The Role of the Specialist Nurse in Falls and Bone Health

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Partnership
The Impact of Falls

• 45% of people over 80 who live in the community fall each year.

• 10 - 25% of fallers will sustain a serious injury.

• 7% of fallers attend ED, 4% serious injury but discharged, 3% being admitted to an in-patient bed.

• 1.5% falls result in hip fractures

• 50% of all care home residents have falls every year
Guidelines and ‘Drivers’

• National Standard Framework for Older People 2001 (Standard 6)

• RCP Falls and Bone Health Audits (RCP 2007, 2009, 2010)

• “Falling Standards Broken Promises” (2010)
  …. “33% of non-hip fracture and 60% of hip fracture patients receiving appropriate management for bone health”

• NICE Falls Guidelines 2004 (updated in 2013)
NICE Falls Guidelines 2004 (updated June 2013)

• Any one in contact with an older person should routinely ask if they have fallen in the last year, the frequency of falls and what happened.

• Those who have fallen or show abnormalities of gait and balance should be offered a multifactorial falls risk assessment.

• All older people who have fallen or are at risk of falling should be offered individualised multifactorial intervention

• Those who do not report a fall, should be asked periodically (every year)
Multifactorial Assessment

• “Suitably trained Falls specialist or a team of clinicians”.

• “Essential elements of falls and bone health risk assessment”.
Community Falls Services

- Traditionally have been ‘therapy led’.
- Falls service (with no bone health management)
- Referred to GP for medical/medication review.
- May refer to community nursing team/community matron/practice nurse.
Development of the Nottingham community Falls and Bone Health Service

- RCP Falls and Bone Health Audits (RCP 2007, 2009, 2010)
- “Falling Standards Broken Promises” (2010)
  .... “33% of non-hip fracture and 60% of hip fracture patients receiving appropriate management for bone health”

- Highlighted need to address falls and fractures.
Nottingham CityCare Falls and Bone Health Service Review

• Met with GP leads/ commissioners/secondary care specialists/Public Health to look at results or RCP/recommendations.

• Scoping what was currently delivered in primary and secondary care.

• Looked at gaps in service delivery and what was needed to deliver a comprehensive falls and bone health community service.

• Identified issues with GP time to complete clinical assessment/manage bone health.

• Identified a need to increase nurse capacity within service to complete a comprehensive, falls and bone health assessment for patients.

• Outcome: Developed an ED Falls pathway-x2 Questions on admission to ED
  • Increased nursing capacity within the Falls MDT
  • Nurse-led falls and bone health clinic pilot for 3 months.
  • Re-named service Falls and Bone Health Service
Falls & Bone Health Pathway

Injurious Fall

Ambulance called…
‘Falls Rapid Response Team’ or EMAS Ambulance team

Patient Transported to Emergency Department (ED)

Patient has initial clinical assessment in ED and referred for multifactorial Falls and Bone health assessment with community FBHS via ED Falls pathway

Non-Injurious Fall

Patient Falls in Community

Referral Sources

GP/ Patient- self referral
Local Authority/voluntary sector
Community Health/social care staff
Care Homes /Home care

All referrals are triaged by Single Point of Access;
Telephone number: 0300 300 3333 Fax number: 0115 883 8371
Urgency of response assessed

Falls and Bone Health Service (FBHS)

Patient seen within 2 weeks
(Criteria - Injurious faller over 65 years who has attended hospital as direct result of a fall)

Comprehensive Falls and Bone health assessment. Team include: Specialist Nurses, Occupational Therapists, Physiotherapists, Clinical Specialist, Health Promotion Specialist and Support Staff. (FBHS will also take complex fallers from CRT/UCT/HRCT)

Intervention can include: One to one exercise, postural stability classes, equipment/adaptations, anxiety management, vestibular rehabilitation, bone health assessment and intervention, medicines review, continence and nutrition assessment.

FBHS Postural Stability Groups. (Delivered in 5 sites across the city) Accessed via CityCare health services-weekly exercise groups for up to 6 months.

Once intervention completed by FBHS patient is discharged from the service with recall set to review in 6 months

FBHS-Nurse-Led Falls and Bone Health Clinics in GP practices. Nurses identify patients at high risk of falls and fracture and invite in to clinic for assessment and intervention as appropriate

NUH Rehabilitation unit/ NUH Falls and Bone Health Clinics.
For Consultant assessment/ further investigation e.g. TILT testing, DXA and specialist osteoporosis management.

