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Terzo Atto

Carissimo Socio,
in questa **newsletter** di **Anìmo,** troverai un breve riassunto del documento conclusivo dell'indagine conoscitiva sulla sostenibilità economica del SSN, presentato a Montecitorio il 17 luglio c.a. durante una conferenza a cui sono state invitate anche le associazioni professionali sanitarie tra cui Anìmo. Troverete inoltre una "overview" di abstracts di articoli selezionati, sulle **cadute dell'anziano** che rappresentano un vero e proprio problema nei nostri reparti di degenza; con tale approfondimento vorremmo condividere con voi la volontà di non considerare le cadute in ospedale come "inevitabili", ma approfondire e studiare delle strategie multifattoriali per prevenirle.
Augurandovi una proficua lettura cogliamo l'occasione per ricordarvi che siamo aperti ai vostri suggerimenti, osservazioni o contributi, che potranno giungerci tramite mail al seguente indirizzo: **info@associazione-animo.it**.
Buona lettura a tutti

Dott.ssa Claudia Gatta
Presidente Anìmo

Nota dalla segreteria Anìmo

Dal 2015 le newsletter verranno inviate esclusivamente ai soci Anìmo in regola con il pagamento della quota associativa 2014 e dell'anno in corso.

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Sostenibilità del Sistema Sanitario Nazionale: Vargiu, Boccia e Lorenzin presentano il Patto della Salute 2014-2016

A cura di
G. Pentella e A. Zuccone

Giovedì 17 luglio alle ore 10, presso la Sala della Regina di Palazzo Montecitorio, è stato presentato il documento conclusivo dell'indagine conoscitiva sulla sostenibilità economica del sistema sanitario italiano intitolato " Sfida della tutela della salute tra nuove esigenze del sistema sanitario e obiettivi di finanza pubblica".
Il documento conclusivo dell'indagine promossa dalle due Commissioni Affari Sociali e Bilancio, impegnate per circa un anno in un lavoro di ascolto, analisi, confronto e sintesi con associazioni, sindacati, istituzioni e centri studi, contiene una serie di proposte concrete e condivise per salvaguardare il sistema universalistico della sanità pubblica e renderlo sostenibile e davvero equo.
Ha moderato il dibattito Paolo Russo (La Stampa). Sono intervenuti i presidenti delle Commissioni Bilancio e Affari Sociali della Camera, Francesco Boccia e Pierpaolo Vargiu. Ha concluso il ministro della Salute, Beatrice Lorenzin.
Sono stati invitati come uditori, le associazioni infermieristiche come ANIMO, le associazioni di medici come FADOI, l'associazione di Tutela dei Diritti del Malato e molti professionisti nel campo della sanità.
Tra i temi centrali del Patto: ticket legati al reddito e alla composizione della famiglia; tre anni di risorse certe per il Fondo

sanitario nazionale; la revisione dei Lea, i livelli essenziali di assistenza; la riorganizzazione complessiva dei soggetti che si occupano di sanità: Aifa (farmaci), Agenas (l'agenzia sanitaria), l'Istituto Superiore di Sanità e il Consiglio Superiore della Sanità.
Nel dettaglio il nuovo documento prevede un'importante spending review con l'impegno concreto di un rinvestimento dei capitali risparmiati all'interno del settore sanitario. Per questo si delineano percorsi chiari di interazione con i territori e le altre amministrazioni centrali per rafforzare la ricerca e lo sviluppo nel settore biomedico. L'interazione servirà anche a "monitorare il prezzo dei farmaci e dei dispositivi e ad offrire i migliori prodotti per la salute dei cittadini". Lorenzin ha poi sottolineato che alle due sfide classiche della sanità: sostenibilità e qualità del servizio, se ne aggiunge una terza, quella dello sviluppo: "Il sistema salute fa parte del sistema paese e intorno alla salute non c'è solo il benessere delle persone, ma c'è anche la qualità dei prodotti agroalimentari, la qualità dell'ambiente, l'industria farmaceutica, l'indotto della ricerca e dell'innovazione e per me tutto questo è il nostro petrolio. È quello che ci può rendere competitivi rispetto agli Usa e ai paesi del Brics (Brasile, Russia, India, Cina e Sudafrica). È un settore che è un brand del made in Italy e quindi deve essere fonte di investimenti".
La riforma prevede di dare all'Aifa i poteri per essere una grande agenzia europea capace di rendere l'Italia competitiva. Luca Pani, direttore generale Aifa, durante il suo intervento, ha "messo sul piatto" alcune proposte di modifiche normative: dare dei prezzi unici a livello nazionale a tutti i medicinali che sono ceduti alle strutture pubbliche; introduzione di liste di riferimento sul prezzo rimborsato dal SSN anche per i medicinali di fascia a brevetto scaduto; superamento della fascia C NN (classe C – Non Negoziata) per alcuni farmaci antitumorali innovativi; individuazione della nuova remunerazione delle farmacie ed infine Agenas dovrà diventare l'agenzia di controllo mentre l'Istituto Superiore di Sanità tornare ad essere il grande istituto di ricerca per cui è nato. Lorenzin ha spiegato inoltre che la sua idea è di mettere il sistema "in rete", facendo dialogare gli enti tra loro in modo da poter partecipare alle sfide al fine di attrarre risorse in maniera coordinata, passando così dalla fase artigianale alla fase industriale".
Per quanto riguarda i sistemi sanitari regionali e le aziende sanitarie, le Commissioni della Camera, auspicano un sistema che premi "la qualità", applicando regole che valorizzino i sistemi sanitari regionali, le aziende sanitarie ospedaliere, gli operatori migliori, anche privati, promuovendo così una virtuosa competizione fra erogatori ed una maggiore autonomia delle aziende in caso di difficoltà sul fronte delle risorse, al fine di gestire in modo flessibile ed efficace i fattori produttivi.
In sintesi, si prevedono tagli non lineari, una sanità integrativa costituita da fondi integrativi e polizze assicurative (collettive e individuali) attraverso una maggior defiscalizzazione, meno potere alle regioni e al Ministro della Finanza e maggior autonomia al Ministero della Salute, centralizzando i controlli e dando maggior forza nella distribuzione dei farmaci a livello nazionale, cambiando la governance. Il nuovo Patto andrà monitorato nella sua attuazione con senso di responsabilità e in un rapporto di leale collaborazione tra le parti, attraverso un tavolo permanente della Conferenza Stato-Regioni che costituirà una sorta di cabina di regia a cui è, tra l'altro, demandata l'elaborazione di proposte per la spending review interna al settore sanitario.
Quindi dopo l'approvazione del Patto per la Salute, la politica è chiamata a nuove scelte coraggiose per vincere la sfida dell'innovazione e della garanzia piena del diritto alla salute.
Come ha detto Lorenzin non bisogna abbassare la testa per guardare i piedi ma volare alto come fanno le aquile.

