key points

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Since 2000, strategies to prevent falls among older people have been enshrined in a range of national and international guidelines, and the NSF for Older People.

Falls in older people have high personal costs and costs to the health services. These costs are escalating, as the population is ageing. In Western societies about a third of people over 65 sustain a 'significant' fall each year, of whom half fall at least twice. The prevalence rises to 50 per cent in women over 80.

There is compelling evidence for the effectiveness of falls prevention strategies in older people living in the community found to be at risk. Some studies have achieved a 30-50 per cent reduction in falls per year.

Falling – especially if recurrent and/or unexplained – is a well recognised, common 'early warning' marker of unmet health need in an older person.

There is substantial potential benefit for older people and the healthcare system in preventing falls and the causes of falls. However, the evidence that falls prevention is being taken seriously in primary care is not compelling.

Falling may result from any cause – pathological, pharmacological or mechanical – that disrupts sensory (for example proprioceptive or visual) input, central processing (such as brain higher centre response or baroreflex sensitivity) or effector output (for example musculoskeletal strength, vasoconstriction or rate-dependent cardiac output).

The ratio of intrinsic, health-related causes to environmental and behavioural (for example risk-taking) causes rises with increasing age. For this reason a history of new, unexplained or recurrent falling in an older person should always be investigated, especially because it is rare for no reversible cause to be found.

Risk detection is best implemented in two stages:

- Stage one: Simple, brief, opportunistic risk finding as part of a regular clinical encounter – an initial 'safety net' approach. This entails no more than routinely eliciting any recent history of falling and observing for gait or balance deficit. Either of these features and/or a history of recurrent falling (especially if unexplained) should trigger further evaluation, usually by referral.
- Stage two: A more detailed, multifactorial assessment of patients identified in stage one. This is the remit of the defined falls service, either based in, or operationally linked to, secondary care.

The precise proportional contribution of falls prevention to fracture prevention (in conjunction with the diagnosis and treatment of osteoporosis) has not been quantified. However, only about half of proximal femoral fracture risk is attributable to reduced bone mass; the remainder is because of non-skeletal risk, particularly the risk of falling.