

Issue date: November 2004

Quick reference guide

Falls: the assessment and prevention of falls in older people

Key priorities for implementation

Case/risk identification

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

Multifactorial falls risk assessment

- Older people who present for medical attention because of a fall, or report recurrent falls in the past year, or demonstrate abnormalities of gait and/or balance should be offered a multifactorial falls risk assessment. This assessment should be performed by healthcare professionals with appropriate skills and experience, normally in the setting of a specialist falls service. This assessment should be part of an individualised, multifactorial intervention.
- Multifactorial assessment may include the following:
 - identification of falls history
 - assessment of gait, balance and mobility, and muscle weakness
 - assessment of osteoporosis risk
 - assessment of the older person's perceived functional ability and fear relating to falling
 - assessment of visual impairment
 - assessment of cognitive impairment and neurological examination
 - assessment of urinary incontinence
 - assessment of home hazards
 - cardiovascular examination and medication review.

Multifactorial interventions

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

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

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

Professional education

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

Implementation

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

Relevant local clinical guidelines, care pathways and protocols should be reviewed in the light of this guidance and revised accordingly.

Further information

Quick reference guide

This quick reference guide to the Institute's guideline on assessment and prevention of falls contains the key priorities for implementation, summaries of the guidance, and notes on implementation. The distribution list for this quick reference guide is available on the NICE website at www.nice.org.uk/CG021distributionlist

NICE guideline

The NICE guideline, 'Falls: the assessment and prevention of falls in older people', is available from the NICE website (www.nice.org.uk/CG021NICEguideline).

The NICE guideline on assessment and prevention of falls contains the following sections: Key priorities for implementation; 1 Guidance; 2 Notes on the scope of the guidance; 3 Implementation in the NHS; 4 Research recommendations; 5 Full guideline; 6 Related NICE guidance; 7 Review date. The NICE guideline also gives details of the scheme used for grading the recommendations, membership of Guideline Development Group and the Guideline Review Panel, and technical details on criteria for audit.

Full guideline

The full guideline includes the evidence on which the recommendations are based, in addition to the information in the NICE guideline. It is published by the National Collaborating Centre for Nursing and Supportive Care, The Royal College of Nursing Institute. The guideline is available on its website (www.rcn.org.uk), the NICE website (www.nice.org.uk/CG021fullguideline) and on the website of the National Electronic Library for Health (www.nelh.nhs.uk).

Information for the public

NICE has produced information describing this guidance for people at risk of falling, their advocates and carers, and the public. This information is available in English and Welsh from the NICE website (www.nice.org.uk/021publicinfo). Printed versions are also available – see below for ordering information.

Review date

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

This guidance is written in the following context:

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

Ordering information

Copies of this quick reference guide can be obtained from the NICE website at www.nice.org.uk/CG021 or from the NHS Response Line by telephoning 0870 1555 455 and quoting reference number N0760. Information for the Public can be obtained by quoting reference number N0761 for the English version and N0762 for a version in English and Welsh.

