Self-learning Guide to:

Assessment and Treatment of Falls

This learning guide is aimed at increasing your knowledge in ...

- Background surrounding falls information
- Assessment of falls in community and acute setting
- Management strategies and prevention of falls

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Note: Video hyperlinks will only work with an updated internet browser
Background

Terminology

Fall: A fall is an event, which results in a person, coming to rest inadvertently on the ground or floor or other lower level

Incidence

Prospective studies undertaken in community settings around the world have found fall rates in older people who live in the community to be approximately 30–40% each year. In the Randwick Falls and Fractures Study conducted in Australia, 39% of 341 women aged 65 years and older (and living in the community) reported one or more falls in a one-year follow-up period. (1) Non-injurious falls in the home tend to be under-reported, resulting in a reporting bias — of the people who fall in the community, fewer than half report the fall to a health care professional.

Consequences & Cost

Falls are the leading cause of injury-related hospitalisation in people aged 65 years and over, and account for 14% of emergency admissions and 4% of all hospital admissions in this age group. (2,3) Falls also account for 40% of injury-related deaths and 1% of total deaths in this age group. (4) Depending on the population studied, anywhere between 22% and 60% of older people suffer injuries from falls: 10–15% suffer serious injuries, 2–6% suffer fractures and 0.2–1.5% suffers hip fractures. (4) The most commonly self-reported injuries include superficial cuts and abrasions, bruises and sprains. The most common injuries that require hospitalisation are hip fractures, pelvic fractures, fractures of the leg, fractures of the radius, ulna and humerus, and fractures of the neck and trunk. (5)

Major consequences of falls include fracture of the hip, long lie- associated with higher mortality rates, restriction of activity, reduced quality of life, loss of independence and a fear of falling.

Finally, falls can also lead to disability and decreased mobility, which often results in dependency on others and therefore an increased probability of requiring residential care.

- The total estimated health cost attributable to falls related injury will increase almost threefold from $498.2 million in 2001 to $1.4 billion in 2051
- In hospitals, there will be 886 000 additional bed days per year or the equivalent of 2500 additional beds permanently allocated to treating injuries from falls
- 3320 additional residential aged care facility places will be required.

To maintain the current health costs, there will need to be a 66% reduction in the incidence of falls by 2051. (6)
Risk Factors

<table>
<thead>
<tr>
<th>Intrinsic Factors</th>
<th>Extrinsic Factors</th>
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<tbody>
<tr>
<td>• Increased age</td>
<td>• Inappropriate footwear (high heels and slippers)</td>
</tr>
<tr>
<td>• History of falls</td>
<td>• Inappropriate spectacles</td>
</tr>
<tr>
<td>• Chronic medical conditions (e.g. stroke, Parkinson’s disease, arthritis)</td>
<td>• Hazards inside and outside the home</td>
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<tr>
<td>• Multiple medications and specific types (e.g. psychoactive medications)</td>
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<tr>
<td>• Impaired balance and mobility</td>
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<tr>
<td>• Reduced muscle strength</td>
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<tr>
<td>• Sensory problems (e.g. impaired vision, peripheral neuropathy)</td>
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<tr>
<td>• Dizziness</td>
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<tr>
<td>• Impaired cognition</td>
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<tr>
<td>• Incontinence</td>
<td></td>
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<tr>
<td>• Depression</td>
<td></td>
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<tr>
<td>• Low levels of physical activity</td>
<td></td>
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<tr>
<td>• Slow reaction time</td>
<td></td>
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<tr>
<td>• Being female</td>
<td></td>
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<tr>
<td>• Fear of falling</td>
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</table>

(Table from the Australian Commission on Safety and Quality in Health Care “Preventing Falls and Harm From Falls in Older People — Best Practice Guidelines for Australian Hospitals and Residential Aged Care Facilities 2009”.)[7]
Falls Prevention Strategies
Best practice for preventing falls in the community includes four components:

- The implementation of standard falls prevention strategies
- The identification of falls risk factors
- The implementation of interventions targeting these risks so as to prevent fall
- The prevention of injury to those people who do fall.

