Government of Western Australia
Department of Health

Stay On Your Feet WA®

Western Australian guidelines for patient education for preventing falls in hospital settings 2025

Older Persons Health Network

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Acknowledgement of Country

WA Health acknowledges the Aboriginal people of the many traditional lands and language groups of Western Australia. It acknowledges the wisdom of Aboriginal Elders both past and present and pays respect to Aboriginal communities of today.

"Using the term Aboriginal"

Aboriginal and Torres Strait Islander may be referred to in the national context and 'Indigenous' may be referred to in the international context.

Within WA, the term Aboriginal is used in preference to Aboriginal and Torres Strait Islander, in recognition that Aboriginal people are the original inhabitants of WA.

No disrespect is intended to our Torres Strait Islander colleagues and community.

Disclaimer

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This guideline is for the hospital setting. It is not intended for use in the residential care setting.

Suggested citation

Department of Health, Western Australia. Western Australian guidelines for patient education for preventing falls in hospital settings 2025. Perth.

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Overview

Falls are a major cause of injury and death among older adults and have serious consequences to their health and wellbeing.[1]

In 2022, the Australian Institute of Health and Welfare reported that falls are the leading cause of hospital injuries and injury deaths among older Australians.[2]

For the 2022 – 23 reporting period, the rate of falls resulting in patient harm in Western Australian (WA) public hospitals was 7.7 (per 1,000 separations) and was the second highest rate nationally.[3] Falls injuries were also estimated to have cost the Australian health system $4.7 billion in 2020-21.[4]

Patient falls education is a planned activity initiated by a healthcare professional in a hospital setting whose goal is to provide information and skills with the intention to change or maintain patient behaviours, promote uptake of falls prevention and management interventions, thereby improving overall health and reducing falls.[5]

Decreasing falls in the hospital setting is highly dependent on patient engagement in falls prevention activities. A patient's beliefs and attitudes are key influencers in facilitating or forming a barrier to engagement in falls prevention strategies.[6] Hospitalised older people consistently underestimate their own risk of falls.[7] Failing to provide patient falls prevention education can lead to falls, resulting in poor patient and health system outcomes.

Health education should encourage people to have the motivation, skills and confidence (self-efficacy) necessary to take action to improve their health.[8] Patient education is more than giving information to patients.[9] Effective patient education ensures that patients have sufficient information and understanding to enable them to make informed decisions regarding their care.[10]

Patient education for falls prevention and management is supported by a comprehensive evidence base demonstrating the link between patient education, reducing the likelihood of falling and rate of falls.[11] Patient education also supports patient empowerment, better health outcomes, better healthcare experience and consumer satisfaction. Patient education also helps to decrease patient anxiety and hospital readmissions rates and increase patient compliance, adherence and knowledge.[12,13] Published research has demonstrated that patient education can be effective in reducing falls-related outcomes, as part of either a multidomain program or single intervention.[14-19]

The World Falls Guidelines[20] recommend that tailored education for falls prevention should be delivered to all hospitalised older adults and other high risk groups. Personalised single or multidomain falls prevention strategies based on identified risk factors, behaviours or situations should be implemented for all hospitalised older adults 65 years of age and over, or younger individuals identified by health professionals at risk of falls.[20]

The *Western Australian guidelines for patient education for preventing falls in hospital settings 2025* provides health professionals working in hospitals the WA Health system with an evidence based approach for undertaking patient education to reduce incidence of falling and improve the patient experience.

It is acknowledged that people engaging with the WA Health system are referred to as consumers. For the purpose of these guidelines, the focus is specifically on consumers that have been admitted as inpatients to a WA hospital. To maintain this specific focus, the target group will be referred to as patients within this document.

Please refer to Falls Prevention and Management in WA webpages for additional information, resources and education.