Urgent Care Team (UCT)

Patient seen within 4 hours
(Criteria Patient needs rapid response to avoid hospital or care home admission)

GtAT completed; Intervention for up to 48 hours and referral onto other service if appropriate. Team includes Social Worker, Physiotherapists, Occupational Therapists, Nurses, Social Worker and AP/support workers.

Health and social care support – up to x4 visits a day from team

Health Reablement Care Teams (HRCT)

Patient seen within 48 hours
(Criteria Patient needs urgent response to avoid hospital or care home admission)

Complete the GtAT – Intensive rehabilitation for 4 weeks, up to x4 visits per day. Team include Physiotherapists, Occupational Therapists, Nurses, Social Worker assessment, Support staff intervention as required

Community Rehabilitation Teams (CRT)

Patient is assessed within 2 weeks
(Criteria -Non-injurious fallers)

Complete the GIAT – Intervention by therapists/ assistants- Physiotherapy, Occupational Therapy and support staff with assessment and intervention as appropriate
Community Falls and Bone Health Team

- MDT Clinical Team
- Team Manager
- Clinical Specialist Nurse
- Specialist Nurses
- Specialist Physiotherapists
- Specialist Occupational Therapists
- Assistant Practitioners (PS Instructors)
- Rehabilitation Support Workers
- Access to Community Geriatricians and Virtual Clinic
Assessment of Patients

Any one of the MDT complete the initial multifactorial assessment, but this is usually the nurse.....

- Medicines review with recommendations to GP on medicine management and prescribing bone health medications.
- Referral to the Community Geriatrician for comprehensive medical assessment (Housebound/CH patients)
- Liaise with GP regarding management of clinical problems and act as a resource re: falls and bone health management.
- Liaise with GP and Specialist Consultants/MDT in secondary care which include FLS, Ortho-Geriatics, Medicine and other specialist services.
- Virtual Clinic with Consultant to discuss patient management and referral for diagnostics/secondary care management.-reduced secondary care referral.
- Referral to Secondary care Falls and Bone Health clinic for further investigation of unexplained falls and management of complex bone health issues by a Specialist Consultant Physician.
- Referral within team to OT/PT/AP/RSW and to other agencies as required e.g. Social Services, City Signposting service, Age UK, etc.
- Written and verbal advice on falls prevention and improving ‘bone health’
Specialist Nurse Case Study

Doris is an 84 year old lady who lives in a residential care home. She was married to Harry for 54 years and has 2 daughters who both visit often. During the second world war she was in the land army and likes to talk about her time she spent in this. She also loved singing and was a member of the church choir. She moved into the care home 2 years ago as she was having recurrent falls and following a fall and hip fracture, her daughters persuaded her to go into full time care. She has a medical history of CVA, Alzheimer's disease, postural hypotension, osteoarthritis and a 10 year history of dizziness which greatly affect her quality of life.

**Medications** - Trazadone 50mgs x1 BD, Amlodipine 5mgs x1 BD, Calcichew D3 forte x1 BD, Chlormethiazole 192mgs x1 nocte, Paracetamol 500mgs x2 TDS, Donepezil 5mgs x1 nocte, Cinnarizine 30mgx1 TDS, Ibugel 5% apply 2-3 x a day.

**On assessment:** Postural BP 142/72, standing 110/60 – symptomatic dizziness and unable to stand upright for 3 minutes. Pulse 74 reg. FRAX 10 year osteoporotic fracture probability score = 33.0%. NOGG- treat fragility fracture.

Daily routine: Breakfast, go back to bed morning and afternoon due to dizziness which had gradually become worse.

**Goal:** To be able to go to Church again.

**Plan:** Discussed with GP reducing meds, checking bloods and starting Bisphosphonate. GP also agreed Consultant review Virtual clinic- Advised to reduce meds slowly and to have a mental health review. GP reduced Trazadone, Cinnarazine and stopped Amlodipine. Changed Chlormethiazole to elixir to titrate down. Raised systolic BP but reduced postural drop to 20. Still dizzy on standing but improved. Falls continued x2 month-loss of balance/dizziness. Reviewed monthly BP, weight (appetite improved), continence, mood/cognition.

