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**Preventing Falls and
Harm from Falls
in Older People**

**Best Practice Guidelines
for Australian
Community Care**

September 2024

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Preventing falls and harm from falls

The *Preventing Falls and Harm from Falls in Older People: Best Practice Guidelines for Australian Community Care* (Falls Guidelines for Community Care) is a support resource based on the *Falls Guidelines for Community Care Reference Document*. They will be published as part of a suite of resources

The Falls Guidelines for Community Care has been developed for health professionals, primary and community providers and the aged care workforce delivering care to older people in Australian community settings. Community settings include older people's homes and places where community care and services are delivered.

The Falls Guidelines for Community Care outlines the recommendations and good practice points for implementing person-centred, fall prevention interventions in community settings. This includes:

- providing fall risk screening and assessment
- tailoring fall risk interventions to address each risk factor
- minimising harm from falls and
- delivering post-fall management.

Recommendations and Good practice points

Recommendations are based on evidence from intervention trials in community settings with falls and/or falls injuries outcomes. The associated level of evidence is aligned to the modified GRADE approach used by the 2022 World Falls Guidelines:

- 1 indicates a strong recommendation
- 2 indicates a conditional recommendation
- A-C indicates high, intermediate, low-quality evidence respectively.

Good practice points guide all aspects of care of older people in the community relevant to falls and fall injury prevention and are based on research and expert opinion on best practice.

All members of the multidisciplinary team have a key role to play in preventing falls

'A fall is an event which results in a person coming to rest inadvertently on the ground or floor or other lower level.' World Health Organization.

Falls are a significant cause of harm to older people living in the community. Falls are a common reason for older people to present to the emergency department and also occur after admission to hospital. Health professionals, primary and community care providers and the aged care workforce collaborate in fall prevention (relative to their scope of practice or role) and engage with the older person and carers.

Effective fall prevention involves a multifactorial approach using a combination of interventions tailored to the person based on an individual fall risk assessment. Using any one intervention on its own is unlikely to reduce the risk of falling.

The content of the Falls Guidelines for Community Care should inform tailored fall prevention interventions to address the older person's fall risk. Multiple health professionals and workers, along with carers and family may be involved in fall prevention for older people living in the community. Not all of the intervention categories include a recommendation. The order of interventions presented in this document does not imply importance of one over another. Where specific health professions are named, this has been informed by evidence.

Older people

Older people are defined as those aged ≥ 65 years. For older Aboriginal and Torres Strait Islander peoples the age ≥ 50 years is used, reflecting the life expectancy gap between First Nations and non-First Nations Australians and the lower proportion of First Nations people aged ≥ 65 years.

Further information on best practice in fall prevention

Refer to the *Falls Guidelines for Community Care Reference Document* for more detailed information on all aspects of the content of the Falls Guidelines for Community Care.

Information on [falls and fall injuries in Australia](#) and [involving older people in fall management](#) are provided at the end of this document.

Preventing falls, harm from falls and maximising mobility to prevent functional decline for older people is an important focus of the strengthened [Aged Care Quality Standards](#) for aged care providers who are registered to provide clinical care.

Separate Falls Guidelines and Reference Documents have been developed for hospitals and residential aged care settings.

Terminology

The terms fall and falls may be used interchangeably. A glossary of key terms is included in the Falls Guidelines for Community Care Reference Document.

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Key messages of the Falls Guidelines for Community Care

- **Falls are a big risk.** Falls are a significant cause of harm to older people.
- **Improvements are required.** The strengthened Aged Care Quality Standards provide improved focus on preventing falls and harm from falls for older people, as recommended by the Royal Commission into Aged Care Quality and Safety.
- **Prevention is key.** Many falls can be prevented.
- **Prevention is everyone's responsibility.** Fall and injury prevention need to be addressed from an individualised, multidisciplinary perspective as well as through community-wide prevention strategies.
- **Partner with older people, carers and family.** Engaging older people, carers and family (to the extent the older person chooses) is an integral part of preventing falls and minimising harm from falls. Support older people to identify goals of care and share decision making about fall prevention interventions.
- **Support coordinated, multidisciplinary care.** Collaborate with the multidisciplinary team to support good clinical care, fall prevention and minimising harm.
- **Managing fall risk factors benefits the whole person.** Managing many of the risk factors for falls, such as delirium, medicines, balance problems, poor vision, incontinence and dizziness, will have wider health benefits for the older person beyond fall prevention.
- **Older people with delirium are at increased risk.** Preventing and managing delirium is important for prevention of injuries from falls.
- **Medicines is a common cause of falls.** A medication review is an important part of fall presentation and assessment.
- **Ensure strategies are resourced and ongoing.** To be effective, fall prevention strategies need to be adequately resourced, monitored and reviewed regularly for effectiveness. This includes a trained, skilled and adequately staffed workforce and access to safe and appropriate equipment and aids for the older person.
- **Target functional mobility.** All older people should undertake exercise that targets balance and functional mobility to prevent falls and harm from falls.
- **Exercise is important.** Specialised fall prevention exercise programs can prevent falls in older people with balance and gait problems.
- **Tailor interventions to the person.** Multifactorial interventions, where a combination of interventions is tailored to each older person are effective for reducing falls in the community.
- **Single interventions can target risk factors.** Falls can be prevented by implementing single interventions that address particular risk factors. For example, reducing medicines that increase fall risk, podiatry for foot pain and surgery for cataract.
- **Home safety visits are beneficial.** Home safety visits from an occupational therapist can prevent falls in older people at high-risk of falling.
- **Review and report every fall.** Determine how and why a fall may have occurred, assess the older person for new fall risks and implement actions to reduce the risk of another fall. The consequences of falls resulting in minor or no injury are often not reported.

