

National Institute for Health and Clinical Excellence

**Falls
Guideline Consultation Comments Table**

Stakeholder	Document	Section	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
Abbott Nutrition	Full	1.1.1.1	11	<p>In terms of patients who are at risk of falls, please consider including patients who are malnourished (under-nourished). Malnutrition may cause reduced muscle strength and fatigue, which in turn may result in falls (MNI, 2012). Harris & Haboubi (2005) and Neyens (2013) also state that malnutrition is a risk factor for falls.</p> <p>Refs: Oral nutritional supplements to tackle malnutrition: a summary for the evidence base, MNI 2012. http://www.medicalnutritionindustry.com/uploads/content/ONS%20dossier%202012/Dossier2012FINAL2012-09-04.pdf</p> <p>Harris D and Haboubi N. Malnutrition screening in the elderly population <i>Journal of the Royal Society of Medicine</i> 2005;98:411-414.</p> <p>Neyens J <i>et al.</i> Malnutrition is associated with an increased risk of falls and impaired activity in elderly patients in Dutch residential long-term care (LTC): A cross-sectional study. <i>Archives of Gerontology and Geriatrics</i> 2013;56:265–269.</p>	<p>Patients who are malnourished are not excluded from the guideline. However, as no specific evidence was identified that met the inclusion criteria; no specific recommendation could be made.</p> <p>Multifactorial falls risk assessments are recommended by this guideline and if malnutrition is identified as a risk factor, nutritional supplements may form part of the multifactorial intervention.</p> <p>The references you have provided do not meet the inclusion criteria for the review questions and so were not considered.</p>
Abbott Nutrition	Full	1.2.2.2	14	<p>We appreciate that comments on this section of the guidance are not being sought at this time However we would like to suggest that when this guideline is updated in the future, consideration is given to the need to identify and treat malnutrition (under-nutrition).</p>	<p>Thank you for your comment. We will pass this information on to the reviews team.</p>
Abbott Nutrition	Full	1.1.2.3	11	<p>If malnutrition is included as a risk factor for falls as suggested above, please consider including nutritional screening (using a validated screening tool such as the 'Malnutrition Universal Screening Tool') to identify individuals with, or at risk of, malnutrition. This screening tool is referenced in NICE CG32.</p>	<p>Malnutrition has not been specifically identified as a risk factor. Therefore the screening tool will not be specifically mentioned.</p>
Abbott Nutrition	Full	1.2.12.5	19	<p>This section states that 'Although there is emerging evidence that correction of vitamin D deficiency or insufficiency may reduce the propensity for falling,</p>	<p>Thank you for your comment. NICE notes your comment.</p>

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				<p>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.'</p> <p>While we appreciate that NICE do not want comments on this section of the guidance at this time, we would like to suggest that in light of more recent clinical data, this section is re-visited when the guideline is next updated. For example, a meta-analysis by Bischoff- Ferrari <i>et al</i>, 2009, concludes that supplemental vitamin D at 700-1000 IU D daily can reduce the incidence of falls among older individuals by 19%.</p> <p>Ref: Bischoff-Ferrari HA <i>et al</i>. <i>BMJ</i> 2009;339:b3692 doi:10.1136/bmj.b3692</p>	
AGILE: Chartered Physiotherapists working with Older People	Full	General	General	The document mentions the use of bed rails in the information and support section. It would be useful to have some guidance on bed rail assessment as this is an acute intervention.	It is beyond the scope of this guideline to provide guidance on bedrail assessment, or assessment of any other intervention that may form part of a multifactorial intervention. It is expected that healthcare professionals will use their clinical judgement and comply with any local policies relating to specific interventions used as part of a multifactorial intervention.
AGILE: Chartered Physiotherapists working with Older People	Full	2	21	Flow-chart. Patients at risk of falls in hospital often have falls risk factors that require further intervention once discharged. We acknowledge that some risk factors will be different in the acute setting but assessments should be shared across the interface. This is not clear in the flow chart.	Thank you for your comment, the algorithm in section 2 of the full guideline has been amended to reflect your comments.
AGILE: Chartered Physiother			76	We support the opportunity for patients to be able to access assessment and provision of walking aids out of hours, following the recommendations in work such as the 'Fallsafe' bundle	Thank you for your comment.

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apists working with Older People					
AGILE: Chartered Physiotherapists working with Older People	Full	General	General	<p>Welcomed the summarised <i>Evidence to recommendation</i> tables as the succinct explanation provides additional clarity to the sections</p> <p>E.g. pg 30, section 3.3.5 and Pg. 74, section 3.4.5</p>	Thank you for your comment.
AGILE: Chartered Physiotherapists working with Older People	Full	1.1.1	11	Using a specific age-band of 50-64 years is not particularly useful. There will be a small but significant number of younger people with gait impairment, stroke, neurological disease admitted to acute care that will be at risk of falls.	We acknowledge that people below the age of 50 are also at risk of falls. However, the remit we received from the Department of Health was to develop a guideline for the assessment and prevention of falls specifically for older people.
AGILE: Chartered Physiotherapists working with Older People	Full	1.1.2.1	11	We also welcome the recommendation that all older people who are admitted to hospital should be considered for an individualised multifactorial risk assessment for their inpatient falls risk	Thank you for your comment.
AGILE: Chartered Physiotherapists working with Older People	Full	1.1.3.1	12	A number of patients will not be able to use call bells- e.g.: dexterity, dementia. Guidance on alternative systems would be useful.	The recommendation does not refer to call bells, but refers to nurse call systems which include traditional call bells as well as alternative systems that are accessible to all.
AGILE: Chartered Physiotherapists working	Full	1.1.3.1	12	Also include, where relevant, onward interventions following discharge from an in-patient setting.	<p>The algorithm in section 2 of the guideline has been amended in line with your suggestion.</p> <p>However changes to the</p>

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with Older People					recommendations will not be made. This is because recommendations covered in section 4 of the guideline (previously section 3) will address the inpatient stay only. Onward interventions following discharge are covered in section 3 (previously section 4) of the guideline and the guideline developer does not have the remit to update these recommendations.
AGILE: Chartered Physiotherapists working with Older People	Full	1.1.1.2	11	Welcome the move away from numerical risk predication tools and emphasis on risk factor assessment.	Thank you for your comment.
AGILE: Chartered Physiotherapists working with Older People	Full	1.1.2.3 and 4	11	Alongside multifactorial assessment and intervention, there needs to be guidance regarding how this information is shared within the team / ward staff, especially key areas such as a person's mobility or transfer capability	A new recommendation has been added to the guideline (recommendation 1.2.3.2) to signpost readers to the Patient experience in adult NHS services guideline (CG138) patient experience guideline (CG138) which covers information sharing.
AGILE: Chartered Physiotherapists working with Older People	Full	1.1.2.4	12	Consider whether interventions for falls can be continued following hospital admission to ensure seamless care with appropriate interventions followed from inpatient settings into community falls prevention interventions.	Whilst it seems intuitive to continue interventions following a hospital admission, the interventions recommended in the inpatient section of this guideline should start and end during the inpatient stay. This is because there are different risks in the inpatient setting to those

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					<p>in the community.</p> <p>Interventions that are more enduring fall into the remit of the community section of this guideline, and there is no remit for the recommendations in this section to be updated.</p>
AGILE: Chartered Physiotherapists working with Older People	Full	3.4.5	76	Although falls prevention guidelines are clear for community settings on discharge from hospital, it would be beneficial to consider the pathway between falls prevention whilst an in-patient and the continuation, when appropriate, of falls prevention interventions in the community.	<p>The GDG agree that the pathway between settings should be a continuation, and the algorithm in section 2 has been amended to reflect this more clearly.</p> <p>The recommendations for the community section and recommendations for the inpatient section were developed separately. This was because of the remit that we were provided with and the sections cannot be 'merged' to better reflect the continuation of the patient pathway. To overcome this, the sections have now been renamed and the terminology used to refer to the sections have also been renamed, the guideline now refers to 'recommendations for all older people' (instead of 'community section'), and 'additional recommendations for older inpatients' ('instead of inpatient section'). We hope that this change in terminology highlights that the</p>

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					recommendations are continuous and the two sections should be considered together.
AGILE: Chartered Physiotherapists working with Older People		3.5.5	84	<p>The statement regarding NHS best practice for patients found on the floor needs clarification. The National Patient Safety Agency report (NPSA/2011/RRR001) state that patients found on the floor should have initial checks and safe retrieval techniques as indicated. The statement on page 84 that patients should be taught how to rise if found on the floor is in conflict with the NPSA report.</p> <p>The draft states that according to current NHS best practice, all patients who are found on the floor should be provided with instructions about how to get up. However, this may have been misinterpreted as CG21 indicates people should be taught strategies how to get up following a further fall and does not relate to what to do when someone is found on the floor.</p> <p>Clarity is therefore required to differentiate between</p> <p>(a) a longer term rehabilitation programme that skills people to get up in case they fall again, and</p> <p>(b) what should happen immediately after someone falls in hospital</p>	Thank you for your comment. The text in the guideline which your comment relates was referring to a study which was removed from the analysis because it taught patients how to get up off the floor once they had returned home. Since this is not an intervention aimed at reducing hospital based falls it is outside the scope of the guideline. The text has now been removed. Because of this, the areas which you have suggested need clarity no longer exist.
AGILE: Chartered Physiotherapists working with Older People	Full	3.6	86	Only one research recommendation for environmental design in inpatient falls is surprising bearing in mind the majority of trials of inpatient falls prevention are low in quality and the results are equivocal.	Another three research recommendations have been added which focus on the prevalence of falls risk factors in older people, causes of unwitnessed falls, and interventions for preventing falls, in addition to the existing research recommendation on environmental adaptations. The GDG felt that research done in these areas would help to improve the evidence base for subsequent updates of this

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Arjohuntleigh	Full	General	General	Change the title of the document to "Falls: assessment and prevention of falls in adult people " (as we see it this cover also people in the middle age), see input on 1.1.1.1.	The title and remit were provided by the Department of Health and are specifically focused on older people. The guideline developer cannot change the remit.
Arjohuntleigh	Full	1.1.1.1	11	Remove the text "aged 50-64 years" – as we see it all adult patients who are identified by a clinician as being at higher risk of falling (for example, patients with a sensory impairment or dementia, and patients admitted to hospital with a fall, stroke, syncope, delirium or gait disturbances) should be covered	We acknowledge that people below the age of 50 are also at risk of falls. However, the remit we received from the Department of Health was to develop a guideline for the assessment and prevention of falls specifically for older people.
Arjohuntleigh	Full	1.1.2.1	11	Ensure that aspects of the inpatient environment that could affect patients' risk of falling (such as flooring, lighting, add bathroom, type of bed and provision of hand holds) are systematically identified and addressed. So we want bathroom and type of bed to be added as inpatient environment to assess.	The GDG have amended this recommendation to reflect your suggestion and have added 'furniture and fittings' to recommendation 1.2.2.1, (previously 1.1.2.1). This is because the GDG felt that 'furniture and fittings' is an inclusive term to refer to bathroom and type of bed as well as any other related items.
Arjohuntleigh	Full	1.1.2.3	12	Ensure that any multifactorial assessment identifies a patient's individual risk factors for falling in hospital that can be treated, improved or managed during their expected stay, including: add " patient transfer method/device used " ref [1]	The GDG felt that patient transfer methods or devices should not be included in this list. This is because the list refers to patient risk factors that should be considered as part of a risk assessment. Transfer methods and devices are interventions that are considered after a risk assessment, and may be included as part of a multifactorial fall prevention

