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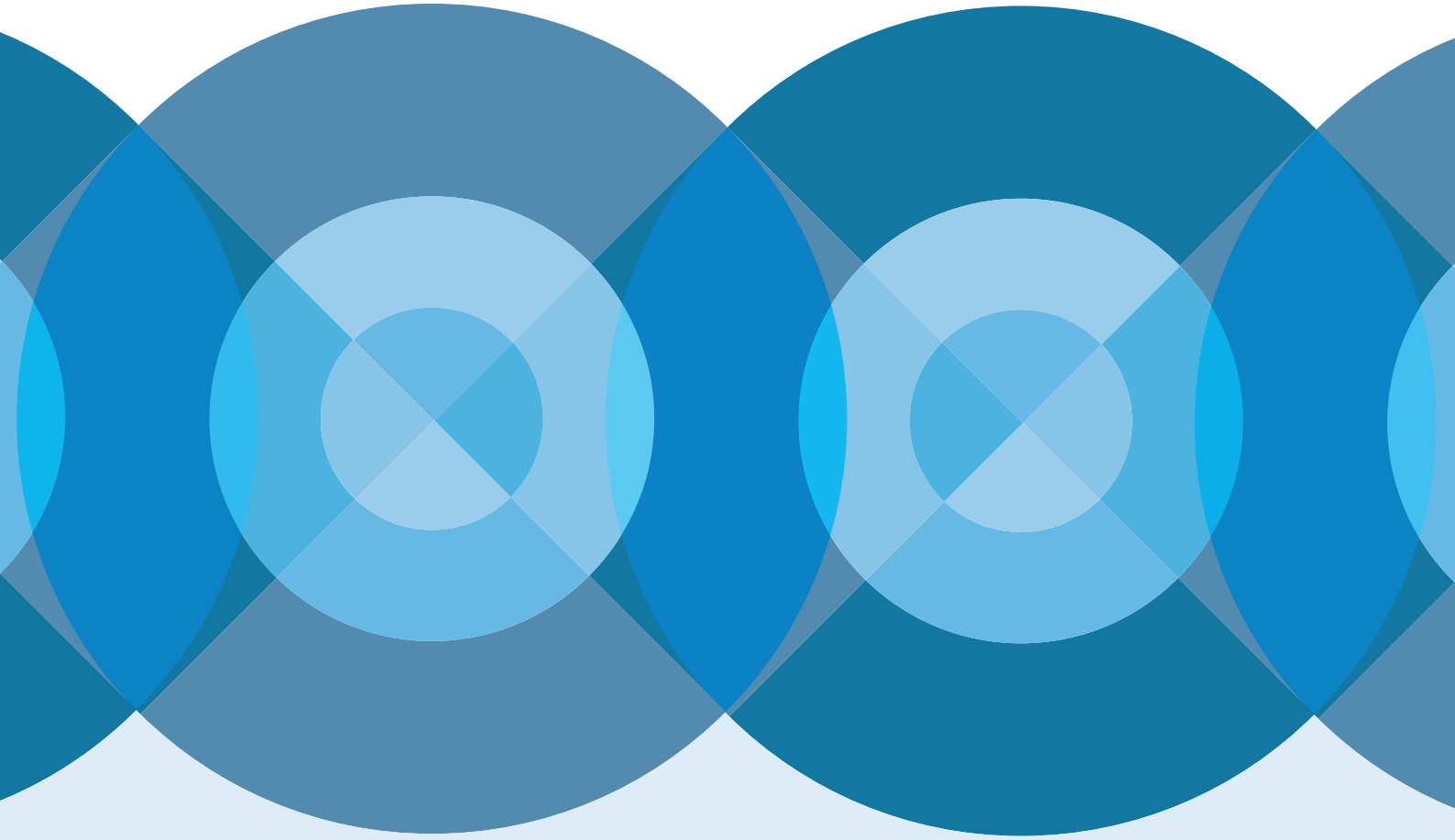

Preventing falls and harm from falls in Older People

Best Practice Guidelines for Community Care in Australia

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Preventing falls and harm from falls in community care

The *Preventing Falls and Harm from Falls in Older People: Best Practice Guidelines for Community Care in Australia* (Falls Guidelines for Community Care) aims to improve the safety and quality of care for older people and offers a nationally consistent approach to preventing falls and harm from falls in community care settings. Separate Falls Guidelines have been developed for the hospital and residential aged care settings.

