# Preventing falls and fall injuries in hospital: a major risk management challenge

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**Abstract**

Accidental falls are the commonest patient safety incident in hospital and are especially common in older patients. They are associated with physical and psychological harm, functional impairment, prolonged hospital stay, cost and opportunity cost. Falls often cause concern and anger from patients' relatives, are a frequent cause of complaints and inquests, and may lead to claims in clinical negligence – albeit that the financial risk from these claims is low. As such, falls and related injuries should be a major concern in risk management and governance for institutions. In reality, falls are often a marker of patients' underlying medical illness and frailty and their occurrence does not necessarily mean that there has been a failure in the duty of care or that anyone or any system is to blame. Falls rates are also dependent on the case-mix and frailty of patients on the unit, so that crude unadjusted comparison of falls rates should not be used in isolation as an indicator of care quality. Nonetheless, there appear to be large variations in falls rates. It may be that some falls are essentially inevitable or unpreventable, but that others are avoidable and unacceptable, especially as we must balance falls prevention against the duty to promote rehabilitation, respect patients' autonomy and avoid an excessively custodial, ageist or risk-averse approach to care. Even though all parties may feel that 'something should be done' to manage the risk, it is not always clear what the interventions should be. This in turn means that institutions may implement interventions or assessments which are neither effective nor evidence-based. The starting point for falls prevention programmes should always be a critical review of such evidence. In this review, we discuss the underlying causes of falls, the potential for learning from incident reporting and claims analysis and, in particular, the academic literature on falls risk assessment tools (for which the evidence base is limited) and on falls prevention interventions. Evidence from clinical trials has shown that it is possible to produce modest reductions in falls rates (if not the number of 'fallers') from whole systems interventions which incorporate a variety of approaches to falls prevention. These interventions are described in detail as well as the limitations of performing research in such a frail and unstable patient group.

## Introduction

Accidental falls may be defined as 'Incidents in which someone suddenly and involuntarily comes to rest on the ground, floor or other lower level'.[1] They are the commonest reported patient safety incident in hospital.[2] Rates have been described of anything from four to 13 falls per 1000 bed days depending on the type of unit.[3,4] A recent publication by the UK National Patient Safety Agency (NPSA) '*Preventing Falls in Hospital*'[2] – analysing critical incidents in acute, community and mental health trusts in England and Wales for 2004–05 – showed a wide variation of reporting but a mean incidence of five falls per 1000 bed days. In that year, there were 206,500 reported falls incidents representing about 32% of the total and falls accounted for 70% of the incidents affecting patients aged over 65 years. As many hospitals were not reliably reporting and, as we know from previous research that there is significant under-recording of falls incidents,[5,6] this is likely to be an underestimation of the real extent of the problem, especially when we consider that falls rates in more tightly monitored intervention studies tend to be much higher.

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Falls are predominantly a problem affecting older people. Currently, around 60% of admissions and 70% of bed days in UK National Health Service (NHS) hospitals are in persons over 65 years old, with the proportion rising exponentially.[7] Older people are to be found in every adult clinical area in hospital and are actually the core users of general medical, surgical and orthopaedic wards as well as of specialist elderly care units. We know that many of these individuals have multiple long-term conditions, multiple medications, frailty or disability, and that both dementia and acute confusion (delirium) are increasingly common in hospital populations and that falls, fractures and mobility problems are among the commonest reasons for initial admission.[8,9] We also know[8,10,11] that hospitals are not traditionally geared up in terms of systems, skill-mix or training to deal adequately with many of these individuals, that performance and funding incentives tend not to help and that older people and those with mental health problems have often been cared for in substandard physical environments. With the portion of the population over 80 years old set to rise by 50% within the next 25 years, the scale of the problem is likely to grow.[7]

