Keywords: Patient safety/ Falls prevention/ Older person

Reducing the risk of inpatient falls

Results of the National Audit of Inpatient Falls report

Recommendations for reducing falls risk

Examples of best practice in hospitals

In this article...

Inpatient falls are common and are a challenge for healthcare professionals, particularly nurses on the front line. Falls in hospital are the most commonly reported patient-safety incident, with more than 240,000 reported in acute hospitals and mental health trusts in England and Wales each year – equating to more than 600 a day (National Patient Safety Agency, 2010).

All falls, even those that do not result in injury, can cause older patients distress and anxiety. Minor injuries from a fall can affect the physical capabilities of people who are frail, reducing their mobility and undermining confidence and independence. Some falls in hospital that cause serious injury, such as hip fracture (more than 3,000 per year) and serious head injury, can result in death (Royal College of Physicians, 2014).

No single or easily defined intervention, when implemented on its own, has been shown to reduce falls. But research has found that multiple interventions by the multidisciplinary healthcare team, tailored to individual patients, can reduce falls by 20–30%.

These interventions are particularly important for patients with dementia or delirium, who are at high risk. While hospitals have fall-prevention policies, they often bear no relation to what actually happens when frail and elderly people are admitted; most are still using unsafe methods to predict falls, according to a major national review.

National audit

The National Audit of Inpatient Falls, published in October, features data on nearly 5,000 patients aged 65 and over, across 170 hospitals in England and Wales (RCP, 2015). This is the first overview of how well trusts and health boards are complying with official guidance on falls assessment and prevention. The audit was established to measure against the National Institute for Health and Care Excellence’s guidance on falls assessment and prevention (NICE, 2013) and other patient-safety guidance on preventing falls in hospital. It was open to all acute hospitals in England and Wales.

The organisational audit had three sections, which were completed at hospital trust or health board level:

» Section 1: background details of the organisation, including occupied bed days and number of falls;

» Section 2: policies, protocols and paperwork;

» Section 3: leadership and service provision.

The clinical audit was a snapshot of care provided to a sample of up to 30 patients (15 consecutively admitted patients over two days), aged over 65, who were in need of a walking aid but could not safely get to it.
hospital for more than 48 hours after being admitted for a non-elective reason. The clinical audit consisted of two sections:

- **Section 1:** evidence of assessment and intervention in case notes;
- **Section 2:** observation at bedside or the patient environment.

### Average number of falls
Participation rates for both audits were high: 95.8% of eligible hospital trusts and local health boards took part in the organisational audit and 90.4% in the clinical audit. It was revealed that the average number of falls per 1,000 occupied bed days in England and Wales is 6.6. This figure was higher than previous smaller-scale audits had shown. The average number of falls resulting in moderate harm, severe harm and death was 0.19 per 1,000 occupied bed days.

While many organisations had fall-prevention policies that included all the key areas of fall prevention, this was not translating into practice on the front line. For example, more than 17% of patients in the study could not reach or see their call bell, while nearly a third (32%) who needed a walking aid could not safely get to it. Nearly all patients had their level of mobility recorded but only 16% had their lying and standing blood pressure documented.

Fewer than half (48%) had their sight checked or their need for visual aids, such as glasses, written on their records.

Another worrying finding was that the vast majority of hospitals were still using fall-risk prediction tools. This was despite guidance issued by NICE, which specifically states that these should not be used. Such tools aim to identify patients who are at low, medium or high risk of falling during a hospital stay, but have been found not to work well.

### Best practice
The report noted best practice in hospitals to prevent falls, identifying several examples that often involved specialist nurses taking the lead on fall prevention.

At Portsmouth Hospitals Trust, a falls and fragility clinical nurse specialist has worked with other clinicians to ensure all patients entering hospital are assessed and measures taken to reduce their likelihood of falling. The trust’s FallSafe programme, introduced three years ago, includes nurses acting as “FallSafe champions”.

At City Hospitals Sunderland Foundation Trust, a specialist nurse was trained in neurocardiovascular investigations and fall prevention, and now trains healthcare assistants to measure postural blood pressure. She also visits high-risk wards and checks patient-care plans.

### Conclusion
Following the audit, its team provided recommendations for clinical staff [Box 1]. They said clinical staff should use the findings of this report to identify which assessments and interventions recommended in NICE CG161 are not being consistently performed (NICE, 2013).

If fall rates are much lower than the national average, reporting processes should be reviewed, because this may indicate issues with underreporting non-injurious falls, they stated.

If fall numbers are higher than the national average, there should be a review of where these falls are taking place to see whether certain clinical areas are having particular difficulties.

Generally, there are “hot spots” due to the nature of the patients, for example, care of older people, general medicine and respiratory medicine, among others. The risks, and therefore the strategies, have to be adapted to the particular problems in each area, but generally identifying delirium is an important factor.

Clinical staff should consider starting critical-incident reviews, if these have not already been set up, when any person has recurrent falls or a fall with a fracture. And the multidisciplinary falls group should review the incidents, as this is a valuable way of sharing and learning. NT

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**BOX 1. KEY RECOMMENDATIONS**

**Summary of recommendations for trusts and local health boards**

- **Falls steering group:** all trusts and health boards should have a board-level falls steering group. This group should regularly review their data on falls and assess the success of their practice against trends in these figures.
- **Falls multidisciplinary working group:** all trusts and health boards should have a falls multidisciplinary working group that monitors interventions to improve prevention of falls in hospital and use proven methods to embed these changes.
- **Do not use a fall-risk prediction tool:** the following groups of inpatients are at risk of falling in hospital: - manage their care accordingly, as per NICE CG161:
  - all patients aged 65 or older;
  - patients aged 50-64 at higher risk of falling due to an underlying condition.
- **Audit bed-rail use:** trusts and health boards need to regularly audit the use of bed rails against their policy and embed changes to ensure appropriate use.
- **Review multifactorial falls risk assessments (MFRAs):** all trusts and health boards should review their MFRAs and associated interventions, ensuring that what is included in the policy actually translates into practice.

**Key indicator recommendations**

- **Dementia and delirium:** falls teams should work closely with dementia and delirium teams to ensure team working for these high-risk patients.
- **Blood pressure:** all patients aged over 65 should have a lying and standing blood-pressure measurement performed as soon as practicable, and actions should be taken if there is a substantial drop in blood pressure on standing.
- **Medication review:** all patients aged over 65 should have a medication review, looking particularly for medications that are likely to increase risk of falling.
- **Visual impairment:** all patients aged over 65 should be assessed for visual impairment and, if present, that their care plan takes this into account.
- **Walking aids:** ensure that all patients who need walking aids have access to the most appropriate walking aid from the time of admission.
- **Continence care plan:** all patients aged over 65 should have a continence care plan developed if there are continence issues.
- **Call bells:** all trusts and health boards should regularly audit whether the call bell is within reach of the patient and embed change in practice if needed.

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For more on this topic go online...

- A care bundle approach to falls prevention
- Bit.ly/NTBundleFalls

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**References**