The Falls Guidelines for Community Care have been developed for routine use by **health professionals, primary care providers, the aged care workforce and other community care staff** in providing care relative to their scope of practice or role to older people in Australian community settings. Community settings include older people's homes and places where community care and services are delivered.

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 home and community care.

The Primary and Community Health Care Standards, which apply to services that deliver healthcare in primary and community settings, have a focus on clinical safety, including comprehensive care and recognising and responding to deterioration and minimising harm.

Recommendations and Good Practice Points

The Falls Guidelines for Community Care outline the recommendations and good practice points for implementing person-centred fall prevention interventions in community settings.

Recommendations are based on evidence from intervention trials in community care settings with falls and/or fall injury outcomes. The associated level of evidence (see Appendix) is aligned with the modified GRADE approach used by the 2022 World Falls Guidelines [1]:

1 indicates a strong recommendation

2 indicates a weak or conditional recommendation

A-C indicates high, intermediate, and low-quality evidence, respectively.

Good practice points should also be considered as they 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.

1 Montero-Odasso M, van der Velde N, Martin FC, et al. World guidelines for falls prevention and management for older adults: a global initiative. Age Ageing. 2022;51(9).

Recommendations in the Falls Guidelines

The Falls Guidelines for Community Care have 14 recommendations:

Exercise to prevent falls

1. 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 include strength training. Ensure health professionals (e.g. physiotherapists or exercise physiologists) or appropriately trained instructors design and deliver exercise programs. (Level 1A)

2. 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)

3. 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)

4. Increased risk of falls

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

Home safety interventions

5. Home safety

Following a home safety assessment, provide tailored 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, or who have recently been discharged from hospital. (Level 1A)

Multiple component and multifactorial interventions

6. 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)

7. Tailored multifactorial interventions

Provide older people at high risk of falls (2+ falls per year) with a fall risk assessment from a health professional to inform tailored fall prevention interventions. Interventions may 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)

Single interventions for specific risk factors

Provide single interventions for older people at increased risk of falls with specific risk factors:

8. Podiatry

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

9. Cataract surgery

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

10 Medicines review

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

11. 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)

12. Eyewear prescription

Advise active older people to use 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)

13. 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 5-15 min exposure, four to six times per week) unless contraindicated. (Level 1B) Avoid high monthly or yearly mega doses of vitamin D as these can increase the risk of falls. (Level 1A)

14. Osteoporosis medicines

Facilitate access to prescribed osteoporosis medicines for older people with diagnosed osteoporosis or a history of minimal trauma fractures, unless contraindicated. (Level 1A)

The terms fall and falls are used interchangeably throughout the guidelines.

How to use the Falls Guidelines for Community Care

The recommendations and good practice points presented in this document are designed to inform tailored fall prevention interventions to address the fall risk of an older person living in the community. Good practice points are listed in each chapter, but the order of these is not indicative of importance. Not all chapters contain recommendations.

The Falls Guidelines for Community Care focus on older people aged 65 and over. A broader age group is used for older Aboriginal and Torres Strait Islander peoples aged 50 years and over.

People outside these age groups are also at risk of falling, including those with a history of falls, disability or conditions that alter functional ability. The recommendations and good practice points in these guidelines reflect the evidence related to older people but may also apply to others at risk of falling where appropriate.

Fall prevention interventions can be:

- **single interventions:** target-specific fall risk factors, such as surgery for cataracts
- **multiple component interventions:** where everyone receives the same, fixed combination of fall prevention interventions, such as tailored ongoing exercise, education and medication review
- **multifactorial interventions:** a combination of interventions tailored to the older person based on an individual assessment.

The following terms are used in these guidelines to classify an older person's fall risk:

- **low risk of falls:** less than one fall a year
- **increased risk of falls:** 1+ falls per year
- **high risk of falls:** 2+ falls per year.

