The role of health professionals in promoting the uptake of fall prevention interventions: a qualitative study of older people’s views

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Abstract

Background: uptake of and adherence to fall prevention interventions is often poor and we know little about older people’s perceptions of and beliefs about fall prevention interventions and how these affect uptake.

Objective: to explore older people’s perceptions of the facilitators and barriers to participation in fall prevention interventions in the UK.

Methods: we undertook a qualitative study with older people who had taken part in or declined to participate in fall prevention interventions using semi-structured interviews (n = 65), and 17 focus groups (n = 122) with older people (including 32 Asian and 30 Chinese older people). This took place in community settings in four geographical areas of the South of England. The mean age of participants was 75 years (range 60–95). Data analysis used a constant comparative method.

Results: older people reported that health professionals and their response to reported falls played a major role in referral to and uptake of interventions, both facilitating and hindering uptake. Health professionals frequently failed to refer people to fall prevention interventions following reports of falls and fall-related injuries.

Conclusions: consideration should be given to inclusion of opportunistic and routine questioning of older people about recent falls by practitioners in primary care settings. Referrals should be made to appropriate services and interventions for those who have experienced a fall to prevent further injuries or fracture.

Keywords: falls, health professionals, ethnic groups, gatekeepers, older people, elderly
Introduction

The prevention and management of falls in older people has become a key public health priority in many Westernised countries [1–3]. Multi-factorial risk assessment and individually tailored home-based exercises have been found to be effective in preventing falls [4–6]. However, uptake of interventions currently averages only 50% [7] and can be as low as 10% [8]. To increase uptake, we need to understand and address the facilitators and barriers to participation in interventions. However, there is little empirical work that has explored older people’s perceptions of interventions.

A systematic review found a number of factors that promoted participation in fall prevention interventions. These included social support and interaction, low-intensity exercise, involvement in decision-making and perception of the programme as positive and life enhancing. Barriers included denial, fatalism, low self-efficacy, past exercise history, fear of falling, stigma and embarrassment. The views of older people from ethnic minority groups were poorly understood and information on patients’ views, compliance with and acceptability of fall prevention programmes was frequently lacking from trials and reviews [9].

The UK National Institute for Health and Clinical Excellence (NICE) [10] makes it clear that health professionals (HPs) have an important role in fall prevention. However, our review found mixed views on the role of HPs. Although some studies identified HPs, in particular physicians, as important in making referrals to fall services [11–14], one study [15] found that HPs were not perceived to be a credible source of advice on exercise. HPs and patients may not share the same agendas and perspectives about falls [16] and professionals need to take into account older people’s views and their need to negotiate their own risk-taking behaviour [17, 18, 19].

The aim of this study was to identify barriers and facilitators to uptake and participation in a variety of fall prevention interventions, including knowledge of services, with a range of older people, including people from two specific ethnic groups (Asian and Chinese). This paper will focus on findings relating to the roles played by HPs in the prevention and management of falls.

Methods

Design

This exploratory qualitative study comprised 17 focus groups (FGs), facilitated by two researchers, lasting about an hour, which were audio-taped, with older people (n = 122) attending (or who had previously attended) fall prevention interventions. Older people were recruited for FGs from a wide range of existing group interventions aimed at fall prevention. As participants were familiar with each other, they appeared comfortable sharing their experiences. Interviews (n = 65) were undertaken with those unable/unwilling to attend a FG and those who had not attended or had withdrawn from an intervention, in order to explore reasons for non-participation.

The large number of FGs and interviews enabled us to include a wide variety of interventions that older people were participating in. Although interviews and FGs generate different types of data, interviews were included as it was felt that those who had declined to participate in an intervention were unlikely to agree to take part in a FG.

Participants were recruited via letter (sent from the intervention co-ordinator) or personal invitation through researchers attending interventions. Academic staff on the study team undertook data collection, and were introduced to participants as researchers. Topic guides were developed in consultation with the study steering group and incorporated issues raised by the systematic review [9]. Participants provided demographic data and completed the Falls Efficacy Scale (FES) (indicates confidence in undertaking activities of daily living without falling) [20].

Setting and participants

Recruitment covered four geographical areas in the South of England. A total of 187 older people including 30 Chinese and 32 Asian older people were purposively sampled. The mean age of participants was 75 years (range 60–95). Participants had experienced at least one of a broad range of interventions (including falls clinics, postural stability classes, T’ai Chi classes and exercise classes).

