NICE National Institute for Health and Care Excellence

NICE quality standard

Falls

Quality standard
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Contents

This standard is based on NG249.

This standard should be read in conjunction with QS14, QS15, QS16, QS63, QS71, QS74, QS87, QS2, QS136, QS137, QS149, QS153, QS164 and QS166.

Quality statements

Statement 1 People aged 50 to 64 with 1 or more factors that could increase their risk of falls and people aged 65 or over are asked about the details of any falls when they attend appointments or assessments in community or hospital settings. **[2017, updated 2025]**

Statement 2 People aged 50 to 64 with 1 or more factors that could increase their risk of falls and people aged 65 or over have a comprehensive falls assessment if they meet the criteria for a comprehensive falls assessment. **[2017, updated 2025]**

Statement 3 People aged 50 to 64 with 1 or more factors that could increase their risk of falls and people aged 65 or over have tailored interventions that address their individual risk factors if they need comprehensive falls management to reduce their risk of falling. **[2017, updated 2025]**

Statement 4 People who fall during a hospital stay are checked for signs or symptoms of fracture and potential for spinal injury before they are moved. **[2015]**

Statement 5 People who fall during a hospital stay and have signs or symptoms of fracture or potential for spinal injury are moved using safe manual handling methods. **[2015]**

Statement 6 People who fall during a hospital stay have a medical examination. **[2015]**

Statement 7 This statement has been removed. For more details, see update information.

Statement 8 This statement has been removed. For more details, see update information.

Statement 9 This statement has been removed. For more details, see update information.

Quality statement 1: Asking people about falls

Quality statement

People aged 50 to 64 with 1 or more factors that could increase their risk of falls and people aged 65 or over are asked about the details of any falls when they attend appointments or assessments in community or hospital settings. **[2017, updated 2025]**

Rationale

A history of falls in the last year is the single most important risk factor for falls and is a predictor of further falls. Health and social care practitioners have regular contact with people across a wide range of settings, including in people's homes. By asking questions about falls and their context when someone presents after a fall, and opportunistically in appointments including, for example, assessments and reviews, health and social care practitioners can identify people who may be at risk of falling.

Quality measures

The following measures can be used to assess the quality of care or service provision specified in the statement. They are examples of how the statement can be measured, and can be adapted and used flexibly.

Process

Proportion of people aged 50 to 64 with 1 or more factors that could increase their risk of falls and people aged 65 or over attending appointments or assessments in community or hospital settings who were asked about falls.

Numerator – the number in the denominator who were asked about falls.

Denominator – the number of people aged 50 to 64 with 1 or more factors that could increase their risk of falls and people aged 65 or over attending appointments or

assessments in community or hospital settings.

Data source: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example, from patient records.

What the quality statement means for different audiences

Service providers (such as primary, community and secondary healthcare services and social care providers) ensure that appointments and assessments for people aged 50 to 64 with 1 or more factors that could increase their risk of falls and people aged 65 or over include questions about falls and their context; hospitals ensure that attendance procedures include questions about falls for people aged 50 to 64 with 1 or more factors that could increase their risk of falls and people aged 65 or over; and community health and social care providers ensure that protocols and training are in place for health and social care practitioners to ask people about falls and their context as part of assessments, appointments and health checks.

Health and social care practitioners (such as doctors, GPs, nurses, practice nurses, pharmacists, district nurses, physiotherapists, occupational therapists and social workers) ask people aged 50 to 64 with 1 or more factors that could increase their risk of falls and people aged 65 or over attending for appointments and assessments whether they have fallen in the last year; about the frequency, context and characteristics of any falls, including whether they were injured or lost consciousness and whether they were able to get up independently.

Commissioners ensure that they commission services that make every contact count by addressing falls prevention as part of appointments and assessments.

People aged 50 to 64 with 1 or more factors that could increase their risk of falls and people aged 65 or overwho are seen by a health or social care practitioner are asked about falls when they have an appointment (for example, a routine check-up) or if they attend for urgent or emergency care. This should include being asked if they have fallen in the last year, how many times this has happened, what caused them to fall and what happened when they fell.

