AGEING WELL: FALLS

NEWCASTLE UNIVERSITY

Newcastle University

WEEK 4 HOW CAN YOU TREAT AND PREVENT FALLS?

TRANSCRIPT OF LIVE EVENT[1]

JAMES: Hello, everyone. Welcome to our second live event on this final week of our Ageing Well Falls Course. It's a real shame that it's the final week and I'm really going to miss the course. For anyone who didn't join us last time, I'm James and I'm a clinical lecturer here in Newcastle. And here we've got Julia Newton.

JULIA: Hi, I'm Julia Newton. I'm Professor of Ageing and Medicine at Newcastle University.

JAMES: And this week we've got Lisa Robinson.

LISA: Hi, I'm Lisa Robinson. I'm a physio in the Falls and Syncope Clinic in Newcastle.

JAMES: So as it's the final week, let's start off with thinking about what's been our highlights so far. What's been your highlight over the last four weeks?

JULIA: I think the thing that I've enjoyed the most is seeing everybody's comments and how much people have contributed to the course, how much they've engaged with the content. Because when we've been putting it all together we thought that it was very valuable to people. But actually to see how enthusiastic people have been and how committed with their time and how engaged they've been has been fantastic, for me as a clinician to see and also for us going forward to know what more we need to do to help people understand more about falls and to do more for themselves, to reduce falls.

JAMES: How about you, Lisa?

LISA: Well, I agree with Julia. I've really enjoyed the interaction and I think what I've taken away the most is just how sometimes very simple advice can make a really big difference. So I think the thing that came across to me is how some of the tips that we've given, and also other learners have given, have really made a difference to people. And that people are actually taking things on board and making very small changes, but they're having quite a large impact.

JAMES: I think the highlight for me was when someone described your front room in the experts' video as being a bit dingy. [Laughter].

[1] http://youtu.be/42pJvZlMPxY

JULIA: Yes, I'm considering redecorating now as a result of that.

LISA: Clearly it was the lighting. [Laughter].

JULIA: Perhaps people didn't realise that most of it was actually filmed at my house, that some of the more light areas were my kitchen.

LISA: I've only ever been in the kitchen, so I haven't made it into the lounge yet.

JAMES: The dungeons.

LISA: The dungeons.

JAMES: Let's move on with the question. So the first question came in from Simone who wanted to know why ulcers develop after a fall. I think this relates to when someone falls and they're not able to get up, and they're lying on the floor and the pressure upon the skin stops the blood getting to that part of the skin. And without the blood flow, the skin cells start to break down and they die, and that can result in an ulcer.

JULIA: So a pressure ulcer.

JAMES: Yeah. That can be worsened if people fall, they can't get up and they're on the floor for so long that they can't get to the loo and they have to pass water. Lying in water can damage the skin even more and make things worse. So next question, from Astrid, how does CBT work? We've spoken quite a lot about CBT in this final week and about fear of falling. Do either of you have any experience of CBT?

LISA: I have limited experience of CBT, and my understanding of CBT is the way that it works is by exploring people's thinking about things and sometimes trying to challenge that thinking in quite a productive way. So sometimes we just make assumptions and we make thoughts about things, and sometimes they aren't terribly helpful. And I think sometimes challenging that thinking in a productive way is often a good way to improve and move on and change behaviour.

JAMES: And there's the vicious cycle of having an intrusive thought about something and then that thought changes the way the body feels. And so it might cause a feeling of sickness or palpitations with the heart beating. And then feeling sick or anxious physically reinforces that thought, makes someone feel more anxious, then the body feels more anxious. And CBT is about breaking that vicious cycle to try and stop those thoughts and attract less negative thoughts about something.

So I think this one is coming to you Julia. This is from Elaine and Charlene. Is there any specific advice for people who fall if they have Parkinson's disease?

