# NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

## Health and social care directorate

## Quality standards and indicators

## Briefing paper

**Quality standard topic:** Falls in older people: preventing a first fall

**Output:** Prioritised quality improvement areas for development.

**Date of Quality Standards Advisory Committee meeting:** 25 May 2016

## Contents

# 1 Introduction

This briefing paper presents a structured overview of potential quality improvement areas for ‘Falls in older people: preventing a first fall’. It provides the Committee with a basis for discussing and prioritising quality improvement areas for development into draft quality statements and measures for public consultation.

## *1.1 Structure*

This briefing paper includes a brief description of the topic, a summary of each of the suggested quality improvement areas and supporting information.

If relevant, recommendations selected from the key development source below are included to help the Committee in considering potential statements and measures.

## *1.2 Development source*

The key development sources referenced in this briefing paper are:

**Primary Source**

Falls in older people: assessing risk and prevention. NICE clinical guideline 161 (June 2013)

A review decision was made in January 2016 not to update this guideline until a Cochrane review and a NICE guideline on multimorbidity, which consider falls as a trigger to holistic assessment for frail older people, have been completed. The next surveillance decision is expected in 2017.

This guideline updated and replaced Falls (NICE clinical guideline 21). New recommendations for older people in hospital were introduced in 2013 alongside the original recommendations from the 2004 guideline. Recommendations are labelled according to when they were originally published.

**Other sources that may be used**

Occupational therapy in the prevention and management of falls in adults: Practice guideline. College of Occupational Therapists (2015).

This guideline has an update scheduled for 2020. The NICE accreditation for the process used to produce guideline lasts for 5 years from January 2013.

Falls - risk assessment. NICE clinical knowledge summary (2014).

# 2 Overview

## *2.1 Focus of quality standard*

This quality standard will cover primary prevention of falls for older people (65 and older) living in the community and during a hospital stay. It will also include people aged 50 to 64 who are in hospital and are judged by a clinician to be at higher risk of falling because of an underlying condition.

It will not cover preventing further falls after an initial fall (secondary prevention) or assessment after a fall. These are covered by the quality standard on falls in older people.

## *2.2 Definition*

There are numerous definitions of a fall. For this quality standard, the clear and simple description of a fall set out in the glossary of the primary development source (Falls in older people: assessing risk and prevention) has been used:

> "An event whereby an individual comes to rest on the ground or another lower level with or without loss of consciousness"

Primary prevention is also described in the guideline glossary as:

> "Interventions that aim to prevent the first fall in a person who is vulnerable to falling because of, for example, unsteady gait, but who has not yet fallen."

## *2.3 Incidence and prevalence*

Falls and fall-related injuries are a common and serious problem for older people particularly among 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 result in no 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 (including around 840 hip fractures, 550 other types of fracture and 30 intracranial injuries). Treating inpatient falls alone costs the NHS more than £15 million per year.

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.

## *2.4 Prevention*

Falls occur most frequently as a consequence of an interaction between risk factors and situations. The major risk factors for falling are diverse, and many of them – such as balance impairment, muscle weakness, polypharmacy and environmental hazards – are potentially modifiable. Since the risk of falling appears to increase with the number of risk factors, multifactorial interventions have been suggested as the most effective strategy to reduce decline in function and independence, and also to prevent the associated costs of complications.

Preventive programmes based on risk factors for falling include strength and balance training, medication review, home hazard intervention and follow-up and cardiac pacing where indicated. Interventions need to target extrinsic factors such as hazards within the home environment, aspects of the inpatient environment such as flooring and lighting for older people in hospital, and intrinsic risk factors, such as mobility, strength, gait, medicine use and sensory impairment

## *2.5 National Outcome Frameworks*

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

**Table 1 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***<br>1A Social care-related quality of life**<br>***Outcome measures***<br>**Carers can balance their caring roles and maintain their desired quality of life**<br>1D Carer-reported quality of life** |
| 2 Delaying and reducing the need for care and support | ***Overarching measure***<br>2A Permanent admissions to residential and nursing care homes, per 100,000 population<br>***Outcome measures***<br>**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**<br>**Earlier diagnosis, intervention and reablement means that people and their carers are less dependent on intensive services**<br>2B Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services* |
| 4 Safeguarding adults whose circumstances make them vulnerable and protecting from avoidable harm | ***Overarching measure***<br>4A The proportion of people who use services who feel safe**<br>***Outcome measures***<br>**Everyone enjoys physical safety and feels secure**<br>**People are protected as far as possible from avoidable harm, disease and injuries**<br>**People are supported to plan ahead and have the freedom to manage risks the way that they wish**<br>4B The proportion of people who use services who say that those services have made them feel safe and secure |
| **Alignment with NHS Outcomes Framework and/or Public Health Outcomes Framework**<br>* Indicator is shared<br>** Indicator is complementary | |

**Table 2 NHS Outcomes Framework 2015–16**

| Domain | Overarching indicators and improvement areas |
|---|---|
| 1 Preventing people from dying prematurely | ***Overarching indicators***<br>1a Potential Years of Life Lost (PYLL) from causes considered amenable to healthcare<br>i Adults<br>1b Life expectancy at 75<br>i Males ii Females |
| 2 Enhancing quality of life for people with long-term conditions | ***Overarching indicator***<br>2 Health-related quality of life for people with long-term conditions** |
| 3 Helping people to recover from episodes of ill health or following injury | ***Overarching indicators***<br>3b Emergency readmissions within 30 days of discharge from hospital*<br>***Improvement areas***<br>**Helping older people to recover their independence after illness or injury**<br>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* |
| 4 Ensuring that people have a positive experience of care | ***Overarching indicators***<br>4a Patient experience of primary care<br>i GP services<br>ii GP Out-of-hours services<br>4b Patient experience of hospital care<br>***Improvement areas***<br>**Improving hospitals' responsiveness to personal needs**<br>4.2 Responsiveness to inpatients' personal needs<br>**Improving people's experience of accident and emergency services**<br>4.3 Patient experience of A&E services<br>**Improving access to primary care services**<br>4.4 Access to i GP services<br>**Improving people's experience of integrated care**<br>*4.9 People's experience of integrated care*** |
| 5 Treating and caring for people in a safe environment and protecting them from avoidable harm | ***Overarching indicators***<br>*5a Deaths attributable to problems in healthcare*<br>*5b Severe harm attributable to problems in healthcare*<br>***Improvement areas***<br>**Reducing the incidence of avoidable harm**<br>*5.4 Hip fractures from falls during hospital care*<br>**Improving the culture of safety reporting**<br>5.6 Patient safety incidents reported |

| **Alignment with Adult Social Care Outcomes Framework and/or Public Health Outcomes Framework** |
|---|
| * Indicator is shared |
| ** Indicator is complementary |
| Indicators in italics in development |

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

| Domain | Objectives and indicators |
|---|---|
| 1 Improving the wider determinants of health | ***Objective***<br>Improvements against wider factors that affect health and wellbeing and health inequalities<br>***Indicators***<br>1.9 Sickness absence rate<br>1.16 Utilisation of outdoor space for exercise/health reasons<br>1.18 Social isolation*<br>1.19 Older people's perception of community safety |
| 2 Health improvement | ***Objective***<br>People are helped to live healthy lifestyles, make healthy choices and reduce health inequalities<br>***Indicators***<br>2.13 Proportion of physically active and inactive adults<br>2.23 Self-reported well-being<br>2.24 Injuries due to falls in people aged 65 and over |
| 4 Healthcare public health and preventing premature mortality | ***Objective***<br>Reduced numbers of people living with preventable ill health and people dying prematurely, whilst reducing the gap between communities<br>***Indicators***<br>4.3 Mortality rate from causes considered preventable**<br>4.11 Emergency readmissions within 30 days of discharge from hospital*<br>4.13 Health-related quality of life for older people<br>4.14Hip fractures in people aged 65 and over<br>4.15 Excess winter deaths |
| ***Alignment with Adult Social Care Outcomes Framework and/or NHS Outcomes Framework*** | |
| * Indicator is shared | |
| ** Indicator is complementary | |
| Indicators in italics in development | |

# 3 Summary of suggestions

## *3.1 Responses*

In total, 22 stakeholders responded to the 2-week engagement exercise which ran from 30/03/16 to 13/04/16.

Stakeholders were asked to suggest up to 5 areas for quality improvement. Specialist committee members were also invited to provide suggestions. The responses have been merged and summarised in table 4 for further consideration by the Committee. General comments, comments about the scope of the quality standard and areas outside of the scope of this quality standard are not summarised in the table. However, full details of all the comments submitted are given in appendix 3 for information.

**Table 4 Summary of suggested quality improvement areas**

| Suggested area for improvement | Stakeholders |
|---|---|
| **Identification of cases** | PHE, SCM, Agile, OM, COT,CO, Lancs Care, RCPE |
| **Risk assessment**<br>• Multifactorial risk assessment<br>• Specific factors to be assessed | CO, COT, PHE, SCM, PHW, RCPE, RCEM, RCN, RSPA, Parkinson's UK, FP |
| **Intervention**<br>• Multifactorial intervention<br>• Specific interventions | Agile, PHE, SCM, CO, COT,PHW, CRE, RCEM, Parkinson's UK, Amaven, TPAH, RSPA, RCP, Ind Age, RCN |
| **Education & information**<br>• Information and education on falls prevention for individuals, carers, professionals and organisations<br>• Training and development for health and social care staff | Ind Age, Lancs Care, Wilts Coun, CO, Parkinson's UK, Amaven, AGILE, SCM, RSPA |
| **Falls programmes**<br>• Strategic approach<br>• Provision of and access to falls prevention programmes | SCM, Parkinson's UK, RSPA |
| **Preventing falls during a hospital stay**<br>• Risk assessment of inpatient environment<br>• Risk assessment of patients including<br>  ○ Multifactorial assessment<br>  ○ Blood pressure<br>  ○ Visual testing<br>  ○ Medication<br>• Interventions<br>  ○ Review of medication<br>  ○ Adherence to interventions | Agile, Ind Age, Guys, RCPE, CO |

Agile
Amaven
CO, College of Optometrists
COT, College of Occupational Therapists
CRE, Care and Repair England
FP, Ferring Pharmaceuticals
Ind Age, Independent Age
Lancs Care, Lancashire Care NHS Foundation Trust
Guys, Guys and St Thomas' NHS Foundation Trust
OM, Optasia Medical
Parkinson's UK
PHE, Public Health England
PHW, Public Health Wales
PSD, Patient Safety Domain NHS Improvement
RCEM, Royal College of Emergency Medicine
RCN, Royal College of Nursing
RCP, Royal College of Physicians
RCPE, Royal College of Physicians of Edinburgh
RSPA, Royal Society for the Prevention of Accidents
SCM, Specialist Committee Member
TPAH, The Princess Alexandra Hospital
Wilts Coun, Wiltshire Council

## *3.2 Identification of current practice evidence*

Bibliographic databases were searched to identify examples of current practice in UK health and social care settings; 1,503 papers were identified for Falls in older people: preventing a first fall. In addition, 125 papers were suggested by stakeholders at topic engagement and 24 papers internally at project scoping.

Of these papers, 5 have been included in this report and are included in the current practice sections where relevant. Appendix 2 outlines the search process.

# 4 Suggested improvement areas

## *4.1 Identification of cases*

### 4.1.1 Summary of suggestions

Several stakeholders suggested identification of cases as an improvement area. The reason given for this is that in order to reduce the risk of someone falling, you first need to identify who is at risk of falling.

Some stakeholders suggested the specific area of quality improvement related to who carries out the identification (such as all healthcare professionals, other professional groups or specific groups such as optometrists), and how it is recorded. Others suggested how cases could be identified including observation of balance and gait; asking people about steadiness; case finding; targeting those at risk of fracture for prevention; and incorporating into management of long term conditions (as such conditions can increase the risk of someone falling).

### 4.1.2 Selected recommendations from development source

Table 5 below highlights recommendations that have been provisionally selected from the development source(s) that may support potential statement development. These are presented in full after table 5 to help inform the Committee's discussion.

**Table 5 Identification of cases**

| Suggested quality improvement area | Suggested source guidance recommendations |
|---|---|
| Identification of cases | **Case/risk identification**<br>NICE CG161 Recommendation 1.1.1.1 (KPI) and 1.1.1.2 (KPI)<br><br>NICE CKS Falls - risk assessment |

**Case/risk identification**

NICE CG161 – Recommendation 1.1.1.1 (key priority for implementation)

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. [2004]

NICE CG161 – Recommendation 1.1.1.2 (key priority for implementation)

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 section 3.3 of the full guideline.) [2004]

NICE CKS Falls - risk assessment – Assessing risk of falling

Identify people aged 65 years and over who:

- Are at risk of falling because they:
    - Have cognitive impairment.
    - Have a visual impairment.
    - Are physically frail or have a condition that affects mobility or balance such as arthritis, diabetes, incontinence, stroke, or Parkinson's disease.
    - Are taking multiple drugs, psychoactive drugs (such as benzodiazepines), or drugs that can cause postural hypotension (such as anti-hypertensive drugs).
    - Have a fear of falling.
- For people who have had one or more falls or are considered to be at risk of a fall, assess their gait and balance, for example by using the Timed Up & Go test and/or the Turn 180° test.

### 4.1.3 Current UK practice

A second national audit of the organisation of services for falls and bone health of older people (Falls and Bone Health Organisational Audit Generic Site Report 2009) took place in 2008. All trusts and primary care organisations were asked to participate, along with a sample of care homes. Levels of participation were high, for example:

- 88% of primary care organisations in England & Wales
- 88% of combined Health and Social Care Trusts in England and Northern Ireland
- 100% of acute trusts in England and Wales
- 76% of mental healthcare trusts
- 73 care homes drawn from 2 national providers.

Organisations were asked if a first level screening tool had been implemented and comprehensively used in the community for older people. Of all primary care

organisations, health and social care trusts and mental healthcare trusts, 26% reported that they had and it was fully used. ‘Fully used’ means used across the whole of a locality by a variety of health and social care professionals and includes questions relating to falls and osteoporosis. A further 65% reported that they had such a tool but it was only partially used.

92% of organisations that had a screening tool reported it included a question for those at risk of falls. This proportion varied by type of organisation:

- 100% of 5 health and social care trusts
- 94% of 154 primary care organisations
- 84% of 38 mental health trusts.

93% of organisations that provided inpatient or resident services reported that assessment documentation incorporated a question on current mobility or balance problems for all older people on admission.

A more recent national audit of falls and bone health in older people (Falling standards, broken promises) in 2010 included a different question about screening tools. The question identified if organisations had implemented a first level screening tool that asked older people if they have fallen within a defined time period (e.g. in the previous 12 months):

- Of primary care organisations, 20% reported that they lacked such a tool. This may not indicate that they have no screening tool, but lack one with questions on past falls.
- Of 79 care homes, 100% reported that their resident admission assessment included falls risk.

### 4.1.4 Resource impact

The costing statement for CG161 stated that the resource impact from implementing this guideline was not expected to be significant. It was acknowledged that there may be costs associated with increasing capacity in falls risk assessment services but organisations were encouraged to assess these locally.

## *4.2 Risk assessment*

### 4.2.1 Summary of suggestions

Risk assessment was suggested as a key area for improvement by most stakeholders. Note that risk assessment specifically relating to inpatients is covered in section 4.6.

**Multifactorial assessment**

Several stakeholders suggested that risks should be assessed as part of a multifactorial assessment. A number also identified specific populations who should be assessed including:

- all people aged 65 and over
- those aged 50 to 64 years judged by a clinician to be at risk of falling
- anyone in an extended care facility
- people who have abnormalities with gait or balance
- people with Parkinson's disease.

**Assessment of specific factors**

Stakeholders also suggested specific factors that should be assessed, sometimes as a component of a multifactorial assessment. These included:

- Home hazard assessment by a range of professionals and services (including 'Home Falls Liaison Service', occupational therapists, fire and rescue services, 'Care and Repair', day care workers) and in a variety of settings (owner occupied homes, rented, residential care)
- Blood pressure assessments (including lying and standing)
- Cognitive impairment or dementia
- Sight testing
- Fear of falling
- Foot problems (including toe nails and inappropriate footwear)
- Gait assessment (using 'Timed Up and Go' tool)
- Urinary incontinence
- Strength and balance assessment
- Assessment of underlying conditions that impair balance / mobility

### 4.2.2 Selected recommendations from development source

Table 6 below highlights recommendations that have been provisionally selected from the development source(s) that may support potential statement development. These are presented in full after table 6 to help inform the Committee's discussion.

**Table 6 Specific areas for quality improvement**

| Suggested quality improvement area | Selected source guidance recommendations |
|---|---|
| Multifactorial assessment | **Multifactorial falls risk assessment**<br>NICE CG161 Recommendations 1.1.2.1 (KPI) and 1.1.2.2<br><br>NICE CKS Falls - risk assessment |
| Specific factors<br>• Home hazard assessment<br>• Blood pressure assessments<br>• Cognitive impairment or dementia<br>• Sight testing<br>• Fear of falling<br>• Foot problems<br>• Gait assessment<br>• Urinary incontinence<br>• Strength and balance assessment<br>• Assessment of underlying conditions that impair balance / mobility | **Multifactorial falls risk assessment**<br>NICE CG161 Recommendations 1.1.2.2<br><br>NICE CKS Falls - risk assessment |

**Multifactorial falls risk assessment**

NICE CG161 Recommendation 1.1.2.1 (key priority for implementation)

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. [2004]

NICE CG161 Recommendation 1.1.2.2

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. [2004]

NICE CKS Falls - risk assessment – Assessing risk of falling

Identify people aged 65 years and over who:

- Are at risk of falling because they:
    - Have cognitive impairment.
    - Have a visual impairment.
    - Are physically frail or have a condition that affects mobility or balance such as arthritis, diabetes, incontinence, stroke, or Parkinson's disease.
    - Are taking multiple drugs, psychoactive drugs (such as benzodiazepines), or drugs that can cause postural hypotension (such as anti-hypertensive drugs).
    - Have a fear of falling.
- For people who have had one or more falls or are considered to be at risk of a fall, assess their gait and balance, for example by using the Timed Up & Go test and/or the Turn 180° test.
- Offer a multifactorial falls risk assessment by an appropriately skilled and experienced clinician (usually in a specialist falls service) to all people aged 65 years and over who:
    - Have had two or more falls in the last 12 months, or
    - Present for medical attention following a fall, or
    - Cannot perform, or perform poorly on, the Timed Up & Go test and/or the Turn 180° test.
- For people who do not have an indication to be referred for a multifactorial risk assessment, reassess at least annually

### 4.2.3 Current UK practice

The national audit of falls and bone health in older people 2010, Falling Standards, broken promises, asked falls service providers if multi-factorial falls risk assessment (MFFRA) was undertaken using a tool which specifies the individual components to be assessed. The question was asked of community service providers, acute

hospital trusts and combined healthcare organisations (organisations that combine 2 or more functions) in England, Wales and Northern Ireland. 15% reported that they did not use such a tool to support MFFRA and a further 30% did not use it fully across the service.

Of those using a tool that specifies individual components:

- 96% ask about risk of fall due to medical conditions
- 95% include documentation of medicines
- 94% include standardised assessments of gait, balance and mobility
- 92% include standing or lying blood pressure
- 89% include cognitive testing
- 84% of providers include continence assessment
- 78% assess for osteoporosis or fracture risk
- 55% of providers use a standardised assessment of fear of falling
- 39% include simple visual assessment

In relation to home hazards, 89% of falls service providers include an assessment of potential hazards in the home as part of the MFFRA. Most providers (70%) require this to be undertaken by an occupational therapist but less than half of providers (47%) use a validated home hazard assessment.

