



Falls Prevention in Practice: Frailty, Medicines and Person-Centred Care

CHAIR



Phil Griffiths

NPCHF Leadership Team | Care
Home Pharmacist

SPEAKER



Dr Graham Stretch

PCPA President | Partner Argyle GP – Head of
Pharmacy, Ealing Community Partners



Falls Week

Medicines, falls & deprescribing

A practical, medication-focused approach for the multidisciplinary team

Dr Graham Stretch

Head of Pharmacy, Ealing Community Partners

1 HOUR • INTERACTIVE

NICE NG249 • STOPPFall



Why this matters

Falls are common, harmful — and often modifiable

30%

of people ≥ 65 fall at least once each year

50%

of people ≥ 80 fall at least once each year

£2.3bn+

annual NHS cost attributed to falls

219,155

fall-related emergency admissions in England, 2023/24

The medication opportunity

- Polypharmacy and anticholinergic burden are associated with higher falls risk.
- Fall Risk Increasing Drugs (FRIDs) can act through sedation, postural hypotension, bradycardia, hypoglycaemia, ataxia and impaired cognition.
- Medication review is a core part of the 2025 NICE comprehensive falls assessment.

Sources: *Pharmaceutical Journal* case-based review (2026); NICE NG249 (2025); Dhalwani et al., *BMJ Open* 2017.

What we will do in the next hour

1

Recognise

Which medicines and mechanisms matter?



2

Assess

How do we link a medicine to this person's fall?



3

Deprescribe

How do we reduce risk without creating new harm?



4

Monitor

What do we check after a change?

Two cases, tools and links

Please challenge the medication decisions — there is rarely one “correct” deprescribing answer.

Case 1 — what would you do first?

A recurrent faller with “good numbers”

The patient

Male older adult • recurrent falls
Mild shuffling gait + intermittent unsteadiness

Timed Get Up & Go: 20 seconds

Hip flexion / knee extension: 3/5

Hand-grip: 26 kg

Mild postural hypotension

Medicines in focus

Lisinopril

Amlodipine

Gliclazide

Metformin

Atorvastatin

Numbers

HbA1c: 41 mmol/mol

LDL-C: 1.1 mmol/L

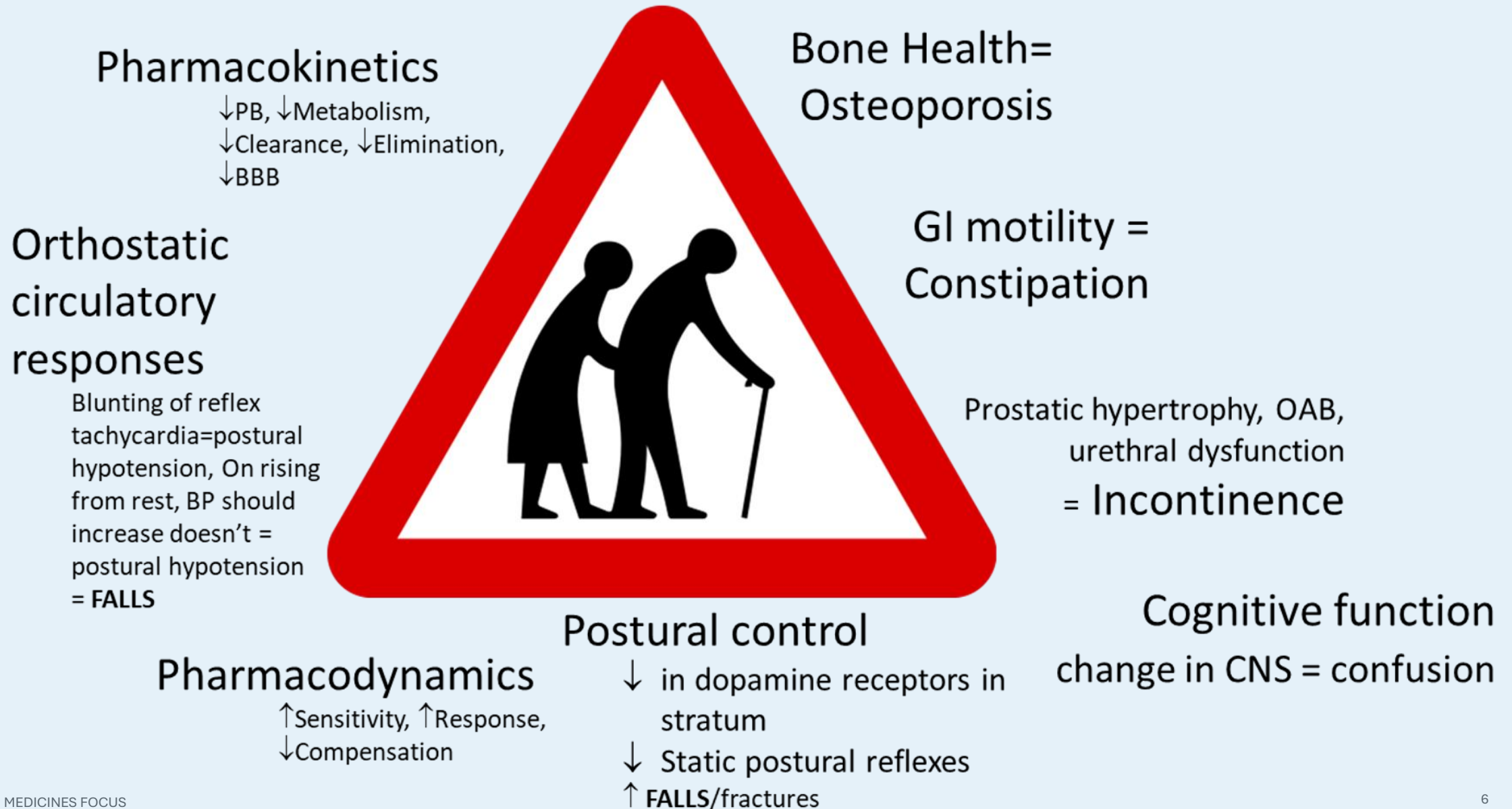
TC: 2.6 mmol/L

Question:

Which medicines would you review first — and why?

use chat – we will revisit these

Physiology of Frailty



‘Geriatric Giants’



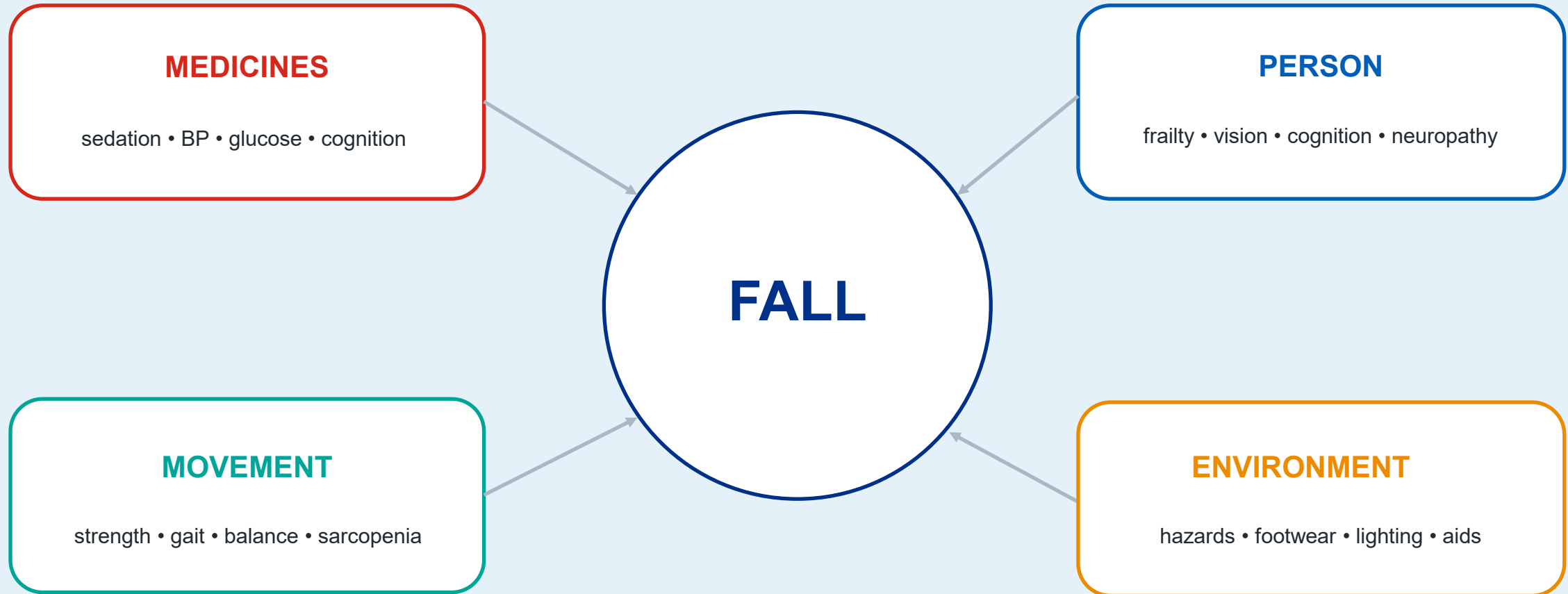
- 1. Immobility**
- 2. Instability**
- 3. Incontinence**
- 4. Intellect**

The giants of geriatrics are immobility, instability, incontinence and intellectual impairment. They have in common multiple causation, chronic course, deprivation of independence and no simple cure.

— Bernard Isaacs, *The Challenge of Geriatric Medicine*, Oxford University Press, 1997

A fall is a syndrome, not a diagnosis

Think complexity, not single causes



NICE NG249: comprehensive falls assessment includes medication review, cardiovascular examination, gait/balance/muscle strength, cognition, vision, continence, osteoporosis risk and more.

NICE 2025: medication review is built into falls care

NG249 replaced CG161 in April 2025

Who gets comprehensive assessment?

Community: people who have fallen and meet higher-risk criteria (frailty, injury requiring treatment, loss of consciousness, unable to get up, or ≥ 2 falls/year).

Hospital + residential care: offer comprehensive falls assessment and management.

What does it include?

Medication review
Lying + standing BP
Gait, balance, mobility + strength
Cognition + mood
Dizziness
Diet / fluid / weight loss
Vision, hearing, feet, continence
Osteoporosis risk

What does NICE say about medicines?

Structured medication review to identify medicines that may increase falls risk and consider adjustment.

