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Article

An Occupational Therapy–Led Multifactorial Fall Prevention Program for Community-Dwelling Older Adults: A Pilot Feasibility Study

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ABSTRACT

Background: Falls threaten older adults' independence and participation in meaningful occupations. From an occupational therapy perspective, fall prevention extends beyond reducing injury risk; it sustains connection, autonomy, and belonging within one's community. This pilot study examined the feasibility, acceptability, and community impact of an occupational therapy–led, occupation-focused fall prevention program designed to enhance safety, participation, and collective well-being among community-dwelling older adults.

Methodology: A quasi-experimental pretest-posttest pilot study was conducted at a community site (seven enrolled; six completed). Six weekly sessions integrated exercise, education, and environmental strategies mapped to the *Occupational Therapy Practice Framework, Fourth Edition*. Feasibility indicators included recruitment, retention, fidelity, acceptability, and contextual barriers. Secondary outcomes included the Timed Up and Go (TUG), 30-Second Chair Stand, Activities-specific Balance Confidence (ABC) Scale, and Falls Efficacy Scale (FES). Quantitative data were summarized using medians and interquartile ranges and analyzed with Wilcoxon signed-rank tests ($\alpha = 0.10$); effect sizes (r) estimated the magnitude of change. **Results:** All feasibility benchmarks were met (86% retention, high attendance, positive feedback). Median TUG improved from 14 to 11 seconds ($r = 0.74$), indicating a potential signal of improved mobility; other measures showed small, nonsignificant directional changes. Participants described increased confidence, mutual encouragement, and social connection, reflecting a shared commitment to safety and interdependence. **Conclusion:** An occupation-based, therapist-led fall prevention program was feasible and well received, fostering safe engagement in daily activities and social connectedness. Preliminary directional changes in mobility and confidence suggest potential benefits for future study of effects on participation and wellbeing. Interpreting outcomes through the doing, being, becoming, and belonging lens highlights how mobility practice, confidence, emerging routines, and mutual support can be advanced together in community programs.

Keywords: Occupational therapy; fall prevention; older adults; community wellbeing; feasibility

INTRODUCTION

Falls are a leading cause of injury associated with increased morbidity, mortality, and loss of independence (Laybourne et al., 2008; Qian et al., 2021). Nearly one in four adults aged 65 and older experience a fall each year, many of which result in serious injury or reduced participation in daily activities (Centers for Disease Control and Prevention [CDC], 2024). Beyond their physical consequences, falls can disrupt older adults' sense of identity, autonomy, and belonging, which are dimensions central to wellbeing and occupational engagement.

In this study, occupational engagement refers to active involvement in and commitment to meaningful activities, whereas occupational participation denotes observable involvement in daily life roles and activities within a social or physical context (American Occupational Therapy Association [AOTA], 2020; Kielhofner, 2002). These constructs are interrelated, with engagement reflecting the subjective experience that supports and sustains participation.

Engagement in physical activity, particularly balance, strength, and endurance training, has long been recognized as a cornerstone of fall prevention (Granacher et al., 2013; Liu-Ambrose et al., 2019; Sherrington et al., 2017). However, exercise alone may not address the complex environmental, behavioral, and psychosocial factors contributing to fall risk. Comprehensive, multifactorial interventions that integrate home safety, education, and behavioral strategies have shown greater effectiveness in reducing falls and promoting sustained safety behaviors (Pillay et al., 2024; van der Velde et al., 2025).
Occupational therapy offers a distinctive contribution to this evidence base by linking safety and mobility to meaningful participation (AOTA, 2020; Elliott & Leland, 2018; Peterson et al., 2012). The profession's holistic scope encompasses environmental modification, education, and behavioral change, as well as physical conditioning. Grounded in the Person–Environment–Occupation–Performance (PEOP) model, occupational therapy targets both individual capacities and contextual barriers that influence participation in daily life (AOTA, 2020; Christiansen & Baum, 1997). This approach positions occupational therapy to address fall risk not simply as a clinical outcome but as a determinant of wellbeing and community inclusion.