Target the older person's risk factors

The Falls Guidelines for Community Care focus on the risk factors relevant to the older person in the community. The management and severity of certain conditions that an older person has may increase the likelihood of fall risk factors.

A range of health professionals, including nurses, medical practitioners, allied health professionals and aged care workers, may be involved in providing care to the older person. Certain health professionals have distinct roles in supporting the reablement and maintenance of an older person's functional capacity. Please note that where specific health professions are named in recommendations, this has been informed by evidence.

Tailored interventions and the person-centred approach

It is recommended that a tailored approach is applied to preventing falls by considering **all** older people at risk of falling. Each older person should be assessed to determine the relevant risk factors, and shared decision-making should be used to determine the appropriate interventions to prevent falls and harm from falls.

The Falls Guidelines for Community Care recognise the important role that an older person's carers, family and substitute decision-makers can play in fall prevention. The extent of the involvement of these people in the care of the older person must be aligned with the wishes of the older person.

Key messages of the Falls Guidlines

Fall prevention is everyone's responsibility

A fall is defined as:

> **An event which results in a person coming to rest inadvertently on the ground or floor or other lower level. World Health Organization.**[2]

Many falls can be prevented. Health professionals, primary and community care providers and the aged care workforce play a key role in preventing falls (relative to their scope of practice or role). Fall and injury prevention needs to be addressed from a tailored, multidisciplinary perspective as well as through community-wide prevention strategies.

The Royal Commission into Aged Care Quality and Safety identified that improvements are required in the care of older people in Australia, including fall prevention.

Falls are a significant cause of harm to older people living in the community

The incidence of falls in Australia is increasing and is expected to increase further as the population ages. Falls are a common reason for older people to present to the emergency department and commencing residential care. Falls also occur after discharge from hospital.

Falls in the community can be prevented by implementing single interventions that target specific risk factors. For example, reducing medicines that increase fall risk, podiatry for foot pain and surgery for cataracts.

Fall prevention is effective when tailored

Effective fall prevention involves tailored interventions based on the older person's individual risk factors. Managing many of the risk factors for falls has wider health benefits for the older person beyond fall prevention.

Older people have the right to make decisions that affect their lives. Respecting these decisions is an important part of this right, even if there is some risk to themselves – this is called dignity of risk. To support the dignity of risk, partner with the older person to:

- identify their goals of care
- share the decision-making on fall prevention interventions
- maintain their independence and quality of life
- involve carers and family to the extent the older person chooses.

Provide education to older people, their carers and family about the older person's fall risk and any tailored fall prevention interventions.

Skill mix and education support good clinical care

A trained and skilled workforce supports good clinical care in the prevention of falls and harm from falls.

Multidisciplinary collaboration by a range of skilled health professionals may be required to engage with the older person to address complex needs and optimise their quality of life. Changes to an older person's fall risk should be communicated with the older person, their carers and family, and the multidisciplinary team.

Fall prevention interventions should be monitored and reviewed regularly for safety and effectiveness.

Review and report every fall

Whether there is injury, minimal harm or no harm from a fall, all falls must be taken seriously. Requirements related to reviewing and reporting falls must be adhered to.

Falls may be the first indication of an underlying condition in an older person that may require assessment.

Determine how and why a fall may have occurred and reassess the older person to identify new fall risk factors. Implement tailored actions to address risk factors and reduce the risk of another fall.

2 World Health Organization. Step Safely: Strategies for Preventing and Managing Falls across the Life-Course. Geneva: World Health Organization, 2021.

Falls and fall injuries 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 or loss of confidence when 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 by supporting older people receiving community care and services who are at risk of falling.

Risk factors for falling in the community

A person's risk of falling increases with age, degree of frailty, acute or chronic medical conditions and history of falls. For those older people living in the community, low levels of physical activity, deterioration in capacity for activities of daily living (including oral health), depression, a fear of falling and being female are also risk factors for falls.

A person's risk of falling increases as the number of risk factors increases. For older people living in the community, the location of a fall is often related to age, sex and degree of frailty.

