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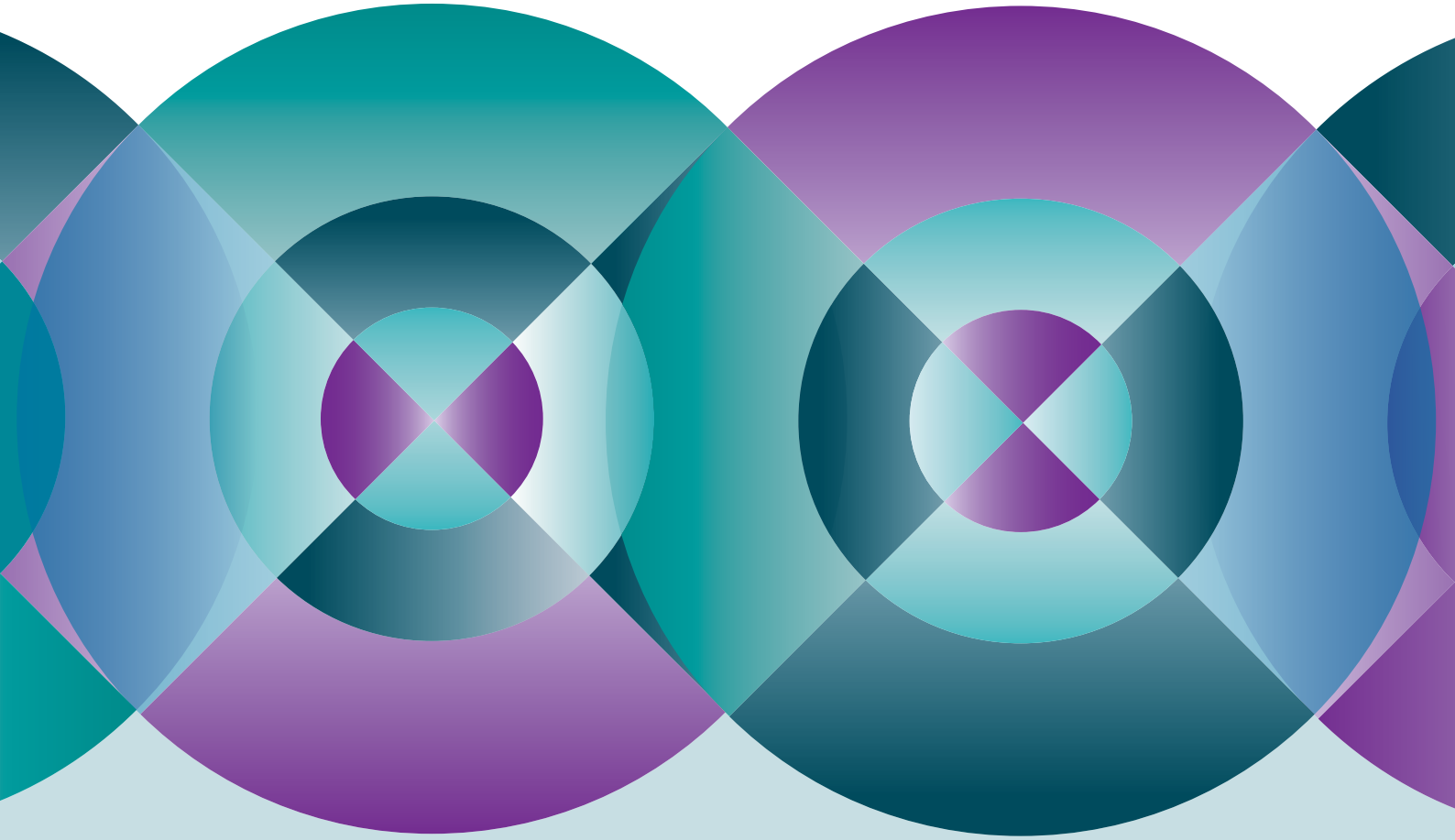

Preventing falls and harm from falls in Older People

Best Practice Guidelines for Australian Residential Aged Care Services

Published by the Australian Commission on Safety and Quality in Health Care

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Preventing falls and harm from falls in residential aged care

The *Preventing Falls and Harm from Falls in Older People: Best Practice Guidelines for Australian Residential Aged Care Services* (Falls Guidelines for RACS) 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 residential aged care settings. Separate Falls Guidelines have been developed for hospital and community care settings.

