National Reducing Harm from Falls Programme
From Atlas to Action

Sandy Blake | Clinical Lead, Reducing Harm from Falls Programme

[Please refer to the Commission website for this video]

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The approach is… individualised care

Every older person is different. Don't try to answer the question 'What will stop older people falling' and just repeatedly ask 'What might stop *this* person falling?'.

Frances Healey RN PhD

The goal is to understand the older person's risks and plan with them and their families and whānau to prevent falls in hospital, residential care, home and in the community

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Our journey at a glance

2012

Scoping and approval process

- Falls prevention approved as the first focus area *Open* campaign

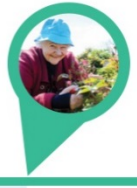
Foundational scoping papers

- 'Scoping the cost of falls'
- 'Falling cost the case for investment'

Programme infrastructure and planning

Expert advisory group and clinical lead appointed

2013



Aprils Falls campaign launched

- Theme: Falls prevention is everyone's business and
- Falls hurt – building the momentum and creating the change platform

Open for better care campaign launched with falls as the first campaign topic

ARC mini collaborative July – Sept 2013

2014

April Falls 2014 launched

Theme: Regional connections and approaches

- Northern region and *First, Do No Harm* – falls related to bedrails.
- Midland region – safe footwear.
- Central region – signalling systems for safe mobilising.
- South Island Alliance – safe care environments.

Expert Dr Frances Healey visits regional gatherings

ARC mini collaborative project completed and evaluated

2015

April Falls 2015 launched

Theme: Regional connections and approaches

Extension of programme into primary care

Stay independent toolkit for use by clinicians in primary care

Visiting experts:

- Prof Lindy Clemson
- Dr Anne-Marie Hill

Summative evaluation commences

2016

April Falls 2016 launched

Theme: Prevention, review and learning from falls

Ongoing engagement/quality improvement resources developed for age related residential care and the hospital

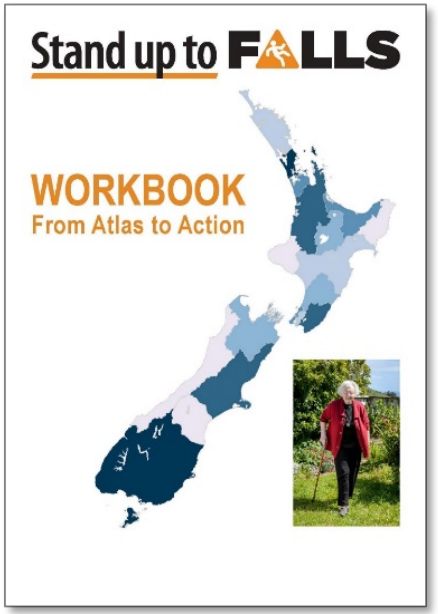
Collaboration with ACC and Ministry of Health to promote an integrated approach to falls and fracture prevention and management

Resources developed:

- Foundational quality improvement toolkit for use in age related residentail care
- Adapting the NHS/Queensland Releasing Time to Care (The Productive Ward) toolkit for the NZ environment.

Summative evaluation commences

- Atlas data – local action – supported by educational webinar
- Eight indicators
- Interactive workbook
- Informs planning and improvement
- Supports the aims of the programme – integration
- Links to falls resources and tools



Second edition

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Atlas – the burning platform

Atlas data for 2015 confirms that for people aged 65 and older, falls are a major cause of injury:

- 110,300 had at lease one ACC claim in 2015 due to all, in other words, 300 ACC claims were accepted every day
- 20,580 were admitted to hospital after a fall
- 3,404 of these admissions were for a fall-related hip fracture

Atlas informs Practice Change ….

Worksheet (page 8)

Average bed days for people +50 admitted with a fall.

Links to MOH system level measurement framework: acute hospital bed days per capita (that is, using health resources effectively)

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Atlas informs Practice Change

Worksheet (page 10)

Percent hip fracture 50+ operated on the same or next day of admission.

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How do we use the data to inform practice and improve care.

