Organisation name Site or unit		STANDARD OPERATING PROCEDURE **Falls Risk Assessment and Prevention**	
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Signature			

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Abbreviations

Abbreviation	Meaning
CG161	NICE clinical guideline 161 (2013), replaced by NG249
NG249	NICE guideline NG249, Falls: assessment and prevention in older people

Abbreviation	Meaning
NICE	National Institute for Health and Care Excellence
SOP	Standard operating procedure
WHO	World Health Organization

Key points

- Do not use a falls risk prediction score to decide who is at risk of falling. Use the falls history and a gait and balance check [1].
- Offer a comprehensive falls assessment to every inpatient and every person in residential care, without further criteria [1].
- In the community, offer a comprehensive assessment to people who have fallen in the past year and are living with frailty, were injured, lost consciousness, could not get up unaided, or fell twice or more [1].
- After any fall: check for injury, ask what happened, decide whether to refer, and advise the patient how to get up and when to seek help [1].
- Review medicines that increase fall risk, especially psychotropic medicines [1].

1. Purpose

To reduce falls and fall-related injury in patients, and to make sure each fall is assessed, treated and learned from. About 28–35% of people aged 65 and over fall each year, and falls are a major cause of injury and loss of independence in this group [2]. This SOP sets out how falls risk is identified, how a comprehensive assessment and intervention plan is made, and what happens after a fall.

2. Scope

Element	Coverage
Who	Patients aged 65 and over, and patients aged 50 to 64 with one or more risk factors [1].
Where	Inpatient wards, day-care, outpatient clinics and residential care where the facility provides care.
When	On admission or first contact; after any fall; when a patient’s mobility, cognition or medicines change; and before discharge.
Not covered	Falls from height and accidents outside clinical care, which are managed under the general risk policy.

3. Definitions

Term	Meaning
Fall	An unintentional event in which a person comes to rest on the ground, floor or another lower level [2].
Near-fall	An event in which a person would have fallen had they not been caught or supported.
Falls history	Whether the person has fallen in the past year, how often, and the circumstances of each fall [1].
Gait and balance check	A simple observed test of walking and balance, such as a timed up and go test or a standing balance test, used to identify impairment [1].
Comprehensive falls assessment	A structured assessment covering the areas in the Procedure section. It is the basis for the falls care plan [1].

Term	Meaning
Postural hypotension	A fall in blood pressure on standing. It is measured lying and then standing, and is one of the factors assessed [1].

4. Background

Falls are one of the most common causes of injury in older people. NICE guideline NG249, published on 29 April 2025 and replacing CG161 of 2013, sets out how to identify people at risk and how to assess and reduce that risk. Its central points for this SOP are that prediction tools should not be used to predict falls, that a comprehensive assessment is offered on the criteria above, and that exercise, medication review and other interventions are chosen to fit the person's identified risks [1]. Vitamin D is not recommended to lower falls risk by itself; NHS advice on vitamin D for bone and muscle health is followed [1].

5. Responsibilities

Role	Responsibility
Clinical director	Approves this SOP, receives the quarterly falls report, and reviews injurious falls.
Ward or unit manager	Ensures assessments are completed, staff are trained, and equipment is available.
Admitting nurse	Takes the falls history and performs the gait and balance check at admission.
Doctor	Completes or leads the comprehensive assessment and reviews medicines and blood pressure.
Physiotherapist and occupational therapist	Assess gait, balance, strength, equipment and the home environment; design and supervise exercise programmes.
Quality and risk team	Analyses falls data, reviews injurious falls, and advises on system changes.

6. Materials and equipment

Item	Requirement
Falls assessment form	The facility's current form, covering the falls history, gait and balance check, and the comprehensive assessment areas.
Blood pressure monitor	Calibrated, with a lying and standing measurement at the time of assessment.
Timer and walkway	For the timed up and go test, over a measured distance on a clear, flat surface.
Falls identifier	A visible marker in the patient's notes or on the bed space, applied as set by the facility's privacy policy.

