Government of **Western Australia**
Department of **Health**

Western Australian guidelines for patient education for preventing falls in hospital settings 2025

Older Person Health Network

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Acknowledgement of Country

WA Health acknowledges the Aboriginal people of the many traditional lands and language groups of Western Australia. It acknowledges the wisdom of Aboriginal Elders both past and present and pays respect to Aboriginal communities of today.

Using the term Aboriginal

Aboriginal and Torres Strait Islander may be referred to in the national context and 'Indigenous' may be referred to in the international context. Within Western Australia, the term Aboriginal is used in preference to Aboriginal and Torres Strait Islander, in recognition that Aboriginal people are the original inhabitants of Western Australia. No disrespect is intended to our Torres Strait Islander colleagues and community.

Disclaimer

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Contact information

For further information contact

Email: Falls.ManagementWA@health.wa.gov.au

Website: health.wa.gov.au

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Overview

Falls are a major cause of injury and death among older adults and have serious consequences to their health and wellbeing.[1] In 2022, the Australian Institute of Health and Welfare reported that falls are the leading cause of hospital injuries and injury deaths among older Australians.[2]

For the 2022 – 23 reporting period, the rate of falls resulting in patient harm in Western Australian (WA) public hospitals was 7.7 (per 1,000 separations) and was the second highest rate nationally.[3] Falls injuries were also estimated to have cost the Australian health system $4.7 billion in 2020-21.[4]

Patient falls education is a planned activity initiated by a healthcare professional in a hospital setting whose goal is to provide information and skills with the intention to change or maintain patient behaviours and promote uptake of falls prevention and management interventions, thereby improving overall health and reducing falls.[5]

Decreasing falls in the hospital setting is highly dependent on patient engagement in falls prevention activities. A patient's beliefs and attitudes are key influencers in facilitating or forming a barrier to engagement in falls prevention strategies.[6] Older adults may underestimate their risk of falling and this should be considered by those delivering patient education.[7] Failing to provide patient falls prevention education can lead to falls, resulting in poor patient and health system outcomes.

Health education should encourage people to have the motivation, skills and confidence (self-efficacy) necessary to take action to improve their health.[8] Patient education is more than giving information to patients.[9] Effective patient education ensures that patients have sufficient information and understanding to enable them to make informed decisions regarding their care.[10]

Patient education for falls prevention and management is supported by a comprehensive evidence base demonstrating the link between patient education and reducing the likelihood of falling and rate of falls.[11] Patient education also supports patient empowerment, better health outcomes, better healthcare experience and consumer satisfaction. Patient education also helps to decrease patient anxiety and hospital readmissions rates and increase patient engagement with and knowledge of falls reduction strategies.[12,13] Published research has demonstrated that patient education can be effective in reducing falls-related outcomes as part of either a multidomain program or single intervention.[14-19]

The World Falls Guidelines[20] recommend that tailored education for falls prevention should be delivered to all hospitalised older adults and other high-risk groups. Personalised single or multidomain falls prevention strategies based on identified risk factors, behaviours or situations should be implemented for all hospitalised older adults 65 years of age and over, or younger individuals identified by health professionals at risk of falls.[20]

Additionally, the Australian Commission on Safety and Quality in Health Care's Preventing falls and harm from Falls in Older People: Best Practice Guidelines for Australian Hospitals[21] provides clear recommendations and good practice points for health professionals to improve the safety and quality of care for older people.

The *Western Australian guidelines for patient education for preventing falls in hospital settings 2025* provides health professionals working in hospitals in the WA Health system with an evidence based approach for undertaking patient education to reduce incidence of falling and improve the patient experience. It is acknowledged that people engaging with the WA Health system are

referred to as consumers. For the purpose of these guidelines, the focus is specifically on consumers that have been admitted as inpatients to a WA hospital. To maintain this specific focus, the target group will be referred to as patients within this document.

Please refer to the Falls prevention and management in WA webpages for additional information, resources and education on falls prevention.

Patient education

Patient education should be part of a multidomain approach to falls prevention.[19] Research has revealed that patients prefer individualised education, as well as consistent and standardised information from all clinical staff.[13,26-28] Research has also found that 70 per cent of patients were comfortable discussing their falls risk with a health professional, with no differences between genders.[29] Patient education programs should be designed based on educational principles and health behaviour change models.[19]

Hospitals provide an opportunity to engage with patients and initiate preventive services. Research has identified critical enablers to providing patient falls prevention education including:

- well designed and interactive education resources tailored to patient's individual needs
- patient-centered hospital processes to empower patients to gain knowledge
- collective responsibility amongst health professionals to create a culture of vigilance regarding preventing hospital falls.[30]

Who should receive patient education?

Falls education should be available to all patients if requested. However, groups of patients that have a higher risk of falls should always receive falls education. These priority patient groups include:

- patients aged 65+ years
- Aboriginal patients aged 50+ years
- patients with a history of falls
- patients with a concussion and/or cognitive impairment
- patients with disability or conditions that alter functional ability
- patients with delirium
- patients with low English proficiency.

When to deliver patient education

Patient education should be delivered at all stages of the hospital journey from the emergency department to inpatient wards, patient discharge and any subsequent outpatient or community services. The patient education will vary depending on the setting, clinical need and patient circumstances.

Four stages of patient education

The patient education will also change as a patient moves through the hospital journey. Patient education is a process with 4 stages and each stage must be addressed for excellence in patient education.[29]

1. Assessment
2. Planning
3. Implementation
4. Evaluation.

Stage 1: Assessment

Patient assessment identifies a patient's falls risk factors and educational needs. The following factors should be reviewed to ensure education is individualised, effective and relevant for the patient:

- **Pre-existing falls prevention and management knowledge** to ensure education is building upon the person's existing knowledge base.
- **Patient's beliefs** regarding the prevention and management of falls. Understanding patient's perceptions of their falls risk will help to direct falls prevention strategies and understand patient behaviours.[31]
- **Emotional barriers including concerns, anxiety and fear of falling**. Previous research has identified that patient's thoughts and feelings about their recovery were the main barriers to engaging in safe strategies, including feeling overconfident, desiring to be independent or not a burden to staff, and thinking that staff would be delayed in providing assistance.[6]
- **Cognitive or physical differences**, such as cognitive impairment, mental health issues, hearing and visual difficulties, disability such as intellectual disability, learning differences (e.g. dyslexia, dysgraphia or dyspraxia), global developmental delay and neurological differences (e.g. autism or Attention deficit hyperactivity disorder (ADHD)) or conditions (e.g. stroke or Parkinson's disease) that could impact the patient's capacity to comprehend and retain education.
- **Communication requirements**, including but not limited to language preference, visual presentation and mode of delivery.[26]

Assessment involves listening to the patient, rather than providing information. It should also include assessment of additional caregiver or family educational needs, as caregivers and family who support the patient can reinforce the education provided. Assessment of the patient should also consider the patient's health literacy and learning style preference and techniques to support health behaviour change.

Health literacy

Health literacy describes how people access, understand and apply health information to make decisions about their health journey.[32] Patients and their support networks come from a range of diverse backgrounds and have varying lived experiences that shape how they manage their health conditions and ongoing care.

It is estimated that around 60 per cent of Australia's population experience low levels of health literacy.[32] Factors that impact health literacy include but are not limited to age, vision or hearing impairment, cognitive or physical differences, level of education, English as an additional language, disability (such as neurological processing differences and intellectual disability) and cognitive decline.

