



Royal College  
of Physicians

National Audit of  
Inpatient Falls (NAIF)



# National Audit of Inpatient Falls (NAIF) Annual report 2021 (2020 clinical and 2021 facilities audit data)

Autumn 2021

In association with



Commissioned by



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## Foreword

One of South Tees Hospitals NHS Foundation Trust's priorities is to minimise harm and improve patient safety for everyone in our care. Our approach is safety first and as well as reducing the number of falls in the organisation we aim to ensure colleagues feel confident and know how to report falls incidents. We recognise the impact that every fall has on the individual themselves but also on their families and carers. As an organisation we take every fracture seriously and have an open and honest culture. We report all femoral fracture-related falls as severe harm and continue to promote a good reporting culture for our organisation. Although COVID-19 presented some major challenges in working practices, all areas had access to equipment which ensured that patients with fractures could be safely moved off the floor. We look forward to continuing all the work we started pre-COVID to improve the experience of those in our care.

Our organisation's participation in the National Audit of Inpatient Falls (NAIF) has led to an improvement in key quality indicators, including an effective post-falls review which has been standardised in the organisation. The format of our falls structured reviews has recently changed to ensure good practice is celebrated but also to highlight the learning. Targeted support in areas that have high falls incidents is beginning to show positive outcomes and accountability of falls rates to our Board is now clear within our patient safety processes.

Our participation in the NAIF has provided yearly insights into expectations of care and compliance with audit recommendations which will improve the care we provide. This audit is a resource that we can use to facilitate the quality of care we deliver based on recognised key performance indicators and clinical standards and we look forward to getting insights from this work.

**Ruth Mhlanga, non-executive director  
South Tees NHS Foundation Trust**





## Clinical lead's foreword

A hip fracture is one of the most severe consequences of a fall. Evaluating the care given to inpatients who experience such fractures, will likely reflect the quality of fall prevention practice and post-fall management available to all inpatients. Not all falls are avoidable, and it is vital that patients are enabled to be active during their inpatient stay. However, it is equally important that all possible steps are taken to identify and address modifiable falls risk factors. For the first time since continuous data collection began in 2019, this NAIF report includes data on the quality of falls prevention practices, specifically the application of [multi-factorial falls risk assessment \(MFRA\)](#) preceding fracture. While three-quarters of patients had an MFRA documented, their quality varied. It is encouraging to see that more than two-thirds of patients had assessment for delirium, continence, mobility and a medication review but it is concerning that less than half had a measurement of lying/standing blood pressure or vision assessment. Interestingly, where these assessments were undertaken, the prevalence of risk factors was high with more than a third of patients exhibiting orthostatic hypotension, delirium, visual impairment and incontinence and over half requiring a walking aid. These data strengthen the case for the value of an MFRA. However, identification of risk factors must be followed by implementation of tailored interventions and care plans.

The audit also presents data on post-fall management, tracking performance against NICE Quality Standard 86, which includes checking the patient for injury before moving, using safe lifting equipment and a prompt medical assessment after the fall. In addition, we have asked when analgesia is given to a patient. These are all vital steps in ensuring that fracture diagnosis is accurate and timely so that any delays to surgery are avoided, and that patients are afforded comfort and dignity in the immediate aftermath of the fall.

The audit has highlighted the potential for inequity in the experience of patients who fracture as an inpatient compared with those whose fracture occurs elsewhere. Inpatients who sustain a femoral fracture are less likely to have prompt surgery, get up the day after surgery and be free of delirium compared with those who sustain hip fracture outside of hospital. They are also twice as likely to die within 30 days. Organisations are urged to review their policies and procedures for managing inpatient fall-related injuries and ensure there are no barriers to providing timely and dignified care in line with hip fracture guidelines.

Participation in NAIF continues to grow. Every organisation that registers and enters data supports the success of this audit and we commend trusts for the high level of data completion in this challenging time. However, reading this report is just the start. The real value of this audit is how the data is used. We encourage clinical leads, falls coordinators, MDT falls groups and executive / non-executive directors to review their trust data and implement focused quality improvement interventions.

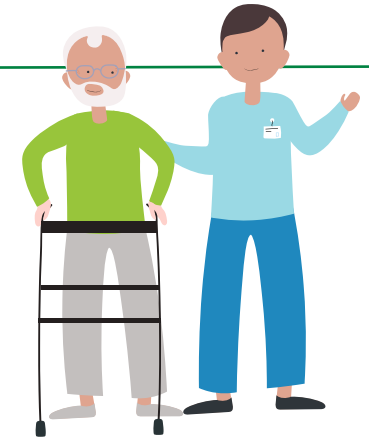
**Julie Whitney, National Audit of Inpatient Falls clinical lead  
Royal College of Physicians**

# Report at a glance – key messages



Engagement in the audit has increased with **79%** of eligible NHS trusts and health boards participating in the National Audit of Inpatient Falls (NAIF). More NHS mental health trusts (**63%** in 2021 vs **38%** in 2020) and specialist trusts (**30%** in 2021 vs **8%** in 2020) are now taking part.

The audit looked at the care given to 1,357 patients who fell while they were in hospital and sustained a hip fracture in 2020 (January to December).