JULIA: So Parkinson's disease is a neurological condition where people can often have difficulties with movement, getting movement initiated, and can have problems with tremor – we call that bradykinesia, the difficulty with getting movement initiated and slow movement. So people with Parkinson's disease

can often walk very differently, so they can have problems with balance and gait, the way that they walk. So trying to keep mobile, a lot of the things that people have learnt through the course are very applicable to people with Parkinson's disease. But also people with Parkinson's disease can often have problems with blood pressure regulation, so they're more likely to drop their blood pressure when they stand up, partly because of having Parkinson's disease itself but also partly because of some of the tablets that people with Parkinson's disease need to take to keep their mobility better.

So it's really important if you have Parkinson's disease and you experience dizziness or light-headedness, particularly when you stand up, that you seek help for that. Because it may be that modifying your medicines or adding medicines like fludrocortisone in and midodrine, which we've talked about this week in the course, they might be of value and reduce symptoms of dizziness and light-headedness when people stand up.

So I think in general, dizziness and light-headedness, go and seek help for that because there's treatments for it. But also, keeping generally fit, active, taking Parkinson's medicines if you're prescribed them so that you can keep more mobile. Lisa might, from a physio point of view, have something to add to that but, from a medical point of view, that's the sorts of things we'd look for in the clinic.

LISA: Yeah, as you say, it's often multi-factorial, isn't it? So a lot of people with Parkinson's, as Julia said, they become very slow in their movements and their walking changes. Often their posture changes as well and they become more flexed, and that can often make them more off-balance. And also they become very stiff in their movements as well. So I think trying to keep active and obviously trying to keep mobile as well, because Parkinson's disease is a progressive condition, so trying to delay those changes as quickly as possible. So being active and trying to keep mobile as well.

JAMES: And I guess another important aspect is to make sure they let the team looking after their Parkinson's disease know if they've got problems with their balance –

LISA: Of course.

JAMES: - or with falls, because they can then access the Falls services.

LISA: Definitely.

JAMES: So the next question comes from Caroline. What is the evidence for the use of hip protectors? We spoke about hip protectors in the last live event but we didn't talk about what the research study showed, whether they're effective or not. One thing I always try to remember is, even if you're wearing hip protectors and you fall, it might absorb some of the impact on the fall if you land on your hip but if you put your hand out and you land on your hand it doesn't prevent a wrist fracture.

JULIA: Absolutely. And the evidence for the benefit of hip protectors is quite controversial because a few years ago there were some studies that suggested that they may be of benefit but then subsequently, when they've been trialled in larger trials, that benefit wasn't as convincing. Part of the

problem seems to be that people will fall when not wearing them. So I think if you wear them, so what we call comply, and you have a fall then they can be of benefit, but the problem relates to the fact that they are difficult to get on, difficult to comply with. And a significant proportion of people in the trials weren't wearing them at the time that they had their fall. So I think it's a very difficult area and individuals have to decide whether it's the right thing for them I think because, at the moment, the evidence is contradictory.

JAMES: Okay. Next we have a question, this must be a popular one because it's from Margaret, Judith and Virginia. Are there any recommended sets of exercises that people can perform to prevent falls but without having to go to their doctor or physiotherapist to get them? Can they do them themselves?

LISA: Yes, there are exercises that people can do at home, and obviously the best evidence is to go to the doctor and be referred for a physiotherapy assessment and have an individualised assessment. But obviously that's not appropriate for everybody. So as a really good resource I would suggest Age UK's website. If you go onto Age UK's website and if you just put in 'strength and balance exercises' it will direct you to some links where there are some exercises which are free to download. And those exercises have been produced by healthcare professionals, so they are safe to do at home, and they are effective at reducing falls.

The other thing, of course, to think about is to join an exercise group, which again isn't for everybody, but I think there are advantages to exercising at home but obviously it's also socially quite useful to exercise. And often you're given homework to do, so you would be able to do some things at home as well. But Age UK would be a good place to start, I think.

JAMES: And just keeping fit and active helps prevent falls but is good for so many other things. And I think someone on the course posted a link too; the NHS has got a Keeping Fit and Active campaign. I can't remember the name of it but someone put a link on the course if people wanted to have a look at that, it had some tips on how to keep fit and active.