Information in the 2015 Fracture Liaison Service Database feasibility study suggests that there is limited recording of assessment of falls risk in electronic GP records. One of the questions the study sought to answer was whether patients who are assessed and treated for osteoporosis and falls risk could be identified from electronic GP records. All GP practices in England and Wales were eligible for inclusion and data was collected for 91 practices. Records were extracted for patients who had a fragility fracture. The report states that coded data on assessment and treatment of falls risk were almost entirely absent from the GP records – only 3.9% of patients with an index fracture in the study period had a record of formal falls risk assessment. Whilst this finding applied only to a subset of patient records, this group of patients would be amongst those likely to have an assessment of falls risk.

Current practice information in relation to assessments in hospital is presented in section 4.6.

### 4.2.4 Resource Impact assessment

The costing statement for CG161 stated that the resource impact from implementing this guideline was not expected to be significant. It was acknowledged that there

may be costs associated with increasing capacity in falls risk assessment services but organisations were encouraged to assess these locally.

## *4.3 Interventions*

### 4.3.1 Summary of suggestions

A range of specific interventions were identified by stakeholders as part of a multifactorial intervention. Specific components include:

- Physical activity
- Strength and balance training
- Modifications to the physical environment
- Housing repair and adaptions, home hazard intervention
- Medication review
- Management plans or care plans to address risk factors
- Referral to falls services
- Accessible eye health information for residents of care homes

### 4.3.2 Selected recommendations from development source

Table 7 below highlights recommendations that have been provisionally selected from the development sources that may support potential statement development. These are presented in full after table 7 to help inform the Committee's discussion.

**Table 7 Specific areas for quality improvement**

| Suggested quality improvement area | Selected source guidance recommendations |
|---|---|
| Multifactorial intervention<br>Specific interventions including:<br>• Physical activity<br>• Strength and balance training<br>• Modifications to the physical environment<br>• Housing repair and adaptions, home hazard intervention<br>• Medication review<br>• Management plans or care plans to address risk factors<br>• Referral to falls services<br>• Accessible eye health information for residents of care homes | **Multifactorial interventions**<br>NICE CG161 Recommendation 1.1.3.1<br><br>**Strength and balance training**<br>NICE CG161 Recommendation 1.1.4.1<br><br>**Exercise in extended care settings**<br>NICE CG161 Recommendation 1.1.5.1<br><br>**Home hazard and safety intervention**<br>NICE CG161 Recommendations 1.1.6.1 and 1.1.6.2<br><br>**Psychotropic medications**<br>NICE CG161 Recommendations 1.1.7.1<br><br>**Interventions that cannot be recommended**<br>NICE CG161 Recommendations 1.1.11.1<br><br>**Interventions that cannot be recommended because of insufficient evidence**<br>NICE CG161 Recommendations 1.1.12.1 to 1.1.12.6<br><br>NICE CKS Falls - risk assessment |

## Multifactorial interventions

NICE CG161 Recommendation 1.1.3.1

All older people with recurrent falls or assessed as being at increased risk of falling should be considered for an individualised multifactorial intervention. [2004]

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. [2004]

**Strength and balance training**

NICE CG161 Recommendation 1.1.4.1

Strength and balance training is recommended. Those most likely to benefit are older people living in the community 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. [2004]

**Exercise in extended care settings**

NICE CG161 Recommendation 1.1.5.1

Multifactorial interventions with an exercise component are recommended for older people in extended care settings who are at risk of falling. [2004]

**Home hazard and safety intervention**

NICE CG161 Recommendation 1.1.6.1

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. Normally this should be part of discharge planning and be carried out within a timescale agreed by the patient or carer, and appropriate members of the health care team. [2004]

NICE CG161 Recommendation 1.1.6.2

Home hazard assessment is shown to be effective only in conjunction with follow-up and intervention, not in isolation. [2004]

**Psychotropic medications**

NICE CG161 Recommendation 1.1.7.1

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. [2004]

**Interventions that cannot be recommended**

NICE CG161 Recommendation 1.1.11.1

Brisk walking. There is no evidence[1] that brisk walking reduces the risk of falling. One trial showed that an unsupervised brisk walking programme increased the risk

[1] This refers to evidence reviewed in 2004.

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. [2004]

**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]. [2004]

NICE CG161 Recommendation 1.1.12.1

Low intensity exercise combined with incontinence programmes. There is no evidence[1] that low intensity exercise interventions combined with continence promotion programmes reduce the incidence of falls in older people in extended care settings. [2004]

NICE CG161 Recommendation 1.1.12.2

Group exercise (untargeted). Exercise in groups should not be discouraged as a means of health promotion, but there is little evidence[1] that exercise interventions that were not individually prescribed for older people living in the community are effective in falls prevention. [2004]

NICE CG161 Recommendation 1.1.12.3

Cognitive/behavioural interventions. There is no evidence[1] that cognitive/behavioural interventions alone reduce the incidence of falls in older people living in the community who are of unknown risk status. Such interventions included risk assessment with feedback and counselling and individual education discussions. There is no evidence[1] that complex interventions in which group activities included education, a behaviour modification programme aimed at moderating risk, advice and exercise interventions are effective in falls prevention with older people living in the community. [2004]

NICE CG161 Recommendation 1.1.12.4

Referral for correction of visual impairment. There is no evidence[1] that referral for correction of vision as a single intervention for older people living in the community is effective in reducing the number of people falling. However, vision assessment and referral has been a component of successful multifactorial falls prevention programmes. [2004]

NICE CG161 Recommendation 1.1.12.5

Vitamin D. There is evidence[1] 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[1] 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.[2] [2004, amended 2013]

### 4.3.3 Current UK practice

Falling standards, broken promises reported that 86% of falls services provided intervention that included supervised exercise training for strength and balance. A smaller proportion (74%) included a validated exercise programme delivered by appropriately trained healthcare professionals and / or exercise specialists.

The audit also found that 93% of falls service providers work with patients to identify difficulties with activities of daily living that place them at an increased risk of falls. The same proportion advise on safety of the home environment and performance of activities of daily living with the ability to provide equipment, adaptations and repairs where necessary.

The college of optometrists Focus on falls 2014 report presents findings of a survey of an unspecified number of falls service teams across the UK. The survey found that:

- 54% of fall services responding always check vision as part of their falls service
- 16% occasionally assess vision

Of those teams that check the vision:

- 85% question the patient
- 38% check the patients' glasses for cleanliness
- 31% ask if the patient can see an object from a distance.

Most current practice information on interventions relates to patients in hospital. This is presented in section 4.6 (Preventing falls during a hospital stay).

[2] The following text has been deleted from the 2004 recommendation: '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.' As yet there is no NICE guidance on the use of vitamin D for fracture prevention.

### 4.3.4 Resource Impact assessment

The costing statement for CG161 stated that the resource impact from implementing this guideline was not expected to be significant. It was acknowledged that there may be costs associated with increasing capacity to provide specific interventions but organisations were encouraged to assess these locally.

## *4.4 Education and information*

### 4.4.1 Summary of suggestions

Education and information was suggested as an area of quality improvement. Within this category, stakeholders identified the provision of information and education on falls and prevention for individuals, carers, professionals and organisations. One stakeholder specifically identified people diagnosed with Parkinson's to receive such information. Another suggested targeting younger people (all aged 30 and over) and raising awareness in relation to bone health, exercise, diet and nutrition in people so that problems can be avoided in later life.

Several stakeholders identified training of health and social care staff as an area for quality improvement. Quality statements on staff training and competency are not usually included in quality standards, though. A concept that underpins all quality standards is that practitioners are appropriately trained and competent to deliver the actions and interventions set out.

### 4.4.2 Selected recommendations from development source

Table 8 below highlights recommendations that have been provisionally selected from the development source(s) that may support potential statement development. These are presented in full after table 8 to help inform the Committee's discussion.

**Table 8 Specific areas for quality improvement**

| Suggested quality improvement area | Selected source guidance recommendations |
|---|---|
| Education & information<br>• Information and education on falls prevention for individuals, carers, professionals and organisations<br>• Training and development for health and social care staff | **Education and information giving**<br>NICE CG161 Recommendation 1.1.10.2<br><br>**Information and support**<br>NICE CG161 Recommendation 1.2.3.1 |

**Education and information giving**

NICE CG161 Recommendation 1.1.10.2

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
- 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. [2004]

**Information and support**

[Note this section of the guideline relates to preventing falls during a hospital stay.]

NICE CG161 Recommendation 1.2.3.1

Provide relevant oral and written information and support for patients, and their family members and carers if the patient agrees. Take into account the patient's ability to understand and retain information. Information should include:

- explaining about the patient's individual risk factors for falling in hospital
- showing the patient how to use the nurse call system and encouraging them to use it when they need help
- informing family members and carers about when and how to raise and lower bed rails
- providing consistent messages about when a patient should ask for help before getting up or moving about
- helping the patient to engage in any multifactorial intervention aimed at addressing their individual risk factors. [new 2013]

### 4.4.3 Current UK practice

The national audit of inpatient falls 2015 asked organisations if inpatient multifactorial interventions included written provision of information: 81% provided written information on falls for the patient and 77% provided written information for family or informal carers. Only 28% of organisations provided written information in any non-English language.

Falling standards, broken promises presents similar findings for falls service providers: Three-quarters of organisations report that written information on falls and bone health is available in patient areas (75%), but less than half provide written information in different languages (41%).

Turning to training, Falling standards, broken promises presents information on training provided on falls and bone health by provider organisations. Around 1 in 4 organisations (27%) had not provided such training to its staff in the last year. There was variation between types of provider, ranging from 19% of acute trusts not providing training in the last year to 73% of care homes not providing training on falls and bone health to their staff.

In relation to care homes, the audit found that 50% of falls services did not provide any training to care homes on when residents should be referred to primary care teams. A similar proportion (49%) did not provide training to care homes on how to identify falls risks to minimise future incidents.

The previous national audit of the organisation of services for falls and bone health of older people collected information on training provided or organised by falls service providers. The 2009 Generic Site Report shows that around two thirds of organisations had provided training to nurses in wards looking after older people (66%); physiotherapists (68%); occupational therapists (67%); and therapy assistants (68%). Approximately half of falls service providers had provided training to doctors in the hospital (47%) and community nurses (45%). Fewer organisations provided training to GPs (25%), pharmacists (26%) and social workers (24%).

### 4.4.4 Resource Impact assessment

The costing statement for CG161 stated that the resource impact from implementing this guideline was not expected to be significant. It was acknowledged that there may be costs associated with increasing capacity in falls risk assessment services but organisations were encouraged to assess these locally.

## *4.5 Falls programmes*

### 4.5.1 Summary of suggestions

Suggestions included the application of a population approach to falls prevention; falls prevention programmes in primary and secondary care; local areas should adopt a strategic approach to falls that includes prevention, and have an injury prevention co-ordinator; and that falls prevention programmes have to be accessible to people with limited mobility or who have communication needs.

### 4.5.2 Selected recommendations from development source

Table 9 below highlights recommendations that have been provisionally selected from the development source(s) that may support potential statement development. These are presented in full after table 9 to help inform the Committee's discussion.

**Table 9 Specific areas for quality improvement**

| Suggested quality improvement area | Selected source guidance recommendations |
|---|---|
| Falls programmes | **Encouraging the participation of older people in falls prevention programmes**<br>NICE CG161 Recommendation 1.1.9.1 |

**Encouraging the participation of older people in falls prevention programmes**

NICE CG161 Recommendation 1.1.9.1

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

- Healthcare professionals involved in the assessment and prevention of falls should discuss what 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. [2004]

### 4.5.3 Current UK practice

No specific current practice information was found in relation to a population approach to falls programmes.

Little information was found in relation to adopting a strategic approach, and what was found relates to organisations as opposed to geographical areas. The national audit of inpatient falls 2015 reported that 100% of organisations had a falls prevention policy. Of these, 73% made reference to NICE guideline CG161.

Falling standards, broken promises reported that 99% of acute trusts had an inpatient or resident falls prevention / reduction policy. A lower proportion of care homes (91%) and community hospitals (78%) reported that they had such polices. The same audit captured information on commissioning strategy. Of sites that commissioned services, 78% had a written local commissioning strategy that covered falls prevention. A smaller proportion of the organisations (63%) indicated that public health analysis contributed to any aspect of the falls commissioning strategy.

Current practice information on access to falls prevention programmes relates to programmes of intervention for patients following multifactorial risk assessment. Falling standards, broken promises reports that only 49% of services routinely provide written agreed intervention plans to patients (derived from individual multifactorial assessment).

The national audit of inpatient falls 2015 organisational audit asked if the inpatient multifactorial intervention included written provision of information: 81% provided written information on falls for the patient and 77% provided written information for family or informal carers. Only 28% of organisations provided written information in any non-English language.

### 4.5.4 Resource Impact assessment

The costing statement for CG161 stated that the resource impact from implementing this guideline was not expected to be significant. It was acknowledged that there may be costs associated with increasing capacity in falls risk assessment services but organisations were encouraged to assess these locally

## *4.6 Preventing falls during a hospital stay*

### 4.6.1 Summary of suggestions

Detailed suggestions for quality improvement areas included assessment of the inpatient environment to reduce risk of falls. Assessing risks relating to the patient was also suggested, both in terms of a multifactorial assessment and also in terms of specific assessments such as blood pressure and visual testing.

Interventions suggested included review of medication, with polypharmacy described as an important contributor to falls, and provision of information and advice to patients to reduce risk of falling. Subsequent adherence to an intervention by a patient was also identified by one stakeholder.

### 4.6.2 Selected recommendations from development source

Table 9 below highlights recommendations that have been provisionally selected from the development source(s) that may support potential statement development. These are presented in full after table 9 to help inform the Committee's discussion.

**Table 9 Specific areas for quality improvement**

| Suggested quality improvement area | Selected source guidance recommendations |
|---|---|
| Preventing falls during a hospital stay | **Predicting patients' risk of falling in hospital**<br>NICE CG161 Recommendations 1.2.1.1 and 1.2.1.2 (KPI)<br>**Assessment and interventions**<br>NICE CG161 Recommendations 1.2.2.1 to 1.2.2.5 |

**Predicting patients' risk of falling in hospital**

NICE CG161 Recommendation 1.2.1.1

Do not use fall risk prediction tools to predict inpatients' risk of falling in hospital. [new 2013].

NICE CG161 Recommendation 1.2.1.2 (key priority for implementation)

Regard the following groups of inpatients as being at risk of falling in hospital and manage their care according to recommendations 1.2.2.1 to 1.2.3.2:

- all patients aged 65 years or older

- patients aged 50 to 64 years who are judged by a clinician to be at higher risk of falling because of an underlying condition. [new 2013]

**Assessment and interventions**

NICE CG161 Recommendation 1.2.2.1

Ensure that aspects of the inpatient environment (including flooring, lighting, furniture and fittings such as hand holds) that could affect patients' risk of falling are systematically identified and addressed. [new 2013]

NICE CG161 Recommendation 1.2.2.2 (key priority for implementation)

For patients at risk of falling in hospital (see recommendation 1.2.1.2), consider a multifactorial assessment and a multifactorial intervention. [new 2013]

NICE CG161 Recommendation 1.2.2.3 (key priority for implementation)

Ensure that any multifactorial assessment identifies the patient's individual risk factors for falling in hospital that can be treated, improved or managed during their expected stay. These may include:

- cognitive impairment
- continence problems
- falls history, including causes and consequences (such as injury and fear of falling)
- footwear that is unsuitable or missing
- health problems that may increase their risk of falling
- medication
- postural instability, mobility problems and/or balance problems
- syncope syndrome
- visual impairment. [new 2013]

NICE CG161 Recommendation 1.2.2.4

Ensure that any multifactorial intervention:

- promptly addresses the patient's identified individual risk factors for falling in hospital and
- takes into account whether the risk factors can be treated, improved or managed during the patient's expected stay. [new 2013]

NICE CG161 Recommendation 1.2.2.5

Do not offer falls prevention interventions that are not tailored to address the patient's individual risk factors for falling. [new 2013]

### 4.6.3 Current UK practice

The 2015 national audit of inpatient falls was undertaken to measure against NICE CG161 and other patient safety guidance on preventing falls in hospital. The audit was open to all acute hospitals in England and Wales and included both an organisational audit (covering policies, protocols, leadership etc.) and a clinical audit (a snapshot of the care provided to a sample of patients aged over 65, who were in hospital for over 48 hours, after being admitted for a non-elective reason).

The organisational audit found that 73% of trusts were using a falls risk screening tool which aims to calculate a person's risk of falling. NICE CG161 states that risk prediction tools should not be used to predict the risk of a patient falling in hospital.

The organisational audit also captured information on inpatient multifactorial falls risk assessment (MFRA). The report states that all organisations appear to use some form of MFRA. The proportions of organisations that included specific components on the MFRA follow:

- 99% included an assessment of a history of falls
- 96% an assessment of continence and toileting
- 93% an assessment of gait, balance and mobility
- 90% an assessment of footwear
- 88% a review of all medication (for medications that increase falls risk)
- 82% an evaluation of vision
- 82% a requirement to check lying and standing blood pressure
- 76% a formal assessment of cognition
- 70% an assessment for fear of falling
- 56% an assessment of a history of blackouts or syncope
- 44% a formal assessment for delirium

The clinical audit also provides information on patients admitted who had assessments documented. The proportions differ from those in the organisational audit. This does not necessarily mean that clinical practice is different to what organisations say they do in terms of falls prevention. It could be that aspects of assessments are taking place but not being recorded in the case notes. Below is a list of the proportion of patients that had evidence documented in their case notes that assessment included a specified intervention:

- 95% a record of level of mobility
- 84% any assessment of urinary continence / frequency / urgency
- 81% being asked about asked about a history of falls
- 73% a medication review (beyond medicine reconciliation) with regard to falls risk
- 58% any assessment of cognitive impairment
- 49% any assessment of fear of falling

- 48% any assessment of vision and/or need for visual aids, including spectacles
- 46% assessment for medications that increase falls risk
- 37% assessed for the presence or absence of delirium or a documented diagnosis of delirium
- 16% measurement of lying and standing blood pressure

The national audit also presents information on inpatient multifactorial falls intervention from an organisational and clinical audit perspective. Again, there are some differences between what organisations reported they did, and what interventions were evidenced in patient records in the clinical audit. The proportion of organisations reporting each type of multifactorial falls intervention is shown below:

- 94% ensuring patients have access to their own spectacles
- 90% review of room / bed space most appropriate for the patient
- 89% modification of medications that increase falls risk
- 87% access to safe footwear
- 86% care plan to support patient with cognitive impairment
- 84% actions when problems with continence are identified
- 73% avoidance of unnecessary sleeping tablets/sedative medication
- 70% provision of walking aids 7-days a week
- 53% delirium management plan

The proportion of patients whose records documented each type of multifactorial falls intervention follow. Note that the proportions exclude patients for whom the specific intervention was not applicable:

- 79% a mobility care plan
- 73% a medication review (beyond medicine reconciliation) with regard to falls risk
- 69% a continence or toileting care plan
- 47% a delirium care plan
- 33% a care plan to support the patient with cognitive impairment
- 97% not given  new night sedation or other sedative medication

The clinical audit also collected information on the proportion of patients where it was documented that a patient had a falls care plan (or equivalent) tailored to the patient. Of inpatients admitted as a result of a fall, 69% had a falls care plan. For inpatients admitted for a reason other than a fall, the proportion with a care plan was lower (62%).

