

DRAFT

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

**Best Practice Guidelines
for Australian
Residential Aged Care Services**

September 2024

Contents

Preventing falls and harm from falls	3
Key messages of the Falls Guidelines.....	5
1 Fall Risk Assessment for Tailoring Interventions	6
Recommendation	6
Good practice points	6
2 Balance and Mobility	8
Recommendations	8
Good practice points	8
3 Cognitive Impairment	9
Good practice points	9
4 Medicines	11
Good practice points	11
5 Continence	12
Good practice points	12
6 Feet and Footwear	13
Good practice points	13
7 Syncope	14
Good practice points	14
8 Dizziness and Vertigo	15
Good practice points	15
9 Vision	16
Good practice points	16
10 Hearing	17
Good practice points	17
11 Environment.....	18
Good practice points	18
12 Monitoring and Observation.....	19
Good practice points	19
13 Restrictive Practices	20
Good practice points	20
14 Hip Protectors	21
Recommendation.....	21
Good practice points	21
15 Vitamin D and Calcium	22

Recommendations	22
Good practice points	22
16 Osteoporosis	23
Recommendation	23
Good practice points	23
17 Post-fall management	24
Good practice points	24

DRAFT

Preventing falls and harm from falls

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

The Falls Guidelines for RACS has been developed for health professionals and aged care workforce providing care to older people in Australian RACS.

The Falls Guidelines for RACS outlines the recommendations and good practice points for implementing person-centred fall prevention interventions in RACS. This includes:

- providing fall risk 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 the best available evidence. 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 RACS relevant to falls and fall injury prevention and are based on research and expert opinion on best practice.

Health professionals and the aged care workforce 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.

Minimising falls and harm from falls remain a key challenge for the quality care of older people who live in RACS. The risk of falls, frequency of falls and the severity of fall-related injury increases with age. Falls are a common reason for older people presenting to the emergency department.

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

The content of this Falls Guidelines for RACS should inform a RACS's fall and fall injury prevention program. Not all of the intervention categories include a recommendation. The order of interventions and strategies presented in this Falls Guidelines for RACS 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.

All people in RACS are at risk of falling so it is important that every person is assessed for their individual fall risk and the appropriate fall and fall injury interventions are implemented.

Further information on best practice in fall prevention

Refer to the *Falls Guidelines for RACS Reference Document* for more detailed information on all aspects of the content of this Guideline.

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

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](#) and apply to providers of RACS.

Separate Falls Guidelines and Reference Documents have been developed for hospital and community care settings.

Terminology

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

DRAFT

Key messages of the Falls Guidelines for RACS

- **Falls are a big risk.** Falls are a significant cause of harm to older people, particularly those living in residential aged care services (RACS).
- **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 and embedded across every aspect of care in RACS.
- **All people in RACS are at risk of falling.** Every person living in RACS needs to have their fall risk assessed on commencement of care and their fall prevention interventions regularly reviewed for safety and effectiveness.
- **Engage 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.
- **Provide adequate staffing and education.** Safe staffing levels and a trained and skilled workforce supports good clinical care in the prevention of falls and harm from falls. Provide tailored fall prevention education to workers, older people, carers and family to identify fall risk factors. Manage risk factors through a multifactorial fall prevention program.
- **Older people with delirium** are at increased risk. Preventing and managing delirium is important for prevention of injuries from falls.
- **Managing fall risks benefits the whole person.** Managing many of the risk factors for falls, including delirium, medicines, balance problems, poor vision, incontinence and dizziness will have wider health benefits for the older person beyond fall prevention.
- **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 access to equipment and aids.
- **Review every fall.** Determine how and why a fall may have occurred, reassess the older person to identify potential new fall risk factors and implement actions to address these risk factors and reduce the risk of another fall. Engage with the older person about the fall to help identify and manage an increased fear of falling and reduce the further risk of falls.
- **Report the fall.** RACS are required to collect data on falls and major injuries, and regularly report on these to the [National Aged Care Mandatory Quality Indicator Program](#). In some states and territories, a fall in a RACS that results in death must be reported to the state coroner.

1 Fall Risk Assessment for Tailoring Interventions

In RACS all older people should be considered at high risk of falls. On commencement of care, all older people should be assessed to identify their fall risk factors and determine the appropriate multifactorial fall prevention interventions for that older person. Fall risk screening is not applicable as all older people are at high fall risk of falls.

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

Chapter 6 of the *Falls Guidelines for RACS* outlines the fall risk factors present in RACS and the associated fall risk assessment tools.

