

BRIEFING TO THE AET COMMITTEE

Subject: Implementation Plan for the NSW Health Management Policy to Reduce Fall Injury Among Older People in HNE Health

Appendix A: Plan



HUNTER NEW ENGLAND
NSW HEALTH

NSW Health Management Policy
to Reduce Fall Injury Among Older People

HNE Health Implementation Plan

July 2007 – June 2010

HNE Fall Injury Prevention Among Older People Advisory Committee

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Background

The NSW Health Management Policy to Reduce Fall Injury Among Older People

The high prevalence of falls and falls injuries in people aged 65 and over is an issue of serious and growing concern. Between one in four^{1,2,3} and one in three^{4,5,6} community-dwelling people aged 65 or over have at least one fall per year, and many fall more than once. Data describing falls in hospitals and residential aged care facilities are less reliable, but falls rates in these settings are generally thought to be even higher⁷, notably in specific clinical groups such as patients who have experienced a stroke⁸. Estimates from residential aged care suggest that the prevalence of falls there may exceed 50%^{9,10}.

Whilst not all falls result in injury or death, the burden of illness from those that do is significant. Older people are generally more susceptible to serious injury from a fall than younger people are¹¹. Hospital stays and rehabilitation can be long and expensive⁸ and having had a recent fall is one of the leading reasons for premature admission to permanent residential aged care¹¹. No other single injury cause, including road trauma, costs the health system more than fall injury⁷ and this is set to increase dramatically as the population ages. If there is no change in the rate of falls injuries across NSW over the next 50 years, the demographic shift of an aging population will result in a doubling of the demands on the resources of the health system, and an extra 800 hospital beds and 1200 nursing home places will be required to meet this demand¹². Even non-injurious falls can have a negative impact on a person's quality of life. A fall can cause an older person to lose confidence, become fearful of falling and reduce their activity levels. In time, this limits their mobility and strength, and therefore actually increases their likelihood of falling again⁹.

In response to these issues, NSW Health developed the *Management Policy to Reduce Fall Injury Among Older People*^{7,13}. The policy recommends strategies across three key settings: the community, acute care and residential aged care. Major policy areas across these settings include generating a low-risk population, preventing injury in people from high risk groups and improving the effectiveness of health and other systems.

A governance structure has been developed to ensure delivery of the plan across NSW (Figure 1). The NSW Health Injury Prevention Policy Branch is responsible for the implementation of this policy across NSW. Program management is overseen by the NSW Leader, Falls Program, and Falls Injury Prevention Coordinators have been appointed in each Area Health Service (AHS). The evaluation of the policy implementation is being independently coordinated by the NSW Injury Risk Management Research Centre. Key indicators have already been included in AHS Performance Agreements.



Figure 1: Plan governance across NSW

The Hunter New England Area Health Service

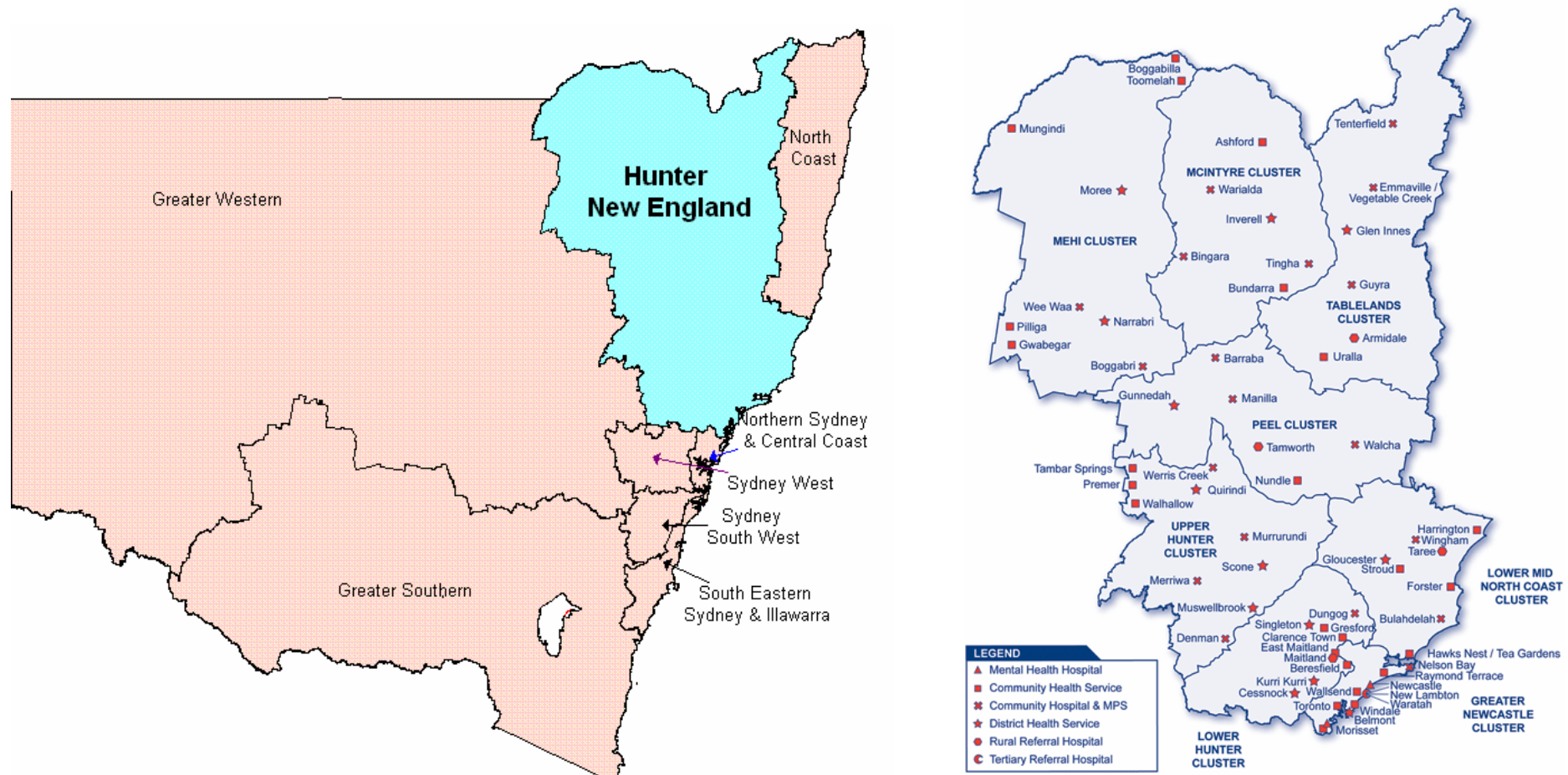


Figure 2: Hunter New England Area Health Service

Hunter New England Health provides care for approximately 840,000 people living across 130,000 square kilometres: an area that spans 25 local government areas. To effectively manage its vast and complex network of health services, Hunter New England Health has established a head office in Newcastle and a regional office in Tamworth. For administrative purposes, it has also divided the geographic area into 8 clusters and 4 acute hospital networks.

Falls injuries in the HNEAHS

■ Demographic profile of older people in the HNEAHS

Table 1: Demographic profile by Cluster and total AHS, 2004		
Cluster	N people aged 65+	Total population
Greater Newcastle	63,341	397,277
Lower Hunter	16,681	138,384
Lower Mid North Coast Cluster	18,488	85,562
McIntyre Cluster	3,671	20,895
Mehi Cluster	3,447	30,266
Peel Cluster	11,277	72,376
Tablelands Cluster	7,250	50,656
Upper Hunter Cluster	4,549	34,419
TOTAL HNEAHS	128,704	829,835

Note: Population estimates as at 30 June 2004.

Source: HOIST - Centre for Epidemiology and Research, NSW Department of Health. [Australian Bureau of Statistics, preliminary estimated residential populations based on 2001 Census counts and mid-series experimental population projections (ABS unpublished)].

■ Projections of the ageing population

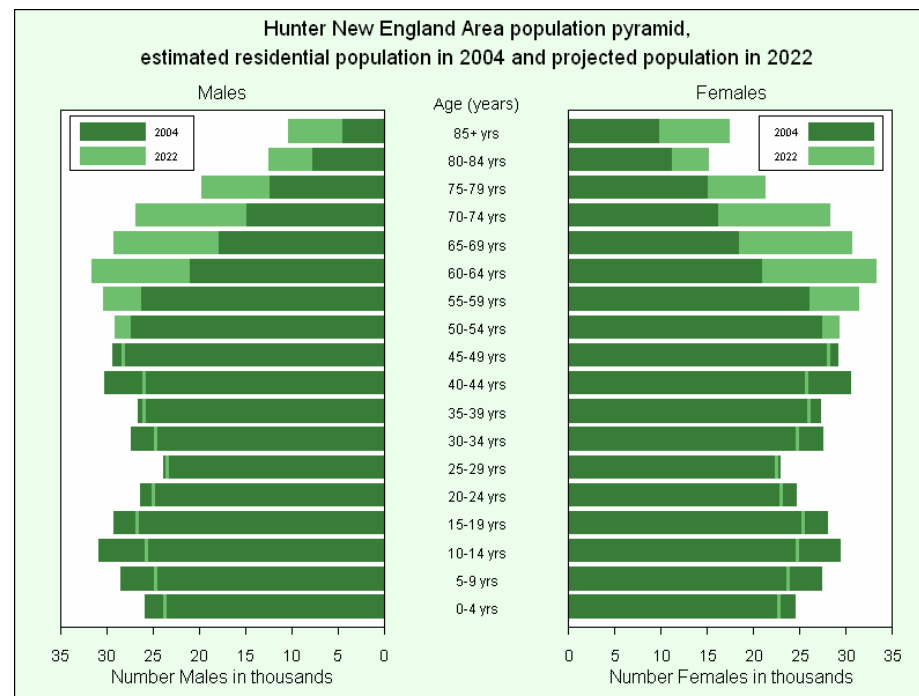


Figure 3: HNEAHS population pyramid 2004 with 2022 projections

Note: Population estimates as at 30 June each year. Where a bar does not have a segment for 2022, the number of people in that category is predicted to decrease by 2022. The predicted number is shown as a lighter coloured line on the overlying 2004 bar.

Source: HOIST - Centre for Epidemiology and Research, NSW Department of Health. [Australian Bureau of Statistics, preliminary estimated residential populations based on 2001 Census counts and mid-series experimental population projections (ABS unpublished)].

■ Falls injury hospital separations - HNEAHS

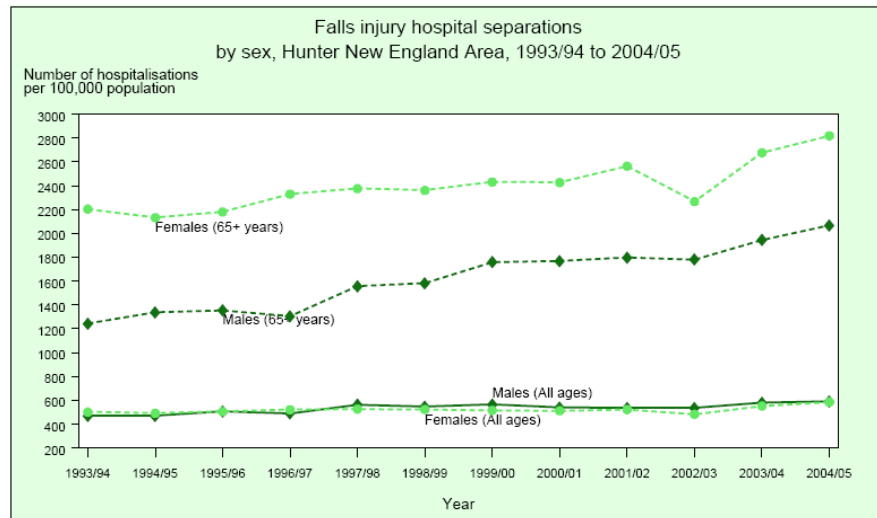


Figure 4: Falls injury hospital separations by sex, Hunter New England Area, 1993/94 to 2004/05

Note: Hospital separations were classified using ICD-9-CM up to 1997/98 and ICD-10-AM from 1998/99 onwards. Records relating to acute hospital transfer, statistical discharge, and same day stays were excluded. Rates were age-adjusted using the Australian population as at 30 June 2001.

