# Fall Prevention and Safe Mobility: A National Practice Module

An evidence-based module for home care teams, built on CDC STEADI and the 2024 USPSTF recommendation, with a nationally adoptable checklist.

> **Why this module matters.** Falls are the leading cause of injury death among adults 65 and older. In 2024 they caused more than 43,000 deaths and about 4.5 million emergency department visits. Most falls are predictable, and many are preventable.

## About this module

This module gives home care teams a shared, evidence-based approach to fall prevention and safe mobility. It follows the CDC's STEADI framework (Stopping Elderly Accidents, Deaths, and Injuries) and the 2024 U.S. Preventive Services Task Force (USPSTF) recommendation. It ends with a checklist that agencies, clinicians, and families anywhere in the United States can adopt.

| Item | Details |
|---|---|
| Who it is for | Health practitioners, home care agencies and supervisors, home care aides, and family caregivers |
| Format | Ten units, case scenarios, a knowledge check, and a national checklist |
| Time | About 3 to 4 hours as a training course, or use single units as refreshers |
| How to use it | Clinicians lead Units 5 and 6. Aides and families focus on Units 2, 4, 7, and 8. Agency leaders use Units 9 and the checklist. |

### Learning objectives

After completing this module, learners will be able to:

1. Describe the national scale and cost of older adult falls.
2. Identify personal, medical, medication, and home risk factors.
3. Explain the STEADI steps: screen, assess, and intervene.
4. Describe the role of each team member, from family caregiver to clinician.
5. Recognize which interventions have the strongest evidence.
6. Perform and teach safe transfers that protect the client and the caregiver.
7. Respond correctly when a fall happens, and report it.
8. Track simple measures that show whether prevention is working.

> **Scope of practice.** Aides and family caregivers observe, support, and report. Screening tests, medication changes, and treatment decisions belong to licensed clinicians. Follow your state scope-of-practice rules and agency policies.

## Unit 1. The national picture

More than one in four older adults falls each year. Because many falls cause no injury, they are easy to overlook, yet a fall in the past year is one of the strongest predictors of another.

| Measure | National figure | Source |
|---|---|---|
| Older adults who report falling in a year | More than 1 in 4; about 14 million (27.6%) in 2020 | CDC |
| Deaths from falls, adults 65+ | More than 43,000 (2024) | CDC |
| Emergency department visits for falls | About 4.5 million (2024) | CDC |
| Hospitalizations after a fall | About 1.4 million per year | CDC |
| Falls causing an injury that needs care or limits activity | About 37% of people who fall (2012 to 2018) | CDC |
| Hospitalizations for hip fracture | About 319,000 per year; falls cause 88% of hip fracture ED visits and stays (2019) | CDC |
| Traumatic brain injury | Falls are the most common cause in older adults | CDC |
| Health care spending on non-fatal falls | $80 billion (2020), up from $50 billion in 2015 | Haddad et al., 2024 |
| Who pays | Medicare about 67%, Medicaid about 4%, older adults and families about 29% | Haddad et al., 2024 |
| Death within one year after hip fracture | May reach 20% to 30% | American Family Physician, 2024 |

### What these numbers mean for home care

- **The home is where most risk lives.** Older adults spend most of their time at home, and many falls happen during ordinary tasks such as walking to the bathroom at night.
- **Medicare carries most of the cost.** Prevention that keeps people out of the emergency department directly reduces public spending.
- **Fear of falling is a risk factor too.** People who fear falling often limit activity, which weakens muscles and balance and raises risk further. This cycle leads to isolation, depression, and loss of independence.
- **The population at risk is growing.** The number of Americans 65 and older reached 61.2 million in 2024, so even a steady fall rate means more falls every year.

