Falls and Fragility Fracture Audit Programme: NAIF Clinical Audit Proforma

Version 6 – Live from 1 January 2025 for January-December 2025 cases

Section 1: Patient Confirmation

	QUESTIONS	FIELD HELP
Q1.0	**Trust or health board assigned**	
	DROP DOWN LIST OF PROVIDERS	*This NAIF record has been assigned to this trust/health board for further investigation. Please check the transfer or admission notes for the details of where the fall occurred.* ***FALL OCCURRED IN ANOTHER TRUST:*** *If the fall occurred in a different trust, it is the responsibility of the clinical lead at that trust to generate and complete a NAIF record.* *If the trust or health board is not listed, please contact the audit support helpdesk (falls@rcp.ac.uk).*
Q1.1	**Did this patient have a fall resulting in an injury or injuries in your Trust / Health Board?**	
	□ Yes - a fall is known to have occurred □ No - no fall known to have occurred (if so, no further data entry required) □ Not applicable □ Not a patient at this Trust/Health Board □ Duplicate record assigned	*Carefully check your records for the patient identified below and answer 'Yes' if you can confirm that the NAIF eligible injuries occurred as a result of an inpatient fall* *If the answer is 'Yes' please complete the NAIF record for this patient.* *If there is no record of a fall that can be linked to the injuries, select no fall known to have occurred. By choosing this answer, you are acknowledging that the patient sustained either a head or spinal injury or fracture as in inpatient in your organisation but there is no record of a related fall. A fall is defined as 'an unexpected event in which the participants come to rest on the ground, floor, or lower level.'' (Lamb et al 2005)* *The inpatient fall is 'not applicable' if the fall is known to have occurred, but not in an inpatient setting, for example in a care home, hospice, other non-hospital care setting. In rare cases (where there is uncertainty as to whether injuries were present prior to admission), clinical judgement may be required to determine whether the injuries are thought to have occurred as a result of the inpatient fall.* *Only one NAIF record is required per patient. All injuries are reported in one case report.* ***Check the online help for further details**.*

Q1.2	**NHS number (mandatory)**	
	_ _ _ _ _ _ _ _ _ _	*The field will accept valid NHS Numbers which are ten numeric digits long.* *You should enter this as "1234567890"* *At the moment, please avoid using spaces or dashes or 3-3-4 format.* *Please use 'OVERSEAS' for patients resident outside the UK..* ***Patients must be over 65 and under 111 years of age.***
Q1.3	**First name(s)**	
Q1.4	**Surname**	
Q1.5	**Date of birth**	
	_ _ / _ _ / _ _	*Only enter patients aged 65 or more on the date of presentation to trauma team/admission.* *In DD/MM/YYYY format*
Q1.6	**Sex**	
	□ Female □ Male	*For those whose gender is different from their sex registered at birth, the answer you record does not need to be the same as their birth certificate.*
Q1.7	**Patient's post code**	
	_ _ _ _ _ _ _	*Record the patient's usual place of residence (home) post-code and not the post code of the hospital where the fall occurred. If the patient has no fixed address enter 'NFA.'* *If patient is admitted from:* *'Holiday residence' - use patient's home postcode* *'Respite care' - use patient's home postcode*

Section 2: Fall and injury details

	QUESTIONS	FIELD NOTES
2.1	**What injury / injuries were sustained as a result of the fall (select all that apply)?**	
	Any of the following listed fractures are classed as eligible for NAIF if they occurred as a result of an inpatient fall: □ Head injury □ Spinal injury □ Hip fracture □ Vertebral fracture □ Rib fracture □ Humeral fracture □ Distal forearm fracture □ Pelvic ring fracture □ Other fracture	*Specific definitions of NAIF eligible injuries can be found here.* ***Select all that apply*** *Trusts / health boards are not expected to investigate for the injuries listed where there is no clinical indication to do so.*
2.2	**Time and date when the patient was admitted to the trust / health board where the fall that caused the injuries occurred:**	
	DATE: DD/MM/YYYY: TIME: HH:MM:	*Please record the date and time the patient arrived at your trust / health board. It is important to record the arrival time because this is the first point of contact with the organisation.* *If there is no recorded time of admission, record the time as midnight on the day of admission.* *Record time in 24hr format*
2.3	**Time and date of the fall that caused the injuries (has to be after time and date of admission):**	
	DATE: DD/MM/YYYY: TIME: HH:MM:	*Please record the date and time of the fall that caused the NAIF eligible injury(ies).* *If there is no record of the time of the fall that caused the injuries, record the time as midnight on the day that the injury is recorded.* *Please note that recording in this way will impact on audit findings for delays to post fall care.* *In the event there is no date recorded for the fall that caused the injury use the date the injury is recorded to generate this case.* *If the time and/or date of the fall that caused the injury was absent, trusts are advised to review their reporting mechanisms.* *Record time in 24hr format*