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					intervention.
Arrhythmia Alliance	NICE	General	General	For clinicians we would recommend a two sided summary and a visual care pathway of the guidelines so that clinicians can easily and quickly understand how to apply the guidelines in practice.	A one sided algorithm is contained in the full guideline (see section 2). In addition, this guideline will be supported by an interactive tool (called Pathways) which is available on the NICE website. The Pathways bring together all related NICE guidance in an easy to access format for use by healthcare professionals and members of the public.
Arrhythmia Alliance	Full	General	General	We would recommend including guidelines on how crucial it is that information and results of the multifactorial assessment and any follow up appointments, tests or medications prescribed as a result are shared with the patient's GP.	A new recommendation has been added to the guideline (recommendation 1.2.3.2) to signpost readers to the Patient experience in adult NHS services guideline (CG138) which covers information sharing.
Arrhythmia Alliance	Full	1.1.1.1	9	A-A welcomes the addition of syncope and the benefit of multifactorial assessments. We would recommend that the guidelines specify the healthcare professionals and types of assessments that should be involved in the multifactorial assessments.	Thank you for your comment. As with many clinical guidelines, we have not made recommendations specific to the role of any particular healthcare professional in order to facilitate local implementation.
Arrhythmia Alliance	Full	1.1.1.1	11	Agree with comment that patients with syncope should be considered at high risk of falls in hospital.	Thank you for your comment.
Arrhythmia Alliance	Full	1.1.2.1	11	We support this addition to the guidelines.	Thank you for your comment.
Arrhythmia Alliance	Full	1.1.3.1	13	Point 6 – Agree. We would suggest that hospitals are guided on how to signpost/contact relevant patient organisations for additional support and information that will aid patients.	A version of this guideline called 'Information for the public' is aimed at patients and carers and does provide a list of relevant organisations for

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					support and information.
Arrhythmia Alliance	Full	1.1.2.2	11	Agree.	Thank you for your comment.
Arrhythmia Alliance	Full	1.1.2.3	12	We would recommend adding syncope to the list.	Syncope syndrome has been added to the list.
Arrhythmia Alliance	Full	1.1.2.3	9	Point 26 - We would recommend adding syncope to the list.	Syncope syndrome has been added to the list.
Arrhythmia Alliance	Full	1.2.2.5	12	Agree.	Thank you for your comment.
Association of British Neurologists	Full	General	General	We believe that the falls guideline as it stands misses an opportunity to provide readers with a clinical assessment summary for evaluating the individual who is at risk of falling. As neurologists we all too frequently see patients with falls who may have already been assessed in a falls clinics, without a diagnosis being made. Examples include people with parkinsonian disorders, that maybe amenable to therapy, and others with a modest drop in their postural blood pressure which is wrongly assumed to be the cause of the falls. We believe that clear guidelines may help to prevent such patients slipping through the net. An accurate diagnosis is clearly the most important factor in falls prevention. The ABN would be pleased to help develop such a diagnostic guideline.	Your suggestion to include accurate diagnosis of the underlying condition that may lead to a fall is outside of the scope of this guideline and is unable to be included.
Association of Directors of Adults Social Services(A DASS)	Full	General	General	ADASS supports this guidance, particularly the intention to undertake a home hazard assessment as part of the discharge planning (See below in italics). However, we seek clarity in regards to resourcing this commitment-if it is a council responsibility, and confirmation that if any assessment identifies hazards, what is the potential implication for councils in terms of responsibility to address risks? <i>Home hazard and safety intervention</i> <i>1.2.6.1 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.</i>	Thank you for your comment. The organisations responsible for addressing the risks identified by a home hazard assessment will differ depending on how care is organised locally. Therefore it would be impractical for the guideline to make recommendations in relation to this area.
Association of Directors of Adults	Full	General	General	In regards to the above assessment, Would this also apply to the age group 50-64 alongside those aged 65+?	It is not in the remit for us to update the community section of the guideline that currently only

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Social Services(A DASS)					<p>includes people aged 65 and older.</p> <p>Although the 50 to 64 age group is not specifically covered in this recommendation, it should not preclude this age group from being offered this intervention if practitioners who implement this guideline judge the intervention to be of benefit.</p>
Atrial fibrillation association	NICE	General	General	We would recommend a summary/care pathway of these guidelines for all clinicians so that it was easy to understand how to apply the guidelines into daily practice.	A one sided algorithm is contained in the full guideline (see section 2). In addition, this guideline will be supported by an interactive tool (called Pathways) which is available on the NICE website. The Pathways bring together all related NICE guidance in an easy to access format for use by healthcare professionals and members of the public.
Atrial fibrillation association	Full	General	General	We would recommend including a statement on the importance of results of multifactorial assessments being shared with GPs.	A new recommendation has been added to the guideline (recommendation 1.2.3.2) to signpost readers to the Patient experience in adult NHS services guideline (CG138) which covers information sharing.
Atrial fibrillation association	Full	1.1.1.1	9	AF Association welcomes the inclusion of syncope and need for multifactorial assessments. We would recommend that the list of multifactorial assessments should be included	<p>Thank you for your comment.</p> <p>The guideline does not recommend a 'type' of multifactorial assessment. Instead, routine hospital assessments should be used to</p>

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					identify factors that can be treated managed or improved during the patients expected hospital stay. The list of factors that a routine multifactorial assessment should cover is provided in recommendation 1.2.2.3 (previously recommendation 1.1.2.3)
Atrial fibrillation association	Full	1.1.1.1	11	We agree with comment that patients with syncope should be considered at high risk of falls in hospital.	Thank you for your comment.
Atrial fibrillation association	Full	1.1.2.1	11	We agree with this addition.	Thank you for your comment.
Atrial fibrillation association	Full	1.1.3.1	13	Point 6 – Agree. We would also suggest that it is recommended that hospitals are encouraged to signpost patients to support organisations.	A version of this guideline called 'Information for the public' The NICE version of this guideline which is aimed at patients and carers and does provide a list of relevant organisations for support and information.
Atrial fibrillation association	Full	1.1.2.2	11	Agree.	Thank you for your comment.
Atrial fibrillation association	Full	1.1.2.3	9	Point 26 – We would recommend adding syncope to the list.	Syncope syndrome has been added to the list.
Atrial fibrillation association	Full	1.1.2.3	12	We would recommend adding syncope to the list.	Syncope syndrome has been added to the list.
Atrial fibrillation association	Full	1.2.2.5	12	Agree	Thank you for your comment.
British Geriatric Society - Falls and	NICE	General	General	Agree with the new recommendations and welcome the clarity of target populations that require assessment and treatment	Thank you for your comment.

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Bone Health Section					
British Orthopaedic Association Patient Liaison Group	Full	1.1.1.1	11	As above	Thank you for your comment.
British Orthopaedic Association Patient Liaison Group	Full	1.1.2.3	12	As above – add 'alcohol' at line 10	The GDG have revised the wording for the recommendation that your comment relates to, and have removed the list of example conditions that may increase an older person's risk of falling. This is because the GDG would prefer clinicians to use their judgement, and providing any sort of list may prevent this from happening. Therefore your suggestion has not been included.
British Orthopaedic Association Patient Liaison Group	Full	1.5	4	Add 'alcohol' within bracketed area. – evidence from local acute hospital shows increasing number of older male patients admitted with #NOF following fall – possible cause is chronic alcohol use (business men).	The GDG have revised the wording for the recommendation 1.2.1.2 (previously 1.1.1.1) which your comment relates to and have removed the list of example conditions that may increase an older person's risk of falling. This is because the GDG would prefer clinicians to use their judgement, and providing any sort of list may prevent this from happening. Therefore your suggestion has not been included.

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British Society for Rheumatology	Full	General	General	The British Society for Rheumatology warmly welcomes this guideline which addresses an important area. We fully endorse the comments made by the National Osteoporosis Society.	Thank you for your comments.
Central and North West London NHS Foundation Trust	NICE	General	General	Suggest they have a specific list of medicines that are prone to contributing to falls: Sedating antihistamines, antihypertensives, diuretics secondary to possible dehydration, sedating pain killers, sedating psychotropic, medicines with significant anticholinergic effects e.g. falls secondary to blurred vision as a side effect	It is not possible to provide an exhaustive list of medicines that contribute to falls. It is expected that a healthcare professional with the skills and competencies for undertaking medication reviews will assess an individual's medication risk on a case by case basis using their own judgement as covered in recommendation 1.2.2.3.
Central and North West London NHS Foundation Trust	NICE	1.1.1.1		This should include patients under the age of 50 who have an acute mental illness or relapse of their mental health condition and are on high doses of antipsychotic medication and restless.	Although we acknowledge that people under the age of 50 are also at risk of falls, this guideline is specifically for older people. People under the age of 50 (with or without underlying conditions such as acute mental illness) are outside the scope of this guideline and so your suggestion cannot be included.
Central and North West London NHS Foundation Trust	NICE	1.1.2.1		Agree with this comment. Regular checks of the environment should be carried out so that hazards can be addressed and removed/modified	Thank you for your comment.
Central and North West London NHS	NICE	1.2.3.1		Medicines withdrawal; may wish to add some details on how some medicines need to be withdrawn more slowly e.g. benzodiazepines.	It is beyond the scope of this guideline to review the range of medications that should be considered for withdrawal, and how withdrawal should occur.

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Foundation Trust					Therefore recommendations about how medicines should be withdrawn cannot be made.
Central and North West London NHS Foundation Trust	NICE	1.2.7.1		Discontinuing psychotropics - perhaps need to expand and say specialist mental health pharmacists may need to be contacted on how it is safest to discontinue x psychotropic agent. Some medicines are short acting e.g. paroxetine and may cause discontinuation effects if stopped abruptly. This may be necessary in some cases but at least if the managing team is aware, they may be able to provide extra mental health support to such patients.	Your comment relates to the community section of the guideline. Comments were not invited for this section as the guideline developer does not have the remit to update these recommendations. Therefore your suggestions could not be considered.
Central and North West London NHS Foundation Trust	NICE	1.1.1.2		agree with comment not to use numerical falls prediction tools especially when working with dementia patients because the risk can be overlooked depending on the score	Thank you for your comment.
Central and North West London NHS Foundation Trust	NICE	1.2.10.2		Carers' and relatives are informed about risks of medicines and falls. All patients and carers should be encouraged to raise their own awareness by reading the medicines leaflet from the manufacturer or in-house leaflets provided by hospitals. Patients and carers should particularly informed about risks of falls secondary to dehydration or being over sedated or confused by certain medicines e.g. diuretics and sedating pain killers, respectively.	Your comment relates to the community section of this guideline. Comments were not invited on this section as these recommendations cannot be changed. Therefore your suggestions will not be included.
Central and North West London NHS Foundation Trust	NICE	1.1.2.3.		This needs further clarification because it states that the assessment should focus on risk factors that can be treated during their current stay. Although this is more realistic, it can be left open to misinterpretation because of its subjectivity eg. Referral for visual impairment can start during the current admission and followed up by the community team if discharged before the appointment	The recommendation you refer to is correct as it stands. Risk factors that can start to be treated during the inpatient stay, but where the benefit will not be seen during the inpatient stay are not included in this recommendation. This is because such an intervention is covered by the