Definitions

Patient health education	Patient education is a planned activity initiated by a healthcare professional whose goal is to provide information, attitude, and skills, with the intention to change health behaviour, promote engagement in interventions, thereby improving overall health.[5]
Health literacy	The cognitive and social skills which determine the motivation and ability of individuals to gain access to, understand and use information in ways which promote and maintain good health. Health literacy is critical to patient empowerment and improving patient access to health information can support their ability to use it effectively.[21]
Behaviour Change Technique	An active component of an intervention designed to change behaviour i.e. goal setting, action planning, graded tasks, etc.[22] Additional training can be found at http://www.bct-taxonomy.com/.
Brief intervention	An intervention that takes very little time to implement.[23]
Tailoring education	Any combination of information or change strategies intended to reach one specific person, based on characteristics that are unique to that person, related to the outcome of interest, and have been derived from an individual assessment.[24]
Multidomain interventions	A combination of 2 or more intervention components across 2 or more domains (e.g. an exercise program and environmental modification) based on a multifactorial falls risk assessment and intended to prevent or minimise falls and related injuries.[20]

Patient education

Patient education should be part a multidomain approach to falls prevention.[19] Research has revealed that patients report preferring individualised education, as well as consistent and standardised information from all clinical staff.[13,25-27] Greenberg et al.[28] found that 70 per cent of patients were comfortable discussing their falls risk with a health professional, with no differences between genders (p=0.57).[28] Patient education programs should be designed based on educational principles and health behaviour change models.[19]
Hospitals provide an opportunity to engage with patients and initiate preventive services. Research has identified critical enablers to providing patient falls prevention education including:

- well designed and interactive education resources tailored to patient's individual needs
- patient-centered hospital processes to empower patients to gain knowledge
- collective responsibility amongst health professionals to create a culture of vigilance regarding preventing hospital falls.[29]

When to deliver patient education

Patient education should be delivered at all stages in the hospital journey from the emergency department, in patient, patient discharge and any subsequent services. The patient education will vary depending on the setting, clinical need and patient circumstances. The patient education will also change as a patient moves through the hospital journey.

Four stages of patient education

The patient education will also change as a patient moves through the hospital journey. Patient education is a process with 4 stages:

1. Assessment
2. Planning
3. Implementation
4. Evaluation

Each component must be equally addressed for excellence in patient education.[28]

Stage 1: Assessment

Patient assessment identifies a patient's falls risk factors and educational needs. The following factors should be reviewed to ensure education is individualised, effective and relevant for the patient:

- **Pre-existing falls prevention and management knowledge** to ensure education is building upon an existing knowledge base.
- **Patient beliefs** regarding the prevention and management of falls. Understanding patients' perceptions of their falls risk will help to direct falls prevention strategies and understand patient behaviours.[30]
- **Emotional barriers including concerns, anxiety and fear of falling**. Previous research has identified that patients' thoughts and feelings about their recovery were the main barriers to engaging in safe strategies, including feeling overconfident, desiring to be independent or not a burden to staff, and thinking that staff would be delayed in providing assistance.[6] The most common task identified as potentially leading to risk-taking behaviour was needing to use the toilet.[6]
- **Cognitive or physical differences**, such as cognitive impairment, hearing and visual difficulties, disability such as intellectual disability, learning differences (e.g. dyslexia, dysgraphia, dyspraxia), global developmental delay, and neurological difference (e.g. Autism, ADHD) that would impact on receipt of education.
- **Communication requirements**, including but not limited to language preference, visual presentation, mode of delivery.[25]

Assessment involves listening to the patient, rather than providing information. It should also include assessment of additional caregiver or family needs, who support the patient, and can reinforce education provided.

Assessment of the patient should also consider the patient's health literacy and learning style preference and techniques to support health behaviour change.

Health literacy

Health literacy describes how people access, understand and apply health information to make decisions about their health journey.[31] Patients and their support networks come from a range of diverse backgrounds and have varying lived experience that shape how they manage their health conditions and ongoing care.