Source: HOIST - Centre for Epidemiology and Research, NSW Department of Health. (NSW Inpatient Statistics Collection and ABS population estimates).

■ Falls injury hospital separations – by cluster

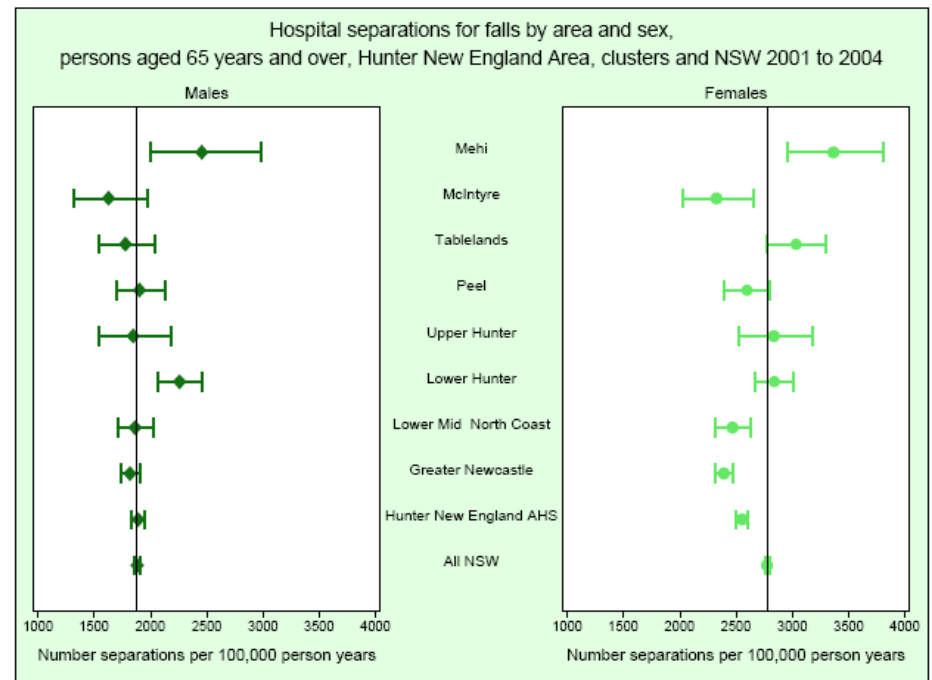


Figure 5: Fall-related injury hospitalisations in older people by cluster, Hunter New England Area, 2001 to 2004.

Note: Hospital separations were classified using ICD-9-CM up to 1997/98 and ICD-10-AM from 1998/99 onwards. Records relating to acute hospital transfer, statistical discharge, and same day stays were excluded. Rates were age-adjusted using the Australian population as at 30 June 2001. Rates are not shown in the graph where they are based on less than five separations. Counts and rates for a cluster are not shown in the table where any result for that cluster is based on less than five separations.

Source: HOIST - Centre for Epidemiology and Research, NSW Department of Health. (NSW Inpatient Statistics Collection and ABS population estimates).

Principles of this plan

With strategies across the community, acute/subacute care and aged care sectors, the principles of the falls policy support Strategic Direction 1 of the NSW State Health Plan: "Prevention is everybody's business" and will also contribute to Strategic Direction 2 "Create better experiences for people using health services"¹⁴.

The following broad principles are outlined in the State policy itself.

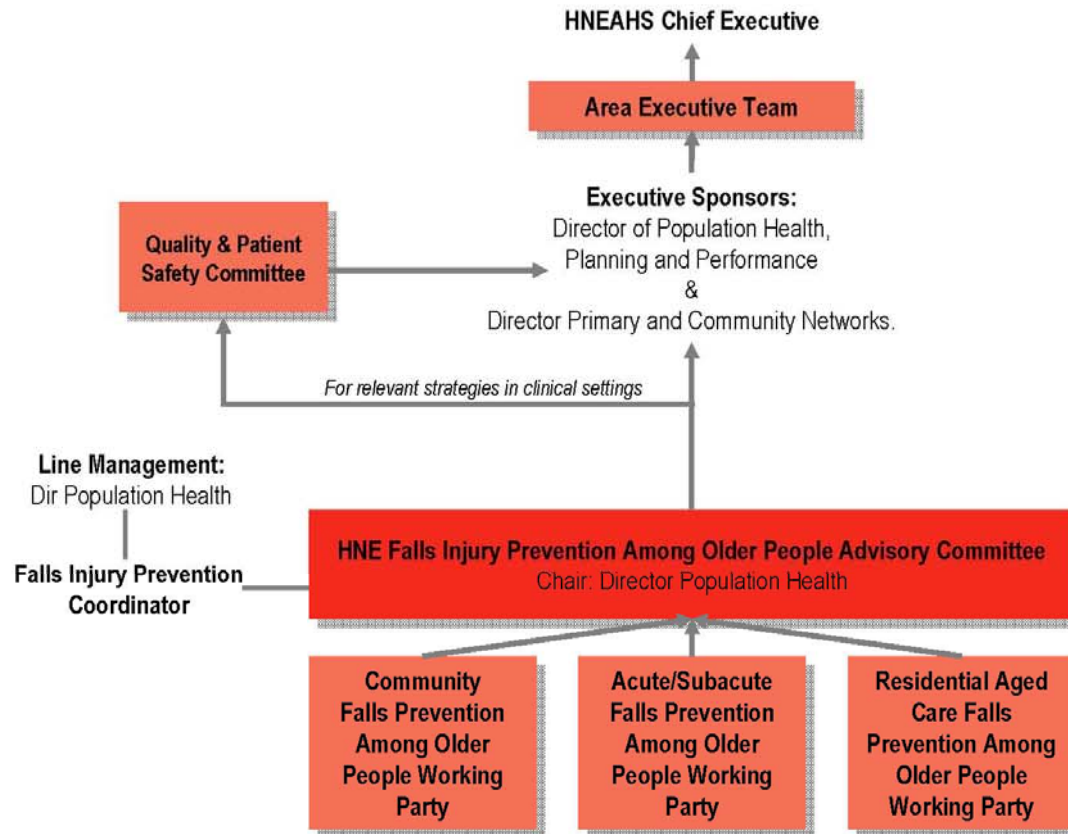
- **Establish a long term, coordinated approach.** The demographic shift of an ageing population will increase for up to fifty years in many locations. This is a long-term issue that requires a long-term commitment. Short-term, non-integrated reactions to changing demand will be ineffective and inefficient.
- **Recognise rights of older people.** Fall injury is preventable. Older people have the right to be provided with the information, treatment, environments and systems that minimise the risk of injury from a fall.
- **Build partnerships with communities and consumers.** Effective fall injury prevention requires the engagement of and commitment by communities. The policy encourages partnerships in developing and implementing prevention strategies.
- **Build the resilience of older people against fall injury.** The concept of 'immunising' against fall injury is based on evidence that the frequency of falling and the resistance of the person to injury can be altered through strategies such as physical activity.
- **Improve environments.** Most of the environments in which older people live and move will be upgraded at some stage. There is a need for a program to ensure that upgrades, as well as general maintenance of facilities, are undertaken in line with best practice for managing the risk of fall injury.
- **Minimise cost and optimise quality of life.** The ageing of the population is likely to increase the cost of health care services. The maintenance of mobility, dignity and purpose must therefore rank high in considering the mix of strategies to be used. This will involve making existing services more effective and efficient and developing new services that respond to the changing lifestyle choices of older people.

In addition to these broad concepts, the following principles have been identified for implementation of the policy by HNE Health.

- **Use evidence to responsibly identify the most appropriate investments in prevention and management.** This policy represents a significant undertaking and investment over a long period. It is essential that decisions about this investment are made responsibly and guided by the available evidence.
- **Recognise and build upon the local work that has already been done.** It is recognised that falls injury prevention initiatives have been underway for some time in the HNEAHS. This plan will respect, learn from and build upon those previous investments. It is not assumed all interventions have to be developed "from scratch" (note throughout this plan, actions often are phrased as "Identify/develop..." to recognise this fact).
- **Build the necessary capacity and infrastructure required to achieve sustainable outcomes.** Many of the strategies described in this plan will require a long-term commitment. Where organisational change is required, investments will be made in building sustainable capacity to ensure this can be delivered for the long-term. It is recognised that short-term "project thinking" will not provide sustainable solutions to this serious and growing issue.
- **Increase information-sharing across the AHS.** Sharing information describing both successful and unsuccessful initiatives will provide valuable insights to falls injury prevention. Efforts will be made to encourage information-sharing in an appropriate, inclusive, constructive and professional manner.
- **Ensure equity across the AHS.** Ensure that application of an equity approach relating to appropriate and accessible service provision for people who:
 - Are Aboriginal or Torres Strait Islander
 - Come from culturally and linguistically diverse backgrounds
 - Have disabilities (eg hearing loss, impaired vision, intellectual disability)
 - Are socio-economically disadvantaged
 - Are geographically isolated or who don't have access to transport.

Plan Governance in HNE Health

Figure 6 demonstrates how governance decisions will travel up through the organisation to the executive. An Advisory Committee will oversee the plan, supported by three working parties which will address the three core settings: Community, Acute/Subacute and Residential Aged Care.



