

GETTING STARTED - Briefing for pilots/early adopters implementing AFFINITY October 2013

CONGRATULATIONS on taking up the challenge to be a pilot/early adopter site. You are probably working in a team located within or across the following settings: primary care, community care, hospitals /groupings or residential care. With the support of your Regional Implementation Team (RIT) leads you are also aligned to a local working group i.e. MDTs from various settings working along an Integrated Care Pathway (ICP).

The **task** 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, for example DNC, formerly catchment areas 6 &7 or ISA Dublin South East/Wicklow or part thereof.

The **integrated care pathway (ICP)** needs to be able to respond to the needs of older person with one or more co-morbidities who is 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 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

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

1. Work from a definite policy document or adapt policy from similar setting where possible,
2. If you are already doing falls prevention/management initiatives, try and enhance or standardise this work, for example servicing a wider audience of service users or getting improved outcomes.
3. If you wish to consider starting a new initiative for falls prevention, target a defined group of service users, 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 70 year olds who attend clinics for flu jab, wound dressings etc.

4. Think through your access, referral 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. 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,

- *Number of older persons (OP) screened over 3 months?*
- *Number who had multi-factorial assessment over 3 months?*
- *Number of people referred on for interventions over 3 months?*
- *Age, date of birth and gender of group of OP seen?*

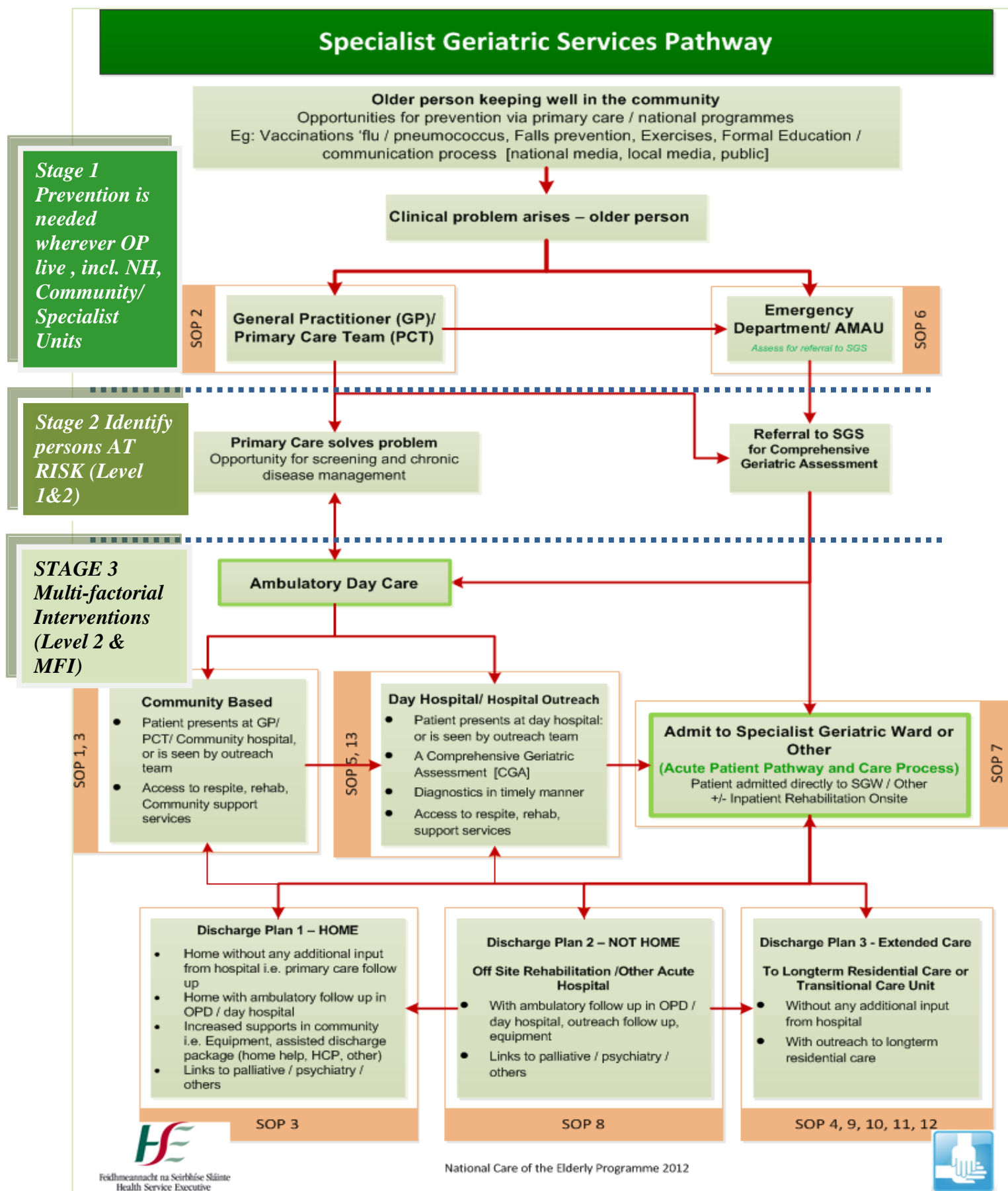
It may also be possible to collate the following information:

- *Number of OP presenting at Emergency Department from named PCT/Residential Care with falls related issues over 3 months,*
- *Number of OP presenting to Out of Hour Services from PCT/Residential Care with falls related issues over 3 months.*

RIT Leads and National Co-ordinators will support you with this.

7. Consider using a Group code (Elderly 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.
8. Feel free to Share your Learnings from successes and challenges. It will build your resilience and empower others.
9. Use the ICP as per the modified Specialist Geriatric Service Model (Appendix 1) to help maintain focus.
10. Time frame of project 6-9 months after which the work of the pilot site(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.
11. Seek support from your Regional Implementation Team (RIT) leads as needed. They will alert the joint national project 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.
12. 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>