Social determinants of health such as a person's education level, employment status, use of illicit drugs, experiences of past torture and trauma, and experiences of racism and discrimination also impact health literacy.[33] The health literacy of patients and their support networks needs to be considered throughout the education process.[26] Research demonstrates that health professionals tend to overestimate a patient's health literacy.[34,35]

Health literacy can be assessed using a variety of tools. Tool selection should take into consideration the factors impacting health literacy. Some standard tests to assess general adult health literacy include the Test of Functional Health Literacy (TOFHLA)[36] and the Rapid Estimate of Adult Literacy in Medicine (REALM).[37]

It is also important to acknowledge cultural and other diversity considerations when engaging in patient education. It is recommended that guidance is sought from Aboriginal Hospital Liaison Officers and diversity teams, such as those that support people with disability, people from culturally and linguistically diverse (CaLD) backgrounds, people from the lesbian, gay, bisexual, transgender, intersex, queer, asexual, sistergirl and brotherboy (LGBTIQA+SB) community and whichever other diversity groups that might need to be included for your setting when developing and engaging patients in education activities.

Planning education content that is easy to understand and accessible for people of all backgrounds, irrespective of their circumstances, will ensure better uptake of health information relating to falls prevention. For more information on supporting Aboriginal people, CaLD people, people with disability and LGBTIQA+SB people, see Appendix 1.

Learning style preference

Every person has a preferred learning style that supports how they receive and understand the education. These include:

- **Visual:** These learners learn best by observing and reading. Approximately 65 per cent of people are visual learners. It is best to provide written information including pictures and diagrams supported by a written explanation in plain and simple English, pitched at a 10-12 year old reading level for these learners.
- **Auditory:** These learners prefer to listen to information and will prefer one-to-one educational sessions or direction to videos or podcasts.
- **Kinaesthetic:** In this case, learners prefer hands-on practice. This can be achieved by demonstrating falls prevention and management strategies, including use of equipment and allowing opportunity for the patient practice.
- **Read/write:** These learners benefit from viewing information in a written form and making notes.

When selecting the format for the education, ensure that it supports a person's communication needs. This can include having the education available in another language, braille or Easy Read, or ensuring that the education is formatted to work with screen readers or has captions. Older people, people who speak English as an additional language (such as CaLD and Aboriginal people) or people with hearing issues may prefer the use of diagrams and charts.

Some people might have more than one learning style preference and their preference may shift depending on the task that is being explained to them due to their cognitive processing capacity. For example, a person might prefer auditory instructions when it is simple a task, but if it is a complex task, they may prefer written instructions. If it is something they are unfamiliar with, they may need to practice the information physically or connect the information to a physical action to help remember it (e.g. counting on fingers). Ultimately it is important to communicate with the person and gain an understanding of how they want information presented.

Communication

It is important to acknowledge that a person's health literacy not only impacts how they process information, but also how they functionally communicate. This will be particularly relevant for people with intellectual disability, cognitive decline, neurological differences and sensory differences. Communication formats such as Easy Read, which is used for people with intellectual disability, may also be helpful for older people, people who speak English as an additional language (such as CaLD and Aboriginal people) and people with neurological processing differences.

People in hospital are given a lot of information, from lots of different people. They often feel anxious, uncomfortable, are not sleeping well, and are worrying about several other things in their life that might be impacted by their stay in hospital. They are likely not processing information at their usual level, which means provision of information in simple formats like Easy Read can be helpful. There are resources and guidelines available to support health staff to convert patient handouts to Easy Read format.

Another option is the use of Social Stories for the delivery of information in an alternate format. Social Stories are personalised short narratives that explain concepts in a clear and concrete way for people with intellectual disability. For more information on supporting the communication needs of people with disability, please see Appendix 1.

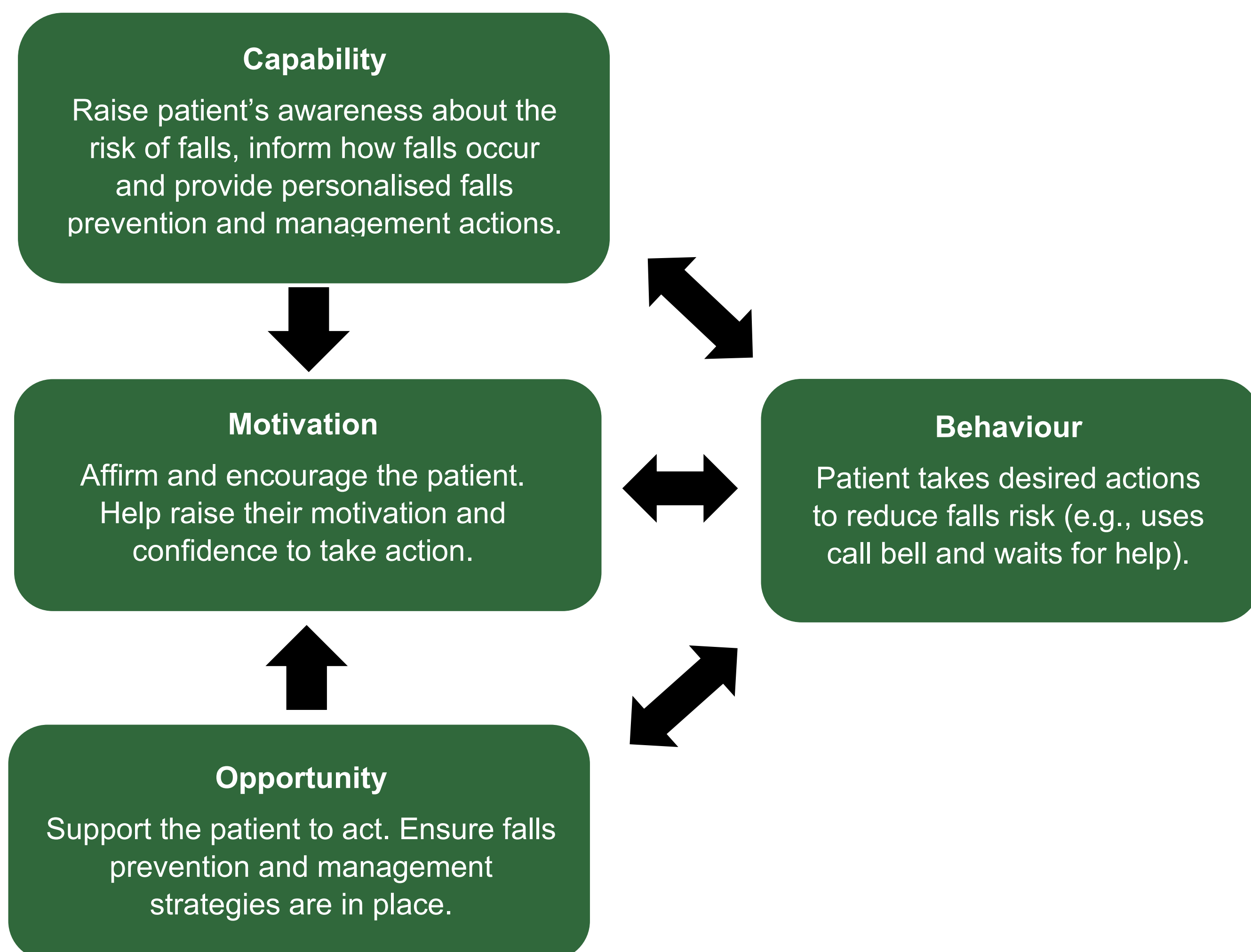
Supporting health behaviour change

Patient education should be based on a health behaviour change model. The Capability, Opportunity and Motivation Behaviour (COM-B) model[38] can support the assessment of a patient's needs. This model is based on the concept that for effective health behaviour change, individual capability, opportunity and motivation need to be present.[38] Patient assessment against the framework can help identify strategies that can support falls prevention and management education.

- **Capability** is defined as a person's physical and psychological capacity to engage in the desired behaviour. To be capable, a person needs to have the necessary knowledge and skills to complete the action.
- **Opportunity** is defined as the factors in the person's environment that make that behaviour possible or prompt it. This includes the physical and social opportunity.
- **Motivation** is defined as the individual's need or want to complete the behaviour.

