



Make A Move Program



**A Multi-Strategy
Home Based Program
for HACC Clients
Aged 80+ Years at
Risk of Falls**

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Make a Move Project Report 2008-2009

Project Name

Multi-Strategy Home-Based Programs for HACC Clients Aged 80+ Years at Risk of Falls.

Project Aim

To promote the health and independence of older people by improving, maintaining or reducing the rate of decline in strength and balance and improve nutrition, footwear and foot care, and vision.

Project Objectives

- To conduct a multi-strategy home-based programs for HACC clients assessed as being at risk of falls;
- To engage appropriately skilled staff to select eligible HACC clients to participate in the program;
- To facilitate ongoing partnerships between allied health professionals and organisations delivering HACC services to older people.

Reflection on Planning Process/Recruitment and Assessment

The original aim of this project was to recruit 30 participants aged over 80 years, particularly those with a history of falls or who have been assessed as being at risk of falling.

Heathcote Health District Nurses and HACC staff were able to identify a number of potential participants based on the criteria of their non-participation in Planned Activity Groups (PAG) or Strength Training Programs and considered as being at risk of falls. These potential participants were sent an information brochure about the Make a Move Project as well as a letter encouraging them to participate in the program. Those people who responded were then assessed in their homes by the District Nurse to consider their eligibility for the project.

Once the nursing assessment identified eligibility, the participants were referred to the Physiotherapist for a comprehensive balance assessment using evidence based tests and the standardised outcome measures to determine suitability for the Make a Move Program.

The Physiotherapist then provided an individual exercise program which was to be implemented by participants supported by the Fitness Instructor employed in the project.

By using the District Nursing and HACC staff who had local knowledge of the potential participants and their unique circumstances, HACC clients at risk of falls were able to be correctly identified. Of the 34 people who were referred for the initial physical assessment, three people (8.8%) were considered to be unsuitable due to one person having dementia, another had multiple hip surgery and the third person had a mobility issue that prevented participation.

Of the remaining 31 participants, seven people dropped out during the course of the program for reasons that each identified in the client survey as being either a lack of time, lack of motivation, health issues or transport problems.

An additional four people were then recruited during the early stages of the program and this meant that 28 participants completed.

Reflection

The initial plan did not need to change as it was clear that the plan for recruitment and assessment was clearly thought out and achievable. Whilst the plan worked effectively for the majority of participants, on reflection, it may have been useful to also investigate participant motivation prior to accepting them into the program. The lack of motivation was the most significant self-identified reason for withdrawal from the program by the seven participants who withdrew. Approximately 20% of the seven who withdrew, did so due to deterioration in their health, unrelated to their participation in the program.

Reflection on the implementation of the program has resulted in a view that further participants could have been recruited later on as more withdrawals occurred. However, this would have been difficult as it would have required further involvement of contracted clinicians and the available funds for this program did not provide for further intakes.

A number of participants specified that without the transport provided as part of the program, they would not have been in the position to participate. The project did not initially identify transport an integral component of the program, however, once identified as an issue, transport was provided for any participant who required it.

Implementation

The activities that were undertaken to establish and implement this program were resource intensive, however, the outcomes of the program for the participants made this investment of resources very worthwhile.

Activities to Set-up the Program

- District Nurse completed a two day Health Coaching Course.
- Detailed plan of the program developed and local schedule documented.
- HACC and District Nursing staff educated on the program information.
- Fitness Instructor contracted and oriented to the program.
- Physiotherapist involvement negotiated.
- HACC and District Nursing staff to identify potential participants.
- Letters and brochures to potential participants sent out.
- Evaluation Plan developed.

Activities to Implement the Program

- District Nurse assessments for each potential participant who had positively responded to the invitation for the program.
- Physiotherapist review of each assessed participant to determine appropriateness of referrals.
- Service Coordination Meeting of staff to agree on participants.
- Exercise program developed by Physiotherapist for each participant based on the Otago Model.
- Fitness Instructor required detailed instruction on the program model to enable her to work with participants to progress their exercise program.
- Podiatrist contracted to provide education and undertake assessments.
- Dietitian Education sessions planned and assessments undertaken.
- Optometrist education session and individual interviews conducted.
- HACC staff continuation in encouraging the participants during each home care session.
- Telephone coaching to motivate participants by District Nurse.
- Pre and post assessments by Physiotherapist.

Description of Settings Where Physical Activity, Nutrition and Foot Care Activities Were Implemented

Transport was provided to bring the Make a Move Program participants to the Planned Activity Group Centre at Heathcote Health for the nutrition sessions, the eye care sessions and the foot care activities. Due to resource issues it was not possible to provide these allied health sessions in the homes of individual participants as Heathcote Health does not have salaried positions for these clinicians.

