

**GETTING STARTED - Briefing for HOSPITAL
Pilots/Early adopters implementing AFFINITY
February 2014**

CONGRATULATIONS on taking up the challenge to be a pilot/early adopter site. You are probably already working in a team located within a hospital /Hospital Group or in the process of starting one. With the support of your Hospital/ Hospital Group Management and your Regional Implementation Team (RIT) leads you may also be aligned in part/full to a local working group i.e. MDTs from various settings such as primary, community and/or residential care who are working along an Integrated Care Pathway (ICP) for a defined population of older persons within a recognised Integrated Service Area (ISA).

The **primary task** of pilots/early adopters is to develop/enhance a falls and bone health ICP for a defined population of persons aged 65 years and older within a specific geographic area/recognised integrated service area (ISA). For example, AMNCH within Dublin Midlands Hospital Group mainly provides services to persons within existing ISA - Dublin South West/Kildare, while St Luke's General Hospital, Kilkenny within Dublin East Hospital Group mainly services existing ISA - Carlow/Kilkenny/South Tipperary.

The **integrated care pathway (ICP)** needs to be able to respond to the needs of older persons with one or more co-morbidities living in their own home with/without a home care package or in a residential care setting who may have fallen at least twice in the last 12 months, with the possibility of the second fall resulting in a hip fracture. Consider using the modified version of the Specialist Geriatric Services Model Pathway (*See Appendix 1 SGS Model Pathway modified*) to help you think through the processes required to ensure the pathway is working well for your service users.

The **aim** of your programme/initiative is to

- Prevent falls,
- Identify and reduce the risk factors for falling,
- Reduce the injuries from falls,
- Manage the impact of falls effectively and
- Improve health and wellbeing through a focus on bone health.

in keeping with the Strategy to Prevent Falls and Fractures in Ireland's Ageing Population, 2008, hereafter known as the National Strategy.

http://hse.ie/eng/services/news/2008_Archive/Aug_2008/Preventing_Falls_and_Fractures.html and the Specialist Geriatric Services Model pathway <http://www.hse.ie/eng/about/Who/clinical/natclinprog/olderpeopleprogramme/olderpeopleprogramme.html> (*See Appendix 1 SGS Model Pathway modified*)

Some **additional steps** * that may help you:

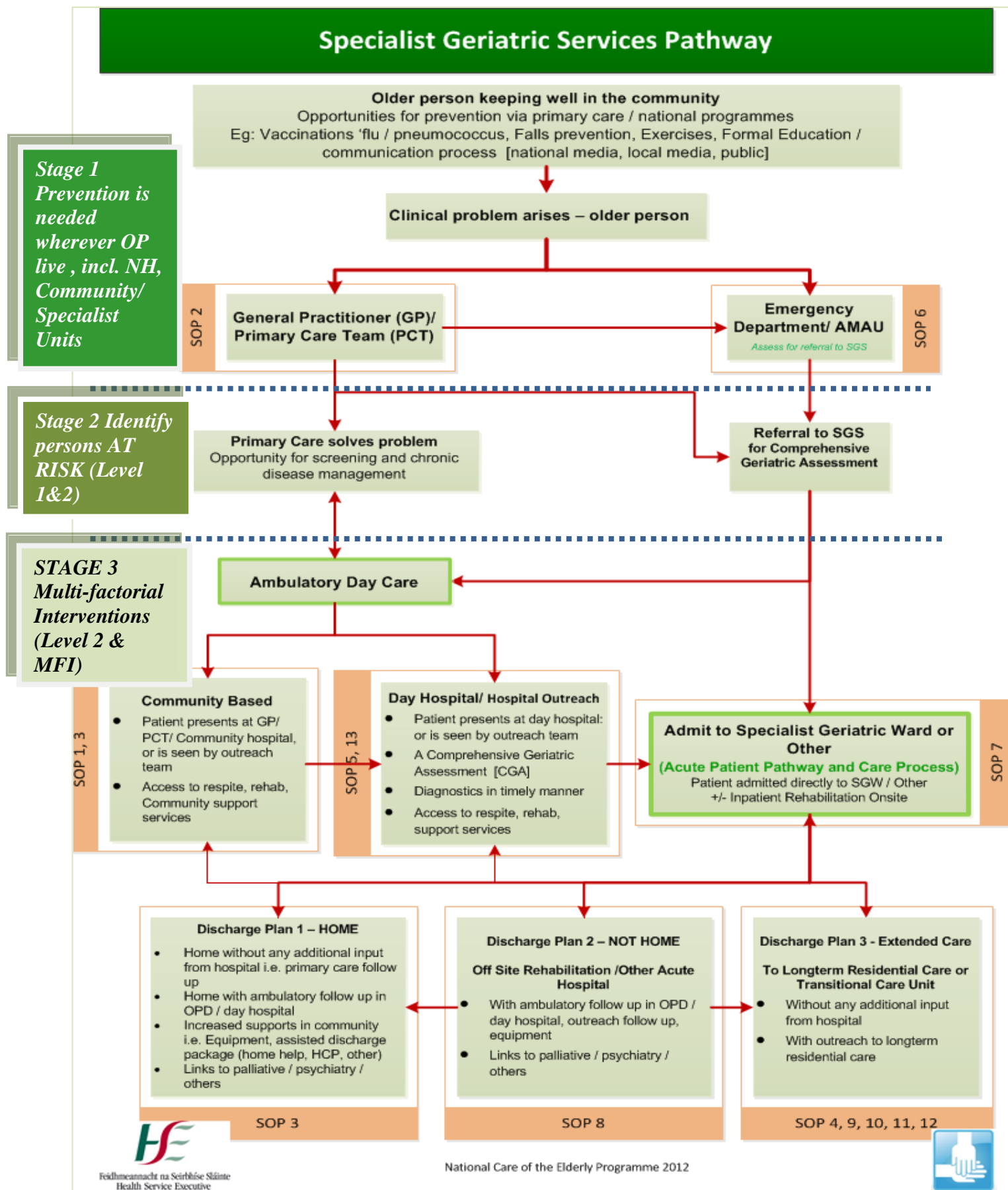
1. **GOVERNANCE:** Work from a definite falls prevention and bone health policy document or adapt policy from similar setting where possible. This will help facilitate a culture of safety, provide strategic direction and enable you to deliver on measurable outcomes. The policy should include guidance and/or direction for post falls management as early detection and measurement of fractured neck of femur and head injury is associated with reduced mortality so early effective treatment is essential.
2. Ensure that any such policy is integrated with your corporate quality and risk management framework. Create explicit links to related policies within your hospital/hospital group e.g. admissions, moving and handling, pressure ulcer prevention, risk management, wandering service/user patient, continence management, medication management, discharge etc
3. Establish/enhance a multi-disciplinary integrated Falls Prevention and Bone Health Team to co-ordinate the policy implementation. Members of this team should be representative of MDT stakeholders, such as Geriatrician/relevant Medical Consultant, Falls/Fracture Liaison/Clinical Nurse Specialist, Occupational Therapist, Physiotherapist, Risk/Quality Manager, Dietician, Pharmacist, Health Promotion. Ensure that adequate consultation takes place in implementing your policy and that your policy and implementation plan is communicated in accordance with your internal communication's policy and governance arrangements.
4. **INTEGRATED SERVICE DELIVERY MODEL:** Think through your access, referral, assessment, intervention and discharge processes and how best to enhance, communicate and standardise these with other MDT members/services.
5. Think through what screening, assessment and intervention tools you are using/ will use and how you will communicate your findings and responses with your service users and other MDT members/services.
6. Support the development; use and monitoring of standard operating procedures and tools in the referral, assessment, interventions and discharge processes, particularly where multiple stakeholders and different health and social care settings are involved.
7. If you are already doing falls prevention/management initiatives, try and enhance or standardise the work, for example servicing a wider group of service users or getting improved outcomes. If you wish to consider starting a new initiative for falls prevention, target a defined group of service users (particularly those considered AT RISK), think through the problem you wish to address, ensure your goals are SMART (specific, measurable, achievable, realistic and timed) and seize opportunities where possible to engage people and resources, both service users and other care professionals i.e. opportunistic screening of all persons 65 years and

older who attend ED, hospital admissions, fracture clinics, OPD, wound dressings etc.