7. Safety and exceptions

- **Injury first.** A patient who has fallen with a suspected injury, a head strike, or a change in consciousness is assessed by the medical team immediately. The falls assessment follows when the patient is stable.
- **Anticoagulated patients.** Any head strike in a patient on an anticoagulant or antiplatelet medicine is treated as a medical emergency, with urgent review, whatever the apparent severity.
- **Restraint is not a falls intervention.** Any restrictive measure must follow the facility's restraint policy and be reviewed daily.

- **Patients who cannot give a history** are assessed by observing mobility and behaviour, with the family or carer consulted.

8. Procedure

Before you start

- Check the patient's current medicines, mobility aids, and any previous falls in the notes.
- Check that the falls assessment form and equipment are available and in working order.

Step 1. Take the falls history (all patients in scope)

1. Ask whether the patient has fallen in the past year, how many times, and the circumstances of each fall. Ask whether they have had a near-fall [1].
2. Record the falls history on the form. Do not use a prediction score to decide whether the patient is at risk [1].
3. Ask about dizziness on standing, and whether the patient is afraid of falling [1].

Step 2. Check gait and balance

1. Observe the patient walking and standing, with their usual aids. Note any unsteadiness, shuffling or need for support [1].
2. Where the patient is able, perform a timed up and go test and a standing balance test. Record the times and any support used.
3. Where the patient fell in the past year but meets none of the criteria for a comprehensive assessment, a gait and balance impairment identified here leads to an exercise programme and consideration of a home hazard assessment [1].

Step 3. Decide on the level of assessment

1. **Inpatients and residential care:** offer a comprehensive falls assessment to every patient [1].
2. **Community:** offer a comprehensive falls assessment if the patient has fallen in the past year and is living with frailty, was injured and needed treatment, lost consciousness in relation to a fall, could not get up unaided, or has fallen twice or more [1].
3. Record the decision and the reason.

Step 4. Complete the comprehensive falls assessment

1. Assess gait, balance, mobility and muscle strength.
2. Carry out a cardiovascular examination, including blood pressure lying and then standing, to detect postural hypotension [1].
3. Review medicines for fall risk. Consider adjusting medicines that increase fall risk. For a patient on psychotropic medicines, review them, discuss the fall risk, and plan withdrawal where appropriate [1].
4. Check vision, urinary continence, cognition and mood. In hospital and residential care, also screen for delirium [1].
5. Check footwear and the condition of the feet.
6. Check hearing, dizziness (consider a Dix–Hallpike test where rotational vertigo is suspected), diet, fluid intake, recent weight loss, alcohol use, and long-term conditions such as arthritis, dementia, diabetes and Parkinson's disease [1].
7. Where the falls are unexplained, investigate carotid sinus hypersensitivity, and consider cardiac pacing if indicated [1].

Step 5. Plan interventions

1. Address each identified risk factor promptly with an intervention that fits it [1].
2. **Exercise:** where an exercise programme is indicated, offer a programme that is delivered by trained professionals, progressive and tailored, focused on balance, coordination, strength and power, and reviewed regularly. Offer supervised exercise, individual or group [1].
3. **Home hazards:** consider a home hazard assessment for community patients with a gait or balance impairment, and at discharge where relevant [1].
4. **Fear of falling:** where exercise has not eased it, consider a cognitive behavioural intervention [1].
5. **Vitamin D:** do not prescribe vitamin D to reduce falls risk on its own. Follow NHS advice on vitamin D for bone and muscle health [1].
6. Record the plan, the responsible person and the review date. Agree the plan with the patient and, where appropriate, the family.

Step 6. Manage a fall

1. Check the patient for injury before moving them. Call the medical team immediately if there is a head strike, a change in consciousness, a suspected fracture, or an anticoagulant on the medicine chart.
2. Ask what happened: the time, the place, what the patient was doing, whether they lost consciousness, and whether they could get up unaided. Record the answers [1].
3. Check the blood pressure lying and standing where the patient is able to stand safely.
4. Refer for a comprehensive falls assessment where the criteria in Step 3 are met. Where the patient was injured, lost consciousness, could not get up, or fell twice or more, refer [1].
5. Advise the patient how to get up after a fall, and when and how to seek help [1].
6. Complete the incident report, and review the falls care plan within 24 hours.

