Falls prevention as everyday heroism
Frances Healey

Anyone with an interest in falls prevention knows that, first and foremost, it’s about multidisciplinary working. That ethos shines through the description in this issue of the New Zealand Medical Journal1 of the Health Quality & Safety Commission’s (the Commission’s) successful three-year initiative working with patients, their families and healthcare staff to reduce the harm from falls.

But of course improving the quality of healthcare is also a multidisciplinary endeavour—not just in the sense of various disciplines of healthcare staff, but the insights we can gain from those who might describe themselves as improvement scientists, healthcare policy researchers, ergonomists, psychologists or ethnographers.

The Health Quality & Safety Commission’s initiative is the first in the world to describe credible reductions on a national scale in the most serious type of harm—the fractured hips from falls in hospitals that lead to long-term loss of independence for most patients who experience them, and are followed by death within weeks or months for too many.2

Healthcare organisations in other countries will have a keen interest in replicating their success, and considering if lessons can be drawn from their description of how they went about this.

But if we also want to succeed, we need to explore why they met with success.

Firstly, in embarking on their improvement journey, the Commission had a theory of change. ‘Theory’ is not a word that strikes joy in the hearts of most clinicians aiming to improve healthcare quality, and I’ve had my own struggles to embrace this aspect of planning quality improvement.3 Davidoff and colleagues4 make a wonderfully articulate case as to why a theory of change matters, but I fear those they were trying hardest to convince will never have read their article—because it had theory in the title.

So to summarise their case at its most basic level: they urge us to articulate why we think an intervention will work, before we attempt to introduce it. These can be ‘small theories’ specific to an area such as a falls prevention initiative or formal, academically framed theories with wider applicability. Without either a ‘small theory’ or a formal theory, our solutions are likely to be a poor match for the barrier or challenge we are trying to overcome.

As I explored in my BMJ editorial,5 following the publication of the admirably conducted but ultimately unsuccessful 6-PACK falls prevention randomised trial,6 we are in a happy place where our ‘small theories’ specific to falls prevention are chiming with wider formal theories of how to make healthcare safer.7

In its efforts to emulate industries with admirable safety records, healthcare had come close to believing careful compliance with a rigidly defined procedure was right in all circumstances. Past falls prevention efforts that were focused on risk scores and a set menu of interventions were part of that ethos. Vincent and Amalberti8 have helped us understand that although this ultra-reliable model is indeed what we need for many healthcare processes, it will be counterproductive if we try to apply the model to all healthcare processes. The Commission’s theory of change was that it needed to support a shift to an adaptive model of falls prevention, where patients, families, whānau and healthcare staff work together to understand what helps each individual older person reduce their falls risk.

Mary Dixon-Woods and her colleagues9 outline the 10 key challenges that any healthcare improvement initiative needs to overcome to succeed at scale. Reflection on New Zealand’s improvement journey shows
how many of these were tackled within their three-year programme. Those challenges tackled include the clinical leadership needed for change, as shown by the inexhaustible Sandy Blake, Director of Nursing, Patient Safety and Quality, at Whanganui District Health Board, and the national leadership demonstrated by the Commission’s selection of falls prevention—an infamously “wicked” healthcare problem—as a major and long-term strand of the national safety programme. This priority setting is not reflected in all developed countries, despite the sheer scale of falls injuries in the community and in hospitals, and the life-changing consequences of those falls.

Also notable is their ability to measure their success on a national scale, not solely through reliance on reported incidents (which will inevitably be affected by changes in the culture of reporting) but through analysis of routine hospital data. The range and quality of resources provided to support improvement—from a national falls atlas of healthcare variation to falls risk assessment tools and care plans—were also clearly a key factor. The Commission’s approach also encompassed promotion and awareness-raising via falls focuses, international visitors and social engagement during the New Zealand national patient safety campaign Open for better care, and yet remained rigorously scientific, as one can see in the cutting edge primers on the evidence base (the ‘10 Topics in reducing harm from falls’). Their ethos of ‘aggregation of marginal gains’ helped avoid overwhelming organisational capacity while the multidisciplinary emphasis avoided tribalism. The Commission’s programme also took an evolutionary approach to the focus of improvement efforts, with an initial priority area of hospitals and care homes later encompassing integration of falls prevention efforts along the patient’s pathway, and then onwards to community falls prevention, which is likely to help secure sustainability.

Vincent and Amalberti’s strategies for safer healthcare in the real world include one more level of response to exceptional circumstances: the ultra-adaptive model, where skilled, respected and charismatic individuals exercise a high degree of personal initiative to lead their teams though challenging and life-threatening emergencies. Chesley ‘Sully’ Sullenberger’s successful landing of US Airways Flight 1549 on the Hudson River is an example from aviation of this heroic approach. For healthcare, the immediate aftermath of the Christchurch earthquake is a powerful example of where this heroic approach was needed and where the healthcare community mobilised rapidly and independently to enable far more lives to be saved than would otherwise have been the case. We’ve seen this again after the Kaikoura earthquake.

Falls prevention is a different, everyday sort of heroism, rather less likely to reach the front pages of the newspapers; the patients saved from harm and the teams who helped them forever nameless. The publication of the Commission’s ‘Reducing harm from falls’ results is a reminder that such quiet heroism is equally to be celebrated.

Competing interests:
Nil.

Author information:
Frances Healey, Deputy Director of Patient Safety Insight, NHS Improvement.

Corresponding author:
Frances Healey, Deputy Director of Patient Safety Insight, NHS Improvement.
frances.healey@nhs.net

URL:
REFERENCES:


