

# Driving Improvement through National Guidance, National and Local Audit

Julie Whitney

15/10/21



Royal College  
of Physicians

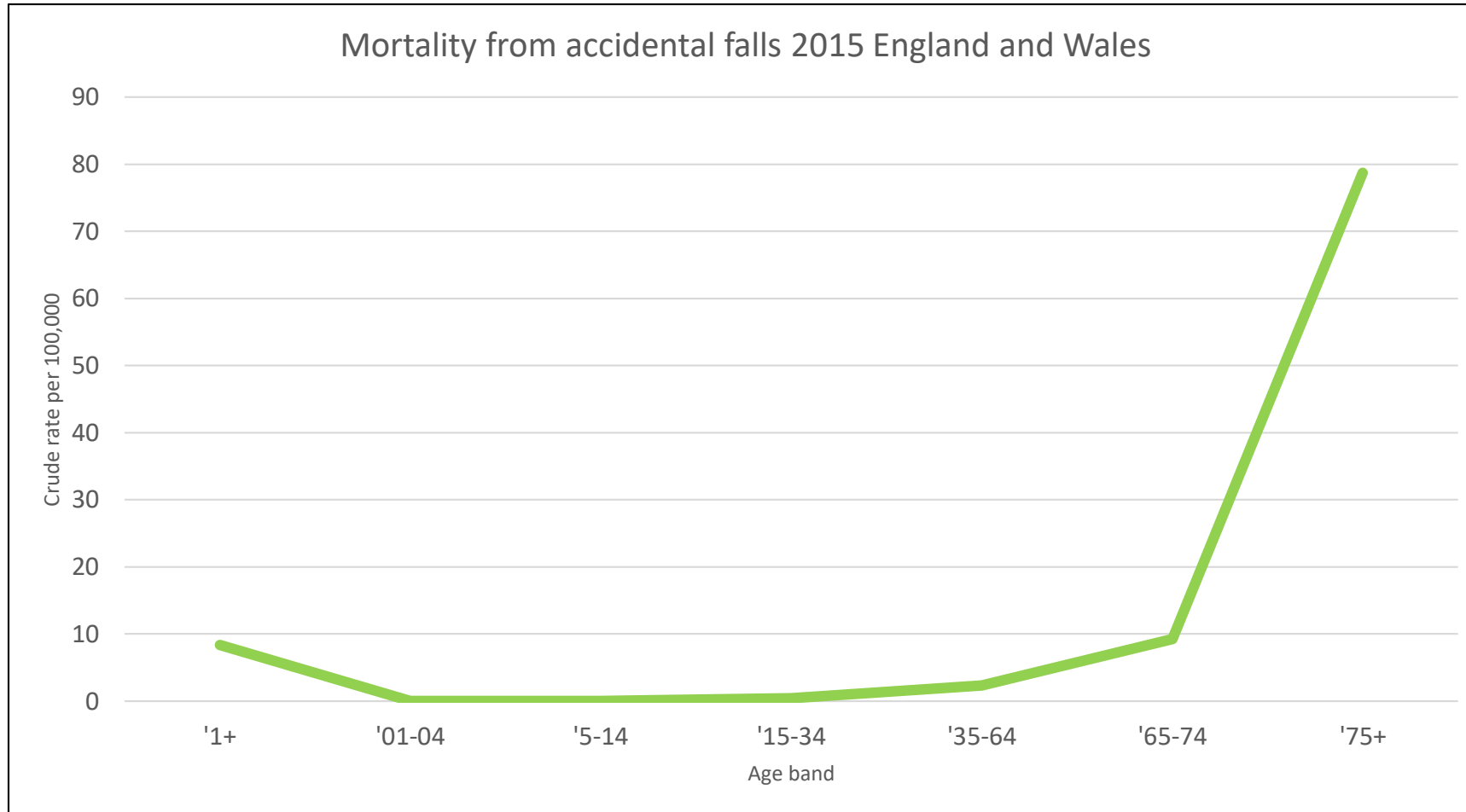
NAIF



# Content

- The problem of inpatient falls
- The guidelines
- The evidence
- Using audit to drive improvement

