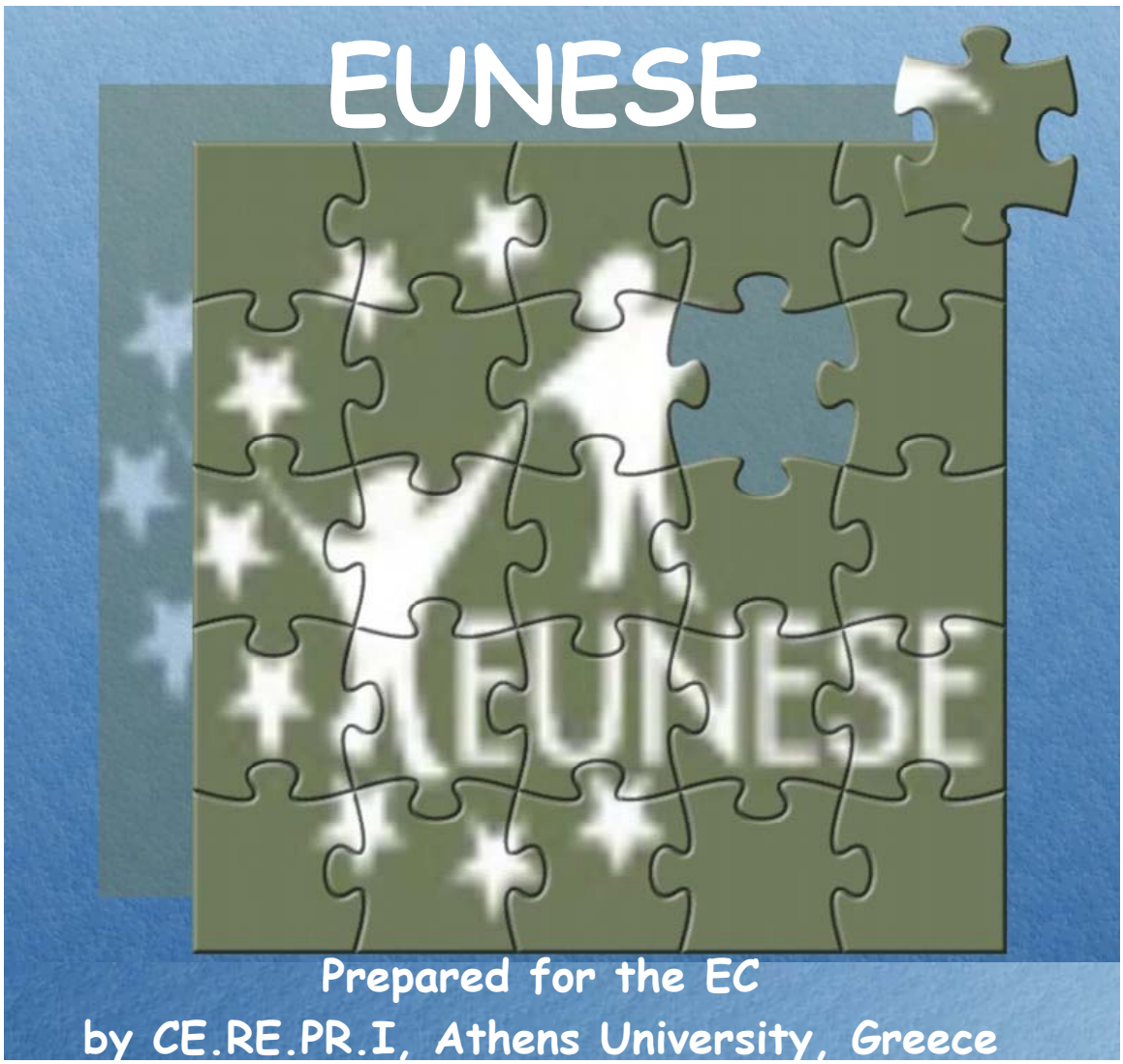
Second Interim Technical Implementation Report
01/07/05 – 01/07/06

APPENDICES



August 2006

7.0 APPENDICES

APPENDIX 1.1 EUNESE Updated Application Form (WG1 - Proj. Leader)

Application Form EUNESE Membership

Name: ☐ **Mr** ☐ **Mrs**

Prof/Dr./other

Professional Occupation:

Organization:

TYPE OF ORGANIZATION: ***(tick one or more of the boxes applied)***

☐ **Research** (research institute, university, hospital)
☐ **Prevention/Practice** ([non]governmental organizations/institutes, providing care for the elderly, implementing on local/national/regional level)
☐ **Policy making** (MoH and related ministries, focal points, senior interest groups)

Address:	
State/Country:	
Phone (+country code):	
Phone direct:	
Fax (+country code):	
Website:	
Email:	

INVOLVEMENT OF ORGANIZATION IN ELDERLY AND SAFETY

☐ research
☐ traffic injury prevention
☐ safety promotion
☐ other, such as
☐ design for all
☐ geriatric care
☐ fall prevention programs
☐ health promotion
☐ fire safety
☐ policy development

DESCRIPTION EXPERTISE

MEMBERSHIP *

Yes, I am interested in the following membership (please tick the box/es of your choice):

Core membership-EUROPEAN
☐ Organization
☐ Individual Professional

Peripheral (associate) membership-NON EUROPEAN
☐ Organization
☐ Individual Professional

Please return this form to:

EUNESE (European NEtwork for Safety among Elderly)
Center for Research and Prevention of Injuries (CE.RE.PR.I)
Department of Hygiene and Epidemiology, Medical School, Athens University
Mikras Asias 75, Athens, 115 27,Greece
Project co-ordinator: Prof. dr. E. Petridou, Kiki Petroulaki (kpetroul@med.uoa.gr)
Phone: + 30 210 746-2187 / 2201, Fax: +30 210 746-2105, e-mail: eunese@med.uoa.gr

OR YOU CAN REGISTER ON OUR WEBSITE: www.eunese.org

* Herewith permission is given to make address and expertise details accessible on the EUNESE website

APPENDIX 1.2 Summary discussion document for the development of the structure and functioning of the network **(WG1)**

Summary of discussion between WG-1 leader and Steering group (1st October 2005)

1. Progress of work

A review of membership criteria and application procedure has been produced and agreed upon
A questionnaire has been sent + results and a list of potential network members has been delivered
Plan and structure for website created
An e-mail reminder sent with short version questionnaire sent to all non responding partners
An e-mail sent to all future members of EUNESE with latest developments and planned actions
A website meeting was organized to discuss the integration/collection of deliverables of WG 2,3,4

2. Issues

i. Purpose of network

EUNESE wants to be more than an exchange network: "aims to reach both the public and the policymaker". During the meeting of the working group coordinators in Bergen (June 2005) it was decided to focus on experts (professionals) only. However the interest in being involved is low (even among the network members), as is the actual contribution to providing the information. Capacity for outreaching activities is in most cases even non-existent. WG 1-leader doubts whether the ambition of Eunese is realistic at this stage.

ii. Lack of content for website

Information for website is hard to get: members do not supply unsolicited and if solicited, information is being presented in a wide variety of forms and quality levels. Standard forms may help but discourage members to report and add to the burden of the overall information management (no information manager foreseen in budgets).
Web design progress depends on clarity on information management process which is lacking at the moment while the structure for the website is now concluded upon.

iii. Budget limitations

Serious short coming in delivery of content for the website has overstretched the budget capacity. If we want to gear the information flow professionally we need to add a post for the info management and therefore new budget. PL foreshadows that cuts in budgets of other WG's may create new budget for this purpose. The PL acknowledges that the quantity and quality delivered by WG 1 is excellent.

3. Requests to Project management: Clear and consistent vision

More realistic definition of the purpose of network is needed.
Project manager is responsible for consistent communication of scope and objectives of the project and its components and to ensure that these objectives remain feasible and provided with the necessary budgets.

Summary of conclusions of WG 1 team members on 2nd October 2005
(Kiki/ Janice/ Taie/ Trea/ Wim)

1. Limited potential of network

It is acknowledged that the infrastructure for elderly safety around Europe is quite weak when compared to Child Safety and that the issue lacks appeal to the politicians and the public.

It is concluded that EUNESEE lacked from the very beginning a clear mission and business plan that is based on the actual demand in the field at national and local level. It still severely lacks a demand-orientation, and most actions aim at pushing products and information pieces that are collected in a fragmented and somewhat haphazard manner.

WG 1 sees a role for the project to play in information exchange but as regards its impact on the work at national and local level one should be very modest. It may inspire professionals to be more active in injury prevention and to implement a few of the tools or suggestions communicated through the project. The outreach to public and politicians will remain limited.

2. Vision on membership

The group concluded that our current experiences forces us to make a decision of quality (solid information from the best performers) versus quantity (all member states being involved but providing low value of information).
The group advises the EUNESE programme management to go for the quality principle.

3. Operational consequences

i. Web access

Web should be publicly accessible. Only dedicated deliverers of content should be mentioned as being the partners in the project. Passive users can subscribe (for e-mail alerts/ may also include all current 'members") but this is may be of relative low value both ways.

ii. Info management

More efforts are needed in getting the proper information and to have it properly presented on the web. This requires an information manager, which needs additional funding (contract ECOSA foresees only technical web maintenance)

iii. Promotion

Promotion only makes sense if the quality of the site is at a sufficient level.

iv. Conference

It is advisable to postpone the Conference until more information is generated from the various WG's (mid 2007) and to use the 1st European Conference in June 2006 for hosting a workshop on elderly safety in order to sound the needs and demands of those working in the field.

APPENDIX 1.3 Alert Newsletter **(WG1)**

Vol. 1, issue 1, July 2006

EuroSafe Alert

European Association for
Injury Prevention and Safety Promotion

This is a quarterly publication published by EuroSafe and supported by the European Commission

"Working together to make Europe a safer Place"

Contents

▶ Welcome note

New' EuroSafe Alert

EuroSafe is pleased to present the first issue of the new EuroSafe Alert, a combination of the WP-AI newsletter and the former Alert.

The integration of these two newsletters is the first visible change reflecting EuroSafe's new role, as from May 2006, as the coordinating body for the communications and support activities of the Commission's injury prevention network under the Public Health Programme. Since the late nineties this function has been carried out by rotating secretariats, the last of which was co-ordinated by the University of Athens who have recently completed their term in office.

The appointment of EuroSafe in this role makes it possible to integrate communication activities with those already developed through EuroSafe, its website, newsletters and other publications. As a professional and representative body EuroSafe can provide an open and participative structure for all who want to be involved, and who are interested, in the activities that are being developed with financial support from the Commission under the Public Health Programme.

EuroSafe would like to thank the European Commission, WHO and all the past secretariats for supporting and managing the WP-AI newsletter and the earlier versions such as the IPP newsletter. A strong foundation has been built which, together with the former EuroSafe Alert, will create a consolidated and effective communication tool.

Justin Cooper, who has been the Editor of the WP-AI, the IPP newsletters and the former Alert for the last five years will also serve as the Editor of the new EuroSafe Alert. By building on the past and maximising current resources EuroSafe will strive to use the new Alert as an effective tool to promote injury prevention in Europe and, in so doing, reach a wider audience of interest groups connected with developments in policy, research and practices relevant for injury prevention.

Rupert Kisser,
Chairman of EuroSafe

▶ Breaking news

Communication on injury prevention on the agenda of the Council of Ministers meeting in second half of 2006

Early June this year, Robert Madelin, director DG Health and Consumer Protection of the European Commission signed the Communication titled "Actions for a Safer Europe". It has been sent to the College of Commissioners for endorsement and released to Member States' governments for discussion during the next meeting of the Council of Health Ministers, planned in the second half of 2006.

A timely initiative of the Commission

Originally it was planned to have the Communication and proposal for a Council Resolution being discussed and agreed during the Austrian Presidency of the Council, but due to other priority issues and an already overloaded health-agenda, it was decided to keep both documents on hold. Nevertheless, the Commission's

▶ Community safety

National Injury Free Days in the Czech Republic

A Seminar on child traffic injuries held on June 1 in the Czech Republic was the occasion for the launch of the National Injury Free Days 2006 campaign which ran from 1 to 11 June, 2006.

The seminar chaired by Alena Steflova brought together experts from all ministries involved (Public Health, Interior, Transport and Education) in addition to the Centre of Injury Prevention, Transport Research Centre, universities and, last but not least, the National Healthy Cities Network. This network presented their activities in the field of traffic injury prevention to local road safety practitioners.

The main topics of the Czech National Injury Free Days, was road safety of child pedestrians and cyclists. Various national and local pro-jects, e.g. "Safe Route to School" and "Ride Your Bike with a Helmet on Only" were carried out. In addition, the Ministry of Transport presented its brand new project "The Action" aimed at road safety among teenagers.

The seminar has proved that the multi-sectoral co-operation and implementation of the WHO injury prevention community based programmes is the right way to solve child traffic injury problems in the Czech Republic.

▶ Safety for seniors

Elderly safety in Europe

Every year 100,000 elderly citizens (>65) of the European Union (EU-25) die of injury. Despite the fact that this age group consti-tutes about 20% of the population, it 'contributes' to almost half of the total number of deaths due to unintentional injuries. In Europe there are a lot of initiatives at national level to improve elderly safety, however, these are mostly fragmented in approach and structure. At European level there has been very little exchange of information and collaboration in the past. It is only in recent years that this has started to change.

In order to create some European synergy in the scientific approach towards fall injuries among seniors, the ProFane network was created three years ago. This network aims to bring together workers from around Europe to focus on a series of tasks required to develop multi-factorial prevention pro-grammes to reduce the incidence of falls and fractures among elderly people.

In 2004, prevention practitioners launched the EUNESE project. This European project aims to improve the safety of elderly by creating a network of professionals that provides sharing of knowledge of good practices in preventing injuries among elderly at home and in residential settings. EUNESE wants to link human resources and stakeholders from existing injury prevention and safety promotion projects among elderly and act as a clearing house of evidence based information. The ultimate goal is to disseminate the knowledge gained in this field to all decision makers involved in social and health care of elderly.

Eurosafe is connected with both initiatives. For instance, EuroSafe leads the EUNESE working group that is responsible for constructing the network of prevention practitioners and policy makers relevant for senior safety. As part of this EuroSafe has helped to create the website for the EUNESE project (http://www.eunese.org) and will organise a European conference on Safety for Seniors in 2007.

EuroSafe will continue to team up with both networks and will help to build a solid knowledge base on injuries among elderly and their prevention for dissemination and facilitating implementation in countries.

In view of the above EuroSafe will be active in creating and maintaining networks for sustainable collaboration in promoting safety for senior citizens in Europe by:

- advertising the magnitude of the problem and the life and cost saving impact of preventive measures;
- disseminating quality data on injury incidence and rates in European countries and main risk factors involved;
- identifying good practices in injury prevention among senior people and case studies on effective interventions;

- producing and regularly updating state of the art fact sheets on major injury risks among seniors;
- Initiating collaborative actions and campaigns for senior safety, complementary to existing programmes and policies in these domains; and
- communicating existing guidelines and protocols on fall prevention and developing (e-learning) training programmes for home visitors and for professionals working in residential care settings.

If you are interested in participating in the EuroSafe Task Force on Safety for Seniors please contact Hannelore Schouten at h.schouten@consafe.nl or tel. + 31 20 511 45 31.

▶ Sport safety

Surfing to Sports Injury Prevention. An online (tailored) sports injury intervention in the Netherlands.

In the Netherlands 7.7 million people (out of a population of 16 million) participate in sports each year and an average of 1.4 million people are injured during sporting activities. Almost 50% of these injuries need medical treatment (average costs each year: € 590 million). As previous interventions had failed to accomplish the aimed 10% decrease in sports injuries the need for personal sport-specific information became apparent. This led to a new strategy for 2005-2008: the intervention 'Surfing to Sports Injury Prevention', an initiative aimed at developing an accessible, reliable and complete internet website with (specific) information about sports injury prevention using tailored health advice.

For individuals participating in sports, information on injury prevention is difficult to find and is spread over numerous sources. With the help of an internet site, it is possible to bring all the available information on the subject to the attention of a broad audience. To achieve a positive change in behaviour, part of the internet site is a tailoring system. Through answering sport related questions, visitors receive personalised advice which is specific to their sport. During 2005-2006 the internet site has been developed for the following sports: field hockey, running, tennis, soccer and fitness. In 2006-2007 the sports volleyball, skiing, snowboarding and korfball will be added.

This is the first online (computer-)tailored sports injury prevention programme that is being developed and is therefore considered a pilot intervention. A systematic approach is used to develop the modules for each sport before going 'online'. During the entire process structural involvement of relevant experts, sports alliances and people participating in sports (all stakeholders) is essential. Hereby a network is created for each sport. With the input of these participants a basis for the successful implementation of the intervention can be created and the content optimised. Important for developing a tailoring system is first of all a good preliminary analysis of behavioural determinants (per sport). Secondly, the use of good, easy maintainable software to build the actual tailoring application. Finally, evaluation of the intervention plays an important role during the process, pre-testing preliminary concepts as well as evaluating the internet site after being 'online' for a while.

The growing group of people participating in sports without a trainer or any guidance will not receive injury prevention information through the usual channels. Therefore, the online tailored system appears to be a promising approach for sports injury prevention and is a relatively easy way to reach a broad range of people and still give personal advice. Other existing online (computer-)tailored health messages, e.g. smoking prevention, nutrition education and promotion of physical activity have already showed promising results. Therefore, expectations are high for sports injury prevention.

For more information please contact Saskia Kloet, Consumer Safety Institute, The Netherlands, s.kloet@consafe.nl

APPENDIX 1.4 Recruitment e-mail to the WHO Focal Points **(WG1)**

Wim Rogmans/CSI
Sent by: Joke Broekhuizen

13-12-2005 07:51

To A. Šeranić
cc
bcc
Subject Subscription network Elderly Safety

Dear Mrs. Seranic,

I hope you all enjoyed your stay in the Netherlands during the WHO Focal Points Meeting last 17th and 18th November, and that you feel energized by the presentations and discussions we had these two days. The WHO-European Office will certainly report to us soon on the conclusions and next steps that e decided to take. This message is only meant to follow up the announcement that Dinesh Sethi made during one of the break out session, when he referred to a European project on elderly Safety.

In annex to this message you will find a brief description of this project as well as a registration from. I would warmly recommend you to subscribe yourself into this network: it ensures you being informed about the latest state of the art in preventing injuries among older persons, and it is free of charge. You can also register yourself as an active member, if your organization has already some expertise developed in this field. In case you hesitate among the various option of subscribing, please tick the option you are most comfortable with as you may always choose to change the status of your registration at a later stage.

For further information, please do not hesitate to contact Mrs. Trea Zevenhuizen (t.zevenhuizen@veiligheid.nl), who will be most pleased to answer your questions.

With kind regards,

Wim Rogmans
Director


eunese_Brochure.pdf Application form for EUNESE membership.pdf

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Consument en Veiligheid
Consumer Safety Institute
Rijswijkstraat 2, 1059 GK Amsterdam
PO Box 75169, 1070 AD Amsterdam
The Netherlands
Tel: +31 (0)20 511 4512
Fax: +31 (0)20 511 4510
www.veiligheid.nl

APPENDIX 1.5 Revised Project Intervention Form **(WG1 – WG2)**

EUNESE Project registration form

Organization

Name lead organization .....

Type of organization (tick one or more of the boxes applied)

- ❍ Research (research institute, university, hospital)
- ❍ Application ((non)governmental organizations/institutes, providing care for the elderly, implementing on local/national/ regional level)
- ❍ Policy making (MoH and related ministries, focal points, senior interest groups)

Address.....

City.....

Country .....

Phone general .....

Fax.....

Website.....

Contact person .....

(full name and initials)

Mr./Mrs.....

Email.....

Intervention

Title .....

.....

.....

.....

Brief intervention description

.....

.....

.....

Priority area: (tick one or more of the boxes applied)

- ❍ Falls
- ❍ Traffic
- ❍ Drowning
- ❍ Poisoning
- ❍ Smoke, fire and flames

Focus area: (tick one or more of the boxes applied)

- ❍ Medication
- ❍ Medical (non medication interventions e.g. therapies, appliances, alternative treatments)
- ❍ Lifestyle
- ❍ Economical
- ❍ Cultural
- ❍ Environmental
- ❍ Other

EUNESE Project registration form

Goals and objectives

General main goal

.....

.....

Specific goal

.....

.....

Concrete, measurable goal

.....

.....

Content/additional information

Mainstreams
- ❍ elderly living independently
- ❍ elderly living dependently in nursing homes/rehabilitation centres

Mainstream specification ((f.i. own home with day care support or nursing home etc, age groups)

.....

.....

Method (type of study)((f.i. intervention, research, literature study, sample size, generalizable)

.....

.....

Status
- ❍ running
- ❍ completed

Starting and completion date project ……..Month/Year to ……. Month/Year

Results

Conclusions

.....

.....

Recommendations

.....

.....

Deliverables (report, leaflets, website etc)(if electronically please attach or send the URL link)

.....

Used literature

.....

.....

EUNESE Project registration form

Evaluation

Was the intervention evaluated?

- ❍ yes
- ❍ no

Results evaluation

.....

Publication

Was it published?

- ❍ yes
- ❍ no

Remaining

Remarks

.....

.....

APPENDIX 1.6 Draft plan for EUNESE Network Conference **(WG1)**

Date: May 7th and 8th 2007
Location: Amsterdam, The Netherlands
Number of participants: 70 -100

Promotion:

- Brochure (PDF-file) with goal, program, call for abstracts will be send by e-mail to all registered members
- Via Eunese website
- At Eurosafe congress and Eurosafe newsletter

Set up of Conference
Severals subjects will be presented during the conference: presentation of EUNESE (recruiting new members), to assist members with advocacy (how to get the topic of safety for elderly on the agenda of national government), networking on national level, communication, implementation of interventions etc.
During the conference it is also important to give members the opportunity to dessiminate their own research results and projects to the members of EUNESE (one of the results of teh questionnaire).
It is also important to create the opportunity for members to learn to know each other. There will be an opportunity during dinner and breaks, but this will aslo be accomplished with the working forms used in the program.

Program

May 7th

9.00 – 9.30	registration
9.30 – 9.45	welcome of project leader Prof. Dr. E. Petridou
9.45 – 10.00	Welcome of Eurosafe (host organisation) Dr. W. Rogmans
10.00 – 11.00	Presentation of EUNESE project (results so far) Kiki Pertoulaki
11.00 – 11.30	Coffee break
11.30 – 12.30	Presentation of EUNESE Pilot projects ▪ Hungary ▪ Poland ▪ Italy ▪ France / Greece
12.30 – 14.00	Lunch
14.00 – 15.00	Workshops (round 1) explanation: every participant will with their application form sign up for two workshops, one in round 1 and one in round 2. If workshops are full, people are divided to their third choice. The workshops will be interactive so also the participants will have input. Advocacy on safety for elderly Keynote speaker Communication with elderly about safety Chris Todd Building a national network Mr. R. Schildmeijer, TNS Nipo Consult

	Implementation of an intervention Keynote speaker
	Registration of mortality and morbidity rates on national level Prof. Dr. E. Petridou
15.30 – 16.00	Coffee break
16.00 – 17.30	Workshop round 2
20.00	Diner

May 8th

9.30 – 10.30	Speed dating Explanation: All the participants get an opportunity to briefly exchange information with other members on the basis of three questions: Who are you (name, function, brief description) What can I learn from you? What information will you need from me? People get 5 minutes and then rotate to someone else. A member will speak to approxmately 10 other members this way.
10.30 – 11.00	Presentation 1 Explanation: The quenstionnairs learnt that the network members want to share their project results with the other networkmembers. The 3 presentations on this second day create an opportunity for this. With the congres announcement there will also be a call for abstract. If possible we will program a presentation about falls, about traffic / road accidents and about poising.
11.00 - 11.30	Coffee break
11.30 – 12.00	Presentation 2
12.00 – 12.30	Presentation 3
12.30 – 14.00	Lunch
14.00 – 14.45	Future of EUNESE Explanation: The members will be devided into different groups who all will discuss an aspect of the future of EUNESE. The different aspects will be deliverd by WG 5.
14.45 – 15.00	Closure by project leader mrs. Prof. Dr. E. Petridou

APPENDIX 1.7 Toolkit for injuries among elderly **(Project Leader)**

Εθνικό και Καποδιστριακό Πανεπιστήμιο Αθηνών
Ιατρική Σχολή - Εργαστήριο Υγιεινής και Επιδημιολογίας

Κέντρο Έρευνας και Πρόληψης Ατυχημάτων
(ΚΕΠΑ)

Προς: Τοπική Αυτοδιοίκηση
ΚΟΙΝΟΠΟΙΗΣΗ
Προγράμματα «Βοήθεια στο Σπίτι»
ΚΑΠΗ
Οίκους Ευγηρίας

Αθήνα _____2005

Αγαπητοί συνάδελφοι,

το Κέντρο Έρευνας και Πρόληψης Ατυχημάτων (Κ.Ε.Π.Α.) του Πανεπιστημίου Αθηνών απευθύνει με την παρούσα επιστολή πρόσκληση συνεργασίας προς τους Φορείς της Τοπικής Αυτοδιοίκησης όσον αφορά την πρόληψη των ατυχημάτων στην τρίτη ηλικία.

Όπως γίνεται φανερό σε ανακοίνωση σχετικού συνεδρίου του προγράμματος «Βοήθεια στο Σπίτι» με τίτλο "Στην 1η γραμμή των κοινωνικών υπηρεσιών" (27-29 Μαΐου 2005, Καρδίτσα), το πρόγραμμα «Βοήθεια στο Σπίτι», που αναλήφθηκε στη χώρα μας κατά τα τελευταία 7 χρόνια, «έχει αναγνωριστεί ως η πιο δημοφιλής πρωτοβουλία της εναλλακτικής προσέγγισης της πρωτοβάθμιας φροντίδας» σύμφωνα με τις προσταγές των χαρακτηριστικών των σύγχρονων κοινωνιών, με πρώτη μεταξύ αυτών την αλλαγή της ηλικιακής σύνθεσης του πληθυσμού και τις δημογραφικές τάσεις.

Όπως επίσης διαφάνηκε από τις προτεραιότητες των θεματικών ενοτήτων του συνεδρίου αυτού, ένας από τους βασικούς στόχους ήταν «η ευαισθητοποίηση της επιστημονικής και ερευνητικής κοινότητας να ασχοληθεί με την έρευνα πεδίου στο αντικείμενο».

Με βάση ευρωπαϊκές επιδημιολογικές στατιστικές, υπολογίζεται ότι κάθε χρόνο περίπου 100.000 άτομα άνω των 65 ετών στην Ευρωπαϊκή Ένωση χάνουν τη ζωή τους εξαιτίας κάποιου ατυχήματος, ενώ εκτιμάται ότι το 30% αυτών των θανάτων θα μπορούσαν να αποφευχθούν. Στη χώρα μας το μέγεθος του προβλήματος των ατυχημάτων και των επακόλουθων τραυματισμών εκτιμάται ότι είναι ανάλογου μεγέθους, με ότι αυτό συνεπάγεται για τα ίδια τα άτομα της τρίτης ηλικίας, τις οικογένειές τους, τους επαγγελματίες υγείας και το σύστημα υγείας γενικότερα.

Θεωρούμε ότι ο σχεδιασμός προληπτικών δράσεων με βάση τις ιδιαίτερες ανάγκες και τα χαρακτηριστικά κάθε περιοχής θα συνέβαλε προς την επιθυμητή κατεύθυνση, τη μείωση δηλαδή των ατυχημάτων των ηλικιωμένων. Με την παρούσα επιστολή το ΚΕΠΑ προτείνει συνεργασία προς κάθε ενδιαφερόμενο Φορέα της Τοπικής Αυτοδιοίκησης που εκ των πραγμάτων διαθέτει γνώση των ιδιαίτερων χαρακτηριστικών και αναγκών της περιοχής, προτιθέμενο από την πλευρά του να συμβάλει με τη γνώση των καλών πρακτικών πρόληψης και την τεχνογνωσία στο χώρο της επιδημιολογικής έρευνας.

Πρώτο βήμα προς την επίτευξη του στόχου αυτού αποτελεί **ο σχεδιασμός και η εφαρμογή συστηματικής καταγραφής των ατυχημάτων των ηλικιωμένων** (συχνότητα, είδος, συνθήκες που λαμβάνουν χώρα κλπ). Για το σκοπό αυτό το ΚΕΠΑ σχεδίασε το συνημμένο Εργαλείο με τίτλο «Πρωτόκολλο Καταγραφής Τραυματισμών Ατόμων Τρίτης Ηλικίας», βάσει του οποίου ο επαγγελματίας υγείας μέσω μιας δομημένης συνέντευξης θα μπορεί να καταγράφει στο αντίστοιχο Απαντητικό Φυλλάδιο όλα τα ιδιαίτερα χαρακτηριστικά του ατυχήματος που θα συναντά στην περιοχή δράσης του, με περαιτέρω στόχο αυτά να ενσωματώνονται σε μια κοινή βάση δεδομένων που θα δημιουργηθεί και θα διατηρείται από το ΚΕΠΑ.

Τα στελέχη των προγραμμάτων «Βοήθεια στο Σπίτι» (ο/η Κοινωνικός/η Λειτουργός, ο/η Επισκέπτης/τρια Υγείας, ο/η ψυχολόγος ή ο/η κοινωνιολόγος και ο/η νοσηλευτής/τρια), καθώς επίσης και το προσωπικό των οίκων ευγηρίας και των ΚΑΠΗ προτείνονται ως κατεξοχήν αρμόδιοι και ειδικοί για να αναλάβουν το έργο της καταγραφής στην περιοχή σας.

Το Κ.Ε.Π.Α. από την πλευρά του θα παράσχει την τεχνογνωσία για την υποστήριξη του εγχειρήματος και συγκεκριμένα την δημιουργία της βάσης καταγραφής ατυχημάτων τρίτης ηλικίας, το εργαλείο και τη μέθοδο καταγραφής, καθώς και την επεξεργασία των δεδομένων που θα προκύπτουν. Μετά από σύντομη περίοδο συλλογής δεδομένων, υπάρχει η δυνατότητα να σχεδιαστούν και να εφαρμοστούν προληπτικές δράσεις που θα στοχεύουν στη μείωση των ατυχημάτων στη συγκεκριμένη περιοχή. Η εφαρμογή της παρέμβασης θα πραγματοποιηθεί στα πλαίσια του Προγράμματος «Ασφαλές Σπίτι» που έχει σχεδιαστεί στα πλαίσια του Ευρωπαϊκού Προγράμματος EUNESE- European Network for Safety among Elderly.

Θεωρούμε ότι για τους Φορείς της Τοπικής Αυτοδιοίκησης που θα συνεργαστούν, κέρδος θα αποτελέσει η εφαρμογή αποτελεσματικών προληπτικών δράσεων για την μείωση των ατυχημάτων στην τρίτη ηλικία, ενώ πιο άμεσα θα γίνει εμφανής μια ουσιαστική διάσταση της ύπαρξης προγραμμάτων και δομών όπως το «Βοήθεια στο Σπίτι» και τα ΚΑΠΗ τα οποία -πέραν της καθημερινής φροντίδας που προσφέρουν στους πολίτες που χρήζουν βοήθειας στο πλαίσιο της αποκατάστασης- είναι επίσης ικανά να συμβάλλουν σημαντικά και στον τομέα της πρόληψης.

Θα χαρούμε να λάβουμε εκ μέρους σας εκδήλωση ενδιαφέροντος για συμμετοχή στο εγχείρημα της καταγραφής.

Για περαιτέρω διευκρινήσεις ή πληροφορίες, παρακαλούμε όπως επικοινωνήσετε μαζί μας Υπεύθυνος/η: Όνομα XXXXXX, τηλ (XXXXXXXXXX) ή μέσω ηλεκτρονικού ταχυδρομείου (XXXXXXXXXXXX).

Κέντρο Έρευνας και Πρόληψης Ατυχημάτων (ΚΕΠΑ)
Εργαστήριο Υγιεινής και Επιδημιολογίας, Ιατρικής Σχολή Πανεπιστημίου Αθηνών
Μικράς Ασίας 75, 115 27 Αθήνα Τηλ.: 210 –7462 187 Fax : 210 -7462 105
www.euroipn.org/cerepri www.eunese.org

Φύλλο Οδηγιών για τον/την Συνεντευκτή

Το παρόν έντυπο αποτελεί συνοδευτικό του "Πρωτοκόλλου Καταγραφής Τραυματισμών Ατόμων Τρίτης Ηλικίας", και απευθύνεται σε Κοινωνικούς Λειτουργούς, Επισκέπτες/ τριες Υγείας, Νοσηλευτές /τριες ή/και άλλους επαγγελματίες υγείας ή κοινωνικούς επιστήμονες που στελεχώνουν προγράμματα «Βοήθεια στο Σπίτι», ΚΑΠΗ και Οίκους Ευγηρίας των Δήμων της χώρας, οι οποίοι θα αναλάβουν το ρόλο του συνεργάτη-συνεντευκτή στην συμπλήρωση του Πρωτοκόλλου για τη συλλογή των σχετικών δεδομένων.

Στόχος της καταγραφής είναι, μέσω της επιδημιολογικής διερεύνησης των χαρακτηριστικών των τραυματισμών και των συνθηκών υπό των οποίων οι τραυματισμοί αυτοί λαμβάνουν χώρα, να δρομολογηθεί ο σχεδιασμός των κατάλληλων προληπτικών δράσεων με βάση τις συγκεκριμένες ανάγκες κάθε γεωγραφικής περιοχής, με απώτερο σκοπό τη μείωση των τραυματισμών και των συνεπειών τους στα ίδια τα άτομα, τις οικογένειές τους και στο σύστημα υγείας συνολικότερα.

Το εργαλείο καταγραφής σχεδιάστηκε από το Κέντρο Έρευνας και Πρόληψης των Ατυχημάτων του Εργαστηρίου Υγιεινής και Επιδημιολογίας του Τμήματος Ιατρικής του Πανεπιστημίου Αθηνών.

Το ερευνητικό εργαλείο της καταγραφής αποτελείται από το παρόν Φύλλο Οδηγιών για τον Συνεντευκτή και το "Πρωτόκολλο Καταγραφής Τραυματισμών Ατόμων Τρίτης Ηλικίας, το οποίο είναι ένα Έντυπο Ερωτήσεων και προ-Κωδικοποιημένων Απαντήσεων για την Καταγραφή Ατυχημάτων Ηλικιωμένων (65+)"

Στο παρόν φύλλο Οδηγιών για τον Συνεντευκτή περιέχεται ο στόχος καθώς και γενικές πληροφορίες για τη δομή του πρωτοκόλλου. Το Πρωτόκολλο καταγραφής περιέχει τις ερωτήσεις εκ των οποίων προκύπτουν τα δεδομένα αναφορικά με τον τραυματισμό και τις συνθήκες υπό των οποίων συνέβη, καθώς και προ-κωδικοποιημένες απαντήσεις για τη συλλογή των δεδομένων (όπου οι απαντήσεις τσεκάρονται στα αντίστοιχα πλαίσια). Για κάθε ερώτηση έχουν καταγραφεί οι πιο συχνές και άρα αναμενόμενες απαντήσεις με τη μορφή πολλαπλών εναλλακτικών επιλογών. Η συλλογή των δεδομένων γίνεται βάσει πλήρως δομημένης ατομικής συνέντευξης (σειρά 29 προκαθορισμένων ερωτήσεων) και πραγματοποιείται από τον συνεργάτη-επαγγελματία υγείας με το άτομο που υπέστη τον τραυματισμό ή, στις περιπτώσεις όπου αυτό δεν είναι εφικτό, με άτομο που έχει το ρόλο φροντιστή του ηλικιωμένου που υπέστη τον τραυματισμό. Ο χρόνος της συλλογής είναι η πιο κοντινή κατάλληλη στιγμή μετά τον τραυματισμό στο σπίτι του πάσχοντος ή σε χώρο όπως το ΚΑΠΗ και η διάρκεια της διαδικασίας υπολογίζεται περίπου στα 15 λεπτά.

Σε γενικές γραμμές η συνέντευξη αποτελείται από πέντε θεματικές ενότητες και κάθε μια απ' αυτές σε υπο-ενότητες. Οι απαντήσεις για όλες τις ερωτήσεις των πέντε ενοτήτων βρίσκονται στο προ-κωδικοποιημένο απαντητικό φυλλάδιο με τη μορφή κλειστών ερωτήσεων πολλαπλών ή εναλλακτικών επιλογών, ενώ υπάρχουν και ερωτήσεις-φίλτρα (συνήθως τύπου Ναι-Όχι) που αποκλείουν ή παραπέμπουν σε επόμενη ερώτηση αναλόγως, όπου ο συνεντευκτής τσεκάρει κάθε φορά την απάντηση, χωρίς να χρειαστεί να καταγράψει όσα ειπωθούν για το περιστατικό.

