

Management of frail older persons through ED/AMAU within the National Falls and Bone Health Implementation Project AFFINITY

Introduction The purpose of National Falls and Bone Health Project is to implement the ‘National Strategy for the Prevention of Falls and Fractures in Ireland’s Ageing Population’,¹ hereafter known as the National Strategy (2008), and to develop a robust governance framework to monitor progress and ensure accountability and sustainability. **AFFINITY** (Activating Falls and Fracture Prevention in Ireland Together) aims to prevent harmful falls amongst persons aged 65 years and older, enhance the management of falls and improve health and wellbeing through a focus on bone health (See Appendix 1 for AFFINITY project overview). 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.

Challenges According to the National Emergency Medicine Programme Report 2012² “*older persons are over represented in ED, accounting for 12-21% of all ED visits*” (p84). It is also reported that they use more resources per ED visit, have a greater level of urgency, stay longer, have a higher rate of missed diagnosis and are more likely to require a return visit. In a study of Accidental Falls in Older Persons using HIPE data (2005-2012), Dr Anne O Farrell, HSE Health Intelligence Unit, found that there were almost 65,000 emergency inpatient hospital discharges with a falls diagnosis during this period, ranging from over 7,322 in 2005 to 8,141 in 2012. While recognising that HIPE data is limited, over 83% of these older persons were admitted from home, with almost 7% from Nursing Homes; However, only 52.5% were discharged home, with some 24.5% going to Nursing Homes or Long Stay Accommodation. Repeat admissions ranged from 3.25-3.75% over this 7 year period. During this time the mean length of stay for older persons with a falls diagnosis increased from 12.7 bed days in 2007 to 14.2 in 2012. Of the injury types sustained over 40% were related to the hip and thigh, some 15% involved the head and over 14% were injuries to the elbow and forearm.

From a Burden of Illness study³ that reported in April 2007 to inform the National Strategy, ED visits ranged in cost per case from an estimated €100-€330 at that time, with an average cost per inpatient stay for all fractures in persons 65 years and older ranging from approximately €7,020 for a 65-69 year old male to €11, 094 for a male, 85 years and older. The total inpatient cost for fractures for the over 65 age group was estimated to be €58 million, with hip fractures representing two thirds of this cost. In a recent Irish Hip Fracture Database eNewsletter (September 2013), it stated that each year in Ireland approximately 3000 persons are hospitalised with a hip fracture. Overall inpatient hip fracture costs are currently estimated to be €35 million, not

¹http://www.hse.ie/eng/services/Publications/services/olderpeople/Strategy_to_Prevent_Falls_and_Fractures_in_Ireland%e2%80%99s_Ageing_Population_-_Full_report.pdf (accessed 26th August, 2013)

² <http://www.hse.ie/eng/about/clinicalprogrammes/emp/empreport2012.pdf> (accessed 26th August, 2013)

³ http://www.hse.ie/eng/services/Publications/services/olderpeople/The_economic_costs_of_falls_and_fractures_in_people_aged_65_and_over_in_Ireland.pdf (accessed 26th August, 2013)

including indirect costs of home and community care services, rehabilitation and long term care etc. Slips/trips/falls contributes annually to over one third of National Adverse Event Management System (formerly STARS Web) reported events from the publicly-funded health and social care system to the State Claims Agency 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 by 2031, given our ageing demographics.

Discussion Points Implementation of the National Falls and Bone Health Strategy has been prioritised by the HSE and the State Claims Agency for implementation in 2013. A project plan to implement the National Strategy has been agreed, to include a governance framework, an integrated service delivery model approach to implementation and Key deliverables. The integrated service delivery model seeks Expressions of Interest (EOI) from potential pilot sites /early adopters (at least one from each of the four HSE Administrative Areas) to implement a Falls and Bone Health integrated care pathway (ICP) for older persons aged 65 years and older in line with the National Strategy and the Specialist Geriatric Services Model. An Online Audit Tool and an Organisational / Unit Falls Readiness Proposal, including Checklist, have been developed to help potential pilots/early adopters determine their ability to deliver an ICP within and across various settings.

It is envisaged that some of these potential pilots sites/early adopters may experience difficulties with **ensuring that older persons who attend ED with a fall are identified as being at risk, assessed fully and given appropriate interventions when required.** This was highlighted from an ED related research study⁴ finding that of 282 persons attending an ED with a fall, 60% had a previous fall (a history of falls is one of the strongest predictors of future falls causing harm) but only 4 persons (1.4%) had ever been assessed for falls risk (Technical Report 6). In this report, it was also extrapolated based on census figures (updated using 2011 census figures here) that between 26,770 (5%) and 42,831 (8%) older persons presenting to ED over a year would be expected to have had at least one fall in the previous 12 months.

