

Falls & Fracture Prevention – Measure & Monitor

**A CONSISTENT APPROACH TO MEASURING AND MONITORING FALLS AND FRACTURE
PREVENTION PROGRAMMES AS OUTLINED IN THE NATIONAL STRATEGY (HSE 2008)**

– A CONSULTATION DOCUMENT

Prepared by

AFFINITY

(Activating Falls & Fracture Prevention in Ireland Together)

– AFFINITY is the National Falls Prevention & Bone Health Implementation Project tasked with implementing the *HSE Strategy to Prevent Falls & Fractures in Ireland's Ageing Population 2008*

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http://ec.europa.eu/research/innovation-union/pdf/active-healthy-ageing/a2_action_plan.pdf

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Introduction

The purpose of this document is to achieve national consensus on a framework of metrics (measures of an organisation/service activities and processes delivered against agreed standards) to enable a consistent approach to measuring and monitoring of falls & fracture prevention programmes (bone health/osteoporosis prevention), primarily being delivered by the Health Service Executive (HSE).

What is the current situation?

A framework of metrics is needed:

- To help professionals articulate a standard of care at key points in the delivery of falls prevention and bone health services.
- To promote a culture of quality and patient safety
- To enable service improvements and learning
- To provide evidence of compliance with legislative, professional and accreditation standards
- To assist in creating an open, transparent learning culture where accountability is an integral component of service delivery

It is proposed that the framework of metrics is based on the following three aspects:

- Structural-related; such as, Access to falls prevention and bone health intervention services
- Process-related; such as, % of persons aged 65 plus who receive an annual falls risk screen
- Outcome-related; such as, hip fracture rates, falls rates

It is proposed that the framework of metrics will be used by the following main health and social care service setting:

- Primary and Community Care
- Residential Care
- Hospitals

There is currently a variety of approaches to capturing metrics relevant to falls & fracture prevention services (bone health/osteoporosis prevention), such as HIPE (Hospital Inpatient Enquiry System), NIMS (National Incident Management System) and/or local databases particular to health and social care settings but as yet there is no consistent approach nationally.

What is needed now?

What is needed is a national consensus as to

- what metrics are required and
- what mechanisms are in place/needed to capture metrics that are most relevant and easily accessible
 - a) to ensure that older persons receive appropriate and timely interventions and prevention services,
 - b) to demonstrate the effectiveness and efficiency of falls & fracture prevention services (bone health/osteoporosis prevention) and
 - c) to provide a mechanism to guide any changes necessary to improve the standard of care in reducing harmful falls and improving bone health.

When you have finished reading this document, we would be most grateful if you would review the suggested framework of metrics relevant to your health and social care setting; Primary &/or Community Care (Appendix I), Residential Care (Appendix II) and Hospitals (Appendix III), and comment on

- whether you agree with the metric and wish to retain it, or disagree and wish to remove it
- whether you would like to add further metrics
- suggested methods for capturing metrics, that may currently be in place or could be implemented.
- Feedback can be paper based or electronic. Please see Appendix I, II or III

Please return to Ms. Louise Holohan (lholahan@ntma.ie) ASAP

If you need further information or clarifications, please contact Irene O'Byrne-Maguire

Tel: 01 – 238 0984 or email: iobyrnemaguire@ntma.ie

Thank you – Your input is crucial to this process

Background to the Problem

Falls are the dominant cause of injuries among older persons, accounting for approximately one third of fatal injuries in persons aged 60 and over. Falls can often lead to long-term physical disability (e.g. loss of mobility), severe dependency and reduction in quality of life.

The causes of falls in older persons are multi-factorial, many of which are modifiable and preventable. Slips/trips/falls contributes annually to over one third of National Incident Management System (NIMS, formerly STARS Web) reported incidents from the publicly-funded health and social care system which could have or did lead to unintended and unnecessary harm. In addition, some €520 million is the estimated annual spend in dealing directly with the sequelae of falls and fractures in the absence of implementation of the National Strategy. If we fail to take decisive action now, this latter annual figure is expected to quadruple to €2 billion by 2031, given our ageing demographics.

