



Commonwealth Department of
Health and
Aged Care

*Falls
prevention
activities for
older people:*

a national stocktake

ENHANCED
PRIMARY CARE
BUILDING BETTER CARE

Falls prevention activities for older people: a national stocktake

*Report to the Commonwealth Department of
Health and Aged Care
Injury Prevention Section
by
National Ageing Research Institute*



NATIONAL
AGEING
RESEARCH
INSTITUTE

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In November 1999, the Commonwealth Department of Health and Aged Care commissioned the National Ageing Research Institute Inc. (NARI) to undertake a stocktake of major organisations conducting falls prevention activities for older people. This report, *'Falls prevention activities for older people: a national stocktake'*, provides an overview of falls prevention activity occurring in Australia at the time of investigation.



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Executive Summary

Falls among older people is a major public health problem in Australia. There has been recognition of the magnitude of the problem throughout the 1990's, and considerable growth in recent years in the number and type of falls and falls injury prevention programs attempting to address the problem. Despite this, the primary indicators of falls related mortality rates and falls related hospitalisation rates have remained relatively stable during the mid to late 1990's. However, case numbers are rising because of the increase in the proportion of the population at the ages of greatest risk. The emotional, physical, personal and health resource costs associated with falls among older Australians are likely to increase further unless coordinated, effective falls prevention strategies are implemented. The Injury Prevention Section of the Commonwealth Department of Health and Aged Care (DHAC) is implementing the *National Falls Prevention for Older People Initiative* announced in the 1999/2000 Federal Budget. Two projects were undertaken to inform planning and implementation of the *Initiative*. The first of these was a review of the current research evidence of effective falls and falls injury prevention programs, in the community, hospital and residential aged care settings. The second is the basis for this report, *Falls prevention activities for older people: A national stocktake*.

The National Stocktake had three primary components.

1. ***Informant interviews*** with key stakeholders, specifically Commonwealth and state/territory departments, as well as representatives from major research institutes and data collection agencies with involvement in fall prevention.
2. ***A paper based survey*** was used to investigate a range of key issues considered important in conducting effective falls prevention programs in the community, hospital, and residential aged care settings. The Stocktake provides a representative overview of these programs rather than an exhaustive list of all programs involved in falls prevention activity in Australia. A total of 122 programs met the criteria for inclusion in the analyses of this report. Responses received were from a broad range of agencies undertaking varied programs aiming to reduce falls and falls related injuries among older people.
3. ***A detailed evaluation*** of a small number of falls prevention programs in each setting was also conducted to demonstrate aspects of best practice, based on previously defined guidelines. In addition, there was a review of two programs that were reported as not being sustainable, to further explore issues associated with sustainability.

Informant interviews

Interviews with key people in Commonwealth and state/territory departments responsible for falls prevention highlighted a diverse range of activity and infrastructure or system support for falls prevention currently in place. A number of states have developed injury or falls specific action plans spanning up to five years. In several states, networks of practitioners, researchers and policy makers have been developed, providing regular

interaction between these key players in falls prevention. Reference groups have also been reported, often with broad representation, including older people or representatives of older adult organisations. Communication between key stakeholders appears to be critical to the development of a coordinated strategic program of falls and falls injury prevention activity. Good communication and collaboration appears to minimise duplication and optimises likelihood of effective, sustainable interventions.

Interviews with researchers identified a number of common themes. There remain many gaps in the available research literature on effectiveness of falls and falls injury prevention, and there appears a need for ongoing funding for quality Australian research to address these gaps. Researchers also stressed that for effective evaluation of falls prevention programs to be achieved, planning and establishment of evaluation needs to be introduced at the time of program development. Strategies to enhance translation of research findings into practice were considered as important as the research findings themselves. Researchers have had significant roles in the falls networks that have developed in several states. Falls networks were considered one useful way to facilitate the translation from research evidence to practice.

Survey results

The majority of falls and falls injury prevention programs responding to the Stocktake survey were from community settings (57%), with 11 per cent from hospital settings, and 11 per cent from residential aged care settings. A further 21 per cent were programs that addressed falls prevention in two or more of these settings. Detailed analyses of all survey respondents as a group, as well as categorised according to community, hospital, residential aged care or mixed setting are provided in this report.

Most commonly, programs developed in the last two years have addressed multiple falls risk factors, and were implemented by allied health and nursing staff. While most programs had undertaken or planned to undertake some form of evaluation, the evaluation usually consisted of satisfaction surveys or pre/post intervention assessment. Ten of the programs reported using a randomised controlled trial design. Forty two per cent of programs had produced a journal article, conference presentation, newspaper article, or project report to facilitate dissemination of outcomes to others involved in falls prevention. The main source of funding for falls and falls injury prevention programs was from within organisations' own budget (core funding), although substantial funding was also provided directly by state and Commonwealth governments for falls/falls injury prevention programs, and indirectly through core funding for many of the health establishments involved in programs.

Over half of the programs reported being based on, or adapted from, existing programs. The setting with the greatest proportion of programs based on or adapted from existing programs was the community setting. Networking and communication between programs about outcomes and effective evaluations were considered critical in building on effective programs, and reducing duplication of ineffective programs. Many resources have been developed for falls and falls injury prevention programs in the different settings. In many cases, however, programs continued to develop their own resources instead of utilising existing resources, where these may exist. Again, communication about availability and

quality of resources would reduce duplication in this area. Only a small number of programs had utilised resources in a language other than English.

The survey included a number of open-ended questions addressing issues of gaps and improvements considered important for falls prevention activity in Australia. There were some common themes in these responses. In community settings, access issues (primarily lack of transport), and limited availability to translators were often cited as barriers to program implementation. Only eight per cent of programs were available in languages other than English. Enablers in the community setting included location of the program (particularly if home based), and provision of transport. Insufficient resources and time were cited as problems in over one third of community setting programs, as were the limited role of general practitioners (GPs), and difficulties recruiting participants.

In hospital settings, problems associated with falls prevention programs were centred on improved workforce training for staff. Issues such as poor compliance and poor attitudes of staff to the program were identified. Given the key role staff play in falls and falls injury prevention programs in hospital settings, these issues need to be addressed. Limited patient transport and limited funding were issues reducing effectiveness of programs. Almost all programs in hospital settings were funded from their core budget, which may indicate that staff involved in these programs are being expected to add their falls prevention activity to already busy caseloads. Strategies to improve workforce training and options for dedicated funding for falls prevention programs in hospitals appear necessary to improve outcomes in this setting. In both the hospital and residential aged care setting, nursing and allied health staff were most commonly involved in program development and implementation.

In residential aged care settings, workforce training issues were again commonly reported as areas for improvement. This included increasing staff awareness of strategies which can be implemented effectively in this setting, as well as changing attitudes and practice among some staff. Low cost for participation in programs, and quality of facilitators for programs were identified as enablers in this setting.

Case studies (best practice and sustainability)

Project co-ordinators for several falls prevention programs in each setting were interviewed, in addition to the information provided from the survey, to investigate in greater detail issues associated with best practice and program sustainability. These have been reported by setting.

In the community setting, key issues that improved program effectiveness were:

- the number and range of interventions available in programs;
- involvement of a range of key stakeholders in program development and implementation;
- interaction between practice and research and pre-planned evaluation; and
- broad promotion of the program to target group.

To achieve effective workforce training, in the community setting, a range of options were needed.

In residential aged care settings and hospital settings, programs considered as examples of best practice were often based on individual risk factor assessment, with targeted multiple interventions available. Workforce training issues were generally considered of greater importance in these settings, given the key role of staff in identification of falls risk and implementation of specific falls risk management strategies. Typically, programs had an evaluation component which incorporated identification of falls and associated injuries, as well as various forms of process and impact measures.

The majority of programs were reported as being sustainable. Most commonly, incorporation of roles into staff job descriptions, and funding availability were factors associated with sustainability. Incorporation of falls program roles into staff job description was also listed as a barrier to effective program implementation, where this occurred for staff without the capacity to take on the additional roles. Issues of program sustainability need to be considered at the time of program development.

Recommendations

Results of the National Falls Prevention Stocktake project have highlighted that there is a strong, varied and growing level of falls prevention activity occurring across Australia. In order to ensure maximum impact of these programs, and to continue to build on the best available programs and research outcomes, a number of actions are necessary.

1. Communication

- Further development and support for state/territory based falls prevention networks to provide a regular forum for communication, networking, sharing of resources, and dissemination of program outcomes. Avenues for communication *between* state/territory networks also need to be explored.
- Formal and informal opportunities for communication between the different levels of government, and between states and territories regarding planned activities, funding opportunities, and program outcomes.
- Formal and informal opportunities for communication between key stakeholder groups, including older people, health practitioners, researchers and policy makers.

2. Resource sharing

- Strategies need to be developed to facilitate awareness of the range of resources available, and how these resources can be acquired, particularly for those involved in new program development.
- Products which are shown to be effective need to be promoted, and availability maintained. There are a number of good products/resources which are no longer available because program funding has ceased.

3. Program evaluation and research

- Where appropriate, evaluation should be incorporated into the development phase of falls prevention programs.
- Quality research programs should be supported to address some of the gaps in available research evidence.
- Researchers have an important role in facilitating the translation of research outcomes to clinical practice.

4. Workforce training

- There appears to be an ongoing need for innovative approaches to increasing opportunities and effectiveness of workforce training in falls prevention. Use of workplace learning and current adult learning techniques is recommended.

5. Co-ordinated effort

- Falls and falls related injury present a major potential health burden for the Australian community. A co-ordinated approach to monitoring, evaluation and implementation of programs will enhance our ability to minimise the health and social impacts of falls and related injuries on older Australians.
- There is currently a relatively high degree of duplication apparent in the falls prevention area – particularly in relation to resource development. Building on current research evidence, resources and practice is essential to ensure an efficient and effective approach to addressing this major health problem.
- The highest proportion of reported programs were operating in the community sector. Funding to and focus on residential aged care and hospital based falls prevention programs has increased in the past 12 months and this trend appears to be continuing. It is important that some of the learnings from the community setting are considered to ensure that there is minimal duplication and maximum effectiveness in these less developed settings.

Summary

This project has provided an overview of the falls prevention activity currently occurring in Australia. Whilst not exhaustive, it does provide a representative snapshot of the programs that are in operation and highlights some of the key issues to ensure effectiveness and sustainability. Issues and gaps to be addressed have been identified as they impact at program, systemic and structural levels. There is a need for co-ordinated policy, planning, research, program development and implementation to ensure that the Australian health and community system is well placed to address this important health issue.

1.0 *Background*

Falls are a major health problem for people aged over 65, with one in three older Australians falling in a 12 month period, and up to 10 per cent suffering serious injuries as a consequence of their fall (Dolinis et al, 1997; Kendig et al, 1996). Recent epidemiological data in Australia indicates that falls related mortality and hospitalisation rates have remained relatively unchanged during the late 1990's (personal communication, J. Harrison, NISU, 2000). However, given the predicted increase in the proportion of the Australian population aged greater than 65 over the next 20 years, the actual number of cases is predicted to rise emphasizing the need to address this problem at a national level. Such an approach would be likely to have a positive effect on the health, social and economic impacts of falls among older people.

There has been increased interest in falls prevention – both primary and secondary – in recent years. The Commonwealth Government has identified injury prevention and control as a National Health Priority Area in Australia. Falls make up the greatest proportion of injuries requiring hospitalisation among older people in Australia. During the mid to late 1990's, this has resulted in a considerable expansion of falls prevention activities at all levels - from large scale randomised controlled trials through to small scale local initiatives such as falls prevention information sessions. While the greatest focus of this activity has been in community settings, some activity has also occurred in acute and residential settings, where data indicates that falls rates are even higher than among community dwelling older people (Evans et al, 1998; Norton et al, 1997; Forster and Young, 1995).

Falls and their consequences are costly in terms of health, social and economic impacts. To ensure these impacts are minimised it is preferable that falls prevention initiatives build on previous work, incorporating knowledge of the strengths and weaknesses of previous programs thereby minimising duplication of effort. With the rapid development of new falls prevention initiatives this has not always occurred in an integrated manner. Strategies need to be introduced to reverse this pattern. The Injury Prevention Section of the DHAC has funded two projects to inform future directions in falls prevention nationally in Australia, as part of the *National Falls Prevention for Older People Initiative*. The first of these, titled “*An analysis of research on prevention of falls and falls injury in older people*” is an extensive review of the available research evidence of what works in falls prevention in the community, hospital, and residential aged care settings (NARI, 2000). The “*National stocktake of major organisations that conduct falls prevention activities for older people*”(referred to hereafter as the National Falls Stocktake project) is the second of these projects. This project is the focus of this report.

Information derived from both of these projects will provide a basis for future planning, communication, and effective development, implementation and evaluation of falls prevention activity within Australia, in conjunction with the established infrastructure and many and varied programs currently in place. A number of key issues need to be explored to provide a sound basis for future coordinated planning of falls prevention programs. These include an understanding of how programs were developed, how they operate, who

runs them, how they are funded and issues such as sustainability, co-ordination, monitoring of outcomes and surveillance. This project - conducted by the National Ageing Research Institute (NARI) in association with the Centre for Applied Gerontology – has investigated the range and scope of falls prevention programs in community, hospital and residential aged care settings across Australia.

Falls and falls injury prevention is an area that has seen increased interest and growth in funding from government and health service providers in recent years. Falls prevention activities cross traditional program and funding boundaries, and to maximise the usefulness of the resource inputs some co-ordination and networking among the various stakeholders is likely to be beneficial. This stocktake of major organisations and agencies involved in falls prevention is an important step in facilitating co-ordination and collaboration across sectors and programs. The project team has endeavoured to be as inclusive as possible with the programs surveyed, however, the information obtained is not exhaustive. Rather it provides a detailed representative sample of falls prevention programs and the structures that support them.

1.1 Project aims

The stated aims for this project were to:

- provide an inventory of the major organisations, across Australia, who manage activities in falls prevention among older people;
- identify and describe significant falls prevention activities undertaken by these organisations in community, residential aged care and acute care settings; and
- identify – where possible – the key elements of interventions that support outcomes in falls prevention strategies.

2.0 *Project scope and method*

This project had two main components.

- 1 A *paper-based survey* of organisations in Australia undertaking organised activities in falls prevention among older people in community, acute and residential settings.
- 2 *Follow-up telephone interviews and consultations* with key stakeholders and interest groups; as well as follow-up telephone interviews with representatives from programs identified as meeting key criteria.

2.1 Survey component

This project has involved taking a snapshot of organised falls prevention activities occurring in Australia, rather than a detailed inventory, and analysis of *all* specific falls prevention programs. The aim was to provide a sense of the current frameworks, infrastructure, key stakeholders, activities and issues in the falls prevention area. The scope of the project was therefore to consider *major* organisations involved in falls prevention activities for older people.

Surveys

The main method of data gathering in this project was via paper based survey. Three surveys were developed – a scoping survey, a full survey, and an abbreviated survey.

Scoping survey

A brief one page scoping survey was sent to over 1000 organisations such as local government and peak agencies to identify programs to send the full survey to. Those organisations identified as being involved in falls prevention activities through the scoping survey were then sent a full survey to complete. Four hundred and eighty nine scoping surveys were returned. Approximately 39 per cent of these responded that they had no current falls prevention activity, and that they did not have knowledge of any organisations that did conduct falls prevention activities. The remaining 61 per cent were either involved in a falls prevention program, or knew of another organisation that was. Many of the programs identified by the scoping surveys had already been included on the mailing list and had received surveys, but where this was not the case, full surveys were subsequently sent.

Full survey

This survey included the following broad areas.

- Description of the programs and intervention activities occurring currently and within the past 12 months.
- Issues associated with program development.
- Settings, delivery methods, sustainability and evaluation.

- Target groups.
- Workforce issues.
- Outcome, effectiveness and efficiency measures where applicable.

The full survey was sent to agencies known to be involved in falls prevention activities, and to those subsequently identified from the scoping survey. In total, 336 full surveys were sent to a range of organisations in acute, community and residential care settings.

Abbreviated survey

A proportion of identified agencies had already participated in a previous study of community falls programs (NARI, 1999) or the Queensland Falls Program Audit (1999). An abbreviated version of the Department of Human Services (Victoria) (Hill et al, 1999) survey seeking only information not covered in the previous surveys was forwarded to these organisations. The project team had access to data from both of the original NARI/DHS and Queensland Falls Program Audit surveys, and was able to compile a complete data set for those responding with an abbreviated survey. Any programs which had responded to an earlier survey, but which had changed substantially since completing the earlier survey, were asked to complete a full survey.

The surveys were compiled using Teleform® scanning software. This program relies on a largely “tick the box” approach – with some capacity for scanning of longer responses. Any open-ended or descriptive information was entered and analysed separately. All data was entered through scanning, and verified for accuracy, prior to being exported to a Microsoft Access database, and to the SPSS statistical analysis software.

Programs and activities have been classified into categories or types so that it has been possible to identify the pattern and trends in falls prevention activity across Australia. Primary classification is according to setting as follows:

- the *community setting*, where programs target falls reduction for older people living in houses, units or apartments in the community;
- the *hospital setting*, where programs target falls reduction for older people in any hospital;
- the *residential aged care setting*, where programs target falls reduction for older people living in residential aged care settings; and
- *mixed settings*, where programs target falls reduction for older people living in two or more of the settings listed above.

2.2 Follow-up interviews and consultation component

The consultation component of the project has involved identifying three major groups of informants.

Teleform® – Cardiff Software Inc, 1782 LaCosta Meadows Drive, San Marcus, CA 92069, USA

Group 1

This group was comprised of the key injury prevention managers in each state and territory, key research bodies and data collection agencies. Consultations with this group provided an overview of the infrastructure and systems in place to support falls prevention activity, with gaps identified.

Government

- Commonwealth Department of Health and Aged Care (DHAC), Population Health Division, Injury Prevention Section.
- State and territory injury prevention managers.
- Contact people for state based Falls Prevention Networks.

Research bodies

- Joanna Briggs Institute of Evidence Based Nursing.
- Prince of Wales Medical Research Institute.
- National Ageing Research Institute.
- Monash University Accident Research Centre (MUARC).
- Institute of International Health Research and Development.

Data collection agencies

- National Injury Surveillance Unit (NISU).
- Australian Incident Monitoring System (AIMS).

Group 2

This group comprised selected best practice programs across community, hospital and residential care settings, in order to facilitate identification of issues surrounding the development, sustainability and potential for intersectoral co-ordination of falls prevention activities.

Key informants conducting programs in community, residential, hospital and multiple settings were selected using the following criteria:

- the number of interventions conducted (program involved multiple interventions, as opposed to a single intervention type);
- program sustainability, ie. processes have been established (or were planned to be established) to facilitate ongoing program operation;
- program evaluation (the program had been evaluated or was planned to be); and
- achievement of objectives; either fully met or partly met.

These criteria were adapted from the project *Falls in Australia: An analysis of recent trends and intervention development* (NARI, 1999).

Of the 122 completed surveys, the number of programs meeting all four of these criteria were:

- Community: 23 (n=69); 33%
- Hospital: 7 (n=14); 50%
- Residential: 7 (n=13); 54%
- Multi-settings: 8 (n=26); 31%

A sample of 10 programs was drawn from this group by reviewing the completed surveys for each of the identified programs to select examples of different types of interventions. Evidence based evaluation guidelines for falls prevention programs, developed by NARI for the project, *Falls in Australia: An analysis of recent trends and intervention development* (NARI, 1999), were modified and used as a basis for interviews and for writing up the selected programs. Much of the required information was available through the survey. Interviews with key informants were used to fill any information gaps. This information was summarised under the following headings for each of the selected programs:

- program design and development;
- program content, including the number and type of programs and risk factors addressed;
- program sustainability; and
- program evaluation methods.

Interviews were also used to fill information gaps in relation to:

- the translation of the program(s) for use in other settings and with different target groups; and
- identification of current activities to address workforce issues relevant to falls prevention activity in community, acute/hospital, and residential aged care settings.

Group 3

Of the 122 completed surveys, 15 programs reported they were not continuing. A small sample of organisations from this group (n=2) was followed up, using the same guidelines as a basis for interviews and writing up. Perceived barriers to sustainability were identified. A further aim was to identify any of these programs that had produced useful falls prevention resources that could potentially be used in other future falls prevention programs.

Advantage of the methodology

The major advantage of the described methodology is that it provides an overview of the range of falls prevention activities (largely from the survey data), together with more detailed analysis of the issues surrounding the development, gaps and overlaps, sustainability and potential for intersectoral co-ordination of falls prevention activities.

When linked with the recently completed analysis of research on preventing falls and falls injuries in older people (DHAC, 2000), this approach enables identification of current 'best practice' activities. It also enables identification of structural, organisational and system issues that need to be addressed to facilitate optimal use of falls prevention resources in the future.

3.0 Infrastructure and systems to support falls prevention activity

3.1 Background

As part of this project NARI conducted interviews with injury prevention managers at Commonwealth and state/territory levels, and senior staff at key research bodies and data collection agencies. These consultations provided an overview of the infrastructure and systems in place to support falls prevention activity.

The purpose of these consultations was to ensure a comprehensive exploration of the perspectives of key stakeholders on issues related to the development of systematic processes for ongoing exchange between data collection agencies, researchers, policy makers and program implementers. There was general consensus that formal mechanisms are required to facilitate this exchange to ensure dissemination of latest research results and to find out what further research is required. The information in this section of the report has been provided and endorsed by the contact person identified.

3.2 Summary of current arrangements – Commonwealth and state/territory governments

In most states/territories and in the Commonwealth, program planning and funding responsibility for falls prevention initiatives is located in the area of injury prevention and control. In Victoria however, the DHS's Aged, Community and Mental Health Division has a lead role in preventing falls among older people.

Interviews with key people in Commonwealth and state/territory departments responsible for falls prevention highlighted a diverse range of activity and infrastructure or system support for falls prevention. A number of states have developed injury or falls specific action plans spanning up to five years. In several states, networks of practitioners, researchers and policy makers have been developed, providing regular interaction between these key players in falls prevention. Reference groups have also been reported, often with broad representation, including older people or representatives of older adult organisations. Communication between key stakeholders appears to be critical to the development of a coordinated strategic program of falls and falls injury prevention activity which minimises duplication and optimises likelihood of effective, sustainable interventions.

In South Australia (SA) falls networks linking health professionals from acute care, residential care, rehabilitation and the community have been established on a statewide basis as well in some regions, to share information on creative approaches to falls prevention.

In New South Wales (NSW) a formal network has been operating for the last six years. In Victoria the inaugural meeting of the falls network was held in October 1999. In Western

Australia (WA) ongoing stakeholder consultation is central in the coordination and implementation of the *Stay on Your Feet WA* (SOYFWA) program.

While statewide falls networks may not be established in every state/territory, information generated by the stocktake project indicate local and regional activity in most states/territories.

The development of coordinated responses to falls prevention is at varying stages in different states/territories. Some states/territories have completed or are in the process of auditing falls prevention activity as a precursor to the development of statewide action plans. In 1998 the Public Health and Development Division of the Victorian DHS commissioned an evaluation of community based falls prevention programs. Queensland Health commissioned a falls audit in 1999. The DHS in SA has contracted the Council on the Ageing to undertake a mapping exercise to identify falls prevention activity in community settings.

Some states, such as Victoria and WA, are in the process of implementing centrally coordinated, comprehensive programs for preventing falls among older people, with clearly stated aims, defined outcomes and with evaluation processes put in place.

The Victorian DHS, *Foothold on Safety* (FOS) program focuses on a range of settings and groups including older people living in their own homes, aged care residential facilities, extended care centres and public places. There are plans for falls prevention projects to be extended into the acute health sector in the future.

The Injury Control Program in the Health Department of Western Australia (HDWA) is responsible for statewide coordination of the SOYFWA program, a five year falls prevention program for seniors, which commenced in 1998. This initiative aims to reduce the expected rate of falls related injuries by 10 per cent in community dwelling seniors residing in WA by the year 2003.

In NSW, implementation of any central office initiatives requires the agreement and commitment of Area Health Services (AHSs). A central office initiative being implemented through AHSs is the *Falls 2000* program, which involves a three year commitment by metropolitan AHSs to increase access to gentle exercise programs and to promote these programs through communication strategies. Falls prevention action plans have been developed at the regional level by some AHSs such as the Central Sydney AHS which coordinates implementation of *Preventing Falls Among Older People Strategic Plan, 1998-2001*. The plan focuses on actions that address falls prevention amongst community dwelling older people. Strategic planning by other AHSs, such as Western Sydney focuses on falls prevention in a range of settings.

NSW Health is interested in reproducing the *Stay on Your Feet* (SOYF) program managed through the Northern Rivers Institute for Population Health and Research based in Lismore, NSW (formerly the Health Promotion Unit of North Coast Public Health). This project provides a successful model for implementing a population based program in an identifiable community through increasing awareness of falls prevention strategies among participating organizations and older people.

In terms of some forward planning identified by states through the consultations, Queensland Health plans to address falls prevention in hospital and residential settings through the Quality and Safety in Healthcare component of the Commonwealth/State Health Care Agreements. Queensland Health is in the process of approving \$2.5 million over three years of the State's Quality funds to falls prevention in hospital and residential aged care settings. Falls prevention projects targeted to community dwelling older people are addressed through other funding initiatives.

A more comprehensive description of the infrastructure and systems in place in each state/territory, and at the Commonwealth level are described below.

3.3 Commonwealth and state/territory governments

3.3.1 Injury Prevention Section, Commonwealth Department of Health and Aged Care

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Injury prevention is one of the six priority health areas for action identified by the Commonwealth Government.

The Injury Prevention Section in DHAC manages the *National Falls Prevention for Older People Initiative*. This \$6.6 million *Initiative* constitutes an integral part of the Enhanced Primary Care (EPC) package which aims to improve health outcomes and quality of life of older Australians. The EPC package was announced in the 1999/2000 Federal Budget.

Funding for the *National Falls Prevention for Older People Initiative* is currently allocated for a four year time frame finishing in June 2003. A significant proportion of the funding will be allocated to capacity building measures aimed to sustain falls prevention activities beyond the lifetime of the *Initiative*.

The *National Falls Prevention for Older People Initiative* focuses on older people living in the community and residential aged care facilities as well as those attended to in acute care. The goal of the *Initiative* is to reduce the incidence of falls as well as the morbidity and mortality associated with these events in Australians aged 65 years and over.

The objectives of the *Initiative* are to:

- identify best practice in falls prevention;
- extend the evidence base through research;
- encourage and facilitate evidence-based best practice in falls prevention in the community, residential aged care facilities and acute care settings;
- increase awareness of falls and interventions among stakeholders;
- enhance access to falls prevention information, strategies and activities for stakeholders;
- build falls prevention capacity through workforce development;
- build partnerships among stakeholders interested in falls prevention in older people; and
- incorporate falls prevention messages into a broad range of health policy responses.

The *Initiative* will comprise two major focus areas: community and residential/acute care.

The activities of the Initiative fall into two major phases and six task groups.

- Phase 1: Planning and development (1999/2000)
- Phase 2: Implementation (2000/2001 – 2002/2003)
 - community demonstration projects;
 - residential aged care & acute care: development of best practice;
 - workforce: development of falls prevention competencies among aged care workers and health professionals;
 - research: closing the gaps in knowledge & improvement of falls surveillance;
 - evaluation & monitoring: progress and performance measurement; and
 - information and liaison: development and implementation of a strategy to support the activities of this Initiative.

The development of a monitoring and evaluation framework to enable ongoing and final assessment of activities is a central component of the *National Falls Prevention for Older People Initiative*. The framework will be in place before core activities of the *Initiative* commence.

Activities of the *Initiative* are being planned using the latest evidence. A project was commissioned from the NARI to identify current best practice from research data as well as gaps in research knowledge. The outcomes of this project are informing progress of the *Initiative*.

Stakeholder consultations started before commencement of the *Initiative* and will remain a significant component. A National Forum held on 1 and 2 June 2000 facilitated networking and the national stocktake of current falls prevention programs will be used to foster communication among falls prevention practitioners. Links have been developed with the Department of Veterans' Affairs, the other key Commonwealth agency involved in falls prevention for older people. State and territory government links exist through the National Public Health Partnership and with injury prevention managers in health departments.

Where responsibility for falls prevention programs rests with other portfolios, contact has been made with relevant officers.

While there are many excellent programs in existence across the country, there is some duplication of effort. There is also disparity in addressing the needs of particular population groups (for instance those of people from culturally and linguistically diverse backgrounds and of people from rural and remote regions).

Australia is well situated to address the problem of falls in older people. A national sharing of expertise, the development of information and resources to support the falls prevention workforce and the application of current evidence-based best practice in the context of this *Initiative* will aim to close existing gaps. In addition, the *Initiative* will address research needs to strengthen the evidence base. Clear communication of research outcomes and resultant best practice combined with ongoing consultation and networking with stakeholders should ensure the best use of resources on a national basis.

3.3.2 Injury Prevention Unit, NSW Health

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The Injury Prevention Unit, NSW Health is responsible for statewide policy development and strategic planning in the area of falls prevention. Regional planning, coordination and program implementation is the domain of the AHSs.

Some AHSs have developed strategic falls prevention action plans for which the Health Promotion Units (HPUs) are responsible. For example, the Central Sydney AHS, HPU (CSAHS, HPU) is responsible for co-ordinating the implementation of *Preventing Falls Among Older People Strategic Plan, 1998-2001*. This plan was developed by the HPU in consultation with key stakeholders, especially General, Geriatric and Rehabilitation Medicine (GGRM), CSAHS, to provide direction for activities for preventing falls among older people over the period 1998-2001. More details of the CSAHSs strategic plan have been provided as one of the case study programs in this report.

As well as the CSAHS, other AHSs with detailed strategic actions for reducing falls amongst older people include the Western Sydney and South Western Sydney AHSs. Another respondent to the survey, the Macquarie AHS aims to improve patient falls prevention and management practices through the implementation of falls risk assessment of patients on admission to hospital and the development of individualised management plans.

AHSs are independent of central office and implementation of any central office initiatives requires their agreement and commitment to report on specific indicators. An example of a statewide initiative being implemented through AHSs is the *Falls 2000* program, which involves a three year commitment by metropolitan AHSs to increase access to gentle exercise programs and to promote these programs through communication strategies.

As well as the development of statewide policy and procurement of resources to implement programs, central office responsibilities also include the:

- development and dissemination of statewide program standards and guidelines including best practice manuals to AHSs; and
- trialing of innovative or investigatory projects to develop a stronger base of evidence of effective interventions to inform policy and program directions.

In this regard, NSW Health is interested in reproducing the SOYF program managed through the Northern Rivers Institute for Population Health and Research based in Lismore, NSW (formerly the Health Promotion Unit of North Coast Public Health). This project provides a successful model for implementing a population based program in an identifiable community in awareness of falls prevention strategies among participating organizations and older people. If adapted in other parts of rural NSW, evaluation strategies would be established at the commencement of the program to assess the most effective ways of systematically addressing falls prevention on a large population basis.

Involvement of key stakeholders in policy development and planning for falls prevention occurs through the informal links established between NSW Health and key research bodies, as well as through the establishment of the NSW Falls Network linking researchers and policy makers with providers of falls prevention programs. The Network, established six years ago, relies on the continuing efforts of interested professionals to coordinate activities, in particular the HPUs of AHSs, who rotate responsibility for organising and conducting the network meetings. Although it operates as a statewide network, it tends to be more metropolitan based in its membership. For those responsible for statewide policy development the Network provides a means of reaching key stakeholders and receiving advice on future policy directions and planning for falls prevention.

3.3.3 Health Outcomes Unit, Queensland Health

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The Health Outcomes Unit, Queensland Health is responsible for strategic planning in the area of injury prevention and control (including falls prevention). Purchasing of falls prevention programs for older people will be guided by the following documents.

- The *Health Outcomes Plan for Injury Prevention and Control 2000-2004*. This plan identifies falls in older people as a priority area. The plan is used to guide funding allocations for injury prevention initiatives across the spectrum. An expert advisory group worked with Queensland Health to provide advice and assistance in the development of the *Health Outcomes Plan*.
- The draft *Statewide Action Plan for the Prevention of Falls Among Older People 2000-2004* addresses falls prevention in the three settings; community, hospital and residential aged care facilities. In 1999 a falls audit was commissioned by Public Health Services as scoping work preceding the development of the *Statewide Action Plan*. The draft Plan has been developed with the advice of a reference group, which has included representatives from across the continuum of care (ie Public Health Services, Acute Care, Aged Care), policy development and epidemiology services.

The *Statewide Action Plan* is based on a multi-strategic approach to reduce the incidence of falling. However resources will be required to fund initiatives recommended through the state Plan. One of the gaps identified by the Health Outcomes Unit is the need for falls management services to which GPs and other health professionals assessing older people for falls risk can refer.

The Department's district health services, of which there are 38, are responsible for service provision and reporting on outcomes as agreed to in service agreements. Outcomes for injury prevention initiatives would be considered in accordance with the above mentioned *Health Outcomes Plan for Injury Prevention and Control 2000-2004*.

Specific funding initiatives for falls prevention will occur through the following mechanisms.

- *The Commonwealth/State Health Care Agreements - Quality and Safety in Healthcare component.* Queensland Health is in the process of approving \$2.5 million over three years of the state's Quality funds to falls prevention in hospital and residential care settings. A Board for the Falls Prevention Program Area, chaired by the Principal Policy Adviser for the Health Outcomes Unit, is overseeing the development of a detailed business case, and will oversee the project when approved. The Board includes the state manager for the DHAC.
- *Health Promotion Queensland, a cross-agency Council administered by Queensland Health.* \$100,000 will be allocated in the next financial year (2000/01) to falls prevention projects targeted to community dwelling older people in provincial and rural communities. Some examples of the types of programs funded include the *Walk Tall Don't Fall* program, provided through the Tropical Health Unit at Mackay and the *Stepping Out* program, previously run through the Tropical Health Unit at Townsville, now conducted through the Townsville Division of General Practice. These programs are multi-faceted health promotion programs incorporating community education with exercise programs and public and home hazard and safety programs.

3.3.4 Department of Human Services, South Australia

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The jurisdiction for planning and policy development in the area of falls prevention rests with the statewide Division of the DHS. The overall aim of this Division, as described in the Department's website, is *to improve the health and wellbeing of the people of SA, within the resources available, through improved planning, contracting and coordination of services provided by metropolitan hospitals, domiciliary care and mental health services, and by increasing the state's capacity to prevent and control disease, illness and injury and promote better health through public and environmental health services.*

Health Promotion SA, a unit within the statewide Division, has identified falls prevention for older people as a priority in its report, *Promoting the Health and Well-being of Older People, Summary of Health Promotion Strategies, 2000-2005*. The Department has contracted the Council on the Ageing to undertake a mapping exercise to identify falls prevention activity in the community setting, and to undertake a literature review of effective falls prevention interventions. This scoping work will inform recommendations to the Department on how falls prevention services/programs can be developed to be as comprehensive and effective as possible.

Falls prevention programs for older people have been developed by health care organizations in response to national and state data identifying falls as a major cause of injury among older people. Some examples include the *Be Safe and Independent at Home* program, a community based injury prevention program developed in 1993 by occupational therapists at Noarlunga Health Services. This program consists of a free home visiting service for people aged 55 years and older living independently in the community; access to subsidised equipment such as grab rails, for people at risk of falling at home; community education about falls prevention; and a balance retraining program, *One Step at a Time* developed and offered by the Health Service's physiotherapists and occupational therapists.

Another initiative, the falls prevention clinic based at the Western Domiciliary Care and Rehabilitation Service, North Western Adelaide Health Service is described in some depth in section 5 of this report, *Falls Prevention Activity in Community Settings*. These initiatives stem from the efforts of interested professionals working in service delivery settings and their ability to attract agency core funding or funding from alternative sources.

As a way to share information on creative approaches to falls prevention, a falls network, based in SA, has been recently established through the Joanna Briggs Institute for Evidence Based Nursing and Midwifery (see section 3.4). The network links health professionals from acute care, residential care, rehabilitation and the community.

Injury Prevention SA has also initiated a falls network, to facilitate exchange of information between agencies. Injury Prevention SA, a not for profit, private organisation, is funded by the DHS, to provide the *Make it Safe* program, a home hazard assessment program available to people over the age of 50, which has a focus on falls prevention. This network includes health professionals, consumer representatives, non-government agencies, such as Council on the Ageing, government agencies such as Department of Veterans' Affairs, Divisions of General Practice and professional interest groups. As well as some metropolitan regions, the network includes representatives from two country regions.

Regional falls networks also exist in some areas, such as the Southern Falls Network. This network includes the Flinders Medical Centre, which is conducting a falls prevention program funded by the Commonwealth through the National Demonstrations Hospitals Program. A case study of this program is included in section 6 of this report, *Falls Prevention Activity in Acute/Hospital Settings*.

3.3.5 Public and Environmental Health Branch, Department of Health and Family Services, Tasmania

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The DHS's, Public and Environmental Health Branch has jurisdiction for falls prevention. A policy officer is engaged full time to work on injury prevention including falls prevention.

The Department's priority is to undertake a strategic planning exercise to establish need and priorities in public health which will in turn influence funding priorities. Currently there is no specific funding allocation for falls prevention initiatives. The Department is interested in evidence of effective interventions and is looking to projects such as the National Falls Stocktake for examples of types of interventions, tools and resources that can be adapted from existing programs.

Falls prevention initiatives that have been established, such as the Falls Prevention Clinic within the Division of Community and Rural Health's Aged Care Unit, stem from the efforts of interested professionals working in service delivery settings and their ability to attract funding from alternative sources.

A loose coalition of workers, known as the Tasmania Injury Coalition, networks and exchanges information. The Coalition is an incorporated body made up of health professionals, GPs, representatives of government and non-government agencies with responsibilities in the area of injury prevention. The Coalition receives no external funding and supports its operations through membership fees and voluntary contributions.

3.3.6 Aged Care Branch, Aged and Community Health Division, Department of Human Services, Victoria

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The DHS recognises injury as a major public health problem and falls prevention among older people has been identified as one of the areas of injury prevention which requires attention. The Department's Aged, Community and Mental Health Division (ACMH) has taken a lead role in preventing falls among older people.

The Division has developed a comprehensive program for preventing falls among older people. The program focuses on a range of settings and groups including older people living in their own homes, aged care residential facilities, extended care centres and public places. There are plans for falls prevention projects to be extended into the acute health sector in the future. The program started with a focus on community based projects, but has since expanded to include projects in all settings. Projects will continue to be rolled out over the next 2-3 financial years.

Falls Prevention Programs

- *Foothold on Safety*

Ten community based falls prevention projects which focus on older people living in their own homes have been funded for four years. Projects commenced in 1998. The *Foothold on Safety* (FOS) grants program supports strategies that are based on the best available evidence and use multiple strategies including awareness raising and educational information sessions for older people and health professionals; home modifications; promotion of physical activity; improved referral systems for older people identified as having a high risk of falling; and hazard identification and modification in public spaces. Five new projects will be funded in 2000-2001.

- *Preventing falls in Aged Care Residential Facilities*
Pilot projects have been implemented in a total of 28 aged care residential facilities, including nursing homes and hostels, across Victoria in 1998-99 and 1999-2000.
- *Extended Care Centres*
DHS has recently awarded funding for four short term projects to prevent falls among older people in the sub-acute inpatient services of Extended Care Centres. The centres awarded funding each operate a Falls and Mobility Clinic. Projects will receive funding of up to \$50,000 in 1999/2000. Further funding may be made available for subsequent falls prevention projects in Extended Care Centres in coming years.

Evaluation

Each component of the Department's falls prevention program is to be evaluated. Monash University Accident Research Centre (MUARC) has been contracted to evaluate the first 10 FOS falls prevention projects in community and residential settings and the nine falls prevention projects in aged care residential facilities funded in 1998-99.

The evaluation of the FOS community falls prevention program is a qualitative and quantitative evaluation of the FOS projects. A variety of methods are being used including surveys, key informant interviews and focus groups of older people.

The main objectives of the evaluations are to provide a critical appraisal of the process and impact of the projects in terms of:

- the access and reach of projects' strategies and activities among the target groups and organizations involved, the extent to which the projects achieved their goals and objectives, any challenges and barriers to implementation identified by participating organizations and how they were dealt with; and
- evidence of any changes in the identified communities in awareness of falls prevention strategies among participating organizations and the target group, community infrastructures and services; linkages between structures, organizations, groups and individuals (eg, joint initiatives, referrals, access to services related to falls prevention); and the rate of falls and fall injuries over the intervention period.

Evaluation of the projects will be completed by September 2000.

Because of the short intervention period (less than twelve months) evaluation of the falls prevention in residential settings program will focus on implementation issues, in particular a critical appraisal to identify key elements of projects, for example, increases in falls prevention awareness, knowledge and behaviours in management, that generate desired changes.

Reference Group on Preventing Falls Among Older People

In developing the falls prevention program the Department has used the advice of a key informant group, the Older Persons Falls Prevention Reference Group, chaired by the Victorian Council on the Ageing and comprised of key research bodies in the area of falls prevention, an extended care centre representative, rural representative, and Departmental representation from the Aged Community and Mental Health Division (ACMH) and the Public Health and Development Division. This mechanism, resourced by ACMH, formally involves a range of stakeholders in policy development and planning for falls prevention.

The Reference Group was also responsible for planning the Falls Prevention Forum held in Community Safety Week in 1998, and the recent state conference on falls prevention (*Stepping up falls prevention*) held in June 2000. The Reference Group has also supported the establishment of the Victorian Falls Network linking providers of falls prevention programs with researchers and policy makers. The inaugural meeting of the Network was held in Geelong on the 8th October 1999. The ongoing development of the Network will rely on the continuing efforts of interested professionals to coordinate activities. The conference in June will serve to further strengthen the already established links.

3.3.7 Injury Control Program, Health Department of Western Australia

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The Injury Control Program in the HDWA is responsible for statewide co-ordination of the *Stay On Your Feet WA* (SOYFWA) program.

SOYFWA is a collaborative falls prevention program for seniors 70 years and over living independently in WA. It is a five year program which aims to reduce the expected rate of fall related injuries in this group of seniors by 10 per cent by the year 2003.

The program was first implemented by the North Coast Public Health Unit in NSW and due to its success was brought to WA and implemented by the South West & Coastal & Wheatbelt Public Health Units. Subsequent success in regional WA led to the program being implemented statewide by the Injury Control Program, HDWA.

The philosophy of SOYFWA is one of collaboration, co-ordination and community involvement, particularly the involvement of seniors themselves. Partnerships have been established with over fifty government and non-government organisations willing to participate in the development and implementation of the program. The concepts of positive ageing and the empowerment of seniors in falls prevention underpins all SOYFWA strategies.

The program, which was launched in 1998, is being implemented in five consecutive phases over a five year period. Each phase that is implemented addresses a key risk factor for falls and reinforces strategies from previous phases. Each phase primarily targets seniors 70 years and over. However, health professionals and others involved with seniors form a secondary target group with a number of strategies in each phase directed at promoting involvement of this secondary target group in assisting seniors to address the different risk factors for falls.

Objectives and the time line for the program are as follows.

Phase 1 ***Awareness Raising Phase***

1998-2003 This phase aims to increase knowledge that falls are preventable and to increase knowledge of the modifiable risk factors for falls.

Phase 2 ***Medications Phase***

This phase aims to increase awareness that some medications, including some over the counter medicines, may increase the risk of falling.

Phase 3 ***Physical Activity, Balance & Gait Phase***

1999-2003 This phase aims to raise awareness of the need to increase physical activity as a means of reducing the risk of falling due to poor balance or irregular walking patterns.

Phase 4&5 will address ***Safe Environments*** and ***Chronic Health Conditions*** and will be launched in 2001 and 2002 respectively. Objectives for these phases will be refined when formative research is completed.

The Injury Control Program, HDWA co-ordinates the management of the program through a Steering Committee and five expert working parties. Each of these expert working parties has been convened to provide specific expertise and advice relevant to the different program phases.

Funding for the SOYFWA program is provided by the Injury Control Program with additional funding being made available through a RHESET grant to train peer educators. A number of Regional Public Health Units also allocate funding to promoting the program. There has also been support from some of the partnership agencies that have included falls prevention in their core business.

Evaluation of the program will be through:

- a baseline risk factor questionnaire to assess baseline attitudes, awareness and number of self reported falls among seniors 70 years and over. Baseline data for 600 respondents was collected prior to the start of the program;
- monitoring of the number of hospital admissions due to falls from the Hospital Morbidity Database which provides information on the type of injury and the length of hospital stay to assess trends in injury rates; and
- phase evaluation will also be conducted which will involve baseline and post intervention testing of key health professionals to determine changes in knowledge and behaviour in relation to falls prevention.

Other falls prevention initiatives in WA include a Hip Protector Study which is being conducted by the Injury Control Council of WA in conjunction with the Injury Control Program, HDWA and the School of Public Health at the University of WA (UWA). Funding has been provided through the DHAC.

This project aims to:

- examine the epidemiology of falls in nursing home residents;
- examine the role of hip protectors in preventing hip fractures in these residents, particularly the levels of compliance in the wearing of hip protectors; and
- establish a surveillance system in the participating nursing homes in order to measure compliance of the nursing staff.

The Injury Control Council also co-ordinates a Falls Prevention Network which provides professional development opportunities for stakeholders in the area of falls prevention.

3.3.8 Australian Capital Territory

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The Department of Health and Community Care has jurisdiction for falls prevention. A draft plan for falls prevention in older persons has been developed for implementation in April 1999. The plan was developed in consultation with the advice from a working group, which included representatives across the continuum of care.

The Plan outlines a continuum approach, with part of that being a Falls Clinic. This plan aims to address three key areas for action.

- (1) Targeted public awareness raising and information aimed at minimising and avoiding risk.
- (2) Improved co-ordination between primary, secondary and tertiary levels of care through clinical pathways and consistent/opportunistic risk assessment protocols.
- (3) Improved capacity for and access to risk assessment, referral and treatment.

The proposal for a tertiary falls clinic within the Canberra Hospital has been put forward by the Aged Care Unit at the hospital. The clinic would assess and establish a program for people presenting with falls related problems in accident and emergency to enhance the identification and treatment of older people at risk of falling.

This proposal is the extension of an existing clinical pathway at the Canberra hospital for those considered at risk of falling. Presently an evaluation of the success of this pathway is being conducted.

There are a number of current activities in falls prevention. The majority of these programs are health promotion including exercise programs, safety and home security programs. For example:

- YMCA program – *Stay on Your Feet* is a falls prevention program for people over 70;
- Council on the Ageing safety and security reviews of older persons home environments;
- *Young at Heart* – a directory of physical activities for older adults; and
- Handy Help Inc – provides a home modification service.

These activities receive financial support from the Home and Community Care Program, Australian Capital Territory (ACT) Bureau of Sport and Recreation, Healthpact and ACT Community Care Health Promotion.

Currently there is no specific funding allocation for falls prevention initiatives e.g. Falls Clinic. The Department is very interested in the policy and planning development of the Commonwealth's *Falls Prevention for Older People Initiative* and the *National Falls Stocktake* particularly in evidence based approaches to falls prevention and intervention and resource allocation.

3.3.9 Northern Territory

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Territory Health Services plays a lead role in the development of falls prevention strategies for older people. These initiatives largely stem from the efforts of interested individuals employed by Territory Health Services and working in service delivery settings and their ability to attract funding for programs. There is no clear program responsibility within the Department for falls prevention for older people. Little research or statistics are available to identify the nature and extent of this public health issue in the Northern Territory (NT),

either in the urban or rural remote areas or within the indigenous population. However dramatic increases in the aged population over the next decade in the NT are expected and those working in aged care are identifying an increasing number of people at risk of falls.

Falls program activity has tended to develop separately in the major centres, Darwin, Katherine and Alice Springs, with little interaction between the key stakeholders. Stakeholders recognise however that communication between them is critical and are in the process of establishing a network to coordinate planning and share resources.

Current activity in each of the three major centres is summarised as follows.

In Darwin, a group of interested therapists from both the acute and community settings have collaborated to devise a basic testing regime designed to identify people at risk of falls who can then be referred to appropriate providers, including the ACAT. The types of interventions that may be initiated through the ACAT team include environmental modifications; independent living aids and devices; medication reviews; personal alarm systems, and vision assessments. A Therapy Day Centre, established by the Salvation Army provides therapy falls groups which address balance and exercise.

Territory Health Services therapists in Darwin are also involved in falls promotion in-service sessions for home and community care workers, carers and other stakeholders.

In Katherine, physiotherapists employed by Territory Health Services are in the process of developing a falls prevention education program to be conducted at regular intervals. The program will take a population based approach as well as targeting those who have fallen or are at risk of falls.

In Alice Springs occupational therapists, physiotherapists and community nurses employed by Territory Health Services are working in collaboration with the Division of GP on a falls prevention education package.

3.4 Research bodies

The research bodies consulted through this project were:

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There was general consensus among the researchers interviewed that formal mechanisms were required to facilitate interaction between clinicians, researchers, policy makers, administrators, industry, and other key stakeholders to ensure dissemination of latest research results and to find out what further research is required. One of the structures that was perceived as providing an effective means of disseminating research findings to the field was falls networks, which provide opportunities for formal and informal exchange between key stakeholders. In most, if not all states, the ongoing development of networks relies on the continuing efforts of interested professionals to coordinate activities, without dedicated resourcing. A key theme from the consultations was that resourcing of networks would be valuable, particularly in establishing systems and processes in the early stages of development for ensuring sustainability of the network process.

As well as the networks operating in some states, a National Falls Taskforce was initiated in 1998 through research from the Australian Patient Safety Foundation in collaboration with the Joanna Briggs Institute. The National Falls Taskforce was established to address the problem of falls in health care institutions and to identify/approach experts in this area. Based in South Australia, the Taskforce aims to become more representative of national interests. A web site for the Australian National Falls Network has been established through the Joanna Briggs Institute to facilitate information sharing and better communication. The web site address is www.joannabriggs.edu.au

As well as falls networks, some states have forged effective partnerships with research bodies through informal contact. In Victoria a key informant group, the Older Persons Falls Prevention Reference Group, has been established. As mentioned earlier in the report this mechanism, resourced by the Department, formally involves a range of stakeholders in policy development and planning for falls prevention.

Regular conferences, such as, the National Injury Prevention Conference held every two years, provide a systematic means through which researchers are able to share evidence and feedback with the states and the Commonwealth.

The key points raised in relation to other improvements that state and Commonwealth governments could initiate were:

- increase available resources to fund research specifically in the area of falls and falls injury prevention. Currently, research funding is highly competitive, and only a small proportion of projects have been successful in receiving funding in this area. Increased falls research funding should:
 - target individual gaps in the existing research. Examples suggested include formal evaluation of simple falls risk screening tools for GPs, falls away from the home, and falls prevention in hospital and residential aged care settings.
 - allow research groups to develop longitudinal programs of research which are planned, build on existing work, and allow interventions to be evaluated systematically.
- commence evaluations of Commonwealth and state funded programs at the time the programs begin, to ensure that the impact of planned interventions can be investigated effectively.
- facilitate the uptake of falls and falls injury prevention programs for older people, where the research indicates good evidence of effectiveness (for example, exercise programs).

3.5 Injury surveillance

3.5.1 The National Injury Surveillance Unit (NISU)

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Government agencies, university researchers, commercial organisations and non-government organizations access statistical and other information on injury occurrence and causes through NISU and Injury Surveillance Units based in some states. The NISU web site is the main source of this description of its role and functions:

NISU undertakes public health surveillance of injury at a national level to support injury prevention and control. The Unit engages in all aspects of surveillance, and places special emphasis on analysis and dissemination of information, and on developing injury surveillance methods.

The Unit is responsible for ensuring that information necessary for injury control is available to those who need to use it. This task involves collecting, processing, analysing and interpreting data, as well as disseminating findings, developing injury surveillance methods for use at local and national level, and linking injury information with preventive activities. In doing so, the Unit informs community discussion and supports policy-making on injury issues.

NISU assists public health injury control by providing a national contact point for liaison and information sharing, producing information resources, and encouraging research.

NISU is the main program of the Research Centre for Injury Studies, which is part of the School of Medicine at the Flinders University of South Australia. NISU and the Research Centre are located in Adelaide, adjacent to the Flinders University campus. The core programs are funded under an agreement between the Australian Institute of Health and Welfare (AIHW) and Flinders University. AIHW funds are supplemented by funding by the Commonwealth Department of Health & Aged Care.

A summary of the major parts of NISU's program can be found in its web site, along with electronic versions of many of its publications. Complementing its surveillance functions NISU has provided services to develop communication and liaison among people engaged in injury control. This has involved organization of conferences, specifically, the Third International Conference on Injury Prevention and Control, held in Melbourne in February

1996. An Australian Directory of Injury Personnel has also been compiled to serve as a tool for networking between those individuals and organisations working or interested in the field of injury control and the Unit publishes a newsletter, the Australian Injury Issues Monitor. The Internet address for NISU is www.nisu.flinders.edu.au.

The main data sets pertinent to the area of falls prevention are:

- routine national hospital discharge data; and
- national mortality data.

In addition to summary reports, NISU produces standard tables providing age and cause specific counts and rates covering injury mortality by state, and is in the process of developing similar tabulations on injury inpatient separations – cases that have had at least one episode of care in a recognised hospital.

Inquiries can also be made of a database containing records of 700,000 emergency department episodes with descriptive details of how the injury was caused and major factors and products involved. This is a closed collection and cannot provide meaningful estimates of incidence rates or trends.

Through its web site any individual can also search for information on injury deaths in Australia from 1979 to 1998.