Most fall risk factors can be addressed systematically to help prevent falls and harm from falls. Fall risk factors include:

- intrinsic risk factors: those that relate to a person's behaviour or condition, and
- extrinsic risk factors: those that relate to a person's environment or their interaction with the environment.

It is important that health professionals, primary care providers, the aged care workforce and other community care staff providing care to older people identify and address fall risk factors to support safe, routine and person-centred care for older people living in the community.

Fall risk after discharge from hospital

Older people have a higher risk of falls and falls with serious injury in the first month after being discharged from hospital, as they have often been acutely unwell and deconditioned from their hospital stay.

Best practice supports the coordination and continuity of care between the hospital, the older person, their carers and family, the older person's general practitioner, health professionals and home and community services. By working in an integrated manner, the needs of the older person across the broader spectrum of health service delivery are more likely to be achieved.

Involving older people, carers and family in fall prevention

It is critical that people are supported to exercise choice and that care is tailored to their different needs. Good clinical care can optimise a 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.

Carers, family and substitute decision-makers may play an important role in the life of the older person, and these relationships should be recognised and respected. Carers may provide comfort, encouragement, reassurance and support to the person that they care for and should be included as partners in facilitating fall prevention.

Communication with and between the multidisciplinary team, including the older person and their carers and family, is critical to effectively preventing and responding to falls. Risks, change or deterioration in the older person's condition should be escalated and communicated as appropriate.

Older people in Australia may experience challenges in accessing care due to geographical location and limitations in the availability of services and workforce. Virtual care strategies (e.g. telehealth) should be supported to facilitate fall prevention interventions when appropriate and available.

Best practice approach for implementation of falls prevention for the older person

Best practice approaches to partnering with older people in fall prevention:

- 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 the older person's health literacy and individual communication needs and preferences, including consideration of any impairments in the older person's cognitive function.
- Provide information in a way the older person understands. 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 offering and facilitating access to interpreters and translations.
- Identify the older person's needs, goals and preferences and support the older person and their carers and family to engage in discussions about preventing falls.
- Find out what personal changes the older person can make to prevent falls and support shared and supported decision-making. This may include changes to the older person's behaviour, environment, clothing and footwear.
- Explore the older person's concerns about what makes it difficult for them to take action to reduce their risk of falls (such as fear of falling, loss of confidence or concern about the stigma associated with using mobility aids) and provide support to overcome these issues.
- Develop fall prevention programs that are flexible and tailored to the older person's individual needs, goals, circumstances and interests.
- Trial a range of fall prevention interventions and review their effectiveness in partnership with the older person and their carers and family.
- Support older people to discuss their ongoing care needs and future medical treatment, including in relation to fall risk, and develop or review advance care planning documents (if they choose).
- Ensure older people living in the community and their carers, families and substitute decision-makers are aware of the mechanisms to provide feedback about fall prevention and how to raise concerns.

Interventions to prevent falls and harm from falls

Fall Risk Assessment for Tailoring Interventions

The risk of falls, frequency of falls and the severity of fall-related injury increase 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 of the person is required.

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

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 a fall risk assessment by a health professional to inform tailored fall prevention interventions. Interventions may 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

Fall risk screening

- All members of the multidisciplinary team should ask the older person 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 to then tailor intervention/s with the older person. Discuss the outcomes of the assessment with the older person and their carers and family.
- 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

- Engage with the older person 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, has benefits beyond fall prevention.
- Complete a comprehensive fall risk assessment of the older person to identify the factors contributing to an increased risk of falling, including cognitive impairment.
- Involve general practitioners or nurse practitioners in fall risk assessment, care coordination and multidisciplinary care planning.
- Develop a tailored fall prevention plan and ensure this is communicated to the older person, their carers and family, health professionals and workers.
- Implement interventions to systematically address the older person's fall risk factors identified through the fall risk assessment. Assessments are only effective when supported by appropriate interventions related to the risks identified.
- Review and evaluate the fall prevention interventions for the older person to ensure they are tailored and effective in partnership with the older person and their carers and family.

- Ensure all health professionals and aged care workers involved in the care of older people receive ongoing education about fall risk and fall prevention.
- Promote regular, proactive and effective communication with the multidisciplinary team, including at transitions of care. Involve the older person and their carers and family and home and community services.