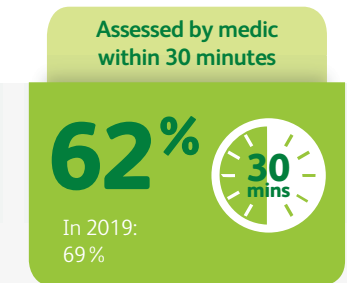
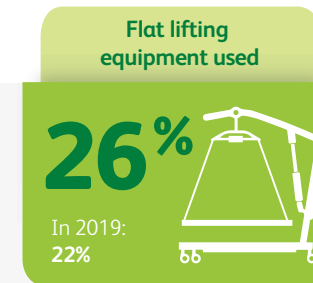
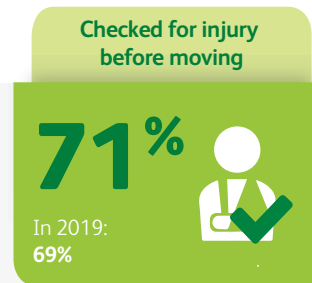


It is necessary to assess older inpatients for factors that increase their risk of falling so that appropriate interventions and care plans can be put into place. Examples of falls risks are difficulty with mobility, impaired vision and delirium. This process is called a multi-factorial fall risk assessment (MFRA). MFRA was complete in **76%** cases but findings from individual components highlight the poor quality of some MFRA's.

The risk factor which was most often assessed was continence with **74%** patients undergoing this component of the MFRA. Vision and lying/standing blood pressure were the least often assessed with **44%** and **35%** patients getting this assessment respectively.



were being followed at the time of the fall that caused the fracture.



## Many inpatients experience delays to hip fracture care.

These delays may partly explain the poorer outcomes in those who fracture as an inpatient. Poor standards of immediate post-fall management, as indicated by performance against [NICE Quality Standard 86](#) statements 4, 5 and 6 are likely to exacerbate these delays.



On average, it took 2 hours following the fall that caused the hip fracture for patients to receive the first dose of pain relief. [NICE Clinical Guideline 124](#) recommends that analgesia should be given immediately.

## Recommendations

### Data quality

1. Clinical leads should assess the extent of the gap between actual and reported falls in your trust or health board if more than 10% of inpatient femoral fractures (IFFs) are recorded in NAIF as not attributable to a fall. Higher proportions of IFFs not attributed to a fall suggest under-reporting.

### Clinical

2. Clinical leads should implement quality multi-factorial risk assessments (MFRAs) in all ward types, as inpatient falls can happen anywhere.
3. Senior leaders and clinical teams should run at least one quality improvement (QI) project per year aimed at improving the quality of MFRA and to ensure care plans are followed.
4. Falls leads and clinical teams should use QI methods to address poor performance against NICE Quality Standard 86 statements 4, 5 and 6 (NAIF KPIs 2, 3 and 4).

4: Checks for injury after an inpatient fall

5: Safe manual handling after an inpatient fall

6: Medical examination after an inpatient fall

Timely and effective post-fall management improves outcomes for patients.

5. Clinical teams should administer analgesia as soon as a provisional diagnosis of IFF is made, aiming for within 30 minutes of the fall.
6. Senior leaders should review patients who have experienced delays in starting femoral fracture management in inpatient settings to identify where systems and processes can be improved to avoid delays.

### Dissemination

7. Falls leads and senior leaders should review NAIF reports and online real-time data for your trust in quarterly meetings of multidisciplinary team (MDT) falls working groups, so that these can be drivers for local QI projects.

### Leadership/resources

8. Senior leaders should include time for participation in NAIF and related QI activities in job specifications and plans for falls leads/practitioners/coordinators.

## Introduction

Falls remain one of the leading causes of harm in hospital settings.

In January 2019, NAIF relaunched as a continuous audit including all cases of hip fracture sustained in inpatients in England and Wales. The first year of this new iteration involved a short and simple dataset (phase I) to test the process of identifying cases through the National Hip Fracture Database (NHFD) and allocating those to the falls team in the trust or local health board (LHB) where the person fell.

In our first report in March 2020, we found that participation was good, completion rates were excellent, and we were able to present data on performance against [NICE QS 86](#): standards 4, 5 and 6 for post-fall management.<sup>1</sup> These standards are now key performance indicators (KPIs) for NAIF.

### NAIF key performance indicators 2021

**KPI 1: Participation in the audit (completion of facilities data and registration with Crown Informatics)**

**KPI 2: Check for and identification of injury before movement from the floor**

**KPI 3: Safe manual handling methods used to move the patient from the floor**

**KPI 4: Medical assessment within 30 minutes of the fall that caused the fracture**

## Methods

### Clinical audit

Following the successful roll-out of phase I in 2019, from January 2020 the dataset was expanded to include more questions about fall prevention activities and what happened at the time of the fall that caused the fracture (phase II).

Cases continued to be derived from patients entered onto the NHFD where it was indicated the fracture occurred in an inpatient setting. All English NHS trusts and Welsh health boards with inpatient beds were eligible to participate in NAIF. From April 2020, other [types of femoral fracture](#) were included in the NHFD.

Therefore, NAIF cases were patients who sustained a femoral fracture in an inpatient setting which was the result of a fall. The process of case ascertainment is illustrated in figure 1.