3 months later - reviewed in CH by Psychiatrist - stopped Donepezil, and Trazadone as not beneficial.

**Outcome:** BP showed no deficit 2 months post stopping meds although raised 160/80. Quality of life very much improved sleeping and activity increased. Checked Bisphosphonate compliance. Only intermittent dizziness on rising in morning - coping strategies. Sat out in garden for a review.

Review 1 month later - been to Church for first time in many years, no further falls. Started chair based exercise in CH.
Audit outcomes…..

The number of falls, ED attendances and admissions to hospital that patients report at 6 months after intervention by the community Falls and Bone Health service was reduced by 68%.

(Average number of falls prior to intervention 4.9 falls per year)
‘Better Balance Better Bones’ Project
Aims and Outcomes

The overall aim of the project was to reduce admissions to hospital from falls and fragility fractures.

To identify patients within primary care who had fallen and/or fractured and initiate assessment of their falls and fracture risk through a Nurse-led clinic in GP practices.

To identify patients early within primary care who were at risk of a first fall/fracture through the identification of risk factors and initiate assessment of their falls and fracture risk through a Nurse-led clinic in GP practices.

To provide practices with support to enable active identification and management of these patients as well as relevant training and education on clinical management and service care pathways.
‘Better Balance Better Bones’ Pilot Project

Nurse recruited from community FBHS. Identified patients from GP records who were at high risk of falls and fractures and invite them in to a Nurse-led falls and bone health clinic.

Completed a comprehensive falls and fracture assessment. Initiated intervention as appropriate.

Assessment uploaded onto template based on local/national guidelines imbedded into GP system.

Discussed management plans with the patient and their GP-care plan agreed.

Patients in Care Homes and Housebound patients were also seen and assessed.
Pilot Project Results

Increase in falls and bone health assessments completed on ‘at risk’ patients.

Risk registers developed for Falls and Osteoporosis patients (in line with QOF targets)

Improvements in the numbers of patient’s prescribed appropriate bone health medication and a decrease in medications which increase falls risk.

Increased referrals for DXA scans, to community primary care services including Occupational Therapy for home assessment, Physiotherapy- including referral to Postural Stability groups, Continence service, Dietician, social services etc.

Health education advice on nutrition and bone health, smoking cessation programmes, alcohol advice, increasing ‘weight-bearing’ exercise as well as written and verbal advice on reducing falls risk.

Referral to secondary care Falls and Bone Health consultant services for diagnostics and specialist management of patients with complex falls/osteoporosis.

Positive patient feedback……. “liked being seen in GP practice”…… ..…”good to have time to discuss health issues with the Nurse”.

Positive GP feedback…. “help with the long term management of patients as well as improving patients awareness of osteoporosis” ……. “this is an excellent new service which offers easier access to advice on patients with osteoporosis and how best to manage them”.

Secondary care feedback…”reduction in inappropriate referrals into clinics and more complex patients being seen”
Commissioned Services and Future Developments

- 32 Nurse-led community Falls and Bone Health clinics a month in Nottingham City-plan to increase service to all practices.
- Pilot of a community ‘Nurse-led’ IV. Osteoporosis treatment service.
- Virtual Falls and Osteoporosis Clinics-plan to increase x2 monthly.
- Health Promotion Bone health Initiatives with School Nurses, Health Visitors and Midwives in Nottingham.

(Nottingham CityCare Partnership, Nottingham University Hospitals NHS Trust, Nottingham University, Nottingham City Public Health)
Hip Fracture Rates for the City of Nottingham

4.14i - Hip fractures in people aged 65 and over (Persons)

Nottingham

Directly standardised rate - per 100,000

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Source: Hospital Episode Statistics (HES), Health and Social Care Information Centre for the respective financial year, England. Hospital Episode Statistics (HES) Copyright © 2014, Re-used with the permission of The Health and Social Care Information Centre. All rights reserved. Local Authority estimates of resident population, Office for National Statistics (ONS) Unrounded mid-year population estimates produced by ONS and supplied to the Public Health England
Thank-you for listening ..... 

Any Questions?