COMMUNITY FALLS FOLLOW UP PROGRAM

A COLLABORATION BETWEEN QLD AMBULANCE SERVICE, MN COMMUNITY AND ORAL HEALTH DIRECTORATE AND PHN TEAM CARE CO-ORDINATION

THE PROBLEM

- July to December 2018 QAS responded to ~1200 callouts per month due to a falls related incident
- 50% of the call outs remained at home and did not get transferred to hospital
- Many call outs were to a person who fell multiple times within the month
- Follow-up care for those that do not go to hospital was variable and dependent upon the patient or their family initiating contact with their primary care provider or other formal support services

The consequences of falls resulting in minor or no injury are often neglected. Factors such as fear of falling and reduced activity level can profoundly affect function and quality of life, and increase the risk of seriously harmful falls.
(ACSQHC, 2009)

RESPONDING TO THE PROBLEM

MN Queensland Ambulance Service, Brisbane North PHN and MNHHS Community and Oral Health Collaborative pilot project to implement and evaluate a new falls community response pathway over a 6-month trial period

Metro North Hospital and Health Service

Putting people first

AIMS OF THE PROJECT

- Trial an integrated community response falls pathway for those patients attended by QAS but not transported to hospital that improves patient access to post-falls management and care coordination.
- Reduce the rate of falls and fall injuries, and improve functional capacity and quality of life, among older community-dwelling adults.
- Promote the use of evidence base practice in the management of the older person who falls at home.
- Evaluate the impact of the pathway on the patient and health service outcomes and identify opportunities for improvement and scalability

CRITERIA FOR COMMUNITY FALLS FOLLOW UP PROJECT

- Consenting adults who reside within The Prince Charles Hospital Catchment area
- Falls must occur within the patient's home
- Fall meets the definition of an unintentional fall
- Person to be aged over 65

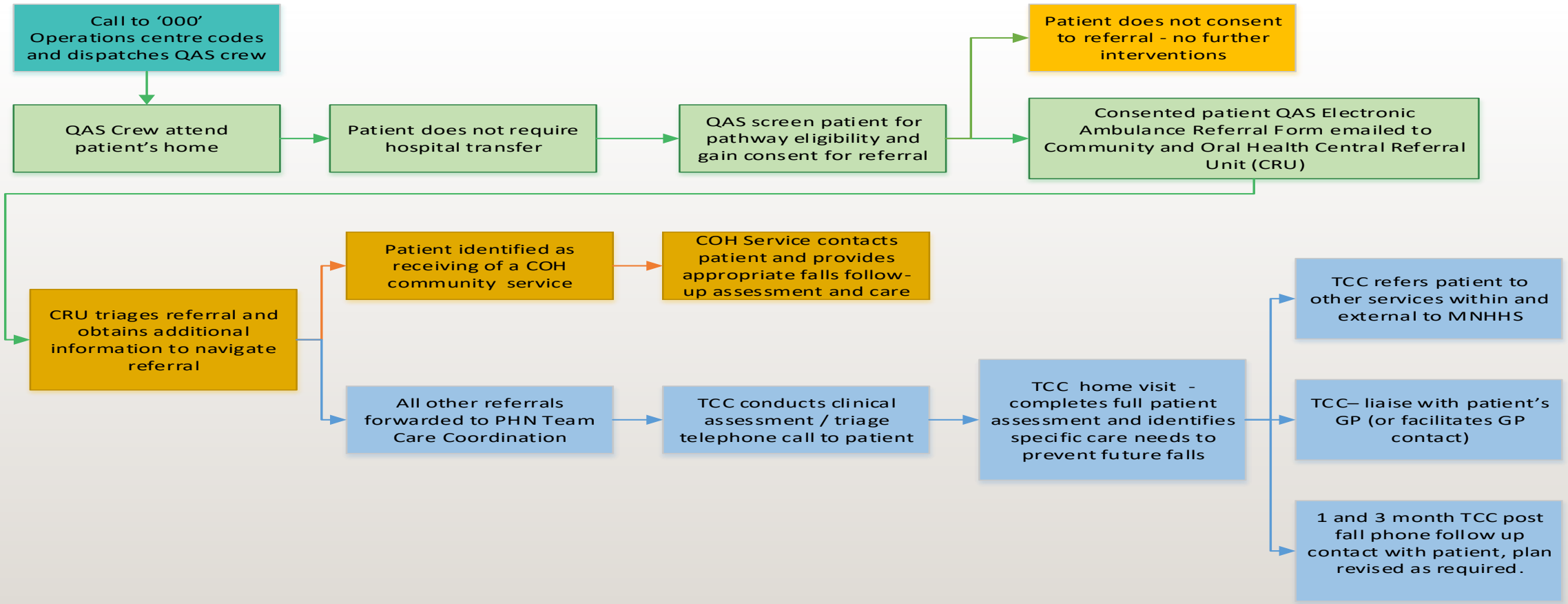
Excluded

- Falls in Residential Aged Care facilities
- People who were documented to be aggressive, or abusive
- People had an alcohol and/or drug related fall

The Prince Charles Hospital Catchment area

Albany Creek, Aspley, Bald Hills, Boondall, Bracken Ridge, Bray Park, Bridgeman Downs, Carseldine, Cashmere, Chermside, Chermside West, Dayboro, Deagon, Eaton Hills, Everton Park, Geebung, Hills District, Kedron – Gordon Park, Lawnton, McDowall, Northgate – Virginia, Nudgee – Banyo, Nundah, Petrie, Samford Valley, Sandgate – Shorncliffe, Stafford, Stafford Heights, Strathpine - Brendale, Taigum – Fitzgibbon, Wavell Heights, Wooloowin - Lutwyche, Zillmere.

