**Falls and Fragility Fracture Audit Programme: National Audit of Inpatient Falls January 2023 [FINAL]**

**Clinical Audit Proforma (VERSION 5)**

**Section 1: Patient Confirmation**

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|  | **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 patient should be assigned to another trust or health board, please choose that organisation and save this record, this will transfer it and the record will no longer be on your organisation’s list of NAIF records to complete. If the trust or health board is not listed, please contact the helpdesk (**falls@rcp.ac.uk**)*  |
| **Q 1.1** | Did this patient have a fall resulting in a femoral fracture in your Trust / Health Board? |
|  |  Yes - a fall is known to have occurred No - no fall known to have occurred Not applicable Not a patient at this Trust/Health Board Duplicate record | *Carefully check your records for the patient identified below and answer 'Yes' if you can confirm* 1. *The patient was an inpatient in your organisation at time in question and,*
2. *“) that there was a documented fall that resulted in a femoral fracture.*

*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 femoral fracture, select no fall known to have occurred. By choosing this answer, you are acknowledging that the patient sustained a femoral fracture as in inpatient in your organisation but there is no record of a related fall. Over 95% of hip fractures occur as a result of a fall. Trusts with high rates of fractures that are not related to falls will be asked to review their fall reporting mechanisms.* *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, A&E or other non-trust based care setting.* *Select not a patient at this trust/health board if there is no record of the patient on your systems.* *If there are two records for the same patient, select duplicate record on the incomplete record and this will not be included in any online or editorial reporting.* *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)****Check the online help for further details.*** |

**Section 2: Fall details**

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|  | **QUESTIONS** | **FIELD NOTES** |
| 2.1 | Time and date when the patient was admitted to the trust / health board where the fall resulting in the femoral fracture occurred: |
|  | DATE: DD/MM/YYYY:TIME: HH:MM: | *Please record the date and time the patient arrived at your hospital. 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* |
| 2.2 | Time and date of fall which caused the femoral fracture: |
|  | DATE: DD/MM/YYYY:TIME: HH:MM: | *Please record the date and time of the fall that caused the femoral fracture.**If there is no record of the time of the fall that caused the femoral fracture, record the time as midnight on the day that the femoral fracture 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 fracture, use the date of fracture used to generate this case.* *If the time and/or date of the fall that caused the fracture was absent, trusts are advised to review their reporting mechanisms.* *Record time in 24hr format* |
| 2.3a | 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.*  |
| 2.3bType of ward/unit | 1. Acute
	1. Emergency department
	2. Ambulatory care
	3. Medical admission unit (including clinical decision units)
	4. Surgical admissions unit
	5. Medical (general and speciality)
	6. Surgical (general, speciality excl. orthopaedic
	7. Trauma/orthopaedics (including elective orthopaedics)
	8. Older person’s / frailty
	9. Other
2. Community
	1. General
	2. Continuing healthcare
	3. Learning disability
	4. Palliative care
3. Mental health
	1. General adult
	2. Learning disability
	3. Older people
4. Integrated trust and Welsh HB
	1. Emergency department
	2. Ambulatory care
	3. Medical admission unit (including clinical decision units)
	4. Surgical admissions unit
	5. Medical (general and speciality)
	6. Surgical (general, speciality excl. orthopaedic
	7. Trauma/orthopaedics (including elective orthopaedics)
	8. Older person’s / frailty
	9. Other acute
	10. General community
	11. Continuing healthcare
	12. Learning disability
	13. Adult mental health
	14. Older adult mental health
	15. Palliative care
	16. Other community / MH
 | *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 use the choice of general or other.* |