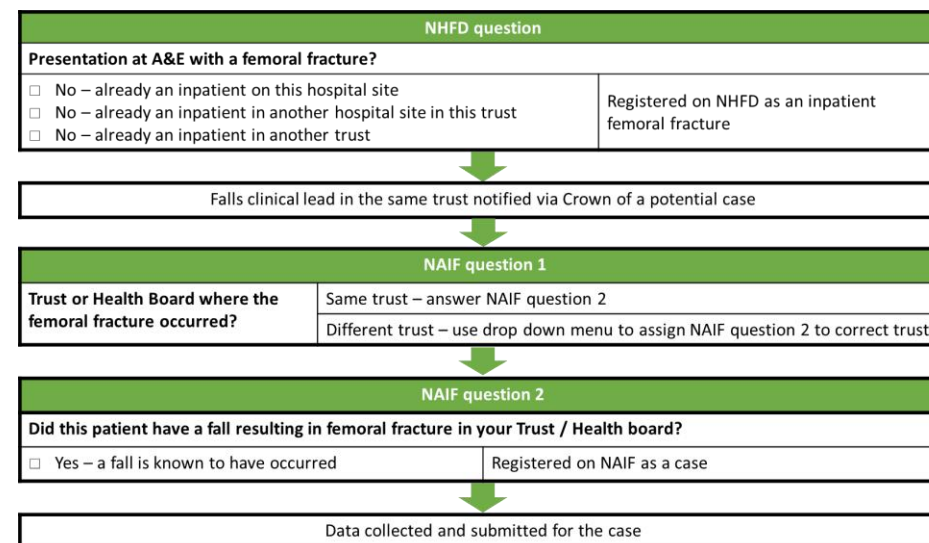


Figure 1. Case ascertainment for NAIF

Once the falls lead had accepted that the femoral fracture occurred in their organisation and resulted from a fall, audit questions could be completed. Patient-level data was requested about:

- > fall risk assessments and interventions preceding the inpatient femoral fracture
- > what happened at the time of the fall
- > immediate post-fall management.

## Clinical audit findings

### Participation (KPI 1)

Of the 213 eligible trusts in England and Wales, 169 participated in the facilities audit and have registered with the Crown webtool (see figure 2).

Year	2019	2020	2021
Participating trusts	168/217 (77%)	161/215 (75%)	169/213 (79%)

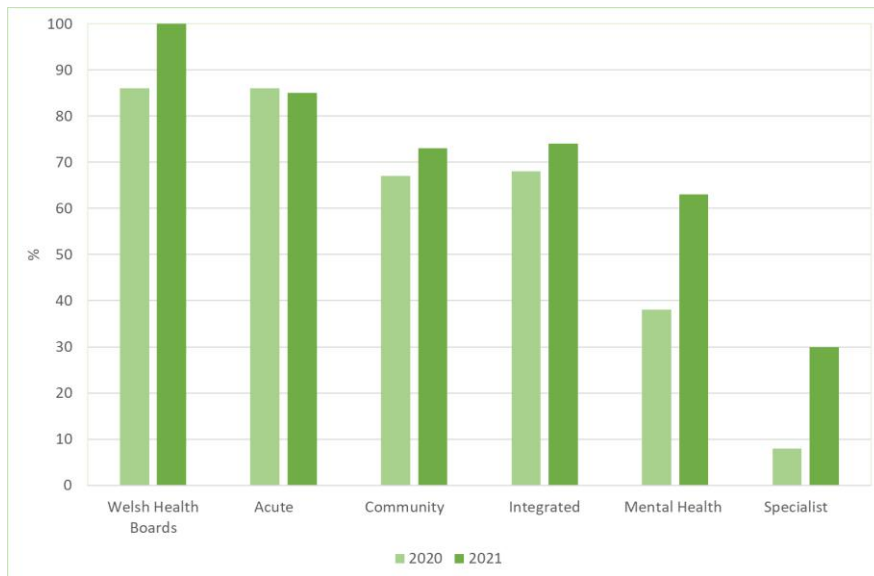


Figure 2. Participation based on trust type (percentage)

In this audit cycle, participation has markedly improved in mental health and specialist trusts.

### Audit cases

There were 2,052 inpatient femoral fractures (IFF) recorded on the NHFD and highlighted to NAIF teams to complete. NAIF teams designated 145 cases as ‘not applicable’ (an option indicating the fracture had not happened in an inpatient setting) and 550 were not attributed to an inpatient fall. This left

1,357 cases for analysis (see figure 3 for case ascertainment). All cases were fractures of the hip.

**Twenty-nine percent of inpatient femoral fractures were not attributed to a fall – this is much higher than the 5% that might be expected.<sup>2</sup>**

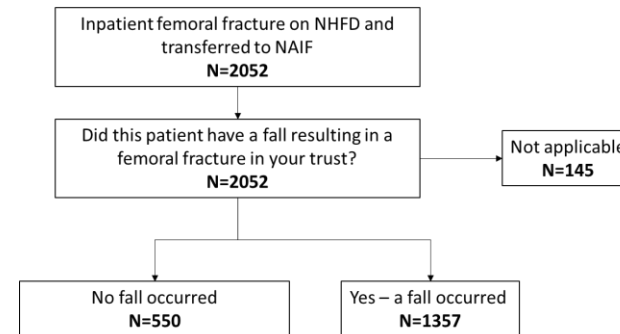


Figure 3. Case ascertainment for 2020

**Recommendation 1:** Clinical leads should assess the extent of the gap between actual and reported falls in your trust if more than 10% of IFFs are recorded in NAIF as not attributable to a fall. Higher proportions of IFFs not attributed to a fall suggest underreporting .