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					recommendations in the community section of this guideline.
Central and North West London NHS Foundation Trust	NICE	1.1.2.4		Realistic but very subjective as to what is achievable – this will depend on the current resources and may lead to not aiming for improvement in the services.	Thank you for your comment. Individual organisations are responsible for the implementation of these recommendations however they see fit.
Central and North West London NHS Foundation Trust	NICE	1.1.2.5		Realistic but very subjective as to what is achievable – this will depend on the current resources and may lead to not aiming for improvement in the services.	Thank you for your comment. Individual organisations are responsible for the implementation of these recommendations however they see fit.
Central and North West London NHS Foundation Trust	NICE	1.2.12.5		Should all "high risk" patients be started on Adcal D3, as we assume most >65 year olds are deficient in vitamin D (as per DOH letter, Feb 2012)? It is quite expensive to check routine vitamin D levels in patients as a baseline. However, should all patients be given a prescription for Adcal D3/Calcichew D3 and have their vitamin D levels measured after 3 months? This would be subject to the individual not having a contra-indication to taking extra calcium. **It would be great to have a consensus from Clinicians on their view to starting "high risk" low vit D patients on a combination preparation. I understand single vitamin D preparations are coming onto the market but these are not readily available in all areas yet.	<p>A small amount of evidence was found in relation to vitamin D supplementation but the studies were not high quality and did not support the use of vitamin D for inpatient fall prevention. Thus no recommendation was made about vitamin D.</p> <p>Vitamin D was previously reviewed in the community section of the guideline, but again the evidence was uncertain and no recommendation about its use could be made.</p> <p>Thus the use of vitamin D cannot be recommended for</p>

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					inpatients or older people in the community.
College of Occupational therapists	Full	General	General	Additional comments in summary: There is a lack of Assistive technology identified for its important role within falls prevention and management within the community and the inpatient settings. Promoted greatly within the Prevention package for Older People.	Assistive technologies were not specifically mentioned as no evidence was found relating to them but they could form part of a multifactorial intervention which is recommended by this guideline. The text in section 4.4.5 'other considerations' has been amended to make this clearer to readers.
College of Occupational therapists	Full	General	General	REHABILITATION is provided for all patients within both settings to promote independence and encourage activity and falls prevention techniques. It is essential in recovery and managing all falls.	The suggestion to include rehabilitation is outside the scope of this guideline.
College of Occupational therapists	Full	General	General	FUNCTIONAL ABILITY - actual and perceived needs to be identified in both settings and assessed / treated accordingly. Standardised tools / outcome measures could be utilised.	A multifactorial assessment (see recommendation 1.2.2.4) may include an assessment of functional ability, and is therefore included in the current guideline recommendations
College of Occupational therapists	Full	General	General	BEHAVIOURAL assessment – particularly within an inpatient setting for falls risk taking behaviour or stabilising medical conditions etc.	A multifactorial assessment (see recommendation 1.2.2.4) may include an assessment of behaviour, and is therefore included in the current guideline recommendations
College of Occupational therapists	Scope	2.4.1 b	4	This could apply to any adult, not just those over 50.	Although it can apply to all adults, the remit we were provided with from the Department of Health was for a specific guideline for older people, which is why the guideline focuses only on older people.
College of Occupational	Scope	2.6.1 a	5	Ensure all staff use a thorough falls assessment method.	Your comments relate to the scope. This document was

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al therapists					subject to stakeholder consultation and was finalised in early 2012. Your suggestions may be considered in future updates
College of Occupational therapists	Scope	2.6.1 b / c	5	Information needs to be provided on admission and attendance / participation in group and / or 1:1 falls sessions.	Your comments relate to the scope. This document was subject to stakeholder consultation and was finalised in early 2012. Your suggestions may be considered in future updates
College of Occupational therapists	Scope	2.6.1 d	5	See previous training comment.	Your comments relate to the scope. This document was subject to stakeholder consultation and was finalised in early 2012. Your suggestions may be considered in future updates
College of Occupational therapists	Scope	2.6.2 a	6	This appears a "lost opportunity" to standardise care across all Trusts.	Your comments relate to the scope which has previously been consulted on and has now been finalised. Therefore no changes can be made to the scope.
College of Occupational therapists	Scope	2.6.2 b	6	Should apply to all adults.	Your comments relate to the scope which has previously been consulted on and has now been finalised. Therefore no changes can be made to the scope.
College of Occupational therapists	Scope	2.6.2 f	6	The Guidance SHOULD include rehabilitation as this is a key target in the NHS Outcome Framework and many people do not receive rehabilitation and it is viewed as a luxury rather than core to recovery.	Your comments relate to the scope which has previously been consulted on and has now been finalised. Therefore no changes can be made to the scope.
College of	Scope	2.1 a	2	What is the evidence for this age range of 50+ ?	Your comments relate to the

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Occupational therapists					<p>scope which has previously been consulted on and has now been finalised. Therefore no changes can be made to the scope at this stage. Changes can only be made to the guideline.</p> <p>In response to your comment, the addition of the 50+ age group to the inpatient section of the guideline is based on equalities legislation, not on evidence. It would be unlawful of NICE not to include this group in this new section of the guideline.</p>
College of Occupational therapists	Scope	2.1 c	2	What does the data re: falls in hospitals indicate with regard to age? – This should inform age range for the guideline.	<p>Your comments relate to the scope which has previously been consulted on and has now been finalised. Therefore no changes can be made to the scope at this stage. Changes can only be made to the guideline.</p> <p>The age range covered by the guideline was informed by the Department of Health which provided a remit to NICE to develop guidelines on the assessment and prevention of falls specifically in older people. In 2010 equalities legislation came into effect which prevented the guideline using the 65+ age group used in the previous guideline, since the term 'older people' can refer to</p>

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College of Occupational therapists	Scope	2.1 d	2	Second sentence should say "This is in part because of EXISTING and newly acquired risk factors".	anyone over the age of 50. Your comments relate to the scope which has previously been consulted on and has now been finalised. Therefore no changes can be made to the scope at this stage. Changes can only be made to the guideline.
College of Occupational therapists	Scope	2.1 d	2	"Unfamiliar surroundings" in the guideline should be clarified to include orientation to the ward, flooring, lighting, temperature, signage, equipment etc. KINGS FUND environmental Ax tool available. With dementia monies available / strategy care should include this and it is essential for ALL patients.	Your comments relate to the scope which has previously been consulted on and has now been finalised. Therefore no changes can be made to the scope at this stage. Changes can only be made to the guideline.
College of Occupational therapists	Scope	2.2 c	3	Staff training must be included if a consistent service model is to be delivered. All trusts need to offer a robust training package for staff of all levels to ensure they have adequate awareness of falls and how to manage them effectively.	Your comments relate to the scope which has previously been consulted on and has now been finalised. Therefore no changes can be made to the scope at this stage. Changes can only be made to the guideline.
College of Occupational therapists	Scope	2.3 a	3	This contradicts section 2.3b re people aged 50-64 with underlying health conditions being at higher risk of falls in hospital – they are also at higher risk in the community yet often excluded from fall prevention services based on younger age – e.g. adults with Learning Disabilities.	Your comments relate to the scope which has previously been consulted on and has now been finalised. Therefore no changes can be made to the scope at this stage. Changes can only be made to the guideline. In response to your comment, we feel that the statements do not contradict each other. Although people living in the

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					community may also be at risk of falling from a younger age, the risk is much higher in the inpatient setting due to acute illness, unfamiliar surroundings etc.
College of Occupational therapists	Scope	2.3 b	4	The age limit is arbitrary – why 50? Should apply to all adults admitted to hospital.	The age limit is in compliance with both the remit provided by the department of health (for a guideline specifically for older people) and for current equalities legislation (which states that age should not be a discriminatory factor). Since older age can be considered to start from age 50, this is the age group the guideline must include.
College of Occupational therapists	Scope	2.7 e	6	Standardisation of outcome measure used would enable review of standards met across all Trusts. Are there adequate and robust tools? Direction from above is required to ensure services use, even if they don't like them.	Your comments relate to the scope which has previously been consulted on and has now been finalised. Therefore no changes can be made to the scope at this stage.
Department of Health	Full	General	General	No comment	Thank you for reading the guideline
Elcena Jeffers Foundation	Full version	general	Whole document	Falls is not taken seriously enough by people who suffer from falls. This could also be not taken seriously by some professionals. EJF will be very interested in future work in researching the results of falls.	Thank you for your comment.
Falls and fractures alliance Executive board	Full	General	General	The document mentions the use of bed rails in the information and support section. It would be useful to have some guidance on bed rail assessment as this is an acute intervention.	It is beyond the scope of this guideline to provide guidance on bedrail assessment, or assessment of any other intervention that may form part of a multifactorial intervention. It is expected that healthcare professionals will use their clinical judgement and any local

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					policies relating to specific interventions used as part of a multifactorial intervention.
Falls and fractures alliance Executive board	Full	2	21	Flow-chart. Patients at risk of falls in hospital often have falls risk factors that require further intervention once discharged. We acknowledge that some risk factors will be different in the acute setting but assessments should be shared across the interface. This is not clear in the flow chart.	Thank you for your comment, the algorithm in section 2 of the full guideline has been amended to reflect your comments.
Falls and fractures alliance Executive board	NICE	General	General	The FFAEB, a board that serves a coalition of health providers, charity sector representatives, secondary care sector professions, allied health professions and the public health sector welcomes the recommendations made on preventing falls during hospital stays in the update to CG21. If this document is extended to Adult Social Care the review will need to be more far-reaching as they do not take into account the settings in which people live and in which care is received.	Thank you for your comment. The extension into social care and any necessary changes needed will be considered when the guideline is reviewed for update.
Falls and fractures alliance Executive board	Full	Section 3.4.5	76	We support the opportunity for patients to be able to access assessment and provision of walking aids out of hours, following the recommendations in work such as the 'Fallsafe' bundle	Thank you for your comment.
Falls and fractures alliance Executive board	Full	General	E.g. pg 30, section 3.3.5 and Pg. 74, section 3.4.5	Welcomed the summarised <i>Evidence to recommendation</i> tables as the succinct explanation provides additional clarity to the sections	Thank you for your comment.
Falls and fractures alliance Executive board	Full	1.1.1	11	Using a specific age-band of 50-64 years may not be useful. There will be a small but significant number of younger people with gait impairment, stroke, neurological disease admitted to acute care that will be at risk of falls.	We acknowledge that people below the age of 50 are also at risk of falls. However, the remit we received from the Department of Health was to develop a guideline for the assessment and prevention of falls specifically for older people.
Falls and	Full	1.1.2.1	11	We also welcome the recommendation that all older people who are admitted	Thank you for your comment.

