



Falls in older people

Quality standard

Published: 25 March 2015

[nice.org.uk/guidance/qs86](https://www.nice.org.uk/guidance/qs86)

Contents

Quality statements.....	5
Quality statement 1: Identifying people at risk of falling.....	7
Quality statement.....	7
Rationale	7
Quality measures	7
What the quality statement means for different audiences.....	8
Source guidance.....	9
Definitions of terms used in this quality statement	9
Equality and diversity considerations.....	10
Quality statement 2: Multifactorial risk assessment for older people at risk of falling.....	11
Quality statement.....	11
Rationale	11
Quality measures	11
What the quality statement means for different audiences.....	13
Source guidance.....	13
Definitions of terms used in this quality statement	14
Quality statement 3: Multifactorial intervention	16
Quality statement.....	16
Rationale	16
Quality measures	16
What the quality statement means for different audiences.....	17
Source guidance.....	18
Definitions of terms used in this quality statement	18
Quality statement 4: Checks for injury after an inpatient fall.....	20
Quality statement.....	20
Rationale	20
Quality measures	20

What the quality statement means for different audiences.....	21
Source guidance.....	21
Definitions of terms used in this quality statement	21
Quality statement 5: Safe manual handling after an inpatient fall	23
Quality statement.....	23
Rationale	23
Quality measures	23
What the quality statement means for different audiences.....	24
Source guidance.....	24
Definitions of terms used in this quality statement	24
Quality statement 6: Medical examination after an inpatient fall.....	26
Quality statement.....	26
Rationale.....	26
Quality measures	26
What the quality statement means for different audiences.....	27
Source guidance.....	27
Definitions of terms used in this quality statement	28
Quality statement 7: Multifactorial risk assessment for older people presenting for medical attention	29
Quality statement.....	29
Rationale.....	29
Quality measures	29
What the quality statement means for different audiences.....	30
Source guidance.....	31
Definitions of terms used in this quality statement	31
Quality statement 8: Strength and balance training.....	33
Quality statement.....	33
Rationale	33

Quality measures	33
What the quality statement means for different audiences.....	34
Source guidance.....	35
Definitions of terms used in this quality statement	35
Quality statement 9: Home hazard assessment and interventions	37
Quality statement.....	37
Rationale	37
Quality measures	37
What the quality statement means for different audiences.....	39
Source guidance.....	39
Definitions of terms used in this quality statement	40
Equality and diversity considerations.....	40
Update information.....	41
About this quality standard.....	42
Improving outcomes	42
Resource impact.....	43
Diversity, equality and language	43

This standard is based on CG161.

This standard should be read in conjunction with QS14, QS15, QS16, QS63, QS71, QS74, QS87, QS2, QS136, QS137, QS149, QS153, QS164 and QS166.

Quality statements

Statement 1 Older people are asked about falls when they have routine assessments and reviews with health and social care practitioners, and if they present at hospital. [new 2017]

Statement 2 Older people at risk of falling are offered a multifactorial falls risk assessment. [new 2017]

Statement 3 Older people assessed as being at increased risk of falling have an individualised multifactorial intervention. [new 2017]

Statement 4 Older people who fall during a hospital stay are checked for signs or symptoms of fracture and potential for spinal injury before they are moved. [2015]

Statement 5 Older people who fall during a hospital stay and have signs or symptoms of fracture or potential for spinal injury are moved using safe manual handling methods. [2015]

Statement 6 Older people who fall during a hospital stay have a medical examination. [2015]

Statement 7 Older people who present for medical attention because of a fall have a multifactorial falls risk assessment. [2015]

Statement 8 Older people living in the community who have a known history of recurrent falls are referred for strength and balance training. [2015]

Statement 9 Older people who are admitted to hospital after having a fall are offered a home hazard assessment and safety interventions. [2015]

NICE has developed guidance and a quality standard on patient experience in adult NHS services (see the NICE pathway on [patient experience in adult NHS services](#)), which should be considered alongside these quality statements.

Other quality standards that should be considered when commissioning or providing falls services include:

- [Head injury](#) (2014) NICE quality standard 74
- [Hip fracture in adults](#) (2012 updated 2016) NICE quality standard 16

A full list of NICE quality standards is available from the [quality standards topic library](#).

Quality statement 1: Identifying people at risk of falling

Quality statement

Older people are asked about falls when they have routine assessments and reviews with health and social care practitioners, and if they present at hospital. [new 2017]

Rationale

A history of falls in the past year is the single most important risk factor for falls and is a predictor of further falls. Health and social care practitioners have regular contact with older people across a wide range of settings, including in people's homes. By asking questions in routine assessments and reviews about falls and their context, health and social care practitioners can identify older people who may be at risk of falling. If there is concern that a person is at risk of falling, they can be referred to, or advised to see, a healthcare professional or service to further assess their risk.

Quality measures

Structure

a) Evidence of local arrangements to ensure that older people are asked about falls when they have routine assessments and reviews with primary care services.

Data source: Local data collection.

b) Evidence of local arrangements to ensure that older people are asked about falls when they have routine assessments and reviews with community health and social care practitioners.

Data source: Local data collection.

c) Evidence of local arrangements to ensure that older people are asked about falls when they present at hospital.

Data source: Local data collection.

Process

a) Proportion of older people asked about falls during routine assessments and reviews with primary care services.

Numerator – the number in the denominator where the person was asked about falls.

Denominator – the number of older people who have had a routine assessment or review by a primary care service.

Data source: Local data collection based on reviews of individual care records.

b) Proportion of older people asked about falls during routine assessments and reviews with community health and social care practitioners.

Numerator – the number in the denominator where the person was asked about falls.

Denominator – the number of older people who have had a routine assessment or review with a community health or social care practitioner.

