Preventing Falls: What Works

A CDC Compendium of Effective Community-based Interventions from Around the World

by

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Older adults value their independence, and a fall can significantly limit their ability to remain self-sufficient. More than one-third of people aged 65 and older fall each year, and those who fall once are two to three times more likely to fall again. Fall injuries are responsible for significant disability, reduced physical function, and loss of independence. In 2000, direct medical costs for fall injuries totaled $19 billion. However, we know that falls are not an inevitable result of aging. In recent years, systematic reviews of fall intervention studies have established that prevention interventions can reduce falls.

The Centers for Disease Control and Prevention (CDC) developed the *Compendium of Effective Community-based Interventions* to help public health practitioners effectively address the problem of falls. This *Compendium* includes specific interventions that have rigorous scientific evidence of effectiveness and provides relevant information about these interventions to public health practitioners, senior service providers, and others who wish to implement fall prevention programs.
Process

CDC gathered information about science-based fall prevention intervention studies that met the following criteria:*

- Included community-dwelling adults aged 65 and older
- Used a randomized controlled study design
- Measured falls as a primary outcome (did not include intervention studies using other outcomes, such as balance improvement or reduced fear of falling)
- Demonstrated statistically significant positive results in reducing older adult falls

Using this selection process, CDC identified 14 studies of effective fall interventions published before January 2006.

* For details about the selection process, see Appendix A.

Content

The Compendium groups interventions into three categories: exercise-based, home modification, and multifaceted interventions. Information about each intervention was obtained from the published study and by directly contacting the principal investigator. Each is presented using a standardized format that includes a short summary of the research study and results as well as a longer section describing relevant details about the intervention. The intervention description includes information about the focus, program setting, content, number of sessions, duration, provider, provider’s training, key elements, available intervention materials, and contact information for the study’s principal investigator.

The Compendium also has appendices. These include a figure illustrating the intervention study selection process; a bibliography of the research studies; tables comparing the participating populations, study characteristics, and intervention characteristics of the 14 studies; and supplemental materials, such as assessment instruments and evaluation materials, provided by the principal investigators.
Exercise-based Interventions

Stay Safe, Stay Active (Barnett, et al.) ................................................................. 5
The Otago Exercise Program (Campbell, et al. and Robertson, et al.) ............. 7
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Veterans Affairs Group Exercise Program (Rubenstein, et al.) ...................... 15
Simplified Tai Chi (Wolf, et al.) ......................................................................... 17
This study used weekly structured group sessions of moderate-intensity exercise, held in community settings, with additional exercises performed at home. Participants were 40 percent less likely to fall and one-third less likely to suffer a fall-related injury compared with those who did not receive the intervention.

**Population:** Participants were individuals at risk for falling because of lower limb weakness, poor balance, and/or slow reaction time. All were aged 67 or older and lived in the community. About two-thirds of participants were female.

**Geographic Locale:** Southwest Sydney, Australia

**Focus:** Improve balance and coordination, muscle strength, reaction time, and aerobic capacity.

**Program Setting:** Classes were conducted in local indoor lawn bowling and sports clubs that hosted community programs for various sports and exercise activities, comparable to U.S. community exercise, sports, and recreation facilities. Many lawn bowling and sports clubs also included other indoor attractions such as restaurants, meeting facilities, and movies.

**Content:** The classes were designed by a physical therapist to address physical fall risk factors: balance and coordination, strength, reaction time, and aerobic capacity. Each class began with 5 to 10 minutes of warm-up that included stretching of the major lower limb muscle groups and 10 minutes of cool-down that included gentle stretching, relaxation, and controlled-breathing practice. Each class included music chosen by the participants.

The classes included the following types of exercises:

- Balance and coordination exercises, including modified Tai Chi exercises, practice in stepping and in changing direction, dance steps, and catching and throwing a ball
- Strengthening exercises, including exercises that used the participant’s weight (e.g., sit-to-stand, wall press-ups) and resistance-band exercises that worked both upper and lower limbs
- Aerobic exercises, including fast-walking practice with changes in pace and direction

As the classes progressed, the complexity and speed of the exercises and the resistance of the bands were steadily increased.

Participants also took part in a home exercise program using content from the exercise class and recorded their participation in a home exercise diary.
**Duration:** A total of 37 1-hour classes were conducted once a week over a 1-year period.

**Delivered by:** Nationally accredited exercise instructors who had been trained to conduct this exercise program by a licensed physical therapist (accredited by Australia’s National Association for Gentle Exercise). The study used currently accredited exercise leaders who already had a good understanding of the exercise principles.

Before classes began, regular meetings were held with the exercise leaders to discuss the content and how the classes would be run, giving leaders ownership in the program. Training included approximately 6 hours of additional meetings, discussion, and practice sessions before beginning the program. During the classes, instructors were visited by the physical therapist for support once each term.

**Minimum Level of Training Needed:** Information was not provided by the principal investigator.

**Key Elements:**
- This study used health practitioners to assess and recruit participants. General practitioners are in an ideal position to both identify older people at risk of falls and to support their participation in an exercise program when appropriate.
- The program used existing services and facilities in the community, so it is likely to be sustainable and transferable to other settings.

**Available Materials:** In addition to the guidance received during the exercise sessions, participants received:
- A home exercise program based on class content*
- A “hot tips” sheet listing practical strategies for avoiding falls such as where to place hands and feet if a loss of balance occurs*  
  
  * See Appendix D-1.


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**Contact**
Practitioners interested in using this intervention may contact the principal investigator for more information:

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The Otago Exercise Program

This intervention, tested in four randomized controlled trials and one controlled multi-center trial, was an individually tailored program of muscle-strengthening and balance-retraining exercises of increasing difficulty, combined with a walking program. This extensively tested fall prevention program is now used worldwide.

Overall, the fall rate was reduced by 35 percent among program participants compared with those who did not take part. The program was equally effective for men and women. Participants aged 80 years and older who had fallen in the previous year showed the greatest benefit.

Population: Participants were aged 65 to 97 years and lived in the community.

Geographic Locale: Dunedin, New Zealand

Focus: Improve strength and balance with a simple, easy-to-implement, and affordable home-based exercise program.

Program Setting: The program was conducted in participants’ homes and was intended for people who did not want to attend, or could not reach, a group exercise program or recreation facility.

Content: A physical therapist (PT) or nurse visited each participant four times at home over the first 2 months (at weeks 1, 2, 4, and 8) and visited again for a booster session at 6 months. To maintain motivation, participants were telephoned once a month during the months when no visits were scheduled.

The first home visit lasted an hour; all subsequent visits took about half an hour. During the visits, the PT or nurse prescribed a set of in-home exercises (selected at appropriate and increasing levels of difficulty) and a walking plan.
The exercises included:

- Strengthening exercises for lower leg muscle groups using ankle cuff weights
- Balance and stability exercises such as standing with one foot in front of the other and walking on the toes
- Active range of motion exercises such as neck rotation and hip and knee extensions

Participant safety was ensured by tailoring the exercise program and by giving participants instructions and an illustration for each exercise.

**Duration:** The exercises took about 30 minutes. Participants were encouraged to complete the exercises three times a week and to walk outside the home at least two times a week. Exercises then were continued on an ongoing basis. In three trials, the exercise program was prescribed for 1 year and in one trial was extended to 2 years.

**Delivered by:** The program was delivered by either a PT experienced in prescribing exercises for older adults, or a nurse who was given special training and received ongoing supervision from a PT.

**Minimum Level of Training Needed:** PTs can deliver the program immediately after reading the manual. Nurses can be trained to deliver the program after a 2-day training program and with ongoing supervision by a PT.

**Key Elements:** PTs should understand the research evidence on which the program is based and avoid adding or subtracting exercises from the set used in the trials, as this particular combination of exercises worked to reduce falls.

**Available Materials:** The Otago Exercise Program instruction guide, which describes the program exercises, is available to health professionals at: [http://www.acc.co.nz/injury-prevention/home-safety/older-adults/otago-exercise-programme/index.htm](http://www.acc.co.nz/injury-prevention/home-safety/older-adults/otago-exercise-programme/index.htm)
Study Citation:
Primary studies


Supplemental articles

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This study compared the effectiveness of a 6-month program of Tai Chi classes with a program of stretching exercises. Participants in the Tai Chi classes had fewer falls and fewer fall injuries, and their risk of falling was decreased 55 percent.

**Population:** Participants were inactive seniors aged 70 years or older. Three-quarters were female. All participants lived in the community.

**Geographic Locale:** Portland, Oregon, USA

**Focus:** Improve balance and physical performance with Tai Chi classes designed for older adults.

**Program Setting:** The Tai Chi programs were conducted in community settings such as local senior centers and adult activity centers.

**Content:** The program included 24 Tai Chi forms that emphasized weight shifting, postural alignment, and coordinated movements. Synchronized breathing aligned with Tai Chi movements was integrated into the movement routine.

Each session included instructions in new movements as well as review of movements from previous sessions. Each practice session incorporated musical accompaniment.

Each hour-long session included:
- A 5- to 10-minute warm-up period
- Practice of Tai Chi movements
- A 5- to 10-minute cool-down period

Practicing at home was encouraged and monitored using a home-practice log.

**Duration:** One-hour classes were held three times a week for 26 weeks, followed by a 6-month period in which there were no organized classes.

**Delivered by:** Experienced Tai Chi instructors who followed the classical Yang style, which emphasizes multidirectional weight shifting, body alignment, and coordinated movement of the arms, legs, and trunk.
**Minimum Level of Training Needed:** Instructors should be familiar with the fundamental principles of Tai Chi and the major postures and movements, be able to follow the training protocol, and have experience teaching physical activity to older adults.

**Key Elements:**
- Program settings can include facilities such as senior centers, adult activity centers, and community centers.
- An average class size of 15 is ideal for effective learning and teaching.
- For this program to be successful, participants should attend Tai Chi classes at least two times a week and participate actively in class.
- Tai Chi can also be used in rehabilitative settings where the emphasis is on retraining balance in older adults.

**Available Materials:** The *Tai Chi: Moving for Better Balance* program package, specifically designed for community-dwelling older adults and senior service providers, is available from Dr. Fuzhong Li. The package contains an implementation plan, training manuals, and class materials on videotape and/or DVD.


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This study evaluated a 12-month group exercise program for frail older adults. The program was tailored to each participant's abilities. Overall, the fall rate was 22 percent lower among people who took part in the program, and 31 percent lower among participants who had fallen in the previous year, compared with those who were not in the program.

**Population:** Ages ranged from 62 to 95, although nearly all were 70 years or older. Most study participants were female. Participants lived in retirement villages and most were independent.

**Geographic Locale:** Sydney and Wollongong, Australia

**Focus:** Increase participants' strength, coordination, balance and gait, and increase their ability to carry out activities of daily living such as rising from a chair and climbing stairs.

**Program Setting:** Programs were conducted in common rooms in residential care community centers and senior centers within the retirement villages.

**Content:** The group classes included weight-bearing exercises and balance activities that were challenging but not so difficult as to discourage participation or cause any adverse events. The program emphasized social interaction and enjoyment.

The program consisted of four 3-month terms. The first term included understanding movement, how the body works, training principles, and basic exercise principles. This was followed by progressive strength training and increasingly challenging balance exercises, using equipment to maintain interest. In each term, the exercise sessions built on the skills acquired in the previous term.

Each hourlong class had three segments:

- A 5- to 15-minute warm-up period that included chair-based activities, stretching large muscle groups, and later in the program, slow to moderate walking.
- A 35- to 40- minute conditioning period that included aerobic exercises, strengthening exercises, and activities to improve balance, hand-eye and foot-eye coordination, and flexibility. As the program progressed, the number of repetitions of each exercise increased, beginning with 4 repetitions at week 2 and reaching 30 by week 10. Thirty repetitions were maintained for rest of the program.
• A 10-minute cool-down period that included muscle relaxation, controlled breathing, and guided imagery.

