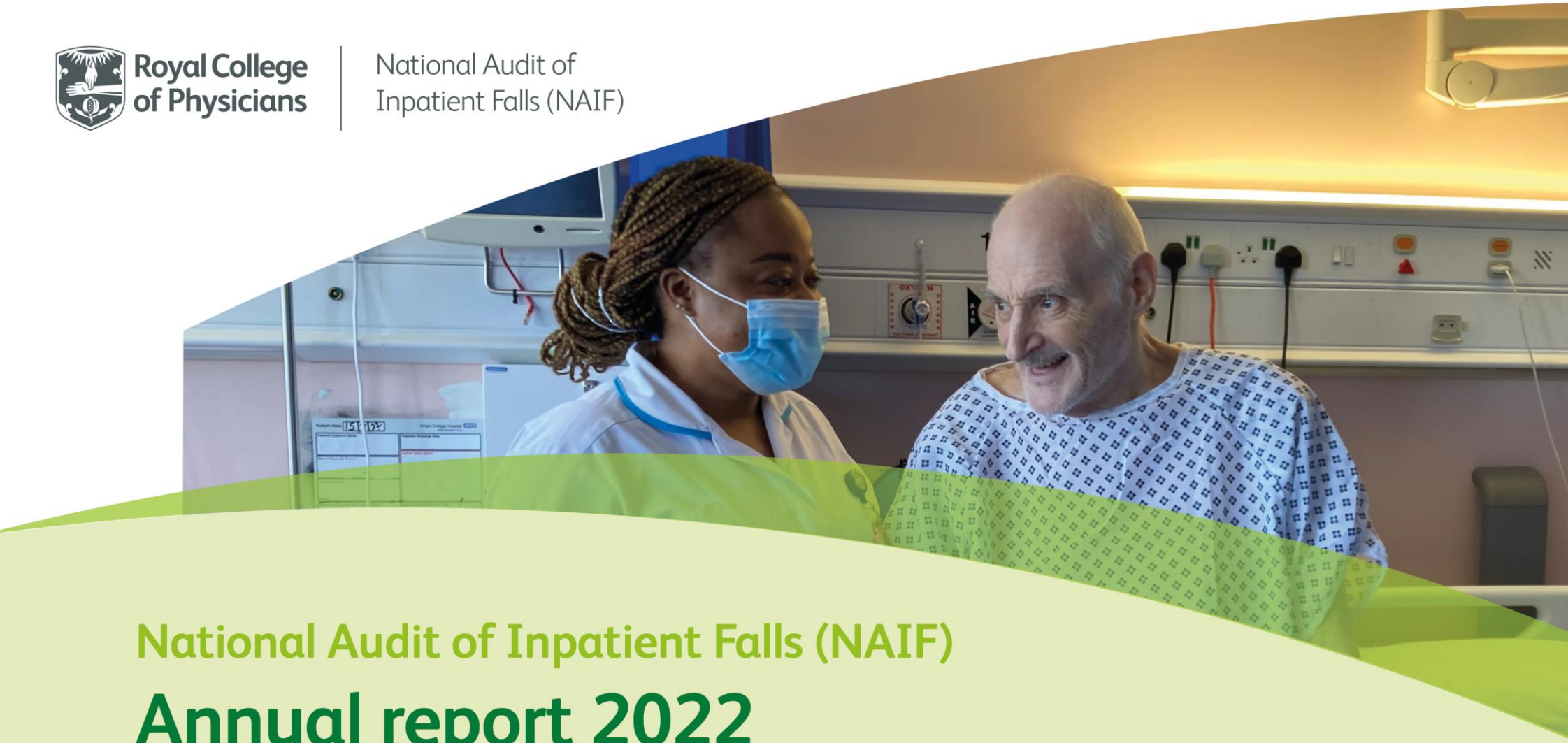
Royal College of Physicians | National Audit of Inpatient Falls (NAIF)



National Audit of Inpatient Falls (NAIF)

Annual report 2022

Working together to improve inpatient falls prevention (2021 clinical and 2022 facilities audit data)

Autumn 2022

In association with

BGS 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

Foreword

In 2020, I joined the National Audit of Inpatient Falls (NAIF) as clinical fellow, and I have been working alongside the team throughout what has been an extremely challenging time for organisations across the country.

Aside from my work as the NAIF clinical fellow, I work clinically as the lead physiotherapist across the health and ageing units at King's College Hospital in London. In my clinical practice, I see first-hand how devastating an inpatient fall can be for both the patient and healthcare professional alike, and how important it is for us as clinicians to learn from these events and improve.

