



Slips/Trips/Falls –*the CIS Perspective*

Irene O' Byrne-Maguire
Clinical Risk Advisor
with CIS remit for Slips/Trips/Falls
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Aims of presentation

- What is the Clinical Indemnity Scheme about?
- Where are we at with respect to Slips/Trips/Falls
- What is needed to effect change?
- How do we get there?



Organisational Structure

National Treasury Management Agency
Manages National Debt

State Claims Agency

Manages claims against public bodies on behalf of the State
Est. under NTMA(Amendment) Act 2000. (Start date : 3 December 2001)

Clinical Indemnity Scheme

Manages claims/ risk management in Public Health sector
Est. 1 July 2002; Delegation Order made: 18 February 2003.
(S.I. No. 63 of 2003 National Treasury Management Agency (Delegation of Functions) Order 2003, amend 2007)



Enterprise Liability



We're in this together.



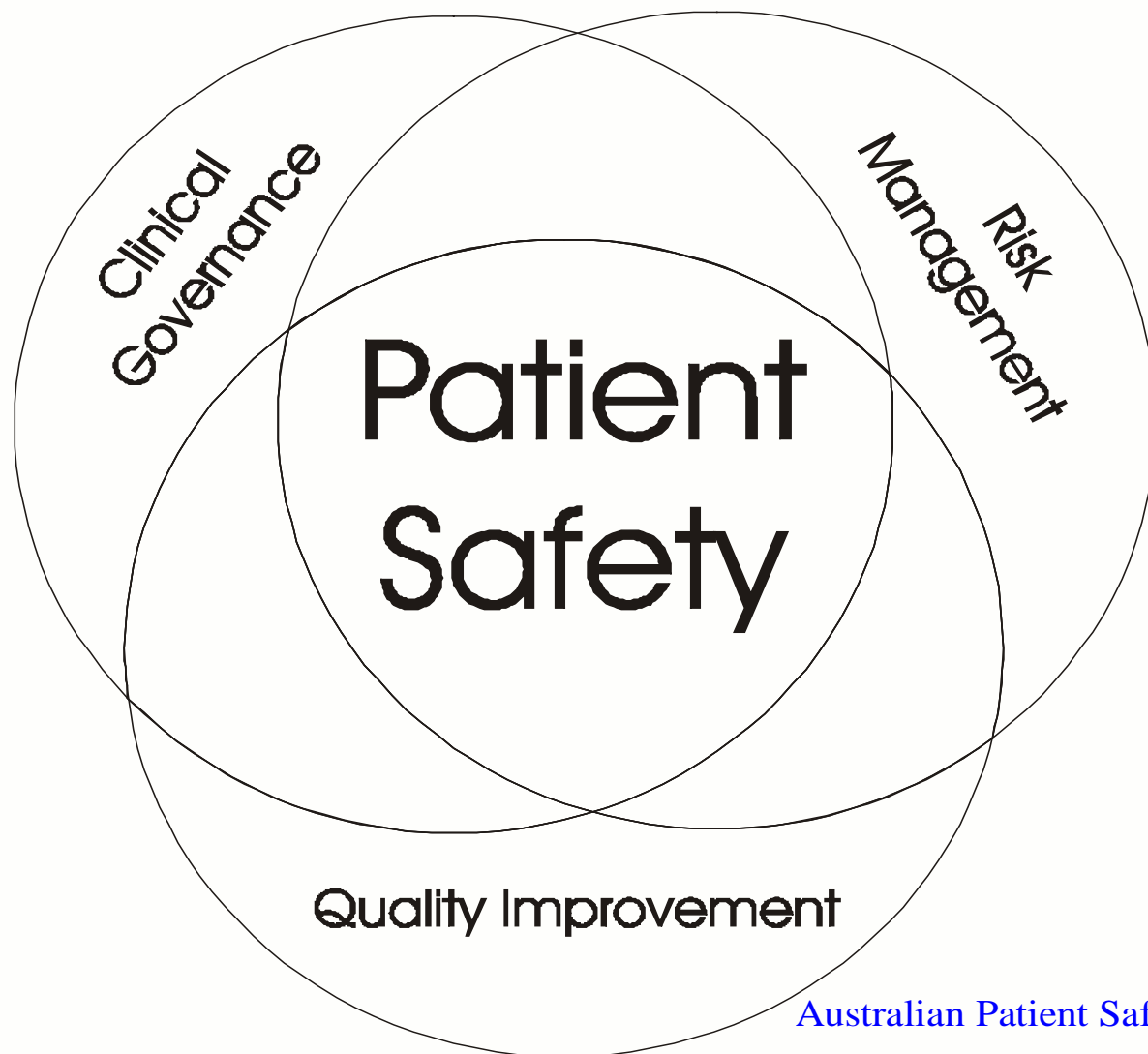
Clinical Indemnity Scheme (CIS)

Objectives

- To drive and support a patient safety culture
- To reduce the number of clinical claims
- To manage clinical claims in a cost-effective and timely manner



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Australian Patient Safety Foundation

Attributed to Hippocrates



How does CIS drive and support patient safety?

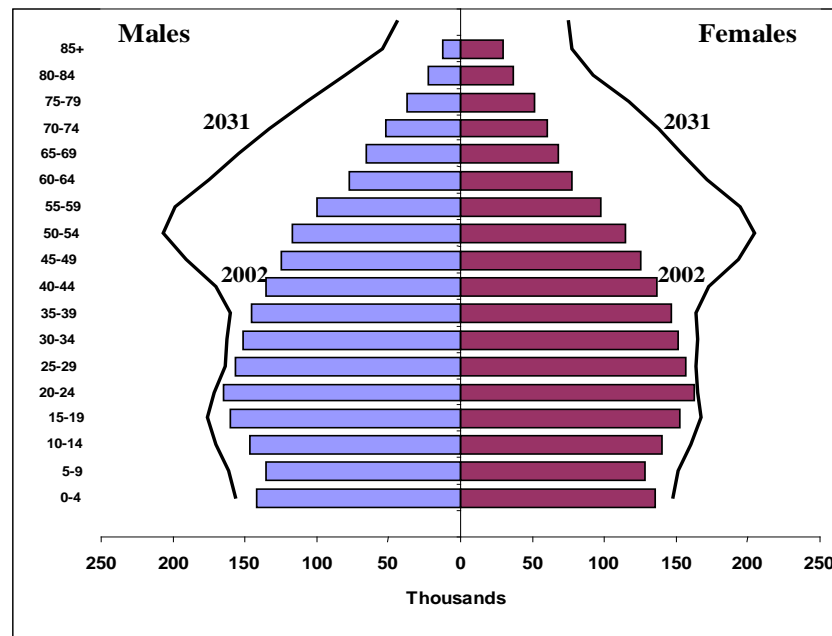
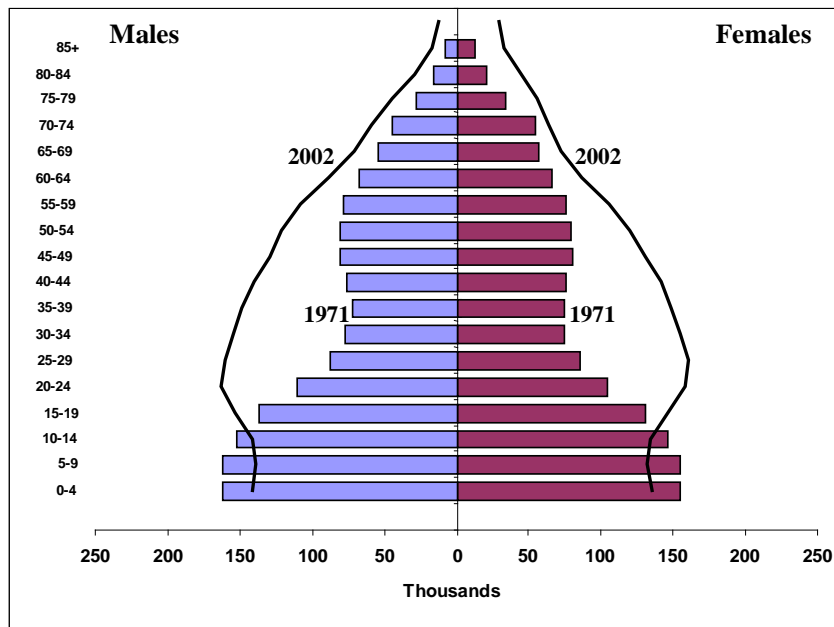
- Collection and analysis of incident/near-miss data
- Closed claims analysis
- Training and education
- Collaboration with educational/professional bodies, statutory and voluntary organisations.



Where are we at with respect to Slips/Trips/ Falls?