Step 7. Review at discharge

1. Before discharge, consider referral to community services for the risk factors identified during the stay [1].
2. Give the patient written advice on falls prevention and on how to get up after a fall.

9. Worked examples

Situation	What to do
Example A. An 84-year-old woman is admitted after a fall at home with a hip fracture.	She was injured and needed treatment, so she meets the community criteria. As an inpatient she is offered a comprehensive falls assessment in any case. Review her medicines (for example, a sedating medicine), check lying and standing blood pressure, and carry out a gait and balance check before she is mobilised. Refer to physiotherapy and occupational therapy before discharge.
Example B. A 72-year-old man attends clinic and says he has had no falls, but he is unsteady when he stands up.	Use the falls history and the gait and balance check, not a prediction score. He has had no falls, so the criteria in Step 3 are not met. Because of the unsteadiness, identify the cause, check lying and standing blood pressure, and review his medicines. Consider an exercise programme if he has a balance impairment.
Example C. A patient on an anticoagulant falls and hits her head, but says she feels well.	This is a medical emergency under the anticoagulant rule. Call the medical team immediately, do not wait for the falls assessment, and record the time and circumstances.
Example D. A patient falls for the second time in three months, with no injury.	The patient has fallen twice or more, so refer for a comprehensive falls assessment. Check the falls history, medicines and blood pressure, and review the falls care plan within 24 hours.

