NHS

National Institute for Clinical Excellence

Falls

The assessment and prevention of falls in older people

Clinical Guideline 21
November 2004

Developed by the National Collaborating Centre for Nursing and Supportive Care

Clinical Guideline 21
Falls: the assessment and prevention of falls in older people

Issue date: November 2004

This document, which contains the Institute's full guidance on Falls: the assessment and prevention of falls in older people, is available from the NICE website (www.nice.org.uk/CG021NICEguideline).

An abridged version of this guidance (a 'quick reference guide') is also available from the NICE website (www.nice.org.uk/CG021quickrefguide). Printed copies of the quick reference guide can be obtained from the NHS Response Line: telephone 0870 1555 455 and quote reference number N0760.

Information for the Public is available from the NICE website or from the NHS Response Line (quote reference number N0761 for a version in English and N0762 for a version in English and Welsh).

This guidance is written in the following context:

This guidance represents the view of the Institute, which was arrived at after careful consideration of the evidence available. Health professionals are expected to take it fully into account when exercising their clinical judgement. The guidance does not, however, override the individual responsibility of health professionals to make decisions appropriate to the circumstances of the individual patient, in consultation with the patient and/or guardian or carer.

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The quick reference guide for this guideline has been distributed to the following:

- Primary care trust (PCT) chief executives
- NHS trust chief executives in England and Wales
- Clinical governance leads in England and Wales
- Audit leads in England and Wales
- Local health board (LHB) chief executives
- Medical and nursing directors in England and Wales
- NHS trust, PCT and LHB libraries in England and Wales
- Consultants in rehabilitation medicine in England and Wales
- Consultants in elderly care in England and Wales
- Consultant psychogerantology in England and Wales
- Accident and Emergency consultants in England and Wales
- Consultants in occupational health in England and Wales
- Clinical directors for physiotherapy in England and Wales
- Directorate nurse managers for rehabilitation, occupational therapy and accident and emergency in England and Wales
- GPs in England and Wales
- Practice nurses, community nurses and health visitors in England and Wales
- Chief pharmacists, heads of drug purchasing, heads of drug information, GP prescribing advisors and purchase advisors in England and Wales
- Strategic health authority chief executives in England and Wales
- Directors of directorates of health and social care
- NHS Director Wales
- Chief Executive of the NHS in England
- NHS Executive regional directors
- Patient advocacy groups
- Commission for Health Improvement
- NHS Clinical Governance Support Team
- Chief Medical, Nursing and Pharmaceutical Officers in England and Wales
- Medical Director and Head of NHS Quality − Welsh Assembly Government
- Representative bodies for health services, professional organisations and statutory bodies and the Royal Colleges

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Key priorities for implementation

Case/risk identification

- Older people in contact with healthcare professionals should be asked routinely whether they have fallen in the past year and asked about the frequency, context and characteristics of the fall/s.
- Older people reporting a fall or considered at risk of falling should be observed for balance and gait deficits and considered for their ability to benefit from interventions to improve strength and balance. (Tests of balance and gait commonly used in the UK are detailed in the full guideline.)

Multifactorial falls risk assessment

- Older people who present for medical attention because of a fall, or report recurrent falls in the past year, or demonstrate abnormalities of gait and/or balance should be offered a multifactorial falls risk assessment. This assessment should be performed by healthcare professionals with appropriate skills and experience, normally in the setting of a specialist falls service. This assessment should be part of an individualised, multifactorial intervention.
- Multifactorial assessment may include the following:
  - identification of falls history
  - assessment of gait, balance and mobility, and muscle weakness
  - assessment of osteoporosis risk
  - assessment of the older person's 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.

Multifactorial interventions

- All older people with recurrent falls or assessed as being at increased risk of falling should be considered for an individualised multifactorial intervention.
- In successful multifactorial intervention programmes the following specific components are common (against a background of the general diagnosis and management of causes and recognised risk factors):
    - strength and balance training
    - home hazard assessment and intervention
    - vision assessment and referral
    - medication review with modification/withdrawal.
- Following treatment for an injurious fall, older people should be offered a multidisciplinary assessment to identify and address future risk, and individualised intervention aimed at promoting independence and improving physical and psychological function.