**Duration:** One-hour classes were held twice a week for 12 months. The program consisted of four successive 3-month terms.

**Delivered by:** Six exercise instructors were trained to deliver the program. All had previously completed a training course conducted by the Australian Council for Health, Physical Education, and Recreation on leading exercise programs for frail, older people. The project coordinator regularly observed the instructors to provide support and to monitor program fidelity and consistency.

Everyone involved in implementing the program received specific 1-day training and met regularly to discuss issues and training updates.

**Minimum Level of Training Needed:** Instructors should have taken an exercise instructor course as well as a specific course on teaching exercise to older adults.

**Key Elements:** Information was not provided by the principal investigator.

**Available Materials:** No intervention materials were available at the time of publication.


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Veterans Affairs Group Exercise Program

This study evaluated a structured group exercise program for fall-prone older men. During the 3-month program, participants were two-thirds less likely to fall compared with those who did not take part in the program.

Note: This study calculated the fall rate as the number of falls per hour of physical activity.

**Population:** All participants were aged 70 or older and lived in the community. All were males who had at least one of these fall risk factors: leg weakness; impaired gait, mobility, and/or balance; and had fallen two or more times in the previous 6 months.

**Geographic Locale:** Los Angeles, California, USA

**Focus:** Increase strength and endurance and improve mobility and balance using a low- to moderate-intensity group exercise program.

**Program Setting:** The program was conducted at a Veterans Affairs ambulatory care center.

**Content:**

- Strength training included hip flexion, extension, abduction, and adduction; knee flexion and extension; squats, dorsiflexion, and plantar flexion. Over the first 4 weeks, participants increased each exercise from one to three sets of 12 repetitions. Resistance levels also were increased progressively. The rate of progression was modified for subjects with physical limitations.

- Endurance training used bicycles, treadmills, and indoor walking sessions. Endurance training alternated between cycling (once a week), using a treadmill (twice a week), and indoor walking that included a walking loop as well as two flights of stairs (twice a week). Heart rates were monitored to ensure that participants did not exceed 70 percent of their heart rate reserve.

- Balance training used a rocking balance board, balance beam, obstacle course, and group activities such as balloon volleyball and horseshoes. Balance training sessions were held twice a week and increased in difficulty over the 12-week program.
**Duration:** Three 1 ½-hour sessions a week for 12 weeks.

**Delivered by:** Exercise physiology graduate students with training from experienced exercise physiologists or physical therapists.

**Minimum Level of Training Needed:** Facilitators should have approximately 2 weeks of on-the-job training by an experienced exercise physiologist or physical therapist.

**Key Elements:**
- Using a group format and providing a wide variety of exercise activities
- Focusing on strength, balance, and endurance
- Providing personal encouragement and reinforcement

**Available Materials:** No materials were available at time of publication.


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This study compared a 15-week program of Tai Chi classes that used 10 simplified movements, with a balance training program. After 4 months, the risk of falling more than once among participants in the Tai Chi classes was almost half that of people in the comparison group.

Participants reported that after the study they were better able to stop themselves from falling by using their environment and appropriate body maneuvers. After the study ended, almost half the participants chose to continue meeting informally to practice Tai Chi.

**Population:** All were 70 years or older and lived in the community. Most study participants were female.

**Geographic Locale:** Atlanta, Georgia, USA

**Focus:** Improve strength, balance, walking speed, and other functional measures among seniors using Tai Chi.

**Program Setting:** The program used facilities in a residential retirement community.

**Content:** Participants were taught a simplified version of Tai Chi. The 108 existing Tai Chi forms were synthesized into a series of 10 composite forms (see Appendix D-2) that could be completed during the 15-week period. The composite forms emphasized all elements of movement that generally become limited with age.

Exercises systematically progressed in difficulty. The progression of movements led to gradually reducing the base of standing support until, in the most advanced form, a person was standing on one leg. This progression also included increasing the ability to rotate the body and trunk as well as performing reciprocal arm movements. These exercises were led during the group sessions; however, individuals were encouraged to practice these forms on their own, outside of the group setting.

Example of a simplified Tai Chi form:
**Duration:** The 15-week program included:
- Twice weekly 25-minute group sessions
- Weekly 45-minute individual contact time with the instructor
- Twice daily 15-minute individual practice sessions at home without an instructor

**Delivered by:** A Tai Chi Quan grand master with 50 years of experience instructed the classes and met individually with participants. A nurse/coordinator maintained contact with participants to ensure their participation.

**Minimum Level of Training Needed:** Information was not provided by the principal investigator.

**Key Elements:** This program needs to be led by a very experienced Tai Chi grand master. No elements should be changed in order to replicate these results among seniors who are similar to study participants.

**Available Materials:** Illustrations of the 10 Tai Chi exercises are found in Appendix D-2.


Supplemental article

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Home Visits by an Occupational Therapist (Cumming, et al.)................................. 21
Falls-HIT (Home Intervention Team) Program (Nikolaus, et al.) .............................. 23
Home Visits by an Occupational Therapist

This intervention used an occupational therapist (OT) who visited participants in their homes, identified environmental hazards and unsafe behaviors, and recommended home modifications and behavior changes. Fall rates were reduced by one-third but only among men and women who had experienced one or more falls in the year before the study.

Population: All participants were 65 or older and lived in the community. More than half of the participants were female.

Geographic Locale: Sydney, Australia

Focus: Assess and reduce home hazards.

Program Setting: The program was conducted in participants’ homes.

Content: The OT visited each participant’s home and conducted an assessment using the standardized Westmead Home Safety Assessment form (see Available Materials below). The OT identified environmental hazards such as slippery floors, poor lighting, and rugs with curled edges, and discussed with the participant how to correct these hazards.

Based on standard occupational therapy principles, the therapist also assessed each participant’s abilities and behaviors, and how each functioned in his or her home environment. Specific unsafe behaviors were identified such as wearing loose shoes, leaving clutter in high-traffic areas, and using furniture to reach high places. The OT discussed with the participants ways to avoid these unsafe behaviors.

Two weeks after the initial home visit the OT telephoned each participant to ask whether they had made the modifications and to encourage them to adopt the recommended behavioral changes.
Duration: One-hour home visit with a follow-up telephone call 2 weeks later. Total contact time was approximately 2 hours.

Delivered by: An occupational therapist with 2 years experience.

Minimum Level of Training Needed: A degree in occupational therapy is the minimum qualification needed to conduct the home assessments, develop the recommendations, and supervise the home modifications.

Key Elements:
• Using an experienced occupational therapist is critical
• These researchers emphasized that this study should not be used to justify widespread, untargeted home modification programs implemented by people who do not have skills in caring for older people

Available Materials: Information on the falls prevention kit, which includes the Westmead Home Safety Assessment form and a booklet that gives background information on falls and hazards can be purchased from the following company:

Co-ordinates Therapy Services
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Falls-HIT (Home Intervention Team) Program

This intervention provided home visits to identify environmental hazards that can increase the risk of falling, provided advice about possible changes, offered assistance with home modifications, and provided training in using safety devices and mobility aids. The fall rate for participants was reduced 31 percent. The intervention was most effective among those who had experienced two or more falls in the previous year; the fall rate for these participants was reduced 37 percent.

**Population:** Participants were frail community-dwelling older adults who had been hospitalized for conditions unrelated to a fall, and then discharged to home. Participants showed functional decline, especially in mobility. All were 65 years or older and lived in the community. Three-quarters were female.

**Geographic Locale:** Mid-sized town, Southern Germany

**Focus:** Assess and reduce fall hazards in participants’ homes.

**Program Setting:** Intervention team members contacted patients once or twice while they were hospitalized to explain the program. The program took place in participants’ homes.

**Content:** The first home visit was conducted while the participant was still hospitalized. Two team members, an occupational therapist with either a nurse or a physical therapist, depending on patient’s anticipated needs, conducted a home assessment. They identified home hazards using a standardized home safety checklist and determined what safety equipment a participant needed.

During two to three subsequent home visits, an occupational therapist or nurse met with the participant to:

- Discuss home hazards
- Recommend home modifications
- Facilitate necessary modifications
- Teach participants how to use safety devices and mobility aids when necessary
Duration: The program consisted of two or more home visits, each lasting about 1.5 hours. After the participant was discharged from the hospital, three home visits typically were needed to provide advice on recommended home modifications and to teach the participant how to use safety devices and mobility aids. On average, the total individual contact time was 8 hours.

Delivered by: The home intervention team was composed of a physical therapist, occupational therapist, three nurses, a social worker, and a secretary. Occupational therapists generally worked with all participants. Depending on individual need, either a physical therapist or nurse also helped the participant. The social worker was available to provide information about ambulatory services and to help participants complete applications for additional money from the mandatory care insurance.

Minimum Level of Training Needed: Information was not provided by the principal investigator.

Key Elements: Participants met all intervention team members at the hospital before they were discharged, which facilitated follow-up.

Available Materials: A standardized home safety checklist is available in German only.

Study Citation: Nikolaus T, Bach M. Preventing falls in community-dwelling frail older people using a home intervention team (HIT): Results from the Randomized Falls HIT Trial. Journal of the American Geriatrics Society. 2003 Mar;51(3):300-5.

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Stepping On (Clemson, et al.) ................................................................. 27
PROFET (Prevention of Falls in the Elderly Trial) (Close, et al.) .................. 31
The NoFalls Intervention (Day, et al.) ..................................................... 33
The SAFE Health Behavior and Exercise Intervention (Hornbrook, et al.) .... 37
Yale FICSIT (Frailty and Injuries: Cooperative Studies of Intervention
  Techniques) (Tinetti, et al.) .................................................................. 39
A Multifactorial Program (Wagner, et al.) .................................................. 43
This study used a series of small group sessions to teach fall prevention strategies to community-dwelling older adults. The fall rate among participants was reduced about 30 percent compared with those who did not receive the intervention. The intervention was especially effective for men. The fall rate among male participants was reduced almost two-thirds.

**Population:** Participants were individuals who had fallen in the previous year or who were concerned about falling. All were 70 years or older and lived in the community. Most study participants were female.

**Geographic Locale:** Sydney, Australia

**Focus:** Improve self-efficacy, empower participants to make better decisions and learn about fall prevention techniques, and make behavioral changes.

**Program Setting:** Initial sessions were conducted in easily accessible community settings. Refreshments were provided before and after the sessions to give participants an opportunity to talk to each other and with the facilitators and content experts. Follow-up visits took place in the participants’ homes.

**Content:** The program addressed multiple fall risk factors: improving lower limb balance and strength, improving environmental and behavioral safety in both the home and community, and encouraging visual and medical screenings to check for low vision and possible medication problems.

Each session covered a different aspect to reducing fall risk:
- Session 1: Risk appraisal; introducing balance and strength exercises
- Session 2: Review and practice exercises; how to move safely in the home
- Session 3: Hazards in and around the home and how to remove or reduce them
- Session 4: How to move safely in the community; safe footwear and clothing
- Session 5: Poor vision and fall risk; the benefits of vitamin D, calcium, and hip protectors
• Session 6: Medication management; review of exercises; more strategies for moving safely in the community
• Session 7: Review of topics covered in program
• Follow-up home visit: Review fall prevention strategies; assist with home adaptations and modifications, if needed
• Three-month booster session: Review achievements and how to maintain motivation.

Duration:
• Seven weekly 2-hour program sessions
• A 1 to 1 ½ -hour home visit, 6 weeks after the final session
• A 1-hour booster session 3 months after the final session

Delivered by: An occupational therapist (OT) facilitated the program and conducted the home visits.

A team of content experts, trained by the OT and guided by the *Stepping On* manual, led the sessions. These included:
• A physical therapist who introduced the exercises and led a segment on moving about safely.
• An OT who led segments on home safety, community safety, behavioral methods to sleeping better, and hip protectors.
• An older adult volunteer from the Roads and Traffic Authority who spoke on pedestrian safety.
• A retired volunteer nurse from the Medicine Information Project who discussed how to manage medications.
• A mobility officer from the Guide Dogs who spoke on coping with low vision. (The *Stepping On* manual has a topics section that outlines the information required to run this session.)

