

**DAREBIN FALLS  
PREVENTION  
SERVICES AUDIT  
REPORT**

**FOOTHOLD ON SAFETY (6)**



**AUGUST 2007**

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## EXECUTIVE SUMMARY

The incidence of falls amongst older people is high with one in three older Victorians experiencing a fall each year. Falls can often be perceived to be a natural occurrence with ageing and limited mobility. Whilst age itself is a risk factor for falls, many factors can contribute to an individual's risk of sustaining a fall. Reducing the incidence of falls is underpinned by the identification and management of multiple falls risk factors. This involves a multi-factorial approach from a range of health care workers within and across agencies.

The Foothold on Safety Project (6) works within an integrate health promotion framework in which agencies across the health care spectrum and non health care sectors work collaboratively to implement strategies which promote healthy outcomes. The project is funded over a three year period from 2005-2008 by the Department of Human Services. The project is managed by the North Central Metro Primary Care Partnership (NCMPCP), which covers the municipal areas of Whittlesea, Yarra and Darebin. In 2005-2006 the project was based in the City of Whittlesea. From 2006-2007 it was based in the City of Yarra and as from March 2007 it has been based in the City of Darebin. The aim of the project is to reduce the incidence of falls amongst people aged 65 and over and living in their own homes targeting those of linguistically and diverse background.

This report serves to identify current falls prevention practices and gaps in the City of Darebin.

- Statistical data sourced includes City of Darebin community profile data and falls related hospital admitted cases from the Victorian Admitted Episodes Dataset attained from the Victorian Injury Surveillance unit.
- A literature review of evidence based best practice in falls prevention was conducted and provided a basis for comparison against which recommendations will be made.
- A falls prevention questionnaire was distributed to a number of key local agencies. Questions were grouped under the following categories:
  - Screening methods
  - Referral Pathways and Barriers
  - Workforce Development
  - Current Gaps in Falls Prevention
  - Foothold on Safety Project Outcomes
- The following findings emerged from this audit:
  - There is a lack of formal screening of clients aged 65 and over
  - There are a higher percentage of Australian born Darebin residents admitted to hospital for a falls related injury than any other CALD group.
  - A home hazard modification is an effective intervention only for clients who have had a history of a fall or who are visually impaired.

- Agencies have requested increased access to falls prevention services/programs
- A request for falls prevention training/education to service providers has emerged as an important issue.
- An increase in falls prevention community awareness is an identified need amongst agencies
- Recommendations include:
  - Promote a generic screening tool for use by local agencies, particularly CACPs providers, HACC assessment offers and practice nurses.
  - Educate carers and clients of falls risk factors and the availability of local falls prevention services.
  - Provide training to agency staff on the use of falls risk screening and action plan tool as an attachment to the SCTT form.
  - Develop and promote use of a local services directory to be used with the screening tool to assist staff when referring client to services and programs.
  - Heighten awareness of the high incident of falls amongst Australian born Darebin residents to agency staff.
  - Develop an education kit in relevant community languages which is to be distributed by agency staff to clients and their carers.
  - Establish a falls prevention resource centre at Darebin Community Health.

## **ACRONYMS**

<b>ACAS</b>	<b>Aged Care Assessment Service</b>
<b>CACPS</b>	<b>Community Aged Care Packages</b>
<b>CALD</b>	<b>Culturally and Linguistically Diverse</b>
<b>CRC</b>	<b>Community Rehabilitation Centre</b>
<b>FOS</b>	<b>Foothold on Safety</b>
<b>HACC</b>	<b>Home and Community Care</b>
<b>IHP</b>	<b>Integrated Health Promotion</b>
<b>NCMPCP</b>	<b>North Central Metropolitan Primary Care Partnership</b>
<b>SCTT</b>	<b>Service Coordination Tool Templates</b>
<b>VAED</b>	<b>Victorian Admitted Episodes Dataset</b>

This audit report has been developed by the Foothold on Safety Project officer in consultation with the Darebin Working Group to identify current practices and gaps in falls prevention amongst local agencies in Darebin. These practices pertain to clients aged 65 and over, who are residing in community dwellings in Darebin and not living in an assisted living setting.

Information gathered will be compared against evidence based best practice and proven health promotion practices and interventions.

The audit will serve to form recommendations and assist in prioritising sustainable project strategies and interventions to be implemented in the City of Darebin.

## **1. INTRODUCTION**

The Foothold on Safety Project (6) is funded by the Department of Human Services, Aged Care Branch. The project is managed by the North Central Metro Primary Care Partnership and has operated in the Cities of Whittlesea and Yarra. The project commenced operating in Darebin in March 2007 and is due for completion in February 2008.

The project works within an integrated health promotion framework to reduce the incidence of falls amongst older people, targeting those of culturally and linguistically diverse background through strategies such as workforce development, capacity building, social marketing and raising community awareness. The steering group for the project is the Integrated Health Promotion Group which is represented by key local agencies across the primary care partnership catchment. A local working group, consisting of Darebin agency representatives meets monthly to oversee and develop appropriate local strategies and to assist with embedding strategies within their respective organisations. Most members of the working group work in the area of falls prevention or in the provision of aged care services.

A major function of the project is to conduct an audit of key local agencies to identify current practices, strategies and gaps in falls prevention. This information can provide a baseline against which strategies can be measured and evaluated.