Οι πέντε ενότητες και οι υπο-ενότητες έχουν ως ακολούθως:

Πρώτη Ενότητα: Γενικές πληροφορίες για τον ερωτώμενο Δημογραφικά στοιχεία Συνθήκες διαβίωσης Καθημερινές Συνήθειες Γενική κατάσταση υγείας	**Τέταρτη Ενότητα:** Αντιμετώπιση του τραύματος Είδος περίθαλψης που παρασχέθηκε Διάγνωση Θεραπευτική αγωγή
Δεύτερη Ενότητα: Συνθήκες του ατυχήματος Χρόνος Τόπος Δραστηριότητα την ώρα του ατυχήματος Κατάσταση συνείδησης την ώρα του ατυχήματος	**Πέμπτη Ενότητα:** Ιστορικό ατυχημάτων Είδος ατυχημάτων κατά το περασμένο έτος Συχνότητα Επιπτώσεις
Τρίτη Ενότητα: Φύση του ατυχήματος Αιτία ατυχήματος Είδος τραύματος Μέρος σώματος που τραυματίστηκε Διερεύνηση εμπλοκής αντικειμένου στο ατύχημα Διερεύνηση εμπλοκής εσφαλμένης ενέργειας του ιδίου ή άλλου στο ατύχημα	**Σας ευχαριστούμε πολύ για τη συνεργασία**

Πρωτόκολλο Καταγραφής Τραυματισμών Ατόμων Τρίτης Ηλικίας
Έντυπο Ερωτήσεων και προ-Κωδικοποιημένων Απαντήσεων για την Καταγραφή Ατυχημάτων Ηλικιωμένων (65+)

ΠΡΩΤΗ ΕΝΟΤΗΤΑ – ΓΕΝΙΚΕΣ ΠΛΗΡΟΦΟΡΙΕΣ «Θα σας ρωτήσω στην αρχή μερικά πράγματα για σας»	
1	Φύλο [μπορεί να συμπληρωθεί χωρίς σχετική ερώτηση] 01 Άνδρας 02 Γυναίκα
2	«Πόσων χρονών είσαστε κε …. / κα…..;» _____ [Σημειώνετε την ηλικία]
3	«Έχετε πάει σχολείο;» ή «Τι εκπαίδευση έχετε πάρει;» 01 Αναλφάβητος 02 Δημοτικό 03 Δευτεροβάθμια εκπαίδευση (6ετής) 04 Ανώτερη εκπαίδευση 05 Ανώτατη εκπαίδευση
4	«Σήμερα είσαστε συνταξιούχος;» «Τι δουλειά κάνατε όταν εργαζόσασταν;» [αν «Όχι», «Τι δουλειά κάνετε;»] 01 Ναι _____ [Σημειώστε είδος εργασίας] 02 Όχι _____ [Σημειώστε είδος εργασίας]
5	**[Ερώτηση 5α]** «Ποια είναι η οικογενειακή σας κατάσταση;» ή «Είστε παντρεμένος /η;» 01 Άγαμος/η 02 Παντρεμένος/η 03 Χήρος/α 04 Διαζευγμένος/η 05 Συγκατοίκηση **[Ερώτηση 5β]** «Με ποιον ζείτε;» [Εφόσον απαντήσει «5» ➔[Ερωτήσεις 5γ και 5δ. Διαφορετικά➔Ερώτηση 6] 01 Με τον/τη σύζυγο 02 Με την οικογένεια (παιδιά) 03 Με συγγενείς 04 Μένει μόνος/η ΑΛΛΑ δίπλα σε συγγενείς/ φίλους 05 Μόνος /η **[Ερώτηση 5γ.]** «Ποιος σας φροντίζει;» 01 Παιδιά 02 Συγγενείς 03 Κάποιος επαγγελματίας (βοηθός) 04 Άλλο [σημειώστε] _____ **[Ερώτηση 5δ.]** «Πόσο συχνά έχετε επαφή (με αυτόν που σας φροντίζει);» 01 Πολλές φορές τη μέρα 02 Κάθε μέρα 03 Αρκετές φορές τη βδομάδα 04 Κάθε βδομάδα 05 Κάθε μήνα 06 Πιο σπάνια
6	«Γενικά, περνάτε πολλές ώρες στο σπίτι;» 01 Είμαι συνέχεια στο σπίτι 02 Βγαίνω, αλλά λίγο 03 Έτσι κι έτσι 04 Βγαίνω πολύ συχνά 05 Συνήθως λείπω από το σπίτι
7	«Πώς περνάτε συνήθως την ώρα σας στο σπίτι;» ή «Τι κάνετε συνήθως όταν είσαστε στο σπίτι;» 01 Δραστήριος, εργάζεστε 02 Δραστήριος, περπατάτε 03 Κάθεστε, διαβάζετε 04 Κάθεστε, βλέπετε τηλεόραση 05 Ξαπλωμένος, στο κρεβάτι 06 Άλλο (προσδιορίστε) _____
8	«Τώρα θα σας ρωτήσω σε γενικές γραμμές για την υγεία σας»
	[Ερώτηση 8α.] Έχετε προβλήματα με την όρασή σας; 00 Όχι [προχωρήστε ➔Ερώτηση 8β.] 01 Ναι 02 Χρήση γυαλιών [υπογραμμίστε: μόνο για διάβασμα-πρεσβυωπίας-φοράει πάντα] 03 Καταρράκτης [υπογραμμίστε: ΑΡ-ΔΕ-ΑΜΦΩ] 04 Επέμβαση καταρράκτη [υπογραμμίστε: ΑΡ-ΔΕ-ΑΜΦΩ] 05 Γλαύκωμα 06 Πλήρης απώλεια όρασης **[Ερώτηση 8β.] «**Έχετε προβλήματα με την ακοή σας;» 00 Όχι [προχωρήστε ➔Ερώτηση 8γ.] 01 Ναι 02 Μικρή δυσκολία [υπογραμμίστε: ΑΡ-ΔΕ-ΑΜΦΩ] 03 Σοβαρά προβλήματα [υπογραμμίστε: ΑΡ-ΔΕ-ΑΜΦΩ] 04 Χρήση ακουστικών Βαρηκοΐας 05 Κώφωση **[Ερώτηση 8γ.]** (κινητικά, αν δεν είναι εμφανές, σχετική ερώτηση: «Έχετε κάποιο πρόβλημα που να σας εμποδίζει να περπατάτε ή γενικά να κινείστε;») 00 Όχι [προχωρήστε ➔Ερώτηση 8δ.] 01 Ναι 02 Χρήση καροτσιού (υπογραμμίστε: λόγω ασθένειας, ατυχήματος, εκ γενετής) 03 Χρήση βοηθήματος (Π) (υπογραμμίστε: λόγω ασθένειας, ατυχήματος) **[Ερώτηση 8δ.] «**Έχετε κάποια χρόνια ασθένεια όπως (διαβάστε από τη λίστα ή δώστε μερικά παραδείγματα)»] 00 Όχι 01 Υπέρταση 02 Οστεοπόρωση 03 Διαβήτης 04 Καρδιολογικό 05 Αρθρίτιδα 06 Parkinson 07 Κατάθλιψη 08 Αλλεργίες 09 Παχυσαρκία 10 Αλκοολισμός 11 Άλλο [Σημειώστε] _____ **[Ερώτηση 8ε.] «**Φάρμακα παίρνετε;» 00 Όχι [προχωρήστε ➔Ερώτηση 9.] 01 Κάποιες φορές (π.χ. πονοκέφαλος γρίπη) 02 Ένα τη μέρα 03 Δύο-Τρία τη μέρα (είδη φαρμάκου, όχι ποσότητες του ίδιου) 04 Τέσσερα και πάνω τη μέρα (είδη φαρμάκου, όχι ποσότητες)
ΔΕΥΤΕΡΗ ΕΝΟΤΗΤΑ - ΣΥΝΘΗΚΕΣ ΤΟΥ ΑΤΥΧΗΜΑΤΟΣ «Τώρα θα σας ρωτήσω μερικά πράγματα για το πότε και πώς συνέβη το ατύχημα»	
9	«Πότε ακριβώς σας συνέβη το ατύχημα;» **[Ερώτηση 9α.]** «Θυμάστε την ημερομηνία;» 99 Δεν θυμάμαι [προχωρήστε ➔Ερώτηση 9β] _____ [Σημειώστε την ημερομηνία] **[Ερώτηση 9β.]** «Τι ημέρα ήταν;» 99 Δεν θυμάμαι [προχωρήστε ➔Ερώτηση 9γ] 01 ΔΕΥ 02 ΤΡΙ 03 ΤΕΤ 04 ΠΕΜ 05 ΠΑΡ 06 ΣΑΒ 07 ΚΥΡ **[Ερώτηση 9γ.]** «Τι ώρα ήταν περίπου;» 99 Δεν θυμάμαι [προχωρήστε ➔Ερώτηση 1] _____ [Σημειώστε την ώρα]
10	**[Ερώτηση 1α]** «Στο σπίτι συνέβη το ατύχημα;»

	88 Δεν ξέρω [προχωρήστε ➔Ερώτηση 12] 99 Δε θυμάμαι [προχωρήστε ➔Ερώτηση 12] 00 Όχι [προχωρήστε ➔Ερώτηση 11] 01 Ναι **[Ερώτηση 1β]** «Πού» ή «Σε ποιο χώρο;» 01 Κουζίνα 02 Καθιστικό 03 Υπνοδωμάτιο 04 Σκάλες 05 Μπάνιο 06 Χολ 07 Βεράντα 08 Γκαράζ 09 Κήπος 10 Άλλο [Διευκρινίστε] _____ **[Ερώτηση 1γ]** «Σε τι σπίτι μένετε;» 01 Μονοκατοικία 02 Διαμέρισμα 03 Χώρος φιλοξενίας (οίκος ευγηρίας κλπ) 04 Άλλο [Προσδιορίστε]_____ **[Ερώτηση 1δ]** «Σε τι κατάσταση θα λέγατε ότι είναι το σπίτι σας;» 01 Άριστη 02 Καλή 03 Έτσι κι έτσι 04 Κακή 05 Πολύ κακή
11	**[Ερώτηση 11α]** «Εκτός σπιτιού λοιπόν. Πού ακριβώς συνέβη;» 01 Δρόμος 02 Πεζοδρόμιο 03 Χώρος αναψυχής /δημόσιος χώρος (π.χ. πλατεία) 04 Χώρος άθλησης 05 Δημόσιο κτίριο 06 Εξοχικό 07 Αγρός 08 Σκάλες (όχι του σπιτιού) 09 Μέσο μαζικής μεταφοράς 10 Άλλο [Προσδιορίστε] **[Ερώτηση 11β]** «Θυμάστε τι καιρό είχε εκείνη τη μέρα;» [μπορεί να ισχύουν ταυτόχρονα πάνω από μία επιλογές] 88 Δεν ξέρω [προχωρήστε ➔Ερώτηση 12] 99 Δε θυμάμαι [προχωρήστε ➔Ερώτηση 12] 01 Λιακάδα/ ζέστη 02 Βροχή 03 Κρύο 04 Χιόνι 05 Πάγος
12	«Θυμάστε τι κάνατε την ώρα που σας συνέβη το ατύχημα» 88 Δεν ξέρω [προχωρήστε ➔Ερώτηση 13] 99 Δεν θυμάμαι [προχωρήστε ➔Ερώτηση 13] 01 Οικιακές δουλειές 02 Προσωπική υγιεινή 03 Περπάτημα 04 Καθώς σηκώνονταν από το κρεβάτι ή καρέκλα 05 Επισκευές 06 Εν ώρα εργασίας 07 Φυσική άσκηση 08 Άλλο [Προσδιορίστε] _____
13	«Εκείνη τη μέρα, πριν σας συμβεί το ατύχημα, σε γενικές

14	«Θυμάστε ακριβώς πώς και τι έγινε;» Κατάσταση συνείδησης την ώρα που συνέβη το ατύχημα 88 Δεν ξέρω [προχωρήστε ➔Ερώτηση 15] 99 Δεν θυμάμαι [προχωρήστε ➔Ερώτηση 15] 01 Ίλιγγος 02 Λιποθυμία (Απώλεια συνείδησης) 03 Στραβοπάτημα 04 Σκουντούφλημα 05 Γλίστρημα 06 Υπερ-προσπάθεια 07 Άλλο [Προσδιορίστε]_____

ΤΡΙΤΗ ΕΝΟΤΗΤΑ - ΦΥΣΗ ΤΟΥ ΑΤΥΧΗΜΑΤΟΣ **«Ας μιλήσουμε τώρα για το ατύχημα.»**	
15	«Ποια ήταν η κύρια αιτία για το ατύχημά σας αυτό;» 88 Δεν ξέρω [προχωρήστε ➔Ερώτηση] 99 Δεν θυμάμαι [προχωρήστε ➔Ερώτηση] 01 Πεζός σε σύγκρουση με όχημα (αυτοκίνητο-μηχανή-άλλο) 02 Τροχοφόρο(αυτοκίνητο) [Υπογραμμίστε: Οδηγός, Επιβάτης] 03 Μηχανή [Υπογραμμίστε: Οδηγός, Επιβάτης] 04 Ποδήλατο [Υπογραμμίστε: Οδηγός, Επιβάτης] 05 Πτώση [Υπογραμμίστε: ίδιο επίπεδο-σκαλί-σκάλα-ύψος>1 μ] 06 Από σύγκρουση με αντικείμενο: _____ 07 Πυροβολισμός, όπλο (εξαιρούνται μη-γεμάτα όπλα) 08 Πληγή από αιχμηρό όργανο/ κόψιμο/ τρύπημα 09 Φωτιά/φλόγες 10 Ζεστό υγρό ή καυτό αντικείμενο 11 Εισπνοή καπνού /αερίου 12 Δηλητηρίαση 13 Παρολίγον πνιγμός /πνιγμός /βύθιση (σε νερό) 14 Ξένο σώμα (πνιγμονή) 15 Υπεράσκηση 16 Δηλητηρίαση από φαρμακευτικά σκευάσματα (φάρμακα) 17 Επιβλαβείς επιδράσεις από χειρουργική επέμβαση ή άλλη ιατρική φροντίδα 18 Εκούσιος τραυματισμός (βία) 19 Εκούσιος αυτοτραυματισμός 20 Άλλο [Προσδιορίστε] _____
16	«Θα μου πείτε τι πάθατε από αυτό το ατύχημα;» Είδος τραύματος (Μπορείτε να επιλέξετε πάνω από ένα) 01 Κάταγμα 02 Τρύπημα /κέντρισμα 03 Κόψιμο 04 Έγκαυμα 05 Δηλητηρίαση 06 Ασφυξία, πνιγμονή 07 Πνιγμός 08 Μώλωπες, γρατσουνιές κλπ 09 Άλλο [Περιγράψτε]_____

17	«Που τραυματιστήκατε;» ή «Σε ποιο σημείο χτυπήσατε;» Μέρος του σώματος που τραυματίστηκε (Μπορείτε να επιλέξετε πάνω από ένα) 01 Κεφάλι (πού): _____ 02 Αυχένας 03 Πάνω άκρα (υπογραμμίστε: ΑΡ-ΔΕ-ΑΜΦΩ) 04 Κάτω άκρα (υπογραμμίστε: ΑΡ-ΔΕ-ΑΜΦΩ) 05 Ψηλά στον κορμό (πού) _____ 06 Χαμηλά στον κορμό (πού) _____ 07 Εσωτερικό όργανο (ποιο) _____ 08 Αισθητήριο όργανο (ποιο) _____ 09 Άλλο [Προσδιορίστε] _____
18	**ρώτηση 18α]** «Υπάρχει κάποιο αντικείμενο που να σχετίζεται με το ατύχημά σας;» ή «Κάποιο πράγμα που μεταφέρατε ή σηκώνατε; ή κάποιο ρούχο ή παπούτσια που φορούσατε; Κάποια επιφάνεια πάνω στην οποία χτυπήσατε, συγκρουστήκατε, γλιστρήσατε ή σκοντάψατε; κλπ.» Όχι [προχωρήστε ➔Ερώτηση 2] Ναι [Προσδιορίστε] _____ **ρώτηση 18β]**]«Το αντικείμενο αυτό ήταν:» αβάστε τις επιλογές και επιλέξτε μία απάντηση] 01 Η αιτία του ατυχήματος 02 Όχι η αιτία, αλλά έκανε τα πράγματα χειρότερα 03 Δεν ήταν η αιτία του ατυχήματος αλλά προκάλεσε τον τραυματισμό (π.χ. αν γλίστρησε στο πάτωμα και χτύπησε στο τραπέζι, το τραπέζι προκάλεσε τον τραυματισμό) 04 Κάτι που χρησιμοποιούσατε εκείνη τη στιγμή, αλλά δεν προκάλεσε ούτε το ατύχημα ούτε τον τραυματισμό (π.χ. μεταφέροντας ένα δίσκο γλιστρήσατε και πέσατε αλλά ο δίσκος δεν ήταν η αιτία της πτώσης ούτε σας τραυμάτισε) *05 Άλλο [Προσδιορίστε]* _____
19	«Εάν έπρεπε να πείτε τι έφταιγε για το ατύχημα, αυτό θα ήταν» (Διαβάστε τις επιλογές και επιλέξτε όσες χρειάζεται) 01 Χρησιμοποίησα μη-προβληματικό αντικείμενο με λάθος τρόπο 02 Το προϊόν ήταν κακοσχεδιασμένο (όσον αφορά σχεδιασμό) 03 Το προϊόν ήταν κακοφτιαγμένο (\κατασκευή, υλικά) 04 Το προϊόν ήταν παλιό / σπασμένο/ ελαττωματικό 05 Η ετικέτα ή οι οδηγίες του προϊόντος ήταν λάθος 09 Άλλο [Περιγράψτε] _____ 88 Δεν ξέρω
20	«Όταν ένα προϊόν συνοδεύεται από οδηγίες, τις διαβάζετε;» [Διαβάστε τις επιλογές] 01 Πάντα 02 Συνήθως 03 Κάποιες φορές 04 Σπάνια 05 Ποτέ
21	«Εάν έπρεπε να δηλώσετε μόνο μια κύρια αιτία του ατυχήματος, τι θα ήταν;» [Επιλέξτε μόνο μία απάντηση] 01 Κάτι που κάνατε εσείς 02 Κάτι που έκανε κάποιος/οι άλλος/οι 03 Ένα αντικείμενο (προϊόν) 04 Κάτι στο γύρω περιβάλλον (του σπιτιού ή έξω απ' αυτό); 05 Άλλο [Προσδιορίστε] _____ 88 Δεν ξέρω
22	«Τι ήταν αυτό που προκάλεσε τον τραυματισμό (όχι το ατύχημα);» [Καταγράψτε. Σημείωση: π.χ. σκόνταψα πάνω σε ένα παιχνίδι (=αιτία ατυχήματος) αλλά χτύπησα το κεφάλι στο τραπέζι=αιτία τραυματισμού)] _____ _____
23	«Πώς σκέφτεστε ότι θα μπορούσε να προβλεφθεί ή να αποφευχθεί το ατύχημα» ή «Νομίζετε ότι αυτό θα μπορούσε να γίνει;» 01 Όχι 02 Ναι [Προσδιορίστε] _____

ΤΕΤΑΡΤΗ ΕΝΟΤΗΤΑ - ΑΝΤΙΜΕΤΩΠΙΣΗ ΤΟΥ ΤΡΑΥΜΑΤΟΣ	
24	**[Ερώτηση 24α]** «Πήγατε στο γιατρό;» ή «Πήρατε ιατρική φροντίδα;» 01 Όχι [Προχωρήστε ➔Ερώτηση 26] 02 Ναι **[Ερώτηση 24β]** «Πήγατε στο νοσοκομείο;» 01 Όχι [Προχωρήστε ➔Ερώτηση 26] 02 Ναι [Προσδιορίστε χρόνο νοσηλείας] _____
25	«Τι διάγνωση έκανε ο γιατρός;» [Εάν πάνω από μία, επισημάνετε την κύρια διάγνωση με 1 και τις δευτερεύουσες με 2-7] 99 Δεν θυμάμαι [Προχωρήστε ➔ Ερώτηση 26] 01 Κάκωση/ μώλωπας / γδάρσιμο 02 Κάταγμα 03 Χαρακιά/ κόψιμο 04 Εσωτερικό τραύμα 05 Διάσειση 06 Διάταση/ εξάρθρωση 07 Άλλο [Προσδιορίστε] _____
26	«Τι θεραπεία (θεραπευτική αγωγή) πήρατε;» [Περιγράψτε. Εδώ περιλαμβάνεται και όποια άλλη θεραπεία λήφθηκε αργότερα] _____ _____

ΠΕΜΠΤΗ ΕΝΟΤΗΤΑ - ΙΣΤΟΡΙΚΟ ΑΤΥΧΗΜΑΤΩΝ	
27	Πόσα ατυχήματα είχατε τον τελευταίο χρόνο; [Καταγράψτε με κριτήριο το πώς αντιμετωπίστηκαν οι τραυματισμοί που προέκυψαν από τα ατυχήματα] Που εξαιτίας τους να πήγατε στο Νοσοκομείο: _____; Που εξαιτίας τους να πήγατε σε γιατρό_____ ; Που αντιμετωπίστηκαν στο σπίτι (χωρίς γιατρό)_____ ;
28	[**Ερώτηση 28α]** «Έχετε πέσει τον τελευταίο χρόνο;» 01 Όχι [Προχωρήστε ➔ Ερώτηση 29] 02 Ναι _____ φορές **Ερώτηση 28β] «**Ποιο ήταν το αποτέλεσμα της πτώσης;» 01 Τίποτα 02 Ελαφρό τραύμα 03 Αιμάτωμα 04 Κάταγμα 05 Άλλο [Περιγράψτε] _____
29	«Είχατε κάποιο τραυματισμό από τους παρακάτω τους 12 τελευταίους μήνες;» [Διαβάστε τις επιλογές] 01 Κόψιμο _____φορές 02 Τρύπημα _____φορές 03 Κάψιμο _____φορές 04 Δάγκωμα _____φορές 05 Δηλητηρίαση _____φορές 06 Άλλο [Περιγράψτε] _____ _____φορές

Ονοματεπώνυμο Συνεντευκτή:

_____

Περιοχή:

_____

Ημερομηνία:

_____

Χώρος συνέντευξης:

APPENDIX 2.1 "Who is Who elderly related Organizations" database **(Project Leader)**

The following table lists the elderly-related links that were located after searching through the internet using as keywords "elderly", "aged", "ageing", "old-people" AND "care", "injury prevention" AND "organization", "institute", "agency", "NGO", "Governmental". Many of the links were also located via the "useful links" pages of other pages.

Organization's Name	**Website**
3rdagehomes.org	http://www.3rdagehomes.org/
AARP (formerly American Association of Retired Persons)	http://www.aarp.org/
Access to the RN+ Systems Fall Prevention and Restraint Reduction newsletter	http://www.rnplus.com/newsletter.html
ACIOG - Age Concern Institute of Gerontology, King's College London	http://www.kcl.ac.uk/kis/schools/life_sciences/health/gerontology/top.html
Administration on Aging (USA)	http://www.aoa.dhhs.gov/aoa.html
Age & Opportunity, Ireland	http://www.olderinireland.ie/
Age & Opportunity, Marino Institute of Education	http://www.olderinireland.ie/healthservices/index.htm
Age & Opportunity, Newsletter	http://www.olderinireland.ie/publications/newsletters.htm
Age Action Ireland	http://www.ageaction.ie/
Age and Ageing	http://ageing.oxfordjournals.org/
Age Concern England	http://www.ace.org.uk/
Age Concern New Zealand	http://www.ageconcern.org.nz/
Age Concern Northern Ireland	www.ageconcernni.org
Age Concern UK	http://www.ageconcern.org.uk/
Age Exchange	http://www.age-exchange.org.uk/
Age in Action	http://www.age-in-action.co.za/
Age Posi+ive	http://www.agepositive.gov.uk/
AGE, the European Older People's Platform	http://www.age-platform.be/
Ageing & Society	http://www.cambridge.org/uk/journals/journal_catalogue.asp?historylinks=ALPHA&mnemonic=ASO
Ageing and Ethnicity Web	http://www.aeweb.org/
Ageline	http://research.aarp.org/ageline/home.html
AgeNet	http://agenet.agenet.com/
Aging in America	http://www.ifa-fiv.org/en/www.aginginamerica.org
ALIVE, the European challenge to ageing	http://www.alive-eu.org/index-gb.htm
American Association of Retired Persons (AARP)	http://www.AARP.org/
American Hospital Association (AHA)	http://ww.aha.org/index.asp
American Nurses Association (ANA)	http://www.ana.org/
Association of Retired and Persons over 50	http://www.arp.org.uk/
A-Z Care Homes Guide	http://www.carehomes.co.uk/
Berlin Aging Study (BASE)	http://www.base-berlin.mpg.de/
Better Government for Older People	http://www.bgop.org.uk/
Better Government for Older People (BGOP)	http://www.bettergovernmentforolderpeople.gov.uk/
Breaking Point Osteoporosis campaign	www.breakingpoint.ie
British Association for Service to the Elderly	http://www.base.org.uk/

British Geriatrics Society	http://www.bgs.org.uk/
British Society for Research on Ageing	http://www.bsra.org.uk/
British Society of Gerontology	http://www.britishgerontology.org/
Care & Repair, England	http://www.careandrepair-england.org.uk/
Care Alliance Ireland	http://www.carealliance.ie/
Care Local	http://www.carelocal.homestead.com/
Care Services Improvement Partnership (CSIP)	http://www.olderpeoplesmentalhealth.csip.org.uk/
CareandHealth	http://www.careandhealth.com/
CareNET	http://www.carenet.org.uk/
Carers Association	http://www.carersireland.com/
CDC - National Center for Injury Prevention: A Toolkit to Prevent Senior Falls	http://www.cdc.gov/ncipc/pub-res/toolkit/toolkit.htm
CDC National Center for Injury Prevention	http://www.cdc.gov/ncipc/falls/default.htm
Center for Disease Control (CDC)	http://www.cdc.gov/
Centre for Care of Older People (CCOP)	http://online.northumbria.ac.uk/faculties/hswe/research/ccop /ccop.htm
Centre for Economic Research on Ageing	http://www.ifs.org.uk/cera/index.shtml
Centre for Policy on Ageing	http://www.cpa.org.uk/
Centre for Research on Ageing and Gender, University of Surrey	http://www.soc.surrey.ac.uk/crag/
Centre for Social Policy Research and Development, University of Wales, Bangor	http://www.bangor.ac.uk/csprd/home.htm
Citizen Information Database	http://www.cidb.ie/
Comhairle	http://www.comhairle.ie/
COTA National Seniors	http://www.cota.org.au/
Council on the Ageing	http://www.vicnet.net.au/%7Ecotaa/
Cyberseniors	http://www.dibbs.net/points/cyberseniors.html
DaneAge	http://www.aeldresagen.dk/informationpage.asp?id=F733179E-A1C3-4AC3- 200-D105FB5FF992
Dementia Information Centre for Carers	http://www.disc.org.uk/
Dementia Services Development Centre, Stirling	http://www.dementia.stir.ac.uk/
Dementia Web	http://dementia.ion.ucl.ac.uk/
Department of Elder Affairs, Florida	http://www.state.fl.us/doea/doea.html
Department of Social and Family Affairs	http://www.welfare.ie/
Design for Ageing Network Europe (DAN)	http://www.hhrc.rca.ac.uk/programmes/designage/DAN/index.html
DesignAge	http://www.hhrc.rca.ac.uk/programmes/designage/
Deutsches Zentrum fór Alternsforschung	http://www.dzfa.uni-heidelberg.de/
Deutsches Zentrum fór Altersfragen	http://www.dza.de/
DIEL, (Advisory committee on Telecommunications for Disabled and Elderly People)	http://www.acts.org.uk/diel/default.htm
Digital Unite	http://www.digitalunite.net/
Disability Information Ireland	http://www.disability.ie/
Dublin City Development Board	http://www.dublin.ie/
Eastern Regional Health Authority	http://www.erha.ie/
EDAGE, India	http://www.edage.org/main.htm
Education Resource Guide	http://vaww.ncps.med.va.gov/fallstoolkit/resources/other/ Education_Resource_Guide.pdf
ElderCare Web, Aging, Death and Dying	http://www.elderweb.com/
Employers Forum on Age	http://www.efa.org.uk/
Energy Action Ltd	www.energyaction.ie/links.html

English Longitudinal Study of Ageing	http://www.ifs.org.uk/elsa/index.htm
ERoSH (Emerging Role of Sheltered Housing)	http://www.shelteredhousing.org/
EURAG, European Federation of the Elderly	http://www.eurag-europe.org/
Eurolink Age	http://www.eurolinkage.org/euro/
European Anti Poverty Network	http://www.eapn.ie/
European Federation of Older People (EURAG)	http://www.eurag-europe.org/
Fifty Plus Net (Canadian Association of Retired Persons)	http://www.fifty-plus.net/
Financial Information	http://www.askaboutmoney.com/
Foresight	http://www.foresight.gov.uk/default800ns.htm
Friends of the Elderly	http://www.friendsoftheelderly.ie/
GeroCare, European Network for the Care of Older People	http://www.kda.de/gerocare/gc-engl.htm
Gerontology in the Netherlands	http://gerontologie.pagina.nl/
Gerontology Research Centre, Simon Fraser University, Vancouver, Canada	http://www.harbour.sfu.ca/gero/
GeroWeb, Wayne State University, Institute of Gerontology, Detroit, Michigan	http://www.iog.wayne.edu/IOGlinks.html
Global Action on Aging	http://www.globalaging.org/index.htm
Greater London Forum for the Elderly	http://www.btinternet.com/%7Eblackheath/GLForum/GLFindex.htm
Growing Older, The ESRC Research Programme on Extending Quality of Life	http://www.shef.ac.uk/uni/project/gop/
Guideforlife	http://www.guideforlife.com/gfl/
Health and Age	http://www.healthandage.org/
Health topic: Aging	http://www.who.int/health_topics/aging/en/%22
Health Web: Geriatrics & Gerontology	http://www.uic.edu/%7Epjones/geriatrics/hw/ggfront2.htm
Healthworks online	http://www.healthworks.co.uk/
Help the Aged	http://www.helptheaged.org.uk/
HelpAge India	http://www.helpageindia.org/
HelpAge International	http://www.helpage.org/
Info-Med UK Limited - ad referendum - Geriatrics	http://www.info-med.co.uk/adref/geriat/ge_t.htm
Institute for Human Development, Life Course and Aging, University of Toronto, Canada	http://www.utoronto.ca/lifecourse
Institute for the Health of the Elderly , University of Newcastle	http://www.ncl.ac.uk/ihe/
International Association of Gerontology, Canada	http://www.sfu.ca/iag
International Association of Homes and Services for the Ageing	http://www.iahsa.net/
International Federation on Ageing	http://www.ifa-fiv.org/fr/accueil.aspx
International Federation on Ageing, Montreal, Canada	http://www.mbnet.mb.ca/crm/ca/advoc/ifa.html
International Longevity Centre UK	http://www.ilc-uk.org.uk/
International Network for the Prevention of Elder Abuse	http://www.inpeabuse.org/
Internet and E-Mail Resources on Aging	http://www.aoa.dhhs.gov/aoa/pages/jpostlst.html
Keele Centre for Social Gerontology	http://www.keele.ac.uk/depts/so/csg/index.htm
King's College London, Courses in Gerontology	http://www.kcl.ac.uk/kis/schools/life_sciences/health/gerontology/menu/course.html
Leadership Council of Aging Organisations	http://www.lcao.org/
MediaAge	http://www.mediaage.net/
National Ageing Research Institute, Melbourne	http://hermes.its.unimelb.edu.au/%7Eu5533827/narihome.html
National Aging Information Center, Washington DC	http://www.aoa.dhhs.gov/naic/default.htm
National Collaboration on Ageing Research	http://www.shef.ac.uk/ukncar/
National Council on Ageing and Older People	http://www.ncaop.ie/

National Guideline Clearinghouse™ (NGC), a public resource for evidence-based clinical practice guidelines.	http://www.guideline.gov/body_home_nf.asp?view=home
National Institute on Aging	http://www.nia.nih.go/
National Institutes of Health (NIH)	http://www.NIH.gov
National Patient Safety Foundation	http://www.ama-assn.org/med-sci/npsf/main.htm
National Pensioner's Convention	http://www.natpencon.org.uk/
National Service Framework for Older People	http://www.doh.gov.uk/nsf/olderpeople.htm
NIACE, Older and Bolder	http://www.niace.org.uk/Research/older_bolder/default.htm
OASIS: information on services, benefits and entitlements	http://www.oasis.gov.ie/
Office of Seniors Interests, Western Australia	http://www.osi.wa.gov.au/index.html
Older Feminists' Network	http://www.ofn.org.uk/
Older Women's Network, Europe	http://www.eurplace.org/orga/own/
Oxford Dementia Centre	http://www.brookes.ac.uk/dementia/
Oxford Institute of Ageing	http://www.ageing.ox.ac.uk/
Pensions Ombudsman	http://www.pensionsombudsman.ie/
Pfizer, Healthy Ageing Advocacy Forum	http://www.experience-exchange.org/
Population Aging Research Center, University of Pennsylvania	http://lexis.pop.upenn.edu/aging/aging.html
Portal Mayores, Spain	http://www.imsersomayores.csic.es/index-en.html
Portals Aging	http://www.portals.pdx.edu/%7Eisidore/aging.html
Positive Ageing Foundation of Australia	http://www.positiveageing.com.au/
Research Group on Aging and the Life Course (FALL), Berlin	http://userpage.fu-berlin.de/%7Eifs/fall/falleol.htm
Research into Ageing	http://www.ageing.org/index.html
Retired and Senior Volunteer Programme	http://www.csv-rsvp.org.uk/
Safe USA: Preventing Falls Among Older Adults	http://www.safeusa.org/olderfalls.htm
Senior Help Line	http://www.thirdage-ireland.com/
Seniornet	http://www.seniornet.com/
Seniors Computer Information Project, Manitoba, Canada	http://www.crm.mb.ca/index.html
Seniors Network	http://www.seniorsnetwork.co.uk/
SENIORWEB, Austria	http://www.seniorweb.at/
SENIORWEB, Netherlands	http://www.seniorweb.nl/un/start.asp
Sheffield Institute for Studies on Ageing	http://www.shef.ac.uk/%7Esisa/
Singapore Action Group on Elders (SAGE)	http://www.sage.org.sg/
St George's Hospital Medical School, Department of Geriatric Medicine	http://www.sghms.ac.uk/gm/index.htm
The Administration on Aging	http://www.aoa.dhhs.gov/
The Aged Family Uganda (TAFU)	http://www.geocities.com/agedr/aged/index.htm
The American Association for Retired Persons	http://www.aarp.org/
The Campaign Against Age Discrimination in Employment	http://www.caade.net/
The Canadian Centre for Elder Law Studies (CCELS)	http://www.ccels.ca/
The Center for Aging Research and Clinical Care	http://www.cornellaging.org/ http://www.cornellaging.org/medical/unit_gero.html
The ESA Research Network on Ageing in Europe	http://www.ageing-in-europe.de/
The European Commission, Ageing Policy	http://www.europa.eu.int/comm/employment_social/soc-prot/ageing/index_en.htm
The European Older People's Platform (AGE)	http://www.age-platform.org/
The Gerontological Society of America	http://www.geron.org/
The Gerontology Research Centre, Lund, Sweden	http://www.ldc.lu.se/geron/GCMainP.htm

The Inter-Ministerial Group on Older People	http://www.cabinet-office.gov.uk/servicefirst/index/opmenu.htm
The Merck Institute of Aging & Health: Falls Toolkit	http://www.miahonline.org/tools/falls/
The National Archive of Computerized Data on Aging	http://www.icpsr.umich.edu/NACDA/index.html
The Older People and Life project, University of Sydney	http://www2.fhs.usyd.edu.au/arow/opal/
The Open University, Centre for Ageing and Biographical Studies	http://www.open.ac.uk/hsc/researchCABS.htm
The Program on Aging, JDC-Brookdale Institute, Israel	http://www.jdc.org.il/brookdale/age.html
The Social Gerontology Group, Department of Sociology, Uppsala University, Sweden	http://www.soc.uu.se/research/gerontology.html
The University of Georgia Gerontology Center	http://www.geron.uga.edu/
Third Age	http://www.seniortimes.ie/
Third Age Employment Network	http://www.taen.org.uk/
Third Age Press	http://www.thirdagepress.co.uk/
Third Age Unit for Research Into Usability and Safety	http://www.lboro.ac.uk/taurus/index2.htm
TNO Centre for Ageing Research, Leiden, Netherlands	http://www.tno.nl/homepage.html
Tokyo Metropolitan Institute of Gerontology, Japan	http://www.tmig.or.jp/
TARKI, Hungary	http://www.tarki.hu/adatbank-e/elderly/
U3A, The Third Age Trust, University of the Third Age	http://www.u3a.org.uk/
UK Coalition on Older Homelessness	http://www.olderhomelessness.org.uk/
VA National Center for Patient Safety. “Tips on Reducing Falls.” TIPS, Topics in Patient Safety, Newsletter. 2002, 2(3)	http://vaww.ncps.med.va.gov/TIPSarchive02.html
VHA National Center for Patient Safety. Patient Personal Freedoms and Security. Fall Prevention and Management.” October 2001	http://www.patientsafety.gov/FallPrev/howtostart.html
VISN 8 Patient Safety Center of Inquiry	http://www.patientsafetycenter.com/
World Health Organisation, Geneva, Switzerland	http://www.who.ch/

APPENDIX 2.2 Morbidity Data – Greece **(Project Leader)**
(Sample Pages-Full document available at the Stats Portal)

Analysis of morbidity data from Greece for the five leading causes of unintentional injury death among elderly in EU25

The purpose of this report is to present proportional indicators for 5 causes of unintentional injuries among the elderly (65+ years) in Greece. These causes were chosen based on their highest ranking among all causes of injury mortality in the EU25. The indicators presented could potentially be applied for other EU countries as well, provide a basis for comparisons between them and ultimately assist in the identification of appropriate prevention measures.