### Completion

For most audit questions, completion was good, with more than 98% data completed. The exceptions were:

Question	Missing data
MFRA date	343/1,357 (25%)
Type of enhanced supervision	169/360 (53%)
Call bell next to patient at time of fall	564/1,357 (42%)
Patient informed to ask for help before moving	777/1,357 (57%)
Alternative approach if can't use call bell	1,086/1,357 (80%)
Walking aid in reach at time of fall	850/1,357 (63%)
Analgesia prescribed after fall that caused fracture	530/1,357 (39%)



Due to the levels of missing responses, the questions shown in green text above will not be presented in this report.

The COVID-19 pandemic influenced NAIF data collection in 2020 in that an extension to the time provided for data submission was required, but the pandemic does not appear to have adversely affected data completeness.

### Characteristics of inpatient femoral fractures (IFF)

**Most IFFs occur on medical wards, almost twice as many as on older people’s wards.**

Inpatient femoral fractures (IFF) occurred a median of 3 days after admission (interquartile range (IQR): 1–6). Most falls that resulted in IFF occurred on medical wards, followed by wards for older people/frailty wards and assessment units/emergency departments (see figure 4).

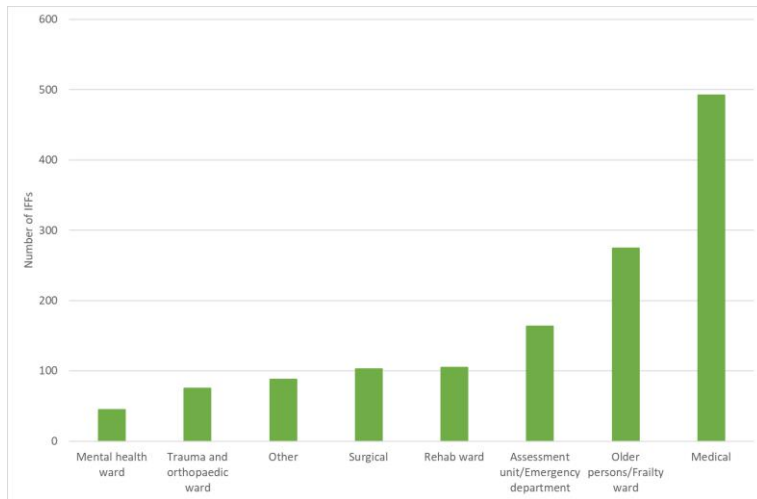


Figure 4. Number of IFFs by ward

**Recommendation 2:** Clinical leads should implement quality multi-factorial risk assessments (MFRA) in all ward types, as inpatient falls can happen anywhere.

The inpatient femoral fracture rate was calculated using data from the number of IFFs in each trust and the occupied bed day data provided in the

facilities audit. The mean rate of inpatient femoral fracture was **6 per 100,000** occupied bed days (OBD), ranging from 0–19 (see figure 5).

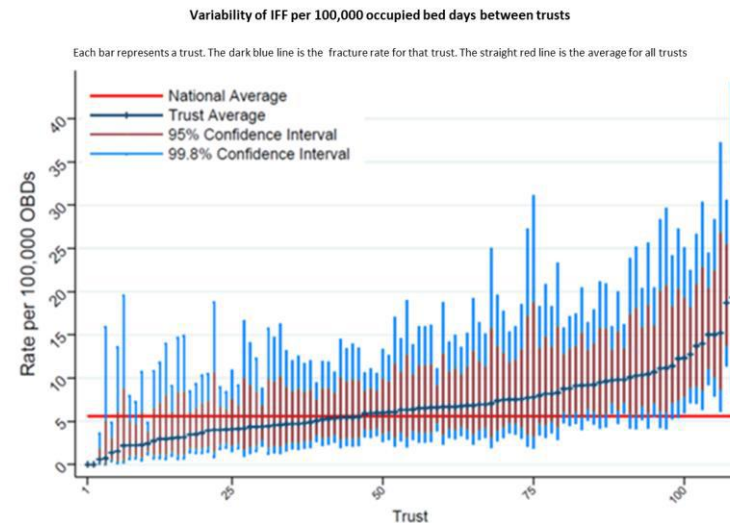


Figure 5. Variation in IFF rate per 100,000 occupied bed days

Just over a quarter (27%) of falls that resulted in IFF were witnessed. In most cases (83%), the patient was alone when they fell, while 13% were with a staff member. Walking on the ward was the activity most frequently engaged in when an IFF was sustained (see figure 6).