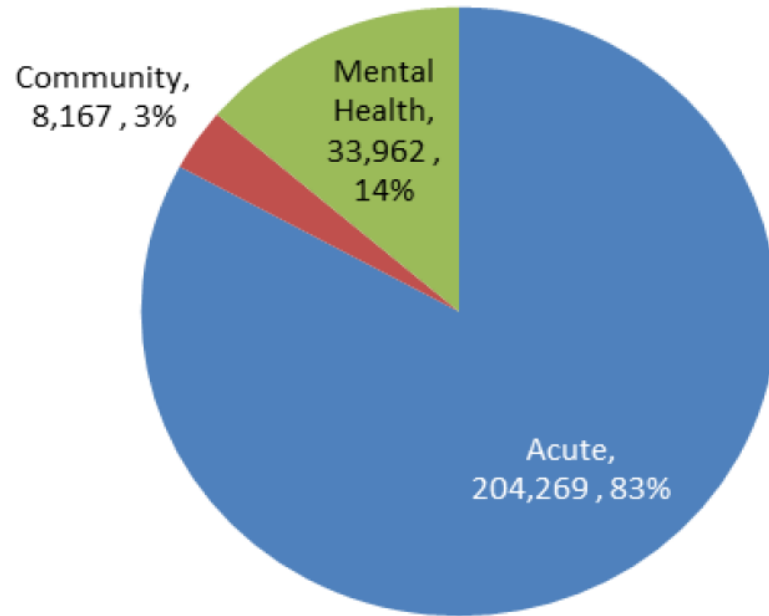
# The Problem of Falls



Office for National Statistics

# Inpatient falls

Figure 1: Breakdown of total reported inpatient falls 2015/16

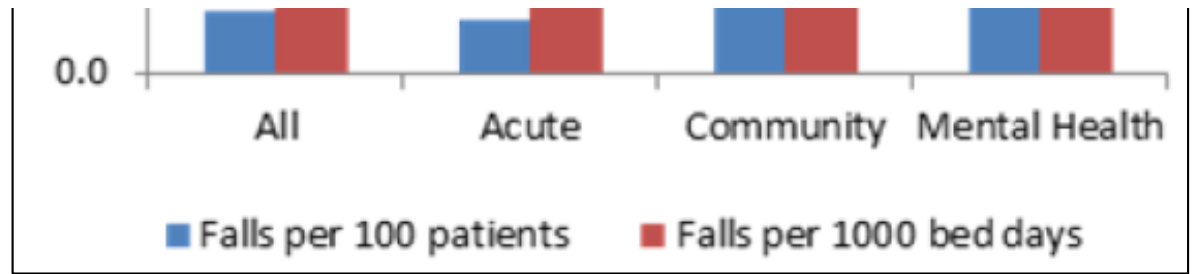
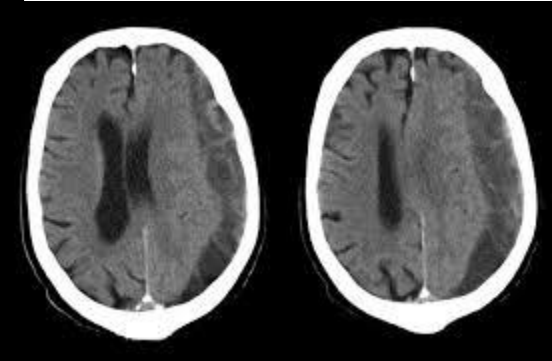


Source: National Reporting and Learning System 2015/16

# The Problem with Falls

**Table 1: Breakdown of reported falls within age groups (all hospital settings in England)**

Age group	Total falls (15/16)	Breakdown by severity (%)				
		No harm	Low harm	Moderate harm	Severe harm	Death
Under 65	57,000	73.4	24.9	1.5	0.2	0.0
Over 65	190,000	71.1	26.0	2.2	0.6	
Total	247,000	71.9	25.5	2.0	0.5	



*“Like most people, I’d always considered a hospital to be a place of safety. So, when my mother was admitted to A&E after breaking her hip, I took it for granted that she’d be in safe hands, and that staff would do everything possible to make her better.”*

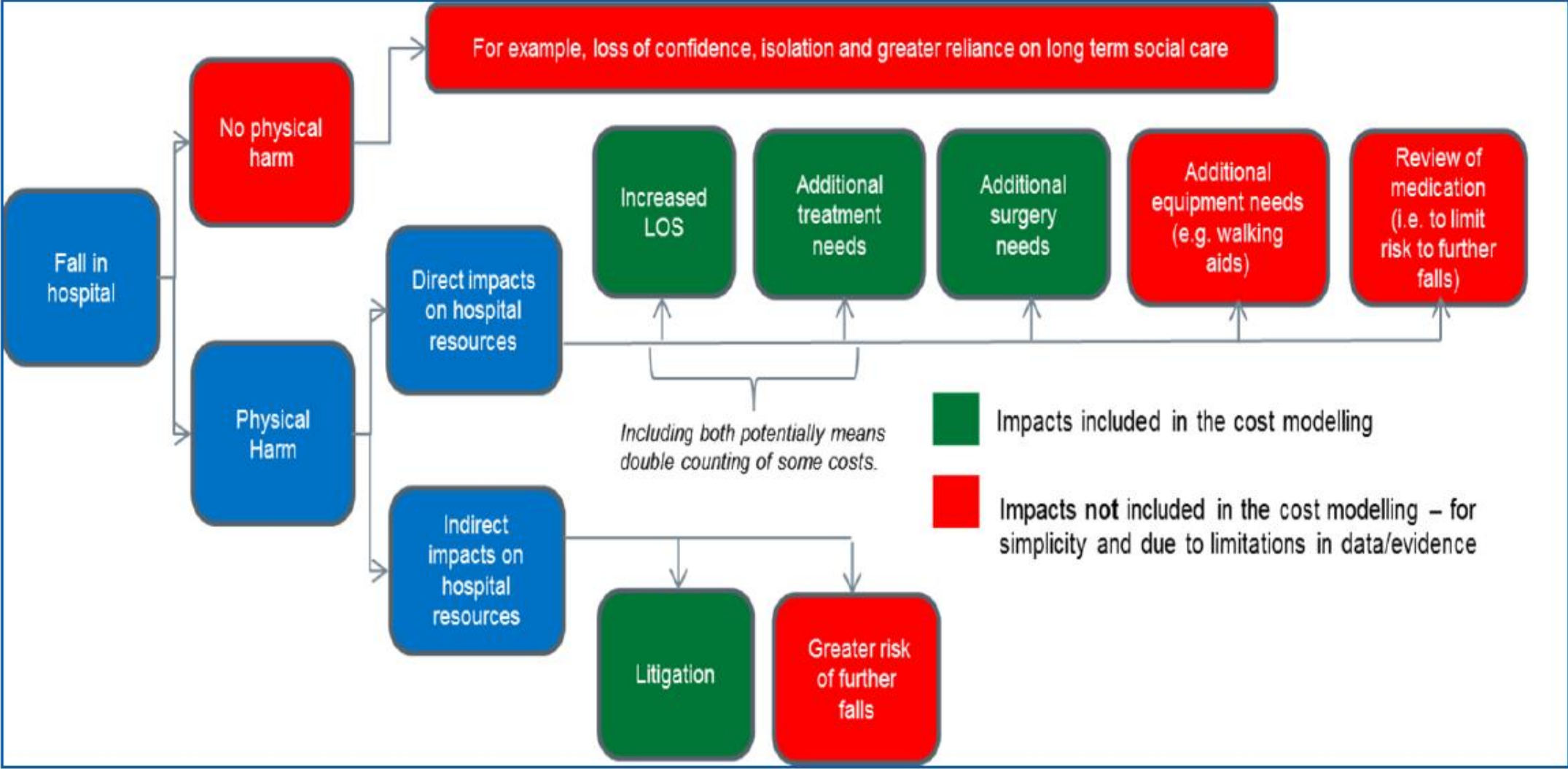
Julia Ellis (chair of the FFFAP Patient and Carer Panel)

