Strengths and Weaknesses of Falls Prevention Strategies

Dr Dawn Skelton,
Reader in Ageing & Health, Glasgow Caledonian University

http://go.to/flippic
My presentation will....

- Very briefly explore the prevalence and consequences of falls
- Discuss the evidence base in relation to single interventions and population-based interventions
  - Strengths and Weaknesses
- Very briefly explore the gaps in the evidence base
- Be available to download
Prevention of Falls Network Europe (ProFaNE)

www.profane.eu.org

Discussion Board
Resources
Information
2-Monthly e-newsletter
Figure 9. Mortality rate (age standardised - per 100,000) due to falls in the elderly (65+) in the EU25 and EEA, in countries having less than 10% “Other and unspecified” (Table 1)

<table>
<thead>
<tr>
<th>Country</th>
<th>Mortality Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Greece</td>
<td>14.4</td>
</tr>
<tr>
<td>Estonia</td>
<td>24.8</td>
</tr>
<tr>
<td>Slovakia</td>
<td>33.1</td>
</tr>
<tr>
<td>Lithuania</td>
<td>35.1</td>
</tr>
<tr>
<td>Iceland</td>
<td>38.9</td>
</tr>
<tr>
<td>Austria</td>
<td>50.3</td>
</tr>
<tr>
<td>Belgium</td>
<td>57.8</td>
</tr>
<tr>
<td>Ireland</td>
<td>61.7</td>
</tr>
<tr>
<td>Latvia</td>
<td>65.3</td>
</tr>
<tr>
<td>Poland</td>
<td>66.4</td>
</tr>
<tr>
<td>Italy</td>
<td>73</td>
</tr>
<tr>
<td>Slovenia</td>
<td>89.1</td>
</tr>
<tr>
<td>Finland</td>
<td>94.9</td>
</tr>
<tr>
<td>Czech Republic</td>
<td>112.2</td>
</tr>
<tr>
<td>Hungary</td>
<td>164.5</td>
</tr>
</tbody>
</table>

10 fold difference in mortality from falls in different EU countries

European Network on Safety among Elderly (EUNESE) Priorities for Elderly Safety in Europe 2006
Falls in the UK

- 11 million people aged > 65 yrs
- 28,000 women aged > 90 yrs
- Fractures costs £1.8 billion pa
- 1 Hip Fracture every 10 mins
- 1 Wrist Fracture every 9 mins
- 1 Spine Fracture every 3 mins
- 500 admitted to Hospital every day
- 33 never go home

Annual European Home and Leisure Accident Surveillance Survey (EHLASS) Report UK 2000
DoH Prevention Package 2009
How common are falls?

- In > 75s, falls are the leading cause of death resulting from injury.
- 75-80% of falls are not reported.
- 1 in 3 >65’s and 1 in 2 >80’s fall p.a.
- 10% of all call-outs for UK Ambulance Service are for people aged 65+ who have ‘fallen’ but nearly half are not taken to Hospital.

Falls more common in people with multiple medical conditions and with poor function and mobility.

There are global variations in fall rates (eg China 6-20%, Japan 20%), and few figures are available for developing world.

Appear to be racial differences in likelihood of a fall (white Caucasians particularly at risk).

Women are more likely to fall than men, and to suffer non-fatal injuries (higher risk of osteoporosis).

Social deprivation linked to nocturia and falls at night.

(WHO 2007, Booth 2009)
Risk factors for hip fracture in women

Bone related
- Bone mass
- Bone geometry
- Bone turnover
- Microarchitecture

Fall related
- Age
- Genetics
- Maternal hip fracture
- Previous fracture
- Weight
- Mobility
- Smoking
- Self-related health
- Neuromuscular function
- Cognitive impairment
- Visual acuity
- Drug therapy
- Fall mechanics

Masud & Morris, Age & Ageing 2001; 30-S4: 3-7

With thanks to Dr David Reid, University of Aberdeen & NOS
Consequences of Hip Fracture

