



Royal College
of Physicians

National Audit of
Inpatient Falls (NAIF)

Beyond hip fracture:

reporting on the expansion to include other injuries for the first time

The 2026 National Audit of Inpatient Falls (NAIF)
report on 2025 clinical data and facilities audit

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Report at a glance

This is the first NAIF report to use the new case ascertainment method and include inpatient fall-related injuries beyond hip fractures, which can affect patients' recovery and confidence.

As changes in case ascertainment and case mix limit direct comparisons with previous years, the key clinical findings from 2025 are:

33% of cases had a high-quality multifactorial assessment to optimise safe activity (MASA) (KPI 1) during admission, before the injurious fall.



Delirium screening continues to decline, similar to the pattern we have noted over the prior 4 years.



Recording of actual measures related to MASA (such as blood pressure and 4AT scores) is still very low.



Significant improvements are still needed in post-fall management, particularly in effective checks for injuries (KPI 2) and medical examination (KPI 4). Preliminary data suggest patients with pelvic ring, vertebral and rib fractures receive poorer care than those with other injuries.

This mirrors findings from the NHFD and FLS-DB.

NEW KPI

Managing pain after an injurious inpatient fall is essential, to minimise distress for patients and to optimise outcomes. In this report, we introduce KPI 5 – this measures whether a patient has been **given analgesia within 30 minutes of the fall**.



In 2025, this was achieved in **39%** of cases.



We also present the first facilities audit since 2022, measuring leadership, policy, process and governance. Most questions are NAIF-recommended practices, and results are broken down by setting to show variation.

Recommendations call on integrated care boards (ICBs) and Welsh HBs to:

1. strengthen oversight of participation and case ascertainment
2. standardise post-fall processes and workforce competency
3. ensure effective falls governance.



NAIF has identified four areas for healthcare improvement, referred to as 'spotlights'. Based on report findings, these highlight where trusts and HBs can focus improvement activity to support better patient care.

The full FFFAP glossary is [available here](#).

Introduction

The National Audit of Inpatient Falls (NAIF) is part of the [Falls and Fragility Fracture Audit Programme](#) (FFFAP) (alongside the [National Hip Fracture Database](#) (NHFD) and the [Fracture Liaison Service Database](#) (FLS-DB)) commissioned by the [Healthcare Quality Improvement Partnership](#) (HQIP), funded by NHS England and the Government of Wales as part of the [National Clinical Audit and Patient Outcomes Programme](#) (NCAPOP).

Between 2019 and 2024, patients were identified from the NHFD and eligible for NAIF if they had sustained a femoral fracture as a result of an inpatient fall. From January 2025, NAIF moved to direct data entry¹ and included patients who met the following criteria:



This is the first NAIF report from the expanded audit. This report presents patient cases² where a fall with an [eligible injury](#) occurred between January and December 2025. All injuries resulting from each inpatient fall were recorded, meaning that some cases are associated with two or more injuries. Trusts in England and health boards (HBs) in Wales were also asked to complete the facilities audit.

Clinical audit methods

Data were collected from health records of eligible patients to evaluate actions to enable patients to move safely taken prior to the injurious inpatient fall, as well as the immediate post-fall management.

¹ Records are created manually instead of being generated automatically from records entered in NHFD.

Facilities audit methods

All trusts and HBs were invited to complete a facilities audit between January and March 2026. This consists of 15 questions about leadership, policy, process and governance in the organisation. The facilities audit is available for organisations to complete at any time, to suit the needs of organisational service evaluation and development of business cases.

About the patients

Demographic information

The country, age, sex and socioeconomic background of patients are shown in Table 1. The [Index of Multiple Deprivation](#) (IMD) can be used to examine the health of people living in the most deprived (IMD 1) through to the more affluent (IMD 5) geographical areas. There were more cases in those aged over 75, but no difference by sex or IMD quintiles. The average age at the time of the fall was 82.

		N	%
Country	England	3,909	93
	Wales	247	6
Sex	Female	2,195	52
	Male	1,996	48
Index of Multiple Deprivation (IMD) quintile	1 Most deprived	753	18
	2	820	20
	3	853	20
	4	897	21
	5 Least deprived	833	20
Age	Years		
	65–74	744	18
	75–84	1,729	41
	85 and over	1,718	41

Table 1. Age, sex and socioeconomic background data for NAIF cases

² Fall-related injuries are referred to as cases, as data are collected based on each inpatient fall that results in an eligible injury. An individual patient could be a 'case' more than once within the year.

