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Team-Based Fall Prevention in Community Rehabilitation

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Abstract

Falls in community-dwelling adults, particularly older people and individuals with impaired mobility, arise from interacting physical, environmental, medication-related, sensory, behavioral, and functional factors. Consequently, a rehabilitation programme that addresses balance alone may leave other modifiable risks unresolved. Evidence available through 2021 demonstrates that exercise can reduce fall rates in community-dwelling older adults and that multifactorial approaches combining risk assessment with individually targeted interventions can also reduce fall rates. A 2021 network meta-analysis identified exercise, assistive technology, environmental assessment and modification, quality-improvement strategies, and basic fall-risk assessment as recurring components associated with favorable outcomes. The present study develops a simulation-based model of team-based fall prevention in community rehabilitation. Because no original rehabilitation dataset was supplied, 720 synthetic community-rehabilitation profiles were modeled across usual rehabilitation, an exercise-focused pathway, and a team-based multifactorial pathway. Numerical findings are methodological illustrations and do not represent observed clinical effect sizes.

The simulated Composite Fall-Risk Burden Score decreased from 72 at baseline to 62 after 16 weeks of usual rehabilitation, to 48 with exercise-focused rehabilitation, and to 34 with the team-based multifactorial pathway. The team-based condition also demonstrated higher modeled completion of home-safety recommendations, mobility-aid optimization, medication-risk clarification, and sustained exercise participation. These patterns reflect the theoretical advantage of matching interventions to identified risk factors rather than assuming that all individuals require the same fall-prevention treatment. Systematic reviews have found that multifactorial interventions may reduce fall rates, while high-certainty evidence supports balance and functional exercise as an important component of community fall prevention. The paper emphasizes that “team-based” care should not mean accumulating multiple referrals without coordination. Effective fall prevention requires a shared risk formulation, clear professional responsibilities, patient-defined goals, rapid communication when risks change, and monitoring of whether recommendations are actually implemented. Adherence is particularly important because earlier evidence showed substantial variation in long-term participation across fall-prevention components.

Keywords: fall prevention; community rehabilitation; interprofessional care; physiotherapy; occupational therapy; older adults; multifactorial intervention; patient safety

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1. Introduction

Falls constitute an important public-health and rehabilitation concern because they can lead to injury, loss of mobility, fear of falling, reduced confidence, activity restriction, and greater dependence. The World Health Organization has long emphasized that fall risk in older age reflects multiple interacting biological, behavioral, environmental, and socioeconomic factors rather than a single isolated deficit. Its falls-prevention framework therefore supports risk identification combined with interventions directed toward modifiable contributors.

The strongest community evidence concerns older adults, although similar principles may apply to other rehabilitation populations with impaired balance or mobility. Exercise is one of the best-supported preventive components. Sherrington and colleagues' Cochrane evidence synthesis found that exercise reduced the rate of falls among community-dwelling people aged 60 years and older by approximately 23%, while balance and functional exercise reduced falls by approximately 24%. Programmes combining several exercise types, commonly balance and functional exercise with resistance work, produced even larger pooled reductions, although effects differed according to programme type and evidence certainty.

Exercise alone, however, does not address every reason a person may fall. An older adult may simultaneously have impaired lower-limb strength, an unsafe walking aid, sedating medication, orthostatic symptoms, poor lighting at home, loose rugs, inappropriate footwear, visual impairment, urgency when reaching the bathroom, and fear-driven activity restriction. Lusardi and colleagues emphasized that falls are multifactorial and that no single screening measure accurately captures future fall risk in all community-dwelling adults. This complexity provides the clinical rationale for team-based rehabilitation, because different professional disciplines possess complementary expertise relevant to different risk domains.

The evidence for multifactorial prevention supports this broader approach while requiring careful interpretation. Hopewell and colleagues' review and a later meta-analysis of 41 trials involving nearly 20,000 participants concluded that multifactorial interventions may reduce fall rates and may produce smaller reductions in the proportion experiencing one or recurrent falls; heterogeneity between programmes was substantial. Dautzenberg and colleagues' 2021 network meta-analysis similarly found that exercise, assistive technology, environmental assessment and modification, basic risk assessment, and quality-improvement strategies frequently appeared in effective single or multiple interventions. These findings indicate that multifactorial care can be beneficial, but they do not establish that simply increasing the number of interventions automatically improves outcomes.