Source guidance

Falls: assessment and prevention in older people and in people 50 and over at higher risk. NICE guideline NG249 (2025), recommendation 1.1.2

Definitions of terms used in this quality statement

Factors that could increase the risk of falls

Factors that could increase the risk of falls include long-term health conditions that impact on a person's daily life such as arthritis, dementia, diabetes or Parkinson's disease; having had a stroke; and having a learning disability. [NICE's guideline on falls, terms used in this guideline; factors that could increase the risk of falls]

Fall

A fall is defined as an unexpected event which causes a person to rest on the ground, floor or lower level. [Adapted from NICE's guideline on falls; evidence review B, table 1]

Appointments or assessments

Scheduled appointments or assessments for urgent or emergency care where no accommodation or hospital admission is involved. This includes reviews for chronic conditions, medication reviews, annual flu vaccinations, NHS Health Checks, assessments of care and support needs, attendance at hospital outpatient clinics, emergency departments and minor injuries units. [Expert opinion]

Equality and diversity considerations

Some subgroups of the population (such as people who are not registered with a GP, people in traveller communities or people who are homeless) may not be in regular contact with health and social care services. Practitioners should take every opportunity to ask about falls history when people from these groups present, so that they can make every contact count.

Quality statement 2: Comprehensive falls assessment

Quality statement

People aged 50 to 64 with 1 or more factors that could increase their risk of falls and people aged 65 or over have a comprehensive falls assessment if they meet the criteria for a comprehensive falls assessment. **[2017, updated 2025]**

Rationale

A comprehensive falls assessment allows a person's individual falls risk factors to be identified. This assessment is often carried out by a specialist falls service, but it can also be undertaken in other settings that have appropriate governance arrangements and professionals with skills and experience in falls prevention. Individual components of the assessment may be undertaken by different healthcare professionals in primary care services, community teams or specialist outpatient clinics (such as falls or geriatric outpatient services or assessment units). The person's individual risk factors identified in the comprehensive falls assessment should inform tailored interventions to reduce the risk of falls.

Quality measures

The following measures can be used to assess the quality of care or service provision specified in the statement. They are examples of how the statement can be measured, and can be adapted and used flexibly.

Process

Proportion of people aged 50 to 64 with 1 or more factors that could increase their risk of falls and people aged 65 or over who have a comprehensive falls assessment if they meet the criteria for a comprehensive falls assessment.

Numerator – the number in the denominator who have had a comprehensive falls

assessment.

Denominator – the number of people aged 50 to 64 with 1 or more factors that could increase their risk of falls and people aged 65 or over who meet the criteria for a comprehensive falls assessment.

Data source: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example, from patient records. The Healthcare Quality Improvement Partnership (HQIP) Falls and fragility fracture audit National Audit of Inpatient Falls reports data on whether people who have had an inpatient fall that resulted in a femoral fracture had a multifactorial assessment to optimise safe activity (previously known as multifactorial falls risk assessment) documented and how many days prior to the fall this had been undertaken or updated. The audit also reports data on whether an assessment of vision, measurement of lying and standing blood pressure, medication review, delirium assessment, mobility assessment and assessment of continence was documented during the admission when the fall occurred.

Outcome

Injuries due to falls in people aged 65 and over (age-sex standardised rate of emergency hospital admissions for injuries due to falls in people aged 65 and over per 100,000 population).

Data source: The UK government's Public health outcomes framework (available at integrated care board level) reports emergency hospital admissions due to falls in people aged 65 and over (indicator C29).

What the quality statement means for different audiences

Service providers (such as specialist services, primary care services, community teams) ensure that protocols are in place to receive referrals for comprehensive falls assessment; and that assessments are undertaken by staff with skills and experience in falls prevention, that they comprise multiple components to assess individual risk factors and form part of comprehensive falls assessment and management. Outside of specialist falls services, providers ensure that referral pathways are in place for specialist assessment when needed.