Analysis

Data analysis was qualitative, using a constant comparative approach drawing on the grounded theory method [21]. Audiotapes were fully transcribed and anonymised. The analysis involved reading field notes and transcripts and listening to interviews in order to gain a ‘general sense’ of the data. Following this, data were coded, themes identified and categories developed. Data were coded independently by at least two researchers, and then rigorously scrutinised by the research team. Data from Asian and Chinese older people were translated and transcribed by the bilingual researchers and analysed separately initially before being compared with the rest of the data. Any disagreements were resolved through discussion. Lay members of the steering group were also involved in the process of analysis, following training by the research team.

Results

Table 1 summarises the socio-demographic characteristics of participants.

This paper focuses on the findings relating to one of the major categories emerging from the data that of healthcare professionals and their role as either facilitators or barriers to the participation of older people in fall prevention.

Health professionals: promoting fall prevention?
interventions. Within these data, two major themes were identified; ‘telling a health professional’ and ‘health professional response’. Additional quotes that represent and illustrate the themes described below have been set out in Boxes 1 and 2. Older people readily engaged with discussions about fall experiences with the researchers and each other with similar experiences discussed in both FGs and interviews, though they acknowledged that falls were not something they generally discussed.

**Telling a health professional**

Participants explained that a major hurdle was their reluctance to tell HPs that they had experienced a fall. In line with other work in this area, many of the falls experienced were unreported. A sample of data from the interviews and FGs relating to this theme is discussed below and presented in Box 1.

Reasons given for non-reporting to HPs included beliefs that falls were not medical and therefore there was ‘no point telling the doctor’. Respondent 1 (Quote 1) expressed amazement that professionals would be interested. Other people did not think that falls were serious enough to ‘bother the doctor about’. For respondent 2 (Quote 2), there is clearly a level of symptom severity that had to be reached before he considered something serious enough to present to his doctor, and falls were deemed too trivial. Others felt that their doctor was ‘too busy’ to be bothered about their fall experiences; and many seemed concerned about not being ‘a burden’ to health services.

Sometimes people explained that they had reported their fall after consulting a HP for another reason. For example, respondent 4 explained how she had told her GP about a

### Box 1. Theme: telling a health professional

- **Feel health professionals not interested/not relevant**
  
  (1) I’m surprised that they would be interested to talk about falls. That’s not something medical, is it? I’ve never imagine it’s a medical condition. (Interview Chinese Male, attended T’ai Chi class)

  (2) No. You know … my GP, he don’t take notice. You just don’t do it! I don’t know why, you know; it looks as though going to a doctor and saying ‘I fell over’, you feel a bit of a wimp … You know so you don’t do it. There’s a lot of things when you get old, you don’t do just because you think you’re going to look a bit of an idiot. (Focus Group Male, had not attended an intervention)

  (3) You think they’ve got more time to do other things rather than worrying about you with a bit of a fall or smaller ailments, well what we consider a smaller ailment. (Focus Group Male, had not attended an intervention)

- **Telling after attendance for another reason**

  (4) … landed on my face but no damage. I mean I have been terribly lucky and I think it was sort of soon after that that I was seeing the Doctor for this prescription update so I told him and he said ‘oh I think you’d benefit if you went to the Falls Group’ so that was how it happened. (Interview 10 Female Attended Falls Clinic and Balance Group)

  (5) … because I’d broken my glasses but in any case I was due for a routine eye check so I’d gone to S (the optician) then and it was then really that she said ‘well I think you ought to have a complete MOT’ as she called it from the doctor … So I went to the doctor then and he discovered I’ve got high blood pressure … I wouldn’t have gone to the doctors otherwise. (Interview 36 Female Attended Optician after falling and breaking spectacles)
Health professionals: promoting fall prevention?

Box 2. Theme: health professional response

- Health professional: navigating and facilitating access to interventions
  (6) I was told about the falls clinic by a friend of (falls specialist nurse) in actual fact and do you think I could find anybody at the hospital, at the doctor's surgery or anyone else who had ever even heard of it… It took me 6 months before I found out where it was and what it was and everything else. (Focus Group 10 Attended Postural Stability Class)

(7) I'm diabetic and I started staggering around earlier this year, round about May. And I saw the doctor and the doctor recommended me to go to the Falls Clinic and I have had some benefit from it really. The main thing was for me physiotherapists who put me on to certain exercises and they made a difference. (Focus Group 13 Attended Parkinson's Society Exercise Group & Falls Clinic Group)

(8) I think once again, you know, with the GPs, the poor guys they can't keep up with all the new developments that are going on … (Focus Group 09 Attended Osteoporosis Society)

(9) I have never been given any information. I did not even know it is available. … But yes I don't like doing something that I have no information about. It would be very handy if the doctors or the other staff would give you some kind of leaflets when you go to see them with a fall. It would give you a sense of empowerment if you know what I mean. (Interview Asian 07 Female Did not attend intervention)

