

The “*Rise and Shine*” Falls Programme in Co. Clare

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Presentation Outline

- ◆ Describe journey, since 2007, of implementing falls prevention and bone health programmes in Primary Care / Older Persons Services in Co Clare
- ◆ Describe the significance of building partnerships and working collaboratively within and across teams to enable this work

Chronology of Events

Falls Prevention Programmes were piloted by a number of PCTs in Clare



DoH&C publish **Strategy to Prevent Falls and Fractures in Ireland's Ageing Population, 2008**



Development of a policy document for the implementation of Falls Algorithm, National Falls Strategy



Multidisciplinary Falls programme established in St. Joseph's Hospital with countywide access



Clare Falls Project Group was set up to implement Falls Strategy in the community setting

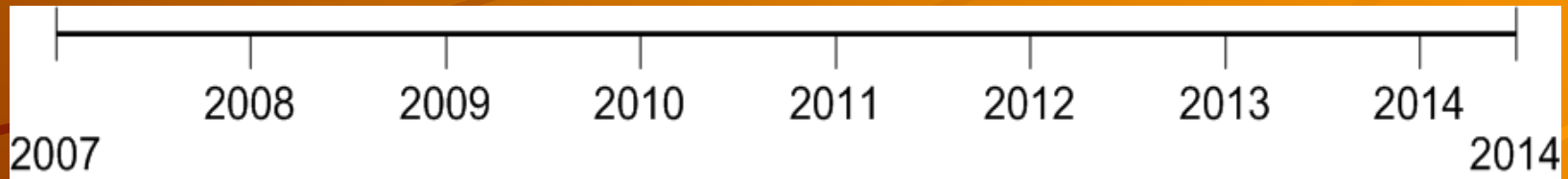


FROP- Com Risk Assessment Tool was **piloted** for use in the community setting by PT/OT/Nursing staff in Primary Care, Co . Clare

Chronology of Events

Amendment of our local policy document to reflect the National Falls Guideline , V1.2

National Falls Group published “ **A Guide to Falls Screening and Multifactorial Falls Risk Assessment in Primary Care**”



Clare Falls programme was reviewed and target areas for action identified in light of National Falls Group publication

St. Joseph's Hospital Falls programme is discontinued to allow devolvement of programme to Primary Care

Multidisciplinary steering group from Primary Care is convened to review the programme in light of KPI i.e. 3 Falls Programmes in Clare



The “*Rise and Shine*” Programme 2014

- ◆ Implementation of the “Guide to Falls Screening and Multi-factorial Falls Risk Assessment in Primary Care”,

by means of the PPPG

- ◆ “*Guideline for the Management and Recording of Falls*”, by all Nursing, Occupational Therapy , Physiotherapy and Podiatry staff in all of the Primary Care teams in Primary Care Networks in Co. Clare

