MBA Healthcare and Hospital Management 2015-2017
Summer Training at World Health Organization

PREVENTION AND MANAGEMENT OF PATIENT FALLS IN HEALTHCARE FACILITIES

INTRODUCTION

World Health Organization defines falls as an event which results in a person coming to rest inadvertently on the ground or floor or other lower level. The global health estimates mention that there are about **693,000** death occur due to falls.

WHO fact sheets of October 2012 mentions that over 80% of fall related fatalities occur in low- and middle income countries. Falls are reported as the second leading cause of accidental/ unintentional injury deaths world-wide. Falls rank as the 12th leading cause of death among 5–9 year olds and 15-19 year olds. Falls lead to substantial morbidity and mortality. Mortality rates are **highest among those aged 70** and over, but begin to increase after 30 years of age and also have a significant peak in the neonatal period. Mortality is the tip of the iceberg, with morbidity and disability important burdens for survivors of falls, their families, and societies. Various factors may lead to in-patient falls causing serious injuries and sometimes death. Patient Falls are largest single category of reported incidents in hospitals according to Joint commission. The incidence rate of falls in inpatients is three times that for community-dwelling persons aged ⩾65 years. In-hospital **newborn falls** occur at a rate of **1.6 to 4.4 per 10,000** live births (Helsley et al. 2010). Falls are associated with increased length of hospital stay and greater health care costs. **Operational costs** for fallers with serious injury are about **$14,000** higher than non-fallers. In one study, a fall with injury added 6.3 days to the hospital stay.

VISION

All lower and middle income countries have national action plans on prevention and management of patient falls. The healthcare facilities have all type of provisions for preventing in hospital falls. A focal point in every Region who is reported of every single fall occurring in hospitals.

OBJECTIVE

1. To assess the extent of awareness on the risk factors causing patient fall in healthcare facilities.
2. To collect information about methods of prevention and management of patient falls globally.
3. To find out countries having national action plans/ guidelines on prevention and management of patient falls in healthcare facilities.

METHODOLOGY

Conducted a Literature Review on Situational analysis
Tool Prepared - Questionnaire

QUESTIONNAIRE ON PATIENT FALLS

1. a). Are you aware of any initiative, policy or program for Fall prevention, Fall management or Prevention and Management of falls in your country?
   Yes ☐ No ☐
   b).If your answer to the above mentioned question is Yes, p lease mention the Level at which it is present:
   i) a).National ☐
   ii) b).Regional ☐
   iii) c). Local ☐
   Please give the description of the above mentioned Initiative/Policy/Program in the box provided below
2. a). Are there any Key Partners/ Non-Governmental Organizations / Civil Society Organizations in your country who are specifically working on Patient Falls?
   Yes: ☐ No: ☐
   b). If your answer to above mentioned question is yes then please mention at which level:
   i) National ☐
   ii) Regional ☐
   iii) Local ☐
   iv)
3. a). Are there any guidelines on prevention of Patient falls/ management of Patientfalls/ prevention and management of Patient falls?
   Yes: ☐ No: ☐
   b). if your answer to the above question is yes please share the details in the box provi ded below:

MY WORLD HEALTH ORGANIZATION EXPERIENCE:

Department: Patient Safety and Quality Improvement The **Consultative Meeting on Global Patient Safety Challenge- Medication Safety**

MyLearning:

- Purpose of a Consultative meetings – develop and enrich a new project/ health issue proposed.
- Stakeholders are identified – experts on the topic from various member states. The participants can be referred by Ministry of health of respective countries.
- Functioning of working groups/ facilitation of working groups
- Compiling report of a consultative meeting.
- Things necessary for conducting a consultative meeting – timing, venue, chairperson, agenda, seating arrangements, note taker, refreshments , reception

The WHA Side Event on Medication Safety

My Learning:

- Objective of a side event is to inform the Member states about the new issues being addressed and their participation is required to achieve the target.