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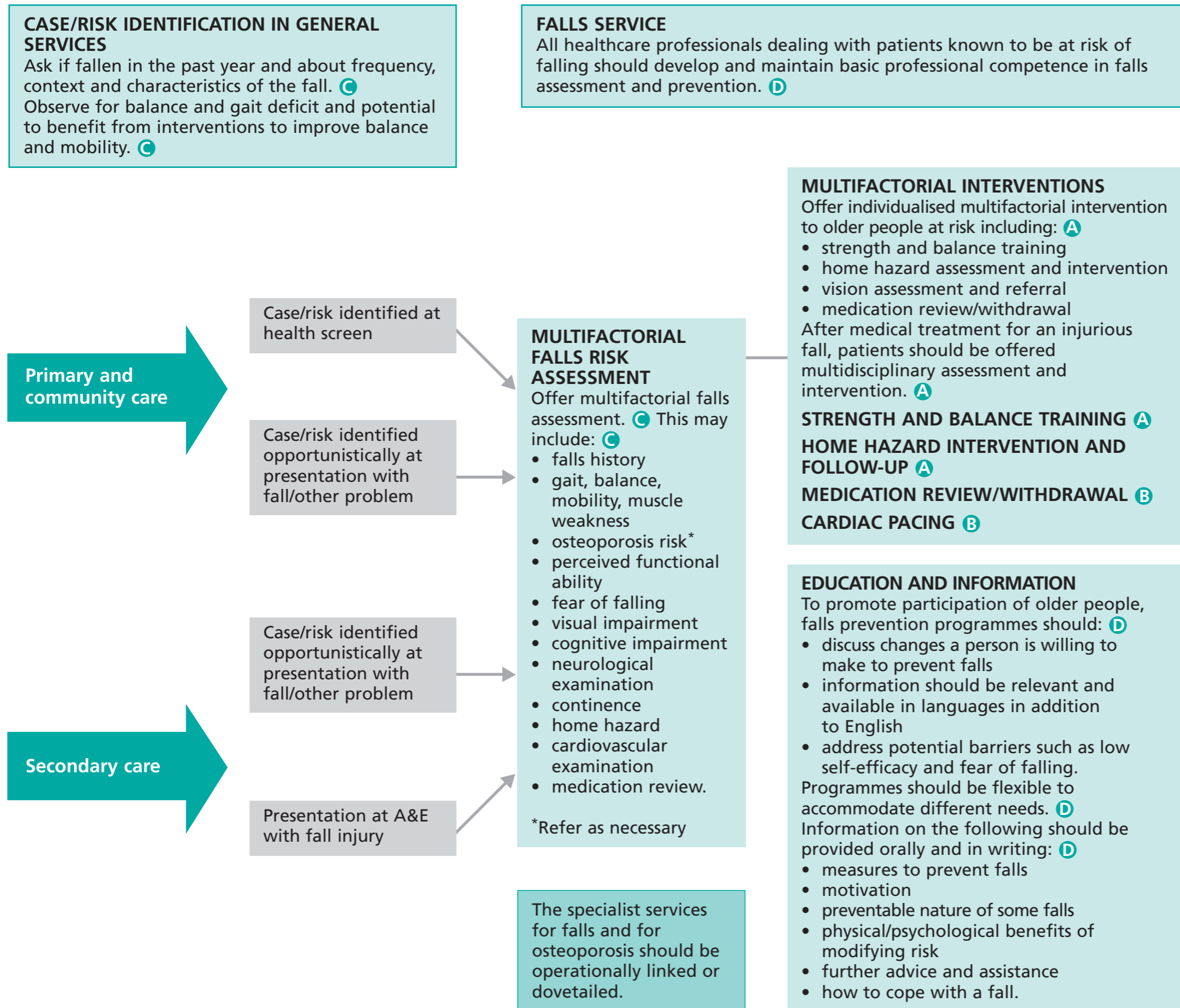
MidCity Place, 71 High Holborn, London WC1V 6NA; website: www.nice.org.uk

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Clinical Guideline 21

Developed by the National Collaborating Centre for Nursing and Supportive Care

Patient referral and care pathway



Interventions that cannot be recommended
Brisk walking. There is no evidence that brisk walking reduces the risk of falling. One trial showed that an unsupervised brisk walking programme increased the risk of falling in postmenopausal women with an upper limb fracture in the previous year. However, there may be other benefits of brisk walking by older people.

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.

- **Low intensity exercise combined with incontinence programmes.** There is no evidence that low intensity exercise interventions combined with continence promotion programmes reduce the incidence of falls in older people in extended care settings.
- **Group exercise (untargeted).** Exercise in groups should not be discouraged as a means of health promotion, but there is little evidence that exercise interventions that were not individually prescribed for community-dwelling older people are effective in falls prevention.
- **Cognitive/behavioural interventions.** There is no evidence that cognitive/behavioural interventions alone reduce the incidence of falls in community-dwelling older people of unknown risk status. Such interventions included risk assessment with feedback and counselling and individual education discussions. There is no evidence that complex interventions in which group activities included education, a behaviour modification programme aimed at modifying risk, advice and exercise interventions are effective in falls prevention with community-dwelling older people.
- **Referral for correction of visual impairment.** There is no evidence that referral for correction of vision as a **single** intervention for community-dwelling older people is effective in reducing the number of people falling. However, vision assessment and referral has been a component of successful **multifactorial** falls prevention programmes.
- **Vitamin D.** There is evidence that vitamin D deficiency and insufficiency are common among older people and that when present they impair muscle strength and possibly neuromuscular function via CNS-mediated pathways. In addition, the use of combined calcium and vitamin D3 supplementation has been found to reduce fracture rates in older people in residential/nursing homes and sheltered accommodation. Although there is emerging evidence that correction of vitamin D deficiency or insufficiency may reduce the propensity for falling, there is uncertainty about the relative contribution to fracture reduction via this mechanism (as opposed to bone mass) and about the dose and route of administration required. No firm recommendation can therefore currently be made on its use for this indication. Guidance on the use of vitamin D for fracture prevention will be contained in the forthcoming NICE clinical practice guideline on osteoporosis, which is currently under development.
- **Hip protectors.** Reported trials that have used individual patient randomisation have provided no evidence for the effectiveness of hip protectors to prevent fractures when offered to older people living in extended care settings or in their own homes. Data from cluster randomised trials provide some evidence that hip protectors are effective in the prevention of hip fractures in older people living in extended care settings who are considered at high risk.