In planning policy and funding initiatives, of interest to policy makers are trends in injury rates. Through the survey for the stocktake many agencies indicated that programs were developed in response to local data. In evaluating the effectiveness of programs or specific interventions, a conclusion that may be easy to leap to is that the change in some mass indicator, such as the number (or rate) of hospital admissions due to falls can be used to assess whether a particular type of intervention has worked or not. In cautioning against over reliance on changes in mass indicators, the Director of NISU explained that variations in rates could be due to various factors other than change in incidence, and change in incidence is not necessarily due to the intervention of interest. It is not generally feasible to answer causal questions (ie. did a particular intervention cause a reduction in falls injury incidence) simply on the basis of monitoring mass data such as hospitalisations. Such causal questions are generally best answered by analytic epidemiological studies.

Nevertheless, falls mortality and hospitalisation data remain key indicators of case burden and risk. Another function for monitoring can arise when interventions (preferably ones for which analytic studies have provided evidence of effectiveness) are decided upon, and implementation commences. Monitoring can be used to measure and track implementation of the intervention. For example, if the intervention is a certain type of exercise program directed to a particular segment of the population, then one might monitor the extent and distribution of uptake of the program in the target population (for example) as additional indicators of effectiveness.

3.5.2 The Australian Patient Safety Foundation (APSF)

Contact

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The Australian Patient Safety Foundation (APSF) is a non-profit, independent, incorporated organisation dedicated to the advancement of patient safety. The APSF is responsible for the *Australian Incident Monitoring System (AIMS)*. Introduced in 1996, AIMS provides a mechanism for any incident or accident (actual or potential) in the health care system to be reported using a single standard form. Incidents are classified on corresponding software using two unique classification systems.

Using AIMS gives an organisation the potential to:

- reduce adverse events and their high associated costs;
- enhance the quality of health care and service delivery;
- document the progress and steps taken for anything that has gone wrong;
- compare an organisation with like organisations;
- reduce insurance premiums and exposure to liability; and
- contribute to a national effort to enhance the safety of health care.

AIMS can be purchased by health units and is currently installed across a wide variety of sites eg. acute care (adult and children), aged care, mental health and community care. There are two aspects to the system.

Incident reporting at hospital sites. This information, through the use of APSF software, is coded at the health unit site and a comprehensive set of reports is produced to assist senior management in identifying problems.

- (1) ***Incident monitoring***. APSF collects all data to create a national database enabling health units to compare their performance. Data is de-identified and aggregated at the national level with the ultimate outcome of coordinating system-based strategies to better detect, manage and prevent incidents.
- (2) Information on the reports is protected by both Commonwealth and state legislation (with compliance with appropriate procedures specific for each set of legislation) and cannot therefore be used in a court of law. Complete confidentiality is guaranteed that any information received at APSF is kept secure and in the strictest confidence.

In providing this information to its users, APSF has become an agent in facilitating exchange of information between sites when users are seeking creative approaches to addressing systemic issues impacting on the frequency of adverse events.

APSFs vision is to eliminate preventable injury in health care by encouraging the documentation of potential, as well as harmful, incidents. System problems can often be detected from analysis of potential risks or near misses.

The philosophy for pricing AIMS is based on the activity levels of the health unit, ie. the expected number of incidents. The price structure has three components – a one-off licence fee and establishment fee, an annual maintenance fee and supplementary training of coding staff.

4.0 Survey overview – responses across all settings

In total, 146 full or abbreviated surveys were completed and returned. The number of returned surveys represents a 43 per cent response rate from those who were sent a full survey. While this response rate is relatively low, it is considered to be reasonably representative of the spread, range and nature of falls and falls injury prevention programs within Australia. A number of factors were considered to contribute to the relatively low response rate. These included:

- the short time frame for completion of the survey response;
- that several other survey approaches have been made to falls prevention programs in some states over the past 18 months; and
- that those involved in falls and falls injury prevention activity report having limited time capacity beyond the scope of their current projects in which to undertake additional activities (that is, resources appear to be stretched).

Of the 146 returned surveys, only 122 were included in the analyses for this report. The 24 surveys not included in the analyses of this report include:

- surveys received too late for inclusion in the analyses (n=8). Contact details for these programs have been included in the full listing of programs responding to the National Falls Stocktake survey; and
- surveys received from programs which have stopped running 12 months or more prior to the National Falls Stocktake survey, programs not yet running, or surveys received from programs which were not targeted to falls or falls injury prevention specifically (n=18). These programs were considered beyond the scope of the project, and have not been included in the database of programs.

The following information and analyses are based on data from the 122 surveys that were scanned and verified using the Teleform[®] software program.

4.1 Location by state

Falls and falls related injury prevention was identified as a key component of one of the national health priority areas – injury prevention and control – in the early 1990's. Subsequent activity at both a national and state level has seen the development of strategic plans and a diverse range of falls prevention programs to address this significant public health problem.

Falls and falls injury prevention programs in all states/territories responded to the survey. The greatest response rate was from WA, where 53 per cent of surveys sent were completed and returned. Although a larger number of surveys were received from Victoria and NSW both states had a lower response rate (41% and 35% respectively) (Figure 4.1).

4.2 Program setting

Falls and falls injury prevention programs occur in varied settings. For the purposes of this report, programs have been classified under four broad setting types.

1. **Community settings** where the group targeted by the falls prevention program are older people who live in their own homes. Approximately 30 per cent of people aged greater than 65 living in the community experience one or more falls in a 12 month period, with the rate rising with increasing age (Kendig et al, 1996; Dolinis et al, 1997). The greatest proportion of published research studies investigating effectiveness of falls prevention programs have been undertaken in the community setting (DHAC, 2000). The majority of the programs described in the completed surveys in the falls stocktake were from community based programs (57%) (Figure 4.1). Data for the community setting has been analysed separately and is reported in section 5.
2. **Hospital settings** where the group targeted by the falls prevention program are older people in any hospital setting. Older people hospitalised with specific clinical conditions such as stroke are reported to experience high falls rates (46%, Forster and Young, 1995). Under the category of hospital settings, there are a range of hospital types, such as acute hospitals, rehabilitation hospitals, geriatric or extended care centres, and psychiatric hospitals. Of the 122 programs reported, 14 (11%) were based in hospital settings. Data for the hospital setting has been analysed separately and is reported in section 6.
3. **Residential aged care settings** where the group targeted by the falls prevention program are older people who live in supported accommodation. Up to 50 per cent of older people living in residential aged care settings experience one or more falls in a 12 month period (Rubenstein et al, 1990; Lord et al, 1991). Furthermore, older people in residential aged care settings have a 10 fold increased risk of sustaining a hip fracture relative to community dwelling older people (Butler et al, 1996). The level and type of support in different types of residential aged care settings varies considerably, from low level care (hostel and special accommodation houses), through to high level care (nursing home care). There are a small number of published research studies demonstrating a reduction in falls rates in residential aged care settings (DHAC, 2000). These studies have incorporated a comprehensive review of the resident's falls risk factors, with targeting of multifactorial interventions (Rubenstein et al, 1990; Ray et al, 1997). Thirteen of the programs reported in the falls stocktake (11%) were based in residential aged care settings. Data for the residential aged care setting has been analysed separately, and is reported in section 7.
4. **Mixed settings** where the group targeted by the falls prevention program included two or more of the settings described above, or broad programs incorporating a range of interventions (for example, strategic plans developed by local or state government). Twenty six (21%) of the completed surveys were based in mixed settings. Issues related to mixed setting programs have been included in section 8 of this report.

Figure 4.1 Distribution of falls and falls injury prevention programs by state and setting

Org state	Community	Hospital Aged Care	Residential Setting	Mixed	Total	Total sent	% returned
ACT	4	1	0	2	7	17	41%
NSW	11	5	2	6	24	68	35%
NT	1	0	0	0	1	5	20%
Qld	7	0	1	4	12	52	23%
SA	6	3	0	2	11	38	29%
Tasmania/ King Island	2	1	0	0	3	11	27%
Vic	26	2	9	9	46	111	41%
WA	12	2	1	3	18	34	53%
Total	69	14	13	26	122	336	

Data regarding setting were established by reviewing information on completed surveys from question 21 (who were the target group/s) and question 22 (where was the program based or conducted).

Within each of these setting classifications, there remains considerable heterogeneity among the groups targeted by the falls prevention programs. As such, the nature of falls prevention programs within a setting type may vary considerably.

4.3 Types of organisations

A primary contact person for each falls prevention program was identified, and their organisation reported in the survey. The type of organisations listed as the primary contact for falls prevention programs varied considerably, particularly in the community setting. The majority of programs in each of the community, hospital, and residential aged care settings listed a health establishment (for example, extended care centres, hospitals, community health centres, and government public health units) as the primary contact organisation. Research organisations, community older adult organisations, and local government were the primary contact organisation for a smaller number of projects (Figure 4.2). A smaller range of organisations was listed as the primary contact organisation for falls and falls injury prevention programs in hospital and residential aged care settings.

Figure 4.2 Primary organisation type by setting

Type of Organisation	Sector				Total
	Community	Acute/ Hospital	Residential Aged Care	Mixed Setting	
Commonwealth Government	2	0	0	0	2
Community/Older Adult Organisation	6	0	1	1	8
Health Establishment	35	13	4	16	68
Industry organisation	1	0	0	0	1
Local Government	8	0	0	1	9
NGO	0	0	2	2	4
Professional Association	6	0	1	1	8
Research Organisation	7	1	2	3	13
Residential Aged Care Facility	0	0	3	0	3
State/territory Government	2	0	0	2	4
Other	2	0	0	0	2
Total	69	14	13	26	122

4.4 Falls risk factors addressed

Falls among older people often have multi-factorial causes and falls and falls injury prevention programs may address any one or more of the falls risk factors, through a variety of approaches. The majority of the programs addressed multiple falls risk factors (95%), with an average of nine (SD=3.5) falls risk factors targeted by each program. The most common falls risk factors addressed overall were medication (83%), indoor hazards (81%), balance and gait (81%), inactivity (77%), medical conditions (76%), and sensory impairment (72%) (Figure 4.3). Similar falls risk factors featured prominently in the falls prevention programs in each of the settings, although muscle weakness and foot problems/footwear were both more commonly addressed in residential aged care settings compared to the other settings.

The multiple risk factor approach incorporated into the majority of the programs reported is consistent with research evidence in the community and residential aged care settings which support multiple falls risk factor management (Tinetti et al, 1994; Close et al, 1999; Rubenstein et al, 1990; Ray et al, 1997). Seventy per cent or more of the education, exercise, environmental hazard assessment, individual risk factor assessment, public hazards, health promotion, and protocol development programs addressed nine or more falls risk factors.

Figure 4.3 Falls risk factors addressed by the programs, by setting

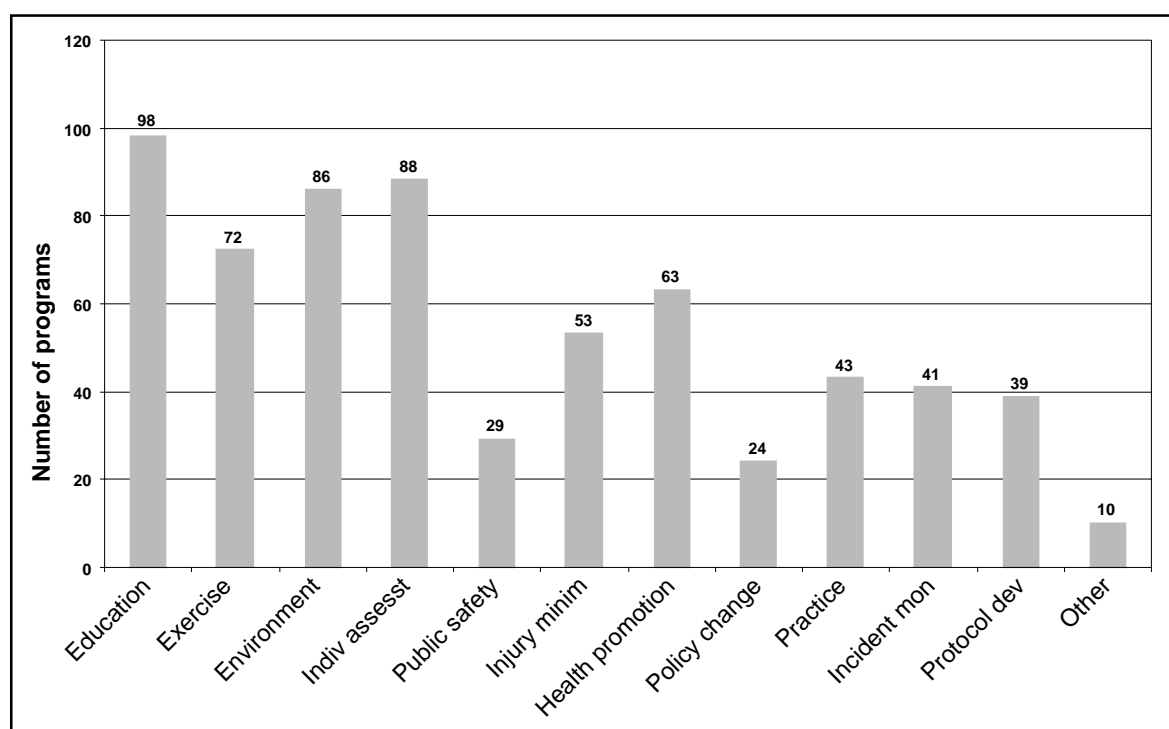
	Sector				
	Community (n=69)	Hospital (n=14)	Residential care (n=13)	Mixed setting (n=26)	Total (n=122)
Medication	53	13	12	23	101
Medical condition	50	12	11	20	93
Sensory impairment	49	12	9	18	88
Foot problems	45	5	11	17	78
Footwear problems	47	9	11	16	83
Dizziness	45	8	8	20	81
Balance and gait	56	11	11	21	99
Lower limb weakness	43	8	12	17	80
Inactivity	55	9	12	18	94
Indoor hazards	56	11	13	19	99
Public hazards	33	0	5	14	52
Fear of falling	41	7	7	13	68
Nutrition	29	4	8	11	52
Other	8	2	3	3	16

Note: Multiple choices permitted

4.5 Type of falls/falls injury prevention programs

In each of the settings, the most common program types were education, environmental assessment, and individual assessment. Exercise programs were also frequently adopted (Figure 4.4). Current research evidence indicates that approaches incorporating individual assessment (Gillespie et al, 1998; Close et al, 1999), or exercise programs (Wolf et al, 1996; Campbell et al, 1997), particularly those incorporating a balance component (Province et al, 1995), are most likely to achieve reduced falls rates among older people. Fifty six programs (46%) incorporated both exercise and individual assessment types of interventions.

Figure 4.4 Type of falls prevention program



Note: Multiple choices permitted

KEY

Environment: environmental hazard assessment and modification

Indiv asst: Individual risk factor assessment and management

Public safety: public hazard/safety program

Injury minim: Injury minimisation

Health prom: Health promotion products/literature

Practice: practice improvement

Incident mon: Incident monitoring

Protocol dev: Protocol/guidelines development

Other: included visual screening & referral, production of a falls manual, information on existing sources, policies and programs.

Most of the programs (n=87, 71%) reported being multi-faceted; that is, they incorporated two or more integrated interventions. Nine programs (7%) reported two or more discrete interventions, and six programs (5%) reported conducting a single intervention only.

4.6 Who was involved in the development of the falls/falls injury prevention program?

People from a range of backgrounds were involved in the development of the falls/falls injury prevention programs (Figure 4.5). Most commonly, allied health professionals (73%) and nurses (47%) were involved. Previously reported best practice guidelines for falls prevention program development (Hill et al, 1999) have identified that involvement of the target group (in many cases, older people) and involvement of people from a range of backgrounds in the program development, are key factors in enhancing the likelihood of the program being taken up by the target group and being sustained. Forty two per cent of completed surveys reported more than three different individual/group types were involved in the program development. In the community setting, older people were involved in the development of 65 per cent of programs, while participation of older people in falls prevention program development in hospital and residential aged care settings was considerably lower. The “other” category comprised a range of groups/individuals, with the most common being health promotion officers, followed by emergency services, YMCA, GP Division project officers and ACATs.

Fifty six per cent of programs involved academic/research personnel or falls specialists in program development.

Figure 4.5 Individuals/groups involved in program development, by setting

	Sector				Total (n=122)
	Community (n=69)	Hospital (n=14)	Residential care (n=13)	Mixed setting (n=26)	
Older people	26	1	4	9	40
Carers/relatives	5	0	4	5	14
Medical professional	27	6	4	5	42
Nursing/care staff	23	13	7	14	57
Allied health	50	10	11	18	89
Local council	20	0	1	5	26
Government department	18	0	4	5	27
Older adult organisation*	14	0	0	3	17
Academic/research	24	3	4	6	37
Falls/injury prevention specialist	17	1	4	9	31
Other	19	4	1	3	27

Note: Multiple choices permitted

*Older adult organisation = Older adult/ethnic/community organisation

When programs were grouped according to those involving academic or research staff in program development (n=37) and those not involving academic or research staff, a higher proportion of programs involving these staff reported having:

- completed, or intending to do an evaluation (94% vs 79%); and
- a randomised controlled study as one form of evaluation achieving some or all of their outcomes (20% vs 2%).

4.7 Who implemented the program?

Falls and falls injury prevention programs have been implemented by people from a wide range of backgrounds. Overall, allied health professionals and nurses were most likely to implement Australian falls and falls injury prevention programs. This is also the case within each of the settings (Figure 4.6). These groups were also those most frequently involved in the development of the programs. Interestingly, only a small proportion of programs included falls specialists and academic/research staff in program implementation.

Figure 4.6 Individuals/groups involved in program implementation, by setting

	Sector				Total (n=122)
	Community (n=69)	Hospital (n=14)	Residential care (n=13)	Mixed setting (n=26)	
Older people	15	0	2	5	22
Carers/relatives	7	1	3	4	15
Medical professional	18	2	3	7	30
Nursing/care staff	14	13	10	12	49
Allied health	41	10	10	15	76
Local council	14	0	0	2	16
Health promotion officer	16	2	0	5	23
Government department	9	0	0	0	9
Hospital	4	8	2	9	23
RACF*	3	0	8	10	21
Older adult organisation**	9	0	0	2	11
Academic/research	5	2	1	3	11
Falls specialist	6	1	2	6	15
Other	12	1	1	2	16

Note: Multiple choices permitted

*RACF = Residential Aged Care Facility

** Older adult organisation = Older adult/ethnic/community organisation

4.8 Who were the target groups for program?

Eighty six per cent of programs reported that one of their target groups was older people. Seventy two per cent targeted “at risk” clients. The five most common target groups in each setting have been shaded in Table 4.7. Older people, and “at risk clients” were common target groups in all settings. In contrast, nurses were less commonly the target group in community settings compared to the other settings. Older adult organisations and veterans were commonly the target group for community based programs. Those programs targeting medical/nursing/allied health practitioners were usually education programs, as were those focussing on community organisations and older adult organisations.

Figure 4.7 Target group/s for the falls/falls injury prevention program by setting

Target group	Sector				Total (n=122)
	Community (n=69)	Hospital (n=14)	Residential care (n=13)	Mixed setting (n=26)	
Older people	63	9	10	23	105
At risk clients*	45	13	9	21	88
Carers/relatives	24	6	4	10	44
Medical practitioners	19	3	4	13	39
Nurses	12	9	6	15	42
Allied health	17	5	4	16	42
Community organisation	14	0	0	8	22
Older adult organisation	22	1	0	11	34
Hospital	4	7	0	15	26
RACF**	6	0	10	18	34
Local council	11	1	0	5	17
Health promotion officer	7	1	0	7	15
Home care worker	14	1	0	9	24
Home maintenance service	4	0	0	6	10
General population	12	2	0	7	21
Ethnic population	10	0	0	2	12
Rural population	9	0	0	6	15
Men	17	4	2	9	32
Women	19	4	2	9	34
Veterans	20	0	0	11	31
Other	9	2	3	2	16

Note: Multiple choices permitted

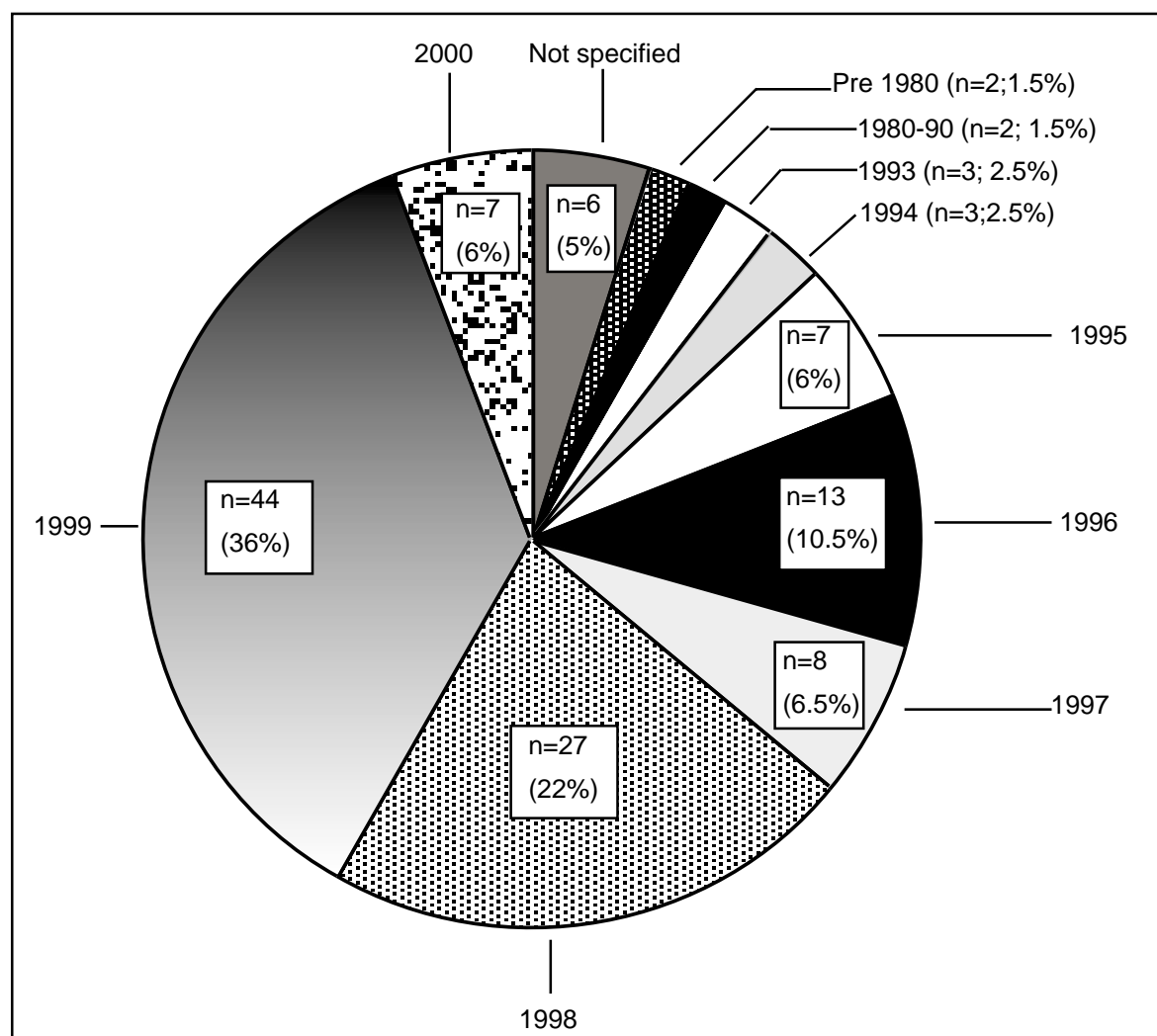
*At risk clients or clients who have fallen

**RACF: residential aged care facility

4.9 Year that programs were introduced

The stocktake focussed on programs that were currently running or those that had been conducted in the previous 12 months. Programs surveyed were most likely to have commenced in either 1998 or 1999. This is similar to the trend identified in another community based falls prevention program database (Hill et al, 1999), and is likely to reflect the growth in recognition of the magnitude of the problem of falls in Australia, and increased resources directed to this area during the mid to late 1990's. Analysis of this data by states reflected a similar picture in each state. A very small number of reported programs have been running for over 20 years. Eighty nine per cent of the programs responding to the stocktake survey are still running, with most of the programs that have stopped running operating for less than 12 months. Almost all of the programs that have stopped running were time-limited from the program outset, although unavailability of funding was identified as an associated factor in half of these cases.

Figure 4.8 Year in which programs commenced



4.10 Reason for introducing the intervention

Falls prevention programs can be introduced for a range of reasons. Although availability of funding is often a key consideration, and was cited by 44 programs as a key reason, a larger proportion of programs were introduced either in response to local data about the magnitude of the problem of falls and falls injuries, or as a health professional initiative (Figure 4.9). This pattern was similar across most states. Twenty six programs cited other reasons for their program being introduced. Most commonly, these included a state or national priority, perceived need, or an identified increase in falls or falls related admissions.

Figure 4.9 Reason for introducing intervention by state

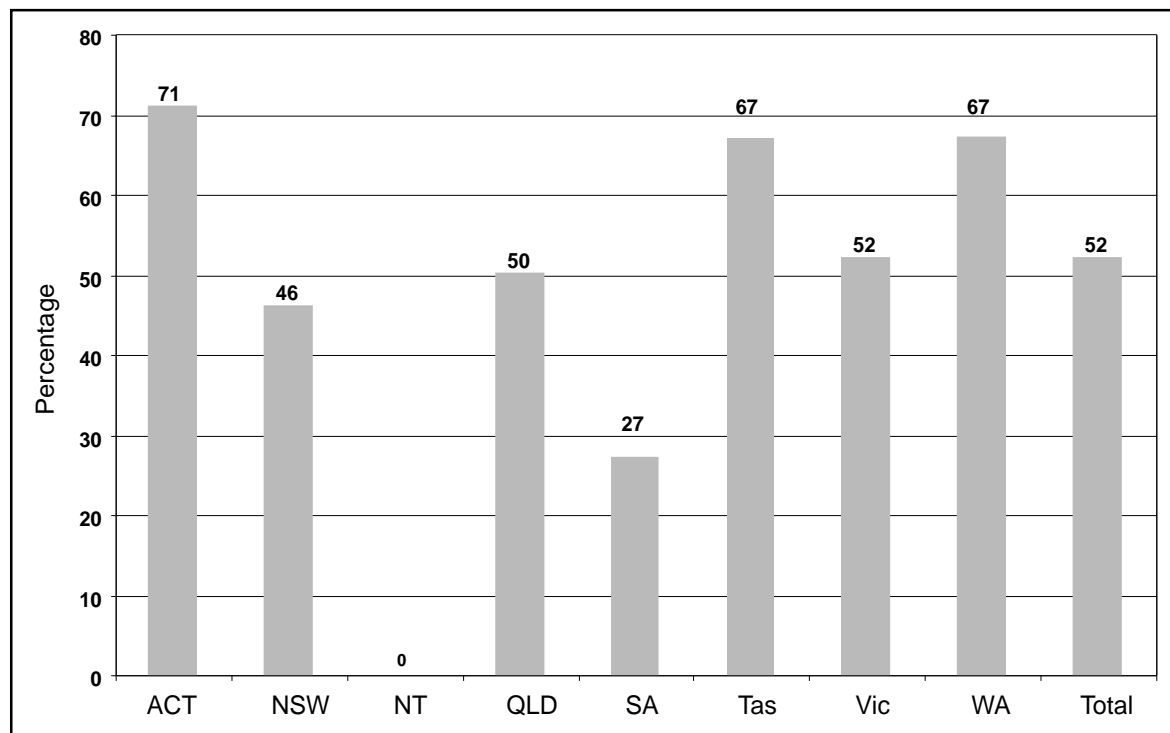
State	Local data	Availability of funding	Health professional initiative	Other	Total number of programs in each state*
ACT	2	2	3	1	7
NSW	13	10	16	6	24
NT	0	0	1	0	1
Qld	7	6	6	5	12
SA	8	2	9	2	11
Tasmania/King Island	2	0	2	0	3
Vic	20	19	30	10	46
WA	9	5	14	2	18
Total	61	44	81	26	122

* Note: Multiple choices permitted

4.11 Incorporation of existing programs into program development

An approach to best practice when developing a new falls prevention program may involve identifying any similar programs available and incorporating appropriate aspects of that program into the new program. Utilisation of existing resources which were shown to be well developed or effective also have the potential to be incorporated into new programs, reducing duplication of resources. Over half of the programs were based on, or adapted from, an existing program.

Figure 4.10 Percentage of programs based on existing programs, by state



4.12 Resources used – language other than English

Program resources have been analysed by setting, due to the specific nature of many of these. Overall, a large number of resources were utilised. However, only ten of the programs (8%) used resources which were available in languages other than English. Seven of these programs were in the community setting, and two were across mixed settings, and one in a residential aged care facility. Those resources which were available in languages other than English included pamphlets, booklets, home/environmental hazard checklists, videos, a self-screening checklist, and the *Community Liaison and Advisory Safety Project (CLASP)* kit of slides/overheads. In most cases, one or more resources were translated into a number of languages by each program. Languages other than English which were used for falls/falls injury prevention resources were:

- Chinese (n=6);
- Greek (n=5);
- Italian (n=5);
- Vietnamese (n=3);
- Spanish (n=3);
- Arabic (n=3);
- Polish (n=2);
- Korean (n=1);
- Turkish (n=1); and
- Finnish (n=1).

4.13 Transfer of program to other settings

As indicated in section 4.2, and also in the falls prevention literature (DHAC, 2000), the majority of work in falls prevention appears to be occurring in the community sector. Many of the falls risk factors are similar between settings, although there are some specific differences, such as range of co-morbidities, and capacity for independent activities that may limit direct transfer of falls prevention programs between settings. Nonetheless, there are likely to be components of some of the successful community based falls prevention programs that can inform and apply across settings. Just over one fifth of respondents indicated that their programs had been translated into another setting. Most of these were programs in the community setting, and were most commonly education programs and individual risk factor assessment and management programs.

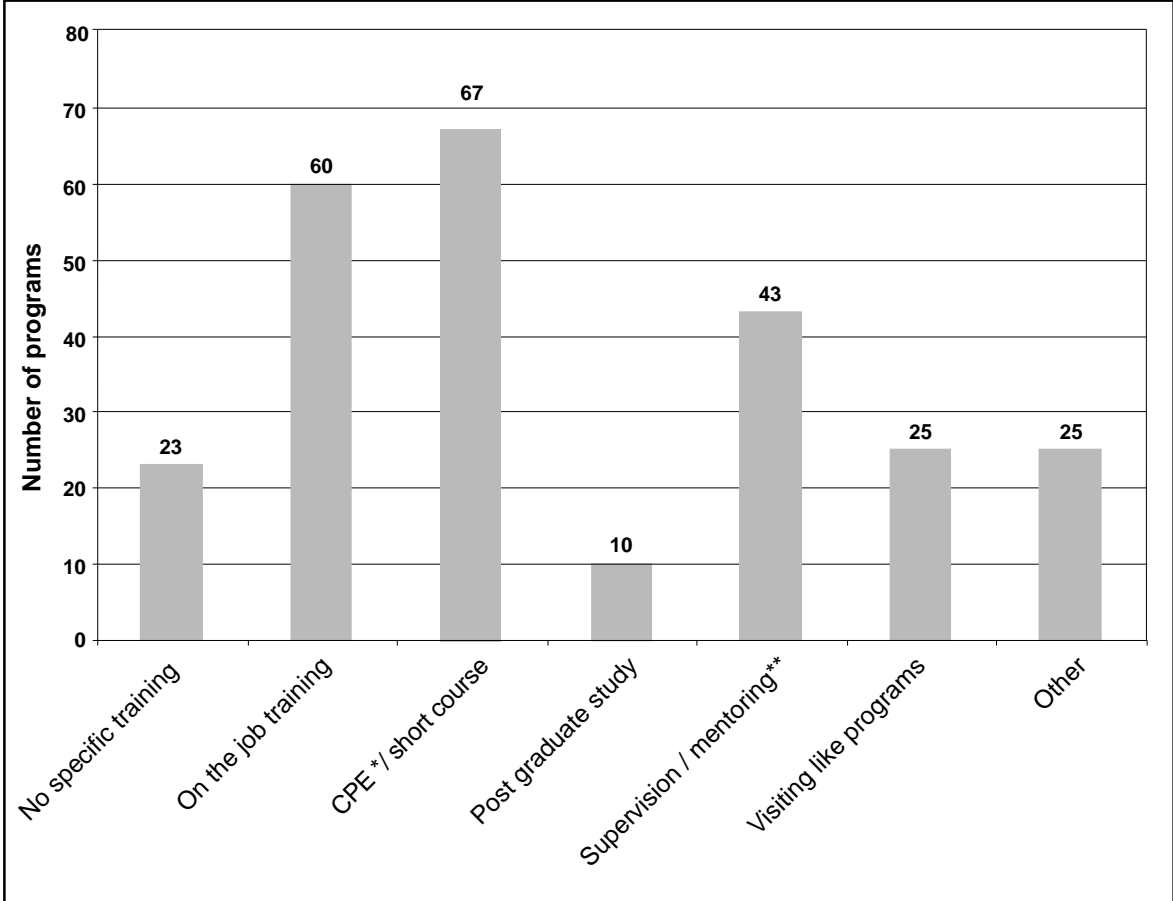
Figure 4.11 Number of programs which have been transferred to other settings

Program translated	Frequency
Yes	28
No	85
Not recorded	9
Total	122

4.14 Type of training provided for those implementing the program

Some of those involved in program implementation have an extensive background in falls prevention, while others are new to the area. In order to further develop the skills and knowledge of those currently involved in falls prevention activity, and to increase the overall workforce in this area, avenues for workforce training are necessary. Most commonly, this was achieved through continuing professional education, short courses, and lectures (55%), and on the job training (49%). The methods of delivery of professional education, short course and lecture sessions were not explored in the Stocktake survey. This area warrants further investigation, as standard methods of workforce training have been shown to achieve little change in behaviour in the education literature (Davis, 1985). Commonly, programs utilised several avenues of workforce training.

Figure 4.12 Type of training involved for those implementing program



Note: Multiple choices permitted
 *CPE: continuing professional education
 **Supervision/monitoring: by an experienced practitioner

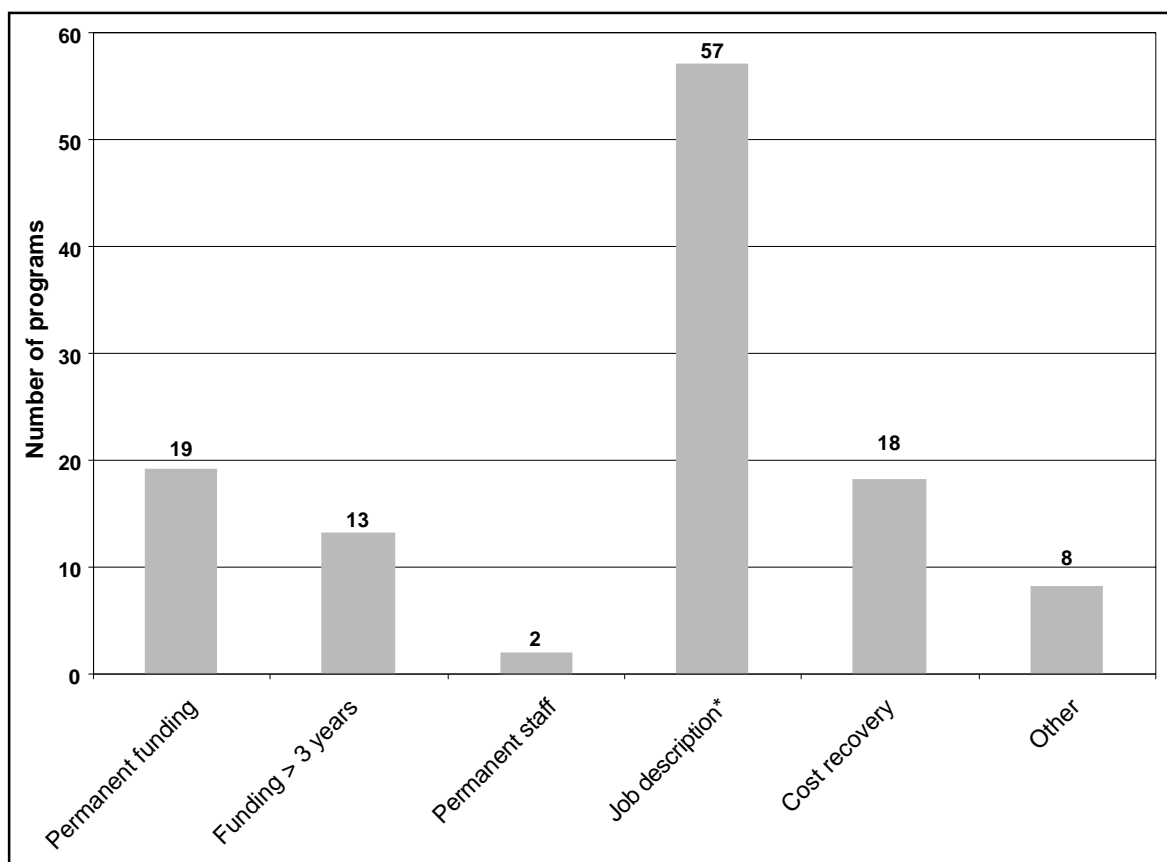
Surprisingly, only 20 per cent of programs used visiting of like programs as a training component for project staff. This form of training is likely to involve sharing of information about what works and what doesn't work, and sharing of resources so that new programs build on the strengths of existing programs. Included in the category "other" was the practice of employing appropriately qualified staff, networks or collaboration with other stakeholders and reading literature on falls.

4.15 Sustainability

Sustainability has been identified as an important component of many falls prevention programs. In a small number of cases, often those that were part of a formal research program in the area of falls prevention, there was a pre-planned finishing date.

Of the programs responding to the stocktake survey, 93 (76%) reported that their program was sustainable. The most common factor associated with program sustainability was the incorporation of the program duties into the job description of staff. A number of other issues were cited in the "other" category, including incorporating the program into core business or putting policies into existing frameworks, ongoing use and availability of resources, and collaborative efforts and support.

Figure 4.13 Factors associated with program sustainability



Note: Multiple choices permitted

*Job description: program duties incorporated into job description

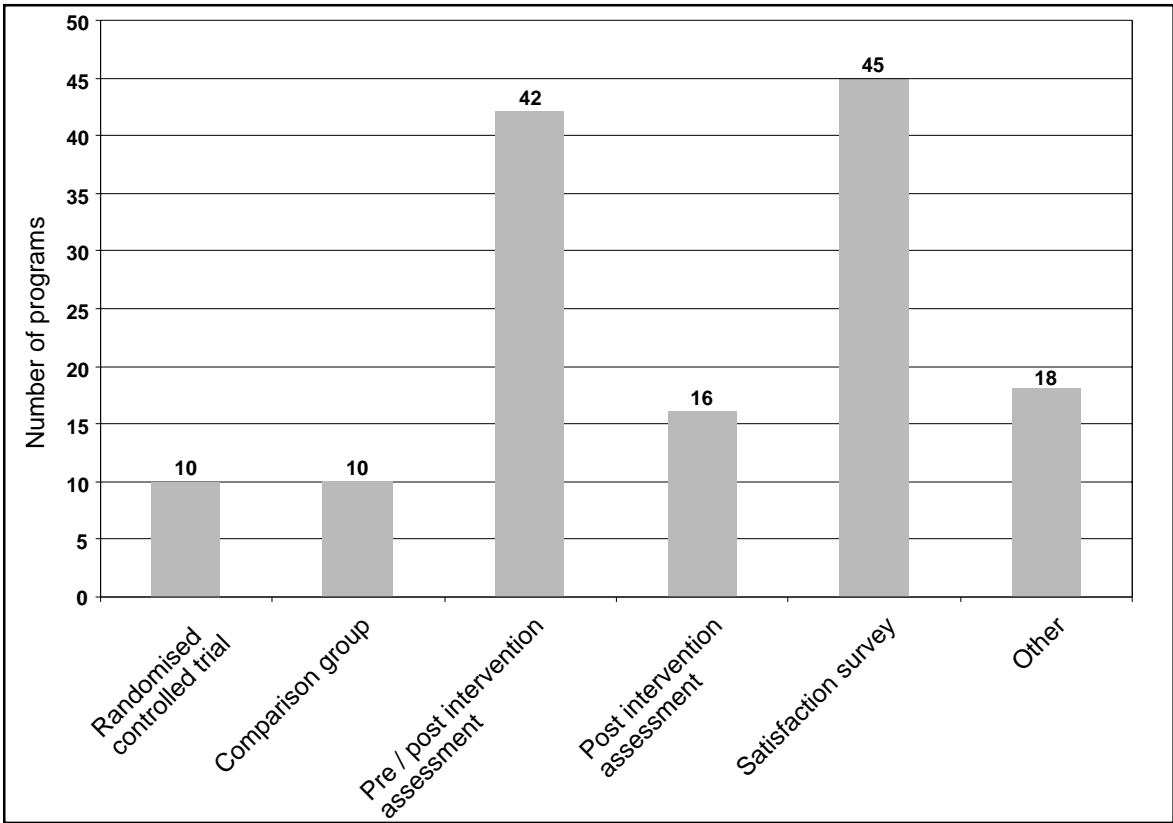
Fifteen of the programs reported that they were not sustainable. Twelve programs cited funding as the reason for this non-sustainability. Of these 12 programs, four also cited staffing issues and two stated staffing and program design issues were involved. Two other programs cited program design and one program indicated that sustainability was not evident at this initial evaluation stage. One of the programs citing program design indicated that the program was never intended to be sustainable, it was a research program.

4.16 Evaluation of programs undertaken

Given the current gaps in the evidence regarding what works in falls and falls injury prevention, particularly in the hospital and residential aged care settings (DHAC, 2000), there is a need for programs to incorporate elements of evaluation. Sixty per cent of the 111 programs which provided a response to this question reported having performed an evaluation, a further 24 per cent reported that they plan to undertake an evaluation, and 16 per cent reported they had not/were not planning any evaluation.

For the purposes of this Stocktake survey, the type of evaluation has been classified in five broad categories. The randomised controlled trial provides the strongest form of evidence regarding the effectiveness of specific interventions, although it is acknowledged that this approach may not be practical or necessary for the majority of programs. Ten of the programs in the stocktake survey reported using a randomised controlled trial (Figure 4.14). Eighty per cent of these programs using a randomised controlled trial evaluation were conducted in NSW and Victoria (Figure 4.15), although only 57 per cent of all programs were undertaken in these two states.

Figure 4.14 Type of evaluation undertaken/planned



Note: Multiple choices permitted

Most commonly, the method of evaluation was a satisfaction survey (37%) and pre/post research design (34%). The classification of “other” included a clinical audit, cost effectiveness analysis, review of statistics and strategies, tracking of hospital admissions, telephone follow-up three months after admission and out-sourced evaluations.

Of note, all of the programs reporting involving academic/research staff in program implementation reported having done, or intending to do, an evaluation. None of the 17 programs reporting that they were not going to do an evaluation had academic/research staff involved in program implementation.

In many programs, more than one method of evaluation was used/planned. The most common combination was pre/post intervention assessment together with a satisfaction survey (n=25, 20%).

Figure 4.15 Type of evaluation process performed/planned, by state

State	Randomised controlled trial	Comparison group	Pre/post assessment	Post intervention assessment	Satisfaction survey	Other	Total
ACT (n=7)	0	1	1	1	3	0	6
NSW (n=24)	5	2	9	5	8	6	35
NT (n=1)	0	0	0	0	0	0	0
Qld (n=12)	0	1	3	0	5	1	10
SA (n=11)	1	1	4	0	4	3	13
Tas (n=3)	0	0	1	1	0	0	2
Vic (n=46)	3	4	20	9	20	6	62
WA (n=18)	1	1	4	0	5	2	13
Total	10	10	42	16	45	18	141

Note: Multiple choices permitted

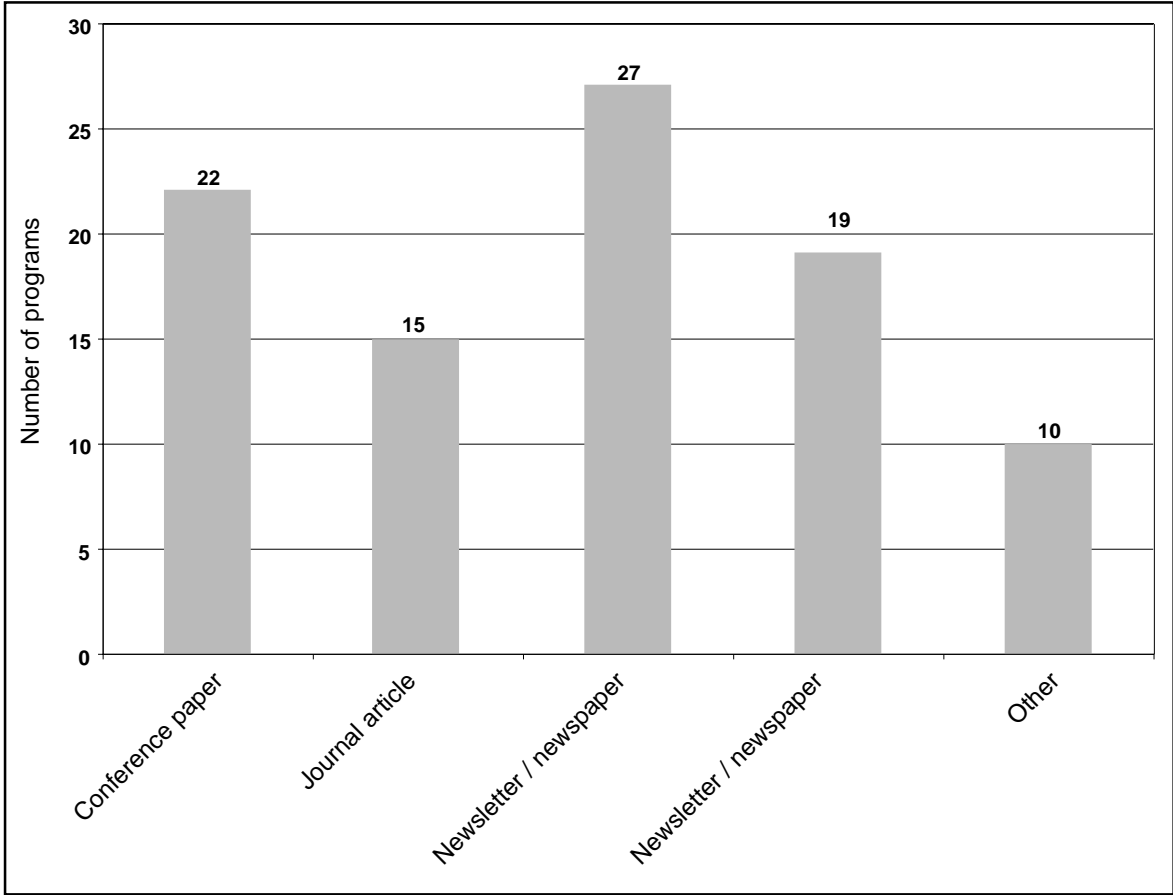
Seventy one of the 77 programs who reported they had or were planning to undertake an evaluation, responded to the question of who conducted the evaluation. Seventy three per cent of these programs reported that the evaluation was planned to be carried out inhouse, that is, no independent evaluation of the program was undertaken. The most commonly reported alternatives to in house were evaluations conducted by independent research/evaluation consultants and various government departments.

Programs were asked to report on whether the program objectives were assessed as part of the evaluation. Seventy eight programs responded to this question. Of those responding, 40 per cent reported that the objectives were met, 59 per cent reported that the objectives were partly met, and only one per cent reported that their objectives were not met.

4.17 Documentation of program published

Dissemination of program methodologies and outcomes is essential to ensure that new programs, or those in the process of review, are able to base their new program or modifications on the best available information. Effective communication of program methodologies and outcomes should also reduce duplication of resources. The most commonly used form of externally accessible documentation was newspapers/newsletters (27 programs) (Figure 4.16). Of note, 15 journal articles had been published from the 122 programs responding to the survey, and 22 conference presentations had been made. Nineteen programs had produced a formal report. In total, 51 of the 122 programs (42%) produced one or more types of documentation about their program.

Figure 4.16 Publication of program results



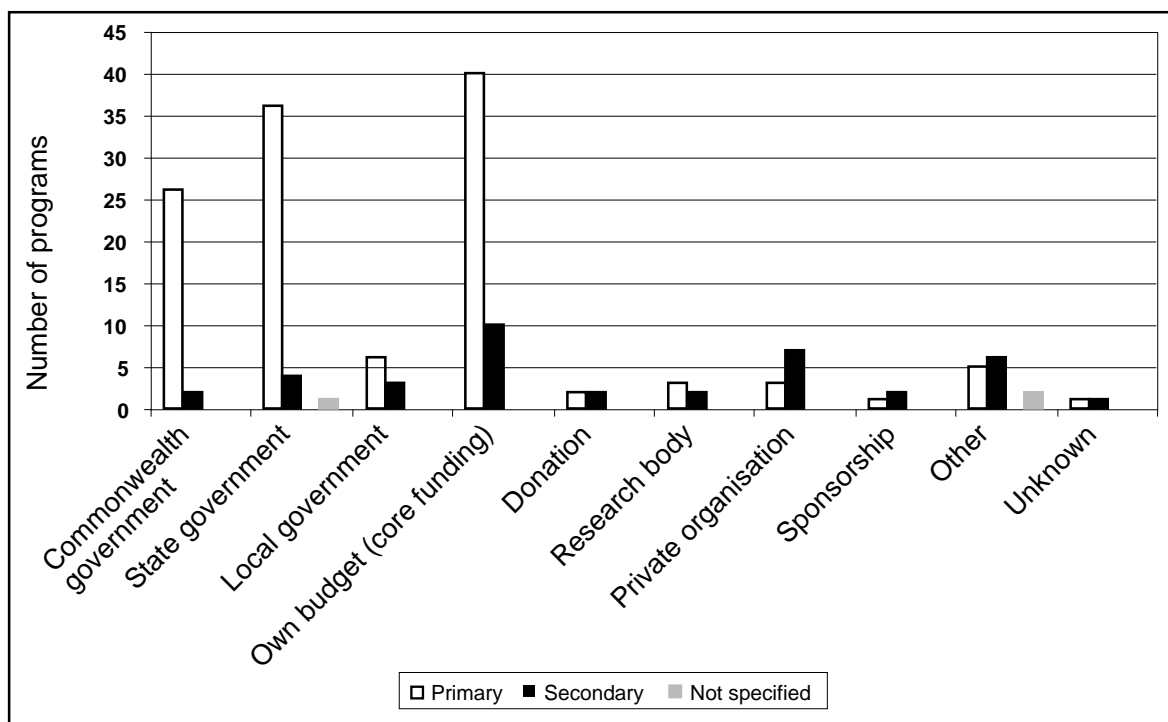
Note: Multiple choices permitted

4.18 Program funding

A range of primary and secondary funding sources for falls prevention programs were reported. The largest proportion of programs (32%) reported funding from within their core budget. Thirty per cent of programs received primary funding from the state government, while 21 per cent received primary funding from the Commonwealth government. These were the three major sources of funding for falls prevention programs. These figures need to be considered in the context that many of the programs identifying “core budget” as a source of funding were often health care facilities, which in many cases are state funded.

Only 41 per cent of programs reported the amount of funding provided for their program. Program funding ranged from \$150 to over \$1,000,000, with a median amount of \$29,000. A number of programs noted that funding amounts were estimates only, and that “in kind” support was often provided (such as venue or staffing).

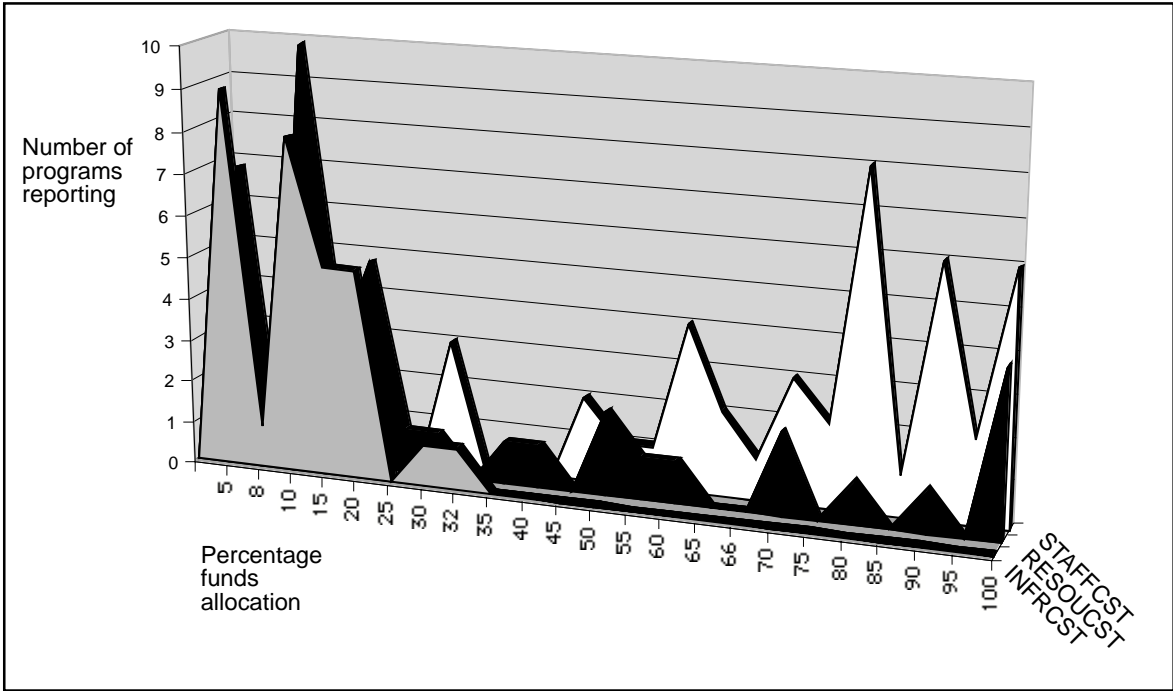
Figure 4.17 Primary and secondary distribution of funding sources for programs



Note: Multiple choices permitted

Survey respondents were asked to estimate the breakdown of program funds between infrastructure costs (eg. rent, phones, maintenance, etc), program resources (eg. pamphlets, checklists), and staffing. Figure 4.18 indicates that more programs allocate a higher percentage of funds to staffing costs. Programs resources (pamphlets, checklists etc) are more likely to account for a lower proportion of funds in most programs.