- By Year 2030 expected 100,000 hip fractures a year.
- **Risk** of a hip # **10x** higher for those in *residential settings* than in *own home*
- **50%** of individuals will die, move into a nursing home or be in hospital within **six** months of Hip #
- **80%** do not regain pre-fracture mobility
Cost to the Individual

- **Injuries** include:
  - Cuts and lacerations,
  - Deep bruises, Soft Tissue Injuries,
  - Dislocations, Sprains
  - Increase in joint pain

- Less than 5% of all falls result in a fracture
- Long lie’s (floor) & complications
- Depression, fear of falling
- Avoidance of activities and social isolation

Skelton & Todd, WHO, 2004
For a typical PCT: 300k population

- ~ 300 - 350 hip fractures pa
- > 1000 other fragility fractures
- > 15,000 fall each year, 6000 twice or more
- > 70 per week will attend A&E

- This costs PCT & council £50m per annum
- This will increase 50% by 2020

DoH Prevention Package 2009
Objective 1: Improve outcomes and improve efficiency of care after hip fractures – by following the 6 “Blue Book” standards

Objective 2: Respond to the first fracture, prevent the second – through Fracture Liaison Services in acute and primary care

Objective 3: Early intervention to restore independence – through falls care pathway linking acute and urgent care services to secondary falls prevention

Objective 4: Prevent frailty, preserve bone health, reduce accidents – through preserving physical activity, healthy lifestyles and reducing environmental hazards
Bone health opportunities missed

- Royal College of Physicians (RCP) 2009 audit of falls and bone health services
  - “systems to ensure initiation of secondary prevention medical treatments for osteoporotic fragility fractures are not in place”.

- In the RCP national clinical audit of 2007, only 19% of over 5,000 patients presenting to hospital with a non-hip fragility fracture were on the appropriate bone medication three months later.
  - Yet over 40% of people who sustain a hip fracture have had a previous non-hip fragility fracture.
Exercise opportunities missed

81% run strength and balance training classes BUT Average duration 8 weeks and frequency once per week!

Lamb et al, SDO report, 2008
Falls Prevention Approaches

- **Individual Approach (high risk patients)**
  - Multi-factorial (eg. PROFET - *Close et al, 1999*)
    - *2004 Review - Multifactorial trials reduce risk (RR 0.82) Chang 2004*
    - *2008 Review - Multifactorial trials ineffective - Gates 2008*
  - Uni-factorial (eg. FaME - *Skelton et al, 2005*)
    - *Exercise only trials reduce risk (RR 0.86) Chang 2004*
    - *Pacemakers, Cataract Removal, Medication Withdrawal*

- **Population based approach (targeting communities)**
  - Emerging evidence (*McClure, 2005*)
  - Most include increasing awareness and physical activity, medication and home hazard reviews
    - *Reductions in injuries 6-33% but no RCTs*
Different costs to interventions

<table>
<thead>
<tr>
<th>Intervention type</th>
<th>Intervention Components</th>
<th>Delivered by</th>
<th>High risk Cost analysis per fall prevented</th>
<th>Low risk or unspecified risk Cost analysis per fall prevented</th>
</tr>
</thead>
<tbody>
<tr>
<td>individually customised multifactorial interventions</td>
<td>Assessment, exercise, behaviour modification, medication</td>
<td>Multi-disciplinary</td>
<td>Total healthcare costs per fall prevented - in those at high risk(^b)</td>
<td>Total healthcare costs per fall prevented - in those at low risk(^c) EUK 2698(^d)</td>
</tr>
<tr>
<td>(1 study)</td>
<td></td>
<td></td>
<td>Cost saving(^b)</td>
<td></td>
</tr>
<tr>
<td>Same multiple risk factors targeted to all participants</td>
<td>Falls related knowledge, attitudes, behaviours, and risk factor awareness campaign</td>
<td>Multi-disciplinary</td>
<td>_</td>
<td>Net monetary benefit to cost ratio for the intervention of 20.8 to 1(^c)</td>
</tr>
<tr>
<td>(1 study)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Single Factor interventions (7 studies)</td>
<td>Strength and balance training (3 studies)</td>
<td>Physiotherapists and Nurses trained in delivery of exercise</td>
<td>For those aged 80 years or older Cost saving(^b)</td>
<td>Mean cost EUK 173 in research setting(^c) EUK 942 in community health care setting(^c)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Home Safety and modification (3 studies)</td>
<td>Occupational Therapist</td>
<td>In visually impaired older people, cost EUK 304(^b)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Occupational Therapist</td>
<td>In those recently discharged from hospital (fall in last year) Cost saving(^c)</td>
<td>In those recently discharged from hospital (not fall in last year) EUK 3040(^d)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Occupational Therapist</td>
<td>Hypothetical cost modelling EUK 1652(^b)</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Ophthalmic surgeon</td>
<td>Base case one year incremental cost effectiveness ratio EUK 4732(^b)</td>
<td></td>
</tr>
</tbody>
</table>

