



# NATIONAL CLINICAL GUIDELINE FOR THE PREVENTION OF FALLS IN ELDERLY PEOPLE

## Quick guide

Consider offering balance training to elderly people who are living at home and are at risk of falling.

### **Weak recommendation**

The right choice of intensity and quantity of balance training is essential for optimal effect. Training sessions should therefore be scheduled for at least twice a week for several months, and should always be supplemented with daily home exercises and a progressive activity programme.

Consider offering balance training to elderly people who are living in institutional care and are at risk of falling.

### **Weak recommendation**

In order to obtain a real strength increase in the practitioner, strength training should be performed with a relatively high loading level (8-12 RM). In order to avoid overload injuries and maintain the motivation in the elderly person, this loading level requires thorough warm-up as well as a period of systematic progression from a starting point of, e.g., 15 RM.

If strength training is chosen as an intervention for malnourished elderly people, special attention is required, since the strength increase may be limited and may even, in the worst case scenario, be just the opposite, i.e. a loss of muscle mass and therefore loss of function.

Consider offering 'movement concepts' such as Tai Chi, yoga, dance or dance-like training to elderly people who are living at home and are at risk of falling.

### **Weak recommendation**

Different 'movement concepts' may impact on different elements of balance. Classical Tai Chi, e.g., consists of slow controlled movements, which primarily require control of the body's centre of gravity, whereas dance-like interventions are more aimed at increasing the ability to change direction and the perception of one's position in the room.

It is important that the instructor in question does not only have the adequate skills in the form of movement taught, but also the professional skills required for handling elderly people who are at risk of falling. This is essential for ensuring that the training will be safe and will be organised in such a way that the chosen elements of the form of movement taught will have the greatest possible impact in terms of reducing the risk of falling.



Consider offering vestibular rehabilitation (VR) to elderly people with diagnosed vestibular dysfunction.

**Weak recommendation**

There is no evidence concerning what to include in VR in order to obtain an optimal effect. In the studies included, gaze stabilisation exercises in which the head is moved while keeping the eyes fixed on an external target was a commonly used exercise. This approach did not show any significant effect.

The effect of VR is based on central compensation for injury in the vestibular signaling pathway. It is therefore important to ensure that patients are assessed, prior to referral to VR, to determine whether dizziness and balance problems are caused by vestibular injury and not another pathology.

In order to obtain a significant effect of VR, a sufficient quantity is required both in the form of the intervention period, for which the working group recommends a minimum of 3 months, and also in the form of daily home exercises performed in parallel.

Benzodiazepines should be discontinued in elderly people in case of more than 4 weeks of use, since benzodiazepines increase the risk of falling.

**Strong recommendation**

Prescribing benzodiazepines may be relevant as a short-term intervention in case of severe anxiety. However, discontinuation according to the current guidance on the prescription of addictive drugs should always be considered as soon as possible, and the intervention period should generally not exceed 4 weeks. A tapering plan must be prepared, and the tapering is to be carried out in cooperation with the treating doctor with regular follow-up.

Selective serotonin receptor inhibitors (SSRIs) should only be used upon due consideration and only if non-pharmacological treatment has been ineffective, in elderly people over the age of 65 suffering from a moderate depression, since SSRIs may increase the risk of falling and the effect on depression and quality of life is likely to be negligible.

**Weak recommendation AGAINST**

Initiation of SSRIs in elderly people should only be considered in case of moderate to severe depression. Furthermore, SSRIs should be offered with supplementary talk therapy and not as a stand-alone treatment, see the DHA's guidance in this field. Treatment with SSRIs must always be assessed regularly by the treating doctor and discontinuation should be considered at least annually.

In the event of discontinuation of SSRIs, it is important to prepare a tapering plan in cooperation with the treating doctor based on the specific patient's needs, the duration of the treatment and any symptoms. Attention should be paid to the fact that depressed mood may arise from discontinuation of SSRIs and that it is not necessarily due to a newly onset depression.



Consider offering changes that will improve the safety in the home environment to elderly people who are living at home and are at risk of falling.

**Weak recommendation**

Changes in the home environment should be implemented according to an individual professional assessment of the elderly person's activities at home.

Some elderly people may experience such changes as an unnecessary interference in the private sphere. It is therefore important that the professional responsible for assessing the home and the elderly person's activities in it demonstrates good communication skills and includes the elderly person's preferences (including aesthetic preferences) in the evaluation.

Consider offering systematic skills development in fall prevention to healthcare professionals working with elderly people in nursing homes and home care to prevent falls among residents.

**Weak recommendation**

In order to initiate changes in an organisation through education, it should be followed by an implementation process in which new skills and procedures are incorporated in clinical practice and evaluated and adjusted according to the possibilities and limitations of the organisation.

About the quick guide

This quick guide contains the key recommendations from the national clinical guideline for the prevention of falls in elderly people. The guideline was prepared by the DHA.

The guideline concerns elderly people over the age of 65 who are at risk of experiencing falls and focuses on some of the factors that increase the risk of falls in elderly people. Elderly people with specific diagnoses which are known to increase the risk of falls, e.g., dementia, stroke etc. are not included in this guideline and therefore the recommendations cannot be directly applied to this group of elderly people, since one cannot expect the same effect of the interventions.

Thus, the guideline contains recommendations for selected parts of the field only and therefore must be seen alongside the other guidelines, process descriptions etc. in this field.

**Further information at [sundhedsstyrelsen.dk](http://sundhedsstyrelsen.dk)**

At [sundhedsstyrelsen.dk](http://sundhedsstyrelsen.dk), a full-length version of the national clinical guideline is available, including a detailed review of the underlying evidence for the recommendations.

**About the national clinical guidelines**

The national clinical guideline is one of the 3 national clinical guidelines targeted at vulnerable elderly people within the framework of the agreement on special funding for healthcare and the elderly for 2016-2019.

Further information about the choice of subjects, method and process is available at [sundhedsstyrelsen.dk](http://sundhedsstyrelsen.dk).