

**LIVE STRONGER
FOR LONGER**

PREVENT FALLS & FRACTURES

Improving falls and fracture service outcomes for older people prevention and rehabilitation

A STORY OF CHANGE

Making a difference for Muriel and George

This narrative uses parallel time-lines to explore the different paths that a couple's life can take when circumstances change and they become reliant upon the health system for appropriate care.

Muriel, aged 82, has a chronic respiratory condition (COPD) which she manages with regular exercise and three monthly visits to her GP for checks and repeat prescriptions. She and her husband, George, a retired accountant, have a married son living overseas. Muriel is a keen gardener, belongs to a walking group and is an active member of Probus. They have lived in the same three bedroom two storey house for 45 years. Muriel broke her wrist seven years ago when she was using a spade in the garden.



Muriel



George

The old story...

Muriel's husband George has Parkinson's disease and has mobility issues. He is unable to climb stairs and sleeps downstairs. Muriel has never driven but George has recently failed his driving test, so she is no longer able to regularly get to her Probus meetings.

She has reduced her regular walking group activity as George becomes anxious if she is away from home for any length of time. She continues to spend a part of each day in the garden but has noticed that she has become short of breath with heavy gardening activities over the winter. George can't get outside that much anymore so is now unable to help Muriel. She is no longer confident that she could keep up with her friends in the walking group.

Mid-afternoon on a Friday, Muriel slips on the laundry floor, falling between the washing machine and the wall. She is not able to get herself up and George is not able to assist her. George contacts the St John ambulance by activating his medic alert alarm. Muriel is in a lot of pain from her bruised ribs and hip, and is short of breath. She is unable to weight bear. The paramedics are concerned and decide to take her to hospital.

Muriel is transferred to an orthopaedic ward and three days later undergoes a hip replacement. After a week she is transferred to the Older Person's Health Rehabilitation Unit. She receives physiotherapy and occupational therapy as an inpatient but there is no specific intervention to address her risk of further falls or her risk of further fragility fracture in hospital or on returning home. She worries about how George is coping with the changed circumstances.

In the meantime George has been placed in residential care while Muriel is in hospital. Muriel stays in hospital for eight weeks, during which time George's health has deteriorated and he is assessed as needing to move into the hospital part of the rest home. He has had several minor falls in Aged Residential Care and has lost confidence to attend social activities at the facility. Muriel is later discharged to residential care in a village in the same complex but is now anxious about having another fall. She no longer gets out in the garden.

The new story...

Muriel was started on osteoporosis medication seven years ago when her wrist injury was recognised as a fragility fracture. She met with the fracture liaison nurse at that time and has been attending a class based strength and balance programme with friends ever since.

As Muriel needs to spend more time at home with George she is no longer able to get to her community exercise group. She has noticed that while working in her garden that she is tiring easily and has nearly fallen on two occasions. She mentions this to the practice nurse when she is getting her flu vaccination. The nurse notices she can't get out a chair without using her hands and refers her to the local physiotherapist that delivers the "in-home" programme. As part of the initial strength and balance assessment and home check, the physio notices that one of the laundry taps drips water onto the laundry floor and that a mat in the kitchen needs to be removed. A local plumber fixes the tap. The physio establishes that Muriel and George are both appropriate for a home-based strength and balance programme. She discusses this with their Primary Care Team at their weekly meeting and modifies the programme to suit Georges Parkinson's-related mobility issues based upon the discussion.

As Muriel's strength and balance improves over the following months she no longer reports concerns about falling in the garden and is more confident with heavier household tasks. She no longer needs to provide the same level of mobility support to George as his strength improves also.

George has a stay in hospital after falling on the back step and breaking his ankle. The admitting physician contacts George's GP and discusses his home situation and health care. He notes George's falls risk at home and the ward staff are alerted to these risk factors so that his inpatient care includes engaging the rest of the family in his safe hospital care. He continues his strength and balance programme as part of the inpatient rehabilitation delivered by the ward physiotherapist. At the discharge planning meeting the team, including the ACC Enabling Independence (EI) case manager, discuss protective factors to incorporate into his return home including falls risk, home hazard check and bone health lifestyle factors. In discussion with his Primary Care team George is discharged from hospital early as part of a supported discharge service that provides up to six weeks of intensive rehabilitation and support.

The Early Discharge Team work with George to establish a goal orientated rehabilitation plan and part of this plan includes strength and balance exercises, nutritional advice and the value of joining a local exercise group when appropriate. Upon transfer out of the Early Discharge Service the coordinator determines that George would benefit from a more challenging falls prevention programme in his home specifically designed for his Parkinson's disease. This information is included in the discharge summary to his General Practice. The ACC EI case manager and the Falls Prevention Physiotherapist are made aware of this at their weekly Primary Care team meeting. Their home care support worker who assists them with some personal cares incorporates appropriate functional strength into ADL's, reducing the need for extra support.

Muriel graduates to a strength and balance class run in the local school hall that she attends with friends from the Probus group and she re-joins her local walking group. Their great grandchildren have been given a book by the primary care nurse that encourages young children to identify hazards in their grandparent's home and ensure that their elderly family members do not trip or slip on toys and mats etc by keeping the house tidy. While the children see this as a fun game this strategy helps reduce their grandparent's risk of falling.

Muriel and George continue to live independently in their own home with increased mobility and confidence to complete their usual daily tasks.