LISA: Yeah, there's a lot of things that you can do if you think that you're somebody who doesn't like exercise as such, but just little things like taking the stairs rather than escalators and things like that through the day, and they will all add up and make a difference. Getting off the bus a stop early and just walking that slightly longer distance, and things like that.

JULIA: Or walking to work, even.

LISA: Or walking to work – as I did today, yes.

JAMES: Well done, Julia – that must be the first time in a long time. [Laughter].

JULIA: It's Christmas.

JAMES: Next from Barbara. She was worried about concerns that people might not wear a pendant alarm because it might accidentally be activated, or people worried that they're going to waste someone's time if they press their buzzer. And the stigma of being seen to be wearing one. Is there

anything we can do to reassure people that these are really good devices and they shouldn't worry about disturbing people?

JULIA: Well that's the job of the person at the end of the phone –

LISA: Yes.

JULIA: - that's what they're employed to do. So actually, in terms of a job creation scheme, think about it like that, that actually it's lots of people wearing these devices who ultimately feed into somebody who has a job as a consequence. And they are very effective and they give people confidence that there's going to be somebody to help them should there be problems. So it's very simple and, to me, is real common sense that if you're on the floor and you need help it's a very simple way of getting help. They're usually designed in such a way that it's really very hard to press them accidentally, so I think people should not worry; it's an unnecessary worry. It's more of a worry about having a fall than a worry about wearing the pendant, I would have thought.

LISA: Yeah certainly, I agree with Julia and I think from my experiences working in the community I think people are very happy to answer the calls, particularly if they are a false alarm. I used to work in a service where people would stay with us for up to six weeks and we used to do lots of home visits and overnight stays. So what we would actually do is, if that person had a pendant alarm, we would just activate it and obviously the person at the other end would reply. And we would say, "We're just checking that it's working okay because Mrs Such-and-Such is home for the evening," or whatever. And they usually say, "That's absolutely fine, no problem." And that often reassures people.

With regards to acceptability, obviously they can be worn underneath the clothing, so if people don't feel that they want it on display then just popping it underneath their shirt or jumper is fine. Or the other option is the wristwatch which, again, sometimes people feel is less noticeable. And that's sometimes more difficult to activate accidentally as well. But they would much rather people pressed it, or it went off accidentally, and they would just say, "Oh yes, sorry, I pressed it accidentally," than people didn't wear it or they didn't use it and they had a fall.

JULIA: I would also add that the reluctance to wear it because of what people might think actually is a cultural issue, and older people shouldn't worry about what the general public think. That's the general public's fault, not the person who's wearing the device's problem. And actually, in society, we should be much more accepting of our older people and the technologies that they might need to remain independent. Because ultimately, the more technologies we can introduce that allow people to remain independent as they age, the better it is for society. So I think more and more we'll start to see things developing that will allow people to remain in their own homes, and pendants are just one of them.

JAMES: And someone pointed out on the course that you can get a mobile phone that has an alarm button on it to contact people. So if that's more acceptable to people then that might be a good idea.

LISA: Yeah.

JULIA: The difficulty is you've got to have that with you, haven't you? And I leave my mobile phone all over the place. Whereas actually, the pendants are great, or the watch is, because they're physically attached to you, so wherever you go it's there and you can't lose it or leave it somewhere.

LISA: And I think as well it's a bit like anything new, when you first get something new you're a little bit self-conscious about it. Some of our patients who come into clinic actually come into clinic with their pendant alarm on and they've actually forgotten that they've got it on, because it's become such a part of their daily routine. So they'll actually still have it round their neck when they come to their appointment. And that's great to see because it means that they're wearing them.

JAMES: And just for anyone that doesn't know how they work, we added a link onto the page on the course where people could go and visit a website from a company who makes them and make sure how they work and how they can be used. So the next question is from Judy, why do we take smaller steps when we're fearful of falling and why does that especially occur on ice? Well I can answer the question relating to ice. It's all to do with friction and balance. So when we put our foot forward we land on the back part of our foot and the pressure is going forward, and when we take off from our back foot we take off from the front part of the foot with pressure going back. So that's two small areas on a slippery surface with a lot of pressure going through them. And that's why that increases the risk of falls.

