

Appendix 3  
**Detailed Written Feedback from the four HSE  
Administrative Regions**

## Feedback from Falls Workshop

AS EXTRAPOLATED FROM WRITTEN FEEDBACK RECEIVED FROM THE  
FOUR HSE ADMINISTRATIVE REGIONS

### **HSE South**

#### **Context**

There was one table from HSE South with eight people on this table. Professions/specialisms represented were physiotherapy, nurse practice development, geriatric specialist registrar, risk management and acting assistant director of nursing.

#### ***Written feedback primarily addresses the second question: What is needed?***

Greater awareness; leadership; standards; falls clinics; integrated care delivered through primary care teams -supported by training and multiple disciplines working together, ownership and commitment at all levels.

Education and awareness was proposed as being a critical component in promoting an integrated care approach and delivering to an integrated care pathway. It was suggested that education and awareness would also be needed for the general population, healthcare workers, community services and professional GPs and public health nurses.

Communication was perceived to be one of the critical elements overall. It was felt that education awareness, amongst the various groups mentioned, would be critical in the development of a shared risk assessment. Some elements to be included in the risk assessment would be: *Have you fallen?, Are you afraid of falling?, Are you less mobile 12 months later?*

The risk assessment team would support the development of an integrated falls pathway, which would be overseen in the community by the GPs and the public health nurses. It would link into the secondary care system through Emergency Departments and Falls Clinics. The latter could be based within the community or within hospitals. Patients would need access to geriatricians for work ups if needed and the community services for follow up and discharge care facilitating a multi-factorial intervention approach. The key elements of this approach is a shared risk assessment, feeding into an integrated falls pathway with multi-factorial interventions available to meet the health and wellbeing needs of the older person who is at risk of falling.

## **HSE West**

### ***Context***

There were two tables from HSE West.

On Table 10 there nine people. Professions/ specialisms represented were clinical risk management, physiotherapy managers, clinical nurse managers, quality and safety co-ordinators, clinical nurse manager with responsibility for osteoporosis and a health promotion officer.

On table six there were seven people on this table. Professionals/specialisms represented were risk managers, clinical nurse managers and staff nurses from Sligo, Limerick, Galway and the North West.

### ***Written feedback to questions (abbreviated) – Can you deliver? and What is needed?***

**Table 10**, in response to question one, stated “no”. However, it was noted that Milford Care Centre, Limerick and Sligo Primary Care Team, Ballyshannon have in place falls preventative programmes that addresses the needs of people considered high risk. It was stated that it was difficult to identify those who had had a fall in the first instance. It was felt that older person who are voters are driving the need for falls preventative programmes.

In response to question two, what is needed is leadership and co-ordination of effort, preventative education and health promotion information in nursing homes, GP practices, primary care centres, available to older peoples groups, community OTs, home help and family and patients/clients. They believe a national strategy is needed to set the agenda and a person dedicated to older person care, with a unit for falls would be invaluable. A coordinator is needed to drive falls and bone health in the HSE West, particularly in the PCCC sector.

Co-ordination, leadership, geography and funding are seen as big barriers to progress. Research and development and audit need to keep pace with any new developments to ensure the effectiveness and efficiency of any potential services. ‘Lots of money’ is needed to make this happen. ‘A good referral system doesn’t necessarily cost much’. Advertising will help with building understanding of how to refer. Upskilling and education of the various professionals is needed to build a shared understanding of what is needed. Sustainable engagement by staff delivering these services, supported by an overarching national body steering the gains. A national database would need to be developed to ensure effectiveness and value for money. Access to the services would be important, and education the public in preventative measures.

