

The National Audit of Inpatient Falls (NAIF)

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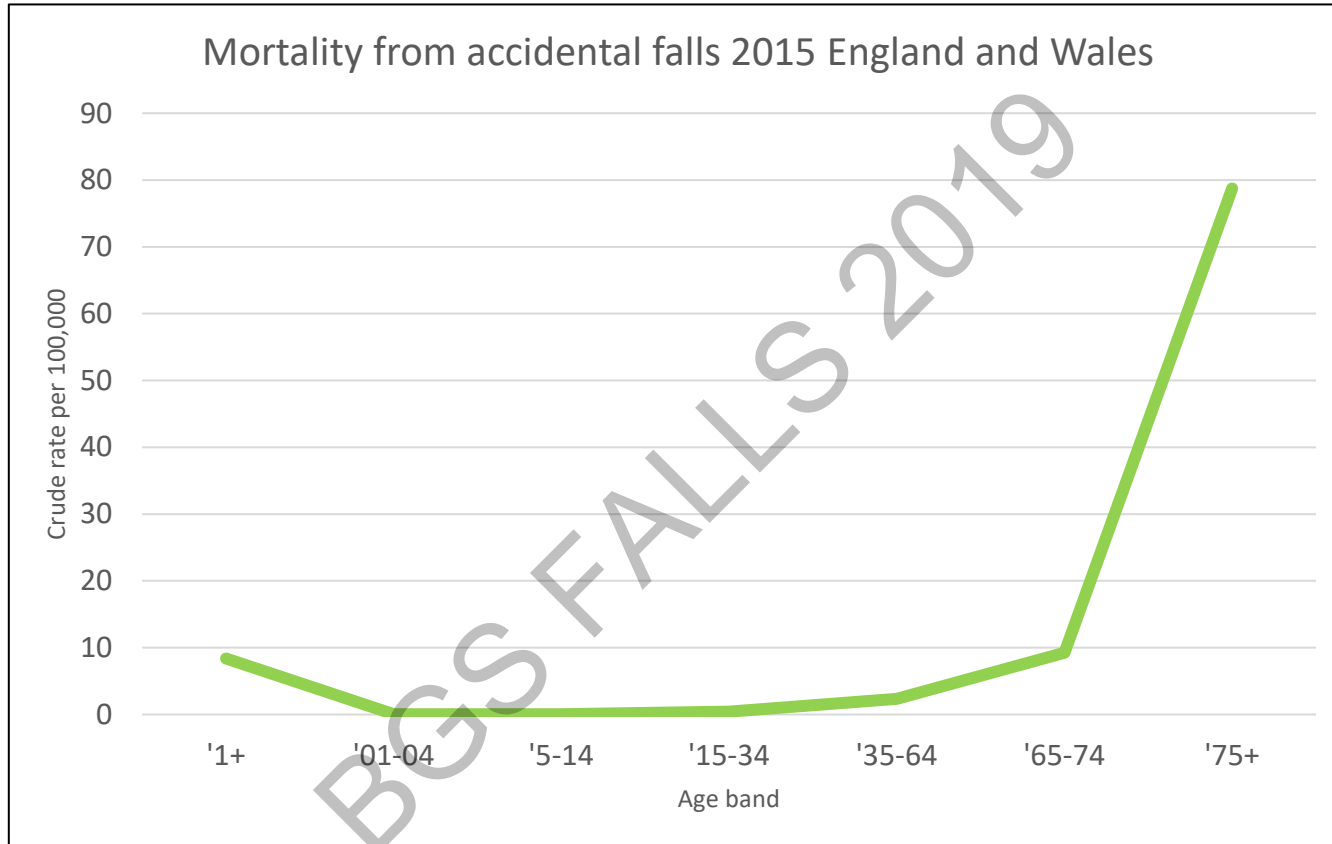
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Content

- The problem of inpatient falls
- History of NAIF
- Next steps for NAIF
- Progress to date



