NICE National Institute for Health and Care Excellence

Falls in older people: assessment after a fall and preventing further falls

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NICE quality standard 86

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Contents

Introduction

This quality standard covers assessment after a fall and preventing further falls (secondary prevention) in older people living in the community and during a hospital stay. Secondary prevention focuses on interventions targeted at older people with a history of falls. Older people are those aged 65 years and over. For more information see the falls in older people: assessment after a fall and preventing further falls overview. The following falls quality standard topics are also scheduled for future development:

- Falls: prevention.
- Falls: regaining independence for older people who experience a fall.

Why this quality standard is needed

Falls and fall-related injuries are a common and serious problem for older people, particularly those who have underlying pathologies or conditions. Falls are a major cause of disability and the leading cause of mortality resulting from injury in people aged 75 and older in the UK.

People aged 65 and older have the highest risk of falling. Around 30% of adults who are over 65 and living at home will experience at least 1 fall a year (approximately 2.5 million people in England). This rises to 50% of adults over 80 who are either at home or in residential care.

Most falls do not result in serious injury, but annually approximately 5% of older people living in the community who fall experience a fracture or need hospitalisation. The Royal College of Physicians (2011) report Falling standards, broken promises highlights that falls and fractures in people aged 65 and over account for over 4 million hospital bed days each year in England alone.

Falls in hospitals are the most common patient safety incidents reported in hospital trusts in England. The National Patient Safety Agency (2011) report Essential care after an inpatient fall states that each year around 282,000 patient falls are reported to the NHS England's Patient Safety division from hospitals and mental health units. A significant minority of these falls result in death or in severe or moderate injury.

The human cost of falling includes distress, pain, injury, loss of confidence, loss of independence and mortality. Falling also affects the family members and carers of people who fall. Falls are

estimated to cost the NHS more than £2.3 billion per year. Therefore falling has an impact on quality of life, health and healthcare costs.

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

- health-related quality of life for older people
- social care-related quality of life for older people
- patient safety incidents reported
- injuries resulting from falls in people aged 65 and over
- fall-related fractures in people aged 65 and over.

How this quality standard supports delivery of outcome frameworks

NICE quality standards are a concise set of prioritised statements designed to drive measurable improvements in the 3 dimensions of quality – patient safety, patient experience and clinical effectiveness – for a particular area of health or care. They are derived from high-quality guidance, such as that from NICE or other sources accredited by NICE. This quality standard, in conjunction with the guidance on which it is based, should contribute to the improvements outlined in the following 3 outcomes frameworks published by the Department of Health:

- NHS Outcomes Framework 2015–16
- Adult Social Care Outcomes Framework 2015–16
- Public Health Outcomes Framework 2013–2016.

Tables 1–3 show the outcomes, overarching indicators and improvement areas from the frameworks that the quality standard could contribute to achieving.

Table 1 NHS Outcomes Framework 2015–16

Domain	Overarching indicators and improvement areas

1 Preventing people from dying prematurely	***Overarching indicator*** 1a Potential Years of Life Lost (PYLL) from causes considered amenable to healthcare i Adults 1b Life expectancy at 75 i Males ii Females
2 Enhancing quality of life for people with long-term conditions	***Overarching indicator*** 2 Health-related quality of life for people with long-term conditions** ***Improvement areas*** **Ensuring people feel supported to manage their condition** 2.1 Proportion of people feeling supported to manage their condition **Reducing time spent in hospital by people with long-term conditions**
3 Helping people to recover from episodes of ill health or following injury	***Overarching indicator*** 3b Emergency readmissions within 30 days of discharge from hospital (PHOF 4.11*) ***Improvement areas*** **Improving recovery from injuries and trauma** 3.3 Survival from major trauma **Improving recovery from fragility fractures** 3.5 Proportion of patients recovering to their previous levels of mobility/walking ability at i 30 and ii 120 days **Helping older people to recover their independence after illness or injury** 3.6 i Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation service (ASCOF 2B**)

4 Ensuring that people have a positive experience of care	***Overarching indicator*** 4b Patient experience of hospital care ***Improvement areas*** **Improving people's experience of integrated care** 4.9 People's experience of integrated care (ASCOF 3E**)
5 Treating and caring for people in a safe environment and protecting them from avoidable harm	***Overarching indicators*** 5a Patient safety incidents reported 5b Safety incidents involving severe harm or death 5c Hospital deaths attributable to problems in care
Alignment across the health and social care system * Indicator shared with Public Health Outcomes Framework (PHOF) ** Indicator complementary with Adult Social Care Outcomes Framework (ASCOF)	