**Section 3: MFRA**

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|  | **QUESTIONS** | **FIELD NOTES** |
| 3.1 | Was a documented multi-factorial risk assessment (MFRA) completed? |
|  |  Yes No documented MFRA(if yes – answer 4.1a) | *A definition of MFRA can be found in the download section. This specifies what the National Audit of Inpatient Falls agrees to be the necessary components of a MFRA.* *RCP MFRA guide link -* [*https://www.rcplondon.ac.uk/file/15246/download*](https://www.rcplondon.ac.uk/file/15246/download) |
| 3.1a | How many days prior to the fall that caused the fracture had the multifactorial risk fall risk assessment (MFRA) been undertaken or updated? |
|  | Days: | *The number of days should be counted from either the first MFRA or a subsequent update. Whichever date is closest to the fall that caused the fracture should be used.**RCP MFRA guide link -* [*https://www.rcplondon.ac.uk/file/15246/download*](https://www.rcplondon.ac.uk/file/15246/download) |
| 3.2 | Prior to the fall that caused the femoral fracture, had this patient had any other falls during the same admission? |
|  |  Yes No(if yes answer 4.3) | *Indicate 'Yes' if there are any falls recorded that occurred before the one that caused the femoral fracture. This should refer to falls that occurred during the SAME admission (to the Trust/Health Board) as the one that caused the femoral fracture, even if the falls occurred in other ward locations. Do not include falls that occurred before the admission episode in question or during previous admissions.* |
| 3.3 | Was there documented evidence that the MFRA and intervention plan had been reviewed following the inpatient fall(s)? |
|  |  Yes No | *Review the actions taken after each inpatient fall. If there was more than one fall, only indicate 'Yes' if there is documented evidence of a re-assessment after every fall. See definition of MFRA and intervention plan (downloads page).* |
| 3.4 | Had the patient had a documented assessment of vision during the admission when the fall that caused the femoral fracture occurred? |
|  |  Yes - no visual impairment identified Yes - visual impairment identified 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 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.*  |
| 3.5 | Had the patient had a documented lying / standing blood pressure measurement during the admission when the fall that caused the femoral fracture occurred? |
|  |  Yes - no evidence of orthostatic hypotension (go to 4.5a) Yes - evidence of orthostatic hypotension (go to 4.5a) Not documented Not possible | *Definition of lying / standing BP and OH (link to the RCP guidance).**Only use 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 femoral fracture.* |
| 3.5a | *Was the date and time of BP measurement recorded?* |
|  | * Yes** No* | *Use the time and date of the most recent lying and standing blood pressure before the fall that caused the fracture.* |
| 3.5b | Date of lying / standing BP |
|  | DATE: DD/MM/YYYY:* Not documented (go to 4.6)
 |  |
| 3.5c | Date of lying / standing BP |
|  | TIME: HH:MM:  | *Record time in 24hr format* |
| 3.5d | *What were the BP values?* |
|  | Lying BP (after 5 minutes supine)Systolic:Diastolic:Pulse:Standing (after 1 minute)Systolic:Diastolic:Pulse:Standing (after 3 minutes)Systolic:Diastolic:Pulse:  | *Leave blank if not recorded**Systolic limits 50 to 250**Diastolic limits 40 to 150**Pulse limits 10 to 210* |
| 3.6 | Is there documented evidence that the patient had a medication review during the admission when the fall that caused the femoral fracture occurred? |
|  |  Yes 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 impossible or inappropriate to assess the patient for this. Not applicable can be used 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 culprit drug- 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 culprit drugs to score as ' Yes - Patient was assessed’ even if a medication review was not formally recorded.*  |
| 3.7 | Did the patient have a delirium assessment and corresponding care plan (if required) during the admission when the fall that caused the femoral fracture occurred? |
|  |  Yes: delirium identified - care plan documented (answer 3.7a)Yes: Not delirious on formal assessment (answer 3.7a) No: delirium identified - but no care plan documented (answer 3.7a)No: No assessment for delirium documented  | *A delirium care plan includes a standardised assessment for the presence of delirium. If delirium is present, there should be a management plan in place which may consist of generic measures known to reduce delirium intensity and/or specific interventions tailored to assessment findings. This can be in the form of a specific care plan or detailed in the clinical notes.**If a patient develops a new onset confusion, assessment for delirium and initiation of a care plan should begin without delay. Therefore, if there is evidence the patient has developed a new confusion before the fall that caused the fracture, but this was not identified on formal delirium assessment, answer not documented.*  |
| 3.7a | Was the time and date of 4AT recorded: |
|  |  Yes No | *Use the time and date of the most recent 4AT before the fall that caused the fracture.* |
| 3.7b | Date of 4AT: |
|  | DATE: DD/MM/YYYY: | *Use the time and date of the most recent 4AT before the fall that caused the fracture.* |
| 3.7c | Time of 4AT: |
|  | TIME: HH:MM | *Record time in 24hr format* |
| 3.7d | 4AT score: (a number) |
| 3.8  | Was a NEWS2 score recorded during the admission when the fall that caused the femoral fracture occurred? |
|  |  Yes No |  |
| 3.8a | Date of last NEWS2 score before the fall that caused femoral fracture: |  |
|  | DATE: DD/MM/YYYY: |  |
| 3.8b | Time of last NEWS2 score before the fall that caused femoral fracture: |
|  | TIME: HH:MM | *Record time in 24hr format* |
| 3.8c | Last recorded NEWS2 score before the fall that caused the femoral fracture: (a number scale 0-20) |  |
| 3.8d | Did the patient have new confusion (C) recorded in the section on consciousness in the last recorded NEWS2 score before the fall that caused the femoral fracture?  |
|  |  Yes No |  |
| 3.9 | Did the patient have a mobility assessment and corresponding mobility plan (if required) during the admission when the fall that caused the femoral fracture occurred? |
|  |  Yes: mobility impairment identified - mobility plan documented Yes: no mobility impairment identified No: mobility impairment identified but no mobility plan documented No: no assessment of mobility documented  | *Mobility impairment is indicated by difficulty with transfers, walking and/or balance. This may present as unsteadiness, the need for supervision or aids and/or inability to perform mobility tasks independently.**A mobility plan should provide information about the optimal supervision, correct walking aid provision, rehabilitation plans, adjustment of bed/chair heights, appropriate use of bed rails, correct provision of aids for toileting.* |
| 3.10 | Was there evidence that the patient had an assessment of continence and corresponding continence care plan (if required) during the admission when the fall that caused the femoral fracture occurred? |
|  |  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: Assessments**