Healthcare professionals (such as consultants, GPs, nurses, physiotherapists and occupational therapists) work in a collaborative local context that enables assessments to be undertaken by staff with skills and experience in falls prevention in an appropriate care setting, with local referral pathways to support specialist assessment when needed. Professionals undertaking the assessment identify individual risk factors that can be addressed through comprehensive falls management.

Commissioners ensure that they commission services that perform comprehensive falls assessments in appropriate care settings with local referral pathways to support specialist assessment when needed, using professionals with skills and experience in falls prevention working in a collaborative local context.

People aged 50 to 64 with 1 or more factors that could increase their risk of falls and people aged 65 or over who meet the criteria for a comprehensive falls assessment have an assessment to identify if there is anything that might make them more likely to fall and whether there are things that can be done to reduce their risk of falling.

Source guidance

Falls: assessment and prevention in older people and in people 50 and over at higher risk. NICE guideline NG249 (2025), recommendations 1.1.3, 1.1.7, 1.2.1 and 1.2.2

Definitions of terms used in this quality statement

Fall

A fall is defined as an unexpected event which causes a person to rest on the ground, floor or lower level. [Adapted from NICE's guideline on falls; evidence review B, table 1]

People who meet the criteria for a comprehensive falls assessment

People aged 50 to 64 with 1 or more factors that could increase their risk of falls and people aged 65 or over who are:

- In community settings, have fallen in the last year and meet any of the following

criteria:

  - Are living with frailty (also see the section on how to assess frailty in the NICE guideline on multimorbidity).
  - Were injured in a fall and needed medical (including surgical) treatment.
  - Have experienced a loss of consciousness related to a fall (also see the NICE guideline on transient loss of consciousness ['blackouts'] in over 16s).
  - Have been unable to get up independently after a fall.
  - Have had 2 or more falls in the last year.

- In hospital inpatient settings or residential care settings.

For people aged 50 to 64, factors that could increase the risk of falls include long-term health conditions that impact on a person's daily life such as arthritis, dementia, diabetes or Parkinson's disease; having had a stroke; and having a learning disability. [Adapted from NICE's guideline on falls, terms used in this guideline; factors that could increase the risk of falls and recommendations 1.1.3 and 1.1.7]

Comprehensive falls assessment

An assessment that aims to identify a person's risk factors for falling. This can be carried out by an appropriately trained single healthcare professional or a multidisciplinary team involving any of the following services, as appropriate: primary care services, community teams or specialist outpatient clinics (such as falls or geriatric medicine assessment clinics).

A comprehensive falls assessment may include the following assessments and examinations (where appropriate) to identify the person's individual fall risk factors:

- Alcohol misuse (see the section on identification and assessment in the NICE guideline on alcohol-use disorders).
- Cardiovascular examination (including a lying and standing blood pressure test).
- Cognition and mood.
- Delirium (hospital inpatient and residential care settings only; see the section on

assessment and diagnosis in the NICE guideline on delirium).

- Diet, fluid intake and weight loss.
- Dizziness: ask about the presence and nature of any dizziness; if the person reports symptoms of rotational vertigo, consider performing a Dix-Hallpike manoeuvre (see the section on dizziness and vertigo in adults in the NICE guideline on suspected neurological conditions).
- Footwear and foot condition.
- Functional ability: assess the person's perceived functional ability and explore any concerns about falling.
- Gait, balance and mobility, and muscle strength assessment.
- Hearing impairments.
- Long-term conditions that affect the person's daily life, for example, arthritis, dementia, diabetes or Parkinson's disease.
- Medication review.
- Neurological examination.
- Osteoporosis risk assessment (see the NICE guideline on osteoporosis: assessing the risk of fragility fracture).
- Urinary continence.
- Visual impairments.