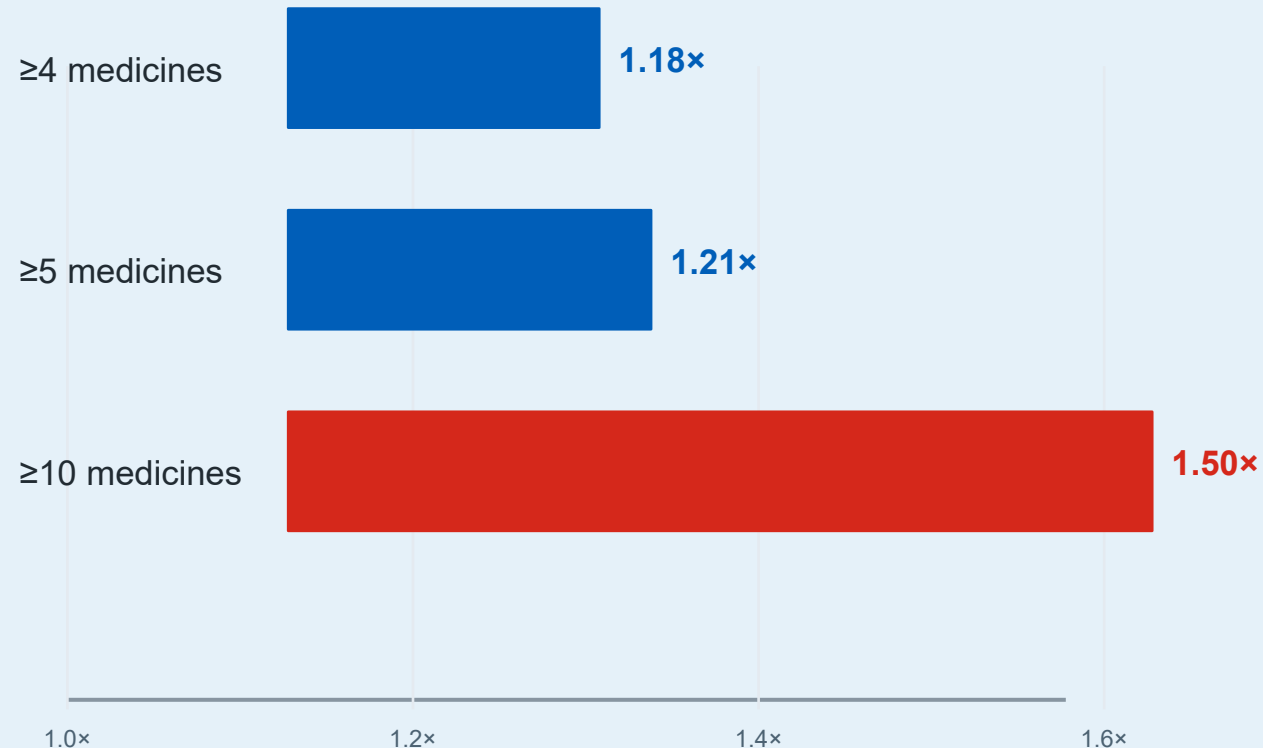
Psychotropics: review, discuss increased falls risk and plan withdrawal where appropriate.

Vitamin D: for bone/muscle health — not as a specific falls-prevention drug.

Polypharmacy: risk rises as the medication count rises

Association $\neq$ causation — but the signal is clinically useful

Adjusted rate of falls vs people below each polypharmacy threshold



What this means in practice

Medication count is a trigger to look harder — not an indication to stop medicines indiscriminately.

Ask:

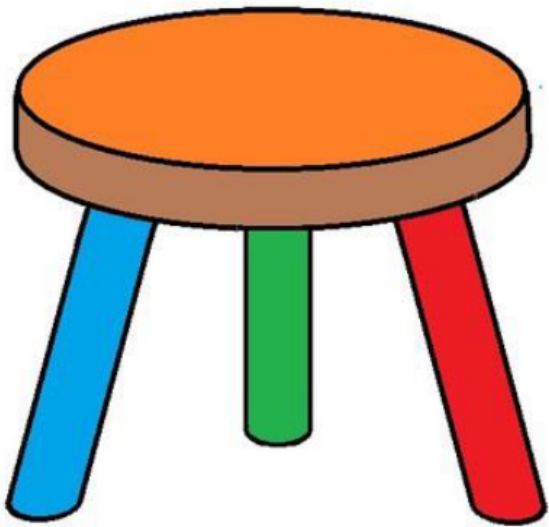
- Which drugs are FRIDs?
- Which mechanisms match the fall?
- Is the indication still valid?
- Is the dose still right for frailty / renal function / goals?
- Can we reduce burden safely?

≥10 medicines → ~50% higher adjusted rate of falls

Dhalwani NN et al. BMJ Open 2017;7:e016358. Adjusted IRR: ≥4 drugs 1.18; ≥5 drugs 1.21; ≥10 drugs 1.50.

Title

Integrating best research evidence with clinical expertise and patient values *(Sackett et al. BMJ 1996)*



- ✓ Best available research evidence
- ✓ Clinical judgement of the practitioner
- ✓ Patient's circumstances, goals, values & wishes

How medicines make people fall

Six mechanisms explain most medication-related risk

1

SEDATION

benzodiazepines • opioids • antipsychotics

2

ORTHOSTASIS

antihypertensives • nitrates • α -blockers

3

BRADYCARDIA

rate-limiting drugs • interactions

4

HYPOGLYCAEMIA

sulfonylureas • insulin

5

ANTICHOLINERGIC

blurred vision • delirium • dizziness
• cognition

6

ATAXIA / WEAKNESS

antiepileptics • CNS drugs • muscle symptoms

STOPPFall: a practical FRID screen

European Delphi consensus + deprescribing guidance

Why it was developed

- Clinicians are often reluctant to deprescribe FRIDs.
- National lists varied in which medicines were considered fall-risk increasing.
- 24 experts from 13 European countries completed the Delphi rounds.
- Consensus produced 14 medication classes plus practical withdrawal / monitoring advice.



Use it as a conversation starter

- 1 Is this a FRID?
- 2 Is there still a valid indication?
- 3 Is there a safer alternative?
- 4 Does the mechanism fit this person's falls?
- 5 Does it need tapering?
- 6 What must we monitor after the change?