# The Problem with Falls

Falls in hospital can result in:

- Loss of confidence and slower recovery, even when physical harm is minimal
- Distress to families and staff
- Legal action against hospital trusts
- Overall costs to hospitals of £630 million per year

# The Problem with Falls





# The Guidelines

**NICE**

National Institute for  
Health and Care Excellence

# NICE CG161

Search NICE...



Home > NICE Guidance > Conditions and diseases > Injuries, accidents and wounds > Injuries, accidents and wounds: general and other

## Falls in older people: assessing risk and prevention

Clinical guideline [CG161] Published date: June 2013 [Uptake of this guidance](#)

Guidance

Tools and resources

Information for the public

Evidence

History

Overview

Introduction

Patient-centred care

Key priorities for implementation

1 Recommendations

2 Research recommendations

3 Other information

### Guidance

[Share](#) [Download](#)

NICE interactive flowchart - Preventing falls in older people

Quality standard - Falls in older people

Next >

This guideline covers assessment of fall risk and interventions to prevent falls in people aged 65 and over. It aims to reduce the risk and incidence of falls and the associated distress, pain, injury, loss of confidence, loss of independence and

# How to prevent falls in hospital settings?

Identify those at high risk

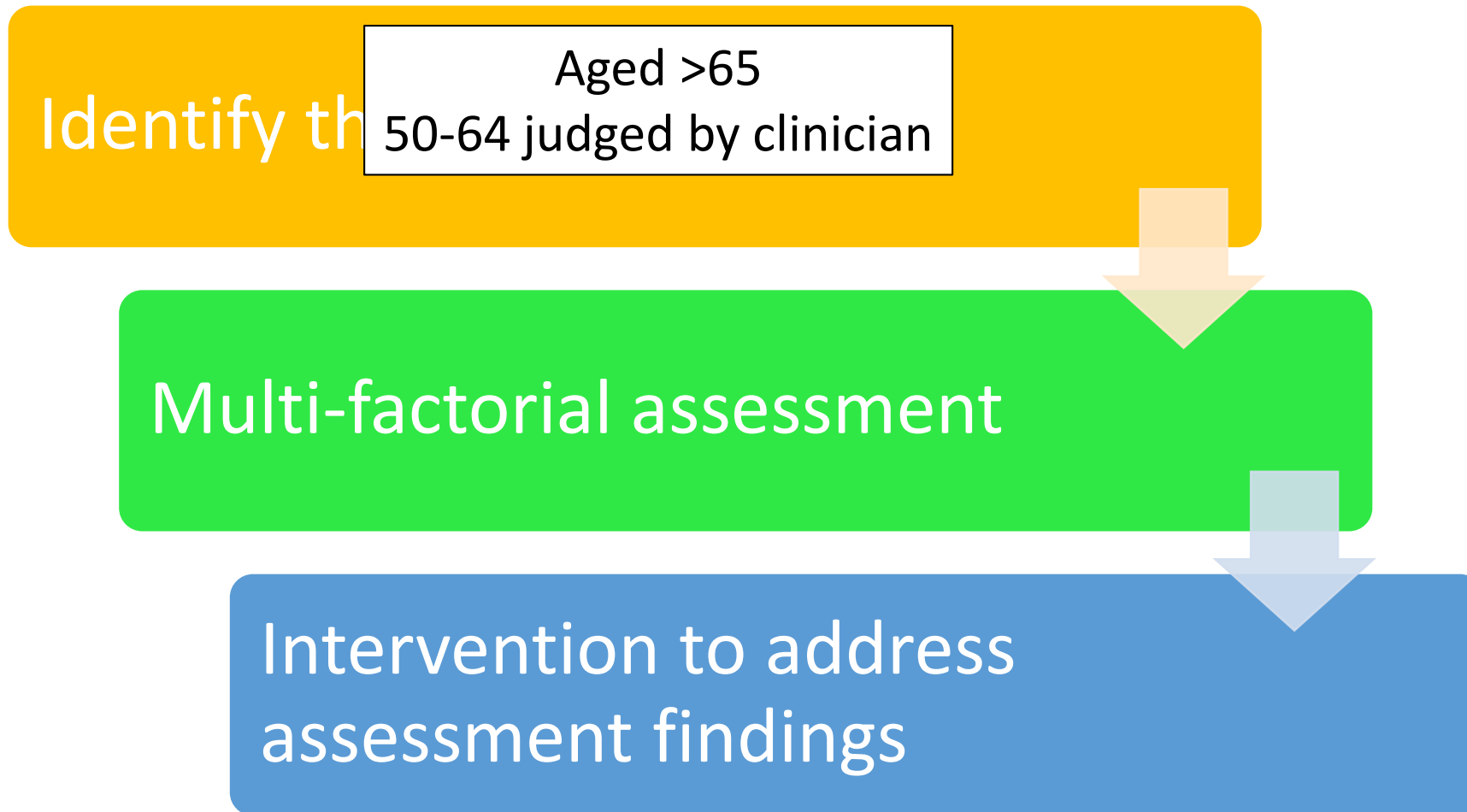
```
graph TD; A[Identify those at high risk] --> B[Multi-factorial assessment]; B --> C[Intervention to address assessment findings];
```