Number and type of injuries sustained

In 2025, 4,191 eligible inpatient fall cases were reported by 169 trusts and 7 HBs. About 6% of falls resulted in more than one injury. The most common single injury type was hip fracture (35%) followed by head injury (22%) (see Table 2).

Injury type*	Cases	%
Hip fracture	1,481	35
Head injury	916	22
Pelvic ring fracture	225	5
Distal forearm fracture	209	5
Humeral fracture	199	5
Rib fracture	142	3
Vertebral fracture	91	2
Spinal injury	81	2
Other fracture	612	15
* Where single injury was reported		
Two or more injuries	235	6

Table 2. Injury types reported.

How effective was case ascertainment?

As this is the first year NAIF collected data through direct entry, effectiveness of this process is untested. Secondly, with the expansion to include other injury types, the exact denominator for all eligible cases in trusts and HBs is unknown. To evaluate case ascertainment, the following methods were used:

1. Comparing numbers of participating trusts / HBs and inpatient hip fractures recorded in 2025 with the same data collected in 2024.
2. Comparing inpatient hip fracture data from the 2025 NHFD with hip fractures recorded in NAIF in 2025.
3. Ascertaining whether the [1:5 rule](#) (as used by FLS-DB) to calculate how many other fragility fractures would be expected per hip fracture, is applicable to the new NAIF dataset.

Some patients had more than one inpatient fall resulting in an eligible injury during 2025, with 86 patients having two, and three patients having three, eligible fall episodes. Each of these is counted as a case.

Reviewing the specific injury types recorded among cases with two or more injuries revealed a total of 1,578 hip fractures, 1,033 head injuries and 103 spinal injuries. See [this link](#) for the definitions of eligible injuries.

A detailed report covering these aspects of case ascertainment that contributes to the conclusions below can be [found here](#).

Using a new case ascertainment method, we estimate that this report includes just under 90% of expected fall-related inpatient hip fractures, based on comparisons with both 2024 NAIF data and 2025 NHFD data.

In contrast, the number of other injuries identified was lower than expected relative to hip fracture numbers. This suggests the new case ascertainment method is working well for identifying eligible hip fracture cases but may not yet be capturing all other fractures and eligible injuries.

The true number of fall-related injuries eligible for NAIF remains uncertain. Further data collection will be needed to establish a more reliable baseline for non-hip fracture injuries.

Our new outlier process will support ongoing efforts to improve case ascertainment and ensure more complete reporting.

Data completeness

Data completeness for the 2025 audit can be found [here](#). Less than 1% of data were missing for each question, except for actual lying/standing blood pressure and 4AT scores (see Tables 3a and 3b), and the questions on immobilisation.

Clinical audit findings

The injurious fall occurred a median of 7.5 days (interquartile range 2–25) after admission, with 13% having fallen once and 7% having fallen twice or more prior to this fall during the same admission.

Most cases came from acute trusts (73%), with 19% from integrated trusts (including Welsh HBs which are classified as integrated trusts), 4% from community and 4% from mental health trusts. Around one-third of all falls happened on medical wards (n=1,394), more than on frailty/older persons wards (n=980). For more information on ward types where falls occurred, see [this link](#).

Multifactorial assessment to optimise safe activity (MASA)

The MASA considers six actions to help patients stay active while in hospital, with the aim of reducing the risk of falls and preventing deconditioning. A full description of the comprehensive assessment recommended for all inpatients over the age of 65 is provided in our [guidance](#) based on [NICE guideline NG249](#).