STOPPFall: the 14 medication classes

Most are psychotropic — but not all

Benzodiazepines

Antipsychotics

Antiepileptics

Anticholinergics

Diuretics

α -blockers — BPH

Cardiac vasodilators

Z-drugs / BZD-related

Antidepressants

Opioids

Sedating antihistamines

α -blockers — hypertension

Centrally acting antihypertensives

Overactive bladder / urge incontinence drugs

STOPPFall Delphi consensus. Note: sulfonylureas were discussed as a higher-risk subclass of oral hypoglycaemics, but oral hypoglycaemics were not one of the 14 final classes.

Psychotropics: the highest-yield review

Sedation, cognition, orthostasis and motor effects overlap

Benzodiazepines / Z-drugs

Daytime sedation • psychomotor impairment • cognitive effects

Usually taper; monitor insomnia, anxiety, agitation; consider delirium/seizure risk

Antipsychotics

Sedation • α -blockade • anticholinergic effects • EPS

Usually taper when appropriate; monitor recurrence of target symptoms

Antidepressants

Sedation • orthostasis • hyponatraemia • anticholinergic activity

Usually taper; TCAs generally more fall-risk increasing than others

Antiepileptics

Ataxia • somnolence • impaired balance

Consider taper if indication permits; monitor seizure recurrence

NICE 2025 specifically identifies psychotropics: review, discuss the increased falls risk and plan withdrawal as appropriate.

STOPP/Fall deprescribing guidance; NICE NG249 1.3.3 and 1.3.22.

Pain medicines: treat pain, but reduce avoidable CNS burden

Opioids

- Slow reaction time, sedation and impaired balance are key fall mechanisms.
- STOPPFall: strong opioids considered more fall-risk increasing than weak opioids.
- Review ongoing indication, dose, breakthrough use, renal function and co-prescribed sedatives.
- If deprescribing: usually taper and monitor recurrence of pain and withdrawal symptoms.

Gabapentinoids / antiepileptics

- Think ataxia, somnolence, dizziness and impaired balance.
- Confirm the indication: epilepsy vs neuropathic pain vs other use.
- Check renal function and cumulative CNS depressant burden.
- Do not abruptly stop antiseizure therapy; tapering and monitoring depend on indication and seizure risk.

Deprescribing 1

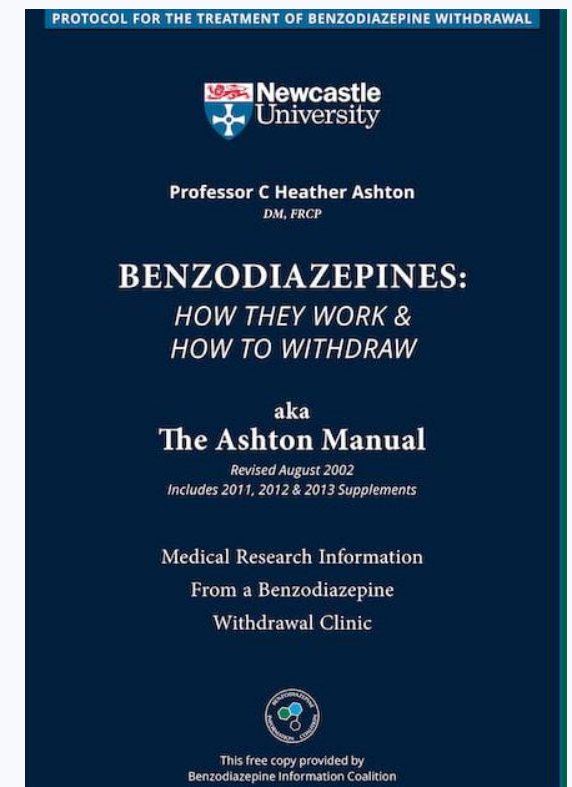
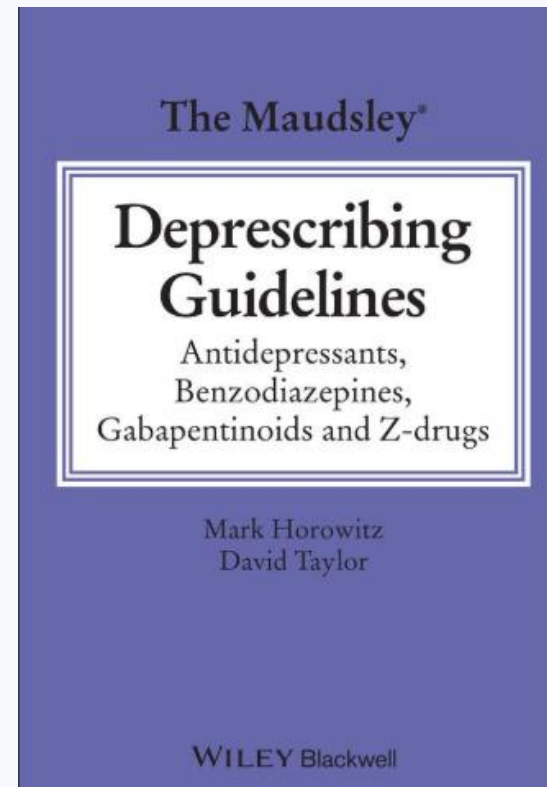
Choose a medication class to see the decision advice for withdrawing the medication among fallers