Consistent with contemporary occupational therapy theory, we interpret outcomes through the four interdependent dimensions of occupation: doing, being, becoming, and belonging, proposed as a hallmark of occupational therapy models (Hitch & Pepin, 2021). These constructs originate from occupational science, which conceptualizes human occupation as a means of fostering identity, purpose, and social connection (Hitch & Pepin, 2021; Wilcock, 1998). In the context of fall prevention, this lens positions mobility work (doing) within identity and confidence (being), the adoption of new habits and capabilities over time (becoming), and social connection and reciprocity (belonging), clarifying how occupation-based strategies can support participation and wellbeing.

Despite strong evidence for multifactorial interventions, implementation in community settings remains inconsistent due to limited resources, fragmented services, and weak interdisciplinary coordination (Lee & Yu, 2020; Lombard et al., 2019; van der Velde et al., 2025). Occupational therapists are well positioned to bridge this gap by integrating physical, cognitive, and environmental

strategies into everyday occupations, consistent with prior research on multidisciplinary fall prevention (Elliott & Leland, 2018; Lee & Yu, 2020). However, few studies have examined the feasibility and acceptability of occupational therapy–led, occupation-focused fall prevention programs implemented in real-world community contexts.

Research seldom integrates exercise-based fall prevention with occupation-centered strategies such as home and environmental modifications, activities of daily living (ADL) retraining, and adaptive equipment use, which are central to occupational therapy practice. Addressing this gap provides needed evidence on how occupational therapy approaches can be feasibly delivered within resource-limited contexts while promoting engagement, safety, and participation among older adults. Accordingly, this pilot study aimed to evaluate the feasibility and acceptability of an occupational therapy–led, occupation-focused fall prevention program for community-dwelling older adults and to explore preliminary functional signals (mobility, strength, balance confidence, fear of falling).

METHODS

This pilot feasibility study used a quasi-experimental pretest-posttest design at a suburban community-based interdisciplinary care program in Delaware, United States. An occupational therapy–led, six-session group intervention integrated exercise and education to target functional mobility, balance confidence, and overall fall risk. Primary outcomes were feasibility and acceptability. Secondary, exploratory measures were the Timed Up and Go, 30-Second Chair Stand, Activities-Specific Balance Confidence Scale, and Falls Efficacy Scale.

Participants

Seven community-dwelling older adults (aged 65-84 years) were initially enrolled from a suburban interdisciplinary care program; one participant withdrew, resulting in a retention rate of 86% (6 of 7 completed). Participants completed a researcher-developed multiple-choice survey that gathered demographic information (age range, gender, living situation, caregiver availability, mobility device use) and fall history (past year, six months, one month), including typical fall locations. Participant characteristics are summarized in Table 1.

Table 1: Participant Characteristics (n=6)

Characteristic	n
Gender	
Female	5
Male	1
Living Situation	
Lives alone	4
Lives with others	2
Caregiver Support	
Has caregiver	2
No caregiver	4
Fall History	
0 falls	2
1-2 falls	4

A purposive sampling strategy was used to recruit participants meeting predefined eligibility criteria: aged 55 or older, enrolled in the program, community-dwelling, capable of following multi-step commands, able to read and understand English, and ambulatory for household distances (with or without a mobility device). Individuals with conditions that made participation unsafe were excluded. Eligible participants were screened, provided informed consent, and then completed pretest assessments. This approach ensured a sample of community-dwelling older adults with diverse fall risk levels, appropriate for

evaluating the program's feasibility and acceptability.

Although the sample included predominantly female participants (five women, one man), this distribution reflected the typical gender composition of older adult participants in community-based fall prevention and wellness programs, where women are consistently overrepresented. For example, women comprised approximately 77% of participants across 108 community-based fall prevention trials (Sherrington et al., 2021). Given the study's feasibility focus and small sample size, no gender-based comparisons were conducted.

Individual race and ethnicity data were not collected to protect participant anonymity given the small sample size. To provide contextual demographic information, the program took place in Newark, Delaware, a suburban community with a population of approximately 30,000 residents. Based on United States (U.S.) Census estimates, the population is 66% White, 11% Black or African American, 8% Asian, 5% two or more races, and 7% Hispanic or Latino.

About 13% of residents are foreign-born, and 27% live below the poverty line, reflecting economic diversity within the community (U.S. Census Bureau, 2023). Although insurance status was not collected, approximately 5% of Newark residents lack health insurance, indicating potential disparities in access to preventive and rehabilitation services (U.S. Census Bureau, 2023).