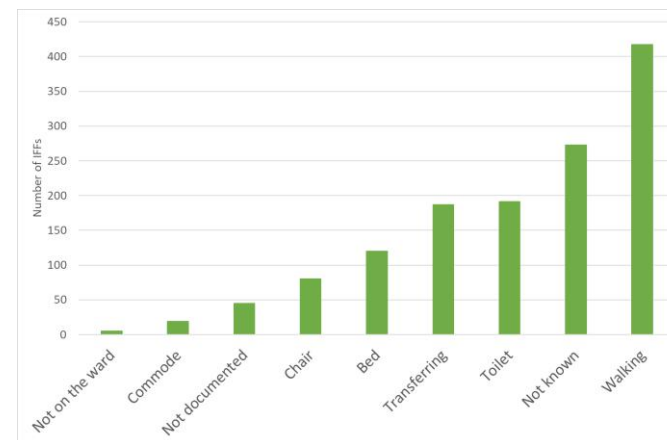


Figure 6. Activity at the time of the fall

## Fall prevention activity prior to the IFF

**Multi-factorial fall risk assessment (MFRA) was reported as completed in 76% of cases, but findings from individual components of the MFRA highlight the poor quality of some MFRA.**

A multi-factorial fall risk assessment (MFRA) was recorded prior to the IFF in 76% (1,016/1,341) of cases and where it occurred, MFRA was conducted a median of 3 days (IQR 1–6) prior to the fall that caused the IFF. For most patients (80%), the fall that caused the IFF was the first fall in hospital. Of the 20% who had previously fallen, 60% had a subsequent review of the MFRA.

Although the proportion of patients with recorded MFRA was high, the individual components of MFRA were less evident. Lying/standing blood pressure (LSBP) was recorded in 35% cases and vision in 44% (see figure 7). The proportion with LSBP is low, but better than the last snapshot audit in 2017 where only 19% had this assessment.<sup>3</sup>

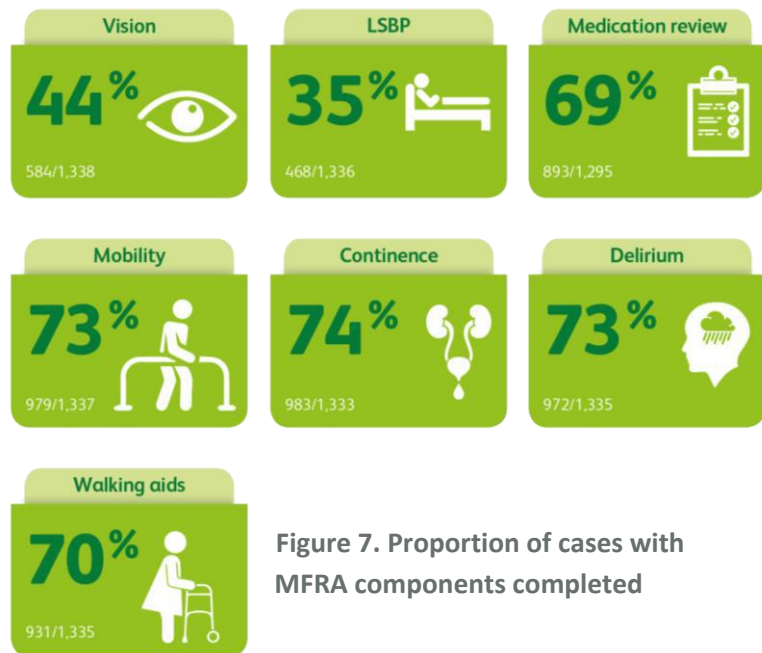


Figure 7. Proportion of cases with MFRA components completed

In cases where individual components of MFRA were completed and recorded, we found that 50% of patients required a walking aid, 44% had incontinence, 41% a visual impairment, 33% orthostatic hypotension and 31% delirium (see figure 8).

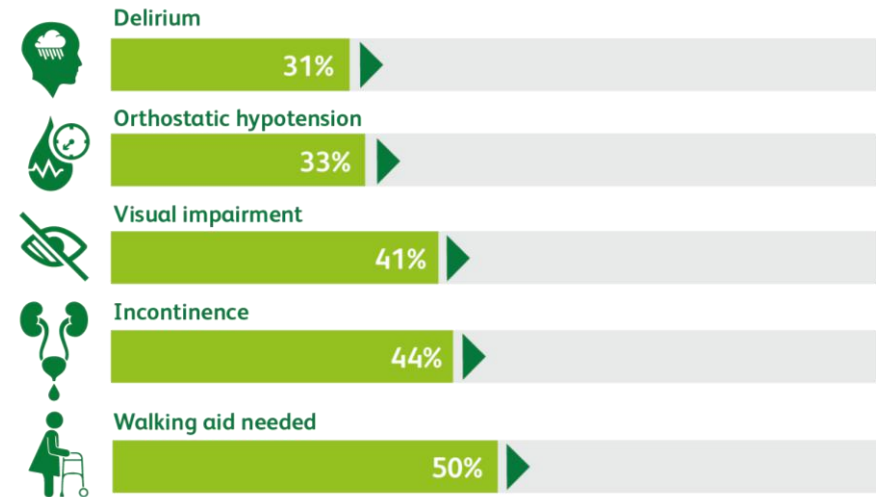


Figure 8. Prevalence of risk factors identified

### Prevalence of risk factors is high among inpatients who sustain IFFs.

The high prevalence of risk factors for falls illustrated in figure 8 reinforces the importance of assessment to identify and address each risk factor. There are NAIF resources available covering how to assess for orthostatic hypotension [measuring lying/standing blood pressure](#) and [a vision assessment tool](#).

