National Audit for Falls and Bone Health in Older People 2010 Clinical Audit

Group 2 Data Collection Form
(Hip fragility fracture patients)

The web tool will be open for data entry on 12 August 2010

Data is to be collected and then entered onto the web tool by Monday 20th December 2010
Between 20th and 30th December 2010 we ask you to export your data and check it for accuracy.
There will not be an opportunity to change information after 12 midday on Thursday 30th December because the web tool will be locked and all data will be with the statistician for analysis.
If, as you collect the information you find there is a need to explain your answers further, write a comment beside the question so that you can transfer this to the web tool comment box at a later date. Any questions contact: fbhop@rcplondon.ac.uk

Use the help notes to ensure your answers are consistent

DEMOGRAPHICS AND CASE MIX

Is this a data validation check? O Yes O No

Enter your number for this patient here

Patient audit number (web tool)
(Assigned by web tool on data inputting) **(Add number here when entering data on web tool)**

Auditor
(please select all that apply)

- ☐ Doctor
- ☐ Nurse
- ☐ Therapist
- ☐ Pharmacist
- ☐ Clinical Audit
- ☐ Other (please specify)

Age ☐☐☐

Sex ☐ Female ☐ Male

Usual place of residence

- ☐ Private residence
- ☐ Warden assisted
- ☐ Residential care home
- ☐ Care home (with nursing)
- ☐ Other (please specify)

Does this patient live alone?
O Yes O No

Has the patient fractured as the result of a fall (exclude high-trauma injuries)? O Yes O No

Date of the fall
☐☐/☐☐/☐☐☐☐ (DD/MM/YYYY)

(Only include patients that fall & fracture a maximum of 5 days prior to presentation date)

Injury incurred – what was fractured?

- ☐ Hip (intracapsular)
- ☐ Hip (extracapsular to include intertrochanteric & subtrochanteric)
- ☐ Hip (other)

1.1 PRESENTATION

1.1.1 Place of presentation
(Where patient attended NHS services for assessment / treatment)

☐ A&E
☐ MIU
☐ Other (give details)

1.1.2 Registration date (DD/MM/YYYY)
(Week-day will be automatically displayed on the web tool)

DD/MM/YYYY
☐☐/☐☐/☐☐☐☐

Registration time (24 hour clock)

HH:MM
☐☐:☐☐ hours

1.1.3 Date of discharge / admission / transfer from place of presentation?
(Date of discharge / transfer from A&E / MIU etc)

DD/MM/YYYY
☐☐/☐☐/☐☐☐☐

Time of discharge / admission to a ward/ transfer from another department from place of presentation? (if not documented, use time of first notes entry *following* transfer)

HH:MM
☐☐:☐☐ hours

1.1.4 Was the patient admitted to an acute unit?
(If **yes**, go to 1.1.4.1. If you have answered **No** go to 1.1.6)
If **yes,** you will not be able to answer 1.1.7

O Yes O No

1.1.4.1 In the first week of admission (or acute peri operative period) on what ward did the patient spend the majority of their time?

☐ Orthopaedic ward
☐ Orthogeriatric ward
☐ Dedicated hip fracture ward
☐ General geriatric ward in acute trust
☐ Other acute hospital ward (give details)
☐ Community hospital – Geriatrician input
☐ Community hospital - other
☐ Other (give details)

1.1.4.2 Was transfer for rehabilitation in an NHS setting required?
(If **yes**, go to 1.1.4.3. If you have answered **No** go to 1.1.5)

O Yes O No

1.1.4.3 In what type of NHS setting was rehabilitation performed for the patient?

☐ Orthogeriatric ward
☐ Dedicated hip fracture ward
☐ General geriatric ward in acute trust
☐ Other acute hospital ward (give details)
☐ Community hospital – Geriatrician input
☐ Community hospital - other
☐ Other (give details)

1.1.4.4 Date patient moved to rehabilitation setting

DD/MM/YYYY
☐☐/☐☐/☐☐☐☐

1.1.4.5 On what ward/unit did the patient spend the majority of time between acute admission and discharge from NHS care?

