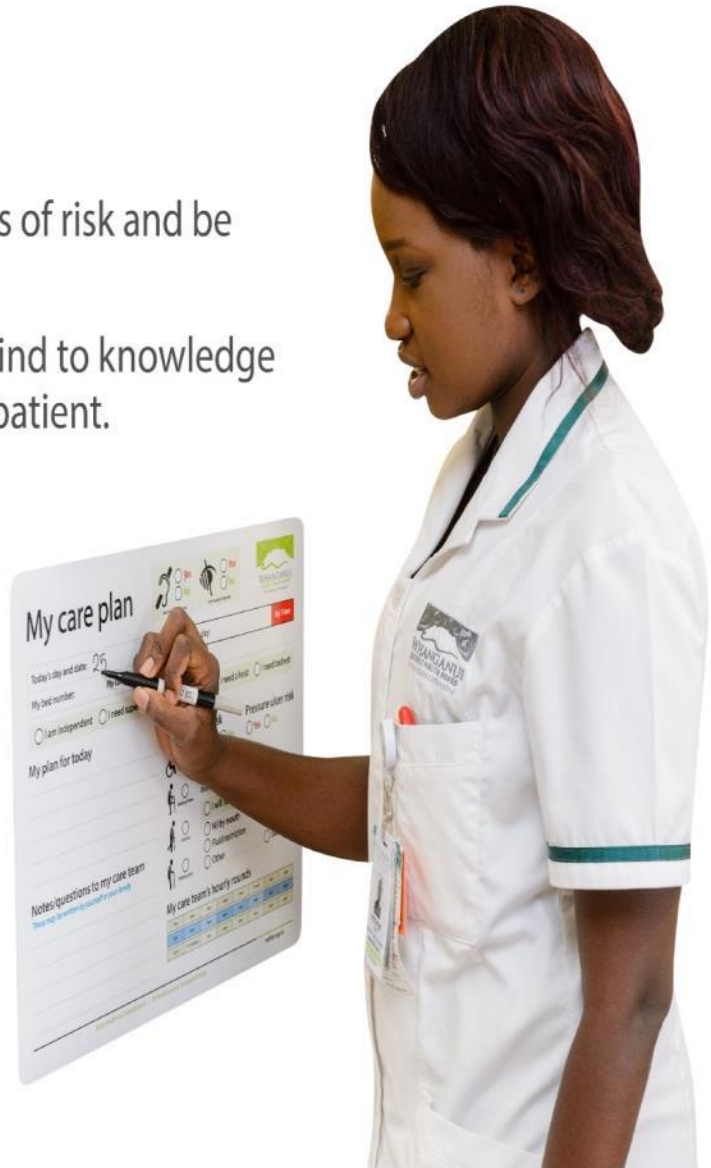
- Focus on the individual & their family/whānau

RISK ASSESSMENT

- Move away from predictive scores
- Universal falls precautions implemented for every patient.