**Recommendation 3:** Senior leaders and clinical teams should run at least one quality improvement (QI) project per year aimed at improving the quality of multi-factorial fall risk assessment (MFRA) and to ensure care plans are followed.

### Enhanced supervision

The data suggest that many patients prescribed enhanced supervision are unsupervised when they fall.

It was reported that an enhanced supervision prescription was in place for 33% of patients. The question on the type of enhanced supervision was poorly completed, but there were no clearly favoured methods. This finding is of interest as only 13% of falls occurred while a member of staff was present.

### Bed height and bed rails

In most cases (62%), there was no record that the bed height had been adjusted for the patient. These findings suggest that either bed height is rarely considered, or more likely is rarely documented.

Bed rail assessment was performed for 78% of cases with 52% of those assessed requiring bed rails. Of the cases involving a fall from the bed, 89% were adherent to the bed rail prescription. Bed rail assessments are undertaken and followed in most cases.

### Compliance with care plans

Less than half of delirium care plans and less than three-quarters of mobility plans were followed at the time of the fall.

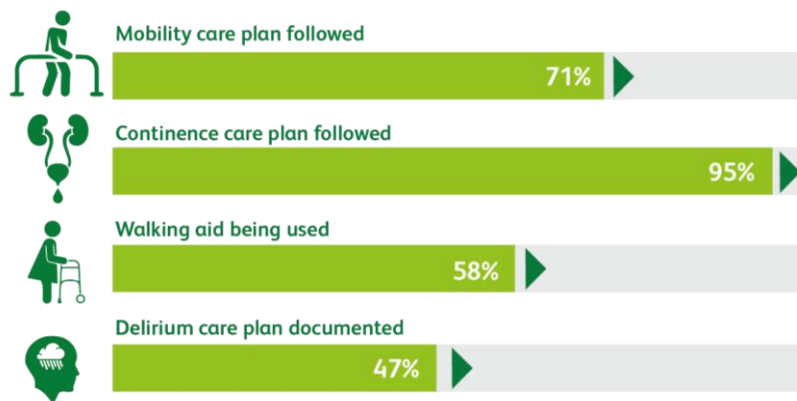


Figure 9. Proportion of care plans followed in full

Where patients had risk factors identified in MFRA, there was variability in how care plans were followed, ranging from 47% of delirium care plans to 95% continence care plans being followed in full (see figure 9).

### Post-fall management (KPIs 2, 3 and 4)

Although compliance with NICE QS 86 statements 5 and 6 has improved slightly, there is plenty of scope for improving practice in checking for injury before moving, and the use of flat lifting equipment to move patients from the floor.

There has been a small improvement from the previous year in the proportion of patients who are checked for injury before moving, moved from the floor using flat lifting equipment and assessed by a medical practitioner within 30 minutes of falling (see figure 10 and table 1).

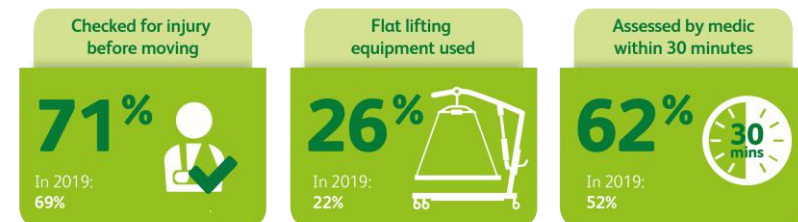


Figure 10. Performance against NICE QS 86 statements 4, 5 and 6.

Our second KPI, checking for injury before moving, requires the check to occur and injury to be suspected. The proportion of cases achieving this is unchanged.

Table 1. Checked for injury (KPI 2) figures

	2019	2020
Checked for injury before moving and injury suspected (KPI 2)	799/1629 (49%)	627/1338 (47%)

**Recommendation 4:** Falls leads and clinical teams should use quality improvement (QI) methods to address poor performance against NICE Quality Standard 86, statements 4, 5 and 6 (NAIF KPIs 2, 3 and 4). Quality statements:

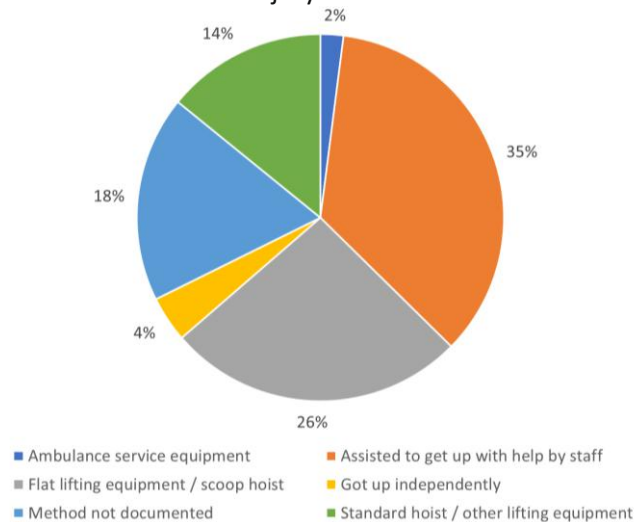
**4: Checks for injury after an inpatient fall**

**5: Safe manual handling after an inpatient fall**

**6: Medical examination after an inpatient fall**

**Timely and effective post-fall management improves outcomes for patients.**

A range of methods for moving from the floor were used, as illustrated in figure 11. The most common method for moving from the floor was ‘assistance by staff’. Manually assisting a patient who has fractured their femur from the floor risks the patient experiencing unnecessary pain and discomfort as well as staff injury.



