CENTRE FOR RESEARCH IN GERIATRIC MEDICINE
THE UNIVERSITY OF QUEENSLAND

Evaluation of the Falls Safety Officers Implementation Pilot

FINAL REPORT

Prepared for
Patient Safety Centre
&
Health Promotion Branch
Queensland Health

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LIST OF ABBREVIATIONS

AHS	Area Health Service
CAHS	Central Area Health Service
CALD	Culturally and Linguistically Diverse
CCI	Community Capacity Index
CHIC	Connecting Healthcare in Communities
CHIP	Community Hospital Interface Program
COTA-Q	Council on the Ageing- Queensland
DAART	Domiciliary allied health acute care and rehabilitation service
DVA	Department of Veteran Affairs
ED	Emergency Department
FSO	Falls Safety Officer
HACC	Home and Community Care
H/RCF	Hospital/Residential Care Facilities
HSD	Health Service District
KPI	Key Performance Indicator
NAHS	Northern Area Health Service
NGO	Non-Government Organisation
NHMRC	National Health and Medical Research Council
PAH	Princess Alexandra Hospital
PSO	Patient Safety Officer
QH	Queensland Health
RBWH	Royal Brisbane and Women's Hospital
SAHS	Southern Area Health Service
SOYF	Stay on Your Feet
SWOT	Strengths, Weaknesses, Opportunities, Threats
TAFE	Technical and Further Education
TPCH	The Prince Charles Hospital

EXECUTIVE SUMMARY

This report *Evaluation of the Falls Safety Officers Implementation Pilot: Final Report* details the results of the evaluation of an implementation pilot for enhancing Queensland Health's response to falls prevention in older people - 'Queensland Stay On Your Feet®- in community, hospital and residential aged care facilities'. The purpose of the project was to trial in Queensland a workforce enhancement strategy at an Area Health Service (AHS) level to support and coordinate evidence based falls prevention implementation across the health continuum. The expected outcome was to inform the development of a cross continuum service delivery model evidenced by a consistent, coordinated, evidence based approach to falls prevention for older persons across the health continuum at Health Service District (HSD), Area Health Service (AHS) and statewide levels. The project was conducted over the period February 2008 to January 2009. The results and key learnings from the first six months of the project (February to July 2008) were detailed in the Mid-Term Evaluation Report in August 2008.

In Section 1 of this report, the project rationale is outlined and includes the extent of the problem of falls in Queensland, together with state and national policy documents and resources guiding the project. There is international and national interest in translating falls research evidence and policy into practice, and examples from the UK, the USA and Australian States are discussed. In Queensland, the FSO Implementation Pilot Project was planned based on key learnings from a number of projects. These included the community based Stay On Your Feet project in Wide Bay/Burnett and the Patient Safety Centre sponsored projects to implement the Australian Safety and Quality in Health Care Guidelines for falls prevention (the 'Green Box") into public and private hospitals and aged care facilities in Queensland. The FSO Implementation Pilot in Queensland has implications for efforts to diffuse evidence-based practices for falls prevention across the continuum of care and will contribute to the literature on effectiveness of dissemination of falls prevention guidelines into practice.

Section 2 summarises the Mid Term Evaluation results and recommendations. The main recommendation was to consolidate gains that had been achieved so as to meet key performance indicators. Adopting the recommendations meant that the project was not extended beyond the priority districts as was originally intended. Other factors which resulted in changes to the project plan in the last six months of the project are discussed, including the effect on the project of Queensland Health restructuring in August 2008 and FSO staff attrition.

Section 3 outlines changes to the evaluation methodology over the duration of the project. Results of the evaluation are presented as process, impact and outcome indicators. The process and impact indicators (the project Key Performance Indicators) are summarized below.

Indicators	Evaluation Results
Process: a) Number and range of stakeholders engaged	Stakeholder contacts: • Northern Area contacted over 520 stakeholders across 5 HSDs. • Central Area contacted over 210 stakeholders in 4 priority HSDs. • Southern Area contacted over 240 stakeholders in 4 priority HSDs. Stakeholders across all HSDs covered a range of staff from hospitals, residential aged care facilities, community health, HACC and Population Health, community NGOs and local government. Stakeholders completed a total of 182 scoping/stocktake surveys. • Northern –28 from community and 16 from hospital/RCF; • Central -43 from community and 26 from hospital/RCF; • Southern – 45 from community and 24 from hospital/RCF.
b) Number of district planning days held	Northern Area: 9 planning workshops across 5 HSDs attended by 352 participants* included: • 4 community; • 1 H/RCF ; • 4 cross continuum . Separate education sessions included 2 community and 12 H/RCF. Central Area: 12 planning/education sessions attended by 283 participants* included: • 3 cross continuum; • 8 community workshops ; • 1 hospital. Southern Area: 18 planning/ education sessions attended by 285 participants* included: • 3 cross continuum ; • 6 community ; • 7 hospital ; • 2 residential aged care . *Participants may have attended more than one planning day session.
c) % of Qld Health facilities (hospitals and RCFs) provided with the opportunity for workforce skill enhancement/training.	Northern Area: 62.2% Central Area: 75.9% Southern Area: 66.7%

Indicators	Evaluation Results
Impact: a) Development of HSD specific falls prevention action plans	At the completion of the project, action plans were in various stages of development. Those underway included: • Northern Area: Townsville (cross continuum); Charters Towers (cross continuum); Ingham (H/RCF, community); Ayr (community), Bowen (H/RCF, community), Mount Isa (community, H/RCF), Cairns (community), Tablelands (hospital). • Central Area: TPCH (hospital), Redcliffe (hospital), Caboolture (hospital), Northside (RCF), RBWH (hospital, community), Sunshine Coast /Cooloola (cross continuum), and Central Queensland (cross continuum). • Southern Area: Gold Coast (cross continuum), Logan Beaudesert (H/RCF, community), QEII (hospital, community), Redlands (hospital, RCF, community), Southside (cross continuum), Southern Rural (cross continuum), Toowoomba (hospital), District (RCF), Northern Rural (cross continuum), Toowoomba and Darling Downs (cross continuum).
b) Establishment and / or maintenance/enhancement of HSD falls prevention working groups (or equivalent)	Northern • Cairns community has a Senior Safety Group and Tablelands have a hospital working group. • Mount Isa had an existing Senior Safety Group and a hospital working group that needed support to reconvene. • Townsville has a *Stepping Out* community based group, no hospital group (but a falls specialist officer) and Parklands RCF started a working group. • Bowen had a hospital working group which needed further support to enhance function. • Charters Towers had an existing cross continuum working group with limited representation from the wider community. Richmond and Hughenden link into the Charters Towers Falls Prevention Working Group through the hospital. Central • Sunshine Coast /Cooloola cross continuum working group has been enhanced. Gympie and Sunshine Coast have developed Healthy Ageing Partnerships. • Central Queensland cross continuum falls working group was established. Gladstone Hospital and Banana Hub working groups were maintained. Rockhampton Healthy Ageing Partnership was maintained. • Northside District Steering Committee was formed. Redcliffe has a hospital working group and a community Healthy Ageing Partnership. Caboolture/Kilcoy developed a hospital working group. TPCH*'STEPS'* was dissolved and reformed under a new acute falls working group. RCF working group has been enhanced. • RBWH had an existing hospital based working group which has been maintained.

Indicators	Evaluation Results
	Southern • Southside District cross continuum working group was established. Existing working groups at Logan (hospital/RCF and community), QEII (hospital/RCF and community), and Redlands/Bayside (hospital/RCF and community) were re-invigorated. • PAH had an existing falls prevention working group. • Ipswich West Moreton had an existing hospital working group and a community working group. • Gold Coast District Falls Injury Prevention Committee with cross continuum membership had been established as well as a Healthy Ageing Group. • In Toowoomba and Darling Downs HSD, a district cross continuum working group was established. Working groups from Toowoomba (hospital and community), Southern Rural (cross continuum), Northern Rural (cross continuum), and district (RCF) were enhanced.

An expected outcome of the project was the development of a consistent, coordinated, evidence based approach to falls prevention for older persons across the health continuum at Health Service District (HSD) levels. Capacity across the workforce for the development of a cross continuum approach to falls prevention was gauged from interviews with key stakeholders using the Community Capacity Index. Overall, a modest increase in capacity for network partnerships was observed across the HSDs from baseline to follow-up. A second outcome measured was the change in falls and fall-related injuries in older Queenslanders as a result of the project. As expected, the graphs of hospital admissions for falls and fall-related injuries and reported clinical incidents did not show discernable changes over the duration of the project. As this was a pilot of a workforce enhancement strategy and not an intervention directly targeting older people, it was not expected that there would be a reduction in falls or fall related injuries as a result of the project, nor could any trend observed be attributed to the project.

Section 4 of the report outlines the project implications. Achievements of the project are discussed, together with key learnings for project implementation. The FSO Pilot Project achieved considerable progress towards a number of its key objectives and performance indicators. The project has effectively raised the profile of falls and falls prevention activities for older people as important issues. The cross-continuum approach in reducing falls and their impact on older people has been promoted, ensuring that effective strategies are implemented for identifying people at risk at the interfaces between the community, hospital and residential care facilities and intervening at those junctures. The key learnings for project implementation are discussed in relation to role of FSO's, organisational readiness, stakeholder engagement, planning days/workshops, working groups and project sustainability, together with associated barriers and facilitators. Barriers mainly concerned the limited timeframe of the project to achieve the KPIs, staff issues including workload and capacity, and district restructuring. Facilitators included FSO training, support from project management and Population Health Units, as well as executive sponsorship.

Stakeholder feedback on the Cross-Continuum Service Delivery Model, which was promoted in the FSO project, was generally positive and the strengths and benefits of the model are discussed in Section 4.

Recommendations that emerged from stakeholder feedback were that, for a Service Delivery Model to be successfully implemented, it should:

- be based on *needs analysis* of the target group;
- enable *communication* within and between settings;
- be *flexible* so that it can be adapted to meet the needs at district and local levels;
- have systems for the accurate monitoring and reporting of *falls data;*
- include systems for *quality improvement* and continuing education on best practice;
- ensure that auditing and *evaluation* processes are in place;
- develop a *governance* system that embeds falls prevention as "core business" and involves all stakeholders;
- be adequately *funded* and resourced and equitable across the state;
- be compatible with other relevant service delivery models and be *integrated* with existing services;
- utilise *standardised assessment tools* that permit transfer of information across the continuum of care.

The opportunities from this project are that momentum has been built for falls prevention in Queensland across the health continuum. The formal evaluation provides evidence for the cross continuum model of service delivery for implementing a statewide falls prevention strategy. The lessons learned and wealth of data from this project should inform the next step, which is to develop and implement a comprehensive and well resourced statewide falls injury prevention model so that the work that has been done is sustainable.

SECTION 1

PROJECT RATIONALE

PROJECT OVERVIEW

This project was an implementation pilot for enhancing Queensland Health's response to falls prevention in older people - 'Queensland Stay On Your Feet®- in community, hospital and residential aged care facilities'. The 12 months project commencing in February 2008 was funded by the Patient Safety Centre, Queensland Health as part of its Falls Injury Prevention Program.

PROJECT BACKGROUND

FALLS AND EXTENT OF PROBLEM FOR QUEENSLAND [1]

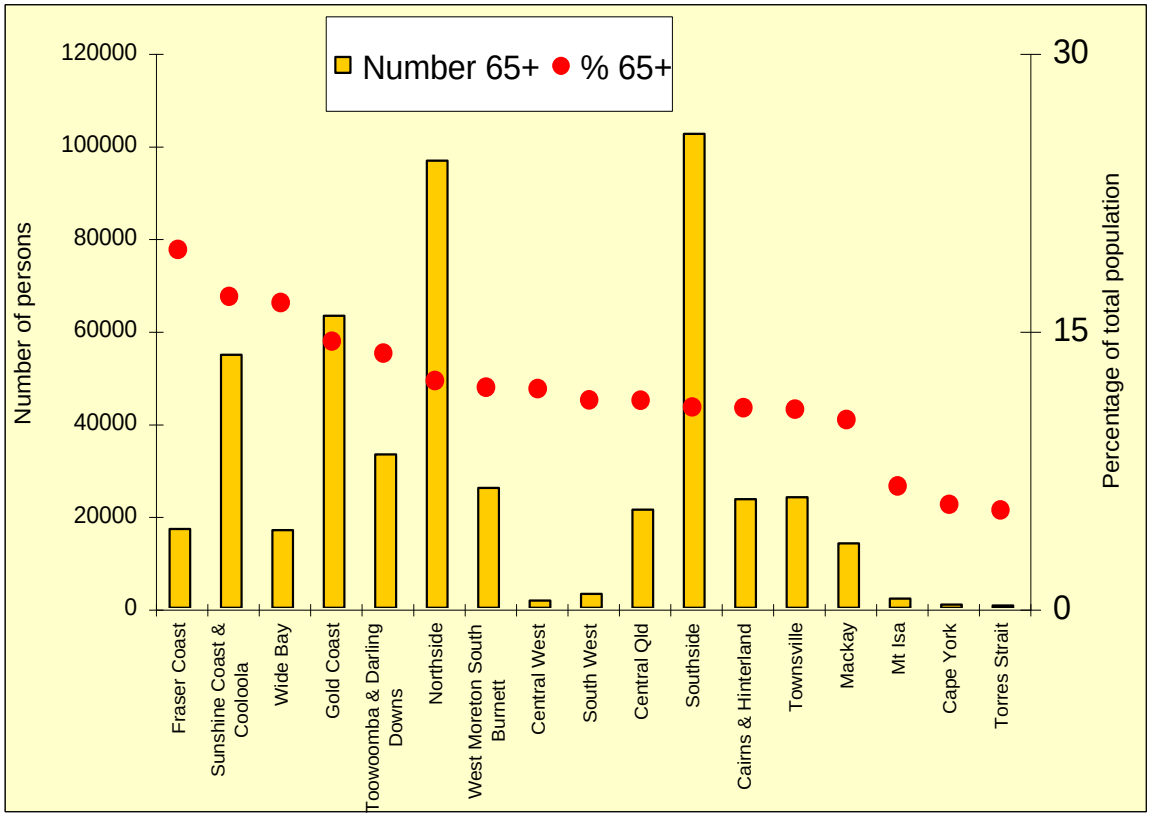
The proportion of the population aged over 65 years is increasing. Falls are the most common form of injury among this age group and result in high costs to the health system and considerable adverse effects for the individual. Most falls by older people are preventable and the benefits of prevention are considerable for both individuals and health care organisations (Queensland Health, 2007), page 12.

Currently a window of opportunity exists in which to invest additional resources to reduce falls and their related injuries among older people. The proportion of Queenslanders aged 65 and over is projected to increase from 12% in 2006 to 26 % by 2051 (Queensland Health, 2006). A report by Moller (Moller, 2003) estimates that if additional efforts to reduce falls in this age group are not comprehensively implemented before 2017, when 15% of the population in Queensland will be aged 65 years and over, the total cost of treatment will rise to a point that is likely to make investment in prevention difficult. However, in some areas of Queensland the percentage of older people is already greater than 15% as shown in Figure 1.

The Moller report (Moller, 2003) predicts that by 2051, over 500 additional hospital beds and 850 nursing home places will be needed in Queensland to treat the consequences of falls and that a 66% reduction in prevalence of falls is needed to maintain cost parity between 2001 and 2051.

[1] What's happening about falls prevention in Queensland? SOYF Information Sheet, Injury Prevention, Health Promotion Unit, Queensland Health, 2008

Figure 1: Queensland Population Aged 65 and Over



Source: Presentation by Margaret Bright, Population Health Branch, Queensland Health to AFSO Training Workshop 5 February 2008

Statistics on falls in Queensland can be accessed through the Queensland Health Stay On Your Feet® website: http://www.health.qld.gov.au/stayonyourfeet/statistics/

These data show that preventing falls in older people (65 years and older) is a priority given that:

- Falls are the second most frequent condition resulting in an avoidable hospital admission.
- Falls among people 65 years and older account for 80% of the occupied bed days for all falls in all age groups, 11.8% of occupied days for all conditions in this age group and 5.5% of occupied bed days for all conditions in all age groups.
- The incidence is estimated to be approximately 1 in 3 older Queenslanders falling annually with the rate higher in hospitals and residential aged care facilities.
- In 2005/2006 19,074 older Queenslanders were hospitalised as a consequence of falls, rising to 22,088 in 2006/2007 and 22,850 in 2007/2008. In 2005, the main cause of death was listed as falls for 119 Queenslanders aged 65 and over, rising to 162 in 2006.
- For patients in Queensland Health facilities, falls are the commonest reported cause of patient harm, with 3945 falls reported as resulting in patient harm during 2006/2007 (Patient Safety Centre, 2008).
- The impact to individuals and costs to the healthcare system are high.
- Most falls can be prevented and are not an inevitable part of growing old.

QUEENSLAND HEALTH POLICY

A number of Queensland Health policy documents show that Queensland Stay On Your Feet® model for falls prevention in older people across the health continuum aligns with strategic directions in Queensland Health.

The *Queensland Statewide Health Services Plan 2007–2012* (Queensland Government, 2007b) identifies as goals:

- to improve access to safe and sustainable health services;
- to better meet people's needs across the health continuum.

Congruent with the explanatory notes of the *Statewide Health Services Plan 2007-2012* p32-33, this model specifically supports the goal of improving access to safe and sustainable health services by working in partnerships with other service providers and increasing capacity in the health sector to better meet people's needs across the health continuum by systematically addressing falls in older people.

The *Queensland Health Strategic Plan 2007-12* (Queensland Government, 2007a) outlines key initiatives to address these goals, including addressing known high risk areas of patient harm such as falls injury (page 5) and implementing falls injury prevention programs across the health continuum (page 7).

Queensland Population Health Plan 2007-2012 (Queensland Health, 2007) proposes to invest in actions to address priority population health issues for critical life stages. A priority area is to reduce the proportion of older people who experience a fall by enhancing statewide capacity at population health, health service district, government and non-government levels to implement a multi-strategy falls prevention approach for older people.

Queensland Stay On Your Feet® model for falls prevention in older people across the health continuum supports this plan's vision to prevent injury, promote health and wellbeing, create safe and healthy environments and work in partnership. Overall, the model directly contributes to the action of addressing the priority population of older people and working toward reducing the proportion of older people who experience a fall.