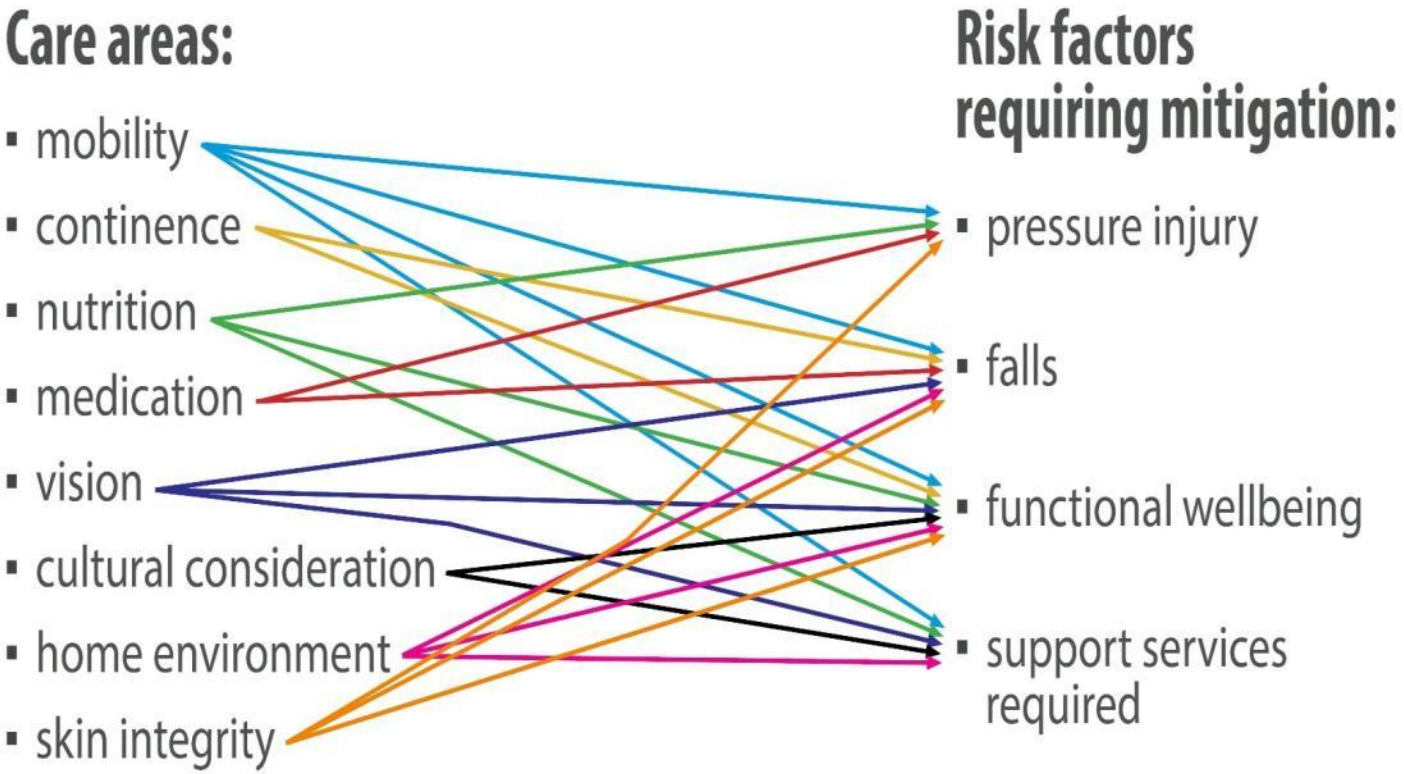
CARE PLANNING

- Falls risks identified must inform the plan of care
- Supported by 'essential cares' for all patients regardless of risk and be audited for compliance
- Must be individualised - if you've read the care plan blind to knowledge about the patient you should be able to visualise the patient.
- Must be formulated with the patient and the family. Remember - the family knows what will work best.
- The care plan is not just one written document but is reinforced on patient boards and signalling charts and should be discussed at every handover, preferably at the bedside.



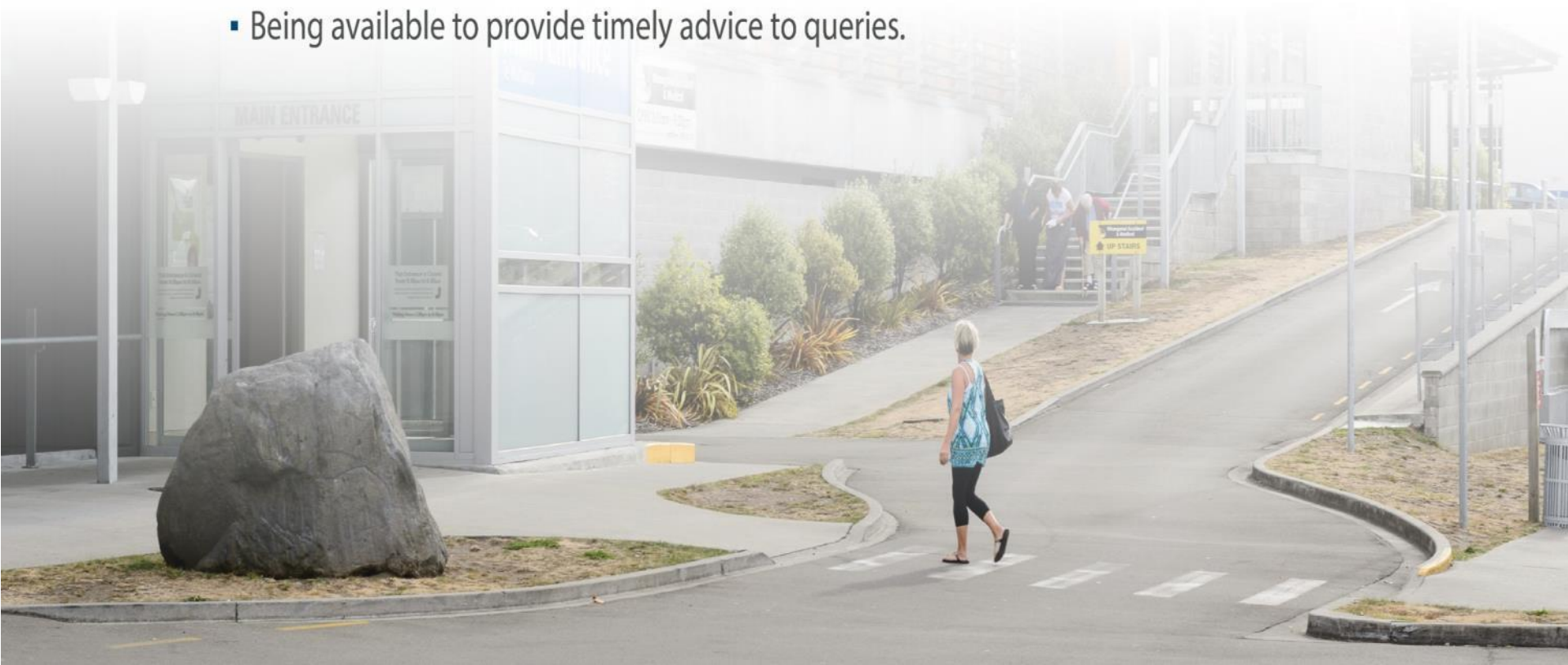
RISK ASSESSMENT

COMMON CONTRIBUTORY FACTORS



VISION TRANSLATED INTO CLINICAL PRACTICE

- Supported by clinical lead visits to all hospitals.
- Individualised focus on that particular hospital's falls prevention problems and success.
- Promoting the latest evidence and prompting practical application.
- Linked hospitals with others who had implemented strategies successfully.
- Being available to provide timely advice to queries.



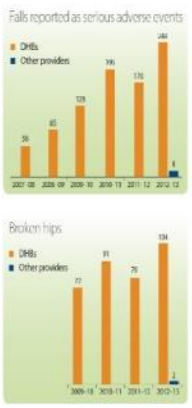
REDUCING HARM FROM FALLS - 10 TOPICS

Ten evidence-based topics (updated in 2017)

- Created a safe & trusted source of information.
- Provided consistent commentary across the sector.
- Eliminated things which did not add value.