\(^a\) Not observed. \(^b\) Both cost saving and cost effectiveness are presented. \(^c\) Cost saving and cost effectiveness. \(^d\) For community health care setting.
PROFET: targeting risk factors
(Close et al. Lancet 1999)

- Medical assessment
  - General medical
  - Postural hypotension
  - Visual acuity
  - Balance
  - Cognition and affect
  - Corotid sinus syndrome

- Occupational Therapy
  - Function
  - Physical handicap
  - Psychological handicap
  - Environmental hazards

- Referral / intervention
  - Day hospital
  - GP
  - O/P
  - Optician
  - Social services
  - Supply minor equipment

The rate of falls was reduced by 60%
Review: Falls clinic effectiveness
Comparison: 01 All studies
Outcome: 04 Fall-related injury

<table>
<thead>
<tr>
<th>Study or sub-category</th>
<th>Treatment n/N</th>
<th>Control n/N</th>
<th>RR (random) 95% CI</th>
<th>Weight %</th>
<th>RR (random) 95% CI</th>
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<tbody>
<tr>
<td>Tinetti</td>
<td>10/125</td>
<td>12/122</td>
<td>0.81 [0.36, 1.81]</td>
<td>8.63</td>
<td></td>
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<tr>
<td>Wagner</td>
<td>63/635</td>
<td>88/607</td>
<td>0.68 [0.51, 0.93]</td>
<td>20.85</td>
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<tr>
<td>Close</td>
<td>8/141</td>
<td>16/163</td>
<td>0.58 [0.26, 1.31]</td>
<td>8.38</td>
<td></td>
</tr>
<tr>
<td>Van Haestregt</td>
<td>26/129</td>
<td>21/123</td>
<td>1.18 [0.70, 1.98]</td>
<td>14.31</td>
<td></td>
</tr>
<tr>
<td>Gill</td>
<td>1/92</td>
<td>5/92</td>
<td>0.20 [0.02, 1.68]</td>
<td>1.68</td>
<td></td>
</tr>
<tr>
<td>Shaw</td>
<td>37/130</td>
<td>31/144</td>
<td>1.32 [0.87, 2.00]</td>
<td>17.31</td>
<td></td>
</tr>
<tr>
<td>Davison</td>
<td>6/139</td>
<td>11/154</td>
<td>0.53 [0.20, 1.39]</td>
<td>6.55</td>
<td></td>
</tr>
<tr>
<td>Lord</td>
<td>80/202</td>
<td>67/201</td>
<td>1.19 [0.92, 1.54]</td>
<td>22.29</td>
<td></td>
</tr>
<tr>
<td>Total (95% CI)</td>
<td>1613</td>
<td>1606</td>
<td>0.90 [0.68, 1.20]</td>
<td>100.00</td>
<td></td>
</tr>
</tbody>
</table>

Total events: 231 (Treatment), 251 (Control)
Test for heterogeneity: Ch² = 15.79, df = 7 (P = 0.03), I² = 55.7%
Test for overall effect: Z = 0.70 (P = 0.49)
Falls Clinics

- Geriatrician, Physio, OT, nurse
- **Strengths**: Intensive CGA assessment and onward referral
  - Intended interventions not always undertaken
  - Not always evidence based interventions
- **Weaknesses**: different messages from different professionals, lots of double handling and assessment but little ‘action’, lots of waiting around, concern about institutionalisation….lots of DNAs...