### 4.6.4 Resource Impact assessment

The costing statement for CG161 stated that the resource impact from implementing this guideline was not expected to be significant.  It was acknowledged that there may be some costs associated with increasing the level of physiotherapy support in

an inpatient setting and improving the availability of walking aids to people admitted to hospital.

## *4.7 Additional areas*

### Summary of suggestions

The improvement areas below were suggested as part of the stakeholder engagement exercise. However they were felt to be either unsuitable for development as quality statements, outside the remit of this particular quality standard referral or require further discussion by the Committee to establish potential for statement development.

There will be an opportunity for the QSAC to discuss these areas at the end of the session on 25 May 2016.

#### Developmental areas / emergent practice

Stakeholders were able to suggest areas of emergent practice that are underpinned by NICE guidance or NICE accredited guidance. The following suggestions were made, but are not specifically underpinned by guidance at this point in time.

- Fire and rescue service interventions: Stakeholders suggested fire and rescue service interventions to prevent falls as part of ‘safe and well’ visits.
- MoVE programme: A programme in a pilot phase that supports those who work with older people to develop a person-centred series of activities. Pilot is looking at impact of physical activity on prevention of falls.
- Catch 22: Project to stimulate research on the impact of housing interventions in health and care, including falls prevention.
- Following up falls: A stakeholder pointed out the importance of following up falls. Although this would largely be for secondary prevention, it could prevent others having a first fall.
- Technology to prevent falls: Examples to support falls prevention were suggested such as ‘Living it Up’ and ‘Making Life Easier’.
- Self-assessment tool for ‘The prevention and management of falls in the community: A framework for action’. Scotland
- Proactive Care Programme: A programme where GPs identify the most vulnerable patients on their lists for a proactive programme of care.
- Training: To allow professionals to provide primary prevention messages; Making Every Contact Count
- Opportunistic detection of vertebral fractures in images acquired for investigation of other conditions

### Service arrangements

A number of suggestions related to the arrangement and configuration of services. These included access to occupational therapists and physiotherapists 7 days a week; access to acute elderly care physicians 5 or 7 days per week; communication between services (e.g. between hospital and community physiotherapy); acute frail elderly units alongside CDUs; and more community facilities. These suggestions are not necessarily specific to prevention of falls and would be better addressed by upcoming quality standards on service provision, such as seven day working.

### Falls prevention strategies in care homes

One stakeholder identified this as an area for quality improvement as older people living in care homes are more likely to fall than people in the community. The stakeholder also commented that prevention strategies should not stifle the independence of residents. Whilst the development sources include older people in care homes within their scope, there are no specific recommendations that cover falls prevention strategies in care homes.

### Analysing and learning from falls

Whilst the focus of the quality standard is preventing a first fall, a stakeholder suggested that learning from falls is a key area. Analysing why falls happen can prevent other falls from occurring. This area is outside of the scope of this quality standard.

### Audit and measurement

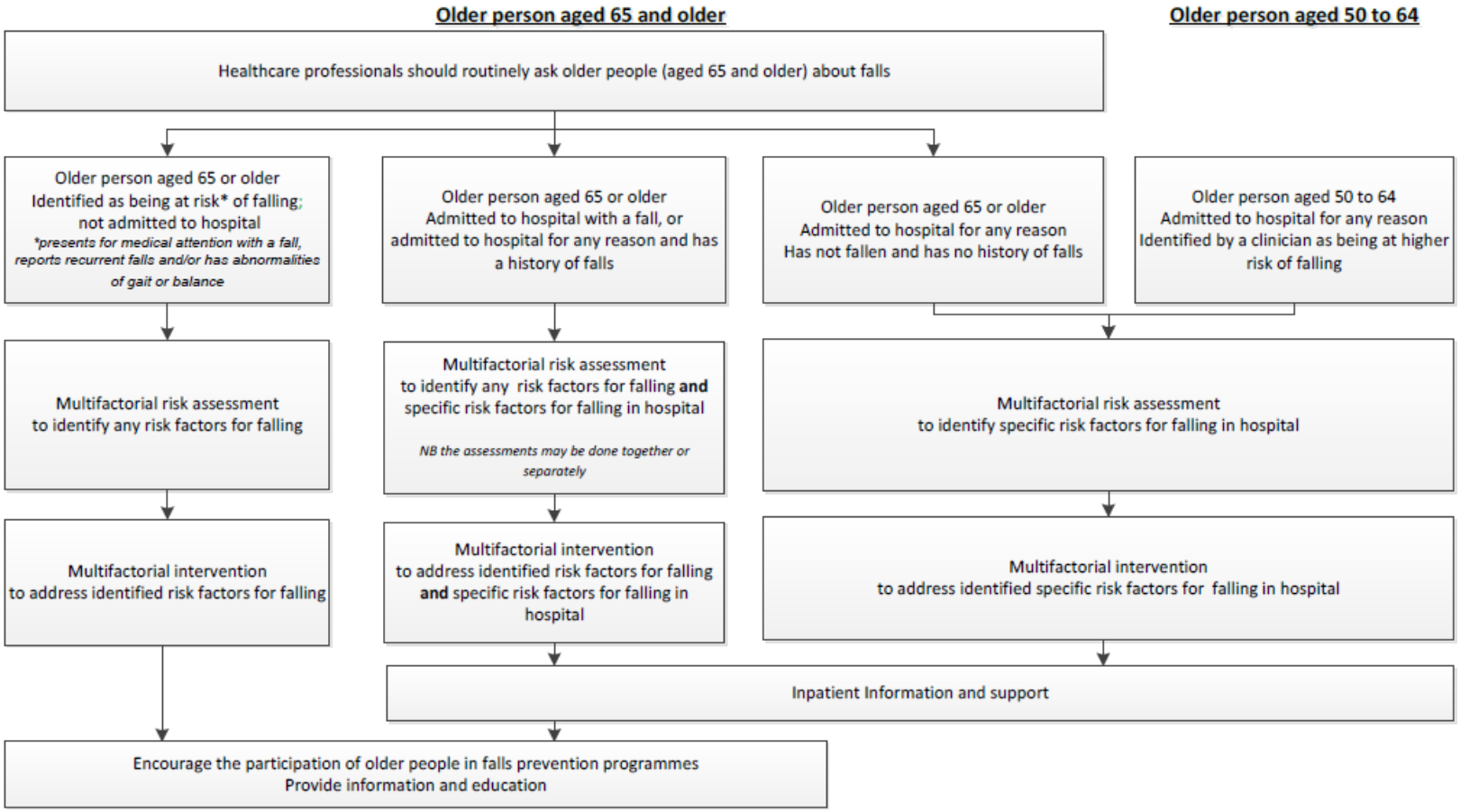
One stakeholder identified audit as an area for quality improvement and stated that the quality statements should be measurable using clinical audit. Another identified national and local data as being essential to planning and evaluation. Whilst these comments are relevant to the development of the quality standard (which will contain measures), they are not areas that can be progressed as quality statements.

### Scope and timing

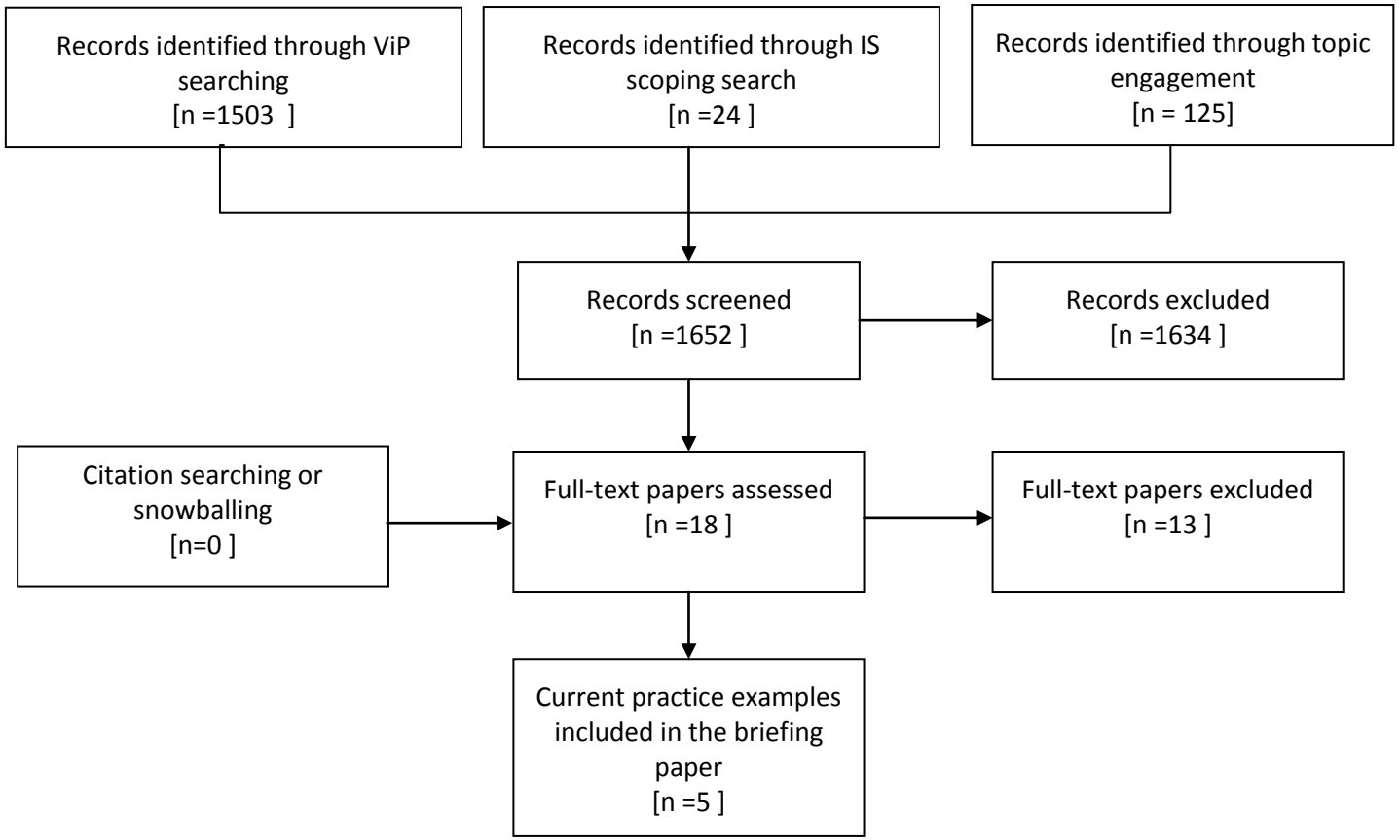
A number of stakeholders made comments relating to the scope as opposed to specifying key areas for quality improvement. All comments received are included in Appendix 3.

## Appendix 1: Additional information

Care pathway from CG161 (full guideline)



## Appendix 2: Review flowchart



## Appendix 3: Suggestions from stakeholder engagement exercise – registered stakeholders

| ID | Stakeholder | Key area for quality improvement | Why is this important? | Why is this a key area for quality improvement? | Supporting information |
|---|---|---|---|---|---|
| **Identification of cases** | | | | | |
| 1 | Public Health England | KA for quality improvement 1 Case / risk identification and multifactorial risk assessment. Better monitoring of those individuals who are at risk; the intervention advice provided by professionals and also the implementation of advice. | To identify those at risk of a first fall and so deliver appropriate interventions. Without this happening effectively and at scale, further activity is not possible | In terms of parts of the care system:<br><br>For primary care: to ensure that all patients with relevant pre-conditions are flagged on GP systems; offered appropriate bone strengthening drugs; and actions audited using the systems.<br><br>For secondary care: still far too low assessment and follow up for those suffering marker conditions and incidents coming into contact with secondary care.<br><br>Patients with an existing condition that puts them at higher risk of a primary fall should be risk assessed by clinicians and advised on interventions. Existing medical conditions, such as such as dementia, arthritis, diabetes, incontinence, stroke, , alcoholism, or Parkinson's disease that put patients at higher risk of a primary fall should be risk assessed by clinicians and advised on interventions | For the impact of alcohol<br><br>Older people and alcohol misuse: Helping people stay in their homes (pdf - 579Kb) |

| ID | Stakeholder | Key area for quality improvement | Why is this important? | Why is this a key area for quality improvement? | Supporting information |
|---|---|---|---|---|---|
| | | | | There are two areas where quality improvement is required. Firstly in terms of the range of professional groups carrying this out and secondly in terms of this being documented. PHE has been piloting a programme in which members of three Fire and Rescue Service identified a large number of vulnerable older people at risk of falls and referred appropriately. Current recommendations refer only to healthcare professionals. It is suggested that the recommendation is extended beyond healthcare professionals to other professional groups. The other recommendation is to ensure that the process of case / risk identification and carrying out a multi-factorial risk assessment is documented in order to ensure that falls prevention service effectiveness can be assessed ie it is necessary to know many cases were identified and how many were referred to particular interventions. Therefore the recommendation should make explicit reference to these processes being documented. | |
| 2 | SCM2 | KA for quality | To identify those at risk of a | In terms of parts of the care system: | For the impact of alcohol |

| ID | Stakeholder | Key area for quality improvement | Why is this important? | Why is this a key area for quality improvement? | Supporting information |
|---|---|---|---|---|---|
| | | improvement 1 Case / risk identification and multifactorial risk assessment. Better monitoring of those individuals who are at risk; the intervention advice provided by professionals and also the implementation of advice. | first fall and so deliver appropriate interventions. Without this happening effectively and at scale, further activity is not possible | For primary care: to ensure that all patients with relevant pre-conditions are flagged on GP systems; offered appropriate bone strengthening drugs; and actions audited using the systems.<br><br>For secondary care: still far too low assessment and follow up for those suffering marker conditions and incidents coming into contact with secondary care.<br><br>Patients with an existing condition that puts them at higher risk of a primary fall should be risk assessed by clinicians and advised on interventions. Existing medical conditions, such as such as dementia, arthritis, diabetes, incontinence, stroke, , alcoholism, or Parkinson's disease that put patients at higher risk of a primary fall should be risk assessed by clinicians and advised on interventions<br><br>There are two areas where quality improvement is required. Firstly in | Older people and alcohol misuse: Helping people stay in their homes (pdf - 579Kb) |

| ID | Stakeholder | Key area for quality improvement | Why is this important? | Why is this a key area for quality improvement? | Supporting information |
|---|---|---|---|---|---|
| | | | | terms of the range of professional groups carrying this out and secondly in terms of this being documented. PHE has been piloting a programme in which members of three Fire and Rescue Service identified a large number of vulnerable older people at risk of falls and referred appropriately. Current recommendations refer only to healthcare professionals. It is suggested that the recommendation is extended beyond healthcare professionals to other professional groups. The other recommendation is to ensure that the process of case / risk identification and carrying out a multi-factorial risk assessment is documented in order to ensure that falls prevention service effectiveness can be assessed i.e. it is necessary to know many cases were identified and how many were referred to particular interventions. Therefore the recommendation should make explicit reference to these processes ebbing documented. | |
| 3 | SCM 3 | Key area for quality improvement 1<br><br>Older people | This will need to include primary care, A&E and social care settings. | Falls are not an inevitable consequence of old age; rather they are nearly always due to one or more underlying risk factors. | NICE Clinical Guidelines 161; Falls https://www.nice.org.uk/Guidance/CG161 |

| ID | Stakeholder | Key area for quality improvement | Why is this important? | Why is this a key area for quality improvement? | Supporting information |
|---|---|---|---|---|---|
| | | 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. | People at risk of falling or who have fallen may be reluctant to discuss balance and mobility problems with anyone, especially if they have not fallen or not been injured following a fall. People may be reluctant because they think balance and mobility problems are just part of getting older. | Recognising the risk factors is crucial in preventing falls and injuries.<br><br>Many individuals are at high risk but not identified as such and so miss out on potential interventions not just to prevent further falls but also improve quality of life and independence. A great deal of primary prevention could be undertaken with exercise interventions in primary care.<br><br>Falling standards, broken promises (RCP, 2011) showed that the assessment and prevention of further falls was not always undertaken for older people who attended A&E following a fall and fracture (excluding hip and head) and who were then discharged home or to their normal place of residence. We believe that the quality standard should ensure individuals who cross care boundaries in this way are flagged-up so that a multi-disciplinary assessment and appropriate interventions can occur. An assessment should also be prompted for individuals who have | College of Occupational Therapists: Occupational therapy in the prevention and management of falls in older adults http://www.cot.co.uk/sites/default/files/publications/public/Falls-guideline.pdf<br><br>AGS/BGS Clinical Practice Guideline: Prevention of Falls in Older Persons http://www.medcats.com/FALLS/frameset.htm<br><br>Age UK/ NOS – Breaking Through http://www.nos.org.uk/document.doc?id=987<br><br>RCP Falling standards, broken promises https://www.rcplondon.ac.uk/projects/falls-audit-reports |

| ID | Stakeholder | Key area for quality improvement | Why is this important? | Why is this a key area for quality improvement? | Supporting information |
|---|---|---|---|---|---|
| | | | | fallen two or more times when they attend A&E. | |
| 4 | AGILE | Case finding people at risk of falls. | Without effective case finding there is no clear mechanism for identifying those patients at risk of falls. This should include particular reference to case finding amongst those with a new or early dementia diagnosis. | National Audits of Falls and Bone Health have shown that case finding is patchy. | The quality standard should aim to ensure that all organisations are asked to evidence that asking about falls and risk factors for falling is part of their core assessments for patients in both inpatient and community settings. This should include those working within the ambulance service and those working within the voluntary sector. |
| 5 | Optasia Medical | Prioritise subgroups of older people who are at a greater risk of fracture following a fall. | Falling itself is not the main problem; the subsequent fracture is and its consequences. Sizeable subgroups of older people are at far higher risk of fracture following a fall. We would suggest, therefore, that particular consideration be given to identifying these high risk subgroups including e.g. women, poor bone health, chronic steroid use, previously undiagnosed vertebral fracture. See below for | We believe that prioritising the identification of subgroups at particular risk of fracture following a fall, for falls prevention, will more quickly reduce consequential fractures than a more general targeting of older people. | Guidance already exists to identify those at risk of fragility fracture – CG146. We suggest that this should be explicitly integrated into the guidance for identification and assessment of those for those older people who are at a higher risk of fracture following a fall. |

| ID | Stakeholder | Key area for quality improvement | Why is this important? | Why is this a key area for quality improvement? | Supporting information |
|---|---|---|---|---|---|
| | | | related point. | | |
| 6 | AGILE | Onward referral for strength and balance training | Patients who present with markers of frailty should have appropriate screening for gait and balance problems to enable them to be referred on for evidence based exercise to address these where appropriate. Failure to do so will leave patients whose balance could be improved at risk of further deterioration. Attention should be given to those with a new or early dementia diagnosis who may be at increased risk of impaired gait and balance. | Meta-analyses, RCTs and international guidance supports provision of strength and balance training as a single intervention, or as part of a multifactorial intervention for those people who are at risk of falling. | The quality standard should require:-<br>• Organisations to have appropriate screening in place<br>• Organisations to have clear onward referral pathways to evidence based exercise in place.<br>• Commissioners to have clearly commissioned sufficient evidence based exercise programmes to meet the predicted demand within the organisations.<br>• Commissioners to ensure there is a local training and development strategy that ensures there are enough exercise providers with nationally recognised exercise qualifications in place. |
| 7 | College of Occupational Therapists | Key area for quality improvement<br>4.<br>Falls Prevention incorporated into Long Term | Many long term conditions increase an individual's risk of falls however often falls occur with a progression of the condition. Often at this stage it can be too late to | Falls prevention programmes should be incorporated into long term conditions management at the earliest opportunity and should link to key areas:<br>1. Living well and keeping active | http://www.parkinsons.org.uk/sites/default/files/fs97_occupationaltherapy.pdf<br><br>http://www.cot.co.uk/sites/default/files/publications/public/Fall |

