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QUALITATIVE REVIEW ARTICLE

Older people's experiences of falling and perceived risk of falls in the community: a narrative synthesis of qualitative research

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Abstract

Background. Falls are a major problem for older people and healthcare services across the world. Accidental falls in the community are a persistent problem that is generally recognised as an intrinsic risk of aging. This review provides a new synthesis of evidence that considers older people's perception of falls in the community as new insights are needed if the increasing problems of falls are to be addressed.

Aim. To examine qualitative research exploring older people's experiences of falling and the perceived risk of falling in the community. This will contribute new insights into how falling is perceived by the older community.

Design. Synthesis of the qualitative literature employing Noblit and Hare's method of Reciprocal Translation (Noblit & Hare 1988). CINAHL, Medline, EMBASE, PsychINFO and BNI were searched 1999-2015.

Methods. Noblit and Hare's (1988) method of reciprocal translations was used to conceive this meta-ethnographic synthesis. The ENTREQ statement (Tong 2012) was employed as a tool for reporting the synthesis of qualitative research. The PRISMA statement (Moher 2009) was used for reporting the different phase of the literature search, and the CASP (CASP 2014) appraisal tool was used as an appraisal framework.

Results. Eleven papers fit the inclusion criteria and revealed a series of themes. These were: falls as a threat to personal identity, falls as a threat to independence, falls as a threat to social interaction and carefulness as a protective strategy.

Conclusion. Many older people reject the label of 'at risk of falling' because of the perceived implication of dependency and incompetence. To be considered 'at risk' of falling is perceived as threatening the identity of individuals who are comfortable maintaining their own independence. However, there are also those who accept the risk of falling and in doing so choose carefulness as a personal strategy to manage the risk. For the majority of older people, maintaining independence is the key motivator influencing their actions. Independence to pursue social interaction safeguards against loss of identity, social isolation and negative feelings of dependency. Falling in the community is a problem that persists, despite intervention of local health teams. This article contributes to a body of evidence on older people's experience of falling in the community with the aim of providing new insights for nurses as they approach the issues with patients.

Keywords. Older people, falls, community, qualitative methods, nursing, reciprocal translation.

Summary Statement of Implications for Practice

What does this research add to existing knowledge in gerontology?

- This review contributes to the body of evidence by highlighting the perceptions of older people in the community considered at risk of falling. Falls are a problem beyond physical harm, threatening personal identity, independence and social interaction.
- Falls are negatively associated with ageing with the result that many older people deny their falls or risk of falling. The terminology of falls prevention is viewed negatively by older people denying their falls or risk of falling. As a result they do not engage in falls prevention measures to reduce the risk of falls.
- Despite multiple previous reviews on the topic, the problem persists meaning new interpretations are required.

What are the implications of this new knowledge for nursing care with older people?

- Management of falls risk could be portrayed more acceptably if it is through constructive, proactive health behavior. By creating a more positive attitude towards living well, older people will be more likely to engage in healthy, and therefore risk reducing behaviours.
- Many older people reject the label of 'at risk of falling' because of the perceived implication of dependency and incompetence. As a result older people fail to engage with the interventions put in place to assist them in reducing their risk of falling.

How should the findings be used to influence practice or research?

- Understanding older people's reluctance to engage with falls prevention schemes should encourage nurses to consider alternative strategies to encourage this population.
- Research is needed to understand the perception of falls in older people with dementia living in the community. In the same way we need to understand the issues faced by older people living in the community, there will be issues specific to those with dementia. These issues will need to be understood by nurses so that the appropriate services may be engaged.

Introduction

Falls are a major problem for older people and for health and social services worldwide (World Health Organization 2007). In the United Kingdom (UK), up to 30% of people aged over 65 years old fall each year, although only one in five falls require medical attention and less than one in ten results in a fracture (Gillespie et al. 2009). In a Global Report on Falls Prevention for the World Health Organisation, Yoshida (2007) reported that the frequency of falls increases with age and frailty; and most occur during the day, with only 20% occurring at night. Men are more likely to fall while being active outdoors, while women are more likely to fall in the home. In fact, women are 40-60% more likely to fall than men and over twice as likely to suffer fractures (Yoshida 2007).

