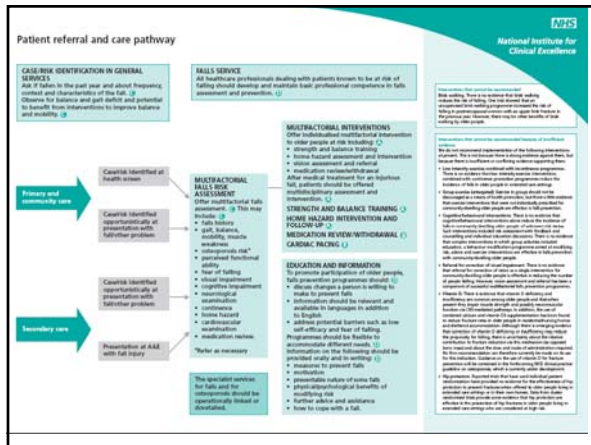


Falls Clinics; the Physician's perspective

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"Multifactorial assessment and targeted intervention for preventing falls... systematic review and meta-analysis"

S. Gates et al, Br Med J 2008; 336: 130-3

EDITORIAL

Multifactorial Fall-Prevention Strategies: Time to Retreat or Advance

The articles by Hendriks et al.¹ and Elley et al.² in the current issue of the *Journal of the American Geriatrics Society* (JAGS) share several features. Both manuscripts describe well-conducted clinical trials of attempts to implement multifactorial fall-prevention strategies in real-world settings. Hendriks et al.¹ studied older adults seen in articles published in 2007 alone. About half of the clinical trials involved investigation of single interventions and half involved multifactorial or multicomponent interventions. The primary outcome was falling in many of the studies, although proximate outcomes such as strength, balance, and confidence were common as well. Few studies had had

Tinetti M. J Am Geriatr Soc 2008; 56: 1563-65

Effectiveness of Falls Clinics: An Evaluation of Outcomes and Client Adherence to Recommended Interventions

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OBJECTIVES: To evaluate outcomes associated with falls clinic programs.
DESIGN: Longitudinal.
SETTING: Thirteen outpatient falls clinics in Victoria, Australia.
PARTICIPANTS: Four hundred fifty-four people referred for clinic assessment (mean age ± standard deviation 77.9 ± 8.8; 73% female).
INTERVENTION: After assessment, multifactorial interventions were organized to address identified risk factors.

falls clinic management. *J Am Geriatr Soc* 56:600-608, 2008.

Key words: falls; injury; risk factor; elderly; assessment; intervention

Research evidence indicates that multifactorial interven-

J Am Geriatr Soc 2008; 56: 600-8

- 13 Falls Clinics (Hospital & Health Centres)
- 73% female, 63% multiple falls, 10% fractures
- Referrals >50% from GPs re Falls, gait problems, dizzy
- Compared Falls data & Secondary outcomes after 6 mos
- Falls Clinic Minimum Data Set (FC MDS)

J Am Geriatr Soc 2008; 56: 600-8

Recommended interventions; 5.7 +/- 2.3 per client

Home modifications	50%	Footwear change	19%
Home exercise programs	47%	Footcare	17%
D Hosp /Community therapy	41%	Hip protectors	17%
Home modifications	34%	Vision check	16%
Medical tests/care plans	30%	Medication reduction	16%
Group exercise	25%	Behavioural/safety advice	15%
Gait aid change	25%	Others	10%

J Am Geriatr Soc 2008; 56: 600-8

Table 4. Falls and Injurious Falls at Initial and Follow-Up Assessments (n = 254*)

	Falls	6-Month Pre Initial Clinic Assessment	6-Month Post Initial Clinic Assessment	P-Value
Clients falling, n (%)	199 (77.6)	92 (37.6)	.00	
Fallers falling more than once, n (%)	142 (71.7)	53 (57.6)	.004	
Clients having injurious falls, n (%)	123 (61.3)	55 (22.9)	.00	
Clients seeking medical attention after a fall, n (%)	69 (33.1)	29 (12.0)	.00	
Number of falls				
Mean ± standard deviation	3.45 ± 7.6	1.27 ± 4.9	.00	
Median (range)	2 (0-100)	0 (0-70)	.00	

* A small number of the 254 clients had missing data on one or more variables at the initial or 6-month assessment, resulting in fewer than 254 comparisons for some analyses.

J Am Geriatr Soc 2008; 56: 600-8

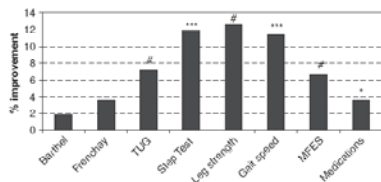


Figure 1. Percentage improvement on secondary measures of the Minimum Data Set. Barthel Index, Timed Up and Go (TUG), leg strength, and Modified Falls Efficacy Scale (MFES) data positively skewed, pre-post analysis using Mann-Whitney U-test (# $P < .006$, significant after Bonferroni adjustment; * Paired t-test, $P < .06$ (nonsignificant after Bonferroni adjustment). *** Paired t-test, $P < .006$ (significant after Bonferroni adjustment).

J Am Geriatr Soc 2008; 56: 600-8

The Winchester Falls project

- Cluster randomised controlled trial,
- 505 community fallers not seen in ED
- Falls follow-up over 12 months

- Control 'Usual care' 84%
- Nurse-led falls prevention 87%
- Day hospital MDT assessment 75%

CL Spice et al; *Age Ageing* 2009; 38: 33-40

“Attitudes of GPs to falls clinic services”

- Questionnaire survey
- Positive response regarding medical management
- Uncertainty whether clinic had actually reduced falls

No financial incentive for GPs in the NHS

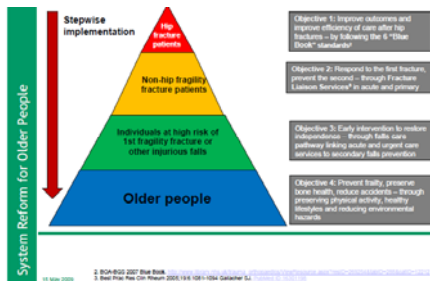
C. Beer, Austr Family Physn 2006; 35(12): 2006

Barriers to Falls prevention clinics

- Administration
Paperwork, dull
long questions, repetition
- Time
Waiting time for appointment
Dependence on clinic timetable
Time investment too big
Having to leave the home
- Communication
Patients felt criticised
- Attitudes
Professionals deciding what
is good for the patient
- Lack of motivation/energy
- Falls seen as accidents related
to ageing rather than preventable
- Costs
Lack of alternative therapy
at home, accessing clinics etc

Evron et al, J Public Health 2009; 37: 728-35

Dept. of Health Commissioning toolkit 2009



Personal perspective on Falls clinics

- Falls clinics address frailty & functional decline
- The CGA including medical component is associated with improved outcome
- Giddiness, Syncope, Bone health, OA joints etc can be addressed
- Clinics should aim to provide treatment rather than referral
- Suitable for select cases
- Falls services need to be well organised and supported.
- Several negative outcome trials exist including nurse-led and those in community.
- DOH toolkit 2009 is an NHS priority and incorporates falls work