The Problem of Falls



Office for National Statistics

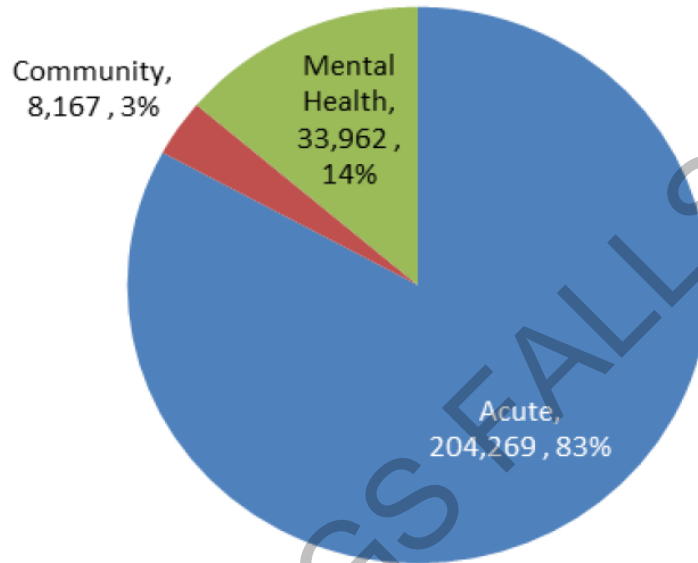


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Inpatient falls

Figure 1: Breakdown of total reported inpatient falls 2015/16



Source: National Reporting and Learning System 2015/16

NHS Improvement 2017



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The Problem with Falls

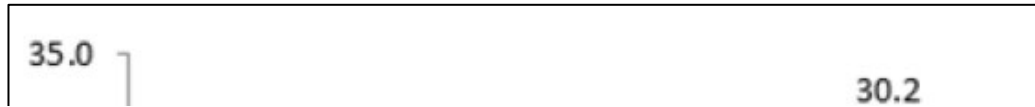
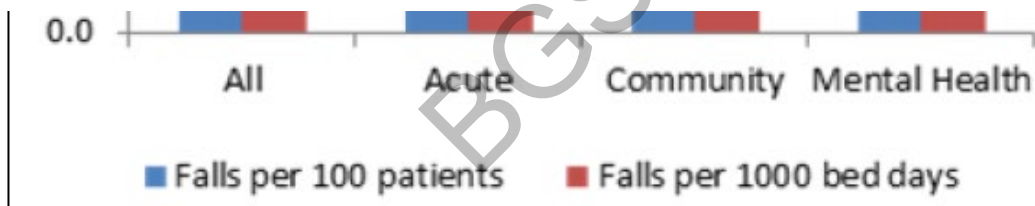
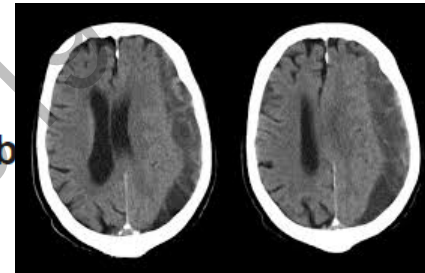


Table 1: Breakdown of reported falls within age groups by severity (all hospital settings in England)

Age group	Total falls (15/16)	Breakdown by severity (%)				
		No harm	Low harm	Moderate harm	Severe harm	Death
Under 65	57,000	73.4	24.9	1.5	0.2	
Over 65	190,000	71.1	26.0	2.2	0.6	
Total	247,000	71.9	25.5	2.0	0.5	



