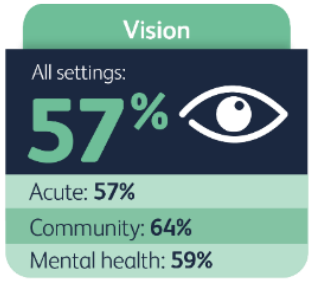
Supplementary paper

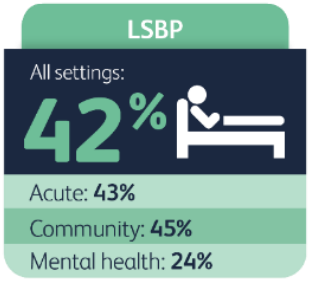
National Audit of Inpatient Falls Annual report 2024: A comparison of audit data from different inpatient settings

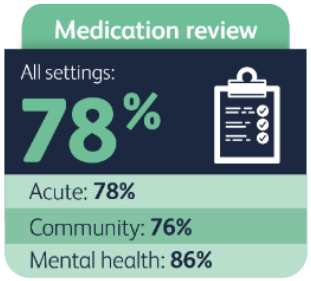
Report at a glance

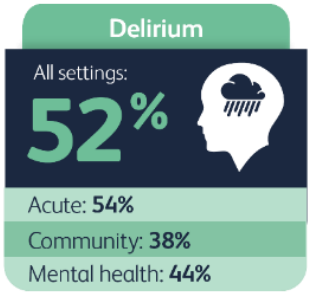
1,604 patients with fall-related inpatient femoral fractures were analysed to compare NAIF audit performance by three inpatient settings: acute, community and mental health.

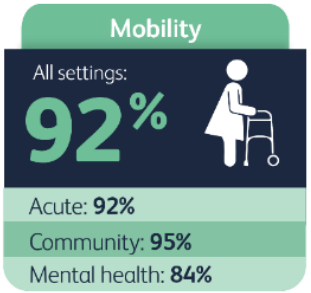
Multifactorial risk assessment

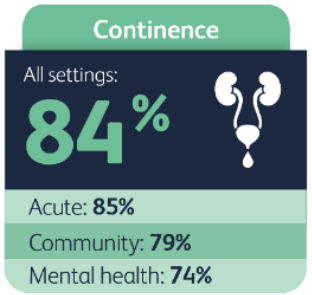




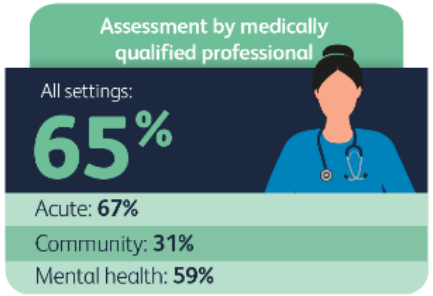


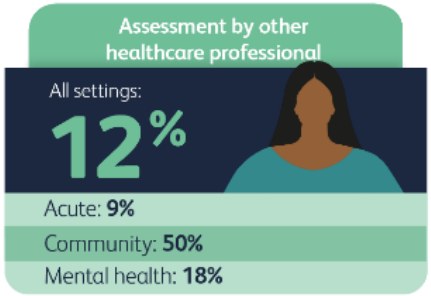






Post-falls management





Recommendations and next steps

- The recommendations in the main report apply to all settings
- NAIF will consult to determine the best way to support community and mental health settings to improve completion of multifactorial assessments (MASA)
- The training needs and competencies of non-medical healthcare professionals and psychiatrists will be considered in the production of upcoming NAIF post-fall assessment resources
- NAIF will look for ways to support community and mental health settings to gain access to flat lifting equipment

Falls prevention activity prior to the fall and fracture

Methods

Data collected from the National Audit of Inpatient Falls (NAIF) between January and December 2023 were broken down and analysed by setting based on the reported location of the fall. For acute, community and mental health trusts, this was done based on reported trust type, while for integrated trusts and Welsh health boards, this was done based on the ward type indicated (as in Table 1 below). The full details of NAIF methods are available in the main report.

As there is no agreed definition as to what constitutes each of the settings considered, this information is based on the trust and ward type reported at audit data entry.

Table 1. Categorisation of setting based on trust/ward type reported

Response for each NAIF case	Setting	Response for each NAIF case	Setting
Acute trust	Acute	Community trust	Community
All wards		All wards	
Integrated trust and Welsh HB		Integrated trust and Welsh HB	
Emergency department		General community	
Ambulatory care		Continuing healthcare	
Medical admission unit		Palliative care	
Surgical admissions unit			
Medical		Mental health trusts	Mental health
Surgical		All wards	
Trauma/orthopaedics		Integrated trust and Welsh HB	
Older people/frailty		Learning disability	
Other acute		Adult mental health	
		Older adult mental health	

Audit findings

In 2023, 1,609 cases of fall-related inpatient femoral fracture (IFF) were reported in the National Audit of Inpatient Falls (NAIF), 1,604 specified the setting in which the fall occurred. Most falls (91%) occurred in acute settings, but 78 (5%) occurred in community settings, and 69 (4%) in mental health settings.