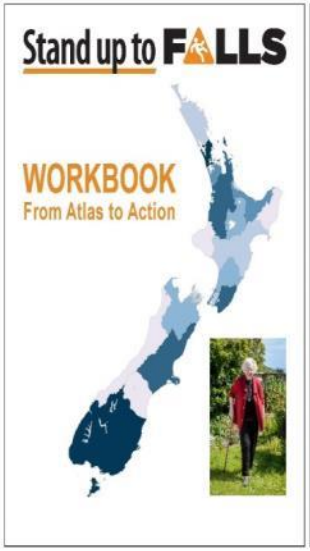
FACE-TO-FACE ENGAGEMENT

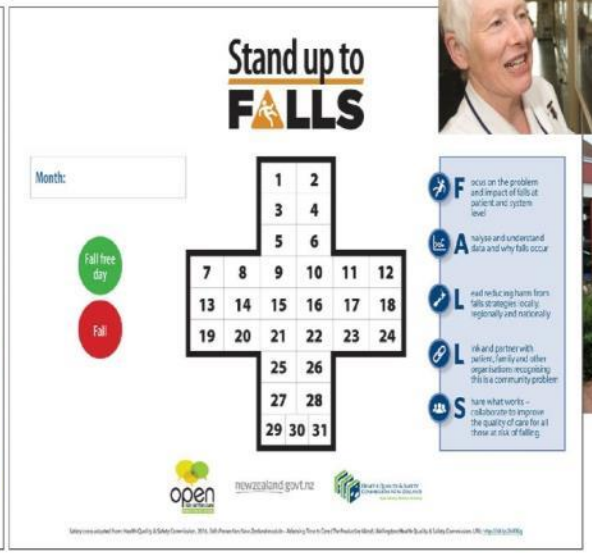
- Site visits by National Clinical Lead
- Meetings at a local and regional level
- Expert Speakers / Webinars
- Engagement with National Directors of Nursing Group, Allied Health and Funding & Planning
- Multiple stakeholder engagement
- Leverage off other priorities
- System approach



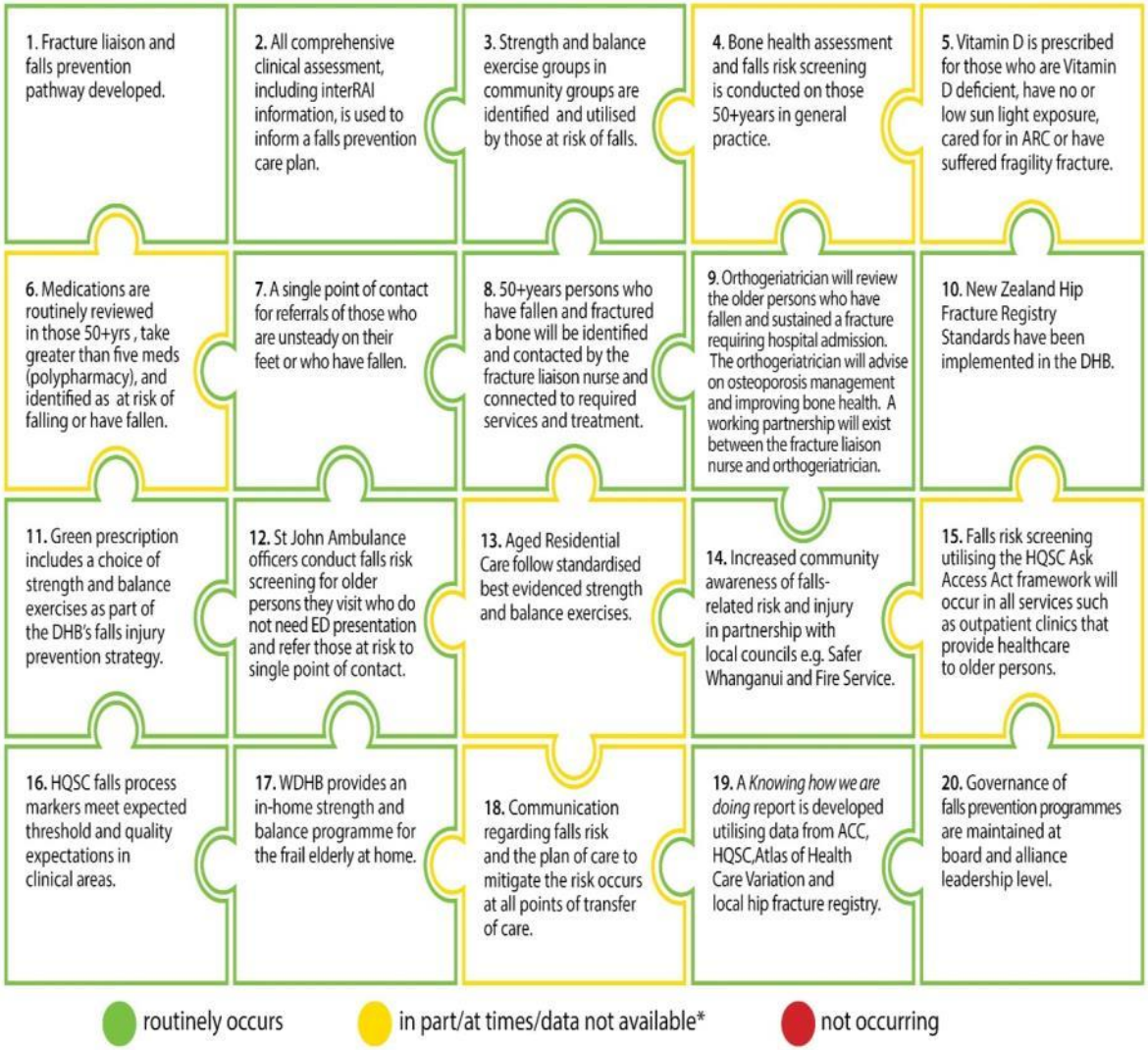
CAMPAIGN FOCUS (annual April Falls focus)