A considerable body of literature exists on the prevention of falls and fall-related injuries [fracture prevention (bone health/osteoporosis prevention)]. Successful prevention strategies include

- identifying persons at risk for sustaining serious injury from a fall,
- performing a multifactorial assessment to identify known risk factors for falls and fractures
- delivering co-ordinated, multi-disciplinary interventions, including preventive actions, to modify or compensate for risk factors, and
- systematic reporting of falls related incidents and their consequences.

AFFINITY

AFFINITY (Activating Falls and Fracture Prevention in Ireland Together) is the National Falls Prevention and Bone Health Implementation Project. AFFINITY is tasked with implementing the aims, vision and objectives of the '*National Strategy for the Prevention of Falls and Fractures in Ireland's Ageing Population*', hereafter known as the National Strategy; and to develop a robust framework to measure and monitor falls & fracture prevention programmes (bone health/osteoporosis prevention) to ensure accountability and sustainability.

See National Strategy for details:

[http://www.hse.ie/eng/services/Publications/olderpeople/Strategy to Prevent Falls and Fractures in Ireland%E2%80%99s Ageing Population.html](http://www.hse.ie/eng/services/Publications/olderpeople/Strategy_to_Prevent_Falls_and_Fractures_in_Ireland%E2%80%99s_Ageing_Population.html)

The **vision** of AFFINITY, like the National Strategy, is

“a life free from (harmful) falls and fractures in our ageing population”

The **aim** of the AFFINITY implementation project is to

- Prevent harmful falls;
- Identify and reduce the risk factors for falls and poor bone health;
- Reduce the injuries from falls;
- Manage harmful falls effectively; and
- Improve health and wellbeing of older persons through a focus on bone health

Falls & Fracture Prevention (Bone Health/Osteoporosis Prevention) – Service Delivery Model

A *service delivery model* describes the way services are organised to deliver the right care to the right patient/service user by the right people at the right time. The model of service delivery being promoted by AFFINITY to prevent falls and fall-related injuries is an Integrated Care Pathway, as outlined in the National Strategy and the National Clinical Programme Older People Specialist Geriatric Services Pathway (Appendix IV).

There are three stages to the AFFINITY Integrated Care Pathway (Appendix V):

- Stage 1: Prevention
- Stage 2: Case Finding
- Stage 3: Co-ordinated Interventions
 - These three stages are implemented across all healthcare settings including; primary and/or community care, residential care and hospitals.

Stage 1: Prevention represents the point where the vast majority of persons aged 50 and over will be at any given time. Behaviours, activities and measures at this stage can reduce the risk of fall, the risk of recurrent falls, the risk of harmful falls, the risk of fracture and the risk of another fracture. Many interventions at this stage may specifically target falls and fracture prevention but may also contribute to active and healthy ageing, such as general health improvement campaigns on a wider scale.

- Metrics relevant to Stage 1 may be:
 - Increased healthy life expectancy; Secondary bone health management post fall/ fragility fracture
- Methods of capturing metrics relevant to Stage 1 may be:
 - Self-reported life expectancy survey; Irish Hip Fracture Database (hip only)

Stage 2: Case Finding represents approaches, processes and activities which will identify those at risk of falling, at risk of harmful fall, or at risk of fracture (or osteoporosis) who may benefit from individualised falls and fracture prevention (bone health/osteoporosis prevention) interventions. These persons may identify themselves or be identified through targeted or opportunistic screening. This is an important stage to ensure that limited resources are targeted most appropriately. It involves a multi-factorial assessment (MFA) (Appendix VI) in those persons at risk of falling or at risk of fracturing (or osteoporosis).

- Metrics relevant to Stage 2 may be:

- % Residents/persons 65 years and older who receive annual falls screen and/or Multifactorial assessment (MFA)
- Methods of capturing metrics relevant to Stage 2 may be:
 - PCT database; Nurse/Midwife Quality Care Metrics

Stage 3: Co-ordinated Interventions are delivered to persons who are identified as being at risk of falling, at risk of harmful fall, or at risk of fracture (or osteoporosis). Activities and interventions, such as multi-factorial interventions (MFI) based on a multi-factorial assessment (MFA), aim to risk of falling, at risk of harmful fall, or at risk of fracture (or osteoporosis), as well as retain or restore independence. Stage three feeds back into stage one for ongoing self-management (secondary prevention) with support provided as required.