## Unit 2. Why falls happen

Most falls have several causes at once. A 2023 analysis of nearly 71,000 community-dwelling older adults found that the strongest risk factors were a prior fall, balance problems, fear of falling, and dementia. The more risk factors a person has, the higher the risk.

| Type | Risk factors | What a caregiver may notice |
|---|---|---|
| **Fall history** | A fall in the past year, especially more than one, or a fall with injury | Bruises, reluctance to talk about a fall, "I just slipped" |
| **Strength, gait, and balance** | Weak legs, slow or shuffling walk, poor balance, recent illness or hospital stay | Pushes up with arms to stand, holds furniture to walk, unsteady turning |
| **Medications** | Four or more medicines, or any fall-risk medicine (see below) | Drowsiness, dizziness, confusion after a new or changed medicine |
| **Blood pressure on standing** | Orthostatic hypotension, dehydration | Lightheaded when getting up, especially in the morning or after meals |
| **Vision and hearing** | Cataracts, glaucoma, macular degeneration, multifocal lenses, hearing loss | Misjudges steps, bumps into objects, avoids going out at night |
| **Feet and footwear** | Foot pain, numbness, long nails, loose slippers, socks on smooth floors | Shuffles, walks barefoot or in socks, worn shoes |
| **Chronic conditions** | Parkinson's disease, stroke, arthritis, diabetes, heart disease, osteoporosis, depression, pain | Changes in walking, numb feet, low blood sugar episodes |
| **Thinking and mood** | Dementia, delirium, depression | Forgets walker, tries to get up alone, new confusion |
| **Bladder and bowel** | Urgency, frequent night urination, incontinence | Rushes to the bathroom, gets up several times at night |
| **Home environment** | Clutter, loose rugs, poor lighting, no grab bars, stairs without rails, pets underfoot | Dark hallways, cords across paths, items stored high or low |
| **Behavior** | Rushing, climbing on chairs, not using a prescribed device, alcohol use | "I didn't want to bother anyone" |

### Medicines that increase fall risk

CDC's STEADI materials point clinicians to the American Geriatrics Society Beers Criteria to identify medicines that increase fall risk. Common classes include:

| Medicine class | Examples | Why it matters |
|---|---|---|
| Sleep medicines and sedatives | Benzodiazepines, "Z-drugs" such as zolpidem, some antihistamines such as diphenhydramine | Drowsiness, slowed reaction, confusion |
| Opioid pain medicines | Oxycodone, hydrocodone, tramadol | Sedation, dizziness |
| Antidepressants and antipsychotics | Many classes | Sedation, low blood pressure on standing |

| Medicine class | Examples | Why it matters |
|---|---|---|
| Seizure medicines | Several agents | Dizziness, unsteadiness |
| Blood pressure medicines and diuretics | Many agents, especially after a dose change | Low blood pressure on standing, urgency |
| Diabetes medicines | Insulin, sulfonylureas | Low blood sugar |
| Anticholinergic medicines | Some bladder, allergy, and stomach medicines | Confusion, blurred vision |

**Caregivers:** Never stop or change a medicine without the prescriber. Report new dizziness, sleepiness, or confusion to the nurse or clinician the same day.

## Unit 3. The national framework

Three national sources guide fall prevention for older adults living at home. Together they say: screen everyone, assess people at risk, and give them the interventions with the strongest evidence.

| Source | What it says | What it means in practice |
|---|---|---|
| **CDC STEADI** | A three-step approach for health care providers: **screen** for fall risk, **assess** modifiable risk factors, and **intervene** with effective strategies. Follow up in 30 to 90 days, and rescreen every year or after any fall. | Every older client should be screened at least yearly. Every fall triggers a new look. |
| **USPSTF, 2024** | Recommends exercise interventions for community-dwelling adults 65 and older at increased risk of falls (grade B, moderate net benefit). Multifactorial interventions have a small net benefit and should be offered selectively, based on the person's circumstances. | Exercise is the first-line intervention. Multifactorial plans are added for people with several risk factors. |
| **World Falls Guidelines, 2022** | International guidance that stratifies older adults by risk and recommends assessment and tailored intervention for those at high risk. | Match the intensity of the plan to the level of risk. |

### Federal programs that support prevention

- **Medicare Annual Wellness Visit** includes a review of functional ability and safety, which is an opportunity for fall screening.
- **Medicare Part B** covers medically necessary physical and occupational therapy, which can address strength, balance, gait, and home safety.
- **Medicare caregiver training services** have been payable since January 1, 2024, so clinicians can bill for teaching family caregivers skills such as safe transfers.
- **Administration for Community Living (ACL)** supports evidence-based falls prevention programs through Older Americans Act Title III-D funds and discretionary grants. Local Area Agencies on Aging often offer these programs free or at low cost.