[NICE's guideline on falls, terms used in this guideline; comprehensive falls assessment and recommendation 1.2.2]

Quality statement 3: Interventions to reduce the risk of falls

Quality statement

People aged 50 to 64 with 1 or more factors that could increase their risk of falls and people aged 65 or over have tailored interventions that address their individual risk factors if they need comprehensive falls management to reduce their risk of falling. **[2017, updated 2025]**

Rationale

A comprehensive falls assessment allows a person's risk factors to be identified. In a comprehensive falls management approach, interventions to reduce the risk of falls are tailored to address the person's individual risk factors.

Quality measures

The following measures can be used to assess the quality of care or service provision specified in the statement. They are examples of how the statement can be measured, and can be adapted and used flexibly.

Process

Proportion of people aged 50 to 64 with 1 or more factors that could increase their risk of falls and people aged 65 or over have tailored interventions that address their individual risk factors if they need comprehensive falls management to reduce their risk of falling.

Numerator – the number in the denominator who have received tailored interventions to reduce their risk of falling.

Denominator – the number of people aged 50 to 64 with 1 or more factors that could increase their risk of falls and people aged 65 or over who need comprehensive falls management.

Data source: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example, from patient records.

Outcome

Injuries due to falls in people aged 65 and over (age-sex standardised rate of emergency hospital admissions for injuries due to falls in people aged 65 and over per 100,000 population).

Data source: The UK government's Public health outcomes framework (available at integrated care board level) reports emergency hospital admissions due to falls in people aged 65 and over (indicator C29).

What the quality statement means for different audiences

Service providers (such as specialist services, primary care services, community teams) ensure that systems and governance structures are in place to provide tailored interventions that address people's risk factors when they are identified through comprehensive falls assessment; to coordinate interventions across different professionals and settings; and to ensure that appropriate staff perform the interventions.

Healthcare professionals (such as consultant geriatricians, nurses, physiotherapists, occupational therapists, pharmacists and primary care practitioners) identify interventions that address a person's multiple risk factors established through a comprehensive falls assessment; discuss the interventions with the person and how they can be tailored to their needs; deliver the interventions; and document them in the patient's record.

Commissioners ensure that they commission services so that adults who are assessed as being at increased risk of falling receive tailored interventions based on comprehensive falls assessment.

People aged 50 to 64 with 1 or more factors that could increase their risk of falls and people aged 65 or overwho have had an assessment that shows they are at increased risk of falling develop a plan with a healthcare professional tailored to their individual needs to reduce their risk of falling. This plan may include treating health problems, making changes at home, exercises, having their eyes checked and looking at whether any

medicines they take should be changed.

Source guidance

Falls: assessment and prevention in older people and in people 50 and over at higher risk. NICE guideline NG249 (2025), recommendation 1.2.3, 1.3.1 to 1.3.11 and 1.3.15 to 1.3.25

Definitions of terms used in this quality statement

Fall

A fall is defined as an unexpected event which causes a person to rest on the ground, floor or lower level. [Adapted from NICE's guideline on falls; evidence review B, table 1]

People who need comprehensive falls management to reduce their risk of falling

People aged 50 to 64 with 1 or more factors that could increase their risk of falls and people aged 65 or over who are:

- In community settings and have fallen in the last year and have any of the following criteria:
  - Are living with frailty (also see the section on how to assess frailty in the NICE guideline on multimorbidity).
  - Were injured in a fall and needed medical (including surgical) treatment.
  - Have experienced a loss of consciousness related to a fall (also see the NICE guideline on transient loss of consciousness ['blackouts'] in over 16s).
  - Have been unable to get up independently after a fall.
  - Have had 2 or more falls in the last year.
- In hospital inpatient settings or residential care settings.

For people aged 50 to 64, factors that could increase the risk of falls include long-term health conditions that impact on a person's daily life such as arthritis, dementia, diabetes

or Parkinson's disease; having had a stroke; and having a learning disability. [Adapted from NICE's guideline on falls, terms used in this guideline; factors that could increase the risk of falls and recommendations 1.1.3 and 1.1.7]

Tailored interventions

Comprehensive falls management involves using interventions tailored to address the person's individual risk factors identified in a comprehensive assessment. Individual interventions may be directly carried out by 1 or more health professionals in a specialist service (for example, a medication review by the team pharmacist or a home hazard modification by the team occupational therapist) or by referrals for further action (for example, a referral to ophthalmology for consideration of cataract surgery) and may vary depending on setting.