Scale of the Problem: Demography

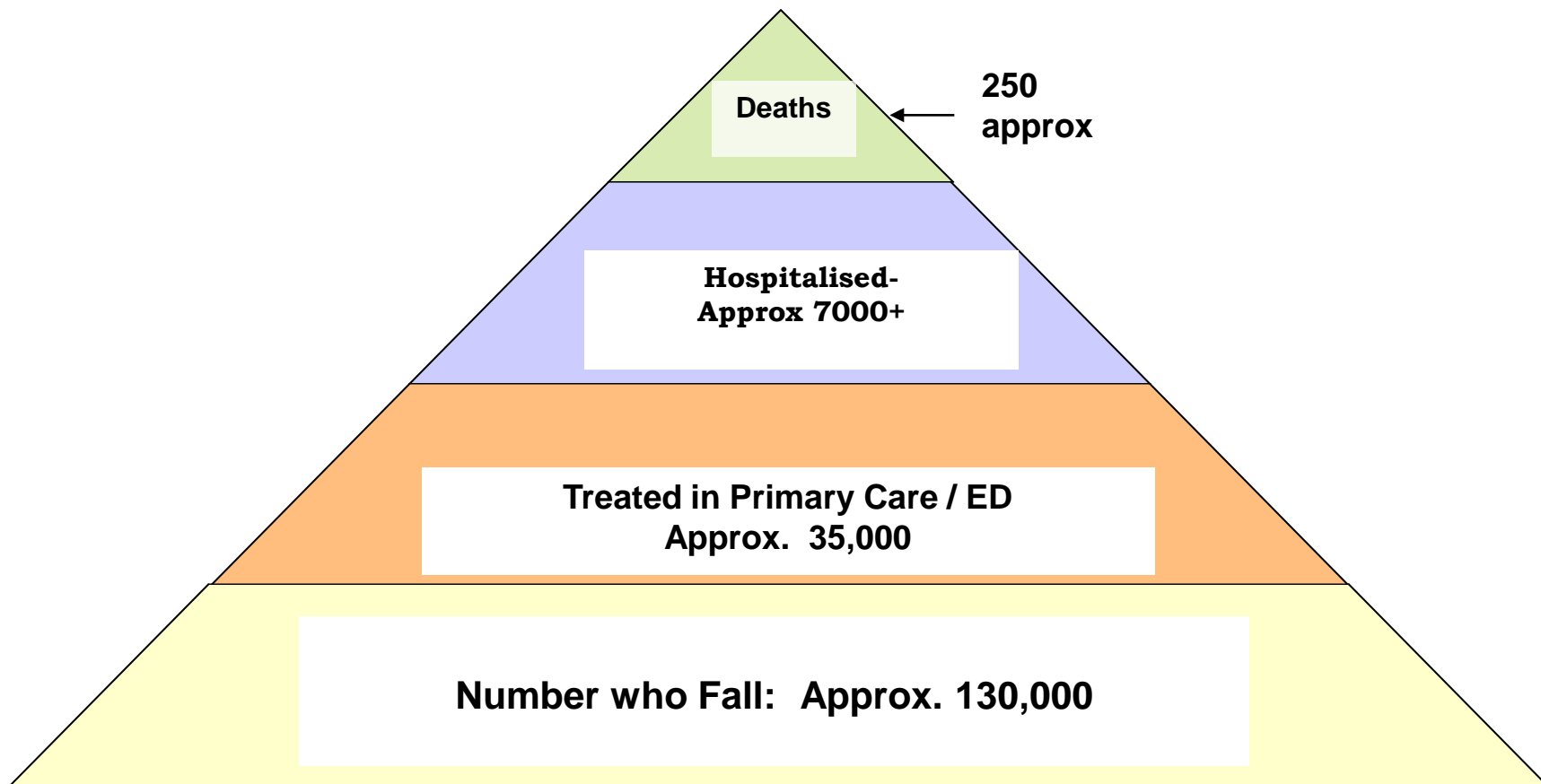


Fall related injuries are more common as we age and live longer. By 2031:

- Population will be 5 million
- One million 65 years and over – biggest increase in 80+ age group
- 50% in 80+ age group fall each year
- Older women are 65% of 80+ age group- they are at greatest risk.



Annual Health Burden of Falls for Older Irish People



Total Population >65 = 468,000 or 11% (2006)



Fall Claims from 2004 -2010 *as of 18th Oct*

- Falls Claims =129 (€5.4m total incurred)
- 33 falls related deaths *where outcome included*
- 38 falls related fractures *where outcome included*



Burden to the Economy

If current trends continue estimated costs will be:

€520 - €551 million by 2010
€922 - €1077 million by 2020
€1587 - €2043 million by 2030

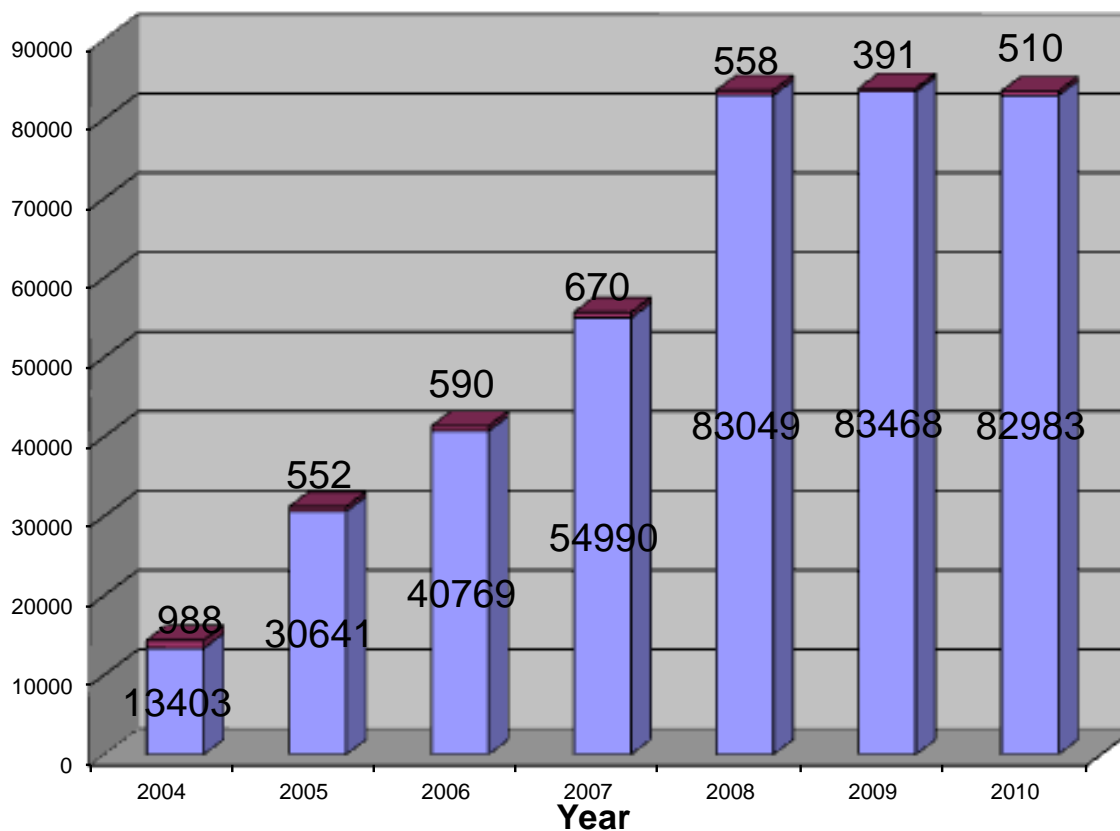
Brenda Gannon, Eamon O'Shea , Eibhlin Hudson
Irish Centre for Social Gerontology, NUI, Galway (2006)



389,813 clinical incidents/“near misses” logged on the live system to end of Dec 2010.