**Figure 11. Methods for moving the patient from the floor**

In the 2020 audit, we asked about non-medical staff involved in post-fall assessments. Of all the patients who had assessments within 30 minutes, 14% (136/964) were by non-medical practitioners.

**On average, it took 2 hours from the fall until the first dose of analgesia was given.**

Analgesia was prescribed for 78% of patients, not prescribed in 5% of cases and not recorded in 17%. It took a median of 2 hours (IQR 1-5) for analgesia to be provided. NICE guidelines for management of hip fracture ([CG 124](#)) recommend immediate analgesia for patients presenting to hospital with hip fracture.<sup>5</sup> Inpatients should be offered the same standard of care.

**Recommendation 5:** Clinical teams should administer analgesia as soon as a provisional diagnosis of IFF is made, aiming for within 30 minutes of the fall.

The patient’s next of kin were contacted in 85% cases. In 10% of cases next of kin contact was not documented, 3% were not contactable and 2% had no next of kin.

**Delays to starting hip fracture care**

Delays to starting hip fracture care were reported in 18% of cases. The most common reason was a delay in identification of the fracture. The definition of a delay to starting hip fracture care was not specified, but at the discretion of the data inputters.

<b>Identification of the hip fracture</b>	<b>67%</b>
<b>Access to diagnostics (X-rays, scans etc.)</b>	<b>39%</b>
<b>Within hospital transfer</b>	<b>19%</b>
<b>Transfer to another hospital</b>	<b>10%</b>
<b>Unavailability of trained HCP to undertake assessment</b>	<b>7%</b>

**Recommendation 6:** Senior leaders should review patients who have experienced delays in starting femoral fracture management in inpatient settings to identify where systems and processes can be improved to avoid delays



## Facilities audit findings

[NICE Clinical Guideline CG161](#) recommends that screening tools are not used. The use of fall risk screening tools has decreased slightly from last year but is still higher than in 2019. Trusts are encouraged when answering this question to carefully read the guidance on this in the NAIF webtool which gives a clear definition of a screening tool.

**Table 2. General facilities questions**

	2019	2020	2021
Screening tool is used	32%	40%	36%
There is a system for assessing the extent of the gap between actual and reported falls	29%	37%	40%
Falls resulting in hip fracture are routinely reported as severe harm	22%	30%	25%
Bed rail audit carried out in last 12 months	43%	52%	40%
Flat lifting equipment is available on all sites	65%	72%	72%
Inpatient wards/units have access to walking aids for newly admitted patients 7 days per week?	57%	64%	66%

There have been consistent small improvements in the proportion of trusts assessing gaps in falls reporting, providing access to flat lifting equipment and having a policy that ensures newly admitted patients have access to walking aids 7 days a week (see table 3). However, these figures are still very low, indicating considerable variation between organisations.

**Table 3. Written information about falls prevention**

	2019	2020	2021
Written information about fall prevention available?	89%	89%	92%
Not available on any wards reviewed	-	12%	17%
In less than half of wards reviewed		18%	21%
More than half of wards reviewed		34%	21%
In all wards		36%	41%

Written information about falls prevention was available in 92% of trusts and health boards and spot checks found information available on all wards surveyed in 41% of trusts (table 3). Some trusts reported that there had been a change in policy in relation to written information for patients during the

COVID-19 pandemic, therefore these additional factors should be considered when comparing results from 2019 to 2021.

Falls training was reported as mandatory in 52% of trusts; an increase of two percentage points from last year. In 2021, the [Carefall](#) and [Fallsafe](#) E-learning programmes were refreshed and relaunched.

**Table 4. Executive involvement in falls prevention**

	2019	2020	2021
Executive director with specific responsibility for falls	86%	87%	89%
Non-executive director with specific responsibility for falls	42%	49%	57%

There has been little change in the proportion of trusts with an executive director responsible for falls, but an increase in trusts with non-executive directors (NEDS) taking responsibility for falls (see table 4). NAIF has previously produced [resources for governors, NEDS and other health champions](#) to encourage engagement with audit outputs.

**Table 5. Falls working groups**

	2019	2020	2021
Multi-disciplinary group that meets at least 4 times a year	87%	84%	87%
Quarterly incidence of falls routinely presented	98%	97%	99%
Information on falls rates expressed as falls per occupied bed days	88%	82%	86%
Quarterly data on falls rates and trends provided to directorates, wards and units	-	94%	91%

Most trusts and health boards (87%) meet as a multidisciplinary group to discuss falls, and present data on falls which is shared with individual directorates and wards (table 5).

**Recommendation 7:** Falls leads and senior leaders should review NAIF reports and online real-time data for your trust or health board in quarterly meetings of multidisciplinary team (MDT) falls working groups, so that these can be drivers for local QI projects.

**Recommendation 8:** Senior leaders should include time for participation in NAIF and related QI activities in job specifications / plans for falls leads / practitioners / coordinators.