By year 2013-15 in our DHB area, percentage and count of hip fractures operated on the day of admission or the next day were:

Year	National mean	Our Whanganui DHB area	
	Percentage	Count	Percentage
2013	71.6	**40**	76.9
2014	74.4	**58**	96.7
2015	76.4	**52**	89.7

Link to integrated programme approach: Hip Fracture Registry implementation

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By age group in our DHB area in 2015
average bed-days for people 50+ admitted with a fall were:

Age group (2015)	**National mean**	**Our Whanganui DHB area**	
	Average bed-days	Count	Rate per 1000
50 - 64 years	4.5	478	5
65 - 74 years	8	581	5.6
75 - 84 years	11.6	1076	8.2
85+ years	14	2400	14.5

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By gender in our DHB area in 2015
average bed-days for people 50+ admitted with a fall were:

Gender (2015)	National mean	Our Whanganui DHB area	
	Average bed-days	Count	Average bed-days
Female	10.9	2748	8.9
Male	9.2	1787	9.5

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Links indicators to Hip Fracture Registry

- Provides a “helping hand” to promote whole of system approach/integration.
  - 76 percent of people with a hip fracture are operated on the same or next day of admission
  - 21 percent of people received bisphosphonate medication on discharge following an operation for hip fracture

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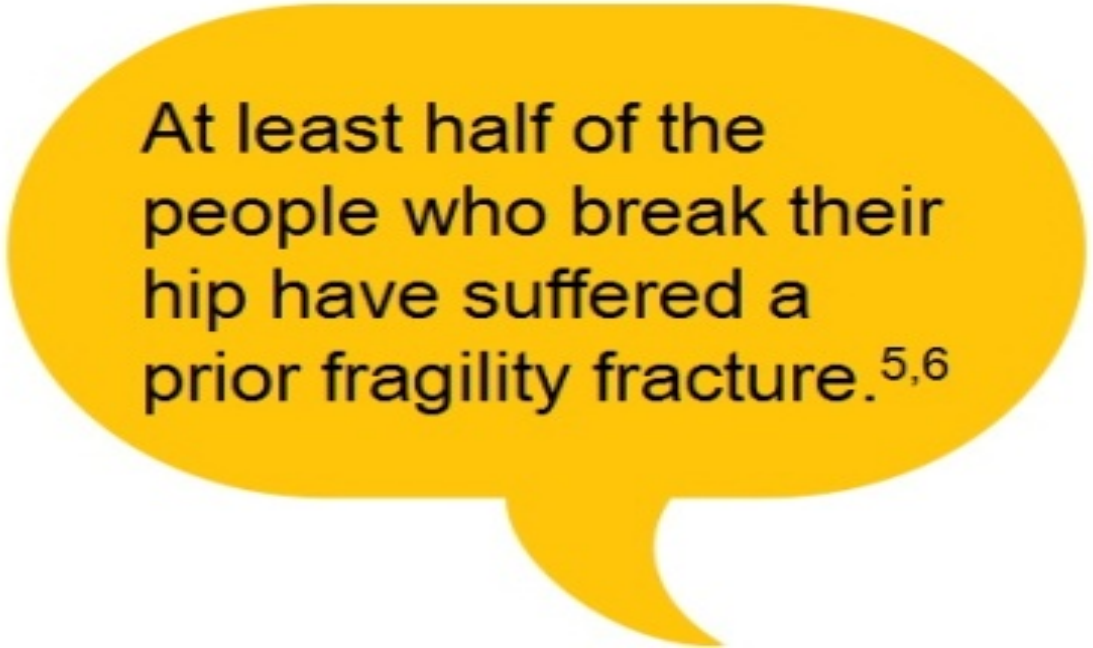
Supports Fracture Liaison Services



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Engagement and Reach -website

Page	Total page views
Health Quality Evaluation	850
Atlas of Healthcare Variation	679
ASH adult	55
ASH child	9
ASH older people	11
Asthma	107
Cardiovascular disease	74
Demography	30
Diabetes	128
Falls	3375
Gout	98
Maternity	40
Mental health	105
Opioid	154
Polypharmacy	101
Suicide (hidden)	7
Surgical procedures	57
Trauma	32
Well child	49

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Atlas drives integration

10 TOPICS
in reducing harm from falls

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Hāpai ake te taiora

TOPIC 10 An integrated approach to falls in older people: **what is your part?**

Increased longevity can be acknowledged as a public health achievement, but it is equally important to address the challenge of adding 'life to years'. This includes reducing the impact falls and resulting injuries have on wellbeing, coping and independence. Since the evidence for effective fall prevention programmes is well established, the next step is wider implementation. In this, the last of 10 Topics, we ask you to look at the part you can play within your sphere of influence and networks to use this evidence to improve practice and service provision.

