

| Project Proposal | |
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| Project Title: Falls and Bone Health Project Proposal | |
| Section A | Project Outline: |
| Project Rationale | Fall injuries are responsible for significant disability, reduced physical function, and loss of independence in the elderly. Falls are costly and complex and are preventable. Falls are not an inevitable part of ageing. |
| Project Purpose: | To construct and implement a framework which will develop sustained good health, prevent falls and related injuries, and improve bone health to give older persons a better quality of life and independence. |
| Project Goal: | <ul style="list-style-type: none"> (a) To prevent falls; (b) Identify and reduce the risk factors for falling; (c) To reduce the injuries from falls; (d) Management of falls; (e) Improve health and wellbeing through a focus on bone health; <p>...for persons 65 years and older in the Republic of Ireland through implementation of the Strategy to Prevent falls and Fractures in Ireland's Ageing Population, 2008, hereafter known as the National Strategy.</p> |
| Broad statement of Scope: | To implement the National Strategy and to create a governance framework to monitor progress and accountability. |
| Project Objectives: | To have a clear path on how to deliver the implementation plan within set timeframes, areas of responsibility and accountability and measurable outcomes. |
| Anticipated Benefits: | <ul style="list-style-type: none"> • Clarity with regard to what must be done and how it must be done in order to reduce falls; • Independence and improved health and well-being for older persons; • Clear policy direction and adherence; • Cost-savings; reduce claims; • Healthy service users/citizens Improved Healthy Life Years (HLY) |
| Key Success Factors: | <ul style="list-style-type: none"> • Active and Healthy Ageing Citizens |

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| | <ul style="list-style-type: none"> • Clear, effective and sustainable integrated care pathways to prevent falls, identify those AT RISK and manage those who have fallen • Buy-in from the multiple stakeholders; • Improvement of baseline data; • Effective leadership; • Reduced hospital admissions; • Reduced cost of falls-related injuries and complications; • Key performance indicators achieved; <p>See Appendix 1 for details.</p> |
| Quality Definition | <p>GOAL: To deliver high quality, high value, accessible and equitable falls preventions and bone health services with reduced variance.</p> <p>The plan has been designed to achieve certain parameters by close of business 2013.</p> <ul style="list-style-type: none"> • Identify and support at least one Pilot implementation site in each of the 4 HSE Administrative Regions that can meet the majority of the requirements of a Falls and Bone Health Integrated Care Pathway • Establish robust governance arrangements for Falls and Bone Health at National, Regional and Local level such that achievements, barriers and challenges can be adequately addressed in a timely and effective manner. • Ensure adequate metrics are in place to gather relevant baseline data and to capture continuous improvements or otherwise as roll out of the learnings from Pilot sites is progressed. • Identify opportunities for engagement with other relevant initiatives being worked through the system, for example Specialist Geriatric Services Model, HSE Falls Indicator's Project and NCEC Osteoporosis Guidelines Group |
| Major Deliverables: | <p>Major deliverables will depend on resources available and timeliness of same:</p> <ul style="list-style-type: none"> • Standardise falls prevention and bone health plan; • Standardise assessment diagnosis and treatment plans appropriate to service user needs across various settings; • Identify and monitor baseline data sources to measure continuous improvements or otherwise • Develop and monitor clear processes in particular ICPs across multiple settings in line with Specialist Geriatric Services Model. |

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| | <ul style="list-style-type: none"> • Establish firm and responsive governance arrangements • Official launch of NCEC Guiding Framework/Clinical Guidelines to prevent falls and fractures in Ireland's Ageing Population. • Recognised as a national leader in falls prevention and bone health within the European Innovation Partnership Forum |
| Estimated Timeframe: | <ul style="list-style-type: none"> • Draft implementation plan agreed by end Q2 2013 • Formation of sponsorship, implementation and working groups by end Q2 2013 • Identify and initiate implementation pilot sites by end Q3 • Outputs of the various governance groups to be apparent by end of Q4 2013 • Engagement with other relevant projects to build Traction within the system by the end Q4 2013 • Progress review of 2013 deliverables and plan for Year 2 2014 by the end of Q 4/.begin Q1 2014 |
| Estimated Budget: | <ul style="list-style-type: none"> • No separate funding stream -working within existing resources where practically possible |
| Constraints: | <ul style="list-style-type: none"> • Complexity of the issues; • Size of the task (including prevention and treatment); • Buy-in from such a diverse group of stakeholders; • Co-morbidity; • Multi-factorial nature of the clinical picture; • Multiple unknowns; • Must be integrated with other work that is going on in older persons services and other care groups and under the new HSE Directorate structure still to be confirmed |
| Assumptions: | <ul style="list-style-type: none"> • The stakeholder group needs to be reviewed extended with clear mechanisms for consultation and engagement. • The previously devised implementation plans needs to be reviewed and updated, • The implementation recommendations need to be prioritized, with interdependencies and resources identified to action. • There is good commitment to delivering on this project, • It is the right time to deliver (appreciation of the previous work done). |
| Potential Risks: | <ul style="list-style-type: none"> • The complexity of the issues, the multiplicity of stakeholders and the differing agendas involved in the project at a time if significant changes politically, |

