Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

Quality Improvement Division

QI TALK TIME

Building an Irish Network of Quality Improvers

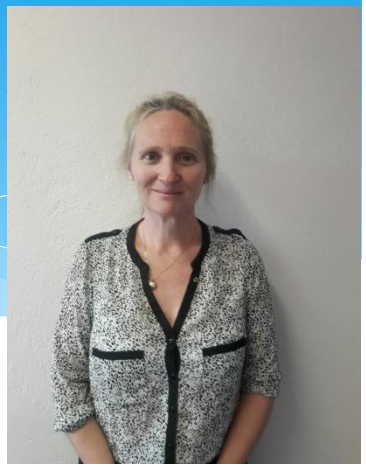
Developing an integrated approach to Falls management 2018:

1pm Tues April 30th 2019

Connect **Improve** **Innovate**

Speakers

Liz O'Sullivan Physiotherapy Manager in Cork South PCC & Bantry General Hospital. She is a strong exponent of healthy active aging. A member of the Cork Falls Prevention steering group and contributes to development of integrated Fall Prevention services in Cork. These include Staying Fit for the Future exercise classes for adults with low falls risk, MDT Falls Risk Assessment Clinics (FRAC) in Primary Care, Continuing Care and also Specialist Falls Services.



Mary Jordan is a Senior Physiotherapist working in Mayo Primary, Community and Continuing Care. She is a native of Castlebar who graduated from UCD with Bachelors of Physiotherapy Degree. Mary has 30 years experience, with a background in MSK & Neurological Physiotherapy.

Mary works in Community services in Mayo for 11 years with Elderly/ Neurological caseload involved in Health Promotion initiatives including Active Retirement Groups promoting Bone Health & the importance of being active.

Instructions

* Interactive

* Sound:

Computer or dial in:

Telephone no: 01-5260058

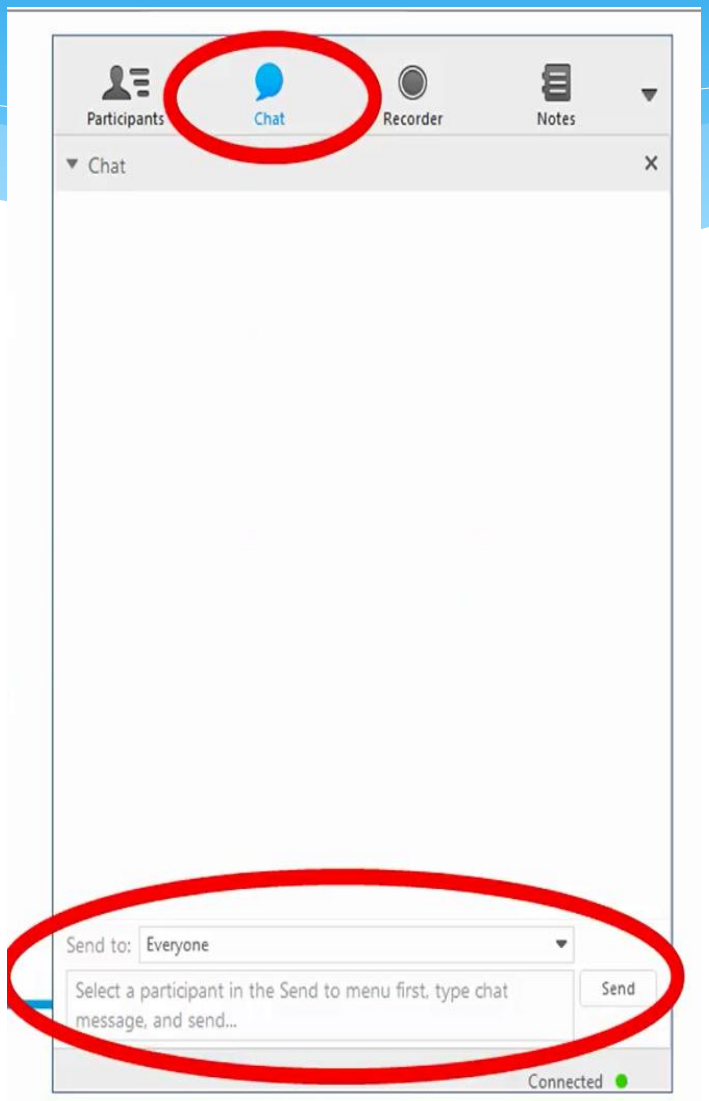
Event number: 843 892 389#

Chat box function

* Comments/Ideas
* Questions

* Keep the questions coming

* **Twitter: @QITalktime**



Seirbhís Sláinte Níos Fearr á Forbairt | Building a Better Health Service

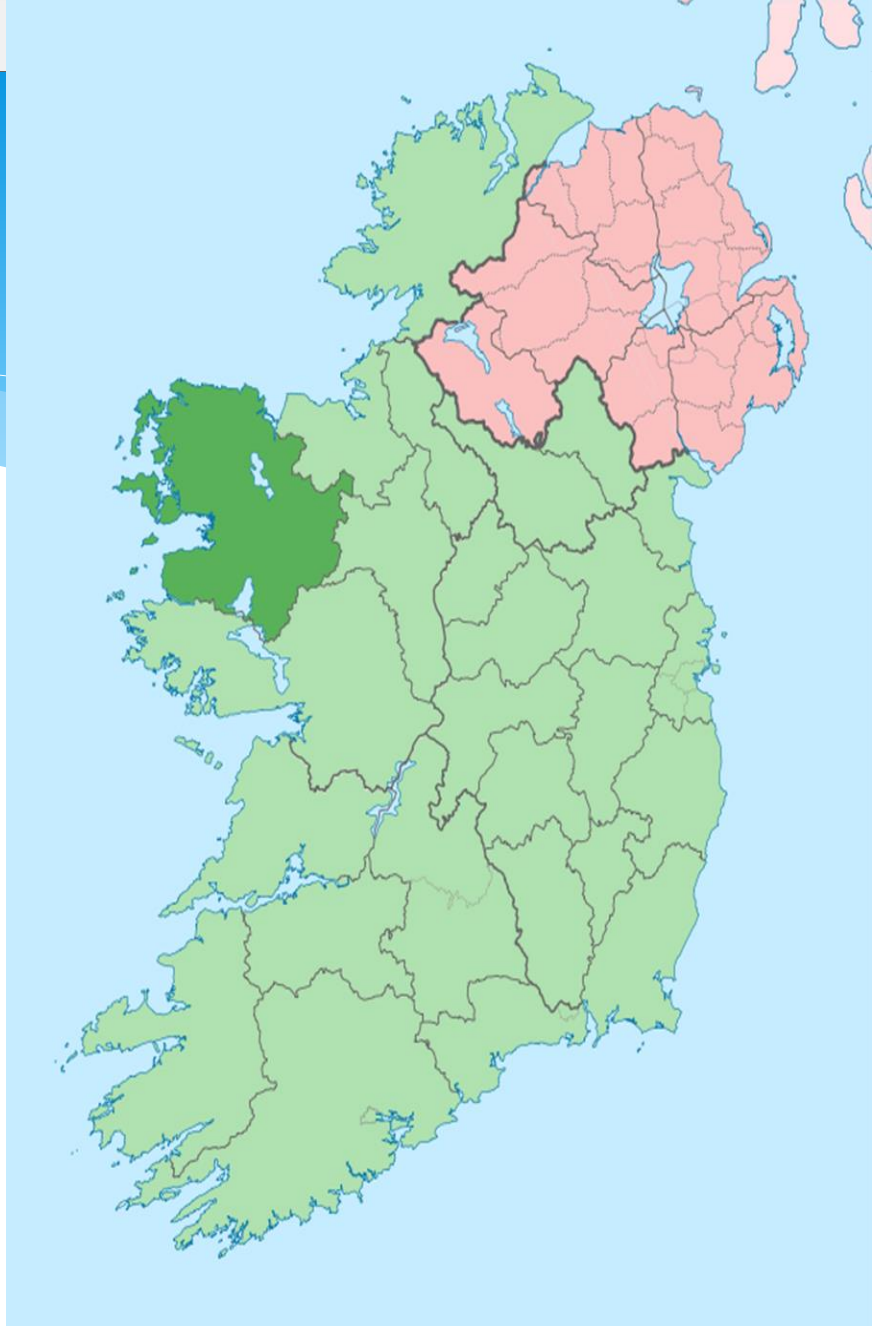
Stay Steady Mayo

Mary Jordan, Senior Physiotherapist
Caitlin Woods, Senior Physiotherapist

Swinford Health Centre, Co. Mayo
Community Healthcare West

Introduction

- Facts about Falls
- What is Stay Steady Mayo
- What we achieved
- What we learned
- The future
- Older Persons Needs



Definition of a Fall

* **A fall has been defined as an event which results in a person coming to rest inadvertently on the ground or floor or other lower level.**

World Health Organisation, 2007

Facts about Falls

* 30% of people over 65 years and 50% of those over 80 years will experience at least one fall each year.
* TILDA 2014- prevalence of falls has increased by 7% since 2011 report
* Older people have highest risk of death or serious injury resulting from fall and the risk increases as the individual gets older.
* If the current trend continues, deaths and injuries due to falls in older individuals could double over the next twenty years.(National Strategy to prevent Falls and Fractures in Irelands Aging Population, 2008)

Consequences of Falls

* 35,000 older adults sustain moderate or serious injury following a fall
* Over 7,000 people who fall are hospitalised
* 75% of injuries in older adults are due to falls. 10% of all older adults are treated for injuries annually
* Falls kill approx. 250 older adults in Ireland annually
* Current cost of falls/fractures is 520m, predicted to be 2,043m by 2030
* Hip fractures are one of most serious injuries with over 3,000 per year. (IHFD,2014)
* Over 300,000 people over 50 years have Osteoporosis

Mayo Facts

- Mayo has highest percentage of 65-79 years old in Ireland at 13.3%

- Mayo has third highest percentage of Older Old, i.e. over 80 years, at 4.2% of the population. This age group can experience more poverty, social isolation and poorer health than younger old.