Improvement is of course the key motivation for doing any audit and yet often, due to many different factors, it can be difficult to make improvement a sustainable reality.

Over the past year the Royal College of Physicians (RCP) has embarked on a collaborative series across the Falls and Fragility Fracture Audit Programme (FFFAP), and as a NAIF team we have been working alongside organisations wanting to make their audit data count. Projects have focused on trust performance against NAIF KPIs and have included looking at improving measurement and recording of lying and standing blood pressure (LSBP) and mobility.

These collaboratives have used the principles of quality improvement (QI) to drive forward local projects, to help positively use an individual organisation's audit data to improve their patient care.

As a NAIF team we invite all readers of the report to use the links and resources included, alongside your individual trust-level data, to drive QI projects locally. There is one chance to get falls prevention right, these resources will help to make sustainable improvements in the care of patients at risk of an inpatient fall.

Francesca Roberts, clinical fellow for NAIF

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Report at a glance – key messages

Femoral fractures sustained in inpatient settings result in poorer patient experience and worse outcomes compared with fractures that occur outside of hospital.

Femoral fractures can occur on any ward – not just on older people's wards.
There is only one chance to get things right – most (80%) femoral fractures occur on the first inpatient fall.

The records of inpatients who had a femoral fracture as a result of a fall were audited for the presence of multifactorial falls risk assessment (MFRA) prior to the fracture and post-fall management immediately afterwards.

85%

of trusts and local health boards (LHBs) in England and Wales participated in the audit this year.

Vision	LSBP	Medication review
52%	39%	74%
In 2020: 44%	In 2020: 35%	In 2020: 69%

Delirium	Mobility	Continence
66%	92%	83%
In 2020: 73%	In 2020: 73%	In 2020: 74%

There have been improvements in the proportion of patients receiving MFRA component assessments, the exception being delirium assessment. However, completion of lying and standing blood pressure assessment remains below 50%. Two-thirds of MFRAs included fewer than five of these six component assessments.

Checked for injury	Safe method for moving from the floor	Medical assessment within 30 minutes
77%	29%	60%
↓ In 2020: 71%	↓ In 2020: 26%	↑ In 2020: 62%
↓ In 2019: 69%	↓ In 2019: 22%	↓ In 2019: 52%

Post-fall management KPIs continue to gradually improve, but only one-third of patients with a femoral fracture are moved from the floor using flat lifting equipment. Using flat lifting equipment reduces the risk of pain and distress for patients who have sustained a femoral fracture.

Next steps for trusts/LHBs:

- review local data on webtool and in the trust report
- identify areas for action in your organisation
- use quality improvement methods to find out why it is a problem, design an improvement intervention to address the problem, measure the impact of the intervention and ensure changes are sustained.

Executive summary

It is encouraging that participation in the National Audit of Inpatient Falls (NAIF) is continuing to grow with 85% of trusts / local health boards (LHBs) having completed the facilities audit. We would like to thank all organisations for taking part and inputting their data. This report was only made possible by the contribution of the participating trusts and LHBs. The analysis of clinical cases shows that injurious falls can occur on any ward and quality improvement (QI) for falls prevention should avoid focusing only on those for older people.

Most femoral fractures occur on the first fall, so there is one chance to get falls prevention right. This requires patients to have a high-quality multi-factorial falls risk assessment (MFRA) in order to implement interventions to address identified risk factors. **This report defines high-quality MFRA as when a patient has documented evidence of assessment of at least five of the following six assessments: lying and standing blood pressure (LSBP), vision, mobility, delirium, continence and medication review.** In this report we will present high-quality MFRA as a new KPI for NAIF. This reflects the importance of MFRA in falls prevention. However, it is vital to remember that high-quality MFRA is just the first step. To prevent falls, action addressing identified risk factors must follow.

We have seen a steady improvement in post-fall management with higher compliance with the National Institute for Health and Care Excellence (NICE) quality standard 86 on checks for injury before moving, and use of safe lifting methods to move the patient from the floor. An inpatient femoral fracture is an experience which will be more distressing without prompt access to analgesia. An effective check for injury before movement will support effective clinical management of the fracture. NICE guidelines for hip fracture (CG124) recommend immediate pain relief on suspicion of hip fracture and to consider nerve block when preoperative pain cannot be controlled with paracetamol and opioids. The importance of effective and safe post-fall management is highlighted by the significantly poorer experience of patients who sustain a fracture as an inpatient compared with that of people admitted to hospital because of the same injury.