COMMUNITY FALLS PATHWAY



OUTCOMES OF THE PILOT PROJECT – THE FIRST 3 MONTHS

- TPCH Catchment had an average of 9 falls / day that QAS responded to
- 3 - 4 falls / day are not transported to the Emergency Department
- Referrals from QAS did not reach full potential with only 45 people referred
- QAS are currently focusing on increasing referrals to the service

REFERRALS TO SERVICE PERSON PROFILE

- Average age 84 with a frailty score of 5
- In the previous 18 months these 45 patients had:
  - 478 healthcare encounters with MNHHS services (admissions, ED presentations, outpatient appointments, community based care), an average of 10.6 health care encounters per patient
  - 120 hospital admissions with an average of 6.24 days
  - 501 hours of ED presentations with a average of 4.9 hours per presentation
  - 180 outpatient appointment with 27% new appointments

Frailty score of 5 = Mildly Frail

These people often have more evident slowing and need help in high order activities of daily living. Typically mild frailty progressively impairs more lower level activities of daily living

$1,036 = the average cost an Emergency Department presentation for the frail older person staying 4.73hours

$5,211= the average cost of an inpatient hospital admission for the elderly person with an average length of stay of 2.21 days.

EFFECTIVENESS OF THE PROGRAM

- Most QAS referrals are received within 1-2 days of fall and are navigated to the next care provider within 1 day of receipt.
- Less than half of referrals progressed to receiving a direct face to face service intervention after their first contact with PHN Team Care Co-ordination.
- The majority of referrals are not progressed due to clients or their family members declining follow-up.
- Clients whose referrals do not progress are more likely to be admitted to hospital within 3 months compared to clients whose referrals progress to direct service provision.
- For referrals not progressed the main reason for hospital admission was falls related in over 75% of cases.

SERVICES PROVIDED TO RECIPIENTS OF THE PROGRAM

For clients receiving PHN services referrals are actioned within 1 day of receipt and a face to face visit is conducted within 3 days of referral. Specific interventions undertaken by Team Care Co-ordination include:

- referral to Allied Health services (Occupational Therapy (55%), Physiotherapy, Podiatry and Speech Pathology)
- referral/visit to General Practitioners
- referral to My Aged Care and Aged Care Assessment Team (ACAT)
- information provided on personal alarm systems and home safety
- engage existing service providers
- co-ordinating an increase in services
- onward referral to active at home programs

- In one case the TCC noted a deteriorating client and coordinated hospital readmission.

THE STORY OF MRS PD

THE FALL

Mrs PD fell at home while putting out the washing, tripping over a mat she had placed under the line so she did not get dirty shoes.

QAS responded to the OOO phone call, assessed Mrs PD and found no injuries requiring hospital care

QAS with Mrs PDs consent referred her to the Community Falls Project.

Referral was processed by COH and referral sent to Team Care Co-ordination.

INITIALHOME CONTACT and ASSESSMENT

Team Care Co-ordination undertook a home visit and completed a comprehensive client and environment assessment .

ACTIONS TAKEN

OT referral for home safety and mobility review and hand therapy.

Referred for Personal Safety Alarm with key safe.

Mrs PD provided with information on the Active at Home program through Burnie Brae.

Loose mats under line removed during TCC visit.

Education on loose mats, steps, small dog provided. Checks on use of walking stick, grab rails, ramp and bathroom equipment already installed.

OUTCOMES

TCC funded private OT. Recommendation to move clothesline and mats accepted by client. OT discussed major mods for stair lift with client.

Burnie Brae to commence Active at Home exercise program

Final Outcome 6/8/19: referrals actioned, exercise program in place, personal alarm installed and has an alternate clothesline to use with easier access, some mats remain as client has declined to move them.

IMPACT

Mrs PD has not been admitted to hospital post fall

LEARNING FROM THE PROJECT SO FAR

- Elderly people who fall at home often do not recognise / acknowledge the future risk of a further fall and therefore do not always accept the option to participate in the program.
- Timing of referral is critical to acceptance of the need to engage.
- Participants of the program reduce their risk of a further fall compared to those that decline participation
- Most elderly people who fall at home have had contact with a hospital either in an emergency department, an admission or an outpatient appointment multiple times in the proceeding 12 months to being referred to the program.
- Clients who have a home care package benefit in place are less likely to engage with the program as they believe they are already getting adequate services but the evidence is that they still benefit from participation

A partnership approach to problem solving has enabled the Community Falls Program to enhance the lives of elderly people living in their own homes by implementing individualised strategies to prevent further falls.

QLD Ambulance Service, Metro North Community and Oral Health Directorate and Brisbane North PHN Team Care Co-ordination are committed to working together to improve the lives of frail elderly people in the community at risk of further falls.