Falls in Older Adults
The Saskatchewan Experience

Jenny Basran MD FRCPC
October 2012

What is a fall?

"An unexpected event in which a person comes to rest on the ground, floor or lower level"

- Controversy re: inclusion of:
  - Unwitnessed falls where the patient/client/resident is unable to explain the events and there is evidence to support that a fall has occurred; and
  - Near falls, where the patient/client/resident is eased to the floor or lower surface by staff or family members.
  - Near falls, where the patient/client/resident experiences a loss of balance and is able to correct themselves before an actual fall occurring.
- Research vs Real Life

Lamb, S.E., Jorstad-Stein, E.C., Hauer, K., & Bedier, C. (2005). Development of a common outcome dataset for fall prevention injury trials: The Prevention of Falls Network Europe consensus. *Journal of the American Geriatrics Society, 53*(9), 161-22

Falls Statistics

- Every year:
  - In community:
    - 1 in 3 (35%) adults over age 65 will fall
    - 1 in 2 (50%) adults over age 80 will fall
  - 35% home care patients will fall
  - 40% long term care patients will fall
- Falls account for
  - Majority of injury related hospitalizations in older adults
    - 77% for males, 88% for females
    - Avg LOS ~ 50% longer for falls than all other causes of hospitalization
  - 40-50% of all LTC admissions

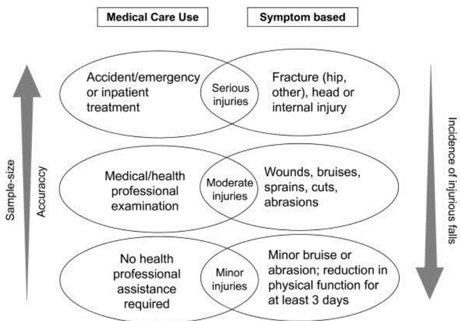
Fall related injuries

- 22 – 60% will suffer injury from falls
  - 15-25% falls ➔ serious injuries – fractures, head & spinal cord injuries, contusions
    - 2-6% ➔ fractures
- 90% of all hip fractures due to a fall
  - 50% of all hip fracture patients already had a fracture
  - 25% hip fracture patients will die within 6 -12 months
  - 40% mortality following hip fracture if LTC patient

Standardized system for categorizing and defining fall-related injuries

Category	Definition
a - serious injury	medically recorded fracture, head or internal injury requiring accident and emergency or inpatient treatment
b - moderate injury	wounds, bruises, sprains, cuts requiring a medical/health professional examination such as physical examination, x-ray, suture
c - minor injury	minor bruises or abrasions not requiring health professional assistance; reduction in physical function (e.g. due to pain, fear of falling) for at least three days.
d - no injury	no physical injury detected

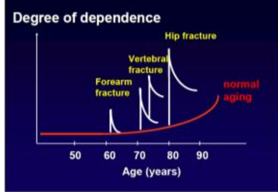
Schwenk M et al. (2012) Definitions and methods of measuring and reporting on injurious falls in randomized controlled fall prevention trials: a systematic review. *BMC Med Res Methodol* 12:50.



Schwenk M et al. (2012) Definitions and methods of measuring and reporting on injurious falls in randomized controlled fall prevention trials: a systematic review. *BMC Med Res Methodol* 12:50.

Injuries Sustained From Falls

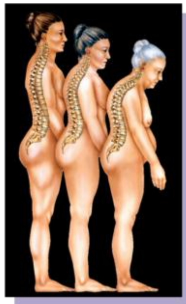
- Cuts, abrasions, bruises & sprains – most common
- Fractures – most dangerous, especially hip
  - Most do not regain previous level of functioning



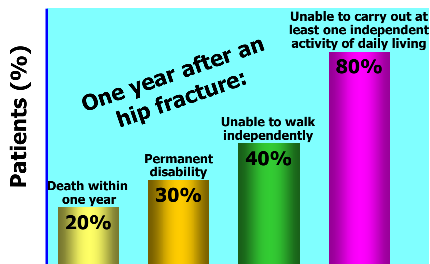
  - Increased mortality – short and long term

Morbidity after vertebral fractures

- Back pain
- Loss of height
- Deformity
  - Kyphosis
  - Protuberant abdomen
- Reduced pulmonary function
- Decreased Quality of Life
  - Self-esteem
  - body image
  - sleep problems