- ☐ Orthopaedic ward
- ☐ Orthogeriatric ward
- ☐ Dedicated hip fracture ward
- ☐ General geriatric ward in acute trust
- ☐ Other acute hospital ward
- ☐ Community hospital – Geriatrician input
- ☐ Community hospital - other
- ☐ Other (give details)

1.1.5 Date of discharge from inpatient NHS care? (i.e. the date of return to usual residence or new **permanent** residence)

DD/MM/YYYY
☐☐/☐☐/☐☐☐☐

1.1.5.1 What was the discharge destination from this complete episode?

- ☐ Usual residence
- ☐ Other private address
- ☐ Warden assisted (new)
- ☐ Residential care home (new)
- ☐ Nursing home (new)
- ☐ Other (give details)

1.1.6 Did the patient have rehabilitation or support at home from a specialist early supported discharge team? O Yes O No

1.1.7 **If not admitted to acute hospital,** where was the patient discharged to following assessment at ED/MIU?
(If you have answered **Yes** to 1.1.4 you cannot answer this question)

- ☐ Usual residence
- ☐ Other private address
- ☐ Intermediate care bed
- ☐ Residential care home (new)
- ☐ Nursing home (new)
- ☐ Other (give details)

1.1.8 Did the patient have any *unplanned* readmissions within 28 days of discharge from the presenting episode? O Yes O No

1.2. Initial and pre-operative management of hip fracture patient

1.2.11 Was there documented assessment of pain severity (e.g. pain score) within the place of first presentation?

1.2.12 Was adequate analgesia administered within 60 minutes of hospital attendance, or prior to attendance by ambulance personnel? O Yes O No
(If **yes** then answer 1.2.2. If **no** go to 1.2.3)

1.2.2 Date analgesia **first** administered? DD/MM/YYYY ☐☐/☐☐/☐☐☐☐

Time analgesia **first** administered? HH:MM ☐☐:☐☐ hours

1.2.3 Was pressure ulcer risk assessment carried out and appropriate equipment documented as used within 4 hours, or documented as assessed and not required?
☐ Yes
☐ No
☐ Not required

1.2.4 Were IV fluids both prescribed and administered within 12 hours of presentation, or documented as assessed and not required?
☐ Yes
☐ No
☐ Not required

Are the following documented within the patient's initial and / or pre-operative clinical records:

1.2.5 Details of co-morbidities with specific mention of the presence or absence of both cardiac and respiratory disease? O Yes O No

1.2.6 History of cognitive impairment / dementia prior to the fracture? O Yes O No

1.2.7 Assessment of cognitive function using a standardised scale? (Note that the AMT4 is insufficient in this setting). O Yes O No

If **yes** go to 1.2.7i. If **no** go to 1.2.8

1.2.7i Whether the results were normal or abnormal?
☐ Normal
☐ Abnormal

1.2.8 List of current medications including doses and frequencies? O Yes O No

1.2.9 A record of the presence or absence of cardiac murmurs? O Yes O No

1.2.10 Full blood count and renal function test results? O Yes O No

1.2.11 Oxygen saturation on room air? O Yes O No

1.2.12 Administration of some form of medical thromboprophylaxis within 24 hours of admission? O Yes O No
(If **yes** go to 1.2.14. If **no** go to 1.2.13)

1.2.13 Does the clinical record show documentation of a clinical decision NOT to prescribe thromboprophylaxis? O Yes O No

1.2.14 Was the patient seen within 72 hours of admission for specialist medical assessment by a geriatrician? O Yes O No

1.2.15 Has an integrated hip fracture care pathway been used (that has been agreed by geriatrician, orthopaedic surgeon and anaesthetist)? O Yes O No