Benzodiazepines	Antidepressants	Antipsychotics
Opioids	Antiepileptics	Diuretics
Centrally-acting antihypertensives	Vasodilators used in cardiac diseases	Alpha-blocker antihypertensives
Alpha-blockers for benign prostate hyperplasia	Sedative antihistamines	Medications for overactive bladder and urge incontinence

kiktools.amsterdamumc.org/falls/decision-tree/

Start over

Back



Deprescribing 2

LiveWell with pain

ABOUT ▾ EXPLORE ▾ NEWS ▾ RESOURCES ▾ SHOP

<https://livewellwithpain.co.uk/>

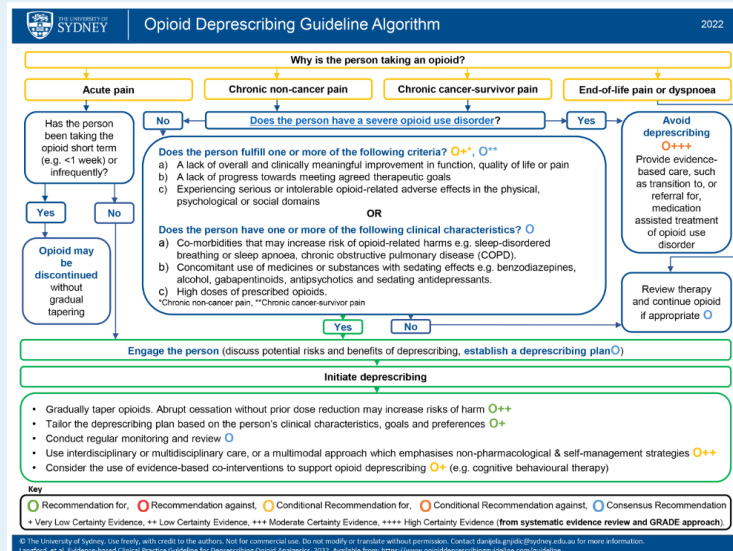
Explore our free resources – choose one of these options:



Take me to resources for practitioners supporting pain self-management



Take me to resources for people living with persistent pain



<https://doi.org/10.5694/mja2.52002>

NHS
Oxford University Hospitals
NHS Foundation Trust

Search

Home About us ▾ Hospitals ▾ Patient guide ▾ More ▾

Listen / Translate

Home > Our services > Referral information > Pain Management Centre > Opioids and chronic pain

Resources for primary care regarding opioids and chronic pain

Opioid reduction templates

To estimate the morphine equivalent dose, a patient information sheet and **templates for opioid reduction**:

- [Fentanyl patch fortnightly reduction \(Excel, 15 KB\)](#)
- [Immediate release morphine weekly reductions \(Excel, 15 KB\)](#)
- [Morphine fortnightly reduction both doses \(Excel, 15 KB\)](#)
- [Morphine fortnightly reduction evening first \(Excel, 15 KB\)](#)
- [Morphine fortnightly reduction morning first \(Excel, 15 KB\)](#)
- [Morphine weekly reduction both doses \(Excel, 14 KB\)](#)
- [Morphine weekly reduction evening first \(Excel, 16 KB\)](#)
- [Morphine weekly reduction morning first \(Excel, 15 KB\)](#)
- [Oxycodone fortnightly reduction both doses \(Excel, 14 KB\)](#)
- [Oxycodone fortnightly reduction evening first \(Excel, 15 KB\)](#)
- [Oxycodone fortnightly reduction morning first \(Excel, 15 KB\)](#)
- [Oxycodone weekly reduction both doses \(Excel, 14 KB\)](#)
- [Oxycodone weekly reduction evening first \(Excel, 16 KB\)](#)
- [Oxycodone weekly reduction morning first \(Excel, 15 KB\)](#)

where the spreadsheet will **self-populate** once the current dose of opioid is entered.

Diabetes: “tight control” can become a falls risk

Hypoglycaemia is a medication adverse effect, not a badge of success

Falls mechanisms

- Hypoglycaemia → weakness, confusion, loss of consciousness
- Nocturia / urgency from hyperglycaemia can increase night-time exposure
- Frailty, weight loss and reduced intake change treatment risk
- Renal impairment can increase exposure to some glucose-lowering drugs

Case 1: HbA1c 41 mmol/mol on gliclazide + metformin

The PJ case considered this too tight in the context of mild frailty and falls; gliclazide was deprescribed, with repeat HbA1c and safety-netting.

Review the target — not just the result

Age, frailty, comorbidity, hypoglycaemia risk, life expectancy, treatment burden and patient goals all matter.

Adapted from Pharmaceutical Journal case (2026); NICE NG28 and JBDS frailty guidance referenced in the source article.

Anticholinergic burden: cumulative exposure matters

Small anticholinergic effects can add up

In 411 acute admissions aged ≥ 65 :

- Polypharmacy: 88.0% in those admitted with a fall vs 76.3% without a fall.
- Each 1-point rise in ACB score: OR 1.15 for falls.
- ACB score 3 vs 0: >50% higher estimated chance of falling.
- Among fall admissions: 29.8% drug-related orthostatic hypotension; 24.7% drug-related bradycardia; 37.3% centrally acting drugs; 12.0% inappropriate hypoglycaemics.

ACB

blurred vision
confusion / delirium
dizziness
sedation
constipation
urinary retention
Dementia risk

Anticholinergic review: think cumulative risk

Often no single drug looks dramatic — the total burden does – cognitive decline – dementia risk

Amitriptyline

sleep / neuropathic pain

Oxybutynin

overactive bladder

Chlorphenamine

allergy / itch

Quetiapine

behaviour / sleep / mental health

Cyclizine

nausea / dizziness



Review sequence

- 1 Confirm indication
- 2 Identify strongest contributors
- 3 Prioritise the least beneficial / most harmful
- 4 Substitute or taper safely
- 5 Monitor symptoms + falls + function

PCPA ACB Toolkit

Reducing the risks associated with anticholinergic medicines, this practical toolkit brings together the key resources, guidance, and tools.

