Acknowledgements

- Lynette Cohen  NUM
- Tai Tak Wan  Medical Director
- Jo Mortimer  Occupational Therapist
- Minh Pham  Physiotherapist
- Jennifer Djukic  Registered Nurse
- Vicki Knol  Former ASET
- Katrina Stott  ASET
Demographics

- Fairfield Hospital has approximately 200 beds, serving a population of 181,936 with a high proportion (over 71%) of CALD (Culturally and Linguistically Diverse) population. (ABS Census 2001)

- Approximately 10% of the population is over 65y/o. (ABS Census 2001)

- Approximately 20% of Emergency Department (ED) presentations are over 65y/o. Up to 20% of these presentations are falls-related. (Management Policy to Reduce Fall Injury Among Older People, NSW Health 2004)

- Fairfield data shows 4 falls-related presentations per day – 3 out of 4 are not admitted. (FHS EDIS data)
In 2003 the SWSAHS circulated clinical practice guidelines for falls prevention in the elderly (Management Policy to Reduce Fall Injury Among Older People, NSW Health 2004)

Guidelines proposed:
- Intrinsic risk factors and subsequent falls risk should be assessed
- Coordinated multidisciplinary individualized intervention
Ambulatory Care FIT

Staffing

- Medical Director
- NUM
- R/N’s
- Allied Health
  - O/T
  - Physio
  - S/W
The F.I.T. Program

- Coordinated multidisciplinary team
- Weekly Team Case planning conference
- Multidisciplinary input regarding falls investigation and intervention
- Designated Allied Health, Nurses and Doctors
F.I.T. Pathway

Non-admitted Emergency Department Patients

Primary Health Nursing /Community

Allied Health

VMO/Specialist and GP’s

Falls Risk Screening Assessment

Yes, at Risk

No further Action required

Falls Risk Assessment

Inpatients

Assessment by FIT
ASET, Medical, Nursing and Allied

Case Planning

Active involvement – Follow-up review at 3rd and 12th week.

Inactive Involvement – 24th week

Instructions given to call F.I.T. if falls increase

Interventions
Investigations
O.T.
S.W.
Physio/Able and Stable
Mobility & Aids assessment
Medication R/V
Education
Podiatry
Eye
Hearing

Interventions
Allied Health
Referral
Patient
Education Staff
Education

? Referral to FIT
Case Conference Form

NAME: XXXXXX  DATE OF INITIAL ASSESSMENT: 12/2/2007

Quick screen score

Initial Assessor: _______________________________

RISKS:
- Medical
- Medication
- Falls
- Home Hazards
- Risk Taking Behaviors
- Vision
- Mobility
- Home needs
- Cognitive
- Others

<table>
<thead>
<tr>
<th>DATE</th>
<th>SEEN BY</th>
<th>ISSUES</th>
<th>ACTION</th>
<th>OUTCOME</th>
</tr>
</thead>
<tbody>
<tr>
<td>12/2/07</td>
<td>O/T</td>
<td>Unsafe access to house - fell on steps</td>
<td>Rail request submitted</td>
<td>Rail installed 22/11/06</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Pt reluctant to accept help with at risk</td>
<td>Advice/encouragement.</td>
<td>Agreed to family assistance</td>
</tr>
<tr>
<td></td>
<td></td>
<td>tasks</td>
<td>Education booklet provided</td>
<td></td>
</tr>
<tr>
<td>12/2/07</td>
<td>Physio</td>
<td>Poor balance</td>
<td>Home exercises with view to attendance at Able and Stable</td>
<td>Commence A&amp;S program on 1/3/07</td>
</tr>
<tr>
<td></td>
<td></td>
<td>C/O fatigue – takes sedatives</td>
<td>Advised to see LMO for referral to Falls Clinic for Medical Review</td>
<td>Seen in Falls Clinic 26/2/07</td>
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<tr>
<td>26/2/07</td>
<td>Medical Director</td>
<td>Medications – Long term use of sedatives</td>
<td>Liaise with GP for sedative reduction program and recommendations for investigations of findings</td>
<td>Patient to be reviewed in 2 weeks – Appointment made for 12/3/2007</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Balance.</td>
<td>Eyesight</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Eyesight</td>
<td>Fatigue</td>
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</table>
F.I.T. strategies

- Expansion of Able and Stable program
  = exercise + client education
- GP awareness and Education
- Community Nurse Education
- Increase community awareness
- CALD Education
Interventions

- Medical Assessment/Advice
- Community Services
- Education
- Mobility Aids
- Home Visits
  - Physical assessment/treatment Post injury
  - ADL assessment
  - Modifications
  - Equipment
- Exercise program
  - Able and Stable
  - Home Program
Able and Stable program

Exercise Program

- Target population: >65y.o with history of falls
- A 9 week exercise program
- Pre and post individual assessment
- Tai Chi, balance and proprioceptive training, lower limb strengthening
- Outcome measures = PSFS, ABC, functional reach and sit-to-stand
Education Program