| ID | Stakeholder | Key area for quality improvement | Why is this important? | Why is this a key area for quality improvement? | Supporting information |
|---|---|---|---|---|---|
| | | Conditions Management | prevent falls from reoccurring. | 2. Multifactorial risk assessment.<br><br>For example: When working with a person with Parkinson's Disease.<br><br>*Occupational Therapy in the prevention and management of falls in adults practice guideline* 2. recommends that occupational therapists should offer home safety assessment and modification for older people with a visual impairment. Opportunities should be made available for appropriate signposting to occupational therapy. | s-guideline.pdf<br><br>http://www.college-optometrists.org/filemanager/root/site_assets/commissioning/falls/focus_on_falls_report_240414.pdf |
| 8 | College of Optometrists | Optometrists and Dispensing Opticians should be empowered to spot at risk groups and refer to specialist falls services | As vision plays such a fundamental role in risk of falling and the vast majority of patients seen by optometrists and Dispensing Opticians are in the target group for this quality standard, both professions are therefore in a prime position to become a sanctioned identifier of those at increased risk. | Even a simple change in glasses prescription or a patient wearing bi/multi-focals can drastically increase the risk of a fall in the over 65s. The benefits of empowering optometrists to be official risk identifiers would be vast. | http://www.college-optometrists.org/en/EyesAndTheNHS/focus-on-falls/index.cfm |
| 9 | Lancashire Care NHS Foundation | Key area for quality improvement 1 | The avoidance/prevention of a fall has implications for health, social and financial | Current focus has been on secondary prevention of falls. With the ageing population primary | Nice Guideline 161 |

| ID | Stakeholder | Key area for quality improvement | Why is this important? | Why is this a key area for quality improvement? | Supporting information |
|---|---|---|---|---|---|
| | Trust | Identification of person at risk of fall The standard within NICE CGL 161 (2013) states that older people in contact with health care professionals should be asked about falls in the last year-consideration should also be given to those people having near misses /being concerned about their steadiness but not yet had a fall | burden. | prevention has a role to maintain independence and prevention of the first fall. | |
| 10 | Royal College of Physicians of Edinburgh | Ascertainment and recording of fall events | Primary prevention of falls should ideally identify and remediate fall risk factors before a fall event occurs. The majority of fall prevention studies have included people who have sustained at least one fall, so are not truly primary prevention. However, given the high prevalence of falls in people aged > 65 years (35% or more), it is | NICE guidance recommends routine questioning about frequency and circumstances of falls in older people when in contact with healthcare professionals. It is unclear whether this is routinely incorporated into clinical practice and whether a recording of falls, or falls risk factors results in measures to address these. | Falls in older people: assessing risk and prevention NICE guidelines [CG161] Published date: June 2013. |

| ID | Stakeholder | Key area for quality improvement | Why is this important? | Why is this a key area for quality improvement? | Supporting information |
|---|---|---|---|---|---|
| | | | important to differentiate between those with fall risk factors who have fallen, and those with fall risk factors who have not fallen. | | |
| **Risk assessment** | | | | | |
| 11 | Royal College of Physicians of Edinburgh | Ascertainment and recording of fall risk factors | Identification and documentation of fall risk factors is the first step in determining whether a person is at higher risk of falls. | Epidemiological evidence that the risk of a fall rises with increasing number of falls risk factors in a non-linear relationship.<br><br>The quality standard should consider defining which fall risk factors are to be routinely included, given the multiple and diverse independent fall risk factors that have been identified in previous epidemiological studies. | Gillespie LD, Robertson MC, Gillespie WJ, Sherrington C, Gates S, Clemson LM, Lamb SE. *Interventions for preventing falls in older people living in the community*. Cochrane Database of Systematic Reviews 2012, Issue 9. Art. No.: CD007146. DOI: 10.1002/14651858.CD007146.pub3. |
| 12 | Royal College of Emergency Medicine | Routine lying and standing (orthostatic ) blood pressure assessments | | | |
| 13 | SCM 1 | Mental Health Factors<br>service areas – primary and secondary care; also residential care | Important to identify if there are signs of mild cognitive impairment or dementia. Dignity and privacy to be borne in mind for these groups of patients in particular. | I have raised this because some patients have told me they may not see objects which are in front of them. Treatment eg medication may prevent a fall.<br>I have noted that cognitive talking interventions are outside of scope so I have not included fear of falling | Royal College of Physicians Health Foundation Fallsafe Report.<br>NICE guidance 161<br>Conversations with members of the research network in Alzheimers Society |

| ID | Stakeholder | Key area for quality improvement | Why is this important? | Why is this a key area for quality improvement? | Supporting information |
|---|---|---|---|---|---|
| | | | | (even though I feel it is important). | |
| 14 | Public Health Wales | Eyesight checks | We know that poor eyesight / lack of correction of poor eyesight is a key risk factor for falling | Clear referral pathways between all organisations working with never fallers need to be in place | |
| 15 | SCM 3 | Key area for quality improvement 3<br><br>Older people should be asked about fear of falling and how this may restrict activity as a behavioural response | Evidence on fear of falling highlights the integral link between fear and activity levels. Although reducing the number of falls may be a key outcome for falls prevention activities, the potential to restrict activity as a behavioural response to fear of falling can be to the detriment of activities of daily living and occupational engagement.<br>People have different attitudes and levels of tolerance to risk.<br>Health and social care professionals therefore have a valuable role in working with service users, caregivers, family and friends to achieve a balance of risk and activity. | Old age, female gender, limitations in activities of daily living, impaired vision, poor perceived health, chronic morbidity, falls, low general self-efficacy, low mastery, loneliness, feelings of anxiety, and symptoms of depression were identified as univariate correlates of severe fear of falling and avoidance of activity<br><br>Fear may be experienced by people who have fallen and people who have never fallen<br>and is experienced by up to half of older people living in the community (Zijlstra et al<br>2007). Fear of falling is, therefore, an important factor, particularly given its potentially detrimental consequences on an individual's lifestyle and activities.<br>The concept of self-efficacy, or the degree of confidence a person has in carrying out everyday activities without falling, is an important factor | College of Occupational Therapists: Occupational therapy in the prevention and management of falls in older adults http://www.cot.co.uk/sites/default/files/publications/public/Falls-guideline.pdf |

| ID | Stakeholder | Key area for quality improvement | Why is this important? | Why is this a key area for quality improvement? | Supporting information |
|---|---|---|---|---|---|
| | | | | that needs to be considered in falls prevention and management.<br><br>Anecdotal evidence shows that fear of falling is often not part of a key intervention as part of a falls service delivery plan | |
| 16 | Royal College of Physicians of Edinburgh | Recording of fear of falling | Fear of falling is associated with an increased risk of early admission to institutional care, and is in itself associated with an increased risk of falls. | Standardised recording of fear of falling and interventions undertaken to address this. There is weak evidence that exercise intervention can reduce fear of falling. | Kendrick D, Kumar A, Carpenter H, Zijlstra GAR, Skelton DA, Cook JR, Stevens Z, Belcher CM, Haworth D, Gawler SJ, Gage H, Masud T, Bowling A, Pearl M, Morris RW, Iliffe S, Delbaere K. *Exercise for reducing fear of falling in older people living in the community.* Cochrane Database of Systematic Reviews 2014, Issue 11. Art. No.: CD009848. DOI: 10.1002/14651858.CD009848.pub2. |
| 17 | Royal College of Nursing | Regular foot checks and toe nail cutting | Many older people have serious problems with their feet. The lack of regular access to affordable podiatry can mean that toenails cause huge problems that result in falls. Inappropriate footwear is | | |

| ID | Stakeholder | Key area for quality improvement | Why is this important? | Why is this a key area for quality improvement? | Supporting information |
|---|---|---|---|---|---|
| | | | also a significant risk factor. | | |
| 18 | Public Health Wales | Gait assessment using timed up and go test | We should always ask about falls history in older people's contacts with the NHS. But, for those that do not have a history of falling, their "gait" should then be assessed using Timed Up and Go (or similar) to determine whether referral to maintain low falls risk is necessary | There is a lack of clear guidance on what to do with never fallers to preserve that status.<br>There is also a lack of guidance on "scores" on e.g. TUG that would indicate increasing risk of falling | |
| 19 | Royal College of Emergency Medicine | Health visitor assessments in young children (prevention) | | | |
| 20 | College of Occupational Therapists | Key area for quality improvement 2.<br>Keeping Safe at Home: reducing risks of falls | Home safety interventions to prevent falls are only effective as part of a multifactorial approach to falls prevention. Home hazard assessment is shown to be effective only in conjunction with follow up and intervention, not in isolation.<br>The evidence suggests Occupational Therapy home hazards intervention | • Fire and Rescue Services, Day Care Services, Social Work and Care & Repair for example, complete home safety visits. It is important that these should address falls hazards with appropriate follow up and intervention.<br>• *Occupational Therapy in the prevention and management of falls in adults practice guideline:* 3. recommends pre- and post-discharge home assessment to | http://www.cot.co.uk/sites/default/files/publications/public/Falls-guideline.pdf |

| ID | Stakeholder | Key area for quality improvement | Why is this important? | Why is this a key area for quality improvement? | Supporting information |
|---|---|---|---|---|---|
| | | | to prevent falls is effective for individuals with severe visual impairment or functional decline (COT 2015). | reduce risk of falls following discharge from inpatient rehabilitation facility.<br>4. recommends service users who are living in the community are given advice, instruction and information on assistive devices as part of a home hazard assessment. | |
| 21 | Public Health England | KA for quality improvement 3<br><br>Home hazards assessments and safety interventions / modifications undertaken | NICE CG 161 and NICE QS 117 | • Home Falls Liaison Services (HFLS) - these are very variable across the country and there are different models (eg primary care based; secondary care based) – Is there any evidence showing differential outcomes from having an HFLS as to outcomes and is there any evidence as to which of these different models are move effective and efficient?<br>• There is a wide variation in falls and fractures taking place in Nursing Homes and the residential care sector: are there standards and models which be promulgated. programmes focussing on training of both staff aware residents) which have been shown to be effective and reduce falls and fractures? | |

| ID | Stakeholder | Key area for quality improvement | Why is this important? | Why is this a key area for quality improvement? | Supporting information |
|---|---|---|---|---|---|
| | | | | • As applied to people living in different settings (ie owner occupiers; those in either private or social rented sector and those in residential care | |
| 22 | SCM 2 | KA for quality improvement 3<br><br>Home hazards assessments and safety interventions / modifications undertaken | NICE CG 161 and NICE QS 117 | • Home Falls Liaison Services (HFLS) - these are very variable across the country and there are different models (e.g. primary care based; secondary care based) – Is there any evidence showing differential outcomes from having an HFLS as to outcomes and is there any evidence as to which of these different models are move effective and efficient?<br>• There is a wide variation in falls and fractures taking place in Nursing Homes and the residential care sector: are there standards and models which be promulgated (e.g. programmes focussing on training of both staff aware residents) which have been shown to be effective and reduce falls and fractures?<br>• As applied to people living in different settings (i.e. owner occupiers; those in either private or social rented sector and those | |

| ID | Stakeholder | Key area for quality improvement | Why is this important? | Why is this a key area for quality improvement? | Supporting information |
|---|---|---|---|---|---|
| | | | | in residential care | |
| 23 | SCM 1 | Environmental Factors<br>service areas – home hazard assessments (occupational therapists); primary care; discharge in secondary care; organisations eg Equipment Advice Service | Important to carry out home hazard assessments (may have different label – in my locality it is called falls detection). Any proposed provision and/or work should be expedited | Important to identify specific problem areas such as steps and also objects which may cause obstruction. Also lighting. Important to look at possibilities of walking aids, lifts, hand rails.<br>Also possibility of relocation. | NPSA Slip trips & falls 2007 & 2010<br>NICE guidance 161<br>DOH Prevention Package for older people resources<br>Family experience – Falls Detection Meeting at my uncle's home 2 wks ago |
| 24 | Royal College of Emergency Medicine | Home safety assessment in elderly (prevention) | | | RCEM would encourage this work to link up with other initiatives to prevent and reduce falls in the elderly, for example RoSPA's 'Stand Up'.<br><br>RoSPA is inviting all partners who are involved in improving health and quality of life for older people to "Stand Up" and join a national<br>movement to actively promote measures that will prevent falls and reduce their impact when they do occur. |
| 25 | The Royal | Key area for quality | Provision of home safety | Research suggests that low-cost | http://www.healthyhousing.org. |

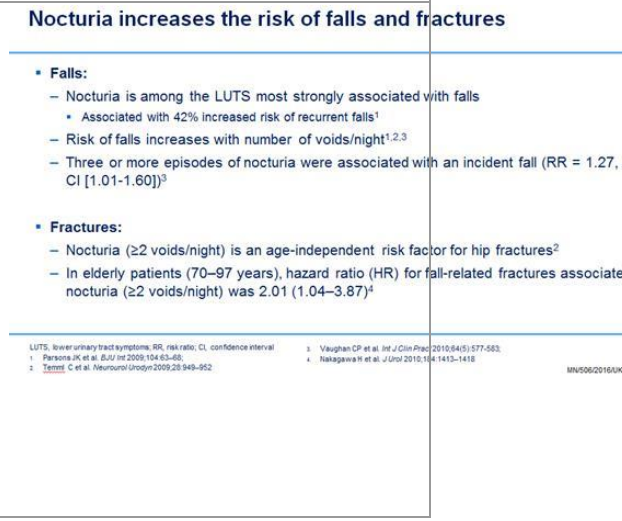
| ID | Stakeholder | Key area for quality improvement | Why is this important? | Why is this a key area for quality improvement? | Supporting information |
|---|---|---|---|---|---|
| | Society for the Prevention of Accidents | improvement 3 Providing home safety assessments | assessments to older people is a key service which enables them to make informed choices about keeping safe and preventing unintentional injury. This has been recognised by, for example, Fire Services, with the provision of home fire safety checks but there is the potential for much wider application. | home modifications and repairs can be a means to reduce injury in the general population.<br><br>There is no consistent provision of home safety assessments across the country although there are significant examples of good practice from which quality standards could be developed and applied nationally. The development of a standard assessment tool could make a significant contribution to the reduction of unintentional injury | nz/wp-content/uploads/2010/01/Home-modi%EF%AC%81cations-to-reduce-injuries-from-falls-in-the-Home-Injury-Prevention-Intervention-Lancet-published.pdf |
| 26 | SCM 3 | Key area for quality improvement 2<br><br>For patients at risk of falling in hospital consider a multifactorial assessment and a multifactorial intervention | All inpatients aged 65 years or older should be considered at risk of falling as well as patients aged 50 to 64 years who are judged by a clinician to be at higher risk of falling. These patients should have their falls risk factors assessed and interventions should be implemented in accordance with to the patient's individual risk factors. | Research has shown that falls can be reduced by 20-30% through multifactorial assessment and interventions. The aim of these assessments and interventions is to identify and treat the underlying reasons for falls, such as muscle weakness, cardiovascular problems, dementia, delirium and medication. However, audits have found low levels of implementation of these assessments and interventions in UK hospitals. | NICE Clinical Guidelines 161; Falls https://www.nice.org.uk/Guidance/CG161<br><br>Royal College of Physicians https://www.rcplondon.ac.uk/resources/falls-prevention-resources<br><br>National Patient Safety Agency http://www.nrls.npsa.nhs.uk/resources/collections/10-for-2010/reducing-harm-from-falls/?entryid45=59821<br><br>National Patient Safety Agency |

| ID | Stakeholder | Key area for quality improvement | Why is this important? | Why is this a key area for quality improvement? | Supporting information |
|---|---|---|---|---|---|
| | | | | | and Patient Safety First http://www.patientsafetyfirst.nhs.uk/Content.aspx?path=/Campaign-news/current/Howtoguidefalls/ |
| 27 | Royal College of Physicians of Edinburgh | Access to multifactorial falls assessment | Evidence from NICE guidance and Cochrane review of 30% reduction in rate of falls with multifactorial falls prevention programmes. | Multifactorial falls risk assessment and intervention has consistently demonstrated a reduction in fall rates in those with established falls history. However, there is less strong evidence in earlier stage of fall history where fall risk factors may be more economically addressed with early exercise intervention.<br><br>NIHR portfolio study - PreFIT falls prevention (currently under analysis) examines the difference between exercise intervention and multifactorial intervention in older patients with identified fall risk factors (Prof Sally Lamb, Warwick University). | Gillespie LD, Robertson MC, Gillespie WJ, Sherrington C, Gates S, Clemson LM, Lamb SE. *Interventions for preventing falls in older people living in the community*. Cochrane Database of Systematic Reviews 2012, Issue 9. Art. No.: CD007146. DOI: 10.1002/14651858.CD007146.pub3.<br><br>Falls in older people: assessing risk and prevention NICE guidelines [CG161] Published date: June 2013 |
| 28 | College of Occupational Therapists | Key area for quality Improvement 3. Multifactorial Risk Assessment | Multifactorial risk assessment should be completed if a person has abnormalities with gait or balance or in an extended care facility such as care | Anyone in an extended care facility is at risk of falls irrespective of whether they have fallen before. Scored risk prediction tools for falls are still used in some settings despite NICE recommendations not | http://www.nhsggc.org.uk/media/233749/caas-standards-acute-gp-hospitals-april-2015.docx |