Nutrition Setting

A dietitian from the Rural Health Team at Bendigo Health facilitated the information sessions on the importance of good nutrition in preventing falls. These sessions were conducted in the early stages of the program. Two sessions were facilitated and involved combined Planned Activity Group and Make a Move participants. Follow up on these nutrition sessions were undertaken by the District Nurse and HACC staff in the homes of participants.

Foot Care Setting

The local Podiatrist provided information sessions to the participants in two sessions combined with the Planned Activity Group participants at the Centre. Follow up care has been provided in the Podiatry Offices in Heathcote for individual participants.

Eye Care Setting

An Eye Care Centre Optometrist from Bendigo attended the PAG Centre and carried out a vision assessment on each of the Make a Move Program participants. Two participants required further follow-up and new glasses.

Physical Activity Setting

Physical activities were undertaken in the participants own homes and the Fitness Instructor and the District Nurse visited on several occasions to review the way the exercises were being implemented by the participants.

The exercises were individually tailored to the participant's capacity by the Physiotherapist.

Impact /Effectiveness

Information used for Engagement of Participants

The information used to engage the participants was firstly an information brochure for the program with a letter of invitation to participate. These were sent to all potential participant. At the commencement of the program, an individual exercise plan based on the Otago Model was provided to each participant. Other information was the Strength Training Home Based Exercise Poster prepared by Physiotherapists of the Bendigo Loddon Primary Care Partnership (PCP) and a range of good nutrition literature developed by dietitians and distributed by the Rural Health Team dietitian.

The brochure, 'Fall and Fracture: Most people don't see them coming' produced by the Australian Optometrists Association was provided to each participant following their eye care interview and education session.

In addition, a falls prevention booklet, "This Way Up" produced by Bendigo Health Care Group in 2000 which covers vision, exercise, medications, eating, footwear, home safety and community safety was distributed to every participant.

All of the above information was drawn from evidence relating to falls prevention strategies and risks.

Reach of Project

The specified target group for this project was HACC eligible people aged 80 + years. Of the 28 participants who completed the program, 82% were from this target group with the eldest participant being 92 years and the youngest 80 years. Of the remaining 18% of participants, all met the criteria of being at risk of falling, however, these were not in the target age group with the youngest person aged 70 and the eldest aged 75.

How Did HACC Clients Feel About the Project?

75% of the participants completed the Satisfaction Survey. The outcomes of these surveys demonstrated that:

- 100% of the respondents were satisfied with the content of the program and 53% of these were very satisfied.
- 100% of respondents were satisfied with the leaders of the program (District Nurse, Physiotherapist and Strength Trainer) with 53% of these being very satisfied.

- 92% of participants thought the telephone coaching was effective, with 42% stating that it was very effective. 8% of participants thought that the telephone coaching was not effective.

Case Study

Mr Z, aged 85 years, accepted the invitation from Heathcote Health to participate in the Make a Move Program for people living in the community and who were aged over 80 years. Mr Z lives alone in his own home and was not very active. He lacked confidence as he had previously had a falls, which although it did not cause long term injury, it had caused pain and he had been told by his family what a 'lucky escape' he had, as the fall could have caused broken bones. This had resulted in Mr Z losing confidence and was concerned about undertaking physical activity in case it resulted in a fall.

Following his initial assessment by the Community Health Nurse, using the Service Coordination Tool Templates (SCTT), and a further physical and balance assessment by the Community Physiotherapist, Mr Z commenced his exercise program at home. Mr Z was pleased that Heathcote Health organised his transport to attend the group sessions on nutrition, podiatry and eye care as he does not have a car and relies on his daughter to come out to Heathcote from Bendigo once each fortnight to take him shopping.

Mr Z was appreciative of the telephone calls that he received from the Nurse at least once a fortnight and said ; *" sometimes I just felt I could not be bothered doing my exercises when the phone would ring and there was Deb encouraging me and asking me how I was going and telling me how well I was doing. This motivated me to get up and get going with my program. Other times when I did not feel like doing the routine I wondered what I would tell her the next time she rang so I would just do the exercises so I could report."*

When he received his final assessment it was identified that Mr Z had improved his functional reach by 6cm as well as improved his balance and his confidence. This improvement in Mr Z's confidence means that he is now continuing the exercises and walks into town which is a distance of around 4 kilometres. This has made Mr Z far more independent and he has developed a range of community connections that he did not have prior to commencing the program.

Important Conditions Required for Successful Implementation

Staff and /or participants identified the following issues as being important for successful implementation of a physical activity program:

- Clear explanation of what the program is trying to achieve. This needs to be explained to the staff involved and the participants at the commencement of the project.
- Clarify the expectations the participants may have about their participation in the program and ensure each person has a clear understanding of what could be expected.
- Reinforce purpose of program and review the participants' implementation of the designated exercise program regularly as it is easy for them to go off track.
- Ensure staff members follow the program guidelines and do not change anything without first receiving approval from the Project Reference Group (this happened on one occasion where the Fitness Instructor changed the exercise program with no consultation with the Physiotherapist or the Project Reference Group).