Recommendation

Multifactorial fall prevention: Provide multifactorial fall prevention strategies as part of routine care for all older people. This should include:

- Regularly assessing both individual and service level fall risk factors, including assessment for environmental interventions and medication review.
- Developing a targeted and individualised fall prevention plan of care based on the findings of the older person's fall risk assessment.
- Providing education and engaging workers about preventing falls and harm from falls in older people. (Level 1A)

Good practice points

- Consider all older people to be at high risk of falls. Implement fall prevention strategies and interventions, informed by comprehensive multifactorial assessment and goals of care to minimise risk.
- Consider all people with mobility or cognitive disabilities to be at high risk of falls, regardless of age.
- Discuss risk of falls and fall prevention strategies with older people, carers and family (to the extent that the older person chooses).
- Ensure all health professionals and workers involved in the care of older people receive ongoing education about fall risk and fall prevention.
- Support the use of telehealth to facilitate fall prevention assessment and interventions for older people when appropriate and available.
- Support behavioural strategies and sleep hygiene to help regulate sleep-wakefulness cycles of older people and improve sleep quality. Minimise disturbing noise and disruptive care practices to optimise sleep duration and quality in older people.
- Ensure that older people are provided with healthy diets that contain 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.
- Provide meal assistance to older people who request or require help with eating and drinking to support nutritional intake and hydration.

- Support older people's choice to restrict alcohol consumption to within [guideline levels](#).
- Facilitate the involvement of the older person's general practitioner in care planning to maintain function and mobility, support reablement and ensure multidisciplinary care.
- Discuss risk of falls and fall prevention strategies with older people, carers and family (to the extent that the older person chooses).
- Ensure delirium prevention, assessment and management is considered as part of falls prevention.
- Promote regular and effective communication among members of multidisciplinary teams caring for older people at risk of falls and include family and carers (to the extent that the older person chooses).

DRAFT

2 Balance and Mobility

Most older people living in RACS have poor balance and mobility. Increasing age, inactivity, disease processes and muscle weakness are factors that contribute to impaired balance. Balance and mobility are likely to further deteriorate if older people become less active and rely on assistance to perform activities of daily living rather than being supported to maintain their independence. These factors contribute to the high rate of falls in older people in RACS.

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

Recommendations

Tailored exercise: Provide tailored supervised exercise to all older people who choose to participate. Ensure health professionals (e.g. physiotherapists or exercise physiologists) or appropriately trained instructors design and deliver the exercise programs. (Level 1B)

Continued exercise: Provide continued exercise for fall prevention as the effect of structured exercise programs diminishes over time once the program has ended. (Level 1A)

Good practice points

- Use assessment tools to:
 - quantify the extent of balance and mobility limitations and muscle weakness of the older person
 - guide exercise prescription for the older person
 - measure improvements in balance, mobility and strength in the older person.
- Facilitate older peoples' participation in effective and continued exercise programs that:
 - are tailored to the older person's abilities and preferences
 - include balance and strength exercises
 - are of moderate intensity
 - are sufficiently resourced, safe and engaging
 - are feasible to implement and accessible to all older people
 - include safe mobility and assessment of the need for walking aids.
- Determine and provide the level of hands-on assistance required for the older person's safe mobility.
- Support older people to exercise choice and dignity of risk to achieve their goals and maintain their independence and quality of life.
- Balance the risk and benefits of restricting an older person's activity and maintaining mobility to minimise deconditioning and functional decline.
- Consider the risk of falls and frailty in older people and younger people with mobility or cognitive disability.

3 Cognitive Impairment

Cognitive impairment, including delirium and dementia, is associated with increasing age and 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 RACS Reference Document* provides information on the fall risks associated with cognitive impairment, tools for assessing a person's cognitive status, and links to additional resources.