We recommend that trusts/LHBs use NAIF data to identify areas where their falls prevention activity or post-fall management could be improved and use quality improvement methodology to plan and conduct improvement initiatives. We strongly recommend that trusts/LHBs focus on process measures including NAIF KPIs and the recommendations made in this report. We also encourage rapid reflection and learning from fall incidents rather than additional burdensome paperwork. We have produced Hot debrief and After-action review resources for this purpose. These processes have been designed to align with the new NHS England Patient Safety Incident Response Framework.

We do not recommend that trusts/LHBs try to use their falls or fracture rate data to benchmark performance against other organisations. This is not meaningful as it does not account for differences in hospital caseloads and the completeness of falls reporting. Instead, we recommend focusing on:

1. **Completeness of falls reporting, including:**
   - **using a tool to ascertain reporting gaps**
   - **reviewing all inpatient femoral fractures not known to be a result of a fall.**
2. **Changes in fall/fracture rates within the organisation, with the aim of:**
   - **presenting and discussing organisational rates in regular multidisciplinary team (MDT) falls working groups**
   - **using run or statistical process control (SPC) charts to measure change over time with non-random variation or control limits applied to detect change**
   - **informing a review by executive and non-executive directors who hold responsibility for falls.**

Care home side report

This year the team has explored the feasibility of extending NAIF to care homes. The findings have been published in a side paper accompanying this report.

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Methods

All English NHS trusts and Welsh LHBs with inpatient beds were eligible to participate in NAIF.

Clinical audit

- The National Hip Fracture Database (NHFD) identified femoral fractures that occurred in the inpatient setting, referred to in this report as: inpatient femoral fracture (IFF).
- The NAIF team reviewed each IFF case and indicated if the fracture was due to an inpatient fall, referred to in this report as: fall-related IFF.
- Patients in English trusts and Welsh LHBs with fall-related IFFs sustained in 2021 were eligible NAIF cases requiring clinical audit data to be collected.

Facilities audit

- Trusts and LHBs completed a set of questions about their organisation in March 2022.

NAIF key performance indicators 2022

- **KPI 1:** Participation in the audit
- **KPI 2:** Checking for injury before moving from the floor
- **KPI 3:** Moving the patient safely from the floor
- **KPI 4:** Carrying out a prompt medical assessment after the fall
- **KPI 5:** High-quality MFRA prior to the fall (new)

Findings

Participation (KPI 1)

Of the 207 eligible trusts and LHBs, 176 (85%) participated in 2022. This is an increase of 6 percentage points from 2021 (Fig 1).

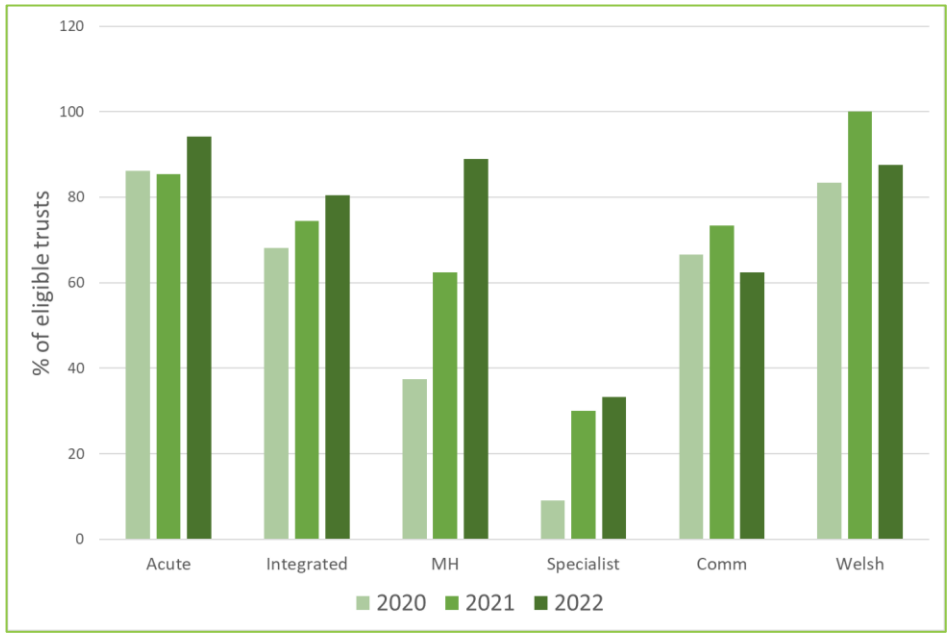

Fig 1. Participation in the audit by trust type

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Where the fracture happens matters

More than 50,000 people sustained a femoral fracture in England and Wales in 2021. Of these, 2,006 occurred in inpatient settings (NHFD). People who sustained an inpatient femoral fracture took longer to see a geriatrician, have surgery and get up after surgery. They were also more likely to experience delirium postoperatively and less likely to be discharged to their usual place of residence (Fig 2).