- Provide transport for any sessions held outside the participants' homes.
- Mix the home based sessions with some group meetings to encourage peer support.
- Make sure the program is provided on a client centred model.

Partnerships

Establishment and Maintenance of the Partnerships

The Make a Move Project commenced with the convening of a Project Reference Group which consisted of staff from a number of work units within Heathcote Health as well as the private Physiotherapist and a staff member from the Bendigo Loddon PCP. These meetings resulted in shared knowledge of the work being undertaken in the different work units and a more effective service coordination process. An increased understanding of Allied Health and Allied Health Services has occurred within Heathcote Health by Nursing and HACC staff. As a result of this, there has been an increase in referrals from the District Nursing Department to Allied Health Clinicians.

A strong partnership resulted with the Planned Activity Group staff and District Nurses and the program has increased attendance numbers at the Planned Activity Group by 29%. The education sessions of the program were held at the PAG Centre and provided an opportunity to encourage attendance to other activities being held there.

The partnerships were maintained by building the relationships, ongoing meetings and between meeting discussions related to the outcomes being sought for the project.

Continuation of the Partnerships

Two HACC Personal Care Assistants are nearing completion of the Allied Health Assistant course. After completion of the course it is intended that they will provide support in physical exercise and activities to residential and to community clients, supported by the partnership with the Physiotherapist. This partnership with the private Physiotherapist will continue to be maintained and will progress in order to ensure safe and appropriate exercise programs are developed for the frail older HACC clients at home so that their independence can be preserved for as long as possible.

The Health Coaching undertaken by the District Nurse will be utilised in the work being implemented with HACC clients of Heathcote Health. The District Nurses will continue their partnership with PAG and HACC staff to encourage older persons to remain active in their own homes and this will become part of Heathcote Health's core business.

Heathcote Health's Home and Community Care workers are now aware of the importance of documenting any falls that are reported within the community, therefore, regular updating of the Community Falls Register is now occurring. This will be continually encouraged by the Community Care Coordinator and District Nursing office. The report certainly shows positive results with the participants increasing awareness of the risks of falls and their responsibility in regards to the prevention of risks.

The PCP PAG Resource booklet which provides various initiatives for keeping participants in PAG active during their session will now be used in the Heathcote Planned Activity Group. The PCP Strength Training Poster which was developed by physiotherapists and fitness educators will be distributed to all participants.

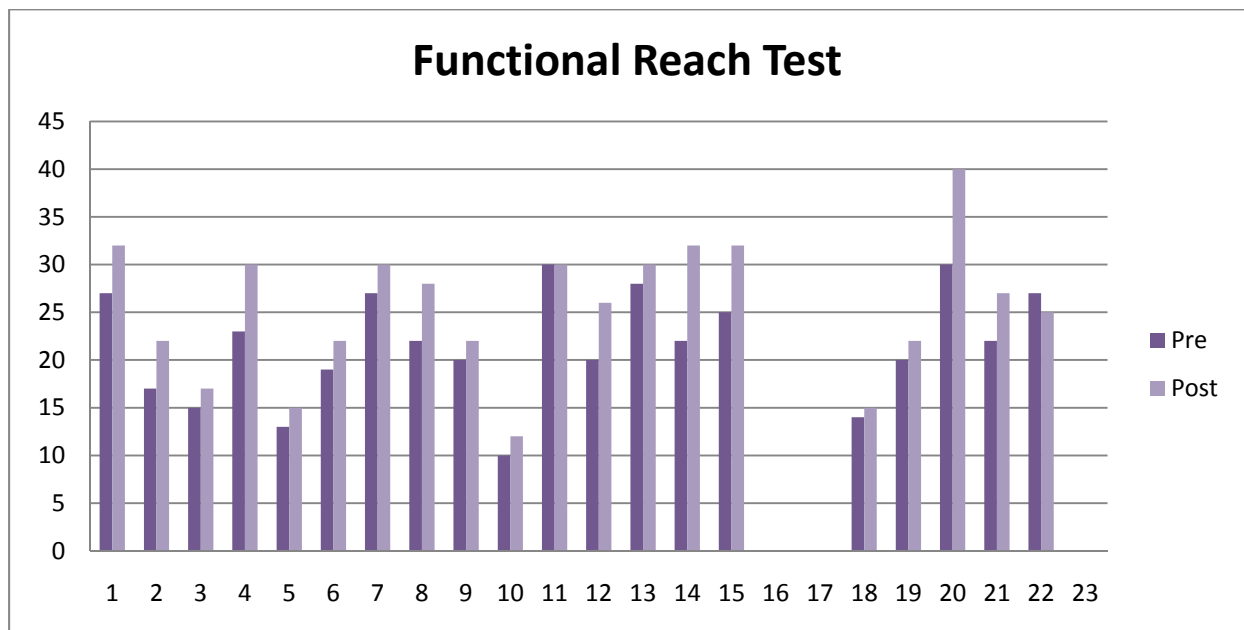
Outcomes

Physical Outcomes

Participants were assessed by the Physiotherapist at the commencement and conclusion of the program. These assessments included Functional Reach, Step Test, Timed Up and Go Test and the Modified Falls Efficacy Scale.