FALLS INJURY PREVENTION POLICY GUIDING THE PROJECT

National Falls Prevention for Older People Plan: 2004 *Onwards* (National Public Health Partnership, 2005b) outlines guiding principles and supports working in a coordinated approach across all settings through partnerships. Falls related injury prevention is seen as a role and responsibility of all those who work with older people. The *National Falls Prevention for Older People Plan: 2004 Onwards* was developed to provide a strategic framework for coordinated action across the continuum of care and was endorsed by the Australian Health Ministers Advisory Council in July 2005.

National Injury Prevention and Safety Promotion Plan 2004-2014 (National Public Health Partnership, 2005c) supports the focus on the priority action area of falls in older people using a life course approach. In addition, the plan advocates working collaboratively to develop and disseminate information, and to build the capacity of health professionals and other service providers to prevent falls among older people.

National Aboriginal and Torres Strait Islander Safety Promotion Strategy (National Public Health Partnership, 2005a) supports addressing falls prevention in a holistic way that is relevant and sensitive to the social and cultural needs of Aboriginal and Torres Strait Islander peoples. This is best achieved by working collaboratively to develop community driven strategies that reduce risk environments and behaviours and increase community capacity to promote wellbeing in Aboriginal and Torres Strait Islander communities.

In *Queensland Population Health's Strategic Directions for Injury Prevention and Safety Promotion 2008-2011* (Queensland Health, 2008) (page 3), it is proposed over the next three years to develop a business case based on evidence from current approaches and analysis of gaps, and advocate for increased investment in falls prevention across the health continuum in collaboration with the Patient Safety Centre. To develop an agreed model to sustain an integrated falls prevention program through the patient safety workforce, Population Health supported Falls Safety Officers (employed by the Patient Safety Centre) to enable the development and implementation of falls prevention/healthy ageing action plans in Health Service Districts. Work undertaken with Falls Safety Officers to identify current gaps in service capability in the community setting will inform the business case (page 7).

RESOURCE GUIDELINES FOR FALLS PREVENTION

Based on reviews of the evidence, a number of guidelines applicable for community, acute and /or residential care have been developed for the prevention of falls (American Geriatrics Society, British Geriatrics Society, & American Academy of Orthopaedic Surgeons Panel on Falls Prevention, 2001; Baraff, Della Penna, Williams, & Sanders, 1997; Feder, Cryer, Donovan, & Carter, 2000; McInnes, Gibbons, & Chandler-Oatts, 2005; Moreland et al., 2003; National Collaborating Centre for Nursing and Supportive Care, 2004; Scott, Dukeshire, Gallagher, & Scanlan, 2001) and fall-related injuries, such as hip fracture (Gourlay, Richy, & Reginster, 2003; Scottish Intercollegiate Guidelines Network, 2002).

Australian resources

Queensland Stay On Your Feet® Community Good Practice Guidelines: Preventing falls, harm from falls and promoting healthy active ageing in older Queenslanders (Peel, Bell, & Smith, 2008) provide the research evidence to support community based falls prevention practice. The web-based toolkit Queensland Stay On Your Feet® Community Good Practice Toolkit (2008) provides information on how to conduct falls prevention activities in a community setting. These resources are available at http://www.health.qld.gov.au/stayonyourfeet

The Home and Community Care (HACC) Falls Prevention in Older People Best Practice Resource Kit (http://www.health.qld.gov.au/hacc/HACCfallsprev.asp) is a comprehensive package for use in the home and community setting. The kit encompasses a whole of service model and includes:

- an implementation guide for Service Providers;
- client Capacity building tools to support clients manage their own falls risk. (Two booklets, *Staying On* and *One Step Ahead)*;
- client information brochure;
- a CD containing an electronic version of all documents, clinical tools, training resources for both clients and workers and a video clip.

The Australian Council for Safety and Quality in Health Care's *Preventing falls and harm from falls in older people: Best practice guidelines for Australian hospitals and residential aged care facilities* (Australian Council for Safety and Quality in Health Care, 2005b, 2008), commonly referred to as the "Green Box", is designed to inform clinical practice and assist facilities to develop and implement practices to prevent falls and injuries from falls. An Implementation Guide (Australian Council for Safety and Quality in Health Care, 2005a) is an associated resource providing a stepped approach to planning, implementation and evaluation a fall-prevention program.

Falls Prevention Guidelines for the Emergency Department were developed by National Ageing Research Institute for the Australian Government Department of Health and Ageing (National Ageing Research Institute, 2007). The purpose of these guidelines is to provide an evidence based framework for older people who present to an Emergency Department (ED) to receive appropriate screening, referral and management of their falls risk factors.

IMPLEMENTING RESEARCH EVIDENCE IN FALLS PREVENTION INTO PRACTICE

Despite increasing evidence of the effectiveness of falls prevention strategies, with the development of guidelines as outlined previously, translating research evidence into practice remains problematic (Baker et al., 2005; Poulos, Zwi, & Lord, 2007). Evaluating system-wide fall prevention programs is crucial for translating the now substantial trial-based evidence of the efficacy of certain fall-prevention measures into practice (Day, Finch, & Segal, 2008). A UK report (Husk, Potter, & Lowe, 2006) assessed progress against the April 2005 National Service Framework for Older People (United Kingdom Department of Health, 2001) milestone "All local health and social care services should have established an integrated falls service for older people". Overall the audit results suggested that most areas have the infrastructure with potential to identify need and for provision of specialist falls assessment and treatment. Despite this, the amount of clinical activity was surprisingly low, there were notable gaps in provision, and arrangements in hospitals for case finding and secondary prevention were inadequate. Other audits of practice have generally found poor compliance with evidence based strategies for falls and fall-related injury prevention. (Hippisley-Cox, Bayly, Potter, Fenty, & Parker, 2007; Kimber & Grimmer-Somers, 2008; Martin, Husk, Lowe, Grant, & Spencer-Williams, 2007; Salter et al., 2006), although there are some successes (Clements, 2008; Fortinsky et al., 2008; Tinetti et al., 2008; Wenger et al., 2009).

There has been no evaluation in Australia measuring the use or effectiveness of tools such as the 'Green Box' (Department of Health Western Australia, 2008) although an evaluation of the effectiveness of *Minimising Risk of Falls and Fall-related Injuries: Guidelines for Acute, Sub-acute and Residential Care Settings* has been undertaken in Victoria (Victorian Quality Council, 2006). The project, conducted in two Victorian health services for a 12 month period (2005-06), evaluated three phases: planning, implementation and management. Analysis of the data indicated that there was a reduction in falls per 1,000 bed days in the majority of the wards and increased compliance with the falls minimisation strategy.

Also lacking in the literature is evidence of effective approaches to diffusion of best practice falls prevention strategies into routine health care of older adults. Baker and colleagues (Baker et al., 2005) outlined steps taken to disseminate an evidence based falls risk assessment and management strategy into clinical practice throughout a defined geographic area in Connecticut, USA. Provider working groups that included 10 to 15 providers, usually in supervisory roles, were set up to serve as the primary forum for planning and implementing activities. Membership comprised hospital case management/discharge planners, ED physician directors, primary care providers, home care, and outpatient rehabilitation staff. A variety of methods was employed to encourage professional behaviour change among the targeted providers. Evaluation of this program (Tinetti et al., 2008) concluded that dissemination of evidence about falls prevention, coupled with interventions to change clinical practice, may reduce fall-related injuries in older persons.

In the UK, Husk (Husk, 2008) recently reported on a method for achieving changes in practice as a result of the national audit of the organization of services for falls and bone health in older people (Husk, Potter, & Lowe, 2006). An action planning workshop was held to use the indicators from the national audit report and to transfer these to an action plan template to assist sites to benchmark performance and for the development of a "coordinated, integrated, multidisciplinary falls and bone health service at local level" as described in the National Service Framework for Older people (United Kingdom Department of Health, 2001).

IMPLEMENTING FALLS PREVENTION IN AUSTRALIA

In Australia, some of the States are planning statewide approaches to the delivery of falls prevention services for older people.

In Victoria[2], the Discussion Paper *Preventing Falls in Victoria 2007-12* (Victorian Government Department of Human Services, 2007) elicited more than 40 written responses. The comments in the responses are being used, together with the findings of a review conducted by the National Ageing Research Institute (NARI) to inform a framework and action plan to be distributed in 2009. NARI was funded to undertake a review of the 102 projects funded by Aged Care Branch in four settings since 2000-2007. The final draft review is also informing the development of the framework and action plan.

[2] Information supplied by Margaret Thomas, Department of Human Services, Victoria.

The current draft action plan is looking to support and promote:

- healthy active living;
- increased information/knowledge/awareness/self awareness;
- workforce learning and development and organisational culture;
- managing risks to prevent falls;
- access to support, services and care for those at risk and those who have experienced a fall;
- safe infrastructure and products;
- improving the evidence base and its use to inform practice.

The Primary Care Partnership (PCP) strategy has provided Victoria with an unprecedented opportunity to build the ongoing capacity of the human services system to plan and deliver effective, integrated health promotion. Falls prevention funding provides opportunities for PCPs to work with a range of partners across multiple settings, including public sector residential aged care services and other not for profit agencies within a designated local catchment area. Working directly with acute and residential services enables PCP member agencies to facilitate better admission and discharge planning and provides older people with a seamless response to reduce the risk of falls and improve injury prevention.

In NSW [3], the Falls Prevention Program is a state-wide program to prevent falls and fall-related injury and to reduce fall related admission to hospital. This is to be achieved by the implementation of a range of falls prevention strategies across community, hospital and residential aged care settings. In July 2004, the NSW Health Minister launched the *Management Policy to Reduce Fall Injury Among Older People* for implementation across the state. The responsibility for the implementation of the NSW Falls Policy is shared by agreement, with the Centre for Health Advancement, NSW Department of Health and the Clinical Excellence Commission (CEC). A Leader, NSW Falls Prevention Program was appointed in late 2005 to the CEC to provide state-wide leadership, co-ordination and support to the Area Health Services.

The implementation of the NSW Falls Prevention Program involves:

- recruitment of the Area Falls Prevention Co-ordinators (AFC) within each of the eight Area Health Services (AHS);
- establishment of an AFC List-serve to facilitate collaboration and to ensure that there is sharing of good initiatives for implementation across the AHSs;
- provision of a generic role description and terms of reference for an Area Falls Management Committee to provide governance and support consistency across the state in the implementation of the falls prevention initiatives;
- development of Area Falls Prevention Plans which is based on the NSW Health Falls Policy and prioritisation of falls prevention initiatives over 2-3 years;
- formation of working groups within each AHS to progress hospital, community and residential aged care strategies.

[3] Information supplied by Lorraine Lovitt, Leader, NSW Falls Prevention Program, Clinical Excellence Commission, Sydney, NSW

The NSW Falls Prevention Network is hosted at the Prince of Wales Medical Research Institute (POWMRI)(www.powmri.edu.au/fallsnetwork). A part-time project officer has been appointed, whose role is to provide a newsletter bi-monthly with updates on latest falls prevention research and highlights of presentations and forums that have been held across the state. Meetings (metropolitan and rural) are convened to present on the latest update in falls research and evidence and to share falls prevention initiatives. A list-serve with over 700 members from NSW, across Australia and overseas provides a mechanism for clinicians to seek information and problem-solve various issues relating to their practice.

Evaluation of the NSW Falls Prevention Program is being conducted by Dr Wendy Watson, Senior Research Fellow, Injury Risk Management Research Centre (IRMRC).

In Western Australia[4], the Falls Prevention Model of Care for the Older Person has been developed by the Falls Prevention Executive Advisory Group as part of the overarching Model of Care for the Older Person in Western Australia (Western Australian Department of Health, 2008).

The Falls Prevention Model of Care for the Older Person must:

- align with the Aged Care Network, Model of Care for the Older Person in Western Australia and other related models);
- be evidence based;
- engage and strengthen primary care partnerships across the continuum of care;
- strengthen the role of the community and non health sector through education and training;
- provide falls prevention at every opportunity across the continuum of care;
- address the inequalities of access to falls prevention strategies;
- acknowledge the importance of the carer as an integral component of the care team;
- foster communication and support between sectors to ensure the transition of older people is better managed.

In South Australia[5], there is varied work happening at regional levels, but statewide the three key items being progressed currently include:

- the development of a strategic framework for the state;
- a health policy guideline for health service;
- KPIs for health service district Chief Executive Officers based on completion of tasks beginning with an initial stock-take/gap analysis followed by development of site based plan requiring establishment of local committee's/working groups.

[4] Information supplied by Hannah Seymour, Clinical Lead, Falls Prevention Network, Health Network Branch, Department of Health, WA

[5] Information supplied by Michelle Sutherland, Falls Prevention Program Manager, Clinical Systems, Safety and Quality Team, Department of Health, SA

IMPLEMENTING FALLS PREVENTION IN QUEENSLAND

The FSO Implementation Pilot Project was planned, based on key learnings from a number of projects conducted in Queensland.

In 2001-2006 a community-based falls prevention project *Stay on Your Feet* was conducted by Queensland Health's Wide Bay Population Health Unit and evaluated by researchers from Queensland University of Technology and Injury Prevention and Control Australia Ltd (http://www.health.qld.gov.au/stayonyourfeet/trial_project/). The project was modelled on an effective community-based intervention run in the Northern Rivers region of New South Wales during the 1990s (Kempton, van Beurden, Sladden, Garner, & Beard, 2000). Project design and activity priorities were determined using a community development approach through consultation with members of the primary target group. Implementation was guided by a series of locally determined and evidence- based community action plans. Among the recommendations from the project was the need for a cross-continuum approach, an integrated and coordinated response across settings by working with clinical service providers and non-clinical community-based agencies.

After the development of the National Guidelines for Falls Prevention and Implementation Guide in 2005, Queensland Health undertook a program to implement the guidelines. In May 2006, the Principal Project Officer for Falls Injury Prevention at the Patient Safety Centre facilitated training and planning workshops around the implementation of the "Green Box" in Queensland Health hospitals and residential aged care facilities. Almost every health service district throughout Queensland received this training and all who had received the training had established working groups with action plans developed. This training was specifically for public hospitals and aged care facilities. District audits of the level of implementation of standard falls prevention strategies and falls prevention interventions from the National Guidelines were conducted in 2006 (pre-implementation) and 2007 (post-implementation). The results showed that there had been a change in the implementation of falls prevention strategies and interventions between 2006 and 2007. While it was acknowledged that accurate collection of data was an issue, the results represented a positive step forward as they demonstrated a move from only assessing for falls risk, to the implementation of some evidence-based strategies to prevent falls among older people in Queensland Health hospitals and residential aged care facilities.

In 2007, the Patient Safety Centre also provided workshops on the National Falls Prevention Guidelines to the private aged care and acute sectors throughout Queensland. Overall the acceptance and positive feedback from the workshops was very good. It became apparent during these sessions that the development of working partnerships between Queensland Health and the private sector needed to be encouraged.

Many community-based agencies also requested to attend training workshops as there were no comparable guidelines or training available to them at that time. The gap in the guidelines for falls prevention in the community was addressed in 2007 with the development by Patient Safety Centre and the Health Promotion Unit of Queensland Health of the *Queensland Stay On Your Feet® Community Good Practice Guideline*s and *Toolkit*.

A Joint Work Plan established between the Patient Safety Centre and Health Promotion Unit agreed to support a cross-continuum approach to falls prevention activities. In the development of the Falls Safety Officer Implementation Pilot Project, the many learnings of the early work was utilised, including agreement that a cross-continuum approach was necessary.

The project plan for the implementation pilot for enhancing Queensland Health's response to falls prevention in older people - 'Queensland Stay On Your Feet® - in community, hospital and residential aged care facilities' was outlined in Section 1 of the Mid Term Evaluation Report. The next section of this report outlines changes to the project following the mid term review.

The results of the FSO Implementation Pilot in Queensland have implications for efforts to diffuse evidence-based practices for falls prevention across the continuum of care and will contribute to the literature on effectiveness of dissemination of falls prevention guidelines into practice.

SECTION 2

PROJECT POST MID TERM

PROJECT SYNOPSIS

As outlined in the Mid Term Evaluation Report, the purpose of the project was to trial in Queensland a workforce enhancement strategy at an Area Health Service (AHS) level to support and coordinate evidence based falls prevention implementation across the health continuum. The expected outcome was to inform the development of a cross continuum service delivery model evidenced by a consistent, coordinated, evidence based approach to falls prevention for older persons across the health continuum at Health Service District (HSD), Area Health Service (AHS) and statewide levels.

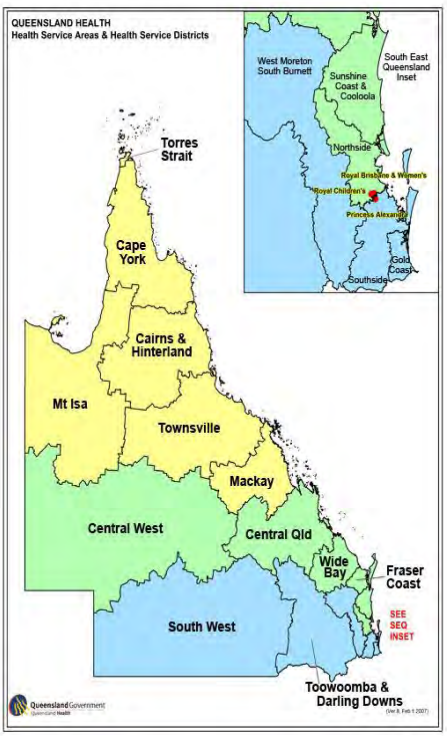
The workforce enhancement strategy involved the appointment of two Falls Safety Officers (FSOs) (one for public hospitals and residential aged care facilities (H/RCF) and one for the community sector) in each Area Health Service (Northern, Central and Southern). These six Falls Safety Officers commenced on 5 February 2008. Priority Health Service Districts and facilities were identified using population ageing projections and hospital falls morbidity data, including hip fractures. The priority districts at the commencement of the project are shown in Figure 2.

Figure 2: Area Falls Safety Officers' Priority Health Service Districts (February 2008)

Northern Area Health Service:
- Cairns & Hinterland
- Townsville
- Mount Isa
- Mackay

Central Area Health Service:
- Northside
- Sunshine Coast /Cooloola
- Central Queensland
- Royal Brisbane and Women's Hospital

Southern Area Health Service:
- Southside
- Gold Coast
- West Moreton/South Burnett
- Princess Alexandra Hospital



Source: http://www.health.qld.gov.au/maps/ (February 2008)

To support HSDs to translate falls prevention evidence and good practice into coordinated, effective and sustainable action, the recommended resources for use included:

- The National Falls Prevention Guidelines for Australian Hospitals and Residential Aged Care Facilities ('Green Box').
- Queensland Stay On Your Feet® Community Good Practice Guidelines and Toolkit.