Supporting Topic 10's themes – coordinated care, patient experience and quality of care – are two required readings that make this a learning activity for professional development hours. The first reading looks at the meaning of person-centred care for people with multiple health problems. The second required reading conveys practical wisdom for quality improvement projects drawn from real-life experience.

What are we trying to achieve?

Falls are the leading cause of injury for older people, and account for half of all health lost due to injury (both years lived with disability and early death).[1] Falls in older people impact at every level – from individuals and their families/whānau to government spending in health and community-based services.[2]

According to the World Health Organization, fall prevention programmes are effective when they reduce the:

- **risk of falling** or the number of individuals who fall – measured as whether a person has any falls (or no falls) within a defined period of time
- **rate of falls** or the total number of falls in a particular time period (one person may not fall at all and another may fall more than once) measured as, for example, falls per person/year or falls per 1000 bed/days.

Reducing the risk of falling and rate of falls will reduce fall-related injuries, and effective programmes also seek to reduce the **severity of fall-related injuries**.[3]

The intent of our national Reducing Harm from Falls programme goes beyond preventing falls and reducing severity of injuries. It also encompasses the clinical care and wider support that **promote the best possible outcomes** for those who have suffered harm related to a fall.

Falls in older people: where to start?

The Triple Aim has been widely adopted as a framework for designing sustainable and integrated health care services intended to be people-centred, equitable, accessible, safe, effective and efficient.[4,5] These simultaneous and interdependent aims need to be balanced:

- improving the quality of health care and patient experience
- better overall health of a defined population
- cost effectiveness in service provision.[6]

A whole-of-system approach is needed for the population of concern – older people – a group ranging from those who are generally healthy and active, to those who are frail or live with complex chronic conditions or dementia, to those at the end of life.[7,8] From a fall prevention perspective, subgroups of this population can be targeted for interventions ranging from cost-effective, population health-based primary prevention (such as home or community-based balance and strength-exercise programmes) to high-cost treatment and rehabilitation (such as orthogeriatric care after hip fracture).

What an integrated approach means

Integrated care is seen as critical to supporting older people in living safely and independently at home, helping them avoid admission to hospital and recovering after discharge from hospital.[9]

Unconnected and fragmented services impact negatively on patient outcomes and experience of care, but integrated care ensures that services are coordinated around the needs and goals of the older person, their families/whānau and other carers.

... those involved with planning and providing services must impose the user's perspective as the organising principle of service delivery.[10]

Integration across the system and organisations happens at several levels and/or dimensions:

- clinical and service integration when care and support are planned and delivered for a patient and their family/whānau, including the support that promotes self-care and independence (micro level)
- organisational and professional integration through networks, alliances and partnerships (meso or middle level)

Continued over

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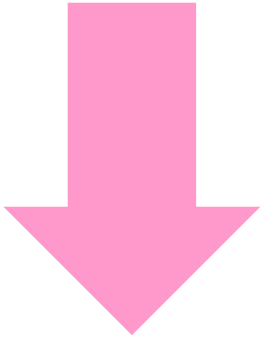
Harm reduced/cost savings
July 2013 to December 2016



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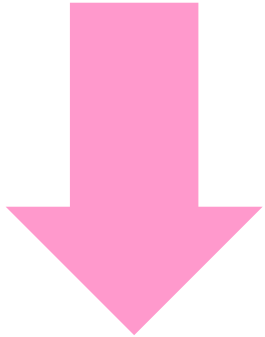

NZ$4 million

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But it's even bigger than that

On average an avoided broken hip gives an extra 1.6 years of healthy life…

…this adds up to an additional 140 years of healthy life, worth NZ$25 million

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Thank You

Falls are Everyone's Business

www.hqsc.govt.nz reducing harm from falls

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