- Falls Hurt
- Falls Prevention is Everyone's Business
- Out Damn Clutter
- Stand Up to Falls
- Live Stronger for Longer.





JIGSAW

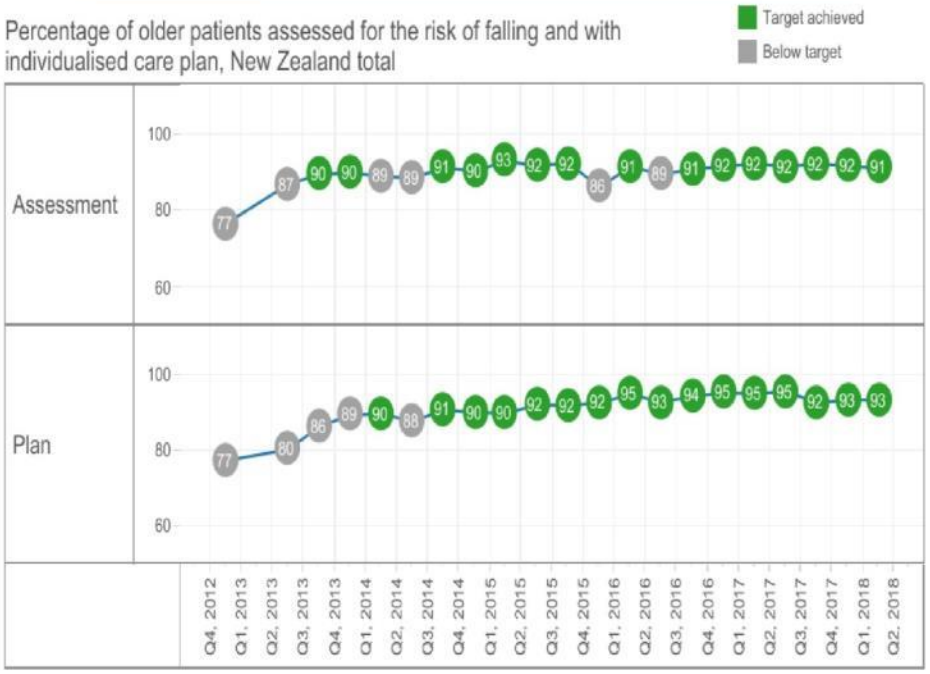

1. Fracture liaison and falls prevention pathway developed.
2. All comprehensive clinical assessment, including interRAI information, is used to inform a falls prevention care plan.
3. Strength and balance exercise groups in community groups are identified and utilised by those at risk of falls.
4. Bone health assessment and falls risk screening is conducted on those 50+years in general practice.
5. Vitamin D is prescribed for those who are Vitamin D deficient, have no or low sun light exposure, cared for in ARC or have suffered fragility fracture.
6. Medications are routinely reviewed in those 50+yrs , take greater than five meds (polypharmacy), and identified as at risk of falling or have fallen.
7. A single point of contact for referrals of those who are unsteady on their feet or who have fallen.
8. 50+years persons who have fallen and fractured a bone will be identified and contacted by the fracture liaison nurse and connected to required services and treatment.
9. Orthogeriatrician will review the older persons who have fallen and sustained a fracture requiring hospital admission. The orthogeriatrician will advise on osteoporosis management and improving bone health. A working partnership will exist between the fracture liaison nurse and orthogeriatrician.
10. New Zealand Hip Fracture Registry Standards have been implemented in the DHB.
11. Green prescription includes a choice of strength and balance exercises as part of the DHB's falls injury prevention strategy.
12. St John Ambulance officers conduct falls risk screening for older persons they visit who do not need ED presentation and refer those at risk to single point of contact.
13. Aged Residential Care follow standardised best evidenced strength and balance exercises.
14. Increased community awareness of falls-related risk and injury in partnership with local councils e.g. Safer Whanganui and Fire Service.
15. Falls risk screening utilising the HQSC Ask Access Act framework will occur in all services such as outpatient clinics that provide healthcare to older persons.
16. HQSC falls process markers meet expected threshold and quality expectations in clinical areas.
17. WDHB provides an in-home strength and balance programme for the frail elderly at home.
18. Communication regarding falls risk and the plan of care to mitigate the risk occurs at all points of transfer of care.
19. A *Knowing how we are doing* report is developed utilising data from ACC, HQSC,Atlas of Health Care Variation and local hip fracture registry.
20. Governance of falls prevention programmes are maintained at board and alliance leadership level.
routinely occurs
in part/at times/data not available*
not occurring

