SESLHD FALLS INJURY PREVENTION PLAN 2013-2018

Working together to improve the health and wellbeing of our community

Health
NSW GOVERNMENT
South Eastern Sydney
Local Health District

SESLHD Falls Injury Prevention Plan 2013-2018

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Prepared by the Directorate of Planning and Population Health
South Eastern Sydney Local Health District

October 2013

Contents

Foreword

On a typical day,
***24** adults residing in SESLHD*
*are **hospitalised due to a fall.***
For many, the consequences will be
life-changing, or even fatal.

In South Eastern Sydney Local Health District, our vision is *working together to improve the health and wellbeing of our community*. As our population ages, few issues will affect that health and wellbeing of the older members of our community as significantly as falls and injuries from falls.

Falls that result in an injury can have severe consequences: lengthy hospitalisations, rehabilitation, and loss of independence. No other injury cause (including road trauma) has a greater impact on the NSW Health system, and injuries from falls are a leading cause of premature admission to residential aged care. Even if an injury is not sustained, the loss of confidence, and a fear of future falls, is often the reason that an older person becomes less active and more socially withdrawn. It is a cruel irony that this in itself increases the risk of future falls and injuries.

Yet falls can be prevented. They are not the inevitable result of ageing. From the formative years of youth, a greater focus on nutrition and physical activity will help to build healthy bones. As we approach middle age, a continued focus on healthy lifestyles, most notably physical activity that increases strength and challenges balance, can have a protective effect against future falls and injuries. Those in our communities who are at greatest risk can be identified as they come into contact with relevant primary and community services, and referred into more specific individual assessment and multifactorial prevention programs. And we can do more to ensure that our health facilities provide a safe environment, one that is protective against falls, and an appropriate clinical focus on prevention both during care and after discharge.

By any measure, this is a major issue, and a large and ambitious plan. It can only be achieved through effective partnerships across both the community and acute care sectors, with external partners such as Medicare Locals and local governments, and with substantial resource investments. But this must be weighed against the consequences of doing nothing, and the spiralling treatment costs that would most surely result. We remain committed to working together to reduce injuries from falls in SESLHD, and this plan describes our priorities and actions to that end for the next five years.

Mr Terry Clout
Chief Executive
SOUTH EASTERN SYDNEY LOCAL HEALTH DISTRICT

Glossary of Key Terms and Abbreviations

ACSQHC	Australian Commission on Safety and Quality in Health Care
ASET	Aged care Services Emergency Team
Aged Standardised Rates	Aged Standardised Rates take into account how many people of different ages there are in the population being looked at (the population profile). This allows a comparison to be made that is not affected by different population profiles over time or across different geographic areas.
Built Environments	Built environments refer to the communities we design and live in, including physical things such as outdoor spaces, buildings, transportation and housing, and the broader relationship these have to the cultural and societal aspects of our environments, such as social participation, inclusion and support. There is a growing body of literature that reflects the importance of the built environment in our capacity for active ageing and healthy lifestyles throughout life.
CALD	Culturally and Linguistically Diverse. Cultural and linguistic diversity refers to the wide range of cultural groups that make up the Australian population and Australian communities. The term acknowledges that groups and individuals differ according to religion and spirituality, racial backgrounds and ethnicity as well as language. The term 'culturally and linguistically diverse background' is used to reflect intergenerational and contextual issues, not just the migrant experience.
CEC	NSW Clinical Excellence Commission
IIMS	NSW Health Incident Information Management System
LHD	Local Health District
Multifactorial interventions	Multifactorial interventions involve assessment of the specific risks of an individual followed by a set of individually tailored interventions.
NGO	Non-Government Organisation
NSW Falls Prevention Program	State-wide program managed by the Clinical Excellence Commission (CEC) with strategic implementation oversight of the NSW Health Policy Directive PD2011_029: *Prevention of Falls and Harm from Falls among Older People: 2011-2015*.
OT	Occupational Therapist
Prevention – Primary	Primary prevention activities occur at the earliest stage of intervention, aiming to prevent a health problem before it develops. Primary prevention typically has the widest reach as it includes large, relatively healthy populations. In this context, the primary prevention of injuries from falls can include physical activity and nutrition strategies to improve balance and bone strength across all ages.
Prevention – Secondary	Secondary prevention activities aim to discover health issues while they are in their earliest stage of development, and address and hopefully reverse them before they become too advanced. This may include screening strategies to identify high-risk people. Secondary prevention typically has a narrower reach than primary prevention, but can still be substantial if large proportions of the population are at potential risk.
Prevention – Tertiary	Tertiary prevention activities occur at the most intense level, with people for whom the health issue has clearly emerged. In this context, it could include the management of people who have already fallen, or who are very frail. This includes a large element of clinical care but there remains a preventive aspect of this, in terms of managing risk factors and reducing them if possible, or at least minimising the harm that might occur from a fall.
SAC	Severity Assessment Coding – a rating system (1,2,3,4) for recording clinical incidents that occur in health care facilities. There are four SAC ratings, ranging from SAC1 (extreme risk) to SAC4 (low risk). The data in this report classify deaths due to falls as SAC 1 and serious injuries due to falls as SAC 2.
Screening & Assessment	These are terms to describe clinical processes to determine the falls risk of an individual. Although not used with complete consistency, *screening* typically refers to a relatively simple process (eg set of questions) that will triage risk status (eg high/low) whereas *assessment* (or *multifactorial assessment*) typically refers to a more complex process, often undertaken by a multidisciplinary team, that yields more clinically meaningful information such as what particular factors the person is at risk from (eg poor balance, vision, medications etc).
SESLHD	South Eastern Sydney Local Health District
SESLHD PD 248	The current SESLHD policy document describing falls injury prevention protocols for publically managed hospitals.
Standard 10	The accreditation standard for hospitals, *Standard 10: Preventing Falls and Harm from Falls*

Use of the term "Aboriginal" in this document. In accordance with NSW Health policy, the term "Aboriginal" is used throughout this document to include Aboriginal and Torres Strait Islander peoples. No disrespect is intended towards our Torres Strait Islander staff, patients or communities, whose contribution is gratefully acknowledged.

Executive Summary

Injuries from falls in Older People

Injuries from falls are a leading cause of morbidity and mortality in older people. At least 1 in 4 people aged 65 years and over fall at least once per year[1]. In NSW, these account for approximately 400 deaths and 27,000 hospitalisations per annum, as well as around 18% of Emergency Department presentations by this age group[2]. Whilst not all falls will result in an injury, the consequences of those that do can be severe, even fatal[2, 3]. For those that do survive, hospitalisation and rehabilitation are often lengthy and expensive[4]. Many never regain adequate function or independence to return home, and require transfer into long-term residential aged care[4].

Fortunately, falls and injuries from falls *are* preventable. There is good evidence for both the effectiveness and cost-effectiveness of a range of strategies across community settings[5-8] as well as health facilities[6, 7, 9-12]. Developed in consultation with key stakeholders, this plan describes a comprehensive set of evidence-based priorities and actions across these settings. They are consistent with the NSW Health Policy Directive PD2011_029: *Prevention of Falls and Harm from Falls among Older People: 2011-2015*[13], best practice guidelines produced by the Australian Commission on Safety and Quality in Health Care[8-10] and relevant accreditation standards[14].

Within the South Eastern Sydney Local Health District (SESLHD), the rate of injuries from falls in community-dwelling older people has risen to higher than the NSW rate for both men and women in recent years[15]. In SESLHD and across all of NSW, hospitalisations due to injuries from falls are increasing over time despite substantial investments in falls injury prevention over the last decade[15]. This is being driven not only by the increasing total proportion of people over 65, but also by the increasing proportion of those that will reach the age of eighty or ninety, for whom the risk and consequences are much greater[4, 16].

Falls that occur within health facilities are also a serious concern. Over the last 5 years in SESLHD, there have been around 5 fall-related deaths and almost 50 serious (SAC2) injuries per annum in patients aged 65 and over.

The development of an evidence-based local plan for falls injury prevention has been highlighted as a SESLHD priority in both the *SESLHD Strategy 2012-2017* and the *SESLHD Healthcare Services Plan 2012-2017*. This plan has been developed and will be delivered in accordance with the principles outlined in those documents.

Strategies for Prevention in Community Settings

The vast majority of injuries from falls occur in community settings, mostly in a person's own home[1, 17]. A complex set of risk factors includes a previous history of falls, increasing age, medical conditions and reduced mobility[18]. Environmental hazards may combine with and increase the complexity of an individual's risk. And certain groups may have higher levels of personal risk and/or require more specific and tailored prevention to meet their particular needs, such as Aboriginal people, people from culturally and linguistically diverse backgrounds, people with mental illness, people accessing drug and alcohol services, and people with specific medical issues such as HIV. All of these complex factors must be considered when planning community based strategies.

At the primary prevention level, the best evidence is for the protective effect of physical activity[5, 19]. Appropriate physical activity can build strength and improve balance, making a person less likely to fall and more resilient against injury if a fall does occur. In developing this plan, the following important questions were considered:

- What current opportunities are there in SESLHD for older people to be active? How can we build upon these?
- How can we increase participation in organised groups that are designed to protect against falls and injuries?
- How can better healthy built environments encourage an increase other independent physical activity?
- How can this be achieved at a broad enough level to achieve population change?

There is also a need to identify those people who are most at risk and intervene more directly. Multifactorial interventions involve assessment of the specific risks of an individual followed by a set of suitably tailored interventions. This reflects the wide range of potential risk factors described earlier, and is consistent with Australian

best practice guidelines[8-10]. This may occur across a range of settings, from General Practitioners and community health services[20-22] to more specifically targeted and clinically intensive outpatient clinics, where interventions are delivered by a multidisciplinary team of health professionals[23, 24]. Questions to be answered within this plan included:

- What is the scope of these multifactorial interventions already being delivered?
- What clinical approaches and external partnerships are required to increase this?
- How can we build the capacity of these providers and connect them more effectively with other prevention?

On a much broader level, there also is value in asking: how far back should falls injury prevention begin? Whilst most falls and injuries from falls occur in older age, some do occur earlier (notably in vulnerable groups) and a whole-of life approach to building healthy bones could prevent injuries later in life for all. To that end, this plan also considers:

- What are broader, whole-of-life strategies to build a more resilient future population?
- How can this be connected to other SESLHD programs and prevention initiatives?
- How should this connect to other SESLHD plans and governance?

Strategies for Prevention in Health Facilities Managed by SESLHD

Around 2% of all injurious falls occur within hospitals. Whilst this is a fraction of the total community incidence, ANY fall that occurs in a hospital is a serious issue, both in terms of immediate clinical needs and the broader organisational duty of care. It is an urgent issue being addressed across NSW through the Clinical Excellence Commission's NSW Falls Prevention Program, and is the subject of a new national accreditation standard (*Standard 10: Preventing Falls and Harm from Falls*[14]). Injuries from falls are much more common in the frail populations of residential aged care facilities, which are also subject to accreditation and quality standards. Best practice guidelines for both settings have been developed by the Australian Commission on Safety and Quality in Health Care[9, 10].

The consultation process for the health facilities section of this plan was predominantly conducted through the SESLHD Health Services Falls Prevention Advisory Committee. Detailed input was provided by representatives from each facility Falls Committee or Quality Manager, and broader consultation then occurred across the District (see Appendices). Through this consultative process, a number of specific local priorities were identified. These were:

- Exploration of methods to improve **supervision and surveillance** of high risk patients, such as increased nocturnal surveillance, the engagement of carers, families or volunteers at high risk times, and the use of Patient Specials where clinically warranted.
- More strategic coordination to address issues in **a more consistent, collaborative** manner across the LHD.
- Identification of groups with **particular needs and/or increased risks** (including <65 years).
- A coordinated and **strategic approach to the accreditation process**, including more clinically meaningful audit and compliance monitoring processes to better inform practice.
- Improvements to the **quality and consistency of data collection**, and more strategic use of data to inform and then evaluate facility-based interventions.
- A greater focus on "near miss" **opportunities for early intervention**, such as people who attend Emergency Departments due to a fall but are not admitted.
- Improved focus on future falls injury prevention through the discharge planning process, notably stronger connections and **referrals to risk-appropriate community-based prevention programs** and services.
- Strategic and coordinated approaches to common **staff training and professional development** needs.
- Ensuring that facilities have long-term **plans to procure equipment and devices** to prevent injuries from falls.

Falls injury prevention is a significant issue, with a complex set of strategies required across multiple settings. Results may take time to become measurably apparent, and prevention will require a long-term vision and sustained commitment[8-10]. But through effective partnerships and long-term, strategic vision, this can be achieved. In the following pages, the key strategies for each setting are described.

What We Will Do in Community Settings

PRINCIPLES

- Take an evidence-based approach to the selection of priorities and the development and implementation of interventions.
- Recognise, consolidate and strategically build upon the work that has already been done in the District, such as delivering exercise programs and supporting the development of healthy built environments.
- Create linkages to broader whole-of-life and healthy ageing strategies to build a resilient future population.
- Ensure essential linkages to prevention activities in SESLHD facilities including our hospitals and community health facilities.

PRIORITIES

We will provide appropriate governance and ensure the engagement of key stakeholders across the District.

C1 Ensure that there is an appropriate governance structure to support strategic and collaborative plan delivery.

We will advocate for relevant, whole-of-life strategies across the District to build a more resilient future population.

C2 Advocate for and support District-wide planning for whole-of-life strategies such as calcium intake, Vitamin D and physical activity, early intervention, and appropriate service planning to reduce injuries from falls.

We will increase physical activity, through both organised groups and healthy built environments.

C3 Identify, consolidate and promote the existing range of opportunities for appropriate physical activity.
C4 Identify gaps in access to opportunities for physical activity and take a strategic approach to address these.
C5 Build the capacity of activity providers to deliver appropriate, effective and sustainable activities.
C6 Develop strategies to improve the built environment, to support active and healthy ageing.
C7 Promote physical activity to key stakeholders and the community in the broader context of healthy ageing.

We will deliver evidence-based, multifactorial Interventions (assessment and tailored strategies).

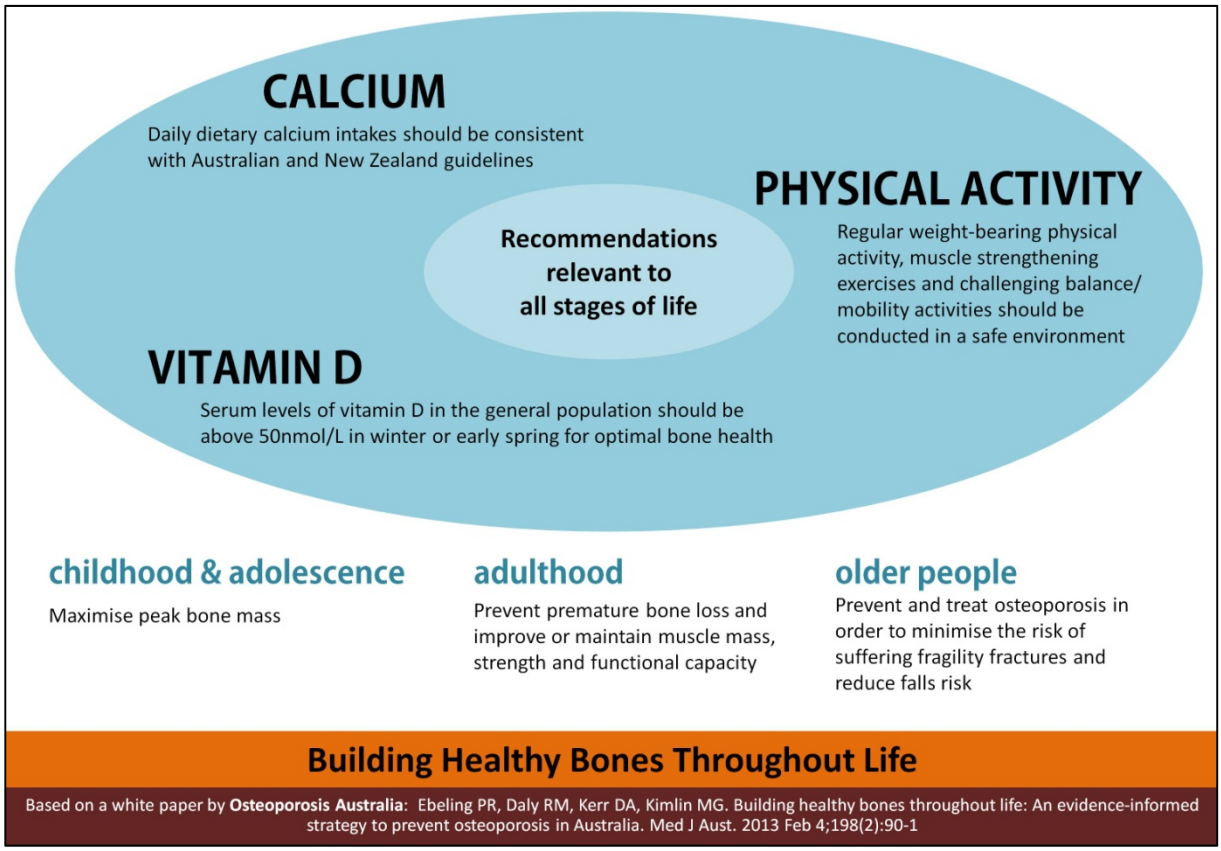
C8 Develop a strategic approach to increase the scope and quality of multifactorial interventions (involving falls risk assessment and subsequent tailored risk-reduction strategies).
C9 Build the capacity of relevant service providers to implement evidence-based multifactorial interventions in a wide-reaching, sustainable manner.

PARTNERS

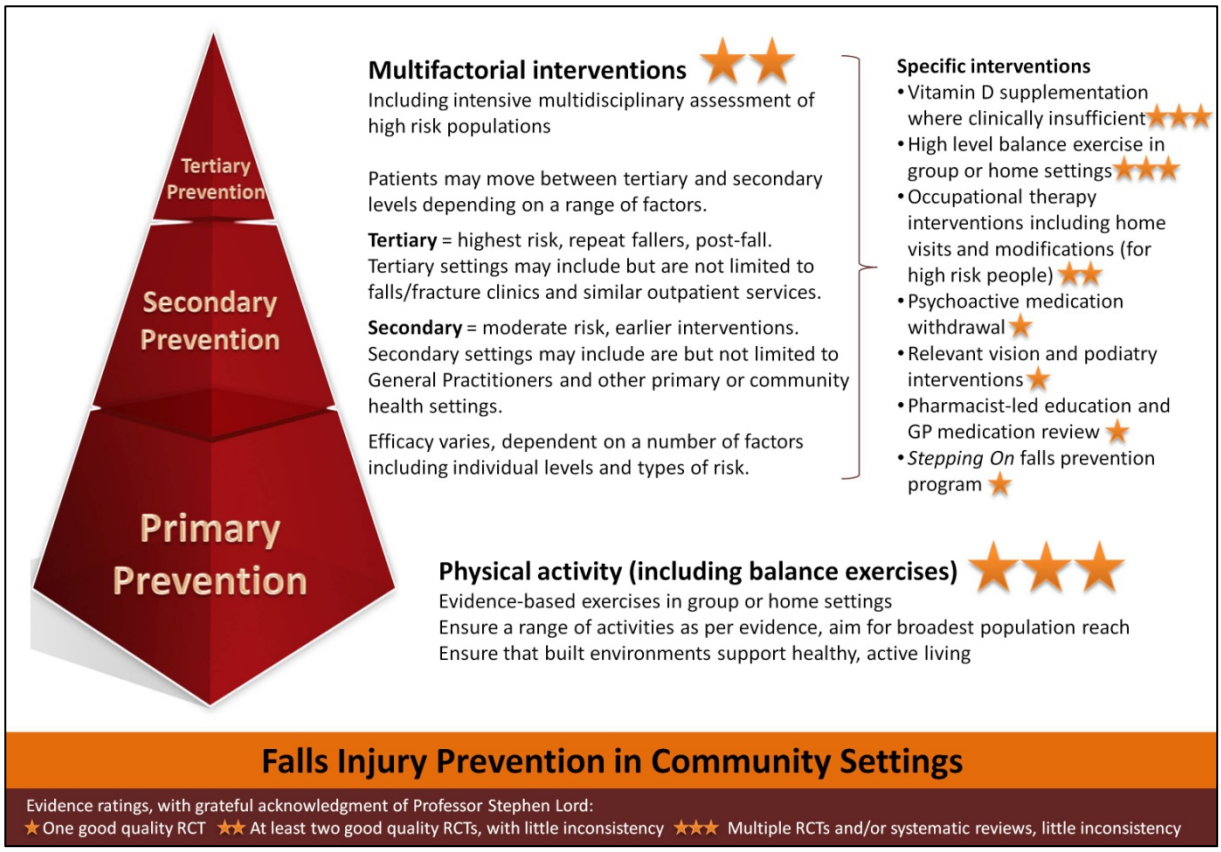
In addition to essential partnerships throughout the SESLHD organisation itself, external partners in this plan will include but are not limited to the following.

- Medicare Locals
- Primary health practitioners, including General Practitioners and Practice Nurses
- Local Governments, particularly those with the highest rate of falls (eg Rockdale)
- Physical activity coordinators and providers, including but not limited to SHARE, AIM for Fitness, Strengthening for Over 60s, Stepping On
- The NSW Falls Prevention Program (CEC)
- Centre for Population Health (NSW Health)
- Community stakeholders including Carers groups

A Snapshot of the Whole of Life Approach to Building Healthy Bones



A Snapshot of the Best Evidence for Falls Injury Prevention in Community Settings



What We Will Do in Health Facilities Managed by SESLHD

PRINCIPLES

- Ensure compliance with all relevant accreditation requirements and standards including ACSQHC National Standard 10 and the Aged Care Act 1997 and subsequent associated legislation.
- Take a collective, strategic approach to District-wide falls injury prevention in SESLHD facilities including the adoption of resources developed by the CEC where appropriate.
- Take an evidence-based approach to the selection of priorities and the development and implementation of interventions and ensure the monitoring, evaluation and reporting of outcomes.
- Ensure essential linkages to prevention activities in community settings to promote adequate and timely follow up for those at continued risk of falling.
- Identify and support clinical champions to foster and drive a focus on falls injury prevention.

PRIORITIES

We will provide appropriate governance and ensure the engagement of key stakeholders across the District.

H1. Ensure that there is an appropriate governance structure to support strategic and collaborative plan delivery.

We will take a collective, strategic approach to planning and implementing prevention initiatives.

H2. Determine an appropriate scope of focus (beyond simply "65 and over") for the routine actions to be undertaken within health facilities (such as protocols describing routine screening and individual care plans). This is to ensure that the needs of other high risk populations are appropriately considered.
H3. Ensure consistency of SESLHD practice with ACSQHC best practice guidelines, other relevant clinical practice recommendations and ongoing reviews of evidence.
H4. Adopt a collective and strategic approach to achieving relevant accreditation.

We will address specific issues and priorities identified by key stakeholders.

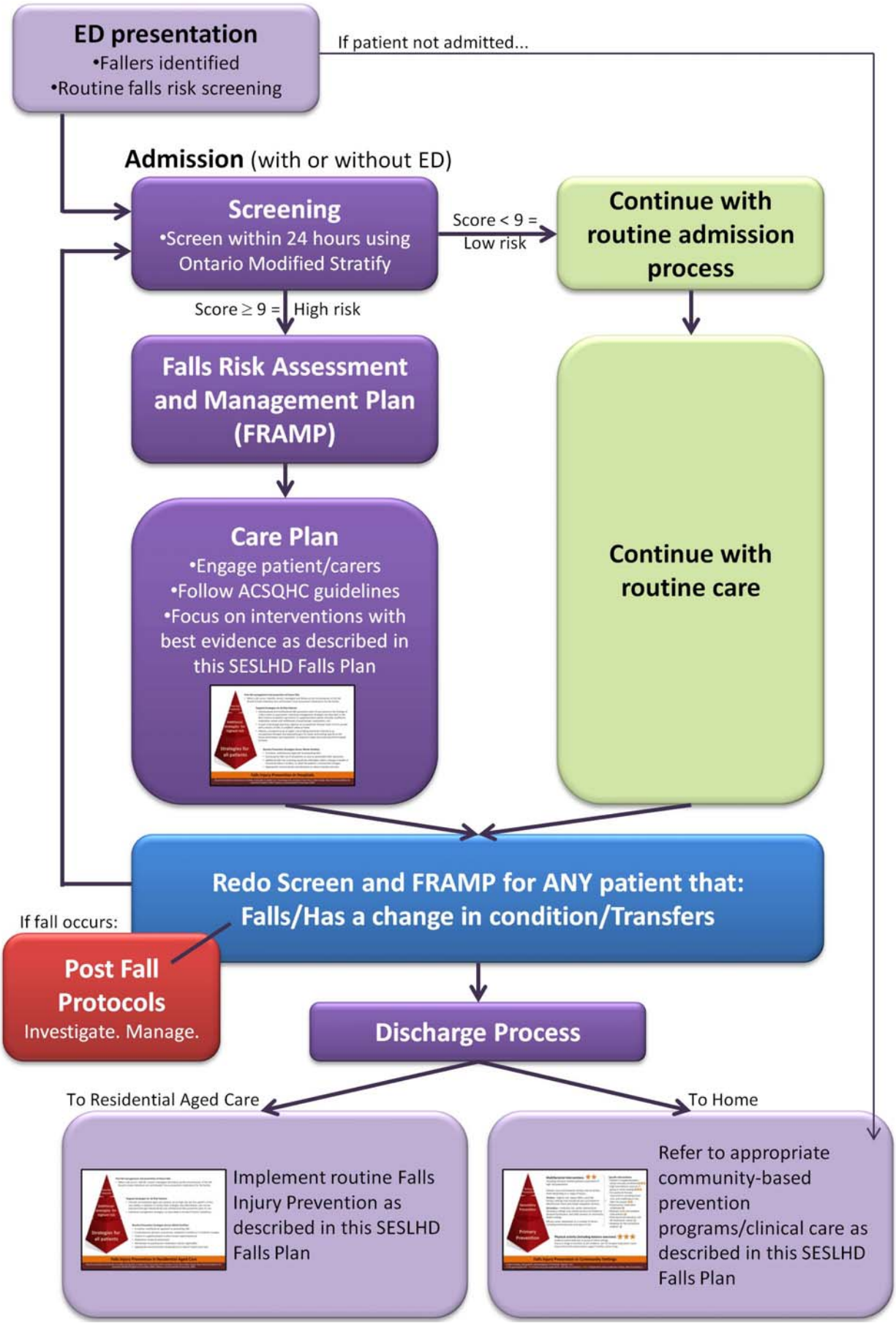
H5. Improve the consistency and quality of relevant data collection and reporting across facilities, and the proactive use of this information in strategic and operational planning.
H6. Implement a strategic approach to compliance monitoring that will provide meaningful feedback to inform quality falls injury prevention action across facilities.
H7. Explore and implement strategies to improve supervision and surveillance relevant and appropriate to the context of each ward/facility.
H8. Ensure that falls injury prevention strategies have an appropriate focus and design to meet the needs of special population groups, notably Aboriginal patients and people from CALD communities.
H9. Implement strategies to more effectively address falls injury prevention with patients attending Emergency Departments, particularly those not admitted to hospital.
H10. Implement a strategic and collaborative approach to discharge planning that includes stronger linkages with community-based preventive services.
H11. Implement a strategic and collaborative approach to staff orientation, ongoing training and professional development opportunities related to falls injury prevention.
H12. Ensure that equipment, devices and environments are available to implement prevention strategies for patients at risk of falling.

PARTNERS

In addition to essential partnerships throughout the SESLHD organisation itself, external partners in this plan will include but are not limited to the following.