- Metrics relevant to Stage 3 may be:
 - % Residents/persons 65 years and older who receive Multifactorial Interventions (MFI) in response to findings from Multifactorial assessment (MFA)
 - % of Residents/persons 65 years and older who have received hip fracture care in line with 6 Blue book Standards
- Methods of capturing measures and monitors relevant to Stage 3 may be:
 - PCT Database; Nurse/Midwife Quality Care Metrics; Irish Hip fracture database (IHFD)

Framework of Proposed Metrics

The framework of proposed metrics (Appendix VII) aims to include key metrics that will help ensure a consistent approach to measuring and monitoring falls & fracture prevention programmes (bone health/osteoporosis prevention) nationally.

These metrics will be captured across the three stages of the AFFINITY Integrated Care Pathway, within the three main healthcare settings (Figure 1.)

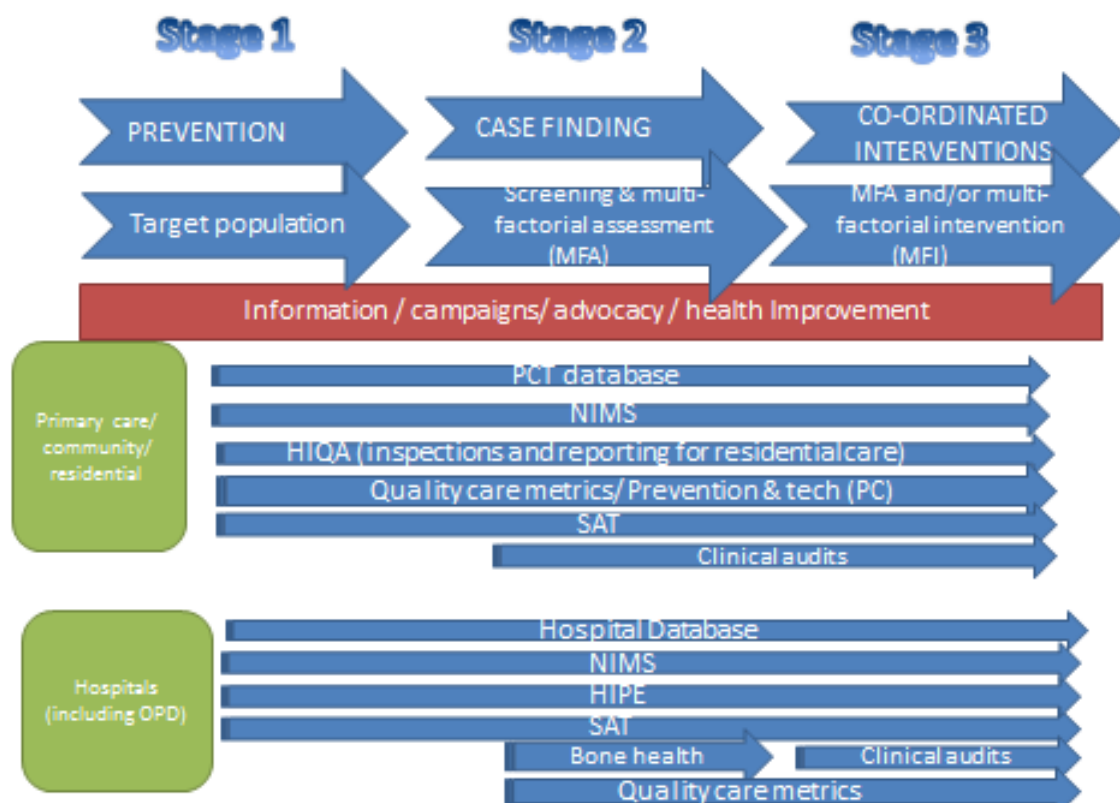


Figure 1. Metrics common to three stages of care within three main health and social care settings

and will align with the HSE Healthstat Framework using the following criteria outlined in HIQA Key Performance Indicators:

