NATIONAL INSTITUTE FOR HEALTH AND CLINICAL EXCELLENCE

Centre for Clinical Practice

SCOPE (Amended January 2013)

Clinical guideline title: Falls: assessment and prevention of falls in older people.

This scope has been amended to reflect that 'Falls' NICE clinical guideline 21 (2004) has been extended to include assessment and prevention of falls in older people in the inpatient setting.

1 Introduction

1.1 Clinical guidelines

Clinical guidelines are recommendations by NICE on the appropriate treatment and care of people with specific diseases and conditions within the NHS. They are based on the best available evidence.

This scope defines what the guideline will (and will not) examine, and what the guideline developers will consider.

This is an extension to 'Falls', NICE clinical guideline 21 (2004). See sections 2.2 and 2.3 for details of which sections will be extended. We will also carry out an editorial review of all new recommendations to ensure that they comply with NICE's duties under equalities legislation.

This extension to NICE clinical guideline 21 is being undertaken as part of the guideline review cycle and because the scope of the original guideline has been extended to cover inpatient settings. Other areas of the guideline will not be updated at this time.

2 Need for guidance

2.1 Epidemiology

a) Falls and fall-related injuries are a common and serious problem for older people (aged 50 and older), especially among those who have underlying pathologies or conditions.

b) People aged 65 and older have the highest risk of falling, with 30% of people older than 65 and 50% of people older than 80 falling at least once per year. This costs the NHS more than £2.3 billion per year.

c) Falls in hospitals are the most common patient safety incidents reported in hospital trusts in England, and treating inpatient falls alone costs the NHS more than £15 million per year.

d) People in hospital have a greater risk of falling than people in the community. This is in part because newly acquired risk factors (such as acute illness, delirium, cardiovascular disease, impaired mobility, medication and syncope) and unfamiliar surroundings can increase the risk of falling.

e) The human cost of falling includes distress, pain, injury, loss of confidence, loss of independence and mortality. Falling also affects relatives and carers. Therefore, falling has an impact on quality of life, health and healthcare costs.

2.2 Current practice

a) NICE clinical guideline 21 'Falls: assessment and prevention of falls in older people' (2004) covers falls prevention in community settings. It recommends that older people (aged 65 and older) who have fallen or who are at risk of falling should be identified, risk assessed, and considered for an individualised multifactorial intervention.

b) NICE clinical guideline 21 also covers people who present at hospital as a result of falling, and makes recommendations on what should happen to prevent falls after they return home. However, the guideline does not make recommendations on preventing falls during a hospital stay.

c) As part of the 3-year review of the guideline, concerns were raised about the appropriateness of the original guideline scope's exclusion of the inpatient setting, because effective interventions in community settings cannot simply be transferred to inpatient settings.

d) Overall, the review concluded that the guideline is up to date and is still consistent with international guidance. But it also concluded that an extension of the guideline to cover inpatient settings, was needed for statutory bodies that are directly or indirectly responsible for providing services for people at risk of falling.

2.3 Relationship with previous guidance

a) The 2011 review of the guideline found no basis for updating the existing guidance or extending it to people younger than 65. Thus, the existing recommendations for preventing falls in the community will remain unchanged.

b) The extension of the scope to include the prevention of falls in inpatient settings will focus on patients aged 65 and older, the same age group as was covered by the original guideline. The epidemiology data presented in section 2.1 suggest that using the age of 65 as a cut off is a proportionate means of directing resources for falls prevention, because this is the group most at risk. The guideline update will also consider people between the ages of 50 and 64 who have been identified as being at higher risk of falling because of underlying pathologies or conditions. This remains consistent with the original remit from the Department of

Health, which was to develop clinical guidelines on 'the assessment and prevention of falls, including recurrent falls in older people'.

2.4 Population

2.4.1 Groups that will be covered

a) All hospital inpatients aged 65 or older.

b) Hospital inpatients aged 50 to 64 who have been identified as being at higher risk of falling (for example, people with a sensory impairment, or people admitted to hospital with a fall, stroke, syncope, delirium or disturbances of gait).

