Royal College of Physicians

National Audit of Inpatient Falls (NAIF)

# Comprehensive assessment for inpatients

## A guide for clinicians

In association with

British Geriatrics Society
Improving healthcare for older people

British Orthopaedic Association

Royal Osteoporosis Society
Better bone health for everybody

Commissioned by

HQIP
Healthcare Quality Improvement Partnership

# Contents



# Comprehensive assessment

NICE clinical guideline 249 covers the assessment of fall risk and interventions to prevent falls in all individuals aged 65 and over, as well as those aged 50–64 who are at increased risk. The guideline aims to reduce the risk and incidence of falls alongside the associated distress, pain, injury, loss of confidence, loss of independence and mortality.

Comprehensive falls assessment is designed to identify a person's risk factors for falling. This assessment may be conducted by a suitably trained single healthcare professional or a multidisciplinary team. Relevant services that may be involved include primary care, community teams or specialist outpatient clinics such as falls clinics or geriatric medicine assessment clinics.

The National Audit of Inpatient Falls (NAIF) includes all inpatients aged 65 and over who have sustained any fracture, head injury or spinal injury as a result of an inpatient fall. NAIF collects data on six components of the comprehensive assessment, which together form the multi-factorial assessment to optimise safe activity (MASA). This approach is intended to minimise the burden of data collection and emphasise assessments and interventions considered most effective for fall prevention.

Further information can be found in 'What is a multi-factorial assessment to optimise safe activity (MASA) for the purposes of the National Audit of Inpatient Falls (NAIF)?'. It is recommended to navigate through the document to review the components suggested by NICE, including guidance on conducting the assessments and recommendations for interventions to address each component during both admission and discharge (where appropriate).

# Comprehensive assessment and interventions for inpatient settings

For each comprehensive component, the following assessments and examinations are recommended to identify individual patient fall risk factors, as well as relevant interventions and management strategies for consideration during both inpatient admission and post-discharge (where appropriate).

Components included in MASA*

| Comprehensive assessment component | Assessment process/ question/tool | Interventions to address component |
|---|---|---|
| **Vision**  | Ask about spectacle use. Measurement of distance and near visual acuity using the RCP 'Look out!' vision tool. | **During inpatient admission:**<br>> Ensure access to own clean spectacles.<br>> Appropriate supervision in new environment for people with severe visual impairment.<br>> Keep ward areas and toilets well lit and clear of clutter, trip or slip hazards.<br>> Provide colour coding to bays/rooms and clear signage for toilets and other facilities.<br>> Use adequate contrast between colours of equipment, décor and walking aids for people with visual impairment (local adaptations advised depending on resource availability).<br>> Provide information and educational materials for the patient and their family.<br><br>**For discharge:** Advise about eye tests and spectacles. Referral for cataract extraction if indicated. |
| **Cardiovascular**  | Perform and record lying standing BP as per RCP guidance (include measurement of pulse). | **During inpatient admission:** If orthostatic hypotension identified:<br>> Review medication<br>> Assess fluid balance/hydration<br>> Manage medical causes such as sepsis<br>> Formalise strategies to minimise impact (ie sitting up slowly)<br>> Consider compression socks and stockings.<br><br>Further investigations as appropriate if there is evidence of syncope. |

* Repeat the MASA components weekly, or sooner if the patient has a recent fall or any change in condition.

Components included in MASA*

| Comprehensive assessment component | Assessment process/ question/tool | Interventions to address component |
|---|---|---|
| **Delirium (NICE clinical guideline 103)**  | Screening using the 4AT. | **During inpatient admission:** Manage underlying cause of delirium and consider the following to reduce fall risk:<br>> Awareness of how to identify unmet needs that they may not be able to easily express – use the 'This is me' document.<br>> Alternative methods to using the call bell / remembering verbal instructions if supervision or assistance is needed to walk.<br>> Provide person-centred occupation appropriate to abilities to alleviate boredom.<br>> Continence management plan may include a toileting routine, intentional rounding and management of constipation, hydration and medication.<br>> Provide information and educational materials for the patient and their family.<br>**For discharge:** Consider community follow-up for patients with unresolved delirium on discharge. |
| **Medication review**  | Structured medication review that identifies medications that could potentially increase falls risk and assesses the clinical indication for deprescribing or withdrawal. Such a review may in some cases recommend starting a new prescription. Validated tools are available to carry out structured medication review. | **During inpatient admission:** Document actions where new prescriptions are started or changes to prescriptions are made to reduce risk drugs, or provide a rationale to continue a drug associated with risk of falls.<br>> Provide information and educational materials for the patient and their family.<br>**For discharge:** Ensure medication changes are clearly communicated to the primary care team (and care home, if appropriate). |

* Repeat the MASA components weekly, or sooner if the patient has a recent fall or any change in condition.