- Structural Measures
 - o Relates to the resources of the health and social care system that contribute to its ability to meet the healthcare needs of the population. Structural indicators refer to the resources used by an organisation to deliver healthcare and includes buildings,

equipment, the availability of specialist personnel and available finances. It will include issues on Governance arrangements

- Process Measures

- Relates to what is actually done for the service user and how well it is done. Process indicators measure the activities carried out in the assessment and treatment of service users and are often used to measure compliance with recommended practice, based on evidence or consensus of experts. For example the requirements needed to ensure persons aged 50 and older have access to appropriate services according to need, in a timely manner and in an appropriate setting. Process measures can be further categorised as input or output measures, where inputs refers to the resources used to deliver a particular output. For example competent staff (input) are needed to deliver multifactorial assessments (output) and relevant interventions (output) tailored to older persons' needs.

- Outcome Measures

- Relates to the state of the health of the individual of population resulting from their interaction with the health and social care system. It can include lifestyle improvements, emotional responses to illness or its care, alterations in levels of pain, morbidity and mortality rates, and increased level of knowledge. These measures are used to determine and evaluate the quality of care against a standard; Access, Quality and Value metrics take account of service equity, fairness and service user preferences.

The framework of proposed metrics (Appendix VII) gives an example of what measures (either existing or aspirational) could be considered and how these measures could be captured using the HSE Healthstat Framework Model.

What next?

We want to know

- what metrics to measure and monitor Falls prevention and bone health programmes do you think are most appropriate under each stage of service delivery model for your healthcare setting (whether existing or aspirational) and
- what do you think is the best way to capture this information (whether existing or aspirational)

There are three electronic spread sheets attached for the main health and social care settings (primary/community care, residential care and hospitals) and there are three tabs in each spread sheet (Structural Measures, Process Measures and Outcome Measures).

Please

- Review the electronic attachments (Appendix I, II, III) to this email most relevant to your health and social care setting.
- Share this document with as many people within your organization/ service/ setting as possible such as
 - o Medical personnel for example gerontology, orthogerontology, endocrinology or Surgery; such as orthopaedics
 - o Physiotherapy, Occupational Therapy, Nursing, Radiography, and Clinical Nutrition & Dietetics
 - o Bone & Joint Services; such as DXA, Fracture Liaison Service,
- State whether you agree or disagree with the proposed metric(s) in each tab of the spread sheet
- Add other metrics to the spread sheet that you think are appropriate
- Suggest methods of capturing these metrics, whether existing or aspirational

Please return to Ms. Louise Holohan (lhohan@ntma.ie) by 1st June 201

If you need further information or clarifications, please contact Irene O'Byrne-Maguire