Figure 4.18 Breakdown of distribution of funding



Infrcst: Infrastructure; Resoucst: Program resources; Staffcst: Staffing

4.19 Other analyses

In the following sections of this report, analyses of the survey data are reported individually for each of the community, hospital, residential aged care settings, and where practical, for mixed settings. This includes specific sub-analyses for these settings on the data from this section, together with several additional items, including:

- where the program was conducted;
- access to the program;
- resources developed/utilised;
- promotional material; and
- barriers and enablers associated with participation in the program.

5.0 *Falls prevention activity in community settings*

The majority of falls and falls injury prevention programs completing the falls stocktake survey were targeting their program to reduce falls and falls related injuries among older people living in community settings (69 of the 122 programs). This section provides a breakdown of responses for the community setting.

5.1 Summary

Many of the trends observed for the overall responses to the stocktake survey were similar when analysed separately for the community setting. Key issues arising included the following.

- a) Most common program types were education (84%), environmental assessment/modification (77%), individual assessment (68%), and exercise (64%). These were also the four most common intervention types across all settings combined. Forty nine programs (40%) incorporated all four of these intervention types in their programs. Ninety three per cent of community programs addressed multiple falls risk factors, with the most common risk factors addressed being indoor hazards, balance and gait, inactivity, and medication.
- b) Similar to the analyses for all settings combined the majority of community programs targeted older people (91%), and at risk clients (65%).
- c) Fifty nine per cent of community programs were commenced in the years 1998 to 2000. This is similar to the proportion of programs across all settings that have developed in this time frame.
- d) The greatest proportion of community based falls and falls injury prevention programs were introduced as a response to health professionals' initiative (65%), although 48 per cent were introduced at least partly in response to local data about the problem of falls and falls injury, and 36 per cent were at least partly introduced because of availability of funding.
- e) Access to community based programs was fairly evenly distributed between self referral, GPs referral, and other health professional referral.
- f) Fifteen community based programs (22%) were reported as being transferred to other settings, a similar proportion to those in the overall analyses.
- g) Most commonly, staff involved in programs received training through short courses/lectures (52%), on the job training (46%), and supervision/mentoring (42%). A smaller proportion of programs in the community setting reported no specific training for their workforce (17%).
- h) A similar proportion of programs in community settings were sustainable, compared to each of the other settings. The major factor associated with sustainability of community based falls and falls injury prevention programs was incorporation of

program duties into the job descriptions of staff (41% of programs). However, this was also identified as a problem by some organisations, with staff expected to take on additional duties rather than having additional funds/staff.

- i) Falls and falls injury prevention programs in community settings were most commonly promoted using promotional material (fliers, brochures, newsletters) (80%), press and other media (65%), and via GPs (42%). Promotional materials were often widely distributed, most commonly to older people/carers/relatives generally, to “at risk” clients, community organisations, health professionals, and health establishments.
- j) A wide range of resources/tools were used in community based falls prevention programs. These most commonly included pamphlets/information sheets, environmental hazard check lists, books/booklets, posters/calendars, and resource kits. For most of the resources/tools used, more programs developed their own resource/tool relative to the number who utilised an existing resource/tool. This may indicate a degree of duplication of resources/tools, and may be related to a lack of awareness about the availability of existing resources. Videos and medication cards were the two types of resources/tools where a much greater proportion of programs utilised existing resources/tools than developing their own.
- k) Similar to the other settings, the largest proportion of programs were funded from their own budget (core funding), although state governments and the Commonwealth government also funded a range of programs (36% and 29% respectively).
- l) Estimates of participation numbers were provided by the majority of programs, and these varied widely, from 10 for a small, multiple risk factor program incorporating education and environmental assessment and modification, to 16,000 for a large scale program involving education, environmental assessment and modification, public hazard management, injury minimisation, health promotion, and product development. The median number of participants in falls prevention programs in the community was 150.
- m) Most programs had no costs for participants. Of the small minority that did charge a fee, costs were less than \$6.50 per session in most cases.
- n) Program evaluation has been undertaken in 55 per cent of programs in the community setting, with a further 20 per cent reporting that they intend to undertake an evaluation. Most commonly, satisfaction surveys and pre/post assessments were the method of evaluation used (41% and 33% respectively). These methods of evaluation do not allow conclusions to be drawn about effects on falls or falls injuries. Eight of the programs (12%) reported using a randomised controlled design. Over half of the program’s evaluations were conducted in house. Of those reporting “other”, most commonly utilised avenues for evaluation included independent research/evaluation consultants (n=5), and government departments (n=4).
- o) A range of objectives were listed for the community programs, with over half (52%) aiming to reduce falls or falls related injuries. Other objectives were impact or process in nature. Many organisations had not completed their evaluations to identify whether the program had achieved the stated objectives. Of those responding, 13 (31%) reported they had fully achieved their objectives, 29 (69%) reported they had partly achieved their objectives, and no programs reported not meeting their objectives.

5.2 Thematic analysis of descriptive data

A number of the questions in the stocktake survey were open-ended, allowing respondents to answer the questions without being limited to set responses. The amount written and nature of comments varied widely between respondents. The project team have reviewed all responses, and developed key themes from these responses. These are described below.

5.2.1 Key objectives of the program

A range of program objectives was reported. Including:

- reducing falls/falls injury (n=36);
- health promotion by raising awareness and educating health professionals and older people of fall risks/strategies/services (n=26);
- improving environmental safety, through assessments/modifications and the reporting of public risks (n=22);
- improving the physical status of individuals - balance/mobility/strength (n=19);
- improving confidence/reducing fear of falling (n=9);
- quality use of medication (n= 7);
- behaviour modification (n=7);
- increasing referrals (n=5);
- maintaining independence (n=3); and
- self directed action/care (n=3).

Other aims cited were to reach a diverse group of older people, reduce health costs, and for safety strategies to be incorporated into daily lives and routines. One project's stated aim was to evaluate the effectiveness of interactive workshops as a means to transfer information from research to clinical practice and to identify barriers and solutions to this transfer.

5.2.2 Transferability of the program

Of the 15 programs that had translated their program to a different setting or target group, few specified both the new group/setting and the key features that made this transfer possible.

Three organisations targeted different ethnic groups. Two were aimed at the Italian community (one using dubbed videos and translated overheads), and the third involved the printing *Home Safety Checklist for Home Carers* in different languages.

The education component of one program, which included the loan of a display, made it applicable to various groups/centres. Being a topic of general interest and the multi-faceted nature of another allowed for flexibility and therefore was easily presented to other groups. Another program indicated that overheads detailing main risk factors enabled talks to be modified to younger Rotary groups and to train professional carers working with older adults. An interactive workshop was the key feature in another program. The interactive structure of this workshop enabled application to different practitioner/professional groups,

through in-depth discussion and the opportunity to tailor discussion to the participant's interests/work setting. One organisation reported that they collaborated closely with a hospital and this was possible because the client group was similar across medical services (from GP to hospital to GP).

Other key features were listed without specifying the new group/setting. Features included programs based on assessment and identification of risk factors, involving an integrated home safety/security program and readily generalisable exercise program/class.

Organisations indicating that transfer was not possible listed a number of reasons. Six indicated the program had a specific target/setting/purpose – ie. healthy aged, older people, frail aged. This also included one organisation that stated that their program was a model of service delivery particularly relevant to the current trends in the health system that support patients at risk of adverse events in their own home.

Three programs indicated that an interdisciplinary team/network of services was critical to the success of the program, hence limiting transferability. One program - a clinic - stated that it was critical to have available other falls prevention services operating in varied settings (community, acute, rehabilitation, residential) within a wider healthcare network of services.

Budget/resource restraints (n=4), language/cultural differences (n=3), and the need for specialist staff (n=2) were some of the other features limiting transferability.

5.2.3 Barriers and enablers to target group participation

The survey asked respondents to describe any barriers or enablers they discovered to the target group participating in the program. Respondents tended to describe barriers rather than enablers.

Community based falls prevention programs identified a number of barriers. Access issues, primarily lack of transport, were the most commonly cited barrier (27 out of 69 respondents). Access to translators and a long waiting list were also mentioned. Two respondents raised cost as a barrier. Motivation of the target group, a lack of interest and a perception that the issue of falls is not pertinent to them was also identified as a barrier to participation by a number of respondents (14 out of 69 respondents). Other less commonly raised issues were the varying abilities of the target group participating in the program, illness suffered by the target group and their fears associated with participating. In contrast, unrealistic expectations of the target group were also reported. One respondent also included the limited availability of occupational therapy and physiotherapy services as a barrier. Issues associated with staffing were raised as barriers by a further two respondents. The demands placed on individuals participating in a research project were also identified as barriers to participation (2 out of 69 programs).

Factors identified as enablers to participation by the target group were less frequently cited than barriers. The location of the program was identified as enabler for those programs based in the home, or held in usual meeting places for the target group, or not held in aged care sites (4 out of 69 respondents). Two respondents regarded the provision of transport as an enabler to participation. The involvement of carers in the program (2 out of 69 respondents) and the incorporation of peer educators (3 out of 69 respondents) were also

noted to be enablers to participation. Two respondents recorded the provision of morning tea and free resources as enablers.

Sixteen of the 69 respondents did not list any barriers or enablers.

5.2.4 Problems and issues

Respondents were asked to detail any problems or issues associated with implementing their program. Some common themes between the settings can be observed.

Insufficient resources and time was identified by 24 of the 69 respondents as a problem. In particular, staff being required to incorporate falls prevention activities into their regular duties rather than additional funds being allocated to implement the program. The limited availability of physiotherapy services was also identified by one respondent as a problem. Five respondents reported resistance to change or participation by staff, local councils, community health services and older people. A number of issues associated with the involvement of GPs in programs were reported. The issues were educating GPs regarding their on-going role in falls prevention, accessing GPs, time constraints of GPs, and reliance on GPs for the program to succeed. Ten of the 69 respondents reported difficulties recruiting participants. Three respondents reported difficulties associated with co-ordinating the program. A range of other issues were identified by individual respondents. These were:

- lack of transport and logistics of providing transport to a large number of people;
- a waiting list;
- sufficient time being required to bring about “systems change”;
- interventions not personally self-sustaining;
- isolation from other agencies;
- lack of space;
- lack of media advertising associated with limited funds;
- difficulties accessing researchers; and
- a lack of awareness by health professionals of each other’s roles.

5.2.5 Enhancements to program effectiveness

Generally, better resources, both human and financial, were considered necessary to make programs more effective. Sixteen of the 69 programs indicated that funding/more resources were needed. Five indicated that funding was required for additional staff. Another eight programs also listed the need for more staff. More support from a number of groups was also identified, ie. GPs, geriatricians, health service, research team and closer liaison with ACATs and more allied health involvement (n= 6). Better promotion was an issue for five respondents; this included needing more time for health promotion activities and taking a global approach to promotion. Transport needs were identified in four instances and the need for outcome measures in three instances.

The following issues were also noted. The need for more sessions (n=3); the need for multidisciplinary/intersectoral teams (n=3), and the need to increase consumer involvement

(n=2) and access by ethnic groups (n= 2). In these latter cases, it was considered that improved involvement/access could be achieved through peer education (n=2).

Other singular issues raised include more precise information on how to reduce risk factors; improving health professional's awareness of falls issues; a greater evidence base for effective interventions; evaluation; earlier referrals; improved pre-screening; better referrals to/from agencies and mechanisms for the follow up of those at risk; expansion to other community groups; prolonged community education; business sponsorship; increased and more accessible staff training for those in remote areas.

5.2.6 Service gaps and areas for improvements

A large number of service gaps in falls and falls injury prevention were reported by survey respondents. The most commonly cited gap was inadequate resources for effective implementation of programs, both in terms of funding, and staffing. Low levels of awareness in older people themselves about the risks of falling and injury associated with falls was also frequently cited, and considered to be an important issue to overcome if falls and falls injury prevention programs are to have significant uptake by older people in community settings. Inadequate communication and networking between programs, workers in the field and researchers was another area warranting greater attention. Falls prevention programs in rural settings, and those targeting older people from non-English speaking backgrounds were also highlighted as areas not frequently addressed by current programs. Some of the other responses to this question included:

- inadequate transport (n=3);
- inadequate/insufficient workforce training in the area of falls prevention (n=3);
- insufficient research (n=3);
- need to involve GPs in programs (n=2); and
- early identification of those at risk of falling (n=2).

The survey question asking about areas for improvement identified similar areas to those identified as gaps. Most common responses included improving resources and funding; improving the awareness of older people about falls risk factors; strategies to reduce risk; greater collaboration between all stakeholders, including all levels of government; and improved workforce training. Other improvements cited less often were:

- early identification of falls risk (n=4);
- improved translation of research findings into clinical practice (n=3);
- increased focus on environmental issues in the outdoors (n=3); and
- increased research of what works in falls prevention (n=2).

Under other issues, increased networking was also cited a number of times as a valuable area to develop, although one respondent reported that there “seems to be too many networks springing up”. Integration and communication between networks which develop or become more established would appear to be important.

5.2.7 Resources used/developed

A large number and type of resources were used in community based falls and falls injury prevention programs, with the largest proportion of most types of resources being developed specifically for the individual program. Videos and medication cards were the only types of resources where an existing tool was more commonly used. Some responses to the request to provide the resources title were inadequate to identify the resource (eg. “home hazard assessment tool”). A list of the most commonly reported resources to be used from already existing programs is shown below.

- *Stay on Your Feet* booklet or calender (6);
- *Standing on Your Own Two Feet* video and resource kit (AP&SF) (5);
- HDWA brochures/checklists (SOYFWA) (3);
- NARI “*Falls can be a problem in health older people*” brochure (3);
- NSW Health home hazard checklist (3);
- Department of Veterans’ Affairs slideshow (2);
- Westmead Home Hazard Assessment (2);
- “*Balancing Acts: Falls and Older People*” video and handbook (2)
- NARI “*Falls can be a problem in healthy older people*” poster (2);
- Southern Public Health Unit (WA) Peer Educator Training Kit (2);
- Active Australia information (2);
- Medication Information Project (MIP) (1);
- Department of Veterans’ Affairs Medication Cards (1);
- Hip protector pamphlet (1);
- “*Don’t come a cropper: Rural Seniors Talk About Falls*” video (1);
- Queensland Health overhead/education kit (1);
- Move Safely, Age Well (City of Maribyrnong) calender (1);
- “*Living at home safely*” video (Education Model Australia) (1);
- “*Safety and injury prevention with home care video*” (Central Goldfields Shire) (1);
- *Screening Assessment for Falls Prevention* (SAFE; Peninsula Health Care Network) (1);
- “*Staying On*” video (1).

A range of other pamphlets, posters, education kits, videos and other resources were developed specifically by a program for their own use. Most commonly, these were pamphlets/information sheets (38% of programs), environmental home hazard checklist (25%), book/booklet (19%), and resource kit (17%).

5.2.8 Resources in languages other than English

Only a small number of programs utilised resources which were in languages other than English. These included:

- *Community Liaison & Advisory Safety Project (CLASP, Council on the Ageing – ACT)* have produced a kit, which has been translated into Spanish, Chinese (Mandarin), Vietnamese and Finnish;
- Goulburn Valley Rural Health Team has produced booklets in Arabic, Chinese, Greek and Italian;
- LaTrobe City Shire has produced safety booklets in different languages;
- Maribyrnong City Council has produced a falls prevention booklet in Chinese, Italian, Greek, Vietnamese, and Spanish. They also have a falls prevention video in Polish, Chinese, Greek, and Italian;
- Central Sydney Area Health Service, Health Promotion Unit has home environment checklists in Arabic, Chinese, Greek, and Italian;
- City of Yarra has a home hazards checklist, and a video (*APSF – Standing on your own two feet*) translated into Arabic, Cantonese, Greek, Italian, Turkish, Polish, and Vietnamese.
- City of Greater Dandenong “*Secure Seniors*” program has a number of council publications in different languages.

Two programs included under the category of “mixed settings” with a community focus in their falls prevention activities reported using resources in a language other than English. These were:

- Blacktown-Mt Druitt Health utilised the NSW Health booklet (languages not listed); and
- Tropical Public Health Unit reported using a self-screening checklist and a home/ environmental hazard checklist, available in Spanish, Greek, Italian, and Chinese.

5.3 Case studies

A small number of programs responding to the National Falls Stocktake survey have been selected for more detailed presentation in the form of case studies. These programs were selected as examples which met four key criteria representing previously identified aspects of best practice. These criteria included that the program incorporated more than one intervention type, that it was sustainable, that it had undertaken, or planned to undertake a formal evaluation, and that the program objectives were either fully or partly met.

5.3.1 Case study 1: Central Sydney Area Health Service, Health Promotion Unit, Camperdown, NSW

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Program description

The Central Sydney Area Health Service, Health Promotion Unit (CSAHS, HPU) is responsible for co-ordinating the implementation of *Preventing Falls Among Older People Strategic Plan, 1998-2001*. This plan was developed by the HPU in consultation with key stakeholders, especially General, Geriatric and Rehabilitation Medicine (GGRM) and CSAHS to provide direction for activities for preventing falls among older people over the period 1998-2001.

The CSAHS covers ten local government areas. They are Ashfield, Burwood, Concord, Canterbury, Drummoyne, Leichhardt, Marrickville, Strathfield, and parts of South Sydney and the City of Sydney.

The strategic plan includes awareness raising, community education, increasing physical activity opportunities incorporating balance and resistance training, research and policy development, practice improvement, environmental hazard assessment and modification, and working with GPs and other health professionals.

Target group

The *Preventing Falls Among Older People Strategic Plan, 1998-2001* adopts a multi strategic approach, ...*due to the limited evidence of the role played by the different risk factors and their interactions, and regarding the most effective strategy for different target groups.* (Stackpool, G, CSAHS, 1999).

Two specific target groups have been selected:

- people over the age of 65 who have experienced their first fall; and
- people over the age of 75 years with multiple risk factors for falling.

Program aims

The strategic plan aims to reduce the rate of hospital admissions as a result of a fall for people over 65 years. The plan has sixteen objectives.

Program design and development

The strategic plan was developed in response to the need for a planned and co-ordinated approach across the AHS to prevent falls among older people. The design and development of the Plan has drawn on information in the literature regarding evidence of effective interventions. The Plan also drew on the work initiated by the Northern Rivers AHS in 1992 (then known as the North Coast Public Health Unit).

The Plan has been developed in consultation with other CSAHS units including GGRM and Migrant Health Team, as well as other key stakeholders such as, the Centre for Education and Research on Ageing (CERA, a joint centre of Concord Hospital and Sydney University), SHARE (a non-profit organisation providing community health education and which also provides gentle exercise programs for older people, including those from non-English speaking backgrounds), Divisions of General Practice, local government and the *Medicine Information Persons* project.

The risk factors addressed through the strategic plan include medications, medical conditions, unwise use of medications, sensory impairments, balance and gait, lower limb weakness, physical inactivity, indoor and public environmental hazards.

Program content

A number of strategies have been implemented by the CSAHS to prevent falls and fall injuries. Some of these strategies were initiated prior to the development of the strategic plan and have been maintained. Some initiatives are identified as follows.

Community education and awareness raising

- Education targeting older adults has been conducted by the HPU and *Falls Busters* teams, the latter consisting of community and hospital-based GGRM staff who provide community and inpatient education on falls prevention. Hospital-based GGRM staff from Balmain Hospital were also involved in a patient education trial in collaboration with the HPU. The trial, initiated in 1997, focused on reducing individuals' risks of falling for people being discharged home from hospital.
- Peer educators have also been trained as Medicine Information Persons since 1992.
- CSAHS developed and published a booklet containing information on risk factors for falling, preventive strategies and locally available services, titled *Staying on Your Feet*, which was distributed to service providers, community organisations and others (this book is now out of print but was revised by the then North Coast Public Health Unit into the *Stay on Your Feet* book).
- A forum targeting falls in public places was held in 1997 for local councils and health agencies in the area to attend.
- Falls prevention expos have been held for non-English speaking groups.
- Safe footwear displays have been placed in local shopping centres.

Physical exercise initiatives

- Tai Chi has been promoted and classes established for older people. More inquiries were received than could be accommodated in the classes funded.
- A water exercise program for older people, WAVES, has been running since 1990 and SHARE gentle exercise classes since 1993.
- Publication in 1995 and 1998 of a booklet titled *Make A Start* which promotes physical activity amongst older people and provides contact details for local physical activity opportunities. This booklet was distributed through GPs, service providers, seniors organisations and advertised in local print media.

Initiatives in residential care facilities

- A forum for residential care managers and health workers, addressing the issue of falls in aged care facilities, was held in 1996. A second forum for this group is to be held in July 2000; and
- Publication of a falls prevention training package *Putting your best foot forward: preventing and managing falls in aged care facilities*, by CERA in 1998.

Initiatives on hospital wards

- Development and trial of a patient falls risk assessment tool and protocol to reduce incidence of falls on geriatric wards is in progress.

Research projects

- An NHMRC funded research project with the Department of Public Health and Community Medicine, University of Sydney, assessing the impact of occupational therapy home assessments on the incidence of falls was recently completed.
- A community-based falls prevention education research project funded by NHMRC and implemented by the University of Sydney, Cumberland College of Health Sciences and GGRM is in progress.

Program sustainability

The implementation of the strategic plan is funded from the AHSs and other key-stakeholders' core budgets. The HPU seeds some initiatives but alternative funding sources are required for programs to be sustained. Generally however, the HPU seeks funding through other sources, such as Department of Veterans' Affairs, Active Australia, and research foundations to initiate programs as part of the strategic plan implementation.

Program evaluation

All strategies initiated through the plan include an evaluation component and a review of the strategic plan will be conducted in 2001.

A randomised control trial was conducted to evaluate the impact of home modifications on the incidence of falls (NHMRC funded research project). Findings have indicated a significant reduction in the number of people who had sustained a fall in a twelve month period following an occupational therapy assessment of the home environment, in an at risk subgroup (those who experienced a fall in the 12 months preceding the intervention).

Another randomised control trial (NHMRC funded) of a community-based falls prevention education program is in progress.

Mentioned in the Plan was the need for stronger evidence for effective interventions to reduce falls.

Transferability to other settings

The CSAHS has initiated strategies which are conducted in a variety of settings, many of which are primarily targeted to community dwelling people. Community education resources were identified as a feature of programs that could be transferred across settings.

Workforce issues

One of the workforce issues currently being addressed by the CSAHS HPU is the training of non-professional staff conducting gentle exercise programs to increase their awareness of the importance of incorporating balance and muscle strength training to address falls risk. As well as gentle exercise leaders, the HPU is also interested in assessing the knowledge of falls risk factors of staff conducting activity programs, especially physical activity programs, in day care centres for the frail-aged.

Ongoing education and training of clinical staff, dissemination of research findings and translating research into practice are other issues of concern.

5.3.2 Case study 2: Western Domiciliary Care and Rehabilitation Service, North Western Adelaide Health Service, South Australia

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Program description

The establishment of the Western Domiciliary Care and Rehabilitation Service Falls and Balance Clinic in 1997 followed the completion of a research project that involved the identification by clinical staff of individuals at risk of falling. The Falls and Balance clinic incorporates assessment by a multi-disciplinary team. The coordinator of the clinic generally begins the assessment with a home visit. Clients then attend the clinic and are assessed by a geriatrician, followed by a physiotherapist who determines if clinical psychology, nutrition or podiatry input is required. The occupational therapist undertakes a home visit unless this has recently occurred. A report is sent to the client's GP following the assessment. The clinic staff are involved in the implementation of recommendations to emerge from the assessment. This encompasses the introduction of a home based exercise program. Clients are re-assessed eight weeks after the initial assessment generally by the physiotherapist alone who will repeat those parts of the assessment where problems were identified.

Target group

The program targets a specific risk group, older people who have fallen and who are at risk of further falls. Clients of the clinic are usually very frail with a number of intrinsic factors that place them at high risk of falls. The clinic has recently adopted two streams of care. Complex cases are seen by the whole team and non-complex cases are only seen by a physiotherapist. Clients with severe dementia, major system failure or multiple joint pathology are not seen by the clinic due to their inability to participate in the program. About 80 clients participate in the program in a full year.

Program aims

The program provided through the Clinic has clearly stated and measurable aims and objectives. The primary aim is to reduce falls and injury associated with falls, by addressing the intrinsic and extrinsic factors placing the person at risk of falls, such as impaired balance, muscle strength, nutritional state and home hazards.

Program design and development

The design and development of the program has drawn on information in the literature regarding the success with multi-disciplinary strategies which used risk factor abatement (eg. Tinetti et al, 1994). In the research study conducted by the Western Domiciliary Care and Rehabilitation Service prior to establishing the Clinic, individuals identified at risk of falling by clinical staff, were randomly allocated to a control or intervention group. The control group received usual domiciliary care and the intervention group were assessed by a geriatrician, physiotherapist and occupational therapist with a management plan implemented. Follow-up was undertaken approximately three months after the intervention.

The program draws on a diverse range of expertise including a geriatrician, physiotherapist, occupational therapist, podiatrist, and community nutrition worker. Paramedical staff, trained by physiotherapists, are used to conduct home-based exercise programs with individual clients.

Referrals for the Falls and Balance Clinic come from Domiciliary Care Assessors with the Western Domiciliary Care and Rehabilitation Service, the ACAT, GPs or other health professionals. Older people may also self refer.

Access to the program is facilitated through exercise programs being conducted in the home. Transport is arranged, if required, to enable people to attend the Clinic for assessments. As noted above, a follow up assessment after people have been on the program for eight weeks has been factored into the design of the program.

Program content

The program involves a multi-faceted, individualised program designed to address multiple falls risk factors. These interventions include structured individual risk factor assessment and management incorporating access to other health practitioners as required, home based exercise programs tailored to individual needs, environmental hazard assessment and modification and education. The risk factors addressed through the program include

medication use, medical conditions, sensory impairments, foot problems, dizziness, balance and gait, lower limb weakness, inactivity, indoor environmental hazards, fear of falling and nutrition.

Program sustainability

The program was established in 1997 with funds allocated by Western Domiciliary Care and Rehabilitation Service with additional funding provided by a South Australian Health Commission Health Enhancement Grant. There is no specific government funding program, State or Commonwealth, to directly support the Clinic. The Coordinator for the Clinic has reported through the survey that the effectiveness of the Clinic is limited through lack of funds to provide additional staff time. Other improvements to enhance the program's effectiveness include better screening of referrals to ensure their suitability and earlier referral of those at risk of falls.

In terms of the sustainability of the program at an individual level, people remain active clients of the Western Domiciliary Care and Rehabilitation Service. In addition, the improvements gained through the home based exercise program are maintained through exercise, such as walking, being incorporated into their domiciliary care. People may also be linked into community based day therapy programs and may be ready to participate in group exercise programs, their ability to participate in an group exercise program dependent on the strength gained through the home based exercise program. Access to the range of falls prevention activities and programs is promoted through networks of providers involved in falls prevention activity. The Western Domiciliary Care and Rehabilitation Service has initiated in their region a network of allied health workers and are keen to see this network extended to include other relevant providers. The Service is particularly interested in establishing referral pathways that ensure a person's falls risk factors are identified as they move through different settings, from home to hospital or to residential care.

Program evaluation

The program has been evaluated using a randomised controlled trial. Program objectives have been met, either partly or in full. The results of this evaluation are available in a report from Western Domiciliary Care, and are in the process of being prepared for publication.

Transferability to other settings

The interventions offered by the Clinic are tailored to individual needs. Clients of the Clinic at the Western Domiciliary Care and Rehabilitation Service have been referred because they require an individualised risk factor assessment and management program. Home based exercise programs are offered because the individual will need to be physically supported. In a group situation the exercise could subject them to further risk. Home based programs also mean the person is being assisted to safely navigate any hazards in the environment where they spend most time. It also obviates the need for client transport and results in a higher rate of motivation and compliance.

Through the falls network it has initiated in its region, the Western Domiciliary Care and Rehabilitation Service is particularly interested in establishing referral pathways that ensure a person's falls risk factors are identified as they move from home to hospital or to residential care. The Clinic Coordinator's view is that as people move through different settings, intrinsic falls risk factors will in most cases remain the same. The most common exception is likely to be medications. Strategies are therefore required to ensure that a person's falls risk factors are identified as they move through different settings. As well as referral pathways these strategies may include common falls risk identification tools and communication protocols for coordination of client care.

Workforce issues

Staff at the Clinic at the Western Domiciliary Care and Rehabilitation Service have kept up to date with latest research findings through continuous literature searching and through the recruitment of undergraduate and postgraduate therapy students for placements, who through their research uncover new literature. Staff at the Clinic run seminars for other health professionals interested in falls prevention, provide orientation and act as mentors for new staff.

5.3.3 Case study 3: Southern Highlands Division of General Practice, Bowral, NSW

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Program description

The central feature of this program is the development and promotion of resources for GPs to conduct a falls assessment of their clients. These resources include an assessment tool, supported by guidelines (a flip chart titled *GPs Guide to Falls Prevention*), which detail assessment processes and management and referral options post assessment.

A communication and education strategy has also been developed to encourage older people to request a falls assessment by their GP. This has included:

- the development of a three week community education program for seniors;
- *Safety First Seniors*, promoted through GPs;
- information dissemination through the local emergency department reminding older people presenting with a fall or near fall, to visit their GP for a falls assessment; and
- presentations to community based seniors groups and delivery of in-service sessions through aged care service delivery agencies.

Target group

The program focuses on preventing falls in older people over the age of 65. The program also targets GPs for practice improvement in assessment of falls risk.

Program aims

The primary aim is to reduce falls in older people over 65, by assisting practice improvement by GPs and increasing older people's awareness of the range of falls risk factors and preventive strategies.

Program design and development

The design and development of the GP falls assessment tool has been based on other tools identified through a literature search. Particular reference has been made to the work of Dr David Conforti, Director of the Aged Care Assessment Service, Liverpool Health Service, South West Sydney AHS. The development of the assessment tool and other program resources was overseen by a committee which included two GPs from the GP Division.

In response to anecdotal evidence, indicating that falls risk assessment by GPs is more likely to occur if requested by the client, as compared with assessments initiated by GPs, the program has focused on developing a range of communication and education strategies for raising awareness of falls risk factors and preventive strategies amongst older people. The main vehicle for encouraging older people, particularly those who have fallen or at risk of falling, to visit their GP for a falls assessment has been through regularly conducting the community education program for seniors, *Safety First Seniors*. Communication strategies have also targeted staff in hospital emergency departments and aged care service delivery settings.

Older people are able to participate in the *Safety First Seniors* program at no cost. At least 74 older people attended the program in 1999. The GP Divisions' falls prevention program also includes conducting presentations for seniors groups such as Probus, on request. A further 500 people attended these presentations in 1999, as well as in-service training sessions for service delivery organisations.

Program content

The program involves a number of interventions including an individualised risk factor assessment by GPs using a comprehensive assessment tool. Assessment guidelines detail management and referral options post assessment.

The *Safety First Seniors* education program incorporates access to other health professionals. The education is conducted by the Project Officer, the Clinical Nurse Consultant for the GP Division, as well as an occupational therapist and Medicine Information Person. The program incorporates a balance exercise demonstration and short practice session led by the occupational therapist.

Risk factors addressed through the program are medications, medical conditions, sensory impairments, foot problems, footwear problems, dizziness, balance and gait, inactivity, exercise opportunities locally, weight training information for seniors, indoor

environmental hazards, public environmental hazards, how to deal with falls at home and in public, nutrition, information about useful aids eg. hip protectors, and alarm systems.

Resources developed through the program include an assessment tool, supported by guidelines (a flip chart titled *GPs Guide to Falls Prevention*) as well as information for GPs on home exercises and *Safety First Seniors* to distribute to their clients.

Program sustainability

The program was introduced in 1998. Continuation of communication and education strategies, as outlined above, to increase community awareness of falls prevention and remind people to request a falls risk assessment by their GP, depend on ongoing funding to continue the project officer position.

Program evaluation

The program successfully applied to the Royal Australian College of GPs (RACGP) to award 20 clinical audit points to GPs for completing five falls assessments. As part of their continuing education GPs need to obtain a minimum of 20 clinical audit points over 3 years. The number of GPs applying to the RACGP for clinical audit points for conducting falls assessments has been identified as one indicator upon which to monitor the performance of the program. An impact evaluation of the program has not been possible as no baseline data was collected at the commencement of the program.

Transferability to other settings

It is possible that the falls risk assessment tool, developed through this project, could be used in an emergency care unit. People identified at risk of falls could be reminded to request a falls risk assessment from their GP, or alternatively to refer to other appropriate external agencies, for further diagnosis, treatment and prevention. While this type of collaboration was sought with local emergency care units in the district served by the GP division, efforts to disseminate client information regarding falls risk assessment by GPs were sometimes impeded by the day to day pressures faced by staff providing emergency care.

Workforce issues

The project officer for the program has spent time visiting other like programs and attending conferences and seminars to keep up to date with other approaches to addressing falls risk assessment.

5.3.4 Case study 4: City of Whitehorse No Falls Program, Monash University Accident Research Centre, Victoria

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This summary of the No Falls Program has drawn on two sources: the National Falls Stocktake survey and a paper presented, on behalf of the No Falls Research Team at the National Falls Prevention in Older people Forum, Canberra, 1-2 June 2000.

Program description

The Monash University Accident Research Centre (MUARC), in collaboration with the City of Whitehorse, conducted the *No Falls* program, a randomised factorial trial of falls prevention among community dwelling older people, in 1996. The trial took place in the local government area of the City of Whitehorse, a predominantly middle class area in the eastern suburbs of Melbourne.

The program was supported by funding from the National Health and Medical Research Council (Commonwealth Department of Health and Aged Care), Victorian Department of Human Services (Aged Care), City of Whitehorse, Victorian Health Promotion Foundation, Rotary and the National Safety Council.

The program involved three interventions, targeting strength and balance, home hazards and poor vision, designed with a view to implementation through existing structures and services.

Target group

Potential participants were the estimated 13,670 people 70 years and over living in private dwellings in the City of Whitehorse.

Program aims

This research program was designed to determine the impact of three interventions, and their various combinations, on falls incidence. The three interventions were home hazard modification, vision correction and exercise.

Program methods

Participants for the *No Falls* program were recruited through a letter of invitation sent to all people over 70 years of age on the electoral role and a follow up phone call. The program also gained publicity through the local media and through presentations to community groups.

The trial had a full factorial design, with eight groups defined by either the presence or absence of the three interventions. All but one of the groups received at least one intervention; the subjects in the group allocated none of the three interventions were offered a deferred program, which began after the substantive study. Participants (n=1107)

were randomly assigned to one of the eight groups, following an individual assessment covering activity levels, falls history, home hazards, vision, and balance. A nurse conducted assessments in accordance with the *No Falls Assessor's Manual*, developed specifically for the program.

Risk factors addressed in the *No Falls* program included, balance, lower limb weakness, poor vision, and indoor environmental hazards.

Interventions

Strength and balance

The strength and balance intervention involved participation in a weekly exercise class for 15 weeks supplemented with home exercises which participants were encouraged to do daily. The exercises were designed by a neurological physiotherapist to improve flexibility, leg strength, and balance. Some tailoring to individual needs was possible by substitution of each exercise with a less demanding routine.

Resources developed specifically for the program included *No Falls Exercise Program* and *No Falls Home Exercise Sheet*.

Home hazards

The home hazard intervention was based on removal or modification of the identified home hazards by the participants themselves or via the City of Whitehorse Home Maintenance program. Participants were offered three hours labour for home modifications for free. A 'home hazard assessment tool' was developed from existing tools to suit the program's purposes.

Vision

The vision intervention was based on referral to the appropriate eye care provider if vision fell below pre-determined criteria during the baseline assessment, and if the participant was not already receiving treatment for the problem identified.

All participants were required to complete a *Falls Calendar* on a daily basis for a period of eighteen months, returning the calendar at the end of each month to MUARC. Participants who recorded a fall during any month were followed up to gather more information.

Program evaluation

The results of the evaluation of the program are continuing, and being prepared for publication. The program was associated with changes in some of the targeted risk factors, and preliminary results indicate an encouraging impact on falls.

Program sustainability

The City of Whitehorse *No Falls* program was established as a research program and was never intended to be ongoing. However there are some continuing exercise programs. Other actions required to facilitate the uptake of interventions are detailed below under the heading *Transferability to other Settings*.

Transferability to other settings

This program has not been used in any other settings or with different target groups.

Facilitating the uptake of interventions, should the research indicate good evidence of effectiveness, would entail the following.

- Involvement of occupational therapists in assessment for home modifications particularly for older people at high risk of falls. There is good research evidence from other studies that environmental modification mediated through occupational therapists reduces falls among older people with a recent falls history. Three hours labour for home modifications was also provided free through the research program.
- Funding to produce an exercise manual and any other resources for public dissemination.
- With respect to the exercise intervention, community based programs would not necessarily have to provide free transport and free classes, as provided through the research program. Obviously these measures increase participation, but it is probably unrealistic for widespread implementation. Classes would need to be low cost, and exercise program providers for older people obviously need to consider transport as an issue for participation.

Workforce issues

On the job training and supervision were provided for those involved in the implementation of the *No Falls* program. Program staff included Registered Nurses and VICFIT exercise leaders, many of whom already had a good level of training.

However, widespread implementation of the interventions would not necessarily require registered nurses. In the context of the research program, the nurses' main role was to conduct baseline interviews and assessments that were required to reliably collect data for analysis. Vision screening can be picked up through GPs. However it is the research team's view that exercise classes need to be led by VICFIT or similarly qualified instructors.

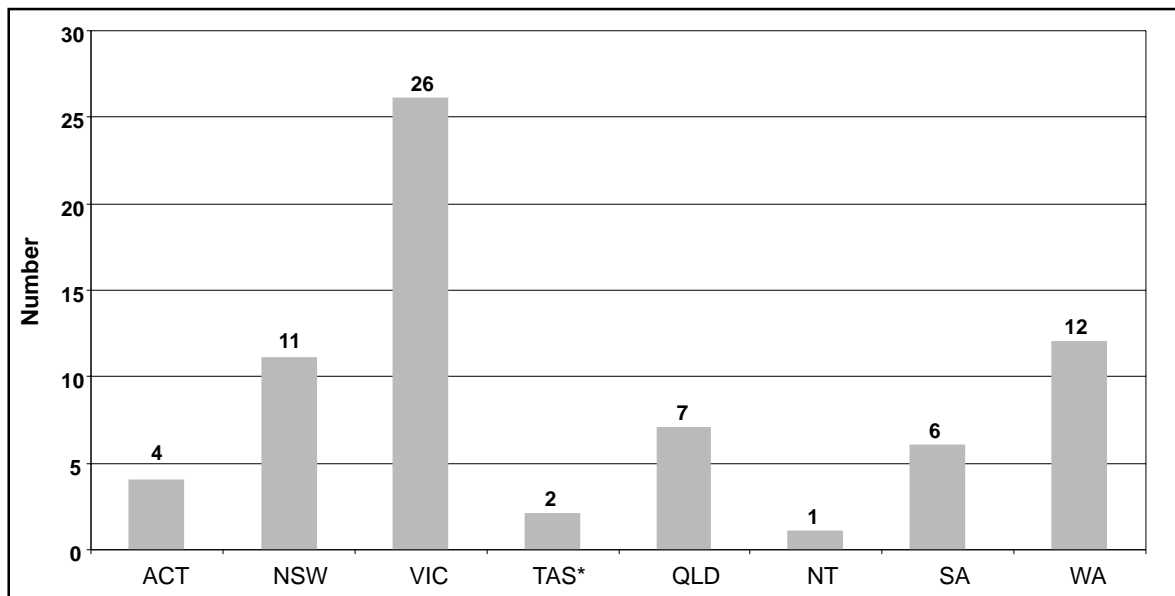
5.4 Survey results (graphs and tables) for the community setting

Sixty nine of the 122 scanned programs were conducted in a community setting. The results for community programs have been summarised in section 5.1, and are presented in figures in this section.

5.4.1 Location by state

Most of the responses from community falls prevention programs came from Victoria, followed by Western Australia and New South Wales.

Figure 5.1 Survey respondents by state



*Tasmania data also includes one program from King Island

5.4.2 Falls risk factors addressed

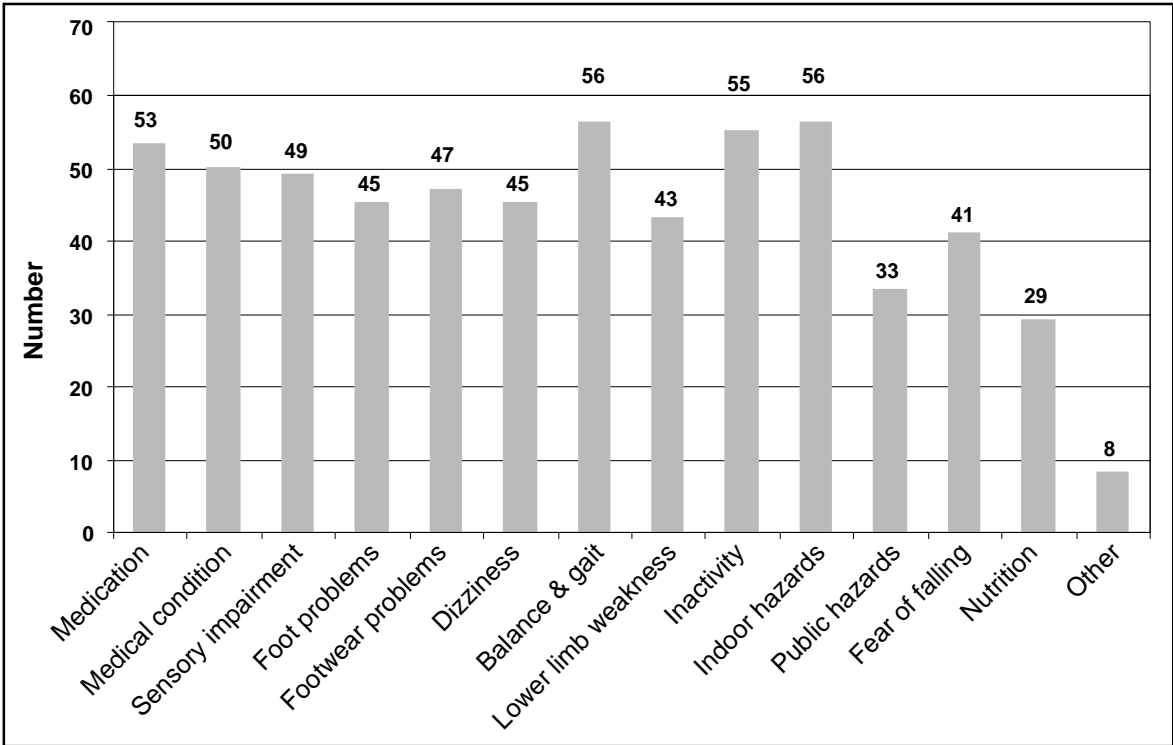
Almost all of the community programs addressed multiple risk factors (n = 64). An average of nine falls risk factors were addressed per program.

The risk factors addressed are highlighted in figure 5.2 overleaf, with most of the common falls risk factors addressed by most of the programs. The four most common falls risk factors addressed by community based falls and falls injury prevention programs were:

- balance and gait (n=56);
- indoor hazards (n=56);
- inactivity (n=55); and
- medications (n=53).

In total, 35 programs addressed a minimum of these four most common risk factors. When analysing those programs which did address at least these four risk factors (n=35), the most common program types were education, environmental assessment, exercise, and individual assessment. These were also the four most common program types in the community settings when all programs were analysed (figure 5.3).

Figure 5.2 Risk factors addressed



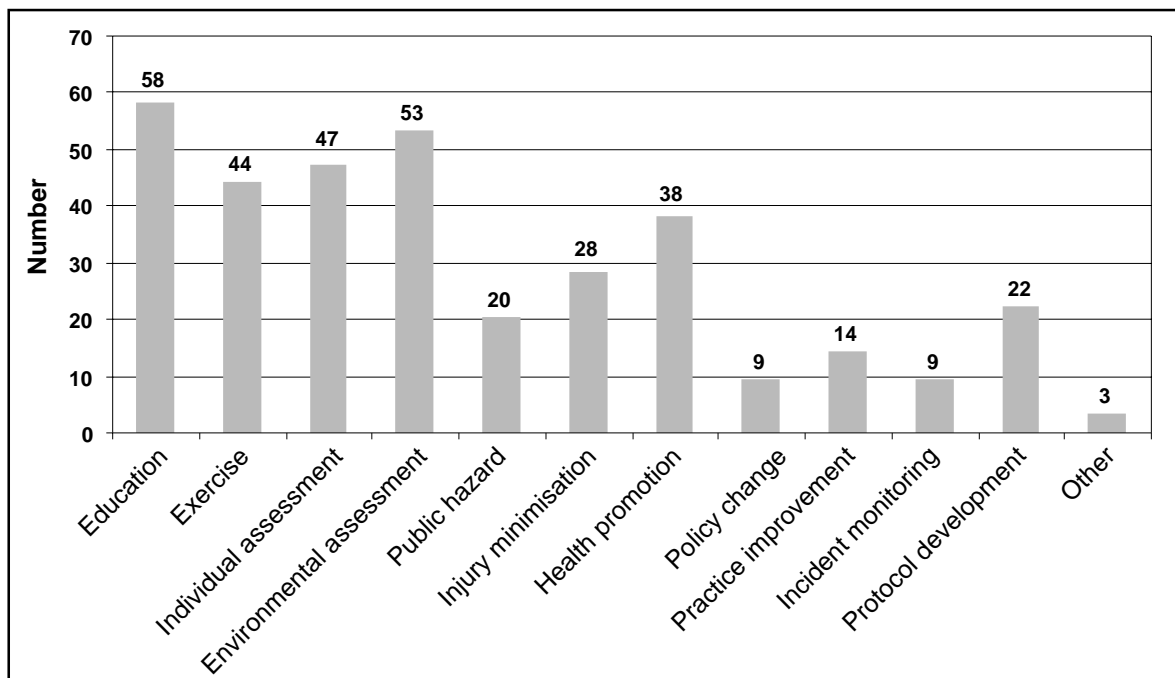
Note: Multiple choices permitted

5.4.3 Type of falls/falls injury prevention program

The 69 community focused programs include a range of falls/injury interventions. Most focused on education, individual and environmental assessment, and exercise.

The majority of programs implement a number of interventions (n=51). It is interesting to note, that a high proportion of community programs implement education and environmental assessment programs, although there is little research evidence supporting either of these approaches (although environmental assessment by an occupational therapist has recently been shown to be effective in reducing falls rates in a sample of “at risk” community dwelling older people). A smaller, but still substantial proportion of programs were based on individual assessment and exercise approaches (for which there is stronger research evidence supporting these approaches in community settings) (DHAC, 2000).

Figure 5.3 Type of falls/injury prevention interventions

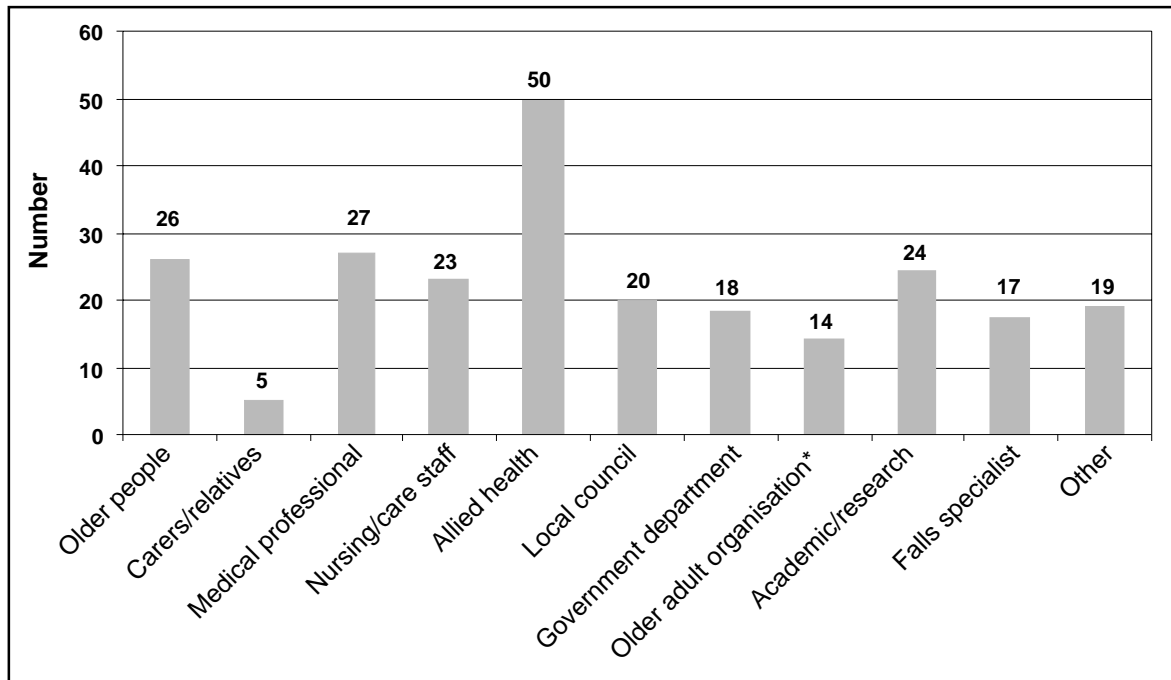


Note: Multiple choices permitted

5.4.4 Who was involved in program development?

Allied health professionals were almost twice as likely to be involved in the development of community based falls and falls injury prevention programs than other groups (figure 5.4). On average, four different groups were involved in development of community based programs, indicating considerable networking and collaboration between groups. A diversity of groups involved in program development was considered to be important criteria in the guidelines for evaluating falls prevention programs (NARI, 1999).

Figure 5.4 Who was involved in the development of the program?



Note: Multiple choices permitted

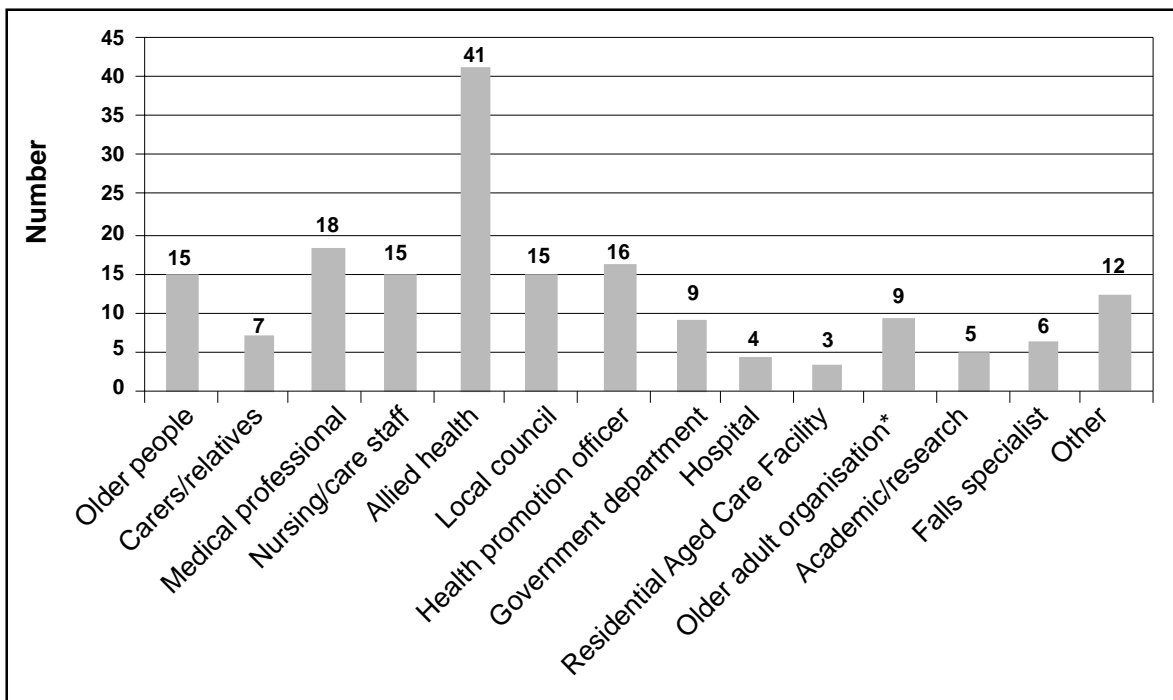
*Older adult organisation = Older adult/ethnic/community organisation

Other includes: Health Promotion Officers, emergency services, project officers of Division of GP.

5.4.5 Who implemented the program?

Allied health staff were clearly the group most commonly involved in implementing the majority of community falls and falls injury prevention programs (59%). Older people, consumer organisations and carers and relatives were also commonly involved in implementing falls and falls injury prevention programs. An average of three groups were involved in the implementation of community based falls prevention programs. Involvement of the target group (commonly older people, carers and relatives, and consumer organisations) has been reported as important in the development and implementation of falls and falls injury prevention programs (NARI, 1999).

Figure 5.5 Who implemented the program?