## **2. BACKGROUND**

Falls have an enormous impact on mortality and morbidity amongst older people. People who have had a fall, even without sustaining an injury, may have a greater fear of falling which leads to anxiety, increased dependency, and restriction of daily activities.<sup>1</sup> The estimated cost of falls related injuries in

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<sup>1</sup> Statewide action plan: Falls Prevention in Older People 2002-2006

2001 was \$498.2 million.<sup>2</sup> Approximately one in three Australians living at home experience a fall annually.<sup>3</sup>

A fall is defined as 'Unintentionally coming to rest on the ground, floor, or other lower level.'<sup>4</sup>

The risk factors for falls can be grouped as personal (intrinsic) and environmental (extrinsic) risk factors.<sup>5</sup>

Personal factors include:

- Increasing age and associated limited mobility and health,
- gender- females are at higher risk of falls than males,
- poor muscle tone and strength which are associated with low levels of physical activity,
- more than three medications particularly psychotropic drugs, visual impairment,
- alcohol use,
- a history of falls and
- the presence of medical conditions such as Parkinson's disease, dementia, depression, low blood pressure, incontinence osteoporosis and diabetes.

These factors can be further grouped into three areas: lifestyle related choices, risks related to medical conditions and non amendable risk factors.<sup>5</sup> Lifestyle related choices such as alcohol consumption, diet and physical activity levels can be addressed earlier in life. This point affirms the importance of a preventative and proactive approach to managing and minimising falls risk factors.

There is an increased risk of falling in the presence of medical conditions such as impaired vision, hearing and balance problems, impaired circulation, dementia, and arthritis. The increase in falls risk can also be attributable to medications used to manage these medical conditions.

Non amendable risk factors such as age, a history of falling and gender should draw attention to the healthcare provider of the client's increased falls risk.

Environmental risk factors include:

1. unstable, poorly fitted footwear,
2. uneven flooring
3. loose floor coverings,

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<sup>2</sup> Moller, 2003)

<sup>3</sup> Lord et al, 1993; Dolinis et al, 1997; Morris et al.2004)

<sup>4</sup> Wolf, S., Barnhart, H., Kutner, N., McNeley, E., Coolger, C., Xu, T. et al. [1996]. Reducing frailty and falls in older persons: An investigation of Tai Chi and computerised balance training. *Journal of the American Geriatrics Society*.44 489-97.

<sup>5</sup> Preventing Fall Injuries in older People Briefing Paper-Older People Living Independently in the Community Injury Prevention & Policy Unit, NSW Health

4. poor lighting,
5. height of chairs and beds and
6. restrictive floor plans.<sup>5</sup>

“Most falls have multiple causes.”<sup>6</sup> Shoba, 2005, states that there is a direct correlation between the number of risk factors and an individual’s risk of falling.

### **3. METHODOLOGY**

The information used in producing this report consists of statistical data; a literature review of evidence based falls prevention strategies and responses to a questionnaire distributed to key local agencies to ascertain current practices and gaps in falls prevention.

#### **3.1 STATISTICAL DATA**

Statistical data sourced include:

- community profile available from the City of Darebin,
- SWITCH data from Darebin Community Health
- the number of Darebin residents admitted to hospital for a falls related injury. The Victorian Admitted Episodes Dataset (VAED) which is a state-wide collection of all Victorian private and public hospital admissions
- the number of general practitioners in Darebin who conducted an aged care assessment for clients aged 75 and over during July 2005 until June 2006. An aged care assessment must include a client’s recent history of a fall, continence issues and cognitive impairment.
- the number of requests made to Ambulance Victoria to assist older Darebin residents who have experienced a fall without sustaining an injury or without requiring hospitalisation.

#### **3.2 LITERATURE REVIEW**

A search of literature websites and other sources was conducted to identify most recent evidence based best practice in the management of risk factors and falls prevention practices. This information will be used as a basis for comparison when forming recommendations, targeting interventions to ‘at risk’ groups and developing resources.

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<sup>6</sup> Shoba, S.R., Prevention of Falls in Older Patients. *American Family Physician* 2005; 72:81-8, 93-4.

### **3.3 QUESTIONNAIRES**

An electronic questionnaire was distributed to key local agencies to identify falls prevention practices in place and gaps in falls prevention practices. Some agencies completed a hardcopy version.

## **4. CONSTRAINTS**

Some statistical data, whilst available, was not feasible to collect due to cost or lack of specific local information. A falls risk screening forms part of the over 75 aged care assessments completed by general practitioners. This included a request which was made to the Health Insurance Commission for the number of Darebin general practitioners who performed a 75 plus aged care assessment, which includes a falls risk screening component.

The number of requests made to Ambulance Victoria to assist older Darebin residents who have experienced a fall without sustaining an injury or without requiring hospitalisation was also difficult to obtain.

## **5. FINDINGS**

The data collected was categorised under the following sub-headings: statistical, literature review, survey findings.

### **5.1 STATISTICAL DATA**

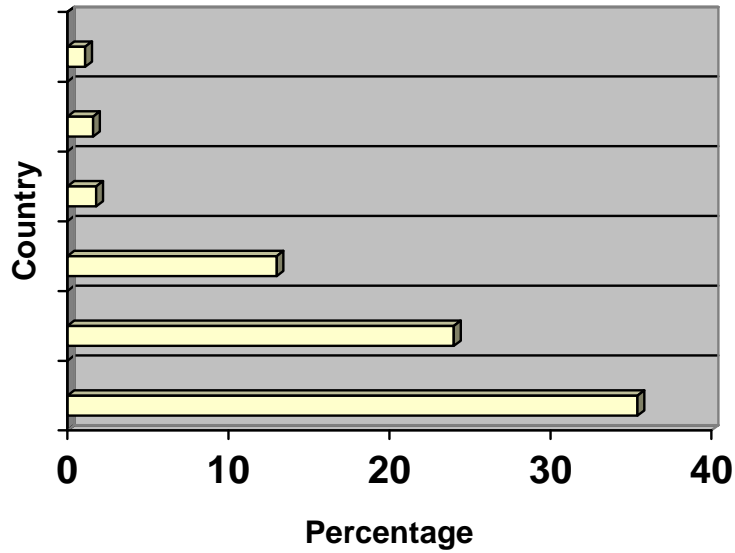
#### **5.1.1 City of Darebin Community Profile**