at 087 – 672 7705 or iobyrnemaguire@ntma.ie

Thank you – Your input is crucial to this process

Appendices

Appendix I

Primary & Community Care: Framework of Measures and Monitors



Falls in
Community.xls

Appendix II

Residential Care: Framework of Measures and Monitors

See Primary & Community Care Appendix 1 above

Appendix III

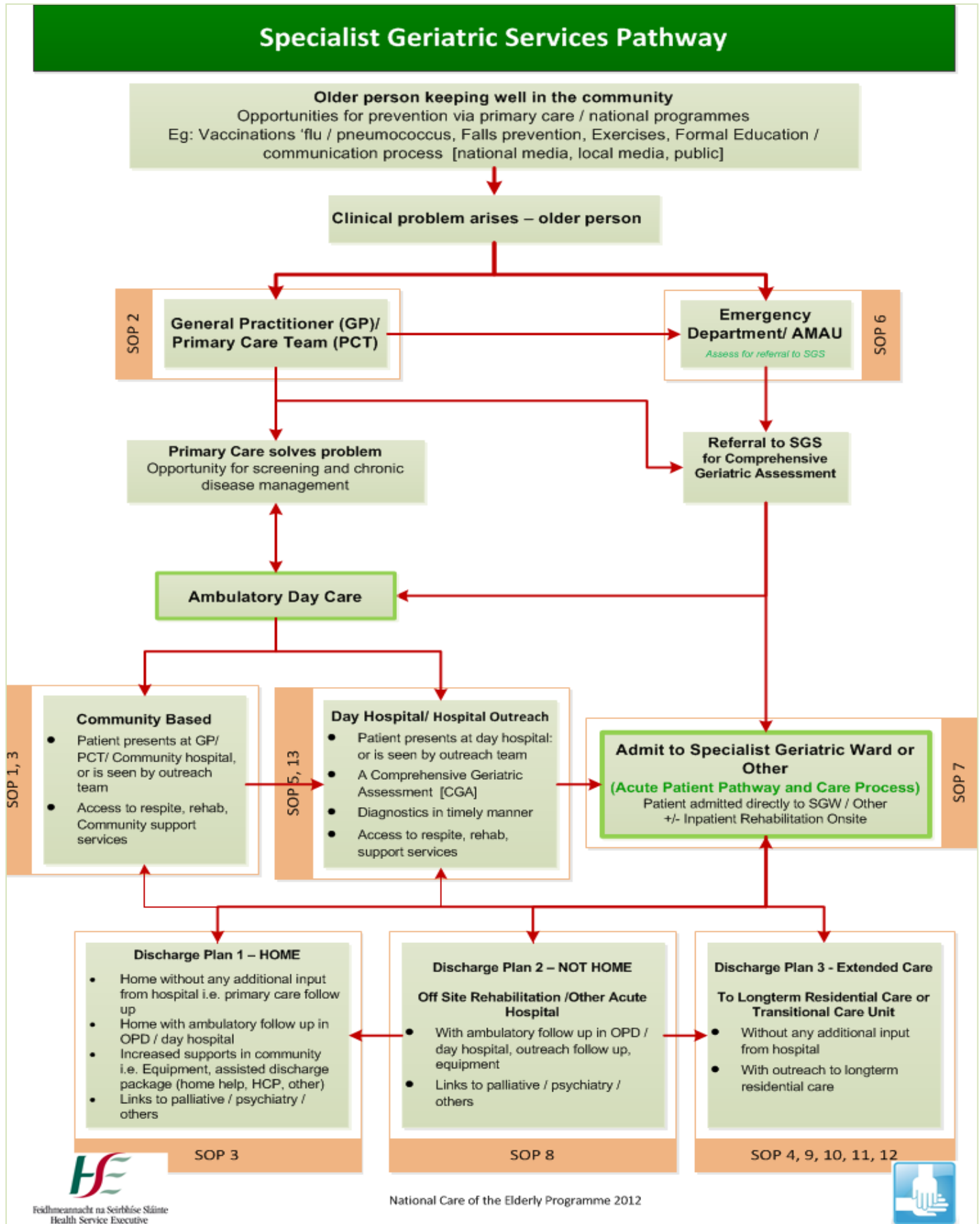
Hospital: Framework of Measures and Monitors



AFFINITY M&M
Hospital.xlsx

Appendix IV

National Clinical Programme Older Person's Specialist Geriatric Services Pathway



Appendix V

AFFINITY Integrated Care Pathway (Model of Service Delivery)

STAGES OF CARE	COMMUNITY SETTING	HOSPITAL SETTING
1. PREVENTION Falls and Fracture Prevention	Older person keeping well in the community 65 years and older (falls)	Older person 65 years and older keeping well attending out-patients (falls)
	Person keeping well in the community 50 years and older (osteoporosis)	Person 50 years and older keeping well attending outpatients (osteoporosis)
	<i>Clinical problem arises eg. Fall with suspect fractured hip</i>	
	Referral to GP/out of hours GP service/Primary Care Team	• Or/and Referral to Emergency Department / AMAU
2. CASE FINDING Level 1. Screening Assessment Level 2. Multifactorial Risk Assessment <i>(if necessary)</i>	Problem resolved (if possible) with opportunity seized for screening and chronic disease management in clinic/at home/L RC 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)
3. COORDINATED INTERVENTION Level 2. Multifactorial Risk Assessment <i>(if not already completed)</i> Level 3. Multifactorial Risk Interventions	<p>Ambulatory Day Care that is Community based i.e. GP/PCT/OPD/Community hospital/outreach team for respite, rehab, community supports</p> <p>Day Hospital/Hospital Outreach for timely diagnosis/CGA/access to respite, rehab, community support such as equipment, HCP, home help etc</p> <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</p> <p>+/- inpt rehabilitation onsite</p>

Appendix VI

Sample Multifactorial Assessment

The form is intended to be completed by any healthcare professional on a primary care team. As local arrangements may vary the assessor/health care professional should complete the form in so far as their scope of practice allows and refer to their colleagues as required for full completion of the appropriate parts. The Clinician who initiates the process should maintain the record of the assessment and a register should be maintained by the Primary Care Team or Administration Support. This register would allow clients to be called back for follow up as required.