2. Objectives of the Study

2.1 To Examine Fall Prevention as a Team-Based Rehabilitation Process

The first objective is to conceptualize fall prevention as an interprofessional rehabilitation process rather than a single-profession intervention. The framework begins with a multidomain assessment covering fall history, balance, gait, lower-limb function, transfer ability, mobility aids, medications, environmental hazards, vision, footwear, orthostatic symptoms, fear of falling, cognitive or behavioral barriers, and the person's normal daily activities. Clinical implementation studies of the STEADI

approach demonstrate that structured fall-risk programmes can integrate gait, vision, orthostatic blood pressure, medication, foot and footwear, and other assessments into team-based care.

The value of team involvement lies in complementary expertise rather than simple professional numbers. A physiotherapist may recognize dynamic-balance impairment while an occupational therapist identifies the environmental situation in which instability becomes dangerous. A medication review may identify a potentially modifiable pharmacological risk, but that information needs to be interpreted alongside the individual's clinical condition and prescribing priorities. Dautzenberg and colleagues' synthesis supports the relevance of combining multiple evidence-based components according to individual risk rather than treating fall prevention as exercise alone.

2.2 To Evaluate Coordinated Risk Reduction Rather Than Isolated Interventions

The second objective is to compare usual rehabilitation, exercise-focused fall prevention, and a coordinated multifactorial pathway. Exercise receives substantial emphasis because the evidence supporting balance and functional exercise is comparatively strong. The team-based pathway, however, adds targeted interventions only when the corresponding risk is present.

This risk-matched design is important because unnecessary interventions can increase burden and reduce adherence. Multifactorial approaches are intended to respond to identified factors, not to provide every participant with every possible preventive service. The 2020 meta-analysis of multifactorial programmes found meaningful reductions in fall rate but considerable heterogeneity, suggesting that programme composition and delivery matter substantially.

2.3 To Examine Adherence and Implementation as Core Fall-Prevention Outcomes

The third objective is to assess whether recommendations are actually adopted. A home-safety assessment provides little benefit if modifications are unaffordable or unacceptable, an exercise plan cannot reduce risk when it is abandoned, and a mobility aid cannot help if the patient finds it impractical and does not use it.

Nyman and colleagues' analysis of community fall-prevention trials found that participation and adherence varied considerably across intervention components. At twelve months, they estimated that only about half of community-dwelling older people initially targeted for fall-prevention intervention might still be adhering, after accounting for recruitment, attrition, and adherence. The present study therefore treats implementation and patient engagement as core outcomes rather than assuming that referral equals prevention.

3. Review of Literature

3.1 Exercise, Balance, and Functional Mobility in Community Fall Prevention

Exercise has the strongest and most consistent evidence among community-based fall-prevention strategies. Sherrington and colleagues' systematic review included 59 trials and nearly 13,000 participants and found high-certainty evidence that exercise reduced fall rate by approximately 23%. Balance and functional exercise demonstrated a similar effect, while programmes combining several exercise categories showed a larger pooled reduction, although with somewhat lower certainty.

The nature of exercise matters. Fall-prevention programmes are generally more defensible when they challenge balance progressively and address function relevant to everyday movement rather than relying solely on general walking or low-intensity activity. Earlier evidence-based physical-therapy reviews similarly emphasized combinations of balance and strength training as particularly important for community-dwelling older adults. This supports a physiotherapy role focused not merely on providing exercise sheets but on assessment, progression, task difficulty, transfer into daily activity, and safe adaptation for individual capacity.

Exercise can also influence psychological dimensions of falling. Fear of falling may lead individuals to restrict activity, which can contribute to further functional decline. A Cochrane review found that exercise probably produces a small-to-moderate reduction in fear of falling immediately after intervention, although the evidence was affected by risk of bias in many trials. Community rehabilitation should therefore monitor confidence and activity participation alongside strength or balance measures.