## Unit 4. Roles on the team

Fall prevention works when everyone knows their part, and information flows quickly to the person who can act on it.

| Team member | Main responsibilities |
|---|---|
| **Family caregiver** | Keep the home safe, encourage daily exercise, help with footwear and devices, watch for changes, and tell the clinician about every fall, even without injury. |
| **Home care aide** | Follow the care plan, use safe transfer methods, keep paths clear, make sure devices are within reach, and report falls, near misses, and new symptoms the same day. |
| **Agency supervisor or nurse** | Screen at intake and yearly, assess the home, write the mobility plan, train aides, review every fall report, and coordinate with the clinician. |
| **Primary care clinician** | Complete the STEADI assessment, review medicines, check orthostatic blood pressure, manage conditions, and make referrals. |
| **Physical therapist** | Assess gait, strength, and balance, prescribe exercise, fit and train on walking aids, and teach safe transfers. |
| **Occupational therapist** | Assess the home and daily activities, recommend modifications and equipment, and teach safer ways to bathe, dress, and toilet. |
| **Pharmacist** | Review all medicines, including over-the-counter products, and suggest safer options to the prescriber. |
| **Community program leader** | Deliver evidence-based programs such as A Matter of Balance, Tai Chi, or Otago. |

# Unit 5. Screening and assessment

### Step 1. Screen

STEADI uses three key questions. A “yes” to any one means the person is at risk and needs further assessment. The 12-question Stay Independent brochure is an alternative; a score of 4 or more indicates risk.

| Key question | If yes, also ask |
|---|---|
| Do you feel unsteady when standing or walking? | When does it happen? Is it getting worse? |
| Do you worry about falling? | Have you stopped doing things because of this worry? |
| Have you fallen in the past year? | How many times? Were you injured? |

Aides and families can ask these questions and report the answers. The nurse or clinician decides on next steps.

### Step 2. Assess (clinicians and therapists)

For people at risk, STEADI recommends evaluating gait, strength, and balance, and identifying modifiable risk factors.

| Test | How it is done | Common threshold for concern |
|---|---|---|
| **Timed Up and Go (TUG)** | Person stands from a chair, walks 10 feet at a normal pace, turns, walks back, and sits. | 12 seconds or longer suggests increased fall risk. Also watch for slow steps, loss of balance, or short strides. |
| **30-Second Chair Stand** | Person sits with arms crossed and stands fully as many times as possible in 30 seconds. | A score below the average for age and sex (table below) indicates risk. |
| **4-Stage Balance Test** | Person holds four positions without support: feet side by side, semi-tandem, tandem (heel to toe), and one leg, for 10 seconds each. | Unable to hold the tandem stance for 10 seconds suggests increased risk. |
| **Orthostatic blood pressure** | Blood pressure lying down, then after standing 1 and 3 minutes. | A drop of 20 mmHg or more systolic, or 10 mmHg or more diastolic, or symptoms such as lightheadedness. |
| **Vision** | Visual acuity check, such as a Snellen chart. | Any new or uncorrected vision problem |
| **Feet and footwear** | Inspect feet and shoes; check sensation. | Pain, numbness, deformity, or unsafe footwear |
| **Medication review** | Review all prescription and over-the-counter medicines. | Any fall-risk medicine, or four or more medicines |
| **Home hazards** | Home safety assessment, ideally by an occupational therapist. | Any hazard in the checklist at the end of this module |

### 30-Second Chair Stand: below-average scores

Scores below these numbers indicate increased fall risk (CDC STEADI).

| Age | 60–64 | 65–69 | 70–74 | 75–79 | 80–84 | 85–89 | 90–94 |
|---|---|---|---|---|---|---|---|
| Men: fewer than | 14 | 12 | 12 | 11 | 10 | 8 | 7 |
| Women: fewer than | 12 | 11 | 10 | 10 | 9 | 8 | 4 |

**Safety during testing.** Stand close enough to steady the person during every test. Stop if they become unsteady, short of breath, or in pain. People who cannot stand without help are already at high risk and do not need to complete the test.

