Criteria for European Network for Safety among Elderly (EUNESE)

In order to create a network with experienced experts in the fields of injury prevention, geriatric health and advocates for senior citizens, the Steering Committee agreed upon the following membership criteria. These criteria will guarantee a network of highly experienced people. These members will act as catalysts to invite newcomers. The network will consist of (representatives of) member organisations that meet all the following criteria.

Potential membership:
- The network members are likely to be from organisations that are concerned with either implementing safety promotion programs among elderly on a large scale or research studies concerning safety of elderly (features, causes of accidents, risk factors, promotion strategies etc.).
- The network members must be settled in a European country. With “European” the following countries are meant: 25 EU countries, 3 EFTA countries and 4 nominated countries. In addition to the European members of the network, the network will work together with the WHO, EU and ECOSA on this project.

Benefits for members:
The main benefit is that the highest level of injury prevention among elderly becomes accessible to all European countries. In more specific terms the benefits of membership of the network are the following:
- Access to information (fact sheets, figures, good practices, tools)
- Accessibility to experts / professionals working on safety promotion among elderly people.
- Handbook of good practice (what does work, what doesn’t work)

Terms of reference of the Network:
- Exchange and sharing of information of research, interventions and products.
- Development of partnerships.
- Implementation / promotion of good or promising (evidence based) practices in European countries.
- To influence key decision makers and leaders at a national and European level to enhance public health policies and funding for elderly safety promotion initiatives.
- To establish a European Network for safety among elderly on a long-term basis.

Contribution
With their application for membership an organisation has to demonstrate their contribution to the terms of reference.
The members contribute both financial by attending meetings at their own expense and practically. With the application the organisation also agrees to share information on good practice or research results.

The potential network member has to fit in one of organisations in table 1 and be able and willing to make the mentioned contribution. Only an organisation that fits in one or more of the table 1 described categories can apply for membership.

<table>
<thead>
<tr>
<th>Organisation:</th>
<th>Contribution</th>
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<tbody>
<tr>
<td>(Semi) public agencies for well being and/or community care, addressing also the issue of the 'Third agers'.</td>
<td>They put the subject on their national agenda and seek research or good practice information in their country.</td>
</tr>
<tr>
<td>Research institutes with studies on safety promotion among elderly (features, causes, risk factors, promotion strategies etc.)</td>
<td>Share research results and deliver input for a good practice manual.</td>
</tr>
<tr>
<td>Universities with studies on safety promotion among elderly (features, causes, risk factors, promotion strategies etc.)</td>
<td>Share research results and deliver input for a good practice manual.</td>
</tr>
<tr>
<td>Organisations with capacity for in implementation of safety promotion projects on a national scale, e.g. also for elderly safety.</td>
<td>Share (good) practice about implementation of promotion programs. Seek additional contributions in their own country.</td>
</tr>
<tr>
<td>National branch organisations working with elderly care or national organisations providing services for elderly.</td>
<td>Opening to logistic networks for dissemination. Implementers.</td>
</tr>
<tr>
<td>National lobby associations for elderly or representative of seniors themselves (target audience involvement)</td>
<td>They can influence national and European policies. They may also be a partner with implementation of safety promotion programs</td>
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</table>

Table 1. List of potential member organisations and their possible contributions to EUNESE. N.B. In addition to table 1 it has to be remarked that one organisation or institute may fit in more than one category. That will depend on their national organisational structure.
APPENDIX 1.2

Questionnaire about the needs and expectations of its (potential) members

EUNESE

European Network for Safety among Elderly

Questionnaire
The questionnaire

With this questionnaire our goal is to gather as much information as possible about the different organisations in Europe which are working in the field of safety promotion among elderly.

We kindly invite you to fill in this questionnaire as detailed and complete as possible. If your organisation is not operating within the field of safety promotion for elderly people, would you please fill in part A (question 1 to 4) and return the questionnaire? This is to know that you are not working in this field and we will not bother you with reminders to send us the questionnaire. Last but not least, please note that filling in the questionnaire will only take 10 to 15 minutes of your time.
# A. Your organisation

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<th>Name</th>
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<th>Website</th>
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</table>
1) What is the mission statement of your organisation?

2) What kind of organisation is the organisation you are working for?
   (More than one answer possible)
   - (National) Government
   - (semi) public agencies for well being / community care
   - Research institute
   - University
   - National branch organisation
   - (National) Health Organisation
   - Organisation representing elderly
   - (National) organisation for Consumer Safety Promotion
   - Non Governmental Organisation (NGO)
   - Other, please specify:

3) What kind of professionals and advocates you think should benefit from the EUNESE network?
   (More than one answer possible)
   - Researchers
   - PR officer
   - Medical professionals
   - NGO staff
   - Consultants
   - Project co-ordinators, please specify:

   - Other, please specify:
4) **In what kind of way is your organisation involved in safety promotion for elderly?**
   (More than one answer possible)

- Research
- Health promotion
- Geriatric care
- Safety promotion
- Policy development
- Design for all
- Traffic injury prevention
- Fire safety
- Fall prevention programs
- Other, such as:

- Not involved in safety for elderly people

⇒ **Thank you for filling in this questionnaire.**
   **Please return it to the return-address!**

5) **Concerning the most important area you filled-in in question 4, what specific elderly safety topic are you / your organisation working on?**

6) **How many years has your organisation been involved in projects /programs for safety promotion among elderly?**
   years

7) **What potential benefits does EUNESE offer your organisation?**
B. Needs and expectations of information

Please tick your answer on a scale from 1 to 6 (1 is not important, 6 is very important)

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<tbody>
<tr>
<td>1) EUNESE functions as an international centre of information about safety promotion among elderly</td>
<td>Not important</td>
<td>1 □</td>
<td>2 □</td>
<td>3 □</td>
<td>4 □</td>
<td>5 □</td>
</tr>
<tr>
<td>2) EUNESE gives information about different projects / programs on safety promotion among elderly in different European countries</td>
<td>Not important</td>
<td>1 □</td>
<td>2 □</td>
<td>3 □</td>
<td>4 □</td>
<td>5 □</td>
</tr>
<tr>
<td>3) EUNESE contributes to the exchange, improvement, and evaluation of information about safety promotion among elderly in the European Union</td>
<td>Not important</td>
<td>1 □</td>
<td>2 □</td>
<td>3 □</td>
<td>4 □</td>
<td>5 □</td>
</tr>
<tr>
<td>4) EUNESE functions as a permanent platform for discussion, exchange of ideas and information (virtual conference)</td>
<td>Not important</td>
<td>1 □</td>
<td>2 □</td>
<td>3 □</td>
<td>4 □</td>
<td>5 □</td>
</tr>
<tr>
<td>5) EUNESE gives a summary of recent research and intervention projects, programs on safety promotion among elderly in the European Union</td>
<td>Not important</td>
<td>1 □</td>
<td>2 □</td>
<td>3 □</td>
<td>4 □</td>
<td>5 □</td>
</tr>
<tr>
<td>6) EUNESE can be consulted about “good practices” of safety promotion projects for elderly</td>
<td>Not important</td>
<td>1 □</td>
<td>2 □</td>
<td>3 □</td>
<td>4 □</td>
<td>5 □</td>
</tr>
<tr>
<td>7) A good practice manual should be provided by EUNESE for the projects / programs on safety promotion among elderly</td>
<td>Not important</td>
<td>1 □</td>
<td>2 □</td>
<td>3 □</td>
<td>4 □</td>
<td>5 □</td>
</tr>
<tr>
<td>8) EUNESE provides statistical data and information about injuries among elderly in Europe</td>
<td>Not important</td>
<td>1 □</td>
<td>2 □</td>
<td>3 □</td>
<td>4 □</td>
<td>5 □</td>
</tr>
<tr>
<td>Question</td>
<td>Rating Options</td>
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<tr>
<td>9) EUNESE provides fact sheets with information about safety products for elderly</td>
<td>Not important 1 2 3 4 5 6 very important</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10) EUNESE provides an up-to-date list with published reports and information about safety promotion among elderly</td>
<td>Not important 1 2 3 4 5 6 very important</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11) EUNESE provides a “who’s who” list of professionals and advocates working on safety promotion among elderly</td>
<td>Not important 1 2 3 4 5 6 very important</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12) EUNESE opens up all kinds of information, consultation, and results via an internet-website</td>
<td>Not important 1 2 3 4 5 6 very important</td>
<td></td>
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<td></td>
<td></td>
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</tr>
</tbody>
</table>

13) What kind of information should be available via the EUNESE web-site (more than one answer possible)

- Information about your organisation
- Research projects
- Intervention projects / programs
- Public information material
- Product information
- Standards and legislation
- “Good practices”
- Other, please specify:

- Fact sheets
- Reports
- Reference materials
- Newsletters
- Information about Congress/ meetings
- Recent literature
- Who’s who
C. Who do you think should belong to EUNESE and how could they contribute?

1) Potential members of EUNESE are: (more than one answer possible)

- Organisations of advocacy for elderly
- Commercial organisations
- Health organisations
- Healthcare organisations
- Local authorities
- Other, such as:
  - National government
  - Universities
  - Safety organisations
  - NGO’s
  - Welfare for elderly people
  - Scientists

2) Is your organisation prepared to make a financial contribution to EUNESE in exchange for membership?

- Yes
- Yes, but only in a way of travelling costs for attending meetings
- No, because:

3) Is your organisation prepared to make an other contribution in a way of delivering information, agenda setting, sharing results, deliver input for a good practice manual etc.?

- Yes, such as:
- No

4) How often do you think the members of EUNESE should meet?

- Twice a year
- Annually
- Once in two years
- Not on a regular basis
- Not at all
- Other, please specify:
5) Do you want to become a member of EUNESE?

☐ Yes
☐ No
☐ Probably in the (nearby) future
☐ Other, such as:

Thank you very much!

PLEASE RETURN THE COMPLETED QUESTIONNAIRE TO:

Ducht Consumer Safety Institute
t.a.v. Mrs. H. Schouten
PO Box 75169
1070 AD AMSTERDAM
The Netherlands

Fax: + 31 20 669 28 31

E-mail: h.schouten@veiligheid.nl
APPENDIX 1.3

Results of a questionnaire about the needs and expectations of its (potential) members
Report by: Working group 1 of EUNESE

Introduction
In order to build an adequate network is necessary to establish the needs and demands of the potential members. To create a lively network one needs to make sure the members will benefit from their membership.
A questionnaire has been sent to potential members with questions about the kind of information the potential network members will extract from the network, their possible contribution, list of interests for the website and information about their own organization.
The main objective was to get at least one member from each of the 31 European countries.

This report contains the result of this questionnaire. The main conclusions follow the presentation of the results. There are also recommendations which should be taken into consideration for building the network and the planned website.

Method
A questionnaire was created with the advice of the members of workgroup 1 of EUNESE. After consultation with the project management of EUNESE and the Steering Committee, the final version was created. The questionnaire is attached to this report as annex 1.
The questionnaire was sent out by the end of December 2004 to all ECOSA members, the Safe Cities and the EUNESE partners by e-mail. On January 31 a reminder was send by e-mail. A copy of this reminder is attached as annex 2. The questionnaires returned later than February 25 will only be used to complete the membership list. The results will not be included in the other results of the questionnaire.

The data from the questionnaire has been put in Excel database. Excel is adequate for simple statistical analysis. This is sufficient to analyze the results of the questionnaire and to create an overview of the potential members and their need and expectations of EUNESE.

Results
The results of the questionnaire are presented below.

Response and characteristics
By February the 28th 51 organizations from 19 European countries responded. A list of the responses from the different countries is presented at table 1.
Table 1: responses to questionnaire by country

<table>
<thead>
<tr>
<th>Country</th>
<th>Number of questionnaires returned</th>
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<tbody>
<tr>
<td>England</td>
<td>10</td>
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<tr>
<td>Austria</td>
<td>3</td>
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<tr>
<td>Italy</td>
<td>7</td>
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<tr>
<td>Switzerland</td>
<td>1</td>
</tr>
<tr>
<td>France</td>
<td>2</td>
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<tr>
<td>Lithuania</td>
<td>1</td>
</tr>
<tr>
<td>Netherlands</td>
<td>11</td>
</tr>
<tr>
<td>Estonia</td>
<td>2</td>
</tr>
<tr>
<td>Denmark</td>
<td>1</td>
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<tr>
<td>Poland</td>
<td>4</td>
</tr>
<tr>
<td>Cyprus</td>
<td>1</td>
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<tr>
<td>Slovakia</td>
<td>1</td>
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<tr>
<td>Latvia</td>
<td>1</td>
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<td>Czech Republic</td>
<td>1</td>
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<td>Greece</td>
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<tr>
<td>Ireland</td>
<td>1</td>
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<tr>
<td>Hungary</td>
<td>1</td>
</tr>
<tr>
<td>Germany</td>
<td>1 (no questionnaire received; interest by e-mail)</td>
</tr>
<tr>
<td>Portugal</td>
<td>1 (no questionnaire received; interest by e-mail)</td>
</tr>
</tbody>
</table>

A review of the kind of organizations which responded is presented in figure 1.

Figure 1: Kind of organizations the respondents are working for

Most of the responses came from universities, national health organizations and research institutes. Among the “others” were:
- National voluntary organization
- Agency for safety promotion
- Collaboration within institutes concerning safety promotion
- Semi government
- Semi government
- Local public health district
University hospital
Private limited company
Distributor of hip protectors
Trade union

These respondents are involved in elderly safety projects in different ways. Figure 2 shows how these organizations are involved in safety promotion for the elderly.

Figure 2: Involvement of respondents in safety promotion for elderly

Most of the respondents are involved in research, health promotion for the elderly and fall prevention. “Others” included:
- Implementation of programs in nursing homes
- Data analysis
- Teaching post graduate students
- Cardiac rehab groups

The respondents had an average of 11 years working in the field of safety promotion among the elderly.

From these respondents 29 memberships can be extracted, 11 respondents said they probably wanted to become a member in the future. And 3 people filled in “Other, such as”:
- Are already partner in working group 4
- Require more information to decide
- Depends on future of organization.

A list of people who want to become a member is attached as annex 3.

The potential benefits respondents attach to EUNESE are as follows:
- Exchange of information, ideas (12x)
- Contact with other professionals (7x)
- Good / best practice (6x)
- Sharing (research) results (6x)
- Networking (5x)
- Don’t know (2x)
- Utilize facilities (1x)
Observation (1x)

Needs and expectations of information

The questionnaire also asked the potential members what they expect from EUNESE. What kind of information do they want? How do they see the function of EUNESE and what kind of information and materials should be provided?

Figure 3 gives a review about the needs and expectations of the respondents regarding EUNESE.

Figure 3: needs and expectations of information provided by EUNESE

![Bar Chart](image)

Figure 3 shows that all possibilities were considered as important. Most important are: to function as an international centre of information, to provide information about projects, exchange of information and to provide a summary of research and intervention projects.

Figure 4 shows what the respondents think it is important to provide on the EUNESE website.

Figure 4: Kind of information that should be available on EUNESE website

![Bar Chart](image)
The most important request for the EUNESE website is information about research projects, intervention projects and good practice. Information about congresses and meetings should also be provided.

**Membership**
The respondents were asked who they think should become a member of EUNESE. Their answers are presented in figure 5.