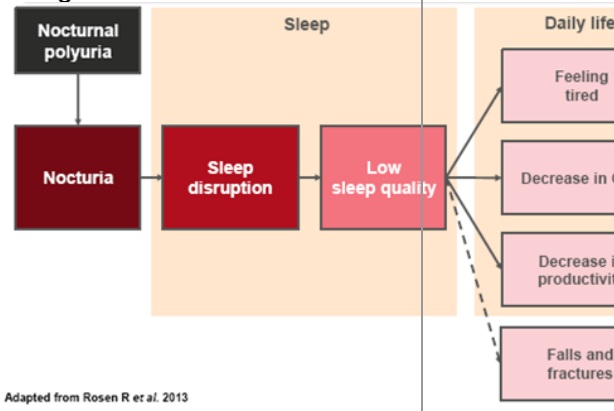
| ID | Stakeholder | Key area for quality improvement | Why is this important? | Why is this a key area for quality improvement? | Supporting information |
|---|---|---|---|---|---|
| | | | home or hospital (NICE, CAAS and Care Inspectorate). | to use these in hospital settings 1.2.1.1.<br><br>Key area for improvement is that multifactorial risk assessment should be completed as part of an individual's care plan in extended care settings on admission, during a change of circumstance e.g. new medication, acute illness. This should be routinely reviewed. | |
| 29 | Parkinson's UK | Providing multifactorial falls risk assessment to all people with Parkinson's | People with Parkinson's can be at risk of falling more due to some of their symptoms including: freezing, loss of balance, general muscle weakness, problems with gait or shuffling, low blood pressure, and eye problems. Also some Parkinson's medications can also be a cause of falls.<br><br>Workaround falls prevention should be symptom specific not age related. | It is important that people with Parkinson's are helped to prevent falling, rather than only dealing with consequences after a fall has taken place.<br><br>While the condition is more prevalent in those over 65, around a third of people with Parkinson's develop symptoms before the age of 65, and one in 100 before the age of 40. Parkinson's UK recommends that everyone with Parkinson's, regardless of age, is offered a multifactorial risk assessment to help reduce the risk of falling. | "Freezing is the cause of many a fall for me. The problem is, my body goes faster than my feet, so I often leave them on the pavement!" Josie, diagnosed in 2007<br><br>Falls are a significant problem both in the later stages of Parkinson's and in optimally medicated early-stage Parkinson's (Bloem, Bastiaan R., et al. "Prospective assessment of falls in Parkinson's disease." *Journal of neurology* 248.11 (2001): 950-958.).<br><br>Research has shown that a combination of both disease- |

| ID | Stakeholder | Key area for quality improvement | Why is this important? | Why is this a key area for quality improvement? | Supporting information |
|---|---|---|---|---|---|
| | | | | | specific and balance- and mobility-related measures can accurately predict falls in individuals with PD (Kerr, G. K., et al. "Predictors of future falls in Parkinson disease." *Neurology*75.2 (2010): 116-124.).<br><br>There are a number of recent publications that build on these findings developing risk falls assessment and screening:<br><br>• Research article '*Three Simple Clinical Tests to Accurately Predict Falls in People with Parkinson's Disease*' by Serene S. Paul, BAppSc(Phty)(Hons), Colleen G. Canning, PhD, Catherine Sherrington, PhD, Stephen R. Lord, PhD, DSc, Jacqueline C. T. Close, MD, Victor S. C. Fung, PhD, FRACP<br>• Research article: '*Prediction of Falls and/or Near Falls in People with Mild Parkinson's Disease*' by Beata Lindholm, Peter |

| ID | Stakeholder | Key area for quality improvement | Why is this important? | Why is this a key area for quality improvement? | Supporting information |
|---|---|---|---|---|---|
| | | | | | Hagell, Oskar Hansson, Maria H. Nilsson Department of Neurology, Skåne University Hospital, Malmö, Sweden, Published Jan 30th 2015 |
| 30 | SCM 4 | Key area for quality improvement 2<br><br>Considering those with multimorbidity (or specifically, those with conditions that affect mobility or balance, for example arthritis, diabetes, stroke, Parkinson's disease) to be at higher risk of falls and refer to a specialist falls service at an early stage | Evidence that conditions known to impair balance or mobility increase risk of falls, and that having more than one of these conditions further increases the risk. | Evidence from multiple sources including NICE CKS 2014. This is a realistic standard that GPs can carry out in primary care and has a measurable end point i.e. are those with multimorbidity being considered for falls referral? | |
| 31 | College of Optometrists | Sight-testing in all Falls risk assessments | The chances of having reduced vision greatly increases with age and older people with reduced vision are more likely to fall. Vision is fundamental to | We are pleased that the NICE Guideline 161 asserts that vision should be a part of any falls multi-factorial assessment and a core part of falls interventions.<br>We feel that vision should be a | Please see the Thomas Pocklington Trust report *Falls in older people with sight loss: a review of emerging research and key action points* published June 2013, for |

| ID | Stakeholder | Key area for quality improvement | Why is this important? | Why is this a key area for quality improvement? | Supporting information |
|---|---|---|---|---|---|
| | | | coordinating our movement – balance and postural stability are directly affected by vision. In addition, vision is fundamental to adapt gait to enable safe travel though the environment, avoiding obstacles and negotiating steps and stairs. | consideration in all aspects of a patient pathway through falls services - including prevention and rehabilitation programmes. | further evidence.<br>The College of Optometrists published the *Focus On Falls* report which looks specifically at the relationship between falls and vision, making several practical recommendations for falls services and the optometric sector. |
| 32 | Public Health Wales | Strength and balance assessment / training | Good strength and balance are well known to reduce the risk of falls | There is a lack of clear guidance for never fallers on what they should do to stay that way. Plus, these people also need to be able to access information and / or classes if they require them | |
| 33 | Ferring Pharmaceuticals | There is a section referring to the prevention of falls of older people during a stay in hospital but there is nothing around prevention of falls of older people at home due to an underlying/ undiagnosed condition. | Potential to miss an opportunity to prevent falls. | Costs of hip fractures due to nocturia estimated to be €1 billion in Europe and $1.5 billion in USA (van Kerrebroeck 2010, Holm-Larsen 2014. Therefore, we propose that aside of urinary incontinence, nocturia due to nocturnal polyuria is also included as part of the multifactorial health assessment, as if it is diagnosed and treated appropriately it will reduce the risk of falls and fractures particularly for the for the >65s and thereby improving the QoL for patients and reducing the humanistic and economic |  |

| ID | Stakeholder | Key area for quality improvement | Why is this important? | Why is this a key area for quality improvement? | Supporting information |
|---|---|---|---|---|---|
| | | | | burden. | |
| 34 | SCM 1 | Underlying Physical Conditions/Illnesses : service areas – primary and secondary care; also residential care | Important to investigate whether a patient at risk has underlying physical medical conditions such as vertigo. It is important to diagose correctly eg Hallpike's Man for BPPV but this may not be suitable for all patients (eg due to frailty or osteoporosis or other orthopaedic problems.) There are effective treatments (medication). But conversely there may be medications which may have side effects such as dizziness. Exercise regimes may be beneficial where there is weakness and gait problems.. Other conditions are around cardiac and urinary problems. Vision is also important – does the patient need spectacles? Are there clothing/footwear issues? | If these issues are tackled, in my view the risk of falling can be diminished. I have reached this view as a result of personal experience - an attack of BPPV. Also from reading (i) the Occupational Therapy in the prevention & management of falls in adults. Also (ii) the Footcare sevices for older people | (I) College of Occupational Therapists 2015<br>(II) Age UK Falls Prevention Guide |
| 35 | Royal College of Nursing | Better identification of people at risk of falling due to their | Early identification of those at risk should be undertaken with screening | | Falls in older people: assessing risk and prevention https://www.nice.org.uk/guidan |

| ID | Stakeholder | Key area for quality improvement | Why is this important? | Why is this a key area for quality improvement? | Supporting information |
|---|---|---|---|---|---|
| | | underlying medical conditions e.g. hypotension | and if appropriate scans and treatment with approved regime of therapy including exercise and drugs. | | ce/cg161 |
| 36 | Ferring Pharmaceuticals | The quality standard will cover primary prevention of falls for older people It will not cover preventing further falls after an initial fall (secondary prevention) or assessment after a fall. These are covered by the quality standard on falls in older people.<br><br>In the guideline for 'falls in older people: assessing risk and prevention' it is stated that as part of the multifactorial assessment health problems that may increase their risk of falling must be assessed. | Primary prevention needs to address full assessment to be optimal and exclude associated causes. | The prevalence of nocturia increases with age and it has also been associated with an increased risk of falls and fractures.] Increased risk of falling associated with nocturia (OR 1.84, 95% CI 1.05-3.22; Stewart et al., 1992) = increased risk of fractures (OR 1.8, 95% CI 1.1-3.0; Asplund, 2006)] | Nocturia is defined by the International Continence Society (ICS) as the need to wake to void during a night's sleep, with each void preceded and followed by sleep (Van Kerrebroeck et al., 2002). Nocturnal polyuria is defined by the ICS as production of >20-33%* of total urine volume at night.<br>  |

| ID | Stakeholder | Key area for quality improvement | Why is this important? | Why is this a key area for quality improvement? | Supporting information |
|---|---|---|---|---|---|
| | | These include an assessment of urinary incontinence, where medication review with modification/withdrawal is recommended. | | | |
| **Intervention** | | | | | |
| 37 | Public Health England | KA for quality improvement 2<br><br>Promote physical activity as per UK CMO guidelines, October 2015, for adults and older adults.<br>Referring those at risk of a first fall to evidence based strength and balance programmes.<br><br>Implementing NICE NG 16 | Building strength and improving balance will reduce falls.<br>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 intervention programmes.<br><br>Increasing moderate and vigorous intensity activity will reduce risk of impairments resulting from preventable LTCs which in turn can result in falls (e.g. | There is a need to ensure that referrals to strength and balance programmes are followed up to assess levels of commencement and completion of the programmes. Recent work carried out by PHE as part of its Population Healthcare Programme worked with 11 local authority public health teams in assessing local falls and fracture prevention systems. Although nine areas stated that there was a documented requirement to deliver strength and balance programmes, none of the areas were able to provide information about numbers of people referred to the programmes or completing the programmes. Therefore we suggest that the recommendation should read “Older people living in the | Health Survey for England: http://www.hscic.gov.uk/searchcatalogue?productid=19587&q=title%3a%22Health+Survey+for+England%22&sort=Most+recent&size=10&page=1#top<br><br>Public Health Outcome Indicators 2.13i and 2.13ii http://www.phoutcomes.info/public-health-outcomes-framework#page/0/gid/1000042/pat/6/par/E12000004/ati/102/are/E06000015/iid/90362/age/1/sex/1 |

| ID | Stakeholder | Key area for quality improvement | Why is this important? | Why is this a key area for quality improvement? | Supporting information |
|---|---|---|---|---|---|
| | | | visual impairment secondary to type 2 diabetes)<br><br>Reducing sedentary time will help to maintain mobility and strength therefore reduce risk of falls.<br><br>Aligned with changes in the built environment which support and promote safer physical activity: e.g. design and maintenance of public paths, crossings and links with public transport. If the built environment is unsafe for older people or poses barriers or risks, then people become inactive and are less likely to achieve the CMO guidelines. | community are at risk of a first fall falls referred for strength and balance training and followed up".<br><br>A recent unpublished survey of GPs shows that knowledge of CMO guidelines and use of assessment tools is hugely variable.<br><br>For older adults, there is little evidence of targeted physical activity messages<br><br>The built environment and well-designed outdoor spaces can enhance the long-term health and wellbeing of those who use them regularly, reduce the risk of falls, promote physical activity and reduce social isolation. | Please see recent Housing Lin/ PHE publications:<br>Active Ageing and the Built Environment (pdf - 961Kb)<br><br>Inclusive Design for Getting Outdoors – www.idgo.ac.uk/pdf/Intro-leaflet-2012-FINAL-MC.pdf |
| 38 | SCM 2 | KA for quality improvement 2<br><br>Promote physical activity as per UK CMO guidelines, October 2015, for adults and older adults. | Building strength and improving balance will reduce falls.<br>Balance impairment and muscle weakness caused by ageing and lack of use are the most prevalent modifiable risk factors for falls. Strength and balance | There is a need to ensure that referrals to strength and balance programmes are followed up to assess levels of commencement and completion of the programmes.<br>Recent work carried out by PHE as part of its Population Healthcare Programme worked with 11 local authority public health teams in | Health Survey for England: http://www.hscic.gov.uk/searchcatalogue?productid=19587&q=title%3a%22Health+Survey+for+England%22&sort=Most+recent&size=10&page=1#top<br><br>Public Health Outcome Indicators 2.13i and 2.13ii |

| ID | Stakeholder | Key area for quality improvement | Why is this important? | Why is this a key area for quality improvement? | Supporting information |
|---|---|---|---|---|---|
| | | Referring those at risk of a first fall to evidence based strength and balance programmes.<br><br>Implementing NICE NG 16 | training has been identified as an effective single intervention and as a component in successful intervention programmes.<br><br>Increasing moderate and vigorous intensity activity will reduce risk of impairments resulting from preventable LTCs which in turn can result in falls (e.g. visual impairment secondary to type 2 diabetes)<br><br>Reducing sedentary time will help to maintain mobility and strength therefore reduce risk of falls.<br><br>Aligned with changes in the built environment which support and promote safer physical activity: e.g. design and maintenance of public paths, crossings and links with public transport. If the built environment is unsafe for older people or poses barriers or risks, then | assessing local falls and fracture prevention systems. Although nine areas stated that there was a documented requirement to deliver strength and balance programmes, none of the areas were able to provide information about numbers of people referred to the programmes or completing the programmes. Therefore we suggest that the recommendation should read “Older people living in the community are at risk of a first fall falls referred for strength and balance training and followed up”.<br><br>A recent unpublished survey of GPs shows that knowledge of CMO guidelines and use of assessment tools is hugely variable.<br><br>For older adults, there is little evidence of targeted physical activity messages<br><br>The built environment and well-designed outdoor spaces can enhance the long-term health and wellbeing of those who use them regularly, reduce the risk of falls, promote physical activity and reduce | http://www.phoutcomes.info/public-health-outcomes-framework#page/0/gid/1000042/pat/6/par/E12000004/ati/102/are/E06000015/iid/90362/age/1/sex/1<br><br>Please see recent Housing Lin/ PHE publications: Active Ageing and the Built Environment (pdf - 961Kb)<br><br>Inclusive Design for Getting Outdoors – www.idgo.ac.uk/pdf/Intro-leaflet-2012-FINAL-MC.pdf |

| ID | Stakeholder | Key area for quality improvement | Why is this important? | Why is this a key area for quality improvement? | Supporting information |
|---|---|---|---|---|---|
| | | | people become inactive and are less likely to achieve the CMO guidelines. | social isolation. | |
| 39 | College of Optometrists | Accessible eye-health information on patients resident in care homes | With the majority of care home residents likely to have a visual impairment of some sort (and in many cases elements of dementia) the risk of falling is high. | Spectacles with personalised initials engraved, colour-coding for noting which glasses should be worn for which scenario (reading etc) could all help to ensure that residents are going about their daily business with their vision at an optimum. | Effectiveness of multifaceted fall-prevention programs for the elderly in residential care M D Cusimano, J Kwok, K Spadafora http://injuryprevention.bmj.com/content/14/2/113.abstract Dyer, CAE et al. Falls prevention in residential care homes: a randomised controlled trial http://ageing.oxfordjournals.org/content/33/6/596.short |
| 90 | Independent Age | Falls prevention; care planning | Many people who have suffered a fall or have a medical condition which puts them at higher risk of a fall will have undergone a care and support assessment. This assessment should lead to a detailed care plan for the person concerned. All care plans should account for preventative measures, including falls prevention, and not just focus on existing acre and support | NICE should consider how its guidance is communicated to organisations who create care plans. It should work to have confidence that care planning – for people moving from an acute care setting back home or into another acre setting – give sufficient regard to falls prevention.<br><br>We know from a recent public survey that many older people and their families are receiving insufficient acre plans or written records following an assessment. | Independent Age – Year one of the Care Act: taking its first steps. |

| ID | Stakeholder | Key area for quality improvement | Why is this important? | Why is this a key area for quality improvement? | Supporting information |
|---|---|---|---|---|---|
| | | | needs. This is also relevant for carers' assessments. | | |
| 40 | Public Health Wales | Internal and external environmental modification / safety | Ensuring that the home and leisure (including pavements) environments are safe, with no / few trip hazards will reduce falls risk and encourage physical activity, which will further reduce falls risk, creating a positive feedback loop | Home modifications are normally only made after falls. Environmental modifications are often seen as costly and unnecessary | |
| 41 | Care and Repair England | Key area for quality improvement 1<br><br>Developing standards for tackling housing disrepair and adaptation as an essential part of preventing a first fall for older people | The homes that people live in significantly impact on their wellbeing. Older people spend more time in their homes than any other age group. Good housing helps older people to stay warm, safe and healthy.<br><br>Most older people live in what is called 'mainstream' or 'general needs' housing (as opposed to specialist housing or residential care), and most own their homes.<br><br>Home adaptations and repairs can improve the quality of life for people as they age, helping them to | *Please note the reports identified here are covered in the right hand column as supporting information*<br><br>Statistics from the Building Research Establishment (BRE), in our report *Off the Radar*, (set out in the first left hand column) identify that there are still many older people living in poor housing and hence at risk of a first fall due to a Cat 1 hazard.<br><br>A recent report from the Local Government Ombudsmen Service, *Making a House a Home,* identified some delays to the Disabled Facilities Grant process by local councils that has meant difficulties for people wanting to adapt their homes. Whilst not widespread these | The cost of poor housing to the NHS,<br>Simon Nicol, Mike Roys, Helen Garrett, BRE, 2015<br><br>Off the Radar: Housing Disrepair and Health impact in later life, Care and Repair England, 2016<br><br>Making a house a home: Local Authorities and disabled adaptations: Focus report: learning lessons from complaints from Local Government Ombudsman (LGO), 2016<br><br>Heywood, FS & Turner, L, Better outcomes, lower costs: |

| ID | Stakeholder | Key area for quality improvement | Why is this important? | Why is this a key area for quality improvement? | Supporting information |
|---|---|---|---|---|---|
| | | | feel more confident and in control of their daily activities, can help to prevent falls, and can prevent or delay a move into residential care.<br><br>The broader impact of poor housing on health is clear.<br><br>The 'one year' cost to the NHS of treating conditions caused by poor housing is estimated at £1.4bn. The cost to the NHS in the first year treatment costs of the poorest housing among older households (55+0 is c. £624 million. (BRE 2015 *The cost of poor housing to the NHS)*<br><br>Our report - *Off the Radar* - from analysis by the Building Research Establishment (BRE) identifies that: -<br><br>* Some 1.2 million (21% or one in five) of households aged 65 years or over lived | delays need to be tackled to ensure work is undertaken as soon as practically possible. There is also good practice in adaptations delivery which we highlight below. It is important to ensure the best options are available for all to prevent falls including adaptations.<br><br>*Off the Radar* also identifies the decline in budgets for private sector housing repair and renewal. It argues that tackling housing disrepair has benefits for health and social care as well as for individuals in areas such as falls prevention and improved quality of life. There is good practice in some localities where financial and practical help is available for repairs work with consequent positive impact on falls prevention.<br><br>Many home improvement agencies and FirstStop housing options advice services offer information and advice and support to enable older people to make the necessary changes to their homes. This support is not universally available and could be encouraged and enhanced by a | implications for health and social care budgets of investment in housing adaptations, improvement and equipment – a review of the evidence, Office for Disability Issues, University of Bristol and Department for Work and Pensions, 2007<br><br>University of Warwick, London School of Hygiene and Tropical Medicine, Office of the Deputy Prime Minister Statistical evidence to support the Housing Health and Safety Rating System volume II – summary of results.<br>Office of the Deputy Prime Minister, London, 2003<br><br>Making the Case First Stop Advice: the evidence for integrated, impartial information and advice about housing and care for older people, Kevin Cooper, Care and Repair England and EAC FirstStop, 2015<br><br>PHE Falls and Fragility |

| ID | Stakeholder | Key area for quality improvement | Why is this important? | Why is this a key area for quality improvement? | Supporting information |
|---|---|---|---|---|---|
| | | | in a home that failed to meet the Decent Homes standard in 2012.<br><br>* The vast majority (79%) of households aged 65 years or over living in a non-decent home were owner occupiers (934,000).<br><br>* The main reason for homes failing the Decent Homes standard is the presence of a Category 1 hazard. The two commonest Category 1 hazards are falls risk and excess cold.<br><br>* 731,000 households aged 65 years or over lived in a home with a Category 1 hazard, 85% (619,000) in owner occupied homes.<br><br>* The majority (78%) of older people with long term illness or disability living in a non-decent home are owner occupiers. | Quality Standard that identifies help with repairs and adaptations and housing information and advice as an essential ingredient in first falls prevention.<br><br>FirstStop housing options services have been evaluated, demonstrating the impact on older people's quality of life including reduced risk of falls as well as savings to health and social care by dealing with the consequences of poor and inappropriate housing.<br><br>For information on Home Improvement Agencies' work on adaptations and linked repairs see https://homeadaptationsconsortium.wordpress.com/good-practice/<br><br>For general information on home improvement agencies see http://www.foundations.uk.com/<br><br>For information on First Stop advice services see http://www.firststopcareadvice.org.uk/projects/ | Population Health Care Programme http://www.healthcarepublichealth.net/falls-and-fragility-fractures.php<br><br>NICE Quality Standards on Preventing Excess Winter Deaths and Illness Associated with Cold Homes, March 2016<br><br>NICE Quality Standards on Falls in Older People, March 2015 |