Minimum Level of Training Needed: The program should be facilitated by a health professional with experience both in group work and in working with older adults in community settings.

This program requires a physical therapist, an OT, a person trained in road safety for older drivers who can discuss pedestrian safety, a low vision expert, and a nurse or community pharmacist who can discuss medications. Other potentially useful content experts include a podiatrist or perhaps a nutritionist. All content experts need to receive training in fall prevention.
**Key Elements**: Using content experts is critical. It is also important to let each expert know what is expected of them, to provide feedback, and to make sure each focuses on fall prevention.

The *Stepping On* manual is essential for all program facilitators and provides a step-by-step guide to running the 7-week group program. It outlines topic areas and provides the background information for each content expert.

Chapters include:
- Essential background information for understanding the conceptual underpinning of the program and the group process
- Valuable content information for all the key fall prevention areas that can be used to train local experts participating in the program
- A guide to useful resources
- Handouts for group participants
- Ideas on recruitment and evaluation

Work is ongoing to develop training workshops and certification for *Stepping On* program leaders.
Available Materials: The program manual *Stepping On: Building Confidence and Reducing Falls. A Community-Based Program for Older People* by Dr. Lindy Clemson is available at:

Freiberg Press Inc  
bfreiberg@cfu.net  
2302 W. 1st St.  
Cedar Falls, IA 50613  
USA


Contact  
Practitioners interested in using this intervention may contact the principal investigator for more information:

Lindy Clemson, PhD  
School of Occupation & Leisure Sciences  
The University of Sydney  
P.O. Box 170  
Lidcombe 1825  
Australia  
Tel: +61 (2) 9351 9372  
Fax: +61 (2) 9351 9166  
E-mail: L.Clemson@fhs.usyd.edu.au
This intervention provided medical assessments for fall risk factors with referrals to relevant services and an occupational therapy home hazard assessment with recommendations for home modifications. After 12 months, those in the intervention group were 60 percent less likely to fall once and 67 percent less likely to fall repeatedly (at least three times), compared with those who did not receive the intervention.

**Population:** Participants were seniors who had been treated for a fall in a hospital emergency department. All were aged 65 years and older and lived in the community. Two-thirds of participants were female.

**Geographic Locale:** London, United Kingdom

**Focus:** Identify medical risk factors and home hazards, and provide referrals and/or recommendations to reduce fall risk and improve home safety.

**Program Setting:** The medical assessment took place in an outpatient hospital clinic. The occupational therapy assessment took place in participants’ homes.

**Content:** The medical assessment was conducted soon after the fall that was treated in the emergency room. It included assessments of visual acuity, postural hypotension, balance, cognition, depression, and medication problems. The results were used to identify and address problems that could contribute to fall risk. Participants received referrals to relevant services, as appropriate, based on identified risk factors.

The home assessment was conducted during a single visit. The occupational therapist (OT) identified environmental hazards in the home such as uneven outdoor surfaces, loose rugs, and unsuitable footwear. Based on findings, the OT provided advice and education regarding safety within the home, made safety modifications to the home with the participant’s consent, and provided minor safety equipment.

The OT made social service referrals for participants who required hand rails, other technical aids, adaptive devices such as grab bars and raised toilet seats, and additional support services.

**Duration:** The average length of the medical assessment was 45 minutes. The average length of the home assessment was 60 minutes.

**Delivered by:** A physician specializing in geriatrics conducted the medical assessment. An OT delivered the home hazard assessment.
Minimum Level of Training Needed: This program could be implemented by:

- Appropriately trained geriatricians
- General practitioners with a strong interest in older adult health
- Trained physical therapists or nurses with the support of a general practitioner in case medication modification, referrals to specialists, or other medical services were required

Key Elements: For medication review and modification, a medical specialist rather than a general practitioner is recommended.

Available Materials:

- Folstein mini-mental state examination (see Supplemental Articles)
- Modified geriatric depression scale (see Supplemental Articles)
- Snellen vision assessment chart
- Medical assessment form*—the form used in the outpatient hospital clinic setting
- Accident and emergency assessment tool*—the instrument used in the emergency department to identify people at high risk of falling and those who should be referred for a comprehensive geriatric assessment
- Environmental hazards checklist*—the checklist used to guide the home assessment
* See Appendix D-3.


Supplemental articles


Contact
Practitioners interested in using this intervention may contact the principal investigator for more information:

Jacqueline Close, MD
Prince of Wales Medical Research Institute
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Sydney NSW 2031, Australia
Tel: +61 (2) 9399 1000
Fax: +61 (2) 9399 1082
E-mail: j.close@unsw.edu.au
The NoFalls Intervention

This study looked at the effectiveness of group-based exercise in preventing falls when used alone or in combination with vision improvement and/or home hazard reduction. The intervention components focused on increasing strength and balance, improving poor vision, and reducing home hazards.

The group-based exercise was the most potent single intervention; when used alone, it reduced the fall rate by 20 percent. Falls were reduced further when vision improvement or home hazard reduction was combined with exercise. The most effective combination was the group-based exercise with both vision improvement and home hazard reduction. Participants who received all three components were one-third less likely to fall.

Population: All participants were aged 70 and older and lived in the community. Sixty percent were female.

Geographic Locale: City of Whitehorse, Melbourne, Australia

Focus: Increase strength and balance, improve poor vision, and reduce home hazards.

Program Setting: The exercise program was delivered in community settings such as exercise rooms in fitness centers and community health centers. The vision intervention was delivered via usual services available in the community. Participants went to their optometrist or ophthalmologist if they had one. If any further action was required, it was facilitated using normal services such as hospitals for cataract surgery, optometrists for new glasses, and general practitioners or ophthalmologists for medication if required. The home hazard intervention was conducted in participants’ homes.
Content:

Exercise: The exercise intervention consisted of weekly 1-hour classes plus daily home exercises. Classes were designed by a physical therapist to improve flexibility, leg strength, and balance. About one-third of the exercises were devoted to balance improvement. Exercises were adjusted for participants with limitations. Music was played during the sessions.

Leaders provided a social time with coffee and tea after each session to talk informally about exercise improvements and opportunities.

Vision improvement: The vision intervention included referral to an appropriate eye care provider if a participant’s vision fell below predetermined criteria during the baseline assessments for visual acuity, contrast sensitivity, depth perception, and field of view. Criteria for referral included more than four lines difference between the line of smallest letters read correctly on the high and low contrast sections of the vision chart or any loss of field of view.

A referral was recommended if:
(1) A potential visual deficit was identified and the participant was not already receiving treatment, or
(2) If a deficit had been identified previously but the participant had not received treatment during the previous 12 months. The intervention consisted of the participant receiving the recommended treatment by an appropriate specialist.

Home hazard reduction: The home hazard assessment consisted of a walk-through using a checklist for those rooms used in a normal week. The checklist included a comprehensive section defining the different areas of the house and specific hazards. The checklist was divided into rooms or areas of the house—access points (main entry door, back door, etc.), hallways, stairwells, dining room, living room, den, bedrooms, and wet areas (kitchen, bathroom, laundry rooms). Within each of these areas, the focus was on steps and stairs, floor surfaces, lighting, and some key furniture items or fixtures such as a favorite chair or bathroom fixtures.

After the assessment, the results were discussed with the participant and potential interventions described in the checklist were suggested. If the participant agreed to the intervention, it was determined who would carry it out. Hazards could be removed or modified by the participant, their family, the City of Whitehorse home maintenance program, or some other person. Study staff visited the participants’ homes and provided quotes for the materials needed for the suggested modifications; labor was provided free of charge.
**Duration:**
Exercise: Weekly 1-hour group classes for 15 weeks and 25 minutes of daily home exercises.

Vision improvement: Duration depended on the specific intervention (such as cataract surgery or new glasses).

Home hazard reduction: Duration depended on the length of time the home modifications were left in place by the participant.

**Delivered by:**
Exercise: Classes were led by trainers who were accredited to lead exercise classes for older adults, and were trained in the *NoFalls* program by the physical therapist who designed the program.

Vision improvement: Initial assessment was conducted by nurses with up to a half-day’s training required on the vision assessment. Detailed vision assessment was conducted by each participant’s usual eye care provider, general practitioner, local optometrist, or ophthalmologist.

Home hazard reduction: Home assessments were conducted by research nurses who followed the study protocol for assessment with 1 day of training required on the home hazard assessment. Modifications were undertaken by participants, their family or a private contractor, or by the City of Whitehorse home maintenance program.

**Minimum Level of Training Needed:**
Exercise: Requires a basic level of exercise leadership training such as that received by a physical therapist or certified fitness instructor.

Vision and home hazard assessments: Nurses or other allied health professionals with the appropriate training.

**Key Elements:** Although the most effective single component was the *NoFalls* exercise program, the complete program should be followed because partial implementation may not reduce falls.
Available Materials: The NoFalls exercise program manual, which was developed for trained professionals, is available free of charge in electronic format at http://www.monash.edu.au/muarc//projects/nofalls/.

These researchers have not made the home assessment protocol available because this intervention component by itself was not effective.


Contact
Practitioners interested in using this intervention may contact the principal investigator for more information:

Lesley Day, PhD, MPH
Accident Research Centre
Building 70, Monash University
Wellington Road
Clayton Victoria 3800, Australia
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Fax: +61 (3) 9905 1809
E-mail: NoFalls.enquire@general.monash.edu.au
The SAFE Health Behavior and Exercise Intervention

The Study of Accidental Falls in the Elderly (SAFE) health behavior intervention was a program of four group classes on how to prevent falls. The classes addressed environmental, behavioral, and physical risk factors and included exercise with instructions and supervised practice. The home safety portion included a home inspection with guidance and assistance in reducing fall hazards.

Overall, participants were 15 percent less likely to fall compared with those who did not receive the intervention. Male participants showed the greatest benefit.

**Population:** All were participants were 65 years or older and lived in the community. About 60 percent of participants were female.

**Geographic Locale:** Portland, Oregon, and Vancouver, Washington, USA

**Focus:** Reduce risky behaviors, improve physical fitness through exercise, and reduce fall hazards in the home.

**Program Setting:** No information was available on where risk education and group exercise classes took place. Home safety inspections were conducted in participants’ homes.

**Content:** The SAFE health behavior intervention consisted of four 1 ½-hour group classes that used a comprehensive approach to reducing fall risks. Classes addressed environmental, behavioral, and physical risk factors.

Classes included:
- A slide presentation on common household risks
- Discussions of behavioral risks such as walking on ice or using a chair to reach high places
- A self-appraisal of home hazards using a specially designed form
- Small group sessions during which participants worked together to develop action plans

Each class session also had an exercise component that included a brief demonstration of fall prevention exercises and about 20 minutes of supervised practice. Participants received a manual describing the exercises and were encouraged to begin walking at least three times a week.

The exercises were chosen to:
- Actively involve all parts of the body
- Maintain full range of motion of all joints
- Strengthen muscles
- Improve posture
- Improve balance
During the home safety inspection, the assessor inspected the participant’s home and identified fall hazards using a standard protocol. The assessor encouraged the participant to remove or repair the hazards identified during this initial visit. The participant was also given fact sheets on how to obtain technical and financial assistance for making repairs and modifications to his or her home.

After the four classes were completed, the assessor returned to the participant’s home to check on the progress of repairs and to offer financial and technical assistance if needed, as well as discounts on safety equipment.

**Duration:**
- Two home visits, each lasting about 15 minutes
- Four weekly 1 ½-hour classes (including 20 minutes of supervised exercise) over a 1-month period

**Delivered by:**
- The home inspection was performed by a BA-level home assessor who was trained during a 2-day program that included practice assessments of elderly volunteers’ homes.
- The fall prevention program and exercise sessions were delivered by MA-level lifestyle change experts with various backgrounds including health behavior change and sports training. Each group meeting was conducted by a team consisting of a lifestyle change expert and a physical therapist.