**Figure 5: Potential members of EUNESE are:**

<table>
<thead>
<tr>
<th>Potential members of EUNESE</th>
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<tr>
<td>Advocacy organizations</td>
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<td>Commercial organizations</td>
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<tr>
<td>Health care organizations</td>
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<tr>
<td>Local authorities</td>
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<tr>
<td>National government</td>
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<tr>
<td>Safety organizations</td>
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<tr>
<td>NGOs</td>
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<tr>
<td>Other</td>
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The organizations mentioned most were: health care organizations, universities and safety organizations. The respondents were also asked if they are prepared to make a financial contribution to EUNESE in exchange for membership. Figure 6 shows the results.

**Figure 6: contributions potential members are prepared to make**

- Yes: 17; 45%
- Only in way of travel costs: 5; 14%
- No: 15; 41%
At least 59% (45% + 14%) of the respondents are prepared to make a financial contribution in exchange for membership. The 41% who are not prepared to make a financial contribution mostly give lack of finance as the main reason. Most organizations (90%) are prepared to make other contributions. The contribution mentioned most is sharing results / information (19x).

Exchange of information will not only be achieved by a website. In order to create a real network meetings between the network members are important. Figure 7 shows the response to the suggestion for regular meetings. There is a clear preference (44%) for an annual meeting.

Figure 8: How often should the EUNESE members meet?

Conclusion and Recommendations
The main objective of the questionnaire was to interest at least one member in each of the 31 European countries. This goal has not been achieved yet. Responses were received from 19 different European countries. This results in a list of potential members from 16 European countries (for detailed information see annex 3). Member organizations are expected from three further countries, Belgium, Portugal and Germany.

It is remarkable that 9 of the EUNESE partners did not respond at all to the questionnaire. These partners will receive a second reminder by e-mail.

In order to get members in all 31 European Countries additional action to promote EUNESE is recommended. A proposal for this will be discussed within work group 1.

In the response several countries are over represented: England, Italy and The Netherlands. This makes the conclusions difficult to generalize to all European countries. It also makes it clear that in these countries there is more interest in the subject of safety promotion for the elderly. Their experiences and knowledge should be used by EUNESE.

It is further recommended to create national networks for safety promotion for elderly people on a national level in these countries in order to exchange results and information. In The Netherlands such a national network already exists.
Although 59% (22) of the members are willing to make a financial contribution, only 14% (5) are prepared to pay for membership. Considering the over representation of European countries with better BNPs, it is recommended that network members only contribute by way of travel expenses for meetings. Funds for maintaining a website and project management for the long term should be found. Working group 5 should take this into consideration.

In order to create a lively network it is really important that EUNESE offers its members something they want. The most important thing network members want is to exchange information, research results, ideas. This has to be facilitated by EUNESE.

EUNESE should support two different ways to create the exchange of information / results.

First EUNESE should provide information on a website. The main topics on this website should be information about research projects, intervention projects and good practice. It is also important to provide information about meetings and congresses. This has to be taken into account when developing the website.

Second EUNESE should organize annual meetings. During these meetings the main focus has to be on presentation of projects and research and exchange of information. These are subjects that were identified as very important by the respondents.

It is also important to ensure people have some connection with the other network members. The results of the questionnaire shows that the network members themselves consider the following organizations as potential members: organizations of advocacy of elderly, health (care) organizations, universities, safety organizations and organizations concerning welfare for elderly. All these organizations were mentioned by more than 30 potential members.

When looked at in more detail, these organizations can be divided into two groups: a research group and an intervention group. It is important that EUNESE will facilitate both groups and – more important – will bring them together into one network. Therefore it is important that both groups will benefit from their membership. EUNESE has to provide information that is relevant and important to researchers as well as to more practical professionals.

These recommendations should not only be taken into account in working group 1, but also in the other working groups.
APPENDIX 1.4

European network for safety among elderly, Step-by-step plan for website EUNESE

Phase 1: Task formulation, definition

*Market analysis; which relevant websites are there on the area of elderly?*

- [www.profane.eu.org](http://www.profane.eu.org)
- [www.kennisnetwerk.nl](http://www.kennisnetwerk.nl)
- [www.healthandage.com](http://www.healthandage.com) (falls and injuries part)
- [www.safeaging.org](http://www.safeaging.org) gather and share the best information and resources on senior safety, including fall prevention, pedestrian and motor vehicle safety, and prevention of elder abuse. Both professional/elderly
- [www.cdc.gov](http://www.cdc.gov) (falls as small part)
- [www.helptheaged.org.uk](http://www.helptheaged.org.uk)

*How would you distinguish, related to the other sites/organizations?*
- Focus on unintentional accidents, injury prevention
- To function as an international centre of information
- To provide information about projects
- Exchange of information
- To provide a summary of research and intervention projects

*Determine level of ambition: What do you promise the visitor to do with the website?*

National organizations can learn from each other’s experience and knowledge and use the content.

*What do you want to accomplish?*

**Definition**
- To enhance the quality and impact of the safety promotion among the elderly in Europe.
- To build a European network that will ensure harmonization of core activities pertaining to injury control and safety promotion among elderly.

Objectives (translated to the website see: structure):
- Exchange and sharing information of research, interventions and products and develop partnerships:
- Implementation/promotion of good practice or promising approaches (evidence based) in European countries based on the good practice manual.
- To influence key decision makers and leaders at a national and European level to enhance public health policies and funding for elderly safety promotion initiatives.
- ‘Think-thank’ where members of the network can put questions or find input to solutions for bottlenecks. (contact with other professionals, networking)
- To establish and operationalize a European Network for safety among elderly on a long-term base.

**Planning: when should the website be on-line?**
*Rough draft*
July: first setup of website: main structure for brainstorm meeting with the working groups?
1-2 October: Presentation demonstration version in Greece
31 October: final agreement on structure/design
Beginning January 2006: final version website
* more detailed timetable in other document.

**What is the target audience? For whom is the website?**
- Experts involved in research, health promotion and injury/fall prevention in universities, national health organizations, research institutes, geriatric health, consumer protection, advocates for senior citizens and social welfare of older people. Organizations that are concerned with implementing safety promotion programs and research studies concerning safety of elderly.
- key decision makers and leaders at a national and European level

**How can you make you proposition clear and concrete?**
- Not too much text per frame
- Straight language, accessible for professionals as well as policy makers

**Content/structure**
- **Content:**
  Features/cause of accidents, risk factors, promotion strategies, information about research projects, intervention projects and good practice. information about congresses and meetings
  Focus areas: fire, traffic safety, falls, burns and scalds, safety at home, exercise, products, risk profiles, medication.

- **Structure:**
  Home (about EUNESE, contact details, vision, mission)
  The homepage should be so that in one glimpse it is clear what the site offers. The visitor should feel welcome, should be focused on their benefit and fast in transferring to the right information. Steady items such as agenda, news on the website give structure to the site.
  Secretariat/ Members only: meeting minutes and related documents, fact sheets, figures, good practices, tools, contact directory experts, handbook of good practice
  Projects: per country, kind project, categories injuries: unintentional
  Partners/members: list of partners/working groups plus web links and members
  News and events: press releases, articles, publications, agenda
  Statistics: injury/mortality data
**Literature:** To inventorise literature and the setup of a databank. Classification according to the subject and determine the applicable side.

**Think-tank?:** question and answer section? Or other interactive tools: forum -> discussion, tools –in which visitor can get a better image of the subject, video/audio

**How to position the partners? (mention name and logo, e-mail addresses, links)**

**Name:** the name and email address of the website should be decided on. A logo should be created.

How do you accomplish that the visitor stays interested and comes back?
- Posting current information on meeting and congresses regularly
- Putting on new projects regularly
- Diversity in projects
- Interactive element
- Keeping them informed by mail: opportunity to sign in for updates

**Which projects will be mentioned?**

**Which advisory tools are there?**

**Which functionalities can the visitor use?**
- Ask for advice
- Statistics
- Request for an update/ email newsletter?

**Atmosphere/ look&feel. What is the tone-of-voice?**
Professional, reliable, to the point, fast

**How to seduce the visitor?**
- Clear navigation

**Distinguish in types of visitors?**
- Language is English, but the text should be clear for non native speakers

**Strategy; what makes the website exclusive?**
- The link between practitioners and researchers
- Accessibility to experts
- Open for policy makers

**How to keep your visitor?**
- New, up to date and practical information. Keep the information continuously up to date and always check the content with the goals. Highest level of injury prevention data accessible for all European countries. (specific info only for members)
- The site should be loaded fast.
To keep the visitor satisfied:
- Suggestion pop up screen with questions

Findable, what do you do to attract people, to the site and fast?
- URL to all communication material
- emailing
- login website to search machines, logical URL
- Newsletter?

Preconditions
- Size: flexible frame setting: de site should look good on a big screen
- Minimum resolution 800x600 pixels
- Preventing of scrolling
- Do not make the page too big: the homepage max. 80 Kb (including images etc.), for the other pages max of 60 Kb.

Readability:
Text should be well to read on a small as a big the screen

Radiation:
Reliable, involved, urges to click through
Use of colours: colours of nature linked to images, other colours to other menu items
Content Management System (CMS): site should be easily to maintain or to be updated, in order to put on new content.
Speed: What are the minimum speed demands for the different parts of the website? (Download of video/audio of PDF’s, use of flash or lots of bigger pictures)
How does the site acts on a Mac?

Navigation:
- Simplicity is the keyword: all information should be found in less than 3 clicks
- Menu on the left side; the middle for information.
- If we have several menu lists or more menus to be shown, it should be clear that they are complementary (f.i. a main menu and a submenu) or that they refer to the information (‘redundancy’).
- For visitors it should be clear how they can get back and indeed how they can navigate into the site more deeply.
- Ensure ability to go back to home page or to run a search is built in from all pages
- The menu parts: home, project, partners, members, news should be always close at hand.
- Unambiguous as to set up and structure
- Back button to different site frames
- Forms can be downloaded through a link to printing friendly version (pdf-files)
- Navigation ease is important when it is focused on more than one target group??
Search:
Quick search field and expanded search method

Extra navigation parts
- Back-button should be working on the browser
- Simple home button

Most basic parts of the site are informative and static.
1. Static
   Steady text
   Pictures/ video/ audio
   Information/ background (general)
   Other (colofon etc.)
2. Dynamic
   Changing text/current (news, events)
   Pictures/ video/ audio
   Newsletter?
3. Interactive communication (think-thank, forum?)
   Exchange of latest information (mailing list)
   Links

Phase 2: Proposal and advice (first draft; no content or design, only structure)
- Advice on structure
- Technical aspects clarified (maintenance design/content)
- Provide content for basic structure

Phase 3: Functional design (base navigation (online design)).
Design concept based on the preconditions and strategy.
In the functional design all parts will be described in detail. It is a manual aiming to
provide complete clarity on the design, the content (? in a later stage) and the
structure of the website. When the concept and functional design has been
approved, the green light can be given for the production of the site.

Phase 4: Realization
Collection of material. All needed texts, pictures and other visual material.
Production: website will be produced.

Phase 5: Launch/fine-tuning
Launch of the website. Last edits will be collected and made:
Bugs: programming errors and change of requests, other than in the functional
design.
Phase 6: Maintenance
Think about the updating of the content or the improving or filling of certain functioning. Who is responsible for: the answering of email, think-thank, editorial maintenance, analyzing web statistics.
Repair bugs, new desires in structure, redesigning themes.

Research: (to monitor the course of the site and to create a better view on the desires and complaints of the visitor, research needs to be done.

Additional activities and costs to be considered:
Promoting the site, expanding the site, adjust the logo, payment for search machines.
APPENDIX 1.5
Sitemap of the Website

Home
- bi liner
- logo
- search
- target audience

New on the website

Contact
(Address details and email, submit information via email, application form, register)

About us:
- objectives, goals etc
- List of partners & Project partners
- contact (see contact Menu)

Links
- by priority area

Priority areas
- burns and scalds
- drowning
- falls
- fire
- medication/ Poisoning
- traffic

Good practice manual
- pdf manual

Projects
- projects by priority area
- projects by country
- materials by country
- materials by priority area
- link to register form

News & events
- events
- past events (interlink with meet. docs)
- press releases

Member area
- list of members (projects, links)
- terms of reference
- meeting documents

Statistics
- injury
- mortality
- morbidity data by priority area
- By country

Literature
- by priority areas
- By country
APPENDIX 2.1

EUNESE (European Network for Safety among the elderly): Patterns and suggested explanations for the differential injury mortality among elderly in the EU-25

Source: WHO mortality database, last available three years’ average for each country (circa 2000-2002) adjusted by CEREPR for project: EUNESE

List of provided tables:

Intentional Injuries

- Age adjusted mortality rate due to suicide /100,000 people among elderly (65+ years) in the EU-25, excluding countries with < 1,000,000 inhabitants
- Age adjusted mortality rate due to suicide /100,000 people among elderly (65+ years) by gender in the EU-25, excluding countries with < 1,000,000 inhabitants
- Age adjusted mortality rate due to other violence /100,000 people among elderly (65+ years) in the EU-25, excluding countries with < 1,000,000 inhabitants
- Age adjusted mortality rate due to other violence /100,000 people among elderly (65+ years) by gender in the EU-25, excluding countries with < 1,000,000 inhabitants

Unintentional Injuries

- Age adjusted mortality rate due to fall injuries /100,000 people among elderly (65+ years) in the EU-25, excluding countries with < 1,000,000 inhabitants
- Age adjusted mortality rate due to fall injuries /100,000 people among elderly (65+ years) by gender in the EU-25, excluding countries with < 1,000,000 inhabitants
- Age adjusted mortality rate due to road traffic injuries /100,000 people among elderly (65+ years) in the EU-25, excluding countries with < 1,000,000 inhabitants
- Age adjusted mortality rate due to road traffic injuries /100,000 people among elderly (65+ years) by gender in the EU-25, excluding countries with < 1,000,000 inhabitants
- Age adjusted mortality rate due to drowning /100,000 people among elderly (65+ years) in the EU-25, excluding countries with < 1,000,000 inhabitants
- Age adjusted mortality rate due to drowning /100,000 people among elderly (65+ years) by gender in the EU-25, excluding countries with < 1,000,000 inhabitants
- Age adjusted mortality rate due to fire and flames /100,000 people among elderly (65+ years) in the EU-25, excluding countries with < 1,000,000 inhabitants
- Age adjusted mortality rate due to fire and flames /100,000 people among elderly (65+ years) by gender in the EU-25, excluding countries with < 1,000,000 inhabitants
- Age adjusted mortality rate due to poisoning /100,000 people among elderly (65+ years) in the EU-25, excluding countries with < 1,000,000 inhabitants
- Age adjusted mortality rate due to poisoning /100,000 people among elderly (65+ years) by gender in the EU-25, excluding countries with < 1,000,000 inhabitants

List of provided maps

**Intentional Injuries**
- EU-25 Mortality Rate due to Suicide (circa 2001) among Elderly (65+ years)
- EU-25 Mortality Rate due to Other violence (circa 2001) among Elderly (65+ years)

**Unintentional Injuries**
- EU-25 Mortality Rate due to Fall Injuries (circa 2001) among Elderly (65+ years)
- EU-25 Mortality Rate due to Road Traffic Injuries (circa 2001) among Elderly (65+ years)
- EU-25 Mortality Rate due to Drowning Injuries (circa 2001) among Elderly (65+ years)
- EU-25 Mortality Rate due to Fire and Flames (circa 2001) among Elderly (65+ years)
- EU-25 Mortality Rate due to Poisoning (circa 2001) among Elderly (65+ years)
APPENDIX 2.2

EUNESE (European Network for safety among the elderly):
Road traffic injuries among elderly in Greece
Tables prepared by CEREPRRI