Additional reporting linkages

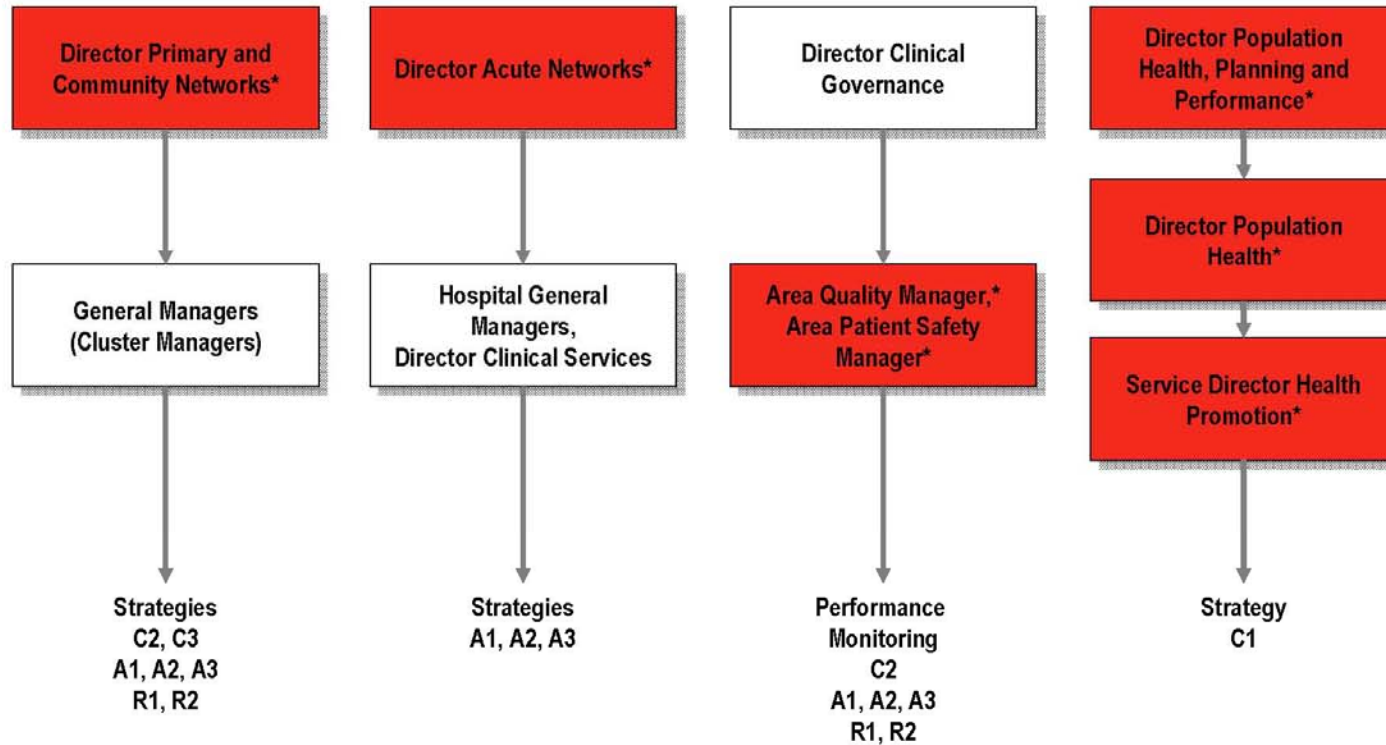
Due to the multifaceted requirements of this plan and the interdisciplinary nature of the strategies, there are a number of reporting relationships. These include but may not be limited to:

- The HNE Area Executive Team
- The Clinical Excellence Commission via the NSW Leader, Falls Injury Prevention Program
- NSW Health via the Injury Prevention Policy Branch
- HNE Aged Care and Rehabilitation Services Clinical Network
- HNE Acute Network/Cluster Quality and Patient Safety Committees
- HNE Clinical Streams
- HNE Area Quality Use of Medicines Committee

Figure 6: Plan governance in HNE Health

■ **Supporting the implementation process**

The governance structure provided in Figure 6 demonstrates how recommendations will be made and passed *up* through the organisation for endorsement. It is equally important to consider how the implementation will flow *down* through the organisation as well. Figures 7 describes the delegation flow for the implementation of the plan. Through the delegations shown, the strategies in this plan will be implemented and monitored. Red boxes in this diagram indicate members of the Advisory Committee: their direct involvement will ensure smooth implementation.



* Positions in red boxes are members of the Advisory Committee

Figure 7: Delegation flow for implementation

The strategy tables provided later in this document provide a more detailed breakdown of the responsibility for each of the specific plan actions. Where there is overlap in the delegation flow for the same strategy (eg A1, A2 and A3 as shown below), the Advisory Committee will ensure that there is appropriate consultation, communication and alignment.

In addition to the direct delegation of responsibilities shown in Figure 7, a wider communication process will be undertaken to enable the delivery of this plan. This will include communication through a number of clinical streams, networks, committees and identified positions. Figure 8 shows some of these likely communication channels. Additional channels for appropriate communication will be identified as the plan is implemented.

This will be expanded in a detailed communication plan that is being developed separate to this document.



Figure 8: Communication and information flow (in addition to direct delegations shown in Figure 7).

Implementation Plan: The Community Setting

Plan at a glance

Implementation of these strategies will be overseen by the Community Falls Injury Prevention Among Older People Working Party.

THE COMMUNITY SETTING

C1. Implement population-based prevention strategies for people living independently in the community.

- C1.1 Ensure the availability and promotion of appropriate physical activity groups that meet the needs of people aged 50 and over.
- C1.2 Ensure that there is opportunity for people aged 50 and over to participate in self-directed physical activity.
- C1.3 Provide low-cost community education strategies to support the state-wide social marketing campaign.
- C1.4 Work with local governments to reduce environmental risks in public places.

C2. Implement opportunistic brief intervention strategies for older people coming into contact with AHS services*.

- C2.1 Identify appropriate screening and assessment tools.
 - C2.2 Identify/develop and implement appropriate protocols for screening, brief intervention and referrals for patients that attend AHS services or are visited by relevant AHS community staff (eg CHCs, MPSs, home visiting etc).
- * Excludes Emergency Departments/Inpatient care (addressed in Acute/Subacute Setting strategies).*

C3. Strategies for people other relevant service providers (non-AHS).

- C3.1 Support other relevant service providers to deliver brief falls injury prevention strategies.

GETTING IT DONE

Actions to consider across all strategies

Leadership – Who will drive this process?

Who will be accountable for ensuring that it is delivered?

Organisational strategies – What is required within the organisation to facilitate and enable this? Example: written policies, endorsement and support of Area Executive.

Resources and tools – What is required to achieve this?

From funding sources to specific tools such as screening instruments.

Workforce development – What support do staff need?

May include formal training opportunities and informal approaches such as networks, mentoring and peer support.

Performance monitoring and feedback – How will we know if this is working?

Will include a process to monitor the performance of all units and provide feedback.

Figure 9: “Plan at a glance” – the Community Setting

Background and context

■ Actions occurring across NSW

NSW Health is coordinating a number of state-wide activities which will support the implementation of the policy across all Area Health Services.

- A social marketing campaign is being planned for 2008/9 and/or 2009/10. The campaign will provide a range of educational messages regarding falls injury prevention, with the primary recommendation being to increase physical activity to build resilience and hence build resilience against falls injuries. Secondary messages may include additional protective strategies which older people can undertake such as medication management, appropriate footwear, vision checking, home safety and the use of personal alarms. An important aspect of the campaign will be a focus on the concept of maintaining independence. It is important to ensure that a fear of falling is not inadvertently generated, as this actually increases the likelihood that an older person will become inactive and ultimately more frail and susceptible to fall injury.
- NSW Health will establish a permanent 1800 number to provide the community with access to information and advice about falls injury prevention. The main focus of this call centre will be the promotion of physical activity groups which provide appropriate activities for older people.
- A new training and accreditation scheme will be delivered through the fitness industry. This will provide training for people to deliver physical activity groups specifically designed to reduce falls injuries in older people. Leaders who complete this program will become eligible for fitness industry accreditation and insurance, and will be subject to their quality assurance frameworks. This will be important to area health service staff who will be seeking to refer community members only to those physical activity groups that are known to be appropriate and safe.

■ Focus for HNE Health

Within this state-wide context, the focus of HNE Health in this setting will include the following.

- The availability of physical activity opportunities suitable for people in or approaching older age (broadly including people aged 50 and over) will be increased. The AHS will not deliver these activities directly, but will instead build partnerships with private providers and build their capacity to do so, notably in the more rural and remote areas where current access to such activities is poor. This may include providing AHS venues for private leaders to run groups in. Organised physical activity groups that meet evidence, safety and quality criteria will be identified and/or formed to fit within the state-wide initiatives described above, notably to meet the industry accreditation standards and be sustainably promoted through databases managed by the state-wide 1800 line.
- Investments will also be made to support self-directed physical activity opportunities for older people (ie in addition to the organised groups described above). This will primarily be achieved by working with local governments and other relevant partners to build and maintain environments that support this.
- The state-wide social marketing campaign will be supported locally. There is no need to duplicate the state investment, and whilst education is an important aspect of falls injury prevention, the evidence suggests that it has a relatively small impact compared to the other strategies described herein. Local education strategies will therefore be low-cost and opportunistic. As with the state initiatives, the focus will be on “maintaining independence”.
- Brief interventions will be identified/developed for delivery through area health service providers such as community health services. This will represent a multi-strategic approach to falls injury prevention, and will include attention to related issues such as bone strength. Screening, brief advice, further clinical assessment where appropriate and follow-up referrals will be included in new protocols to be developed in consultation with the Quality and Patient Safety Committee and Clinical Governance. Implementation will be supported by resources, workforce development strategies and ongoing performance monitoring. Some community health services already have similar strategies in place which may form the basis of a more systematic, AHS-wide approach.
- The capacity for non-AHS delivery of brief interventions will also be explored. Possible settings include General Practice and various community services targeting older people. The AHS will play a supportive role in encouraging the appropriate delivery of brief interventions in these settings.

Detailed strategies and actions

Strategy C1: Implement population-based prevention strategies for people living independently in the community.

Sub-strategy	Actions			Responsibility ¹	Resource Implications ²
	2007/8	2008/9	2009/10		
C1.1 Ensure the availability and promotion of appropriate physical activity groups that meet the needs people aged 50 and over.	C1.1.1 Identify private providers and build partnerships. Identify current PA group availability and gaps in access.			HNEPH (leadership role) in partnership with the Active Over 50s program	\$\$ (HNEPH resourced to take leadership, but may require additional resources when rolling out across AHS).
	C1.1.2 Fill identified gaps through training new leaders, matching leaders to new venues etc.				
	C1.1.3 Identify/develop a sustainable professional network to support PA providers.				
	C1.1.4 Agree upon an appropriate "badging" model for AHS recommendation of appropriate PA groups. To include: criteria for endorsement and risk management strategies.				
		C1.1.5 Identify/develop a sustainable mechanism to track availability of AHS-recommended PA groups.			

¹ As this is a plan specifically for the AHS, "Responsibility" refers to AHS personnel/units only. However this does not preclude partnerships with other agencies.

² Similarly, "Resource Implications" refers to AHS resources only. These have been coded as follows:

\$ = achievable within current resources, \$\$ = achievable with some additional resources, \$\$\$ = will require significant additional investment

Sub-strategy	Actions			Responsibility ¹	Resource Implications ²
	2007/8	2008/9	2009/10		
		C1.1.6 Promote AHS-recommended PA groups to the public.		HNEPH (leadership role) in partnership with the Active Over 50s program. Additional support from HNEAHS Public Affairs.	\$
		C1.1.7 Encourage and support relevant service providers to refer patients/clients to AHS-recommended PA groups.		HNEPH (leadership role) in partnership with the Active Over 50s program. Additional support from the Aged Care and Rehabilitation Network.	\$
	C1.1.8 Develop appropriate performance indicators for C1.1			Community Working Party with support from Falls Injury Prevention Coordinator	\$
	C1.1.9 Collect appropriate performance indicators and provide reports to the HNE Falls Injury Prevention Advisory Committee (first due December 2007).				
C1.2 Ensure that there is opportunity for people aged 50 and over to participate in self-directed physical activity.	C1.2.1 Identify potential opportunities for self-directed PA such as walking (ie in addition to the more formally managed group activities described above). Work with relevant partners (such as local governments) to ensure that there is a supportive environment for these activities.			HNEPH Working in partnership with other groups to be identified as part of this action.	\$
	C1.2.2 Develop appropriate performance indicators for C1.2			Community Working Party with support from Falls Injury Prevention Coordinator	\$
	C1.2.3 Collect appropriate performance indicators and provide reports to the HNE Falls Injury Prevention Advisory Committee (first due December 2007).				
C1.3 Provide low-cost community education strategies to support the state-	C1.3.1 Establish feasible and equitable protocols for responding to community requests for information.			HNEPH	\$

Sub-strategy	Actions			Responsibility ¹	Resource Implications ²
	2007/8	2008/9	2009/10		
wide social marketing campaign.	C1.3.2 Identify/develop appropriate low-cost community education materials and dissemination strategies. May include: medication management, appropriate footwear, vision checking, home safety, personal alarms (etc).			HNEPH	\$
		C1.3.3 Deliver low-cost education strategies that support the state-wide social marketing campaign.		HNEPH with support as appropriate from partners including those identified earlier (eg Active Over 50s, groups to be identified in C1.2.1).	\$
	C1.3.4 Develop appropriate performance indicators for C1.3			Community Working Party with support from Falls Injury Prevention Coordinator	\$
	C1.3.5 Collect appropriate performance indicators and provide reports to the HNE Falls Injury Prevention Advisory Committee (first due December 2007).				