Recent data on falls incidence is limited, though in the UK, falls cost the National Health Service more than £2 billion a year, and with the number of people aged over 65 years old predicted to increase by 2 million in 2021, there are concerns that the trajectory is set to continue upwards (Tian et al. 2013). High income countries account for 25% of the total number of fatal falls worldwide, the highest rates occurring in European countries (Yoshida 2007). As a result, the UK National Health Service has initiated falls prevention programmes to manage the anticipated risk to people aged over 65 years of age.

However, there is some evidence to suggest that efforts by healthcare professionals to intervene to reduce the risk of falls are poorly taken up and often rejected by the populations they are aiming to support (Yardley 2005; Nyman & Ballinger 2007). The geographical aspect may cause difficulties in some communities where the location of a group intervention may cause difficulties for older people willing to attend. Alternatively, falls prevention advice is regarded as useful in principle, but the common sense advice offered may not be perceived as relevant or appropriate (Yardley 2007).

While a large body of quantitative evidence exists including the causes, number and treatment of falls, there is rather less literature on the experiences and perspectives of older people themselves. In order for nurses to influence healthy behaviours they need to understand the perception of the people they are caring for. Thus, the focus of this review is to gain insight into the experience of older people who fall in the community and in doing so assist nurses' decision-making for their patients. The evidence examined includes the perception of falling or the risk of falling by those considered at risk by the healthcare profession. This article has gathered information to create a synthesis to assist nurses in their understanding of the issues faced by older people. This understanding will aid them in their efforts to place the appropriate services with their patients.

Methods and methodology

This article employs the “Enhancing transparency in reporting the synthesis of qualitative research (ENTREQ) Statement” (Tong et al. 2012) as a guide for reporting the synthesis of qualitative health research.

All of the studies identified share themes and concepts of falling as they are perceived by older people living in the community, therefore there are themes that translate across studies. The similarities in the studies enables the use of reciprocal translation as a method of synthesis (Noblit and Hare 1988).

This review employed a pre-planned sensitive search strategy that combined the population and context was employed to search for evidence, relating to falls, experience and qualitative methodology. The search was not exhaustive. CINAHL, Medline and EMBASE were searched using the exploded terms [ACCIDENTAL FALLS] OR [FALLING] AND [FRAIL ELDERLY]. PsychInfo and BNI were searched using the exploded terms [FALLS] OR [HEALTH IMPAIRMENTS] AND “elder*” and BNI with exploded term [ELDERLY:ACCIDENTS] AND “fall*” AND “qualitative”. A comprehensive report of the different phases of the search strategy can be seen in the PRISMA flowchart (see Figure 1).