Components included in MASA*

| Comprehensive assessment component | Assessment process/ question/tool | Interventions to address component |
|---|---|---|
| **Gait, balance and mobility, and muscle strength assessment**  | Walking and transfer assessment which includes:<br>> Supervision/assistance requirements for transfers and walking<br>> Equipment and walking aids required for transfers and walking<br>> Risks contributing to deconditioning | **During inpatient admission:** Care plan to specify how supervision and assistance will be provided to ensure the patient can remain as active as possible.<br>> Mobility aids (if needed) to be in reach of the patient.<br>> Ensure bed and chair heights are optimised for each patient and that, if used, bed rail assessments are completed.<br>> Appropriate equipment for moving and handling to be available on the ward and in working order.<br>> A personalised care plan in place to optimise physical activity and reduce sedentary time during the admission.<br>> Ensure appropriate clothing and footwear for moving around is available.<br>> Provide information and educational materials for the patient and their family.<br>**For discharge:** Consider referral for community fall prevention exercise. |
| **Urinary continence**  | Question about / observation of continence, any accidents, urgency, frequency and use of pads (note any change in continence associated with the hospital admission). | **During inpatient admission:** Continence care plan which may include:<br>> Supporting adequate hydration.<br>> Support with toileting, using the toilets on the ward as the default approach.<br>> Avoidance of urinary catheters with clear justified reason for their use.<br>> Review of the anticholinergic effect of medications used to manage bladder conditions and consideration of alternatives.<br>> Consideration of non-pharmacological approaches such as pelvic floor muscle training and bladder training to manage urinary incontinence.<br>**Do not use pads to compensate for reduced mobility.**<br>**For discharge:** Ensure appropriate community management, including continuation of pelvic floor / bladder training and/or community pad provision and equipment needs (ie bottle/ commode). |

* Repeat the MASA components weekly, or sooner if the patient has a recent fall or any change in condition.

| Comprehensive assessment component | Assessment process/ question/tool | Interventions to address component |
|---|---|---|
| **Alcohol misuse (NICE clinical guideline 115)**  | Record history of alcohol intake to identify those with history of harmful or hazardous drinking. Assess for symptoms of / determine the risk of acute alcohol withdrawal while admitted. | **During inpatient admission:** Follow NICE guidelines on managing acute alcohol withdrawal.<br><br>**For discharge:** Education/support for withdrawal. |
| **Cognition**  | Note any history of cognitive impairment / dementia in health records or reported by the patient or their family. | **During inpatient admission:** See interventions for delirium.<br><br>**For discharge:** Consider community follow-up for patients with new cognitive impairment while in hospital. |
| **Diet, fluid intake and weight loss**  | Note BMI and any recent weight loss to calculate malnutrition universal screening tool (MUST) score.<br><br>Identify and record any reasons why oral intake of food and fluids may be impaired. | **During inpatient admission:** Care plan to support adequate nutrition and fluid intake. Investigate reasons for weight loss and implement interventions to address malnutrition if indicated. |
| **Dizziness (NICE clinical guideline 127)**  | Ask about the presence and nature of any dizziness. | **During inpatient admission:** Investigation of causes including:<br><br>> Lying/standing blood pressure<br>> Cardiovascular examination<br><br>If suspected vertigo and appropriate for the patient's condition, consider a Dix-Hallpike manoeuvre.<br><br>**For discharge:** Consider referral for further investigation and/or treatment of vertigo. |

