Appendix L – Deleted text from Section 4

All text in this appendix has been deleted from section 4 of the guideline.

Introduction

Executive summary

A version for health professionals (NICE version) and a version for patients and carers (Information for the public) are also available.

Principles of practice and summary of guideline recommendations

Principles of practice

The principles outlined below describe the ideal context in which to implement the recommendations in this guideline. These have been adapted from the NICE clinical practice guideline: Pressure ulcer prevention (2003). These principles were submitted to a consensus process and were refined, following Guideline Development Group feedback.

Person-centred care

- Patients and their carers should be made aware of the guideline and its recommendations and be referred to NICE's version, Information for the public.
- Patients and their carers should be involved in shared decision-making about individualised falls prevention strategies.
- Health care professionals are advised to respect and incorporate the knowledge and experience of people who have been at long-term risk of falling and have been self-managing this risk.
- Patients and their carers should be informed about their risk of falling, especially when they are transferred between care settings or discharged home from hospital settings.

A collaborative multidisciplinary approach to care

- All members of the multidisciplinary team should be aware of the guideline and all care should be documented in the patient's health care records.

Organisational issues

- An integrated approach to falls prevention with a clear strategy and policy should be implemented. It should be operationally linked to bone health (osteoporosis) and cardiac pacing services in such a way as to avoid duplication.
- Care should be delivered in a context of continuous quality improvement, where improvements to care following guideline implementation are the subject of regular feedback and audit.
- Commitment to and availability of education and training are needed to ensure that all staff, regardless of profession, are given the opportunity to update their knowledge base and are able to implement the guideline recommendations.
- Patients should be cared for by personnel who have undergone appropriate training and who know how to initiate and maintain correct and suitable preventative measures. Staffing levels and skill mix should reflect the needs of patients.

Audit support within guideline

The guideline provides audit criteria and advice (see page 80).

Audit criteria

The audit criteria below are to assist with implementation of the guideline recommendations. The criteria presented here are considered to be the key criteria associated with the guideline recommendations. They are suitable for use in primary and secondary care, for all patients at risk of falling or who are known fallers.

Possible objectives for an audit

Audits can be carried out in different care settings to ensure that individuals who are known fallers or at risk of falling are offered appropriate information, assessment and interventions aimed at reducing the incidence of falls and are involved in decisions about their care having been informed about the rationale for falls assessment and prevention.

People that could be included in an audit

An audit could be conducted in settings where people are known to be at high risk of falling, for example those who attend A&E with fall-related trauma and within extended care settings.

Data sources and documentation of audit

Systems for recording the necessary information, which will provide data sources for audit, should be agreed by trusts. Whatever method is used for documentation, the processes and results of assessment and planned interventions should be accessible to all members of the multidisciplinary team. In relation to assessment, this should include the name of the assessment tool or process used.

Documentation of the factors taken into consideration when deciding the most appropriate intervention should occur. In addition, the reasons for any changes in the intervention should also be documented.

The fact that carers and patients have been informed about falls prevention should be documented. Patients and carers should be directly questioned about their satisfaction with, and the adequacy of, the information provided and this should be documented in either the patient notes or in another source as agreed by the trust.

Trusts should establish a system of recording when relevant staff have been educated in falls assessment and prevention and should implement a process for reviewing education needs relating to this topic.

Measures that could be used as a basis for an audit

The table below suggests measures that could be used as a basis for audit.

Criterion	Exception	Definition of terms
1. Case/risk identification Health care professionals routinely ask older people in their care about previous falls.	None	Older people will be asked if they have fallen in the past year, and about the frequency, context and characteristics of the fall.
Older people with a history of falling or considered at risk of falling are observed for gait and balance problems and considered for interventions to improve strength and balance.	None	
2. Interventions to prevent falls Older people presenting to a health care professional because of a fall or reporting recurrent falls in the past year should be offered a multifactorial falls assessment and be considered for individualised multifactorial interventions.	Those patients who decline particular interventions	Multifactorial assessment may include the following: • identification of falls history • assessment of gait, balance and mobility, and muscle weakness • assessment of osteoporosis risk • assessment of the older person's perceived functional ability and fear relating to falling • assessment of visual impairment • assessment of cognitive impairment and neurological examination • assessment of urinary incontinence • assessment of home hazards • cardiovascular examination and medication review.
• All older people with recurrent falls or assessed as being at increased risk of falling are considered for an individualised multifactorial intervention.	None	In successful multifactorial intervention programmes the following specific components are common: • strength and balance training • home hazard assessment and intervention • vision assessment and referral • medication review with modification/withdrawal.
3. Rehabilitation Following treatment for an injurious fall, older people should be offered an assessment to identify and address future risk and tailored intervention aimed at promoting independence and improving physical function.	None	
4. Education and information giving Older people at increased risk of falls are offered information on reducing risk of falls and appropriate interventions.	None	Information may be given orally or in writing.
5. Health care professionals caring for older people are trained in: • falls risk assessment • appropriate referral of people at increased risk of falls • measures to decrease the likelihood of falls.	None	

Clinicians should review the findings of measurement, identify whether practice can be improved, agree on a plan to achieve any desired improvement and repeat the measurement of actual practice to confirm that the desired improvement is being achieved.

Dissemination

The guideline will be produced in a full and summary format and a version for the public (Information for the public).

Full copies of the guideline will be available through the NICE website (http://www.nice.org.uk) in PDF format and summary through the National Electronic Library for Health NeLH (http://www.nelh.nhs.uk/) and National Guideline Clearinghouse (http://www.guidelines.gov).

Scheduled review of guideline

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