Tables for all road users

- 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
- 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
- Distribution of the 3357 road traffic injuries among elderly (65+) recorded in Greece by EDISS during 1996-2003, by type of road user, vehicle and gender
- Distribution of the 3357 road traffic injuries among elderly (65+) recorded in Greece by EDISS during 1996-2003, by outcome and type of vehicle. Median length of stay in hospital by type of vehicle also included.
- Incidence rate (per 1000 people) of traffic injuries among elderly (65+) in Greece, by age group and gender

Tables for pedestrians

- Distribution of the 1318 road traffic injuries among elderly (65+) pedestrians recorded in Greece by EDISS during 1996-2003, by gender and age group
- Distribution of the 1318 road traffic injuries among elderly (65+) pedestrians recorded in Greece by EDISS during 1996-2003, by outcome and mechanism of injury
- Distribution of the 1318 road traffic injuries among elderly (65+) pedestrians recorded in Greece by EDISS during 1996-2003, by outcome and vehicle involved in the injury
- Distribution of the 1318 road traffic injuries among elderly (65+) pedestrians recorded in Greece by EDISS during 1996-2003, by type of injury and vehicle involved
Distribution of the 1318 road traffic injuries among elderly (65+) pedestrians recorded in Greece by EDISS during 1996-2003, by body part injured and vehicle involved

Distribution of the 1310 road traffic injuries among elderly (65+) drivers recorded in Greece by EDISS during 1996-2003, by age group and vehicle

Distribution of the 1310 road traffic injuries among elderly (65+) drivers recorded in Greece by EDISS during 1996-2003, by cause of injury and type of vehicle

Distribution of the 1310 road traffic injuries among elderly (65+) drivers recorded in Greece by EDISS during 1996-2003, by outcome and driver’s vehicle

Distribution of the 1310 road traffic injuries among elderly (65+) drivers recorded in Greece by EDISS during 1996-2003, by type of injury and driver’s vehicle

Distribution of the 1310 road traffic injuries among elderly (65+) drivers recorded in Greece by EDISS during 1996-2003, by part of body injured and driver’s vehicle

Tables for passengers

Distribution of the 564 road traffic injuries among elderly (65+) passengers recorded in Greece by EDISS during 1996-2003, by age group and passenger’s vehicle

Distribution of the 564 road traffic injuries among elderly (65+) passengers recorded in Greece by EDISS during 1996-2003, by cause of injury and passenger’s vehicle

Distribution of the 564 road traffic injuries among elderly (65+) passengers recorded in Greece by EDISS during 1996-2003, by outcome and passenger’s vehicle

Distribution of the 564 road traffic injuries among elderly (65+) passengers recorded in Greece by EDISS during 1996-2003, by type of injury and passenger’s vehicle

Distribution of the 564 road traffic injuries among elderly (65+) passengers recorded in Greece by EDISS during 1996-2003, by part of body injured and passenger’s vehicle

Fall related injuries among elderly in Greece

Tables prepared by CEREPR

- Incidence rate per 1000 elderly people (65+ years) of falls requiring hospital contact, recorded by EDISS during 1996-2003, by age and gender
- Distribution of the 31589 fall injuries among elderly (65+), recorded in Greece by EDISS during 1996-2003, by mechanism of fall and age group
- Distribution of the 31589 fall injuries among elderly (65+), recorded in Greece by EDISS during 1996-2003, by place and age group
- Distribution of the 31589 fall injuries among elderly (65+), recorded in Greece by EDISS during 1996-2003, by mechanism and place (absolute numbers only)
- Distribution of the 31589 fall injuries among elderly (65+), recorded in Greece by EDISS during 1996-2003, by mechanism and place (column percent only)
- Distribution of the 31589 fall injuries among elderly (65+), recorded in Greece by EDISS during 1996-2003, by type of injury and gender
- Distribution of the 31589 fall injuries among elderly (65+), recorded in Greece by EDISS during 1996-2003, by type of injury and age group
- Distribution of the 31589 fall injuries among elderly (65+), recorded in Greece by EDISS during 1996-2003, by part of body and type of injury
- Distribution of the 14817 fractures due to fall among elderly (65+), recorded in Greece by EDISS during 1996-2003, by part of body and age group
- Distribution of the 31589 fall injuries among elderly (65+), recorded in Greece by EDISS during 1996-2003, by type of injury and mechanism of fall
- Distribution of the 31589 fall injuries among elderly (65+), recorded in Greece by EDISS during 1996-2003, by outcome and age group. Median length of stay in hospital by age group also included
- Distribution of the 31589 fall injuries among elderly (65+), recorded in Greece by EDISS during 1996-2003, by outcome and mechanism of fall
APPENDIX 2.3

EHLASS/HLA/IDB morbidity data - background information
EUNESE WG2

Austria

Face to face interviews with hospital patients (or accompanying persons) by specially trained stuff (EHLASS Interviewers).

Data are collected at emergency units and injury departments in a sample of seven hospitals: 4 general hospitals, 1 trauma centre, 1 children hospital. See annual report for details (www.sicherleben.at).

The EHLASS data are representative for the country (about 2% of the Austrian population, factor 50).

Coding Manual: V2000

Denmark

The Danish Injury Register collects data from emergency departments of (so far) five Danish hospitals: Glostrup, Herlev, Frederikssund, Randers and Esbjerg. All participating hospitals are general public hospitals.

The catchment areas of these hospitals constitute a representative sample of approximately 15% of the Danish population.

Coding Manual: V2000

France

France participated in the EHLASS from the day it started on the European level in 1986. Before this date, there was no systematic registration of accidents. In France, the system was called EPAC, what stands for "Enquête Permanente sur les Accidents de la vie Courante" (= permanent survey about the current life accidents). This system collects data about unintentional injuries incurred at home, at school, during sporting activities or in leisure time. Intentional injuries (such as suicide or attempted suicide, violence, aggression and acts of war), work and traffic accidents are not registered in the system. Accidents with bicycles, roller-skates, children's scooters or any other non-motorized means of transport on wheels are in this registration system considered as "current life accidents" and therefore have to be registered.

Since 2000, the EPAC registration is directed by the "Institut de Veille Sanitaire" (InVS).
The registration of the EPAC data is continuous in the emergency sections of a few participating hospitals. Since 1986, 6 to 10 hospitals have voluntarily participated in the registration every year (6 hospitals in 2001 and 2002).

Each hospital has one medical and one administrative member of personnel who are the spokespersons for the InVS and who are responsible for the data collecting. The personnel that collects, completes and checks the data in the emergency departments before the registration, receives training for the encoding of the data and the use of the nomenclature. Regular exchanges of information between the hospitals and the InVS make it easier to solve problems with the encoding.

After control on the local level, the data were transmitted every month to the organism that was charged with the computer management of the database. After reception, the data are checked on coherence, contents, etc. Incoherent data are sent back to the hospitals for correction. This correction must be made rapidly to allow the integration of the final data in the EPAC database on the national level within 3 months at the latest after the consultations at the emergency departments took place. After that, the data are periodically (every 3 months) sent to the InVS, where they are processed.

Hospitals that participate in the EPAC, must also participate every year in specific studies about accidents in the private sphere in collaboration with the InVS: e.g. making a study about a specific kind of accident or a specific target group, collecting more detailed data during a certain period, etc. Sometimes a test is performed on the collection of more precise data in view of a possible permanent integration in the registration system. In 2002, for instance, the feasibility of the introduction of a measure for gravity was tested in some hospitals: the Abbreviated Injury Scale (AIS).

The data that are collected in France, meet the European requirements. Up to 2002, the data were coded using the V1986 nomenclature and afterwards transposed in V2000 to meet the European demands. From 2003 onward, the hospitals will gradually switch to the V2000 nomenclature. The compatibility of the consecutive nomenclatures is guaranteed by the InVS.

The quality of the data is tested at least once a year. These check-ups look at the reliability, homogeneity, quality and exhaustiveness of the data. The technical and methodological modalities of the check-ups are determined by the InVS in deliberation with the participating hospitals.

The participating hospitals represent little over 3% of the total activity of the emergency departments of all the hospitals in France. The data collected about the accidents in the private sphere are not representative. However, the participating hospitals show varied activities and different situations: with regard to size (big and small hospitals), geographic situation (by the sea, in the mountains, in a tourist region or not...), with university character or not. The addition of a postal code to the variables that have to be registered is meant to improve the information about the representative value of the database.
**Greece**

It is a hospital based data collection system.


The participating hospitals changed over time. Since 1994, data are delivered from 2 general public in Athens and one trauma and one paediatric hospital.

All types of elderly injuries treated at the Emergency Departments (ED) of a network of three participating hospitals are regularly recorded in this database. Specifically, data are contributed by two hospitals with defined population coverage, namely the district hospital of Volos in the Magnesia region of the Greek mainland and the district hospital of Kerkyra on the island of Corfu. The cases, which are recorded in these two hospitals, cover about 2.2% of injuries in Greece excluding the Greater Athens Area. The other hospital, namely Asclipeion of Voula Trauma hospital is situated in the Greater Athens area and cover about 2.2% of the ED visits of the underlying elderly population.

Specially trained health visitors interviewed in the injured person who visited the ED or their escort; this personnel is supervised by physicians. The working schedule covers the time period 7a.m. to 11p.m. Information on injuries happening during the night is based on outpatient records. The data are recorded in a pre-coded questionnaire, which covers socio-demographic variables (gender, age, nationality), event characteristics (place, activity, mechanism, time) and nature of injury (type of injury, injured body part, number of injuries, treatment). Particularly for road traffic injuries a specially prepared questionnaire is filled in which includes information about the vehicles involved, the type of road user, the type of collision, weather, road and lighting conditions, possible cause of accident, use of helmet and seatbelt and possession of driving license. The data are subsequently coded in detail under ICD-9, ICD-10 and the European Home and Leisure Accident Surveillance System (EHLASS) coding manuals.

During the eight-year period 1996-2003, a total of 45392 injuries among elderly (65+) were recorded by EDISS. Of them, 31589 were caused by falls. During the same period a total of 3357 road traffic injuries were also recorded.

**The Netherlands**

The Dutch Injury Surveillance System (LIS) records information about patients who are treated at the Emergency Departments of Dutch hospitals. The Consumer Safety Institute uses this data to identify problem areas and to set priorities within them. This eventually leads to preventive policies.
LIS compiles data about home and leisure, traffic, sport and occupational accidents, as well as about violence and self-mutilation.

LIS can also record patients without injuries. These are people who report to the Emergency Department because of an illness or other disorder, and those who come in for checks or follow-up treatment.

The approximately 15 hospitals that participate in LIS form a representative sample of the general and teaching hospitals in the Netherlands. Based upon this sample, a reliable estimate can be made of the total number of accident-related emergency visits of all Dutch hospitals.

Each hospital has its own method for collecting the data to be recorded in LIS. As far as possible, LIS data gathering is integrated within the Emergency Department's regular registration activities.

In general terms, most hospitals work in the following manner:

- **Emergency form**
  
  When a patient reports to the Emergency Department, the receptionist completes an Emergency form for the hospital administration. On this form, both the basic data and, if the patient has an injury, the injury event data are noted.

- **LIS coding**
  
  The data on the Emergency form are coded and entered into LIS, with a separate LIS document being created for each incoming patient. Data coding and entry may be done either by the staff who completed the Emergency form – for example, the assigned doctor or nurse – or by the hospital administration.

- **Data submission**
  
  The hospital regularly sends a copy of its LIS information by modem to the central database at the Consumer Safety Institute. Patients' names, addresses and other identifying details are not submitted. Consequently, LIS conforms with the Dutch Personal Data Protection Act.

In order to guarantee the quality of LIS, the inputted data are checked in a variety of ways.

The fourteen hospitals that participated in 2002 in LIS form a representative sample of the general and university hospitals with an Emergency Department in the Netherlands.

LIS records whether a patient is admitted to the hospital due to an injury. Via the (LMR, Prismant), it is known how many accident victims are admitted to a hospital nationally. Because it is assumed that the ratio of the hospital admissions registered in LIS to the nationally registered hospital admissions is about the same as the ratio of the number of Emergency Department
treatments registered in LIS to the national number of Emergency Department treatments, the national number of Emergency Department treatments can be estimated with the aid of LIS.

Sweden

Every injured person visiting an emergency room at a participating hospital is registered in the ISS. The information about the accident and injury is received both from the patients and from the medical personnel. The patient fills a form regarding the circumstances of the injury event and the medical personnel reports the administrative and medical information. The information is then sent to special trained coding personnel that will do the coding, check the quality and put the information into a local database in their county. Once a year the database is uploaded to the Centre for Epidemiology at the National Board of Health and Welfare where the Swedish ISS will be completed and stored.

During 2001-2003 the Swedish ISS (or EHLASS as we still names it in Sweden), consisted of 9 hospitals that together covered about 6% of the entire Swedish population. The catchment area for the hospitals consists of 27 municipalities in 3 different counties. 4 of the hospitals are situated in the southwest part of Sweden, 4 in the middle part and 1 in the north. The "sample" has almost the same distribution on age and sex as the entire Sweden, but none of the hospitals is situated in a major urban (metropolitan) area, and we have no idea if the injury pattern differs between the major urban areas and the rest of Sweden. So then, here we might have a problem due to representativity.

Citizens of Sweden have their own personal identification number (PIN), which is recorded in the ISS. Matching the PIN-code with the national registration gives the patients home municipality code. Due to the geographical structure we know that about 10 percent of the patients treated at the participating hospitals are living in municipalities outside the catchment area. But we also know that approximately 10 percent of the population living in the catchment area will get treated in a hospital not participating in the ISS. So we don't consider this as a problem.
| Age | Population EHLASS area | | | | | Population entire Sweden | | | | Coverage (%) | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Age | Male | Female | Totalt | Male | Female | Totalt | Male | Female | Totalt | Male | Female | Totalt | Male | Female | Totalt |
| | 65-74 | 22098 | 24629 | 46727 | 22137 | 24548 | 46685 | 22366 | 24517 | 46883 | 345797 | 392911 | 738708 | 348646 | 392357 | 741003 | 352857 | 393217 | 746074 |
| | 75-84 | 15659 | 21333 | 36992 | 15644 | 21208 | 36852 | 15595 | 21163 | 36758 | 242246 | 343383 | 585629 | 241843 | 341079 | 582922 | 242024 | 340411 | 582435 |
| | 85+ | 4098 | 8545 | 12643 | 4135 | 8568 | 12703 | 4244 | 8805 | 13049 | 64266 | 143461 | 207727 | 65309 | 144561 | 209870 | 66670 | 146075 | 212745 |
| | Totalt | 41855 | 54507 | 96362 | 41916 | 54324 | 96240 | 42205 | 54485 | 96690 | 652309 | 879755 | 1532064 | 655798 | 877997 | 1533795 | 661551 | 879703 | 1541254 |
| | Male | Female | Totalt | Male | Female | Totalt | Male | Female | Totalt | Male | Female | Totalt | Male | Female | Totalt |
| | 65-74 | 6,4 | 6,3 | 6,3 | 6,3 | 6,3 | 6,3 | 6,3 | 6,2 | 6,3 | 6,3 | 6,3 | 6,3 | 6,3 | 6,3 | 6,3 |
| | 75-84 | 6,5 | 6,2 | 6,3 | 6,5 | 6,2 | 6,3 | 6,4 | 6,2 | 6,3 | 6,4 | 6,2 | 6,3 | 6,4 | 6,2 | 6,3 |
| | 85+ | 6,4 | 6,0 | 6,1 | 6,3 | 5,9 | 6,1 | 6,4 | 6,0 | 6,1 | 6,4 | 6,0 | 6,1 | 6,4 | 6,0 | 6,1 |
| | Totalt | 6,4 | 6,2 | 6,3 | 6,4 | 6,2 | 6,3 | 6,4 | 6,2 | 6,3 | 6,4 | 6,2 | 6,3 | 6,4 | 6,2 | 6,3 |
APPENDIX 2.4

First report on
the deliverables - WG 2:
Interventions and bibliographical survey

EUNESE

July 2005 - version 1

Working Group 2:
Federal Institute for Occupational Safety and Health,
Germany
Karolinska Institutet, Sweden
Medical University of Warsaw, Poland
Ministerio de Saude, Observatorio Nacional de Saude
University of Akdeniz, Medical School, Turkey
University College Dublin, Ireland

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0. Introduction

The report will give the presentation of the results obtained by the CRIOC for gathering the information for the purpose of the EUNESE-project. The following data will be detailed:

1. Bibliographical survey: gathering of pertinent literature
2. List of information sources relevant to the project
3. Demographic data for the elaboration of the policy manual
4. Interventions: gathering of national interventions
Methodology

Research team
In order to carry out the assignment that was given to the CRIOC, our centre has assembled a multidisciplinary team to resolve to problem of the data collection taking in account the different objectives of the EUNESE project. It was important to use the complementary capacities of the collaborators of the CRIOC. Therefore the team was composed of the following persons:

- A librarian
- Researchers specialised in the prevention of accidents
- Researchers specialised in social studies and behaviour
- A responsible for the administration of the database
- The coordinator for the work group WG2.