Le cadute negli anziani

a cura di
Fabio Bertoncini e Michela Piasentin

Uno degli aspetti ancora molto dibattuto in sanità a livello mondiale, proprio per la sua intrinseca complessità multifattoriale in termini di prevedibilità, gestione ed implicazioni, e il problema delle cadute negli anziani.
Sebbene l'incidenza sia maggiore nella popolazione anziana (1), sono da ritenere a rischio tutte le persone che accedono alle strutture sanitarie poichè in fase acuta, o perchè caratterizzate da particolari patologie (ad esempio persone affette da cancro in fase terminale) o da situazioni fisiologiche (ad esempio donne in gravidanza con una postura sbilanciata o episodi lipotimici) (2).
Secondo L'OMS il 30% delle persone sopra i 65 anni cade ogni anno e per le persone sopra ai 75 anni i tassi sono piu elevati. Ed ancora il 78% delle cadute che si verificano in ospedale e rappresentato da "cadute prevedibili" (3).
La valutazione del rischio deve essere effettuata mediante uno strumento standardizzato e attraverso la valutazione clinica del professionista, elemento irrinunciabile nella definizione del rischio, in quanto nessuno strumento di valutazione, da solo, è in grado di identificare tutte le persone a rischio o tutti i fattori di rischio (4;5).

Una revisione critica della letteratura pubblicata nel 2003 sottolinea come nessuna di queste scale sembri essere stata sufficientemente studiata in termini di validità ed affidabilità (6).

La **Morse Fall Scale (MFS)** è una scala di valutazione utilizzata al fine di rilevare quali pazienti sono a rischio di caduta e quali no; è una scala ordinale con un tempo di impiego basso che varia dai 3 ai 5 minuti. E' indicato sia per valutare il rischio di caduta in reparti acuti sia per i reparti non acuti.

Il punteggio da 0 a 125 e stato stratificato dagli autori secondo la seguente modalità:

da 0 a 24	basso rischio
da 25 a 50	medio rischio
> di 50	alto rischio

E' una scala di valutazione che indaga il vero rischio di caduta e non la capacità di deambulazione del paziente, in quanto a soggetti allettati o altamente assistiti assegna punteggi negativi, proprio per il basso rischio di caduta correlato a supervisione. (7)

GLI INTERVENTI MULTIFATTORIALI

Con la pianificazione dell'assistenza si possono ridurre le cadute in ospedale e nelle case di riposo(8). E' stato dimostrato che gli interventi multifattoriali mirati sono in grado di ritardare e ridurre le cadute dei pazienti ospiti nelle residenze assistenziali (9).

Gli interventi multifattoriali comprendono:

⇒ **Esercizio fisico;**
⇒ **Revisione delle terapia farmacologiche;**
⇒ **Modifiche ambientali;**
⇒ **Ausili per la deambulazione;**
⇒ **Uso di calze antiscivolo negli anziani (10);**
⇒ **Formazione del personale;**
⇒ **Educazione sanitaria;**
⇒ **Problem solving dopo la caduta.**

ESERCIZIO FISICO
L'esercizio fisico per migliorare la forza e la resistenza fisica, l'addestramento a una corretta andatura e un programma di passeggiate riduce il rischio di cadute. Occorre pero sempre associare altri interventi, poichè da solo l'esercizio fisico non riduce il tasso di cadute. (11)

TERAPIA FARMACOLOGICA
La rivalutazione della terapia assunta dal soggetto e la riduzione del numero di farmaci può avere un effetto positivo sulla riduzione delle cadute nell'anziano. (12). Quando il numero di farmaci prescritti è di 4 o più, il rischio di caduta aumenta, come emerge da uno studio su 227 ospiti di strutture sanitarie residenziali di età superiore ai 65 anni.(13).