### **Table Six**

In response to the first question, they said possibly in some areas of the service. However, what is missing is an integrated approach, and good leadership. In addition, funding of full time equivalents was seen as being particularly problematic. Communications between the disciplines, infrastructure and equipment upkeep and limited multi disciplinary working practices in some areas were also seen as barriers. In response to question two on what’s needed to allow them to deliver, the response was the following: multi-disciplinary working, good communications, suitable infrastructure, strong leadership, education and training to balance risks, adequate supervision, appropriate use of beds, aids and appliances to ensure that patients are not over-restrained and adequate staffing to support co-ordination of services, involving family members.

It was felt that Medical Assessment Units supporting working Emergency Departments (Eds) would be a good place to start delivering falls and bone health services -integrated care pathways could be developed from within EDs via MAUs EDs would refer patients appropriately to Specialist or Community Services as needed. Risk Assessments would be needed to identify those at greatest risk. In addition dexametaphosphate scans for everyone who falls to ensure the integrity of their bone health and medication reviews would be necessary. An ethical approach to all of this would be key in the development of policies and procedures to standardise services. Adequate consent guidelines to support the practice and the use of restraints would need to be considered. Champions would be needed to persist in driving the process forward.

## HSE Dublin North-East

### **Context**

There were one table from HSE North East. On Table 2 there six people. Professions/ specialisms represented were physiotherapy, health promotion and nurse practice development, PCCC based professionals and hospital based professionals.

### **Written feedback to questions (abbreviated) –Can you deliver? and What is needed?**

In answer to question one “can you deliver ...” it seemed to be a “no”. It was important to recognise that these services were considered to be primary providers of social services as opposed to health services i.e social services, voluntary sector, nursing homes and non healthcare professionals operating within these sectors. All these services work independent of each other and there is no current shared falls screening tool in place. Linkages would need to be developed between these groups to enable them to work together on this issue. The infrastructure would need to be developed to enable this to work. The lack of integrated education to build understanding between services would be necessary to enable a more integrated approach.

No agreed national standards, although now HIQA are developing nursing home standards. There are also no regulations for building houses, to perhaps prevent falls and they felt that, on the whole, this is outside of their control. In response to question two “what is needed to enable you to deliver ...” they felt that generalist services are starting to need this aspect of engaging with care pathways and that patients greater than 65 years of age having a falls assessment would need to have a falls assessment or undergo screening. New developments would be needed in terms of policy development and education of staff to deliver on this. In some areas this would be specific disciplinary learnings that would need to happen to enable good use of the roles and a better integration within the teams.

Currently there is no overall strategy to drive this, they need uniformity of standardisation in terms of the use of tools. Perhaps a community base too and a hospital base too might be necessary. Liaison would be needed between the disciplines, especially an allied health professionals nursing and medics co-ordinator would be important. A falls liaison person to drive the work. Specialist falls services would also need to be set up. A falls steering group would be needed, as currently there is no falls clinic available in Dublin North-East. There is also a lack of ICT central database systems and support for any such initiative.

It was also felt that the National Falls and Bone-health Strategy would be critical in driving a proactive integrated agenda. The roll-out would be critical and the integration of different agencies at a high level will be important and the development of an Irish care pathway modelled on what has been developed elsewhere would be necessary. Locally what is needed is local policies and personnel links operating nationally, regionally and locally – as in a co-ordinator to drive the initiatives forward. Resources will be needed in terms of ICT and specialist falls clinics and there may be more than one in Dublin North-East. Integrated care pathway will be necessary for acute inpatients and perhaps another for the community and action plans arising from those. Rapid access to a medical assessment unit for diagnostics, better liaison between the acute and community, dedicated falls and bone health services in primary care, agreed risk assessment screening to primary and acute care,

educational training for staff and then research and development around falls prevention. Internal evaluation and audit will be necessary for any such new initiatives and money, money, money – the restructuring of how this money is spent. Conversations will be needed around this, long term commitment funding will be necessary to ensure sustainability and the purchase of additional equipment for interventions will be important. A multi and inter-disciplinary approach will be critical to the success of any such intervention.

## HSE Dublin Mid Leinster

### **Context**

There were seven tables from HSE Dublin Mid-Leinster.