- Reports of attendance suggest that the population reach of fall clinics is low (<3% of the population at risk)

  Lamb 2008, Gates 2008
Behavioural Modifications

- Stepping On (Clemson, 2004)
- Small Group Learning Environment
- $N = 310 >70s$ with history or concern about falls
- Aimed to improve self efficacy and encourage behaviour change (exercise, medication, home and outdoor safety, vision)
- 31% reduction in falls
OT Intervention

Cumming et al, JAGS 1999
- 65+ years, 1 year, n= 530, RCT
- OT home visit < 3 wks hospital discharge
- list of recommendations and telephone call 2 wks later
- Subjects with fall(s): 36% vs 45% [p=0.05]

Interactive interventions delivered by professionals involving older people in discussion around falls, behaviour and lifestyle are more successful with high risk groups

(WHO 2007)
– Consider major modifiable risk factors

– Consider bone health / risk of fracture

– Consider if onward referral necessary

– Not be repeated by everyone that comes into contact with an older person!

– Lead to effective interventions

– Be predictive??

Oliver 2009
Systematic reviews of tools that predict risk of a future fall

- **Myers H 2003**
- **Oliver D et al 2004**
- **Scott V et al 2007**
- **Hill K and Haines T 2008**

- All cast doubt on predictive validity of falls tools
- And show up the almost total lack of validated tools in community or nursing home or mental health setting
So what about case finding for bone fragility?

Used to determine 10 year fracture risk in community dwelling adults – then NOGG suggests guidance on treatment.
FRAX in a falls clinic population?

- NOGG advice (DEXA or treat) followed:
  - 46% (n=6) of those with OP at either spine and/or hip would **not be treated or advised a DEXA**
  - Of those where DEXA was advised, 72% did not have osteoporosis (n=13)
  - Treatment advised in 2 patients both of whom had osteoporosis on subsequent DEXA

**McCarthy C, Skelton DA, Gallacher S, Mitchell LE** Abstract presented at 10th National Conference on Postural Stability and Falls, Blackpool, 07/09/09
Tools to target your intervention eg.

<table>
<thead>
<tr>
<th>Category</th>
<th>Options</th>
</tr>
</thead>
<tbody>
<tr>
<td>Balance and Strength</td>
<td>Exercise (group or home) / Walking aids</td>
</tr>
<tr>
<td>Lower Urinary Tract Symptoms</td>
<td>Continence training / Surgical / Medical</td>
</tr>
<tr>
<td>Fear of Falling</td>
<td>CBT / Counselling / Exercise / Hip Protectors</td>
</tr>
<tr>
<td>Vestibular Function</td>
<td>Vestibular Rehabilitation Exercise / Surgery</td>
</tr>
<tr>
<td>Postural Hypotension</td>
<td>Pre-transfer exercise / Behavioural / Surgical stockings / Medical</td>
</tr>
<tr>
<td>Vision</td>
<td>Surgery / Glasses / OT</td>
</tr>
<tr>
<td>Foot health</td>
<td>Chiropody / Insoles / Surgery</td>
</tr>
</tbody>
</table>

......
Weaknesses in Evidence

- Falls definition
- Consensus on outcome measures
- Consensus on reporting intervention detail
- ? Fall per unit of activity – exposure to risk
- Different models of delivery?
- Cost effectiveness and utility reporting rare

- Poor fidelity at implementation (eg. 12 week exercise programme 😞)

Lamb 2005, 2008, Skelton & Todd 2004
When do we become “fallers” instead of “trippers”? 

Fracture site changes with age, *wrist* fractures more common in younger people, *hip* fractures more common in older people. 

Reaction times and gait speed slows, balance deteriorates, strength reduces.....
Functional Ability in older age

EVEN HEALTHY OLDER PEOPLE LOSE...