- **Engage with the older person** to help identify and manage an increased fear of falling and reduce the risk of falls.

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1 Fall Risk Screening and Assessment

The risk of falls, frequency of falls and the severity of fall-related injury increases with age. As falls are not inevitable, fall-risk screening and assessment tools can help predict, prevent and manage a fall.

Fall risk screening is a quick process that aims to identify people at increased risk of falling and helps determine if a more detailed fall risk assessment is required.

Fall risk assessments aim to identify factors that increase fall risk for a person that may be addressed through a fall intervention.

Chapter 6 of the *Falls Guidelines for Community Care Reference Document* outlines the fall risk factors present in the community and the associated fall risk assessment tools.

Recommendations

Education and exercise: Provide older people at increased risk of falls (1+ falls per year) home and community safety education in addition to exercise. (Level 1A)

Tailored multifactorial interventions: Provide older people at high risk of falls (2+ falls per year) with an individualised assessment by a health professional to inform tailored fall prevention interventions. Interventions include exercise, home safety, assistive devices, medication reviews, interventions to maximise vision, podiatry and strategies to address concerns about falling, anxiety, depression and cognitive impairment. (Level 1B)

Good practice points

- Engage with older people to identify their fall risk, goals of care and fall prevention interventions. Managing risk factors including delirium, balance problems, vision and medicines that increase the risk of falling have benefits beyond fall prevention.
- Involve general practitioners in fall risk assessment and multidisciplinary care planning.
- Facilitate access to appropriately qualified health professionals and evidence-based services for fall prevention that support older people to maintain independence and undertake reablement.
- For older people with a fear of falling, facilitate access to prescribed exercise, cognitive behavioural therapy and occupational therapy as part of a multidisciplinary approach.
- Ensure all health professionals and aged care workers involved in the care of older people complete ongoing education about fall risk and fall prevention.
- Support the use of telehealth consultations to facilitate fall prevention interventions for older people when appropriate and available.
- Support older people to choose a balanced diet that contains sufficient protein to maintain muscle mass, include potassium, calcium, vitamin D, dietary fibre and vitamin B12 and contain little to no added sugar, saturated fats and sodium. Facilitate access to a dietician when required.
- Facilitate access to meal assistance for older people who request or require help with eating and drinking to support nutritional intake and hydration.
- Support behavioural strategies and sleep hygiene to help regulate sleep-wakefulness cycles of older people and improve sleep quality.
- Support older people's choice to restrict alcohol consumption to within [guideline levels](#).

- Promote regular and effective communication with the multidisciplinary team caring for older people at risk of falls, including the older person and their carers and family (to the extent the older person chooses).

Fall risk screening

- General practitioners, health professionals, primary care providers and aged care workers should ask older people at least once every year about their experience of falls and how they proactively manage their fall risk.
- Screen all older people annually for their fall risk using a validated tool.
- Use fall risk screening to guide a detailed fall risk assessment and related intervention/s with the older person. Discuss the outcomes of assessment with the older person, carers and family (to the extent the older person chooses).
- Assess older people who have fallen in the past year with a simple, validated test of balance or gait on a fall risk screening tool. For older people who perform poorly, conduct a detailed assessment to identify contributory fall risk factors.

Fall risk assessment

- Undertake a comprehensive fall risk assessment to identify the factors contributing to an increased risk of falling, including cognitive impairment.
- Develop an individualised plan for the older person to prevent falls and harm from falls. Ensure delirium prevention, assessment and management is considered as part of falls prevention.
- Involve the older person, carers and family (to extent the older person chooses). They have an important role in fall prevention.
- Implement interventions to systematically address the older person's fall risk factors identified through the fall risk assessment. Assessments are only useful when supported by appropriate interventions related to the risks identified.
- Review and evaluate the fall prevention interventions to ensure they are tailored and effective, in partnership with the older person, carer and family (to the extent the older person chooses).

2 Balance and Mobility

Most falls occur due to a loss of balance while a person is upright or walking. Increasing age, inactivity, disease processes and muscle weakness are factors that contribute to impaired balance. Older people may compensate for poor balance by walking more slowly, varying step length and timing, and/or adopting a conservative gait, which increases the risk of falling.