It is estimated that around 60 per cent of Australia's population experience low levels of health literacy.[31] Factors impacting on health literacy include but are not limited to age, vision or hearing impairment, cognitive or physical differences, level of education, English as an additional language, cognitive of physical differences, disability (such as neurological processing differences and intellectual disability) and cognitive decline. Social determinants of health such as a person's education level, employment status, use of illicit drugs, experiences of past torture and trauma, and experiences of racism and discrimination also impact health literacy.[32] The health literacy of patients and carers needs to be considered

throughout the education process.[25] Research demonstrates that health professionals tend to overestimate a patient's health literacy.[33-34]

Health literacy can be assessed using a variety of tools. Tool selection should take into consideration the factors impacting health literacy. Some standards tests to assess general adult health literacy include the Test for Functional Health Literacy[35] (TOFHLA) and the Rapid Estimate of Adult Literacy in Medicine[36] (REALM).

It is also important to acknowledge cultural and other diversity considerations when engaging in patient education. It is recommended that guidance is sought from Aboriginal Hospital Liaison Officers and diversity teams, such as those that support people with disability, culturally and linguistically diverse (CaLD) backgrounds, LGBTIQA+SB community and whichever other diversity groups that might need to be included for your setting when developing and engaging patients in education activities (Appendix 1). Planning education content that is easy to understand and accessible for people of all backgrounds, irrespective of their circumstances, will ensure better uptake of health information relating to falls prevention.

Learning style preference

Every person has a preferred learning style which supports knowledge receipt. These include:

- Visual: These learners learn best by observing and reading. Approximately 65 per cent of people are visual learners. It is best to provide written information including pictures and diagrams supported by a written explanation in plain and simple English, pitched at a 10-12 year old reading level for these learners.
- Auditory: These learners prefer to listen to information and will prefer one-to-one educational sessions or direction to videos or podcasts.
- Kinaesthetic: In this case, learners prefer hands-on practice. This can be achieved by demonstrating falls prevention and management strategies, including use of equipment and allowing opportunity for the patient practice.
- Read/Write: These learners benefit from viewing information in a written form and making notes.

When selecting the format(s) ensure that the format supports a person's communication needs - i.e. is in braille, formatted to work with screen readers, has captions, is in Easy Read format etc.

Often people don't fit into a singular category but multiple and they may shift their preference depending on the task that is being explained to them due to their cognitive processing capacity. For example, a person might be fine with auditory instructions when it is simple but if complex, they may prefer written instructions, and if it is something they are wholly unfamiliar with they may need to practice the information physically or connect the

information to a physical action to help remember it (like counting on fingers). Ultimately it is important to communicate with the person and gaining an understanding of how they want information presented.

Communication difference

It is important to acknowledge that it is not just about how people process information that impacts their literacy but how they functionally communicate. This will be particularly relevant for people with intellectual disability, cognitive decline, neurological difference, and sensory difference. Communication formats such as Easy Reads which are largely used for people with intellectual disability are extremely helpful for people with English as an alternative language and for people with neurological processing differences. People in hospital are given a lot of information, from lots of different people. They often feel anxious, uncomfortable, are not sleeping well, and are worrying about lots of other things in their life that might be being impacted by their stay in hospital. They are likely not processing information at their usual level, which means provision of information in simple formats like easy read can be helpful.

Supporting health behaviour change

Patient education should be based on a health behaviour change model. The Capability, Opportunity and Motivation Behaviour (COM-B) model[37] can support the assessment of a patient's needs. This model is based on the concept that for effective health behaviour change, individual capability, opportunity and motivation need to be present.[37] Patient assessment against the framework can help identify strategies that can support falls prevention and management education.

