Royal College of Physicians | Falls and Fragility Fracture Audit Programme

Improving inpatient fall care - NHFD and NAIF working in collaboration

Introduction/Overview

The NHFD v12 dataset includes a new section to understand inpatient hip fracture in collaboration with the National Audit of Inpatient Falls (NAIF). This will help hospitals, trusts and health boards to improve their inpatient falls care.

An inpatient is a patient in a non-permanent bed-based setting commissioned or managed by an acute, community or mental health Trust/healthboard. Permanent nursing and care home residents do not fall into this category.

The inpatient fall section will only activate if the patient sustained their hip fracture as an inpatient either in your own trust, or in another trust/health board. This will then trigger a requirement for the 'falls team' in the nominated trust to investigate and document the care the patient received before and after the fall as part of the NAIF audit.

Inpatient fall section

If you answer the 'Presentation with hip fracture via A&E' question with any of the 'inpatient' options, this will activate the inpatient fall section. Otherwise, the inpatient section will be disabled.

Is this hip fracture due to an inpatient fall?

This question aims to confirm if the patient's hip fracture was due to an inpatient fall:

- **Yes - hip fracture is due to an inpatient fall**
  There is clear documentation to indicate that the hip fracture was definitely caused by a recent inpatient fall, whilst the patient was an inpatient within a 'healthcare trust' setting.

- **No - no fall known to have occurred**
  There is no indication in the patient notes that the hip fracture was caused by a recent inpatient fall.

- **Not applicable**
  The fall did not occur within a healthcare trust or health board or does not apply in your country, (Northern Ireland or Scotland).

  If you confirm a fall occurred the remaining questions will be enabled. If enabled, use the patients care notes or transfer details to complete the remaining questions:

  - When did the fall occur?
  - Type of ward where fall happened?
  - In which trust or local health board did the fall occur? (enabled if not your own trust)

Once the patient details have been completed and saved, an audit record will be created in NAIF for the trusts 'falls team' to complete automatically.

Date of fall

Enter the time and date of the fall as documented in the patient notes. This should be the time and date of the actual fall or a close estimate of the actual time, rather than the date of diagnosis, assessment or transfer.

In which trust or health board did the fall occur?

This question is enabled if the patient was an inpatient at another trust. Otherwise, your own trust will be pre-set.

Select a 'healthcare trust' from the available list. You can type part of the name to narrow the list to match the letters typed.

If the trust/health board you want to enter is not on the list, please use the 'New trust' button/option to request a new entry to be added to the list. Once the trust/health board has been setup, it will be added to the list and applied to this record.

Once the patient details have been saved (including the NHS number), an audit record will be created in NAIF for the trust's 'falls team' to complete automatically.

The Falls Audit record (The NAIF record)

To create a NAIF audit record, the following data must be supplied:

- NHS number - *(essential to identify the patient - DoB, gender and postcode are also used)*
- Admitted via A&E - *(answered with an 'inpatient' option selected)*
- Fall status confirmed - *('Is this hip fracture due to an inpatient fall?')*

...and if so:

- When did the fall occur
- Type of ward
- The inpatient trust - *(If not your own trust)*

Once the inpatient details have been completed and the NHFD record saved, an audit record will be created in NAIF for the trusts 'falls team' to complete automatically and a link to the NAIF record will be provided where you can open the record to review it, but not make any direct changes to it.

If this data is not available, then the record will not be created and the link will not be available ('No NAIF record available').

The NAIF record also includes (when the data is available in NHFD):

- A&E Admission date and time
- The name of your unit, hospital and trust
- The name of the person creating this record

NAIF Dataset

The NAIF audit asks the trust's falls team to answer the following questions:

1. Is the fall categorically known to have occurred for this patient? (Inpatient fall confirmation)
2. Time and date of fall which caused hip fracture?
3. Time and date when the patient was admitted to the hospital where the fall resulting in the hip fracture occurred?
4. Type of ward where fall that resulted in the hip fracture happened?
5. Is there documented evidence in the clinical notes that the patient was checked for symptoms or signs of potential for spinal injury and fracture before they were moved?
6. What manual handling method was used to move the patient following the fall that caused the hip fracture?
7. Is there documented evidence that the patient had a medical assessment following the fall that caused the hip fracture?
8. What level of harm was attributed to the fall that caused the hip fracture

Full dataset details are available at the end of this guide or check for the latest version on the downloads page in the NAIF audit webtool.