As you know, the causes of falls in older persons are multi-factorial, many of which are modifiable and preventable, if assessed appropriately and in a timely manner. In a more recent study by the Royal college of Physicians in the UK (2011)⁵ only 32% of persons with a non-hip fracture and some 67% of those with a hip fracture received an **assessment to find out whether they were at risk of more falls and fractures.** This resulted in a recommendation that all older persons attending ED should be routinely screened for their falls and fractures, and this should be monitored annually. In Dr Anne O'Farrell's HIPE study mentioned previously, fractured neck of femur represents 18,361 (38.2%) of all fall related inpatient hospital discharges over the study period.

⁴Technical Report 6

http://www.hse.ie/eng/services/Publications/services/olderpeople/Emergency_Department_attendance_due_to_fall_related_injuries_among.pdf (accessed 26th August, 2013)

⁵ Falling Standards, Broken Promises - Report of the National audit of Falls and one health in older people 2010
http://www.rcplondon.ac.uk/sites/default/files/national_report.pdf (accessed 26th August, 2013)

In this same UK study *Falling Standards, Broken Promises*, it was reported that most patients do not receive **adequate assessment and care before their operation to repair a hip fracture**. Only 30 % of patients received adequate pain relief in the first hour, care of pressure areas such as heels and bottom in the first four hours and fluids via drip in the first 12 hours to prevent confusion caused by dehydration. The UK study recommended that all hospitals providing emergency care introduce a “care bundle approach” for persons with fractured hips, to include these items as a minimum requirement.

This UK study ⁶ also revealed that **only 22% of persons with hip fractures received care in line with three core standards** i.e. surgery within 36 hours of arriving at ED, assessed by a specialist doctor for older persons within 72 hours and use of an agreed pathway to enable them to make a quicker and more complete recovery. My understanding is that there will be Irish data available from the Irish Hip Fracture Database on this issue

In addition, **many older persons who attend ED may or may not be admitted**.⁷ When admitted with a falls-related injury, the older person may be treated by a number of specialties where the injury may be dealt with but not necessarily the cause. Of the 37 acute hospitals who responded to an audit survey in 2006 to inform the National Strategy only 6 had a specialised multidisciplinary falls service, with some 13 reporting having one in a re-audit survey (2010). As per the National Strategy on hip fracture management standards, Standard 6 states that all patients presenting with a fragility fracture following a fall should be offered a multidisciplinary assessment and interventions to prevent future falls.

According to the National Emergency Medicine Programme Report 2012 (section 12.6) there are many innovative and person focussed solutions being explored and implemented nationally to address the health and social care needs of older persons in a timely manner. These solutions are being worked on in collaboration with Geriatricians and other specialists, the Acute Medicines Programme, Older Persons, Primary care amongst others Clinical Care Programmes, GPs and other community services and of course the SDU. The AFFINITY project is particularly interested in supporting your work on *“joint adaptation of care pathways..., the development of referral protocols and the sharing of clinical guidelines across assessment units and hospitals”* and of course other care settings as appropriate (See Appendix 2 for Schematic Integrated Care Pathway falls and bone health to support your thinking on this issue). Anne Marie Ryan and I, as joint-co-ordinators of the project, would welcome an opportunity to discuss the issues raised in this document at your earliest convenience.

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⁶ Ibid

⁷ http://www.hse.ie/eng/services/Publications/services/olderpeople/Strategy_to_Prevent_Falls_and_Fractures_in_Ireland%e2%80%99s_Ageing_Population_-_Full_report.pdf (accessed 26th August, 2013)

APPENDIX 1: National Falls and Bone Health Implementation Project

AFFINITY

Introduction The purpose of National Falls and Bone Health Project is to implement 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 governance framework to monitor progress and ensure accountability and sustainability. 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) aims to prevent harmful falls amongst persons aged 65 years and older, enhance the management of falls and improve health and wellbeing through a focus on bone health.

Core principles of AFFINITY are: **Integration, Implementation and Innovation.**

Background 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 Adverse Event Management System (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.