Sub-strategy	Actions			Responsibility ¹	Resource Implications ²
	2007/8	2008/9	2009/10		
C1.4 Work with local governments to reduce environmental risks in public places.	C1.4.1 Explore options for hazard reduction with key partners such as local governments (eg through improved planning processes). May consider: <ul style="list-style-type: none"> • slipping and tripping hazards • lighting design and intensity • clear marking of changes in level • installation of hand rails grab rails in ablution areas. This action may include lobbying for action at the State level.			HNEPH	\$
		C1.4.2 Build the capacity of local governments to systematically include agreed strategies into their planning processes.		HNEPH	\$
	C1.4.3 Develop appropriate performance indicators for C1.1			Community Working Party with support from Falls Injury Prevention Coordinator	\$
	C1.4.4 Collect appropriate performance indicators and provide reports to the HNE Falls Injury Prevention Advisory Committee (first due December 2007).				

Strategy C2: Implement opportunistic brief intervention strategies for older people coming into contact with AHS services.

NB excludes Emergency Departments and inpatient services: these are addressed in the Acute Setting section of this plan.

Sub-strategy	Actions			Responsibility	Resource Implications
	2007/8	2008/9	2009/10		
C2.1 Identify appropriate screening and assessment tools.	<p>C2.1.1 Identify current practice across the AHS.</p> <p>Screening = stratifies patients to High/Low etc.</p> <p>Assessment = more detailed diagnostic assessment to specifically identify which risk factors require clinical attention.</p>			<p>Community Working Party to take leadership, with input from:</p> <ul style="list-style-type: none"> • Area Allied Health Committee • Aged Care and Rehabilitation Clinical Network • Managers of CHCs and MPSs • Rankin Park Day Hospital Falls Clinic • Aged Care Assessment Teams • Transitional Aged Care Service • Community nurses • Physiotherapists • Occupational Therapists • IT staff (eg re: CHIME) • Patient Safety Officers • AHS HACC positions • Other relevant staff as appropriate <p>NB. HNE Falls Injury Prevention Advisory Committee to ensure that there are appropriate linkages between <i>all</i> actions in this plan related to screening and assessment tools.</p>	\$

Sub-strategy	Actions			Responsibility	Resource Implications
	2007/8	2008/9	2009/10		
	C2.1.2 Agree upon criteria for tool selection, for endorsement by Quality and Patient Safety Committee. (Although a single tool across the AHS is preferable, this may not be feasible. This proposes that different tools may be used but that all must meet the agreed criteria).			<p>Community Working Party to take leadership, with input from:</p> <ul style="list-style-type: none"> • Area Allied Health Committee • Aged Care and Rehabilitation Clinical Network • Managers of CHCs and MPSS • Rankin Park Day Hospital Falls Clinic • Aged Care Assessment Teams • Transitional Aged Care Service • Community nurses • Physiotherapists • Occupational Therapists • IT staff (eg re: CHIME) • Patient Safety Officers • AHS HACC positions • Other relevant staff as appropriate 	<p>\$\$</p> <p>This may benefit from recruitment of a project officer (or equivalent) to support scoping, development and preparation for the whole AHS.</p>
	C2.1.3 Develop appropriate performance indicators for C2.1			Community Working Party with support from Falls Injury Prevention Coordinator	\$
	C2.1.4 Collect appropriate performance indicators and provide reports to the HNE Falls Injury Prevention Advisory Committee (first due December 2007).				

Sub-strategy	Actions			Responsibility	Resource Implications
	2007/8	2008/9	2009/10		
C2.2 Identify/develop and implement appropriate protocols for screening, brief intervention and referrals for patients that attend AHS services or are visited by relevant AHS community staff (eg CHCs, MPSs, home visiting etc).	C2.2.1 Identify which AHS units and personnel are appropriately placed to deliver this intervention, and investigate the current practices where strategies are already in place.			<p>Community Working Party to take leadership, with input from:</p> <ul style="list-style-type: none"> • Area Allied Health Committee • Aged Care and Rehabilitation Clinical Network • Managers of CHCs and MPSs • Rankin Park Day Hospital Falls Clinic • Aged Care Assessment Teams • Transitional Aged Care Service • Community nurses • Physiotherapists • Occupational Therapists • IT staff (eg re: CHIME) • Patient Safety Officers • AHS HACC positions • Other relevant staff as appropriate 	<p>\$\$</p> <p>This may benefit from recruitment of a project officer (or equivalent) to support scoping, development and preparation for the whole AHS.</p>

Sub-strategy	Actions			Responsibility	Resource Implications
	2007/8	2008/9	2009/10		
	<p>C2.2.2 Identify/develop written protocols for the endorsement of the Quality and Patient Safety Committee.</p> <p>To include:</p> <ul style="list-style-type: none"> • Screening process • Brief interventions as required (eg brief advice, brief home safety audits if home visiting etc). • Appropriate referral protocols to additional services as required (eg more comprehensive clinical assessment if appropriate, PA groups, falls clinic, GP care, vision checks). • Appropriate systems for maintaining records of screening, outcomes and referral pathways. • Appropriate processes to identify service blocks and recommend solutions. 			<p>Community Working Party to take leadership, with input from:</p> <ul style="list-style-type: none"> • Area Allied Health Committee • Aged Care and Rehabilitation Clinical Network • Managers of CHCs and MPSS • Rankin Park Day Hospital Falls Clinic • Aged Care Assessment Teams • Transitional Aged Care Service • Community nurses • Physiotherapists • Occupational Therapists • IT staff (eg re: CHIME) • Patient Safety Officers • AHS HACC positions • Other relevant staff as appropriate 	<p>\$\$</p> <p>This may benefit from recruitment of a project officer (or equivalent) to support scoping, development and preparation for the whole AHS.</p>

Sub-strategy	Actions			Responsibility	Resource Implications
	2007/8	2008/9	2009/10		
	C2.2.3 Identify/develop written resources to support implementation of protocols.			Community Working Party to take leadership, with input from: <ul style="list-style-type: none"> • Area Allied Health Committee • Aged Care and Rehabilitation Clinical Network • Managers of CHCs and MPSS • Rankin Park Day Hospital Falls Clinic • Aged Care Assessment Teams • Transitional Aged Care Service • Community nurses • Physiotherapists • Occupational Therapists • IT staff (eg re: CHIME) • Patient Safety Officers • AHS HACC positions • Other relevant staff as appropriate 	\$\$ This may benefit from recruitment of a project officer (or equivalent) to support scoping, development and preparation for the whole AHS.
	C2.2.4 Identify/develop a process for monitoring compliance with the new protocols.			Clinical Governance, with strategic support as appropriate from Community Working Party.	\$

Sub-strategy	Actions			Responsibility	Resource Implications
	2007/8	2008/9	2009/10		
		<p>C2.2.5 Identify/develop and deliver appropriate strategies to implement new protocols across HNE Health. These may include:</p> <ul style="list-style-type: none"> • Identification of “change agents” in each facility/team, to take a leadership role • Written protocols (see C2.2.2) • Written resources (see C2.2.3) • Staff training • Communication strategies • Performance monitoring and feedback 		<p>Community Working Party to have strategic oversight and ensure communication and information sharing across the AHS.</p> <p>Managers of individual facilities/teams to take local responsibility for rollout, reporting up through usual management hierarchy (see page 9 of this plan).</p>	\$\$
		<p>C2.2.6 Track compliance with protocols over time, and feed this information back to individual facilities and teams.</p>		<p>Clinical Governance, with strategic support as appropriate from Community Working Party.</p>	\$
	<p>C2.2.7 Develop appropriate performance indicators for C2.2</p>			<p>Community Working Party with support from Falls Injury Prevention Coordinator</p>	\$
		<p>C2.2.8 Collect appropriate performance indicators and provide reports to the HNE Falls Injury Prevention Advisory Committee (first due December 2007).</p>			

Strategy C3: Implement opportunistic brief intervention strategies for older people coming into contact with other (non-AHS) relevant service providers.

Sub-strategy	Actions			Responsibility	Resource Implications
	2007/8	2008/9	2009/10		
C3.1 Support other relevant service providers to deliver brief falls injury prevention strategies.	C3.1.1 Identify which service providers are appropriately placed to deliver brief interventions such as screening, brief advice and referral. May include (but not limited to): General Practitioners, Practice Nurses, community services accessing older people.			Community Working Party to take leadership, with input from: <ul style="list-style-type: none"> • HNEPH • HACC • Department of Veterans' Affairs • Private home nursing providers • Department of Ageing, Disability and Home Care • Divisions of General Practice / Practice Nurses • Commonwealth Carelink • Other relevant organisations as appropriate 	\$
	C3.1.2 Consult with service providers to determine current capacity, activities and potential for brief interventions.				

Sub-strategy	Actions			Responsibility	Resource Implications
	2007/8	2008/9	2009/10		
		<p>C3.1.3 Build the capacity of these service providers to increase their delivery of brief interventions. Actions will depend on context but may include:</p> <ul style="list-style-type: none"> • Identification/development/provision of written protocols/policies. • Identification/development/provision of resources to support implementation (such as tools and written information). • Workforce development and training. 		<p>Community Working Party to take strategic leadership, in partnership with all relevant organisations identified in C3.1.1/C3.1.2</p> <p>As C3 refers to non-AHS organisations, a decision must be made regarding the level of investment that HNE Health wishes to make. This is to be determined by the HNE Falls Injury Prevention Among Older People Advisory Committee. The resource implications shown here are options for consideration.</p>	<p><i>Minimal model (\$):</i> Share copies of all resources developed for C2/C3.</p> <p><i>More intensive model (\$\$):</i> Recruitment of a project officer (or equivalent) for this specific role. Could be aligned with similar tasks described in C2.</p>
	C3.1.4 Develop appropriate performance indicators for C3.1			Community Working Party with support from Falls Injury Prevention Coordinator	\$
	C3.1.5 Collect appropriate performance indicators and provide reports to the HNE Falls Injury Prevention Advisory Committee (first due December 2007).			Community Working Party with support from Falls Injury Prevention Coordinator	\$

Implementation Plan: The Acute/Subacute Care Setting

Plan at a glance

Implementation of these strategies will be overseen by the Acute/Subacute Falls Injury Prevention Among Older People Working Party.

THE ACUTE/SUBACUTE SETTING

A1: Implement systematic data collection and screening protocols in Emergency Departments.

- A1.1 Improve triage coding at the front desk to ensure there are valid and reliable data describing ED presentations related to a fall.
- A1.2 Identify/develop appropriate screening tools which are feasible to use in EDs.
- A1.3 Identify/develop and implement appropriate protocols for screening and referral in the ED setting.