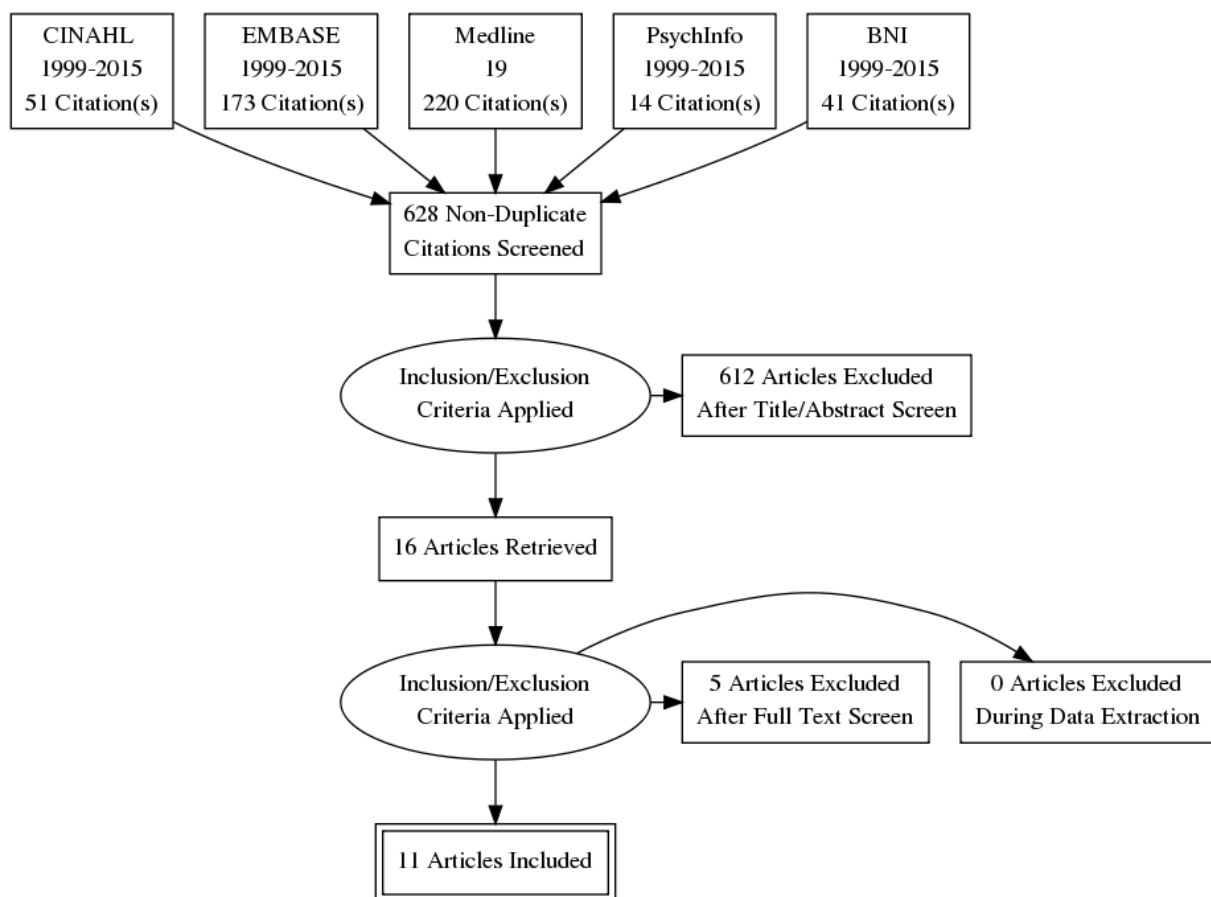


Figure 1. Literature review flowchart

Papers were included if they were written in English, published 1999 to 2015, and included older people’s perspectives of falls or falling in the community. The initial search yielded 628 articles. Articles excluded were those not of a qualitative research design or those that were irrelevant to the research objective and were discarded if they were duplicated across databases, in a language other

than English, opinion pieces or systematic literature reviews. Studies were excluded if they took place in hospitals or other care settings, if they were investigating the impact of a specific intervention or prevention programme, or if they were evaluating assessment tools. The search process was conducted by the first author and audited by a health librarian. Eleven papers were identified as fitting the inclusion criteria (see Figure 1), though two were reports from the same data set (Roe 2008, 2009).

Eleven papers were examined to evaluate rigour, credibility and relevance, using the Critical Appraisal Programme (CASP 2014) for qualitative research, and conducted independently by the author. Findings were tabulated into a table of evidence (see Table 1). Each paper was reviewed to determine the perceptions of older people towards falling, and themes central to the perceptions of falling and risk as given by the informants.

Table 1. Summary of included studies.