In hospital settings, some 30–40% of falls result in physical injury.[2,12] Fractures occur in only 1–3% of hospital falls, mostly in patients who have osteoporosis (so called 'fragility fractures') but such fractures, especially those of the hip and pelvis, carry considerable morbidity and mortality. Other common fragility fractures can also be very disabling – for instance, six weeks in

a wrist plaster cast or arm sling will significantly impair an older person's functional independence and ability to cope. Head injuries may occasionally lead to serious consequences such as subdural haematomas. Even apparently 'minor' soft tissue injuries, for example, sprained wrists/ankles or bruising, can have very serious effects on rehabilitation and independence in frail older people who already have poor functional reserve. In addition to the physical injuries resulting from falls, they are associated with fear of falling, anxiety and depression, loss of confidence and increased length of stay, and are a major factor in decisions to discharge from hospital to long-term care settings.[13] They are also a source of concern for the patients' relatives who may feel that in 'a place of safety' like a hospital that something should have been done to prevent the fall and that the occurrence of a fall represents a failure in the duty of care – 'surely something could have been done to stop it?',[14] even though in many cases, this view represents a fundamental misunderstanding of the nature of illness, rehabilitation and risk.

In turn, such falls lead to guilt and anxiety among staff either because they feel responsible for allowing the fall to occur or because of the threat of complaint, litigation or even Coroner's inquests when someone has died following a fall on the ward. For all these reasons, falls are a major problem for individuals who suffer them, for staff who care for them and the patients' relatives and should be regarded as a major risk management issue for hospitals. A further crucial point is that the occurrence of a fall should always signal potential reversible underlying medical problems and is often a marker for change in a person' s condition. It is not therefore sufficient simply to fill out a critical incident form and to establish whether the person has been hurt. Rather as part of good governance and risk management, we should use the incident report as a reason to look for causes and review preventative care plans.

## Why do falls happen?

Of course it is possible for relatively young and fit people to suffer isolated falls due to a trip hazard, syncope (i.e. blackouts/fainting) or temporary confusion/agitation in the face of acute medical illness. However, the majority of falls in hospital are in older people with a peak age being between 75–80 years.[2] Many older people who are frail or have some functional impairment are prone to falls, immobility or confusion in the face of even sometimes quite minor medical illnesses.[3,10,15,16] Moreover, they tend to have an accumulation of disabilities, multiple medications which can contribute to falls and they are more prone to fainting or transient confusion. Falls are also one of the commonest reasons for attendance to Accident and Emergency and admission to hospital in the first place.[17] And even in the community some 50% of people over 80 years old will fall once a year on average,[18] with considerably higher rates among the residents of care homes – many of whom are admitted to hospital.[4,19]

Although falls may occasionally have one simple explanation, they are generally the result of synergistic interactions between frailty, long-term medical illness, acute medical illness, medications, the person's own behaviour and environmental hazards.[3,16,20] It is also crucial to recognize that, in the hospital setting when we are trying to encourage people to regain independence, respect their personal autonomy and mobilise them prior to discharge, that falls will happen and are an inevitable if unwelcome part of encouraging older people to rehabilitate following transient disability associated with illness. A unit with zero falls is very unlikely to be a unit where effective rehabilitation is taking place. Older people should not be subjected to an over custodial approach which concentrates excessively on minimising risk at the expense of their personal autonomy or recovery.[14,21,22] Nonetheless some falls are more acceptable than others and there is plenty that can be done to modify the risk.[23]

A useful way of thinking about the causes of falls is the D.A.M.E. classification.[3,24]

### *D (Drugs and alcohol)*

Older people being admitted to hospital are often on multiple medications and especially drugs which can lower the blood pressure or slow the heartrate thereby leading to fainting, sedation or drowsiness (e.g. sleeping tablets, sedatives, antidepressants, painkillers), or those which can cause unsteadiness or muscle weakness which increases the risk of falls.[25] It is therefore important, especially in people who are falling or fainting, to go through the list of prescribed medicines and consider the risk/benefit ratio for each of them and minimize the number of unnecessary prescriptions.