A2. Improve the quality and consistency of data collected to describe inpatient falls.

- A2.1 Ensure that the data collected describing inpatient falls (eg through IIMS) are valid and reliable.

A3. Improve the prevention and management of falls injuries in inpatients.

- A3.1 Identify/develop appropriate screening and assessment tools which are feasible to use in the inpatient setting.
- A3.2 Identify/develop appropriate protocols for screening on admission.
- A3.3 Identify/develop targeted strategies to prevent falls and falls injuries in patients identified as being at high risk.
- A3.4 Identify/develop broad falls injury prevention strategies for all patients, regardless of risk.
- A3.5 Identify/develop appropriate post-fall management strategies.
- A3.6 Identify/develop appropriate discharge planning protocols.
- A3.7 Implement change management strategies to support sustainable the delivery of strategies A3.1 – A3.6.

GETTING IT DONE

Actions to consider across all strategies

Leadership – Who will drive this process?

Who will be accountable for ensuring that it is delivered?

Organisational strategies – What is required within the organisation to facilitate and enable this? Example: written policies, endorsement and support of Area Executive.

Resources and tools – What is required to achieve this?

From funding sources to specific tools such as screening instruments.

Workforce development – What support do staff need?

May include formal training opportunities and informal approaches such as networks, mentoring and peer support.

Performance monitoring and feedback – How will we know if this is working?

Will include a process to monitor the performance of all units and provide feedback.

Figure 10: “Plan at a glance” – the Acute/Subacute Setting

Background and context

■ Actions occurring across NSW

NSW Health is coordinating a number of state-wide activities which will support the implementation of the policy across all Area Health Services.

- The choice of screening and assessment tools has been the focus of much discussion across NSW. Whilst consensus on a single tool for use by all might be seen by some as ideal, it is unlikely because of the significant investments already made in many areas, and the different context of clinical services from busy metropolitan hospitals to small rural clinics. It is more likely that consensus will be reached on general quality criteria for tool selection, and a small number of specific tools recommended. The Falls Injury Prevention Coordinators across the State are discussing this in depth, and the Prince of Wales Medical Research Institute is providing expert input on tools for the emergency department setting in particular.
- The Australian Council for Safety and Quality in Health Care has released a resource kit of “Best Practice Guidelines for Australian hospitals and residential aged care facilities”. Known colloquially in clinical circles as “The Big Green Box”, this kit has already been disseminated across the State. NSW Health is funding a rural telehealth pilot project to provide supportive training to clinicians in a number of sites including Tamworth and Taree. If this pilot is successful, additional training will be provided more widely to support its implementation.

■ Focus for HNE Health

Within this state-wide context, the focus of HNE Health in this setting will include the following.

- Efforts will be made to improve triage coding at the front desk of Emergency Departments (EDs) to improve the data describing ED presentations related to a fall. The validity and reliability of these data are essential not only to plan individual patient care, but to provide a larger picture of trends in fall injuries across the AHS.
- Appropriate protocols for falls risk screening in EDs will also be identified/developed and implemented. In recognition of the busy nature of EDs, the process will be kept minimal, with screening simply designed to identify high risk patients and make appropriate referrals for follow-up care. Follow-up may range from the referral of relatively low-risk people to population strategies such as physical activity groups to interventions for higher risk patients such as more detailed clinical assessment and treatment by general practitioners and/or community health services.
- Inpatient care will be improved in two ways. Firstly, efforts will be made to improve the quality and consistency of data collected to describe inpatient falls. Again, this is necessary not only to improve individual patient care but also to provide a clearer understanding of trends across the AHS. Secondly, a number of strategies will be identified/developed to prevent and manage falls by inpatients. These will include screening on admission, more detailed clinical assessment of higher risk patients, targeted prevention strategies for high risk patients, and broader environmental strategies to protect all patients. Post-fall management will be improved when incidents do occur, and appropriate discharge planning protocols will be enacted. This set of strategies will require significant investment over time in the organisational change required for sustainable outcomes, from the endorsement and support of the AHS executive and relevant groups such as the Quality and Patient Safety Committee and Clinical Governance, to resource identification/development, staff training, compliance monitoring and performance feedback.
- All strategies will be delivered with appropriate reference to “Best Practice Guidelines for Australian hospitals and residential aged care facilities”.

This setting in particular reflects the importance of the principles outlined earlier: that a long-term, coordinated approach is essential, and that investments in building capacity will be required to ensure sustainable outcomes.

Detailed strategies and actions

Strategy A1: Implement systematic data collection and screening protocols in Emergency Departments.

Sub-strategy	Actions			Responsibility ³	Resource Implications ⁴
	2007/8	2008/9	2009/10		
A1.1 Improve triage coding at the front desk to ensure there are valid and reliable data describing ED presentations related to a fall.	A1.1.1 Establish what the current practices and issues are across the AHS.			Acute/Subacute Working Party to take leadership, with input from: <ul style="list-style-type: none"> • General Managers • ED managers • ED nurse educators • Nurse educators • ED data coders • IT staff • CNCs in aged care positions • ASET nurses • Allied Health staff working in EDs • Medical staff • CAPAC (re: referral) • Other relevant staff as appropriate 	\$
	A1.1.2 Identify/develop appropriate protocols for triage coding, for the endorsement of the Quality and Patient Safety Committee.				
	A1.1.3 Work with relevant AHS units to ensure that organisational systems (eg IT) can support the new protocols.				
	A1.1.4 Identify/develop a process for monitoring compliance with the new protocols.			Clinical Governance, with strategic support as appropriate from Acute/Subacute Working Party.	\$

³ As this is a plan specifically for the AHS, "Responsibility" refers to AHS personnel/units only. However this does not preclude partnerships with other agencies.

⁴ Similarly, "Resource Implications" refers to AHS resources only. These have been coded as follows:

\$ = achievable within current resources, \$\$ = achievable with some additional resources, \$\$\$ = will require significant additional investment

Sub-strategy	Actions			Responsibility ³	Resource Implications ⁴
	2007/8	2008/9	2009/10		
		A1.1.5 Roll out new protocols, including the identification/development and delivery of training to ED staff.		Acute/Subacute Working Party to have strategic oversight and ensure communication and information sharing across the AHS. ED managers to take local responsibility for rollout, reporting up through usual management hierarchy (see page 9 of this plan).	\$\$
		A1.1.6 Track compliance with protocols and changes in data collection over time, and feed this information back to individual EDs, hospital general managers and cluster managers.		Clinical Governance, with strategic support as appropriate from Acute/Subacute Working Party.	\$
		A1.1.7 Incorporate data in all relevant reporting frameworks throughout the AHS (including senior levels) to encourage increased attention to data quality and trends.		Required at multiple levels: <ul style="list-style-type: none"> • HNE Falls Injury Prevention Advisory Committee • Acute/Subacute Working Party • Falls Injury Prevention Coordinator • ED managers • Clinical Governance 	\$
	A1.1.8 Develop appropriate performance indicators for A1.1			Acute/Subacute Working Party with support from Falls Injury Prevention Coordinator	\$
	A1.1.9 Collect appropriate performance indicators and provide reports to the HNE Falls Injury Prevention Advisory Committee (first due December 2007).				

Sub-strategy	Actions			Responsibility ³	Resource Implications ⁴
	2007/8	2008/9	2009/10		
A1.2 Identify/develop appropriate screening tools which are feasible to use in EDs.	A1.2.1 Identify what tools are currently being used in EDs across the AHS. Screening = stratifies patients to High/Low etc.			Acute/Subacute Working Party to take leadership, with input from: <ul style="list-style-type: none"> • General Managers • ED managers • ED nurse educators • Nurse educators • ED data coders • IT staff • CNCs in aged care positions • ASET nurses • Allied Health staff working in EDs • Medical staff • CAPAC (re: referral) • Other relevant staff as appropriate NB. <ul style="list-style-type: none"> • Review/research is being undertaken at the State level that will inform this process. Falls Injury Prevention Coordinator can provide details and contacts. • HNE Falls Injury Prevention Advisory Committee to ensure that there are appropriate linkages between all actions in this plan related to screening and assessment tools. 	\$
	A1.2.2 Agree upon criteria for tool selection, for endorsement by Quality and Patient Safety Committee. (Although a single tool across the AHS is preferable, this may not be feasible. This proposes that different tools may be used but that all must meet the agreed criteria).				

Sub-strategy	Actions			Responsibility ³	Resource Implications ⁴
	2007/8	2008/9	2009/10		
A1.3 Identify/develop and implement appropriate protocols for screening and referral in the ED setting.	A1.3.1 Identify/develop written protocols for the endorsement of the Quality and Patient Safety Committee which describe: <ul style="list-style-type: none"> • Screening protocols and who will be responsible for this • Referral response (including a focus on what is appropriate and feasible) • Record keeping 			Acute/Subacute Working Party to take leadership, with input from: <ul style="list-style-type: none"> • General Managers • ED managers • ED nurse educators • Nurse educators • ED data coders • IT staff • CNCs in aged care positions • ASET nurses • Allied Health staff working in EDs • Medical staff • CAPAC (re: referral) • Other relevant staff as appropriate 	\$
	A1.3.2 Identify/develop written resources to support implementation of protocols.				
	A1.3.3 Identify/develop a process for monitoring compliance with the new protocols.			Clinical Governance, with strategic support as appropriate from Acute/Subacute Working Party.	\$
		A1.3.4 Roll out new protocols, including the identification/development and delivery of training to ED staff.			Acute/Subacute Working Party to have strategic oversight and ensure communication and information sharing across the AHS. ED managers to take local responsibility for rollout, reporting up through usual management hierarchy (see page 9 of this plan).

Sub-strategy	Actions			Responsibility ³	Resource Implications ⁴
	2007/8	2008/9	2009/10		
		A1.3.5 Track compliance with protocols over time, and feed this information back to individual EDs, hospital general managers and cluster managers.		Clinical Governance, with strategic support as appropriate from Acute/Subacute Working Party.	\$
	A1.3.6 Develop appropriate performance indicators for A1.3			Acute/Subacute Working Party with support from Falls Injury Prevention Coordinator	\$
	A1.3.7 Collect appropriate performance indicators and provide reports to the HNE Falls Injury Prevention Advisory Committee (first due December 2007).				

Strategy A2: Improve the quality and consistency of data collected to describe inpatient falls.