MEASUREMENT APPROACH

QUALITY & SAFETY MARKERS

Prevention fall in-hospital causing FNOF

Falls process markers	Assess vs plan	Falls outcome marker	Saving from prevention



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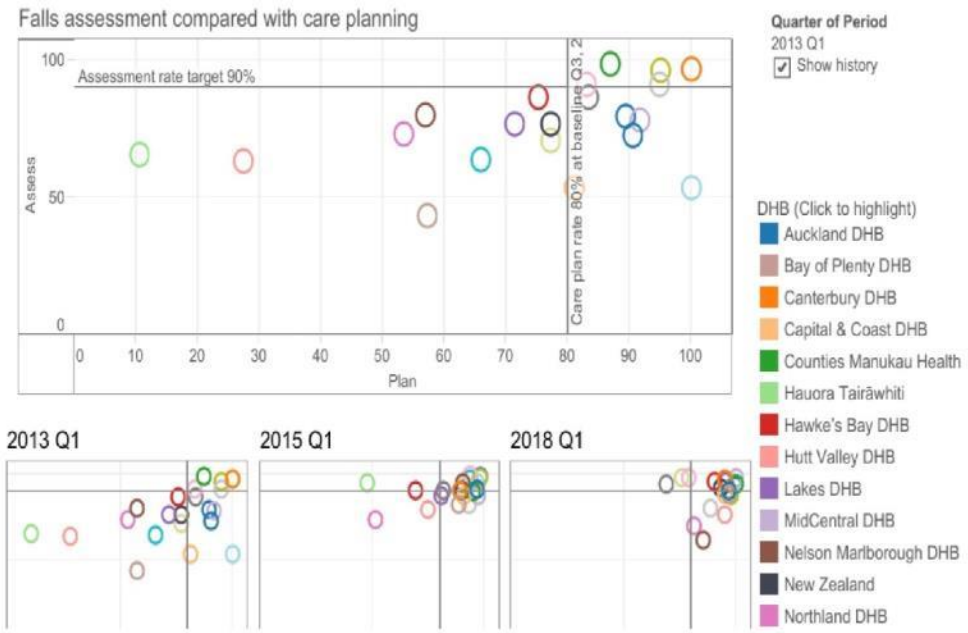

MEASUREMENT APPROACH

QUALITY & SAFETY MARKERS

Prevention fall in-hospital causing FNOF

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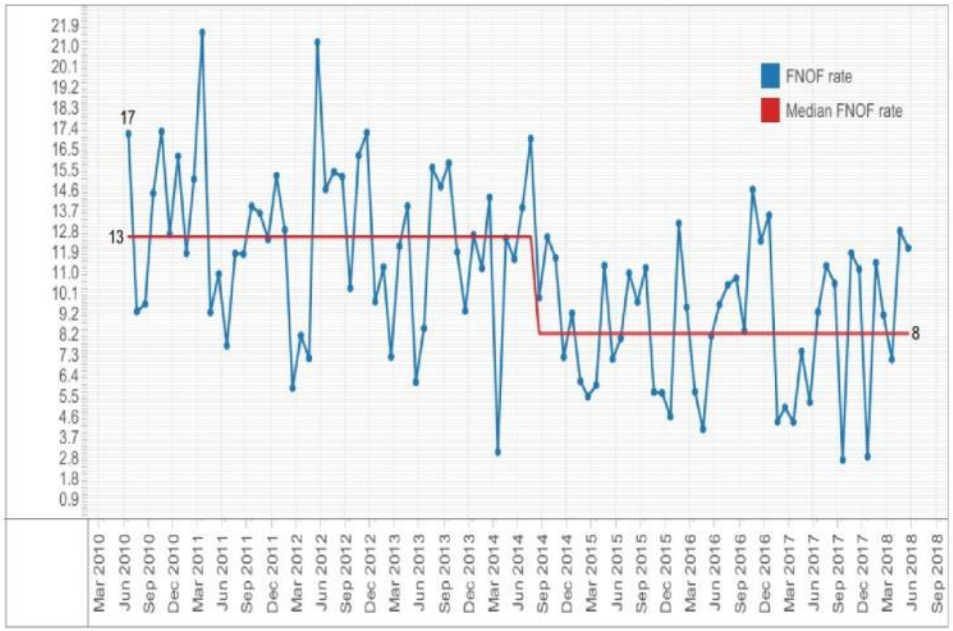
Run chart: Number of in hospital falls causing fracture neck of femur per month per 100,000 admissions