3.2 Environmental, Medication, and Assistive Risk Management

Environmental hazards represent another important intervention domain. The earlier Cochrane review by Gillespie and colleagues concluded that home-safety assessment and modification could reduce fall rate and risk, particularly within appropriate populations. Pighills and colleagues reported that occupational-therapist-directed environmental assessment significantly reduced falls among high-risk individuals in their trial, illustrating the possible importance of professional reasoning when translating hazard identification into meaningful modification.

The literature also demonstrates that environmental intervention is not universally effective. A large 2021 trial of occupational-therapist-delivered home assessment and modification did not find evidence of reduced falls in the study population. These differing results are methodologically important: removing a hazard may be highly useful for a person whose fall risk is strongly environment-dependent, but blanket home modification among relatively heterogeneous populations cannot be assumed to generate the same benefit. A team-based programme should therefore connect environmental recommendations with observed functional behavior, actual fall circumstances, and patient priorities.

Medication-related risk is similarly complex. Polypharmacy has been associated with increased fall rates in older populations, but medication quantity alone is not sufficient to determine causation or justify indiscriminate deprescribing. Dhalwani and colleagues reported an association between use of five or more medications and increased fall rate among older adults. A team-based pathway should consequently include medication review where clinically indicated, with decisions made by appropriately qualified prescribers or pharmacists and informed by indication, dose, adverse effects, orthostatic symptoms, sedation, interaction, and patient goals.

3.3 Multifactorial Programmes, Team Coordination, and Engagement

Multifactorial interventions typically begin with assessment and then allocate interventions according to identified risks. Hopewell and colleagues and the later 2020 meta-analysis found that such programmes may reduce fall rates among community-dwelling older adults, although effects on fractures, hospital admissions, and quality of life were less certain and heterogeneity remained substantial. The evidence

therefore supports targeted multifactorial prevention while cautioning against exaggerated claims concerning every downstream outcome.

Dautzenberg and colleagues' 2021 network meta-analysis provides further support for combining components. Their review of 192 studies found exercise associated with fewer fallers and a lower fall rate; common components of multiple interventions associated with benefit included exercise, assistive technology, environmental modification, quality-improvement strategies, and basic falls-risk assessment. Multifactorial interventions were associated with a reduced fall rate, although the reduction in the number of individuals who experienced at least one fall was not statistically conclusive. This distinction should be preserved in research reporting because reducing repeated falls among high-risk individuals is not identical to preventing every first fall.

A team-based programme must also avoid fragmentation. STEADI implementation research demonstrates that clinical teams can systematically screen and respond to multiple risk domains, but implementation varied across interventions, with medication reduction being particularly difficult. The lesson is that assessment systems need downstream capacity. Screening a problem that no team member is responsible or able to address creates documentation rather than prevention.

4. Research Methodology

4.1 Research Design and Synthetic Population

The present investigation adopts a simulation-based longitudinal comparative design. No community-rehabilitation patients were recruited, no fall incidents were prospectively observed, and no clinical records were accessed. Synthetic data were used because no empirical dataset was supplied and because fictional clinical observations should not be presented as completed patient research.

The modeled cohort contains 720 community-dwelling rehabilitation clients with elevated fall risk. For conceptual consistency with the strongest evidence base, the simulated population is oriented primarily toward older adults and individuals with mobility-related rehabilitation needs. The cohort is divided equally across three conditions: usual community rehabilitation, an exercise-focused fall-prevention pathway, and a team-based multifactorial pathway.Each condition contains 240 synthetic cases and is followed for 16 weeks. All three begin with the same mean Composite Fall-Risk Burden Score of 72 to permit transparent comparison.

4.2 Team Roles and Measurement Framework

The team-based pathway begins with a shared assessment and assigns intervention responsibility according to the risk identified. Physiotherapy addresses gait, balance, strength, transfers, exercise progression, and mobility aids. Occupational therapy examines home hazards and the interaction between function and everyday tasks. Nursing contributes monitoring, education, orthostatic or continence concerns, and coordination. Medication concerns are communicated to pharmacists or prescribing clinicians. Vision, footwear, cognition, or medical risks are referred appropriately.