Feasibility Indicators and Benchmarks

Feasibility was evaluated using prespecified indicators and thresholds common to early-phase implementation research. The program was considered feasible if most indicators met or exceeded the following thresholds: (1) recruitment of ≥6 participants within the designated window; (2) retention of ≥80% of enrolled participants through all sessions and post-testing; (3) median attendance of at least 4 of 6 sessions per participant; (4) fidelity of ≥85% of core session components delivered, verified via facilitator checklist; (5) ≥70% of completers providing positive feedback and reporting at least one safety-oriented behavior change; and (6) zero serious adverse events. Barriers and facilitators were tracked, with feasibility supported if barriers could be managed without halting program delivery.

Data Collection

Feasibility Outcomes

We recorded recruitment and retention from enrollment and attendance logs; session fidelity via a facilitator checklist; acceptability via brief post-program feedback capturing perceived usefulness and any safety-oriented behavior changes; and safety events plus contextual barriers/facilitators in field notes. Fidelity was self-assessed by the facilitator using a standardized session checklist that listed core components and timing targets; no independent observation or double coding was conducted.

Outcome Measures (Secondary/ Exploratory)

These measures were selected for their ability to capture both the physical and psychosocial dimensions of occupational performance related to mobility and balance confidence, key determinants of participation in daily and community life. This study used standardized assessments to explore preliminary outcomes of the fall prevention program:

Timed Up and Go (TUG) Test: The TUG measured functional mobility and fall risk by timing how long it took participants to stand from a chair, walk 10 feet, turn, return, and sit down. A commonly used threshold of 12 seconds was applied to indicate elevated fall risk (Podsiadlo & Richardson, 1991). Shorter times reflect better functional mobility and lower fall risk. It has excellent test-retest reliability (ICC = 0.97) in older adult populations.

30-Second Chair Stand Test: This test assessed lower body strength and endurance, by counting the number of full stands a participant completed from a standard chair within 30 seconds. Testing followed a standardized protocol in which participants sat with arms crossed over the chest and rose to a full standing position repeatedly for the duration of the trial; a stand completed more than halfway at the end of 30 seconds was counted, and use of the arms resulted in a score of zero. Lower numbers of stands indicate increased fall risk when compared with age- and sex-based normative values (CDC, 2017). It demonstrates strong reliability (ICC = 0.84–0.97) (Jones et al., 1999).

Self-report measures

Two self-report measures were included: the Activities-Specific Balance Confidence (ABC) Scale and the Falls Efficacy Scale (FES).

ABC Scale: The ABC Scale consists of 16 items measuring self-reported confidence in performing daily activities without losing balance. Grounded in Bandura's theory of self-efficacy, it defines fear of falling as "balance confidence," or "confidence in the ability to maintain balance while performing selected activities" (Powell & Myers, 1995). Participants rated each item from 0% (no confidence) to 100% (complete confidence), and scores were expressed as overall percentage confidence, consistent with established scoring guidelines. Higher total scores indicate greater balance confidence. If differing confidence levels were reported for directional tasks (e.g., "up vs. down stairs"), the lower value was recorded in accordance with scoring guidelines. The ABC demonstrates high internal consistency (Cronbach's alpha = 0.96) (Huang & Wang, 2009).

FES Scale: The FES includes 10 items assessing confidence in completing mobility-related tasks without falling. Each item is rated from 1 (extreme confidence) to 10 (no confidence at all). Like the ABC, the FES is based on a self-efficacy framework and defines fear of falling as "low perceived self-efficacy at avoiding falls during essential, non-hazardous activities of daily living" (Tinetti et al., 1990). Scores were summed to produce a total score ranging from 10 to 100, with higher scores reflecting lower confidence. The FES demonstrates strong internal consistency (α = .901) and test-retest reliability (r = .71) in older adults.

Together, these assessments supported a comprehensive evaluation of participants' functional abilities and fall-related concerns as they relate to engagement in daily occupations.

Procedure

Data collection and delivery were organized into three phases: baseline assessment (week 1), six weekly intervention sessions (weeks 2–7), and post-intervention assessment with brief acceptability feedback (week 8). Fidelity, attendance, and safety events were recorded each week.