MODIFICHE AMBIENTALI
La valutazione del rischio ambientale nelle aree comuni e nelle stanze dei pazienti è efficace nella prevenzione delle cadute. (14). Fra le più comuni cause ambientali di caduta vi sono: la mancanza di parapetto o corrimano sulle scale, pavimenti sdrucciolevoli, mobilio instabile, scarsa illuminazione. In uno studio randomizzato non in cieco su 9 strutture sanitarie residenziali svedesi, vengono raccomandate modifiche ambientali quali: spostare mobili che possono provocare cadute (per esempio eliminando i mobili che inducono rischio di inciampo come poggiapiedi o fissando quelli che possono spostarsi come letti e carrozzine), asciugare le zone di pavimento bagnate, disporre corrimano alle pareti e migliorare l'illuminazione. (15)

FORMAZIONE DEL PERSONALE
La formazione del personale è efficace nella riduzione delle cadute, specie gli interventi formativi di tipo seminariale di durata da 1 a 4 ore nel corso dei quali viene distribuito materiale informativo su incidenza, rischio, misure di prevenzione e vengano fornite informazioni sulle strategie di prevenzione e indicazioni rivolte agli operatori sanitari. (16)

EDUCAZIONE SANITARIA

Gli interventi educativi rivolti all'anziano riducono la paura di cadere. Gli incontri individuali favoriscono l'interazione con la persona e la valutazione da parte dell'infermiere, mentre gli incontri di gruppo oltre a essere meno onerosi in termini di tempo favoriscono la comunicazione fra i pazienti (17). Nei colloqui dovrebbero essere affrontati i seguenti argomenti: (18).

- educazione dell'anziano e di chi lo assiste sui rischi di caduta, sulla sicurezza e sulla limitazione delle attività;
- orientamento nella zona letto, nei servizi del reparto e su come utilizzare il campanello per chiedere assistenza;
- insegnamento della corretta postura e della lentezza nel passare da una posizione all'altra;
- adozione di programmi educativi per i nuovi pazienti e per quelli ad alto rischio;
- interventi in caso di incapacità a rialzarsi;
- importanza di mantenersi attivi e in movimento;
- esercizi per mantenere e migliorare la forza ossea
- l'alimentazione: integrazione della dieta con calcio e vitamina D (valutare con il medico la necessità di assumere dei supplementi nutritivi di calcio e/o di vitamina D, prevenendo anche l'insorgenza dell'osteoporosi. Gli infermieri forniscono ai clienti informazioni sui benefici della vitamina D. Inoltre, le informazioni su dieta, stile di vita e la scelta di trattamento per la prevenzione dell'osteoporosi è rilevante in relazione alla riduzione del rischio di frattura.

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REFERENCE N°1

NICE guidelines, "Falls: Assesment and Prevention of falls in older People"
National Institute for Clinical Excellence. Clinical Guideline 161. Jun 2013.

Falls and fall-related injuries are a common and serious problem for older people. People aged 65 and older have the highest risk of falling, with 30% of people older than 65 and 50% of people older than 80 falling at least once a year.
The human cost of falling includes distress, pain, injury, loss of confidence, loss of independence and mortality. Falling also affects the family members and carers of people who fall. Falls are estimated to cost the NHS more than £2.3 billion per year. Therefore falling has an impact on quality of life, health and healthcare costs.
This guideline provides recommendations for the assessment and prevention of falls in older
people. It is an extension to the remit of NICE clinical guideline 21 (published November 2004) to include assessing and preventing falls in older people during a hospital stay (inpatients). The new recommendations for older people in hospital (2013) sit alongside the original
recommendations from the 2004 guideline. It is important to emphasise that all of the 2004
recommendations are just as relevant and important now as they were when they were originally published.

REFERENCE N°2

London: British Ortopaedic Association, 2003.
The care of fragility fracture patients"
Marsh D, Simpson H et al.

Already the Trauma and Orthopaedic units in the United Kingdom are struggling to deliver high quality care to the large number of elderly osteoporotic fracture patients presenting to them. Yet the size of the problem can reliably be predicted to worsen considerably in the next few decades. In the next 40 years, the number of people over 60 years of age will rise by around 50%, whereas the number of those over 90 years of age will double1. The implications of this, for example for hip fracture numbers, depend on what happens to the age-specific incidence. A study in Oxford in 1983 showed that the age-specific incidence of hip fracture had doubled since 27 years earlier2. Although the numbers are uncertain, the least pessimistic estimates lead us to expect a doubling of the incidence of fragility fractures by the year 2050.
As well as proximal femur, other fractures including Colles fracture, vertebral fracture, humeral neck fracture and pelvicfracture commonly occur as a consequence of osteoporosis, resulting in a cumulative 1 in 3 lifetime risk of an adult woman having an osteoporotic fracture3. The prevalence in males is also substantial, with a 1 in 12 lifetime risk. Current costs to the NHS of osteoporosis and osteoporotic fracture care are estimated at almost £2bn per annum. These epidemiological trends pose enormous challenges to our society, not least to trauma and orthopaedic units, which are threatened with being completely overwhelmed. Since fracture is the main significant consequence of osteoporosis, it is essential that orthopaedic surgeons play their part in defining what is needed to enable the NHS to cope with the coming onslaught and ensure timely treatment and good outcomes for future patients. It is also vital that we persuade those responsible for setting service development priorities of the inescapable requirement to supply those needs.

REFERENCE N°3
WHO, "Falls" Fact Sheet N.344 2012

Falls are the second leading cause of accidental or unintentional injury deaths worldwide.
Each year an estimated 424 000 individuals die from falls globally of which over 80% are in low- and middle-income countries.
Adults older than 65 suffer the greatest number of fatal falls. 37.3 million falls that are severe enough to require medical attention, occur each year. Prevention strategies should emphasize education, training, creating safer environments, prioritizing fall-related research and establishing effective policies to reduce risk. A fall is defined as an event which results in a person coming to rest inadvertently on the ground or floor or other lower level. Fall-related injuries may be fatal or nonfatal1 though most are non-fatal. For example, of children in the People's Republic of China, for every death due to a fall, there are 4 cases of permanent disability, 13 cases requiring hospitalization for more than 10 days, 24 cases requiring hospitalization for 1–9 days and 690 cases seeking medical care or missing work/school.