Key Performance Indicator (KPI) 1: High-quality MASA

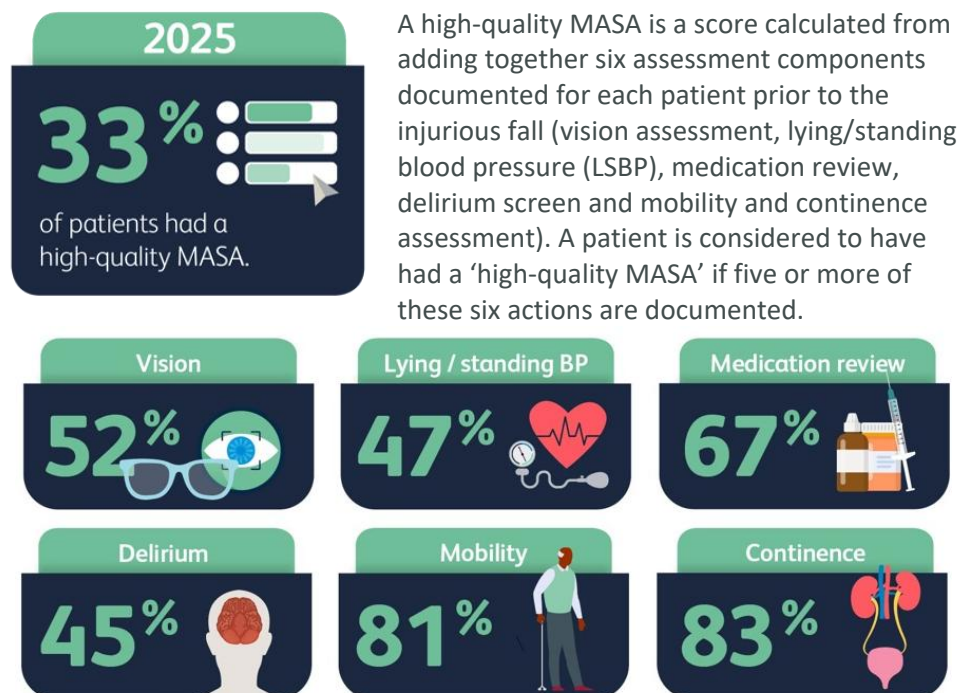


Fig 2. Proportion of each MASA component documented in 2025

As audit methods and case ascertainment have changed, comparison with previous years is limited. However, delirium screening notably continues to decline, following the pattern seen over the past 4 years.

Following feedback on difficulties completing MASA in emergency departments (EDs), we analysed KPI 1 performance in ED settings only. Of the 6% of cases (n=257) that occurred in EDs, 3% (n=8) had a high-quality MASA before the fall.

Clinical assessment in detail

As in previous years, the audit requested actual LSBP and 4AT data. There is little change in the proportion of cases where these data are provided (see Tables 3a and 3b) and in prevalence of orthostatic hypotension and delirium (Table 3c) compared with [2024](#). Trusts and HBs should ensure that the data for the MASA are easily visible to clinicians and staff submitting audit data.

Lying and standing blood pressure (LSBP)	
Question: Did the patient have a documented lying/standing blood pressure measurement during the admission, but before the fall that caused the injury(ies)? (Y/N)	
LSBP not possible	13%
LSBP recorded (where not impossible)	48%
Percentage of cases with actual BP and heart rate measures entered onto the webtool	
Measure recorded for 5 min supine	20%
Measure recorded for 1 min standing	12%
Measure recorded for 3 min standing	8%
Median time from LSBP to fall	4 days

Table 3a. Lying/standing blood pressure – exploration

Delirium assessment	
Question: Was the patient screened for delirium using 4AT during the admission, but before the fall that caused the injury(ies)? (Y/N)	
Delirium assessment recorded	45%
Percentage of cases with actual date, time and 4AT score entered onto the webtool	
Date and time of 4AT recorded	28%
Median time from 4AT to fall	4 days

Table 3b. Delirium screening – exploration

Prevalence (where measured)	
Orthostatic hypotension at 1 min standing	24%
Orthostatic hypotension at 3 min standing	20%
Median 4AT score	2
4AT score of 4 or more (indicating delirium)	38%

Table 3c. Prevalence of orthostatic hypotension and delirium

Post-fall management

Actions taken after a fall have the potential to influence outcomes and patient experience. If a post-fall check indicates an injury, this should influence selection of moving and handling techniques, access to pain relief and the medical examination. It is important that the method used to move a patient from the floor takes account of any suspected injuries. This reduces the risk of worsening the injury and minimises pain and distress. Prompt medical examination is necessary to ensure that further investigations and management of injuries are expedited. KPIs 2, 3 and 4 relate to [NICE quality standard 86](#), statements 4, 5 and 6.

KPI 2: Check for injury before moving and injury suspected

As all patient cases analysed had an injury, this figure should be 100%.