Single interventions that are effective in reducing falls include exercise (particularly exercise programs that include balance training), vitamin D supplementation (although only in people with low vitamin D levels) and home safety interventions (again, only in high-risk subgroups of older people) (8,9, 10):

Multiple interventions tested in Australia that was effective in reducing the rate of falls (e.g. the Stepping On Program) included (11):

- Exercise
- Participant education
- Home safety

Interventions combining one or more of the following components have proven effective in reducing the risk of falls (10,12):

- Exercise and home safety
- Exercise and vision assessment
- Exercise, vision assessment and home safety.

Evidence shows that several different types of exercise programs reduce both the rate of falls and the risk of falling in older people living in the community. The following types of exercise tested in randomized controlled trials have been found to prevent falls in older people living in the community:

- Home-based balance and strength training i.e. The Otago Exercise Programme (13,14)
- Group-based tai chi (15-18)
- Other group exercise programs i.e. exercise programs need to have a component that challenges balance and have a higher total dose of exercise (19-22)

Implications for practice in an acute setting

- Referral of at risk patients to community exercise programs/physiotherapy upon discharge will help to reduce the likelihood of re-admission of the patient due to a fall.
- Referral to community OT/Involvement of acute occupational therapist home safety assessment and modification program by an experienced occupational therapist significantly reduced falls in the subgroup of older people who reported a fall in the previous year (decrease of 36%) (23).
- Almost all high quality studies that have successfully reduced fall rates in the communit have all excluded people with a significant degree of cognitive impairment or dementia.

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Falls Risk Screening and Assessment

Screening is a process that primarily aims to identify people at increased risk. Falls risk assessments aim to identify factors that increase the risk of falling and that may be amenable to intervention. Screening and assessment need to be linked to an action plan to address any modifiable falls risk factors they identify. In some randomized controlled trials, using age alone as an entry criterion has prevented falls (16).

Falls Screen
Screening is used to estimate person’s risk of falls and classify the risk as high or low. The simplest falls risk screens that can be easily incorporated into routine care should record the older person’s history of falls in the past 12 months and their balance and mobility status. This includes:
- History of falls in past 12 months
- Balance and mobility performance

OR a multiple item screening tool can be used such as:

<table>
<thead>
<tr>
<th>Timed Up and Go Test (^{(24,25)})</th>
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<tbody>
<tr>
<td><strong>Description</strong></td>
</tr>
<tr>
<td><strong>Time Needed</strong></td>
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<tr>
<td><strong>Criterion</strong></td>
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<thead>
<tr>
<th>Sit to Stand Test (^{(26)})</th>
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<tbody>
<tr>
<td><strong>Description</strong></td>
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<tr>
<td><strong>Time Needed</strong></td>
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<td><strong>Criterion</strong></td>
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<th>FROP- Com Screen (^{(27)})</th>
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<td><strong>Description</strong></td>
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<tr>
<th>Alternate Step Test (^{(26)})</th>
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<tbody>
<tr>
<td><strong>Description</strong></td>
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<tr>
<td><strong>Time Needed</strong></td>
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Note: Video hyperlinks will only work with an updated internet browser
A time of ≥10 seconds indicates increased risk of falling

When the threshold score of a screening tool is exceeded, a falls risk assessment should be conducted as soon as practicable. If the score is not exceeded, standard falls prevention strategies apply. Older people, who perform poorly on a simple test of balance or gait, or on a falls risk-screening tool, should undergo a detailed assessment to identify contributory risk factors.

**Falls Risk Assessment**

Assessing falls risk typically involves either the use of multifactorial assessment tools that cover a wide range of falls risk factors, or functional mobility assessments that focus on the physiological and functional domains of postural stability, including vision, strength, coordination, balance and gait.

Examples of falls risk assessment tools are:

<table>
<thead>
<tr>
<th><strong>Quick Screen</strong> [26]</th>
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<tbody>
<tr>
<td><strong>Description</strong></td>
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<td><strong>Time Needed</strong></td>
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<tr>
<td><strong>Criterion</strong></td>
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<table>
<thead>
<tr>
<th><strong>FallScreen- A physiological profile assessment</strong> [28]</th>
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</thead>
<tbody>
<tr>
<td><strong>Description</strong></td>
</tr>
<tr>
<td><strong>Time Needed</strong></td>
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<td><strong>Criterion</strong></td>
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</tbody>
</table>
Screening & Management Strategies for Common Risk Factors

Based on the assessment outcome, assessors might refer to other health professionals for more detailed assessment and management of identified risk factors.