Multi-factorial assessment

Intervention to address  
assessment findings

- **1.2 Preventing falls in [older people](#) during a hospital stay**
- **1.2.1 Predicting patients' risk of falling in hospital**
- 1.2.1.1 **Do not** use fall [risk prediction tools](#) to predict inpatients' risk of falling in hospital. **[new 2013]**
- 1.2.1.2 Regard the following groups of inpatients as being at risk of falling in hospital and manage their care according to recommendations 1.2.2.1 to 1.2.3.2:
  - all patients aged 65 years or older
  - patients aged 50 to 64 years who are judged by a clinician to be at higher risk of falling because of an underlying condition. **[new 2013]**

# How to prevent falls in hospital settings?



# Multi-factorial Assessment

Multi-factorial assessment

NICE CG161:

- cognitive impairment
- continence problems
- falls history, including causes and consequences (such as injury and fear of falling)
- footwear that is unsuitable or missing
- health problems that may increase their risk of falling
- medication
- postural instability, mobility problems and/or balance problems
- syncope syndrome
- visual impairment

# Multi-factorial Intervention

Intervention to address  
assessment findings

NICE CG161:

1.2.2.4 Ensure that any [multifactorial intervention](#):

- promptly addresses the patient's identified individual risk factors for falling in hospital **and**
- takes into account whether the risk factors can be treated, improved or managed during the patient's expected stay. **[new 2013]**

1.2.2.5 Do not offer falls prevention interventions that are not tailored to address the patient's individual risk factors for falling. **[new 2013]**

# Quality standards



Read about [our approach to COVID-19](#)

[Home](#) > [NICE Guidance](#) > [Conditions and diseases](#) > [Injuries, accidents and wounds](#)

## Falls in older people

Quality standard [QS86] Published: 25 March 2015 Last updated: 31 January 2017

[Quality standard](#)[Tools and resources](#)[History](#)[Overview](#)[Quality statements](#)

Quality statement 1: Identifying  
people at risk of falling

### Quality standard

[Download \(PDF\)](#)

NICE interactive flowchart - Preventing falls in older people



# NICE Quality standard 86: 4, 5 and 6

- Quality statement 4: Checks for injury after an inpatient fall
- Quality statement 5: Safe manual handling after an inpatient fall
- Quality statement 6: Medical examination after an inpatient fall

# The evidence



**Cochrane**  
**Library**

Cochrane Database of Systematic Reviews

## **Interventions for preventing falls in older people in care facilities and hospitals (Review)**

Cameron ID, Dyer SM, Panagoda CE, Murray GR, Hill KD, Cumming RG, Kerse N

# Cochrane Findings

## Additional physiotherapy (supervised exercises) in rehabilitation wards (subacute setting):

- Uncertain due to low quality evidence
- Rate ratio: 0.59, 95% CI 0.26 to 1.34 / Risk ratio: 0.36, 95% CI 0.14 to 0.93

## Bed and chair sensor alarms in hospitals:

- Uncertain due to low quality evidence
- Rate ratio: 0.60, 95% CI 0.27 to 1.34 / Risk ratio: 0.93, 95% CI 0.38 to 2.24

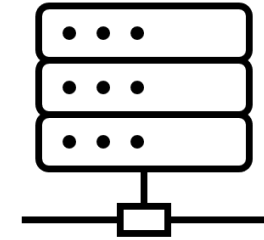
## Multifactorial interventions:

- Uncertain due to low quality evidence
- May reduce rate of falls
- Rate ratio: 0.80, 95% CI 0.64 to 1.01 / Risk ratio: 0.82, 95% CI 0.62 to 1.09
- More likely in a subacute setting. Rate ratio: 0.67, 95% CI 0.54 to 0.83