Reference	Methodology and method	Sample	Aim/s
Berlin Hallrup et al (2009)	Phenomenological lifeworld approach through interviews	Purposive sample to create variation 13 women living on their own in rural areas	To explore the lived experience of fall risk from a lifeworld perspective in elderly women with previous fragility fractures
Dollard et al (2012)	Grounded theory. Semi-structured Interviews, purposively sampled	Community dwelling 6 women and 3 men aged over 65-85y years	To understand older peoples' perception of their and other older people's falls' risk. Increase understanding of why older people might not believe falls are relevant to themselves
Hawley (2009)	Grounded theory. Unstructured interviews	9 older people over 60 years' old who had been falls rehabilitation. One participant lived in a nursing home, three lived with spouses, the rest alone	To explore what might encourage older people to exercise at home after falls rehabilitation
Horton (2006)	Exploratory design, grounded theory analysis. In depth interviews	Convenience sample of 40 older people living in the SE England. 20 men, 20 women aged 56-95 years old	Explore the influence of gender on older people's perceptions of their risk of falling and their actions to prevent future falls
Kong et al (2002)	Explorative qualitative approach with semi-structured interviews	20 informants with recent falls experience either in the community or hospital setting	To explore the psychosocial consequences of falling with a group of older Chinese who had recently fallen
Mahler et al (2011)	Narrative interviews inspired by interpretative phenomenology using thematic analysis	5 women aged 81-94 years. Ad-hoc sampling according to willingness and ability to talk in-depth with a stranger	To illuminate the experiences and the meaning of fear of falling in a daily-life context
Porter (1999)	Open ended interviews using descriptive phenomenology approach	Sub sample of 9 women, aged 83-96 years	To explore a neglected realm of frail older womens' experience of falling to the floor and trying to get up while at home alone
Roe et al (2008)	Semi-structured interviews and follow up interview thematic content analysis	Convenience sample of 27 older people aged between 65-98 years	To explore the experiences of older people who suffered a recent fall and identify possible factors

Roe et al (2009)	An exploratory, qualitative design involving two time points. Semi-structured interviews	A convenience sample of 27 older people who had a recent fall	that could contribute to service development. To explore the experiences of older people who had a recent fall and its impact on their health, well-being, quality of life and related factors. To explore older people's experiences and views of formal services following a fall and the role of social networks and informal care
Walker (2011)	Semi-structured interviews Video observation and examination of participant referral records	13 participants, 11 interviewed	To explore the experiences of older people who had a recent fall and its impact on their health, well-being, quality of life and related factors. To explore older people's experiences and views of formal services following a fall and the role of social networks and informal care
Yardley et al (2006)	Focus groups and semi-structured interviews qualitatively analysed using thematic analysis and constant comparison	66 community-dwelling older people aged between 61-94 years	To gain an understanding of older people's perceptions of falls prevention advice, and how best to design communications that will encourage older people to take action to prevent falls

All articles share the interest in the phenomena of older peoples' perception of falling in the community. This type of reciprocal translation synthesis (Nobilt and Hare 19988) requires similar studies that can be 'added' together. It enables a more holistic understanding of how falls are perceived by the older population and, in turn, guide nurses towards the most appropriate measures in their approach to falls prevention. The author read each paper several times focusing on concepts and themes the authors employed to describe their participants' experience of falls in the community. The themes identified were 'translated' across the studies. (See Table 2). All interpretations were grounded in the articles synthesised. When the concepts and themes were identified from all papers, a second author (DJ) discussed the descriptive themes to further develop the themes for discussion. The synthesised themes and their application to older people's perception of falling will be reviewed in the synthesis of findings.

Table 2. Themes identified.

