WELSH INFORMATION STANDARDS BOARD

DSC Notice:	DSCN 2021 / 11
Date of Issue:	1st April 2021

Welsh Health Circular / Official Letter: N/A	**Subject:** Digitisation of Nursing Documentation – Falls & Bone Health Multifactorial Assessment
Sponsor: Jean White, Chief Nursing Officer, Welsh Government Claire Bevan, Senior Responsible Officer / Director of Quality, Safety, Patient Experience & Nursing, Welsh Ambulance Services NHS Trust	
Implementation Date: March 2021	

DATA STANDARD CHANGE NOTICE

A Data Standard Change Notice (DSCN) is an information mandate for a new or revised information standard.

This DSCN was approved by the Welsh Information Standards Board (WISB) at its meeting on 18th March 2021.

WISB Reference: ISRN 2019 / 010

Summary: The introduction of a standardised digital Falls & Bone Health Multifactorial Assessment tool to be used across the secondary care setting in Wales.

Applies to: This standard applies to all NHS Wales health boards and trusts that provide patient care in a secondary care setting.

Please address enquiries about this Data Standard Change Notice to the Data Standards Team in NHS Wales Informatics Service

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The Welsh Information Standards Board is responsible for appraising information standards. Submission documents and WISB Outcomes relating to the approval of this standard can be found at:

http://howis.wales.nhs.uk/sites3/page.cfm?orgid=742&pid=24632

DATA STANDARD CHANGE NOTICE

Introduction

The Digitisation of Nursing Documentation project has been established with a view to delivering standardised agreed electronic nursing documentation, in support of Work stream 2 of the Prudent Healthcare Strategy. The project's first phase has been funded by the Welsh Government Efficiency Through Technology Fund (ETTF) with the aim of making an agreed first tranche of digitised nursing documents available nationally by November 2019.

One of the key success factors of the digitisation of nursing documents will be to collaboratively define and develop information data standards and patient level data that will inform current and future system developments. This will include learning from existing e-nursing documents projects and pilots across Wales. This will provide one standard set of assessments and documents with the potential to provide safe and effective care to the population of Wales irrespective of location, and improve patient, carer and staff experience. The aim is to release nurses from the administrative burden of completing paper-nursing documents to spend more time on direct patient care.

Nursing colleagues, from across all NHS Wales health boards and trusts, have identified the first set of nursing documents to be digitised for secondary care settings. Prioritised documents have been determined on where the greatest value is perceived to be attributed to patient care and nursing time.

Included in the first set of documents to be developed digitally is an all Wales Continence Assessment. This DSCN mandates the data fields and associated definitions to be collected as part of the continence assessment.

Scope

The digitised Falls & Bone Health Multifactorial Risk Assessment tool will be implemented across all NHS Wales health boards and trusts that provide patient care in a secondary care setting.

Developing e-nursing- documents for primary and community care settings are not in scope as these are in scope for existing programmes. The project will work closely with these programmes to ensure a consistent use of national information standards.

Actions

Local Health Boards / Trusts:

- Ensure that local processes and systems have been updated to comply with the standard set out in the Information Specification within this DSCN.

NHS Wales Informatics Service:

- Ensure that all national systems have been updated to comply with the standard set out in the Information Specification within this DSCN.

SPECIFICATION

Information Specification

The table below lists the Data Items and corresponding definitions and values that make up the information standard mandated by this DSCN. Please refer to Appendix A at the end of this DSCN for a more detailed specification.

User Interface Name	Field Identifier	Definition	Data Value Format (code or other value)	Value Sets
Date of Assessment or Review	Assessment_Date	This is the date the actual risk assessment (or review) was carried out with the patient	8 digit numeric, CCYYMMDD 6 digit numeric: hh:mm:ss	
Falls history Circle how many falls in the last 12 months (each fall increases risk)	Falls_history	This is to indicate the number of falls the patient has had within the last 12 months	n1	0 1 3 4 5 +
Has the patient had an inpatient fall since last assessment?	Inpatient_fall	This is to indicate whether the patient has had an inpatient fall since the last assessment	n1	1 Yes 2 No
Does the patient have a fear of falling / anxiety?	Falls_fear_anxiety	This is to indicate whether the patient has a fear of falling / anxiety	n1	1 Yes 2 No
Multifactorial actions & interventions careplan details	Inpatient_fall_actions	This is for the assessor to detail any multifactorial actions	Free Text	