Clinical events reported per year

Incidents Claims

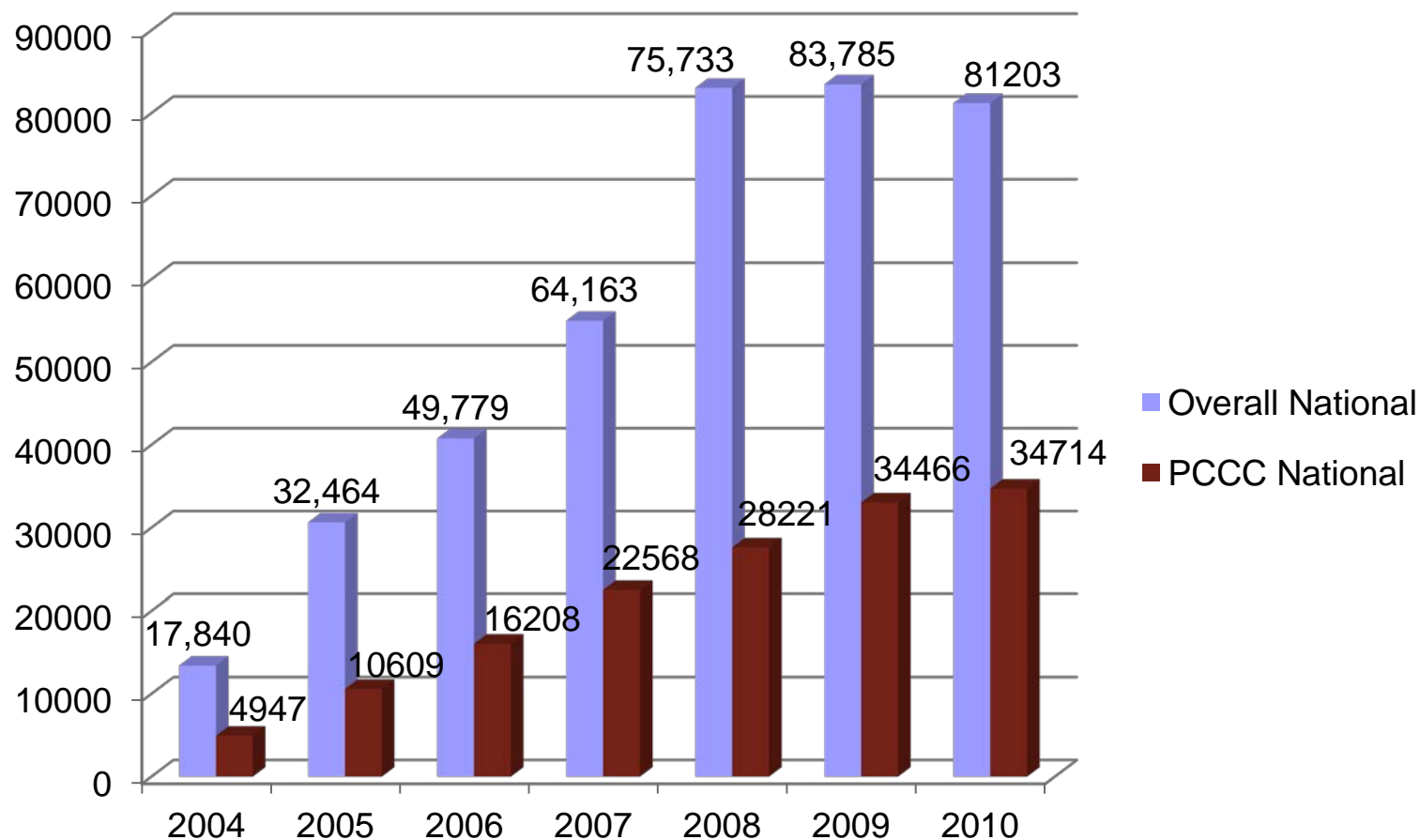


3,522 of these events have gone on to become claims



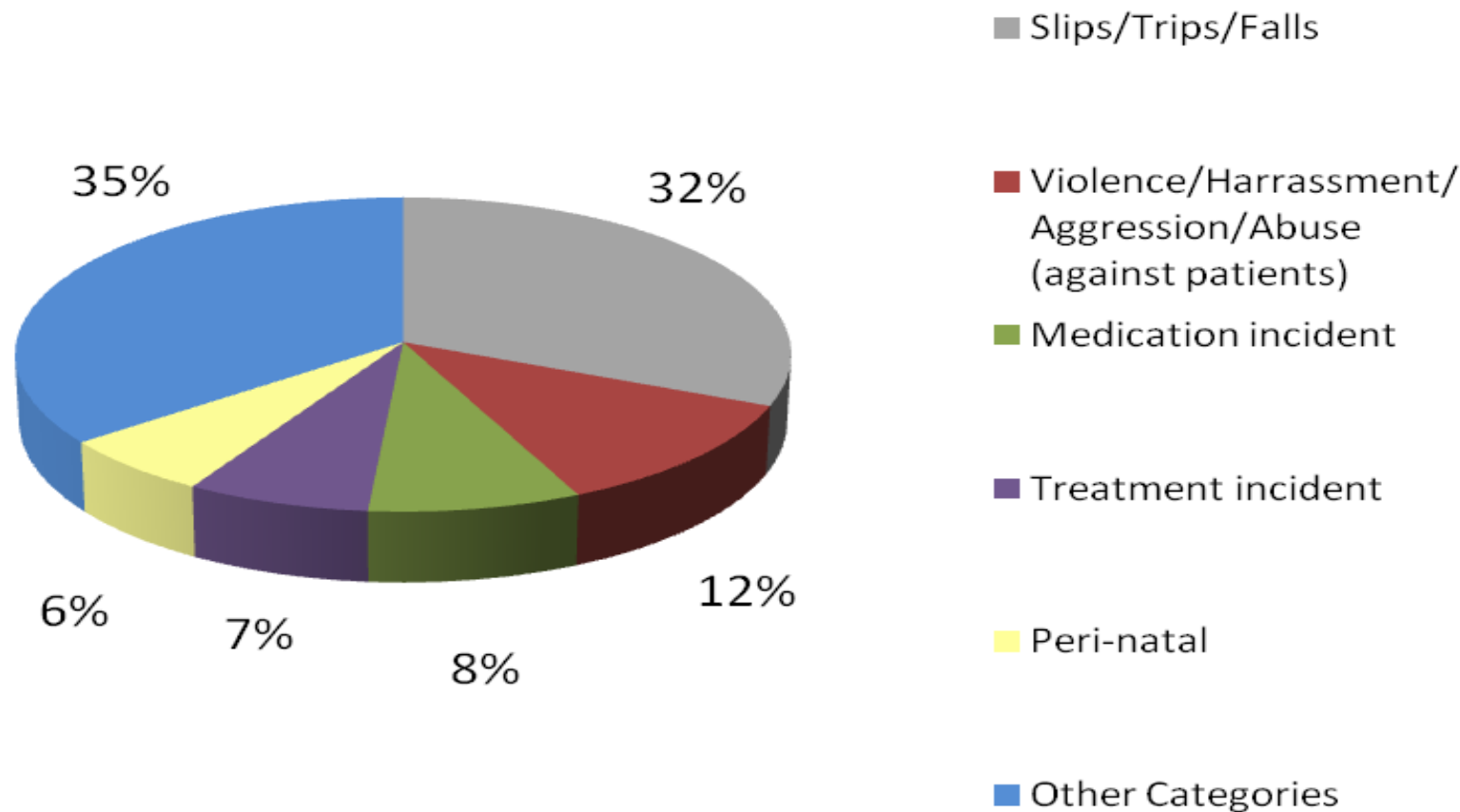
National & PCCC 2004-2010

(as of 11th April 2011)



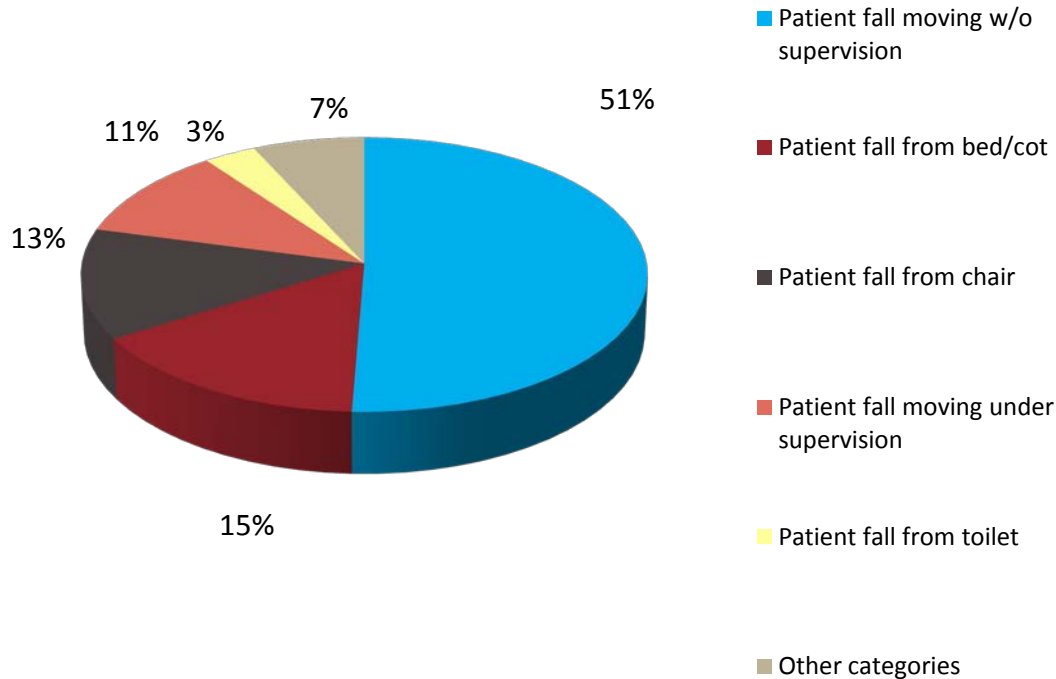


Clinical Incidents/near-misses reported to the CIS (Jan-Dec 2010) N=83,483 *as of 13th May 2011*