Important – Changing patient or trust/health board identity

Please make sure the NHS number and trust/health board details are correct. If the NHS number changes in NHFD, any details entered into NAIF will be deleted automatically and a new 'empty' record allocated to the newly changed NHS number. Similarly, if the allocated trust/health board changes in NHFD, the NAIF record must be allocated to the new trust/health board and the previous NAIF data will be deleted automatically.

Please try to ensure that the patient identity and trust details are correct to avoid the falls teams investigating false alarms. Once all the inpatient fall details have been saved, any changes to these details will be shared with the NAIF audit automatically.

Information governance

The NHFD operates under an approved 'consent exemption' legal basis (Section 251). This authorisation has been extended to support the National Audit of Inpatient Falls. This allows patient identifiable data to be shared with NAIF 'falls teams' so that inpatient falls can be investigated. This data should not be used for any other purpose and is being provided solely to support the NAIF audit purpose and should not be shared with any third party.

Caldicott Guardian

For the national audit to be successful, it is important that we are able to achieve a high level of engagement with clinical teams in hospitals. As your trust/health board has registered to participate in this audit, we recommend you ensure you have granted caldicott guardian approval before your trust submits data in 2019.

Full audit details: www.rcplondon.ac.uk/projects/outputs/naif-transition-continuous-audit
or by emailing: falls@rcplondon.ac.uk

RCP FFFAP
Email: falls@rcplondon.ac.uk - Phone: 020 3075 1511/1266 - 9am-5pm, Monday to Friday
Website: www.rcplondon.ac.uk/fffap

Royal College of Physicians | Falls and Fragility Fracture Audit Programme

NAIF Clinical Audit Proforma

NHS Number/Patient ID:

1.1 - Is the fall categorically known to have occurred for this patient?	○ Yes ○ No **If you answer 'No', there will be no further questions to answer.**	Only answer 'No' if there is no evidence of a fall recorded in any of the patient's clinical records or in organisational incident reporting systems during the inpatient stay in question.
2.1 - Time and date of fall which caused hip fracture	DD / MM / YYYY HH : MM	If there were several falls and it is not clear which fall resulted in the fracture, use clinical judgement.
2.2 - Time and date when the patient was admitted to the hospital where the fall resulting in the hip fracture occurred	DD / MM / YYYY HH : MM	This admission date relates to the date the patient was admitted to the inpatient setting where the fall resulting in hip fracture occurred. Not the admission for the treatment of the hip fracture.
2.3 - Type of ward where fall that resulted in the hip fracture happened? Admissions unit e,g, Emergency department (ED), Acute Medicine Unit (AMU) or Clinical Decision Unit (CDU) or equivalent.	○ Admissions unit ○ Medical ○ Mental health ward ○ Older persons / frailty ward ○ Rehab ward ○ Surgical ○ Trauma and orthopaedic ward ○ Other	If your Trust does not have wards categorised as medical, surgical, admissions unit, older persons/frailty, rehab or mental health ward, select 'other'
3.1 - 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 ○ Yes - no injury suspected ○ No	If there is no outcome of the check for signs and symptoms documented in the clinical notes, answer no.
3.2 - What manual handling method was used to move the patient following the fall that resulted in the hip fracture? (as documented in the clinical notes)	○ Hoist ○ Flat lifting equipment ○ Ambulance service equipment ○ Staff assisted to get up (without equipment) ○ Got up independently ○ Method not documented	Note: record as 'Staff assisted to get up' if the patient was moved without equipment being used.
3.3 - Is there documented evidence that the patient had a medical assessment following the fall that resulted in the hip fracture?	○ Yes - medical assessment (or transfer to ED organised) within 30 minutes ○ Yes - medical assessment within 12 hours ○ No - medical assessment not recorded or it was undertaken more than 12 hours after fall.	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.
3.4 - What level of harm was attributed to the fall that resulted in the hip fracture?	○ Death ○ Severe harm ○ Moderate harm ○ Low harm ○ No harm	Please indicate the level of harm attributed to this fall as validated in your local reporting system (i.e. Datix, Ulysses or other).