2.4.2 Groups that will not be covered

a) People younger than 65 without underlying conditions or pathologies that increase the risk of falling.

b) People who fall or who are at risk of falling in the community.

2.5 Settings and services

a) All hospital settings, including acute hospitals, community hospitals and mental health trusts.

2.6 Management

2.6.1 Key issues that will be covered

a) Structures and processes to assess modifiable and non-modifiable risk factors for inpatient falls.

b) Interventions to prevent inpatient falls.

c) Education and information about falls prevention for inpatients and carers.

2.6.2 Key issues that will not be covered

a) Methods of identifying inpatients aged 65 and older who are at risk of falling, as all of these patients are considered to be at risk because of their age.

b) Methods of identifying inpatients aged 50 to 64 who are at risk of falling, as these people will be identified by a clinician on an individual basis using their clinical judgement.

c) Service delivery issues relating to preventing falls in community and inpatient settings.

d) Treating and managing acute injuries sustained in a fall.

e) The effectiveness of interventions aimed at preventing, treating and managing health conditions associated with falls, except in the context of interventions to prevent inpatient falls.

f) Managing the consequences of, and rehabilitation after, an inpatient fall, except where this relates to preventing further inpatient falls.

2.7 Main outcomes

a) Rate of falls (and proportion of people who fall).

b) Impact of falls and complications as a consequence of falls.

c) Mortality.

d) Patient satisfaction and experience of falls prevention, interventions and strategies.

e) Quality of life (for example, fear, confidence and functioning).

f) Activities of daily living.

g) Adherence to falls prevention strategies (by patients, healthcare professionals and other staff).

h) Resource use and costs (for example, length of stay).

2.8 Review questions

a) What assessment tools or processes should be used to identify modifiable and non-modifiable risk factors for falling while in hospital? Does the assessment tool or process vary by underlying pathology?

b) What interventions reduce the risk and/or the severity of a fall in hospital, compared with usual care? Which interventions are the most effective? Does the intervention vary by underlying pathology?

c) What are the education and information needs of hospital inpatients and their carers after a hospital-based falls risk factor assessment in hospital?

2.9 Economic aspects

Developers will take into account both clinical and cost effectiveness when making recommendations involving a choice between alternative interventions. A review of the economic evidence will be conducted and analyses will be carried out as appropriate. The preferred unit of effectiveness is the quality-adjusted life year (QALY), and the costs considered will usually be only from an NHS and personal social services (PSS) perspective. Further detail on the methods can be found in 'The guidelines manual' (see section 8).

3 Status

3.1 Scope

This is the final scope.

3.2 Timings

The development of the guideline recommendations and the quality standard will begin in January 2012.

4 Related NICE guidance

4.1 NICE guidance that will be extended by the guidance

This guideline will be an extension to the following NICE guidance:

- Falls. NICE clinical guideline 21 (2004)

4.2 Other related NICE guidance

Published

- Service user experience in adult mental health. NICE clinical guideline 136 (2011)
- Hip fracture. NICE clinical guideline 124 (2011)
- Delirium. NICE clinical guideline 103 (2010)
- Medicines adherence. NICE clinical guideline 76 (2009)
- Mental wellbeing and older people. NICE public health guidance 16 (2008)
- Stroke. NICE clinical guideline 68 (2008)
- Head injury. NICE clinical guideline 56 (2007)
- Dementia. NICE clinical guideline 42 (2006)
- Parkinson's disease. NICE clinical guideline 35 (2006)

In development

NICE is currently developing the following related guidance (details available from the NICE website):

- Osteoporosis. NICE clinical guideline. Publication expected July 2012.
- Patient experience in adult NHS services. NICE clinical guideline. Publication expected 2012.

5 Further information

Information on the guideline development process used for this guideline is provided in the following documents, available from the NICE website:

- 'How NICE clinical guidelines are developed: an overview for stakeholders the public and the NHS'
- 'The guidelines manual' (2009).
- 'Developing NICE quality standards: interim process guide'.

Information on the progress of the guideline and quality standard is also available from the NICE website.