Person-centred care

- Facilitate access to appropriately qualified health professionals and evidence-based services for fall prevention that support the older person to maintain independence and undertake reablement.
- Facilitate access for older people with a fear of falling or loss of confidence with mobility to prescribed exercise, cognitive behavioural therapy and occupational therapy as part of a multidisciplinary approach to reduce the risk of falls.
- Support the use of virtual care (e.g. telehealth) to facilitate fall prevention interventions for older people when appropriate and available.
- Support the older person to choose a nutritious diet that contains sufficient protein to maintain muscle mass, includes potassium, calcium, vitamin D, dietary fibre and vitamin B12 and contains little to no added sugar, saturated fats and sodium. Facilitate access to a dietitian where required.
- Facilitate access to meal support 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 the sleep-wakefulness cycles of the older person and improve their sleep quality.
- Partner with older people to reduce the risks of alcohol-related harm. See the Australian guidelines to reduce health risks from drinking alcohol.

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 or adopting a conservative gait, which all increase the risk of falling.

Tailored fall prevention exercise programs can prevent falls in older people with balance and gait problems. Exercise that targets balance and functional mobility is effective in preventing falls and harm from falls.

Recommendations

Ongoing exercise for all: Support all older people to undertake 2 to 3 hours of exercise per week on an ongoing basis to prevent falls. Primarily target balance and mobility and include strength training. Ensure health professionals (e.g. physiotherapists or exercise physiologists) or appropriately trained 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 tailored exercise programs. Supervision or assistance from a health professional (e.g. physiotherapists or exercise physiologists) or an appropriately trained instructor may be required to ensure the older person exercises safely and effectively. (Level 1A)

Good practice points

- Use assessment tools to:
  - ☐ assess whether the older person is at high risk of falling
  - ☐ quantify the extent of the older person's balance and mobility limitations and muscle weakness
  - ☐ guide the prescription of exercise, mobility aids and equipment for the older person
  - ☐ measure improvements in the older person's balance, mobility and strength.
- Partner with the older person to develop tailored 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, and 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 and maintain independence and quality of life.
- Support older people to consider participating in exercise programs to prevent falls such as group exercise classes, tai chi and strength and home balance training.
- Include reactive balance training in fall prevention exercise programs for older people where possible, as it is highly task-specific to preventing falls. Cognitive-motor training, such as exergames, is also beneficial.
- 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.

Interventions to prevent falls and harm from falls

- Facilitate access to online tailored balance and strength training for older people who are unable to access a health professional, such as people living in rural and remote areas.
- Consider a life-course approach to physical activity and encourage activities that build strength and balance, particularly among people in middle age.

Cognitive Impairment

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

Delirium is more common when an older person is acutely unwell. Preventing and managing delirium is important for the prevention of injuries from falls.

People at any age can have cognitive impairment due to acquired brain injury, mental health conditions and other pre-existing conditions.

Good practice points

- Ensure people with cognitive impairment receive a comprehensive fall risk assessment on commencement of care.
- Modify fall and fall injury prevention interventions as appropriate for people with cognitive impairment to maximise the intervention's feasibility and efficacy for the individual.
- Regularly reassess the cognitive status of older people, including when there is a change in their condition and after a fall.
- Use a validated tool 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. Consider sepsis as a cause for delirium. See the Sepsis Clinical Care Standard.
- When delirium has been identified in an older person, ensure that the multiple component interventions recommended for preventing and managing delirium are in place, including involving the older person's substitute decision-maker, carers or family and modifying the older person's environment. Use the Australian Clinical Practice Guidelines for the Management of Delirium in Older People. See the Delirium Clinical Care Standard.
- Assess older people with gradual-onset, progressive cognitive impairment to determine a 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.
- 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 facilitates 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 carers and family in the assessment and design of fall prevention interventions.

Medicine and Medicines Review

There is a recognised association between medication use and falls in older people. Medicines can contribute to falls. A medication review is an important part of fall presentation and risk assessment.

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. Classes of medicines 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.