2.4	Type of trust / health board where fall happened	
	□ Acute □ Community □ Mental health / learning disabilities □ Integrated □ Welsh health board	*If your Trust includes a combination of acute, community, learning disabilities or mental health – choose integrated.*
2.4a Type of ward /unit	**Acute** a. Emergency department b. Ambulatory care c. Medical admission unit (including clinical decision units) d. Surgical admissions unit e. Medical (general and speciality) f. Surgical (general, speciality excl. orthopaedic g. Trauma/orthopaedics (including elective orthopaedics) h. Older person's / frailty i. Other **Community** a. General b. Continuing healthcare c. Learning disability d. Palliative care **Mental health** a. General adult b. Learning disability c. Older people **Integrated trust and Welsh HB** a. Emergency department b. Ambulatory care c. Medical admission unit (including clinical decision units) d. Surgical admissions unit	*An admission unit is a short stay decisions unit e.g. Acute Medicine Unit (AMU) or Clinical Decision Unit (CDU) or equivalent.* *Ambulatory care covers patients who are not formally admitted but are not classed as an outpatient (outpatients = those with booked appointments). An example of ambulatory care would be a Same Day Emergency Care unit where patients are taken for an assessment with no fixed appointment time.* *If none of these categories are appropriate used the choice of general or other.*

	e. Medical (general and speciality) f. Surgical (general, speciality excl. orthopaedic g. Trauma/orthopaedics (including elective orthopaedics) h. Older person's / frailty i. Other acute j. General community k. Continuing healthcare l. Learning disability m. Adult mental health n. Older adult mental health o. Palliative care p. Other community / MH	
2.5	**Was this the first fall this admission?**	
	□ Yes □ No – one previous fall □ No – two or more previous falls	*Indicate 'No' if there are any falls recorded that occurred before the one that caused the injury.* *This should refer to falls that occurred during the SAME admission (to the Trust/Health Board) as the one that caused the injury , even if the falls occurred in other ward locations.* *Do not include falls that occurred before this admission episode or during previous admissions.*

Section 3: Multi-factorial Assessment to optimise Safe Activity

	QUESTIONS	FIELD NOTES
3.1	**Did the patient have a documented assessment of vision during the admission but before the fall that caused the injury(ies)?**	
	□ Yes - no visual impairment identified (go to 3.1a) □ Yes - visual impairment identified (go to 3.1a) □ No / not documented	*A vision assessment should identify the presence of visual impairment and/or the need for visual aids such as spectacles.* *The following three elements are necessary for a vision assessment to meet the criteria for this audit:* *(1) questioning about spectacle use and simple testing of* *(2) distance and* *(3) near vision* *(see Q1-3 in the RCP tool – this is an example only, it is not necessary to use the RCP tool in order to answer Yes to this question).* *This question relates to an assessment of vision only and does not require medical diagnosis, an assessment and referral to specialist where appropriate would be enough to answer yes to this question.* *Refer to: 'Look out! Bedside vision check for falls'.*
3.1a	**How many days before the fall (that caused the injuries) was vision assessed?**	*Calculate how many days before the fall the vision assessment was done. If less than 1 day, can use a decimal place (i.e. 0.5 = vision assessment performed 12 hours before the fall)*
3.2	**Did the patient have a documented lying / standing blood pressure measurement during the admission but before the fall that caused the injury(ies)?**	
	□ Yes - no evidence of orthostatic hypotension (go to 3.2a) □ Yes - evidence of orthostatic hypotension (go to 3.2a) □ Not documented □ Not possible	*Definition of lying / standing BP and OH (link to the RCP guidance).* *Only select the option 'not possible', if the patient was unable to stand for this assessment for the duration of their inpatient stay prior to the injury.*
3.2a	**How many days before the fall (that caused the injuries) was LSBP assessed before the fall?**	*Calculate how many days before the fall the lying / standing blood pressure was done. If less than 1 day, can use a decimal place (i.e. 0.5 = assessment performed 12 hours before the fall)* *Please note that number of days cannot exceed the number of days patient was admitted*
3.2b	**What were the BP values?**	*Leave blank if not recorded*