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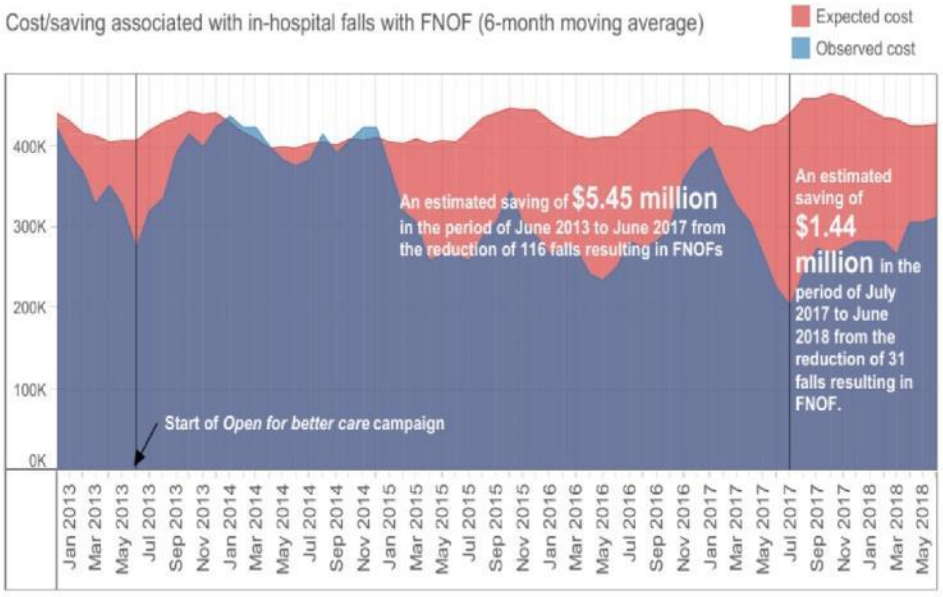
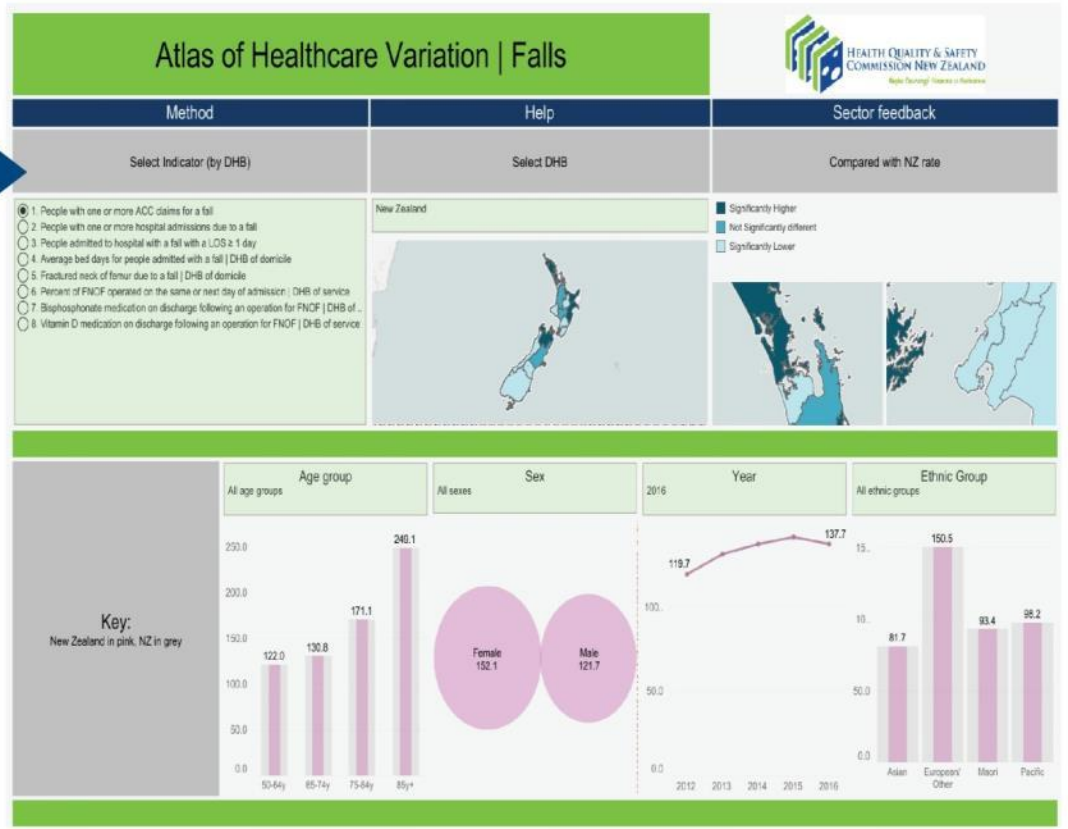


The saving is based on an estimated cost of $47,000 for a fall with a fractured neck of femur.

MEASUREMENT APPROACH

ATLAS OF HEALTHCARE VARIATION



MEASUREMENT APPROACH

ATLAS OF HEALTHCARE VARIATION

CROSS-SECTOR PARTNERSHIPS

ACC
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CROSS-SECTOR PARTNERSHIPS

Sharing a common vision or goal

- Value of older people in our society
- Fall and fracture is an injury & more...
- Sustainable approach to funding Health & Insurer
- Evidence at population level

Common goal to keep Muriel independent & well at home

LIVE STRONGER FOR LONGER
PREVENT FALLS & FRACTURES

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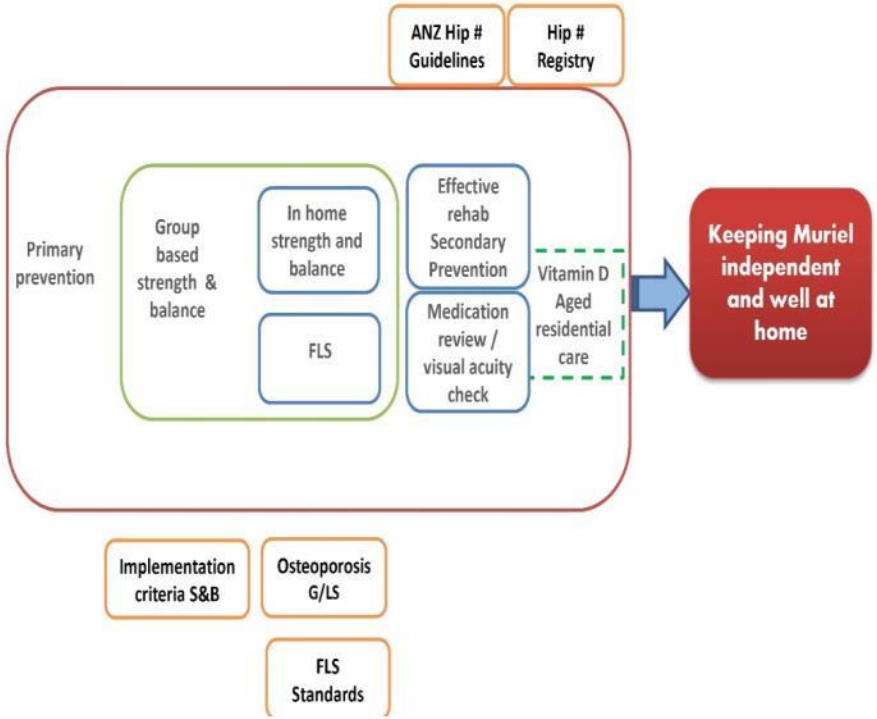
CROSS-SECTOR PARTNERSHIPS