Data retrieved from the Emergency Department Injury Surveillance System (EDISS) database, developed by the Center for Research and Prevention of Injuries (CEREPRI), were used to study the pattern of

- fall injuries
- road traffic injuries
- burn injuries due to fire, flames and contact with hot objects
- accidental poisonings
- accidental drowning and near-drowning injuries

among elderly (65+ years old) in Greece.

These 5 categories of injuries account for the highest numbers of deaths due to unintentional injuries among elderly in EU25 as can be seen in the following table.

Average number of unintentional injury deaths among elderly (65+) in EU25 (excluding countries with population <1,000,000) of the last 3 available years, by cause of death.

Cause of death	N
Accidental falls	39600
Motor vehicle traffic	10486
Smoke fire and flames	1585
Accidental poisoning total	1583
Accidental drowning and submersion	1385
Environmental factors	944
Transport non motor vehicle	845
Machinery cutting piercing instruments	228
Firearm missile	43
Other or unspecified injury	21303
Total	78002

(Source: Injury Statistics Portal, http://www.euroipn.org/stats_portal/ utilizing data from the WHO mortality database)

Fall related injuries among elderly in Greece

During the eight year period 1996-2003, a total of 30694 fall related home and leisure injuries among elderly (65+) were recorded by EDISS accounting for 82.5% of the total home and leisure injuries among elderly.

Demographic characteristics

The majority of fall related injuries concerned females (72%) with no significant differences among age groups (Table 1) while among all other home and leisure injuries males up to 74 years old outnumbered females (52% vs. 48%) whereas for ages 75+ the pattern is reversed (46% vs. 54%). Furthermore, among fall related injuries, about 32% concern ages 80+ whereas among other injuries only 14% (data not shown).

Event characteristics

Most of the falls (70%) occurred at the same level mostly due to stumbling (37%) or slipping (27%). Falls from greater height account for 26% of the total falls. More specifically, 5% and 4% of the injuries occurred after a fall from a bed or chair respectively, falls from stairs/ladder account for 14% of the injuries and 3% occurred from other height. For 2% of the total injuries due to fall the mechanism was fall in/from vehicles and in another 2% the mechanism was unknown. Concerning age, the percent of the injured persons due to fall from stumbling increases with age whereas falls due to slipping decrease by age. Falls from bed or chair are more frequent in the age group 85+ years (13% and 6% respectively). In contrast, falls from stairs/ladder and from other height are more common among the younger ages (65-74 years) (Table 2).

Home inside is the most common place where falls occurred (40%). More specifically, the bedroom accounts for 12% of the injuries but the percentage is increasing with age and reaches 26% among the age group 85+ years. The kitchen accounts for 7% and the bathroom for 5% of the cases. Injuries which occurred around the house account for 25%. One out of 5 injuries occurred on the road or pavement. A small number of cases (3%) occurred in farm areas mostly among men and younger ages. Another 3% occurred in commercial and service areas. Finally 3% occurred at hospitals and nursing homes and become more common as the age increases (Table 3).

The proportion of slipping was higher in the bathroom (64%) whereas the proportion of stumbling was higher on the road/pavement (54%). Falling from bed, apart from the bedroom, is also common in hospitals and nursing homes (21%). Falls from chair occur more often in the kitchen (24%). Falls from stairs or ladder are more frequent in home other and around (32% and 26% respectively) and in commercial and service areas (32%). Falls from other height are more common in farm areas (25%) (Table 5).

There were no significant differences observed between the days and the seasons either by age group or gender. About one out of three injuries occurred during 10:00

Table 1: Distribution of the 30694 fall injuries among elderly (65+), recorded in Greece by EDISS during 1996-2003, by age and gender

Gender	Age 65-74		75-84		85+		Total	
	N	col %	N	col %	N	col %	N	col %
Male	4365	29.2	2985	27.3	1392	28.8	8742	28.5
Female	10575	70.8	7931	72.7	3446	71.2	21952	71.5
Total	14940	100.0	10916	100.0	4838	100.0	30694	100.0

Table 2: Distribution of the 30694 fall injuries among elderly (65+), recorded in Greece by EDISS during 1996-2003, by mechanism of fall and age group

Mechanism of fall	Age 65-74		75-84		85+		Total	
	N	col %	N	col %	N	col %	N	col %
In/from vehicle	*311*	*2.1*	*172*	*1.6*	*30*	*0.6*	*513*	*1.7*
On the same level	*10411*	*69.7*	*7826*	*71.7*	*3360*	*69.5*	*21597*	*70.4*
stumbling	5148	34.5	4222	38.7	1972	40.9	11342	37.0
slipping	4586	30.7	2832	25.9	999	20.6	8417	27.4
other on the same level	677	4.5	772	7.1	389	8.0	1838	6.0
From height	*4026*	*26.9*	*2747*	*25.1*	*1345*	*27.8*	*8118*	*26.4*
from bed	342	2.3	671	6.1	623	12.9	1636	5.3
from chair	581	3.9	468	4.3	273	5.6	1322	4.3
from stairs/ladder	2588	17.3	1412	12.9	392	8.1	4392	14.3
other height	515	3.4	196	1.8	57	1.2	768	2.5
Unknown	*192*	*1.3*	*171*	*1.6*	*103*	*2.1*	*466*	*1.5*
Total	14940	100.0	10916	100.0	4838	100.0	30694	100.0

Road traffic injuries among elderly in Greece

During the eight year period 1996-2003, a total of 3357 road traffic injuries among elderly (65+) were recorded by EDISS.

All road users

Of the total 3357 road traffic injuries among elderly recorded by EDISS, 1318 (39%) were pedestrians, 1310 (39%) were drivers, 564 (17%) were passengers and 165 (5%) were unspecified road users. (Table 1)

About 22% of the injuries occur to motorcycle occupants and 23% to car occupants but the proportions decrease with age. (Table 2)

With regard to gender, women are more frequently injured as pedestrians than men (57% vs. 30%), and as passengers either in car or on motorcycle. Males on the other hand are mostly injured as drivers. (Table 3)

The most severe injuries occurred among pedestrians as 32% of them were hospitalized, 3.3% deceased and the median length of stay in hospital was 5 days. Among bicycle occupants, 30% were hospitalized, 2.2% deceased and the median length of stay was 3 days. The hospitalization percentage of car occupants was similar (31%) but the rest of the respective numbers for both car and motorbike occupants were smaller (Table 4).

Pedestrians

During the years 1996-2003 a total of 1318 elderly pedestrians were recorded by EDISS.

As expected, among all road users, the proportion of pedestrians gets higher as the age progresses and reaches as high as 74% among the age group 85+ (Table 2). Under the age of 75 it is females who are mostly injured as pedestrians whereas over 75 years it is mostly men especially among the age group 85+ (Table 5).

About 32% of the injured pedestrians stated that they crossed the road without checking and this becomes more common as the age progresses. Another 19% stated that they were not able to estimate correctly the traffic situation. For another 13%, the victims were injured while walking along the street and not using the pavement. 6% were hit by a vehicle while getting across using a zebra-crossing, 7% during other crossing and 13% during other or unspecified walking in the road (Table 6).

Pedestrians are usually hit by cars (60%) (789 cases out of 1318, Table 7) especially when

- walking along the road (69%, data not shown)
- crossing a zebra-crossing (and/or with green light: 69%, with red light: 63%, data not shown)
- walking on the pavement (67%, data not shown)

Pedestrians are hit by motorcycles (35%) (457 cases out of 1318, Table 7) more often when

Tables for all road users

Table 1: Distribution of the 3357 road traffic injuries among elderly (65+) recorded in Greece by EDISS during 1996-2003, by type of road user and age group

Type of road user	Age								Total	
	65-69		70-74		75-84		85+			
	N	col %	N	col %	N	col %	N	col %	N	col %
Pedestrian	335	28.2	389	36.9	477	49.7	117	74.0	1318	39.3
Driver	552	46.5	427	40.6	312	32.5	19	12.0	1310	39.0
Passenger	240	20.2	184	17.5	129	13.5	11	7.0	564	16.8
Unspecified	60	5.1	53	5.0	41	4.3	11	7.0	165	4.9
Total	1187	100.0	1053	100.0	959	100.0	158	100.0	3357	100.0

Table 2: Distribution of the 3357 road traffic injuries among elderly (65+) recorded in Greece by EDISS during 1996-2003, by road user's vehicle and age group

Vehicle	Age								Total	
	65-69		70-74		75-84		85+			
	N	col %	N	col %	N	col %	N	col %	N	col %
Pedestrian	335	28.2	389	36.9	477	49.7	117	74.0	1318	39.2
Bicycle	51	4.3	51	4.8	77	8.0	6	3.8	185	5.5
Motorcycle	346	29.1	243	23.1	156	16.3	6	3.8	751	22.4
Car	339	28.6	250	23.7	158	16.5	15	9.5	762	22.7
Other or unspecified	116	9.8	120	11.4	91	9.5	14	8.9	341	10.2
Total	1187	100.0	1053	100.0	959	100.0	158	100.0	3357	100.0

Burn injuries due to fire, flames and contact with hot objects among elderly in Greece

During the eight year period 1996-2003, a total of 320 burn injuries due to fire, flames and contact with hot object among elderly were recorded by EDISS accounting for 0.9% of the total home and leisure injuries among elderly.

Demographic characteristics

The majority of burn injuries due to fire, flames or contact with hot object concerned females (63%) except in the age group 85+ in which males account for 62% (Table 1).

Event characteristics

Home inside is the most common place for a burn injury to occur (83%) especially the kitchen (72%). However, it is females who are more frequently injured in the kitchen (72% vs 39%) whereas males are injured more frequently than females in other places inside or around home but also in areas other than home (Table 2). Elderly people over 84 years old were almost exclusively burned inside home (Table 3).

Overall, these injuries occur mostly during leisure activities (38%), cooking (29%) and other domestic work (13%). Other activities include cleaning (5%), do-it-yourself work (4%) and vital activity (7%). However, females are burned more often than males during domestic work such as cooking (40%), cleaning (6%) or other domestic work (13%) whereas males are more often burned during leisure activities (56%), do-it-yourself work (9%) and vital activities (8%). (Table 4) Leisure and vital activities are also more common among elderly over 84 years old (62% and 10% respectively) whereas the proportion of cooking decreases as the age progresses (Table 5).

The most common object for causing burns was hot water (33%) while for 21% of the cases the burn was caused by out of control flames or explosion, mostly among males (29% vs. 17%). Flames or explosions were caused by flammable liquids (8%), camping gas or gas canisters (7%) or other products (7%). The high proportion of burns due to camping gas reflects the fact that the use of this product is very common in Greek households. Other objects that caused burns after contact especially among women are cooking oils (14%), drink, food or steam (12%), heating apparatus (6%), cooker, oven and cooking utensils (5%) while for burns due to motorcycle exhaust pipes (3%) the proportion was higher among males (Table 6). With respect to age the proportion of flames and explosions raises to 38% among 85+ and to 14% regarding heating apparatus (Table 7).

The percentage of burns which occurred during winter and spring was 57%. Almost half of the injuries occurred during 10am and 4pm. There was also an increased risk of burns noticed during the weekends (35%) especially for women (41% vs. 25%). (data not shown)

Injury characteristics

Tables

Table 1: Distribution of the 320 burn injuries among elderly (65+), recorded by EDISS during 1996-2003, by age group and gender

Gender	Age 65-74		75-84		85 +		Total	
	N	col %	N	col %	N	col %	N	col %
Male	84	38.4	21	26.3	13	61.9	118	36.9
Female	135	61.6	59	73.7	8	38.1	202	63.1
Total	219	100.0	80	100.0	21	100.0	320	100.0

Table 2: Distribution of the 320 burn injuries among elderly (65+), recorded by EDISS during 1996-2003, by place and gender

Place	Gender Male		Female		Total	
	N	col %	N	col %	N	col %
Kitchen	46	39.0	146	72.2	192	60.0
Inside home, other	35	29.7	37	18.3	72	22.5
Around the house	15	12.7	7	3.5	22	6.9
Other	17	14.4	5	2.5	22	6.9
Unspecified	5	4.2	7	3.5	12	3.7
Total	118	100.0	202	100.0	320	100.0

Table 3: Distribution of the 320 burn injuries among elderly (65+), recorded by EDISS during 1996-2003, by place and age group

Place	Age 65-74		75-84		85+		Total	
	N	col %	N	col %	N	col %	N	col %
Kitchen	129	58.9	53	66.2	10	47.6	192	60.0
Inside home, other	48	21.9	14	17.5	10	47.6	72	22.5
Around the house	14	6.4	8	10.0	0	0.0	22	6.9
Other	18	8.2	3	3.8	1	4.8	22	6.9
Unspecified	10	4.6	2	2.5	0	0.0	12	3.7
Total	219	100.0	80	100.0	21	100.0	320	100.0

Accidental poisonings among elderly in Greece (excluding contact with poisonous animals)

During the eight year period 1996-2003, a total of 22 accidental poisonings among elderly (65+) were recorded by EDISS accounting for 0.06% of the total home and leisure injuries among elderly. The small number of poisoning cases recorded can be attributed to the fact that adult poisoning cases are regularly treated in departments of Internal Medicine and thus are not captured by EDISS.

Brief analysis

The majority of accidental poisonings concerned females (59%) and ages 65-74 years (64%) (Table1). These injuries took place mostly inside home (50%) (Table 2) and were caused by soap and detergents (36%), food (36%), pharmaceutical products (14%), white spirit (9%) and agricultural chemicals (5%). Almost half of them required hospitalization with 5.5 days median length of stay (data not shown) but the proportion was higher among poisonings from food (75%) and agricultural chemical (100%). No deaths were recorded (Table 3).

Tables

Table 1: Distribution of the 22 accidental poisonings among elderly (65+), recorded by EDISS during 1996-2003, by age group and gender

Gender	Age 65-74		75-84		85 +		Total	
	N	col %	N	col %	N	col %	N	col %
Male	8	57.1	1	14.3	0	0.0	9	40.9
Female	6	42.9	6	85.7	1	100.0	13	59.1
Total	14	100.0	7	100.0	1	100.0	22	100.0

Table 2: Distribution of the place of the 22 accidental poisonings among elderly (65+), recorded in Greece by EDISS during 1996-2003

Place	N	col %
Home inside	11	50.0
Other	9	40.9
Unspecified	2	9.1
Total	22	100.0

Table 3: Distribution of the 22 accidental poisonings among elderly (65+), recorded by EDISS during 1996-2003, by outcome and product causing the poisoning.

Outcome	Product										Total	
	Soap, detergent		Food		Pharma-ceutical		White spirit		Agri-cultural chemical			
	N	col %	N	col %	N	col %	N	col %	N	col %	N	col %
Examined	2	25.0	1	12.5	2	66.7	0	0.0	0	0.0	5	22.7
Treated	5	62.5	1	12.5	0	0.0	1	50.0	0	0.0	7	31.8
Hospitalized	1	12.5	6	75.0	1	33.3	1	50.0	1	100.0	10	45.5
Total	8	100.0	8	100.0	3	100.0	2	100.0	1	100.0	22	100.0

APPENDIX 2.3 Morbidity Data – Denmark **(Project Leader)**
(Sample Pages-Full document available at the Web-board)

Analysis of morbidity data from Denmark for the five leading causes of unintentional injury death among elderly in EU25

Fall related injuries among elderly in Denmark

During the three year period 2002-2004, 18701 fall related home and leisure injuries among elderly (65+) were recorded in Denmark by EHLASS, accounting for 73.7% of the total recorded home and leisure injuries among elderly.

Demographic characteristics

The majority of fall related injuries concerned females (71%) but the proportion increased with age from 65% for ages 65-74 years to 78% for ages 85+ years (Table 1). This is in contrast to all other home and leisure injuries in which males up to 74 years old outnumbered females (52% vs. 48%) whereas in the ages 75+ years the pattern is reversed (39% vs. 61%) (data not shown). Furthermore, among fall related injuries, about 47% concern ages 80+ whereas among other injuries only 20% (data not shown).

Event characteristics

Most of the falls (83%) occurred at the same level. Falls from height account for 15% of the total falls. More specifically, falls from stairs/ladder account for 7%, 3% and 1% occurred after a fall from a bed or chair respectively and 4% occurred from other height. For 2% the mechanism was unknown. Concerning age, the percent of injured persons due to fall on the same level increases with age. Falls from bed also increase with age while falls from stairs decrease. (Table 2).

Home inside is the most common place where falls occurred (37%). More specifically, the bedroom/living room accounts for 21% of the injuries but the percentage is increasing with age and reaches 25% among the age group 85+ years. The bathroom accounts for 5% and the kitchen for 1% of the cases. Injuries which occurred around the house account for 22% while injuries which occurred at a road or pavement account for 18%. A significant proportion of injuries occurred in hospitals and nursing homes (14%) which increased with age reaching 28% among the age group 85+ years. Finally, 2% of the injuries occurred in commercial and service areas, very few injuries occurred in farm areas and 7% in other or unspecified areas (Table 3).
The proportion of falls on the same level was higher in bathroom (95%) and on road/pavement (94%) as well as farm areas (100%) though the respective number of falls was very small to make safe conclusions. Falling from bed, apart from the

Table 1: Distribution of the 18701 fall injuries among elderly (65+), recorded in Denmark by EHLASS during 2002-2004, by age and gender

Gender	Age 65-74		75-84		85+		Total	
	N	col %	N	col %	N	col %	N	col %
Male	2223	35.4	2166	29.2	1107	22.1	5496	29.4
Female	4048	64.6	5246	70.8	3911	77.9	13205	70.6
Total	6271	100.0	7412	100.0	5018	100.0	18701	100.0

Table 2: Distribution of the 18701 fall injuries among elderly (65+), recorded in Denmark by EHLASS during 2002-2004, by mechanism of fall and age group

Mechanism of fall	Age 65-74		75-84		85+		Total	
	N	col %	N	col %	N	col %	N	col %
Fall on the same level	*4970*	*79.3*	*6257*	*84.4*	*4359*	*86.9*	*15586*	*83.3*
on unspecified floor, flooring, indoors	1530	24.4	2861	38.6	2662	53.0	7053	37.7
on unspecified surface	696	11.1	765	10.3	510	10.2	1971	10.5
on processed stone surface, outdoors	790	12.6	772	10.4	305	6.1	1867	10.0
other	1954	31.2	1859	25.1	882	17.6	4695	25.1
Fall from height	*1154*	*18.4*	*1056*	*14.3*	*610*	*12.1*	*2820*	*15.1*
from bed	90	1.4	185	2.5	230	4.6	505	2.7
from chair	111	1.8	80	1.1	52	1.0	243	1.3
from stairs/ladder	594	9.5	530	7.2	188	3.7	1312	7.0
other height	359	5.7	261	3.5	140	2.8	760	4.1
Other or unspecified	*147*	*2.3*	*99*	*1.3*	*49*	*1.0*	*295*	*1.6*
Total	6271	100.0	7412	100.0	5018	100.0	18701	100.0

Road traffic injuries among elderly in Denmark

During the three year period 2001-2003, a total of 2100 road traffic injuries among elderly (65+) were recorded. In most of them (56%) the victim was bicycle occupant or a car occupant (22%). Pedestrians accounted for 9% and occupants of heavy vehicles accounted for 7% but the respective proportions increased with age and were also higher among females. Finally, a minor 6% concerned moped and motorcycle occupants, especially males (Tables 1 & 2).

Table 1: Distribution of the 2100 road traffic injuries among elderly (65+), recorded in Denmark during 2001-2003, by mode of transport of victim and age group.

Mode of transport of victim	Age 65-74		75-84		85+		Total	
	N	col %	N	col %	N	col %	N	col %
Pedestrian	82	7.0	80	10.4	18	11.8	180	8.6
Bicycle	661	56.4	432	56.0	74	48.3	1167	55.6
Other two-wheeler	85	7.2	33	4.2	8	5.2	126	6.0
Moped	*74*	*6.3*	*28*	*3.6*	*6*	*3.9*	*108*	*5.1*
Motorcycle, motor-scooter	*11*	*0.9*	*5*	*0.6*	*2*	*1.3*	*18*	*0.9*
Car	271	23.0	149	19.3	32	21.0	452	21.5
Passenger car	*267*	*22.7*	*146*	*18.9*	*31*	*20.3*	*444*	*21.1*
Van, pick-up truck	*4*	*0.3*	*3*	*0.4*	*1*	*0.7*	*8*	*0.4*
Other or unspecified	76	6.4	78	10.1	21	13.7	175	8.3
Lorry, truck, bus, etc.	*59*	*5.0*	*69*	*8.9*	*17*	*11.1*	*145*	*6.9*
Other specified	*13*	*1.1*	*9*	*1.2*	*4*	*2.6*	*26*	*1.2*
Unspecified	*4*	*0.3*	*0*	*0.0*	*0*	*0.0*	*4*	*0.2*
Total	1175	100.0	772	100.0	153	100.0	2100	100.0

Table 2: Distribution of the 2100 road traffic injuries among elderly (65+) recorded in Denmark during 2001-2003, by mode of transport of victim and gender

Mode of transport of victim	Gender Male		Female		Total	
	N	col %	N	col %	N	col %
Pedestrian	63	6.5	117	10.4	180	8.6
Bicycle	556	57.2	611	54.2	1167	55.6
Other two-wheeler	102	10.4	24	2.2	126	6.0
Moped	*87*	*8.9*	*21*	*1.9*	*108*	*5.1*
Motorcycle, motor-scooter	*15*	*1.5*	*3*	*0.3*	*18*	*0.9*
Car	216	22.2	236	20.9	452	21.5
Passenger car	*210*	*21.6*	*234*	*20.7*	*444*	*21.1*
Van, pick-up truck	*6*	*0.6*	*2*	*0.2*	*8*	*0.4*
Other or unspecified	37	3.7	138	12.3	175	8.3
Lorry, truck, bus, etc.	*18*	*1.8*	*127*	*11.3*	*145*	*6.9*
Other specified	*17*	*1.7*	*9*	*0.8*	*26*	*1.2*
Unspecified	*2*	*0.2*	*2*	*0.2*	*4*	*0.2*
Total	974	100.0	1126	100.0	2100	100.0

Burn injuries due to fire, flames and contact with hot objects among elderly in Denmark

During the three year period 2002-2004, a total of 113 burn injuries due to fire, flames and contact with hot object among elderly were recorded in Denmark by EHLASS accounting for 0.4% of the total home and leisure injuries among elderly.

Demographic characteristics

The majority of burn injuries due to fire, flames or contact with hot object concerned females (58%) especially in the age group 85+ in which all cases concerned females (Table 1).

Event characteristics

Home inside is the most common place for a burn injury to occur (71%) half of which occur in kitchen. However, it is females who are more frequently injured inside home (80% vs. 58%) whereas males are injured more frequently than females around home or in other places (Table 2). Among people over 84 years old, 82% were burned inside home (Table 3).

Most of the burns were caused by flames/explosion (31%) while for 23% of the cases the burn was caused by hot water, mostly among females (26% vs. 19%). Other objects that caused burns after contact, especially among females, are cooking oils (7%), cooker, oven and cooking utensils (6%) while for burns due to drink/food/steam (10%) and heating apparatus (7%) the proportions were higher among males (Table 4). About 16% of burns were caused by other or unspecified objects. With respect to age, the proportion of flames/explosions raises to 45% among 85+ and to 18% regarding heating apparatus (Table 5).

The percentage of burns which occurred during winter and spring was 58%. About 43% of burns occurred during 12:00pm and 3:59pm and 35% during 4:00pm and 9:59pm. There was also an increased risk of burns noticed during the weekends (34%) especially for women (38% vs. 27%). (data not shown)

Injury characteristics

Most of the burns were located in the upper limbs (42%) especially wrist, hand or fingers (34%) which was more common among females (39% vs. 27%). Lower limbs accounted for 26% but the proportion was higher among males (33% vs. 20%) and concerned mostly the ankle, foot or toes (14%). Less often, burns were located on the trunk (19%) and the head (13%) (Table 6) but the respective proportions were much higher among ages 85+ (64% and 27% respectively, Table 7).

Most of the elderly were examined or treated (46%) while for 43% follow up was necessary. The proportion of hospitalized elderly persons was 6% with median length of stay 3 days (Table 8). Cooking oil/butter, flames/explosions and drink/food/steam were responsible for the most severe burns since the respective proportions of hospitalization were the highest (13%, 11% and 9% respectively) but numbers are

Table 1: Distribution of the 113 burn injuries among elderly (65+), recorded in Denmark by EHLASS, during 2002-2004, by age group and gender

Gender	Age 65-74		75-84		85 +		Total	
	N	col %	N	col %	N	col %	N	col %
Male	31	48.4	17	44.7	0	0.0	48	42.5
Female	33	51.6	21	55.3	11	100.0	65	57.5
Total	64	100.0	38	100.0	11	100.0	113	100.0

Table 2: Distribution of the 113 burn injuries among elderly (65+), recorded in Denmark by EHLASS, during 2002-2004, by place and gender

Place	Gender Male		Female		Total	
	N	col %	N	col %	N	col %
Kitchen	13	27.1	27	41.5	40	35.4
Inside home, other	15	31.2	25	38.5	40	35.4
Around the house	14	29.2	7	10.8	21	18.5
Other	4	8.3	5	7.7	9	8.0
Unspecified	2	4.2	1	1.5	3	2.7
Total	48	100.0	65	100.0	113	100.0

Table 3: Distribution of the 113 burn injuries among elderly (65+), recorded in Denmark by EHLASS, during 2002-2004, by place and age group

Place	Age 65-74		75-84		85+		Total	
	N	col %	N	col %	N	col %	N	col %
Kitchen	24	37.5	13	34.2	3	27.3	40	35.4
Inside home, other	18	28.1	16	42.1	6	54.5	40	35.4
Around the house	14	21.9	6	15.8	1	9.1	21	18.5
Other	7	10.9	1	2.6	1	9.1	9	8.0
Unspecified	1	1.6	2	5.3	0	0.0	3	2.7
Total	64	100.0	38	100.0	11	100.0	113	100.0

Accidental poisonings among elderly in Denmark

During the eight year period 2002-2004, a total of 93 accidental poisonings among elderly (65+) were recorded in Denmark by EHLASS accounting for 0.4% of the total home and leisure injuries among elderly.

Demographic characteristics

The majority of accidental poisonings concerned females (59%) without significant variation by age group (Table1).

Event characteristics

The majority of poisonings occurred inside home (79%) while 9% occurred around home and 12% in nursing homes. However, the proportions of inside and around home decrease by age whereas the proportion of nursing home increases, reaching 33% among ages 85+ years (Table 2).

Nearly two in three poisonings were caused by smoke while one in five was caused by chemical products but the latter was more frequent among females than males (24% vs. 13%) (Table 4). About 10% were caused by pharmaceutical products but the proportion increased to 33% among ages 85+ years (Table 3). A minor 4% was food poisoning and 3% was caused by other products (Table 3).

Most of the recorded poisonings occurred during the winter (39%) and spring (27%) (data not shown).

Injury characteristics

The proportion of elderly who were hospitalized reached 40% and the median length of stay in hospital was 1 day. There was 1 death recorded (Table 5) of an 89 year old female due to smoke.

Table 1: Distribution of the 93 accidental poisonings among elderly (65+), recorded in Denmark by EHLASS during 2002-2004, by age group and gender

Gender	Age 65-74		75-84		85 +		Total	
	N	col %	N	col %	N	col %	N	col %
Male	16	41.0	15	41.7	7	38.9	38	40.9
Female	23	59.0	21	58.3	11	61.1	55	59.1
Total	39	100.0	36	100.0	18	100.0	93	100.0

Table 2: Distribution of the 93 accidental poisonings among elderly (65+), recorded in Denmark by EHLASS during 2002-2004, by place and age group

Place	Age 65-74		75-84		85+		Total	
	N	col %	N	col %	N	col %	N	col %
House, inside	32	82.0	29	80.6	12	66.7	73	78.5
Around the house	5	12.8	3	8.3	0	0.0	8	8.6
Nursing home	1	2.6	4	11.1	6	33.3	11	11.8
Other	1	2.6	0	0.0	0	0.0	1	1.1
Total	39	100.0	36	100.0	18	100.0	93	100.0

Table 3: Distribution of the 93 accidental poisonings among elderly (65+), recorded in Denmark by EHLASS during 2002-2004, by product and age group

Product	Age 65-74		75-84		85+		Total	
	N	col %	N	col %	N	col %	N	col %
Smoke from fire	24	61.5	25	69.4	10	55.6	59	63.4
Other chemical	8	20.5	8	22.2	2	11.1	18	19.4
Pharmaceutical	1	2.6	2	5.6	6	33.3	9	9.7
Food	4	10.3	0	0.0	0	0.0	4	4.3
Other	2	5.1	1	2.8	0	0.0	3	3.2
Total	39	100.0	36	100.0	18	100.0	93	100.0

Table 4: Distribution of the 93 accidental poisonings among elderly (65+), recorded in Denmark by EHLASS during 2002-2004, by product and gender

Product	Gender Male		Female		Total	
	N	col %	N	col %	N	col %
Smoke from fire	25	65.7	34	61.9	59	63.4
Other chemical	5	13.2	13	23.6	18	19.4
Pharmaceutical	5	13.2	4	7.3	9	9.7
Food	2	5.3	2	3.6	4	4.3
Other	1	2.6	2	3.6	3	3.2
Total	38	100.0	55	100.0	93	100.0

APPENDIX 2.4 Literature Review Protocol **(Project Leader)**

1. Review Question
2. Search Strategy
3. Inclusion/Exclusion criteria
4. Method will be used to synthesize literature, interventions and information on identified studies and interventions
5. Extraction and Presentation of data

1. REVIEW QUESTION

The location of literature (published and grey), interventions and resources addressing five priority areas (falls/traffic/poisoning/drowning/burns) of unintentional injury prevention among seniors 65+

2. SEARCH STRATEGY

What (type of source that will be searched)

a. Literature (published)
b. Grey Literature
c. Resources (List of)
d. Interventions (practices and policies)

Keywords: separate and combined searches will be conducted

a. "senior citizens" or "elderly" or "aged" or "age 65+" or "old people" or "third age" …

AND

b. "prevention" or "intervention" or "practice" or "policy" or "guidelines" or "report" …

AND

c. "unintentional injuries" and/or
"fall(s)" and/or
"traffic accident(s)" and/or "traffic injuries" and/or "road safety" and/or "motor
vehicle injury/ies" and/or "pedestrian" and/or
"poisoning" and/or
"drowning" and/or
"fire(s)" or "flames" or "burn(s)"

SEARCH APPROACHES

How: A. Electronic search (Internet)

Electronic Databases

a. AMED: Allied and Complementary Medicine
b. CINAHL Nursing & Allied Health
c. Cohrane Library –Interscience (Wiley Version)
d. CRD: Center of Review and Dissemination Databases
    i. DARE: Database of Assessment of Reviews of Effectiveness,
    ii. NHS EED: NHS Economic Evaluation Database
    iii. HTA: Health Technology Assessment database
e. EBM Reviews: Evidence Based Medecine Reviews
f. EconLit: American Economic Association's electronic bibliography of economic literature
g. EMBASE: The Excerpta Medica database for biomedical and pharmacological information
h. ERIC: Education Resources Information Center
i. Eurobarometer
j. Harrison's Principles of Internal Medicine
k. Health Information Research Unit
l. HealthWeb - Evidence Based Health Care
m. HEED: Health Economic Evaluations Database
n. Infotrieve: Free Medline search yearwise with full-text document delivery
o. International Association of Gerontology and Geriatrics -IAGG
p. LILACS: Latin American and Caribbean Health Sciences Literature

q. MEDLINE
r. Ovid Core Biomedical Collection: A selection of 15 must have medical journals in one convenient package
s. Primary Care- Clinical Practice Guidelines
t. PsycINFO (APA): comprehensive international bibliographic database of psychology
u. PsycLit: Literature Reference for Psychology
v. PubMed: U.S. National Library of Medicine
w. SafetyLit: Injury Research and Prevention Literature
x. Science Citation Index: Journal List Options
y. SSCI: Social Science Citation Index and Social SkiSearch: access to current & retrospective bibliographic information
z. SPECTR: Social, Psychological, Educational and Criminological Trials Registered
aa. TRANSPORT database
bb. US National Guideline Clearinghouse
cc. WebSPIRS: SilverPlatter's Information Retrieval System for the World Wide Web
dd. WHO database on the Internet
ee. … (to be modified or completed where needed)

Other Electronic sources (related to the topic sites, from related organizations, networks, etc.)

How: B. Manual Search (Libraries)
Where (range of sources)

a. Hand searching of references of published articles (mainly for identifying grey literature) of relevant journals and Correspondence with identified authors (experts) aiming to search for additional relevant studies, new or ongoing studies of relevance and to enquire about relevant grey literature
[Key people and professional organizations may also be contacted to identify missed papers, unpublished or in-progress research]
b. Using existing reviews of the literature (where possible)
c. Identification of direct relevance references from the reference lists of known papers and books
d. Associated literature and references attached to a single reference
e. Search using author names
f. Search in particular journals publishing large numbers of articles in the area
g. Examination of the reference lists of identified studies [The bibliographies and reference lists of all retrieved articles could be searched to increase the likelihood of identifying all relevant studies]

3. INCLUSION/EXCLUSION CRITERIA

AIM: To operationalize the review question, putting it into a practical format in order to decide which studies should be included in the review and which ones should not.

1. Population of interest: men and women 65+ year old
2. Relativity: the subject of literature as well as the target of intervention to be relevant with one or more of the five types of injuries or with unintentional injuries in general
3. Time settings: 10 previous years
4. Language: English, French, Italian (studies in a different language could be also included in the database given that the title and abstract is in English or had been reviewed by one of the EUNESE partners or members)

4. METHOD USED TO SYNTHESIZE LITERATURE AND INTERVENTIONS AND INFORMATION ON IDENTIFIED STUDIES AND INTERVENTIONS

AIM: to collate and summarize the results of included studies [an overview of all potential important evidence will be provided in the form of two or more systematic literature reviews by

type of injuries (**topics and number of reviews will be depending on the number and topic of retrieved publications**)].

5. DATA EXTRACTION

METHOD: Titles and abstracts of the search results will be screened for relevance regarding the review question by one reviewer based on the above-mentioned inclusion criteria

PRESENTATION OF DATA

AIM: The standardization of the description and reporting of literature as well as interventions that would make them much easier to locate and access

The data presentation will be realized via a comprehensive and user-friendly constructed Access database. More specifically, for each study and intervention the following pieces of information will be included:

Type of record

- Article
- Review
    - Systematic
    - Meta-analysis
    - General
    - Cochrane
- Research
    - RCT (Randomized control trial)
    - Case-control (between subject design)
    - Case crossover (within subject design)
    - Cross sectional (correlational study)
    - Cohort study
    - Descriptive (observational study)
    - Case study
    - Other: _____
- Policy paper
    - Government policy
    - Private policy report
    - Guideline
    - Consensus statement
- Grey Literature
    - Thesis
    - Doctoral dissertations
    - Conference papers
    - Product document
- Book
- Report
- Leaflet
- Intervention
- Resource
    - Site
    - Organization
    - Other?