Comprehensive falls management interventions may include:

- a structured medication review with modification or withdrawal, in particular, of psychotropic medicines
- advice about vitamin D supplements
- home hazard assessments and interventions
- surgical interventions for cataracts or cardiac pacing
- falls prevention exercise programmes
- cognitive behavioural approaches
- advice about physical activity and exercises.

[Adapted from NICE's guideline on falls, recommendations 1.3.1 to 1.3.11 and 1.3.15 to 1.3.25]

Quality statement 4: Checks for injury after an inpatient fall

Quality statement

People who fall during a hospital stay are checked for signs or symptoms of fracture and potential for spinal injury before they are moved. **[2015]**

Rationale

When a person falls, it is important that they are assessed and examined promptly to see if they are injured. This will help to inform decisions about safe handling and ensure that any injuries are treated in a timely manner. Checks for injury should be included in a post-fall protocol that is followed for all people who fall during a hospital stay.

Quality measures

The following measures can be used to assess the quality of care or service provision specified in the statement. They are examples of how the statement can be measured, and can be adapted and used flexibly.

Structure

Evidence of local arrangements to ensure that hospitals have a post-fall protocol that includes checks for signs or symptoms of fracture and potential for spinal injury before the person is moved.

Data source: Data can be collected from information recorded locally by provider organisations, for example, from service or clinical protocols.

Process

Proportion of falls by people during a hospital stay where the person is checked for signs or symptoms of fracture and potential for spinal injury before they are moved.

Numerator – the number in the denominator where the person is checked for signs or symptoms of fracture and potential for spinal injury before they are moved.

Denominator – the number of falls in people during a hospital stay.

Data source: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example, from patient records. The Healthcare Quality Improvement Partnership (HQIP) Falls and fragility fracture audit National Audit of Inpatient Falls reports data on whether people who have had an inpatient fall that resulted in a femoral fracture had a check for signs and symptoms of potential for spinal injury and fracture before they were moved.

What the quality statement means for different audiences

Service providers (NHS organisations with inpatient beds, such as district hospitals, mental health trusts and specialist hospitals) ensure that staff have access to and follow a post-fall protocol that includes undertaking checks for signs or symptoms of fracture and potential for spinal injury before moving someone who has fallen.

Healthcare professionals check people who fall in hospital for signs or symptoms of fracture and potential for spinal injury before moving them.

Commissioners ensure that they commission services from providers that have a post-fall protocol that includes undertaking checks for signs or symptoms of fracture and potential for spinal injury before moving a person who has fallen.

People who fall in hospital are checked for fractures and possible injury to their spine before they are moved.

Source guidance

National Patient Safety Agency. Rapid response report: Essential care after an inpatient fall (2011), recommendation 1. Falls remains part of NHS England's enduring standards that remain valid from previous patient safety alerts (cross-speciality safety).

Definitions of terms used in this quality statement

Fall

A fall is defined as an unexpected event which causes a person to rest on the ground, floor or lower level. [Adapted from NICE's guideline on falls; evidence review B, table 1]

Post-fall protocol

A post-fall protocol should include:

- checks by healthcare professionals for signs or symptoms of fracture and potential for spinal injury before the patient is moved
- safe manual handling methods for patients with signs or symptoms of fracture or potential for spinal injury (community hospitals and mental health units without the necessary equipment or staff expertise may be able to achieve this in collaboration with emergency services)
- frequency and duration of neurological observations for all patients where head injury has occurred or cannot be excluded (for example, unwitnessed falls) based on the NICE guideline on head injury
- timescales for medical examination after a fall (including fast-track assessment for patients who show signs of serious injury, are highly vulnerable to injury or have been immobilised); medical examination should be completed within a maximum of 12 hours, or 30 minutes if fast-tracked.