The City of Darebin, provides data on local demographics based on drawn from the Australian Bureau of Statistics 2006 Census. At the time of writing the report this information was not available on the council website but was available on request from the City of Darebin strategic planning unit. The information relevant to this report and project include age distribution, country of birth of residents aged 65 and over and main language spoken. This information provides an overview of the target group and assists when planning project interventions and strategies such as resource development and community awareness strategies.

35.4% of older Darebin residents were born in Australia, 24% were born in Italy which represented the second highest population group and highest group of those born overseas. Those born in Greece were 13.0%, the second highest overseas born group followed by 1.8% born in England, 1.6% born in Macedonia and 1.1% of this group was born in Lebanon. During the same time period, the population of Darebin residents aged 65 and over also increased since the 2001 census.

Country of birth information is illustrated in Graph 1.

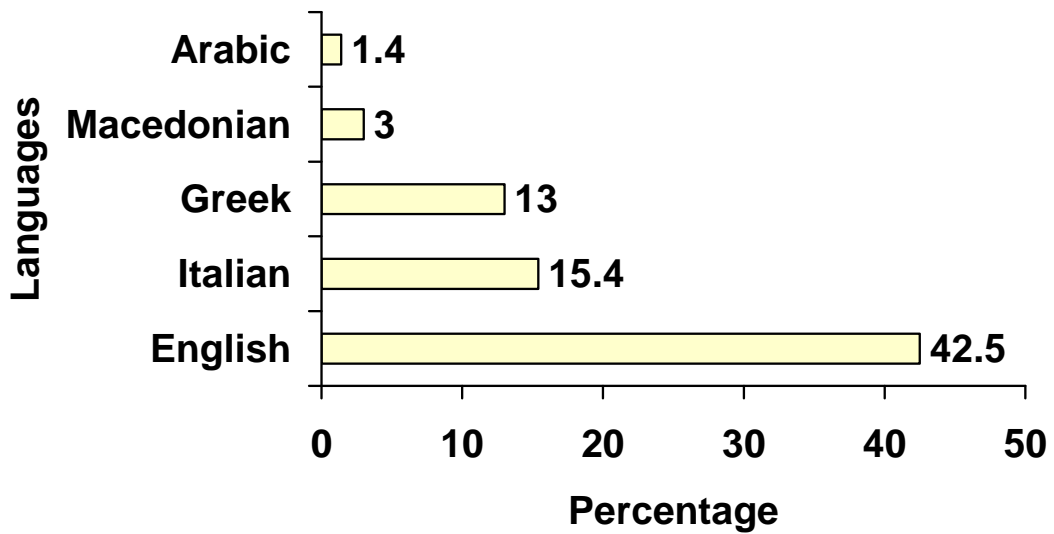
### Country of Birth of Older Residents



Country	Australia	Italy	Greece	England	Macedonia	Lebanon
Percentage	35.4	24	13	1.8	1.6	1.1

Languages spoken at home are illustrated in Graph 2 below.

### Languages Spoken by Older Residents



### 5.1.2 Victorian Admitted Episodes Dataset

Victorian Admitted Episodes Dataset (VAED) is a statewide collection of all Victorian private and public hospital admissions. The collection of a minimum dataset is required in order for the Department of Human Services to adequately fund the public hospitals under the case mix funding system. VAED has been collected and analysed by the Victorian Injury Surveillance Unit.

Overall the Darebin data was comparable with the statewide data.

All figures relate to data collected during July 2000 until December 2005.

Table 1 below provides a comparison of hospital falls related admission numbers for Darebin residents and Victorian residents.

The data demonstrates that during the period 2000/01 to 2004/05 there has been a steady increase in VAED falls related data from 15.9% to 21.7% which is consistent with Victorian figures. The most recent data for a completed year, 2004/05, shows Darebin residents have a slightly higher percentage of falls related hospital injuries admissions compared to the state-wide figure, 21.7 % to 20.1% respectively.

Refer to Table 1 below.

YEAR	2000/01	2001/02	2002/03	2003/04	2004/05	July 2005-05	Total
Darebin Frequency	653	725	730	738	891	376	4113
Darebin Percentage	15.9	17.6	17.7	17.9	21.7	9.1	100
Victorian Frequency	20613	22090	22298	24042	25559	12443	127045
Victorian Percentage	16.2	17.4	17.6	18.9	20.1	9.8	100

**Table 1. Comparison of falls related hospital admissions for Darebin residents compared to the state-wide figures.**

A breakdown of the age groups shows that the incidence of falls increases with age, refer to Table 2:

Age Group	65-69yrs	70-74	75-79	80-84	85 and over
Darebin	7.9	13.6	19.7	22.8	36.0
Victorian	8.1	11.8	18.7	23.9	37.5

**Table 2. Age groups of VAED for Darebin and Victorian residents.**

Female Darebin residents represented 70.2% of admissions compared to 29.8% of males. These figures are consistent with the Victorian figures.

Most falls injuries, 43.8%, occurred in the home.