MID TERM EVALUATION RESULTS

The Mid Term Report detailed the key strategies and performance indicators for implementation of the project plan. Evaluation results of KPIs as at 30 July 2008 are summarised in Table 1.

Table 1: Summary of Mid Term Evaluation Results

Key Performance Indicators	Mid Term Results
Number and scope of key internal and external stakeholders across the health continuum engaged within each HSD identifying current levels of falls prevention capacity and activity.	Stakeholder contacts: • Northern Area contacted over 470 stakeholders across 5 HSDs. • Central Area contacted over 130 stakeholders in 4 priority HSDs. • Southern Area contacted over 190 stakeholders in 4 priority HSDs. Capacity was measured through key stakeholder interviews from priority districts using the capacity building framework. Twenty-two interviews were conducted from hospital, residential aged care and community. Baseline data indicates the following for priority districts: • Networking: mainly the community sectors had more capacity for networking and partnerships, whilst hospitals and RCF sector worked independently and did not consider cross continuum as important to their core business. • Knowledge transfer: there is limited existing capacity within districts to share knowledge about local activities, programs and address falls at a local level. • Problem solving: West Moreton community showed considerable capacity and Townsville some capacity to problem solve, whilst all other priority districts had limited problem solving capacity. • Infrastructure: very few examples of investment in networks policy development, social, human and financial capital for falls prevention across the continuum.

Key Performance Indicators	Mid Term Results
	Identified levels of current falls prevention activity within the hospital and community using a scoping/stocktake survey. Total number of forms returned was 115. • Northern –community 28 and hospital 2; • Central -community 28 and hospital 10; • Southern - community 42 and hospital 5.
Facilitation of District Planning days (encompassing the health continuum) in each HSD of the allocated AHS that includes workforce skill enhancement/training.	• Northern Area: Community Falls Prevention workshops were held at Cairns, Ayr/Burdekin, Bowen, Collinsville and Townsville. Hospital Workshops were held at Ayr and Bowen. Cross continuum workshops were held at Mount Isa, Charters Towers and Townsville. • Central Area: Cross continuum workshops were held at Sunshine Coast /Cooloola, Northside (Redcliffe and Caboolture) and Central Queensland. • Southern Area: Community workshops were held at Gold Coast, Redlands, Logan and QEII. Hospital and RCF Workshops were held at Redlands, Moreton Bay, Logan and QEII.
Collaborative development of HSD specific falls prevention action plans based on good practice that builds upon relevant existing evidence based activities, defines roles and responsibilities of stake-holders and includes means for reporting progress.	Action plans are still being developed by each priority district. Those that are underway include: • Northern Area: Ayr, Burdekin, Bowen, Collinsville, Mount Isa, and Charters Towers. • Central Area: Redcliffe, Caboolture, Sunshine Coast / Cooloola, Northside and Central Queensland. • Southern Area: Gold Coast, Southside including Logan Beaudesert, QEII and Bayside and Redlands.
Establishment and / or maintenance/enhancement of HSD falls prevention working groups (or equivalent) to oversee ongoing implementation of HSD falls prevention action plans.	Northern • Cairns community has a Senior Safety Group and no hospital group. • Mount Isa had an existing Senior Safety Group and a hospital working group that needed support to reconvene. • Townsville had *Stepping Out* and no hospital group and Parklands RCF started a working group. • Bowen had a hospital working group that needed further support to enhance its function. • Charters Towers had an existing cross continuum working group with limited representation from the wider community.

Key Performance Indicators	Mid Term Results
	Central • Sunshine Coast / Cooloola cross continuum working group was established. There was an existing Hospital and RCF working group which was integrated into the cross continuum group. • Central Queensland cross continuum falls working group was enhanced. Gladstone Hospital, Moura Hospital, Theodore Hospital and Biloela Hospital had existing falls prevention working groups. • Northside cross continuum working group was formed. Redcliffe has a hospital working group and a community healthy ageing partnership. Caboolture/Kilcoy developed a hospital working group and a Caboolture Healthy Ageing Partnership was formed. The Prince Charles Hospital *'STEPS'* was dissolved and reformed under a new acute falls working group. • RBWH had an existing hospital based working group with plans for expansion to include community. Southern • Logan had an existing hospital/RCF working group and community working group. • QEII had an existing Brisbane South Community Health Services Falls Prevention and Management Committee within community. • Redlands/Bayside had an existing falls prevention working group for hospital/RCF and for the community. • PAH had an existing falls prevention working group . • Ipswich West Moreton had an existing hospital working group and a community working group. • Gold Coast District had a Falls Injury Prevention Committee with cross continuum membership.
Rollup of HSD falls prevention action plans into AHS Falls Injury Prevention Work Plans.	The action plans will not be rolled into area action plans due to the Queensland Health Reform as of 15 August, 2008, whereby Districts were realigned and Area Health Services were devolved. Action plans are being developed for the priority districts following the restructure.

PROJECT PLAN MODIFICATIONS

MID TERM EVALUATION RECOMMENDATIONS

Project recommendations in the Mid Term Report resulted in modification to the project plan for the final six months. The recommendations were for FSOs to:

- Consolidate work in the districts where work had already commenced, following-up and supporting working groups to ensure that action plans were developed and sustainable.
- Expand on stakeholder engagement by encouraging more people to complete the stocktake/scoping tools.
- Increase stakeholder's awareness and engagement by explaining the purpose and benefits of the falls prevention cross continuum model by using the:
    - definition developed*: 'An organised delivery of evidence based falls prevention interventions through communication, coordination and partnerships between all sectors from the wider community, primary health care, acute, residential aged care facilities and rehabilitation sectors'*;
    - the model (poster and pull out in guidelines);
    - background paper and case studies accessible from the Stay On Your Feet ®website.
- Emphasise and provide education sessions and up skilling the workforce.
- Review the format of future planning days/workshops to allow sufficient time to deliver all components.

Adopting these recommendations meant that the project was not extended beyond the priority districts as was originally intended. Other factors resulted in changes to the project plan in the last six months of the project. These included Queensland Health restructuring and staff attrition.

QUEENSLAND HEALTH RESTRUCTURE

On 15 August 2008, Queensland Health announced a reorganization to abolish Area Health Services and Health Service Districts were amalgamated to form 15 Districts from the previous 20. The new structure is shown in Figure 3.

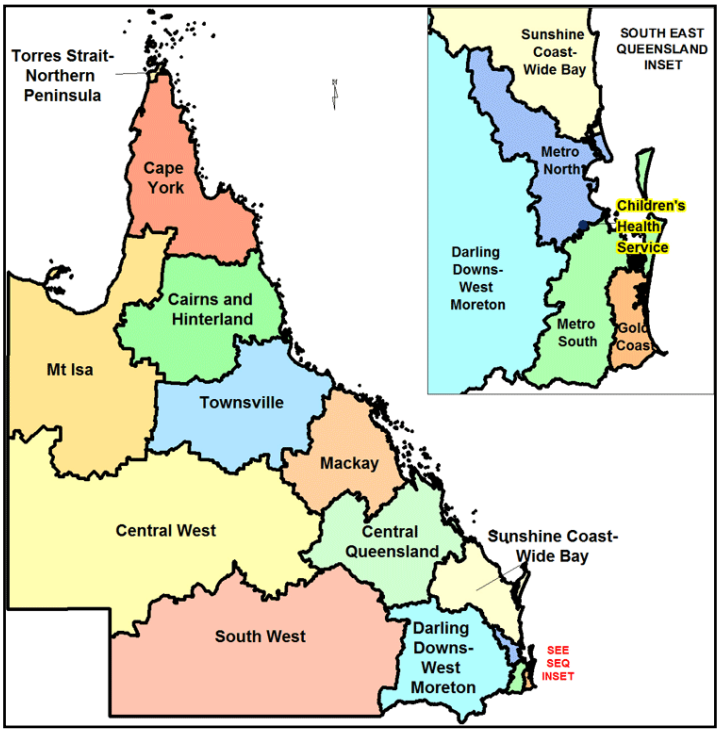
Health Service District realignment and removal of Area Clinical Governance half way through the project had a significant impact, affecting reporting structures and action plans developed for this project. There were changes to Executive Sponsors for the District Cross Continuum Steering Groups and hospital and community working groups. Experience with restructures and reforms from 2006 to 2008 had a critical impact on key internal stakeholders in relation to their ability and willingness to acknowledge falls prevention as a priority and to commit to work other than perceived core business. External stakeholders such as Local Government Authorities also restricted their involvement and commitment to the development of cross continuum action due to Council amalgamations also occurring. In addition, the new districts did not align with the local government districts, which affected data collection and population information.

In the Northern Area, the Queensland Health devolvement of area health services in August 2008 adversely affected project operations in the Northern Area. FSO access to local resources and support was extremely limited (for example, vehicle, stationary, administration, local line management authority, office equipment/space). Consequently, more time was spent on administrative and organisational activities than anticipated.

In Central Area, the priority district boundaries changed with Sunshine Coast District formed through amalgamating the Sunshine Coast/Cooloola, Wide Bay and Fraser Coast Health Service Districts. Metro North incorporated Northside Health Service District and Royal Brisbane and Women's Hospital. The changing district boundaries impacted on staff roles.

In Southern Area the priority district boundaries changed with Metro South incorporating Southside and Princess Alexandra Hospital and Darling Downs-West Moreton District incorporating former Toowoomba, Darling Downs and West Moreton South Burnett Districts. Prior to the amalgamation, it was decided in July 2008 to focus additionally on the HSDs of Toowoomba and Darling Downs and South West, in recognition of other priorities in the Princess Alexandra Hospital and West Moreton-South Burnett priority areas. With amalgamation, staff redeployment and freezing of positions meant that vacancies due to FSO attrition could not be filled. This particularly affected the Southern Area where the appointment of a new community FSO was delayed for 22 weeks.

Figure 3: Health Service Districts Queensland Health (August 2008)



Source: http://www.health.qld.gov.au/maps/ (August 2008)

STAFF ATTRITION

As reported in the Mid Term Report, there was a high attrition rate among FSOs. Four FSOs (Northern Area Community FSO, both Central Area FSOs and Southern Area Community FSO) left the project at the end of six months and another (Northern Area H/RCF FSO) left in October 2008. This attrition was attributed to the short term of the project, with FSO staff feeling insecure in their temporary positions. Resignations occurred when staff sought, or were offered, positions that were at a higher level, were direct patient care or a permanent position. In addition, there was some uncertainty about funding after June 2008 due to Queensland Health finance business rules, which would not allow the original twelve month funding to be allocated (rolled over) into the next financial year. The H/RCF FSO position in NAHS remained vacant from the second week in October 2008 and due to re-structuring as described earlier, the community FSO position in SAHS was vacant from July until November 2008.

PROJECT STRATEGIES MODIFICATION

Project strategy modifications as a result of these factors are detailed in FSO Exception Reports.

In Northern Area, for the second half of the pilot project the decision was made to identify HSD Facilities/ Sectors that had the most potential to achieve the desired outcomes of the project and develop strategies to follow-up with all stakeholders who had been key players in the pilot project at the local level. Local Government Authorities where there was a HSD Facility/ Sector and where there had been stakeholder engagement were followed up for the next phase of cross continuum action planning (Townsville, Cairns, Charters Towers, Cook, Mount Isa). Because of the vast size of the Northern Area and consequent time taken to access and attend education and workshop sessions, FSOs decided to restrict other project activities to their local areas.

In Central Area, due to the project timeframe, engagement with additional HSDs (Central West and Wide Bay) was restricted. The cross continuum working groups (Northside and Sunshine Coast / Cooloola) that were based on the 'Hub and Spoke' model' (page 66, Mid Term Evaluation Report) needed to be re-established to account for the new district boundaries. This required FSOs to reengage with priority districts to discuss and consider alternative structures to the 'Hub and Spoke' model. Because of limited data to inform service gaps and support action plan development, renewed emphasis was placed on the administration of scoping tools with key stakeholders. Responding to identified limited involvement of the community sector, it was planned to deliver community workshops / planning days to enhance understanding and awareness of community guidelines, facilitate gaps analysis and district falls prevention planning and promote cross-continuum approaches. Key hospital and RCF staff were also invited to participate.

In Southern Area for the second half of the project, the decision to identify HSD Facilities/ Sectors that had the most potential to achieve the desired outcomes of the project meant that work would focus on Southside and Toowoomba and Darling Downs District to support the approved proposed

district structures through education, reconvening and enhancement of existing groups and the creation of district cross continuum committees.

The evaluation results from the second half of the project reflected the revised approach to the project, particularly the decision to consolidate the work in priority districts and not to expand into other districts unless there was an expressed interest and capacity to do so. These results are outlined in the next section.

SECTION 3

EVALUATION POST MIDTERM

EVALUATION METHODOLOGY

The evaluation methodology was outlined in the Mid Term Evaluation Report. Changes to the methodology that occurred over the life of the project are outlined below.

DAILY PROCESS LOGS

Daily process logs were required to be maintained by the FSOs recording daily activities using the Queensland Health electronic project activity logging system. The process log monitoring system was initially developed by the Centres for Disease Control and Prevention. It was converted into an electronic web-based application by Injury Prevention and Control (Australia) Pty Ltd as a method of monitoring activities of project officers for process evaluation of a childhood injury prevention program in Queensland (Turner, Yorkston, Hart, Drew, & McClure, 2006). The evaluation plan for the FSO project sought to utilise this system in the same way to monitor process activities including stakeholder engagement, resource dissemination and administration.

The web-based application required considerable modification by the University of Queensland IT staff, in conjunction with the original developer, in order to make it suitable for use by FSOs. The program was not available until July 2008 and FSOs were trained in its use on 9 July 2008. In the meantime daily activities were documented according to the instructions in the Evaluation Checklist outlined in Appendix 1 of the Mid Term Evaluation Report.

Besides the delay in getting the program operational, several difficulties arose with the electronic logging system. It was time consuming for FSOs to enter data, leading to missing data and the quality of data received was inconsistent. When away from remote access, FSOs continued to use a daily log word document or excel spreadsheet to 'cut and paste' into the process log system. If the document was long, information was cut off and not able to be retrieved by the evaluation team. In addition, the output functions of the process logging system did not allow reporting of data in a format suitable for analysis. In September 2008, Central Area FSOs devised an excel spreadsheet logging system that was more suitable for this project, although FSOs who wished to, could continue with the electronic logging system.

The evaluation team does not recommend the use of the web-based electronic logging system in its current stage of development.

GOAL ATTAINMENT SCALES (GAS)

The methodology for recoding and quantifying project goal attainment was adapted from Kloseck (Kloseck, 2007). In the GAS instrument, FSOs identified short, medium and long term goals (KPIs from the project plan), and the actions that were needed to achieve them. A quantitative measure of goal attainment was self-assessed at two monthly intervals. It was found that the GAS reports duplicated information that was in the Monthly Status Reports completed by FSOs as a requirement of Queensland Health. Therefore, the GAS reports provided no additional information and were not required to be completed for evaluation purposes in the second half of the project.

REPORTING FORMAT

Although the mid term evaluation results were reported using the RE-AIM format (Glasgow, Vogt, & Boles, 1999), it was not considered a suitable format to report the final evaluation results. However, these parameters were still covered implicitly under the relevant sections of process, impact and outcome evaluation.

EVALUATION RESULTS

PROCESS EVALUATION

The extent to which the project reached the intended target group was assessed by the following KPI measures:

a. Number and range of stakeholders engaged;
b. Number of district planning days held;
c. Percentage of Queensland Health facilities provided with the opportunity for relevant staff/falls working groups to receive workforce skill enhancement/training.

a. Number and range of stakeholders engaged

The number and range of stakeholders engaged was assessed from various data sources including stocktakes, contact databases and lists of attendees at planning days.

Northern Area

In the second half of the project, in Townsville HSD, 20 additional stakeholders were reached through forum follow-up, attending meetings, facilitating working group action plans, operational partnerships with the Health Service District, Quality and Safety and Population Health, Health Promotion and dissemination of resources (SOYF Good Practice Guidelines, National H/RCF Guidelines, long and short SOYF checklists and local information). In Cairns and Hinterland HSD, the FSO reported 19 additional stakeholders were engaged through stocktakes, forum follow-up, active operational partnerships with Population Health, Health Promotion and distribution of resources. In

Mount Isa HSD, 9 additional stakeholders were reached through forum follow-up, H/RCF education sessions and distribution of resources. Over the period of the pilot project, 520 stakeholders were contacted. The total number of completed scoping/stocktakes was 44 (28 from the community and 16 from the hospital/RCF sector). The range of stakeholders engaged included Queensland Health staff in hospitals and rehabilitation, primary health care, state and private residential aged care facilities, relevant government and community based service providers, local councils and the business sector.

Central Area

In the four priority districts in Central Area, mapping tools (scoping and stocktakes) were completed for an additional 15 stakeholders from hospitals and RCF facilities and 15 from organisations within the community. The total number of completed scoping/stocktakes was 69 (43 from community and 26 from the hospital/RCF sector). Over the period of the pilot project, over 210 stakeholders were listed on the stakeholder contact database. The range of stakeholders included Queensland Health staff from hospitals, residential care facilities, community health, HACC and Population Health, as well as community Non-Government Organisations (NGOs), such as Divisions of GPs, Blue Care, Oz Care, Spiritus, and local government.

Southern Area

In the Southern Area the FSO H/RCF extended the project into the former Toowoomba and Darling Downs HSD which is now part of the Darling Downs West Moreton HSD. An additional 40 stakeholders, including representatives from nursing, allied health, community health, Population Health and patient safety from acute and residential aged care facilities across the district were contacted by the FSO H/RCF. Over the 12 months, over 240 stakeholders were listed on the stakeholder contact database and 69 completed scoping/stocktakes (45 from community and 24 from the hospital/RCF sector) were received. The range of stakeholders included Queensland Health staff from hospitals, residential care facilities, community health, HACC and Population Health, as well as community NGOs. The engagement of community stakeholders was greatly assisted by collaboration with Health Promotion Units in Brisbane South and Gold Coast Population Health.

b. Number of district planning days held

Northern Area

In the Northern Area, over the duration of the project there were 9 planning workshops across 5 HSDs (Townsville, Cairns and Hinterland, Mount Isa, Cape York and Mackay[6]):

- 4 community (Townsville, Ayr, Bowen, Cairns);
- 1 hospital/RCF (Ayr/Bowen);
- 4 cross continuum (Townsville, Charters Towers, Mount Isa, Cooktown).

[6] After Queensland Health re-structuring, Bowen and Collinsville became part of Mackay HSD. Prior to re-structure these towns had been part of the Townsville HSD.