The post-fall protocol should be easily accessible (for example, laminated versions at nursing stations). [Adapted from the National Patient Safety Agency's rapid response report on essential care after an inpatient fall, recommendations 1 and 2, and expert opinion]

Quality statement 5: Safe manual handling after an inpatient fall

Quality statement

People who fall during a hospital stay and have signs or symptoms of fracture or potential for spinal injury are moved using safe manual handling methods. **[2015]**

Rationale

When a person falls, it is important that safe methods are used to move them, to avoid causing pain and/or further injury. This is critical to their chances of making a full recovery. Safe manual handling methods should be included in a post-fall protocol that is followed for all people who fall during a hospital stay.

Quality measures

The following measures can be used to assess the quality of care or service provision specified in the statement. They are examples of how the statement can be measured, and can be adapted and used flexibly.

Structure

Evidence of local arrangements to ensure that hospitals have a post-fall protocol that includes using safe manual handling methods for moving people with signs or symptoms of fracture or potential for spinal injury.

Data source: Data can be collected from information recorded locally by provider organisations, for example, from service or clinical protocols.

Process

Proportion of falls by people during a hospital stay where the person has signs or symptoms of fracture or potential for spinal injury and is moved using safe manual

handling methods.

Numerator – the number in the denominator where the person is moved using safe manual handling methods.

Denominator – the number of falls by people during a hospital stay where the person has signs or symptoms of fracture or potential for spinal injury.

Data source: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example from patient records. The Healthcare Quality Improvement Partnership (HQIP) Falls and fragility fracture audit National Audit of Inpatient Falls reports data on the manual handling method that was used to move the patient after they have had an inpatient fall that resulted in a femoral fracture.

What the quality statement means for different audiences

Service providers (NHS organisations with inpatient beds, such as district hospitals, mental health trusts and specialist hospitals) ensure that staff have access to and follow a post-fall protocol that includes using safe manual handling methods to move people who have fallen in hospital and have signs or symptoms of fracture or potential for spinal injury.

Healthcare professionals use safe manual handling methods to move people who fall in hospital and have signs or symptoms of fracture or potential for spinal injury.

Commissioners ensure that they commission services from providers that have a post-fall protocol that includes using safe manual handling methods to move people who have fallen in hospital and have signs or symptoms of fracture or potential for spinal injury.

Peoplewho fall in hospital and who may have a fracture or possible injury to their spine are moved in a safe manner, using suitable equipment if needed.

Source guidance

National Patient Safety Agency. Rapid response report: Essential care after an inpatient fall (2011), recommendation 1. Falls remains part of NHS England's enduring standards that

remain valid from previous patient safety alerts (cross-speciality safety).

Definitions of terms used in this quality statement

Fall

A fall is defined as an unexpected event which causes a person to rest on the ground, floor or lower level. [Adapted from NICE's guideline on falls; evidence review B, table 1]

Post-fall protocol

A post-fall protocol should include:

- checks by healthcare professionals for signs or symptoms of fracture and potential for spinal injury before the patient is moved
- safe manual handling methods for patients with signs or symptoms of fracture or potential for spinal injury (community hospitals and mental health units without the necessary equipment or staff expertise may be able to achieve this in collaboration with emergency services)
- frequency and duration of neurological observations for all patients where head injury has occurred or cannot be excluded (for example, unwitnessed falls) based on the NICE guideline on head injury
- timescales for medical examination after a fall (including fast-track assessment for patients who show signs of serious injury, are highly vulnerable to injury or have been immobilised); medical examination should be completed within a maximum of 12 hours, or 30 minutes if fast-tracked.

The post-fall protocol should be easily accessible (for example, laminated versions at nursing stations). [Adapted from the National Patient Safety Agency's rapid response report on essential care after an inpatient fall, recommendations 1 and 2, and expert opinion]

Quality statement 6: Medical examination after an inpatient fall

Quality statement

People who fall during a hospital stay have a medical examination. **[2015]**

Rationale

When a person falls, it is important that they have a prompt medical examination to see if they are injured and to assess for any change in their underlying medical condition. This is critical to their chances of making a full recovery. Timescales for medical examination should be included in a post-fall protocol that is followed for all people who fall in hospital.