As opposed to flat feet on the floor because smaller steps allow us to put our feet flat on the ground, rather than our heel or our toe, and that increases the friction and can prevent falls. I don't know why we take smaller steps in other areas where we might be fearful of falling but it might be learned behaviour from a fear of falling on ice.

LISA: Yeah, it could be, and I think it's the same principle, I think it's about maximising the amount of time that you have both feet in contact with the floor. And obviously we talked about Parkinson's disease before, and people who have Parkinson's disease tend to develop quite slow shuffling gaits, and that puts them at more risk of falling. But as you say, the normal way to walk is to stride out with the heel down first, and when people shuffle, although they feel that it makes them safer it actually makes them more prone to tripping and falling because they don't pick their feet up as well as they should do.

JAMES: And going back to the issue of ice and snow, there was a trial showing that those devices that you can buy that attach onto the bottom of your shoes actually do prevent falls on snow and ice. So if anyone is particularly worried, there is evidence that they do work. So the next one for Lisa and Julia, from Claire and Dominique, there's all kinds of things out there that might help people with their balance or might not, but they're for sale and people don't know whether to buy them or not – wobble boards, Nintendo Wii Fit, aqua aerobics. I bet there's hundreds more.

LISA: Yes.

JAMES: Are they useful?

LISA: I think everything's useful within the right context. I think there's good evidence emerging, good scientific evidence for Wii Fit as an exercise. I think unless exercise is something you particularly enjoy doing, we all know exercising is a little bit of a chore, so I think anything that makes exercise a little bit fun is a good thing. And I think increasingly, I'm getting reports from people who are coming in and using Wii Fit with their children or their grandchildren, and I think again that makes it a little bit more normal as well. Like Julia was saying, a little bit more acceptable to exercise. So there is good evidence for that.

Aqua aerobics, again, is a good exercise for strengthening and also for cardiovascular fitness. The advantage to exercising in water if people have painful joints is that it provides support. Exercising in water wouldn't necessarily improve balance but it would improve strength and endurance, which indirectly could improve balance. And again, it tends to be quite an enjoyable activity.

Wobble boards are good because we've talked a little bit on the course about the importance of ankles and how important they are for balance. But again, if somebody has very stiff, painful ankles it can be quite difficult to control. So I would be a little bit cautious about that and maybe get some advice. But yes, they are good within the right context.

JAMES: Okay. The next one is from Deb who wanted to know can dehydration and the sedentary lifestyle contribute to problems with the inner ear and balance and falls, I guess? When I was at medical school ten years ago I distinctly remember being taught about how alcohol affects the middle ear and why the room spins when we go to bed after we've been drinking. And it's because the hairy protrusions in the fluid in our inner ear detect the movement of the fluid as our head turns and the density of that fluid affects how quickly that fluid moves. And alcohol very much affects how dense that fluid is. So when you go to bed at night that fluid moves much more quickly than it would normally because of the alcohol, and it makes the room spin.

So I would presume from that that dehydration could make the inner ear susceptible to balance problems. So I would say, avoid dehydration to keep the inner ear healthy. What about sedentary lifestyle, Lisa?

LISA: Well we've talked generally about sedentary lifestyles in terms of falls risk generally. I think in terms of inner ear problems, I wouldn't say that a sedentary lifestyle would cause an inner ear problem particularly, but I do know that not being active after an inner ear problem can delay recovery. So as we all know, if we've had an acute episode of dizziness we tend to avoid moving our head and we tend to try and control our movements very closely. But actually, because we're not activating those hair cells and we're not sending signals to the brain that can sometimes slow recovery.

So again, usually people recover naturally just because we become more mobile as we start to feel better. If that's a problem and if dizziness persists then again physiotherapy can often be useful, and there are graded sets of exercises that we can take people through to get them moving again and to help with their dizzy symptoms. And they're often very effective.

