LIVING FULLY AND FREE OF FALLS

In the Nelson Marlborough Community

Delivering a sustainable falls prevention model of care that is aligned with evidence based practice for the frail elderly population

CHALLENGES BRINGS OPPORTUNITIES

Falls are a leading cause of injury in the older population. Causes are multi-factorial and the incidence increases with age. As we age there is a reduction in strength and balance in combination with increasing co-morbidities. There are many ways to mitigate this risk.

Nelson Marlborough Health (NMH) in partnership with ACC endorsed the development of the **In Home Falls Prevention (IHFP) programme.** The programme provides falls prevention in the home for frail older adults with a focus on strength and balance exercises. Development of a model of care needed to acknowledge four key drivers:

- **Evidence based practice:** The literature strongly endorses strength and balance training in the home over an extended period of time.
- **Workforce challenges:** Increasing demand on Physiotherapy required a sustainable and efficient workforce model. This was an opportunity to embrace the NMH implementation of the Calderdale Framework (CF). The CF is a clinically-led workforce development tool that provides opportunities to standardise patient care and achieve service efficiencies in a lean environment. This enables registered staff to work at the top of their scope following appropriate delegation to the Allied Health Assistant (AHA) workforce.
- **Financial challenges:** The programme needed to engage widely across our community to ensure a region-wide reduction in falls.
- **Health equity:** To promote health equity the age-related inclusion criteria for Māori and Pasifika populations were lowered.

BUILDING A TEAM

Scope: Previous research guided the programme to develop a robust inclusion criteria.

Engagement: Collaborating with the wider health team has incorporated ideas and feedback during the development phase. This contribution has ensured positive engagement during implementation. Strong relationships have been built with GPs, Practice Nurses, Allied Health clinicians, Needs Assessors, St John's and home-based support agencies.

Region wide promotion has extended the reach into the community with initiatives such as attending the Positive Ageing Expo, presentations to local community groups and a drop-in clinic at a GP practice.

SUSTAINABLE MODEL OF CARE

The IHFP programme has been successful in achieving a sustainable model of care. Confidence in this innovative model has been provided by the robust governance of the Calderdale Framework.

The programme consists of an initial assessment in the home by a registered Physiotherapist to prescribe appropriate exercises. Over the next six months this is followed by AHA support with alternating phone call interventions and home visits.

Delegation: The Physiotherapist's role is focussed on assessment and oversight. This can be multi-factorial and includes adaptations to co-morbidities, allocation of mobility aids, education on falls, home safety and bone health. The AHA's role is focussed on establishing a longer-term therapeutic relationship to empower the participants in self-management. Regular contact ensures close monitoring and appropriate progressions. The CF enables safe delegation ensuring an efficient service delivery and wider reach.

Patient/ Whānau involvement: Given that falls risk is multi-factorial (i.e. physical, emotional, cognitive and environmental) patient education and engagement with family and whānau involvement is critical for the programme to succeed.

Duration: The length of the programme allows us to be valuable 'eyes and ears' in the participant's homes. This ensures that appropriate referral to the wider health team can occur. As an example, the programme proactively identified several elderly neglect cases which led to referrals to appropriate services to help our participants.

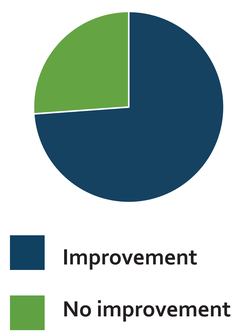
OUTCOMES

The Timed Up and Go (TUG) score is a validated outcome measure that assesses mobility and is a predictor of falls risk. This is assessed on the first visit to obtain a baseline measurement and then repeated at week 12.

Of the 241 participants where data was available, 178 showed improvement (74%). The factors that contribute to no improvement are a recent medical event or a deterioration in a pre-existing medical condition that adversely affected their exercise tolerance.

Recognising that there are factors contributing to a lack of improvement or data may be the fragility of many participants; for example, those moving to aged residential care.

IMPROVEMENT OF TUG SCORES FROM BASELINE TO WEEK 12



WHAT OUR PEOPLE SAY ABOUT THE PROGRAMME

" Prior to the programme I had fallen 50 times within the past 12 months, now after completing the falls programme I haven't fallen at all."

" I am walking so well now and no longer need my walking stick indoors."

" I feel that the home visits combined with the length of the programme has been helpful in getting a good exercise routine established. I felt that the 'check-up' phone calls kept me motivated. I am now able to walk to the supermarket, park and coffee shop with my wife."

" I have noticed getting out of a chair is much easier only six weeks into the programme. I'm also finding that I feel stronger when walking."

FUTURE FOCUS

Vulnerable populations: To develop a model of care to achieve greater involvement and improved outcomes for Māori and Pasifika populations.

Wider reach: To continue to promote the benefits of the IHFP to the community and to the wider community of health professionals.

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