NHS Improvement 2017



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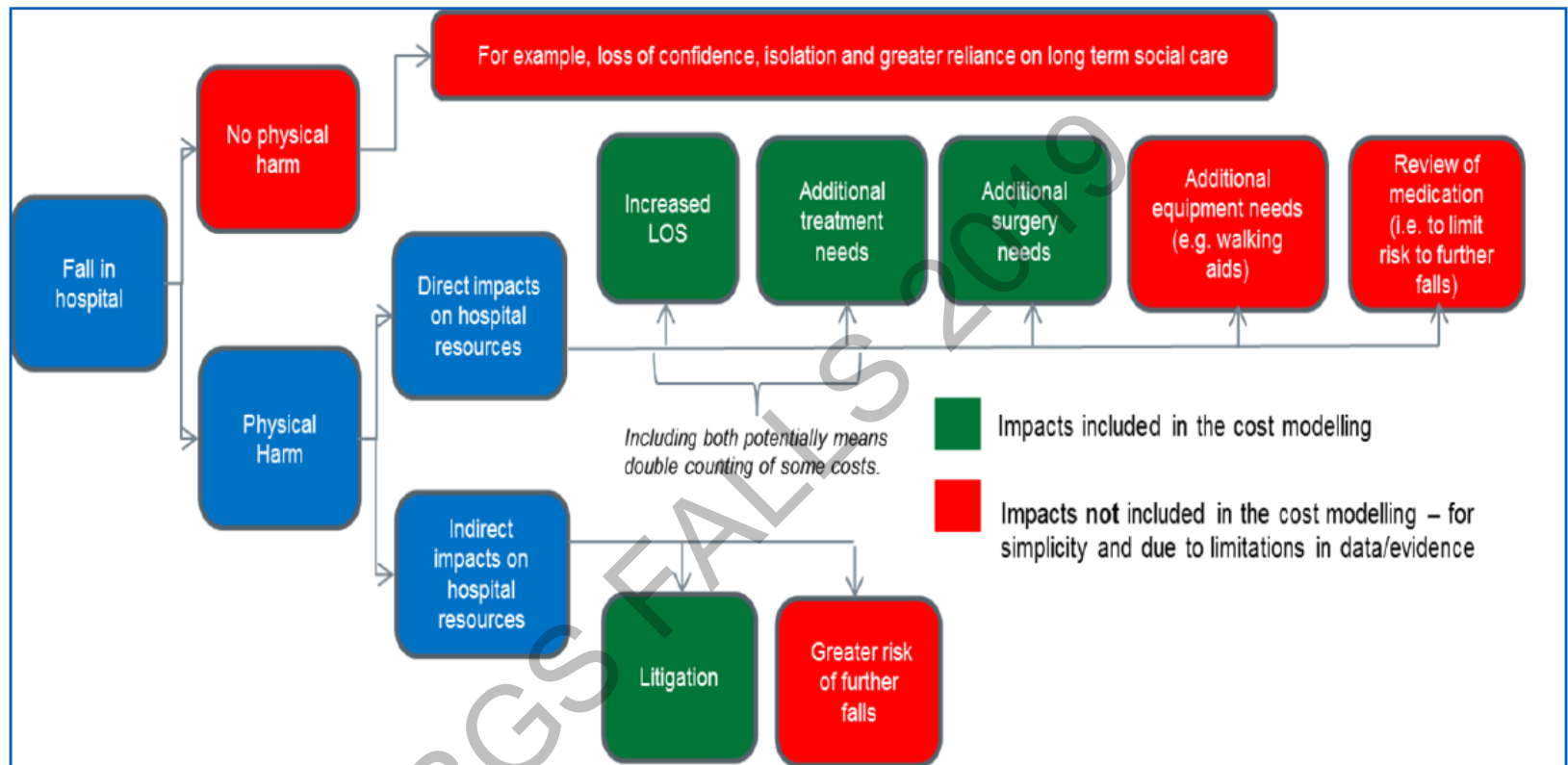
The Problem with Falls

Falls in hospital can result in:

- Loss of confidence and slower recovery, even when physical harm is minimal
- Distress to families and staff
- Legal action against hospital trusts
- Overall costs to hospitals of £630 million per year.



The Problem with Falls



NHS Improvement 2017



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Preventing inpatient falls

Identify those at high risk

Multi-factorial
assessment

Intervention to address
assessment findings



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NICE CG161

The screenshot shows the NICE website interface. At the top, the NICE logo and name 'National Institute for Health and Care Excellence' are on the left. Navigation links for 'NICE Pathways', 'NICE guidance' (highlighted), 'Standards and indicators', and 'Evidence services' are in the center. A 'Sign in' button is on the right. Below the navigation bar is a search bar with the placeholder text 'Search NICE...'. The breadcrumb trail reads: 'Home > NICE Guidance > Conditions and diseases > Injuries, accidents and wounds > Injuries, accidents and wounds: general and other'. The main title is 'Falls in older people: assessing risk and prevention'. Below the title, it says 'Clinical guideline [CG161] Published date: June 2013' and includes a link 'Uptake of this guidance'. A horizontal menu below the title has tabs for 'Guidance' (selected), 'Tools and resources', 'Information for the public', 'Evidence', and 'History'. Under the 'Guidance' tab, there is an 'Overview' section with a list of topics: 'Introduction', 'Patient-centred care', 'Key priorities for implementation', '1 Recommendations', '2 Research recommendations', and '3 Other information'. To the right of this list, under the 'Guidance' heading, there are links for 'Share' and 'Download', and a list of resources: 'NICE interactive flowchart - Preventing falls in older people' and 'Quality standard - Falls in older people'. A 'Next >' button is also visible. A large, semi-transparent watermark 'BGS FALLS 2019' is overlaid diagonally across the page.

