

What is a multi-factorial assessment to optimise safe activity (MASA) for the purposes of the National Audit of Inpatient Falls (NAIF)?

From 2025 onwards, we will be changing the terminology describing the assessments to support falls prevention activities.

Assessment to optimise safe activity

The NAIF team recognise that physical activity levels are very low in people admitted to hospital. Research suggests that [inpatients spend 87–100% of the day in bed or sitting](#) and on average, [older inpatients take around 600 steps a day](#). This is a fraction of that recommended for good health and research has found that [step count doubles the day after older people are discharged home](#).

The physical inactivity imposed by hospitalisation is associated with rapid deconditioning leading to [functional decline](#), [more readmissions](#) and [increased mortality](#). These effects are particularly pronounced in older people – the group of patients most likely to experience an inpatient fall.

Around 30% of older inpatients will experience hospital-acquired deconditioning (HAD) and it should be considered as a [significant potential harm for older people in hospital](#).

The way in which hospital staff consider falls risk in the context of physical activity is a key driver of HAD. Due to the nature of the human movement (where there is a small base of support and high centre of gravity), standing up and walking notably increases the possibility a fall will occur. Therefore, an understandable instinct is to seek to reduce falls by limiting time spent upright and moving. However, this approach is flawed as the muscle weakness, loss of balance skill and reduction in general fitness caused by HAD will not only further increase the risk of falls, it will expose patients to similar if not greater levels of harm from the range of negative consequences.

The purpose of the Multifactorial Assessment to optimise Safe Activity (MASA) is to prepare and encourage a hospitalised older adult to be as active as possible by identifying and addressing issues that may compromise their safety when moving around. We hope that positive communication concerning being active, rather than the more negative message of preventing a feared event (a fall), will enable staff, patients and families to feel confident in encouraging activity and thus reducing HAD, while minimising the risks of falls.

The first six components of the MASA are considered to be a minimum standard for an assessment to be described as a MASA within the scope of the National Audit of Inpatient Falls. A patient who has five or more of these factors assessed will be considered to have had a 'high quality MASA'. This is the first Key Performance Indicator for NAIF.

Risk factor to be assessed	Assessment process / tool	Intervention to address impairment
Vision	<p>A question about spectacle use. Measurement of distance and near visual acuity. RCP 'Look Out' vision tool</p>	<ul style="list-style-type: none"> > Access to own, clean spectacles. > Appropriate supervision in new environment in cases of severe visual impairment. > Keep ward areas and toilets well lit, clear of clutter, trip or slip hazards. > Provide colour coding to bays / rooms and clear signage for toilets and other facilities. Use adequate contrast between colours of equipment, décor, walking aids for people with visual impairment (local adaptations advised depending on resource availability). > Provide information and educational materials for the patient and their family – available here.
Lying/ standing blood pressure	<p>Measured as per RCP guide</p>	<ul style="list-style-type: none"> > Medication review, assessment of fluid balance / hydration, management of medical causes such as sepsis, strategies to minimise impact (i.e. sitting up slowly), stockings.
Presence of delirium	<p>Screening using 4 assessment test (4AT)</p>	<ul style="list-style-type: none"> > Awareness of needs relating to cognitive impairment, "This is me" document, consideration of supervision requirements, alternative methods to using the call bell / remembering verbal instructions > Alternative methods to using the call bell / remembering verbal instructions if supervision or assistance is needed to walk. > Providing person-centred occupation appropriate to abilities to alleviate boredom. > Continence management plan may include toileting routine, management of constipation, hydration, medication. > Provide information and educational materials for the patient and their family – available here.

<p>Medication review</p>	<p>Structured medication review that identifies medications that could potentially increase falls risk and assesses the clinical indication for deprescribing or withdrawal. Such as review may in some cases recommend starting a new prescription.</p> <p>Validated tools are available to carry out structured medication review.</p>	<ul style="list-style-type: none"> > Documented actions including making changes to prescriptions to reduce risk drugs, start new prescriptions or provides rationale to continue a drug associated with risk of falls. > Provide information and educational materials for the patient and their family – available here.
<p>Mobility assessment</p>	<p>Walking and transfer assessment which includes:</p> <ul style="list-style-type: none"> > Supervision / assistance required for transfers and walking > Equipment and walking aids required for transfers and walking <p>Risks contributing to deconditioning</p>	<ul style="list-style-type: none"> > Care plan to specify how supervision and assistance will be provided to ensure the patient can remain as active as possible. > Mobility aids (if needed) to be in reach of the patient. > Ensure bed and chair heights are optimised for each patient and that if used, bed rail assessments are completed. > Appropriate equipment for moving and handling to be available on the ward and in working order. > A personalised care plan in place to optimise physical activity and reduce sedentary time during the admission. > Ensure appropriate clothing and footwear for moving around is available. > Provide information and educational materials for the patient and their family – available here.
<p>Continence assessment</p>	<p>Assessment to ascertain the presence of urinary and/or faecal incontinence.</p>	<ul style="list-style-type: none"> > Continence care plan which may include: > Supporting adequate hydration. > Support with toileting, using the toilets on the ward as the default approach. > Avoidance of urinary catheters with clear justified reason. > Review of the anticholinergic effect of some medications used to manage bladder conditions and consideration of alternatives. > Consideration of non-pharmacological approaches such as pelvic floor muscle training and bladder training to manage urinary incontinence.

References and national guidelines

- > [NICE falls 161](#)
- > [NICE Quality standard 86](#)
- > [NICE delirium 103](#)
- > [NICE delirium QS63](#)
- > [NICE urinary incontinence](#)
- > [World Falls Guidelines](#)