In addition 14 education sessions were held:

- 2 community (Collinsville, Innisfail);
- 12 hospital/RCF (Bowen, Ayr, Ingham, Hughenden, Innisfail/Tully, Cairns (2 sessions), Mareeba, Atherton, Mossman, Herberton, Gordonvale).

In all, attendances at workshops and education sessions numbered 352. Attendees included QH acute sector staff, QH community staff, Population Health, community service providers, residential aged care, rural & remote health services, NGOs (support services & advocacy groups, CALD and Indigenous groups, consumers, Division of GPs, Commonwealth Carelink, Centrelink, DVA, Local Government, State Government (Home Assist Secure)).

FSOs also attended post planning day follow-up meetings. This involved summarising data of work undertaken in the District and feedback information; identifying and consulting with key stakeholders; attending falls prevention working group meetings or community group meetings to re-establish rapport, identify the group's status of development in planning and implementing good practice falls prevention, feedback on the Planning Days; facilitating progress on cross continuum action and identifying support mechanisms for 'post' Falls Safety Project.

Central Area

In the Central Area, over the duration of the project there were 12 planning /education sessions held including:

- 3 cross continuum planning days held in the first half of the year (Sunshine Coast/Cooloola, Central Queensland, and Northside HSDs (Redcliffe and Caboolture));
- 8 community workshops held in the second half of the year (Sunshine Coast/Cooloola, Northside (RBWH, TPCH (2 sessions)), Central Queensland (Rockhampton, Biloela, Emerald, Gladstone);
- 1 acute care (RBWH)

In all, attendances numbered 283. Attendees included representatives from QH acute sector staff, QH community staff, HACC, Population Health, community service providers, public and private and residential aged care staff, community NGOs (community support & advocacy groups, CALD groups, consumers, Division of GPs, Commonwealth Carelink, DVA, Local Government, State Government (Home Assist Secure) and TAFE).

Southern Area

In the Southern Area over the duration of the project 18 planning/education sessions were held over the duration of the project across (old) HSDs (Southside, West Moreton South Burnett, South West, and Gold Coast). They included:

- 3 cross continuum (Southside, West Moreton South Burnett (Toowoomba Darling Downs), Gold Coast);
- 6 community (Southside-Logan/Beaudesert, QE11, Redlands; South West- Roma, Charleville; Gold Coast);

- 7 acute care sector (Southside-Logan/Beaudesert, QE11, Redlands; West Moreton South Burnett-South Rural (Inglewood), North Rural (Dalby), Outer Remote (Miles), Toowoomba);
- 2 residential aged care sector (Southside- Redlands; West Moreton South Burnett- Toowoomba)

In all, attendances numbered 285. Attendees included representatives from QH acute sector staff, QH community staff, HACC, Population Health, public and private residential aged care staff, State and Local Government and community NGOs (representing 79 organisations).

c. Percentage of Queensland Health facilities provided with workforce skill enhancement training

The number of Queensland Health facilities (public hospitals and state government residential aged care facilities) where at least one member of staff participated in workforce skill training is shown in Figure 4.

Northern Area

The percentage of Queensland Health facilities (public hospitals and state government residential aged care facilities) across the four priority HSDs where at least one member of staff participated in workforce skill training was 62.2%. Health facilities in the Mackay Health Service District (Mackay, Sarina, Clermont, Moranbah, Dysart) were not provided education in the National Good Practice Guidelines (Green Box). Bowen and Collinsville were part of the Townsville HSD, prior to the restructure. Over the period of the pilot project the Mackay District had competing priorities related to the severe flooding in the area and district restructure. When reviewed in August, compatible dates to provide education sessions in the area were affected by the most recent Queensland Health reform on 15 August with the devolvement of Area Health Services and the subsequent resignation of the H/RCF project officer.

Additional facilities in the Cape York HSD (Cooktown Hospital and Wujal Wujal Community Hospital) participated in an education workshop which included the Best Practice Guidelines for Community and Hospital & Residential Aged Care Facilities.

Central Area

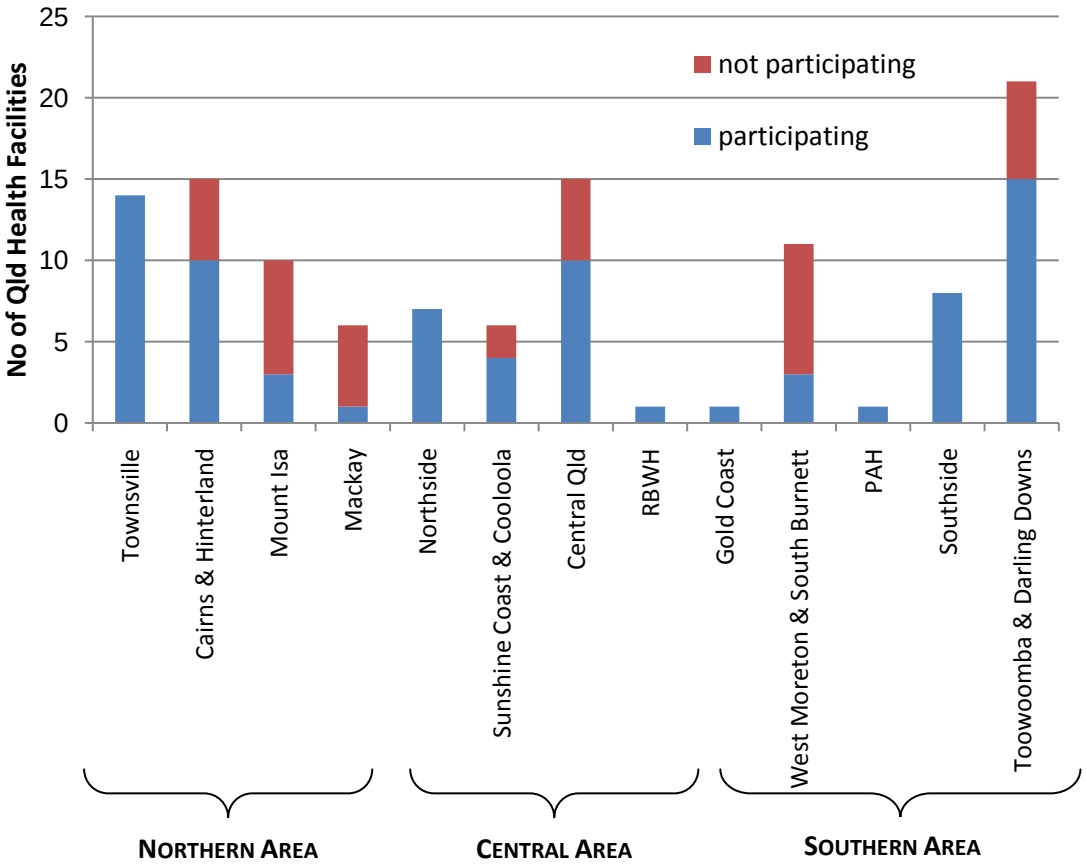
Planning days in Sunshine Coast, Redcliffe/Caboolture and Central Qld in the first half of year had the Green Box and Community Guidelines education component. In the second half of the project, Green Box training was delivered to staff at RBWH. All community health facilities within priority districts were invited to attend Community Stay On Your Feet® Best Practice Guideline workshops. The percentage of Queensland Health facilities across the four priority HSDs where at least one member of staff participated in workforce skill training was 75.9%.

Southern Area

The percentage of Queensland Health facilities (public hospitals and state government residential aged care facilities) across five districts (including the four priority districts as well as Toowoomba

and Darling Downs HSD) receiving training was 66.7%. The main reason for not offering training in other sites, particularly in West Moreton & South Burnett was lack of interest on the part of HSDs, time constraints, geographical distances and having no staff member in the FSO community role from 20th June 2008 until 17th November 2008.

Figure 4: Proportion of Queensland Health Facilities Participating in Training



IMPACT EVALUATION

The impact of the project was measured by the following KPIs:

a. Development of HSD specific falls prevention action plans;
b. Establishment and / or maintenance/enhancement of HSD falls prevention working groups (or equivalent).

a. Development of HSD specific falls prevention action plans

The aim of planning days was to develop an action plan based on the priorities from each of the sectors and identified gaps in working and communicating across the health continuum. The action plans were to identify who was responsible for falls prevention care and management, what evidence based interventions were appropriate for each setting and what professional resources were recommended and available. An action plan template was provided for this purpose.

The action plans were to articulate short, medium and long term goals for falls prevention in the next three years to help inform the service delivery model. FSOs were to support working groups in the finalisation of action plans. At the completion of the project action plans were in various stages of development as outlined below.

Northern Area

In Townville HSD:

- *Townsville:* Priorities and strategies were identified for community, H/RCF and across the continuum of care. The draft action plan reflected the following good practice strategies: education & awareness raising (flow chart); risk assessment & referral process (discharge planning); medication management & Home Medication Reviews; promotion of physical activities; reduction of public hazards; increased access to transport & mobility aids; implementation of Flinders Model of Care Coordination. The FSO reported that there needed to be stronger executive direction and support for the Cross Continuum Model to work.

- *Charters Towers:* Priorities and strategies were identified across the continuum of community and H/RCF. The draft cross continuum action plan reflected good practice strategies such as: education & awareness raising; communication (discharge planning & referral processes); Increase in opportunities for physical activity; reduction of public hazards; increase in stakeholder membership. Richmond and Hughenden linked into the Charters Towers Falls Prevention Working Group through the hospital.

- *Ingham:* Action plan development is in the early stages for the hospital and residential aged care facilities. Of high priority for Ingham hospital, identified in gap analysis at the Townsville HSD cross-continuum planning day, were strategies to address continence management as well as referral to professionals outside the hospital. The Active Ingham Committee agreed to incorporate good practice strategies within their current action plan based on the Community Guidelines.

- *Ayr:* A community action plan has been drafted which reflects good practice strategies such as: education and awareness of healthy ageing/falls prevention activities; peer education; Increase in physical activity.

- *Bowen*: H/RCF facilities identified gaps in service provision and developed a reporting structure and process. High risk areas in the Bowen and Collinsville acute and aged care sector included lack of flow chart to follow-up, need for staff education and medication reviews. These priorities were reflected in action planning at the Townsville HSD cross continuum planning day. Bowen community developed a healthy ageing action plan and included as priority strategies education and awareness of healthy ageing and falls prevention activities, reduction of public hazards, increased access to medication reviews, physical activity, and transport.

In Mount Isa HSD:

- Mount Isa (draft community and cross continuum) action plans reflected good practice strategies such as: education & awareness raising; communication (discharge planning & referral processes); medication profiles & Home Medication Reviews; yellow envelope; gentle exercises; reduction of public hazards. The FSO reported that although the plans were developed against good practice principles, the capacity of the participating organisations to implement them will be limited. The H/RCF sector intended to develop their own action plan specific to their needs. Further contact was required with the H/RCF sector to progress this action plan.

In Cairns & Hinterland HSD:

- The FSO reported that indirect engagement with the Hinterland Falls Prevention Working Group led to ongoing electronic support and advice in applying good practice in the development of their action plan and terms of reference.

Central Area

Whilst draft action plans were developed for each District that held a Falls Planning Day and provided to the newly formed falls working parties, the working parties have not been able to develop these further. To date there have been no Cross-continuum action plans finalised within the Central Area.

In the first six months of the project, Central Queensland, Sunshine Coast / Cooloola, and Northside (Redcliffe/Caboolture) each had draft action plans developed for acute, community and cross continuum. However these could not be acted on because membership of working groups was still being finalised and terms of reference were in draft stages. When the committees met, they found that the information within the draft action plans was limited and did not address the breadth of action required in falls prevention across the continuum.

In the second six months the focus of the newly appointed FSOs was to work with Districts to develop the working party foundations (structure/ membership / terms of reference) and then to collect and collate more comprehensive data to inform the action plans. This was achieved through the use of stocktake and scoping tools and through the delivery of workshops.

In Central Queensland HSD:

- Community workshops at Biloela, Rockhampton, Gladstone and Emerald identified a number of gaps in service delivery based on community best practice guidelines and detailed in the FSO community reports. These gaps included opportunities for physical activity programs; reduction of environmental hazards; medication management; education and awareness programs for older people and health professionals; access and availability of specialist services and support groups; transport issues. The data were collated to assist in the development of the Central Queensland cross-continuum falls working party action plan.

- The District Group (with poor community representation) is working on priorities identified at the FSO falls planning workshops including: finalisation of falls management policy across CQHSD; standardisation of falls risk assessment and interventions across CQHSD; enhancement of capacity for medication review to reduce risk of falls; achieving best practice in implementation of community falls prevention action and strategies; facilitating ongoing education of staff (including medical officers) regarding falls prevention; monitoring and evaluation of outcomes of falls prevention strategies including consistency in falls and near miss reporting.

In Northside HSD:

- *TPCH*: The TCPH workshop identified gaps in service delivery according to the community framework categories of individual risk (low, medium and high). In particular, the need for an up to date, staff accessible database of community information (for example on exercise, social activities, service providers and subsidy programs) was identified as well as the need to increase in-patient awareness of falls prevention strategies. Not all strategies could be addressed in the hospital setting and the TPCH is working on local priorities including wrist band identification standards. They are waiting for direction from the Cross-Continuum group prior to developing a formal action plan.

- *Redcliffe*: The Redcliffe Hospital Falls Working Group is working on priorities identified in the action plan developed from the planning day. These include improvement of staff education; standardisation of assessment; review and analysis of falls incident reporting; implementation of patient education; and improvement of medication reviews.

- *Caboolture*: The Caboolture Hospital Falls Working Group is a newly formed group. To date, they have concentrated on raising the profile of falls at Caboolture Hospital and are waiting on direction from the cross-continuum group prior to progressing any further.

- *Northside RCF*: The falls prevention group is working on an action plan which addresses a range of priorities including establishing membership, identifying resource requirements and review of risk assessment tools.

In Sunshine Coast/Cooloola HSD:

- The Sunshine Coast/Cooloola community falls workshop identified a number of gaps in service delivery based on community best practice guidelines. Among recommendations was the need for a central database for the Sunshine Coast to assist service liaison. The information was collated to develop a list of priorities for presentation to the district cross-continuum working group.

- The district cross-continuum working group is developing an action plan for 2009 addressing the new district (Sunshine Coast-Wide Bay) falls structure; mapping of assessment tools, intervention strategies and referral; education and data reporting.

In RBWH HSD:

- The RBWH "What's in the Green Box" workshop for the acute sector identified a number of gaps in service delivery which will be taken forward to the RBWH Falls Committee. These included the need for discharge education for medications, environmental design to minimise falls risk, and in-patient falls education including advice on appropriate footwear.

- The RBWH community sector workshop identified a number of service gaps based on community best practice guidelines, as detailed in the FSO summary report. Among the recommendations based on gap analysis were the development of a database of services to assist referral and discharge processes; the need for community education and physical activity programs targeting older adults; and sufficient funding/staffing to support home environment assessments, modifications and equipment. Results of the workshop will be reported to the Northside Cross-continuum falls working party so that the data may be utilised to advise the Metro North cross-continuum falls working party action plan.

Southern Area

A key element of the process that was followed in developing actions plans in the Southside HSD and Toowoomba and Darling Downs HSD was the use of District Executive Approved Falls Prevention Strategies and Committee Structures (see figures 5 and 6). FSOs conducted education and gap analysis in line with the Green Box National Guidelines for Hospital and RCF and SOYF Community Guidelines at separate falls prevention planning sessions. In areas where rural sites were included, an overview of the SOYF guidelines was provided as well as education and review of the National Guidelines to encourage a cross continuum approach. Rural areas did not have enough staff to have separate community groups.

The gap analysis strategies were summarised into a point plan and a report of the workshop was distributed to the Chairperson of the group to collate and develop the action plan. The development of local action plans was supported and monitored by the FSO (Hospital/RCF) by attending committee meetings or by telephone contact. Community groups were supported by the Community FSO and Population Health (in the absence of the Community FSO). The development of a District cross continuum action plan was facilitated by FSOs, in consultation with the District Executive Sponsors, by the presentation of the local action plans and identification of the common issues. Completed action plans and analysis against good practice as detailed by the FSOs are summarised below.

In Southside HSD:

- *Logan-Beaudesert:* The H/RCF falls collaborative is working on interventions that comply with the National guidelines and include standard strategies and interventions identified in gap analysis. The issues to be addressed include admission, assessment and discharge processes and staff education. The community stocktake identified gaps in service delivery for those at low, medium or high falls risk, including services and information for CALD groups. The need for a resources directory was identified. The action plan of the community falls prevention committee

builds on the gap analysis workshop and includes objectives to raise awareness among older people's groups and health professionals of falls risk factors and falls prevention activities and services.

- *QE11:* The action plan of the Hospital Falls Prevention Committee complies with the National guidelines. The strategic directions are to engage with staff, patients and carers, and support best practice in identification and management of high risk fallers. The action plan of the Brisbane South Community Health Service Falls Prevention and Management Committee complies with the SOYF Community guidelines and includes standard strategies and interventions identified through gap analysis. The main strategic directions are to raise awareness of falls risk factors; identify those at risk; enhance referral pathways (for medication reviews, vision assessments and OT home assessments); address barriers to physical activity; and to support falls prevention workforce.

- *Redlands:* The Redlands Health Service action plan reflects interventions which comply with National guidelines. It includes strategies to minimise preventable harm from falls such as awareness raising; medication review; staff education; data reporting; safe mobilisation; standardised risk assessment ;and environmental assessment. The Bayside Residential Aged Care Falls Prevention Group is working on implementation. Measurement, monitoring and review are already established through residential management processes. Patient education was identified as a gap in service delivery. The action plan of the Redlands Community-based Falls Prevention Collaborative complies with the SOYF Community guidelines and includes standard strategies and interventions identified through gap analysis. The main strategic directions are to raise awareness among older people's groups and health professionals of falls risk factors and falls prevention activities and services; enhance systems for identifying those at risk; identify referral pathways; and positively influence opportunities for active ageing.

- *Southside District*: The District Cross Continuum action plan is not yet finalised. The aims are to use consistent referral pathways and processes to support falls prevention across the continuum (community, acute facilities and residential facilities).

In Toowoomba and Darling Downs HSD:

- *Southern Rural (Inglewood Health Service):* The action plan interventions comply with the National Guidelines and include standard strategies and interventions identified through gap analysis such as staff education; improved assessment of environmental hazards; medication reviews; referral to physical activity programs; and documentation of falls prevention interventions. The working group has been encouraged to include the wider community to further cross continuum issues.