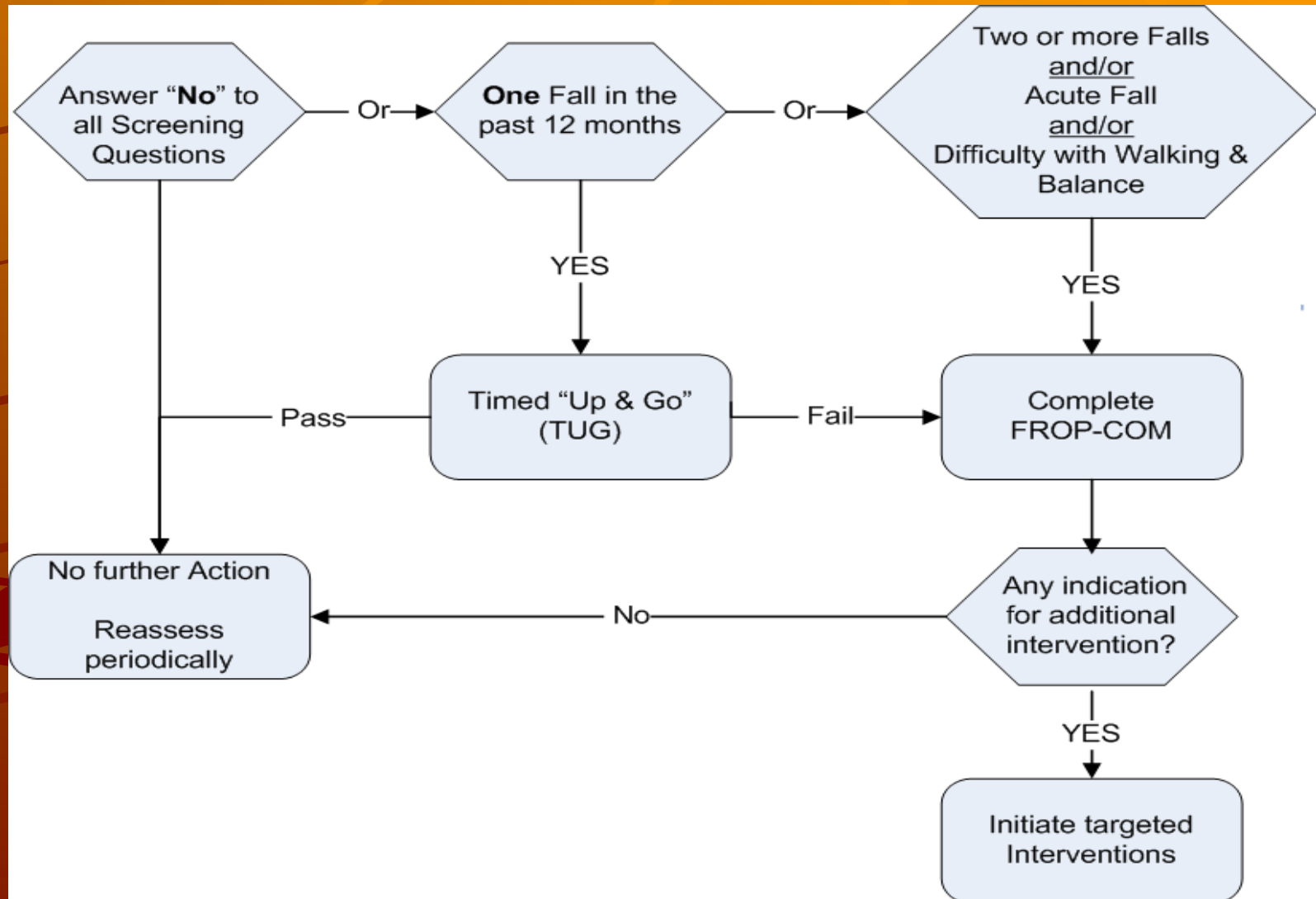
Target Population

- ◆ *"The target population for the guidelines ideally are*
 - older people (≥ 65 years)*
 - living in the community*
 - availing of services provided at Primary Care level.*

However, because of the potential workload involved and the variability of resources locally that screening and multifactorial falls risk assessment should be targeted towards the higher risk groups such as elderly people who attend Emergency Departments or out of hours GP Services with a history of falls, frail elderly, and older people attending day centres".

Extract from "A Guide to Falls Screening and Multi-factorial Falls Risk Assessment in Primary Care, V1.2 "