- Medicare Locals
- Primary health practitioners, including General Practitioners and Practice Nurses
- Ambulance Service of NSW
- NSW Agency for Clinical Innovation
- The NSW Falls Prevention Program (CEC)
- Community Stakeholders including Carers groups
- Non-government organisations

The Patient Journey



How We Will Deliver the Plan

Implementation of this plan will be coordinated by the Planning and Population Health Directorate. District Steering Committees will be formed in each of the main settings to provide strategic planning direction and practical support. In both cases, similar or related groups have existed previously, and many of those stakeholders will again be involved here, providing valuable experience and professional networks. Appropriate communication strategies will be developed to ensure the engagement of and regular contact with these and other key stakeholders.

A reporting framework and timetable will be established. This will include annual progress reports to the District Executive Team, District Clinical and Quality Council and the Board, with additional interim progress reports to be tabled throughout the year at each of the Steering Committees.

The actions within this plan are wide-reaching and will have inevitable resource implications. Whilst this may present a challenge within a system already under financial pressure, such costs must be weighed against the consequences of doing nothing, and the spiralling treatment costs that would most surely result. Resource implications are noted in particular for:

- Mandatory implementation of Standard 10 across all hospitals.
- Occupational Therapists and Physiotherapists are likely to see an increase in referrals.
- Many of the Aboriginal and CALD strategies described will most likely require direct resourcing.
- If a population-level effect is truly to be achieved, then the Health Promotion team will require adequate resourcing to achieve adequate population reach of evidence-based prevention programs.

How We Will Measure Our Success

- At the community level, we will monitor age standardised rates of overnight stay hospitalisations due to falls by SESLHD residents aged 65 years and over.
- Within facilities managed by SESLHD, we will monitor SAC 1 (death) and SAC 2 (serious harm) incidents due to falls by people aged 65 and over in health facilities managed by SESLHD.

At the community level, we will also monitor:

- Participation in physical activity.
- The scope of multifactorial interventions delivered by relevant community and primary health care services across SESLHD.
- Indicators relating to the whole-of-life actions described in this plan (eg through the Healthy Children's Initiative).
- Considerations of quality, access and population reach.
- Other relevant indicators as described in the body of this plan.

Within facilities managed by SESLHD, we will also monitor:

- ALL fall-related SAC1 and SAC2 incidents, regardless of age.
- The achievement of relevant accreditation of all facilities managed by SESLHD.
- Actions related to the delivery of specific interventions, notably those supported by the best evidence.
- Considerations of quality clinical practice.
- Other relevant indicators as described in the body of this plan.

About SESLHD

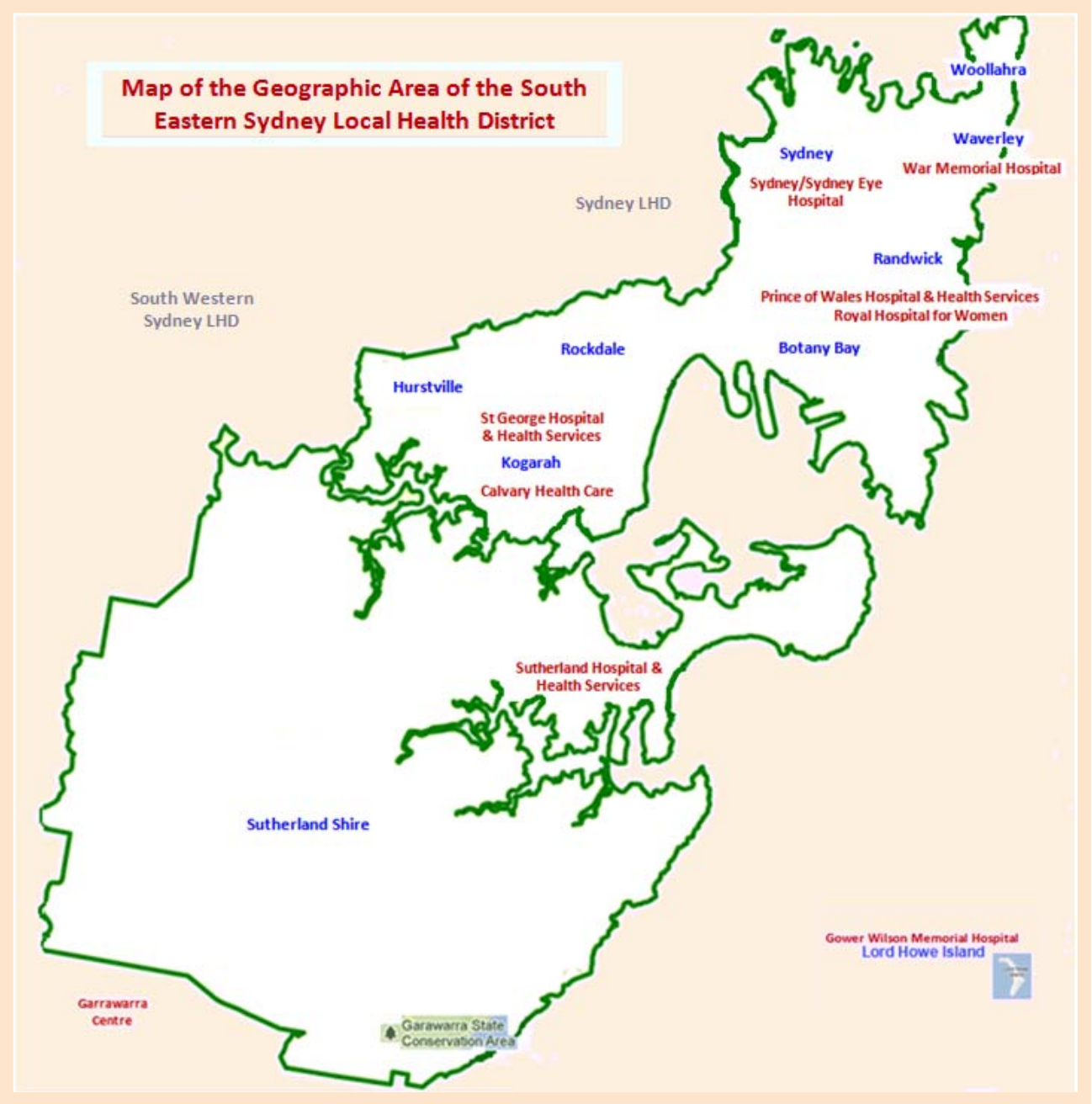
Our Vision

Working together to improve the health and wellbeing of our community.

Our Purpose

SESLHD exists to:

- Promote, protect and maintain the health of its community.
- Provide safe, quality, timely & efficient care to all who need it.
- Address gaps in health service access and health status.



SESLHD covers nine NSW Local Government Areas from Sydney's Central Business District to the Royal National Park in the South. The District also provides a key role in assisting residents of Lord Howe Island and Norfolk Island with access to hospital and health services, including state-wide services. The District has a complex mix of highly urbanised areas, industrialised areas and low density suburban development areas in the south. The District supports a culturally and linguistically diverse population of over 840,000 people.

The services provided across the District include population health programs and services; ambulatory, primary health care and community services; hospital inpatient and outpatient services, and imaging and pathology, among others. Facilities include six public hospitals and associated health services: Prince of Wales; Royal Hospital for Women; St George; Sutherland; Sydney / Sydney Eye; and Gower Wilson Memorial on Lord Howe Island. The District also provides one public residential aged care facility (Garrawarra Centre), and oversees two third schedule health facilities: War Memorial Hospital (third schedule with Uniting Care) and Calvary Healthcare (third schedule with Little Company of Mary Health Care).

Other public health facilities that deliver services to the local population include Sydney Children's Hospital (Randwick), St Vincent's Hospital (Darlinghurst) and Sacred Heart Hospice. Primary Health Care Organisations located in the South Eastern Sydney Region include the Eastern Sydney and South Eastern Sydney Medicare Local. Private hospitals and services also provide services to our population.

A number of fundamental principles guide our decisions on the directions and actions to take with regard to the development and delivery of health care within the District. These are outlined in the South Eastern Sydney LHD Strategy 2012-2017.

Despite the great improvements in average life expectancy achieved in recent decades, health gains have not been equally shared across the population of SESLHD. One of the District's key priorities is to **reduce inequities in health service access and health outcomes.** Those most at risk of experiencing health inequities are our most vulnerable population groups. Vulnerable populations are those at greater risk for poor health status and access to health care.

As occurs in the rest of Australia, the most stark variation in health status between population groups resident in SESLHD is between Aboriginal and non-Aboriginal Australians. Other vulnerable populations in the District include the socio-economically disadvantaged, the homeless, people with disabilities, people with low English proficiency, refugees, those with human immunodeficiency virus (HIV), and those with other chronic health conditions, including severe mental illness. The vulnerability of these individuals is enhanced by age, sex, ethnicity, culture, and factors such as poor access to health care. Their health and health care problems can also intersect with social factors, including poor housing and social capital, and inadequate education. The numbers within some of these vulnerable populations in SESLHD are increasing, particularly as the population ages, e.g. people living with diabetes and HIV. The health and non-health service needs of these populations are important, with social disadvantage likely compounded by poorer general health than the more advantaged and vice versa. Chronic illnesses and the impact of these illnesses are more prevalent among vulnerable populations.

SESLHD aims to provide high quality appropriate prevention and care to all people, including those from vulnerable population groups. To achieve this, it is guided by a range of state and local key strategies and plans, which have been developed to:

- Support national, state and local planning efforts to achieve systems of care that meet the specific needs of vulnerable populations
- Achieve equity in health care access and quality, and address concerns faced by vulnerable populations
- Document and track health care quality for vulnerable populations

See **Appendix A** for a list of State and District strategies and plans that inform and support high quality health service provision for all in need in our District.

This plan will contribute to the *Population Health Plan* and other clinical service plans developed by the District as shown in the SESLHD Planning Framework (Figure 1). Implementation will be coordinated by the Planning and Population Health Directorate, with input from and partnerships between the other directorates and facilities described herein.

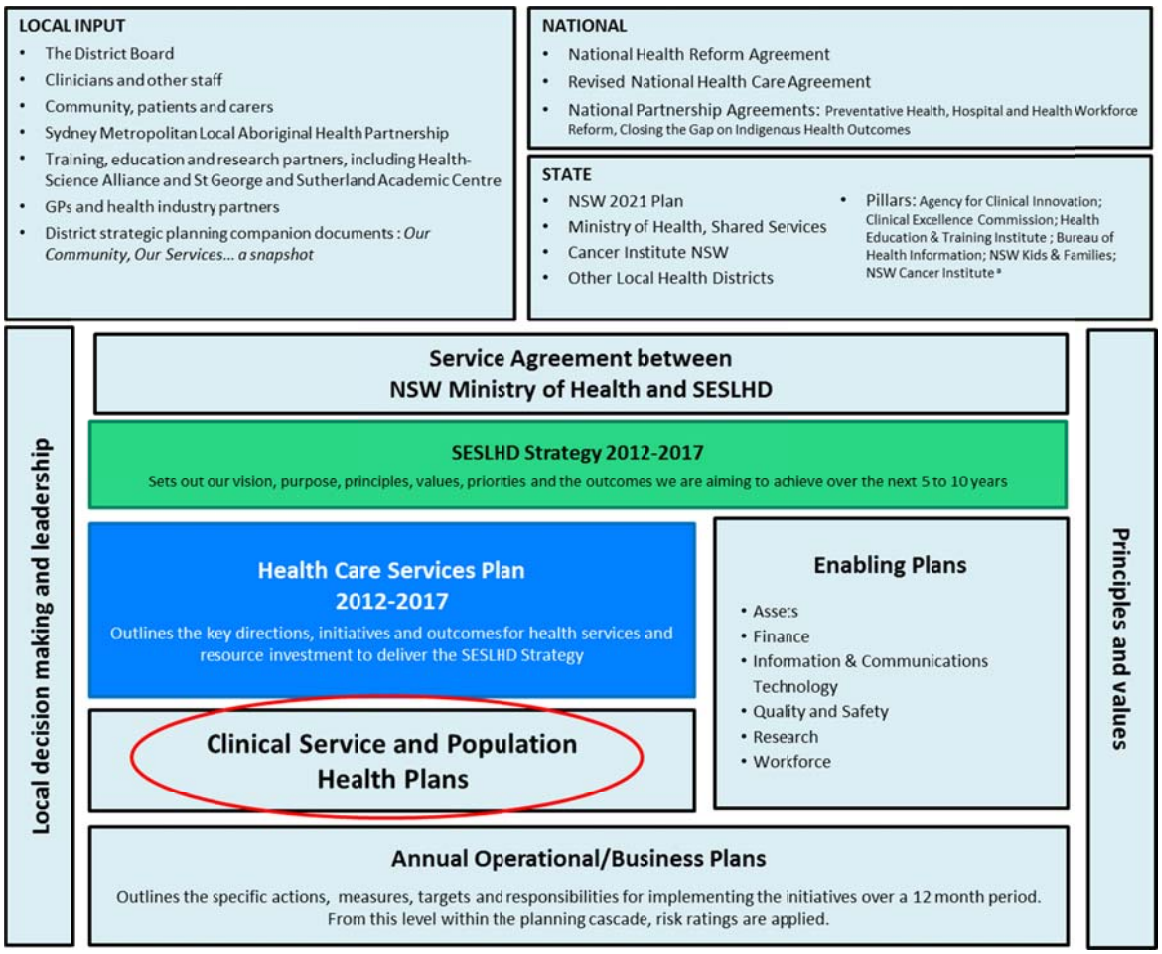


Figure 1: The SESLHD Planning Framework

[a] The Pillars and their main roles are:

- Agency for Clinical Innovation (ACI) – design and implementation of models of care and improved patient pathways.
- Clinical Excellence Commission (CEC) – policy and strategy related to system-wide improvement of quality and safety
- Health Education Training Institute (HETI) – leadership, undergraduate, vocational training in addition to postgraduate services
- Bureau of Health Information (BHI) – independent reporting on the performance of the NSW public health system
- NSW Kids and Families – statutory health corporation that champions the health interests of children and young people
- Cancer Institute NSW – a NSW State government funded agency established to lessen the impact of cancer in NSW

The Sydney Metropolitan Local Aboriginal Health Partnership involves the Aboriginal Medical Service Co-operative Ltd at Redfern, the SESLHD and two other Local Health Districts (Sydney and Northern Sydney to ensure that the expertise of Sydney Metropolitan Aboriginal community is brought to health care processes.

Shared services include HealthShare NSW, eHealth NSW, NSW Health Pathology and Health Infrastructure NSW.

Other Local Health Districts closely linked with SESLHD include: geographically and/or functionally defined LHDs which have services provided by the SESLHD.

Population Projections across SESLHD

As the population increases and ages, issues related to injuries from falls in older people will inevitably have an increased impact on the health system. Projections of changes to the population profile are therefore particularly relevant to this plan.

In 2011, the SESLHD resident population was estimated to be 838,416, with 45% living in the Northern Sector (378,680) and 55% in the Southern Sector (459,736). Our population is projected to reach 887,289 by 2021 and 928,928 by 2031 (Table 1).

Between 2011 and 2021, the SESLHD population is projected to increase by +5.8% (48,873 people), which is just over half the average population growth rate in NSW (+11.1%). In the following decade, from 2021 to 2031, population growth (+4.7%) is expected to be less than a half of the average for NSW (+10.1%) (Table 2).

Population growth is expected to be highest in the Northern Sector, which will account for 53% (25,674) of the expected increase in population between 2011 and 2021.The Southern Sector will account for 47% (23,199) of the expected increase.

Consistent with the pattern for NSW as a whole, between 2011 and 2021, the fastest growing age group in SESLHD will be the 70-84 years age group (+26%). Over the following decade, the largest increase will be seen in those aged 85 and over (Table 3).

Table 1: Projected population numbers, Northern and Southern Sectors of SESLHD and NSW, 2011 – 2031

	2011	2021	2031
Northern Sector	378,680	404,354	428,092
Southern Sector	459,736	482,935	500,837
SESLHD	838,416	887,289	928,928
NSW	7.208M	8.008M	8.817M

Source: Department of Planning & Statewide Services Development Branch, NSW Health, March 2009, NSW Health Population Projection Series 1.

Table 2: Projected population growth (%), Northern and Southern Sectors of SESLHD and NSW, 2011 – 2031

	2011- 2021	2021 - 2031
Northern Sector	+6.8%	+5.9%
Southern Sector	+5.0%	+3.7%
SESLHD	+5.8%	+4.7%
NSW	+11.1%	+10.1%

Source: Department of Planning & Statewide Services Development Branch, NSW Health, March 2009, NSW Health Population Projection Series 1.

Table 3: Population numbers and growth (%) by age group, SESLHD, 2011– 2021

Age group (yrs)	2011	2021	Growth (%)	2031	Growth (%)
0-4	51,055	51,924	+2%	53,413	+3%
5-24	198,177	209,004	+6%	216,791	+4%
25-39	215,272	219,829	+2%	225,635	+3%
40-54	168,700	171,653	+2%	174,484	+1%
55-69	121,679	130,986	+8%	133,556	+2%
70-84	64,618	81,545	**+26%**	95,887	**+18%**
85+	18,916	22,348	**+18%**	29,160	**+31%**
Total	838,417	887,289	6%	928,926	5%

Source: Department of Planning & Statewide Services Development Branch, NSW Health, March 2009, NSW Health Population Projection Series 1.

Falls and Harm from Falls

The Burden of Illness

Injuries from falls are a leading cause of morbidity and mortality in older people. At least 1 in 4 people aged 65 years and over fall at least once per year[1].

Whilst not all falls will result in an injury, the consequences of those that do can be severe, including fractures and head injuries[2]. As many as one-third of those hospitalised due to a fall injury such as a hip fracture do not survive beyond one year later[3]. For those that do survive, the period of hospitalisation and rehabilitation is substantial and expensive[4]. Many never regain adequate physical function and independence to return home, and require transfer into long-term residential aged care[4]. The likelihood of this varies markedly depending on age and other health issues, but extends as high as 60% in some groups[16]. Injuries from falls are widely acknowledged to be a leading cause of premature admission to residential aged care[4, 16].

In NSW, approximately 400 deaths and 27,000 hospitalisations per annum are due to falls in people aged 65 and over[25], as are around 18% of Emergency Department presentations by this age group[2]. The cost is substantial: no other injury cause (including road trauma) has a greater impact on the NSW Health system[26]. In an analysis of the incidence and cost of falls injury among older people in NSW, the costs for 2006/7 were estimated to be over $550 million, over half of which was directly attributable to hospital inpatient, outpatient and emergency department care, and almost a further quarter were attributable to residential aged care[27]. Local estimates suggest the cost within SESLHD would have been over $70 million in this same period.

Furthermore, this cost burden is increasing as the population ages. Hospitalisations due to injuries from falls are increasing over time (Figure, Figure 2)[15]. Detailed long-term projections of the likely cost of injuries from falls to the health system undertaken for the Commonwealth[28] noted that a marked increase is being driven not only by the increasing total proportion of people over 65, but also by the increasing proportion of those that will reach the age of eighty or ninety, for whom the risk and consequences are much greater[4, 16]. As the population ages, more and more people are expected to be living alone with dementia, and will be highly vulnerable to falls as well as other health risks[29]. The author concluded that:

> ***"It is clear from the results that if nothing is done to reduce the rate of fall related injury, the cost of treating these injuries will become so great that it will be difficult to fund prevention programs, thereby creating a cost spiral..."***
>
> Moller (2003) Projected costs of fall related injury to older persons due to demographic change in Australia, p4.

Even in those instances where an injury does not occur, there are potentially serious consequences. Non-injurious falls are frequently associated with a fear of falling. Feelings of anxiety, hopelessness and depression can in turn result in reduced physical and social function, which in themselves are harmful[30, 31].

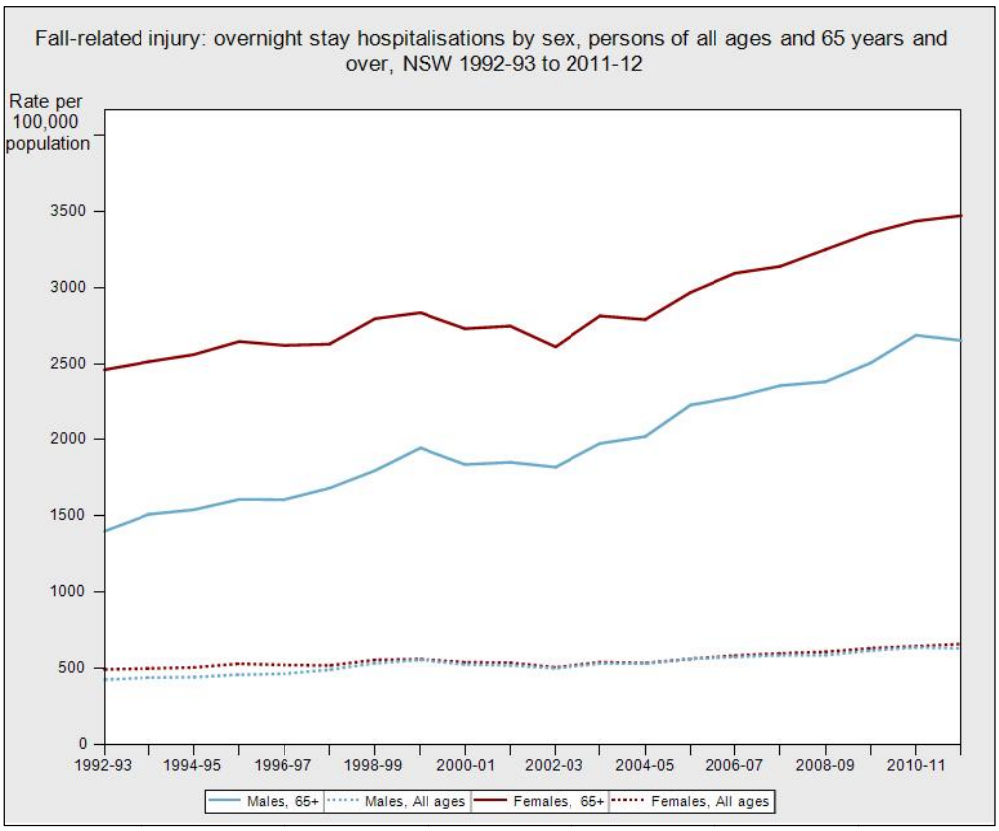


Figure2: Trends in Hospitalisations Due to Falls, NSW – OVERNIGHT STAY.
Source: Health Statistics NSW.

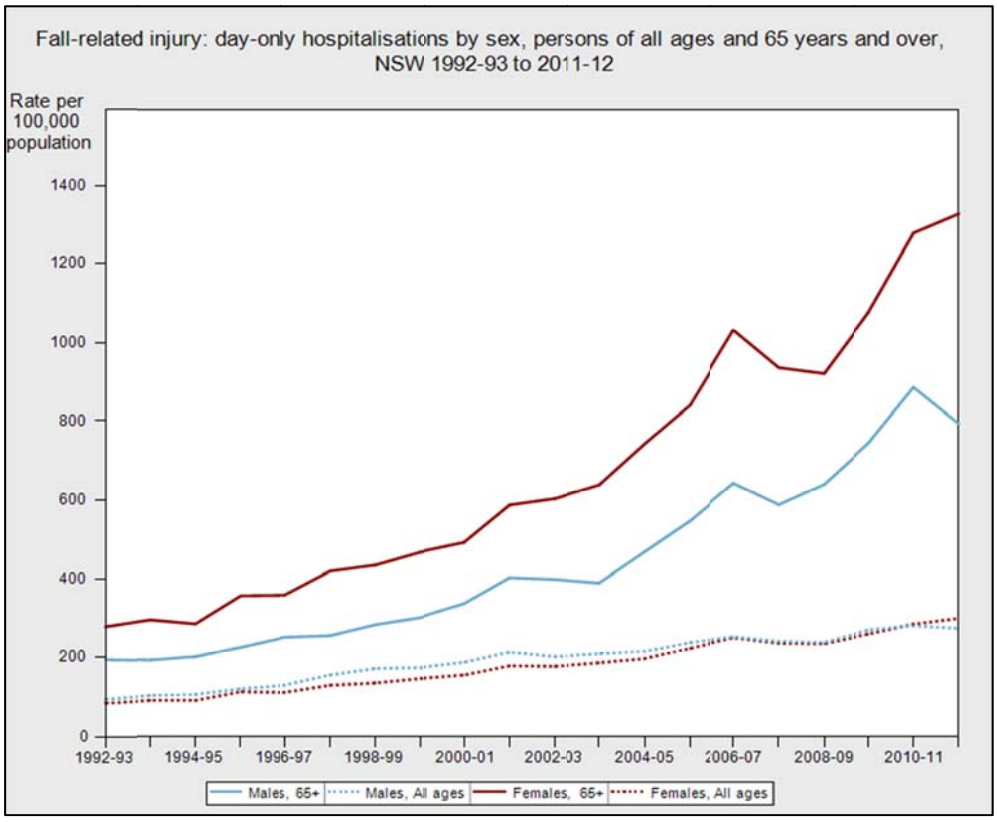


Figure 2: Trends in Hospitalisations Due to Falls, NSW – DAY ONLY.
Source: Health Statistics NSW.

Injuries from falls in SESLHD

In SESLHD, as across all NSW, fall-related hospital separations have increased over the last decade.

Whilst the NSW and SESLHD rates were comparable until around 2005, SESLHD then increased at a faster rate before appearing to plateau slightly in more recent years (Figure 3).

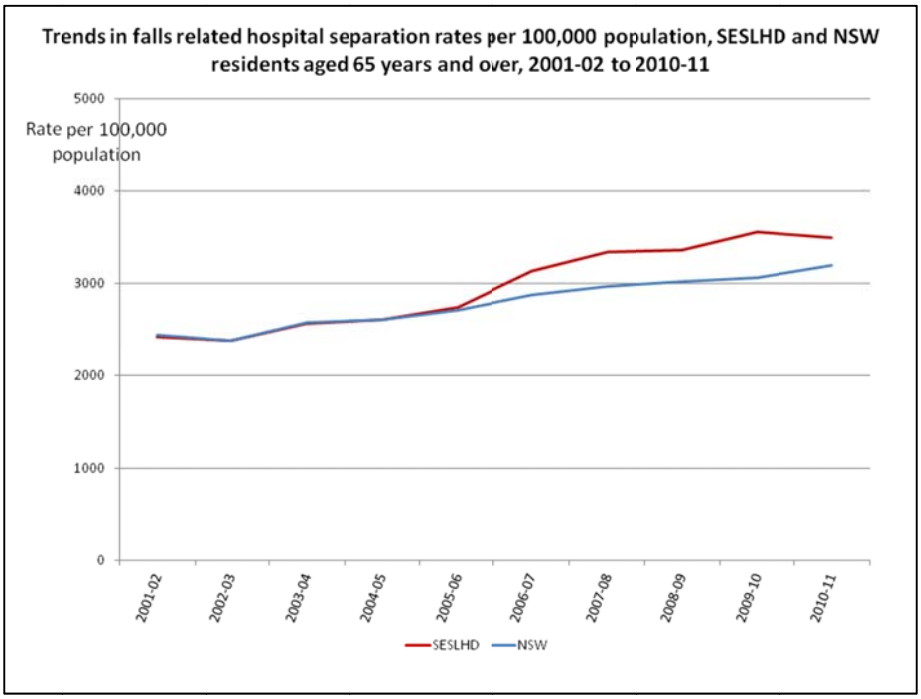


Figure 3: Trends in fall-related hospital separation rates per 100,000 population, SESLHD and NSW residents aged 65 years and over, 2001-02 to 2010-11.
Source: NSW Admitted Patient Data Collection and ABS population estimates (HOIST).

In recent statistics, fall-related injury overnight stay hospitalisations in SESLHD were higher than the NSW average for both males and more notably so for females (Figure 4).

(NB this is the same dataset as the final point of the trends shown in Figure 3).

