

# Falls Prevention

## A Geriatrician's Perspective

A falls prevention clinic has been running at the Community Rehabilitation Unit in Hobart for approximately 4 years. The clinic is multidisciplinary and the core personnel are a Physiotherapist, an Occupational Therapist, a Geriatrician and a Pharmacist.

The clinic receives referrals from General Practitioners as well as a few from Specialist Medical Practitioners (e.g. Neurologists). Many referrals seem to have been instigated by Community Service providers such as Community Nurses. Each member of the multidisciplinary team performs a semi-structured assessment and data is stored electronically.

The Geriatrician performs a general medical assessment as well as a focussed assessment, which includes:

1. Falls history: mechanism of falling e.g. syncope, vertigo, slip, trip etc.
2. Cognition and mood assessment.
3. Drug history and medication review.
4. Neurological and musculoskeletal examinations (includes vision and foot assessment).
5. Assessment for postural hypotension.

Important findings from these assessments include the finding that the majority of Falls Clinic attendees have an underlying neurological diagnosis, which is generally a brain disease.

The most common diagnoses are:

- (a) *Deep White Matter Ischaemic Disease* leading to mild cognitive dysfunction, gait dyspraxia and balance impairment. This diagnosis is generally associated with a long history of hypertension, diabetes or cigarette smoking.
- (b) *Parkinsonism*: The commonest subtype of Parkinsonism has been Idiopathic Parkinson's disease but, there have been a handful of patients with drug-induced Parkinsonism (most commonly secondary use of stemetil), and the less common Parkinsonian syndromes e.g. Progressive Supranuclear Palsy (Steele Richardson Syndrome).

We have found that many Falls Clinic attendees have major co-morbid medical illnesses and health problems. It seems common (probably for a great variety of reasons) that these problems have not been addressed prior to the clinic referral. Many times these problems do not appear to have been mentioned to the patient's General Practitioner. Common co-morbid issues are pain (wide variety of causes), osteoporosis, continence problems, vision and hearing difficulties and foot problems.

We have found that many patients have serious psycho-social morbidity, which appears to be directly related to the mobility and balance defects. These problems include depression, fear of further falling and social isolation.

There seem to be a number of potentially reversible barriers to progress in rehabilitation, which we see commonly. These include pain, depression and cognitive impairment. None of these problems are absolute barriers to rehabilitation but often there is a great need to reduce pain and depression before a physiotherapy program can be helpfully undertaken.

I will briefly relate how I understand the roles of the Physiotherapist, Occupational Therapist and Pharmacist. We meet for approximately half an hour weekly to discuss all referred patients following our assessments and formulations. Our Occupational Therapist has provided us with feedback from previously seen patients (in general this has been very favourable). As a group we feel that multidisciplinary assessment and management is of great importance in providing the best insight into our patients' problems and guiding rational interventions.

The Physiotherapist performs a detailed, structured balance and gait assessment and detailed muscle power testing and has developed considerable expertise in vestibular function assessment and rehabilitation (e.g. for conditions such as benign positional vertigo).

The Occupational Therapist performs a structured home safety assessment. Data is collected relating to fear of further falling (Falls Efficacy Scale) and social functioning.

The Pharmacist takes a detailed drug history, and at the patient's home completes a brief nutritional assessment. As many of our patients are very restricted in their mobility, many are at risk of Vitamin D deficiency because of poor sunlight exposure. Supplementation with vitamin D and calcium is encouraged for these patients. The Pharmacist assists patients who are having compliance problems and provides information and advice about medications. Some information and support is provided for patients who are attempting to get off benzodiazepines and other medications, which seem to have contributed to falls risk.

Management Strategies are broad ranging and targeted to the individual patient's needs. We see the critical importance of the General Practitioner and Community Service Providers being acknowledged and treated as equal partners in the collaborative effort and we encourage clear communication lines to provide good initial referral information and subsequent feedback.

We do recognise that some of our patients' needs can be met with existing Community Services but other, higher risk patients, will require interventions provided through the clinic. We have developed a variety of patient information handouts, which are generally found to be helpful.

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