- We, Community Physiotherapists , working with older people identified a need to address Falls Risk in the Community dwelling population.

Otaga Exercise Programme

* Effective in reducing falls in community dwelling older people
* Most effective in those older than 80 years with previous falls (cost saving), but still effective for those over 65 years (cost effective)
* Group based delivery more effective than home based delivery
* Adhered to better if support options included(DVD, Booklet, IT solutions)
* Improves executive function (cognition) and reduces mortality

The Otaga Exercise Programme decreases falls by increasing function, strength and balance

Referrals

* G.P's in area- write out to all G.P's 6 weeks before class begins
* Acute services –Home First Team in MUH
* PHN's in area 6 weeks beforehand
* MSK Physiotherapists in catchment area also
* Other AHP's in area

Criteria For referral

* Have fallen
* Have fear of falling
* Unsteady gait or balance issues

What is Stay Steady Mayo

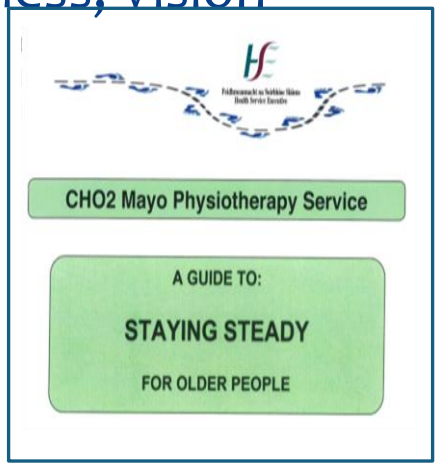
* Group exercise class centred on evidenced based Otaga Exercise Programme.
* Running since 2010, twice a year.
* Eight week progressive exercise programme, with:
  * pre-assessment,
  * once weekly group exercise,
  * home programme (carried out twice a week),
  * follow up phone call at 12 weeks,
  * final assessment at 16 weeks.

What we do

* Pre-assessment individually
* Outcome Measures: Berg Balance Scale, Timed Up and Go, Short Falls Efficacy Scale and Five Times Sit To Stand
* MDT: Dietitian, OT, Pharmacist and Continence Nurse
* Staying Steady Booklet (Rev. 3): OEP, Walking, Fitness, Vision &

  Hearing, Medications, Feet, Bone Health,

Environmental Hazards, What to do if you have a Fall.



Stay Steady Mayo

* Meets Best Practice Guidelines to Prevent and Manage Falls in Older People (Nat. Strategy to Prevent Falls and Fractures in Ireland's Aging Population 2008)
* Meets many HIQA Standards for Safer Better Healthcare for Primary Care
* Cost neutral
* Meets recommendations of NCPOP for Older Person Keeping Well in the Community

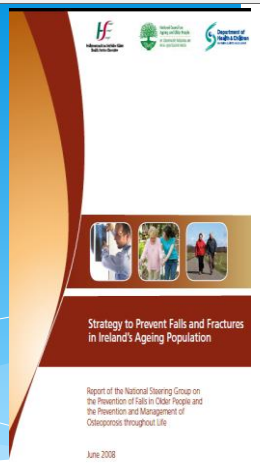
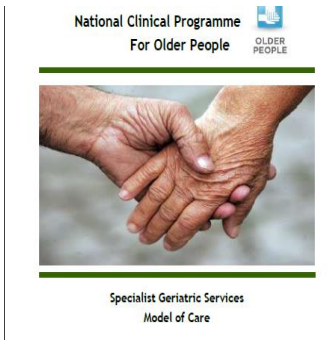