8. Ensure that location, design and layout of new/refurbished facilities are suitable for their stated purpose and comply with all relevant statutory provisions and building regulations; Such facilities need to be accessible, safe, hygienic, spacious and well maintained to reduce the risk of falls.
9. Ensure that equipment purchases, adaptations made and preventative maintenance activities are of such a standard as to reduce the risk of falls.
10. Housekeeping needs to be sufficiently prioritised to reduce the risk of falls.
11. Use checklists such as general environmental checklists, service user/patient specific checklists and safe shoe checklist for those considered AT RISK to help standardise and maintain focus.
12. Consider identifying one department/ward as a specialist falls management and bone health centre of excellence.
13. Provision and or guidance must be considered in relation to medical reassessment following a first fall as falls can also be an indication of an underlying illness or that the patient's condition has deteriorated. Unless a first fall leads to a review, including medical assessment, the patient is likely to fall again.
14. Provision should be made to do an individualised discharge plan for each patient which includes falls prevention and bone health strategies for the service user/patient and/or family.
15. Consideration to be given regarding the process for timely, clear communications with GPs and Community teams, who will require discharge summaries, detailing relevant assessment findings and interventions done and recommended.
16. Ensure that OPs, especially those considered AT RISK, can access falls and bone health services regardless of their first point of contact. *The referral and intervention process for patients who have fallen while in hospital and following discharge should be clearly stated as they may need support from a Social Worker, Occupational Therapist and Physiotherapist to help them return home safely. They may need a home safety assessment and alterations, equipment to improve their safety, installation of emergency call systems, check calls or visits and advice as to how to get up safely after a fall and how to contact the hospital and/or falls service if required. Use the ICP as per the modified Specialist Geriatric Service Model Pathway (Appendix 1) to help maintain focus.*
17. **CHANGE MANAGEMENT SUPPORTS:** Think through how you will know that you are making a difference, to help ensure a good experience for service users and a quality service is being delivered? What data will I collate and how best to do this? For example, how best to collate documented evidence of the percentage of service users/patients who have been screened, received multifactorial assessments for falls prevention and bone health and appropriate multifactorial interventions.

18. Can you work with existing process and outcome indicators to enable the sustained delivery of high quality, safe, reliable outcomes for service users or do you need to develop, implement and monitor new ones? AFFINITY RIT Leads and National Joint Co-ordinators will support you with this.
19. Develop a system for the review of falls incidents so that emerging patterns in relation to falls and bone health are identified in relation to the number of incidents, resultant injuries and severity, time of day, location, etc.
20. Consider using a Group code (Older Person Services) on NAEMS (formerly STARSWeb) to capture any events that may need to be reported. This will allow you to analysis your interventions against those OP who fall and have received no/limited inputs.
21. Ensure auditable programmes and service user feedback mechanisms are in place to demonstrate high quality, safe, reliable outcomes for service users.
22. Ensure that falls and fracture prevention and management education and learning is aligned with professional development and performance management strategies. Actions could include appropriate staff induction, online learning, blended learning and quality improvement programmes.
23. Feel free to Share your Learnings from successes and challenges. It will build your resilience and empower others.
24. Time frame of Installation 1 pilot project 6-9 months after which the work of the pilot(s) will be evaluated and learnings shared. This will involve identifying such issues as what OP were screened, what assessments and interventions were conducted, what impact was there in terms of processes and service user outcomes and how were challenges worked through.
25. Seek support from your AFFINITY Regional Implementation Team (RIT) leads as needed. They will alert the National Joint Co-ordinators (Anne Marie and Irene) on any issues in respect of the working of the pilot sites who will always try to support you.
26. Remember some issues will need a national or regional focus, hence the governance structures that are in place. **GOOD LUCK**

Appendix 1 SGS Model Pathway modified



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>Eg. 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>	<p>Admit to Specialist Geriatric Ward or Other +/- inpt rehabilitation onsite</p>