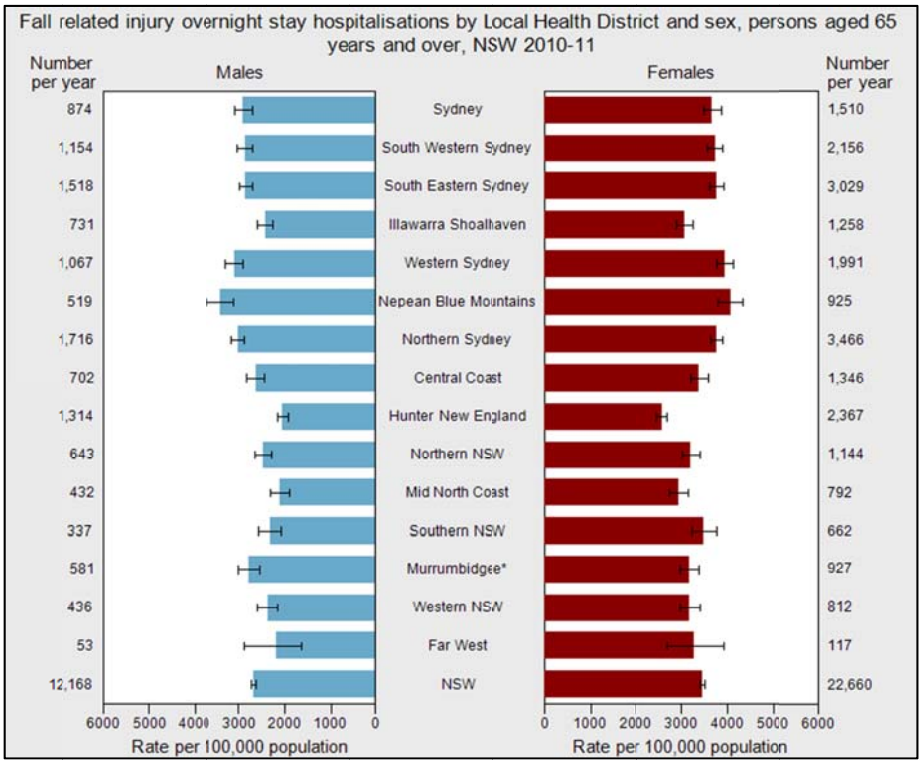


Figure 4: Fall-related injury overnight stay hospitalisation by LHD.
Source: Health Statistics NSW.

Trends across age groups

Consistent with the evidence described earlier, the most substantial burden of illness and the greatest increase over time have been observed in the 85+ age group (Figure 6).

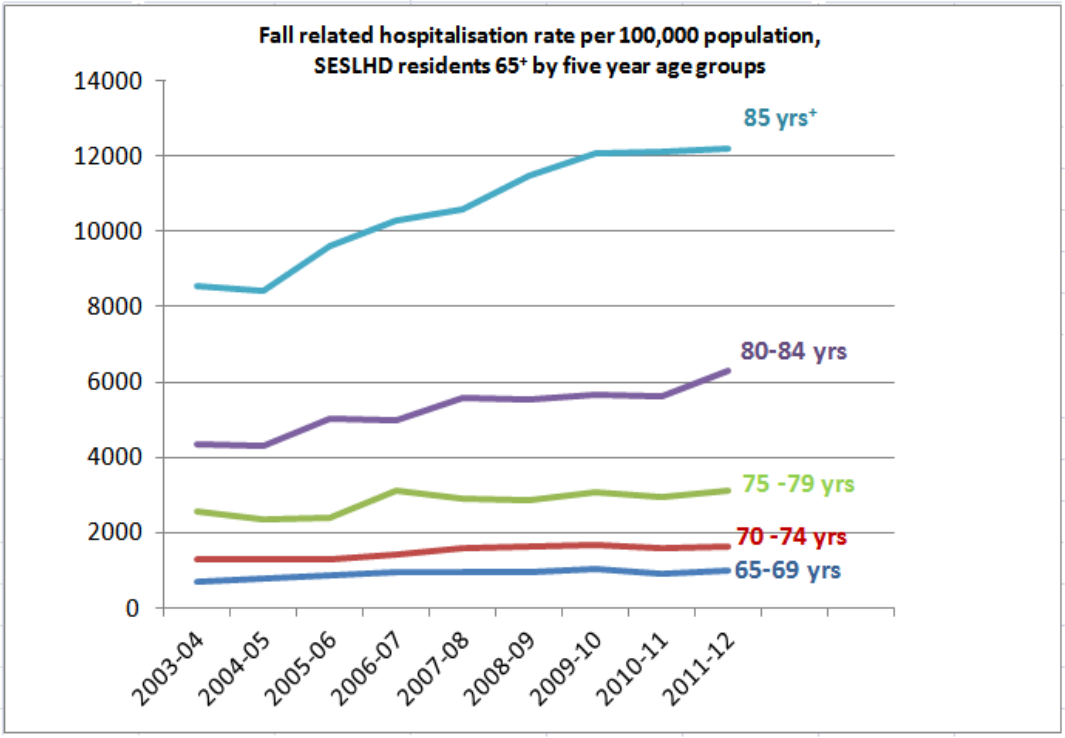


Figure 6: Fall-related hospitalisation rates per 100,000 population, SESLHD residents aged 65 years and over, by 5 year age group.
Source: NSW Admitted Patient Data Collection and ABS population estimates (SAPHaRI).

Local Government Areas

All local government areas within the South Eastern Sydney Local Health District have higher than state average rates of fall related hospitalisations. See Figure 7.

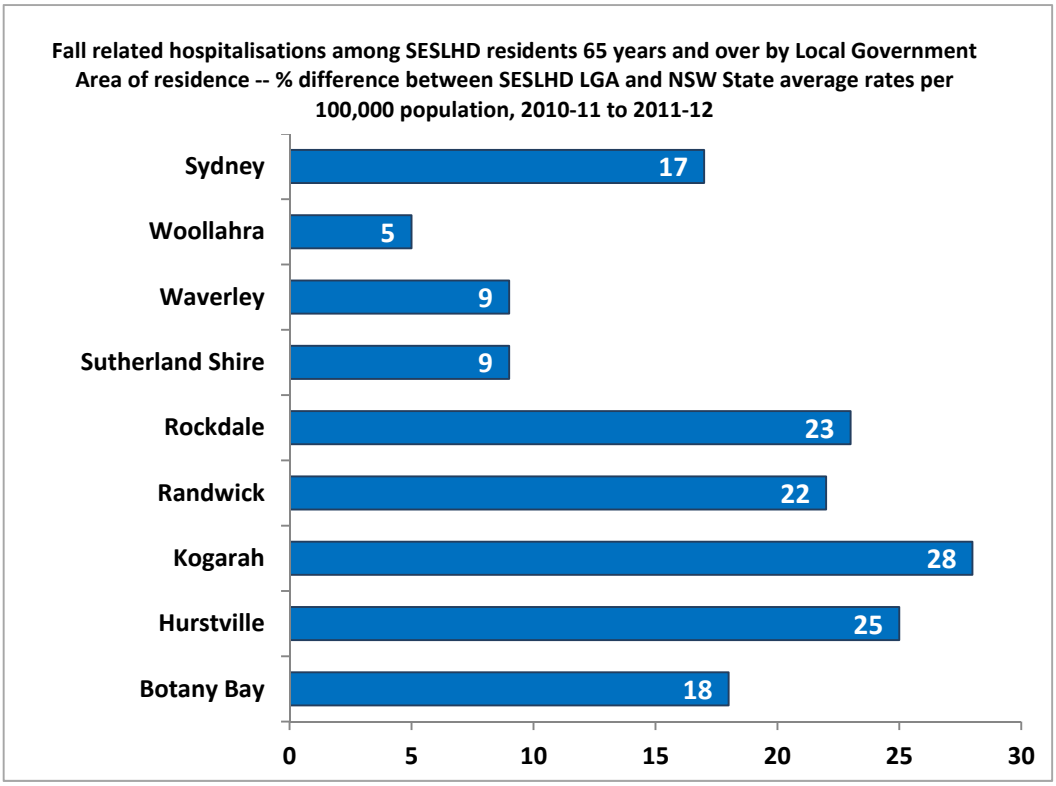


Figure 7: Fall related hospitalisations among SESLHD residents 65 years and over by Local Government Area of residence -- % difference between SESLHD LGA and NSW State average rates per 100,000 population, 2010-11 to 2011-12
Source: NSW Admitted Patient Data Collection and ABS population estimates (SAPHaRI).

Aboriginal People

Injuries from falls are one of the rare indicators where the marked inequities experienced by Aboriginal people are not as clearly seen, although recent data begin to suggest a clearer trend (Figure 5). A number of factors may influence this, including the younger life expectancy of Aboriginal people (meaning there are fewer frail, elderly Aboriginal people) as well as methodological issues (including poor identification and recording) which may influence data quality. It is essential that the needs of Aboriginal people be considered, particularly in terms of the design and delivery of interventions that will be respectful and appropriate to the needs of the local communities[13, 32].

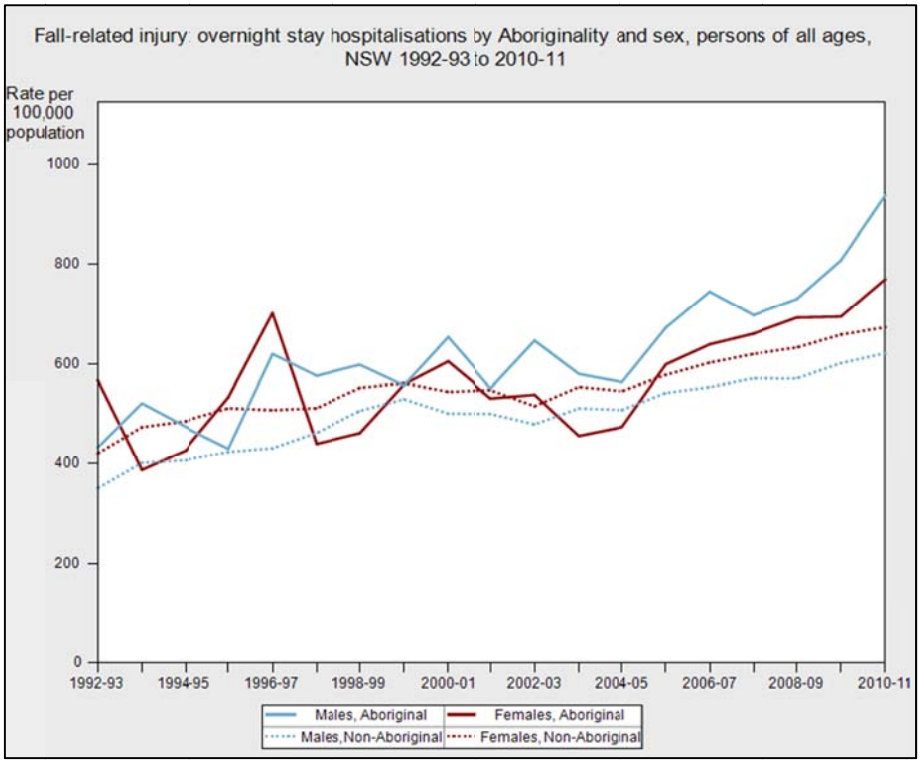
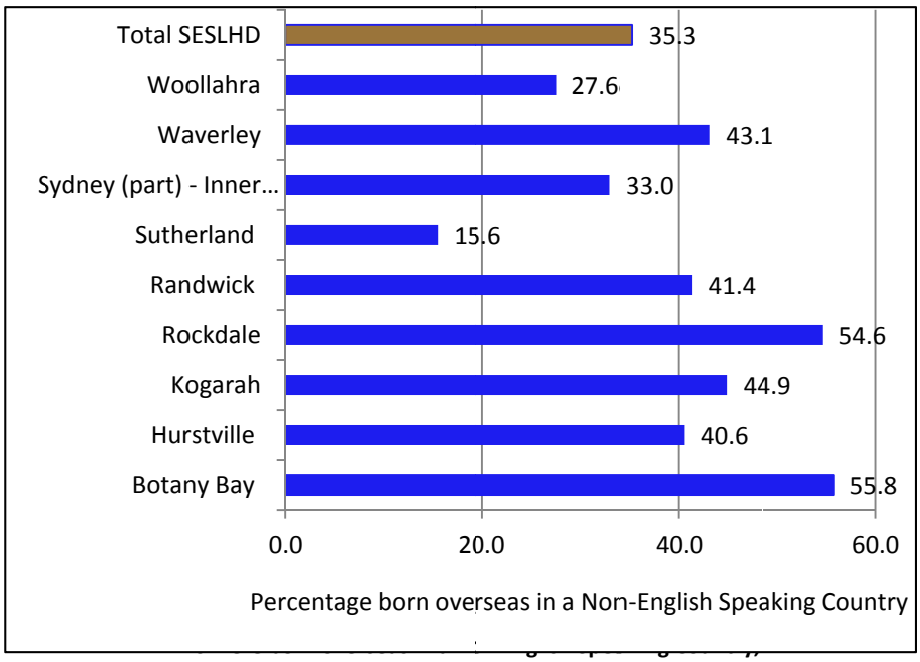


Figure 5: Trends in Hospitalisations Due to Falls, by Aboriginality and Gender.
Source: Health Statistics NSW.

Culturally and Linguistically Diverse Communities

Whilst 26% of the total SESLHD population were born overseas in a non-English speaking country, this increases to 35% of those aged 65 and over across the district, and is substantially higher in some areas (Figure 6).

Cultural diversity also extends beyond language spoken, with a range of other factors requiring consideration when planning interventions. It will be essential that the actions described in this plan appropriately target and meet the needs of these groups.



by Local Government (or Statistical Local) Area, 2011.
Source: ABS Census 2011 - TableBuilder Basic, accessed 9 July 2013
Notes: "Non-English speaking countries" excludes Australia, New Zealand, United Kingdom, Ireland, Canada, United States of America and South Africa.
Residents where Country of Birth is `Not Stated' have been excluded.

Injuries from falls in SESLHD facilities

Fall-related incidents that occur in SESLHD facilities are recorded in IIMS (NSW Health Incident Information Management System). The raw numbers of SAC 1 (deaths) and SAC 2 (serious injury) incidents that have occurred in health facilities managed by SESLHD are shown in Figure 7.

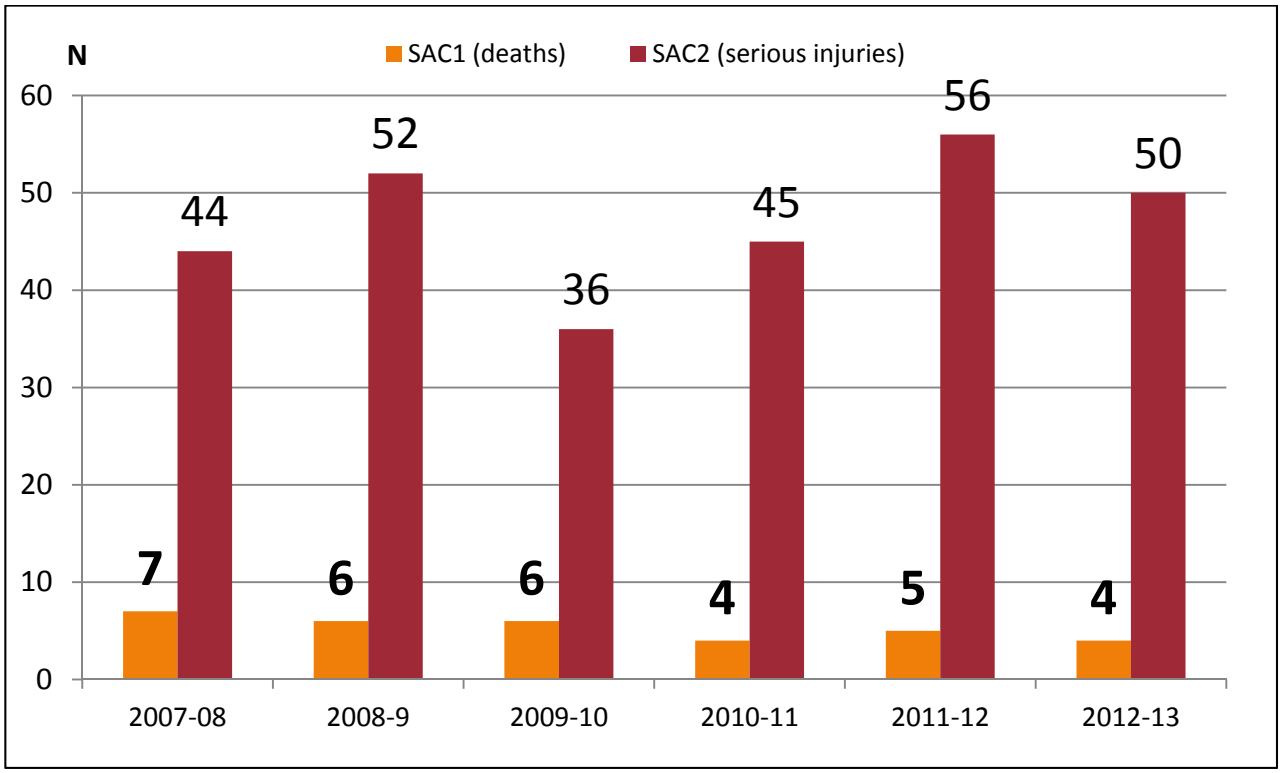


Figure 7: Fall-related SAC 1 (deaths) and SAC 2 (serious injuries) in health facilities managed by SESLHD.
Source: IIMS data provided by SESLHD Clinical Governance.

Whilst it is tempting to examine data from other Local Health Districts (LHDs) in order to "benchmark" the performance of SESLHD, this is problematic for a number of reasons.

- Whilst each SAC 1 incident is of serious concern, from a statistical viewpoint the figure is relatively low, so even a small variation from one year to the next can markedly affect the "relative performance" of each LHD.
- It is not uncommon for a single high-risk person to have multiple falls, complicating the SAC 2 data.
- Different facilities have markedly different populations with markedly different risks – for example, a residential aged care facility with a population of high-risk, frail patients or a rehabilitation hospital that predominantly serves older people. It is neither clinical meaningful nor reasonable to compare facilities within such a variable context, and LHD totals or averages would miss this clinically important concept.
- Raw numbers of falls-related incidents are clearly influenced by the number of bed days within each District. However for the reasons described above, calculation of a standardised rate is **not** recommended by the Clinical Excellence Commission, as such rates have been shown to be unstable and difficult to interpret meaningfully.
- A strong commitment to reporting is a vital part of a falls preventing culture within facilities. Reporting and long-term monitoring provide both insight and motivation for change. It is important to avoid imposing any unreasonable or clinically flawed indicators that would have a detrimental effect on that reporting culture.

There is no doubt that the raw figures shown in Figure 7 are concerning. Beyond the raw figures shown, however, the most meaningful clinical practice is to examine the data at a local level, and track local trends over time.

Where Do Most Falls Occur?

The location of falls by people aged 65 and over is described variously in publications based on community-dwelling population samples[1] or hospital records[17]. Although the populations and scope of these reports vary considerably, the following generalisations can be drawn.

Most falls occur at home (around half of falls requiring hospitalisation [17, 33] and up to three-quarters of all falls[1]). Around two-thirds of these falls occur inside, in areas such as living rooms, hallways and bedrooms. Relatively few falls actually occur in bathrooms, stairs or from ladders and stools[6]. The remaining one-third of home-based falls occur in the yard or driveway[1].

Falls in residential aged care facilities account for a further 23% of falls requiring hospitalisation[33]. Another 2% occur in health facilities such as hospitals[33]. Clinical incident management analyses published by the NSW Clinical Excellence Commission (CEC) determined that falls are the most frequently identified incidents within the NSW public health system, and equal-third highest cause of death from such incidents[34].

It should be acknowledged that significant investments have been made over the last decade to increase the reporting of falls incidents within NSW Health facilities, notably through two major policy initiatives[13, 26]. This may have had an effect on the relative rank of identified falls within other hospital data. Nonetheless, the data clearly indicate that this is a high priority for action within the NSW public health system.

The remaining falls occur in a range of community settings, most commonly footpaths, followed by various service areas, open spaces and inside public buildings[1].

The location of fall varies considerably by age, gender and health issues such as frailty. For example, the older you are, the more likely a fall is to occur at home. Females are more likely to fall inside the home than males, and more older men fall in the yard. Put simply, the location of falls is associated with where people spend the majority of their time[6].

The Risk Factors for Falls

Risk factors for falls are varied and complex. A recent, large NSW study found that the following factors had the strongest correlation to falls risk[18]:

- Having fallen in the past 12 months
- Being aged 85 years or over
- Having one or more relevant medical conditions including cataracts, musculoskeletal system and connective tissue disorders, and major diseases of the circulatory, respiratory and nervous systems
- Using four or more medications
- Requiring a mobility aid
- Being overweight
- The risk of multiple falls was highest for individuals aged 85+ years and those who experienced circulatory diseases, used four or more medications and used mobility aids.

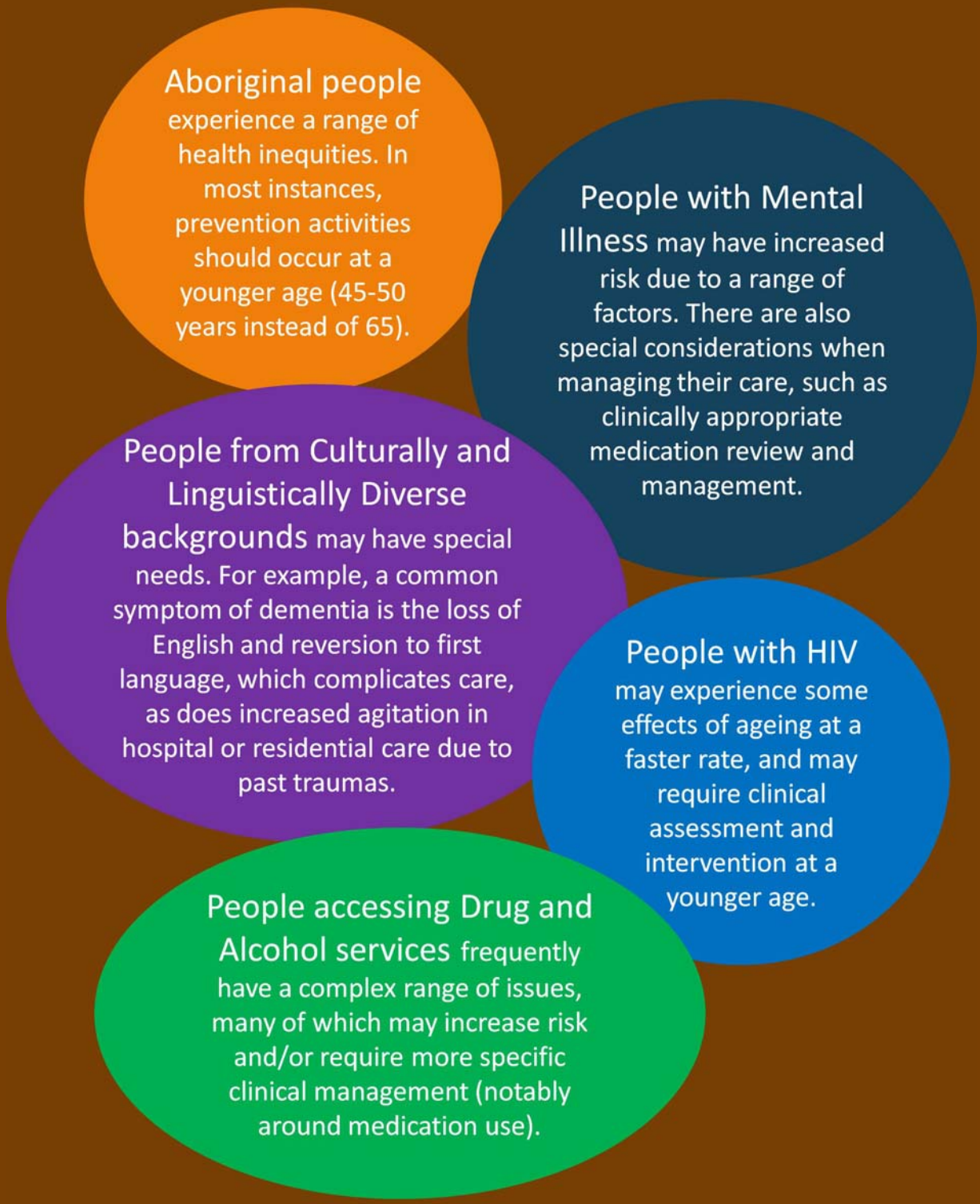
Additional factors related to the individual include having poor balance, reduced mobility, confusion, dementia, poor vision, incontinence and poor general health and/or disabilities. People with certain health issues experience heightened risks for a range of complex reasons. Additional environmental factors include poor lighting, clutter, changing flooring levels with no contrast, loose carpets, slippery floors and uneven foot paths. These are just some of the many complex factors associated with falls and injuries from falls, the consequences of which will vary from person to person, and which are frequently inter-related (eg poor vision and uneven footpaths may combine to present substantial risk)[35].

Key Points

1. **Falls injury prevention is an extremely complex issue, with multiple considerations that will vary from one individual to the next.**
2. **Despite the complexity, falls are not an inevitable result of ageing: many risk factors are modifiable.**
3. **The complex mix of interventions required to address a health outcome with multiple factors (rather than directly modifying just one behaviour) requires a long-term, strategic approach. It has been recognised that results may take time to become measurably apparent, and prevention will require a long-term vision and sustained commitment[8-10].**

Understanding the Needs of Special Groups

There are many groups in our communities who have particular needs that must be taken into account when planning prevention activities. The following are examples only, and many other issues may require appropriate attention both at the community and individual clinical levels.



A Strategic Context for Planning

Injuries from falls prevention is an issue of substantial concern and is a high priority for preventive action. This plan has been developed with appropriate reference to a number of key documents.

Policies and Plans

- *Population Health Priorities for NSW: 2012–2017*[36]
- NSW Health Policy Directive PD2011_029: *Prevention of Falls and Harm from Falls among Older People: 2011-2015*[13].

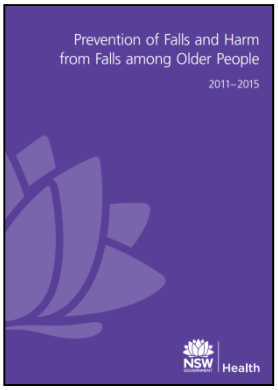
Quality Standards (Accreditation)

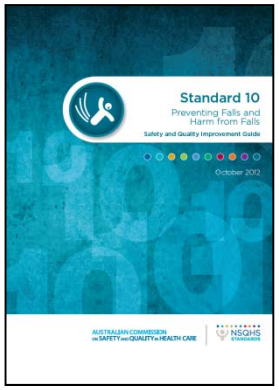
- *Safety and Quality Improvement Guide Standard 10: Preventing Falls and Harm from Falls*, released by the Australian Commission on Safety and Quality in Health Care (ACSQHC) in October 2012[14].
- The *Aged Care Act 1997* and subsequent associated legislation such as the *2011 Accreditation Grant Principles* that apply to residential aged care facilities.

Best practice guidelines produced by ACSQHC

- *Best Practice Guidelines for Preventing Falls and Harm from Falls in Community Care*[8]
- *Best Practice Guidelines for Preventing Falls and Harm from Falls in Hospitals*[10]
- *Best Practice Guidelines for Preventing Falls and Harm from Falls in Residential Aged Care Facilities*[9]

The Clinical Excellence Commission (CEC) provides strategic and clinical support, and oversees the NSW Falls Prevention program. The CEC has been closely involved in the implementation of the NSW Health policy and has advised on the development of this plan.