Ethical Considerations

Ethical approval for the study was obtained from the Institutional Review Board (IRB) of

Trinity Health Mid-Atlantic (IRB #2024-32). Written informed consent was obtained from all participants prior to data collection. Confidentiality was protected by de-identifying data and limiting access to authorized study personnel.

To ensure participant safety, all sessions were held in an accessible community space with stable flooring, sturdy seating, and adequate lighting. The facilitator monitored participants during physical activities, provided rest breaks as needed, and maintained emergency contact procedures in accordance with site policy. No transportation assistance or financial incentives were provided.

Baseline Data Collection

Baseline data collection occurred in week one and included the Timed Up and Go (TUG) Test, the 30-Second Chair Stand Test, the Activities-Specific Balance Confidence (ABC) Scale, the Falls Efficacy Scale (FES), and a demographic survey. These pre-assessments established initial measures of participants' functional performance and perceived fall risk.

Intervention Implementation

The intervention phase spanned weeks two through seven and consisted of a six-session fall prevention program. Each session lasted approximately 60 minutes and was conducted once weekly in a small group format (6 participants), providing a total intervention dosage of six contact hours. Weekly sessions combined education and guided physical activity grounded in participants' daily routines, addressing home and community safety, balance and strengthening exercises, and lifestyle factors such as diet and hydration that influence wellbeing and occupational engagement. Including baseline and post-intervention assessments and one standardized self-report survey, total participant involvement across the study was approximately 6.5 hours.

Each session followed a consistent structure: approximately 20 minutes of guided physical activity and review of the home exercise program (HEP), 15 minutes of education through a brief slideshow, and 15 minutes of an interactive game to reinforce learning. The remaining time allowed for discussion, questions, and short breaks. Participants received individualized HEPs with photo-based exercise instructions and written educational checklists corresponding to each week's topic.

Program content was developed by the principal investigator, an occupational therapy doctoral capstone student, and then reviewed by faculty and site mentors with expertise in fall prevention and community-based care before implementation. The program was subsequently delivered by the principal investigator to ensure consistency and fidelity. Program sessions were explicitly mapped to *Occupational Therapy Practice Framework—Fourth Edition* (OTPF-4) domains to foreground occupation-based aspects (AOTA, 2020):

- ***Session 1: Balance + Home Safety*** *(Habits/Routines; Performance Patterns)*: Balance exercises and discussion of home fall risks (bathroom, kitchen, bedroom) followed by a Jeopardy-style review game.
- ***Session 2: Core Strength + Community Mobility*** *(Context & Environment; ADLs/IADLs)*: Core strengthening with education on community fall risks and adaptive equipment; reinforced with a photo-matching activity.

- ***Session 3: Upper Extremity Strength + Lifestyle Factors*** *(Client Factors → Balance/Strength; Occupations)*: Upper extremity strengthening with education on physical activity, nutrition, and hydration; reinforced through trivia.
- ***Session 4: Lower Extremity Strength + Medication Safety*** *(Motor Skills; Occupations)*: Lower extremity exercises with education on medication management and its impact on balance; reinforced through a Family Feud-style activity.
- ***Session 5: Chair Yoga/Mindfulness + Fall Response*** *(Community Mobility; Routines/Roles)*: Chair yoga and mindfulness exercises with education on how to respond after a fall; reinforced through a Bingo activity.
- ***Session 6: Cardiovascular Endurance + Behavioral Strategies*** *(Performance Patterns; Education/ Advocacy)*: Cardiovascular endurance training paired with education on behavioral fall-prevention strategies (e.g., energy conservation, asking for help, avoiding multitasking), followed by a cumulative review board game. Content choices were intentionally consistent with CDC-endorsed, evidence-based programs (e.g., Otago, Stepping On, Tai Chi: Moving for Better Balance) and guideline-recommended environmental/ functional assessment emphases, clarifying how an occupational therapy-led group can operationalize national priorities in a community setting (Galet et al., 2023; Peterson et al., 2012).

Post-Intervention Evaluation

Post-intervention evaluation occurred in week eight using the same assessment tools administered during baseline (excluding the demographic survey). Open-ended feedback was also solicited during post-assessment discussions to gather informal insights on program effectiveness and areas for improvement. These comments were used descriptively to inform interpretation of findings in the discussion but were not formally analyzed.

