Technical Report 5

Consultation Process

Technical report to NCAOP/HSE/DOHC

By
Ms Anna de Siún and Mr Stephen O Hare

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Introduction

Consultation was undertaken with organisations / groups that are involved in fall prevention and bone health services. The purpose of the consultation was to identify areas of unmet need and suggest ways to meet that need particularly in relation to health education and promotion, assessment / identification of people at risk, intervention, rehabilitation, care pathways /continuity of care and prevention/management of falls. There was a 60% response rate to the questionnaire.

1. Falls

The views of the respondents were categorised as follows:

Education and Health Promotion

- Education, awareness and prevention are key factors of fall prevention.
- Education and training need to reach many groups of people: older people themselves and their families, the general population, personnel who provide the health service, personnel involved in the design and maintenance of public buildings /areas and those operating public services.
- While there are a range of methodologies for reaching these people, it is important that the approaches be tailored to the roles and needs of each group.

Assessment / Identification of People at Risk

- There is a need for a standardised approach to identifying people who are at risk of falling. The lack of this approach is one of the major barriers to developing a Falls service.
- Greater communication and integration between different services (health and other services) is needed so as patient needs can be met in a coherent manner.
- National guidelines for identifying and managing older people at risk of falling are needed. These should be communicated to all relevant health care personnel.
- The identification of high risk older people should take place in the community /primary health care service.
- A specialist fall service should be established in hospitals to manage those who are identified as high risk.

Interventions

- Lack of service development and resource allocation were reported as the major barrier to people receiving appropriate intervention after a fall.
- Proper service integration and referral structures need to be developed if a service is to be effective.
Rehabilitation
- The role of the Physiotherapist in rehabilitation is essential. Lack of community physiotherapy posts leads to long waiting lists and poor rehabilitation when it is needed most.
- The need for community based rehabilitation teams is a priority. Current resources are not adequate to provide appropriate rehabilitation in the community.
- The issue of fear of falling and the need to develop a patient’s confidence was also highlighted and addressed as part of a comprehensive falls service.
- More rehabilitation resources are required.
- The needs of people after a fall related injury should be addressed in the forthcoming Rehabilitation Strategy.

Care Pathway/Continuity of Care
- The priority is the development of a falls assessment pathway that also addresses the needs of people who are uninjured but who are at ongoing risk.
- When an older person attends the health service after a fall, their injury is treated but usually not the cause of the injury or the risk factors that can be minimised. The intervention to address risks often depends on the awareness, interest and time available of individual practitioners.
- Where referrals to appropriate services are made, often there are long waiting times due to lack of resources.
- A patient pathway should be developed to manage people who are identified as being at risk.

Residential Care
- All public and private residential care centres should have a falls prevention service.
- They should have appropriate resources e.g. physiotherapy, occupational therapy and dietetic services.
- It was suggested that all residential centres should have physical activity/exercise classes, combined with individualised physiotherapy intervention where appropriate (e.g. for people with cognitive impairment or a high degree of physical dependence).
- It was recommended all residential care facilities could be linked with community rehabilitation teams or hospital based falls teams to ensure specialised care for residents and ongoing education and training for staff.

Prevention and Management of Falls
The strongest themes emerging in this section were:
- the need for education among the general population, in schools, with older people and health care providers.
• The need for more a structured approach to the assessment and management of older people who are at risk of falling.
• Fall prevention and interventions services need to be resourced.
• The development of the primary care team structure was suggested as a way of ensuring a strong emphasis on prevention and education in the community.
• A more active role is needed from local authorities to reduce hazards outside the home and help prevent falls.

2. Osteoporosis

Promotion of bone health:
- Bone health awareness has to start in childhood with the development of a healthy lifestyle in particular diet, exercise and smoking avoidance.
- A primary care multidisciplinary team approach is the main focus of the serviced from prevention to rehabilitation.
- Health professionals need a risk assessment tool to assist in identifying those at greatest risk.

Identification of those at risk of osteoporosis
- The general population and health professionals should be aware of high-risk groups in the population and the recommended approach to their management.
- The service needs to be integrated between primary care and hospitals. The service needs to be delivered by a consultant in the hospital setting with links to Primary Care.
- Multidisciplinary teams should include Physiotherapists, Occupational Therapists, Dieticians and Medical Social Workers.
- Primary care is the best setting for patient assessment, management and dissemination of health information.
- Access to diagnostic services should be increased in primary care to help identify those at risk. Particular need to increase access to diagnostics for GMS patients.
- Of greatest importance is the need to develop robust guidelines and protocols to facilitate early identification of high-risk individuals.

Access to Diagnostic Services
- DXA services should be provided in every acute hospital in Ireland and at selected community locations.
- Measures to reduce financial constraints in relation to access should be introduced to improve equity of access.
- Standardisation of screening protocols and guidelines should be introduced for both
DXA facilities whether public or private.

- There is a need to develop referral protocols to improve selective case finding techniques. High-risk patients should be screened first.
- Significant improvements in investment, availability and staffing resources are required.

**Management of osteoporosis**

- Need to follow up with clients whose medication “doesn’t agree with them”.
- Need for training of health care professionals in relation to medication and prescribing, Need to “teach clients the value of medication”.
- Improved education and information on nutrition and supplementation to aid pharmacological and non-pharmacological interventions.
- Establish a multidisciplinary approach to management of patients with osteoporosis and osteoporosis related fracture.
- Develop tailored and accessible programmes to promote the benefit exercise for bone health pre and post fracture – high intensity strength training, weight bearing exercise.

**Rehabilitation following a Fragility Fracture**

- Greater resources need to be directed to improve rehabilitation services particularly in relation to staffing.
- As a high number of fractures among older people are due to falls there is a particular need for nurse specialists and physiotherapists to assist in rehabilitation.
- Access to community based mobility / balance / strength training as part of post fracture rehabilitation should be introduced.
- Need to standardise provision of Home Care Packages.

**Post-Fracture Liaison Services / Community Services**

- A Fracture Liaison Service, led by a Clinical Nurse Specialist, is a well-established model that ensures a high level of communication and continuity of care, with cost-effective targeting of therapy.
- A Fracture Liaison Service should be present at any hospital in which a patient presents with a fracture. Where patients are transferred from an ED in a hospital to a centralised fracture clinic elsewhere, the FLS may be located at the centralised site, provided there is sufficient time available at the clinic or elsewhere to meet the patient, carry out an assessment and offer treatment and lifestyle advice.
- Connecting new services to existing and primary care teams and community based care initiatives is essential for providing continuity of care.