



FALLS LINKS

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2009

WELCOME

This issue of Falls Links features:

- A report on the seminar presented by A/ Prof Claire Robertson at the George Institute of International Health. Copies of this presentation will be available on a CD. Send an e-mail to e.vance@powmri.edu.au to obtain your copy.
- Report from the Area Health Services on the Physical Activity Grant 2009 Initiatives commencing on page 3.
- The Focus report in this issue looks at Incorporating Psychological Factors in falls risk assessment by Professor Kaarin Anstey and Amy Dawel from the Ageing Research Unit, Australian National University and it commences on page 8.

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Physical Activity Grant 2009



Greater Southern Area Health Service Physical Activity leaders training weekend workshop participants

Otago Exercise Program: effectiveness, cost effectiveness and widespread implementation

**A/Prof Clare Robertson, Dunedin School of Medicine,
University of Otago, New Zealand**

A/Prof Clare Robertson presented at the George Institute for International Health on Tuesday 6th October. Her presentation focused on the research basis for the National Falls Prevention Program in New Zealand as well as cost effective falls prevention strategies for the different health care settings. Clare also spoke about the rollout of Otago Exercise Program (OEP) and Tai Chi by the Accident Compensation Corporation (ACC), a national no fault insurance scheme that covers all New Zealanders and visitors to New Zealand.



In New Zealand 27% of total inpatient costs are related to falls injuries. Clare reported on reviews of both single and multifactorial interventions for community falls prevention and the findings indicated that single factor interventions were equally as effective as multifactorial interventions.

The OEP is a progressive program of home based exercises prescribed by a physiotherapist but can be delivered by other trained health professionals such as nurses. This is a program of 5 home visits over a 6 month period starting at weeks 1, 2,4,8 and a boost visit at 6 months. There are also monthly phone calls from the providers over the 12 month period and participants are assessed prior to commencing the program and at 6 and 12 months. The program, requires a commitment to do the prescribed exercises for 30-minutes 3 times weekly and includes walking twice a week if safe for participants. Adherence to the program varies but after 12 months, 80% of participants are still doing some exercise. Eligibility for the program is community dwelling older people ≥ 80 years who had experienced a fall in the previous year.

The rollout of the OEP is being supported by the ACC and the program is available free of charge to all NZ health professionals and web based training is available for physiotherapists. A number of trials have shown the effectiveness of this program not only in NZ but also in Canada. There is no cost to participants to take part in the OEP program.

The other exercise program supported by the ACC is Tai Chi. There has been good evidence of Tai Chi's effectiveness in reducing falls in community dwelling older people. Tai Chi classes are subsidised and participants pay \$3 per class to attend. Classes are 2 x 45-60 minute sessions per week for 20 weeks. Tai Chi is offered to community dwelling people ≥ 65 years, who had a fall in the previous year.

These exercise programs are delivered by a number of organisations that were successful in a tender process with 50 OEP contracts and 40 Tai Chi contracts nationwide and over 12,000 participants ≥ 65 years taking part in the 2 programs during 2008/09 .

Clare also spoke on the importance of economic evaluation of intervention studies and that very few studies include this. This information is vital for funding of interventions by health services. The OEP costs NZ\$549 per client to deliver but leads to a reduction in falls of 40-61% and a cost saving of NZ\$1803 per fall prevented. The Tai Chi program costs NZ\$303 per client to run with a falls reduction of 13%.

Other strategies that are receiving funding include Vitamin D supplementation for residents in Residential Aged Care Facilities (RACF) and an exercise trial in an RACF in Auckland.

The ACC site with information on the OEP and other falls prevention initiatives is at:

<http://www.acc.co.nz/preventing-injuries/injury-prevention-strategies/PI00132>

Physical Activity Grant 2009

Centre for Health Advancement, NSW Department of Health

The Centre for Health Advancement allocated a small funding grant to assist Area Health Services to implement physical activity initiatives to support falls prevention amongst community-dwelling older adults. A summary of the Physical Activities projects conducted by each Area Health Service is included below.

Northern Sydney Central Coast (NSCCH)

1. Increase home based physical activity opportunities for less active, community dwelling older people in the NSCCH area.

- Distribution of a DVD package (Staying Active, Staying Safe) to GPs with strict criteria for which patients could receive the package.
- Distribution of a DVD package (Staying Active, Staying Safe) to community service providers with training provided by Sally Castell, Health Promotion and developer of the DVD material.

A reply evaluation was included in the package and a follow up questionnaire is being administered to GPs and service providers.

2. To enhance existing Tai Chi classes in the NSCCH area to increase the opportunities for participation in community based physical activity programs.

- Advertising of Tai Chi classes encouraged potential clients to phone in for an information package, which included free class passes.

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South Eastern Sydney Illawarra Area Health Service

BEST at home

The BEST (Balance Exercise Strength Training) at home project is based on the exercises used in the Otago Exercise Program. The project involves participants attending an introductory workshop where they are given a resource pack, which includes an exercise manual, pedometer, Heartmoves DVD, ankle weight, calendar and book. The participants are also given instruction on how to perform the balance and strength exercises by a physiotherapist and undergo basic functional testing of balance and strength.

Participants record their exercise participation and any falls that may occur on a calendar provided as part of the project. The calendar is returned at the end of each month.

At the end of twelve weeks, participants are asked to return to a second workshop where they will receive further exercise instruction to ensure participants are completing the exercises correctly and progressions to make the exercises more challenging (if required). Participants will also repeat the same measures of balance and strength.

The program will run for 24 weeks and at the end of the program participants will be asked to complete an evaluation questionnaire, to determine project satisfaction, acceptability and compliance.

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North Coast Area Health Service

This grant was obtained by CHEGS inc (Community Health Education Groups). They currently provide about 40 physical activity classes per week in over 15 centres on the North Coast. In many towns, it is the only formal physical activity available. CHEGS inc. undertook to:

1. Extend the network of Fitness Leaders in NCAHS: Progress to date: Currently there are three people undertaking their Certificate III in Fitness, with another two identified to commence before the end of 2009.
2. Facilitate both introductory and follow-up Tai Chi training: Progress to date: Tai Chi for Arthritis Master trainer Elva Arthy will be running a two-day workshop on 7th and 8th November at Coraki. Ten participants are registered to attend this training.

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Sydney South West Area Health Service

The modified Otago exercise program: A pilot study investigating the effects of an Otago exercise program with group based classes on falls in people aged 75 years or older at risk of falling.