Data source: Local data collection based on reviews of individual care records.

c) Proportion of older people asked about falls when they present at hospital.

Numerator – the number in the denominator where the person was asked about falls.

Denominator – the number of older people who have presented at hospital.

Data source: Local data collection based on reviews of individual care records.

Outcome

Number of older people alerted to a risk of falling.

Data source: Local data collection based on reviews of individual care records.

What the quality statement means for different audiences

Service providers (such as primary, community and secondary healthcare services and social care providers) ensure that routine assessments, reviews and health checks for older people include questions about falls and their context; hospitals ensure that attendance procedures include questions about falls for older people; and community health and social care providers ensure that

protocols and training are in place for health and social care practitioners to ask older people about falls and their context as part of assessments and reviews.

Health and social care practitioners (such as GPs, practice nurses, pharmacists, district nurses, physiotherapists, occupational therapists, social workers and care home workers) ask older people whether they have fallen in the past year; about the frequency, context and characteristics of any falls; and if they ever lose their balance or feel unsteady on their feet. If a person's answers suggest they are at risk, practitioners refer them to, or advise them to see, a healthcare professional or service to further assess their risk. In all settings, practitioners communicate in a way that recognises that some older people are reluctant to admit to falling, and do not repeat questions about falls if a person has recently been asked.

Commissioners (such as clinical commissioning groups, NHS England and local authorities) ensure that they commission services that address falls prevention as part of routine assessments and reviews for older people.

Older people who are seen by a health or social care practitioner are asked about falls when they have regular check-ups or if they attend hospital. This should include being asked if they have fallen in the past year, how many times this has happened, what caused them to fall, what happened when they fell, and whether they ever lose their balance or feel unsteady on their feet.

Source guidance

Falls in older people: assessing risk and prevention (2013) NICE guideline CG161, recommendation 1.1.1.1

Definitions of terms used in this quality statement

Fall

A fall is defined as an unintentional or unexpected loss of balance resulting in coming to rest on the floor, the ground, or an object below knee level.

[NICE's clinical knowledge summary on [falls – risk assessment](#)]

Older people

Older people are those aged 65 and over living in their own home or in an extended care setting such as a nursing home or supported accommodation.

[Adapted from NICE's guideline on [falls in older people: assessing risk and prevention](#)]

Routine assessments and reviews

Routine assessments and reviews are defined as planned, recurring appointments with health and social care practitioners where a person is assessed or reviewed. These include reviews for chronic conditions such as diabetes, hypertension, heart failure or chronic obstructive pulmonary disease; medication reviews; annual flu vaccinations; NHS Health Checks; assessments of care and support needs; and reviews of care and support plans.

[Expert opinion]

Present at hospital

Attending hospital for assessment or treatment that does not involve an overnight stay. This includes day case admissions, outpatient attendances and A&E attendances but excludes inpatient admissions.

[Adapted from NICE's guideline on [falls in older people: assessing risk and prevention](#)]

Equality and diversity considerations

Some subgroups of the population (such as people who are not registered with a GP, people in traveller communities or people who are homeless) may not be in regular contact with health and social care services. Practitioners should take every opportunity to ask about falls history when people from these groups present, so that they can make every contact count.

Quality statement 2: Multifactorial risk assessment for older people at risk of falling

Quality statement

Older people at risk of falling are offered a multifactorial falls risk assessment. [new 2017]

Rationale

There are over 400 risk factors associated with falling, and the risk of falling appears to increase with the number of risk factors. A multifactorial falls risk assessment allows interventions to be targeted at a person's specific risk factors to help prevent future falls. This assessment is often carried out by a specialist falls service, but it can also be undertaken in other settings that have appropriate governance arrangements and professionals with skills and experience in falls prevention. Individual components of the assessment may be undertaken by different healthcare professionals, but each element has to be combined to form a single multifactorial assessment. This assessment should form part of an individualised multifactorial intervention to prevent further falls.

Quality measures

Structure

a) Evidence of local arrangements to ensure that older people at risk of falling are referred to healthcare professionals with skills and experience in carrying out multifactorial falls risk assessment.

Data source: Local data collection.

b) Evidence of local arrangements to ensure that multifactorial assessment comprises multiple components to identify individual risks of falling.

Data source: Local data collection.

c) Evidence of local arrangements for access to a specialist falls service comprising a multidisciplinary team with access to diagnostic, assessment and intervention facilities.

Data source: Local data collection.

Process

a) Proportion of older people at risk of falling presenting to a healthcare professional who are referred for multifactorial falls risk assessment.

Numerator – the number in the denominator where the older person was referred for a multifactorial falls risk assessment.

Denominator – the number of older people presenting to a healthcare professional who are considered to be at risk of falling.

Data source: Local data collection based on reviews of individual care records.

b) Proportion of older people at risk of falling who have a multifactorial falls risk assessment following referral by a healthcare professional.

Numerator – the number in the denominator where the older person has had a multifactorial falls risk assessment.

Denominator – the number of older people at risk of falling referred for a multifactorial falls risk assessment by a healthcare professional.

Data source: Local data collection based on reviews of individual care records.

Outcome

a) Number of older people alerted to their specific risks of falling.

Data source: Local data collection based on reviews of individual care records.

b) Proportion of older people with underlying health problems identified.

Data source: Local data collection based on reviews of individual care records.

c) Rate of falls in older people.

Data source: Local data collection based on reviews of individual care records.

d) Injuries due to falls in people aged 65 and over (age-sex standardised rate of emergency hospital admissions for injuries due to falls in people aged 65 and over per 100,000 population).

Data source: [Public health outcomes framework](#) (available at local authority level) and [CCG improvement and assessment framework](#) (available at clinical commissioning group level).