Figure 1: Themes for Quality and Safety

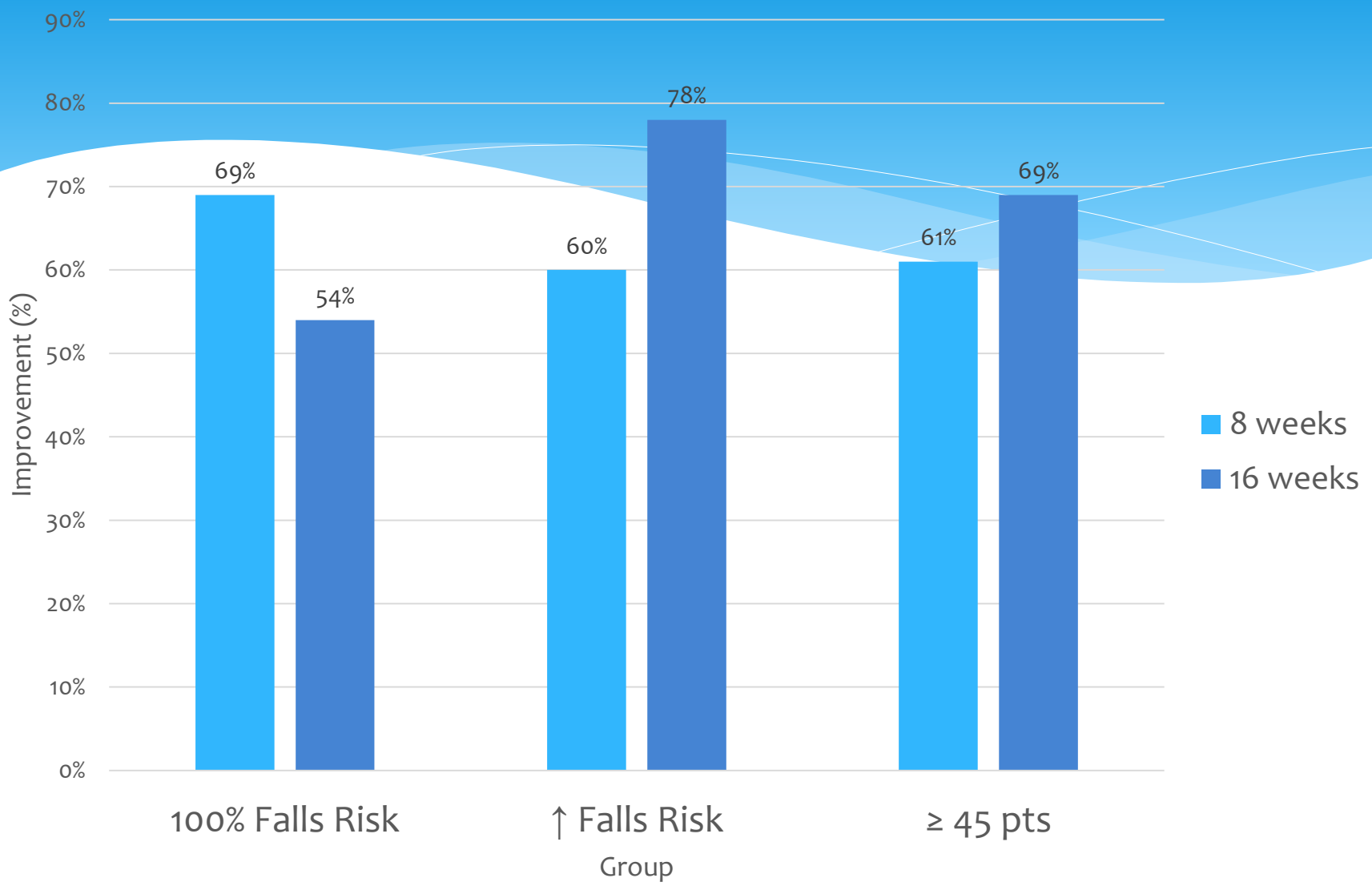


Results: First Five Years

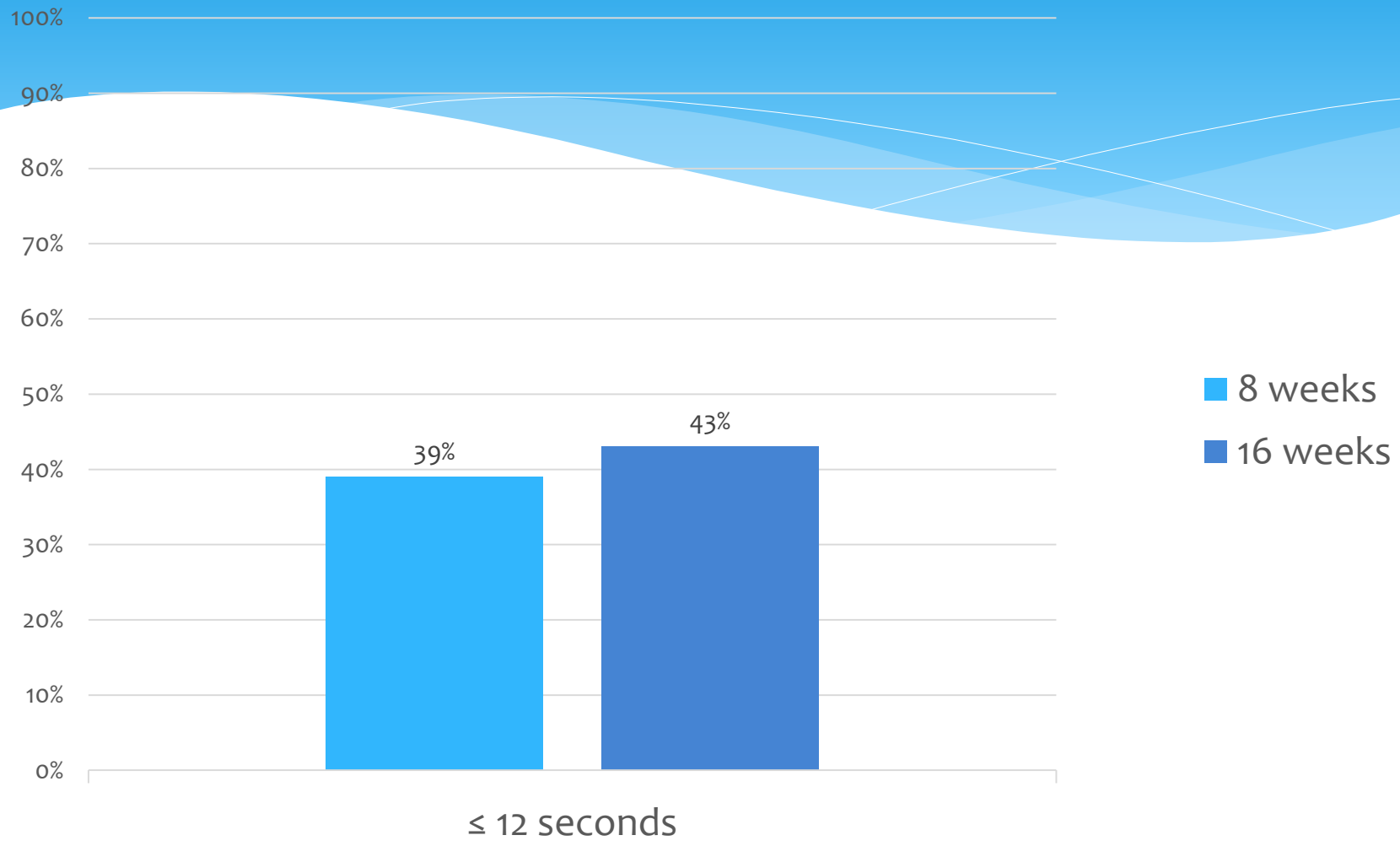
* 77% of participants completed the 8 weeks*
* 58% returned after 16 weeks
* 75% of those who completed the 8 weeks returned at 16 weeks

*(n=89)

