

Fixing frequent fallers – a rural initiative

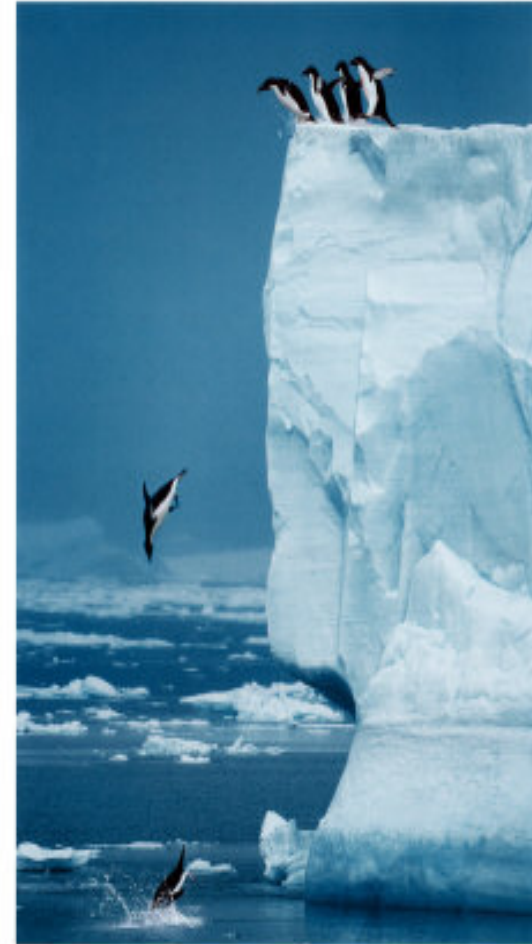
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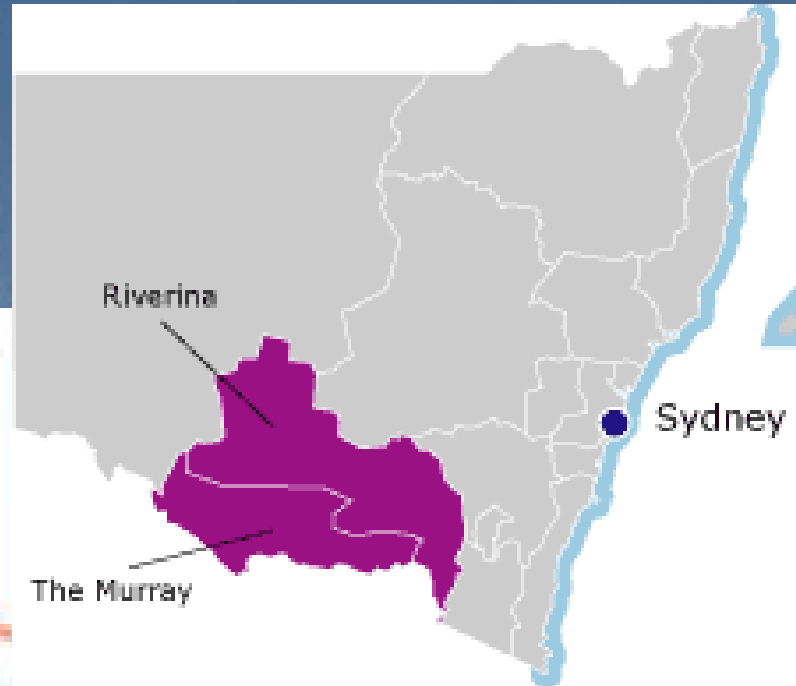
genesis

- 2006 – development of multidisciplinary falls clinic, Wagga Aged Care Services
- 2007 - initiative of Riverina Div GP/ GSAHS to target 'at risk' community fallers esp. through the GP 75 plus health assessment.
- 2007-8 - dissemination of project to involve smaller rural towns as well as a major regional centre.

geography

- Elderly population \sim 13% of population of 100,000
- 2002 – UNSW study in Wagga showed a falls rate of 1:3 community elderly per year.
- Each fall results in 12% seeking medical attention and 1:100 fracturing their hip.