# Role of audit



## National Audit of Inpatient Falls (NAIF) Audit report 2020

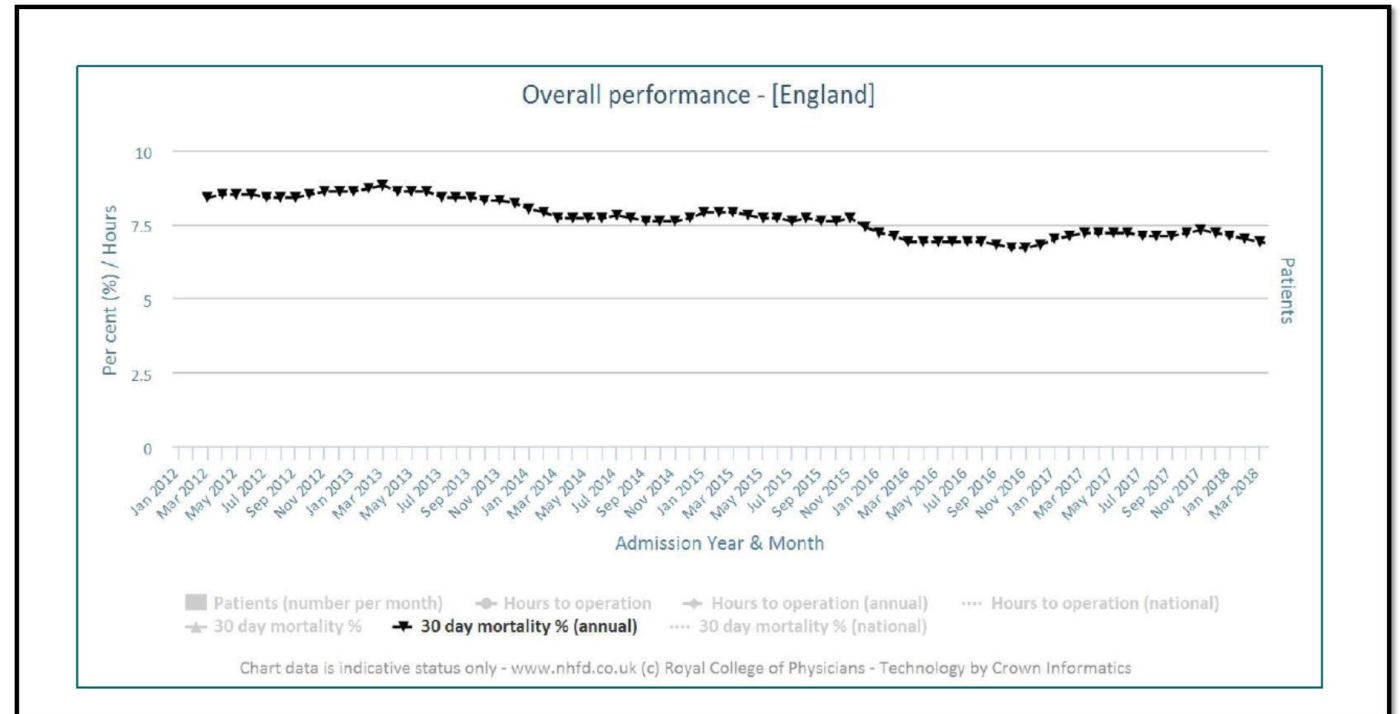
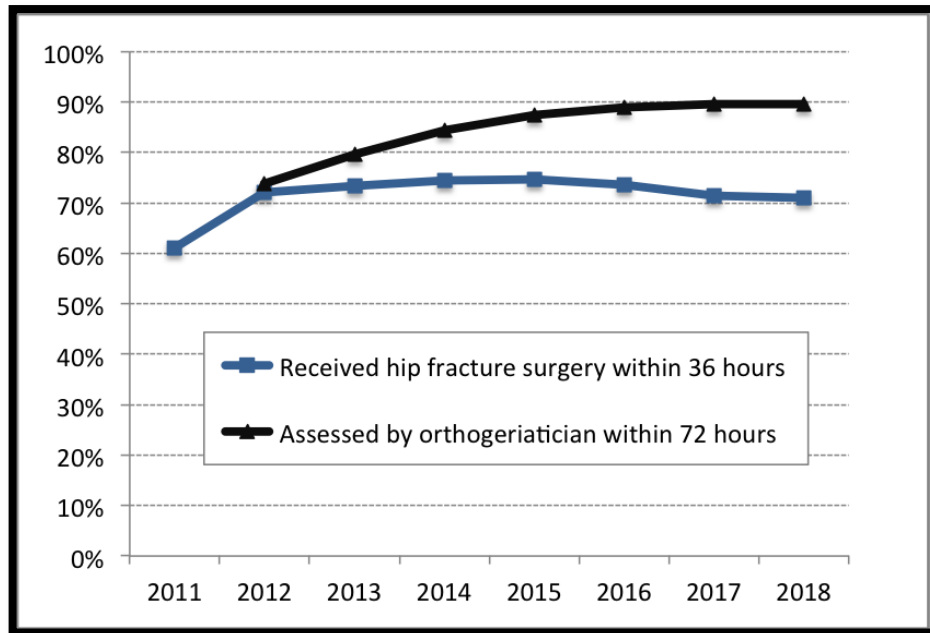


# History of the National Audit of Inpatient Falls (NAIF)

- Commissioned by Health Quality Improvement Partnership (HQIP) contracted to the Royal College of Physicians (RCP)
- Two 'snapshot audits', in both 2015 and 2017 (15 consecutive non-elective admissions aged >65 over 2 days in May).
- Moved to continuous audit in January 2019. All inpatient hip fractures in England and Wales.