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Table 1: Proposed Framework for Team-Based Community Fall Prevention

Domain	Proposed Assessment	Primary Team Contribution	Main Outcome
Balance and Functional Mobility	Balance, transfers, gait and functional movement	Physiotherapy	Improved dynamic stability
Strength and Physical Capacity	Lower-limb and task-specific functional capacity	Physiotherapy	Improved mobility reserve
Home Environment	Lighting, surfaces, bathroom, stairs, access routes and task hazards	Occupational therapy	Hazard reduction
Mobility Aids	Fit, technique, maintenance and real-world use	Physiotherapy / Occupational therapy	Safer mobility
Medication-Related Risk	Sedation, hypotension, interactions and medication burden	Prescriber / Pharmacist with team referral	Risk clarification
Vision and Footwear	Relevant sensory, footwear and foot concerns	Team screening and appropriate referral	Safer environmental interaction
Fear and Activity Restriction	Confidence, avoidance and perceived fall risk	Rehabilitation team	Increased safe activity
Education and Adherence	Understanding and implementation of prevention plan	Nursing / Entire team	Sustained participation
Composite Fall-Risk Burden	Combined modifiable functional and contextual risks	Entire team	Primary simulated outcome

Source: Author-developed simulation framework informed by community exercise evidence, multifactorial reviews, occupational home-safety research, and structured fall-risk programmes.

The Composite Fall-Risk Burden Score is a hypothetical research construct ranging from 0 to 100, where higher values represent greater unresolved modifiable risk. It is not presented as a validated clinical scale and should not be adopted clinically without development and validation.

4.3 Simulation Procedure and Analytical Strategy

The usual rehabilitation condition was modeled as general functional rehabilitation without a systematic fall-prevention protocol. Some fall-related risk factors could still improve because conventional therapy may improve strength, mobility, or confidence.

The exercise-focused pathway added individualized progressive balance and functional exercise. This pathway was assigned a stronger decline in modeled risk because exercise has a comparatively robust evidence base for reducing falls in community-dwelling older adults.

The team-based multifactorial pathway combined exercise with individually indicated environmental assessment, mobility-aid optimization, medication-risk clarification, patient and caregiver education, and referrals for sensory or other relevant concerns. It was modeled as providing the greatest reduction because multiple modifiable risks are addressed rather than a single domain. The direction of the modeled effect is informed by multifactorial evidence, but the numerical magnitude is not taken from any clinical trial.

Descriptive analysis was used. Inferential *p*-values were intentionally omitted because statistical significance generated from simulated observations would not constitute empirical evidence. A future clinical trial should use prospectively recorded falls, falls per person-year, injurious falls, validated mobility measures, fear-of-falling measures, adherence, environmental changes, medication outcomes, and healthcare utilization.

5. Analysis

The simulated results demonstrate progressively larger reductions in Composite Fall-Risk Burden as intervention intensity becomes more coordinated.

Table 2: Simulated Outcomes Across Community Rehabilitation Pathways

Outcome	Usual Rehabilitation	Exercise-Focused Pathway	Team-Based Multifactorial Pathway
Simulated Cases	240	240	240
Baseline Fall-Risk Burden	72	72	72
Week-8 Fall-Risk Burden	66	56	47
Week-16 Fall-Risk Burden	62	48	34
Modeled Risk-Burden Reduction	10 points	24 points	38 points
Recommended Exercise Maintained at Week 16	48%	69%	78%
Identified Home Risks Addressed	28%	35%	76%