Encouraging the participation of older people in falls prevention programmes including education and information giving

- Individuals at risk of falling, and their carers, should be offered information orally and in writing about what measures they can take to prevent further falls.

Professional education

- All healthcare professionals dealing with patients known to be at risk of falling should develop and maintain basic professional competence in falls assessment and prevention.

The following guidance is evidence based. The grading scheme used for the recommendations (A, B, C, D or good practice point [GPP]) is described in Appendix A; a summary of the evidence on which the guidance is based is provided in the full guideline (see Section 5) and we encourage users to consult this document for further details. Attention is also drawn to the service framework algorithm and the principles of practice (Appendices E and F).

1 Guidance

1.1 Case/risk identification

1.1.1 Older people in contact with healthcare professionals should be asked routinely whether they have fallen in the past year and asked about the frequency, context and characteristics of the fall/s. **C**

1.1.2 Older people reporting a fall or considered at risk of falling should be observed for balance and gait deficits and considered for their ability to benefit from interventions to improve strength and balance. (Tests of balance and gait commonly used in the UK are detailed in the full guideline, see Section 5.) **C**

1.2 Multifactorial falls risk assessment

1.2.1 Older people who present for medical attention because of a fall, or report recurrent falls in the past year, or demonstrate abnormalities of gait and/or balance should be offered a multifactorial falls risk assessment. This assessment should be performed by a healthcare professional with appropriate skills and experience, normally in the setting of a specialist falls service. This assessment should be part of an individualised, multifactorial intervention. **C**

1.2.2 Multifactorial assessment may include the following: **C**

- identification of falls history
- assessment of gait, balance and mobility, and muscle weakness
- assessment of osteoporosis risk

- assessment of the older person's 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.

1.3 Multifactorial interventions

1.3.1 All older people with recurrent falls or assessed as being at increased risk of falling should be considered for an individualised multifactorial intervention. **A**

In successful multifactorial intervention programmes the following specific components are common (against a background of the general diagnosis and management of causes and recognised risk factors): **A**

- strength and balance training
- home hazard assessment and intervention
- vision assessment and referral
- medication review with modification/withdrawal.

1.3.2 Following treatment for an injurious fall, older people should be offered a multidisciplinary assessment to identify and address future risk and individualised intervention aimed at promoting independence and improving physical and psychological function. **A**

1.4 Strength and balance training

1.4.1 Strength and balance training is recommended. Those most likely to benefit are older community-dwelling people with a history of recurrent falls and/or balance and gait deficit. A muscle-strengthening and balance programme should be offered. This should be individually prescribed and monitored by an appropriately trained professional. **A**

1.5 Exercise in extended care settings

1.5.1 Multifactorial interventions with an exercise component are recommended for older people in extended care settings who are at risk of falling. **A**

1.6 Home hazard and safety intervention

1.6.1 Older people who have received treatment in hospital following a fall should be offered a home hazard assessment and safety intervention/modifications by a suitably trained healthcare professional. This should normally be part of discharge planning and be carried out within a timescale agreed by the patient or carer, and appropriate members of the healthcare team. **A**

1.6.2 Home hazard assessment is shown to be effective only in conjunction with follow-up and intervention, not in isolation. **A**

1.7 Psychotropic medications

1.7.1 Older people on psychotropic medications should have their medication reviewed, with specialist input if appropriate, and discontinued if possible to reduce their risk of falling. **B**

1.8 Cardiac pacing

1.8.1 Cardiac pacing should be considered for older people with cardioinhibitory carotid sinus hypersensitivity who have experienced unexplained falls. **B**

1.9 Encouraging the participation of older people in falls prevention programmes

1.9.1 To promote the participation of older people in falls prevention programmes the following should be considered. **D**

- Healthcare professionals involved in the assessment and prevention of falls should discuss which changes a person is willing to make to prevent falls.
- Information should be relevant and available in languages other than English.
- Falls prevention programmes should also address potential barriers such as low self-efficacy and fear of falling, and encourage activity change as negotiated with the participant.