This team has come together on several occasions to define the criteria for research, to evaluate the pertinence of the information and to define the format under which the data could be delivered to the project leader and the WG coordinators.

In order to get the best result and to complete the research, the CRIOC has also assured itself of the contribution of external experts. In Belgium several organisations of the medical sector, the prevention and education have been contacted:

- Regional institutes for the promotion of health (VIG, Educasanté),
- Several medical faculties of universities,
- The Cochrane Collaboration (via the CEBAM, Belgian Centre for Evidence Based Medicine),
- A network of experts, among them some experts in gerontology.

This approach allows the CRIOC to develop their experience and to respond to the demands of the project partners, namely the coordinators of the other work groups and of the project. The needs of the project have evolved during the first year and have been discussed during the meetings of Paris (WG4, April 2005) and Bergen (coordination, June 2005).

On the other hand, the partners of the EUNESE project have been invited to deliver all documents pertinent to the project and especially "grey" documents which have not been published, put online or could not be found for other reasons (language of the document, absence of an abstract or key words in English,...).

- Invitation from the responsible of the project via the web board (November 2004)
- Repeated demands, by phone, email or at meetings, from the WG2 coordinator.
Information sources
The number of databases which are accessible on line is very high and will continue to grow permanently considering the development and the accessibility of the Internet. The quantity of information available is hence unlimited and it is therefore impossible to pretend to collect all the information on the subject.
This is why it is important to retain only the information of quality: this means among other things that the scientific level should be evident and that the source has to be identified clearly.
In order to evaluate the pertinence of the information sites on the internet, the CRIOC has based its work on the recommendations of the Health Summit Working Group ("Criteria for assessing the quality of health information on the internet-policy paper").
The CRIOC has carried out its research with the help of the following information:
- Databases dedicated to medicine, prevention, epidemiology, statistical information of economic or social nature, ...
- Medical newsletters, specialised reviews, ...
The following reliable sources, although not exhaustive, have been taken in account during the collection of information:
- Medical search engines like Pubmed, Medscape, JAMA, SagePublications and Safetylit
- EBM sources, Cochrane Library (database systematic reviews)
- Eurostat, Eurobarometer
- Sites on Injury Prevention
- Sites of the Health Development Agency, the WHO, ...

The criteria for the bibliographic research
Which information has been collected for the bibliographic review? The criteria established for the first collect are the following:

- Type of documents:
  - Online articles on the internet (from sites dedicated to health)
  - Articles in specialised reviews
  - Books
  - Reports, published or not
  - Annals of symposiums
  - Leaflets
  - Product documentation

- Date of the documents
The last 5 years, since 1999, were in first instance taken into consideration.

- The language of the documents
From which country the documents must be come from? From Europe, as the project concerns the European citizens. The language of the systematic search was English and French.

- Level of documents specialties
Scientific, prevention area, for professionals

- Keywords
The project deals with safety promotion and control of injuries among older people living in their house or in nursing homes in European Union. So as concerned the Internet research, the CRIOC used different combined key words:
- elderly, old people, aging
- injury, safety
- home, nursing
- campaign, prevention, intervention
- fall, suicide, drowning, ...

For the collect of the information, the CRIOC has proceeded itself to the main research of the documents. He took care of the collaboration of its Belgian network experts. Along side of the project, holding account the first results of the research of information and others specific demands of others works groups, the researches have been refined. Therefore, some relevant references from i.e. USA, Canada or Australia have also been taken into account, as documents in other languages or older than 5 years.
The relevance of the collected information has been discussed during the meetings. In addition to the criteria evoked before, the main criteria of the selection for the publications are: the scientist character of the publication, the source and the level of publication (peer review).

**Structure of the information**

Several questions arose to the CRIOC about this subject because the structure in which the information can be provided depends, in fact, on the users of the information:
- Which format for the computer file?
- Who develop the structure?
- Who must consult the information which has been collected? (EUNESE members, the public?)
- What sort of request we are supposed to make within the database?
- How the information must be display? (Output, presentation of the data in a rapport)
- Which are the fields necessary? And their format? (ex: key words = list closed)

Moreover, the action plan of WG2 has planed to use the web board of WP-AI waiting for the development of the web site by the WG1. Nevertheless, the EUNESE partners use the first one rarely so it was not possible to collect the information as it supposed to be. Despite of this, some of the EUNESE-partners provided references or sources of information directly to the WG2-coordinator or via the WG2-partners.

Concerning so far the development of the EUNESE web site, it is actually in progress under the responsibility of WG1. The CRIOC is actively taking part to the works as WG2 coordinator.

In conclusion, the project development and the consultations of the different partners in the way to collect and evaluate the information have pointed out the fact that the answers to the previous questions are not so evident and univocal.
Structure defined by the CRIOC
In order to record all the references on a uniform way, the CRIOC finally decided to create a database under the Access MS format (file EUNESE-LIT.mdb).

The file contains the following categories of information (recorded in the table "Documents"):
- the author(s), the title, the language,
- the type of document,
- for a publication in a journal: the name of the journal, the volume-number and the pages,
- and/or the editor, the edition place and the number of pages (if applicable),
- the link to the web source ("weblinksource"), the link to the document ("weblinkitem"), the identification if it is free to be downloaded on the Internet ("free/freeweb") and the abstract when it was free downloadable, the identification if it concerns a review.

The documents are categorized in the following types (see the table "type of document"):

- a article
- b book
- c factsheet
- d leaflet
- e private report
- f product document
- g public report

Results
At this stage, the database contains 220 references of documents, with a good proportion of reviews. Some documents are particularly relevant in terms of good practices and would have to be a good starting point for the elaboration of the policy manual.
The documents are distributed according to the types of documents as shown in the graph 1: the majority of the documents are of course articles.

![Graph 1](image1)

Most of documents are not free available on the Internet with their full text (graph 2).

![Graph 2](image2)

Even English the most used language is for the publications, some of the collected documents are in Dutch, French or German (graphs 3 and 4).
Graph 3

Graph 4
About 16% of the recorded documents are reviews of the literature (graph 5).

The database allows a lot of other possibilities for the users:

- to sort the data for each category of information,
- to select the documents which meet the requirements defined by the user,
- to access the document if it is on the Internet.

**Future tasks proposed**

In the future, new categories could be allocated to the information recorded in the database. The documents can be classified according to other criteria after discussion with the project leader and the WG coordinators. The choice of key words is also of prime importance.

For example, the documents could be identified looking to their nature (study, recommendations, review, ...) and to the type of study conducted, where applicable (randomized control trial, retrospective study, population-based study, case-control study, etc...).

The presentation of the data can always be improved to make the information more user-friendly as it is. The format has to be agreed with the other Working Groups of the project to suit their requirements in order to achieve the objectives of the project, i.e. the elaboration of the EUNESE website.

It is of prime importance to distinguish the tasks of each working group and to reinforce the collaboration in order to guarantee the sustainability of the work done till now.
List of information sources relevant to the project

Purpose

One of the tasks of the Working Group 2 is to provide a list of information sources relevant to the project.

Methodology

The research was performed by different ways:
- On the internet, by keywords like health, elderly, association, etc...
- By asking the partners of the project to give information sources,
- By exchange with other experts on the field.

In order to evaluate the credibility and the pertinence of the web sources on the internet, the CRIOC has mainly used the following criteria:
- the owner of the information source is identified (presentation-homepage) and the contact details are mentioned;
- the languages available on the home page: how many and which ones?:
  - it means one or more languages understandable by the CRIOC team: English, French, Dutch, German, Italian, Spanish, so that the websites can be evaluated,
  - or in another European language in case the web source was provided directly by a Eunese partner;
- the possibility to perform a search on the website does exist;
- there is a page of in-links and it is preferably categorized;
- the navigation in the website is easy;
- there is a sitemap.

The collected web sources were classified into the following categories in order to give a first view of the available sources:
- association
- general-health
- organization
- prevention
- pub-libraries
- quality review
- training
- various.

The categories have to be further discussed on the project together with the other working groups. Indeed the categorization has to be adapted to the intended users of the web sources. This point has to be further discussed on the overall project.

The web sources are recorded in a table so that it is easy to sort the information.
Results

The first results are given in the file named *LIST WEB SOURCES-1.0 (Excel file)*. The file contains about a hundred web sources. The list is given hereunder (*LIST WEB SOURCES-sheet List*). The following graphs give the distribution of the web sources by category, in number and in percentage.
Future tasks proposed

In the future, new categories could be allocated to the web sources. Any additional details about the web sources could also be mentioned, like the target country, the subjects, the existence of a list of links, the available languages, etc. The presentation can also be modified to suit other format requirements which would be expected i.e. by the other Working Groups of the project.

Of course, the following elements have to be taken into account before proceeding:

- the necessity to categorize the information to be loaded on the EUNESE-website, which has to be created under the responsibility of Working Group 1:
  - some ideas were already discussed (and this for the first time) during the meetings hold in Bergen (June 2005) and Brussels (July 2005);
  - a brainstorming will take place beginning of September, in order to discuss the structure of the website and the format of the information.

- the needs to search new kind of information which could emerge from the work completed on the project.
Demographic Data for the elaboration of the policy manual

Methodology

In order to write the policy manual, the Working Group 4 asked in April 2005 the support from WG2 in delivering some demographic data on the development of the elderly groups 65+ in the European countries and in Europe (ref.: draft of the minutes of the meeting in Paris).
If possible, the information would have to give the anticipated numbers of 65+ (and divided into 65-79, 80-89 and 90+) in 2030 and in 2050 in total, and in percentage of the whole population in the European countries and in Europe.
A first screening of information was asked by 1st of July 2005.
This report is the summary of the information submitted to the WG4-coordinator on July 1st and 5th.

Conclusions

In this document CRIOC reported the relevant sources of information on demographic projections which can be valuable for the purpose of the policy manual.
The WG4-coordinator expressed his satisfaction.

Future tasks proposed

WG2 will update this list of information sources in function of the needs of the other Working Groups. The remaining working budget has to be taken into account.
**Interventions**

**Methodology**

During the meeting held in Athens in November 2004, the kind of interventions to be gathered was discussed. The partners underlined the importance of collecting the information according to the following criteria:

- Target age of elderly: under and upper limits
- Independently or nursing homes residents
- Type of injuries
- Mechanism of the intervention
- Life style or medication

After the meeting, a form was developed and sent to the WG2-partners and the internal evaluator of the project, for collecting comments. The final form is given in annex to this chapter.

It was agreed in Athens to try to collect at least 2 evidence-based interventions by country (examples of transferable practices). For this purpose, the EU-25 states were allocated to the WG2-partners (at that time: 7, plus the observer of the WG2 meeting) asking them to contact some countries according to the following table:

<table>
<thead>
<tr>
<th>Project Partner</th>
<th>Belgium</th>
<th>Germany</th>
<th>Ireland</th>
<th>Poland</th>
<th>Portugal</th>
<th>Sweden</th>
<th>Turkey</th>
<th>UK (Obs.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Austria</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Belgium</td>
<td>X</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Cyprus</td>
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<td>X</td>
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<tr>
<td>Czech republic</td>
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<tr>
<td>Denmark</td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Estonia</td>
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<tr>
<td>Finland</td>
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<td>X</td>
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<tr>
<td>France</td>
<td>X</td>
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<tr>
<td>Germany</td>
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<td>X</td>
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</tr>
<tr>
<td>Greece</td>
<td>X</td>
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<tr>
<td>Hungary</td>
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<td></td>
</tr>
<tr>
<td>Ireland</td>
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<tr>
<td>Italy</td>
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<tr>
<td>Malta</td>
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<td>X</td>
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<tr>
<td>Latvia</td>
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<td></td>
<td>X</td>
</tr>
<tr>
<td>Liechtenstein</td>
<td>X</td>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Norway</td>
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<td></td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Poland</td>
<td></td>
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<td></td>
<td></td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Portugal</td>
<td></td>
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<td></td>
<td></td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Slovak Republic</td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Spain</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sweden</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The Netherlands</td>
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<td></td>
<td></td>
<td></td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Turkey</td>
<td></td>
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<td></td>
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<td></td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>United Kingdom</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>X</td>
</tr>
</tbody>
</table>

*Collection of information on EUNESE project (meeting on Nov. 21, 2004)*
**Results**

The following table gives an overview of the interventions collected at the hand of the form, for each country of Europe

<table>
<thead>
<tr>
<th>Country</th>
<th>Number of filled forms collected</th>
<th>Subject</th>
</tr>
</thead>
<tbody>
<tr>
<td>Austria</td>
<td>1</td>
<td>falls, 65+</td>
</tr>
<tr>
<td>Belgium</td>
<td>TBD</td>
<td>1) falls (<a href="http://www.valpreventie.be">www.valpreventie.be</a>)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2) violence (national campaign)</td>
</tr>
<tr>
<td>Cyprus</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Czech Republic</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Denmark</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Estonia</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Finland</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>France</td>
<td>4</td>
<td>falls, 65+, various risk levels</td>
</tr>
<tr>
<td>Germany</td>
<td></td>
<td>1) mobility, 70+</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2) falls, 80+, physical training</td>
</tr>
<tr>
<td>Greece</td>
<td>3</td>
<td>1) design for disabilities</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2) injury prevention campaign, 65+</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3) road traffic, pilot open care centre</td>
</tr>
<tr>
<td></td>
<td></td>
<td>4) all, police environment, vehicle technology</td>
</tr>
<tr>
<td>Hungary</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Ireland</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Italy</td>
<td>2</td>
<td>1) housewives, domestic accidents, law insurance</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2) social and public health care assistance to the whole population</td>
</tr>
<tr>
<td>Malta</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Latvia</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Liechtenstein</td>
<td>0</td>
<td>no intervention available in the country</td>
</tr>
<tr>
<td>Norway</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Poland</td>
<td>0</td>
<td>2 ref. of articles</td>
</tr>
<tr>
<td>Portugal</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Slovakia</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Spain</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Sweden</td>
<td>2</td>
<td>1) falls, 65+, hip fracture</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2) falls, 65+, healthy lifestyle (qi gong)</td>
</tr>
<tr>
<td>The Netherlands</td>
<td>TBD</td>
<td><a href="http://www.veiligheid.nl">www.veiligheid.nl</a></td>
</tr>
<tr>
<td>Turkey</td>
<td>2</td>
<td>1) indep 60+, observation, accidents</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2) retrospective study, all, falls-suicide</td>
</tr>
<tr>
<td>United Kingdom</td>
<td>TBD</td>
<td></td>
</tr>
</tbody>
</table>

Table: status in june 2005 about the collecting of the grey interventions (TBD = interventions received but have to be reported under the standard form)
The fact that there is no intervention collected till now from some countries can be explained by the following elements:

- two of the WG2 partners withdrawn from the project (Ireland, Portugal),
- some countries did not implemented till now any prevention programs among elderly and actually expect to change this situation thanks to their participation to the EUNESE-project and network,
- the grey interventions are indeed no easy to find and it requires a lot of effort to come in contact with the ad-hoc organisations who can deliver the information,
- Organisations specialized in prevention do not exist in all countries.