On **table three**, there were four people signed in. They were representatives from physiotherapy, nurse management from large Dublin teaching hospitals and from the smaller acute hospital and from HSE Midlands area.

**Table five and thirteen** came together to form one table. On this table there were five people, representatives from HSE environmental group, a risk manager of a PCCC area, an OT, a co-ordinator for healthy aging programmes and a team leader in a district care unit.

**Table eleven** did not complete the sign off sheet. If memory serves me there were approximately eight people at the table with a good mix of professionals.

**Table twenty** – sign in sheet was not used for this table. If memory serves there were at least six people on this table from a variety of professional backgrounds.

**Table fifteen** – there were four people, a clinical nurse manager, a risk manager in the midlands area, a health and safety co-ordinator and a registered nurse in a private care setting.

**Table seventeen** – There were six people, clinical nurse managers, a project manager for older people, director of nursing, a healthcare risk manager and acting assistant director of nursing operating in care homes, personnel representing disability services and specialist units such as an orthopaedic centre and a rehabilitation hospital.

**Table sixteen** – There were seven people: a clinical nurse manager with responsibility for falls, senior physiotherapist, a pharmacist, another physiotherapist, assistant director of nursing in a private care establishment, a clinical nurse specialist in a large, acute teach hospital and a registered nurse in a private nursing home setting.

**Table twenty** – No sign in sheet available.

### ***Written feedback to questions (abbreviated) – Can you deliver? and What is needed?***

**Table three** – In response to question one they mentioned that they have community OT physiotherapy services, some areas have better links between these services. The lack of funding and dedicated teams of physio/OT/dietician/nurse a multi-disciplinary services dedicated to falls is a gap. They is also a lack of funding for a co-ordinator for falls in bone health. Not all of their patients are at risk, but they feel that only high risk patients can be met by existing services and the HSE information leaflets on falls are available, but not widely known.

In terms of what is needed, their response from Table Three is multi-disciplinary teams that have access to consultant gerontologists. They feel that a cross-sectoral approach would be important in each local area network. They feel that a dedicated co-ordinator would be relevant and that would be a healthcare professional. There should be one point of entry for high risk patients who need advanced interventions

and a hospital setting would be appropriate for that. They feel education programmes are needed and awareness (about risk assessments and standardisation of tools to do this reporting) will be needed around the strategy. Education and funding from drug companies and charitable NGOs to support research.

**Table five and thirteen** – In relation to the first question asked, “can you deliver ...”, the response from this amalgamated table was that the need is not currently being met, but the potential is there. Barriers include things like financing of funding of services, issues around suitability of personnel and access, urban/rural divide and physical infrastructure is a problem and clinician training and awareness of best practice in this area. Also the presence and knowledge of a referral process and the isolation of certain groups. Solutions being proposed are the introduction of a falls risk assessment tool, in addition it would be important to upskill homecare workers in assisting older people with falls prevention. The important of awareness of educating family, community and primary care teams would be an important resource in preventing falls. ??? of auditing resources and information technology back-up systems, changing staff attitudes and creating supportive environments for older people.

In response to the second question, “what is needed to ensure that people who fall, or at risk of falling have their needs met ...”, the response to what is needed was: leadership at many different levels (nationally, regionally and locally), responsibility, reporting structures, auditing and monitoring systems, planning and enabling systems also need to be put in place. Commitment from the HSE and the government (Department of Health and Children and the Department of the Environment), planning the practicalities and infrastructure to allow this to happen, holistic assessment of those at risk in the community. In addition a greater understanding of the roles and responsibilities, in other words “not being afraid to ask” in permanent service users and their families and carers, those who work with older people, neighbours advocates.

“evaluation of services from a service users perspective ...”, adopting a life stages approach, addressing the individual health behaviours of younger people and the broader dimensions of health, including affordability of healthcare, investing in health promotion.