61.6% of those requiring hospital admissions were born in Australia. Residents born in Italy accounted for 14.0% of falls related hospital admissions and are the second highest group represented in the VAED data.

### **5.1.3 SWITCH**

Falls specific data was unattainable as allied health staff at Darebin Community Health do not record falls specific codes in the SWITCH database.

## **5.2 LITERATURE REVIEW**

The websites searched to conduct this review are listed in APPENDIX 1. Recent studies showed a change in evidence on strategies that are most effective in reducing falls among older community dwellers. Unequivocal evidence indicates that the most effective strategy in falls prevention is targeted interventions following an evaluation (screening) to identify individual risk factors.<sup>6</sup> These interventions include exercise programs which incorporate a strength and balance component, medication review, home hazard identification, implantation of cardiac pacemaker, hip protectors and footwear assessment.

A satellite presentation to the Queensland Falls Prevention Network by Associate Professor Stephen Lord and Dr Cathy Sherrington in February 2007 rated various interventions in terms of their effectiveness in falls prevention. Progressive strength and balance training for at risk groups was the most effective form of exercise, Tai Chi also rated well.

A home hazard modification conducted by an occupational therapist was an effective intervention for clients who had a history of falling or visual mobility problems.

Cataract surgery was also an effective intervention. Interventions evaluated to be less effective by Lord & Sherrington, were withdrawal of psychotropic drugs and implantation of pacemakers. Shoba, 2005, found in one study that the intervention group implanted with a pace maker exhibited a reduction in falls by two thirds.

Hip protectors do not reduce the risk of falls but have been advocated to reduce the risk of sustaining a hip fracture in high risk groups such as those in nursing homes. A systematic review has found that there is inconclusive

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<sup>6</sup> Shoba, S.R., Prevention of Falls in Older Patients. *American Family Physician* 2005;72:81-8, 93-4.

evidence to support this claim and no evidence that they benefit elderly people living in their own homes.<sup>7</sup>

Multi disciplinary, multi factorial assessment of community dwellers has been found to significantly reduce falls when compared to a control group with similar risk factors.<sup>6</sup>

The effectiveness of exercise as a falls prevention strategy has been well documented and proven. Lord & Sherrington, 2007, found **it is crucial that balance training is a core component of an exercise regime**. Other key features of a successful falls prevention exercise regime are: progressive in intensity, 3 weekly sessions with duration of 60 minutes (clients may need to build up to this level) for at least a 6 week program. Programs should be delivered by a trained instructor to ensure the exercise is challenging, progressive in intensity and safe.

The following interventions were found by Lord & Sherrington, 2007, to have little or minimal effectiveness in falls prevention: brisk walking, chair based gentle exercise programs, Tai Chi in frail populations, stand alone modifications, falls prevention in the cognitively impaired, Otago exercise program in < 80, with visual impairment or taking psychotropic drugs.

### **5.3 QUESTIONNAIRES**

The Darebin falls prevention questionnaire was developed by the project officer and ratified by the working group prior to distribution. The questionnaire was based on that used to conduct the Yarra audit, however, several questions were omitted and some rephrased. The reasons being that the information gathered from these questions in the Yarra audit was not helpful in terms of developing project recommendations or prioritising targeted interventions and strategies. Another reason for rephrasing the questionnaire was to develop a condensed and simplified questionnaire which was user friendly for respondents.

Most questions were multiple choice with the option of providing additional responses or 'other' responses. Two questions were open ended questions which were not answered by all respondents.

The questionnaire was distributed electronically using a free software called Zoomerang, which is available on the internet. Most questionnaires were delivered in this mode, some respondents did not have electronic access and others were not in the initial distribution were administered a hardcopy version or downloaded the questionnaire to be completed in hardcopy form and returned for inclusion in the results. A copy of the questionnaire is attached as Appendix 2.

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<sup>7</sup> Parker MJ, Gillespie WJ, Gillespie LD. Hip protectors for preventing hip fractures in older people. Art. No.: CD001255. DOI: 10.1002/14651858.CD001255.pub3.

The total number of agencies included in the distribution was 41. In total 26 agencies completed the questionnaire, this represents a 62% response rate. The questionnaire was distributed to a broad scope of health service agencies ranging from the acute sector to community welfare agencies. Not all agencies were located in Darebin but provide services to Darebin residents. A list of participatory agencies and position of personnel who completed the questionnaire is provided in Appendix 3. Agencies which were described as not for profit, aged care and community aged care packages providers were grouped under community welfare sector agencies.