Project Overview The National Falls and Bone Health Strategy has been prioritised for implementation by the HSE and the SCA in 2013. Anne Marie Ryan, HSE Office of the Assistant National Director for Older Persons and Irene O’ Byrne-Maguire, Clinical Risk Adviser with the State Claims Agency, are joint co-ordinators for the project since mid February. Dr Tara Coughlan is the designated Clinical Lead for Falls and Bone Health within the Clinical Care Programme for Older Persons (NCPOP). A submission to the National Clinical Effectiveness Committee (NCEC) to seek national recognition for the Guiding Framework/Clinical Guidelines to Prevent Falls and Fractures in Ireland’s Ageing Population has been achieved and will need to be progressed in the coming months. A submission on the Diagnosis and Management of Osteoporosis in Ireland is already being progressed through the NCEC process. A project plan to implement the National Strategy has been agreed, to include a governance framework, an integrated service delivery model approach to implementation and Key Deliverables.

Governance Arrangements The governance framework includes a

- National Sponsorship Team
- National Implementation Team
- Regional Implementation Team aligned to the four HSE Administrative Regions

The National Sponsorship Team (NST) comprises members from the HSE, State Claims Agency, Department of Health, Service Delivery Unit and the Clinical Care Programmes. Its remit is to act as a “clearing house” to enable the project meet its goals. This team is accountable to Social Care Directorate lead, Pat Healy. The National Implementation Team (NIT) comprises members from various disciplines and settings and with various roles to ensure adequate representation of a “whole system” integrated approach needed. Its remit is to work with the National Joint Co-ordinators to deliver on the National Falls and Bone Health Implementation

Project. The Regional Implementation Teams (RIT) will serve to enable the pilot sites/early adopters identified to implement an integrated service delivery model for falls and bone health in line with the Specialist Geriatric Services Model and the clinical guidelines to prevent falls and fractures in Ireland's ageing population (currently being progressed through the NCEC process). Each RIT is being co-led by Older Persons and Primary Care Leads and will need to take account of new governance arrangements as they evolve.

Integrated Service Delivery Model The proposed implementation approach seeks Expressions of Interest (EOI) from potential pilot sites /early adopters (at least one from each of the four HSE Administrative Regions) to implement a Falls and Bone Health integrated care pathway (ICP) for older persons aged 65 years and older in line with the National Strategy and the Specialist Geriatric Services Model. An Online Audit Tool and an Organisational / Unit Falls Readiness Proposal including Checklist have been developed to help potential pilots determine their ability to deliver an ICP within and across various settings. Key members from various settings and disciplines need to commit to working together (MDT) for a 12 month period for a designated population. The MDT team must be empowered to do so by their respective organisational managers/leads.

This Online Audit Tool is based on a national audit tool developed, implemented and evaluated by the Royal College of Physicians, UK in 2005 to measure the progress of falls and bone health services within the UK. This ICP approach feeds into and draws support from the quality and patient safety agenda and HSE clinical governance arrangements operating nationally. It also serves to "test" the integrity of the Specialist Geriatric Services Model, a blueprint for the development of comprehensive, integrated and service-user focussed services for older persons nationally. It is expected to seek expressions of interest from the system **as a whole** after the first joint Regional Implementation Team meeting scheduled for Monday June 10th, 2013.

Change Management Supports To support the National Project AFFINITY a "**Falls**" *collaborative education and training programme* focusing primarily on falls prevention in hospital settings in HSE West Administrative Area was launched early May. This programme can be seen as an enabler for AFFINITY in that it will help commence falls prevention and bone health initiatives or can be used as an enhancer for those teams that already have falls prevention initiatives in place. The "Falls" collaborative programme uses the validated quality improvement methodologies of the Institute of Health Care Improvement (IHI) *Break Through Series* and offered *Free* enrolment. Work is also being progressed on exploring other education and training interventions such as a training needs analysis survey, quality improvement supports and e-learning packages.

A **Web-based Repository** is being developed to promote clear, consistent and timely communications at a system level the system of relevance to the National Falls and Bone Health Implementation Project AFFINITY. It is envisaged that this portal will share news updates and key information on

- Governance Arrangements and Action minutes
- The Integrated Service Delivery Model;
- "Best of Breed" policies, procedures, guidelines and tools;
- Web links to sentinel websites and other key resources

E Learning supports developed in other jurisdictions, in addition to our own, will be posted to help build competency and capability within the system. Opportunities will be afforded to the system as a whole to share their "best of breed" resources to support the implementation of the National Strategy. Other initiatives of national and international import that are related to falls and bone health will be identified and shared on the web portal as resources allow.

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APPENDIX 2: 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 is needed wherever OP lives, incl. Nursing Home, community/ specialist units etc	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/Communi ty 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