In order to have a better overview of the details of the collected interventions, the CRIOC created a database to record all of them (file \textit{INTERVENTIONS.mdb}). All the fields which are part of the collecting form are included in the database. So it is easier for the users, including the WG4-coordinator, to find and select the information.

This database can be updated as soon the CRIOC receives new information. The database actually contains 13 references of interventions with summary. Some interventions were received too late to be recorded in the file or have to be first translated to English before recording (interventions from Belgium, the Netherlands, United Kingdom, and France).

The interventions can be distributed according to the population target as shown in the graph:

\begin{center}
\textbf{Target population}
\end{center}

\begin{center}
\begin{tikzpicture}
\pie{15\%=A,31\%=I,54\%=NH}
\legend{\textcolor{red}{A} : all elderly, \textcolor{blue}{I} : living independently, \textcolor{green}{NH} : living not indep.}
\end{tikzpicture}
\end{center}
Looking to the description of the interventions, we can make the following observations:

- The interventions are not reported on the same way; in spite of the categories proposed on the form;
- Some interventions are very general and are not specific dedicated to the prevention among elderly;
- Most of the interventions concern the prevention of fall injuries;
- The type of intervention or study is not always reported and certainly not on a standard way, probably because the form did not propose a multiple choice for this category of information.

**Future tasks proposed**

In August 2005, the interventions collected since the edition of this report will be included in the database and delivered to the WG4 for the preparation of the policy manual.

During the meeting hold in Brussels on July 7th 2005, it was agreed between WG1 and WG2 to propose the following action plan to collect more interventions:

- to modify the form taking into account the observations made by the CRIOC,
- to post on the EUNESE website, as soon as possible, the new collection form together with the overview of the already collected interventions (number by country),
- the WG1-coordinator to send a request to the EUNESE-members and to motivate them to deliver any relevant intervention.

The narrow collaboration between WG1 and 2 co-ordinators will be continued the next months and the efforts done by WG1 to develop the EUNESE-Network will be used to contribute to the future work of the WG2.
Annex

**Intervention Registration Form**

Please Type-in your name here:

### 1. Issues covered by the Intervention

#### 1.1 Please identify the Group(s) of Ages covered by the intervention:

- [ ] 65+
- [ ] 65-69
- [ ] 70-74
- [ ] 75-79
- [ ] 80-84
- [ ] 85+
- [ ] Other please specify

#### 1.2 The intervention dealt with elderly people:

1.2.1 Living independently:

- [ ] Not stabilized stay (social excluded)
- [ ] Own home with no formal support
- [ ] Own home with day care support
- [ ] Own home with live-in carer
- [ ] Other please specify

1.2.2 Living in nursing homes / rehabilitation centers:

- [ ] housing scheme– no warden
- [ ] sheltered housing
- [ ] residential home
- [ ] nursing home
- [ ] mentally infirm nursing home
- [ ] Other please specify

#### 1.3 Other exclusion or inclusion criteria applied by the intervention (e.g. intervention that excluded people suffering from dementia)

#### 1.4 Population covered by the intervention (sample size of the study):

#### 1.5 Type of the study (e.g. control, randomization etc):
1.6 From the following aspects, check the ones the intervention did consider:

<table>
<thead>
<tr>
<th>Aspect</th>
<th>Please specify:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medication</td>
<td></td>
</tr>
<tr>
<td>Medical (non medication interventions e.g. therapies, appliances, alternative treatments)</td>
<td></td>
</tr>
<tr>
<td>Lifestyle</td>
<td></td>
</tr>
<tr>
<td>Economical</td>
<td></td>
</tr>
<tr>
<td>Cultural</td>
<td></td>
</tr>
<tr>
<td>Environmental</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
</tr>
</tbody>
</table>

1.7 External Causes of Morbidity and Mortality Covered by the Intervention:

<table>
<thead>
<tr>
<th>Description</th>
<th>ICD10 (External Causes of Morbidity and Mortality)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pedestrian injured in road accident</td>
<td>V0x</td>
</tr>
<tr>
<td>Pedal cyclist injured in road accident</td>
<td>V1x</td>
</tr>
<tr>
<td>Motorcycle rider injured in road accident</td>
<td>V2x</td>
</tr>
<tr>
<td>Occupant of three-wheeled motor vehicle injured in road accident</td>
<td>V3x</td>
</tr>
<tr>
<td>Car occupant injured in road accident</td>
<td>V4x</td>
</tr>
<tr>
<td>Occupant of pick-up truck or van injured in road accident</td>
<td>V5x</td>
</tr>
<tr>
<td>Occupant of heavy transport vehicle injured in road accident</td>
<td>V6x</td>
</tr>
<tr>
<td>Bus occupant injured in road accident</td>
<td>V7x</td>
</tr>
<tr>
<td>Other road accidents</td>
<td>V8x</td>
</tr>
<tr>
<td>Water-transport-related accidents</td>
<td>V90-94</td>
</tr>
<tr>
<td>Air and Space transport related accidents</td>
<td>V95-97</td>
</tr>
<tr>
<td>Falls</td>
<td>W0x-1x</td>
</tr>
<tr>
<td>Exposure to inanimate mechanical forces (e.g. injured by objects)</td>
<td>W2x-4x</td>
</tr>
<tr>
<td>Exposure to animate mechanical forces injured by another person, living creatures, e.g. animals)</td>
<td>W5x-64</td>
</tr>
<tr>
<td>Accidental drowning and submersion</td>
<td>W65-74</td>
</tr>
<tr>
<td>Threats to breathing</td>
<td>W75-84</td>
</tr>
<tr>
<td>Exposure to electric current, radiation, excessive temperature or pressure</td>
<td>W85-99</td>
</tr>
<tr>
<td>Exposure to smoke, fire and flames</td>
<td>X0x</td>
</tr>
<tr>
<td>Exposure to heat and hot objects</td>
<td>X1x</td>
</tr>
<tr>
<td>Exposure to venomous animal or plant</td>
<td>X2x</td>
</tr>
<tr>
<td>Exposure to forces of nature</td>
<td>X3x</td>
</tr>
<tr>
<td>Poisoning and exposure to harmful substances</td>
<td>X4x</td>
</tr>
<tr>
<td>Overexertion and strenuous or repetitive movements, Lack of food and water, Travelling</td>
<td>X5x</td>
</tr>
<tr>
<td>Intentional self-harm</td>
<td>X60-X84</td>
</tr>
<tr>
<td>Assault</td>
<td>X85-Y09</td>
</tr>
<tr>
<td>Intentional Injuries with undetermined intent</td>
<td>Y10-Y34</td>
</tr>
<tr>
<td>Legal Intervention and Operations of War</td>
<td>Y35-Y36</td>
</tr>
<tr>
<td>Medical Complication</td>
<td>Y40-Y84</td>
</tr>
<tr>
<td>Supplementary factors related to causes of morbidity and mortality classified elsewhere</td>
<td>Y9x</td>
</tr>
</tbody>
</table>
1.8 Is the intervention generalizable? please identify the factors that demonstrate the generalizability:

<p>| | |</p>
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2. Contact and other information

2.1 Contact information relative to the intervention: (contact person details, web-site, mail address etc):

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2.2 Country of Origin:

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2.3 Year(s) of implementation (e.g. 2003-2004):

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2.4 Short Description of the Intervention, including objectives, mechanisms and implementation:

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2.5 Was the intervention evaluated? □ Yes □ No

2.6 In the case of evaluated intervention, please describe the results of the Evaluation (including e.g. possible changes to legislation, procedures or systems):

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2.7 Was the intervention published? □ Yes □ No

2.8 Select the origin of information regarding the intervention:

- □ Scientific Publication
- □ Leaflet
- □ Conference
- □ Internet/Website
- □ Book
- □ Authorities’ Report

Please provide all the available information of the origin (e.g. for a scientific publication, the title of the journal, issue, pages and year):

<p>| | |</p>
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</tr>
</thead>
</table>
2.9 Any other comments:

Working Group 2 co-ordinator:
Ariane Van Cutsem (ariane.van.cutsem@crioc.be)
Carine Renard (carine.renard@crioc.be)

CRIOC
Rue des Chevaliers 18
1050 Bruxelles
Tel. +32 (0)2 547 06 11 – Fax +32 (0)2 547 06 01
APPENDIX 3.1

Nursing homes for the elderly

1. Name of the nursing home:
2. Address:
3. Director:
4. Type of the home:
   a. Day care
   b. Residential
      i. For elderly
      ii. For disabled
      iii. For psychiatric patients
      iv. Others

5. Owner of the nursing home:
   a. Government
   b. Non government
      i. The Church
      ii. Private person
      iii. Association
      iv. Foundation
      v. Non-profit company
      vi. Profit oriented company

6. Number of rooms (accommodation)

7. Residents all together:
   a. From which male:……. 65 years old and +:
   b. From which female:……. 65 years old and +:

8. All injuries (poisonings) needed medical care in 2004:
   a. GP…….cases
   b. Outpatients clinics:
   c. Hospitals:

9. Injuries by part of the body:
   a. Head, neck
   b. Trunk
   c. Upper limbs
   d. Lower limbs
   e. Organs

10. Type of injuries
    a. Fracture
    b. Collusion
    c. Cut
    d. Prick
    e. Burn
    f. Suffocation
    g. Unintentional poisoning
    h. Suicide
i. Others, ....

11. Construction of the building.
   a. One-blocked building
      i. One-floor
      ii. Two-, or more…… floors
           1. elevator exists
           2. no elevator
   b. One floor buildings: …….

12. What kind of environmental risk can you find in the surroundings?
   a. Uneven, slippery surfaces outside
   b. Uneven surfaces inside
   c. Missing bars outside
   d. Missing bars inside
   e. Others…….

13. Did you make some reconstruction for easier mobility of residents within the last 3 years?
   a. Yes
   b. No – there was no need, but it was needed
   c. No
   d. Ongoing

14. If the answer on the previous question was „yes”, please specify:

15. Please, rank your nursing home 1-5, according to the level causing injury. (1 – very much, 5 – not at all)

1  2  3  4  5

16. If you are not very satisfied with your nursing home, please specify what is it needed for safety of elders?

Thank for your collaboration!
APPENDIX 3.2

Questionnaire for elderly - 65 years and older, living alone - regarding injuries

1. Age:

2. Sex:

3. Do you have phone connection?
   a. No
   b. Fixed line phone only
   c. Cell phone only
   d. Both

4. Do you have any relatives, friends with whom you have any connection?
   a. Yes, relatives
   b. No relatives
   c. Relatives, but no connection
   d. Neighbors
   e. Friends
   f. No relatives, no friends

5. How often do you meet with persons an intimate terms with you?
   a. Several times a day
   b. Every day
   c. Several times a week
   d. Every week
   e. Every month

6. If you do not meet them do you keep in touch with them on phone?
   a. Yes, regularly
   b. Rarely
   c. No

7. Do you visit a GP?
   a. No
   b. Yes, regularly
   c. Yes, sometimes

8. Does a GP visit you?
   a. No
   b. Yes, if necessary
   c. Yes, regularly

9. Do other health personnel’s visit you?
   a. No
   b. Yes, if necessary
c. Yes, regularly
10. Do social personnel visit you?
   a. No
   b. Yes, if necessary
   c. Yes, regularly

11. Did you fall down during the last three months?
   a. No
   b. Yes

12. If yes, how many times?

13. What was the result of the fall?
   a. Nothing
   b. lesion
   c. heamatoma
   d. fracture
   e. other…

14. Have you ever have in your life a bone fracture in consequence of a fall?
   a. No
   b. Yes

15. If yes, how many times?

16. Did you have any type of injuries during the last 3 months?
   a. Cut
   b. Stab
   c. Burn
   d. Bite
   e. Unintentional poisoning
   f. Other….

17. Do you use a stick or other device when walking?
   a. Never
   b. Sometimes
   c. Always

18. If you use any device, you do it
   a. Of your own free will
   b. Because GP recommended

19. Do you have any of the following illnesses?
   a. Do not know about any illnesses
   b. Hypertension
   c. Arrhythmia
   d. Stroke
   e. Diabetes
f. Arthritis and arthrosis
g. Parkinson disease
h. Depression
i. Eye diseases (cataract, glaucoma)
j. Allergy
k. Alcohol related disease
l. Thinness
m. Obesity
n. Osteoporosis

20. Do you take any medicine?
   a. Never
   b. Sometimes
   c. Only for exact illnesses (e.g. flue, etc.)
   d. Regularly

21. If you take medicine regularly, how many types?
   a. One
   b. Two-three
   c. Four
   d. More, than four

22. Do you suffer from insomnia?
   a. No
   b. Yes

23. What pills do you take? Please specify.

24. Do you need glasses?
   a. Never
   b. For reading only
   c. For long-sightedness
   d. Always

25. The status of your hearing? Please circle the most suitable answer.
   a. Perfect
   b. Has a little difficulty both side
   c. Has difficulty on one side
   d. Has serious hearing problem
   e. Deaf

26. During the day you are
   a. Active, working
   b. Active, walking and relaxing (recreating)
   c. Basically sitting and reading
   d. Basically sitting and watching TV or listening to the radio
   e. Basically lying in/on bed

27. Do you do gardening?
a. Yes
b. No
c. Sometimes

28. How often do you go to the street?
   a. Several times a day
   b. Every day
   c. Every week
   d. More rarely, than once a week
   e. Not at all

29. How do you travel?
   a. Drive a car yourself
   b. Take the bus
   c. Take the train
   d. Are taken by car
   e. Other, please specify
   f. Do not travel at all

30. If you do not travel, it is because (Please, specify.)
Home and its surroundings
Additional questionnaire for the independently living elderly

Population of the settlement: Relief: a. flat b. downy c. hilly (mountainous)

Street

1. What was the street made of?
   a. Pure Concrete
   b. Tile from concrete/concrete slab
   c. Bitumen
   d. Gravel
   e. Other, specify
   f. No built up pavement at all

2. Is there any bicycle traffic on the pavement on the street do you use?
   a. No
   b. Yes

3. Is there any busy street close to your home?
   a. Yes
   b. No

4. Are there any zebra-crossing on the busy street?
   a. Yes
   b. No

Yard

1. Are there any built up pavements in your yard?
   a. No
   b. Yes

2. If you have built up pavements, their surfaces is
   a. Smooth
   b. Graveled
   c. Discontinuous
   d. Slippery

3. Are there any stairs between the levels of the house and/or yard?
   a. No
   b. Yes, 1-2 steps
   c. Yes, 3 and more steps