Chapter 7 of the *Falls Guidelines for Community Care Reference Document* provides more detailed information about fall prevention interventions and assessing balance, mobility and strength in older people.

Recommendations

Ongoing exercise for all: Support all older people to undertake 2-3 hours of exercise per week on an ongoing basis to prevent falls. Primarily target balance and mobility and strength training. Ensure appropriately trained health professionals (e.g. physiotherapists, exercise physiologists or osteopaths) or instructors design and deliver exercise programs. (Level 1A)

Cognitive impairment: Support older people with mild cognitive impairment or mild to moderate dementia to undertake exercise to prevent falls if they choose to (Level 1B).

Low risk of falls: Support older people at low risk of falls (less than one fall a year) to attend community exercise or safely undertake home exercise. (Level 1A)

Increased risk of falls: Provide older people at increased risk of falls (1+ falls per year) with individualised exercise programs. Supervision or assistance from an appropriately trained health professional or instructor may be required to ensure the older person exercises safely and effectively. (Level 1A)

Good practice points

- Support older people to consider exercise programs to prevent falls such as group exercise classes, tai chi and strength and home balance training.
- Consider including reactive balance training in fall prevention exercise programs for older people as it is highly task-specific to preventing falls. Cognitive-motor training such as exergames could also be considered.
- Use assessment tools to:
 - assess whether the older person is at high risk of falling
 - quantify the extent of balance and mobility limitations and muscle weakness
 - guide exercise prescription
 - measure improvements in balance, mobility and strength.
- Partner with the older person to develop individualised exercises that focus on maintaining the balance and movement required for functional tasks in their environment. This includes sit-to-stand, squats, reaching while standing, standing with a narrower base of support, stepping and walking in different directions, speeds, environments and while dual tasking. Weights can be added to some exercises to increase difficulty.
- Support older people to exercise choice and dignity of risk to achieve their mobility and functional goals, maintain independence and quality of life.
- Ensure exercises prescribed for the older person are challenging (to enhance neural, muscular and skeletal function), safe (to prevent injuries) and achievable (for sufficient dose and sense of mastery). Review and progress the older person's exercises regularly to ensure that an optimal level of difficulty is maintained.
- Consider a life-course approach to physical activity and promote activities that build strength and balance, particularly among people in middle-age.

3 Cognitive Impairment

Cognitive impairment, including delirium and dementia, is a major risk factor for falls. Delirium is more common when an older person is acutely unwell. Cognitive impairment may directly influence a person's ability to evaluate and respond to their environment and safely carry out everyday activities.

Although increased age is the strongest risk factor for cognitive impairment, people at any age can have cognitive impairment due to acquired brain injury, mental health conditions and other pre-existing conditions.

Chapter 8 of the *Falls Guidelines for Community Care Reference Document* provides detailed information about dementia and delirium, the fall risks associated with cognitive impairment and tools for assessing a person's cognitive status.

Good practice points

- Ensure people with cognitive impairment have a comprehensive fall risk assessment on commencement of care.
- Ensure fall and fall injury prevention interventions are provided to people with cognitive impairment (to the extent the older person chooses). Modify interventions as appropriate to maximise feasibility and efficacy.
- Regularly reassess the cognitive status of older people and when there is a change in their condition, including after a fall.
- Use a validated tool such as the 4AT to assess older people for delirium, particularly when there is an acute change in cognitive function. Start treatment based on the cause when it can be identified.
- When delirium has been identified, ensure that the multicomponent interventions recommended for preventing and managing delirium are in place, including involving the substitute decision-maker, family or carers and modifying the environment. Use the Australian [Clinical Practice Guidelines for the Management of Delirium in Older People](#). See the [Delirium Clinical Care Standard](#). Consider sepsis as a cause, see the [Sepsis Clinical Care Standard](#).
- Undertake detailed assessment of older people with gradual-onset, progressive cognitive impairment to determine diagnosis. Identify and address reversible causes where possible. Use the Australian [Clinical Practice Guidelines and Principles of Care for People with Dementia](#)
- Involve older people with cognitive impairment and their substitute decision-makers in supported decision-making about fall prevention interventions. Carers and family who know the older person may suggest ways to support them. Ensure they are included to the extent that the older person chooses.
- Support information sharing about exercise and fall prevention recommendations with the older persons' carers and family (to the extent that the older person chooses), to support continued engagement and participation in daily living activities.
- For people with cognitive impairment, use [reasonable adjustments](#) to implement the *Falls Guidelines for Community Care*. Reasonable adjustments should include (but are not limited to):
 - Employing dementia enabling techniques to create a physical environment that promotes people living with dementia to feel supported and engaged.
 - Using tailored communication approaches to encourage the person's participation in decision-making and care planning.

- Involving the person's family and carers in the assessment and design of fall prevention intervention to the extent the person chooses.

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4 Medicines

There is a recognised association between medication use and falls in older people.