## Unit 6. Interventions that work

STEADI's third step is to intervene. The table below links each risk factor to the actions recommended in CDC's STEADI guidance, with the strength of evidence where national sources give it.

| Risk found | Recommended action | Who leads |
|---|---|---|
| Poor gait, strength, or balance | Exercise is the intervention with the strongest evidence (USPSTF grade B). Refer to physical therapy or an evidence-based program. The most common effective regimen in studies was 2 to 3 sessions a week for 12 months, focused on gait, balance, and functional training, plus strength. | Clinician, PT, program leader |
| Fall-risk medicines | Stop, switch, or reduce the dose of medicines that increase fall risk, where safe. | Prescriber, pharmacist |
| Orthostatic hypotension | Adjust medicines, encourage fluids, teach foot pumps and slow position changes, and consider compression stockings. | Clinician, nurse |
| Vision problems | Refer to eye care. Consider cataract surgery where indicated. Use single-vision glasses for walking outdoors. | Clinician, eye specialist |
| Feet or footwear problems | Refer to podiatry. Choose shoes with a firm sole, good traction, a low heel, and a secure fit. | Clinician, podiatrist |
| Vitamin D deficiency | Treat confirmed deficiency. In people without deficiency, a large study found supplementation does not reduce falls. | Clinician |
| Home hazards | Occupational therapy home safety evaluation and modifications. | OT, family, agency |
| Bladder urgency or night urination | Evaluate causes, review diuretic timing, use a bedside commode or urinal, and light the path. | Clinician, nurse |
| Osteoporosis or fracture history | Evaluate bone health to reduce injury if a fall occurs. | Clinician |
| Fear of falling | Programs such as A Matter of Balance build confidence and activity. | Program leader, family |

### Evidence-based community programs

ACL and the National Council on Aging (NCOA) maintain a list of programs that meet ACL's criteria for evidence-based falls prevention. Selected examples:

| Program | Format | Best for |
|---|---|---|
| **A Matter of Balance** | Eight-week structured group program | People who fear falling and have limited activity |
| **Otago Exercise Program** | 17 strength and balance exercises; 8-week clinical phase led by a PT or PT assistant, then 4 to 10 months of self-management | Frail or homebound people; works at home |
| **Tai Ji Quan: Moving for Better Balance** | Two 1-hour sessions a week for 24 weeks | People able to stand and move with some support |

| Program | Format | Best for |
|---|---|---|
| **Stepping On** | Group workshop covering many prevention strategies | People who have fallen or fear falling |
| **SAIL (Stay Active and Independent for Life)** | Strength, balance, and fitness class, three times a week | Adults 65+ able to exercise in a group |
| **CAPABLE** | Five months at home: up to 10 OT visits, 4 nurse visits, and handyman repairs | Low-income older adults with difficulty in daily activities |
| **Home Hazards Removal Program (HARP)** | One to five in-home sessions with an OT, plus a booster at three months | People with home hazards |
| **YMCA Moving For Better Balance** | 12-week instructor-led program based on Tai Chi principles | Adults 65+, or 45+ with related conditions |

To find a local program, contact the Area Agency on Aging through the Eldercare Locator (1-800-677-1116 or eldercare.acl.gov).

## Unit 7. Safe transfers and mobility

Transfers, such as moving from bed to chair or onto the toilet, are high-risk moments for both the client and the caregiver. Safe technique protects both. Follow the mobility plan written by the nurse or therapist.

### Before every transfer

- ☐ Know the plan: how much help the person needs, which device to use, and whether two people or a lift are required.
- ☐ Explain each step to the person and ask them to help as much as they safely can.
- ☐ Clear the path and lock the wheels of beds, wheelchairs, and commodes.
- ☐ Put on non-slip footwear for the client and yourself.
- ☐ Place the chair or wheelchair close, at an angle, on the person's stronger side.
- ☐ Use a gait belt if the plan calls for one. Never lift by the arms or under the armpits.
- ☐ Check for dizziness. Have the person sit on the edge of the bed for a minute before standing.

### Body mechanics for the caregiver

| Do | Do not |
|---|---|
| Keep your feet shoulder-width apart, one slightly forward | Twist your back while lifting |
| Bend your knees and hips, keep your back straight | Bend at the waist to lift |
| Hold the person close to your body | Let the person hold onto your neck |
| Turn with your feet, pivoting your whole body | Lift more than you can safely handle |
| Count down together: "one, two, three, stand" | Rush or pull suddenly |

> **Know the safe limit.** Research from NIOSH (Waters, 2007) recommends that one caregiver manually lift no more than 35 pounds of a patient's weight, even under ideal conditions. Above that, use assistive devices such as a mechanical lift, sit-to-stand aid, or slide board, with training.

