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

What is your hospital doing to prevent falls?

This resource is aimed at those who are looking to influence and improve the care and management of patients who have fallen in an inpatient setting. This might include anyone: patients, relatives or carers, who would like information to support conversations with care providers, commissioners, governors and non-executive directors. Falls are the most frequently reported incident affecting hospital inpatients, with 247,000 falls occurring in inpatient settings each year in England alone.

The actions below are designed to help you find out whether your hospital is meeting recommended targets and to raise areas in need of improvement with the board of governors, commissioners or other group.

You can ask the hospital Patient Advice and Liaison Service to help you find the right person to speak to about this.

Recommendation: **All trusts and health boards should register with, and participate in, the National Audit of Inpatient Falls (NAIF).**

77%

Audit result: 77% of all eligible organisations participated.

Action

Find out if your local hospital is **participating in the audit** by viewing the State of the Nation reports for **England** and **Wales** on the Royal College of Physicians' website.

Recommendation: **There should be committed members at board level who have a responsibility for falls.**

90%

Audit result: 90% of organisations had someone in an executive role with responsibility for falls.

Action

Find out if there is an **executive director and a non-executive director with responsibility** for falls who sit on the board at your trust or health board.

Recommendation: **The trust or health board should have a patient safety group that meets to discuss falls at least four times a year.**

87%

Audit result: 87% of organisations said they had a patient safety group that met to discuss falls at least four times a year.

Action

Ask your local trust or health board if they have a patient safety group and how often they meet, and if falls is always on their agenda.

Recommendation: **Patients who usually need a walking aid such as a stick or walking frame should be provided with one as soon as possible on admission to hospital.**

56%

Audit result: 56% of organisations had a policy to provide patients with a walking aid on admission to hospital, for those who usually needed one.

Action

Ask if your hospital has a policy to **provide walking aids** to people who need them as soon as they are admitted and that the aids are available 7 days a week.

Based on data from the National Audit of Inpatient Falls, published 12 March 2020. Find out more about preventing falls in hospital. Publication review date: March 2023

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How does your hospital deal with inpatient falls?

This resource is aimed at those who are looking to influence and improve the care and management of patients who have fallen in an inpatient setting. This might include anyone: patients, relatives or carers, who would like information to support conversations with care providers, commissioners, governors and non-executive directors.

Recommendation: After a fall, patients should be checked for injury before they are moved.

45%

Audit result: Of those patients who sustained a hip fracture while they were in hospital, 45% were checked before they were moved..

Actions

- Ask what procedure your hospital uses to **check patients for signs of injury** after they have fallen.
- Find out how many patients with hip fracture were checked in this way before they were moved by **asking to see your trust's NAIF report**.

Recommendation: After a fall resulting in suspected fracture or spinal injury, patients should be moved from the floor using a safe lifting method.

20%

Audit result: 20% of patients who sustained a hip fracture while in hospital were moved using a safe lifting method.

Actions

- Find out whether your trust or health board has **flat lifting equipment** on all sites.
- Find out how many patients with hip fracture were moved using flat lifting equipment by **asking to see your trust's NAIF report**.

Recommendation: Patients should be assessed by a doctor within 30 minutes of a fall where serious injury is suspected (NB If on a site without a full-time doctor, an ambulance should be called).

54%

Audit result: 54% of patients who had a hip fracture while in hospital were assessed by a doctor within 30 minutes of a fall, where serious injury was suspected.

Action

Find out how many patients with hip fracture were **seen by a doctor within 30 minutes of the fall** by asking to see your trust or health board's NAIF report.

Recommendation: The level of harm recorded in reporting systems following an inpatient hip fracture should be severe.

67%

Audit result: For 67% of patients with inpatient hip fracture, severe harm was recorded.

Actions

- Find out if your trust or health board has a policy that ensures all falls that result in inpatient hip fracture are **reported as severe harm**, regardless of the circumstances of the fall.
- You can also **ask to see your NAIF trust report** to find out what proportion of falls with hip fracture were reported as resulting in severe harm.

Based on data from the National Audit of Inpatient Falls, published 12 March 2020. Find out more about preventing falls in hospital. Publication review date: March 2023

The Flesch-Kincaid grade level for this document is 9.3, equivalent to a UK reading age of 10–13 years.