4. If you have stairs, are there any bars nearby?
   a. yes
   b. no

5. If you have stairs, are the steps the same size? (Do they have the same height?)
6. Do you have any garden around the house you are cultivating?
   a. No
   b. Flower garden
   c. Vegetable garden
   d. Fruit garden

7. What kind of works do you do in the garden?
   a. Hoeing
   b. Weeding
   c. Pruning
   d. Go up (mount) the ladder
   e. Spraying
   f. Watering
   g. Cutting the grass

8. Do you have any field far from your house, where you are working?
   a. No
   b. Yes

9. Do you keep any farm animals?
   a. No
   b. Yes, small animals
   c. Yes, big animals

10. Are the gates easy to open?
    a. Yes
    b. No

Rooms

1. Are there any thresholds between the rooms?
   a. Yes, with height of… And with the width of…
   b. No
   c. A few

2. Width of the doors
   a. Less, than 85 cm
   b. 85 cm and more

3. Do you have any free strings on the floor (phone, refrigerator, TV) you may slip up?
   a. No
   b. Yes, one
   c. Yes, several

4. Do you have any carpets?
   a. No
   b. Wall- to-wall carpeting
   c. One big carpet
   d. Several small rugs

5. If you have rugs or carpet, are those even?
a. Yes  
 b. No, 1-2 are curly  
 c. No, more are curly

**Kitchen**

1. What is the floor in the kitchen made of?  
   a. Cold flooring  
   b. Parquetry  
   c. Concrete  
   d. PVC  
   e. Dirt floor

2. Are there any uneven surfaces in the kitchen?  
   a. No  
   b. Yes

3. Are the household utensils on a height that is easy to reach?  
   a. Yes  
   b. No, too high (higher 1,2 m)  
   c. No, too low (lower 0,7 m)

4. Do you have tap in the kitchen?  
   a. Yes, cold- and hot water  
   b. Yes, cold water  
   c. No

5. If you have no tap in the kitchen, where should you go to take water?  
   a. To the street  
   b. To the yard  
   c. To an other room inside the house

6. Do you keep flowers on a height you can not reach from floor?  
   a. Yes  
   b. No

**Bathroom**

1. Do you have a bathroom?  
   a. yes  
   b. no

2. Do you have WC inside the house?  
   a. yes  
   b. no

3. What can we find in the bathroom?  
   a. bathtub  
   b. Shower  
   c. Grip near tub  
   d. Rubber mat on the bathroom floor  
   e. Rubber mat in the tub  
   f. Grip near WC  
   g. Wash-hand basin
h. Gas-boiler
i. Electric boiler
j. Wood-burning stove

The house in general

1. Heating
   a. Central
   b. Individual heating with gas
   c. Individual wood heating
   d. Mixed

2. Lighting
   a. Bulb less, than 60 W
   b. Neon lighting

3. Are there any lamps at the stairs?
   a. Yes
   b. Yes, but not everywhere
   c. No

4. Is there a cellar in the house?
   a. No
   b. Yes, under the building
   c. Yes, in the separate building

5. Do you use the cellar regularly?
   a. No
   b. Only for keeping vegetable
   c. Yes, for wine-keeping

6. Is there an attic or upper storey in the house which you use?
   a. Yes
   b. No
## APPENDIX 3.3

### QUESTIONARIO IT-EN

*Circumstances of the incident*  \( h = \)

<table>
<thead>
<tr>
<th></th>
<th>PLACE OF INJURY</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>AT HOME</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bathroom</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bedroom</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kitchen</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stairs</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Living room</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Other</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>OUTDOORS</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Elsewhere indoors</td>
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<td></td>
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<tr>
<td>Street</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bus</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Bycicle</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Car</td>
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<td></td>
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<tr>
<td>Other</td>
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<td></td>
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<tr>
<td>Mountain</td>
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<td></td>
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<tr>
<td>Hospital</td>
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<tr>
<th></th>
<th>IMPACT SURFACE</th>
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<tbody>
<tr>
<td>HARD (pavement, road…)</td>
<td></td>
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<tr>
<td>SOFT (herb, carpet,…..)</td>
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<tr>
<th></th>
<th>HEIGHT TO FALL</th>
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<tbody>
<tr>
<td>From the bed</td>
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<tr>
<td>From ortostatic position</td>
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<tr>
<td>From a chair</td>
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<tr>
<td>Stairs</td>
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<tr>
<td>Height &gt; 2 m</td>
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<tr>
<th></th>
<th>DIRECTION OF THE FALL</th>
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<tbody>
<tr>
<td>Frontwards</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Laterally</td>
<td></td>
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<tr>
<td>Backwards</td>
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<tr>
<td>Downwards</td>
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<tr>
<td>Other</td>
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<th>WET OR SLIPPERY SURFACE</th>
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<th></th>
<th>ACTIVITY AT THE TIME OF INJURY</th>
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<tr>
<td>None</td>
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</tr>
<tr>
<td>Standing up</td>
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<tr>
<td>Sitting or laying down</td>
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<td></td>
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<tr>
<td>Turning</td>
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<tr>
<td>Changing position</td>
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<td></td>
</tr>
<tr>
<td>Stretching</td>
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<td></td>
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<tr>
<td>Bendino</td>
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<td></td>
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<tr>
<td>Making a step</td>
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<td></td>
</tr>
<tr>
<td>Walking ahead</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Walking backwards</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Coming up or down the stairs</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Walking downwards</td>
<td></td>
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</table>
Walking upwrads (climbing)  
Cycling  
Skiing  
Other:  
UNKNOWN

**ENVIRONMENTAL CONDITIONS (OBJECTS)**

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<thead>
<tr>
<th>No</th>
<th>Yes</th>
<th>UNKNOWN</th>
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</thead>
</table>

**OBJECTS THAT MAY HAVE CONTRIBUTED TO THE FALL TO HAPPEN**

<p>| OBJECTS | AT HOME | | | | FAR FROM HOME | | | |
|---------|---------| | | | INDOORS | OUTDOORS | | | |
| CHAIRS OR OTHER FURNITURE | | | | | | |
| CARPET, PAVEMENT | | | | | | |
| ELECTRIC WIRES | | | | | | |
| STAIRS, STEPS | | | | | | |
| WALKER, STAMPS | | | | | | |
| SHOES | | | | | | |
| SHEETS | | | | | | |
| CLOTHING | | | | | | |
| PETS | | | | | | |
| DOOR, HANDLE | | | | | | |
| IRREGULAR PATH | | | | | | |
| OTHER | | | | | | |</p>
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<thead>
<tr>
<th>Individual Risk Factors</th>
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<tbody>
<tr>
<td>Age</td>
</tr>
<tr>
<td>Age of menopause</td>
</tr>
<tr>
<td>Weight (kg)</td>
</tr>
<tr>
<td>Weight increase at the age of 25</td>
</tr>
<tr>
<td>Height (cm)</td>
</tr>
<tr>
<td>Height at the age of 25</td>
</tr>
<tr>
<td>Anamnestic femoral fracture (maternal)</td>
</tr>
<tr>
<td>Anamnestic hyperthyroidism</td>
</tr>
<tr>
<td>Use of benzodiazepine of long term action</td>
</tr>
<tr>
<td>Use of antiepileptics</td>
</tr>
<tr>
<td>Use of anticoagulants</td>
</tr>
<tr>
<td>Use of diuretics</td>
</tr>
<tr>
<td>Use of corticosteroid (&gt; 5 mg/day, &gt; 3 month)</td>
</tr>
<tr>
<td>Introit of caféine (&gt; 3 coffee/day)</td>
</tr>
<tr>
<td>Smoker (more than 10 a day)</td>
</tr>
<tr>
<td>How much walking time a day?</td>
</tr>
<tr>
<td>Assisted walk</td>
</tr>
<tr>
<td>Km walked a day</td>
</tr>
<tr>
<td>Standing up less than 4 hours a day</td>
</tr>
<tr>
<td>Fitness/gym (&gt; once a week)</td>
</tr>
<tr>
<td>Unable to stand up from chair</td>
</tr>
<tr>
<td>Visual acuity (1-10/10)</td>
</tr>
<tr>
<td>Pulse when relaxed &gt; 80 heartbeats minute</td>
</tr>
<tr>
<td>Any fracture after the age of 50</td>
</tr>
<tr>
<td>Number of falls during the last year</td>
</tr>
<tr>
<td>Kyphosis</td>
</tr>
<tr>
<td>Long lasting immobilisation (&gt; 3 month)</td>
</tr>
<tr>
<td>Handicap (ADL)</td>
</tr>
<tr>
<td>Ictus</td>
</tr>
<tr>
<td>Dementia</td>
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<td>Cardiovascular problems</td>
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<td>Haematological diseases</td>
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<td>Hypertension</td>
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<td>Rheumatic diseases</td>
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<td>Endocrine diseases</td>
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<td>Gastroenterologic diseases</td>
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<td>Renal diseases</td>
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<td>Diabetes mellitus</td>
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<td>Cataract</td>
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<td>Malignant neoplastic diseases</td>
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<td>Chronic obstructive pulmonary diseases</td>
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<td>Gonartrosi</td>
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<td>Coxartrosi</td>
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<td>Dizziness (vertigo)</td>
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<td>Calcium introit (mg/day)</td>
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<td>Vitamina D supplement in the last year (&gt;100000 UI)</td>
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<tr>
<td>Use of thiazidics</td>
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<td>Treatment for osteoporosis in the last year</td>
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<td>Femoral bone mineral density: T score</td>
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</table>
| Z score                                                     | 143
Virtual modeling of a safe household environment for elderly citizens

Pilot Project Structure

Coordinators:
  Constantin Scarvelis, GERAHM, France
  Agis Terzidis, CEREPRI, University of Athens, Greece

Partners:
  Efstratia Toumpi, Architect- Greece

I. BACKGROUND AND MOTIVATION

Every year, around 100,000 elderly (> 65 years) citizens of the European Union die of preventable injuries. Despite the fact that elderly citizens constitute only 20% of the total European population, preventable injuries in this age group actually cause 47% of the total number of deaths due to preventable injuries.

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. The increasing numbers of older people, combined with changes in the way these people want to live their later years and their expectation of a higher quality of life, have therefore created a pressing need for new and safe housing options.

Until the 1980s, the approach to housing for the elderly was anything but admirable. Individuals not able to live in their own home had to fall back on an 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 the most significant is the concept that the needs of the elderly are not reducible to a single, limited set of design solutions.

II. AIMS AND OBJECTIVES

The main objective of the report will be to provide the elderly with simple design solutions and guidelines to make their home safe. It will also provide architects and civil
engineers with the essentials they need to jump-start the design of a safe environment for the elderly. Finally it will be a resource for students and teachers of gerontology.

To this end, we will examine the ageing process of the human body and its implications on safety. We will also examine various aspects of the design and function of housing for the elderly, in particular those related to ensuring a safe environment for them. Domestic hazards will be outlined and solutions will be purposed for the creation of a safe environment. Examples of safe housing will be provided, supported with technical information and charts of design criteria.

III. RESEARCH AND METHODOLOGY

An effort will be made to bring together and analyze a large amount of data concerning the present status of individual housing for elderly. The aim will be to understand the problems that the elderly face and provide simple and understandable ways to improve their living. To conclude, project photographs, diagrams, floor plans, and details of a variety of building subtypes will be provided and design solutions will be purposed. The report will be comprised of three parts:

A) The Aging Process

To understand why elderly are injured inside their own home, it is important to understand some of the basics of the aging process in the human body, with its range of barriers and limitations, and to see how it should impact the design.

The body is composed of a variety of interactive systems that jointly ensure its smooth operation. As the individual ages, these systems begin to deteriorate in a relatively predictable way. Thus, to design a house that suits the needs of the elderly, it is important to take into account these physical changes and the implications they have on the capabilities of the individual. 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 particular, this part of the report will analyze the following systems followed by the design implications that will be purposed:

- Communicating Systems
- Mechanical Systems
- Control Systems
- Detection Senses
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.

B) Common Problems, Design Guides and Recommendations for Specialized Spaces

The second part of this report will focus on the most common problems typical houses for elderly have, and will offer design solutions that can be easily followed by the elderly that have a medium income. By identifying hazardous environments, multiple options will be given to create a safe house, taking in mind the every-day needs of the elderly. This will be achieved by demonstrating photographs, floor plans and sketches together with step-by-step guidelines. In addition, products, materials and furniture that can be found easily will be demonstrated.

In conclusion, different design aspects will be studied related to every part of the house. Some of these will be:

- Site planning/ Parking/Access
- Accessibility
- Corridors
- Creating a safe bathroom (Bathing equipment)
- Organizing the Kitchen and Eating area
- Windows and Window Coverings
- Heating and Air-Conditioning
- Acoustic Control
- Lighting Systems
- Structural Systems
- Roofing
- Flooring
- Wall coverings
- Interior Finishes and Furniture

Deliverables: A glossary, 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 with all the details to jump-start a design of a safe home.
C) Safe House Design

The last part will focus on the actual design of a typical safe house, following European design standards and the guidelines that were presented in the second part. The project will involve a rather small house of approximately 70sq.m, which will consist of a living room, a kitchen with an eating area, a bedroom, a bathroom and a small storage room. Details of the exterior design will be shown along with the parking area. Furniture and finishes will also be clearly visible.

This house will be demonstrated by a 3d visual pilot by using a walk-through exploration of the exterior and interior of the house. The walk-through will be accompanied by verbal explanation focusing on the most important aspects of the design.

**Deliverables:** A compact disc containing the 3d visual plot for general use.

IV. TIME-PLAN

The following milestones are specified:

- **Phase 1: October 2004- June 2005**
  - Development of the proposal that will be implemented.
  - Literature review and experts’ consultation
  - Development of a draft of the Home-safety glossary
  - Development of the first draft floor plan of the prototype house

- **Phase 2: July 2005- January 2006**
  - Develop a 3d visual pilot of the prototype house
  - Distribution of the draft floor plan of the prototype house and of the 3d visual plot for evaluation
  - Finalization of the Home-safety glossary
  - Final version of the floor plan of the prototype house.
  - Final version of the 3d visual pilot of the prototype house
  - Development of a technical report for the civil engineers.

- **Phase 3: February 2006- March 2007**
  - Disseminate developed materials
  - Final report
V. EXPECTED RESULTS

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 simple solutions. The results of the project will be distributed, in the form of a brochure, to all institutions that are directly connected with the elderly. In conclusion, the ultimate result of this project will be to improve the safety of the elderly, taking in mind their habits and daily needs.

VI. BIBLIOGRAPHY

5. Neufert Ernst and Peter. Neufert Architects’ Data. Bousmaha Baiche DipArch, MPhil, Phd, and Nicholas Walliman, DipArch, PhD, RIBA, School of Architecture, Oxford Brookes University
8. Bonifazi, W.L. 1999. Bathing the Alzheimer’s Patient in Long-Term Care. Contemporary Long-Term Care, March
12. J. Downey Jeffrey. Increasing safety in assisted living: as assisted living facilities gain popularity, they are taking on responsibilities that they are not equipped to ... protect the elderly. : An article from: Trial [HTML]
APPENDIX 4.1

Content of the best practice policy manual on elderly safety
WG4 meeting in Paris 14-15. April 2005

The number of pages to be about the same as the brochure on Child Safety made by European Child Safety Alliance – 28 pages in print, each page ¾ of A4
(some case stories “Touching stories” to be included here and there in the manual)

1. Why action for elderly safety in the European countries?
   - Individual suffering, increased mortality, increased disability, economy
   - Prognosis for the increase of the elderly population in the European countries the next 50 years – and for injuries.

