NATIONAL INSTITUTE FOR HEALTH AND CLINICAL EXCELLENCE

GUIDELINES EQUALITY IMPACT ASSESSMENT FORM RECOMMENDATIONS

As outlined in the guidelines manual NICE has a duty to take reasonable action to avoid unlawful discrimination and promote equality of opportunities. The purpose of this form is to document that equalities issues have been considered in the recommendations of a clinical guideline.

Taking into account **each** of the equality characteristics below the form needs:

- To confirm that equality issues identified in the scope have been addressed in the evidence reviews or other evidence underpinning the recommendations
- To ensure the recommendations do not discriminate against any of the equality groups
- To highlight areas where recommendations may promote equality.

This form is completed by the National Collaborating Centre and the Guideline Development Group **for each guideline** before consultation, and amended following consultation to incorporate any additional points or issues raised by stakeholders.

The final version is submitted with the final guideline, signed by the NCC Director and the Guideline Development Group (GDG) Chair, to be countersigned by the GRP chair and the the guideline lead from the Centre for Clinical Practice.

EQUALITY CHARACTERISTICS
Sex/gender • Women • Men
Ethnicity • Asian or Asian British • Black or black British • People of mixed race • Irish • White British • Chinese • Other minority ethnic groups not listed
Disability • Sensory • Learning disability • Mental health • Cognitive • Mobility • Other impairment
Age[1] • Older people • Children and young people • Young adults [1.] Definitions of age groups may vary according to policy or other context.
Sexual orientation & gender identity • Lesbians • Gay men • Bisexual people • Transgender people
Religion and belief
Socio-economic status Depending on policy or other context, this may cover factors such as social exclusion and deprivation associated with geographical areas (e.g. the Spearhead Group of local authorities and PCTs, neighbourhood renewal fund areas etc) or inequalities or variations associated with other geographical distinctions (e.g. the North/South divide, urban versus rural).
Other categories[2] • Gypsy travellers • Refugees and asylum seekers • Migrant workers • Looked after children • Homeless people [2.] This list is illustrative rather than comprehensive.

GUIDELINES EQUALITY IMPACT ASSESSMENT FORM: RECOMMENDATIONS

Guideline title: Falls

1. Have the equality areas identified in the scope as needing attention been addressed in the guideline?

Please confirm whether

- the evidence reviews addressed the areas that had been identified in the scope as needing specific attention with regard to equalities issues.

Please note this also applies to consensus work in or outside the GDG

- the development group has considered these areas in their discussions

Note: some issues of language may correlate with ethnicity; and some communication issues may correlate with disability

The main equality issue identified during scoping was with respect to the equality characteristic of age. Our remit has been to develop an extension to clinical guideline 21 which would consider groups aged 65 years and older and those people aged 50-64, who may have underlying conditions which put them at greater risk of falling within the inpatient setting.

The first evidence review undertaken looked at which screening tools or processes should be used to identify modifiable and non-modifiable risk factors for falling for patients in hospital and whether this varied by setting. Through guideline development group (GDG) interpretation of the included evidence and expertise, the GDG felt that the screening tools assessed did not have enough accuracy and believed that currently there was no way of predicting the risk of falling for the populations considered within this extension to the guideline. It was felt that all inpatients aged 50-64 years old and identified as at risk of falling by a clinician and all patients aged 65 years and older should have their care managed as if they are at risk of falling.

The second evidence review conducted looked at interventions to reduce older patients' risk of falling and/ or the severity of a fall in hospital, compared with usual care and whether this differed by inpatient setting. The GDG considered the various inpatient settings which emerged within the evidence base. The GDG felt that many older inpatients will have multiple risk factors for falling, and so single interventions were unlikely to work. The GDG felt that the evidence for multifactorial falls risk interventions was stronger. There were 2 main elements to most multifactorial interventions from the evidence reviewed that the GDG felt were significant for patients at risk of falling in hospital; general improvements to the inpatient environment (such as adequate lighting, handholds, etc.), and targeted multifactorial interventions that link to each patient's own multifactorial assessment.

The third evidence review carried out looked at education and information needs of patients and their family members and carers after a hospital-based falls risk assessment, or a fall in hospital. The GDG discussed the need to provide information to patients and their family members and carers that is relevant and useful. However, the GDG recognised that the ability of some patients (such as those with memory problems or cognitive impairment) to understand and retain information may be compromised. Qualitative evidence identified that patients and their families and carers are often unaware of the patient's fall risk, and that some patients who are aware of their increased falls risk feel they are burdening staff if they ask for help. The GDG felt that this was an accurate reflection of the inpatient experience and wanted to emphasise the need for healthcare

professionals to provide consistent explanations about the patient's individual risk factors for falling and encourage them to ask for help when moving around the hospital. One recommendation was made in this area to highlight the important aspects of information and support for inpatients at risk of falling and to specify that this should take into account the ability of the patient's to understand and retain information.

2. Do any recommendations make it impossible or unreasonably difficult in practice for a specific group to access a test or intervention?

For example:

- Does access to the intervention depend on membership of a specific group?
- Does using a particular test discriminate unlawfully against a group?
- Do people with disabilities find it impossible or unreasonably difficult to receive an intervention?

➢ Other than the issue(s) identified below, none of the recommendations within the guideline make it impossible or unreasonably difficult in practice for the population covered by the guideline to access an intervention, information and support.

As part of the first evidence review, the GDG decided upon a 'do not do' recommendation for the use of numerical fall risk screening tools to predict inpatients' risk of falling in hospital, this avoids any discrimination in terms of one person receiving screening over another. A second recommendation which came out of this review also states which groups of inpatients should be regarded as being at risk of falling in hospital. This includes all patients aged 65 years and older or patients aged 50 – 64 identified by a clinician as being at higher risk of falling. Examples of underlying pathologies which may increase risk of falling within the 50—64 age group are given but are not restricted to those listed.

3. Do the recommendations promote equality?

Please state if the recommendations are formulated so as to promote equalities, for example by making access more likely for certain groups, or by tailoring the intervention to specific groups?

The recommendations are worded and formulated to promote equalities whilst taking into account patient's needs and preferences. The new recommendations cover all inpatients irrespective of gender, ethnicity, disability, religion or beliefs, sexual orientation and gender identity or socio-economic status who are 65 years and older or 50-64 years and identified by a

clinician as being at risk of falling. Where recommendations are specific to a certain age group at risk of falling in hospital, this distinction has been clearly made.

Providing recommendations for older people at risk of falls in hospital has addressed a previously large gap in guidance on falls. There are now recommendations which will address inpatient risk of falling and interventions to reduce risk of falling as well as for community-dwelling older people.