- *Toowoomba*: The action plan of the Toowoomba Hospital is in the early development and implementation phase of interventions which comply with the National Guidelines. Gap analysis priorities include development and review of local procedures such as risk screening and assessment; auditing; referral flow chart; patient risk identification; and staff training to increase the profile of falls prevention.

- *District Residential Aged Care:* The action plan reflects the theoretical background of the NARI research project being undertaken at Mount Lofty, utilising the Falls Champions model. The gap analysis issues identified in the workshop conducted by FSOs include the need for improvements in assessments of environmental hazards; medication reviews; footwear reviews; resident observation and surveillance measures; and resident and staff education.

- *Northern Rural (Dalby Health Service):* The action plan reflects some areas for improvement based on the National Guidelines. Gap analysis identified as priorities the need to develop and review local procedures including risk screening, assessment; audits; referral flow chart; discharge planning; and flagging and identification of at risk patients. Regular in-service education of staff was seen as a priority.

- *Northern Rural Remote (Miles Health Service):* Strategies in the action plan based on gap analysis included the need to develop and review local procedures such as risk screening; assessment; audits,; referral flow chart; flagging and patient identification; and staff training to increase falls prevention awareness.

- *Toowoomba and Darling Downs District:* The district cross continuum action plan is still in early draft stage. It reflects the gaps and issues discussed at the Inaugural Cross Continuum Steering Committee and gaps are in line with the SOYF Community and National Guidelines. Links are being established with the"Older Person's Information Network", Toowoomba.

In the Gold Coast HSD:

- The Gold Coast District had a cross continuum action plan at the commencement of the FSO project. FSOs supported and reviewed the existing action plan, measured against the National Guidelines. As well as FSOs endorsed input and links to the Healthy Ageing Collaborative being developed throughout the year by Gold Coast Population Health Unit so that action plans would be further enhanced to reflect community issues.

Figure 5: Southside District Falls Prevention Structure

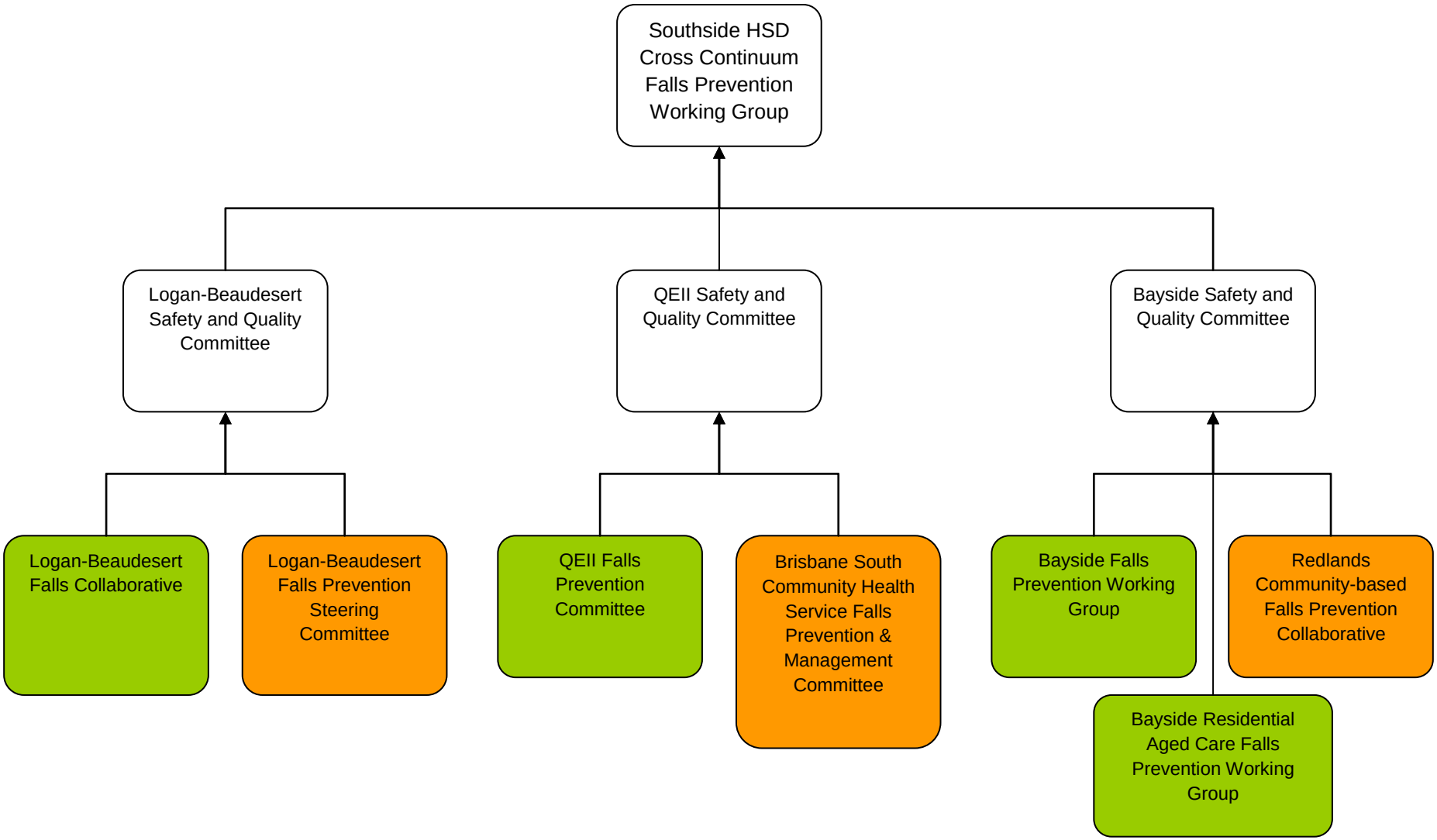
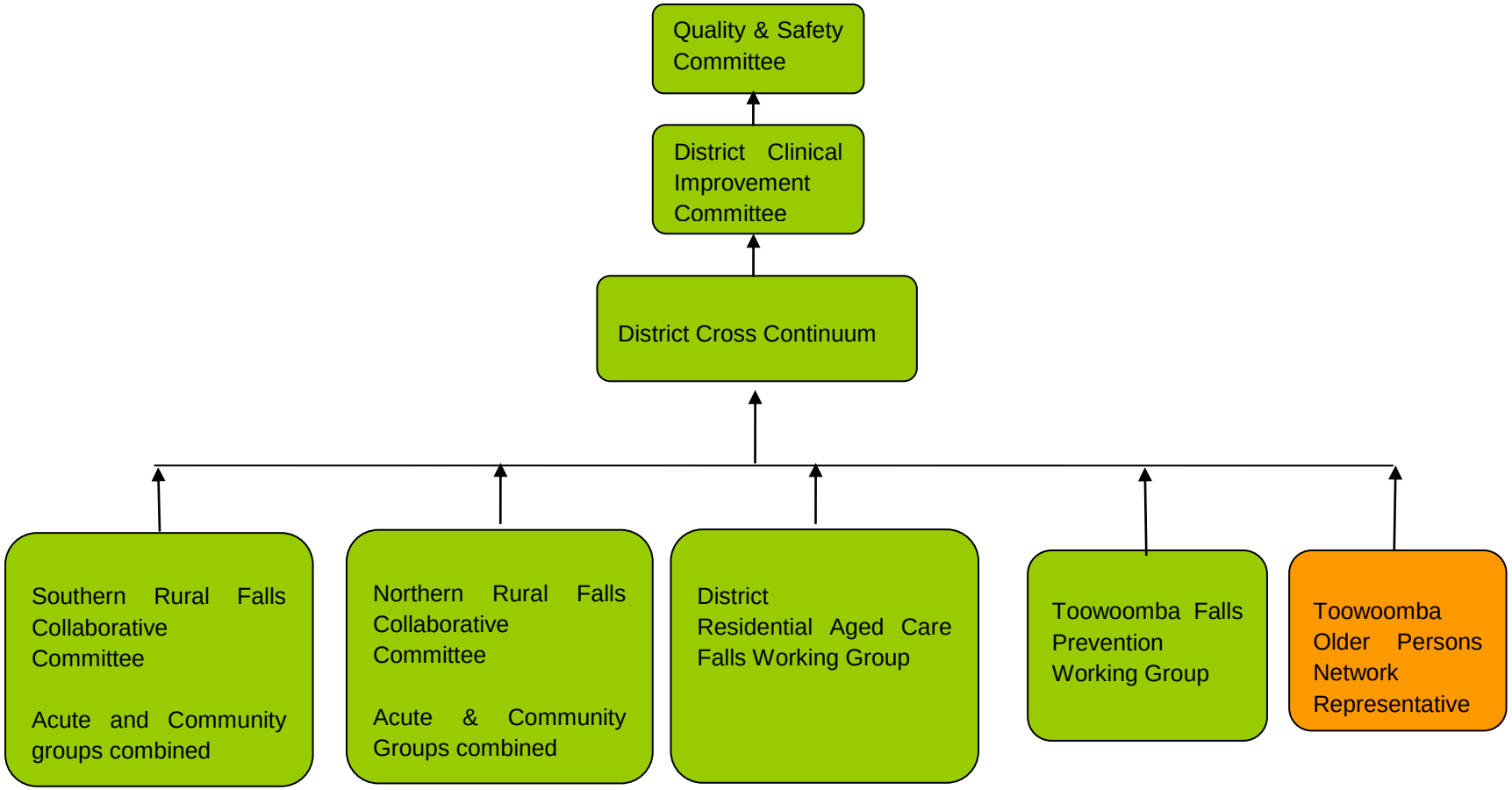


Figure 6: Toowoomba and Darling Downs Falls Prevention Structure



b. Establishment and / or maintenance/enhancement of HSD falls prevention working groups (or equivalent)

Northern Area

In Townsville HSD:

- As reported in the Mid Term Report, Townsville Stepping Out Committee has a well established community based group.
- There is no hospital working group, but Townsville Hospital has a falls specialist officer.
- Parklands RCF has started a working group.
- The hospital working group in Bowen needed further support to enhance function.
- Charters Towers had an existing cross continuum working group.

FSO (Community) strategy in the second half of the project mainly consisted of engaging with the current community committee (Stepping Out) to build its capacity to oversee the action plan and implement activities and to strengthen membership across the continuum.

In Mount Isa HSD:

- Mount Isa H/RCF falls prevention working group is inactive and further support is needed to regenerate the group.
- The Mount Isa Safe Communities Senior Safety working group is currently on hold due to the loss of the previous Regional Council champion post election.

In Cairns and Hinterland HSD:

- The Cairns Safe Communities Senior Safety working group was managing the action plan.
- The Cairns Hospital was not ready to develop a falls prevention working group, which could not be organised within the time frame of the project. To support future planning and education in Cairns, the FSO commenced mapping of services and gap analysis through the stock take process in partnership with Tropical Population Health Services.
- The Tablelands has a hospital falls prevention working group. The FSO enhanced links with Tropical Population Health Services and Cairns Base Hospital.

Central Area

Whilst Districts were generally supportive to create cross-continuum falls working parties there were several factors identified that delayed the development of working parties, most notably the governance structure and geographical scope of cross-continuum representation. Within the Central Area there are currently 14 working groups with falls prevention and/or a falls management focus. Four new working groups were established as a direct result of this project, three working groups were enhanced and six groups were maintained as follows.

In Northside HSD:

- A district falls steering committee was established with FSOs contributing to the draft model (refer figure 7). Negotiations are continuing on how the model will be implemented across the new Metro North HSD.
- The TPCH STEPS group was dissolved and enhanced with FSO assistance to include hospital membership only. The TPCH Falls Prevention Working Group works on local priorities in the acute sector. They are waiting for direction from the Cross-Continuum group prior to developing a formal action plan.
- The Redcliffe Hospital Falls Prevention Committee Group established with FSO involvement continues to meet and work on local priorities identified in the action plan developed at the falls planning day.
- The Redcliffe Healthy Ageing Partnership was maintained.
- Caboolture/Kilcoy Hospital Falls Prevention Committee established with FSO involvement held a Falls Prevention Week in late November 2008 to celebrate the launch of the Caboolture Hospital Falls Prevention Committee and raise the profile of falls prevention at Caboolture Hospital. They are waiting for direction from the Cross-Continuum group prior to developing a formal action plan.
- RCF Falls Prevention Committee has been enhanced with membership extended to include staff from RCFs and the Brain Injury Unit in the District.

In RBWH HSD:

- The RBWH Falls Working Party has been maintained.

In Sunshine Coast/ Cooloola HSD:

- The District Falls Steering Committee has been enhanced. Initially this was Nambour Hospital Falls Committee. Following the planning day this group expanded to include membership from across the district.
- The Cooloola/Gympie Healthy Aging Partnership is under development.
- The Sunshine Coast Healthy Aging Partnership has been maintained.

In Central Queensland HSD:

- The Falls Management Committee was established. The Working Group continues to work on priorities identified in the planning day action plan. Priorities identified at four community workshops are to be reported for consideration in the action plan.
- Gladstone Hub Falls Working Group was maintained.
- Banana Hub Falls Working Group was maintained.
- Rockhampton Healthy Aging Partnership was maintained.

The community healthy ageing partnerships are led by health promotion staff in Population Health, with a focus on healthy ageing, chronic disease prevention, including the prevention of falls.

Southern Area

In Southside HSD:

- A District Cross Continuum Falls Prevention Working Group was established to develop district-wide falls prevention strategies in Southside HSD according to the endorsed structure (Figure 5).

Existing falls prevention working groups were re-invigorated through the development of local action plans. These included:

- Logan-Beaudesert Falls Collaborative (hospital);
- Logan-Beaudesert Falls Prevention Steering Committee (community);
- QEII Falls Prevention Committee (hospital);
- Brisbane South Community Health Service Falls Prevention and Management Committee (community);
- Bayside Falls Prevention Working Group (hospital);
- Redlands Community-based Falls Prevention Collaborative (community);

In Gold Coast HSD:

- A District Gold Coast Falls Collaborative had been established; however the FSO supported this group throughout the project.
- The Healthy Ageing Group was established and enhanced by the Population Health Unit and developments would be fed through the District Gold Coast Falls Collaborative.

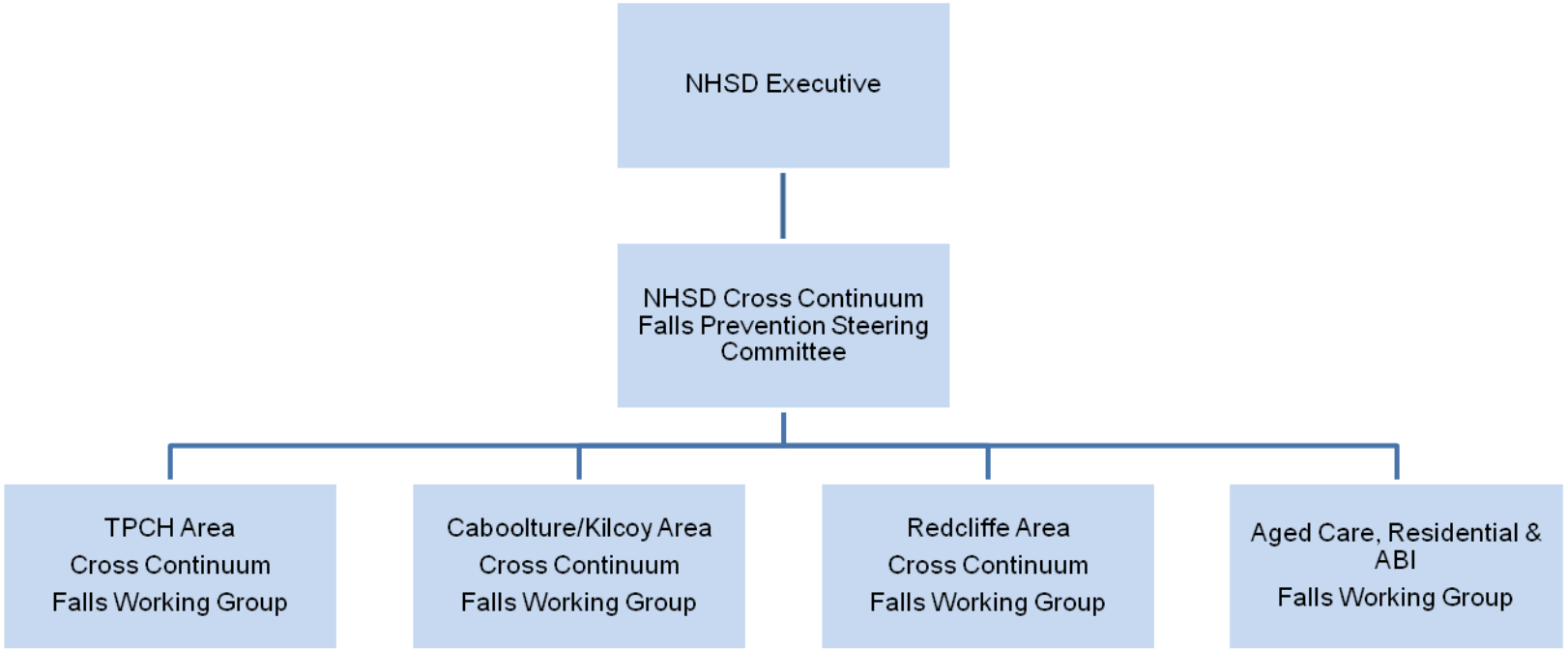
In the Toowoomba and Darling Downs HSD

- A District Cross Continuum Falls Prevention Working Group has been established to develop district-wide falls prevention strategies according to the endorsed structure (Figure 6).

The following working groups have enhanced membership:

- Toowoomba Health Service Falls Prevention Working Group (Acute) is enhancing membership to include NUM's from the majority of departments.
- Southern Rural Working group has features of cross continuum as they have community representatives. Membership is being enhanced to reflect the wider community.
- Northern Rural Falls Working Group has features of cross continuum as they have community representatives. Membership is being enhancing to reflect the wider community.
- Northern Rural (outer remote) Falls Working Group has representatives from the acute sector.
- Aged Care District Falls Working Group includes members from the Toowoomba and Darling Downs and South Burnett Aged Care Facilities. Mental Health representatives (Baillie Henderson and Toowoomba Health Service) have chosen to join this District Committee.
- The Older Person's Information Network has representatives from Community Health and Transition Care.

Figure 7: Northside HSD Falls Prevention Draft Structure



The process and impact indicators are summarised in Table 2.