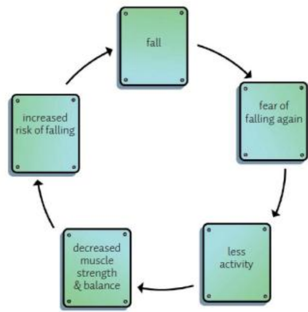


Significant functional impairment

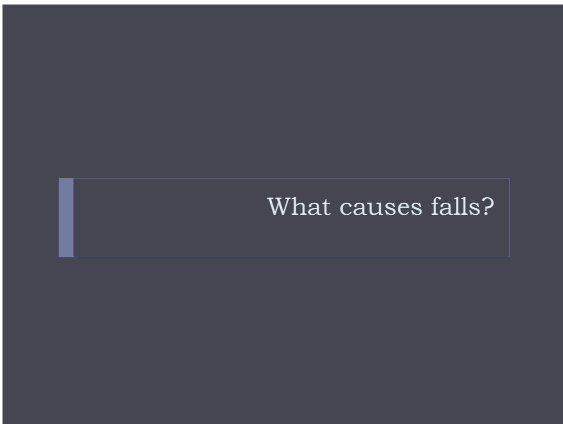


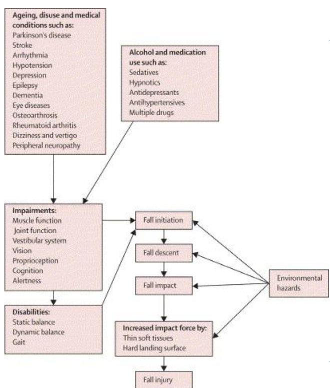
Cooper C, Am J Med, 1997;103(2A):12S-17S

Fear of Falling = Vicious Cycle



- 48% say they are afraid of falling again
- 25% decrease their activity





older adults who are **predisposed** because of accumulated effects of diseases / impairments (intrinsic)

↓

Are exposed to **precipitating** challenges (extrinsic)

What can we do?

- Falls are common in older adults, but are not a normal part of aging
- Health professionals can:
  - Assess patients who are at risk of falling or who have fallen to find reasons for falls
  - Implement universal precautions & specific appropriate interventions
  - Encourage Vitamin D supplementation
    - ? all LTC patients (if no contraindications)
- What resources are available?
  - Canada - Safer Healthcare Now – Falls Prevention Kit
  - Scotland - Social Care & Social Work – Managing Falls in Care Homes
  - American / British Geriatric Society - guidelines
  - Australia – guidelines for acute care, community and LTC
  - ProFANE - Prevention of Falls Network Europe (great website)

Saskatchewan Ministry of Health

- In 2011 falls prevention identified as a strategic priority as part of the Saskatchewan Surgical Initiative
  - Committed funding - expenses
- Phase one - Long-Term Care (LTC) Falls Prevention and Reduction Initiative, with targets for:
  - Reducing the number of LTC residents who experience a fall
  - Reducing the number of surgeries performed as a result of resident falls
  - Increasing the number of facilities that have implemented the SHN! Falls prevention bundle
- Contact information: nglenn@cpsi-icsp.ca

Saskatchewan Falls Collaborative

- Updated SHN's "Getting Started Kit"
  - New national expert panel updating kit
  - Incorporate what we learned in Saskatchewan
- Expert panel – front line clinicians
  - Geriatrician, pharmacist, physical/occupational therapists, nurses, care aids, quality improvement coordinators
- Webex sessions & Face to face meetings
  - Facilitated by SHN, CPSI, Health Quality Council
- Shared resources
  - Updated "Getting Started Kit" with new framework, evidence, appendix of resources
  - Change package – summary of high leverage ideas
  - Google Listserve, Dropbox, email questions