The check took place 5 minutes (1-10 mins) after the fall. There appear to be some differences in KPI 2 depending on the injury sustained, with this KPI being achieved more frequently after hip fracture, spinal injury and two or more injuries compared with pelvic ring and rib fracture (see Fig 3).

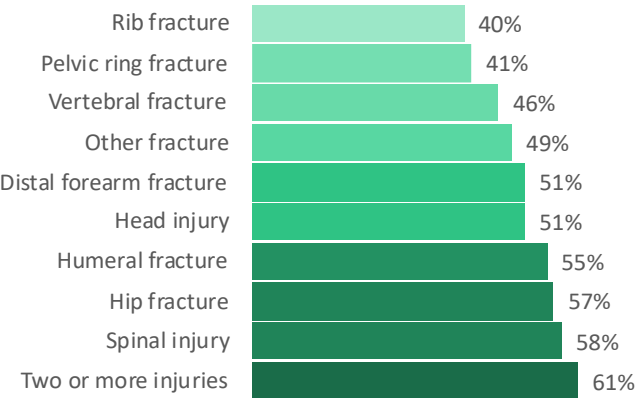


Fig 3. Check for injury before moving and injury suspected – performance by injury type



This finding is based on small numbers but aligns with [preliminary findings](#) from NHFD and FLS-DB suggesting poorer management of older people with pelvic ring fracture.

KPI 3: Safe lifting equipment used to move the patient from the floor

A range of safe lifting methods were recorded, with assistance from staff being the most common (see Fig 4).

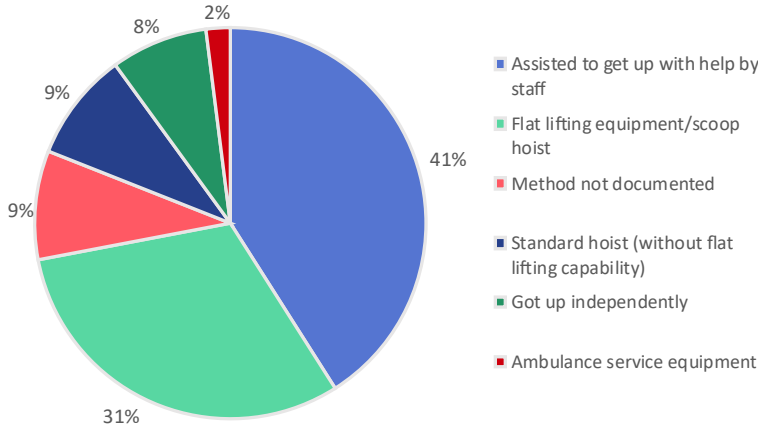
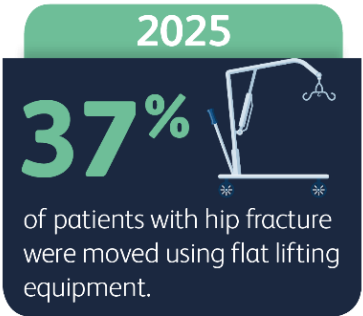


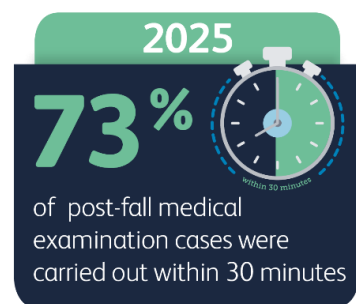
Fig 4. Method for moving from the floor



NAIF’s expansion to other injuries means that it is no longer appropriate for us to recommend that all patients are moved using flat lifting equipment. While flat lifting is recommended for people with hip fractures, it may not always be indicated for other injuries. Therefore, KPI 3 continues to analyse the proportion of patients *with hip fracture* who are moved using flat lifting equipment.

In 2026, we plan to present data on appropriate methods for moving patients with spinal injury.

KPI 4: Medical examination within 30 minutes of the fall that caused the injury



Last year, KPI 4 changed in accordance with the revised [NICE quality standard 86](#) to reflect that it is no longer stipulated that this assessment is carried out by a doctor. For 2025, the KPI now reflects the proportion of cases where the patient had an examination conducted by any healthcare professional (HCP) within 30 minutes of the fall.

