CQUIN CCG7: Three high impact actions to prevent hospital falls

Advice and FAQs

Julie Windsor
Patient Safety Clinical Lead – Medical Specialties and Older People

NHS England and NHS Improvement
Hello. These **hints and tips** slides should help you find your way around the set-up and delivery of the new Preventing Hospital Falls CQUIN.

This presentation and the resources on the [resources page](#) should answer most things but for any further queries please email [patientsafety.enquiries@nhs.net](mailto:patientsafety.enquiries@nhs.net)

The three high impact actions making up the CQUIN have been carefully chosen not only because they have good evidence behind them but they also engender multidisciplinary falls prevention working, which we know is the most effective intervention of them all!

You could perhaps consider them to be a ‘trojan horse’ as they ensure your multifactorial falls assessments and intervention plans fully align with NICE guidance, are fully embedded across your hospitals and work well for all patients aged 65 and over.

*All best wishes*

*Julie*
Inpatient falls – the big picture

• Falls in hospitals are the most commonly reported patient safety incident with more than 235,000 falls reported in acute hospitals, community hospitals and mental health trusts in England annually. The true figure will be higher as a proportion of falls are not reported.

• Each year almost 3,000 falls in hospital in England result in hip fracture or brain injury, typically subdural haematoma.

• Costs for patients are high in terms distress, pain, injury, loss of confidence, loss of independence and mortality, and costly in terms of increased length of stay to assess, investigate or treat even modest injury.

• A fall in hospital often affects plans for a patient to return home or to their usual place of care as it impacts on the older person’s confidence and the confidence of their family and carers.

• An economic analysis commissioned by NHS Improvement estimated that the overall cost of reported inpatient falls (including the cost of extra treatment, length of stay and litigation) as £630 million annually.
Why a falls CQUIN?

- **NICE Clinical Guideline 161** sets out recommendations for preventing falls in older people with key priorities for implementation for all older people in contact with healthcare professionals, and preventing falls during a hospital stay.

- **Past national inpatient falls audits** demonstrated that adoption and delivery of NICE guidance has been inconsistent and variable across providers, while quality improvement projects such as *FallSafe* and *other QI collaborative programmes* demonstrate that significant improvements can be achieved.

- A range of support and resources is available to providers that indicate potential for a CQUIN to achieve substantial improvements in key processes that reduce the risk of falls within one year.

- This CQUIN incentivises and encourages trusts to focus their improvement efforts on the delivery of three high impact actions for falls prevention in hospital. These actions require nursing, pharmacy, medical and physiotherapy input.
What is the falls CQUIN?

The Commissioning for Quality and Innovation (CQUIN) scheme makes a proportion of a trust’s income conditional on demonstrating improvement in a specified area of care. Payment is based on how well the trust does against minimum and maximum thresholds of achievement which in this case (falls) is determined by case note audit.

Make sure you read through both the CQUIN guidance and specifications documents for key information on the indicator itself, how to conduct the case note audit and details of performance and payment thresholds. We have also gathered together lots of clinical resources to help you.
Have you got the essentials?

These recommendations have previously been made by NICE and confirmed by National Audit, but you must have the right building blocks in place to both drive and support your improvement journey. For this CQUIN the most important will be:

**Multidisciplinary falls steering group** with wide membership representing all relevant professional groups. This is essential for ‘sign up’ as the proposed changes will affect all staff groups across nearly all specialties where patients over 65 are admitted.

**Removal of falls risk screening tool and its replacement with MDT falls assessment for all patients over 65.** Any tool that screens patients over 65 ‘in’ or ‘out’ of an inpatient falls pathway or assigns a hierarchy of risk (low/moderate/high) needs to be replaced with an **multifactorial falls risk assessment for all patients aged 65 and over** that is also applicable to patients aged 50 to 64 with an underlying condition likely to put them at risk of falling.

**Every ward will need access to walking aids seven days a week.** Either by purchase of ward stock, access to therapy stores or another suitable local arrangement.
Who does the audits? Trusts need to set up their own local audit process in line with section 4 in the specifications. This ideally should be a collaboration between trust CQUIN staff, clinical audit staff and clinicians. The CQUIN metrics do not require any clinical judgements to be made.

