Whanganui Falls Prevention and Fracture Liaison Workplan 2016 -17

20 POINT WORKPLAN

1. Fracture liaison and falls prevention pathway developed using map of medicine platform.

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

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

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

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

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

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.

9. Orthogeriatrician will review the older persons who have fallen and sustained a fracture requiring hospital admission. The orthogeriatrician will advise on osteoporosis management and improving bone health. A working partnership will exist between the fracture liaison nurse and orthogeriatrician.

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

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

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

13. Standardised best evidenced strength and balance exercises are advocate for aged residential care.

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

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.

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

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

18. Communication regarding falls risk and the plan of care to mitigate the risk occurs at all points of transfer of care.

19. A *Knowing how we are doing* report is developed utilising data from ACC, HQSC,Atlas of Health Care Variation and local systems.

20. Governance of falls prevention programmes are maintained at board and alliance leadership level.

routinely occurs | in part/at times/data not available* | not occurring

Developed by Mary Stewart and Sandy Blake | updated 18.11.16