What the quality statement means for different audiences

Service providers (such as specialist falls services) ensure that protocols are in place to receive referrals of older people at risk of falling; and that assessments are undertaken by staff with skills and experience in falls prevention, that they comprise multiple components to assess individual risk factors and form part of a multifactorial intervention. Outside of specialist falls services, providers ensure that referral pathways are in place for specialist assessment when needed.

Healthcare professionals (such as consultants, GPs, nurses, physiotherapists and occupational therapists) work in a collaborative local context that enables assessments to be undertaken by staff with skills and experience in falls prevention in an appropriate care setting, with local referral pathways to support specialist assessment when needed. Professionals undertaking the assessment identify individual risk factors that can be addressed through multifactorial intervention.

Commissioners (such as clinical commissioning groups and NHS England) commission services that perform multifactorial falls risk assessments in appropriate care settings with local referral pathways to support specialist assessment when needed, using professionals with skills and experience in falls prevention working in a collaborative local context.

Older people at risk of falling are offered an assessment to identify if they have fallen in the past year or if they have problems with balance or walking. This assessment will show if there is anything that might make them more likely to fall and whether there are things that can be done to prevent this.

Source guidance

- [Falls – risk assessment](#) (2014) NICE clinical knowledge summary
- [Falls in older people: assessing risk and prevention](#) (2013) NICE guideline CG161, recommendations 1.1.2.1 (key priority for implementation) and 1.1.2.2

Definitions of terms used in this quality statement

Fall

A fall is defined as an unintentional or unexpected loss of balance resulting in coming to rest on the floor, the ground, or an object below knee level.

[NICE's clinical knowledge summary on [falls – risk assessment](#)]

Older people

Older people are those aged 65 and over living in their own home or in an extended care setting such as a nursing home or supported accommodation.

[Adapted from NICE's guideline on [falls in older people: assessing risk and prevention](#)]

At risk of falling

People aged 65 years and over who have had 2 or more falls in the past 12 months, or demonstrate abnormalities of gait or balance.

[Adapted from NICE's guideline on [falls in older people: assessing risk and prevention](#), recommendation 1.1.2.1, and clinical knowledge summary on [falls – risk assessment](#)]

Multifactorial falls risk assessment

An assessment with multiple components that aims to identify a person's risk factors for falling. This assessment should be performed by a healthcare professional with appropriate skills and experience. It should be part of an individualised, multifactorial intervention. A multifactorial falls risk assessment may include the following:

- identification of falls history
- assessment of gait, balance and mobility, strength and muscle weakness
- assessment of osteoporosis risk
- assessment of fracture risk
- assessment of perceived functional ability and fear relating to falling

- assessment of visual impairment
- assessment of cognitive impairment and neurological examination
- assessment of urinary incontinence
- assessment of home hazards
- cardiovascular examination and medication review.

[Adapted from NICE's guideline on [falls in older people: assessing risk and prevention](#), recommendations 1.1.2.1 and 1.1.2.2, and expert consensus]

Quality statement 3: Multifactorial intervention

Quality statement

Older people assessed as being at increased risk of falling have an individualised multifactorial intervention. [new 2017]

Rationale

The causes of falls are multifactorial, and the risk of falling appears to increase with the number of risk factors. Multifactorial falls risk assessment allows a person's risk factors to be identified. Multiple interventions can then target these specific risk factors and reduce several components of falls risk.

Quality measures

Structure

Evidence of local arrangements to ensure that older people assessed as being at increased risk of falling have an individualised multifactorial intervention.

Data source: Local data collection.

Process

Proportion of older people assessed as being at increased risk of falling who have an individualised multifactorial intervention.

Numerator – the number in the denominator where the older person has received an individualised multifactorial intervention.

Denominator – the number of older people assessed as being at increased risk of falling.

Data source: Local data collection. Numerator sourced from individual patient records.

Denominator sourced from information collected in multifactorial falls risk assessments.

Outcome

a) Rates of falls in older people.

Data source:Local data collection based on reviews of individual care records.

b) Injuries due to falls in people aged 65 and over (age-sex standardised rate of emergency hospital admissions for injuries due to falls in people aged 65 and over per 100,000 population).

Data source:Public health outcomes framework (available at local authority level) and CCG improvement and assessment framework (available at clinical commissioning group level).

c) Proportion of older people who have received a multifactorial intervention for falls who feel able to manage activities of daily living.

Data source:Local data collection based on surveys of older people who have had a multifactorial intervention for falls.

What the quality statement means for different audiences

Service providers (such as specialist falls services) ensure that systems and governance structures are in place to provide interventions to address people's individual risk factors when they are identified through multifactorial risk assessment; to coordinate interventions across different professionals and settings; and to ensure that appropriate staff perform the interventions.

Healthcare professionals (such as consultant geriatricians, nurses, physiotherapists, occupational therapists and primary care practitioners) identify interventions to address an older person's specific risk factors established through a multifactorial falls risk assessment; discuss the interventions with the person and how they can be tailored to their needs; deliver the interventions; and document them in the patient's record.

Commissioners (such as clinical commissioning groups and NHS England) ensure that they commission services so that older people who are assessed as being at increased risk of falling receive an individualised multifactorial intervention based on multifactorial falls risk assessment.

Older people who have had an assessment that shows they are at increased risk of falling develop a plan with a healthcare professional to stop them from falling. This plan may include treating health problems, making changes at home, exercises to help their strength and balance, having their eyes checked and looking at whether any medicines they take should be changed.

Source guidance

- [Falls – risk assessment](#) (2014) NICE clinical knowledge summary
- [Falls in older people: assessing risk and prevention](#) (2013) NICE guideline CG161, recommendation 1.1.3.1

Definitions of terms used in this quality statement

Fall

A fall is defined as an unintentional or unexpected loss of balance resulting in coming to rest on the floor, the ground, or an object below knee level.