Note: Multiple choices permitted

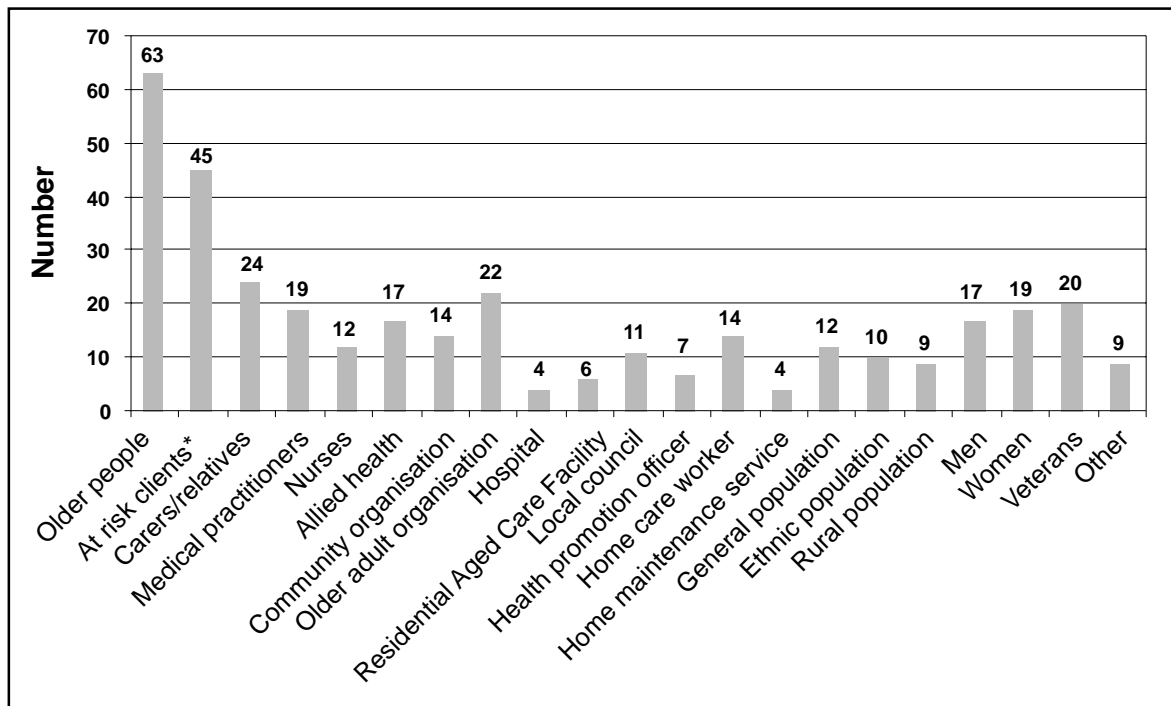
*Older adult organisation = Older adult/ethnic/community organisation

Other includes: Program/project officer, service groups, licensed clubs, safety officer, quality co-ordinator.

5.4.6 Target groups

Older people generally, at risk clients who have fallen, and carers/relatives were the main groups who were the focus of community based programs. Few programs were gender specific. A range of workforce groups were also targeted by many programs, including medical practitioners, nurses, allied health staff and home care workers. These programs were often education programs aiming to improve identification of risk, and management or referral processes.

Figure 5.6 Target groups



Note: Multiple choices permitted

*At risk clients or clients who have fallen

5.4.7 Year that program was introduced

Many of the community based falls and falls injury prevention programs are relatively new, with 59 per cent having been introduced since 1998. This links with an increasing focus at both state and national level of the significance of falls and falls related injuries as a major public health problem for community dwelling older people from early 1990's onwards. It would be expected that the full effect of many of the relatively new programs would not be evident in key indicators for up to several years.

An important issue to be managed well with so many new programs recently developed, and with the likelihood of this trend continuing for at least the next few years is to optimise communication between programs regarding:

- what works;
- what doesn't work;
- dissemination of program outcomes; and
- what resources are available.

5.4.8 Reasons for introducing the program

The reasons for the introduction of the program were primarily based on a health professional initiative (n=45) and secondly on local data (n=33). Approximately one third (n=25, 36%) of the programs suggested that available funding was the reason for program introduction.

5.4.9 Incorporation of existing programs into program development

It is interesting to note that 55 per cent of programs reported that they had drawn on existing programs when setting up. This has the advantage of minimising duplication of potential pitfalls, and sharing of established resources. It also presents the risk that unevaluated ineffective programs may be perpetuated.

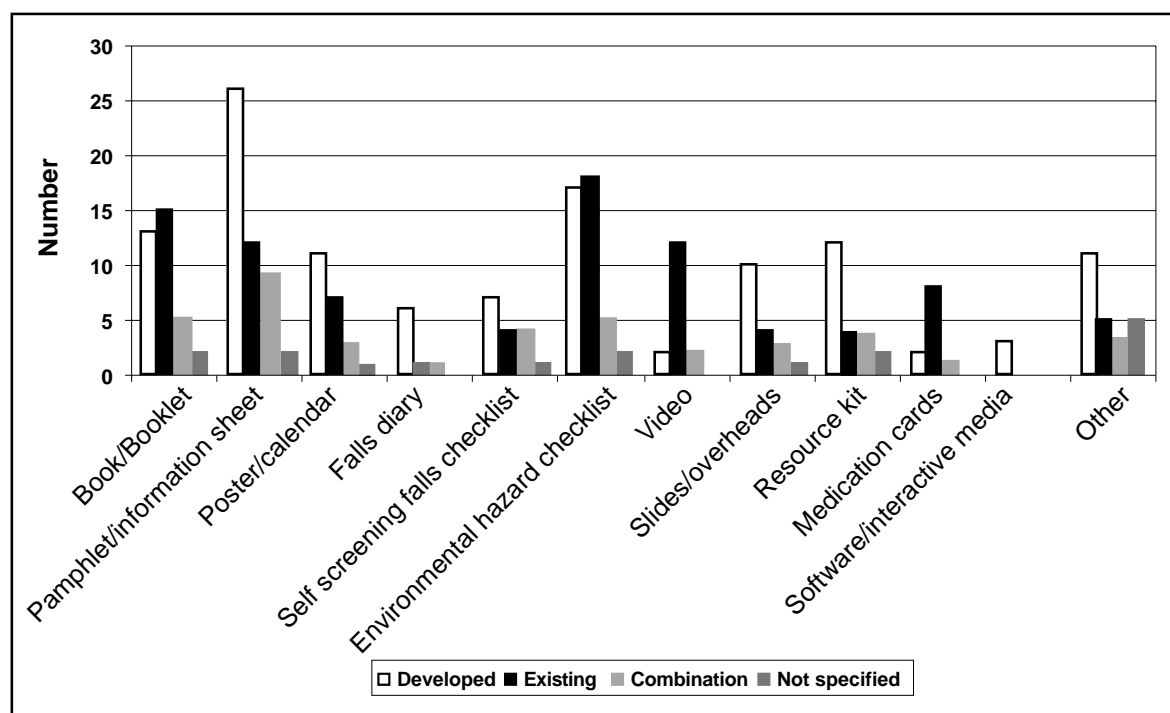
5.4.10 Resources/tools used

A variety of resources were used in community based falls and falls injury prevention programs (Figure 5.7). Pamphlets and environmental hazard checklists were the most common resource developed specifically for a program, with a third of programs developing their own pamphlets/information sheets, and a quarter of programs developing their own environmental hazard checklist. This is likely to represent considerable duplication of effort and resources in the development of these resources.

Most common type of resources which were used from existing programs were environmental hazard checklists, books/booklets, and videos. In particular, videos are a relatively expensive resource to produce, increasing the importance to utilise existing products if they suit the program needs.

Greater detail about the specific resources used, including those in languages other than English have been reported in sections 5.2.7 and 5.2.8 respectively.

Figure 5.7 Resources/tools used



Note: Multiple choices permitted

5.4.11 Program access

In most cases, programs had several avenues of access including referral by self (n=46), GP (n=41), or other health professionals (n=43). Only 25 per cent of programs had only one avenue of access.

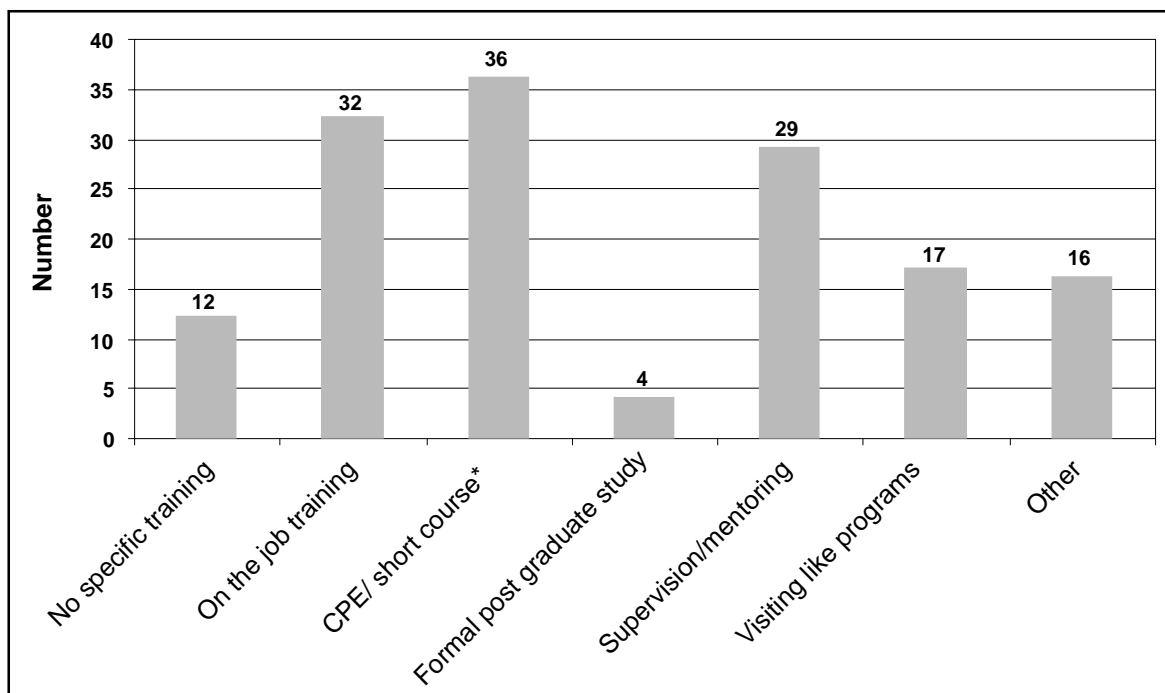
5.4.12 Transfer of program to other settings

The majority of community programs (70%) had not been translated to other settings.

5.4.13 Type of training provided for those implementing program

Workforce training in community based falls and falls injury prevention programs most commonly involved more than one avenue (58% of programs). Most commonly, on the job training, supervision/mentoring, and short courses (CPE) were the avenues used. Twelve programs (17%) of programs offered no specific workforce training options.

Figure 5.8 Workforce training provided to program implementers



Note: Multiple choices permitted

*CPE (Continuing Professional Education)/short course/lecture

Other includes: Collaboration/networks/discussion with other professionals/stakeholders, employment of qualified staff.

5.4.14 Program sustainability

An important issue which needs to be considered in falls and falls prevention program development and implementation in the community setting is that of sustainability. Only programs which are currently running, or have run in the last 12 months were included in the national falls stocktake analyses. Six per cent (n=4) of programs had stopped running in the past 12 months. Most common types of programs among those that had stopped running were environmental hazard assessment, exercise, individual assessment, or injury minimisation component.

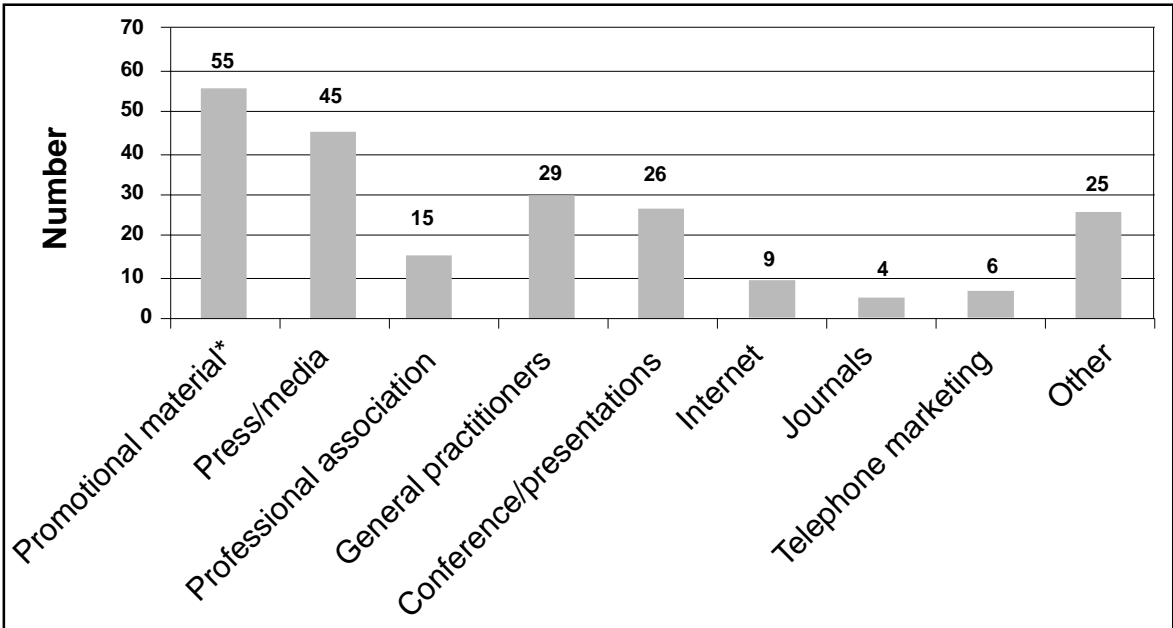
Three of the four programs that were completed stated that completion was pre-planned, with one of these also stating that the program outcomes had been achieved. The fourth program identified funding as the reason for the program finishing. In addition to the four programs which have stopped running in the past 12 months, a further four programs that are currently running indicated they have a pre-planned completion date. Funding issues were also cited as a factor in four of the eight programs.

Most of the programs (n=52) which were not completed, or pre-planned to finish at a set time, were judged by the person completing the survey to be sustainable. Reasons given for programs being judged to be sustainable included permanent funding, funding for three years, permanent staff, incorporated into job description, and cost recovery implementation. Most commonly reported factors associated with program sustainability were program duties being incorporated into job description of staff, and availability of permanent staff. Of the eight programs considered to be unsustainable, two were reported to be due to program design, three were related to funding, two reported staffing and funding issues and the last program listed staffing, funding and program design.

5.4.15 Promotion of programs

Over three quarters of programs used promotional material such as fliers, pamphlets and newsletters to promote the program (figure 5.9). Press and local media were also frequently used. GPs were used to promote the programs in 42 per cent of programs. Marketing of programs was done through a number of avenues directly to older people and also via the health professionals and community groups with whom they interact (figure 5.10). Only three programs did not use any of the listed promotional avenues. The average number of avenues for program promotion was three.

Figure 5.9 How programs were promoted

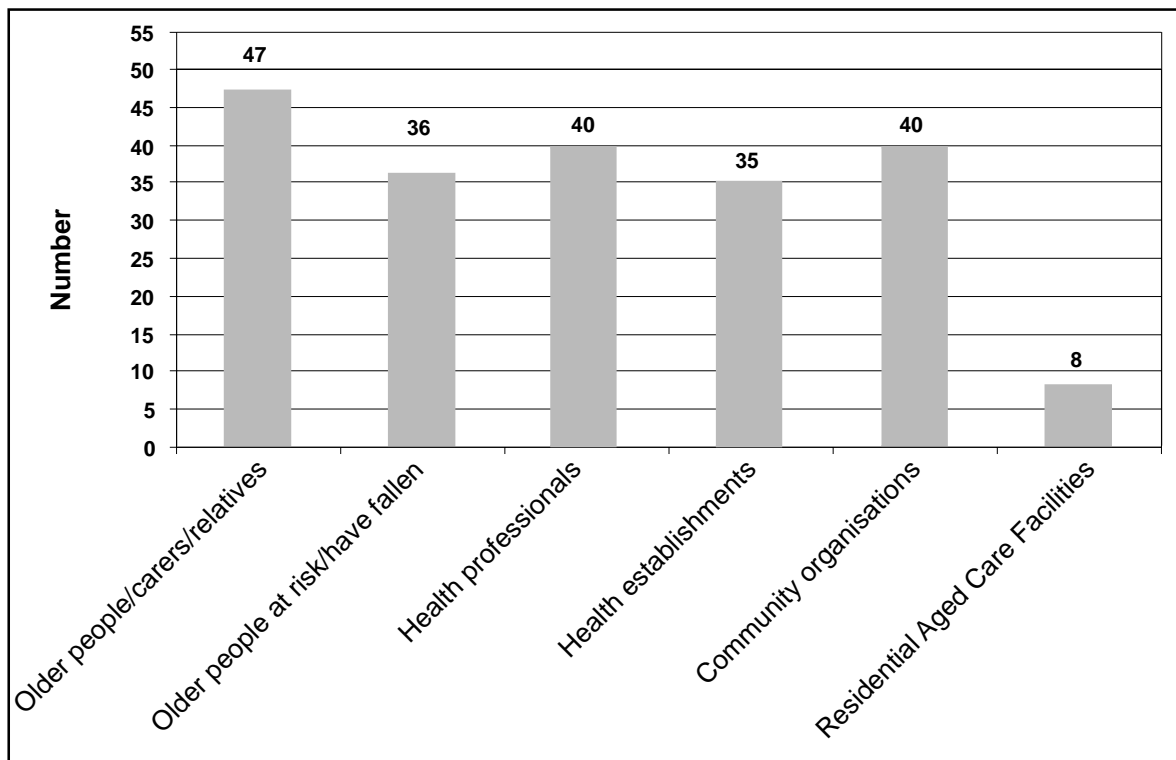


Note: Multiple choices permitted

*Promotional material – flyers, pamphlets, newsletters

Other includes: Contacting community groups, events, displays, expo, open day, launches.

Figure 5.10 Who received promotional material?



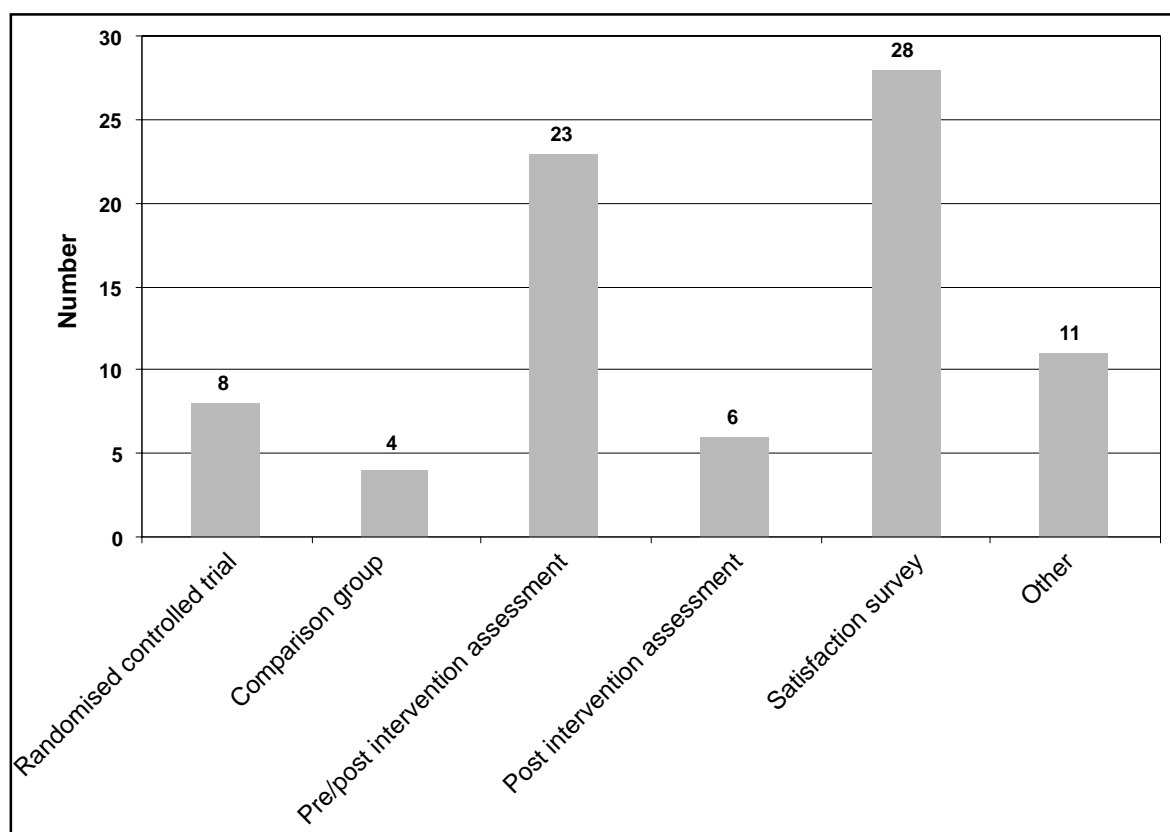
Note: Multiple choices permitted

Note: Local council was not included as a separate group, but most likely included in community organisations.

5.4.16 Program evaluation

The majority of programs (55%) reported that some form of evaluation had been conducted or was planned. Most commonly, the evaluations were conducted in house (n=30). Most evaluations comprised a pre-post intervention assessment or a consumer satisfaction survey (Figure 5.11). These types of evaluation provide information on the process and to some extent, the impact of programs. However, they do not provide an evaluation of the outcome or program effectiveness. Eight programs utilised a randomised controlled trial design.

Figure 5.11 Type of evaluation



In thirteen programs (19%), program objectives were achieved. In the majority of those reporting that their objectives were “partly met” (n=29), this was because the evaluation had not been completed to date.

5.4.17 Program funding

The three main sources of primary funding for falls and falls injury prevention programs in the community setting were:

- own budget (core funding) (32% of programs);
- state government (30%); and
- Commonwealth government (20%).

It should be noted that many of the organisations involved in the community based programs were health facilities such as community health centres and hospital out-patient services, and that the core budget of many of these ultimately is derived from a state or commonwealth source.

For the majority of programs an additional stream or specific funding was not identified.

In kind support

Thirty four programs responded to the question regarding in kind support for their program. Eight indicated that they received no in kind support. Very few respondents were able to estimate or provide a dollar value for the in kind support received. Infrastructure support (car, desk/office space, computers etc) was the most frequently cited response (n= 9), three also specified receiving administrative support. One respondent stated this infrastructure support was available for 3 years, one estimated the value of the infrastructure support to be \$3000, and one stated all core funding for structure/staff was in kind.

Eight respondents received support from partner/other agencies. Most did not stipulate the nature of the support received. Responses included:

- Participation in the planning and implementation of the program of up to 30 hours per agency representative;
- Support from Allied Health Professionals;
- Co-operation and support from various community groups;
- One organisation's membership were asked for support as required; and
- Support from a pharmaceutical company for the program launch.

Three respondents provided values without detailing the in kind support received (one cited \$320,000 per annum, and two cited \$5,000).

Other in kind support included:

- The use of a local council pamphlet;
- A session facilitator's time to run the sessions and academic/practitioners assisted with the recruitment of staff for the sessions;
- Mailouts by organisations to promote resources, articles in newsletters, volunteers to man displays and the dissemination of resources;
- Existing staff (health professionals) time for planning and initial implementation, and contributions by two honours students and a part time masters student.

6.0 Falls prevention activity in hospital settings

Fourteen of the 122 falls and falls injury prevention programs (11%) completing the falls stocktake survey were targeting their program to reduce falls and falls related injuries among older people in hospital settings. This section provides a breakdown of responses for the hospital setting.

6.1 Summary

Many of the trends observed for the overall responses to the stocktake survey were similar when analysed separately for the hospital setting. Key issues arising are listed below.

- a) Most common program types were individual assessment (86%), education (79%), practice improvement (79%), and incident monitoring (71%). In contrast to the community setting, environmental assessment/modification (57%), and exercise (36%) were less commonly used interventions. All programs addressed multiple falls risk factors. Most common risk factors addressed differed a little from the community setting, with medication, medical conditions, and sensory impairment being most often addressed, and balance and gait, and indoor hazards being slightly less frequently addressed. Although inactivity was addressed by over half (64%) of the programs, this was a substantially lower proportion than addressing this risk factor in the community setting.
- b) Falls and falls injury prevention programs in hospital setting more commonly target at risk clients more than older people generally, in contrast to the community setting.
- c) Nursing staff (93%) were most commonly involved in the implementation of programs in hospital settings, compared with the majority of programs being implemented by allied health staff in community settings. Allied health staff were still involved in the implementation of many programs (71%). Medical professionals were involved in the implementation of only two of the 14 programs (14%).
- d) Almost two thirds (64%) of the programs in hospital settings had commenced in 1999, or 2000, indicating a recent increase in falls prevention activity in the hospital settings.
- e) Almost all of the hospital based falls and falls injury prevention programs were introduced as a response to local data (93%), although 64 per cent were also at least in part due to a health professional initiative. In contrast to community settings, a very small proportion (14%) were initiated at least in part as a response to funding being available (compared to 36% in community settings).
- f) Access to hospital based programs was quite different to that reported in community settings, with the majority reporting other. Under this category access was generally available to patients of the hospital or on admission to hospital.

- g) Only one hospital based program reported that it had been transferred to other settings (7%). This low rate is less than half that reported in the community setting.
- h) Most common forms of workforce training for hospital staff involved in falls and falls injury prevention programs were short courses and on the job training.
- i) Eleven of the 14 programs reported they were sustainable, a similar proportion to the community setting. Similar to the community setting, the major factor associated with sustainability of hospital based falls and falls injury prevention programs was incorporation of program duties into the job descriptions of staff (57% of programs).
- j) None of the listed options for promotion of hospital based falls prevention programs were commonly used. Half of the programs responded as other, which included inward/hospital training/education sessions and meetings. Promotional materials were often widely distributed, most commonly to health professionals and health establishments.
- k) A wide range of resources/tools were used in hospital based falls prevention programs. These most commonly included pamphlets/information sheets, and slides/overheads for education programs. Six programs listed other resources/tools, which included incident forms and visual cues (signs, stickers, wristbands). The majority of resources/tools used developed specifically for the program, which may indicate a degree of duplication of resources/tools. A small number of programs used existing books/booklets, pamphlets/information sheets, environmental hazard checklist, video, resource kit, and a medication card.
- l) Similar to the other settings, the largest proportion of programs were funded from their own budget (core funding), with one program being funded by a state government.
- m) Estimates of participation numbers were provided by less than half of the programs, and these varied widely, from 50 to 2300. The median number of participants in falls prevention programs in the hospital setting reporting this data was 580.
- n) All programs except one reported no cost to participants, with the one program charging participants the costs of physiotherapy sessions.
- o) Program evaluation has been undertaken in half of the hospital based programs, with a further 21 per cent reporting that they intend to undertake an evaluation. Most commonly, pre/post assessments, or just post intervention assessments were the method of evaluation used (36% and 21% respectively). None of the program evaluations reported in hospital settings were undertaken as a randomised controlled trial. This may in part be due to the difficulties of utilising this approach in the hospital setting. It also reflects the published research available on falls prevention in hospital settings. Similar to the community setting, over half of the programs evaluations were conducted in house.
- p) A range of objectives were identified for the falls and falls injury prevention programs in hospital settings. Over two thirds reported a reduction in falls or falls related injuries as a goal. Other objectives involved changes in process or impact measures, such as increasing staff or patient awareness of falls risk factors, improving environmental safety, and improving patients balance and mobility.

6.2 Thematic Analysis of Descriptive Data

A number of the questions in the stocktake survey were open ended, allowing respondents to answer the questions without being limited to set responses. The amount written and nature of comments varied widely between respondents. The project team have reviewed all responses, and developed key themes from these responses. These are described below.

6.2.1 Key objectives of the program

A range of program objectives were reported. These included:

- reducing falls/falls injury (n=10);
- health promotion, by raising the awareness and educating health professionals and patients/relatives of fall risks and strategies (n=2);
- improving environmental safety (n= 2);
- improving the physical status of individuals - balance/mobility/strength (n=2); and
- developing/accessing a tool to assess the risk of falling (n=2).

Other stated aims in single instances included reducing fear of falling, increasing referrals, minimising the use of restraints, developing best practice, developing a database of falls in hospitals, implementing and evaluating a multi-strategy approach to falls prevention and evaluating the validity of a risk assessment tool.

6.2.2 Transferability of the program

In hospital settings only one program was transferred to another setting - a community setting. Patients leaving the hospital will be followed up in community/transitional care settings by primary health nurses/therapists, and then by their GP when returned to their community. The program involved integrating three programs for holistic care.

Three programs indicated that their program was not transferable because they were target/setting specific ie. inpatient, acutely ill older people not in their own environment. One respondent also highlighted the diversity within the hospital setting, indicating a need for a rehabilitation specific assessment tool because client management was different to that in an acute setting.

Further limitations to transferability identified in the survey responses were:

- limited access to multi-disciplinary teams (n=2); and
- busy workloads - nursing staff are seen as the key people to activate the program and are often short staffed and do not always have management support.

An aspect of one program which was considered possibly transferable to another setting was the staff education program and incident report.

6.2.3 Barriers and enablers to target group participation

The survey asked respondents to describe any barriers or enablers they discovered to the target group participating in the program. Respondents tended to describe barriers rather than enablers.

Four out of the 14 hospital based programs identified a barrier to the participation of the target group. The barriers were patient transport, funding, co-operation, and the cognitive abilities of the target group. No further details were provided by the respondent noting co-operation as a barrier. No enablers to participation were identified.

6.2.4 Problems and issues

Respondents were asked to detail any problems or issues associated with implementing their program.

Issues associated with staffing were identified by seven of the 14 respondents. In contrast to the community based programs staff resources were highlighted as a problem by only one of these seven respondents. Other issues were staff compliance and attitudes to the program, varying degrees of interest by staff with some not regarding falls prevention as part of their role, and limitations associated with falls prevention education for staff not being classified as compulsory. Two respondents also noted reaching the target group as a problem. Lack of time and the validity of the risk assessment tool used were identified as problems in single programs.

Given that staff in hospitals are key stakeholders in the implementation of falls prevention programs in this setting, there appears to be a need for optimising staff involvement. Strategies to enhance staff knowledge in the area of falls prevention, to facilitate behaviour change, and improve compliance and enthusiasm for staff with falls prevention programs need to be developed, implemented and evaluated.

6.2.5 Enhancements to program effectiveness

Staffing and education issues were the main themes that emerged in relation to improving program effectiveness in hospitals. These include the need for:

- more staff time to implement the program;
- a paid project co-ordinator;
- someone to evaluate the program;
- more commitment by medical staff to records and write up outcomes/diagnosis of falls;
- multiple/longer staff education sessions addressing interventions for specific risk factor; and
- more time for staff education.

Other issues cited were funds for special equipment, building modification and a less sensitive risk assessment tool (further details were not provided).

6.2.6 Service gaps and areas for improvements

The most commonly cited gap in falls prevention activity in the hospital setting was related to inadequate workforce training. A smaller proportion of respondents also identified inadequate resources, poor networking between those involved in falls prevention at all levels, and insufficient research as other gaps warranting attention.

Similar issues were raised when respondents were asked what areas of falls prevention needed improvement. Thirty six per cent of programs identified the need for improved access and quality of workforce training. Increased collaboration between all key stakeholders in falls prevention activity, and improved resources and funding were also reported by a smaller proportion of respondents. Single responses also indicated a need for retraining of the ability for older people to get up from the floor after a fall, improved incident monitoring/data collection, and more rigorous evaluation of programs.

6.2.7 Resources utilised/developed

A relatively small number of falls/falls injury prevention resources were reported being used in the hospital setting. The most common resources were pamphlets and posters, and slides/overheads for education programs. Resources identified by survey respondents were:

- patient falls risk assessment tool (n=4) ;
 - *Falls Risk Assessment Tool (FRAT)* (n=1);
- falls prevention resource kit (n=1);
- *Think Pink* falls risk scheme (pink stickers used for those at risk) (n=1);
- pamphlets:
 - *What to bring to hospital;*
 - *Preventing falls for seniors and carers;*
- posters:
 - *Don't let falls get you down;*
 - *Stay afloat/aloft;*
 - *Wear safe slippers;*
 - *Use the safety walking track;*
- adhesive label This medicine may cause dizziness when you stand up quickly. Ask your Doctor or pharmacist for advice;
- medication cards; and
- falls prevention flow chart.

A number of hospital based programs also used resources which were developed in other settings. These included:

- CERA education kit *Putting your best foot forward* (n=1);
- North Coast Public Health Unit *Stay on your feet book* (n=1);
- Queensland Health video *Staying on living at home safely* (n=1); and
- NSW Health *Home safety checklist*.

6.2.8 Resources in languages other than English

No resources were available in languages other than English in the hospital setting.

6.3 Case studies

A small number of programs responding to the National Falls Stocktake survey have been selected for more detailed presentation in the form of case studies. These programs were selected as examples which met four key criteria representing previously identified aspects of best practice. These criteria included that the program incorporated more than one intervention type, that it was sustainable, that it had undertaken, or planned to undertake a formal evaluation, and that the program objectives were either fully or partly met.

Two of the case study programs operate through hospital emergency departments, and involved coordinated care programs for those admitted to hospital as a result of their fall related injuries, or those discharged home after acute management of their falls related injuries. While these programs have an integrated approach to falls prevention across the continuum of care, they have been included under the broad classification of hospital based programs.

6.3.1 Case study 1: Aged Care Services, Caulfield General Medical Centre, Victoria

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This summary of the above program has drawn on two sources: the National Falls Stocktake survey and an abstract, *Prediction and Prevention of Falls in an Aged Care Hospital Unit*, prepared by the research team, W Gee, S Scharf, C Fong, D Fowler and D Fonda, for the Annual Scientific Meeting of the Australian Society for Geriatric Medicine, Cairns 2000.

Program description

In 1999, the Caulfield General Medical Centre trialed a risk assessment tool in a general aged care hospital ward. The falls risk assessment tool, known as STRATIFY, was found to have a high level of reliability and validity in an elderly care unit in the United Kingdom (Oliver et al., 1997). The assessment tool was applied over one month to 56 consecutive admissions to a general aged care hospital ward at the Caulfield Hospital and evaluated for its reliability prior to being applied to all admissions to the ward, an estimated 720 in a full year.

The program involves structured individualised risk factor assessment and management incorporating referral to other health professionals, such as physiotherapists, occupational therapists and dieticians, as required.

Target group

The target group for the program are those admitted to the aged care hospital ward, which is a general ward providing evaluation, acute care and rehabilitation. Those identified at high risk receive a multi-disciplinary falls prevention program. This involves referral to other health professionals to develop an individualised program. Those assessed at risk of falls were followed up prospectively.

Program design and development

The program aims to identify older patients at high risk of falls on admission to hospital and to reduce the rate of falls and injury in the hospital. It draws on published evidence, in particular, Oliver et al, *Development and evaluation of evidence based risk assessment tool (STRATIFY) to predict which elderly inpatients will fall: Case control and cohort studies*, British Medical Journal, 1997, pp 1049-53.

The program also intends to increase the awareness of medical and general hospital staff that some falls are preventable by involving them in program development and implementation. A multi-disciplinary falls working group has been established to oversee the program and is responsible for continuous auditing of the rate of falls in the hospital.

Program content

The program addresses multiple risk factors for falling including medications, medical conditions, sensory impairments, foot problems, footwear problems, dizziness, balance and gait, lower limb weakness, inactivity, fear of falling and nutrition, through referrals, as required, to health professionals. There is no one standard program, such as an exercise program.

The program also focuses on environmental hazard assessment and modification. Three electronic beds have been purchased by the hospital to be used by those most at risk.

As well as raising awareness of falls prevention by involving staff in program development and implementation, there is a formal education component to the program to improve practice among medical staff. The education program is provided by an Advanced Trainee Registrar in Geriatric Medicine to medical staff.

Program sustainability

The program has been funded through the hospital's own budget. Permanent staff are involved in implementation of the program and the program duties have been incorporated into staff job descriptions. However, in the Stocktake survey responses, the hospital reported that the program could be made more effective through more staff time for implementation, a paid project coordinator to provide central coordination of falls prevention activities, funds for special equipment, such as electronic beds, and building modifications to the hospital to address environmental hazards. Inadequate staff resources have hindered the implementation of the program.

Any actions to facilitate ongoing maintenance of improvements to reduce an individual's risk of falls when they leave hospital are made through routine discharge planning.

Program evaluation

The process by which the program was evaluated involved a pre and post intervention assessment and a post intervention assessment. Falls were defined in a standardised way and recorded prospectively following an individual's falls risk assessment. Interventions were implemented primarily in the high risk group. Findings confirmed the assessment tool, STRATIFY, was reasonably effective discriminating between high and low risk and that the rate of falls in the hospital ward had decreased.

There was no significant change in the rates of serious injury although the incidence of serious injury was low in both the pre and post intervention groups.

Transferability to other settings

The program, currently in its pilot phase, is likely to be applicable to other hospital wards. It is possible that the risk assessment tool and falls prevention program would be applicable in a residential setting such as a nursing home.

Workforce issues

Through the Stocktake survey, the hospital identified workforce training to increase awareness in general medical staff that some falls can be prevented as one of the gaps to be addressed to improve falls prevention for older people. Through the program some training has been provided with opportunities for staff to attend short courses, lectures, and to be mentored by experienced practitioners.

Better networking was identified as an improvement needed in the area of falls prevention to generally facilitate communication between like programs.

6.3.2 Case study 2: Flinders Medical Centre, South Australia

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Program description

The Flinders Medical Centre (FMC) is responsible for the implementation of the *National Demonstration Hospitals Program (Phase 3) (NDHP3) Aged Care Project: Falls Prevention Program*, introduced in 1999. This program comprises two components. The first, involves the screening of all patients who present to FMC with a falls related injury, including those admitted and those who are returned home or to other dwellings, and the subsequent development of individual intervention plans for those identified at risk of falls. GPs are involved in continually monitoring these plans with clients upon their discharge from hospital.

The second component involves establishing a regional network to develop a co-ordinated and strategic response to falls prevention by the primary care service system.

Target group

The program targets people 65 years and older presenting to FMC with a fall related injury. The program also targets key stakeholders, including hospital medical and nursing staff, allied health professionals, GPs, community organisations, local councils and aged care facilities, to achieve a coordinated regional response to falls prevention.

Program aims

The program is directed at falls reduction and fracture prevention practices that:

- are satisfactory to both consumers and GPs; and
- reduce falls and falls related presentations to the Emergency Department.

Program design and development

The design and development of the program has drawn on information in current literature and has been informed by program generated data, which revealed a high rate of falls in the area. A database of patients presenting at the FMC emergency department, established through the project, identified over 450 falls related presentations to the Emergency Department over a 22 week period that involved people over the age of 65 years. Of these, 38 per cent had related fractures.

The program design has also been informed by the research study conducted by the FMC in which individuals identified at risk of falling by a clinical nurse were randomly allocated to a control or intervention group. The control group received usual inpatient care and the intervention group received an individual risk factor assessment and a multi-factorial intervention plan was implemented. Follow-up was undertaken approximately six months post recruitment.

The program is led by the Head of the Department of Rehabilitation and Aged Care (across the FMC and the Repatriation General Hospital) and a senior geriatrician. A steering committee for the project has been established and includes consumer representation. Input from consumers has also been received through a survey to ascertain consumer views on the barriers to implementing interventions. Other stakeholder interests, such as GPs, have been canvassed through focus groups and through regional network meetings, established as part of the project.

A small project team of allied health professionals, nursing staff and other key project staff meet regularly.

Program content

The program involves a structured individual risk factor assessment of older people presenting at the Emergency Department with a falls related injury. A multi-factorial intervention plan is offered and developed in partnership with the patient and carer. These interventions include referral to exercise programs in the region, which focus on balance and are specifically designed for those with a history of falling, environmental hazard assessment and modification (in the hospital and at home) and education.

The patient's GP receives the individual's intervention plan and best practice guidelines for managing patients who have fallen to assist them in working with the patient to reduce the risk of further falls. A database of falls prevention services, achieved through the establishment of a regional falls network, is also made available to GPs and other health professionals and is to be available on the Internet.

Risk factors addressed through the program include medications, medical conditions, sensory impairment, foot and footwear problems, dizziness, balance and gait, lower limb weakness, inactivity, indoors and public environmental hazards, fear of falling and nutrition.

The program has developed education materials, including pamphlets, leaflets and posters, in addition to a falls diary for patient use and best practice guidelines for managing patients who have fallen for use by GPs and other health professionals.

Program sustainability

While the follow-up for the randomised trial will be completed in August 2000, the expiry date for the (NDHP3) *Aged Care Project: Falls Prevention Program* is 31 January 2001. However, to ensure the program is sustainable, screening of people presenting at the Emergency Department has been incorporated into the functions of the Physiotherapy Department and the Emergency to Home Outreach Service (ETHOS).

Program evaluation

Evaluation of the program has already been implemented and conducted in house in the form of randomised controlled trials. The purpose of the evaluation is to measure whether the interventions implemented impact on patient outcomes in the area of falls reduction, and whether there is an increase in uptake of appropriate strategies for falls reduction (for example, osteoporosis treatment and uptake of exercise programs).

The randomised control trial has been utilised to assess the feasibility, suitability and the effectiveness of the post acute management of falls prevention implemented during the project.

Results of the evaluation should be known in August 2000.

Transferability to other settings

The screening tool used in this program to identify falls risk was based and adapted from:

- the South East Institute of Public Healths (SEIPH) *Guidelines for the Prevention of Falls in Older People* (Health Promotion Division of the Department of Health, 1998); and
- Gillespie LD, Gillespie WJ, Cumming R, Lamb SE, Rowe BH, *Interventions to Reduce the Incidence of Falling in the Elderly* (Cochrane Review); in: The Cochrane Library, issue 3, 1998 Oxford: Update Software.

The tools used for screening and for developing individual intervention plans were identified as elements of the program that could be applied in other settings. Additionally, the FMC identified a number of elements to their program that could be integrated into other programs, such as:

- working in partnership with patients to develop individual intervention plans;
- collaboration with GPs to ensure continued management of intervention plans;
- best practice guidelines for managing patients who fall; and
- strategically utilising and integrating existing services to ensure a coordinated regional response to falls prevention.

Workforce issues

The program has focused on bringing together experts in the area to share resources and information, and to develop new networking processes. The program is ongoing and will allow for specific training where required and will enable the region to develop a more strategic approach to reducing falls.

6.3.3 Case study 3: Goulburn Valley Health, Shepparton, Victoria

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Program description

Goulburn Valley Health (GVH) is also responsible for the implementation of a *National Demonstration Hospital Program*. This program is an integrated service pathway project focusing on improving the model of care for older people, who present to the Hospital Emergency Department following a fall.

The program commencing on 3 July 2000, will involve the risk screening of all older persons who present to GVH Emergency Department to determine if they are at risk of needing services post discharge. Those at risk will have a need for service assessment completed. All those who present to the Hospital following a fall, including those admitted and those who are returned home or to other dwellings, will have an individual falls intervention plan in addition to the needs for service assessment. The program will have a specific emphasis on information transfer between acute and primary health and community support services, including GPs, to ensure ongoing monitoring of individual intervention plans. A Memorandum of Understanding is being developed between GVH and the Goulburn Valley Division of General Practice to recognise opportunities for collaboration and to enhance communication.

As well as acute services, GVH is responsible for the operation of four residential aged care facilities; a psycho-geriatric facility, a hostel and two nursing homes. In collaboration with the Shepparton Retirement Villages, GVH is also responsible for the implementation of the Prevention of Falls in Residential Care Facilities project funded through the Victorian Governments Foothold on Safety (FOS) program. A mechanism has been

established to link the two programs and to facilitate the adaptation of falls prevention strategies developed through each project for use in different settings. For example, a falls incident report currently being trialed in the residential aged care facilities to identify key intrinsic and extrinsic causes of adverse incidents, will be considered as part of the hospitals investigations into incident reporting systems.

Target group

The acute program will target older people who have been admitted to hospital following a fall and older people determined to be at risk post discharge from the Emergency Department. The program defines older people as women and men aged 65 years and older, and Aboriginal and Torres Strait Islander women and men aged 45 years and older. The program will also be directed toward further education of nurses and allied health staff of the acute and residential aged care facilities.

Program aims

The aims of the *GVH National Demonstration Hospital Program* include:

- reduction of unplanned re-presentation and readmission to hospital;
- reduction of inappropriate admissions to hospital;
- reduced length of stay in hospital; and
- increased integration of service-providers (including internal allied health and specialist professionals and external ACATs, linkages programs and GPs into GVH).

Program design and development

The GVH program was developed in response to local data that indicated a high rate of falls in some of the surrounding areas; the impact falls presentations on the acute care sector, as well as the current emphasis on falls prevention in health. The growth of the ageing population in the region gave impetus to the program.

In designing the program a literature search was conducted and best practice models were identified. Evidence from the Frankston Hospital's *Assessing Directions of Care* project and the Flinders Medical Centre's *Emergency to Home Outreach Program*, indicated that a multi-disciplinary approach facilitating increased integration of assessment, treatment and preventive interventions is beneficial to older clients and is also beneficial in reducing falls. The GVH program also adapted similar processes to those instituted by the Assessment Service provided by the Monash Medical Centre Emergency Department.

Development of the program has involved consultation with older people, medical practitioners, nurses, allied health professionals, local councils and falls prevention specialists. A consultative project team has also been established and includes the project officer for the *Foothold on Safety* project based at Shepparton and representatives of the ACATs, nursing staff, local council, GPs, and allied health professionals.

Program content

The GVH *National Demonstration Hospital Program* is in the process of being established and will offer a multi-faceted approach to falls prevention. An Older Persons Care Coordinator (OPCC), with a background in nursing and with experience in both acute and community settings, will be engaged by GVH to coordinate discharge planning with an emphasis on the development of a falls risk management plan for older people who present following a fall. The program will involve the screening of all older people who present to GVH emergency department. Those who present to the hospital following a fall, including those admitted and those who are returned home or to other dwellings, will have an individual falls intervention plan. Risk will be identified on admission using an adaptation of the four question Thomas risk screen, developed for the Victorian DHS, which identifies those patients requiring discharge planning. A fifth question has been added to the screen, identifying people who have suffered a fall in the last six months. After being identified as being at risk by the triage nurse the individual will be referred to the OPCC for a service needs assessment and subsequent organisation of services. The needs assessment will highlight criteria that relate to falls risks.

The OPCC will also have an education role, providing information to clients, carers and staff on the needs of older persons, discharge planning and falls.

As well as the direct services provided to older people the program has a service development component, which will include the establishment of exercise programs including Tai Chi classes, through the GVH outpatient services. Tai Chi classes have already commenced in the residential aged care facilities and in GVH's Rehabilitation Unit. The development of a falls and balance clinic is also planned to provide a multi-disciplinary approach to falls diagnosis, treatment and prevention.

On a systemic level, the program will focus on incident monitoring to ascertain the reasons for falls amongst older people in acute and residential settings. A trial of a falls report is underway in the residential aged care facilities to identify key causes of adverse incidents. This reporting mechanism aims to assess where an incident has occurred, what the surfaces were like, what time of day the fall occurred, and any other extrinsic factors. An assessment of the individuals falls risk factors and the development of an individual intervention plan will supplement this report. This falls risk assessment is conducted on admission to residential care, at six monthly intervals as well as following any falls.

Risk factors addressed through the program include medications; medical conditions; sensory impairments; foot problems; footwear problems; dizziness; balance and gait; lower limb weakness; inactivity; indoors and public environmental hazards; fear of falling and nutrition.

The program will be developing a number of resources and tools including, book/lets, pamphlets, posters, slides/overheads, self-screening falls risk assessment tools and environmental hazards checklists. A consumer diary for in-patients has already been developed for the program and will be used for evaluation purposes.

Existing resources such as the videos, *Balancing Acts: Falls and Older People* and *Standing on Your Own Two Feet*, will be used in education programs.

Program sustainability

The implementation of the GVH *National Demonstration Hospital Program* was funded primarily by the Commonwealth Government. The OPCC will be funded through the State Government through their Effective Discharge Strategy and GVH's core budget. An ongoing commitment of funding from GVH's core budget will require the project to demonstrate cost effectiveness. Evaluation of the cost effectiveness of the program will be through reductions in length of stay of inpatients, inappropriate admissions and unplanned re-admissions.

Program evaluation

It is intended that internal evaluation will be implemented by 3 July 2000 on commencement of the program and will be completed by February 2001. Evaluation will be conducted internally to address the specific key performance indicators noted above. External evaluation will be conducted by the Commonwealth Government using Rainbow Indicators, which measure overall hospital performance. The process for evaluation will include pre/post intervention assessments.

Staff and consumer focus groups, along with consumer diaries will be used to measure satisfaction. Consumer diaries have been developed for this program which will allow patients to record their hospital stay, including fall-related incidents. Clients will be requested to retain the diary for two weeks after discharge so that they can record their transition home. An interview will be conducted regarding the diary two weeks after discharge.

Transferability to other settings

It is anticipated that certain aspects of GVH's falls prevention strategy could be adapted to different settings, such as the falls incident report and the falls risk assessment and management tool to assist staff in identifying the cause of a fall and to suggest interventions.

Workforce issues

The design and development of this program has involved on the job training, continuing professional education, supervision/mentoring by experienced practitioners, and time spent visiting other similar programs. Increased funding for specialist staff in rural areas and training for resident medical officers were viewed as enhancements required to increase the programs effectiveness.

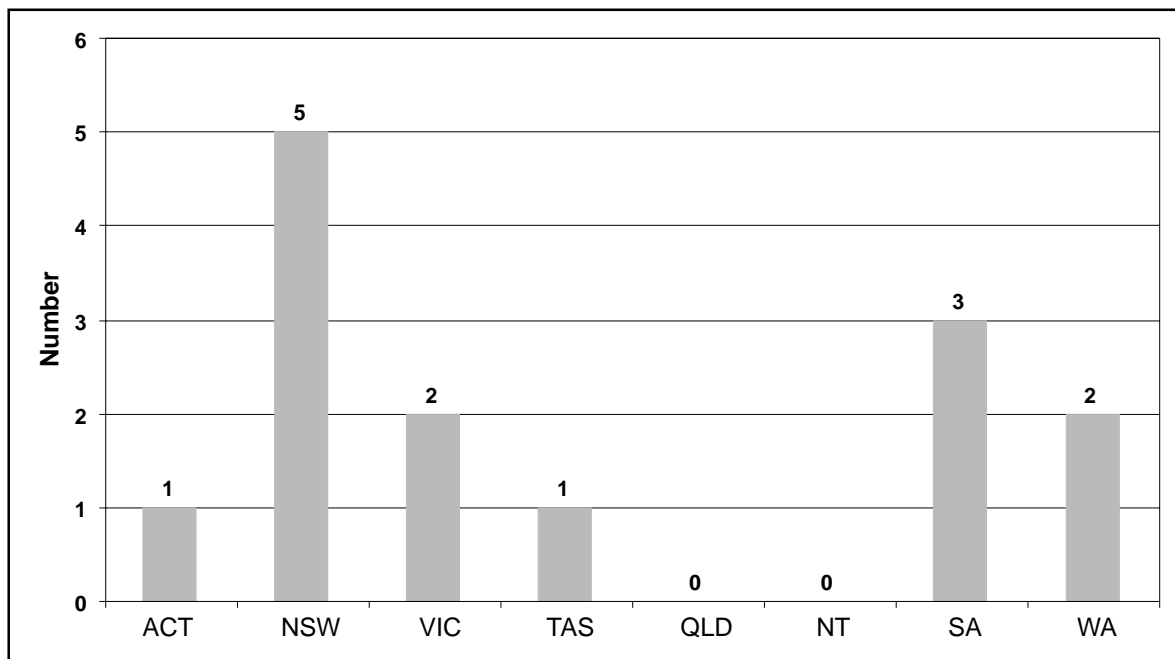
6.4 Survey results (graphs and tables) for the hospital setting

Fourteen of the 122 scanned programs were conducted in a hospital setting. The results for the falls prevention programs in hospital settings have been summarised in section 6.1, and are presented in figures in this section

6.4.1 Location by state

The greatest proportion of responses to the Stocktake survey for programs in hospital settings were from New South Wales, followed by South Australia, Victoria and Western Australia (figure 6.1). This differs from the community setting, where Victoria had more than double as many programs responding to the Stocktake survey as any other state.