Table 2 The Adult Social Care Outcomes Framework 2015–16

Domain	Overarching and outcome measures
1 Enhancing quality of life for people with care and support needs	***Overarching measure*** 1A Social care-related quality of life* ***Outcome measures*** **People manage their own support as much as they wish, so that they are in control of what, how and when support is delivered to match their needs.** 1B Proportion of people who use services who have control over their daily life **Carers can balance their caring roles and maintain their desired quality of life.** 1D Carer-reported quality of life*

2 Delaying and reducing the need for care and support	***Overarching measure*** 2A Permanent admissions to residential and nursing care homes, per 100,000 population ***Outcome measures*** **Everybody has the opportunity to have the best health and wellbeing throughout their life, and can access support and information to help them manage their care needs.** **Earlier diagnosis, intervention and reablement means that people and their carers are less dependent on intensive services.** 2B Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services** (NHSOF 3.6 i–ii) **When people develop care needs, the support they receive takes place in the most appropriate setting, and enables them to regain their independence.** 2C Delayed transfers of care from hospital, and those which are attributable to adult social care
3 Ensuring that people have a positive experience of care and support	***Overarching measure*** **People who use social care and their carers are satisfied with their experience of care and support services.** 3A Overall satisfaction of people who use services with their care and support New measure for 2014/15: 3E Improving people's experience of integrated care* (NHSOF 4.9) ***Outcome measures*** **People know what choices are available to them locally, what they are entitled to, and who to contact when they need help.**

4 Safeguarding adults whose circumstances make them vulnerable and protecting from avoidable harm	***Overarching measure*** 4A The proportion of people who use services who feel safe* ***Outcome measures*** Everyone enjoys physical safety and feels secure People are protected as far as possible from avoidable harm, disease and injuries
Aligning across the health and care system * Indicator complementary ** Indicator shared	

Table 3 Public health outcomes framework for England, 2013–2016

Domain	Objectives and indicators
2 Health improvement	***Objective*** People are helped to live healthy lifestyles, make healthy choices and reduce health inequalities 2.24 Injuries due to falls in people aged 65 and over
4 Healthcare public health and preventing premature mortality	***Objective*** Reduced numbers of people living with preventable ill health and people dying prematurely, while reducing the gap between communities ***Indicators*** 4.3 Mortality rate from causes considered preventable** (NHSOF 1a) 4.11 Emergency readmissions within 30 days of discharge from hospital* (NHSOF 3b) 4.13 Health-related quality of life for older people 4.14 Hip fractures in people aged 65 and over 4.15 Excess winter deaths

Alignment across the health and care system

* Indicator shared with NHS Outcomes Framework

** Indicator complementary with NHS Outcomes Outcomes Framework

Patient experience and safety issues

Ensuring that care is safe and that people have a positive experience of care is vital in a high-quality service. It is important to consider these factors when planning and delivering services relevant to falls.

NICE has developed guidance and associated quality standards on patient experience in adult NHS services and service user experience in adult mental health services (see the NICE pathways on patient experience in adult NHS services and service user experience in adult mental health services), which should be considered alongside this quality standard. They specify that people receiving care should be treated with dignity, have opportunities to discuss their preferences, and be supported to understand their options and make fully informed decisions. They also cover the provision of information to patients and service users. Quality statements on these aspects of patient experience are not usually included in topic-specific quality standards. However, recommendations in the development sources for quality standards that impact on patient experience and are specific to the topic are considered during quality statement development.

Coordinated services

The quality standard for assessment and prevention of further falls in older people specifies that services should be commissioned from and coordinated across all relevant agencies encompassing the whole falls care pathway. A person-centred, integrated approach to providing services is fundamental to delivering high-quality care to older people who experience a fall.

The Health and Social Care Act 2012 sets out a clear expectation that the care system should consider NICE quality standards in planning and delivering services, as part of a general duty to secure continuous improvement in quality. Commissioners and providers of health and social care should refer to the library of NICE quality standards when designing high-quality services. Other quality standards that should also be considered when choosing, commissioning or providing a high-quality falls service are listed in related quality standards.

Training and competencies

The quality standard should be read in the context of national and local guidelines on training and competencies. All health and social care practitioners involved in assessing, caring for and treating older people who experience a fall should have sufficient and appropriate training and competencies to deliver the actions and interventions described in the quality standard. Quality statements on staff training and competency are not usually included in quality standards. However, recommendations in the development sources on specific types of training for the topic that exceed standard professional training are considered during quality statement development.

Role of families and carers

Quality standards recognise the important role families and carers have in supporting older people who experience a fall. If appropriate, health and social care practitioners should ensure that family members and carers are involved in the decision-making process about investigations, treatment and care.

List of quality statements

Statement 1. 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.

Statement 2. 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.