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| | economically and technologically. |
| Section B | Factors to address re: other projects and processes |
| Project Dependencies: | <ul style="list-style-type: none"> • Stakeholder buy-in; • That the project is logical, and based on robust evidence (theory and practice); • That it is recognised to be of value to older persons' health; • That citizens, providers and funders can see/experience the direct benefits of the project; • That there is a clear method/understanding of how to create this improved and person centered service delivery model; • That there is a continued mandate and support at various levels within the system |
| Impact of project on other processes: | <ul style="list-style-type: none"> • Emergency Department attendances and inpatient hospital admissions • Outpatient and Community based day services • Improved health in a range of other systems as a result of service user interventions; • Alignments with implementations plans for SGS • Alignments with existing and potential agendas for Clinical Care Programmes such as Primary Care, Non electives such as EM, AMP, Rehabilitation Medicine and Electives such as Orthopaedics, Surgery, Chronic Diseases and other services, including Medication Management, MH and Acute Coronary Syndrome • Additional impacts of the project to be determined. |
| Section C | Structure/Personnel/Information Requirements |
| Project Structure/Personnel | <ul style="list-style-type: none"> • Overall project sponsors are Ms. Laverne McGuinness (Chief Operating Officer) and Noel Mulvihill AND Older Persons • National Project Co-ordinators/Co chairs NIT: Ms Irene O Byrne/Maguire SCA & Ms Anne-Marie Ryan HSE • Sponsorship Team Mr. Noel Mulvihill,. AND Older Persons (Co chair); Dr. Allish Quinlan, Head of CIS (Co-chair; Dr. Tara Coughlan, National Falls and Bone Health Lead, CCPOP; Mr Barry Murphy, Representative from DOH, Mr Conor Leonard Representative from SDU • National Implementation Team (see original list) and query additional stakeholders i.e Finance, Pharmacy/Medicine Policy, SDU representative, Clinical Dietetics, Health Intelligence, Regional Representative, representative from Academic Institution, Quality & Patient Safety and Comm's Dept and other representatives |

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| | <p>co-opted when required.</p> <ul style="list-style-type: none"> • Secretariat to be identified from within Older Persons • Regional Implementation Teams linked to existing 4 HSE Administrative Regions to be established • Patient Representative (2 representatives if possible) to be determined • Health Intelligence re internal consultancy |
| Information Requirements: | <ul style="list-style-type: none"> • Sponsorship Team to meet Quarterly but at minimum twice yearly • Implementation Teams to meet every 2nd month or sooner as appropriate ; • Communications electronically using teleconferences as appropriate • Joint National Project Co-ordinators to meet/communicate regularly to ensure effectiveness and congruence. |

Appendix 1

Key Performance Measures

Standards as per the National Strategy 2008

Hip Fracture Management

Standard 1: All patients with hip fracture should be admitted to an acute orthopedic ward within 4 hours of presentation

Standard 2: All patients with hip fracture who are medically fit should have surgery within 48 hours of admission, and during normal working hours

Standard 3: All patients with hip fracture should be assessed and cared for with a view to minimising their risk of developing a pressure ulcer

Standard 4: All patients presenting with a fragility fracture 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 therapies to prevent future osteoporotic fractures

Standard 6: All patients presenting with a fragility fracture following a fall should be offered multidisciplinary assessment and intervention to prevent future falls

Are all of these standards being captured by IHFD as is?

Proposed stats that may be collected within the PCT's,

1. Number of people screened over 3 months
2. Number who had multi-factorial assessment over 3 months
3. Number of people referred onwards over 3 months

It may be possible to collate this information in the future:

1. Number of people over 65 yrs presenting at ED from named PCT with falls related issues over 3 months (It seems to me that we could ask HIPE to amend Admission Source to get this data?)
2. Number of people over 65 yrs presenting to Out of Hour Services from named PCT with falls related issues over 3 months (Would be curious as to availability of GP computer logs to give this data?).

Metrics currently collected by acute hospitals (Compstat)

Time to Surgery - % & Cumulative YTD % of emergency hip fracture surgery carried out within 48 hours of admission (pre-op LOS 0 1 or 2 dys)

Time to Surgery - Number & Cumulative YTD # of emergency hip fracture surgery carried out within 48 hours of admission (pre-op LOS 0 1 or 2 dys)

Time to Surgery - Total number & Cumulative YTD Total # of emergency hip fracture surgeries

(Are there ages and/or age ranges available with these figures?)

Time to Surgery - Rolling 12 months -% of emergency hip fracture surgery carried out within 48 hours of admission (pre-op LOS 0 1 or 2)

Time to Surgery - Rolling 12 months - Number of emergency hip fracture surgery carried out within 48 hours of admission (pre-op LOS 0 1 or 2)

Time to Surgery - Rolling 12 months - Total number of emergency hip fracture surgeries

Metrics being collected through HIPE:

Number and Age-standardised rate for those 65years and older emergency hospital admissions for falls related injury

Age-specific rate for those 65years and older emergency hospital admissions for falls related injury

Additional relevant data available via HIPE:

LOS

Percentage service who were Repeat Admissions

Type of fall

Type of Injury

Place of Occurrence

Admission Source

Discharge Status

Demographic profile

Co-morbidities

Month of occurrence

Specific nature of injury i.e. Fracture neck of femur

Mortality and morbidity

Metrics being collected by NAEMS (formerly STARSWeb)

NAEMS collects reported incidence of falls related events that occurred while in care. All enterprises indemnified by the State Claims Agency are statutory mandated to report such events when service users are under clinical care with HSE enterprises only (from 2010) capturing events that are Clinical and /or Employee and /or Public Liability related.

National aggregated reports are available at

<http://www.stateclaims.ie/ClinicalIndemnityScheme/starswebStats.html>

and specific reports are available on request.

Metrics being collected by HIQA linked to Residential Care standards for Older Persons

Mandatory reporting of falls causing harm to HIQA within three days.
Inspections query systems and processes in place with respect to falls prevention/reduction and management when they occur.