FLS service improvement through proactive telephone appointments – KPI 2, 3, 4, 5, 6, 7, 8

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Background

Once low trauma fractures were identified, patients were historically sent a postal FLS questionnaire to complete and return for the fracture liaison service (FLS) team to assess. If the patient did not return the questionnaire within a month, a reminder was posted, then a month later the patient was discharged. We redesigned the FLS to send all patients a telephone appointment for a bone health assessment, if they did not attend they were given one additional appointment.

What did you do?

To capture more FLS patients as the response rate was around 22%. We knew those least likely to return their questionnaires were the older patients, especially those who were housebound or in a care home, with a high risk of future fractures. In return, more patients would be assessed and commenced on treatment if appropriate.

Process

- Lead nurse
- FLS nurse
- FLS pharmacist

I discussed the plan with the lead nurse and we agreed this appeared to be a productive way forward for the service. Together with the pharmacist, we had a meeting where we planned our telephone clinics and communicated the plan to the admin team.

We are a small organisation, working closely together in an open office space, from the senior leadership team to the office assistants. We have excellent communication channels for making a change in clinical practice.

We calculated how many questionnaires we posted out monthly so we knew how many telephone appointments we would require. I had recently come into post as an FLS nurse so there was capacity to assess more patients.

We calculated we would require around 35 telephone appointments weekly, arranged for the clinics to be created, and, instead of posting a questionnaire, the patients were posted an appointment letter. This was all done within a week.

Outcomes

We now assess around 90% of identified fractures (previously 22% with postal questionnaires). We assess both care home and housebound patients, which was rare previously. We knew the demand for face-to-face bone health appointments would increase for those requiring injectable medications, but it has surpassed our expectations. We have 18 face-to-face bone health appointments for drug education and screening for denosumab, zoledronic acid, teriparatide and romosozumab but this is never enough, plus home visits for housebound patients. We are currently recruiting for a new bone health nurse to increase our capacity for these clinics.

We did not consider the number of DEXA scans we order and how this would impact the radiology department and our workload – reviewing DEXA scans to finalise FLS treatment plans is time consuming.

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What did you learn?

- If I was to make this change again, I would potentially do it in stages and send telephone appointments to the high-risk fractures and keep low risk as questionnaires to increase activity gradually.
- I would also consider the potential impact on DXA, access to different treatments if more patients are assessed and recommended treatment. For example, ensure that there is the capacity to commence the medications recommended such as zoledronate and denosumab.
- I would also consider adding in balancing measures such as time to assessment, initiation by 16-week monitoring so you can see how changing one part of the FLS pathway may be affecting another part. There is more information about balancing measures in the FLS-DB improvement workbook.

Key learning point for other units

If you are struggling to reach all FLS patients, find the group which is being missed and those at highest risk of future fractures in order to devise a service that will reach those most vulnerable.

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