Good practice points

- Identify and assess the fall risk factors for people with cognitive impairment 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).
- Reassess the older person's cognition regularly 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.
- Where delirium has been identified, ensure that the multicomponent interventions recommended for preventing and managing delirium are in place for the older person, 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 and, where possible, identify and address reversible causes. Use the Australian [Clinical Practice Guidelines and Principles of Care for People with Dementia](#).
- Involve older people with cognitive impairment and substitute decision-makers in supported decision-making about which fall prevention intervention to use, and how to use them. Family and carers know the older person and may suggest ways to support them. Ensure the family and carers are included to the extent that the older person chooses.
- Support information sharing about exercise and other fall prevention recommendations with the older persons' carers and family (to the extent the older person chooses) to support continued engagement and participation.
- Implement models of care that enable adequate supervision, equipment and support, and responds to fluctuations in the older person's mobility, cognitive state, as well as the impact of changed behaviours on others.
- Use [reasonable adjustments](#) for people with cognitive impairment to implement the *Fall Guidelines for RACS*. Reasonable adjustments should include (but are not limited to):
 - employing dementia enabling techniques to create a physical environment that promotes older people living with dementia to feel supported and engaged
 - using tailored communication approaches to encourage participation in decision-making and care planning with the older person

- involving family and carers (to the extent the person chooses) in assessment and design of intervention strategies.

DRAFT

4 Medicines

There is a recognised association between medicines use and falls in older people. Medicines use in RACS is commonplace. 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 due to ageing.

Chapter 13 of the *Falls Guidelines for RACS 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.

Good practice points

- Ensure that a medical practitioner and/or a credentialed pharmacist takes a best possible medication history and reviews all the older person's medicines:
 - at least yearly
 - after a fall
 - after initiation of a new medicine
 - after a change in the older person's health status
 - after a dose or regimen change of a medicine
 - after admission to hospital or a rehabilitation service.
- Facilitate access to regular medication review, 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).
- Assess fall history and fall risk before using medicines that may increase fall risk. Medicines that can predispose to falls include psychotropics, (e.g. antidepressants, antipsychotics, benzodiazepines, opioids and some antihistamines). Medicines affecting blood pressure, blood glucose levels and anticholinergics, including medicines to treat urinary incontinence, can cause dizziness, increasing fall risk.
- Facilitate access to a medical or nurse practitioner for prescribing medicines. Ensure medicines are commenced with an age-appropriate dose and doses are adjusted slowly based on regular monitoring for efficacy and emergence of any adverse effects.
- Consider non-medicine strategies for behaviour support planning, promoting sleep, 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](#).
- Advise older people taking medicines that increase fall risk about ways to reduce their likelihood of falling. These include discussing risks when these medicines are started or doses increased, reporting symptoms such as dizziness and using strategies such as getting up slowly from a chair or bed.
- 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, nocturia (urge to urinate at night) and urinary frequency are common in older people and are associated with an increased risk of falls and harm from falls in RACS. 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 can reduce the risk of falls and harm from falls when included as part of a 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 RACS Reference Document* provides detailed information about the incontinence risk factors associated with falls in RACS, strategies to promote continence and reduce the risk of falls and links to resources on managing incontinence.

Good practice points

- Ensure that a continence assessment is completed to identify and treat factors that can cause or contribute to incontinence in the older person. 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 what assistance is required for toileting. This may include developing individualised toileting plans for those at risk of falling, providing regular, proactive toileting assistance, using continence aids and providing supervision in bathrooms.
- Proactively manage the older person's nocturia and frequency as part of a multifactorial approach to care. Use the Guidelines on [urinary tract infection in aged care facility residents](#).
- Manage symptomatic bacteriuria and reduce inappropriate use of screening and treatment with antimicrobials.

6 Feet and Footwear

Foot problems and inappropriate footwear are contributing factors to mobility impairment in older people and are directly associated with an increased risk of falling in RACS.

Appropriate footwear can improve the mobility, balance and gait of an older person. Multifactorial fall prevention interventions which incorporate appropriately fitted and safe shoes or footwear for the older person result in a demonstrable reduction in falls in RACS.

Chapter 10 of the *Falls Guidelines for RACS 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.

Good practice points

- Assess if the older person has any foot problems and if their footwear is safe and well-fitted.
- Facilitate access to a podiatrist for assessment and treatment of older people with foot conditions and foot pain.
- Encourage the older person to use 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
 - firm soles to optimise foot position sense
 - easy fastening and only including laces if the person can tie them.
- Encourage the use of safe well-fitting footwear, as opposed to non-slip socks, as these are better for fall prevention.

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 RACS Reference Document* details the main types of syncope, the principles of care for syncope and further information on the diagnosis and management of syncope.

Good practice points

- Ensure older people who experience unexplained falls or episodes of collapse, including pre-syncopal or syncopal episode (including postural hypotension), are urgently assessed by a medical practitioner to establish the underlying cause.
- Facilitate access to a medication review, including identifying medicines that may cause postural hypotension.
- Facilitate access to a medical practitioner to consider all appropriate treatment options for older people diagnosed with the cardio inhibitory form of carotid sinus hypersensitivity, including the fitting of a dual-chamber cardiac pacemaker.

