

# Falls Prevention Health Network

## Falls Prevention Model of Care for the Older Person in Western Australia

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Health Networks Branch  
Working Together to Create a Healthy WA





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## EXECUTIVE SUMMARY

The Falls Prevention Model of Care for the Older Person has been developed by the Falls Prevention Executive Advisory Group as part of the overarching Model of Care for the Older Person in Western Australia.

The model builds upon the significant work that has occurred over the last 10 years in the area of falls prevention, whilst addressing some of the barriers in the current system that have prohibited the delivery of an evidence based integrated and coordinated falls prevention service.

The Falls Prevention Model of Care addresses the needs and requirements of the:

- the well older person who has not experienced a fall and the preventative mechanisms required to delay the onset of the first fall;
- older person who has had a fall and the delivery of a range of quality services and interventions to reduce subsequent falls;
- older person who has had a fall to reduce the risk and severity of an injury following the fall.

Central to this model of care is the continued support and expansion of the Stay On Your Feet Western Australia<sup>®</sup> Resource Information Centre and the establishment of a Statewide Falls Prevention Education and Training Centre.

The establishment of the resource and education and training centre will appropriately enable many falls prevention services to be provided in the primary, community and non health sector, whilst ensuring that services provided in the WA Health system are evidence based and consistent regardless of the geographical setting or sector.

### Recommendations

- Maintain and expand Stay On Your Feet Western Australia<sup>®</sup> (SOYFWA<sup>®</sup>) as the brand for falls prevention for older people across the continuum of care through the development and implementation of the SOYFWA<sup>®</sup> Resource Information Centre;
- Establish the State-wide Falls Prevention Education and Training Centre to ensure that consistent evidence based exercise programs are delivered;
- Establish the Falls Specialist Coordinator positions;
- Endorse the Specialised Falls Service that consists of a partnership between the General Practitioner, Department of Geriatric Medicine and the Falls Specialist Coordinator;
- Develop a specific model of care focusing on the configuration and terminology of Day Hospitals that are linked to hospitals in the Western Australian system;
- Develop a specific model of care for osteoporosis;
- That the Specialised Falls Service aligns with regional aged care units;



- Ensure the integration of evidence-based falls prevention programs into clinical practice to reduce inpatient falls and falls related injuries; and
- Continue WA representation on the National Injury Prevention Working Group to progress a national implementation strategy for falls prevention in older person.

Dr Hannah Seymour

CLINICAL LEAD

FALLS PREVENTION NETWORK



## 1. INTRODUCTION

The World Health Organisation defines a fall as an event which results in a person coming to rest inadvertently on the ground or floor or other lower level (1).

The population as defined in this document relates to all individuals aged 65 years and older. As the life expectancy of the Aboriginal and Torres Strait Islander (ATSI) population is lower than the non ATSI population and thus conditions associated with ageing occurs sooner, the age of 45 years and older for ATSI individuals has been adopted by the Model of Care for Older Person.

The aim of this Model of Care is to review current service delivery and propose a new model of care to reduce falls risk, fall incidents, and falls related injuries.

## 2. VISION

For older people to remain independent and at a reduced risk of falls or subsequent falls and fall related injuries.

## 3. OBJECTIVES

The broad focus of the Model of Care for Falls Prevention for the Older Person is to:

- Delay the onset to the first fall by increasing the period of time that older persons are well aged with minimal or low risk of falls, through health promotion, primary prevention and early assessment;
- Improve the range and quality of services for the older person at risk of falls or following a fall to ensure access to best practice falls prevention interventions that are integrated and delivered seamlessly by health care providers across the continuum of care. These should be delivered in a primary care setting where appropriate.
- Reduce the risk and severity of injury following a fall by identifying and treating osteoporosis across the continuum of care and implementing injury prevention strategies for those at highest risk of falls.



## 4. GUIDING PRINCIPLES

The new Falls Prevention Model of Care for the Older Person must:

- Align with the Aged Care Network, Model of Care for the Older Person in Western Australia (2) and other related models (3, 4);
- Be evidence based;
- Engage and strengthen primary care partnerships across the continuum of care;
- Strengthen the role of the community and non health sector through education and training;
- Provide falls prevention at every opportunity across the continuum of care;
- Address the inequalities of access to falls prevention strategies;
- Acknowledge the importance of the carer as an integral component of the care team;
- Foster communication and support between sectors to ensure the transition of older people is better managed.