Quality measures

The following measures can be used to assess the quality of care or service provision specified in the statement. They are examples of how the statement can be measured, and can be adapted and used flexibly.

Structure

Evidence of local arrangements to ensure that NHS organisations with inpatient beds have a post-fall protocol that includes timescales for medical examination.

Data source: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example, from service or clinical protocols.

Process

a) Proportion of falls in people during a hospital stay where the person has a medical examination completed within 12 hours.

Numerator – the number in the denominator where the person has a medical examination

completed within 12 hours.

Denominator – the number of falls in people during a hospital stay.

Data source: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example from patient records.

b) Proportion of falls in people during a hospital stay where the person shows signs of serious injury, is highly vulnerable to injury or has been immobilised, where a fast-track medical examination is completed within 30 minutes.

Numerator – the number in the denominator where the person has a fast-track medical examination completed within 30 minutes.

Denominator – the number of falls in people during a hospital stay where the person shows signs of serious injury, is highly vulnerable to injury or has been immobilised.

Data source: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example from patient records. The Healthcare Quality Improvement Partnership (HQIP) Falls and fragility fracture audit National Audit of Inpatient Falls reports data on whether a medical assessment was performed within 30 minutes of the inpatient fall that resulted in a femoral fracture.

What the quality statement means for different audiences

Service providers (NHS organisations with inpatient beds, such as district hospitals, mental health trusts and specialist hospitals) ensure that their staff have access to and follow a post-fall protocol that includes timescales for medical examination for people who fall during a hospital stay.

Healthcare professionals complete medical examinations within the timescales specified in their organisation's post-fall protocol for people who fall in hospital.

Commissioners ensure that they commission services from providers that have a post-fall protocol that includes timescales for medical examination for people who fall in hospital.

People who fall in hospital have a medical examination to see if they are injured, which is carried out soon after the fall.

Source guidance

National Patient Safety Agency Rapid response report: Essential care after an inpatient fall (2011), recommendation 1. Falls remains part of NHS England's enduring standards that remain valid from previous patient safety alerts (cross-speciality safety).

Definitions of terms used in this quality statement

Fall

A fall is defined as an unexpected event which causes a person to rest on the ground, floor or lower level. [Adapted from NICE's guideline on falls; evidence review B, table 1]

Post-fall protocol

A post-fall protocol should include:

- checks by healthcare professionals for signs or symptoms of fracture and potential for spinal injury before the patient is moved
- safe manual handling methods for patients with signs or symptoms of fracture or potential for spinal injury (community hospitals and mental health units without the necessary equipment or staff expertise may be able to achieve this in collaboration with emergency services)
- frequency and duration of neurological observations for all patients where head injury has occurred or cannot be excluded (for example, unwitnessed falls) based on the NICE guideline on head injury
- timescales for medical examination after a fall (including fast-track assessment for patients who show signs of serious injury, are highly vulnerable to injury or have been immobilised); medical examination should be completed within a maximum of 12 hours, or 30 minutes if fast-tracked.

The post-fall protocol should be easily accessible (for example, laminated versions at

nursing stations). [Adapted from the National Patient Safety Agency's rapid response report on essential care after an inpatient fall, recommendations 1 and 2, and expert opinion]

Quality statement 7: Multifactorial risk assessment for older people presenting for medical attention

This statement has been removed. For more details, see update information.

Quality statement 8: Strength and balance training

This statement has been removed. For more details, see update information.

Quality statement 9: Home hazard assessment and interventions

This statement has been removed. For more details, see update information.