	Identity	Carefulness	Independence	Social interaction
Berlin Hallrup et al (2009)	✓	✓	✓	✓
Dollard et al (2012)	✓	✓	✓	✗
Hawley (2009)	✓	✗	✓	✓
Horton (2006)	✓	✓	✓	✗
Kong et al (2002)	✓	✓	✗	✓
Mahler et al (2011)	✓	✓	✓	✗
Porter (1999)	✓	✓	✓	✗
Roe et al (2008)	✓	✓	✓	✗
Roe et al (2009)	✓	✓	✓	✓
Walker (2011)	✓	✓	✓	✓

Synthesis of Findings

This article presents the evidence that accidental falls in the older community is recognised as a worldwide problem however, it is one that persists. This implies that healthcare professionals require new ways of understanding the issues relevant to the older community where falls may be a risk. Examination of the literature revealed that falls have multiple effects on those falling well beyond any immediate physical harms. Complex sequelae were revealed. These were; falls as a threat to personal identity, falls as a threat to independence, falls as a threat to social interaction and carefulness as a protective strategy. These themes are discussed in detail below.

Falls as a threat to personal identity

Falling affected confidence so severely that it represented a threat to personal identity. Acceptance of being at risk undermined an individuals' status as competent and independent and assumed an acceptance of becoming old and infirm. The importance of identity is the focus of two of the articles examined in this review in response to the evidence that some qualitative research identified older people distancing themselves from being labelled as 'at risk of falling' or as 'fallers'. Falling is a threat to the identity of a person who would prefer to be regarded as the type of person who does not fall (Dollard et al. 2012). It has been noted in the literature that one of the reasons offered for the poor uptake of falls prevention programmes is the concept that individuals reject the idea of being 'at risk' (Yardley et al 2006, Walker et al 2011, Dollard et al 2012).

In a relatively large study of 66 people, aged 61-94 years living in the community, informants distanced themselves from the perceived threat to their identity because they did not wish to be considered old and infirm. Although falls prevention advice was considered useful, informants stated it was for 'other people in need of it' while they defined themselves a 'non-fallers' (Yardley et al 2006). Their own falls were credited with being isolated events of carelessness or illness. A male informant, aged 81, had fallen out of bed four times in the previous 8 months and yet considered himself a 'non-faller'. However, study authors surmised that most people in the study were aware of their likelihood of falling, they simply refused to allow themselves to be defined as potential 'fallers' (Yardley, 2006). These findings are congruent with subsequent similar studies.

In a study to explore the meaning of falling for older people, Walker et al (2011) found participants endeavoured to repudiate the label of an older person, as utilised by health services, i.e. everyone over 65. Their study included 11 informants who had participated in a falls prevention programme. The informants described a typical 'faller' as being over the age of 80, with ill health and/or immobility. Only two of the nine informants considered themselves to be 'fallers'; one of whom had experienced five falls in an 18-month period. Study findings suggest that participants assessed themselves based on individual perceptions of health and role in society, and suggested a lack of recognition of age and gender difference might contribute to the low uptake of falls prevention services (Walker, Wendy, Porock Davina, Timmons 2011; Horton 2007). Health professionals should be aware that falls prevention messages are likely to be rejected if the target group associate the message with a negative identity (Dollard et al. 2012).

A few informants stated they had forgotten or simply denied their fall to the interviewer in Kong and colleagues (2002) study, which aimed to explore the psychosocial consequences of falling. The study

included 20 older Chinese people who had recently experienced a fall, either in the community or in the hospital setting; half of whom had a previous history of falls prior to the most recent. This response was attributed to a defensive mechanism allowing the individual to continue to view themselves as intact. Chinese culture influences values and beliefs, including response to health and illness, so findings from other studies may not reflect the findings found in Hong Kong (Kong et al. 2002).

In a grounded theory study, involving 20 men and 20 women, Horton (2007) explored the influence of gender on older people's perception of their risk of falling and their actions to prevent future falls. All had experienced two or more falls in the previous 12 months and were living in the community. The differing perceptions of men and women influenced their actions to prevent further falls. Older men perceived themselves as 'responsible' and 'rational' individuals who expected to reduce their own risk of falling while older women's expectations of themselves and their peers explained their tendency to blame themselves or others for their fall (Horton 2007).