JAMES: **I remember around two or three months ago, I had an episode of labyrinthitis and it was awful, every time I moved or got up out of bed the room was spinning and I was –**

LISA: It's an awful feeling.

JAMES: **- pretty much in bed for two days. And of course, some people can have vertigo and dizziness for much longer periods, and it can really affect people's lives.**

LISA: Definitely. And that's why it can be quite a good idea if it persists to get some advice, because people are often worried about how much to do and what's too much and what are the right and wrong things to do. And often it's our bodies' own reaction that if something makes us feel dizzy we try to avoid doing it. Whereas actually, feeling a little bit dizzy in a controlled way is the way that our brain learns to adapt, and it learns to improve. So often a lot of what we do with physiotherapy is showing people that making themselves a little bit dizzy every so often is actually a good way to recover.

JAMES: **Have you ever had vertigo or light-headedness?**

JULIA: Except for related alcohol [laughter], when I was much younger and foolish. So I've experienced it, the head spinning, and it really, really is unpleasant. But I've never had labyrinthitis or vertigo itself, no.

JAMES: **Have you ever fainted?**

JULIA: I've fainted when pregnant. I had a couple of bad experiences when I was expecting my eldest, who's now 16, and that was very strange, the sense of lack of control. I could feel that my blood pressure was dropping and I had to lie down in the street – and people would step over me. It was just the most strange feeling. And when I sat up I felt very light-headed again, and it went away again when I laid down. So I do have first-hand knowledge of that, but more the draining, pre-syncope feeling rather than the vertiginous feeling.

JAMES: **Have you ever had dizziness Lisa?**

LISA: Yeah, I've had dizziness before and again, like you say, when I've had dizziness it tends to last hours rather than days, and it is very disabling. It's really difficult to know what to do because often I find that when I feel acutely dizzy, if I close my eyes all I want to do is sleep, but if I close my eyes it actually makes me feel more dizzy. And often if I lie flat it tends to make me feel more dizzy. So it's very disabling and it's very frustrating. But fortunately, it's not something that's lasted more than a couple of hours.

JAMES: **I remember there were lots of comments at the very start of Week 3 when we showed the video of how to get up after a fall. And the demonstration was in someone who was fairly fit and well and mobile. But there were lots of comments about people who had problems with their knees or their ankles or a lack of strength in their hands and arms. Are there other methods that can help people get up after a fall?**

LISA: Yes, and sometimes it is individualised. Obviously, that would be the way that we would recommend because once you're on all fours then you're able to be

a little bit more mobile. So if there isn't a chair to hand you can usually find somewhere that you're able to move to. If kneeling is difficult then probably what we would recommend is that somebody try to shuffle on their bottom, which isn't as easy but it is effective, to see whether they can just lever themselves up on their arms. If getting up independently is difficult because of knee or other joint problems then I think it goes back to having a strategy in place such as the pendant alarm, or possibly a mobile phone, or some sort of way of summoning help really.

I think the other problem is that for some people they haven't actually been down on the floor for a long time. I think as we get older we tend to spend less time on the floor. And so I think what's frightening for people is that they just don't know whether they can get up or not. So they worry about not just falling but the consequences of that fall. So one of the things that we do quite often is we actually, as part of our therapy, help people to get down onto the floor and explore the best way for them to get up, because they know that it's in a very safe environment and if they have difficulties that there's somebody there to help them. And sometimes that's just reassuring, just knowing that they've been down on the floor and they've been able to get up, and sometimes finding what is the best strategy for them as well.

JULIA: Yes, I think the video for the lady getting up off the floor was very interesting, because that's my mum – if people hadn't realised there was a family likeness between us. And you're absolutely right in that she worried enormously – about doing that manoeuvre. But since she's been on the floor and you've taught her that, she feels much more empowered to be able to get up off the floor should something happen. And that's made a big difference to her confidence.

LISA: Definitely.