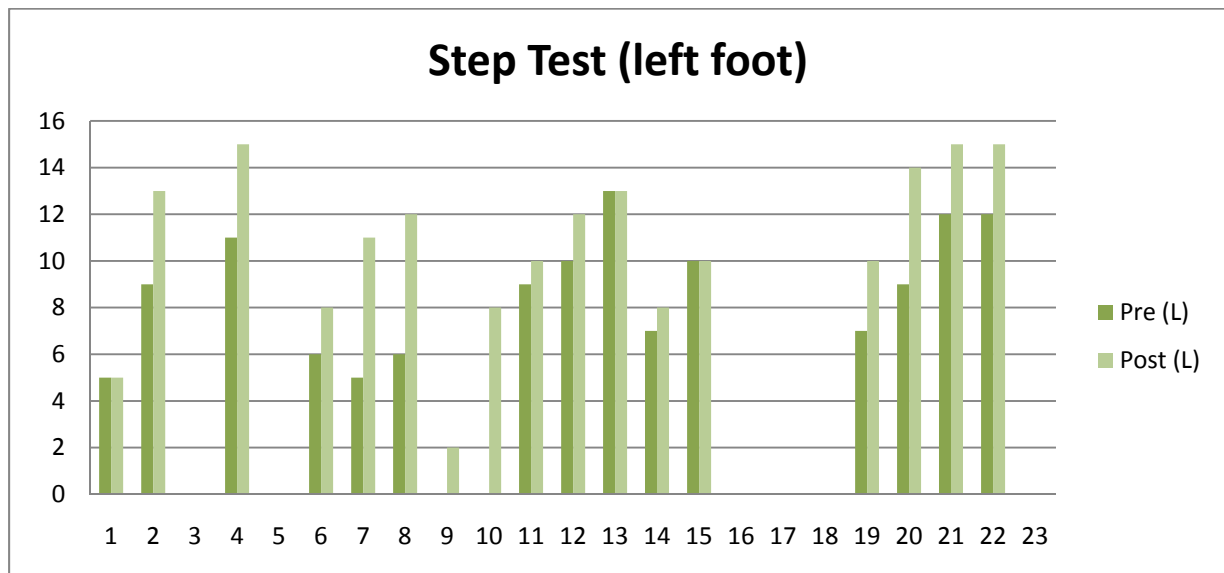
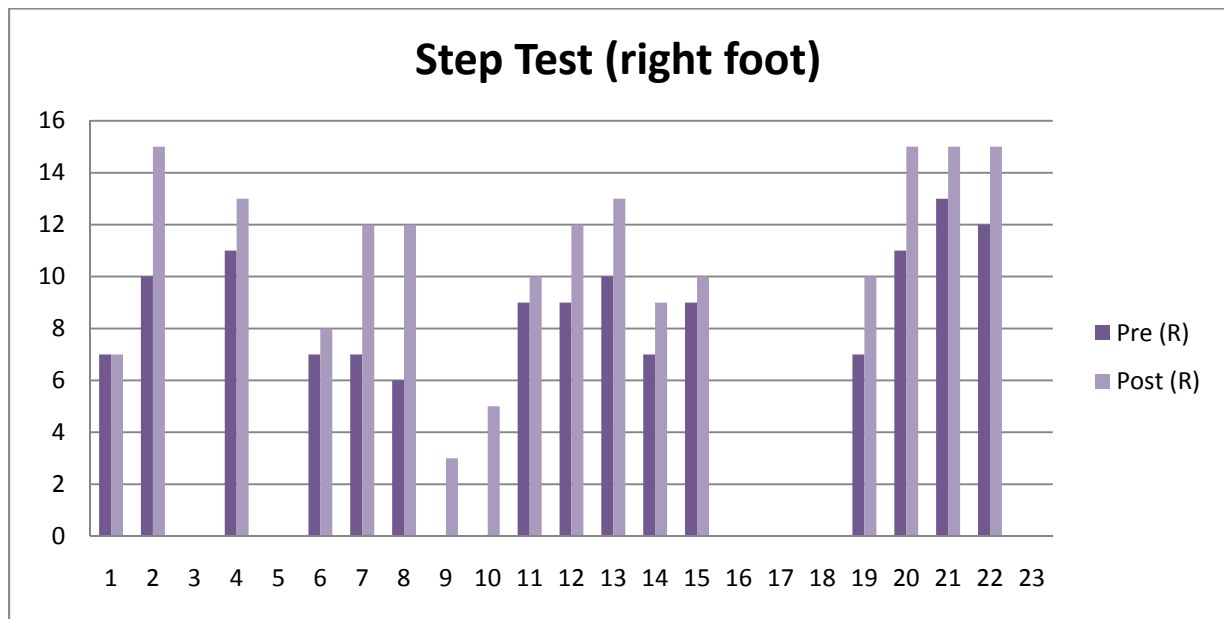
Functional Reach Test