**Minimum Level of Training Needed:** Information was not provided by the principal investigator.

**Key Elements:** Information was not provided by the principal investigator.

**Available Materials:** No intervention materials were available for distribution at the time of publication. Please contact the principal investigator for information on how to obtain the exercise manual.

**Study Citation:** Hornbrook MC, Stevens VJ, Wingfield DJ, Hollis JF, Greenlick MR, Ory MG. Preventing falls among community-dwelling older persons: Results from a randomized trial. *The Gerontologist.* 1994 Feb;34(1):16-23.

**Contact**
Practitioners interested in using this intervention may contact the principal investigator for more information:

Mark C. Hornbrook, PhD
Kaiser Permanente Center for Health Research
3800 N Interstate Ave
Portland, OR 97227
Tel: 503-335-6746
E-mail: mark.c.hornbrook@kpchr.org
This study used a tailored combination of intervention strategies based on an assessment of each participant’s fall risk factors. Participants were about 30 percent less likely to fall compared with people who did not receive the intervention.

**Population:** Participants were members of a health maintenance organization. All were 70 years or older and lived in the community. Most participants were female.

**Geographic Locale:** Farmington, Connecticut, USA

**Focus:** Identify and modify each participant’s risk factors.

**Program Setting:** The intervention was delivered to participants in their homes.

**Content:** This program provided an individualized intervention for each participant. The content varied based on the fall risk factors identified. Possible intervention components included medication adjustment, recommendations for behavioral change, education and training, home-based physical therapy, and a home-based progressive balance and strengthening exercise program.

The selection of interventions was guided by decision rules and priorities. No participant received more than three balance and strength training programs.
<table>
<thead>
<tr>
<th>Risk Factor</th>
<th>Intervention</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Assessed by a nurse practitioner:</strong></td>
<td></td>
</tr>
<tr>
<td>Postural hypotension</td>
<td>Behavioral recommendations such as elevating the head of the bed and using ankle pumps; made changes in medications</td>
</tr>
<tr>
<td>Use of sedative-hypnotic medication</td>
<td>Education; discontinued medication; non-pharmacological alternatives</td>
</tr>
<tr>
<td>Use of 4+ prescription medications</td>
<td>Reviewed medications with primary physician; the final decision on medication changes was made by the primary physician</td>
</tr>
<tr>
<td>Inability to transfer safely to bathtub or toilet</td>
<td>Training in transfer skills; home modifications (such as installing grab bars and a raised toilet seat)</td>
</tr>
<tr>
<td>Environmental hazards</td>
<td>Home modifications (such as removing rugs and installing railings)</td>
</tr>
<tr>
<td><strong>Assessed by a physical therapist:</strong></td>
<td></td>
</tr>
<tr>
<td>Gait impairments</td>
<td>Gait training; use of assistive devices; balance and/or strengthening exercises</td>
</tr>
<tr>
<td>Impairments in transfer skills or balance</td>
<td>Training in transfer skills; home modifications; balance exercises (progressing through 4 levels of difficulty)</td>
</tr>
<tr>
<td>Impairment in leg or arm strength or in range of motion</td>
<td>Progressive strengthening exercises with resistance bands and putty, increasing resistance after participant could complete 10 repetitions; exercises were performed for 15-20 minutes twice a day</td>
</tr>
</tbody>
</table>
Duration: The intervention was conducted over a 3-month period. The amount and duration of contacts varied by the type of interventions received.

Delivered by: A nurse practitioner and physical therapist (PT) conducted the risk factor assessments. Medication adjustments were undertaken in cooperation with the participant’s primary physician who made the final decision on medication changes. The PT conducted all physical therapy and supervised exercise sessions.

Minimum Level of Training Needed: The assessment requires at least a well trained paraprofessional such as a PT assistant or licensed practical nurse (LPN). The intervention needs at least a BA-level nurse. The physical therapy portion requires a physical or occupational therapist, or a physical or occupational therapy assistant with supervision by a physical or occupational therapist.

Key Elements: The assessments need to be clearly linked to the intervention components. The minimum risk factor interventions include (1) postural blood pressure and behavioral recommendations; (2) medication review and reduction (especially psychoactive medications); (3) balance, strength, and gait assessments and interventions; and (4) environmental assessment and modification.

It is essential that the progressive balance and strength exercise program includes both supervised and at-home (unsupervised) components.

Available Materials: Intervention materials including risk factor assessments and treatment worksheets, medication reduction strategies, balance exercises, home safety checklists, and information sheets can be requested through the intervention Web site: http://www.fallprevention.org.

**Supplemental articles**


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**Contact**

Practitioners interested in using this intervention may contact the principal investigator for more information:

Mary Tinetti, MD  
Department of Epidemiology and Public Health  
Yale University School of Medicine  
Internal Medicine-Geriatrics  
PO Box 208025  
New Haven, CT 06520-8025  
Tel: 203-688-5238  
Fax: 203-688-4209  
E-mail: Mary.tinetti@yale.edu
A Multifactorial Program

This study tested a moderate-intensity intervention that used tailored strategies based on assessments of each participant’s risk factors. After 1 year, participants were 10 percent less likely to fall and 5 percent less likely to have an injurious fall, compared with people who received usual medical care.

**Population:** All participants were 65 years and older and lived in the community. About 60 percent of participants were female.

**Geographic Locale:** Seattle, Washington, USA

**Focus:** Reduce disability and/or falls by: improving physical fitness, modifying excessive alcohol use, improving home safety, reducing psychoactive medication use, and improving hearing and vision.

**Program Setting:** Participants received the assessments and interventions from a nurse at local health maintenance organization (HMO) centers. Participants conducted a home assessment or had it done by a family member or volunteer.

**Content:** The assessments consisted of simple screening tests for six risk factors. The intervention content varied based on the individual’s risk factors.

<table>
<thead>
<tr>
<th>Risk Factor</th>
<th>Intervention</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inadequate exercise</td>
<td>Participated in a 2-hour exercise orientation class testing fitness, given exercise instruction, and encouraged to begin a program of brisk walking</td>
</tr>
<tr>
<td>Excessive alcohol use</td>
<td>Referred to an alcohol treatment program if alcoholism was suspected, or given an instructional booklet that provided strategies for limiting use</td>
</tr>
<tr>
<td>Home hazards</td>
<td>Assessed home safety using an instructional home safety checklist</td>
</tr>
<tr>
<td>Use of psychoactive drugs</td>
<td>Reviewed medications using a pharmacist and sent written recommendations to the participant’s primary care provider</td>
</tr>
<tr>
<td>Impaired hearing</td>
<td>Had a hearing aid evaluation. Program provided behavioral intervention classes for participants with uncorrectable deficits</td>
</tr>
<tr>
<td>Impaired vision</td>
<td>Corrected when possible. Participants with uncorrectable visual impairments received information about available community resources</td>
</tr>
</tbody>
</table>

43
Duration: The initial visit consisted of a 1 to 1 ½-hour interview. The length and number of subsequent sessions varied by the type of interventions selected for each participant.

Delivered by: The program was delivered by a single nurse educator who received brief training by the research team. There was no formal curriculum because only one nurse was involved. Either trained volunteers or participants’ family members completed the home safety assessment using the provided checklist.

Minimum Level of Training Needed: Information was not provided by the Principal Investigator.

Key Elements: The nurse’s follow-up phone contacts and home visits may have had positive effects on participants’ health that were independent of the interventions for specific risk factors.

Available Materials: No intervention materials were available for distribution at the time of publication.


Contact
Practitioners interested in using this intervention may contact the principal investigator for more information:

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E-mail: wagner.e@ghc.org
Appendix A

Intervention Study Selection Process
Intervention Study Selection Process

In 2003, the Rand Corporation was commissioned by the Centers for Medicare and Medicaid Services (CMS) to review and analyze the existing research in fall prevention interventions. They conducted a comprehensive literature search and reviewed 826 intervention studies, of which 95 met the following selection criteria: (1) included adults aged ≥65 years; (2) used a randomized controlled trial or controlled clinical trial study design; (3) identified falls as an outcome; and (4) measured the number of falls at least 3 months after the start of the intervention. Of the 95 studies, 57 had falls as a primary outcome and 38 of the 57 reported either the number of subjects who fell at least once, or the monthly rate of falling. Rand included these 38 studies in their meta-analyses to determine the effectiveness of fall prevention interventions (categorized as exercise, education, environmental modification, or multiple component interventions).*

Beginning with data from the 38 studies Rand included in their meta-analysis (used by permission, L. Rubenstein, personal communication), CDC identified those that met the following inclusion criteria: (1) included community-dwelling adults aged ≥65 years; (2) used a randomized controlled study design; (3) measured falls as a primary outcome; and (4) demonstrated statistically significant positive results for at least one fall outcome (i.e., showed statistically fewer falls for intervention participants). As illustrated in Figure 1, CDC excluded 1 study that focused on nursing home residents, 4 that did not include falls as the primary outcome, and 25 that did not demonstrate statistically significant, positive results. Of the remaining eight, two described the same study and were combined. Lastly, CDC also identified seven studies published after the Rand Report that met the established criteria. In total, the Compendium includes 14 studies published before January 2006.

Figure 1. Flow chart showing the selection process for studies used in the *Compendium*

826 Fall intervention studies

95 Relevant & rigorous studies

57 Falls as an outcome

38 Rand Report: Data on subjects who fell at least once or the monthly fall rate

1 Nursing home population

4 Falls not the primary outcome

37 Community-dwelling population

25 Not statistically significant positive results

8 Met CDC criteria

1 Reported on same study

7 Relevant, rigorous & effective studies published 2003-2005

14 Compendium studies
Appendix B

Bibliography of Compendium Studies
Bibliography of Compendium Studies and Supplemental Articles


Dec;47(12):1397-1402.