The Guiding principles for medication management in the community should be used to promote the safe, quality use of medicines and medication management. Taking the best possible medication history (that includes all prescribed, over-the-counter and complementary medicines) and a review of the older person's medicines should be a core part of a fall risk assessment. Guidance on appropriate prescribing and medicine selection practices, including management of polypharmacy and deprescribing in the older person, can be found in the RACGP aged care clinical guide (Silver Book).

Recommendation

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

Good practice points

- Facilitate access to a medical practitioner, nurse practitioner and a pharmacist or credentialled pharmacist to take the best possible medication history and review of all the older person's medicines:
  - ☐ at least yearly
  - ☐ after a fall
  - ☐ after initiating 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.
- When medicines that increase fall risk are prescribed, medical or nurse practitioners should document the purpose of the medicine, consider comorbidities, 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. This includes discussing the risks when the older person commences a new medicine or when the dose of an existing medicine is increased. Encourage the older person to report symptoms such as dizziness and use strategies to minimise fall risk, such as getting up slowly from a chair or bed.

Interventions to prevent falls and harm from falls

- Facilitate access to a home medicines review by a credentialled pharmacist that includes an accurate history, reconciliation and review of the older person's medicines, with a particular focus on medicines that affect cognition, falls and osteoporosis. Consider the option to deprescribe and, if feasible, adjust, taper or cease medicines that increase fall risk (sometimes referred to as fall-risk-increasing drugs).
- Support health professionals in providing and discussing medicines-related information with the person, their carer, and/or family when treatment options are being considered (including reviewing and/or deprescribing medicines) and when treatment decisions have been made.
- Facilitate access for the older person to relevant health professionals to implement non-medicine strategies for behaviour support planning, promoting sleep and addressing anxiety, depression and pain when indicated. Psychotropic medicines should only be considered when the changed behaviours are causing significant distress or risk of harm to the person or others. If prescribed, document the purpose of the psychotropic medicine and the plan for review. See Psychotropic Medicines in Cognitive Disability or Impairment Clinical Care Standard.
- Communicate any recent or proposed changes to an older person's medicine regime to the multidisciplinary team at transitions of care.

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 continence issues. Enquire routinely and sensitively about incontinence symptoms (rather than relying on the older person to raise the topic).

Good practice points

- Complete a continence assessment 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 by the older person to a specialist continence service when required.
- Develop a plan with the older person that addresses their needs and preferences for toileting. This may include continence aids.
- Proactively 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.
- Manage symptomatic bacteriuria and reduce inappropriate use of screening and treatment with antimicrobials. Asymptomatic bacteriuria does not need to be treated.
- Facilitate access to an occupational therapist (when required) to assess the older person sitting and standing from the toilet and the need for equipment or modifications such as handrails.

Feet and Footwear

Foot problems and inappropriate footwear are contributing factors to mobility impairment and are risk factors for 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 that incorporate appropriately fitted and safe footwear reduce falls and fractures from a fall for older people in the community.

Recommendation

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

Good practice points

- Assess if the older person has any foot pain or problems and if their footwear is safe and well fitted.
- 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.

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 (the amount of pressure needed to maintain blood flow to the brain).

Recommendation

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

Good practice points

- Ensure 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.
- Facilitate a medication review of the older person to identify medicines that may cause postural hypotension.

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 positional vertigo.

The prevalence of dizziness is associated with a high risk of falling in older people. 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.

Good practice points

- Assess older people complaining of dizziness and vertigo for vestibular dysfunction (balance problems), gait 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 a physiotherapist who can assess and manage vestibular-related balance problems in the older person. Implement interventions for benign paroxysmal positional vertigo and vestibular rehabilitation when indicated.

Vision

Vision loss is a common chronic condition in older people in Australia.

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

Older people rely heavily on vision to control their balance, identify hazards or obstacles and navigate safely around them. Poor vision is also associated with increased frailty. Regular vision assessment is an important part of falls prevention.

