FALLS IN THE ELDERLY

Falls clinics no panacea

Dr Jed Rowe set up the UK's first falls clinic long before the older people's national service framework. But he argues that, despite its success, it is not the best model of preventive care

Hospital-based clinics may be best focused on older people who fall through syncope or complex dizziness

Research into falls in older people has happened in four distinct phases.

Sheldon's classic paper in the *BMJ* in 1960 ended the first descriptive phase. Epidemiological studies then delineated risk factors and broad interventions based on these did reduce falls.

Since then, the efficacy of single interventions on targeted patient groups has been explored to discover which is most effective.

Nearly 20 years ago, when a definitive set of risk factors was available, my unit in Liverpool attempted to integrate them into clinical practice. In spite of a facilitator running an intensive education programme and putting check-lists in case records, we never managed to get a satisfactory response. Consequently, the first 'well-balanced clinic' or 'falls clinic' was established.

This demanded a reorganisation of the conventional order of examination, because the assessments were longer and more arduous than the frail individuals attending could tolerate.

By the time the national service framework (NSF) for older people came out in 2001, we had three clinics in south Birmingham and most of the techniques and interventions used had been validated elsewhere.

While the NSF promoted interventions in falls and certainly raised awareness, some clearly felt the easiest response was a reflex referral to a falls clinic.

Unfortunately, this approach is doomed. Around 15,000 older people will fall annually in a district general hospital catchment area. While the weekly falls clinic might try to see four people in a session – of whom one will not turn up because they have fallen, died, been admitted or for some other reason – the A&E department will have seen more than 100.

So hospital-based falls clinics should probably be concentrating on those in whom syncope or complex dizziness might be an issue.

Clear evidence

While this may seem a derogation of duty, the evidence is clear that this is the correct approach. In trials in Otago, New Zealand, men and woman aged 75 and over were recruited from age/sex registers and randomised to receive an exercise and balance training programme or general health promotion.

There was a 30 to 50 per cent reduction in falls lasting for two years through physiotherapy and subsequently by community nurses who received some simple training. The programme is not difficult to introduce (*see weblink below*).

However, the programme does ask patients to buy one-kilogram ankle weights and stay committed to the training, which escalates in intensity as new targets are achieved.

More recently, evidence from Australia and the UK also demonstrates that after the individual assessment, the exercise can be delivered in a group setting. The health economics have been published and the trials took place in a health system that is directly analogous to the NHS.

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The Royal College of Nursing calendar last year proclaimed the effect of nurses on reducing falls, so this surely cannot be seen as esoteric practice anymore.

One of the challenges will be to enthuse practice nurses in one of the best-validated public health interventions. Perhaps the ineffective or unassessed aspects of the over-75s check should be replaced with exercise and balance training.

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ref BMJ 2001; 322: 697 & 701
web www.acc.co.nz/injury-prevention/growing-and-living-safely/older-adults/preventing-falls/otago-exercise-programme

Striking the right balance with old people

Patients want exercise and balance training as much as doctors, says **Prof Lucy Yardley**

Falls contribute to over half of hospital admissions for accidental injury, and risk of falling is a major cause of distress and loss of independence in older people. Consequently, falls prevention is a key public health priority in the national service framework for older people.

Systematic reviews have established that simple interventions – especially training in home-based exercises to improve strength and balance – can reduce the risk of falling.

But there is evidence many older people do not take up these measures. In studies of community interventions, up to 90 per cent of those invited declined the offer to take part.

We carried out focus groups and interviews with 66 older people to find out how they viewed advice about falls prevention. We discovered that older people interpreted falls prevention as consisting of hazard reduction, principally by restricting their lifestyle in ways they found unacceptable.

Potentially patronising

For example, they said they objected to things such as wearing different clothing, rearranging their home, and avoiding 'risky' activities. Advice about hazard reduction was typically viewed as common sense, and therefore potentially patronising and only suitable for the extremely old and frail. Some people said that worrying about falling all the time would make life intolerable.

> **'Advice needs to be tailored to the situation and capabilities of the individual, and may be targeted for reasons of cost-effectiveness at those most at risk'**

We then carried out a questionnaire survey of 715 older people to find out what characteristics were associated with acceptance of an offer of instructions on how to do exercises to improve balance.

People who wanted to do the exercises believed that:

- They were suitable for someone like themselves;
- Other people thought they should do them;
- They would be enjoyable and improve functioning and confidence;
- They would do them no harm and they would be able to do them.

Surprisingly, intention to do the exercises was not influenced by a higher risk of falling – due to unsteadiness or illness – or by a greater fear of falling, or beliefs about the causes of falling.

The key implications of this research for improving uptake of falls prevention advice are that older people are:

- Generally unaware of the potential for preventing falls by means of exercises to improve strength and balance, but when this information was provided, it was well received;
- More motivated to engage in exercises to improve balance for their broad positive benefits (such as improved balance, health, mobility, strength, confidence and enjoyment) than because of risk or fear of falling;
- Therefore more likely to act on advice that emphasises the potential to prevent falls by positive action – improving balance – rather than by the much less desirable method of restricting activity or changing lifestyle.

Perhaps simply renaming 'falls prevention services' as 'balance improvement services' will improve uptake. Advice needs to be tailored to the situation and capabilities of the individual, and may be targeted for reasons of cost-effectiveness at those most at risk.

But it should not be presented to patients as necessary because of age or infirmity as no one thinks of themselves as so old and frail that they need advice.

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web www.helptheaged.org.uk/Health/HealthyAgeing/Falls/_practitioners.htm