Sub-strategy	Actions			Responsibility	Resource Implications
	2007/8	2008/9	2009/10		
A2.1 Ensure that the data collected describing inpatient falls (eg through IIMS) are valid and reliable.	A2.1.1 Review the current data collection protocols across the AHS and identify issues of concern.			Acute/Subacute Working Party to take strategic leadership and ensure communication and information sharing across the AHS. Patient Safety Officers to take local leadership and responsibility, reporting up through usual management hierarchy (see page 9 of this plan). Additional input to be sought from: <ul style="list-style-type: none"> • General Managers • Quality and Patient Safety Committee • Nursing Unit Managers • Clinical Governance • Other relevant positions as appropriate 	\$
	A2.1.2 Identify/develop recommendations for improving data collection for the endorsement of the Quality and Patient Safety Committee, including written protocols for the collection, retrieval and reporting of data. This should include regular (eg monthly) detailed reporting at the ward level to highlight issues to staff and encourage problem solving for future prevention.				
	A2.1.3 Identify/develop support resources as required (eg but not limited to written manuals, tools, intranet site etc).				
	A2.1.4 Identify/develop a process for monitoring compliance with protocols.			Clinical Governance, with strategic support as appropriate from Acute/Subacute Working Party.	\$

Sub-strategy	Actions			Responsibility	Resource Implications
	2007/8	2008/9	2009/10		
		<p>A2.1.5 Deliver workforce development strategies to implement new protocols and ensure compliance. These may include:</p> <ul style="list-style-type: none"> • Staff training • Written resources • Performance monitoring and feedback • See also A2.1.3 		<p>Acute/Subacute Working Party to take strategic leadership and ensure communication and information sharing across the AHS.</p> <p>Patient Safety Officers to take local leadership and responsibility, reporting up through usual management hierarchy (see page 9 of this plan).</p> <p>Additional input to be sought from:</p> <ul style="list-style-type: none"> • General Managers • Quality and Patient Safety Committee • Nursing Unit Managers • Clinical Governance • Other relevant positions as appropriate 	<p>\$\$</p> <p>See also A3.7.3 – may be appropriate to tie these activities together</p>
		A2.1.6 Track compliance with protocols in each facility, providing ongoing feedback individual units, hospital general managers and cluster managers.		Clinical Governance, with strategic support as appropriate from Acute/Subacute Working Party.	\$
		A2.1.7 Incorporate IIMS data in all relevant reporting frameworks throughout the AHS (including senior levels) to encourage increased attention to data quality and trends.		<p>Required at multiple levels:</p> <ul style="list-style-type: none"> • HNE Falls Injury Prevention Advisory Committee • Acute/Subacute Working Party • Falls Injury Prevention Coordinator • Patient Safety Officers • Clinical Governance 	\$

Sub-strategy	Actions			Responsibility	Resource Implications
	2007/8	2008/9	2009/10		
	A2.1.8 Develop appropriate performance indicators for A2.1			Falls Injury Prevention Coordinator + Acute/Subacute Working Party	\$
	A2.1.9 Collect appropriate performance indicators and provide reports to the HNE Falls Injury Prevention Advisory Committee (first due December 2007).				

Strategy A3: Improve the prevention and management of falls injuries in inpatients.

Sub-strategy	Actions			Responsibility	Resource Implications
	2007/8	2008/9	2009/10		
A3.1 Identify/develop appropriate screening and assessment tools which are feasible to use in the inpatient setting.	A3.1.1 Identify current practice across the AHS and consult key stakeholders. Screening = stratifies patients to High/Low etc.			Acute/Subacute Working Party in partnership with Community Working Party (who have a similar strategy). Input from: <ul style="list-style-type: none"> • General Managers • Quality and Patient Safety Committee • Nursing Unit Managers • Patient Safety Officers • Nurse Educators • Allied Health Services • Other relevant positions as appropriate NB <ul style="list-style-type: none"> • HNE Falls Injury Prevention Advisory Committee to ensure that there are appropriate linkages between all actions in this plan related to screening and assessment tools. • Falls Injury Prevention Coordinator to provide insight to what is happening in other AHSs. 	\$
	A3.1.2 Agree upon criteria for tool selection, for endorsement by Quality and Patient Safety Committee. (Although a single tool across the AHS is preferable, this may not be feasible. This proposes that different tools may be used but that all must meet the agreed criteria).				

Sub-strategy	Actions		Responsibility	Resource Implications
<p>A3.2 Identify/develop appropriate protocols for screening on admission.</p>	<p>A3.2.1 Identify current practice across the AHS and consult key stakeholders.</p>		<p>Acute/Subacute Working Party to take strategic leadership.</p> <p>Input from:</p> <ul style="list-style-type: none"> • General Managers • Quality and Patient Safety Committee • Patient Safety Officers • Nurse educators • Nursing Unit Managers • Allied Health Services • Other relevant positions as appropriate 	<p>\$\$</p> <p>Appointment of a Project Officer may streamline and simplify this process. They could take overall responsibility for A3.2-A3.6 (preparation for AHS-wide rollout).</p>
	<p>A3.1.2 Identify/develop written protocols for the endorsement of the Quality and Patient Safety Committee which describe the screening process and record keeping</p>			
<p>A3.3 Identify/develop targeted strategies to prevent falls and falls injuries in patients identified as being at high risk.</p>	<p>A3.3.1 Identify current practice across the AHS and consult key stakeholders.</p>		<p>Acute/Subacute Working Party to take strategic leadership.</p> <p>Input from:</p> <ul style="list-style-type: none"> • General Managers • Quality and Patient Safety Committee • Patient Safety Officers • Nurse educators • Nursing Unit Managers • Allied Health Services • Other relevant positions as appropriate 	<p>\$\$</p> <p>Appointment of a Project Officer may streamline and simplify this process. They could take overall responsibility for A3.2-A3.6 (preparation for AHS-wide rollout).</p>
	<p>A3.1.2 Identify/develop written protocols for high risk patient care, for the approval of the Quality and Patient Safety Committee. This may include identification of individual high-risk patients and/or entire wards, as appropriate. Protocols may include:</p> <ul style="list-style-type: none"> • More detailed clinical assessment of individuals to specifically identify which risk factors require clinical 			

Sub-strategy	Actions		Responsibility	Resource Implications
	<p>attention.</p> <ul style="list-style-type: none"> • Specific strategies tailored to identified risk (mobility care, physiotherapy etc). • Additional routine clinical prevention practices for all patients in high risk wards. 			
<p>A3.4 Identify/develop broad falls injury prevention strategies for all patients, regardless of risk.</p>	<p>A3.4.1 Identify current practice across the AHS and consult key stakeholders.</p>		<p>Acute/Subacute Working Party to take strategic leadership. Input from:</p> <ul style="list-style-type: none"> • General Managers • Quality and Patient Safety Committee • Patient Safety Officers • Nurse educators • Nursing Unit Managers • Allied Health Services • Other relevant positions as appropriate 	<p>Appointment of a Project Officer may streamline and simplify this process. They could take overall responsibility for A3.2-A3.6 (preparation for AHS-wide rollout).</p>
<p>A3.4.2 Identify/develop written protocols for the approval of the Quality and Patient Safety Committee. These may include:</p> <ul style="list-style-type: none"> • Improvements to lighting, flooring, trip hazards, ward design and furniture. • Long-term strategies addressing facility maintenance and design. 				
<p>A3.5 Identify/develop appropriate post-fall management strategies.</p>	<p>A3.5.1 Identify current practice across the AHS and consult key stakeholders.</p>			

Sub-strategy	Actions		Responsibility	Resource Implications
	<p>A3.5.2 Identify/develop written protocols for the approval of the Quality and Patient Safety Committee. These may include:</p> <ul style="list-style-type: none"> • Reporting process • Clinical review • Identify/develop a clinical management plan <p>These protocols will be consistent with all existing policies.</p>		<p>Acute/Subacute Working Party to take strategic leadership. Input from:</p> <ul style="list-style-type: none"> • General Managers • Quality and Patient Safety Committee • Patient Safety Officers • Nurse educators • Nursing Unit Managers • Allied Health Services • Services likely to receive discharge referrals (eg CAPAC) • Other relevant positions as appropriate 	<p>\$\$</p> <p>Appointment of a Project Officer may streamline and simplify this process. They could take overall responsibility for A3.2-A3.6 (preparation for AHS-wide rollout).</p>
<p>A3.6 Identify/develop appropriate discharge planning protocols, ensuring consistency with NSW Health Discharge Planning: Responsive Standards (revised) PD 2007_003.</p>	<p>A3.6.1 Identify current practice across the AHS and consult key stakeholders.</p>			
	<p>A3.6.2 Identify/develop written protocols for the approval of the Quality and Patient Safety Committee. These may include:</p> <ul style="list-style-type: none"> • Recommended clinical follow-up • An appropriate process for referral to additional services (including a focus on what referral is feasible and available). 			

Sub-strategy	Actions		Responsibility	Resource Implications
<p>A3.7 Implement change management strategies to support sustainable the delivery of strategies A3.1 – A3.6.</p>	<p>A3.7.1 Identify/develop written resources as required to support the implementation of all strategies described above.</p>		<p>Acute/Subacute Working Party to take strategic leadership. Input from:</p> <ul style="list-style-type: none"> • General Managers • Quality and Patient Safety Committee • Patient Safety Officers • Nurse educators • Nursing Unit Managers • Allied Health Services • Other relevant positions as appropriate 	<p>\$\$</p> <p>Potentially same PO as described above.</p>
	<p>3.7.2 Identify/develop a process for monitoring compliance with all new protocols.</p>			
		<p>A3.7.3 Roll out new protocols. Support strategies for this process may include:</p> <ul style="list-style-type: none"> • Identified leadership at the local and AHS level (“change agents”) • Written policies and protocols for action • Tools to support implementation (eg written resources) • Workforce development strategies • Routine performance monitoring and feedback <p>NB Consider an AHS-wide rollout process as per Smokefree Policy.</p>	<p>Acute/Subacute Working Party to take strategic leadership and ensure communication and information sharing across the AHS.</p> <p>NUMs and Patient Safety Officers to take local leadership and responsibility, reporting up through usual management hierarchy (see page 9 of this plan).</p> <p>Additional input to be sought from:</p> <ul style="list-style-type: none"> • General Managers • Quality and Patient Safety Committee • Clinical Governance • Allied Health Services • Other relevant positions as appropriate 	<p>\$\$\$</p> <p>Likely to be most significant resource implication of all acute strategies. Requires identification of change agents in each facility. Main resource cost is staff time / backfilling.</p>

Sub-strategy	Actions		Responsibility	Resource Implications
		A3.7.4 Track compliance with protocols over time, and feed this information back to individual units, hospital general managers and cluster managers.	Clinical Governance, with strategic support as appropriate from Acute/Subacute Working Party.	\$
	A3.7.5 Develop appropriate performance indicators for A3.1-3.7		Falls Injury Prevention Coordinator + Acute/Subacute Working Party	\$
	A3.7.6 Collect appropriate performance indicators and provide reports to the HNE Falls Injury Prevention Advisory Committee (first due December 2007).			

Implementation Plan: Residential Aged Care

Plan at a glance

Implementation of these strategies will be overseen by the Residential Aged Care Falls Injury Prevention Among Older People Working Party.

THE RESIDENTIAL AGED CARE SETTING

These strategies are mandatory for the beds under the direct management of the HNEAHS. They are a *recommendation only* for other Residential Aged Care Facilities. The AHS will encourage and support non-AHS facilities to implement these strategies as appropriate and within available resources.

R1: Implement systematic data collection and analysis protocols in residential aged care facilities.

- R1.1 Ensure that data collection and analysis protocols to describe falls incidents and injuries in AHS facilities are consistent with industry standards and NSW Falls Policy requirements.
- R1.2 Encourage and support non-AHS facilities to adopt similar data collection and analysis protocols.

R2: Encourage the use of strategies of known effectiveness to reduce near misses, falls and falls injuries.

- R2.1 Ensure that an appropriate falls injury prevention policy and program is implemented in all AHS facilities.
- R2.2 Encourage and support non-AHS facilities to adopt similar falls injury prevention policies and programs.

GETTING IT DONE

Actions to consider across all strategies

Leadership – Who will drive this process?

Who will be accountable for ensuring that it is delivered?

Organisational strategies – What is required within the organisation to facilitate and enable this? Example: written policies, endorsement and support of Area Executive.

Resources and tools – What is required to achieve this?

From funding sources to specific tools such as screening instruments.

Workforce development – What support do staff need?

May include formal training opportunities and informal approaches such as networks, mentoring and peer support.