Recommendations

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

Eyewear prescription: Advise active older people to use 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.
- Advise older people and carers that extra care is needed when new glasses (lenses) are prescribed.
- 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.
- Implement strategies to maximise independence for older people who have visual impairment.
- If the older person has fallen, facilitate access to an optometrist or orthoptist for a detailed assessment and a fall-specific eye examination.

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.

Poor balance, walking difficulties, impaired cognition and functional decline, are also associated with hearing impairment and an increased risk of falling.

Good practice points

- Encourage older people to have annual hearing assessments and management with an audiologist to maximise hearing. Support the older person to see an audiologist when required.
- Encourage older people to wear their hearing aids when mobilising. Ensure that the hearing aids are working.
- 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 hearing devices (such as a pocket talker that amplifies sound closest to the listener while reducing background noise) or a hearing loop (a sound system that can broadcast to hearing aids) to communicate with an older person with a hearing impairment, as required and in line with the older person's preferences.

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.

Recommendation

Home safety: Following a home safety assessment, provide tailored 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 recently been discharged from hospital. (Level 1A)

Good practice points

- Facilitate access to an occupational therapist to assess older people at increased risk of falling for modifications to the environment, equipment or aids and training to maximise safety.
- Identify how an older person navigates their environment as part of an environmental assessment and to inform fall prevention interventions.
- Work collaboratively with the older person to identify environmental hazards and develop and implement acceptable environmental modifications inside and outside their home.
- Talk with the older person about strategies, equipment, aids and devices that the older person could use to encourage safety, detect falls and minimise a long lie on the floor following a fall.

Monitoring and Observation

Falls by older people living in the community 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 living 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 and their carers and family about the older person's risk of falling and actions they can take to reduce this risk could prevent falls and reduce harm from falls.

Good practice points

- Identify the monitoring and observation needs of older people living with dementia or delirium. Engage with the older person and their carers and family and other health and aged care providers who are involved in developing a plan of care to manage the older person's risk of falls.
- Discuss the options of electronic devices, sensors, and video or audio monitoring/ communication systems with the older person.

Restrictive Practices

Restrictive practices refer 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 falling. 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 Commonwealth aged care legislation contains protections and safeguards that must be satisfied by aged care providers who are registered to provide home and community care before the provider can use a restrictive practice.

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

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 of the older person to identify possible causes of changed behaviours. Treat and 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. See the Delirium Clinical Care Standard.
- Ensure that a person-centred, effective behaviour support planning is developed in partnership with the older person and their substitute decision-makers, carers and family to manage changed behaviours associated with cognitive impairment, including delirium. Focus on caring for the older person by understanding the cause of the behaviour 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 Commonwealth aged care legislation 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 with the older person or substitute decision maker, explain the benefits and risks of the restrictive practice to be used, and document informed consent if use is agreed upon. 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 upon by the health practitioner and the multidisciplinary team.
- Continue non-medicine behaviour support strategies in the event a restrictive practice is used.

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. There are three types of hip protectors – soft, hard and adhesive.

As a hip fracture intervention strategy, hip protectors should only be considered if the older person is likely to wear them.

Good practice points

- Prioritise older people who fall frequently, have osteoporosis or a low body mass index for consideration of the use of hip protectors to reduce the risk of fall-related fractures as part of a multifactorial approach.
- Understand 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.
- Provide information to older people and their carers, family and substitute decision-makers to support informed decision-making about the use of hip protectors.
- Provide training to the workforce, the older person and their carers and family in the correct use and care of hip protectors.
- When using hip protectors as part of a fall prevention strategy, regularly check that the:
  - ☐ older person is wearing their hip protectors
  - ☐ hip protectors are in the correct position on the older person
  - ☐ hip protectors are not causing pressure on the older person's skin that may contribute to pressure injuries
  - ☐ hip protectors do not affect the ability of the older person to toilet independently
  - ☐ older person has not stopped wearing the hip protectors because of discomfort, inconvenience or another reason.

Vitamin D and Calcium

Low vitamin D levels are associated with an increased risk of hip fracture resulting from a fall and are significantly more common among older people living with dementia and older people have dark skin (as increased skin pigment reduces the amount of vitamin D production after sun exposure) and people who are heavily clothed and veiled (such as for cultural or religious reasons).