The Falls Guidelines for RACS have been developed for routine use by **health professionals and the aged care workforce** in providing care relative to their scope of practice or role to older people in Australian residential aged care services (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 that apply to providers of RACS.

Recommendations and good practice points

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

Recommendations are based on evidence from intervention trials in RACS with falls and/or falls injuries as outcomes. The associated level of evidence (see Appendix) is aligned to 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 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 RACS have seven recommendations:

1. Multifactorial interventions

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

- regularly assessing both individual and RACS level fall risk factors, including assessment for environmental interventions and medication review
- developing a tailored fall prevention plan based on the findings of the older person's fall risk assessment
- providing education and engaging the workforce about preventing falls and harm from falls in older people. (Level 1A)

2. 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)

3. Continued exercise

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

4. Hip protectors

Consider the use of hip protectors for older people to reduce the risk of fall-related hip fractures. (Level 2A)

5. Dairy food provision

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

6. 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 or once yearly mega doses of vitamin D, as they can increase the risk of falls. (Level 2A)

7. Osteoporosis medicines

Administer prescribed osteoporosis medicine for older people with diagnosed osteoporosis or a history of minimal trauma fractures, unless contra-indicated. (Level 1A)

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

How to use the Falls Guidelines for RACS

The recommendations and good practice points presented in this document are designed to inform a RACS's fall and fall injury prevention program. 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 RACS focus on older people 65 and over. A broader age group is used for older Aboriginal and Torres Strait Islander peoples 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 are the actions and strategies used to prevent falls or harm from falls. Interventions are more effective when they target the individual's fall risk factors (multifactorial interventions) and when they are tailored and person-centred.

Target the older person's risk factors

The Falls Guidelines for RACS have been developed to provide recommendations and good practice points for fall prevention when older people in RACS present with different fall risk factors. 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 and aged care workers, may be involved in fall prevention with the older person. Allied health professionals have distinct roles in supporting the reablement and maintenance of an older person's functional capacity. 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 RACS consider that **all** older people are at high risk of falling and individually assess each person to determine which fall prevention interventions are necessary.

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

Key messages of the Falls Guidelines for RACS

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, and Health professionals and the aged care workforce play a key role in preventing falls in RACS. Organisation-wide fall and injury prevention needs to be addressed and embedded across every aspect of care in RACS. Fall prevention should be a core element of an older person's plan of care in a RACS.

All people in RACS are at risk of falling

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 and commencing care in a RACS.

Every person living in RACS should be considered at high risk of falling and be individually assessed for which fall prevention interventions are necessary.

Fall prevention is effective when tailored

Effective fall prevention involves tailored interventions based on the older person's individual risk factors. Using any one intervention on its own is unlikely to reduce the risk of falling. 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.

Safe staffing levels, skill mix and education support good clinical care

Safe staffing levels and a trained and skilled workforce support 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 person to address complex needs and optimise their quality of life. Changes to a person's fall risk should be communicated to the person, their carers and family and the multidisciplinary team.

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

Review and report every fall

Support the person's choices and dignity of risk with fall prevention by:

- identifying their goals of care
- maintaining their independence and quality of life
- sharing the decision-making with the older person on fall prevention interventions.

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 RACS

Falls are a significant cause of harm to older people. 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. Over half of the older people who fall injure their upper or lower limbs, and over a third injure their head or face.

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

There is a human cost to falls. Falls may result in an increased risk of health complications, extended hospitalisation, rehabilitation, increased care needs, fear of falling, loss of confidence in walking and, far too commonly, death.

Risk factors for falling in RACS

A person's risk of falling increases with age, degree of frailty, acute or chronic medical conditions and a history of falls. General poor health or a deterioration in functional capacity for tasks and activities of daily living, including oral health, are also risk factors for falls.

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

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 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.

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 the RACS. 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 and preferences.

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 an older person's life and relationships should be recognised and respected.

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 greater challenges in accessing care due to geographical location, mobility, money, 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 in the older person

Best practice approach 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, and support 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 and when they choose).
- Ensure older people living in RACS and their carers, family and substitute decision-makers know how to provide feedback and how to raise concerns.

Interventions to prevent falls and harm from falls

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 and injury prevention interventions must be regularly reviewed for safety and effectiveness.

Fall risk screening is not applicable in RACS, as all older people are at high risk of falls.

Fall risk assessments aim to identify factors that increase an older person's fall risk that may be addressed through a tailored fall intervention.