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 and vertigo increases markedly with age and is associated with an increased risk of older people falling in RACS.

Poor sensorimotor function, impaired balance control, anxiety and neck and back pain are 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 RACS 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 and vertigo.

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.
- Review the older person's medicine regimen to identify medicines contributing to dizziness or postural hypotension, including antihypertensives, antidepressants, anticholinergics, hypoglycemics.
- 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 in RACS often have more significant visual impairment, with the leading causes of visual impairment being cataracts and age-related macular degeneration.

Chapter 14 of the *Falls Guidelines for RACS 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.

Good practice points

- Facilitate access to eye examinations for the older person on commencement of care and annually.
- When updating the older person's glasses, limit the change in prescription where possible. Advise older people and carers that extra care is needed when new glasses are prescribed.
- Ensure older people who use glasses have accessible, clean glasses and to wear them. If the older person has different glasses for reading and distance, ensure they wear distance glasses when mobilising.
- Facilitate timely referral to a medical practitioner for cataract surgery for both eyes for older people with clinically significant visual impairment primarily due to cataracts (unless contraindicated). See the [Cataract Clinical Care Standard](#).
- Ensure an occupational therapist conducts an environmental assessment and provides modification for older people with severe visual impairment.

10 Hearing

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

Chapter 15 of the *Falls Guidelines for RACS 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 in a RACS.

Good practice points

- Facilitate the older person's access to hearing examinations on commencement of care and annually.
- Encourage older people to wear their hearing aids when mobilising. Ensure that the hearing aids are working.
- 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 and in line with the older person's preferences.
- Facilitate access for older people with undiagnosed hearing problems to an audiologist.

11 Environment

Environmental factors associated with an increased fall risk for older people in RACS include poor lighting, uneven or slippery floors or risk-taking behaviour such as using unstable furniture as a walking aid.

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 RACS Reference Document* details the various tools which are available to assess older peoples' fall risk in RACS.

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

Good practice points

- Ensure that the older person's environment is reviewed and modified as part of a multifactorial approach in a fall prevention program.
- Facilitate the older person's access to assessment by an occupational therapist and physiotherapist. This includes environmental assessment and interventions, prescribing equipment and education for older people to maximise their safety and independence.
- Ensure the documentation and escalation requirements for falls caused by environmental factors are used to inform the fall prevention interventions.
- Provide education for the workforce and the older person about environmental risk factors for falls, fall prevention and management strategies. This includes conducting environmental risk assessments and the safe and appropriate use of equipment to minimise harm from falls.
- Consider options with the older person for the placement of their furniture and belongings to maximise their access and minimise their fall risk.
- Conduct reviews of the older persons' environment regularly. Review all aspects of the environment (i.e.: clothing, furniture, lighting, floor surfaces, clutter and spills, and mobility aids) and modify as necessary to reduce the risk of falls. Best practice is to combine environmental reviews with work health and safety audits.
- For new residential aged care service builds and renovations, follow the [Guidelines on National Aged Care Design Principles](#).
- Ensure that the older person's environment conforms with Australian Standards AS3811 for hard-wired consumer communication and alarm system for use in healthcare facilities.

12 Monitoring and Observation

In Australia, about 20% of falls leading to hospitalisation occur in RACS. Many falls are unwitnessed. Many falls happen in the immediate bedside area. 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.

Monitoring and observation provides an opportunity to support and supervise the mobility and transfers of older people in RACS. Monitoring and observation approaches are useful in preventing falls when an older person is at risk of falling, particularly when getting out of a bed or a chair unsupervised.

Care must be taken to ensure that monitoring does not infringe on the older persons' autonomy or dignity and RACS must have clear policies and procedures in place for using monitoring and observation.

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

Good practice points

- Ensure that older people with dementia or delirium are frequently monitored and observed to manage their risk of falls.
- Provide regular monitoring and observation of transfers and mobility for older people as part of a multifactorial fall prevention program. Assist at-risk older persons in the bathroom when required.
- Ensure that the workforce is aware of the fall-risk status of each older person and what level of supervision each older person requires.
- Agree the use of monitoring and observation strategies, such as sighting charts and fall alerts with the older people and implement these strategies as part of a multifactorial fall prevention program.

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. The [Quality of Care Principles 2014](#) (Part 4A) contain protections and safeguards that must be satisfied by approved providers of RACS before using restrictive practices.