REFERENCE N°4

Copenhagen, WHO Regional Office for Europe (Health Evidence Network report; http://www.euro.who.int/document/E82552.pdf, accessed 5 April 2004).
What are the main risk factors for falls among older people and what are the most effective interventions to prevent these falls?
Todd C, Skelton D. (2004)

This report is HEN's response to a question from a decision-maker. It provides a synthesis of the best available evidence, including a summary of the main findings and policy options related to the issue. Fall prevention programmes can be effective in reducing the number of people who fall and the rate of falls. Targeted strategies aimed at behavioural change and risk modification for those living in the community appear to be most promising. Multifactorial intervention programmes that include risk factor assessment and screening have been shown to be effective. However, no screening tools have been rigorously validated across countries and further work is needed in this area. HEN, initiated and coordinated by the WHO Regional Office for Europe, is an information service for public health and health care decision-makers in the WHO European Region. Other interested parties might also benefit from HEN. This HEN evidence report is a commissioned work and the contents are the responsibility of the authors. They do not necessarily reflect the official policies of WHO/Europe. The reports were subjected to international review, managed by the HEN team.

REFERENCE N°5

Med J Aust. 2006 Apr 17;184(8):372-3.

Preventing falls among elderly people in the hospital environment.
Kannus P, Khan KM, Lord SR.
Falls and related injuries among seniors are a compelling ongoing priority for Australian health research.
PMID: 16618232

REFERENCE N°6

Int J Nurs Pract. 2003 Aug;9(4):223-35.
Hospital fall risk assessment tools: a critique of the literature.
Myers H.

Abstract
There are numerous fall risk assessment tools developed for use by nurses in hospitals; however, few of them have established validity and reliability. This article will examine the current state of knowledge in regard to fall risk assessment tools through review and critique of the literature on the topic. Recommendations for future research on fall risk assessment tools will be made and a conceptual framework detailing the relationship between the variables involved in assessing the accuracy of fall risk assessment tools will be presented.

PMID:12887374

REFERENCE N°7

Age Ageing. 2006 May;35(3):311-3. Epub 2006 Mar 9.

Evaluation of the Morse Fall Scale in hospitalised patients.
Schwendimann R[1], De Geest S, Milisen K.

Abstract
Sir—Several risk factors associated with falls in hospitalised patients have been identified. Although a substantial number of assessment instruments for identifying hospitalised patients at risk of falling exists, their generalisability is limited because only a few have been tested in settings other than those in which they were originally developed. The Morse Fall Scale (MFS) has been evaluated in different hospital settings and has been used in a variety of patient populations. In search of an appropriate tool to identify admitting patients for risk of falling, the MFS appears to be most elaborate in view of its extensive development and testing in different hospital populations compared with others. Its easy application in clinical practice supported this choice. However, no investigation to date has reported results of different cut-off scores of the scale. This study aimed to evaluate the diagnostic value of different MFS cut-offs to determine which score would be most useful in identifying in-hospital patients at risk of falls.

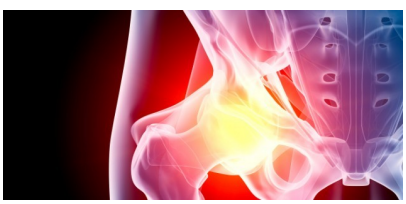
PMID: 16527829

REFERENCE N°8

Age Ageing. 2004 Jul;33(4):390-5. Epub 2004 May 19.
Using targeted risk factor reduction to prevent falls in older in-patients: a randomised controlled trial.
Healey F[1], Monro A, Cockram A, Adams V, Heseltine D.

Abstract
BACKGROUND: falls and related injuries are known to be a significant problem for older people. There is evidence that identifying and addressing individual risk factors can reduce the incidence of falls in the community but no evidence of the effectiveness of targeted risk factor reduction methods applied to hospital in-patients.
OBJECTIVE: to test the efficacy of a targeted risk factor reduction core care plan in reducing risk of falling while in hospital.
DESIGN: a group (ward) randomised trial.
SETTING: elderly care wards and associated community units of a district general hospital in the North of England.
SUBJECTS: all elderly patients who received care in eight wards and community units during a 12-month study period.
METHODS: matched pairs of wards were randomly allocated to intervention or control groups. In the intervention wards, staff used a pre-printed care plan for patients identified as at risk of falling and introduced appropriate remedial measures. Numbers of falls in each group were then compared.
RESULTS: after introduction of the care plan there was a significant reduction in the relative risk of recorded falls on intervention wards (relative risk0.79, 95% CI 0.65-0.95) but not on control wards (RR 1.12, 95% CI 0.96-1.31). The difference in change between the intervention wards and control wards was highly significant (RR 0.71, 95% CI 0.55-0.90, P = 0.006). There was no significant reduction in the incidence of falls-related injuries.
CONCLUSION: the use of a core care plan targeting risk factor reduction in older hospital in-patients was associated with a reduction in the relativerisk of recorded falls.

Comment in : Difficulties encountered in hospital falls prevention research. [Age Ageing. 2005]
PMID:15151914



REFERENCE N°9

J Am Geriatr Soc. 2003 Mar;51(3):306-13.