Balance and mobility limitations

Increasing age, inactivity, chronic disease and muscle weakness can impair balance abilities. Exercise is an effective single intervention for preventing falls in older people as mentioned previously \(^{(10)}\). It is important to note exercise programs shown to be effective in preventing falls are available and should be used, because some types of exercise programs reduce falls and others do not.

A systematic review found that gait or balance limitations are the most consistent predictors of future falls. Between 50% and 70% of falls in older people occur when walking \(^{(29)}\). To avoid a fall while walking, an individual needs to be able to control the body’s position as it moves forward in space, while safely negotiating obstacles, different terrains and unexpected events. Consequently, fallers walk more slowly and adopt a conservative gait pattern \(^{(29)}\).

Balance is the ability to complete a wide range of tasks safely, and is measured in many different ways. Poor performance on various balance tests has been associated with falls in older people who live in the community. After controlling for balance, muscle weakness has been found to be an independent risk factor for falling. Muscle weakness makes a separate contribution to falls, over and above the effect of balance \(^{(28)}\).

Fortunately, impairment on several of the physical factors associated with falls can be reduced using exercise. Systematic reviews have shown that well-designed exercise programs can improve balance and strength \(^{(30,31)}\).

Assessing Balance and strength

Tools for assessing balance

<table>
<thead>
<tr>
<th>Test</th>
<th>Description</th>
<th>Time to complete (mins)</th>
<th>Level that is predictive of falling</th>
</tr>
</thead>
<tbody>
<tr>
<td>Postural sway and leaning balance tests(^{(28)}) (\text{[Watch]})</td>
<td>As part of the Physiological Profile Assessment (PPA), sway is measured using a sway meter that measures displacement of the body at waist level. During standing balance tests, the person has to stand as still as possible for 30 seconds, with eyes open then closed; once on the floor then once on a piece of medium-density foam rubber (15 cm thick). During leaning balance tests, the person has to lean forward and backwards as far as possible, or follow a track.</td>
<td>5–10</td>
<td>Part of the PPA</td>
</tr>
<tr>
<td>Functional Reach(^{(32)}) (\text{[Watch]})</td>
<td>FR is a measure of balance and is the difference between a person’s arm length and maximal forward reach, using a fixed base of support. FR is a simple and easy-to-use clinical measure that has predictive validity in identifying recurrent falls.</td>
<td>1-2</td>
<td>≤10 inches</td>
</tr>
<tr>
<td>Alternate Step Test (AST)(^{(26)}) (\text{[Watch]})</td>
<td>AST is a measure of lateral stability. It involves the time taken to complete eight steps, alternating between left and right foot, as fast as possible, onto a step 19 cm high and 40 cm deep.</td>
<td>1-2</td>
<td>10 seconds</td>
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Note: Video hyperlinks will only work with an updated internet browser
### Tools for assessing mobility

<table>
<thead>
<tr>
<th>Test</th>
<th>Description</th>
<th>Time to complete (mins)</th>
<th>Level that is predictive of falling</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Six-Meter Walk Test (SMW)</strong> (<a href="#">26</a>) (Watch)</td>
<td>SMW measures a person’s gait speed along a corridor (over a distance of 6 metres) at normal walking speed.</td>
<td>1–2</td>
<td>6 seconds</td>
</tr>
<tr>
<td><strong>Timed Up and Go Test (TUG)</strong> (<a href="#">24,25</a>) (Watch)</td>
<td>TUG measures the time taken for a person to rise from a chair, walk 3 metres at normal pace and with their usual assistive device, turn, return to the chair and sit down.</td>
<td>1-2</td>
<td>≤10 inches</td>
</tr>
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### Tools for assessing strength

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<thead>
<tr>
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</thead>
<tbody>
<tr>
<td><strong>Sit-to-Stand Test (STS)</strong> (<a href="#">26</a>) (Watch)</td>
<td>STS is a measure of lower limb strength, and is the time needed to perform five consecutive chair stands from a seated position.</td>
<td>1–2</td>
<td>12 seconds</td>
</tr>
<tr>
<td><strong>Spring balance</strong> (<a href="#">28</a>)</td>
<td>As part of the PPA, the strength of three leg muscle groups (knee flexors and extensors and ankle dorsiflexors) is measured while participants are seated. In each test, there are three trials and the greatest force is recorded.</td>
<td>5</td>
<td>Part of the PPA</td>
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### Scales for assessing balance and gait