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fractures alliance Executive board				to hospital should be considered for an individualised multifactorial risk assessment for their inpatient falls risk.	
Falls and fractures alliance Executive board	Full	1.1.3.1	12	A number of patients will not be able to use call bells- e.g.: dexterity, dementia. Guidance on alternative systems would be useful.	The recommendation does not refer to call bells, but refers to nurse call systems which include traditional call bells as well as alternative systems that are accessible to all.
Falls and fractures alliance Executive board	Full	1.1.3.1	12	Also include, where relevant, onward interventions following discharge from an in-patient setting.	<p>The algorithm in section 2 of the guideline has been amended in line with your suggestion.</p> <p>However changes to the recommendations will not be made. This is because recommendations covered in section 4 of the guideline (previously section 3) cover the inpatient stay only. Onward interventions following discharge are covered in section 3 of the guideline (previously section 4) and the guideline developer does not have the remit to update these recommendations.</p>
Falls and fractures alliance Executive board	Full	1.1.1.2	11	We welcome the move away from numerical risk predication tools and towards risk factor assessment. No specific reference is currently made to what form of assessment should be used and this presents an opportunity to set a standardised approach to falls risk assessment in a secondary care environment.	A routine clinical assessment should be used instead of a fall risk prediction tool. The order of the recommendations has changed to make this clearer. In addition, the wording of the recommendation has now been changed. The term 'numerical' has been removed from the recommendation as the GDG do not want to advocate the use of

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					<p>any form of risk prediction tools, including those that do not generate numerical scores, as well as those that do.</p> <p>A more in-depth explanation for the rationale of the GDG is provided in section 4.3.5 (previously 3.3.5) under 'Evidence to recommendations' and then 'trade-offs between benefits and harms'. Here it states the reasons why falls risk prediction tools should not be used and explains that a hospital's routine clinical assessment procedures should identify factors for falls that can be treated managed or improved during the inpatient stay.</p>
Falls and fractures alliance Executive board	NICE	1.1.2.2	10	Secondary care falls risk assessment is appropriately highlighted but there needs to be strong emphasis on the importance of having effective and integrated community and primary care falls services to signpost to following the secondary care risk assessment.	A new recommendation has been added to the guideline (recommendation 1.2.3.2) to signpost readers to the Patient experience in adult NHS services guideline (CG138) which covers information sharing.
Falls and fractures alliance Executive board	NICE	1.2.2.2	13	Although CG146 is listed as related NICE guidance, where osteoporosis risk assessment is included in the multifactorial risk assessment there is an opportunity to highlight, with a minor change in wording, CG146 as the recommended means of assessment.	Your comment relates to the community section of the guideline. Comments on this section were not invited as it is not possible to make any changes so your suggestion cannot be included.
Falls and fractures alliance	Full	1.1.2.3 and 4	11	Alongside multifactorial assessment and intervention, there needs to be guidance regarding how this information is shared within the team / ward staff, especially key areas such as a person's mobility or transfer capability	A new recommendation has been added to the guideline (recommendation 1.2.3.2) to

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Executive board					signpost readers to the Patient experience in adult NHS services guideline (CG138) patient experience guideline (CG138) which covers information sharing.
Falls and fractures alliance Executive board	Full	1.1.2.4	12	Consider whether interventions for falls can be continued following hospital admission to ensure seamless care with appropriate interventions followed from inpatient settings into community falls prevention interventions.	<p>Whilst it seems intuitive to continue interventions following a hospital admission, the interventions recommended in the inpatient section of this guideline should start and end during the inpatient stay. This is because there are different risks in the inpatient setting to those in the community.</p> <p>After discharge from hospital, a person who has also been identified as being at risk of falling in the community should be offered interventions in line with their community based multifactorial falls risk assessment,</p>
Falls and fractures alliance Executive board	Full	Section 3.4.5	76	Although falls prevention guidelines are clear for community settings on discharge from hospital, it would be beneficial to consider the pathway between falls prevention whilst an in-patient and the continuation, when appropriate, of falls prevention interventions in the community.	<p>The GDG agree that the pathway between settings should be a continuation, and the algorithm in section 2 has been amended to reflect this more clearly.</p> <p>The recommendations for the community section and recommendations for the inpatient section were developed separately. This was because of the remit that we were provided with and the</p>

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					<p>sections cannot be 'merged' to better reflect the continuation of the patient pathway. To overcome this, the sections have now been renamed and the terminology used to refer to the sections have also been renamed, the guideline now refers to 'recommendations for all older people' (instead of 'community section'), and 'additional recommendations for older inpatients' ('instead of inpatient section'). We hope that this change in terminology highlights that the recommendations are continuous and the two sections should be considered together.</p>
Falls and fractures alliance Executive board	Full	3.5.5	84	<p>The statement regarding NHS best practice for patients found on the floor needs clarification. The National Patient Safety Agency report (NPSA/2011/RRR001) state that patients found on the floor should have initial checks and safe retrieval techniques as indicated. The statement on page 84 that patients should be taught how to rise if found on the floor is in conflict with the NPSA report.</p> <p>The draft states that according to current NHS best practice, all patients who are found on the floor should be provided with instructions about how to get up. However, this may have been misinterpreted as CG21 indicates people should be taught strategies how to get up following a further fall and does not relate to what to do when someone is found on the floor.</p> <p>Clarity is therefore required to differentiate between</p> <p>(a) a longer term rehabilitation programme that skills people to get up in case they fall again, and</p>	<p>Thank you for your comment. The text in the guideline which your comment relates was referring to a study which was removed from the analysis because it taught patients how to get up off the floor once they had returned home. Since this is not an intervention aimed at reducing hospital based falls it is outside the scope of the guideline. The text has now been removed. Because of this, the areas which you have suggested need clarity no longer exist.</p>

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				(b) what should happen immediately after someone falls in hospital	
Falls and fractures alliance Executive board	NICE	1.2.12.5	17	We note the following deletion "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."; and wish to highlight the need for a full clinical guideline on osteoporosis.	Thank you for your comment, NICE notes your comment.
Falls and fractures alliance Executive board	Full	3.6	86	Only one research recommendation for environmental design in inpatient falls is surprising bearing in mind the majority of trials of inpatient falls prevention are low in quality and the results are equivocal.	Another three research recommendations have been added which focus on the prevalence of falls risk factors in older people, causes of unwitnessed falls, and interventions for preventing falls, in addition to the existing research recommendation on environmental adaptations. The GDG felt that research done in these areas would help to improve the evidence base for subsequent updates of this guideline.
Hip impact protection Ltd	NICE full version	General	General	There is no mention in the entire document of shock absorbing flooring. This is a major omission and destroys the credibility of this document completely. This flooring is widely used in kids' playgrounds, is not especially expensive and there are numerous studies that have shown it to be very effective in reducing injuries of all kinds especially in an institutional setting. Why is there no mention of it in the entire document, either the 25% that we can comment on or the 75% that we are not permitted to comment on?	Thank you for your comment. Shock absorbing floors were not mentioned because there was no evidence found in relation to its effectiveness that matched the inclusion criteria of the review.
Humber NHS Foundation Trust	Full	general	11	Relieved that the age group 50 to 64 considered, but this is still too limiting.	Although the 50-64 age group may appear limiting, there is no remit to include people younger than 50 in this guideline. This is because the remit provided by the Department of Health was specifically for older people.
Humber	Full	Figure 1	50	A very poor model and is not advocated. It is complex and does not	This is a health economic

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NHS Foundation Trust				demonstrate an easy patient flow	model, not a patient pathway. The patient pathway is at the front of the guideline (section 2, page 24) and demonstrates the patient flow.
Humber NHS Foundation Trust	Full	general	9	Line 16, 17, 18 – this is a very important statement. Falls assessment & intervention must be effective and designed to meet patient's individual risk factors that can be 'treated, improved or managed' – this is a key statement.	Thank you for your comment.
Humber NHS Foundation Trust				Visual impairment is important, especially when a patient is in an unfamiliar environment.	Thank you for your comment.
Humber NHS Foundation Trust	NICE	1.1.1.1	8	Review of medication in hospital is important. Staff must not just review medication, they should consider if a prescribed drug increases the risk of falls and if there is an alternative that would reduce or stop that risk.	Medication review was considered an important part of a multifactorial fall assessment, and if medication is identified as a risk factor it is expected that an appropriately trained individual will make a judgement about whether an appropriate linked intervention would be to reduce, stop or switch to an alternative medication. Recommendation 1.1.1.1 which your comment relates to is now recommendation 1.2.1.2
Humber NHS Foundation Trust	NICE	1.1.1.1	10	Very important that all considered at risk of falls should be assessed with a multifactorial assessment.	Thank you for your comment.
Humber NHS Foundation Trust	NICE	1.1.2.1	10	Assessment of environment is very important and must be included. There must be consideration to the layout and furniture used. A patient who has had a stroke would be betting getting out of bed to sit in their chair on their strong side.	Your comment relates to the environmental design of hospitals. No evidence was identified that met the inclusion criteria in relation to this and so the GDG have made a research recommendation in this area as

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					it is an important area to consider.
Humber NHS Foundation Trust	Full	1.1.2.1 to 1.1.3.1	11	Concerned that this document is age related (age discrimination). Acknowledge that the majority of older people fall, but the principles can be disseminated across all adults.	The age range covered by the guideline was informed by the Department of Health in the remit provided to NICE. The remit from the Department of Health is to develop guidelines on the assessment and prevention of falls specifically in older people. The term 'older people' refers to anyone over the age of 50, which is covered by the guideline. Including people under the age of 50 is outside the remit set out by the Department of Health.
Humber NHS Foundation Trust	NICE	1.1.3.1	11	<p>The key is giving patients & carers relevant oral and written information. Especially taking into account their ability to understand and retain information. This is a very important statement. However, it is the quality of that information and its relevance's that is key.</p> <p>The missing element here is telling individuals what are the risk factors that might make them fall. E.g. – getting up from a chair or bed too quickly (their blood pressure might drop and they become dizzy). They should be given information to assist them in making-informed choices.</p>	We agree with your comment and feel that the current recommendations regarding information for patients and carers reflect this.
Humber NHS Foundation Trust	Scope	2.6.1 (d)	5	A weakness of the consultation document - Do not think that the current proposals are comprehensive in preventing falls in inpatient settings, managing care pathways or staff training.	Your comments relate to the scope. This document was subject to stakeholder consultation and was finalised in early 2012. Your suggestions may be considered in future updates
Humber NHS Foundation Trust	Full	1.1.1.2	11	This is a correct statement and highly advocated. The missed opportunity is that it is not reflected in community. Patients at low risk can have one risk that actually makes them at great risk of falls. Please consider rolling this across the full guidelines, not just inpatient.	Although this may seem intuitive to include in both the inpatient and community sections, we had no remit to alter the community section of the guideline and so

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					did not review any evidence to support making the suggested change.
Humber NHS Foundation Trust	Scope	2.6.2 (f)	6	A weakness of the consultation document is that this is not covered. Question – where will staff access this?	Your comments relate to the scope which has previously been consulted on and has now been finalised. Therefore no changes can be made to the scope.
Humber NHS Foundation Trust	NICE	1.1.2.3	11	Missing – assessment of 'postural hypotension' (lying, sitting, standing blood pressure)	The GDG feel that your suggestion is already included in the bullets 'falls history' and 'health problems that may increase the risk of falling', Therefore your suggestion will not be added.
Humber NHS Foundation Trust	NICE	1.2.2.3	11	Who would do the assessment and at what level. There are different levels of assessment and the outcome will depend on the quality and expertise of the person completing. Need clarity.	We would expect this recommendation to be appropriate for all staff involved in the care of older people – this may be physiotherapists, nurses, occupational therapists and others. As with many clinical guidelines, we have not made recommendations specific to the role of any particular healthcare professional in order for particular specification to be made locally, according to local need and available skill sets.
Humber NHS Foundation Trust	NICE	1.1.2.4	11	Missing - the use of Telecare / Telehealth equipment. Including falls detectors, chair and bed sensors.	Specific recommendations on telecare/ telehealth were not made because no evidence was found to support their use.
Humber NHS Foundation	Scope	2.5	5	States all hospital settings (including acute hospitals, community and mental health trust. Within mental health trusts this should be more distinct – inpatient mental health (forensic, adults, older people and learning disability).	Your comments relate to the scope which has previously been consulted on and has now