| ID | Stakeholder | Key area for quality improvement | Why is this important? | Why is this a key area for quality improvement? | Supporting information |
|---|---|---|---|---|---|
| | | | There is a well evidenced link between housing conditions and falling (Heywood et al) and also analysis of how poor or unsuitable housing conditions increases the risk of falls.(University of Warwick)<br><br>* The total number of Cat1 hazards associated with falls risk for households of 55yrs and over is 794,689<br><br>* The most common Cat1 hazards for those aged 65yrs and over were those associated with the risk of falls (368,000). Risk of falls on stairs were the most common (230,000) followed by falls on level, falls between levels, then falls associated with bathing.<br><br>Whilst incidences (and seriousness of health/ care consequences) of falls increase with age, in terms of the prevention agenda | | |

| ID | Stakeholder | Key area for quality improvement | Why is this important? | Why is this a key area for quality improvement? | Supporting information |
|---|---|---|---|---|---|
| | | | and ‘upstream interventions’ removal of Cat1 falls hazards for all ‘younger old’ age groups would be beneficial.<br><br>This is highlighted in the Quality Standard topic overview and would certainly be beneficial for those people identified as high risk in the 50 – 64 age group as suggested.<br><br>The NICE Quality Standard on *Preventing Excess Winter Deaths and Illness Associated with Cold Homes* identifes the link betweeen cold homes and falls.<br><br>To quote the Standard ‘Cold homes and poor housing conditions have been linked with a range of health problems in children and young people, including respiratory health, growth and long-term health. In older | | |

| ID | Stakeholder | Key area for quality improvement | Why is this important? | Why is this a key area for quality improvement? | Supporting information |
|---|---|---|---|---|---|
| | | | people, cold temperatures increase the risk of heart attack, stroke and circulatory problems, respiratory disease, flu and hospital admission. They also lower strength and dexterity, leading to an increase in the likelihood of falls and accidental injuries.'<br><br>The NICE Quality Standard on *Falls in Older People* also sets a Quality Standard (6) on home hazard assessment and intervention recognising the link between home circumstances and falls risk.<br><br>This Standard states that 'adapting or modifying the home environment is an effective way of reducing the risk of falls for older people living in the community.' Whilst this standard (which expects a home hazard assessment) applies following a hospital | | |

| ID | Stakeholder | Key area for quality improvement | Why is this important? | Why is this a key area for quality improvement? | Supporting information |
|---|---|---|---|---|---|
| | | | admission we would propose that this undertaken to prevent a first fall so that modifications and repairs are undertaken.<br><br>A first fall can be prevented by including a focus in this Quality Standard on fixing/ modifying the home environment /dealing with home hazards for older people. It is important because a poor home environment contributes to falls risks and affects many older households.<br><br>The right home environment needs to be free from hazards, safe from harm and promote a sense of security. Items such as poor lighting, rugs, stairs, floors, cold rooms and steps can all increase the risk of a first fall. | | |
| 42 | Public Health England | KA 4 for quality improvement | There is good evidence that timely appropriate and effective advice, by | | |

| ID | Stakeholder | Key area for quality improvement | Why is this important? | Why is this a key area for quality improvement? | Supporting information |
|---|---|---|---|---|---|
| | | Pharmacists should give advice about preventing falls when medicines that have a potential to increase the incidence of falls and review Older people who are prescribed more than 3 medications. Pharmacist's should also signpost to relevant evidence based physical activity interventions. | pharmacist's can drive significant improvements in the incidence of falls. NICE -CG 161, | | |
| 43 | SCM 2 | KA 4 for quality improvement<br><br>Pharmacists should give advice about preventing falls when medicines that have a potential to increase the incidence of falls and review Older people who are prescribed more than 3 medications. Pharmacists should | There is good evidence that timely appropriate and effective advice, by pharmacist's can drive significant improvements in the incidence of falls. NICE -CG 161, | | |

| ID | Stakeholder | Key area for quality improvement | Why is this important? | Why is this a key area for quality improvement? | Supporting information |
|---|---|---|---|---|---|
| | | also signpost to relevant evidence based physical activity interventions. | | | |
| 44 | Royal College of Emergency Medicine | Review of polypharmacy in the elderly with better guidelines for management. | | | RCEM would like to highlight the potential benefits of use of the STOPPSTART Tool in the elderly when reviewing medication |
| 45 | SCM 4 | Key area for quality improvement 1<br><br>Addressing polypharmacy in older people to reduce the risk of falls | There is strong evidence that polypharmacy increases the risk of falls (NICE 2013 guidelines) | Polypharmacy is commonplace in older people. this standard would therefore impact a significant proportion of those at risk of falls – small intervention for large benefit | |
| 46 | Royal College of Nursing | Early recognition of those people on medication that would exacerbate the risk of fall | Many medications can cause fluctuations in blood pressure which can cause a fall. | Nurses often see patients being prescribed multiple medications by different healthcare professionals and the consequence of this is that falls assessment may not be recognised as being required. | Falls in older people: assessing risk and prevention https://www.nice.org.uk/guidance/cg161 |
| 47 | Public Health Wales | Medicines management | We know that medications can increase the risk of falling. The implications for any new medications in terms of falls risk need to be | Once prescribed, medicines are rarely withdrawn even though there is a known falls risk. There are tools that are available to guide use of medicines and how this will affect | |

| ID | Stakeholder | Key area for quality improvement | Why is this important? | Why is this a key area for quality improvement? | Supporting information |
|---|---|---|---|---|---|
| | | | considered before prescribing. | falls risk. Some of these tools are better regarded than others, e.g., NO TEARS and STOPP/START v BEERS | |
| 48 | Parkinson's UK | Providing multifactorial interventions for all people with Parkinson's | Many people with Parkinson's can be supported to reduce their risk of falls by making simple changes to their lifestyle. If they were given this information early on, it could prevent them falling and injuring themselves. | Not everyone is always offered multifactorial interventions.<br><br>Parkinson's UK believe everyone with Parkinson's, regardless of age, who is at risk of falling should be offered a multifactorial intervention. | From the '*Falls and Parkinson's*' information sheet developed by Parkinson's UK, the following areas are mentioned:<br>• Clearing away as much clutter as possible, and arranging furniture so that moving around it is as easy as possible.<br>• Installing hand or grab rails in tight spaces, such as toilets, bathrooms and by the stairs. Non-slip mats in the bathroom will also help.<br>• Making sure homes are well lit.<br>• Applying strips of coloured tape to the edge of steps to reduce slipping and to make them more visible.<br>• Consider a community alarm system<br>*<br>http://www.parkinsons.org.uk/content/falls-and-parkinsons-information-sheet |

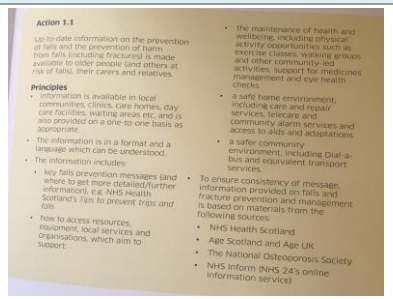
| ID | Stakeholder | Key area for quality improvement | Why is this important? | Why is this a key area for quality improvement? | Supporting information |
|---|---|---|---|---|---|
| | | | | | Much of the research into the intervention of falls in Parkinson's has centered around exercise. Whilst the benefits of exercise in Parkinson's are generally accepted, it is often reported that insufficient evidence is available to support the value of exercise in reducing falls or depression (Goodwin, Victoria A., et al. "The effectiveness of exercise interventions for people with Parkinson's disease: A systematic review and meta-analysis." Movement disorders 23.5 (2008): 631-640). Whilst most publications suggest the presence of perceived benefits, the effect of exercise based therapies on falls often fails to reach statistical significance. However publications from last year; a meta-analysis of exercise therapy and randomized control trial of physical therapy, suggest benefits exist. |

| ID | Stakeholder | Key area for quality improvement | Why is this important? | Why is this a key area for quality improvement? | Supporting information |
|---|---|---|---|---|---|
| | | | | | The Cochrane Library published an intent to do a systematic review of all fall interventions in Parkinson's in 2015. The results are not yet published but will likely form the most significant evidence for this topic when finished (Canning, Colleen G., et al. "Interventions for preventing falls in Parkinson's disease." *The Cochrane Library* (2015).) Also of interest is PDSAFE – an ongoing randomized control trial in this area; protocol published as Goodwin, Victoria A., et al. "A multi-centre, randomised controlled trial of the effectiveness of PDSAFE to prevent falls among people with Parkinson's: study protocol." *BMC neurology* 15.1 (2015): 81. |
| 49 | AGILE | Patient management plans | For patients at risk of falling attention should be given to ensuring they have a clearly agreed management plan addressing all their identified risk factors and | Without a clear management plan, overseen by a named accountable professional, falls risk factors may not be modified resulting in the individual remaining at risk. | |

| ID | Stakeholder | Key area for quality improvement | Why is this important? | Why is this a key area for quality improvement? | Supporting information |
|---|---|---|---|---|---|
| | | | that this is not duplicated between organisations. | Organisations should aim to share this information rather than duplicate it and to communicate it at key transition points in a patients journey (e.g admission to and discharge from hospital). | |
| 50 | Amaven | Physical activity should be an essential part of any older person's medical plan | Through extensive research there is evidence that physical activity and regular exercise have many benefits for our health, including better balance, stability and stronger core, which impact our risk of falls. | Guidelines published by the four UK Chief Medical Officers (CMOs) in a joint CMO report Start Active, Stay Active covering information about physical activity in the early years, children and young people, adults and older adults.<br><br>The report highlights the benefits of regular exercise for our health and, has highlighted it as a major factor in preventing falls. | Please see the report Start Active, Stay Active. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216370/dh_128210.pdf |
| 51 | Amaven | All those who are at risk of a fall to have easy access to appropriate and enjoyable physical activity/exercise as per their needs and ability | There are many factors preventing older people from being active, these can include confidence, lack of knowledge of the benefits, inappropriate local activity choice. People need to also have access to activities that they enjoy, as an individual and in a social environment as they would be more likely to continue to | The British Heart Foundation: Interpreting the physical activity guidelines for active older adults document highlights the barriers to older adults being active. This document is based on findings from the Start Active, Stay Active document and provides guidelines for those who work with older adults.<br><br>The document highlights the UK culture of growing sedentary | Please see the document Interpreting the physical activity guidelines for active older adults. http://www.bhfactive.org.uk/resources-and-publications-item/39/428/index.html |

| ID | Stakeholder | Key area for quality improvement | Why is this important? | Why is this a key area for quality improvement? | Supporting information |
|---|---|---|---|---|---|
| | | | be active. | behaviour as we get older and factors that can encourage people to continue a level of activity as we get older. | |
| 52 | The Princess Alexandra Hospital | Embedding of physical activity as part of daily routine for older inpatients | Older patients remain sedentary for the majority of their inpatient stay and so become weaker, more dependent and frail. | It is well established in the research and through clinical experience that patients spend between 70 & 90% of their hospital stay sedentary *(D,Skelton et al. Agility, Summer 2014).* It is also well established that sitting for prolonged periods causes severe health issues that contribute to a person's fall's risk such as weakness, low B.P and worsening dependence *(D,Skelton et al. Agility, Winter 2014).* Yet regular activity (as opposed to structured rehab) is not referred to in most falls guidelines. The evidence would suggest minimum activity guidelines for older people need to be set and adhered to in the inpatient setting too. | Supporting information<br><br>Government report into Sedentary behaviour and obesity: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213745/dh_128225.pdf<br><br>Physical activity guidelines for older adults: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213741/dh_128146.pdf |
| 53 | The Royal Society for the Prevention of Accidents | Key area for quality improvement 5 Development of falls prevention services including exercise classes. | Falls prevention clinics and falls prevention exercise has been proven to be extremely effective in reducing falls.<br>It plays an important role in | Falls destroy confidence, increase isolation and reduce independence, with around 1 in 10 older people who fall becoming afraid to leave their homes in case they fall again. | http://www.bhfactive.org.uk/userfiles/Documents/FallsPreventionGuide2013.pdf |

| ID | Stakeholder | Key area for quality improvement | Why is this important? | Why is this a key area for quality improvement? | Supporting information |
|---|---|---|---|---|---|
| | | | the falls care pathway, both in terms of primary and secondary prevention, and can significantly contribute to reducing the financial burden on the NHS and social care by preventing fractures and avoidable hospital admissions. | Tailored exercise programmes can reduce falls by as much as 54 per cent | |
| 54 | College of Occupational Therapists | Key area for quality improvement 1 Living well and keeping active | Fear of Falling can be experienced by 50% of people who have never fallen (Shaffer et al 2008). Falls prevention should focus on living well and keeping active to help build confidence and improve health and wellbeing. | *Occupational Therapy in the prevention and management of falls in adults practice guideline* recommends 7.2. Keeping active: reducing fear of falling.<br>People should be offered the opportunity to be signposted and supported by an occupational therapist to address fear of falling that may be restricting their activity.<br><br>Stage One of *The prevention and management of falls in the community: A framework for action* recommends supporting health improvement and self-management to reduce the risk of falls and fragility fractures.<br>Action 1.1 | http://www.cot.co.uk/sites/default/files/publications/public/Falls-guideline.pdf<br><br>http://www.knowledge.scot.nhs.uk/fallsandbonehealth/the-national-falls-programme.aspx<br><br>http://www.scotland.gov.uk/Publications/2014/10/9431<br><br>http://www.clch.nhs.uk/media/123164/fear_of_falling_and_anxiety.pdf<br><br>http://www.nhsinform.co.uk/falls/<br><br>https://fallsassistant.org.uk/help<br><br>https://flourish.livingitup.org.uk/ |

| ID | Stakeholder | Key area for quality improvement | Why is this important? | Why is this a key area for quality improvement? | Supporting information |
|---|---|---|---|---|---|
| | | | |  <br>Action 1.1<br>Up-to-date information on the prevention of falls and the prevention of harm from falls (including fractures) is made available to older people (and others at risk of falls), their carers and relatives.<br>Principles<br>• Information is available in local communities, clinics, care homes, day care facilities, waiting areas etc, and is also provided on a one-to-one basis as appropriate.<br>• The information is in a format and a language which can be understood.<br>• The information includes:<br>• key falls prevention messages (and where to get more detailed/further information), e.g. NHS Health Scotland's *Tips to prevent trips and falls*<br>• how to access resources, equipment, local services and organisations, which aim to support:<br>• the maintenance of health and wellbeing, including physical activity opportunities such as exercise classes, walking groups and other community-led activities, support for medicines management and eye health checks<br>• a safe home environment, including care and repair services, telecare and community alarm services and access to aids and adaptations<br>• a safer community environment, including Dial-a-bus and equivalent transport services.<br>• To ensure consistency of message, information provided on falls and fracture prevention and management is based on materials from the following sources:<br>• NHS Health Scotland<br>• Age Scotland and Age UK<br>• The National Osteoporosis Society<br>• NHS Inform (NHS 24's online information service)<br><br>There is variation in consistency of message, information provided on falls and fracture prevention.<br><br>• Consideration should be given to the role of the wider community services on a prevention pathway such as the voluntary sector who can support people to live well and keep active.<br>• Education on living well and keeping active should be available in a variety of formats and should be included in programmes such as leisure strength and balance classes.<br>• Self-management information should be readily available e.g. NHS inform and sel- referral to services to enable individuals to take control of their own health timeously. | content/falls<br><br>https://www.nice.org.uk/guidance/cg161/chapter/1-recommendations |

| ID | Stakeholder | Key area for quality improvement | Why is this important? | Why is this a key area for quality improvement? | Supporting information |
|---|---|---|---|---|---|
| | | | | • Individuals should be offered opportunities to increase their physical activity and include strength and balance. (NICE 1.1.4)<br>• *Occupational Therapy in the prevention and management of falls in adults practice guideline* 15. recommends:<br>Activities to improve strength and balance should be incorporated into daily activities and occupations that are meaningful to the individual to improve and encourage longer term participation in falls prevention programmes. | |
| 55 | Royal College of Physicians (RCP) | Key area for quality improvement 1: Intervention | Our patient representatives stress that first falls are devastating in their impact on confidence leading to reduced independence and increasing isolation, which in turn exacerbates the lack of mobility and balance. Once a fall has happened, speedy access to occupational therapists is required to help identify any aids that may be needed, and physiotherapists to correct any gait problems | | |

| ID | Stakeholder | Key area for quality improvement | Why is this important? | Why is this a key area for quality improvement? | Supporting information |
|---|---|---|---|---|---|
| | | | and restore confidence. The more time passes before such interventions the more confidence is lost and the harder it is to recover.<br><br>Our patient representatives note that care and nursing homes may at times exacerbate issues eg if a resident is slow at walking, it may be easier for staff to advise patients to get into a wheelchair than wait for them to slowly make their own way. | | |
| **Education and information** | | | | | |
| 56 | Independent Age | Falls prevention; information and advice | As our society ages falls prevention needs to be a public health priority.<br><br>We know that older people frequently fall in their own home. This can be due to loose carpeting and rugs, other obstacles around the home and the absence of grab rails/secondary banisters etc. | NICE's own guidance -Falls in older people: assessing risk and prevention – recommends<br><br>'Individuals at risk of falling, and their carers, should be offered information orally and in writing about:<br><br>'what measures they can take to prevent further falls<br>where they can seek further advice and assistance' | Independent Age – Information and advice since the Care Act – how are councils performing? (Link unavailable at date of submission due to website being down 13.4.2016)<br><br>British Red Cross – Prevention in action |

| ID | Stakeholder | Key area for quality improvement | Why is this important? | Why is this a key area for quality improvement? | Supporting information |
|---|---|---|---|---|---|
| | | | Information and advice about falls prevention is essential for individuals, carers and organisations. | Recent research carried out by Qa research, for Independent Age, found that only 70% of local authorities are providing online information and advice across all the areas required of them under the Care Act 2014. This included information and advice on prevention of care and support needs.<br><br>The latter has been supported by a recent report by the British Red Cross into the quality of preventative services – Prevention in action<br><br>It is essential that local authorities and NHS organisations make information and advice available on falls prevention. NICE should take steps, in partnership with other organisations if necessary, to ensure it has confidence in this area. Information and advice on access to the Disability Facilities Grant is of particular relevance in this regard. We know take-up is limited and people should make the most of increased funding for the Fund.<br><br>We are also aware of variability regarding information and advice | |