Figure 6.1 Survey respondents by state



6.4.2 Falls risk factors addressed

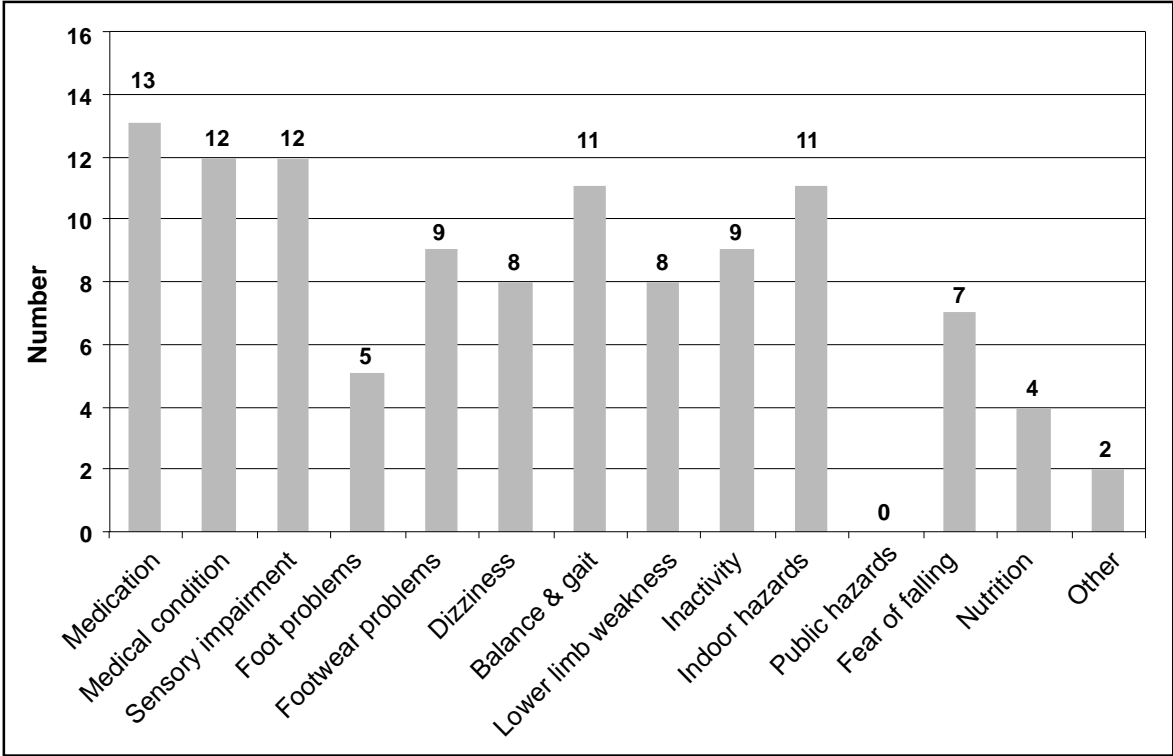
Almost all of the programs in the hospital setting addressed multiple risk factors (n=10). An average of eight falls risk factors were addressed per program.

The risk factors addressed are highlighted in figure 6.2 below, with most of the common falls risk factors addressed by most of the programs. The most common falls risk factors addressed by falls and falls injury prevention programs in hospital settings were:

- medications (n=13);
- medical conditions (n=12);
- sensory impairment (n=12);
- balance and gait (n=11); and
- indoor hazards (n=11).

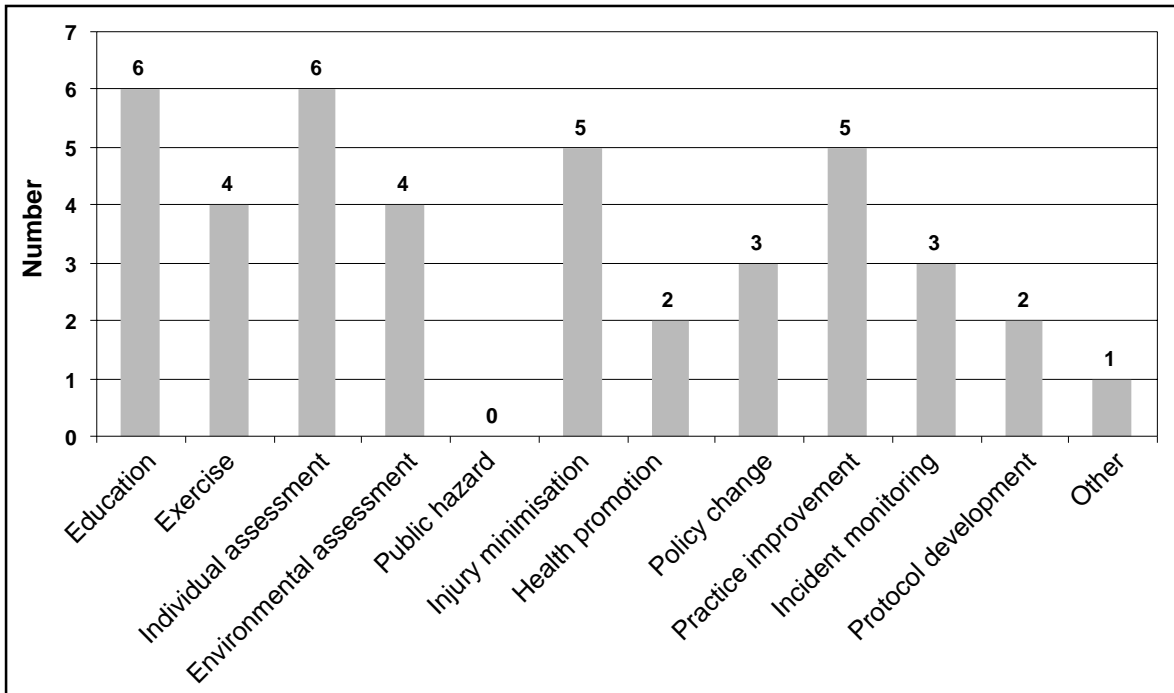
In total, six programs addressed a minimum of these five most common risk factors. When analysing those programs which did address at least these four risk factors (n=6), the most common program types were education, individual assessment, injury minimisation and practice improvement. These were among the most common program types in hospital settings when all programs were analysed (Figure 6.4).

Figure 6.2 Risk factors addressed



Note: Multiple choices permitted

Figure 6.3 Program type for those programs addressing five most common falls risk factors (n=6)



Note: Multiple choices permitted

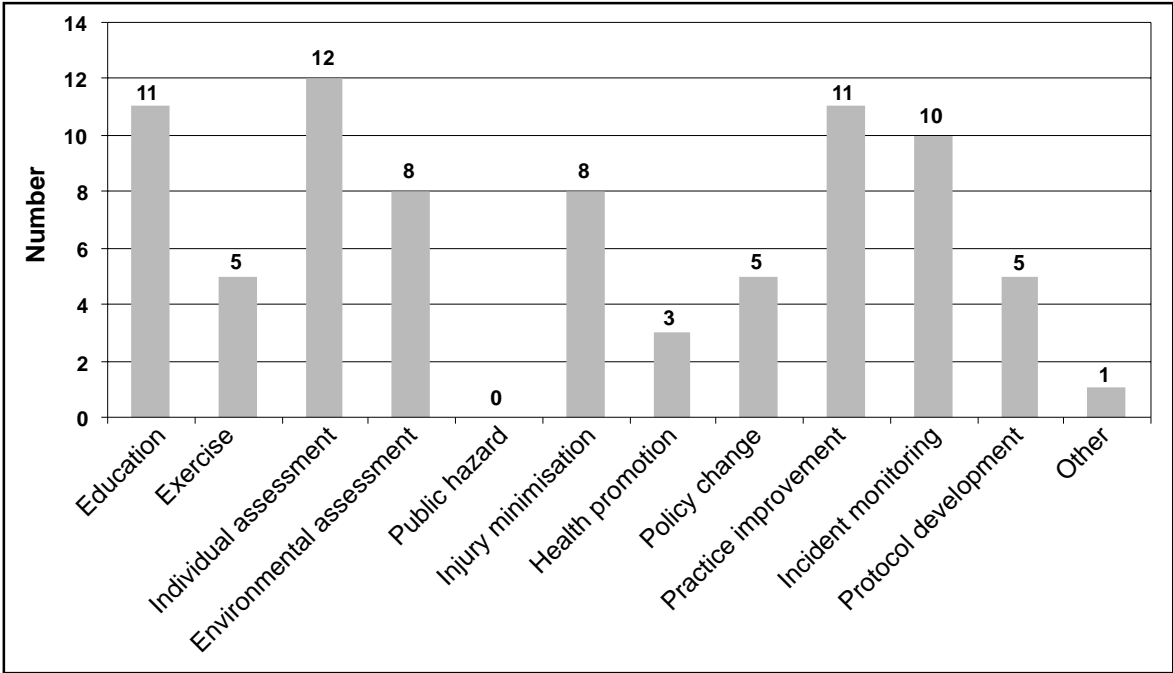
6.4.3 Type of falls/falls injury prevention program

The 14 hospital focused programs include a range of interventions. All programs included more than one type of intervention. Most programs included individual assessment or education. There were also a number of programs addressing systemic and procedural activities such as, practice improvement or incident monitoring, rather than specific individual interventions. Injury minimisation was also an intervention in 57 per cent of the programs in hospital settings, compared to only 40 per cent of programs of this type in the community setting. This may reflect the greater proportion of frailer older people in hospital settings relative to the community setting.

It is clear that the majority of programs implement a number of interventions. Ten of the hospital focused programs have nominated the provision of multi-faceted interventions. Although the research evidence supporting specific interventions to reduce falls and falls related injuries in hospital settings is minimal, it is likely that approaches utilising individual risk assessment and management will be effective, as has been shown in the residential aged care setting (DHAC 2000). It is interesting to note that 86 per cent of programs incorporated an individual risk factor assessment and targeted management program. However, there is little information about the type of risk factor assessment in this setting, although it is likely to involve some medical/allied health staff. Several programs reported using risk screening tools, although there is little consensus about which tool best meets this need. In contrast to the community setting, where 38 per cent of programs included an exercise intervention, only 29 per cent of programs in hospital settings utilised this approach.

All of the programs were multi-faceted, combining more than one intervention type.

Figure 6.4 Type of falls/injury prevention interventions



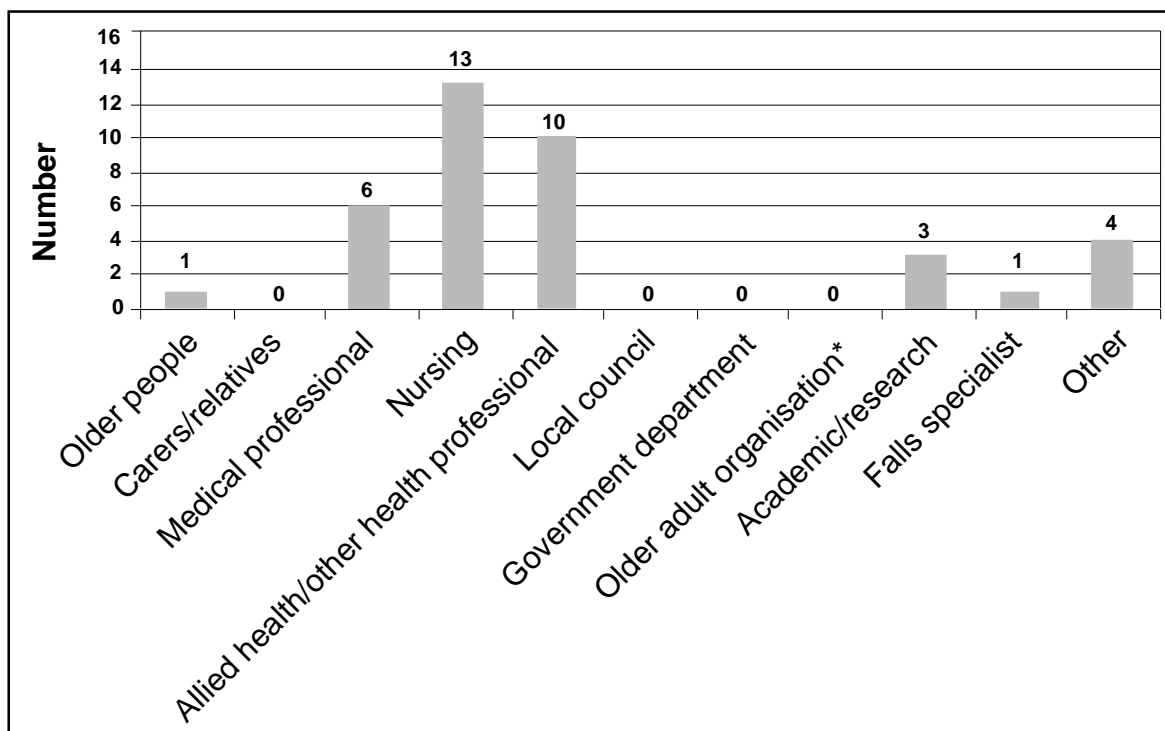
Note: Multiple choices permitted

6.4.4 Who was involved in program development?

Reflecting their key role in falls prevention in hospital settings, nurses were involved in the development of 13 of the 14 programs. Allied health professionals were also likely to be involved in the development of hospital based falls and falls injury prevention programs (Figure 6.5). On average, three different groups were involved in development of hospital based programs, being lower than the four groups on average involved in community based falls prevention programs. A diversity of groups involved in program development was considered to be important criteria in the guidelines for evaluating falls prevention programs (NARI, 1999).

Of note, older people, and their relatives/carers were rarely involved in falls and falls injury prevention programs in hospital settings, compared to 38 per cent of community based programs involving older people in program development. This may reflect different target groups for the programs between settings, with a much higher proportion of programs in hospital settings targeting staff.

Figure 6.5 Who was involved in the development of the program?



Note: Multiple choices permitted

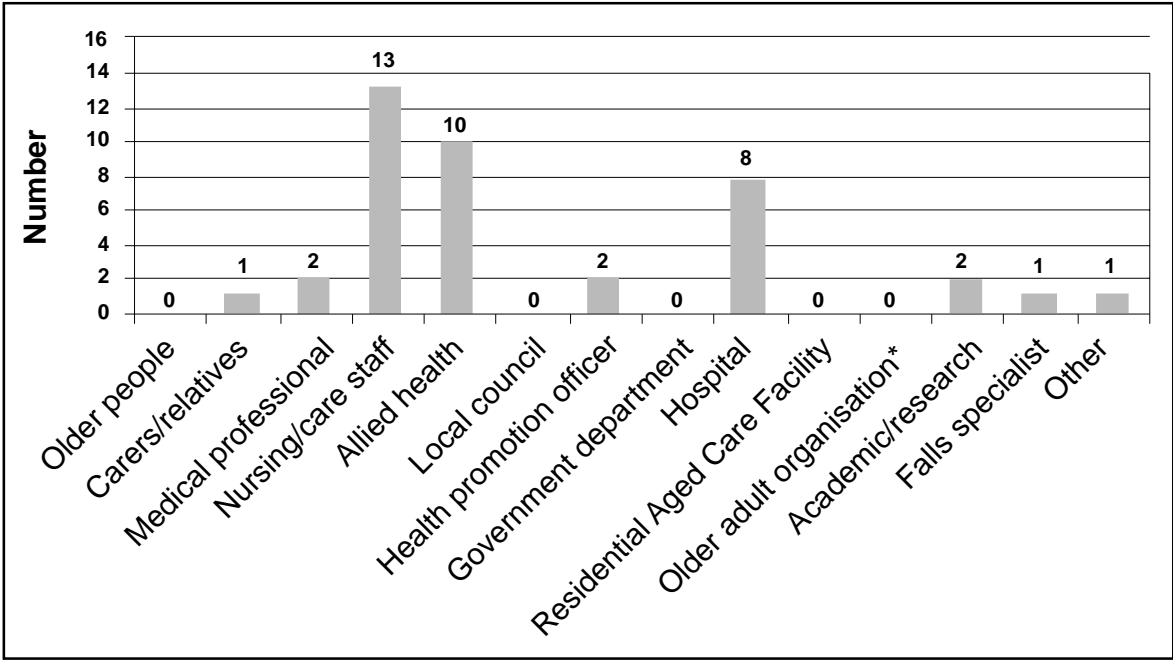
*Older adult/ethnic/community organisation.

Other includes: Risk management staff, benchmark group facilitators, multi-disciplinary group.

6.4.5 Who implemented the program?

Hospital staff, predominantly nursing and allied health professionals, were also involved in the implementation of the majority of programs. An average of three groups were involved in the implementation of hospital based falls prevention programs. Interestingly, only two of the programs involved medical staff in program implementation. Medical staff would appear to be key staff in hospital based falls prevention programs, particularly given the high emphasis on medical risk factors targeted by these programs. There may be a need to explore options for increasing involvement of medical staff in falls prevention program implementation in hospital settings.

Figure 6.6 Who implemented the program?



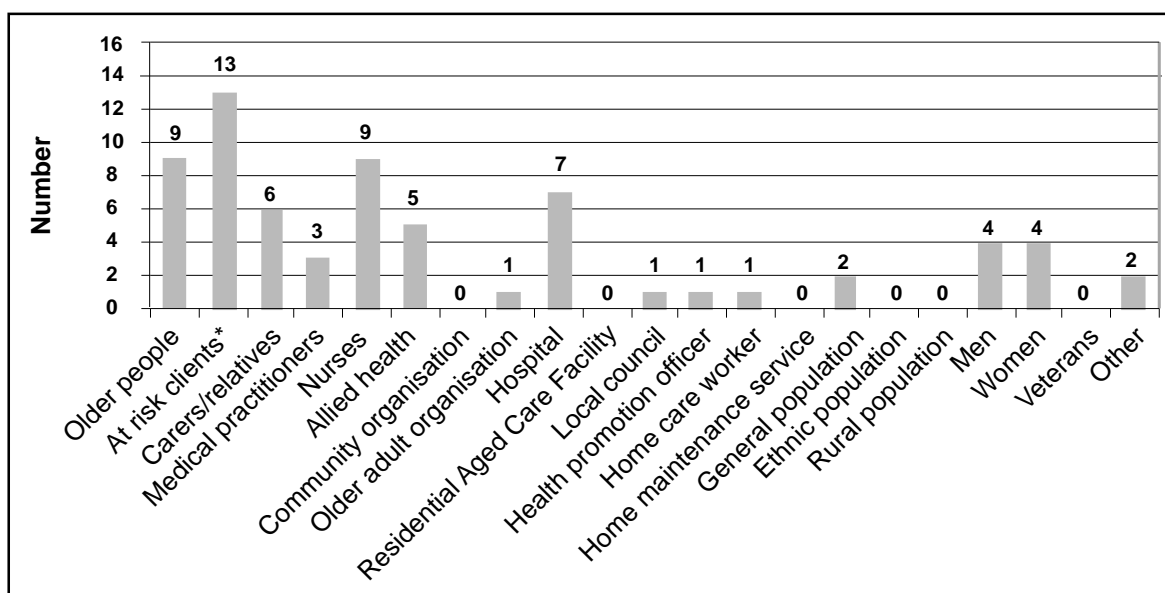
Note: Multiple choices permitted

*Older adult organisation = Older adult/ethnic/community organisation

6.4.6 Target groups

Predominantly older people and people at risk of falling or who have fallen (n=13) were the main target groups for falls and falls injury prevention programs in hospital settings. Staff of the hospital (in particular nursing staff and allied health staff) were the next most common target group. Involvement of the hospital staff as main target groups in the hospital setting highlights the need for effective workforce training for these groups. Problems with workforce training were highlighted in responses to the descriptive section of the survey identifying areas in need of improvement (see section 6.2.4).

Figure 6.7 Target groups



Note: Multiple choices permitted

*At risk clients or clients who have fallen

6.4.7 Year that program was introduced

A substantial proportion of the programs (71%) have been introduced since 1998, and most programs are still in operation. It would be expected that the full effect of the relatively new programs on reducing falls and falls related injuries in hospital settings would not be evident for up to several years.

As in the community setting, an important issue to be managed well with the high proportion of programs recently developed, and with the likelihood of this trend continuing for at least the next few years is to optimise communication between programs regarding:

- what works;
- what doesn't work;
- dissemination of program outcomes; and
- what resources are available.

Poor networking between falls prevention workers in hospital settings was identified as an area requiring future improvement. In order to maximise outcomes in reducing falls and falls related injuries in hospital settings in the near future, strategies to promote networking for workers in hospital settings will be important to develop and support.

6.4.8 Reasons for introducing the program

The reasons for the introduction of the falls prevention programs were primarily based on local data (n=13) and secondly as a health professional initiative (n=9). This is the reverse pattern to community programs which were established as a result of a health professional initiative and secondly as a result of local data. It should be noted that in the majority of programs, a combination of both local data and health professional initiative were responsible for introduction of programs. Funding availability was only identified as a factor in two programs.

6.4.9 Incorporation of existing programs into program development

A much smaller percentage of programs (29%) in the hospital setting reported being based on existing programs, compared to 55 per cent in the community setting. This may be related to the limited evidence about successful interventions in the hospital setting, or to the limited opportunities for networking and sharing information about what works between staff involved in falls and falls injury prevention in the hospital setting.

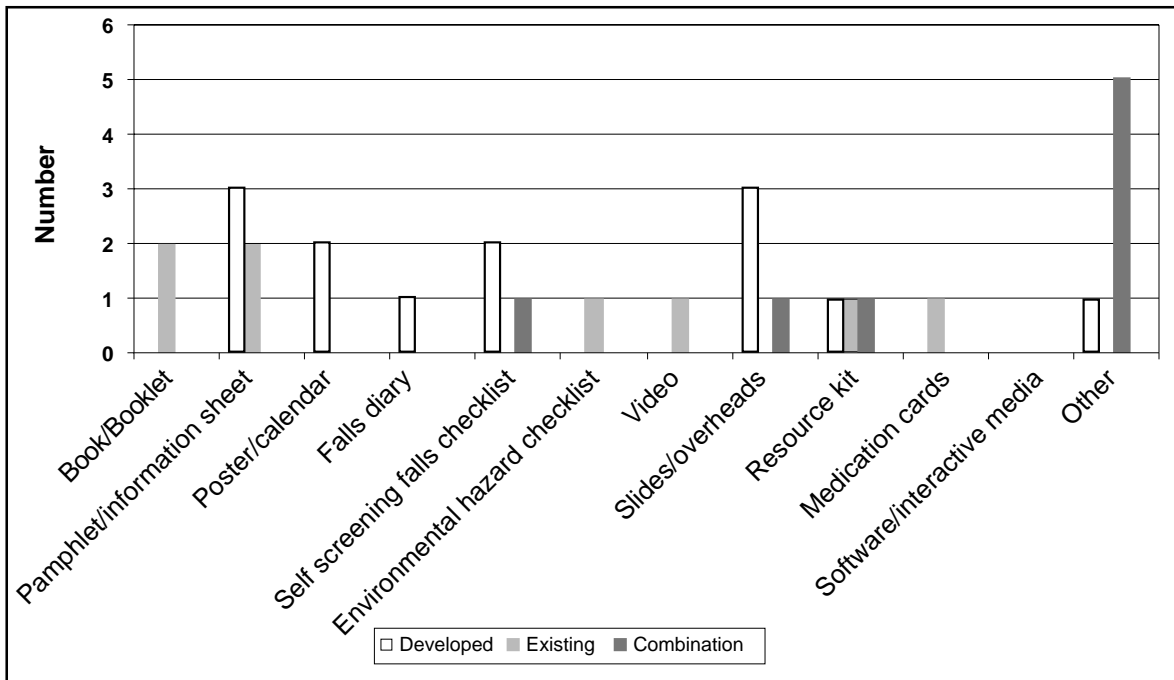
6.4.10 Resources/tools used

A smaller range of resources were used in falls and falls injury prevention programs in the hospital setting relative to the community setting (Figure 6.8). Pamphlets/information sheets, and slides/overheads for staff education were most commonly used, and these were most commonly developed specifically for the program. This may represent considerable duplication of effort and resources in the development of these resources.

Most common type of resources which were used from existing programs were books/booklets, and again, pamphlets/information sheets.

Greater detail about the specific resources used, including those in languages other than English have been reported in sections 6.2.7 and 6.2.8 respectively.

Figure 6.8 Resources/tools used



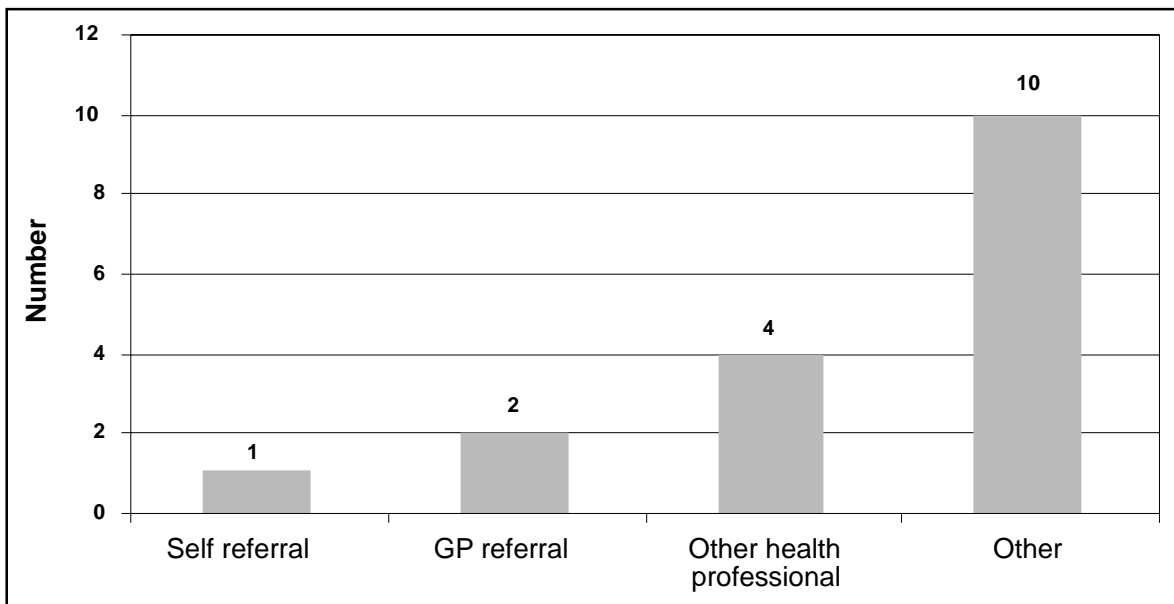
Note: Multiple choices permitted

Other includes: Incident reports and visual cues (signs, stickers, wristbands)

6.4.11 Program access

The majority of programs could be accessed by patients admitted to the hospital, with no other criteria for involvement in the program (listed as other in Figure 6.9).

Figure 6.9 How the program is accessed



Note: Multiple choices permitted

Other includes: Patients of the hospital/on admission to hospital (n=8)

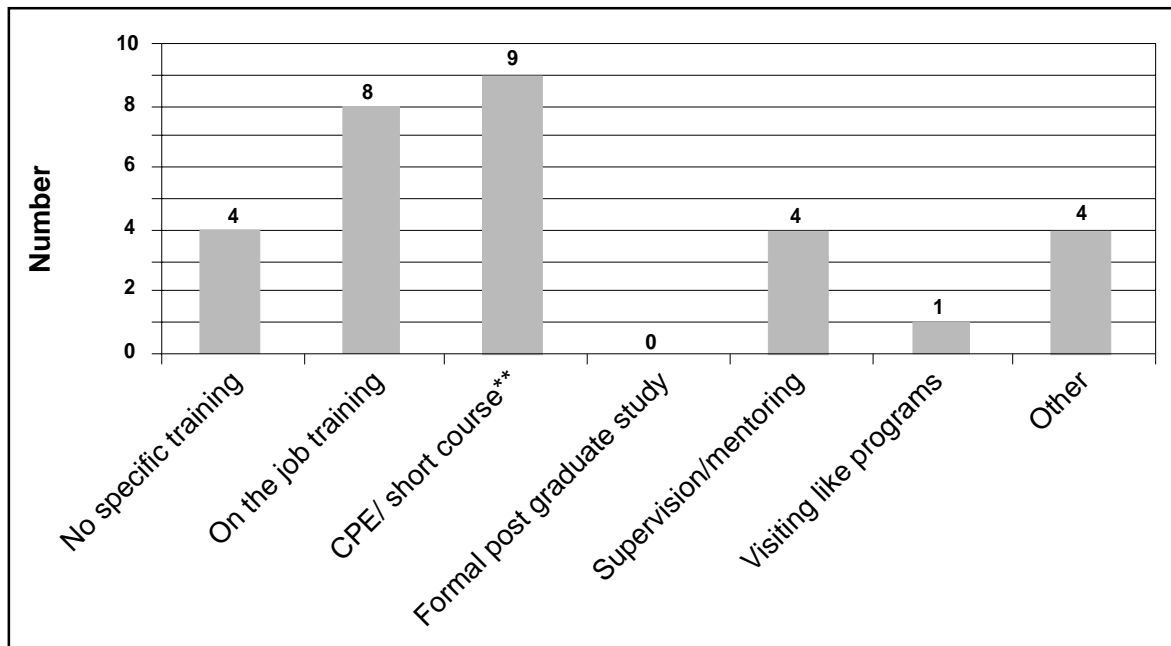
6.4.12 Transfer of program to other settings

Only one program (7%) reported being transferred to another setting. Given the short duration since commencement of most of the programs, and the limited evidence about effectiveness of programs in this setting to date, this is not surprising. Nonetheless, some of the innovative approaches currently being trialled in hospital settings may have future capacity for transfer to other settings, although this warrants further investigation.

6.4.13 Type of training provided for those implementing the program

Workforce training in falls and falls injury prevention programs in hospital settings most commonly involved one avenue (57% of programs). Similar to the community setting, the most common avenues used were on the job training, short courses (CPE), and supervision/mentoring. Four programs (29%) offered no specific workforce training options.

Figure 6.10 Workforce training provided to program implementers



Note: Multiple choices permitted

*CPE (Continuing Professional Education)/short course/lecture

Other includes: Inservice/staff education sessions

6.4.14 Program sustainability

An important issue which needs to be considered in falls and falls prevention program development and implementation in the hospital setting is that of sustainability. Only programs which are currently running, or have run in the last 12 months were included in the national falls stocktake analyses. Fourteen per cent of programs (n=2) had stopped running in the past 12 months. One program was current when the survey was completed

but was due to cease in March 2000. The two programs which have stopped running stated that this was pre-planned (n=2), and one also listed personnel being unavailable as a contributory factor to the program stopping.

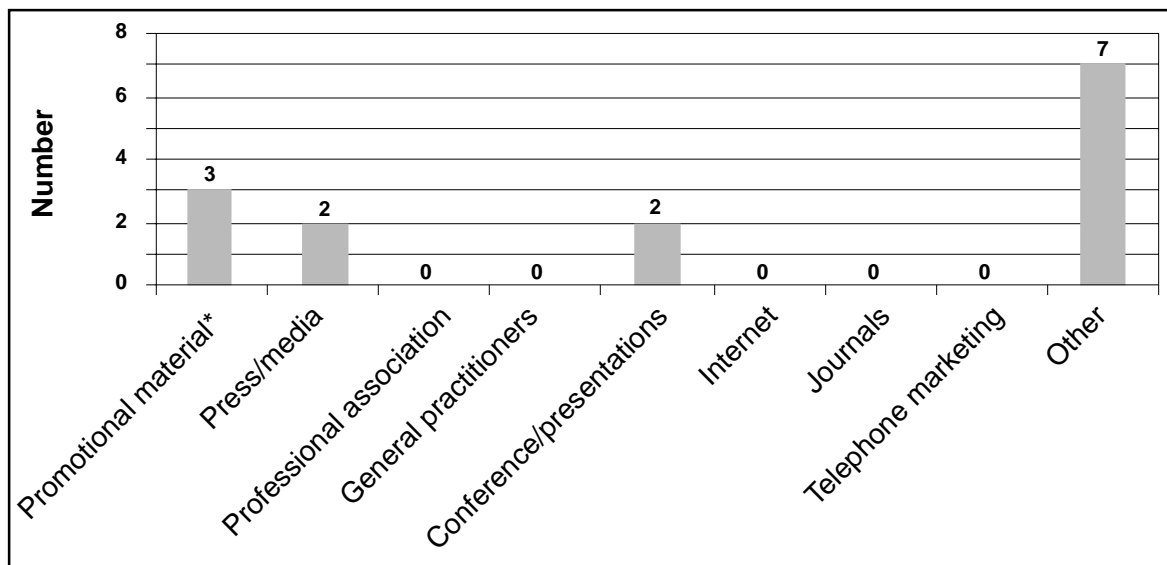
Most hospital-based programs were considered to be sustainable. Two of the programs which did not respond were pre-planned to stop and had already stopped (see above), with one of these programs also being limited by lack of personnel and insufficient participation or interest. (One program did not report whether it was still current).

The most commonly reported factors associated with program sustainability were program duties being incorporated into job description of staff (n=8), and availability of permanent staff (n=4).

6.4.15 Promotion of programs

In contrast to the community and residential aged care settings, relatively few methods of program promotion were used in hospital settings (Figure 6.11). The average number of avenues for program promotion was one. This may be related to the relatively defined and accessible target groups for falls prevention programs in hospitals, those being patients and staff. Health professionals and health establishments were identified as those most commonly receiving promotional materials (Figure 6.12).

Figure 6.11 How the program was promoted

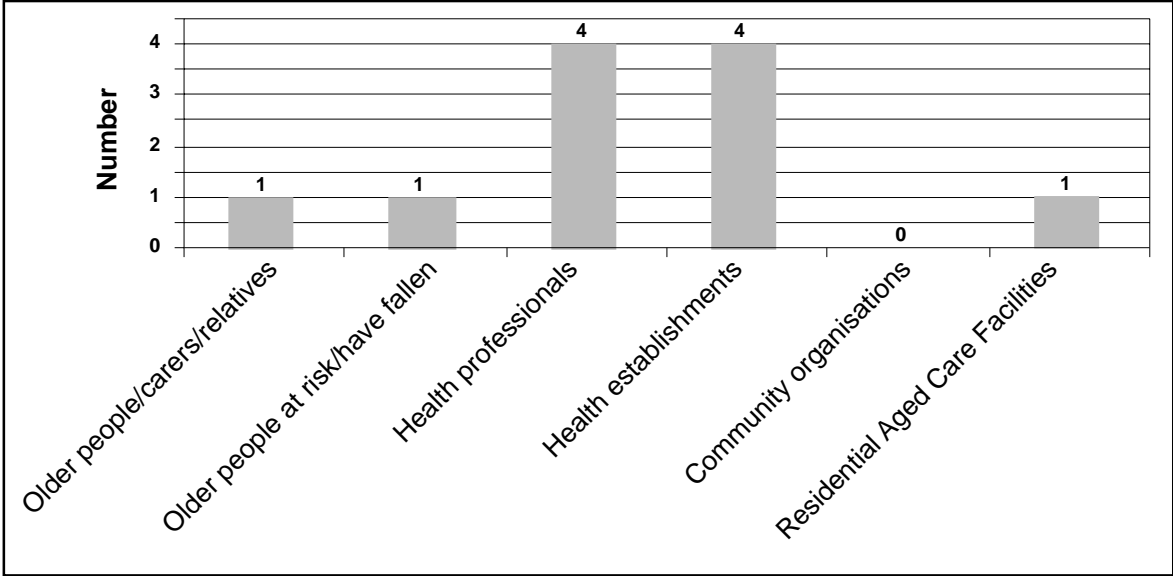


Note: Multiple choices permitted

Other: other methods of promotion, most commonly by inward/hospital training and education sessions and meetings (n=5).

*Promotional material flyers, pamphlets, newsletters

Figure 6.12 Who received promotional material?



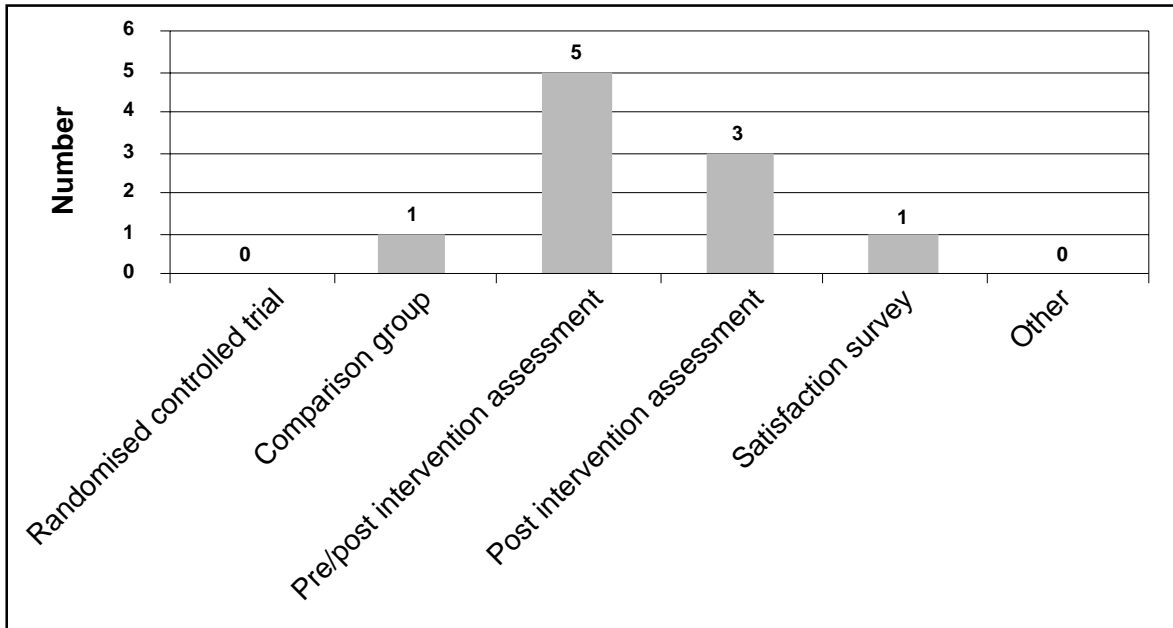
Note: Multiple choices permitted

6.4.16 Program evaluation

The majority of programs (71%) reported that some form of evaluation had been conducted or was planned. In almost all of those conducting evaluations, the evaluation was being performed in house (n=8). Most evaluations comprised a pre-post intervention assessment or a post intervention assessment (Figure 6.13). None of the falls/falls injury prevention programs being conducted in hospital settings reported using a randomised controlled trial design in their evaluation. Clearly there are some difficulties associated with conducting randomised controlled trials in this setting, given the short length of stay, and poor medical status of many older people in hospitals. Nonetheless, there exist opportunities for conducting this form of trial in the hospital setting, and such studies are needed given the lack of research evidence available about effective falls prevention interventions in the hospital setting.

Eight of the programs undertaking an evaluation indicated that they had partly or fully achieved their objectives.

Figure 6.13 Type of evaluation



Note: Multiple choices permitted

6.4.17 Program funding

Almost all programs in the hospital setting who responded to the question regarding funding sources identified that their primary funding was from within core budget (n=8). It should be noted that the core budget of hospitals is derived from government sources. Nonetheless, there is a considerable mismatch in sources of funding between the different sectors, and there appears to be a need for dedicated funding for falls prevention programs in the hospital setting.

Funding

Only two organisations specified the amount of funding received. One was for an approximate amount of \$1,000 obtained from the organisation’s “own budget”, the other an amount of \$4,600, the funding source was classified as “other”—it was a quality grant. Only two organisations provided an estimate of how funds were allocated. Both respondents indicated that 100 per cent of funding was allocated to staffing.

In kind support

Six programs responded to this question, three indicating that they did not receive any in kind support. Other responses included:

- support through the clinical pathways unit for review and evaluation of data;
- staff time to attend project development and planning meetings; and
- a relative of an aged care co-ordinator donated artwork.

No value estimates were provided for these “in kind” contributions to programs.

7.0 Falls prevention activity in residential aged care settings

Thirteen of the 122 falls and falls injury prevention programs (11%) completing the falls stocktake survey were targeting their program to reduce falls and falls related injuries among older people in residential aged care settings. A breakdown of responses for the residential aged care setting are included in this section.

7.1 Summary

Many of the trends observed for the overall responses to the stocktake survey were similar when analysed separately for the residential aged care setting. Key issues arising are listed below.

- a) Most common program types were individual assessment (92%), education (77%), incident monitoring (77%), and environmental assessment/modification (77%). Exercise (69%), and practice improvement (69%) were also commonly used interventions. All programs addressed multiple falls risk factors. Most common risk factors addressed differed a little from both the community and hospital settings, with indoor hazards (100%), medication (92%), lower limb weakness (92%), and inactivity (92%) being most often addressed, and medical conditions, feet and footwear problems, and balance and gait being slightly less frequently addressed. In contrast to the other settings, feet and footwear was a risk factor addressed much more commonly in the residential aged care setting.
- b) Similar to all settings, falls and falls injury prevention programs in residential aged care settings target older people (77%) and at risk clients (69%). Nurses were also the target group for 46 per cent of programs.
- c) Nursing staff and allied health staff were involved in the implementation of an equal number of programs (76%) in residential aged care settings. Medical professionals were involved in the implementation of only three of the 13 programs (23%).
- d) Over two thirds (69%) of the programs in residential aged care settings had commenced in 1999 or 2000, indicating a recent increase in falls prevention activity in residential aged care settings.
- e) Three quarters (77%) of the programs were developed at least in part due to health professionals initiative. Funding being available was cited as a factor by 54 per cent of programs, while in contrast to the hospital setting, only 23 per cent were developed in response to local data. This may be in part a reflection of the limited data being collected systematically within residential aged care settings, as there is currently no standardised format for collecting and analysing falls related data in residential aged care settings.
- f) Similar to the hospital setting, the majority of programs reported other as the way for the program to be accessed. Only 23 per cent of programs were accessed by referral by

nursing or allied health staff, and none by the GPs. The other category mainly included access by residential aged care facility staff and/or residents (n=7).

- g) Only two residential aged care falls or falls injury prevention programs reported that they had been translated to other settings. This low rate is similar to that reported for the community and hospital setting.
- h) Most common forms of workforce training for falls prevention programs in residential aged care settings were short courses (54%), and on the job training (46%).
- i) Eleven of the 13 programs reported they were sustainable, a similar proportion to the community and hospital settings. Similar to both the community and hospital settings, the major factor associated with sustainability of residential aged care based falls and falls injury prevention programs was incorporation of program duties into the job descriptions of staff (62% of programs).
- j) Promotional material such as fliers/pamphlets/newsletters, and promotion within professional associations were the most common avenues for promoting falls and falls injury prevention programs in residential aged care settings. Promotional materials were most often distributed directly within their own, or other, residential aged care settings.
- k) A wide range of resources/tools were used in residential aged care falls prevention programs. In contrast to the other settings, the majority of resources/tools used were based on existing tools (booklets, environmental checklists, videos, slides/overheads, and resource kit). The most commonly used resources/tools included environmental hazard checklist, book/booklets, pamphlets/information sheet, self screening checklist, and resource kits.
- l) In contrast to both the community and hospital settings, a larger proportion of programs had a primary funding source of Commonwealth or state government, although 38 per cent also reported own budget (core funding) as a primary funding source.
- m) Estimates of participation numbers were provided by most of the programs, and these varied widely, from 12 to 800. The median number of participants in falls prevention programs in residential aged care settings was 62. Of those programs reporting costs to participants, all reported no actual cost (although two reported a cost to the setting of \$20-\$30 for purchasing of falls prevention kits/manuals).
- n) Program evaluation has been undertaken in slightly more than half of the residential aged care based programs, with a further 38 per cent reporting that they intend to undertake an evaluation. Similar to the hospital setting, pre/post assessments, or just post intervention assessments were most commonly used methods of evaluation (38% and 31% respectively). Only one of the programs reported in residential aged care settings was undertaken as a randomised controlled trial. Similar to the community setting, the majority of the programs' evaluations were conducted in house (69%).
- o) A range of objectives were identified for the falls and falls injury prevention programs in residential aged care settings. Most commonly, these were to reduce falls and falls related injuries, to raise awareness among staff and residents about effective ways to minimise falls risk, to improve documentation and data on rates of falls in residential aged care settings, and to improve environmental safety.

7.2 Thematic Analysis of Descriptive Data

A number of the questions in the Stocktake survey were open-ended, allowing respondents to answer the questions without being limited to set responses. The amount written and nature of comments varied widely between respondents. The project team reviewed all responses, and developed key themes from these responses as described below.

7.2.1 Key objectives of the program

Survey respondents for programs in residential aged care settings described a broad range of objectives. These included:

- reducing falls/falls injury (n=6);
- health promotion by raising the awareness and educating staff and residents of falls risks and management strategies (n=4);
- establishing the incidence of falls and their causes in facilities (n=4);
- improving environmental safety (n= 3);
- to introduce a falls audit and risk management program/tool (n=2);
- improving the physical status of individuals - balance/mobility/strength (n=2);
- to produce a falls prevention strategies manual for residential aged care facilities (n=1);
- improve best practice understanding and practice (n=1);
- develop a sustainable program which includes policies and procedures for falls prevention and on-going staff education (n=1);
- to establish measures contributing to the independent evaluation of the program (n=1); and;
- to look at the effectiveness of hip protectors and compliance.

7.2.2 Transferability of the program

Two programs in residential settings were/are being trialed in other settings. One was in a complex care wing. They found that the social skills/activities were able to be adapted to suit non-demented residents and those with lower needs (a hostel). The other was trialed in a hospital. The assessment resources, tools and strategies were easily adapted and other interventions (vision/hearing checks, physiotherapy, podiatry) were all reported to be suitable for use in acute settings.

Responses from organisations that did not translate their program included that although the program was aimed at residential facilities and staff it could apply to staff caring for the frail in the community; and the falls risk assessment and incident report could be adopted by other organisations.

Other respondents interpreted the question of transferability to include transfer of the program to other residential facilities. One indicated that their program was well suited to other facilities but funding was needed for the establishment phase, after this the program could be self sustaining. However the respondents did not believe sufficient funding was available to establish this program in other facilities. Another respondent indicated that the

environmental audit should be easily implemented in other residential facilities, however the activity/exercise program was specific to resident interests and what was currently done at that facility (what works in one supported residential service may require considerable modification in other).

Two other respondents indicated that their program was residential care specific, however one also listed a number of enablers. They stated that the resident profile identifying risk factors could be applied to anybody, that the hazard identification could be done anywhere, and their education program could be adapted.

7.2.3 Barriers and enablers to target group participation

Respondents were asked to describe any barriers or enablers they discovered to the target group participating in the program. Respondents tended to describe barriers rather than enablers.

A variety of factors were identified as barriers to the target group participating in residential care programs. These factors included motivation and support from management. Three of the 13 respondents reported limited staff time and competing tasks as barriers. Staff resistance to education and the adoption of a non-medical model was also reported. Non-compliance of the target group was also regarded as a barrier. One respondent identified the concentration ability of members of the target group with some form of dementia as a barrier. Programs incorporating no cost, an excellent facilitator and being conducted in the home of the target group were individually cited as enablers to target group participation. Another program, which provided free hip protectors for residents identified as at risk of falls and falls related injuries, cited the lack of cost to residents as an enabler.

7.2.4 Problems and issues

Respondents were asked to detail any problems or issues associated with implementing their program. Some common issues were observed between respondents.

Factors that were identified as barriers to the participation of the target group in programs were also identified as factors impacting on the implementation of these programs. Primarily, lack of staff time was cited by respondents as a problem (four out of 13 respondents). Other problems identified were associated with the commitment of staff and other health professionals to the program. One respondent reported that “generating staff interest in a process they think they know all about already” was a problem. Another respondent commented that “GP’s indifference to the program and its ability to make a difference” was a problem. The reliability and consistency of nursing staff to complete the required documentation was noted as a problem by one of the 13 respondents. In relation to the participation of nursing staff one respondent indicated that there was initially reluctance, however, staff became more enthusiastic when they learnt that the program was to be on-going. Ethical issues associated with gaining consent of the target group was also raised by one respondent. The (lack of) aesthetics of hip protectors was noted by another respondent as an important issue.

7.2.5 Enhancements to program effectiveness

Training for staff was a common issue identified as a means to improve program effectiveness (n=5). One of these programs specifically noted that a GP training program would enhance their program effectiveness. Limited resources/funds, in relation to both staff and time (n=4) was also an issue, as indicated by comments such as “more time, less demand!”; and “more time, more staff!”. One respondent also indicated a need for someone to drive the program. One of these organisations suggested that a financial reward for facilities implementing a falls prevention program would be an incentive.

Other items listed included the need for an increased period of study; a longer time frame to see measurable data change; dedicated time to implement small regular exercise program, and a new physical environment.

7.2.6 Service gaps and areas for improvements

Most commonly cited service gaps in residential aged care settings were inadequate workforce training, and inadequate resources to conduct programs effectively. Other issues raised included lack of networking between groups involved in falls and falls injury prevention, the need for publicity/information dissemination about programs which are effective, the need for national levels of best practice to be identified, problems associated with working in rural areas, and difficulties translating research findings into practice.

In response to the question of what areas need improvement, responses were along similar lines to the service gaps identified. Improved workforce training, improved resources/funding were most commonly highlighted. Increased networking or collaboration between those involved in falls prevention activity, improved data collection and incident monitoring, and increased awareness of falls risk factors, and management strategies for older people were also raised as important areas for improvement.

7.2.7 Resources used/developed

A broad mix of resources were used in the residential aged care falls prevention programs, with more programs using existing resources than developing their own. Some of the resources utilised from existing programs were developed for use in other settings (eg. Australian Pensioners & Superannuants Federation video—*Standing on your own two feet*). Those resources identified from other programs which were used in residential aged care settings falls and falls injury prevention programs were:

- FRAT (Falls Risk Assessment Tool) pack (n=2);
- CERA education manual - *Putting your best foot forward* (n=1);
- Falls Prevention manual by Meg Butler (New Zealand) (n=1); and
- Falls series video from Training Health and Educational Media Pty Ltd (n=1).

A number of other resources were developed specifically for the program in question. These included the following.

- Multimedia falls prevention workshop course (two half days still in development stage);

- Pamphlets
 - *Falls, footwear and feet;*
 - *Falls and vision;* and
 - *Falls and exercise.*
- Self screening falls risk checklists.

7.2.8 Resources in languages other than English

None of the resources identified as being used in residential aged care settings had been developed in languages other than English.

7.3 Case studies

A small number of programs responding to the National Falls Stocktake survey have been selected for more detailed presentation in the form of case studies. These programs were selected as examples which met four key criteria representing previously identified aspects of best practice. These criteria included that the program incorporated more than one intervention type, that it was sustainable, that it had undertaken, or planned to undertake a formal evaluation, and that the program objectives were either fully or partly met.

7.3.1 Case study 1: Grace McKellar, Barwon Health, North Geelong, Victoria

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Program description

The project, established in 1999 and due to finish in August 2000, aims to reduce the incidence of falling amongst residents of Supported Residential Services (SRS - a private, for profit form of residential care that provides minimal levels of assistance with personal care). Out of a total 12 SRSs in the regional area, seven are participating in the project. The interventions include:

- the introduction of a falls risk assessment and management tool for staff to use;
- the introduction of a standardised form to record falls events in SRSs; and
- education for staff and residents about falls incidence, risk factors for falling and preventive strategies.

The falls risk assessment and management tool incorporates suggested interventions to address identified risk factors, such as, referral to other health practitioners.

Target group

The project targets staff and older residents of SRSs. An estimated 200 residents will participate in the project. The application of the falls risk assessment and management tool is specifically targeted to existing residents with a history of falling and new residents, although facilities have been encouraged to assess all residents for falls risk.

Program aims

The project has clearly stated and measurable aims.

- To reduce the incidence of falling amongst residents of SRSs.
- To quantify the magnitude of the problem of falls within SRSs.
- To introduce a falls risk assessment and management tool for staff to use.

Program design and development

The project has been based on the need for a multi-factorial and multi-strategic approach to reduce incidence of falling. Some aspects of the project have been drawn from other falls prevention resources, for example the falls risk assessment and management tool is a modified version of the falls risk screening tool developed by the CERA.

A working group has been established to oversee the project. The working group was initiated by the project auspice, the Grace McKellar Centre, and involves a diversity of expertise in the project. Members of the working group include falls/injury prevention specialists from the Falls and Mobility Clinic at the Grace McKellar Centre, SRS staff, medical, nursing and allied health professionals, and a representative of the state government funding body, the DHS.

Program content

The interventions include structured assessment of residents by SRS staff using a falls risk assessment and management tool. The project also involves education for staff and residents about falls incidence, risk factors for falling and preventive strategies.

The tool has been modified to enable personal care attendants to use the tool along with nursing staff. Assessment, using the tool, takes up to 20 minutes, however more time is required to implement the interventions to address the identified risk factors, such as, referral to other health professionals. The risk factors may include medication use, medical conditions, sensory impairments, foot problems, footwear problems, dizziness, balance and gait, lower limb weakness, inactivity, indoor environmental hazards, public environmental hazards, fear of falling and nutrition.

As well as raising awareness of falls prevention by involving SRS staff in the project development and implementation, there is an informal training component to the project to improve practice in SRSs. Informal training sessions are held with staff in each facility to introduce and explain the application of the falls assessment and management tool and the falls incident report form. A falls prevention resource manual is provided to each staff member providing information on falls risk factors and resource lists. Follow up sessions are held with staff after they have used the tool to obtain feedback.

Residents and their relatives have also been invited to project information sessions. Attendance at these sessions by residents relatives was low. Printed materials providing information on falls prevention and services in the area, such as the Falls and Balance Clinic, have been distributed.

Program sustainability

The project aims to achieve sustainability through ongoing use of the project resources (the assessment tool, incident reporting form) by staff. However staff time to utilise the falls risk assessment and management tool and to implement interventions to reduce residents risk of falling have been identified as a barrier by SRS staff participating in the project. Some of the SRSs have indicated that they will use the assessment tool for all new admissions.

Re-assessment of an individual residents falls risk is recommended every twelve months or following an acute illness.

Program evaluation

An evaluation to assess the projects effectiveness in achieving a reduction in the incidence of falls is planned for August 2000. This will involve pre and post intervention analysis of falls data, using completed falls incident report data and completed assessment tools. The evaluation will also involve post intervention assessment of staff knowledge.

The evaluation will not be used to assess the reliability of the assessment tool. However the need for a validated screening tool to determine the level of falls risk amongst community dwelling older people and those in residential care was identified by survey respondent for this program as one of the gaps in falls prevention.

This program is also part of a broader evaluation being conducted by an independent research consultant.

Transferability to other settings

The falls risk assessment and management tool and falls incident report could potentially be adopted by other organisations.

Workforce issues

As mentioned above, increasing awareness of SRS staff of falls prevention was achieved through:

- their participation in project development and implementation;
- informal training; and
- through information sessions.