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Trust					been finalised. Therefore no changes can be made to the scope at this stage.
Humber NHS Foundation Trust	Scope	2.8	7	A weakness of the consultation document – we do not think that this is robustly covered. There are big gaps.	Your comments relate to the scope which has previously been consulted on and has now been finalised. Therefore no changes can be made to the scope at this stage.
Humber NHS Foundation Trust	Scope	3.1	8	A weakness of the consultation document – we do not think that this is robustly covered. There are big gaps.	Your comments relate to the scope which has previously been consulted on and has now been finalised. Therefore no changes can be made to the scope at this stage. Changes can only be made to the guideline.
Lancashire Care NHS Foundation Trust	NICE	1.1.2.3	11	"health problems that may increase their risk of falling" - examples may be useful in the interpretation for clinical staff e.g. chest or urinary infection, orthostatic hypotension	The GDG would prefer clinicians to use their judgement about which health problems can increase the risk of falling, and providing any sort of list may prevent this from happening. Therefore your suggestion has not been included.
Lancashire Care NHS Foundation Trust	NICE	1.1.2.3	11	This section identifies risk factors for falling but with no reference to bone health or fracture risk assessment for in patients. Clearly for inpatients with a fracture this is relevant and as part of a multifactorial falls assessment. CGL124 is referred to on page 20 , but for a dovetailed and comprehensive approach falls and fracture prevention should be considered together and this should be more clear in the recommendations. It is referred to in NPSA documents Reducing harm in falls in mental health settings and NPSA reducing harm from falls and NICE CG21(2004)	The related guidance that you suggest is included in the guideline under section 5.5 'Related NICE guidance'. In addition, this guideline will be supported by an interactive tool (called Pathways) which is available on line. The tool brings together all related NICE guidance in an easy to access format for use by healthcare professionals and members of the public.

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Lancashire Care NHS Foundation Trust	Full	3.6	86	Under list of research recommendations :Rephrase of adjustments to the ward environment aimed at reducing the risk of patients falling <u>and injuries</u> in <u>hospital</u> It is necessary to emphasize <u>injuries</u> as if you put down a non slip flooring this is usually thin and rigid which if lying on concrete floor may give rise to a serious injury even though falls may have been reduced. To say flooring that reduces falls is not adequate it should include <u>injury</u>	The research recommendation has been amended in line with your comment.
National Care Forum	NICE	General	General	It would appear that the intention is to extend this document to Adult Social Care. References are made to the standards applying to care homes. Having read the document (NICE version) I do not believe that the review goes far enough; the amendments are only minor and are not cognisant of the settings in which people receive care or live their lives.	This document is intended to provide guidance for the care of NHS patients. The extension into social care and any necessary changes needed will be considered when the guideline is reviewed for update.
National Osteoporosis Society	NICE	General	General	The National Osteoporosis Society welcomes the recommendations made on preventing falls during hospital stays in the update to CG21.	Thank you for your comment.
National Osteoporosis Society	NICE	1.1.1.2	10	This recommendation states that numerical scores should not be used; but there is no explicit reference as to what form of assessment should be made. This presents an opportunity to be explicit and get a more standardised approach to falls risk assessment in a secondary care environment.	A routine clinical assessment should be used instead of a fall risk prediction tool. The order of the recommendations has changed to make this clearer. In addition, the wording of the recommendation has now been changed. The term 'numerical' has been removed from the recommendation as the GDG do not want to advocate the use of any form of risk prediction tools, including those that do not generate numerical scores, as well as those that do. A more in-depth explanation for the rationale of the GDG is

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					provided in section 4.3.5 (previously 3.3.5) under 'Evidence to recommendations' and then 'trade-offs between benefits and harms'. Here it states the reasons an explanation of why falls risk prediction tools should not be used is provided, as well as an explanation stating and explains that a hospital's routine clinical assessment procedures should identify factors for falls that can be treated managed or improved during the inpatient stay.
National Osteoporosis Society	NICE	1.1.2.2	10	Secondary care falls risk assessment is appropriately highlighted but there needs to be strong emphasis on the importance of having effective and integrated community and primary care falls services to signpost to following the secondary care risk assessment.	A new recommendation has been added to the guideline (recommendation 1.2.3.2) to signpost readers to the Patient experience in adult NHS services guideline (CG138) which covers information sharing.
National Osteoporosis Society	NICE	1.2.2.2	13	Although CG146 is listed as related NICE guidance, where osteoporosis risk assessment is included in the multifactorial risk assessment there is an opportunity to highlight, with a minor change in wording, CG146 as the recommended means of assessment.	Your comment relates to the community section of the guideline. Comments on this section were not invited as it is not possible to make any changes so your suggestion cannot be included.
National Osteoporosis Society	NICE	1.2.12.5	17	We note the following deletion "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."; and wish to highlight the need for a full clinical guideline on osteoporosis.	Thank you for your comment. NICE notes your comment.
NHS Airedale,	Full	General	General	There is no consensus on an assessment tool for use with inpatients and some colleagues feel this might be an issue	The GDG felt that a specific assessment tool was not

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Bradford and Leeds					necessary. Instead they felt that a multifactorial falls risk assessment should cover the areas highlighted in recommendation 1.2.2.3 (previously 1.1.2.3) Local organisations may choose how they implement this based on local need and skills.
NHS Airedale, Bradford and Leeds	Full	General	General	Looking at the 2013 additions it is a concern that the number of patients that could be deemed "high risk" aged 50 to 64 years will require a full assessment - this is an issue for acute settings presumably not community as it only mentions inpatients for the time being. If after the consultation this changes to all adults - it would imply that Falls clinics and Community Falls services may have to accept younger patients, and this may require investment.	The 50 to 64 age group only applies to inpatient settings.
NHS Airedale, Bradford and Leeds	Full	General	General	"There is no guidance around how the acute hospitals interface with the community i.e. on ensuring that there is onward referral/transition of patients where appropriate into a community falls pathway/appropriate support. This applies both to patients leaving accident and emergency departments and hospital wards. We feel that this is an important area in ensuring patient safety/continuity of care across organisations.	A new recommendation has been added to the guideline (recommendation 1.2.3.2) to signpost readers to the Patient experience in adult NHS services guideline (CG138) which covers information sharing.
NHS Commissioning Board	Full	General	General and page 9 lines 5-12	The guideline is concerned with groups of patients as follows. "Regard the following groups of inpatients as being at risk of falling in hospital and manage their care according to recommendations 1.1.2.1 to 6 1.1.3.1: 7 – all patients aged 65 years or older – patients aged 50 to 64 years who are identified by a clinician as being at higher risk of falling (for example, patients with a sensory impairment or dementia, and patients admitted to hospital with a fall, stroke, syncope, delirium or gait disturbances). [new 2013] [1.1.1.1] "	There are many reasons why a person aged 50 to 65 could be at risk of falling during their hospital stay and it would be impossible for the guideline to provide an exhaustive list. Healthcare professionals are expected to use their clinical judgement to assess individuals risk on a case by case basis, and to encourage this the GDG decided to amend

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				<p>For the group of patients aged 50-64 years, the guideline mentions particular groups who should be identified by a clinician as at higher risk of falling.</p> <p>Should those with multimorbidity (more than one condition) be mentioned as a group of patients at higher risk of falling. This group are particularly likely to be infirm, physically deconditioned, and be on multiple medications that might contribute to falling.</p>	<p>recommendation 1.1.1.1 (now recommendation 1.2.1.2) and have removed the list of example conditions.</p>
NHS Direct	NICE	1.1.1.1	8 & 10	<p>I realise the age group 50 – 64 years is included in the populations covered by this guideline but shouldn't anyone with a sensory impairment or having had a stroke for example, be identified as being at higher risk of falling, not just that age group?</p>	<p>We acknowledge that people under the age of 50 may also be at risk of falling (due to stroke or sensory impairment for example), but the remit provided by the Department of Health was to develop a guideline on falls assessment and prevention specifically for older people. Therefore people under the age of 50 are beyond the remit of the guideline.</p>
Northampton General Hospital	Full	1.1.1.2	11	<p>Regarding the suggestion of stopping to use numerical risk assessment tools - I concur that the current evidence supports this statement, however I am concerned that Trusts will dispense with any form of assessment leaving up to individual clinicians to decide who is at risk. NICE have identified what factors should be included in the multifactorial assessment. We really feel it would be more helpful for the creation of an assessment proforma that all hospitals must use. Clearer guidance is essential in this regard. Providing some examples of risk assessment tools which are user friendly and validated would also be useful as an alternative approach.</p>	<p>We feel that enabling local organisations to use local resources (i.e. existing assessment forms) will be of more benefit than describing a particular set of criteria that should be assessed. This is because duplication may occur, and cause distress to the patient (i.e. repeatedly answering similar questions, waiting for a specific falls assessment to be done in addition to other assessments they require). Although this may be perceived as a risk in that some organisations may fail to do any assessment, we feel it is up to individual organisations to</p>

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					determine how to implement these recommendations, and there is the opportunity for local organisations to develop their own assessment proforma if appropriate.
Nottingham shire Healthcare NHS Trust	Scope	2.4.1 b	4	This could apply to any adult, not just those over 50	<p>Although it can apply to all adults, the remit we were provided with from the Department of Health was for a specific guideline for older people, which is why the guideline focuses only on older people.</p> <p>If a healthcare professional involved in the care of a person under the age of 50 believes that the recommendations are relevant then there is no reason why this guideline cannot be used.</p>
Nottingham shire Healthcare NHS Trust	Scope	2.6.2 a	6	This appears a “lost opportunity” to standardise care across all Trusts	Your comments relate to the scope which has previously been consulted on and has now been finalised. Therefore no changes can be made to the scope. Since the scope informs the development of the guideline the area that you mention cannot be included in the guideline.
Nottingham shire Healthcare NHS Trust	Scope	2.6.2 b	6	Should apply to all adults	The remit we were provided with from the Department of Health was for a specific guideline for older people, which is why the guideline focuses only on older people.