[NICE standards](#) implicitly expect that an HCP carrying out a post-fall examination will be [competent](#). However, we found that in 15% of cases, an injury was not suspected after this examination. Since all NAIF cases have an injury, this indicates that some post-fall examinations may be ineffective.

When analysing by injury type, there was an 11-percentage point difference in KPI 4 achievement between the injury type with the lowest (rib fracture) and the highest (humeral fracture and head injury) – see Fig 5.

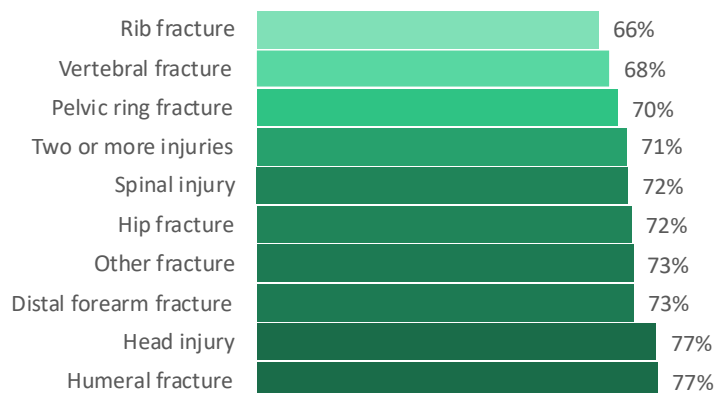


Fig 5. Medical examination within 30 minutes – performance by injury type

As with KPI 2, KPI 4 performance was also poorer for patients with vertebral and pelvic ring fractures.

KPI 5: Analgesia administered within 30 minutes of the fall



NAIF has reported on post-fall analgesia administration for several years. In this report, we are introducing this as a fifth KPI. Inadequate pain control after a fall-related injury can cause significant distress and contributes to poorer outcomes for patients. KPI 5 indicates the proportion of patient cases who were given analgesia within 30 minutes of the fall.

In 2025, 60% of patients were prescribed analgesia, which was administered a median of 50 minutes after the fall. Thirty-nine per cent received analgesia within 30 minutes.

Other findings

New in 2025: neurological observations and immobilisation

As NAIF expanded to collect information about the management of fall-related head and spinal injuries, additional questions about neurological observations and immobilisation were added. Neurological observations, as recommended in [NICE guideline NG232](#), should be undertaken when head injury as a result of a fall has occurred or is suspected.

For patients who have fallen and a spinal injury is suspected, immobilisation should be considered as per [NICE guidelines NG41](#).

Three-quarters of all cases had documented neurological observations. However, 10% of the patients who sustained head injuries had no record of this having been done. Immobilisation of the head and neck was rarely applied, with less than a quarter of patients with confirmed spinal injuries having a record of immobilisation being used (see Table 4).

Percentage of cases where neurological observations was applied	
All cases	74%
Cases with head injuries	90%
Percentage of cases where immobilisation was applied	
All cases	7%
Cases with spinal injuries	23%
Cases with head injuries	9%

Table 4. Neurological observations and immobilisation findings

Reporting of harm

Moderate harm was the most common attribution in the National Learning and Reporting System, equating to 57% of all cases (see this [link for data](#)). Further guidance on how NHS England recommends harm is reported can be found [here](#).

Delay to care

As it was difficult to find one definition of a delay to onward care that would apply to all settings and injuries, this question simply asked if the clinical team felt that there had been a delay in care. These were reported in 22% of cases, with evident variation depending on injury type (Fig 6). Patients with pelvic ring and multiple injuries were most likely to experience delay.

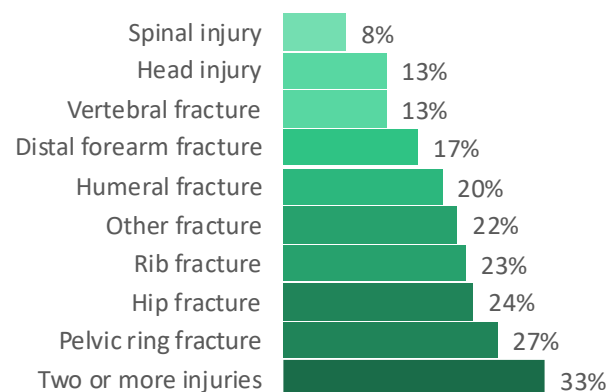


Fig 6. Delays to onward care – performance by injury type

Learning from inpatient falls

A hot debrief or SWARM huddle describes a process of reviewing the events surrounding the fall and is recommended to take place before the end of the same shift. An after-action review or structured debrief is a more in-depth multidisciplinary exploration of the fall, recommended to take place within 5 working days of the fall (see our [Patient Safety Incident Response Framework \(PSIRF\)](#) approach for more details). Hot debriefs were undertaken in nearly half of cases, while after-action reviews were more common, with two-thirds of cases explored in this way. Expanding the audit to different injuries has not significantly changed these proportions when compared to 2024 (table 5).