An older person's risk of falls may increase with the use of certain medicines, polypharmacy, inappropriate prescribing, medicine side effects and pharmacokinetic and pharmacodynamic changes with ageing. Medicine classes that increase the risk of falling in older people include opioids, sedatives and hypnotics, neuroleptics and antipsychotics, antidepressants, benzodiazepines and certain classes of cardiovascular medications. A review of medication should be a core part of a fall risk assessment.

Chapter 13 of the *Falls Guidelines for Community Care Reference Document* details the classes of medicines which are likely to increase fall risk, principles of care in medicines safety and advice on relevant Australian professional practice standards and guidelines.

Recommendation

Medication review: Facilitate access to collaborative medication reviews by a general practitioner and credentialed pharmacist, in conjunction with the older person to minimise use of psychotropic medicines and other medicines that increase the risk of falls. (Level 2B)

Good practice points

- Ensure that a medical practitioner, credentialed pharmacist or prescriber takes a best possible medication history and reviews all the older person's medicines:
 - at least yearly
 - after a fall
 - after commencement of a new medicine
 - after a change in the older person's health status
 - after a dose or regimen change of a medicine.
- Facilitate access to a home medicines review for the older person undertaken by a credentialed pharmacist that includes an accurate history, reconciliation and review of the older person's medicines, with particular focus on medicines that impact on cognition, falls and osteoporosis. Consider adjusting, tapering or ceasing medicines that increase fall risk (sometimes referred to as fall-risk increasing drugs).
- Facilitate access for the older person to relevant health professionals to consider non-medicine strategies for behaviour support planning, promoting sleep and addressing anxiety, depression and pain. Psychotropic medicines should only be considered when the changed behaviours is causing significant distress or risk of harm to the person or others. Document the purpose and the plan for review. See [Psychotropic Medicines in Cognitive Disability or Impairment Clinical Care Standard](#).
- When medicines that increase fall risk are prescribed, medical or nurse practitioners should document the purpose of the medicine, ensure commencement at an age-appropriate dose, adjust doses slowly based on regular monitoring for efficacy and emergence of adverse effects, and document the plan for review. Advise older people who are taking medicines that increase fall risk about ways to reduce their likelihood of falling.
- Communicate any recent or proposed changes to a person's medicines regime to the multidisciplinary team at transitions of care.

5 Continence

Bladder and bowel symptoms, including urinary and fecal incontinence and nocturia (urge to urinate at night) can increase an older person's risk of falling. Older people may make extraordinary efforts to avoid an incontinent episode, which may increase their risk of falling.

Good continence care is person-centred, evidence-based and optimises the older person's dignity, comfort, function and mobility. Supporting older people to manage incontinence may improve overall care and reduce the risk of falls and harm from falls when included as part of an older person's multifactorial fall prevention program.

Older people are often reluctant or embarrassed to discuss issues around continence. Enquire routinely and sensitively about incontinence symptoms (rather than relying on the older person to raise the topic).

Chapter 9 of the *Falls Guidelines for Community Care Reference Document* provides detailed information about the incontinence risk factors associated with falls in the community, strategies to promote continence and reduce the risk of falls and advice on where to access resources to assist in managing incontinence.

Good practice points

- Ensure that a continence assessment is completed with the older person to identify and treat factors that can cause or contribute to incontinence. Implement interventions to minimise fall risk related to incontinence and facilitate access to a specialist continence service when required.
- Develop a plan with the older person that considers their needs and preferences for toileting. This may include continence aids.
- Identify and manage an older person's nocturia, frequency, difficulties mobilising to the toilet and issues with urinary tract function as part of a multifactorial approach to care. Escalate to a medical practitioner when required.
- Facilitate access to an occupational therapist (when required) to assess the older person sitting and standing from the toilet and the need for rails.

6 Feet and Footwear

Inappropriate footwear and foot problems are contributing factors to mobility impairment and are contributing factors to falls and fractures in older people.

Appropriate footwear can improve the mobility, balance and gait of an older person and reduce their risk of falling. Multifactorial fall prevention interventions which incorporate appropriately fitted and safe footwear reduce falls and fractures from a fall for older people in the community.

Chapter 10 of the *Falls Guidelines for Community Care Reference Document* details the characteristics of the best footwear for preventing falls, podiatry interventions and care strategies to improve foot condition and reduce falls, and advice on where to access additional resources.

Recommendation

Podiatry: Provide older people with foot problems or disabling foot pain with access to multifaceted podiatry intervention. (Level 1A)

Good practice points

- Assess foot problems and footwear-related risk factors for falls as part of an older person's individualised, multifactorial intervention for preventing falls. This includes ill-fitting or inappropriate footwear, foot pain and other foot problems.
- Provide older people with education and information on safe shoes, managing foot problems and improving foot care. Facilitate access to a podiatrist when required.
- Encourage the use of safe well-fitting footwear that includes:
 - heels that are low and square to improve stability
 - a supporting ankle collar to improve stability
 - soles with tread to prevent slips
 - easy fastening and only including laces if the person can tie them
 - firm soles to optimise foot position sense.