## Summary

This is the first report of the full NAIF dataset. The good news is that participation continues to grow, with increasing numbers of mental health and specialist trusts using it. With a few exceptions, adding new questions has not compromised data completeness. It is also reassuring to see that despite the challenges posed by COVID-19 in 2020, there have been small improvements in all of our key performance indicators.

However, there is still work to do to improve prevention and management of inpatient falls and fractures. We now have baseline data on completion of MFRA. The evidence from this audit is that falls risk factors are prevalent in people who go on to sustain an inpatient femoral fracture, emphasising the importance of risk factor detection and management. NAIF has defined what should be included in an MFRA; a process that prompts interventions that are tailored to assessment findings rather than a tick-box exercise. To effectively assess quality, future reports and KPIs will focus on individual components of MFRA as a marker of MFRA quality. The longer-term goal will be to reduce variability between trusts in the rate of inpatient femoral fracture.

Two previous reports ([NAIF 2020 annual report](#) and [NAIF Interim annual report 2021](#)) have emphasised the variance between patients who sustain a hip fracture in an inpatient setting, compared with those who fracture in the community, both in terms of outcomes and care.<sup>1,6</sup> These disparities are a call to action for continuing improvement in immediate post-fall management for inpatients, including identification of fracture, handling procedures that do not cause more harm and swift access to analgesia.

## Next steps

### New KPIs for NAIF

From 2021, we propose six new KPIs relating to components of the MFRA. These will be in addition to the existing four KPIs.

### Participation

**KPI 1:** Participation in the audit

### Post-fall management

**KPI 2:** Check for injury before movement from the floor

**KPI 3:** Safe manual handling methods used

**KPI 4:** Medical assessment within 30 minutes

### Multi-factorial risk assessment

**KPI 5:** Assessment of vision

**KPI 6:** Assessment of lying/standing blood pressure

**KPI 7:** Evidence of medication review

**KPI 8:** Delirium assessment and care plan (if indicated)

**KPI 9:** Mobility assessment and plan (if indicated)

**KPI 10:** Continence assessment and plan (if indicated)

### Real-time data reporting

KPIs 2, 3 and 4 are now available for organisations to review on the [Crown webtool](#). This will provide trusts and health boards with more up-to-date audit data to support quality improvement projects. In future, the additional KPIs will be added and there are plans for these KPIs to be made available to the public. For more information, contact [falls@rcp.ac.uk](mailto:falls@rcp.ac.uk)

### Gaining insight from inpatient falls (GIIF)

Inpatient falls that result in fracture can be very distressing not only for the patient, but for all concerned. We are currently developing processes to learn from these events without the need for lengthy investigations. When pilot work is complete, we plan for these processes to be available to falls teams. For more information, contact [falls@rcp.ac.uk](mailto:falls@rcp.ac.uk)

### Post-fall check guidance

The previous two reports have highlighted the challenge of conducting effective post-fall checks before moving a patient so as to recognise injury. A group from NAIF are working on guidance which should be available late in 2021. For more information, contact [falls@rcp.ac.uk](mailto:falls@rcp.ac.uk)

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## Abbreviations and glossary

### Glossary

A full glossary with the technical terms referred to in this report is [available online](#). Below is a list of the abbreviations used throughout the report.

<b>CG</b>	clinical guideline
<b>CQC</b>	Care Quality Commission
<b>HCP</b>	healthcare professional
<b>IFF</b>	inpatient falls fracture
<b>IQR</b>	inpatient quality reporting
<b>KPI</b>	key performance indicator
<b>LHB</b>	local health board
<b>LSBP</b>	lying/standing blood pressure
<b>MDT</b>	multidisciplinary team
<b>MFRA</b>	multi-factorial risk assessment
<b>NAIF</b>	National Audit of Inpatient Falls
<b>NHFD</b>	National Hip Fracture Database
<b>NICE</b>	National Institute for Health and Care Excellence
<b>OBD</b>	occupied bed days
<b>QI</b>	quality improvement
<b>QS</b>	quality standards

# National Audit of Inpatient Falls annual report 2021

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### Falls and Fragility Fracture Audit Programme

The National Audit of Inpatient Falls (NAIF) is run by the Care Quality Improvement Department (CQID) of the Royal College of Physicians (RCP). It is part of the Falls and Fragility Fracture Audit Programme; one of three workstreams that also include the Fracture Liaison Service Database (FLS-DB) and National Hip Fracture Database (NHFD). The programme is commissioned by the Healthcare Quality Improvement Partnership (HQIP).

### Healthcare Quality Improvement Partnership

The National Audit of Inpatient Falls is commissioned by the Healthcare Quality Improvement Partnership (HQIP) as part of the National Clinical Audit and Patient Outcomes Programme (NCAPOP). HQIP is led by a consortium of the Academy of Medical Royal Colleges, the Royal College of Nursing, and National Voices. Its aim is to promote quality improvement in patient outcomes, and to increase the impact of clinical audit, outcome review programmes and registries on healthcare quality in England and Wales. HQIP commissions, manages and develops the National Clinical Audit and Patient Outcomes Programme (NCAPOP), comprising around 40 projects covering care provided to people with a wide range of medical, surgical and mental health conditions. The programme is funded by NHS England, the Welsh Government and, with some individual projects, other devolved administrations and crown dependencies [www.hqip.org.uk/national-programmes](http://www.hqip.org.uk/national-programmes)

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