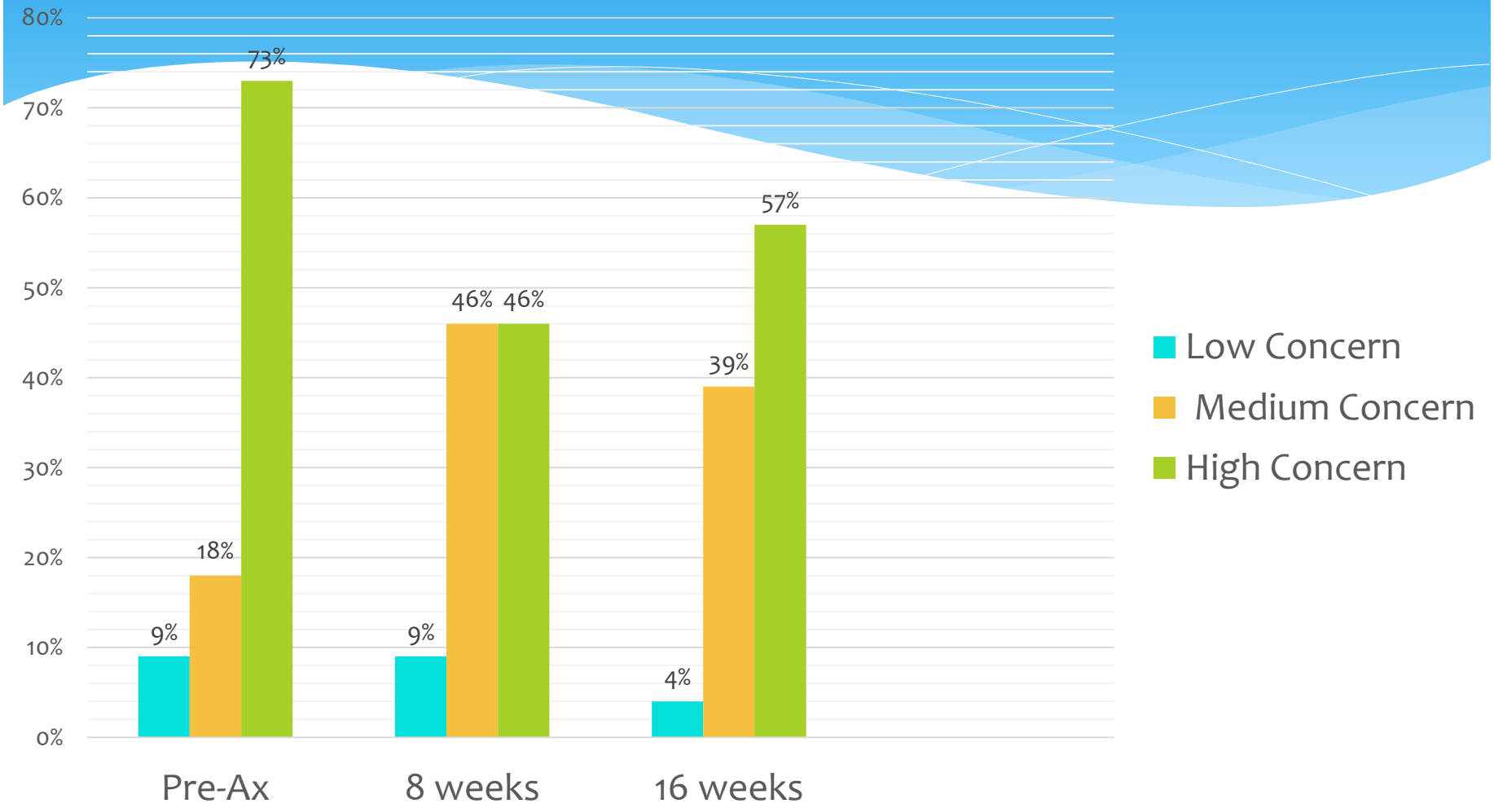
Improvement in Berg Balance Scale



Improvement in TUG



Short Falls Efficacy Scale



Feedback from Participants

Loved it, didn't know I could do so much

Would definitely recommend it to a friend

Lovely to exercise as part of a group

Has given me more confidence walking and with ADL

Nice to meet new people

Want it to continue on

Maggie's Story

* 80 years old
* Fell during night when got up to go to bathroom. Had taken sleeping pill. On floor for half an hour. Xray: #Right hip, DHS next morning
* Attended for out-patient physiotherapy. Gait was slow with two elbow crutches and Maggie was quite anxious about walking and required supervision. She was commenced on hip ROM and Strengthening programme and when completed was referred by Physiotherapist to Stay Steady Class
* Lives alone in bungalow with family close by

Pre-Ax

- Berg Balance Scale = 35
- TUG = 21s with elbow crutch
- SFES = 17 (High)

8 Weeks

- Berg Balance Scale = 48
- TUG = 18s with walking stick
- SFES = 15 (High)

16 Weeks

- Berg Balance Scale = 49
- TUG = 16s with walking stick
- SFES = 17 (High)

Maggie's Story: Feedback

* 'Helped me a lot'
* 'Lovely to meet people'
* 'I walk more now'
* 'Very happy with it'

Conclusion

- 8 week Otaga Programme showed **significant benefits** in reducing falls risk and improving balance
- High Falls Risk Group (BBS) the effect was best seen at end of 8 weeks. **Remained benefit** at 16 weeks but less than at 8 weeks
- The 'At Increased Risk Group' and high end of BBS group there was also improvement at 8 weeks and this **continued at 16 weeks**
- TUG, which may pick up changes in higher functioning group showed an improvement of 39% after 8 weeks and this **increased to 43% at 16 weeks**
- Confidence Scale showed 27% reduction in High Concern Category after 8 weeks, reducing to 45.5%. This increased to 57% at 16 weeks which was still better than pre-Ax at 73%

What we have learned so far

- ✓ The best predictor of success is the participants own motivation to improve
- ✓ People do better when they can attend group classes
- ✓ As the Otaga is a progressive programme it can be used for wide variety of participants
- ✓ More dependant older people would benefit from continuing the programme for longer
- ✓ Contacting participants individually improves participation rates

* New Consultant Led Elderly Day Hospital (ICPOP) starting in Castlebar Primary Care for MDT Assessment of unexplained/complex fallers. Will link with this as Community Resource.

* Programme recently started in north and south Mayo. We hope to support physiotherapists in rolling out programme in west Mayo.

* Need to address lack of transport

* Link with Mayo Sports Partnership to provide a step down programme in community

What Older People in the Community Want

* Classes to continue on
* Tea would be nice and a place to meet and talk after the class
* Accessible transport to attend on weekly basis
* Activity classes for Older People to be available in own area

CORK
Falls Prevention
Stay steady and strong

April 30th 2019

Liz O'Sullivan , Physiotherapy Manager Cork South PCC and Bantry General Hospital

on behalf of the Cork Falls Service

CÚRAM SLÁINTE POBAIL
CORCAIGH CIARRAÍ
CORK KERRY
COMMUNITY HEALTHCARE

HSE

Aim of Cork Fall Prevention Service

To have an integrated Pathway for Prevention of Falls and Fractures which aims to deliver an accessible responsive service to people at risk of falling.

To provide evidence based fall prevention assessment and interventions to at risk patients by skilled health professionals using standardised fall risk assessment tools across community and specialist falls services so that preventable falls may be avoided .