### Common transfers

| Transfer | Key steps |
|---|---|
| **Sit to stand** | Scoot to the front of the seat, feet flat and slightly back, lean forward "nose over toes," push up from the armrests, stand fully and pause before walking. |
| **Bed to chair (stand-pivot)** | Chair at a 45-degree angle on the stronger side, wheels locked. Help the person stand, pause, take small steps to turn, reach back for the armrests, and sit slowly. |
| **Toilet** | Use grab bars or a raised seat, not towel bars. Back up until the legs touch the toilet, reach for the bars, and lower slowly. |
| **Car** | Seat pushed back. Person sits first, then swings the legs in together. Reverse to get out. |

| Transfer | Key steps |
|---|---|
| **Walking with a device** | Walker: move the walker, step in with the weaker leg, then the stronger leg. Cane: hold it on the stronger side and move it with the weaker leg. |

### Mobility every day

- Encourage short walks and the exercises the therapist prescribes. Bed rest and sitting for long periods weaken muscles quickly.
- Keep walkers and canes within reach, including at night.
- Use night lights from bed to bathroom.
- Schedule toileting before bed and on waking for people with urgency.
- Report any new difficulty walking, standing, or transferring the same day. It may signal illness, a medicine problem, or the need for a new plan.

# Unit 8. When a fall happens

> **Stop and check first.** Do not rush to lift the person. Getting someone up the wrong way can worsen an injury and hurt the caregiver.

### Step by step

1. **Stay calm and reassure the person.** Ask them to stay still while you check.
2. **Check for danger signs.** Call 911 if the person is unconscious, has trouble breathing, has chest pain, hit their head (especially if they take a blood thinner), has new confusion, severe pain, bleeding, a bone that looks out of place, or cannot move a limb.
3. **If there are no danger signs,** ask whether they feel able to get up. If not, or if you are unsure, keep them warm and comfortable and call for help.
4. **To get up safely (only if uninjured and able):** roll onto the side, get onto hands and knees, crawl to a sturdy chair, place hands on the seat, bring the stronger leg forward, push up, then turn and sit. Do not lift them yourself.
5. **If they cannot get up,** call for help. Use a lift assist from emergency services if needed.
6. **Watch for 24 to 48 hours** for headache, drowsiness, vomiting, confusion, or new pain, and seek care if any appear.
7. **Report every fall** to the nurse, supervisor, and clinician, even if there is no injury.
8. **Look for the cause** and update the plan.

### The danger of a “long lie”

Lying on the floor for a long time after a fall can cause dehydration, pressure injuries, and muscle breakdown, and greatly increases fear of falling. People at high risk who are often alone should have a way to call for help, such as a wearable alert device or a phone within reach, and should practice how to get up.

### After-fall review

| Question | Notes |
|---|---|
| When, where, and doing what? | |
| Any warning signs (dizziness, rushing, new medicine, illness)? | |
| Footwear, device, and lighting at the time? | |
| Injury and care received? | |
| Clinician notified? Date: | |
| What will change in the plan? | |

## Unit 9. Measuring results

Track a few simple measures. They show whether prevention is working and are useful evidence for partners, payers, and funders.

| Measure | How to calculate | Who tracks |
|---|---|---|
| Fall rate | Falls ÷ total client days × 1,000 | Agency |
| Injurious fall rate | Falls with injury ÷ total client days × 1,000 | Agency |
| Screening rate | Clients screened in the past 12 months ÷ all clients 65+ | Agency |
| Plan rate | At-risk clients with a written fall prevention plan ÷ all at-risk clients | Agency |
| Referral rate | At-risk clients referred to PT, OT, or a program ÷ all at-risk clients | Agency, clinician |
| Post-fall review | Falls reviewed within 72 hours ÷ all falls | Agency |
| Emergency visits after falls | Count per quarter | Agency, family |
| Caregiver training | Aides trained in safe transfers in the past 12 months ÷ all aides | Agency |

**Reading the numbers.** A rise in reported falls after training can mean better reporting, not worse care. Look at injurious falls and trends over at least two quarters.

# Unit 10. Case scenarios

### Case 1. Mr. A, age 82

Mr. A lives alone and has an aide four hours a day. He started a new blood pressure medicine two weeks ago. The aide notices he holds the wall when he gets up in the morning and says he feels “woozy.” He has not fallen.