*Supplemental article
Appendix C

Tables

Table 1  Overall Population Characteristics
Table 2  Study Characteristics
Table 3  Intervention Characteristics
<table>
<thead>
<tr>
<th>Study</th>
<th>No. Study Participants</th>
<th>Mean Age</th>
<th>% Female</th>
<th>Race/ Ethnicity</th>
<th>Socioeconomic Status</th>
<th>Previous Falls</th>
<th>Other Characteristics</th>
</tr>
</thead>
<tbody>
<tr>
<td>Barnett 2003</td>
<td>163</td>
<td>75</td>
<td>67%</td>
<td>90% used English as primary language</td>
<td>Study conducted in low SES areas</td>
<td>42% fell in past year</td>
<td>27% lived alone</td>
</tr>
<tr>
<td>Campbell 1997</td>
<td>233</td>
<td>84</td>
<td>100%</td>
<td>Most were White</td>
<td>20% used community services</td>
<td>44% fell in past year</td>
<td></td>
</tr>
<tr>
<td>Clemson 2004</td>
<td>310</td>
<td>78</td>
<td>74%</td>
<td>NA*</td>
<td>52% had below average weekly income</td>
<td>65% fell in past year</td>
<td></td>
</tr>
<tr>
<td>Close 1999</td>
<td>397</td>
<td>78</td>
<td>66%</td>
<td>NA</td>
<td>NA</td>
<td>65% fell in past year</td>
<td>61% lived alone</td>
</tr>
<tr>
<td>Cumming 1999</td>
<td>530</td>
<td>77</td>
<td>57%</td>
<td>100% White</td>
<td>NA</td>
<td>31% fell in past year</td>
<td>37% used a walking aid</td>
</tr>
<tr>
<td>Day 2002</td>
<td>1,090</td>
<td>76</td>
<td>60%</td>
<td>77% born in Australia</td>
<td>Study conducted in mainly middle class area</td>
<td>6% fell in past year</td>
<td>54% lived alone 47% married</td>
</tr>
<tr>
<td>Hombrock 1994</td>
<td>3,182</td>
<td>73</td>
<td>62%</td>
<td>90% White</td>
<td>33% education &gt; HS</td>
<td>15% fell in past year</td>
<td>37% lived alone 56% married</td>
</tr>
<tr>
<td>Li 2005</td>
<td>256</td>
<td>77</td>
<td>70%</td>
<td>90% White</td>
<td>92% education ≥ HS, 68% income &lt; $35,000</td>
<td>37% fell in past 3 months</td>
<td>48% lived alone</td>
</tr>
<tr>
<td>Study</td>
<td>No. Study Participants</td>
<td>Mean Age</td>
<td>% Female</td>
<td>Race/Ethnicity</td>
<td>Socioeconomic Status</td>
<td>Previous Falls</td>
<td>Other Characteristics</td>
</tr>
<tr>
<td>-----------</td>
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<td>----------------------</td>
<td>----------------</td>
<td>-----------------------</td>
</tr>
<tr>
<td>003</td>
<td>551</td>
<td>80</td>
<td>86%</td>
<td>100% White</td>
<td>NA</td>
<td>34% fell in past year</td>
<td>22% in assisted living housing</td>
</tr>
<tr>
<td>2003</td>
<td>360</td>
<td>82</td>
<td>73%</td>
<td>98% White</td>
<td>NA</td>
<td>30% ≥ two falls in past year</td>
<td>All showed functional decline, especially in mobility</td>
</tr>
<tr>
<td>2000</td>
<td>59</td>
<td>75</td>
<td>0%</td>
<td>95% White</td>
<td>63% education &gt; HS</td>
<td>56% fell in past 6 months</td>
<td>73% married</td>
</tr>
<tr>
<td>994</td>
<td>301</td>
<td>78</td>
<td>69%</td>
<td>NA</td>
<td>31% education &gt; HS</td>
<td>43% fell in past year</td>
<td>44% married</td>
</tr>
<tr>
<td>1994</td>
<td>1,559</td>
<td>73</td>
<td>59%</td>
<td>93% White, 7% Nonwhite</td>
<td>25% education &gt; 16 years, 35% income &lt; $15,000</td>
<td>33% fell in past year</td>
<td></td>
</tr>
<tr>
<td>996</td>
<td>200</td>
<td>76</td>
<td>81%</td>
<td>Most were White</td>
<td>77% education &gt; HS</td>
<td>36% fell in past year</td>
<td></td>
</tr>
</tbody>
</table>

*Information available*
Table 2: Study Characteristics continued (1 of 10)

<table>
<thead>
<tr>
<th>Study</th>
<th>Location</th>
<th>Study population &amp; recruitment</th>
<th>Inclusion Criteria</th>
<th>Exclusion Criteria</th>
<th>Defined Falls</th>
</tr>
</thead>
<tbody>
<tr>
<td>Barnett 2003</td>
<td>SW Sydney, Australia</td>
<td>Recruited while patients in general practice clinics or attending hospital-based PT clinics</td>
<td>Age 65+ and &gt;1 physical impairment assoc w. fall risk (lower limb weakness, poor balance, slow reaction time)</td>
<td>Cognitive impairment, degenerative conditions or medical conditions precluding participating in an exercise program</td>
<td>Yes</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Method of Recording Falls</th>
<th>Length of Follow-up</th>
<th>Fall Outcomes</th>
<th>Results*</th>
<th>Adverse effects</th>
</tr>
</thead>
</table>
| Postal surveys sent to participants each month. If not received within 2 weeks, participant was interviewed by telephone. | 12 months | Fall rate  
Fall w/ injury | $RR = 0.60 \ (0.36-0.99)  
RR = 0.66 \ (0.38-1.15)$ | None |

<table>
<thead>
<tr>
<th>Study</th>
<th>Location</th>
<th>Study population &amp; recruitment</th>
<th>Inclusion Criteria</th>
<th>Exclusion Criteria</th>
<th>Defined Falls</th>
</tr>
</thead>
<tbody>
<tr>
<td>Campbell 1997</td>
<td>Dunedin, New Zealand</td>
<td>Women registered with a general practice in Dunedin were invited by GP to take part.</td>
<td>Age 80+ and able to move around within their own home</td>
<td>Cognitively impaired or receiving physical therapy</td>
<td>Yes</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Method of Recording Falls</th>
<th>Length of Follow-up</th>
<th>Fall Outcomes</th>
<th>Results*</th>
<th>Adverse effects</th>
</tr>
</thead>
</table>
| Participants given 12 pre-addressed & stamped monthly fall calendar postcards. If one was not received, participant was interviewed by telephone. | 12 months | Fall rate  
First fall  
First fall w/ injury | $RR = 0.67; \ p<0.05  
HR = 0.81 \ (0.56-1.16)  
HR = 0.61 \ (0.39-0.97)$ | None |
<table>
<thead>
<tr>
<th>Study</th>
<th>Location</th>
<th>Study population &amp; recruitment</th>
<th>Inclusion Criteria</th>
<th>Exclusion Criteria</th>
<th>Defined Falls</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clemson 2004</td>
<td>Sydney, Australia</td>
<td>Community residents recruited through referrals, advertisements, &amp; community organizations</td>
<td>Age 70+, had a fall in past year or fear of falling, &amp; spoke English</td>
<td>Cognitively impaired or homebound</td>
<td>No</td>
</tr>
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</tr>
<tr>
<td>Method of Recording Falls</td>
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<td>Results*</td>
<td>Adverse effects</td>
<td></td>
</tr>
<tr>
<td>Participants mailed in a pre-addressed, stamped calendar each month.</td>
<td>14 months</td>
<td>Fall rate, overall Fall rate, males Fall rate, females</td>
<td>RR = 0.69 (0.50-0.96) RR = 0.32 (0.17-0.59) RR = 0.96 (0.50-1.85)</td>
<td>None</td>
<td></td>
</tr>
<tr>
<td>Study</td>
<td>Location</td>
<td>Study population &amp; recruitment</td>
<td>Inclusion Criteria</td>
<td>Exclusion Criteria</td>
<td>Defined Falls</td>
</tr>
<tr>
<td>Close 1999</td>
<td>London, United Kingdom</td>
<td>Community residents treated in an ED for a fall, sent letters &amp; contacted by telephone</td>
<td>Age 65+, ambulatory, &amp; had been treated for a fall</td>
<td>Cognitively impaired &amp; had no regular caregiver, or spoke little or no English</td>
<td>Yes</td>
</tr>
<tr>
<td>Method of Recording Falls</td>
<td>Length of Follow-up</td>
<td>Fall Outcomes</td>
<td>Results*</td>
<td>Adverse effects</td>
<td></td>
</tr>
<tr>
<td>Postal questionnaires were sent to participants every 4 months.</td>
<td>12 months</td>
<td>Total number of falls Fall risk Risk of ≥3 falls</td>
<td>183 vs. 510; p&lt;0.002 OR = 0.39 (0.23-0.6) OR = 0.33 (0.16-0.68)</td>
<td>None</td>
<td></td>
</tr>
<tr>
<td>Study</td>
<td>Location</td>
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</tr>
<tr>
<td>Cumming 1999</td>
<td>Sydney, Australia</td>
<td>Recruited while hospital patients or from among people attending outpatient clinics or a local senior center</td>
<td>Age 65+, ambulatory</td>
<td>Cognitively impaired &amp; not living with someone who could give informed consent &amp; report falls, or planned to have a home assessment by an OT</td>
<td>No</td>
</tr>
</tbody>
</table>

**Method of Recording Falls**

Monthly falls calendar was completed daily & returned by mail each month. If not received within 10 days, participant was interviewed by telephone.

**Length of Follow-up**

12 months

**Fall Outcomes**

Fall rate for participants w/ no falls at baseline. Fall rate for participants w/ falls at baseline.

**Results**

- RR = 1.03 (0.75-1.41)
- RR = 0.64 (0.50-0.83)

**Adverse effects**

None
<table>
<thead>
<tr>
<th>Study</th>
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<th>Location</th>
<th>Length of Follow-up</th>
<th>Method of Recording Falls</th>
<th>Defined Falls</th>
<th>Exclusion Criteria</th>
<th>Inclusion Criteria</th>
<th>Results*</th>
<th>Adverse effects</th>
</tr>
</thead>
<tbody>
<tr>
<td>Day 2002</td>
<td>Identified from electoral roll &amp; through general practitioners. Subjects were sent letters &amp; then contacted by telephone.</td>
<td>Melbourne, Australia</td>
<td>18 months</td>
<td>Monthly calendar postcards completed daily &amp; returned by mail if not received within 5 working days after end of month, participant was interviewed by telephone.</td>
<td>No</td>
<td>Planning to move within 2 years, recent physical activity with a balance component, unable to walk 10-20 m, help or angina, severe respiratory or cardiac disease, cognitively impaired, had undergone recent major home modifications, or did not have physician approval</td>
<td>70+, owns or leases home, able to make home modifications</td>
<td>Exercise alone: RR = 0.82 (0.70-0.97) Exercise + vision: RR = 0.73 (0.58-0.91) Exercise + home mod: RR = 0.76 (0.60-0.95) Exercise + vision + home mod: RR = 0.67 (0.51-0.88)</td>
<td>None</td>
</tr>
<tr>
<td>Study</td>
<td>Location</td>
<td>Study population &amp; recruitment</td>
<td>Inclusion Criteria</td>
<td>Exclusion Criteria</td>
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</tr>
<tr>
<td>Hornbrook 1994</td>
<td>Portland OR &amp; Vancouver WA metro area</td>
<td>Members of a Kaiser Permanente HMO were recruited by mail</td>
<td>Age 65+, ambulatory</td>
<td>Blind, deaf, housebound, non-English speaking, severely mentally ill, terminally ill, not willing to travel or lived &gt;20 mi. from research center</td>
<td>Yes Also “near falls”</td>
<td></td>
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</table>

<table>
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<tr>
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</tr>
</thead>
</table>
| Fall reported by postcard as soon as it occurred. Participant interviewed by telephone about circumstances & consequences. Monthly diaries monitored quarterly by mail or telephone for self-reported falls & associated injuries & medical care. | 24 months         | Fall risk  
Fall risk for men  
Fall risk for men age 75+ | OR = 0.85 (p<.05)  
OR = 0.82 (p<.05)  
OR = 0.53 (p<.05) | None |
<table>
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<tr>
<th>Study</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Li 2005</td>
<td>Portland, OR</td>
<td>Subjects enrolled in the Legacy Health System in Portland, OR were sent letters from their physicians encouraging them to participate</td>
<td>Age 70+, inactive, ambulatory, no chronic medical problems that would limit participation, had a physician’s clearance to participate, &amp; not cognitively impaired</td>
<td>In poor health, had difficulty with language or transportation</td>
<td>Yes</td>
</tr>
</tbody>
</table>

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</thead>
<tbody>
<tr>
<td>Falls recorded daily in a fall calendar that was collected by a research assistant.</td>
<td>12 months</td>
<td>Fall rate, Multiple fall rate</td>
<td>RR = 0.35 (p&lt;0.001) &lt;br&gt; RR = 0.45 (0.30-0.70)</td>
<td>None</td>
</tr>
<tr>
<td>Study</td>
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<td>Exclusion Criteria</td>
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</tr>
<tr>
<td>Lord 2003</td>
<td>Sydney &amp; Wollongong, Australia</td>
<td>Residents of self-care and intermediate-care retirement villages attended information sessions &amp; then were approached individually</td>
<td>Age 62+</td>
<td>Cognitively impaired, had a medical condition that prevented participation in an exercise program, or already attended exercise classes of equivalent intensity</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
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</thead>
</table>
| Completed monthly questionnaires. If not received within a week after end of month, received home visits or telephone calls. Nursing staff at each intermediate-care site also kept a falls record book. | 12 months           | Fall rate  
Fall rate for participants w. no falls at baseline  
Fall rate for participants w. falls at baseline | RR = 0.78 (0.62-0.99)  
RR = 0.88 (0.65-1.20)  
RR = 0.69 (0.48-0.99) | None               |
<table>
<thead>
<tr>
<th>Study</th>
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<th>Exclusion Criteria</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Nikolaus 2003</td>
<td>Mid-sized town, Southern Germany</td>
<td>Recruited while inpatients at a geriatric clinic</td>
<td>Lived at home before hospital admission, had multiple chronic conditions or functional deterioration, &amp; were discharged to home</td>
<td>Severe cognitive decline, terminal illness, or lived &gt;15 km away</td>
<td>Yes</td>
</tr>
</tbody>
</table>