Data Analysis

Feasibility indicators were summarized descriptively and judged as met or not met against the prespecified thresholds. Quantitative outcome measures were analyzed using descriptive and inferential statistics. Medians summarized baseline and post-intervention scores on the TUG, 30-Second Chair Stand, ABC, and FES. To characterize variability in this small, non-normally distributed sample, interquartile ranges (IQRs) were calculated for all outcome measures. To illustrate individual variability and change over time, participant-level paired plots were generated for all outcome measures (TUG, 30-Second Chair Stand, ABC Scale, and FES).

Given the small sample size (n = 6) and non-normal distributions, Wilcoxon signed-rank tests (two-sided, $\alpha = .10$) were used to compare pre- and post-intervention scores. Beyond hypothesis testing, effect sizes (reported as r) for paired change were computed and interpreted using conventional thresholds (≈0.10 small, ≈0.30 moderate, ≥0.50 large) (Kazis et al., 1989). No adjustment for multiple comparisons was applied, consistent with the feasibility focus**.** Given the exploratory design, results were interpreted to inform future occupation-centered research rather than to establish causal inference. All analyses were conducted using SPSS and Microsoft Excel.

RESULTS

This section presents feasibility outcomes (recruitment, retention, fidelity, acceptability, and barriers) as well as exploratory preliminary results from standardized outcome measures (Timed Up and Go Test, 30-Second Chair Stand Test, Activities-Specific Balance Confidence Scale, and Falls Efficacy Scale). These quantitative results are exploratory and intended to identify potential signals of change to inform future trials, rather than to infer effectiveness.

Feasibility

All a priori feasibility benchmarks were met (Table 2). Recruitment and retention were strong, with six of seven participants completing the program (86%).

Table 2: Feasibility Indicators, Benchmarks, and Observed Values

(n = 7 enrolled; n = 6 completed)

Indicator	Benchmark (a priori)	Observed in this study	Met?
Recruitment	≥6 enrolled within 1 week	7 enrolled within 1 week	Yes
Retention	≥80% complete sessions + post-test	6/7 (86%) completed all sessions and post-testing	Yes
Attendance	Median ≥4/6 sessions	Median = 6/6 sessions (100% attendance)	Yes
Fidelity	≥85% core components delivered per session	All 6 sessions delivered by single facilitator; 100% core components verified via checklist	Yes
Acceptability	≥70% positive feedback and ≥1 behavior change	Majority reported home safety changes; positive feedback	Yes
Safety	0 serious adverse events	0	Yes
Barriers/Facilitators	No cancellations due to barriers	Condensed 6-week timeline identified as barrier but managed without cancellation or protocol deviation	Yes

Fidelity was maintained through consistent delivery by a single facilitator, and attendance was high; all six participants attended all sessions. Informal feedback indicated the program was well-received, with participants adopting safety-oriented behaviors such as addressing home hazards. Barriers included the condensed six-week schedule; these were managed without session cancellation or protocol deviation.

Preliminary Outcomes

Functional mobility (Timed Up and Go Test)

The median decreased from 14.00 s to 11.00 s (pre-test IQR = 6; post-test IQR = 4), Z = −1.807, p = 0.071, r = 0.74 (large). Two participants moved from above to below the commonly used 12-second risk threshold. Participant-level paired data are presented in Figure 1.