All 3 conditions influence the likelihood of a behaviour occurring and the completed behaviour can then influence the conditions. For example, successful implementation of safe behaviour for falls prevention can increase a patient's capability, and therefore, they are more motivated to engage in this behaviour.[38]

Figure 1: How to engage with patients to reduce the risk of falls in hospitals using the COM-B model.[38]



For more information on risk factors for falls and examples of how to conduct assessments for risk factors, please refer to the Preventing falls and harm from Falls in Older People: Best Practice Guidelines for Australian Hospitals.[21]

Stage 2: Planning

Planning involves discussion with the patient to mutually determine the goals. Discussion will be based on the health professional's assessment findings and the patients' health literacy, values, beliefs and goals. It is important to acknowledge diversity considerations when engaging in patient education to support person-centred, trauma informed and culturally appropriate care. It is recommended that health professionals actively engage and partner with the patient and their key support networks to identify their communication needs, and anything else that will support them to implement their goals.

It is also important that guidance is sought from Aboriginal Hospital Liaison Officers and diversity teams, such as those that support people with disability, CaLD people, LGBTIQA+SB people and whichever other diversity groups that might need to be included for your setting when developing and engaging patients in education activities. There may also be risks or factors impacting the behaviour change that are unique to an individual that a health professional might not consider. For example, someone with autism might not like the feel of the material on the handles of a walker and that might present a barrier to using the mobility aid. See Appendix 1 for more information on supporting education within priority populations.

Goals, jointly set with the patient, should address priority modifiable risk factors. Examples include regular use of walking aids, engagement in balance and strength improving exercises, and consistent use of call bells. This approach ensures goals are tailored to the patient's individual needs and encourages active participation in prevention strategies. These are chosen before the educational content and strategies are determined.[26] Health professionals should prioritise essential information and avoid overloading the patient or their support network.

Planning patient education also includes identifying when and how the falls prevention management education will be provided and reinforced. This includes identifying strategies to deliver education in line with a patient's learning preference and communication needs, such as the use of demonstrations, provision of written resources or direction to online information. Please refer to the section on learning style preferences above for more information.

Health professionals may also consider the use of behaviour change techniques (BCTs), which are different strategies to support behaviour change. Research has revealed that the most promising BCTs for falls prevention are goal setting, graded tasks and behavioural practice or rehearsal.[39] Information about health consequences, salience of consequences and emotional consequences were considered least effective.[39]

A multidisciplinary team (MDT) approach, which includes the patient and their support team, is required to support patient falls prevention and achieve their identified goals. When using this approach, consider each team member's responsibilities, including:

- How will the patient be supported to be a member of the team to support shared decision making?
- Who is the patient's support team and how they are involved?
- Who is involved in assessment and goal setting?
- How are patient's goals supported by consistent education, support and positive reinforcement?
- How are the patient's goals communicated to the MDT?
- Who provides the initial education?
- How is the education reinforced by the rest of the MDT?

For auditing questions to assess how well a ward delivers patient education for preventing falls, see Appendix 2.

For people with communication differences or disability, you will also need to consider involving a person who they trust who can help to reinforce the importance of falls prevention strategies. Guidance on identifying the support network and roles of people is available in the Hospital Stay Guidelines. See Appendix 1 for more information on supporting people with disability.

Cognitive impairment

As mentioned previously, cognitive impairment could impact a patient's capacity to comprehend and retain education. As such, it is important that the patient education is tailored for patients with cognitive impairment, such as dementia.

The following organisations provide training and support for health professionals on caring for a patient with cognitive impairment:

- Alzheimer's WA
- Dementia Australia
- Dementia Support Australia
- Dementia Training Australia.

It is also important that the support network of patients with cognitive impairment are involved in the education and discussion on falls prevention.

Stage 3: Implementation

Implementation includes the delivery of falls prevention and patient education and is dependent on the mutually agreed goals. Strategies to support the delivery and implementation of patient education include:

- use language that is familiar to patients and their support network
- avoid medical terminology or jargon
- teach the most important information first
- make teaching as simple as possible without losing meaning
- organise content logically
- break down information into short sections
- use short words and sentences
- use a conversational tone
- use visuals to enhance teaching dependent on the patient's learning style and preferences
- leave 'pauses' in the conversation for the patient to reflect and ask questions
- give patients time to process the information
- give patients time to ask questions at a later stage
- incorporate active learning to engage patients
- make alternate formats available when required.[13]

For examples of interventions to prevent falls, please refer to Preventing falls and harm from Falls in Older People: Best Practice Guidelines for Australian Hospitals.[21]

Written education

Provide the patient with written and visual information to support recall. Verbal information is often recalled incorrectly or forgotten when patients experience stress.[5] Any written patient education should be in line with the patient's communication, language and cultural needs.

Development of any written material should consider readability and can be assessed using tools such as the Suitability Assessment of Materials (SAM).[40] The SAM assesses literacy demand, learning stimulation and cultural appropriateness. Other tools include:

- Hemingway Editor App
- Readability Formulas
- Document Readability Calculator
- SHeLL Editor.

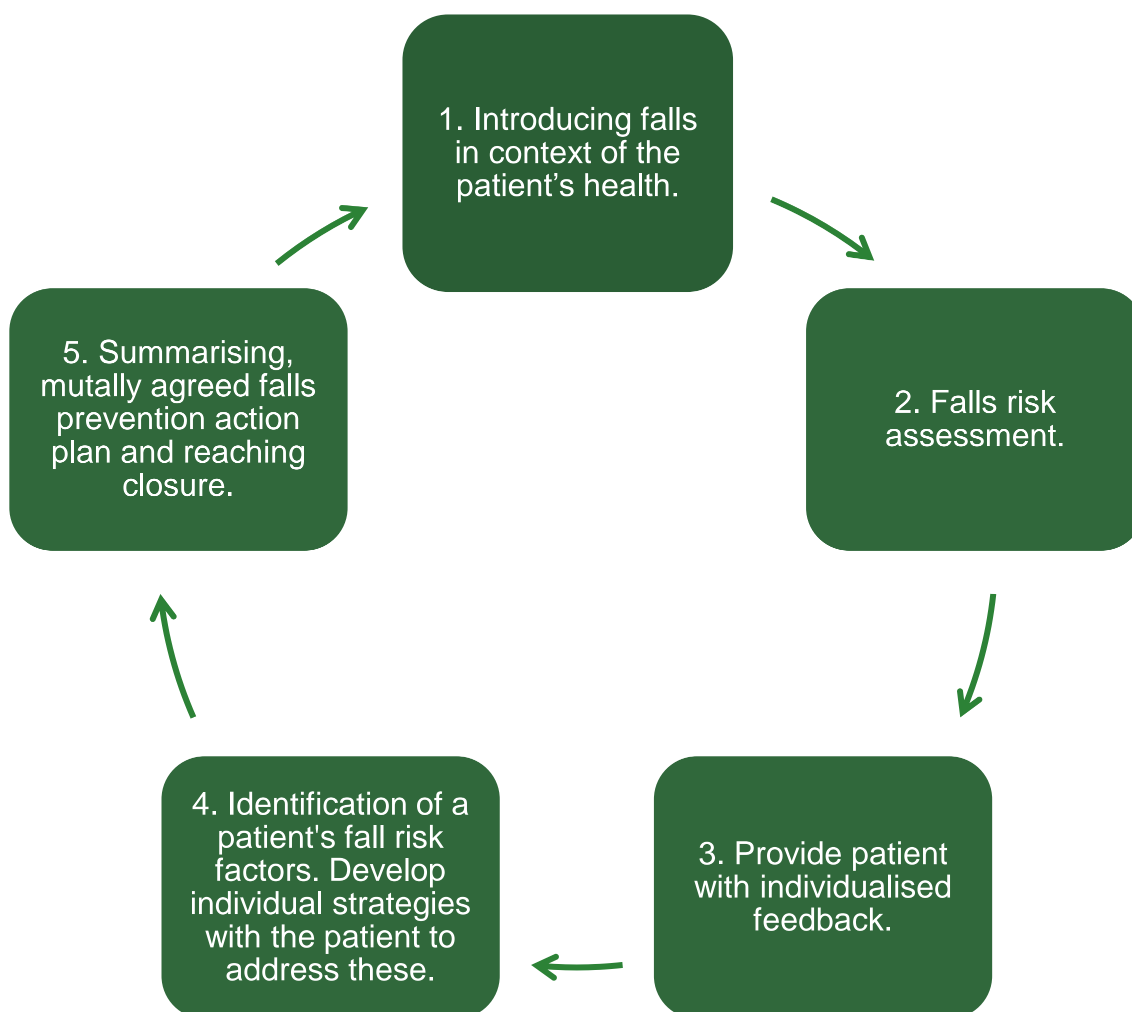
Implementation of falls prevention and patient education may also consider brief interventions using motivational interviewing and involving the patient's support network.