Slips/Trips/Falls reported to the CIS (Jan-Dec 2010)

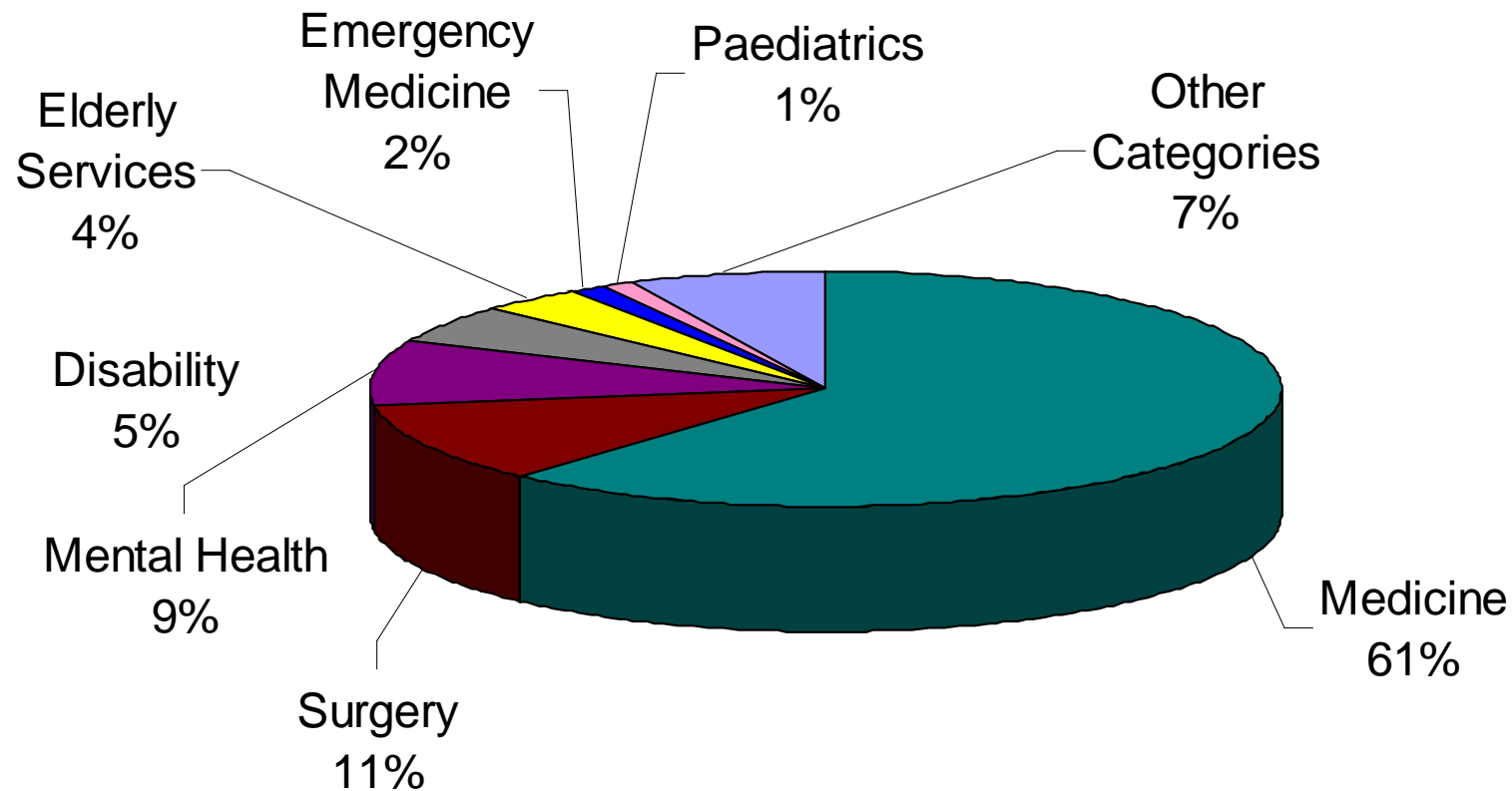


Slips/Trips/Falls events

Incident Type (gen)	Count
Patient fall moving w/o supervision	13,314
Patient fall from bed/cot	4,065
Patient fall from chair	3,417
Patient fall moving under supervision	2,827
Patient fall from toilet	851
Other categories	
Patient fall from commode	445
Patient fall from trolley	115
Patient fall from hoist	30
Not specified	1,224
Grand Total:	26,288



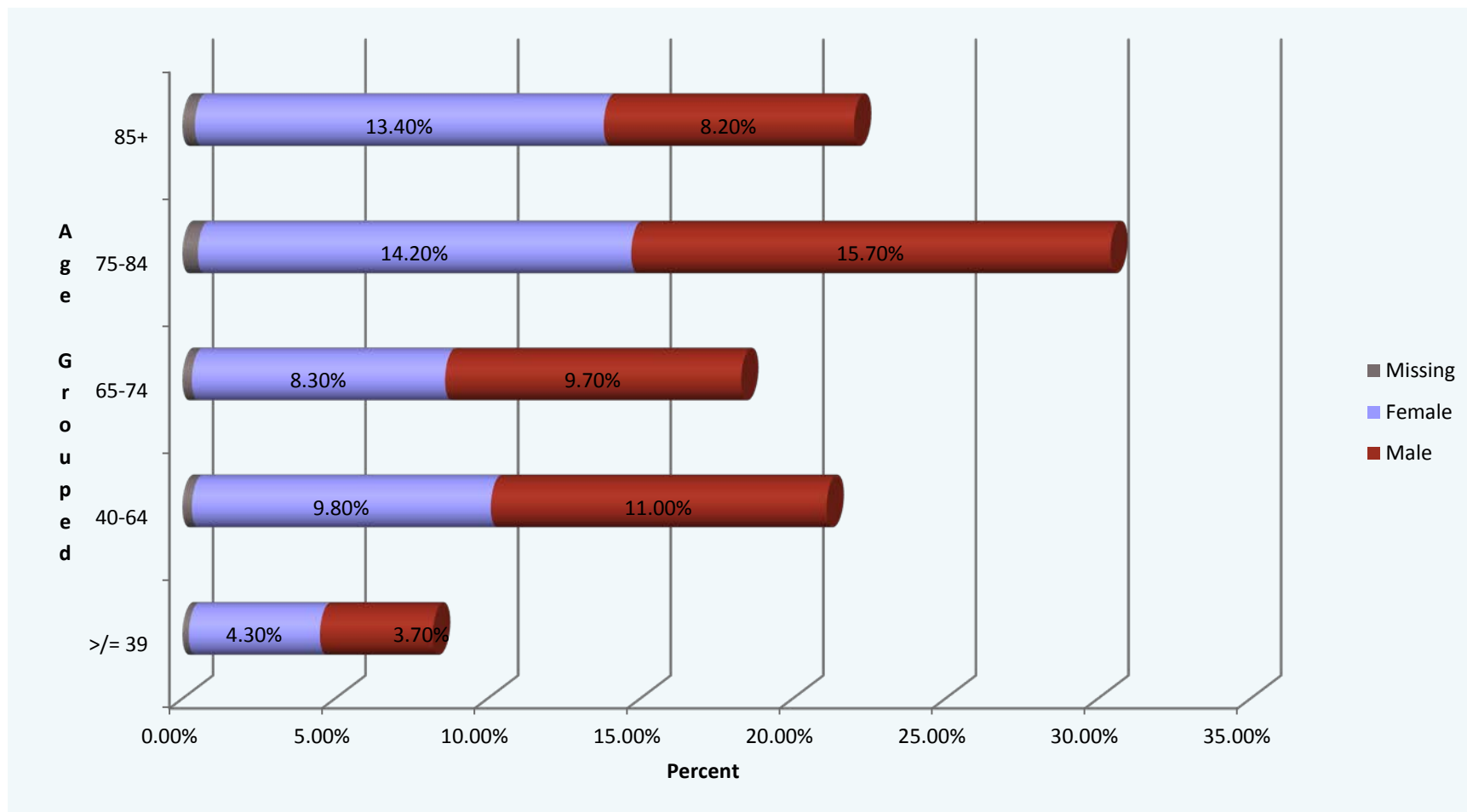
Slips/Trips/Falls Events created 04-09 by Specialty



