North Burnett Continuum of Care Project case study

This section discusses a project run by Queensland Health's North Burnett Health Service District (NBHSD) and Wide Bay Population Health Unit to prevent falls across the continuum of care.

About the North Burnett Health Service District and population

The NBHSD encompasses the area in Queensland between Biggenden in the south and Monto in the north. The District includes the five main communities of Biggenden, Gayndah, Mundubbera, Eidsvold and Monto, which all have a rural hospital. The health service facilities in each community range in size from 11 beds to 22 beds. The District's Community Health Centre is based at Gayndah and provides outreach services to all NBHSD communities.

The District's population is about 10,199 people, with 2,402 people aged over 60 years. When compared to Queensland's population, the District has a higher proportion of older people. Projected population figures for the District also indicate that while the total population is decreasing, the population aged between 60 and 80 years is increasing. Based on these figures, it is estimated that 800 older people could fall in one year (24.1% of the population aged over 60 years).

Getting started

The need for an ongoing and comprehensive approach to falls prevention was identified through discussions between the District Health Service Manager and the Director of Wide Bay Health Promotion Services.

In November 2005, a community consultative forum was held with representatives from NBHSD, Population Health, the local council, Blue Care, the local Division of General Practice, Queensland Ambulance Service, age care facilities, community organisations and local community members. The forum identified existing services in the North Burnett District, barriers and opportunities as well as resources available.

As a result of the initial forum, a working group was formed including members from NBHSD, Wide Bay Population Health Unit, Blue Care, the local council and a 'Stay on your Feet' community ambassador. The core working group localised an existing continuum of care model and developed an action plan over a two month period. Attendees from the initial forum also were invited to comment on these documents during their development.

The model was trialled over a six month period (February to August 2006) and a strategy plan was implemented concurrently. The working party met bi-monthly and were instrumental in progressing the project's action plan. The project was implemented using existing resources of key stakeholders.

Taking action

Major falls prevention strategies were as follows.

- A community falls questionnaire was developed and distributed over a three month period by District hospitals, HSD staff at local events (ie. agricultural shows), doctor's surgeries, local pharmacies, Queensland Ambulance Service stations, Blue Care respite and home services. The questionnaire provided localised self-reported data on the number of falls in the last six months, injuries sustained, time and location of fall, contributing factors and physical activity participation. The information collected was used to develop potential future initiatives.
- A pilot eight week falls prevention program was developed and implemented at Mundubbera. Program topics included lifestyle assessment, medication safety, diet and nutrition, balance and strengthening exercises and home safety. The pilot program had an average attendance of 15 people. Overall feedback was very positive, with similar programs being planned for other NBHSD communities.
- Updated lists of physical activities in each community and existing community sporting groups were created. These lists were an important resource for referring individuals to local exercise/recreation groups. Sport and recreation groups were seen as a potential avenue for promoting existing programs like 'Lighten Up'.

Sustainability of the continuum of care approach

The pilot project has established a basis for future falls prevention and healthy active ageing work by providing the momentum and capacity for other initiatives and projects. A key element has also been the level of commitment from the District Manager and the Clinical Executive Team.

Current HSD initiatives include:

- revising the pilot eight week falls prevention program by incorporating feedback from the District's dietician and physiotherapist
- appointing the District dietician to coordinate the eight week education program and community falls prevention initiatives (as part of their position)
- appointing the District patient safety officer to drive healthcare-based falls prevention strategies (as part of their position)
- establishing a falls prevention resource group chaired by the patient safety officer, with representation from community health and every health facility in the District to:
  - develop an action plan to implement the 'Preventing Falls and Harm from Falls in Older People' guidelines within the health care setting, as well as screening and risk assessment tools
  - guide the development of a multidisciplinary falls prevention resource manual, including policies and procedures, all hospital and community falls prevention tools, alert processes, contact lists, resources lists and education materials for staff, patients, relatives and medical officers
  - designate a falls resource person for each participating facility (or two people at some facilities), who will be responsible for introducing the falls manual
  - educate staff on the completion of the District's falls manual

- the future development of a falls data collection tool to identify District and community trends and guide future falls prevention planning which will, in time, be placed at GP surgeries, Queensland Ambulance Service, Blue Care, and other local health care providers to gain data from across the spectrum of care
- making falls prevention a mandatory area for each facility's service improvement/operational plan, which will be reported on monthly
- adding falls prevention as a standing agenda item at all clinical meetings.

Barriers/solutions

- Feedback suggested the continuum of care model used was not practical or user friendly for a wide target audience. It was recommended that the model be re-packaged if used again.
- A challenge was maintaining interest and involvement from all services across the continuum of care.
- The capacity of HSD staff to participate or coordinate activities was limited. This was particularly challenging for the small allied health workforce who had roster commitments and heavy workloads.
- It was challenging for people to regularly attend working party and planning meetings, due to other work commitments/meetings. As a result, overlap with other projects is being minimised and the program is being streamlined as much as possible.
- A challenge was maintaining the original direction and keeping those involved updated. Regular communication was extremely important (eg. meetings, telephone, email).

Resources/tools

- National Falls Prevention Guidelines
- Prevention and Primary Health Care Framework for Falls in Older People (Stay On Your Feet WA, 2004-2007)
- *Don't fall for it. Falls can be prevented: A guide to preventing falls for older people.* (2004). Adelaide West Stay on Your Feet and National Ageing Research Institute.
- Stay on Your Feet Wide Bay volunteer ambassador case study
- Project-related resources.

For more information

- Patient Safety Officer – NBHSD
- Health Promotion Officer – Wide Bay Population Health Unit
- Dietician (Community Health), NBHSD

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