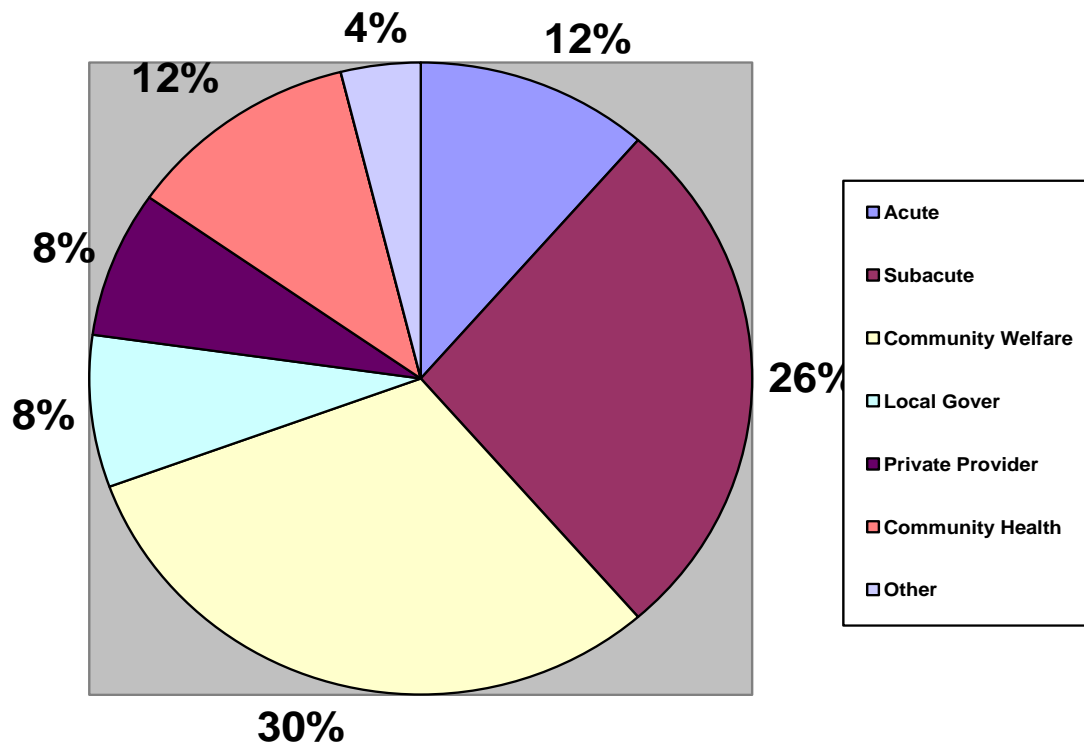
The questionnaire served to identify current practices in the management of falls risk factors and invite comments from agencies on current gaps in falls prevention services in Darebin and suggestions on the project outcomes.

The questions target the following areas:

- Screening methods
- Referral pathways and associated barriers
- Workforce development in the field of falls related assessments
- Current gaps in falls prevention in Darebin and what agencies would like the Foothold on Safety Project achieve.

The graph illustrates the diversity of agencies across the health care spectrum which participated in this survey.

### Cross -section of Health Sectors Represented in Survey



The scope of services available for people aged 65 years and over ranged from allied health services including occupational therapy, physiotherapy and podiatry. 39% provide case management services and 26% offered planned activity group services. Home and community care services were provided by 30% of agencies. Fifty percent responded 'other', which included rehabilitation medicine, dental and optometry services carer support and community aged care packages, extended aged care packages and brokerage services and low vision services.

### 5.3.1 Screening Methods

The methods used by agencies to identify "at risk" clients were:

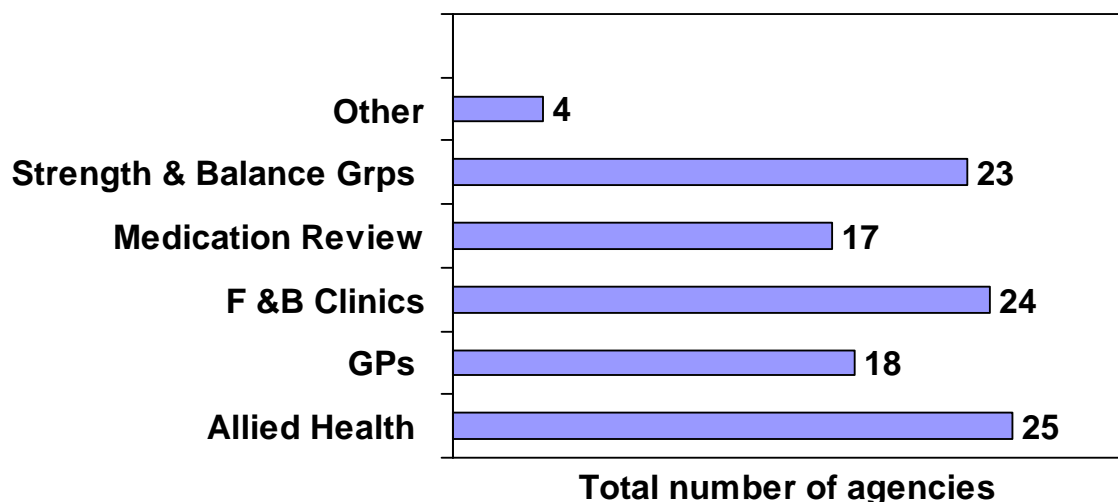
- 88% (n= 23) of agencies relied on a relative to report a client's fall history.
- The client's report of falls history was the method of identification used by 84% (n= 22) of agencies.
- A falls risk screening tool was used by 50% (n=13) of agencies;
- 38% (n=10) of agencies reported a heavily medicated client as the screening for falls risk with
- 31 % ( n=8) based their assumption on the client's age and condition.
- 42% (n=11) stated they used other methods to identify 'at risk' clients.

Of the 13 agencies which use a screening tool, four were community welfare agencies, which are providers of community aged care packages (CACPS), three each were subacute and community health services, two acute sector agencies and one local government service sector. A screening tool may be a component of a discipline specific assessment or form part of a hospital in-patient admission.

### 5.3.2 Referral Pathways and Barriers

Graph 2 illustrates agency referral pathways for falls assessment following screening of client.

#### Referral Pathways



The number of falls assessment referrals made over the preceding month ranged from one to 28; the majority of agencies were unable to provide the information.

When agencies were asked of the forms of barriers they encounter when referring clients for falls assessments, most commented on long waiting lists (80%, n=23). Transport for clients was also a problem (58%, n=15), boundary restrictions (35%, n=9) and eligibility criteria (27%, n=7) were noted access barriers. Waiting lists for community health services and community rehabilitation centres were stated. Other barriers were non compliance by the client.