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Nottingham shire Healthcare NHS Trust	Scope	2.6.2 f	6	The Guidance SHOULD include rehabilitation as this is a key target in the NHS Outcome Framework and many people do not receive rehabilitation and it is viewed as a luxury rather than core to recovery	Your comments relate to the scope which has previously been consulted on and has now been finalised. Therefore no changes can be made to the scope. Since the scope informs the development of the guideline the area that you mention cannot be included in the guideline.
Nottingham shire Healthcare NHS Trust	Scope	2.1 a	2	What is the evidence for this age range of 50+?	<p>Your comments relate to the scope which has previously been consulted on and has now been finalised. Therefore no changes can be made to the scope at this stage. Changes can only be made to the guideline.</p> <p>In response to your comment, the addition of the 50+ age group to the inpatient section of the guideline is based on equalities legislation, not on evidence. It would be unlawful of NICE not to include this group in this new section of the guideline.</p>
Nottingham shire Healthcare NHS Trust	Scope	2.1 c	2	What does the data re falls in hospitals indicate with regard to age – this should inform age range for Guidance	<p>Your comments relate to the scope which has previously been consulted on and has now been finalised. Therefore no changes can be made to the scope at this stage. Changes can only be made to the guideline.</p> <p>The age range covered by the guideline was informed by the</p>

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					Department of Health which provided a remit to NICE to develop guidelines on the assessment and prevention of falls specifically in older people. In 2010 equalities legislation came into effect which prevented the guideline using the 65+ age group used in the previous guideline, since the term 'older people' can refer to anyone over the age of 50.
Nottingham shire Healthcare NHS Trust	Scope	2.1 d	2	Second sentence should say "This is in part because of EXISTING and newly acquired risk factors .."	Your comments relate to the scope which has previously been consulted on and has now been finalised. Therefore no changes can be made to the scope at this stage. Changes can only be made to the guideline.
Nottingham shire Healthcare NHS Trust	Scope	2.1 d	2	"Unfamiliar surroundings" in the Guidance should be clarified to include orientation to the ward, flooring, lighting, temperature, signage, equipment etc	Your comments relate to the scope which has previously been consulted on and has now been finalised. Therefore no changes can be made to the scope at this stage. Changes can only be made to the guideline.
Nottingham shire Healthcare NHS Trust	Scope	2.2 c	3	Staff training must be included if consistent service model to be delivered	Your comments relate to the scope which has previously been consulted on and has now been finalised. Therefore no changes can be made to the scope at this stage. Changes can only be made to the guideline.
Nottingham shire	Scope	2.3 a	3	This contradicts section 2.3b re people aged 50-64 with underlying health conditions being at higher risk of falls in hospital – they are also at higher risk	Your comments relate to the scope which has previously

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Healthcare NHS Trust				in the community yet often excluded from fall prevention services based on younger age – e.g. adults with Learning Disabilities	<p>been consulted on and has now been finalised. Therefore no changes can be made to the scope at this stage. Changes can only be made to the guideline.</p> <p>In response to your comment, we feel that the statements do not contradict each other. Although people living in the community may also be at risk of falling from a younger age, the risk is much higher in the inpatient setting due to acute illness, unfamiliar surroundings etc.</p>
Nottinghamshire Healthcare NHS Trust	Scope	2.3 b	4	The age limit is arbitrary – why 50? Should apply to all adults admitted to hospital	The age limit is in compliance with both the remit provided by the department of health (for a guideline specifically for older people) and for current equalities legislation (which states that age should not be a discriminatory factor). Since older age can be considered to start from age 50, this is the age group the guideline must include.
Nottinghamshire Healthcare NHS Trust	Scope	2.7 e	6	Standardisation of outcome measure used would enable review of standards met across all Trusts	Your comments relate to the scope which has previously been consulted on and has now been finalised. Therefore no changes can be made to the scope at this stage.
Royal College of Nursing	Full		4	Recognising older people to include those aged 50 or more; could do with clearer direction of the definition of older people.	The definition of older people is in the glossary and in the introduction (under 'methods

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					used to develop this guideline, page 6)
Royal College of Nursing	Full	General	General	The Royal College of Nursing welcomes proposals to update this guideline. It is timely.	Thank you for your comment.
Royal College of Nursing	Full	General		Good to include guideline on falls in inpatient settings.	Thank you for your comment.
Royal College of Nursing	Full		9	Line 27: Good to include visual impairment	Thank you for your comment. The GDG have revised the wording for the recommendation 1.2.1.2 (previously 1.1.1.1) which your comment relates to and have removed the list of example conditions that may increase an older person's risk of falling. This is because the GDG would prefer clinicians to use their judgement, and providing any sort of list may prevent this from happening. Therefore your suggestion has not been included.
Royal College of Nursing	NICE		5	It was helpful to make distinctions between the types of interventions, e.g. What must and must not and what should and should not' as well as what could be used. In general the style of presentation is user-friendly and helpful.	Thank you for your comment.
Royal College of Nursing	Full	1.1.2.1	11	'Ensure that aspects of the inpatient environment that could affect patients' risk of falling (such as flooring, lighting and provision of hand holds) are systematically identified and addressed'- Whose role? Physios? Nurses? OTs? The practical value of these recommendations is good although the levels of responsibility (e.g. organisational/ individual) could be clearer.	We would expect this recommendation to be appropriate for all staff involved in the care of older people – this may be a physiotherapist, nurse, occupational therapist or others. As with many clinical guidelines, we have not made recommendations specific to the role of any particular healthcare

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					professional in order to facilitate local implementation.
Royal College of Nursing	Full	1.1.3.1	13	<p>'Helping the patient to engage in any multifactorial interventions that are part of their care plan'.</p> <p>Whose role is this?</p>	<p>We would expect this recommendation to be appropriate for all staff involved in the care of older people. As with many clinical guidelines, we have not made recommendations specific to the role of any particular healthcare professional in order to facilitate local implementation.</p>
Royal College of Nursing	Full	1.1.1.2	11	<p>'Do not use numerical fall risk prediction tools to predict inpatients' at risk of falling in hospital.'</p> <p>If these are not recommended, alternatives should be offered.</p>	<p>A routine clinical assessment should be used instead of a fall risk prediction tool. The order of the recommendations has changed to make this clearer. In addition, the wording of the recommendation has now been changed. The term 'numerical' has been removed from the recommendation as the GDG do not want to advocate the use of any form of risk prediction tools, including those that do not generate numerical scores, as well as those that do.</p> <p>A more in-depth explanation for the rationale of the GDG is provided in section 4.3.5 (previously 3.3.5) under 'Evidence to recommendations' and then 'trade-offs between benefits and harms'. Here it states the reasons why falls risk prediction tools should not be</p>

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					used and explains that a hospital's routine clinical assessment procedures should identify factors for falls that can be treated managed or improved during the inpatient stay.
Royal College of Nursing	Full	3.3.2	24	(Schunemann A. et al. 2008). - should be 'Schunemann et al (2008)'.	This has been corrected.
Royal College of Nursing	Full	3.3.2	23	Lin 22: 'the initial search review'- what was the scope of the review? How far back?	The details of the search strategies used for each review question, and when they were carried out are in appendix B. The searches were conducted between November 2011 and July 2012, and re-run in September 2012 with no date restrictions applied. Therefore the searches go as far back as the databases allow.
SCIE	Full	General	General	The draft has no specific references to social care although care plans and prevention on return from hospital are considered in the draft	A social care representative was part of the guideline development group and their views were considered throughout this guideline. However, we did not have a remit to make recommendations in this area.
SCIE	Full	General	General	How will the QS scope include social care, if not prompted by the original version of the Guide?	Quality standards are based on all accredited guidance including those developed by NICE, If social care guidance has been developed by the time the QS is developed, it will be considered.
SCIE	Full	1.1.3.1	12	Suggest additional bullet point: reviewing existing social care plan or considering assessment of individual and carer needs	It is not within the remit of NICE clinical guidelines to make specific recommendations on social care planning.

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SCIE	Full	1.2.6.1	14	Add 'liaison with social care' made as appropriate	Your suggestion relates to the community section of this guideline. Comments were not invited on this section as the guideline developer does not have the remit to update these recommendations. Therefore your suggestions could not be considered.
SCIE	Full	1.2.10.2	15	..where they can seek further advice and assistance including ' <i>from social care services</i> '	Your comment relates to the community section of this guideline. Comments were not invited on this section as these recommendations cannot be changed. Therefore your suggestions will not be included.
SDMA (Surgical Dressing Manufacturers Association)	Full	General	General	<p>We appreciate the opportunity to comment on the January 2013 draft of the NICE guidelines on 'Falls: assessment and prevention of falls in older people'. Our comments concern the issue of wearable hip protectors.</p> <p>We note that no mention is included of wearable hip protectors within the newly drafted sections of the NICE guidelines on falls in the hospital inpatient setting. We note that the guidelines provide information on the value of hip protectors in the community which we regard as incomplete (as explained below). We believe that, unless corrections are made, this will contribute to the denial of an important opportunity for fall injury prevention for patient groups who are willing and able to wear hip protectors.</p> <p>We recognise that the NICE guidelines in the area of hip protectors were based on review and analysis of randomised clinical trials from an 'intention to treat' perspective, and borrowed largely from Cochrane reviews [1,2] using a similar approach. We see two major limitations to this approach.</p> <p>First, poor user compliance has been observed among randomised clinical trials of hip protectors (typically lower than 50%), and this prevents an intention to treat meta-analysis from reflecting the benefit of this intervention for patients who are willing to wear them. Furthermore, clinical trials of hip protectors have been powered to yield only a handful of hip fractures in the</p>	<p>Hip protectors were included in the guideline (see review protocol, Appendix E page 2). The references you have provided do not meet the criteria for consideration in the review (see appendix E page 2) and no other evidence that met the review criteria were found in our literature searches. Therefore no specific recommendation could be made about them.</p> <p>In the previous systematic reviews for the community section, again there was insufficient evidence to support the use of hip protectors in community settings, and it was not in the remit for us to update this section using the methods that you propose.</p>

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				<p>intervention and control groups, and the vast majority of fractures in the intervention groups have occurred when participants were not wearing hip protectors. Intention to treat analyses ignore whether individuals in the intervention group were wearing hip protectors at the time of falling, and simply examine differences in fracture rates between the intervention and control groups. While an important consideration in decision making by health organisations, intention to treat results are misleading when there is poor compliance among the trials in uptake with the intervention, as has been the case for hip protectors. These concerns were noted by the Cochrane authors, who stated 'poor acceptance and adherence by older people offered hip protectors have been key factors contributing to the continuing uncertainty' based on an intention to treat analysis [2].</p> <p>Second, there has been a high degree of variability among clinical trials in the products used for evaluation [3], and their protective value in lowering the force applied to the hip during a fall. This questions the rationale of combining results through meta-analysis. Recently published biomechanical testing results indicate a wide range of force attenuation (varying from 3-40 %) among commercially available products [4], and among those used in clinical trials. Of particular concern is the observation that the device used in the influential 'unilateral' hip protector trial published in 2007 in JAMA [5] performed in the bottom quartile in force attenuation. When considered with other recently discovered problems in study design [6] that invalidate the assumption of equal exposure, we strongly recommend that this trial should be excluded in the analysis and conclusions provided in the NICE guidelines.</p> <p>Clearly, a wider perspective is needed in evaluating the benefits of hip protectors. For patients who are willing to wear them, the key question is whether hip protectors reduce the risk for hip fracture if worn at the time of a fall. Here, there is convincing evidence that specific types of hip protectors yield reductions of 69-83% in fracture risk [7-9]. These are important results to convey to elderly people who are willing to wear hip protectors.</p> <p>Furthermore, improvements continue to be made in both user compliance (e.g. commitment among care staff to use) and biomechanical performance of hip protectors [3]. The most recent Cochrane review on hip protectors noted the need for 'the development of internationally recognised standards for biomechanical testing procedures for all forms of hip protectors'. A major</p>	