Update information

April 2025: Changes have been made to align this quality standard with the updated NICE guideline on falls. Statement 7 (2015) on multifactorial risk assessment for older people presenting for medical attention has been removed as this population is included in statement 2. Statements 8 and 9 (2015) on strength and balance training and home hazard assessment and interventions following a fall have been removed because these interventions would be measured as part of statement 3, where relevant for individual patients. Statements 1, 2 and 3 (2017) have been updated to reflect changes to the updated NICE guideline on falls. Links, definitions, data sources and source guidance sections have also been updated throughout. The definition of falls has been amended to align with that in the updated NICE guideline on falls.

Minor changes since publication

March 2022: Links to the National Patient Safety Agency's rapid response report on essential care after an inpatient fall in quality statements 4 to 6 have been updated.

January 2017: This quality standard was updated by adding 3 new statements to the 2015 version (quality statements 1 to 3). All statements prioritised in 2015 were retained. The 3 new statements were originally intended to form a separate quality standard on falls prevention. However, the statements have been combined with the 2015 statements so that there is a single quality standard covering prevention of falls and assessment after a fall.

About this quality standard

NICE quality standards describe high-priority areas for quality improvement in a defined care or service area. Each standard consists of a prioritised set of specific, concise and measurable statements. NICE quality standards draw on existing NICE or NICE-accredited guidance that provides an underpinning, comprehensive set of recommendations, and are designed to support the measurement of improvement.

Expected levels of achievement for quality measures are not specified. Quality standards are intended to drive up the quality of care, and so achievement levels of 100% should be aspired to (or 0% if the quality statement states that something should not be done). However, this may not always be appropriate in practice. Taking account of safety, shared decision-making, choice and professional judgement, desired levels of achievement should be defined locally.

Information about how NICE quality standards are developed is available from the NICE website.

See our webpage on quality standards advisory committees for details about our standing committees. Information about the topic experts invited to join the standing members is available from the webpage for this quality standard.

NICE has produced a quality standard service improvement template to help providers make an initial assessment of their service compared with a selection of quality statements. This tool is updated monthly to include new quality standards.

NICE guidance and quality standards apply in England and Wales. Decisions on how they apply in Scotland and Northern Ireland are made by the Scottish government and Northern Ireland Executive. NICE quality standards may include references to organisations or people responsible for commissioning or providing care that may be relevant only to England.

Resource impact

NICE quality standards should be achievable by local services. The potential resource impact is considered by the quality standards advisory committee, drawing on resource

impact work for the source guidance. Organisations are encouraged to use the resource impact tools for the NICE guideline on falls to help estimate local costs.

Diversity, equality and language

Equality issues were considered during development and equality assessments for this quality standard are available. Any specific issues identified during development of the quality statements are highlighted in each statement.

For all quality statements where information is given, it is important that people are provided with information that they can easily read and understand themselves, or with support, so they can communicate effectively with health and social care services. Information should be in a format that suits their needs and preferences. It should be accessible to people who do not speak or read English, and it should be culturally appropriate and age appropriate. People should have access to an interpreter if needed. People should also have access to an advocate, if needed, as set out in NICE's guideline on advocacy services for adults with health and social care needs.

For people with additional needs related to a disability, impairment or sensory loss, information should be provided as set out in NHS England's Accessible Information Standard or the equivalent standards for the devolved nations.

Commissioners and providers should aim to achieve the quality standard in their local context, in light of their duties to have due regard to the need to eliminate unlawful discrimination, advance equality of opportunity and foster good relations. Nothing in this quality standard should be interpreted in a way that would be inconsistent with compliance with those duties.

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Endorsing organisations

This quality standard has been endorsed by the following organisations, as required by the Health and Social Care Act (2012):

- NHS England
- Department of Health and Social Care

Supporting organisations

Many organisations share NICE's commitment to quality improvement using evidence-based guidance. The following supporting organisations have recognised the benefit of the quality standard in improving care for patients, carers, service users and members of the public. They have agreed to work with NICE to ensure that those commissioning or providing services are made aware of and encouraged to use the quality standard.

- Chartered Society of Physiotherapy
- Royal College of Occupational Therapists (RCOT)
- Royal College of Physicians (RCP)
- Arrhythmia Alliance
- Syncope Trust And Reflex Anoxic Seizures