Table 2: Summary of Process and Impact Evaluation Results

Indicators	Evaluation Results
Process: d) Number and range of stakeholders engaged	Stakeholder contacts: • Northern Area contacted over 520 stakeholders across 5 HSDs. • Central Area contacted over 210 stakeholders in 4 priority HSDs. • Southern Area contacted over 240 stakeholders in 4 priority HSDs. Stakeholders across all HSDs covered a range of Queensland Health staff from hospitals, residential aged care facilities, community health, HACC and Population Health, as well as community NGOs and local government. Stakeholders completed a total of 182 scoping/stocktake surveys. • Northern –28 from community and 16 from hospital/RCF ; • Central -43 from community and 26 from hospital/RCF ; • Southern – 45 from community and 24 from hospital/RCF .
e) Number of district planning days held	Northern Area: 9 planning workshops across 5 HSDs attended by 352 participants* included: • 4 community; • 1 H/RCF ; • 4 cross continuum. Separate education sessions included 2 community and 12 H/RCF. Central Area: 12 planning/education sessions attended by 283 participants* included: • 3 cross continuum; • 8 community workshops; • 1 hospital. Southern Area: 18 planning/ education sessions attended by 285 participants* included: • 3 cross continuum; • 6 community; • 7 hospital; • 2 residential aged care *Participants may have attended more than one planning day session.

Indicators	Evaluation Results
f) Percentage of Queensland Health facilities (hospitals and RCFs) provided with workforce skill enhancement/training.	Northern Area: 62.2% Central Area: 75.9% Southern Area: 66.7%
Impact: b) Development of HSD specific falls prevention action plans	At the completion of the project, action plans were in various stages of development. Those underway included: • Northern Area: Townsville (cross continuum); Charters Towers (cross continuum); Ingham (H/RCF, community); Ayr (community), Bowen (H/RCF, community), Mount Isa (community, H/RCF), Cairns (community), Tablelands (hospital). • Central Area: TPCH (hospital), Redcliffe (hospital), Caboolture (hospital), Northside (RCF), RBWH (hospital, community), Sunshine Coast /Cooloola (cross continuum), and Central Queensland (cross continuum). • Southern Area: Gold Coast (cross continuum), Logan Beaudesert (H/RCF, community), QEII (hospital, community), Redlands (hospital, RCF, community), Southside (cross continuum), Southern Rural (cross continuum), Toowoomba (hospital), District (RCF), Northern Rural (cross continuum), Toowoomba and Darling Downs (cross continuum).
c) Establishment and / or maintenance/enhance ment of HSD falls prevention working groups (or equivalent)	Northern • Cairns community has a Senior Safety Group and Tablelands have a hospital working group. • Mount Isa had an existing Senior Safety Group and a hospital working group that needed support to reconvene. • Townsville has a *Stepping Out* community based group, no hospital group (but a falls specialist officer) and Parklands RCF started a working group. • Bowen had a hospital working group which needed further support to enhance function. • Charters Towers had an existing cross continuum working group with limited representation from the wider community. Richmond and Hughenden link into the Charters Towers Falls Prevention Working Group through the hospital. Central • Sunshine Coast/Cooloola cross continuum working group has been enhanced. Gympie and Sunshine Coast have developed Healthy Ageing Partnerships. • Central Queensland cross continuum falls working group was established. Gladstone Hospital and Banana Hub working groups were maintained. Rockhampton Healthy Ageing Partnership was maintained.

Indicators	Evaluation Results
	• Northside district steering committee was formed. Redcliffe has a hospital working group and a community Healthy Ageing Partnership. Caboolture/Kilcoy developed a hospital working group. TPCH*'STEPS'* was dissolved and reformed under a new acute falls working group. RCF working group has been enhanced. • RBWH had an existing hospital based working group which has been maintained. Southern • Southside District cross continuum working group was established. Existing working groups at Logan (hospital/RCF and community), QEII (hospital/RCF and community), and Redlands/Bayside (hospital/RCF and community) were re-invigorated. • PAH had an existing falls prevention working group. • Ipswich West Moreton had existing hospital working group and a community working group. • Gold Coast District Falls Injury Prevention Committee with cross continuum membership had been established, as well as a Healthy Ageing Group. • In Toowoomba and Darling Downs HSD, a district cross continuum working group was established. Working groups from Toowoomba (hospital and community), Southern Rural (cross continuum), Northern Rural (cross continuum), and district (RCF) were enhanced.

OUTCOME EVALUATION

As a result of the FSO project the expected outcomes include:

a. the development of a consistent, coordinated, evidence based approach to falls prevention for older persons across the health continuum at Health Service District (HSD) levels;

b. a reduction in falls and fall-related injuries in older Queenslanders.

a. the development of a consistent, coordinated, evidence based approach to falls prevention for older persons across the health continuum at Health Service District (HSD) levels

The measure to determine whether capacity to implement falls prevention activities for older people across the health continuum had developed or changed over the life of the FSO project was the Community Capacity Index (Bush, 2002). As described in the Mid Term Report, interviews were conducted with key stakeholders from a range of community and health care organisations across the priority HSDs (except Mackay) at the commencement of the project. Follow-up interviews were conducted approximately 6 months following the baseline interview, from September to November

2008. In the majority of cases (95%), the same respondent participated in both the baseline and follow-up interview.

In the Southern Area the FSO project had been extended in the second half of 2008 to include the (former) Toowoomba and Darling Downs HSD. An additional three baseline interviews were conducted in late September with representatives from organisations in this district. Follow-up interviews were conducted with these stakeholders in early December.

The Community Capacity Index (CCI) assesses four key domains:

- Network partnerships – the relationships between groups and organisations within a community or network,
- Knowledge transfer – the use and transfer of knowledge between the groups and organisations within a community or network,
- Problem solving ability – the ability to use well-recognised methods to identify and solve problems that arise in the development and implementation of a program or activity, and
- Infrastructure – the level of investment in a network by the groups and organisations that make up the network.

The follow-up interviews primarily focused on changes in the capacity for network partnerships as it was considered that, if change occurred within the project's limited timeframe, it would be most apparent at this level. In addition to assessing whether changes in the level of community capacity had occurred, secondary aims of the interview were to ascertain:

a. to what extent such change could be attributed to the involvement of the FSOs;
b. how effective the FSOs were in furthering the uptake of falls prevention activities for older people within their local area;
c. what barriers and enablers were encountered in implementing a cross-continuum health service delivery model for preventing falls among older people; and
d. recommendations for implementing a cross-continuum health service delivery model.

The following figures (8-10) show capacity for network partnerships at baseline and follow-up. It is important to note that the purpose of the graphs is to demonstrate change within a community pre and post implementation, rather than to compare communities against each other.

Northern Area

Figure 8: Northern Area- Capacity for Network Partnerships

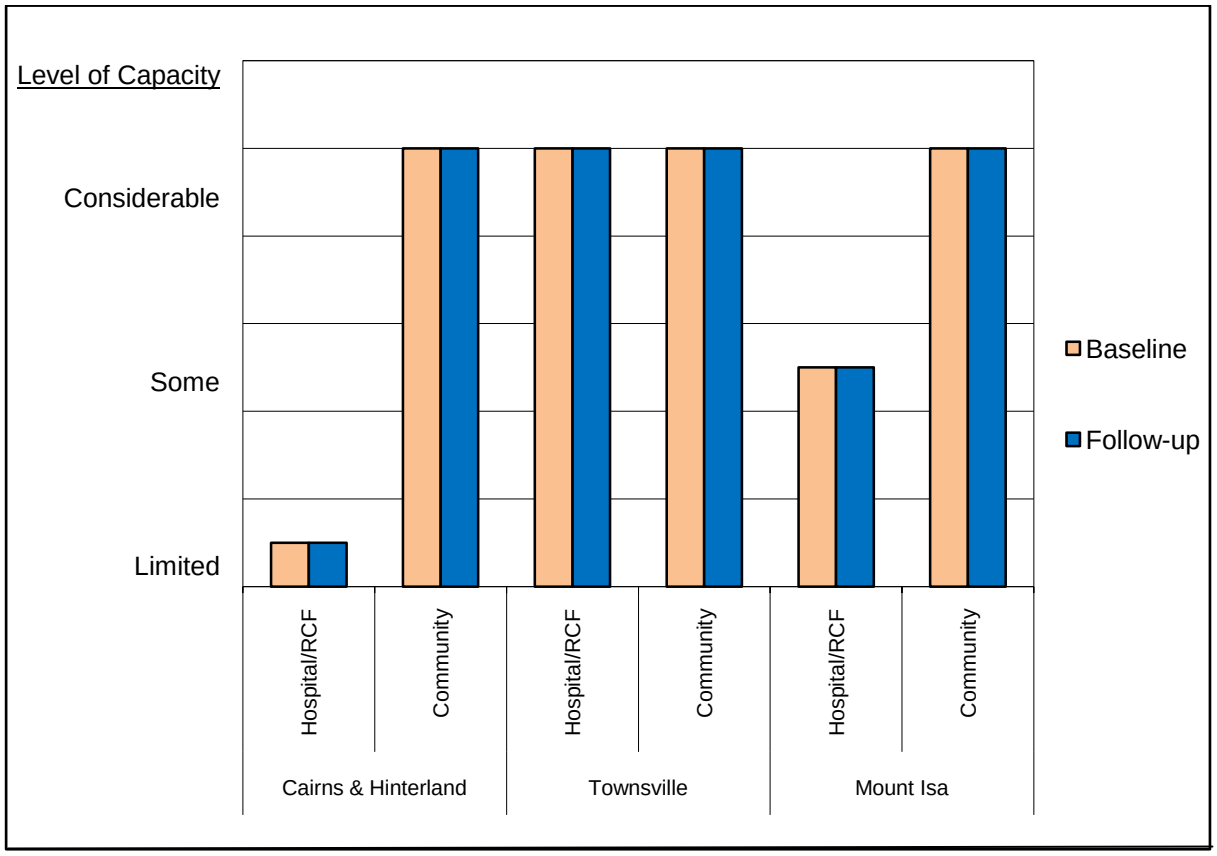


Figure 8 shows that essentially there was no change in any of the HSDs in the Northern Area. The lack of change was possibly due to a high level of capacity in terms of network partnerships at baseline.

Although Mackay HSD was a priority area for the FSO project, implementation of the project in this area was delayed for the first 6 months of 2008 because Mackay was recovering from severe flooding. In the second half of 2008, the FSOs didn't have capacity to implement the project in Mackay. Consequently no key stakeholder interviews were conducted in Mackay HSD.

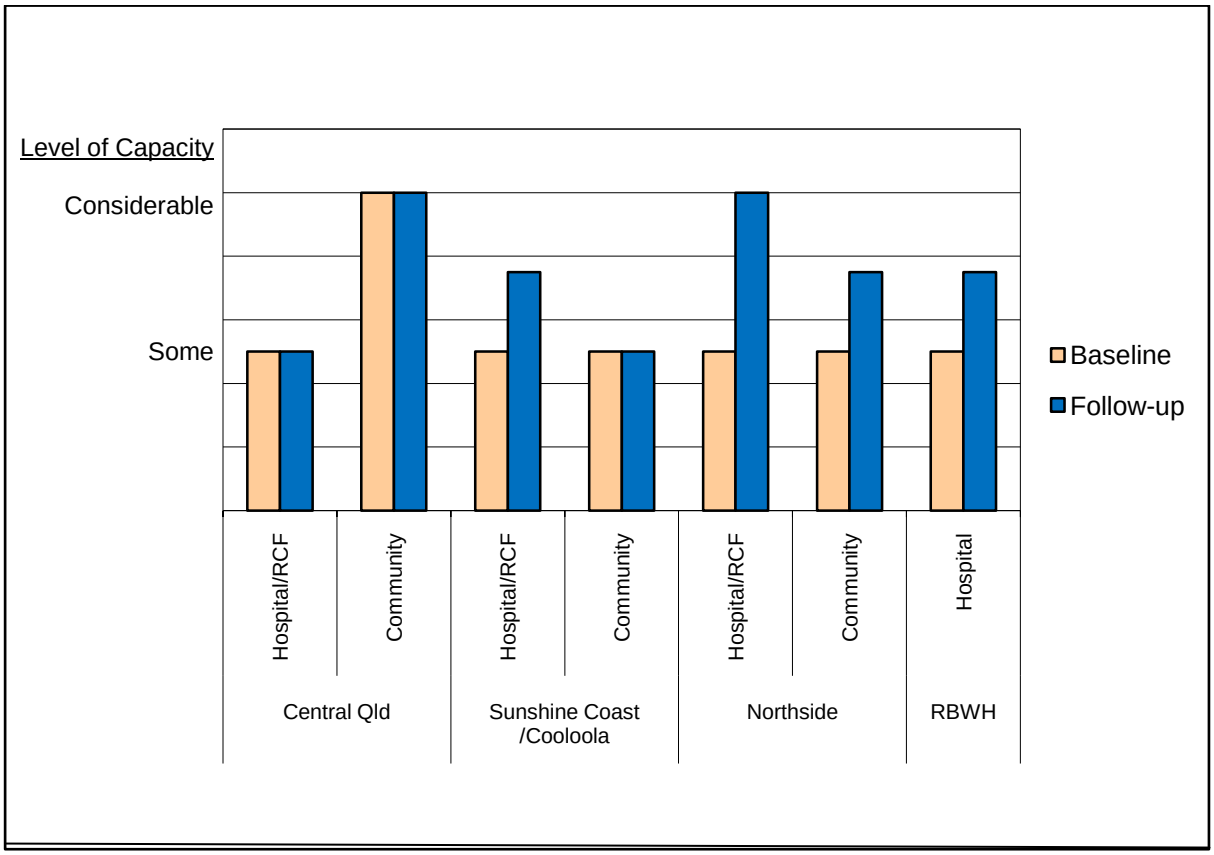
Central Area

Figure 9 shows that increased capacity was evident in the Central Area where the focus in the second half of the year was on consolidation. Areas that demonstrated increased capacity included the Sunshine Coast/Cooloola and RBWH hospital sector and both the hospital/RCF and community sectors within the Northside HSD. Feedback from stakeholders at baseline had been negative with feeling that structures had been imposed on them that did not meet their needs. The FSOs' focus in the second half of the project was to understand what stakeholders knew about the project, who

was engaged, what was working and what was not and to understand existing structures and processes.

Some follow-up key stakeholder interviews took place before the community workshops were delivered in the latter part of 2008 so that there may have been further positive changes that were not recorded in the CCI interviews.

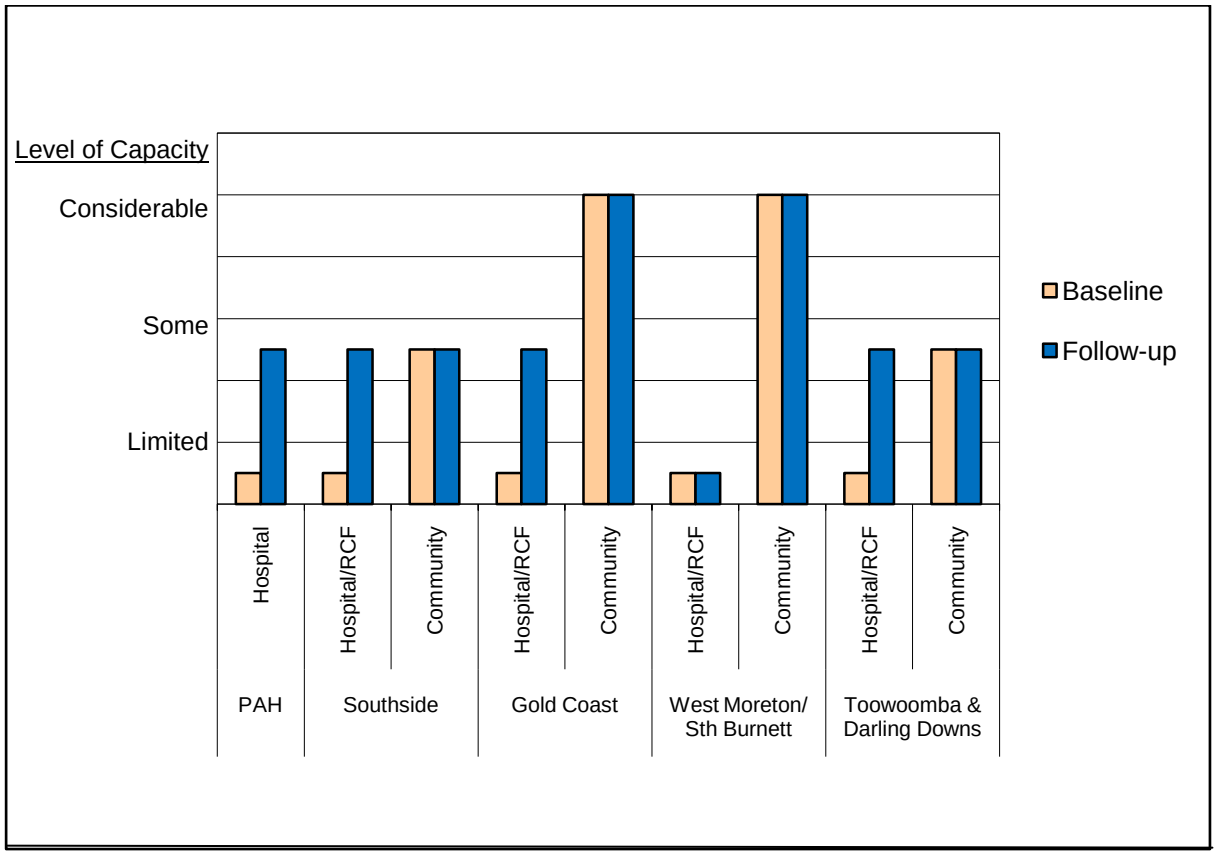
Figure 9: Central Area-Capacity for Network Partnerships



Southern Area

Figure 10 shows the capacity for network partnerships at baseline and follow-up within the Southern Area. Sectors that demonstrated increased capacity included the hospital/RCF sectors within the PAH, Southside, Gold Coast and Toowoomba/Darling Downs areas. The FSO community position was vacant for most of the second half of the project, so that changes in capacity in the community sector were not expected. The FSO for the H/RCF sector was able to extend the project into Toowoomba and Darling Downs HSD in the second half of the year. An increased capacity for network partnerships in the hospital/RCF sector was demonstrated in a short timeframe.

Figure 10: Southern Area-Capacity for Network Partnerships



b. Falls and fall-related injuries in older Queenslanders

Data on falls and fall related injuries in older Queenslanders was provided by Queensland Health.