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|  | **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 (go to 4.2) | *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*](https://www.nice.org.uk/guidance/qs86/chapter/Quality-statement-4-Checks-for-injury-after-an-inpatient-fall) |
| 4.1a | *Was the date and time of post fall check recorded:* |
|  |  Yes  No (go to 4.2) | *enter the time that the post fall check was undertaken* |
| 4.1b | Date of post fall check |
|  | DD/MM/YY  |  |
| 4.1c | Time of post fall check: |
|  | HH:MM | *Record time in 24hr format* |
| 4.2 | What manual handling method was used to move the patient following the fall that caused the femoral fracture (as documented in the clinical notes)? |
|  |  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*](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 of the fall that resulted in the femoral fracture? |
|  |  Assessment by medically qualified professional (go to 4.3a)  Assessment by other healthcare professional (go to 4.3a)  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. When completing this audit, the definitions used by the NICE quality standards should be used.**If a patient is seen by a non-medical professional first, but subsequently reviewed by a medically qualified professional within 30 minutes, answer: Assessment by a medically qualified professional within 30 minutes.*  |
| 4.3a | Was the date and time of medical assessment recorded: |
|  |  Yes  No (go to 4.4) | *enter the time that the medical assessment was undertaken* |
| 4.3b | Date of medical assessment: |
|  | DD/MM/YY |  |
| 4.3c | Time of medical assessment: |
|  | HH:MM | *Record time in 24hr format* |
| 4.4 | Was analgesia given following the femoral fracture? |
|  | 🗆 Yes🗆 Not prescribed (go to 4.5)🗆 Not recorded (go to 4.5) | *The time restriction rules for this question are:**a. Fall must occur after initial admission date**b. Analgesia must come after admission, not before.**c. Analgesia may be administered up to 8 hours prior to fall, but after admission.**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, enter the time and date of the analgesia given before the fall. Only use this option if the reason for not administering post-fall analgesia was because it would result in overdose. .* |
| 4.4a | *Date that first dose of analgesia was given:* |
|  | DD/MM/YY |  |
| 4.4b | *Time that first dose of analgesia was given:* |
|  | HH:MM | *Record time in 24hr format* |
| 4.5 | What level of harm was attributed to the fall that caused the femoral fracture? |
|  |  Death Severe harm Moderate harm Low harm No harm | *See NRLS guidance.*<https://www.england.nhs.uk/wp-content/uploads/2019/10/NRLS_Degree_of_harm_FAQs_-_final_v1.1.pdf>*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 in hip fracture* |
| 4.6 | Was there documented evidence that appropriate action was taken to inform the patient’s named contact within 24 hours of the fall that caused the fracture? |
|  |  The named contact was contacted The patient had requested not to contact their named contact There was no named contact or the named contact was uncontactable Not documented |  |
| 4.7 | From reviewing the documentation, did there appear to be any delays in transfer for femoral fracture care? |
|  |  Yes No | *The audit already captures data on time between fall and start of hip fracture care. Therefore, the audit team are asked to complete this section if they judge hip fracture care to have been delayed as indicated in the clinical notes.**Hip fracture care should begin as soon as a fracture is suspected. Adequate analgesia, diagnosis and medical stabilisation with the aim of prompt surgery is the expected standard of hip fracture care.* *Answer up to the point at which your trust was responsible for fracture care (i.e. a community or mental health trust can only answer for time until transfer to acute hospital).* |
| 4.8 | *Was the date and time of X-ray recorded?* |
|  | * Yes
* No (go to 4.9)
* Not known as patient was transferred to acute hospital for assessment (go to 4.9)
 |  |
| 4.8a | Date of x-ray: |
|  | DD/MM/YY  |  |
| 4.8b | Time of x-ray: |
|  | HH:MM | *Record time in 24hr format* |
| 4.9 | *Was the date and time that the patient transferred to orthopaedic care recorded?* |
|  | * Yes
* No (go to 5.10)
* *Not applicable as patient was transferred to acute hospital for assessment (go to 5.10)*
* *Not applicable as patient not transferred to orthopaedic care/patient already in orthopaedic care*
 | *Consider transfer to orthopaedic care within the same hospital / trust as:** *Moving to a trauma or orthopaedic ward*