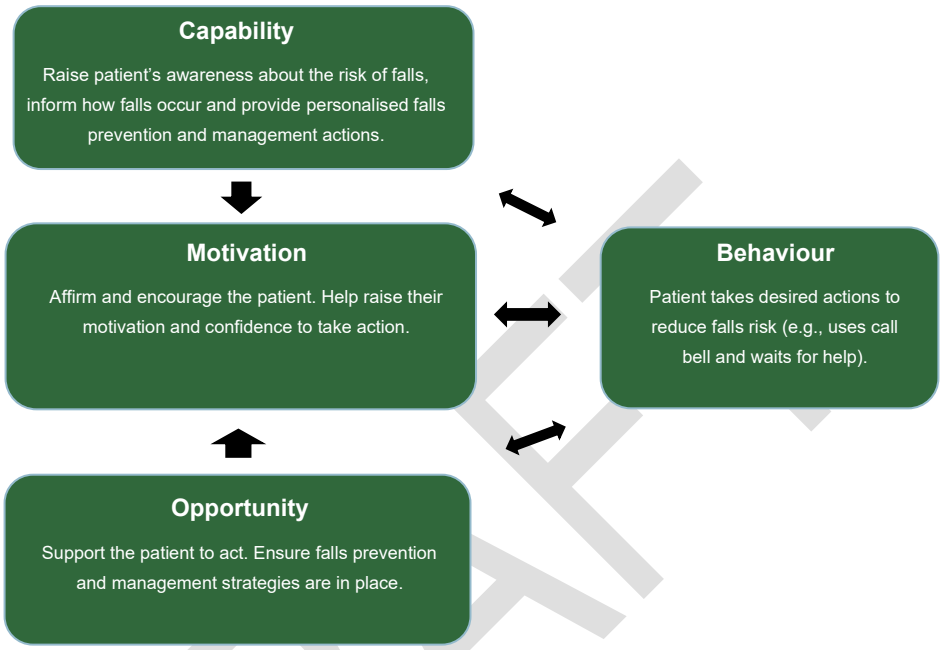
Capability is defined as a person's physical and psychological capacity to engage in the desired behaviour. To be capable, a person needs to have the necessary knowledge and skills to complete the action.

Opportunity is defined as the factors in the person's environment that make that behaviour possible or prompt it. This includes the physical and social opportunity.

Motivation is defined as the individual's need or want to complete the behaviour.

All 3 conditions influence the likelihood of a behaviour occurring and the completed behaviour can then influence the conditions. For example, successful implementation of safe behaviour for falls prevention can increase a patient's capability, and therefore, they are more motivated to engage in this behaviour.[37]

***Figure 1*:** Hospital falls: Engaging with patients to reduce falls risk using the Capability, Opportunity and Motivation Behaviour System.[37]



Stage 2: Planning

Planning involves discussion with the patient to mutually determine the goals. Discussion will be based on the health professional's assessment findings and the patients' health literacy, values, beliefs and goals. It is important to acknowledge diversity considerations when engaging in patient education to support person-centred, trauma informed and culturally appropriate care. It is recommended that health professionals actively engage and partner with the patient and their key support networks to identify their communication needs, and anything else that will support them to implement their goals. It is also that guidance is sought from Aboriginal Hospital Liaison Officers and diversity teams, such as those that support people with disability, culturally and linguistically diverse (CaLD) backgrounds, LGBTIQA+SB community and whichever other diversity groups that might need to be included for your setting when developing and engaging patients in education activities (Appendix 1). There may also be risks or factors impacting the behaviour change that are unique to an individual, that a health professional might not necessarily consider. For example, someone with autism might not like the feel of the material on the handles of a walker and that might limit their compliance.

Goals, jointly set with the patient, should address priority modifiable risk factors. Examples include regular use of walking aids, engagement in balance and strength improving exercises, and consistent use of call bells. This approach ensures goals are tailored to individual's needs and encourages active participation in prevention strategies. These are chosen before the educational content and strategies are determined.[25] Health professionals should prioritise essential information and avoid overloading the patient or their support network.

Planning patient education also includes identifying when and how the falls prevention management education will be provided and reinforced. This includes identifying strategies to deliver education in line with a patient's learning preference and communication needs, such as the use of demonstrations, provision of written resources or direction to online information. Please refer to the section on learning style preferences above for more information.

Health professionals may also consider the use of Behaviour Change Techniques (BCTs), which are different strategies to support behaviour change. Research has revealed that the most promising BCTs for falls prevention are goal setting, graded tasks and behavioural practice or rehearsal.[38] Information about health consequences, salience of consequences and emotional consequences were considered least effective.[38]

A multi-disciplinary team (MDT) approach, including the patient's support term, is required to support patient falls prevention and achievement of management goals identified.

Consider each team member's responsibilities including:

- Who is involved in assessment and goal setting?
- Who is the patient's support team and how they are involved?