Falls Intervention Model
1. Prevention: Universal Fall Precautions (SAFE) for all a) Safe Environment, Assist with Mobility, Fall Risk Reduction, Engage Patient and family.
2. Screen all patients/ clients/ residents for risk of falls b) Assess all patients'/clients'/residents' falls risk on admission, following a significant change in status, following a fall or near-fall, and on a regularly scheduled basis.
3. Multifactorial Risk Assessment in All Patients at Risk *Patient/Client/Resident level:* a) Fall history, observations of gait and balance and identify risk factors *Organizational level:* a) Develop organizational policies for falls prevention/reduction and management that includes roles and responsibilities of entire health team (care providers and maintenance/housekeeping staff). b) Develop approaches for regular safety checks and include environmental audits and modifications as a component of falls prevention strategies. c) Investigate each fall or near fall (near miss) to identify contributing factors and to prevent re-occurrence.
4. Create Personalized Care Plan Addressing the Specific Fall Risk Factors a) Implement appropriate interventions specific to the risk factors identified and customized to the unique characteristics of the patient/client/resident. b) Modify the environment and provide personal device, if required, to reduce risk of falls-related injury.
5. Document, evaluate and educate about Falls Risk a) Create a record that summarizes the assessment findings and rationale for interventions. b) Communicate the results of the falls risk assessment to the healthcare team, patient/client/resident, and the family. c) Educate all staff on the prevention of falls and fall injuries. d) Evaluate the effectiveness of the care plan.

New Framework

(Getting Started Kit – Saskatchewan version)

1. Prevention: Universal Fall Precautions for All

1. Prevention – Universal Falls Precautions

- 2 assumptions – in acute and LTC
  - All patients are at risk for falls
  - Everyone has a role in fall prevention
- S.A.F.E.
  - S – safe environment – bedrails down, clutter-free, brakes on, lights
  - A – assist with mobility – twice a day, scheduled toileting, glasses, aids
  - F – fall risk reduction – call bells, lower bed, proper footwear
  - E – engage patients & families – discuss risk factors, mutual plan
- 3 questions to ask before exiting a patient's room:
  - "Do you need to use the toilet?"
  - "Do you have any pain or discomfort?"
  - "Do you need anything before I leave?"

2. Screen all patients for risk of falls

2. Screen all patients for risk of falls

- Screening not enough → do something with risk factors
- Must be validated and standardized
  - DO NOT MAKE UP YOUR OWN
  - periodically test tool - two staff administer separately then compare
- Not one that can be used across entire continuum of care
  - Community / Home Care
    - American Geriatrics Society (AGS/BGS) Fall Prevention Guidelines
    - Falls Risk for Older People – Community setting (FROP-Com) – National Ageing Research Institute
    - Strategies and Actions for Independent Living (SAIL)/ Promoting Active Living (PAL) – BC Fraser Health, Vicky Scott
  - Long term Care – is everyone already at risk?
    - Scott Fall Risk Screening Tool for Residential Care
    - Morse Fall Scale (needs to be calibrated for each site)
    - Scotland SCSWIS Multifactorial Risk Assessment & Management tool

Older person encounters healthcare provider [A]

2 Screen for fall(s) or risk for falling (See questions in sidebar) [B]

Sidebar: Screening for Fall(s) Questions

1. Two or more falls in prior 12 months?
2. Presents with acute fall?
3. Difficulty with walking or balance?

3 Answers positive to any of the screening questions? (See sidebar) [C] — Yes → 7; No → 4

4 Does the person report a single fall in the past 12 months? [D] — Yes → 5; No → 10

5 Evaluate gait and balance [E]

6 Are abnormalities in gait or unsteadiness identified? — Yes → 7; No → 10

7
1. Obtain relevant medical history, physical examination, cognitive and functional assessment
2. Determine multifactorial fall risk:
   a. History of falls
   b. Medications
   c. Gait, balance, and mobility
   d. Visual acuity
   e. Other neurological impairments
   f. Muscle strength
   g. Heart rate and rhythm
   h. Postural hypotension
   i. Feet and footwear
   j. Environmental hazards

[F]

8 Any indication for additional intervention? — Yes → 9; No → 10

9 Initiate multifactorial/multicomponent intervention to address identified risk(s) and prevent falls:

1. Minimize medications
2. Provide individually tailored exercise program
3. Treat vision impairment (including cataract)
4. Manage postural hypotension
5. Manage heart rate and rhythm abnormalities
6. Supplement vitamin D
7. Manage foot and footware problems
8. Modify the home environment
9. Provide education and information