7.3.2 Case study 2: Mercy Aged Care Services, Nudgee, Queensland

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Program description

In 1999, the physiotherapist at Mercy Aged Care Services trialled the education program, *Putting your best foot forward* produced by the CERA. This involved conducting resident meetings to increase awareness of falls prevention and to introduce systems enabling residents to suggest actions that could minimise hazards. Sessions with nursing and personal care staff were run consecutively. The Service has also trialled a falls risk assessment tool, based on tools developed by CERA and a falls prevention program based at the Royal Melbourne Hospital (RMH). Assessment incorporates referral to other health professionals as required, accessed through the Mater Hospital. Interventions have mainly focused on environmental audits to reduce hazards.

Target group

Mercy Aged Care Services is a residential care service run by the Sisters of Mercy for older people. The Service provides hostel (100 beds) and nursing home care (38 beds). The falls prevention initiative targets older people who have fallen and who are at risk of further falls.

Program aims

Through increasing awareness of falls prevention and introducing systems for reporting actions that could minimise hazards, the Service aims to reduce falls, promote constant review of the environment, and improve management of falls risk of high risk residents.

Program design and development

The interventions described were initiated by the physiotherapist in response to an increasing incidence of falls. The falls assessment tool is a modified version of the assessment tools developed by CERA and the program at RMH. The assessment is used to discriminate between those at high and low risk.

Program content

The interventions include a structured assessment by the physiotherapist incorporating a falls risk assessment tool. The project also involves education for staff and residents about risk factors for falling and preventative strategies.

Following the assessment of the individuals falls risk other interventions may be implemented to address identified risk factors. These risk factors may include medication use; medical conditions; sensory impairments; foot problems; footwear problems; dizziness; balance and gait; lower limb weakness; inactivity; indoor environmental hazards; and nutrition.

The physiotherapist will develop an individualised exercise program for those who may benefit from muscle strengthening. This usually involves only a small number of residents. Many of the residents are very frail and there is a tension between encouraging mobilisation and risk avoidance. This issue arises particularly in relation to residents in the high care categories in hostels where there is little carer support to assist individuals with exercise programs, individual or group based.

Program sustainability

Initiatives to reduce falls were commenced in 1999. The physiotherapist, a permanent staff member, is solely responsible for the implementation of initiatives.

Staff time to utilise the falls risk assessment and management tool and to implement interventions to reduce residents risk of falling have been identified as a barrier to ongoing sustainability. There is therefore an emphasis on environmental assessment and modification rather than on other interventions which could address intrinsic risk factors. Exercise programs have been difficult to initiate particularly for residents who are very frail and who would need to be physically supported in an individualised program. In a group situation the exercise could subject them to further risk.

Program evaluation

To date there has been no evaluation of the program. Monthly monitoring of falls occurs through continuous auditing, made possible through the introduction of falls incident reporting forms.

Transferability to other settings

The need for a validated screening tool to determine the level of falls risk amongst older people in residential care was identified as one of the gaps in falls prevention. Tools validated in an aged care hospital ward could potentially be applied in a nursing home environment.

Workforce issues

This initiative has provided opportunities for nursing and personal care staff, as well as residents, to attend information sessions to increase their awareness of falls prevention. An identified need was for better networking to facilitate exchange of information between like programs.

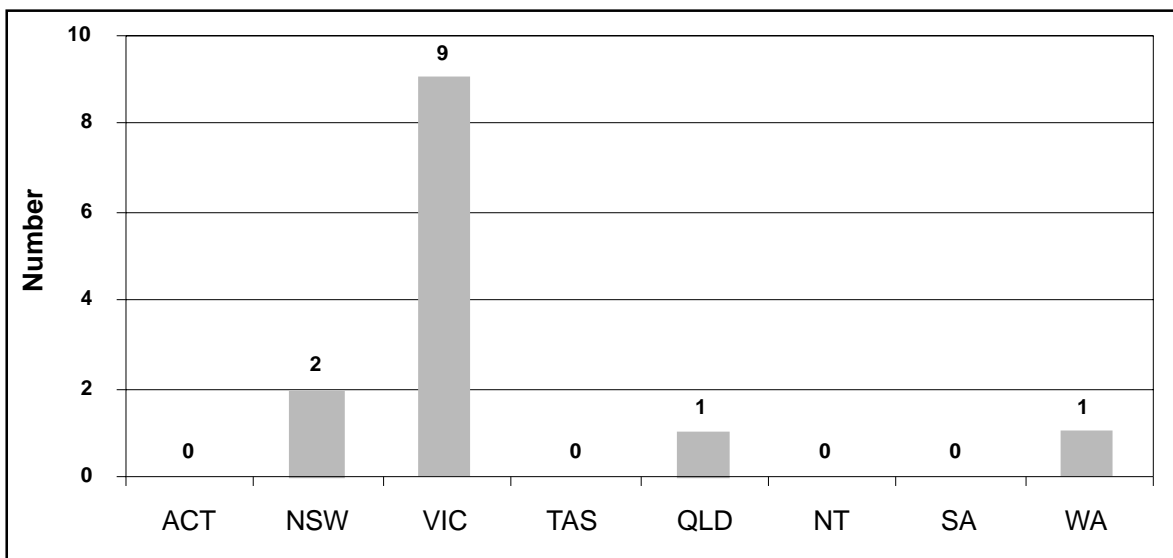
7.4 Survey results (graphs and tables) for the Residential Aged Care setting

Thirteen of the 122 scanned programs (11%) were conducted in residential aged care settings. The results for the falls prevention programs in hospital settings have been summarised in section 7.1, and are presented in figures in this section.

7.4.1 Location by state

The greatest proportion of responses to the Stocktake survey for programs in residential aged care settings were from Victoria, followed by New South Wales (figure 7.1). A number of the Victorian programs have been funded through the second phase of the *Foothold on Safety* program (see section 3.3.6).

Figure 7.1 Survey respondents by state



7.4.2 Falls risk factors addressed

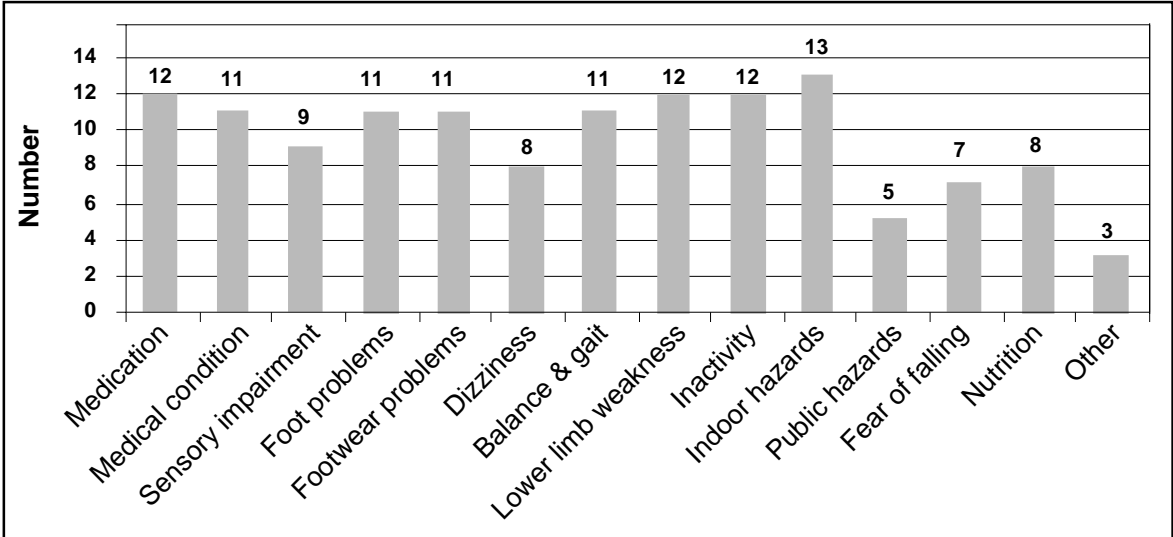
All of the programs in residential aged care settings addressed multiple risk factors. An average of 10 falls risk factors were addressed per program.

The risk factors addressed are highlighted in figure 7.3 below, with most of the common falls risk factors addressed by most of the programs. The most common falls risk factors addressed by falls and falls injury prevention programs in residential aged care settings were:

- indoor hazards (n=13);
- inactivity (n=12);
- lower limb weakness (n=12); and
- medications (n=12).

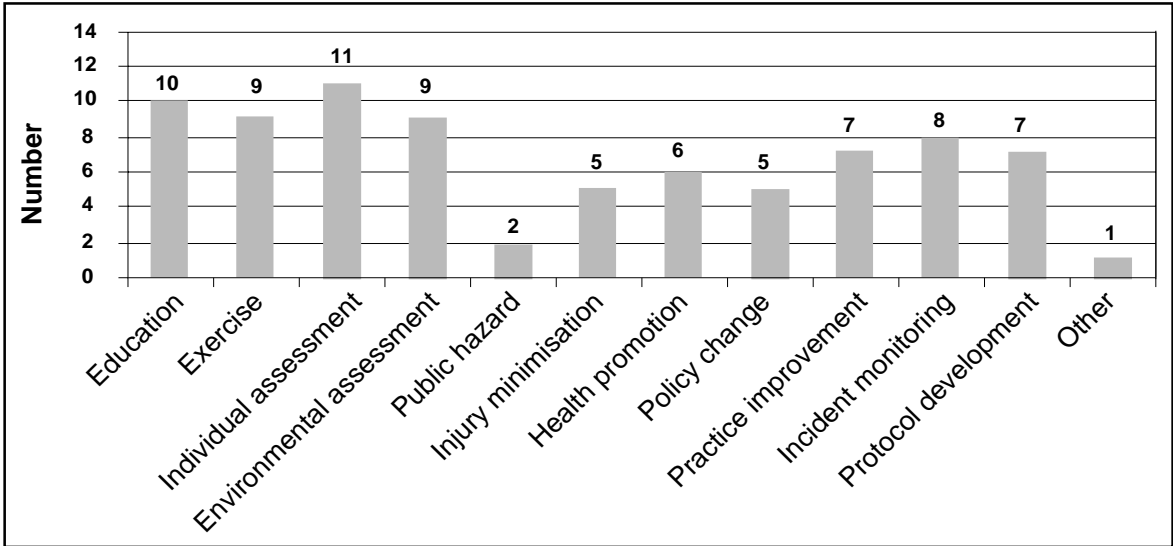
In total, 11 programs addressed a minimum of these four most common risk factors. When analysing those programs which did address at least these four risk factors (n=11), the most common program types were individual assessment, education, exercise, and environmental hazards review and modification. These were among the most common program types in residential aged care settings when all programs were analysed (figure 7.4).

Figure 7.2 Risk factors addressed



Note; Multiple choices permitted

Figure 7.3 Program type for those programs addressing four most common falls risk factors (n=11)



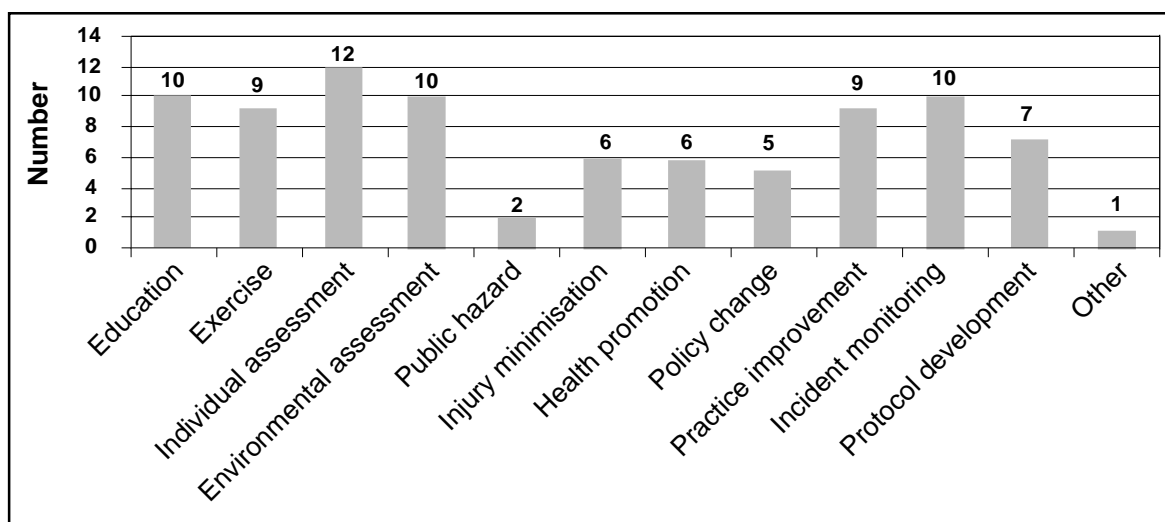
Note: Multiple choices permitted

7.4.3 Type of falls/falls injury prevention program

The 13 residential aged care setting programs include a range of interventions (figure 7.4). All programs included more than one type of intervention. Most programs included individual assessment, education, environment assessment/modification, and exercise. The majority of programs also addressed systemic and procedural activities such as practice improvement or incident monitoring, as well as specific individual interventions. Injury minimisation was also an intervention in 46 per cent of the programs in residential aged care settings, compared to only 40 per cent of programs of this type in the community setting.

All residential aged care setting programs implemented more than one intervention type, either as separate (distinct) programs (n=1), or multi-faceted (linked) programs (n=10), or a combination of both (n=2). The research evidence of effective falls prevention programs in the residential aged care setting shows that approaches utilising individual risk assessment and management are effective (DHAC 2000). Twelve of the 13 programs (92%) incorporated an individual risk factor assessment and targeted management program.

Figure 7.4 Types of falls/injury prevention programs

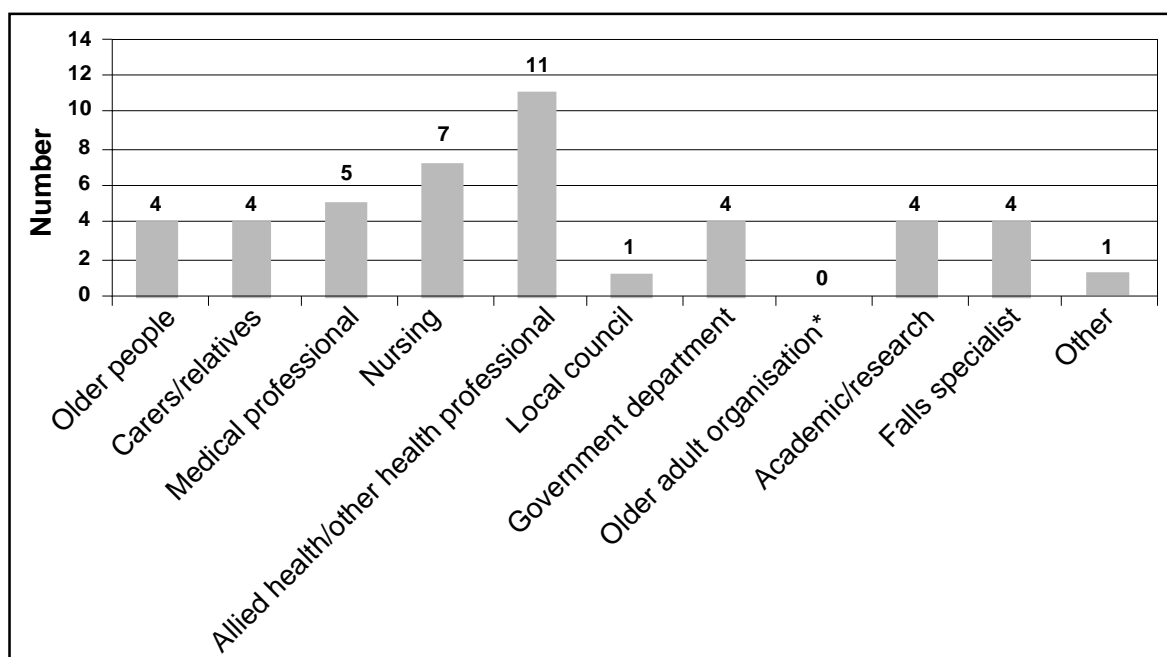


Note: Multiple choices permitted

7.4.4 Who was involved in program development?

Allied health professionals were the most common group involved in the development of hospital based falls and falls injury prevention programs (85%, Figure 7.5). Nursing staff were also commonly involved in program development (54%). On average, three different groups were involved in development of residential aged care based programs. A diversity of groups involved in program development was considered to be important criteria in the guidelines for evaluating falls prevention programs (NARI, 1999).

Figure 7.5 Who was involved in development of the program?



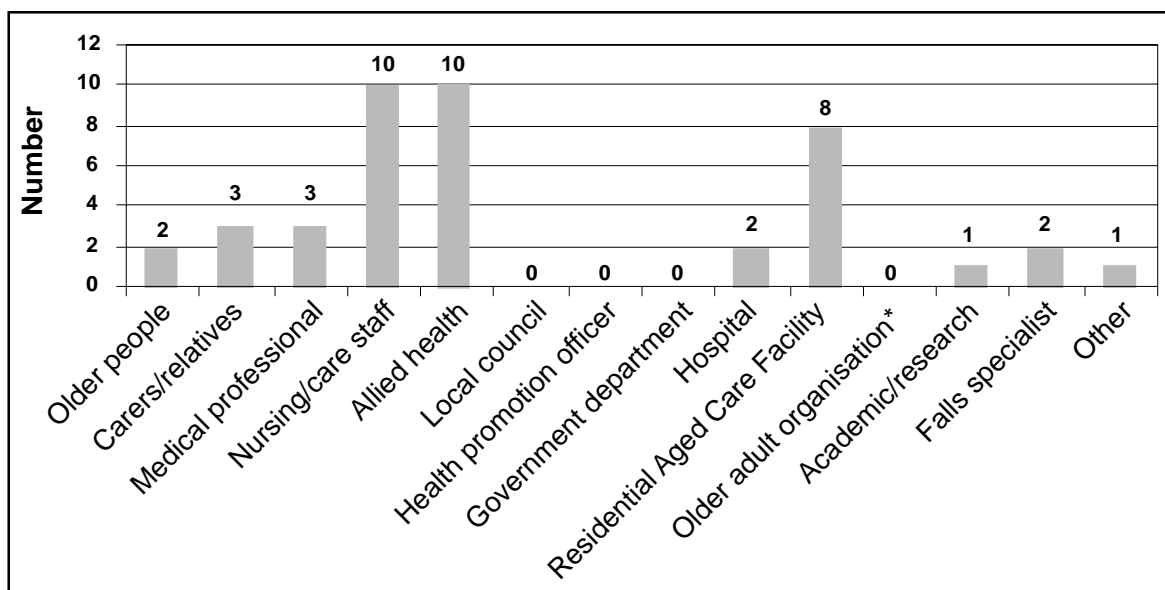
Note: Multiple choices permitted

*Older adult/ethnic/community organisation

7.4.5 Who implemented the program?

Staff, predominantly nursing and allied health professionals, were also involved in the implementation of the majority of programs. An average of three groups were involved in the implementation of residential aged care based falls prevention programs. Interestingly, only three of the programs involved medical staff in program implementation. Medical staff would appear to be key staff in residential aged care falls prevention programs. There may be a need to explore options for increasing involvement of medical staff in falls prevention program implementation in residential aged care settings.

Figure 7.6 Who implemented the program?



Note: Multiple choices permitted

*Older adult organisation = Older adult/ethnic/community organisation

7.4.6 Target groups

Predominantly older people and people at risk of falling or who have fallen were the main target groups in residential aged care falls prevention programs. Nursing staff, allied health staff, and medical staff were also often reported as target groups for falls prevention programs. Involvement of the staff as a main target group in the residential aged care setting highlights the need for effective workforce training for these groups, as identified also in the hospital setting. Problems with workforce training were highlighted in responses to the descriptive section of the survey identifying areas in need of improvement (see section 7.2.4 and 7.2.5).

7.4.7 Year that program was introduced

Most of the programs (77%) have been introduced since 1998, and almost programs are still in operation. It would be expected that the full effect of the relatively new programs on reducing falls and falls related injuries in residential aged care settings would not be evident for up to several years.

As in the community and hospital settings, an important issue to be managed well with the high proportion of programs recently developed, and with the likelihood of this trend continuing for at least the next few years is to optimise communication between programs regarding:

- what works;
- what doesn't work;
- dissemination of program outcomes; and
- what resources are available.

Networking between falls prevention workers in residential aged care settings was identified as an area requiring future improvement. In order to maximise outcomes in reducing falls and falls related injuries in residential aged care settings in the near future, strategies to promote networking for workers in this setting will be important to develop and support.

7.4.8 Reasons for introducing program

The reasons for the introduction of the falls prevention program were primarily based on health professional initiative (n=10), with availability of funding also being cited as a factor in over half of the programs (n=7). The proportion of programs reporting availability of funding as a factor in program development in the residential aged care setting was considerably higher than that in the community (36%) and hospital (14%).

7.4.9 Incorporation of existing programs into program development

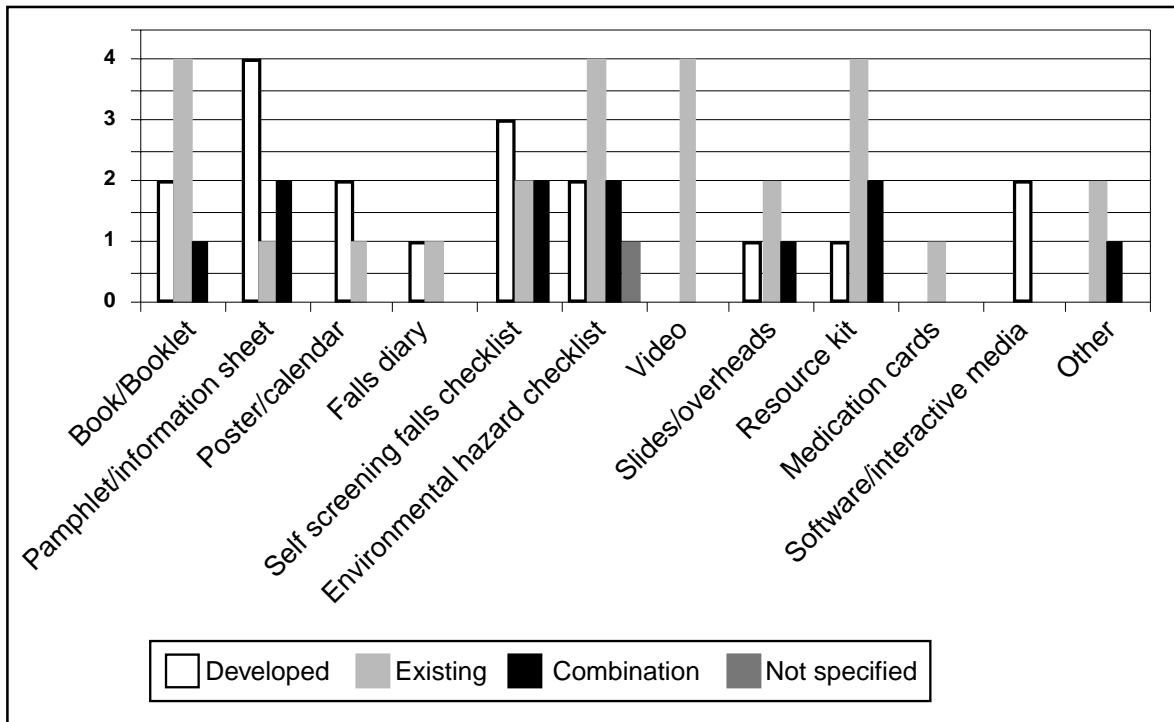
Fifty four per cent of residential aged care programs were modelled on an existing program. This percentage is similar to that in the community setting (55%), and is an indication that some systems are in place to facilitate sharing of information between programs.

7.4.10 Resources/tools used

A wide range of resources were used in falls and falls injury prevention programs in residential aged care settings (figure 7.7). Environmental hazard checklists, books/booklets, pamphlets/information sheets, and resource kits were most commonly used. In contrast to the hospital setting, more existing resources were used, relative to resources developed specifically for the program. This is consistent with the higher proportion of programs in residential aged care settings being based on existing programs (section 7.4.9).

Greater detail about the specific resources used, including those in languages other than English have been reported in sections 7.2.7 and 7.2.8 respectively.

Figure 7.7 Resources/tools used



Note: Multiple choices permitted

7.4.11 Program access

The majority of programs were able to accessed by residents and staff of the residential aged care settings with no other criteria for involvement in the program.

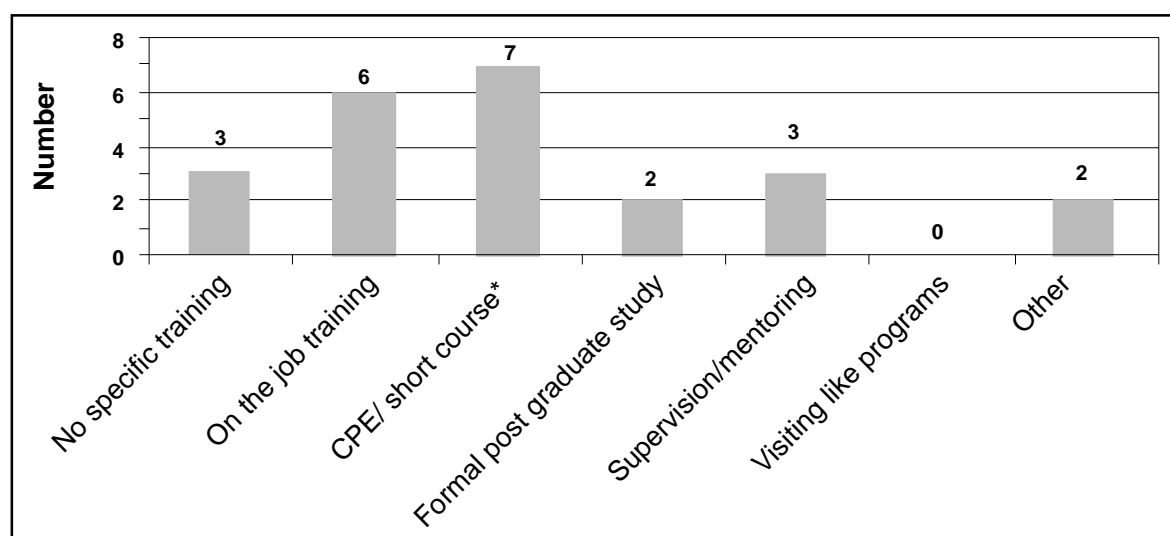
7.4.12 Transfer of program to other settings

Only two of the 13 programs were translated to other settings. One of these programs was taken to another facility where it is being trialed in a complex care wing. The social skills/ activities were able to be adapted to suit non-demented residents and those with lower needs (hostel residents). The other was trialed in a hospital.

7.4.13 Type of training provided for those implementing program

Almost half of the programs used two or more avenues of workforce training for staff involved in program implementation (46%). Similar to the community and hospital settings, the most common avenues used were on the job training, and short courses (CPE). Three programs (23%) offered no specific workforce training options (Figure 7.8).

Figure 7.8 Workforce training provided to program implementers



Note: Multiple choices permitted

*CPE (Continuing Professional Education) / short course / lecture

7.4.14 Program sustainability

An important issue which needs to be considered in falls and falls prevention program development and implementation in all settings is that of sustainability. Only programs which are currently running, or have run in the last 12 months were included in the national falls stocktake analyses. Only one program (8%) had stopped running in the past 12 months.

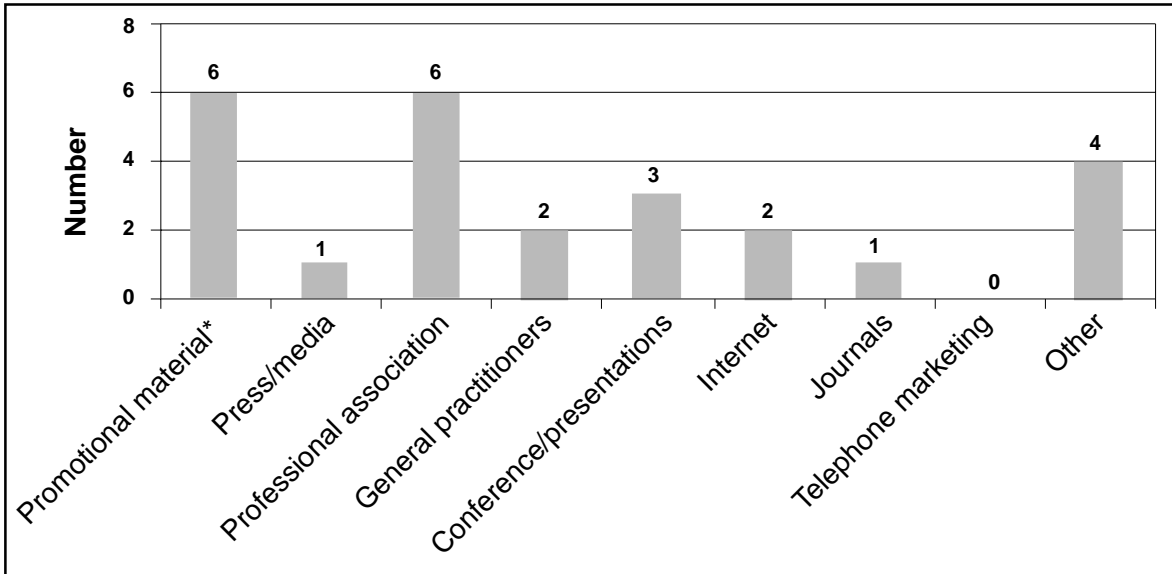
Two organisations indicated that their programs were not sustainable (including the one which had stopped running), one due to funding, the other to funding and staffing issues.

Most commonly reported factors associated with program sustainability were program duties being incorporated into job description of staff (n=8), availability of permanent staff (n=3), and cost recovery being implemented (n=3).

7.4.15 Promotion of programs

In residential aged care settings, a range of methods of program promotion were used (figure 7.9). The average number of avenues for program promotion was three. Most commonly, promotion of programs was within/to residential aged care facilities, as well as to health professionals (Figure 7.10).

Figure 7.9 How the programs were promoted

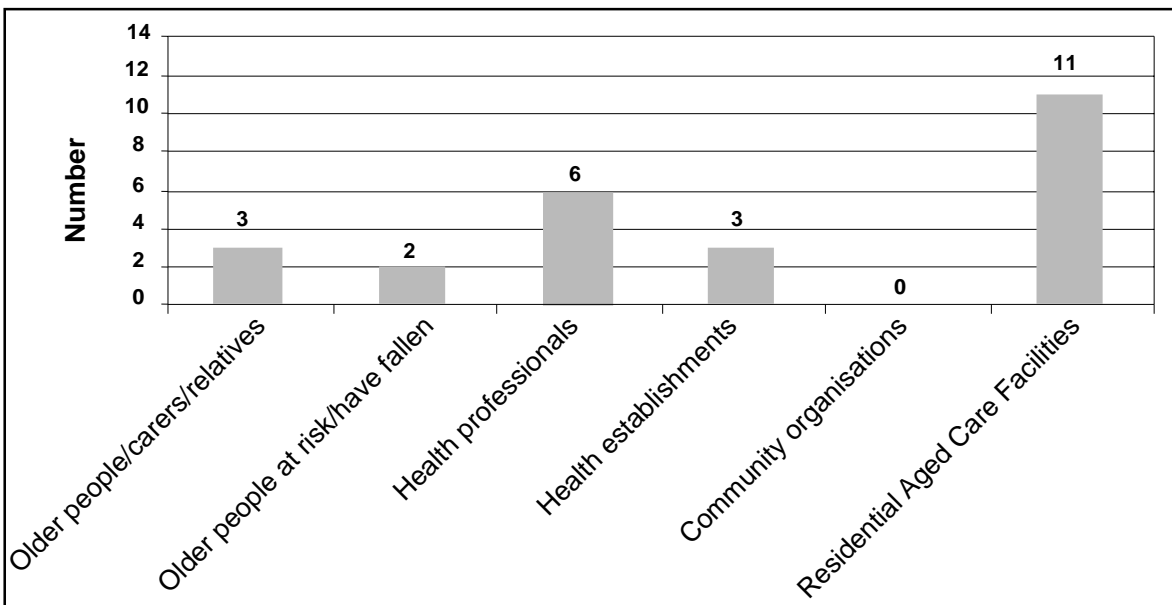


Note: Multiple choices permitted

*Promotional material flyers, pamphlets, newsletters

Other includes: Lectures/presentations to staff, residents and carers

Figure 7.10 Who received promotional material?



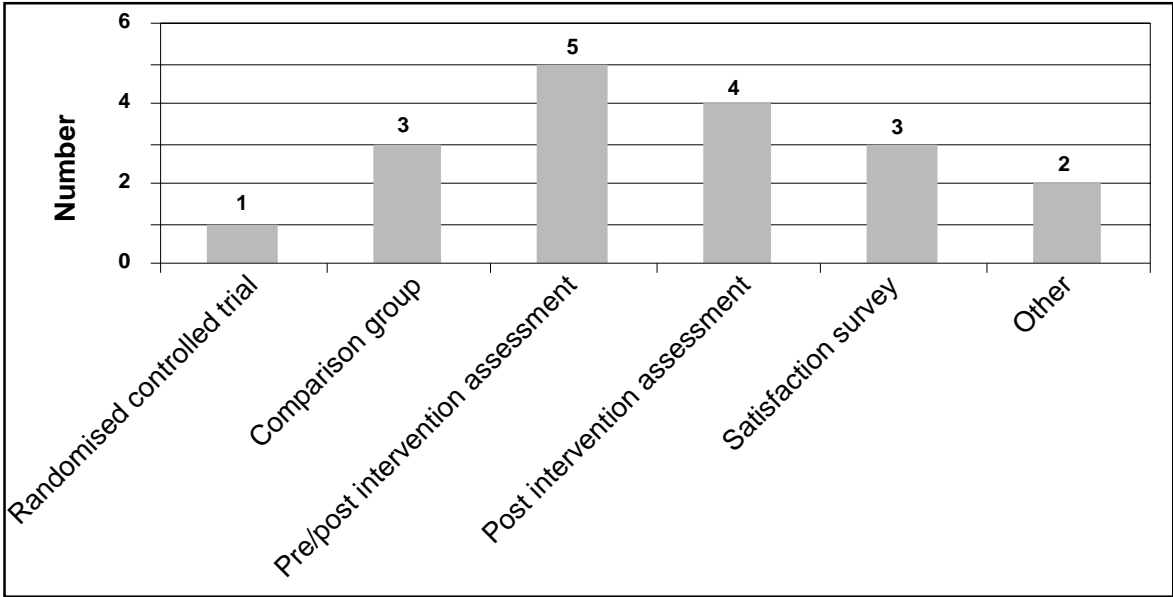
Note: Multiple choices permitted

7.4.16 Program evaluation

Twelve of the 13 programs (92%) reported that some form of evaluation had been conducted or was planned. In almost all of those conducting evaluations, the evaluation was being performed in house (n=9). Most evaluations comprised a pre-post intervention assessment or a post intervention assessment (Figure 7.11). Only one of the falls/falls injury prevention programs (8%) being conducted in residential aged care settings reported using a randomised controlled trial design in their evaluation.

Nine of the programs undertaking an evaluation indicated that they had partly or fully achieved their objectives.

Figure 7.11 Type of evaluation



Note: Multiple choices permitted

7.4.17 Program funding

Primary funding sources for falls and falls injury prevention programs in the residential aged care setting were spread fairly evenly between direct commonwealth or state sources, and core funding.

In kind support

Seven of the 13 programs responded to this question. Four indicated that they did not receive any in kind support and one did not specify the type of in kind support received. The two other programs indicated that administrative support was provided, one of these also stated that steering committee input was received, and the other an office and computer. No amounts were provided.

8.0 *Falls prevention activity in mixed settings*

Twenty six programs (21%) indicated they operated in various combinations of the community, hospital, or residential aged care settings. These programs have been considered separately, under the heading “mixed settings”. Because of the diversity of the programs, much of the survey data was considered to be too broad to enable meaningful detailed analysis, as has been undertaken for each of the settings individually. However, programs which cross setting boundaries may provide useful information, particularly when considering issues related to program transferability. Some of the descriptive items from the National Stocktake survey, and two case studies based on programs from mixed settings have been included in this section.

8.1 Summary

The programs represented a broad mix of all combinations of community, residential aged care and hospital settings. Overall, the 26 programs included 23 component programs from the community setting, 22 from the residential aged care setting, and 18 from the hospital setting. The mix of programs were:

- community and residential aged care n = 10;
- community and hospital n= 4;
- hospital and residential aged care n= 3; and
- community and hospital and residential aged care n= 9.

Although the thematic analyses raised many similar issues to those identified in the individual settings and the overall analyses, the key theme to note is the emphasis on adapting aspects of programs in one setting to another setting. This has been reinforced in the two case studies reported in greater detail in this section. While there does not seem to be universal strategies which can be derived from the level of analysis available from the Stocktake, the case studies provide clear examples of ways in which transfer between settings can be successfully achieved.

Not all aspects of all programs will be transferable between settings. There are unique characteristics which need to be given consideration in determining whether one or more components of a program in one setting may transfer to another, including:

- characteristics of the older people in each type of setting (for example, level of frailty);
- the support network, including staff and family available; and
- issues related to the settings themselves (for example, short length of stay in acute hospitals).

However, given the increasing research evidence about effective falls prevention programs, particularly in the community setting, and the increasing number of programs developing

in all settings, there should be considerable scope for greater transfer of program components between settings in the future.

To foster improved transfer of aspects of programs in one setting to another, there are a number of important activities that need to be supported. These include improvements in:

- communication and networking so that those developing programs are aware of what is available, and what has been effective. A variety of avenues should be available for this, including the Internet, paper based information, and face to face opportunities such as workshops;
- evaluation of programs, so that those shown to be effective can be showcased;
- dissemination of information about resources developed, so that duplication of resource development is minimised. This should include easily accessible information about contact details, costs, and where possible, information about the quality of the resource; and
- dissemination of program outcomes, including opportunities to present results in journal papers, health professionals magazines, conferences, workshops, newsletters for groups representing older people.

8.2 Thematic analyses

8.2.1 Key objectives of the program

Falls prevention programs in mixed settings described a range of objectives. These included:

- reducing falls/falls injury (n=12);
- health promotion by raising the awareness and educating health professionals and older people of fall risks/strategies/services (n=11);
- improving environmental safety, through assessments/modifications and hazard reports (n= 5);
- improving the physical status of individuals—balance/mobility/strength (n=4);
- improving confidence/reducing the fear of falling (n=4);
- to encourage/help implement a falls program at a facility or facilities (n=3); and
- to monitor falls/examine data collection process (n=2).

Indicative of the more global approach in many mixed setting programs were objectives to increase the integration of services, establishing clinical pathways, and improving multi-skilling and intersectorial collaboration.

Other objectives also include increasing access to services, identifying the appropriateness of existing information and developing appropriate information/education packages, and the quality use of medication.

8.2.2 Enhancements to program effectiveness

Funding (n=9) was the most commonly cited issue in relation to improving program effectiveness, including the need for localised funding, for staff to devote time to the program, for specialist staff; for further activities or growth (n= 2), and to extend the program to ensure sustainability (n=2). As one respondent pointed out, it takes a long time to get strategies established and incorporated into core business. Sustainability/ incorporating the program into core business was listed by a further two programs. Another respondent stated that a more structured program with inbuilt follow up and support for facilities would improve sustainability.

Some other issues identified were:

- improved promotion of the program (n=2) including making information available at older persons groups or libraries;
- staff education/training (n=2);
- a catalogue of educational material and other resources;
- a dedicated program project officer;
- inter-disciplinary respect and collaboration and the ability to case conference;
- annual assessment of tools;
- analysis of patient feedback;
- participants to be reviewed;
- early notification of first time fallers;
- incorporating more individual assessments and strategies (limited by available resources);
- greater community discharge supports, extra sessions and offering the program to other health and community workers; and
- the need for older people to own and run the program themselves.

8.2.3 Resources developed/used

A broad mix of resources were used by programs operating in mixed settings. Most of these have been previously reported in the description of the single settings. Resources reported in the mixed settings programs were:

- Stay on your feet book (n=2);
- Department of Veterans Affairs *It couldn't happen to me* education kit (n=2);
- APSF video *Standing on your own two feet* (n=2);
- FRAT (Falls Risk Assessment Tool) pack (n=1);
- NARI falls prevention posters/pamphlets (n=1);
- DHS (Victoria) Taking injury prevention forward book (n=1);
- *Don't come a cropper* video (n=1);
- Department of Veterans Affairs medication cards (n=1);

- CERA education package *Putting your best foot forward* (n=1);
- *Balancing Acts: Falls and older people* training package for GPss (n=1);
- AIMS pamphlets/posters/video/multimedia for use with AIMS software (n=1);
- Active Ageing posters (n=1);
- Professional guidelines pharmacy courses (n=1);
- Video —*Falls prevention and emergency assistance* (Training Health and Education Media) (n=1);
- *Healthy homes* party kit (n=1);
- *Falls prevention in nursing homes* booklet (n=1);
- *How to keep the spring in your step* self screening falls risk checklist (n=1);
- *Designing together for safe living* pamphlet, with the Building Designers Association (n=1); and
- DHS video *Home safety* (n=1).

In addition, a number of programs also cited other tools, without identifying information, for example, home environmental hazard checklists (n=5); self screening checklists (n=2); a GP information card (n=1); management pathways (n=1); and a number of different pamphlets.

8.2.4 Resources in languages other than English

Two of the mixed setting programs reported using resources which were available in languages other than English. These resources were:

- the NSW Health home hazard checklist languages not specified; and
- a self screening checklist and home hazard checklist, available in Spanish, Greek, Italian, and Chinese.

8.3 Case studies

8.3.1 Case study 1: Western Victorian Division of General Practice

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This program has been funded as part of the Victorian DHS *Foothold on Safety* program. *Foothold on Safety* initially targeted falls prevention in community settings, and has more recently included falls prevention programs in other settings. This project, which focuses on residential aged care settings, has been included in the mixed setting section of the report because of the close interaction between falls prevention work occurring in all three settings by the project group, including the adaptation of a tool developed and tested in the acute care setting.

Program description

The Western Victorian Division of General Practice in partnership with the Wimmera Health Care Group (WHCG), Horsham, is responsible for the implementation of the *Falls Prevention in Residential Facilities* program, funded by the Victorian state government through its *Foothold on Safety* falls prevention program. The program introduced in the WHCGs residential aged care facilities, is based on a falls prevention program developed and trialed by the WHCG in an acute setting.

The program involves individual risk factor assessment and management incorporating an assessment and rectification of any environmental hazards contributing to falls. Over the course of the program/project, the participating residential facilities will be assisted to establish their own reporting, auditing and falls risk management systems on a self-sustaining basis by incorporating program duties into job descriptions of nursing and allied staff.

Target group

The program targets residents of residential aged care facilities, who are 65 years and older and at risk of falls and/or have fallen. The program is also directed towards educating carers, relatives, medical practitioners, nurses, and allied health professionals to effectively implement strategies for falls prevention.

Program aims

Identified program objectives include to:

- develop a profile of the falls occurring in the participating facilities;
- commence and refine a falls audit and risk management assessment program for each of the participating facilities; and
- produce a manual of falls prevention strategies in residential facilities.

Program design and development

A falls prevention program developed and trialed by the WHCG in an acute setting, was adapted for use in the WHCGs residential facilities in response to identified gaps in falls prevention programs in residential settings. The program was established in 1999 when funding became available. The program design is based on a literature review, with particular attention to types of interventions undertaken and their effects.

The program draws on a diverse range of expertise for the implementation of interventions, including carers and relatives of residents of the aged care facilities, GPs, nursing staff, physiotherapists, occupational therapists, podiatrists, in addition to specialist services such as Vision Australia.

Program content

The three key elements to the program are listed below.

- **Falls audit.** This involves the investigation of falls to define the causative factors and mechanism of falls. The project officer in consultation with allied health professional(s), reviews the individual and the site of each fall. A falls reporting system has been developed alongside the Australian Incident Monitoring System established in each facility.
- **Risk identification.** This involves identifying the individuals falls risk factors as well as identifying environmental hazards. Individuals are assessed to determine factors placing them at increased risk of falls, such as, poor mobility, vertigo, medication effects, confusion, fear of falling and poor vision. Re-assessment occurs at monthly intervals. An environmental audit of the facility is also undertaken and regularly reviewed at three monthly intervals.
- **Risk management.** On the basis of each individuals falls risk profile a risk management plan is developed to reduce the risk of subsequent falls. This may include medication monitoring, mobility aids or behavioural strategies. Where environmental hazards are identified action is taken to rectify the problem, for example, improving lighting or installing safety apparatus.

The program has been promoted to residents, their carers and relatives, health professionals and GPs through the distribution of printed materials and, in the case of GPs, through the Internet.

Educational materials have been specifically developed for the program, including an information folder for staff working in the residential facilities. A number of existing tools and products have been adapted for use in the program including:

- *Standing on Your Own Two Feet* (video and booklet), Australia Pensioners and Superannuants Federation;
- *Falls Prevention Manual*—Meg Butler New Zealand;
- *FRAT Pack*—Peninsula Falls Prevention Service, Peninsula HealthCare Network; and
- *How to Keep the Spring in Your Step* self risk assessment.

These materials are not available in languages other than English.

Program sustainability

The program has three years funding, although funding for the project workers position will cease in July 2000. Over the course of the program/project, the facilities will be assisted to establish their own reporting, auditing and falls risk management systems on a self-sustaining basis by incorporating program duties into job descriptions of nursing and allied staff.

A manual detailing falls prevention strategies trialed through the program will be produced for dissemination to other residential facilities.

Program evaluation

The Monash University Accident Research Centre (MUARC) has been contracted by the Victorian DHS to evaluate this program as part of its overall evaluation of the *Foothold on Safety* falls prevention projects in community and residential settings.

Because of the short intervention period (less than twelve months) evaluation of the falls prevention in residential settings program will focus on implementation issues, in particular a critical appraisal to identify key elements of projects, for example, increases in falls prevention awareness, knowledge and behaviours in management, that generate desired changes.

Transferability to other settings

This program was initially conducted in an acute setting (trials by the WHCG). Risk assessment tools and implementation strategies have been adapted for use in the residential setting. Other interventions, such as vision/hearing checks, physiotherapy and podiatry are also versatile enough to be used in acute or residential settings.

Workforce issues

Using educational strategies such as on the job training, continuing professional education and supervision by an experienced practitioner, staff of the residential facilities have increasingly become open to changing work practices to incorporate falls prevention strategies in response to identified individual and environmental risk factors.

8.3.2 Case study 2: Australian Association of Consultant Pharmacy

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Program description

Established in 1995 the Australian Association of Consultant Pharmacy is responsible for the *Medication Review in Aged Care Facilities* program. The program involves accredited pharmacists reviewing the medication regimens of people in aged care facilities and community dwelling veterans and war widows with the aim of monitoring and preventing medication-related falls. The Commonwealth government has primarily funded the program, with secondary contributions from the Pharmaceutical Society and the Pharmacy Guild of Australia.

Target group

The *Medication Review* program targets older people mostly over 65 years, residing in aged care facilities and veterans who are at risk of medication misadventure. It also aims to educate pharmacists, medical practitioners, nurses and staff of aged care facilities. Pharmacists and aged care facility nursing staff identify people who might benefit from the

program on the basis of specific risk criteria. These criteria are based on evidence of contributing factors which are associated with increased risk of medication misadventure, for example, the number of medicines, doses, conditions, the drug itself and the characteristics and experiences of the person. Veterans and war widows can access the program by GP referral.

Program aims

The program aims to reduce medication-related problems, including medication-related falls. It also endeavours to ensure quality use of medication.

Program design and development

Based on medication review and management programs in Australia (from 1992) and also in the USA, the program was designed and developed by accredited pharmacists and pharmacy organisations in conjunction with the Commonwealth Department of Health and Aged Care (DHAC).

The program is offered to all at risk people in aged care facility approved beds (currently around 113,050 are involved in contracts for medication reviews), and to Department of Veterans Affairs (DVA) clients (currently around 240,000 would take medications). However, not all of the DVA clients would be at risk and need a medication review.

The *Medication Review* program is promoted through professional associations, GPs, aged care facilities and community organisations for veterans and war widows. An estimated 3,000 copies of printed promotional materials are produced and distributed each year. Some pharmacists also make direct approaches to GPs and aged care facilities to promote the program. Information about the program has also been disseminated through conference papers, journal articles, reports and newsletters.

Program content

The *Medication Review* program involves individual risk factor assessment and management in the form of pharmacists reviewing the medication regimen of older people in aged care facilities and community dwelling veterans and war widows.

This program extends to all aged care facilities across Australia. A facility and the pharmacist make an agreement that is approved through DHAC. Quarterly reports are made to the Commonwealth. Participation in the program is at no cost to the aged care facility.

GP referral to the program is not mandated for people residing in aged care facilities and participating in the program. However, the pharmacist must involve and consult with the GP. In the case of older people who, due to cognitive deficits, are unable to provide informed consent for the service, the usual procedure of consent from their delegated authority is required.

The medication reviews are conducted according to guidelines endorsed by the Pharmaceutical Society of Australia. Additional training necessary for accreditation which is conducted by a variety of University Pharmacy Schools and the Australian College of

Pharmacy Practice, address the issues to be covered as does a great deal of a pharmacist's initial training. There are specific professional requirements for documentation that the pharmacists use to report, document and monitor the issues dealt with.

Program sustainability

The *Medication Review* program is ongoing. Funding is tied to the DHAC and Pharmacy Guild Agreement on pharmacy remuneration.

Program evaluation

Evaluation of the *Medication Review* program in the form of pre and post intervention assessment is ongoing and is conducted by academics. Evaluation addresses changes in medications, improvement in patient well being and GP and nursing staff satisfaction with processes and outcomes.

Transferability to other settings

The program is easily adaptable as the criteria for identifying people who might benefit from the program medication review (as described in the target group section) can be applied in any setting.

Workforce issues

As part of their accreditation program, pharmacists receive on the job training, continuing professional education, supervision by an experienced practitioner and the opportunity to pursue formal post-graduate study.

However the *Medication Review* program also requires pharmacists to sensitively promote the benefits of the service to other health professionals as they rely on nursing staff and GPs to implement the recommended changes. Educational pamphlets and information sheets have been specifically developed to assist awareness raising amongst nursing staff in aged care facilities.

9.0 *Sustainability*

Program sustainability is often an objective in its own right for falls and falls injury prevention programs. The majority of programs described in the previous sections of this report have indicated that they believe they will be sustainable. Of those indicating they were/are not sustainable, a small number were pre-planned to finish after a set period. Examples of these include some of the research studies reported.

In particular, efforts should be undertaken to ensure programs identified as being effective are able to be sustained. Equally importantly, programs shown to be ineffective need to be identified as such, and either modified or stopped. As such, sustainability needs to be considered in conjunction with other key issues such as effectiveness, cost benefit analysis, and program reach. This type of analysis is beyond the scope of the National Falls Prevention Stocktake project. However, some issues associated with sustainability have been explored in this section of the report, in two case studies on projects where part or all of the project was unable to be sustained.

9.1 Summary

Similar to issues associated with evaluation of falls and falls injury programs, sustainability is another area which should be given consideration in the planning or developmental stages of a program. Some avenues for falls and falls injury prevention programs to become sustainable include:

- permanent or long term funding being available;
- permanent staff being allocated to specific roles within a program;
- cost recovery mechanisms implemented; and
- program duties incorporated into the job description of staff.

Limited or short term funding has been frequently identified as a factor limiting both the likelihood of effectiveness, and the sustainability of falls and falls injury prevention programs. While there are, and will continue to be funding opportunities for new programs, innovative strategies are required to consider options for achieving longer term sustainability, without necessarily requiring full funding long term. There is also a need for program funders to consider the distribution of their funds, in particular whether fewer, larger scale and sustainable programs may be a more viable option in some cases, relative to a larger number of very short duration funded programs.

The other commonly cited factor associated with increased sustainability, but also as a barrier to program effectiveness in some cases was the incorporation of program duties into job descriptions of staff. If staff have the capacity, then this appears to be a positive way of achieving program sustainability. However, staff in a number of programs reported that they were already working at capacity level, and found additional demands associated with new falls and falls injury prevention programs roles being allocated to them were beyond the limit of what they could effectively carry out.

Issues associated with improved sustainability of falls and falls injury prevention programs warrant further investigation. Promotion of those strategies shown to be effective should further improve the sustainability of falls and falls injury prevention programs in Australia.

9.2 Case studies

9.2.1 Case study 1: Redcliffe-Caboolture Health Service District

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Program description

In 1999, the Redcliffe-Caboolture Health Service District (RCHS), covering an area north of Brisbane, established a Falls Prevention Working Party. This Working Party is in the process of developing and implementing a multi-faceted program. Key interventions to be developed through the program include education and awareness raising, home hazard assessment, and exercise.

The program is supported by agency core funding in addition to contributions from Quota International (a womens service organisation).

Target group

The program target group includes people over the age of 60 years, particularly those people deemed to be at risk or who had previously fallen. The program is also designed to raise awareness of falls risk amongst carers and relatives of older people and older adult organisations.

Program aims

The program aims to reduce the risk of injury and loss of confidence in the older population by providing a coordinated and multi-factorial Falls Awareness Program in the Redcliffe-Caboolture Health Service District. Specific objectives include:

- increasing awareness of the high incidence and the possible long term implications of having falls;
- reducing the risk of falls in the home environment by providing home hazard assessments;
- providing the opportunity for participants to initiate self-directed actions by maintaining a falls calendar; and
- the improvement of general fitness levels of participants through an appropriately designed exercise program.

Program design and development

The program was developed in response to an identified community need to stem the high incidence of falls among older people in the community. The program was adapted from the University of Queensland initiative, *No Falls! No Fear! Falls Prevention* project.

The program draws on a diverse range of expertise including nurses, occupational therapists, physiotherapists, podiatrists, social workers and dieticians. These professionals are responsible for implementing interventions conducted in clients homes and in community facilities.