Effectiveness of a multifaceted intervention on falls in nursing home residents.

Becker C[1], Kron M, Lindemann U, Sturm E, Eichner B, Walter-Jung B, Nikolaus T.

Abstract

OBJECTIVES: To evaluate the effectiveness of a multifaceted, nonpharmaceutical intervention on incidence of falls and fallers.
DESIGN: Prospective, cluster-randomized, controlled 12-month trial.
SETTING: Six community nursing homes in Germany.
PARTICIPANTS: Long-stay residents (n = 981) aged 60 and older; mean age 85; 79% female.
INTERVENTIONS: Staff and resident education on fall prevention, advice on environmental adaptations, progressive balance and resistance training, and hip protectors.
MEASUREMENTS: Falls, fallers, and fractures.
RESULTS: The incidence density rate of falls per 1,000 resident years (RY) was 2,558 for the control group (CG) and 1,399 for the interventiongroup (IG) (relative risk (RR) = 0.55, 95% confidence interval (CI) = 0.41-0.73). Two hundred forty-seven (52.3%) fallers were detected in the CG and 188 (36.9%) in the IG (RR = 0.75, 95% CI = 0.57-0.98). The incidence density rate of frequent fallers (>2/year) was 115 (24.4%) for the CG and 66 (13.0%) for the IG (RR = 0.56, 95% CI = 0.35-0.89). The incidence density rate of hip fractures per 1,000 RY was 39 for the CG and 43 for the IG (RR = 1.11, 95% CI = 0.49-2.51). Other fractures were diagnosed with an incidence density rate of 52 per 1,000 RY for CG and 41 per 1,000 RY for IG (RR = 0.78, 95% CI = 0.57-1.07).
CONCLUSION: The incidence density rate of falls and fallers differed considerably between the control and intervention groups. The study was underpowered to demonstrate a significant difference of hip or nonhip fractures. Because of a low fracture rate in both groups, the investigation of fracture rates would have required a larger sample size to detect an effect of the intervention.
PMID:12588573

REFERENCE N°10

Prevention of falls in the elderly: a review.

Karlsson MK[1], Vonschewelov T, Karlsson C, Cöster M, Rosengen BE.

Abstract

AIMS: Falls often result in soft tissue injuries, dislocations, fractures, longstanding pain and reduced quality of life. Therefore, fall preventive programmes have been developed.
METHODS: In this review, we evaluate programmes that in randomized controlled trials (RCT) have been shown with fall reducing effect.
RESULTS: Physical exercise that includes several training modalities, especially balance and strength training, is the only intervention programme that reduces both the number of fallers and the number of falls in community dwellers. Home hazards modification reduces the fall risk in community-living elderly but has the best effects in high risk groups when the programme is led by occupational therapists. Vitamin D supplement in those with low levels of vitamin D, adjustment of psychotropic medication and modification of multi-pharmacy are drug-related programmes that reduce the fall risk. Anti-slip shoe devices in elderly who walk outdoors during icy conditions and multifaceted podiatry to patients with specific foot disability are interventions targeted at the lower extremities with a fall-reducing effect. First eye cataract surgery and pacemakers in patients with cardio-inhibitory carotid sinus hypersensitivity are surgical procedures with fall-reducing effect. Multifactorial standardized preventive programmes that include an exercise component and individually-designed subject-specific programmes also reduce the number of falls.
CONCLUSIONS: Fall preventive interventions should be provided to elderly by a structured approach, especially to high risk groups, as to reduce the number of falls and fallers.

PMID:23554390

REFERENCE N°11

Cochrane Database Syst Rev. 2003;(4):CD000340.

Interventions for preventing falls in elderly people.

Gillespie LD[1], Gillespie WJ, Robertson MC, Lamb SE, Cumming RG, Rowe BH.

Update in : Cochrane Database Syst Rev. 2009;(2):CD000340.

Abstract

BACKGROUND: Approximately 30 per cent of people over 65 years of age and living in the community fall each year; the number is higher in institutions. Although less than one fall in 10 results in a fracture, a fifth of fall incidents require medical attention.
OBJECTIVES: To assess the effects of interventions designed to reduce the incidence of falls in elderly people (living in the community, or in institutional or hospital care).
SEARCH STRATEGY: We searched the Cochrane Musculoskeletal Group specialised register (January 2003), Cochrane Central Register of Controlled Trials (The Cochrane Library, Issue 1, 2003), MEDLINE (1966 to February 2003), EMBASE (1988 to 2003 Week 19), CINAHL (1982 to April 2003), The National Research Register, Issue 2, 2003, Current Controlled Trials (www.controlled-trials.com accessed 11 July 2003) and reference lists of articles. No language restrictions were applied. Further trials were identified by contact with researchers in the field.
SELECTION CRITERIA: Randomised trials of interventions designed to minimise the effect of, or exposure to, risk factors for falling in elderly people. Main outcomes of interest were the number of fallers, or falls. Trials reporting only intermediate outcomes were excluded.
DATA COLLECTION AND ANALYSIS: Two reviewers independently assessed trial quality and extracted data. Data were pooled using the fixed effect model where appropriate. **MAIN RESULTS:** Sixty two trials involving 21,668 people were included. Interventions likely to be beneficial: Multidisciplinary, multifactorial, health/environmental risk factor screening/intervention programmes in the community both for an unselected population of older people (4 trials, 1651 participants, pooled RR 0.73, 95%CI 0.63 to 0.85), and for older people with a history of falling or selected because of known risk factors (5 trials, 1176 participants, pooled RR 0.86, 95%CI 0.76 to 0.98), and in residential care facilities (1 trial, 439 participants, cluster-adjusted incidence rate ratio 0.60, 95%CI 0.50 to 0.73) A programme of muscle strengthening and balance retraining, individually prescribed at home by a trained health professional (3 trials, 566 participants, pooled relative risk (RR) 0.80, 95% confidence interval (95%CI) 0.66 to 0.98) Home hazard assessment and modification that is professionally prescribed for older people with a history of falling (3 trials, 374 participants, RR 0.66, 95% CI 0.54 to 0.81) Withdrawal of psychotropic medication (1 trial, 93 participants, relative hazard 0.34, 95%CI 0.16 to 0.74) Cardiac pacing for fallers with cardioinhibitory carotid sinus hypersensitivity (1