Assessor: _____ Date: ____ / ____ / ____ Information obtained from: ☐ Client ☐ Carer ☐ Other (specify) _____

DEMOGRAPHIC DETAILS

Name: _____
 Address: _____
 Phone: _____
 Date of Birth: ____ / ____ / ____
 GMS/LTI Card No: _____

Next of kin: _____
 Relationship: _____
 Phone: _____
 GP Name: _____
 GP Address: _____
 GP Phone: _____

MEDICAL HISTORY

SOCIAL HISTORY

Living Alone: ☐ Yes ☐ No
 Carer: ☐ Yes ☐ No

1. FALLS HISTORY

History of Falls: ☐ Yes ☐ No

Number of falls in last 12 months? _____ Location of fall(s): ☐ Indoors _____ ☐ Outdoors _____

Time of day fall(s) occurred: _____

How did the fall occur / what was the activity at the time? _____

What (in the person's opinion) was the cause of the fall(s)? _____

Has the person changed their routine or environment since the fall? ☐ Yes ☐ No

Was the person able to get up from the floor? ☐ Yes ☐ No

Did the person receive any injuries as a result of the fall? ☐ Yes ☐ No

Was the person able to summon help following the fall? ☐ Yes ☐ No

Episodes of dizziness associated with falling? ☐ Yes ☐ No

Does the person have a pendant alarm? ☐ Yes ☐ No

Episode of blackout ☐ Yes ☐ No

(If Yes) Was the person wearing pendant alarm at time of fall? ☐ Yes ☐ No

☐ Yes ☐ No ☐ N/A

2. GAIT AND BALANCE				
Gait analysis (unsteady on feet/shuffles/uneven stride length, etc.)		Poor balance: <input type="checkbox"/> Yes <input type="checkbox"/> No Reported difficulty climbing stairs/steps to house: <input type="checkbox"/> N/A Walking aid: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, please specify: _____		
3. FUNCTIONAL ABILITY				
Activities of Daily Living: Ask the client if they are: Independent (I), require Assistance (A), or Dependent (D) with each of the following tasks:				
Personal Activities of Daily Living (Dressing, Bathing, Toileting):		<input type="checkbox"/> I <input type="checkbox"/> A <input type="checkbox"/> D		
Transfers (Toilet, Bed, Chair):		<input type="checkbox"/> I <input type="checkbox"/> A <input type="checkbox"/> D		
Domestic Activities of Daily Living (Housework, Meal Preparation, Shopping):		<input type="checkbox"/> I <input type="checkbox"/> A <input type="checkbox"/> D		
4. FEAR OF FALLING				
Fear of falling or restricting any activity they appear capable of doing:		<input type="checkbox"/> Yes <input type="checkbox"/> No		
If Yes, details: _____				
5. HOME SAFETY				
Does the client have:		Steps/Stairs in the home either inside or outside unprotected by a rail? <input type="checkbox"/> Yes <input type="checkbox"/> No A shower with step or a bath without grab rails? <input type="checkbox"/> Yes <input type="checkbox"/> No Indoor hazards present (cluttered rooms, rugs, cords)? <input type="checkbox"/> Yes <input type="checkbox"/> No		
6. PERCEIVED FUNCTIONAL ABILITY				
Demonstrates decreased awareness in reporting falls, risks and consequence of falls:		<input type="checkbox"/> Yes <input type="checkbox"/> No		
7. COGNITIVE FUNCTION				
Complete the Abbreviated Mental Test Score – Appendix 7				
8. URINARY INCONTINENCE				
Urinary Incontinence:		<input type="checkbox"/> Yes <input type="checkbox"/> Urgency <input type="checkbox"/> Nocturia <input type="checkbox"/> Other (specify) _____ <input type="checkbox"/> No		
9. FOOT PROBLEMS AND FOOTWEAR				
Foot problems, i.e. corns, bunions, swelling, overgrown toenails:		<input type="checkbox"/> Yes <input type="checkbox"/> No		
Inappropriate, poorly fitting or worn footwear:		<input type="checkbox"/> Yes <input type="checkbox"/> No		
10. ASSESSMENT OF MOOD				
During the last month have you been bothered by feeling sad, depressed or hopeless?		<input type="checkbox"/> Yes <input type="checkbox"/> No		
During the last month have you often had little interest or pleasure in doing things?		<input type="checkbox"/> Yes <input type="checkbox"/> No		
11. NUTRITION				
11 (i)	Weight loss (within previous 12 months):		<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Loss of appetite:		<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Are there issues impacting on dietary intake:		<input type="checkbox"/> Yes <input type="checkbox"/> No	
<i>(If client answers Yes, carry out 11(ii) as appropriate ('MUST' screening – refer to MUST tool in Appendix 4))</i>				
11 (ii)	Height:	Weight (kg):	BMI (kg/m ²):	'MUST' Score: _____ 0 – Low risk: Monitor 1 – Med risk: Implement 'First Line Dietary' advice (Appendix 4) ≥ 2 – High risk: Implement 'First Line Dietary' advice (Appendix 4) and refer to dietician