NICE National Institute for Health and Care Excellence

NICE Pathways NICE guidance Standards and indicators Evidence services Sign in

Search NICE...

Home > NICE Guidance > Conditions and diseases > Injuries, accidents and wounds > Injuries, accidents and wounds: general and other

Falls in older people: assessing risk and prevention

Clinical guideline [CG161] Published date: June 2013 [Uptake of this guidance](#)

Guidance Tools and resources Information for the public Evidence History

Overview

Introduction

Patient-centred care

Key priorities for implementation

1 Recommendations

2 Research recommendations

3 Other information

Guidance

[Share](#) [Download](#)

NICE interactive flowchart - Preventing falls in older people

Quality standard - Falls in older people

This guideline covers assessment of fall risk and interventions to prevent falls in people aged 65 and over. It aims to reduce the risk and incidence of falls and the associated distress, pain, injury, loss of confidence, loss of independence and

Next >



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NICE CG161

- 1.2 Preventing falls in older people during a hospital stay
- 1.2.1 Predicting patients' risk of falling in hospital
- 1.2.1.1 **Do not** use fall risk prediction tools to predict inpatients' risk of falling in hospital. **[new 2013]**
- 1.2.1.2 Regard the following groups of inpatients as being at risk of falling in hospital and manage their care according to recommendations 1.2.2.1 to 1.2.3.2:
 - all patients aged 65 years or older
 - patients aged 50 to 64 years who are judged by a clinician to be at higher risk of falling because of an underlying condition. **[new 2013]**



Preventing Inpatient Falls



Multi-factorial Assessment

NICE CG161:

- cognitive impairment
- continence problems
- falls history, including causes and consequences (such as injury and fear of falling)
- footwear that is unsuitable or missing
- health problems that may increase their risk of falling
- medication
- postural instability, mobility problems and/or balance problems
- syncope syndrome
- visual impairment



Multi-factorial Intervention

NICE CG161:

1.2.2.4 Ensure that any [multifactorial intervention](#):

- promptly addresses the patient's identified individual risk factors for falling in hospital **and**
- takes into account whether the risk factors can be treated, improved or managed during the patient's expected stay. **[new 2013]**

1.2.2.5 Do not offer falls prevention interventions that are not tailored to address the patient's individual risk factors for falling. **[new 2013]**

Recent updates



**Cochrane
Library**

Cochrane Database of Systematic Reviews

Interventions for preventing falls in older people in care facilities and hospitals (Review)

Cameron ID, Dyer SM, Panagoda CE, Murray GR, Hill KD, Cumming RG, Kerse N



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Cochrane Findings

Additional physiotherapy (supervised exercises) in rehabilitation wards (subacute setting):

- Uncertain due to low quality evidence
- Rate ratio: 0.59, 95% CI 0.26 to 1.34 / Risk ratio: 0.36, 95% CI 0.14 to 0.93

Bed and chair sensor alarms in hospitals:

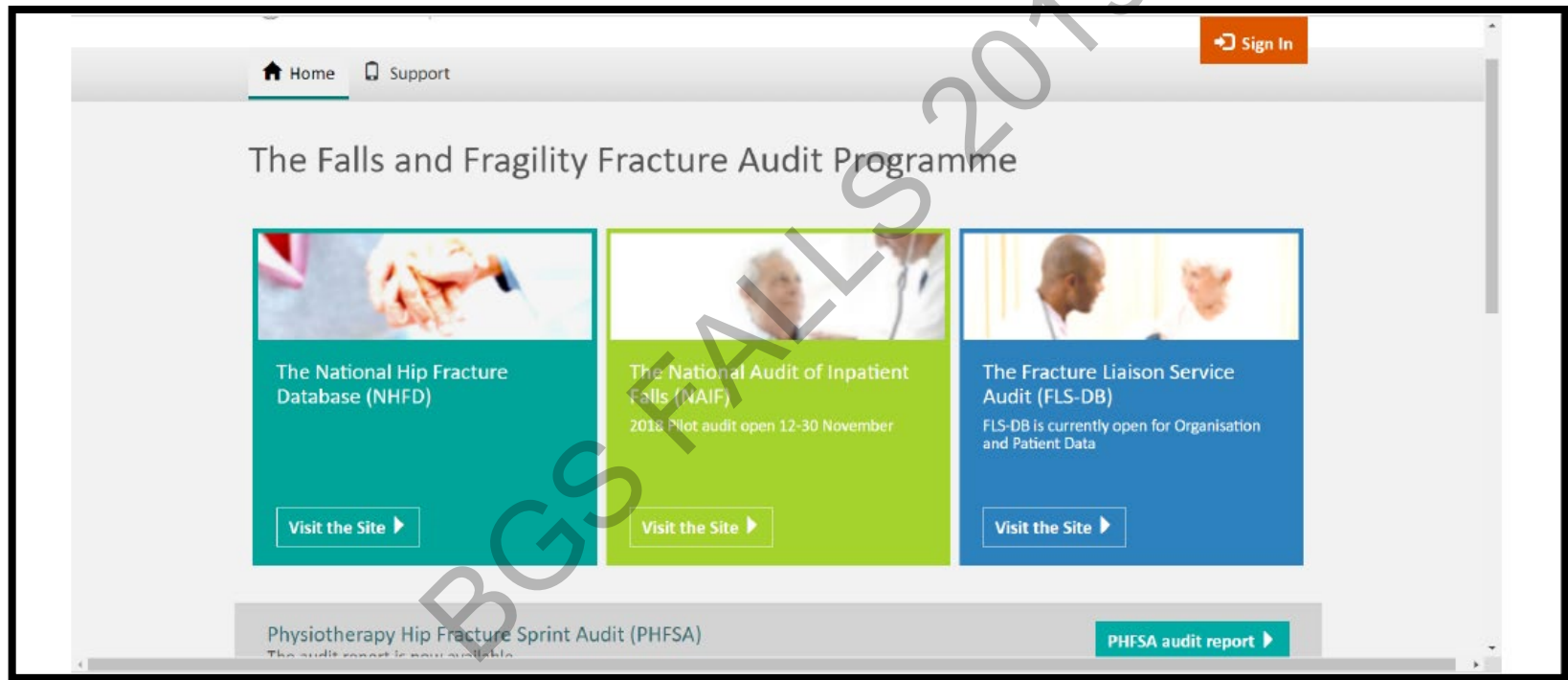
- Uncertain due to low quality evidence
- Rate ratio: 0.60, 95% CI 0.27 to 1.34 / Risk ratio: 0.93, 95% CI 0.38 to 2.24

Multifactorial interventions:

- Uncertain due to low quality evidence
- May reduce rate of falls
- Rate ratio: 0.80, 95% CI 0.64 to 1.01 / Risk ratio: 0.82, 95% CI 0.62 to 1.09
- More likely in a subacute setting. Rate ratio: 0.67, 95% CI 0.54 to 0.83



<https://www.fffap.org.uk>



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Audit Programme (FFFAP)



National audit of inpatient falls



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History of the Audit

- Funded by Health Quality Improvement Partnership (HQIP) contracted to the Royal College of Physicians (RCP)
- Two 'snapshot audits', in both 2015 and 2017 (15 consecutive non-elective admissions aged >65 over 2 days in May).
- The audit programme developed tools for hospitals to improve the falls prevention care given and provided workshops to promote QI



Key Performance Indicators

KPI	2015	2017
Delirium assessment	37%	40%
Continence care plan	69%	67%
Lying / standing BP	16%	19%
Medication review	46%	48%
Vision assessment	48%	46%
Call bell within reach	82%	81%
Walking aid within reach	68%	72%



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The Snapshot Audits

- Good completion rates
- Feedback from users that it was straightforward to complete

But...