10 Reassess periodically

AGS/BGS Guidelines for Prevention of Falls in Older Adults

J Am Geriatr Soc 2010

www.americangeriatrics.org/health_care_professionals/clinical_practice/clinical_guidelines_recommendations/2010

Screening Questions

1. 2 or more falls in the past 12 months
2. Presents with acute fall
3. Difficulty with walking or balance

If no → do they have one fall in last 6 months → if yes → evaluate gait & balance (TUG) → if abnormal → to yes

- (TUG = Timed Up and Go)

If yes →multifactorial fall risk assessment and intervention

Screening tools – community / home care

- FROP-Com

Promoting Active Living (PAL): Best Practice Guidelines for Fall Prevention in Assisted Living©

National Ageing Research Institute

www.health.gov.bc.ca

Screening Tools - LTC

- Scott Fall Risk Screening Tool for Residential Care

SCOTT FALL RISK SCREENING TOOL for Residential Care©

Reason for completing tool *(circle one)*: 1. New admission; 2. Change of status; 3. Yearly review; 4. Serious fall injury/multiple falls. *[TO BE COMPLETED BY RN, LPN or PT/OT]*

RISK FACTOR PRESENT	CIRCLE	POSSIBLE STRATEGIES
More than 2 falls in previous 6 months	6	Review circumstances of prior falls from fall reports.
Impaired mobility, balance or gait	2	Refer for PT/OT assessment / recommend use of hip protectors.
Altered mental state (e.g., delirium, brain injury, dementia, depression)	2	Monitor daily for change in mental status and ability to remember and follow instructions.
Attempts to unsafely get out of bed due to lack of understanding, agitation or restlessness	3	If confused with impaired mobility, assess for bed alarm / mats / monitoring.
Move to facility in past month	1	Screen for fall risk / assess for mobility.
Dizziness or vertigo	1	Check for orthostatic hypotension, dehydration and vestibular problems. Refer for medical assessment.
Generalized weakness (see back page for indicators)	1	Assess for insomnia, pain, malnutrition, hypoxia or disease. Refer for medical assessment.
Alterations in urinary and bowel elimination (frequency, urgency, incontinence, etc.)	1	Bladder/bowel routine / bedside commode or light if unsafe at night.
Greater than 7 medications, especially narcotics, anti-depressants, anti-psychotics, diuretics	1	Regular review of medications.
Any prescribed benzodiazepine or psychotropic medications	1	Refer to pharmacist/ physician for reduced dose or alternatives to benzodiazepine or psychotropic meds.
Immobile (unable to walk or stand unaided)	-5	Precautions for falling from bed or chair. Plan for fracture risk related to osteoporosis.
TOTAL		

Risk Assessment Total Score *see reverse for further guidelines for item completion.*
Score <7 – universal precautions for fall, plus a plan in place to reduce impact of each indentified risk above.
Score ≥ 7 – deemed to be at high risk for falls.
Score >12 – deemed to be at high risk for falls and unsafe ambulation.

IF resident score <7- plan in place for each risk and:
Follow universal fall prevention plan, including:
- bed in low position
- call bell in place
- good fitting footwear
- incontinence precautions
- environment uncluttered, good lighting, accessible grab bars, non-slip floors
- apply strategies based on risk items above

IF resident score ≥7- plan in place for each risk and:
In addition to universal fall prevention plan, develop tailored falls prevention plan based on risk items above and put in chart, including:
- bedside safety plan put in prominent location in room
- include high risk status in shift report & chart
- least restraint precautions
- hip protectors, bed / chair alarm, as needed
- notify family of fall risk through letter / brochure

IF unsafe ambulation with score >12:
In addition to above, assess for appropriate wheelchair use / least restraints / hip protectors / personal alarm systems. Notify family through letter and/or brochure regarding unsafe ambulation and fall risk.
Comments:

To use
Contact: vicky.scott@gov.bc.ca

SCSWIS social care and social work improvement scotland
NHS SCOTLAND

managing falls and fractures in care homes for older people
Good practice self assessment resource

- www.scswis.com
- Self-assessment guide
- Information, guidance & tools
- Multifactorial Risk Assessment and Management tool (#5)