<table>
<thead>
<tr>
<th>Test</th>
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<th>Level that is predictive of falling</th>
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<tbody>
<tr>
<td><strong>Berg Balance Scale</strong> (<a href="#">33</a>) (View)</td>
<td>The Berg Balance Scale is a 14-item scale designed to measure balance of the older adult in a clinical setting with a maximum total score of 56 points</td>
<td>15-20</td>
<td>≤40</td>
</tr>
<tr>
<td><strong>Tinetti Performance-Oriented Mobility Assessment Tool (POMA)</strong> (<a href="#">34</a>) (View)</td>
<td>The POMA measures a person’s gait and balance. It is scored on the person’s ability to perform specific tasks, with a maximum total score of 28 points.</td>
<td>10–15</td>
<td>≤24</td>
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</table>

### Scales for assessing confidence and falls efficacy

<table>
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<tr>
<th>Test</th>
<th>Description</th>
<th>Time to complete (mins)</th>
<th>Level that is predictive of falling</th>
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<tbody>
<tr>
<td><strong>Falls Efficacy Scale International (FESI)</strong> (<a href="#">35</a>) (View)</td>
<td>The FESI provides information on level of concern on a four-point scale (1 = not at all concerned, 4 = very concerned) across all 16 activities of daily living (eg cleaning the house, simple shopping, walking on uneven surfaces).</td>
<td>5</td>
<td>Score ≥23 indicates high level of concern</td>
</tr>
</tbody>
</table>

Effective exercise programs for preventing falls mainly comprise challenging and progressive balance exercises. The exercise program should be tailored to the existing levels of fitness and targeted to the older person’s particular deficits and lifestyle. For optimal benefit, exercises should be conducted while standing, if possible.

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**Features that should be included in an exercise program**

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<thead>
<tr>
<th>Feature</th>
<th>Description</th>
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| **Program**      | The core of the exercise program should be balance training (preferably in weight bearing positions) that aims to reduce the amount of support. Additionally, the exercise program can include components of:  
  • Moderate-intensity resistance training  
  • Endurance exercises to increase general fitness (not a walking program on its own). |
| **Modalities**   | Exercise programs should be designed or delivered by a trained professional (e.g. physiotherapist or exercise physiologist) to ensure the exercises are challenging yet safe. |
| **Intensity**    | Individually prescribed and progressive (the instructor must be sensitive to fatigue levels of individual participants and tailor the intensity of the program accordingly). |
| **Setting**      | Individual or group.                                                                                                                        |
| **Duration of program** | Ongoing exercise.                                                                                                                           |

*(Table from the Australian Commission on Safety and Quality in Health Care *“Preventing Falls and Harm From Falls in Older People — Best Practice Guidelines for Australian Hospitals and Residential Aged Care Facilities 2009”* (7)).*

**Cognitive impairment**

Cognitive impairment affects approximately 6–10% of older people who live in the community (36). There is a 70-80% increased risk of a fall within this subgroup (36). Dementia and delirium are the two most common forms of cognitive impairment in older people.

In this group, impairment of gait and balance are exaggerated, psychoactive medications are more commonly prescribed, and orthostatic hypotension is more prevalent. Cognitive impairment may increase the risk of falling by directly influencing the older person’s ability to understand and manage environmental hazards, through a tendency to increased wandering, and through altered gait patterns and impaired postural stability (37).

Liaison with Occupational Therapy, Speech Pathology and the medical team may be required if concerned about cognitive status. The **Rowland Universal Dementia Scale (RUDAS)**, **Folstein Mini-Mental State Examination (MMSE)** and **Confusion Assessment Method (CAM)** are all tools that can be used to assess cognitive status. If an older person with cognitive impairment does fall, reassess their cognitive status, including presence of delirium (e.g. using the Confusion Assessment Method tool).

Interventions shown to work in cognitively intact populations should not be withheld from cognitively impaired populations; however, interventions for older people with cognitive impairment may need to be modified and supervised as appropriate.

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Feet and footwear
A physiotherapy assessment should include screening for ill-fitting or inappropriate footwear and for foot pain and other foot problems, because these are risk factors for falls. Physiotherapists should educate older people and provide information on foot problems and foot care, and refer them to a podiatrist when necessary.