- Strength (1% to 2% p.a.)
- Power (3% to 4% p.a.)
- Bone density (Women: 1% to 3%, Men: 0.4% p.a.)
- Balance, Coordination and reaction
- Transfer skills
- Maintenance of temperature control
- Vision, hearing and other balance sensory inputs

Sedentary behaviour increases the loss of performance...
Exercise to Prevent Falls

Exercise *could* help fallers in a number of ways:

- Reducing Falls (or injurious falls)
- Reducing known Risk Factors for Falls
- Reducing Fractures? (or changing the site of fracture)
- Increasing Quality of Life & Social Activities
- Improving bone density
- Reducing Fear
- Reducing Long Lies
- Reducing Institutionalisation

Sherrington 2008; Skelton & Dinan 1999; NICE 2004
Wide range of abilities and needs

Figure 4: Maintaining functional capacity over the life course

Source: Kaolache and Kickbusch, 1997
Not all physical activity is safe for fallers!

- RCT Increasing physical activity in people with previous upper arm fracture
- Intervention: Brisk walking
- Control: exercise of upper arm
- Falls risk ↑ (Brisk walking > control)
- Fracture risk ↑ (Brisk walking > control)
- Beware unsafe pavements!

NICE 2004 do not recommend brisk walking!

Ebrahim et al. (1997)
Results

RR = 0.83
95%CI 0.75-0.91
P<0.001

17% reduction in falls

I² = 62% moderate heterogeneity

Sherrington et al., JAGS 2008
Highly challenging Balance Training

- Exercise in standing involving:
  - movement of the centre of mass
  - narrowing of the base of support
  - minimising upper limb support

24%
RR 0.76
(95%CI = 0.62 to 0.93)

Sherrington et al., JAGS 2008
**Individually tailored programme: Campbell, BMJ 1997**
- 80+ years, n=233, home-based, physiotherapist
- 1 year, falls ↓ 32%, injuries ↓ 39%

**Nurse delivered programme at home: Robertson, BMJ 2001**
- 75+ years, n= 240, home-based, district nurse
- 1 year, falls ↓ 46%, ↓ serious injuries and hospital costs

**Nurse programme at GP centres: Robertson, BMJ 2001**
- 80+ years, n=450, home-based, general practice nurse
- 1 year, falls ↓ 30%, injuries ↓ 28%

**Visually Impaired Older People: Campbell, BMJ 2005**
- 1 year, home-based. Only effective with full compliance, falls ↓ 28%

**6 month programme: Liu-Ambrose, JAGS 2008**
- 70+ years, home-based, cognitive function improvements after 6 months and after 1 year falls ↓ 47%
FaME Group Exercise
Managing frequent fallers

- Women aged 65+ with a history of 3 or more falls in previous year
- 9 months community based intervention
- Group exercise – individually tailored, trained exercise instructors (PSIs)
- Falls risk decreased by half – RR 0.46
- Significantly less people in exercise group had died, entered a nursing home or were in hospital after 3 years

FaME
FUNCTIONAL ABILITY & BONE

- Functional Reach 20%
- Up and go 20%
- Floor rise 50%
- Balance 60%

- Fun and social activity
- Confidence in balance
- Reduced anxiety and fear
- ‘tripping’ not ‘falling’
- Playing with grandchildren
- ‘Caring’ skills

![Graph showing % change after intervention with error bars for different body parts including L2-L4 Spine, Neck of Femur, Wards Triangle, and Greater Trochanter, with p<0.05 for certain conditions.](graph.png)
Avoiding long lies?
Long lies with or without injury

- Long lies (> 1-2 hours) lead to an increased risk of:
  - dehydration
  - hypothermia
  - pneumonia
  - pressure sores
  - kidney failure
  - depression
  - post fall syndrome
  - death

(Tinetti 1993, 1994)
High Dose

- 50+ hours
  - At least 2 hours a week of exercise for at least 6 months
  - Home or group-based or a combination of both

20%

RR 0.80
(95%CI =0.65 to 0.99)

Sherrington et al., JAGS 2008
No reduction:
RR 0.95 (0.78 to 1.16)

No reduction:
RR 0.96 (0.80 to 1.16)

No reduction:
RR 0.91 (0.79 to 1.05)

Increased risk:
RR 1.20 (1.00 to 1.44)
Reducing barriers

■ Walk from Home
■ Keighley Peer Mentors
  Mary Moffat - 93
  – Referred by physio after a fall
  – Loss of confidence and fear of falling
  – Isolated and lonely and dependent upon others to get out
Tai Chi – secondary prevention in younger years?