trial, 175 participants, WMD -5.20, 95%CI -9.40 to -1.00) A 15 week Tai Chi group exercise intervention (1 trial, 200 participants, risk ratio 0.51, 95%CI 0.36 to 0.73). Interventions of unknown effectiveness: Group-delivered exercise interventions (9 trials, 1387 participants) Individual lower limb strength training (1 trial, 222 participants) Nutritional supplementation (1 trial, 46 participants) Vitamin D supplementation, with or without calcium (3 trials, 461 participants) Home hazard modification in association with advice on optimising medication (1 trial, 658 participants), or in association with an education package on exercise and reducing fall risk (1 trial, 3182 participants) Pharmacological therapy (raubasine-dihydroergocristine, 1 trial, 95 participants) Interventions using a cognitive/behavioural approach alone (2 trials, 145 participants) Home hazard modification for older people without a history of falling (1 trial, 530 participants) Hormone replacement therapy (1 trial, 116 participants) Correction of visual deficiency (1 trial, 276 participants). Interventions unlikely to be beneficial: Brisk walking in women with an upper limb fracture in the previous two years (1 trial, 165 participants). **REVIEWER'S CONCLUSIONS:** Interventions to prevent falls that are likely to be effective are now available; less is known about their effectiveness inpreventing fall-related injuries. Costs per fall prevented have been established for four of the interventions and careful economic modelling in the context of the local healthcare system is important. Some potential interventions are of unknown effectiveness and further research is indicated.

Comment in
Review: interventions targeting intrinsic and environmental risk factors reduce falls in older persons. [ACP J Club. 2004]
Update of
Cochrane Database Syst Rev. 2001;(3):CD000340.
PMID: 14583918

REFERENCE N°12
Pharmacoepidemiol Drug Saf. 2002 Mar;11(2):97-104.
Medication use and risk of falls.
Neutel CI[1], Perry S, Maxwell C.

Abstract
PURPOSE:
Injuries due to falls are an important public health concern, particularly for the elderly, and effective prevention is an ongoing endeavour. The present study has two related objectives: (1) to describe associations between drug use and falls in an institutionalized population, and (2) to identify a high risk subgroup within the larger population.
METHODS:
The initial analysis was based on a population of 227 residents who were followed over a 1-year period. Logistic regression techniques were used to estimate odds ratios (ORs) of the association of falls and drug use. The study of potential 'high-risk' groups employed a case-crossover design to estimate the risk of falling associated with starting a new drug course.
RESULTS:
Relatively weak ORs for risk of falling were observed for various drug classes; the highest OR was for benzodiazepines (BZD) at OR = 1.8 (unadjusted). Residents taking multiple drugs were at particular risk for falling, e.g. an OR of 6.1 for those using 10+ drugs. The case-crossover analysis indicated that residents starting a new BZD/antipsychotic were at very high risk (OR = 11.4) for experiencing a fall.
CONCLUSIONS:
Residents who took many different types of medications, as well as residents starting a new BZD/antipsychotics were at greatly increased risk of falling. These are high risk groups where increased monitoring or adjustments to drug regimens could lead to prevention of falls.
Comment in
Comment on 'Medication use and risk of falls' by Neutel et al. [Pharmacoepidemiol Drug Saf. 2002]
PMID: 11998544

REFERENCE N°13
N Engl J Med. 1998 Sep 24;339(13):875-82.
Antidepressants and the risk of falls among nursing home residents.
Thapa PB[1], Gideon P, Cost TW, Milam AB, Ray WA.

Abstract
BACKGROUND:
In nursing home residents, the use of tricyclic and other heterocyclic antidepressants is associated with an increased risk of falls. The newer selective serotonin-reuptake-inhibitor antidepressants are largely free of the side effects of the tricyclic agents thought to cause falls and so have been hypothesized to be safer for those at high risk for falls.
METHODS:
We retrospectively identified an inception cohort of 2428 nursing home residents in Tennessee who were new users of tricyclicantidepressants (665 subjects), selective serotonin-reuptake inhibitors (612 subjects), or trazodone (304 subjects) or nonusers of antidepressants(847 subjects). We ascertained the number of falls during therapy and during a similar follow-up period for nonusers, then calculated the rate ratios for falls with adjustments for an extensive set of potential confounding factors.
RESULTS:
The new users of each type of antidepressant had higher rates of falls than the nonusers, with adjusted rate ratios of 2.0 (95 percent confidence interval, 1.8 to 2.2) for tricyclic antidepressants, 1.8 (1.6 to 2.0) for selective serotonin-reuptake inhibitors, and 1.2 (1.0 to 1.4) for trazodone. The rate ratios increased with the daily dose for tricyclic antidepressants, reaching 2.4 (95 percent confidence interval, 2.1 to 2.8) for doses of 50 mg or more of amitriptyline or its equivalent, and for the serotonin-reuptake inhibitors, reaching 1.9 (1.7 to 2.2) for 20 mg or more of fluoxetine or its equivalent. The elevated rates of falls persisted through the first 180 days of therapy and beyond.
CONCLUSIONS:
In this large study of nursing home residents, there was little difference in rates of falls between those treated with tricyclicantidepressants and those treated with selective serotonin-reuptake inhibitors. Hence, the preferential use of the newer antidepressants is unlikely to reduce the higher rate of falls among nursing home residents taking antidepressants.
Comment in
Depression in the elderly--falls and pitfalls. [N Engl J Med. 1998]
Antidepressants and falls among nursing home residents. [N Engl J Med. 1999]
PMID:9744971