### 5.3.3 Workforce Development

Sixty nine percent (n= 18), of agencies surveyed stated their staff conducted falls assessments. However, there appears to be some confusion between falls risk screening and falls assessment. Following a review of the data, a more accurate estimate of agencies which provide falls assessments is 38% (n=10), which consists of six subacute services, two community health services, one acute sector service and one private provider.

Some of these referrals were not specifically for a falls assessment, however, a falls assessment or home safety assessment is a core component of the discipline assessment.

No. of agencies which conduct falls Ax	No of falls Ax referrals received in May 07.	No, of agencies which provide assess 't for gov't funded personal alarms	No. of clients assessed for personal alarm in May 07	No. of agencies whose staff conduct HSA	No. of agencies which provide HAS refresher training.
10	Nil-28.	15	One-15.	22	5

**Table 3: Agencies which conduct: falls assessments, government funded personal alarms assessment and home safety assessments.**

Subacute services received referrals from aged care assessment, inpatient services, general practitioners and other subacute services such as falls and balance clinic referrals to CRC services.

Community allied health services at community health centres received referrals from general practitioners, inpatient allied health services and requests for referrals from family members. Other agencies which provide falls assessments receive referrals from community occupational therapists, carers and consumers.

The client eligibility criteria to receive a government funded personal alarm are narrow. The assessors for government funded personal alarms is limited to local government where funded for HACC services, ACAS, occupational therapists and nurses in a community health service, nominated district nursing services, HACC funded aboriginal agencies and public sector funded community rehab centres (for community rehabilitation clients only) and multi purpose services.<sup>7</sup> There are no eligibility criteria required for a privately funded personal alarm.

### **5.3.4 Current Gaps in Falls Prevention**

The widespread views on current gaps in falls prevention in Darebin are the long waiting lists and lack of timely access to services such as falls and balance clinics. A lack of a formal screening tool and training for workers were also identified as gaps. Other gaps identified included a

- lack of low cost gentle exercise programs,
- more community health services, such as physiotherapy and occupational therapy,
- more health promotion time for service providers to deal and address risk factors preventatively.
- A need for education of risk factors was expressed.
- funding restrictions exclude recipients of a CACP package from accessing HACC funded services and thus can restrict these clients from receiving timely and accessible falls prevention services. Funding guidelines state that HACC services should not be available to individuals who receive Government subsidised services similar to HACC services unless the service in question is not expected to be funded as part of the CACP package. For example individuals may access a HACC funded day centre community nurse as this service is not expected to be provided under a CACP package.<sup>8</sup>
- A greater awareness of falls risk factors is needed.

### **5.3.5 Foothold on Safety (6) Project Outcomes**

The final question asked what agencies would like the Foothold on Safety Project to achieve. The responses included:

1. An overwhelming request for increased access to falls prevention programs/services
2. Staff training and education in falls prevention.
3. Increase awareness of falls education and prevention to clients and their families

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<sup>7</sup> Personal Alert Victoria Program and Funding Guidelines. 1<sup>st</sup> Edition. 2003.

<sup>8</sup> Community Aged Care Package Guidelines, Draft.2007. Retrieved 10<sup>th</sup> July, 2007 from <http://www.health.gov.au/internet/wcms/Publishing.nsf/Content/ageing-cacp-guidelines.htm>

4. Clients required more awareness/education on how to access local services.
5. A generic assessment tool.
6. An increase in community education in falls prevention.
7. Reduce waiting list.
8. More falls prevention services.
9. General practitioner education on local exercise programs available, affordable transport.
10. Availability of falls prevention resources, and
11. An increased awareness to service providers on falls prevention services available.

## 6. ANALYSIS

### 6.1 STATISTICAL DATA

The proportion of Darebin residents aged 65 and over continues to rise. According to the Australian Bureau of Statistics 2006 Census of Population and Housing, 15.9% of Darebin's population is aged 65 and over, significantly higher than the Melbourne Statistical Division of 12.8%. There has been a marginal increase in the number of Darebin residents aged 65 and over, since the '01 census when this age group represented 15.8% of the population. There has been a decrease in the 65-74 age groups and an increase in the number of residents aged 75 and over since 2001.

VAED data shows a steady increase in the number of hospital episodes of care for falls related injuries amongst older Darebin residents. This pattern is consistent with Victorian data. Darebin female residents represent over 70% of hospital admissions which reflects state-wide data for female hospital admissions and affirms evidence based data which identifies females as having a greater falls risk.<sup>5</sup>

Australian born Darebin residents account for 61.6% (n=2534) of episodes of care and Italian born and Greek born residents account for 14% (n=576) and 6.2% (n=254) of episodes of care respectively.

- K.Ashby, personal communication on July 2, 2007, cited the VAED caveat to explain how the data is collected.

"Each record in the database represents an episode of care, not necessarily one incident. A patient may be transferred between; and within hospitals for various episodes of care and will therefore be represented by more than one record. This is estimated to account for 10% of the database."

Based on this explanation, the figures were revised and calculated as a percentage of the total population for each CALD group which translate as the following:

- 31.6% of Australians born Darebin residents have been admitted to hospital for a falls related injury.
- 10.5% of Italian born Darebin residents have been admitted to hospital for a falls related injury.

- 8.6% of the population of Greek born Darebin residents have been admitted to hospital for a falls related injury.

Australian born residents have a significantly higher incidence of falls than any other CALD group in Darebin.