[NICE's clinical knowledge summary on [falls – risk assessment](#)]

Older people

Older people are those aged 65 and over living in their own home, or in an extended care setting such as a nursing home or supported accommodation.

[Adapted from NICE's guideline on [falls in older people: assessing risk and prevention](#)]

Assessed as being at increased risk of falling

People identified as being at increased risk of falling through a multifactorial falls risk assessment, which is an assessment with multiple components to identify a person's risk factors for falling.

[Adapted from NICE's guideline on [falls in older people: assessing risk and prevention](#)]

Individualised multifactorial intervention

An individualised multifactorial intervention is an intervention with multiple components that aims to address the risk factors for falling that are identified in a person's individual multifactorial assessment. Specific components common in successful multifactorial interventions are:

- strength and balance training
- home hazard assessment and intervention

- vision assessment and referral
- medication review with modification or withdrawal.

The following interventions are not recommended to address falls risk factors due to insufficient or conflicting evidence, although they may result in other health benefits:

- low intensity exercise combined with incontinence programmes
- group exercise (not individually prescribed)
- cognitive behavioural interventions
- referral for correction of visual impairment as a single intervention
- vitamin D
- hip protectors
- brisk walking.

[Adapted from NICE's guideline on [falls in older people: assessing risk and prevention](#), recommendation 1.1.3.1, and clinical knowledge summary on [falls – risk assessment](#)]

Quality statement 4: Checks for injury after an inpatient fall

Quality statement

Older people who fall during a hospital stay are checked for signs or symptoms of fracture and potential for spinal injury before they are moved. [2015]

Rationale

When a person falls, it is important that they are assessed and examined promptly to see if they are injured. This will help to inform decisions about safe handling and ensure that any injuries are treated in a timely manner. Checks for injury should be included in a post-fall protocol that is followed for all older people who fall during a hospital stay.

Quality measures

Structure

Evidence of local arrangements to ensure that hospitals have a post-fall protocol that includes checks for signs or symptoms of fracture and potential for spinal injury before the older person is moved.

Data source: Local data collection. Results for 2011 were collected by the pilot audit by the Royal College of Physicians (2012) [Report of the 2011 inpatient falls pilot audit](#), section 2: Policy, protocol and paperwork, table 2.5.1 (a).

Process

Proportion of falls by older people during a hospital stay where the person is checked for signs or symptoms of fracture and potential for spinal injury before they are moved.

Numerator – the number in the denominator where the person is checked for signs or symptoms of fracture and potential for spinal injury before they are moved.

Denominator – the number of falls in older people during a hospital stay.

Data source: Local data collection.

Outcome

(a) Level of harm caused by falls in hospital in people aged 65 and over.

Data source: Local data collection.

(b) Injuries resulting from falls in hospital in people aged 65 and over.

Data source: Local data collection.

What the quality statement means for different audiences

Service providers (NHS organisations with inpatient beds, such as district hospitals, mental health trusts and specialist hospitals) ensure that staff have access to and follow a post-fall protocol that includes undertaking checks for signs or symptoms of fracture and potential for spinal injury before moving an older person who has fallen.

Healthcare professionals check older people who fall in hospital for signs or symptoms of fracture and potential for spinal injury before moving them.

Commissioners (clinical commissioning groups and NHS England) ensure that they commission services from providers that have a post-fall protocol that includes undertaking checks for signs or symptoms of fracture and potential for spinal injury before moving an older person who has fallen.

Older people who fall in hospital are checked for fractures and possible injury to their spine before they are moved.

Source guidance

National Patient Safety Agency (2011) [Rapid response report: Essential care after an inpatient fall](#), recommendation 1

Definitions of terms used in this quality statement

Fall

A fall is defined as an unintentional or unexpected loss of balance resulting in coming to rest on the floor, the ground, or an object below knee level.

[NICE's clinical knowledge summary on [falls – risk assessment](#)]

Post-fall protocol

A post-fall protocol should include:

- checks by healthcare professionals for signs or symptoms of fracture and potential for spinal injury before the patient is moved
- safe manual handling methods for patients with signs or symptoms of fracture or potential for spinal injury (community hospitals and mental health units without the necessary equipment or staff expertise may be able to achieve this in collaboration with emergency services)
- frequency and duration of neurological observations for all patients where head injury has occurred or cannot be excluded (for example, unwitnessed falls) based on the NICE guideline on [head injury](#)
- timescales for medical examination after a fall (including fast-track assessment for patients who show signs of serious injury, are highly vulnerable to injury or have been immobilised); medical examination should be completed within a maximum of 12 hours, or 30 minutes if fast-tracked.

The post-fall protocol should be easily accessible (for example, laminated versions at nursing stations).

[Adapted from the National Patient Safety Agency's rapid response report on [essential care after an inpatient fall](#), recommendations 1 and 2, and expert consensus]

Quality statement 5: Safe manual handling after an inpatient fall

Quality statement

Older people who fall during a hospital stay and have signs or symptoms of fracture or potential for spinal injury are moved using safe manual handling methods. [2015]

Rationale

When a person falls, it is important that safe methods are used to move them, to avoid causing pain and/or further injury. This is critical to their chances of making a full recovery. Safe manual handling methods should be included in a post-fall protocol that is followed for all older people who fall during a hospital stay.

Quality measures

Structure

Evidence of local arrangements to ensure that hospitals have a post-fall protocol that includes using safe manual handling methods for moving older people with signs or symptoms of fracture or potential for spinal injury.

Data source: Local data collection. Results for 2011 were collected by the pilot audit by the Royal College of Physicians (2012) [Report of the 2011 inpatient falls pilot audit](#), section 2: Policy, protocol and paperwork, table 2.5.1 (b).

