Submission

Draft recommendations and Good Practice Points from the Australian Fall Prevention Guidelines

Survey responses

Submitted online

Submission by the **Australian Physiotherapy Association**

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Authorised by:

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Acknowledgement of Traditional Owners

The APA acknowledges the Traditional Custodians of Country throughout Australia and their connections to land, sea and community. We pay our respect to their Elders past and present and extend that respect to all Aboriginal and Torres Strait Islander Peoples today.

About the Australian Physiotherapy Association

The Australian Physiotherapy Association's (APA) vision is that all Australians will have access to quality physiotherapy, when and where required, to optimise health and wellbeing, and that the community recognises the benefit of choosing physiotherapy. The APA is the peak body representing the interests of Australian physiotherapists and their patients. It is a national organisation with state and territory branches and specialty subgroups.

The APA represents more than 32,000 members. The APA corporate structure is one of a company limited by guarantee. The APA is governed by a Board of Directors elected by representatives of all stakeholder groups within the Association.

We are committed to professional excellence and career success for our members, which translates into better patient outcomes and improved health conditions for all Australians. Through our National Groups we offer advanced training and collegial support from physiotherapists working in similar areas.

1. Executive summary

The Australian Physiotherapy Association (APA) is pleased to provide feedback to Draft Recommendations and Good Practice Points from the Australian Fall Prevention Guidelines prepared for the Australian Commission on Safety and Quality in Health Care by the Australia and New Zealand Falls Prevention Society.

On the whole, the guidelines are well written and clear but would benefit from inclusion of critical specificity in a number of areas outlined in our recommendations and responses to ensure appropriate falls prevention and management service delivery and health outcomes, including:

- identification and specificity wherever relevant of qualified professionals such as physiotherapists in delivering falls prevention and management and in guidance/supervision of other members of the workforce;
- outlining the role of GPs in falls prevention through identification, care planning and referral to healthcare professionals;
- guidance on alcohol consumption and its relationship to falls;
- greater focus on identifying risks in the home and residential care environment; and
- further specificity in the guidance on vestibular assessment.

Falls prevention and management in aged care starts many years prior to accessing the system. It would be beneficial if the guidelines recognised and aligned with a lifespan approach to falls prevention; for example, education and interventions for improving bone density management in younger age groups.

The guidelines do not acknowledge the impact of staffing levels of facilities (residential and hospital) in managing falls. Supervising older people, particularly those living with cognitive impairment, requires adequate staffing levels to supervise and identify fluctuations in mobility, cognitive state and manage the potential interactions with other residents or patients in the context of managing falls.

The APA provided feedback to the consultation via an online survey. This document captures that feedback.

The APA invites the opportunity to participate in any future refinement of the guidelines and development of other materials.

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2. Recommendations

Recommendation 1	Identification and specificity wherever relevant of qualified professionals such as physiotherapists in delivering falls prevention and management and in guidance/supervision of other members of the health and aged care workforce. While the guidelines have identified some professions (for example, occupation therapists for home assessment and podiatry for foot care), it employs generic terminology “suitably qualified health professional" when referencing clinical care that would be more appropriately delivered by physiotherapists.
Recommendation 2	Acknowledge that in rural and remote areas there is crossover of responsibilities of healthcare professionals who may work to extended scope to address workforce shortages.
Recommendation 3	Consider replacing the wording of ‘restraint’ with ‘restrictive practice’
Recommendation 4	Include guidance on alcohol consumption as it relates to falls prevention and dignity of risk.
Recommendation 5	Reframe assessment parameters of balance and mobility to include reference to strength and sensation as integral to balance assessment.
Recommendation 6	Further refine vestibular assessment guidance, including specifying that vestibular assessments are to be conducted by GPs or suitably trained physiotherapists and completed in all patients who experience falls, not just limiting assessment to those who complain of dizziness.[1] Clearly state that dizziness is not always related to vestibular impairment.
Recommendation 7	Include recommendations for dosage and type of exercise to provide more practical guidance for clinicians when they are looking at the good practice points.
Recommendation 8	Define relevant assessment tools and outcome measures for falls screening, strength, balance, mobility (e.g., FRAT for RAC). To ensure it is standardised and measurable across settings.
Recommendation 9	Consider the inclusion of not just environmental modifications but consideration of the assessment and interventions relating to how an older adult navigates their environment.
Recommendation 10	Define Older Australian. • As per draft of new Aged Care Act: • 65 years or older • 50 years or older, if they are an Aboriginal or Torres Strait Islander person, or homeless or at risk of becoming homeless.
Recommendation 11	Define cognitive impairment as per a specific Mini-Mental State Examination (MMSE).
Recommendation 12	Consider replacing the wording of ‘restraint’ with ‘restrictive practice’.