RACS providers are required to document and report data on the use of restrictive practices to the Australian Government Department of Health and Aged Care through the [National Aged Care Mandatory Quality Indicator Program](#).

Restrictive practices should not be a substitute for supervision, inadequate staffing or lack of equipment.

Chapter 13 of the *Falls Guidelines for RACS Reference Document* provides information about the fall risks associated with cognitive impairment. Chapter 18 outlines principles of care in assessing the need for restrictive practices and considering alternatives in minimising the risk of falls by older people in RACS.

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 an increased risk of falls.
- Conduct a comprehensive assessment to identify possible causes of changed behaviours in the older person. 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-medicine strategies should be used as the primary strategies for managing changed behaviours. See the [Delirium Clinical Care Standard](#).
- Develop person-centred, effective behaviour support plan in partnership with the older person, substitute decision-makers, carers and family (to the extent the older person chooses) to manage changed behaviours associated with cognitive impairment, including delirium. 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 must only be used as a last resort, in the least restrictive form and for the shortest possible time necessary to prevent harm to the older person or others. Follow [legislative requirements](#) on the use of 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 in addressing the changed behaviours, discuss options, 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 RACS Reference Document* outlines the evidence for the use of hip protectors, 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 RACS.

Recommendation

Hip protectors: Consider hip protectors for reducing risk of fall-related hip fractures in older people. (Level 2A)

Good practice points

- Consider hip protectors for older people who fall frequently, have osteoporosis and /or a low body mass index.
- Provide information to support informed decision-making about the use of hip protectors with older people, carers and substitute decision makers.
- When using hip protectors as part of a fall prevention strategy regularly check that:
 - the older person is wearing their protectors
 - the hip protectors are in the correct position on the older person
 - the hip protectors are not causing pressure on the older person's skin that may contribute to pressure injuries
 - the hip protectors do not impact on the ability of the older person to toilet independently
 - the older person has not stopped wearing the hip protectors because of discomfort, inconvenience or another reason.
- Provide training to the workforce, the older person and their support people in the correct use and care of hip protectors.
- Do not share hip protectors among older people as they are a personal garment.

15 Vitamin D and Calcium

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. Frail older people in RACS may be at greater risk of vitamin D deficiency because sun exposure recommendations can be difficult to achieve. Furthermore, sun exposure may not work in older people if their skin does not convert cholesterol precursors to vitamin D efficiently.

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.

Low vitamin D levels are associated with increased risk of hip fracture from a fall and is significantly more common among older people who are frail, have dementia and 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.

Chapter 20 of the *Falls Guidelines for RACS 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 in RACS.

Recommendations

Menus reflect dietary requirements and preferences: Ensure menus have at least 3.5 servings of dairy foods (milk, yoghurt, cheese) daily to meet protein and calcium requirements. Engage dietitians to assist with menu design that reflects dietary requirements and older people's needs and preferences. (Level 1B)

Vitamin D and supplements: Administer recommended doses of daily or weekly vitamin D supplements to all older people unless contra-indicated. (Level 1A) Avoid monthly doses or yearly mega doses of vitamin D as they can increase the risk of falls in older people. (Level 1A)

Good practice points

Facilitate access to a medical practitioner if dietary calcium intake is insufficient. Calcium supplementation for older people should be restricted to a maximum dose of 500 – 600 mg elemental calcium per day (if dietary calcium intake is insufficient). There is concern that calcium supplementation increases the risk of cardiovascular events.

16 Osteoporosis

There is evidence of undertreatment of osteoporosis in older people in RACS. 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 in RACS may prevent fractures, even if bone density is not altered.

Chapter 21 of the *Falls Guidelines for RACS Reference Document* outlines the medicines shown to be effective as first-line treatments for osteoporosis, discusses the principles of care in managing osteoporosis in the context of minimising falls in older people and provides information about additional resources to help in managing osteoporosis.

Recommendation

Osteoporosis medicines: Administer prescribed osteoporosis medicines (unless contra-indicated) for older people with diagnosed osteoporosis or a history of low-trauma fractures. (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.
- Facilitate all older people accessing an assessment of osteoporosis. Do not wait for a fracture to check for osteoporosis.
- Establish protocols to deliver osteoporosis treatment for older people who have sustained a minimal trauma fracture, in partnership with the older person's medical practitioner.
- 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 are unable to be safely administered oral bisphosphonates, facilitate access to a medical practitioner to consider long-acting injectable osteoporosis medicines.
- For older people on osteoporosis treatment, facilitate access to co-prescribed vitamin D with calcium.