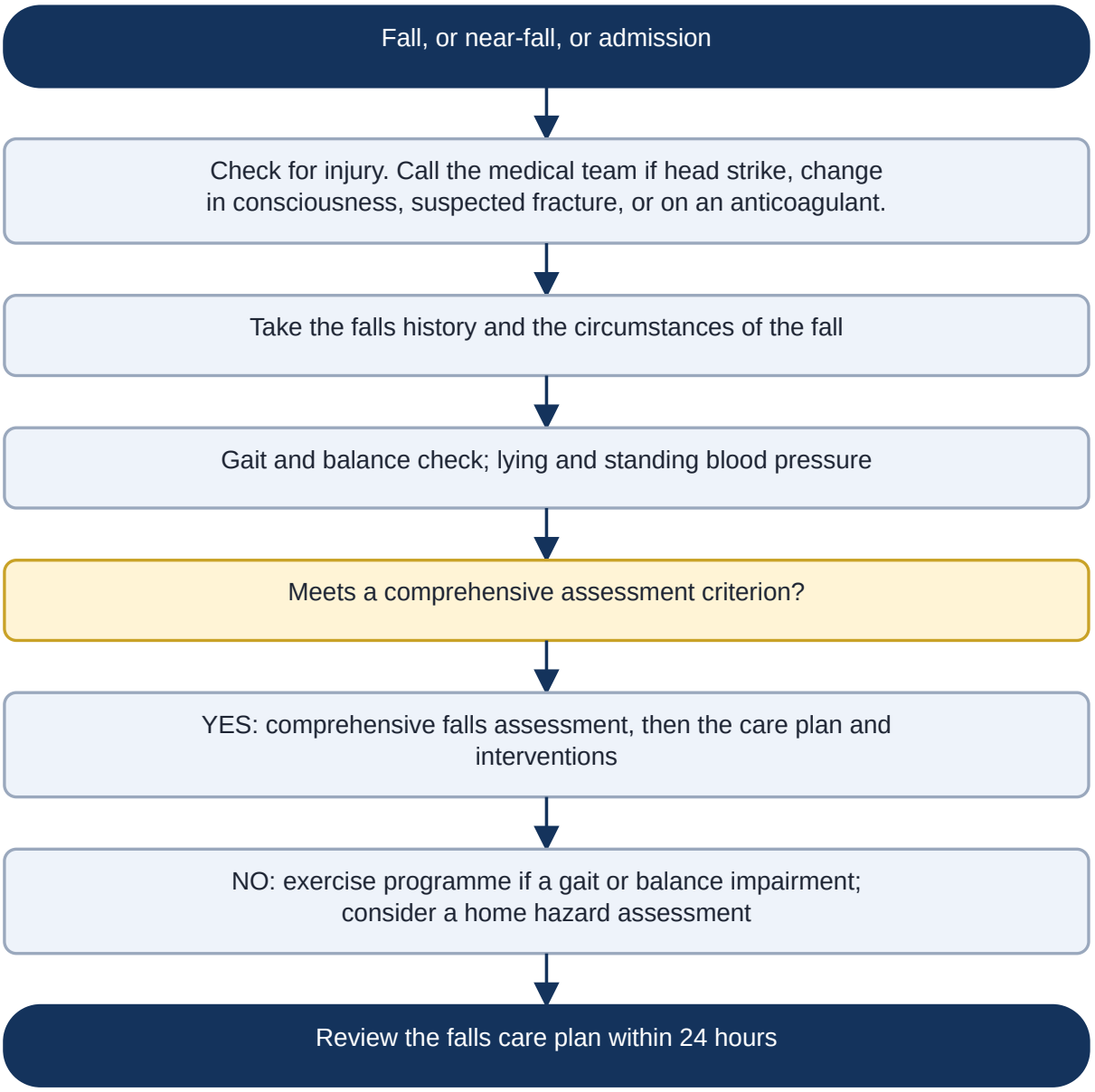


Figure 1. Process

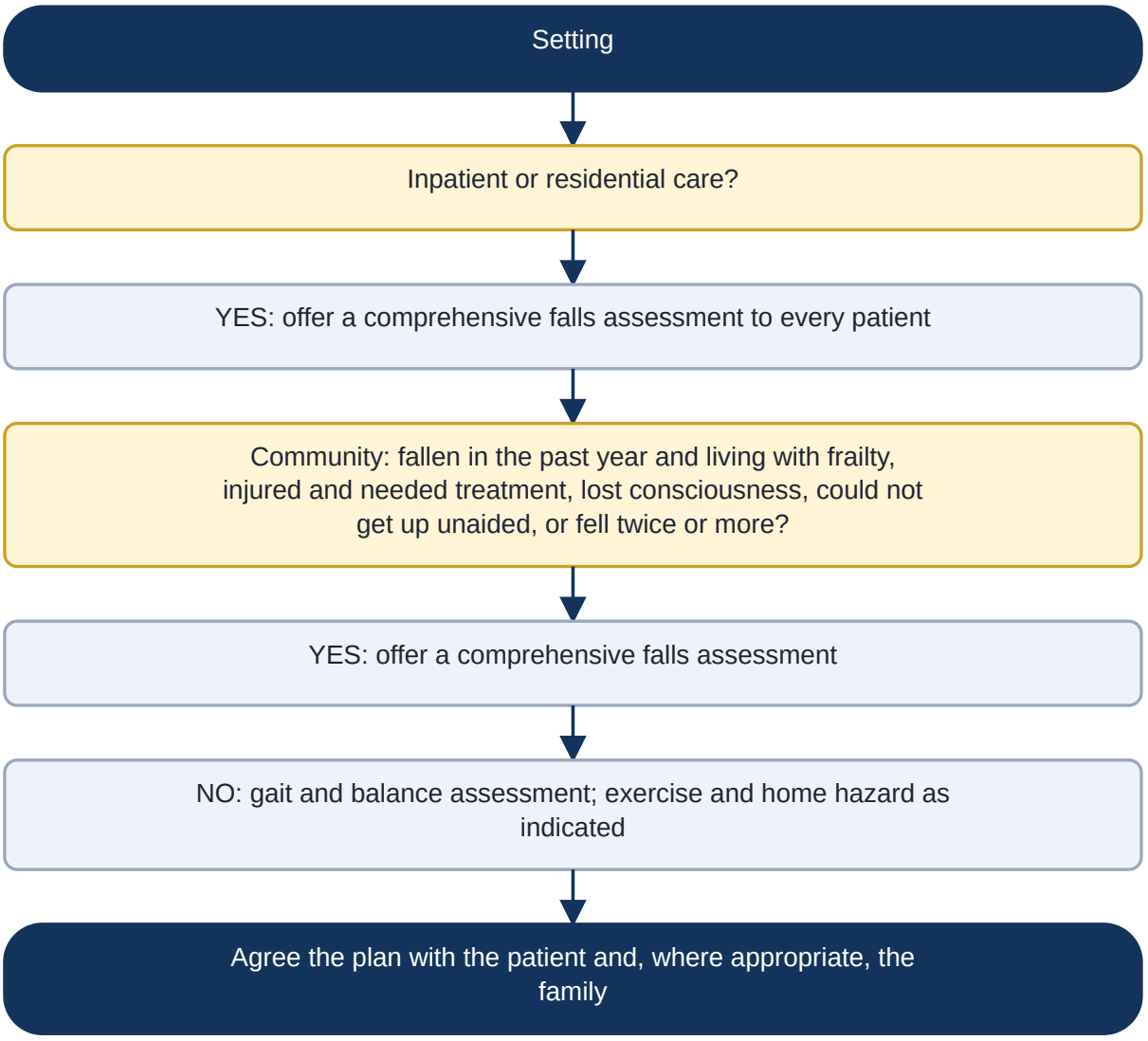


Figure 2. Decision rules

10. Decision points

If	Then
Fall with head strike, change in consciousness, suspected fracture, or on an anticoagulant	Immediate medical review, then the falls assessment.
Patient fell in the past year and meets a community criterion	Offer a comprehensive falls assessment.
Patient fell in the past year, meets no criterion, and has a gait or balance impairment	Offer an exercise programme; consider a home hazard assessment.
Unexplained fall	Investigate carotid sinus hypersensitivity; consider cardiac pacing if indicated.
Patient refuses an intervention	Record the refusal, explain the risk, and review with the patient and family within the shift.

11. Escalation

Event	Inform	Timescale
Fall with injury	Medical team, nurse in charge and the patient's family	Immediately
Fall with serious harm (fracture, head injury)	Unit manager, risk team, and the duty of candour process	Immediately; incident report within 24 hours
Falls rate above the facility threshold	Unit manager and quality team	Within one week

12. Monitoring and compliance

Indicator	Target	Method	Frequency	Owner
Inpatients with a comprehensive falls assessment	100% of inpatients	Audit of 20 records per unit	Monthly	Ward manager
Falls history and gait and balance check recorded on admission	100% of admissions in scope	Audit of 20 records per unit	Monthly	Ward manager
Post-fall review within 24 hours	100% of falls	Incident review	Monthly	Quality team
Falls per 1,000 occupied bed days, and injurious falls	Set and reviewed by the facility	Incident data	Quarterly	Quality team

13. Records

Record	Kept in	Retention
Falls history, gait and balance check and comprehensive assessment	Patient record	As set by the institutional retention policy