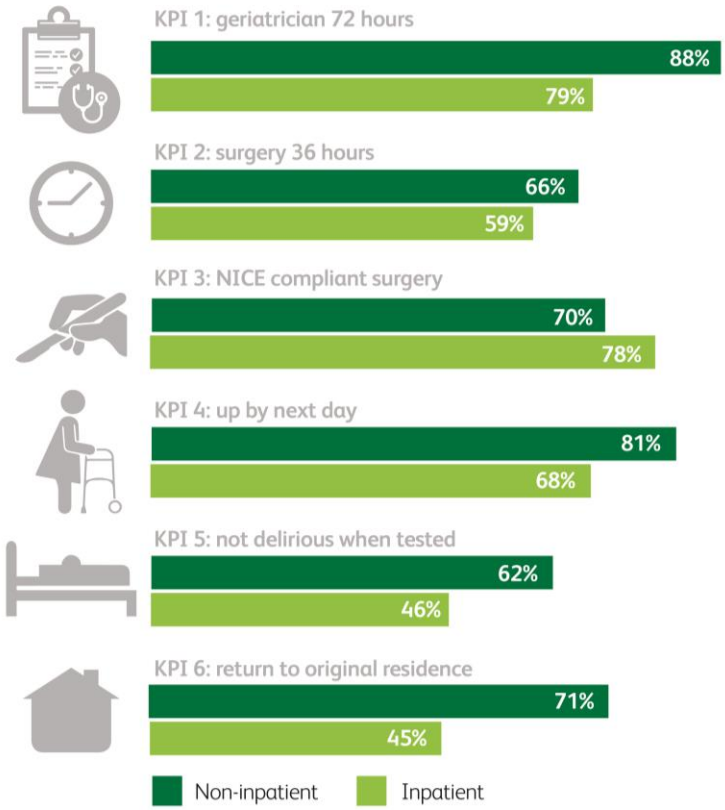

Fig 2. The six key performance indicators for the NHFD

Audit cases – key facts

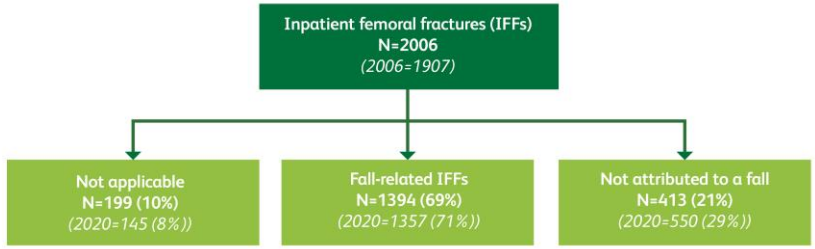

Fig 3. Case ascertainment for 2021

A total of 1,394 cases were eligible for the clinical audit. The proportion of IFFs not known to be a result of a fall reduced from 29% in 2020 to 21% in 2021 (Fig 3).

Completion

Most questions were answered, with >98% completion. The exceptions were two questions:

- Time from MFRA to fall = 26% missing, and
- Time from fall to administration of analgesia = 43% missing.

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Characteristics of fall-related inpatient femoral fractures

The average number of IFFs per trust/LHB was 13, ranging from 0–49. The IFF rate was calculated using data from the number of IFFs in each trust/LHB and the occupied bed day (OBD) data provided by NHS England and Wales. The mean rate of inpatient femoral fracture was **4 per 100,000** OBDs, ranging from 0–14.