Performance monitoring and feedback – How will we know if this is working?

Will include a process to monitor the performance of all units and provide feedback.

Figure 11: “Plan at a glance” – the Residential Aged Care Setting

Background and context

It is important to note that the majority of residential aged care facilities across NSW are not managed by area health services – estimates suggest that fewer than 5% of the total residential aged care beds in this region are under AHS management. The falls policy describes strategies which are appropriate in all residential aged care facilities, but there is no mandate to enforce this in privately-managed facilities. Indeed, the AHS may have a relatively small influence within this sector. The strategies described herein are therefore *mandatory* for the all beds/facilities under the direct management of the HNEAHS and are a *recommendation* for non-AHS facilities. The AHS will encourage and support non-AHS facilities as appropriate. This may be as simple as a willingness to share the resources and tools developed for prevention in AHS beds/facilities, or may involve more significant capacity building strategies if the interests of non-AHS facilities and resources allow.

■ Actions occurring across NSW

- The Australian Council for Safety and Quality in Health Care has released a resource kit of “Best Practice Guidelines for Australian hospitals and residential aged care facilities”. Known colloquially in clinical circles as “The Big Green Box”, this kit has been disseminated across the State and will provide valuable direction for all residential aged care strategies. NSW Health is supporting an education campaign to support this dissemination.

■ Focus for HNE Health

- In late 2004, the former Hunter Area Health Service was successful in obtaining a Health Promotion Demonstration Grant for a program to reduce falls injuries in residential aged care. Funding of \$285,000 was obtained for a three-year program which aimed to achieve the following:
 - To identify/develop an appropriate, evidence-based multi-factorial program to reduce hip fractures in aged care facilities
 - To test and document the feasibility of implementing the program
 - To engage relevant stakeholders and project partners, including general practitioners
 - To document the resources required to successfully implement the program
 - To explore the sustainability of the intervention, notably with respect to identification of the resources required for ongoing maintenance of the intervention, and
 - To identify/develop a model of intervention to be implemented across other Area Health Services in NSW and beyond.

This ongoing project has provided significant learnings and directions for the rollout of this policy. It has confirmed the importance of a multi-strategic approach to falls injury prevention, and including attention to related issues such as bone strength. Accordingly, this implementation plan includes:

- Investments to improve the quality of data describing falls incidents and injuries in residential aged care settings. The validity and reliability of these data are essential not only to plan individual patient care, but to provide a larger picture of trends in fall injuries across the AHS.
- A comprehensive falls policy and program is recommended for all residential aged care facilities. This will include:
 - Provision of information to potential residents and their carers during the pre-admission process
 - Use of appropriate Falls Risk Assessment Tools
 - Falls Risk Assessment of all residents on admission, annually, change in health/functional status and change in environment
 - The use of hip protectors for high-risk residents
 - Strategies to support an adequate intake of calcium and vitamin D
 - Exercise programs to optimise muscle strength and mobility
 - Post-falls assessment and management guidelines

Detailed strategies and actions

Strategy R1: Implement systematic data collection and analysis protocols in residential aged care facilities.

Sub-strategy	Actions			Responsibility ⁵	Resource Implications ⁶
	2007/8	2008/9	2009/10		
R1.1 Ensure that data collection and analysis protocols to describe falls incidents and injuries in AHS facilities/beds are consistent with industry standards and NSW Falls Policy requirements.	R1.1.1 Agree upon appropriate protocols for endorsement of the Quality and Patient Safety Committee.			Residential Aged Care Working Party to take leadership, with input from: <ul style="list-style-type: none"> Quality and Patient Safety Committee Aged Care and Rehabilitation Services Clinical Network Site/Facility Managers Quality Coordinators Patient Safety Officers IT staff Other relevant staff as appropriate 	\$
	R1.1.2 Ensure that organisational systems (eg IT) can support the protocols.			Site/Facility Managers to take local leadership and responsibility, reporting up through usual management hierarchy. Residential Aged Care Working Party to take strategic leadership – eg. to ensure communication and information sharing across the AHS.	\$

⁵ As this is a plan specifically for the AHS, “Responsibility” refers to AHS personnel/units only. However this does not preclude partnerships with other agencies.

⁶ Similarly, “Resource Implications” refers to AHS resources only. These have been coded as follows:

\$ = achievable within current resources, \$\$ = achievable with some additional resources, \$\$\$ = will require significant additional investment

Sub-strategy	Actions			Responsibility ⁵	Resource Implications ⁶
	2007/8	2008/9	2009/10		
	R1.1.3 Develop appropriate resources to support implementation (eg written tools and manuals as required).			Residential Aged Care Working Party to take strategic leadership. Detail of recommendations and resources to be developed by: <ul style="list-style-type: none"> • Quality Coordinators • Patient Safety Officers • Staff that enter data into IIMS • Data entry personnel • Other relevant staff as appropriate NB if a project officer is appointed to support all strategies in this setting (see note on R2) they could also support this process.	\$
	R1.1.4 Deliver workforce development strategies to implement new protocols and ensure compliance.				
	R1.1.5 Identify/develop a process for monitoring compliance with the new protocols.				\$
	R1.1.6 Track compliance with protocols in each facility, providing ongoing feedback to individual facilities and cluster managers.				\$

Sub-strategy	Actions			Responsibility ⁵	Resource Implications ⁶
	2007/8	2008/9	2009/10		
	R1.1.7 Incorporate data in all relevant reporting frameworks throughout the AHS (including senior levels) to encourage increased attention to data quality and trends.			Required at multiple levels: <ul style="list-style-type: none"> • HNE Falls Injury Prevention Advisory Committee • Residential Aged Care Working Party • Falls Injury Prevention Coordinator • Clinical Governance • Site/Facility Managers • Facility Quality Coordinators • Primary & Community Care Network General Managers 	\$
	R1.1.8 Develop appropriate performance indicators for R1.1			Falls Injury Prevention Coordinator + Residential Aged Care Working Party	\$
	R1.1.9 Collect appropriate performance indicators and provide reports to the HNE Falls Injury Prevention Advisory Committee (first due December 2007).				

Sub-strategy	Actions			Responsibility ⁵	Resource Implications ⁶
	2007/8	2008/9	2009/10		
R1.2 Encourage and support non-AHS facilities to adopt similar data collection and analysis protocols.		<p>R1.2.1 Share information and resources to encourage appropriate data collection and analysis in non-AHS facilities. This may include:</p> <ul style="list-style-type: none"> – Copies of endorsed protocols. – Copies of support resources such as written manuals. – Copies of staff training materials. 		<p><i>Yet to be determined.</i></p> <p>R1.2 refers to the 95% of residential aged care beds that are NOT AHS-managed.</p> <p>HNE Health currently has no funded person to liaise with or support these facilities. However the current Health Promotion Demonstration Grant Scheme – Falls Injury Reduction in RACF Project (described on p42) is testing a model whereby a temporary Project Officer has been employed in this role.</p> <p>Decisions regarding future investment in similar actions should be made based on the outcomes of that research project. Preliminary results will be available in late 2007.</p>	<p><i>Minimal model (\$):</i> Share copies of all resources developed for R1.1.</p> <p><i>More intensive model (\$\$/\$\$\$):</i> Creation of a new long-term position based on outcomes of the current research project.</p>
		R1.2.2 Develop appropriate performance indicators for R1.2		Falls Injury Prevention Coordinator + Residential Aged Care Working Party	\$
		R2.2.3 Collect appropriate performance indicators and provide reports to the HNE Falls Injury Prevention Advisory Committee (first due December 2007).			

Strategy R2: Encourage the use of strategies of known effectiveness to reduce near misses, falls and falls injuries.

Sub-strategy	Actions			Responsibility	Resource Implications
	2007/8	2008/9	2009/10		
R2.1 Ensure that an appropriate falls injury prevention policy and program is implemented in all AHS facilities/beds.	R2.1.1 Establish current practice across all facilities and consult with key stakeholders.			Residential Aged Care Working Party to take leadership, with input from: <ul style="list-style-type: none"> Quality Patient and Safety Committee Aged Care and Rehabilitation Services Clinical Network Site/Facility Managers Patient Safety Officers Other relevant staff as appropriate 	<p style="text-align: center;">\$\$</p> <p>Appointment of a Project Officer may streamline and simplify this process. They could take overall responsibility for all actions in R2.1, in preparation for AHS-wide rollout.</p>
	R2.1.2 Agree upon an appropriate protocol for the provision of information on pre-admission to prepare potential clients and families for strategies and possible costs.				
	R2.1.3 Agree upon an appropriate falls risk assessment tool OR agreed criteria that an alternative chosen tool must meet, for approval by the Quality and Patient Safety Committee. (Although a single tool across the AHS is preferable, this may not be feasible. This proposes that different tools may be used but that all must meet the agreed criteria).			As above. NB <ul style="list-style-type: none"> HNE Falls Injury Prevention Advisory Committee to ensure that there are appropriate linkages between all actions in this plan related to screening and assessment tools. 	

Sub-strategy	Actions			Responsibility	Resource Implications
	2007/8	2008/9	2009/10		
	R2.1.4 Agree upon a protocol for a falls risk assessment to be conducted of all residents on admission, annually, upon change in health/functional status and upon change in environment, for approval by the Quality and Patient Safety Committee.			Residential Aged Care Working Party to take leadership, with input from: <ul style="list-style-type: none"> • Quality Patient and Safety Committee • Aged Care and Rehabilitation Services Clinical Network • Site/Facility Managers • Patient Safety Officers • Other relevant staff as appropriate 	\$\$ Appointment of a Project Officer may streamline and simplify this process. They could take overall responsibility for all actions in R2.1, in preparation for AHS-wide rollout.
	R2.1.5 Agree upon a protocol for the use of hip protectors for high-risk residents, for approval by the Quality and Patient Safety Committee.				
	R2.1.6 Agree upon protocols to support an adequate intake of calcium and vitamin D, for approval by the Quality and Patient Safety Committee.				
	R2.1.7 Agree upon protocols for the use of exercise programs to optimise balance, strength and mobility, for approval by the Quality and Patient Safety Committee.				

Sub-strategy	Actions			Responsibility	Resource Implications
	2007/8	2008/9	2009/10		
	R2.1.8 Agree upon protocols for post-fall assessment and management, for approval by the Quality and Patient Safety Committee.			Residential Aged Care Working Party to take leadership, with input from: <ul style="list-style-type: none"> Quality Patient and Safety Committee Aged Care and Rehabilitation Services Clinical Network Site/Facility Managers Patient Safety Officers Other relevant staff as appropriate 	\$\$ Appointment of a Project Officer may streamline and simplify this process. They could take overall responsibility for all actions in R2.1, in preparation for AHS-wide rollout.
	R2.1.9 Develop written resources as required to support the implementation of all strategies described above.				
	R2.1.10 Develop a process for monitoring compliance with all new protocols.			Clinical Governance, with strategic support as appropriate from Acute/Subacute Working Party.	\$
		R2.1.11 Roll out new protocols, including the development and delivery of staff training.		Site/Facility Managers to take local operational responsibility, reporting up through usual management hierarchy (see page 9 of this plan). Residential Aged Care Working Party to take strategic leadership and ensure communication and information sharing across the AHS.	\$\$ Likely to vary from one facility to the next, dependent on current practices and therefore extent of changes required.