1.9.2 Practitioners who are involved in developing falls prevention programmes should ensure that such programmes are flexible enough to accommodate participants' different needs and preferences and should promote the social value of such programmes. **D**

1.10 Education and information giving

1.10.1 All healthcare professionals dealing with patients known to be at risk of falling should develop and maintain basic professional competence in falls assessment and prevention. **D**

1.10.2 Individuals at risk of falling, and their carers, should be offered information orally and in writing about: **D**

- what measures they can take to prevent further falls
- how to stay motivated if referred for falls prevention strategies that include exercise or strength and balancing components
- the preventable nature of some falls
- the physical and psychological benefits of modifying falls risk
- where they can seek further advice and assistance
- how to cope if they have a fall, including how to summon help and how to avoid a long lie.

1.11 Interventions that cannot be recommended

1.11.1 **Brisk walking.** There is no evidence that brisk walking reduces the risk of falling. One trial showed that an unsupervised brisk walking programme increased the risk of falling in postmenopausal women with

an upper limb fracture in the previous year. However, there may be other health benefits of brisk walking by older people.

1.12 Interventions that cannot be recommended because of insufficient evidence

We do not recommend implementation of the following interventions at present. This is not because there is strong evidence against them, but because there is insufficient or conflicting evidence supporting them.

1.12.1 **Low intensity exercise combined with incontinence programmes.** There is no evidence that low intensity exercise interventions combined with continence promotion programmes reduce the incidence of falls in older people in extended care settings.

1.12.2 **Group exercise (untargeted).** Exercise in groups should not be discouraged as a means of health promotion, but there is little evidence that exercise interventions that were not individually prescribed for community-dwelling older people are effective in falls prevention.

1.12.3 **Cognitive/behavioural interventions.** There is no evidence that cognitive/behavioural interventions alone reduce the incidence of falls in community-dwelling older people of unknown risk status. Such interventions included risk assessment with feedback and counselling and individual education discussions. There is no evidence that complex interventions in which group activities included education, a behaviour modification programme aimed at modifying risk, advice and exercise interventions are effective in falls prevention with community-dwelling older people.

1.12.4 **Referral for correction of visual impairment.** There is no evidence that referral for correction of vision as a **single** intervention for community-dwelling older people is effective in reducing the number of people falling. However, vision assessment and referral has been a component of successful **multifactorial** falls prevention programmes.

1.12.5 **Vitamin D.** There is evidence that vitamin D deficiency and insufficiency are common among older people and that when present they impair muscle strength and possibly neuromuscular function via CNS-mediated pathways. In addition, the use of combined calcium and vitamin D3 supplementation has been found to reduce fracture rates in older people in residential/nursing homes and sheltered accommodation. Although there is emerging evidence that correction of vitamin D deficiency or insufficiency may reduce the propensity for falling, there is uncertainty about the relative contribution to fracture reduction via this mechanism (as opposed to bone mass) and about the dose and route of administration required. No firm recommendation can therefore currently be made on its use for this indication. Guidance on the use of vitamin D for fracture prevention will be contained in the forthcoming NICE clinical practice guideline on osteoporosis, which is currently under development.

1.12.6 **Hip protectors.** Reported trials that have used individual patient randomisation have provided no evidence for the effectiveness of hip protectors to prevent fractures when offered to older people living in extended care settings or in their own homes. Data from cluster randomised trials provide some evidence that hip protectors are effective in the prevention of hip fractures in older people living in extended care settings who are considered at high risk.

2 Notes on the scope of the guidance

All NICE guidelines are developed in accordance with a scope document that defines what the guideline will and will not cover. The scope of this guideline was established at the start of the development process and followed a period of consultation: it is available from www.nice.org.uk/page.aspx?o=30592

The recommendations in this guideline cover the care of older people in the community or extended care setting who are at risk of falling or who have fallen and older people who attend primary or secondary care settings following a fall. The recommendations also apply to families, carers and

healthcare professionals who share responsibility for those who are vulnerable or at risk of falling and those involved in delivery of a service.