12. BONE HEALTH			
<p>Previous low trauma fracture:</p> <p>X-ray evidence of osteopenia:</p> <p>Corticosteroid use (i.e. prednisolone for ≥ 3 months):</p> <p>Family history of osteoporosis (especially maternal hip fracture):</p> <p>Other clinical risk factors: height loss, kyphosis, low Body Mass Index ($<19\text{kg/m}^2$):</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No	<p>Possible secondary osteoporosis (primary hyperparathyroidism, poorly controlled thyrotoxicosis, malabsorption, rheumatoid arthritis, liver disease, alcoholism, primary hypogonadism):</p> <p>Untreated oestrogen deficiency (history of surgical or natural menopause <45 years, secondary amenorrhoea > 6 months not due to pregnancy or primary hypogonadism):</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No
13. DRUG HISTORY			
<p>Medications:</p> <p>Is the client on 4 or more medications? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Is the client on psychotropic medication, e.g. night sedation, anti-depressants, anxiety medication? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>Alcohol:</p> <p>Does the client have alcohol dependency issues? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, alcohol units per week: _____</p>		
<p>List all medications (including dosage): Document below or attach print-out</p> 			
14. VISION			
<p>14 (i) Does the person report any vision related problems, e.g. poor eyesight, cataracts, etc.? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><i>(If client answers Yes complete part (ii) below or complete onward referral for completion)</i></p> <p>Under 70: Has the client had an eye test in the last two years? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>70 or over: Has the client had an eye test in the last year? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Does the client wear bifocals? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>			
<p>14 (ii) Visual acuity test: R= L=</p> <p style="margin-left: 150px;">Are visual fields normal? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>			
15. CLINICAL OBSERVATIONS			
<p>Record BP and HR after 2 minutes lying: BP: ____ / ____ HR: ____ / ____</p> <p>Record BP and HR after 1 minute standing: BP: ____ / ____ HR: ____ / ____</p> <p>(Postural hypotension: fall of 20mmHg systolic or 10mmHg diastolic with dizziness)</p>			
<p>Assessor: _____ Profession: _____ Date: _____</p>			

Appendix VII

Framework of Proposed Metrics

- Suggested framework of measures and monitors is found on the top row
- How these measures and monitors relate to the HSE HealthStat Framework is found in the first column
- Mechanisms to capture this data is identified and a traffic light system is used to denote the status of each mechanism :

Green = Happening Now, ORANGE = Test Mode, RED = Needed

HSE HEALTHSTAT FRAMEWORK –Access, Integration, Resources	STRUCTURAL MEASURES	PROCESS MEASURES (INPUTS)	PROCESS MEASURES (OUTPUT)	OUTCOME MEASURES
ACCESS e.g. Waiting times for planned procedures, ED admissions, therapies, diagnostics, OPD clinics, care group services	Access to falls preventions and bone health intervention services	% residents/persons 65 plus who receive annual screen	Waiting times for critical interventions e.g. BMD services, rehabilitation services (diagnostic and/or therapeutic services)	
	Mechanism to Capture: Healthstat; PCT database; KPIs SGSMModel	Mechanism to Capture: PCT database, GPrecords, SAT; Nursing/Midwifery Quality Care- Metrics	Mechanism to Capture: Healthstat?	