Process

Proportion of falls by older people during a hospital stay where the person has signs or symptoms of fracture or potential for spinal injury and is moved using safe manual handling methods.

Numerator – the number in the denominator where the person is moved using safe manual handling methods.

Denominator – the number of falls by older people during a hospital stay where the person has signs or symptoms of fracture or potential for spinal injury.

Data source: Local data collection.

Outcome

Level of harm caused by falls in hospital in people aged 65 and over.

Data source: Local data collection.

What the quality statement means for different audiences

Service providers (NHS organisations with inpatient beds, such as district hospitals, mental health trusts and specialist hospitals) ensure that staff have access to and follow a post-fall protocol that includes using safe manual handling methods to move older people who have fallen in hospital and have signs or symptoms of fracture or potential for spinal injury.

Healthcare professionals use safe manual handling methods to move older people who fall in hospital and have signs or symptoms of fracture or potential for spinal injury.

Commissioners (clinical commissioning groups and NHS England) ensure that they commission services from providers that have a post-fall protocol that includes using safe manual handling methods to move older people who have fallen in hospital and have signs or symptoms of fracture or potential for spinal injury.

Older people who fall in hospital and who may have a fracture or possible injury to their spine are moved in a safe manner, using suitable equipment if needed.

Source guidance

National Patient Safety Agency (2011) [Rapid response report: Essential care after an inpatient fall](#), recommendation 1

Definitions of terms used in this quality statement

Fall

A fall is defined as an unintentional or unexpected loss of balance resulting in coming to rest on the floor, the ground, or an object below knee level.

[NICE's clinical knowledge summary on [falls – risk assessment](#)]

Post-fall protocol

A post-fall protocol should include:

- checks by healthcare professionals for signs or symptoms of fracture and potential for spinal injury before the patient is moved
- safe manual handling methods for patients with signs or symptoms of fracture or potential for spinal injury (community hospitals and mental health units without the necessary equipment or staff expertise may be able to achieve this in collaboration with emergency services)
- frequency and duration of neurological observations for all patients where head injury has occurred or cannot be excluded (for example, unwitnessed falls) based on the NICE guideline on [head injury](#)
- timescales for medical examination after a fall (including fast-track assessment for patients who show signs of serious injury, are highly vulnerable to injury or have been immobilised); medical examination should be completed within a maximum of 12 hours, or 30 minutes if fast-tracked.

The post-fall protocol should be easily accessible (for example, laminated versions at nursing stations).

[Adapted from the National Patient Safety Agency's rapid response report on [essential care after an inpatient fall](#), recommendations 1 and 2, and expert consensus]

Quality statement 6: Medical examination after an inpatient fall

Quality statement

Older people who fall during a hospital stay have a medical examination. [2015]

Rationale

When an older person falls, it is important that they have a prompt medical examination to see if they are injured. This is critical to their chances of making a full recovery. Timescales for medical examination should be included in a post-fall protocol that is followed for all older people who fall in hospital.

Quality measures

Structure

Evidence of local arrangements to ensure that NHS organisations with inpatient beds have a post-fall protocol that includes timescales for medical examination.

Data source: Local data collection. Results for 2011 were collected by the pilot audit by the Royal College of Physicians (2012) [Report of the 2011 inpatient falls pilot audit](#), section 2: Policy, protocol and paperwork, table 2.5.1 (f).

Process

a) Proportion of falls in older people during a hospital stay where the person has a medical examination completed within 12 hours.

Numerator – the number in the denominator where the person has a medical examination completed within 12 hours.

Denominator – the number of falls in older people during a hospital stay.

Data source: Local data collection.

b) Proportion of falls in older people during a hospital stay where the person shows signs of serious injury, is highly vulnerable to injury or has been immobilised, where a fast-track medical examination is completed within 30 minutes.

Numerator – the number in the denominator where the person has a fast-track medical examination completed within 30 minutes.

Denominator – the number of falls in older people during a hospital stay where the person shows signs of serious injury, is highly vulnerable to injury or has been immobilised.

Data source: Local data collection.

Outcome

Level of harm caused by falls during a hospital stay in people aged 65 and over.

Data source: Local data collection.

What the quality statement means for different audiences

Service providers (NHS organisations with inpatient beds, such as district hospitals, mental health trusts and specialist hospitals) ensure that their staff have access to and follow a post-fall protocol that includes timescales for medical examination for older people who fall during a hospital stay.

Healthcare professionals (medically qualified) complete medical examinations within the timescales specified in their organisation's post-fall protocol for older people who fall in hospital.

Commissioners (clinical commissioning groups and NHS England) ensure that they commission services from providers that have a post-fall protocol that includes timescales for medical examination for older people who fall in hospital.

Older people who fall in hospital have a medical examination to see if they are injured, which is carried out soon after the fall.

Source guidance

National Patient Safety Agency (2011) [Rapid response report: Essential care after an inpatient fall](#), recommendation 1

Definitions of terms used in this quality statement

Fall

A fall is defined as an unintentional or unexpected loss of balance resulting in coming to rest on the floor, the ground, or an object below knee level.

[NICE's clinical knowledge summary on [falls – risk assessment](#)]

Post-fall protocol

A post-fall protocol should include:

- checks by healthcare professionals for signs or symptoms of fracture and potential for spinal injury before the patient is moved
- safe manual handling methods for patients with signs or symptoms of fracture or potential for spinal injury (community hospitals and mental health units without the necessary equipment or staff expertise may be able to achieve this in collaboration with emergency services)
- frequency and duration of neurological observations for all patients where head injury has occurred or cannot be excluded (for example, unwitnessed falls) based on the NICE guideline on [head injury](#)
- timescales for medical examination after a fall (including fast-track assessment for patients who show signs of serious injury, are highly vulnerable to injury or have been immobilised); medical examination should be completed within a maximum of 12 hours, or 30 minutes if fast-tracked.