The Otago program has been shown to be highly effective in reducing the risk of falling in older people with falls risk factors. It consists of an individualised exercise plan developed according to an individual's falls risk factors, delivered and monitored by a trained Otago leader in a person's home. Current strategies for recruiting people into community based physical activity programs cannot screen participants for falls risk, nor can they take into account an individual's falls risk factors.

The study will develop a group based gentle exercise program based on the Otago program. By working in conjunction with the Central Sydney GP Network and local GPs, this project will pilot a model where people aged 75 years and over will be screened by their GP for falls risk and subsequently referred to the modified Otago program, delivered by the project coordinator.

Rather than have extra home visits by the Otago leader, participants will be asked to attend the group based Otago exercise sessions at week 2, 4 and 8 of the project. This will increase compliance to the program, as group based physical activity classes add a social element which engages and motivates older people to continue exercising and also allow monitoring of participant's progress through their exercise plan. This project will assess the effect of the modified Otago program on falls, balance, strength and confidence in avoiding falls. A process evaluation will also be conducted on all aspects of this study with a view to developing a model for implementing on a wider scale.

The project officer is located at the Central Sydney GP Network and they have incorporated the QuickScreen© into their over 75's Health Check checklist, and organised continuing education points for GPs based on falls prevention (medication reviews and QuickScreen©).

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Sydney West Area Health Service

The *Fit & Strong – 65 & Beyond Challenge*, run by Sydney West Area Health Service (SWAHS), was developed as a means of promoting four key healthy lifestyles messages to older people. The messages centre around promoting behaviours that will result in building stronger bones and muscles and preventing falls and fall related injuries. The key messages are:

- be more active
- do strength and balance exercises every day
- get enough calcium everyday
- get enough sunlight to reduce vitamin D deficiency

The Challenge was developed to increase the reach and uptake of falls prevention messages amongst the community in SWAHS. The Challenge employed a basic social marketing approach. Recent research (Todd, 2008) suggests that this approach, when promoting falls prevention messages, enables engagement of a larger sample of the target population, lower cost per person intervention, maximum population benefit, and high population cover.

Two challenges have been run, a pilot in 2008 and one in 2009. The two Challenges attracted over 1,000 participants from local communities. The Challenge has also engaged a number of key partner organisations in each of the Local Government Areas within SWAHS boundaries and promotes the prevention of falls in a variety of settings. The 2009 Challenge was supported by celebrity and Ambassador for Ageing, Ms Noeline Brown.

A participant survey conducted at the completion of the 2009 Challenge showed that 90 percent of participants are more aware of the four key healthy lifestyle messages, have a better knowledge of how to participate in the four key activities, and plan on continuing the key activities in the future. A three month follow up survey is currently being conducted with results available shortly.

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Greater Western Area Health Service

The aims of the program were:

1. To increase the number of trained Tai Chi leaders in Greater Western AHS communities.
2. To provide professional development and re-accreditation, in physical activity falls prevention programs, to existing Physical Activity (PA) leaders in Greater Western AHS communities.
3. To increase the resources available to PA Leaders, for use in physical activity falls prevention programs, in Greater Western AHS communities.

Strategies implemented so far:

- Provision of workforce development – training, re-accreditation and networking of Tai Chi Leaders. Support for two trainers to become Master Tai Chi Trainers with Paul Lam. Professional development and working through regular PA Network Meetings and mandatory First Aid Training for volunteers who are PA leaders. Access was made easier by holding Network meetings in communities across the Area or by supporting leaders attendance at training with travel and accommodation assistance.
- Provision of resources for programs that focus on physical activity for falls prevention to PA leaders by resourcing leaders with timed music, Staying Active Staying Strong resources as a home-based program, equipment to run Stepping On Programs (manuals, weights and DVD) and First Aid kits for groups held in community venues. To ensure ongoing access and safe storage the resources are being held in PA Network

By training and supporting the physical activity leaders we aimed to provide access to physical activity groups in more communities including remote and aboriginal at an affordable cost. Many older people attend these groups.

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Greater Southern Area Health Service

Support for existing falls prevention physical activity initiatives for older adults living in the community. The project aimed to:

- 1) provide Tai Chi for Arthritis update and level 2 training to existing leaders across GSAHS,
- 2) implement the Senior Trainer Model as a support mechanism for leaders in GSAHS,
- 3) provide level 1 Tai Chi for Arthritis training for new leaders to expand the reach of the program and
- 4) support Physical Activity Leader Network meetings.

To date, we have delivered on three of the four proposed activities, deferring the Senior Trainer Model due to logistical difficulties. Two Tai Chi Training weekends were completed (July and September) where 41 existing leaders received update or level 2 training, and a further 52 leaders were trained in level 1 training. Many of these new leaders were targeted from disadvantaged communities and from communities with higher falls rates and have already commenced running of classes in areas not serviced by the network previously.

As of September 2009, approximately 95 Tai Chi classes and 30 Community Exercise classes are being run across 46 communities within GSAHS. Over the past 18 months, our participation rates in classes have been relatively maintained (despite a temporary drop in leader numbers). The greatest number of regular participants are from the 65-74 year old group (448), followed by the 75< group (396), then 55-64 year old group, and a lesser number of people 55>, and were predominantly women.

In April, we ran a very successful network meeting in Wagga with 28 leaders attending. These leaders were treated to some well-deserved recognition from the Ambassador for Healthy Ageing, Noeline Brown, and the opportunity to hone skills in either Tai Chi or Gentle exercise leadership.

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Ms Noeline Brown, Ambassador for Ageing; Brendan Pearson, Health Development Program Coordinator (Physical Activity), Andrew Goh, Director, Health Promotion; Lorraine Dubois, Acting Area Falls Co-ordinator

Hunter New England Area Health Service (HNEAHS)

In order to build the capacity of fitness providers to offer appropriate fall preventive exercise programs for people aged over 50, HNE Population Health have implemented a range of strategies including: fitness leader training; leader mentoring (fitness and business skills); development of supporting resources to assist leaders to start-up new classes; and strengthening of professional and referral networks.

In the Hunter, where trained fitness leaders were already offering classes, strategies focused on working with Active Over 50 (AO50) and up-skilling leaders. Key training strategies are; the inclusion of fall prevention exercise content into the existing AO50's 2-day accreditation course (14 Continuing Education Credits (CECs)) and the development of 'Action Balance for Seniors' top-up training 3 hour course (3 CECs).