7 Syncope

Syncope is a brief loss of consciousness and is commonly described as fainting or passing out. Older people are more likely to experience syncopal events due to age-related physiological changes that affect their ability to adapt to changes in cerebral perfusion.

Chapter 11 of the *Falls Guidelines for Community Care Reference Document* details the main types of syncope, the principles of care for syncope and further information on the diagnosis and management of syncope.

Recommendation

Pacemakers: Facilitate access to a medical practitioner to treat older people diagnosed with the cardio inhibitory form of carotid sinus hypersensitivity with fitting of a dual-chamber cardiac pacemaker. (Level 2B)

Good practice points

- Ensure that older people who experience unexplained falls or episodes of collapse, including presyncopal or syncopal episodes (including postural hypotension) are urgently assessed by a medical practitioner to establish the underlying cause.
- Undertake a medication review, identifying medicines that may cause postural hypotension.

8 Dizziness and Vertigo

Dizziness is a term used to describe a range of sensations such as feeling lightheaded, foggy or unsteady. Vertigo is a sensation of spinning. The most common diagnosis for dizziness is benign paroxysmal vertigo.

The prevalence of dizziness is associated with an increased risk of falling in older people. Poor sensorimotor function, impaired balance control, anxiety and neck and back pain linked to dizziness and falls. Older people with dizziness are also at high risk of experiencing fall-related fractures.

Chapter 12 of the *Falls Guidelines for Community Care Reference Document* discusses how to assess dizziness and vertigo and the associated principles of care, and details different interventions which can reduce the symptoms of dizziness.

Good practice points

- Assess older people complaining of dizziness and vertigo for vestibular dysfunction, gait and balance problems, postural hypotension and anxiety.
- Assess the older person for postural hypotension with tests of lying and standing blood pressure.
- Facilitate access for a review of the older person's medicines regimen to identify any medicines contributing to dizziness or postural hypotension, including antihypertensives, antidepressants, anticholinergics and hypoglycaemics.
- Facilitate access to an appropriately trained medical practitioner or vestibular physiotherapist to assess dizziness and vestibular-related balance problems and implement interventions for benign paroxysmal positional vertigo including vestibular rehabilitation when indicated.

9 Vision

Older people with impaired vision are twice as likely to fall compared to older people without vision problems.

Chapter 14 of the *Falls Guidelines for Community Care Reference Document* discusses the eye diseases associated with an increased risk of falling, principles of care including eye screening tests, optimal and gradual prescription change and advice on where to get further information and helpful resources.

Recommendations

Cataract surgery: For older people with clinically significant visual impairment primarily due to cataract, facilitate timely referral to medical practitioner for cataract surgery in both eyes (unless contraindicated). (Level 1A).

Eyewear prescription: Advise active older people to use tinted single-lens distance glasses (rather than bifocal, multifocal or progressive lenses) when active outdoors. (Level 2B). When updating the older person's glasses prescription, limit the change in prescription where possible. (Level 2B)

Good practice points

- Include a vision test as part of an older person's fall risk assessment.
- Encourage older people to have annual eye examinations with an optometrist to maximise vision. Facilitate access to the optometrist when support is required.
- Implement strategies to maximise independence for older people who have visual impairment.
- Support older people who use glasses to have accessible, clean glasses and to wear them. If the older person has different glasses for reading and distance, encourage them to wear distance glasses when mobilising.
- If the older person has fallen, facilitate access to an optometrist or orthoptist for a detailed assessment and a fall-specific eye examination.

10 Hearing

Hearing impairment contributes to falls in older people as those with hearing impairments may fail to detect environmental hazards outside their line of sight. Balance, walking difficulties, impaired cognition and functional decline area also associated with hearing impairment and increase the risk of falling.

Chapter 15 of the *Falls Guidelines for Community Care Reference Document* discusses the evidence of hearing impairment in relation to fall risk and the principles of care in minimising the risk of falls by people with hearing loss.

Good practice points

- Encourage older people to have annual hearing tests with an audiologist to maximise hearing. Facilitate access to the audiologist when support is required.
- Implement strategies to maximise independence with older people who have hearing impairment. If the older person has fallen, facilitate access to an audiologist for a detailed assessment and fall-specific hearing examination.
- Use a pocket talker (a device that amplifies sound closest to the listener while reducing background noise) to communicate with an older person with a hearing impairment, as required.
- Encourage older people to wear their hearing aids when mobilising. Ensure that the hearing aids are working.

11 Environment

For older people who live in the community, about 50% of falls occur within their homes and immediate home surroundings. For those recently discharged home from hospital, approximately 70% of falls occur in the home or nearby.

Assessing how the older person functions within their environment and identifying any hazards that might cause the older person to fall will inform what behavioural and environmental factors need to be addressed to reduce the risk of falls.

Chapter 6 of the *Falls Guidelines for Community Care Reference Document* details the various tools which are available to assess older peoples' fall risk in community settings.