See Appendix 3 for consumer resources you can give to patients.

Brief intervention (including motivational interviewing)

Several studies have reported that standardised Screening, Brief Intervention and Referral to Treatment (SBIRT) can effectively change health behaviours and reduce injury recurrence[41-43] and be appropriate for some hospital settings. A brief intervention for falls would involve 5 steps (see Figure 2). Emphasising motivational interviewing techniques allows the healthcare professional to promote healthy behaviour change and support the patient's commitment to engage in the intervention.[44] Overall, motivational interviewing aims to initiate change for harm reduction.[44]

Figure 2: Brief intervention therapy cycle for falls prevention education.



Involving the support network

With patient consent and if appropriate, provide the falls prevention and management education to the patient's support network. Support network involvement is known to reinforce the education provided and increases the patient's social support for engagement in interventions. Involving the support network is also important for patients with cognitive impairment and disability. Avoid using acronyms and jargon so that the support network can understand and assist with the implementation of the falls prevention strategies.

Stage 4: Evaluation

Health professionals need to evaluate the success of the patient education provided by reviewing the patient's understanding of the education provided and goals set. This is not a test of the patient's knowledge, rather a test of how well the health professional explained the concept.

The teach-back technique is recommended to verify and determine the patient's understanding of the education provided (see Appendix 4 for additional resources regarding the teach-back method). This requires the health professional to ask the patient to explain the details of the education back to the health professional in their own words. This supports the patient's understanding and comprehension and helps to reinforce the education.[45] Steps include:

- ask the patient to explain the information provided back to you in their own words
- assess the patient's current understanding
- explain and discuss misunderstandings until understanding is achieved
- ensure that the patient is aware it is the responsibility of the health professional to explain information correctly.

Health professionals may also wish to consider evaluating positive patient engagement and implementation of falls prevention strategies.

Discharge education

In the first month after a hospital discharge, older people have a higher risk of falls with serious injury.[21] Therefore, it is important that falls education is provided when a patient is discharged to prevent falls in the community and reduce incidents of patient harm and potential readmission to hospital. Discharge falls education should be included in discharge planning from the beginning. Steps include:

- have a discussion with the patient about preventing falls where they live, including risk factors and interventions
- provide written information that summarises the key points
- involve the patient's support network in the education, where appropriate and where consent has been given.

It is also important that an overview of the falls education provided to patients is included in discharge summaries to the patient's primary health care team, as well as residential aged care home (RACH) if relevant.

There are a range of resources that can help patients prevent falls after they have been discharged from hospital. Injury Matters is funded by the Department of Health to deliver the Stay On Your Feet® program in WA. They provide a range of educational materials to help prevent falls in the community. More information on the program can be found here: www.injurymatters.org.au/programs/stay-on-your-feet/. For more patient education resources, see Appendix 3.

For more information on discharge planning and transition planning, please refer to the Preventing falls and harm from Falls in Older People: Best Practice Guidelines for Australian Hospitals.[21]

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References

1. WA Department of Health. Position statement – impact of COVID-19 on the risk of falling. Perth (AU): WA Department of Health; 2023. Available from: www.health.wa.gov.au/~/media/Corp/Documents/Health-for/Infectious-disease/COVID19/Impact-of-COVID-19-on-the-risk-of-falling-for-older-people.pdf.

2. Australian Institute of Health and Welfare. Falls in older Australians 2019-20: hospitalisations and deaths among people aged 65 and over. Canberra (AU): Australian Institute of Health and Welfare; 7 April 2022. Available from: www.aihw.gov.au/reports/injury/falls-in-older-australians-2019-20-hospitalisation/contents/summary.

3. Productivity Commission. Report on Government Services 2025. Canberra (AU): Australian Government; 6 February 2025. Available from: www.pc.gov.au/ongoing/report-on-government-services/2025/health/public-hospitals.

4. Australian Institute of Health and Welfare. Injury in Australia: Falls. Canberra (AU): Australian Institute of Health and Welfare; 15 November 2024. Available from: www.aihw.gov.au/reports/injury/falls.

5. Findeis A, Patyk M. Guidelines for developing patient education materials. In: Mechanick Jo, Kushner RF, Editors. Creating a lifestyle medicine center: From concept to clinical practice. Cham: Springer International Publishing; 2020. P. 145-60.

6. Hill AM, Francis-Coad J, Haines TP, Waldron N, Etherton-Beer C, Flicker L, Ingram K, McPhail SM. ‘My independent streak may get in the way’: How older adults respond to falls prevention education in hospital. BMJ Open. 2016; 6(7):e012363.

7. Dolan H, Slebodnik M, Taylor-Piliae R. Older adults’ perceptions of their fall risk in the hospital: An integrative review. Journal of Clinical Nursing. 2022;31(17-18):2418-36.

8. World Health Organization. Health education: Theoretical concepts, effective strategies and core competencies: A foundation document to guide capacity development of health educators. Cairo: World Health Organization; 2012. Available from iris.who.int/handle/10665/119953.

9. Abayowa J. Effective patient education strategies and how using visuals helps change patient behaviour. Vennage; 2021. Available from venngage.com/blog/patient-education/#:~:text=Let%E2%80%99s%20explore%20in%20more%20details%20about%20effective%20patient....%208%208.%20Spend%20more%20time%20with%20patients.

10. American Family Physician. Patient Education. American Family Physician; 2000;62(7):1712-1714.

11. Morris ME, Webster K, Jones C, Hill AM, Haines T, McPhail S et al. Interventions to reduce falls in hospitals: A systematic review and meta-analysis. Age and Ageing. 2022;51(5):afac077.

12. Hill AM, McPhail S, Waldron N, Etherton-Beer C, Ingram K, Flicker L, et al. Fall rates in hospital rehabilitation units after individualised patient and staff education programmes: A pragmatic, stepped-wedge, cluster-randomised control trial. The Lancet. 2015;385(9987):2592-9.

13. Heng H, Jazayeri D, Shaw L, Kiegaldie D, Hill A-M, Morris ME. Hospital falls prevention with patient education: A scoping review. BMC Geriatrics. 2020;20:1-12.

14. Cameron ID, Dyer SM, Panagoda CE, Murray GR, Hill KD, Cumming RG, Kerse N. Interventions for preventing falls in older people in care facilities and hospitals. Cochrane Database of Systematic Reviews. 2018;9(9):CD005465.