Action Areas from the NSW Falls Policy

1. Provide, or arrange for, screening, assessment and management of falls risk factors among older people presenting to NSW Health services following a fall, or at high risk of falls, in accordance with best practice guidelines.
2. Minimise the risk of falls occurring within NSW Health facilities, and minimise the risk of injury should a fall occur, by implementing the recommendations from best practice guidelines for falls prevention.
3. Implement best practice in management of falls risk for older people residing in NSW Health residential aged care services (such as multi-purpose services and State Government Residential Aged Care Facilities).
4. Support provision of appropriate exercise programs for older people at risk of falls and promote uptake of these programs.
5. Provide older people and their families and carers with information about action they can take to reduce the risk of falls and injury from falls.
6. Support healthy, active ageing by continuing support for healthy lifestyles and for effective management of chronic disease.
7. Consider and respond to specific information and service needs of special groups within the population, including Aboriginal people, people from Culturally and Linguistically Diverse backgrounds, people experiencing socio-economic disadvantage, people living in remote areas, people with cognitive impairment, people with a disability, and people living in residential aged care facilities.
8. Identify opportunities to promote best practice in falls prevention within external organisations and external providers of health and aged care.
9. Support the conduct and dissemination of research to advance falls prevention policy and practice.

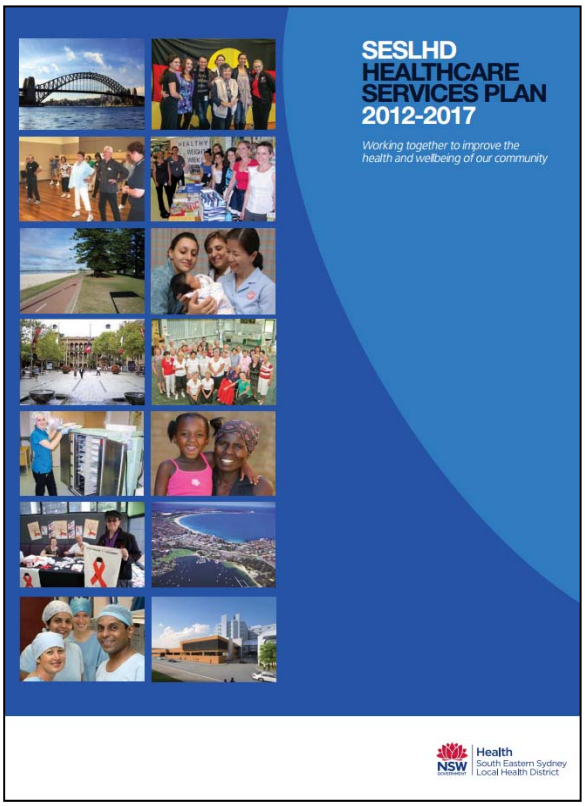
Relevance to key SESLHD Plans

The South Eastern Sydney LHD Strategy 2012-2017 outlines the vision, values, purpose, principles for decision making, our priorities and desired outcomes for our organisation and services over the next five years. The Strategy directly refers to falls injury prevention in terms of the stated outcome goals for:

Area of Focus 1: Communities and Patients
Reduced potentially avoidable physical or mental health conditions and events, including falls, attempted suicides, cancer and diabetes complications and vaccine-preventable diseases.

Area of Focus 3: Clinical Networks and Services
Compliance with national standards for high quality and safe health care, with reduced infections, medication errors and falls in hospital.

The SESLHD Healthcare Services Plan 2012-2017 provides the direction for the development of our services and programs to ensure they remain focused on addressing the health needs of the community. It is forward looking, laying the foundation for sustainable health care. This falls injury prevention plan will notably contribute to the following:



1.2.c Involve older people as health care partners and encourage their ongoing input into health care and service delivery that is appropriate to the needs of the aged.

1.2.i Develop, implement and evaluate a SESLHD Falls Prevention Plan to reduce the rates of falls in SESLHD facilities; improve patient awareness of the relevant risks and how to prevent their occurrence; and build the capacity of SESLHD staff to support falls prevention.

1.3.c Reduce the incidence, morbidity and mortality associated with falls in SESLHD residents through partnerships with community groups offering a range of health promotion initiatives including home based strength/balance courses; vision assessments; and peer education.

1.3.g Establish a cross-sector healthy built environment alliance that provides leadership and action for healthier, more liveable communities by creating opportunities for people to engage in active lifestyles (e.g. improving walkability of suburbs, safety, access to outdoor free gym equipment etc).

Broader Strategic Considerations

Discussion of "older people" in this document has thus far referred to those aged 65+. This group has the highest risks, most substantial burden of illness, and is the focus of most research and policies. Plans need to define a reasonable scope in order to allocate resources most effectively and responsibly.

However, a broader strategic vision is worthy of discussion. One of the best primary prevention strategies for injuries from falls is appropriate physical activity, particularly that which improves balance[5]. It would be short-sighted to start such exercise at 65; it is likely (though harder to prove) that appropriate exercise at a younger age will have a protective effect later in life[19]. Physical activity is also an important part of a healthy lifestyle, with a wider range of physical and mental health benefits across all ages [37-40].

When, then, should falls injury prevention begin? How far back should we extend the scope of activity? A recent white paper for the prevention of osteoporosis emphasised the importance of a whole-of life approach, with particular focus on adequate calcium intake, Vitamin D levels and appropriate physical activity across all ages[41]. Whilst there are immediate issues to be addressed in the older population, investments must also be made with the long-term goal of generating a lower-risk future population.

To add to the complexity of planning, there is also a need to consider the risk of falls injury across a range of populations and settings, many of which are the focus of separate SESLHD plans (Figure 8). In the management of complex health needs, increased falls risk and incidents can be a significant issue with substantial clinical implications. Other settings may present an opportunity for early intervention within the context of other clinical care.

Therefore this plan cannot be written in strategic isolation. It must sit within a wider scope. Two levels of action are proposed:

1. **This plan will describe the most immediate, directly relevant and evidence-based actions for falls injury prevention, and**
2. **There will be a broader strategic undertaking to incorporate relevant falls injury prevention actions across SESLHD planning and service delivery.** *(as per Figure 8 – see planning tables later in this document for specific actions to achieve this).*

SESLHD Plans

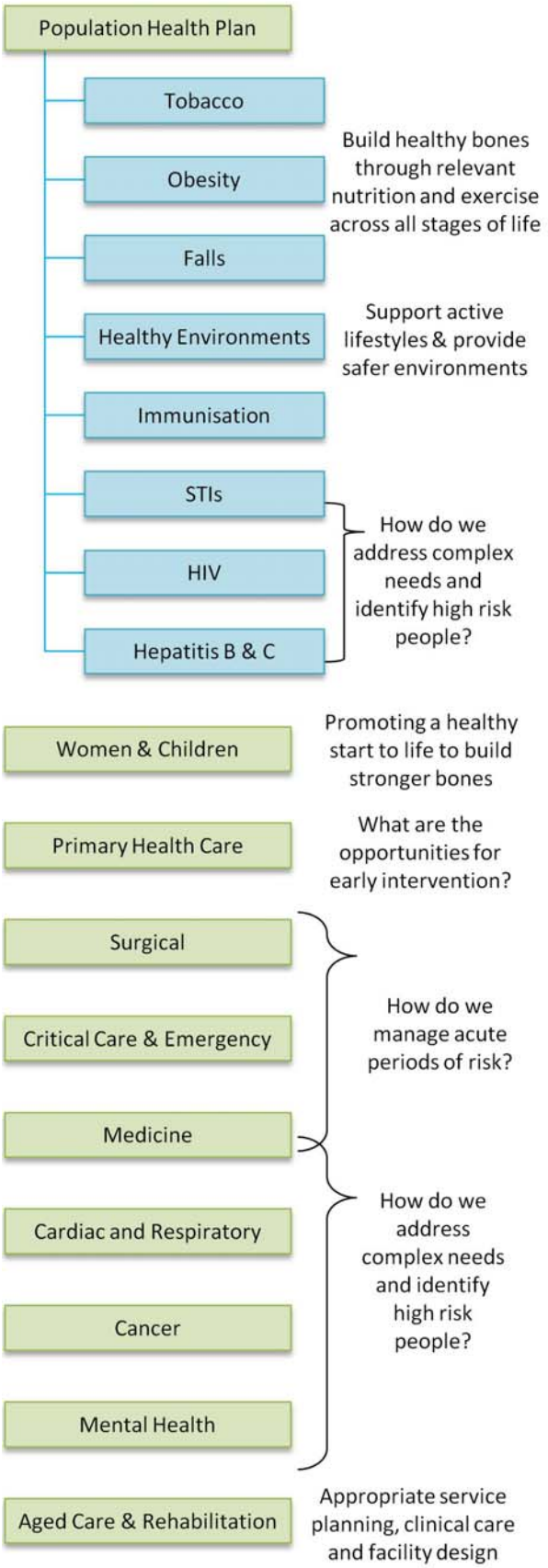


Figure 8: Broader Strategic Considerations Across SESLHD Planning

A Consumer Representative's Story

Jan Denniss is a dedicated member of the district's Consumer Advisory Group. She has been a volunteer at St George Hospital in varying capacities for more than 13 years, and despite her contribution to a number of committees as a Consumer Representative, still finds time to volunteer at the St George Hospital Medical Library, which is a good way to keep in touch with a variety of people in the hospital setting.

Jan volunteered to be the Consumer Representative for the SESLHD Health Services Falls Prevention Advisory Committee as she felt she could contribute ideas for the prevention of falls in hospitals, having had experience as a volunteer in the Falls Prevention Volunteer Program at St George Hospital and previously having been on the St George Hospital Falls Prevention and Management Committee.

The role of a Consumer Representative is very worthwhile and rewarding and an important way to give a more human face to a patient's perspective. Jan says that she is treated as a valued member of the committee and that as a consumer, her views are listened to and appreciates that she is "allowed to ask anything, say what she wants to say and is given honest answers."

Jan particularly valued the district wide representation on the committee, where ideas and actions from over all the LHD were shared. It also gave her a greater appreciation of the difficulties faced in changing practices, the budgetary and workforce constraints that prevent change and that there are no easy answers to falls prevention.

Some of her ideas for falls injury prevention include increasing the number of Lo Lo beds on aged care wards, so that the impact of a fall from bed is reduced, and she would also like to see a NSW wide Volunteer Falls Prevention Program to provide a workforce of trained volunteers to help supervise and observe high risk falls patients in hospitals.

The District is fortunate to have committed people like Jan who give of their time to promote the consumer's cause and give us a better understanding of their needs. Working together with people like Jan will allow us to improve the planning and delivery of healthcare services to the community.

The Inaugural SESLHD Health Facilities Falls Prevention Advisory Committee, June 2012

Prevention in Community Settings

What the Evidence Says

Evidence Specific to Older People

A large number of research trials and reviews have been published regarding falls prevention for people living in the community, including a number Cochrane Collaboration reviews[3, 5, 42, 43]. Community-based actions supported by the evidence are as follows.

Physical Activity

Physical activity can improve strength and balance, reduce falls and reduce fractures due to falls[5]. Exercises that specifically challenge balance, undertaken either in a group program or home-based program are most effective[19]. This includes group-based exercise such as Tai Chi [44], other group-based balance and strengthening exercise programs[45] and home-based exercise programs such as the Otago Exercise Program, which is taught by health professionals during home visits and is particularly suitable for people aged 80 years and over[46]. In any format, exercise should be undertaken for a minimum of 2 hours per week, becoming a routine part of life[19].

Many other forms of exercise, from dance to lawn bowls, may also be advantageous but their contribution to the prevention of falls and injuries from falls is not understood. In the absence of direct research, the criteria described by the reviewers is an appropriate means by which to judge the suitability of activities, notably the inclusion of exercises that specifically challenge balance[19]. The most recent Cochrane review of interventions for people living in the community also noted the importance of variety, with programs containing two or more categories of exercise shown to be effective[5].

The usefulness of walking as an exercise to reduce falls has recently been debated. According to the published literature, walking does not appear to prevent falls, and may even present some risks compared to more carefully controlled group exercise programs[19]. However the research issues are complex, and walking has many broader benefits[38-40]. Walking is therefore not excluded as an exercise activity in the context of falls injury prevention, but walking alone is insufficient, should be undertaken in combination with (and not detracting from) appropriate balance training, and should include a mechanism through which to assess suitability to individual patient risks[19].

Multifactorial interventions

Multifactorial interventions involve assessment of the specific risks of an individual followed by a set of individually tailored interventions. This reflects the wide range of potential risk factors described earlier, and reduces the rate of falls, though the research is predictably complex with some mixed outcomes[5]. Nonetheless the multifactorial approach is widely recommended[8-10, 13, 21]. The highest risk people typically receive these interventions in an outpatient or community clinic setting, delivered by a multidisciplinary team of health professionals[23, 24]. People with moderate to lower risk can benefit from lower intensity care models delivered through primary and community health settings such as General Practitioners [20-22].

Home Safety Assessment and Modification

Given the high proportion of falls that occur in the home[1, 17], home safety interventions are an appropriate consideration. Whilst high-level evidence in this area is lacking and often confounded by the multifactorial nature of interventions delivered in this setting[43], strategies including home safety assessment and subsequent modification have been shown to be effective, particularly for people in high risk groups, and when delivered by an Occupational Therapist[5].

Tailored Interventions Targeting Specific Risks

Vitamin D supplementation. It is estimated that 46% of women and 22% of men over 65 years have Vitamin D insufficiency[47]. Vitamin D affects bone and muscle health[48], and Vitamin D supplementation can reduce falls by up to 43% in people with an insufficiency[5, 47]. It is important to medically determine this insufficiency to target the intervention appropriately.

Medication Review and Management. The use of four of more medications is a risk factor for falls[18] but interventions that aim to reduce the number prescribed do not necessarily reduce falls nor injuries from falls. The best evidence relates to the withdrawal of specific types of medication, such as psychotropic drugs[5]. Educational programs for general practitioners

have been effective[49]. It must be noted however that there are potential consequences of the withdrawal of certain medications, particularly but not limited to those with mental illness. This must be carefully managed through appropriate consultation and collaboration between specialist medical and pharmacist teams.

Vision. Expedited cataract surgery for the first eye (4 weeks versus 12 month waiting times) has been shown to be effective[50] though not similarly so for the second eye[51]. Some research trials to improve vision have had a negative result, with an increase in falls observed after interventions such as the provision of new prescription glasses[52]. This does not preclude the importance of vision assessment and correction in older people, but they may require time to adjust to new prescription glasses and may be at increased risk during this period. The use of multifocal prescription glasses, which impair depth perception and edge-contrast sensitivity, more than doubles falls risk[53].

Additional Specific Medical Interventions. Cardiac pacing in fallers with cardioinhibitory carotid sinus hypersensitivity and multifaceted podiatry interventions for people with disabling foot pain have all been shown to reduce falls risk[5].

What About Awareness Campaigns?

There is no evidence that community education alone has had any effect[5, 21]. Many older people self-exclude from falls injury prevention messages, deeming them irrelevant based on a false perception of their own risk[54]. Furthermore given the potential consequences of a fear of falling, information must be delivered with great care to avoid doing harm. Large scale awareness campaigns are rarely undertaken for falls injury prevention, though they may be considered for broader (and more positive) issues such as healthy and active ageing. There also may be value in including educational components in multifactorial interventions, where information can be directly and personally targeted, and delivered appropriately[5, 21].

Specialist Falls Injury Prevention Programs

Specialist programs that combine evidence-based strategies for falls injury prevention are particularly useful for targeted secondary prevention (ie for people with identified risks). The *Stepping On* program is being implemented across NSW with special funding through the NSW Ministry of Health (see a more detailed description later in this document).

Figure 9: Graduates of the Stepping On program

Osteoporosis and Low Trauma Fractures

Osteoporosis is a condition in which bones become fragile and more likely to fracture, due to the loss of minerals such as calcium at a rate faster than the body can replenish them, and subsequent loss of bone density or mass. Over 1.2 million Australians have osteoporosis, with a further 6.3 million with bone density in the range between normal (healthy) and osteoporosis (known as osteopenia)[41]. Despite this, the condition is poorly recognised and diagnosed, often only when a low trauma fracture occurs (such as a fall from standing height)[55]. The ACSQHC guidelines[10] and a recently-published Australian review of osteoporosis management[41] cite strong evidence to support offering appropriate treatment to people with diagnosed osteoporosis or a history of low-trauma fracture.

Appropriate models of care include coordinated, intensive models of care for secondary fracture prevention[56], such as Minimum Trauma Fracture Clinics, Osteoporosis Fracture/Re-fracture Prevention Services. There are many factors to consider, including the broad recommendations for calcium, vitamin D and physical activity, as well as more specific clinical issues such as various clinical assessment (eg bone mineral density testing). A number of clinical services have been trialled and adopted throughout NSW in recent years, including some within SESLHD, but not with coverage across the whole District. Appropriate service planning to meet the needs of all SESLHD residents requires consideration.

Whole of Life Strategies

As described earlier, the prevention of injuries from falls in older people should also include consideration of the whole life span. Improving bone health to reduce the chance of a fracture later in life is one such example of building a more resilient future population, by reducing a range of chronic diseases and frailty that increase the risk of falls and injuries from falls.

Early in 2013, the Medical Journal of Australia published a special supplement: *Building healthy bones throughout life – An evidence-informed strategy to prevent osteoporosis in Australia*[41]. Three key priorities were highlighted: nutrition (notably adequate calcium intake), vitamin D levels and appropriate physical activity. For example, 82-89% of Australian girls aged 12-16 years and 44% of Australian boys aged 12-16 years do not meet the recommended guidelines for calcium intake[57]. From the benefits of breastfeeding through to bone health testing later in life, a range of strategies to promote a lasting healthy lifestyle were described, many of which have benefits far greater than injury prevention alone. To the extent that it is practical, appropriate actions are included in this plan. But as discussed earlier, these are broader strategic issues that deserve and require consideration at a wider level across SESLHD. To that end, actions are also described to influence that process.

Creating an Environment that Supports Active Living

In the NSW Falls Prevention Baseline Survey, more than 4 out of 5 older people who were not doing enough physical activity expressed a desire to do so in the future[1]. The efficacy of evidence-based, group exercise programs has already been established. But regardless of the evidence, many older people may simply not wish to join a structured group program. If a population-wide reduction in the falls injury is to be achieved, one size will not fit all. Planning must include a range of options to meet different needs and interests, particularly as life-long exercise habits are recommended and required for maximum benefit[19].

The role of the built environment in promoting and supporting healthy lifestyles, including self-directed physical activity, is being increasingly recognised as an important priority for population health[58] and specifically for healthy ageing[59]. This includes urban planning to improve the local environment, from the provision of physical activity amenities and safe, appropriate and appealing parks and public spaces to practical risk reduction such as footpath maintenance and hazard reduction. The built environment plays an important role in facilitating healthy and active ageing and maintaining confidence in older people[60, 61].

Cross-sectoral partnerships, particularly with local governments, are vital to this undertaking. Locally, SESLHD has committed to develop a specific plan on Healthy Environments, in partnerships with a range of key stakeholders.

The Cost-Effectiveness of Interventions

In 2010, an economic evaluation of falls injury prevention strategies in NSW described the cost-effectiveness of interventions for community dwelling older people[7]. Tai Chi and group-based exercise were recognised as being cost-effective, as were home hazard assessment, expedited cataract surgery and psychotropic medication withdrawal, though the latter three findings are specific only to certain high-risk patient populations.

As always, a myriad of factors must be considered when interpreting these results, including practical issues such as the reach and cost-per-participant of interventions such as exercise groups, which can vary greatly, and clinical factors such as local waiting times for procedures such as expedited cataract surgery (as noted earlier, the original evidence refers to 4 weeks versus 12 month waiting times). Practical application notwithstanding, the economic evaluation suggests that there is a sound economic case to be made for the implementation of these strategies in SESLHD.

A Strategic View of Prevention

Figure 10 and Figure 11 provide an overview of the broad range of actions that can and should be taken to prevent injuries from falls later in life. These include whole-of-life actions to build healthy bones (Figure 10) as well as the specific, evidence-based interventions which more directly target older people (Figure 11). It is important to balance approaches to generate a low risk future population with the more immediate concerns, and manage resources appropriately across this whole continuum.

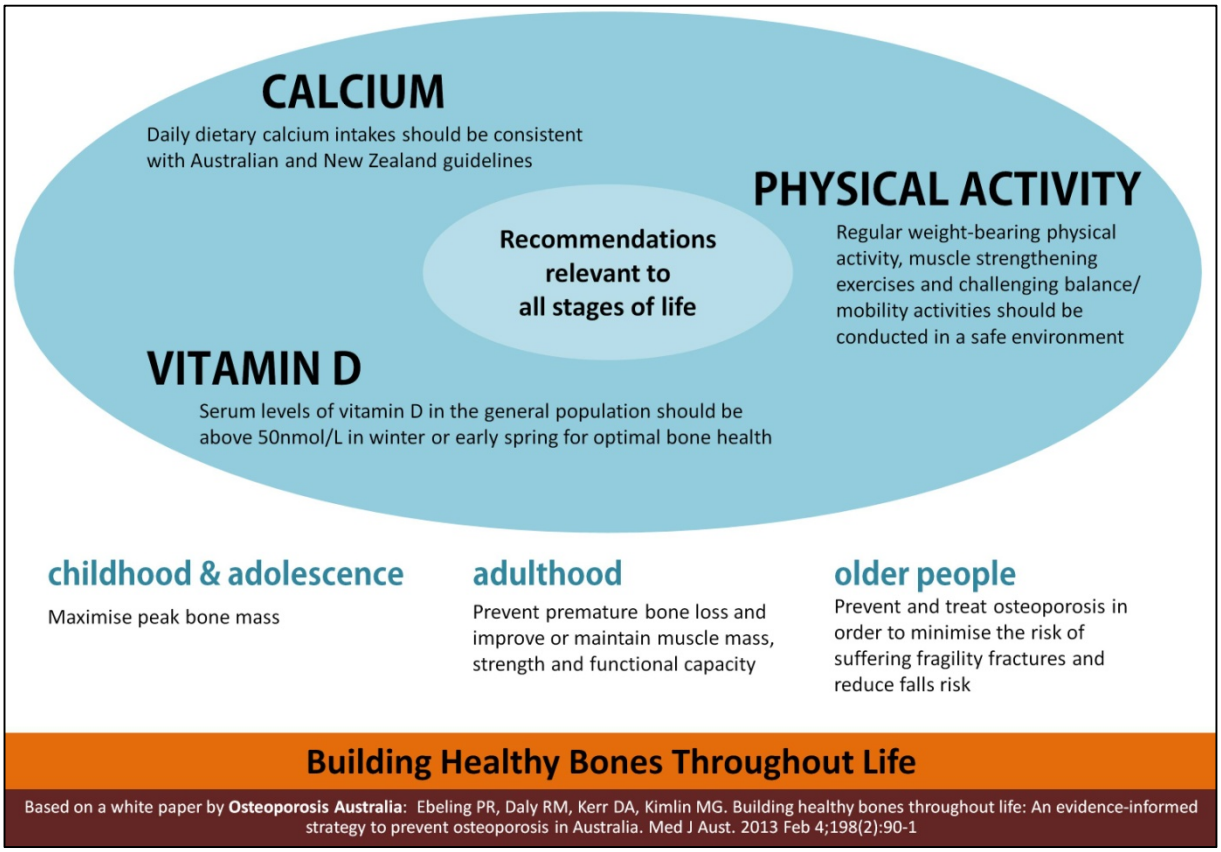


Figure 10: A Whole-of-Life Approach to Building Healthy Bones

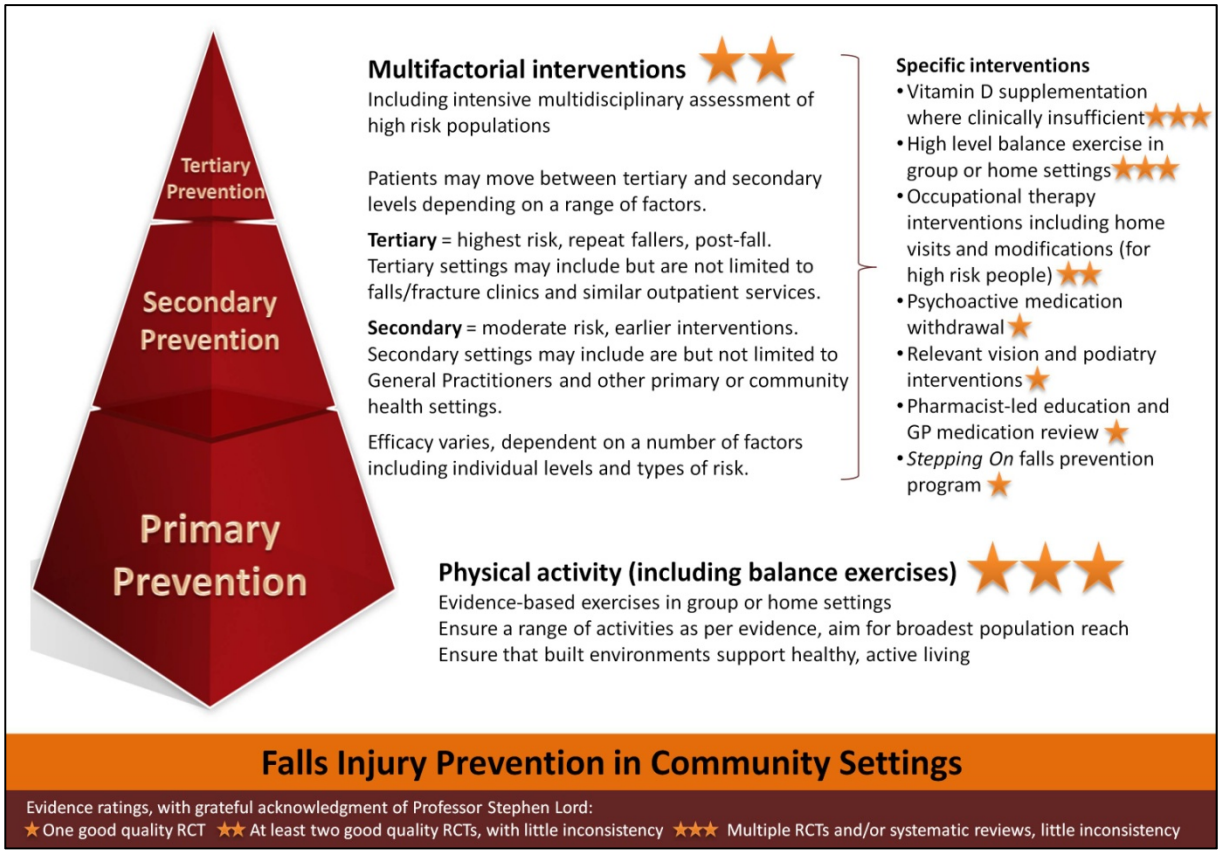


Figure 11: Specific, Evidence-Based Interventions for Older People

Current Activity and Gaps in SESLHD

The consultation process for this section of the plan included discussions with the Planning and Population Health Directorate, the Ambulatory and Primary Health Care Directorate and a range of clinical, community, allied and rehabilitation health services (See Appendix B). Aboriginal Health and Multicultural Health personnel provided insights to the needs of their populations and will aid the facilitation of appropriate community consultation and engagement in the future. Representatives of Medicare Locals, local governments, fitness industry providers, various community and aged services and the Ambulance Service of NSW also provided input.

The consultation process culminated in a collaborative round table and planning workshop held in May 2013. Representatives of these and other groups provided valuable input to the development of this plan, at this workshop and through the subsequent circulation of plan drafts. Please refer to Appendix B for more details.

Round table discussions at the Community Workshop

Whole-of-life strategies at the population level present a myriad of challenges, from resources to reach. The current focus across NSW is childhood. The *NSW Healthy Children Initiative* (HCI) is working in settings that engage children 0-18 years and encourage and support their families to adopt healthy lifestyles. Healthy weight, healthy eating, physical activity and breastfeeding and reducing sedentary behaviours are all recommended to maximise peak bone mass during childhood and adolescence, with potential to reduce future falls risk[41].

HCI programs implemented in SESLHD by the Health Promotion Service include:

- *Munch and Move* (early childhood sector).
- *Live Life Well @ School* (a "whole of school" approach within primary schools).
- *Go 4 Fun* (an after-school healthy lifestyle program for children aged 7-13 years who are above their ideal weight).