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 RACS workers should be aware of:

- what constitutes a fall
- what to do when a person falls
- what follow-up is necessary, including completing incident management 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 RACS Reference Document* includes a guide to managing the older person immediately after a fall, outlines what should be included in a RACS's falls policy and practice guidelines and discusses important considerations for the older person after the fall including loss of confidence.

Good practice points

- Provide post-fall response and clinical care to the older person immediately after a fall. Assess whether basic life support is needed and provide as required. Undertake a baseline assessment including vital observations and assess for injury. If the older person has hit their head, has new onset confusion, or if their fall was unwitnessed, undertake neurological observations. Determine the type and frequency of monitoring of the older person that is required. Consider other factors that may contribute to clinical deterioration such as anticoagulant medicines, delirium and sepsis.
- Complete a comprehensive assessment for every older person who falls that includes a medication review. Use this assessment to inform a multidisciplinary care plan that addresses comorbidities and fall risk factors to reduce the risk of another fall.
- Identify, investigate and report the cause of the fall by the older person and the injuries related to the fall. The fall investigation needs to include environmental, social and clinical causes, including medicines. Consider a medication review of the older person with a structured tool to detect medicines that increase fall risk and identify target medicines for deprescribing.
- Undertake a post-fall analysis to inform evaluation of the older person's multidisciplinary care plan and the fall prevention interventions. Address any identified comorbidities or fall risk factors 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 changes to organisational practices and policies can prevent falls.
- Conduct an in-depth analysis for all falls, particularly when there has been a serious injury or death following a fall.
- Ensure that training and education in post fall management, reporting and documentation are provided to the workforce when appropriate.
- Report data on falls and falls with major injury to the Australian Government Department of Health and Aged Care through the [National Aged Care Mandatory Quality Indicator Program](#).

Falls and fall injuries in RACS

In Australia, fall-related injury is a leading cause of morbidity and mortality for older people, with more than a third of falls in RACS resulting in injury and one in five resulting in hospitalisation.

In RACS, fall rates vary according to case mix which sees the rate of falls 33% higher in respite compared to older people living permanently in RACS.

There is a human cost of falls for the older person, their carers and family. Falls may result in increased risk of health complications, extended hospitalisation, rehabilitation, increased care needs, fear of falling, loss of confidence in walking, premature entry into RACS and far too commonly death.

Falls account for the highest health system costs for injury and are more than double that of road trauma.

Characteristics of falls

A person's risk of falling increases as their number of risk factors increases. In RACSs, older people who are more mobile are at greater risk of falling than those who are immobile.

Over half of the older people who fell injured their upper or lower limb and over a third injured their head or face.

Risk factors for falling in RACS

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

- Increased age
- Acute health status
- History of previous falls
- Wandering
- Cognitive impairment
- Maximal drop in postprandial (after eating) systolic blood pressure of at least 20 mm Hg, and in diastolic blood pressure of at least 10 mm Hg within three minutes of standing
- Deterioration in function with activities of daily living
- Reduced lower body (hip to toes) strength or balance
- Unsteady gait or use of a mobility aid
- Independent transfers or wheelchair mobility
- Use of antidepressant medicines, psychotropic medicines, polypharmacy or medicine side effects
- Impaired vision
- Diabetes mellitus.

Extrinsic risk factors are factors that relate to a person's environment or their interaction with the environment. These include relocation between settings and environmental hazards.

It is important that the RACS workforce knows how to identify and address fall risk factors to support routine and person-centred care for all older people in a RACS.

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 support 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 aged care workers may be involved as part of the multidisciplinary team. Communication with and between the multidisciplinary team, including 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 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 supporting the person's understanding through tailored communication.
- Identify older people's individual communication needs (including cognitive impairment) and preferences and provide 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 choice and exercise 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 reviewing their effectiveness in partnership with older people and their carers and family.
- Ensure the older person and their carers and substitute decision-makers are aware of the mechanisms to provide feedback about fall prevention and how to raise concerns about care.

AUSTRALIAN COMMISSION
ON SAFETY AND QUALITY IN HEALTH CARE

Level 5, 255 Elizabeth Street, Sydney NSW 2000
GPO Box 5480, Sydney NSW 2001

Phone: (02) 9126 3600

Email: mail@safetyandquality.gov.au

Website: www.safetyandquality.gov.au