93.4 % of reports from Nursing/Midwives



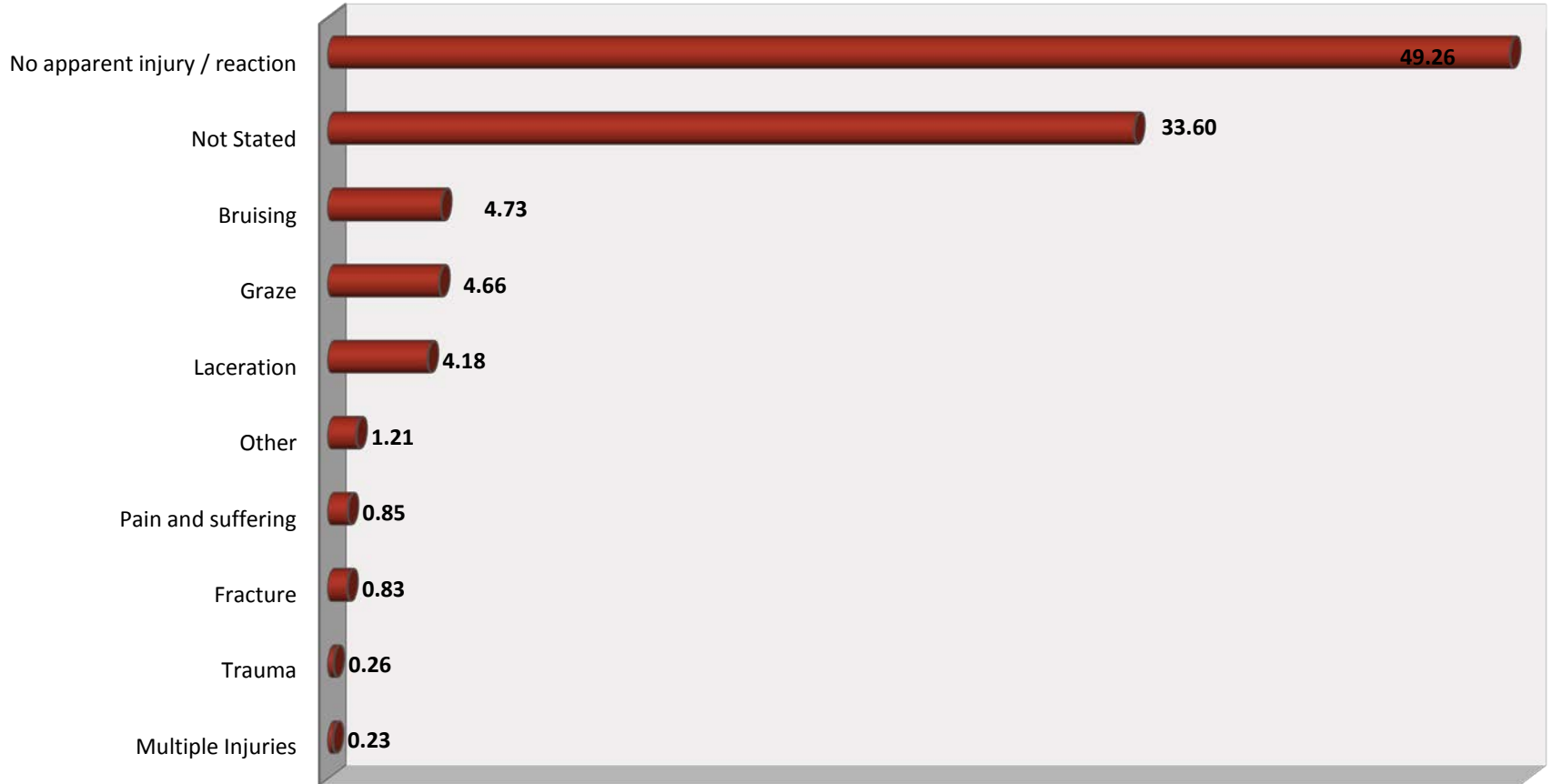
Age grouped by gender -2010



- Missing
- Female
- Male



Outcome recorded in 66.4% of events -2010





Key findings Nationally-STARSWeb 2004-2008

76.8 % falls reported outcome- “*No apparent injury/reaction.*”

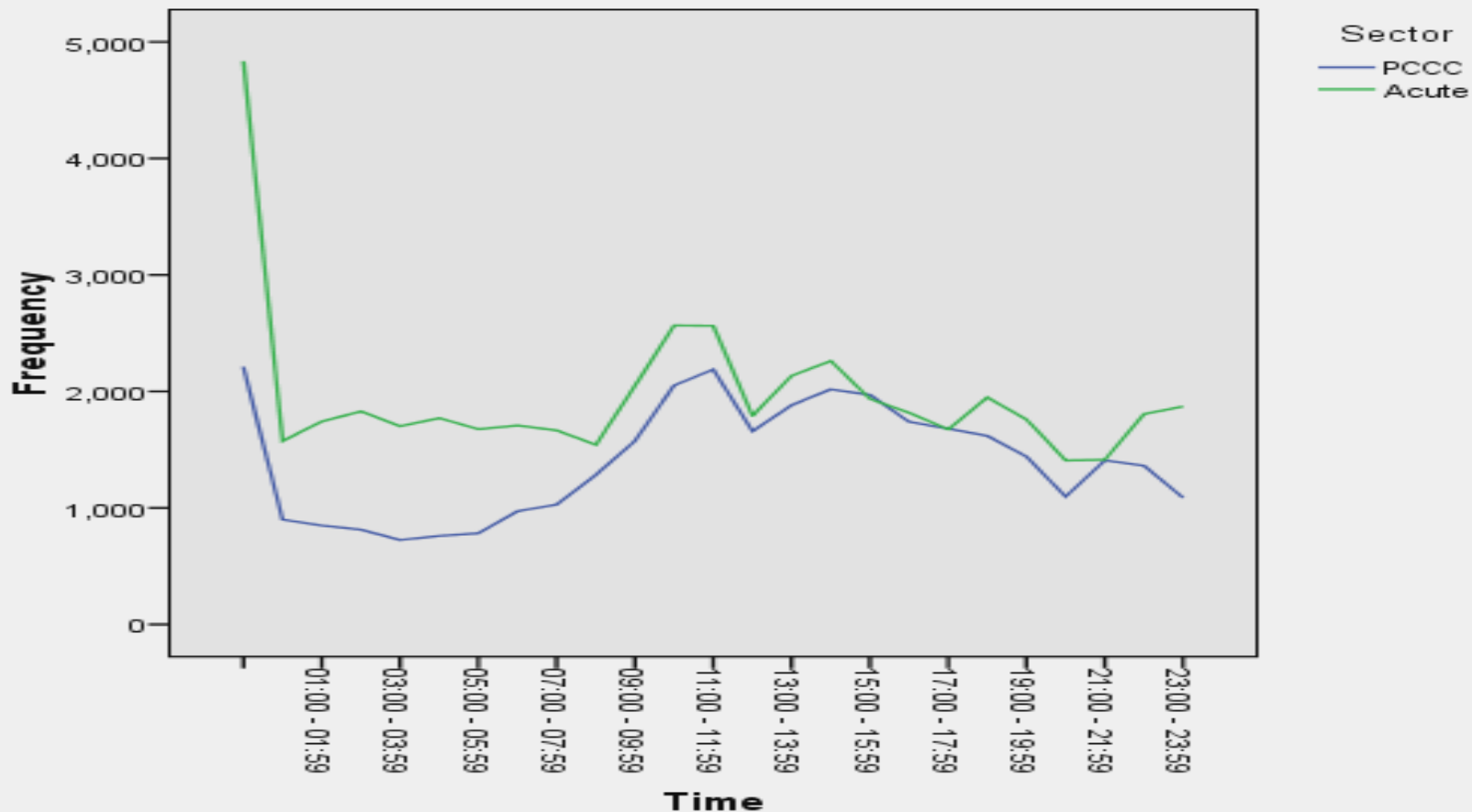
Outcomes risk rated High/Moderate :

- **pain & suffering (76.4%).**
- **fracture (68.6%),**
- **laceration (14.9%),**
- **bruising (11.5%),**

<http://www.lenus.ie/hse/handle/10147/81015>



Frequency of Falls events by Time of Day and Sector from 1st Jan. 2004 - 30th Sept. 2008.



