Report at a glance – key messages

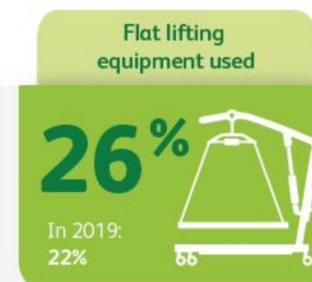
Engagement in the audit has increased with 79% of eligible NHS trusts and health boards participating in the National Audit of Inpatient Falls (NAIF). More NHS mental health trusts (63% in 2021 vs 38% in 2020) and specialist trusts (30% in 2021 vs 8% in 2020) are now taking part.

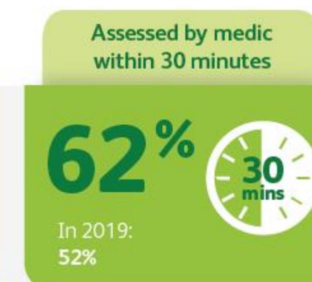
The audit looked at the care given to 1,357 patients who fell while they were in hospital and sustained a hip fracture in 2020 (January to December).

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 MFRAs.

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.