| ID | Stakeholder | Key area for quality improvement | Why is this important? | Why is this a key area for quality improvement? | Supporting information |
|---|---|---|---|---|---|
| | | | | available for several groups in the health and social care system:<br><br>- visitors in care homes<br>- inpatients in hospital (please see below)<br>- patients being discharged from hospital<br>- visitors in hospital | |
| 57 | Lancashire Care NHS Foundation Trust | Key area for quality improvement 2 Falls education for people who have not had a fall and maybe at risk of falls | It would help people to feel in control, be autonomous in maintaining their independence | Variable education in hospitals and community due to caseload pressures. COT guidelines (2015)recommend that the service user feels in control | COT guidelines (2015 |
| 58 | Wiltshire Council | Increasing awareness of bone health in the younger population (30+ years) and the benefits of certain types of exercise for bone health. | Primary falls prevention tends to focus on the older population. Evidence shows that exercise and diet in the younger age groups is critical to ensuring that bones stay strong and healthy with good muscle mass to limit the effects of ageing. | Primary prevention for falls is focused upon the older age population. If we are to stem the flow of older adults with poor bone health and reduced muscle mass then prevention messages must start sooner. | |
| 59 | Wiltshire Council | Increased awareness of the importance of diet and nutrition in the younger population | Primary falls prevention tends to focus on the older population. Evidence shows that exercise and diet in the younger age groups is | Primary prevention for falls is focused upon the older age population. If we are to stem the flow of older adults with poor bone health and reduced muscle mass then | |

| ID | Stakeholder | Key area for quality improvement | Why is this important? | Why is this a key area for quality improvement? | Supporting information |
|---|---|---|---|---|---|
| | | (30+ years) for bone health. | critical to ensuring that bones stay strong and healthy with good muscle mass to limit the effects of ageing. | prevention messages must start sooner. | |
| 60 | College of Optometrists | Information on relationship between eye health and falls risk | Besides all the major eye conditions (AMD, Glaucoma, Cataract, and Diabetic Retinopathy), dementia, stroke and diabetes can cause an increase in falls risk due to visual implications. | Information at the point of diagnosis on the crucial link between vision and falls would be beneficial for both health professionals and patients. | References:<br>College of Optometrists and The British Geriatric Society. *The importance of vision in preventing falls, a*vailable from http://tinyurl.com/vision-falls. Accessed 18.7.2014.<br>Abdelhafiz, A.H. and Austin, C.A Visual factors should be assessed in older people presenting with falls or hip fracture *Age and Ageing* 2003 32(1), 26-30<br>Ivers RQ, Cumming RG, Mitchell P et al. Visual impairment and falls in older adults: the Blue Mountains Eye Study. *J. Amer Ger. Soc*. 1998 46(1): 58-64<br>Cummings SR. Treatable and untreatable risk factors for hip fracture. *Bone* 1996 18(3 suppl): 165S-167S<br>Jack DI, Smith T, Neoh C et al. Prevalence of low vision in elderly patients admitted to an |

| ID | Stakeholder | Key area for quality improvement | Why is this important? | Why is this a key area for quality improvement? | Supporting information |
|---|---|---|---|---|---|
| | | | | | acute geriatric unit in Liverpool: elderly people who fall are more likely to have low vision *Gerontology* 1995 41(5), 280-5<br>Patino CM, McKean-Cowdin R, Azen SP et al Central and peripheral visual impairment and the risk of falls and falls with injury *Ophthalmology* 2010 117(2) 199-206 |
| 61 | Parkinson's UK | Provide relevant education and information to all who need it. | It is vital that people with Parkinson's who are at risk of falling receive information and support soon after diagnosis and as quickly as possible after a fall.<br><br>In section 1.1.10.2 the guideline suggests types of information that should be given to people who fall and their families. It states pointing to *'where they can seek further advice and assistance'*. It does not specifically state what types of organisation they should recommend. | Parkinson's UK recommends that this guideline should specifically include information signposting people who fall and their families towards patient organisations and charities as a good source of reliable information, as well as often having support groups and activities. | A particular research highlight is the randomized control trial published in 2015 (Morris, Meg E., et al. "A randomized controlled trial to reduce falls in people with Parkinson's disease." *Neurorehabilitation and neural repair* 29.8 (2015): 777-785). The physical therapy described in this paper was delivered with fall prevention education, which may account for a statistically significant result where other exercise based therapies have failed to show this.<br><br>Of interest may be the Emily Stack paper, which addresses the need for better |

| ID | Stakeholder | Key area for quality improvement | Why is this important? | Why is this a key area for quality improvement? | Supporting information |
|---|---|---|---|---|---|
| | | | | | understanding of the causes of falls and discovers a simple education based intervention that may prevent falls. The conclusions of this paper state "Slowing down and concentrating on a single task (without unnecessary distraction) might reduce falls more effectively than waiting for the effects of an exercise programme to afford some protection and/or for pavements to be better maintained: testing this hypothesis warrants further research."<br><br>Relevant references include:<br>• Research article '*Slow Down and Concentrate: Time for a Paradigm Shift in Fall Prevention among People with Parkinson's Disease?*' by Emma L. Stack and Helen C. Roberts, Academic Geriatric Medicine, Faculty of Medicine, University of Southampton, Mailpoint 807, University Hospital |

| ID | Stakeholder | Key area for quality improvement | Why is this important? | Why is this a key area for quality improvement? | Supporting information |
|---|---|---|---|---|---|
| | | | | | Southampton, Tremona Road, Southampton SO16 6YD, UK.<br>• Clinical research article '*A Randomized Controlled Trial to Reduce Falls in People With Parkinson's Disease*' by Meg E. Morris, PhD, Hylton B. Menz, PhD, Jennifer L. McGinley PhD, Jennifer J. Watts, MComm (Ec), Frances E. Huxham PhD, Anna T. Murphy PhD, Mary E. Danoudis MPT, and Robert Iansek, PhD. |
| 62 | Amaven | Robust training and knowledge development for those who work with people at risk of falls to support them to be more active and sustain the healthy lifestyle. | Many older people are cared for by an array of health and non-health professionals. The more knowledge these professionals have about older people's capabilities, the activities available to them and the benefits, the more likely they will encourage and support the older adults to be more active. Something is better than nothing so irrespective of the role of the professional, if they have | The British Heart Foundation: Interpreting the physical activity guidelines for active older adults document highlights the barriers to older adults being active. This document is based on findings from the Start Active, Stay Active document and provides guidelines for those who work with older adults.<br><br>The document provides guidelines for people who work with older adults highlights the need for better knowledge, ideas and support. | Please see the document Interpreting the physical activity guidelines for active older adults. http://www.bhfactive.org.uk/resources-and-publications-item/39/428/index.html |

| ID | Stakeholder | Key area for quality improvement | Why is this important? | Why is this a key area for quality improvement? | Supporting information |
|---|---|---|---|---|---|
| | | | the knowledge and understanding they will be more likely to encourage and motivate those they have contact with.<br><br>NICE called on councils and health and wellbeing boards to provide meaningful, person-centred activities which can reduce the cost of care, help people retain independence and identity and support Councils to meet their duty of care. | | |
| 63 | AGILE | Training and Development | Falls prevention (both case finding and implementing individual action plans) should be everyone's responsibility within health and social care. To achieve this all staff working with those at risk should receive appropriate training according to nationally agreed minimum standards. Training and development should include a strategy to promote awareness amongst the general | Workforce considerations are such that it may not be feasible for all older people at risk to be assessed by a full MDT. Therefore everyone requires training in case finding and local referral pathways. This should be underpinned by clear guidance about what staff might be expected to delivery generically and what requires onward referral to specific disciplines or specialties. | This quality standard should require all organisations to evidence that staff receive appropriate training and development. This will require organisations to collect numerator and denominator data on numbers of staff trained and evidence that the quality of training meets agreed standards.<br>Falls prevention awareness raising within the general population should be a key feature of public health policy |

| ID | Stakeholder | Key area for quality improvement | Why is this important? | Why is this a key area for quality improvement? | Supporting information |
|---|---|---|---|---|---|
| | | | population of identification of their own falls risk | | and strategy at local level and local public health teams should be able to evidence this. |
| 64 | SCM 1 | Giving assistance service areas – primary care, occupational therapists,, organisations such as Care Link | Effective education and training for professional and domestic carers and/or family members. Important to incorporate ppi so that it is patient/carer focussed. Important to encourage patients in secondary care to ask for help especially when getting up | I have raised this as some patients have told me they feel pushed or pulled by the person giving assistance | .<br>NICE guidance 161 (though the focus is on education) Communications with patients in my role as a Patient Safety Champion |
| 65 | The Royal Society for the Prevention of Accidents | Key area for quality improvement 2 Training for Injury Prevention Practitioners | Injury prevention is a key public health issue which can be addressed by a range of practitioners including district nurses, support workers, care assistants, health visitors, fire services, third sector organisations. All those involved in working with older people would benefit from clear and consistent injury prevention training | There is currently no requirement for injury prevention training or a recognised level of training for practitioners who deliver injury prevention as part of their work. A recognised level of training, such as the RoSPA City and Guilds home safety training, would increase the standard and consistency of advice and support given to Older people and their families to help them prevent injuries | |
| **Falls programmes** | | | | | |
| 66 | SCM 3 | Key area for quality improvement 4 | Creating a robust and healthy population will | There is a need for greater community awareness of the | Public Health Outcomes Framework 2013-2016: |

| ID | Stakeholder | Key area for quality improvement | Why is this important? | Why is this a key area for quality improvement? | Supporting information |
|---|---|---|---|---|---|
| | | Increase planning and investment to improve the general population's ability to adopt healthy behaviours. | reduce the risk of falls and ensure people remain independent for as long as possible in life. There is evidence to support that the application of a population approach to falls prevention in the community can promote change on a mass level, creating a culture where falls prevention behaviours are the norm. | importance of physical activity and nutrition in relation to healthy ageing and motivation to adopt these behaviours. These are key factors in reducing falls in older people as well as contributing to overall health and wellbeing.<br>Supporting programmes which improve optimal peak bone mass during early life, and physical activity, healthy eating and maintaining independence during adult life can help reduce the burden of falls and resulting injury on health and social care services. | https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216159/dh_132362.pdf<br><br>DOH Prevention package for older people: http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/en/Publicationsandstatistics/Publications/dh_103146<br><br>WHO Global Report on Falls Prevention in Older Age: http://www.who.int/ageing/publications/Falls_prevention7March.pdf<br><br>The King's Fund – http://www.kingsfund.org.uk/publications/exploring-system-wide-costs-falls-older-people-torbay |
| 67 | SCM 1 | Falls Prevention Programmes service areas – primary and secondary care | In my view these are important from an empowerment perspective – can promote independence and confidence. Information should be in different and | I have highlighted this as I believe such programmes can have long term benefits. I expect monitoring and feedback are crucial. | NICE guidance 161 |

| ID | Stakeholder | Key area for quality improvement | Why is this important? | Why is this a key area for quality improvement? | Supporting information |
|---|---|---|---|---|---|
| | | | appropriate formats. | | |
| 68 | The Royal Society for the Prevention of Accidents | Key area for quality improvement 1 Local areas have an injury prevention co-ordinator and a clear falls prevention strategy focusing on prevention and not just the delivery of falls services | Co-ordination of programmes and strategies to reduce unintentional injury is a key factor in their success | Very few areas have a designated injury prevention co-ordinator and where these are in place they are often under constant threat due to budget constraints. Evidence shows that activity is most successful and consistent where a co-ordinator is in place<br><br>Tackling falls requires a strategic approach and the commitment of a wide range of services; many areas are already developing falls strategies. Often these focus on the response when a person first enters the system after a fall. This maybe too late for at least a third of over 65s, who never fully recover from that first fall. Falls, and fear of falling, have a significant individual human cost. Fewer than half of older people with a hip fracture return home and, for some, it is the event which forces them to move into residential care.<br><br>Greater emphasis on prevention is required. Rather than just joining up services for those who have experienced a fall, we also need to strengthen the ethos of making | Delivering Accident Prevention in the new public health system. http://www.rospa.com/about/currentcampaigns/publichealth/ |

| ID | Stakeholder | Key area for quality improvement | Why is this important? | Why is this a key area for quality improvement? | Supporting information |
|---|---|---|---|---|---|
| | | | | every visit count. The burden on the NHS and society and the social isolation caused by falls and the resulting reduction in mobility can be reduced if we challenge the assumption that they are an inevitable part of ageing. | |
| 69 | Parkinson's UK | Ensuring falls prevention programmes are accessible to those with limited mobility or communication barriers | Anything to help prevent people with Parkinson's from falling should be implemented. | It is important that people with Parkinson's at risk of falls are encouraged to take part in activities that will prevent future falls, regardless of their age.<br><br>The guideline talks about falls prevention programmes in 1.1.9. It is not clear if this involves individual guidance at the person's home, or if the person at risk of falls would have to travel to a group meeting.<br><br>People with Parkinson's who are at risk of falls may struggle to travel to a community group meeting.<br><br>Parkinson's UK recommends that people are given a choice about whether to take part in falls prevention programmes in the community or their own home. | 70% of people with Parkinson's will fall at least once per year, with over a third experiencing falls repeatedly, resulting in fractures, broken bones and hospital admissions http://www.parkinsons.org.uk/news/12-january-2016/common-dementia-drug-could-improve-parkinsons-symptoms#sthash.tz8desDU.dpuf<br><br>"With the degeneration of dopamine producing nerve cells, people with Parkinson's often have issues with unsteadiness when walking. As part of the condition, they also have lower levels of the chemical acetylcholine, which helps us to concentrate. This makes it extremely difficult to balance and walk at the same |

| ID | Stakeholder | Key area for quality improvement | Why is this important? | Why is this a key area for quality improvement? | Supporting information |
|---|---|---|---|---|---|
| | | | | | time." Dr Emily Henderson http://www.parkinsons.org.uk/news/12-january-2016/common-dementia-drug-could-improve-parkinsons-symptoms#sthash.tz8desDU.dpuf<br><br>Relevant sources include:<br>• '*Toward Affordable Falls Prevention in Parkinson's Disease*' by Nienke M. de Vries PhD, Jorik Nonnekes, MD PhD, and Bastiaan R. Bloem, MD PhD<br>• '*Effects of Tai Chi on balance and fall prevention in Parkinson's disease: a randomized controlled trial*' by Qiang Gao, Aaron Leung, Yonghong Yang.<br>• '*Economic Evaluation of a Falls Prevention Exercise Program Among People With Parkinson's Disease*' Inez Farag, PhD, Catherine Sherrington PhD, Alison Hayes PhD, Colleen G. Canning PhD, Stephen R. Lord PhD, Jacqueline C.T. |

| ID | Stakeholder | Key area for quality improvement | Why is this important? | Why is this a key area for quality improvement? | Supporting information |
|---|---|---|---|---|---|
| | | | | | Close MD PhD.<br>• *'Rivastigmine for gait stability in patients with Parkinson's disease (ReSPonD): a randomised, double-blind, placebo-controlled, phase 2 trial*' by Emily J Henderson, Stephen R Lord, Matthew A Brodie, Daisy M Gaunt, Andrew D Lawrence, Jacqueline C T Close, A L Whone, Y Ben-Shlomo |
| **Preventing falls during a hospital stay** | | | | | |
| 70 | AGILE | Environmental modification | Primary prevention of falls in hospital setting should require all providers of inpatient services for >65s to have in place a system of ensuring wards have been reviewed to ensure they are 'falls prevention friendly.' This will prevent falls due to preventable environmental reasons. | National Patient Safety organisation data is clear, amongst other things, on the importance of:-<br>• appropriate signage<br>• access to falls alarms<br>• review of falls incidents leading to understanding where and when falls are most likely to happen underpinned by appropriate action based on that analysis<br>• access to appropriate footwear for those without | The quality standard should require all organisations to have evidence of having conducted estates review of inpatient settings to ensure key environmental issues are addressed. It should give guidance on the key areas those reviews should consider. |
| 71 | Independent Age | Falls prevention in hospital | Falls in hospital accounted for 324,000 (26%) of all patient safety incidents in | A falls risk assessment should be carried out for every patient who requires one and a reassessment for | |

| ID | Stakeholder | Key area for quality improvement | Why is this important? | Why is this a key area for quality improvement? | Supporting information |
|---|---|---|---|---|---|
| | | | hospitals in 2011. We appreciate falls in hospital have been a long term problem for the NHS and that this issue is relatively well researched. Despite this evidence falls prevention in acute settings still requires improvement. | patients who are in hospital for extended periods or whose medication/treatment might affect their mobility when in hospital. The latter should be part of regular activity on geriatric wards or for patients with severe osteoporosis.<br><br>Information and advice for patients in hospital about what would reduce their risk of a fall should be widely available. Advice for patients' friends and families should also be available for how to help patients move around the ward and how patients are helped in and out of bed. | |
| 72 | Guys and St Thomas' NHS Foundation Trust | Key area for quality improvement 4 | Patient adherence to interventions | With a range of interventions available, ensuring patients adhere or continue to adhere to can be challenging | |
| 73 | Guys and St Thomas' NHS Foundation Trust | Key area for quality improvement 2 | Inpatient Lying and Standing Blood Pressure Measurement:<br>There is evidence that hypotension and orthostatic hypotension are an important risk/contributor to falls. | The RCP National Inpatient Falls Audit highlighted lying and standing blood pressure (with actions taken if there is a substantial drop in blood pressure on standing) as another key area for improvement. Within the audit lying and standing blood pressure was highlighted as one of the 7 key indicators identified by the multidisciplinary advisory group on | Please see the Royal College of Physicians National Audit of Inpatient Falls 2015 which highlights falls medication reviews as a quality indicator. http://www.rcplondon.ac.uk |

| ID | Stakeholder | Key area for quality improvement | Why is this important? | Why is this a key area for quality improvement? | Supporting information |
|---|---|---|---|---|---|
| | | | | the basis that they were indicative of good practice and achievable aims for quality improvement. | |
| 74 | Guys and St Thomas' NHS Foundation Trust | Key area for quality improvement 1 | Inpatient Falls Medication Review:<br>There is evidence that medications and particularly Polypharmacy are an important risk/contributor to falls. | The RCP National Inpatient Falls Audit highlighted medication review as one of the key areas for improvement. Within the audit medications was highlighted as one of the 7 key indicators identified by the multidisciplinary advisory group on the basis that they were indicative of good practice and achievable aims for quality improvement. | Please see the Royal College of Physicians National Audit of Inpatient Falls 2015 which highlights falls medication reviews as a quality indicator. http://www.rcplondon.ac.uk |
| 75 | Royal College of Physicians of Edinburgh | Identification and management of inpatient falls risk factors to reduce frequency of inpatient falls | Evidence that multifactorial falls prevention programmes can reduce inpatient falls rates by 18%. | Inpatient falls prevention demonstrated to be poorly implemented nationally through RCPL audits. | National Audit of Inpatient Falls. RCPL. http://bit.ly/1MhH47I. |
| 76 | Guys and St Thomas' NHS Foundation Trust | Key area for quality improvement 3 | Inpatients Falls Assessment | The risk factor targeting recommended by NICE could be over inclusive and can result in large numbers of patients identified with risk factors – is it possible to segment to levels of risk | |
| 77 | College of Optometrists | In-patient bedside assessments to include adequate vision check | In-patient falls are costly, both in financial terms and for the patient. Visual testing should be a core part of every bedside- | The Royal College of Physicians published the first national inpatient falls audit in October 2015. The audit was created to measure against the National Institute for Health and | More data can be found here: www.rcplondon.ac.uk/fffap |

