THE PROGNOSIS OF RECURRENT FALLS IN THE ELDERLY LIVING AT HOME

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Introduction
Reduction in falls is a target in Health of the Nation, yet its natural history is poorly understood. This study examines the relation of falls to other areas of disability, to mortality and admission to care.

Method
The Gloucestershire Longitudinal Study of Disability was a 3 year prospective survey of 1815 persons over 75 who underwent health checks in Primary Care using a validated instrument called the Elderly At Risk Rating Scale. The data on falls came from a single question asking the number of falls in the preceding 3 months.

Results
The prevalence of any recent fall was 12%, with more than 1 fall in 42%. This was unrelated to age, but falling was more common in women than men (13.6% vs 9%, p=0.03). Cluster analysis found falls were most closely related to confusion and sadness. Transition from non-faller to faller occurred in 11% per annum, while 70% of fallers did not report falls the following year. Falling was thus inconsistent year on year, unlike other areas of disability. Mortality in the year after the interview was consistently greater in fallers by about twofold (16.4% if 1 fall vs 8.5% if no falls); fallers had a fourfold greater risk of admission to care (9.7% >1 fall vs 1.4% no falls).

Conclusion
Falling greatly increases the risk of admission to care in the following year, but falling is highly changeable over time.

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<th>Relative Risk</th>
<th>No falls</th>
<th>One fall</th>
<th>&gt;1 fall</th>
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<tbody>
<tr>
<td>Of death</td>
<td>1.0</td>
<td>0.9</td>
<td>1.3</td>
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<tr>
<td></td>
<td>2.4</td>
<td>1.5</td>
<td>2.2</td>
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<tr>
<td>Of NH/RH</td>
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<td>3.2</td>
<td>2.8</td>
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<td></td>
<td>2.4</td>
<td>3.9</td>
<td>8.3</td>
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ASSESSING THE VALUE OF FALLS RISK FACTOR CHECKLISTS IN A GERIATRIC ASSESSMENT UNIT

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Introduction: Multiple-risk factor intervention has been shown to reduce recurrent falls in the elderly but it is likely that many falls risk factors are not addressed in routine clinical practice. The aim of this study was to assess whether the use of risk factor checklists improves documentation of falls risk factors and diagnosis of causes of falls.

Methods: Multidisciplinary checklists were introduced to identify falls risk factors in those admitted with a fall to a Geriatric Assessment Unit. Audit of documented risk factors was performed on 50 sets of notes before and after checklist introduction.

Results: Case ascertainment was 100% in both groups for the medical notes, 80% and 82% for the physiotherapy notes and 90% and 96% for the occupational therapy (OT) notes. Use of the medical checklist resulted in significant improvement in documentation of postural blood pressure from 22 (44%) to 37 (77%), (p=0.002), visual acuity from 22 (44%) to 35 (70%), (p=0.015); lower limb joint examination from 12 (24%) to 24 (48%), (p=0.02); and Abbreviated Mental Test from 38 (76%) to 46 (94%), (p=0.03). The physiotherapy checklist improved documentation of balance from 13 (32%) to 25 (61%), (p=0.02), there was non-significant improvement in documentation of footwear and lower limb strength. The OT checklist improved documentation of house access from 26 (58%) to 43 (90%), (p=0.001); assessment of furniture hazards from 12 (27%) to 38 (79%), (p=0.00001); and presence of alarm systems from 25 (56%) to 44 (92%), (p=0.0002). Other home visits were performed in the post-checklist group 28 (58%) compared with 3 (7%) in the pre-checklist group, although they were considered unnecessary in 40 (95%) of the pre-checklist group. The number of patients with an identified cause for falls in the general practitioner (GP) discharge summary improved from 39 to 49.

Conclusions: Simple checklists improved documentation of risk factors causing falls, however, in many areas further improvements are still necessary. More causes of falls were identified to the GP.

DETERMINANTS OF PATIENT MOOD AND CARER STRAIN DURING COMMUNITY STROKE REHABILITATION

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Introduction
Although early hospital discharge of patients with new stroke for rehabilitation in the community may theoretically improve mood, supporting severely disabled patients at home may cause caregiver strain. This study assessed anxiety and depression, and caregiver strain, in 69 patients discharged early from hospital for community rehabilitation.

Methods
Patient mood was assessed using the Hospital Anxiety and Depression Scale. Carer strain was assessed using the Relatives Stress Scale. Patient disability was measured using the Barthel Index.

Results
Patient Barthel Indices were 13.7±4.8 (mean (SD)) and 17.7±3.4 (p<0.001), anxiety scores 10.8±4.4 and 8.0±3.5 (p<0.001), and depression scores 10.6±3.9 and 9.8±3.6 (p=NS) before and after community rehabilitation. Carer (n=42(61%)) Stress scores were 32.4±10.1 and 26.6±9.0 (p<0.02) respectively. Anxiety scores on starting rehabilitation correlated negatively with age (r=-0.40 (p<0.01)) but not Barthel Index (r=-0.11(p=NS)). Depression scores correlated negatively with Barthel Index on starting (r=-0.42 (p<0.02)) and completing rehabilitation (r=-0.37(p<0.01)). Initially, carer strain was related to patient depression (r=0.65 (p<0.001)) and Barthel Index (r=-0.58(p<0.001)) but not anxiety (r=0.22 (p=NS)). Absolute falls in Carer Strain Scores during rehabilitation correlated with increases in patient Barthel Indices (r=-0.72 (p<0.001).

Conclusions
Following discharge, carer strain and patient depression were related to disability. Carer strain and patient anxiety, but not depression, improved during community rehabilitation. Improvements in patient disability were strongly associated with reductions in carer strain.