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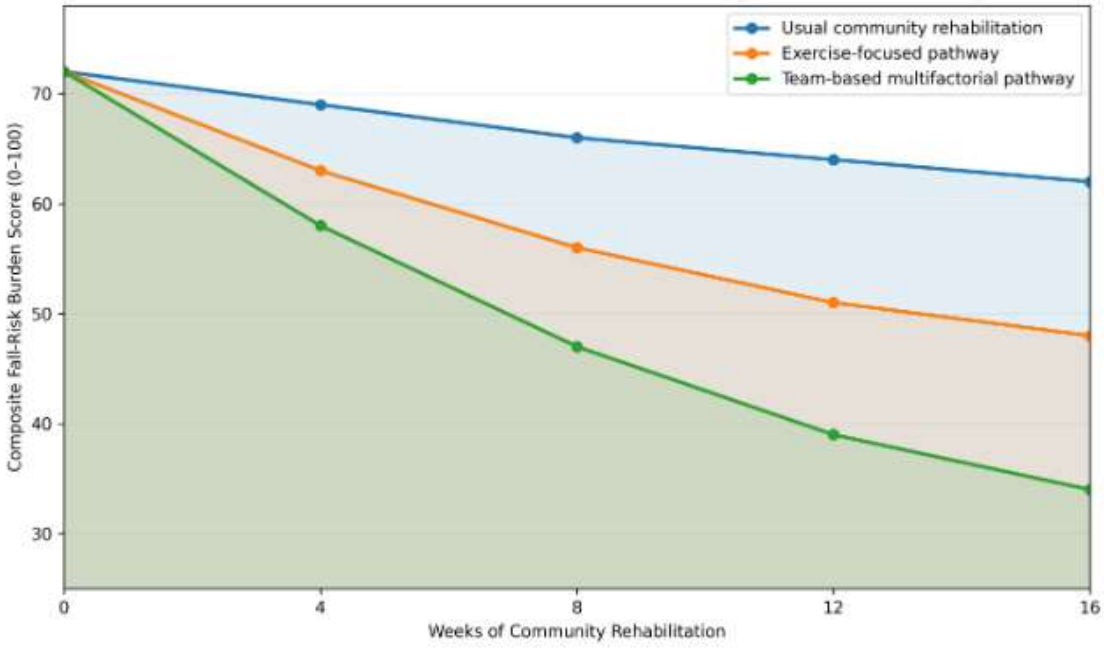
Outcome	Usual Rehabilitation	Exercise-Focused Pathway	Team-Based Multifactorial Pathway
Mobility-Aid Problems Resolved	39%	54%	81%
Medication Concerns Appropriately Reviewed	31%	34%	74%

Source: Author-generated simulated data. Values are hypothetical and are not observed fall-prevention outcomes.

The usual rehabilitation condition produces a modest ten-point reduction, reflecting general functional gains without systematic risk-factor management. The exercise-focused condition produces a larger 24-point decline. This direction is consistent with high-certainty evidence supporting exercise, especially balance and functional exercise, for fall prevention.

The team-based pathway produces the largest modeled improvement, declining by 38 points from baseline. Its theoretical advantage arises not because each team member independently adds an intervention, but because the treatment plan is constructed around the individual's particular combination of risks. Multifactorial reviews support this individualized principle while showing heterogeneity in real-world effects.

Graph 1: Simulated Reduction in Fall-Risk Burden Across Community Rehabilitation Pathways



The area graph shows increasing separation between the three pathways across the 16-week rehabilitation period. All conditions begin at a risk-burden score of 72. By week 4, the team-based

pathway falls to 58 compared with 63 in exercise-focused care and 69 under usual rehabilitation. At week 16, scores are 34, 48, and 62 respectively.

Key Finding: The simulation suggests that exercise provides a substantial foundation for community fall prevention, while the greatest modeled reduction occurs when exercise is combined with coordinated management of environmental, mobility, medication, and other individual risks.

This result should not be interpreted to mean that every patient needs multiple professional referrals. The appropriate team response depends on the risk profile. A patient whose principal modifiable problem is deconditioning may require mainly physiotherapy and exercise, whereas another whose falls occur during night-time bathroom transfers in a hazardous home while taking several potentially problematic medicines may require broader coordinated intervention.

6. Discussion

6.1 Team-Based Prevention Should Begin With a Shared Risk Formulation

Team-based fall prevention is most effective conceptually when all professionals are working from the same explanation of why this particular person is at risk of falling. Without a shared formulation, the physiotherapist may focus on balance, the occupational therapist on rugs and stairs, the nurse on education, and the physician on medication without understanding how these factors interact during the patient's actual falls.