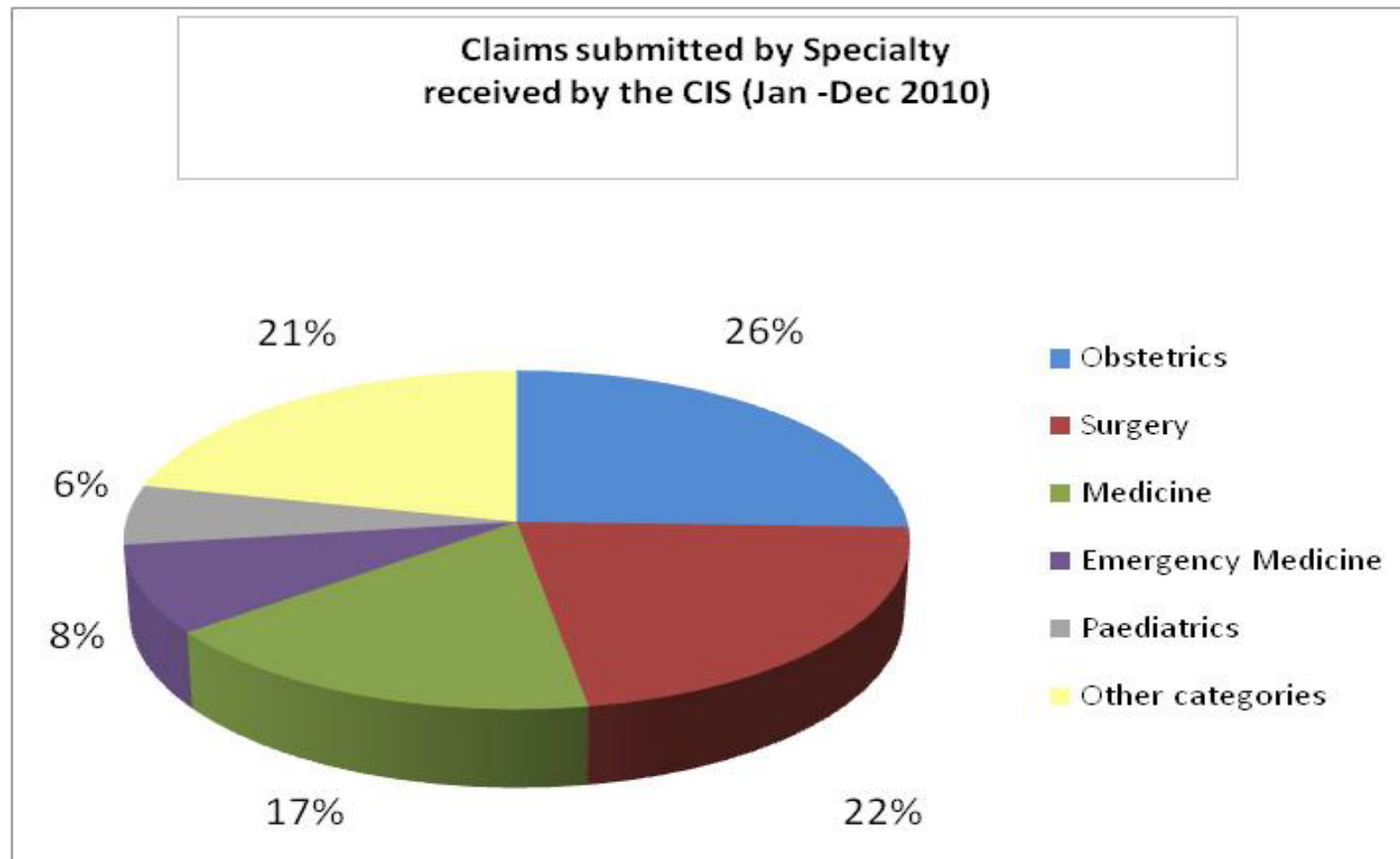
**Peak times for falls- 10.00-11.59 & 14.00-14.59.
41.5% between 20.00-08.00.**



Risk Factor	Significant Total	Mean RR / OR	Range
Muscle weakness	10 / 11	4.4	1.5-10.3
History of Falls	12 / 13	3.0	1.7-7
Gait deficit	8 / 11	2.9	1.3-5.6
Balance deficit	8 / 8	2.9	1.6-5.4
Use of assistive device	6 / 12	2.6	1.2-4.6
Visual defect	3 / 7	2.5	1.6-3.5
Arthritis	8 / 9	2.4	1.9-2.9
Impaired ADL	8 / 9	2.3	1.5-3.1
Depression	3 / 6	2.2	1.7-2.5
Cognitive Impairment	4 / 11	1.8	1.0-2.3
Age > 80	5 / 8	1.7	1.1-2.5



Claims submitted to SCA Jan.-Dec. 2010 (N=475)





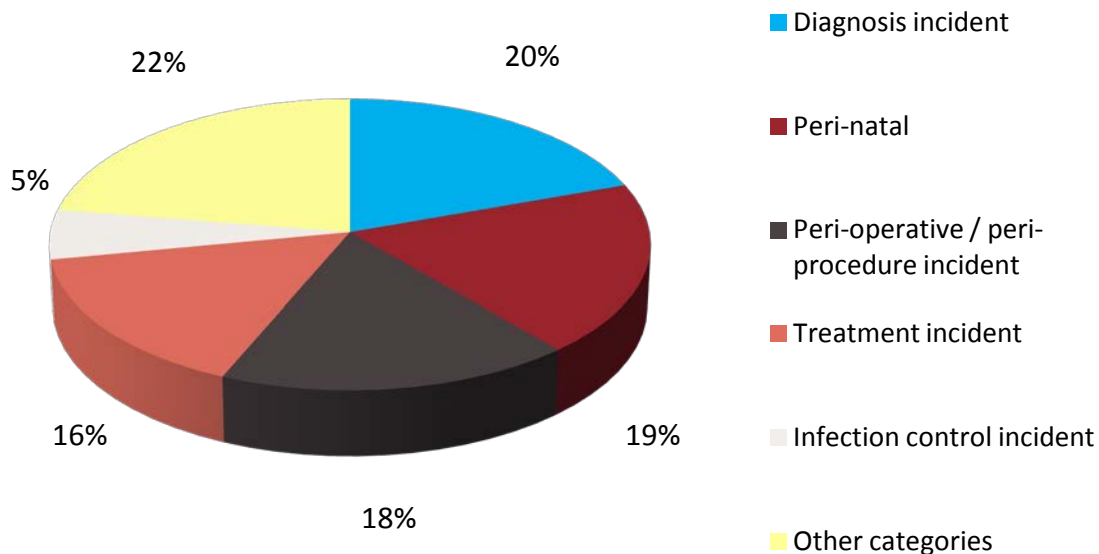
Learning from Claims

- Consent
- Communication issues
- Team working
- Medical records, missing, incomplete, illegible, altered
- Confidentiality

<http://www.stateclaims.ie/ClinicalIndemnityScheme/publications/2010/CISNewsletterJune2010.pdf>



Claims submitted by Incident Type (Jan-Dec 2010)



Claims submitted by incident type

Incident Type	Count
Diagnosis incident	93
Peri-natal	91
Peri-operative / peri-procedure incident	84
Treatment incident	74
Infection control incident	26
Other categories	107
Grand Total	475
Other categories	
Slips/Trips/Falls	14
Medication incident	9
Unplanned events	6
Equipment/Device Incident	4
Blood transfusion incident	3
Discharge incident	3
Inappropriate Behaviour	3
Self-Harm	3
Records/Documentation Incident	2
Unexplained Injury/Unknown Cause	2
Violence/Harrassment/Aggression/Abuse	2
Consent / confidentiality incidents	1
Not specified	55
Total:	107



Story of a claim

28/2/04 @16.30

- 85 Y.O. lady presented to A&E c/o:
- Increasing shortness of breath x 5 days.
- Underlying diagnosis of COPD, Parkinsons' disease.
- Triaged by nurse at 16.47-non-acute.

Seen by medical team @ 19.30.

Diagnosis:

Exacerbation of COPD with new onset of A Fibrillation.

Charted for admission.



Story of a claim-contd.

- No bed available.
- Patient transferred on trolley to large observation room.
- Regular nursing obs. noted patient requested bed pan at reasonable intervals.



Story of a claim-contd.

1/3/2004 @3.40 hrs. (35 hours post-admission)

- Patient found on floor of toilet
- c/o pain left hip
- X-rays confirmed fractures of left Femur and left Radius.



Story of a claim-contd.

- Patient admitted to ward immediately
- Too ill for surgery
- Developed aspiration pneumonia, contracted MRSA infection and developed bowel obstruction.
- 2 weeks in ICU
- RIP April 2nd 2004.



