Cork Integrated Falls Service: New ways of working in specialist, community and continuing care

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On behalf of the Cork Integrated Falls Service Steering Group
Building on previous groundwork

2007: Local Falls Service Mapping Exercise

2012: Falls workshop

2013: Business Case - no funding

2014: Business case for expanded service

2015: Funding for 3 posts

Q3 - Commenced implementation
Our project

The project has three main work streams:

- building community capacity for falls risk assessment
- re-engineering specialist falls services to improve access
- standardising continuing care assessments and prevention strategies
Aim

To ensure that people at risk of falling have access to timely assessment by health professionals with the knowledge and skills to do a comprehensive standardised fall risk assessment in the appropriate setting whether community or specialist falls services.
Falls Risk Assessment Clinics (FRAC)

- 2 clinics set up to date,
  - 4 by end of 2016,
  - 2 by end Q1 2017
- 42/165 referrals triaged to a FRAC (25%).
- 31 clients assessed (74%).

**Falls Risk Assessment Clinic**

- Multidisciplinary (OT, Physio, Nurse)
- Validated assessment tool
- Training & coaching
- Administrative support
- Standardised documentation

*I like the fact that its MDT based and that there’s a steering group and that there’s funding, and that there are these things behind it... (health professional)*
Re-engineering specialist falls services
Syncope Clinic: complex falls & blackout

Waiting times/Patients seen in specialist syncope clinic (2014-2016)
Continuing Care Stream

- 17 Community hospitals & Community Nursing Units
- Implementation lead at each hospital/CNU
- Group education sessions & workshops (e.g. risk assessment)
- Standardised documentation
- Collation and monitoring of falls data with staff feedback

![Figure. Number of falls and injuries (2015, n=8 hospitals)](chart.png)
Integrated Falls Service

- 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

Adults at risk of (recurrent) falls
Pathway Utilisation

165 referrals

MDT Triage

- FRAC 25% (n=42)
- CR&ST 25% (n=41)
- Specialist MDT Clinic 22% (n=37)
- Syncope clinic 10% (n=16)
- Other specialists & investigation 3% (n=5)
- Not suitable 12% (n=20)
- To be confirmed 2% (n=4)

Figure. Number of referrals & triage to each path (June-August 2016)
Governance structure

Project Sponsor
Ger Reaney
Chief Officer

Project Implementation Group
Gabrielle O’Keeffe (Chair)/Suzanne O’Sullivan, Eileen Moriarty Project Manager, Kieran O’Connor, Pat Barry, Falls Development Coordinator, Liz O’Sullivan, Work Steam Leads

Community Capacity Building
Co-Leads: Eileen Cronin TDO/ Nicola Brett ADPHN, CR&ST, Physio, OT, Nursing, Community Workers, Health Promotion, Others

Specialist Falls Service
Liz O’Sullivan Community Physio Manager, Kieran O’Connor, Pat Barry, ATC, CR&ST, Falls Development Coordinator, ANPs

Continuing Care
Lead: Rosemary Murphy, DONs Community Hospitals & CNUs

Evaluation
Lead: Olivia Wall Senior OT, S McHugh UCC, Falls Dev. Coordinator, Administrator, Eileen Moriarty, Kieran O’Connor
Lessons learned

• Resilience is essential

• Foster & empower frontline leaders

• Meaningful change takes time & you must bring people with you

• By examining & understanding the structure & system you work within you can make improvements

• Key role of falls pathway coordinator & administrative support for ongoing and sustained implementation
Integrated Care Framework for Older Persons

1. Establish Governance Structures

2. Undertake Population Planning for Older Persons
   - Risk Stratification
   - Very High Risk: 1% of Older Persons, 10% Cost
   - High Risk: 4% Older Persons, 17% Cost
   - At Risk: 15% Older Persons, 25% Cost
   - Minimal Risk: 80% Older Persons, 48% Cost

3. Map Local Care Resources

4. Develop Services and Care Pathways
   - Rehabilitation
   - Ambulatory Services (e.g., Day Hospital)
   - Acute Care
   - Nursing Homes
   - Dementia
   - Falls, etc.

5. Develop New Ways of Working
   - In-reach and Outreach
   - New Roles Including Case Management Approach for Long Term Complex Needs

6. Develop Multi-Disciplinary Teamwork and Create Clinical Network Hub
   - Co-ordination between Care Providers

7. Person-Centred Care Planning and Service Delivery

8. Supports to Live Well
   - Promote support for older persons to live well in the community
   - Information & Advice
   - Community Transport
   - Social Activities
   - Support Carers
   - Home Modifications & Handy Person
   - Medication Management
   - Shopping

9. Enablers
   - Develop Workforce
   - Align Finance
   - Information Systems

10. Monitor and Evaluate
    - Track Service Developments
    - Measure Outcomes
    - Staff and Service User Experience