Promotional material, such as fliers, pamphlets and newsletters, were distributed to older people, carers, relatives, community organisations, health professionals and health establishments. Information about the program was also advertised in the media/press.

Program content

Key interventions currently being developed through the program include education and awareness raising, home hazard assessment, and exercise. The risk factors that the RCHS program aims to address through its program include medications, sensory impairments, foot and footwear problems, dizziness, balance and gait, lower limb weakness, indoor environmental hazards, fear of falling, nutrition and incontinence.

An education program based on the *Falls Prevention Kit* developed by Queensland Health will be targeted to older people as well as older adult organisations and will be conducted in six to eight weeks and will incorporate an exercise program.

This education program will be supplemented with:

- the distribution of 500 falls calendars to older people, to encourage self-directed action to prevent falls. These will be accompanied with six and 12 months return questionnaires for the purposes of follow up; and
- the distribution of a home falls prevention checklist to encourage older people to identify any home hazards and seek assistance to address these through home modifications.

The program will also involve modifying an existing falls risk assessment tool, currently used in acute settings, to adapt it for use in a community setting.

Program sustainability

Some aspects of the program will be incorporated into the agency's services, such as the home falls prevention checklist, and the risk assessment tool. Ongoing funds are required however to systematically conduct education, awareness raising and exercise programs and to increase allied health resources to assess and appropriately recommend interventions to address identified falls risk factors.

Program evaluation

Evaluation is intended to take place in January 2001. Feedback questionnaires distributed with falls calendars are due to be returned in June and December 2000. Information gathered through the questionnaire will be used to assess the benefits of the education program.

Transferability to other settings

The program has not been used in any other settings or with different target groups. Some elements of the program have commenced, but on going education and exercise programs are yet to be implemented. However, the education and exercise element of the program may be transferable to other contexts in the future.

Workforce issues

Lack of appropriate staff has been a problem in the implementation of the program. Limited availability of physiotherapy time has held up the implementation of proposed programs.

9.3.2 Case study 2: Southern Domiciliary Care and Rehabilitation

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Program description

Southern Domiciliary Care and Rehabilitation (SDCR) is responsible for the implementation of the *Mobility Assessment and Advice* Program. Introduced in 2000, this new program provides community access to skilled advice and information on how to manage mobility issues. The program involves a one-off assessment by a physiotherapist in the clients home and in public spaces to identify falls risk factors and to recommend appropriate interventions.

Target group

The *Mobility Assessment and Advice* program is available to older people as well as young people with disabilities. The program is directed toward anyone at risk of falls.

Program aims

The *Mobility Assessment and Advice* program aims to ensure people with low levels of disability, ineligible for formal services provided through SDCR, have access to mobility assessment and advice which may:

- assist clients to feel safer and more confident in their mobility; and
- increase clients awareness of how to maintain and improve their mobility.

Program design and development

SDCR provides services for people with moderate and severe disabilities. SDCR also receives referrals to assist those with low levels of disability, but still at risk of falls. However, service eligibility criteria restricts the delivery of domiciliary services to people with moderate to severe disabilities. In response to this service gap SDCR is piloting a 12 month program that provides a point of access for people in the community seeking information and advice on mobility issues.

The program was publicised through GPs and the use of promotional material. The program can be accessed through self-referral, or referrals from GPs or other health professionals.

Program content

The program involves a one-off assessment by a physiotherapist in the clients home and in public spaces to identify falls risk factors. The key intervention through the program is individually tailored exercise programs for clients to conduct in the home, as well as advice and referral to community based exercise programs, subsidised services and, equipment and home modification programs, such as the Injury Prevention Councils *Make it Safe* program.

Client assessment aims to address a broad range of factors to ensure needs are appropriately identified. Risk factors addressed through the program include medications, medical conditions, sensory impairments, foot and footwear problems, dizziness, balance and gait, lower limb weakness, inactivity, indoor environmental hazards, fear of falling and nutrition.

According to their needs, clients are offered:

- functional gait and transfer assessment in the community;
- gait and balance re-training provided on an individual basis by a physiotherapist (if ongoing support is needed a referral to a community based service is made);
- training in the use of specific mobility aids as required;
- home safety assessment and advice on identified home modifications;
- information on falls prevention, including how to get up following a fall; and
- information and referral to relevant programs, such as exercise programs, mobility aid centres, and GPs.

Costs for mobility aids have to be met by clients. Home modifications may be subsidised through the above-mentioned *Make it Safe* program.

Program sustainability

The *Mobility Assessment and Advice* Program is funded for 12 months and will terminate in February 2001. The program receives funding of \$17,000 from the agency's core budget and \$5,000 in kind support. Ongoing funding is required to sustain the program to meet the cost of physiotherapist assessment and implementation of any required interventions. At this stage however, there is no funding available after February 2001. Attempts are being made to secure ongoing funding through the Home and Community Care program.

Program evaluation

An evaluation of the program is intended and is most likely to involve a post intervention assessment using a questionnaire.

Transferability to other settings

The program could potentially provide a model for providing preventative measures.

Workforce issues

As the key program staff are physiotherapists additional training has not been necessary. Effort has been concentrated however on developing some consistent measures to be used by physiotherapists in their assessments, particularly in testing for balance.

Abbreviations

ACAT/ACAS	Aged Care Assessment Team/Service
ACMH	Aged, Community and Mental Health
AHS	Area Health Services
AIHW	Australian Institute of Health and Welfare
AIMS	Australian Incident Monitoring System
APSF	Australian Patient Safety Foundation
CERA	Centre for Education and Research on Ageing
CLASP	Community Liaison & Advisory Safety Project
CPE	Continuing Professional Education
CSAHS	Central Sydney Area Health Service
DHAC	Department of Health and Aged Care
DHS	Department of Human Services
EPC	Enhanced Primary Care (Package)
ETHOS	Emergency to Home Outreach Service
FMC	Flinders Medical Centre
FOS	Foothold on Safety
FRAT	Falls Risk Assessment Tool
GGRM	General, Geriatric and Rehabilitation Medicine
GP	General Practitioner
GVH	Goulburn Valley Hospital
HACC	Home and Community Care
HDWA	Health Department of Western Australia
HPU	Health Promotion Unit
MUARC	Monash University Accident Research Centre
NARI	National Ageing Research Institute
NCPHU	North Coast Public Health Unit
NDHP3	National Demonstrations Hospital Program 3
NHMRC	National Health & Medical Research Council
NIPAC	National Injury Prevention Advisory Committee

NISU	National Injury Surveillance Unit
OPCC	Older Persons Care Coordinator
PHU	Public Health Unit
RACF	Residential Aged Care Facility
RCS	Resident Classification Scale
RCHS	Redcliffe-Caboolture Health Service
RMH	Royal Melbourne Hospital
SD	Standard Deviation
SDCR	Southern Domiciliary Care and Rehabilitation
SEIPH	South East Institute of Public Health
SHARE	A non-profit organisation which provides community health education and a gentle exercise program, supported by the South Eastern and Central Sydney Area Health Promotion Units.
SOYF	Stay on Your Feet
SOYFWA	Stay on Your Feet Western Australia
SRS	Supported Residential Services
STRATIFY	A falls risk assessment tool (Oliver et al, 1997)
UWA	University of Western Australia
WAVES	A program of gentle hydrotherapy exercise (Sydney)
WHCG	Wimmera Health Care Group
YMCA	Young Mens' Christian Association

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Appendix A

Directory of falls and falls injury prevention programs

Directory of Falls and Falls Injury Prevention Programs

May 2000



Introduction

This directory of falls prevention programs has been produced by the National Ageing Research Institute as part of a national stocktake of major organisations that conduct falls prevention activities for older people. The stocktake was commissioned by the Injury Prevention Section in the Commonwealth Department of Health and Aged Care under the 1999-2003 National Falls Prevention for Older People Initiative.

A paper-based survey was used to investigate a range of key issues in conducting effective falls prevention programs in community, residential aged care and acute care settings. One hundred and forty six surveys were returned (response rate of 43 %). Responses were received from a broad range of agencies undertaking varied programs aimed at reducing falls in older people. The survey does not represent an exhaustive list of programs involved in falls prevention activity in Australia but is considered to provide a representative overview of these programs.

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*Falls and Falls Injury Prevention Programs
in Community Settings*

Organisation Western Domiciliary Care and Rehabilitation Service

Suburb Woodville **State** SA **Postcode** 5011

Contact Name Michele Sutherland **Phone Number** 08 82228000

Partner Agency University of South Australia (Faculty of Allied Health)

Program Name Falls and Balance Clinic, Western DomCare

Sector 1 (*1 = Community; 2 = Hospital; 3 = Residential; 4 = Mixed setting*)

Year 1996 **Still** 1 (*1 = yes; 0 = no*)

Program

The establishment of the Falls and Balance clinic followed the completion of a research project which involved the identification of individuals at risk of a falling by domiciliary staff. Subjects were then randomly allocated to a control or intervention group. The control group received domiciliary care and the intervention group were assessed by a geriatrician, physiotherapist and occupational therapist with a management plan implemented. Follow-up was undertaken approximately three months after the intervention. The Falls and Balance clinic incorporates assessment by a multidisciplinary team. The co-ordinator of the clinic generally begins the assessment with a home visit. Clients then attend the clinic and are assessed by a geriatrician followed by a physiotherapist who determines if clinical psychology, nutrition or podiatry input is required. The occupational therapist will undertake a home visit unless this has recently occurred. A report is sent to the client's general practitioner (GP) following the assessment. The clinic staff are involved in the implementation of recommendations to emerge from the assessment. This encompasses the introduction of a home based exercise program. Clients are re-assessed eight weeks after the initial assessment generally by the physiotherapist alone who will repeat those assessments where problems were identified. The clinic has recently adopted two streams of care. Complex cases are seen by the whole team and non-complex cases are only seen by a physiotherapist. The clinic referrals come from a number of sources including GP's and domiciliary care staff. Clients with severe dementia, major system failure or multiple joint pathology are not seen by the clinic.

Organisation St Marks Adult Day Centre

Suburb Chadstone **State** Vic **Postcode** 3148

Contact Name Robyn Manning **Phone Number** 03 98073634

Partner Agency

Program Name [no title]

Sector 1 (*1 = Community; 2 = Hospital; 3 = Residential; 4 = Mixed setting*)

Year 1999 **Still** 1 (*1 = yes; 0 = no*)

Program

Adult Day Centre providing maintenance exercises, socialisation and respite for carers. Education in strategies to prevent and minimise falls and injury. Exercises to increase/maintain coordination, strength.

Organisation Lower North Community Health Service
Suburb Clare **State** SA **Postcode** 5453
Contact Name Mandy Sidwell **Phone Number** 08 88423355

Partner Agency

Program Name The Right Step Forward

Sector 1 (1 = Community; 2 = Hospital; 3 = Residential; 4 = Mixed setting)

Year 1998 **Still** 1 (1 = yes; 0 = no)

Program

Contact made with key community groups in the Lower North of SA - Occupational Therapists and Physiotherapists visited and offered presentation (approximately 45). Covered "physical biological", risk factors of falls and environmental risks. Handouts included home checklist, information, exercises, information on medications/eyesight/osteoporosis and others. Liaison with GP's / hospitals - also distributed checklists / safety information to all in target group (65 and over). "Black Spots" in community identified and notified to council's. Home safety assessments (Occupational Therapist) and mobility assessments (Physiotherapist), were offered to

Organisation Teamcare Health Coordinated Care Trial
Suburb Lutwyche **State** QLD **Postcode** 4030
Contact Name Rosemary Foster **Phone Number** 07 38578233

Partner Agency

Program Name Staying on Your Feet

Sector 1 (1 = Community; 2 = Hospital; 3 = Residential; 4 = Mixed setting)

Year **Still** (1 = yes; 0 = no)

Program

Educational sessions with displays, held during February to March 1999. Each session was introduced by a GP. A falls kit developed by the Community Health Centre for presentations was used. Displays and staff were provided by Home Assist/Secure and the Independant Living Centre. The displays were of handy gadgets and safety items.

Organisation Tropical Public Health Unit - Mackay
Suburb Mackay **State** QLD **Postcode** 4740
Contact Name Paul Vardon **Phone Number** 07 32340111
Partner Agency
Program Name Walk Tall, Don't Fall
Sector 1 (*1 = Community; 2 = Hospital; 3 = Residential; 4 = Mixed setting*)
Year 1996 **Still** 1 (*1 = yes; 0 = no*)

Program

The program was designed to reduce the incidence of falls in people over 60 years of age in the Mackay area. Strategies included: to identify risk factors, prevention strategies and barriers to change. To increase awareness of older people and the community on the issues of falls and falls prevention. To empower older people to facilitate change in their own environment.

Organisation South East Coastal Mental Health Service
Suburb Esperance **State** WA **Postcode** 6450
Contact Name Gemma O'Dea **Phone Number** 08 90717111
Partner Agency
Program Name Stay on Your Feet
Sector 1 (*1 = Community; 2 = Hospital; 3 = Residential; 4 = Mixed setting*)
Year 1999 **Still** 1 (*1 = yes; 0 = no*)

Program

Training members of the public to do home visits and do individual assessments, to provide information to the Community and to their peers.

Organisation Combined Pensioners & Superannuants Association of NSW
Suburb Surrey Hills **State** NSW **Postcode** 2010
Contact Name **Phone Number** 02 92813588
Partner Agency
Program Name Medicine Information Project/Medicine Information Person Project
Sector 1 (*1 = Community; 2 = Hospital; 3 = Residential; 4 = Mixed setting*)
Year 1961 **Still** 1 (*1 = yes; 0 = no*)

Program

The project has involved training people over the age of 50 as Medicine Information Persons (MIPS) to work on a voluntary basis providing education to older people on the wise use of medication. The MIPS peer educators speak to community organisations on request for 20 minutes followed by 10 minutes of discussion. MIPS are also commonly invited to participate in falls prevention education seminars, speaking in conjunction with other health professionals on risk factors for falling and preventative strategies. Medication cards and other resources are distributed at MIPS presentation and have been developed in an array of languages. MIPS volunteers have been drawn from a range of ethnic groups in order to provide education for non-English speaking background

Organisation Peninsula Health Care Network, Aged Care & Rehabilitation Programme
Suburb Mount Eliza **State** Vic **Postcode** 3930
Contact Name Peter Hough **Phone Number** 03 97881273
Partner Agency
Program Name Falls and Mobility (Balance) Clinic
Sector 1 (*1 = Community; 2 = Hospital; 3 = Residential; 4 = Mixed setting*)
Year 1995 **Still** 1 (*1 = yes; 0 = no*)

Program

The Falls and Balance Clinic incorporates a multi-disciplinary assessment of older people who have fallen or who are at risk of falling. The client is assessed by a geriatrician, dietician, physiotherapist and occupational therapist. The majority of client's also receive a home hazard assessment by the occupational therapist. Where risks are identified management strategies are developed and implemented. Recommendations to emerge from the assessment process are sent to the clients' general practitioner. The client is also informed of the recommendations the day after the assessment. (Falls and Balance Clinic is part of the Peninsula Falls Prevention Service which also includes: Falls Service Coordinator located in Domiciliary Care: All referrals are screened and directed to either the falls clinic, home based assessment and intervention or a Community Rehabilitation Centre; Residential Care: FRAT Pack; Residential Project; Coordinator of 'Foothold on Safety' project: Program

Organisation City of Yarra
Suburb Abbotsford **State** Vic **Postcode** 3121
Contact Name Jan Crowe **Phone Number** 03 92055555
Partner Agency Moreland City Council; Hume City Council
Program Name Stay on Your Feet Yarra Falls Prevention
Sector 1 (*1 = Community; 2 = Hospital; 3 = Residential; 4 = Mixed setting*)
Year 1998 **Still** 1 (*1 = yes; 0 = no*)

Program

One of ten Foothold on Safety projects currently underway throughout Victoria. This program has been implemented in three local councils with a range of strategies being implemented in each municipality. The strategies to be implemented in the City of Yarra include training for home care workers regarding falls prevention with an emphasis on environmental hazards. Community education for older adult organisations utilising the Australian Pensioners and Superannuants Federation video 'Standing On Your Own Two Feet' which has been translated into a number of community languages using the combined resources of the three councils. Other strategies include conducting a falls prevention seminar for health professionals and participating in the development of a public hazard reporting

Organisation Central Coast Health, Public Health Unit
Suburb Gosford **State** NSW **Postcode** 2250
Contact Name Annie Warn **Phone Number** 02 43202111
Partner Agency
Program Name Active Over 50 (New component: Active Over 50 Easy Start)
Sector 1 (*1 = Community; 2 = Hospital; 3 = Residential; 4 = Mixed setting*)
Year 1995 **Still** 1 (*1 = yes; 0 = no*)

Program

An exercise program for people over the age of 50. A range of exercise classes are offered including gentle exercise, aqua aerobics and line dancing. Classes are conducted by qualified fitness leaders who have attended a falls injury prevention seminar and undertaken gentle exercise training. Classes are held at a number of venues including private fitness centres, church halls, community health centres and local pools. A number of classes are held throughout the week. A medical clearance certificate has been developed for participants to check with their GP prior to attending the classes. The Active Over 50 program has been adopted in a number of health services in NSW. Following the findings from research carried out by the Central Coast Area Health Service a new component was added to the program - Active Over 50 Easy Start. They found that GPs were referring clients who were not fit for gentle exercising and that they needed to go back a step. Clients are first screened by phone to find appropriate participants. Those who were deemed fit enough were referred to the main Active Over 50 program. The Easy Start program is a 12 week program, attended twice a week. At the first visit a physiotherapist undertakes an

Organisation Hornsby Health Hips, Rehabilitation Studies Unit
Suburb Ryde **State** NSW **Postcode** 1680
Contact Name Ian Cameron **Phone Number** 02 98089236
Partner Agency
Program Name Hornsby Healthy Hips (Hip Protector Project)
Sector 1 (*1 = Community; 2 = Hospital; 3 = Residential; 4 = Mixed setting*)
Year 1996 **Still** 1 (*1 = yes; 0 = no*)

Program

This study has involved the recruitment of women over the age of 75, with a recent history of falling, into a two year study examining the impact of hip protectors on the incidence of hip fracture. The study is also exploring issues of compliance and cost effectiveness. 300 women have been randomised to both a control group and an intervention group. Both groups have been interviewed by a research nurse before randomisation and again at 12 months and 2 years into the study. The intervention group have been supplied with 3 pairs of hip protector underpants to be worn throughout the study. Participants are contacted every four months to determine if any falls and injuries associated with falling have been sustained in that time. Compliance is monitored by the adherence nurses, part of this involves random home visits by the nurses to check compliance.

Organisation Ravensthorpe Health Service
Suburb Ravensthorpe **State** WA **Postcode** 6346
Contact Name Stephen Farrington **Phone Number** 08 98381006
Partner Agency
Program Name Healthy Ageing
Sector 1 (*1 = Community; 2 = Hospital; 3 = Residential; 4 = Mixed setting*)
Year 2000 **Still** 1 (*1 = yes; 0 = no*)

Program

Gentle gym: Exercise for the elderly. Business Gym: Exercise for women 40 - 60 years old. Nutrition education for the elderly: Healthy eating in general but emphasis on osteoporosis prevention. Hazard in the home assessment for HACC clients. Hazard in the town assessment - recommendations - shire. Policy guidelines for meals on wheels regarding nutrition for elderly.

Organisation Accident Research Centre, Monash University
Suburb Clayton **State** Vic **Postcode** 3800
Contact Name Lesley Day **Phone Number** 03 99051862
Partner Agency Victorian Health Promotion Foundation; Rotary; National Safety Council; Melbourne University Statistical Consulting Centre retained as consultant.
Program Name City of Whitehorse No Falls Program

Sector 1 (1 = Community; 2 = Hospital; 3 = Residential; 4 = Mixed setting)

Year 1996 **Still** 0 (1 = yes; 0 = no)

Program

A research project implemented by Monash University Accident Research Centre (MUARC) and Whitehorse City Council which was designed to determine the impact of three interventions, and their various combinations, on falls incidence. The three interventions were home hazard modification, vision correction and exercise. There were eight groups of older people receiving either no intervention, one intervention or a combination of interventions. Total number of participants was 1,107. Participants were over the age of 70 and had satisfied the inclusion criteria for the project. Each participant was required to complete a calendar on a daily basis for a period of eighteen months, returning the calendar at the end of each month to MUARC. Follow-up was made with participants who recorded a fall during any month to gather more information about the fall. An assessment of each participant by a nurse over a 2 hour period was conducted prior to each participant being randomised into one of the eight groups. The assessment covered activity levels, falls history, home hazards, vision, and balance. If participants were assigned to the group receiving home hazard modification, they were advised of the hazards that had been identified in the initial assessment. The nurse sent the recommendations to the modification service for participants within this intervention group where this was required and agreed to by the participant. Three hours labour for home modifications was offered free. Vision was assessed by the nurse and those within this intervention group were referred to an optometrist where appropriate. The exercise intervention involved participation in a weekly exercise class for 15 weeks focusing on improving balance. At the end of the 15 weeks participants were provided with an information sheet detailing the exercises to enable them to continue to exercise at home. Participants in this group were asked to indicate on the calendar with an 'E' the days that they exercised. At the end of the eighteen months half of the participants were re-assessed by the nurse using the same assessment tool

Organisation Southern Domiciliary Care and Rehabilitation
Suburb Parkholme **State** SA **Postcode** 5043
Contact Name Gisela Van Kessel **Phone Number** 08 82773366
Partner Agency
Program Name Mobility Assessment and Advice Programme

Sector 1 (1 = Community; 2 = Hospital; 3 = Residential; 4 = Mixed setting)

Year 2000 **Still** 1 (1 = yes; 0 = no)

Program

Clients are offered as appropriate for their needs: functional gait and transfer assessment in the community; gait and balance re-education (if ongoing a referral to a centre based service is made); assessment and training in the use of specific mobility aids (provision at clients cost); home safety assessment with advice and prescription for home modifications (implementation at clients cost); education on what to do following a fall, including getting up (referrals made to available falls prevention programmes); and advice on available relevant resources.

Organisation OT Australia - Victoria
Suburb North Fitzroy **State** Vic **Postcode** 3068
Contact Name Louise Johnson **Phone Number** 03 94816866
Partner Agency
Program Name Falls Prevention Seminar
Sector 1 (*1 = Community; 2 = Hospital; 3 = Residential; 4 = Mixed setting*)
Year 2000 **Still** 0 (*1 = yes; 0 = no*)

Program

Falls prevention program to educate occupational therapists involved in falls prevention work - to promote best practice, share ideas and knowledge across the profession. One day program, additional courses will be conducted if requested by OTs.

Organisation Redcliffe-Caboulture Health Service District
Suburb Redcliffe **State** QLD **Postcode** 4020
Contact Name Jo Walters **Phone Number** 07 32848333
Partner Agency
Program Name RCHSD Falls Prevention Working Party
Sector 1 (*1 = Community; 2 = Hospital; 3 = Residential; 4 = Mixed setting*)
Year 1999 **Still** 1 (*1 = yes; 0 = no*)

Program

Whole program still being developed at this stage. 1) One off education sessions to existing communitiy groups. 2) Developed & distributed 500 falls calendars including pamphlets, checklists, and six and twelve month return questionnaires. 3) Developed Home Falls Prevention checklist. 4) Modified a Risk Assessment Tool. 5) Doing individual home assessment. 6) Planning 6-8 week combined education/exercise programs.

Organisation Salvation Army Day Therapy Centre
Suburb Darwin **State** NT **Postcode** 0800
Contact Name Jane Pool **Phone Number** 08 89410961
Partner Agency
Program Name [no title - not formal at present]
Sector 1 (*1 = Community; 2 = Hospital; 3 = Residential; 4 = Mixed setting*)
Year **Still** 1 (*1 = yes; 0 = no*)

Program

Clients are referred from Aged Care Assessment Team. Each client is assessed by a physiotherapist and Occupational Therapist re mobility/falls risk/home set-up/postural instability/aids etc. Interventions applied as appropriate eg, therapy program, aid prescription etc.

Organisation City of Tea Tree Gully Home Assist
Suburb Modbury **State** SA **Postcode** 5092
Contact Name John Middleton **Phone Number** 08 83977213
Partner Agency
Program Name Home Assist
Sector 1 (*1 = Community; 2 = Hospital; 3 = Residential; 4 = Mixed setting*)
Year 1995 **Still** 1 (*1 = yes; 0 = no*)

Program

Risk assessment, equipment installation (rails, ramps), home modifications (minor - toilet doors, swing toilet doors outwards), household maintenance (gutter cleaning) etc, security audits (installation of locks etc). General scheme of which falls is only one risk factor, they even include advocacy.

Organisation Shire of Busselton
Suburb Busselton **State** WA **Postcode** 6280
Contact Name David Pipel **Phone Number** 08 97810400

Partner Agency

Program Name Seniors Footpath Patrol

Sector 1 (*1 = Community; 2 = Hospital; 3 = Residential; 4 = Mixed setting*)

Year 1993 **Still** 1 (*1 = yes; 0 = no*)

Program

This is a public safety program involving older people participating in the identification of hazardous footpaths. Participants meet as a group, with the Home and Community Care coordinator and a representative from technical services from the local council, to report on identified hazards and to receive feedback on actions being taken by the local council to remedy previously identified footpaths in need of repair. The group emerged from a Seniors' Forum which was a project involving workshops with older people to identify and develop strategies to overcome issues impacting on their independence. From these workshops groups have been formed to address problems identified. Apart from each group addressing a particular issue the participating seniors also meet twice a month for discussion of pertinent issues and to enable guest speakers to present to the group. The Department of Veterans' Affairs presented their Quality of Life program at one of these meetings which led to the formation of the

Organisation Centre for Clinical Epidemiology & Biostatistics, University of Newcastle
Suburb Newcastle **State** NSW **Postcode** 2300
Contact Name Julie Byles **Phone Number** 02 49215000

Partner Agency Department of Veterans Affairs

Program Name DVA Preventative Care Trial

Sector 1 (*1 = Community; 2 = Hospital; 3 = Residential; 4 = Mixed setting*)

Year 1998 **Still** 1 (*1 = yes; 0 = no*)

Program

A randomised controlled trial involving the recruitment of well veterans and war widows over the age of 70 who are gold cardholders, from rural and metropolitan areas, into one of four intervention groups and a control group. The intervention groups receive a health professional visit by a community health nurse, occupational therapist, ACAT or physiotherapist who work through a checklist with the veteran. The checklist addresses a range of issues including general health, home safety and falls history. A report identifying any problems is developed and copies given to the veteran and their general practitioner. Health information literature is also provided to veterans in the intervention groups to facilitate action. A telephone survey is completed with control group participants on an annual basis. Each of the four intervention groups differ between the frequency of the home visits by the health professional, the frequency of the follow-up and the frequency of the reports to the veterans' general practitioner.

Organisation Maribyrnong City Council
Suburb Footscray **State** Vic **Postcode** 3011
Contact Name Sylvie Leber **Phone Number** 03 96880148
Partner Agency Western Region Health Centre
Program Name Maribyrnong Falls Prevention Project: Move Safely - Age Well
Sector 1 (*1 = Community; 2 = Hospital; 3 = Residential; 4 = Mixed setting*)
Year 1998 **Still** 1 (*1 = yes; 0 = no*)

Program

One of ten Foothold on Safety projects currently underway throughout Victoria. This program incorporates a range of strategies including the training of bilingual peer educators, by an occupational therapist, for them to be involved in falls prevention awareness raising in the community. A public launch of the program has been held with invitations sent to a range of groups. They have developed a falls prevention display which has been placed in shopping centres, pharmacies, council buildings and other suitable locations. They have also developed a booklet which discusses the incidence of falls and includes a home safety checklist and other information about personal safety. A podiatrist from a community health centre has also been given a seeding grant to undertake shoe parades for the target group. The program will also involve: undertaking public safety audits and working with the local council to promote safer environments; developing links with a local university and TAFE Institute to involve students in pertinent research projects; and encouraging the adoption of falls prevention education within Home

Organisation Injury Control Council of WA
Suburb West Perth **State** WA **Postcode** 6005
Contact Name Jill Darby **Phone Number** 08 94207212
Partner Agency Health Department of WA
Program Name Falls Awareness Raising Program
Sector 1 (*1 = Community; 2 = Hospital; 3 = Residential; 4 = Mixed setting*)
Year 2000 **Still** (*1 = yes; 0 = no*)

Program

Proposed program for 2000, it is in the formative stage and subject to funding. [To involve education, public hazard/safety program, injury minimization, health promotion products/literature, practice improvement and peer education training and implementation.]

Organisation Gascoyne Public Health
Suburb Carnarvon **State** WA **Postcode** 6701
Contact Name Jenny Payet **Phone Number** 08 99410568
Partner Agency Community & Mental Health
Program Name Stay on Your Feet
Sector 1 (*1 = Community; 2 = Hospital; 3 = Residential; 4 = Mixed setting*)
Year 1999 **Still** 1 (*1 = yes; 0 = no*)

Program

Includes: 1) Falls Advice Service - volunteers (seniors). 2) Community Education. 3) Support Group. They service Denham, Exmouth and Carnarvon.

Organisation Sutherland Shire Division of General Practice
Suburb Miranda **State** NSW **Postcode** 2228
Contact Name Antonia Brien **Phone Number** 02 95254011
Partner Agency
Program Name Falls & Injury Prevention Program
Sector 1 (*1 = Community; 2 = Hospital; 3 = Residential; 4 = Mixed setting*)
Year 1999 **Still** 1 (*1 = yes; 0 = no*)

Program

Preventative: to reduce the incidence of fractures (through falling) in the target population. Interventions: osteoporosis support group, GP education seminars, assessment tools.

Organisation Sunbury Community Health Centre

Suburb Sunbury **State** Vic **Postcode** 3429

Contact Name Jo Howard **Phone Number** 03 97444455

Partner Agency Hume City Council (Foothold on Safety Funding)

Program Name Falls and Mobility Intervention Program

Sector 1 (*1 = Community; 2 = Hospital; 3 = Residential; 4 = Mixed setting*)

Year 1999 **Still** 1 (*1 = yes; 0 = no*)

Program
Education, environmental hazard assessment & modification & individual risk factor assessment and

Organisation Quality Assurance Unit, Royal Australian College of General Practitioners - Victoria

Suburb Burwood **State** Vic **Postcode** 3125

Contact Name Pam Montgomery **Phone Number** 03 92070321

Partner Agency

Program Name Falls and Older People

Sector 1 (*1 = Community; 2 = Hospital; 3 = Residential; 4 = Mixed setting*)

Year 1997 **Still** 1 (*1 = yes; 0 = no*)

Program
A clinical audit for GPs. Involves a practice audit of five patients at risk, feedback about performance, educational material for GP, then a re-audit of five different patients.

Organisation Southern Highlands Division of General Practice

Suburb Bowral **State** NSW **Postcode** 2576

Contact Name Gail Atkins **Phone Number** 02 48616084

Partner Agency

Program Name Falls Prevention Programme

Sector 1 (*1 = Community; 2 = Hospital; 3 = Residential; 4 = Mixed setting*)

Year 1998 **Still** 1 (*1 = yes; 0 = no*)

Program

GP's Guide to Falls Prevention flipchart, GP's Falls Risk Assessment Sheet for individual patients. Clinical Audit Points for five patients screened. Three week community and GP referral education session. In-service offered to all relevant agencies- talks as guest speaker to clubs (400 people in 1999). (Community: education; GPs- individual risk factor analysis & management and protocol/guidelines development)

Organisation Angliss Health Service

Suburb Upper Ferntree Gully **State** Vic **Postcode** 3156

Contact Name James Tulloch **Phone Number** 03 97646111

Partner Agency

Program Name Angliss Health Service Falls and Balance Clinic

Sector 1 (*1 = Community; 2 = Hospital; 3 = Residential; 4 = Mixed setting*)

Year 1999 **Still** 1 (*1 = yes; 0 = no*)

Program

Assessment clinic for individual clients referred to service by GPs. Assessed by a geriatrician, physiotherapist and occupational therapist when indicated. Plans for treatment instituted. Reviewed at 6 weeks and 6 months.

Organisation Noarlunga Health Services
Suburb Noarlunga Centre **State** SA **Postcode** 5168
Contact Name Karen Dixon **Phone Number** 08 83849229
Partner Agency Injury Prevention SA Inc; Okaparinga Council - Home Assistance Scheme.
Program Name Be Safe and Independent at Home
Sector 1 (*1 = Community; 2 = Hospital; 3 = Residential; 4 = Mixed setting*)
Year 1993 **Still** 1 (*1 = yes; 0 = no*)

Program

Program currently consists of: a free home visiting service for people aged 55 year and older living independently in the community; access to subsidised equipment for older people who are at risk of falling at home and who could not otherwise afford them (provided by Injury Surveillance SA); community education about falls prevention (falls prevention brochure, self-assessment checklist for hazards and information displays used in health education activities); a balance retraining program - One Step at a Time - developed and offered by physiotherapists and

Organisation School of Nursing, Curtin University
Suburb Shenton Park **State** WA **Postcode** 6008
Contact Name Annette Brown **Phone Number** 08 92663660
Partner Agency Teaching hospitals in WA
Program Name Falls Prevention for Seniors
Sector 1 (*1 = Community; 2 = Hospital; 3 = Residential; 4 = Mixed setting*)
Year 1994 **Still** 1 (*1 = yes; 0 = no*)

Program

Education re risks. Self assessment of risk. Physical assessment. Physiotherapy Intervention. Podiatry

Organisation Woden Senior Citizens Club Inc
Suburb Woden **State** ACT **Postcode** 2606
Contact Name Pat Cummins **Phone Number** 02 62822573
Partner Agency YMCA, ACT Bureau of Sport & Recreation.
Program Name Falls Prevention
Sector 1 (*1 = Community; 2 = Hospital; 3 = Residential; 4 = Mixed setting*)
Year 1999 **Still** 0 (*1 = yes; 0 = no*)
Program
Strength, balance and posture.

Organisation Department of Rehabilitation and Aged Care, Repatriation General Hospital
Suburb Daw Park **State** SA **Postcode** 5041
Contact Name Craig Whitehead **Phone Number** 08 82751103
Partner Agency
Program Name Falls and Fracture Clinic
Sector 1 (*1 = Community; 2 = Hospital; 3 = Residential; 4 = Mixed setting*)
Year 1999 **Still** 1 (*1 = yes; 0 = no*)
Program
Multidisciplinary risk factor identification and management clinic and group physiotherapy program.

Organisation Pharmacy Guild of Australia (WA Branch)
Suburb West Perth **State** WA **Postcode** 6005
Contact Name Ian Crawford **Phone Number** 08 93824069
Partner Agency Those organisations falling under the umbrella of HDWA - Injury Control Programme.
Program Name Stay on Your Feet
Sector 1 (*1 = Community; 2 = Hospital; 3 = Residential; 4 = Mixed setting*)
Year 1998 **Still** 1 (*1 = yes; 0 = no*)

Program

For the Guild's participation: Medicine, Awareness Raising, Chronic conditions. The aim of this medication awareness falls prevention program is to increase the awareness of the links between medication use and falls in older people, and to encourage people over 65 to actively seek medication reviews and ask questions about their medication. This is a collaborative project involving general practitioners, pharmacists and other health

Organisation Townsville Division of General Practice
Suburb Townsville **State** QLD **Postcode** 4810
Contact Name Alison Hogg **Phone Number** 07 47244910
Partner Agency
Program Name Stepping Out - A Falls Prevention
Sector 1 (*1 = Community; 2 = Hospital; 3 = Residential; 4 = Mixed setting*)
Year 1996 **Still** 1 (*1 = yes; 0 = no*)

Program

1. Home carers do a questionnaire with clients. 2. Home carers do a course at TAFE. 3. Exercise programs for elderly include: Sizzling Dances. 4. Community Education. 5. Peer Education. 6. Health Promotion.

Organisation Kalamunda Health Service

Suburb Kalamunda **State** WA **Postcode** 6076

Contact Name Tia Lockwood **Phone Number** 08 94543411

Partner Agency Regional Public & community Health Unit

Program Name Stay on Your Feet Project

Sector 1 (*1 = Community; 2 = Hospital; 3 = Residential; 4 = Mixed setting*)

Year 1999 **Still** 1 (*1 = yes; 0 = no*)

Program

Support Group, 'Stay on Your Feet', (SOYF) focuses on 8 major causes of falls. The interventions look at each of the risk factors. Awareness raising in senior's groups of the risk factors and awareness of the available services and products that can assist in reducing the number of falls.

Organisation Aged Care Services

Suburb Parkes **State** NSW **Postcode** 2870

Contact Name Debra Tooley **Phone Number** 02 68634222

Partner Agency

Program Name Falls Management Programme

Sector 1 (*1 = Community; 2 = Hospital; 3 = Residential; 4 = Mixed setting*)

Year 1999 **Still** 1 (*1 = yes; 0 = no*)

Program

[Education; environmental hazard assessment & modification; individual risk factor assessment/management; Health promotion products/literature.]

Organisation Angliss Health Service, Home for Rehab
Suburb Upper Ferntree Gully **State** Vic **Postcode** 3156
Contact Name Alison Lunt **Phone Number** 03 97646111
Partner Agency
Program Name Falls Prevention
Sector 1 (*1 = Community; 2 = Hospital; 3 = Residential; 4 = Mixed setting*)
Year 1998 **Still** 1 (*1 = yes; 0 = no*)

Program

6 week centre based course involving education and exercise. Clients are also visited at home by Occupational Therapists for home. Assessment of risks and exercises set up in home.

Organisation Ovens & King Community Health Service
Suburb Wangaratta **State** Vic **Postcode** 3677
Contact Name Gail O'Donnell **Phone Number** 03 57222355
Partner Agency Wangaratta Base Hospital
Program Name Stepping Out in Spring
Sector 1 (*1 = Community; 2 = Hospital; 3 = Residential; 4 = Mixed setting*)
Year 1999 **Still** 0 (*1 = yes; 0 = no*)

Program

Peer educators were trained to deliver the program with the support of an allied health professional. Peer educators were self selected from existing community groups.

Organisation National Ageing Research Institute
Suburb Parkville **State** Vic **Postcode** 3052
Contact Name Keith Hill **Phone Number** 03 93897148
Partner Agency Melbourne Extended Care & Rehabilitation Service
Program Name National Ageing Research Institute, /Melbourne Extended Care Rehabilitation Service Falls and Balance Clinic

Sector 1 (*1 = Community; 2 = Hospital; 3 = Residential; 4 = Mixed setting*)

Year 1988 **Still** 1 (*1 = yes; 0 = no*)

Program

Older people with falls or falls risk referred for comprehensive assessment by geriatrician, physiotherapist, occupational therapist and nurse. Individualised risk factor management program developed and implemented, or referral to appropriate management program instigated.

Organisation Department of Veteran's Affairs - WA State Office
Suburb Perth **State** WA **Postcode** 6001
Contact Name **Phone Number** 08 93668222
Partner Agency Injury Control Program, WA Department of Health (Main Partner - coordinators of the program for SOYF-WA)
Program Name Stay on Your Feet - WA

Sector 1 (*1 = Community; 2 = Hospital; 3 = Residential; 4 = Mixed setting*)

Year 1988 **Still** 1 (*1 = yes; 0 = no*)

Program

Five year falls prevention program for seniors. A collaborative multi-faceted program. Awareness raising, environments, balance & gait, medications and chronic conditions & physical activity.

Organisation Capital Rehabilitation
Suburb Deakin **State** ACT **Postcode** 2600
Contact Name Geoffrey Speldewinde **Phone Number** 02 62851833

Partner Agency

Program Name Falls Risk Assessment and Rehabilitation

Sector 1 (1 = Community; 2 = Hospital; 3 = Residential; 4 = Mixed setting)

Year 1999 **Still** 1 (1 = yes; 0 = no)

Program

Medical assessment of patient. Falls Risk Assessment Screening test (as per Dr. S. Lord, Prince of Wales Hospital). Education/Counselling/Strategies for Patient. Develop specific strengthening protocol with that person. (available on-site or elsewhere).

Organisation Central Sydney Area Health Service, Health Promotion Unit
Suburb Camperdown **State** NSW **Postcode** 2050
Contact Name Gai Stackpool **Phone Number** 02 95159600

Partner Agency General, geriatric & rehabilitation medicine CSAHS; Migrant Health Team CSAHS; Divisions of General Practice; Local Government; Medicine Information Persons

Program Name Preventing Falls Among Older People, Falls Prevention Strategic Plan CSAHS

Sector 1 (1 = Community; 2 = Hospital; 3 = Residential; 4 = Mixed setting)

Year 1998 **Still** 1 (1 = yes; 0 = no)

Program

Strategic plan aims to coordinate and provide strategic direction for falls prevention work across Central Sydney area Health Service Health Promotion Unit (CSAHS). It identifies target groups, key stakeholders and strategies for implementation. It takes a multi-strategic, multi-level, sectional approach.

Organisation Knox Community Health Service
Suburb Wantirna South **State** Vic **Postcode** 3152
Contact Name Helen Furniss **Phone Number** 03 92988318

Partner Agency

Program Name [no title]

Sector 1 (*1 = Community; 2 = Hospital; 3 = Residential; 4 = Mixed setting*)

Year 1996 **Still** 1 (*1 = yes; 0 = no*)

Program

Individuals and physiotherapists, occupational therapists, R/Nurse, Dietician and Podiatrists as appropriate. Assistance to be introduced for all referred older persons. Group projects - Gentle exercise, Keep fit.

Organisation Goulburn Valley Rural Health Team
Suburb Shepparton **State** Vic **Postcode** 3630
Contact Name Judy Glover **Phone Number** 03 58316192

Partner Agency

Program Name Foothold on Safety

Sector 1 (*1 = Community; 2 = Hospital; 3 = Residential; 4 = Mixed setting*)

Year 1998 **Still** 1 (*1 = yes; 0 = no*)

Program

One of ten Foothold On Safety projects currently underway throughout Victoria. A range of strategies have been employed including a launch of the program which was attended by older people and involved a number of guest speakers. Education for older adult groups has been conducted and the training of peer educators is also envisaged. Falls prevention displays have been positioned in a hospital, library and local supermarkets. Education has also been provided for general practitioners, using the Balancing Acts resource manual, and home and community care workers, district nurses and adult day activity support service staff. Other strategies include: the establishment of an Access and Safety Committee with membership including a local councillor and a consumer representative; the involvement of Vision Australia in conducting mobility access audits; and education for town planners regarding the Disability Discrimination Act and issues surrounding the design of buildings is also planned. The incorporation of a falls risk factor assessment into the referral forms for the rural health team has occurred. Upon receipt these forms are reviewed with an occupational therapist or physiotherapist subsequently

Organisation Injury Control Program, Health Department of Western Australia
Suburb Perth Business Centre **State** WA **Postcode** 6849
Contact Name Sallee Pettit **Phone Number** 08 92222135
Partner Agency Over 150 organisations listed.
Program Name Stay on Your Feet WA (SOYFA) - A collaborative Falls Prevention Program for Seniors.
Sector 1 (*1 = Community; 2 = Hospital; 3 = Residential; 4 = Mixed setting*)
Year 1998 **Still** 1 (*1 = yes; 0 = no*)

Program

Stay on Your Feet WA (SOYFWA) is a 5 year falls prevention program for seniors. Due to the enormity of the developmental process, the primary risk factors for falls will be addressed in successive phases. 1. Awareness raising. 2. Medicines. 3. Physical Activity Balance and Gait. 4. Safe Environments. 5. Chronic Conditions.

Organisation Murrindindi Community Health Service
Suburb Eildon **State** Vic **Postcode** 3713
Contact Name Linda Rautela **Phone Number** 057742404
Partner Agency Shire of Murrindindi, Alexandra and District hospital
Program Name Keep Moving in Murrindindi
Sector 1 (*1 = Community; 2 = Hospital; 3 = Residential; 4 = Mixed setting*)
Year 1998 **Still** 1 (*1 = yes; 0 = no*)

Program

Program was funded for one year and had four (4) aims to achieve: 1. Setting up of community advisory group to assist in disseminating/feeding back information and aid planning of educational sessions. 2. Training of home care workers in assessment and referral. 3. Setting up of exercise groups aimed at balance/strength training. 4. Training of GPs in Alexandra to refer clients to Domiciliary Falls Alexandra Service.

Organisation Prince of Wales Medical Research Institute
Suburb Randwick **State** NSW **Postcode** 2031
Contact Name Stephen Lord **Phone Number** 02 93822721

Partner Agency

Program Name Falls in Older People: Risk Factors & Strategies

Sector 1 (*1 = Community; 2 = Hospital; 3 = Residential; 4 = Mixed setting*)

Year 1998 **Still** 1 (*1 = yes; 0 = no*)

Program

A randomised controlled trial involving three groups of older people over the age of 75. A control group, minimal intervention group and extensive intervention group. Participants are recruited via the Medical Benefits Fund database. They are assessed on a number of measures including dynamic balance and reaction time which are repeated at 12 months. Vestibular function and vision also from part of this initial assessment. The test results are compared with available normative data. A falls calendar is completed by participants in each group with reported falls followed up to determine the circumstances of the fall. For the extensive intervention group participants may receive up to four interventions depending on the risk(s) identified. One intervention is referral to an optometrist or ophthalmologist for review of glasses or removal of cataracts etc. for those participants with vision problems. For participants with poor sensation they are referred to the general practitioner and/ or educated by a research assistant regarding strategies to reduce their risk of falling. Counselling is provided to those with impaired vestibular function. The final possible intervention is a balance and strengthening exercise program which is again provided depending on the outcomes of the initial tests. The exercise program is tailored to the individuals needs with the exercise classes held twice a week for one year. The minimal intervention group receive information sheets on how to reduce their risk of falling, a demonstration of exercises that can be conducted at home along with a list of existing exercise classes. 200 participants are to be recruited into each group.

Organisation Department of Veterans' Affairs
Suburb Woden **State** ACT **Postcode** 2606
Contact Name Lindy Dunn **Phone Number** 02 62896181

Partner Agency

Program Name HomeFront

Sector 1 (*1 = Community; 2 = Hospital; 3 = Residential; 4 = Mixed setting*)

Year 1999 **Still** 1 (*1 = yes; 0 = no*)

Program

This program offers free home hazard assessments for veterans who are gold cardholders. Subsidies to the value of \$150 for modifications are also offered. Veterans contact the Veterans' Home Maintenance Help Line who set up the assessment process. On completion of the assessment by the assessors, who are predominantly occupational therapists and community nurses, the assessment form is sent to the Veterans' Home Maintenance Help Line who organise quotes for the required modifications. The contracting organisation for the program and assessment process, World Care, contact the veteran to ensure the works have taken place.

Organisation City of Greater Dandenong
Suburb Springvale **State** Vic **Postcode** 3171
Contact Name Jan Ryan **Phone Number** 03 92395290
Partner Agency Country Fire Authority & Victoria Police
Program Name Secure Seniors
Sector 1 (*1 = Community; 2 = Hospital; 3 = Residential; 4 = Mixed setting*)
Year 1999 **Still** 1 (*1 = yes; 0 = no*)

Program

Secure Seniors program targets all residents over 65, but potentially identifies those at higher risk of injury, fire and crime. The program has a number of components. 1) Self Audit Checklist (to identify and rectify potential health well being hazards). 2) Professional Audit Kit (for professionals to further audit homes of older people). 3) Volunteer Program - who contact regularly identified high risk older people. 4) Participation Prospectus to engage the support of community agencies, groups and business sectors.

Organisation Bundoora Extended Care Centre
Suburb Bundoora **State** Vic **Postcode** 3083
Contact Name Michael Dorevitch **Phone Number** 03 92613100
Partner Agency
Program Name Falls and Balance Service
Sector 1 (*1 = Community; 2 = Hospital; 3 = Residential; 4 = Mixed setting*)
Year 1999 **Still** 1 (*1 = yes; 0 = no*)

Program

Comprehensive assessment is multidisciplinary which includes environmental hazard assessment and modification. Recommendations identify risk factors and interventions offered. Medical/physiotherapy/Occupational Therapy assessment. Referral to clinical psychologist in clients with fear of falling issues. Home assessments via Occupational Therapists.

Organisation Isis Primary Care
Suburb Altona Meadows **State** Vic **Postcode** 3028
Contact Name Surinder Dhar **Phone Number** 03 93607555
Partner Agency
Program Name Fall Busters
Sector 1 (*1 = Community; 2 = Hospital; 3 = Residential; 4 = Mixed setting*)
Year 1994 **Still** 1 (*1 = yes; 0 = no*)

Program

An education program for older people conducted four times a year at the community health centre and occasionally at an adult day activity centre in the area. The education is conducted by either an occupational therapist, a podiatrist or a physiotherapist. The education session is for two hours covering a range of falls prevention topics. Individual follow-up of participants occurs as required. A resource manual including an outline of the time to be spent on each topic and overheads to use in the presentation has been developed to facilitate the

Organisation Pharmaceutical Society of Australia
Suburb Parkville **State** Vic **Postcode** 3052
Contact Name Michael Scavone **Phone Number** 03 99039584
Partner Agency Inner South Community Health Service (Foothold on Safety Project)
Program Name Foothold on Safety
Sector 1 (*1 = Community; 2 = Hospital; 3 = Residential; 4 = Mixed setting*)
Year 1999 **Still** 1 (*1 = yes; 0 = no*)

Program

As for foothold on safety program but with emphasis on effects of medication on falls. PSA is involved through committee and project membership on the Foothold on Safety Project, provision of advice about medication that places people at risk of falls and the distribution of a Pharmacy Self-Care Card on Falls Prevention. As part of the Pharmacy Self Care Program of the Pharmaceutical Society of Australia a number of fact cards for pharmacists and their customers have been developed. The Preventing Falls fact card covers a number of risk factors for falling and preventive strategies. The fact card along with supporting resources which include more detailed information about the specific topic are distributed to pharmacists who are members of the Pharmacy Self Care Program. The fact cards may be on display at pharmacies for consumers to take at their leisure or located at the counter for the pharmacist to discuss with appropriate clients or concerned family members and carers. The fact cards are free for consumers. Pharmacists are provided with the first 20 cards free, subsequent cards cost \$3.50 for 20 cards.

Organisation Department of Physiotherapy, University of Queensland
Suburb St Lucia **State** QLD **Postcode** 4072
Contact Name Jenny Nitz **Phone Number** 07 33655328

Partner Agency

Program Name Balance & Falls Assessment & Treatment Clinic

Sector 1 (1 = Community; 2 = Hospital; 3 = Residential; 4 = Mixed setting)

Year 1975 **Still** 1 (1 = yes; 0 = no)

Program

Current program is provided to individuals and based on assessment findings. They include education, and treatment aimed at flexibility, strength, postural stability and balance focusing on visual, vestibular, somatosensory and motor integration.

Organisation Community Health Bendigo
Suburb Eaglehawk **State** Vic **Postcode** 3556
Contact Name Bronwyn Holmberg **Phone Number** 03 54300534

Partner Agency

Bendigo Healthcare Group; City of Greater Bendigo; Bendigo & District Division of GPs.

Program Name "Stay on Your Feet" Falls Program

Sector 1 (1 = Community; 2 = Hospital; 3 = Residential; 4 = Mixed setting)

Year 1998 **Still** 1 (1 = yes; 0 = no)

Program

A multi strategic intersectional program to reduce falls. GPs and health professionals: individual risk assessment, referrals and advice. Education: peer trainer. Health Promotion (Falls Co-ordinator). Public Hazards (Falls Co-ordinator/City of Greater Bendigo). Policy change (Falls Co-ordinator/health care providers/local council). Exercise: falls prevention exercise requirements imbedded in Local Fitness for Older Adults Program. One of ten Foothold on Safety projects currently underway throughout Victoria. This program incorporates a number of strategies including education for general practitioners, home and community care workers and other health professionals. The promotion of the existing Falls and Balance Clinic to general practitioners and the promotion of the home hazard assessment and modification service offered by Home Front to veterans who are gold cardholders. Further initiatives have included working with the Accident and Emergency (A&E) Department at the local hospital to capture people over the age of 60 presenting to A&E after a fall, but who are not admitted, through the development of a management pathway which aims to include education and the instigation of appropriate referrals. The involvement of older people as peer educators, promoting falls prevention and home safety, and peer exercise motivators form other components of this project. A six week falls prevention exercise program which incorporates education will also be conducted.

Organisation Coastal & Wheatbelt Public Health Unit
Suburb Northam **State** WA **Postcode** 6401
Contact Name Di Rayner **Phone Number** 08 96220127
Partner Agency
Program Name Stay on Your Feet - WA
Sector 1 (*1 = Community; 2 = Hospital; 3 = Residential; 4 = Mixed setting*)
Year 1997 **Still** 1 (*1 = yes; 0 = no*)

Program

This program has incorporated falls prevention education and exercise. Committees involving older people and health professionals have been established in each town for the purpose of determining the falls prevention activities to be implemented. The injury prevention officer serves as a resource person for the committees. Home safety parties have been one of the approaches adopted for providing older people with information on how to improve safety in their homes. Older people have been invited to have a home safety party following their attendance at a falls prevention talk. The home safety parties are similar in format to a Tupperware party although the safety products on display are not sold at the party. Seniors have been trained as peer educators and exercise leaders. Peer educators have been involved in presentations, home safety parties, expos and shows. Peer exercise

Organisation Institute for International Health
Suburb Crows Nest **State** NSW **Postcode** 1585
Contact Name Robyn Norton **Phone Number** 02 99266399
Partner Agency
Program Name Translation of Research into Practice (TRIP)
Sector 1 (*1 = Community; 2 = Hospital; 3 = Residential; 4 = Mixed setting*)
Year 1999 **Still** 1 (*1 = yes; 0 = no*)

Program

The Translation of Research into Practice project is part of the general Injury Prevention Program at the Institute for International Health. TRIP (the Translation of Research into Practice project) aims to improve practice in the implementation of research evidence concerning falls and fall related injury among older people. TRIP involved the conduct of interactive workshops with 5 groups of health professionals that have been identified as the major types of medical/health professionals responsible for the delivery of programs in falls and fall - related injury

Organisation University of Sydney

Suburb Lidcombe **State** NSW **Postcode** 1825

Contact Name Lindy Clemson **Phone Number** 02 93519372

Partner Agency Mercy Family Centre, Balman League Club, Central Sydney 'Area Health Service'.