Background

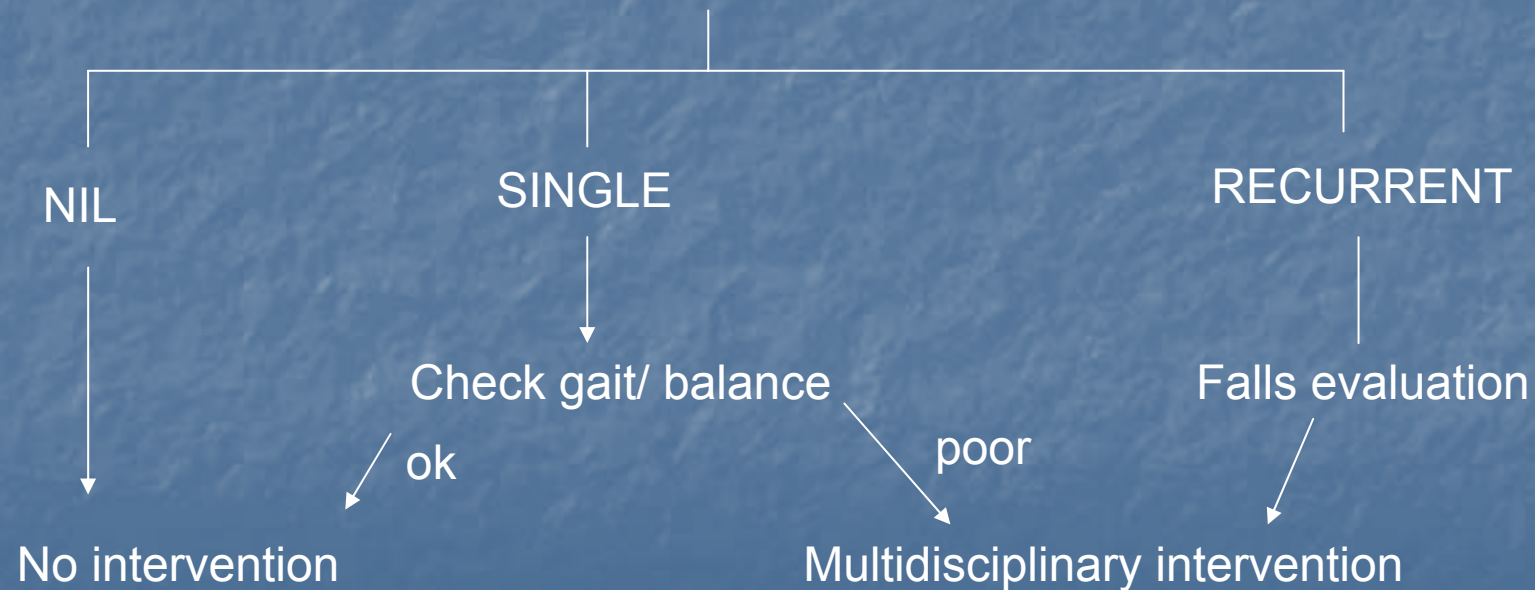


aims

- To identify 'at risk' community fallers and intervene with an EBM approach.
- Complement the local falls initiatives of NSW DOH in areas of falls prevention in the wider community and state health facilities.
- 'at risk' fallers – JAGS algorithm/ PROFET study
- EBM – falls/ injury prevention needs to be multifactorial because the causation is multifactorial! Minimum skill set – medicine/ physiotherapy/ occupational therapy.