For each type of record the following information will be included:

- Regarding Articles, Reviews, Epidemiological Studies, Policy Papers, Grey Literature
    - Title
    - Author(s)
    - Journal
    - Volume no
    - Year
    - Number of pages
    - Key words
    - Abstract
    - Priority area (what type of injury(ies) it aims to study/prevent)
    - Accessibility (online)
    - Link

- Regarding Books, Reports, Leaflets,
    - Title
    - Authors
    - Editor
    - Year of publishing
    - Number of pages
    - ISBN
    - Key words
    - Abstract
    - Priority area (what type of injury(ies) it aims to study/prevent)
    - Accessibility (online)
    - Link
- Regarding Interventions
    - Type of project: research, intervention, campaign,
    - Target group identity
        - age group (range)
        - gender: male -female
        - State of living: independently living - dependently living
        - Group targeted: Community, Individual, Family)
        - Level of attempted prevention (primary / secondary /tertiary)
    - Level of implementation (International /European /National /local)
    - Place of implementation (country / county)
    - Stage: Ongoing / completed
    - Existence of Evaluation: Yes/no
    - Level of effectiveness (high / medium /low/none) [If there is any evaluation]]
    - Priority area the intervention targeting (what type of injury(ies) it aims to study/prevent)
    - Accessibility (online)
    - Link
- Regarding list of resources
    - E-address
    - Name of agency / organization
    - Character of organization (prevention / policy / intervention)
    - Accessibility (online)

APPENDIX 2.5 Eunese Literature database **(Project Leader)**

Database Description of literature relevant to the EUNESE project

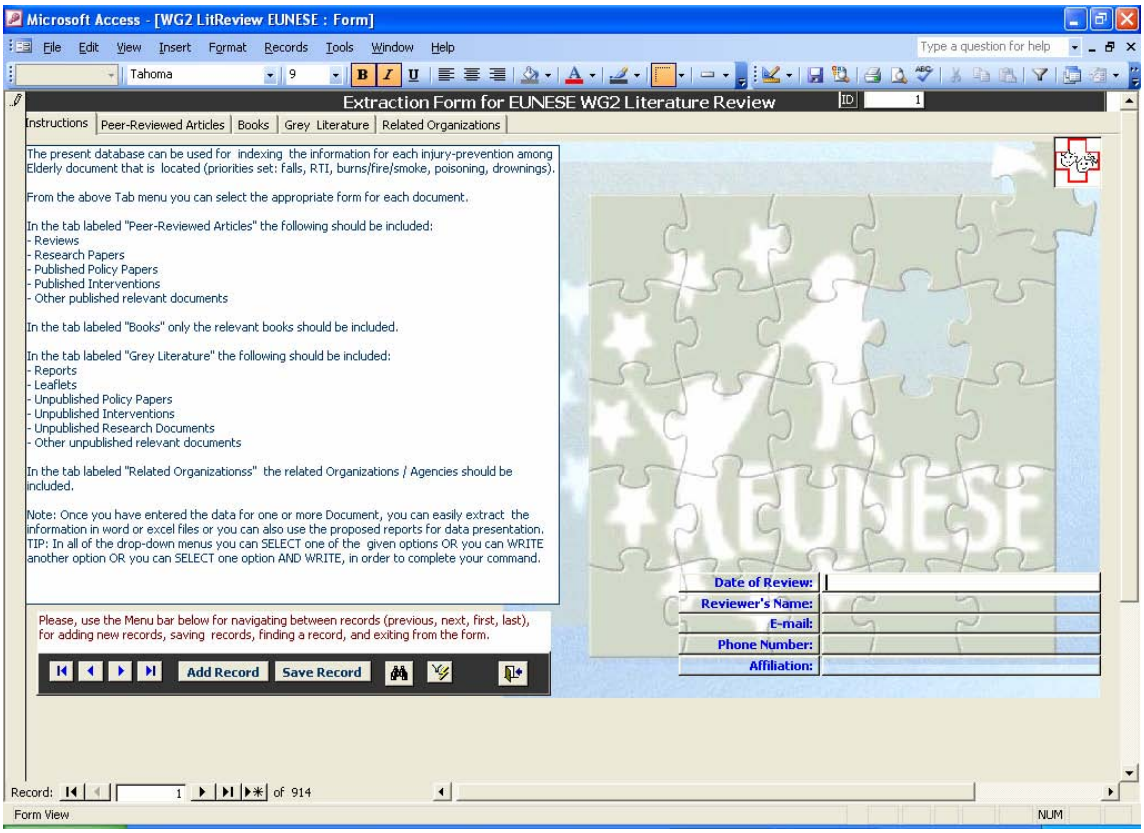
Two of the main tasks of WG2 are:

- to gather all related literature in order to be uploaded on the website.
- to conduct a Systematic Literature review of interventions designed to prevent injuries in the elderly population

Both tasks address five priority areas (falls/traffic/poisoning/drowning/burns) of unintentional injury prevention among seniors 65+

Based on the Literature Review Protocol (APPENDIX 2.4) an Access database describing each of the entries was developed. The database includes four different forms for peer-reviewed articles, books, grey literature and relevant organizations, respectively (see Picture 1).

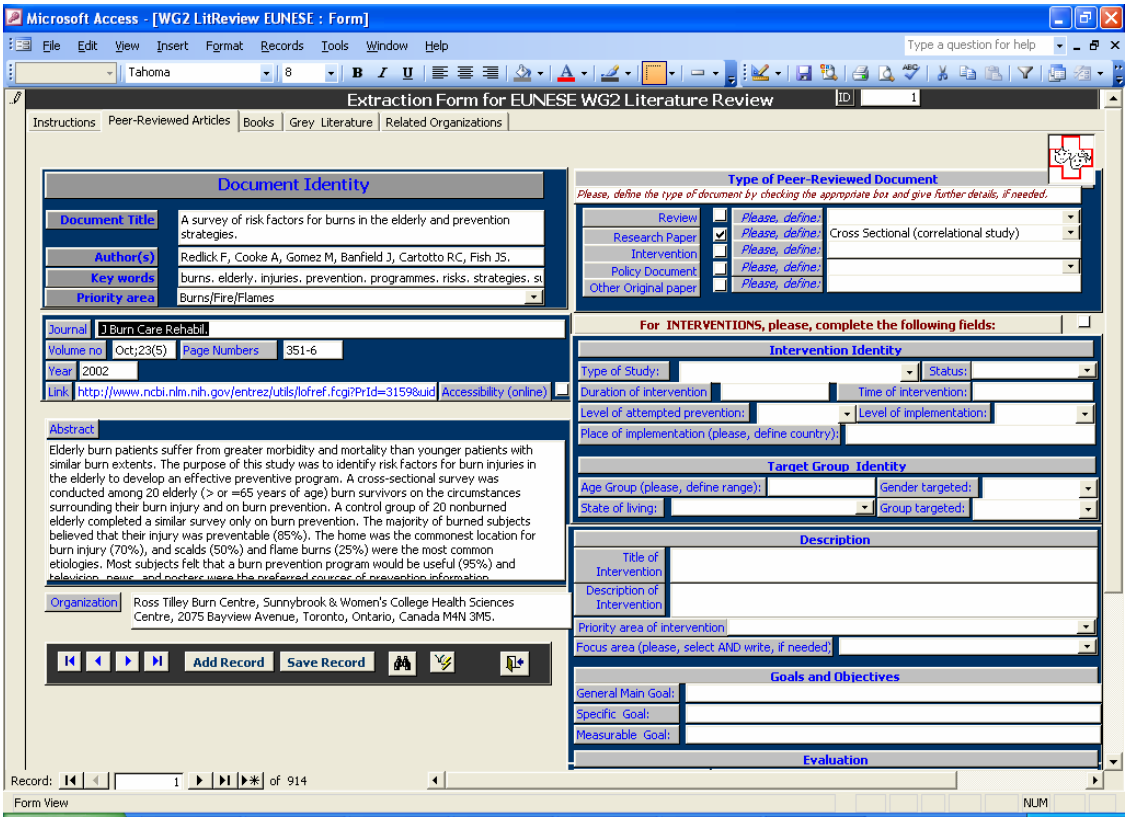
Picture 1. Access database for the description of literature related to EUNESE



The section describing interventions that was embedded into the peer-reviewed articles form (see Picture 2) was developed according to the revised form of the Project Intervention Form that was created by WG2 and WG1 Coordinators. This

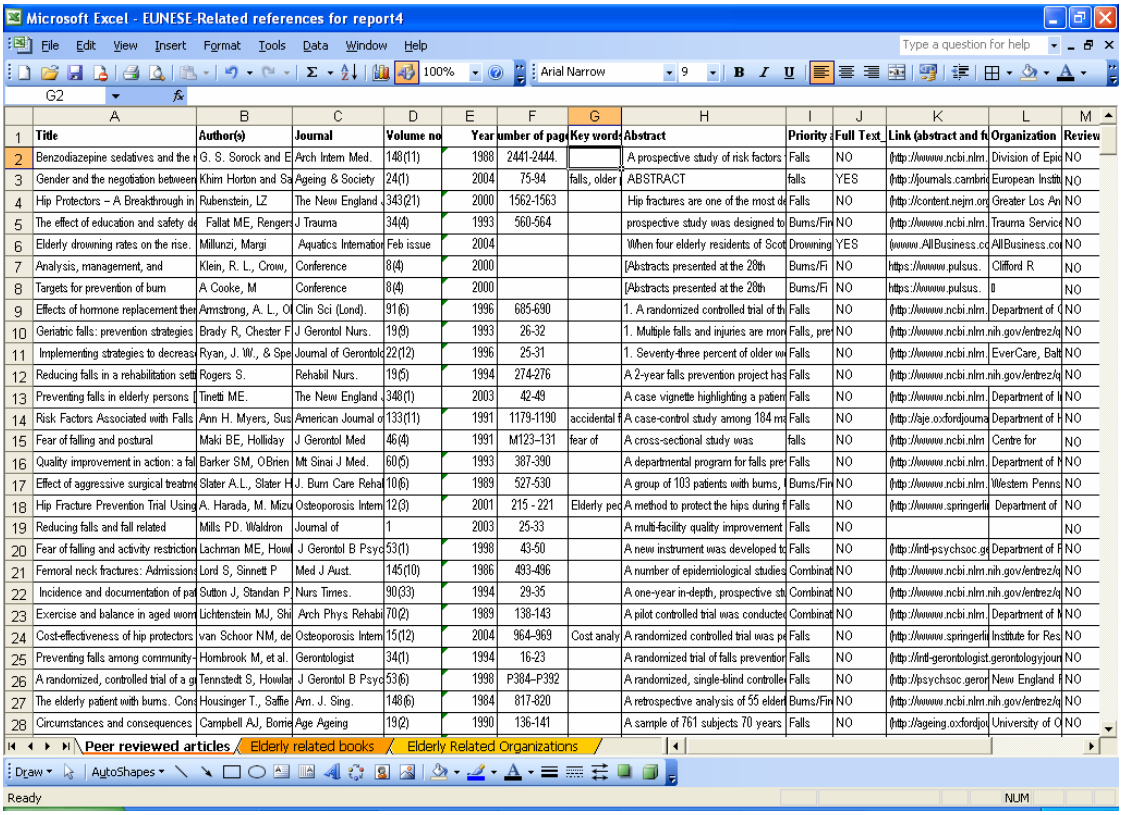
form was also used for the extraction of information used in the Systematic Literature Review.

Picture 2. Access database for the description of peer-reviewed articles and interventions



Since March 2006, after CEREPRI undertook the work of WG2, a systematic search was conducted in order for peer-reviewed articles, books and relevant organizations and websites to be identified. The content of the database was extracted into three separate Excel files (see Picture 3) for peer-reviewed articles, books and related organizations, and was sent to the WG1 Coordinator in order to be uploaded on the website.

Picture 3. Excel database including descriptions of peer-reviewed articles related to EUNESE



Description of the Information included in the Database

The database contained 809 entries, distributed as follows:

Total Records: 809[2]

Breakdown of the records

Articles: 522

Books: 102

Related organizations: *185 (see Appendix 2.1)*

A detailed description is provided in the sections that follow for each type of information included in the database.

[2] **Note 1:** During the search, fact sheets, reports, leaflets, etc. were also located and will be included in the next review report along with additional peer review articles and books.
Note 2: Interventions will also be included in the next literature review report (including the interventions provided to CEREPRI by all of the EUNESE partners as well as the interventions included in the Systematic Literature Review).

Peer Reviewed Articles

In regards to the peer review articles, information provided to WG1 for each article include:

- Title
- Author(s)
- Journal where the article was published
- Volume number
- Year of publishing
- Page numbers
- Abstracts
- Priority area
- If full text accessibility (online) is available
- Links (abstract and full text, if available)
- Organization's name

Keywords (if available) as well as type of the articles (research paper, review, policy document, etc.) are provided.

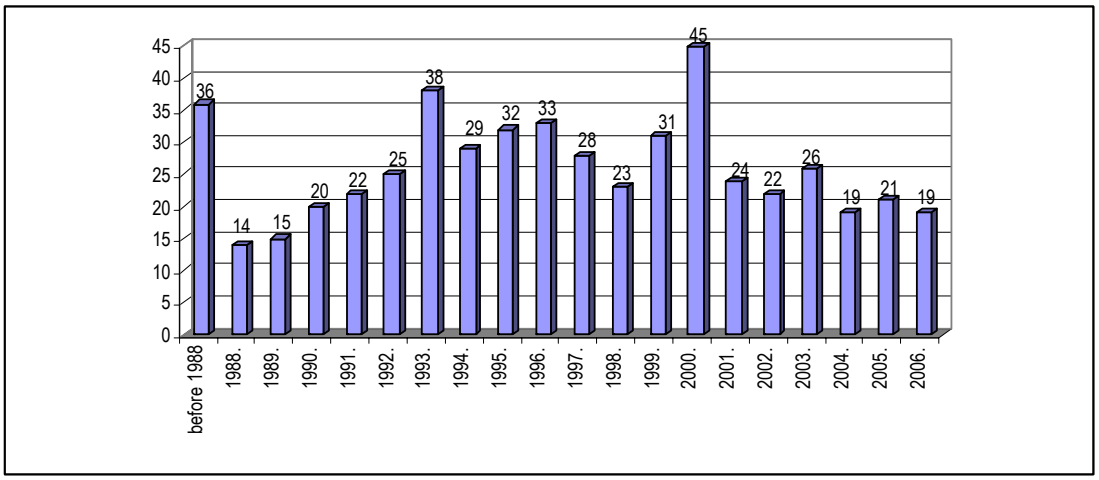


Figure 1. **Peer-reviewed articles by publication year.**

- Of the 522 articles recorded, 33.7% (176) were published during the period 2000-2006, 53.8% (281) during 1990-1999 and 12.6% (65) before 1990. In Figure 1 the distribution by "publication year" is illustrated.

- Articles titles, authors and journals are provided for all of the records. Page numbers are not provided for 17 out of 522 articles.
- Of the 522 articles, abstracts are provided for 473 and were not available or not found for the remaining 49 articles (see Figure 2).
- From the total amount of articles found, web links are available for 485 and unavailable for 38 (see Figure 3).
- Free full text accessibility (online): Only 19% (100 articles) were accessible full text for free while more than 80% (422) were not accessible (see Figure 4)

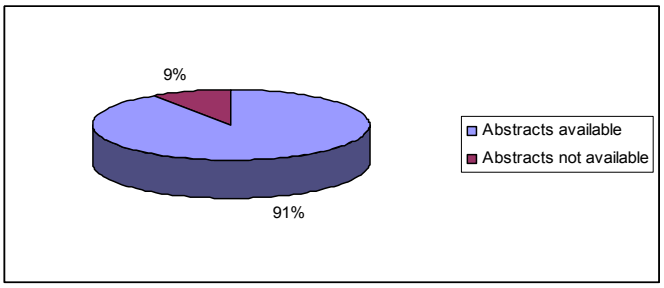


Figure 2. Availability of abstracts in peer-reviewed articles

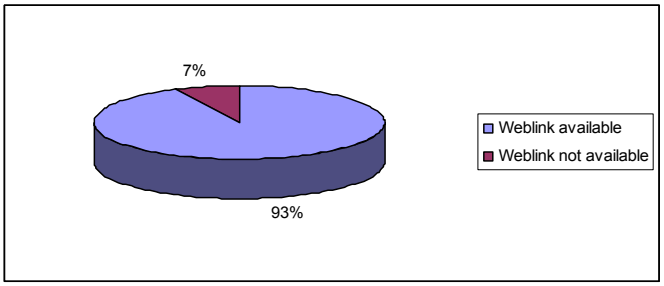


Figure 3. Web link availability in peer-reviewed articles

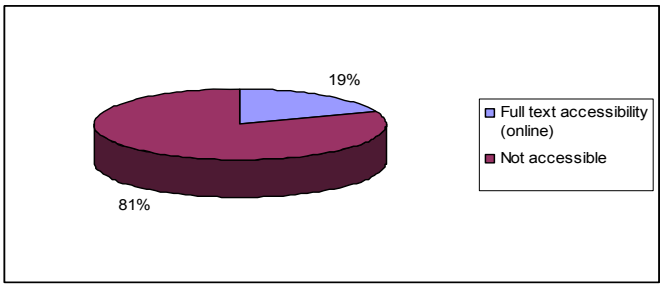


Figure 4. Free full text accessibility in peer-reviewed articles.

- Regarding the type of the articles, in the vast majority these are research papers (363) and reviews (72). Research papers are mainly RCTs (Randomized Control Trials) [almost one third], cohort studies, prospective studies, cross-sectional studies, case-control studies and case studies, cooperative studies, descriptive (observational) studies, retrospective studies, quasi-experimental design studies, etc. Reviews include systematic reviews, Cochrane reviews, meta-analyses, retrospective studies, etc. There are also 21 articles referring to interventions' evaluations and/or descriptions, 4 referring to guidelines and 16 in the category "other", which includes reports, newsletters, fact sheets, editorial notes, symposium abstracts, etc.
- Regarding priority areas, the majority of the articles (318 articles, consisting of 61%) refers to falls and fall related injuries, prevention, interventions, etc. Almost

1/5 (102 articles) includes a combination of elderly-related injuries. Fifty-three refer to burns, fire and flames; 20 to road traffic injuries; and 13 to geriatric trauma in general. For drowning and poisoning only 3 and 4 articles respectively, were found. It is obvious that the vast majority of literature and research work regarding injuries among elderly people are directed mainly to falls.

- Located articles were published in 155 different journals. The “Journal of the American Geriatric Society”, “Age and Ageing” and “British Medical Journal” were the most frequent with 69, 46 and 18 records respectively. Of the fifty-four Journals in the list, from 2 to 16 articles were located, while the remaining 98 articles were located in 98 different Journals.

List of Journals

J of the American Geriatrics Society	[69]	Nurs Res	[2]
Age & Ageing	[46]	Mt Sinai J Med.	[2]
BMJ	[18]	J Nurses Staff Dev.	[2]
The Journals of Gerontology Series A:		J Gerontol Nurs.	[2]
Biological Sciences and Medical Sciences	[16]	J Bone Miner Res.	[2]
Journal of Gerontology	[16]	J Biomech	[2]
JAMA	[14]	Irish J of Medical Science -Supplement	[2]
The New England Journal of Medicine	[13]	Geriatr Nurs.	[2]
American Journal of Epidemiology	[11]	Emerg Med J.	[2]
Burns	[11]	Emerg Med Clin of N Amer	[2]
American Journal of Public Health	[10]	Danish Medical Bulletin	[2]
Phys Ther	[9]	Conference abstract	[2]
The Gerontologist	[8]	Clinical Rehabilitation	[2]
J Trauma	[8]	Canadian Journal of Public Health	[2]
Injury Prevention	[8]	Arch Surg	[2]
Cochrane Database Syst Rev.	[8]	Annals of Burns and Fire Disasters	[2]
Arch Phys Med Rehabil	[8]	Annals Internal Med	[2]
Am J Prev Med.	[7]	Ann Surg	[2]
Accid Anal and Prev	[7]	Am J Nurs.	[2]
Osteoporosis International	[6]	Am J Med	[2]
Arch Intern Med	[6]	Am J Emerg Med	[2]
Annals of Internal Medicine	[6]	J Neurosci Nurs.	[2]
J Burn Care Rehabil.	[5]	Z Gerontol Geriatr	[1]
Rehabil Nurs.	[5]	The bulletin & clinical review of bum inj.	[1]
Morbidity & Mortality Weekly Report	[4]	Surgery	[1]
Lancet	[4]	Statistical Bulletin	[1]
J Trauma	[4]	Sports Medicine	[1]
Clin Geriatr Med	[4]	Scandinavian Journal of Public Health	[1]
Physiother Theory Pract	[4]	Safety Science	[1]
J of Epidemiology & Community Health.	[4]	Res Q Exerc Sport.	[1]
Postgraduate Medicine	[3]	Public Health Rep	[1]
Nurs Times.	[3]	Public Health Nursing	[1]
Nurs Stand	[3]	PharmacoEconomics	[1]
Med J Australia	[3]	Pacing Clin Electrophysiol	[1]
J Aging Phys Activity	[3]	Outcomes Manag Nurs Pract.	[1]
Geriatrics	[3]	Nursing	[1]
Clinics in Geriatric Medicine	[3]	Nord Med.	[1]
Burns Incl Therm Inj.	[3]	Nigerian Journal of Surgical Research	[1]
Australian Journal of Public Health	[3]	Mobility needs and safety issues	[1]
Ann. Medit. Bums Club	[3]	MJA	[1]
J Gerontol B Psychol Sci Soc Sci	[3]	Mil Med.	[1]
WMJ.	[2]	Med Sci Sports Exerc.	[1]
The Practitioner	[2]	Med Care	[1]
Public Health	[2]	Kans Nurse.	[1]

Jt Comm J Qual Saf.	[1]
J of Neurological Neurosurgery & Psychology	[1]
Journal of Healthcare Safety.	[1]
Journal of Gerontological Nursing	[1]
Journal of Clinical Nursing	[1]
Journal of Applied Gerontology	[1]
Journal of Aging and Health	[1]
J. Bum Care Rehabil.	[1]
J Telemed Telecare.	[1]
J Surg Res.	[1]
J Pract Nurs	[1]
J Nutr	[1]
J Nurs Qual Assur.	[1]
J Nurs Manag.	[1]
J Nurs Adm.	[1]
J Healthc Qual.	[1]
J Gerontol Nurs.	[1]
J Forensic Sci.	[1]
J Diabetes Complications .	[1]
J Community Health	[1]
J Clin Nurs.	[1]
J Clin Epidemiol	[1]
J Burn Care Res.	[1]
J Burn Care Rehabil	[1]
J Biomech Eng.	[1]
J Am Coll Surg	[1]
J Aging Health	[1]
J Adv Nurs.	[1]
Isr J Med Sci	[1]
Int J Geriatr Psychiatry	[1]
Int J Clin Pract.	[1]
Inquiry	[1]
Image J Nurs Sch.	[1]
Hosp Case Manag.	[1]
Home Health Care Management & Practice	[1]
Health Promotion International	[1]
Focus Over Fifty (online)	[1]
Fam Pract	[1]
Evid Based Med	[1]
European Journal of Public Health	[1]
Ergonomics	[1]
Epidemiological Bulletin	[1]
Epidemiol Rev.	[1]
Effective Health Care	[1]
Drug Intelligence & Clinical Pharmacy	[1]
Dimens Health Serv.	[1]
Dement Geriatr Cogn Disord.	[1]
CMAJ	[1]
Clin Sci (Lond).	[1]
Clin Plast Surg	[1]
Clin Orthop Relat Res.	[1]
Cerebrovascular Diseases	[1]
Can J Surg	[1]
Can Fam Physician.	[1]
Calcif Tissue Int	[1]
British Journal of Sports Medicine	[1]
British Journal of Occupational Therapy	[1]
Br J Hosp Med	[1]
Bone	[1]
Arch Ophthalmol	[1]
Arch Gerontol Geriatr.	[1]
Aquatics International	[1]
Appl Nurs Res.	[1]
Annual Review Public Health	[1]
Ann of Epidemiol	[1]
American Journal of Geriatric Psychiatry	[1]
Amer J Phys Med Rehabil.	[1]
Am. Surg.	[1]
Am. J. Sing.	[1]
Am J Occup Ther.	[1]
Am Fam Physician.	[1]
Alcohol Clin Exp Res	[1]
Ageing and Society	[1]
Acta Orthop Belg.	[1]
Acta Clin Belg,	[1]
Acta Chir Plast.	[1]
ACP J Club.	[1]
Acad Emerg Med	[1]

Books

A total of 102 elderly-related books have been recorded in the database. Most of these books do not refer exclusively to elderly-related injuries, but all of them include information regarding this age group.

For all of the books the following information is provided:

- Title
- Author(s)
- Year
- Editions
- ISBN (or OCLG respectively)
- Priority area
- Comments (if available)

In Figure 6 the type of injury the books addressed is illustrated while in Figure 7 the distribution by publication year is presented.

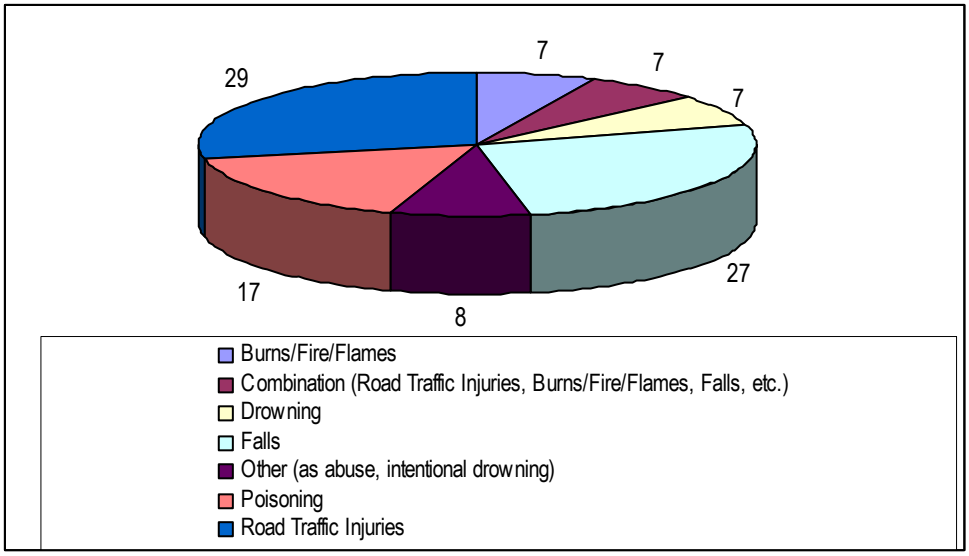


Figure 6. Books by type of injury addressed.

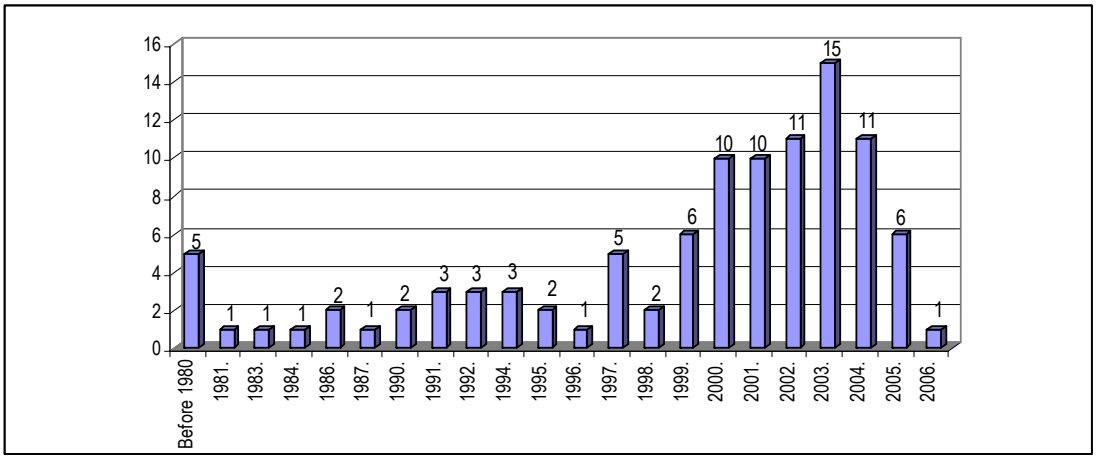


Figure 7. Books by publication year.

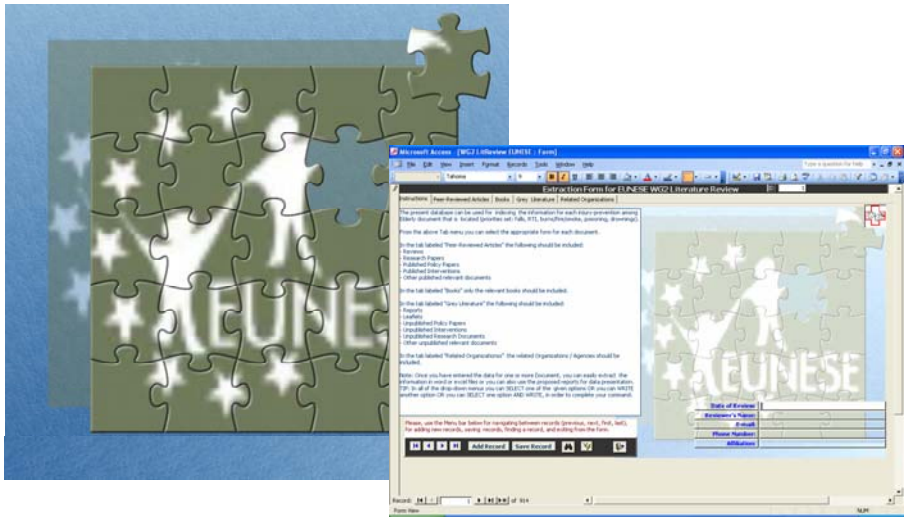
APPENDIX 2.6 Systematic Literature Review (sample pages of the 1st draft-full document available at the Web-board)
(Project Leader-D.Stone & S. Jeffrey)

SYSTEMATIC LITERATURE REVIEW (first draft)

S Jeffrey

DH Stone

Paediatric Epidemiology and Community Health (PEACH) Unit
University of Glasgow



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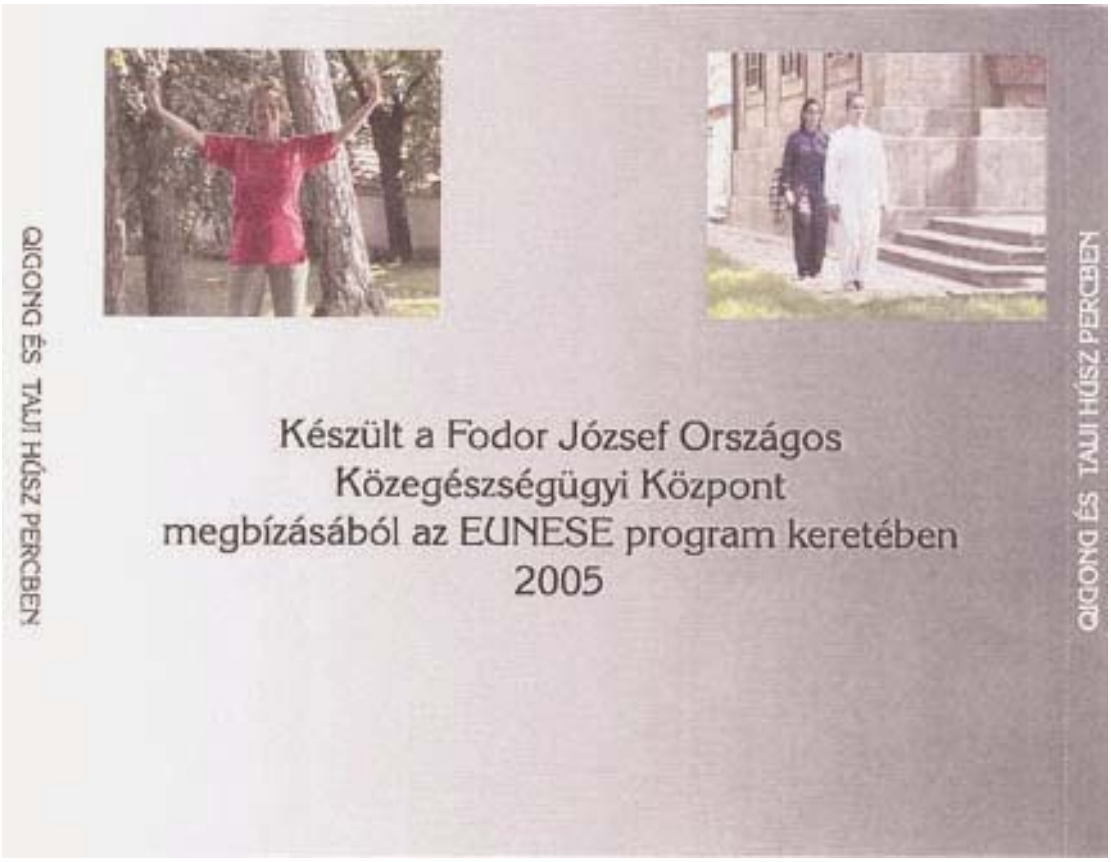
July 2006

Contents

APPENDIX 3.1 Tai Chi DVD - cover page **(WG3:PP1)**



APPENDIX 3.2 Leaflet **(WG3:PP1)**

Kiadja:
Fodor József Országos Közegészségügyi Központ
Az EUNESE program keretében

2005.

Jegyezze meg!

- A zuhanyzó, szőnyegek mindig biztonságosabb, mint a kád.
- Jobban teszi, ha nem fürdik akkor, ha egyedül van otthon.
- Ha bizonytalan, ingatag a járása, vagy szédül, használjon járókeretet.
- Ne rohanjon a telefonhoz. Mondja meg barátainak, rokonainak, hogy időbe telik, amíg felveszi a kagylót.
- Tegye a telefont közel az ágyhoz, ha lepihen.
- Legyen az ágy, díványy, fotel elég magas akkor, hogy könnyedén fel tudjon állni.
- Legyen könnyen elérhető az éjjeli lámpája az ágy mellett.
- A világítás legyen elég erős, de ne káprázatosan.
- Soha ne használja mások gyógyszerét, és Ön se ajánlja a sajátját másnak. Azonos nevű gyógyszer is különböző mennyiségű hatóanyagot tartalmazhat. Más szerekkel együttadva pedig végzetes is lehet.

Balesetmentes idős éveket!

Ötletek ahhoz,

hogyan tegyük biztonságosabbá otthonunkat

Tisztelt Olvasó!

Nem is gondolnánk arra, hogy a sok-sok éve megszokott kellemes, biztonságosnak tűnő otthoni környezet is mennyi veszélyt rejthet. Márpedig a balesetek 60%-a otthonunkban történik az emberekkel. Annyi minden okozhat balesetet: megcsúszunk, elesünk, elcsúszunk, elcsúszunk ...Ön tényleg mindent megtett-e azért, hogy megelőzze a balesetet, hogy otthona tényleg nyugalmas és biztonságos legyen?

Nézzük meg együtt!