Table 2 shows the average length of stay for a patient before an IFF. There is a significant increase in the days a person is admitted between each setting from acute (8 days) to mental health (35 days).

Table 2: Length of stay in setting prior to fall

	Acute	Community	Mental health
Median length of stay in days (IQR)	8 (2–22)	21 (11–37)	35 (16–85)

These data could be used by settings to target timing of completion and frequency of reviewing completion of multifactorial assessments. Many fall-related IFFs do not happen early on in the admission. Average length of stay in an acute hospital is 7.5 days (OECD), suggesting that most IFFs in this setting occur towards the end of an admission, or in people more likely to already be experiencing a longer than average admission. The time between admission and IFF is 3 weeks in community and 1 month in mental health settings, emphasising the need for regular review of multifactorial assessments, as the condition of a patient is likely to change over these time periods.

Post-fall management

Table 4 presents the post-fall management (including NAIF KPI 2,3 and 4) data by setting.

The multifactorial assessment for safe activity (MASA) considers six factors that influ ence safe activity, which are potentially modifiable or require care plans to accommodate. A score of 5 or more is considered high quality and is key performance indicator (KPI) 1 for NAIF. See the main report for more details.

This indicates that less than half of all inpatients received a high-quality MASA. Acute settings appear to perform slightly better, but there are only six percentage points between settings, suggesting no significant difference. Looking at the individual assessment components (Table 3), there are mixed findings in that community and mental health settings performed better in some areas (vision and medication review respectively) but worse in others (delirium for community and lying/standing BP, delirium, mobility and continence assessment for mental health). Assessment tools and processes are largely tailored towards acute settings so may need to be adapted for community and mental health.

Table 3: Multifactorial assessment for safe activity completion*

	All settings	Acute	Community	Mental health
Vision assessment completion (%)	57	57	64	59
Lying and standing BP completion (%)	42	43	45	24
Medication review completion (%)	78	78	76	86
Delirium assessment completion (%)	52	54	38	44
Mobility assessment completion (%)	92	92	95	84
Continence assessment completion (%)	84	85	79	74

* A meaningful difference is considered to be five percentage points above or below the overall average.

Table 4: Post-fall management comparison*

	All settings	Acute	Community	Mental health
Check for injury before moving (%) (KPI 2)	77	77	87	76
Injury suspected following assessment (%)	53	52	65	53
Use of flat lifting equipment (%) (KPI 3)	33	34	29	12
Post-fall assessment by medical qualified professional (%): (KPI 4)	65	67	31	59
Received analgesic in 30 minutes	26	26	41	35
Time from fall to X-ray (hours)	4	4	7	6
Time from fall to orthopaedic review (hours)	15	15	14	13
Transfer to acute (hours)	8	11	5	7

* A meaningful difference is considered to be five percentage points above or below the overall average or 50% longer or shorter.

Table 5 presents post-fall assessment by medically qualified professional (KPI 4) further broken down to consider assessment by other professionals.

Table 5: Post-fall assessment*

	All settings	Acute	Community	Mental health
Assessment by medically qualified professional (%)[a]	65	67	31	59
Assessment by other healthcare professional (%)	12	9	50	18
Total (%)	77	76	81	76

*A meaningful difference is considered to be five percentage points above or below the overall average

[a] NAIF specifies that medically qualified professional is understood to be a medically qualified doctor.

Data suggest that outside the acute hospital setting, and in particular, in community settings, other healthcare professionals frequently complete the post-fall assessment. This is an interesting finding considering that community settings were more likely to effectively identify the injury in the post-fall check and both community and mental health settings were more likely to provide analgesia within 2 hours. However, it is important that post-fall assessment resources consider the training needs of non-medical professionals to appropriately support these settings. NAIF is currently in the process of providing more guidance on the post-fall assessment, which will consider these findings.

Recommendations

The recommendations in the main report apply to all settings.

The following actions will be taken in response to these findings:

- NAIF will consult to determine the best way to support community and mental health settings to improve completion of multifactorial assessments (MASA)
- The training needs and competencies of non-medical healthcare professionals and psychiatrists working in community and mental health settings will be considered in the production of upcoming NAIF post-fall assessment resources
- NAIF will look for ways to support community and mental health settings to gain access to flat lifting equipment

More research is needed to fully understand the underlying factors, but these data suggest that non-medical professional post-fall management could be effective in these settings. In fact, there was better identification of injury and more rapid administration of analgesia despite lower proportions of medical doctors completing assessments. Consideration could be given to adapting NICE quality standard on this (QS 86, standard 6) to widen the scope for practice based on competencies rather than professional background.