- Community Dwelling older people - mild deficits of strength/balance
- 2x/week for 15 weeks
- Cut trip and fall rate by half \textit{Wolf et al. (1996)}

- Frail older adults aged 70-97
- 2 x/week for 48 weeks

- Community Dwelling older people aged 70+
- 3 x/week for 24 weeks

Wider Benefits of Exercise

- **Psychological**
  - Anxiety, depression, sleep, fear of falling

- **Physiological**
  - Maintain bone density, ability to perform everyday activities, reduce breathlessness, reduce stiffness and chance of injury

- **Psychosocial**
  - Isolation, social contacts, peer support, playing with grandchildren, using the bath

- **Even the very frail**
  - DVT, constipation, transfer skills
Too frail to benefit?

**Dose response curve**

- The lower the baseline level of physical activity, the greater the health benefit associated with an increase in physical activity. Exercise can be adapted for any medical condition.  

*(Haskell 1994)*

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**Figure 1.** The dose-response curve represents the best estimate of the relationship between physical activity (dose) and health benefits (response). The lower the baseline physical activity status, the greater will be the health benefit associated with a given increase in physical activity (arrows A, B, and C).
Patients in Hospital

- 3 rehabilitation and care of the elderly wards, 626 patients, 80 yrs
- Falls risk card, exercise programme, education and hip protectors
- Intervention group had less falls, most significant >45 days


- Tai Chi + reaching + stepping + transferring chair to chair
- 1 physiotherapist to max 4 patients, 3 x p/w, 45 mins.
- 173 patients, 82 yrs, sub-acute ward
- Halved the number of falls (participant days in hospital)

Nursing Home Residents

Individually tailored GROUP exercise as part of a multifactorial intervention (staff training, environment modification, drug review etc)


Components of multifaceted interventions *in Hospitals and in Care Homes*

- Risk stratification or labelling
- Risk factor assessment (and tailored intervention)
- Medical review (inc. cardiovascular risk)
- Nursing review/care plan
- Education (staff/patients/carers)
- Exercise/Additional Physiotherapy
- Equipment/environmental change/A.T.
- Medication review/adjustment
- Restraint reduction/removal
- Hip protectors

Addressing balance in all settings

4 weeks 3 x p/w (5-20mins)

Improvements in
- Ankle Strength
- Lower limb Power
- Balance (TUSS and sway)
- Balance confidence
- Functional Reach
- Timed Up & Go

Gaps in evidence....

- Patient concordance and presentation of information
- Fear of falling and activity avoidance
- Ethnicity and Socioeconomic deprivation
- Reducing falls and injury in stroke, parkinson’s, dementia....
- Different professionals or models of delivery
- Different models of exercise (home vs group, games for health) and necessary duration / intensity / frequency and type
- Different exercise in different population groups?
- Value of falls prevention on other outcomes (quality of life, depression, other syndromes of ageing)
- Getting people to USE fall alarms
- Tele-health and technology opportunities
Perceptions of falls prevention messages

It’s good advice - for ‘them’ - only seen as relevant to ‘elderly’

*Because we’re that much fitter -- we don’t really take too much notice of it, only for other people, for other disabled or elderly people that we have to watch when we’re – we always watch older people anyway.*

(man aged 79 in sheltered accommodation)

Rejected by fit, younger people, seen as humiliating

*I wouldn’t go for that [advice] because it didn’t apply to me in any shape or form. Is there a bit of pride, is there a bit of “Well, you know, I’m not there yet”*

(fit woman in 60s)


Ballinger C, Clemson L. *B J Occ Ther* 2006
Recommendations for Promoting the Engagement of Older People in Falls Prevention Exercise

Yardley L, 2007

1. **Raise awareness** in the general population that undertaking specific physical activities has the potential to improve balance and prevent falls
2. When offering or publicising interventions, **promote benefits which fit with a positive self-identity**
3. Utilise a variety of forms of **social encouragement** to engage older people in interventions
4. Ensure the intervention is **designed to meet the needs, preferences and capabilities** of the individual
5. **Encourage self-management** rather than dependence on professionals by giving older people an active role
6. Draw on **validated methods** for promoting and assessing the processes that maintain adherence, especially in the longer-term
Concordance with interventions?