In 2008, HNE Population Health subsidised the training of 21 fitness leaders from the Hunter and Lower Mid North Coast as accredited AO50 providers. Course participants were provided with mentoring and support to assist them to set up new AO50 classes in areas of identified need.

In 2009, 21 AO50 accredited leaders completed an 'Action Balance and marketing of classes' training session. All participants were provided with equipment start up kits (including balls and therabands) to encourage them to incorporate more balance and strength exercises in their classes and a "Marketing Guide" for starting up and sustaining classes.

In New England, where there are a limited number of trained fitness leaders, strategies focused on ensuring modules specific to training older adults were made available in the Certificate III and IV in Fitness training courses provided by New England Institute of TAFE (Armidale). The 'Move it or lose it: teaching exercise to older persons' program includes: balance and strength exercise content; fitness skill mentorship by TAFE teacher; local work experience classes; and business mentorship by a business development specialist. Program costs have been subsidised by HNE Population Health and TAFE NSW. The first program commenced in Semester 2 2009 and will target potential leaders from identified high need areas across New England.

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Weekend Training workshop for fitness leaders in HNEAHS

FEATURE FOCUS REPORT

INCORPORATING PSYCHOLOGICAL FACTORS IN FALLS RISK ASSESSMENT

Professor Kaarin J Anstey & Amy Dawel, Ageing Research Unit, Centre for Mental Health Research, The Australian National University

Recent evidence indicates psychological factors, including well-being and cognitive function, are significant independent predictors of falling. Here we summarise relevant psychological factors identified by our research using data from the Australian Longitudinal Study of Ageing (ALSA) and the Prevention of Older Persons' Injury (POPI) study, and make some suggestions about how they can be incorporated in falls risk screening.

FINDINGS FROM THE AUSTRALIAN LONGITUDINAL STUDY OF AGEING (ALSA)

This study involved a baseline sample of 2,087 individuals aged 70 years and over. Data was collected in six waves over an 8-year period from 1992 to 2000. Our research drew on those waves which included clinical assessments (Waves 1, 3 & 6, spanning the full 8-year study period). We examined measures of psychological wellbeing and cognitive function as predictors of falls in community-dwelling individuals without cognitive impairment. Falls information was available for 787 participants at Wave 6 and thus our research focused on these individuals.

WELL-BEING

Three aspects of psychological well-being were assessed – depression, morale and expectancy of control – using the Centre for Epidemiologic Studies Depression Scale (CES-D), the Philadelphia Geriatric Centre Morale Scale, and the Expectancy of Control subscale from the Desired Control Measure (DCM) respectively. The outcome variable was self-reported falls in the past year.

Statistical analyses controlled for demographic variables (gender, age and education), health (self-rated health, medical conditions, psychotropic medication, and tobacco and alcohol use), sensorimotor function (visual acuity, grip strength and balance) and cognitive function (Mini-Mental State Examination; MMSE).

We use multilevel models to estimate whether wellbeing predicted falling longitudinally, after adjusting for covariates. Our results showed that each of the three well-being measures independently predicted fall rates, even when all other variables were controlled for. Specifically, higher depression and lower morale and control at Wave 1 were associated with an increased rate of falling during follow-up. Individuals who showed an increase in depressive symptoms and decreases in morale over the course of the study also had increasing fall rates over the follow-up period. Levels of perceived control did not change significantly during the study. Overall these findings show that psychological wellbeing predicts falling independent of physical function and other sensorimotor risk factors.

COGNITIVE FUNCTION

Measures of cognitive function that were evaluated as predictors of falls included: The included the Mini-Mental State Examination (a test of general cognition that is used to screen for dementia); National Adult Reading Test (NART; a test of premorbid intellectual function); Similarities (verbal reasoning questions); Digit Symbol Substitution (a measure of processing speed); and measures of immediate memory.

Statistical analyses controlled for demographic variables, health and sensorimotor function (as for the well-being analyses). We found that initial cognitive performance and cognitive decline over the 8-years of follow-up both predicted falling. Importantly, cognitive decline was found to be more useful in predicting falls risk than initial cognitive performance. The implications of these findings are that longitudinal assessment of healthy older adults may be more useful than one-off assessments to identify those who are increasingly at risk of falling.

Risk of falling during the course of the study was best predicted by declines in NART scores, processing speed, and immediate memory. MMSE performance had some predictive value for the full sample but it no longer predicted fall rates when participants scoring below the cut-off for probable dementia (i.e., score < 24) were excluded, indicating MMSE performance is not a useful predictor of fall rates for individuals with clinically intact cognitive functioning.

FINDINGS FROM THE PREVENTION OF OLDER PERSONS' INJURY STUDY (POPI)

In another study, conducted at the Prince of Wales Medical Research Institute and the Queensland University of Technology, we investigated neuropsychological and mental health predictors of self-reported retrospective falls. We found that higher levels of depressive symptoms were associated with greater fall rates. When the sample was

divided into non-fallers, those who fell once in 12 months, and those who fell multiple times in 12 months, we found some interesting patterns. The multiple fallers performed worse than non-fallers on all cognitive measures but the single fallers showed only very subtle differences that were only picked up because we used experimental laboratory-based tasks. Specifically, we found that single fallers had a poorer capacity to inhibit irrelevant stimuli, which is an aspect of executive function. They did not have slower reaction times or worse balance. Hence we concluded that very subtle neuropsychological changes in later life may predispose individuals to falling, even when those individuals have no cognitive impairment.

INCORPORATING PSYCHOLOGICAL FACTORS IN FALLS RISK ASSESSMENT

Our research suggests that psychological measures do contribute independently to explaining the risk of falling. Thus there is potential to enhance falls assessment by incorporating brief psychological measures at initial screening and in ongoing assessments to detect cognitive decline.

The research we have done to date, however, does not evaluate implementation of psychological measures in screening batteries. Rather it only suggests that risk assessment would be improved by incorporating psychological measures. Therefore we still need to evaluate how much improvement in falls risk assessment is achieved by adding these measures. This research needs to be done to quantify to properly address how psychological evaluation improves falls prevention strategies. There are two areas where psychological measure are important – initial assessment and ongoing assessment.

Initial assessment.

Initial falls risk assessment may benefit from including measures of depression such as a short form of the Centre for Epidemiological Studies Depression Scale (CES-D) or the Geriatric Depression scale. It is possible this information is obtained in other assessments so that health professionals may need to identify ways of integrating information from different sources. Brief cognitive screening measures, such as a digit-symbol coding test or dot-to-dot test (Trails A & B), will also indicate if there is a deficit in processing speed that might increase falls risk. Clinically significant depression is treatable in older adults with both medication and talking therapies, and hence treating depression may also reduce falls risk (although psychotropic medication may increase falls risk).