A multifactorial comprehensive fall risk assessment will assess both intrinsic and extrinsic fall risk factors related to an older person's health status, functional capacity and environment. Identified risks must be addressed by reliably planning, tailoring and implementing interventions shown to minimise the risk of falls and harm from falls.

Recommendation

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

- regularly assessing both individual and RACS level fall risk factors, including assessment for environmental interventions and medication review
- developing a tailored fall prevention plan based on the findings of the older person's fall risk assessment
- providing education and engaging the workforce about preventing falls and harm from falls in older people. (Level 1A)

Good practice points

- Consider all older people in RACS to be at high risk of falls. Implement fall prevention interventions informed by comprehensive multifactorial fall risk assessments and the goals of care for the older person to minimise risk. Ensure delirium prevention, assessment and management are part of falls prevention.
- Consider all people with mobility or cognitive disabilities to be at high risk of falls, regardless of age.
- Ensure all health professionals and workers involved in the care of older people receive ongoing education about fall risk and fall prevention.
- Facilitate the involvement of the older person's general practitioner and nurse practitioner to coordinate care planning to maintain the older person's function and mobility, support reablement and ensure multidisciplinary care. Promote regular and effective communication with health professionals and workers about the older person's fall prevention plan of care, including with the older person's carers and family.
- Support the use of virtual care (e.g. telehealth) to facilitate fall prevention assessment and interventions for older people when appropriate and available.
- Support behavioural strategies and sleep hygiene to help regulate the older person's sleep-wakefulness cycles and improve their sleep quality. Minimise disturbing noise and disruptive care practices to optimise sleep duration and quality for older people.

Interventions to prevent falls and harm from falls

- Ensure older people are provided with nutritious diets, in line with their preferences, which 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 dietitian when required.
- Provide meal assistance to older people who request or require help with eating and drinking to support nutritional intake and hydration.
- Partner with older people to reduce the risks of alcohol-related harm. See the Australian guidelines to reduce health risks from drinking alcohol.
- Engage with the older person following a fall to help identify and manage an increased fear of falling or loss of confidence with mobility to reduce the further risk of falls.

Balance and Mobility

Most older people living in RACS have poor balance and mobility and limited strength. Increasing age, inactivity, disease processes and muscle weakness can impair balance and contribute to a person's fall risk. An unsteady gait and the use of a mobility aid or a wheelchair are common fall risk factors for older people living in RACS.

Balance, mobility and strength 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.

People living in RACS who are frail or who have cognitive impairment or mobility disability can benefit from fall prevention interventions when tailored to their specific fall risk factors.

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 after the program has ended. (Level 1A)

Good practice points

- Assess the older person's balance, mobility and strength using validated tools to:
  - ☐ quantify the extent of balance, mobility and muscle strength of the older person
  - ☐ guide the prescription of exercise, mobility aids and equipment for the older person
  - ☐ measure improvements in balance, mobility and strength in the older person.
- Provide the level of hands-on assistance required to meet the older person's mobility needs.
- Support older people to exercise choice and dignity of risk to achieve their goals and maintain their independence and quality of life.
- Facilitate older people's 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 mobility aids.
- Balance the risks and benefits of restricting an older person's activity with maintaining their mobility to minimise the older person's functional decline and support safe mobilisation.

Cognitive Impairment

Cognitive impairment, including delirium and dementia, is associated with increasing age and 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 an acquired illness, brain injury, mental health conditions and other pre-existing conditions.

Good practice points

- Assess the older person's cognition on the commencement of care. Reassess their cognition regularly and when there is a change in their condition, including 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.
- 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 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 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 the choice of fall prevention interventions and how to use them. Carers and family know the older person and may suggest ways to support them.
- Implement models of care that enable adequate supervision, equipment and support for the older person and respond to fluctuations in the older person's mobility, cognitive state and the impact of changed behaviours on others.
- For people with cognitive impairment, use reasonable adjustments 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 facilitates people living with dementia to feel supported and engaged
  - ☐ using tailored communication approaches to encourage the older person's participation in decision-making and care planning
  - ☐ involving the older person's carers and family in the assessment and design of fall prevention interventions.

Medicine and Medicines Review

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

The use of medicines 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.

Classes of medicines that are known to increase the risk of falling in older people include opioids, sedatives and hypnotics, neuroleptics and antipsychotics, antidepressants, benzodiazepines and certain classes of cardiovascular medicines.

The Guiding principles for medication management in RACS should be used to promote the safe, quality use of medicines and medication management. 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).