algorithm

- *JAGS May 2001*
- Case finding in 10 care – no. falls past yr



Fallers in ED

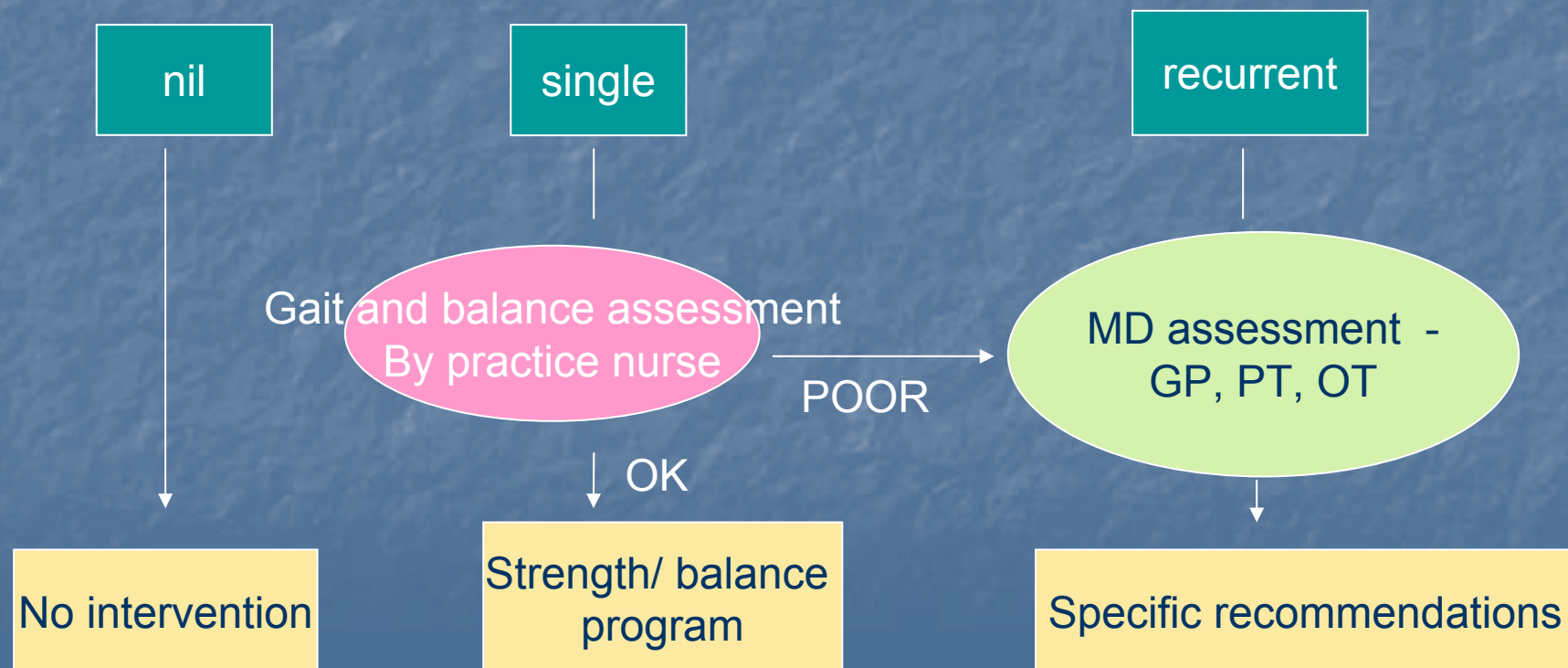
- Prevention of falls in the elderly trial (PROFET)
Close J et al Lancet 1999
- Community elders who fell and presented to ED – intervention arm had medical and OT assessment vs 'usual care'.
- 12 months – falls reduced by 61%, admissions to hospital by 39% and slower decline in function (Barthels)

project development

- Collaborative – Div GP, GSAHS, Comm., RACFs and community reps.
- Utilised the falls clinic mechanism at Wagga Aged Care Services and developed model for Cootamundra, Tumut and Junee
- Trained practice nurses to identify and refer frequent or 'at risk' fallers.
- Utilised ASET nurse to refer elderly fallers.

referral pattern

- Case finding in general practice by 75 plus assessment (and via ED by ASET nurse).



'Falls clinic'

- Referral to GP from practice nurse or ASET/hospital.
- Medical assessment (GP)->
- Physio assessment and appt. for OT home visit made.
- OT home visit
- OT/PT feedback to GP who then implements various recommendations (GPMP).

exclusions

- Age < 65 yrs (55 if ATSI)
- Dementia
- 'unwilling'

Medical assessment

- Double appointment organised
- Check list with prompts to appropriate interventions/ referrals.
- Faxed to PT Aged Care Services Wagga for co-ordination of PT and OT assessments local or surrounding centres)

- Falls history
- Cardiovascular (esp postural hypotension)
- neurological
- medication
- substance abuse
- vision
- cognitive impairment
- osteoporosis

allied health assessment

- Physiotherapist - static and dynamic balance, gait, muscle strength, lower limb problems, footwear.
- Occupational therapist – home assessment for falls hazards, behavioural issues, home mods, hip protectors.

recommendations

- Often – medication reduction, osteoporosis treatment, eyesight referrals, mobility aids, strength and balance training, home modifications, hip protectors.
- Try to limit number of recommendations to improve compliance.

Data (so far!)

'hopes'

- Reduction in falls and more importantly injury/ fracture rates in the intervention group.
- Increased awareness of falls/ injury prevention in general practice and increased intervention rates.
- If the model is proven successful – adoption in other rural/ regional communities.



Questions ?