

Fall-Prevention Education and Supervised Balance-Strategy Practice for Older Outpatients: A Community Service Activity



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Abstract: Falls are a major source of injury and functional decline among older adults. Brief fall-prevention education delivered during outpatient waiting time may provide an opportunity to discuss modifiable hazards and introduce safe balance practice. Objective: This community service activity aimed to deliver fall-prevention education and supervised balance-strategy practice and to document implementation feasibility and participant engagement. The activity was conducted incidentally within routine services at the Outpatient Clinic of Ibnu Sina YW-UMI Hospital, Makassar, on May 25, 2026. Two adults aged 60 years or older with mobility-related complaints were available and participated. The program comprised approximately 10 minutes of interactive education using visual media and leaflets, a balance-strategy demonstration, supervised practice, and individual guidance. Knowledge responses were explored through unstructured questions and answers, while exercise performance was observed without a standardized checklist or quantitative scoring. Both participants engaged in the discussion, identified several fall-related conditions after the education, and reproduced the demonstrated movements with guidance from the team. These observations describe participation during a single session and do not establish improvement in knowledge, balance, or fall risk. A brief outpatient education and supervised-practice format was feasible with the two participants present and allowed immediate correction of movements. Future activities require broader recruitment, a documented and reproducible exercise protocol, standardized assessments, and follow-up.

Keywords: older adults; accidental falls; balance training; health education; community service.

1. Introduction

Falls constitute a substantial public-health burden. The World Health Organization estimates that approximately 684,000 fatal falls occur annually, more than 80% of them in low- and middle-income countries, while 37.3 million falls require medical attention each year. Adults older than 60 years account for the greatest number of fatal falls (Ghasemi et al., 2025). A recent systematic review estimated that 20% to 30% of community-dwelling adults aged 65 years or older experience at least one fall annually (Pillay et al., 2024). Consequences include injury, fracture, reduced mobility, fear of falling, and loss of functional independence.

Fall risk reflects the interaction of intrinsic and environmental conditions. Reduced lower-extremity strength, impaired gait or balance, sensory limitations, chronic illness, previous falls, and medication exposure can coexist with hazards such as slippery surfaces, inadequate lighting, unsuitable footwear, missing handrails, and obstacles in walking areas. Current international guidance recommends person-centred risk stratification followed by assessment and management of modifiable factors rather than relying on a single intervention for every older adult (Montero-Odasso et al., 2022).

Exercise programmes that challenge balance and functional performance can reduce falls when delivered with sufficient dose and progression (Sherrington et al., 2019). Indonesian studies have also reported improved balance or lower measured fall risk after structured balance exercise (Royani et al., 2025). Those findings arose



from repeated training and quantitative assessment. They provide a rationale for introducing balance practice but do not imply that one brief demonstration can improve balance or prevent falls.

The outpatient clinic was selected because older patients with mobility-related complaints were encountered during routine service visits, and waiting time offered a practical opportunity for brief, face-to-face counseling. The community-service team selected balance-strategy practice because its movements could be demonstrated directly and adapted to each participant's observed mobility during a supervised encounter. Education addressed both personal and environmental hazards, while demonstration and practice allowed the team to observe whether participants could reproduce the movements with guidance.

This community service activity aimed to deliver fall-prevention education and supervised balance-strategy practice to older outpatients and to describe implementation feasibility, engagement, verbal knowledge responses, and observed ability to follow the demonstrated movements. It was not designed to test intervention effectiveness or to measure changes in balance or fall risk.

2. Materials and Methods

Activity Design and Setting

This report describes a single community service and educational activity using a participatory format. The activity was conducted on May 25, 2026, in the outpatient waiting area of Ibnu Sina YW-UMI Hospital, Makassar. It combined health education, visual materials, demonstration, supervised practice, and individual guidance. No comparison group, pretest-posttest instrument, or quantitative balance assessment was used.