2.1 OPERATIVE PHASE

2.1.1 Was the patient operated on?
(If you answered **Yes** go to 2.1.1.1. If you have answered **No** you need to go to 2.2. You cannot answer 2.2.6 - 2.2.7.) O Yes O No

2.1.1.1 Surgery date?
(Day of surgery is automatically calculated)
(If **not operated on**, then go to section 2.2)
DD/MM/YYYY
☐☐/☐☐/☐☐☐☐

Surgery time?
(Time from registration to surgery is automatically calculated on the web tool) (If time to surgery ≤ 36 hours skip 2.1.4 - 2.1.5)
HH:MM
☐☐:☐☐ hours

2.1.2 Was pressure-relieving equipment documented as being used in theatre, or assessed and not required?
☐ Yes
☐ No
☐ Not required

2.1.3 Was cement used as part of the operative process? O Yes O No
(If **Yes** go to 2.1.3.1. If **No** go to 2.1.4)

2.1.3.1 Was it clearly documented in the operative notes that canal irrigation was performed prior to broaching the canal and that this was introduced using a cement gun, or equivalent? O Yes O No

2.1.4 Do the clinical notes indicate a reason or reasons for surgery being delayed > 36 hours from presentation? Skip this question if time to surgery ≤ 36 hours. (If **Yes** to 2.1.4 go to 2.1.5, If **No** go to 2.1.6) O Yes O No

2.1.5 What was the main or the only reason indicated?

(Tick one option only)
Skip this question if time to surgery ≤ 36 hours.

☐ Awaiting orthopaedic diagnosis or investigation (including X-ray)
☐ Medically unfit requiring stabilisation preoperatively
☐ Awaiting medical review
☐ Awaiting medical investigation
☐ Organisational or capacity issues
☐ Other (give details)

2.1.6 What was the grade of the most senior Surgeon present?
☐ Consultant
☐ Non-consultant career grade
☐ ST3+ speciality trainee
☐ Other

2.1.7 What was the grade of the most senior Anaesthetist present?
☐ Consultant
☐ Non-consultant career grade
☐ ST3+ speciality trainee
☐ Other

2.2 POST OPERATIVE PHASE

Do the clinical notes made pre-surgery or within 48 hours post surgery include the following documentation:

2.2.1	Pre-admission functional ability (minimum of wash, dress, meals)?	O Yes	O No
2.2.2	Pre-admission mobility including use of walking aids?	O Yes	O No
2.2.3	Pre-admission social support?	O Yes	O No
2.2.4	Do the clinical notes (including care pathway *documentation*) indicate that a multidisciplinary team (medical, nursing and AHP) has discussed this patient within 7 days of admission?	O Yes	O No
2.2.5	Was a formal assessment of cognitive function, including where indicated a delirium screen (e.g. CAM), performed within 72 hours of surgery (or admission if not operated)?	O Yes	O No

If not operated on: do not answer 2.2.6 or 2.2.7.

2.2.6	Was an attempt made within 24 hours of surgery to mobilise the patient? (As a minimum, documentation should reflect attempts to stand up, transfer and walk a few steps) (If **yes** go to 2.2.7. If **No** go to 2.2.6.1)	O Yes	O No
2.2.6.1	Was sitting out of bed documented as being delayed for medical reasons *other than delay in post-operative X-ray*?	O Yes	O No
2.2.7	Was the patient seen within 24 hours of surgery by a physiotherapist or trained worker?	O Yes	O No
2.2.8	Was patient seen within 72 hours of surgery (or admission if not operated) by an occupational therapist or supervised OT technical assistant?	O Yes	O No
2.2.9	Was there regular (at least twice-weekly) documented input from a geriatrician (consultant, NCCG or supervised trainee of ST3 level or above) during the acute care spell?	O Yes	O No
2.2.10	Is it documented that patient and /or carer views were used in discharge planning?	O Yes	O No
2.2.11	Has the patient's data been entered into the National Hip Fracture Database (NHFD)?	O Yes	O No

SECONDARY PREVENTION can be completed at various stages after the fall and fracture

3.1 MULTI-FACTORIAL FALLS RISK ASSESSMENT

Not all components of a multi factorial risk assessment are relevant for all patients. Components may be performed at various stages after the fall has occurred and not all simultaneously.