- Continuous audit more likely to drive improvement
- Patient data was not identifiable so no way to link to outcomes



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What next

2018-2021

- Transition to continuous audit style
- Feasible starting point = inpatients who have a fall resulting in a hip fracture

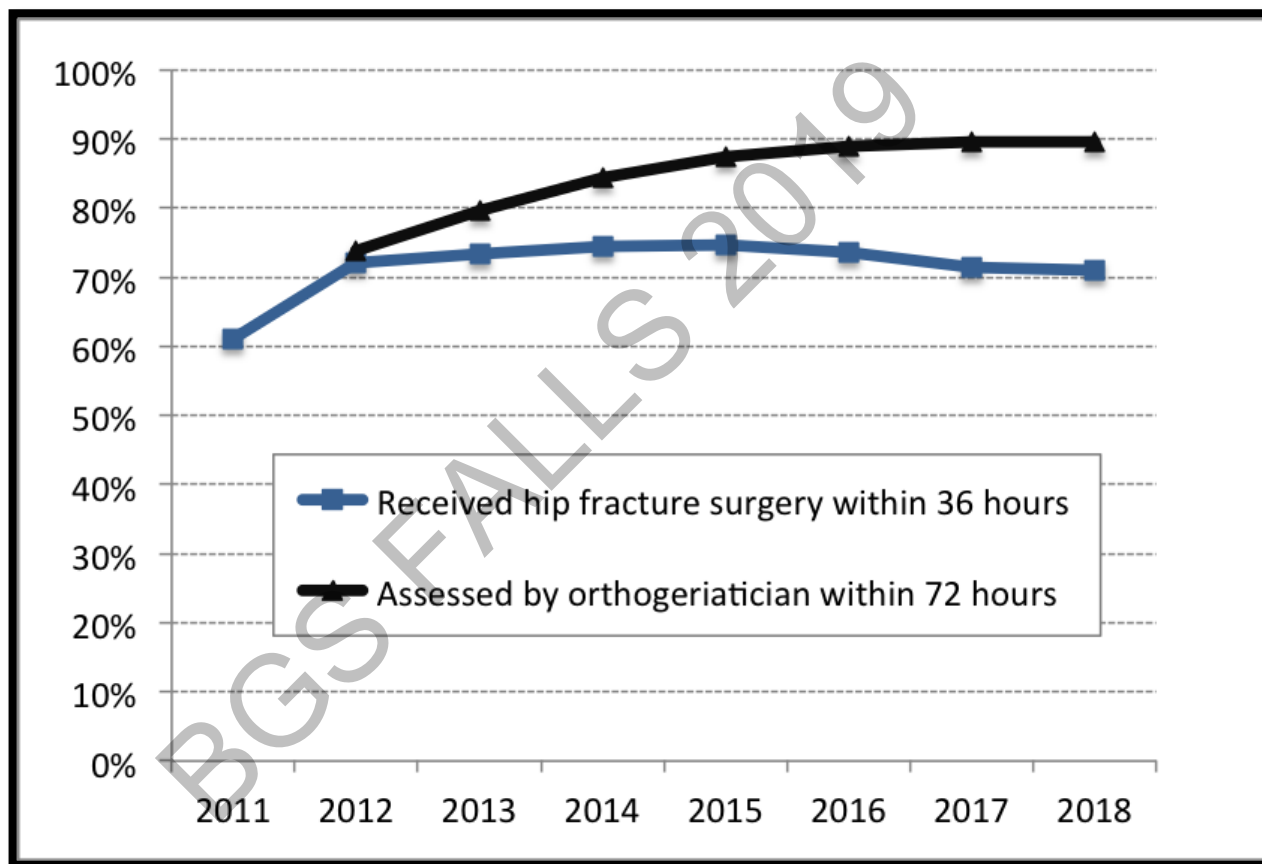


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Why continuous?