Hot debrief / SWARM huddle	
Any	64%
Within the same shift	34%
After action review / structured debrief	
Any	68%
Within 5 working days	27%

Table 5. Learning from falls

Spotlights for healthcare improvement



NAIF has identified four priority areas for healthcare improvement, referred to as 'Spotlights'. These are based on the report findings and highlight where trusts and health boards can focus improvement activity to support better patient care. Click the box to read more.

Facilities audit findings

All participating organisations were asked to complete a facilities audit before 31 March 2026, answering questions about leadership, policies, processes and governance. The proforma for the facilities audit can be [found here](#). All questions are NAIF-recommended practices (unless specified otherwise).

[One hundred and thirty-one English trusts and four Welsh HBs](#) submitted facilities data for this analysis.

Leadership on falls (Table 6)

In last year's report, we recommended leadership and service configurations for managing inpatient falls ([recommendation 1 from 2025 report](#)).

This facilities audit showed that most organisations have an executive director with responsibility for falls, but only around half have someone with the same responsibility within the non-executive directorship.

Leadership	All	Acute	Integrated	Community	Mental health	Welsh HB
Named NAIF clinical lead	97%	99%	100%	89%	94%	75%
Named executive director with responsibility for falls	86%	90%	72%	78%	94%	100%
Named non-executive director with responsibility for falls	58%	64%	44%	44%	47%	100%

Table 6. Leadership on falls

Organisational falls policies (Table 7) – key findings

> Risk assessment tools remain in use

Despite not being recommended in [NICE NG249](#), risk assessment tools remain in use, particularly in community trusts and Welsh HBs.

> Case ascertainment process and mandatory falls training

Only around half of organisations have systems in place to identify reporting gaps and deliver mandatory falls training.

> Rating of harm for hip fractures

One in four trusts and health boards do not classify all hip fractures as severe harm, despite recommendations from [NHS England](#) and NAIF ([recommendation 2 from 2025 report](#)) to adopt this practice.

> Patient Safety Incident Response Framework (PSIRF)

Most trusts have implemented a [falls-specific PSIRF](#).

Policies	All	Acute	Integrated	Community	Mental health	Welsh HB
Used risk tools to predict risk of falls (not recommended)	14%	10%	12%	44%	18%	25%
Have a system for reporting gaps between actual and reported falls	53%	60%	31%	44%	53%	100%
All falls resulting in hip fracture are reported as severe harm	75%	81%	65%	56%	71%	75%
Falls prevention training is mandatory for clinical staff	56%	58%	56%	44%	44%	75%
Policy to ensure patients have access to walking aids 7 days a week	69%	74%	72%	89%	38%	50%
A falls-specific PSIRF has been implemented	95%	100%	92%	89%	88%	N/A

Table 7. Organisational falls policies

Organisational processes (Table 8) – key findings

> Bedrail audits

Just over half of trusts and HBs have not undertaken a bedrail audit in the last year. It is important to ensure that bedrails are being applied safely and only in [specific circumstances](#). This was lowest among mental health trusts, partly because many do not use bedrails.

> Access to flat lifting equipment

Availability increased from 76% in 2022 to 82%, but challenges remain in mental health and community settings, where smaller sites and fewer falls can make provision and training harder to justify.

> Quality improvement (QI) activity is widespread

Almost all organisations (96%) report completing QI projects relating to falls in the previous year. Organisations are encouraged to share successful falls improvement projects through the [NAIF improvement repository](#).