### *A (Age-related physiological changes)*

It is natural for people to lose muscle strength and balance as they get older, although exercise can help reverse this decline. Postural stability is worsened, reflexes become slower, visual problems accumulate and bones lose density, with an increasing prevalence of osteoporosis which means that fragility fractures are increasingly common even from fairly minor falls. The cardiovascular system is also much less likely to cope with problems such as dehydration or infection, leading to a higher incidence of low blood pressure and related faints.[10] Older people are also far more susceptible to becoming acutely confused (delirium) in the face of illness and we know that delirium in hospital inpatients is very common, under-recognized and poorly treated.[26,27]

### *M (Medical causes)*

Because many older people in hospital *are* frail and have poor functional reserve, any illness, drug effect or environmental hazard is much more likely to result in falls or immobility than in younger people. Acute illness often presents itself with falls and immobility in older people. Such presentations are not, as is still commonly written in patients' notes, completely inappropriately a '*social admission*' or '*acopia*' but the results of a genuine illness which requires a proper diagnosis and a treatment plan, just as much as any more clear-cut presentation in a younger, fitter individual. Various conditions which lead to muscle weakness or gait instability (e.g. stroke, Parkinson's disease, etc.) will also increase the propensity to fall as will conditions leading to fainting, e.g. cardiac rhythm disturbances, postural hypotension (i.e. blood pressure dropping when a person stands up, again very common in older hospitalized patients).

### *E (Environmental causes)*

Floor type can influence both fall and fracture risk,[28] environmental hazards, spillages or clutter can increase the risk of falls as can inadequate levels of lighting, visual contrast between surfaces of visibility for safe observation of patients. The height of beds and chairs, availability of walking aids and call buttons

are also crucial. Moreover, a noisy or poorly lit environment can further precipitate confusion and it should be borne in mind that an increasing proportion of the older hospitalized population also suffer from dementia so that when placed in an unfamiliar environment with insufficient reassurance and monitoring, they are more likely to become restless and fall.

Within the population of hospital inpatients, there are clearly some individuals who will only fall once generally in the first few days of admission when they are recovering from their acute illness and going through a transient period of instability. There are other individuals often with agitation, wandering, confusion or gait instability who are prone to falling repeatedly.[2,12,23] It may be that different interventions are required for these two groups. In view of the synergistic causation of falls it is also important to realize that labelling falls as 'mechanical' is simplistic. Most people who are tripping repeatedly are doing so because of other factors such as muscle weakness, gait instability, sensory loss, etc.

## Can falls in hospital reliably be predicted?

There has been considerable interest – both from researchers and especially from staff and risk managers in the frontline providing hospital care – in *Falls Risk Assessment Tools* which purport accurately to discriminate patients' risk of falling,[29–31] the idea of these tools being that if one can identify patients at the highest risk then efforts can be concentrated on these patients. It is also true that one of the biggest predictors of future falls is that somebody has already fallen once, with around 50% of falls in people who have already fallen once on the ward – emphasizing the need to come up with tailored falls reduction plans for each patient who falls, rather than simply filling in a form simply for administrative purposes. There are a few individuals (usually those who are restless, agitated and unsteady but able to leave their chair or bed on their own however unsafely) who may account for a high proportion of reported falls, who fall repeatedly and for whom different strategies may be needed. The remaining 50% or so of falls occur in patients who fall once only during admission, so that predicting the 'first fall' by use of a reliable tool seems an attractive enterprise. Certainly, the use of such tools might help focus the mind and raise awareness in much the same way as do screening tools for say poor nutrition or risk of pressure sores.[2,23] Nonetheless, there are serious problems associated with using them.[32] In order to be operationally useful, a clinical prediction tool needs to have been validated prospectively in the setting in which it is to be used (or at least a similar population) – we cannot simply 'import a tool' from another setting/population or culture and assume it will work. To be operationally useful, the tool should have sufficiently high predictive validity to give staff accurate information about patients' risk. Predictive validity has a number of components:[29,33]

- *Sensitivity* – the 'true positive rate' or the percentage of all patients who fell who had been predicted as 'high risk';
- *Specificity* – the 'true negative rate' or the percentage of patients who didn't fall who had been predicted as 'low risk';
- *Positive predictive value* – the percentage of patients predicted as being at high risk who do go on to fall;
- *Negative predictive value* – the percentage of patients predicted as low risk who go on not to fall;
- *Total predictive accuracy* – the correct discrimination of fallers and non-fallers.

In addition, such tools should be completed easily, quickly without the need for detailed assessments or tests – and reliably with good agreement between staff. They should have a small number of items with weightings which are not arbitrary.