# Why move from snapshot to continuous audit?

- To provide ongoing data to support driving improvement
- Data can be linked to outcomes



# Processes since January 2019



- Identify inpatient fall with hip fracture (NHFD)



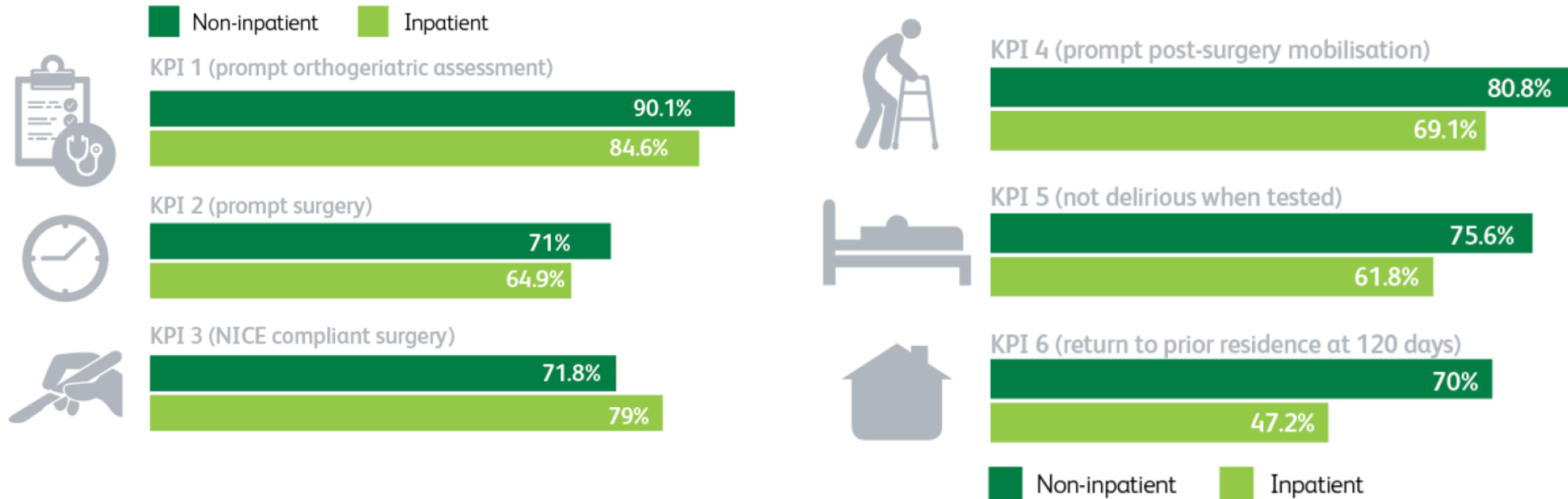
- Notify relevant falls audit team



- Audit team to review patient notes and extract data on:
  - Fall prevention activities prior to the fracture (CG161)
  - Post fall management (QS86 q4,5 and 6)

# Findings from 2019 (reported March 2020)

Figure 7. Difference between KPIs in hip fractures sustained as a non-inpatient or an inpatient.



Mortality (30-day)

