

18. Communication regarding falls risk and the individualised plan of care (to mitigate risks) occurs at all ‘transfer of care’ points.

**3.** Strength and balance exercise groups in the community are identified and utilised by those at risk of falls.

*Provided as a working template example – modelled on Whanganui DHB’s*

 *Falls Prevention and Fracture Liaison Work-plan 2016–17*

Developed by Mary Stewart and Sandy Blake

15. Falls risk screening utilising the HQSC ‘Ask Access Act’ framework will occur in all services such as outpatient clinics that provide healthcare to older persons.

14. Increased cross sector collaboration to raise community awareness of falls-related risk and injury.

12. St John Ambulance officers conduct falls risk screening for older persons they visit who do not need ED transfer and refer those at risk to a single point of contact for follow up.

11. Green prescription includes a choice of strength and balance exercises as part of the DHB’s falls injury prevention strategy.

10. New Zealand Hip Fracture Registry and the Clinical Care Standards have been implemented in the DHB.

9. Ortho-geriatrician will review the older persons who have fallen and sustained a fracture requiring hospital admission; advise on osteoporosis management and improving bone health. A working partnership will exist between the FLS nurse and the ortho-geriatrician.

1. Fracture liaison and falls prevention pathway developed using ‘map of medicine platform’ (or similar).

7. A single point of contact for referrals of those 50+ years who are unsteady on their feet or who have fallen.

8. 50+years persons who have fallen and fractured a bone will be identified and contacted by the fracture liaison nurse and connected to required services and treatment.

6. Medications are routinely reviewed in those 50+yrs, who take greater than five meds (polypharmacy), and identified as at risk of falling or have fallen.

**A systematic approach to falls and fracture prevention and management**

**- 20 Point Work Plan -**

⚫ not yet occurring

⚫ in part/at times/data
 not available

⚫ routinely occurs

5. Vitamin D is prescribed for those who are Vitamin D deficient, have no or low exposure to sunlight, are cared for in ARC or have suffered fragility fracture.

13. Standardised best practice (evidence informed) strength and balance exercises are advocated for in aged residential care.

2. All comprehensive clinical assessment, including interRAI information, is used to inform a falls prevention care plan.

4. Bone health assessment and falls risk screening is conducted on those 50+ years in general practice.

19. A ‘*Knowing How We Are Doing’* report is developed utilising data from ACC, HQSC, Atlas of Healthcare Variation and local systems.

17. DHB develops an in-home falls prevention programme including assessment and treatment for the frail and elderly at home.

16. HQSC falls process markers meet expected threshold and quality expectations in clinical areas.

20. Governance of falls and fracture prevention programmes are maintained at board and alliance leadership level, and incorporate a cross sector / system perspective.