## 5. METHODOLOGY

The Falls Prevention Health Network Executive Advisory Committee (Appendix 1) which is comprised of a range of key stakeholders across the acute, community and residential aged care health sectors was tasked to develop this Falls Prevention Model of Care for the Older Person, as a key component of the Western Australian Health Reform Agenda.

The development of the model has included preliminary consultation with the Office of Aboriginal Health and the Aged Care Policy Directorate, and the analysis and integration of a number of national and state policies, frameworks and models of care including:

- National Falls Prevention for Older People (NFPOP) Plan: 2004 Onwards (5)
- The Falls Policy for Older Western Australians (6)
- Falls Model of Care (Draft 1) (7)
- Model of Care for the Older Person in Western Australia 2007 (2)
- Model of Care - Rehabilitation and Restorative Care services for the Older Person in WA (Draft) (3)
- Orthogeriatric Model of Care (Draft) (4)

Specifically this Model of Care has been guided and is aligned with the Model of Care for the Older Person and as such the “phases of ageing” (described below) which reinforces the concept that older people are not a uniform group and their risk of a fall is intricately linked to ageing. This approach has been adopted and is used to describe current and future service needs of the population.



The three phases of ageing as cited in the Model of Care for the Older Person are (8):

*Entering old age phase:* This is a socially constructed definition of old age that includes people who have completed their 'working life', retired from full paid employment and released from child rearing responsibilities, but are active and independent and may remain so later into old age.

*Transitional phase:* These people are in transition between healthy, active life and frailty. The transition often occurs in the seventh or eight decade but can occur at any time. It is usually in this phase that the onset of ill health is first experienced.

*Frail older phase:* These are people who are vulnerable as a result of health problems such as stroke or dementia have social support care needs or a combination of both, often experienced only in later old age.



## 6. DRIVERS FOR CHANGE

The last 10 years has seen a significant growth in falls prevention initiatives in health services, non government agencies, in residential aged care, home and community care services and in the private sector in Western Australia.

Many of these falls prevention initiatives however have been developed independently with little coordination between programs.

### 6.1 Lack of Appropriate Falls Prevention Resources

There is currently no or few appropriate falls prevention resources, tools or physical activity programs designed specifically for the following populations:

- Transitional Phase
- Frail Aged Phase
- Older Adults with mental health disorders
- Aboriginal and Torres Strait Islander (ATSI)
- Cultural and Linguistic Diverse Groups (only five CALD Groups have translated falls prevention resources)

### 6.2 Inconsistency in the Type, Configuration and Access of Falls Prevention Services

The types of services for falls prevention, the workforce delivering these and the accessibility of people to these services varies throughout the Western Australian Health System. In some areas best practise in falls prevention is delivered while in others resources are not utilised as effectively. For example there is:

- A lack of consistency in the application of evidence based screening, assessment and intervention of an older person's falls risk throughout metropolitan and rural WA Health;
- Varying levels of funding and staffing for the delivery of falls prevention services within Area Health Services has led to inequity in the services available for the older person;
- Limited access to Specialist Falls Services for the transitional and frail aged in rural and regional areas and residential aged care facilities.

### 6.3 Workforce

Overall workforce knowledge of falls identification and prevention strategies is poor across all sectors.

- Volunteers trained in the use of SOYFWA® resources are most suitable for the entering and early transitional phase.



- There is a general lack of trained professionals in the fitness industry and non government sector with knowledge of evidence based falls prevention programs.
- Private allied health professionals who provide falls prevention programs for those entering old age may have knowledge deficits, and or lack of awareness of suitable resources available from SOYFWA®.
- Many allied health professionals employed by the acute public health sector lack current evidence based knowledge in falls assessment and programs.
- There is a generalised shortage of allied health professionals, such as physiotherapists which impacts on the ability of programs, such as mobility classes to grow.

## 6.4 Demographics

### Age profile

The evidence that Australia's population is ageing is well documented. Data from the Australian Bureau of Statistics, 2006 Census indicates that 12% of the Western Australian population was over the age of 65, with forward projections for the population 60 years and over indicating an increase from 17% of the population in 2006 to 26% in 2051 (9). More significant is the increase in the population of older people aged 80, which is expected to treble over the next 40 years (10).

The Aboriginal and Torres Strait Islander (ATSI) population comprises approximately 3% of the total population of Western Australia, however the percentage of ATSI who are greater than 45 years and older equates 29% of the total ATSI population (9).

### Falls incidence

Approximately one in three people aged 65 and over who live at home fall each year. Of these 10% will have multiple falls and more than 30% will require medical attention (11).