The functional reach test is a performance measure which identifies forward reach ability in bilateral stance (self-generated perturbation). The functional reach score is the difference in distance between the starting reach and the furthest reach (cm). The difference between erect standing and furthest possible reach (distance in centimetres) is recorded. Twenty participants were assessed using the functional reach test. Eighteen participants increased the distance they could reach with one participant extending her reach by 10cms. The average increase was 3.4cms.



Step Test

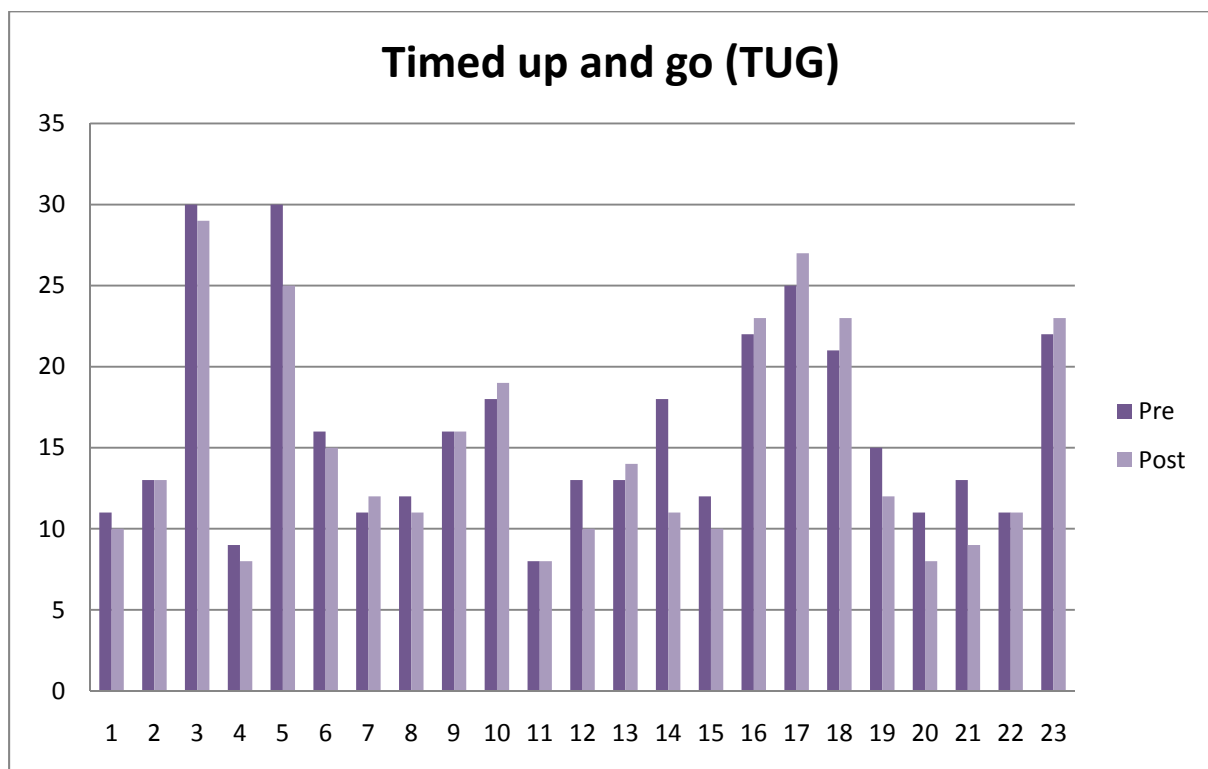
The number of steps a participant could take on their right and left foot were counted over a set period of time. Seventeen participants were able to participate in this test. The outcome, which is most noteworthy, was that by the end of the program two participants who were unable to complete this test at the beginning of the program were able to take part at the end of the program. Sixteen of the 17 participants increased the number of steps they took in the timed period with the highest increase being 8 steps, and the average being 2 steps.



Timed Up and Go Test

This test was conducted pre and post program to measure speed during several manoeuvres which potentially threaten balance. The participant commences the test while seated in a standard chair with arms resting on the chair's arms. The participant then stands, walks three metres to a wall, turns without touching the wall, returns to the chair, turns and then sits down. Timing is undertaken using a stopwatch.