Ongoing assessment.

Ideally, GPs or other health professionals would assess older adults regularly on a number of key health indicators (e.g., blood pressure, cholesterol, iron levels, etc.) including falls risk factors. Whilst regular health checks for older adults are not yet available in Australia (except in private practice) they are in some other countries. This practice would allow for better monitoring and detection of early changes that may indicate an underlying health problem (e.g., increasing blood pressure, increasing depressive symptoms, declining cognition, declining vision, etc.) which in turn would allow for prevention strategies to be implemented routinely.

CONCLUSION

We conclude that psychological factors need to be considered as independent risk factors for falling and hence falls risk assessment may be improved by including measures of depression and cognitive function.

For further details of our research, please see the following publications:

- Anstey, K. J., von Sanden, C., & Luszcz, M. A. (2006). An eight-year prospective study of the relationship between cognitive performance and falling in very old adults. *Journal of the American Geriatrics Society*, 54, 1169-1176. doi:10.1111/j.1532-5415.2006.00813.x
- Anstey, K. J., Burns, R., von Sanden, C., & Luszcz, M. A. (2008). Psychological well-being is an independent predictor of falling in an 8-year follow-up of older adults. *The Journals of Gerontology*, 63, 249-257.
- Anstey, K. J., Wood, J., Kerr, G., Caldwell, H., & Lord, S.R. (2009). Different cognitive profiles for single compared to recurrent fallers without dementia. *Neuropsychology*, 23, 500-508.

RECENT ABSTRACTS FROM THE RESEARCH LITERATURE

REVIEWS

Fall prevention with supplemental and active forms of vitamin D: a meta-analysis of randomised controlled trials.

Bischoff-Ferrari HA, Dawson-Hughes B, Staehelin HB, Orav JE, Stuck AE, Theiler R, Wong JB, Egli A, Kiel DP, Henschkowski J.

Br Med J BMJ 2009; 339: b3692.

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DOI: [10.1136/bmj.b3692](https://doi.org/10.1136/bmj.b3692) (Copyright © 2009, BMJ Publishing Group)

ABSTRACT

OBJECTIVE: To test the efficacy of supplemental vitamin D and active forms of vitamin D with or without calcium in preventing falls among older individuals.

DATA SOURCES: We searched Medline, the Cochrane central register of controlled trials, BIOSIS, and Embase up to August 2008 for relevant articles. Further studies were identified by consulting clinical experts, bibliographies, and abstracts. We contacted authors for additional data when necessary. Review methods Only double blind randomised controlled trials of older individuals (mean age 65 years or older) receiving a defined oral dose of supplemental vitamin D (vitamin D(3) (cholecalciferol) or vitamin D(2) (ergocalciferol)) or an active form of vitamin D (1alpha-hydroxyvitamin D(3) (1alpha-hydroxycalciferol) or 1,25-dihydroxyvitamin D(3) (1,25-dihydroxycholecalciferol) and with sufficiently specified fall assessment were considered for inclusion.

RESULTS: Eight randomised controlled trials (n=2426) of supplemental vitamin D met our inclusion criteria. Heterogeneity among trials was observed for dose of vitamin D (700-1000 IU/day v 200-600 IU/day; P=0.02) and achieved 25-hydroxyvitamin D(3) concentration (25(OH)D concentration: <60 nmol/l v >or=60 nmol/l; P=0.005). High dose supplemental vitamin D reduced fall risk by 19% (pooled relative risk (RR) 0.81, 95% CI 0.71 to 0.92; n=1921 from seven trials), whereas achieved serum 25(OH)D concentrations of 60 nmol/l or more resulted in a 23% fall reduction (pooled RR 0.77, 95% CI 0.65 to 0.90). Falls were not notably reduced by low dose supplemental vitamin D (pooled RR 1.10, 95% CI 0.89 to 1.35; n=505 from two trials) or by achieved serum 25-hydroxyvitamin D concentrations of less than 60 nmol/l (pooled RR 1.35, 95% CI 0.98 to 1.84). Two randomised controlled trials (n=624) of active forms of vitamin D met our inclusion criteria. Active forms of vitamin D reduced fall risk by 22% (pooled RR 0.78, 95% CI 0.64 to 0.94).

CONCLUSIONS: Supplemental vitamin D in a dose of 700-1000 IU a day reduced the risk of falling among older individuals by 19% and to a similar degree as active forms of vitamin D. Doses of supplemental vitamin D of less than 700 IU or serum 25-hydroxyvitamin D concentrations of less than 60 nmol/l may not reduce the risk of falling among older individuals.

EPIDEMIOLOGY AND RISK FACTORS FOR FALLS

Comparison of balance assessment modalities in emergency department elders: a pilot cross-sectional observational study.

Caterino JM, Karaman R, Arora V, Martin JL, Hiestand BC.

BMC Emerg Med 2009; 9(1): 19. DOI: [10.1186/1471-227X-9-19](https://doi.org/10.1186/1471-227X-9-19) (Copyright © 2009, BioMed Central)

ABSTRACT

BACKGROUND: More than one-third of US adults 65 and over fall every year. These falls may cause serious injury including substantial long-term morbidity (due declines in activities of daily living) and death. The emergency department (ED) visit represents an opportunity for identifying high risk elders and potentially instituting falls-related interventions. The unique characteristic of the ED environment and patient population necessitate that risk-assessment modalities be validated in this specific setting. In order to better identify elders at risk of falls, we examined the relationship between patient-provided history of falling and two testing modalities (a balance plate system and the timed up-and-go [TUG] test) in elder emergency department (ED) patients.

METHODS: We conducted a cross-sectional observational study of patients greater than or equal to 60 years old being discharged from the ED. Patient history of falls in the past week, month, 6 months, and year was obtained. Balance plate center of pressure excursion (COP) measurements and TUG testing times were recorded. COP was recorded under four conditions: normal stability eyes open (NSEO) and closed (NSEC), and perturbed stability eyes open and closed. Correlation between TUG and COP scores was measured. Univariate logistic regression was used to identify the relationship between patient-provided falls history and the two testing modalities. Proportions, likelihood ratios, and receiver-operating-characteristic (ROC) curves for prediction of previous falls were reported.