Falls as a threat to independence

Independence is important, the lengths individuals will go to maintain their independence says much about the individual managing their risk of falling. Independence is closely guarded and for some asking for assistance may be seen as an unacceptable loss of independence (Yardley et al 2006). Dependency means that an individual has to rely on other people's goodwill, thus compromising their own needs. Older people may be unwilling to ask for assistance as this may be another step towards surrendering their independence. Individuals will try to maintain their independence as far as possible because a restriction in activity will lead to feelings of frustration and a sense of loss related to being unable to do the things they could do before (Hawley 2009, Kong 2006). For some individuals there may also exist a sense of being a burden to families, and being unable to fulfil their usual role expectations at home (Kong et al. 2002).

Falls as a threat to social interaction

For the individual who falls, social interaction can be jeopardised by restricting activity, reducing the ability to leave home and leading to isolation which in turn, results in feelings of frustration and anxiety (Roe 2009).

Social interaction is important for a good quality of life. Walker et al (2011) emphasised the need for social interaction, because it naturally places individuals into groups and categories from which a sense of identity can develop. Hawley reported one participant who described losing her main chance for social interaction because she could no longer go to church, and this had clearly impacted on her quality of life (Hawley 2009). Formal care and informal support networks can provide support that is highly valued at a time when an individual is vulnerable due to unexpected changes in their living circumstances. Older people, most often women, living alone with the risk of falling derive support from social meetings where, combined with physical activities, they can challenge the limits of their own abilities (Berlin Hallrup et al. 2009; Roe et al. 2009; Hawley 2009). In view of this, it is sensible to consider social interaction an important component of any falls prevention programme.

Social interactions are not only important to individuals for peer support, they also represent a support network for health professionals in their endeavours to encourage individuals to engage in programmes to increase and improve mobility. Hawley (2009) revealed that relationships with

professionals, families and friends as part of a social network during and after falls rehabilitation can impact on uptake and the continuation of exercise (Hawley 2009). For one of the female participants in this study, her only social interaction was during the rehabilitation programme, and this provided the encouragement she needed to retain her independence. For the health professional, providing an individualised programme and follow up helps to engage the individual by providing another benefit; personal interaction. As if to demonstrate the power of health professionals in influencing participation, Walker (2011) found that many participants attended and continued with a programme out of respect for those who referred them or delivered it, as opposed to the feeling they needed the service or might benefit. In Hawley's study, some individuals stated that unless they had someone to tell them to follow their exercises, they didn't bother to continue home exercise. Indeed, if these activities are characterised by fun and games in a trust based atmosphere, there are many potential health benefits, including improvements in mobility (Berlin Hallrup et al. 2009).

Local informal care and support networks are as important as formal care for older people at risk of falls or who have fallen (Roe et al. 2009). A different perspective comes from the person living at home alone, because of the challenges in maintaining the range of personal choices around their living arrangements. Good relationships with professional helpers must be maintained to ensure help where it is necessary (Mahler & Sarvimäki 2012).

Carefulness as a protective strategy

Carefulness as a protective strategy is a theme throughout the literature reported here. Moving more carefully is safer, and even if there is a reduction in living space, mobility can be maintained (Berlin Hallrup et al. 2009). Regardless of whether an individual acknowledges a fear of falling, most informants recognised the need for carefulness. Being careful in response to possible risk could be considered in a positive light, since carelessness was often criticised. Indeed, women would accept blame if they could attribute their fall to carelessness. Some older people chastised and blamed themselves for not taking care when they fell, accepted responsibility for their behaviour as the cause of their fall, and claimed to take more care to prevent further falls (Dollard et al. 2012). In this way they minimised the perception they were the type of person who could fall. This helped them to maintain their identity as an independent person.