Safe footwear characteristics include:
- Soles: shoes with thinner, firmer soles appear to improve foot position sense; a tread sole may further prevent slips on slippery surfaces
- Heels: a low, square heel improves stability
- Collar: shoes with a supporting collar improve stability

Dizziness and Vertigo
The prevalence of dizziness increases with age. Vestibular dysfunction has been identified in approximately 50% of people over the age of 70 years who are referred to a dizziness clinic for evaluation. The single most common diagnosis of this dizziness is benign paroxysmal positional vertigo (BPPV). People with BPPV often have balance problems; however, more research is needed to see whether there is an association between BPPV and falling in older people.

Physiotherapy Assessment
- A history of vertigo or a sensation of spinning is highly characteristic of vestibular pathology.
- Assess peripheral vestibular function using the Halmagyi headthrust test. It has good sensitivity only if the vestibular dysfunction is severe or complete.
- Use the Dix–Hallpike test to diagnose benign paroxysmal positional vertigo, which is the most common cause of vertigo among older people, and which can be identified in the community setting. This is the only cause of vertigo that can be treated easily.

Physiotherapy Intervention
- Use vestibular rehabilitation to treat dizziness and balance problems where indicated. Brandt and Daroff exercises — these can be done regularly at home.
- Use the Epley manoeuvre to manage benign paroxysmal positional vertigo.
- For ongoing or complex management in the community refer to a vestibular Physiotherapist.

Syncope
Syncope is defined as a transient and self-limiting loss of consciousness. A number of conditions can present with syncope and all share the final common pathway of cerebral hypoperfusion leading to an alteration in consciousness. Older people are more predisposed to syncopal events due to age-related physiological changes that affect ability to adapt to changes in cerebral perfusion.

Some of the more common causes of syncope in older people include vasovagal syncope, orthostatic hypotension, carotid sinus hypersensitivity, cardiac arrhythmias, aortic stenosis and transient
ischaemic events.

If identified, assessment and management of potential causes of presyncope and syncope should form part of a multifactorial intervention to reduce the rate of falls in older people, Physiotherapy assessment and intervention is not always indicated in this population.

**Medications**

A number of epidemiological studies have shown an association between medication use and falls in older people (10,45,46). The risk of falls can be increased by medication interaction, unwanted side effects (such as dizziness) and even the desired effects of medications (such as sedation).

Certain classes of medication are more likely to increase the risk of falls in older people, for example:

- Centrally acting or psychoactive medications are most likely to contribute to falls; benzodiazepines are particularly strongly associated with falls. (47)
- Antidepressants are associated with higher risk of falls, in particular, selective serotonin reuptake inhibitors (SSRIs) and tricyclic antidepressants. (47)
- Antiepileptic drugs and drugs that lower blood pressure are weakly associated with an increased risk of falls (references). (47)
- Some cardiovascular medications (diuretics, digoxin and type IQ anti-arrhythmic drugs), are weakly associated with an increased risk of falls. (48)

Not adhering to drug therapy, including medication misuse and overuse, and inappropriate prescribing can also increase the risk of adverse effects, in particular falls. The risk of falling also increases with the number of medications used by the patient. (45)

Older people living in the community should have their medications (prescribed and non-prescribed) reviewed at least yearly, and for those on four or more medications, at least six monthly. (10) A medication review and modification should be undertaken as part of a multifactorial approach to falls prevention by Pharmacist or treating physician. (45)

**Individual Surveillance and Observation**

An Australian report on falls leading to hospitalisation found that half of these falls (49.1%; N=32 770) occurred in the home, including in the driveway (49). Liaison with Occupational Therapy may be required to assist with discharge planning prior to return to home if patient deemed appropriate for this management.

Strategies include:

- Bed, chair or foot alarms can alert a carer that the person is attempting to mobilise.
- A personal alarm, when worn, can trigger an alert that a person has fallen, and minimise the time they lie on the floor.

Other non-physiotherapy specific risk factors that should be noted by physiotherapist are:
- Continence (manage problems associated with urinary tract function as part of a multifactorial approach to care, refer for continence assessment if concerned,)
- Vision (include eye test as part of falls risk assessment and encourage regular eye examinations) and;

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Minimising Injuries from falls

**Hip Protectors**

Hip protectors are one method that aims to reduce the risk of hip fracture. Hip protectors come in various styles, but are designed to absorb or disperse forces on the hip if a fall onto the hip area occurs. Hip fractures are one of the more severe injuries associated with a fall and usually require surgery and lengthy rehabilitation. Only 60% of people discharged home after a hip fracture regain their previous level of mobility 12 months later. [13]

Hip protectors should not be relied on to reduce falls-related injuries in the community setting due to problems with adherence. However, because they offer some protection to older people in residential aged care, hip protectors can be considered in acute settings as part of a strategy to minimise harm from falls, as long as they are worn properly and their use is monitored.