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 body's 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. When consumed, a small amount of calcium is absorbed into the blood and used for the healthy functioning of the heart, muscles, blood and nerves.

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 5-15 min exposure, four to six times per week) unless contraindicated. (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

- Assess the adequacy of vitamin D and calcium in an older person's diet as part of a fall risk assessment.
- Encourage the older person 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 prescribe a weekly dose preparation of vitamin D if appropriate.
- Facilitate access to a medical practitioner if an older person's dietary calcium intake is insufficient. Calcium supplementation for older people should be restricted to a maximum dose of 500 – 600 mg of elemental calcium per day. There is concern that calcium supplementation increases the risk of cardiovascular events.
- Review the older person's medicines regimen when commencing calcium supplementation, as calcium has the potential to interact with certain medicines and several medicines may adversely affect calcium levels.

Osteoporosis

Osteoporosis is a condition that causes bones to become thin, weak and fragile. This occurs when bones lose minerals, such as calcium, faster than the body can replace them. 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 low.

Recommendation

Osteoporosis medicines: Facilitate access to prescribed osteoporosis medicines for older people with diagnosed osteoporosis or a history of minimal trauma fractures unless contraindicated. (Level 1A).

Good practice points

- Facilitate access to an osteoporosis assessment for all older people. Do not wait for a fracture to check for osteoporosis.
- Develop strategies for strengthening and protecting the older person's bones to reduce bone injuries from falls. This includes improving muscle strength, optimising functional capacity and improving the safety of the older person's environment.
- 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 medications such as oral bisphosphonates, facilitate access to a medical practitioner to assess the appropriateness of a long-acting injectable medicine for the treatment of osteoporosis.
- For older people who are using medicines to treat osteoporosis, facilitate access to co-prescribed vitamin D with calcium, as directed by a medical practitioner.
- Encourage bone health management in younger age groups by providing information and education about a life course approach to bone density management.

Post-fall Management

All falls, including falls which result in minor or no injury, must be taken seriously. 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, nurse 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's fall risk following a fall, and
- the need to implement actions to address the older person's fall risk factors to reduce the risk of another fall.

If, while providing care to an older person in their home, a community care professional notices signs that indicate a fall may have occurred (for example, the older person has unexplained bruising), the worker should discuss this with the older person and emphasise the importance of being assessed by a suitably qualified health professional to see whether the older person needs treatment.

Good practice points

- Immediately after a fall, provide a post-fall response, clinical care and escalation where required. In collaboration with the older person and their 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.
- Conduct a post-fall analysis to inform the evaluation of the older person's multidisciplinary care plan, including fall prevention interventions. Address any comorbidities and fall risk factors to reduce the risk of another fall and update the plan.
- Support more mobile older people to improve their ability to rise from the floor after a fall unassisted to reduce the risk of a 'long-lie' occurring.
- At transitions of care for the older person, ensure communication of any falls or identification of fall risk with all relevant members of the older person's multidisciplinary team. See Principles for safe and high-quality transitions of care.
- Analyse fall 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.

Appendix

Levels of evidence

The table below details the modified GRADE system used in the Falls Guidelines to evaluate the strength of evidence of fall prevention interventions. This system is adapted from the 2022 World Falls Guidelines for Prevention and Management of Falls in Older Adults.[3]

Recommendations	**Strength of Recommendation**	**1**	**Strong:** benefits clearly outweigh undesirable effects.
		2	**Weak or conditional:** either lower quality evidence or desirable and undesirable effects are more closely balanced.
	Quality of evidence	**A**	**High:** further research is unlikely to change confidence in the estimate of effect.
		B	**Intermediate:** further research is likely to have an important impact on the confidence in the estimate of effect and may change the estimate.
		C	**Low:** further research is very likely to have an important impact on the confidence in the estimate of effect and is likely to change the estimate.
Good practice points	In cases where no quality studies are available for interventions likely to have benefits based on expert opinion, good practice points were formulated.		

3 Montero-Odasso M, van der Velde N, Martin FC, et al. World guidelines for falls prevention and management for older adults: a global initiative. Age Ageing. 2022;51(9).

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