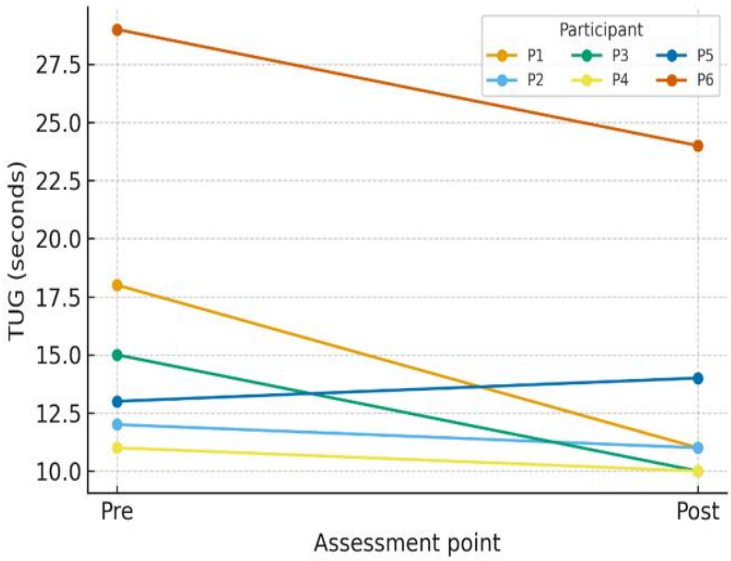

Figure 1: *Participant-level Paired Plot for the Timed Up and Go (TUG)Test*

Lower body strength (30-second Chair Stand Test) The median increased from 7.50 to 9.50 repetitions (pre-test IQR = 3; post-test IQR = 5), Z = −0.276, p = 0.783, r

= 0.11 (small). Participant-level paired data are presented in Figure 2.

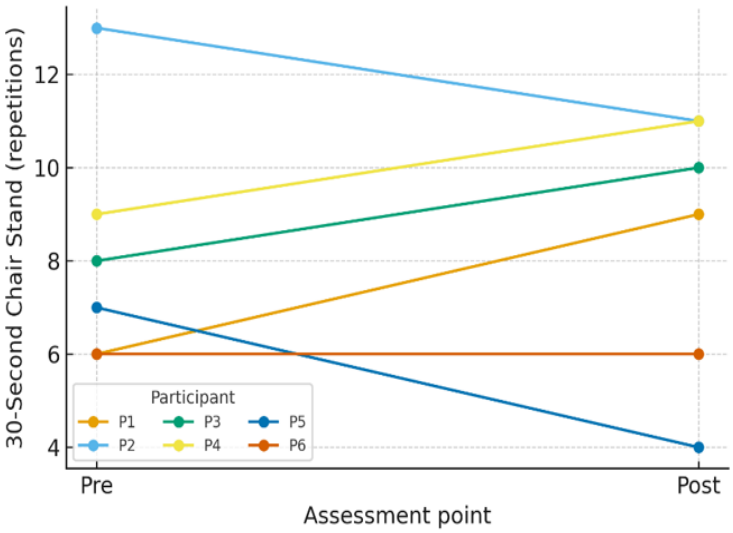

Figure 2: *Participant-level Paired Plot for the 30-second Chair Stand Test*

Balance confidence (ABC Scale)

The median increased from 73.50% to 77.75% (pre-test IQR = 16; post-test IQR = 14), Z = −0.734, p = 0.463, r = 0.30 (small–moderate). Participant-level paired data are presented in Figure 3.

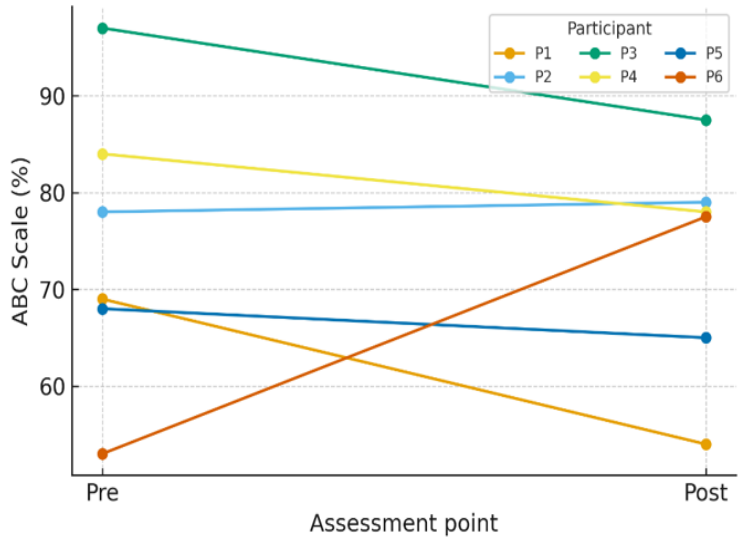

Figure 3: *Participant-level Paired Plot for the ABC Scale*

Fear of falling (FES Scale)

The median decreased from 16.50 to 15.00 (pre-test IQR = 12; post-test IQR = 10), Z = −0.405, p = 0.686, r = 0.17 (small). Participant-level paired data are displayed in Figure 4 on the next page.