INTEGRATION e.g. Day case rates, ALOS, day of procedure admission rates, use of bed days, diagnostic services, delayed discharges	Organisational/Unit Readiness to include leadership, governance, FBH committee, local policy, staff/SU supports, education & Learning, Visibility, Audit	% residents/persons 65 plus who receive screen plus MFA	LOS hip fractures	Death rates
	Mechanism to Capture: AFFINITY SCA, NOCA?	Mechanism to Capture: <i>PCT database; SAT; Nursing/Midwifery Quality Care- Metrics GPreCORDs?</i>	Mechanism to Capture: <i>HIPE IHFD, Healthstat; KPIs SGSMODEL</i>	Mechanism to Capture: <i>NIMS; HSE QPS systems?</i>
	Environmental checklists	% residents/persons 65 plus who receive screen plus MFA & MFI as needed	LOS head injuries	Hip fracture rates
	Mechanism to Capture: <i>SAT</i>	Mechanism to Capture: <i>PCT database, Nursing/Midwifery Quality Care- Metrics ? if there is a standard; GPreCORDs?</i>	Mechanism to Capture: <i>HIPE, Healthstat; KPIs SGSMODEL</i>	Mechanism to Capture: <i>HIPE IHFD,</i>
	Structural Integrated Care Pathway audit tool based on UK validated tool	% hip fractures receive BH assessment and rehabilitation	Falls prevention & BH documentation to audit integrity and quality of ICP	Head injury rates

	Mechanism to Capture: AFFINITY SCA, NOCA?	Mechanism to Capture: HIPE IHFD Nursing/Midwifery Quality Care- Metrics ? if there is a standard	Mechanism to Capture: PCT database, Nursing/Midwifery Quality Care- Metric ? if there is a standard	Mechanism to Capture: NIMS; HSE QPS systems?
		% receive post falls management (care bundle) other than hips fractures and/head injury	Meaningful post falls documentation to audit integrity and quality of ICP	Other Injurious fall rates
		Mechanism to Capture: NAEMS, PCT database Nursing/Midwifery Quality Care- Metrics ? if there is a standard	Mechanism to Capture: Nursing/Midwifery Quality Care- Metrics? if there is a standard	Mechanism to Capture: NIMS; HSE QPS systems?
INTEGRATION e.g. Day case rates, ALOS, day of procedure admission rates, use of bed days, diagnostic services, delayed discharges				Post injury morbidity/sequelae eg. mobility issues/fear falling
				Mechanism to Capture: NIMS; TILDA; HSE QPS systems?
				Quality of Life (QoL) measures
				Mechanism to Capture: NIMS; TILDA; SAT; HSE QPS systems?; KPIs SGSMModel

INTEGRATION e.g. Day case rates, ALOS, day of procedure admission rates, use of bed days, diagnostic services, delayed discharges				Discharge status-home, extended care (transitional, LRC,)
				Mechanism to Capture: <i>HIPE; KPIs SGSMoel</i>
				Severity of injury – catastrophic, major(serious), moderate, minor, no injury
				Mechanism to Capture: <i>NIMS</i>
RESOURCES e.g. Staffing & absenteeism, mngt therapies, budget/spend, meeting activity targets	Critical Incident Analysis processes	Service user/population profiles –age, gender, frailty, morbidity		Service User Experiences Survey
	Mechanism to Capture: <i>NIMS; HSE QPS systems?</i>	Mechanism to Capture: <i>CSO, TILDA; Health Intelligence</i>		Mechanism to Capture: <i>HSE QPS systems?</i>
	Mechanisms to report Hip fracture and/or head injury			Worker culture surveys
	Mechanism to Capture: <i>NIMS</i>			Mechanism to Capture: <i>HSE QPS systems?</i>