JULIA: So people's comments on the discussion boards were very interesting about her being very fit, because actually she's not perhaps as fit as people perceived her to be. And she most certainly had never been on the floor for many years, and after her fall it was one of the things that she was very fearful about – would she be able to get up if my dad wasn't there? So it was very useful for her to learn that technique.

LISA: Yes, and obviously we went out to film that and what you saw was a relatively short. We did actually practice that for quite a long time before the filming which was useful, and as you say it's just worth putting the time aside because it can be quite time-consuming but worth doing when you hear those kind of outcomes.

JAMES: Okay. What about when we're outside and we fall over? Are the strategies the same or different?

LISA: Very similar. I think one of the advantages – or disadvantages, depending on the way you view it – to falling outdoors is that there are often people around, and often people are very quick to come to your assistance. And that can be a good thing, but sometimes not so good, because often when you fall you are a little bit shocked and a little bit winded, and people can sometimes be a little bit too ready to come and try and get you back onto your feet. And just as we said

on the video, it’s sometimes worth just taking a second to make sure that you are okay and that you haven’t injured yourself.

So I think often there is assistance, but yes I would probably say similar principles apply, to look really, ‘is there somewhere that I can pull myself up from’ perhaps kneeling or something like that, like a low wall or a lamppost. But usually there is assistance available, and if not then can somebody get some help in terms of can they ring an ambulance for you? Again, not terribly dignified, and I think that’s what people worry about, the social stigma of falling. But usually I think people are helpful in that sort of situation.

JAMES: This issue of making sure it’s safe to stand up first is so important.

LISA: It is, yes.

JAMES: And we see in clinic quite often that people have fainted, and people rush to their assistance and the instinct is to help them to their feet. But their blood pressure is low and they need to be down for their blood pressure to have time to get back up again.

JULIA: Yes absolutely. And there's no problem with lying on the floor. The only problem in people’s heads is, as you say, the stigma of lying there on the floor. When I had my episodes and people were stepping over me, it was just the way it had to be. And I knew that I would never see these people again and it didn’t matter what they thought. If they thought I was drunk or whatever, it didn’t matter; I just needed to get feeling better and that meant me lying down. And that’s what we advise patients in clinic is not to worry about what other people think, that’s of no relevance. What you need to do is think about number one and get to a point that you're feeling well enough to stand up again without just keeling over again.

LISA: And I think often, I have been out and about and people have fallen, and I think usually what happens is a passer-by offers to take people home, and things like that. And there's this thing that people have, “No, I came to do my Christmas shopping,” for example, “I must carry on.” And actually, if you’ve had a fall and you're shaken then it’s absolutely fine to go home and take it easy and things. But I think people are so worried about what other people might think, that I’ve come into town to do this and I must carry on doing it. And actually, perhaps what you do need to do is go home and just take things easy for the rest of the day.

JULIA: One of the things that I’m always worried about is people trying to catch people as they fall. And using my own example of my mum and dad, my dad does have a habit of trying to catch my mum, and she has a habit of letting him. And actually, that can be quite dangerous – because you can end up injuring yourself as a carer if you're not careful. And ultimately, if you're fit and well, the consequences of you being pulled to the ground unexpectedly can have catastrophic consequences. So we are taught in the hospital that we have to be very careful if people are falling and not to catch them, because it may be detrimental to ourselves. And the same would apply out there in the community – just don’t try and catch somebody because, if they're going down like a sack of potatoes, you may hurt yourself and then you're of no use to anybody.

JAMES: **Something that has been coming up repeatedly on the course is that people weren't aware that Falls clinics or services even existed. So how can people find out if they've got a local Falls service, and what can they do to access it?**

JULIA: All NHS hospitals have a dedicated Falls service, it's a requirement of the NICE guidelines – (National Institute for Clinical Excellence guidelines) for falls management. So there will be a Falls clinic in every NHS hospital in the UK. Now, in some places that will be a day hospital as part of the department of geriatric medicine, or it may be a dedicated specific unit like we have in Newcastle. Or it may simply be an individual who has an interest in falls prevention. Generally your local GP, your primary care physician, will know who are the falls experts, or what the falls pathway is for your local area. So that's probably a good port of call.