The post-fall protocol should be easily accessible (for example, laminated versions at nursing stations).

[Adapted from the National Patient Safety Agency's rapid response report on [essential care after an inpatient fall](#), recommendations 1 and 2, and expert consensus]

Quality statement 7: Multifactorial risk assessment for older people presenting for medical attention

Quality statement

Older people who present for medical attention because of a fall have a multifactorial falls risk assessment. [2015]

Rationale

When older people present for medical attention because of a fall it provides their healthcare practitioner with a good opportunity to begin the process of undertaking a multifactorial falls risk assessment. A multifactorial falls risk assessment aims to identify a person's individual risk factors for falling. This will enable practitioners to refer the person for effective interventions targeted at their specific risk factors, with the aim of reducing subsequent falls.

Quality measures

Structure

Evidence of local arrangements to ensure that older people who present for medical attention because of a fall have a multifactorial falls risk assessment.

Data source: Local data collection.

Process

a) Proportion of older people who present for medical attention to their general practice because of a fall who have a multifactorial falls risk assessment.

Numerator – the number in the denominator who have a multifactorial falls risk assessment.

Denominator – the number of older people who present for medical attention to their general practice because of a fall.

Data source: Local data collection. Contained within the Royal College of Physicians' [Fracture Liaison Service Database](#).

b) Proportion of older people who present for medical attention at hospital because of a fall who have a multifactorial falls risk assessment.

Numerator – the number in the denominator who have a multifactorial falls risk assessment.

Denominator – the number of older people who present for medical attention at hospital because of a fall.

Data source: Local data collection. Royal College of Physicians (2011) [Falling standards, broken promises: report of the national audit of falls and bone health](#), Organisational audit results, section 5.1: Multifactorial falls risk assessment.

c) Proportion of older people who present for medical attention at walk-in health centres because of a fall who have a multifactorial falls risk assessment.

Numerator – the number in the denominator who have a multifactorial falls risk assessment.

Denominator – the number of older people who present for medical attention at walk-in health centres because of a fall.

Data source: Local data collection.

What the quality statement means for different audiences

Service providers (such as general practice, specialist falls services, community and secondary care services) ensure that staff are trained to undertake multifactorial falls risk assessments for older people who present for medical attention because of a fall.

Health and social care practitioners undertake a multifactorial falls risk assessment for older people who present for medical attention because of a fall, or refer them to a service with staff who are trained to undertake this type of assessment.

Commissioners (clinical commissioning groups) ensure that they commission services that have the capacity and staff who are trained to undertake multifactorial falls risk assessments for older people who present for medical attention because of a fall.

Older people who are seen by a healthcare professional (such as their GP or a nurse) because of a fall have an assessment that aims to identify anything that might make them more likely to fall, and

to see whether there are things that can be done to help them avoid falling in future. This assessment will be done by a specialist healthcare professional.

Source guidance

Falls in older people: assessing risk and prevention (2013) NICE guideline CG161, recommendations 1.1.2.1 (key priority for implementation) and 1.1.2.2

Definitions of terms used in this quality statement

Fall

A fall is defined as an unintentional or unexpected loss of balance resulting in coming to rest on the floor, the ground, or an object below knee level.

[NICE's clinical knowledge summary on [falls – risk assessment](#)]

Multifactorial falls risk assessment

An assessment with multiple components that aims to identify a person's risk factors for falling. This assessment should be performed by a healthcare professional with appropriate skills and experience. It should be part of an individualised, multifactorial intervention. A multifactorial falls risk assessment may include the following:

- identification of falls history
- assessment of gait, balance and mobility, strength and muscle weakness
- assessment of osteoporosis risk
- assessment of fracture risk
- assessment of perceived functional ability and fear relating to falling
- assessment of visual impairment
- assessment of cognitive impairment and neurological examination
- assessment of urinary incontinence
- assessment of home hazards

- cardiovascular examination and medication review

[Adapted from NICE's guideline on [falls in older people: assessing risk and prevention](#), recommendations 1.1.2.1 and 1.1.2.2, and expert consensus]

Present for medical attention

Older people who fall may present for medical attention in a variety of settings and to different healthcare practitioners. Examples of settings include general practice, emergency departments, inpatient wards, walk-in health centres and community services.

[Expert consensus]

Quality statement 8: Strength and balance training

Quality statement

Older people living in the community who have a known history of recurrent falls are referred for strength and balance training. [2015]

Rationale

Balance impairment and muscle weakness caused by ageing and lack of use are the most prevalent modifiable risk factors for falls. Strength and balance training has been identified as an effective single intervention and as a component in successful multifactorial intervention programmes to reduce subsequent falls. It is important that strength and balance training is undertaken after a multifactorial falls risk assessment has been completed.

Quality measures

Structure

Evidence of local arrangements to ensure that older people living in the community who have a known history of recurrent falls are referred for strength and balance training.

Data source: Local data collection.

Process

a) Proportion of older people living in the community with a known history of recurrent falls reporting to their GP who are referred for strength and balance training.

Numerator – the number in the denominator referred for strength and balance training.

Denominator – the number of older people living in the community with a known history of recurrent falls reporting to their GP.

Data source: Local data collection. The Royal College of Physicians (2011) [Falling standards, broken promises: report of the national audit of falls and bone health](#) includes questions on strength and balance training within the section on Organisational audit results, section 5.4: Interventions for falls prevention. Contained within the Royal College of Physicians' [Fracture Liaison Service Database](#).

b) Proportion of older people living in the community who report recurrent falls to a healthcare practitioner in hospital who are referred for strength and balance training.