	Igen	Nem
1. Rögzítettek-e a kisebb szőnyegek?	☐	☐
2. Felesleges kiszögelléseket, akadályokat eltávolíttatták lakásából?	☐	☐
3. Van betét a kádjában vagy zuhanyzójában, amely megakadályozza az elcsúszást?	☐	☐
4. Van ülőke a zuhanyzó alatt?	☐	☐
5. Van a kád mellett kilépő, amely jól tapad a lövezethez?	☐	☐
6. Van kapaszkodó a zuhanyzó vagy kád melletti falon?	☐	☐
7. Kerülik a padlóáfényezést, hogy kevésbé legyen síkos a padló?	☐	☐
8. Kerüli a szőnyeg-, szőnyeg- és lépcső mintát?	☐	☐
9. Jól megvilágított a ház, lakás?	☐	☐
10. Használ mozgásérzékelős szürkületben és sötétben?	☐	☐
11. Jól megvilágított a belső lépcsőház, külső lépcsők?	☐	☐
12. A lépcsők mindkét oldalán biztonságos korlát van?	☐	☐

	Igen	Nem
13. A külső bejáró szőnyegek (telefon, lámpa) biztonságosan elhelyezettek?	☐	☐
14. Azok a tárgyak, amelyeket gyakran használ a háztartásban, könnyen elérhetők?	☐	☐
15. Ügyel arra, ne legyen csúszós a cipője talpa?	☐	☐
16. Inkább házi cipőt visel papucs helyett?	☐	☐
17. Használ adagoló dobozt a gyógyszereknek?	☐	☐
18. Biztonságos helyen tárolja gyógyszereket?	☐	☐
19. Bizonyos gyógyszerek fokozzák a balesetveszélyt. Kérdezze meg orvosát, az Ön gyógyszerének van-e ilyen mellékhatása?	☐	☐
20. Ügyel rá, hogy ne álljon fel hirtelen, mert egyensúlyát vesztheti?	☐	☐
21. Kerüli a hirtelen fejfordítást, mert annak következtében rövid ideig szédülését vesztheti?	☐	☐
22. Ülve öltözködik és vetkőzik?	☐	☐
23. Van telefon az ágya mellett?	☐	☐
24. Használ botot, sétapálcát, ha szükséges?	☐	☐
25. Ha csúszós, jeges az út, csúszásmentesítő teszi a bot végét?	☐	☐

Az építményen, berendezéseken, használati tárgyakon kívül fontos, hogy ne legyünk magányosak, tartsunk kapcsolatot szomszédokkal, barátokkal, rokonokkal – akiktől szükség esetén segítséget tudunk kérni.

APPENDIX 3.3 Safe Home Leaflet **(WG3:PP4)**

European Network
for Safety among Elderly

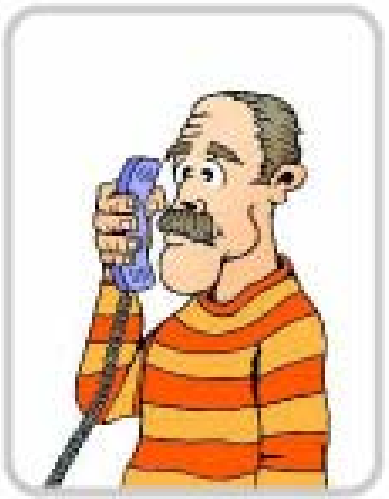
National and Kapodistrian
University of Athens
Medical School

Center for Research
and Prevention of Injuries

GERAHM
Groupe d'Etudes et de Recherches
pour l'Aide aux Handicapés Moteurs
Centre de Formation, Documentation,
Recherche, Publication

This brochure was developed
in the context of the Pilot Project
"Virtual modeling of a safe household
environment for elderly citizens",
assigned to the 3rd Working Group
of the *European Network*
for Safety among Elderly (EUNESE)

Contact



CEREPRI
University of Athens, Medical School
Dept. of Hygiene and Epidemiology

Mikras Asias 75, Athens, 115 27, Greece
Telephone: + 30 210 7462 187
Fax: + 30 210 - 7462 105
Web site: www.eunipn.org
e-mail: agierz@med.uoa.gr

Useful Tips
for Housing Safety
FOR ELDERLY

Things you can do to prevent falls:

In the bathroom:

- Keep the floor dry after taking a shower. If possible place a bathroom mat, but secure it properly to diminish the chances of tripping over it.
- Install safety rails.
- Never use a towel rack, soap tray, shelves or similar items that are not anchored in the wall.
- Add non-slip strips to the tub/shower floor.
- If you are unsteady, use a shower chair and a handheld shower attachment.
- Do not lock the bathroom door.
- Install a phone in the bathroom.
- Install a handheld shower hose with extra long cord.

In the bedroom:

- Get up slowly after you sit or lie down. Sit on the edge of the bed/chair until you are sure you do not feel dizzy.
- Wear sturdy shoes with thin, non-slip soles. (Avoid slippers and athletic or jogging shoes with thick soles.)
- Improve the lighting in your bedroom.
- Put in brighter bulbs. You may want to buy compact fluorescent light bulbs that cost less to use. Use lamp shades to reduce glare.
- Organize your clothes for easy reach.
- Place clothes in drawers no lower than your knees or higher than your chest.
- Do not wear clothing that is too long or too loose.
- Keep a telephone within easy reach.
- Avoid using slippery fabrics such as satiny sheets or comforters.
- Install a smoke detector in or near your bedroom.
- NEVER smoke in your bed.
- Install a night light.

In your everyday moves:

- Exercise regularly. Exercise makes you stronger and improves your balance and coordination.
- Have your doctor or pharmacist look at all the medicines you take, even over-the-counter medicines. Some medicines can make you sleepy or dizzy.
- Have your vision checked at least once a year by an eye doctor. Poor vision can increase your risk of falling.
- It is safest to have uniform lighting throughout a room. Add lighting to dark areas. Hang light weight curtains or window shades to reduce glare from bright windows and doors.
- Eliminate obstacles.
- Paint a contrasting colour on the top front edge of all steps so you can see the stairs better. For example, if you have dark wood use light coloured paint.
- Keep emergency numbers in large print near each phone.
- Put a phone near the floor in case you fall and can't get up.
- Think about wearing an alarm device that will bring help in case you fall and can't get up.
- Remove things you can trip over (such as papers, books, clothes, and shoes) from stairs and places where you walk.
- Remove small throw rugs or use double sided tape to keep the rugs from slipping.
- Keep items you use often in cabinets you can reach easily without using a step stool.
- Always keep cabinet drawers closed so you won't stumble over them.
- When lifting an object wear good supportive shoes.
- Keep the object close to your body.
- Place anchored hand rails on both sides of stairs.
- When climbing a staircase keep at least one hand on the handrail, concentrate on what you are doing, and don't be distracted by sounds. Also, never carry any package that will obstruct your view of the next step.
- Make sure steps and treads of all staircases are even.
- Make sure stairs are slip resistant.
- Eliminate torn or worn coverings, or folds in the carpet.
- Use a portable phone and keep emergency numbers close.

APPENDIX 3.4 An A-Z Guide to a Safe House for Elderly [sample pages] **(WG3:PP4)**

AN A-Z GUIDE
TO
A Safe House
FOR ELDERLY

Author: Eva Toumpi
Sketches: Kostas Vichos
Book Design: Kostas Zissimopoulos
Coordination:
• Agis Terzidis, Center for Research
and Prevention of Injuries (CE.RE.PR.I),
• Constantin Scarvelis, GERAHM
Groupe d' Etudes et de Recherches
pour l'Aide aux Handicapes Mentaux

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Dept. of Hygiene and Epidemiology,
Mikras Asias 75, Athens, 115 27, Greece
Telephone: + 30 210 –7462 187
Fax: + 30 210 -7462 105
Web site: www.euroipn.org
e-mail: agterz@med.uoa.gr

• The photographs on this guide was donated by Yiorgos Nikolouzis, whose support we warmly acknowledge.
Contact details: Yiorgos Nikolouzis. Telephone: + 30 210 –9836699

• All floor plans that appear in this guide were taken from the Safe House Design developed in the context of the Pilot Project "Virtual modeling of a safe household environment for elderly citizens" and are designed by the architect Eva Toumpi. Note that they are indicative and that alternative but equally efficient designs are also possible.

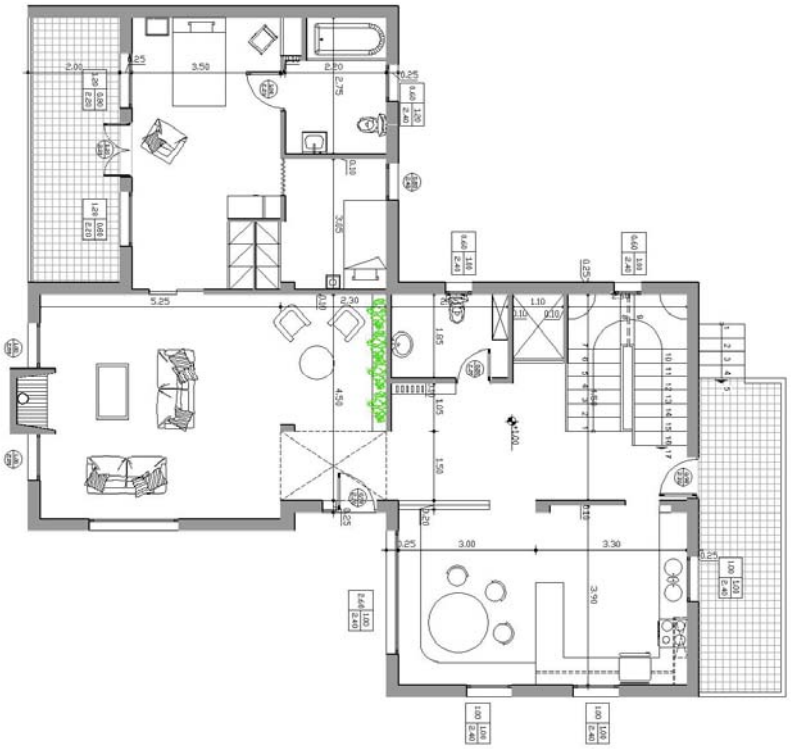
This guide was developed in the context of the Pilot Project **"Virtual modeling of a safe household environment for elderly citizens"**, assigned to the 3rd *Working Group of the European Network for Safety among Elderly* (EUNESE), a 36-month project coordinated by the *Center for Research and Prevention of Injuries* (CE.RE.PR.I), of the *Athens University Medical School* and co-financed by *DG SANCO* (Directorate C-Public Health and Risk Assessment, Health & Consumer Safety), aiming to address injury prevention and safety promotion among senior citizens through the development of an *EU Network*.

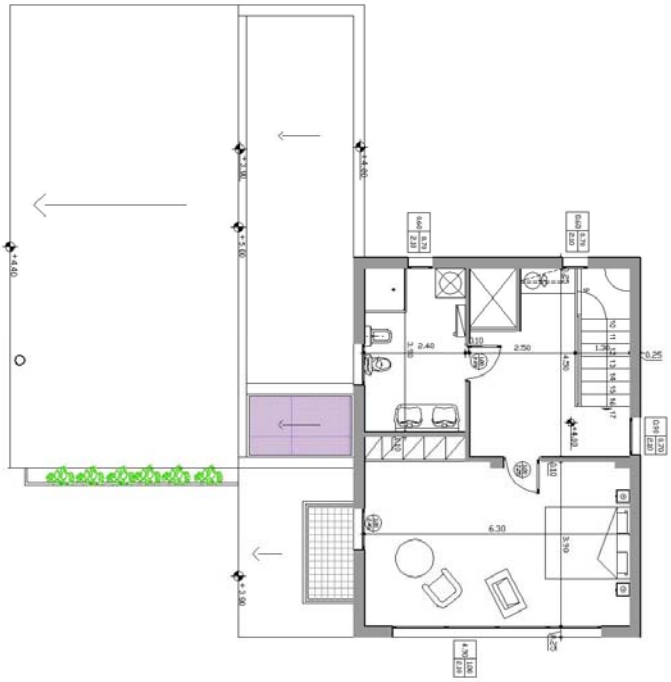
A

Acoustic control

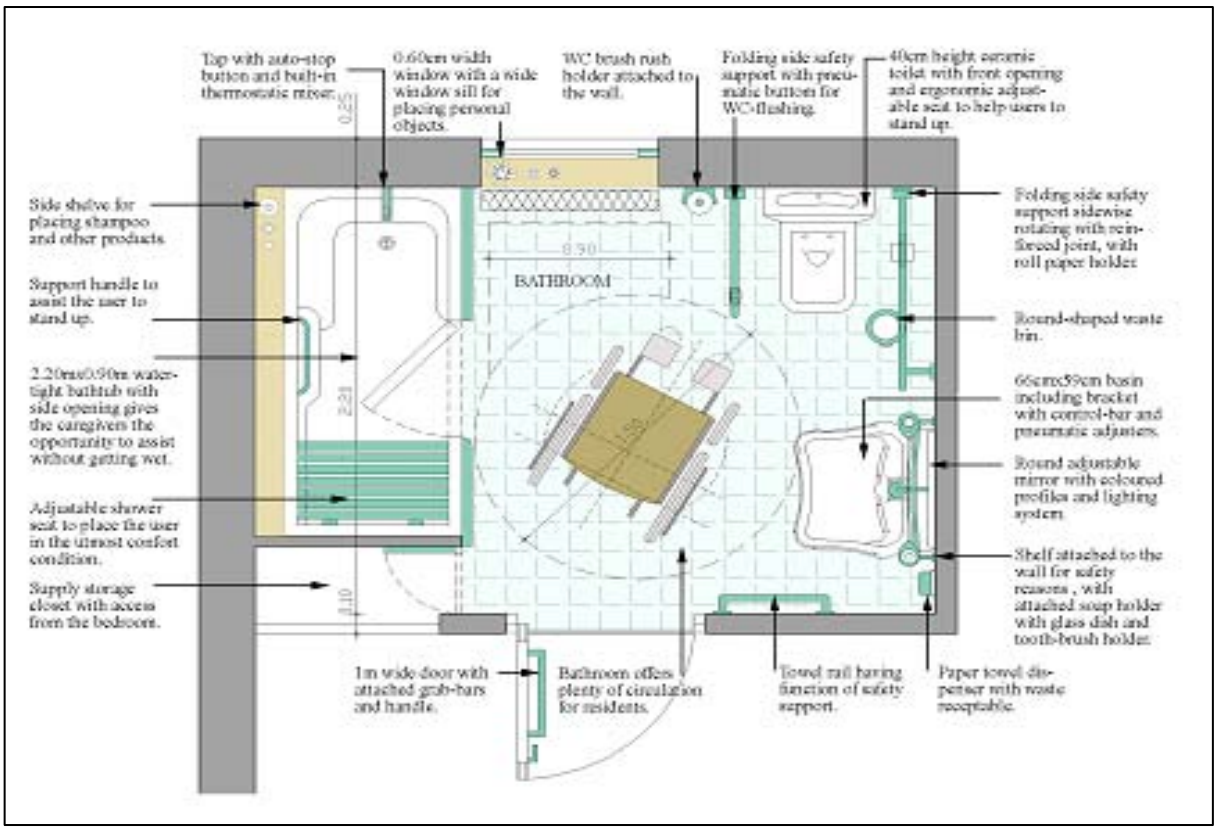
Hearing loss is an important factor in the aging process. Poor acoustical design in senior housing can make it difficult for residents to hear and be heard, and may cause them discomfort, contributing to fear, embarrassment, depression, or isolation. Even those with hearing aids are affected by background noise. Although new developments in hearing-assistance technology have helped to minimise this problem, some older hearing aid models still may amplify background noises along with messages, making it difficult for hearing-assisted individuals to distinguish the message addressed to them. It is therefore vital that senior living spaces be designed to deal with the way sound will travel in interior spaces, to accommodate hard-of-hearing and hearing-assisted residents.

APPENDIX 3.5 First Floor Plan and Ground Floor Plan **(WG3:PP4)**





APPENDIX 3.6 3-D Visual Plot [sample pictures] **(WG3:PP4)**




3D Graphics + Programming, (c) 2005 Stergios Palamas
Architecture Design, (c) 2005 Eva Toumpi


3D Graphics + Programming, (c) 2005 Stergios Palamas
Architecture Design, (c) 2005 Eva Toumpi

APPENDIX 3.7 Evaluation plan **(WG3:PP4)**

Brief Description of Pilot Project 4

Aim of the pilot project

Prevention of home accidents among elderly

Objective

Intervention aiming to sensitize the target group populations on the improvement of the home environment through home environmental modifications

Target groups

1. Architects, Designers and Civil Engineers (Group of Experts)
2. Independently living elderly (Elderly living in Nursing Homes are not included)
3. Open Care Centers for the Elderly (OCCE) and Nursing Homes staff members such as Social Workers, Health Visitors, Nurses, etc.

Material

3D visual plot of the prototype house
Floor plan of the prototype house
Technical report for Architects, Designers and Civil Engineers
"Home Safety Glossary"
Informational Leaflet

AIMS of the EVALUATION

1. The assessment of the quality and sufficiency of the material
2. The assessment of the intervention effectiveness i.e. the public health impact of the project
3. The assessment of what is needed for the further improvement of the material as well as the interventions, if any

EVALUATION PROCESS: The evaluation will be realized in two phases

PHASE 1

Evaluation of the material by Group of Experts

Process

Send the material for evaluation to a group of Experts (including Greek and European Experts)

Tool

Self-administrated Questionnaire regarding the quality and sufficiency of the material

PHASE 2

Brief description of the Effectiveness of the Intervention Evaluation Process (Independently Living Elderly and Staff Members of OCCE and Nursing Homes)

Process

Pre-Intervention measure (baseline)

Intervention

Raise awareness regarding the problem

Information about the project

Main intervention (using the respective material for each target group)

Post-Intervention measure

Tools

Questionnaires (pre- and post-questionnaire)

Structured interviews (pre- and post- interview)

The Reasoning behind the Evaluation

1. What we evaluate and why:
   The "Safe Home" Project material regarding its quality and the effectiveness of the intervention (the extent to which the aims and objectives will be achieved)
2. Contributors:
   Evaluation:
   - **is designed by CEREPRI**
   - **will be implemented in collaboration with Social Workers and Health Visitors**
   - **the participants: the independently living elderly, the Open Care Centres for the Elderly & Nursing Homes' staff members and a team of Architects, Designers and Civil Engineers (as an experts group).**
3. Design of the evaluation tools (questionnaires/interview):
   The questionnaire and the interview would include questions in relation to the issue of home accidents among elderly regarding knowledge, attitudes and the extent to which the participants are persuaded of the usefulness of the proposed modifications.
   Evaluation tools will be designed by taking into account
   - **the specific characteristics of the population targeted**
   - **the available time for the evaluation process**
   - **the available human resources (Social Workers, Nurses, Health Visitors)**
   - **the content of the respective informational material**
4. Planning of the evaluation strategy (where, when, training of the partners)
   The Evaluation will be realized in two phases:
   Phase 1: Evaluation of the material by Group of Experts
   Phase 2: Evaluation of the Effectiveness of the Intervention (Independently Living Elderly and Staff Members of OCCE and Nursing Homes)
   - Before the intervention
   - After the intervention's completion

   Evaluation Phase 2 will take place
   - **in the OCCE (independently living elderly and staff members)**
   - **in the Nursing Homes (staff members)**

   The collaborators will be trained by CE.RE.PR.I.
5. Coordination (who)
   Coordinator of Pilot Project 4
6. Data (which information will be collected, referring to what)
   Data will be collected referring to
   - demographic characteristics of the participants (before the intervention)
   - home accident background (before the intervention)
   - knowledge (before and after the intervention)
   - attitudes about the problem and its prevention (before and after the intervention)
   - behaviors (before the intervention)
   - hypothetical behaviors (based on what the participants will declare) (before and after the intervention)
   - degree of satisfaction about the intervention (after the intervention)
   - degree of satisfaction in regards to the material (after the intervention)
   - [Alteration of the number of accidents – if it is feasible for this to be measured before and after the intervention]
7. Data analysis
8. Evaluation Report

During the design of the Evaluation tools the following issues will be addressed

1. **Face validity**
   - Did we find the appropriate target group?
   - Were the material and the intervention properly adapted for the characteristics of the target groups for whom they were planned?
2. **Effectiveness of the implementation and quality of the material**
   - Is the implementation in alignment with the plan?
   - Were the participants satisfied with the implementation regarding:
     - the place
     - the time
     - the process
     - the facilitators
   - Appropriateness of the material:
     - Could the participants comprehend the materials' content?
     - Was it appealing?
     - Was it understandable?
     - Was it user friendly?
     - Was it accepted?
     - Was it direct?
     - Was it persuading?
   - Also evaluated (mainly by the experts group) is to what extent:
     - The necessary materials for proposed modifications are accessible
     - The proposed modifications can be applied
     - The proposed modifications could become accepted
     - The information material is sufficient
3. **Assessment of the direct effect of the intervention on the participants regarding:**
   - Knowledge:
     - To what extent the participants are aware of the problem and its causes (before and after the intervention)
     - To what extent the participants are aware of prevention measures for home environment accidents among senior citizens (before and after the intervention)
     - To what extent the participants are aware of the existence of the suggested material for the modifications and if these are accessible
   - Attitude:
     - To what extent the participants regard the problem as an important one
       - Referring to its consequences
       - Referring to its frequency
       - If in any way they do anything about it
       - If they are going to do something about it
     - To what extent a personal involvement in a home accident in the past affects
       - knowledge
       - attitudes
       - the degree of susceptibility to the problem
     - Degree of sensitization
       - Did the participants' attitudes on specific issues that the material addressed change?
       - Is the desired change towards the intended direction achieved?
     - Do participants seem to be persuaded and to what extent?

Plan for the evaluation of Pilot Project 4 (gray cells) taking into account the target group, the material that is used and the evaluation tool

PHASE 1 **Procedure**	**Experts Group:** **Architects, Designers and Civil Engineers**
Send material for Evaluation	1. Floor plan of Safe Home 2. 3D visual plot of the prototype house (self-navigation) **3.** Technical Report
Evaluation Tool	**Tool:** Self-administrated Questionnaire

PHASE 2 Target group **Procedure**	**Independently Living Elderly**	**Open Care Centers for the Elderly and Nursing Home Staff Members**
Pre-Intervention Measure	**Tool:** Pre-Intervention Interview	**Tool:** Pre-Intervention Questionnaire A
Information on the problem and the project	**Suggested medium:** Lecture	**Suggested medium:** Lecture and/or presentation
Main intervention	**Material:** 1. Informational Leaflet 2. 3D visual plot of the prototype house (navigation by the facilitator)	**Material:** 1. Informational Leaflet (for the Open Care Centers for the Elderly only) 2. 3D visual plot of the prototype house (for the Open Care Centers for the Elderly only) (navigation by facilitator)
Post-Intervention Measure	**Tool:** Post-Intervention Interview	**Tool:** Post-Intervention Questionnaire A

Target groups: Independently living elderly Care takers of the Open Care Center for the Elderly Staff Members	Nursing Home Staff Members Experts Group: Architects, Designers & Civil Engineers

Education medium for raising awareness in regard to the problem and on the Project: Lecture (2 short sessions respectively) Presentation (2 short parts respectively)	**List of Intervention materials** Informational Leaflet Home Safety Glossary Floor plan of the prototype house 3D visual plot of the prototype house (X2 manipulations: self and navigation by facilitator) Technical Report

List of Evaluation tools (all of the questionnaires as well as the interview will be planned by taking into account the assessed available time and the needs / specific characteristics of each group: Structured Pre-Intervention Interview [for the elderly] Structured Post-Intervention Interview [for the elderly] Pre-Questionnaire A [for Open Care Centers for the Elderly and Nursing Home Staff Members] Post-Questionnaire A [for Open Care Centers for the Elderly and Nursing Home Staff Members] Self-administrated Questionnaire [for Architects, Designers and Civil Engineers]	**Target Groups' Participation in Evaluation Process** • Elderly ➔ Structured interview conducted by Social Workers or Health Visitors (two measures, before and after the intervention) • Open Care Centers for the Elderly staff members ➔ Questionnaires' completion (two questionnaires before and after the intervention) • Nursing Home Staff Members ➔ Questionnaires' completion (two questionnaires before and after the intervention) • Experts Group: Architects, Designers and Civil Engineers ➔ Completion of self-administrated Questionnaire

APPENDIX 3.8 2nd Interim Report submitted by the Pilot Project 2 Coordinator **(WG3:PP2)**

AZIENDA ULSS 20 DI VERONA
Sede legale: via Valverde n. 42 - 37122 Verona - Tel. 045/8075511 Fax 045/8075640
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Servizio Progettazione, Formazione e Relazioni Esterne Socio Sanitarie
Tel. 045/807 6040 Fax 045/807 6044
E-mail: internazionali@ulss20.verona.it

Working Group 3

PP2: Prevention of falls and fractures among elderly women in Veneto, Italy

---

1. Brief Description

Pilot Project Structure

Coordinators:

Claudio Detogni, Azienda, ULSS 20 Verona, Italy
Maider Ensunza Arrien, Azienda ULSS 20 Verona, Italy

Partners:

- *University of Verona, (Faculty of Medicine and Surgery), Italy*
- *Azienda Ospedaliera di Verona, Italy*

Aims and products

The main objectives of this pilot project are to prevent falls and fractures among the elderly people (over 65), especially among women, to improve the knowledge elderly people have about risk factors of injuries, and to raise awareness and sensibility among the population as well as among doctors.

Products

- Questionnaires intending to measure environmental risk factors, home injuries, nutrition and use of medication
- Information- "awareness rising" campaign
  - Development of a leaflet on injury prevention for elderly
  - Organisation of two small-scale educational activities (workshops).

Action Plan

Phase 1: February 2005 – June 2005:

- Development of the questionnaires
- Administration of 100 first step questionnaires among women admitted to hospitals both in Verona and San Bonifacio

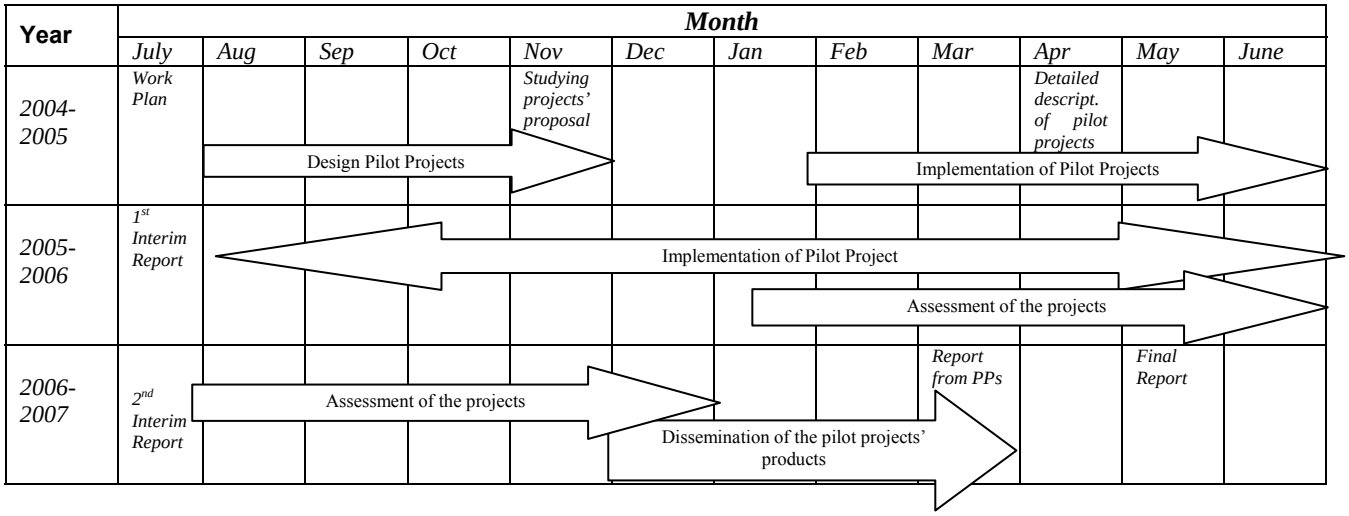
Phase 2: July 2005- January 2006

- Analysis of collected data
- Organization of the workshops

- Educational initiatives addressed to health care providers and the general population

Phase 3: January 2006- December 2006
- Administration of a follow up questionnaire
- Analysis of the follow-up questionnaires
- Final report

2. Timetable



3. Work Progress

Implementation

If, on the one hand, individual and environmental risk factors for femoral fracture are rather well known, it is unknown the prevalence and the incidence of each of these single factors in the local reality. The knowledge of the latest is of utmost importance for undertaking useful strategies for prevention, preferably and above all non pharmacological ones, among the population.
Since July 1st 2005, a first updating with the preliminary results of the data collection was done for a presentation of the state of the art during the meeting in Eretria.
Case histories: elderly women clients,consecutively admitted to hospital for a first femoral fracture of non neoplastical nature. Specific and validated questionnaires were distributed among the clients by purposely trained operators. Furthermore, personal identifying data, anthropometric and those regarding living conditions and results from any other casual survey were collected. At the same time, the same questionnaire was distributed among a control group.
Preliminary results: the first results of the analysis of 100 elderly women with femoral fracture reported that the fracture was not due to an efficient trauma and that the clients showed an appropriate neurological conditions to fill in the questionnaire.
The average age turned out to be 81±8 years. Before the fracture happened, more than a 50% of them walked less than 30 minutes a day or they used to walk less than 1 km a day or even used to stand still less than 4 hours a day; 20% of them needed help/assistance for walking and 10% was not able to stand up from a chair. Among the anamnestic risk factor for fracture, only a 3% reported a family history femoral fracture of the mothers' and only a 5% smoked or used to smoke. In 96% of the cases, the fracture was associated to a fall, in 74% of the cases related to an orthostatic position. In 73% of the cases, the accident has occurred at home, mostly in the kitchen or in the bedroom and in 23% of the cases with the contribution of an object. The 40% had already fallen at least once during the last year and 25% of them more than once. In 34% of the cases, clients had already suffered from a bone fracture after the age of 5.
These preliminary results already appointed preferably the way to move ahead in order to prevent femoral fractures among the elderly.Since then, the collaborators involved in this EUNESE project have been dealing with other 172 new questionnaires that have been distributed and collected. This means that up to day, 272 questionnaires have been distributed and collected.

Evaluation

From October 2005 onwards, the collaborating staff has started to contact those clients that had been admitted to hospital between 6 months and a year ago because of a fracture and that had previously accepted to be contacted though the phone (around 90% of the women with fractures or their relatives had agreed so). A short questionnaire for the evaluation of the mobility and the quality of life after the fracture (Eurogol[3]- for life quality and HAQ[4]- for level of autonomy) was are being used.

Dissemination

The outcomes and results of the final analysis and evaluation will have an impact in the definition of the best practices on prevention both at national and international context.
Together with the questionnaires, the staff collaborating with the university and the hospital have proceed to distribute the guide "A safe house for the elderly", prepared in the context of this project, previously translated and modified by the staff of the International Relations Office. The Department of rheumatology and the Service dealing with mobility and safety among the elderly have actively collaborated ion order to look after the contents of such a guide.

4. Concerns or difficulties / Outcomes

In general, the clients admitted to hospital because of fractures have easily agreed to answer to the questionnaires; however, a 10% of these clients have not agreed, either because they were reluctant or due to the severity of the fracture and, therefore, unable to answer positively.
The main difficulty the team has encountered up to the moment, as already underlined and raised, is the reduced budget. Scarce resources incur in the difficulty of identifying people ready to collaborate with the project.
A big effort is being done in order to create synergies with other ongoing activities, so that activities and initiatives that can lead to the success of this pilot project.
Although it was foreseen to organise small scale workshops, the scarce resources allocated to the pilot projects and the administrative difficulties that imply getting funding from the involved institutions, it has been impossible to organise such activities. So small meetings and educational initiatives have been addressed to health care providers and university junior researchers that have shown an interest in this field.
These two meetings have taken place within the context of the 3rd Fair of the Elderly held in Verona (May, 2006), under the auspices of Prof. Adami Silvano and Dr. Rossini Maurizio, in collaboration with the Mobility department of the ULSS 20 Verona (Dir. Valsecchi Massimo). Although the invitation was extended to all the elderly clients that for one reason or the other, independently of the injuries, illnesses or affections that caused their visit to the local health agencies, there has been little participation (around 40 people).

5. Future Tasks attitude

Implementation, evaluation and dissemination

Given the shortness of economic resources and the impossibility to get any further funding, the activities foreseen for the forthcoming six months will be those of proceeding with the distribution and collection of questionnaires on the evaluation of the "postfracture" cases[5]

[3] *Medical Outcomes Study Short Form 36 (SF-36; Ware JE et al, Med Care 30:473; 1992) when being dismissed from hospital and again between 6 months and 1 year after dismissal. It consists of 36 questions that have between 2 and 6 possible answers, that allow the evaluation of 8 domains regarding health conditions: physical mobility, limitation of the roles for public health, social activity, vitality and energy, pain, mental health and limitations due to emotional disorders or health disorders generally speaking. The score goes from 0 (bad health conditions) to 100 (best possible health conditions).*

[4] Rapid Disability Rating Scale (RDRS, version 2; Linn MW et al, J Am Geriatr Soc, 30:378; 1982). This scale includes 18 voices divided into 3 different groups: daily activity (eating, walking, mobility, personal hygiene and washing, dressing up, personal care, adaptation); degree of independence (including communication, hearing, sight, diet, laying in bed during the day, urinary incontinence and therapies) and cognitive difficulties (mental confusion, no cooperation and depression). The 18 voices are classified according to an scale that goes from 0 (the best) to 3 (the worst). So total scores can go from 0 (no functional limitation) up to 54 (global severe functional limitation).

[5] After having analysed the situation (identify risk factors that may have contributed or that may have been at the origin of a fall that has caused a fracture through the distribution of the questionnaires), and after the distribution of the leaflets on safety promotion developed under this same project and the meetings held on the voluntary basis of the collaborating staff, the follow up questionnaires (this is to say the same questionnaires) will help to assess if any behavioural change has taken place. As no other specific intervention is foreseen, the only thing that can be done is to compare if thanks to the

As regards the dissemination of the products, the team intends to keep on distributing a “homemade” copy of the guide translated into Italian (as no resources are left for a proper printing of the leaflet), and then proceed to the free dissemination of the results of the pilot project through the mailing list and contacts of the people active and passively involved in this project (hospitals, daycare institutions, government, NGOs, business, etc.).

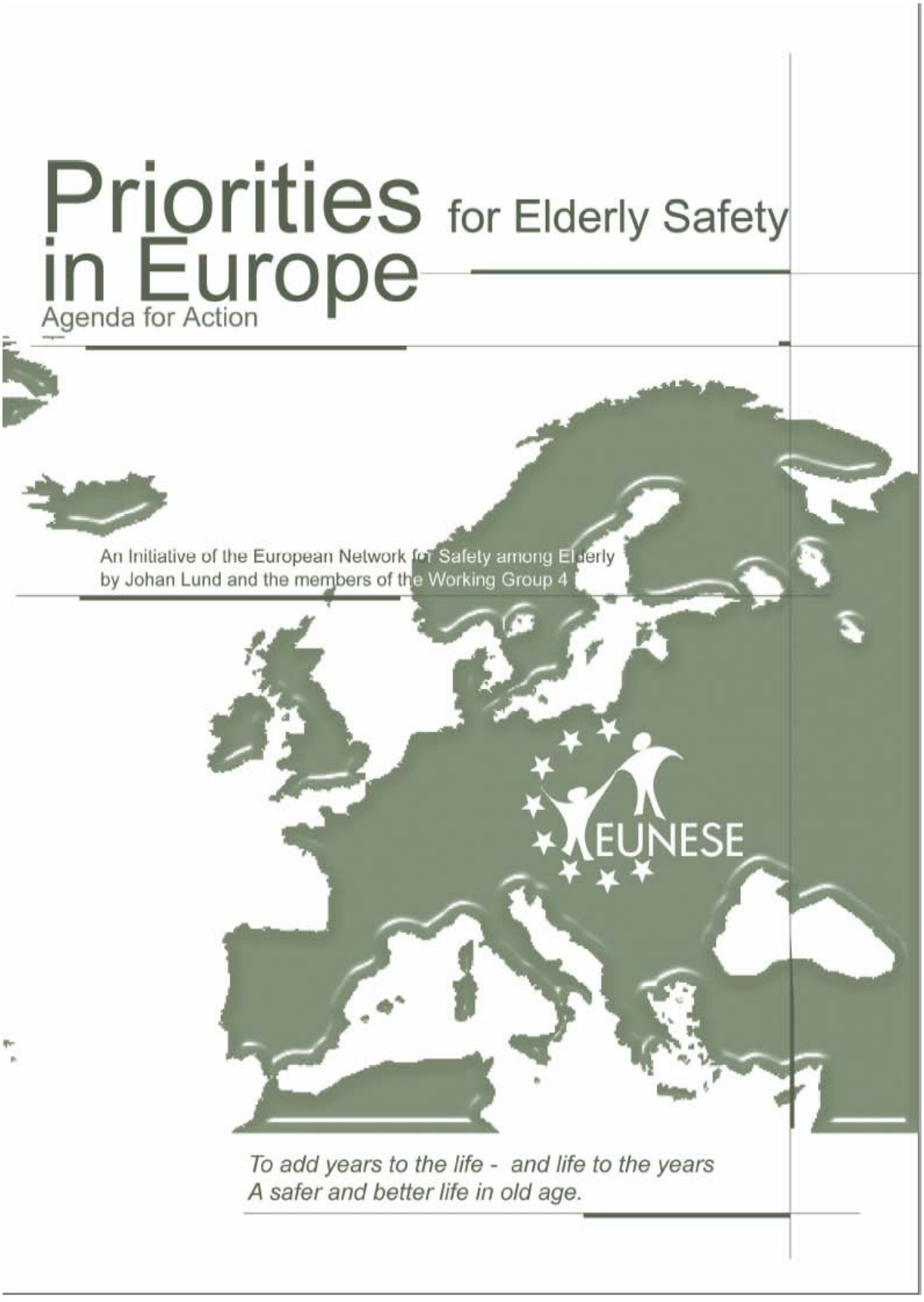
6. Meetings

- Attendance to the Sixth European Congress on Clinical and Economic Aspects of Osteoporosis and Osteoarthritis (15-18 March 2006, Vienna, Austria)

Dott. Claudio Detogni
Ufficio Rapporti Internazionali

information and awareness raising campaign, elderly people (and specially women) have changed attitude and have assumed a different approach in order to prevent risk taking and avoid risky situations.