The Royal Hospital for Women, Sydney Children's Hospital and midwifery and paediatric services in St George and Sutherland Hospitals also play a key role in promoting breast feeding and healthy nutrition and physical activity for children and families.

A state-wide plan for nutrition and physical activity is currently in development (*Healthy Eating and Active Living*). This will guide the future development of interventions that will contribute to the whole-of-life issues and goals promoted in this plan, including a focus on adults.

Substantial investments have also been made in programs targeting falls injury prevention in older people more specifically. An important aspect of this plan is to identify, consolidate and build upon these investments. They include but are not limited to:

- A wide range of exercise programs is available. *SHARE* is a not-for-profit organisation that coordinates physical activity opportunities for older adults in SESLHD and Sydney South West LHD. *AIM for Fitness* (Active, Involved, Mature) is a community based education and exercise program for people aged 60 and over. Eastern Sydney Medicare Local and Sutherland Shire Council provide an evidence-based GP exercise referral scheme. Many other programs are also available, such as *Strengthening for Over 60s*. Activity providers include the private sector, NGOs and local governments.
- The availability of exercise programs across the District has been strategically mapped at various times by the Health Promotion team. Service Directories have been previously produced, but are not seen as a sustainable model for the future. The focus has appropriately shifted to encouraging providers to list their activities on the Active and Healthy website, a State-wide, publically-accessible database. The site is maintained by the NSW Falls Prevention Program.
- SESLHD directs NSW Ministry of Health funding for the coordination of *Stepping On*, an evidence-based program that provides group exercise,

education and individualised follow-up at the secondary prevention level[62] (as described earlier).
- A home-based exercise program (*BEST at Home*) has been piloted in a number of settings. Based on the Otago program described earlier, pilot delivery has included CALD communities of Chinese and Spanish speaking older people.
- Partnerships have been established with key stakeholders including Rockdale City Council and the South Eastern Sydney Medicare Local to increase physical activity through built environment strategies.
- The NSW *Get Healthy Information and Coaching Service* (for healthy weight) is promoted locally.
- Some SESLHD outpatient and community health facilities provide exercise opportunities as part of community care, discharge planning or rehabilitation. Home-based exercise programs have also been developed locally.

Strategic gaps were also identified, for future focus. In the area of physical activity:

- Better connectivity and communication across key stakeholders will strengthen strategic vision and planning. Organisational restructures have created significant challenges in this area. But there is great potential and explicitly expressed willingness to improve coordination in the future.
- Whilst efforts have been made to map and promote the availability of appropriate activities, a recognised communication gap between clinical, community health and community providers hinders the potential for direct referral into programs. At the same time that potential referrers (eg clinical staff) commented on a perceived lack of opportunities, activity providers were simultaneously reporting difficulties in generating adequate numbers for their groups. Improved connectivity, communication and shared planning can address these issues.
- There is a need for more directly relevant services for Aboriginal people and CALD communities.
- The importance of built environment strategies was highlighted as a priority for future planning, so that there is a broader scope than just groups.

Multifactorial interventions were strongly supported both by evidence and local stakeholders. At the primary health care level, General Practitioners and community-based service providers are well placed to delivered such interventions. The Ambulance Service of NSW expressed interest in expanding their preventive actions. There is already an abundance of Australian literature describing clinical protocols, tools and resources for multifactorial interventions[8, 20, 22, 63-65]. The strategic gaps related to local issues.

- A more coordinated approach is required to engage providers and support interventions.
- An immediate priority is clarification of post-assessment referral pathway options across the prevention continuum and across the LHD.
- There is a significant opportunity to intervene with older people who have experienced a “near miss” or relatively minor incident, such as those attended by Ambulance Service of NSW (but are not transported to hospital) and those who attend Emergency Departments due to a fall (but do not require admission). Routine and systematic assessment and referral should be a priority.
- All SESLHD hospitals routinely assess the falls risk of all people aged 65+. This also represents an opportunity to proactively direct appropriate patients into prevention programs after discharge.
- A number of tertiary fall and minimum trauma fracture clinics exist in SESLHD outpatient services. These receive referrals both through the community sector and hospital discharge processes. Appropriate linkages across the scope of this plan are required (see later discussion).

The Scope of Future Actions

The scope of actions described in this plan will vary, depending on intent.

- A strong focus on healthy childhoods will continue at the population level, through the HCI program.
- Physical activity strategies for older people will be broadly targeted at people aged 50 and over. This strikes a balance between earlier intervention yet ensuring that activities will be directly relevant, appealing and useful to older people, and based upon falls injury prevention evidence.
- Multifactorial interventions will also broadly targeted at people aged 50 and over. It would be neither feasible nor evidence-based to require this across the whole population. However clinical judgement must apply; intervention at a younger age may be appropriate in many instances.

Within this scope, flexibility is encouraged as required.

STEPPING ON

Stepping On offers older people a way of reducing falls and increasing self confidence in situations where they are at risk of falling. This secondary prevention program targets people who have been identified as being at risk of falls and injuries from falls.

Over 7 weeks of group sessions, the program addresses falls risks, strength and balance exercises, home hazards, footwear, vision and falls, safety in public places, community mobility, coping after a fall, and understanding how to initiate a medication review. Participants are also linked to other relevant community-based services as needed.

A randomised controlled trial of Stepping On found a 31% reduction in falls in the intervention group. NSW Health has subsequently funded an ongoing state-wide rollout of the program.

In SESLHD, Stepping On has been delivered in a range of settings throughout the District, and has included programs for specific CALD communities including Arabic, Macedonian and Cantonese.

iPREFER

intervention to PREvent Falls after Emergency Response

iPREFER is a current research project funded through the NSW Health Promotion Demonstration Grants Scheme.

The randomised controlled trial is examining a new model of care to safely assess, intervene and prevent further falls and fall related injury in older people who call an ambulance as a result of a fall but are not subsequently conveyed to hospital.

The project will contribute to knowledge about models of care that can safely prevent further falls and fall related injury in older people, and is an example of the strong research culture within SESLHD and partnerships to achieve our goals. The research team includes representatives from:

Neuroscience Research Australia

Ambulance Service of NSW

The George Institute for International Health

The University of Sydney

Aged Care and Post Acute Care Services, Prince of Wales Hospital, SESLHD

What We Will Do in Community Settings

Principles

We will:

- Take an evidence-based approach to the selection of priorities and the development and implementation of interventions.
- Recognise, consolidate and strategically build upon the work that has already been done in the District, such as delivering exercise programs and supporting the development of healthy built environments.
- Create linkages to broader whole-of-life and healthy ageing strategies to build a resilient future population.
- Ensure essential linkages to prevention activities in SESLHD facilities including our hospitals and community health facilities.

Priorities

We will provide appropriate governance and ensure the engagement of key stakeholders across the District.

C1. Ensure that there is an appropriate governance structure to support strategic and collaborative plan delivery.

We will advocate for relevant, whole-of-life strategies across the District to build a more resilient future population.

C2. Advocate for and support District-wide planning for whole-of-life strategies such as calcium intake, Vitamin D and physical activity, early intervention, and appropriate service planning to reduce injuries from falls.

We will increase physical activity, through both organised groups and healthy built environments.

C3. Identify, consolidate and promote the existing range of opportunities for appropriate physical activity.

C4. Identify gaps in access to opportunities for physical activity and take a strategic approach to address these.

C5. Build the capacity of activity providers to deliver appropriate, effective and sustainable activities.

C6. Develop strategies to improve the built environment, to support active and healthy ageing.

C7. Promote physical activity to key stakeholders and the community in the broader context of healthy ageing.

We will deliver evidence-based, multifactorial Interventions (assessment and tailored strategies).

C8. Develop a strategic approach to increase the scope and quality of multifactorial interventions (involving falls risk assessment and subsequent tailored risk-reduction strategies).

C9. Build the capacity of relevant service providers to implement evidence-based multifactorial interventions in a wide-reaching, sustainable manner.

Partners

Partners in this plan will include but are not limited to the following.

Within SESLHD:

- Planning and Population Health Directorate, notably the SESLHD Falls Prevention Program Coordinator and the Health Promotion Team
- Ambulatory and Primary Health Care Directorate, notably including Aboriginal Health and Multicultural Health
- A range of clinical, community, allied and rehabilitation health services
- Prevention programs in SESLHD health care facilities (as per other section of this plan – to create better linkages and increase referrals)

External Partners:

- Medicare Locals
- Primary health practitioners, including General Practitioners and Practice Nurses
- Local Governments, particularly those with the highest rate of falls (eg Rockdale)
- Physical activity coordinators and providers, including but not limited to *SHARE, AIM for Fitness, Strengthening for Over 60s, Stepping On*
- The NSW Falls Prevention Program (CEC)
- Centre for Population Health (NSW Health)
- Community stakeholders including Carers groups

Implementation

The following detailed implementation plan maps specific actions against the priorities listed previously (C1-C9). It should be noted that these actions are subject to resources. Prioritising the allocation of those resources should follow the evidence described in this plan (notably Figure 8).

Table 4: Implementing the Plan: Community Settings

C1. Ensure that there is an appropriate governance structure to support strategic and collaborative plan delivery.		
How	**When**	**Whom**
C1.1. Identify stakeholders and form an appropriate **District Steering Committee for Falls Injury Prevention in Community Settings** to oversee implementation of this plan. This may include but is not limited to: SESLHD Planning and Population Health Directorate, Ambulatory and Primary Health Care Directorate, relevant clinical, community and rehabilitation services, SHARE, Medicare Locals, local governments, fitness industry providers, Ambulance Service of NSW and relevant community and aged services.	Establish in Year 1, continuing in Years 2,3,4,5	Planning and Population Health Directorate
C1.2. Develop additional communication strategies to engage and collaborate more widely with relevant stakeholders across the community setting.	Establish in Year 1, continuing in Years 2,3,4,5	District Steering Committee for Falls Injury Prevention in Community Settings
C1.3. Ensure the consistency of actions described in this plan with the appropriate evidence and key publications such as *Best Practice Guidelines for Preventing Falls and Harm from Falls in Community Care*[8]	Years 1,2,3,4,5	District Steering Committee for Falls Injury Prevention in Community Settings
C1.4. Develop appropriate indicators for this plan, and a process and schedule for reporting results to the SESLHD Executive and any relevant external stakeholders.	Establish in Year 1, continuing in Years 2,3,4,5	District Steering Committee for Falls Injury Prevention in Community Settings

C2. Advocate for and support District-wide planning for and commitment to broader, whole-of-life strategies and appropriate service planning that are conducive to falls injury prevention.		
How	**When**	**Whom**
C2.1. Ensure that falls injury prevention (notably physical activity strategies) is not undertaken in strategic isolation. Advocate for the appropriate inclusion of falls injury prevention strategies across the relevant scope of SESLHD plans and initiatives, and appropriate cross-linkages to this plan and the partners and key stakeholders engaged in its delivery. Include consideration of, but not limited to: • Whole-of-life population health and health promotion strategies, such as relevant physical activity and nutrition strategies within Population Health Plans addressing Obesity and Healthy Environments, and Women and Children's Services. • Inclusion of an appropriate matrix of actions across a range of services – eg. efforts to improve childhood nutrition could occur through midwifery services, Healthy Children's Initiative (HCI) actions, community health settings, clinicians etc. • Appropriate actions to identify high risk individuals or populations and manage their falls risk appropriately, through plans such as the Population Health Plan, Drug and Alcohol Services, Mental Health Services and specific disease plans such as Cancer, Cardiac and Respiratory, Medicine and Chronic Care, where co-morbidities may include or increase falls injury risk. • Opportunities for early intervention to reduce falls injury risk, such as Primary Health Services. • Service plans with a large population of older people who may be at risk, such as Aged Care and Rehabilitation. • Any plans or investments relating to the design of facilities, to incorporate more appropriate designs and features to reduce falls. • Any plans or investments relating to the procurement of relevant equipment for facilities, notably hospitals, rehabilitation services and the residential aged care facility.	Years 1,2,3,4,5	District Steering Committee for Falls Injury Prevention in Community Settings Planning and Population Health Directorate to facilitate access and partnerships Support from Executive Sponsors NSW Falls Prevention Program (CEC)
C2.2. Continue to implement the HCI population health strategies focussed on healthy childhoods, ensuring that strategies are included that will have benefits for bone health. This includes: • *Munch and Move* • *Live Life Well @ School* • *Go 4 Fun*	Years 1,2,3,4,5	Planning and Population Health Directorate, notably Health Promotion, and relevant HCI program partners

C3. Identify, consolidate and promote the existing range of opportunities for appropriate physical activity.		
How	**When**	**Whom**
C3.1. Build appropriate linkages, partnerships and communication strategies between the key stakeholders in this area, to maximise outcomes, notably between activity providers and those who may refer people to them. This includes but is not limited to: • Planning and Population Health Directorate, notably the Health Promotion team • Activity providers including but not limited to SHARE, Stepping On, AIM for Fitness, Strengthening for Over 60s and other activity providers include the private sector, NGOs and local governments. • Potential referrers including but not limited to Medicare Locals, General Practitioners and Practice Nurses, SESLHD community, allied health and rehabilitation teams, hospital discharge planners and the Ambulance Service of NSW. • Community stakeholders including community members, carers groups, Aboriginal Health and communities, Multicultural Health and CALD communities. • Broader relevant partnerships with organisations such as (but not limited to) Osteoporosis Australia, Arthritis Australia/NSW, Exercise and Sports Science Australia. • Ensure linkages to existing partnerships and programs, such as the GP Exercise Referral Scheme run by Sutherland Shire Council and the South Eastern Sydney Medical Local.	Year 1, with ongoing maintenance thereafter	Planning and Population Health Directorate District Steering Committee for Falls Injury Prevention in Community Settings Key stakeholders as listed
C3.2. Identify the full scope of activities currently available across SESLHD. Ensure consideration of a range of activities, including organised groups and home based activities. With input from those health professionals who will ultimately be asked to refer people to them, determine the appropriateness of these activities in terms of training of the providers, safety and quality issues.	Year 1	Planning and Population Health Directorate Key stakeholders as per C4.1
C3.3. Consult with these activity providers to establish current practices, and local opportunities and barriers related to current and future service delivery.	Year 1	Planning and Population Health Directorate, notably the Health Promotion team Activity providers
C3.4. Consider the evidence for which activities are likely to be protective against falls and injuries from falls, and to which sub-populations different activities will be targeted.	Year 1, with ongoing maintenance thereafter	Planning and Population Health Directorate, notably the Health Promotion team Activity providers

C3.5. Proactively encourage all activity providers to register details on the Active and Healthy website. Provide support and ongoing skills as required to assist them in listing relevant programs.	Year 1, with ongoing maintenance thereafter	Planning and Population Health Directorate, notably the Health Promotion team Activity providers, potential referrers and other community stakeholders as above. NSW Falls Prevention Program (CEC)
C3.6. Develop future mechanisms to ensure that the Active and Healthy website is promoted to activity providers on a regular basis and that details are kept up to date. Include mechanisms to identify future new activities and new activity providers.	Year 1, with ongoing maintenance thereafter	Planning and Population Health Directorate, notably the Health Promotion team Activity providers, potential referrers and other community stakeholders as above. NSW Falls Prevention Program (CEC)
C3.7. Work with potential referrers (such as General Practitioners and community-based services) to identify and overcome any barriers to referral. Consider the needs of referrers such as clear pathways, timely and accurate information, access and a process for feedback.	Year 1,2,3,4,5	Planning and Population Health Directorate, notably the Health Promotion team Activity providers, potential referrers and other community stakeholders as above.
C3.8. Disseminate information on the availability of activities and use of the website to all potential referrers such as General Practitioners, health service staff and others with access and opportunity for brief assessment and referral strategies (see also C8, H9 & H10).	Year 1,2,3,4,5	Planning and Population Health Directorate, notably the Health Promotion team Activity providers, potential referrers and other community stakeholders as above.
C3.9. Develop a range of communication strategies to promote appropriate activities and specifically the Active and Healthy website directly to the community. Ensure all communication strategies are appropriate to the issues of falls injury prevention described earlier (notably fear of falling issues).	Year 1,2,3,4,5	Planning and Population Health Directorate, notably the Health Promotion team Activity providers, potential referrers and other community stakeholders as above. NSW Falls Prevention Program (CEC)
C3.10. Develop appropriate tailored communication strategies to appropriately reach special populations, including but not limited to Aboriginal people and those from CALD communities (notably people from non-English speaking backgrounds).	Year 1,2,3,4,5	Planning and Population Health Directorate, notably the Health Promotion team Activity providers, potential referrers and other community stakeholders as above.

C4. Identify gaps in access to opportunities for physical activity and take a strategic approach to address these.		
How	**When**	**Whom**
C4.1. Work with stakeholders including community members to identify gaps in access, including but not limited to: • Capacity for population reach • Geographic gaps, with particular consideration of local government areas with high rates of falls. • Aboriginal people • People from Culturally and Linguistically Diverse (CALD) backgrounds, with particular consideration of local government areas with large CALD populations. • Gaps in the types of activities available, to ensure the widest possible relevance across the community. Includes but not limited to activity type, intensity, fitness required and setting (group/home-based).	Year 2	Planning and Population Health Directorate, notably the Health Promotion team Activity providers, potential referrers and other community stakeholders as above.
C4.2. As per C3.4, consider the evidence for which activities are likely to be protective against falls and injuries from falls, and to which sub-populations different activities will be targeted.	Year 1, with ongoing maintenance thereafter	Planning and Population Health Directorate, notably the Health Promotion team Activity providers
C4.3. Work with stakeholders including community members to identify potential barriers to participation, including but not limited to: • Cost, notably considering the options for people from low socio-economic groups • Transport • Cultural appropriateness, including language	Year 2	Planning and Population Health Directorate, notably the Health Promotion team Activity providers, potential referrers and other community stakeholders.
C4.4. Work with local activity providers and/or potential new activity providers to address the gaps identified.	Years 2&3 (intensive focus) with plans for sustainable maintenance beyond this	Planning and Population Health Directorate, notably the Health Promotion team Activity providers, potential referrers and other community stakeholders.
C4.5. Identify other community services or organisations that provide access to the target population, and work with these to incorporate falls injury prevention strategies where appropriate (including referral into existing preventive activities wherever possible).	Years 2&3 (intensive focus) with plans for sustainable maintenance	Planning and Population Health Directorate, notably the Health Promotion team
C4.6. Build appropriate linkages to relevant opportunities to expand physical activity programs, such as (but not limited to) the new Healthy *Ageing Project Initiative* being funded by NSW Sport and Rec and NSW Ministry of Health.	Years 2&3 (intensive focus) with plans for sustainable maintenance beyond this	Planning and Population Health Directorate, notably the Health Promotion team Activity providers, potential referrers and other community stakeholders as above. NSW Ministry of Health
C4.7. Ensure that all new activities are listed on the Active and Healthy website and promoted to potential referrers and the broader community (in accordance with C3.6, C3.8 and C3.9).	Years 2&3 (intensive focus) with plans for sustainable maintenance beyond this	Planning and Population Health Directorate, notably the Health Promotion team Activity providers, potential referrers and other community stakeholders.

C5. Build the capacity of activity providers to deliver appropriate, effective and sustainable activities.

How	When	Whom
C5.1. Use the database generated by entries into the Active and Healthy website to identify the "workforce" of activity providers (including volunteers where appropriate) and implement proactive strategies to build their capacity to deliver activities that are evidence-based, wide-reaching and sustainable. This may include but is not limited to: • Identification of the "workforce" • Ongoing communication strategies to engage providers and create connectivity across the workforce • Provision of updates and information including new research evidence and information about activities delivered elsewhere • Provision of/facilitation of access to resources and tools available to support quality practice • Provision of/facilitation of access to professional development opportunities such as training workshops • Collective strategic planning and shared problem-solving • Connection to other professional networking opportunities such as those provided by the NSW Falls Prevention Network and the NSW Falls Prevention Program (CEC). • Liaison with the Centre for Population Health to determine potential for central support for capacity building strategies.	Years 2,3,4,5	Planning and Population Health Directorate, notably the Health Promotion team Activity providers, potential referrers and other community stakeholders as above. NSW Falls Prevention Program (CEC)

C6. Develop strategies to improve the built environment, to support active and healthy ageing.

How	When	Whom
C6.1. Ensure appropriate linkages with significant SESLHD investments, notably the Population Health Plan.	Years 1,2,3,4,5	Planning and Population Health Directorate, notably the Health Promotion team Local governments Premier's Council for Active Living NSW Ministry of Health
C6.2. Develop, implement and evaluate local strategies to improve built environments to encourage healthy, active lifestyles. Include consideration of, but not limited to: • Safe, appropriate and appealing parks and public spaces • Urban design suitable for the needs of older people • The provision of physical activity amenities such as fitness equipment • Practical risk reduction such as footpath maintenance and hazard management • Transport considerations • Linkages to other relevant community activities		Planning and Population Health Directorate, notably the Health Promotion team Local governments Premier's Council for Active Living NSW Ministry of Health

C7. Promote physical activity to key stakeholders and the community in the broader context of healthy ageing.		
How	**When**	**Whom**
C7.1. Proactively seek opportunities to embed appropriate physical activity recommendations into any relevant communication strategies, awareness campaigns, community interventions or other strategies undertaken across SESLHD.	Years 1,2,3,4,5	All stakeholders and partners, led by Planning and Population Health Directorate District Steering Committee for Falls Injury Prevention in Community Settings
C7.2. Incorporate positive messages describing the protective effect of appropriate physical activity for falls injury prevention into collaborations with any relevant partners or groups.	Years 1,2,3,4,5	All stakeholders and partners, led by Planning and Population Health Directorate District Steering Committee for Falls Injury Prevention in Community Settings
C7.3. Advocate state-wide social marketing of healthy ageing messages, and specifically the promotion of the Active and Healthy website	Years 1,2,3,4,5	All stakeholders and partners, led by Planning and Population Health Directorate District Steering Committee for Falls Injury Prevention in Community Settings NSW Falls Prevention Program (CEC)
C8. Develop a strategic approach to increase the scope and quality of multifactorial interventions (involving falls risk assessment and subsequent tailored risk-reduction strategies).		
How	**When**	**Whom**
C8.1. Ensure the consistency of actions described in this section with the appropriate evidence and key publications such as *Best Practice Guidelines for Preventing Falls and Harm from Falls in Community Care*[8] and the Royal Australian College of General Practitioners *Guidelines for preventive activities in general practice (8th edition)*[22]	Years 1,2,3,4,5	District Steering Committee for Falls Injury Prevention in Community Settings
C8.2. Identify the scope of health professionals and other service providers who currently deliver multifactorial interventions or have the potential to do so in the future, including but not limited to: • General Practitioners • Community and allied health staff • Hospital discharge planners • Emergency Departments (notably ASET staff) • Ambulance Service of NSW	Year 1	Planning and Population Health Directorate, Community/Allied Health, hospital Discharge Planners, ASET staff, Medicare Locals, Ambulance Service of NSW

	And including but not limited to those that provide services to populations with special needs who may benefit from similar interventions, such as: • Aboriginal People • People from CALD backgrounds • People with mental illnesses • People with HIV • People with drug and alcohol dependencies		
C8.3.	Consult with these health professionals and other service providers to establish current practices, and local opportunities and barriers related to current and future service delivery.	Year 1	Planning and Population Health Directorate, Community/Allied Health, hospital Discharge Planners, ASET staff, Medicare Locals, Ambulance Service of NSW
C8.4.	Identify the best practice guidelines, specific clinical protocols, tools and resources that will support implementation of evidence-based practice and avoid unnecessary local development and duplication.	Year 1	Planning and Population Health Directorate, Community/Allied Health, hospital Discharge Planners, ASET staff, Medicare Locals, Ambulance Service of NSW
C8.5.	(Note parallel strategy to that described in H10.2) Identify and map the scope and range of evidence-based referral options and appropriate referral pathways into primary, secondary and tertiary prevention, including but not limited to: • Primary prevention, specifically appropriate physical activity • Secondary prevention such as the *Stepping On* program, Otago-style home-based exercises for more frail populations, and Occupational Therapy, vision and podiatry services • Tertiary services such as coordinated, intensive models of care for secondary fracture prevention, eg Minimum Trauma Fracture Clinics, Osteoporosis Fracture/Re-fracture Prevention Services, falls clinics, relevant clinical testing and diagnostic services (eg bone mineral density testing) and other relevant outpatient services	Establish in Years 1,2 Maintain and build upon in Years 3,4,5	Planning and Population Health Directorate, Community/Allied Health, hospital Discharge Planners, ASET staff, Medicare Locals, Ambulance Service of NSW
C8.6.	Identify gaps in current activities and services, including but not limited to: • Capacity for population reach • Geographic gaps, with particular consideration of local government areas with high rates of falls. • The needs of Aboriginal people • People from CALD backgrounds, with particular consideration of local government areas with large CALD populations. • The scope of and relevance of multifactorial interventions to the needs of individuals, from relatively well, middle-aged adults to the more frail and elderly population.	Year 1	Planning and Population Health Directorate, Community/Allied Health, hospital Discharge Planners, ASET staff, Medicare Locals, Ambulance Service of NSW

• Ensure that there is equitable access across the District to appropriate, evidence-based services. • Ensure appropriate linkages with a range of stakeholders identified in this plan, notably potential referrers within the health service (eg Discharge Planners) and in community settings (eg General Practitioners).		
C8.7. Ensure appropriate cross linkages between services. For example, link the activities of community Occupational Therapists with other initiatives such as Chronic Care.	Year 1	Planning and Population Health Directorate
C8.8. Explore the feasibility and effectiveness of proactive strategies being trialled to identify and intervene with high risk older people who have had a "near miss", such as: • Those have presented to local Emergency Departments due to a fall, but were subsequently discharged to home without admission. • Those who are attended by the Ambulance Service of NSW but do not require transport to care (see current iPREFER RCT)	Year 1	Planning and Population Health Directorate, ASET staff, Ambulance Service of NSW, iPREFER research team
C8.9. Ensure that there is capacity of the HIV sector to identify falls risk in terms of planning for an ageing population of people living with HIV with complex care needs • Provide appropriate HARP sector workforce development and training specific to identifying falls risk for people living with HIV with complex care needs e.g., multiple co-morbidities, neurocognitive disease • Include falls risk and prevention activities as part of any HARP SESLHD planning in terms of HIV Complex Care and Ageing	Year 1,2,3	Planning and Population Health Directorate, HIV AIDS and Related Programs (HARP)
C9. Build the capacity of relevant service providers to implement evidence-based multifactorial interventions in a wide-reaching, sustainable manner.		
How	**When**	**Whom**
C9.1. Use the information and resources collected through C8 to provide strategic leadership and professional support as appropriate, including but not limited to: • Ongoing communication strategies to engage service providers and create connectivity across the workforce • Provision of updates and information including new research evidence and information about activities delivered elsewhere • Provision of/facilitation of access to specific clinical protocols, tools and resources available to support quality practice • Provision of/facilitation of access to professional development opportunities such as training workshops • Collective strategic planning and shared problem-solving • Connection to other professional networking opportunities such as those provided by the NSW Falls Prevention Network and the NSW Falls Prevention Program (CEC).	Years 2,3 (intensive period) with ongoing support as appropriate thereafter	Planning and Population Health Directorate, Community/Allied Health, hospital Discharge Planners, ASET staff, Medicare Locals, Ambulance Service of NSW

Prevention in Health Facilities Managed by SESLHD

What the Evidence Says

Evidence-based preventive activities in health facilities have the potential to reduce falls and injuries from falls both in the immediate facility environment and into the future once a patient is discharged to home. The best practice guidelines for hospitals[10] and residential aged care facilities[9] produced by ACSQHC outline the key evidence for falls injury prevention in these settings.

Common messages highlighted in both these guidelines are reproduced in Table 5.