The guideline does not cover hospitalised patients or people who bed bound.

The interventions that are not covered in this guideline are as follows.

- Prevention and treatment of osteoporosis, which is the subject of a separate NICE guideline under development. However, the parallel importance of both falls and bone health as risk factors for fracture has led to a degree of liaison in the preparation of both guidelines and will in practice require a coordinated approach to service delivery.
- The management of hip and other fractures.
- The prevention of falls in acute settings.

3 Implementation in the NHS

3.1 In general

Local health and social communities should review their existing practice for the assessment and prevention of falls in older people against this guideline. The review should consider the resources required to implement the recommendations set out in Section 1, the people and the processes involved and the timeline over which full implementation is envisaged. It is in the interests of people at risk of falling that the implementation timeline is as rapid as possible.

Relevant local clinical guidelines, care pathways and protocols should be reviewed in the light of this guidance and revised accordingly. Attention is drawn to the generic example in Appendix E.

Specialist falls services may vary among providers in the detail of configuration, staffing and leadership. The most cost-effective configuration is not yet established. Specialist falls services should, however, be operationally linked to both bone health (osteoporosis) services and cardiac pacing services.

This guideline should be used in conjunction with the National Service Framework for Older People (2001) in England and will support the implementation of Standard Six and Standard Two (Falls and Single Assessment Process) and Medicines management.

3.2 Audit

Suggested audit criteria are listed in Appendix D. These can be used as the basis for local clinical audit, at the discretion of those in practice.

4 Research recommendations

The following research recommendations have been identified for this NICE guideline.

- Further analysis of existing trial data is needed to identify which components of multifactorial interventions are important in different settings and among different patient groups.
- Future trials should be designed and analysed with the intention of identifying cost-effective components of multifactorial programmes for particular groups of older people in different settings.
- Evaluation of multi-agency falls prevention programmes to measure the impact of these programmes on reducing falls, injurious falls and fractures in older people.
- Falls prevention trials with a focus on injury reduction (such as fracture outcomes) and fall related outcomes are needed.
- Research into the optimal methods of risk assessment for falls in older people and evaluation of whether high risk individuals can be stratified in terms of who will most benefit from assessment and intervention.
- Trials investigating the most effective strategy for preventing falls and fractures in older people with cognitive impairment and dementia.
- UK based cost-effectiveness analysis of falls prevention strategies.

- Trials are needed to investigate the effectiveness of hip protectors compared with other fracture prevention strategies in older people at high risk of falling.

5 Other versions of this guideline

The National Institute for Clinical Excellence commissioned the development of this guidance from the National Collaborating Centre for Nursing and Supportive Care. The Centre established a Guideline Development Group, which reviewed the evidence and developed the recommendations. The members of the Guideline Development Group are listed in Appendix B. Information about the independent Guideline Review Panel is given in Appendix C.

The booklet *The guideline development process – an overview for stakeholders, the public and the NHS* has more information about the Institute's guideline development process. It is available from the Institute's website and copies can be ordered by telephoning 0870 1555 455 (quote reference N0472).

Full guideline

The full guideline, 'The assessment and prevention of falls in older people', is published by the National Collaborating Centre for Nursing and Supportive Care, The Royal College of Nursing Institute. It is available on its website (www.rcn.org.uk), the NICE website (www.nice.org.uk) and on the website of the National Electronic Library for Health (www.nelh.nhs.uk).

Information for the public

A version of this guideline for people at risk of falling, their advocates and carers, and for the public is available from the NICE website (www.nice.org.uk/CG021publicinfo) or from the NHS Response Line

(0870 1555 455; quote reference number N0761 for an English version and N0762 for an English and Welsh version). This is a good starting point for explaining to patients the kind of care they can expect.