APPENDIX 4.1 Policy Manual (Sample pages-Full text available at the web-board and EUNESE website) **(WG4)**



Executive summary

Each year approximately 10% of the elderly population (65+) will be treated by a medical doctor due to an injury. Falls are the dominant cause of injuries among elderly people, then traffic accident, burns and fires, drowning, and poisoning. Each year approximately 100,000 elderly in the EU25 and EEA countries will die due to an injury. About half of these are due to a fall. A lot more will survive. However, a serious injury, and especially a fall can lead to short- or long- term physical disability, anxiety, depression, reduced confidence and social isolation. The loss of life quality might be very high. In addition to the human suffering, to treat and rehabilitate elderly people require a large proportion of the health expenditures. There are countries in Europe with much higher mortality rates due to elderly injuries than others. Those who can successfully manage this area will achieve greater gains in reducing their overall elderly injury death rates.

While the entire population in Europe is anticipated to increase towards 2025, and decrease after 2025, the elderly population will increase substantially during the entire period. While there now are 4 persons 15-64 years old to each elderly (65+), in 2050 it is anticipated that there will only be two persons (15-64) to one elderly (65+). The need to prevent hip fractures and other injuries in old age seems to be increasing in importance. If something is not done and the fracture rate will remain the same, fall related injuries will overload the hospital and nursing home systems in the future.

Elderly injuries can be prevented. Prevention measures might be divided into three main groups: a) Awareness raising and attitude modification measures such as mass media campaigns, leaflets, film, video; b) Behaviour modification measures such as training and exercise, rewards; c) Structural modification measures such as environmental changes, regulations. Strongest positive effects are often obtained by a combination of preventive measures from the groups (orchestration). Some population-based interventions in European countries have reduced fall-related injuries in independent living elderly by 6 to 33%. In a nursing home study in Sweden, a 36-week multifactorial intervention reduced falls by 40% and hip fractures by 75% compared to a control group. Regulation in the traffic area (seat belts, alcohol limit, bicycle helmets, etc.) and in the fire area (smoke alarms) has proved to reduce fatalities for the entire population, elderly people included. Some driving courses for elderly people showed that those attending the courses had fewer accidents than elderly drivers without courses. Other examples of interventions on elderly injuries giving positive effects are referred to in this manual.

Infrastructures for injury prevention might be established. Few countries in Europe have established concrete targets for prevention of elderly injuries in a way that it is possible to measure if the targets will be fulfilled. Most of them are rather vague or non-existing.

The following recommendations are given:

Recommendation no. 1
That each member state in the EU and in the EEA should establish national action plans for prevention of elderly injuries. Targets should be defined in a way that it is possible to measure if the targets will be fulfilled. Prevention measures should be taken, and annual reports should be given. An interministerial taskforce lead by the Ministry in charge may further facilitate for enabling co-ordinated action in the countries.

Recommendation no. 2
That each member state in the EU and EEA establish health based injury registration systems enabling sound and valid injury statistics to be produced. The European Commission to ensure that such systems are working. With such systems it will be possible to compare the statistics across the countries in Europe, in order to monitor the injury situation, and to find the factors involved in the injuries in order to design preventative measures.

Recommendation no. 3
That each member state in the EU and EEA report the fatalities in the elderly according to common coding rules, ensuring that it is possible to compare mortality statistics across Europe. That World Health Organisation increases their efforts in order to create a common understanding of the coding system and to control the quality of the statistics.

Recommendation no. 4
That each member state in the EU and EEA, together with the European Parliament and European Council establish one day of the year as a Day for Elderly Safety. Such a common day across Europe might raise awareness on prevention of elderly injuries.

Recommendation no. 5
That each member state in the EU and EEA build capacity for conducting research on elderly injuries, to understand their causes, to identify preventative measures, to plan and implement intervention studies, to evaluate intervention studies in order to find cost effective prevention measures.

Recommendation no. 6
That each member state in the EU and EEA develop networks at central and local levels to promote implementation of evidence-based best practices.

APPENDIX 5.1 Methodology (**WG5)**

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Working Group 5

METHODS

Submitted by:

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16 January 2006

Brief Background

Working group 5 has been assigned the task of conducting a "feasibility study". In more concrete terms, the feasibility study is designed to assess the results of EUNESE and determine if its objectives have been achieved. To this end, the study will focus on evaluating the EUNESE network and the main deliverables of the overall project. This information will subsequently contribute to an overall assessment of the added value of EUNESE in terms of injury prevention and the potential sustainability of the network for enlargement and future activities.

The evaluation of the network and project deliverables will achieve the following major objectives:

1. assessment of the usefulness and added value of the network for injury prevention in the elderly;
2. assessment of the organizational and technical capacity of the network to achieve objectives, including obstacles to implementation and;
3. assessment of the costs to maintain the network and the potential for consistent funding.

A brief overall methodology will be presented below and following this a detailed description of the rationale and criteria to be used in the individual assessments.

Overall Methodology

Data collection instruments, protocols and procedures

The primary instrument to be used in the collection of evaluation data will be a structured questionnaire developed for WG coordinators, network members and potential funding sources. In addition, a separate survey tool (of participants) will be used in the evaluation of some deliverables (e.g. website, network conference). A summary of the evaluation process can be found in ATTACHMENT 1. The 3 principal surveys will be distributed via email with telephone follow-up of unanswered surveys after 2 weeks. For the network member survey, all members as of the date of distribution will be surveyed (list provided by WG1). Contacts for potential funders sources will be solicited in the network member survey and a questionnaire will be distributed to these contacts as per the survey timeline. In the case that the network members do not respond with potential funding sources, we will survey them again at the Network conference. Evaluation of the network conference will be carried out as an on-site questionnaire of participants and a post conference review of conference participation statistics (TBD).

Information sources / documents to be reviewed

Mixed information sources will be used in the collection of evaluation data. In addition to the survey information, these will include, the original project proposal, management plan, work plans, meeting minutes, interim reports, and the internal evaluator assessments.

Data Analysis

Checklists of network evaluation and sustainability criteria will be developed and used to tabulate results from all information sources. Final assessment of sustainability will be based on the fulfilment of the majority of criteria. Final evaluation of the network will be based on an overall qualitative assessment and quantitative assessments of indicators for individual program deliverables.

Survey data will be analysed using Microsoft Excel 2003. Each yes/no answer will be tabulated and in the end a final score will be assigned.

Data presentation and dissemination methods

Sustainability and evaluation criteria checklists will be presented in tabular form in the final report**.** These will be accompanied by narrative descriptions of the individual criteria in the context of EUNESE. Some indicators of individual project deliverables will be presented graphically. The evaluation of each deliverable will start immediately after its completion. Each WG coordinator should inform WG5 when a deliverable is considered completed, so that we can start the evaluation. The result of the evaluation will be promptly transmitted to the project coordinator and to the WG responsible for that deliverable so that changes can be carried out, if necessary.

The final report on the feasibility and sustainability of the network will be sent to the project leader, to each WG coordinator (who will transmit it to WG members), to the internal evaluator and to the steering committee.

EVALUATION OF EUNESE NETWORK

Network assessment will cover five main areas of investigation:

I. EFFECTIVENESS: Are the network's goals and objectives clear and are they being achieved? Is the knowledge being produced relevant to the needs of the target audience/users?

II. STRUCTURE AND GOVERNANCE: How is the network organized and how is it making decisions on its work? Are structural and governance issues impeding its effectiveness?

III. EFFICIENCY: Are the transactional costs of collaboration a significant barrier to success? Is capacity being built across the network to strengthen members' ability to collaborate on research and communications?

IV. RESOURCES: Does the network have the required resources to operate?

V. LIFE-CYCLE: How is the network performing given its stage in development? Is the network growing?

To investigate each of these areas, in addition to a review of the EUNESE products/deliverables and most relevant internal documents, three separate surveys will be conducted. The targets of the surveys will be:

1. EUNESE Working Groups (WG): the purpose of this survey, starting in May 2006, will be to collect information on:
    - ***a.*** initial objectives and expectations of each WG
    - *b.* Barriers to completing deliverables (communication problems, budget problems, etc.) . Delays or reduced quality of the deliverables will be assessed as a result of obstacles encountered.
    - ***c.*** outcomes/deliverables produced
    - ***d.*** costs incurred (for the preparation of each deliverable and for its update/maintenance)
2. Network Members: the purpose of this survey, starting in June 2006, will be to collect, from all members recruited so far by WG1, information on the perceived benefits (for

members themselves and for the prevention of injuries among the elderly) of the Network, and on the relevance and usefulness of the knowledge being produced.

3. Potential funding sources: this survey will be carried out toward the end of the Project (October 2006), when potential funding sources can see what the Network can offer and when the resources needed for the Network to operate are estimated. Estimation of network costs will come from the questions on costs of ongoing deliverables (e.g. website, network administration, database maintenance) in the WG coordinators survey and interviews with project management staff. This will be an approximate estimate since the amount of resources needed to start up a network is different from amounts needed to sustain the network in various future stages. In addition, in-kind (e.g. services provided by network members, time) costs can not be estimated in monetary terms. The purpose of the survey of potential funding sources, identified with the help of the other WGs, will be to assess their willingness to fund the Network in the future.

The surveys will be designed so that information can be obtained relating to the five main criteria listed above, which we discuss briefly here.

I. EFFECTIVENESS

Effectiveness will be a crucial aspect to consider when evaluating the EUNESE Network since it will tell us if objectives have been achieved and if any benefits have been produced by the network. The starting point for evaluating effectiveness will be the Network Strategic Plan (Management Plan). In fact, it contains a statement of the goal of the Network and identifies the relationships that the Network needs to build and sustain. To assess effectiveness, we will look at specific indicators that help monitor changes as signals of the Network's effectiveness. Indicators can be grouped into three categories:

A. ***Indicators of changes in the knowledge base*** identify the extent to which the Network is generating new knowledge and/or repackaging it for presentation in a

new and innovative manner. These indicators will be identified not only through the above mentioned surveys of Network members and potential sources of funding, but also through the evaluation of the EUNESE deliverables, and, after its implementation, through analysis of the website server logs and user surveys. Indicators of changes in the knowledge base should include:

1. I*ndicators of joint value creation*
    a. Was there an advantage from the collaboration of partners on work?
        i. Evidence of substantive discussion on research issues at meetings
        ii. Evidence of increasing frequency of emails among partners on research issues
        iii. Number of peer review of papers by partners
        iv. Evidence of joint research on projects, co-authorship
2. I*ndicators of capacity development in research*
    a. Were network contributions to knowledge strengthened by the undertaking of new research by members?
        i. Frequency of trainings in the research process and issues under investigation
        ii. Amount of information provided to members to support research
        iii. Evidence of specific new research projects
        iv. Small research grants

B. Indicators of changes in communications practices include the promotion of knowledge and information by the Network, the organization of workshops and consultations, the use of communication professionals, the products, the use of electronic media, and of mainstream media. It is also important to look at how these methods change over time and how the dissemination of these products are timed to when policy makers are most likely to be influenced by the information they provide. Some indicators in this category include:

1. *Indicators of opportunity management*

a. What means have the Network used to promote knowledge/information and in what contexts?
b. Have network members actively promoted the findings of the network in these contexts?

2. *Indicators of opportunity creation*
    a. Has the network organized conferences and workshops to inform policy makers of the issues and research?
3. *Consultation of communication professionals*
    a. To what degree have communication professionals been used to assist in network communications?
4. *Product indicators*
    a. What are the various product lines that have been produced by the network (e.g. research papers, policy notes, briefings papers, newsletters)?
    b. Are these being published in academic journals as well as "in-house"?
5. *Media indicators*
    a. Is the network using the electronic media as a form of communication (e.g. website, email lists)? Is research available on the website?
    b. Are individual member websites linking to the Network website as a resource?
    c. Is there a public email list that promotes the work of the Network and do members contribute to it?
    d. Are members pooling resources in enlisting the mainstream media?

C. ***Indicators of changes in relationships*** are important measures of effectiveness in that a network leverages change through relationships. These indicators will be assessed through the surveys and through the monitoring of participation in

events hosted by the Network. Some indicators that may be assessed are included below:

1. Are there clear **agendas** for who the Network is trying to influence (the "actions" the Network tries to promote from each type of audience)?
2. Are the communication strategies used in line with these agendas?
3. Does the network have a clear idea of **who** they are trying to influence (the "audience")?
4. How are key people made aware of the network's activity?
5. Monitoring of participation at key network events: numbers of participants , sectors represented and levels of influence of participants of network events.
6. Monitoring of network members' contact with key policy makers: numbers of meetings and direct contacts with key decision makers
7. Numbers of requests for new work and project proposals from decision makers

II. STRUCTURE AND GOVERNANCE

It will be important to evaluate structure and governance of the EUNESE Network because the way decisions are made within the Network influences its performance. Through a review of the main EUNESE deliverables and the survey of WG coordinators and network members, we will explore the following aspects:

A. How the Network was formed

1. Have there been clear criteria for membership selection?
2. Has performance been hampered or improved by these selection criteria?
3. What were members' reasons for joining the Network and their expectations?
4. Do these expectations correspond to the goals of the network?

B. Structure of the Network. Based on the analysis of the working relationships (assessed in the survey of WG coordinators), we will get a better understanding if the Network is structured more along the lines of a collaborative model, where all members interact consistently with each other and with the coordinators, or to the

so-called "hub and spokes" type, where one organization manages the operations of the Network and partners work individually (in this case hampering the network added value of joint productivity). In addition, we should be able to answer the following questions:

1. How is the network coordinated?
2. Has there been a terms of reference laid out and performance appraisal of the coordinator?

C. Formalization of the Network. Through the WG coordinator survey and the review of official EUNESE documents, we will explore if there have been clear duties and responsibilities for partners, the level of comprehensiveness of their contracts, and how their work plans were created. The following questions should be answered in order to get a clear understanding of how the Network will be governed:

1. *Memoranda of understanding (MOU)*
    a. Have MOU or governance agreements been established?
    b. If there are MOU, are there mechanisms outlined for decision making on network activity? If not, how are members involved in these decisions?
    c. What are the duties and responsibilities of members?
    d. Are they clearly laid out in the network governance agreements to allow for accountability?
2. *Contracts with members*
    a. Are contracts made with members to perform specific projects?
    b. Are they strictly bilateral or do they involve other members of the network?
3. *Work plans for members*
    a. Are commitments with donors translated into written work plans for members (making members accountable for specific deliverables)?

b. Are commitments made by members at meetings transformed into an actionable work plan in which performance can be measured?
c. Do members clearly understand and agree to what is expected of them?

4. *Contracts with donors*
    a. Who is accountable to the donor? Is it only the coordinating organisation or are provisions made for members to be directly accountable?
    b. Who carries the greatest benefit or risk from success or failure?

III. EFFICIENCY

Efficiency relates to the transactional costs of collaboration, which can endanger the success of the Network. To explore efficiency, we will look at the following issues:

A. Internal communications and interaction among partners

1. Is a mix of tools used to engage members in discussion and collaboration (e.g. meetings, WEB, telephone calls, email communication).
2. Is there consistent use of an internal network email list or intranet (WEB Board)? Is it used as a means of communication between members or solely as a tool to disseminate information from the coordinating group to members?
3. What has been the level of attendance at network meetings?

B. Institutional support It is important to investigate if individual partners are supported adequately by their institutions for involvement in the network and where the capacity in a network is being built.

1. Is participation in the network restricted to a single person from an institution or are many individuals involved from a single institution?
2. Are there conflicts between a member's institutional priorities and network priorities?
3. How is the participation and results from work carried out in the network incorporated into the member institution's agenda?

C. Systems and procedures This aspects regards the procedures for contracting, financial disbursement, proposal development and reporting; it can be evaluated

through the assessment of network members' satisfaction. Since many of these procedures will not yet be fully applicable due to the early stage of the network, it may be difficult to assess this element. However, in the context of EUNESE, we can use as a proxy for network administration, the administration that is currently in place for the EUNESE project. In this case, the survey of WG coordinators may help to answer some of these questions. Issues of streamlining procedures may also be addressed if problems are identified.

IV. RESOURCES

Networks are notoriously costly to operate. There are many factors which play into the cost of operating a network including size, scope, amount of voluntary support from members and the stage in life cycle. Networks in start-up stages are much more costly than those in the growth period. We should estimate if the resources consumed in the start-up of the network were greater or less than expected and what the reasons for over or under budgeting were.

There are 3 major types of resources that are needed in a network:

A. ***Human resources*** We will evaluate the stability of network participation and coordination looking at the level of turnover in individual network members and members representing institutions and in coordination and management of the Network. In the short term, limited turnover reflects a good choice of participants and a high level of commitment. In addition, the number of network members will be used as an indicator of the network's established effectiveness.

B. ***Financial resources*** The costs of operating a network is often difficult to estimate since in-kind contributions are a major resource for networks and almost impossible to estimate in monetary terms. Financial resources needed for the Network's future activities (as opposed to cost of start-up) will be estimated from the results of the WG coordinator survey and interviews with project leadership. In this survey WG coordinators will be asked to describe all the resources

consumed by the activities of the Network. The major categories of cost that will be estimated are:

1. ***Network overhead***
2. ***Travel***
3. ***Administrative***
4. ***Communication***
5. ***Personnel*****:** coordinator, technical staff, administrator

C. ***Time*** Towards the end of the project, and before surveying potential funding sources, we will assess if the time span of the Network has been established. In addition, we will see if there have been delays in some deliverables, possibly indicating critical areas of Network operation.

V. LIFE-CYCLE

Life-Cycle analysis is a process which compares a certain network with the performance of others at the same developmental stage. However, since all networks are different this is almost impossible. However, it is possible to observe the organizational growth of the EUNESE Network from its birth to more advanced stages, describing the level of performance according to its phases (beginning, growth, decline, and possibly ling term sustainability). The life-cycle of a successful network can last many years (10 or more depending on the type of network). For this reason, we will <u>not</u> be able to perform this type of evaluation on the EUNESE Network because at the closing date of the EUNESE Project, the Network will be still in a very initial stage. We will however attempt to take into consideration the early developmental stage of the Network in the final assessment.

EVALUATION OF DELIVERABLES

As part of the evaluation of the results of the EUNESE Project, WG5 will evaluate the following deliverables:

I. **NETWORK WEBSITE**
II. **NETWORK CONFERENCE**
III. **NETWORK BUILDING**
IV. **DATA COLLECTION REPORT**
V. **PILOT PROJECTS MATERIALS (E.G. LEAFLETS)**
VI. **PILOT PROJECTS FINAL REPORT**
VII. **BEST PRACTICE POLICY MANUAL**
VIII. **INFORMATION LEAFLETS.**

I. WEBSITE EVALUATION

The evaluation of the EUNESE Web Site developed by WG1 will take place after its completion and will be based on the following criteria:

A. **Scope**:
   1. Is it clearly stated?
   2. Is the philosophy and the background of the authors of the website clearly stated?

B. **Content:**

   Accuracy:
   1. Are there any biases?
   2. Is the information reliable and error-free?

   Authority:
   1. Are sources of information stated?
   2. Can authors be contacted for clarification?

   Currency:
   1. Are the web pages dated?

2. Is the website regularly updated? How frequently?
3. Are dates of update stated?

Uniqueness:

1. Does the website provide information not found elsewhere?

Links with other resources:

1. Are the links well chosen, well organized, and/or evaluated/annotated?
2. Are they up to date?
3. Are the resource links reliable?
4. Do they indicate bias?

***Quality of writing*:**

1. Is it written in clear, concise and understandable language?
2. Is the information provided in the major European languages?

C. <u>Design</u> (GRAPHIC/MULTIMEDIA):

1. Do visual effects improve or hinder access to the site (large and unnecessary graphics may inhibit access)
2. Is the site visually pleasing but without unnecessary decoration?
3. Is advertising used appropriately or does it detract from the value of the information?
4. Is the design consistent between different parts of the website?

D. <u>Purpose/Audience</u>:

1. Is it clearly stated?
2. Does the site fulfil the stated purpose?
3. Is content appropriate to the audience it is intended for?

E. <u>Workability</u>

User friendliness:

1. Are there site aids to navigation such as, a site map, index, menu system?
2. Is there help available? Is it useful? Is it context sensitive?
3. Are the menus easy to read and navigate?

Required computing environment:

1. Is the website accessible from any software and user interface?
2. Is special hardware required to access the website?
3. Are there any geographical access restrictions?

Searching:

1. Is a search engine provided?
2. Is there an advanced search engine provided?
3. Is it intuitive?

Browsability/Organization:

1. Is information organized in a logical way?
2. Are documents provided in printable pdf format, html, normal text?

Connectivity:

1. Is it readily accessible or often overloaded/offline?
2. How much time do pages take to load?

F. Review/Feedback:

1. Is it possible for site visitors to give feedback?

G. Cost:

1. Are pages/documents free or pay-per-use?
2. If there are online transactions, are they secure?

H. Usage

1. Web server logs can tell us if there has been growth in traffic to the website and the most frequently accessed documents and pages

A special section will include an evaluation on the website presentation of the literature database.

II. NETWORK CONFERENCE EVALUATION

The evaluation of the EUNESE Conference, organized by WG1, will take place at the conclusion of the conference and will be based on the review of the following aspects:

A. Planning

1. Was there evidence of sufficient advanced planning?
2. Invitations / publicity?
3. Content: Was it in line with the scope of the project?
4. Number of countries invited to the event

B. **Event Organization**

1. Suitable location?
2. Suitable facilities?
3. Suitable time for conference / sessions?

C. **Participation**

1. Number of participants
2. Type of participants
3. Countries represented

D. **Cost:**

1. Was there a conference fee?
2. How much of conference costs were covered by this fee?

E. **Attendees**: Attendees will be surveyed with a brief questionnaire at the end of the event. The survey will be aimed at assessing their opinion on:

1. Knowledge transfer
2. Networking
3. Meeting of expectations
4. Event organisation

III. EVALUATION OF THE NETWORK BUILDING

The evaluation of the EUNESE Network Building by WG1 will take place towards the end of the project and will be based on the following criteria:

A. **Existence of criteria for Network membership**
B. **Overall number of members recruited in the Network**
C. **Overall number of countries from which members come**

D. **Type of members recruited from each country**: at least one member from each target group: a. research (research institutes, universities, hospitals), b. prevention and practice (NGOs/institutes, elderly care organizations), c. policy makers (ministry of health, related ministries, focal points)

IV. Evaluation of the Data Collection Report and Database

The evaluation of the report on the data collection will take place after its completion and take into account the following aspects:

A. **Methods**: presence of a detailed methods section in the report explaining the strategy for searching the documents

B. **Completeness:** number of documents included in the literature review, number of and types of databases searched, and relevance of documents to the scope of EUNESE

C. **Database Characteristics/Content:**

Appropriateness:

1. Is the content appropriate for the users of the database?

Accuracy:

1. Does the content of the database accurately reflect the search strategy used?

Comprehensiveness:

1. Number of titles in the database (indexed, abstracts, full text, by type of publication)
2. How often is the database updated?

Clarity:

1. Are the database field names comprehensive and understandable?
2. Are references complete?
3. Are author names references in a consistent manner (e.g. last name, first initial)?

Usability

1. Is the database easily searchable and intuitive (e.g. by keyword, topic, date, type of publication and author)?
2. Are field names easily searchable?
3. Is it possible to set limits to searches (e.g. by language, publication type or year, etc)?
4. Is searching by truncation, stemming and wildcards possible?
5. Are search requests retrieved within a short time span (<1 minute)?
6. Are references available in list format?
7. Are links to full texts and/or abstracts available?
8. Can references be sorted?[
9. Are web links to references provided?

D. **Discussion**: presence of a section in the report highlighting the limitations of the database

V. Evaluation of the Pilot Projects Materials

The evaluation of materials developed in the pilot projects conducted by WG3 will consider the following aspects:

A. **Presentation**

1. Visual appeal: graphic/text mix
2. Use of colours appropriate with clear distinction between background and text
3. Clarity of diagrams, photos, or tables (if any)
4. Appropriateness of images for target group
5. Appropriateness of print size
6. Adequate number of headings
7. Readability and consistency of layout
8. Offensive to anyone?

B. **Writing/Grammar Style**

1. Quality of writing: clear simple and correct

2. Appropriateness of language style for target audience
3. Wording: easily understandable for target audience, there is no excessive wordiness
4. Grammar, punctuation, capitalization and/or spelling

C. **Content Information**

1. Accurate
2. Up-to-date
3. Complete: any important information left out?
4. Technical terms clearly explained?
5. Offensive to anyone?

VI. Evaluation of the Pilot Projects Report

Pilot projects are carried out by WG3. In the evaluation of the report we will consider if it includes the following key information:

A. **Description of the rationale** of each pilot project
B. **Description of the project**
    1. setting
    2. methods
    3. results
C. **Description of the project evaluation**, including a detailed explanation of the methods used to evaluate the project and of the indicators that were chosen:
    1. qualitative/quantitative
    2. process/outcome

VII. Policy Manual Evaluation

The policy manual produced by WG4 will be evaluated based on the following aspects:

A. **Organization**:

Does it contain?:

1. Table of contents

2. Consistent format
3. Comprehensive index
4. Cross-references
5. Date of creation/revision

B. <u>Comprehensive</u>:

Does the manual address all relevant issues?

C. <u>Usable</u>:

Is it organized in a format that is easily referenced?

D. <u>Policy Characteristics</u>

Complete:

Do the policies recommend what action should be taken, the purpose of it, and sometimes who should take it?

Clear/Concise:

Are the recommended policies clearly and concisely stated?

Flexible:

Are the recommended policies easily modifiable when circumstances change?

Distinctive:

Can the policies be distinguished easily from regulations?

Without operational details:

Are the policies without operational details which may vary from time to time and from situation to situation?

Appropriate:

1. Are the policy recommendations supported by current scientific evidence (are references listed)?
2. Are the policies up-to-date and compliant with the laws and regulations?
3. Are the policies recommended appropriate for all European countries?

VIII. EVALUATION OF INFORMATION LEAFLETS

The evaluation of information leaflets to be produced by WG4 will consider the following aspects:

A. **Presentation**

1. Visual appeal: graphic/text mix
2. Use of colours appropriate with clear distinction between background and text
3. Clarity of diagrams, photos, or tables (if any)
4. Appropriateness of images for target group
5. Appropriateness of print size
6. Adequate number of headings
7. Readability and consistency of layout
8. Offensive to anyone?

B. **Writing/Grammar Style**

1. Quality of writing: clear simple and correct
2. Appropriateness of language style for target audience
3. Wording: easily understandable for target audience, there is no excessive wordiness
4. Grammar, punctuation, capitalization and/or spelling

C. **Content Information**

1. Accurate
2. Up-to-date
3. Complete: any important information left out?
4. Technical terms clearly explained?
5. Offensive to anyone?

EVALUATION OF EUNESE NETWORK SUSTAINABILITY

5 major areas will be assessed in the study of sustainability of the EUNESE network, each of which are treated separately below:

I. INTERNAL RELATIONS

II. EXTERNAL RELATIONS AND CONTEXTUAL FACTORS

III. ONGOING RELEVANCE

IV. FINANCIAL ASPECTS

V. INSTITUTIONALIZATION

The criteria for sustainability to be addressed within each of the major areas will be assessed through occasional surveys, interviews and direct observation of working group coordinators, network members and potential funding sources (see survey timeline).

I. INTERNAL RELATIONS

A. SHARED OWNERSHIP AND MUTUAL TRUST

1. Were potential network members involved at the visioning stage of the network?
2. Do members feel they drive the network as a whole?
3. Is horizontal communication within the network adequate?
4. Is communication supported across language barriers?
5. Is autonomy of network members maintained along with previous personal and institutional commitments?
6. Are membership levels appropriately situated to promote continuity?
7. Is the network rooted at the level from which it will eventually need to seek sponsorship?
8. Is there devolving responsibility for network publicity and finances to members?
9. Is there centralized or decentralized governance? Does centralized governance alienate network members?

B. DYNAMISM OF CONNECTIONS AND INTERACTIONS AMONG MEMBERS

1. Have steps been taken to ensure that members of the network can collaborate? How? Is the membership base too broad (diverse)?
2. Are there structures and systems for shared, or even rotational leadership?
3. Does the network facilitate interchanges among members? How?

C. OPEN VERSUS SELECTIVE APPROACHES TO MEMBERSHIP

1. Is there a balanced network membership? (e.g. balanced between open and closed, selective membership or "levels" of membership)

D. INDIVIDUAL VERSUS INSTITUTIONAL MEMBERSHIP

1. Is there institutional membership that can provide continuity, resources, on-going mandates and broader circles of contacts and influence?

E. ALLOWING FOR VARYING LEVELS OF ENGAGEMENT WITH THE NETWORK AS OPPOSED TO INSISTING ON A STRICT APPROACH TO EQUALITY OF RELATIONS.

1. Are there "circles of participation" which allow network members to engage in the network to varying degrees with the flexibility to change levels of participation over time?

II. EXTERNAL RELATIONS AND CONTEXTUAL FACTORS

A. CREDIBILITY

1. Is there production of quality (original) research and products?
2. Does the network maintain (and publicize) high ethical standards for research and dissemination?
3. Does the network involve research users in the design of the network?
4. Does the network actively cultivate a reputation that leads to membership, expansion, institutionalization and revenue?
5. Does the network ensure that it's products are appropriate to the audience they are serving?

B. CONSTRUCTIVE ENGAGEMENT AND COMMUNICATION WITH STAKEHOLDERS AND TARGETS

1. Is the network able to communicate its purpose in effective terms?
2. Has it established effective communication strategies dispersed among its members?
3. Are communication strategies sensitized to the political context in which it operates?
4. Is there effective communication directed towards users and funders?
5. Has it established positive, non-threatening relationships with other organizations which serve overlapping purposes?
6. Has the network entered into relationships/linkages with members' institutions?
7. Has the network been able to build upon these links and in a way that does not undermine members' ability to fulfil regular duties?

III. ONGOING RELEVANCE

A. ADAPTABLE MANAGEMENT STRUCTURE AND CULTURE

1. Is there monitoring and evaluation built into the management structure that allows for periodic assessment of the network's focus, systems, structures, functions and products, in order to plan adaptations as necessary (not just evaluation of project results)?
2. Is there a broad research agenda which allows the network to easily adapt the focus as needed to address the needs of the user and target group without compromising the basis for collaboration among network members and its ability to address locally driven issues?
3. Is there a flexible organisational structure which promotes adaptability to new demands?

B. BRINGING IN NEW PEOPLE

1. Does the network use various means to recruit new participants as the need arises (e.g. when deciding which themes and capacities it wishes to broaden or deepen)?
2. Does the network allow its members to work together around a common goal or is it just information sharing?

C. NETWORK PRODUCTS

1. Is the network able to produce tangible results (i.e. products, research)?

IV. FINANCIAL SUSTAINABILITY

A. LONG-TERM AND FLEXIBLE DONOR COMMITMENTS

1. Is there a long term donor commitment of more than 3 years?
2. Is funding flexible; allowing for shifts in network focus?
3. Does funding cover all costs including core administrative, communication and travel costs?

B. REVENUE GENERATION

1. Is there revenue generation through various means (e.g. commercialization of research results, consulting contracts, donor projects, membership fees, contributions, income from signatory nations, etc.)?

C. DIVERSIFICATION OF DONOR BASE

1. Is there a diverse donor base (e.g. multi-sectoral including national governments and the private sector)?
2. Does the donor base provide other in-kind supports and opportunities?
3. Does the network have marketing and communication expertise with skills that can be used to attract donors?
4. Is the network able to concisely explain its program?
5. Is budgeting for network overheads included within project proposals?
6. Are network activities divided into manageable chunks that donors can take on?
7. Are donors and potential donors incorporated into the network structure?
8. Is there a good balance between a diverse donor base that still permits flexibility in the network structure, management and research interests?

D. MINIMIZING OPERATING COSTS

1. How have overhead costs been minimized?
    - Balancing competitive salaries to obtain qualified coordinators with need to contain costs

- Enlisting volunteer labour by members
- Avoiding institutionalization of costs by the "secretariat"

2. Are researchers able to find outside resources to support their work for the network?

V. INSTITUTIONALIZATION

1. Is the network completely institutionalized or is there a balance between institutional and individual membership?

2. Has the network devolved some of it's activities or processes?

3. Has the network been incorporated as a formal legal entity?

Below is listed a summary of the steps that will be undertaken in the evaluation process.

ATTACHMENT 1

SUMMARY OF STEPS IN THE PROCESS

First Survey of WG coordinators
(start May 2006)

Review of documentation
(until the end of the Project)

Review of deliverables
(until the end of the Project)

Survey of Network members enrolled so far
(start Jun 2006)

Survey of potential funding sources
(start Oct 2006)

Second Survey of WG coordinators
(start Nov 2006)

Discussion of results within WG5

Draft of report and recommendations

Finalization of report and recommendations
June 2007

APPENDIX 5.2 WG Coordinator Survey (Sample Survey for WG1) **(WG5)**

UNIVERSITA' DEGLI STUDI DI UDINE
Dipartimento di Patologia e Medicina Sperimentale e Clinica
Cattedra di Igiene
Direttore: Prof. Fabio Barbone
Via Colugna, n. 40 – 33100 Udine
Tel. 0432/559601 – Fax 0432/559427

EUNESE
WG Coordinator Survey

May 2006

Dear WG Coordinator,

This is the first in a series of surveys that have been designed as part of the evaluation of the EUNESE network and the main deliverables of the overall project. This information will subsequently contribute to an overall assessment of the added value of EUNESE in terms of injury prevention and the potential sustainability of the network for enlargement and future activities. For a complete presentation of the methodology to be used, please refer to the final copy of the methodology document which includes the criteria to be used in evaluation of your deliverables (attached in this email).

The first survey presented here aims to elicit your response as a WG coordinator since the start of the project to the end of April 2006. A subsequent survey that will be issued in June 2006 will concern your role as a network member.

We ask that you complete the questionnaire and forward it by email to D'Anna Little, University of Udine, Institute of Hygiene and Epidemiology (little.danna@uniud.it) **by May 23, 2006.** If you have any questions, either Francesca Valent or I can be reached at +39 0432 559601.

We thank you in advance for your collaboration.

Instructions:

1. Please answer all questions as they pertain to your activity as WG coordinator. It is designed to be completed on the computer.
2. If you click a check box ☐, an X will be added. If you make an error, you may clear the box by reclicking.
3. The shaded boxes following some questions are designed to add an unlimited amount of free text. Make sure the box is highlighted when typing.
4. You can move between questions using the "tab" key.
5. Please remember to save the form each time it is accessed.

Working Group 1

The following questions relate to the part of your work plan that is concerned with establishment of the network.	
1. How was your work plan created?	
2. Have you been able to follow it exactly?	Yes ☐ No, for a few of its aspects ☐ No, for many of its aspects ☐ No, not at all ☐
3. If not, can you please explain why?	