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<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>Kept a falls diary &amp; also contacted monthly by phone.</td>
<td>12 months</td>
<td>Fall rate Fall rate for participants w. ≤1 fall at baseline Fall rate for participants w. ≥2 falls at baseline</td>
<td>IRR = 0.69 (0.51-0.97) IRR = 0.91 (0.72-1.22) IRR = 0.63 (0.43-0.94)</td>
<td>None</td>
</tr>
</tbody>
</table>

<table>
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<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>Rubenstein 2000</td>
<td>Los Angeles, CA</td>
<td>Male patients at VA Ambulatory Care Center recruited through flyers and telephone screening</td>
<td>Age 70+, ambulatory, had at least one of 4 risk factors (lower extremity weakness, impaired gait, impaired balance, or &gt;1 fall in past 6 months)</td>
<td>Exercised regularly, had cardiac or pulmonary disease, a terminal illness, severe joint pain, dementia, medically unresponsive depression, or progressive neurologic disease</td>
<td>No</td>
</tr>
</tbody>
</table>

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<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>Questioned about falls and injuries every 2 weeks by phone or in-person during exercise class.</td>
<td>12 weeks (at end of intervention)</td>
<td>Activity-adjusted fall rate**</td>
<td>RR = 0.37 (p=.027)</td>
<td>None</td>
</tr>
<tr>
<td>Study</td>
<td>Location</td>
<td>Study population &amp; recruitment</td>
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</tr>
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<td>------------</td>
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<td>-------------------------------------------------------------------------------------</td>
<td>------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Tinetti 1994</td>
<td>Southern Connecticut</td>
<td>Members of an HMO, contacted first by letter &amp; then screened by telephone</td>
<td>Age 70+, ambulatory in own home, had at least one of 9 risk factors (postural hypotension; used sedatives; ≥4 medications; inability to transfer; gait impairment; loss of strength or range of motion; home hazards)</td>
<td>Cognitively impaired or had participated in vigorous sports or walking for exercise in previous month</td>
</tr>
</tbody>
</table>

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<tr>
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<th>Results*</th>
<th>Adverse effects</th>
</tr>
</thead>
</table>
| A monthly falls calendar was returned by mail. If a calendar was not received or if it indicated any falls, participant was interviewed by telephone. | 12 months | Fall rate
Falls per person-week | RR = 0.76 (0.58-0.98)
RR = 0.69 (0.52-0.90) | None |
<table>
<thead>
<tr>
<th>Study</th>
<th>Location</th>
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<th>Exclusion Criteria</th>
<th>Defined Falls</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wagner 1994</td>
<td>Seattle, WA</td>
<td>Random sample of HMO members sent an introductory letter followed by a mail questionnaire</td>
<td>Age 65+, ambulatory, independent in ADLs</td>
<td>Institutionalized or seriously ill</td>
<td>Yes</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
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<th>Adverse effects</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mailed questionnaires at baseline, at 1 &amp; at 2 years; If not returned, participants were interviewed by telephone. Falls were identified through self-report and hospital discharge files.</td>
<td>24 months</td>
<td>Difference in % falling Falls, Year 1 Falls, Year 2 Fall w. injury, Year 1 Fall w. injury, Year 2</td>
<td>-9.3% (4.1-14.5) +2.2% n.s. -4.6% (p&lt;.01) +3.3% n.s.</td>
<td>None</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Study</th>
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<th>Study population &amp; recruitment</th>
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<th>Exclusion Criteria</th>
<th>Defined Falls</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wolf 1996</td>
<td>Atlanta, GA</td>
<td>Community seniors &amp; residents of an independent living facility, recruited through advertisements &amp; direct contact</td>
<td>Age 70+, ambulatory, willing to participate weekly for 15 wk program and at 4-month follow-up</td>
<td>Severely cognitively impaired or had debilitating conditions such as metastatic cancer, Parkinson’s disease, stroke, or profound visual deficits</td>
<td>Yes</td>
</tr>
</tbody>
</table>

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<tr>
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<th>Results*</th>
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</thead>
<tbody>
<tr>
<td>Monthly calendar or monthly phone calls from staff.</td>
<td>7-20 months</td>
<td>Fall risk ≥1 falls w. injury</td>
<td>RR = 0.53 (0.32-0.86) RR = 0.81 (0.33-2.02)</td>
<td>None</td>
</tr>
</tbody>
</table>

Results shown with 95% confidence intervals. * RR = Relative Rate, HR = Hazard Ratio, OR = Odds Ratio, IRR = Incidence Rate Ratio **per 1,000 hrs of activity
<table>
<thead>
<tr>
<th>Study</th>
<th>Focus</th>
<th>Providers</th>
<th>Structure</th>
<th>Number of sessions</th>
<th>Provider Contact Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Barnett 2003</td>
<td>Exercise program to improve balance, coordination, strength, reaction time, &amp; aerobic capacity</td>
<td>Accredited exercise instructors trained to provide intervention</td>
<td>Group exercise classes</td>
<td>37 weekly 1-hour classes</td>
<td>Classes: 37 hours</td>
</tr>
<tr>
<td>Campbell 1997</td>
<td>Improve strength &amp; balance with simple home-based exercise program</td>
<td>Physical therapist or nurse</td>
<td>One-on-one exercise training at home</td>
<td>Exercise program ½ hour 3 times a week Walking ½ hour 3 times a week</td>
<td>4 home visits: 1-hour each</td>
</tr>
<tr>
<td>Clemson 2004</td>
<td>Learn fall prevention techniques, Improve self-efficacy &amp; make behavioral changes</td>
<td>Occupational therapist &amp; team of trained content experts</td>
<td>Small group classes</td>
<td>7 weekly 2-hour program classes 1 home visit 6 weeks after the final class 1 booster session 3 months after the final class</td>
<td>Classes: 14 hours Home visit: 1 to 1½ hours Booster: 1½ hours</td>
</tr>
<tr>
<td>Close 1999</td>
<td>Identify medical risk factors &amp; home hazards; provide referrals and recommendations to reduce fall risk &amp; improve home safety</td>
<td>Physician &amp; occupational therapist</td>
<td>One-on-one</td>
<td>2 sessions—one for each type of assessment</td>
<td>Medical assessment: ¾ hour Home assessment: 1 hour</td>
</tr>
<tr>
<td>Cumming 1999</td>
<td>Assess &amp; reduce home hazards</td>
<td>Occupational therapist</td>
<td>One-on-one</td>
<td>1-hour home assessment &amp; follow-up telephone call</td>
<td>Total about 2 hours</td>
</tr>
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</table>
Table 3: Intervention Characteristics continued (2 of 3)

<table>
<thead>
<tr>
<th>Study</th>
<th>Focus</th>
<th>Providers</th>
<th>Structure</th>
<th>Number of sessions</th>
<th>Provider Contact Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hombrock 1994</td>
<td>Reduce risky behaviors, improve physical fitness &amp; reduce home hazards</td>
<td>BA-level assessor trained for intervention, health behaviorist &amp; physical therapist</td>
<td>Group exercise classes &amp; home visits</td>
<td>4 weekly 1½-hour group sessions (incl. 20 minutes group exercise), Two 15-minute home visits</td>
<td>Classes: 6 hours Home visits: 1½ hours</td>
</tr>
<tr>
<td>Li 2001-2002</td>
<td>Improve balance &amp; physical performance</td>
<td>Experienced Tai Chi instructors who followed the classical Yang style</td>
<td>Group classes</td>
<td>1-hour sessions 3 times a week for 26 weeks</td>
<td>Classes: 78 hours</td>
</tr>
<tr>
<td>Lord 2003</td>
<td>Increase strength, coordination, balance, &amp; gait &amp; improve ADLs</td>
<td>Trained exercise instructors certified for leading programs for older adults</td>
<td>Group exercise classes</td>
<td>1-hour class 2 times a week for 12 months (four 3-month terms)</td>
<td>Classes: 96 hours</td>
</tr>
<tr>
<td>Nikolaus 2003</td>
<td>Assess &amp; reduce home hazards</td>
<td>Home intervention team incl. 3 nurses, a physical therapist, an occupational therapist, a social worker, &amp; a secretary</td>
<td>Home visits</td>
<td>2+ (usually 3-4) home visits, about 1½ hours each visit</td>
<td>Home visits: 8 hours on average</td>
</tr>
<tr>
<td>Rubenstein 2000</td>
<td>Increase strength &amp; endurance, improve mobility &amp; balance</td>
<td>Exercise physiology graduate students with on-the-job training or experienced physical therapist</td>
<td>Group exercise classes</td>
<td>1½-hour class 3 times a week for 12 weeks</td>
<td>Classes: 54 hours</td>
</tr>
<tr>
<td>Study</td>
<td>Focus</td>
<td>Providers</td>
<td>Structure</td>
<td>Number of sessions</td>
<td>Provider Contact Time</td>
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</tr>
<tr>
<td>Tinetti 1994</td>
<td>Identify &amp; modify each participant's fall risk factors</td>
<td>Medication adjustments coordinated w. participant's primary physician; exercise sessions conducted by PT</td>
<td>Varied by type of intervention</td>
<td>Varied by type &amp; number of interventions received</td>
<td>Varied</td>
</tr>
<tr>
<td>Wagner 1994</td>
<td>Reduce disability and/or falls by addressing 6 specific risk factors</td>
<td>Specially trained nurse-educator</td>
<td>Home visit with follow-up behavioral intervention</td>
<td>Initial interview 1 to 1 1/2-hours Length &amp; number of subsequent sessions varied by type of intervention(s)</td>
<td>Varied</td>
</tr>
<tr>
<td>Wolf 1996</td>
<td>Improve strength, balance, walking speed &amp; physical functioning</td>
<td>Tai Chi master</td>
<td>Group classes w. individual practice at home</td>
<td>25-minute group classes 2 times a week for 15 weeks &amp; 15-min practice at home 2 times a week</td>
<td>Classes: 12 hours</td>
</tr>
</tbody>
</table>
Appendix D

Original Intervention Materials

Appendix D-1  Barnett Materials
Appendix D-2  Wolf Materials
Appendix D-3  Close Materials
South Western Sydney Area Health Service
Health Promotion
A Unit of the Division of Population Health

Falls Prevention Project
Stay Safe Stay Active
EXERCISES

1. Warm up

Breathe in deeply through nose, lift arms above head and stretch. Lower arms and breathe out 6 times.

2. Shoulder rolls (Flexibility)

Gently rotate shoulders up to ceiling, backwards, and down. Then reverse; up, forward and down. 6 times each way.
Exercises

3. March on spot (mobility)

Hold onto chair with 2 hands. Walking on the spot. Try to lift knees a bit higher than usual. Step 10 times with each leg.

4. Ankle (strength)

Hold onto chair. Rise up onto toes of both feet, hold for 5 seconds, then lower. Keep heels on the floor and lift toes off the floor hold for 5 seconds. Repeat both movements 6 times.
5. **Knee bend (strength)**

Hold on to chair. Stand with knees soft and back straight. Keep knees pointing over toes. Bend your knees gently, and then raise your body by straightening your knees. Do this 6 times.

