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CONFERENCE ABSTRACT

Community teams, specialist fall services and emergency department implementing an integrated regional falls risk assessment and prevention pathway

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Introduction: In 2008, the national strategy for the prevention of falls and fractures in Ireland was published. In 2009, a detailed mapping exercise in our region demonstrated the size of our problem showing 4,680 emergency department attendances locally for falls annually, 21,500 acute bed-days used after falls and falls-related local health cost of €31 million. We had elements of good practice but services for falls management were neither coordinated nor integrated.

Practice change: We took a whole-system approach to the delivery of services for falls in older people. Since 2012 a multidisciplinary clinician group has worked with regional management to improve falls services. Our project has four main work streams: building community capacity for fall risk assessment; re-engineering specialist fall services to improve access; standardising continuing care falls assessment; and promoting healthy ageing to prevent falls.

Aim: We aim to deliver 1,300 additional multifactorial fall risk assessment places yearly. Our objective was to implement an integrated pathway between emergency department, community services and specialist services for falls prevention.

Targeted population: Our catchment population has ~300,000 people in mixed urban and rural settings. A large stakeholder workshop was held in July 2014. The change management process is coordinated through monthly steering group meetings along with weekly teleconferences with four project work-streams leads.

Highlights: In 2015, a regional falls coordinator and an administrator were appointed. The continuing care work-stream has separate funding, allowing an experienced nurse support 17

community units for 12 months to implement a standardized approach to falls. Otherwise, all developments were within existing resources.

A simplified referral pathway with a single point of access was established. Five new community-based falls risk assessment clinics using validated user-friendly assessment tool were formed. Mentoring by experienced staff is important to support each new community clinic. Pathways now exist linking the emergency department, geriatric medicine specialist services and the community falls services.

A medical fall clinic and a multidisciplinary community rehabilitation team were integrated into a single specialist fall service and a weekly triage meeting started. The referral rate has doubled in the past six months with over 80 new cases now triaged monthly. By re-engineering the specialist service, we reduced the waiting times for medical appointments from over three months to two weeks.

Conclusions & Discussion: By following a national strategy supported by detailed local data a change management approach has delivered a system-wide integrated falls service in our region. The success of this project has depended on securing buy in from key stakeholders. With complex interacting services having a single point of contact through the falls service coordinator has been essential. Clinicians and management building trust and working together over time was central to this project. A robust evaluation of "how" this change has been achieved is underway to ensure the learning is transferable to other areas.

Lessons learned:

Resilience is essential in such a large project

Change of this scale requires top down support for a bottom up approach

Ongoing ownership by those involved in service delivery is important

Keywords: falls; whole-system; multidisciplinary; care pathways