Figure 11 shows rates of Queensland hospital admissions for falls per 100,000 of the population. The numerator was the number of admitted patient episodes of care where there was an external cause of falls (ICD10 W00-W19) for patients aged 65 and over in public and private acute hospitals, Queensland for the calendar years 2006, 2007 and 2008. The data source was the Queensland Hospital Admitted Patient Data Collection, Queensland Health extracted on 6 May, 2009. The denominator was the population of Queensland aged 65 and over estimated at 30 June for the years 2006, 2007 and 2008, extracted from the Australian Bureau of Statistics (ABS) Catalogue No. 3201.0 http://www.abs.gov.au/AUSSTATS/abs@.nsf/DetailsPage/3201.0Jun%202008?OpenDocument

Figure 12 shows the rates per 100,000 population for admitted patient episodes of care where there was a diagnosis of fractured neck of femur (ICD10 S72.0) for patients aged 65 and over in public and private acute hospitals, Queensland for the calendar years 2006, 2007 and 2008. The data source for the numerator was the Queensland Hospital Admitted Patient Data Collection, Queensland Health extracted on 6 May, 2009. The population denominator was based on ABS data as above.

Figure 11: Hospital Admissions for Falls

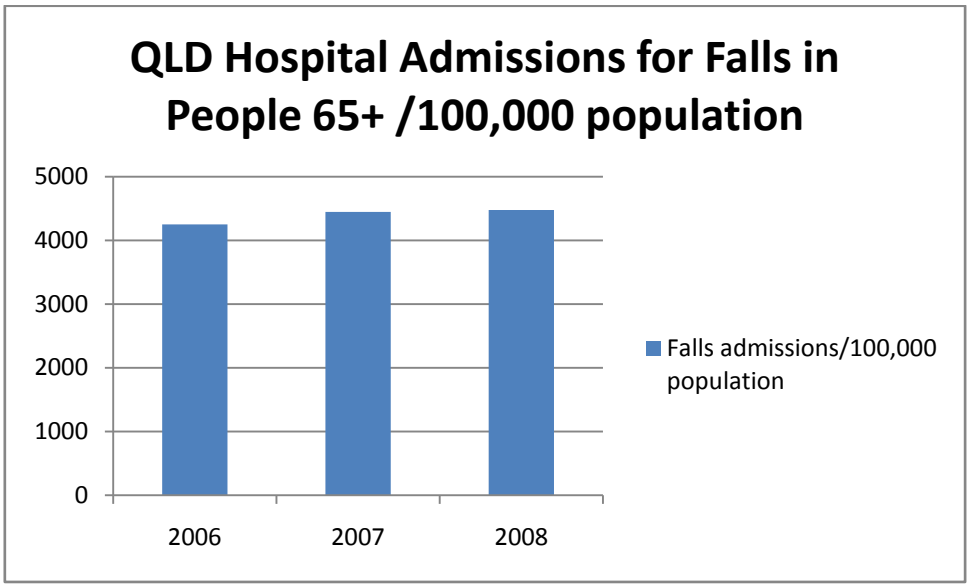


Figure 12: Hospital Admissions for Fractured Neck of Femur (#NOF)

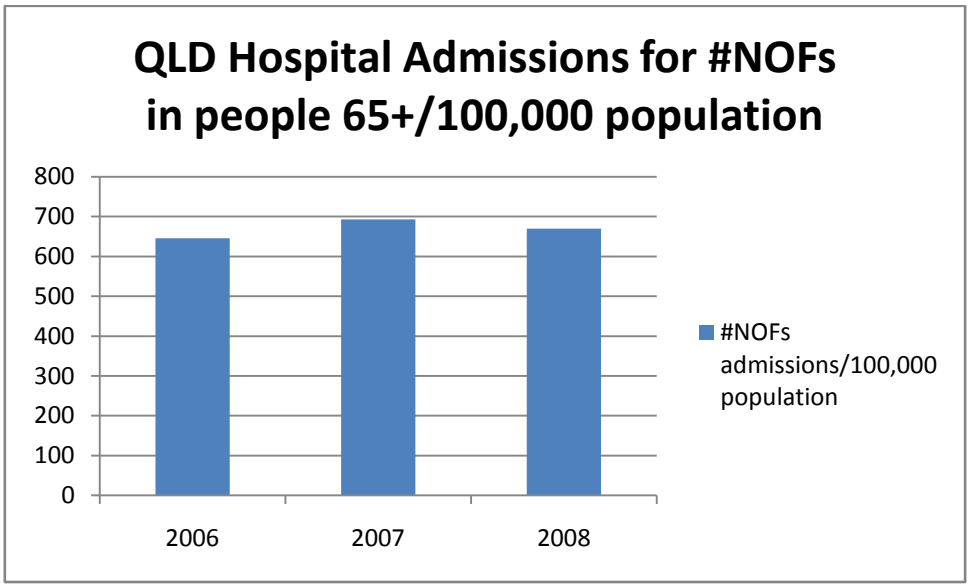
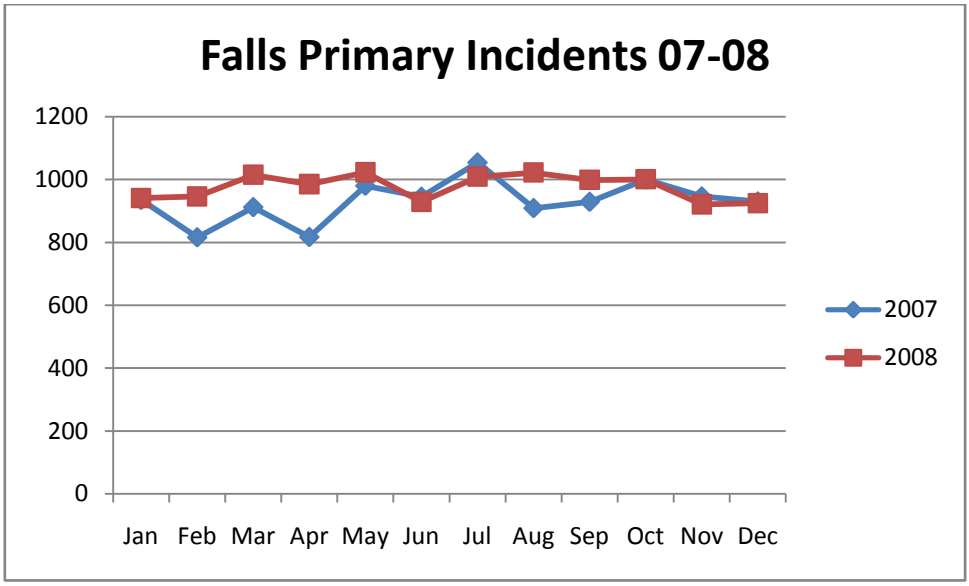


Figure 13 shows the number of reported clinical incidents in Queensland health facilities by month for the years 2007 and 2008. The data source was the PRIME database, Patient Safety Centre.

Figure 13: Reported Clinical Incidents Queensland Statewide for Falls 2007-08



From the data presented in the graphs, it is not possible to determine trends in falls over the duration of the project. As this was a pilot project of a workforce enhancement strategy and not an intervention directly targeting older people, it was not expected that there would be a reduction in falls or fall related injuries as a result, nor could any reduction, if it occurred, be attributed to the project.

SECTION 4

PROJECT IMPLICATIONS

KEY LEARNINGS

ACHIEVEMENTS

In spite of the project's limitations and the barriers to its implementation (outlined below), the FSO Pilot Project has been successful in achieving considerable progress towards a number of its key objectives and KPIs. In the first instance, the project has effectively raised the profile of falls and falls prevention activities for older people as important issues - largely achieved through the FSOs making contact and engaging with large numbers of key stakeholders across the community, acute and residential sectors. The project has also reminded people of the importance of a cross-continuum approach in reducing falls and their impact on older people, and the importance of ensuring that effective strategies are implemented for identifying people at risk at the interfaces between the community, hospital and residential care facilities and intervening at those junctures.

The project was also successful in disseminating a large amount of information and resources regarding falls for older people and achieved considerable progress towards two KPIs, namely, conducting district planning days in each HSD and providing staff within Queensland health facilities with the opportunity to receive training in falls prevention. The SOYF Good Practice Guidelines, the National H/RCF guidelines and long and short checklists were widely distributed and well received through the planning days, workshops and staff education sessions that were conducted across the acute, community and residential care sectors in Queensland. These activities also provided stakeholders with valuable information and training regarding best practice in falls prevention for older people and activities, including local initiatives, currently being undertaken in this regard.

One of the anticipated benefits of the project at the outset was the formation and enhancement of local and strategic partnerships between key stakeholders. Feedback from the FSOs and other key stakeholders indicates that this benefit has been realised to a large degree and it was reported that the project provided an excellent opportunity for networking through the planning days and enabled partnerships and linkages to be developed across sectors. Communication across the sectors also improved as a result of the planning days and provided attendees with an opportunity to share information regarding falls prevention activities within their sectors as well as learn about initiatives in other sectors.

Another of the project's KPIs was the establishment and/or maintenance/ enhancement of HSD falls prevention working groups (or equivalent). Considerable progress towards this KPI was achieved and working groups were established in some areas where previously there had been none, and re-energised in other areas, partly evident through an increase in the number and scope of participants. The FSOs promoted the establishment/enhancement of working groups through directly contacting key stakeholders who, in turn assisted with the establishment/enhancement of the working groups; through working collaboratively with executive sponsors to establish governance structures, through the planning days/workshops that were held, as well as through attendance at meetings of the working groups. The establishment of the working groups and the requirement for groups to formalise goals, objectives, roles and responsibilities through the development of action plans also provided people working in the area of falls prevention for older people with some direction. Finally, substantial progress was also made towards the KPI of developing HSD specific falls prevention action plans to guide future action, with evidence based action plans being drafted in many areas.

Although not a stated objective of the project at its commencement, data from both the project and its evaluation has provided a wealth of information, specific to Queensland, regarding the implementation of large scale falls prevention activities. The lessons learned from this project can usefully inform future health promotion activities.

In summary, key achievements of the FSO project were:

- the profile of falls and falls prevention activities for older people was raised;
- the importance of a cross-continuum approach to falls prevention was emphasised;
- information and education regarding falls and falls prevention strategies for older people was widely disseminated and provided across the community, hospital and residential care sectors in Queensland;
- networking opportunities were provided via the planning days. This facilitated the establishment of new partnerships and strengthened communication and linkages across sectors;
- working groups were established/re-energised to continue work in falls prevention for older people across Queensland;
- working group reporting structures were established/realigned in collaboration with executive sponsors
- HSD specific action plans were developed to guide future falls prevention activities for older people; and
- valuable information was provided regarding the successful implementation of large scale health promotion activities.

LESSONS LEARNT FROM PROJECT IMPLEMENTATION

Data regarding barriers and facilitators in relation to key elements of the project was obtained from the process logs and status reports maintained by FSOs, minutes of meetings (Advisory Group and weekly teleconferences between project management and FSOs), final project reports from FSOs and

Acting Principal Project Officer, as well as information provided by key stakeholders during interviews and planning day evaluations. The data was synthesised and analysed to identify key themes in relation to the role of FSOs, organisational readiness, stakeholder engagement, planning days/workshops, and working groups, as well as general facilitators and barriers which influenced the longer term sustainability of the project.

Role of FSOs

Lessons from the NSW Area Falls Coordinator Program, which commenced in 2006, indicated that the model of one falls coordinator per health service area to work across the continuum was too large a body of work for one individual. Hence the Queensland AFSO model of having two staff in each AHS (one for community and one for H/RCF) was adopted, reflecting the Joint Work Plan between the Health Promotion Branch and Patient Safety Centre.

On the whole, this approach of having two FSOs (one for community and one for the acute and residential aged care sector) was effective when they worked as a team and had complementary skills. Feedback from stakeholders indicated that FSOs played a valuable role coordinating falls prevention activities, providing ongoing training, resources and support as well as providing on-going direction for the working groups. Even though the focus of the project implementation was on four priority HSDs in each AHS, FSOs did not achieve their KPIs, suggesting that the project scope was too large for two FSOs per AHS. There was general consensus that permanent roles for FSOs should be district wide and multidisciplinary to undertake data analysis, education, advice in relation to care planning and consultancy and that there should be one person that is facility based and one that is community based to focus on prevention.

Regarding the necessary skills of the FSO role, FSOs reported that professional experience and local knowledge were important facilitators in project implementation. The establishment of prior working relationships with stakeholders in the area facilitated their engagement in this project. The Acting Principal Project Officer stressed the need for FSOs to have strong project management, presentation, information technology, communication and marketing skills. Workshops for skills enhancement and development were conducted during the course of the project. However, the marketing and communication of the project remained an issue, with some confusion amongst stakeholders about what the project was meant to achieve. Recruiting people with the right skill mix for the FSO role is an important project facilitator.

Organisational Readiness

The FSO exception reports highlighted the lack of local readiness and capacity, especially in the acute sector, to undertake falls prevention. A low level of capacity was also evident from key stakeholder interviews in the initial phases of project implementation. This was unexpected because of prior work by the Principal Project Officer, who had been to each district and completed a gap analysis, supported working groups and started actions plans in 2006/2007. The FSOs found that the groups had disbanded, action plans were not developed, and falls prevention was still considered as an additional activity and not as core business for the hospital staff. The lack of a uniform and advanced

state of readiness within partners and potential stakeholders may have been due to changes in key contacts or district priorities. Alternately the prior falls prevention activity may not have been sufficient and the health provider characteristics, organisational context and the attitudes held may not have been conducive to effectively translate evidenced based policy into practice. These factors may not have been given sufficient consideration and assessment before commencing this project.

In addition, the readiness of each community to embark on action plans or a cross-continuum model was not fully considered and rather than working with local communities at their level of readiness, some communities felt pushed into undertaking various activities, hence jeopardising the project's sustainability. Requesting sectors to work across the health continuum requires major collaboration and an organisational change process. The project initially encountered strong resistance, when sectors could not see the benefit of working outside their own area and felt the need to get their own house in order first.

Project team members attended a Building Change Resilience workshop post Mid Term Review which was designed to assist them in facilitating organisation change. In the second half of the year it was evident from FSO reports and stakeholder interviews that the attitude from key stakeholders was more positive towards the project. Positive feedback also followed the very well attended falls forum in August 2008, where the Stay On Your Feet® website, toolkit and resources were launched. Promotion of these resources at the beginning of the project may have aided marketing and engagement of stakeholders. There is, therefore, a need to determine the readiness of the organisation and practitioners to adopt change before program implementation can be successful. Including falls prevention as a performance requirement within role descriptions for Chief Executives of Districts, Executive Directors of Nursing, Allied Health, Aged Care and Community Health would also ensure that there is a flow down effect for promoting falls prevention as "everybody's business".

Stakeholder Engagement

Establishment of effective working relationships takes time. FSOs reported that, because of the short timeframe of the project, there was limited available time in which to identify all stakeholders, meet with them and make the necessary investment required to establish partnerships. Service directories and/or a comprehensive, up to date electronic database of stakeholders aided the ability of FSOs to readily contact and engage key stakeholders. The geographical size of some districts made it time consuming and expensive for FSOs to travel to meet face-to-face with stakeholders - an important facilitator to establishing a high level of engagement. Hence, the number of such meetings was limited, particularly in more remote areas. In order to enable engagement at a local level, some key stakeholders recommended that FSOs be appointed for each HSD, since it was considered to be a barrier to stakeholder engagement and project implementation if the FSO was not physically located in the area for which they were responsible.

Initially there was some inflexibility in implementing the project creating a degree of resistance among some stakeholders to working collaboratively with the FSOs. For example, some stakeholders reported that certain concepts that they considered were not relevant in their HSDs (for example, the 'hub and spoke' model) were imposed on them. As the project progressed, however, a more

flexible approach became apparent with the result that stakeholders were more willing to work in partnership with the FSOs. A key lesson for project implementation was that falls prevention initiatives should be driven by local need and that different models for program delivery and establishment of working groups may be necessary.

Stakeholders were more readily engaged by explaining the purpose and benefits of the falls prevention cross continuum model using the definition and resources developed. Lack of engagement of medical staff, including GPs was noted as a barrier in implementation. It was recommended that to engage clinicians, heath professionals, Non-Government Organisations and older people themselves, a statement of benefits needs to be formulated and clearly articulated, that includes system and personal benefits (for example, improved services, efficiency of service delivery, risk management and reduction).

Planning Days

The model for planning days/workshops as proposed in the FSO training module was not implemented as planned. Following evaluation feedback on planning days reported in the Mid Term Review, the format of planning days was adapted to meet local needs and staff availability. Difficulty in organising simultaneous acute and community sector planning days and the need to have more time to present the guidelines and for gap analysis meant that separate sessions were conducted for community and acute sectors in the latter half of the project. While this approach worked well, it did create a dilemma of how to balance the approach of education and yet retain a cross continuum focus in the HSDs,

The planning days were time consuming to organise and involved issuing invitations, finalising numbers, organising venues and catering as well as distributing, collecting and collating information from gap analysis and evaluation forms on the day. Administrative support to assist with some of these tasks was essential, as was the involvement of team work between FSOs and with their health promotion colleagues in Population Health and Patient Safety Officers and Falls Specialist Officers in the acute sector.

In general, the evaluation by attendees at planning days was positive and the opportunity for networking and learning about cross continuum activities was appreciated by participants. Participants reported that planning days had been very informative and that the program content was excellent. Planning days raised awareness of resources and aided access to information. The use of local data, as well as the application of worksheets to an individual's own area, was effective in facilitating learning. A sound knowledge in the area of falls prevention by the facilitator added to their credibility, while the ability to communicate and engage effectively with an audience as well as encourage participation and interaction within the group were factors that contributed to a successful planning day.

Working Groups

Working groups have been a feature of strategies to audit, disseminate and implement evidence based practice in falls prevention. In this project, working groups were facilitated when 'falls champions' were identified and district governance structures were established with the support of executive sponsors. The success and sustainability of working groups depended on establishing Terms of Reference and defining roles and responsibilities. The perceived dominance and control of working groups by nursing staff was an issue in some acute and residential care sectors and may have been because there are generally more nurses on staff in these settings than there are allied health personnel. In addition, nurses are generally more involved in direct patient care than are allied health staff and hence falls may have been perceived primarily as a nursing issue. Overcoming 'turf wars' by ensuring representation and participation by all personnel who work with older people is important, if falls prevention is to be promoted as a multi-disciplinary issue.