(10) The people that we trust, i.e. our doctors, have said we think you should go to this sort of thing, told us that this was something that we should go to. So we made a point of doing it. I think if I'd just seen it on a note or a thing come through the door I wouldn't have bothered quite frankly but the fact that it was addressed to me … (Focus Group 07 Attended Independent Living Group)

- Acting as a barrier to accessing interventions
  (11) She is not interested. Anytime I go to speak to her, all she does is she keeps staring at her computer. She will not spare you a single glance while you are talking. As soon as I have finished talking, she hands me my prescription and out I am sent. If I insist I am feeling very unwell, then she will check my blood pressure. (Interview Asian 04 Female Did no attend intervention)

(12) … you know they just sort of washed my face and whatever and patched it up and there was a little scar but they didn't do anything about it and there was no question of a Falls Clinic or anything like that at that stage. (Interview 09 Male Did not attend Falls Clinic following referral)

(13) Well it goes back a long way. I had a very good doctor, years ago, and then the next one didn't seem interested … ‘Oh see the surgery nurse’ so I thought ‘right I shan't bother’. So I didn't. (Interview 04 Female Did not attend Falls Clinic Exercise Group following referral)

- Language barriers
  (14) The staff at that hospital could not speak Urdu or Punjabi, I can't speak English … (Interview Asian 04 (F), DNA: 66 - 67)

(15) Maybe they think I don't speak English, and they may feel it hard to explain. It must be hard for me to try and explain things in Chinese. I certainly don't expect them to do that, but if I was in Hong Kong and had to see a doctor, then that's simple. They speak to me in Chinese, and we are clear about what the problem is. But here, it's difficult. I tend to rely on my daughter to ask those questions. (Chinese Focus Group 1 Attended T'ai Chi)

Navigating or gatekeeping: a role for health professionals?

In cases where older people had reported falls or had needed medical attention for the injuries sustained following a fall, older people responded and interacted with HPs in different ways as shown in Box 2. Older people reported having great difficulty in finding information relating to falls and locating fall prevention interventions. One woman took 6 months to locate a postural stability exercise group, having had no help from her GP who was unaware of the intervention (Participant 6).

Health professionals’ response: navigating and facilitating access to interventions

Some GPs did have knowledge of fall prevention services and made referrals to these. Both the following woman and Participant 7 were referred and described positive experiences, though neither had previously heard about the falls clinic.

Well I went to the Doctor, I had to go anyway and I said 'I keep falling over what can I do about it' and she did a few testy things and she asked me if I felt giddy or anything and I don't do any of those things,
and so she said ‘well why don’t I send you to the Falls Clinic’ and I’d never heard of it before and I thought it was absolutely the tops. (Interview 03 Female Attended Falls Clinic)

Participant 8 expressed sympathy for the GP as they felt it was difficult for them to ‘keep up with all the new developments’, a not uncommon finding. Few older people were critical of HPs. One person had found her GP ‘difficult’, and so had avoided attending until ‘I heard she’d left, so I said right I’ll go and see the new one’.

Participants perceived HPs as having an important role as ‘navigators, referrers and information providers’ in our existing complex health systems (Participant 9). What is clear is that fall prevention interventions were taken particularly seriously if they were recommended by health-care professionals especially GPs and this encouraged attendance.

Health professionals’ response: acting as a barrier to accessing interventions

While some older people were assessed and referred promptly by HPs to falls services, others reported that HPs had little or no knowledge of local fall prevention interventions.

Participants expected to be able to find information through their GP’s surgery, but many had not experienced this, for example, the following woman noted that surgeries have regular clinics for many other health issues.

You see the doctors surgeries have diabetic clinics, because they have to, and they have clinics for mums, they have pregnancy clinics … but I don’t suppose there’s any GP surgeries that actually have once a month clinic for people who might fall. (Focus Group Attended Osteoporosis Society)

Many Asian older people interviewed reported they had told their doctor about falls but were frustrated that nothing happened as a result (e.g. Participant 11). Lack of follow-up was described by those who had attended an emergency department for treatment of fall-related injuries. None of the people we spoke to had been referred for any type of follow-up after attending emergency departments. Participant 12 described being ‘patched’ up and sent out. Participant 13 describes the variability in individual doctors’ interest in them, but also demonstrates the value placed on doctors taking them seriously—when she was referred to the nurse, she felt she was being fobbed off, so ‘didn’t bother’ seeing her.