The data to be collected here should be derived from assessments that are carried out by the local falls service team or by staff adhering to processes within a locally developed falls pathway.

3.1 FALLS

3.1.0	Was a multi-factorial risk assessment performed?	O Yes	O No
3.1.1	Did the falls assessment include a history of falls in the past year?	O Yes	O No
3.1.2	Did the falls assessment include the context of the *presenting* fall (place and activity)?	O Yes	O No
3.1.3	Was there documented evidence of the consideration of the cause of the index fall (aetiology) *including* transient loss of consciousness?	O Yes	O No
3.1.4	Did the assessment document the presence or absence of any previous syncope, blackout, or unexplained fall(s)?	O Yes	O No
3.1.5	Does the clinical record include a standardised assessment of cognitive function *(not including pre-op for hip fracture, unless this was normal)*?	O Yes	O No

You cannot answer this question if the answer to 1.2.7i was **Normal**.

3.2 MEDICATION

Medication review

3.2.1	Does the clinical record include any features of a medication assessment at the time of the fall?	O Yes	O No
3.2.2	Was the patient on any psychotropic (see help notes) medication at the time of the fall?	O Yes	O No
3.2.3	Was the patient was on night sedation (see help notes) medication at the time of the fall?	O Yes	O No

Medication intervention

3.2.4	By 12 weeks after the fall was there *evidence* of a medication review? (Can be in hospital, at home, in clinic etc.)	O Yes	O No
3.2.5	By 12 weeks after the fall was the patient on any psychotropic (see help notes 3.2.2) medication?	O Yes	O No
3.2.6	By 12 weeks after the fall was the patient on any night sedation (see help notes 3.2.3) medication?	O Yes	O No

3.3 CARDIOVASCULAR

Did the patient's cardiovascular assessment include:

3.3.1	Documentation of presence or absence or heart murmurs?	O Yes	O No
3.3.2	Performance of an ECG? (If you have answered **Yes** go to 3.3.3. If you have answered **No** go to 3.3.4.)	O Yes	O No
3.3.3	Documentation that the ECG was analysed?	O Yes	O No
3.3.4	Documented lying and standing blood pressure readings? (Exception – if patient is unable to stand)	☐ Yes ☐ No ☐ Unable to stand	

3.3 CARDIOVASCULAR (continued)
Did the patient's cardiovascular assessment include:

3.3.5 Did cardiac assessment reveal an abnormality requiring further investigation or onward referral? (Also answer No if no assessment done) O Yes O No
(If **Yes** go to 3.3.6, If **No** go to 3.4)

3.3.6 Is there evidence of referral to/for further investigation or assessment for cardiac disease? O Yes O No

3.4 VISION

3.4.1 Did the patient have any assessment for visual impairment? ☐ Yes ☐ No ☐ Registered blind
(Assessing reading only is insufficient, as near sight is not relevant to falls risk)

3.5 CONTINENCE

3.5.1 Did the patient have any assessment of urinary function, including continence status? O Yes O No
(If you have answered **Yes** go to 3.5.2. If **No** go to 3.6.)

3.5.2 Was there any impairment of urinary function or continence? O Yes O No
(If you have answered **Yes** go to 3.5.3. If **No** go to 3.6.)

3.5.3 Was referral made for continence problems from the assessment, or is there clear documentation that referral was not required? ☐ Yes ☐ No ☐ Not required

3.6 ASSESSMENT OF MOBILITY AND FUNCTION

3.6.1 Do the clinical records indicate that a gait, balance and mobility assessment was performed within 12 weeks of the fall? ☐ Yes ☐ No ☐ Immobile ☐ Declined
(If you have answered **Yes** go to 3.6.2. If you have answered **No**, **Immobile** or **Declined** go to 3.6.5.)