15. Lee D-CA, Pritchard E, McDermott F, Haines TP. Falls prevention education for older adults during and after hospitalization: A systematic review and meta-analysis. Health Education Journal. 2013;73(5):530-44.

16. Miake-Lye IM, Hempel S, Ganz DA, Shekelle PF. Inpatient fall preventon programs as a patient safety strategy: A systematic review. Annalos of Internal Medicine. 2013;158(5_Part_2):390-6.

17. Avanecean D, Calliste D, Contreras T, Lim Y, Fitzpatrick A, Effectiveness of patient-centered interventions on falls in the acute care setting compared to usual care: A systematic review. JBI Evidence Synthesis. 2017;15(12):3006-48.

18. Hempel S, Newberry S, Wang Z, Booth M, Shanman R, Johnson B, et al. Hospital fall prevention: a systematic review of implementation, components, adherence, and effectiveness. Journal of the American Geriatrics Society. 2013;61(4):483-94.

19. Heng H, Slade SC, Jazayeri D, Jones C, Hill A-M, Kiegaldie D, et al. Patient perspectives on hospital falls prevention education. Frontiers in Public Health. 2021;9:592440.

20. Montero-Odasso M, Van Der Velde N, Martin FC, Petrovic M, Tan MP, Ryg J, et al. World guidelines for falls prevention and management for older adults: a global initiative. Age and ageing. 2022;51(9):afac205.

21. Australian Commission on Safety and Quality in Health Care. Preventing Falls and Harm from Falls in Older People: Best Practice Guidelines for Australian Hospitals. 2025. Available from: www.safetyandquality.gov.au/our-work/falls-prevention.

22. Michie S JM. Behaviour Change Techniques. In: Gellman MD TJ, editor. Encyclopedia of Behavioral Medicine. New York, NY: Springer New York; 2013. P. 182-7.

23. Henry-Edwards S, Humeniuk R, Ali R, Monterio M, Poznyak V. Brief intervention for substance abuse: A manual for use in primary care. Geneva, World Health Organization, 2003.

24. World Health Organization. Health literacy and health behaviour. 2009. Available from: www.who.inet/teams/health-promotion/enhanced-wellbeing/seventh-global-conference/health-literacy.

25. Kreuter MW, Farrell DW, Olevitch LR, Brennan LK. Tailoring health messages: Customizing communication with computer technology: Routledge; 2013.

26. Cutilli CC. Excellence in patient education: Evidence-based education that “sticks” and improves patient outcomes. Nursing Clinics. 202;55(2):267-82.

27. Shaw L, Kiegaldie D, Heng H, Morris ME. Interprofessional education to implement patient falls education in hospitals: Lessons learned. Nursing Open. 2023;10(1):36-47.

28. London F. No Time to Teach: The Essence of Patient and Family Education for health Care Providers: Pritchett & Hull; 2009.

29. Greenberg MR, Moore EC, Nguyen MC, Stello B, Goldberg A, Barraco RD, et al. Perceived fall risk and functional decline: Gender differences in patient’s willingness to discuss fall risk, fall

history, or to have a home safety evaluation. The Yale Journal of Biology and Medicine. 2016;89(2):261-7.

30. Heng H, Kiegaldie D, Slade SC, Jazayeri D, Shaw L, Knight M, et al. Healthcare professional perspectives on barriers and enablers to falls prevention education: A qualitative study. PLoS One. 2022;17(4):e0266797.

31. Dabkowski E, Cooper SJ, Duncan JR, Missen K. Exploring hospital inpatients' awareness of their falls risk: A qualitative exploratory study. International Journal of Environmental Research and Public Health. 2022;20(1):454.

32. Australian Commission on Patient Safety and Quality in Health Care. Health Literacy – Taking action to improve safety and quality. 2014. Available from: www.safetyandquality.gov.au/publications-and-resources/resource-library/health-literacy-taking-action-improve-safety-and-quality.

33. Rolova G, Gavurova B, Petruzelka B. Health Literacy, Self-Perceived Health, and Substance Use Behavior among Young People with Alcohol and Substance Use Disorders. International Journal of Environmental Research and Public Health. 2021;18(8):4337.

34. Voigt-Barbarowicz M, Levke Brutt A. The agreement between patients' and healthcare professionals' assessment of patients' health literacy: A systematic review. International Journal of Environmental Research and Public Health. 2020;17(7):2372.

35. Wallace L. Patients' health literacy skills: The missing demographic variable in primary care research. Annals of Family Medicine. 2006; 4(1):85-86.

36. Parker RM, Baker DW, Williams MV, Nurss JR. The test of functional health literacy in adults: a new instrument for measuring patients' literacy skills. Journal of General Internal Medicine. 1995;10:537-41.

37. Arozullah AM, Yarnold PR, Bennett CL, Soltysik RC, Wolf MS, Ferreira RM, Lee SY, Costello S, Shakir A, Denwood C, Bryant FB. Development and validation of a short-form, rapid estimate of adult literacy in medicine. Medical Care. 2007;45(11):1026-33.

38. Michie S, van Stralen MM, west R. The behaviour change wheel: A new method for characterising and designing behaviour change interventions. Implementation Science. 2011;6(1):42.

39. Vestjens L, Kempen GI, Crutzen R, Kok G, Zijlstra GR. Promising behaviour change techniques in a multicomponent intervention to reduce concerns about falls in old age: a Delphi study. Health Education Research. 2015;30(2):309-22.

40. Doak CC, Doak LG, Root JH. Teaching patients with low literacy skills. The American Journal of Nursing. 1996;96(12):16M.

41. van Loom M, van Gaalen AC, van der Linden MC, Hagestein-De Brujin C. Evaluation of screening and brief intervention for hazardous alcohol use integrated into clinical practice in an inner-city emergency department. European Journal of Emergency Medicine. 2017;24(3):224-9.

42. Mitchell AM, Kane I, Lindsay DL, Hagle H, Puskar K, Aiello J, et al. Educating Emergency Department Registered Nurses (EDRNs) in screening, brief intervention, and referral to treatment (SBIRT): Changes in attitudes and knowledge over time. International Emergency Nursing. 2017;33:32-6.

43. Harper KJ, Barton AD, Arendts G, Edwards DG, Petta AC, Celenza A. Controlled clinical trial exploring the impact of a brief intervention for prevention of falls in an Emergency Department. Emergency Medicine Australasia. 2017;29(5):524-30.

44. Center for Substance Abuse Treatment. Brief interventions and brief therapies for substance abuse. Rockville (MD): Substance Abuse and Mental Health Services Administration (US), 1999.

45. Yen PH, Leasure AR. Use and effectiveness of the teach-back method in patient education and health outcomes. Federal Practitioner. 2019;36(6):284.

46. World Health Organization. Health Equity. Available from: www.who.int/health-topics/health-equity#tab=tab_1.

47. Think Change Resolve Consultancy. National consultation on health care for LGBTIQA+ communities. Available from: assets.healthequitymatters.org.au/wp-content/uploads/2024/09/04020838/Community-Consultation-Report.pdf.

48. Australian Bureau of Statistics. Western Australia: Aboriginal and Torres Strait Islander population summary. 2022. Available from: www.abs.gov.au/articles/western-australia-aboriginal-and-torres-strait-islander-population-summary.

49. Australian Bureau of Statistics. Aboriginal and Torres Strait Islander life expectancy. 2023. Available from: www.abs.gov.au/statistics/people/aboriginal-and-torres-strait-islander-peoples/aboriginal-and-torres-strait-islander-life-expectancy/latest-release.

50. Australian Institute of Health and Welfare. Injury in Australia: Falls. 2025. Available from: www.aihw.gov.au/reports/injury/falls.