Table 5: Key Messages from the Best Practice Guidelines for Preventing Falls and Harm from Falls in Hospitals and Residential Aged Care

- Many falls in hospitals and residential aged care can be prevented.
- Fall and injury prevention need to be addressed at both point of care and from a multidisciplinary perspective.
- Managing many of the risk factors for falls (eg delirium or balance problems) will have wider benefits beyond falls prevention.
- Engaging older people is an integral part of preventing falls and minimising harm from falls.
- Best practice in fall and injury prevention includes implementing standard falls prevention strategies, identifying fall risk and implementing targeted individualised strategies that are resourced adequately, and monitored and reviewed regularly.
- The consequences of falls resulting in minor or no injury are often neglected, but factors such as fear of falling and reduced activity level can profoundly affect function and quality of life, and increase the risk of seriously harmful falls.
- The most effective approach to falls prevention is likely to be one that includes all staff in health care facilities engaged in a multifactorial falls prevention program.
- At a strategic level, there will be a time lag between investment in a falls prevention program and improvements in outcome measures.

Whilst a comprehensive set of actions is described in the best practice clinical guidelines, it is useful to consider which are supported by the strongest evidence, and should therefore take priority when allocating resources. Following the same evidence rating system as applied in the community setting, those actions are described in Table 6[66].

Table 6: Strongest Evidence for Falls Injury Prevention in Hospitals and Residential Aged Care settings

★★★	Vitamin D supplementation in residential aged care
★★	Intensive multidisciplinary assessment of high risk populations
★★	Intensive interventions in hospitals
★★	Comprehensive geriatric assessment in residential aged care
★	Withdrawal of psychoactive medications
★	Medication review in residential aged care

A noteworthy difference in the evidence for these settings is physical activity, a strongly supported primary prevention strategy for community-dwelling adults[5, 19, 44, 46]. In the hospital and residential aged care settings, however, the evidence is mixed. Exercise in subacute hospital settings appears to be effective for patients with admissions longer than a few weeks, but in residential aged care it may be that exercise programmes increase falls in frail residents and reduce falls in less frail residents[11].

Appropriate prior assessment, specific exercise prescription and supervision are essential[9]. This demonstrates the complex variations in populations and context that must be considered when planning falls injury prevention across different settings.

Guidelines for Prevention in Hospitals

Falls injury prevention in the hospital setting is now subject to a new (September 2012) National Standard, *Standard 10: Preventing Falls and Harm from Falls*[14]. Standard 10 is not limited to the prevention of falls and injuries from falls in people aged 65 and over, but also includes wider consideration of younger people at increased risk of falling, such as those with a history of falls, neurological conditions, cognitive problems, depression, visual impairment or other medical conditions leading to an alteration in their functional ability[14]. This section of the SESLHD plan will address the broader scope accordingly.

Standard 10 refers the reader to the ACSQHC guidelines for best practice, and includes additional discussion of the importance of appropriate governance and systems for falls injury prevention within health facilities, and the engagement of and communication with patients and carers.

ACSQHC guidelines recommend the following standard interventions for hospitals.

- Appropriate falls risk screening and assessment.
- A multifactorial approach to preventing falls should be part of routine care for all older people in hospitals.
- Develop and implement a targeted and individualised falls prevention plan of care based on the findings of a falls screen or assessment.
- As part of discharge planning, organise an occupational therapy home visit for people with a history of falls, to establish safety at home.
- Patients considered to be at higher risk of falling should be referred to an occupational therapist and physiotherapist for needs and training specific to the home environment and equipment, to maximise safety and continuity from hospital to home.

Specific recommendations describe:

- Falls risk screening and assessment
- *Management strategies for common falls risk factors:* Balance and mobility limitations, cognitive impairment, continence, feet and footwear, syncope, dizziness and vertigo, clinically appropriate medication management, vision, environmental considerations, individual surveillance and observation and restraints.
- *Minimising injuries from falls:* Vitamin D and calcium supplementation, and Osteoporosis management.
- *Responding to falls:* Post-fall management protocols.
- Additional "good practice points" for clinical staff.

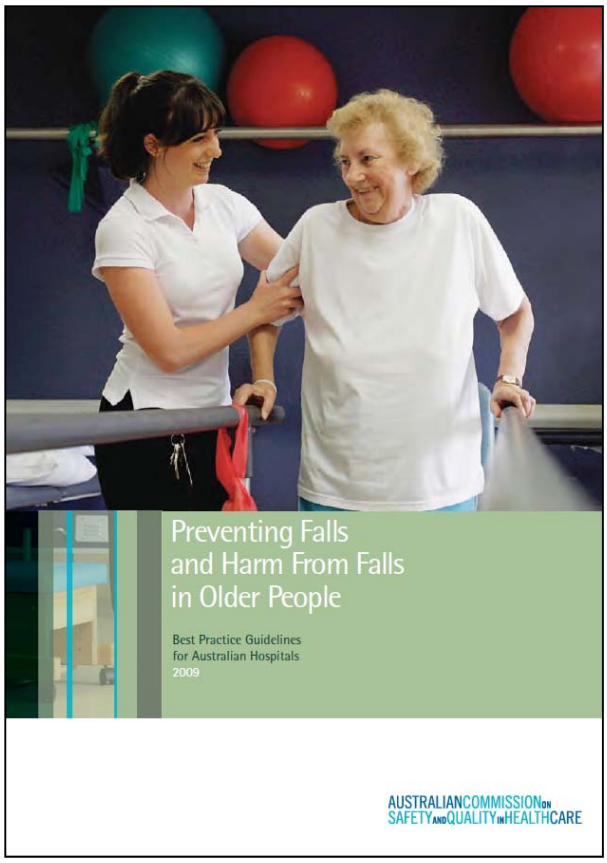
Guidelines for Prevention in Residential Aged Care

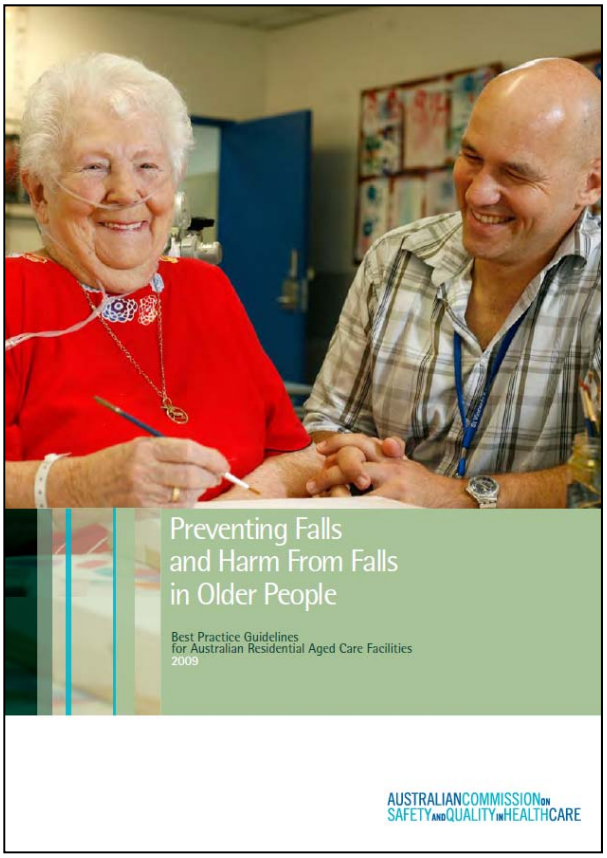
Like the hospital setting, falls injury prevention in the Residential Aged Care setting is also subject to relevant National Standards, under the *Aged Care Act 1997* and subsequent associated legislation such as the *2011 Accreditation Grant Principles*. Although falls injury prevention is not described as specifically as it is in Standard 10, it is nonetheless included within the scope of the standards (notably *Standard 2: Health and Personal Care* and *Standard 4: Physical environment and safe systems)* and is described more specifically in evidence-based best practice guidelines produced by ACSQHC[9].

The guidelines are similar in scope and content to those described for the hospital setting, including similar key messages to those described in Table 5.The following specific actions are recommended.

- Appropriate falls risk screening and assessment.
- A multifactorial approach using standard falls prevention interventions should be routine care for all residents of residential aged care facilities.
- In addition to a multifactorial approach using standard falls prevention interventions, develop and implement a targeted and individualised falls prevention plan of care based on the findings of a falls screen or assessment.
- Provide vitamin D with calcium supplementation to residents with low blood levels of vitamin D, because it works as a single intervention to prevent falls.
- Residents should have their medications reviewed by a pharmacist.

Specific recommendations are included that describe falls risk screening and assessment in this setting, followed by specific management strategies that address same themes as the hospital guidelines described earlier (management strategies for common risk factors, minimising injuries from falls, and responding to falls). "Good practice points" are also included throughout the document.





The Cost-Effectiveness of Prevention Interventions

The 2010 economic evaluation falls injury prevention strategies in NSW described earlier also considered cost-effectiveness in residential aged care facilities[7].

Within residential aged care facilities, medication review, hip protectors, vitamin D supplementation, multiple interventions and multi-factorial interventions were all found to be cost-effective. As described earlier, the interpretation of these results and extrapolation to local settings should be made with some caution, as there are a number of potentially confounding factors, such as the scale of local investment and the processes for intervention delivery. However the economic evaluation certainly suggests that there is a sound economic case to be made for implementing these strategies in SESLHD.

There is very little evidence regarding the cost-effectiveness of interventions delivered in hospitals. The large variation in scope, scale, service context, population and intervention type in that setting complicates the economic methodology and makes any result difficult to interpret at any practical level. However the concepts in residential aged care are to some extent generalisable, and the evidence described earlier does provide a strong rationale for action in the hospital setting.

A Strategic Set of Evidence-Based Interventions

As with community settings, it can be useful to visualise the scope of preventive activities in health care facilities. The concept of primary, secondary and tertiary prevention is not as directly applicable to this setting as it is in the community, but the broader concept can be applied by describing the most wide-reaching strategies at the base (common strategies across facilities for all patients), and working upwards to consider more specifically targeted individual risk management strategies in the middle, and finally the post-fall management strategies that are implemented when falls occur within facilities.

These concepts are mapped for hospitals (Figure 12) and residential aged care facilities (Figure 13).

Figure 12: Falls Injury Prevention in Hospitals

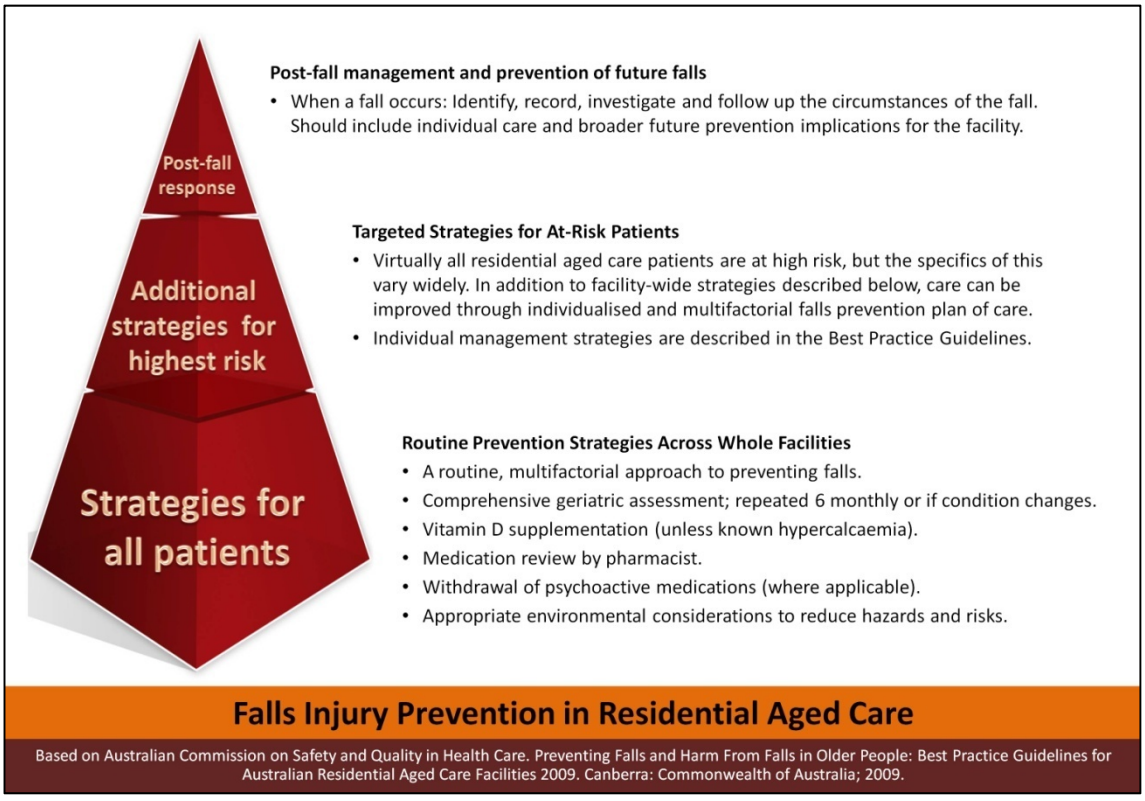


Figure 13: Falls Injury Prevention in Residential Aged Care

Current Activity and Gaps in SESLHD

The consultation process for this plan was predominantly conducted through the SESLHD Health Services Falls Prevention Advisory Committee.

Detailed interviews were undertaken with representatives from each of the health service local committees or other representatives such as Quality Managers (see Appendix B). These representatives provided an overview of current activities, strategic issues and future priorities for their respective facility, which formed the basis of further planning processes including a planning meeting held in May 2013. Members of the Advisory Group and additional key stakeholders participated a facilitated round table discussion to determine the foremost priorities to be included in this plan.

Broader consultation was undertaken as required, including but not limited to discussions with ASET (Aged care Services Emergency Team) personnel, Drug and Alcohol services, Mental Health services, Aboriginal Health, Multicultural Health, aged care nurses, community and rehabilitation services, carers programs, a community representative, and more broadly including the NSW Falls Prevention Program at the CEC and the NSW Ministry of Health (see Appendix B). All identified key stakeholder were provided with the opportunity to comment on the draft plan.

Falls Prevention and Management for Older Patients in Acute and Subacute Facilities (PD 248) is an endorsed SESLHD procedure document that describes activities in this setting including assessment, multidisciplinary falls prevention management plans, and ongoing protocols for clinical care, data and reporting and discharge planning[67]. All SESLHD hospitals have a site Falls Committee or address implementation of PD 248 through other local governance (eg Quality Committees). An SESLHD Health Services Falls Prevention Advisory Group provides oversight and strategic direction at the District level, reporting through District Executive Sponsors to the District Clinical and Quality Council. The group is chaired by the SESLHD Falls Prevention Program Coordinator, an identified District-wide position funded by the NSW Ministry of Health to provide strategic direction and support to falls injury prevention activities in both health service and broader community settings.

SESLHD also has one publically managed residential aged care facility, Garrawarra Centre. Although the context is different, Garrawarra is also bound by PD 248 where clinically and contextually relevant, and has representation on the Advisory Group. Other residential aged care facilities within SESLHD are privately managed and therefore not bound by the scope of this plan (although information-sharing across all facilities is encouraged).

The highest priority identified was preparation for accreditation under the new Standard 10 requirements, both at the individual facility level and more strategically across the whole District. Parallel quality and accreditation priorities were identified in the residential aged care facility at Garrawarra.

Additional priorities for action were identified through gap analyses, local consultation and a strategic planning meeting. These priorities were:

- To improve strategic coordination and governance to more effectively and collaboratively plan, implement and evaluate falls injury prevention actions in SESLHD health facilities. It was noted that this would most likely include a revision of PD 248 to reflect the new Standard 10 and a review of the Terms of Reference of the Advisory Group to better reflect future practice and priorities.
- To ensure that falls injury prevention actions across health facilities more appropriately meet the needs of special populations, such as Aboriginal people and those from CALD communities, and to identify patients other than those aged 65+ who require appropriate falls injury preventive care.
- To improve the quality and consistency of data collection and reporting, both as a means of tracking progress and as a more strategic process to proactively identify issues across the District and within individual health facilities.
- To improve compliance auditing procedures to provide more meaningful data and qualitative feedback to inform and improve clinical service delivery and management. This priority was noted in response to concerns that preparation for new accreditation processes could easily become a quantitative “tick-a-box” process that would lack meaningful depth and relevance.

- To explore and improve supervision and surveillance strategies across facilities. A variety of innovative strategies were noted and there is potential for better information-sharing and planning across the District.
- To explore opportunities to more effectively intervene with patients who present to Emergency Departments due to a fall, particularly those discharged without admission (with appropriate linkages to the community section of this plan).
- To improve the proactive inclusion of falls injury prevention strategies through discharge planning, and build more effective connections to relevant community-based prevention strategies (also linked to the community section of this plan).
- To provide a more strategic and coordinated approach to staff training and other aspects of professional development related to falls injury prevention across the District.

The Scope of Future Actions

As in the community setting, some definition of age target is required in this health facilities section of the plan to inform relevant action and manage resources responsibly. That is particularly important where mandatory protocols are in place, such as routine screening for falls risk on admission to hospital. It would be neither feasible nor evidence-based to require this across the whole population.

SESLHD PD 248 *Falls Prevention and Management for Older Patients in Acute and Subacute Facilities* currently describes mandatory actions such as falls risk screening for people all people aged 65 and over, and from the earlier age of 45 for Aboriginal people. The identification of the additional population subgroups and services that may warrant earlier intervention is recommended. More broadly, appropriate clinical judgement can and should be applied to ensure that appropriate preventive care is provided to all patients that require it.

Whilst this plan focuses on hospitals and the residential aged care facility, as that is where the greatest impact is seen, additional actions are noted for a broader scope of SESLHD facilities and services.

Standard 10: Preventing Falls and Harm from Falls

Criteria to achieve the Preventing Falls and Harm from Falls Standard
Governance and systems for preventing falls
Health service organisations have governance structures and systems in place to reduce falls and minimise harm from falls.
Screening and assessing risks of falls and harm from falling
Patients on presentation, during admission, and when clinically indicated, are screened for risk of a fall and the potential to be harmed from falls.
Preventing falls and harm from falling
Prevention strategies are in place for patients at risk of falling.
Communicating with patients and carers
Patients, families and carers are informed of the identified risks from falls and are engaged in the development of a falls prevention plan.

Preventing Falls and Harm from Falls in Hospital

Our desire to reduce falls and injury associated with falls is driven not by a national standard but a genuine wish not to harm the patients we provide care for on a daily basis. That said, the complexity and case mix of the patients, including their physical and cognitive abilities vary enormously and to consider falls prevention in isolation of a number of other quality makers of care in hospital is a missed opportunity. Over the years an evidence base has emerged that tells us that it is possible to prevent falls in hospital but the literature has largely focused on older people in aged care wards and the interventions have varied in type and intensity.

So what do we need to do to reduce falls in our hospitals in SESLHD? There is no simple recipe that we can follow, but here are some key ingredients which when combined are likely to have a positive impact over time:

1. **Data, data, data!! Get your data, understand your data and use your data to drive change and evaluate impact.**
2. **Ensure somebody understands and can interpret the nuances of the literature so that the right intervention/s is targeted at the right individual/s and resources are deployed effectively and efficiently.**
3. **Work in an appropriate size team / unit to make change happen. This will usually be at ward level and the support of the NUM is critical. If there isn't nursing leadership at this level, change rarely happens.**
4. **Screening for risk of falls needs to be systematized across a hospital. Avoid using multiple tools and accept that whilst one tool is never perfect, consistency for staff moving between wards is important.**
5. **Act, implement and document when somebody is identified as high risk.**
6. **Ensure that staff are able to identify and manage people with a delirium or a dementia. Understand what triggers behaviours and anticipate care needs including regular toileting and managing pain.**
7. **Have access to equipment that may help in reducing falls or harm from falls and know what sort of patient would benefit from which device – Lo Lo beds, alarm mats etc.**
8. **Avoid the use of drugs that we know cause harm in older people unless there is a clear clinical indication.**
9. **Provide ongoing support, training and education for staff in a range of areas relevant to falls prevention including managing the confused hospitalized older person, continence management and medication management.**
10. **Learn from events where harm occurs in an environment that isn't punitive and reward and praise staff where there is evidence of improvement in practice and outcomes.**

Of course, sustainable change takes time to happen and cultures, attitudes and behaviours that have developed over years will not simply alter overnight. Preventing falls in hospitals is a marathon not a sprint, but the reward is worth it.

ASSOCIATE PROFESSOR JACQUI CLOSE

Principal Research Fellow, Neuroscience Research Australia
Conjoint Associate Professor, University of NSW
Consultant Geriatrician, Prince of Wales Hospital

Associate Professor Jacqui Close is a renowned falls injury prevention researcher and geriatrician. Over the past 15 years she has combined research with clinical practice and provided leadership in relation to ensuring that research is translated into policy, guidelines and everyday practice. Professor Close is a member of the local Advisory Committee and has provided valuable support for the development of this plan.

What We Will Do in Health Facilities Managed by South Eastern Sydney Local Health District

Principles

We will:

- Ensure compliance with all relevant accreditation requirements and standards including ACSQHC National Standard 10 and the Aged Care Act 1997 and subsequent associated legislation.
- Take a collective, strategic approach to District-wide falls injury prevention in SESLHD facilities including the adoption of resources developed by the CEC where appropriate.
- Take an evidence-based approach to the selection of priorities and the development and implementation of interventions and ensure the monitoring, evaluation and reporting of outcomes.
- Ensure essential linkages to prevention activities in community settings to promote adequate and timely follow up for those at continued risk of falling.
- Identify and support clinical champions to foster and drive a focus on falls injury prevention.

Priorities

We will provide appropriate governance and ensure the engagement of key stakeholders across the District.

H1. Ensure that there is an appropriate governance structure to support strategic and collaborative plan delivery.

We will take a collective, strategic approach to planning and implementing prevention initiatives.

H2. Determine an appropriate scope of focus (beyond simply “65 and over”) for the routine actions to be undertaken within health facilities (such as protocols describing routine screening and individual care plans). This is to ensure that the needs of other high risk populations are appropriately considered.

H3. Ensure consistency of SESLHD practice with ACSQHC best practice guidelines, other relevant clinical practice recommendations and ongoing reviews of evidence.

H4. Adopt a collective and strategic approach to achieving relevant accreditation.

We will address specific issues and priorities identified by key stakeholders.

H5. Improve the consistency and quality of relevant data collection and reporting across facilities, and the proactive use of this information in strategic and operational planning.
H6. Implement a strategic approach to compliance monitoring that will provide meaningful feedback to inform quality falls injury prevention action across facilities.
H7. Explore and implement strategies to improve supervision and surveillance relevant and appropriate to the context of each ward/facility.
H8. Ensure that falls injury prevention strategies have an appropriate focus and design to meet the needs of special population groups, notably Aboriginal patients and people from CALD communities.
H9. Implement strategies to more effectively address falls injury prevention with patients attending Emergency Departments, particularly those not admitted to hospital.
H10. Implement a strategic and collaborative approach to discharge planning that includes stronger linkages with community-based preventive services.
H11. Implement a strategic and collaborative approach to staff orientation, ongoing training and professional development opportunities related to falls injury prevention.
H12. Ensure that equipment, devices and environments are available to implement prevention strategies for patients at risk of falling.

Partners

Partners in this plan will include but are not limited to the following.

Within SESLHD:

- SESLHD Health Facilities, notably hospitals and the residential aged care facility
- Planning and Population Health Directorate, notably the SESLHD Falls Prevention Program Coordinator and the Health Promotion Team
- Ambulatory and Primary Health Care Directorate, notably Aboriginal Health and Multicultural Health
- Clinical Governance
- Emergency Departments, notably ASET staff
- Prevention programs in SESLHD community settings (as per other section of this plan – to create better linkages and increase referrals)

External Partners:

- Medicare Locals
- Primary health practitioners, including General Practitioners and Practice Nurses
- Ambulance Service of NSW
- NSW Agency for Clinical Innovation
- The NSW Falls Prevention Program (CEC)
- Community Stakeholders including Carers groups
- Non-government organisations

CLINICAL EXCELLENCE COMMISSION

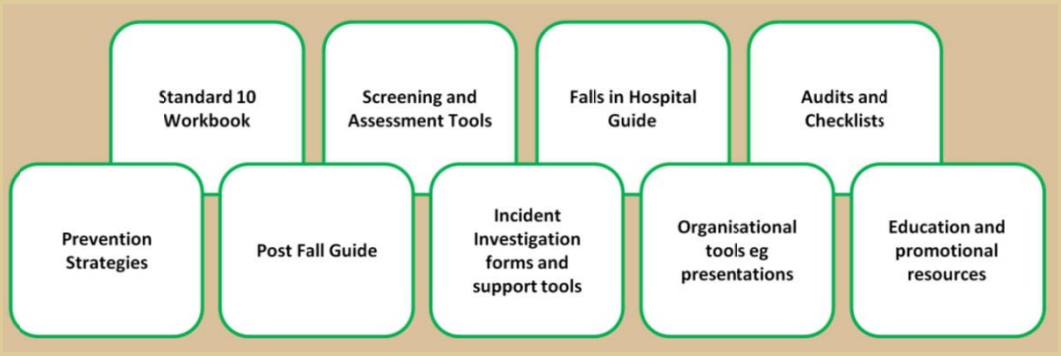
NSW FALLS PREVENTION PROGRAM

NEW in August 2013: The CEC Hospital Package

Through its NSW Falls Prevention program, the CEC has undertaken a process to develop a support package for hospitals. There has been significant consultation with staff from LHDs and a process of approval through the State Forms Management Committee.

A package of supporting documents has been released to help hospitals meet Standard 10 accreditation.

The falls risk screen tool is the Ontario Modified Stratify (Sydney Scoring) and the associated assessment tool is the Falls Risk Assessment and Management Plan (FRAMP). The Falls Screen is to be completed on admission to identify patients falls risk factors. If falls risk have been identified a Falls Risk Assessment and Management Plan (FRAMP) is to be completed and interventions actioned for the falls risk factors that have been identified in the screen. Care planning should be discussed with the patient or family/carers and falls risk interventions communicated at handover. A range of other support tools have been released in a package.



As a principle of this plan (see H4.2 on page 69) there will be a District-wide agreement to use the standard falls injury prevention protocols, tools and resources developed by the CEC as a default, wherever this is feasible. Alternative protocols, tools and resources will only be developed locally if the Steering Committee for Falls Injury Prevention in Health Facilities determines that the available tools cannot meet local needs.