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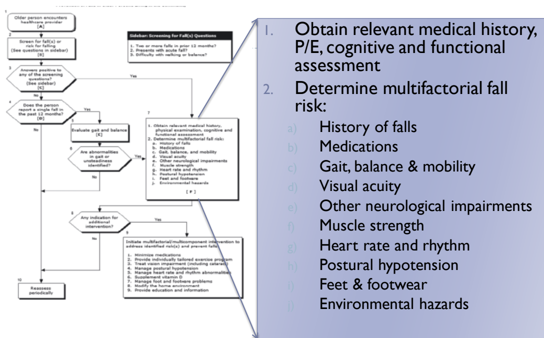
3. Multifactorial Risk Assessment for all Patients at Risk

3. Multifactorial Risk Assessment for All At Risk Patients

- Individual Level
  - Fall history
  - Identify risk factors
  - Physical Exam – including gait & balance assessment
- Organizational Level
  - Policies and procedures
  - Roles & responsibilities of entire team – care providers, maintenance / housekeeping
  - Safety checks, environmental audits
  - Investigate each fall (or near fall) for contributing factors to prevent recurrences



1. Obtain relevant medical history, P/E, cognitive and functional assessment
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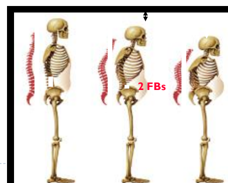
   e) Other neurological impairments
   f) Muscle strength
   g) Heart rate and rhythm
   h) Postural hypotension
   i) Feet & footwear
   j) Environmental hazards

www.americangeriatrics.org/health_care_professionals/clinical_practice/clinical_guidelines_recommendations/2010

Physical Exam Essentials

- Lying and Standing BP & HR
  - Greater than 20 mmHg drop in SBP and 10 mmHg drop in DBP +/- symptoms
  - Does BP & HR go back to baseline after 3-5 min?
    - If not, consider autonomic dysfunction
- Look for vertebral fractures (osteoporosis)
  - Weight & Height
  - Wall-occiput distance
  - Rib-pelvic distance
- Timed Up and Go (TUG)



Osteoporosis Canada Recommendations for Clinical Assessment of Osteoporosis (2010)

Assessment	Recommended Elements of Clinical Assessment
Physical examination	Measure weight (weight loss of ≥10% since age 25 is significant)
	Measure height annually (prospective loss > 2cm) (historical height loss > 6 cm) Measure rib to pelvis distance ≤ 2 fingers' breadth Measure occiput-to-wall distance (for kyphosis) > 5cm — Diagnosis of vertebral fractures
	Assess fall risk by using Get-Up-and-Go Test (TUG) (ability to get out of chair without using arms, walk several steps and return)

www.osteoporosis.ca

Osteoporosis physical exam

Green, A. JAMA 2004; 292(23):2890-2900

4. Create personalized care plan - specific fall risk factors

Multifactorial Interventions

1. Minimize medications, especially psychoactive drugs
2. Provide individually tailored exercise program
3. Treat vision impairment (ie: cataracts)
4. Manage postural hypotension
5. Manage heart rate & rhythm abnormalities
6. Supplement Vitamin D
7. Manage foot & footwear problems
8. Modify the home environment
9. Provide education and information

- 27% (2-37%) fall risk reduction for community dwelling older adults

4. Create Personalized Care Plan Addressing the Specific Fall Risk Factors

- Appropriate interventions for specific risk factors
  - Withdrawal of psychotropics – ↓ falls by 63%
  - Cardiac pacing – pts with carotid hypersensitivity - ↓ falls up to 70%
  - Cataract surgery – ↓ falls by 40%
- Customized to unique characteristics of the individual
  - Tai Chi classes – ↓ falls by 49%
  - Professionally supervised strength & balance training –↓ falls by 20%
  - High dose (2 hrs/wk X 6 months) - ↓ falls by 42%
  - Otago (home based program) - ↓ falls by 34%
- Modify environment
  - Home modifications in fallers can ↓ falls by 34%
- Provide personal device
  - Mobility aids, hip protectors - ↓ falls by 80%