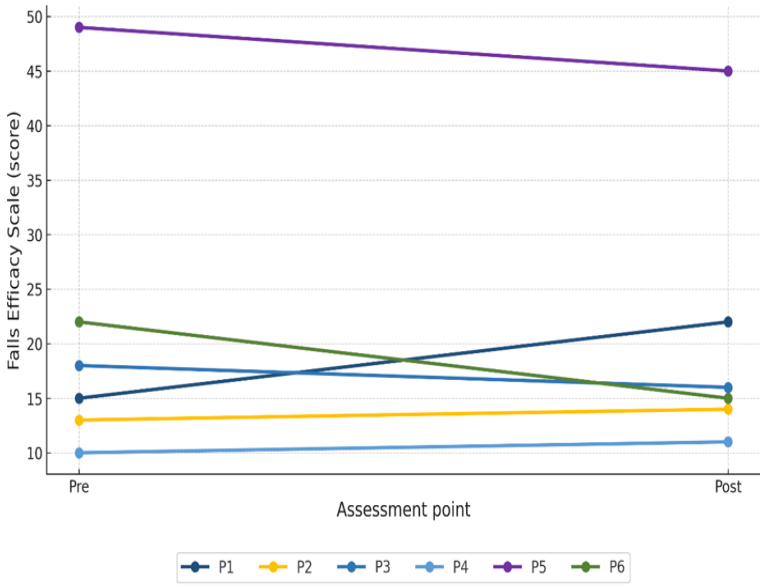

Figure 4: *Participant-level Paired Plot for the Falls Efficacy Scale*

DISCUSSION

This pilot study suggests that an occupational therapy–led fall prevention program can be implemented in a community-based setting, with high retention and positive participant feedback. Six of seven participants completed the program (86% retention), and informal reports indicated that participants made practical safety-oriented changes such as taping down rugs, using non-slip mats, and reducing clutter in walkways. These findings extend prior evidence supporting sustainable, community-based models of fall prevention by illustrating how occupational therapy–led programming can be feasibly integrated into existing service structures (Elliott & Leland, 2018; Lee & Yu, 2020).

A distinctive contribution of this pilot lies in its occupational therapy lens. Consistent with previous research, occupational therapy integrates physical activity with education and environmental modification to address both performance-based and contextual factors (AOTA, 2020; Elliott & Leland, 2018; Peterson et al., 2012). This approach reflects the Person–Environment–Occupation–Performance (PEOP) model and is consistent with World Falls Guidelines advocating multifactorial, individualized interventions (Christiansen & Baum, 1997; van der Velde et al., 2025). By embedding behavior change strategies and environmental adaptations alongside mobility training, occupational therapy addresses gaps not consistently covered in broader fall prevention literature and offers a pathway to reduce injuries, preserve independence, and lower costs (Ong et al., 2021; Pillay et al., 2024).

This framing explicitly links practical program elements to occupational science theory clarifying the pathway from intervention ingredients to participation and wellbeing (Wilcock, 1998). Interpreted through the doing–being–becoming–belonging lens, mobility practice and home-safety actions (doing), increased confidence (being), emergent routines (becoming), and mutual encouragement (belonging) illustrate how an occupation-focused approach supports participation alongside safety (Hitch & Pepin, 2021).

Participants reported applying safety strategies in daily activities and feeling more confident during routine tasks. Taken together, these findings suggest that occupational therapists can screen for fall risk, embed balance and strength practice within ADLs and IADLs, implement targeted home and community environmental modifications (including device selection and fit), and integrate therapist-led groups within community services (AOTA, 2020; Elliott & Leland, 2018). These peer processes also point to community-level impact, as mutual support and shared routines may diffuse safety norms beyond the individual. This interpretation aligns with occupational science, which positions occupation as both a means and an end to enhancing wellbeing, belonging, and identity across contexts (Hitch & Pepin, 2021; Wilcock, 1998). By situating mobility and safety within this framework, the program demonstrates how occupational therapy can operationalize occupational science concepts in community health practice.

