**Falls and Fragility Fracture Audit Programme: National Audit of Inpatient Falls January 2021**

**Clinical Audit Proforma (VERSION 3)**

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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 healthboard is not listed, please contact the helpdesk (*[*falls@rcplondon.ac.uk*](mailto:falls@rcplondon.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 only answer 'Yes' if you can confirm the patient was an inpatient in your organisation at time in question and 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 the fall, select no fall known to have occurred. The inpatient fall is 'not applicable' if the fall occurred in a care home, hospice or other non-trust based care setting. Select no 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.*  ***Check the online help for further details.*** |

**Questions 2**

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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.* |
| 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* |
| 2.3 | Type of ward where fall happened: | |
|  |  Medical   Assessment unit / Emergency department   Mental health ward   Older persons/frailty ward   Rehab ward   Surgical   Trauma and orthopaedic ward  community   Other | *Assessment unit is a short stay decisions unit e,g, Emergency department(ED), Acute Medicine Unit (AMU) or Clinical Decision Unit (CDU) or equivalent.*  *If your trust does not have wards categorised as medical, surgical, admissions unit, older persons/frailty, rehab or mental health ward, select ‘other’.* |

**Questions 3**

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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 3.1a) | *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.* |
| 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.* |
| 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 3.3) | *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).* |
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| 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 simple 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   Yes - evidence of orthostatic hypotension   Not documented   Not possible | *Definition of lying / standing BP and OH (link to the RCP guidance).*  *Only use the option not possible, if the patient was unable to stand for the duration of the inpatient stay prior to the femoral fracture.* |
| 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*  *(3) 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  Yes: Not delirious on formal assessment   No: delirium identified - but no care plan documented  No: No assessment for delirium | *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.* |
| 3.8 | 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 | 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. |
| 3.9 | 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 | *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.* |
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**Questions 4**

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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   Yes - no injury suspected   No | *If there is no outcome of the check for signs and symptoms documented in the clinical notes, answer 'No'.* |
| 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 / other lifting equipment   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 'Staff assisted to get up' if the patient was moved without equipment being used. If the ambulance service was known to use flat lifting equipment select ‘flat lifting equipment’, only select ambulance service equipment if the equipment was not known to be flat lifting equipment* |
| 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 within 30 minutes   Assessment by other healthcare professional within 30 minutes Assessment by medically qualified professional within 12 hours   No assessment 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. 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.* |
| 4.4 | Time and date that first dose of analgesia was given following the femoral fracture? | |
|  | 🗆 Yes  🗆 Not prescribed  🗆 Not recorded  Time of analgesia:  Date of analgesia: | The time restriction rules for this question are:   1. 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.* |
| 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://improvement.nhs.uk/documents/1673/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 next of kin (NOK) within 24 hours of the fall that caused the fracture? | |
|  |  NOK were contacted   The patient had requested not to contact NOK   No NOK OR NOK were 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.* |
| A | *Unavailability of an appropriately trained individual to assess the patient following the fall?* | |
|  |  Yes   No |  |
| B | *Delay in accessing diagnostics (X-ray, CT, MRI)?* | |
|  |  Yes   No |  |
| C | *Delay was due to time taken to arrange a within hospital transfer?* | |
|  |  Yes   No |  |
| D | *Delay was due to time taken to transfer to another hospital?* | |
|  |  Yes   No |  |
| E | There was a delay in identification / diagnosis of hip fracture | |
|  |  Yes   No |  |

**Questions 5**

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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) for the hot debrief template.* |
| 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) for the after-action review template.* |