Seeing the whole - aligning activities to mutually reinforce the impact on outcomes



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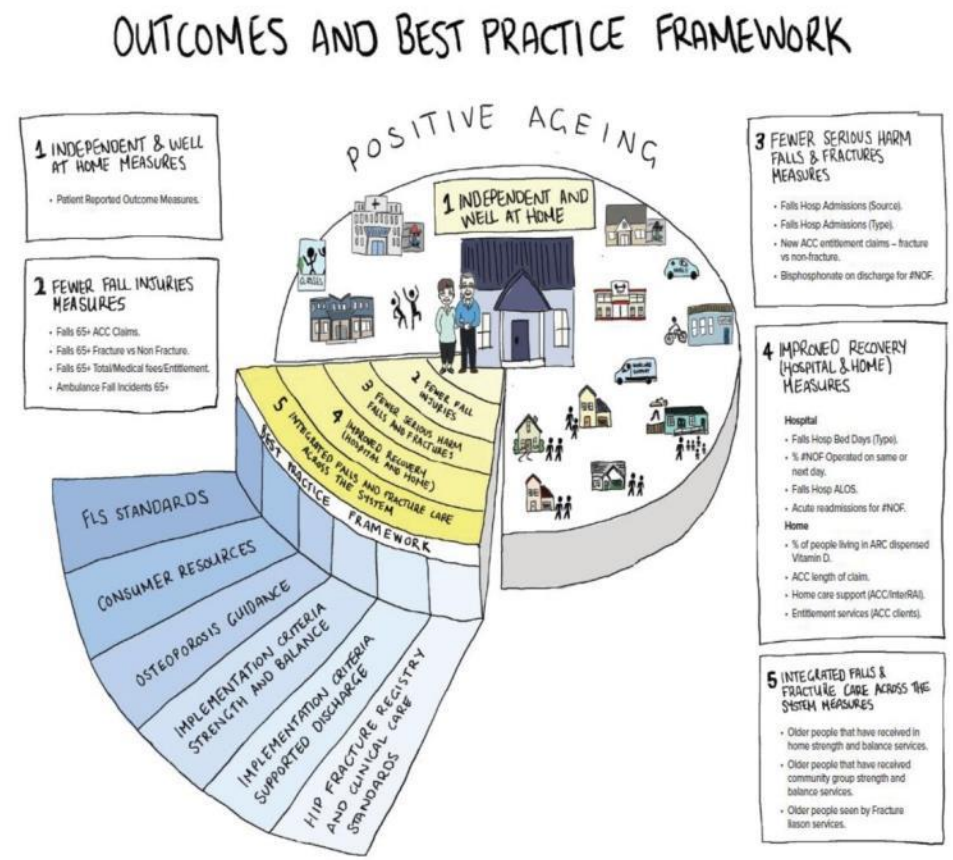
COLLECTIVE OUTCOMES



LIVE **STRONGER** FOR **LONGER**

PREVENT FALLS & FRACTURES

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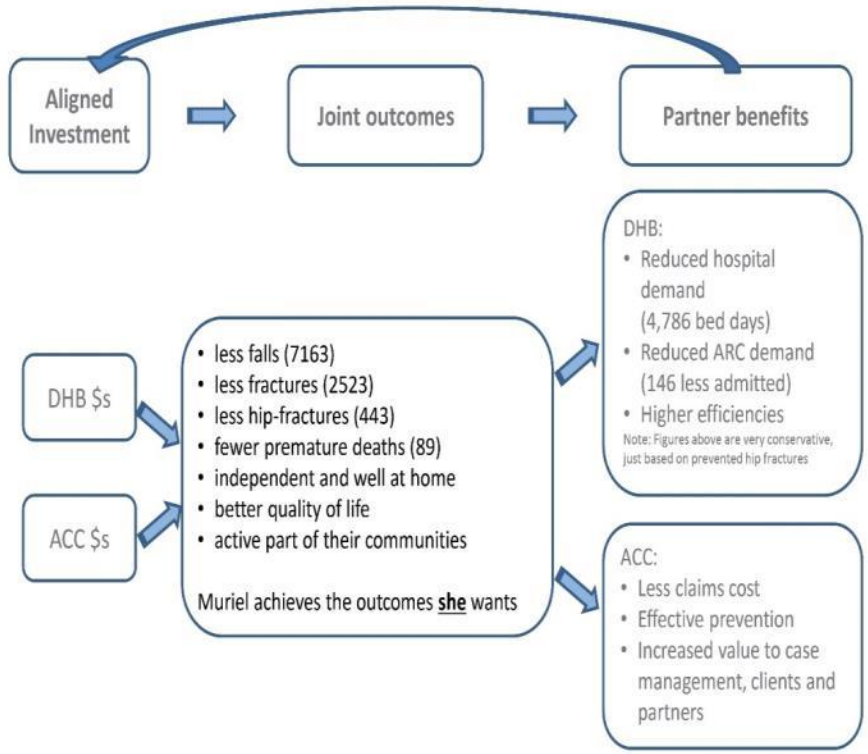
CROSS-SECTOR PARTNERSHIPS

Why does the new approach matter?