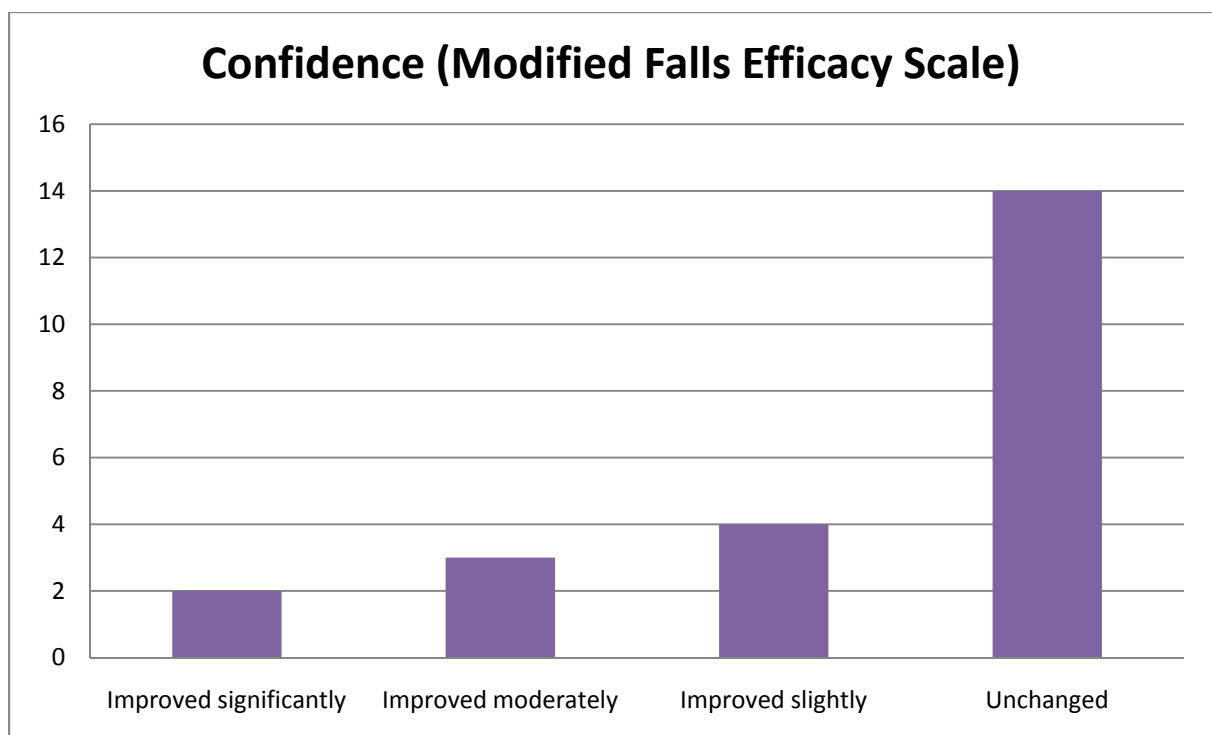
The participants, due to the normal ageing process, would be expected to deteriorate over time, however, it was found that 7 of the 23 participants who underwent pre and post testing (30.4%) demonstrated positive improvement in this test. 17.4% participants experienced no change. One participant showed significant deterioration with the pre program test being seven seconds better than the post test. Upon investigation it was found that this participant had ceased the balance exercises part way through the program. 47.9% of the participants experienced minor negative changes of minus one to minus three seconds, however, this is less than would be expected in this age cohort and their participation in the program has likely slowed down their age related deterioration in joints and muscles.



Modified Falls Efficacy Scale

This scale relates to the confidence of the person in carrying out each of 14 activities without falling. The resulting overall score is obtained by averaging the score for which each of these items were rated by the participant.

The improvements in confidence were very pleasing with 39.1% of participants' confidence improving. 8.6% of participants improved significantly, 13% improved moderately and 17.4% improved slightly. Whilst 60% of participants reported that they did not think their confidence had improved, it is important to note that these results are attributed to a survey of the participants pre and post program. Participants' feelings about their confidence can be attributed to a variety of issues, including their footwear on each day of the survey and their health (including mental health) at the time of completing each survey.



Nutrition Outcomes

The Dietitian believes that majority of the participants were aware of the health benefits of good nutrition and therefore the presentation was a reinforcement of their existing knowledge.

21% of the participants have had follow up appointments with the dietitian in their homes and participants have reported that they are now more aware of having to cook nutritious meals and those that are unable to do this are now receiving delivered meals from Heathcote Health.