Participant Recruitment and Eligibility

The activity was implemented incidentally within routine outpatient services and was not preceded by scheduled or population-based recruitment. Potential participants were approached onsite among older outpatients who were waiting for health services. The documented eligibility characteristics were age of at least 60 years, presence at the outpatient clinic during the activity, mobility-related complaints, and willingness to participate in the education and exercise demonstration. Recruitment was based on availability during the activity period rather than random sampling. Participation was limited to two older adults because the activity occurred incidentally during routine service delivery and only those present and available at that time could be included. Individual age, sex, diagnosis, fall history, use of an assistive device, and specific fall-risk conditions were not recorded and cannot be reconstructed retrospectively.

Educational and Exercise Procedures

The educational component lasted approximately 10 minutes. Using verbal explanation, visual media, and leaflets(Nanlohy et al., 2024; Suardi, 2025; Sulfikar et al., 2024), the team discussed intrinsic and extrinsic fall-related conditions and practical safety measures for daily activities. Participants could ask questions during and after the explanation. The community service team from the Nursing Study Program then demonstrated simple balance-strategy movements and invited each participant to practise in turn under direct supervision. Movements were adjusted to the participant's observed mobility. The exercise component was delivered once within the same encounter. Because this was an incidental service activity rather than a standardized training programme, fixed repetitions, holding times, and rest intervals were not prospectively specified. The team remained beside the participant and provided guidance as required. Formal predefined stopping criteria were not documented, which limits reproducibility and should be corrected in future implementation.

Table 1. Components and documentation of the community service activity

Stage	Activity	Documented procedure	Duration/evaluation
1	Preparation and coordination	Coordination with the outpatient clinic; preparation of leaflets and visual media.	Not evaluated
2	Fall-prevention education	Interactive explanation of intrinsic and environmental fall-related conditions and daily safety measures.	Approximately 10 minutes; unstructured questions and answers

Stage	Activity	Documented procedure	Duration/evaluation
3	Demonstration and supervised practice	One-session demonstration of simple balance-strategy movements followed by individual practice with direct guidance.	Single encounter; repetitions and holding times were not standardized
4	Immediate process evaluation	Observation of engagement, verbal responses, and ability to reproduce demonstrated movements with guidance.	No standardized criteria or quantitative score

Evaluation

Knowledge was explored through unstructured questions and answers. The team noted whether participants could mention fall-related conditions discussed during the session, but no predetermined question set, scoring rubric, baseline assessment, or pass criterion was used. Practical ability was evaluated through direct observation of whether participants attempted, followed, and reproduced the demonstrated movements with guidance. No standardized observational checklist, functional balance scale, or fall-risk measure was administered. The reported outcomes are process observations rather than measurements of change.

Ethical and Administrative Considerations

The activity was organized as an incidental community service programme integrated into routine outpatient services rather than as human-participant research or an effectiveness study. Formal ethics committee review was not sought because there was no experimental allocation, research recruitment, standardized research data collection, or collection of identifiable personal information. Operational implementation was coordinated with the outpatient clinic. The two participants received a verbal explanation of the activity and participated voluntarily. Written research consent was not obtained because the activity was not conducted as research. Results are presented in aggregate, and no identifiable participant photographs are included in this manuscript.

3. Results

Participation and Implementation

Two older adults completed the education and supervised-practice session. Both remained engaged during the activity, asked questions, and took turns practising the demonstrated movements. The limited number allowed close individual guidance but does not indicate that the format would be feasible for a larger outpatient group.

Table 2. Available participant characteristics and observed responses

Characteristic or observation	Participant 1	Participant 2
Age and sex	Not recorded	Not recorded
Mobility-related complaint	Reported; specific complaint not recorded	Reported; specific complaint not recorded
Assistive-device use	Not recorded	Not recorded
Fall history or clinical fall-risk condition	Not formally assessed	Not formally assessed
Participation in education	Engaged and asked questions	Engaged and asked questions
Verbal response after education	Identified several fall-related conditions; no score assigned	Identified several fall-related conditions; no score assigned
Observed exercise performance	Reproduced demonstrated movements with guidance	Reproduced demonstrated movements with guidance

Immediate Knowledge Responses

During the post-education discussion, both participants could mention several conditions associated with falls and stated that they would be more cautious during daily activities. Because the questions were not

standardized and no baseline knowledge score was obtained, these responses cannot be interpreted as measured knowledge improvement or retained learning.