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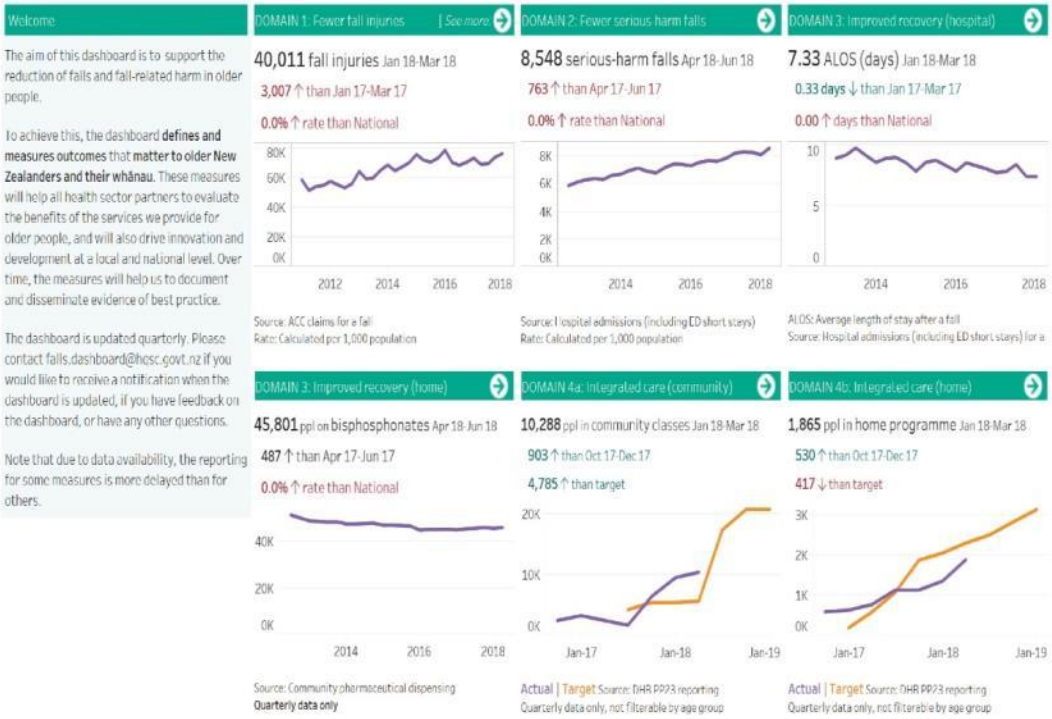
CROSS-SECTOR PARTNERSHIPS

Outcomes dashboard - *www.livestronger.com*



LIVE STRONGER FOR LONGER
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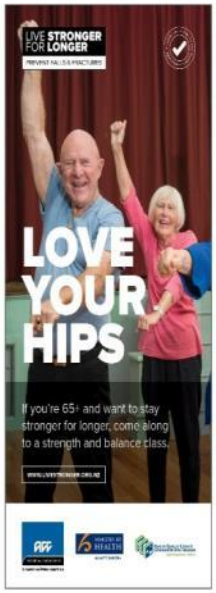
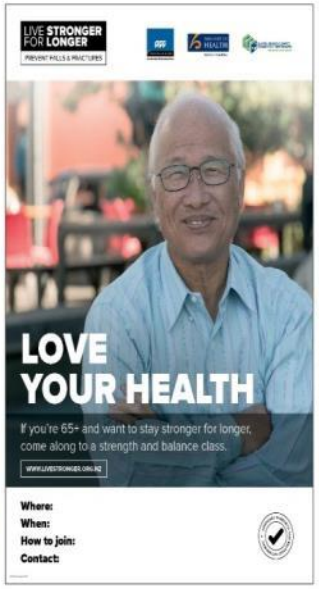
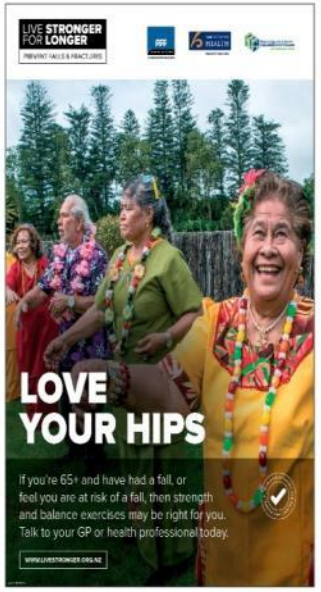
CROSS-SECTOR PARTNERSHIPS

IN SUMMARY:

- Establish common goals based on all perspectives
- Align activities and effort nationally and locally
- Measure outcomes together.
- Work together at multiple levels.







THANK YOU TO OUR PARTNERS


Kaua e rangiruatia te hapai o te hoe;
e kore to tātou waka e ū ki uta.
Do not lift the paddle out of unison
or our canoe will never reach the shore.