Is the patient taking any of the following medication? Anticoagulants	Anticoagulants	This is to indicate whether the patient is currently taking anticoagulants	n1	1 Yes 2 No
Sedatives, hypnotics, antipsychotics or diuretics	Sed_hypn_antipsych_diuretics	This is to indicate whether the patient is currently taking sedatives, hypnotics, antipsychotics or diuretics	n1	1 Yes 2 No
Medications that lower BP or cause dizziness	meds_lower_bp	This is to indicate whether the patient is currently on medication that lowers their blood pressure or causes dizziness	n1	1 Yes 2 No
Multifactorial actions & interventions careplan details	Meds_actions_careplan	This is to detail any multifactorial actions and interventions care plan that has been arranged regarding the patients medication	Free Text	
Are there any of the following associated Risks: Medically unwell e.g. scoring on NEWS	Medically_unwell	This is to indicate whether the patient is medically unwell e.g. scoring on NEWS	n1	1 Yes 2 No
Risk of seizures	Seizures	This is to indicate whether the patient is at risk of seizures	n1	1 Yes 2 No
Postural drop in BP	Postural_drop_in_bp	This is to indicate whether the patient has a postural drop in BP	n1	1 Yes 2 No
Multifactorial actions & interventions careplan details	associated_risks_actions	This is to detail any multifactorial actions and interventions care plan that has been arranged regarding any associated risks	Free Text	

Any issues with Cognitive / Mental State e.g. Agitated, restless, impulsive, disorientated or confused? THINK DELIRIUM and its cause	Cognitive_mental_state	This is to indicate whether the patient is agitated, restless, impulsive, disorientated, confused or has no issues with cognitive / mental state	n1	1 Yes 2 No
Multifactorial actions & interventions careplan details	Cognitive_actions_careplan	This is to detail any multifactorial actions and interventions care plan that has been arranged regarding the patient cognitive / mental state	Free Text	
Any mobility issues e.g. • Needs help to stand, transfer and/or walk • Tries to walk unaided but unsafe, e.g. to toilet • Uses walking aids • Gait or balance problems • Seating? E.g. slipping out of chair	Mobility	This is to indicate whether the patient has any mobility issues	n1	1 Yes 2 No
Any foot health issues: Does the patient have appropriate footwear?	Appropriate_footwear	This is to indicate whether the patient has appropriate footwear	n1	1 Yes 2 No
Foot health / pain?	foot_health_pain	This is to indicate whether the patient has any problems with foot health / pain	n1	1 Yes 2 No
Multifactorial actions & interventions careplan details	Foot_health_actions_careplan	This is to detail any multifactorial actions and interventions care plan that has been arranged regarding the patients foot health / pain	Free Text	

Any Sensory Deficits: Vision and / or hearing impairment?	Vision_hearing_impairment	This is to indicate whether the patient has any vision and / or hearing impairment	n1	1 Yes 2 No
Numbness, weakness or spatial perception problems?	Numbness_weakness_spatial_perception	This is to indicate whether the patient has any numbness, weakness or spatial perception problems	n1	1 Yes 2 No
Multifactorial actions & interventions careplan details	Sensory_deficits_actions_careplan	This is to detail any multifactorial actions and interventions care plan that has been arranged with regards to the patients sensory deficits	Free Text	
Are there any issues with the following: e.g. Equipment, nutrition and hydration, continence bundle, dementia, pain assessment, substance misuse, sleep deprivation and rest?	Other _issues	This is to indicate whether there are any issues with the following: e.g. Equipment, nutrition and hydration, continence bundle, dementia, pain assessment, substance misuse?	n1	1 Yes 2 No
Multifactorial actions & interventions careplan details	Other_issues_actions_careplan	This is to detail any multifactorial actions and interventions care plan that has been arranged with regards to any other issues the patient may have	Free Text	
Does the Patient and Family identify other risks?	Patient_family_perspective	This is to detail whether the patients and family have identified any other risks	n1	1 Yes 2 No
Multifactorial actions & interventions careplan	Patient_family_perspective_actions_careplan	This is to detail any multifactorial actions and interventions care plan that has been arranged with regards to any risks identified by the patient or family	Free Text	

Is there a history of fracture or oesteoperosis?	Fracture_history_osteoperosis	This is to indicate whether the patient has a history of fractures or oeteoperosis	n1	1 Yes 2 No
Multifactorial actions & interventions careplan details	Fractuire_history_actions_careplan	This is to detail any multifactorial actions and interventions care plan that has been arranged with regards to there being a history of fracture or oesteoperosis	Free Text	
Based on this assessment are there any targeted interventions required?	Targeted_interventions	This is to indicate whether (based on this assessment) any targeted interventions are required	n1	1 Yes 2 No
Multifactorial actions & interventions careplan details	Targeted_interventions_actions_careplan	This is to detail any multifactorial actions and interventions care plan that has been arranged if targeted interventions are required	Free Text	
Any other details?	Any_other_details	This is to include any other details relevant to the falls assessment	Free Text	
After reviewing this risk assessment is the patient at risk of falls?	Risk_of_falls	This is to indicate that after reviewing the risk assessment the patient is or isnt at risk of falls	n1	1 Yes 2 No

Appendix

Falls & Bone Health Multifactorial Risk Assessment