CORK Falls Prevention
Stay steady and strong

CÚRAM SLÁINTE POBAL
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CORK KERRY
COMMUNITY HEALTHCARE

HSE

Getting our ducks in a row

* **2009** ; Falls mapping ; 90 patients a week to CUH ED; no onward referrals /service
* **2011** -2012 National tool and Quickscreen trialled
* **2012** ; Business case ; Unfunded ; Unsuccessful
* **2014** ; Solutions focussed collaborative workshop
* **2015** Project Initiation Document; Governance Structures and 3 WTE resources ; KPI of 6 FRAC Clinics in PCT with existing PCT resources ; 1,200 patient Ax per annum

Governance and workstreams

Project sponsors – CO /GM

Integrated MDT Steering Group for overarching project implementation , chaired by Clinical Projects Facilitator, progress review and action

Evaluation work stream

Community Work Stream
Capacity building
FRAC
Continuing Care
Communication
Community Linkages

Specialist Services ;
CRST Rehab
Specialist Falls Clinic
Service Data

CORK Falls Prevention
Stay steady and strong

CORCAIGH CIARRAÍ CORK KERRY

Cork Integrated Falls Service

Adults at risk of falls

- GP, ED,
- Community Physio/ OT
- Public Health Nurse

Single Point of Referral

Standardised referral form

MDT triage meeting

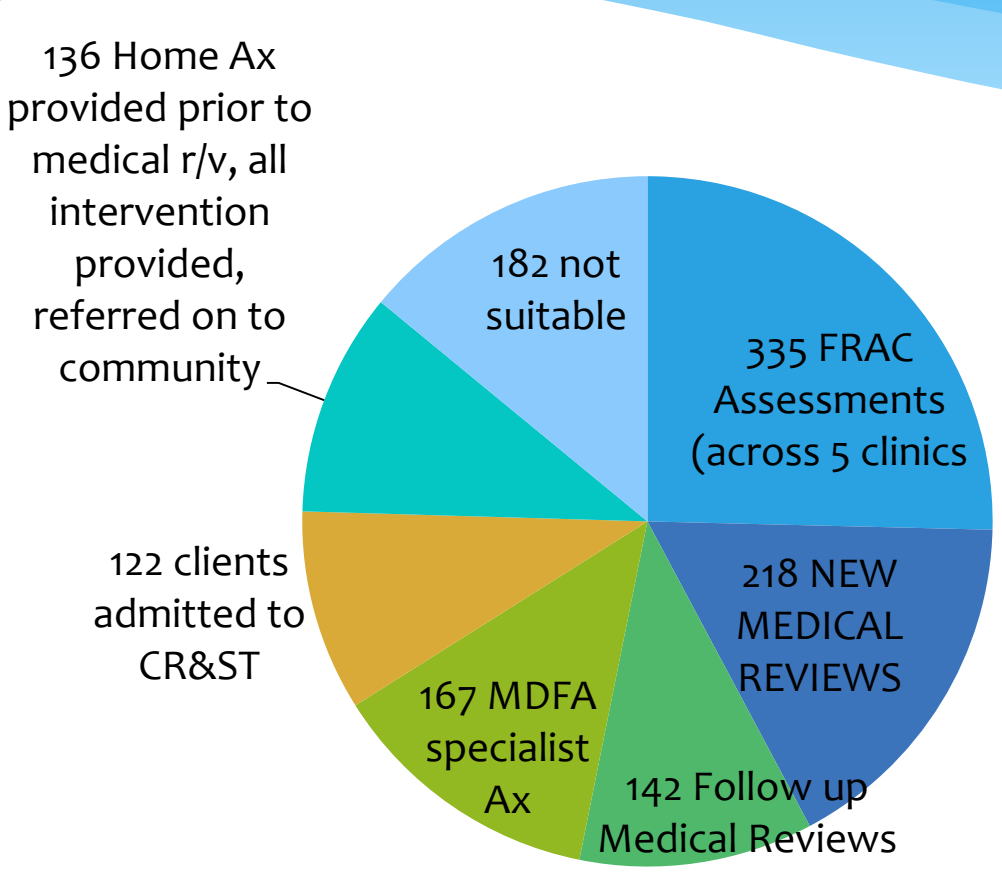
- Falls Risk Assessment Clinic (FRAC)
- Community Rehab & Support Team (CR&ST)
- Specialist MDT Clinic +/- geriatric assessment
- Syncope Clinic
- Other specialist clinics & investigation

Local initial enablers for Cork Falls Services

* A long time in gestation with a passionate desire to prevent falls rather than trying to fix people after a fall
* Willingness to work together and with others
* Appointment of former PT manager as Clinical Project Facilitator , reporting directly to our CO .
* Existing MDT CR&ST and Steady Up falls service expertise
* Appointment at falls coordinator and clerical support to create a single point of contact for the standard referral and standard Falls Screen
* Facilities at Assessment and Treatment Centre
* Participative educational MDT workshops