The residential aged care setting has the highest rate of falls with a rate three times as high, and falls injury rates up to ten times higher than a community setting (12).

### Service Utilisation

The number of falls related presentations at a metropolitan WA public Emergency Department in 2001 - 2002 was 18,706 or 892 per 10,000 and the number of hospital admissions during this period was 5,923 (13). The cost to the WA Health system during this time was \$83 million, or approximately 1.5% of the total health expenditure for the 2001 - 2002 period (13).

Inpatient falls are also of significant concern. In 2005 to 2006 there were 6,141 incidences recorded in WA public hospitals (14).

As the population grows so to does the demand for health services. It is projected that in the absence of effective prevention and lower treatment costs for falls related injuries, the cost to the WA Health system will be \$174 million in 2021(13).



## 6.5 Lack of Evaluation

Over the last 10 years there has been increasing evidence of the effectiveness of falls prevention strategies, particularly in a community setting. Furthermore there have been national guidelines such as the Best Practice Guidelines for Acute and Residential Aged Care Facilities (often referred to as the “Green Box”) (14) and state based programs, such as Stay On Your Feet Western Australia® (SOYFWA®) that have been produced to assist in the prevention and management of falls.

The effectiveness of falls prevention strategies have not been rigorously evaluated, and there are currently no standardised data collection processes evaluating the usage of SOYFWA® resources, assessing the participation of older persons in physical activity programs, or measuring the use or effectiveness of tools such as the “Green Box” (14).



## 7. FUTURE MODEL OF CARE

The new Falls Prevention Model of Care for the Older Person must:

- Align with the Aged Care Network, Model of Care for the Older Person (2) and other related models (3, 4);
- Be evidence based;
- Engage and strengthen primary care partnerships across the continuum of care;
- Enhance the role of the community and non health sector through education and training;
- Provide falls prevention at every opportunity across the continuum of care;
- Address the inequalities of access to falls prevention strategies;
- Acknowledge the importance of the carer as an integral component of the care team;
- Foster communication and support between sectors to ensure the transition of older people is better managed.

The Future Model of Care is described below utilising a continuum of care approach, as each sector has an important and integral role in falls prevention for the older person. Of most importance is the understanding that if the enablers (discussed later) are implemented the reliance on the acute public health system is minimised.

### 7.1 Primary Care Sector

#### *Health Promotion and Prevention*

#### **Stay On Your Feet Western Australia®**

The SOYFWA® integrated approach to falls prevention remains an integral component of the new Falls Prevention Model of Care for the Older Person. Older people, their friends and families will continue to be encouraged to address the following Nine Steps to Stay On Your Feet®:

Step 1: Be Active

Step 2: Manage Your Medicines

Step 3: Manage Your Health

Step 4: Improve Your Balance

Step 5: Walk Tall

Step 6: Foot Care and Safe Footwear

Step 7: Regularly Check Your Eyesight

Step 8: Eat Well for Life

Step 9: Identify, Remove and Report Hazards



## Targeted Prevention Programs

Older People should be encouraged to participate in multi-component physical activity programs such as Tai Chi which improve mobility, muscle strength, balance, leg power and agility.

These individual or group based programs can be delivered by health and non health related professionals in a community or primary care setting. Non government organisations, local government's, private allied health specialists and the fitness industry will be encouraged to provide this service, once appropriately trained and supported by the Falls Prevention Education and Training Centre in collaboration with SOYFWA®.

Other identified programs, such as "Find 30™" and "Go for 2 Fruit and 5 Veg®" which contribute indirectly to falls prevention through the promotion of a healthy lifestyle will continue to be supported.

### *General Practitioner*

General Practice provides an important role in falls prevention. The General Practitioner (GP) will be encouraged to utilise resources and tools developed by the SOYFWA® Resource Information Centre to delay the onset of the first fall through early assessment. As an individual ages and their care becomes more complex the GP will continue to be their primary health care coordinator but will have access to varying services depending on an individuals need. This will include direct referral pathways to the other components of the Specialised Falls Service, allowing them to access specialised skills without the need for the patient to be admitted to the acute sector.

As an older persons co-morbidities increases their risk of falls will also increase. It is vital that GP's are informed about falls prevention strategies and are aware of services to support this role. This would importantly include GP's caring for those in residential care facilities utilising Enhanced Primary Care (EPC) initiatives where available and educating the older person about health promotion and targeted prevention programs, such as physical activity programs.