- How will the patient themselves be supported to be a member of the team to support shared decision making?
- How are the patient's goals communicated to the team?
- Who provides the initial education?
- How is this reinforced by the rest of the MDT?
- How are patient's goals supported by consistent education, support and positive reinforcement?
- For people with differences or disability, this will also need to consider who the person trusts - they will listen to them and probably ignore others due to individual preferences and previous experiences.

Guidance on identifying the support network and roles of people is available in the Hospital Stay Guidelines.

Appendix 2 contains suggested auditing questions.

Stage 3: Implementation

Implementation includes the delivery of falls prevention and management patient education and is dependent on the mutually set goals.

Strategies to support implementation include:

- use language that is familiar to patients and support network
- avoid medical terminology or jargon
- teach the most important information first
- make teaching as simple as possible without losing meaning
- organise content logically
- chunk information into short sections
- use short words and sentences
- use conversational tone
- consider timing and pain levels – patients have advised that they prefer education early in their admission when they start to recover.
- use visuals to enhance teaching dependent on the patient's learning style and preferences
- leave 'pauses' in the conversation for the patient to reflect and ask questions
- giving patients time to process the information, based on their own communication needs, and giving them time to ask questions at a later stage if needed
- incorporate active learning to engage patients.[13]

Written education

Provide the patient with written and visual information to support recall. Verbal information is often recalled incorrectly or even forgotten when patients experience stress.[5] Any written patient education should be in line with the patient's communication, language and cultural needs.

Development of any written material should consider readability and can be assessed using tools such as the Suitability Assessment of Materials[39](SAM). The SAM assesses literacy demand, learning stimulation and cultural appropriateness. Other tools include the Simple Measure of Gobbledygook, which is available at readabilityformulas.com/ or www.online-utility.org/english/readability_test_and_improve.jsp.

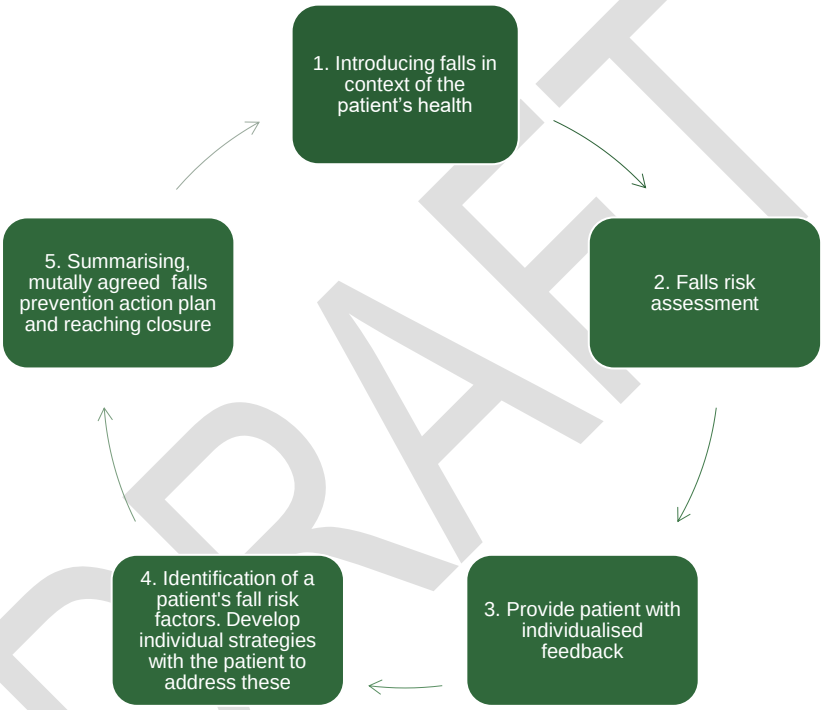
See Appendix 3 for resources to access.

Implementation of falls prevention and patient education may also consider brief interventions using motivational interviewing and involving the patient's support network.