Foot Care Outcomes

The private Podiatrist in Heathcote provided podiatry support to participants in the program and conducted an information session on the importance of good foot care and the increased risk of falls in relation to ill-fitting shoes. The Podiatrist has reported that 55% of the participants have had follow up visits for foot care in the Podiatry Rooms.

Vision Outcomes

An Optometrist conducted vision assessments on the Make a Move participants. Participants were also given an application form for a Victorian Eye Care subsidy.

The reported outcomes from the Optometry eye care sessions indicate that most participants wore glasses for either general vision or reading. Whilst 96% of the participants were up to date with regular Optometry vision reviews, four percent of participants who were well overdue for an eye examination have since followed this up with a local Optometrist and received new glasses.

Falls Register

The project initiated a review of the Community Falls Register which was found to be grossly incorrect. Quite a number of falls were discovered during the initial nursing assessment and these had not been documented in the Community Falls Register of HACC clients. The District Nursing staff and HACC staff are now required to complete an Incident Report on every fall that is reported to them by HACC recipients. Falls of HACC clients will also be reported by Nursing staff if these clients attend the afterhours emergency unit at Heathcote Health. The Community Falls Register currently lists 22 reported falls from June 2009 – May 2010. A Falls Risk Assessment Tool (FRAT) has been developed to be used as a Risk Factor/Referral Checklist including an Action Plan to address the risk. This tool will be triggered for use when an Incident Report is lodged at Heathcote Health or when an initial assessment notes a recent fall.

The only reported participant fall during the program was one participant who had ceased the balance improvement exercises without the knowledge of the Project Reference Group or the Physiotherapist.

The number of falls will be reviewed each quarter and strategies implemented to contain the number of falls in the community.

The evidence, both qualitative and quantitative, as stated above, has demonstrated that the Make a Move Project for this HACC cohort aged 80 + Years has contributed to an improvement in the client group's health and independence.

Sustainability

Many of the deliverables of this project have now been built into the core business of Heathcote Health HACC Program. Negotiations will be held with the Rural Health Team to ensure that any new HACC client aged over 80 years, (or current clients who reach 80 years) , will be referred to a dietitian for education on good nutrition in relation to preventing falls. An annual information session will also be held at the Planned Activity Group to encourage participants to review their own diets and develop meal plans to improve their own nutrition and reduce their risk of falling.

Provision will be made in the Planned Activity Group budget for an annual visit by the Podiatrist to the Planned Activity Group to deliver evidence based foot care advice, and educate the participants on the importance of good fitting shoes to prevent falls. The General Practitioners in Heathcote will be encouraged to refer eligible older persons to the Podiatrist under the appropriate MBS items for an annual foot care assessment.

The ongoing relationships developed with the participants of this project will be continued and the sense of community connectedness that resulted from the program will be maintained through a variety of ways. These participants will continue to be invited to attend special events arranged by Heathcote Health and encouraged to participate in the PAG.

Two HACC Personal Care Assistants are nearing completion of the Allied Health Assistant course and, following completion, it is intended that they will provide assistance in exercise and physical activity to residential and community clients with the support of the Physiotherapist.

Heathcote Health's Home and Community Care PCA's are now aware of the importance of documenting any falls that are reported within the community and, therefore, regular updating of the Community Falls Register is now occurring. This will be continually encouraged by the Community Care Coordinator and District Nursing staff

Lastly, the exercises undertaken will be continued by the majority of participants and all have reported that they are now aware of the benefits of increasing the amount of walking that they do on a daily basis.

Whilst ongoing funding support would enable specific strength training sessions to be held in small groups and individually, the main initiatives of the program have been built into the core business of HACC at Heathcote Health and the Service will endeavour to implement these initiatives as far as is possible.

Issues/Barriers

Most of the issues identified in this program were a result of the level of funds provided for such an ambitious project. An example of this is the use of the Optometrist with only one visit for the participants to be able to be bulkbilled to Medicare and therefore future visits had to be paid for by the program which made them unaffordable.

In addition, lack of resources prevented the Podiatrist from seeing each person individually and those sessions had to be combined into a group session as bulk billing the participants was not an option for the Podiatrist. Whilst this affected the initial assessment, a significant number of participants followed up with the Podiatrist at their own cost.

In hindsight because Heathcote Health does not have salaried Allied Health Clinicians, the grant provided for the project did not cover the expenses that were necessary and Heathcote Health met many of the costs through existing core funds.

A further issue for the program was the fact that many of the potential participants, i.e. those aged 80+ years, had chronic health conditions and the physiotherapy assessment identified that it was unsafe for these people to participate in the program. This clearly established the importance of early intervention to encourage and support those who are in a younger age cohort to maintain or commence an exercise program that can be undertaken daily, regardless of transport accessibility or weather conditions. A home based exercise program is ideal for this purpose.