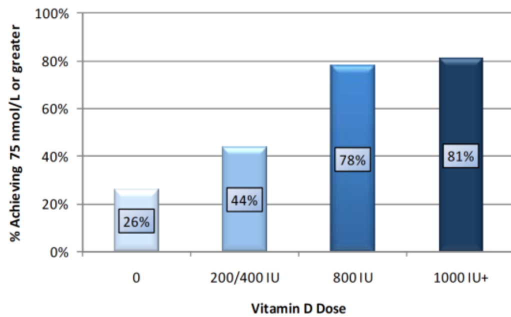
Vitamin D Supplementation – Must Do

- Low Vitamin D levels cause:
  - Muscle weakness & atrophy (esp fast twitch fibers)
  - Increased postural sway
  - Impaired psychomotor function
  - Increased bone turnover → osteoporosis
  - Osteomalacia → migratory pain in bones
- Benefits:
  - Vitamin D reduced future falls risk up to 34%
  - Potential – cancer, CV, anti-inflammatory
- OP Canada guidelines – Vitamin D 1000 - 2000 IU OD

Vitamin D in LTC

- Best intervention to prevent falls in LTC
  - Mandated in Australia / NZ
  - Fraser Health Region (BC)
- Dose? Daily may be best.
  - ViDOS study (40 LTC - Ontario):Vitamin D3 1000 IU OD
  - Fraser Health Region: 20,000 IU D3 weekly
  - Australia / NZ:
    - Loading dose: 2 X 50,000 IU D3 in first month
    - Maintenance dose: 50,000 IU D3 per month
- Not for patients with hypercalcemia and/or severe renal failure (GFR<20 mL/min)

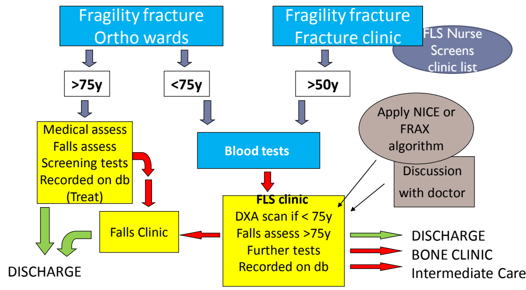
ViDOS study



Risk Factors for Injury following fall

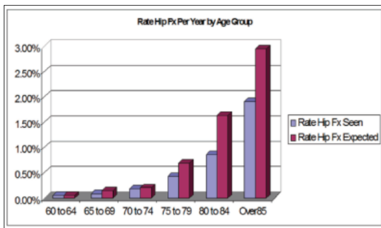
- Osteoporosis assessment
  - Care gap
- Anticoagulation:
  - Usual benefits outweigh risks unless repeat or high risk faller (>300 falls per year)
- Can the person get up from fall?
  - Teach them how to get up
- Is there a way to notify others in case of falling?
  - Lifeline & accessible telephones
  - Friendly phone calls, visits

Ipswich Hospital NHS Trust
Fracture Liason Service (FLS)



Clunie and Stephenson. Journal of Orthopaedic Nursing (2008) 12, 156–162

Kaiser Permanente
FLS Southern California Style

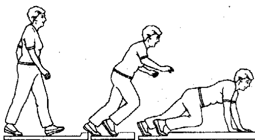


- 37% reduction in expected hip fractures → 50% this year
- Saved 100,000 hip fractures = $5 billion annually

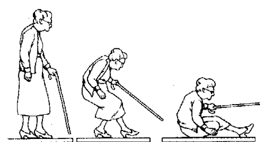
Dell et al. JBJS 2008;90:54:188-194

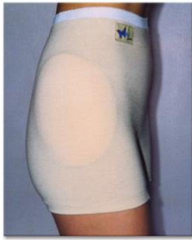
Do we fall differently when we age?

Young adult

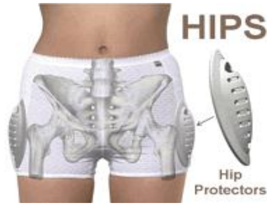


Older adult





Hip Protectors



- 80% risk reduction of fracture following a fall but poor compliance
- not all hip protectors same - Fraser Health Region Kit – Safehip & Hipsaver

5. Document, evaluate and educate about Falls Risk

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- Home care
  - Fall calendar
  - Home / environmental scan for risk factors
  - Exercise – community or home based
- Long term care
  - Fall diaries
  - Measles charts
- Outcome measures, audits
  - Safer Healthcare Now!
  - PDSA cycles
- Ongoing education
  - But not as a stand alone intervention – not enough

Measles Chart

Tool 13b: Measles chart example

82 81 80 79 78 77 76 75 74 73 72 71
83 84 85 Bathroom Bath room Lounge Dining Conservatory COURTYARD GARDEN Bath 70 69 68 67 Nurse
Hair-dressers Clinical Staff Kitchen Lounge 59 60 61 62 63 Assist Bath 64 65 66

Home Based Exercise Programs

- Published in June 2011
- Free to print and distribute to patient
- Make own DVD by having patients model

http://www.laterlifetraining.co.uk/home-exercise-booklets-free-to-download/

How did it work in Saskatchewan?