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3. APA's response to the consultation questions

Q1. Are the recommendations and good practice points clear?

RESIDENTIAL: YES **COMMUNITY: YES** **HOSPITAL: YES**

The wording is clear but very broad and open to interpretation. There is a lack of specificity about the role of qualified healthcare professionals and would benefit from clarification – for example, services "provided by" or" under guidance of a health professional or [specific health profession] and following assessment by a health professional.

Provide advice using a screening tool –recommendations need to be clear as to which tool - congruent to evidence-based practice. We would like to see more specificity outlining the intensity of the exercise recommendations.

Thorough recent reviews of evidence are referenced in the recommendations. However the potential for education and improvement in practice will be more informative if these are included within the recommendations themselves. We question if users and funders would explore the references to research in sufficient depth.

Q2. Is the content of the recommendations and good practice points appropriate?

RESIDENTIAL: YES **COMMUNITY: YES** **HOSPITAL: YES**

The guidelines are well written and cover a broad range of relevant topics that contribute to holistic falls prevention. It is encouraging to see that common clinical practice for falls prevention is reflected in the recommendations and good practice points (the evidence and current good clinical practice) align.

Content from a clinical perspective is thorough but could benefit from greater specificity about the role of physiotherapists and GPs and more detail about how it relates to other systems. We suggest further refinement to include and encompass all falls prevention and management standards that hospitals must comply with. These are not referred to.

Environmental aspects of the recommendations are quite patient-specific and micro level. We would suggest more reference to evidence about the design of the facility, for example recommended lumens of lighting for optimal vision and minimal glare and reflection on the ground. Environmental design would be helpful particular for facility management and improvement, and new builds. Assessment and intervention about how an older person navigates their environment are also important considerations in falls prevention.

Residential aged care services recommendations

It would be beneficial to include recommendations for environmental design that is higher on the hierarchy of control that influences falls risk factors, e.g. those identified in the Kings Fund Enhancing Healing Environments tool.

Provide multifactorial fall prevention as part of routine care for all older people. This includes the regular review of personal and environmental risk factors and education/engagement of staff. Develop a targeted and individualised fall prevention plan of care based on the findings of the fall risk assessment. (Level 1A).

Align with Australian Commission on Safety and Quality in Health RACF Guidelines on Preventing Falls and Harm from Falls[2] environmental recommendations including that "residents considered to be at a higher risk of falling should be assessed by an occupational therapist and physiotherapist for specific environmental or equipment needs and training to maximise safety."

Consideration for further inclusion of residential aged care environmental considerations about the impact of noise (which may be distressing to surrounding residents).

The guidelines do not address access and financial accountability of falls prevention and management. Addressing that resourcing of these guidelines and provision of appropriate equipment, use of technology and alarms is important. For example, clarification of delineation between what a service provider is expected to provide compared to what a patient has the ability to pay for themselves.

We welcome the inclusion of equipment in the guidelines but note the lack of clarity across current reform about how that must be funded. In the implementation of the guidelines further consideration must applied to how this will be funded.

All guidance related to tailored exercise programs should specify that the role pf physiotherapy. For example, that they are to be “assessed, prescribed and monitored by a qualified health professional such as a physiotherapist, with aspects of the program delegated where appropriate to an allied health assistant under the supervision of allied health professional such as a physiotherapist”. From rural perspective (e.g. MPS service), it may be worth identifying what aspects of the exercise program can be delegated to an allied health assistant or care staff.

Further clarification of the roles of service providers in environments and home modification is required to encompass physiotherapy. For example, physiotherapists have a role in assessing the environment and considering where there is potential for falls to occur and integrating recommendations into care plans accordingly, assisting the person to navigate the environment where the environment cannot be adapted and making refer to occupation therapists if required.

Community services recommendations

Provide people at high risk of falls (e.g. people who fall 2+ times per year) with an individualised assessment from a health professional, such as a physiotherapist. This assessment should inform tailored interventions, including exercise, home safety, assistive devices, medication reviews, podiatry and strategies to address concerns about falling, anxiety and depression. (Level 1B)

APA comment: Insert reference to fear avoidance. Specify “a qualified health professional such as a physiotherapist”.

Environmental considerations: This section is focused on assistive devices as opposed to environmental design such a furniture placement and lighting. Clarification of the roles of service providers in environments and home modification is required. For example, physiotherapists have a role in assessing the environment and considering where there is potential for falls to occur and integrating recommendations into care plans accordingly, assisting the person to navigate the environment where the environment cannot be adapted and making refer to occupation therapists if required.