Numerator – the number in the denominator referred for strength and balance training.

Denominator – the number of older people living in the community who report recurrent falls to a healthcare practitioner in hospital.

Data source: Local data collection. The Royal College of Physicians (2011) [Falling standards, broken promises: report of the national audit of falls and bone health](#) includes questions on strength and balance training within the section on Organisational audit results, section 5.4: Interventions for falls prevention.

Outcome

Rates of recurrent falls in older people.

Data source: Local data collection.

What the quality statement means for different audiences

Service providers (such as specialist falls services, district general hospitals, community health providers, independent sector providers and charities) ensure that staff are trained to deliver and monitor strength and balance training programmes for older people living in the community who have a known history of recurrent falls.

Health and social care practitioners are aware of local referral pathways for falls and ensure that older people living in the community who have a known history of recurrent falls are referred to a service that has staff who are trained to deliver and monitor a strength and balance training programme.

Commissioners (clinical commissioning groups and local authorities) ensure that they commission services that have the capacity and staff who are trained to deliver and monitor strength and balance training programmes for older people living in the community who have a known history of recurrent falls.

Older people living in the community (for example, in their own home or in sheltered or supported accommodation) who have fallen more than once in the past year have the opportunity to see an

expert who will help them start a programme of exercises (sometimes called 'strength and balance training') to build up their muscle strength and improve balance. These exercises will be designed specifically for them, and the expert will check how they are getting on.

Source guidance

- College of Occupational Therapists (2015) [Occupational therapy in the prevention and management of falls in adults](#), recommendation 15
- [Falls in older people: assessing risk and prevention](#) (2013) NICE guideline CG161, recommendations 1.1.1.2, 1.1.3.1 and 1.1.4.1

Definitions of terms used in this quality statement

Fall

A fall is defined as an unintentional or unexpected loss of balance resulting in coming to rest on the floor, the ground, or an object below knee level.

[NICE's clinical knowledge summary on [falls – risk assessment](#)]

Older people living in the community

Community settings include:

- people's own homes and other housing, including temporary accommodation
- extra care housing (such as warden supported, sheltered or specialist accommodation)
- Shared Lives Scheme (formerly Adult Placement Scheme) living arrangements
- supported living.

[Expert opinion]

Recurrent falls

Recurrent falls is defined as falling twice or more within a time period of 1 year.

[Expert consensus]

Strength and balance training

A strength and balance training programme should be individually prescribed and monitored by an appropriately trained professional.

[NICE's guideline on [falls in older people: assessing risk and prevention](#), recommendation 1.1.4.1, and expert consensus]

Quality statement 9: Home hazard assessment and interventions

Quality statement

Older people who are admitted to hospital after having a fall are offered a home hazard assessment and safety interventions. [2015]

Rationale

Adapting or modifying the home environment is an effective way of reducing the risk of falls for older people living in the community. Home hazard assessment undertaken in the person's home, and intervention if needed, has been identified as a component in successful multifactorial intervention programmes. It is important that a home hazard assessment is undertaken after a multifactorial falls risk assessment has been completed.

Quality measures

Structure

a) Evidence of local arrangements to ensure that older people who are admitted to hospital after having a fall are offered a home hazard assessment.

Data source: Local data collection.

b) Evidence of local arrangements to ensure that older people who are admitted to hospital after having a fall are offered safety interventions if these are identified by a home hazard assessment.

Data source: Local data collection. The Royal College of Physicians (2011) [Falling standards, broken promises: report of the national audit of falls and bone health](#) Clinical audit results, section 3: Multifactorial risk assessment and intervention contains the following question: Were appropriate home hazard interventions offered?

Process

a) Proportion of older people admitted to hospital after a fall who are offered a home hazard assessment.

Numerator – the number in the denominator offered a home hazard assessment.

Denominator – the number of older people admitted to hospital after having a fall.

Data source: Local data collection.

b) Proportion of older people admitted to hospital after having a fall who have a home hazard assessment that is performed in their home.

Numerator – the number in the denominator who have a home hazard assessment performed in their home.

Denominator – the number of older people admitted to hospital after having a fall.

Data source: Local data collection. The Royal College of Physicians (2011) [Falling standards, broken promises: report of the national audit of falls and bone health](#) Clinical audit results, section 3: Multifactorial risk assessment and intervention contains the following question: Was an access or home visit/assessment performed in the patient's own environment?

c) Proportion of older people whose home hazard assessment identified a need for safety interventions who are offered those interventions.

Numerator – the number in the denominator who are offered safety interventions.

Denominator – the number of older people whose home hazard assessment identified a need for safety interventions.

Data source: Local data collection. The Royal College of Physicians (2011) [Falling standards, broken promises: report of the national audit of falls and bone health](#) Clinical audit results, section 3: Multifactorial risk assessment and intervention contains the following question: Were appropriate home hazard interventions offered?

d) Proportion of older people who accepted the offer of safety interventions who received those interventions.

Numerator – the number in the denominator who received safety interventions.

Denominator – the number of older people who accepted the offer of safety interventions.

Data source: Local data collection.

Outcome

Falls rates in the home for older people.

Data source: Local data collection.

What the quality statement means for different audiences

Service providers (such as community health trusts, independent sector providers and district general hospital trusts) ensure that they employ staff with the expertise to perform home hazard assessments for older people who are admitted to hospital after having a fall and, if appropriate, the assessment is followed up with the offer of safety interventions and/or modifications.

Healthcare professionals (in particular occupational therapists) ensure that they perform home hazard assessments for older people who are admitted to hospital after having a fall, and offer safety interventions and modifications as appropriate. This should happen in the person's home and within a timescale that is agreed with the person or their carer.