5 Jun 2026

[Bit.ly/ACBtools](https://bit.ly/ACBtools)



Blood pressure and bladder medicines: look for orthostasis

The symptom may be dizziness — or there may be no symptom at all

High-yield classes

Diuretics
α-blockers for hypertension
α-blockers for BPH
Centrally acting antihypertensives
Cardiac vasodilators
Overactive bladder / urge incontinence medicines

What to look for

Low BP or orthostatic drop
Dizziness / light-headedness
Syncope / presyncope
Nocturia + rushing to toilet
Volume depletion
Electrolyte disturbance
Blurred vision / confusion from anticholinergic bladder drugs

Medication questions

Is BP treatment still aligned with frailty and goals?
Which agent is most likely to cause symptoms?
Can dosing time be changed?
Is the diuretic still needed / at the right dose?
For LUTS/OAB: can we reduce anticholinergic load or use a safer strategy?

Orthostatic hypotension: sustained fall in SBP ≥ 20 mmHg or DBP ≥ 10 mmHg within 3 minutes of standing (consensus definition).

Postural hypotension: make the measurement useful

A number only matters if it changes the plan

Consensus definition: sustained fall in systolic BP ≥ 20 mmHg or diastolic BP ≥ 10 mmHg within 3 minutes of standing.

Lie / rest

baseline BP



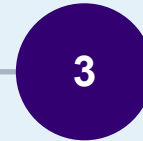
Stand

repeat promptly



3 min

repeat BP + symptoms



Act

link to medicines +
hydration + illness



Medication review is strongest when the physiology and the medicine mechanism line up.

Freeman R et al. Clin Auton Res 2011;21:69–72; NICE NG249 includes lying and standing BP in comprehensive assessment.

Sarcopenia: medicines are only part of the answer

Strength and balance interventions often matter more than another prescription

Recognise it

Loss of muscle strength, mass and function

Clues: slow gait, difficulty rising, reduced grip strength, low activity, weight loss, recurrent falls

Screening tools such as SARC-F can support assessment.

Medication lens

Sedatives → less activity

Hypotension → fear / instability

Anticholinergics → cognition / vision

Some drugs can cause muscle symptoms

But avoid assuming statins are the cause of weakness without evidence.

Treat the syndrome

Progressive strength + balance exercise

Adequate nutrition / protein where appropriate

Vitamin D for bone/muscle health in line with NHS advice

Home hazard review

MDT follow-up

PJ case: resistance-band strengthening + community physiotherapy + dietitian + home assessment were combined with medicines optimisation.

Case 1 — what would you do first?

A recurrent faller with “good numbers”

The patient

Male older adult • recurrent falls
Mild shuffling gait + intermittent unsteadiness
Timed Get Up & Go: 20 seconds
Hip flexion / knee extension: 3/5
Hand-grip: 26 kg
Mild postural hypotension

Medicines in focus

Lisinopril
Amlodipine
Gliclazide
Metformin
Atorvastatin

Numbers

HbA1c: 41 mmol/mol
LDL-C: 1.1 mmol/L
TC: 2.6 mmol/L

Question:
Which medicines would you review first — and why?

Case 1 — the medication decisions

Prioritised, shared and monitored

Gliclazide

STOP

Tight control (HbA1c 41) + hypoglycaemia risk in frailty/falls

Amlodipine

STOP

Mild postural hypotension; choose one antihypertensive to reduce

Atorvastatin

STOP after discussion

Primary prevention + excellent lipids + patient preference to reduce burden; evidence on sarcopenia/statins is mixed (pleiotropic considerations)

Lisinopril

CONTINUE

BP treatment retained; monitor BP after change, renal benefits in diabetes

Metformin

CONTINUE

Ongoing diabetes therapy; review future HbA1c and nutrition

Key principle: change the medicines most plausibly linked to harm — not simply the largest number of medicines.

Adapted from the Pharmaceutical Journal case. The decisions were patient-specific and are not universal deprescribing rules.

Case 1 — medicines alone did not “fix” the falls

The outcome came from coordinated MDT care

1

Pharmacy

FRIDs identified
Deprescribing +
counselling

2

Medicine

CGA-style assessment
BP • bone • neuro •
diabetes

3

Physio

Progressive resistance
programme
Community physiotherapy

4

Dietitian

Nutritional review
Sarcopenia support

5

OT / falls team

Home hazards
Rails for stairs + bath

3-month follow-up

No further falls • grip strength 26 → 31 kg • hip/knee strength 3/5 → 4/5 •
greater confidence • reduced medication burden

Does a STOPPFall proforma change practice?

BGS quality-improvement project in geriatric inpatients

Deprescribing in Older Adults with Falls using the STOPPFall Tool: A Quality Improvement Project

Dr Ella Wooding, Dr Anchal Gupta, Dr Khansaa Talaat, Dr Zareena Sa Khan, Dr Thai Wong, Professor Tahir Masud, Dr Ruth Willott. With supervision from Professor Tony Avery.

Background

One of the most important modifiable risk factors associated with falling is the use of falls-risk inducing drugs (FRIDs). The World Falls Guidelines identified this as a key domain and recommended that a validated screening and assessment tool such as STOPPFall should be used in medication reviews targeted to falls prevention in older adults (1).

A proforma was created based on the STOPPFall Tool (2) to aid doctors in performing structured medication reviews in patients with falls. The research question was 'in older adult inpatients with falls, does use of the STOPPFall screening tool increase deprescribing of FRIDs?'

Method

The project was carried out on inpatient Geriatric wards. Patients were included if they were inpatients and had been admitted with a fall, had a history of recurrent falls and/or had an inpatient fall. FRID classes were identified using STOPPFall, and FRIDs prescribed on admission and discharge were determined using discharge letters. The primary outcome was the number of FRIDs stopped or dose reduced on discharge. An online survey assessed doctors' confidence in deprescribing.