- What risk factors are present?
- What should the aide do today?
- What might the clinician assess?

*Discussion:* New medicine, possible orthostatic hypotension, and morning unsteadiness. The aide reports the same day, encourages him to sit before standing, and keeps the walker close. The nurse alerts the prescriber, who may check orthostatic blood pressure and adjust the medicine.

### Case 2. Mrs. B, age 76, with dementia

Mrs. B gets up at night to use the bathroom and forgets her walker. Her daughter found her on the floor last week. She was not hurt.

- Why must this fall be reported?
- What home changes could help?
- Which programs or referrals may fit?

*Discussion:* Any fall, even without injury, is the strongest predictor of another. Options include motion-sensor night lights, a bedside commode, a scheduled bathroom trip before bed, a bed alarm if appropriate, an OT home assessment, and a clinician review of medicines and bladder symptoms.

### Case 3. Mr. C, age 69, after a hip replacement

Mr. C is home after surgery and wants to “get back to normal” fast. He refuses to use the shower chair.

- What are the risks?
- How can the team respect his goals and keep him safe?

*Discussion:* Explain the reasons, involve him in choices, follow the surgeon’s and therapist’s precautions, and focus on his goal: home exercise from the PT builds strength faster than rushing.

## Knowledge check

1. About how many older adults report falling each year in the United States? *(More than 1 in 4; about 14 million)*
2. What are the three STEADI key questions? *(Unsteady standing or walking? Worried about falling? Fallen in the past year?)*
3. Which intervention has the strongest evidence according to the USPSTF? *(Exercise)*
4. What Timed Up and Go result suggests increased fall risk? *(12 seconds or longer)*
5. Name three medicine classes that increase fall risk. *(For example, sedatives, opioids, blood pressure medicines)*
6. Should vitamin D be given to everyone to prevent falls? *(No. Treat confirmed deficiency.)*
7. What is the recommended maximum manual lift for one caregiver? *(35 pounds of patient weight)*
8. Name four reasons to call 911 after a fall. *(Head strike on a blood thinner, unconsciousness, new confusion, severe pain, deformity)*
9. Should a fall without injury be reported? *(Yes, always.)*
10. How often should older adults be rescreened? *(Every year, and after any fall)*

## National Fall Prevention and Safe Mobility Checklist

This checklist puts national guidance into one tool that agencies, clinicians, and families in any state can adopt. The "National basis" column shows where each item comes from. Adapt it to your state rules and agency policies.

| Client name or ID | Date | Completed by and role |
|---|---|---|
| Clinician | Agency | Next review date |

### A. Screening (every client 65+, at intake, yearly, and after any fall)

| Action | National basis | Done | Notes |
|---|---|---|---|
| Ask the three key questions: unsteady, worried, fallen in past year | CDC STEADI | ☐ | |
| If fallen: record number of falls and any injury | CDC STEADI | ☐ | |
| Or complete Stay Independent brochure (risk if score is 4 or more) | CDC STEADI | ☐ | |
| Report a positive screen to the nurse or clinician | CDC STEADI | ☐ | |

### B. Assessment (people at risk; clinician or therapist)

| Action | National basis | Done | Notes |
|---|---|---|---|
| Gait, strength, and balance: TUG, 30-Second Chair Stand, 4-Stage Balance | CDC STEADI | ☐ | |
| Orthostatic blood pressure, lying and standing | CDC STEADI | ☐ | |
| Medication review using the Beers Criteria, including over-the-counter products | CDC STEADI; AGS | ☐ | |
| Visual acuity | CDC STEADI | ☐ | |
| Feet and footwear | CDC STEADI | ☐ | |
| Vitamin D intake and status; bone health | CDC STEADI | ☐ | |
| Conditions: cognition, mood, continence, pain, chronic disease | CDC STEADI | ☐ | |
| Home hazards, ideally by an occupational therapist | CDC STEADI | ☐ | |