2. Some definitions

3. Visions and targets for elderly safety in Europe WHO, some national targets (e.g. the French target to reduce the prevalence of falls 65+ with 25 % in five years). Three target groups: a) Elderly 65+ with good health, living at home b) Elderly 65+ living at home and need some sort of help, c) Elderly 65+ living in institutions.

4. Elderly injuries – statistics
   - Mortality, may be some morbidity.
   - This manual will focus on unintentional injuries.

5. Elderly population in European countries will increase

6. Various cultures across Europe regarding caring for the elderly and consequences for their safety

7. Elderly injuries can be prevented
   - Introduction to the three main accident groups in general, effective strategies for prevention.

8. How to reduce the aging process (50% of the injuries are related to internal reasons): nutrition, exercises, less medication, vision, balance, etc. This is relevant for all injury groups.

9. Tree main injury groups will be focused on, with 5-10 evidence-based best practices on each of them (with references) as examples that they can be prevented – mainly focused on external reasons – environmental and organisational factors.
   - Fall injuries
   - Road traffic injuries
   - The rest group consists of some minor groups as: a) Fire and flames, b) drowning, c) poisonings, d) other?

10. How to create an infrastructure for injury prevention?
    - Safe communities
    - How to co-operate between central and local levels?
    - How to design intervention project?

11. The European network on elderly safety (EUNESE), important links.
Web-boards, also known as Internet Forums or Bulletin Boards, are one of the most widely used means of electronic communication and discussion. Some of their significant features are:

- The ability to host conversations organized in thematic groups.
- The archiving of the exchanged messages and the ability to perform searches among them.
- The hosting of different user-groups and define various levels of access rights.

Following the recommendation by the Technical Advisor, in order to ensure the effective flow of pertinent injury prevention information, the WP-AI Secretariat has developed, on behalf of the EC, a web-board using popular, proven and freely available (open source) development tools minimizing the time, effort and cost of development. Currently, 95 members are registered on the web-board.

A special, restricted thematic group has been opened for use by the EUNESE members. This thematic group will facilitate communication needs of the EUNESE
members and until the project’s web-site is developed will also facilitate the dissemination of the project’s documents and deliverables.

The WP-AI web-board can be visited at the following link: http://www.euroipn.org
APPENDIX 5.2
EUNESE Brochure

"La vie est l’ensemble des forces qui résistent à la mort!"
"Life is the gathering of forces opposing death"
General Charles de Gaulle

EUNESE at a glance
Every year ~100,000 elderly (≥65 years) citizens of the European Union (EU 27) die of the most preventable cause of death, namely injuries. Despite the fact that they constitute ~20% of the population, they "contribute" 47% of the total number of deaths due to unintentional injuries. Therefore co-ordinated action needs to be taken in order to efficiently tackle this threat.

The main goal of EUNESE is to build a European network to ensure harmonisation of all activities for injury control and safety promotion among the elderly. By exploiting data sources that have been supported by the European Commission, the EUNESE project seeks to assess the risk profile of injuries and identify the most effective solutions, springing from the rich diversity of cultural and social variation across Europe.

A 5-year action plan will be set up based on cost efficient practices for prevention of injuries among both independently living elderly as well as those living in care home settings, which will be specified in a policy manual.

EUNESE will try to link human resources and stakeholders from existing injury prevention and safety promotion projects among elderly and not an excelling 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 healthcare of elderly.

Injury deaths among older people across Europe

Network Building:
This will be done by invitation and active recruitment of experienced and motivated members, which will contribute to create a momentum and act as catalysts to identify and recruit other members to the network.

Marketing techniques, e.g. "Who’s Who?" for injury prevention among elderly people and a "EUNESE Project Information" website will be the tools that will assist in the further development of the network.

Collaboration with World Health Organization (WHO), European Consumer Safety Association (ECCSA) and relevant health networks will ensure necessary duplication of work that has already been done and increase the potential for common actions.

2. Setting Policy Priorities
- Identification of the epidemiological spectrum of injuries and risk factors as well as of best practices for injury prevention concerning elderly
- Creation of a "Best practices for injury prevention" policy manual
- Development of the 5-year work plan for action in the enlarged European Union focusing on injury control and safety promotion among elderly

Main objectives of EUNESE
1. Creating a Network:
Network Membership:
The aim is to include participants with diverse background, which will contribute to the exchange of ideas, experiences and information in order to improve the well-being of elderly people. Participants (individuals or members of organisations/ institutions) will come from the fields of:
- Injury research and prevention
- Geriatric health
- Consumer protection
- Accessibility for senior citizens
- Social welfare of older people

Network Members:
3. Implementing Cost Efficient Projects

The network will be involved in projects to implement these measures that would focus on the safety of homes, institutions, public health areas most frequently frequented by elderly and recreational areas selected to address all those “BEs” of injury prevention:

- Engineering, e.g., adapting the architectural modifications for a safer environment for elderly in houses and residential care settings
- Education, e.g., training materials, disease learning
- Enforcement guidelines for safety in environments frequented by elderly

4. Disseminating results

Dissemination will be achieved through EU and international fora as well as through:

- EUNSE Website
- Cooperative networks
- Web network
- Scientific publications
- Printed materials
- Press releases
- Public hearings

Sponsorship

The project seeks to collaborate with organizations interested in sponsoring the development of the project activities and the sustainability of the Network on a long-term basis.

Who’s Who?

Coordination and leadership:
Center for Research and Prevention of Injuries (CERRP),
Department of Hygiene and Epidemiology
Athens University Medical School, Greece

Partners:

24 European Countries in partnership with the EC

- Austria
- Belgium
- Bulgaria
- Czech Republic
- Denmark
- Estonia
- Finland
- France
- Germany
- Greece
- Hungary
- Italy
- Latvia
- Lithuania
- Malta
- Netherlands
- Norway
- Poland
- Portugal
- Romania
- Slovakia
- Slovenia
- Spain
- Sweden
- Switzerland
- United Kingdom

with the collaboration of the World Health Organization

Duration

EUNSE is a 26-month project (July 2004 - June 2007)

Why join EUNSE Network?

- We all desire a safe Europe for all elderly people
- We all believe in cooperation and the power of exchanging information
- We all need accessibility to experts' opinions
- We all need reference materials with specialized information (best practices).
- We all believe that the rich diversity of cultures and history across Europe offers opportunities to learn from each other and implement the most cost-effective practices.

LET’S JOIN FORCES

“Health is a human right. My biggest challenge is to advance that right across the Union in a world where the threats are real and our means not unlimited.”

Markos Kyprianou, EU Health Commissioner

Contact details:
CERRP, 72, Souda, Athens 112 37, Greece
Telephone: (30) 210 614190, Mobile: (30) 6933042919
markos@eunse.gr, facebook: hy gripa marcos
In continuation to the activities of WG2 “Gathering of Information”, we have developed a questionnaire that focuses on identification and homogeneous gathering of information from readily accessible and grey sources on elderly injury. This collected information will also be a useful source for the development of the Policy Manual (WG4).

Therefore, we would like to kindly invite you to complete the following questionnaire that includes information concerning injuries among elderly, taking into account aspects such as: morbidity data, literature review, specific interventions, national initiatives, legislation.

Please be so kind to answer to as many questions as possible in order to have the most complete information available. We would appreciate if you could send back this questionnaire by………………. As some answers may take longer to complete than others, we would invite you to send the questionnaire in stages in order for us to begin working with the analysis of the available answers as soon as possible.

We thank you in advance for your contribution and collaboration.
I. Information concerning the availability of data

Please indicate below which of the following data concerning injuries among elderly are available in your country. Could it be possible for you to provide us with such data?

<table>
<thead>
<tr>
<th>Data concerning injuries at the age group 65+</th>
<th>Availability of data (Yes / No)</th>
<th>Time period coverage</th>
<th>Organisation responsible for data collection</th>
<th>Variables Recorded</th>
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</thead>
<tbody>
<tr>
<td>Morbidity</td>
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<tr>
<td>Hospital discharge</td>
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<td>National health survey</td>
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<td>Other (please specify)</td>
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<td>Direct medical cost</td>
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<td>Quality of life data</td>
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<td>Other (please specify)</td>
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Hospital discharge data:

Concerning hospitalization data in particular, we consider this is a great opportunity to collect them for all age groups in collaboration with the participating countries. The results will be disseminated and presented in a comparable way via the website of EUNESE.

*In Annex 1, you can find the available forms to complete*

II. Access to nationals studies

It is also important to have access and to gather information concerning health and/or economic impact of injuries among elderly estimated from nationally representative studies not easily accessible by non-nationals, e.g. publications in national languages.

So if there are such recent (over the last 2 years) studies in your country, please provide a summary of key points / references in English.
III. Learning the local situation

Have there been any significant initiatives (national/regional/local) for the prevention of injuries among elderly in recent years?

Such initiatives could concern for example new legislative regulations or/and community based injury prevention efforts, initiatives which evaluated terms of cost-effectiveness, published, etc.

If you have access to this kind of information please provide a brief description/references.

For a more detailed description of interventions there is the electronic registration form whose address on the website will be available very soon.

o Do you know the percentage of elderly people who live independently or live in nursing homes correspondingly in your country?

o Could you provide a list of the main stakeholders involved in decision-making process for injury prevention among elderly?

o Do you know the level of funding available for injury prevention overall and especially concerning the focused age group in your country?
IV. **Attitudes / behaviours**

- Do you have any available information concerning the attitudes and behaviours of elderly and/or caregivers facing injuries in your country?
- Is there any information about high/low risk injury behavior of elderly in your country?

If not, would it be possible to run a very short study, e.g. with group focus interviews, in order to add this information?

V. **Other information you would like to add**
Annex 1

Data request I:

Number of hospital discharges due to injury and poisoning by age groups, gender and type of injury (Ncoded).

Data format required:

- 3 separate tables as Table 1 for each of the last 3 available years.
- 3 more tables as Table 1 for each of the 3 years which are 10 years earlier than the last available.
  e.g. if 1999, 2000 and 2001 are the last available years, please provide data also for 1989, 1990, 1991. If data are not available for 10 years earlier you may provide more recent data.

For each provided year with data for hospitalizations, please provide one table as Table 2 with the respective population of the country for that year.

Table 1: Number of hospital discharges by type of injury, age group and gender

<table>
<thead>
<tr>
<th>Type of injury</th>
<th>Gender</th>
<th>0</th>
<th>1-14</th>
<th>15-24</th>
<th>25-34</th>
<th>35-44</th>
<th>45-54</th>
<th>55-64</th>
<th>65+</th>
<th>65-74</th>
<th>75-84</th>
<th>85+</th>
<th>Total</th>
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<tr>
<td>Fracture of skull and face (ICD9 800-804)</td>
<td>Male</td>
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<td>Fracture of vertebral column (ICD9 805-806)</td>
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<td>Fracture of rib(s), sternum, larynx, and trachea (ICD9 807)</td>
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<td>Other fractures of trunk (ICD9 808-809)</td>
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<td>Fracture of other parts of femur (ICD9 821)</td>
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<tr>
<td>Fracture of tibia, fibula and ankle (ICD9 823,824)</td>
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<td>Dislocations, sprains and strains (ICD9 830-848)</td>
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<td>Other intracranial injuries (&lt;span style=&quot;font-style:italic&quot;&gt;ICD9 851-854&lt;/span&gt;)</td>
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<td>Injury to nerves and spinal cord (&lt;span style=&quot;font-style:italic&quot;&gt;ICD9 850-857&lt;/span&gt;)</td>
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<td>Internal injury of chest, abdomen and pelvis (&lt;span style=&quot;font-style:italic&quot;&gt;ICD9 860-869&lt;/span&gt;)</td>
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<td>Open wound of eye, ear and head (&lt;span style=&quot;font-style:italic&quot;&gt;ICD9 870-873&lt;/span&gt;)</td>
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<td>Open wound of upper limb (&lt;span style=&quot;font-style:italic&quot;&gt;ICD9 880-887&lt;/span&gt;)</td>
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<td>Open wound of lower limb (&lt;span style=&quot;font-style:italic&quot;&gt;ICD9 890-897&lt;/span&gt;)</td>
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<tr>
<td>Other open wounds and injuries to blood vessels (&lt;span style=&quot;font-style:italic&quot;&gt;ICD9 874-879, 900-904&lt;/span&gt;)</td>
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<td>Effects of foreign body entering through orifice (&lt;span style=&quot;font-style:italic&quot;&gt;ICD9 930-939&lt;/span&gt;)</td>
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<td>Burns (&lt;span style=&quot;font-style:italic&quot;&gt;ICD9 940-949&lt;/span&gt;)</td>
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<td>Poisonings and toxic effects by medicinal agents (&lt;span style=&quot;font-style:italic&quot;&gt;ICD9 960-979&lt;/span&gt;)</td>
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<td>Toxic effects of substances chiefly non medicinal (&lt;span style=&quot;font-style:italic&quot;&gt;ICD9 980-989&lt;/span&gt;)</td>
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<tr>
<td>Complications of medical and surgical care (&lt;span style=&quot;font-style:italic&quot;&gt;ICD9 996-999&lt;/span&gt;)</td>
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<td>Late effects injuries, poisonings, toxic effects and other causes (&lt;span style=&quot;font-style:italic&quot;&gt;ICD9 905-909&lt;/span&gt;)</td>
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<td>Early complications of trauma (&lt;span style=&quot;font-style:italic&quot;&gt;ICD9 958&lt;/span&gt;)</td>
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<tr>
<td>Other and unspecified effects of external causes (&lt;span style=&quot;font-style:italic&quot;&gt;ICD9 990-995&lt;/span&gt;)</td>
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<td>Crushing injury (&lt;span style=&quot;font-style:italic&quot;&gt;ICD9 925-929&lt;/span&gt;)</td>
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<td>Other injuries (&lt;span style=&quot;font-style:italic&quot;&gt;ICD9 910-924, 959&lt;/span&gt;)</td>
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**Table 2: Population**

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<thead>
<tr>
<th>Gender</th>
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<th>1-4</th>
<th>5-14</th>
<th>15-24</th>
<th>25-34</th>
<th>35-44</th>
<th>45-54</th>
<th>55-64</th>
<th>65+</th>
<th>65-74</th>
<th>75-84</th>
<th>85+</th>
<th>Total</th>
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<tbody>
<tr>
<td>Population</td>
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</table>
Data request II:

For the last available year and for each of the following age groups

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<th>Age group</th>
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<th>25-44</th>
<th>45-64</th>
<th>65+</th>
<th>65-74</th>
<th>75-84</th>
<th>85+</th>
<th>Total</th>
</tr>
</thead>
</table>

Please fill Table 3 with the number of hospital discharges by type of injury, the result of treatment and gender. The categories for the result of treatment as they appear in the table are only indicative and may differ for each country.

Also, specify the median length of stay (in days) by type of injury, age group and gender. Should the median length of stay not be available, please provide the average length of stay.