The Patient Journey

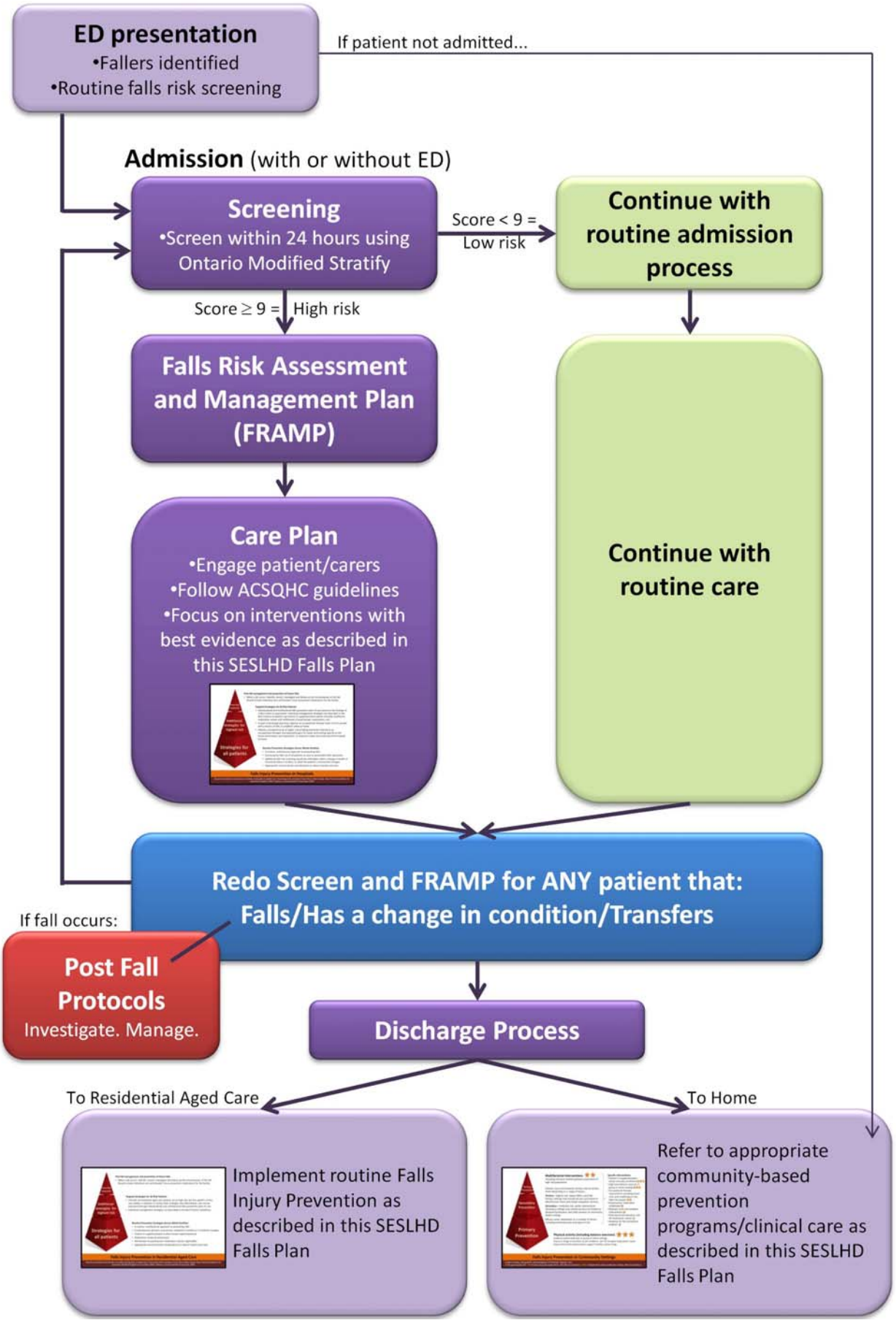


Figure 14: The Patient Journey

Improving Supervision and Surveillance

Any nurse will be quick to confirm that clinically appropriate supervision and surveillance of older people is essential to the prevention of falls and injuries from falls. The best practice guidelines for hospitals produced by ACSQHC describe the need for increased supervision of notably high risk groups, such as those who are cognitively impaired, in rehabilitation wards, or those who are acutely unwell[10]. A primary reason for routine screening in admission, after a change in condition or after transfer is to identify those patients who have the greatest need of increased or improved supervision and surveillance.

With a wide range of clinical settings across SESLHD, including acute and sub-acute care, as well as residential aged care patients, there is no single strategy to meet this need. The local context, clinical issues and availability of staff and equipment will all require consideration. Strategies noted in this plan include:

- Increased nocturnal surveillance strategies (notably around toileting)
- Frequent rounding
- The use of volunteers
- Engagement of families and carers at high risk times
- Co-location of high risk patients
- Direct nurse station supervision of co-located high risk patients
- Pairing high risk patients with younger room-mates to communicate issues to nursing staff
- Use of local data review to identify high risk times and settings to inform risk management
- The use of appropriate equipment such as low beds and/or bed sensors
- Clinically appropriate use of Patient Specials

Engaging families at high risk times

When staff at War Memorial Hospital undertook an analysis of their SAC data describing fall-related incidents, they discovered that a large number of falls were occurring between 11am and 12md. They began a concerted campaign to proactively engage carers and families to visit during this high risk period. Visiting times were changed, posters displayed and families were engaged directly to assist. With more people present to observe patients and warn staff of potential dangers, the hospital was able to achieve a reduction in falls and injuries from falls.

Equipment

Appropriate equipment can play a vital role in protecting patients, particularly when staff numbers are reduced (such as overnight) and/or with high risk patients. For example, the Garrawarra Centre provides 120 high care residential aged care beds. BED SENSORS on all beds of their mobile/weight bearing residents warn staff if they are trying to move unassisted, and can avert a serious incident. LOW BEDS (such as Lo Lo Nursing Beds) can also reduce the likelihood of a serious injury and are already in use in some but not all SESLHD facilities.

Volunteers

The potential for volunteers on wards to reduce falls was examined in a research study undertaken here in SESLHD and published in 2005. Patients assessed at high falls risk were accommodated in a room staffed by volunteer companion-observers. For safety reasons, the volunteers did not ambulate patients, but they engaged them in conversation, played cards, opened meals and used the call bell to summon nurses if patients attempted to move from the bed or chair without assistance. NO falls occurred when volunteers were present, and a 44% overall reduction in falls was reported at the ward level.

Implementation

The following detailed implementation plan (Table 7) maps specific actions against the priorities listed previously (H1-H12). It should be noted that these actions are subject to resources. Prioritising the allocation of those resources should follow the evidence described in this plan, with a notably focus on those interventions support by the strongest evidence, notably Vitamin D supplementation in residential aged care, intensive multidisciplinary assessment of high risk populations, intensive interventions in hospitals, comprehensive geriatric assessment in residential aged care, withdrawal of psychoactive medications, and medication review in residential aged care (see Table 6).

Table 7: Implementing the Plan: Health Facilities Managed by SESLHD

H1. Ensure that there is an appropriate governance structure to support strategic and collaborative plan delivery.		
How	**When**	**Whom**
H1.1. Revise the governance structure of the SESLHD Health Services Falls Prevention Advisory Committee to reflect the strategic direction and priorities of this plan. • Ensure a strong focus on proactive, collaborative action. • Develop new Terms of Reference to be consistent with this plan and with direct reference to key policy, accreditation and clinical practice documents. • Revise the title to **District Steering Committee for Falls Injury Prevention in Health Facilities** for consistency with the corresponding community governance structure (see C1) and to reflect a new strategic direction with a stronger action (*steering*) rather than passive (*advisory*) focus. • Revise the membership of the new Steering Committee to reflect the new Terms of Reference. Ensure appropriate seniority of membership to achieve the Terms of Reference. • Ensure strong and direct links to and engagement of the District Executive Sponsors.	Year 1 with ongoing maintenance in Years 2,3,4,5	District Steering Committee for Falls Injury Prevention in Health Facilities District Executive Sponsors
H1.2. Increase the capacity for direct actions to be undertaken by the Steering Committee. Form scope-specific and time-limited Working Groups as required to undertake the collective actions described (eg see H2.1, H5.2, H8.1, H8.2 and H10.1)	Year 1,2,3,4,5	District Steering Committee for Falls Injury Prevention in Health Facilities
H1.3. Review the governance structures of the committees at each health facility. Ensure that each has: • A written Terms of Reference that clearly links to the Terms of Reference of the District Steering Committee for Falls Injury Prevention in Health Facilities and to this plan. • Appropriate seniority of the Chair, who has capacity to influence meaningful clinical change within the facility. • Appropriate seniority of committee membership to achieve the Terms of Reference required. • Direct and clear lines of reporting within the facility (to an	Year 1 with ongoing maintenance in Years 2,3,4,5	Facility Committees Facility Executive Sponsors With support from the District Steering Committee for Falls Injury Prevention in Health Facilities

appropriately senior level of management) and to the District Steering Committee for Falls Injury Prevention in Health Facilities. This should include Executive Sponsor/s at every facility (such as Operations Managers, Quality Managers or equivalent appropriate senior management). • Mandatory representation on the District Steering Committee for Falls Injury Prevention in Health Facilities, preferably by the local committee Chair.		
H1.4. Revise PD 248 to reflect the strategic directions and actions described in this plan, and in relevant policy, accreditation and clinical practice documents. NB actions described later in this table will contribute to this, and the timing of these actions should be coordinated accordingly.	Years 1,2	District Steering Committee for Falls Injury Prevention in Health Facilities District Executive Sponsors Facility Committees Facility Executive Sponsors
H1.5. Ensure that falls injury prevention is not undertaken in strategic isolation. • As a principle of planning and implementation for all of the strategies described herein, ensure consideration of broader issues such as healthy ageing. • Facilitate appropriate linkages to other plans and activities across SESLHD. Advocate for inclusion of relevant actions and indicators in other SESLHD plans, policies and protocols. • Advocate for cross-membership across relevant committees and groups as required.	Years 1,2,3,4,5	District Steering Committee for Falls Injury Prevention in Health Facilities District Executive Sponsors to facilitate access and influence as required to achieve this
H1.6. Identify and support clinical champions to foster and drive a focus on falls injury prevention.	Years 1,2,3,4,5	District Steering Committee for Falls Injury Prevention in Health Facilities All facilities
H1.7. Develop additional communication strategies to engage and collaborate more widely with relevant stakeholders as required across these settings. Ensure that all relevant services within the District have been considered, including inpatient and outpatient services, specialist clinical services, Non-Emergency Patient Transport Services, and any other relevant facilities or teams. A review of the SAC data to determine which falls are occurring (including the low impact or "near miss" incidents within SAC 3 and SAC 4) will provide a useful insight to this process.	Establish in Year 1, continuing in Years 2,3,4,5	District Steering Committee for Falls Injury Prevention in Health Facilities
H1.8. Develop appropriate indicators for this plan, and a process and schedule for reporting results to the SESLHD Executive and any relevant stakeholders.	Establish in Year 1, continuing in Years 2,3,4,5	District Steering Committee for Falls Injury Prevention in Health Facilities

H2.	**Determine an appropriate scope of focus (beyond simply "65 and over") for the routine actions to be undertaken within health facilities (such as protocols describing routine screening and individual care plans). This is to ensure that the needs of other high risk populations are appropriately considered.**		
How		**When**	**Whom**
H2.1.	Form a Working Group to deliver the following actions, and engage and consult with stakeholders in this area to advise on the most appropriate strategic direction and actions.	Year 1	District Steering Committee for Falls Injury Prevention in Health Facilities Working group to address scope of settings and populations NSW Falls Prevention Program (CEC)
H2.2.	Review data from IIMS, other relevant records and consult with key stakeholders to identify population groups and/or settings that should be considered. This may include but is not limited to: • Patients with neurological conditions • Patients with cognitive problems • Patients with mental illness such as depression • Patients with drug and alcohol dependency • Patients with visual impairment • Patients with other medical conditions or disabilities leading to an alteration in their functional ability • Post-operative patients • New mothers (post-birth) • Aboriginal patients (already included in PD 248 as requiring earlier intervention from the age of 45: review and ensure appropriate consideration across all actions)	Year 1	Working group to address scope of settings and populations NSW Falls Prevention Program (CEC)
H2.3.	Present recommendations to the District Steering Committee for Falls Injury Prevention in Health Facilities.	Year 1	Working group to address scope of settings and populations NSW Falls Prevention Program (CEC)
H2.4.	Incorporate approved recommendations into: • District Steering Committee for Falls Injury Prevention in Health Facilities Terms of Reference • Individual facility committee Terms of Reference • The revision of PD 248 • All relevant clinical protocols, tools and resources • All relevant staff orientation and training • All relevant data and reporting protocols	Year 1,2,3	Working group to address scope of settings and populations District Steering Committee for Falls Injury Prevention in Health Facilities District Executive Sponsors to facilitate access and influence as required to achieve this

H3. Ensure consistency of SESLHD practice with ACSQHC best practice guidelines, other relevant clinical practice recommendations and ongoing reviews of evidence.		
How	**When**	**Whom**
H3.1. Ensure that all policies, protocols, tools and resources in use across **SESLHD hospitals** are consistent with ACSQHC guidelines for best practice, notably including (but not limited to): • Appropriate falls risk screening and assessment. • A multifactorial approach to falls injury prevention as part of routine care. • Targeted and individualised falls prevention plan care plans based on the findings of screening and assessment. • As part of discharge planning, organise an occupational therapy home visit for people with a history of falls, to establish safety at home. • Patients considered to be at higher risk of falling should be referred to an occupational therapist and physiotherapist for needs and training specific to the home environment and equipment, to maximise safety and continuity from hospital to home.	Years 1,2,3,4,5	District Steering Committee for Falls Injury Prevention in Health Facilities Facility Committees NSW Falls Prevention Program (CEC)
H3.2. Ensure that all policies, protocols, tools and resources in use in the **SESLHD Garrawarra Centre** are consistent with ACSQHC guidelines for best practice, notably including (but not limited to): • Appropriate falls risk screening and assessment. • A multifactorial approach using standard falls prevention interventions should be routine care for all residents of residential aged care facilities. • In addition to a multifactorial approach using standard falls prevention interventions, develop and implement a targeted and individualised falls prevention plan of care based on the findings of a falls screen or assessment. • Provide vitamin D with calcium supplementation to residents with low blood levels of vitamin D. • Residents should have their medications reviewed by a certain medications must be considered, particularly but not limited to those with mental illness. This must be carefully managed through appropriate consultation and collaboration between specialist medical and pharmacist teams. Ensure appropriate linkages with RMMR (Residential Medication Management Review) services and QUM (Quality Use of Medicines). http://www.health.nsw.gov.au/internet/main/publishing.nsf/Content/8ECD6705203E01BFCA257BF0001F5172/$File/natstrateng.pdf	Years 1,2,3,4,5	District Steering Committee for Falls Injury Prevention in Health Facilities Facility Committees NSW Falls Prevention Program (CEC)
H3.3. Ensure that SESLHD falls injury prevention activities are consistent with and linked to broader clinical improvement initiatives and activities, including but not limited to the CEC Falls Prevention Program, CEC Top 5 (dementia) program and other relevant strategic commitments.	Years 1,2,3,4,5	District Steering Committee for Falls Injury Prevention in Health Facilities, Facility Committees, NSW Falls Prevention Program (CEC)

H4. Adopt a collective and strategic approach to achieving relevant accreditation.		
How	**When**	**Whom**
H4.1. Implement routine and transparent process for collective preparation for accreditation and collaborative problem solving to address common issues. • Table Accreditation Preparation Gap Analyses undertaken by individual facilities at the District Steering Committee for Falls Injury Prevention in Health Facilities for discussion. • Report on the accreditation processes as they take place in individual facilities. • Identify commonalities for collective, strategic action and establish scope-specific and time-limited Working Groups to collaboratively address them. • Identify any issues that require a senior, strategic response across SESLHD and engage District Executive Sponsors to advocate for this at the appropriate level.	Years 1,2,3,4,5	District Steering Committee for Falls Injury Prevention in Health Facilities Facility Committees
H4.2. Implement collective principles to ensure quality and efficiency in falls injury prevention practice across SESLHD. For example: • Endorse a District-wide agreement to use standard falls injury prevention protocols, tools and resources developed by the CEC as a default. • If none are available or they are unsuitable for SESLHD needs, the CEC is to be approached directly to discuss options. • If the CEC is unable to provide appropriately modified protocols, tools and resources upon direct request, the District Steering Committee for Falls Injury Prevention in Health Facilities should first determine whether a Working Group should be formed to address collective local needs. • An individual facility should only develop their own protocols, tools or resources as a last resort, if none of these strategies resolve the issue.	Years 1,2,3,4,5	District Steering Committee for Falls Injury Prevention in Health Facilities Facility Committees NSW Falls Prevention Program (CEC)
H4.3. Ensure that all approved recommendations are appropriately incorporated into: • District Steering Committee for Falls Injury Prevention in Health Facilities Terms of Reference • Individual facility committee Terms of Reference • The revision of PD 248 • All relevant clinical protocols, tools and resources • All relevant staff orientation and training • All relevant data and reporting protocols	Years 1,2,3,4,5	District Steering Committee for Falls Injury Prevention in Health Facilities Facility Committees District Executive Sponsors to facilitate access and influence as required to achieve this

H5. Improve the consistency and quality of relevant data collection and reporting across facilities, and the proactive use of this information in strategic and operational planning.		
How	**When**	**Whom**
H5.1. Implement strategies to improve the validity and reliability of data collected at the facility level, notably SAC 3 and 4 data which are acknowledged to be inconsistent. Include consideration of: • Local leadership regarding data quality issues • Appropriate protocols and tools for data collection • Staff orientation and training • Mentoring, supervision and performance management • Ongoing quality assurance mechanisms including audits	Years 1,2 with ongoing maintenance in Years 3,4,5	Facility Committees with support from Clinical Governance NSW Falls Prevention Program (CEC)
H5.2. Form a Working Group to determine and define minimum reporting requirements across the SESLHD. Include a representative from all facilities and engage and consult with stakeholders in this area to advise on the most appropriate strategic direction and actions.	Years 1,2	Working Group to address data and reporting issues, with leadership from Clinical Governance NSW Falls Prevention Program (CEC)
H5.3. Within the scope of H5.2, include the following minimum reporting requirements for facilities (this does not preclude additional local data analyses and reporting as required): • Report on a monthly basis by facility and/or ward as appropriate to the setting • Report on SAC 1,2,3,4 (individual data, not grouped codes) • Report on raw data and standardised data (per 1,000 occupied bed days) monthly, shown as a 2 year trend (NB this is to be interpreted within the limitations of rates described earlier, to add to the complete local picture) • Explore opportunities to report relevant pharmacy data such as Vitamin D and psychotropic medication use • Report for all patients aged 65+ plus any specific groups/settings identified through the processes described in H2.	Establish in Years 1,2 Maintain in Years 3,4,5	Establishment: Working Group to address data and reporting issues, with leadership from Clinical Governance Maintenance: Facility Committees with ongoing support from Clinical Governance as required NSW Falls Prevention Program (CEC)
H5.4. Within the scope of H5.2, include the following minimum reporting requirements at the District level on a quarterly basis, by District and by individual facility: • SAC 1,2 (individual data, not grouped codes) • Raw data and standardised data (per 1,000 occupied bed days) monthly, shown as a 2 year trend (NB the latter is to be interpreted within the limitations of rates described earlier, to add to the complete local picture) • Explore opportunities to report relevant pharmacy data such as Vitamin D and psychotropic medication use • Report for all patients aged 65+ plus any specific groups/settings identified through the processes described in H2.	Establish in Years 1,2 Maintain in Years 3,4,5	Establishment: Working Group to address data and reporting issues, with leadership from Clinical Governance Maintenance: District Steering Committee for Falls Injury Prevention in Health Facilities with ongoing support from Clinical Governance as required NSW Falls Prevention Program (CEC)

H5.5. As an annual exercise, revisit the District-wide data analyses established in H2.2 to proactively consider whether any wider inclusion of at-risk groups should be considered in the future (eg look for clusters of incidents in previously unreported groups, such as people aged 60-64).	Years 1,2,3,4,5	District Steering Committee for Falls Injury Prevention in Health Facilities (Clinical Governance representative)
H5.6. Use data to routinely and proactively inform strategic and operational planning. Include considerations such as: • Track changes in relevant indicators relative to the introduction of actions stemming from this plan. Use positive outcomes to advocate for continued/increased resource allocation to effective strategies. • Use data to proactively advocate for appropriate strategic and organisational action to reduce injuries from falls. Identify any issues that require a senior, strategic response across SESLHD and engage District Executive Sponsors to advocate for this at the appropriate level.	Years 1,2,3,4,5	District Steering Committee for Falls Injury Prevention in Health Facilities District Executive Sponsors to facilitate access and influence as required to achieve this

H6. Implement a strategic approach to compliance monitoring that will provide meaningful feedback to inform quality falls injury prevention action across facilities.

How	When	Whom
H6.1. Review the auditing requirements of relevant accreditation processes in hospitals and residential aged care. • Follow the basic principle described in H4.2 – to use existing CEC tools if they are appropriate, and only develop alternative local tools where there is an agreed need to do so. • Ensure that appropriate auditing tools are used systematically. • Ensure consistency across all facilities and regular reporting back to the District Steering Committee for Falls Injury Prevention in Health Facilities. • Consider the usefulness of the auditing process and reporting, in terms of assessing the actual quality of interventions, rather than a quantitative checklist. • Consider implications for staff training. • Consider implications for performance management.	Years 1,2,3,4,5	District Steering Committee for Falls Injury Prevention in Health Facilities Facility Committees Clinical Governance NSW Falls Prevention Program (CEC)
H6.2. Retain a focus on outcomes rather than processes – recognising that auditing provides a valuable mechanism within falls injury prevention, but the measure of success is not in audit results, but the SAC data described in H5.3 and H5.4.	Years 1,2,3,4,5	District Steering Committee for Falls Injury Prevention in Health Facilities District Executive Sponsors Facility Committees Facility Executive Sponsors

H7. Explore and implement strategies to improve supervision and surveillance relevant and appropriate to the context of each ward/facility.		
How	**When**	**Whom**
H7.1. Collectively and strategically explore the range of supervision and surveillance strategies currently employed across SESLHD, and more widely through discussion with the CEC NSW Falls Prevention Program, including but not limited to: • Nocturnal surveillance strategies • Frequent rounding • Toileting issues • The use of volunteers • Engagement of families and carers at high risk times • Co-location of high risk patients • Direct nurse station supervision of co-located high risk patients • Pairing high risk patients with younger room-mates to communicate issues to nursing staff • Use of local data review to identify high risk times and settings to inform future risk management strategies • The use of appropriate equipment such as low profiling beds and/or bed sensors • Clinically appropriate use of Patient Specials	Years 1,2	District Steering Committee for Falls Injury Prevention in Health Facilities Facility Committees NSW Falls Prevention Program (CEC)
H7.2. Employ strategies appropriate to the context of each ward/facility and track progress over time using IIMS data and additional qualitative feedback from staff, patients and families/carers.	Years 1,2,3,4,5	Facility Committees
H7.3. Review and discuss the range of supervision and surveillance strategies at least annually at the District Steering Committee for Falls Injury Prevention in Health Facilities. Identify any issues to be proactively addressed. Identify any issues that require a senior, strategic response across SESLHD and engage District Executive Sponsors to advocate for this at the appropriate level.	Years 1,2,3,4,5	District Steering Committee for Falls Injury Prevention in Health Facilities District Executive Sponsors to facilitate access and influence as required to achieve this
H7.4. Explore the benefit of specific equipment, devices and environments for patients at risk of falling, particularly those with confusion or delirium – see H12 for specific actions.	Years 1,2,3,4,5	District Steering Committee for Falls Injury Prevention in Health Facilities – Working Group for Aboriginal Health Issues Facility Committees

H8. Ensure that falls injury prevention strategies have an appropriate focus and design to meet the needs of special population groups, notably Aboriginal patients and people from CALD communities.		
How	**When**	**Whom**
H8.1. Form a Working Group to work collaboratively with the SESLHD Aboriginal Health Service and relevant patient, carer and community stakeholders to improve the quality and appropriateness of falls injury prevention strategies in hospitals and residential aged care for Aboriginal people. Include consideration of (but not limited to): • All relevant clinical protocols, tools and resources • The revision of PD 248 • Staff orientation and training • Data collection and reporting protocols • Engagement of families and carers • Ongoing quality assurance and performance monitoring processes to ensure future quality care • Inclusion in appropriate SESLHD strategic and policy documents, including more broadly than this plan.	Establish in Years 1,2,3 Maintain in Years 4,5	District Steering Committee for Falls Injury Prevention in Health Facilities – Working Group for Aboriginal Health Issues Facility Committees Aboriginal Health District Executive Sponsors to facilitate access and influence as required to address broader strategic issues NSW Falls Prevention Program (CEC)
H8.2. Form a Working Group to work collaboratively with the SESLHD Multicultural Health Service, Diversity Health Coordinators based in facilities, and relevant patient, carer and community stakeholders to improve the quality and appropriateness of falls injury prevention strategies in hospitals and residential aged care for people from CALD communities. Include consideration of (but not limited to): • All relevant clinical protocols, tools and resources • The revision of PD 248 • Staff orientation and training • Data collection and reporting protocols • Engagement of families and carers • Ongoing quality assurance and performance monitoring processes to ensure future quality care • Inclusion in appropriate SESLHD strategic and policy documents, including more broadly than this plan.	Establish in Years 1,2,3 Maintain in Years 4,5	District Steering Committee for Falls Injury Prevention in Health Facilities – Working Group for CALD Issues Facility Committees Multicultural Health Diversity Health Coordinators District Executive Sponsors to facilitate access and influence as required to address broader strategic issues
H8.3. Undertake similar processes to meet the needs of any other group/s that require appropriate attention (as identified through H2.2).	Years 1,2,3,4,5	District Steering Committee for Falls Injury Prevention in Health Facilities Facility Committees

H9. Implement strategies to more effectively address falls injury prevention with patients attending Emergency Departments, particularly those not admitted to hospital.

How	When	Whom
H9.1. Work with Emergency Departments (notably ASET staff) to determine the most feasible strategies for the ED setting. This may include but is not limited to: • Routine identification, assessment and data recording of any person who attends ED due to a fall. • Routine falls risk screening for falls risk of any person aged 65 and over (45 and over for Aboriginal people, and potentially other identified groups according to the outcomes of H2.2), regardless of their reason for presentation to ED.	Establish in Years 1,2,3 Maintain in Years 4,5	District Steering Committee for Falls Injury Prevention in Health Facilities Facility Committees ASET staff NSW Falls Prevention Program (CEC)
H9.2. Focus on preventive strategies for patients who are not admitted, and therefore will not be more comprehensively assessed and managed through the protocols for falls injury prevention described earlier in this plan. Explore options for brief interventions and/or follow-up strategies such as those described in the community settings portion of this plan (eg see C8 and C9). Ensure appropriate engagement of carers in these protocols.	Establish in Years 1,2,3 Maintain in Years 4,5	District Steering Committee for Falls Injury Prevention in Health Facilities Facility Committees ASET staff NSW Falls Prevention Program (CEC)

H10. Implement a strategic and collaborative approach to discharge planning that includes stronger linkages with community-based preventive services.

How	When	Whom
H10.1. Form a Working Group to engage and consult with stakeholders in this area, notably including Planning and Population Health Directorate, Community/Allied Health, hospital Discharge Planners, ASET staff, Medicare Locals, Ambulance Service of NSW.	Year 1	Working Group to address discharge planning Linkages to stakeholders via the District Steering Committee for Falls Injury Prevention in Community Settings
H10.2. (Note parallel action to that described in C8.5) Identify and map the scope and range of evidence-based referral options and appropriate referral pathways into primary, secondary and tertiary prevention, including but not limited to: • Primary prevention, specifically appropriate physical activity • Secondary prevention such as the *Stepping On* program, Otago-style home-based exercises for more frail populations, and Occupational Therapy, vision and podiatry services • Tertiary services such as falls and fracture clinics and other relevant outpatient services	Years 1,2	Planning and Population Health Directorate, Community/Allied Health, hospital Discharge Planners, ASET staff, Medicare Locals, Ambulance Service of NSW

H10.3. Develop systematic, strategic discharge planning options and protocols to ensure a more strategic and coordinated response across the District. Ensure that all approved recommendations are appropriately incorporated into: • The revision of PD 248 • All relevant clinical protocols, tools and resources • All relevant staff orientation and training	Establish in Years 2,3 Maintain and build upon in Years 4,5	Planning and Population Health Directorate, Community/Allied Health, hospital Discharge Planners, ASET staff, Medicare Locals, Ambulance Service of NSW
H10.4. Ensure that injury prevention strategies at discharge are efficiently and practically aligned or integrated with other clinical priorities at discharge. For example, link the review of fall-risk-related medications to the broader medication action plan, in line with the guiding principles to achieve continuity in medication management. http://www.health.gov.au/internet/main/publishing.nsf/Content/5B47B202BBFAFE02CA257BF0001C6AAC/$File/guiding.pdf	Years 1,2,3,4,5	Hospital Medical Staff, Discharge Planners
H10.5. Ensure effective linkages to relevant actions in the community settings section of this plan, notably but not limited to C8.8: Explore the feasibility and effectiveness of proactive strategies being trialled to identify and intervene with high risk older people who have had a "near miss", such as: • Those have presented to local Emergency Departments due to a fall, but were subsequently discharged to home without admission. • Those who are attended by the Ambulance Service of NSW but do not require transport to care (see current iPREFER RCT)	Year 1	Planning and Population Health Directorate, ASET staff, Ambulance Service of NSW, iPREFER research team
H10.6. Ensure families and carers are appropriately engaged in the discharge process, particularly but not limited to circumstances where there are impaired cognition and/or language issues.	Years 1,2,3,4,5	Working Group, hospital Discharge Planners, ASET staff

H11. Implement a strategic and collaborative approach to staff orientation, ongoing training and professional development opportunities related to falls injury prevention.

