Falls and Fragility Fracture Audit Programme – using national audit data to monitor risk of hip fracture as a result of an inpatient fall

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Aims

Inpatient falls are a major concern for patients, their families and clinical staff. Hip fracture outcome is especially poor for people who sustain this injury while an inpatient. Critical incident monitoring is valuable, but is limited by inconsistent and incomplete reporting of events. We are therefore developing a more objective measure of individual trust performance.

Methods

In 2015, the National Audit of Inpatient Falls (NAIF) surveyed all trusts and health boards in England and Wales to identify the number of occupied beds and of recorded inpatient falls in each organisation during the 2014 calendar year. In the same calendar year, the National Hip Fracture Database (NHFD) identified 58,589 hip fractures presenting to acute orthopaedic services across these 136 trusts and health boards. We have linked the findings of these two audits.

Results

In total 2,214 (3.8%) of new hip fractures occurred in people who were already inpatients – in the same hospital, or another hospital site of the same trust/health board. This figure is far higher than the figure of 1,414 for all 'inpatient falls leading to serious harm or death' that these trusts and health boards had identified from their own surveillance figures. Nearly all hip fractures occurring in hospital should be recorded as 'severe harm', as identified by the National Reporting and Learning System definition 'fall resulting in harm causing permanent disability or the person is unlikely to regain their former level of independence'. Hip fracture numbers will vary with the size of different organisations, so for each trust/health board, we combined the NHFD figure with the total number of occupied bed days they reported to NAIF. On average, trusts and health boards reported one inpatient hip fracture per year for every 41 occupied beds, but this figure ranged from 16 to 748 occupied beds across different trusts and health boards.

Conclusions

Inpatient falls surveillance figures supplied by trusts and health boards to the NAIF clearly tended to understate the potential harm that may have resulted – with only 1,414 out of over 200,000 such events being categorised as leading to serious harm. NHFD figures for inpatient hip fractures provide a simple alternative measure of this aspect of patient safety. We have since refined the NHFD's approach to coding inpatient hip fractures to provide a reliable measure of this aspect of patient safety. As a result of this study, the Falls and Fragility Fracture Audit Programme plans to develop a focus on hip fractures as a 'tracer condition' with which to help trusts and health boards monitor the incidence, prevention and consequences of falls among their inpatients. It will also mean that each case can provide a focus for detailed consideration of the falls risk assessment and prevention provided to individual patients, formalising processes of root cause analysis, as well as examining the care provided immediately after a fall. ■

Conflict of interest statement

None declared.

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