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				<p>step towards this goal has been achieved through publication of biomechanics testing guidelines by the International Hip Protector Research Group [10], which are the basis for current efforts by the British Standards Institute to develop testing standards for wearable hip protectors [CH/205/1/2 Hip Protectors].</p> <p>In summary, we urge revision of the NICE fall guidelines to better reflect the benefit of hip protectors to elderly people who are willing to wear them. In a revised version, we would hope to see discussion of the evidence from clinical trials that specific types of hip protectors provide a substantial reduction (of greater than 50%) in fracture risk when worn at the time of a fall. We would also like to see a more careful explanation that poor user compliance in existing trials, and lack of consistency in product selection, has limited our ability to identify (through meta-analysis) the clinical effectiveness of hip protectors, from an intention to treat perspective, although efforts are underway that address these challenges. Finally, we highlight the need to exclude the unilateral hip protector trial [5, 6] in formulating any conclusions from clinical trials of hip protectors.</p> <p>Surgical Dressing Manufacturers Association 19 February 2013</p> <p>References</p> <ol style="list-style-type: none"> 1. Parker MJ, Gillespie LD and Gillespie WJ. Hip protectors for preventing hip fractures in the elderly. Cochrane Database Syst Rev 2003; (3): CD001255. 2. Gillespie WJ, Gillespie LD and Parker MJ. Hip protectors for preventing hip fractures in older people. Cochrane Database Syst Rev 2010; (10): CD001255. 3. Cameron ID, Robinovitch S, Birge S, et al. Hip protectors: recommendations for conducting clinical trials--an international consensus statement (part II). Osteoporos Int 2010; 21(1): 1-10. 4. Laing AC, Feldman F, Jalili M, et al. The effects of pad geometry and material properties on the biomechanical effectiveness of 26 commercially 	

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				<p>available hip protectors. J Biomech 2011; 44(15): 2627-35.</p> <p>5. Kiel DP, Magaziner J, Zimmerman S, et al. Efficacy of a hip protector to prevent hip fracture in nursing home residents: the HIP PRO randomized controlled trial. JAMA 2007; 298(4): 413-22.</p> <p>6. Bauchner H and Fontanarosa PB. Expression of Concern: Kiel et al. Efficacy of a hip protector to prevent hip fracture in nursing home residents: the HIP PRO randomized controlled trial. JAMA. 2007;298(4):413-422. JAMA 2012; 308(23): 2519.</p> <p>7. Kannus P, Palvanen M, Niemi S, et al. Increasing number and incidence of fall-induced severe head injuries in older adults: nationwide statistics in Finland in 1970-1995 and prediction for the future. Am J Epidemiol 1999; 149(2): 143-50.</p> <p>8. Forsen L, Sogaard AJ, Sandvig S, et al. Risk of hip fracture in protected and unprotected falls in nursing homes in Norway. Inj Prev 2004; 10(1): 16-20.</p> <p>9. Cameron ID, Cumming RG, Kurrle SE, et al. A randomised trial of hip protector use by frail older women living in their own homes. Inj Prev 2003; 9(2): 138-41.</p> <p>10. Robinovitch SN, Evans SL, Minns J, et al. Hip protectors: recommendations for biomechanical testing--an international consensus statement (part I). Osteoporos Int 2009; 20(12): 1977-88.</p>	
Sheffield Teaching Hospital Foundation Trust	Full	General (but also section 2 and 3.3.5 "Other considerations")	General Plus p21 & 31	<p>The original guidance does not distinguish between community and inpatient falls. One of the key elements of the guidance that:</p> <p><i>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. (1.2.1.1)</i> now appears only in the community section. We already know (e.g. from National Falls and Bone Health audits) that onward referral to community led falls services from acute inpatient settings is poor and that many preventable falls continue to occur. The guidance as presented in this draft makes a clear distinction between inpatient and community falls as if these were unrelated. By limiting the routine questioning regarding falls to the community setting, a large number of patients presenting to inpatient settings who could benefit from</p>	<p>The guideline developer does not have the remit to update the original guideline, and so the recommendations for older inpatients were developed separately from the existing recommendations.</p> <p>However, we have amended the guideline text and now refer to recommendations for all older people (instead of 'community setting') and additional</p>

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				<p>multifactorial falls risk assessment and intervention may well be missed. Lack of timely intervention could result in further falls and increased fracture rates and hospitalisation. For example, a patient could be admitted with a UTI or chest infection, not having had a fall which caused this admission, but routine questioning in this setting could identify a history of several falls which would warrant further investigation in the community environment once discharged. The draft guidance does not set out a provision for this to occur and could be a key omission. Indeed, the referral pathway chart in section 2 only makes provision for opportunistic case finding once discharge has occurred. I am concerned that professionals in the inpatient setting will feel “let off the hook” as the wording stands and feel it is not their responsibility to identify falls risk and make appropriate onward referrals.</p> <p>Another example would be a patient who has had six falls with loss of consciousness and undergoes cardiac pacing. The medical falls risk has been identified and modified but associated fear of falling and impact on independence and quality of life may warrant further intervention in the community setting. Again, this person could be lost to follow up if the current wording remains.</p> <p>While the focus on inpatient falls and falls prevention is welcome, I feel that some extra wording to identify the links between inpatient and community falls risk and to encourage the consideration of onward referral to community falls services on discharge would further enhance this guidance</p>	<p>recommendations for older inpatients (instead of inpatient setting). We hope that this better describes the continuation of the patient pathway. The algorithm in section 2 of the full guideline has also been amended to reflect this.</p>
Sheffield Teaching Hospital Foundation Trust	Full	1.1.1	11	Appropriate for inpatients in acute stage of illness to be assessed for risk in hosp setting where they could be confused or disorientated.	Thank you for your comment.
Sheffield Teaching Hospital Foundation Trust	Full	3.3.5	30	Would it be beneficial to clarify who is to carry out the “good routine clinical assessment” and when? There is a risk of over-reliance on doctors to carry out this assessment, which may not occur in a timely fashion (initial medical assessment will focus on the immediate acute need). It might be helpful to state the professionals who might make this clinical assessment e.g. appropriately trained nursing staff, physiotherapists or occupational therapists.	<p>We would expect this recommendation to be appropriate for all staff involved in the care of older people – this may be doctors, nursing staff, physiotherapists, occupational therapists and others.</p> <p>As with many clinical guidelines, we have not made</p>

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					recommendations specific to the role of any particular healthcare professional in order to facilitate local implementation.
Sheffield Teaching Hospital Foundation Trust	Full	3.3.6	31	I feel it would be useful to have all people over age 65 attending Hosp considered for appropriateness of Multifactorial risk assessment. Treatment could be started at a much earlier stage for most.	The recommendation in 1.1.1.1 (now 1.2.1.2) states that all people aged over 65 attending hospital should be considered at risk of falling, and recommendation 1.1.2.2. (now 1.2.2.2.) states that all people at risk of falling should be considered for a multifactorial assessment. The guideline currently supports your comments.
STARS	NICE version	General	General	For clinicians we would recommend a summary/care pathway of these guidelines to show clinicians how to apply the guidelines in practice.	A one sided algorithm is contained in the full guideline (see section 2). In addition, this guideline will be supported by an interactive tool (called Pathways) which is available on the NICE website. The Pathways bring together all related NICE guidance in an easy to access format for use by healthcare professionals and members of the public.
STARS	Full	General	General	We would recommend including a statement on the importance multifactorial assessment results being shared with a patient's GP.	A new recommendation has been added to the guideline (recommendation 1.2.3.2) to signpost readers to the Patient experience in adult NHS services guideline (CG138) which covers information sharing.
STARS	Full	1.1.1.1	9	STARS welcomes the inclusion of syncope and need for multifactorial assessments. We would recommend that the list of multifactorial	Thank you for your comment.

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				assessments should be included- For example, what multifactorial assessments should be used in the assessment?	The guideline does not recommend a specific 'type' of multifactorial assessment. Instead, routine hospital assessments should be used to identify factors that can be treated managed or improved during the patients expected hospital stay. Some examples of the factors that routine assessment should cover is provided in recommendation 1.2.2.3 (previously recommendation 1.1.2.3)
STARS	Full	1.1.1.1	11	Agree with comment that patients with syncope should be considered at high risk of falls in hospital.	Thank you for your comment.
STARS	Full	1.1.2.1	11	We agree with this addition.	Thank you for your comment.
STARS	Full	1.1.3.1	13	Point 6 – Agree. Also recommend hospitals are equipped to signpost patients to appropriate organisations.	It is beyond the remit of NICE to signpost to other organisations.
STARS	Full	1.1.2.2	11	Agree.	Thank you for your comment.
STARS	Full	1.1.2.3	12	We would recommend adding syncope to the list.	Syncope syndrome has been added to the list.
STARS	Full	1.1.2.3	9	Point 26 – We would recommend adding syncope to the list.	Syncope syndrome has been added to the list.
STARS	Full	1.2.2.5	12	Agree	Thank you for your comment.
Tees Esk and Wear NHS Foundation Trust	Full	General	General	Very happy with this proposed guidance. It reflects the trusts falls pathway and its slips trips and falls policy. Very happy that it is now including those people 50+ years in inpatients	Thank you for your comment.
The College of Optometrists and the Optical Confederation	NICE	Key priorities for implementation	8	We are pleased to see that visual impairment is now included as a key priority.	Thank you for your comment.
The	NICE	1.1.2.1	10	We agree with this suggestion. We would also suggest having a	Your comment relates to the

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College of Optometrists and the Optical Confederation				recommendation for appropriate contrast between, for example, level changes (such as steps) and flat flooring, to help people with visual impairment recognise that there is a hazard that needs negotiating.	environmental design of hospitals. No evidence was identified that met the inclusion criteria in relation to this and so the GDG have made a research recommendation in this area as it is an important area to consider.
The College of Optometrists and the Optical Confederation	NICE	1.1.2.3	11	We are pleased to see the inclusion of visual impairment. This should include an assessment visual acuity and visual field.	We agree with your suggestion and feel that the current wording of the recommendations includes an assessment of visual field and acuity.
The College of Optometrists and the Optical Confederation	Full	1.1.2.3	12 line 9.	<p>We strongly welcome and support the inclusion of visual impairment as a risk factor to identify then treat, improve or manage during patients' stay. There is significant evidence to demonstrate the link between visual impairment falls and fractures.</p> <p>References College of Optometrists and The British Geriatric Society. <i>The importance of vision in preventing falls</i>, available from http://tinyurl.com/vision-falls. Accessed 11.2.2013. Abdelhafiz, A.H. and Austin, C.A Visual factors should be assessed in older people presenting with falls or hip fracture <i>Age and Ageing</i> 2003 32(1), 26-30 Ivers RQ, Cumming RG, Mitchell P et al. Visual impairment and falls in older adults: the Blue Mountains Eye Study. <i>J. Amer Ger. Soc.</i> 1998 46(1): 58-64 Cummings SR. Treatable and untreatable risk factors for hip fracture. <i>Bone</i> 1996 18(3 suppl): 165S-167S Jack DI, Smith T, Neoh C et al. Prevalence of low vision in elderly patients admitted to an acute geriatric unit in Liverpool: elderly people who fall are more likely to have low vision <i>Gerontology</i> 1995 41(5), 280-5 Patino CM, McKean-Cowdin R, Azen SP et al Central and peripheral visual impairment and the risk of falls and falls with injury <i>Ophthalmology</i> 2010 117(2) 199-206 Knudtson MD, Klein BE, Klein R Biomarker of aging and falling: the Beaver Dam eye study <i>Arch Gerontol Geriatr</i> 2009 49(1) 22-26</p>	Thank you for your comment.