Observed Exercise Performance

Both participants attempted the demonstrated balance movements and reproduced them with direct guidance. The observation was limited to the session itself. Balance performance, gait, fear of falling, and fall risk were not quantitatively assessed, and independent performance after the activity was not examined.



Figure 1. Patient Education Process

4. Discussion

The activity showed that a brief education and supervised-practice format could be delivered to the two older outpatients who were available during the implementation period. Both participants engaged in discussion and reproduced the demonstrated movements with guidance. These findings concern implementation and immediate participation. They do not demonstrate that knowledge, balance, mobility, fear of falling, or fall risk improved.

Using an outpatient waiting period may make preventive information accessible without requiring a separate visit. Clinical fall-prevention frameworks support incorporating screening, education, assessment, and management into outpatient care, while tailoring recommendations to the older person's risk profile and preferences (Barmantloo et al., 2020; Montero-Odasso et al., 2022). The present activity addressed only education and a brief practice component. It did not provide formal risk stratification or multifactorial assessment, so it should be viewed as an introductory community-service encounter rather than a complete fall-prevention programme.

Combining verbal education, visual materials, demonstration, and supervised practice had practical advantages within this encounter. Education introduced modifiable hazards, demonstration made the movements visible, and individual practice allowed immediate correction when participants required guidance. The ability to reproduce a movement during supervision is a process indicator, not evidence of motor learning or safe independent performance. A standardized teach-back question set and an observational checklist would make future process evaluation more transparent.

The rationale for including balance practice is supported by evidence from structured exercise programmes. A Cochrane review found that exercise programmes, particularly those emphasizing balance and functional tasks, reduce falls among community-dwelling older adults (Sherrington et al., 2019). A recent systematic review restricted its evidence synthesis of fall outcomes to trials with at least three months of follow-up, illustrating the longitudinal assessment required to evaluate actual falls (Pillay et al., 2024). Indonesian studies reporting changes

in balance or fall-risk scores likewise used repeated exercise and quantitative instruments (Krisna Putri Widayati & Erika Dewi Noorratri, 2024; Royani et al., 2025). Those results cannot be transferred to a single demonstration involving two participants.

Family involvement may extend safety messages beyond the clinic. A recent scoping review identified family involvement, individualized care, health education, home modification, and referral as recurring nursing approaches for supporting caregivers in fall-risk management (Almeida et al., 2024; Correia et al., 2023). Family members can help identify household hazards, reinforce safe use of assistive devices, and support exercise only when the movements have been individually assessed as appropriate. In the present activity, family participation was informal and was not evaluated, so its contribution cannot be determined (Schulz et al., 2020).

Several limitations restrict interpretation. Participation was limited to two individuals because recruitment occurred incidentally during routine outpatient services rather than through a scheduled programme. Demographic and clinical characteristics were not recorded, preventing assessment of participant heterogeneity or exercise suitability. The exercise component occurred once, and fixed repetitions, holding times, and formal stopping criteria were not prospectively standardized. Knowledge and skill evaluation relied on unstructured questions and direct observation without baseline measures, standardized criteria, or follow-up. No balance scale, gait assessment, fall-risk instrument, or fall surveillance was used. Future implementation should prospectively record participant characteristics, use a reproducible protocol with explicit safety criteria, apply standardized process and outcome measures, involve family members systematically, and assess performance after repeated sessions.

Activity Output

The activity produced a brief fall-prevention education session, participant leaflets, supervised balance-strategy practice, and documentation for a community service report. The leaflet was intended as a reminder of the information discussed during the session; its use after the activity was not assessed.

5. Conclusions

A brief outpatient fall-prevention education and supervised balance-practice activity was implemented with two older adults. Both participants engaged in the discussion, identified several fall-related conditions after education, and reproduced the demonstrated movements with guidance. These observations support feasibility for the two-person encounter but do not establish improvement or effectiveness. A larger programme would require broader recruitment, complete participant and protocol documentation, repeated sessions, standardized assessments, and follow-up of balance and fall-related outcomes.

Conflict of Interest

The authors declare no conflict of interest related to this community service activity or manuscript

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