Chapter 16 of the *Falls Guidelines for Community Care Reference Document* discusses the principles of care in minimising environmental hazards to reduce the risk of falls by older people in community settings.

Recommendation

Home safety: Following a home safety assessment, provide individualised home safety interventions, delivered by an occupational therapist, for older people at increased risk of falls, including those:

- with severe visual impairment
- who have fallen in the past year
- who need help with everyday activities
- who have mobility impairment or use a mobility aid
- who have been recently discharged from hospital. (Level 1A)

Good practice points

- Facilitate access to an occupational therapist to assess older people at increased risk of falling for environmental or equipment needs and training to maximise safety.
- Consider how an older person navigates their environment as part of environmental assessments and interventions.
- Work collaboratively with the older person to develop and implement acceptable environmental modifications.
- Consider strategies, equipment and devices relevant to the older person to promote safety, detect falls and minimise a long lie on the floor following a fall.

12 Monitoring and Observation

Falls may be associated with delirium, restlessness, agitation, attempts to mobilise to the toilet, stand, turn and transfer, or due to reduced problem-solving abilities in people with dementia. Older people who live alone and sustain falls are at risk of spending prolonged periods on the floor following a fall.

Providing education to the older person, carers and family (to the extent the older person chooses) about their risk of falling and actions they can take to reduce this risk, could prevent falls and reduce harm from falls.

Chapter 17 of the *Falls Guidelines for Community Care Reference Document* outlines principles of care in monitoring and observing older people in minimising the risk of falls in Community Care and a range of monitoring and observation systems that could be implemented.

Good practice points

- Consider the monitoring and observation needs of older people with dementia or delirium. Engage with the older person, carers, family and other health and aged care providers who are involved to develop a plan of care to manage their risk of falls.
- Discuss the option of a personal alarm with an older person at increased risk of falls. When worn, the personal alarm can trigger an alert that an older person has fallen so that timely assistance can be provided.
- Discuss the options of electronic sensors, video or audio monitoring/ communication systems for the older person.

13 Restrictive Practices

Restrictive practices refers to any practice, intervention or mechanism that restricts the rights or freedom of an individual and is used to control or modify that individual's behaviour, including reducing a person's risk of fall. Restrictive practices include chemical restraint, environmental restraint, mechanical restraint, physical restraint and seclusion. If used, restraints should be the last option considered.

In Australia, the use of restrictive practices is strictly regulated and monitored to protect the health, rights and dignity of older people receiving aged care services. Restrictive practices should not be a substitute for supervision, inadequate staffing or lack of equipment.

Chapter 18 of the *Falls Guidelines for Community Care Reference Document* outlines principles of care in assessing the need for restrictive practices and considering alternatives in minimising the risk of falls by older people.

Good practice points

- When an older person exhibits changed behaviours (i.e. agitation or aggression), assess and respond to any immediate risks to the person or others, including increased risk of falls.
- Conduct a comprehensive assessment to identify possible causes of changed behaviours. Treat and/or manage any causes of these behaviours such as delirium, or unmet needs, including pain, thirst, hunger or feeling hot or cold. Non-medication strategies should be used as the primary strategies for managing changed behaviours.
- Ensure that a person-centred, effective behaviour support plan is developed in partnership with the older person, substitute decision-makers, carers and family to manage changed behaviours associated with cognitive impairment. This focuses on caring for the older person by understanding the cause of the behaviour, meeting any unmet needs and treating reversible causes.
- Restrictive practices refer to any practice or intervention that restricts the rights or freedom of movement and include the use of psychotropic medicines as chemical restraint. Restrictive practices must only be used as a last resort, in the least restrictive form and for the shortest possible necessary to prevent harm to the older person or others. Follow [legislative requirements](#) on the use of for restrictive practices and relevant national, local or state policies, procedures and regulations. See the [Psychotropic Medicines in Cognitive Disability or Impairment Clinical Care Standard](#).
- If alternatives to restrictive practices are exhausted, discuss options and explain the benefits and risks and document informed consent from the older person or substitute decision maker if use is agreed. In an emergency, if consent is not obtained, follow appropriate regulations. Document the rationale for using restrictive practices and the anticipated duration and criteria for cessation agreed on by the health practitioner and the multidisciplinary team.
- If a restrictive practice is used in preventing falls or harm from falls in the older person also continue with non-medication strategies.

14 Hip Protectors

Hip fractures are usually the result of a fall and are one of the more severe injuries associated with a fall.

Hip protectors are one approach to reducing the risk of hip fracture. Hip protectors aim to reduce the risk of hip fracture by absorbing or dispersing forces away from the hip if a fall onto the hip area occurs.

Chapter 19 of the *Falls Guidelines for Community Care Reference Document* outlines the evidence for the use of hip protectors in preventing hip fractures in older people, the types of hip protectors and the risks associated with their use, and the principles of care in using hip protectors to help prevent hip fractures in older people in the community.