| Comprehensive assessment component | Assessment process/ question/tool | Interventions to address component |
|---|---|---|
| **Footwear and foot condition**  | Ascertain whether footwear is missing or unsuitable. Visual inspection of the feet for foot problems that impact walking. | **During inpatient admission:** Arrange for patients to have access to their own suitable clothing and footwear during admission.<br>Support the necessary footcare for maintaining mobility while an inpatient.<br><br>**For discharge:** Consider referral to community podiatry or footcare services. |
| **Functional ability**  | Assess the person's perceived functional ability and explore any concerns about falling. Ask if the patient is concerned about falling. | **During inpatient admission:** Consider short-form FES-I to establish how concern about falling impacts on perceived ability to undertake functional activities. Consider any concerns about falling that may lead to activity limitation, while in hospital, in the mobility care plan.<br><br>**For discharge:** Consider referral for community fall prevention exercise. |
| **Hearing impairments**  | Question about any hearing difficulties and hearing aid use. | **During inpatient admission:** Ensure hearing aids (if used) are available and in working order. Use adaptations to support communication as indicated. Examination for earwax.<br><br>**For discharge:** Consider referral for hearing aids or further audiology assessment if indicated. |
| **Mood**  | Note any history of mood disorders / depression in health records or reported by the patient or their family. | **During inpatient admission:** Further investigation using geriatric depression scale-15. Consider specialist assessment/management if mood disorder is impacting on mobility and rehabilitation or prescribed antidepressants are thought to be contributing to fall risk. |
| **Neurological examination**  | Can the patient move all four limbs normally? Any abnormalities in walking or balance that cannot be explained by current condition? | **During inpatient admission:** If impairments in movement are noted, arrange for a healthcare professional (with appropriate skills) to perform neurological assessment including tone, reflexes, sensation, motor function and cranial nerves. Investigate unexplained signs and symptoms as appropriate. |
| **Osteoporosis risk assessment (NICE clinical guideline 146)**  | Was the patient admitted with a fracture or sustained a fracture while in hospital? | **During inpatient admission:** Perform FRAX and follow osteoporosis NICE guidance. If clinically indicated, start on bone therapy while still in hospital. If indicated, consider dose of IV bisphosphonate before discharge, where adherence to oral bisphosphonates in the community is likely to be challenging.<br><br>**For discharge:** Referral for further investigation/management if indicated at discharge. |

# Acknowledgements

This resource was developed by Julie Whitney, NAIF clinical lead, supported by the National Audit of Inpatient Falls Advisory Group and Subgroup.

**Alice Kilby**, consultant therapist for falls prevention and management
**Anne Robinson**, FFFAP patient and carer panel representative
**Ben Hitchman**, FFFAP programme coordinator
**Bonnie Wiles**, FFFAP deputy programme manager
**Catherina Nolan**, clinical lead occupational therapist, Royal College of Occupational Therapy
**Dr Sunil Nedungayil**, FFFAP senior clinical lead
**Faiza Asadi**, FFFAP programme coordinator
**Jason O'Flaherty**, nurse representative
**Jo Copeman**, nurse representative
**Julie Windsor**, patient safety clinical lead – medical specialities/older people, NHS England Patient Safety
**Maisie Baker**, physiotherapist, AGILE falls and bone health officer
**Matthew Murden**, NAIF clinical fellow
**Rosie Dickinson**, FFFAP programme manager
**Sally Wilson**, UK professional lead for older people and dementia, Royal College of Nursing
**Sarah Brown**, FFFAP patient and carer panel representative
**Sarah Howie,** British Geriatrics Society consultant orthogeriatrician
**Sarah Pryor**, NAIF clinical fellow
**Sue Dewhirst**, public health policy manager, NHS Public Health Team, NHS England
**Yueli Ang**, FFFAP project manager

## Falls and Fragility Fracture Audit Programme

The National Audit of Inpatient Falls (NAIF) is run by the Care Quality Improvement Directorate (CQID) of the Royal College of Physicians (RCP). It is part of the Falls and Fragility Fractures Audit Programme (FFFAP), one of three workstreams that also include the Fracture Liaison Service Database (FLS-DB) and National Hip Fracture Database (NHFD). The programme is commissioned by the Healthcare Quality Improvement Partnership (HQIP) and works within a governance structure that includes the programme's board, advisory group and Patient and Carer Panel.

## Healthcare Quality Improvement Partnership

The Falls and Fragility Fracture Audit Programme is commissioned by the Healthcare Quality Improvement Partnership (HQIP) as part of the National Clinical Audit and Patient Outcomes Programme (NCAPOP). HQIP is led by a consortium of the Academy of Medical Royal Colleges and the Royal College of Nursing. Its aim is to promote quality improvement in patient outcomes and, in particular, to increase the impact that clinical audit, outcome review programmes and registries have on healthcare quality in England and Wales. HQIP holds the contract to commission, manage and develop NCAPOP, comprising around 40 projects covering care provided to people with a wide range of medical, surgical and mental health conditions. The programme is funded by NHS England, the Welsh government and, with some individual projects, other devolved administrations and crown dependencies.

## The Royal College of Physicians

The Royal College of Physicians is a registered charity that aims to ensure high-quality care for patients by promoting the highest standards of medical practice. It provides and sets standards in clinical practice, education and training, conducts assessments and examinations, quality assures external audit programmes, supports doctors in their practice of medicine, and advises the government, public and profession on healthcare issues.

National Audit of Inpatient Falls (NAIF)

Royal College of Physicians
11 St Andrews Place
Regent's Park
London NW1 4LE

Tel: +44 020 3075 1511
Email: falls@rcp.ac.uk

www.rcp.ac.uk

LinkedIn

#NAIF

Registered Charity No. 210508

Royal College of Physicians

National Audit of Inpatient Falls (NAIF)