## **6.2 LITERATURE REVIEW**

The literature unequivocally supports a multi component approach to manage and reduce the incidence of falls amongst older residents. An exercise regime which consists of balance retraining is an effective falls prevention strategy.

## **6.3 QUESTIONNAIRES**

### **6.3.1 Screening Methods**

Half of the participatory agencies systematically use a screening tool to identify clients' falls risks. Most agencies relied on a history of a fall as reported by either family member or the client themselves as a falls risk screening method. This illustrates a lack of early intervention in the preventative management of a client's falls risks. This method does not assist to identify clients who may have a moderate falls risk status due to the presence of other risk factors but have not yet experienced a fall. A history of falls should initiate a falls assessment referral as these clients have an increased risk of further falls.<sup>1</sup>

Four of the eight community welfare agencies use a screening tool. All of the community welfare agencies in the survey provide community aged care packages to Darebin residents. Community aged care packages are funded by the Commonwealth government to provide tailored care packages for individuals with complex needs who require low level care and wish to remain living in their own homes. Residents require an assessment by an aged care assessment service to determine their eligibility for a CACP.<sup>9</sup> The remaining four community welfare agencies relied on a reported falls history as a method to identify 'at risk' clients. One agency which did not use a screening tool, commented that the ACAS referral would usually identify a client's falls risk.

Three out of seven subacute agencies use a screening tool. Subacute services include falls and balance clinics and Community Rehabilitation Centres. Some subacute responses stated that the initial referral via the acute sector usually includes a completed falls risk screening or where the reason for the referral was due to a client's history of falls, a screening tool was not necessary and would result in a duplication of screening.

**Overall there is a distinct lack of formal screening of clients' falls risk status undertaken by surveyed agencies.**

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<sup>9</sup> <http://www.health.gov.au/internet/wcmsPublishing.nsf/Content/ageing-publicat-qcoa-03info.htm>  
Accessed 25-6-07.

All agencies documented client treatment and outcomes in the client's file. Half of the agencies (n=13) used the information collected as part of the screening process in program development. Screening and client assessment outcomes were discussed at case study meetings in 42 % ( n=11) of agencies. 23 % ( n=6) of agencies stated that the information gathered in the screening process was used to initiate a referral for further assessment. Only 19% (n=5) of agencies recorded information obtained from the screening process in a database.

### **6.3.2 Referral Pathways and Barriers**

Following screening, 97% of agencies refer 'at risk' clients to allied health services (n=25) and 92% (n=24) of agencies refer to falls and balance clinics. The high number of agencies referring clients to strength and balance exercise programs, 88%, (n=23) illustrates a general understanding of the management of falls risk factors amongst agencies' staff.

Surprisingly general practitioners did not receive the greatest number of falls assessment referrals. 69% (n=18) of agencies referred clients to general practitioners.

### **6.3.3 Workforce Development**

Agencies which conduct falls assessment were not asked if any referrals received were 'inappropriate' or did not meet eligibility criteria or if an alternative local service may have been a more suitable option for the client. It is also unknown as to the number of agencies which have an intake process to screen clients to determine their eligibility to access the service and as to the client's risk status.

Most home safety assessments were conducted by occupational therapists, physiotherapists and nurses. Care coordinators and cases managers and social workers also received training to provide home safety assessments. Falls prevention training and assessment should form part of minimum professional competency standards for professionals such as occupational therapists and as such refresher training is not indicated. Professional development and continuing education may include home safety assessments. Some agencies provided refresher 'in-house' training.

### **6.3.4 Current gaps in falls prevention and FOS (6) project outcomes**

The following discussion relates to the combined responses to the final two open ended questions.

Overwhelmingly agencies identified lack of timely accessible falls prevention services as a current gap and would like the project to increase access to these services. It is beyond the scope of this project to increase the number of falls prevention services or to have a direct effect on existing waiting lists. This project works within a health promotion framework to deliver objectives using strategies such as capacity building of agency staff in their knowledge and skills in falls prevention and raising community awareness on falls prevention. This report however may be used to lobby for an increase in service and program provision and underline the need for increased services in Darebin.

## **RECOMMENDATIONS**

The recommendations drawn from this report are:

### **CAPACITY BUILDING**

1. Promote a generic screening tool for use by local agencies, particularly CACPs providers, HACC assessment offers and practice nurses.
2. Provide training to agency staff on the use of falls risk screening and action plan tool as an attachment to the SCTT form.
3. Develop and promote use of a local services directory to be used with the screening tool to assist staff when referring client to services and programs.
4. Create a referral pathways flow chart to assist service providers identify most appropriate service/agency and to provide a coordinated care plan.
5. Develop an education kit in relevant community languages which is to be distributed by agency staff to clients and their carers.
6. Provide falls prevention refresher training to case managers, HACC assessment officer and aged care workers, particularly those working in a domiciliary setting.
7. Work with agencies to embed falls prevention strategies and practices planning processes such as City of Darebin Municipal Public Health Plan and Community Safety Plan.
8. Establish links with Whittlesea and Yarra networks which have a falls prevention focus. Examples are the Whittlesea Physical Activity Network and Yarra HACC services network.
9. Continue to work with NCMPCP IHP agencies to enhance cross over opportunities with agencies outside of Darebin.
10. Establish a falls prevention resource centre at Darebin Community Health.

### **SOCIAL MARKETING**

11. Increase community awareness through use of local media and resources such as posters located in community settings, e.g. libraries.

### **HEALTH EDUCATION AND SKILL DEVELOPMENT**

12. Establish a pool of volunteers to deliver peer led falls prevention education talks post project.
13. Heighten awareness of the high incident of falls amongst Australian born Darebin residents to agency staff.
14. Educate carers and clients of falls risk factors and the availability of local falls prevention services.