6. **Sit to Stand (strength)**

Sit in chair against wall. Stand up with out using your hands 6 times. If this is too hard use a pillow on the chair to start until you get stronger.
Exercises

7. Calf (stretch)

Hold onto chair; stretch one leg behind, toes facing forward, gently bend front knee until you feel a stretch in your calf. Hold stretch for 10 seconds. Do 6 stretches.
Hold onto chair, stretch as in previous picture. When you feel the stretch in your back calf, keep the heel of that foot on the ground, and slightly bend the back knee.
General Information on Exercise

As we age our muscles tend to become less flexible and strong, and our joints become stiffer. This can affect our balance. Exercise is the best way to improve strength and mobility. Greater strength and mobility means you may be able to recover your balance if you loose it, therefore avoiding a fall.

Tips for Exercising

- Wear comfortable clothes and shoes
- Drink some water before and after exercise
- Do exercises slowly and gently
- If you feel pain STOP that exercise and discuss with your exercise leader or project manager
- If you feel breathless or dizzy STOP and rest
Well done you have now completed all the exercises Exercises. If you have and questions or concerns regarding the exercise program please don’t hesitate to contact your gentle exercise leader or the project manager.

Project Manager

Anne Barnett
Health Promotion Unit
Hugh Jardine Building
Locked Mail Bag 7017
Liverpool NSW 1871

Tel. 9828 6008

C 1999
Stay Safe Stay Active
Daily Exercise Program

1. Warm up

2. Shoulder rolls (Flexibility)

3. March on spot (mobility)

4. Ankle (strength)

5. Knee bend (strength)

6. Sit to Stand (strength)

7. Calf (stretch)

8. Calf (stretch)

Thank you Sally Castell for your diagrams
Stay Safe Stay Active
Daily Exercise Program (Stage 2)

1. Hip to the side *

2. Foot Circles *

3. Lift leg backwards *

4. Shoulder blade exercises**

5. Arm curl **

6. Knees in and out **

7. Ankle Pumps **

8. Hip extension **

Thank you to Stay on Your Feet* and Roybal - Boston University** for allowing us to use your diagrams
Tips to Prevent Falling

1 Medications
Discuss with GP or Pharmacist if you feel they may be causing drowsiness or dizziness

2 The environment
Loose rugs, slippery surfaces, unsecured cords, poor lighting especially at night, and spills of water or grease, all increase the risk of falling. Try and clear away clutter, especially where you need to walk, and secure rugs with grippers to the floor. Mop up any spills immediately.

3 Shoes
Wear non-slip shoes that fit well, and have laces or Velcro fastening. Shoes with medium or low heels, which are rounded, are better than high thin heels. Slippers and thongs are not a good idea, as they do not offer enough support. Be careful of wet or slippery surfaces.

4 Hearing
A loss of hearing can cause dizziness and balance problems, see your GP if this occurs. It could be something as simple as a lump of wax.

5 Vision
Adequate lighting is very important, do not forget to turn light on if you get up at night, or keep a nightlight on – keep your glasses by your bed! Bifocals can make going up and down stairs difficult as they alter the perception of where the stair edges are. When walking outside in the sun it is useful to wear a broad rimmed hat, it helps you pick up contrasts on the ground such as steps and edges. Remember to have annual eye tests, as this can detect any changes in your vision.

6 Good diet
Eat a well balanced diet, and don’t allow yourself to become too thin.

7 Colds/Sinus
If you have a cold or sinus problems then take extra care as this can affect your balance

8 Walking aid
If you use a walking aid, make sure the rubber on the bottom is not worn, and keep it by the bed at night in case you need to get up.

If you do fall in the house do not panic. Stay still for a few minutes to get over the shock. If you are OK try to slide yourself over to a sturdy piece of furniture, sofa, bed or chair and position yourself along side of it. Get into a kneeling position and gradually push yourself up and sit down until you recover. If you are unable to move try and cover yourself with something to keep warm, until help arrives.
FORM 1. OPENING FORM

FORM 2

FORM 3

FORM 4

FORM 5

FORM 6

FORM 7

FORM 8

FORM 9

FORM 10
APPENDIX: DIRECTIONS AND THERAPEUTIC ELEMENTS FOR LEARNING 10 FORMS OF TC

FORM 1. Directions
(1) Stand upright with feet shoulder-width apart, toes pointing forward, arms hanging naturally at sides. Look straight ahead (1A).
(2) Raise arms slowly forward to shoulder level, palms down. The hands do not go above the shoulders and the elbows are held in (1B & 1C).
(3) Bend knees as you press palms down gently, with elbows dropping towards knees. Look straight ahead (1D).

FORM 1. Therapeutic elements 3, 4
This "warmup" form begins with nonstressful bilateral stance where all thoughts other than those about movement clear the head. Attention is directed to relaxing all muscles except those of the legs—the feet are to "stick to the ground." As movement begins, concentration is directed to move all four extremities at the same constant speed that begins and ends concomitantly in the arms and legs.

FORM 2. Directions
The body is turned slightly to the left, with left foot at 9 o'clock for a left bow stance. The left forearm and back of hand are at shoulder level, while right hand is at the side of right hip, palm down. Look at left forearm (2A). Turn torso slightly to left (9 o'clock) while extending left hand forward, palm down. Turn torso slightly right while pulling both hands down in a curve past abdomen, until right hand is extended sideways at shoulder level, palm up, and left forearm is across chest, palm turned inward. Shift weight onto right leg. Look at right hand (2B). past face, palm turned slowly outward, while left hand moves in a curve past abdomen up to shoulder level with palm turned slowly obliquely inward (4B & 4C).

FORM 2. Therapeutic elements 1-7
The trunk and head rotate while both feet remain on floor. The arms move in asymmetrical positions so that the center of mass is extended further from left to right due to arm positions. The trunk and head are kept erect so that rotation is around a central axis. The body weight is predominantly on a flexed leg for greater balance and strength mechanism.

FORM 3. Directions
Look straight ahead; face 9 o'clock with weight on left leg in a bow stance and hands forward at shoulder height in a pushing position (3A). Turn both palms downward as right hand passes over left wrist, moves forward, then to the right until it is on the same level with left hand. Separate hand shoulder-width apart and draw them back to the front of abdomen, palms facing obliquely downward. At the same time, sit back and shift weight onto right leg, slightly bent, raising toes of left foot. Look straight ahead (3B & 3C).

FORM 3. Therapeutic elements 1-4 & 7
The body center of mass moves diagonally posteriorly than other forms with a decreased base of support from only heel contact of the left leg, demanding greater balance and strength than the previous form. The trunk rotation is decreased and the arm movement is symmetrical.

FORM 4. Directions
Turn torso to the left (10-11 o'clock), shifting weight to left leg. Move left hand in a curve past face with palm turned slowly leftward, while right hand moves up to the front of left shoulder with palm turned obliquely inward. As right hand moves upward, right foot and left foot are parallel and 10 to 20cm apart. Look at right hand (4A). Turn torso gradually to the right (1 to 2 o'clock), shifting weight onto right leg. At the same time, move right hand continuously to right.

FORM 4. Therapeutic elements 1-7
While the legs are symmetrical, weight is shifted laterally. The arms are asymmetrical, the trunk and had rotate with arm movement. Both knees are flexed and weight shifts to the leg on the side to which the arms are moving.

FORM 5. Directions
Turn torso slightly to the right, moving right hand down in a curve past abdomen and then upward to shoulder level, palm up and arm slightly bent. Turn left palm up and place toes of left foot on floor. Eyes first look to the right as body turns in that direction, and then to look at left hand (5A & 5B).

FORM 5. Therapeutic elements 1-7
Again a smaller base of support with the majority of weight on one extremity. The arm on the weight bearing side is curved back into shoulder extension. Done on the right leg and then reversed and done on the left leg. Again trunk rotates at the end of the movement.
FORM 6. Directions
Hold torso erect and keep chest relaxed. Move arms in a curve without stretching them when you separate hands. Use waist as the axis in body turns. The movements in taking a bow stance and separating hands must be smooth and synchronized in tempo. Place front foot slowly in position, heel coming down first. The knee of front leg should not go be-yond toes while rear leg should be straightened, forming a 45° with ground. There should be a transverse distance of 10 to 30cm between heals. Face 9 o'clock in final position.

FORM 7. Therapeutic elements 1-7
Hand assumes a position of holding a ball initially. Movements in the form are diagonals and rotations of the trunk and head. Movements slide back and forth in and out of 6A and 6B, and then position is reversed for right and left.

FORM 7. Directions
Turn torso to the right (11 o'clock) as right hand circles up to ear level with arm slightly bent and palm facing obliquely upward, while left hand moves to the front of the right part of chest, palm facing obliquely downward. Look at right hand (7A). Turn torso to the left (9 o'clock) as left foot takes a step in that direction for a left bow stance. At the same time, right hand draws left hand past right ear and, following body turn, pushes forward at nose level with palm facing forward, while left hand circles around left knee to stop beside left hip, palm down. Look at fingers of right hand (7B & 7C).

FORM 7. Therapeutic elements 1-7
This form begins in the position of 7A, but with both feet flat on the floor. They remain on the floor throughout the exercise. Move in and out of the position 7A, B, C, A, B, C; then reverse right-left positions.

FORM 8. Directions
Continue to move hands in a downward-inward-upward curve until wrists come in front of chest, with right hand in front and both palms turned inward. At the same time, draw right foot to the side of left foot, toes on floor. Look forward to the right (8A). Separate hands, turning torso slightly to 8 o'clock and extending both arms sideways at shoulder level with elbows slightly bent and palms turned outward. At the same time, raise right knee and thrust foot gradually towards 10 o'clock. Look at right hand (8B & 8C).

FORM 8. Therapeutic elements 1-7
With the elderly, the kick is only a small part of their available range. The form is utilized for kicking with both dorsiflexion and plantar flexion of the foot. Forms 8 and 9 are the most stressful for maintaining balance due to the small base of support and the extreme movement of the kicking leg. However, forms are done continuously with slow movements and a strong degree of concentration. The range for the kick is not extreme in the elderly.

FORM 9. Directions
Shift weight onto right leg and draw left foot to the side of right foot, toes on floor. At the same time, move both hands in a downward-inward-upward curve until wrists cross in front of chest, with left hand in front and both palms facing inward. Look forward to the left (9A & 9B). Separate hands, extending both arms sideways at shoulder level, elbows slightly bent and palms facing outward. Mean-while, raise left knee and thrust foot gradually towards 4 o'clock. Look at left hand (9C & 9D).

FORM 9. Therapeutic elements 1-7 The same as Form 8 but right and left are reversed.

FORM 10. Directions
Turn palms forward and downward while lowering both hands gradually to the side of hips. Look straight ahead (10A, 10B & 10C).