RESULTS: Fifty-three subjects were enrolled, 11% had fallen in the previous week and 42% in the previous year. There was no correlation between TUG and any balance plate measurements. In logistic regression, neither testing modality was associated with prior history of falls (p>0.05 for all time periods). Balance plate NSEO and NSEC test-

ing cutoffs could be identified which were 83% sensitive and had a negative likelihood ratio (LR-) of 0.3 for falls in the past week. TUG testing was not useful for falls in the past week, but performed best for more distant falls in the past month, 6 months, or year. TUG cutoffs with sensitivity over 80% and LR(-) of 0.17-0.32 could be identified for these time periods.

CONCLUSIONS: Over 40% of community-dwelling elder ED patients report a fall within the past year. Balance plate and TUG testing were feasibly conducted in an ED setting. There is no relationship between scores on balance plate and TUG testing in these patients. In regression analysis, neither modality was significantly associated with patient provided history of falls. These modalities should not be adopted for screening purposes in elders in the ED setting without validation in future studies or as part of multi-factorial risk assessment.

Elderly patient's mortality and morbidity following trochanteric fracture. A hundred cases prospective study.

Mnif H, Koubaa M, Zrig M, Trabelsi R, Abid A.

Orthop Traumatol Surg Res 2009; ePub(ePub): ePub.

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DOI: [10.1016/j.otsr.2009.08.001](https://doi.org/10.1016/j.otsr.2009.08.001)

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ABSTRACT

BACKGROUND: Trochanteric fractures are a major source of mortality, morbidity and functional impairment in the elderly. Morbidity is closely related to the degree of instability and comminution and is substantially influenced by the quality of reduction and internal fixation. Advanced age and associated co-morbidities are two decisive factors of mortality secondary to trochanteric fracture.

OBJECTIVES: This prospective study examined the epidemiological profile of trochanteric fractures and assessed mortality and morbidity with the aim of establishing management guidelines and improving prevention strategies.

MATERIAL AND METHODS: One hundred patients were included; 60% were male. Mean age was 76 years (range, 60-96 yrs). One, or more than one, co-morbidities were present in 68% of cases. The fractures were caused by a simple fall in 90% of cases. Fractures were classified according to the criteria of Ramadier and the ones of Ender. Sixty-five percent of these fractures were unstable. A dynamic hip screw was systematically used as the standard means of internal fixation.

RESULTS: Anatomic and functional results were analyzed in 82 patients (18 had died within the first year following fracture occurrence). Mean follow-up period was 24 months (range, 12-36 months). Bone healing was achieved in 96% of cases. There were numerous postoperative complications (four cases of thromboembolism, fourteen immobility-related complications, two infections, six secondary displacement combined to loss of fixation, four non-unions, and nine malunions). At 2 years follow-up, 28 patients had died. Mortality was strongly correlated with older age (over 90 years), associated co-morbidity and fracture instability. Good functional outcomes (72%) correlated with younger age (60-74 years), fracture stability, adequate reduction and internal fixation.

DISCUSSION: In stable trochanteric fractures, osteosynthesis by dynamic screw-plate is more effective than alternative techniques (blade-plate, nail-plate, Ender nail or even trochanteric nail). In unstable trochanteric fractures, delayed weight-bearing should be preferred to avoid mechanical complications. In fractures that are unstable or extend far below the lesser trochanter, trochanteric nailing is indicated since providing enhanced stability, but sometimes at the cost of insufficient reduction. The treatment objective should be the complete resumption of weight-bearing as early as possible with the fewest possible complications. Prevention consists in detecting and treating osteoporosis and countering the causes of falls in elderly subjects (muscular reinforcement and correction of neurosensory deficit).

Histories including number of falls may improve risk prediction for certain non-vertebral fractures in older men.

Faulkner KA, Chan BK, Cauley JA, Marshall LM, Ensrud KE, Stefanick ML, Orwoll ES.

Inj Prev 2009; 15(5): 307-11.

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DOI: [10.1136/ip.2009.021915](https://doi.org/10.1136/ip.2009.021915) (Copyright © 2009, BMJ Publishing Group)

ABSTRACT

OBJECTIVE: To determine whether information on number of falls on a falls history screen predicts risk of non-vertebral and hip fracture.

METHODS: A cohort of 5995 community-dwelling men aged 65 years and older (mean 73.7) was followed over 7.2 years for incident non-vertebral fractures. Cox proportional hazard models were used to calculate hazard ratios (HRs) (95% CI) for incident fracture comparing a history of one and two or more falls with no falls. Models were adjusted for age, clinic, body mass index, height, femoral neck bone mineral density and whether the participant had a non-trauma fracture after the age of 50.

Baseline indicators for measuring progress in preventing falls injury in older people.

Dowling AM, Finch CF.

Aust N Z J Public Health 2009; 33(5): 413-7.

Affiliation: NSW Injury Risk Management Research Centre, University of New South Wales.

DOI: [10.1111/j.1753-6405.2009.00421.x](https://doi.org/10.1111/j.1753-6405.2009.00421.x) (Copyright © 2009, John Wiley and Sons)

ABSTRACT

OBJECTIVE: Over recent years, there has been increasing attention given to preventing falls and falls injury in older people through policy and other initiatives. This paper presents a baseline set of fall injury outcome indicators against which these preventive efforts can be assessed in terms of monitoring the rate of fall-related deaths and hospitalisations.

METHODS: ICD-10-AM coded hospital separations, Australian Bureau of Statistics (ABS) mortality and ABS population data were used to determine the rate of fall-related injury mortality and hospitalisations occurring in people aged 65+ years in New South Wales (NSW), Australia, over the six-year period from 1998/99 to 2003/04, inclusive.

RESULTS: Baseline trends for one fatality and five separations-based metrics are presented. Overall, fall mortality rates increased over the six years, with higher rates in males. Falls hospitalisation rates also increased slightly, with higher rates in females. The rates of hip fracture and pelvic fracture hospital separations generally declined over the six years and were highest in females. The level of unspecified and missing information about the place where falls occur increased by 1.5%.

CONCLUSION: Baseline trends in fall injury outcome metrics highlight the severity and frequency of fall injuries before wide scale implementation of the Management Policy to Reduce Fall Injury Among Older People in NSW.

IMPLICATIONS: Future use of these metrics will help to evaluate and monitor the progress of falls prevention in older people in NSW. They could also be adopted in other jurisdictions.

Central nervous system medication changes and falls in nursing home residents.