Good practice points

- Consider hip protectors to reduce the risk of fall-related fractures for older people who fall frequently, have osteoporosis and /or a low body mass index.
- Assessment for hip protectors should consider the preferences of the older person, their mobility, cognition and functional skills, including their dexterity with dressing to determine whether they can use hip protectors independently.
- When an older person chooses to use hip protectors, health professionals teach older people and carers how to wear them correctly to ensure their effectiveness.
- Regularly check that the hip protectors:
 - are being worn, are comfortable and are in the correct position (issues with non-adherence due to discomfort or inconvenience is common)
 - are not causing pressure on the skin that may contribute to pressure injuries
 - do not impact on the ability of the older person to toilet independently
- Consider the use of hip protectors to reduce fall-related hip fractures as part of a multifactorial approach to preventing harm from falls.

15 Vitamin D and Calcium

Low vitamin D levels are associated with an increased risk of hip fracture from a fall and is significantly more common among older people with dementia and older people from culturally and linguistically diverse groups.

Vitamin D may prevent falls by improving muscle strength and maintaining bone mineral density. Improving calcium and protein intake has also been shown to reduce falls and harm from falls in older people. The main source of vitamin D is from skin exposure to daylight. Sourcing vitamin D from dietary intake alone is insufficient to achieve healthy levels of vitamin D.

Calcium is essential for building and maintaining healthy bones throughout life. A small amount of calcium is absorbed into the blood and used for the healthy functioning of the heart, muscles, blood and nerves.

Chapter 20 of the *Falls Guidelines for Community Care Reference Document* outlines the evidence for Vitamin D supplementation in preventing falls, including sun exposure, and the principles of care in using vitamin D as an intervention in preventing falls in older people.

Recommendations

Vitamin D supplementation: Support access to recommended doses of daily or weekly vitamin D supplements for older people deficient in vitamin D or with little sunlight exposure (i.e., less than 5-15min exposure, four to six times per week) unless contra-indicated. (Level 1B) Avoid high monthly or yearly mega doses of vitamin D as these can increase the risk of falls. (Level 1A)

Good practice points

- Consider the adequacy of vitamin D and calcium in an older person's diet as part of routine assessment of fall risk.
- Encourage older people to choose to include high calcium foods in their diet and exclude foods that limit calcium absorption where this is their choice.
- For older people with cognitive impairment who have difficulties taking a daily dose of vitamin D, facilitate access to a medical practitioner who can consider introducing a weekly dose preparation of vitamin D.
- For older people with insufficient dietary calcium intake, calcium supplementation should be restricted to a maximum dose of 500 – 600 mg elemental calcium per day. There is concern that calcium supplementation increases the risk of cardiovascular events.

16 Osteoporosis

For people with osteoporosis or osteopenia (low bone density), fracture risk increases with each additional fall. While a small proportion of falls result in fractures, most fractures occur as a result of a fall.

Fall prevention interventions that reduce the risk of falls in older people may prevent fractures, even if bone density is not altered.

Chapter 21 of the *Falls Guidelines for Community Care Reference Document* outlines the medicines shown to be effective as first-line treatments for osteoporosis and discusses the principles of care in managing osteoporosis in the context of minimising falls in older people.

Recommendation

Osteoporosis medicines: Facilitate access to prescribed osteoporosis medicines for older people with diagnosed osteoporosis or a history of low-trauma fractures, unless contra-indicated. (Level 1A)

Good practice points

- Develop strategies for strengthening and protecting the older person's bones to reduce bone injuries from falls. This includes improving muscle strength, optimising function and improving environmental safety.
- For all older people, facilitate access to an osteoporosis assessment.
- For older people who are at risk of falls or who have sustained a minimal trauma fracture, facilitate access to a medical practitioner for osteoporosis treatment.
- For older people with a history of recurrent falls, facilitate access to a bone mineral densitometry assessment / Dual Energy X-Ray (DXA) scan to identify possible osteoporosis.
- For older people who have difficulties following the correct and safe manner of taking some oral bisphosphonates, facilitate access to a medical practitioner to consider long-acting injectable osteoporosis medicines.
- For older people who are using osteoporosis treatments, facilitate access to co-prescribed vitamin D with calcium.
- To encourage bone health management in younger age groups, health professionals consider providing information and education about a life course approach to bone density management.

17 Post-fall management

All falls must be taken seriously and require an immediate response. Falls may be the first and main indication of another underlying and treatable condition in an older person. Older people who fall are also more likely to fall again.

All members of the multidisciplinary team, including aged care workers, the general practitioner, registered nurses and health professionals, should be aware of:

- what constitutes a fall
- what to do when an older person falls, or if an older person reports a recent fall
- what follow-up is necessary, including reporting and incident managing processes
- the need to reassess the older person for their risk of falls and harm from falls following a fall.

Chapter 22 of the *Falls Guidelines for Community Care Reference Document* includes a guide to managing the older person immediately after a fall, outlines what should be included in a community service's policy and practice guidelines and discusses important considerations for the older person after the fall including loss of confidence.