Incident report for each fall	Incident management system	As set by the institutional retention policy

14. Training and competence

- **Induction:** the falls history, the timed up and go test, lying and standing blood pressure, and the post-fall steps.
- **Annual update:** the comprehensive assessment and the anticoagulant head-strike rule, with a practical assessment of the timed up and go and blood pressure technique.

15. Related documents

ID	Title	Relationship
CLN-SOP-001-EN	Structured clinical assessment on admission	Admission assessment
CLN-SOP-002-EN	Individualised care planning	Falls care plan

16. References

1. National Institute for Health and Care Excellence. Falls: assessment and prevention in older people and in people 50 and over at higher risk (NICE guideline NG249). Published 29 April 2025; replaces CG161 (2013). Available from: https://www.nice.org.uk/guidance/ng249
2. World Health Organization. WHO global report on falls prevention in older age. Geneva: WHO; 2008. Available from: https://www.who.int/publications/i/item/9789241563536

17. Change history

Version	Date	Summary of change	Approved by
1.0		First approved version.	ASF Expert Committee
1.2		Substantive revision to NICE NG249: removed the admission prediction screen (NG249 advises against prediction tools); added the falls history, gait and balance check, the criteria for a comprehensive assessment, the assessment content, the exercise and medicine rules, the anticoagulant head-strike rule and worked examples.	

Annex A. Falls audit record

Use this record for each audit session. Record one line per patient or observed task. Enter Y, N or NA as shown in the column heading.

Date	Unit	Patient reference	Screen within one shift (Y / N)	Positive screen (Y / N)	Assessment within 24 h (Y / N / NA)	Fall reported (Y / N / NA)	Care plan reviewed within 24 h (Y / N / NA)