Brief intervention including motivational interviewing

Several studies have reported that standardised Screening, Brief Intervention and Referral to Treatment (SBIRT) can effectively change health behaviours and reduce injury recurrence[40-42] and be appropriate for some hospital settings. A brief intervention for falls would involve 5 steps (see Figure 2). Emphasising motivational interviewing techniques allows the healthcare professional to promote healthy behaviour change and support the patient's commitment to engage in the intervention.[43] It is about initiating change for harm reduction.[43]

Figure 2: Brief intervention therapy cycle for falls prevention education



Involving the support network

With patient consent and if appropriate, provide the falls prevention and management education to the patient's support network. Support network involvement is known to reinforce the education provided and increases the patient's social support for engagement in interventions.

Stage 4: Evaluation

Health professionals need to evaluate the success of the patient education provided by reviewing the patient's understanding of the education provided and goals set. This is not a test of the patient's knowledge – rather a test of how well the health professional explained the concept.

The teach back technique is recommended to verify and determine the patient's understanding of the education provided (see Appendix 4 for additional resource). This requires the health professional to ask the patient to explain the details of the education back to the health professional in their own words. This supports the patient's understanding and comprehension and helps to reinforce the education.[44] Steps include:

- ask the patient to explain the information provided back to you in their own words
- check the patient's current understanding
- explain and discuss misunderstandings until understanding is achieved
- ensure that the patient is aware it is the responsibility of the health professional to explain information correctly

Acknowledgements

This guideline was developed as a project of the Older Persons Health Network – Falls Management Special Interest Group with the support of the Falls Community of Practice. Thank you to members of both groups for their subject matter expertise informing the development of the guidelines.

A particular thank you to Dr. Kristie Harper for leading the development of the guidelines and Prof. Anne-Marie Hill, Su Kitchen (Chair), Francene Leaversuch and Melissa Evans for leading the review and consultation.

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Appendix 1: Diversity statement

All people have a right to universal health care and health equity to achieve their full potential for health and wellbeing.[45] WA Health recognises that a safe and responsive health system is imperative to ensure that everyone who accesses our services receives the best quality of care required to significantly improve health care access and health and social and emotional wellbeing outcomes, acknowledging the unique needs and rights of all people.

WA Health embraces the unique needs of everyone that accesses our health system, including, but not limited to, people living in regional and remote areas, Aboriginal people, people from culturally diverse backgrounds, the LGBTIQA+SB people, people with disability, older persons, young people, people with family and carer responsibilities, and those living in varying socio-economic situations, and/or having other characteristics.

Intersectionality is an important concept in acknowledging and supporting diversity. This approach acknowledges the impacts of multiple, intersecting forms of diversity, experiences of marginalisation and implications for access to and experience of health care.[46] Existing public health research suggests that acknowledging these intersections has relevance to, and impact upon, health-related behaviours and outcomes, and can exacerbate the impacts of systemic discrimination, disadvantage and social exclusion on health and wellbeing.

ABORIGINAL PEOPLES

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To ensure the unique rights and needs of Aboriginal people are recognised, the provision of culturally secure and respectful care[47] will embrace a strengths-based paradigm[48], with kinship and Aboriginal culture seen as a vital protective factor. Cultural determinants of health originate from and promote a strengths-based approach. The domains of cultural determinants form cultural identity and act as protective factors for better health and wellbeing. Identified in the Mayi Kuwaya study, cultural determinants comprise of 6 domains including:

1. Connection to country
2. Family, kinship and community
3. Indigenous beliefs and knowledge
4. Cultural expression and continuity
5. Indigenous language
6. Self-determination and leadership[49].

Recognition of intergenerational, institutional, collective, and historical trauma is important. In addition, racism, cultural load[50], and the differences between mainstream systems and more holistic Aboriginal understandings of social and emotional health and wellbeing[51] need to be understood and respected.

PEOPLE FROM CULTURALLY & LINGUISTICALLY DIVERSE (CaLD) BACKGROUNDS

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The WA Department of Health, Clinical Excellence Division has a Cultural Diversity Unit (CDU) within the Health Networks Directorate. The CDU develops and promotes policies, practices and services that strengthen the cultural competency of WA health staff, and improves accessibility, safety, and quality of services for people of culturally and linguistically diverse (CaLD) backgrounds. This includes improving health literacy and better health outcomes for CaLD communities. Many resources for health professionals can be found on the WA Department of Health website: 'Multicultural health - Resources and services' section[52].