If you're not in the UK, it's been interesting on the discussion boards, the differences between the services that are available in different countries. And I think the equivalent of a GP, a primary care physician, would be a good port of call. It may be that your local council or equivalent may have information, or local agencies in the UK, like Age UK, they have local offices. So the equivalent, wherever you are in the world, it may be worth checking out with them what facilities or services are available in your local area.

JAMES: **And probably what I would say for people who can't access a falls clinic, if they're elsewhere in the world, is there are three of the most important things that they could do is ask to see a physiotherapist, ask to see an occupational therapist, and ask to have their medication reviewed with a physician or a primary care person – if there is no dedicated falls service.**

In our last live event, medication, we spoke about the magic number of four, and then in this final week we've spoken about when medications can be used to try and prevent falls. And they're only used in very specific situations to treat something underlying that's causing the falls. It was quite controversial and I just want to make sure that people know that the medicines that we spoke about in Week 4 are to treat specific underlying disorders which are causing the falls.

JULIA: Yes, so they're not treatments that prevent falls per se; they're very much targeted at abnormalities that we know put people at risk of falls. So dropping your blood pressure is a perfect example. So we wouldn't anticipate that, as a result of the course, thousands of people should go on these medicines to prevent falls in the future. They're targeted at specific conditions that we look for and diagnose in the falls clinic. And then also, some of the medicines are there to treat or prevent the consequences of falls, which are things like fractures. So making sure that we treat osteoporosis and make people's bones better means that if people do have a fall then we hope that they are less likely to break anything.

JAMES: **Okay. And this is slightly related to medicine, because I've heard you say this to patients before.**

JULIA: Oh dear.

JAMES: It's all about the importance of drinking water, avoid being dehydrated and you say to people, "Think of water as your medicine."

JULIA: Yeah. So what we like is to recommend to people that they drink two and a half litres of water a day. And the usual response when I say, "Do you drink enough water?" is people always go, "Yes." And then I'll immediately say, "How much is enough for you?" And it generally, almost without exception, is not two and a half litres. Drinking two and a half litres is really quite difficult; it sounds simple and just too good to be true, but actually if you give it a try it's very difficult to do. And if you were to sip that amount of water, you'd be sipping water all day long. And that's what we call a behaviour change, and that's actually quite difficult to integrate into somebody's life.

So the way I try and sell it to people is to take a pint of water four times a day, because think about it in the context that water is your medicine and you take your medicine four times a day. And if you have a pint four times a day then that will get a good amount into you that you'll be able to top up with other drinks throughout the day. And people seem to get that more than sipping water all day long, and as a consequence seem to be more able to comply with it. Because it's easy, as a doctor, just give you a sheet or tell you to do something but actually, out there in the real world, it's not often as easy to do as we would like to think it is. So giving people strategies that help them to do something easier tends to mean, at the end of the day, that they're more likely to do it.

JAMES: Another tip that people tell me that they're doing is that they have a one-litre or a two-litre bottle and they fill it up at the start of every day, and the target is that that bottle needs to be empty by the end of the day.

LISA: Yes, that's a good idea.

JULIA: The other thing people often say is, "I couldn't possibly drink two and a half litres of water because I'll be going to the toilet all the time." And that's generally true at the beginning when you start doing it, but if you persevere then that feeling tends to go away, or you become used to it. So actually, if you persevere it tends to improve.

JAMES: Yes, and actually having concentrated urine irritates the bladder and makes you feel like you need to have a wee just as much as drinking lots. There was a study in a nursing home where they encouraged their residents to drink more water, and actually what they found is that people on average only went to the loo once more per day. So it probably doesn't affect people in the long term as much as they worry about.

Some last-minute questions coming in – there was someone wanting to know if there's any way… falls are common on getting up out of bed, people lose their balance or they struggle. Is there anything that can help people to get out of bed safely and keep their balance?