## C. Intervention plan

| Action | National basis | Done | Notes |
|---|---|---|---|
| Exercise referral: PT or an evidence-based program; 2 to 3 sessions a week | USPSTF 2024 (B) | ☐ | |
| Optimize fall-risk medicines with the prescriber | CDC STEADI | ☐ | |
| Manage orthostatic hypotension | CDC STEADI | ☐ | |
| Eye care and podiatry referrals as needed | CDC STEADI | ☐ | |
| Treat confirmed vitamin D deficiency | CDC STEADI | ☐ | |
| Written plan shared with client, family, and aides | Best practice | ☐ | |
| Follow up in 30 to 90 days | CDC STEADI | ☐ | |

## D. Home environment

| Action | National basis | Done | Notes |
|---|---|---|---|
| Clear walkways; remove or secure loose rugs and cords | CDC; OT practice | ☐ | |
| Bright lighting in halls and stairs; night lights from bed to bathroom | CDC | ☐ | |
| Rails on both sides of stairs | CDC | ☐ | |
| Grab bars by the toilet and in the tub or shower; non-slip mats | CDC | ☐ | |
| Shower chair and raised toilet seat if needed | OT practice | ☐ | |
| Frequently used items between waist and shoulder height | CDC | ☐ | |
| Phone or alert device within reach at all times | Best practice | ☐ | |
| Pets and clutter managed in walking paths | Best practice | ☐ | |

## E. Safe transfers and mobility

| Action | National basis | Done | Notes |
|---|---|---|---|
| Written mobility plan states level of help, device, and number of people | Best practice | ☐ | |
| Caregivers trained in safe transfers and body mechanics | NIOSH; Medicare caregiver training | ☐ | |
| Mechanical aids used above 35 pounds of patient weight | NIOSH (Waters, 2007) | ☐ | |
| Gait belt available when ordered | Best practice | ☐ | |

| Action | National basis | Done | Notes |
|---|---|---|---|
| Walking device fitted by a therapist and kept within reach | CDC STEADI | ☐ | |
| Non-slip, well-fitting footwear | CDC STEADI | ☐ | |

### F. After a fall

| Action | National basis | Done | Notes |
|---|---|---|---|
| Check for danger signs before moving the person; call 911 when needed | Best practice | ☐ | |
| Report every fall to the nurse, supervisor, and clinician | CDC STEADI | ☐ | |
| Watch for delayed symptoms for 24 to 48 hours | Best practice | ☐ | |
| Complete an after-fall review within 72 hours and update the plan | Best practice | ☐ | |
| Rescreen and reassess | CDC STEADI | ☐ | |

### G. Agency program (yearly)

| Action | National basis | Done | Notes |
|---|---|---|---|
| Policy requires fall screening at intake and yearly | CDC STEADI | ☐ | |
| All aides trained in fall prevention and safe transfers | NIOSH; best practice | ☐ | |
| Fall, injury, screening, and referral rates tracked quarterly | Best practice | ☐ | |
| Local evidence-based programs and Area Agency on Aging contacts listed | ACL; NCOA | ☐ | |
| Program reviewed and updated yearly | Best practice | ☐ | |

| | | |
|---|---|---|
| Completed by: signature | Printed name and title | Date |
| Reviewed by (nurse or clinician): signature | Printed name and title | Date |

## Sources and further reading


CDC: Facts About Older Adult Falls (updated Sept. 2026) (cdc.gov)

CDC: About Older Adult Fall Prevention (updated Sept. 2026) (cdc.gov)

CDC STEADI: Preventing Falls in Older Patients, Pocket Guide (cdc.gov)

USPSTF: Falls Prevention in Community-Dwelling Older Adults, 2024 (guidelinecentral.com)

American Family Physician: Falls in Older Adults, May 2024 (aafp.org)

NCOA: Falls Prevention Facts (Haddad et al., Injury Prevention, 2024) (ncoa.org)

NCOA: Evidence-Based Falls Prevention Programs (ncoa.org)

ACL: Evidence-Based Falls Prevention Programs (acl.gov)

Rural Health Information Hub: Caregiver Training Services (ruralhealthinfo.org)

Census data: older adult population 2024 (via Feedbagel) (feedbagel.com)

HealthDay: More Than One in Four Older Adults Report Falling (CDC MMWR) (healthday.com)

This resource is for general education. It does not replace advice from a doctor, nurse, pharmacist, or other qualified professional. You may print, copy, and adapt it for non-commercial use. Please keep the credit to Aricares Alliance. Questions or corrections: contact@aricaresalliance.com.