Statement 3. Older people who fall during a hospital stay have a medical examination.

Statement 4. Older people who present for medical attention because of a fall have a multifactorial falls risk assessment.

Statement 5. Older people living in the community who have a known history of recurrent falls are referred for strength and balance training.

Statement 6. Older people who are admitted to hospital after having a fall are offered a home hazard assessment and safety interventions.

Quality statement 1: 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.

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.

Outcomes

(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 service providers, healthcare professionals and commissioners

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.

What the quality statement means for patients, service users and carers

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) 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. A fall is distinguished from a collapse that occurs as a result of an acute medical problem such as an acute arrhythmia, a transient ischaemic attack or vertigo. [Adapted from Falls – risk assessment (NICE clinical knowledge summary)]

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 shows 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 NPSA Essential care after an inpatient fall, recommendations 1 and 2, and expert consensus]

Quality statement 2: 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.

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 service providers, healthcare professionals and commissioners

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.

What the quality statement means for patients, service users and carers

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) 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. A fall is distinguished from a collapse that occurs as a result of an acute medical problem such as an acute arrhythmia, a transient ischaemic attack or vertigo. [Adapted from Falls – risk assessment (NICE clinical knowledge summary)]

Post-fall protocol

A post-fall protocol should include:

- checks by nursing staff for signs or symptoms of fracture or 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 equipment or 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 following a fall (including fast track assessment for patients with signs of serious injury, or high vulnerability to injury, or who have been immobilised); medical examination should be completed within a maximum time period of 12 hours, or 30 minutes if fast-tracked.

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

There should be access to specialist equipment such as hard collars, flat-lifting equipment and scoops, and staff available who have the expertise to use the equipment, for handling patients with suspected fracture or potential for spinal injury.

[Adapted from NPSA Essential care after an inpatient fall, recommendations 1 and 2, and expert consensus]

Quality statement 3: Medical examination after an inpatient fall

Quality statement

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

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 as part of 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.

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 service providers, healthcare professionals and commissioners

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.

What the quality statement means for patients, service users and carers

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) 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. A fall is distinguished from a collapse that occurs as a result of an acute medical problem such as an acute arrhythmia, a transient ischaemic attack or vertigo. [Adapted from Falls – risk assessment (NICE clinical knowledge summary)]

Post-fall protocol

A post-fall protocol should include:

- checks by nursing staff for signs or symptoms of fracture or 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 equipment or 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 following a fall (including fast track assessment for patients with signs of serious injury, or high vulnerability to injury, or who have been immobilised); medical examination should be completed within a maximum time period 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 NPSA Essential care after an inpatient fall, recommendations 1 and 2 and expert consensus]

Quality statement 4: Multifactorial falls risk assessment

Quality statement

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

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.

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, Organisation 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 service providers, health and social care practitioners and commissioners

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.

What the quality statement means for patients, service users and carers

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 (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. A fall is distinguished from a collapse that occurs as a result of an acute medical problem such as an acute arrhythmia, a transient ischaemic attack or vertigo. [Adapted from Falls – risk assessment (NICE clinical knowledge summary)]

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, strength, balance and mobility
- 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 Falls (NICE guideline CG161), 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 5: 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.

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, includes questions on strength and balance training within the section on Organisation audit results, section 5.3: interventions for falls prevention.

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, includes questions on strength and balance training within the section on Organisation audit results, section 5.3: interventions for falls prevention.

Outcome

Rates of recurrent falls in older people.

Data source: Local data collection.

What the quality statement means for service providers, health and social care practitioners and commissioners

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.

What the quality statement means for patients, service users and carers

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 last 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

- Falls (NICE guideline CG161), recommendations 1.1.1.2, 1.1.3.1 and 1.1.4.1
- College of Occupational Therapists (2015) Occupational therapy in the prevention and management of falls in adults, recommendation 15

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. A fall is distinguished from a collapse that occurs as a result of an acute medical problem such as an acute arrhythmia, a transient ischaemic attack or vertigo. [Adapted from Falls – risk assessment (NICE clinical knowledge summary)]

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

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. [Falls (NICE guideline CG161), recommendation 1.1.4.1, and expert consensus]

Quality statement 6: 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.

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, Clinical audit results, section 3: Multi-factorial 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, Clinical audit results, section 3: Multi-factorial 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, Clinical audit results, section 3: Multi-factorial 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 service providers, healthcare professionals and commissioners

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.

What the quality statement means for patients, service users and carers

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

- Falls (NICE guideline CG161), recommendations 1.1.6.1 and 1.1.6.2
- College of Occupational Therapists (2015) Occupational therapy in the prevention and management of falls in adults, recommendations 1 and 3

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. A fall is distinguished from a collapse that occurs as a result of an acute medical problem such as an acute arrhythmia, a transient ischaemic attack or vertigo. [Adapted from Falls – risk assessment (NICE clinical knowledge summary)]

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.