*Review and preparation for surgery while remaining on the same ward which would include, orthopaedic surgical review, anaesthetic review (including appropriate analgesia), surgical preparation and orthogeriatric assessment – if possible, within the time frame before surgery)**Select ‘Not applicable as patient not transferred to orthopaedic care/patient already in orthopaedic care’ if the patient is for conservative management or already on an orthopaedic unit.* |
| 4.9a | *Date of transfer to orthopaedic care:* |
|  | DD/MM/YY  |  |
| 4.9b | *Time of transfer to orthopaedic care:* |
|  | HH:MM | *Record time in 24hr format* |
| 4.10 | *Was the date and time that the patient transferred to acute hospital recorded?* |
|  | * Yes
* No (go to Q5)
* Not applicable as patient is already in an acute hospital / trust (go to Q 5)
 |  |
| 4.10a | *Date of transfer to acute hospital:* |
|  | DD/MM/YY  |  |
| 4.10b | *Time of transfer to acute hospital:* |
|  | HH:MM | *Record time in 24hr format* |

**Section 5: Post fall review**

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|  | **QUESTIONS** | **FIELD NOTES** |
| 5.1 | Was a hot debrief conducted after the fall? |
|  |  Yes- in the same shift Yes- but could not be done in the same shift No | *NAIF recommends a hot debrief is undertaken in the same shift as the fall that causes the fracture. See (*[*link*](https://www.crownaudit.org/FFFAP/NAIFuat.nsf/docs/DownloadFilesV3/%24File/NAIF_Hot_Debrief_v0.1_pilot.docx?openelement)*) for the hot debrief template. If this is not possible, please ensure sufficient detail is recorded in the incident report and patient records to be able to undertake an after-action review.*  |
| 5.2 | Was there an after-action review conducted with the MDT within 5 days of the fall that caused the femoral fracture? |
|  |  Yes- within 5 working days Yes- but could not be done within 5 working days No | *NAIF recommends an after-action review is undertaken within five days of the fall that caused the fracture. This should be multi-disciplinary exercise. See (*[*link*](https://www.crownaudit.org/FFFAP/NAIFuat.nsf/docs/DownloadFilesV3/%24File/NAIF_After_Action_Review_v0.1_pilot.docx?openelement)*) for the after-action review template.* |