Wii-fit (Nintendo)?

- Whole Body Vibration
- 6 mths, 3 x p/w
- post-menopausal women
- Strength 15%, Balance 20%
- Hip BMD 1%

Verschueren SM et al. 2004
Practical Examples

- Review the local falls pathway
  - community acute providers
- Agree who does what? Who attends specialist clinics?
- Build falls prevention into mainstream services and intermediate care
- Commission effective exercise programmes
- Consider working with leisure services / voluntary sector
GGC Community Falls Prevention Programme

- Specialist falls service which aims to prevent further falls by providing a comprehensive falls screening, health education, exercise, rehabilitation and onward referral

- The service is available to individuals who are over 65, live at home and have had a fall in the last year

- 177 referrals a month Jan-Jun 2008, up to 221 referrals a month Jun-Dec 2008, 250 a month now

- Telephone triage completed within 24 hours of receiving referral

- Home screening completed within 5 working days of triage
In 2006 the GG&C falls and bone health strategy was launched although work towards aspects of this strategy has been ongoing since 1998.

Over a 10 yr period in GGC, there has been a 32% reduction in admissions due to falls at home and a 3.2% reduction in admissions due to hip fractures.

![Graph showing number of admissions following a fall at home over a 10 year period from 1998 to 2008.](image-url)
The role of the OTSW includes:

- Completion of a Falls Risk Screening and Data Collection Tool.
- Raising awareness of falls, consequences and prevention.
- Promotion of functional independence and safety.
- Provision of advice and support to both patients and carers.
- Guided by the Screening Tool, formulates a person centred Action Plan and seeks patient consent.
- Action Plan makes recommendation for referrals on to specialist services and also advice for the patient/carer.
The CFPP patient pathway sees an average of 250 clients/month

- Physiotherapy including exercise sessions: 20%
- Falls Clinic: 17%
- Occupational Therapy: 18%
- Pharmacy: 9%
- Pendant Alarm: 4%
- Podiatry: 4%
- COPT: 3%
- Audiology: 2%
- Continence: 1%
- Dietician: 1%
- SWOT: 1%
- Sensory Impairment: 1%
- DADS: 0%
Glasgow example

GGCNHS Falls Exercise Pathway 2007

Falls screen by healthcare staff (n=807)
With 671 being offered Physiotherapy Assessment

Physiotherapy Assessment determines those able to participate in community based exercise class (n=414)

Home exercise programme advised via locally produced booklet/DVD

PSI trained Physiotherapist NHS Community exercise classes: 12-18 weeks

Physiotherapy led Day Hospital classes or 1:1

GP exercise referral scheme for those not assessed by Physiotherapist

Vitality Classes: Community based, PSI coaches, funded by Culture and Sport Glasgow

Health Care Professional assessment

Local Authority funded classes

Evidence based health funded interventions

Evidence Based Local Authority funded class
Active Ageing Weeks...

- To provide a national and local profile to celebrate and promote the concept of Active Ageing.
- To provide support for local Active Ageing programmes.
- To stimulate debate and policy on Active Ageing.
- To provide a national and local programme of Active Ageing events and promotions.
- To ensure that older people are included in activities designed to leave a health and physical activity legacy.

WANT TO GET INVOLVED: email bob.laventure@ntlworld.com
Olympage Games – Sheffield 2009

- 20 Teams competing
- 6 events
- Teams of 6 – 8 (participants + carers)
- Unruly supporters in team kit!
- Medals, certificates and prizes
- Lots of cheating as well!
Other ideas for AA Weeks

- Walking your local area, be a guide or share your knowledge
- Open days to gyms, community centres with sessions etc.....
- Activity breaks in Libraries
Glasgow SECC Aug 13-17th 2012

www.wcaa2012.com

dawn.skelton@gcal.ac.uk