590 assessments in 2016 ;1120 in 2017; 1305 in 2018

(10 % DNA's across all FRAC and Specialist Clinics in the year, All were contacted and rescheduled or informed referrer client declined service)



- **All not suitable referrals are triaged , discussed with referrer and other services and placed on appropriate pathway by falls co-ordinator.**
- **360 Medical Reviews including both New and Follow up between Dr. Pat Barry and Dr. Kieran O Connor. 218 New Medical reviews.**

Challenges to service effectiveness

* Physical environments for effective FRACs
* Timetabling of 3 very busy healthcare professionals
* Early detection v inappropriate referrals ….
* Different levels and types of expertise
* Patient awareness and understanding of a preventative service
* Sufficient sustainable clinical resources , amidst many competing clinical priorities in PCT
* Nearly forgot ! No database = duplication and time loss

Cork Falls Service Pathway and Process

* Standard Referral form
* Single point of referral ; Falls Office fallsclinic.sfh@hse.ie
* Daily and weekly triage to each patients level of need
* Single database ; Excel , awaiting iPims
* Standardised Screen ; Quickscreen
* Standardised documentation
* Stay Steady and Strong booklet
* Website in process

Specialist Falls Services

* Weekly MDT Triage meetings
* 3 Specialist Falls clinics a week providing medical Ax , including Syncope Ax .
* CRST ; MDT rehab x 6/52
* Seamless integration with ATC and ICT services
* Continence ; Cognition/Perception ; Vestibular ; Neuro , and Dementia service linkages

Fall Prevention in Primary Care

* Level 1 Screening
* FRAC Assessment and Intervention Clinics
* Environmental , cognitive ad Aging Well provided by OT
* Steady Up ABC provided by PT with MDT education
* Liason and working with our acute colleagues
* Integrated work with ICT and FITT
* Frailty programme
* Bone Health a priority for development
* Staying Fit For The Future with Better Balance Better Bones

Physiotherapy Services

* 1 to 1 Physio interventions
* FRAC participation
* From 2 to 14 participative Steady Up classes a week to meet demand for Physiotherapy Ax and Tx
* Rehab Assistant role
* Cascade Tutors x 3 ;Steady Up ABC Review
* A-C approach for risk management and outcomes
* Staying Fit For The Future Better Balance Better Bones
* FITT ; Frailty Interventions ; Strength and Conditioning
* Vestibular rehab
* Super Six exercise leaflet
* Day Care Review ;Getting Exercise on the menu
* Other patient groups ; Neuro MSK

Fall Prevention in Continuing Care

* Standard policy framework for all HSE continuing care community hospitals
* Standard data collection for falls and outcomes
* Fall Prevention champions
* Standard education for everyone
* Post Fall protocol
* Falls Policy now in residential service for adults with intellectual disability
* Clear need for ringfenced PT and OT resources

Integrated Work

* CRST , ICT and FITT were the link services
* Joining the dots between services is easier
* Use of the same Ax and outcomes
* Blue Book Standards
* Fracture Clinic developments
* Access to diagnostics in PCC ; results
* Unscheduled Care Improvements

Primary Fall Prevention starts in the community !

* Falls Are Preventable and not an inevitable part of growing old in Ireland !
* Community Partners , willing and able
* Active Retired networks
* National and local policy ; Age Friendly Ireland
* Cork Sports Patnership, Health Promotion and Healthy Ireland ; Funding , LOCAL FACILITIES , scalable
* ICPOP ; Affinity 2018 -2023 ; Slaintecare

Next Steps for us in Cork

* Evaluate - action on feedback from the UCC Evaluation 2018 ; Clarity ; Primary Prevention; Exercise Adherence particularly amongst Steady Up C / maintenance needs
* Steady Up ABC Review , Implementation, evaluation
* Staying Fit For The Future evaluation and accreditation
* **Clinical resources deficits between PCT and Social Care remain the greatest risk to sustainability of primary prevention /FRAC /Review the model of FRAC in Cork**
* Scope extension to remainder of Cork & Kerry as part of the development of Ambulatory Care Pathways for Older Persons
*
* Further opportunity for integrated work on primary prevention of falls and fragility fractures and **bone health** in community via Affinity and Slaintecare programmes .

Thank You

Do you want to partner with the National Quality Improvement Team?

* Have you got a team who are interested in looking at addressing Falls in your local population

* Want to register to take part in an Improvement Collaborative

* Read more about it here and Register your interest here:

https://www.hse.ie/eng/about/who/qid/resourcespublications/

* Email: teresa.ocallaghan@hse.ie if you have any queries

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Next QI Talktime:

Want to learn more about Assisted Decision making?

Join us on May 14th 1-2 pm

Thank you from all the team @QITalktime
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