Program Name Community Based Falls Prevention Program

Sector 1 (*1 = Community; 2 = Hospital; 3 = Residential; 4 = Mixed setting*)

Year 1999 **Still** 1 (*1 = yes; 0 = no*)

Program

The Community Based Falls Prevention Program aims to enhance self efficacy in falls risk situations, to learn a range of falls prevention strategies, and to facilitate follow through of risk management strategies.

Organisation City of Glen Eira

Suburb Caulfield South **State** Vic **Postcode** 3162

Contact Name David Franklin **Phone Number** 03 95243486

Partner Agency

Program Name 'Foothold On Safety'

Sector 1 (*1 = Community; 2 = Hospital; 3 = Residential; 4 = Mixed setting*)

Year 1998 **Still** 1 (*1 = yes; 0 = no*)

Program

Training peer educators to talk on Falls Prevention. Raising GP awareness of risk factors. Community safety

Organisation Toowong Community Health

Suburb Valley **State** Qld **Postcode** 4006

Contact Name Kathryn Seefield **Phone Number** 07 33715899

Partner Agency Close association with other Community Agencies & Local Hospitals.

Program Name Falls Prevention

Sector 1 (*1 = Community; 2 = Hospital; 3 = Residential; 4 = Mixed setting*)

Year *Still* 1 (*1 = yes; 0 = no*)

Program

Education session involving discussion; photo pictorials of hazardous environments versus positive, simple solutions to risk of falls; visual display of equipment; discussion regarding community services that can assist clients. Intrinsic factors are discussed as time permits e.g. nutrition, incontinence, medications.

Organisation Central Gippsland Health Service Division of Community Care Services

Suburb Sale **State** VIC **Postcode** 3850

Contact Name Sue Turner **Phone Number** 03 51444111

Partner Agency A variety of Coalition Agencies - Acute care facilities, Community health Centres, Older Persons Groups, Community Stakeholders e.g. service clubs. Pharmacists, Opticians

Program Name "Foothold On Safety" - A falls prevention program

Sector 1 (*1 = Community; 2 = Hospital; 3 = Residential; 4 = Mixed setting*)

Year 1998 *Still* 1 (*1 = yes; 0 = no*)

Program

One of ten Foothold On Safety projects currently underway throughout Victoria. A number of strategies have been adopted including the establishment of Tai Chi classes following a local exercise leader participating in a Tai Chi training course. A falls prevention forum involving a number of speakers has been held with the participation of general practitioners, local government, community health nurses, nursing home staff and members of the public. The program has been launched in two major towns. Falls prevention education has been conducted for older adult groups. The training of peer educators is also being pursued. Public safety initiatives are also being explored with the adoption of black spot identification forms being considered.

Organisation Latrobe City Shire
Suburb Traralgon **State** VIC **Postcode** 3844
Contact Name Henk Harberts **Phone Number** 03 51731506
Partner Agency
Program Name Community Safety Promotion
Sector 1 (*1 = Community; 2 = Hospital; 3 = Residential; 4 = Mixed setting*)
Year 1995 **Still** 1 (*1 = yes; 0 = no*)

Program

This pilot project incorporated presentations to older adult groups at Returned Services League clubs, senior citizens centres, the Migrant Resource Centre and other locations conducted by a range of health professionals. Training was conducted for home care workers who distribute the Up and About Falls Prevention Checklist to new clients and have been encouraged to work through the checklist with clients. Meals on Wheels staff also distribute the checklist to new clients. The checklist has also been sent out with rate notices and placed in the local paper annually. Falls prevention has also been incorporated into TAFE courses and training programs for home care workers and volunteers respectively. General injury prevention, including falls prevention, education has been conducted by way of a home safety display positioned at a number of expose and in pharmacies. Public safety has been addressed through an annual 'Spot and fix the hazard' competition.

Organisation Ipswich Community Aid Incorporated
Suburb Ipswich **State** QLD **Postcode** 4305
Contact Name Erik Jansink **Phone Number** 07 38123437
Partner Agency Safe and Confident Swing Program, Home Visiting & Support Service Community Visitors Scheme
Program Name Home Visiting & Support Service
Sector 1 (*1 = Community; 2 = Hospital; 3 = Residential; 4 = Mixed setting*)
Year **Still** (*1 = yes; 0 = no*)

Program

1. 24 hour safety monitoring (via Tunstall Safety Net). 2 Blood pressure & respiratory check on visit. 3. Audit of environment on home visit (approx. 200 clients). 4. Large print calendars - visually impaired. (Falls prevention is listed a a key objective.)

Organisation Community Outreach Services
Suburb Hobart **State** TAS **Postcode** 7000
Contact Name Leigh Tesch **Phone Number** 03 62227208
Partner Agency
Program Name Therapists Promoting Health Unit (previously Falls Prevention Resource Centre)
Sector 1 (*1 = Community; 2 = Hospital; 3 = Residential; 4 = Mixed setting*)
Year 1995 **Still** 1 (*1 = yes; 0 = no*)

Program

An initiative involving the development of a resource library consisting of falls prevention resources which have been developed throughout Australia. For example, home safety checklists, posters, videos, reports and a kit with home safety products. These resources have been distributed and lent to interested parties. Two falls prevention workshops have also been conducted by an occupational therapist, physiotherapist, pharmacist and geriatrician for health workers to attend in Hobart and Devonport. A database of interested workers was also established and a news sheet was formulated and distributed to those listed on the database. Since the completion of this project, involving the development of the resource library and the workshops, falls prevention presentations to community

Organisation Mandurah City Senior Citizens Centre
Suburb Mandurah **State** WA **Postcode** 6210
Contact Name Robyn Lister **Phone Number** 08 95503799
Partner Agency
Program Name Stay on Your Feet WA Program
Sector 1 (*1 = Community; 2 = Hospital; 3 = Residential; 4 = Mixed setting*)
Year **Still** 1 (*1 = yes; 0 = no*)

Program

Education through Peel Region Seniors Expo's held in 1998 and 1999. 1. Exercise program - provided by Robyn Lister for over 50 year old. Light exercises including chair exercise. 2. Education via display stall etc.

Organisation Hepburn Shire Council
Suburb Daylesford **State** Vic **Postcode** 3460
Contact Name Faye McLeod **Phone Number** 03 53482306

Partner Agency

Program Name In Home Safety Guide

Sector 1 (*1 = Community; 2 = Hospital; 3 = Residential; 4 = Mixed setting*)

Year 1997 **Still** 1 (*1 = yes; 0 = no*)

Program

Injury prevention initiative involving the development of a guide for older people to enable them to identify hazards in their homes and adopt strategies to overcome these hazards. The guide includes contact details of local services providers and indicates the availability of safety products. The guide has been distributed to older people throughout the shire. The guide is available in disc form, at a cost of \$300, which enables other local councils to purchase the guide and modify it to include information pertinent to their particular area.

Organisation Council on the Ageing (ACT)
Suburb Hughes **State** ACT **Postcode** 2605
Contact Name Paul Flint **Phone Number** 02 62823777

Partner Agency Australian Federal Police, Emergency Services Bureau

Program Name CLASP - Community Liaison & Advisory Safety Project

Sector 1 (*1 = Community; 2 = Hospital; 3 = Residential; 4 = Mixed setting*)

Year 1997 **Still** 1 (*1 = yes; 0 = no*)

Program

This project offers a free home safety and security assessment. The focus of the project is older people, however, anyone can request an assessment. The assessment is conducted by two workers drawn from members of the police force, ambulance and fire brigade who are on secondment to Council on the Ageing (ACT) for this project. On completion of the assessment clients are asked if they need assistance rectifying the safety and security issues identified. A range of printed resources are provided to clients to facilitate them making modifications. Presentations have been provided to a number of groups to promote CLASP.

Organisation Aged Care Rehabilitation Unit (DHHS, Aged Rural & Community Health)
Suburb Hobart **State** Tas **Postcode** 7000
Contact Name Jennie Delaney **Phone Number** 03 62227312
Partner Agency
Program Name Falls Prevention Clinic
Sector 1 (*1 = Community; 2 = Hospital; 3 = Residential; 4 = Mixed setting*)
Year 1998 **Still** 1 (*1 = yes; 0 = no*)

Program

Falls prevention clinic provides assessment by geriatrician, pharmacist, occupational therapist and physiotherapist. Interventions - referred to existing services - ie OT outreach, physiotherapy programs etc.

Organisation King Island Hospital & Health Service
Suburb Currie **State** King Island **Postcode** 7256
Contact Name Margaret Stingel **Phone Number** 03 64621311
Partner Agency
Program Name Falls Prevention
Sector 1 (*1 = Community; 2 = Hospital; 3 = Residential; 4 = Mixed setting*)
Year 1999 **Still** 1 (*1 = yes; 0 = no*)

Program

Creating an awareness of risks in people's environments and preventative measures that can be instituted to reduce falls and injury using a variety of techniques, eg displays, pamphlets, checklists, exercise, discussion.

Organisation Domiciliary Allied Health Acute Care and Rehabilitation Team (DAART)
Suburb South Brisbane **State** QLD **Postcode** 4101
Contact Name Margaret Tweeddale **Phone Number** 07 38408540

Partner Agency

Program Name DAART (Domiciliary Allied Health Acute Care and Rehabilitation Team)

Sector 1 (*1 = Community; 2 = Hospital; 3 = Residential; 4 = Mixed setting*)

Year 1995 **Still** 1 (*1 = yes; 0 = no*)

Program

This team of allied health professional (including physiotherapy, occupational therapy, pharmacy, dietetics; social work, psychology, speech pathology) receive referrals from hospitals and other community providers (GPs, Community Nurses etc) for assessment and management of patients following acute injury or illness or for injury prevention intervention. (The associated concern may be falls amongst other issues).

Organisation Bunbury Health Services, Primary Health Service Community Health Centre
Suburb Bunbury **State** WA **Postcode** 6230
Contact Name Jan Bain **Phone Number** 08 97922400

Partner Agency

Program Name Stay on Your Feet (& SOYFWA)

Sector 1 (*1 = Community; 2 = Hospital; 3 = Residential; 4 = Mixed setting*)

Year 1996 **Still** 1 (*1 = yes; 0 = no*)

Program

Based on the "Stay on Your Feet" program developed by the North Coast Public Health Unit in NSW. The southern Public Health Unit in SW of WA support and help to resource this program in SW of WA, including the City of Bunbury. Began here in 1996 with 50 plus exercise program run by physiotherapy, then training of "Peer Exercise Leaders". Principles of the program - seniors will take control of health and environmental issues influencing their mobility if they have the information and support to do so; Falls & loss of mobility are not an inevitable part of ageing, but most can be prevented by appropriate action and recognising that there are many factors involved in falls - medication, footwear, balance, gait, inactivity, underlying medical conditions, eyesight, obstacles in the home and the environment. Our program includes - exercise groups, home safety checks, medication checks, footpath audits, awareness raising talks and training of peer educators to take the message to family and friends

Organisation Monashlink Community Health Service
Suburb Hughesdale **State** Vic **Postcode** 3166
Contact Name Shane Kavanagh **Phone Number** 03 98030177

Partner Agency

Program Name Falls Prevention Program

Sector 1 (*1 = Community; 2 = Hospital; 3 = Residential; 4 = Mixed setting*)

Year 1999 **Still** 1 (*1 = yes; 0 = no*)

Program

Three services: fall talks/lectures in health centre or in the community; exercise group incorporating appropriate exercises - each client is individually assessed at the outset; independent assessment/treatment for those unsuitable for group - including OT/Physio/Community Health Nurse.

Organisation Ranges Community Health Service (Belgrave & Lilydalle)
Suburb Belgrave **State** Vic **Postcode** 3160
Contact Name Carina Martin **Phone Number** 03 97548963

Partner Agency

Program Name Staying on Your Feet

Sector 1 (*1 = Community; 2 = Hospital; 3 = Residential; 4 = Mixed setting*)

Year 1993 **Still** 1 (*1 = yes; 0 = no*)

Program

Educational Workshop - This is a falls prevention education program predominantly targeting established older adult organisations. However, education sessions are also held intermittently at the community health service for older people more generally. The education can be conducted by an occupational therapist, physiotherapist, community health nurse, dietician or podiatrist, although it is generally conducted by the occupational therapist and one other health professional. The program caters for small to large groups and runs for a minimum of 1 ½ hours. Individual assessments & intervention - physiotherapy and occupational therapist assessment at the centre or at the clients home, they are then referred to other services within centre and other services outside of the centre. Group programs eg: balance group (exercise based), physiotherapy team offer a range of exercise based group activities - land based, walking group, hydrotherapy & back care group.

*Falls and Falls Injury Prevention Programs
in Acute Care Settings*

Organisation Flinders Medical Centre
Suburb Bedford Park **State** SA **Postcode** 5051
Contact Name Dianne Rogowski **Phone Number** 08 82045511
Partner Agency Southern Division of General Practice. Repatriation General Hospital
Program Name National Demonstration Hospitals Program 3. Aged Care Project Falls program
Sector 2 (*1 = Community; 2 = Hospital; 3 = Residential; 4 = Mixed setting*)
Year 1999 **Still** 1 (*1 = yes; 0 = no*)

Program

To screen all patients who present to Flinders Medical Centre with a fall related incident and to develop individual intervention plans for those at risk. General Practitioners will be involved in continually monitoring the plans with the patient. Also, Best Practice Guidelines have been developed for General Practitioners and other health care providers. A regional network has been established to develop a strategic approach for the region and to improve

Organisation Wingecarribee Health Service - Bowral & District Hospital
Suburb Bowral **State** NSW **Postcode** 2576
Contact Name Beverley Hannah-Tierney **Phone Number** 02 48610294
Partner Agency
Program Name Falls Prevention Programme
Sector 2 (*1 = Community; 2 = Hospital; 3 = Residential; 4 = Mixed setting*)
Year 1999 **Still** 1 (*1 = yes; 0 = no*)

Program

The program is to assess all patients admitted to hospital to ascertain if they are a falls risk. This is ascertained via one document following on from admission process/discharge screening process. "Falls Risk Assessment" - Falls risk patients are identified visually via mobility status signs above bed. Falls risk precautions are put into place. Physiotherapists and significant others are educated regarding falls prevention. A volunteer sitting program has been implemented. Corridor and bathrooms have a special safety walking zone. Laminated and pictorial

Organisation Bunbury Regional Hospital, Health Campus
Suburb Bunbury **State** WA **Postcode** 6230
Contact Name Pearl Howard **Phone Number** 08 97221000
Partner Agency
Program Name "Stay on Your Feet" Falls Prevention
Sector 2 (*1 = Community; 2 = Hospital; 3 = Residential; 4 = Mixed setting*)
Year 1999 **Still** (1 = yes; 0 = no)

Program

Interventions are based on individual risk identification and assessment. Incidents are addressed by multidisciplinary review.

Organisation Sir Charles Gairdner Hospital, University Department of Nursing Research and
Suburb Nedlands **State** WA **Postcode** 6009
Contact Name Helen Myers **Phone Number** 08 93462019
Partner Agency
Program Name Reducing Patient Falls: An Evaluation of the Efficacy of a Multi-Strategy Fall Prevention Program in Acute Care Hospital Ward Settings
Sector 2 (*1 = Community; 2 = Hospital; 3 = Residential; 4 = Mixed setting*)
Year 1999 **Still** 1 (1 = yes; 0 = no)

Program

Research study - Implement and evaluate a multi-strategy fall prevention program. Interventions - 1. Use of risk assessment tool on admission towards. 2. Identifying high risk patients using a pink theme - high risk stickers, pink dots on patient allocation board, pink wristband. 3. Implementation of strategies identified on a standard care plan. 4. Staff education/conscious raising. 5. Review of incident forms. 6. Medication review. 7. Continence

Organisation Macquarie Area Health Service
Suburb Dubbo **State** NSW **Postcode** 2830
Contact Name Adam Drabsch **Phone Number** 02 68812280

Partner Agency

Program Name Patient Falls Prevention Project

Sector 2 (*1 = Community; 2 = Hospital; 3 = Residential; 4 = Mixed setting*)

Year 2000 **Still** 1 (*1 = yes; 0 = no*)

Program

Falls risk assessment of patients on admission and throughout hospital stay. Also development of individual fall management plans. Interventions include basic care practices to prevent falls and also to address individual risk factors, that can be implemented by nursing staff. Staff education program developed and incident reporting form implemented for reporting and monitoring falls incidents.

Organisation Barwon Health - The Geelong Hospital
Suburb Geelong **State** Vic **Postcode** 3220
Contact Name Robyn Blackman **Phone Number** 03 52267111

Partner Agency

Program Name [no title]

Sector 2 (*1 = Community; 2 = Hospital; 3 = Residential; 4 = Mixed setting*)

Year 1999 **Still** 1 (*1 = yes; 0 = no*)

Program

Program aims to minimise the number of falls and the injuries sustained by patients who fall. The program is driven by a falls prevention working party which is addressing the following issues: use of physical restraint to prevent falls (with minimisation the goal), individualised toileting programs for patients, and alternative nursing strategies to manage patients with challenging behaviours.

Organisation Royal Rehabilitation Centre Sydney
Suburb Ryde **State** NSW **Postcode** 1680
Contact Name Linda Glanfield **Phone Number** 02 98071144
Partner Agency
Program Name Falls Prevention and Management
Sector 2 (*1 = Community; 2 = Hospital; 3 = Residential; 4 = Mixed setting*)
Year 1999 **Still** 1 (*1 = yes; 0 = no*)

Program

A Falls Prevention and Management Working Party has recently been convened in an attempt to address the number of falls occurring across the Centre. Quality Grant funding has been obtained to develop a Falls Risk Assessment Tool appropriate for a rehabilitation facility. We have chosen to review a tool developed at the Centre a few years ago and the Statify Tool. Currently in the process of trialing these tools across the Centre, in our Extended Care Service and in the Community Integration Program houses. We intend to hold a number of focus groups with staff to gain feedback on the appropriateness of these tools and their ability to identify clients at risk of falling. The Working Party is also undertaking a review of literature related to falls prevention and management and more specifically to the subject of falls rehabilitation. The development of an appropriate tool to assess clients at risk of falling is the starting point, the Working Party intend to subsequently develop policies and strategies in the

Organisation Moruya District Hospital
Suburb Moruya **State** NSW **Postcode** 2537
Contact Name Barbara Roberts **Phone Number** 02 44741572
Partner Agency South East Public Health Unit through Promotion Officer
Program Name Moruya Hospital Falls Prevention Project
Sector 2 (*1 = Community; 2 = Hospital; 3 = Residential; 4 = Mixed setting*)
Year 1997 **Still** 0 (*1 = yes; 0 = no*)

Program

The programme targets inpatients over 65. Patients targeted in the programme met criteria - 65 plus and/or frail, unsteady gait, poor balance/vision, medications, admitted due to fall. "Falls" flashcard attached to file. Interventions - introduced to "Falls Prevention" home safety checklist (NSW Health). Home Safety video, referred to physiotherapist for gait assessment, OT for home assessment, pharmacist for medication review. Although this program formally finished in October 1998, it has been informally incorporated into nursing care. Set up strategies and a flow chart of action to be taken, developed tools such as icon with a magnetic backing saying: "I need help to

Organisation Hampstead Rehabilitation Centre
Suburb Northfield **State** SA **Postcode** 5085
Contact Name **Phone Number** 08 82221600
Partner Agency
Program Name Falls Working Party
Sector 2 (*1 = Community; 2 = Hospital; 3 = Residential; 4 = Mixed setting*)
Year 1996 **Still** 1 (*1 = yes; 0 = no*)

Program

Recommendations of the Falls Working Party included environmental changes, raising staff awareness and individual assessments. Risk assessment on all clients as part of the initial assessment. Units of care in the nursing care plan to suit individual needs. Appropriate equipment, eg low beds, non slip mats and environmental factors eg, non-slip floors in showers and toilets, good lighting etc.

Organisation Ward 11A, The Aged Care Unit, Canberra Hospital
Suburb Garran **State** ACT **Postcode** 2605
Contact Name June Buchanan **Phone Number** 02 62442774
Partner Agency
Program Name Falls Clinical Pathway
Sector 2 (*1 = Community; 2 = Hospital; 3 = Residential; 4 = Mixed setting*)
Year 1998 **Still** 1 (*1 = yes; 0 = no*)

Program

This initiative involves the inclusion of patients into a clinical care pathway if they are over the age of 75 and have been admitted with a diagnosis of falls where the cause of the fall is unknown or who on admission appear to be at risk of falling. Patients are not put onto the clinical care pathway if the fall resulted from a trip associated with environmental factors. Input from nursing, medical, physiotherapy, occupational therapy and social work is structured into the care pathway. Assessments conducted by the physiotherapist include balance and muscle strength. An assessment of the home environment is commenced in hospital and followed up with a home visit. Medical input includes an assessment of falls history and the circumstances surrounding any preceding falls. Nursing input includes the assessment for postural hypotension. The pharmacist undertakes a review of the patients medications. The development of discharge plan occurs with multidisciplinary input. Hospital staff may then consult with community allied health staff in relation to post discharge management.

Organisation Balmain Hospital

Suburb Balmain **State** NSW **Postcode** 2041

Contact Name Debra Donnelly **Phone Number** 02 93952111

Partner Agency

Program Name Falls Risk Assessment

Sector 2 (*1 = Community; 2 = Hospital; 3 = Residential; 4 = Mixed setting*)

Year 1996 **Still** 1 (*1 = yes; 0 = no*)

Program

The Patient Falls Risk Assessment Tool was developed at Balmain Hospital to best predict patients at risk of falling while in hospital. It is a checklist of predictors (as described in the literature) with a weighting for each predictor. Interventions are then measured against the total score.

Organisation Sunnybank Private Hospital

Suburb Sunnybank **State** QLD **Postcode** 4109

Contact Name Gill Bartley **Phone Number** 07 33456522

Partner Agency

Program Name Falls Minimisation System

Sector 2 (*1 = Community; 2 = Hospital; 3 = Residential; 4 = Mixed setting*)

Year 2000 **Still** (*1 = yes; 0 = no*)

Program

[Proposed program] The program incorporates multiple falls intervention strategies, including environmental, behavioural, educational and intrinsic factors to - 1. Minimise the risk of patient falls/collapse without compromising patient mobility and function. 2. Minimise deleterious effects of a fall where it could not be

Organisation St John's Hospital , Advantage Benchmarking Consortium

Suburb South Hobart **State** Tas **Postcode** 7004

Contact Name Jenny Tufin **Phone Number** 03 62237444

Partner Agency Eleven partners.

Program Name adVANTage Benchmarking Consortium

Sector 2 (*1 = Community; 2 = Hospital; 3 = Residential; 4 = Mixed setting*)

Year 1999 **Still** 1 (*1 = yes; 0 = no*)

Program

11 hospitals in the benchmarking group in the first meeting defined falls as most important item to improve. Subsequent monitoring identified falls in over 70s group, medical/ palliative/ rehabilitation patients most at risk.

Organisation Royal Hobart Hospital

Suburb Hobart **State** TAS **Postcode** 7006

Contact Name Jane Davis **Phone Number** 03 62228318

Partner Agency

Program Name Falls Prevention Guidelines for Royal Hobart Hospital Outpatients Clinic and Falls Prevention Guidelines for Royal Hobart Hospital Perioperative Clinic

Sector 2 (*1 = Community; 2 = Hospital; 3 = Residential; 4 = Mixed setting*)

Year **Still** (*1 = yes; 0 = no*)

Program

[Proposed program] The research plan is to conduct the validated Elderly Falls Risk Screening for all patients over 65 years. (Trial will select one OPD clinic and two days per week at Preoperative Clinic Waiting List for 3 months). High risk patients will be recommended to GP for referral to Falls Prevention Clinic. Medium risk will receive peer educator contact. Low, Medium and High risk will receive health promotional information regarding Falls Prevention

Organisation Joanna Briggs Institute

Suburb Adelaide **State** SA **Postcode** 5000

Contact Name Davide Evans **Phone Number** 08 83034880

Partner Agency Royal Adelaide Hospital

Program Name [no title]

Sector 2 (*1 = Community; 2 = Hospital; 3 = Residential; 4 = Mixed setting*)

Year 1999 **Still** 0 (*1 = yes; 0 = no*)

Program

Prevention of repeat falls (initial pilot study). Risk assessment then program of multiple interventions. (Currently working towards development of a innovation/demonstration ward to evaluate a variety of fall and injury prevention

Organisation Aged Care Services, Caulfield General Medical Centre

Suburb Caulfield **State** Vic **Postcode** 3162

Contact Name David Fonda **Phone Number** 03 92766000

Partner Agency

Program Name Prediction & Prevention of Falls in an Aged Care Hospital Unit

Sector 2 (*1 = Community; 2 = Hospital; 3 = Residential; 4 = Mixed setting*)

Year 1999 **Still** 1 (*1 = yes; 0 = no*)

Program

A falls risk assessment tool (validated) is applied to all admissions to hospital unit. Those at "high" risk receive a multidisciplinary falls intervention protocol/prevention program. Education of staff.

Organisation Royal Adelaide Hospital
Suburb Adelaide **State** SA **Postcode** 5000
Contact Name Annabel Tolfts **Phone Number** 08 82225170
Partner Agency Hampstead Rehabilitation Centre (Annexe of RAH)
Program Name [no title]
Sector 2 (*1 = Community; 2 = Hospital; 3 = Residential; 4 = Mixed setting*)
Year **Still** 1 (*1 = yes; 0 = no*)

Program

Patient is reviewed medically and by physiotherapist and O/T in attempt to identify problems that could respond to management in the acute setting and refer to community agency if appropriate and available. Team approach to reduce risk of falling whilst in hospital.

***Falls and Falls Injury Prevention Programs
in Residential Aged Care Settings***

Organisation St Laurence Community Services
Suburb Lara **State** Vic **Postcode** 3212
Contact Name Jan Taylor **Phone Number** 03 52821405
Partner Agency
Program Name Falls Prevention Program - Residential
Sector 3 (*1 = Community; 2 = Hospital; 3 = Residential; 4 = Mixed setting*)
Year 1994 **Still** 1 (*1 = yes; 0 = no*)

Program

A staff education program has been developed and associated changes in practice are to be implemented. Incident monitoring is in place and guidelines are to be implemented. The program was introduced in 1994, still running but in a different form.

Organisation Wangaratta & District Nursing Home
Suburb Wangaratta **State** Vic **Postcode** 3677
Contact Name Margaret Nicholls **Phone Number** 03 57220196

Partner Agency

Program Name Evening Diversional Therapy Program

Sector 3 (*1 = Community; 2 = Hospital; 3 = Residential; 4 = Mixed setting*)

Year 1997 **Still** 1 (*1 = yes; 0 = no*)

Program

Implemented evening diversional therapy programme in conjunction with incident monitoring, included increased socialisation and normalisation for residents with dementia.

Organisation Wesley Gardens Georgian Aged Care
Suburb Belrose **State** NSW **Postcode** 2085
Contact Name Ann Clarke **Phone Number** 02 94523022

Partner Agency

Program Name Falls Prevention Classes

Sector 3 (*1 = Community; 2 = Hospital; 3 = Residential; 4 = Mixed setting*)

Year 1995 **Still** 1 (*1 = yes; 0 = no*)

Program

Ten month pilot program of exercise and education offered to interested residents in a hostel setting. Program conducted by Physiotherapist and Occupational Therapist following testing, with follow up testing. Three programs were carried out during 1995. Currently exercise & education programmes are continued at two sites -

Organisation Barwon Health - Grace McKellar
Suburb North Geelong **State** Vic **Postcode** 3215
Contact Name Rob Malon **Phone Number** 03 52792222
Partner Agency
Program Name Preventing Falls Amongst Older People in Residential Facilities
Sector 3 (*1 = Community; 2 = Hospital; 3 = Residential; 4 = Mixed setting*)
Year 1999 **Still** 1 (*1 = yes; 0 = no*)

Program

The program is working with seven (7) Supported Residential Service (SRS's) to try to reduce incidence of falling amongst SRS residents. The interventions include: the introduction of a standardised form to record fall events in SRS's education for staff and residents about risk factors for falling and preventive strategies; the introduction of a falls risk assessment and management tool for staff to use.

Organisation Eastern Access Community Health
Suburb East Ringwood **State** Vic **Postcode** 3135
Contact Name Sue Robinson **Phone Number** 03 98793933
Partner Agency City of Maroondah
Program Name Falls Prevention in Maroondah SRS
Sector 3 (*1 = Community; 2 = Hospital; 3 = Residential; 4 = Mixed setting*)
Year 1999 **Still** 1 (*1 = yes; 0 = no*)

Program

The project is a trial of a multifaceted approach within one local SRS with another being involved in staff education and incident monitoring alone.

Organisation Narracan Gardens Aged Care Facility
Suburb Moe **State** Vic **Postcode** 3825
Contact Name Julie Comben **Phone Number** 03 51278462
Partner Agency
Program Name Falls Prevention in Residential Aged Care Facilities
Sector 3 (*1 = Community; 2 = Hospital; 3 = Residential; 4 = Mixed setting*)
Year 1999 **Still** 1 (*1 = yes; 0 = no*)

Program

62 Aged Care Residents. 62 Resident profiles identifying risk factors. Care plans intervention/strategies to minimize risk. Education for staff, resident and relatives. On going evaluation. Measurable data collated in figures

Organisation Injury Control Council of WA
Suburb West Perth **State** WA **Postcode** 6005
Contact Name Gina Arena **Phone Number** 08 94207212
Partner Agency
Program Name "Hip Protector Study" (Epidemiology of Falls in Nursing Home Residents" and 'Compliance of Nursing Staff in the Dressing of residents in external Hip Protectors)
Sector 3 (*1 = Community; 2 = Hospital; 3 = Residential; 4 = Mixed setting*)
Year 1999 **Still** 1 (*1 = yes; 0 = no*)

Program

External Hip Protectors (EHP). 1. Epidemiology of falls in nursing home residents. 2. Compliance of nursing staff in dressin residents in EHP. 3. Analysis of injury surveillance reports in order to determine the effectiveness of

Organisation National Ageing Research Institute/Melbourne Extended Care and Rehabilitation
Suburb Parkville **State** Vic **Postcode** 3052
Contact Name Keith Hill **Phone Number** 03 93897148

Partner Agency

Program Name Falls prevention in supported residential service facilities

Sector 3 (1 = Community; 2 = Hospital; 3 = Residential; 4 = Mixed setting)

Year 2000 **Still** 1 (1 = yes; 0 = no)

Program

Baseline standardisation of documentation of falls in four supported residential settings (SRS's). Introduction of multiple risk factor program. 1. Physical activity and exercise. 2. Staff and resident education program. 3. Environmental audit. 4. Medical review.

Organisation Sunnyside Lutheran Retirement Village
Suburb Horsham **State** Vic **Postcode** 3400
Contact Name Fay Hausler **Phone Number** 03 53820034

Partner Agency Wimmera Health Care Group, Kinnagary Lodge

Program Name Falls Prevention Pilot

Sector 3 (1 = Community; 2 = Hospital; 3 = Residential; 4 = Mixed setting)

Year 1999 **Still** 1 (1 = yes; 0 = no)

Program

Reduce falls in residents in an Aged Care Facility. Implement a multi strategy regarding falls prevention program for older people in an appropriate care facility. Document progress and planning and implementing the project.

Organisation Centre for Education & Research on Ageing
Suburb Concord **State** NSW **Postcode** 2139
Contact Name Chris Shanley **Phone Number** 02 97677670
Partner Agency Concord Hospital (Joint Centre, part of central Sydney Area Health Service) and Department of Medicine, University of Sydney
Program Name Putting Your Best Foot Forward: Preventing and managing falls in aged care facilities
Sector 3 (*1 = Community; 2 = Hospital; 3 = Residential; 4 = Mixed setting*)
Year 1998 **Still** 1 (*1 = yes; 0 = no*)

Program

A written resource package for aged care facilities. Interventions included - assessment and management form for individuals; environmental audit; guidelines for dealing with falls that occur; guidelines for dealing with chronic fallers; guidelines for GP's to help reduce falls; inservice lesson plans and handouts.

Organisation Mercy Aged Care Services
Suburb Nudgee **State** QLD **Postcode** 4014
Contact Name Helen Blake **Phone Number** 07 32609555
Partner Agency
Program Name Falls Prevention Programme
Sector 3 (*1 = Community; 2 = Hospital; 3 = Residential; 4 = Mixed setting*)
Year 1999 **Still** 1 (*1 = yes; 0 = no*)

Program

Our program is based on the "Putting Your Best Foot Forward" program from CERA. We do Risk Assessment on individuals as required. Education for staff and residents and environmental audits, which lead to appropriate strategies for falls prevention. We have an incident reporting system in place.

Organisation West Vic Division of General Practice
Suburb Horsham **State** Vic **Postcode** 3401
Contact Name Wally Coleman **Phone Number** 03 58311756
Partner Agency Wimmera Health Care Group, Horsham.
Program Name Falls Prevention in Residential Facilities
Sector 3 (*1 = Community; 2 = Hospital; 3 = Residential; 4 = Mixed setting*)
Year 1999 **Still** 1 (*1 = yes; 0 = no*)

Program

This falls prevention program involves three components. 1) Falls audit - This will involve the investigation of falls to define the causative factors and mechanisms of falls. A falls reporting system will be developed along side the incident reporting process. 2) Risk identification - A two part process involving risk factor identification of the individual and that of the environment. An individual falls risk assessment will be rated, this will occur on admission to the program and at monthly intervals. An audit of the facility with regard to environmental risk factors will also be undertaken on commencement of the program and reviewed on a three monthly basis. 3) Risk management - On the basis of each individual's falls risk profile, a plan for that particular resident will be developed to reduce the risk. Where falls risk environmental factors are identified, particular actions will be undertaken to

Organisation Uniting Church Lodge Program
Suburb Camberwell **State** Vic **Postcode** 3124
Contact Name M Reimer **Phone Number** 03 98040022
Partner Agency
Program Name Falls Survey
Sector 3 (*1 = Community; 2 = Hospital; 3 = Residential; 4 = Mixed setting*)
Year 1999 **Still** 0 (*1 = yes; 0 = no*)

Program

A survey was done over a period of two months in which each incident from falls were documented, staff filled in an additional form to consider all aspects of the resident, environment and activities.

*Falls and Falls Injury Prevention Programs
in Mixed Settings*

Organisation Occupational Therapy Gold Coast Hospital

Suburb Southport **State** QLD **Postcode** 4215

Contact Name Susan Brandis **Phone Number** 07 55718459

Partner Agency Division of General Practice, Gold Coast Health Promotion, Queensland Health Southern Zone

Program Name "Fall Stop" - Falls Prevention

Sector 4 (1 = Community; 2 = Hospital; 3 = Residential; 4 = Mixed setting)

Year 1995 **Still** 1 (1 = yes; 0 = no)

Program

1. Community Education - Module 1: Falls prevention presentations - questionnaire/screening tool, information provision and booklet, question and answer session, and individual follow up as requested. 2. General Practice - Module 2: Waiting room screening - occupational therapy follow up, screening phone call/interview, home assessment and modifications, and booklet and follow up phone call. 3. Accident and Emergency - Module 3: Screening on admission - home assessment, and equipment prescription and information. 4. Inpatient Hospital - Module 4: Staff education, posters and presentations - falls prevention strategies, identifying armband and bed

Organisation City of Greater Bendigo

Suburb Bendigo **State** Vic **Postcode** 3552

Contact Name Trish Stow **Phone Number** 03 54346431

Partner Agency Bendigo Health Care Group, Bendigo & Division of General Practice; Bendigo Community Health

Program Name Foothold on Safety

Sector 4 (1 = Community; 2 = Hospital; 3 = Residential; 4 = Mixed setting)

Year 1998 **Still** 1 (1 = yes; 0 = no)

Program

To establish linkages between stakeholder agencies develop and distribute education packages and improve access to a range of services. The program includes a household letter drop, a Falls Risk Screening Program, A Safe Environment Campaign, a Falls Hotline, a media campaign, a broad information dissemination to service

Organisation Lutheran Homes Inc
Suburb Glynde **State** SA **Postcode** 5070
Contact Name Anna Sheppard **Phone Number** 08 83370488
Partner Agency
Program Name LHI Falls Prevention Program
Sector 4 (*1 = Community; 2 = Hospital; 3 = Residential; 4 = Mixed setting*)
Year *Still* 1 (*1 = yes; 0 = no*)

Program

1. Assessment (individual session 30mins). 2. Program plan for individual. 3. Twice weekly attendance at group session. (6/8 participants). Participants are booked in pairs at 30 minute intervals. Work on individual programs with a physiotherapist or physiotherapy assistant according to activity. 4. Reviews at 2 months and 3 months, discharge planning. Activities - 1. Graded strategies - postural control. 2. Muscle strengthening. 3. Mobility confidence. 4. Education - handling a fall, get help, get up. 5. Prevention of hazards and risks.

Organisation Australian Patient Safety Foundation
Suburb Adelaide **State** SA **Postcode** 5001
Contact Name Margaret Gehrig **Phone Number** 08 82225422
Partner Agency
Program Name Australian Incident Monitoring System (AIMS)
Sector 4 (*1 = Community; 2 = Hospital; 3 = Residential; 4 = Mixed setting*)
Year 1996 *Still* 1 (*1 = yes; 0 = no*)

Program

AIMS provides software for health care organisations to input details of adverse events into the software and not only tabulate and group, but classify incidents looking at issues such as contributing factors.

Organisation Mid North Coast Health Service (Northern Sector) Health Promotion

Suburb Coffs Harbour **State** NSW **Postcode** 2450

Contact Name Pam Johnson **Phone Number** 02 66591441

Partner Agency

Program Name Establishment of Falls Prevention Network

Sector 4 (*1 = Community; 2 = Hospital; 3 = Residential; 4 = Mixed setting*)

Year 1999 **Still** 0 (*1 = yes; 0 = no*)

Program
 Putting Your Best Foot Forward Seminar for Aged Care Facilities . Various strategies identified in Action Plan by Falls Prevention Network consisting of health workers in Aged Care & Community Nursing.

Organisation Australian Association of Consultant Pharmacy

Suburb Canberra Mail Centre **State** ACT **Postcode** 2610

Contact Name Leone Coper **Phone Number** 02 62701850

Partner Agency Pharmaceutical Society of Australia; The Pharmacy Guild of Australia

Program Name Medication Reviews in Aged Care Facilities

Sector 4 (*1 = Community; 2 = Hospital; 3 = Residential; 4 = Mixed setting*)

Year 1996 **Still** 1 (*1 = yes; 0 = no*)

Program
 Accredited pharmacists review the medication regime of people in aged care facilities (or for veterans & war widows also, living in the community). Interventions to prevent falls due to medication use is a part of the problems monitored and prevented. Nursing staff education in these areas assists.

Organisation Western Sydney Area Health Service Health Promotion
Suburb Parramatta **State** NSW **Postcode** 2150
Contact Name Christine Newman **Phone Number** 02 98403708
Partner Agency Nursing Homes, Acute Hospitals, Aged Day Care Services, Local Government, HAC Services, Community Health, Older People's Consumer Forum
Program Name Falls Prevention

Sector 4 (*1 = Community; 2 = Hospital; 3 = Residential; 4 = Mixed setting*)

Year 1997 **Still** 1 (*1 = yes; 0 = no*)

Program

Area Health Service Program. Risk Management Acute Hospitals and nursing home. Local Government - Environment, service delivery and gentle exercise. Aged Day Care - Gentle Exercise, incidental activity in program planning. Discharge planning and continuity of care. Community - Gentle Exercise programs.

Organisation Aged Care Team, Outreach Service
Suburb Bathurst **State** NSW **Postcode** 2795
Contact Name Suzanne Davis **Phone Number** 02 63328963
Partner Agency
Program Name Falls Prevention

Sector 4 (*1 = Community; 2 = Hospital; 3 = Residential; 4 = Mixed setting*)

Year 1999 **Still** 1 (*1 = yes; 0 = no*)

Program

Falls Clinic - individuals assessed by Rehabilitation Physician, Pharmacist, Occupational Therapists and Physiotherapists. Written referral from GP. Report with recommendation sent to GP. Education of Community Groups - Risk of falls, prevention of falls. Assessment and intervention to reduce risk of falls in Residential Care Facilities. Assessment and intervention to reduce risk of falls in hospital. Patients presenting to Emergency Department. as a result of a fall and discharged home - given falls prevention information package.

Organisation East Grampians Health Service
Suburb Ararat **State** Vic **Postcode** 3377
Contact Name J Waixel **Phone Number** 03 53522221

Partner Agency

Program Name Falls Prevention for Older Adults

Sector 4 (*1 = Community; 2 = Hospital; 3 = Residential; 4 = Mixed setting*)

Year 1999 **Still** 0 (*1 = yes; 0 = no*)

Program

An education session conducted by the West Vic Division of General Practice Falls Prevention Officer. Wally Coleman has conducted a session at the East Grampians Health Service Day Centre. Target group - older adults. Interventions included risk assessment and management.

Organisation Community Health Service (The Prince Charles Hospital & Health Service District
Suburb Fortitude Valley **State** QLD **Postcode** 4006
Contact Name Jan Morrison **Phone Number** 07 32302222

Partner Agency

Program Name Falls Prevention

Sector 4 (*1 = Community; 2 = Hospital; 3 = Residential; 4 = Mixed setting*)

Year 1998 **Still** 1 (*1 = yes; 0 = no*)

Program

1. "Falls Prevention Module" of information presented to community groups and individuals, and other health professionals (currently being evaluated by State, Health Promotion via a kit for sale). 2. Individual assessment case management of community Health clients by Allied Health (Occupational Therapists and Physiotherapists) and nursing staff. Program utilizes Falls Prevention Kit - includes all necessary material on related topics. (OHP's, notes, handouts, evaluations). As well as assistive equipment items for demonstration and large photo illustrations of 'before/after' environmental interventions. This is presented to groups and individuals by Community Health staff. The kit is marketed and sold through Health Promotion Service).

Organisation Health Promotion Unit, Greater Murray Area Health Service

Suburb Albury **State** NSW **Postcode** 2640

Contact Name Nicki Melville **Phone Number** 02 60581700

Partner Agency Local Government; Alliead Health; HACC

Program Name Falls Prevention in Older Adults

Sector 4 (*1 = Community; 2 = Hospital; 3 = Residential; 4 = Mixed setting*)

Year 1996 **Still** 1 (*1 = yes; 0 = no*)

Program

Holistic and integrated program in each of our 29 local government areas (44 towns). Evidence of need provided and community strategies suggested and then developed by each individual community. These include: "All Cause" Injury Prevention; home modification (and assessment); public place assessment and modification; physical activity/strength/balance opportunities; "Be Wise with Medicines".

Organisation South East Coastal Health Service, OT Department, Esperance Community Health

Suburb Esperance **State** WA **Postcode** 6450

Contact Name Gemma O'Dea **Phone Number** 08 90719270

Partner Agency

Program Name Stay on Your Feet (WA)

Sector 4 (*1 = Community; 2 = Hospital; 3 = Residential; 4 = Mixed setting*)

Year 1999 **Still** 1 (*1 = yes; 0 = no*)

Program

Stay on Your Feet (WA) is a collaborative falls prevention program aimed at seniors.

Organisation Healthy Ageing Unit, Department of Social & Preventative Medicine, University of Queensland Medical

Suburb Herston **State** QLD **Postcode** 4006

Contact Name Nancye Peel **Phone Number** 07 33655345

Partner Agency

Program Name 1999 Falls Prevention Audit

Sector 4 (1 = Community; 2 = Hospital; 3 = Residential; 4 = Mixed setting)

Year 1999 **Still** 0 (1 = yes; 0 = no)

Program
Survey of organisations involved in falls prevention services/programs/policies for older Queenslanders.

Organisation Goulburn Valley Health

Suburb Shepparton **State** Vic **Postcode** 3630

Contact Name Yvonne Roberts **Phone Number** 03 58322322

Partner Agency

Program Name National Demonstrations Hospital Program

Sector 4 (1 = Community; 2 = Hospital; 3 = Residential; 4 = Mixed setting)

Year 2000 **Still** 1 (1 = yes; 0 = no)

Program
1. Integrated pathway for older people who present with falls: Development of a model of care for older persons aged 65+ and Koori people 45+ who present to Goulburn Valley Health. The model consists of an Older Persons Care Co-ordinator Role and a program for people discharged from the emergency department and another for people admitted to hospital following falls or with a history of falls. The project will include the trial of a risk screen for discharge planning and a needs for service assessment tool. 2. Reduction of falls involving inpatients at Goulburn Valley Health: Program aimed to reduce falls in the acute and residential care facilities.

Organisation Central Great Southern Community Health Service

Suburb Katanning **State** WA **Postcode** 6317

Contact Name Silvia Clearwater **Phone Number** 08 98215146

Partner Agency

Program Name Stay on Your Feet

Sector 4 (*1 = Community; 2 = Hospital; 3 = Residential; 4 = Mixed setting*)

Year 1998 **Still** 1 (*1 = yes; 0 = no*)

Program

The program promotes the preservation of mobility through general good health and management of both behavioural and environmental risk factors. The program addresses all the recognised risk factors including lack of physical activity, medication, vision, footwear and home modifications.

Organisation Injury Control Council of WA

Suburb West Perth **State** WA **Postcode** 6005

Contact Name Jill Darby **Phone Number** 08 94207212

Partner Agency

Program Name "Falls Prevention Network WA"

Sector 4 (*1 = Community; 2 = Hospital; 3 = Residential; 4 = Mixed setting*)

Year 1995 **Still** 1 (*1 = yes; 0 = no*)

Program

WA Falls Prevention Network provides the avenue for professional development and a forum for Falls Prevention Health Professionals to Network and better co-ordinate local research and activities.

Organisation Alwyndor Rehabilitation & Support Services

Suburb Hove **State** SA **Postcode** 5048

Contact Name June Hudson **Phone Number** 08 82988849

Partner Agency Holdfast Bay City Council

Program Name Balance & Falls Prevention Group

Sector 4 (*1 = Community; 2 = Hospital; 3 = Residential; 4 = Mixed setting*)

Year 1999 **Still** 1 (*1 = yes; 0 = no*)

Program
8 week course (1 hour/week) of exercises, education and discussion. Physiotherapist runs program with an

Organisation Blacktown - Mt. Druitt Health

Suburb Blacktown **State** NSW **Postcode** 2148

Contact Name Michelle Azizi **Phone Number** 02 98317855

Partner Agency

Program Name Falls Prevention Information Package

Sector 4 (*1 = Community; 2 = Hospital; 3 = Residential; 4 = Mixed setting*)

Year 1998 **Still** 1 (*1 = yes; 0 = no*)

Program
To develop a standardised information package for all clients in the 60 plus age group at first point of contact with the organisation.

Organisation School of Nursing, La Trobe University
Suburb Bundoora **State** Vic **Postcode** 3083
Contact Name Alan Pearson **Phone Number** 03 94791111

Partner Agency

Program Name Research Program - Prevention of Falls

Sector 4 (1 = Community; 2 = Hospital; 3 = Residential; 4 = Mixed setting)

Year 2000 **Still** 1 (1 = yes; 0 = no)

Program

There are 3 separate research projects currently proposed or running. The first one looks at the effect of staff education on the incidence of patient falls in Acute Hospitals. The second project looks at the implementation of an individualised risk assessment and intervention program to prevent repeat falls in hospitals and residential aged care. The last program aims to assess the effect of different types of bedrails on falls in acute hospitals.

Organisation Tropical Public Health Unit
Suburb Aitkenvale **State** QLD **Postcode** 4814
Contact Name Bridget Farmiloe **Phone Number** 07 32340111

Partner Agency

Blue Nursing Service; Community Health Services; Townsville City Council; Thuringowa City Council; Townsville Division of GPs; Ethnic Community Care Links; Department of Veterans Affairs.

Program Name Stepping Out

Sector 4 (1 = Community; 2 = Hospital; 3 = Residential; 4 = Mixed setting)

Year 1996 **Still** 0 (1 = yes; 0 = no)

Program

The Stepping Out Program was a four year funded falls prevention project based on best practice (ie multi-strategy including exercise, medication management, home and public hazards, risk assessment, service provider training and community education). The project was coordinated by a project officer in conjunction with a multi-disciplinary steering committee.

Organisation Casterton Community Centre
Suburb Casterton **State** Vic **Postcode** 3311
Contact Name Vickie Williams **Phone Number** 03 54724044

Partner Agency

Program Name Promoting Active Living

Sector 4 (1 = Community; 2 = Hospital; 3 = Residential; 4 = Mixed setting)

Year 1998 **Still** 1 (1 = yes; 0 = no)

Program

We run promotion workshops at various venues including Day Centres, Bush Nursing Centres and Senior Citizens Centres. We included an exercise session, blood pressure and diabetes checks, home safety promotion and falls awareness. With a nutritious lunch provided then showed how to prepare that meal simply.

Organisation Western District Health Service
Suburb Hamilton **State** Vic **Postcode** 3300
Contact Name Enid Smith **Phone Number** 03 55710222

Partner Agency

Program Name Falls Prevention Program

Sector 4 (1 = Community; 2 = Hospital; 3 = Residential; 4 = Mixed setting)

Year 1998 **Still** 1 (1 = yes; 0 = no)

Program

Currently the program is more reactive than pro active, focusing on action following reported incidents within acute and aged care. Home assessments undertaken by occupational therapist following referral to the program.

Organisation Aged Care Program - Southern Healthcare Network

Suburb Cheltenham **State** Vic **Postcode** 3192

Contact Name Sharon Wood **Phone Number** 03 92651000

Partner Agency Acute Rehabilitation Program - Southern Healthcare Network (c/- Hampton)

Program Name Clinical Risk Management Strategy for Patient Falls

Sector 4 (*1 = Community; 2 = Hospital; 3 = Residential; 4 = Mixed setting*)

Year 1999 **Still** 1 (*1 = yes; 0 = no*)

Program

A Falls Prevention Program, implemented as a pilot, that analyses organisational knowledge and attitudes, designs falls education and training, implements Falls Risk Tool for all inpatients. Develops Risk-Pathways. Redesigns data collection and presentation, establishes discharge support options and aims for broader

Organisation Cedar Court Healthsouth

Suburb Camberwell **State** Vic **Postcode** 3124

Contact Name Karen Patten **Phone Number** 03 98092444

Partner Agency

Program Name Falls Prevention & Balance Programme (Safe Walkers)

Sector 4 (*1 = Community; 2 = Hospital; 3 = Residential; 4 = Mixed setting*)

Year 1999 **Still** 1 (*1 = yes; 0 = no*)

Program

Multidisciplinary approach including Physiotherapists and Occupational Therapist, Medical and Psychologist. Assessment and treatment programme. Programme is twice a week for six months with regular reviews.

Organisation Barwon Health - Grace McKellar Centre
Suburb Geelong **State** Vic **Postcode** 3215
Contact Name K Harrison **Phone Number** 03 52792222
Partner Agency
Program Name Rehabilitation & Aged Care Program: Falls & Balance Clinic -Falls Prevention Clinic;
Residential Units - Falls Prevention (Risk Assessment) Program Std 2.14 (Policy)

Sector 4 (*1 = Community; 2 = Hospital; 3 = Residential; 4 = Mixed setting*)

Year 1998 **Still** 1 (*1 = yes; 0 = no*)

Program

Falls and Mobility Clinic - Falls Prevention Program; and in Residential Units - Falls Prevention (Risk Assessment) Program, Std 2.14 (policy).

Organisation Extended Care Service
Suburb Orange **State** NSW **Postcode** 2800
Contact Name Gary Hillier **Phone Number** 02 68634222
Partner Agency Nine nursing homes and satelite hospitals in Mid Western Are Health Service
Program Name Hip Protector

Sector 4 (*1 = Community; 2 = Hospital; 3 = Residential; 4 = Mixed setting*)

Year 1998 **Still** 1 (*1 = yes; 0 = no*)

Program

1. Identification of people (high risk). 2. Full assessment cognitive, physical and functional abilities. 3. Hip protectors worn.

Organisation YMCA of Canberra
Suburb Canberra **State** ACT **Postcode** 2601
Contact Name Helen Palethorpe **Phone Number** 02 62498733

Partner Agency

Program Name 1. Pryme Movers 2. Active aging (off-site program).

Sector 4 (1 = Community; 2 = Hospital; 3 = Residential; 4 = Mixed setting)

Year 1985 **Still** 1 (1 = yes; 0 = no)

Program

Pryme Movers- Course and classes for Older Adults e.g. Pryme Ball, Mobilisers, 60's and Weights, Tai Chi for Arthritis, Monthly special events and Back and Posture Program. Active Ageing - various programs including falls prevention (Stay on Your Feet), in nursing homes and retirement villages.

Organisation Charleville Healthy Ageing Project
Suburb Charleville **State** QLD **Postcode** 4470
Contact Name Sue Jones **Phone Number** 07 46544357

Partner Agency

Program Name "Don't Come a Cropper!" - Rural Falls Prevention project

Sector 4 (1 = Community; 2 = Hospital; 3 = Residential; 4 = Mixed setting)

Year \ **Still** 1 (1 = yes; 0 = no)

Program

23 mm video "Don't come a Cropper!" Older people in SW Qld talk about their falls and give advice. Fridge magnets carrying four (4) advice messages, A3 poster "Don't come a Cropper!" featuring all seven (7) advice messages.