## APPENDIX 1.

### FALLS PREVENTION WEBSITES AND ELECTRONIC JOURNALS SOURCED FOR THIS REPORT

<http://www.health.nsw.gov.au>

<http://www.cochrane.org>

[www.bmj.org](http://www.bmj.org)

<http://www.nari.unimelb.edu.au>

<http://www.aafp.org>

<http://www.pubmed.gov>

Lord, S., & Sherrington, C. (Feb. 2007). *Satellite Presentation to the Queensland Community.*



## Falls Prevention Mapping Questionnaire

- This questionnaire will provide the Footholds on Safety Project (6) with an overview of existing strategies and interventions currently used by agencies in the prevention of falls amongst the 65+ population in the City of Darebin.
- The information collected will be used to identify gaps in the falls prevention work.
- The information will be used to form recommendations and priorities to be undertaken as part of the project that will support agencies in their work in falls prevention.
- **This information is entirely confidential. Neither you nor the organisation will be identified in the report.**

A copy of the report will be sent to all participants in the questionnaire.

### PART A – ORGANISATIONAL DETAILS

Name of organisation:

Person answering questions:

Position within organisation:

Which of the following best describes the sector your organisation belong to?

- Acute
- Subacute
- Domiciliary Nursing
- Community Health
- Community Welfare
- Local Government/Aged and Disability Services
- Private Provider

What services do you provide for the 65+ age group?

- Case Management
- OT
- Physiotherapy
- Podiatry
- PAG Services
- Counselling
- Diabetes Services
- HACC services

Other \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**PART B SCREENING**

**The term “screening” is defined as the initial examination of an individual or group to determine if they have certain risk factors which increases their probability of developing a given disease or condition.**

**How does your organisation identify someone over 65 at risk of falls?  
(Choose one or more responses)**

- Screening tool
- Client reports fall history
- Relative reports fall history
- Assumption – age and condition based
- Heavily medicated
- Other (please specify).....

**What happens to the information collected as part of your screening?  
(Choose one or more responses)**

- Recorded in client’s file
- Recorded internally ie SWITCH or other database
- Used in program development
- Case study discussions
- Internal audit
- Other, (please specify) .....

**PART C – SERVICE PROVISION**

**Does your organisation refer at risk clients to?**

(NB. Can be internal or external to your organisation)

GP's in community health or clinics

Allied Health – please state: .....

Falls and Balance Clinics

Medication review

Strength and Balance exercise groups

Other.....

**How many referrals have been made in the last month? .....**

**Have you experienced any barriers when making referrals to agencies? (Choose one or more responses)**

Long waiting lists

Boundary restrictions

Eligibility criteria

Cost

Transport

Other,(please specify) .....

**D WORK FORCE DEVELOPMENT**

**In these questions the term “assessment” is defined as a systematic way of establishing the type and extent of client support needs.**

**Falls Assessment**

**Do your staff conduct falls assessments YES NO**

**How many falls assessment referrals have you received in the past month?**

**Who are the three main sources of referral for falls assessments to your organisation?**

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**Personal alarms**

**Are your staff trained to assess clients for government funded personal alarms?                    YES   NO**

**If so, how many clients have been assessed for a personal alarm in the past month?**

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**Home Safety Assessment**

*Questions 11-13 relate to client focused home safety assessments. These assessments identify a falls risk to clients in their home environment.*

**Are your staff trained to conduct a home safety assessment?                    YES   NO**

**If yes, which staff have received training? (discipline)**

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**Is a refresher course offered                    YES   NO**

**E CONCLUSION**

**26 What gaps do you think exist in falls prevention services in your locality?**

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**27 What is the main thing you would like to see the FOS (6) project achieve?**

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**Thank you for your time**

*Kerina Princi  
FOS (6) Project Officer  
Mobile: 0408 059 150  
Email: kprinci@ncmpcp.org.au*

## APPENDIX 3-LIST OF PARTICIPATORY AGENCIES

AGENCY NAME	LEVEL OF PERSONNEL WHO COMPLETED QUESTIONNAIRE
Austin Health-Aged Care Case Management Programs	Coordinator
Darebin Community Health Physiotherapy	Team Leader
Wintringham	Manager Community Housing & Support
Darebin Community Rehabilitation Centre	Team Leader
Third Age Australia	Community Programs Coordinator
Austin Health –Domiciliary service and Heart Failure and Cardiac Rehab	Coordinator
Darebin Community Health-PAG	Service Provider
Bundoora Extended Care Centre	Service Provider
St. Vincent;s Health Melbourne	Acting Manger Allied Health & Community Services
Northern Community Options	Clinical Coordinator
Darebin Community Health-Occupational Therapy	Service Provider
The Northern Hospital	Service Provider
Royal District Nursing Service	Service Provider
City of Darebin-Yanada House	Coordinator
Royal Freemasons Homes of Victoria Ltd –Outreach Program	Community Program Manger
Annecto	Coordinator-North West Aged Care
Austin Health	Registered Nurse
Vision Australia	Team Manager
St. Vincents Hospital Melbourne-Rehab in the Home	Service Provider
Bundoora Extended Care Centre	Physiotherapist
City of Darebin –Aged and Disability Services	Team Leader
Salvation Army CACP Provider	Manager
Southern Cross Care	Regional Manager CACP
Bundoora Extended Care Centre	ACAS Manager
Olympia Private Rehabilitation Hospital	Service Provider
Private Medical Clinic	Practice Nurse