Evidence consistently demonstrates the multifactorial nature of community falls. Lusardi and colleagues noted that no single fall-risk measure is sufficiently diagnostic on its own, while multifactorial reviews show that individually targeted combinations can reduce fall rates. A team should therefore reconstruct fall circumstances where possible: what the individual was doing, the environmental conditions, whether dizziness or urgency was present, whether an aid was used, whether fatigue or distraction contributed, and whether similar events have occurred.

The resulting formulation can then determine priority. Not every identified abnormality needs intervention. A mild deficit that has little relationship to actual fall circumstances may deserve less attention than a modifiable risk directly connected with repeated events. This targeted strategy may also reduce treatment burden and improve adherence.

6.2 Exercise Remains Central but Should Be Connected With Everyday Function

The simulated results retain exercise as a strong intervention because the empirical evidence supporting it is substantial. Sherrington and colleagues found high-certainty evidence for a reduction in fall rates and specifically supported balance and functional exercise. Team-based fall prevention should therefore not become so focused on assessment and referral that progressive physical training is diluted.

The community rehabilitation context allows exercise to be linked directly to everyday challenges. A patient who falls while turning in a confined kitchen may require dynamic turning practice rather than only static balance exercises. Someone who loses balance while rising at night may need transfer training, lighting modification, appropriate footwear, and consideration of urgency or dizziness in addition to lower-limb strengthening. Exercise becomes more meaningful when the rehabilitation team connects it to the actual tasks that expose the person to risk.

The evidence also suggests that health-professional delivery can matter. Sherrington and colleagues reported larger effects in trials in which exercise was delivered by health professionals, most commonly physiotherapists. This does not exclude community or self-managed exercise; rather, it suggests that appropriate assessment, progression, and technique may improve programme quality.

6.3 Coordination, Home Context, and Sustainable Fall Prevention

The third implication concerns the home and community environment. Environmental intervention should be personalized. Earlier research demonstrated benefits from occupational-therapist-led environmental assessment among selected high-risk individuals, while the large 2021 trial did not find a fall reduction across its broader study population. This contrast supports targeted environmental reasoning rather than indiscriminate hazard removal.

A home hazard is clinically relevant partly because of how the person interacts with it. The same step may pose minimal risk for one resident and substantial risk for another with poor vision, weakness, impulsive mobility, or an inappropriate walking aid. Occupational therapy can therefore complement physiotherapy by examining the relationship among the individual, daily occupations, equipment, and environment.

Medication concerns provide another example of why collaboration matters. Polypharmacy has been associated with fall risk, but medication modification should remain clinically individualized and should be conducted by appropriately qualified professionals. A rehabilitation therapist may identify dizziness after standing or sedation during sessions, but the team needs a clear communication route to the prescriber or pharmacist rather than attempting to manage pharmacotherapy independently.

7. Conclusion

Falls in community rehabilitation are best understood as outcomes emerging from interacting functional, environmental, behavioral, sensory, and clinical risks rather than as consequences of poor balance alone. Exercise—particularly progressive balance and functional exercise—has a strong evidence base and should remain a central component of prevention. Yet high-risk patients may require additional interventions when falls are also influenced by home hazards, mobility aids, medication effects, sensory limitations, or other modifiable contributors.

The simulation developed in this paper illustrates the theoretical advantage of coordinating these interventions. Composite Fall-Risk Burden decreases from 72 to 62 under usual rehabilitation, to 48 with an exercise-focused pathway, and to 34 under a team-based multifactorial pathway after sixteen weeks. These values are entirely synthetic and must not be presented as clinical efficacy estimates.

Pre-2022 evidence provides a defensible rationale for this model. Multifactorial interventions may reduce fall rates among community-dwelling older adults, while the 2021 network meta-analysis identifies exercise, assistive technology, environmental modification, quality-improvement strategies, and basic fall-risk assessment among relevant intervention components. At the same time, heterogeneous findings concerning environmental intervention and long-term adherence demonstrate why standardized one-size-fits-all programmes should be avoided.

The principal clinical implication is that team-based fall prevention should mean coordinated risk management rather than multiple disconnected referrals. The rehabilitation team should identify why the

individual is falling, determine which risks are modifiable, select the smallest set of meaningful interventions capable of addressing those risks, assign responsibility, and verify implementation.

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