FORM 10. Therapeutic elements
This is a warm-down form like Form 1 and constitutes both a physical and mental ending of the exercise.
Falls Clinic

Day Hospital, Department of Health Care of the Elderly

Name:  
D.O.B.:  
Hosp No:  
GP:  

Referred from:  
Clinic Dr:  
Date referred:  
Date of clinic:  

Fall History
First fall:  Y / N

No of falls in previous year:

Location of fall: Outdoors / Stairs / Kitchen / Bathroom / Living Room / Bedroom / Other

Was fall witnessed:  Y / N

Definite slip/trip:  Y / N  Associated dizziness:  Y / N

LOC:  Y / N  Palpitations:  Y / N

Able to get self off floor:  Y / N  Time on floor (mins):

Injuries sustained from fall: __________________________

Medical History
Heart disease
Stroke
COPD/Asthma
Hypertension
Diabetes
Degenerative joint disease
Cognitive impairment
Visual impairment
Syncope
Epilepsy
Incontinence
Other - (please state) __________________________

Full Drug History

Alcohol: _______ units/week

Smoking: _______ cigarettes/day
Social Circumstances

Lives in: Flat / House / Bungalow / WCF / Residential Home / Nursing Home

Lives alone: Y / N  Stairs: Yes / No

Lambeth / Southwark / Other  Usually able to go out: Yes / No

Mobility: Independent  Services: MOW  Carer: None
   Stick
   Frame
   Wheelchair
   HH
   Personal Care
   District Nurse
   Day Centre
   Day Hospital
   Spouse
   Other family
   Friend/neighbour

Examination

AMT

Age
Time (to nearest hour)
Address for recall
Year
Location
Recognition of two persons
Date of Birth
WW2
Present monarch
Count backwards 20 – 1

Weight: _____ kg
Height: _____ m
Pulse: _____ bpm
   regular / irregular
BP sitting:
BP standing:
Visual acuity
   R Eye
   L Eye

Score:_______ /10 (If <8 do MMSE)

CVS:

Carotid bruits: Yes / No
Valvular defect: Yes / No
LVF: Yes / No
RHF Yes / No
CCF Yes / No

Abdo

RS

JCT Close; Mar 99
Cranial Nerve Deficit:                        Visual Fields:  L Eye       R Eye

                                    Cataract Formation: Yes / No
Hearing: Normal / Shout / Hearing Aid

PNS:

Tone

<table>
<thead>
<tr>
<th>R Arm</th>
<th>L Arm</th>
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<table>
<thead>
<tr>
<th>R Leg</th>
<th>L Leg</th>
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Reflexes

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<th>R</th>
<th>L</th>
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Biceps
Triceps
Supinator
Knee
Ankle
Plantars

Power

Arms         | R | L |
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<thead>
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</thead>
<tbody>
<tr>
<td>Shoulder abduction</td>
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<tr>
<td>Shoulder adduction</td>
<td></td>
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<tr>
<td>Elbow flexion</td>
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<td>Elbow extension</td>
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<tr>
<td>Wrist flexion</td>
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<tr>
<td>Wrist extension</td>
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<tr>
<td>Finger abduction</td>
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<tr>
<td>Finger adduction</td>
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<tr>
<td>Opposition</td>
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Legs         | R | L |
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<tr>
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<tbody>
<tr>
<td>Hip flexors</td>
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<tr>
<td>Hip extensors</td>
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<tr>
<td>Knee flexion</td>
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<tr>
<td>Knee extension</td>
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<tr>
<td>Ankle dorsiflexion</td>
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<tr>
<td>Ankle plantiflexion</td>
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</tr>
</tbody>
</table>

Lower limb

Sensation Intact: Yes / No
Proprioception intact Yes / No
Vibration intact Yes / No

Joint deformities

Good foot care Yes / No
Sensible footwear Yes / No

Timed Up and Go: _______ secs

MMSE (if indicated) _______/30

GDS – 15 Question Form______/15

JCT Close; Mar 99
Summary

Likely Cause of Fall

Risk Factors for Falls

Planned investigations and/or modifications

Follow up Arrangements

Referrals

FBC

LFT’s

U&E

TFT’s

ECG

Vit D

Urinalysis

Signature: 

Print: 

Date: 

JCT Close; Mar 99
## PROFET – Environmental Assessment

<table>
<thead>
<tr>
<th>Name:</th>
<th>Number:</th>
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<table>
<thead>
<tr>
<th></th>
<th>At time of fall</th>
<th>In the home</th>
<th>In the environment</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Slip Hazards</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>Liquid/solid spills</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Wet floors</td>
<td></td>
<td></td>
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<tr>
<td>3</td>
<td>Incorrect footwear</td>
<td></td>
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<tr>
<td>4</td>
<td>Loose mats on polished floors</td>
<td></td>
<td></td>
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<tr>
<td>5</td>
<td>Rain, sleet, snow, ice</td>
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<td></td>
</tr>
<tr>
<td>6</td>
<td>Change from wet to dry surface</td>
<td></td>
<td></td>
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<tr>
<td>7</td>
<td>Unsuitable floor surface</td>
<td></td>
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<tr>
<td>8</td>
<td>Dusty floors</td>
<td></td>
<td></td>
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<tr>
<td>9</td>
<td>Sloping surfaces</td>
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<tr>
<td><strong>Trip Hazards</strong></td>
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<tr>
<td>10</td>
<td>Loose floorboards / tiles</td>
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<tr>
<td>11</td>
<td>Loose and worn mats / carpets</td>
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<tr>
<td>12</td>
<td>Uneven outdoor surfaces</td>
<td></td>
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<tr>
<td>13</td>
<td>Holes / cracks</td>
<td></td>
<td></td>
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<tr>
<td>14</td>
<td>Change in surface level – ramps, steps, stairs</td>
<td></td>
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</tr>
<tr>
<td>15</td>
<td>Cables across walking areas</td>
<td></td>
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<tr>
<td>16</td>
<td>Obstructions</td>
<td></td>
<td></td>
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<tr>
<td>17</td>
<td>Bumps, ridges and protruding nails etc</td>
<td></td>
<td></td>
</tr>
<tr>
<td>18</td>
<td>Low wall and floor fixtures, door catches, door stops etc.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Risk Factors</strong></td>
<td></td>
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<tr>
<td>19</td>
<td>Organisation of walkways</td>
<td></td>
<td></td>
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<tr>
<td>20</td>
<td>Badly placed mirrors / reflections from glazing</td>
<td></td>
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<tr>
<td>21</td>
<td>Poor or unsuitable lighting</td>
<td></td>
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<tr>
<td>22</td>
<td>Wrong cleaning regime / materials</td>
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<tr>
<td>23</td>
<td>Moving goods, carrying, pushing or pulling a load</td>
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<tr>
<td>24</td>
<td>Rushing around</td>
<td></td>
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<tr>
<td>25</td>
<td>Distractions</td>
<td></td>
<td></td>
</tr>
<tr>
<td>26</td>
<td>Fatigue</td>
<td></td>
<td></td>
</tr>
<tr>
<td>27</td>
<td>Effects of alcohol</td>
<td></td>
<td></td>
</tr>
<tr>
<td>28</td>
<td>Effects of other drugs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>29</td>
<td>Other factor (describe)</td>
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</tbody>
</table>
# Falls Assessment Proforma

**Accident & Emergency, Department of Health Care of the Elderly**  
**Falls Specialist Practitioner – Bleep 929 Mon-Fri**

<table>
<thead>
<tr>
<th>Name:</th>
<th>Hosp No</th>
<th>Attending Dr</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date of attendance:</td>
<td>Time:</td>
<td></td>
</tr>
</tbody>
</table>

## Fall History

- **First fall:** Y / N
- **No of falls in previous year:** [ ] (>1 = high risk)
- **Location of fall:** Indoors / Outdoors (indoors = high risk)
  - Was fall witnessed: Y / N
  - Definite slip/trip: Y / N
  - Associated dizziness: Y / N
  - LOC: Y / N
  - Palpitations: Y / N
- **Able to get self off floor:** Y / N (N=high risk)  
  - Time on floor (mins):

## Medical History

- **Heart disease**:  
- **Stroke**:  
- **COPD/Asthma**:  
- **Hypertension**:  
- **Diabetes**:  
- **Degenerative joint disease**:  
- **Cognitive impairment**:  
- **Visual impairment**:  
- **Syncope**:  
- **Epilepsy**:  
- **Incontinence**
- **Other - (please state)**

* **Full Drug History (4+ meds = high risk)**

## Social Circumstances

- Lives in: Flat / House / Bungalow / Maisonette / WCF / Residential Home / Nursing Home

- **Lives alone:** Y / N  
  - **Stairs:** Yes / No

- **Lambeth / Southwark / Other**  
  - **Usually able to go out:** Yes / No

## Mobility:

- **Independent**
- **Stick**
- **Frame**
- **Wheelchair**

## Services:

- MOW
- HH
- Personal Care
- District Nurse
- Day Centre
- Day Hospital

## Carer:

- **None**
- **Spouse**
- **Other family**
- **Friend/neighbour**

## Smoking:

- **no/week**

## Alcohol:

- **units/week**
**Examination**

GCS: BM  
Temp: Pulse: BP; Lying / Standing /

**AMT**
- Age
- Time (to nearest hour)
- Address for recall
- Year
- Location
- Recognition of two persons
- Date of Birth
- WW2
- Present monarch
- Count backwards 20 – 1

Score: /10

**Relevant Systems Examination**

**Injuries Sustained**
- Head injury – no laceration
- Head injury - laceration
- Fracture
- Laceration requiring stitches
- Laceration but no stitches
- Superficial bruising
- No injury

**Indicate site of injury including pressure areas**

**Current Level of Function**
- No change from pre-fall level of function
- Decreased mobility/function but able to go home
- Decreased mobility/function – unable to discharge

**Results**

______________________________

______________________________

**Conclusions**
Likely cause of fall: simple slip/trip, acute illness, multifactorial, unexplained

**Comments**

______________________________

______________________________

* High risk – recommend referral to Falls Clinic if Falls Nurse not available to assess*

**Outcome:**
- Home with GP letter
- Admit to CDU
- Refer to Falls Clinic / Day Hospital
- Refer to Rapid Response
- Refer to DHE (Out-Patients)
- Refer for hospital admission

Signature: _______________  Print Name:_____________________  Date:___________
**A&E Faller**

**Older person presents to A&E with a fall**

Nurse Triage - categorise and place in queue to be seen by relevant professional.

*also*

Mon-Fri (9-5pm) automatic contact of Falls Nurse on bleep 929

---

**Explained fall, no injury causing functional impairment and no underlying risk factors for further falls.**

Discharge and no follow up

**Fracture requiring orthopaedic admission.**
Contact orthopaedic team. Use fracture admission proforma. Inform Staff Grade for Older People in A&E to ensure prompt medical review. #NOF patients should be fast tracked through A&E. Follow up of these patients involves routine Consultant Geriatrician input on wards.

**Fall or fracture requiring admission under medical team.**

Fracture must be reviewed by orthopaedic surgeon and plan of management documented in notes. Falls Nurse to ensure appropriate assessment and evaluation of falls and bone health whilst under medical team. Direct transfers to Dulwich must be clerked by on-call medical team.

**Fall or fracture leading to temporary functional problems and increased care needs but not requiring a hospital admission.**

Refer to either Rapid Response or an Intermediate Care bed.

Consider referral to Falls Clinic

---

**Unexplained fall or history of previous falls but no new functional problems.**

Home with Falls Clinic appointment

**Distal forearm fracture.** Contact orthopaedic surgeons. Falls Nurse will contact patient routinely to ensure subsequent assessment of falls and bone health.

_Jacqueline CT Close. Feb 2003_
**Hip Fracture**

Older person presents to A&E with a hip fracture

- Nurse Triage - fast track protocol. Analgesia given, IV access obtained, fluids started, X-ray undertaken and patient transferred direct toward. Orthopaedic team informed.

Patient clerks using fracture proforma and seen by geriatric team prior to surgery. Baseline Ca checked.

- Routine medical review on weekly consultant WR + input from SpR as requested. Falls risk and bone health assessed. All start Ca/Vit D. Discharge plan discussed

Discharged home with further rehabilitation at home

- Transferred to Elderly Trauma Ward for further rehabilitation.

Out-patient medical follow up and consideration for bisphosphonate therapy

Discharged to Intermediate Care bed for further rehabilitation

*Jacqueline CT Close. Feb 2003*
Low trauma distal forearm fracture

Older person presents to A&E with distal forearm fracture


Patient usually discharged with fracture clinic follow up.

All patients identified through X-ray by Falls Specialist Practitioner. Low trauma fractures routinely offered clinic appointment to assess falls and bone risk factors

Seen in clinic by Falls Specialist Practitioner. Assessed for falls risk factors and given advice on bone health. Assessed for osteoporosis.

If considering treatment in event of diagnosis of osteoporosis - X-ray lateral thoracic and lumbar spine

X-ray shows vertebral collapse and no history of major trauma - treatment offered

X-ray doesn’t show collapse - DEXA requested and decision to treat based on results.

Jacqueline CT Close. Feb 2003