How	When	Whom
H11.1. Consult with representatives from all facilities to determine staff needs and current gaps in relevant workforce development strategies such as staff orientation, ongoing training and professional development opportunities.	Year 1	District Steering Committee for Falls Injury Prevention in Health Facilities Facility Committees NSW Falls Prevention Program (CEC)
H11.2. Identify: • The current range of staff orientation, ongoing training and professional development opportunities related to falls injury prevention at the local facility level. • Additional options available at the District level and developed externally (such as the CEC).	Year 1	District Steering Committee for Falls Injury Prevention in Health Facilities Facility Committees

H11.3. Include consideration of the actions described in this plan and the need for workforce development strategies to maximise their implementation. Develop and maintain District-wide workforce development strategies accordingly.	Establish in Years 2,3 Maintain and build upon in Years 4,5	District Steering Committee for Falls Injury Prevention in Health Facilities Facility Committees
H12. Ensure that equipment, devices and environments are available to implement prevention strategies for patients at risk of falling.		
How	**When**	**Whom**
H12.1. Identify and facilitate access to the equipment, devices and environments required for the patient population being served, as per Standard 10 (10.4.1).	Year 1	District Steering Committee for Falls Injury Prevention in Health Facilities District Executive Sponsors Facility Committees Facility Executive Sponsors NSW Falls Prevention Program (CEC)
H12.2. Develop a log to register and record maintenance of equipment and devices used in falls prevention and management, as per Standard 10 (10.4.1).	Years 1,2	District Steering Committee for Falls Injury Prevention in Health Facilities District Executive Sponsors Facility Committees Facility Executive Sponsors
H12.3. Proactively plan for the long-term procurement of appropriate equipment and devices, and ensure the inclusion of this in all relevant plans at both the facility and District level, as per Standard 10 (10.4.1).	Years 1,2,3,4,5	District Steering Committee for Falls Injury Prevention in Health Facilities District Executive Sponsors Facility Committees Facility Executive Sponsors

Delivering the Plan

Governance Structure

Implementation of this plan will be coordinated by the Planning and Population Health Directorate (Figure 15). District Steering Committees will be formed in each of the main settings to provide strategic planning direction and practical support. In both cases, similar or related groups have existed previously, and many of those stakeholders will again be involved here, providing valuable experience and professional networks. The linkages shown in Figure 15 are already in place for some groups, and recommended for all in the future.

Appropriate communication strategies will be developed to ensure the engagement of and regular contact with these and other key stakeholders.

A reporting framework and timetable will be established. This will include annual progress reports to the District Executive Team, District Clinical and Quality Council and the Board, with additional interim progress reports to be tabled throughout the year at each of the Steering Committees.

Resource Implications

The actions within this plan are wide reaching and have inevitable resource implications. Whilst this may present a challenge within a system already under financial pressure, such costs must be weighed against the consequences of doing nothing, and the spiralling treatment costs that would most surely result.

Resource implications are noted in particular for:

- The implementation of Standard 10 across hospitals (preparation for this has already commenced in most instances).
- Occupational Therapists and Physiotherapists are likely to see an increase in referrals.
- Many of the Aboriginal and CALD strategies described will most likely require direct resourcing.
- If a population-level effect is truly to be achieved (as per the State-determined indicators described herein) then the Health Promotion team will require adequate resourcing to achieve adequate population reach of evidence-based prevention programs. This is a major undertaking.

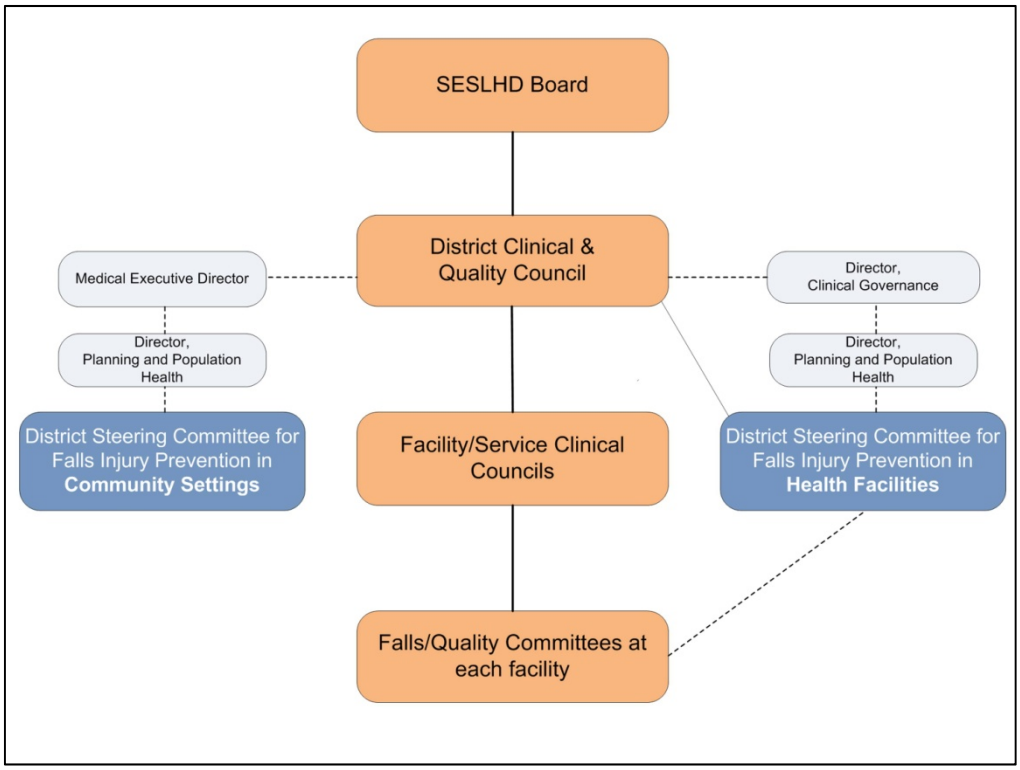


Figure 15: Governance Structure

Indicators

Outcome Indicators

Outcomes of this plan will be monitored through the following key performance indicators (Table 8, Table 9). The primary indicators are consistent with those from the previous NSW Falls Policy. The additional analyses represent priorities determined by SESLHD and are directly related to the actions described in this plan.

Table 8: Outcome Indicators: Population

Primary indicator	Target	Additional Analyses
1. **Age standardised rates of overnight stay hospitalisations due to falls by SESLHD residents aged 65 years and over.** Data source: Health Statistics NSW, using NSW Admitted Patient Data Collection and ABS population estimates. Current data for this indicator are provided in Figure 4, page 23 .	In the next 5 years we will decrease the number of falls related injury hospitalisations for persons over 65 in spite of increasing numbers in this age group. Our aim is to have no increase in SESLHD falls-injury hospitalisation rates (age-standardised, overnight) above SESLHD 2011/12 baseline.	Proportion of SESLHD residents aged 65 years and over who in the last 12 months who have: • Fallen, whether injured or not (including data describing the number of falls) • Required medical treatment as a result of a fall • Required admission to hospital as a result of their fall (links back to main indicator)

Table 9: Outcome Indicators: Clinical

Primary indicators	Target	Additional Analyses
2. **Decrease in the total number of falls for all patients in health facilities managed by SESLHD.** 3. **SAC 1 (death) incidents due to falls by people aged 65 and over in health facilities managed by SESLHD (including acute/subacute facilities and residential aged care).** 4. **SAC 2 (serious harm) incidents due to falls by people aged 65 and over in health facilities managed by SESLHD (including acute/subacute facilities and residential aged care).** Data source: IIMS data provided by SESLHD Clinical Governance. Current data for these indicators are provided in Figure 7, page 26.	In the next 5 years we will decrease the number of falls per 1,000 bed days in spite of increasing admissions to our facilities of persons over 65 to a level no more than the NSW state average using the 2012 figure of 4.1 falls per 1000 bed days as our baseline. SESLHD is committed to reducing fall-related SAC1 incidents towards zero. Numeric targets are an important part of SESLHD planning and our ongoing commitment to quality. The methodological issues related to standardised rates that have been discussed in this plan are acknowledged, and will be duly considered when interpreting these data.	SAC1 and SAC 2 fall-related incidents for ALL ages. Analyses of all SAC indicators will occur at the local facility level and will track trends over time. Analyses will also consider whether falls (notably SAC 2 falls) are of individual patients or repeat fallers. SAC 3 and SAC 4 data (less severe injuries and "near misses") will also be examined at the facility level. Appropriate data will be tabled and discussed by facility/quality committees at each facility and by the District Steering Committee for Falls Injury Prevention in Health Facilities. A summary report will also be tabled to the District Clinical and Quality Council.

Impact Indicators

The following impact level indicators will provide additional insight to the ongoing delivery of the plan.

In Community Settings:

- The proportion of SESLHD residents aged 50 and over participating in adequate physical activity. *Relevant data for this indicator will be available periodically through the NSW Population Health Survey Program and/or the New South Wales Falls Prevention Survey. This will include all forms of physical activity, not just participation in specific programs recommended for falls injury prevention.*
- The proportion of SESLHD residents aged 65 and over participating in physical activity programs specifically designed for falls injury prevention. *This more specific indicator is from the NSW Ministry of Health Population Health Priorities for NSW: 2012-2017[36]. Data source to be confirmed.*
- The scope of multifactorial interventions delivered by relevant community and primary health care services across SESLHD. *This will be determined by local program evaluation data and will most likely include consideration of the linkages, referral pathways and collaborative processes undertaken by community and primary health care services across SESLHD.*
- Separate to this process, a range of indicators will be collected relating to the whole-of-life actions described in this plan (eg through the Healthy Children's Initiative).

In Health Facilities Managed by SESLHD:

- The achievement of relevant accreditation of all facilities managed by SESLHD. *This information will be routinely available through SESLHD Clinical Governance processes.*

Additional impact level indicators may be identified by the District Steering Committees. There is a notable absence of quality data for populations such as Aboriginal people and those from CALD backgrounds. Investigation of possible data sources for these (and advocacy for this as necessary) would provide invaluable insights for program planning and ensure appropriate focus on the needs of these populations.

Process Indicators

Process indicators describe the implementation of actions. As such, they are most appropriately defined during project planning. Without limiting scope, it is likely that that may include the following concepts.

In Community Settings:

- The availability of appropriate physical activity programs across SESLHD, with consideration of number, variety, quality, geographic location and access issues, and populations targeted (etc).
- Indicators related to promotion and awareness.
- Participation in specific programs eg *Stepping On*.
- Descriptive indicators of reach of multifactorial interventions and the scope of preventive actions adopted, including linkages and partnerships.

In Health Facilities Managed by SESLHD:

- The adoption of specific evidence-based falls injury prevention strategies, notably:
  - Vitamin D supplementation in residential care
  - Intensive multidisciplinary assessment of high risk populations
  - Intensive interventions in hospitals
  - Comprehensive geriatric assessment in residential aged care
  - Clinically appropriate withdrawal of psychoactive medications
  - Medication review in residential aged care
  - Referral pathways to community programs
- Indicators of actions in facilities (ideally based on those in accreditation audits) such as
  - % staff receiving appropriate training
  - % of patients/residents assessed for falls risk according to protocols (noting eligibility criteria)
  - % of patients/ residents assessed as being at increased falls risk who receive evidence-based intervention

Across the whole plan:

- The appropriateness and acceptability of actions across all settings to Aboriginal people, people from CALD communities and any other groups identified as having specific needs requiring attention.

References and Appendices

References

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Appendix A: Examples of State & District Strategies & Plans Supporting Vulnerable Populations

Population	NSW	SESLHD
Aboriginal Health	Aboriginal Chronic Conditions Area Health Service Standards (NSW) http://www0.health.nsw.gov.au/pubs/2005/accahss_report.html NSW Aboriginal Health Plan 2013-2023 http://www0.health.nsw.gov.au/policies/pd/2012/PD2012_066.html	SESLHD Aboriginal Health Implementation Plan
Aged	Prevention of Falls and Harm from Falls among Older People: 2011-2015 http://www0.health.nsw.gov.au/policies/pd/2011/PD2011_029.html Dementia Services Framework 2010-2015 http://www0.health.nsw.gov.au/policies/gl/2011/GL2011_004.html Implementation Plan for NSW Dementia Services Framework 2010-2015 www0.health.nsw.gov.au/resources/policies/pdf/cd_dementia_services.pdf	SESLHD Falls Prevention Implementation Plan
Carers	NSW Carers (Recognition) Act 2010 Implementation Plan 2011 – 2014 www.adhc.nsw.gov.au/individuals/caring_for_someone/nsw_carers_recognition_act_2010 NSW Carers Action Plan 2007 - 2012 NSW Carers Action Plan 2007 - 2012 Walking with Carers in NSW http://www0.health.nsw.gov.au/pubs/2012/pdf/walking_with_carers_innsw.pdf	SESLHD Carer Action Plan, 2011-2012 http://seslhnweb/Carer_Support_Services/Local_Carer_Program.asp
Disability	A NSW National Disability Strategy Implementation Plan (NSW Government's initial priorities and actions) is under development. www.adhc.nsw.gov.au/about_us/strategies/national_disability_strategy Service Framework: to improve the health care of people with intellectual disability www0.health.nsw.gov.au/pubs/2012/service_framework_2012.html Access to therapy services for people with an intellectual disability and their families in NSW www0.health.nsw.gov.au/pubs/2010/therapy_mou.html	SESLHD Disability Action Plan 2010-2015

Population	NSW	SESLHD
Homeless	NSW Homelessness Action Plan 2009-2014 http://www.housing.nsw.gov.au/NR/rdonlyres/070B5937-55E1-4948-A98F-ABB9774EB420/0/ActionPlan2.pdf	Regional Homelessness Action Plan 2010-2014 - Coastal Sydney (2010) http://www.seslhd.health.nsw.gov.au/homelessness_health/PolicyContext.asp
Multicultural Health	NSW Health Policy and Implementation Plan for Healthy Culturally Diverse Communities 2012-2016. http://www0.health.nsw.gov.au/policies/pd/2012/PD2012_020.html	Multicultural Health Service Strategic Plan 2010 – 2012 www.sesiahs.health.nsw.gov.au/multicultural_health_service/Documents/SESIAHS%20Multicultural%20Health%20Service%20Strategic%20Plan%20Report.pdf
Refugee Health	Refugee Health Plan 2011-2016 http://www0.health.nsw.gov.au/policies/pd/2011/PD2011_014.html Asylum Seekers - Medicare Ineligible - Provision of Specified Public Health Services http://www0.health.nsw.gov.au/policies/pd/2009/pdf/PD2009_068.pdf	SESLHD Refugee Health Implementation Plan (under development) http://www.sesiahs.health.nsw.gov.au/multicultural_health_service/
Youth Health	Youth Health Policy 2011-2016: Healthy bodies, healthy minds, vibrant futures http://www0.health.nsw.gov.au/policies/pd/2010/pdf/PD2010_073.pdf	Youth Health http://www.seslhd.health.nsw.gov.au/Youth_Health/default.asp

Appendix B: Development of the SESLHD Falls Injury Prevention Plan

The District's Falls Injury Prevention Plan has been developed through a wide consultative process. This process has been described in the relevant sections for each setting (under *Current Activity and Gaps in SESLHD*). The following list acknowledges the contributions of a large number of people who have given of their time and expertise to develop a comprehensive plan to guide the work of falls and falls injury prevention over the next 5 years.

Plan Contributors

SESLHD Health Service Falls Advisory Committee Members

Name	Position/Group Represented
Leanne Reid	Falls Prevention Program Coordinator/Committee Chair
Julie Dixon	Director, Planning and Population Health Directorate
Myna Hua	Manager, Health Promotions Service
George Rubin	Director, Clinical Governance Unit, Executive Sponsor
Elizabeth Abbott	Clinical Coordinator, Mental Health Services for Older People
Louise Baird	Staff Specialist, Geriatric Medicine
Jenny Blennerhassett	Pharmacist, Community Health
Trish Bradd	Director, Allied Health
Kim Brookes	Patient Safety and Consumer Feedback Manager
Jacqui Close	Staff Specialist, Geriatric Medicine
Lynda Craig	Clinical Governance, War Memorial Hospital
Ms Janette (Jan) Denniss	Consumer Representative
Philippa Eccleston	Health Promotions officer, HPS
Debbie Edwards	Patient Safety Officer, POW
Erica Gray *	Manager, Health Promotions Service
Luckman Hlambelo	Clinical governance, Calvary Hospital
Cherie Hooker	Nurse Educator, Aged Care, POW
Maria Jessing	Clinical Improvement Manager, Clinical governance Unit
Deborah Kelly	Clinical Nurse Consultant, Chronic Care Services
Paula McShane	General Manager, Garrawarra
Kristin Mbothu	Director, POW Community Health
Glenn Power *	Clinical Stream Manager, Aged Care and Rehabilitation Services
Nurit Schnapp	Occupational Therapist, War Memorial Hospital

Dieter Schultejohann	Senior Work Health Safety Officer
Susan Sullivan	Manager, Falls Injury Prevention Program, HPS
Nicole Wedell	Nursing Co-Director Aged Care, Rehabilitation and Extended Community Care
Trish Wills	Manager, CPIU, St George Hospital

*No longer working in this position

Others Co-opted to the Committee during Consultation Process

Name	Position
Andrew Lawson	Acting Falls Prevention Program Coordinator
Dan West *	Acting Director, Nursing, Sutherland Hospital, Falls Committee Co-Chair
Danijela Stanisic *	Nurse Unit Manager, St George Hospital, Delegate for SGH Falls Committee Chair
Deborah Maiden	Senior Occupational Therapist, Sutherland Hospital, Falls Committee Co-chair
Elizabeth Endean	Nurse Unit Manager, Aged Care St George Hospital, Falls Committee Chair
Heather Doolan	PACE Project Coordinator, St George Hospital
Karen Crean	Sutherland Hospital Executive Support Nurse Unit Manager, Sutherland Hospital Falls Committee Co-chair
Lyn Woodhart	Manager, CPIU, Royal Hospital for Women
Robyn Gordon	Exercise Physiologist, Garrawarra
Victoria Westley-Wise	Medical Epidemiologist, Directorate, Planning and Population Health

*No longer working in this role for Facility Falls Committees

Community Consultations and Community Falls Roundtable Event

Organisations/groups Represented
Aged and Community Services Association
Ambulance Service of NSW
Ambulatory and Primary Health Care Directorate, (Aboriginal Health and Multicultural Health) SESLHD
Botany Bay City Council
City of Sydney Council
Community Health Service, Calvary Healthcare
Eastern Sydney Medicare Local
Family and Community Services
Garrawarra Centre, SESLHD

Hurstville City Council
Inner South West Community Development Organisation
Northern Sector Aged Care and Community Health Services, SESLHD
Planning and Population Health Directorate, SESLHD
Randwick City Council
Rockdale City Council
SHARE
South Eastern Sydney Medicare Local
Southern Community Care Development Inc
Southern Sector Aged Care and Community Health Services, SESLHD
St George Community Housing
St George Migrant Resource Centre
Sutherland Shire Council
Woollahra Municipal Council

Other Consultations (to be undertaken from July 2013)

SESLHD Facility and Service Clinical Councils
District Clinical and Quality Council
Northern Hospital Network Clinical Council
Mental Health Clinical Council
Royal Hospital for Women Clinical Council
St George Hospital Clinical Council
The Sutherland Hospital Clinical Council

SESLHD Clinical Streams
Aged Care and Rehabilitation
Ambulatory and Primary Health Care
Cancer
Cardiac and Respiratory
Critical Care and Emergency Medicine
Medicine

Mental Health
Medical Imaging
Pathology
Surgical and Anaesthetics
Women's and Children's Health

SESLHD Governance Committees
SESLHD Board
District Executive Team
District Clinical and Quality Council
Medical Staff Executive Council
Executive Directors of Nursing Meeting
District Allied Health Meeting

SESLHD Directorates
Clinical Governance
Directorate Planning and Population Health
Finance and Corporate Services
Information, Communication and Technical services
Nursing and Midwifery
Operations, Ambulatory and Primary Healthcare
Workforce Services

Other Hospitals and Facilities within SESLHD Boundaries
St Vincent's Hospital (Darlinghurst)
Sacred Heart Hospice
Sydney Children's Hospital (Randwick)

Other
Agency of Clinical Innovation
Clinical Excellence Commission (NSW Falls Prevention Program)

Appendix C: Aboriginal Health Impact Statement

Aboriginal Health Impact Statement Declaration

An Aboriginal Health Impact Statement Declaration (and a completed Checklist where necessary) will accompany new policies and proposals for major health strategies and programs submitted for Executive or Ministerial approval. This will ensure that the health needs and interests of Aboriginal people have been considered, and where relevant, appropriately incorporated into health policies.

THE ABORIGINAL HEALTH IMPACT STATEMENT DECLARATION

Title of the policy/initiative: Falls Injury Prevention Plan 2013-2018

Please complete the Declaration below and the Checklist **if required**.

Please tick relevant boxes:

- [x] The health* needs and interests of Aboriginal people have been considered, and appropriately addressed in the development of this initiative.
- [x] Appropriate engagement and collaboration with Aboriginal people has occurred in the development and implementation of this initiative.
- [x] Completed Checklist attached.

OR

- [ ] The health* needs and interests of Aboriginal people have been considered, in the development of this initiative.
- [ ] The Aboriginal Health Impact Statement Checklist does not require completion because there is no direct or indirect impact on Aboriginal people. (Please provide explanation.)

NB with regards to the statement above regarding engagement and collaboration with Aboriginal people: this is just the first planning step in a five-year process. We do not consider the consultation process to be over. The collaboration to date has been appropriate and highly valued, but there will also be substantial ongoing engagement and collaboration in the future.

Head of Unit Name and Title: Gail Daylight

Unit Name: Aboriginal Health Unit

Area Health Service/NSW Health Branch: South Eastern Sydney Local Health District

Signature: G Daylight Date: 06 / 08 / 2013

Contact phone no: 02 9540 8870 Email address: gail.daylight@sesiahs.health.nsw.gov.a

*For Aboriginal people, health is defined as not just the physical well-being of the individual but the social, emotional and cultural well-being of the whole community.

Aboriginal Health Impact Statement Checklist

This Checklist should be used when preparing an Aboriginal Health Impact Statement for new health policies, as well as major health strategies and programs. To complete the checklist and to fully understand the meaning of each checklist item, it is essential to refer to *How to Use the checklist* in Part 3 of the Aboriginal Health Impact Statement.

Development of the policy, program or strategy

1. Has there been appropriate representation of Aboriginal stakeholders in the development of the policy, program or strategy? ☑ Yes ○ No

2. Have Aboriginal stakeholders been involved from the early stages of policy, program or strategy development? ☑ Yes ○ No

Please provide a brief description

This initial planning process has focused on the review of evidence, local data and local actions (past, present and potential for the future). Falls injuries in older people is an emerging issue for Aboriginal health that will require careful consideration. The SESLHD Manager of Aboriginal Health, Gail Daylight, has been the key contact person for this process, providing direct input to the plan, and engaging a range of local stakeholders to provide additional input and advice.

3. Have consultation/negotiation processes occurred with Aboriginal stakeholders? ☑ Yes ○ No ○ N/A

4. Have these processes been effective? ☑ Yes ○ No

Explain

The input provided has been highly valued. This has included identifying the priorities for future action, processes for engaging local staff and communities, evidence review, and providing advice regarding language and presentation of the plan. All suggestions have been taken on board and incorporated into the plan.

5. Have links been made with relevant existing mainstream and/or Aboriginal-specific policies, programs and/or strategies? ☑ Yes ○ No ○ N/A

Explain

This plan flows from the NSW Falls Injury Prevention Policy. That Strategy states that the needs of Aboriginal people should be considered, but SESLHD is free to determine the most appropriate approach at the local level. The plan has been written in a manner to ensure that this occurs.

Contents of the policy, program or strategy

6. Does the policy, program or strategy clearly identify the effects it will have on Aboriginal health outcomes and health services? ☑ Yes ○ No

Comments

On a typical day, 24 adults residing in SESLHD are hospitalised due to a fall. For many, the consequences will be life-changing, or even fatal. Falls injuries are one of the rare indicators where the marked inequities experienced by Aboriginal people are difficult to see: there are fewer frail, elderly Aboriginal people at risk of falling, but poor identification and recording make it difficult properly recognise that do. There is much to be done to more clearly understand the scope of the issue, and address it appropriately.

7. Have these effects been adequately addressed in the policy, program or strategy? ☑ Yes ○ No

Explain

Consideration of the needs of Aboriginal people, engagement of Aboriginal staff and community members, the appropriateness of interventions, and better data and indicators to track progress are described across all parts of the plan. These include primary prevention strategies in community settings (such as physical activity), identification, risk triage and referral into prevention strategies for people coming into contact with relevant services, and falls injury prevention in health facilities managed by SESLHD.

8. Are the identified effects on Aboriginal health outcomes and health services sufficiently different for Aboriginal people (compared to the general population) to warrant the development of a separate policy, program or strategy? ○ Yes ☑ No ○ N/A

Explain

It is preferable to include Aboriginal actions within the main plan rather than develop a separate plan. This will ensure that all aspects of the plan routinely and systematically consider of the needs of Aboriginal people, as should be the case across all services. This will also ensure direct contact and access to the falls injury prevention evidence, intervention tools, infrastructure (such as linkages to the Clinical Excellence Commission NSW Falls Prevention Program) and local resources.

Implementation and evaluation of the policy, program or strategy

9. Will implementation of the policy, program or strategy be supported by an adequate allocation of resources specifically for its Aboriginal health aspects? ☑ Yes ○ No ○ N/A ○ To be advised

Describe

One of the District's key priorities is to adequately resource the health needs to Aboriginal people to reduce inequities of health service access and outcomes. Implementation of actions outlined in this Plan will be prioritised by the overarching committees responsible for implementation/monitoring implementation. All actions which require additional resources will be carried out subject to availability of funds provided by the District or State or Commonwealth.

10. Will the initiative build the capacity of Aboriginal people/organisations through participation? ☑ Yes ○ No ○ N/A

In what way will capacity be built?

Falls is an issue in which little work has previously been done in relation to Aboriginal issues. It was virtually the only health issue in Australia for which Aboriginal people were not deemed to be at higher risk than non-Aboriginal people. As the Aboriginal population ages, the risks associated with old age are becoming more apparent. This represents an opportunity for all the stakeholders involved, Aboriginal and non-Aboriginal alike, to learn more about this issue and build personal and professional capacity through their involvement in the development and implementation of this plan.

11. Will the policy, program or strategy be implemented in partnership with Aboriginal stakeholders? ☑ Yes ○ No ○ N/A

Briefly describe the intended implementation process

This is essential. SESLHD Aboriginal Health will continue to provide input and leadership to ensure this.

12. Does an evaluation plan exist for this policy, program or strategy? ○ Yes ☑ No ○ N/A

13. Has it been developed in conjunction with Aboriginal stakeholders? ○ Yes ○ No ☑ N/A

Briefly describe Aboriginal stakeholder involvement in the evaluation plan

Broad indicators are described (eg a reduction in hospitalisations due to falls) but the specific evaluation plan to track these is yet to be developed. It is important that this occur in the next steps, in consultation with local Aboriginal stakeholders to ensure both relevance and feasibility.

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