Good practice points

- Facilitate access to a medical practitioner, nurse practitioner and pharmacist or a 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.
- Facilitate access to regular medication reviews, with a particular focus on medicines that impact cognition, falls and osteoporosis. Consider options 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 to provide and discuss medicines-related information with the person and their carer and/or family when treatment options are being considered (including the review of and/or deprescribing medicines) and when treatment decisions have been made.
- Assess an older person's fall history and fall risk before using medicines that may increase 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 the emergence of any adverse effects.
- Advise older people taking medicines about ways to reduce their risk 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.
- 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 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 regimen to the multidisciplinary team at transitions of care.

Continence

Bladder and bowel symptoms 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 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 tailored toileting plan with the older person that addresses what assistance they may require for toileting to minimise their risk of falling. This may include providing regular proactive toileting assistance, using continence aids or facilitating supervision in bathrooms.
- Proactively manage the older person's toileting, including nocturia (urge to urinate at night), urgency and frequency as part of a multifactorial approach to care.
- Manage symptomatic bacteriuria and reduce inappropriate use of screening and treatment with antimicrobials. Use the Therapeutic Guidelines on urinary tract infection in RACS. Asymptomatic bacteriuria does not need to be treated.

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 among older people in RACS.

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

Good practice points

- Assess if the older person has any foot pain or 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.
- Support older people to take safe, well-fitting footwear with them when they leave the RACS, such as when transferred to hospital.

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).

Good practice points

- Ensure older people who experience unexplained falls or episodes of collapse, including pre-syncopal 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.
- When an older person is diagnosed with the cardio-inhibitory form of carotid sinus hypersensitivity, facilitate access to a medical practitioner to share decision-making with the older person about appropriate treatment options, including the fitting of a dual-chamber cardiac pacemaker.

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

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.
- Review the older person's medicine regimen to identify medicines contributing to dizziness or postural hypotension, including, but not limited to, 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.

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

Older people in RACS often have significant visual impairment. The leading causes of visual impairment in older people living in RACS are cataracts and age-related macular degeneration.

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.

Good practice points

- Facilitate access to eye examinations for the older person on commencement of care and annually.
- Ensure older people who use glasses (lenses) have accessible, clean glasses and wear them. If the older person has different glasses for reading and distance, ensure they wear their distance glasses when mobilising.
- When updating the older person's glasses, limit the change in prescription where possible. Advise older people and carers that extra care in undertaking daily living activities is needed when using new glasses.
- Facilitate timely referral to a medical practitioner to share decision-making with the older person about 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.

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.

Good practice points

- Facilitate access to hearing assessment and management for the older person on commencement of care and annually. When undiagnosed hearing problems are identified facilitate access to an audiologist.
- Ensure older people who use hearing aids have them within easy reach, that the older person wears their hearing aids when mobilising and that the hearing aids are working.
- Use hearing devices (such as a pocket talker 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.

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.

Good practice points

- Provide orientation to the older person of the RACS environment on commencement of care, including the layout of the area and use of equipment such as call bells, walking aids and adjustable beds and chairs.
- 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 an assessment by an occupational therapist and physiotherapist. This includes an environmental assessment and associated interventions, prescribing equipment, aids, devices and education for older people to maximise their safety and independence.
- Ensure procedures are in place to document, manage and escalate environmental causes of falls.
- Provide education for the workforce and the older person about environmental risk factors for falls, fall prevention and management strategies, and the safe and appropriate use of equipment to minimise harm from falls.
- Talk with the older person about options for the placement of their furniture and belongings to maximise their access to their living space and minimise their fall risk.
- Conduct regular reviews of all aspects of the older person's environment. This includes furniture, lighting, floor surfaces, contrasting fixtures, signage to maximise visual cues and wayfinding, clutter and spills. Modify environmental factors as necessary to reduce the risk of falls. Best practice is to combine environmental reviews with work health and safety audits.
- For new RACS builds and renovations to existing premises, 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 systems for use in healthcare facilities.

Monitoring and Observation

In Australia, about 20% of falls by older people leading to hospitalisation occur in RACS. Many falls are unwitnessed. 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 living with dementia. Many falls in RACS happen in the immediate bedside area.

Monitoring and observation provide 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 person's autonomy or dignity. RACS must have clear policies and procedures in place for using monitoring and observation.