### *Private Allied Health Practitioners*

Private allied health practitioners will be encouraged to utilised resources and tools developed SOYFWA® Resource Information Centre and access education and training opportunities via the State-wide Falls Prevention Education and Training Centre to ensure they are providing evidence based services to the older people they treat.

## 7.2 Acute Care Sector

### *Emergency Departments*

The Falls Prevention Model of Care for the Older Person supports the consolidation of the Emergency Department Care Coordination Teams (EDCCT) operating in metropolitan hospitals and the National Action Plan Care Coordinators located in rural hospitals. Both of these projects are being implemented through WA Health as part of the Council of Australian Government's Long Stay Older Patients' Initiative.



This process involving an Elder Care Pathway risk screening assessment (including falls risk) should continue to be conducted. The health professionals undertaking the assessment should be encouraged to use a Falls Risk Assessment Tool which reflects the evidence based resources that will be developed and available from the SOYFWA® Resource Information Centre. If an older person is identified as at risk of a fall, appropriate interventions should be initiated before being discharged from the Emergency Department. This may involve referral to the Specialised Falls Service.

### *Inpatient*

Many older people who are admitted to hospital will be identified as at risk of a fall. Consolidation and expansion of the current Safety and Quality Investment for Reform (SQiRe) Falls Program which utilises the best practice guidelines known commonly as the “Green Box” is supported by this model to reduce the incidence of inpatient falls through the implementation of targeted interventions.

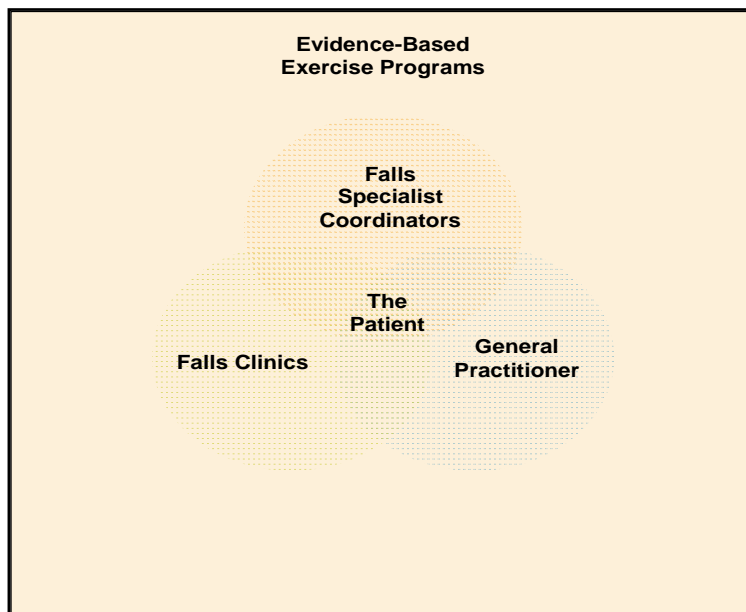
A key component of care for older people in the acute sector is the implementation of interventions to reduce their future risk of falling. This would include medication review, evidence based balance and gait training, where appropriate home safety assessment and the provision of resources for secondary prevention. To support this Model of Care it will be necessary to ensure that all employees of WA Health are provided with targeted professional development which includes evidence based falls prevention and utilises SOYFWA® resources.

## 7.3 Sub Acute Sector

### *Specialised Falls Service*

The Specialised Falls Service comprises of a Falls Specialist Coordinator with the Falls Clinic and the patient’s General Practitioner as shown in the Figure 1.

Figure 1: The Specialised Falls Service





The governance of the Specialised Falls Services will be aligned with the recommendations made in other Models of Care for the Older Person (2). Regardless of the governance structure the importance of a Falls Specialist Coordinator is central to the delivery of this integrated and coordinated Falls Prevention Model of Care for the Older Person. The Specialised Falls Service will have direct links with the patient's General Practitioner, Ambulatory Care Services, Divisions of General Practice and Regional WACHS Aged Care Units.

The key responsibility of the Specialised Falls Service will be to provide detailed assessment of falls risk factors and the development of targeted falls management plans. It will link sectors to ensure optimal service provision for the older person. This service will provide care mostly to the transitional (late) and frail aged older person however will have an important role in support and advice for the General Practitioner.