Cross continuum working groups needed to ensure that all sectors were represented, including organisations external to Queensland Health. There was some reluctance on the part of Non-Government Organisations that value their autonomy, to participate in working groups that were perceived to be answerable to Queensland Health. The clear definition of reporting structures, systems and processes that consider the needs of all participants, and engagement of NGOs at the executive level prior to convening the working groups, is likely to have facilitated the smooth operation of working groups. The healthy ageing partnerships established between Population Health and community groups in some districts were examples of effective working group models, as were the structures established in the Southern Area.

The restructure of the districts and abolition of health service areas during the course of the project was a reported barrier to the establishment and sustainability of working groups. The composition of some working groups had to be revised to re-align with the new boundaries, effectively undoing some of the initial groundwork that had been undertaken previously. The creation of new systems, policies and procedures, as well as reporting channels, in many instances caused uncertainty for staff. Some working groups were placed on hold until the reporting structures had been reorganised, thus delaying the project's progress. Many working groups previously established had lapsed, requiring high work demands on the part of FSOs to reinvigorate and maintain them.

Project Sustainability

The barrier most frequently reported and considered to be the most important obstacle to the longer term sustainability of the project was the time limited nature of project. It was considered by many, that without ongoing support for falls prevention activities by way of continuing funding for a dedicated staff member, the goals of the project would not be sustainable. Such a person would be needed to coordinate falls prevention activities at the district level, provide ongoing training, resources and support as well as provide on-going direction for the working groups. A dedicated person in this position was considered necessary to foster the sharing of resources and provide on-going education for staff working hands-on with patients at high risk for falls and encourage

consistent practices across agencies. The appointment of a dedicated falls coordinator was considered essential if the focus and impetus on falls prevention activities achieved by the FSO project, is to be maintained and that without such a person, the importance of falls prevention activities would eventually diminish as staff become occupied with other priorities and other aspects of their positions. A number of respondents reported that they had witnessed this is relation to other time-limited projects.

The provision of education on a regular basis was considered by many respondents to be the most pressing need due to both staff turnover and the use of agency staff who may not be aware of the falls guidelines. It was also considered important that such education be delivered in a flexible manner including providing education sessions at times to suit staff and delivering education in a variety of formats (e.g. posters, handouts, video) to ensure the information is well disseminated. Due to the project's limited timeframe, however, the opportunity to provide educational opportunities for staff was limited.

By comparison, an important facilitator to the overall success of the project, as well as to its longer term sustainability, was sponsorship at an executive level. It was reported that having this sponsorship provided endorsement of the project and gave a clear message that falls prevention was an important issue and ensured it remained an agenda item. Having this support ensured the project progressed. Without it, only those committed to falls prevention became involved while others became distracted by competing demands and other priorities. Another important factor contributing to the ongoing sustainability of the project was the formalisation of goals, objectives, roles and responsibilities by the working groups through the development of Terms of Reference (TOR) and Action Plans. This requirement provided the groups with ongoing direction as well as plans to continue falls prevention activities for older people beyond the lifespan of the FSO project.

The barriers and facilitators to project implementation are summarised in Table 3.

Table 3: Barriers and Facilitators to Key Elements of the FSO Project

	Barriers	**Facilitators**
Stakeholder Engagement	Lack of organisational readiness Initial lack of marketing of project and resources Insufficient time to conduct needs analysis and scoping Geographical size of districts	FSO skills and knowledge Availability of up to date contact directories Explanation of purpose and benefits of falls prevention cross-continuum model

	Barriers	Facilitators
Planning Days/Workshops	Staff availability Lack of administrative support Inflexible program format	Access to resources and networking opportunities Facilitator skills and knowledge Population Health, PSO support
Working Groups	Staff willingness to embrace cross-continuum membership District restructure	'Falls champions' Executive sponsorship Established district structure Development of Terms of Reference
Project Sustainability	Time limited nature of the project	Incorporation of falls prevention performance requirements into role descriptions

INFORMING A FALLS PREVENTION SERVICE DELIVERY MODEL

One of the aims of the FSO project was to inform the development of a state-wide cross continuum service delivery model evidenced by a consistent, coordinated, evidence based approach to falls prevention for older persons across the health continuum.

A Service Delivery Model (SDM)[7] is defined as *a framework for workplace oriented activity that has defined parameters for the range of service delivered throughout the organisation. A SDM describes and guides the activities that are carried out to meet the priorities of an organisation and the needs of the population.*

An alternative term is "Model of Care" which has elements in common with the SDM definition. The Western Australian Falls Prevention Model of Care (Western Australian Department of Health, 2008)

[7] Queensland Health (2004). Physical Activity Service Delivery Model for Queensland health across the Continuum of Care: A framework for the workforce in the promotion of physical activity within Queensland Health. Brisbane Queensland Health.

aims *to describe the best practice care and services within a health care system for a person or population group as they progress through the stages of a condition, injury or event.*

The definition outlined above specifies a number of elements as important components of a service delivery model. Each element of a SDM needs to be clearly defined at the outset (prior to implementation) so that those involved are able to share a common understanding of the goals and objectives of the program, who will be involved and what will their roles and responsibilities will be, where it will be delivered and by whom, as well as identifying what resources will be available or will be required to effectively implement the model. The elements include:

- the settings and context in which the intervention will occur
- the target group
- the stages of progression (levels of care)
- the interventions
- workforce roles and responsibilities
- resources available/required

THE NEED FOR A FALLS PREVENTION SDM

Many Queensland Health services and programs have been involved in falls prevention, although this only occurred in selected areas within existing resource constraints. The level of activity did not represent the required critical mass of integrated and sustainable evidence based multi-strategy falls prevention activity across the health continuum. As outlined in Section 1, the cross continuum model for falls prevention in older people aligns with strategic directions in Queensland Health.

CROSS CONTINUUM SERVICE DELIVERY MODEL FOR FALLS PREVENTION

The cross continuum SDM for falls prevention illustrated in the Cross- Continuum poster at Appendix A in the Queensland Stay On Your Feet® Community Guidelines (Peel, Bell, & Smith, 2008) was promoted by FSOs as a means to achieve "integrated and sustainable evidence based multi-strategy falls prevention activity across the health continuum".

A cross-continuum SDM[8] may be defined as *the coordinated approach to the delivery of falls prevention programs through communication, coordination and partnerships between all sectors from the wider community, primary health care, acute, residential aged care facilities and rehabilitation sectors.*

In the cross continuum SDM for falls prevention, each of necessary elements are addressed as follows:

[8] Definition developed by FSOs in consultation with the AFSO advisory group and approved by the FIPC Steering Committee.

Settings

The cross-continuum model reflects the movement of a person through the health continuum across the three different settings of community, hospital and residential aged care.

Target Group

Those targeted are people aged 65 and over (over 50 years for Aboriginal and Torres Islander peoples).

Stages of Progression

The cross-continuum model targets older people at all levels of functioning from healthy active ageing (low falls risk) to frail aged (high falls risk). As with the Western Australian Model (Western Australian Department of Health, 2008), the model is designed to address the needs and requirements of the older person at all stages of progression (levels of care), including:

- the well older person who has not experienced a fall and requires preventive mechanisms to delay the onset of the first fall;
- the older person who has had a fall and requires the delivery of a range of quality services and interventions to reduce subsequent falls;
- the older person who has had a fall to reduce the risk and severity of an injury following the fall.

Interventions

The cross continuum model outlines the evidence-based interventions that can be undertaken in relation to the health and well-being of both the population and the individual according to their current setting and level of functioning and risk.

Workforce roles

The health professionals involved in the prevention, care and management of falls represent a range of disciplines, reflecting the need for a multi-disciplinary approach.

Resources

The resources outlined in the cross continuum model include:

- Queensland Stay On Your Feet® Community Good Practice Guidelines and Toolkit;
- The National Falls Prevention Guidelines for Australian Hospitals and Residential Aged Care Facilities (‘Green Box’); and

- Home and Community Care HACC Best Practice Falls Prevention Resource Kit.

Stakeholder Feedback on Cross- Continuum SDM

Feedback on the cross continuum model was obtained from a number of sources, which included key stakeholder interviews, scoping and stocktake tools, workshop evaluations and SWOT analysis at the FSO Final Project Review.

Initially FSOs reported resistance to the cross-continuum model, which was also evident from key stakeholder interviews. Some of these barriers included:

- The benefits of model were not initially explained, nor was it clear how it would work in practice.
- Sectors still wanted to work in 'silos' seeing the needs of the three areas (community, acute, and residential care) as quite different. Many expressed the need to get their "own house in order" before embarking on cross-continuum.
- There was lack of true representation across the continuum, especially from medical staff and NGOs external to Queensland Health.
- The cross continuum approach was often thought of as only involving Queensland Health.
- Assumption of readiness- some of districts/areas weren't ready to implement the cross-continuum falls prevention model.

There has been a culture shift since the mid-term report. It is now evident that generally the cross continuum model is supported and the benefits and purpose of an integrated service delivery model are seen.

The strengths of the model include:

- It enables partnerships across sectors (acute and community).
- The focus is on the client (client-centred).
- It raises the profile of falls across sectors- "falls is everyone's business".
- It enables development and sharing of resources eg checklist. Sharing of resources means less duplication.
- The model gives people direction and structure.
- Action plans give people a sense of ownership.
- Planning days have been a good networking opportunity, for dissemination of information, and useful for gap analysis.
- The model enables links to be established with policy people.
- There is increased interest in the Falls Injury Prevention Collaborative.
- The model introduces some structure for falls prevention while allowing flexibility in implementation.
- The cross continuum approach leads to better knowledge of other activities/resources/places to refer.
- An understanding of falls prevention activities leads to more options and better streamlined referral pathways.

- The cross continuum approach in the development and implementation of action plans ensures activities are progressed.
- There is increased communication across the service continuum eg between hospitals, community and NGOs.
- There is better integration of services.

INFORMING A SDM FOR FALLS PREVENTION – LESSONS FROM THE FSO PROJECT

In informing the SDM, stakeholders also made recommendations about how services should be configured within a SDM. The important themes that emerged from their feedback were that, for a SDM to be successfully implemented, it should also be designed to include strategies for the following:

- Needs analysis;
- Communication within and between settings;
- Flexibility (showing the big picture at district level but allowing for local differences);
- Falls data monitoring and reporting;
- Quality improvement and continuing education;
- Evaluation and cost effectiveness analysis;
- Governance and regulation;
- Financing/ resourcing;
- Integration with other services;
- Standardised assessment instruments and sharing of information across settings.

The following summarises important lessons from the FSO project regarding the development and implementation of a successful cross-continuum SDM for falls prevention among older people. They are grouped in terms of the above categories.

Needs Analysis

- The model should be based on a needs analysis, mapping and identifying current activities on which to build. For a cross-continuum engagement it is important to ascertain what the priorities are, what structures are in place and working well and how to work collaboratively to achieve common goals.

Communication

- It is important to clearly articulate what the potential benefits of the model might be for all stakeholders including consumers. Engagement in the process is likely to be enhanced if stakeholders can clearly see the benefits of their involvement.

- The purpose of the cross continuum working group needs to be clearly stated at the outset. Similarly, guidance should be provided regarding how such groups should operate – e.g. what their agenda or terms of reference might look like, how to write an action plan etc. The provision of a template may be an effective way to provide assistance without being overly prescriptive. It cannot be assumed that all members of the working groups will share a common understanding of how such a group should function nor have the skills or ability to develop evidence based action plans. Ongoing support for some working groups may be required from Queensland Health to guide the implementation, evaluation and review of their action plans until they are sufficiently mature to function independently and have a clear direction.

- The action plans are an important component in the SDM as they provide direction and support future activity. They are a vehicle for collaborative action and enable the group to monitor and review achievement and direction. The action plans should specifically state the actions that have been agreed upon by members of the working group and that can be realistically undertaken, as well as who will be responsible for implementing the action. The outcomes should be measurable and there should be a time line for completion.

- 'Jargon' or language that has a particular meaning specific to a project needs to be clearly articulated to foster a shared understanding of core concepts and improve communication amongst stakeholders. It cannot be assumed that community organisations, particularly NGOs, are familiar with the terminology frequently used by Queensland Health departments.

- The SDM must be supported by a well-functioning system for communication between and across settings. Reporting guidelines should be clear and specific.

Flexibility

- Any model needs to be simple and flexible. As all districts differ in terms of many important characteristics (including geography, climate, demographics, priority issues and resources), it is important that a model can be readily adapted to meet the needs and requirements of the local area. A 'one size fits all' approach will not be effective (e.g. the 'hub and spoke' model doesn't apply in some districts).

Falls Data Monitoring and Reporting

- Systems need to be developed for the accurate and timely reporting and communication of falls data across settings. In addition, questions regarding what data will be reported, how frequently, in what format and to whom it will be reported, need to be resolved.

- To be useful, data must be accurate and hence standardised reporting procedures for falls need to be developed for each setting. The data reporting should include feedback loops.

- A SDM has to ensure auditing processes are in place with timely feedback at the local level. There needs to be PRIME data education for all staff.

Continuing Education

- The FSO project identified a clear need for new staff, especially nurses, to receive orientation and staff education regarding falls prevention. As falls prevention is not incorporated into their basic training and as there are frequent staff changes within Queensland Health and other health care organisations, any such training ought to be provided on an on-going basis via a range of flexible options using contemporary technology.

- A strategy for disseminating best practice and the most recent guidelines regarding falls prevention for older people should be developed. Part of the SDM should be how to stay abreast with evidence based practice.

Evaluation

- The aim of program evaluation is to determine how successful the program or intervention has been in achieving its goals and identifying the successes and failures of the program so as to inform future action. Hence, it is an important element of a SDM. While program evaluation can be expensive, the cost of collecting data can be minimised if data collected from the project can also be used for the purposes of evaluation. Hence, it is important to consider program evaluation when designing a SDM and ensure that existing data collection systems capture data needed for the evaluation.

- A process of auditing service models should be established to determine the extent to which progress towards a cross-continuum SDM has taken place and to identify where gaps exist.

Governance

- To work effectively, it is important that groups be established at a district, not AHS level. A district level approach has the advantage of being able to withstand higher level reorganisations and amalgamations and continue to function irrespective of such changes. It has been further suggested that local groups should be facility based to allow groups to work on local priorities, and that community and hospital sectors have their own groups so they may focus on issues specifically relevant to them and their clients.

- Endorsement at an executive level (for all sectors – community, acute, residential- within and external to Queensland Health) is important if the model is to be effective and the role of the executive sponsor should be clearly articulated. If sponsorship does not occur at this level, the

risk is that more immediately pressing priorities tend to take precedence, with the result that other important issues such as falls prevention are overlooked.

- A whole of government approach is necessary for uptake and commitment, and to ensure that falls prevention is embedded in practice and becomes "core business".

- In addition to executive sponsorship (a top-down approach), bottom-up approaches are also required to develop an effective SDM. Development at the grass-roots level allows the model to be tailored to suit the needs and requirements of local communities, taking into account the resources they have available. A 'bottom up" approach also supports local change champions and cultivates stakeholder support.

- The role of Non-Government Organizations (NGOs) within a QH SDM needs to be clearly defined. Within the FSO project, there was some reluctance, on the part of NGOs, that value their own autonomy, to participate in working groups that are answerable to Queensland Health. Ideally, the roles and responsibilities of each organization involved, including NGOs, should be negotiated in consultation with them and reporting structures, systems and processes that consider the needs of all participants should be clearly defined and developed prior to implementation of the intervention.

Financing/ Resourcing

- To be sustainable the SDM has to be adequately funded and should be equitable across the state.

- It is important to acknowledge that financial resources may be needed to assist districts and other organisations to defray some of the costs incurred in introducing innovations. An important barrier encountered within the FSO project was that many organisations did not have the financial resources to backfill staff and were hence unable to release staff to attend planning days and working group meetings. The necessary infrastructure needs to be in place to support the model.

- The roles and responsibilities of all stakeholders require clarification so that all those involved have a clear understanding of both their own and others' role within the project. This also assists to identify where there might be gaps (e.g. people, tasks to be undertaken) that require filling.

- Falls prevention requires a 'driver' who also needs to be highly visible. It was almost unanimously agreed that there is a need for a permanent staff member to coordinate falls prevention activities at the district level, provide ongoing training, resources and support as well as provide on-going direction for the working groups. As all existing personnel are heavily committed to fulfilling other duties within their roles, it was considered that only a dedicated person would have the time and energy to ensure that the focus remains on falls prevention. The person needs good facilitation skills. Some suggested there was a need for two permanent FSO positions at district

level- one within clinical networks (a falls specialist officer similar to a diabetes nurse educator) and a community falls officer sitting in the Population Health Unit.

Integration

- It is important to utilise and build upon existing structures/working groups when implementing a new program or initiative, particularly those that are working well. The involvement of Population Health Units whose staff had pre-existing relationships with stakeholders and relevant contextual knowledge, contributed to the success of the project in several areas. In addition, processes of the SDM model should be intertwined within existing infrastructures and processes, and use existing reporting structures. This will minimise the time and effort required and reduce the duplication of structures.

- Services need to be well-coordinated and easily accessible by the target group. Development of a service directory would assist referral pathways.

- Referral pathways need to be clearly defined and understood by service providers. Electronic databases to support the referral process should be developed at the local level and be readily accessible by stakeholders.

- The readiness of communities, organisations and services to participate in a cross-continuum SDM varies considerably and should be carefully assessed prior to implementation. A tool such as Victoria Health's *Partnerships Analysis Tool* [9] provides a framework to assist organisations to develop a clearer understanding of the range of purposes of collaborations, reflect on the partnerships they have established and develop ways to strengthen new and existing partnerships. It is important to work with communities and organizations at their level of readiness if they are to fully engage in the project and this may take considerable time.

- The SDM must be compatible with other relevant SDMs eg mental health, dementia, physical activity.

Standardised Assessment Tools

- Resources should be uniform. There should be a standard falls policy for the districts with standardised risk assessment. Currently there is a need to establish processes that meet minimum standards in terms of acute and residential care falls management. There should be consistent procedures and documentation which flags risk and identifies management strategies.

- Essential health-related information should be transferable across the continuum of care. An electronic medical record could make such transmission across sites of care easier. The successful introduction of electronic medical records will depend on the availability of high

[9] http://www.vichealth.vic.gov.au/en/Resource-Centre/

quality, standardized data that is accessible and useful to diverse stakeholders at various levels of the health care system.

CONCLUSION

The opportunities from this project are that momentum has been built for falls prevention in Queensland across the health continuum. The formal evaluation provides evidence for the cross continuum model of service delivery for implementing a statewide falls prevention strategy. The lessons learned and wealth of data from this project should inform the next step, which is to develop and implement a comprehensive and well resourced statewide falls injury prevention model so that the work that has been done is sustainable.

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