Sub-strategy	Actions			Responsibility	Resource Implications
	2007/8	2008/9	2009/10		
		R2.1.12 Track compliance with protocols over time, and feed this information back to individual units, hospital general managers and cluster managers		Clinical Governance, with strategic support as appropriate from Acute/Subacute Working Party.	\$
	R2.1.13 Develop appropriate performance indicators for 2.1.2-2.1.7			Falls Injury Prevention Coordinator + Residential Aged Care Working Party	\$
	R2.1.14 Collect appropriate performance indicators and provide reports to the HNE Falls Injury Prevention Advisory Committee (first due December 2007).				
R2.2 Encourage and support non-AHS facilities to adopt similar falls injury prevention policies and programs.		R2.2.1 Share information and resources to encourage non-AHS facilities to adopt similar policies and programs. This may include: <ul style="list-style-type: none"> – Copies of endorsed protocols. – Copies of support resources such as written manuals. – Copies of staff training materials. 		<i>Yet to be determined.</i> See R1.2 – decisions regarding the potential level of investment in non-AHS facilities are dependent on outcomes of the current Health Promotion Demonstration Grant Scheme – Falls Injury Reduction in RACF Project.	\$ to \$\$\$ <i>See R1.2</i>
		R2.2.2 Develop appropriate performance indicators for R2.2		Falls Injury Prevention Coordinator + Residential Aged Care Working Party	\$
		R2.2.3 Collect appropriate performance indicators and provide reports to the HNE Falls Injury Prevention Advisory Committee (first due December 2007).			

Evaluation and monitoring

NSW Health has engaged the Injury Risk Management Research Centre at the University of New South Wales to develop an evaluation plan for implementation of the policy across NSW. At the time of writing this document, the evaluation plan was not yet finalised. However early feedback from the policy development group provides the following insight to the likely process, impact and outcome indicators that may be used to describe its implementation.

It is important that the local performance indicators developed by HNE Health are consistent with those that will be used by the State, as this will ensure consistency and a smooth reporting process. The development of local performance indicators has therefore commenced but has not been finalised. This will also allow the working parties time to consult with important local stakeholders, whose engagement in the process will be essential for a successful implementation of the plan. All working parties have agreed to finalise this process in time for first reports to be presented to the Advisory Group in December 2007.

The following is an outline of the likely outcome, impact and process indicators for the policy as a whole. This draft information has been provided in liaison with the group developing the state-wide evaluation. The Falls Injury Prevention Coordinator will ensure that the Advisory Group is kept informed of progress on this. **All these measures are consistent with this plan, including proposed clinical governance indicators regarding compliance with clinical protocols.**

Setting	Outcome indicators <i>All Area Health Services are already required to report on the following outcome indicators.</i>	Possible impact indicators (currently in development) <i>Impact indicators represent intermediate measures of the success of interventions. Examples of likely impact indicators may include (but are not limited to) the following.</i>	Possible process indicators (currently in development) <i>Process indicators will describe local activities in each setting. Examples of likely process indicators may include (but are not limited to) the following.</i>
Community	<ul style="list-style-type: none"> To hold steady the current level of hospitalisations from fall injury (specifically number of admissions due to fractured neck of femur in people aged 65 and over). <p><i>This is a dashboard indicator from the HNEAHS Balanced Scorecard – Population Health.</i></p>	<ul style="list-style-type: none"> Proportion of community-dwelling older people who participate in physical activity. Proportion of community-dwelling older people who undertake additional protective actions to prevent falls injuries. Delivery of opportunistic brief interventions by AHSs (eg community health services). Delivery of opportunistic brief interventions by other relevant service providers (eg general practitioners). 	<ul style="list-style-type: none"> Descriptive data re: Activities to increase the access of older people to physical activity opportunities. Descriptive data re: Activities to encourage and support opportunistic brief interventions by relevant service providers within AHSs (eg community health services). Descriptive data re: Activities to encourage and support opportunistic brief interventions by other relevant service providers (eg general practitioners).

Setting	Outcome indicators <i>All Area Health Services are already required to report on the following outcome indicators.</i>	Possible impact indicators (currently in development) <i>Impact indicators represent intermediate measures of the success of interventions. Examples of likely impact indicators may include (but are not limited to) the following.</i>	Possible process indicators (currently in development) <i>Process indicators will describe local activities in each setting. Examples of likely process indicators may include (but are not limited to) the following.</i>
Acute/Subacute	<ul style="list-style-type: none"> To achieve a demonstrable sustained reduction in deaths as a result of a fall in hospital, with a 95% reduction by June 2010 and a 50% reduction achieved by January 2008. <p><i>Progress measure: Number of falls of admitted patients.</i></p> <p><i>Data sources: SAC 1 Clinical RIBS/Root Cause Analysis (RCA) reports and Admitted Patient Data Collection.</i></p>	<ul style="list-style-type: none"> Compliance with appropriate protocols for data collection in Emergency Departments. Compliance with appropriate protocols for brief screening in Emergency Departments. Compliance with appropriate protocols for falls injury prevention and post-fall management in acute/subacute hospital inpatient settings. 	<ul style="list-style-type: none"> Descriptive data re: Activities to introduce appropriate protocols for data collection in EDs. Descriptive data re: Activities to introduce appropriate protocols for brief screening in EDs. Descriptive data re: Activities to introduce appropriate protocols for falls injury prevention in acute/subacute hospital inpatient settings.
Residential Aged Care	<ul style="list-style-type: none"> There are currently no performance indicators for this setting that AHSs are required to report against, as the vast majority of residential aged care beds in NSW are managed by the private or not-for-profit sectors, and are therefore beyond the direct influence of AHSs. In this AHS, estimates suggest that less than 5% of residential aged care beds are under AHS management. The current draft of the State-wide evaluation plan suggests indicators that may be used, but it is not yet clear how these will be collected, nor whether they will be limited to AHS beds only. Evaluation in this setting may ultimately be mainly at the process and impact level. 	<ul style="list-style-type: none"> Compliance with appropriate protocols for data collection in residential aged care beds/facilities directly managed by the AHS. Compliance with appropriate protocols for falls injury prevention in residential aged care beds/facilities directly managed by the AHS. Indicators for non-AHS facilities are yet to be determined, and will depend on how much the AHS decides to invest in this setting. 	<ul style="list-style-type: none"> Descriptive data re: Activities to introduce appropriate protocols for data collection in residential aged care beds/facilities directly managed by the AHS. Descriptive data re: Activities to introduce appropriate protocols for falls injury prevention in residential aged care beds/facilities directly managed by the AHS. Indicators for non-AHS facilities are yet to be determined, and will depend on how much the AHS decides to invest in this setting.

■ **Who is responsible for data collection?**

Responsibility for the collection of data for these indicators is yet to be finalised. This will take place as a part of the state policy evaluation planning process and will include consultation with AHSs through the local Falls Injury Prevention Coordinators. It is likely to be a combination of NSW Health and local AHS data.

- Outcome indicators – it is already the responsibility of individual AHSs to routinely collect data for these indicators.
- Impact indicators – this is likely to be a combination of state-wide and local data collection. This implementation plan describes a process whereby Clinical Governance will develop a process for monitoring compliance with new protocols in community health, acute/subacute and AHS-controlled residential aged care settings. Community indicators are more difficult to collect at the population level (eg indicators of population prevalence of physical activity, knowledge and awareness etc). NSW Health is currently exploring options to collect these population data centrally for all AHSs.
- Process indicators – these indicators are purely descriptive and most appropriately collected by AHSs. This implementation plan describes a process whereby each of the working parties will develop appropriate performance indicators and provide regular reports to the Advisory Group. The Falls Injury Prevention Coordinator will ensure that the same data collected for the Advisory Group meet the needs of any required state-wide reporting.

The following example provides an indication of how the final performance indicators will be written, and their possible data sources. Please note this is a draft only for demonstration purposes. The Working Parties will have completed these by December 2007.

C1. Implement population-based prevention strategies for people living independently in the community.		
Sub-strategy	Performance Indicators	Data source
C1.1 Ensure the availability and promotion of appropriate physical activity groups that meet the needs people aged 50 and over.	<p>Process indicators</p> <ul style="list-style-type: none"> ■ Completion of mapping process and gap identification. ■ N leaders trained, N groups established. ■ Professional support provided for leaders. ■ Promotional activities undertaken. <p>Impact indicators</p> <ul style="list-style-type: none"> ■ Availability of appropriate physical activity groups (including N trained leaders and N groups running). Analyses by cluster including N available groups per capita. ■ Number of direct referrals received from health care providers. <p>Outcome indicators</p> <ul style="list-style-type: none"> ■ Number of people aged 50+ participating in specific groups recommended by the AHS. ■ Proportion of community members aged 50+ participating in organised physical activity groups (prevalence indicator across the population). 	<p>HNEPH/Active Over 50s program data</p> <p>HNEPH/Active Over 50s program data</p> <p>HNEPH/Active Over 50s program data</p> <p>HNEPH/Active Over 50s program data</p> <p>HNEPH/Active Over 50s program data</p> <p>Active Over 50s program data</p> <p>Active Over 50s program data</p> <p>NSW Health (methodology to be developed)</p>

References

1. National Centre for Health Promotion, NSW Health Department (1996) *1994 NSW Health Promotion Survey – technical report*. Sydney: NSW Health Department.
2. Jorm L, Astbury L, Byth F (1995) *New South Wales Health Department Falls Prevention in Older People Campaign: Report on the Baseline Survey*. Sydney: NSW Health Department.
3. Australian Bureau of Statistics (1995). *Falls risk factors for persons aged 65 years and over: New South Wales*. Canberra: Australian Bureau of Statistics. ABS Catalogue No. 4393.1.
4. Dolinis J, Harrison J & Andrews G (1997) Factors associated with falling in older Adelaide residents. *Australian and New Zealand Journal of Public Health*, 21: 462-8.
5. Kendig H, Helme R, Teshuva K, Osborne D, Flicker L & Browning C (1996) Health status of older people project: preliminary finding from a survey of the health and lifestyles of older Australians. Melbourne: Victorian Health Promotion Foundation.
6. Lord S, Ward J, Williams P & Anstey K (1993) An epidemiological study of falls in older community-dwelling women: the Randwick falls and fractures study. *Australian Journal of Public Health*, 17: 240-5.
7. NSW Department of Health (2003) *Management Policy to Reduce Fall Injury Among Older People – Detailed strategies and performance requirements 2003-2007*. Sydney: NSW Health Department.
8. National Ageing Research Institute (2004) *An analysis of research on preventing falls and falls injuries in older people: Community, residential care and hospital settings*. Canberra: Commonwealth of Australia.
9. Tinetti M & Speechley M (1989) Prevention of Falls Among the Elderly. *New England Journal of Medicine*, 320(16): 1055-1059.
10. Norton R & Butler M (1997) *Prevention of Falls and fall-related injuries among institutionalised older people*. Wellington New Zealand: University of Auckland.
11. American Geriatrics Society, British Geriatrics Society and American Academy of Orthopaedic Surgeons Panel on Falls Prevention (2001) Guideline for the Prevention of Falls in Older Persons. *Journal of the American Geriatrics Society*, 49(5): 664-72.
12. Moller J (2001) *Changing resource demands related to fall injury in an ageing population*. Unpublished report prepared for the NSW Health Injury Policy Unit.
13. NSW Department of Health (2003) *Management Policy to Reduce Fall Injury Among Older People – Policy in brief 2003-2007*. Sydney: NSW Health Department.
14. NSW Department of Health (2007) *A new direction for NSW: State Health Plan. Towards 2010*. Sydney: NSW Health Department.

Appendix A

Figure 12: HNE Health Governance Structure for Quality