Good practice points

- Immediately after a fall, provide post-fall response, clinical care and escalation where required. In collaboration with the older person and carer, assess whether basic life support is needed and provide as required.
- Identify, investigate and report the cause and the consequences of the fall.
- Facilitate a comprehensive assessment for every older person who falls and implement immediate actions such as a medication review.
- Undertake a post fall analysis to inform evaluation of the older person's multidisciplinary care, including fall prevention interventions. Address any comorbidities and fall risk factors to reduce the risk of another fall and update the plan.
- At transitions of care for the older person, ensure communication of any falls or identification of fall risk with all relevant members of the multidisciplinary team. [See also Principles for safe and high-quality transitions of care.](#)
- Analyse falls data and delirium data to inform how improvements in practices and policies can prevent falls.
- If an older person has suffered a serious injury or death following a fall, conduct an in-depth analysis of the fall event.

Falls and fall injuries in Australia

For older people in Australia, falls are the leading cause of injury related hospitalisation and fall-related injury is a leading cause of morbidity and mortality for older people.

Many falls occur in situations where older people are undertaking their usual daily activities. In older people who live in the community, about 50% of falls occur within their home or close to home, with falls in public places and other people's homes also common. It is estimated that less than half of all falls are reported to a health professional.

Falls may increase the risk of health complications, including the likelihood of developing a fear of falling, a loss of confidence in walking and in some cases hospitalisation or entry to residential aged care service.

Aged care workers are ideally placed to have a role in fall prevention in supporting older people receiving community care and services who are at increased risk of falling.

Characteristics of falls

A person's risk of falling increases as their number of risk factors increases.

Older people receiving home and community care services are at increased risk of falling with the location of falls related to age, sex and frailty.

Risk factors for falling in the community

Intrinsic risk factors are factors that relate to a person's behaviour or condition, and include:

- Increased age
- History of previous falls
- Chronic medical conditions, such as stroke, Parkinson's disease and arthritis
- Polypharmacy and specific types of medicines such as psychotropic medicines
- Impaired balance and mobility
- Postural instability and muscle weakness
- Sensory issues such as impaired vision and peripheral neuropathy
- Dizziness
- Cognitive impairment, delirium and changes in behaviour
- Urinary frequency and incontinence
- Depression
- Low levels of physical activity
- Slow reaction time
- Fear of falling or loss of confidence walking
- Being female.

Extrinsic risk factors are factors that relate to a person's environment or their interaction with the environment, and include:

- Inappropriate footwear such as high heels or slippers
- Inappropriate use of glasses or changes in prescription
- Environmental risk factors, including hazards inside and outside the home.

It is important that the aged care workforce engages with older people to identify and address fall risk factors in the community to support safe person-centred care fall prevention.

Involving older people, carers and family in fall prevention

Partnering with older people in all aspects of their own care is central to safe, high-quality and person-centred care. Good clinical care can optimise an older person's quality of life, reablement and maintenance of function. Improved health and wellbeing supports older people to continue to participate in activities that are enjoyable and give life meaning.

Fall prevention interventions should be planned and delivered in a way that is culturally safe and trauma-aware, using healing informed care and tailored to the needs of each older person. Carers, family and substitute decision makers may play an important role in facilitating fall prevention and should be included as partners in the older person's care, to the extent that the older person chooses.

A range of health professionals, nurses, medical practitioners and home and community care workers may be involved as part of the multidisciplinary team. Communication with and between the multidisciplinary team, the older person and their carers and family is critical to effectively preventing falls and responding to change or deterioration in the older person's condition.

Best practice approach

Best practice approaches for health professionals and home and community care workers to support older people to partner in fall prevention include:

- Present the fall prevention message in the context of staying independent for longer.
- Be aware that the term 'fall prevention' could be unfamiliar or difficult to understand for many people and support the person's understanding through tailored communication.
- Identify older people's individual communication needs (including cognitive impairment) and preferences and providing information in a way they understand. This may include providing information in the person's own language, using alternative communication approaches such as written formats (e.g. easy read, easy English and accessible formats), multimedia (e.g. images, animation and video), and facilitating access to interpreters and translations.
- Identify older people's needs, goals and preferences and enable older people and their carers and families (to the extent that the older person chooses) to engage in discussions and decision-making about preventing falls.
- Support older people to exercise choice and dignity of risk in the context of an acceptable risk of falling to achieve their goals, maintain independence and quality of life.
- Find out what changes older people are willing to make to prevent falls and support the provision of appropriate options using shared and [supported decision making](#). This may include changes to the older person's behaviour, environment, clothing and footwear.
- Explore the potential barriers that make it difficult for older people to take action to reduce falls (such as low self-efficacy and fear of falling) and provide support to overcome these barriers.
- Develop fall prevention programs that are flexible to accommodate older peoples' individual needs, goals, circumstances and interests.
- Trial a range of fall and fall harm prevention interventions and review their effectiveness in partnership with older people and their carers and family.

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