### *Day Hospital*

This model of care recognises the need for a service similar to the current day hospital for the transitional (late) and frail aged older person. However in alignment with the Service Delivery Model of Care for Rehabilitation and Restorative Care Services for the Older Person in WA (Draft) (3), recommends that the current name needs to reflect a more wellness approach and non inpatient environment and that the configuration of the service is reviewed as part of a specific model of care.

### *Ambulatory Care Services*

Transitional (late) and Frail aged older people who often have multiple co-morbidities require physical activity programs that are delivered by specialised allied health practitioners. For this reason a short term targeted ambulatory care therapy service is supported by this new Model of Care. Referral to this service will be accepted by allied health practitioners, General Practitioners and the Falls Specialist Service.

The role of the current Chronic Disease Management Team (CDMT) should continue to identify falls risk for the patients they are already seeing for other chronic and complex conditions and appropriate interventions implemented.

Due to the multiple factors associated with falls risk often compounded by the older persons associated chronic and complex conditions, transitional (late) and frail older people will be supported by specialised health professionals in areas such as podiatry, pharmacy based medication review, nutrition and hydration, home hazard assessment, eye health and aids and equipment.

## **7.4 Community Care Sector**

### *Day Centres*

Day Centre staff will be encouraged to utilise resources and tools developed by SOYFWA® Resource Information Centre and access education and training opportunities via the State-wide Falls Prevention Education and Training Centre to ensure they are providing evidence based services to the older people they treat. Transitional (late) and



Frail older people will be encouraged to utilise this service which will mostly focus on the provision of maintenance group exercise.

### *Day Therapy Centres*

Day Therapy Centres will continue to provide a wide range of therapy services such as physiotherapy, occupational and speech therapy, podiatry and other therapies. Day Therapy Centre services are provided for frail older people living in the community or residents of a government funded aged care home. The Day Therapy staff will be encouraged to access secondary prevention resources, information and training for falls prevention (via the SOYFWA® Resource Information Centre and the State-wide Falls Prevention Education and Training Centre) to support the delivery of evidence based programs for frail older people.

### *Support Services*

The Community Care Sector in the new Falls Prevention Model of Care for the Older Person will continue to provide a vital role to the older person living in the community, through the provision of support services and in identification of falls risk. If an older person is identified as at risk the community care sector will be encouraged to refer the older person for further management via their General Practitioner.

The WA Health system will be responsible to work with key stakeholders to establish and maintain effective communication and clinical handover arrangements between the sectors. This is of great relevance to the frail older person who moves between them.

## **7.5 Residential Care Sector**

The Residential Care Sector provides a key role in falls prevention and management for the frail aged older person. The Residential Care Sector will be supported and encouraged to use evidence based resources (tools and programs) developed and delivered by SOYFWA® and the State-wide Falls Prevention Education and Training Centre.

The WA Health System will support the Residential Care Sector in this role through the provision of ambulatory care initiatives such as the Residential Care Line (RCL) and through the Specialised Falls Service. The WA Health system will also be responsible to work with key stakeholders to establish and maintain effective communication and clinical handover arrangements between the sectors. This is of great relevance to the frail older person who moves between them.

## **7.6 Country Health Services**

The SOYFWA® Resource Information Centre and the State-wide Falls Prevention Education and Training Centre are both State-wide and will be required to develop resources and deliver programs that take into account the needs of the ATSI population and the availability of services in rural and remote areas. The Specialised Falls Service will play a key role in providing expert advice, triage and support for rural health through the use of mediums such as Telehealth.



## 8. ENABLERS

The following will enable the reorientation of many services out to the community and primary care sector by providing support to these sectors and their providers and ensuring they are delivering evidence based services and programs.

### 8.1 Stay On Your Feet Western Australia® Resource Information Centre

The SOYFWA® Resource Information Centre will:

- Integrate and coordinate a consistent evidence based message for Stay on Your Feet® initiatives across Western Australia.
- Become the single point of access for consumers, health professionals and those businesses and sectors that interact with the aged population, for information and tools on falls prevention, including
  - falls risk assessment tools,
  - health promotion educational packages,
  - referral guidelines, and
  - standardised guidelines for falls prevention strategies

These resources will be developed for each phase of ageing (entering, transitional and frail), with additional resources developed for targeted populations such as Aboriginal and Torres Strait Islander (ATSI), Cultural and Linguistic Diverse (CALD) groups, and “Older Men and Ladders” (15).