**Table 3: Number of hospital discharges and median length of stay by result of treatment, age group and gender**

<table>
<thead>
<tr>
<th>Type of injury</th>
<th>Gender</th>
<th>Result of treatment (indicative)</th>
<th>Median (or average) length of stay</th>
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</thead>
<tbody>
<tr>
<td>Fracture of skull and face (ICD9 800-804)</td>
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<td>Cured</td>
<td>Improved</td>
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<tr>
<td>Fracture of vertebral column (ICD9 805-806)</td>
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<td>Fracture of rib(s), sternum, larynx, and trachea (ICD9 807)</td>
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<tr>
<td>Other fractures of trunk (ICD9 808-809)</td>
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<tr>
<td>Fracture of humerus, radius and ulna (ICD9 812,813)</td>
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<tr>
<td>Fracture of neck of femur (ICD9 820)</td>
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<tr>
<td>Fracture of other parts of femur (ICD9 821)</td>
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<td>Female</td>
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<tr>
<td>Fracture of tibia, fibula and ankle (ICD9 823,824)</td>
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<td>Total</td>
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<tr>
<td>Other fractures of limbs (ICD9 810-811,814-819,822,825-829)</td>
<td>Male</td>
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<td>Total</td>
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<tr>
<td>Dislocations, sprains and strains (ICD9 830-848)</td>
<td>Male</td>
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<td>Female</td>
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<tr>
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<td>Total</td>
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<tr>
<td>Concussion (ICD9 850)</td>
<td>Male</td>
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<td>Female</td>
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<tr>
<td>Other intracranial injuries</td>
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<table>
<thead>
<tr>
<th>(ICD9 851-854)</th>
<th>Male</th>
<th>Female</th>
<th>Total</th>
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<tbody>
<tr>
<td>Injury to nerves and spinal cord (ICD9 850-857)</td>
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<tr>
<td>Internal injury of chest, abdomen and pelvis (ICD9 860-869)</td>
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<tr>
<td>Open wound of eye, ear and head (ICD9 870-873)</td>
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<tr>
<td>Open wound of upper limb (ICD9 880-887)</td>
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<tr>
<td>Open wound of lower limb (ICD9 890-897)</td>
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<tr>
<td>Effects of foreign body entering through orifice (ICD9 930-939)</td>
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<tr>
<td>Burns (ICD9 940-949)</td>
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<td>Poisonings and toxic effects by medicinal agents (ICD9 960-979)</td>
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<td>Toxic effects of substances chiefly nonmedicinal (ICD9 980-989)</td>
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<td>Complications of medical and surgical care (ICD9 990-999)</td>
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<tr>
<td>Late effects injuries, poisonings, toxic effects and other causes (ICD9 965-969)</td>
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<tr>
<td>Early complications of trauma (ICD9 958)</td>
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<tr>
<td>Other and unspecified effects of external causes (ICD9 990-995)</td>
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<tr>
<td>Crushing injury (ICD9 925-929)</td>
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<tr>
<td>Other injuries (ICD9 910-924, 959)</td>
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<tr>
<td>All types of injury</td>
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</table>

**Data request III:**

Please fill in the following table with the number of surgical operations for injury and poisoning by age group and gender for the last available year.
Table 4: Number of surgical operations for injury and poisoning by age group and gender for the last available year

<table>
<thead>
<tr>
<th>Gender</th>
<th>Male</th>
<th>Female</th>
<th>Total</th>
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<tbody>
<tr>
<td>0-14</td>
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<td>15-24</td>
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<td>65-74</td>
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<td>75-84</td>
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<tr>
<td>85+</td>
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<td>Total</td>
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-For the analysis it would be important if you could also provide information related to health care delivery practices in your country and about issues (if available) such as:

1) Has the data concerning the type of injury been coded as principal diagnosis or not?

2) Do the recorded data distinguish between the number of patients who received admitted patient care for their injuries and the number of multiple hospital admissions for individual patients?

-Information concerning the external injury causes is very important, also, and, where available, this should be retrieved.
APPENDIX 5.4

Questionnaire
for independently living elderly

1. Personal Information
   a) Age: □ 65-69 □ 70-74 □ 75-79
       □ 80-84 □ 85+
   b) Gender: □ Male □ Female
   c) Status: □ Single □ Married □ Widow
            □ Separated □ Divorced
   d) Education (what level of education did you complete?)
      Please describe:
   e) Are you presently working?
      □ Yes □ No
      If yes, where?
   f) What was your last occupation before retirement?

2. Support:
   □ No formal support
   □ Day-care support
   □ Live-in carer

3. Do you have:
   a) Visual problems? □ Yes □ No
      Please describe
   b) Hearing problems? □ Yes □ No
      Please describe
   c) Mobility problems? □ Yes □ No
Lower limbs  □ Upper limbs
Please describe

If possible, examination of the mobility and balance with “Get up and go test”

4. Mental status examination

   It is proposed to use the attached Mini-mental scale

5. Chronic medical illness

□ History of stroke
□ Coronary artery disease
□ Arrhythmias
□ Hypertension
□ Chronic obstructive pulmonary disease
□ Arthritis
□ Diabetes mellitus
□ Depression
□ Other (specify)

6. Medication

   Do you receive medication systematically?
□ Yes   □ No

If yes, please indicate the medication you receive from the following categories:
□ Anxiolytics               □ Diuretics
□ Anti-arrhythmics          □ Antihypertensive
□ Medication for insomnia  □ other (specify)

7. Data concerning injuries

   a) Did you fall during the last 12 months?
□ Yes □ No

   If Yes,

   b) How many times did you fall the last 12 months?
□ Once  □ 2  □ 2-5 times  □ several times
c) Description of your more severe fall

i. **Place of injury**

- Bathroom
- Bedroom
- Stairs indoors
- Elsewhere indoors
- Farm
- Road/Pavement
- Sport/Athletic area
- Amusement area
- Public building
- Other (specify)

- Don’t know
- Don’t remember

ii. **Activity at the time of injury**

- Housework (cleaning)
- Housework (repairs)
- Personal hygiene
- Getting up from bed or chair
- At work
- Walking
- During physical exercise
- Other (specify)

- Don’t know
- Don’t remember

iii. **Height to fall:**

- Same level
- <1 metre
- >1 metre

- Other (specify)

- Don’t know
- Don’t remember

iv. **How did the injury happen? (mechanism of the injury)**

- Loss of consciousness
- Dizziness
- Stumbled
- Other (specify)

- Slipped
- Tripped
- Overexertion

v. **Did you seek medical care?**

- Yes
- No

If yes, where?

- At home
- Hospital
- Other (specify)

vi. **Had you been admitted to the hospital?**

- Yes
- No

vii. **Specify the injury**
Main injury (or injuries)
Bodypart 1
Other injury (or injuries)
Bodypart 2

viii. How many days did you stay in the hospital?

ix. Was there a permanent affect from the injury in your usual activities? (e.g. ability to transfer, for bath, using stairs)
☐ Yes ☐ No
If yes, please describe:

d) Description your last fall (if it was not the more severe)

i. Place of injury
☐ Bathroom ☐ Road/Pavement
☐ Bedroom ☐ Sport/Athletic area
☐ Stairs indoors ☐ Amusement area
☐ Elsewhere indoors ☐ Public building
☐ Farm ☐ Other (specify)

☐ Don’t know ☐ Don’t remember

ii. Activity at the time of injury
☐ housework (cleaning) ☐ at work
☐ housework (repairs) ☐ walking
☐ personal hygiene ☐ during physical exercise
☐ getting up from bed or chair ☐ Other (specify)

☐ Don’t know ☐ Don’t remember

iii. Height to fall:
☐ Same level ☐ <1 metre 
☐ Other (specify) ☐ >1 metre

☐ Don’t know ☐ Don’t remember

iv. How did the injury happen? (mechanism of the injury)
☐ Loss of consciousness ☐ Slipped
☐ Dizziness ☐ Tripped
- Stumbled
- Other (specify)

**v. Did you seek medical care?**

☐ Yes ☐ No

If yes, where?

☐ At home ☐ Hospital
☐ Other (specify)

**vi. Had you been admitted to the hospital?**

☐ Yes ☐ No

**vii. Specify the injury**

- Main injury (or injuries)
  - Bodypart 1
  - Other injury (or injuries)
  - Bodypart 2

**viii. How many days did you stay in the hospital?**

**ix. Was there a permanent affect from the injury in your usual activities?**

(e.g. ability to transfer, for bath, using stairs)

☐ Yes ☐ No

If yes, please describe:

---

8. **Attitudes / Behaviours**

   a) **Do you need any external aid?**

   If Yes:
   
   ☐ Aid to prepare meals
   ☐ Aid for home duties
   ☐ Aid for accompaniment
   ☐ Other aid, Please specify:

   b) **Do you fear falling again?**

   ☐ Yes ☐ No

   If yes, score the magnitude of the fear choosing a point in the following scale
No fear  Great fear

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<tr>
<th>0</th>
<th>1</th>
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<th>4</th>
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<th>6</th>
<th>7</th>
<th>8</th>
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<th>10</th>
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</table>

  c) Do you protect yourself from falling?
  □ Yes □ No
  If yes, in what manner?

  d) Describe your usual footwear
  e.g. athletic shoes, high heels, orthopaedic shoes, …


9.1. Housing

  a) Type of housing
  □ House
  □ Apartment
  □ Other (please specify)

  Number of rooms □□

  b) Number of persons living with you:

  c) Information about the house:

  i. Do you have enough space to move easily?
  Please, score following the scale

  No space _____________________________________________________________________________ Adequate space

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<th>2</th>
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</table>

  ii. Description of the bathroom
  Do you have handles? □ Yes □ No
  Do you have bath-mat? □ Yes □ No

  iii. Do you have easy access to light switches when you get up during the night?
iv. Do you keep a night-light?
☐ Yes ☐ No

v. Type of floor e.g.: carpets, tiles, etc…

d) Area
☐ Urban ☐ Suburban ☐ Rural

e) Is there a supermarket, bank, pharmacy, etc in close walking distance?
☐ Yes ☐ No

f) Do you know / have the phone number of emergency aid
☐ Yes ☐ No

g) Do you have an emergency aid alarm?
☐ Yes ☐ No

9.2. Financial situation

a) Monthly income:
☐ Less than 400 euros ☐ Between 800 and 1200 euros
☐ Between 400 and 800 euros ☐ More than 1200 euros

b) External Financial Aid (please specify)

9.3. Social Status

a) Do you live alone?
☐ Yes ☐ No
If No:
☐ Husband / wife ☐ Child ☐ Other (specify):

b) How often does a relative visit you?
☐ Daily ☐ At least once a month
☐ Twice a week ☐ Several times a year
☐ Every two weeks ☐ Once a year
☐ Never

c) Do you telephone each other?
d) Do you have friends?
☐ Yes ☐ No

e) How often do you visit friends / neighbours or they visit you?
☐ Daily ☐ At least once a month
☐ Twice a week ☐ Several times a year
☐ Every two weeks ☐ Once a year
☐ Never

f) How often do you go outside?
☐ More than 3 times a week ☐ Less than once a week
☐ 1 to 3 times a week ☐ Never
☐ Once a week

  g) For what purpose?
☐ Shopping ☐ Activities / walks ☐ Visit a doctor
☐ Other (specify):

h) Do you go out alone?
☐ Yes ☐ No

If not, who is accompanying you?
☐ Domestic assistant ☐ Volunteer
☐ Relative ☐ Organisation for seniors
☐ Friend ☐ Other (specify)

Means of transport:
6.1 APPENDIX

EUNESE (European Network for Safety among Elderly)

To: All EUNESE WG Co-ordinators, CEREPRI Project Management
From: Malcolm Barrow - Internal Evaluator
Monday, July 18, 2005

QUICK QUESTIONNAIRE (Goal Attainment Scaling) – JULY 2005

I would be grateful if all addressees could take a few minutes to answer the questions below and e-mail back to me - if possible, by the end of July. There is no obligation to answer any questions that appear irrelevant or you do not have the time for full answers.

A “Goal” is what you want to achieve
“Goal Attainment Scaling” is a textbook technique of Internal Evaluation used to assess progress towards goals at periodic intervals. The idea is to get an occasional snapshot of progress towards goals so that formative internal evaluation can contribute towards programme improvement

The following questions distinguish between:

**Outcome goals – results expected**
**Process goals – efforts delivered**

QUESTION 1 – Have the Goals allocated to your Work Group turned out to be more or less difficult than expected? (please comment in box or insert YES or NO as appropriate)

<table>
<thead>
<tr>
<th></th>
<th>OUTCOME GOALS</th>
<th>PROCESS GOALS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Goals are turning out to be more difficult and/or more complex than expected</td>
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<tr>
<td>The difficulty and complexity of goals is about as expected</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Goals are turning out to be less difficult and/or less complex than expected</td>
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</tbody>
</table>
QUESTION 2 – Please give an indication of overall progress towards the goals of your Work Group

<table>
<thead>
<tr>
<th>OUTCOME GOALS</th>
<th>PROCESS GOALS</th>
</tr>
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<tbody>
<tr>
<td>Progress towards goals is better than expected at this stage of the timetable</td>
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<tr>
<td>Progress towards goals is consistent with the timetable</td>
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<tr>
<td>Progress towards goals is behind the timetable</td>
<td></td>
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</tbody>
</table>

QUESTION 3 – Please indicate the major barriers towards progress in achieving the goals of your Work Group (please comment in box or insert YES or NO as appropriate:

**YES** indicates you agree with the statement

**NO** indicates you do not agree with the statement

<table>
<thead>
<tr>
<th>OUTCOME GOALS</th>
<th>PROCESS GOALS</th>
</tr>
</thead>
<tbody>
<tr>
<td>There is insufficient support from other Work Groups</td>
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<tr>
<td>There is insufficient support from CEREPRRI or other project support e.g. Internal Evaluator</td>
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<tr>
<td>I would like to see more up to date information on the Web-Board</td>
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<tr>
<td>Changed perspectives have indicated a need for more effort than originally expected</td>
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<tr>
<td>The timetable is too tight</td>
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<tr>
<td>The resources estimated for my Work Group were underestimated</td>
<td></td>
</tr>
<tr>
<td>The scale of the work allocated to my Work Group was underestimated</td>
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</tr>
<tr>
<td>1. Many promising new opportunities for my Work Group have emerged during the work:</td>
<td></td>
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<tr>
<td>2. I have the resources to develop some of these <em>(ignore if 1. above is untrue)</em></td>
<td></td>
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<tr>
<td>3. I do not have the resources for all of these <em>(ignore if 1. above is untrue)</em></td>
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<tr>
<td>I do not have sufficient staff resources for the work allocated to my Work Group</td>
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<tr>
<td>I do not have sufficient money for the</td>
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</table>
activities allocated to my Work Group
Some Partners for my Work Group are not providing all the support expected
I believe my Work Group is providing all the support and information that other Work Groups and CEREPRI expect at this stage
There is so much to do that I feel that I quality standards might be affected
I can see new potential for EUNESE which I would like to discuss with other Work Groups & CEREPRI
I would like more feedback from other Work Groups
I would like more feedback from CEREPRI, and/or the Internal Evaluator

QUESTION 4 – Thinking about progress overall with your Work Group, please indicate which of the following best reflects your current views:

<table>
<thead>
<tr>
<th></th>
<th>OUTCOME GOALS</th>
<th>PROCESS GOALS</th>
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<tbody>
<tr>
<td>I am not entirely confident of completing all the agreed tasks and requirements of the Action Plan</td>
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<tr>
<td>I am completely confident of completing all the agreed tasks and requirements of the Action Plan</td>
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<tr>
<td>More help and support is needed to completing all the agreed tasks and requirements of the Action Plan</td>
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QUESTION 5 – Please take the opportunity to enter in the box below your single best idea for improving progress on this large complex project (this can relate to anything you choose – your Work Group, other Work Groups, CEREPRI, Internal Evaluator etc.)
Thank you for your time if you have got this far! Please e-mail your completed questionnaire **if possible by July 31st 2005** back to:

Malcolm Barrow  
Internal Evaluator, EUNESE  
barrow@btinternet.com  
+44 1707 657957  
+44 7989 320006 (mobile)

Monday, July 18, 2005
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