Commissioners (clinical commissioning groups and local authorities) ensure that they commission services that have the capacity and employ staff with the expertise to perform home hazard assessments for older people who are admitted to hospital after having a fall, and in which the assessment is followed up with the offer of safety interventions and/or modifications as appropriate.

Older people who are admitted to hospital after having a fall are visited in their home after they are discharged by a trained healthcare professional (usually an occupational therapist) who will check for anything that might put them at risk of falling again. If the healthcare professional thinks that making changes in the person's home (for example, changing the layout of furniture) or having special equipment might lower the chances of another fall, they will offer help with this.

Source guidance

- College of Occupational Therapists (2015) [Occupational therapy in the prevention and management of falls in adults](#), recommendations 1 and 3
- [Falls in older people: assessing risk and prevention](#) (2013) NICE guideline CG161, recommendations 1.1.6.1 and 1.1.6.2

Definitions of terms used in this quality statement

Fall

A fall is defined as an unintentional or unexpected loss of balance resulting in coming to rest on the floor, the ground, or an object below knee level.

[NICE's clinical knowledge summary on [falls – risk assessment](#)]

Home hazard assessment

Home hazard assessment should be undertaken in the person's home and should be more than a 'checklist' of hazards. It is essential that the assessment explores how the actual use of the environment affects the person's risk of falling.

[Adapted from the College of Occupational Therapists' practice guideline [Occupational therapy in the prevention and management of falls in adults](#) (2015)]

Equality and diversity considerations

Healthcare professionals undertaking home hazard assessments and offering safety interventions should be aware that age, socioeconomic status, family origin and culture may influence the willingness of people to accept help with home hazards.

Update information

January 2017: This quality standard was updated by adding 3 new statements to the 2015 version. All statements prioritised in 2015 were retained.

Statements are marked as [2015] or [new 2017].

The 3 new statements were originally intended to form a separate quality standard on falls prevention. However, the statements have been combined with the 2015 statements so that there is a single quality standard covering prevention of falls and assessment after a fall.

About this quality standard

NICE quality standards describe high-priority areas for quality improvement in a defined care or service area. Each standard consists of a prioritised set of specific, concise and measurable statements. NICE quality standards draw on existing NICE or NICE-accredited guidance that provides an underpinning, comprehensive set of recommendations, and are designed to support the measurement of improvement.

Information about [how NICE quality standards are developed](#) is available from the NICE website.

The statements in this quality standard have been developed with 2 different quality standards advisory committees. See [quality standard advisory committees](#) on the website for details of standing committee 4 members who advised on the 2017 statements in this quality standard. Information on the standing members who advised on the 2015 statements, along with topic experts who joined each of the committees, is available on the [quality standard's webpage](#).

This quality standard has been incorporated into the NICE pathway on [falls in older people](#).

NICE has produced a [quality standard service improvement template](#) to help providers make an initial assessment of their service compared with a selection of quality statements. This tool is updated monthly to include new quality standards.

NICE produces guidance, standards and information on commissioning and providing high-quality healthcare, social care, and public health services. We have agreements to provide certain NICE services to Wales, Scotland and Northern Ireland. Decisions on how NICE guidance and other products apply in those countries are made by ministers in the Welsh government, Scottish government, and Northern Ireland Executive. NICE guidance or other products may include references to organisations or people responsible for commissioning or providing care that may be relevant only to England.

Improving outcomes

This quality standard is expected to contribute to improvements in the following outcomes:

- falls in older people
- injuries resulting from falls in older people
- hospital admissions resulting from falls in older people

- patient safety incidents reported
- health-related quality of life for older people
- social care-related quality of life for older people
- independence of older people
- mortality in older people resulting from falls and underlying causes.

It is also expected to support delivery of the Department of Health's outcome frameworks:

- [Adult social care outcomes framework 2015–16](#)
- [NHS outcomes framework 2016–17](#)
- [Public health outcomes framework for England, 2016–19.](#)

Resource impact

NICE quality standards should be achievable by local services. The potential resource impact was considered by the quality standards advisory committee for statements 1, 2 and 3, drawing on resource impact work for the source guidance. Organisations are encouraged to use the [costing statement](#) for NICE's guideline on falls in older people to help estimate local costs.

Diversity, equality and language

During the development of this quality standard, equality issues were considered and [equality assessments](#) are available. Any specific issues identified during development of the quality statements are highlighted in each statement.

Good communication between health, public health and social care practitioners and older people at risk of falling, or who have fallen, is essential. Assessment, interventions, care and support, and the information given about it, should be culturally appropriate. It should also be accessible to people with additional needs such as physical, sensory or learning disabilities, and to people who do not speak or read English. Older people should have access to an interpreter or advocate if needed.

Commissioners and providers should aim to achieve the quality standard in their local context, in light of their duties to have due regard to the need to eliminate unlawful discrimination, advance equality of opportunity and foster good relations. Nothing in this quality standard should be interpreted in a way that would be inconsistent with compliance with those duties.

ISBN: 978-1-4731-1128-8

Endorsing organisations

This quality standard has been endorsed by the following organisations, as required by the Health and Social Care Act (2012):

- [NHS England](#)
- [Department of Health and Social Care](#)

Supporting organisations

Many organisations share NICE's commitment to quality improvement using evidence-based guidance. The following supporting organisations have recognised the benefit of the quality standard in improving care for patients, carers, service users and members of the public. They have agreed to work with NICE to ensure that those commissioning or providing services are made aware of and encouraged to use the quality standard.

- [Chartered Society of Physiotherapy](#)
- [Royal College of Occupational Therapists](#)
- [Royal College of Physicians](#)
- [Arrhythmia Alliance](#)
- [Syncope Trust And Reflex Anoxic Seizures](#)