In the article previously cited, Horton (2007) reports gender differences. Although men and women had largely differing approaches to the risk of falling, both employed a careful approach to managing the possibility. Taking care was regarded positively by both men and women, despite the differing perceptions of risk-taking behaviour. Men exerted personal control in their decision-making, whereas women exerted personal control by restricting certain activities and taking care not to place themselves in situations that might pose a problem (Horton 2007). Men were explicit in their approach to the risk of falling, however when women fell, they were inclined to blame themselves for falling and exert their own sense of control by implying it was their decision to place themselves in the position of risk (Horton 2007).

In two studies exclusive to older women, Berlin Hallrup et al (2009) and Mahler and Sarvimaki (2011) utilised a phenomenological approach to illuminate the experiences of older women living alone with the risk of falling. These papers suggest that having the awareness of increased risk and often the fear of falling, too much 'carefulness' could result in women living alone to become isolated as they restricted themselves to their familiar surroundings. As a result, it became more difficult for the women to maintain social relationships meaning they became increasingly isolated (Berlin

Hallrup et al. 2009). However, the women used their own individual strategies to find a balance between the risk of injury and mobility and so the degree to which each employed carefulness differed according to the individual (Berlin Hallrup et al. 2009; Mahler & Sarvimäki 2012).

The literature suggests that older people reflected on their falls and acknowledged it in one of two ways; either they acknowledged their fear, faced it and took steps to minimize it by being careful; or, alternatively, they chose to accept the risk of falling and not to be worried by this risk (Roe et al 2008). Even with the latter option however, they would be careful to avoid what risks they could (Roe et al. 2008). Health professionals describe the fear of falling as a restriction of activity however, for the older person, the fear of falling mainly constituted adaptation and finding a balance in their daily lives (Mahler & Sarvimäki 2012).

Discussion

This review contributes to the field in two ways. First it seeks to understand the issues as they are perceived by the people considered at risk of falling themselves, assuming an emic perspective. Secondly, this new synthesis of understanding aims to assist nurses as they consider appropriate interventions for their patients.

Falls are perceived as a consequence of ageing and part of the life course. Generally, older people are aware that the likelihood of falling increases with age (Yardley 2006). Falls prevention programmes, especially those incorporating strength and balance exercises, can significantly reduce the risk of falling (Yardley 2006). However, uptake rates for these programmes can be as low as 50%, sometimes as low as 10%, and without high participation rates, interventions are unable to prove their effectiveness within the population (Yardley et al 2006).

The interaction of biological factors with behavioural and environmental risks increases the risk of falling (WHO 2007). In a global report, the WHO identifies four areas of falls risk in older age; behavioral, biological, socioeconomic and environmental. This review explores the behavioural aspect of older people as this is most likely to be modifiable by nurses. As the WHO document states, healthy behavioural change is the key to healthy ageing.

The evidence from the literature provides the overarching impression that many older people believe falls prevention advice is simply common-sense, and therefore irrelevant and of little use. This denial of personal relevance illustrates the difficulty health professionals are likely to experience as they work towards persuading older people to undertake physical exercise to prevent or rehabilitate following a fall. Not all people aged over 65 accept the immediacy of the need to protect themselves against falling. Falls may be identified as a lack of control, which for many older people, is unpalatable. However, what is becoming clear through the literature is that there are levels of fitness in people over 65, mainly between those who are physically able and those who are not. The literature reviewed suggests that those who are physically able reject what they consider patronising, common-sense advice from healthcare professionals to be careful. Those who may not be able often choose to deny their deterioration and instead aspire to what they have been able to do previously. They do not wish to be considered at risk or placed in a category of 'older people' as this threatens their identity as active, independent people.