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				<p>Kuang TM, Tsai SY, Hsu WM et al Visual impairment and falls in the elderly: the Shihpai Eye Study <i>J Chin Med Assoc</i> 2008 71(9) 467-72</p> <p>Kulmala J, Era P, Parssinen O et al Lowered vision as a risk factor for injurious accidents in older people <i>Aging Clin Exp Res</i> 2008 20(1) 25-30</p> <p>Lamoureux EI, Chong E, Want JJ et al Visual impairment, causes of vision loss, and falls; the Singapore Malay eye study <i>Invest Ophthalmol Vis Sci</i> 2008 49(2) 528-33</p> <p>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 <i>J Bone Miner Res</i> 2004 19(9) 1539-47</p> <p>Coleman AL, Stone K, Ewing SK et al Higher risk of multiple falls among elderly women who lose visual acuity <i>Ophthalmology</i> 2004 111(5) 857-62</p>	
The College of Optometrists and the Optical Confederation	NICE	1.1.2.4	11	Some causes of visual impairment, such as uncorrected refractive error, can easily and quickly be treated. Others, such as cataract, can be treated but this may take longer. Patients should still be given the opportunity to have remedial visual impairment treated, even if it cannot be done during the patient's expected stay in hospital. We would therefore recommend that if the risk factors cannot be treated during the patient's expected stay, the patient should still be given the option of having the problem itself treated before leaving hospital to reduce the likelihood of the patient falling when discharged from inpatient care.	Any intervention where the benefit will not be achieved during the inpatient stay falls into the remit of the community section. There is no remit to amend any of the existing recommendations for this section; therefore your suggestion will not be included.
The College of Optometrists and the Optical Confederation	NICE	2.1	18	We would suggest that contrast also be considered, as this can help people with visual impairment to navigate in their surroundings. This would include dark toilet seat covers on white toilets, so that the patient can see where the seat is, and whether it is up or down, and dark edges on stairs, so that the patient can see that there are stairs there.	Your comment relates to the environmental design of hospitals. No evidence was found in relation to this and so the GDG have made a research recommendation in this area as it is an important area to consider.
The College of Optometrists and the Optical Confederation	Full	3.6	86	We agree that there is a lack of evidence about how the clinical environment can be improved to reduce the risk of falls amongst patients with visual loss. We welcome the call for further research in this area and will consider how to incorporate this recommendation in our research programme.	Thank you for your comment
The	Full	General	Gener	The Limbless Association are pleased to take part in NICE's consideration of	Thank you for your comments.

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limbless association			al	<p>falls both in and out of hospital. However we note that there does not appear to have been any consideration of the part that Prosthetic limbs play in falls experienced by amputees.</p> <p>Firstly can I say that there is a misconception amongst some medical professionals and politicians that after an amputation you are given a prosthetic limb and you are back to normal. Having lost my left leg above the knee at the age of 3, and I am now age 66, I can state categorically from both my own experiences and as Chairman of the Limbless Association that this is sadly a serious misconception and nothing could be further from the truth.</p> <p>Firstly there are no accurate figures for amputees in the UK and the best figures available suggest that there are between 60,000 – 70,000 amputees.</p> <p>Apart from accidents and war injuries where amputations are traumatic (urgently undertaken to save life). Other amputations including those for congenital deformities are planned with the majority of amputations occurring due to diabetic and vascular problems and in the main tend to affect the 50+ age group.</p> <p>Initially after a lower limb (leg) amputation the biggest danger is that the sleeping patient, dreams that they still have both their legs, wakes up, throws back the covers and tries to stand or walk and falls. This can also occur a long time after the amputation. Most amputees at suffer phantom pains which are very severe, can reduce them to tears and in some cases make them consider suicide</p> <p>After an amputation/s patients are given a wheelchair to help them get around. Unfortunately many wheelchair recipients are living in non-adapted accommodation which means they can be trapped in one room and unable to get to the toilet, answer the door or even make a cup of tea. Indeed from a Health and Safety point of view they would be unable to escape unaided in the event of a fire.</p> <p>Unfortunately some amputees are never given a prosthetic limb and there</p>	<p>People with prosthetic limbs and amputees were considered in the guideline and the recommendations include this group of people.</p> <p>Although no specific evidence was found, the recommendations of this guideline do apply to people with prosthetic limbs and amputees.</p> <p>The guideline text has been amended to make this clearer to readers (see section 4.4.5 'Other considerations')</p> <p>Some of your comments (for example, badly fitting prosthetics or alternatives to plastic prosthetics) relate to issues outside the scope of this guideline. Because of this they cannot be dealt with by a generic guideline on falls prevention.</p>

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				<p>can be many reasons for this. One of the main problems I have found is an allergic reaction or intolerance to the plastics and other materials used to make the present day sockets. I am concerned that many amputees are reacting badly to their sockets. As the prosthetic services no longer has the trades people or the skills to work in wood and metal limbs this could result in some amputees being given a wheelchair and effectively be written off.</p> <p>What of those who are given prosthetic limbs? Well firstly their prosthetic limbs need to have a properly fitting socket and this is where most problems occur. If the socket does not fit properly and they seldom do then it will rub the stump causing pain, blisters, sores, infections. This is bad enough in those with a below knee amputation, but for those with above knee and through hip amputations the socket weight bearing and pressure sores mainly occur in the groin area.</p> <p>Many amputees are now being given one prosthetic limb and no spare which means in some cases they may have to wait up to a month for a repair when it breaks down.</p> <p>Even when a socket is a good fit the stump fluctuates and changes volume due to swelling, reduction, fluid loss, muscular fluctuation, weight loss or gain, the weather, heat, cold, reaction to the socket, walking, sitting and standing.</p> <p>As stated this is the effect experienced by a single below knee amputee who has their own knee and is only missing their ankle joint.</p> <p>For single leg amputees who have an above knee or through hip amputation and rely on an artificial limb (let's call it what it actually is it is not real and can never replace the original) with ankle and knee mechanisms. Problems occur when the other components of the artificial limb is assembled and the limb needs to be set up properly. Due to the varying camber of pavements it is virtually impossible to set up a prosthetic limb except when a top of the range knee unit is fitted. Without this being done amputees often catch their prosthetic foot on the uneven pavement and stumble often twisting and</p>	

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				<p>jarring their back. For amputees without top of the range limbs this can be even worse than a fall, especially for taller amputees.</p> <p>A few lower limb (leg) amputees have top of the range prosthetic limbs (only available to a select few NHS amputees, military amputees in recent conflicts, those with money and those who have this awarded as part of a compensation payment) and these in the event of a fall will lower the amputee slowly preventing serious injury.</p> <p>It has to be remembered that someone wearing only one prosthetic limb does not have the benefit of nerve functions providing feedback to the brain in the same manner as experienced by those with their own limbs. This causes them to misjudge their environment, inadvertently stumble, kick furniture, kick people, stand on things (including other people's feet), trip and fall.</p> <p>Rough ground, pavement camber, sensory slabs at road crossings, slopes, stones are all hazards and painful to walk on and can upset the balance of lower limb (leg) amputees. Freshly mopped and highly polished floors, petrol station forecourts, snow and ice are all no go areas for lower limb amputees.</p> <p>Many amputees have other disabilities and some have multiple amputations. Those with upper limb (arm) amputations can also lose their balance become disoriented or try to catch on to something to prevent a fall forgetting that their limb is no longer there.</p> <p>I would therefore urge that NICE take the unique problems of amputees into consideration when considering the effect of falls in and out of hospital.</p>	
The Society and College of Radiographers	Full	General	General	Whilst we accept that it is aimed at mainly older patients is there guidance for those younger who are prone to falls in care homes due to ataxia conditions etc ?	We acknowledge that people below the age of 50 are also at risk of falls. However, the remit we received from the Department of Health was to develop a guideline for the assessment and prevention of falls specifically for older people.
University	NICE/	general	genera	Outcomes should be demonstrated against evidence base for example,	Thank you for your comment.

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Hospitals Birmingham NHS Foundation Trust	Full		I	ECG's Lying and standing B.P's, urinalysis, footwear and access to walking aids	
University Hospitals Birmingham NHS Foundation Trust	NICE/ Full	general	general	In hospital institutions there should be guidance as to the level of involvement of senior executive and multidisciplinary representation on falls steering groups, there should also be guidance in regards to their accountabilities.	Whilst we acknowledge the importance of your comment, it was not in the scope of the update to address this area. It is anticipated that the area you raise will be addressed in the Older people with multiple morbidities guidance, which is currently being scheduled into the NICE work programme.
University Hospitals Birmingham NHS Foundation Trust	NICE/ Full	general	general	The data collection should be standardised for all care sectors and made clear in the guidance in regards to what is a reportable incidences, for example RIDDOR, where all but digits are reported. Other Trusts have defined a major injury for example fractured neck of femur, sub/extra dural haematomas. Therefore there is real inconsistencies and potential for misrepresentation of benchmarking against Trusts who have a positive reporting culture. Harm as well as falls rates should be reported in terms of harm per 1000 bed days to take into account activity.	We acknowledge the importance of accurate and standardised data collection, but it is beyond the remit of NICE clinical guidelines to make recommendations about standardised data collection. The implementation and audit teams at NICE may be able to offer support for data collection and your comments will be passed on to them.
University Hospitals Birmingham NHS Foundation Trust	NICE/ Full	general	general	The detail of data collection should be clear and transparent, in Birmingham we have written falls and fracture prevention into the specification for commissioning of care to nursing and residential care, to improve the consistency of what data is expected to be reported.	The implementation and audit teams at NICE may be able to offer support for data collection and your comments will be passed on to them.
University Hospitals	NICE/ Full	general	general	The Safety Thermometer has demonstrated the complexity of collating data as not all Trusts have reported in the same way, with 'some' vs. 'all' patient	The implementation and audit teams at NICE may be able to

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Birmingham NHS Foundation Trust				cohorts. The processes and what data should be clear to prevent misinterpretation.	offer support for data collection and your comments will be passed on to them.
University Hospitals Birmingham NHS Foundation Trust	NICE/ Full	general	general	For acute hospitals I would like to see the guidance be clear in regards to improved coding of attendees in the Emergency Department and how this is communicated to the G.P. There should also be improved coding of patients who have been assessed at risk or who have fallen whilst in the setting.	The implementation and audit teams at NICE may be able to offer support for data collection and your comments will be passed on to them.
University Hospitals Birmingham NHS Foundation Trust	NICE /Full Full	General 3.1	General Page 22 lines 13,16	The definition of what a fall is should be defined, I am aware of slips from chair/bed being excluded from falls data	The definition of a fall is provided in the glossary. All studies reporting falls that met the inclusion criteria, regardless of how they were defined were included in this guideline. The way in which each study defined a fall is documented in the evidence tables in appendix E.
University Hospitals Birmingham NHS Foundation Trust	NICE Full	1.1.3 3.5 (and general)	11-12 79 (and general)	The Francis report has made it clear that there is a duty of candour in regards to adverse events, the guidance should reflect this with an integral process to family/N.O.K being informed when a fall occurs (with patient's permission, as applicable). This should also include sharing of investigations following a fall with harm with the patient and/or family.	A new recommendation has been added to the guideline (recommendation 1.2.3.2) to signpost readers to the Patient experience in adult NHS services guideline (CG138) which covers information sharing.