Sorock GS, Quigley PA, Rutledge MK, Taylor J, Luo X, Foulis P, Wang MC, Varadhan R, Bellantoni M, Baker SP.

Geriatr Nurs 2009; 30(5): 334-40

DOI: [10.1016/j.gerinurse.2009.07.001](https://doi.org/10.1016/j.gerinurse.2009.07.001) (Copyright © 2009, Elsevier Publishing)

ABSTRACT

We investigated the role of changes in 6 mutually exclusive medication categories on the risk of falling in nursing home residents. The 6 categories were: gastrointestinal, hypoglycemics, antibiotics, central nervous system (CNS) acting, cardiovascular disease agents, and analgesics. A change was defined as a new start, a dose change, an as-needed dose, or a discontinuation. Incident reports were used to determine the fall date and time. Medication records were abstracted to identify the date of changes before the date of each fall. The 158 residents who fell had 419 recorded falls during 2002 and 2003; they were on average 80.5 years old (SD 8.1; range 65-103), and 67% were men. Within 1-3 days of a change in any CNS medication (antipsychotic, sedative, antidepressant, or antiseizure), the fall risk (odds ratio) increased 3.4-fold (95% confidence interval 1.2-9.5) using 7-9 days prior as comparable control days. No changes in other medication categories had a significant effect on fall risk. These data suggest that the risk of falls among nursing home residents is significantly elevated within 3 days of a CNS medication change.

Falls among community-residing stroke survivors following inpatient rehabilitation: a descriptive analysis of longitudinal data.

Wagner LM, Phillips VL, Hunsaker AE, Fordeucey PG.

BMC Geriatr 2009; 9(1): 46. DOI: [10.1186/1471-2318-9-46](https://doi.org/10.1186/1471-2318-9-46) (Copyright © 2009, BioMed Central)

ABSTRACT

BACKGROUND: Stroke victims are at relatively high risk for injurious falls. The purpose of this study was to document longitudinal fall patterns following inpatient rehabilitation for first-time stroke survivors.

METHODS: Participants (n=231) were recruited at the end of their rehab stay and interviewed monthly via telephone for 1 to 32 months regarding fall incidents. Analyses were conducted on: total reports of falls by month over

time for first-time and repeat fallers; the incidence of falling in any given month; and factors differing between fallers and non fallers.

RESULTS: The largest percentage of participants (14%) reported falling in the first month post-discharge. After month five, less than 10% of the sample reported falling, bar months 15 (10.4%) and 23 (13.2%). From months one to nine, the percentage of those reporting one fall with and without a prior fall were similar. After month nine, those reporting a single fall with a fall history was twice as high compared to those ,without a prior fall, who reported falling. In both cases the percentages were small. A very small subset of the population emerged who fell multiple times each month; most of whom had a prior fall history. At least a third of the sample reported a loss of balance each month. Few factors differed significantly between fallers and non-fallers in months one to six.

CONCLUSIONS: Longitudinal data suggest that falls most likely linked to first time strokes occur in the first six months post discharge, particularly month one. Data routinely available at discharge does not distinguish fallers from non-fallers. Once a fall incident has occurred, however, preventive intervention is warranted.

BIOMECHANICS OF FALLING

Balance control in patients with distal versus proximal muscle weakness.

Horlings CG, Küng UM, van Engelen BG, Voermans NC, Hengstman GJ, van der Kooij AJ, Bloem BR, Allum JH.

Neuroscience 2009; ePub(ePub): ePub.

Affiliation: Radboud University Nijmegen Medical Centre, Donders Institute for Brain, Cognition and Behaviour, Dept. of Neurology, the Netherlands; Dept. of ORL, University Hospital Basel, Switzerland.

DOI: [10.1016/j.neuroscience.2009.09.063](https://doi.org/10.1016/j.neuroscience.2009.09.063) (Copyright © 2009, Elsevier Publishing)

ABSTRACT

Muscle weakness is consistently associated with falls in the elderly, typically when present along with other risk factors. However, it remains unknown whether and how muscle weakness alone affects balance. This hampers development of more effective fall prevention strategies. Clinical observations suggest that the amount and distribution of muscle weakness influences balance control. We therefore investigated balance corrections in patients with either predominantly proximal (limb girdle muscular dystrophy; n=8) or distal (distal spinal muscular atrophy; n=5) leg weakness, and 27 matched healthy controls. Balance was perturbed using surface tilt rotations that were delivered randomly in eight directions. Balance measures were full body kinematics and surface electromyographic activity (EMG) of leg, arm, and trunk muscles. Both patient groups were more unstable than controls, as reflected by greater excursions of the centre of mass (COM), especially in the pitch (anterior-posterior) plane. COM displacements were greater in distal weakness patients. Patients with distal weakness had excessive and unstable trunk, knee and ankle movements, and this was present following both forward and backward directed balance perturbations, possibly reflecting the greater use of distal leg muscles in these directions. In contrast, the less weak proximal weakness patients demonstrated unstable trunk and ankle movements only for backward directed balance perturbations. Both patient groups used arm movements to compensate for their instability. We conclude that primarily distal but also proximal muscle weakness leads to significant postural instability. This observation, together with the retained ability of patients to use compensatory arm movements, provides targets that may be amenable to improvement with therapeutic intervention.

Gait Variability Detects Women in Early Postmenopause With Low Bone Mineral Density.

Palombaro KM, Hack LM, Mangione KK, Barr AE, Newton RA, Magri F, Speziale T.

Phys Ther 2009; ePub(ePub): ePub.

Affiliation: Institute for Physical Therapy Education, Widener University, One University Pl, Chester, PA 19013 (USA). DOI: [10.2522/ptj.20080401](https://doi.org/10.2522/ptj.20080401)

(Copyright © 2009, American Physical Therapy Association)

ABSTRACT

Background: Women in early postmenopause and with low bone mineral density (BMD) may exhibit early markers for physical frailty as a result of sarcopenia and osteopenia.

Objective: The purpose of this study was to determine whether women in early postmenopause and with low BMD exhibit decreased physical performance and differences in gait variability and fall and fracture rates.

Design: This study was an observational cohort design with participants assigned to groups on the basis of BMD status.

METHODS: Fifty-four women, 31 with low BMD and 23 with normal BMD, participated. This study was conducted in a university research facility. Physical performance was measured by assessment of dynamic balance (timed backward tandem walk test), strength (handheld dynamometry of isometric quadriceps muscle force pro-

duction), and free gait speed. Gait variability was assessed on the basis of the coefficient of variation for temporal-spatial gait characteristics. Falls and fractures were assessed for the year after initial testing.