Issues

- Resources-staff levels/mix, bed capacity
- Multi-factorial risk assessment of patient
- Multi-factorial interventions appropriate to patient needs
- Expert report, “Regular nursing obs. noted patient requested bed pan at reasonable intervals-implied she could not mobilise”

Costs

Cost per ICU bed day €2,800 @ 14 days in ICU

Cost per Bed day €868 @ 17 days in General Ward

Total Estimated cost of Patient for 31 days = €53,956



What is needed to effect change?



Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive



National Council on Ageing and Older People
AN CHOMHAIRLE NÁISIÚNTA UM AOSÚ AGUS DAOINE AOSTA



DEPARTMENT
OF HEALTH AND
CHILDREN
AN ROINN
SLAINTE AGUS LEANAÍ

Strategy to Prevent of Falls and Fractures in an Ageing Population

*Report of the National Steering Group
2008*

Life Free from Falls and Fractures in our Ageing Population

Mission
Work with Agencies to Implement and Evaluate the Strategy

Principles

Prevention is Priority

HSE provides Leadership

Evidence-based interventions

Equitable

Long-term

Goals

Greater Awareness

Build Capacity

Comprehensive service

Safer Environment

Objectives

Positive Ageing
Risk reduction
Physical Activity
Bone Health

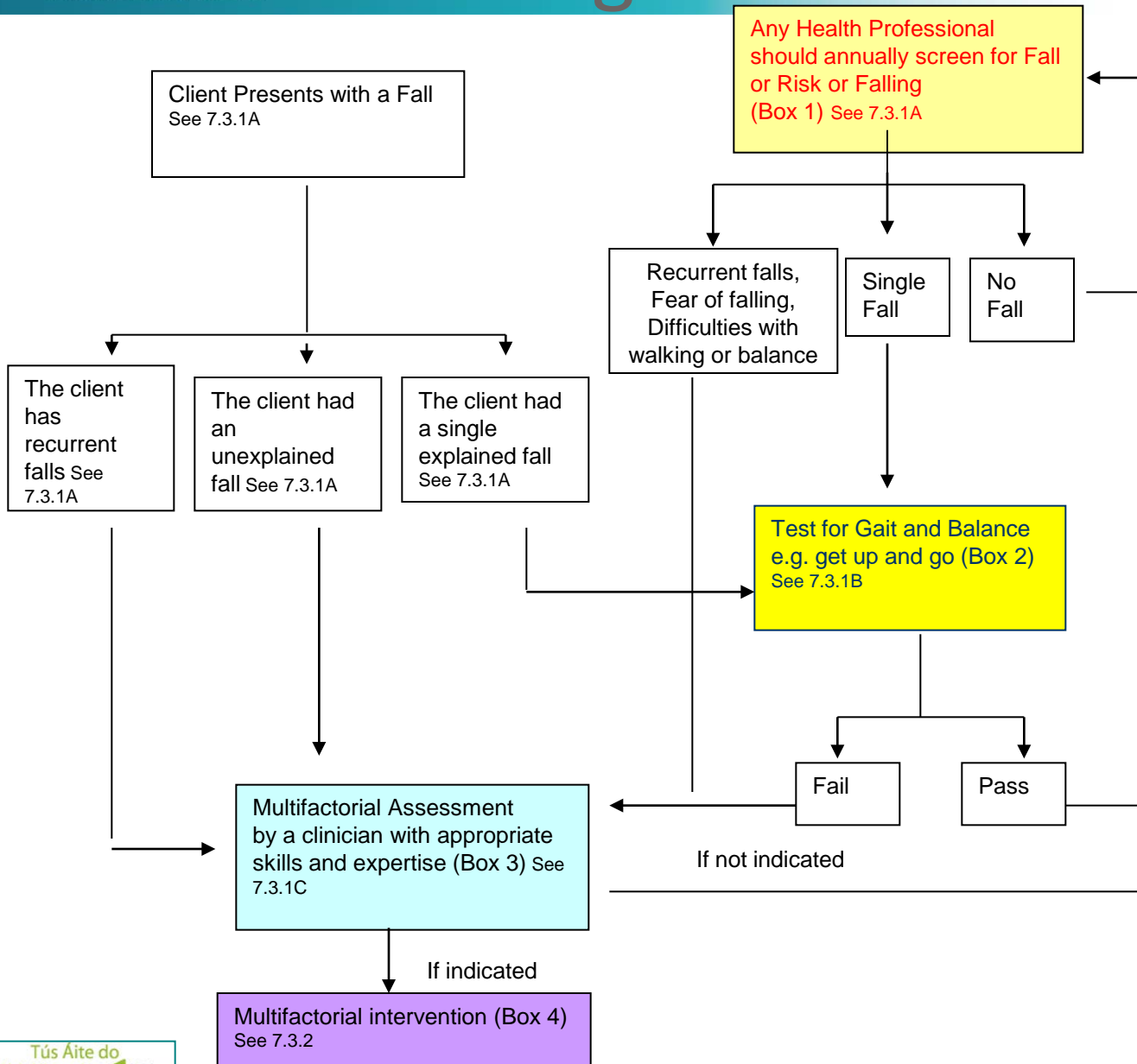
National Steering Group
National Centre
Training
Research
Plan, Monitor, Audit

Implement Guidelines
•Primary Health Care
•Acute Setting
•Long Stay Units

Engage agencies
Balance risk: care process and arch. design
Balance - Quality of Life and Health & Safety
Assistive technology



Falls Algorithm





What is needed?

<http://www.stateclaims.ie/ClinicalIndemnityScheme/publications/2008/LincolnshireIntegratedCarePathway.pdf>

Where are we at?

[HSE South Z-42545.bmp](#)

1. MDT
2. Joint working
3. Prevention
4. Assessment
5. Intervention
6. Documentation
7. Governance

Number 1 indicates that the above are in place or carried out. Zero 0 indicates that they are not.



Multifactorial Assessment

- **Identify falls history**
- **Review medication(s) and dose(s)**
- **Assess:**
 - **gait, balance, mobility and lower extremity joint function**
 - **Osteoporosis risk**
 - **Vision**
 - **Neurological function, muscle strength, proprioception, reflexes and tests of cortical, extrapyramidal and cerebellar function**
- **Examine cognitive function**

Assess:

- **postural blood pressure**
- **Heart rate, rhythm and evidence of structural heart disease**
- **Blood pressure responses to carotid sinus stimulation if appropriate**
- **Urinary incontinence**
- **Vitamin D deficiency**
- **Foot problems and footwear**

Assess:

- **Home hazards**
- **Older person's perceived functional ability and fear relating to falling**

Screen for depression



Multi-factorial Interventions

Manage all known fall risk factors as identified in the multi-factorial assessment

- **Withdraw / minimise:**
 - Psychoactive medications
 - Other culprit medications
- **Prescribe and instruct on the use of assistive devices and Occupational Therapy**
- **Assessment of Vitamin D deficiency**
- **Arrange:**
 - Gait, Strength and balance training
 - Adaptation or modification of home environment
- **Treat / Manage:**
 - Osteoporosis
 - Visual abnormalities
 - Neurological disorders
 - Cognitive impairment
 - Depression
 - Postural hypotension
 - Other cardiovascular abnormalities
 - Functional disability
 - Fear of falling
 - Urinary abnormalities
 - Foot problems and footwear
 - Other relevant acute or chronic medical conditions



Ortho-Geriatric pre- and post-operative acute medical management, rehabilitation and secondary prevention

The following 6 standards for hip fracture care should be adhered to

Standard 1

All patients with hip fracture(s) should be admitted to an acute orthopaedic ward within 4 hours of presentation

Standard 2

All patients with hip fracture(s) who are medically fit should have surgery within 48 hours of admission, and during normal working hours

Standard 3

All patients with hip fracture(s) should be assessed and cared for with a view to minimising their risk of developing a pressure ulcer

Standard 4

All patients presenting with fragility fractures should be managed on an orthopaedic ward with routine access to Geriatrics medical support from the time of admission

Standard 5

All patients presenting with fragility fractures should be assessed to determine their need for therapy to prevent future osteoporotic fractures

Standard 6

All patients presenting with fragility fractures following a fall should be offered multifactorial assessment and intervention to prevent future falls



*Osteoporosis:
Prevention, Early Detection,
Treatment, Management*

Prevention

Treatment

Management

Bone Health Promotion

- Public Awareness
- Nutrition
 - Calcium / Vitamin D
- Health Risks
 - Smoking
 - Alcohol
 - Caffeine
- Physical Activity /Exercise

Early Detection / Risk Factors

- Diagnosis
- Guidelines for Selective Case Finding
- Access / Provision of DXA Units

Type of Fragility Fracture
Osteoporosis Patient Profile

Non-pharmacological Intervention

Pharmacological Intervention

Benefits and Risks

Post Fracture Care

- Integrated Care
- Self Management
- Falls Prevention
- Improved Osteoporosis Practice
- Evidence Based Practice



How do we get there?



