

Affinity Work Plan 2014

The 'National Strategy for the Prevention of Falls and Fractures in Ireland's Ageing Population', hereafter known as the National Strategy, was prioritised for implementation by the HSE and the State Claims Agency in 2013. The vision of the National Strategy is a *"life free from falls and fractures in our ageing population"*. **AFFINITY** (Activating Falls and Fracture Prevention in Ireland Together), the national strategy implementation project, aims to prevent harmful falls amongst persons aged 65 years and older, enhance the management of falls and improve health and wellbeing.

Core principles are: **Integration, Implementation and Innovation**. Core values are: **Mutual respect, Inclusion, Caring and Sharing**.

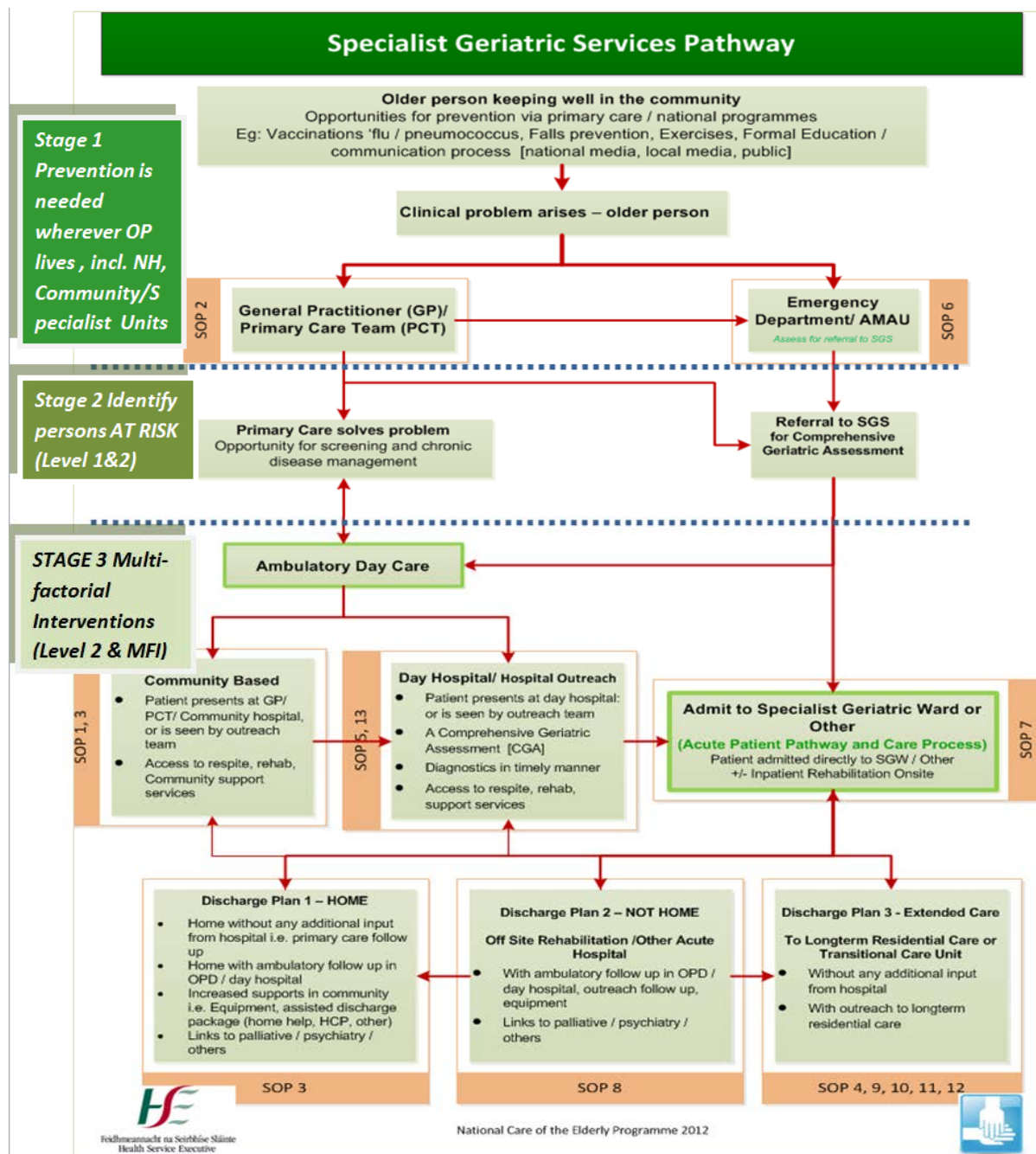
AFFINITY is a national safety and quality improvement project that will need the combined and focussed efforts of everyone to make changes leading to better outcomes for all. To learn more or get involved please contact **National Joint Co-ordinators: Rachel Fitzgerald 01 8908748 or Irene O'Byrne-Maguire 01 664 0984**.