Hospital settings recommendations

1. Provide tailored education to older people without significant cognitive impairment, and to all staff and families. (Level 1B). APA comment: Insert wording “identification of goals of care and ongoing care needs”.

2. Provide personalised multifactorial fall prevention interventions for all older people based on assessment of individual risk factors. (Level 2B) Calculating a fall risk score is not necessary. (Level 2B).

APA comment: Consider specific reference or cover all actions within NSQHS Actions 5.24-5.26 relating to preventing falls and harm from falls, and overall requirements for comprehensive screening and care planning.

3. Following a hip fracture, provide post-operative care in a geriatric orthopaedic service with multidisciplinary comprehensive geriatric assessment, management, and rehabilitation. (Level 1B).
APA comment: Requires a definition of ortho-geriatric services preferred that included in the Australian and New Zealand Guideline for Hip Fracture Care, Consideration to further inclusion of rehabilitation requirements for onward referral for secondary fracture prevention.

Consideration to be given to the development of additional recommendation focused on footwear including consensus on non-slip socks.

Q3. Can the recommendations and good practice points be applied to this setting?

RESIDENTIAL: YES **COMMUNITY: YES** **HOSPITAL: YES**

Q4. Are there any gaps? YES

Across sectors

The incidence reporting best practice points are not well defined. They are described from a prevention perspective but do not incorporate incident investigation, which will be a barrier to the guidelines being integrated well with an organisation's quality improvement process and to improve health outcomes for patients. The more evidence-based intervention incorporated, the lower the likelihood of harm to patients.

Environmental considerations: perhaps consider the inclusion of not just environmental modifications but all the assessment and the intervention of how an older adult navigates their environment.[3]

Falls management content is better documented in community section and should be applied to residential as it is relying on similar evidence of efficacy of approaches.

Vestibular guidance should clearly state that either GPs or physiotherapist to complete assessments. Vestibular assessment should be completed in all patients and not limited to those who complain of dizziness as a recent study showed 61% of fallers have a vestibular impairment (Donovan et al., 2023), and highlight from the same authors in the vestibular section that dizziness is not always related to vestibular impairment in persons who experience falls. It is a very common misconception that if people are not dizzy they won't have a vestibular impairment - and the phrasing of the vestibular sections of the guideline could feed into that.

There is a need for greater clarity about the role of GPs in care planning and referral to appropriately qualified health professionals and evidence-based services, such as physiotherapy, to ensure maintenance and improvement of function and mobility and multidisciplinary care.

The guidelines do not refer to the Impact of staffing levels in a fall. Supervising older people, particularly with cognitive impairment, requires adequate staffing levels to supervise fluctuating behaviour and identify fluctuation mobility, interactions with other residents in the context of managing falls.

Q4. Is the language and format clear and appropriate?

APA response: NO

The language is quite repetitive and it is difficult to search for information within the guidelines. We recommend that core recommendations and setting specific recommendations be separated to reduce repetition.

The purpose of the document is unclear. Do the guidelines relate only to older people or have broader applications? If a whole-of-health perspective is intended further consideration must be made to inter-sectoral falls prevention such community design and accessibility.

Falls prevention and management in aged care starts many years prior to accessing the system. It would be beneficial if the guidelines recognised and aligned with a lifespan approach to falls prevention, for example bone density management in younger age groups.

Q5. What is your preference for the format of future resource development to support implementation of the guidelines?

APA response:

- Videos
- Webinars
- Training resources
- Other: App. Fact sheets or tool kit that orients consumer to falls prevention and management in each setting, e.g. orientation to being admitted to hospital, what to expect from staff and how to empower yourself to remain mobile.

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4. References

[1] Donovan, J., De Silva, L., Cox, H., Palmer, G., & Semciw, A. I. (2023). Vestibular dysfunction in people who fall: A systematic review and meta-analysis of prevalence and associated factors. Clinical Rehabilitation, 37(9), 1229–1247. https://doi.org/10.1177/02692155231162423

[2] https://www.safetyandquality.gov.au/sites/default/files/migrated/30454-RACF-Guidebook1.pdf

[3] Lord, Sr., Menz, H., & Sherrington, C. (2006). Home environment risk factors for falls in older people and the efficacy of home modifications. *Age and Ageing*, *35 Supp 2*, ii55-ii59. https://ezproxy.library.usyd.edu.au/login?url=http://ovidsp.ovid.com/ovidweb.cgi?T=JS&CSC=Y&NEWS=N&PAGE=fulltext&D=amed&AN=0090891