Gerontology & Geriatrics: Research

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Austin Publishing Group

Editorial

Factors Influencing Older Persons' Participation in Community Fall Prevention Program

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Received: June 29, 2016; **Accepted:** July 01, 2016; **Published:** July 05, 2016

Editorial

As our population ages, an increasingly growing number of older persons are living with multiple chronic health conditions that can lead to disability and a debilitated state. This debility can place these persons at an increased risk for falls. According to the literature, one in every three adults falls in the community each year. Falls account for 8.9 million visits to emergency rooms and an estimated 25,000 accidental deaths in the home environment each year [1]. Educating older persons regarding the benefits of participation in a fall prevention program is of primary importance. Education alone, however, is not the primary factor for adherence to fall preventive care. There are facilitators and barriers to active participation. Facilitators include the desire to improve overall health and functional status, maintain independence, promote safety, improve mood and mental health, receive personal advice from a physician, and obtain social support from family and friends. Despite these benefits, there remain barriers to seeking fall prevention care, such as denial of risk for falls or the need for services, lack of interest in group activities, lack of time commitment, perceived personal threat from loss of independence, transportation, and costs [2-4].

Yardley et al. [2] conducted semi-structured interviews in six European countries on 69 people ranging from aged 68 to 97 years to assess their perceptions of advantages and barriers to adherence to fall-related interventions. These individuals varied in their experience of seeking fall prevention care. Each person was asked about strategies to include muscle strength and balance training. Results revealed that older persons were motivated to adhere to training by perceptions of improved health benefits (e.g., muscle strength, balance, and mobility) and independence. Psychosocial benefits included social involvement and meeting new people, enhancing confidence and mood, and promoting interest and enjoyment. The reduction of fall risk was not a sole contributing factor in adherence to fall services. Additional motivators included personal encouragement by a healthcare practitioner as well as having support systems to include family and friends. Barriers to adherence included denial of risk for falls or the need for additional fall prevention services, lack of interest in group activities, time commitment, and non-attendance due to transportation and cost [2].

Snodgrass et al. [3] conducted a 23-item survey on 75 members of community groups aged > 60 years. Eighty-one percent of the participants were physically active and 84% were reasonably confident about their ambulatory status. The surveys were returned by mail. Items included in the survey were self-reported falls, self-confidence upon ambulating, and awareness of fall prevention interventions, required programs for fall prevention services, and motivators and barriers to involvement in physical activity programs. Results revealed that 28% of respondents had a reported fall within the past 6 months, yet only 54% were aware of fall prevention strategies. The features most desired for fall prevention services were programs for group exercises (61%), education and consultation regarding health-related issues (57%), and assessment of vision and need for eyeglasses (52%). The incentives most commonly reported for attending group physical activities included personal advice from a physician to attend (61%) or social support from a friend who attended (55%). The barrier most commonly reported was that of transportation (43%) [3].

Yardley et al. [4] conducted a thematic analysis on 66 people aged 61 to 94 years from various settings and used messages on fall prevention to ignite discussion. The aim of the study was to elicit understanding of the perceptions of older person's advice on fall prevention and how to best structure communications that encourages action among older persons to prevent falls. The analysis revealed that the participants' meaning of "falls prevention" was interpreted primarily as hazard reduction, use of assistive aids, and activity restriction. The awareness of exercises for fall risk reduction by improving muscle strength and balance was only recognized by one person in the study. Advice for fall prevention was generally regarded as useful in theory but not self-relevant or appropriate. Fall prevention advice was regarded as common sense to be given for older or more disabled persons, and was considered potentially worrisome. Findings revealed that the unawareness of fall risks was not the reason older persons rejected fall prevention advice, but the perception of potential threat to identity and independence was a more contributing factor. Although qualitative methods are revealing for person's views related to health, it is necessary to obtain quantitative methods to ascertain the prevalence of these views and their behavioral influence [4].

The perceptions of older persons to actively engage in fall prevention services are guided by various motivating and restraining factors. Healthcare professionals must understand the implications of these factors in order to promote the patient's adherence to fall prevention care. An initial needs assessment must be performed to identify high-risk populations and provide education on how fall prevention services can improve each individual's specific healthcare needs and improve quality of life. Transportation modes must be evaluated to increase accessibility to services and, alternatively, group exercise programs can be held at designated facilities or the senior's home-base site (e.g., church organization, assisted living facility).

Citation: Frieson CW. Factors Influencing Older Persons' Participation in Community Fall Prevention Program. Gerontol Geriatr Res. 2016; 2(4): 1019.

Fall prevention services must not only be accessible but affordable with consideration of costs based upon the target population and demographics, average income levels, insurance coverage, and financial resources. Practitioners must become advocates in promoting fall prevention services, encourage active participation among their patients, and elicit support from family and friends. Critical evaluation of facilitators and barriers by the practitioner can facilitate patient's adherence to fall prevention care.

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Gerontol Geriatr Res - Volume 2 Issue 4 - 2016
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Citation: Frieson CW. Factors Influencing Older Persons' Participation in Community Fall Prevention Program. Gerontol Geriatr Res. 2016; 2(4): 1019.