Saskatchewan Falls Collaborative

25 Teams From Across Saskatchewan

Athabasca Health Authority HC Team (withdrew due to resource issues)

Prairie North Regional LTC Team

Five Hills Regional HC Team
Pioneer Lodge LTC Team
Providence Place LTC Team
Ross Payant Nursing Home LTC Team

Saskatoon Regional HC Team
Sherbrooke/Central Haven LTC Team
Stensrud Lodge LTC Team
Parkridge Centre LTC Team
Extendicare Preston LTC Team
Golden Acres LTC Team
Last Mountain Pioneer Home LTC Team
Luther Care Communities LTC Team
Pleasant View Care Home- Wadena LTC Team
Oliver Lodge LTC Team

Cypress Regional EMS/HC Team
Cypress Regional LTC Team (Represents 12 LTC sites)

Sunrise Regional HC Team
Sunrise Regional LTC Team

RQHR Regional HC Team
RQHR Regional HC Palliative Care Team
Extendicare Parkside LTC Team
Regina Lutheran LTC Team

Sun Country Regional HC Team
Sun Country Regional LTC Team - (including Tatagwa View – Weyburn)
Moose Mountain Lodge LTC Team

51 Saskatchewan Falls Collaborative: Reducing Falls Reducing Harm in LTC and HC

What did we do?

Chartered our Team and Tested Lots of Ideas for Improvement

- Aim — What are we trying to accomplish?
- Measures — How will we know that a change is an improvement?
- Ideas — What changes can we make that will result in improvement?
- Test and implement using small tests of change — Act, Plan, Study, Do

Expanded conditions – Multiple small tests of change

Shared our learning along the way…

- skfallscollaborative@googlegroups.com
- Cisco webex — Monthly Team Calls
- SHN Community of Practice

Used data & feedback for learning

52 Saskatchewan Falls Collaborative: Reducing Falls Reducing Harm in LTC and HC

Measures –

Outcome:

- Fall rate per 1000 resident days (1000 home care clients)
- Percentage of falls causing injury

Process:

- Percentage of residents (clients) with completed falls risk assessment on admission
- Percentage of residents (clients) with completed falls risk assessment following a fall or change in medical status
- Percentage of "at risk" residents (clients) with a documented fall / injury reduction plan

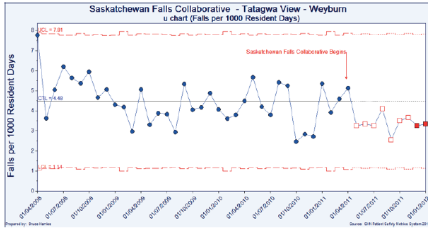
Balancing:

- Percentage of residents with restraints

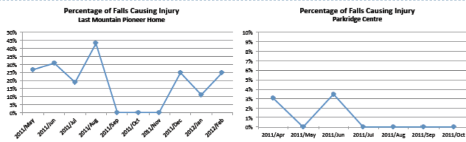
Falls per 1,000 Resident Days

- Sun Country, Five Hills and Saskatoon Health Region facilities reduced total number of falls and total number of falls per 1,000 Resident days by ~ 25%

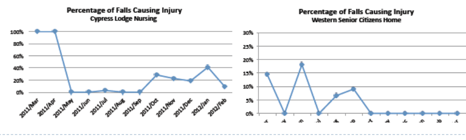
Sun Country Health Region – LTC



Percentage of falls causing injury

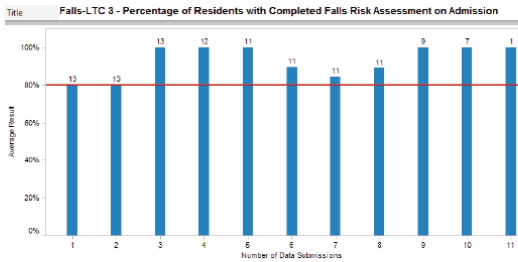


Cypress Health Region-LTC



Percentage of residents / clients with completed falls risk assessment on admission