**Table eleven** - In response to “is your service able to meet the needs of people who fall, or at risk of falling ...”, the answer was “no”, not able to meet the needs of people who fall. The need to define the service was mentioned. The dietary service never consulted in relation to falls prevention and there is no way of referring people who had a fall. Podiatry service is a key stakeholder in falls prevention. There is a huge need for health education and knowledge awareness education at all levels, primary care level, anti-natal care schools all the way through the ages from the cradle to the grave. Lack of a knowledge of who are where to refer to. In addition there is a lack of integration and a need for synergistic, integrated services between the acute and PCCC.

In terms of secondary prevention, are other structures in place in the large institutions? Such things as care pathways, risk assessments are available on an ad hoc basis. In addition, in the Ballymun area, San Andreas, they are in the process of putting in an integrated care pathway in the community as a secondary prevention. There is no accident prevention programme in the psychiatric centre and it is very underdeveloped in every area. In response to question two, “what is needed to meet the need ...”, each community care area should have a co-ordinator for

accident prevention. Services need to be based locally and linked in with hospitals where advanced tests can be available for high risk people.

Medical history cards should be held by the user and enabled to be shared amongst those who need to know the shared ICT system that would be open to OTs, social workers, physiotherapists, podiatrists, GPs, nutritionists, etc. There needs to be a two way referral system available.

**Table fifteen** – In response to question one, from an acute hospital setting perspective, a risk assessment needs to be put in place. This tool would help to identify those at risk of falling and the first point of contact could be the A&E, GPs surgery, social services, public health nurses, occupational therapists and physiotherapists. The importance of identifying those at risk of falls at all these levels would be important. For example, in the A&E setting and OT there could be a professional liaison person from any profession who would co-ordinate the work needed to be done at A&E level.

Proper assessment tools that would encompass environmental checklists. Individual education would take the form of leaflets and would be available at outpatient departments and booked by public health nurses if taken charge. Diagnostic tools and referral need to be put in place. CT, dexta scans and such like. Interventions at primary level: you need to treat the diagnosis, eg osteoporosis and at the secondary level refer to secondary care for treatment such as GP referral into falls clinics.

In terms of what is needed in question two, they felt a co-ordinator was needed with a specific role to bring together the various multi-disciplinary groups into some kind of steering group that would be linked locally, regionally and nationally. Assessment tool in A&E is critical to formalise the risk assessment and develop a care plan. Some kind of liaison nurse in A&E to liaise with GPs. Elective admissions, falls assessment on admission to the ward, this would help and, in terms of correct diagnostic equipment, clinical nurse specialists would also be needed to prevent falls. Clinical nurse specialists need to be aware of the impact of falls for older people, health promotion units, falls clinics, multi-disciplinary teams and IT support to help bring together these various sectors and disciplines and some kind of referral pathway that would help capture the patient journey.

**Table sixteen** – in response to question one, “can you deliver, do you have what is needed to meet the needs of people who fall, or at risk of falling ...” the response was displayed diagrammatically with an integrated care pathway at the heart of the diagram and arrows shooting off what was seen as needed, as opposed to perhaps what is available. Accountability was critical, appropriate housing design, funding, staffing, consistent education was seen as being important.

Standardised assessment tools were also mentioned. The approach needs to be patient centred, families and carers need to be involved, academic support to ensure evidence based practice, access to services needs to be clear, continued and sustained enthusiasm within those services, ongoing service development, individualised flexible needs driven care, evidence based practice, and communication gaps need to be addressed.

Ongoing research and audit to determine performance, a national ICT system to support integrated record keeping and also to allow for monitoring and a link between primary and secondary care is critical and adequate discharge planning.