51. Australian Institute of Health and Welfare. Dementia in Australia. 2025. Available from: https://www.aihw.gov.au/reports/dementia/dementia-in-aus/contents/first-nations-australians-with-dementia/how-many-first-nations-people-have-dementia.

52. Australian Institute of Health and Welfare. Heart, stroke and vascular disease: Australian facts. 2024. Available from: www.aihw.gov.au/reports/heart-stroke-vascular-diseases/hsvd-facts/contents/summary.

53. Australian Institute of Health and Welfare. Diabetes: Australian facts. 2024. Available from: www.aihw.gov.au/reports/diabetes/diabetes/contents/summary.

54. Australian Institute of Health and Welfare. Chronic kidney disease: Australian facts. 2024. Available from: www.aihw.gov.au/reports/chronic-kidney-disease/chronic-kidney-disease/contents/about.

55. Australian Institute of Health and Welfare. Chronic respiratory conditions. 2024. Available from: www.aihw.gov.au/reports/chronic-respiratory-conditions/chronic-respiratory-conditions/contents/first-nations-people-with-asthma.

56. Australian Institute of Health and Welfare. Cancer. 2024. Available from: www.aihw.gov.au/reports/australias-health/cancer.

57. Australian Institute of Health and Welfare. Prevalence and impact of mental illness. 2025. Available from: www.aihw.gov.au/mental-health/overview/prevalence-and-impact-of-mental-illness.

58. Thackrah R D. Culturally secure practice in midwifery education and service provision for Aboriginal women. A thesis presented for the degree of Doctor of Philosophy of The University of Western Australia. 2016. Available from:

api.researchrepository.uwa.edu.au/ws/portalfiles/portal/10908691/THESIS_DOCTOR_OF_PHILOSOPHY_THACKRAH_Rosalie_Dawn_2016.pdf.

59. Arabena K. Preachers, policies and power: the reproductive health of adolescent Aboriginal and Torres Strait Islander peoples in Australia. Health Promotion Journal of Australia. 2006;17:85-90.

60. Government of Western Australia. WA Aboriginal Health Executive Roundtable 2023 Recommendations Report. Aboriginal Health. 2023. Available from: dohhealthpoint.hdwa.health.wa.gov.au/directory/Public Health/Aboriginal Health/Pages/WA-Aboriginal-Health-Executive-Roundtable-2023.aspx.

61. Australian Government. Cultural load, it's a real thing! Australian Public Service Commission. Available from: www.apsc.gov.au/working-aps/diversity-and-inclusion/diversityinclusion-news/cultural-load-its-real-thing.

62. Tujague N, Ryan K. Cultural Safety in Trauma-Informed Practice from a First Nations Perspective. 2023. Published by Billabongs of Knowledge.

63. Wawa Biik. What is yarning? 2023. Available from: wawabiik.com.au/what-is-yarning/.

64. Lin, I., Green, C., & Bessarab, D. 'Yarn with me': applying clinical yarning to improve clinician-patient communication in Aboriginal health care. Australian Journal of Primary Health. 2016; 22(5), 377–382. doi.org/10.1071/PY16051.

65. Government of Western Australia – Office of Multicultural Interests. Census 2021 Highlights: Western Australia's Changing Population and Cultural Diversity. Available from: www.omi.wa.gov.au/resources-and-statistics/wa-diversity-and-statistics.

66. Government of Western Australia – Department of Health. Language Services Policy. Available from: www.health.wa.gov.au/About-us/Policy-frameworks/Communications/mandatory/Language-Services-Policy.

67. Government of Western Australia – Office of Multicultural Interests. WA Multicultural Policy Framework. Available from: www.omi.wa.gov.au/resources-and-statistics/publications/publication/wa-multicultural-policy-framework.

68. Government of Western Australia – Department of Communities. A Western Australian for Everyone – State Disability Strategy 2020-2030. 2020. Available from: www.wa.gov.au/government/document-collections/state-disability-strategy-2020-2030.

69. Australian Bureau of Statistics. Estimates and characteristics of LGBTI+ populations in Australia. 2024. Available from: www.abs.gov.au/statistics/people/people-and-communities/estimates-and-characteristics-lgbti-populations-australia/latest-release.

70. Australian Institute of Health and Welfare. LGBTIQ+ communities. Available from: www.aihw.gov.au/reports-data/population-groups/lgbtiq/overview.

71. Department of Health, Disability and Ageing. National Action Plan for the Health and Wellbeing of LGBTIQA+ People 2025–2035. 2024. Available from: www.health.gov.au/resources/publications/national-action-plan-for-the-health-and-wellbeing-of-lgbtiqa-people-2025-2035?language=en.

72. Australian Human Rights Commission. LGBT older people. Available from: humanrights.gov.au/our-work/sex-discrimination/lgbt-older-people.

73. Ventriglio A, Castaldelli-Maia JM, Torales J, De Berardis D, Bhugra D. Homophobia and mental health: a scourge of modern era. *Epidemiology and Psychiatric Sciences*. 2021;30:e52. doi:10.1017/S2045796021000391.

74. Compass. Abuse of older LGBTI people: the unique challenges. 2025. Available from: www.compass.info/featured-topics/diversity/abuse-of-older-lgbti-people-the-unique-challenges/.

75. WA Department of Health. Western Australian Lesbian, gay, bisexual, transgender, intersex, queer and asexual plus (LGBTIQA+) Inclusion Strategy. Available from: www.wa.gov.au/government/government-initiatives-and-projects/lesbian-gay-bisexual-transgender-intersex-queer-and-asexual-plus-lgbtiqa-inclusion-strategy.

Acronyms

AAC	Augmentative and Alternative Communication
ADHD	Attention deficit hyperactivity disorder
BCT	Behaviour Change Technique
CaLD	Culturally and linguistically diverse
CDU	Cultural Diversity Unit
COM-B	Capability, Opportunity and Motivation Behaviour
GRAI	Gay, Lesbian, Bisexual, Trans, Intersex Rights in Ageing Inc.
LGBTIQA+	Lesbian, gay, bisexual, transgender, intersex, queer and asexual plus
LGBTIQA+SB	Lesbian, gay, bisexual, transgender, intersex, queer, asexual, sistergirl and brotherboy
MDT	Multidisciplinary team
RACH	Residential aged care home
REALM	Rapid Estimate of Adult Literacy in Medicine
SAM	Suitability Assessment of Materials
SBIRT	Screening, Brief Intervention and Referral to Treatment
TOFHLA	Test of Functional Health Literacy
WA	Western Australia

Definitions

Behaviour Change Technique (BCT)	An active component of an intervention designed to change behaviour (i.e. goal setting, action planning or graded tasks).[22] Additional training can be found at www.bct-taxonomy.com/.
Brief intervention	An intervention that takes very little time to implement.[23]
Health literacy	The cognitive and social skills which determine the motivation and ability of individuals to gain access to, understand and use information in ways which promote and maintain good health. Health literacy is critical to patient empowerment and improving patient access to health information can support their ability to use it effectively.[24]
Multidomain interventions	A combination of 2 or more intervention components across 2 or more domains (e.g. an exercise program and environmental modification) based on a multifactorial falls risk assessment and intend to prevent or minimise falls and related injuries.[20]
Patient health education	Patient health education is a planned activity initiated by a healthcare professional whose goal is to provide information and skills, with the intention to change health behaviour and promote engagement in interventions, thereby improving overall health.[5]
Support network	A group of people that provide emotional and practical support to an individual. It typically consists of family, friends and carers.
Tailoring education	Any combination of information or change strategies intended to reach one specific person, based on characteristics that are unique to that person, related to the outcome of interest, and have been derived from an individual assessment.[25]

Appendix 1: Priority populations

All people have a right to universal health care and health equity to achieve their full potential for health and wellbeing.[46] WA Health recognises that a safe and responsive health system is imperative to ensure that everyone who accesses our services receives the best quality of care required to significantly improve their health, social and emotional wellbeing outcomes.