REFERENCE N°14

Cochrane Database Syst Rev. 2012 Dec 12;12:CD005465. doi: 10.1002/14651858.CD005465.pub3.

Interventions for preventing falls in older people in care facilities and hospitals.

Cameron ID[1], Gillespie LD, Robertson MC, Murray GR, Hill KD, Cumming RG, Kerse N.

BACKGROUND:
Falls in care facilities and hospitals are common events that cause considerable morbidity and mortality for older people. This is an update of a review first published in 2010. **OBJECTIVES:** To assess the effectiveness of interventions designed to reduce falls by older people in care facilities and hospitals. **SEARCH METHODS:** We searched the Cochrane Bone, Joint and Muscle Trauma Group Specialised Register (March 2012); The Cochrane Library 2012, Issue 3; MEDLINE, EMBASE, and CINAHL (all to March 2012); ongoing trial registers (to August 2012), and reference lists of articles. **SELECTION CRITERIA:** Randomised controlled trials of interventions to reduce falls in older people in residential or nursing care facilities orhospitals. **DATA COLLECTION AND ANALYSIS:** Two review authors independently assessed risk of bias and extracted data. We used a rate ratio (RaR) and 95% confidence interval (CI) to compare the rate of falls (e.g. falls per person year) between intervention and control groups. For risk of falling we used a risk ratio (RR) and 95% CI based on the number of people falling (fallers) in each group. We pooled results where appropriate. **MAIN RESULTS:** We included 60 trials (60,345 participants), 43 trials (30,373 participants) in care facilities, and 17 (29,972 participants) inhospitals.Results from 13 trials testing exercise interventions in care facilities were inconsistent. Overall, there was no difference between interventionand control groups in rate of falls (RaR 1.03, 95% CI 0.81 to 1.31; 8 trials, 1844 participants) or risk of falling (RR 1.07, 95% CI 0.94 to 1.23; 8 trials, 1887 participants). Post hoc subgroup analysis by level of care suggested that exercise might reduce falls in people in intermediate level facilities, and increase falls in facilities providing high levels of nursing care.In care facilities, vitamin D supplementation reduced the rate of falls (RaR 0.63, 95% CI 0.46 to 0.86; 5 trials, 4603 participants), but not risk of falling (RR 0.99, 95% CI 0.90 to 1.08; 6 trials, 5186 participants).For multifactorial interventions in care facilities, the rate of falls (RaR 0.78, 95% CI 0.59 to 1.04; 7 trials, 2876 participants) and risk of falling (RR 0.89, 95% CI 0.77 to 1.02; 7 trials, 2632 participants) suggested possible benefits, but this evidence was not conclusive.In subacute wards in hospital, additional physiotherapy (supervised exercises) did not significantly reduce rate of falls (RaR 0.54, 95% CI 0.16 to 1.81; 1 trial, 54 participants) but achieved a significant reduction in risk of falling (RR 0.36, 95% CI 0.14 to 0.93; 2 trials, 83 participants).In one trial in a subacute ward (54 participants), carpet flooring significantly increased the rate of falls compared with vinyl flooring (RaR 14.73, 95% CI 1.88 to 115.35) and potentially increased the risk of falling (RR 8.33, 95% CI 0.95 to 73.37).One trial (1822 participants) testing an educational session by a trained research nurse targeting individual fall risk factors in patients at high risk of falling in acute medical wards achieved a significant reduction in risk of falling (RR 0.29, 95% CI 0.11 to 0.74).Overall, multifactorial interventions in hospitals reduced the rate of falls (RaR 0.69, 95% CI 0.49 to 0.96; 4 trials, 6478 participants) and risk of falling (RR 0.71, 95% CI 0.46 to 1.09; 3 trials, 4824 participants), although the evidence for risk of falling was inconclusive. Of these, one trial in a subacute setting reported the effect was not apparent until after 45 days in hospital. Multidisciplinary care in a geriatric ward after hip fracture surgery compared with usual care in an orthopaedic ward significantly reduced rate of falls (RaR 0.38, 95% CI 0.19 to 0.74; 1 trial, 199 participants) and risk of falling (RR 0.41, 95% CI 0.20 to 0.83). More trials are needed to confirm the effectiveness of multifactorial interventions in acute and subacute hospital settings.
AUTHORS' CONCLUSIONS:
In care facilities, vitamin D supplementation is effective in reducing the rate of falls. Exercise in subacute hospital settings appears effective but its effectiveness in care facilities remains uncertain due to conflicting results, possibly associated with differences in interventions and levels of dependency. There is evidence that multifactorial interventions reduce falls in hospitals but the evidence for risk of falling was inconclusive. Evidence for multifactorial interventions in care facilities suggests possible benefits, but this was inconclusive.

