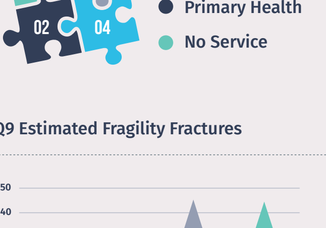
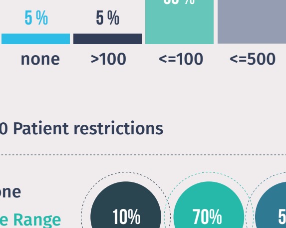
NEW ZEALAND 2020 FACILITY SURVEY RESULTS

CONTEXT

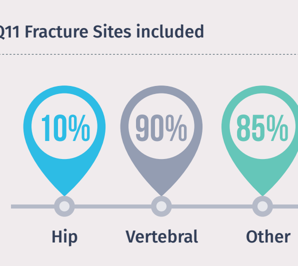
Q7 Service Setting



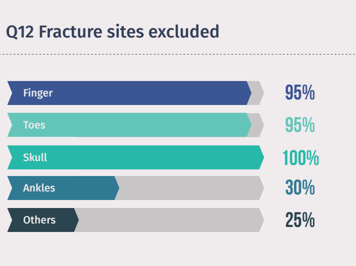
Q8 Estimated Hip Fractures



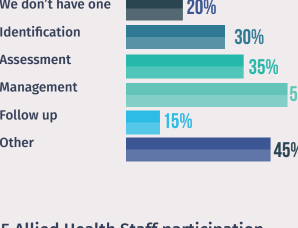
Q9 Estimated Fragility Fractures



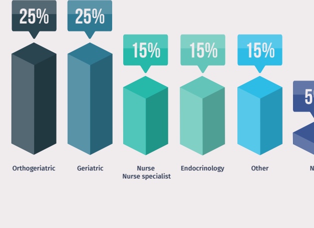
Q10 Patient restrictions



Q11 Fracture Sites included



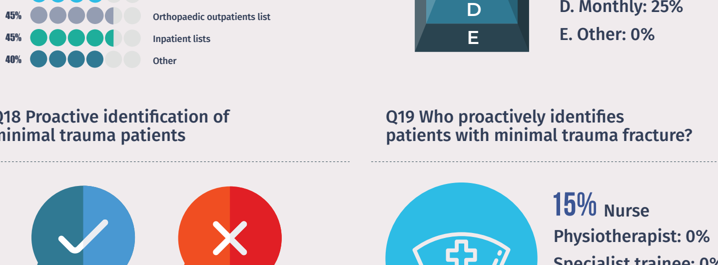
Q12 Fracture sites excluded



Q13 Clinical Service Lead role

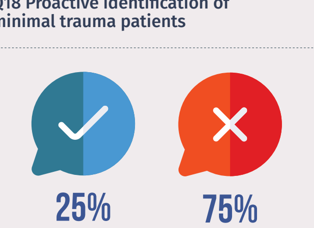
Q14 Clinical Lead discipline

Q15 Allied Health Staff participation

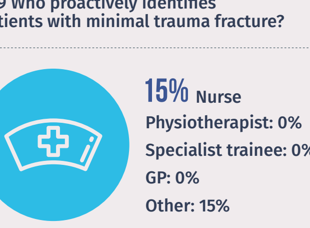


IDENTIFICATION

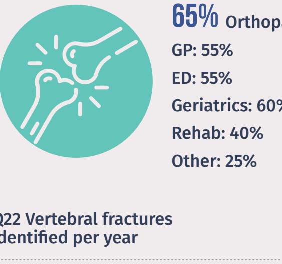
Q16 Proactive case finding methods



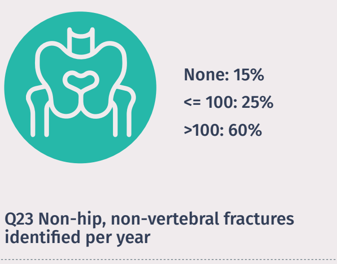
Q17 Case search frequency



Q18 Proactive identification of minimal trauma patients



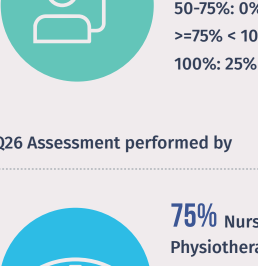
Q19 Who proactively identifies patients with minimal trauma fracture?



Q20 Referrers

Q21 Hip fractures identified per year:

Q22 Vertebral fractures identified per year

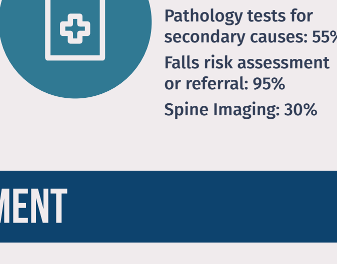


Q23 Non-hip, non-vertebral fractures identified per year

ASSESSMENT

Q24 Portion of identified patients assessed

Q25 Assessment location



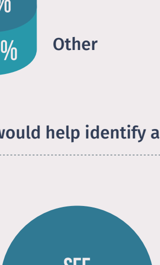
Q26 Assessment performed by

Q27 Assessment Methods

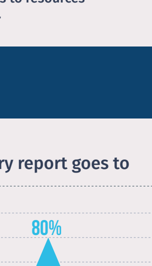
TREATMENT

Q28 Information Provided

Q29 Osteoporosis Pharmacotherapy Recommended:

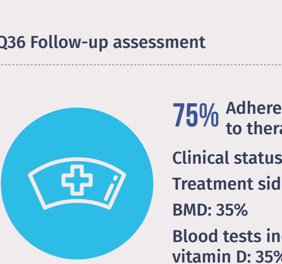


Q30 Osteoporosis Pharmacotherapy Initiated



Q31 High-risk fall patient management

Q32 Identification/Management barriers



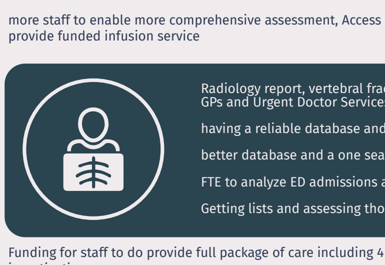
Q33 What would help identify and manage

FOLLOW-UP

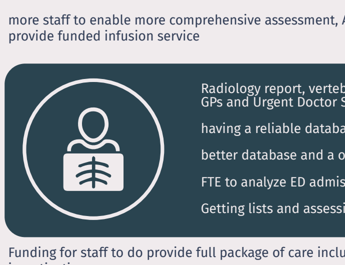
Q34 Summary report goes to

Q35 Follow up offered

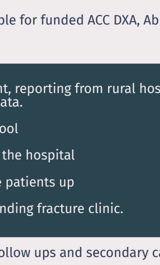
Q36 Follow-up assessment



Q37 Follow-up location



Q38 Discharge Criteria



APPENDIX 1
Q33 WHAT WOULD HELP IDENTIFY AND MANAGE

value placed on such a service so we could set one up.

Funding to case find, I work outside the DHB so do not have access to inpatients I rely solely on referrals. This can be patchy and I definately do not see all our Hip fractures

more staff to enable more comprehensive assessment, Access to DXA not eligible for funded ACC DXA, Ability to provide funded infusion service

Radiology report, vertebral fracture assessment, reporting from rural hospitals, GPs and Urgent Doctor Services, reliable ACC data.

having a reliable database and a one search tool

better database and a one search tool around the hospital

FTE to analyze ED admissions and follow these patients up

Getting lists and assessing those patients attending fracture clinic.

Funding for staff to do provide full package of care including 4 and 12 month follow ups and secondary cause investigation

As work volume increases more time is needed to maintain timely interventions and follow up for FLS

Blue sky thinking - having everyone in the patient journey recognize a fragility fracture and refer haha. Its a time barrier to search through notes, looking for life expectancy (no palliative patients), how fractured, x-ray evidence of fracture, if they have been sorted in hospital ....

"More hours to do the work, Will allow me more time to see the patients. Have input in Orthopaedic clinics to see those patients with fragility fractures there and give them information and education."

I work in 2 different ares, which is ok, but they have different IT sytems, so I have to flit from place to place to get all the information I need for some patients - the most difficult data to collect are from the patients notes that are with GP's that are not with PHO's

Patients with fragility fractures who are hospitalised to be given zolendronate prior to discharge : unless contra-indicated "

More information in the hospital discharge letter about osteoporosis and FLS referral

Funding clinical lead

The Taranaki DHB programme identifies patients and then refers them to general practice for assessment and management

Automated reports from Radiology, referral pathways for community Accident and Medical facilities, further education and relationship building with Primary Care, continuing funding for In Home Strength and Balance Programme.

identifying is mostly ok although having a good pathway from GP to service would help, the processes following on from this is what i'm primarily struggling with having a standardized approach that everyone works off the same plan on and standardized letters, forms etc to make things so faster

Attendance at fracture clinic by FLS nurse, advertising with primary care and A&M's

APPENDIX 2
Q38 DISCHARGE CRITERIA

Completed falls program, seen GP for pharmacological intervention, and improved balance outcomes. If not discharged and referred to an in home program for ongoing support

treatment already initiated prior to event, 12 months post assessment.

Treatment outcome recommended to GP and patient

GP and patient aware of recommendations

Client has received appropriate treatments

Stop point at 12 months post fragility fracture identification

Treatment adherence, medication compliance met at 6 months. Patients provide with sufficient education, nil falls in past 12 months

I have set up a 6 month review and 18 month review as per best practice, but have not go t to either of these in the last 4 years, so the patients are effectively discharged after the bone management plan is sent from me to the general practice team. But saying that i have patient continue to ring for advise and support with this long term journey especially with second line treatments and education on injecting.

"see what the DXA results are, if needing bisphosphainate acertain that it has been commenced - may take waiting a month or so and or sending a reminder letter to the GP

If the patient doesn't fit the criteria for a DXA but needs bisphos or Vt D confirm its been commenced

If assessment is done and there are no new orders e.g. already on bone strengthening medication or DXA was NAD etc"

Once a patient has been assessed for osteoporosis and a letter is sent to their GP regarding treatment recommendations

There is no discharge as remain with GP

Unsure as will vary among practices

we have none

Appropriate response to treatment and having a long term treatment plan