Fall-related IFFs occurred a median of 7 days after admission (interquartile range (IQR): 2–9). Most (80%) IFFs occurred on the first fall, meaning for most patients **there is one chance to get things right.**

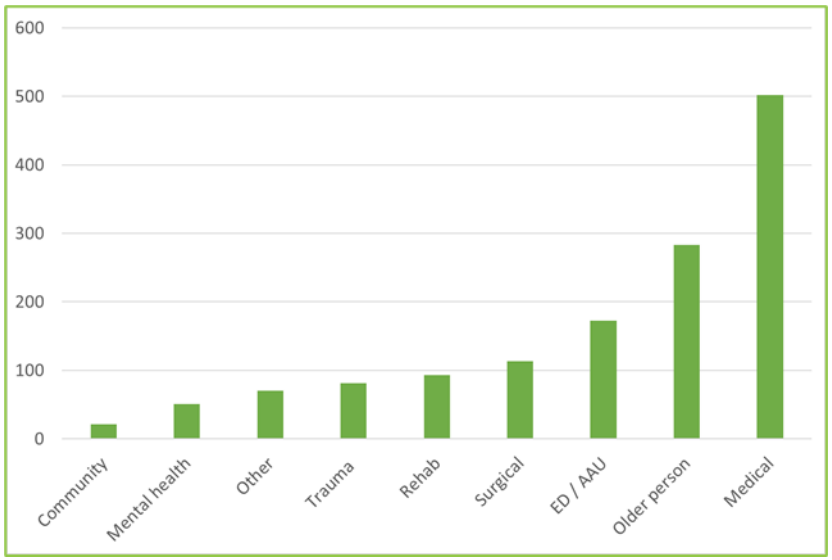

Fig 4. Ward type

Most fall-related IFFs occurred on medical wards, followed by wards for older people / frailty wards and assessment units / emergency departments (Fig 4). This pattern is unchanged from 2020.

Femoral fractures don't only happen on the older people's ward, they are more common on general medical wards.

Falls prevention activity prior to fracture

In 76% of cases, a documented MFRA had been undertaken a median of **3 days before the fall-related IFF** (IQR 1–6).

What constitutes a high-quality MFRA?

The components of an MFRA are described in NICE clinical guidelines (161) and on our webtool resource. NAIF looks at six components of MFRA (Fig 5). These components measure a range of falls risk factors that are potentially modifiable or require care plans to accommodate. This is important as **assessment of risk will not prevent falls unless action is taken to address the identified risk factors**.

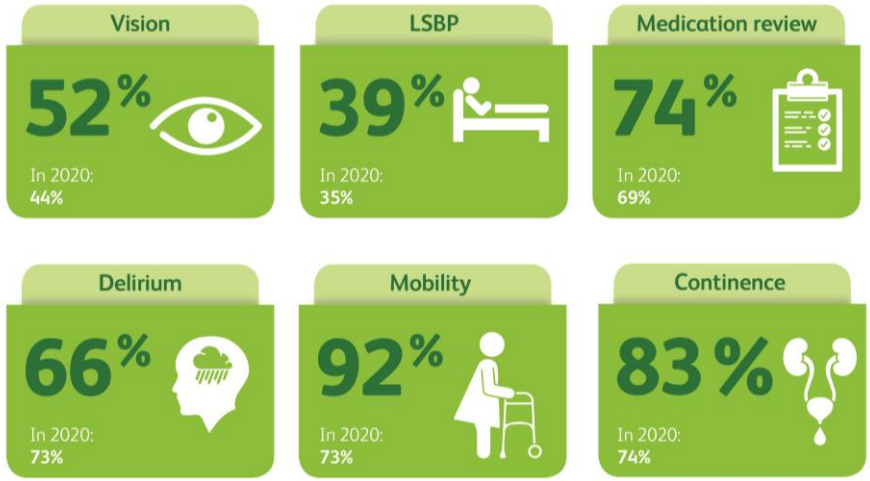

Fig 5. Proportion of cases with risk factor assessment

Improvements are noted in the proportion of patients receiving documented risk factor assessment prior to IFF, but there has been a reduction in the proportion of patients assessed for delirium.

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A new KPI – using the six risk factor assessments to create a measure of the quality of MFRA

This is a score calculated from adding together the six risk factor assessments for each patient. A maximum score of 6 indicates all assessment components were completed for that patient. A high-quality MFRA is defined as a score of 5 or more out of 6. Falls are multi-factorial hence, MFRA needs to include a range of components to be considered high quality.

- Median MFRA quality score in 2021 was 4 (IQR 0–5)
- Proportion of cases with MFRA quality score ≥5 was 31%

The proportion of cases receiving high-quality MFRA (≥5 assessments completed) is a new key performance indicator for the audit in 2022.