Quick reference guide

A quick reference guide for healthcare professionals is also available from the NICE website (www.nice.org.uk/CG021quickrefguide) or from the NHS Response Line (0870 1555 455; quote reference number N0760).

6 Related NICE guidance

The Institute is in the process of developing the following clinical guidelines:

- Osteoporosis: assessment of fracture risk and the prevention of osteoporotic fractures in individuals at high risk. Expected publication date June 2005.
- The management of dementia. Expected publication date 2006.

7 Review date

The process of reviewing the evidence is expected to begin 4 years after the date of issue of this guideline. Reviewing may begin earlier than 4 years if significant evidence that affects the guideline recommendations is identified sooner. The updated guideline will be available within 2 years of the start of the review process.

Appendix A: Grading scheme

The grading scheme and hierarchy of evidence used in this guideline (see Table) are from Eccles and Mason (2001).

Recommendation grade	**Evidence**
A	Directly based on category I evidence
B	Directly based on: • category II evidence, **or** • extrapolated recommendation from category I evidence
C	Directly based on: • category III evidence, **or** • extrapolated recommendation from category I or II evidence
D	Directly based on: • category IV evidence, **or** • extrapolated recommendation from category I, II, or III evidence
GPP	Recommended good practice based on clinical experience of the Guideline Development Group
Evidence category	**Source**
I:	Evidence from: • meta-analysis of randomised controlled trials, **or** • at least one randomised controlled trial
II:	Evidence from: • at least one controlled study without randomisation, **or** • at least one other type of quasi-experimental study
III:	Evidence from non-experimental descriptive studies, such as comparative studies, correlation studies and case–control studies
IV:	Evidence from expert committee reports or opinions and/or clinical experience of respected authorities

Adapted from Eccles M, Mason J (2001) How to develop cost-conscious guidelines. *Health Technology Assessment* 5: 16

Appendix B: The Guideline Development Group

Professor Gene Feder (Group leader)

Department of General Practice & Primary Care, St Bartholomew's and the London Queen Mary's School of Medicine and Dentistry

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Alzheimer's Society

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National Osteoporosis Society

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King's College Hospital (Link Guideline Development Group member for the Osteoporosis Guideline)

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Centre Manager

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Dr Phil Alderson

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Dr Lesley Gillespie

Cochrane, Musculo-skeletal injuries group, UK

Dr Lesley Smith

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Appendix C: The Guideline Review Panel

The Guideline Review Panel is an independent panel that oversees the development of the guideline and takes responsibility for monitoring its quality. The Panel includes experts on guideline methodology, health professionals and people with experience of the issues affecting patients and carers. The members of the Guideline Review Panel were as follows.

Mrs Judy Mead (Chair)
Head of Clinical Effectiveness, Chartered Society of Physiotherapy

Mrs Joyce Cormie
Lay representative

Mrs Gill Hek
Reader in Nursing Research, University of the West of England, Bristol

Ms Karen Cowley
Practice Development Nurse, York Health Services NHS Trust

Mrs Jill Freer
Head of Clinical Governance and Quality Development, Leicestershire, Northamptonshire and Rutland Strategic Health Authority

Miss Amanda Wilde
Reimbursement and Outcomes Manager, ConvaTec Ltd

Appendix D: Technical detail on the criteria for audit

The audit criteria below are to assist with implementation of the guideline recommendations. The criteria presented here are considered to be the key criteria associated with the guideline recommendations. They are suitable for use in primary and secondary care, for all patients at risk of falling or who are known fallers.

Possible objectives for an audit

Audits can be carried out in different care settings to ensure that individuals who are known fallers or at risk of falling are offered appropriate information, assessment and interventions aimed at reducing the incidence of falls and are involved in decisions about their care having been informed about the rationale for falls assessment and prevention.

People that could be included in an audit

An audit could be conducted in settings where people are known to be at high risk of falling, for example those who attend A&E with fall-related trauma and within extended care settings.

Data sources and documentation of audit

Systems for recording the necessary information (which will provide data sources for audit) should be agreed by Trusts. Whatever method is used for documentation, the processes and results of assessment and planned interventions should be accessible to all members of the multidisciplinary team. In relation to assessment, this should include the name of the assessment tool or process used.