Does the clinical record of <u>this</u> assessment include:

3.6.2 Result of a gait, balance and mobility assessment, using a standardised tool (or a decision that further assessment is inappropriate, e.g. severely limited mobility)? O Yes O No

3.6.3 Statement of person's perceived functional ability? O Yes O No

3.6.4 Record of fear of falling during activities of daily living using recognised assessment tool? O Yes O No

Strength and Balance Training interventions

3.6.5 Has the patient participated in any form of exercise programme? ☐ Yes ☐ No ☐ Not relevant ☐ Declined
(If you have answered **Yes** go to 3.6.6. If you have answered **No**, **Not relevan**t or **Declined** go to 3.7.)

3.6.6 Was this an Otago or FaME programme > 12 weeks duration? (Modification or shorter duration is only acceptable if this is clearly documented as being on clinical grounds, including frailty, not if a modified programme is offered as standard). ☐ Yes ☐ No ☐ Modified

3.6.7 Has the strength and balance programme been **prescribed** by an appropriately trained professional? O Yes O No

3.6.8 Has the strength and balance programme been **monitored** by an appropriately trained professional competent to modify and progress the exercise programme? O Yes O No

3.7 SAFETY AT HOME

Skip 3.7 if usual place of residence is a residential or nursing home

3.7.1 Was the patient's home assessed by an Occupational Therapist for home/environmental hazards?
(If **yes** answer got to 3.7.2. If **no, not relevant or declined** go to 3.7.4)

- ☐ Yes
- ☐ No
- ☐ Declined
- ☐ Did not return home

3.7.2 Was an access or home visit/assessment performed in the patient's own environment?
(If you have answered **Yes** go to 3.7.3. If you have answered **No** or **Declined** go to 3.7.4.)

- ☐ Yes
- ☐ No
- ☐ Declined

3.7.3 What home hazard assessment was performed in the patient's own environment?

- ☐ Westmead
- ☐ Home fast
- ☐ Safety Assessment of function for rehabilitation (SAFER)
- ☐ Locally validated tool (provide supporting evidence of validation)
- ☐ Unvalidated tool or no tool

Home hazard interventions

3.7.4 Were appropriate home hazard interventions offered?

- ☐ Yes
- ☐ No
- ☐ Not relevant
- ☐ Declined

3.7.5 Was the patient recommended any form of telecare (such as a pendant alarm) to assist in the management of their falls risk?

- ☐ Yes
- ☐ No
- ☐ Not relevant
- ☐ Declined

3.8 SOCIAL CARE

3.8.1 Was the patient assessed for their need of social care support?
(If **yes** answer 3.8.2. If **no, not relevant or declined** go to 3.9)

- ☐ Yes
- ☐ No
- ☐ Not relevant
- ☐ Declined

3.8.2 Was referral for Social services input offered?

- ☐ Yes
- ☐ No
- ☐ Not relevant/private care
- ☐ Declined

3.9 ORGANISATION OF CARE

3.9.1 Did the multi-factorial falls risk assessment involve a multidisciplinary falls clinic/service?

(If **yes** then answer 3.9.2. If **no or not appropriate**, go to 3.9.3)

- ☐ Yes
- ☐ No
- ☐ Not appropriate

3.9.2 Did the multi-factorial falls clinic/service include medical assessment supervised by a consultant or non-consultant career grade? O Yes O No

3.9.3 Did the multi-factorial falls risk assessment of this patient lead to an individualised intervention plan recorded in the clinical notes?