However, there are older individuals who have accepted that their bodies are ageing, therefore less able, and learn to manage the risk of falling through carefulness. Even those individuals who refused to recognise themselves at risk were prepared to accept that common-sense advice is to be careful, and

this was the primary strategy employed by those who did consider themselves at risk of falling. However, it is when carefulness morphs into a fear of falling that the individuals' independence is threatened. An exaggerated adaptation of the risk of falling and an aging body can increase the possibility of an older person becoming socially isolated in their own home (Berlin Hallrup et al. 2009). The challenge for health professionals is to encourage the positive outcomes of carefulness without sanctioning over-vigilance to the extent that it becomes limiting.

Maintaining independence is a crucial motivator for individuals' decisions in how they approach falls. Either an individual does not wish to be considered without independence or they are striving for it. It is their attitude towards their independence that defines their approach to the risk of falling. The concept of mobility is a common denominator when individuals were asked to define people who fall. It is generally accepted that anyone from any age group could fall, however the older an individual the higher the risk of falling because it is accepted that strength and balance deteriorate with age. Herein lies the rub; people are prepared to accept that there is a risk to themselves, that some choices mean greater risk than others, or even to accept that they make their own risky choices. However, older people may deny the risks once there is a suggestion that their choices may represent an acceptance of old age.

The fact that social interaction is excluded from Mahler and Sarvimaki's (2011) study is telling. The study included five community-dwelling women over 80 years old talking about their perspectives on daily life. The fear of falling dominated the lives of the women, their individual autonomy was maintained against a backdrop of social isolation and dependence on caring staff. These findings are an echo of Porter's (2008) earlier study exploring the experiences of frail older women who had fallen at home alone. Indeed, Roe et al (2008) described feeling alone as a feature of falls, where most falls were reported when women were living alone. This is an issue addressed in their later article, in which they concluded that local informal care and support networks are as important as formal care for older people at risk of falls (Roe et al. 2009). Social interaction was identified as playing a crucial role in falls prevention as it enables the person who has fallen to share experience, gain assistance and encouragement. The importance of positive interaction cannot be over-stated, as Walker (2011) elucidates; the difficulty is when health professionals fail to recognise the need to personalise the interaction and put the individual at the centre of the discussion and decision making. Using the benefits of attending a programme; keeping fit, active, socialising - could be used to promote independent healthy living instead of the perceived inevitability of ageing and losing independence as feared by many people.

It is noteworthy that none of the papers addressed the issues of falling in people with dementia or screened for cognitive impairment. This is significant because people with Alzheimers disease have twice the risk of falling as people the same age without the disease (Yoshida 2007). Only one paper addressed cultural issues (Kong et al. 2002), although this was produced outside the UK, presenting a culture of homogeneity.

Limitations

This review is limited in that it is restricted to papers published in English. Another limitation is that the reasons for individuals not engaging with falls prevention programmes were never fully explored in the included studies, possibly because research examining the effectiveness of particular programmes was excluded from the literature search.

Finally, as with any qualitative review, this paper is limited by author bias. However a subjective perspective provides a unique, human insight into this complex issue.

Conclusion

Management of falls risk could be portrayed more acceptably as a constructive, pro-active health protecting behaviour, rather than as a purely defensive activity. Accepting the idea that everybody risks falling is an important consideration for health professionals in their approach to falls prevention.

Nurses must demonstrate that they understand the issues faced by those who fall in order to influence their behaviour. Professionals with a different contextual understanding from individuals considered at risk of falling, potentially contribute to the lack of engagement with falls prevention programmes. Upholding identity through an individual approach, knowing an individual's approach to perceived risk through carefulness, maintaining lines of communication between individuals, reducing the possibility of social isolation and allowing individuals to share their experience are all ways in which health professionals can demonstrate a patient-centred approach.

We need to understand older people's reluctance to engage with falls preventions schemes in order for such programmes to succeed but also to encourage nurses to consider what alternative strategies need to be employed to engage this population. Health professionals may be acting counter-intuitively, it could be that by forcing older people to face their vulnerabilities, current fall prevention activity is discrediting the abilities of this group of people.

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