RESULTS: Significant between-group differences were found for step time and stance time variability. Limitations The limitations of this study included group assignment on the basis of the results of the most recent bone density scan within the preceding 2 years.

CONCLUSIONS: Women in early postmenopause and with low BMD exhibited increased gait variability in step time and stance time but did not exhibit differences in balance, strength, or gait speed. Gait variability may be more sensitive for detecting differences in women in early postmenopause and with or without low BMD than more typical measures of physical performance.

FEAR OF FALLING

Effects of a Multicomponent Cognitive Behavioral Group Intervention on Fear of Falling and Activity Avoidance in Community-Dwelling Older Adults: Results of a Randomized Controlled Trial.

Zijlstra GA, van Haastregt JC, Ambergen T, van Rossum E, van Eijk JT, Tennstedt SL, Kempen GJ.

J Am Geriatr Soc 2009; ePub(ePub): ePub.

Affiliation: Department of Health Care and Nursing Science, Faculty of Health, Medicine and Life Sciences, CAPHRI-School for Public Health and Primary Care, Maastricht University, Maastricht, the Netherlands.

DOI: [10.1111/j.1532-5415.2009.02489.x](https://doi.org/10.1111/j.1532-5415.2009.02489.x) (Copyright © 2009, John Wiley and Sons)

ABSTRACT

OBJECTIVES: To evaluate the effects of a multicomponent cognitive behavioral intervention on fear of falling and activity avoidance in older adults.

DESIGN: Randomized controlled trial.

SETTING: Community-dwelling adults in the Netherlands. **PARTICIPANTS:** Five hundred forty adults aged 70 and older who reported fear of falling and fear-induced activity avoidance (280 intervention, 260 control).

INTERVENTION: A multicomponent cognitive behavioral group intervention consisting of eight weekly sessions and a booster session. The sessions were aimed at instilling adaptive and realistic views on falls, reducing fall risk, and increasing activity and safe behavior.

MEASUREMENTS: Data on fear of falling, activity avoidance, concerns about falling, perceived control over falling, and daily activity were collected at baseline and at 2, 8, and 14 months.

RESULTS: At 2 months, there were significant between-group differences in fear of falling (odds ratio (OR)=0.11; $P<.001$), activity avoidance (OR=0.26; $P<.001$), concerns about falling (adjusted mean difference=-1.51; $P=.02$), and daily activity (adjusted mean difference=0.95; $P=.01$). At 8 months, there were significant between-group differences in all outcomes and at 14 months in fear of falling ($P=.001$), perceived control over falling ($P=.001$), and recurrent fallers ($P=.02$) but not in activity avoidance ($P=.07$), concerns about falling ($P=.07$), daily activity ($P=.24$), or fallers ($P=.08$).

CONCLUSION: This multicomponent cognitive behavioral intervention showed positive and durable effects on fear of falling and associated activity avoidance in community-dwelling older adults. Future research should focus on improving intervention uptake and adherence, reaching frailer populations, and determining potential intervention effects on functional outcomes.

Validation of the Falls Efficacy Scale and Falls Efficacy Scale International in Geriatric Patients with and without Cognitive Impairment: Results of Self-Report and Interview-Based Questionnaires.

Hauer K, Yardley L, Beyer N, Kempen G, Dias N, Campbell M, Becker C, Todd C.

Gerontology. 2009 Sep 2. Epub ahead of print. Copyright 2009 S. Karger AG, Basel.

ABSTRACT

Background: Frail, old patients with and without cognitive impairment are at high risk of falls and associated medical and psychosocial issues. The lack of adequate, validated instruments has partly hindered research in this field. So far no questionnaire documenting fall-related self-efficacy/fear of falling has been validated for older persons with cognitive impairment or for different administration methods such as self-report or interview.

Objective: To validate the self-report and interview version of the Falls Efficacy Scale (FES) and the Falls Efficacy Scale International Version (FES-I) in frail geriatric patients with and without cognitive impairment.

Methods: 156 geriatric patients in geriatric rehabilitations wards with (n = 75) and without cognitive impairment (n = 81) were included in this study. Reports of fall-related self-efficacy were based on self-reported and interview-based questionnaires. Descriptive statistics, reliability estimates and validation results were computed for the total group and sub-samples with respect to cognitive status, for the 2 different questionnaires (FES/FES-I) and for the 2 administration methods. Test-retest reliability was tested in a subsample of 62 patients.

Results: Internal reliability and test-retest reliability were good to excellent in both the FES and FES-I, with the FES-I showing better internal reliability and the FES better test-retest reliability with respect to cognitively impaired persons. The group of cognitively impaired persons tended to show lower test-retest reliability and mean fall-related self-efficacy and had significantly lower completion rates in self-administered questionnaires. As indicated by significant differences in parameters closely related to falls, such as vertigo, functional performances, fear of falling and history of falls, both the FES and the FES-I showed good construct validity. Effect sizes computed for the above-mentioned groups for fall-related parameters confirmed the results of construct validation.

Conclusion: Both the FES as well as the FES-I showed good to excellent measurement properties in persons with and without moderate cognitive impairment. In frail older persons, especially in persons with cognitive impairment, an interview-based administration method is recommended.

INTERVENTION STUDIES

Pilot study of a fall risk management program for middle aged and older adults with MS.

Finlayson M, Peterson EW, Cho C.

NeuroRehabilitation 2009; 25(2): 107-15.

Affiliation: Department of Occupational Therapy, University of Illinois at Chicago, Chicago, IL, USA.

DOI: 10.3233/NRE-2009-0505 (Copyright © 2009, IOS Press)

ABSTRACT

Objective: To present the outcomes of a pilot study of "Safe at Home BAASE", a fall risk management program designed for middle-aged and older adults with multiple sclerosis.

Methods: Thirty people with multiple sclerosis (mean age=56.7 +/- 7.4) started the manualized program that was delivered by an occupational therapist over six-two hour sessions. A pre/post intervention design with a set of 6 outcome tools was used to evaluate the extent to which the program increased knowledge of fall risk factors, increased knowledge and skills to manage falls and falls risk, and promoted changes in behavior to reduce personal fall risk.

Results: Significant improvements were observed across all tools for participants attending 5:6 program sessions as well as participants attending 4 sessions, although some instruments exhibited poor internal consistency in this sample. Participants reported knowledge gains and using new fall prevention and management strategies after attending the program.