	Lying BP (after 5 minutes supine) Systolic: Diastolic: Pulse: Standing (after 1 minute) Systolic: Diastolic: Pulse: Standing (after 3 minutes) Systolic: Diastolic: Pulse:	*Systolic limits 50 to 250* *Diastolic limits 40 to 150* *Pulse limits 10 to 210*
3.3	**Is there documented evidence that the patient had a medication review during the admission but before the fall that caused the injury(ies)?**	
	□ Yes (go to 3.3a) □ No □ Not applicable	*This question is asking whether the patient's medications were assessed to identify any drugs that might contribute to falls. This could be by a doctor, pharmacist or any other appropriate member of staff. It is also asking whether any changes were made in light of this, or if a decision was recorded that no changes were required/possible.* *Medication review may not always result in de-prescribing of culprit medications known to contribute to falls. Provided the review includes an assessment weighing up the risk and benefit of decisions regarding culprit medications that contribute to fall risk, this constitutes a medication review.* *Answer not applicable if the patient was not on any medication or only topical medication and/or inhalers.* *The auditor is politely reminded that the term "medication review" may not always be present in the patients notes and that quite often this may be deemed to have taken place by the following:* *(1) Discontinuation or reduction of a fall risk inducing drug(FRID)- documented in the patients notes but often more obvious from the medication chart* *(2) The patient's first drug chart, taken from admission, should have a medicines review or reconciliation completed and will often be the most appropriate drugs chart to review for changes to the patient's medicines.* *Reduced/discontinued FRID drugs to score as ' Yes - Patient was assessed' even if a medication review was not formally recorded.* *See Medicines and falls 9 23 (RPSendorsed).pdf (rpharms.com) for more details.*
3.3a	**How many days before the fall (that caused the injuries) was medication review assessed?**	*Calculate how many days before the fall the medication review was done. If less than 1 day, can use a decimal place (i.e. 0.5 = medication review performed 12 hours before the fall)* *Please note that number of days cannot exceed the number of days patient was admitted*

3.4	**Was the patient screened for delirium using 4AT during the admission but before the fall that caused the injury(ies)?**	
	□ Yes (go to 3.4a) □ Other screen used (go to 3.4a) □ Not screened/not documented	*We recommend delirium screening is undertaken using 4AT for all older people admitted to hospital with an unplanned admission.*
3.4a	**Screening outcome?**	
	□ Delirium suspected □ Delirium not suspected	
3.4b	**How many days before the fall (that caused the injuries) was delirium screened for?_the fall**	*Calculate how many days before the fall the delirium screening done. If less than 1 day, can use a decimal place (i.e. 0.5 = screening performed 12 hours before the fall)* *Please note that number of days cannot exceed the number of days patient was admitted*
3.4c	**If 4AT – record score here (a number):**	
3.5	**Did the patient have a documented mobility plan supporting them to be as active as possible before the fall that caused the injuries?**	
	□ Yes □ No	*To answer yes, the care plan must include an assessment that determines the walking aid and supervision required, actions noted to ensure aids and call bells are in reach (where indicated) and what methods will be used to optimise activity levels during the admission.*
3.6	**Was there evidence that the patient had an assessment of continence and corresponding continence care plan (if required) during the admission but before the fall that caused the injury(ies)?**	
	□ Yes - continence problems identified - care plan documented □ Yes - no problems with continence identified □ No - continence problems identified - but no care plan documented □ No - no assessment of continence documented	*An individualised continence care plan consists of a documented assessment of urinary and faecal continence, flagging any problems identified and a plan to address these problems.*