HE Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

Tús Áite do
Shábháilteacht 1 Othar
Patient Safety 1 First

Clinical Governance
We are all responsible...

...and together we are creating a safer healthcare system

Clinical governance helps ensure people receive the care they need in a safe, nurturing, open and honest environment


Clinical Governance

Tel: 01 635 2344
Email: clinical.governance@hse.ie
www.hse.ie

Tús Áite do
Shábháilteacht 1 Othar
Patient Safety 1 First




DML Integrated
Minimum Data Set



Resident Assessment Instruments (RAIs),
Resident Assessment Protocols (RAPs)
&
Personalised Care Planning

DML Services for Older Persons
&
Nursing and Midwifery Planning and Development

 **Heilthseamachtaí na Seirbhíse Sláinte**
Health Service Executive

April 2010



Systems Analysis or Proactive Risk Assessment

Factor type
Patient factors
Task factors
Individual (staff) factors
Team factors
Work environmental factors
Organisational and management factors
Institutional factors



HIQA “National Quality Standards for Residential Care Settings for Older People in Ireland”

- **Standard 10.4** which states *“A general risk assessment is carried out and recorded upon admission to the residential care setting and as indicated by the resident’s changing needs or circumstances and no less frequently than at three monthly intervals”*
- **Standard 26.9** which states *“The Person in charge ensures that all significant events including accidents, injuries, dangerous occurrences and incidents of fire are recorded. Where a significant event involves a resident, the next of kin is notified as soon as possible. This information is audited and feedback and education are provided”*.
- **Standard 30.2** which states *“The Person in charge, for the purposes of ongoing quality monitoring and continuous improvements collects data onresidents who have fallen in the last month...The person in charge ensures that appropriate action is taken in response to any findings of concern arising from the above”*.
- **Standard 32.3** which states *“The Resident’s record includes:a record of any incident involving the resident.....”*



Target: 20% decrease in Fracture Admission Rates in 65+ Age Group in 5 years

- **Death rates:**

- Falls 65-74, 75-84. 85+
- Hip Fracture
- Head Injury

- **Hospitalisation:**

- Hip fractures

- **ED attenders due to fall:**

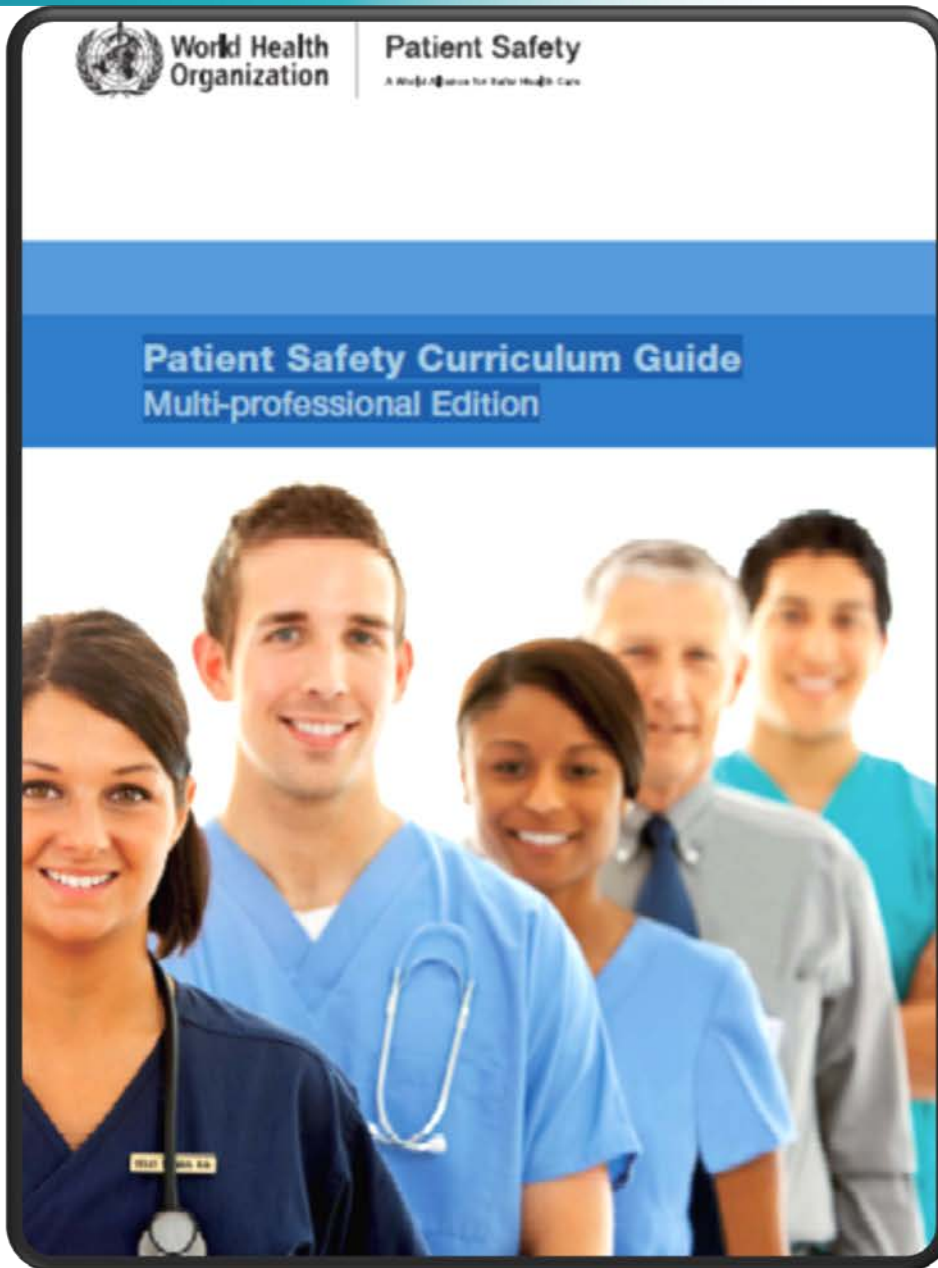
- % received MDT assessment
- % received MDT intervention

- **Residential Care:**

- % with fall policy
- Hip fractures reported
- % residents received yearly assessment
- % residents received MDT interventions

- **Fracture prevention:**

- % fractures who received fracture assessment & appropriate treatment
- Wait time for BMD
- QA for BMD service





CIS Patient Safety Competency Framework

- Preventing wrong site, wrong procedure and wrong patient treatment
- Medicating safely
- Infection control

- Employing best available evidence based practice
- Using IT to enhance safety
- Workplace learning
- Workplace teaching

- Maintaining fitness to work or practice
- Professional and ethical behaviour



- Involving patients and carers as partners in healthcare
- Communicating risk
- Communicating honestly with patients after an adverse event (Open Disclosure)
- Obtaining consent
- Being culturally respectful and knowledgeable

- Recognising, reporting and managing adverse events and near misses
- Managing risk
- Understanding healthcare risk
- Managing complaints

- Being a team player and showing leadership
- Understanding human factors
- Understanding complex organisations
- Providing continuity of care
- Managing fatigue and stress



In Conclusion

Leadership –governance, training, facilities -

improve reporting, investigations & learning

Right people -build a MDT who understand improvement model with clear aims and baseline measures

Sustainability - Make links to other work streams

Frontline actions –after a fall, care for at risk persons & basic assessment and awareness for all



Thank You!

Falls Resources

[http://www.hse.ie/eng/services/Publications/services/Older/Strategy to Prevent Falls and Fractures in Ireland%E2%80%99s Ageing Population.html](http://www.hse.ie/eng/services/Publications/services/Older/Strategy_to_Prevent_Falls_and_Fractures_in_Ireland%E2%80%99s_Ageing_Population.html)
National Falls Strategy

<http://www.patientsafetyfirst.nhs.uk/ashx/Asset.ashx?path=/Intervention-support/FALLSHow-to%20Guide%20v4.pdf>

The “How to” Guide for reducing harm, 2009

<http://www.rcplondon.ac.uk/resources/closing-gap-fallsafe>
FallSafe Care Bundle RCP

<http://www.stateclaims.ie/ClinicalIndemnityScheme/presentations.html>
Falls section

<http://www.profane.eu.org>
Prevention of Falls Network

www.nrls.npsa.nhs.uk/
Contributory Factors Classification Framework