Doctors were described as ‘the people that we trust’. Participant 9 was disappointed not to receive information from her doctor. This adversely affected her decision to attend. Information could also be non-specific and of limited help, for example, one man told us ‘All I have been told is to keep exercising and I will be okay’ (Interview Asian Male).

Language barriers

Language difficulties were an additional hurdle for Asian and Chinese older people (Participant 14), who generally had to rely on their family to translate (Participant 15). Older people unable to speak English were unable to participate in discussions about their care and treatment, including medication they were being prescribed, as one man explained ‘What’s worse, I don’t always know why and what the tablets are doing for me.’ (Chinese Focus Group Attended ‘T’ai Chi.)

Sometimes Chinese older people described taking Chinese medicines and herbal teas, or waiting to seek medical advice until they took a trip to their native country, rather than seeing their UK GP.

I try not to see my doctor if possible. I try to sort myself out. Sometimes I go to the Chinese medicine shop and they advise me what to take… Sometimes I don’t know what the doctor gives me to take. (Chinese Focus Group Attended ‘T’ai Chi.)

No one interviewed mentioned using formal interpretation services when accessing health care.

Discussion

In this study older people described a huge variation in their interactions with HPs, which impacted either positively or negatively on their uptake of fall prevention interventions. Most of the discussions with older people about HPs focused on the GP. There were fewer discussions about other professionals in relation to falls and interventions, such as nurses, physiotherapists or occupational therapists. However, from the discussions we have had with older people, it would appear that there is much scope for professionals to develop their work in this field. In particular, those working in primary and community settings could develop a proactive and opportunistic approach to case-finding as well as referral on to other services. There is evidence from other studies to suggest that older people, including Asian older people, are more likely to increase their physical activity levels following advice from their physicians [22–24].

Many older people have respect for information and advice provided to them by HPs and emphasise the importance of information that has the endorsement of their physician. Professionals working in the community have a particularly important role, as they frequently fulfil a ‘gate-keeping’ role to other services, particularly those located in secondary care settings [25]. Roles vary from the giving of advice and making referrals, to screening for falls and actual delivery of interventions. They therefore have an enormous potential to either facilitate access or act as a barrier to older people accessing fall prevention services. Information to older people needs to emphasise that falls are a medical problem, that they can be prevented and that help is available.

GPs’ surgeries were regarded as pivotal locations for people to access fall prevention advice and information. Uptake of interventions appeared to be influenced, and
given credibility when recommended by HPs. To promote a more proactive approach by GPs and primary care nurses to fall prevention [1, 10, 26], consideration should be given to the inclusion of falls screening, prevention information, advice and referral in the UK Quality and Outcomes Framework of the GPs’ contract (this recommendation supports that of Hippisley-Cox et al. [27] and within services commissioned by the new GP consortia [28]).

Of major concern was the lack of follow-up when older people had presented to health services when a fall had left them with a major injury. Staff in Accident and Emergency departments should refer all older patients who fall to fall prevention services. All patients presenting with fall-related injuries should receive follow-up as recommended by NICE [10] and the UK Department of Health [26].

Encouraging the use of formal interpretation services may also improve access to health-care and health promotion for older people unable to communicate in English.

The findings from our qualitative research are context-specific and therefore caution needs to be taken when extrapolating findings to other areas/groups. Nevertheless, because of the large sample size, the range of geographical areas and variety of interventions involved in the study, as well as the inclusion of ethnic minority groups, the findings of the study should have resonance for the wider community of older people. We did not include older people with cognitive impairments, and further research is required to explore the experiences of this particular group. Although our study included older people from two specific ethnic minority groups, we acknowledge that older people from other ethnic groups may have different experiences and needs that should be explored in future studies.

Conclusions

HPs have a major role to play in the proactive screening and case finding, promoting fall prevention and facilitating older people’s access to fall prevention programmes.

There is a need for better dissemination of information about fall prevention and relevant services to both HPs and the general public.

Consideration should be given to adding targets for falls screening to the UK Quality and Outcomes Framework of the GPs’ contract.

Key points

- HPs should take responsibility for routinely asking older people about their experience of falls and where appropriate refer them to fall prevention interventions.
- When falls have resulted in injury, follow-up should include falls risk assessment.
- Use of interpretation services should be offered to older people for whom English is a second language.

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Authors’ contribution

Study design: A.D., F.B., K.H. and D.J.
Data collection and analysis: A.D., I.M., J.C., K.H. and T.M.

Topic guides can be obtained from the corresponding author.

Conflicts of interest

None declared.

Ethics approval

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References

The impact of anticholinergic burden in Alzheimer’s Dementia—the Laser-AD study

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