Audit Results

102 patients were reviewed at baseline. The percentage of patients prescribed at least 1 FRID was reduced from 84.3% on admission to 65.7% on discharge. A total of 162 FRIDs were prescribed on admission; 73 (45.1%) of these were stopped and 12 (7.4%) were dose reduced.

Survey Results

19 prescribers responded to the online survey. Self-assessment of confidence in deprescribing averaged at 7.74 (1-10 not confident at all to 'very confident'). Confidence increased with seniority: from 6.5 in foundation doctors to 9.0 in consultants.

Grade	Response	Average Confidence
Foundation Doctor	6	6.50
Junior Middle Grade	4	6.75
Senior Middle Grade	1	9.00
Consultant	8	9.00

Conclusion

52.5% of FRIDs prescribed in older adult inpatients with falls were stopped or reduced. The STOPPFall proforma is currently being trialled on Geriatric wards and shows potential in encouraging deprescribing of FRIDs.

References

- Monte-Cassino, M. et al. (2022). World guidelines for falls prevention and management for older adults: a global initiative. Age and Ageing, 51(9), 1-36.
- Seewald, L. et al. (2021). STOPPFall (Screening Tool of Older Persons Prescriptions in older adults with high fall risk): a Delphi study by the EUOMIS Task and Force Group on Fall-Risk-Inducing Drugs. Age and Ageing 50(4), 1189-1199.

102 patients at baseline

84.3% had ≥1 FRID on admission

65.7% had ≥1 FRID on discharge

45.1% of admission FRIDs were stopped

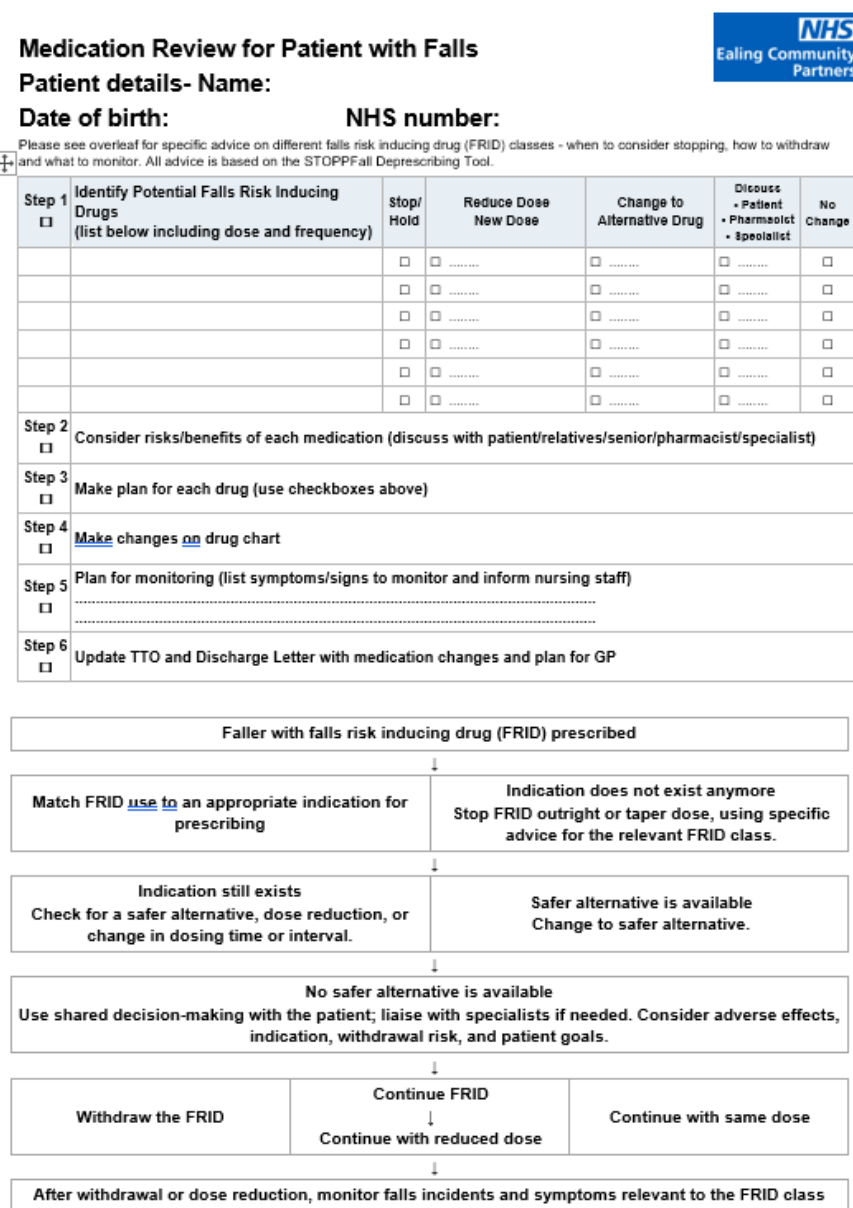
7.4% were dose-reduced

52.5% stopped or reduced overall

A structured prompt can make deprescribing visible and actionable.

Wooding E et al. BGS poster: "Deprescribing in Older Adults with Falls using the STOPPFall Tool". QI data; not a controlled effectiveness trial.

Process



What a good falls-focused medication review sounds like

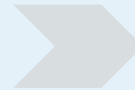
Move from “medicine list” to clinical hypothesis

Less useful

“They are on 12 medicines.”



“This is on the STOPPFall list.”



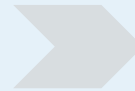
“Their BP is 118/64.”



“Their HbA1c is excellent.”



“They are 88, so stop the statin.”



More useful

“Which of the 12 plausibly contributed to this fall?”

“What mechanism, indication and current benefit?”

“What happens standing — and are they symptomatic?”