Conclusion: "Safe at Home BAASE" appears to have potential to foster changes in knowledge, skills and behavior associated with reduced personal fall risk. Practice implications: Findings suggest that additional research is needed on fall-related assessment tools for this population before a large scale controlled investigation of the intervention can be pursued.

Web-site-based tailored advice to promote strength and balance training: an experimental evaluation.

Nyman S; Yardley L.

J Aging Phys Act 2009; 17(2):210-22.

ABSTRACT

This study evaluated a Web site providing tailored advice to encourage older people to undertake strength and balance training (SBT). Adults age 60-88 (N = 302) were randomized to read either generic advice or advice tailored to their self-perceived balance problems and activity preferences. Between-groups differences in attitudes toward SBT after reading the advice did not quite reach significance (p = .059), but the tailored group reported higher ratings than the generic group that the advice was personally relevant (p = .017) and that the activities would be good for them (p = .047). Within-groups differences in the tailored group showed that completing an action plan increased confidence in undertaking SBT (p = .006). These findings were supported by a meta-analysis that pooled the effect sizes with those of a previous study. Thus, a tailored Web site might be a cost-effective way of encouraging some older people to undertake SBT.

Bedrail use in English and Welsh hospitals.

Healey FM, Cronberg A, Oliver D.

J Am Geriatr Soc. 2009;57(10) :1887-91.

ABSTRACT

OBJECTIVES: To explore rates of bedrail use, nurses rationale, and factors related to bedrail use. **DESIGN:** An overnight observational study of patient and equipment characteristics related to bedrail use, analyzed using a logistic regression model.

SETTING: A stratified random sample of seven organizations, drawn from 167 organizations providing acute general hospital care in England and Wales during 2006. **PARTICIPANTS:** One thousand ninety-two inpatients on adult inpatient wards observed at night. **MEASUREMENTS:** Categorical data on bedrail use related to bed type, mattress type, patient age, nurses' description of patients mobility and confusion, and nurses rationale for bedrail use or non-use.

RESULTS: Approximately one-quarter of patients had full bedrails raised at night; prevention of falls was the nurses main rationale. Full bedrail use was much more likely to occur in patients who nurses described as immobile and very or slightly confused. Older patients appeared no more likely to be given bedrails than younger patients after adjusting for individual patient and equipment factors.

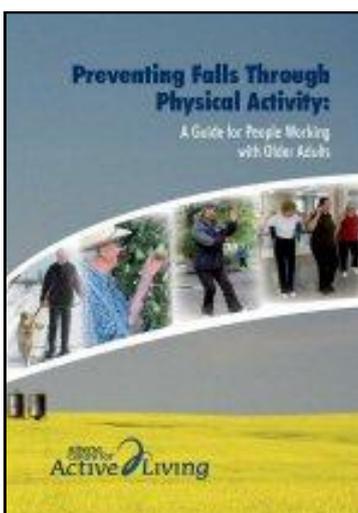
CONCLUSION: Bedrail use varied significantly between organizations and could not be explained by differences in nurses description of patients mobility and confusion levels, equipment, or policy

WEBSITES

<http://www.medicaleducation.co.uk/free.html>

A free on line course on Falls Prevention from the UK for staff of Residential Aged Care Facilities, this course would be suitable for AIN and Personal Care Assistants.

Developed by Kiss of Life Multimedia with BUPA. Preventing Falls in the Care Home - A thirty-minute course This is a Free Course for healthcare assistants and nursing auxiliaries (NVQ Level 2 and 3). In half an hour you can learn WHY older people are at high risk of falling when living in care homes and what YOU can do to prevent these accidents. Although designed for use in care homes this short course is also suitable for training staff working in hospitals and the community.



Preventing Falls Through Physical Activity: A guide for People working with Older Adults

This guide was developed by the Alberta Centre for Active Living in Canada and is specifically designed for activity leaders in rural communities.

This guide is for people who are helping older adults to be active. If you are interested in using physical activity to help older adults to stay independent and lower their risk of falling, this guide is for you.

The guide can be accessed at :

<http://www.centre4activeliving.ca/older-adults/rural/guides/index.html>



[www.powmri.edu.au/
fallsnetwork](http://www.powmri.edu.au/fallsnetwork)

NSW FALLS PREVENTION NETWORK BACKGROUND

The NSW Falls Prevention Network has existed since 1993. The role of this network has grown since its inception and now includes:

- Meetings for discussion of falls related issues;
- Dissemination of research findings both local and international;
- Sharing resources developed and exploration of opportunities to combine resources in joint initiatives;
- Encouragement of collaborative projects and research;
- To act as a group to influence policy;
- To liaise with NSW Health to provide information on current State/Commonwealth issues in relation to falls and
- Maintenance of resources pertinent to the field

The main purpose of the network is to share knowledge, expertise, and resources on falls injury prevention for older people.

The NSW Falls Prevention Network activities are part of the implementation of the NSW Falls Prevention Policy funded by the NSW Department of Health

NETWORK INFORMATION

JOINING THE NETWORK

To join the NSW Falls Prevention Network listserv :

- Send an email to : majordomo@lists.health.nsw.gov.au
- In the body of the message type **subscribe nsw-falls-network** on the next line type **end**
- Do not put anything in the subject line
- You will receive an e-mail to confirm you have been added to the listserv

To unsubscribe from the listserv:

- send an e-mail to the above address and in the body of the message write **unsubscribe nsw-falls-network** on the next line type **end**

If you have any problems contact Esther at e.vance@powmri.edu.au.

SHARE YOUR NEWS AND INFORMATION/IDEAS ON FALLS PREVENTION

Do you have any news on Falls Prevention you want to share with others on the network, or do you want to report on a project that is happening in your area.

Please email Esther with your information. We also welcome suggestions for articles and information you would like to see in this newsletter.

Send your information to e.vance@powmri.edu.au

THE NETWORK LISTSERV

It is great to see the increased activity on the listserv and want to continue to promote this. To send an item to the listserv where all members of the network can see it, send an email to: nsw-falls-network@lists.health.nsw.gov.au

You need to be a subscriber to the listserv to send an email that will be distributed to all members of the on the listserv. Remember to put a short description in the subject line.

Recently some posts to the listserv have bounced due to email address changes in the area health services, you need to re-subscribe with your new e-mail address and unsubscribe from your old address following the Join the Network instructions as