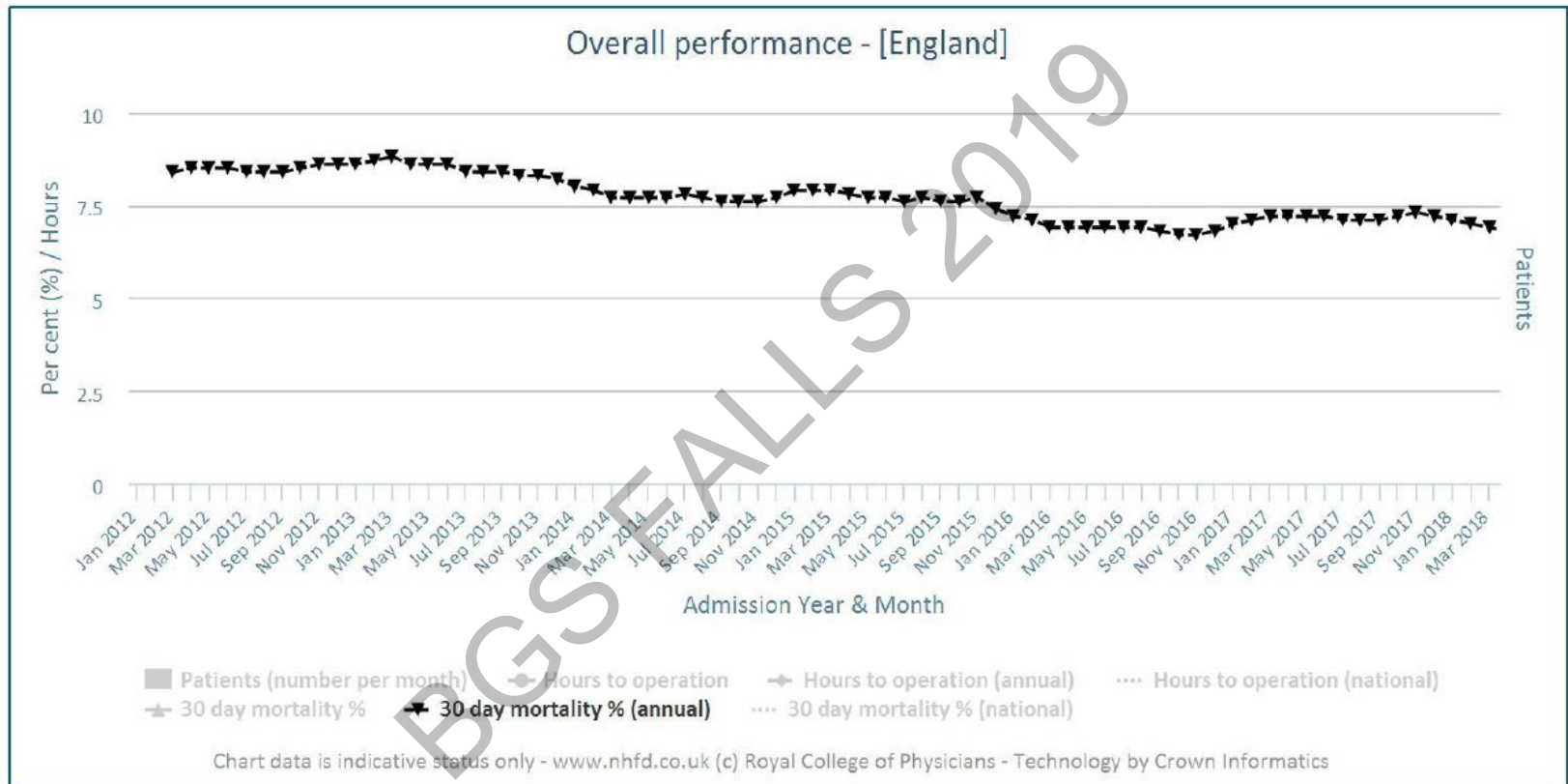
NHFD



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Why continuous?




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New processes

- 
- Identify inpatient fall with hip fracture

- 
- Notify relevant falls audit team

- 
- Audit team to review patient notes and extract data on:
 - Fall prevention activities prior to the fracture (CG161)
 - Post fall management (QS86 q4,5 and 6)



Stage 1 data collection – Jan 2019

- The primary purpose is to test the system for:
 - Identification of the location of inpatient fall that resulted in fracture
 - Linking to the falls teams for the relevant Hospital / Trust
- Minimal dataset:
 - Ward type
 - Point in admission
 - Time of fall
 - Post fall management



Stage 2 data collection – Jan 2020

- Full dataset
- Developed by advisory group
- Public / Patient involvement
- Based on NICE CG 161 and QS86 Q4,5 and 6
- Collected by case note / documentation review for the inpatient period prior to and immediately after the fall that caused the fracture
- Pilot started July 2019



Progress to date –August 2019

- 168 Trusts / Health Boards have participated in facilities audit (74%)
- 900+ inpatient fall related hip fractures cases have been identified by the NHFD between Jan 2019-July 2019
 - 5 hip fractures per day in English and Welsh inpatient settings



Future plans

- Develop a clinical review tool to be used for falls that result in hip fracture

Not in current contract – but other possibilities:

- ? Extend audit to other injury types / harm categories
- ? Extend audit to other settings
- ? Develop a tool that hospitals/ trusts can use to audit their own practice



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