Is an audit pro forma available? Yes, it can be found on our resource page.

How many cases? A minimum of 100 each quarter, or all if your hospital admits fewer than 100 patients per quarter. If using a sampling framework, this needs to make sure that all appropriate patients across the trust are sampled correctly in line with the inclusion and exclusion criteria.

When do we do the audits? Each trust will need to determine what process suits it best to ensure the aggregated data is ready to upload to the national CQUIN submission platform at the end of each quarter.
Inclusions and exclusions

This CQUIN applies to all patients aged 65 years and over who are admitted to an inpatient bed for more than 48 hours.

The three key actions (BP, medications, mobility) must all be checked in all audited case notes, and the answers given as yes or no.

There are two automatic exclusions:

- patient dies during admission (indicates the patient is gravely ill and these assessments as part of a falls assessment are likely to be inappropriate)
- patient is bedbound or hoist dependent throughout their stay (indicates the patient is unable to move to get out of bed unassisted and therefore not at risk of falling).

There are no other exceptions or exclusions. This is to ensure consistent and simple data collection across all providers (trusts).

The maximum payment threshold is set at 80% rather than higher to allow your organisation to achieve the full payment even if some of its patients are affected by some rarer exceptions.
Q1) Lying and standing blood pressure recorded at least once. Y/N

Audit hints and tips

It’s up to each provider to decide who does this assessment and when, and where it is recorded (likely places are electronic vital signs monitoring systems, paper observation charts as part of the patient clinical record, electronic patient records, multifactorial/multidisciplinary falls risk assessment/care plans or medical notes).

Driving improvement

*See resources for detailed advice*, including ‘procedure reminder’ posters and lanyard cards, articles, eLearning, ideas on improvement projects and approaches.
Numerator 2: Hypnotics, antipsychotics or anxiolytics

Q2) Was the patient administered hypnotics or antipsychotics or anxiolytics during their stay. Y/N  If Y, then:

Q2a) Is there a rationale as to why clearly documented? Y/N

Audit hints and tips

The BNF gives current lists of medication names classed as hypnotics or antipsychotics or anxiolytics. You need to check all sections of the medication records (including regular, ‘stat’ and prn sections).

You may need to look in more than one possible place to find where the rationale is documented. Clinicians usually record why they have prescribed or administered a new medication, or decided to continue an existing medication, within the admission assessment, prescribing record, a field in electronic prescribing systems, medical review, a medication review or as part of the multifactorial falls risk assessment, delirium or dementia pathway.

Driving improvement

*See resources for detailed advice* about non-pharmacological management to reduce the need for hypnotics, antipsychotics or anxiolytics, eLearning, NICE guidance and the BNF for clinical guidance for prescribers.
Numerator 3: Mobility assessment

Q3) Did the patient have a mobility assessment within 24 hours of admission? Y/N If Y, then:

Q3a) Was a walking aid required? Y/N, if Y then:

Q3b) Was it provided within 24 hours?

Audit hints and tips

Your local policies and documentation formats are likely to set out who does this assessment, who provides the walking aid and where this might be recorded. The CQUIN doesn’t specify the detail of the assessment or who should carry it out, but the patient must be assessed for how they can (or can’t) mobilise at present, including their need for any walking aid, rather than simply a record of past mobility.

Driving improvement

See resources for detailed advice on effective schemes where this is a shared endeavour by therapy, nursing and support staff, and for eLearning on mobility assessment and the provision of walking aids, ideas on improvement projects and approaches.
Lying and standing blood pressure might not be appropriate for some of our patients, some might refuse.

It would be very unusual for a patient who is standing or mobilising without a hoist and who survives to leave hospital to have a contraindication to having their lying and standing (L&S) BP checked. Remember the CQUIN only asks for one recorded L&S BP per patient stay.

Experience from the National Audit of Inpatient Falls and FallSafe suggests levels of refusal to have L&S BP checked are very low when the reasons are properly explained and the team understand their patients’ needs and preferences, even for patients with significant mental health issues or learning disabilities.

On exceptional occasions it may not be possible to check a L&S BP for an individual patient even once. The maximum payment threshold is set at 80% rather than a higher threshold to allow your organisation to achieve the full payment even if some of your patients are affected by some rare exception.