DISABILITY ACCESS & INCLUSION

Disability access and inclusion is critical to a sense of community where all people belong, are included and can enjoy equal opportunity in all areas of life.

Access and inclusion mean different things to different people. A person's ability to access information, services and facilities is affected by several factors including the scope and complexity of a person's support needs which can vary considerably between individuals. Therefore, processes and outcomes for access and inclusion cannot be prescriptive and must consider the diverse needs of individuals and the nature, strengths, priorities and resources of a community. The common elements of access and inclusion are the removal or reduction of barriers to the participation in the activities and functions of a community, by ensuring that information, services and facilities are accessible to people with various disabilities[53].

LGBTIQA+SB PEOPLES

The Western Australian Lesbian, gay, bisexual, transgender, intersex, queer and asexual plus (LGBTIQA+) Inclusion Strategy[54] strives to improve the health and wellbeing of LGBTIQA+SB populations living in WA.

This Strategy aims to guide the WA health system, health services, healthcare professionals, LGBTIQA+SB people, their families, carers and support networks to meet the health and wellbeing needs of LGBTIQA+SB people living in WA. The Strategy outlines six priority areas for action relating to the health and wellbeing needs for LGBTIQA+SB people living in WA over the next five years.

The strategy's vision is for an equitable, accessible, culturally safe and inclusive WA health system and health services that are responsive to the health and wellbeing needs of LGBTIQA+SB populations living in WA.

USEFUL CONTACTS

Department of Health Aboriginal Health Policy Directorate:
PublicandAboriginalhealthdivision@health.wa.gov.au

Department of Health Cultural Diversity Unit:
culturaldiversity.royalst@health.wa.gov.au

Department of Health Consumer Engagement and Inclusion Team:
DOH.Consumerengage@health.wa.gov.au

Appendix 2: Auditing questions

Each health service/facility may have adapted the provision of the patient education guideline, dependent on site requirements, and therefore, auditing may vary. Please consider:

- How is falls prevention education being provided in your health care setting?
- Who is providing this directly to the patient?
- When is this taking place and being reinforced along the patient's care journey?
- Where is this being documented and communicated across the multidisciplinary team?
- What resources are being utilised to support adult learning and met different learning styles, communication styles, disability needs, cultural needs etc.?
- Is there a review of the quality of the education provided and patient understanding/implementation?
- What is the impact on injurious falls rates?

Appendix 3: Patient education resources

Injury Matters is funded by the Department of Health to deliver the Stay On Your Feet® program in WA. They provide a range of educational materials to help prevent falls in the community. More information on the program and resources can be found here: www.injurymatters.org.au/programs/stay-on-your-feet/.

Appendix 4: Teach back method

Additional resources and information to support use of the Teach Back Method can be found below.

Information and resources

The Teach-Back website is an Australian resource developed by the South Eastern Sydney Local Health District and Deakin University. It has a range of information and resources to support health professionals or community workers integrate the method into their practice.

The Centre for Culture, Ethnicity and Health (CEH) has also developed a guide on Using Teach-back via an Interpreter.

Toolkits

The Always Use Teach-Back! Toolkit describes the principles of plain language, teach-back, coaching and system changes necessary to promote consistent use of teach-back. It's 45-minute Interactive Teach-Back Learning Module includes key content and videos of clinicians using teach-back. The module can be used by clinicians or staff members in a group setting or as a self-directed tutorial.

Videos

The North Western Melbourne Primary Health Network have produced a short video on teach back, which can be found here: www.youtube.com/watch?v=d702HIZfVWs.

For those in WA Health, Fiona Stanley Hospital has multiple resources related to teach-back, which can be found here: Teach-back (health.wa.gov.au).

Additional videos can be found here: www.teachbacktraining.org/.

This document can be made available in alternative formats on request for a person with disability.

health.wa.gov.au