Prevalence of risk factors is high in those who sustain an IFF

In cases where assessment took place, risk factors were identified in the following proportions (Fig 6):

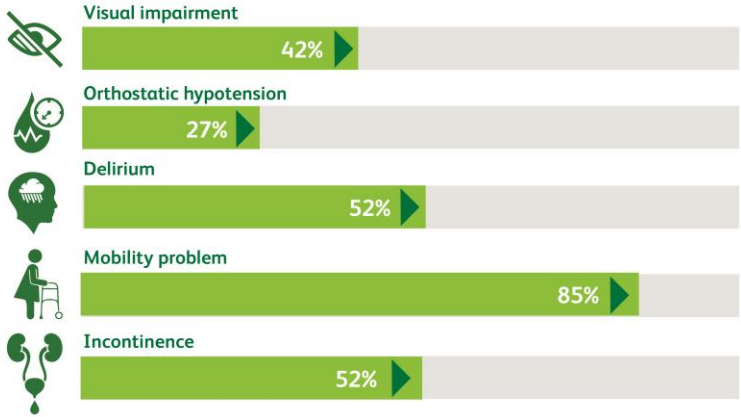

Fig 6. Prevalence of risk factors identified

Care plans in place

Where risk factors were identified, the following proportion of patients had care plans in place (Fig 7):

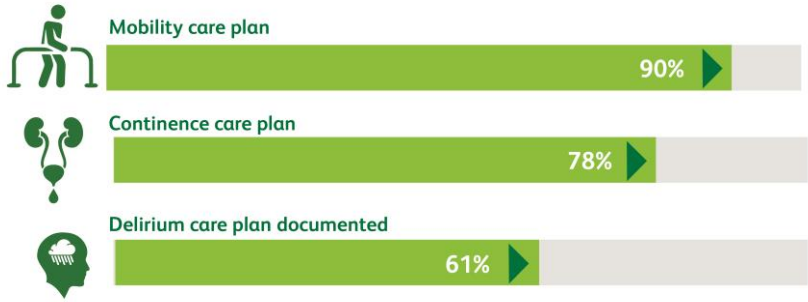

Fig 7. Care plan in place where risk factor identified

Post-fall management

The actions taken after a fall have the potential to influence outcomes and patient experience. If a post-fall check indicates there may be a femoral fracture, this should initiate the use of safe lifting techniques, rapid access to pain relief and prompt diagnosis and management of the fracture.

Check for injury before moving (KPI 2)

There have been steady improvements in the proportion of patients who had a check for injury before moving (Fig 8). **However, in 33% of cases where a check was conducted, an injury was not suspected (all patients had a femoral fracture).**

Safe lifting equipment used to move the patient from the floor (KPI 3)

The majority of patients who experienced a fall-related IFF were not moved from the floor using flat lifting equipment (Fig 8). This risks a more painful and distressing experience for the patient. However, it is encouraging to see small improvements in the proportion where flat lifting was used.

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Medical assessment within 30 minutes of the fall that caused the IFF (KPI 4)

In 60% of cases a patient was seen by a medically qualified professional within 30 minutes of the fall that caused the IFF (Fig 8). This has improved by 8 percentage points since 2019.

Fig 8. KPI 2, 3 and 4 performance

Pain relief after the fracture

There were substantial missing data for the question on time to analgesia, with 43% of cases missing. For those that reported this data, **analgesia was prescribed for 78%** of patients after the fall that caused the IFF, a median of **2 hours after the fall that caused the fracture** (IQR 1–4).

Harm reported after the fracture

In 78% of cases, severe harm was attributed to the fall that caused the fracture (a further 2% were recorded as death). This has increased by 11 percentage points from 67% in 2019, suggesting more organisations are adopting the approach recommended by NHS England of attributing severe harm to a femoral fracture sustained in hospital.

Delay to hip fracture care

Delays to hip fracture care were reported in 20% of cases. The most common reasons were a failure to identify and diagnose the fracture (59% of delays), problems with obtaining X-rays to confirm diagnoses (33% of delays) and need for transfer to another hospital (23% of delays).

Hot debriefs undertaken on the same shift

Hot debriefs were undertaken for 32% of cases and in 16% of cases were done on the same shift.

After action reviews

After action reviews took place after 46% of femoral fractures and were held within 5 working days in 24% of cases.

Facilities audit

The facilities audit continued with the same questions as previous years (Figs 9 and 12) but in 2022, questions were expanded in three areas to provide more detail.

One-quarter (26%) of trusts/LHBs reported undertaking a bed rail audit and answered further questions (Fig 11). Although over half of trusts/LHBs (61%) reported having a policy for 7-day access to walking aids, only a small number answered detailed questions about these audits (Fig 13). Information collected about falls working groups is presented in Fig 10.