Please compile the table below:

Deliverable	Original Deadline	Date of Delivery (if applicable)	Obstacles to completion ?	If yes, please list and describe these obstacles and explain any delays or changes in accomplishment of the deliverable that they may have caused	If you have experienced obstacles, do you feel they have affected the quality of the deliverable?
Network Website			Yes ☐ No ☐		Yes, very much ☐ Yes, somewhat ☐ Yes, slightly ☐ No, not at all ☐
Network Conference			Yes ☐ No ☐		Yes, very much ☐ Yes, somewhat ☐ Yes, slightly ☐ No, not at all ☐
Network building			Yes ☐ No ☐		Yes, very much ☐ Yes, somewhat ☐ Yes, slightly ☐ No, not at all ☐

*The following questions assess **structure and governance** by addressing issues in the formalisation of the network and structure.*		
1. Have there been clear criteria for membership/partner selection? *a.* in the network		Yes ☐ No ☐
b. in the EUNESE project		Yes ☐ No ☐
2. Do you think performance of the Network been hampered or improved by these selection criteria?		Hampered ☐ Improved ☐ Neither hampered or improved ☐
3. In carrying out your work plan, have commitments made by you as a partner been transformed into an actionable work plan in which performance can be measured?		Yes ☐ No ☐
*The following questions aim to assess the **efficiency** of the network in terms of internal communications, systems and procedures and interaction among partners. It is important here to consider that the efficiency of the EUNESE PROJECT is directly related to the efficiency of what will become the EUNESE NETWORK, therefore question 5 aims to assess the current systems and procedures under this assumption.*		
4. Can you give an estimate of the % of use of each of these methods in your communications with partners of the project (other WG coordinators, your WG members and project leadership)? If not used, please write 0%. (all answers together should equal 100%)	Email WEB forum Telephone communication Meetings/conferences Written (by mail)	
5. Are you satisfied with the systems and procedures used for:		
a. Contracting with partners		Yes ☐ No ☐
b. Project work plan development		Yes ☐ No ☐
c. Financial disbursements		Yes ☐ No ☐
d. Reporting to partners		Yes ☐ No ☐
If not, how do you think each of these areas could be streamlined?		

The following questions aim to assess the factors which play into the cost of operating a network including size, scope, amount of voluntary support from members.

Please compile the following tables using **Euro** as the unit currency:

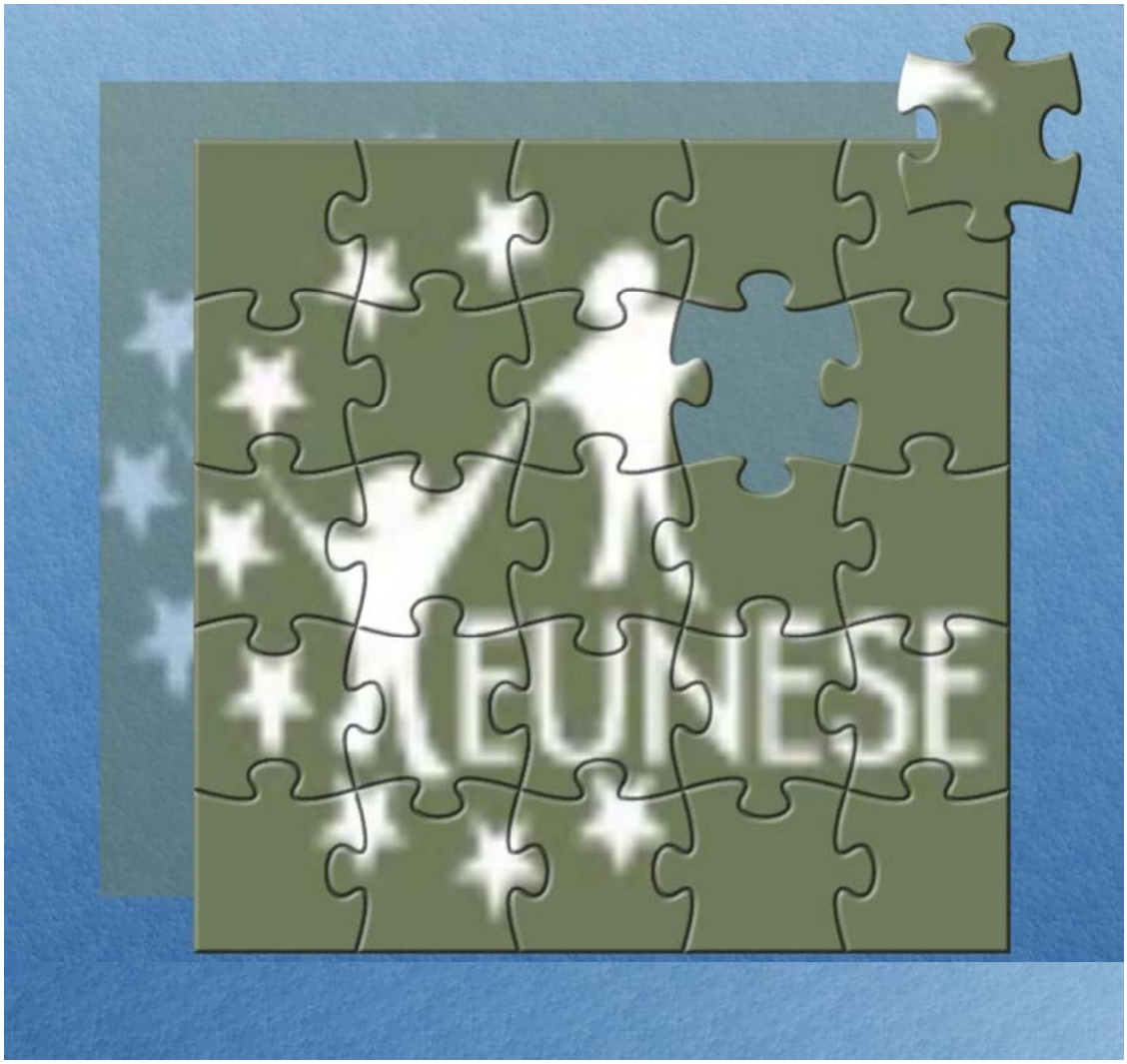
Deliverable	# Personnel assigned	# Personnel currently working on the project	Total Projected Budget	Total amount spent so far (up to end April 2006)	Total Budget anticipated to end of EUNESE project (May 2006-June 2007)	Estimated annual cost for maintenance
Network Website						
Network Conference						
Network Building						

Budget Item	Network Website		Network building		Network Conference	
	Amount spent so far	Anticipated amount	Amount spent so far	Anticipated amount	Amount spent so far	Anticipated amount
Overhead costs						
Travel						
Administrative costs						
Communication						
Personnel						
Other (please list)						

Thank you for participating in the survey!!!

APPENDIX 6.1 Sample pages-Full document available on the Web-board **(Project Leader)**

FIVE-YEAR STRATEGIC PLAN FOR THE PREVENTION OF UNINTENTIONAL INJURIES AMONG THE EU SENIOR CITIZENS



Athens, June 2006

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EXECUTIVE SUMMARY

This Strategic Plan intends to provide a consolidated framework for all EU countries in order to assist them to reduce the burden of injuries among the elderly people in Europe through injury prevention and safety promotion endeavours. It is supplementary to the Policy Manual developed in the context of the European project EUNESE (EUropean NEtwork for Safety among Elderly), which is coordinated by the Centre for Research and Prevention of Injuries (CE.RE.PR.I.), Department of Hygiene and Epidemiology, Athens University Medical School. Thirty-one partners from 23 EU and EEA countries participate in EUNESE project, which started in July 2004 and will run for 36 months under the auspices of DG SANCO (Directorate General of Health and Consumer Protection) within the framework of the Public Health Program of the European Union.

The aim of both this Strategic Plan and the Policy Manual is to provide the EU Commission with valuable tools that can be used to strengthen the efforts for injury prevention and safety promotion among senior EU citizens.

Strategic Goal 1: To use current resources (existing mortality and morbidity injury surveillance systems) and harmonize future efforts of collecting data at EU level to monitor and provide standard and uniform information on the injuries among the elderly for each MS in the EU and EEA; moreover, to use clearly defined and validated injury indicators for mortality and morbidity due to injuries among the elderly

Strategic Objective 1.1. Strengthen the efforts to harmonize current existing injury data resources at EU level

Strategies Description	Target group(s)	Lead(s)	Partner(s)*	Means	Time-frame	Funding source
1.1.a. Strengthen the World Health Organisation's efforts to create a common understanding of the coding system and control the quality of data	**Data source organisations like:** ▪ Hospitals ▪ National Statistical Services collect hospital data ▪ Organisations for injury prevention in MS ▪ IDB National Coordinators	▪ EC, WP-AI ▪ WHO-EURO	▪ WHO focal points ▪ National Statistical Services ▪ Experts ▪ Injury prevention stakeholders	▪ Develop a quality control system (tools and audit committee) ▪ Educate data collectors on proper data collection practices	2008-2011	▪ Use existent infrastructures ▪ EC ▪ Governments ▪ MoH ▪ Municipalities ▪ Prefectures ▪ Private funding sources ▪ Donations ▪ Voluntary work
1.1.b. Establish standards for completeness and accuracy of external cause of injury coding (E-coding) for hospital data		▪ EC, WP-AI ▪ University Departments ▪ National Injury Prevention Organizations	▪ MoH ▪ EUNESE ▪ WHO-EURO ▪ IDB partners and coordinators ▪ Experts ▪ Injury prevention stakeholders	▪ Research ▪ EC Directive/ National Regulation (for developing a common data coding system		
1.1.c. Develop and implement proportional indicators in order to be able to use data from the Injury Data Base (IDB) for comparability among MS				▪ Research ▪ Data collection via Injury Surveillance systems ▪ Relevant policy adoption		
1.1.d. Develop and implement a minimum data set (MDS) that will facilitate a uniform and cost-effective process of data collection and analysis				▪ Research ▪ Data collection via Injury Surveillance systems		
1.1.e. Develop a central structure that will gather, analyse and disseminate all collected elderly-related injury data		▪ EC, WP-AI ▪ EUNESE	▪ MoH ▪ National Health Councils ▪ National Statistical Services	▪ Data gathering and analysis	2008-2012	

Evaluation

Strategy Description	Means	Type of Evaluation
1.1.a. Strengthen the World Health Organisation's efforts to create a common understanding of the coding system and control the quality of data	▪ Develop a quality control system (tools and audit committee) ▪ Educate data collectors on proper data collection practices	▪ Outcome evaluation ▪ Process evaluation
1.1.b. Establish standards for completeness and accuracy of external cause of injury coding (E-coding) for hospital data	▪ Research ▪ EC Directive/ National Regulation (for developing a common data coding system)	▪ Conformance testing ▪ Number of countries formulate regulations according to EC Directive/s (if developed)
1.1.c. Develop and implement proportional indicators in order to be able to use data from the Injury Data Base (IDB) for comparability among MS	▪ Research ▪ Data collection via Injury Surveillance systems ▪ Relevant policy adoption	▪ Outcome evaluation ▪ Number of policies adopted
1.1.d. Develop and implement a minimum data set (MDS) that will facilitate a uniform and cost-effective process of data collection and analysis	▪ Data collection via Injury Surveillance systems ▪ Research	▪ Outcome evaluation
1.1.e. Develop a central structure that will gather, analyse and disseminate all collected elderly-related injury data	▪ Data gathering and analysis	▪ Monitoring ▪ Annual reports

* *Representatives of the target groups will always included among the partners but they are not mentioned in this column for reasons of simplicity*

Strategic Objective 1.2. Implementation of injury related indicators						
Strategies Description	**Target group(s)**	**Lead(s)**	**Partner(s)***	**Means**	**Time-frame**	**Funding source**
1.2.a. Assuring the implementation of uniformly approved injury related indicators (e.g. by use of ECHI) in each EU country	▪ Data source organizations	▪ EC ▪ MoH	▪ Health planning Councils ▪ WHO focal points ▪ EUNESE	▪ Monitoring	2011-2012	▪ EC ▪ MoH ▪ Municipalities
Evaluation						
Strategy Description	**Means**		**Type of Evaluation**			
1.2.a. Assuring the implementation of uniformly approved injury related indicators (e.g. by use of ECHI) in each EU country	▪ Monitoring		▪ Report including effectiveness evaluation			

Strategic Objective 1.3. Monitoring of injuries reporting systems implementation and efficiency						
Strategies Description	**Target group(s)**	**Lead(s)**	**Partner(s)***	**Means**	**Time-frame**	**Funding source**
1.3.a. Assuring by the European Commission that such systems are working in each of the MS and monitor their efficiency.	▪ Data source organizations	▪ EC	▪ MoH ▪ EUNESE	▪ Monitoring ▪ Regulation development/ enforcement	2011-2012	▪ EC ▪ MoH ▪ Municipalities
Evaluation						
Strategy Description	**Means**		**Type of Evaluation**			
1.3.a. Assuring by the European Commission that such systems are working in each of the MS and monitor their efficiency.	▪ Monitoring ▪ Law development/enforcement		▪ Report including effectiveness evaluation (at the end of fifth year of strategic plan implementation) ▪ Number of policies adopted that are attributed mainly to these efforts			

* *Representatives of the target groups will always included among the partners but they are not mentioned in this column for reasons of simplicity*

APPENDIX 6.2 EUNESE Newsletter **(Project Leader)**

EUNESE NEWSLETTER

EUROPEAN NETWORK FOR SAFETY AMONG ELDERLY

FEBRUARY 2006

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BUILDING A EUROPEAN NETWORK

For the first time in the recorded history of medicine, mortality among the elderly is declining as fast as mortality among the younger ages and life expectancy for those who have reached the age of 65 increases sharply. Indeed, at the 65th birthday, in the EU-25 a woman can expect to live another 20 years and slightly less, if man.

The point now is how to improve the quality of life for the elderly and reduce the most unacceptable fraction of the mortality that due to injuries.

Indeed, every year almost 100 000 elderly in the EU-25, that is more than 250 people die every day, only of this most preventable cause of death, namely injuries, whereas more than one third of the health care expenditure is spend during the last year of life.

The EUropean NEtwork for Safety among Elderly (EUNESE) project was established on the July of 2004. More than 30 partners representing 24 EU member states are participating in this project along with the support of the World Health Organization

The aims of EUNESE are not only to act as a platform for the exchange of information and expertise between health practitioners, but also to take a proactive approach in order to reach both the public and policymakers and ensure that the health of the elderly citizens is put at the center of Europe's political agenda.

Specifically, EUNESE pursues the subsequent priorities:

- Establish a sustainable EU-wide network of experts to ensure harmonization of core activities (injury control and safety promotion) among elderly.
- Define EU priorities in injury prevention and to develop a policy manual including the definition of best practices for both independently and dependently living elderly.
- Develop a 5-year strategic plan for injury prevention among elderly.
- Translate policy priorities and evidence-based practices into implementation projects and pilot studies.
- Develop a feasibility study for the sustainability of the Network.

Disseminate information and best practices through the EUNESE web-site, the policy manual and leaflets and through the European and national or local networks.

Consistency, devotion, knowledge and economic support are believed to be the major elements for this effort's success.

WHAT'S IN THIS ISSUE?

In the number one issue of this Newsletter we endow you with information on EUNESE proceedings, a project that although started as an initiative from the injury prevention field, went on to extensively develop capacities in corresponding areas. EUNESE project has a multi-sectorial and a multi-disciplinary approach, ranging from data collection based on reliable statistics such as the new and recently launched Statistics Portal on Accidents and Injuries, to inventive initiatives in order to prevent falls as the Virtual modeling of a safe household environment for elderly citizens, assigned to the 3rd Working Group of the Project.

In this issue our Network associates bring up to date policy manuals and statements for sustainable injury control and elimination of accident risks. The working group "Pilot Projects" defines and implements action plans that bring together experts from different fields of research thus enhancing the potential synergies on common battlegrounds of research. In that perspective, the Pre-event of the first European Conference on Injury Prevention and Safety Promotion, held in Eretria, Greece, from September 29 to October 1, 2005 presented an essential platform for exchange and discussion on prevention actions heartening the ongoing cooperation between all EU Member States. The goal to reduce all types of injuries year upon year remains in the center of our attention.

ELDERLY SAFETY IN EUROPE
BEST PRACTICES POLICY MANUAL

One of the targets of the EUNESE project is to create a best practices policy manual for sustainable injury control and safety promotion in an aging EU society, both independently living and nursing home elderly. The target group for this manual is supposed to be politicians and leading bureaucrats across Europe. The task to develop such a manual has been given to the Working group no. 4 (WG4). A draft of the manual has been delivered in connection with the Pre-event of the First European Conference on Injury Prevention and Safety Promotion in Eretria, Greece at the end of September 2005.

WG4 consists of members from many countries in Europe: Cyprus, Denmark, France, Italy, Liechtenstein, Norway, and Slovakia with Johan Lund from Norway as the group co-ordinator. This broad representation from the north, south, east and west of the European countries should contribute to developing a manual which would cover most of the various safety and caring cultures across Europe.

Another working group in the EUNESE project, WG2, co-ordinated by Ariane van Cutsem from Belgium, has gathered a vast amount of material on morbidity and mortality statistics on elderly injuries from the European countries, as well as on interventions on elderly safety, many of them evidence-based. This material will be evaluated and synthesised by WG4 to be included in the "Best practices manual" to form a valuable basis for the preventative proposals to be given.

There are good reasons for increasing the effort for prevention of elderly injuries across Europe. Elderly injuries already put a heavy burden on the health systems in all European countries, especially the fall injuries. The mortality statistics from the various European countries shows great differences in injury deaths among elderly 65+. Greece and Hungary are the two countries with the lowest and highest fatality rates due to injuries, with 71 and 270 injury deaths per 100,000 per year respectively. The other countries are more or less on a straight line between these two countries. This variation indicates great possibilities for reducing injury deaths in many countries.

The prognoses for the increase of the elderly population in the European countries the next 50 years also show that in most countries there will be a doubling of the elderly population above 65 years. That means that without more efficient prevention activities a doubling of hip fractures will probably occur. There will be more persons suffering, more disabilities, more elderly people with lowered quality of life. Not least, a need for a lot more hospital and nursing home beds for caring for these injured elderly people will arise. Increased injury prevention activities are necessary in order to avoid this situation.

There should be established visions and targets for elderly safety in Europe. A good example is the target from France, to reduce the prevalence of falls in the population above 65 years with 25 % in five years. Similar targets should be established for Europe as well as in the various countries.

Research projects have revealed that the major contributing factors to elderly injuries might be divided in two distinctly different groups which are more of less of the same size (50-50%), i.e. internal and external factors. The internal factors belong to the aging process: reduced vision and hearing, reduced balance, reduced muscle strength and joint flexibility, increased dizziness, sometimes exaggerated medication due to illnesses.

The external factors are environmental as slippery surfaces and soles of the shoes, stumbling pitfalls, poor design of or lacking stepladders, hot water and surfaces, traffic dangers. In order to prevent elderly injuries, it is necessary to intervene towards both of these two groups of contributing factors. The internal factors might be reduced by training, better nutrition, less medication, the external factors especially by environmental and organisational changes.

The policy manual will focus on un-intentional injuries and mainly on the two most important injury groups: fall injuries and road traffic injuries. Evidence-based best practices will be referred to as examples that prevention is possible. There will also be references to some minor injury groups as: fire and flames, drowning, poisonings. These examples will be the base for proposals on concrete injury prevention activities which should be launched in all European countries.

Proposals on how to create infrastructures for injury prevention will be given, both locally and centrally. The WHO-concept of "Safe Communities" is one example of an efficient infrastructure for the prevention of injuries. A remaining challenge is to establish co-operation between central and local levels.

The burden of injuries among elderly is heavy in Europe. There are great potentialities to reduce this burden. This policy manual aims to convince the decision-makers that it is necessary to establish well known injury prevention activities for the elderly all over Europe. Without increased effort, this burden will increase enormously.

An article by Johan Lund, PHD NSF*
Oslo

"Elderly injuries already put a heavy burden on the health systems in all European countries."

**Norwegian Safety Forum is a national center designed to provide information on safety and enhance co-operation between public bodies, non-governmental organizations and trade and industry.*

STATISTIC PORTAL ON ACCIDENT AND INJURIES

A TOOL THAT SIMPLIFIES RESEARCH

The significance of reliable statistics for the research on accidents and injury prevention is incontestable. Through the years, a large number of initiatives and projects have resulted in the availability of a noteworthy number of national and global sources of data and statistics of varying detail, quality, accessibility and codification.

On behalf of the EC and the WP-AI, the Secretariat has launched an ambitious project for the development of a **Statistics Portal on Accident and Injuries** data in close consultation with the Commission Services. The main aim of the Statistics Portal is to become a ***single-entry point*** for accident statistics by integrating, under a ***user-friendly and intuitive interface***, many different European and international accident data sources.

The functionality of the Portal will include:

- Step-by-Step Filtering and Retrieval of Statistics, supported by a collection of different data-sources integrated under a user friendly interface
- Simple and quick access to a selection of important statistics: Using a few mouse-clicks users, even the non-experts, will be able to access meaningful and important statistics (data and charts) covering a wide range of fields
- User-Guide and Links to the various existing data-sources, combined with evaluation, guidelines, availability and accessibility information
- Access to a collection of 'best-practices' documents
- Forums for discussion with other users and field-experts
- Calendar of upcoming events
- Apart from the statistics produced in the context of DG SANCO funded projects on Accidents and Injuries, further data-sources provided by highly regarded systems (e.g. WHOSIS and EDISS) have been considered for integration in the Portal.

The user is able to define step-by-step all the available parameters like the countries of interest (distinct countries or groups of countries e.g. EU15, EU25, candidate countries, etc.), years (distinct years or groups of years e.g. last 3 available years), causes (distinct causes or groups of causes e.g. Falls, Poisoning, Transport), age-groups (detailed or more wide age groups), type of data (e.g. numbers, average of last 3 years, mortality rates) and get back the matching records. At the present stage the pilot version of the portal is updated with more recent data from WHO.

ACTION PILOT PROJECTS

The Working Group "Pilot Projects" has the responsibility to define, formulate, plan and implement "Action Pilot Projects". The Action plan includes the objectives of the pilot projects, the selection criteria, the methodology for the definition, formulation, planning, implementation and assessment of the pilot projects and the dissemination of the results. Likewise, it includes the interim deliverables, the methodology of the pilot projects that directs the independent action plans to proceed.

In short, the main four projects are:

1 "Prevention of falls and fractures among elderly women in Veneto".

The Italian pilot project is developed and implemented by the Azienda ULSS 20 di Verona, in collaboration with the Azienda Ospedaliera and the University of Verona. Its main objective is to prevent falls and fractures that may lead to death among the elderly people (over 65), especially women that appear to be more vulnerable concerning bone fractures.

2 "Prevention of injuries among elderly in two countries of Hungary".

Pilot project realized by the Fodor Jozsef National Center for Public Health in Hungary. It is

designed to take place in two countries of Hungary targeting both on independently living as well as institutionalized elderly. Amid its goals is the improvement of teaching material for students, who will heal and care elderly people.

3 "Injury Prevention among Elderly living in Nursing Homes in the frame of EUNESE project".

The 3rd pilot project is performed by the Health Promotion Unit, Institute of Public Health of the Jagiellonian University Medical College, Krakow, Poland and its prime purpose is to reduce the number of injuries in Nursing Homes.

4 "Virtual modifications of a safe household environment for elderly citizens".

A project realized with the cooperation of two institutions, namely: GERAHM, Groupe d'Etudes et de Recherches pour l'Aide aux Handicapes Menteux from France and CEREPRI, Center for Research and Prevention of Injuries, Greece. The projects includes the design of a virtual 3d visual plot of a house according to the special needs of senior citizens and its demonstration through the EUNESE website.

THE ROYAL SOCIETY FOR THE PREVENTION OF ACCIDENTS POLICY STATEMENT "OLDER DRIVERS"

An article by Janice Cave, RoSPA*, UK

For the purpose of this policy statement, older drivers are defined as drivers over the age of 60 years. However, it is acknowledged that older drivers do not form an homogenous group and wide variations in their characteristics and driving abilities exist within this general category. Older people are a large and increasing proportion of the population. Mobility is vital for people to maintain a full and independent life, therefore, transport policy, vehicle design and the transport environment needs to reflect, and provide for, their needs.

RoSPA does not believe that there should be a maximum driving age beyond which drivers automatically lose their driving license. People age at different rates, thus someone aged 70 years may well be fitter, more alert and active than someone aged 60 years or younger. Research does not indicate that there is an age at which all drivers become unable to drive safely. Setting an arbitrary age limit would inevitably be unfair to some drivers who would be able to drive safely at and beyond the age limit chosen.

However, as people get older, it is inevitable that general health and fitness, eyesight, hearing, reaction time and physical mobility will begin to deteriorate. Since these changes are often gradual, they may not be apparent to the individual concerned or to members of their immediate family or circle of acquaintance. Older drivers may unknowingly experience physical and psychological health problems, which vary widely from individual to individual.

Whilst many older drivers perceive their driving ability has not deteriorated, most do tend to adjust their driving patterns to avoid situations they find difficult, thus reducing their risk of traffic accidents, for example, by avoiding rush hour traffic, night driving and poor weather conditions. There are several areas where action is possible to reduce the road accident risk involving older drivers, each ideally being made available in good time to drivers so that they are able to plan for changes in driving patterns at retirement age.

Medical Checks

Drivers should be encouraged to undergo a formal medical check before renewing their license when they reach 70 years of age, and again each time their license is renewed. Drivers are advised to seek regular medical checks (or at the least, eye checks) from an earlier age. It is noted that vocational drivers are required to undergo medical checks from 45 years of age.

Appropriate information and guidance for primary health care workers is important to assist them in assessing an individual's suitability for driving and to enable them to provide appropriate and sensitive advice.

Serious consideration should be given to a system of compulsory medical checks, and whether such checks might best be conducted by the driver's own GP or by an independent 'driving' doctor.

Awareness, Information and Education

Information, education and publicity are needed to help to raise awareness of the effects of aging, and of the possible effects of medicines on driving performance, amongst older drivers and their relatives. Positive advice on alternatives to driving should be incorporated into any materials and campaigns.

Assessment and Training

Assessment and training courses should be made available to older drivers, tailored to the needs of the individual. Some courses have already been developed. They should include some form of independent assessment as well as encouraging self-assessment by the drivers concerned. However, training needs to be affordable and accessible. The cost, if borne by the drivers themselves, will have a direct effect on the number of drivers willing to take training voluntarily.

The Highway Environment

Older drivers tend to experience particular difficulties in negotiating complex road junctions and in locating and understanding road signs and road-side facilities. Highway design guidelines, and designers themselves should take account of the needs and abilities of older road users.

Vehicle Design

Vehicle designers should take account of the abilities and needs of older drivers too. This is especially important when considering vehicle design and related ergonomics. Vehicle cockpit design and layout is one area where more attention should be paid so that the most-used, and essential controls are in the same places in all vehicles. Action in this field would need to be developed and implemented on an international level. Advanced vehicle telematics may be modified to help accommodate reduced physical ability.

Alternative Transport Modes

Transport planners should be catering for older road users who may be considering giving up driving. It is unlikely that people will consider giving up the freedom and convenience of driving their own car unless there are suitable, safe, clean, attractive, convenient and affordable alternatives.

Planning and land use policies are also crucial, and should be designed to ensure that people (of all ages) have access to local facilities and services, so that the need to travel by car is reduced.

"Older drivers tend to experience particular difficulties in negotiating complex road junctions and in locating and understanding road signs and road-side facilities"

**The Royal Society for the Prevention of Accidents (RoSPA) is a registered charity established over 80 years ago and aims to campaign for change, influence opinion, contribute to debate, educate and inform - for the good of all.*

2ND PROJECT MEETING OF EUNESE IN ERETRIA, GREECE

On October 1st and 2nd, 2005, **CEREPRI**, the project coordinator of the European Network for Safety among Elderly, met with the coordinators and the participants representing most of the 24 European countries involved in the assignment of creating a healthier Europe for the elderly.

The meeting, held at the Hotel Malaconda, in Eretria, Greece, brought together the members of the Steering Committee, Working Group coordinators and the key partners of the project.

Its primal aim was to present and evaluate the 1st year's progress as well as to discuss and collaboratively decide upon the implementation of future activities of the project "European Network for Safety among Elderly" (**EUNESE**).

Working Group sessions were held to define and confirm committed tasks and work plan of each of the five Working Groups created as well as the involvement and participation of the associates.

Dr. Dawn Skelton, University of Manchester, UK, Coordinator of **ProFaNE** –Prevention of Falls Network Europe presented the aim, structure and actions of the network, a project very closely interlinked with EUNESE.

Mr. Malcolm Barrow, Consumer Safety U.K, presented the Internal Evaluators Overview of the project's progress so far. On behalf of Working Group 1, Ms Tea Zevenhuizen, **ECOSA**, The Netherlands, described the navigational structure of the EUNESE Website.

For WG2, Ms Ingrid Vanhaevre, **CRIOC-OIVO** Belgium, made a demonstration of the information gathering, the products delivered so far, tasks achieved, methodological and practical issues, future tasks, timetable and budget of WG2. The Co-coordinator of WG3, Mr. Agis Terzidis, CEREPRI, Greece, presented the progress of the four pilot projects.

Coordinator of WG4, Dr. Johan Lund of the Norwegian Safety Forum depicted the Draft Best Practices Manual and he gave an additional presentation with the modifications agreed upon during the previous WG4 Meeting. WG5, represented at the Meeting by D'Anna Little, **University of Udine**, Italy, portrayed the aim, objectives, work plan and budget of Working Group 5.

The second meeting of EUNESE was a productive attempt to bring up every country to the common goal, the highest level of injury prevention to elderly.

PRE-EVENT OF THE FIRST EUROPEAN CONFERENCE ON INJURY PREVENTION AND SAFETY PROMOTION: TOWARDS A SAFER EUROPE, TIME FOR ACTION

The Working Party on Accidents and Injuries (**WP-AI**) was delighted to be hosting the **Pre-event of the first European Conference on Injury Prevention and Safety Promotion, in Greece, from September 29 to October 1, 2005**. The Pre-event was organized in collaboration with DG SANCO of the European Commission and with the co-sponsorship of the World Health Organization Regional Office for Europe. The event took place at the Hotel "Malaconda" in Eretria, Evia.

The key aim of the conference was to enhance and strengthen the active participation of the new Member States (MS) and candidate countries (Bulgaria, Romania, Turkey and Croatia) towards the reduction of injuries in view of the First European Conference, to be convened in 2006.

The Pre-event aspiration was to provide a platform for exchange and discussion on injury prevention actions initiated over the years by the Commission, WP-AI experts and other relevant organizations as well as encourage ongoing cooperation between all EU Member States, EFTAA-EEA countries (Iceland, Liechtenstein and Norway) and interested stakeholders.

The Pre-event attained to attract a European audience spanning a wide spectrum of disciplines and interests in Injury Prevention and Safety Promotion and did focus on three major pillars in injury prevention:

1) Towards developing information systems on injuries; 2) Addressing the top priority areas in injuries; 3) Implementing prevention strategies in Member States. The scientific program of the event presented innovative topics with plenary sessions, workshops, oral presentations and poster sessions.

The vision of the Working Party on Accidents and Injuries is to reduce all types of injuries year upon year to ensure that the EU is a safe place. To achieve this all MS need to acknowledge the problem and place it on their political agenda. In addition, they need to ensure that the key principles will be incorporated into their national injury prevention strategic plans. This event provided an opportunity for all to world together towards this common goal.

PRESS-CONFERENCE OF THE PRE-EVENT IN ATHENS

A **Press Conference** on the occasion of the Pre-Event of the First European Conference on Injury and Safety Promotion took place on **September, 27 2005** at tbe hotel "Stratos Vassilikos" in **Athens, Greece**.

The Center for Research and Prevention of Injuries (CEREPRI) depicted to the representatives of the greek press a complete preview of the fore coming conference with its objectives, the workshops to be hold, the plenary sessions on topics of concern. In addition CEREPRI provided a Press-Kit to the participants with resourceful information about the invited international associates and speakers of the Pre-event and an in depth depiction of the WHO Regional Office for Europe that co-sponsored the event.

CEREPRI has coordinated over 15 EU projects in the last 5 years and has participated as an active partner in over 15 international projects related to injury prevention. Its results from the scientific work were presented at more than 20 national and international conferences as well as over 35 publications have been published in international peer-review journals.

The conference was graced with the presence of correspondents from major Greek mass media. The interactive discussion and the sharing of information during the Press Conference gave to the Center the possibility to better explain further aspects of the prevention strategies for the reducing of injuries.

CREATING A SAFE HOME FOR THE ELDERLY

Every year, around 100,000 elderly (>65 years) citizens of the European Union die of preventable injuries - 47% of the total number of deaths in this age group. The situation will drastically improve if action is taken so that all the elderly live in a safe home that will fit their special needs and requirements. Until the 1980's the approach to housing for the elderly was disheartening in the often unattractive mix of highly institutional nursing homes, personal care homes of inconsistent quality and a handful of retirement communities).

However, recent efforts to remedy this state of affairs, permitting the elderly to return to their own environment, have yielded some good outcomes, among them, the concept that the needs of the elderly are not reducible to a single, limited set of design solutions. The project has been realized with the cooperation of two institutions, CEREPRI, The Center for the Research and Prevention of Injuries, Greece and GERAHM, Groupe d'Études et de Recherches pour l'Aide aux Handicapés Mentaux, France.

The main objective of the project developed in the context of the Pilot Project "Virtual modeling of a safe household environment for elderly citizens", assigned to the 3rd Working Group of EUNESE is to provide the elderly and experts in related fields (doctors, gerontologists, architects and civil engineers) with simple design ideas and guidelines to make their home safe. To understand why elderly are injured inside their own home, it is important to understand various factors of the problem such as the aging process of the body and its disabilities and the identification of hazardous environments. A well-designed house will not only work around the disabilities that come with aging but will also allow its residents to exercise their remaining abilities as much as possible.

In bringing together and analyzing a large amount of data, and suggesting simple solutions, this project will hopefully appeal to all elderly that are facing problems with their own home and are searching for trouble-free efforts in their everyday life.

The results of the project will be distributed in the following deliverables: An academic report full of pictures and diagrams to be used for students, teachers of gerontology, doctors and anyone interested to learn background information of a safe home. A glossary book, with an A to Z information for the use of elderly mainly accompanied with easy to follow sketches and a technical report for designers, civil engineers and architects. The brochure "Useful Tips of Housing Safety for the Elderly" distributed to all institutions that are directly connected with the elderly. A compact disc containing the 3D visual plot of the prototype house will be created for general use. The ultimate result of this project will be to improve the safety of the elderly, taking in mind their habits and daily needs.

Things you can do to prevent falls:

In the bathroom:

- Keep the floor dry after taking a shower. If possible place a bathroom mat, but secure it properly to diminish the chances of tripping over it.
- Install safety rails.
- Never use a towel rack, soap tray, shelves or similar items that are not anchored in the wall.
- Add non-slip strips to the tub/shower floor.
- If you are unsteady, use a shower chair and a handheld shower attachment.
- Do not lock the bathroom door.
- Install a phone in the bathroom.
- Install a handheld shower hose with extra long cord.

In the bedroom:

- Get up slowly after you sit or lie down. Sit on the edge of the bed/chair until you are sure you do not feel dizzy.
- Wear sturdy shoes with thin, non-slip soles. (Avoid slippers and athletic or jogging shoes with thick soles.)
- Improve the lighting in your bedroom.
- Put in brighter bulbs. You may want to buy compact fluorescent light bulbs that cost less to use. Use lamp shades to reduce glare.
- Organise your clothes for easy reach.
- Place clothes in drawers no lower than your knees or higher than your chest.
- Do not wear clothing that is too long or too loose.
- Keep a telephone within easy reach.
- Avoid using slippery fabrics such as satiny sheets or comforters.
- Install a smoke detector in or near your bedroom.
- NEVER smoke in your bed.
- Install a night light.

In your everyday moves:

- Exercise regularly. Exercise makes you stronger and improves your balance and coordination.
- Have your doctor or pharmacist look at all the medicines you take, even over-the-counter medicines. Some medicines can make you sleepy or dizzy.
- Have your vision checked at least once a year by an eye doctor. Poor vision can increase your risk of falling.
- It is safest to have uniform lighting throughout a room. Add lighting to dark areas. Hang light weight curtains or window shades to reduce glare from bright windows and doors.
- Eliminate obstacles.
- Paint a contrasting colour on the top front edge of all steps so you can see the stairs better. For example, if you have dark wood use light coloured paint.
- Keep emergency numbers in large print near each phone.
- Put a phone near the floor in case you fall and can't get up.
- Think about wearing an alarm device that will bring help in case you fall and can't get up.
- Remove things you can trip over (such as papers, books, clothes, and shoes) from stairs and places where you walk.
- Remove small throw rugs or use double sided tape to keep the rugs from slipping.
- Keep items you use often in cabinets you can reach easily without using a step stool.
- Always keep cabinet drawers closed so you won't stumble over them.
- When lifting an object wear good supportive shoes.
- Keep the object close to your body.
- Place anchored handrails on both sides of stairs.
- When climbing a staircase keep at least one hand on the handrail, concentrate on what you are doing, and don't be distracted by sounds. Also, never carry any package that will obstruct your view of the next step.
- Make sure steps and treads of all staircases are even.
- Make sure stairs are slip resistant.
- Eliminate torn or worn coverings, or folds in the carpet.
- Use a portable phone and keep emergency numbers close.