| ID | Stakeholder | Key area for quality improvement | Why is this important? | Why is this a key area for quality improvement? | Supporting information |
|---|---|---|---|---|---|
| | | | assessment. | Care Excellence (NICE) guidance on falls assessment and prevention https://www.nice.org.uk/Guidance/CG161 and other patient safety guidance on preventing falls in hospital 1-6.<br>The audit was open to all acute hospitals in England and Wales and sought to understand how trusts and hospitals organised themselves in terms of strategic falls prevention work as well as an assessment of how this translated to ward-based care. The audit highlighted that less than half of assessements included an adequate vision check. | |
| **Developmental areas and areas of emergent practice** | | | | | |
| 78 | Optasia Medical | Additional developmental areas of emergent practice | There is growing evidence that large numbers of older people have undiagnosed vertebral fractures indicating poor bone health. Many of these are, therefore, at greater risk of fracture following a fall. We suggest these older people are targeted in the guidance through recommending opportunistic detection of vertebral fractures in images acquired for | It is well established that vertebral fractures are significantly undiagnosed by radiologists e.g. T. Bartalena et al. 'Incidental vertebral compression fractures in imaging studies: Lessons not learned by radiologists', World Journal of Radiology, vol. 2, no. 10, p. 399, 2010.<br><br>Furthermore, large numbers of vertebral fractures are visible in opportunistic imaging e.g. J. E. Adams, 'Opportunistic Identification | The National Osteoporosis Society have recently published Clinical Guidelines that recognise the challenges of identifying vertebral fracture and recommend opportunistic identification of them. |

| ID | Stakeholder | Key area for quality improvement | Why is this important? | Why is this a key area for quality improvement? | Supporting information |
|---|---|---|---|---|---|
| | | | investigation of other conditions. | of Vertebral Fractures', Journal of Clinical Densitometry, Sep. 2015. | |
| 79 | Public Health England | Additional developmental areas of emergent practice | Fire and rescue service interventions to prevent falls as part of safe and well visits. | Fire and rescue services have the potential to impact at scale if falls prevention is built into safe and well visits.<br><br>Integrated pathways to facilitate referrals from Fire and rescue services into falls prevention services will optimise fire and rescue services assessment and first line intervention. | Fire and rescue services conduct over 670,000 safe and well visits per annum. Significant numbers of these visit's include falls prevention advice.<br>PHE is due to publish an evaluation of the impact of fire and rescue service interventions (including falls prevention) on winter related illnesses later in 2016. Which it is anticipated will support this area of emerging practice. |
| 80 | SCM 2 | Additional developmental areas of emergent practice | Fire and rescue service interventions to prevent falls as part of safe and well visits. | Fire and rescue services have the potential to impact at scale if falls prevention is built into safe and well visits.<br><br>Integrated pathways to facilitate referrals from Fire and rescue services into falls prevention services will optimise fire and rescue services assessment and first line intervention. | Fire and rescue services conduct over 670,000 safe and well visits per annum. Significant numbers of these visits include falls prevention advice.<br>PHE is due to publish an evaluation of the impact of fire and rescue service interventions (including falls prevention) on winter related illnesses later in 2016. Which it is anticipated will support this area of emerging practice. |

| ID | Stakeholder | Key area for quality improvement | Why is this important? | Why is this a key area for quality improvement? | Supporting information |
|---|---|---|---|---|---|
| 81 | Amaven | Additional developmental areas of emergent practice | MoVE<br><br>This programme addresses the individual need in all types of settings as it provides knowledge and tools for professionals and carers of older people enabling them to develop their own person-centred plan. | MoVE is a programme that supports those who work with older people to develop a person-centred series of activities for individuals that can be done regularly on a one-to-one basis or in a group setting, in care facilities or in the community.<br><br>The programme is suitable for both frail and mobile older people and aims to positively impact older people's health, independence, brain function, mental wellbeing and confidence.<br><br>The programme is currently in the final stages of a pilot stage and an online portal will be made available in May. Part of the pilot is looking at the impact of physical activity on prevention of falls for people with Dementia and Alzheimer's. | |
| 82 | Care and Repair England | Additional developmental areas of emergent practice | Care and Repair England has been looking at how to stimulate fresh research on the impact of housing interventions in health and care, including falls prevention, bringing together researchers and key stakeholders to work on projects that have practical application. The project is called Catch 22. See http://careandrepair-england.org.uk/?page_id=205<br><br>Work already developing in this field includes the cost/ benefits of adaptations, use of RCT (random controlled trials) in relation to adaptations services, the impact of falls prevention and housing decision making. | | |

| ID | Stakeholder | Key area for quality improvement | Why is this important? | Why is this a key area for quality improvement? | Supporting information |
|---|---|---|---|---|---|
| | | | We would be happy to share and discuss this work with NICE if that would be helpful in developing this Quality Standard.<br><br>We would also draw attention to the planned programme of the Centre for Ageing Better which aims to share and apply evidence to help people age better http://www.ageing-better.org.uk/our-work/topics/<br><br>In its own topic list it has identified homes and neighbourhoods as being critical to enabling people to remain independent and has set an agenda in this area – http://www.ageing-better.org.uk/our-work/topics/feel-in-control/#neighbourhood<br><br>One action being undertaken is an evidence review on the role of home adaptations in improving later life. This work is in development and we have been involved in producing the brief for the review scope. This will be helpful to NICE in gathering more robust evidence on housing interventions on the impact of adaptations on falls prevention (Note the evidence review scope is due for publication on Thursday 14 April 2016) | | |
| 83 | SCM 1 | Additional developmental areas of emergent practice | I understand that this piece of work is on the prevention of primary fall. But I wish to make the point that although all of the above may be in place, the nature of falls is that they are unexpected. Ensuring that there are follow ups following serious falls may in turn prevent further falls which may potentially be primary falls for other | | |

| ID | Stakeholder | Key area for quality improvement | Why is this important? | Why is this a key area for quality improvement? | Supporting information |
|---|---|---|---|---|---|
| | | | patients, is important. | | |
| 84 | College of Occupational Therapists | Additional developmental areas of emergent practice | Technology to support Falls Prevention such as: Living it Up –Falls Assistant, Making Life Easier, Florence.<br><br>Self Assessment of spread: The prevention and management of falls in the community: A framework for action.<br><br>Lianne McInally COTSSOP Falls Forum lead is working with Scottish Fire and Rescue services to prevent falls for people<br><br>Development of prevention services such as Proactive Care teams – identify people at risk of a hospital admission in next 12 months through GP records. MDT assessments and education and support put into address needs- e.g Sussex. | | http://www.knowledge.scot.nhs.uk/media/CLT/ResourceUploads/4061390/Assessment%20Tool%20-%20Teams.xlsx<br>https://www.getflorence.co.uk/<br><br>http://www.knowledge.scot.nhs.uk/media/CLT/ResourceUploads/4061390/Assessment%20Tool%20-%20Teams.xlsx<br><br>lianne.mcinally@yahoo.com<br><br>https://www.england.nhs.uk/wp-content/uploads/2014/06/avoid-unpln-admss-ccg-guid.pdf<br><br>http://www.sussexcommunity.nhs.uk/services/servicedetails.htm?directoryID=22417 |

| ID | Stakeholder | Key area for quality improvement | Why is this important? | Why is this a key area for quality improvement? | Supporting information |
|---|---|---|---|---|---|
| 85 | Public Health England | Development areas | 2. Development areas of emergent practice.<br>Wider professional engagement of identification of older people at risk of a first fall. Professional groups who come into contact with older people at risk of a fall should be trained to provide appropriate primary prevention messages; Making Every Contact Count. | | |
| 86 | SCM 3 | Additional developmental areas of emergent practice | During the development of these quality standards acknowledgement should be given to a variety of quality standards outstanding for publication that have direct links to risk factors related to falls, including: | • Medicines management: managing the use of medicines in community settings for people receiving social care<br>• Community pharmacy: promoting health and well-being<br>• Preventing sight loss<br>• Older people: promoting mental wellbeing and independence through primary, secondary and tertiary prevention<br>• Physical activity: encouraging activity within the general population<br>• Osteoporosis<br>• Prevention of dementia<br>• Programme management: effective ways to run public health programmes to generate a change in behaviour | |
| **Other** | | | | | |
| 87 | SCM 2 | General comments | As a national expert on falls prevention I support a system wide approach to falls prevention which is often referred to as the “DH triangle”.<br><br>This has four components of: | | |

| ID | Stakeholder | Key area for quality improvement | Why is this important? | Why is this a key area for quality improvement? | Supporting information |
|---|---|---|---|---|---|
| | | | • Promoting best practices for hip fractures<br>• Establishing Fracture liaison services to prevent subsequent fractures<br>• Secondary prevention of falls in older people<br>• Primary prevention of falls in older people.<br><br>I believe this integrated system approach which involves collaboration of many key players including NHS, Local authorities, voluntary sector, older people and their family and carers is the only sustainable way to address the wicked problem of falls in older poeple<br><br>I however will focus on the scope of primary prevention of falls as set out in this consultation.<br><br>i. Case / risk identification and multifactorial risk assessment<br>ii. Promoting strength and balance programmes.<br>iii. Home hazards assessments and safety intervention / modifications.<br>iv. Poly pharmacy reviews by pharmacists and signpost to relevant intervention.<br>Existing medical conditions, such as such as | | |
| 88 | Royal College of Emergency Medicine | Access to OT and physio assessments 7 days a week in the ED/CDU | | | |
| 89 | Royal College of Emergency Medicine | Access to acute elderly care physicians 5 days a week (standard) 7 days (aspirational) | | | |
| 91 | Royal College of Physicians (RCP) | Key area for quality improvement 2: Communication | Patient representatives stress that hospital and community physiotherapy departments need to work more closely together so | | |

| ID | Stakeholder | Key area for quality improvement | Why is this important? | Why is this a key area for quality improvement? | Supporting information |
|---|---|---|---|---|---|
| | | | that the hand-over between the two is seamless and without delay. | | |
| 92 | Royal College of Physicians (RCP) | Key area for quality improvement 5: Facilities | Our patient representatives note that ideally we would have more facilities for our older population in local communities. These could be open to both those who self-refer and doctor referrals. | | |
| 93 | Independent Age | Falls prevention in care homes | Falls at home are a common reason for an older person needing to move into a care home, and once there, they will be at higher risk of falling.<br><br>In many cases, this admission may be directly from hospital, and care homes will need to play a role in helping new arrivals to recover mobility lost while | 60% of people living in nursing homes experience recurrent falls each year, compared to 30% of over 65s living in the community. This is in spite of the fact that care homes are dedicated care environments with staff on hand 24 hours a day. There is clearly more to be done to reduce the risk of falling in a care home.<br><br>However, there is also some concern in the sector that overly risk- | Demos, 2014, *Commission on Residential Care*, http://www.demos.co.uk/files/Demos_CORC_report.pdf?1409673172<br><br>Cryer and Patel, 2001, *Falls, Fragility and Fractures,* http://www.kent.ac.uk/chss/docs/falls_fragility_fractures.pdf<br><br>JRF's *Care Homes: Risk and Relationships* programme |

| ID | Stakeholder | Key area for quality improvement | Why is this important? | Why is this a key area for quality improvement? | Supporting information |
|---|---|---|---|---|---|
| | | | in hospital.<br><br>Research into the choices and preferences of older people (including older care home residents) has repeatedly found that independence is an important attribute of a good later life. It is therefore crucial that falls prevention strategies in care homes do not stifle the independence of residents. | averse strategies to reducing and preventing falls can stifle independence and impact negatively on the quality of care and quality of life of residents.<br><br>Quality standards need to balance safety and falls prevention (such as the standards that already exist within NICE's existing guidance on falls in older people) with sensible risk management and the expectation of an enabling ethos, and this should also be reflected in the CQC inspection regime. | |
| 94 | Royal College of Physicians (RCP) | Key area for quality improvement 4: Prevention | Our experts are concerned about funding of large scale fall prevention exercises as primary prevention, as there is currently not enough for secondary prevention. As mentioned under key area for quality improvement 3, our experts would welcome easily auditable outcomes. Patient representatives stress that if a relative or friend is becoming increasingly frail and perhaps at risk of falling, it | | |

| ID | Stakeholder | Key area for quality improvement | Why is this important? | Why is this a key area for quality improvement? | Supporting information |
|---|---|---|---|---|---|
| | | | seems quite difficult to access any services that will help them before they actually have that first fall and hurt themselves. There is not currently an easy, timely, service available which could be tapped into for advice. | | |
| 95 | Public Health England | General comments | i. Case / risk identification and multifactorial risk assessment. Existing medical conditions, such as such as dementia, arthritis, diabetes, incontinence, stroke, or Parkinson's disease that put patients at higher risk of a primary fall should be risk assessed by clinicians and patients advised on interventions<br>ii. Promoting strength and balance programmes.<br>iii. Home hazards assessments and safety intervention / modifications.<br>iv. Poly pharmacy reviews by pharmacist's and signpost to relevant intervention. | | |
| 96 | College of Occupational Therapists | Key area for quality improvement 5 Analysis and Learning from Falls | Up and About in Care Homes Improvement Project found the key to successful falls prevention is to analyse and learn from falls in extended care settings. | Current practice mainly focuses on the management of a fall and can be reactive. Analysing why falls happen and learning from them has been proven to reduce falls and reduce injuries due to falls in extended care (*Up and About in Care Homes*).<br>Key Steps:<br>• Analysing rates and patterns of falls in the service.<br>• Taking an active approach to delivering care at key times | http://www.knowledge.scot.nhs.uk/fallsandbonehealth/the-national-falls-programme/up-and-about-in-care-homes.aspx<br><br>http://www.sqa.org.uk/sqa/46010.html |

| ID | Stakeholder | Key area for quality improvement | Why is this important? | Why is this a key area for quality improvement? | Supporting information |
|---|---|---|---|---|---|
| | | | | individual to a resident's key interventions. These may include hydration, toileting, pain management, physical activity.<br>• Falls prevention and management training are mandatory for all staff groups with particular focus on analysis and learning from falls. | |
| 97 | Royal College of Physicians (RCP) | Key area for quality improvement 3: Audit | Our experts would urge the QS development group to ensure that the wording of the quality statements is sufficiently precise to allow unequivocal measurement by clinical audit providers.<br><br>If QS are recommended in the primary care setting, our experts question how outcomes will be independently measured given the IG access issues and expense of auditing primary care data. | | |
| 98 | The Royal Society for the | Key area for quality improvement 4 National and local | National and local data are essential to strategic local planning and evaluation of | The current levels of data collection and analysis are not sufficient to be able to accurately measure progress | Injury Profiles http://www.apho.org.uk/injuryprofiles |

| ID | Stakeholder | Key area for quality improvement | Why is this important? | Why is this a key area for quality improvement? | Supporting information |
|---|---|---|---|---|---|
| | Prevention of Accidents | data collection | strategies and programmes | in preventing unintentional injuries. The best source, Injury Profiles, is no longer being updated and PHOF outcomes data do not give sufficient richness of data for effective service planning. Accident and Emergency data, particularly for home injuries is not available apart from a recent pilot led by Oxford hospitals and RoSPA. In the absence of a strong national dataset a quality standard should be developed to encourage the development of improved local injury prevention data (perhaps building on the Oxford approach but with a more robust dataset) which can contribute to local strategic development and evaluation and feed into a more robust national picture. | |
| 99 | Royal College of Emergency Medicine | Acute Frail elderly units alongside CDUs | | | |
| 100 | College of Optometrists | | | | **Further references**<br>Knudtson MD, Klein BE, Klein R Biomarker of aging and falling: the Beaver Dam eye study *Arch Gerontol Geriatr* 2009 49(1) 22-26<br>Kuang TM, Tsai SY, Hsu WM |

| ID | Stakeholder | Key area for quality improvement | Why is this important? | Why is this a key area for quality improvement? | Supporting information |
|---|---|---|---|---|---|
| | | | | | et al Visual impairment and falls in the elderly: the Shihpai Eye Study *J Chin Med Assoc* 2008 71(9) 467-72<br>Kulmala J, Era P, Parssinen O et al Lowered vision as a risk factor for injurious accidents in older people *Aging Clin Exp Res* 2008 20(1) 25-30<br>Lamoureux El, Chong E, Want JJ et al Visual impairment, causes of vision loss, and falls; the Singapore Malay eye study *Invest Ophthalmol Vis Sci* 2008 49(2) 528-33<br>de Boer MR, Pluijm SM, Lips P et al Different aspects of visual impairment as risk factors for falls and fractures in older men and women *J Bone Miner Res* 2004 19(9) 1539-47<br>Coleman AL, Stone K, Ewing SK et al Higher risk of multiple falls among elderly women who lose visual acuity *Ophthalmology* 2004 111(5) 857-62 |
| **Scope** | | | | | |
| 101 | Royal College of Physicians of | Extension of age range for quality improvement | Epidemiology indicates that >35% of people aged over 65 years will fall each year. | Epidemiology of falls in age group 50-64 years is less well understood for community dwelling older people | |

| ID | Stakeholder | Key area for quality improvement | Why is this important? | Why is this a key area for quality improvement? | Supporting information |
|---|---|---|---|---|---|
| | Edinburgh | recommendations | It is suggested that if the scope of the document is about prevention of first fall, that the age range is extended to include patients age 50-64 years at a stage when fall risk factors are developing and could be addressed prior to first fall event. | than for hospital inpatients. Nonetheless, true primary prevention of falls would focus on identifying and remediating fall risk factors before a fall occurs. | |
| 102 | Patient Safety Domain NHS Improvement (previously NHS England) | Title and population<br><br>NICE quality standard: Falls in older people: preventing a first fall overview (March 2016)<br><br>Primary prevention: population and community based primary prevention strategies, including the role of A&E, at different stages of the life course | | | The title and scope could benefit from clarification.<br><br>If the intention is to make recommendations about preventing a first fall then I feel this will be very much purely public health orientated healthy aging, prevention of osteoporosis etc. Case finding would then be multi-professional and tied to other pathways for example, osteoporosis, frailty and or multi-morbidity (NICE guidance coming out this autumn I think).<br><br>If not, the trigger for assessment is that the person is presenting to healthcare |

| ID | Stakeholder | Key area for quality improvement | Why is this important? | Why is this a key area for quality improvement? | Supporting information |
|---|---|---|---|---|---|
| | | | | | after an index fall therefore later in the pathway. Many of the links to other guidance etc although absolutely correct refer to this latter point e.g. in A&E the person would be unlikely to be referred on for a potential risk of falls but may in many cases be referred on if they have already fallen. |
| 103 | Patient Safety Domain NHS Improvement (previously NHS England) | The evidence and timing for proposed QS. | | | The evidence for primary prevention for falls has not been recently systematically revisited The recent CG161 (2016) surveillance exercise only looked at selected studies 2013-2015.<br><br>The 2013 CG 21/161 update made no update of the community section therefore there is a gap in the evidence review of over 10 years.<br><br>I am concerned that whilst the broader aspects of primary intervention are unlikely to have changed I am not clear about the recent evidence for the specifics mentioned in the (2014) NICE clinical |

| ID | Stakeholder | Key area for quality improvement | Why is this important? | Why is this a key area for quality improvement? | Supporting information |
|---|---|---|---|---|---|
| | | | | | knowledge summary such as the Timed Up and Go and 180 degree turn.<br><br>The surveillance decision was to review the evidence fully following Cochrane review 2016/17 therefore the timing of this QS seems a little premature. |
| 104 | Royal College of Nursing | Population and setting to be covered | Please could NICE confirm whether the quality standard applies to people living in residential care? | It is important to specify the settings that the proposed standards will cover to enable effective implementation. | |

Note: The ELCENA JEFFERS FOUNDATION also submitted a comments form, but only did so to express an interest in relation to supporting the quality standard.