Incorporates multidisciplinary team

- Includes:
  1. ↑ Home safety
  2. Functional vision
  3. Correct use of mobility aids
  4. Nutrition for healthy living
  5. Safe footwear & feet care
  6. Medication management
  7. Managing continence
  8. “After a fall” strategies
CALD Assessment and Education

- Presenting via interpreter to Immigrants Woman’s Centre at Fairfield and Cabramatta.
  - Groups include: Arabic, Assyrian, Turkish, Chinese and Vietnamese

- Presenting at GP groups

- Education sessions to Aged Care CALD clients and workers in the Aged Care Day Centre
Data Collection

Data is collected on:

- Type and number of falls risks identified
- Number of falls risk factors that are addressed through the program.
- Falls incidence pre and post completion of FIT program
Falls Incidence Data

- 24 patients brought to case conference between October 2006 to January 2007
- 4 non-compliance/participation in program
- Data available on 18/20 patients
- 1 patient with 10+ falls pre and post program excluded from the data analysis
# Falls Risks

<table>
<thead>
<tr>
<th>Number of Falls Risks Identified</th>
<th>Number of Falls Risks Addressed</th>
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<tbody>
<tr>
<td>58</td>
<td>53</td>
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<tr>
<td>Initial Contact</td>
<td>MRN</td>
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<tr>
<td>-----------------</td>
<td>--------------</td>
</tr>
<tr>
<td>11/06</td>
<td>(A) 238146</td>
</tr>
<tr>
<td>1/07</td>
<td>(B) 764653</td>
</tr>
<tr>
<td>11/06</td>
<td>(C) 727753</td>
</tr>
<tr>
<td>1/07</td>
<td>(D) 785168</td>
</tr>
<tr>
<td>5/06</td>
<td>(E) 588971</td>
</tr>
<tr>
<td>2/06</td>
<td>(F) 546706</td>
</tr>
<tr>
<td>4/06</td>
<td>(G) 627034</td>
</tr>
<tr>
<td>5/06</td>
<td>(H) 573469</td>
</tr>
<tr>
<td>3/06</td>
<td>(I) 567716</td>
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<tr>
<td>1/07</td>
<td>(J) 048869</td>
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<td>(K) 703714</td>
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<td>11/06</td>
<td>(L) 647440</td>
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<td>11/06</td>
<td>(M) 635291</td>
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<td>(N) 575887</td>
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<td>(O) 774490</td>
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<td>1/07</td>
<td>(P) 724165</td>
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<tr>
<td>1/07</td>
<td>(Q) 83786</td>
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<tr>
<td>1/07</td>
<td>(R) 599007</td>
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<tr>
<td>2/06</td>
<td>(S) 078641</td>
</tr>
<tr>
<td>10/06</td>
<td>(T) 586908</td>
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<tr>
<td>TOTAL excluding (C) (D) and(F)</td>
<td>17</td>
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Falls Incidence

Number of Falls Pre and Post F.I.T. program for 17 patients

This translates to a **64%** reduction in falls rate
The Cost of Falls
<table>
<thead>
<tr>
<th>Costings</th>
<th>Post fall head laceration with LOC</th>
<th>Post fall hip pain ED presentation with pathology x 1 and x-ray x 1 factored in is:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$75 for ED presentation plus $75.00 per blood test and x-ray plus $150.00 for Head CT</td>
<td>$75.00 per test</td>
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<tr>
<td></td>
<td>O/N hospital bed is $605.00</td>
<td>$225.00</td>
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<tr>
<td></td>
<td></td>
<td>With ALOS for #NOF 7 days equals $604 x 7 = $4,228.00</td>
</tr>
<tr>
<td></td>
<td><strong>Total Cost</strong> $980.00</td>
<td><strong>Total cost</strong> $4,453.00</td>
</tr>
<tr>
<td>FIT costs (excluding Able &amp; Stable program, approx. $120, &amp; additional medical investigations)</td>
<td></td>
<td>(excluding cost of ambulance, prosthesis, rehabilitation and goods &amp; services)</td>
</tr>
<tr>
<td>Cost of FIT 6 month program per client:</td>
<td></td>
<td></td>
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<tr>
<td>4 x Weekly case conference discussion per client</td>
<td>$150.00</td>
<td></td>
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<tr>
<td>Allied health hours per patient</td>
<td>$270.00</td>
<td></td>
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<tr>
<td>Medical/Nursing</td>
<td>$190.00</td>
<td></td>
</tr>
<tr>
<td><strong>Total Cost</strong></td>
<td><strong>$610.00</strong></td>
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</tbody>
</table>
Challenges

- Ability to meet referral demand
- Allied Health Hours
- Follow-up takes 2\textsuperscript{nd} priority to initial intervention.
- CALD clients
- Transport
- Data collection
Future Plans

- Continuation of the program
- Increase involvement with inpatients discharged from the wards
- Expansion of FIT team staffing
- Phone follow-up after 12 months
Questions!