Preliminary outcomes from standardized measures should be interpreted with caution. Median Timed Up and Go (TUG) improved from 14.00 to 11.00 seconds, with two participants moving from above to below the commonly used 12-second fall-risk threshold (Podsiadlo & Richardson, 1991). Although no measure reached conventional statistical significance at $\alpha = .05$; the TUG change met the prespecified exploratory $\alpha = .10$ criterion, indicating a potential signal to warrant further investigation. These heterogeneous response patterns are expected in a small feasibility sample and reinforce that the findings should be viewed as exploratory signals to guide future, adequately powered trials rather than as evidence of effectiveness. The observed shifts align with prior evidence that exercise-based programs can improve mobility and strength, although the small sample ($n = 6$) and condensed duration limited statistical power (Granacher et al., 2013; Liu-Ambrose et al., 2019; Sherrington et al., 2017).

Implementation insights further highlight the adaptability of the program. Partnerships with community organizations and primary

care touchpoints may strengthen referral pathways and continuity, supporting dissemination, and sustainability for occupational therapy-led community programs (Peterson et al., 2012). The condensed six-week format reflected site scheduling and academic timelines, which limited opportunities for extended practice but demonstrated how occupational therapy-led models can be integrated into existing community-based care structures. This pragmatic fit is important where resources are constrained, and it illustrates how occupation-focused group formats can be tailored to local contexts (van der Velde et al., 2025).

Participant feedback, though informal, suggested meaningful translation of program content into daily life. Environmental modifications, heightened awareness of fall risks, and more cautious decision-making were reported. The small, non-significant decrease in FES suggests a modest improvement in perceived fall risk; within a self-efficacy framework, such shifts may help enable participation, although confirmatory qualitative data were not collected in this pilot (Powell & Myers, 1995; Tinetti et al., 1990).

Several limitations should be acknowledged. The small sample (n = 6) and absence of a control group limit generalizability and statistical power. The predominance of female participants may further limit the generalizability of findings to older adult men; future studies should recruit larger and more gender-diverse samples to enhance representativeness and external validity. Although insurance status was not collected, community-level data indicate variability in economic and healthcare access within Newark, Delaware. Future research should examine how socioeconomic and insurance-related factors influence participation and generalizability in community-based fall prevention programs. The short program duration reduced opportunities for skill consolidation and habit formation. Fidelity was self-assessed rather than independently monitored, which may introduce rater bias. Acceptability feedback was informal and not collected through a structured qualitative protocol. Finally, the single-facilitator model may limit transferability to settings with different staffing or workflows.

These implementation insights provide direction for a larger-scale study. Future work should test scalability across multiple facilitators and community sites to determine consistency, training needs, and implementation fidelity. Extending the intervention beyond six weeks and incorporating structured follow-up would better evaluate sustained behavior change. In addition, structured, theory-informed qualitative methods, such as focus groups or semi-structured interviews, are needed to capture mechanisms of change and deepen understanding of participant experience. Together, these insights point toward a next-phase design emphasizing mixed methods, multi-site implementation, and longer-term outcomes to enhance rigor and ecological validity.

Future research should use larger samples, longer intervention periods, and mixed methods to capture both outcomes and participant experience. Qualitative work under an occupation-wellbeing lens could clarify how group processes, reciprocity, and belonging evolve through participation. Trials should specify core occupational therapy components within multifactorial programs and test high-risk subgroups, for example those with dementia, neurological conditions, or experiencing transitions to long-term care. At least six-month follow-up is warranted to assess

sustained behavior change. For practice, implementation studies on referral pathways, facilitation strategies, and community partnerships can support scale-up and equitable access. Theoretically, linking performance skills, environmental adaptation, and social participation would sharpen how occupation-centered fall prevention contributes to well-being. Ultimately, these findings should be understood as preliminary signals within a feasibility framework, rather than evidence of intervention effectiveness.

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CONCLUSION

This pilot study demonstrated the feasibility and acceptability of an occupational therapy–led, occupation-based fall prevention program for community-dwelling older adults. High retention, full attendance, and reported safety behavior changes indicate successful implementation in community settings. Integrating physical activity, client-centered education, and environmental modification highlights occupational therapy's distinct contribution to multifactorial fall prevention. Although exploratory, observed trends suggest potential to enhance both mobility and participation, supporting autonomy, safety, and social connection.

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