Section 4: Post Fall management

	QUESTIONS	FIELD NOTES
4.1	Is there documented evidence in the clinical notes that the patient was checked for signs or symptoms of potential for spinal injury and fracture **before they were moved**?	
	□ Yes - injury suspected (go to 4.1a) □ Yes - no injury suspected (go to 4.1a) □ No	*If there is no outcome of the check for signs and symptoms documented in the clinical notes, answer 'No'.* *Guidance: https://www.nice.org.uk/guidance/qs86/chapter/Quality-statement-4-Checks-for-injury-after-an-inpatient-fall*
4.1a	**Time in minutes from fall that caused the injury (ies) to the post fall check:**	
4.1b	**Was immobilisation used? (RCEM + other work)**	
	□ Yes – blocks □ Yes – spinal board □ Yes – collar □ No	
4.2	**What moving and handling method was used to move the patient following the fall that caused the injury (ies)?**	
	□ Flat lifting equipment/scoop hoist □ Standard hoist (without flat lifting capability) □ Ambulance service equipment □ Assisted to get up with help by staff □ Got up independently □ Method not documented	*As documented in the clinical notes.* *Note: record as 'Assisted to get up with help by staff' if the patient was moved without equipment being used.* *If the patient was moved from the floor by an ambulance service, record the method used.* *Check guidance: https://www.nice.org.uk/guidance/qs86/chapter/Quality-statement-5-Safe-manual-handling-after-an-inpatient-fall*
4.3	**Is there documented evidence that the patient had a medical assessment within 30 minutes following fall that resulted in the injury (ies)?**	
	□ Assessment by medically qualified professional (go to 4.3a-b) □ Assessment by appropriately qualified other healthcare professional (go to 4.3a-b) □ No assessment recorded within 30 minutes (go to 4.4)	*This assessment should be performed by a medically qualified person (as stated in CG161). However, in settings where a doctor is not on site 24/7, a competent health care professional (other than a doctor) can perform an assessment to determine whether a fast track (transfer to emergency department) or routine follow-up (review within 12 hours) is required.* *This assessment should be performed by a medically qualified person (as stated in CG161).* ***Who should complete these assessments?*** *When completing this audit, the definitions used by the NICE quality standards should be used. The initial*

		assessment (described in QS86:4) can be performed by any healthcare professional, but the medical examination (described in QS86:6) should be undertaken by a medically qualified doctor. The purpose of the medical examination is not only to ascertain injury, it is to arrange diagnostic tests (X-ray, CT), to ensure the patient is medically stabilised and to prescribe appropriate analgesia. The patient may be assessed by a non-medical practitioner, but this assessment should translate into a medical examination within 30 minutes if serious injury is suspected. ***In settings without 24/7 medical cover*** *In mental health and community settings where a doctor is not on site 24/7, a competent health care professional should perform an assessment to determine whether a fast track assessment is required. Where a serious injury is suspected, this assessment should result in a decision to arrange ambulance transfer within 30 minutes of the fall. The 30 minute timeframe relates to the time at which the decision is made, rather than when the ambulance arrives.* *Check guidance here.*
4.3a	**Was the injury/ injuries suspected at this medical assessment?**	
	□ Yes □ No	
4.3b	**Time in minutes from fall that caused the injury (ies) to the medical assessment?**	
4.4	**Was analgesia given following the fall that caused the injury (ies)?**	
	□ Yes (go to 4.4a) □ Not prescribed (go to 4.5) □ Not recorded (go to 4.5)	*If for any reason analgesia was not prescribed, tick not prescribed.* *If there is no record of analgesia prescription in the patient's notes, tick not recorded.* *If the patient was prescribed analgesia for another reason prior to the fall and this precluded further administration immediately after the fall that caused the fracture, tick Yes. Only use this option if the reason for not administering post-fall analgesia was because it would result in overdose*
4.4a	**Time in minutes from fall that caused the injury (ies) to administration of analgesia**	
4.5	**Were neurological observations undertaken after the fall that caused the injury (ies)?**	
	□ Yes □ No	

4.6	**What level of harm was attributed to the fall that caused the injuries?**	
	☐ Death ☐ Severe harm ☐ Moderate harm ☐ Low harm ☐ No harm	*See: NRLS guidance* *Please indicate the level of harm attributed to this fall as validated in your local reporting system (i.e. Datix /Ulysses / other). Answer based on level of harm attributed during the admission for the fall resulting the injury.* *Learning Response Tools - NHS Patient Safety - FutureNHS Collaboration Platform*
4.7	**Was there a delay in transfer to the acute hospital recorded?**	
	☐ Yes ☐ No ☐ Not applicable as patient is already in an acute hospital / trust	

Section 5: Post fall review

	QUESTIONS	FIELD NOTES
5.1	**Was a swarm huddle / hot debrief conducted after the fall that caused the injuries?**	
	☐ Yes- in the same shift ☐ Yes- but could not be done in the same shift ☐ No	*NAIF recommends these swam huddle / hot debrief to be conducted in line with the organisations bespoke plan for falls reviews and investigations, as per the PSIRF strategy.* *More resources here*
5.2	**Was there a structured debrief / after-action review conducted with the MDT within 5 days of the fall that caused the injuries?**	
	☐ Yes- within 5 working days ☐ Yes- but could not be done within 5 working days ☐ No	*NAIF recommends these structured debrief / after-action review to be conducted in line with the organisations bespoke plan for fall reviews and investigations, as per the PSIRF strategy* *More resources here*