



Falls Risk & Prevention

Screen with three questions, assess what you find · exercise works, and the medication list is the highest-yield thing you control

Exercise works
alarms do not

SCREEN EVERY OLDER ADULT *three questions, once a year*

THE THREE QUESTIONS

1. Have you fallen in the past year?
2. Do you feel unsteady when standing or walking?
3. Do you worry about falling?

Any yes triggers a full assessment. Ask them of everyone 65 and over at least annually.

ASK ABOUT THE FALL PROPERLY

Was there loss of consciousness? That changes it from a fall to a syncope workup. Ask **where, when, what they were doing, and whether they could get up.** A **long lie** predicts rhabdomyolysis, pressure injury, hypothermia and a poor outcome.

WHY IT MATTERS

Falls are the leading cause of injury and injury death in older adults, and a hip fracture carries high mortality and loss of independence. **Fear of falling is itself a risk factor,** because it causes activity restriction, deconditioning and then more falls.

ASSESS *gait, orthostatics, drugs, and the treatable contributors*

Domain	What to do
Gait, strength and balance	Timed Up and Go: rise from a chair, walk 3 meters, turn, return, sit. 12 seconds or more indicates increased fall risk. Also the 30-second chair stand for lower limb strength and the 4-stage balance test. Watching the patient walk tells you more than any questionnaire
Orthostatic vital signs	Lying then standing at 1 and 3 minutes. A drop of 20 systolic or 10 diastolic is significant. Frequently missed because it is inconvenient, and frequently drug-related and therefore fixable
 Medication review highest yield	The single most modifiable factor, and the one you personally control. Culprits: benzodiazepines and Z-drugs, antipsychotics, antidepressants, opioids, anticholinergics, antihypertensives and diuretics, alpha blockers, hypoglycemics that cause hypoglycemia, and alcohol. Polypharmacy itself is a risk factor, so count the drugs and deprescribe deliberately
Vision, feet and footwear	Check acuity and cataracts. Bifocals and varifocals increase falls on stairs, so consider single-vision distance glasses for walking outdoors. Examine feet, and look at what the patient actually wears: slippers and backless shoes are a recurring cause
The medical contributors	Cognitive impairment and delirium, Parkinson disease and neuropathy, arrhythmia, heart failure, anemia, vitamin B12 deficiency, thyroid disease, incontinence and nocturia driving rushed night trips, and untreated pain. Consider osteoporosis assessment in parallel, since preventing the fracture matters as much as preventing the fall

WHAT ACTUALLY WORKS *and two widely used things that do not*

Intervention	Evidence and practical points
Exercise the strongest single intervention	Strength and balance training, ongoing rather than a short course. Programs such as Otago and tai chi have the best evidence. This is the intervention with the most consistent benefit in community-dwelling older adults, and it must continue to keep working, so refer to something sustainable rather than a 6-week block
Multifactorial intervention	Assess and then treat what you found, which is the point of the assessment above. Most effective in those at highest risk, and it depends on the recommendations actually being carried out rather than simply listed
Home hazard assessment	Occupational therapy home visit: lighting, rugs, cords, bathroom grab rails, stair rails, bed and chair height. Most effective in those with a previous fall or significant impairment, and much less useful as a blanket measure
 Vitamin D for fall prevention	Not recommended for preventing falls in community-dwelling older adults who are not deficient. This surprises people, because it was routine practice for years. Treat genuine deficiency and bone disease on their own merits, but do not prescribe it as a falls intervention
 Bed alarms and restraints	Bed and chair alarms have not been shown to reduce inpatient falls, and physical restraints increase harm, including injury, delirium and deconditioning. Bed rails can convert a low fall into a high one. What works in hospital is purposeful rounding, toileting schedules, delirium prevention, mobility and getting the patient's own glasses, hearing aids and footwear to the bedside

AFTER A FALL IN HOSPITAL *a sequence that is routinely rushed*

Step	Detail
1. Do not move them yet	Assess where they lie. Check for head and cervical spine injury, and for hip fracture, which classically shows a shortened, externally rotated leg. Move the patient only once you have excluded an obvious fracture or spinal injury
2. Full set of observations plus a glucose	Including lying and standing blood pressure once safe, and an ECG. Hypoglycemia, arrhythmia and sepsis all present as a fall in an older adult
3. Ask about anticoagulation immediately	Any head strike on an anticoagulant needs imaging and a period of observation, and a normal initial scan does not exclude delayed bleeding. Ask specifically, since patients often do not volunteer it
4. Find out why	Every inpatient fall is a diagnostic event, not just an incident form. Review the drug chart, look for new delirium, infection, retention and postural drop. The most useful question is what the patient was trying to do, since the answer is usually reaching the toilet unaided
5. Act and communicate	Change what caused it, involve physical therapy, and tell the patient and family what happened and what you are changing. Document the assessment, not only that a fall occurred

PEARLS & PITFALLS

- **Distinguish a fall from syncope.** Loss of consciousness, no memory of hitting the ground, injury to the face because the arms did not protect, or a fall during exertion all point to a **cardiac or neurological cause** and change the workup entirely. Ask a witness where possible.
- **"Mechanical fall" is not a diagnosis.** It is a phrase that ends the thinking. Nearly every fall in an older adult is multifactorial, and labelling it mechanical is how the anticoagulant, the postural drop and the new delirium get missed.
- **Consider imaging even without focal signs in a head-injured older adult on anticoagulants,** and consider a period of observation, since a **subdural can present days to weeks later** with confusion rather than a headache.
- **The most effective prescription is often a subtraction.** Stopping one benzodiazepine or one alpha blocker frequently does more than any device or leaflet, and it is entirely within your control at the point of discharge.