LISA: Yes, there are pieces of equipment that can be provided to help people get out of bed and there's a device called a bed lever which is, it's kind of difficult to explain, but if you imagine it's a bar which sits underneath the mattress. And they can be used for either single or double beds. And then they have a little handle at either side which sits just by the pillow. And it means that, for

example, we've talked about Parkinson's, if you find that you're quite stiff and find it difficult to move, it gives you something to reach for. And then sometimes it helps people as they come from lying to sitting just to have something to rest their hand on as well. And usually that can be provided either through the district nurse, or if you have a physio or an occupational therapist who will come out to see you. And that's a relatively easy piece of equipment to have fitted; if you don't like it, it can be taken away, and it doesn't make any permanent changes.

And then again, I think it's just about technique as well, isn't it, so it's about, we don't sit straight up, so rolling onto your side, dropping your legs over the side of the bed, coming up into sitting. And then as we've described, just taking a minute to make sure that you don't feel dizzy from that postural change before you stand up.

JAMES: Another last-minute question was from someone who sounds like their ankle gives way quite frequently, suddenly without warning, and it's causing them to drop down to the ground. They're asking if there's anything they can do about that.

JULIA: To me, the suddenness of what you've described is unusual and would make me anxious that there may be a problem with ligaments in an ankle that gave way suddenly. There's lots of things nowadays that can be done about ankles that give way and, in those circumstances, I would not recommend just putting up with that. I would suggest seeing a doctor to see whether there might be something that could be done about that ankle, or whether there was a reason structurally why that ankle was giving way. Once you've been to the doctor and that was sorted out, the things to think about are perhaps strengthening the muscles around the joint. The same applies with any joint, a knee, a hip, ankle, strengthening the muscles which support that joint might prevent it actually giving way in the future.

JAMES: Okay. Let's move on to a final question. Will the course be available in the future, and can the participants access the resources that are there now? So, the course officially finishes on Sunday, so people are free to join up, sign up and do the course up until Sunday. And once joined up, people can keep coming back to access the resources, the videos, the downloads. So I would recommend if you know anyone then get them to sign up before Sunday so that they can continue to access them. And I would hope that we would be able to run the course again – I would hope.

JULIA: Yes, I think the anticipation is that the response has been so overwhelming that we really want to give as many people as possible the opportunity to access the course and the material within it. And the hope is that we'll be able to run it again next year. Obviously, we'll publicise that through FutureLearn and, hopefully, we'll be able to have another scheduled run of the course sometime in 2015.

JAMES: And of course, any tips that have been useful for you, you can be part of our team and pass on those tips to people that you know, that you're worried about might be falling or at risk of falls, just to make the impact of the course even bigger.

JAMES: So, final comment. What's your top tips for falls prevention?

JULIA: Oh, good question. So my top tips for falls prevention would be falls are not inevitable, they are preventable, so make sure that you invest in your legs. Make sure when you're younger that you do as much as you can to keep your muscle strength in your legs so that as you age you can keep that going, and your legs remain strong. Get rid of stuff around the house that might get in the way and that you might trip over. And I think probably for me, the final thing is empower yourself; make sure that you know and understand why these things happen and what you can do to reduce your risk.

JAMES: How about from you, Lisa?

LISA: I agree with Julia. I think falls aren't an inevitable part of getting older. I think what this course has demonstrated to me is that there is often a lot that people can do themselves to help with falls, and that a lot of those things aren't massive things, they're actually quite small things but make a large difference. And they're not costly things either. So as Julia mentioned, things like de-cluttering. Being more active, so if exercise is something that's really not for you and you know that you're absolutely going to hate joining an exercise class, just try and make a few small changes. So as I said before, take the stairs rather than the escalator or the lift, get off the bus a stop earlier and just walk a little bit further, take the dog out for a walk, take the grandchildren to the park, things like that. And I think it's just about recognising when you can manage this yourself and then when you need to get perhaps a little bit more professional advice and support as well.

JAMES: Okay. Thanks, Lisa. Thanks, Julia. All the best to everyone for 2015 and thank you very much for joining us here today, and I'm sad to say goodbye.

[End of Recording]