Resources related to the evidence for measurement and quality improvement approaches to L&S BP are available via our resource webpage, including links to NICE 161 and the National Inpatient Falls Audit.
FAQs (hypnotics, antipsychotics or anxiolytics)

Does this mean administered or prescribed? Some patients may have them prescribed on a PRN basis but not actually given.

The CQUIN specification states administered (ie given).

What constitutes a ‘rationale’? And what about patients who have been on them long term?

A rationale is a reason, and in the context of the CQUIN is about the decisions your organisation made – that is, the reason these medications were prescribed or continued in this hospital stay, not the original reason for a long-term prescription.

For a patient who has taken the medication for years, a record that they were already taking it is not in itself an rationale, whereas recording they still require the medication for some clinical reason, or that because the patient is acutely ill it’s not an appropriate time to change it, or that they require a long-term staged withdrawal plan with specialist advice would all count as rationales.

For the data collection, you are simply recording if a reason is given for continuing an existing hypnotic, antipsychotic or anxiolytic and/or starting a new one while the patient is in your care. The CQUIN measurement can’t be defined in a way that requires a subjective judgement, but you should of course aim to work with your clinical falls leads to ensure any reasons recorded increasingly represent best clinical practice.

This CQUIN does not seek to restrict the use of these medications to patients who truly need them but does encourage a full clinical evaluation and management plan that takes into account the increased falls risk for those patients who do require them.
Does it have to be carried out by a physiotherapist?

No. For some patients it will be done by a physiotherapist and for others by a nurse, support worker, physiotechnician, etc. See resources on our website, especially module in e-Learning Preventing Falls in Hospital.

Some patients will be bedbound for the first 24 hours or more after admission but not necessarily for their full stay. How should these patients be included/excluded in terms of mobility assessment?

Even if the patient genuinely couldn’t or shouldn’t leave their bed for the first 24 hours, you would still expect them to have a mobility assessment recording something like ‘hoist only’ or ‘must stay in bed’. Any assessment that a patient cannot or must not walk at all can be considered evidence a walking aid is not required.

A patient who was left in bed for those first 24 hours just because no-one was available to assess whether they could be mobile would not meet the CQUIN criteria!
Do all patients over 65 with a LoS of over 48 hours need to have these assessments? We use a risk assessment tool to determine whether a patient is likely to be a faller. Can we just assess those who our criteria identify to be at risk of a fall?

No. NICE guidance specifies that all patients over 65 (and some aged 50 to 64 who meet certain criteria) should be assessed for falls risk using a multifactorial falls risk assessment (MFRA) and an intervention plan put in place. NICE also specifies that the MFRA includes a medication review, assessment of orthostatic hypotension as part of a cardiovascular assessment and mobility assessment. There are links to relevant resources. An assessment that identifies a patient as likely/unlikely to be a falls risk could indicate the trust is using a falls risk screening tool - which is not the same as an MFRA. NICE and the National Inpatient Falls Audit recommendations stress that screening tools need to be abandoned and replaced by MFRA for all patients. The reason for this is that screening tools are known to over or under-predict risk and only the clinical assessment of all patients can identify which the individuals who are at risk and why.
As well as excluding patients who die during their hospital stay, can we also exclude patients who are ‘entering end of life’?

Your audit sampling frame should be constructed to automatically exclude any patient who dies while an inpatient. This will exclude patients who were so gravely ill that intervention for falls management would likely be inappropriate/unnecessary throughout their stay.

Patients who are approaching end of life (but do not die in your care) often present very challenging fall (and fracture) risks which need to be managed, and the CQUIN data collection should not exclude those patients.

Are community providers suitable for this CQUIN? Can we adapt them locally for non-inpatient providers?

The Preventing Hospital Falls CQUIN is intended for inpatient units only, so in this context a community hospital with beds that people over the age of 65 are admitted/transferred to is included.

A CQUIN for older people in care homes or their own homes would have different content based on a different section of NICE guidance, so we would advise against any local adaptation of this CQUIN for that purpose.
I hope you have found this helpful.

If you have further clinical questions, please email patientsafety.enquiries@nhs.net

Or for CQUIN enquiries e.cquin@nhs.net