Good practice points

- Agree with the older person on the use of monitoring and observation interventions such as sighting charts, alerts and devices and implement these strategies as part of a multifactorial fall prevention program.
- Provide regular monitoring and observation of an older person's transfers and mobility as part of a multifactorial fall prevention program.
- Ensure that older people living with dementia or delirium are frequently monitored and observed to manage their risk of falls and that appropriate resources are in place (including the workforce).
- Ensure that the RACS workforce is aware of the fall-risk status of each older person and what level of supervision each older person requires.
- Encourage carers and family to notify a member of the RACS workforce if the older person requires assistance.
- Identify appropriate resources (including workforce and support systems) for older people who are at higher risk of falling, including assisting those older people at higher risk of falling in the bathroom when required. Ensure policies are in place and roles are clearly defined.

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 registered providers of RACS before the RACS can use a restrictive practice.

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.

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 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 Clinical Practice Guidelines and Principles of Care for People with Dementia and the Delirium Clinical Care Standard.
- Develop a person-centred, effective behaviour support plan 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 with changed behaviours 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. 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. They aim to reduce the risk of hip fracture by absorbing or dispersing forces away from the hip if a fall occurs on the hip area. There are three types of hip protectors: soft, hard and adhesive.

The key factors for the success of hip protectors in preventing harm from falls in RACS appear to be:

- the commitment of RACS workers to supporting the use of hip protectors by older people, and
- educating RACS workers and older persons on how to wear hip protectors and the benefits of hip protectors.

Recommendation

Hip protectors: Consider the use of hip protectors for older people to reduce the risk of fall-related hip fractures. (Level 2A)

Good practice points

- As part of a multifactorial approach, prioritise older people who fall frequently, have osteoporosis or have a low body mass index for consideration of the use of hip protectors to reduce the risk of fall-related fractures.
- 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 impact on 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.
- Do not share hip protectors among older people, as they are a personal garment.

Vitamin D and Calcium

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. Frail older people in RACS may be at greater risk of vitamin D deficiency because sun exposure recommendations can be difficult to achieve. 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. 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.

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 who are frail, are living with dementia, have dark skin (as increased skin pigment reduces the amount of vitamin D production after sun exposure) and are heavily clothed and veiled (such as for cultural or religious reasons).

Vitamin D may prevent fall injuries 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.

Recommendations

Dairy food provision: Ensure menus have at least 3.5 servings of dairy foods (milk, yoghurt, cheese) daily to meet the protein and calcium requirements of older people. 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 contraindicated. (Level 1A) Avoid monthly doses or yearly mega doses of vitamin D as they can increase the risk of falls in older people. (Level 2A)

Good practice points

- Monitor older people's nutritional needs, requirements and preferences, and refer them to a dietitian if required.
- Facilitate access to a medical practitioner if an older person's dietary calcium intake is insufficient. The older person's medicines regimen should be reviewed when considering calcium supplementation, with a maximum dose of 500 – 600 mg of elemental calcium per day. There is concern that calcium supplementation increases the risk of cardiovascular events and has the potential to interact with certain medicines.

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. Medication such as bisphosphonates are often the treatment of choice for 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 low.

Recommendation

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

Good practice points

- Facilitate 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.
- Establish protocols for the treatment of osteoporosis 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.
- 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 unable to safely administer medication such as oral bisphosphonates.
- 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.

Post-fall Management

All falls, including those falls which result in minor or no injury, 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 more likely to fall again. All RACS workers should be aware of:

- what constitutes a fall
- what to do when an older person falls
- what follow-up is necessary, including reporting and incident management 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.

Good practice points

- Provide post-fall response, clinical care and escalation immediately after an older person falls. Assess whether basic life support is needed and provide it as required. Complete a baseline assessment, including vital-sign 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 required type and frequency of monitoring of the older person. Consider other factors that may contribute to clinical deterioration such as anticoagulant medicines, delirium and sepsis.
- Complete a comprehensive assessment, including a medication review, for every older person who falls. Use a structured tool to detect medicines that increase fall risk and identify medicines for deprescribing. Develop 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 any injuries related to the fall. The fall investigation needs to include environmental, social and clinical causes, including medicines.
- Complete a post-fall analysis to inform an 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, ensure communication of any falls or identification of fall risks 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 changes to organisational practices and policies can prevent falls.
- Conduct an in-depth analysis of every fall in a RACS, particularly when there has been a serious injury or death following a fall.
- Ensure that the workforce receives appropriate training and education in post-fall management, reporting and documentation.
- 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.

Appendix

Levels of evidence

The table below outlines 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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