WA Health embraces the unique needs of everyone that accesses our health system, including but not limited to, people living in regional and remote areas, Aboriginal people, people from CaLD backgrounds, LGBTIQA+SB people, people with disability, older persons, young people, people with family and carer responsibilities, and those living in varying socio-economic situations.

Intersectionality is an important concept in acknowledging and supporting diversity. This approach acknowledges the impacts of multiple, intersecting forms of diversity, experiences of marginalisation and implications for access to and experience of health care.[47] Acknowledging these intersections may also impact health-related behaviours and outcomes, whereas not acknowledging the intersections can exacerbate the impacts of systemic discrimination, disadvantage and social exclusion on health and wellbeing.

Below is information and links to resources on how to support Aboriginal people, CaLD people, people with disability and LGBTIQA+SB people.

Aboriginal people

In WA, 89,000 people identify as Aboriginal or Torres Strait Islander.[48] Aboriginal and Torres Strait Islander people have a shorter life expectancy than non-Indigenous people[49], and experience higher rates of falls,[50] dementia,[51] heart disease,[52] diabetes,[53] chronic kidney disease,[54] asthma,[55] cancer[56] and mental health issues[57] than non-Indigenous people.

To ensure the unique rights and needs of Aboriginal people are recognised, the provision of culturally secure and respectful care[58] should embrace a strengths-based paradigm[59], with kinship and Aboriginal culture seen as a vital protective factor. Cultural determinants of health originate from and promote a strengths-based approach. The domains of cultural determinants form cultural identity and act as protective factors for better health and wellbeing.

As identified in the Mayi Kuwaya study, cultural determinants comprise of the following 6 domains:

1. Connection to country
2. Family, kinship and community
3. Indigenous beliefs and knowledge
4. Cultural expression and continuity
5. Indigenous language
6. Self-determination and leadership.[60]

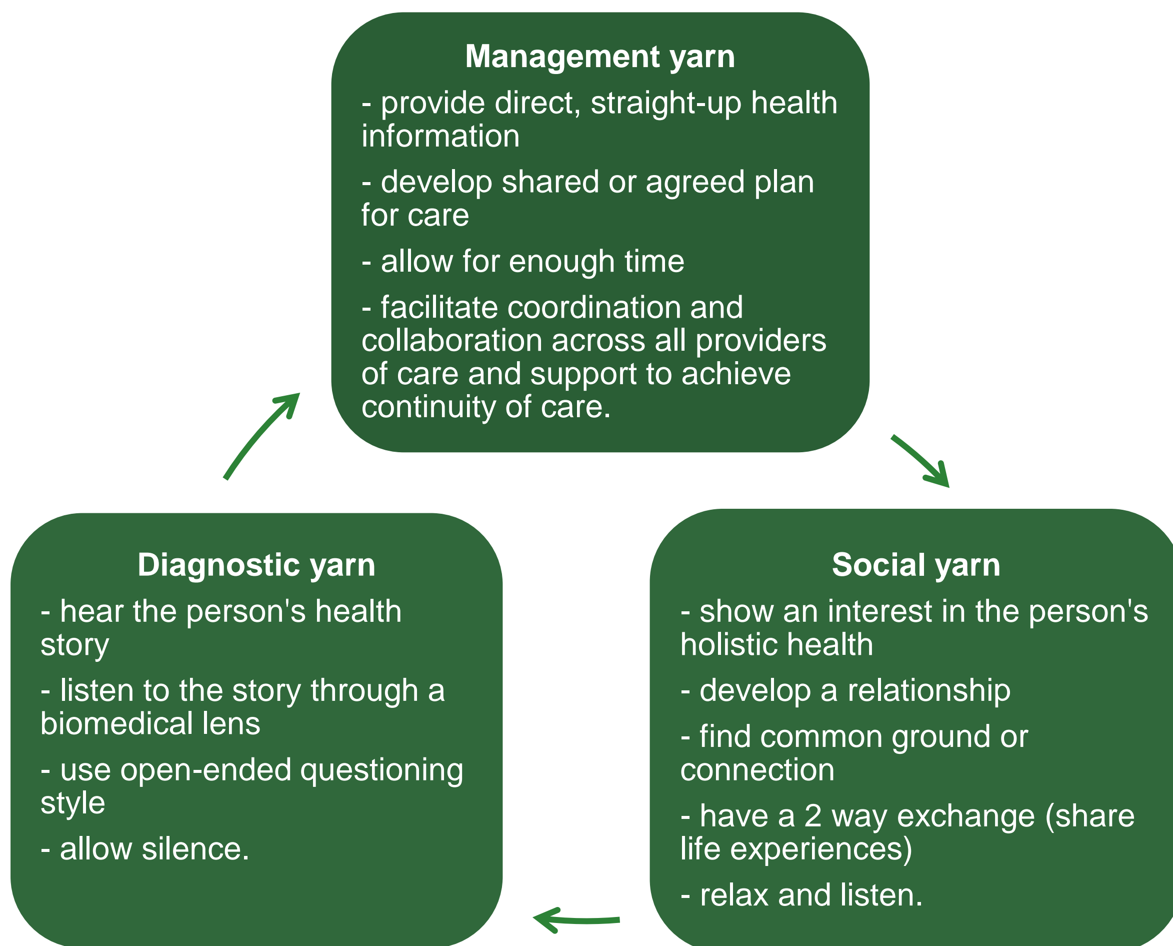
Recognition of intergenerational, institutional, collective and historical trauma is also important. In addition, racism, cultural load[61] and the differences between mainstream systems and more holistic Aboriginal understandings of social and emotional health and wellbeing[62] need to be understood and respected. It is important that the information in this guideline is read in conjunction with these cultural determinants and considerations when caring for Aboriginal people.

It is also important that health professionals build a relationship with Aboriginal patients they are caring for, and this can be achieved through 'yarning'. Yarning is a free-flowing conversation that

allows Aboriginal people to connect and purposefully share knowledge through stories, anecdotes and experiences.[63] When yarning with Aboriginal people, it is important that it is in safe place and that there is active listening and mutual respect for everyone involved.[63]

Health professionals may engage with Aboriginal patients better by using 'clinical yarning'. Clinical yarning is a patient-centred approach that combines Aboriginal cultural communication preferences with biomedical understandings of health and disease (see Figure 3).[64] For more information on clinical yarning, visit www.clinicalyarning.org.au/.

Figure 3: The clinical yarning cycle.[64]



For more information and resources on health for Aboriginal and Torres Strait Islander people, visit healthinfonet.ecu.edu.au/.

People from culturally and linguistically diverse backgrounds

WA has a strong multicultural society and is home to people from over 220 birthplaces.[65] This includes people that have ancestry, or are born in, countries where English is not the primary language, known as people from CaLD backgrounds.

The needs of CaLD communities are varied and complex and often intersect with other population groups. Creating inclusive and welcoming communities for everyone with easy-to-understand information and equitable access to services is important for CaLD communities to thrive and feel a sense of belonging.

The delivery of language services through WA Health's Language Services Policy[66] and WA Health's commitment to the implementation of the State Government's WA Multicultural Policy Framework[67] provides a strong foundation to build inclusive, culturally appropriate and quality service design for people from CaLD backgrounds.

The WA Department of Health has a Cultural Diversity Unit (CDU). The CDU develops and promotes policies, practices and services that strengthen the cultural competency of WA health staff, and improve the accessibility, safety and quality of services for people of CaLD backgrounds. This includes improving health literacy and better health outcomes for CaLD communities.

Many resources for health professionals can be found on the WA Department of Health website: www.health.wa.gov.au/Health-for/Health-professionals/Multicultural-health. Injury Matters also has information on falls prevention for CaLD communities: www.injurymatters.org.au/programs/know-injury/know/cald/.