Using the quality standard

Quality measures

The quality measures accompanying the quality statements aim to improve the structure, process and outcomes of care in areas identified as needing quality improvement. They are not a new set of targets or mandatory indicators for performance management.

We have indicated if current national indicators exist that could be used to measure the quality statements. These include indicators developed by the Health and Social Care Information Centre through its Indicators for Quality Improvement Programme. If there is no national indicator that could be used to measure a quality statement, the quality measure should form the basis for audit criteria developed and used locally.

See NICE's what makes up a NICE quality standard? for further information, including advice on using quality measures.

Levels of achievement

Expected levels of achievement for quality measures are not specified. Quality standards are intended to drive up the quality of care, and so achievement levels of 100% should be aspired to (or 0% if the quality statement states that something should not be done). However, NICE recognises that this may not always be appropriate in practice, taking account of safety, choice and professional judgement, and therefore desired levels of achievement should be defined locally.

Using other national guidance and policy documents

Other national guidance and current policy documents have been referenced during the development of this quality standard. It is important that the quality standard is considered alongside the documents listed in development sources.

Information for the public

NICE has produced information for the public about this quality standard. Patients, service users and carers can use it to find out about the quality of care they should expect to receive; as a basis for asking questions about their care, and to help make choices between providers of social care services.

Diversity, equality and language

During the development of this quality standard, equality issues have been considered and equality assessments are available.

Good communication between health and social care practitioners and older people who experience a fall is essential. Treatment, 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 who experience a fall 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.

Development sources

Further explanation of the methodology used can be found in the quality standards process guide.

Evidence sources

The documents below contain recommendations from NICE guidance or other NICE-accredited recommendations that were used by the Quality Standards Advisory Committee to develop the quality standard statements and measures.

- College of Occupational Therapists (2015) Occupational therapy in the prevention and management of falls in adults
- Falls (2013) NICE guideline CG161
- National Patient Safety Agency (2011) Essential care after an inpatient fall

Policy context

It is important that the quality standard is considered alongside current policy documents, including:

- Royal College of Physicians (2014) The Falls and Fragility Fracture Audit Programme (FFFAP)
- Age UK (2013) Falls prevention exercise – following the evidence
- Welsh Government (2013) The strategy for older people in Wales 2013–2023
- Age UK and the National Osteoporosis Society (2012) Breaking through: building better falls and fractures services in England
- Royal College of Physicians (2012) Implementing FallSafe: care bundles to reduce inpatient falls
- Royal College of Physicians (2012) Older people's experiences of therapeutic exercise as part of a falls prevention service

- Royal College of Physicians (2012) Report of the 2011 inpatient falls pilot audit
- Patient Safety First (2009) The 'how to' guide for reducing harm from falls
- Age UK (2005) Don't mention the F-word: advice to practitioners on communicating falls prevention messages to older people
- Age UK Stop falling: start saving lives and money

Definitions and data sources for the quality measures

- NICE (2014) Falls – risk assessment NICE clinical knowledge summary
- Royal College of Physicians (2012) Report of the 2011 inpatient falls pilot audit
- Royal College of Physicians (2011) Falling standards, broken promises

Related NICE quality standards

Published

- Head injury (2014) NICE quality standard 74
- Hip fracture in adults (2012) NICE quality standard 16
- Patient experience in adult NHS services (2012) NICE quality standard 15
- Service user experience in adult mental health (2011) NICE quality standard 14

Future quality standards

This quality standard has been developed in the context of all quality standards referred to NICE, including the following topics scheduled for future development:

- Complex fractures (including compound fractures)
- Falls: prevention
- Falls: regaining independence for older people who experience a fall
- Fractures (excluding head and hip)
- Regaining independence: short-term interventions to help people to regain independence
- Resuscitation following major trauma and major blood loss
- Service user and carer experience: service user and carer experience of social care
- Social care of older people with more than one physical or mental healthcare long term condition in residential or community settings
- Transition between social care and health care services
- Trauma services

The full list of quality standard topics referred to NICE is available from the quality standards topic library on the NICE website.

Quality Standards Advisory Committee and NICE project team

Quality Standards Advisory Committee

This quality standard has been developed by Quality Standards Advisory Committee 1. Membership of this committee is as follows:

Mr Lee Beresford
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Dr Gita Bhutani
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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.

The methods and processes for developing NICE quality standards are described in the quality standards process guide.

This quality standard has been incorporated into the NICE pathway on falls in older people.

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.

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