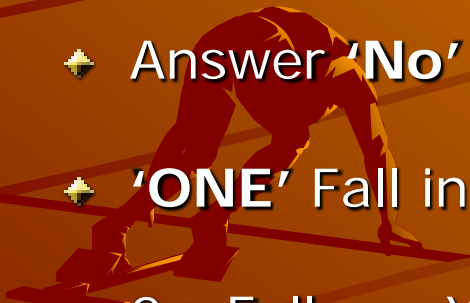
Following the National Falls Algorithm



Screening Questions

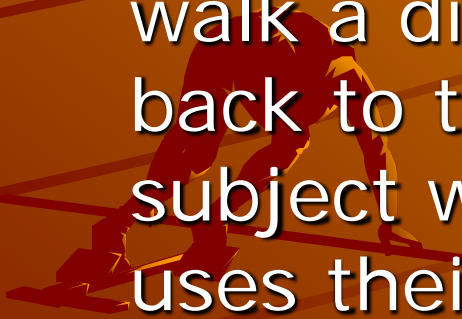
Falls Screening (please circle)

- ◆ 1. Fallen in the past year? Y / N
- ◆ 2. Presents with * Acute Fall? Y / N
- ◆ 3. Difficulty with Walking or Balance? Y / N
- ◆ Answer '**No**' to **ALL** questions = No further Action
- ◆ '**ONE**' Fall in past year = 'Timed Up & Go'
- ◆ 2+ Falls or Yes to Q2 or Q3 above = FROP-Com



Timed Up and Go Test (TUG)

- ◆ The timed "Up and Go" test measures, in seconds, the time taken by an individual to stand up from a standard arm chair, walk a distance of 3 meters, turn, walk back to the chair and sit down. The subject wears their regular footwear and uses their customary walking aid.



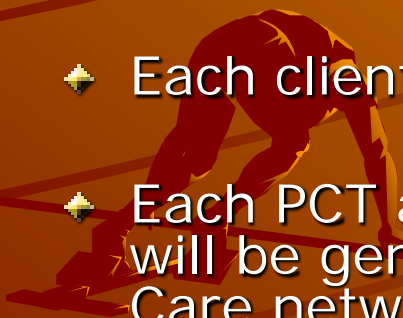
FROP- Com

- ◆ Comprises of 3 documents
- ◆ Guideline on how to use the assessment
- ◆ Risk Assessment – 27 questions that can be completed by any single discipline and indicates if the client is a mild to moderate or a high risk of falls
- ◆ Management options support practitioner in onwards referrals/ action plan
- ◆ Complex clients discussed at Primary Care clinical team meeting with their consent
- ◆ A record sheet of the falls programme is maintained at each Primary Care Team.



Recording of Community Falls Data

- ◆ In April 2014, the Office of the Specialist, Services for Older People HSE West reviewed the "*Rise and Shine*" Falls Programme
- ◆ Subsequently, an excel database was developed to record the information gathered from the FROP-Com Assessment Tool.
- ◆ Each client has a unique ID
- ◆ Each PCT admin support inputs the data monthly and this will be generated onto a master sheet for Clare Primary Care networks.
- ◆ This database will record more comprehensive data on falls in the community.



Falls Database

- ◆ Automatic generation of summary tables for each PCT e.g.
 - Total number of falls
 - Time and location of falls
 - Gender and age profile of clients
 - Age vs No of falls
 - Age vs severity of falls

◆ This data relevant to falls in the community will assist to further develop management strategies, allocating available resources and in delivering evidence based practice.

A Collaborative Approach

- ◆ Key to the successful implementation of the Falls Programme in Co. Clare was :
- ◆ The **project management approach** to designing , planning and reviewing the programme with the OT/PHN/PT managers / Risk Advisor taking the lead from the outset
- ◆ The **collaboration** of the disciplines in primary care in supporting the development and delivery of the programme
- ◆ The **incremental approach** to the roll out of the programme to the teams based on evidence based practice and achievement of clear goals within a timeframe .

The Future

- ◆ Improved liaison between Emergency Departments / Out of Hours GP Services to identify and share information on high risk groups and ensure more timely management in a comprehensive integrated care pathway
- ◆ Introduction of the Single Assessment Tool will support this area of work and the move towards a single shared care plan
- ◆ Analysis of database data to further inform management strategies, resource allocation and evidence based practice.