HIQA Standards – Safer Better Healthcare & Residential Care Standards for OP	Core Affinity Elements	Key Result Areas	Key Deliverables	Timeframe	Lead/Support
Capacity and Capability	Leadership, Governance and Management	Foster accountability, effective management and leadership at all levels to deliver safe, high quality and reliable falls prevention and bone health services for OPs.	<p>Integrate TOR for NST, NIT and RITs using HSE Governance model.</p> <p>Support and enable NST, NIT and RITs to form and realise their potential.</p> <p>Progress National Falls Prevention and Bone Health Guideline through NCEC process and align with Osteoporosis Guideline, where practically possible.</p>	<p>From Q 1</p> <p>From Q1</p> <p>Q1-4</p>	<p>IOBM/AMR</p> <p>IOBM/AMR In collaboration with NST/NIT and RITs</p> <p>Irene In collaboration with NST & sub group NIT</p>

			Give an account of AFFINITY progress/challenges to relevant HSE Executive Management and stakeholders as appropriate.	Q1	AMR/Irene in collaboration with NST.
	Change Management Supports <ul style="list-style-type: none"> – Workforces – Resources – Information 	Identify, develop, deliver and evaluate supports and advices for the MDT workforce to enable them to continuously update and maintain competence (knowledge, skills, attitudes and behaviours) and build capability to deliver high quality, safe reliable care.	Make AFFINITY web repository available and continue to identify and pursue access to other evidence informed resources e.g. Fallsafe, QI tools etc. Explore options for education and learning interventions such as Quality Improvement supports, coaching/mentoring, E Learning, educational resource development and/or identification of “best of breed”	Q1	Irene/ AMR in collaboration with Education and Learning Support Team
		Promote ways of working and harness technological supports that facilitate timely access to good quality information to enable HCP, Managers and Leads to exercise their personal and professional responsibility for the quality, safety and reliability of the services provided.	Build on existing collaborations and establish new ones , in particular where good congruence with AFFINTIY objectives.	Q1-4 From Q1	Irene/ AMR in collaboration with Education and Learning Support Team Irene/ AMR in collaboration with NIT and RITs

Quality Improvements Outcome Indicators 2014 Installation 1 Access: > 10% of population 65 years & older/ per Area Quality: Provide timely help from hospital & community services both to enable Service User (SU) to return to independent living and to prevent further falls & fractures. Value: reduce harmful falls by 30%	Integrated Service Delivery Model and Population Health Improvement approach <ul style="list-style-type: none"> – Person centred care and support – Effective care and support – Safe care and support – Better health and wellbeing 	<p>Develop/enhance person-centred equitable access to services.</p> <p>Support service users in maintaining and improving their own health and wellbeing.</p> <p>Deliver effective coordinated care that is right for them at the right time in the right place.</p> <p>Use/enhance systems in place to identify, prevent or minimise unnecessary or potential harm associated with the provision of care and support to service users.</p>	Support and enable pilots/early adopters to deliver an Integrated Care Pathway (ICP) within and across various settings for a defined population.	Q 1-3	AMR/Irene in collaboration with RITs and NIT
			Work towards standardisation of key interventions while being open to innovative and diverse approaches to actioning same, given resources available.	Q 1-4	Irene/AMR Irene in collaboration with RITs and NIT
			Seek opportunities and fora to share the learnings from pilots/early adopters to problem solve common problems, build capability and sustain the gains.	Q 1-4	Irene/AMR Irene in collaboration with RITs and NIT
			Explore how best to be informed of the service user voice and that of their families i.e. service user surveys, HSE Advocacy	Q 2-4	Irene/AMR in collaboration with HSE Advocacy
			Enhance communications by 1) establishing working links with HSE Communications and other Networks (for example professional and voluntary	Q 1-4	Irene/AMR in collaboration NIT

			bodies), 2) establishing connections with service users and their advocacy groups, 3) enabling virtual and live “peer support”/”communities of practice” to problem solve and share learnings, and 4) ensuring AFFINITY repository is kept updated and responsive to need where practically possible..		
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Schematic Integrated Care Pathway Model for National Falls & Bone health Implementation Project (AFFINITY)

Stage of Care – 1. Prevention 2. Case Finding/AT RISK 3. Interventions	Community Setting	Hospital Setting
FALLS PREVENTION	Older person keeping well in the community 65 years and older	
	Clinical problem arises <i>E.g. Fall with suspect fractured hip</i>	
	Referral to GP/out of hours GP service/PCT	Or/and Referral to Emergency Department/AMAU
CASE FINDING/AT RISK (Level 1 Screening Assessment & Level 2 <i>if necessary</i> Multi-factorial Falls Risk Assessment)	Problem resolved with opportunity seized for screening and chronic disease management in clinic/at home/LRC or transitional unit	<ul style="list-style-type: none"> • If HIP FRACTURE, urgent referral to Orthopaedics & for Medical Assessment if necessary • Referral to Specialist Geriatric Service for Comprehensive Geriatric Assessment (CGA)
INTERVENTIONS (Level 2 Multi-factorial Falls Risk Assessment <i>if not already done</i> & Level 3 Multi-factorial falls Interventions)	<p>Ambulatory Day Care that is</p> <ul style="list-style-type: none"> • Community based i.e. GP/PCT/OPD/Community hospital/outreach team for respite, rehab, community supports • Day Hospital/Hospital Outreach for timely diagnosis/CGA/access to respite, rehab, community support such as equipment, HCP, home help etc. <p>Offsite Rehabilitation/other acute hospital (Model 2/3/4)with ambulatory follow up in OPD/day hospital/hospital outreach with/without links to psychiatry/palliative/others</p> <p>Long term Residential Care Unit (LRCU) With/ without additional inputs from hospital outreach</p>	Admit to Specialist Geriatric Ward or Other +/- inpt rehabilitation onsite