- Promote the use of these resources to all sectors (health and non health related) that interact with an older person, such as:
  - Community (self assessment, local government, fitness industry )
  - Primary Care Sector (General Practice, private allied health services)
  - Acute Care Sector (emergency departments, in patients)
  - Community Care Sector (e.g. Aboriginal Community Controlled Health Services, HACC, DVA)
  - Residential Care Sector (high and low care residential care facilities)
- Collaborate with the State-wide Falls Prevention Education and Training Centre to improve the knowledge and skill base of health and non health related professionals working with older people across sectors.

### 8.2 State-wide Falls Prevention Education and Training Centre

A central falls prevention education and training centre will be established to support existing education and training resources and develop in collaboration with service delivery agencies standardised train the trainer packages that adhere to current best practice.



It is not intended that the State-wide Falls Prevention Education and Training Centre be a physical place requiring extensive additional investment but rather a virtual centre whose responsibility is to provide expertise and share best practice.

The falls prevention education and training centre will for example:

- Develop packages that incorporate evidence based multi - component exercise and Tai Chi based exercise programs that incorporate balance, strength and endurance, such as the 'No Falls" (16) and "OTAGO Exercise Programme" (17), suitable for
  - All Phases of Ageing (Entering Old Age, Transitional Phase and Frail Aged)
  - Individuals and groups
  - Targeted populations (ATSI and CALD)
  - Across metropolitan and rural and remote settings
- Train health and non health related professionals to deliver these programs in the community, primary care setting, and acute sector, thus expanding the falls prevention workforce, whilst ensuring evidence based information and programs are being delivered
- Educate health and non health related professionals about SOYFWA® education resources and tools available to ensure a consistent evidenced message about falls prevention is delivered.

### 8.3 Specialised Falls Service

As discussed previously the components of a Specialised Falls Service include the already existing Falls Clinic, General Practitioner and a new Falls Specialist Coordinator position.

The primary role of the Falls Specialist Coordinator (FSC) is to integrate and communicate across sectors and deliver evidence based education and training. A pilot of this role is currently being undertaken in WA Health as part of the Australian Better Health Initiative and future service developments would be dependent on the evaluation of this project.

The skills required by the Falls Specialist Coordinator (FSC) will include the ability to conduct detailed falls risk assessment and implement interventions to reduce falls and injury from falls. They would be experienced in Aged Care and have an awareness of community and primary care services.

### 8.4 Information and Communication Technology

Effective data systems are required in the primary, acute (Emergency departments and inpatient) and the residential care sector to ensure that the services that are provided in this new Model of Care are effective and reduce the incidence of falls and fall related injuries.

WA Health needs to provide data systems that can capture this data within the WA health system but also can retrieve and recall information from other sectors funded and governed by the Commonwealth.



As the older person often moves between the primary, acute, sub acute and residential care sector an electronic patient data system is required to ensure adequate communication and the effective transition of these people.

The adoption of Telehealth as a key service delivery mechanism, particularly to support the rural sector is supported by this Model of Care.

The SOYFWA® Resource Information Centre is a key enabler to this Model of Care. Pivotal to acting as the single point of access for consumers, health professionals and those businesses and sectors that interact with the aged population, for information and tools on falls prevention is the development and maintenance of a web site.



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## APPENDICES

### Appendix 1: Falls Prevention Health Network Executive Advisory Committee

The Falls Prevention Health Network would like to acknowledge the individuals, groups and organisations who have contributed their time, experience and future vision for the prevention of falls in Western Australia. In particular, the members of the Falls Action Committee listed below:

*Dr Hannah Seymour*, Clinical Lead Falls Prevention Health Network, Consultant Geriatrician Royal Perth Hospital

*Dr Paul Babich*, General Practitioner, Fremantle Regional Division of General Practice

*Ms Ann Banks*, Consumer Representative, Health Consumer's Council WA

*Ms Katherine Birkett*, A/Nursing Director, Medical Specialties Division, Royal Perth Hospital

*Ms Kathryn Devereux*, Chronic Disease Service Project Co-ordinator, Ambulatory Care, Healthy @Home

*Ms Marea Gent*, Senior Development Officer, Health Networks Branch

*Ms Carole Kagi*, Program Manager, Department of Health and Ageing

*Ms Kathy Kavanagh*, Residential Care Manager, Aged and Community Services WA Inc

*Ms Carmel Fitzgerald*, Clinical Systems Coordinator, Amana Living

*Dr Charles Inderjeeth*, Consultant Geriatrician, Sir Charles Gairdner Hospital

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## Appendix 2: Current Service Provision

### Entering Old Age Phase

In entering the first phase of ageing the individual may have few if any risk factors associated with falling and as such is likely to be at no or a low risk of falling. Individuals are essentially well, live independently in the community without assistance and most health care received in this phase of ageing is delivered through the primary care sector.