Processes	All	Acute	Integrated	Community	Mental health	Welsh HB
Bedrail audit undertaken in the last 12 months*	61%	68%	52%	56%	36%	75%
<i>Bedrails not used in trust / HB</i>	3%	0%	4%	0%	18%	0%
Flat lifting equipment available on all sites	82%	96%	73%	56%	47%	75%
Information about falls for patients and families readily available	73%	81%	54%	89%	44%	100%
QI projects undertaken to address inpatient falls in the last 12 months	96%	97%	96%	89%	94%	100%

* Excluding organisations that do not use bedrail

Table 8. Organisational processes relating to falls

Governance (Table 9)

Most trusts and HBs report having falls steering group meetings, with the majority analysing falls data using falls rates per 1,000 occupied bed days.

Governance	All	Acute	Integrated	Community	Mental health	Welsh HB
Multidisciplinary working group that meets four times a year in which:	90%	92%	84%	100%	82%	100%
> falls incidence presented and discussed	98%	100%	95%	100%	93%	100%
> falls rates expressed as occupied bed days	87%	90%	86%	89%	64%	100%
Falls rates presented to individual directorates/departments, wards and units	93%	97%	88%	89%	81%	100%

Table 9. Governance relating to inpatient falls

Recommendations

Recommendation 1

Relevant national policy:
[10 Year Health Plan](#) – digital

Integrated Care Boards (ICBs) and Welsh Health Boards (HBs) to strengthen oversight of participation and case ascertainment in NAIF.

The [NHS 10 Year Health Plan](#) recognises national clinical audits as key drivers of quality improvement. NAIF data are [publicly available](#) to support improvements in falls management, reduce avoidable harm and costs. The case ascertainment [analysis](#) identified areas where eligible cases may be missed, potentially due to non-participation or patient transfers between organisations.

ICBs and Welsh HBs should ensure that:

- a. all eligible trusts and HBs are registered with NAIF and have an appointed [clinical lead](#)
- b. all participating trusts and HBs review the effectiveness of case ascertainment
 - > For trusts and HBs participating in NHFD, compare this to NAIF data to identify discrepancies between hip fracture cases recorded in each audit
 - > All trusts and HBs should compare injurious falls reported in NAIF with those recorded in their National Learning and Reporting System.

Participation in NAIF is mandatory. All trusts and health boards with inpatient beds are eligible to participate. Non-participating organisations, and those returning fewer cases than expected, will be contacted to support improvement through NAIF's planned outlier process.

Recommendation 2

Relevant national policy:
[NICE Quality Standards 86](#)

ICBs and Welsh HBs to ensure standardised post-fall processes and workforce competency to support effective post-fall management.

Despite all cases involving injuries, 47% of patients assessed for injury (KPI 2) and 15% medically examined (KPI 4) had no injury suspected, indicating gaps in effective post-fall management.

Data also show variation in findings depending on injury type (Figs 3, 5 and 6), although more data and better ascertainment of other eligible injuries is needed to confirm this.

ICBs and Welsh HBs should ensure that all trusts and HBs have:

- a. robust post-fall processes in place
- b. a workforce that is adequately trained in all aspects of post-fall management.

Resources are available to support improvement in post-fall management:

- > [Supporting best and safe practice in inpatient settings](#)
- > [Post-fall medical examination for inpatient settings](#)

NAIF is developing online learning modules on post-fall management with NHS England's [Technology Enhanced Learning](#) (TEL). These will complement existing resources, address training gaps and are due to launch in Q1 2027.

Recommendation 3

Relevant national policy:
[10 Year Health Plan](#) – prevention

ICBs and Welsh HBs to ensure effective falls governance arrangements and local policies reviewed against NAIF-recommended practices.

It has been four years since we reported facility audit findings. [Findings](#) in this report highlight areas where further local action may be needed.

Regular reviewing of relevant policies and processes support safer inpatient care by strengthening falls prevention, post-fall management and governance, helping staff deliver safer care and reducing the risk of avoidable harm.

ICBs and Welsh HBs should ensure that all trusts and HBs:

- a. participate in the facilities audit
- b. review their local falls policies and processes using [resources available](#).

Specific areas for focus will depend on each organisation but may include:

- > stopping the use of risk prediction tools
- > implementing a process to identify gaps between actual and reported falls
- > undertaking regular bed rail audit (if bed rails are used in the organisation).

The facilities audit is continuously available on the [webtool](#) and recommendations for improvement are embedded in this tool to provide instant feedback. The proforma for the facilities audit can be [found here](#).

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