RISK FACTORS

INTRINSIC FACTORS

- Age
- Vision
- Balance and Gait
- Alzheimer's/Dementia
- Parkinson's Disease
- Postural Dizziness
- Multiple Medications, psychoactive medications
- Decreased muscle tone
- Orthostatic hypotension
- Stroke
- Hypertension

EXTRINSIC FACTORS

- Physical Environment
- Assistive devices
- Footwear
- Poor lightening
- Slippery floors
- Cluttered corridors
- Bathroom doorway, showers
- Bedside Trolleys
- Bedside rails
- Wheelchairs
- Previous history of Fall
- Fear of falling

WHO's INITIATIVE

To carry forward the message of prevention of falls-

WHO inter-departmental task group - created consisting of **3clusters and 7 departments.**

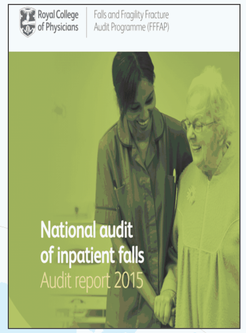
Further Expert Consultation will be organized on "Prevention and Management of Falls" with the objectives to:

Draft and finalize the 'WHO Roadmap for Organization-wide Action'

Outline the priority deliverables and the WHO departments with lead responsibility for achieving these.

KEY FINDINGS

ENGLAND AND WHALES

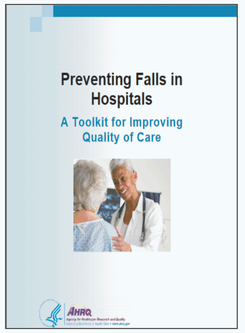


The mean rate of falls per 1,000 Occupied Bed Days as 5.6 for acute hospitals , 8.6 for community hospitals, 3.8 for mental health hospitals. Direct cost of falls - around £15 million a year.

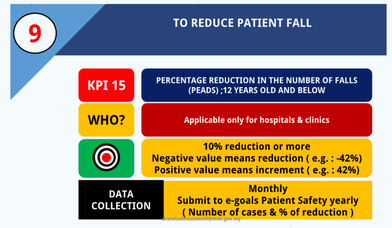
CANADA

Falls account for up to 40% of inpatient incidents
•Falls Quality Audit "Safer Healthcare Now"
•Getting started kit for clinicians

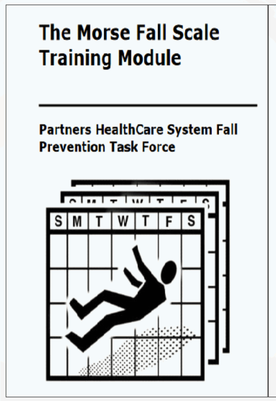
USA



•Rate of fall- 1.3 to 8.9 falls per 1000 patient days higher rates occur in units focusing on eldercare, neurology, rehabilitation
•Developed- A TOOLKIT- negotiating a change process in hospitals.



FALLS RISK ASSESSMENT TOOLS



FALLS RISK ASSESSMENT TOOLS

KEY RECOMMENDATIONS

SAFETY TIPS

ACTIONS REQUIRED AT NATIONAL LEVEL

- Quantify-scale of the problem in the developing countries
- Compile-all the guidelines and toolkits which already exists.
- Prepare-strategies and provide technical support for National Action Plan to prevent and manage patient falls in Healthcare system
- Integrate Strategies at the national level
- Designate a focal point at the national level to monitor the progress.
- Prepare-set of interventions to be followed at institutional level.
- Share success stories for motivation

ACTIONS REQUIRED AT INSTITUTIONAL LEVEL

Medical Superintendents - Supervise the Nursing Staff

- To hourly monitor a patient at risk of falls
- Develop and use health promotion videos at the waiting halls.
- Provide Instruction cards for patients at risk of falls.
- Regular environmental check – uncluttered corridors, soft edged furniture.
- Admit high falls risk patient near to the nurse station.
- Special footwear – provided to prevent slips.
- Alarms in wheel chairs,
- Easy access to lights for the way to toilets.

Emergency call buttons provided to all patients.

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