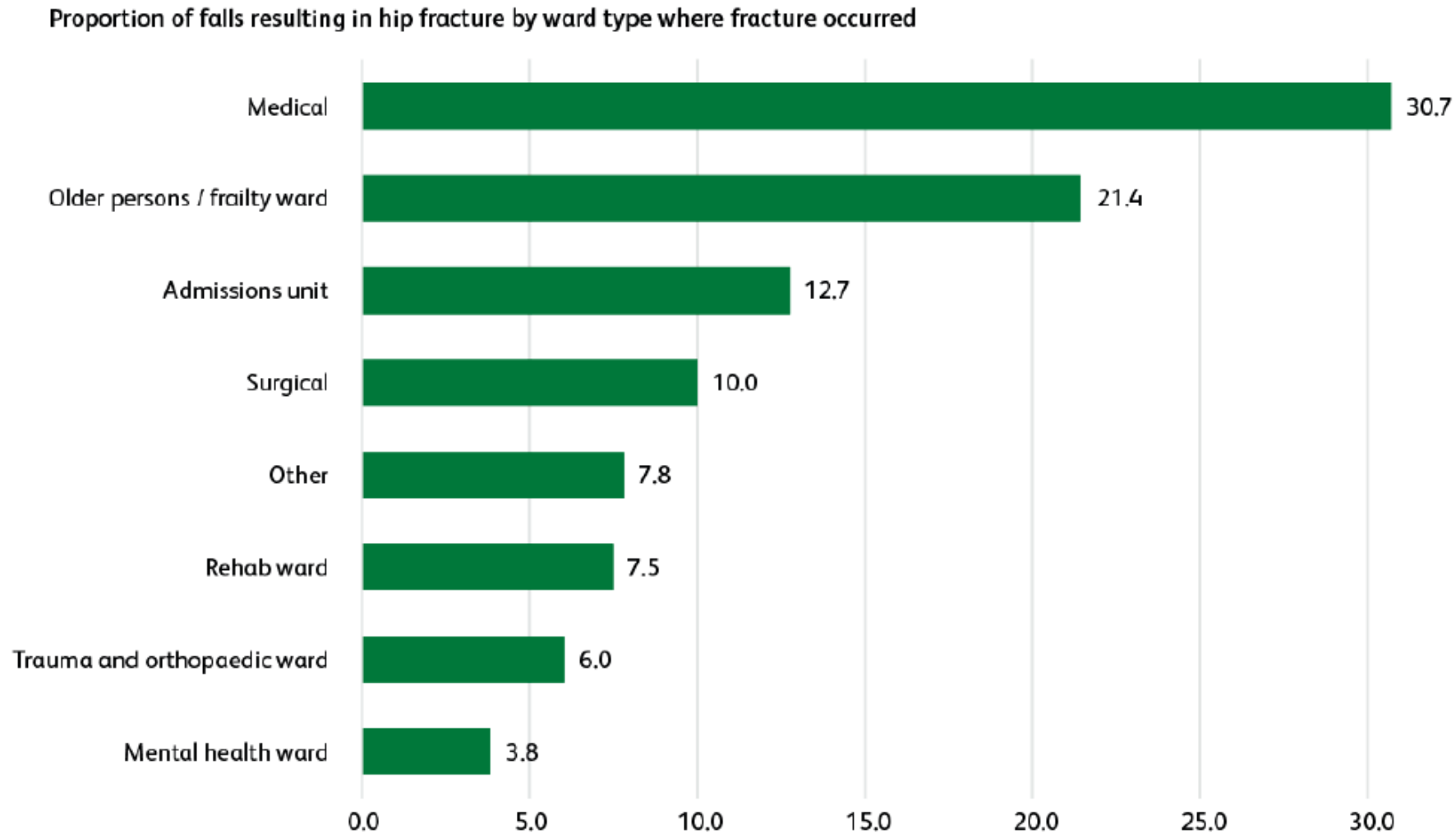
**Inpatient = 12.7%**

Non-inpatient = 5.8%



# Where do falls with hip fracture occur?

Figure 11. Ward type where hip fracture occurred.



# Post fall management – clinical performance

Figure 16. Compliance with NICE quality standards 4, 5 and 6: QS86.



**45%**

were checked for signs of injury before movement from the floor  
QS86=4



**20%**

used safe manual handling methods to move the patient from the floor  
QS86=5



**54%**

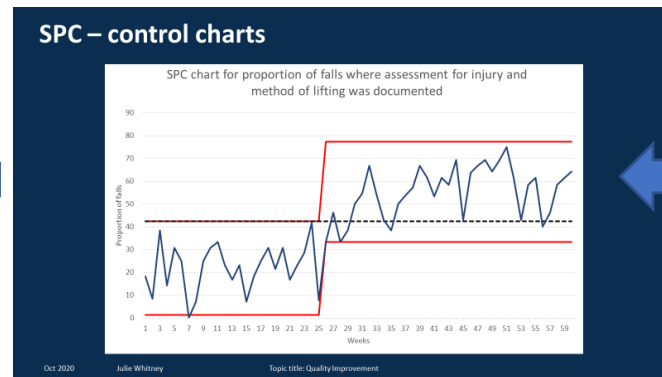
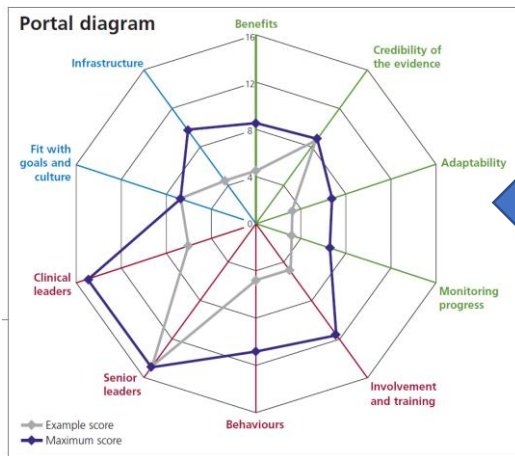
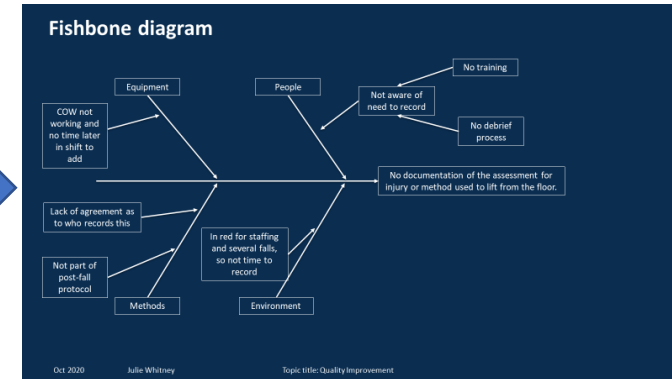
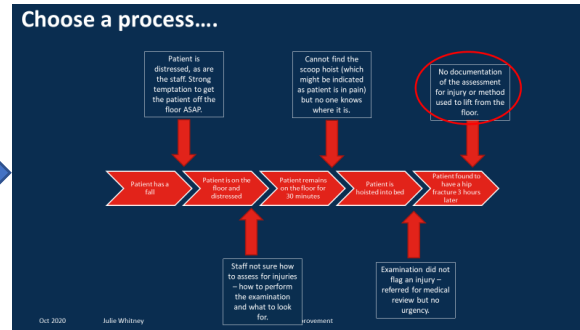
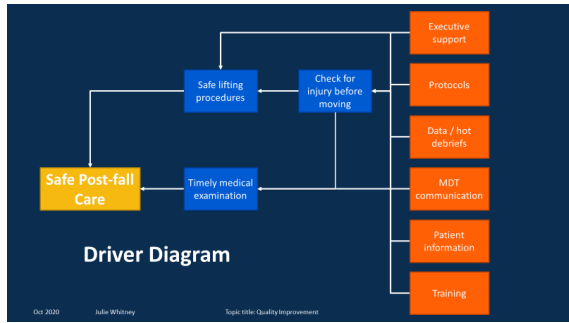
had a medical assessment within 30 minutes  
QS86=6

# Findings from 2020

- Report to be published on 11 November 2021
- Will include data on fall prevention activity prior to the fall that caused the fracture

Watch this space!