Having said this, it is clearly evident that this project was very successful and the participants have certainly reduced their decline in strength and balance, and have improved their knowledge and experience in nutrition, footwear, foot care and vision.

The Future

The Make a Move Project has been an excellent initiative for the community of Heathcote and the staff of Heathcote Health. The future of this project means that:

- Any future home based exercise program will include an assessment of the person's motivation to participate and, based on this assessment, a strategy to increase or maintain motivation will be implemented.
- Provision of transport costs will be included in any new programs planned.
- The importance of specifying and then reinforcing regularly, the purpose of the program will be planned and implemented in all new programs.
- A commitment will be sought from staff at the commencement of all programs to ensure that they follow the guidelines and make no changes without approval of the Project Reference Group.
- Any home based programs will include some group sessions to encourage social connectedness and peer support.
- Heathcote Health will utilise health coaching with all clients to promote self management in health and wellbeing.
- Heathcote Health will seek resources to skill up more staff in health coaching.
- The Community Falls Register will be a priority and will be maintained and measured quarterly with Falls Prevention Strategies implemented for those at risk.
- Heathcote Planned Activity Group will integrate physical activities and good nutrition into its program planning using the PCP PAG Resource booklet (July 2008).
- PCP Strength Training Poster will be distributed to all HACC clients of Heathcote Health.
- New HACC clients aged 80+ years will be referred to the Rural Health Team Dietitian for education on good nutrition to prevent falls.
- An annual information session will be facilitated at the Planned Activity Group to encourage participants to improve nutritional intake.
- The Planned Activity Group will resource an annual Podiatrist visit to deliver evidence based foot care advice and the importance of good fitting shoes to prevent falls.
- GPs will be encouraged to refer appropriate persons for an annual foot care assessment by a Podiatrist.
- Assistance in exercise and physical activities will be provided in the community by the Allied Health Assistants supported by the Physiotherapist.

The Make a Move Project initiatives have been incorporated into the core business of Heathcote Health and will ensure that falls are contained/or reduced within the HACC population of Heathcote.

Conclusion

This Multi-Strategy Home Based Program for HACC Clients Aged 80+ years at Risk of Falling, has given Heathcote Health an opportunity to consolidate a number of initiatives and pieces of outstanding work into practice for the Heathcote community. These are in addition to the aims and objectives agreed with the Department of Health, which funded this project.

These initiatives have included:

- The Active HACC project: Heathcote Health was a part of the City of Greater Bendigo project and recruited 20 clients to the Active HACC project. Some of the clients in this program were a part of that Active HACC project and had already welcomed the increase in activity.
- Strength Training: Heathcote Health has been a part of the Steering Committee and the Physical Activity Consortium of the Bendigo Loddon Primary Care Partnership.
- Planned Activity Group (PAG) review: Heathcote Health had completed an internal review and identified a need to increase attendances within PAG.
- The Health Workforce Australia Caring for Older People project and the recently funded Well for Life Project will build upon the Make a Move project work.

Heathcote Health's ability to plan, implement monitor and evaluate projects has resulted in enhanced capacity with the experience gained by the District Nurse who participated in the project. As a Division 2 Nurse who is transitioning to a Division 1 Nurse in the graduate program at Heathcote Health, this Nurse has gained invaluable experience. This capacity building has been supported by the input from the Bendigo Loddon PCP and the sharing of skills which has supported her throughout the life of this project.

The 80+ age group has been a difficult population cohort to participate in this project. As detailed in the report, the Physiotherapist advised several clients to withdraw due to their complex health conditions and rate of functional decline. The large number of clients who reported no change particularly in the Step Up and Go component further substantiates this observation. This group of the population has proven difficult because of their cognitive function as well as their physical capacity – many of the participants were resistant or unable to change because of their physical and psycho-social status. A younger cohort may have demonstrated more of a change in habit if they had been the targeted group.

Preparation of Report

This report was prepared by Jeanette Grant, Executive Officer of the Bendigo Loddon Primary Care Partnership for Heathcote Health.

The survey and outcome measurements analysis for this report were undertaken by Leah Wilson, Programs Coordinator of Bendigo Loddon Primary Care Partnership using information provided by Thy Tran, Community Physiotherapist and the participant surveys.

Other information for this report was provided and collected by Debbie Puxley, District Nurse, Heathcote Health and Lyn Turner, Project Coordinator, Heathcote Health.

The layout and design of this report is by Leanne Oberin, Bendigo Loddon Primary Care Partnership.

Further Information

For further information on the projects identified in this report contact Lyn Turner, Project Coordinator, Heathcote Health, telephone 5431 0932, email lturner@heathcotehealth.org.

Disclaimer

While all efforts have been made to ensure that the information in this report is accurate, the Bendigo Loddon Primary Care Partnership and Heathcote Health does not accept any liability for any action or loss that is incurred by a person acting on the information contained in this Report.