People with disability

In WA, one in 5 people (or 411,500 people) have a disability and currently 68,000 Western Australians are the primary carer for a friend or family member with a disability[68]. Health staff across all settings play a critical role in implementing strategies that are tailored to the unique needs of people with disability. People with disability may face additional falls risk factors relating to mobility, communication, cognitive function, environmental barriers or the interaction of multiple health conditions.

A person's ability to access information, services and facilities is affected by several factors including the scope and complexity of their support needs which can vary considerably between individuals. Therefore, processes for patient education for falls prevention cannot be prescriptive and must consider the diverse needs of individuals and the nature, strengths, priorities and resources of a community.

For people with complex communication or behavioural needs, health professionals must liaise with someone who knows the person's unique falls risk and educational needs, as well as being able to recognise and respond to their signs of distress, pain and discomfort.

Practical strategies for educating people with disability on falls prevention include using accessible communication, such as:

- adapting and changing language to suit the patient
- using visual supports such as pictures, diagrams or videos
- using Easy Read format or Social Stories.

For people with sensory disabilities:

- Use Auslan or tactile interpreters or captioned materials. The WA Health's Language Services Policy[66] is also applicable for people who are Deaf or hard of hearing and communicate in Auslan.
- Offer Large Print or audio resources.
- Allow extra time for processing.
- Some individuals may require the use of Augmentative and Alternative Communication (AAC) methods. For more information, see the Communication Hub.

For more information and detailed guidance on supporting people with disability, see:

- Hospital Stay Guideline for hospital staff
- Additional guides and resources.

Lesbian, gay, bisexual, transgender, intersex, queer, asexual, sistergirl and brotherboy people

It is estimated that 4.5 per cent of Australians aged 16 years and older are lesbian, gay, bisexual, transgender, intersex or use a different term to describe their sexual orientation.[69] Lesbian, gay, bisexual, transgender, intersex, queer and asexual plus (LGBTIQA+) people experience significant health disparities in many areas, including mental health issues, risky alcohol and other drug use, and increased risk of domestic violence.[70] LGBTIQA+ people also experience stigma, isolation, harassment and violence, which can lead to poorer outcomes than the general population.[71] It is also important to acknowledge that LGBTIQA+SB people are not a homogenous population, and each person has their own unique experience and healthcare needs.[71]

Older LGBTIQA+ people face unique challenges that can increase their risk of falls and poorer health outcomes. Many have lived through periods of criminalisation and discrimination, which can lead to residual fears, reluctance to disclose their identity, or "returning to the closet" in healthcare or aged care settings.[72] This can impact their willingness to seek help or involve support networks. Older LGBTIQA+ people who have experienced homophobia and transphobia across their lives may also carry the effects of trauma, which is associated with higher rates of mental health issues, substance use and chronic illness.[73] These factors can increase vulnerability and may contribute to a greater risk of falls.

Social isolation is a significant concern. Older LGBTIQA+ people are twice as likely to live alone, 2.5 times more likely to be single, and 4 times less likely to have children compared to their heterosexual peers.[74] These factors reduce informal care and support, increasing vulnerability during hospitalisation and recovery. Sensitivity to these issues is essential. Health professionals should avoid assumptions about family structures, respect chosen families, and create safe environments for disclosure.

The State Government has recently developed the Western Australian LGBTIQA+ Inclusion Strategy 2025-2035, which aims to drive inclusion and improve the wellbeing of LGBTIQA+ people in WA.[75] The Strategy includes priority areas relating the health and wellbeing needs for LGBTIQA+ people living in WA.

For more information on supporting LGBTIQA+SB people, visit:

- GRAI (Gay, Lesbian, Bisexual, Trans, Intersex Rights in Ageing Inc.)
- LGBTIQ+ Health Australia.

Useful contacts

- Aboriginal Health Policy Directorate, Department of Health: PublicandAboriginalhealthdivision@health.wa.gov.au
- Cultural Diversity Unit, Department of Health: culturaldiversity.royalst@health.wa.gov.au
- Consumer Engagement and Inclusion Team, Department of Health: DOH.Consumerengage@health.wa.gov.au
- Disability Health Network, Department of Health: healthpolicy@health.wa.gov.au.

Appendix 2: Auditing questions

Each health service may have adapted the provision of the patient education guideline, dependent on site requirements, and therefore, auditing may vary across health services. To evaluate how well a ward delivers patient education for preventing falls, please consider the following auditing questions:

- Is the patient involved in all stages of their falls prevention education?
- How is falls prevention education being provided in your health care setting?
- Who is providing this directly to the patient?
- When is this taking place and being reinforced along the patient's care journey?
- Where is this being documented and communicated across the MDT?
- What resources are being utilised to support adult learning and meet different learning styles, communication styles, disability needs and cultural needs?
- Is there a review of the quality of the education provided and patient understanding/implementation?
- What is the impact on injurious falls rates?

Appendix 3: Patient education resources

Injury Matters is funded by the Department of Health to deliver the Stay On Your Feet® program in WA. They provide a range of educational materials to help prevent falls in the community. More information on the program and resources can be found here: www.injurymatters.org.au/programs/stay-on-your-feet/.

The Older Person Health Network's WA Clinical Health Promotion Falls Working Group have run 2 campaigns, Move it May and No Falls November, to increase awareness of falls prevention amongst consumers in hospital and RACHs. Both campaigns use the Stay On Your Feet® branding.

The Move it May campaign aims to increase awareness of the importance of physical activity as a key method for preventing deconditioning and the risk of falling for older adults, particularly whilst in hospitals or RACHs. More information on the campaign and resources can be found here: www.health.wa.gov.au/Articles/A_E/Campaign-Move-it-May.

The No Falls November campaign aims to raise awareness for falls in hospitals and RACHs by focusing on several risk factors for falls including deconditioning, lack of education and awareness, orthostatic (postural) hypotension, incontinence and cognitive impairment. More information on the campaign and resources can be found here: www.health.wa.gov.au/articles/a_e/campaign-no-falls-november.

Appendix 4: Teach-back method

Additional resources and information to support using the teach-back method can be found below.

Information and resources

The Teach-Back website is an Australian resource developed by the South Eastern Sydney Local Health District and Deakin University. It has a range of information and resources to support health professionals or community workers integrate the method into their practice. More information can be found here: teachback.org/.

The Centre for Culture, Ethnicity and Health has also developed a guide on using teach-back via an interpreter. More information can be found here: www.ceh.org.au/resource-hub/health-literacy-using-teach-back-via-an-interpreter/.

Toolkits

The Always Use Teach-Back! Toolkit describes the principles of plain language, teach-back, coaching and system changes necessary to promote consistent use of teach-back. It also has a 45-minute interactive teach-back learning module that includes key content and videos of clinicians using teach-back. The module can be used by clinicians or staff members in a group setting or as a self-directed tutorial. More information can be found here: teachbacktraining.org/.

Videos

The North Western Melbourne Primary Health Network have produced a short video on teach-back, which can be found here: www.youtube.com/watch?v=d702HIZfVWs.

For those in WA Health, Fiona Stanley Hospital has multiple resources related to teach-back, which can be found here: wahealthdept.sharepoint.com/sites/fsfhg-eat/SitePages/Teach-back.aspx.

For those outside of WA Health, the Fiona Stanely Hospital teach back videos can be accessed here:

- Why teach back is important
- Teach back for pharmacy
- Teach back for peripheral intravenous catheters
- Teach back for open disclosure
- Teach back for the National Disability Insurance Scheme.

Additional videos can be found here: www.teachbacktraining.org/.

This document can be made available in alternative formats on request for a person with disability.

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