Documentation of the factors taken into consideration when deciding the most appropriate intervention should occur. In addition, the reasons for any changes in the intervention should also be documented.

The fact that carers and patients have been informed about falls prevention should be documented. Patients and carers should be directly questioned

about their satisfaction with, and the adequacy of, the information provided and this should be documented in either the patient notes or in another source as agreed by the Trust.

Trusts should establish a system of recording when relevant staff have been educated in falls assessment and prevention and should implement a process for reviewing education needs relating to this topic.

Measures that could be used as a basis for an audit

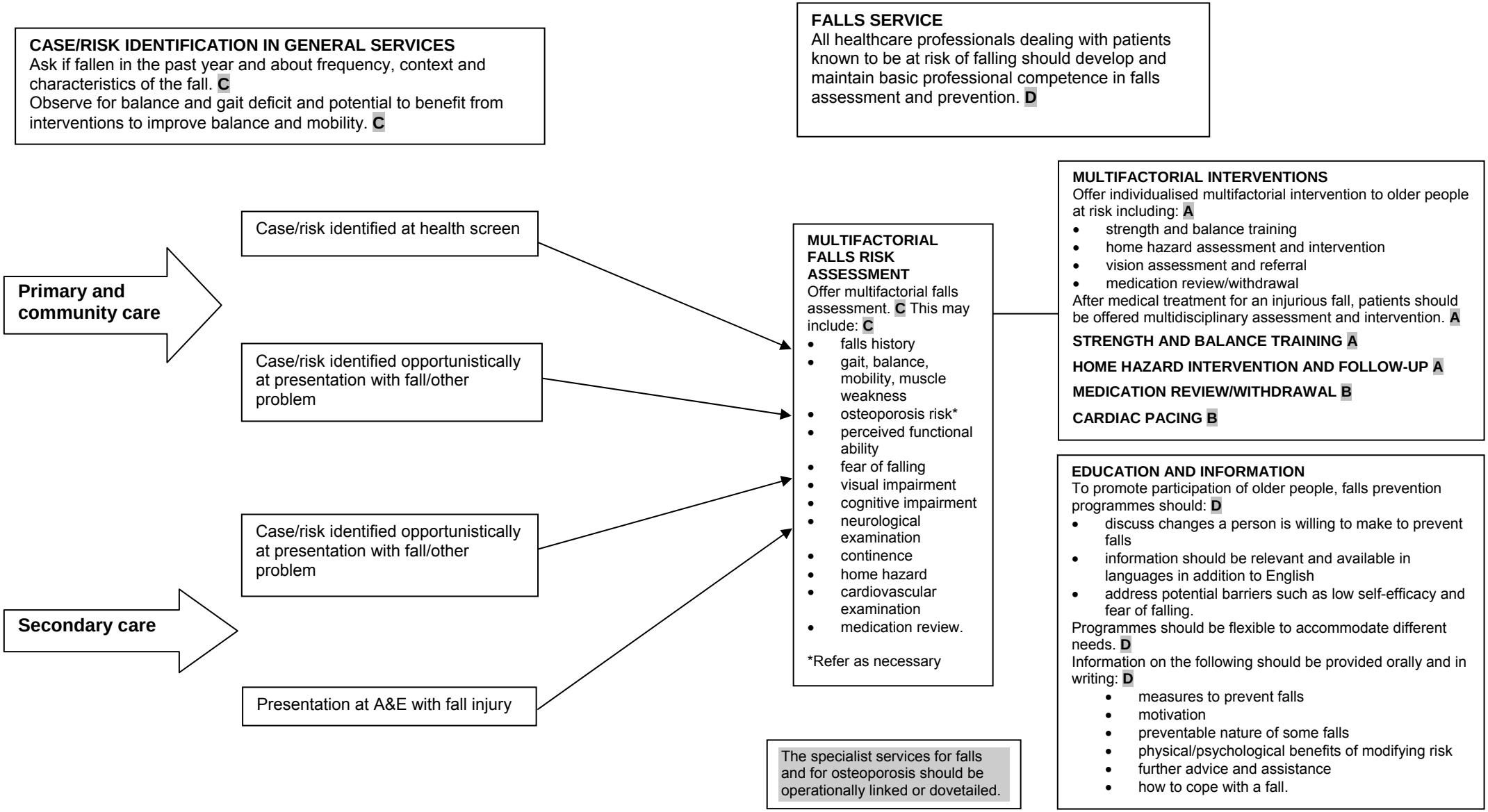
The table below suggests measures that could be used as a basis for audit.

