Table 2: Overview of the randomized controlled trials on multifactorial interventions in the hospital setting, papers included in Cameron (2018) and Morris (2022)

Author	Year	Cameron (2018)	Morris (2022)	Participants	Intervention
Aizen	2015	Cameron (2018) stated that: "*findings of this study were not pooled as some aspects of the study methodology and data collection could not be confirmed*"	X	Geriatric rehabilitation N = 712 Mean age: 80.8 – 84.6	Multifactorial intervention consisting of environmental modification, assistive device, patient education, staff education, fall risk assessment and care plan.
Barker	2016	X	X	Acute medical and surgical wards from 6 hospitals N = 31411 Median age: 67	Multifactorial intervention: 6-PACK program comprising a 9 item falls risk assessment tool and delivery **of one or more of six interventions** to high risk patients: 1) Placement of a 'falls alert' sign above the patient's bed. 2) Supervision of patients while in the bathroom. 3) Use of a low-low bed 4) Ensuring that the patient's walking aid is within reach at all times. 5) Establishment of a toileting regimen. 6) Use of a bed/chair alarm when the patient is positioned in the bed/chair. Staff education integral to implementation. Nurses were asked to update the fall risk tool for each of their patients each shift and to apply a falls alert sign and one or more of the remaining 6-PACK interventions to patients classified as being at high risk
Cumming	2008	X	X	Acute and subacute wards in 12 hospitals N = 3999 Mean age: 79 ± 12.8	**Targeted multifactorial intervention**: a nurse and physiotherapist each worked for 25 hours per week for 3 months in all intervention wards. Provided risk assessment of falls, staff and patient education sessions, drug review, arranged walking aids, eyewear, modification of bedside and ward environments, increased supervision, liaison with staff about confusion and foot problems, an exercise program, and sock alarms for selected patients (maximum of 2 per ward) who staff considered unsafe to walk unsupported
Haines	2004	X	X	Subacute wards N = 626 Mean age: 80 ± 9	Targeted falls risk prevention program **based on identified falls risk** (Peter James Centre Falls Risk Assessment Tool) in additional to usual care. Potential interventions were: 1) supervised exercise program: 45-minute sessions 3 x per week from commencement of intervention until

					discharge. Exercises comprised gait, balance and coordination + strengthening/resistance + 3D (Tai Chi). Exercises were individually tailored. Exercises were delivered by physiotherapist 2) falls risk alert card 3) up to four educational sessions from occupational therapist (OT) at bedside to individual participants of up to 30-minute duration 4) hip protectors
Healey	2004	X	X	Elderly care wards (acute and subacute) N = 1654 Mean age: 81.3	**Targeted risk factor reduction care plan** for patients with a history of falls or a near fall during admission. Based on assessment (and subsequent referral/action) relating to: eyesight (referral to ophthalmologist); medications check for sedatives, anti-depressants, diuretics, polypharmacy, etc (medical review of benefit vs harm); lying and standing blood pressure (advice to participant and referral to medical staff); ward urine test (mid-stream urine if positive for nitrites, blood or protein); difficulty with mobility (referral to physiotherapist); review of bed rail use; footwear safety (advice on replacement); bed height (kept at lowest height); position in ward (placing high risk patients near nurses' station); environmental causes (act to correct); nurse call bell (explained and in reach)
Hill	2015	X	X	Wards in rehabilitation or geriatric evaluation and management units in hospitals. N = 3121 Mean age: 82	**Individualised fall education program**. Safe Recovery program for patients and staff. For patients, an individually-tailored multimedia falls prevention educational package (DVD and workbook) with further face to face follow-up education (including workbook completion and goal setting) with a health professional was provided. Aimed to alert patients to their personal risk of falls, raise their knowledge about falls epidemiology and falls prevention, and to motivate them to engage in falls prevention strategies. Patient education sessions ranged between 15 and 35 minutes with 1-4 sessions per patient. Staff training in the week of the start of the intervention on their unit and feedback to staff weekly, 56% of patients in the intervention arm were eligible to receive the intervention based on their cognitive status.