# How to drive improvement (quality improvement methods)

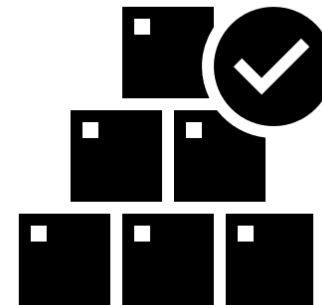
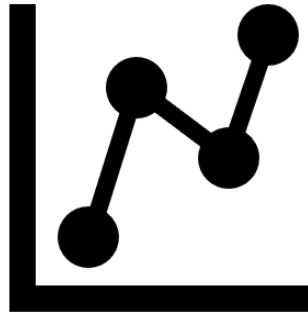


<b>High power</b>	<b>Satisfy</b> Opinion formers. Keep them satisfied with what is happening and review your analysis of their position regularly.	<b>Manage</b> Key stakeholders who should be fully engaged through communication and consultation.
<b>Low power</b>	<b>Monitor</b> This group may be ignored if time and resources are stretched.	<b>Inform</b> Patients often fall into this category. It may be helpful to take steps to increase their influence by organising them into groups or taking active consultative work.
	<b>Low impact/stakeholding</b>	<b>High impact/stakeholding</b>



# How can the (NAIF) audit help with this?

- Data
- Resources
- QI collaboratives



## National Audit of Inpatient Falls (NAIF) Audit report 2020

The screenshot shows a web browser displaying the NAIF audit report for YYY General Hospital. The page features a navigation menu with links for Home, Patients, Reports, Exports, Downloads, and Support. A sidebar on the left lists 'KPIs/Reports', 'Key performance indicators', and 'Downloadable audit reports'. The main content area is titled 'KPI overview: YYY. General Hospital' and includes a note that the data is based on 2 cases averaged over 12 months to the end of June 2020. Three key performance indicators are highlighted in green boxes:

KPI	Local Data	NAIF Overall
1. Checked for signs of injury before movement from the floor	100%	76%
2. Used a safe manual handling method to move patient from the floor	100%	78%
3. Medical assessment within 30 minutes of a fall	100%	68%

At the bottom of the page, there is a footer with the Royal College of Physicians logo (500 years of medicine, 1518-2018) and the Crown Audit logo. Copyright information for 2016-2021 is also present.



Local data – up to date

# Resources:

**Royal College of Physicians | Falls and Fragility Fracture Audit Programme**

**How to measure a lying and standing blood pressure (BP) as part of a falls assessment**

1. Identify if you are going to need assistance to stand the patient and simultaneously record a BP.
2. Use a manual sphygmomanometer if possible and definitely if the automatic machine fails to record.
3. Explain the procedure to the patient.

**Lying**

- 0 min: Ask the patient to lie down for at least five minutes.
- 5 mins: Measure the BP.

**0 - 1 mins**

- Ask the patient to stand up (assist if needed).
- Measure BP after standing in the first minute.

**3 mins**

- Measure BP again after patient has been standing for three minutes.
- Repeat recording if BP is still dropping.
- In the instance of positive results, repeat regularly until resolved.
- If symptoms change, repeat the test.

**Standing**

Notice and document symptoms of dizziness, light-headedness, vagueness, pallor, visual disturbance, feelings of weakness and palpitations.

Advise patient of results and if the result is positive:

- a. Inform the medical and nursing team.
- b. Take immediate actions to prevent falls and/or unsteadiness.

**A positive result is:**

- a. A drop in systolic BP of 20mmHg or more (with or without symptoms).
- b. A drop to below 90mmHg on standing even if the drop is less than 20mmHg (with or without symptoms).
- c. A drop in diastolic BP of 10mmHg with symptoms (although clinically less significant than a drop in systolic BP).

**Royal College of Physicians | Falls and Fragility Fracture Audit Programme (FFFAP)**

**Procedure for measuring lying and standing BP**

- > Use a manual sphyg if possible.
- > Lie down 5 minutes. Take BP 1.
- > Stand up. Take BP 2 in 1st min.
- > After 3 minutes, take BP 3.

Continued opposite >>>

**Look out!**  
Bedside vision check for falls prevention

**BIOS** | **THE COLLEGE OF OPTOMETRISTS** | **THE ROYAL COLLEGE OF OPHTHALMOLOGISTS** | **Royal College of Nursing** | **NHS Improvement**

<https://www.rcplondon.ac.uk/projects/outputs/measurement-lying-and-standing-blood-pressure-brief-guide-clinical-staff>

<https://www.rcplondon.ac.uk/projects/outputs/bedside-vision-check-falls-prevention-assessment-tool>

## Still to come:

- How to do a post fall check
- Learning from inpatient falls – an alternative to investigation/SIRs/RCA in line with NHSE Patient Safety Incident Response Framework (PISRF)

# Quality improvement collaboratives

- Starting a pilot in November 2021
- Depending on the outcome of this, will be made available to more organisations





Thank you & Questions