“Is this target appropriate for frailty and hypoglycaemia risk?”

“What is the indication, time-to-benefit, symptom history and patient preference?” – pleiotropic benefit?

A 10-minute falls-focused medicines screen

For primary care, care homes and post-fall review

0–2 min

Fall story

When? standing? toileting? after dose? dizziness? LOC?

2–4 min

Vitals + context Lying/standing BP • pulse • glucose risk • renal function • hydration

4–6 min

FRID scan

STOPP Fall classes • anticholinergic burden • CNS combinations

6–8 min

Prioritise

No indication? highest harm? easiest safe win? patient goal?

8–10 min

Plan

Taper/stop/substitute • monitoring • follow-up owner • communicate

If the patient is complex, the 10-minute screen identifies what needs a longer structured medication review — it does not replace one.

Care homes: turn every fall into a medication learning event

NICE 2025 recommends structured medication review in residential care

After the fall

- Check injury / acute illness
- Document circumstances + timing
- Review BP, pulse, hydration and glucose where relevant
- Look for recent starts / dose changes
- Check PRN administration before the fall

Within the medication review

- Psychotropics
- Anticholinergic burden
- Diuretics / α -blockers / vasodilators
- Opioids + gabapentinoids
- Hypoglycaemia-causing drugs
- Night-time medicines + toileting risk

Close the loop

- Agree one owner for follow-up
- Record why a drug was changed
- Tell resident / family / care staff what to watch for
- Update MAR / repeat prescriptions
- Reassess falls, function and target symptoms

NICE NG249 1.3.21–1.3.23: structured medication review and psychotropic review/withdrawal planning in residential care settings.

Case 2 — 90 seconds in chat

Which 3 medicines would you review first?

Scenario

84-year-old in a care home
3 falls in 6 weeks, usually on getting up at night
No loss of consciousness
BP 132/70 lying → 106/62 standing
Pulse 58 bpm
eGFR 38 mL/min/1.73m²
Increasing daytime sleepiness

Medicines

Ramipril 10 mg OD
Doxazosin 4 mg nocte
Furosemide 40 mg OD
Amitriptyline 25 mg nocte
Pregabalin 150 mg BD
Codeine 30 mg QDS PRN
Oxybutynin 5mg BD
Metformin 500 mg BD
Apixaban 5 mg BD

Your task

1. Pick the 3 highest-priority medicines to review.
2. Name the mechanism linking each to falls.
3. What would you monitor if you changed them?

Bonus: which medicine should NOT be stopped simply because the patient falls?

Case 2 — one defensible approach

Prioritise mechanisms that match the fall phenotype

Doxazosin

Orthostatic hypotension

Review indication / dose; monitor standing BP + LUTS/BP

Amitriptyline

Sedation + anticholinergic + orthostasis

Clarify indication; taper; monitor pain/sleep/mood + cognition

Pregabalin

Somnolence + dizziness + ataxia

Check renal dosing + indication; taper; monitor neuropathic pain / withdrawal

Oxybutynin

anticholinergic + vision + drowsiness

Clarify indication; trial off; substitute beta-3

Furosemide / ramipril

Volume/BP contribution

Review indication, volume status, HF symptoms, renal function/electrolytes

Apixaban

Not a classic FRID

Do not stop solely due to falls; review indication, dose, renal function and bleeding risk (*458 x a year)

There can be more than one reasonable sequence — document your hypothesis and test it with monitoring.

From Falls Week to routine practice

Three changes that make the biggest difference

1

Make FRIDs visible

Add a STOPPFall/FRID prompt to admission reviews, post-fall reviews, care-home SMRs or clinic templates.

2

Make deprescribing explicit

Record indication, rationale, taper plan, target symptom and what success looks like.

3

Own follow-up

Name who checks BP, symptoms, labs, falls and whether the medicine needs restarting.

Measure something simple: % of fallers with documented FRID review • % with a medication change • % with documented follow-up plan

Five things to remember this afternoon

1

Falls are multifactorial

Medicines are one of the most modifiable contributors — but rarely the only one.

2

Target FRIDs, not medicine count

Polypharmacy is a prompt; mechanism + indication determine priority.

3

Psychotropics deserve attention

NICE explicitly recommends review and withdrawal planning where appropriate.

4

Deprescribing needs a monitoring plan

Taper safely, safety-net and name the follow-up owner.

5

Use the MDT

Strength, balance, nutrition, environment and medication optimisation work together.

“Which medicine is most likely to be doing more harm than good for this person, now?”

Person centered care



Key references & resources

1. NICE. Falls: assessment and prevention in older people and in people 50 and over at higher risk. NG249. 2025.
2. Seppälä LJ et al. STOPPFall: a Delphi study by the EuGMS Task and Finish Group on Fall-Risk-Increasing Drugs. *Age Ageing*. 2021;50:1189–1199.
3. Montero-Odasso M et al. World guidelines for falls prevention and management for older adults. *Age Ageing*. 2022;51(9):afac205.
4. Dhalwani NN et al. Association between polypharmacy and falls in older adults: a longitudinal study from England. *BMJ Open*. 2017;7:e016358.
5. Wong HL et al. Polypharmacy and associated cumulative anticholinergic burden are important predictors of falls risk. *Br J Clin Pharmacol*. 2023;89:2332–2333.
6. Sahota K et al. Case-based learning: optimising falls prevention through a multidisciplinary approach. *Pharmaceutical Journal*. 25 Aug 2026.
7. Wooding E et al. Deprescribing in Older Adults with Falls using the STOPPFall Tool: A Quality Improvement Project. British Geriatrics Society poster.

Links are included in the speaker notes; check local formularies, deprescribing guidance and service pathways before applying medicine-specific changes.