There are three types of hip protectors:

- Soft hip protectors (type A) are available in a variety of designs. Their common feature is that they are made from a soft material, rather than a rigid plastic shell.
- Hard hip protectors (type B) consist of a firmer curved shell, sewn or slipped into a pocket in a lycra undergarment similar to underpants or bike pants.
- Adhesive hip protectors (type C) are an adhesive hip pad that is stuck directly to the skin of the wearer.

Disadvantages of hip protectors is that people often stop wearing them because of discomfort and practicality, adherence to hip protectors are crucial to the effectiveness. For frail, older people, hip protectors can cause difficulties with toileting.

A falls risk assessment should always be performed to assess whether the patient has a high risk of hip fractures and should be considered for the use of the hip protectors. Cognitive status and independence of daily living activities should also be considered whether the patient is appropriate for hip protectors.

If deemed appropriate a Physiotherapist or other members of the health care team should teach older people and their carers how to put hip protectors on properly, because their effectiveness is reduced when they are not worn correctly. When using hip protectors as part of a falls prevention strategy, the health care team or carers should check regularly that the older person is wearing their protectors, that the hip protectors are in the correct position, and that they have not stopped wearing them because of discomfort, inconvenience or other reasons.
Other Interventions
Other non-physiotherapy specific interventions utilised to minimise injuries from falls includes vitamin D and calcium supplementation as well osteoporosis treatment medications (Strontium Ranelate, Selective Oestrogen Receptor Modulators & Bisphosphonates) for at risk individuals.

Post Fall Management in an Acute Setting

Checklist for managing the older person immediately after a fall

- Offer basic life support and provide reassurance
- Check for ongoing danger.
- Check whether the older person is responsive (e.g. responds to verbal or physical stimulus).
- Check the older person’s airways, breathing and circulation.
- Reassure and comfort the older person.
- Check for injuries
- Conduct a preliminary assessment, including checking for level of consciousness and vital signs.
- Check for signs of injury, including abrasion, contusion, laceration, fracture and head injury
- Ensure medical assistance is sought
- Assess whether it is safe to move the older person from their position, and note any special considerations in moving them.
- Ensure ongoing monitoring of the older person, because some injuries may not be apparent at the time of the fall
- Observe older people who have fallen and who are taking anticoagulants or antiplatelets, because they have an increased risk of bleeding and intracranial haemorrhage. Older people who have a history of alcohol abuse may be more prone to bleeding.
- Strategies in the acute setting to manage falls risk:
  - Hi-Lo bed
  - Proximate alarm
  - Red non-slip socks
  - Move to high visibility bed area on ward
  - Falls risk sign above bed-head
  - Regular toileting
  - Nursing special (in consultation with NUM)

Post Fall Follow Up

- Report the fall. Note any details of the fall for reference in reporting the fall and complete an incident-reporting form (Riskman) for all falls.
- Document all details in the older person’s case file
- Discuss the fall and future risk management
- Communicate to all relevant staff, family and carers that the older person has fallen and has an increased risk of falling again.

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• Undertake a falls risk assessment/screening because new risk factors may be present. Implement a targeted, individualised plan for daily care, based on the findings of the falls risk assessment tool.
• Multifactorial interventions should be carried out as appropriate and may include, but are not limited to: gait, balance and exercise programs, footwear review, medication review, hypotension management, environmental modification and cardiovascular disorder treatment as discussed previously.
• New referrals are made to other members of the health care team may now also be appropriate.

Loss of confidence after a fall
A common but often overlooked consequence of a fall is a loss of confidence in walking, or fear of falling, which can occur even in the absence of any injury. Discussion with the older person about any concerns about falling might also be an opportunity to identify its presence.
Upon discharge, common approaches to improving loss of confidence or fear of falling include participation in a balance and mobility training exercise program, education regarding falls risk minimisation and other falls prevention activities, including use of hip protectors.
References


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years and older: a systematic review. Drugs and Aging 25(12):1021–1031.