Update of Cochrane Database Syst Rev. 2010;(1):CD005465.
PMID:23235623

REFERENCE N°15

Ann Intern Med. 2002 May 21;136(10):733-41.

Fall and injury prevention in older people living in residential care facilities. A cluster randomized trial.

Jensen J[1], Lundin-Olsson L, Nyberg L, Gustafson Y.

Abstract

BACKGROUND:
Falls and resulting injuries are particularly common in older people living in residential care facilities, but knowledge about the prevention of falls is limited.
OBJECTIVE:
To investigate whether a multifactorial intervention program would reduce falls and fall-related injuries.
DESIGN:
A cluster randomized, controlled, nonblinded trial.
SETTING:
9 residential care facilities located in a northern Swedish city.
PATIENTS:
439 residents 65 years of age or older.
INTERVENTION:
An 11-week multidisciplinary program that included both general and resident-specific, tailored strategies. The strategies comprised educating staff, modifying the environment, implementing exercise programs, supplying and repairing aids, reviewing drug regimens, providing free hip protectors, having post-fall problem-solving conferences, and guiding staff.
MEASUREMENTS:
The primary outcomes were the number of residents sustaining a fall, the number of falls, and the time to occurrence of the first fall. A secondary outcome was the number of injuries resulting from falls.
RESULTS:
During the 34-week follow-up period, 82 residents (44%) in the intervention program sustained a fall compared with 109 residents (56%) in the control group (risk ratio, 0.78 [95% CI, 0.64 to 0.96]). The adjusted odds ratio was 0.49 (CI, 0.37 to 0.65), and the adjusted incidence rate ratio of falls was 0.60 (CI, 0.50 to 0.73). Each of 3 residents in the intervention group and 12 in the control group had 1 femoral fracture (adjusted odds ratio, 0.23 [CI, 0.06 to 0.94]). Clustering was considered in all regression models.
CONCLUSION:
An interdisciplinary and multifactorial prevention program targeting residents, staff, and the environment may reduce falls and femoral fractures.

Comment in
Prevention of falls and injuries in residential care. [Ann Intern Med. 2002]
Summary for patients in
Ann Intern Med. 2002 May 21;136(10):I50.
PMID:12020141

REFERENCE N°16

BMJ. 2004 Mar 20;328(7441):680.
Interventions for the prevention of falls in older adults: systematic review and meta-analysis of randomised clinical trials.
Chang JT[1], Morton SC, Rubenstein LZ, Mojica WA, Maglione M, Suttorp MJ, Roth EA, Shekelle PG.

Abstract:

OBJECTIVE: To assess the relative effectiveness of interventions to prevent falls in older adults to either a usual care group or control group.
DESIGN: Systematic review and meta-analyses.
DATA SOURCES: Medline, HealthSTAR, Embase, the Cochrane Library, other health related databases, and the reference lists from review articles and systematic reviews.
DATA EXTRACTION: Components of falls intervention: multifactorial falls risk assessment with management programme, exercise, environmental modifications, or education.
RESULTS: 40 trials were identified. A random effects analysis combining trials with risk ratio data showed a reduction in the risk of falling (risk ratio 0.88, 95% confidence interval 0.82 to 0.95), whereas combining trials with incidence rate data showed a reduction in the monthly rate of falling (incidence rate ratio 0.80, 0.72 to 0.88). The effect of individual components was assessed by meta-regression. A multifactorial falls risk assessment and management programme was the most effective component on risk of falling (0.82, 0.72 to 0.94, number needed to treat 11) and monthly fall rate (0.63, 0.49 to 0.83; 11.8 fewer falls in treatment group per 100 patients per month). Exercise interventions also had a beneficial effect on the risk of falling (0.86, 0.75 to 0.99, number needed to treat 16) and monthly fall rate (0.86, 0.73 to 1.01; 2.7).
CONCLUSIONS: Interventions to prevent falls in older adults are effective in reducing both the risk of falling and the monthly rate of falling. The most effective intervention was a multifactorial falls risk assessment and management programme. Exercise programmes were also effective in reducing the risk of falling.

Comment in: Preventing falls in elderly people.
PMID:15031239

REFERENCE N°17

Nurs Older People. 2014 Jul;26(6):18-24.
Assessment and prevention of falls in older people.
Barker W.
Abstract: In June 2013 the National Institute for Health and Care Excellence updated and replaced its 2004 clinical guideline 21 (CG21) on falls with clinical guideline 161 (CG161). Two priorities were outlined in the latter: preventing falls in older people (unchanged from CG21) and preventing falls in older people during a hospital stay (new). CG161 is for health and social care clinicians who care for older people who have fallen or who are at risk of falling. It provides clinicians and commissioners with evidence to implement effective care pathways and recommendations on the assessment and prevention of falls in older people. The amalgamation of the two guidelines has resulted in some disconnection. This article summarises the evidence and supports clinicians in the interpretation of the revised falls guideline.
PMID: 24975078

REFERENCE N°18

RNAO Registered Nurses'Association of Ontario.
Prevention of Falls and Fall Injuries in the older adult.
http://rnao.ca/bpg/guidelines/prevention-falls-and-fall-injuries-older-adult
Last Review: 2011

Increase your confidence, knowledge, skills and abilities in the identification of adults within health care facilities at risk of falling and to define interventions for the prevention of falling.
The guideline does not include interventions for the prevention of falls and fall injuries in older adults living in community settings. The guideline has relevance to areas of clinical practice including acute care and long-term care, and will assist nurses to apply the best available research evidence to clinical decisions, and to promote the responsible use of health care resources.

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