In response to question 2, “what is needed to meet the needs of those who fall, or at risk of falling ...”, they felt what is needed is ending in a diagrammatic representation with the patient needs right in the heart and they have national standards. Awareness is needed amongst the public and clinical personnel of falls and its preventability, also a focus on care at home, continuing education, specialist roles and how best to use those, a national ICT system, equality of services, political awareness, day centre availability, barriers to patient needs, rapid response teams need to be made available, support post-rehab, adequate screening, access to equipment, follow up interventions, quality improvements and feedback around same. The need to reassure patients, to promote independence, annual MOTs was also highlighted, R/V and discuss some fora to discuss ongoing development and locally led services.

**Table seventeen** – in response to the first question, “is your service able to meet the needs of people that are at risk of falling ...”, all that was written in response was that clear lines and responsibilities needed to be available.

They responded extensively to question two, “what is needed ...”, dividing their feedback into child services and residential services. In child services they felt that a patient centred approach was needed, access to specialist services and centres, poly-pharmacy needed to be regularly reviewed. Internally there needed to be some kind of falls co-ordinator, a core group falls prevention team, including dieticians, OTs and physios. A clinical governance structure was needed, such as to allow this to happen and to monitor any implementation, verbally and in culture, that audit needed to be part of the internal infrastructure. Externally collaboration needed to be there with HSE and State Claims Agency. National Falls Strategy needed to be funded and implemented and funding for regional centres of excellence and falls co-ordinators was necessary.

The biggest obstacle, as they understood it, was access to In terms of what is needed from a residential services perspective research on best practice, identification of specific requirements and “reduce the need to reinvent the wheel”. Strategies needed to be piloted before implementation, collaboration with the stakeholders was critical. Identifying assessment tools that are multi-disciplinary, educate all staff with clinical and family and patients. Everybody to have full medical on admission as part of their initial assessment. From the groups identified care plans needed to be devised for low, medium and high risk people.

Specific care plans for risk groups needed to be developed and needed to be implemented and have a system for reviewing those care plans. Access to diagnostics needed to be more readily available and capacity needed to be built into these processes and always reevaluate and reassessment needed to be done, to ensure the efficiency of the services provided.

**On Table 20** – in response to the first question, “is your service able to meet the needs of people who fall, or who are at risk of falling’ they responded as to the availability of non-health services, then generalist services, and then specialist falls services as delineated in the falls and osteoporosis pathway for Lincolnshire, shared with each of the tables.

In terms of non-health services, basically what was available would be day centres, home helps and medical social workers operating with public health nurses. These are available as a resource. In addition family members had access to GPs and A&E and could refer in through these pathways. Nursing home convalescent and

sheltered accommodation referral route was directly into acute care settings and this was what is available on the non-health service level.

On the generalist service level, day hospitals and day centres at these facilities there were balanced tests and lower limb strength tests had been carried out. A&E was also available to provide generalist services and falls prevention programmes operating within these settings to provide education and support people in following through with falls diaries, posters and falls bracelets. Multi disciplinary teams were operating behind these falls prevention programmes. In addition, at this secondary level, there were falls and blackouts units, outpatient services that had access to dexta-scans, also geriatric services, balance classes. There was no country wide multi-factorial falls assessment tool at this point in time. There was also community rehab team near DCU.

Level three specialist falls services following the falls and osteoporosis pathway, there was falls and a blackout unit at St James's Hospital. A three month follow up after discharge for a low trauma fracture. Outpatients follow up in the day hospital, with appropriate referrals to the multi-disciplinary team. Potential fallers refer to crew for intensive rehab, which is available on an out patient ??? (end of side 1 of tape, not continued on other side).

In response to question two, "what is needed ...", Table 20 believed more staff, more money, better facilities in acute rehab settings and community settings. More centres of excellence, especially for rural country areas, better community services and better links between the acute and PCCC sector. Countrywide falls multi-factorial falls assessment tool, central research database, rapid assessment and review of fallers at board level, on sight opticians, chiropodists, orthotcists, specialised dementia units, more staff to supervise patients. Improved links between A&E and orthopaedic teams, more ortho-geriatrician posts available.