#### *Health Promotion*

The role of health promotion in this Falls Prevention Model of Care for the Older Person is to increase the awareness of risk factors and promote self management for healthy living.

In this healthy aged, low risk phase, the current Department of Health, Stay On Your Feet Western Australia<sup>®</sup> (SOYFWA<sup>®</sup>) health promotion initiative dominates as a falls prevention strategy.

The SOYFWA<sup>®</sup> program is currently delivered by the Injury Control Council of Western Australia (ICWA), and incorporates awareness raising, volunteer training and education, an annual Stay On Your Feet<sup>®</sup> week and the new development of a SOYFWA<sup>®</sup> Resource Information Centre.

Other identified programs and services may add value to falls prevention in this phase as they have the potential to impact on the evidenced based risk factors. For example public health campaigns such as “Find 30™” and “Go for 2 fruit and 5 Veg<sup>®</sup>” may contribute indirectly to falls prevention through the promotion of a healthy lifestyle.

#### *Prevention*

The goal is to delay the onset to the first fall by increasing the period of time that older persons are well aged with minimal or low risk of falls.

The key focus is the delivery of physical activity programs such as Tai Chi which improve mobility, muscle strength, balance, leg power and agility.

There are several programs currently delivering community based physical activity programs appropriate in this phase of ageing. The Living Longer Living Stronger (LLLS) program is contracted to incorporate key elements of the SOYFWA<sup>®</sup> falls prevention program together with group based exercise programs. The program is delivered by The Council on The Ageing (WA) (18) in a community setting in both the metropolitan and country regions.

The Healthy Ageing Program is currently being administered by the Community Physiotherapy Service (CPS) (19). The CPS programs focus on maintaining or improving mobility, function and physical activity with an aim to maximising the independence of participants through exercise and self management principles.

Programs are run at recreation or seniors centres, and public pools throughout the Perth metropolitan area. A nominal fee is charged for classes. Referral to the class must be



made by either a doctor or allied health professional. Currently places are limited due to workforce and funding constraints.

Other physical activity and exercise programs are provided in the private sector or coordinated through non - government and other government organisations, such as the National Health Foundations “Heartmoves” exercise program.

### *Assessment*

Specific issues that an older person may have with emerging falls risk factors will typically see them attend their General Practitioner (GP) and allied health services such as physiotherapy, optometry and podiatry within the primary care (often private) sector.

In this phase the SOYFWA<sup>®</sup> program has developed a risk factor assessment checklist and information booklet to support early identification of the risk factors (both internal to the individual and external to the environment) associated with falling. These resources can be completed by the older individual and also utilised by primary care providers.



## **Transitional Phase**

This phase of ageing is the period of time where an older person may experience a first fall with or without injury. The older person is likely to be considered at low to moderate risk of falling, though continues to live independently in the community with or without the support of community services such as house cleaning or in low care residential care facilities.

The primary health care sector continues to play a significant role in the delivery of health services to these older persons but use of the acute care sector begins to emerge.

### ***Health Promotion***

SOYFWA<sup>®</sup> health promotion initiatives continue to dominate the falls prevention strategy.

### ***Prevention***

Community exercise options continue to be available for an older person in the transitional phase with the older person likely to be capable of continuing with an unsupervised exercise program.

The individual may privately purchase aids and equipment as a result of functional changes, unless eligible for equipment prescription programs such as those through Department of Veteran's Affairs or the Disability Service's Commission Aids and Equipment Program (CAEP).

Podiatry services can be assessed privately through a number of local government day centres. Commonwealth day therapy centres also provide access to subsidised allied health services during the latter part of this phase of ageing.

### ***Assessment***

The General Practitioner (GP) continues to have an important role in fall prevention and management. The GP may utilise the Enhanced Primary Care (EPC) initiative to manage risk factors likely to emerge during this phase, however this is only accessible to those individuals who have established chronic and complex conditions.

Older people in this phase are likely to commence accessing services in the acute sector in the event of a fall related injury.

Emergency Department Care Coordination Teams (EDCCT) operating in metropolitan hospitals and the National Action Plan Care Coordinators located in rural hospitals are project being implemented in WA Health as part of the Council of Australian Government's Long Stay Older Patient's Initiative. Both of these projects are performing risk screening of all older people, identifying patients needing specific follow up and investigation in relation to their falls risk, and provide preliminary assessments that can guide further community or acute care management for the older person.