Criterion	Exception	Definition of terms
1. **Case/risk identification** Healthcare professionals routinely ask older people in their care about previous falls.	None	Older people will be asked if they have fallen in the past year, and about the frequency, context and characteristics of the fall.
Older people with a history of falling or considered at risk of falling are observed for gait and balance problems and considered for interventions to improve strength and balance .	None	
2. **Interventions to prevent falls** Older people presenting to a healthcare professional because of a fall or reporting recurrent falls in the past year should be offered a multifactorial falls assessment and be considered for individualised multifactorial interventions.	Those patients who decline particular interventions	Multifactorial assessment may include the following: - identification of falls history - assessment of gait, balance and mobility, and muscle weakness - assessment of osteoporosis risk - assessment of the older person's 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.
3. All older people with recurrent falls or assessed as being at increased risk of falling are considered for an	None	• In successful multifactorial intervention

individualised multifactorial intervention.		programmes the following specific components are common: - strength and balance training - home hazard assessment and intervention - vision assessment and referral - medication review with modification/withdrawal.
4. **Rehabilitation** Following treatment for an injurious fall, older people should be offered an assessment to identify and address future risk and tailored intervention aimed at promoting independence and improving physical function.	None	
5. **Education and information giving** Older people at increased risk of falls are offered information on reducing risk of falls and appropriate interventions.	None	Information may be given orally or in writing.
6. Healthcare professionals caring for older people are trained in: • falls risk assessment • appropriate referral of people at increased risk of falls • measures to decrease the likelihood of falls.	None	

Appendix E: Algorithm

Patient referral and care pathway



Appendix F: Principles of practice

The principles outlined below describe the ideal context in which to implement the recommendations in this guideline. These have been adapted from the NICE Clinical Guideline - *Pressure Ulcer Prevention* (2003).These principles went through a consensus process, were refined and published in order to describe the ideal context in which to implement guideline recommendations.

Person-centred care

Patients and carers should be made aware of the guideline and its recommendations and be referred to the Institute's *Information for the Public*.

Patients and carers should be involved in shared decision making about individualised falls prevention strategies.

Health professionals are advised to respect and incorporate the knowledge and experience of people who have been at long-term risk of falling and have been self-managing this risk.

Patients and their carers should be informed about their risk of falling, especially when they are transferred between care settings or discharged home from hospital settings.

A collaborative multidisciplinary approach to care

All members of the multidisciplinary team should be aware of the guidelines and all care should be documented in the patient's healthcare records.

Organisational issues

An integrated approach to falls prevention with a clear strategy and policy should be implemented. It should be closely and operationally linked to bone health (osteoporosis) and cardiac pacing services in such a way as to avoid duplication.

Care should be delivered in a context of continuous quality improvement where improvements to care following guideline implementation are the subject of regular feedback and audit.

Commitment to and availability of education and training are needed to ensure that all staff, regardless of profession, are given the opportunity to update their knowledge base and are able to implement the guideline recommendations.

Patients should be cared for by personnel who have undergone appropriate training and who know how to initiate and maintain correct and suitable preventative measures. Staffing levels and skill mix should reflect the needs of patients.

The guideline is of relevance to:

- those older people who have fallen or are at risk of falling
- families and carers of older people
- healthcare professionals who share in caring for those who are vulnerable to or at risk of falling
- those responsible for service delivery.