(If **yes,** complete 3.9.4. If **no or not relevant** go to section 4)

- ☐ Yes
- ☐ No
- ☐ Not relevant

3.9.4 Was the intervention plan shared with the patient in writing? O Yes O No

4.1. OSTEOPOROSIS SECONDARY PREVENTION

4.1.1 Was a clinical assessment of osteoporosis/fracture risk performed in line with NICE TA 161 or good practice for men? (Including decision to commence treatment in women aged 75, women 65-74 years and men aged 65 and over with osteoporosis.) O Yes O No

Previous DXA Scan

4.1.2 Does the patient have documented evidence of a previous fragility fracture? O Yes O No

4.1.3 Has the patient had a DXA scan in the 2 years prior to the presenting fracture? O Yes O No
(If you have answered **Yes** go to 4.1.4. If you have answered **No** go to 4.1.5.)

4.1.4 Did the patient's DXA scan show evidence of osteoporosis?
- ☐ Yes
- ☐ No
- ☐ No scan results available

New DXA Scan

4.1.5 Has the patient been referred for a DXA scan following the **presenting fracture?** Or was a clinical decision documented to commence treatment without DXA in female patient aged 75 and over? Or had a DXA been performed previously?
(If you have answered **Yes** go to 4.1.6. If you have answered **No, Clinical decision or previous DXA** go to 4.2.)
- ☐ Yes
- ☐ No
- ☐ Clinical decision
- ☐ Previous DXA

4.1.6 Was the DXA scan performed within 6 weeks of the index fracture? O Yes O No

4.1.7 Did the patient's DXA scan following the **presenting fracture** show evidence of osteoporosis? O Yes O No

4.2 OSTEOPOROSIS INTERVENTIONS

Prior prescription of Calcium, Vitamin D, Bisphosphonates or other osteoporosis medications

4.2.1 Was the patient prescribed Calcium (1 g per day) prior to the fracture? O Yes O No

4.2.2 Was the patient prescribed Vitamin D3 (800 iU per day) prior to the fracture? O Yes O No

4.2.3 Was the patient prescribed a bisphosphonate or other appropriate medication prior to the fracture? (Other licensed and recommended medications are Strontium, Parathyroid hormone analogues, Raloxifene) O Yes O No

Post-fracture prescription of Calcium, Vitamin D, Bisphosphonate or other osteoporosis medications

4.2.4 At 12 weeks post fracture, was the patient prescribed Calcium (1 g per day or equivalent)?
- ☐ Yes
- ☐ No
- ☐ Contraindicated

4.2.5 At 12 weeks post fracture, was the patient prescribed Vitamin D (800 iU per day or equivalent)?
- ☐ Yes
- ☐ No
- ☐ Contraindicated

4.2.6 At 12 weeks post fracture, was the patient prescribed a bisphosphonate?
If you have answered **Yes** go to 5.1. If you have answered **No** go to 4.2.7.
- ☐ Yes
- ☐ No
- ☐ Contraindicated

4.2.7 At 12 weeks post fracture, was the patient prescribed other appropriate therapy for osteoporosis (strontium, parathyroid hormone (PTH), or raloxifene or denosumab)?
- ☐ Yes
- ☐ No
- ☐ Contraindicated

5 INFORMATION PROVISION

5.1	Is it documented within the medical, nursing or therapy notes that oral falls prevention information has been given to the patient or their carer?	O Yes	O No
5.2	Is it documented within the medical, nursing or therapy notes that written falls prevention information has been given to the patient or their carer? (If **Yes**, go to 5.3, If **No** go to 5.4)	O Yes	O No
5.3	Has the written falls information been provided in the patients own (or preferred) language?	O Yes	O No
5.4	Is it documented within the medical, nursing or therapy notes that oral information with regard to bone health has been given to the patient or their carer?	O Yes	O No
5.5	Is it documented within the medical, nursing or therapy notes that written bone health information has been given to the patient or their carer? (If **Yes**, go to 5.6, If **No** go to end)	O Yes	O No
5.6	Has the written information on bone health been provided in the patients own (or preferred) language?	O Yes	O No