### ***Management and Tertiary Prevention***

Older people in this phase are likely to be hospitalised for chronic and complex conditions. The SQulRe Falls Program is currently being implemented across the WA Health system (20). The aim of the program is to reduce the incidence of falls in older



people whilst in hospital. A multi disciplinary team utilises evidenced based resources provided in the “Green Box” to appropriately assess an individuals risk of falling and implementing interventions targeted at reducing an individuals risk (14).

During the latter part of this phase, older people may begin to access the services of the Department of Geriatric Medicine (DGM) Falls Clinic programs and outpatient services depending on the extent of their disabilities and co - morbidities. These services are provided to Perth metropolitan residents however only a few country regional centres are also providing this service.

Ambulatory Care Programs such as Hospital in the Home (HITH) and Rehabilitation in the Home (RITH) are available in the metropolitan area, and currently in various stages of development in rural WA. These services may be provided to patients following an in patient admission and include customised exercise prescription, home safety assessment and access to Home and Community Care (HACC) Services.



## Frail Age Phase

The older person in this phase of ageing is at high risk of falls due to the presence of multiple risk factors and co morbidities. Having had at least one fall but most likely to be a recurrent faller with or without injury, the older person is likely to be living either in the community with community services to support independent or semi independent living or in a low or high residential care setting.

The Primary Care Sector continues to play an important role but the use of acute services is present. These individuals may present to emergency departments and have a higher rate of admission due to their physical frailty and increased risk of injury. They may also be at higher risk of inpatient falls whilst admitted in the acute care sector. Recovery time post fall related injury is longer and there is evidence of increased service use whilst hospitalised (15).

### *Health Promotion*

The current SOYFWA<sup>®</sup> strategies are less applicable during this phase as frail older people are more likely to require support to carry out falls prevention strategies and are less likely to benefit from initiatives that are reliant on self management.

There are currently no other health promotion strategies relevant to this phase of ageing.

### *Prevention*

Access to appropriate physical activity initiatives designed for frail older people can be problematic. Due to their physical frailty, older persons in this phase are likely to require longer periods of rehabilitation and may require long term supervision to facilitate ongoing exercise participation.

Current formal services such as the Community Physiotherapy Services and Department of Geriatric Medicine Day Hospital programs are effective but time limited. There are currently no appropriate community services for the frail aged older person. Therefore an appropriate and effective prevention program for the frail aged older person currently does not exist.

Home and Community Care (HACC) eligible older persons may access program based allied health services through Silver Chain via the Home Independence Program (HIP) or the Personal Enablement Program (PEP) (post acute discharge only). These services are currently provided to metropolitan residents and and currently being progresses through rural/regional WA.

There is inconsistency in the exercise programs being delivered by the Residential Care Facility sector, with some programs being delivered that are not evidence based. Limited access to allied health staff in this sector has compounded this problem.

Frail older people with a longstanding disability may be eligible for aids and equipment through the Disability Services Commission Community Aids and Equipment Program.



### *Assessment*

General Practitioners continue to provide a significant degree of care for the frail older person at risk of falls though they are more likely to seek assistance from the acute sector, particularly services associated with Departments of Geriatric Medicine (DGM).

Many older persons in this phase have complex medical conditions and therefore the use of the Enhanced Primary Care (EPC) is more likely.

### *Management and Tertiary Prevention*

Department of Geriatric Medicine Falls (DGM) Clinics and Day Hospitals currently provide management and tertiary prevention to this older population. Detailed assessment of falls risk factors is undertaken (including balance and mobility assessment) and targeted falls management plans (customised exercise programs, education and behaviour modification) developed and delivered by the sub acute sector.

A Falls Specialist is currently employed by the North Metropolitan Area Health Service. This position acts as a triage to the DGM Falls Clinic from community referrals, undertaking assessment of falls risk and implementation of interventions to the individual in their home environment. The position also provides and interfaces between the acute and primary care sector. Referral to the service is not dependent on an individuals falls risk or functional disability.

Aged Care Assessment Teams (ACAT's) also indirectly assist with reducing falls in the older person through the assessment of common risk factors.

The Home and Community Care sector performs a vital role in providing care for the frail older person to promote and assist independent living. Older people living in residential aged care facilities have varying exposure to strategies such as some ambulatory care programs (Residential Care Line, Hospital in the Home and Rehabilitation in the Home) that may contribute to preventing falls.

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