Saskatchewan Falls Collaborative Team Data



Team Self-Assessment Rating

Average Self-Assessment Rating

5
4.5
4
3.5
3
2.5
2
1.5
1
0.5
0

May-11 Jun-11 Jul-11 Aug-11 Sep-11 Oct-11 Nov-11 Dec-11 Jan-12 Feb-12 Mar-12 Apr-12 May-12

Month

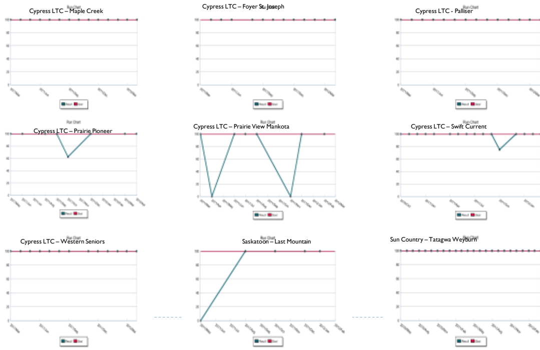
Falls Rate – patient population dependent

Cypress LTC – Maple Creek
Cypress LTC – East End Wolf Willow
Cypress LTC – Foyer St. Joseph
Cypress LTC – Western Seniors
Cypress LTC – Gull Lake
Cypress LTC - Palliser
Cypress LTC – Prairie Pioneer
Cypress LTC – Swift Current
Cypress LTC – Prairie View Mankota
Cypress LTC-Shaunavon Hth Centre
Cypress LTC-Herbert
Cypress LTC-Prairie Hth care Centre-Cabri
Sun Country – Tatagwa Weyburn
Five Hills – Providence Place
Prairie North – Northland Pioneer
Saskatoon – Last Mountain

Percentage of Falls Causing Injury

Sun Country – Tatagwa Weyburn
Cypress LTC-Shaunavon
Saskatoon – LutherCare Home
Cypress LTC – Maple Creek
Cypress LTC – East End Wolf Willow
Cypress LTC – Foyer St. Joseph
Cypress LTC – Gull Lake
Cypress LTC - Palliser
Cypress LTC – Prairie Pioneer
Cypress LTC – Prairie View Mankota
Cypress LTC – Swift Current
Cypress LTC – Western Seniors
Cypress LTC-Herbert
Five Hills – Providence Place
Saskatoon – Last Mountain

Percentage of Residents with a FRA completed on Admission



Next Steps

- Collaborative ended March 2012
  - Desire for teams to stay connected and to spread to other facilities
- Holding the Gain Series initiated
  - Bimonthly calls
  - Guest speakers, break-out sessions
  - Contact and sharing maintained
- Acute Care
  - Releasing Time to Care – many units choosing falls prevention
  - Invited to collaborative from the beginning

Challenges

- Other competing priorities
  - Still a priority in Saskatchewan, but other priorities challenge for time and resources
  - Need to make it part of normal practice, not the "flavor of the day"
  - Leadership support & expectation of ongoing reporting
- Local advocates / leaders – change roles
  - Continued collaborative allows newcomers to get up to date quickly
  - Must include the individuals actually providing the hands on care in the whole process
- How to spread?
  - Continue to show the evidence
  - Saskatchewan Falls Collaborative Overview of Results Report

Conclusions

- Falls are common, but not normal part of aging
- Previous fall is a big predictor of future fall
  - Screen – ask falls history and/or balance problem
  - Always check orthostatic vitals, TUG, OP exam
- Multifactorial – risk factor assessment AND intervention
- Treat fragility fractures – don't need to wait for BMD
- Vitamin D for everyone!
- Get support from local experts
- Share resources
- Measure your progress and share your results
- Falls assessment and management should become part of normal practice

It takes a child one year to acquire independent movement and ten years to acquire mobility.

> An old person can lose both in a day.

Bernard Isaacs