The use of screening tools is still common with 34% of trusts using these. NICE clinical guidelines 161 recommend that screening tools are not used.

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Facilities audit findings

The data on this page summarise answers to the facilities audit questions.

Fig 9. Answers to facilities questions

	2021	2022
Uses a falls risk screening tool	36%	34%
System in place for assessing the gap between actual and reported falls	40%	32%
Flat lifting equipment on all sites	72%	76%
Conducts bed rail audit (see fig 11)	40%	26%
Policy for access to walking aids (see fig 13)	66%	61%
Written patient information on falls is available (see fig 12)	92%	86%
Falls training is mandatory	52%	50%
There is an executive director with specific responsibility for falls	89%	87%
There is a non-executive director with specific responsibility for falls	57%	52%
A multidisciplinary falls working group meets at least four times a year (see fig 10)	87%	86%

Fig 10. Multidisciplinary team working groups

86%
(158/183)

100% (158/158)
Answered these questions

4

Median number of meetings in 2021 with allied health professional (AHP), doctor and nurse present = 4

Information about trust/LHB multidisciplinary team working groups

Proportion of trusts/LHBs using run charts / statistical process control (SPC) charts to analyse trust/LHB falls rates per 1,000 OBDs ▶ 79%

Proportion of trusts/LHBs using non-random variations or control limits ▶ 88%

Proportion of trusts/LHBs undertaking fall-related quality improvement projects ▶ 68%

Fig 11. Bed rail audits

26%
(47/183)

100% (47/47)
Answered these questions

12 months

Median time since last bed rail audit was conducted = 12 months

Information about trust/LHB bed rail audits

Median proportion of beds audited ▶ 36%

Median compliance with policy ▶ 89%

Action taken after the audit ▶ 75%

Fig 12. Written information about falls

Spot check of random 25% of wards found written information available in:

none of the wards ▶ 15%
less than half the wards ▶ 38%
more than half the wards ▶ 22%
all wards reviewed ▶ 25%

Fig 13. Walking aid access audits

61%
(112/183)

8% (9/112)
Answered these questions

11 months

Median time since last walking aid audit conducted = 11 months

Information about trust/LHB walking aid audits

Median proportion of inpatients audited ▶ 82%

Median proportion of patients with the correct walking aid ▶ 94%

Action taken after the audit ▶ 33%

Audit covered:
Weekends and weekdays ▶ 78%
Weekdays only ▶ 72%

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Key messages and recommendations

	Key message	Supporting NAIF data	NAIF recommendation	Responsibility	
1	Fall-related fractures can happen on any ward	Most femoral fractures occurred on medical wards	Inpatients aged >65 should have a high-quality MFRA regardless of their ward	Clinical/leadership	1
2	There is only one chance to get it right	80% of femoral fractures occurred on the first fall	High-quality MFRA is required to identify risk factors and ensure action is taken to address these	Clinical/leadership	2
3	High-quality MFRA is necessary to ensure important fall risk factors are addressed	Two-thirds of MFRAs did not include vital assessment components	Use NAIF data and quality improvement methods to increase the proportion of inpatients who receive a high-quality MFRA	Clinical	3
4	Accurate post-fall checks support effective care	One-third of post-fall checks did not identify an injury – this restricts patient access to safe methods to move from the floor and prompt fracture care	Trusts/LHBs should ensure staff with appropriate competencies are available to carry out post-fall checks 24/7	Clinical	4
5	All inpatients should have access to flat lifting equipment to move patients from the floor	Flat lifting equipment was not used to move the person from the floor in two-thirds of femoral fracture cases	Trusts/LHBs should ensure access to flat lifting equipment is available at all sites	Leadership	5
6	Inpatients who sustain a femoral fracture should have immediate access to analgesia	The median time to receiving analgesia was 2 hours	Trusts/LHBs should ensure prompt medical assessment /diagnosis for inpatients and compliance with hip fracture NICE guidelines	Clinical/leadership	6
7	Improvement activities should focus on fall prevention and post-fall management processes	Hot debriefs were used after 32% and after action reviews after 46% of femoral fractures	NAIF KPIs/recommendations should be the focus of QIPs; benchmarking falls or fracture rates between trusts/LHBs is not recommended	Leadership	7

Key message | Supporting NAIF data | NAIF recommendation | Responsibility

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What to do next

This report provides an overview of falls prevention activity and post-fall management for patients with IFF across England and Wales and the key findings and recommendations relate to national data. The next steps for trusts and LHBs should include:

- reviewing the recommendations from this report against trust/LHB priorities for falls prevention and management
- examining trust/LHB level key performance indicators using the webtool live data and trust reports
- deciding on what local actions should be taken in response to the audit findings and priorities for quality improvement projects (QIPs).