We are on the web:

www.eurojpn.org

EUNESE NEWSLETTER

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This Newsletter was developed in the context of the EUropean NEtwork for Safety among Elderly (EUNESE), a 36-month project coordinated by the Center for Research and Prevention of Injuries (CEREPRI), of the Athens University Medical School and co-financed by DG SANCO (Directorate C-Public Health and Risk Assessment, Health & Consumer Safety), aiming to address injury prevention and safety promotion among senior citizens through the development of an EU Network.

BECOME A MEMBER OF EUNESE

Register online at www.eunese.org

Center for Research and Prevention of Injuries

UPCOMING EVENTS

* The **Ontario Injury Prevention Conference 2006, March 5-7**, encompasses as this year's theme *"Injury Prevention Through the Ages"*, a program content that addresses injury prevention strategies through the ages and stages of human development. More info on: www.oipc.org/

* The **XXII International Winter Road Congress**, held at **Turin-Sestriere, March 27th-30th**, has as focal point road safety and maintenance for development on road policies. Website: www.aipcr2006.it/

* The **8th World Conference on Injury Prevention and Safety Promotion** will be held in **Durban, South Africa** from the **2nd to 5th April 2006**. The *Data to Action* theme challenges injury and safety researchers, practitioners and decision-makers to discuss ways through and by which information can, and indeed must, be translated into the creation of concrete injury prevention policies and practices in action. For further information: http://www.safety2006.info/

* The **2nd International Seminar on Injury Research Methods, 6-7 April 2006**, will take place in **Cape Town, South Africa**. This year, ECOSA has joined forces with the Medical Research Council in South Africa with the objective to exchange knowledge and experiences on concepts and methods applied in injury research.. See more: http://www.mrc.ac.za/confererence/ecosa/

* The **Cape Town International Convention Center** will host the **15th International Safe Communities Conference** from **9th to 11th April 2006**. In the Conference, entitled *"Creating a Safer Environment"* it is envisaged that a local Safe Communities Network will be established with the aspired membership of several South Africa communities. http://www.uct-cmc.co.za/conferences/2006safecom/info.php

* The **59th World Health Assembly**, the supreme decision-making body for WHO will be held from **22nd to 27th May 2006 in Geneva, Switzerland**. The Assembly is attended by delegations from all 192 Member States and its main focus is to determine the policies of the Organization. http://www.who.int/mediacentre/events/2006

* The **First European Conference on Injury Prevention and Safety Promotion: Challenges for a Safer Europe** will be held in **Vienna, Austria**, from **June 25th to 27th, 2006**. The Conference responds to the European Commission's Public Health Programme and its call for action on injury prevention in Member States. A draft *Communication of the Commission* and a draft *Recommendation to the Council of Ministers and the European Parliament* is currently under consultation with the Member States. More information on: http://www.ecosa.org/csi/ecosa2003.nsf/eurosafe UN

About CEREPRI

*Established in 1991 by the Public Health Department of the Hellenic Ministry of Health, Welfare and Social Securities (OJ Hellenic Parliament 1050/91), CEREPRI (Center for Research and Prevention of Injuries) aims to **reduce the number of people who sustain injuries** in Greece and contributes to international injury research and safety promotion.*

CEREPRI not only conducts epidemiological and statistical programs, but also goes beyond facts and figures to accurately develop prevention strategies in many areas that have not previously been dealt with such as intimate partner violence and accidents and injuries among the elderly.

The Center operates on the premises of the Department of Hygiene and Epidemiology of the Medical School at the University of Athens. The Director of the Center is Professor Eleni Petridou.

For EUNESE members, the Newsletters are also available on the WP-AI Web Board under the forum EUNESE: Newsletter

APPENDIX 6.3 WP-AI Vol 1, Issue 1 February 2005 **(Project Leader)**

Action on Accidents and Injuries

WP-AI

Newsletter of the Working Party on Accidents and Injuries
(Supported by the EC Public Health Programme)

Volume 1 • Issue 1
February 2005

Editorial

As of April 1, 2004 the Center for Research and Prevention of Injuries undertook to fulfill the responsibilities of the Secretariat of the Working Party on Accidents and Injuries (WP-AI) within the framework of the Public Health Programme of the European Commission. During the two-year term, some of the key objectives are to:

- **Maintain, strengthen and expand** the Working Party on Accidents and Injuries
- **Integrate new member states and applicant countries** – develop a informative package regarding injury prevention information
- **Ensure the compilation of injury statistical and epidemiological data** documentation from existing sources in collaboration with the Eurostat and make them available to the Commission
- Development of a **long term strategic plan for injury prevention**

In this issue, the cover page is dedicated to child safety. On December 11, the world celebrated the World Day of Children. It is the responsibility of the Member States, parents and the scientific community to ensure that a child grows up in a safe and healthy environment, strong to face the future with optimism.

We are excited to present the new image of the WP-AI Newsletter. Our goal is to publish current and significant injury prevention facts, research, events and activities not only for the purpose of spreading information but also to act as an interactive resource that will enrich your knowledge. While we are confident that you will find the new content beneficial, we welcome any comments you may have.

Eleni Petridou, WP-AI Secretariat

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FOCUS on child safety

Joanne Vincenten, Director, European Child Safety Alliance

Europe's children, from the very youngest to the oldest, are constantly being exposed to a wide range of dangers that could potentially lead to fatal injuries.

According to the World Health Organisation, injury is the leading cause of death for children in Europe and between the ages of 1 and 14 years, an injury death occurs at twice the rate of a death from cancer, or 8 times that of a respiratory-related death. In this Focus on child safety the leading causes of injury deaths are outlined and how the lives of Europe's children can be made safer is discussed.

The leading causes of injury deaths in the EU are the same in all Member States: road accidents, drowning, homicide, falls, fire and suicide. The newest EU-members in general display higher child injury rates with the exception of Malta and Slovenia.

In most countries road accidents are the leading cause of injury deaths, yet in some countries in Central and Eastern Europe drowning ranks the highest. The third leading cause for countries varies between homicide, falls and fires.

Building commitment

Building commitment is essential in reducing child injury rates. Legislation is necessary to ensure greater safety for our children and it is most effective when it is followed by education and training to enable consumers to understand the purpose the new policy serves. Such communication actions should be part of an overall child safety promotion plan which involves all stakeholders, including business, non-govern-mental organisations, and professional groups.

(photo supplied by Sicher Leben)

At the European level, much can be done to foster this process by giving guidance and direction to Member States in this respect. The European Child Safety Alliance serves as the European catalyst through which national and international networks and activities in child injury prevention are facilitated firstly to enhance advocacy for policy and funding changes and secondly to serve as a communications network to share best practices, successful programming and information needs.

Successful Interventions

Injury prevention is the key to reducing child injury rates and the following interventions have all proven to be extremely successful. This information has been pooled by the European Child Safety Alliance and is derived from sources ranging from the British Medical Association to the European Transport Safety Council. For exact references please see the Alliance publication, 'Priorities for Child Safety in the European Union: Agenda for Action', 2004.

European Network for Safety among Elderly: Kick-off meeting in Athens

For the first time in the recorded history of medicine, mortality among the elderly is declining as fast as mortality among the younger ages and life expectancy for those who have reached the age of 65 increases sharply. Indeed, on the 65th birthday, in the EU-25, a woman can expect to live another 20 years. This is slightly less for a man.

The problem now is how to improve the quality of life of the elderly and reduce the most unacceptable fraction of the mortality due to injuries. Indeed, every year almost 100,000 elderly die in the EU-25, that is more than 250 people every day, of this most preventable cause of death, namely injuries, whereas more than one third of the health care expenditure is spent during the last year of life.

Initiated by CEREPRI and run under the auspices of DG SANCO within the framework of the Public Health Program of the European Union, the **European Network for Safety among Elderly (EUNESE)** Project began on July 1st, 2004 and will run for 36 months. This project involves over 30 partners representing 24 different EU countries and aims to reduce injuries among senior citizens.

Specifically, acquired knowledge and policy prevention strategies will be built upon to establish an EU-wide network of safety promotion among both those who live independently and nursing home/institutionalized residents. Furthermore, a best practices policy manual and commonly acceptable information materials will be developed as well as the implementation of pilot projects to enhance safety, reduce injuries and promote health among senior citizens in the EU.

We feel confident that this project will succeed in making a significant difference in this area of health. Indeed, EUNESE is a project of paramount importance, as there is no other such initiative for the harmonization of policies and the development of a concise strategy on injury prevention among the elderly.

The first project meeting was held on November 22 – 23, 2004 in Athens and 22 participants were present. The aim of this meeting was to discuss the overall objectives and deliverables of the project.

Participants at the Kick-off meeting

Working Group sessions were held to define and confirm the specific tasks and work plan of each of the five Working Groups created as well as the involvement and participation of the partners. The first meeting was a successful event bringing together almost all partners and was a good opportunity to meet together and make more concrete the ongoing collaboration.

For more information regarding the EUNESE project, please contact Eleni Petridou at epetrid@med.uoa.gr.

Injury prevention given priority role in Hungary

Due to the priority role injury prevention has been given at the IV Ministerial Conference held in Budapest 2004 and Hungary's participation as an EU Member State in the Working Party on Accident and Injuries the Ministry of Health is backing a more structured approach towards national injury prevention. In 2005 a strategic plan for injury prevention will be drafted and in 2006 financial support will be made available to implement the plan.

> "In 2005 a strategic plan for injury prevention will be drafted and in 2006 financial support will be made available to implement the plan."

The strategic plan will build on the existing injury prevention and data collection activities. In Hungary mortality data are recorded in line with ICD 10 since 1996. On this basis the external causes of death can be followed. (However, this database besides its benefits lacks the description of the external causes including the environment).

Data concerning traffic accidents have been collected for almost 20 years in the same way. The data are published annually by the Hungarian Central Statistical Office. The latest publication contains data for the year 2003 and is printed in two languages: Hungarian and English.

The collection of work related injuries has a long history too. The latest dataset was generated according to EU standards. The data are collected by the National Labour Inspectorate. This institution publishes the work-related injuries on a quarterly-basis and the Hungarian Central Statistical Office publishes information on a yearly-basis.

Injuries in nursery schools, primary and secondary schools are collected by the Ministry of Education. Data analysing figures covering the whole country between 1993-2001 were published in 2004.

In addition to the permanent data collection listed above, in 2001 and 2003 a representative survey was held in Hungary among adults, connecting there health status and health behaviour. The survey was carried out via face to face questionnaires. On the basis of the database a relationship analysis was made of injuries and their relationship to age, sex, job, alcohol consumption and to certain disorders which can cause accidents. This has not yet been published yet.

In addition, a survey on children aged 0-18 years was carried out with the help of district nurses. Data were analysed by age and sex, the results were put on the website of Ministry of Health. This method will be improved, and widespread all over the country, because it give a lot of information hidden from other sectors of health care.

With the implementation of the strategic plan for injury prevention in 2006 Hungary should become a safer place for both children and adults.

For more information please contact Dr. Mária Bényi at benyi.maria@fjokk.hu.

APPENDIX 6.4 WP-AI Vol 1, Issue 3, September 2005 **(Project Leader)**

Vol. 1, issue 3, September 2005

ACTION ON ACCIDENTS AND INJURIES

Newsletter of the Working Party on Accidents and Injuries (supported by the EC Public Health Programme)

WP-AI Editorial

The basic principles of the European Union are the freedom of movement of people, goods, services and capital. In the growing single market, millions of people and products are being transported in greater quantity and speed. Yet, with this increase in mobility, factors such as congestion, pollution and road accidents are also on the rise. Transportation is a vital part of our every day lives and we use roads for business and personal purposes. Nevertheless, nearly 50,000 people die a year due to road accidents. Actions are being carried out in efforts to reduce road traffic accidents. This issue focuses on road traffic accidents, the FOCUS article is attributed to vulnerable road users and on page 3 you will find an interview with the President of FEVR.

We are delighted to inform you that the Pre-event will be taking place this month and invite you to visit our site to register on-line if you have not done so already - http://195.134.113.92/keepasite/pre_event/ There will be two sessions dedicated to new member states and accession countries. During these sessions, experts will present an overview of the injury burden in their new MS, the surveillance systems, interventions, policies and future challenges. In addition, we are honoured to have Mr. Trakatellis, EuroParliament, as a key speaker during the closing ceremony. He will talk about the challenges and perspectives of the Public Health in the EU.

Finally, http://www.actiononinjuries.org, the website of the WP-AI is under construction and will be launched in October 2005. The site will serve to promote the prevention of accidents and injuries by disseminating results derived from projects and research, information and good practices. In regard to the coming launch of the website we are pleased to introduce a slightly different design of the Newsletter.

Your comments are, as always, very welcome.

Eleni Petridou

WP-AI Secretariat

Table of Contents

FOCUS on Vulnerable Road Users

By Frazer Goodwin, Policy Officer, European Transport Safety Council (ETSC)

Venturing onto the road continues to be one of the most risky activities we all engage in during our daily lives. In the EU 25, nearly 50,000 lives are lost annually due to road accidents, while approximately 2.5 million injuries occur.

To put this into another context, it is the same number of lives lost in just over a year as the USA lost during the entire Vietnam War. According to the WHO (World Health Organisation), road accidents and injuries are the ninth highest global cause of DALYs (disability adjusted life years) and are set to be the third highest by 2020 - above HIV/AIDS, tuberculosis, diarrhoeal diseases and war[1].

"In the EU 25, nearly 50,000 lives are lost annually due to road accidents while, approximately 2.5 million injuries occur."

Moreover, it does not matter which type of road transport you use, car, bus, bicycle or walking, all are risky as the appropriate evidence based measures to reduce traffic injuries have not been fully implemented. However, the most vulnerable on the road are those unprotected by an outside shield, namely pedestrians and two-wheelers[2]. Vulnerable road users have a fatal accident risk 7 to 9 times higher than those travelling by car over the same distance[3]. This situation has been compounded by the fact that the greatest efforts in improving road safety have focused on car occupants. Continuing and strengthening these efforts remains important, but it is also vital that transport safety begins to give much more attention to protecting the most vulnerable of our road users.

Furthermore, the situation across Europe for vulnerable road users is as mixed as the general road safety picture. Unsurprisingly, Member States that have a poor record overall on road safety also have a poor record for vulnerable road users. In Poland for example, 45.8% of road deaths are pedestrians or cyclists, whereas the EU average is 24%[4] and this is in a member state where the factors that make roads dangerous such as older vehicles, poor road conditions and low levels of traffic law enforcement all mean that car occupants themselves already have a high risk. The relative risks for vulnerable road users are therefore extremely high.

What is more surprising, however, is that some Member States that have a comparatively good road safety record overall still have high levels of risk for

process by completing an assessment of current leadership, infrastructure and capacity to support child safety in each of their countries. In addition each partner has been working to engage government and national stakeholders to participate in the development of an action plan. National level action planning will begin in 2006.

Regular updates on the project are also available in the CSAP Communiqué, a quarterly newsletter that is available on the Alliance website at http://www.childsafetyeurope.org

For more information on the project please contact the Project Secretariat at secretariat@childsafetyeurope.org

European Network for Safety Among Elderly (EUNESE)

This past July the European Network for Safety among Elderly concluded its first year. The aims of EUNESE are not only to act as a platform for the exchange of information and expertise between health practitioners, but also to take a proactive approach in order to reach both the public and policy-makers and ensure that the health of elderly citizens is placed at the centre of Europe's political agenda.

So far 54 organisations (mostly universities and health care organisations) from 16 European countries have joined the network. Existing members are expected to act as a catalyst for the further recruitment of possible associates and the expansion and strengthening of the network. Sustainability of the network is going to be evaluated during the following years of the project's term. The website of EUNESE, which is currently under development, is expected to be introduced this coming October at the next project meeting.

Both intentional and unintentional causes of death due to injuries among the elderly population (65+), were extracted from WHO's mortality data and used for the calculation of the age-adjusted mortality rates for both intentional and unintentional injuries among senior citizens. Based on the analysis of the data, a document entitled "Patterns and suggested explanations for the differential injury mortality among elderly in the EU-25" was circulated among the EUNESE Partners for comments. The document contained a comprehensive and descriptive outline of the main findings of WHO's mortality data analysis. It also provided valuable information regarding the main causes of death among the elderly due to injuries, by

2. Integrating road safety within sustainable transport and public health policies

When road safety becomes an integral aspect of sustainable transport, the potential additional contribution of such measures as reducing emissions of noise and air pollutants and providing conditions that can promote walking and cycling that were originally designed to achieve other health or environmental protection goals becomes apparent. In addition, the range of strategies available to improve road safety becomes broader and more cost-effective, as investments deliver multiple health benefits compared with piecemeal approaches.

For example, maintaining speeds below levels that may cause death or serious injury not only saves the costs of avoided injuries but also saves costs resulting from air pollution, noise and the barrier effect created by the fear of vulnerable road users to engage in walking and cycling and the resulting health risks related to sedentary lifestyle.

3. Strengthening the role of the health sector

The health sector should consider developing stronger leadership in road safety to be an essential part of its core business and a way of fulfilling its mission of protecting the human right to health. In particular, the health sector should:

- become the leading advocate for road safety;
- provide evidence-based information;
- become active in promoting the demand for greater safety;
- lead research and innovation, and
- mainstream road safety into the policies of other sectors and into the public health agenda.

More information from WHO Europe: http://www.euro.who.int/violenceinjury
Contact: violenceinjury@ecr.euro.who.int

References

1. The World Report on Road Traffic Injury Prevention can be downloaded from http://www.who.int/world-health-day/2004/infomaterials/world_report/en/; the report Preventing road traffic injury: a public health perspective for Europe can be downloaded from http://www.euro.who.int/violenceinjury/injuries/20040326_2

2. The WHO European Region includes 52 Member States

IDB RE-LAUNCHED (Project update)

The IDB Re-launch and Seminar on the 28th and 29th of June 2005 in Luxembourg not only marked the mid-term of the Injury Database Project of the Public Health Programme 2003. It also marked the beginning of a new chapter in the short but nevertheless turbulent history of DG SANCO's central Injury Database: Going public.

The IDB as an internet database was set up under the Injury Prevention Programme in 1999 in order to provide central access to the data collected in the Member States under the EHLASS Programme since 1993. The IDB – then under the name Injury Surveillance System – was rolled out in the participating Member States in 2000 and 2001. However, mainly because of organisational shortcomings, indicated also by the frequent changes of name, this database has led quite a secluded existence.

Preparing for going public and a substantial gain in visibility hence is the main objective for second half of the IDB project. The main prerequisites for the IDB re-launch were presented and discussed at the Luxembourg IDB seminar. These were: draft of the IDB homepage, new IDB query tool, IDB public access dataset and IDB terms of use and data delivery.

Besides an update on IDB product development, under the chair of Horst Kloppenburg, the seminar also featured various presentations on virtually all aspects of national and EU-level use and usefulness of the IDB – given by Birthe Frimodth-Moller, Saakje Mulder, Lucia Masiero, Rupert Kisser, Renzo Pace Asciak and Marc Nectoux to name just a few.

This IDB seminar focussed on the achievements of the "old" IDB network, the EU-15 network on Home and Leisure Accidents. The next seminars will certainly focus on an exciting new IDB development – the All Injury data collection in the new Member States.

Contact: robert.bauer@sicherleben.at

comparing the corresponding mortality rates among the EU25 countries. In addition, a first draft has been developed which includes retrieved resources such as:

- Articles, publications, research papers pertaining to injury prevention and safety promotion among seniors.
- Related websites & organisations
- Information regarding implementation and effectiveness of elderly injury prevention policies, practices and activities.
- Demographic data regarding the increase of elderly population (65+) in Europe.
- Morbidity data, mainly on falls and road traffic accidents, among seniors from five European countries.

These initial lists of resources will be further supplemented and updated throughout the project.

Four operational pilot projects from four Member States have been implemented. These aim to translate policy priorities into specific operational projects, pilot studies and potential guidelines that would create measurable injury prevention efforts geared towards the various sub-segments of the elderly population. These are elderly who are self sufficient (whether living alone or with a partner) and those who live in supportive communities. The emphasis is on evidence-based priority topics (such as injuries among senior residents living in nursing homes and rehabilitation centres, pedestrian injuries, etc.).

A best practices policy manual on sustainable injury control and safety promotion in an aging European society, both for seniors living independently as well as for seniors residing in nursing homes, is being developed. The manual will detail cost-effectiveness and evidence-based best practices for prevention of injuries in the elderly population. A draft manual will be presented at the EUNESE meeting in October.

The second project meeting is on 1-2 October, 2005 in Eretria, Greece. This meeting aims to evaluate the progress of the project so far, enhance the active involvement of all the partners, and to systematise and schedule the future activities of the project.

Contact: sdikal@med.uoa.gr

EVENTS

WP-AI Meeting

To be confirmed

2005

14-16 September
The 1st Safe Community Conference on Injury Surveillance
E-mail: jon-andreas.jenssen@trondheim.kommune.no
Web: http://www.trondheim.com/safecity

29 September– 1 October, Eretria, Greece
Pre-Event to the First European Conference on Injury Prevention and Safety Promotion Towards a Safer Europe: time for action
E-mail: sanast@med.uoa.gr,
Web: http://195.134.113.92/keppasite/pre_event/

4-7 October, Madrid, Spain
Trafic
E-mail: trafic@ifema.es
Tel: +34 9172 25790

November 6-8, Halifax, Canada
Canadian Injury Prevention and Safety Promotion Conference
Evidence to Action: Injury, Violence and Suicide Prevention
Tel.: +1 613 798 8029
E-mail: purpledog@sympatico.ca
Web: http://www.injurypreventionconference.ca

November 9-11, Karlstad, Sweden
6th Nordic Safe Communities Conference
Conf. Secretariat: Janet Edwards
E-mail: janet.edwards@srv.se
Web: http://www.raddningsverket.se/nscc

November 14-15, Solihull, England
Reducing risks and injuries at home: National home safety congress 2005
Tel.: +44 870 777 2120
E-mail:events@rospa.com
Web: http://www.rospa.com

2006

27-30 March, Torino, Italy
XII International Winter Road Congress, PIARC
E-mail:piarc2006@congressiefiere.com
Website: www.aipcr2006.it

1 April, Durban, South Africa
6th International Conference on Measuring the Burden of Injury
More information: Stephen Luchter
E-mail: sluchter@earthlink.net

2-5 April , Durban, South Africa
8th World Conference on Injury Prevention and Safety Promotion
Web: safety2006.info

April 6-7, Cape Town, South Africa
2nd International Seminar on Injury Research Methods
Organised by ECOSA-Eurosafe & the Medical Research Council, Cape Town
More information: Saakje Mulder
E-mail: s.mulder@consafe.nl
Web: http://www.mrc.ac.za/conference/ecosa/index.htm

If you would like your event to be listed in the Agenda please contact j.cooper@consafe.nl

Working Party on Accidents and Injuries

The WP-AI was established in 2003 under the guidelines laid out by the Council and the European Parliament and replaces the former Injury Prevention Programme (IPP). The aim of the WP-AI is to support public health activities that seek to reduce all accidents and injuries.

Co-ordinating Secretariat (April 2004 to March 2006)

Eleni Petridou, Project Leader and Stephanie Anast, Collaborator, Center for Research and Prevention of Injuries Medical School, University of Athens. *For enquiries please contact Stephanie at sanast@med.uoa.gr*

Newsletter Editorial Board

E. Petridou, Medical School, University of Athens, Greece

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B. Thelot, Institut de Veille Sanitaire

Y. Rahim, Norwegian Safety Promotion Centre

Editor & Design

Justin Cooper: *For editorial matters please contact Justin at: j.cooper@consafe.nl*

For WP-AI members, the Newsletters are also available on the WP-AI Web-Board under the forum Function II: Dissemination

APPENDIX 6.5 Safe Community Weekly News (SCWN) (**Project Leader)**

KAROLINSKA INSTITUTET
Department of Public Health Sciences
Division of Social Medicine

WHO COLLABORATING CENTRE
ON
COMMUNITY SAFETY PROMOTION

SAFE COMMUNITY WEEKLY NEWS

No. 15
June 2006

******* LETTER FROM THE EDITOR*********

Welcome to the fifteenth issue of Safe Community Weekly News in 2006, the electronic Safe Community Weekly News is edited by the European Safe Community Network, International Safe Community Support Team and the WHO CC on Community Safety Promotion on behalf of Safe Communities Network.

WHAT IS NEW AT SAFE COMMUNITIES?

In this issue:

CONFERENCE: **4th Asian Regional Conference on Safe Communities, Thailand**
SITE VISIT: **Safe Community site visit to Townsville/Thuringowa, Australia**
CONFERENCE: **International Conference on Injury Prevention and Safe Community Development, Vietnam**
AWARDS: **VSCN wins the Practitioner Award in the 2005 Community Safety - Crime Prevention Awards', Australia.**
PROGRAM: **Finding unsafe spots in the Neihu Safe Community, Taiwan**
NETWORK: **EUNESE: EUropean NEtwork for Safety among Elderly**
SEMINAR: **Seminar on Child Traffic Injury Prevention, Czech Republic**
BOOK: **Injury and Violence Prevention: Behavioral Science Theories, Methods, and Applications**
VIDEO: **Fire Safety Promotion Activities in Youth Park Community, Jinan, China**

****

4th Asian Regional Conference on Safe Communities, Bangkok, Thailand

www.safethai2007.com

'Incorporating Global Thinking; Cultivating Local Strategy'

November 2007:
21-24 Conference;
25-26 Tsunami Site visit

loga 1

Information: johnny@stjohn.ac.th
raapp@mahidol.ac.th

EUNESE: EUropean NEtwork for Safety among Elderly

www.eunese.org

EUNESE: EUropean NEtwork for Safety among Elderly (EUNESE)

Initiated by **CEREPRI** and run under the auspices of **DG SANCO** within the framework of the **Public Health Program** of the **European Union**, the EUNESE Project began on July 1st, 2004 and will run for 36 months. This project involves over 30 partners representing 23 different EU countries and aims to reduce injuries among senior citizens, both independently living as well as elderly living in residential care settings. It's main objective is to **build a strong and sustainable Network** aiming **to identify the common EU priorities** in injury **prevention and safety promotion for the elderly within the EU.**

If you wish to:

- **Disseminate your Institute's Good Practice**(s) and **projects** related to injury prevention and safety promotion for the elderly, through EUNESE's Newsletter and/or website (downloadable Project Registration Form at www.eunese.org → *Projects*)
- **Share** with us any **news** you think that may be of interest to the EUNESE Network
- **Become a member of EUNESE** (downloadable Application form at www.eunese.org → *Member area* → *become a member*)
- **Subscribe** to receive **EUNESE's Newsletter** (for non-members)

Please contact the Project Coordinator, Kiki Petroulaki, at eunese@med.uoa.gr or visit our website at www.eunese.org to download the respective form(s).

Disseminating Good Practices and Policies across Europe
for the reduction of
Road Traffic Injuries, Alcohol related Injures and Occupational Injuries

Initiated by CEREPRI and run under the auspices of DG SANCO within the framework of the Public Health Program of the European Union, the **APOLLO Project** (Strategies and Best Practices for the Reduction of Injuries), began on December 1st, 2005 and will run for 36 months. The project is divided into six Work Packages.

One of the main aims of **Work Package 3** is to identify ways to **overcome the barriers** in applying good practices and efficient policies to achieve tangible prevention of unintentional injuries in all age groups, focusing on **Road Traffic, Occupational**, and **Alcohol related injuries.**

If your Organisation is involved in injury prevention, or if you are aware of any evaluated and proven effective **practices and policies** related to prevention of Road Traffic, Occupational, or Alcohol related injuries and **you would like to share them with us**, please contact the WP-3 project Coordinator, Kiki Petroulaki, at apollo-wp3@med.uoa.gr

For Further information please contact the Project Coordinator, Kiki Petroulaki, at eunese@med.uoa.gr

APPENDIX 6.6 Progress Report for Secretariat **(Project Leader)**

Please email the completed form to the Secretariat no later than November 14, 2005.
Email: sanast@med.uoa.gr

Title of project:	European Network for Safety among Elderly (EUNESE)
Start Date and duration:	1st July 2004 36 months
Project Leader and institute:	Eleni Petridou Center For Research and Prevention of Injuries (CEREPRI) Department of Hygiene and Epidemiology Medical School, Athens University, Greece
Progress period:	January 2005 to December 2005.
Number:	Agreement Number – 2003316

This form was completed by: Kiki Petroulaki
Date: December 1, 2005

1. What were the main objectives during this period (as of January 2005) and to what extent have they been achieved?

a. Building a European Network of experts on the field of injury prevention and safety promotion among the elderly
b. Gathering and systematizing all pertinent information
c. Implementing four pilot projects and developing materials for dissemination
d. Developing a Draft Best Practices Policy Manual on Elderly Safety

2. Recent developments and progress

Provide a complete record of recent tasks/activities being carried out as of March 2005.

WG1

Membership Criteria & Application Procedure of the EUNESE network

- Development of the criteria for membership
- Development of the application procedure and form

Structure and Organization of the Network

- Recruitment of members
  - 76 members (actual and future) from 24 European countries

List of future members and assessment of their possible contribution

- Analysis of data from the need assessment study and conclusions drawn:
- Needs Assessment Report
- Membership Database

EUNESE Network Website

- Construction of the Web Site
  - demonstration version (based on the needs of the potential members)
  - pilot-tested during a meeting in Amsterdam

WG2

List of related information Sources

- A list of information sources relevant to the program were listed and grouped into 8 categories (Association, General health, Organization, Prevention, Pub Libraries, Quality Review, Training, Various)

Gathering and systematisation of Mortality Data (CE.RE.PR.I.)

- WHO's data on mortality due to injuries
  - was filtered according to the project's scope and target population (65+)
  - was used to calculate age-adjusted mortality rates for intentional & unintentional injuries
  - led to the production of a document entitled "Patterns and suggested explanations for the differential injury mortality among elderly in the EU-25"
    - indicating the main causes of death among the elderly due to injuries
    - comparing the corresponding mortality rates of the EU25 countries

Gathering and systematisation of Morbidity Data (CE.RE.PR.I. & CRIOC)

- EDISS Database, Greece, registered information includes (CE.RE.PRI.)
- National Statistical Service of Greece (NSSG): Non-fatal injuries data processed to produce hospitalisation rates for femoral fractures (CE.RE.PRI.)
- A Morbidity Data series for six (6) EU countries (raw data) retrieved by CRIOC

Literature Review: Articles, Publications and Research Papers

- Relevant literature collected

Information regarding application and effectiveness of elderly injury prevention

policies, practices and activities

- Developed an information collection form
- Collected interventions from 10 countries. Interventions reported in English (13) were summarized by CRIOC in an Access Database
- Set a strategy for gathering additional interventions
- Literature Review of best practices (COCHRANE Review)

WG3

- Definition of the methodology of the pilot projects
- Detailed description of each pilot project, including methodology
- Implementation of the pilot projects

Pilot Project 1. Prevention of injuries among elderly in two counties in Hungary

- a) Institutionalized elderly
  - Questionnaire on risk factors, type of institution, and type of injury was developed
  - Survey was conducted among physicians working in all Nursing Homes (31)
  - Data were collected and analysed
- b) Independently living elderly
  - Two questionnaires on environmental and medical risk factors and type of injury were developed
  - Data were collected from 314 independently living elderly
  - Collected data are being currently analysed

Pilot Project 2. Prevention of falls and fractures among elderly women in Veneto, Italy

- A questionnaire (with three sections) was developed
- Administrated to elderly female that were hospitalized due to a fall that caused a fracture
  - 100 questionnaires have been collected

Pilot Project 3. Injury prevention among elderly living in Nursing Homes in the frame of the EUNESE project, Poland

- Feasibility study for the implementation of the project
- Tools development

- Questionnaire assessing the structure of the nursing home institutions

· Falls monitoring chart
· Developed the content of the training for intervention in Nursing Homes
· Organized the training of Nursing Home Staff
· Implemented the falls monitoring systems in three Nursing Homes

Pilot Project 4. Virtual modeling of a Safe Household environment for elderly citizens, France-Greece

· Literature review and experts' consultation
· Developed a leaflet with safety tips for the elderly
· Developed a draft of the Home-safety glossary
· Developed the first draft floor plan of the prototype house

WG4

- Literature and interventions review for the best practices manual (+WG2)
- Edited 1st draft of the Best Practices Policy Manual (injury control and safety promotion for independently living and institutionalized elderly)
- 1st revision of the Manual (Eretria, Greece, September 2005)
  - Suggestions for the quality evaluation process
- Edited 2nd draft of the Manual

2b. Meetings

Outline recent meetings, outcomes and/or next planned meeting

WG4 Meeting in Paris April 14th-15th 2005

The reason for the meeting was for the members to become acquainted with each other and to start the process of discussing the content of the first deliverables of the group: The best practices policy manual on elderly safety in Europe. Ariane Van Cutsem was especially welcomed to the meeting as the work of WG4 is very much dependent on the information gathered by WG2.

Specific outcomes were the adoption of a draft content of the policy manual aiming to convince the policy-makers that it is necessary to establish injury prevention activities for the elderly throughout Europe. Through the presentation of evidence-based best practices, the manual should also demonstrate that it is possible to reduce elderly injuries. It was agreed that intentional injuries (suicides and violence) should be excluded from the manual. Best practices on three injury types are going to be presented, namely: a) falls, b) road traffic accidents, and c) the remaining injuries as one group: drowning, fire and flames, poisonings etc. Finally, the WG4 agreed on the amount of information that should be provided by WG2 to be used for the synthesis of the best practices policy manual

WG Coordinators Meeting, June 15th 2005

A meeting of the Work Group Coordinators was held on June 15, 2005 in Bergen, Norway. The objective of this meeting was to discuss the progress, deliverables, barriers and future perspectives of the project. Additional points of discussion were the deployment of the most effective ways to enhance active interaction among EUNESE members (meetings, use of the WP-AI Web-board, comments on the project's deliverables) the linkage to other related injury prevention projects, the development of the EUNESE website (content-outline, user-friendly for elderly), as well as fund raising.

The need for better cohesion and communication among the project partners was stressed. The project outcomes so far were presented by each of the Coordinators and the obstacles that could cause any delay were sufficiently addressed.

WG2 Meeting in Brussels, July 7th 2005
The meeting was held to provide support to Working Group 2, to identify and report progress of WG2 towards the required deliverables, to identify and remove any barriers, and to facilitate meeting the agreed timetable and programmes of work to ensure that all requirements are met.

WG1 Meeting in Amsterdam, September 5th 2005
This meeting was scheduled in order to provide the WG1 Coordinators with the input of Working Group 1 members and of the Coordinators of the other work groups concerning the structure and content of the website. During this meeting the website pilot tested.

WG4 Meeting in Eretria, Greece, September 28th – 29th, 2005
This meeting was held in order to review, discuss and suggest proposals for the draft Good Practices Policy Manual, which the WG4 Coordinator had delivered on 17 September, 2005 in order to allow partners to be prepared to make comments. During this meeting, the draft was thoroughly reviewed, all of its details were commented on, and specific proposals were made for its revision, by WG partners, Antero Heloma and CEREPRI. The main concern that the manual should reflect the EU picture with regards to the top five causes of injuries has been successfully addressed.

2nd Project Meeting in Eretria, Greece, October 1st-2nd, 2005
During the 2nd EUNESE Meeting, all Working Groups had the opportunity to present their work progress so far. Future action plans were discussed in detail and agreed upon, in order to ensure integration and consistency of progress. In this context, any existing or anticipated barriers were addressed and the most effective ways to overcome them were identified.

Planned Meetings
Steering Committee Meeting, Luxembourg, December 7th, 2005
This meeting will be held in order to finalize the work plan for the Working Groups for the next two years of the project's life. Future tasks and timetables will be discussed, as well potential future barriers and solutions will be proposed.

3rd Project Meeting in Vienna, June 2006

3. Completed deliverables (if applicable)
Present finalized deliverables and include preliminary recommendations (if possible)
There aren't any finalized deliverables yet as the project is still in the first year of its life and it was not anticipated to have finalized deliverables during this time.

4. Concerns or difficulties
Present any difficulties with regards to the administrative and technical aspects of the project together with alternative recommended solutions.

Due to the large number of partners a great effort is required to be invested in the management of the project. It also made it difficult for all of the partners to participate in the meetings.
Flexibility from both the partners' and coordinator's part is the only effective strategy that can be proposed to overcome this type of barriers.

5. What are the main objectives for the next six months?

- Strengthen and expand the Network
- Design a study that will assess the sustainability of the Network
- Design the evaluation of the Network and the project's products
- Upload information on the EUNESE website
- Develop information materials
- Disseminate information and products (through the EUNESE website and otherwise)
- Continue the implementation of the pilot projects
- Evaluate & finalize the Policy Manual

Thank you for answering these questions.