These discussions should take place in the trust/LHB falls steering group and the outcomes disseminated to all relevant stakeholders. The report and local action plan should be shared with the executive and non-executive director who has responsibility for falls.

Falls are everyone's business – who should do what?

There are many recommendations in this report that require action from patient-facing clinical teams. However, it is important to remember that changes in clinical practice will only occur if supported with appropriate systems and structures that are reinforced by those in leadership roles.

Where to start with quality improvement projects

Plan

Use the data to decide the aim of the project and focus on one KPI rather than several. Once you have decided on the KPI you would like to address, devise a plan for including relevant stakeholders and involving patients.

Many people start QIPs with a firm intervention plan. In clinical care, we would not provide a treatment without first conducting a clinical assessment. Similarly, QIPs should begin by evaluating the factors influencing performance using methods such as driver diagrams, process mapping and fishbone diagrams. This will enable teams to plan the most appropriate intervention to address a problem. For example, evaluation may identify that the reason for low rates of LSBP measurement is due to lack of equipment. Addressing this with an education intervention would not effectively tackle this problem.

Do

Implement the intervention on a small scale to start with, for example select one ward or unit. This can be scaled up to the rest of the organisation if it works. Avoid designing an overcomplex intervention. The simpler an intervention, the more feasible and acceptable it is likely to be when there are limited resources.

See below for specific resources to support improvement activities relating to MFRA and post-fall management.

Study

Before starting the intervention, decide on easy to collect outcome, process and balancing measures and establish run or SPC charts. Where possible, use routinely collected data involving trust/LHB business intelligence to provide automated dashboards, or use NAIF live data.

Act

Evaluate the effect of the intervention on the agreed measures. Plan the next cycle of improvement, consider how to sustain and scale up improvements.

Key performance indicators for 2023

Participation will no longer be a KPI in 2023, so KPI numbers will be changing.

1. **High-quality MFRA prior to the fall**
2. **Check for injury before moving**
3. **Flat lifting equipment used to move the patient from the floor**
4. **Assessment by a medic within 30 minutes of the fall**

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Resources to support improvement

The sections below include links to and information on useful resources.

KPIs for NAIF

Real time trust/LHB level NAIF KPI performance data for KPIs 2, 3 and 4 can be found on the webtool. These 12-month data are updated quarterly.

Trust/LHB reports

Trusts/LHBs will be provided with individualised reports with their own data, alongside the national figures included in this report.

Support with multi-factorial falls risk assessment

- Description of MFRA
- How to measure lying and standing blood pressure
- Look out vision assessment tool
- Look out vision assessment video
- NICE guidelines (CG161)

Support with post-fall management

- NICE quality standards 86
- NICE guidelines for hip fracture (CG124)
- Post-fall management resources
- Hot debrief
- After action review

Support with quality improvement

- Quality improvement material

Support for patients and healthcare champions

- How should your hospital prevent and respond to falls during your stay?
- Information about inpatient falls for patients

Training and development

- CareFall and FallSafe
- Learning from inpatient falls – hot debrief
- Learning from inpatient falls – after action review
- How to get falls e-learning fixed into your organisation

Abbreviations

AHP	allied health professional
BP	blood pressure
CG	clinical guideline
IFF	inpatient femoral fracture
IQR	inpatient quality reporting
KPI	key performance indicator
LHB	local health board
LSBP	Lying and standing blood pressure
MDT	multidisciplinary team
MFRA	multi-factorial falls risk assessment
NAIF	National Audit of Inpatient Falls
NHFD	National Hip Fracture Database
NICE	National Institute for Health and Care Excellence
OBD	occupied bed days
QI	quality improvement
SPC	statistical process control

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National Audit of Inpatient Falls annual report 2022

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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 Fracture 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).

Healthcare Quality Improvement Partnership
The National Audit of Inpatient Falls 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, the Royal College of Nursing, and National Voices. Its aim is to promote quality improvement in patient outcomes, and to increase the impact of clinical audit, outcome review programmes and registries on healthcare quality in England and Wales. HQIP commissions, manages and develops 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 www.hqip.org.uk/national-programmes.

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