While this might seem an academic and dry discussion, it is important to realize that unless the tools really do fulfil these criteria they will be fairly useless at correctly classifying fallers and non-fallers. Yet many units are using tools which have simply been 'home-made' with an arbitrary selection of items and weightings and never validated, or importing tools of dubious value in their own population. Even the two best validated risk assessment tools in hospital patients – the STRATIFY score[34] and Morse Falls Scale[35] – both of which have been subjected to several independent evaluations, do not perform equally well in all settings.[36]

It is also important to realize that simply performing a risk assessment does not mean that an intervention has been carried out and may simply give false reassurance.[2,29] Assessment is meaningless without intervention. Also, those factors which predict falls are not necessarily synonymous with those which cause them so there is also a place for risk factor tools which prompt staff to look at common reversible risk factors and do something for each one. Within the hospital setting, the same handful of reversible risk factors consistently emerges. These are essentially: inter-current illness; previous falls/postural instability/muscle weakness, urinary frequency/incontinence, confusion, restlessness or agitation, visual impairment, 'culprit' drugs, postural hypotension or other causes of fainting or environmental factors. Any falls intervention therefore needs to identify these factors and produce a care plan to address each one.

It is very important to realize in this context that there is no room for 'therapeutic nihilism'. The core message of geriatric medicine is to turn apparently functional problems such as falls or immobility into reversible diagnoses and do something about them. Even where the problem cannot be abolished, it can be ameliorated. Even when falls can't be prevented completely, their frequency can be reduced. Even when this is not possible, it is possible to minimize the consequences of falls such as injury.[24,37]

## So which interventions *do* work?[4,38]

It is comparatively hard to perform conventional clinical trials research in the setting of acute or frail hospital patients often with high turnover and often unable to give informed consent. Unsurprisingly there have been any number of 'before and after' studies where some kind of falls prevention policy has been introduced to a unit and the falls rates have merely been described before and afterwards. Most of these studies, while admirable in intent, are deeply flawed as credible science. Firstly because falls are not reliably recorded in critical incident forms and are subject to considerable recording bias; secondly because of the Hawthorne effect (whereby the very process of observing practice will alter it to produce spurious apparent effects of interventions); third, many of these studies are also significantly underpowered to detect any difference in fall, let alone injury rates. The fourth problem is that there are inevitably underlying variation and secular trends in fall rates and other factors such as unit case-mix, staffing, layout, etc. These could all have influenced the falls rate so it is hard to

attribute the apparent reduction to the intervention provided without much more rigorous control than a mere 'before and after' design. However, there have been one or two more methodologically rigorous studies that have demonstrated a reduction in fall rates.

A recent UK Department of Health funded systematic review and series of meta-analyses concluded that using multifaceted fall prevention interventions it was possible to achieve a falls rate reduction of about 18%,[4] though there was no clear evidence that the number of people who fell or the injury rate could be reduced. Particularly good models of practice (i.e. studies of good methodological quality, adequate controls for confounders and where falls were genuinely reduced in the context of 'real life' clinical practice) are from Healey,[39] Haines[40] and Fonda.[41] Interestingly, only one of these (Haines) used any kind of formal risk assessment scoring system. The general approach in all studies was to concentrate on people who had fallen or who had suffered near misses, putting together a multidisciplinary plan of interventions for common reversible risk factors. Fonda, while it was a 'before and after' study, described the total quality management initiative with year on year sustained reductions in falls rates over three years showing just what can be achieved with a concerted effort in this area. These studies all used a variety of interventions including environmental safety, post-fall care planning, assessment and management plans for common risk factors, medication review, staff education and policies and additional physiotherapy, though the precise composition varied from study to study.

In terms of single interventions to prevent falls or injuries, the review showed some evidence that flooring type can reduce the rate of injuries resulting from falls.[28,42] Another study showed that comprehensive geriatric assessment, as a secondary consequence, could reduce falls.[43] There was no clear evidence for hip protector pads to prevent fracture in hospital inpatients and their adherence to these devices tends to be low;[44] nor for bed or chair alarms or other assistive technology (despite many positive 'case studies' reported by the manufacturing companies in their marketing material); nor for medication review as a single intervention. There is some evidence now that better medicine management[45] and screening/treatment for delirium[26] can reduce the falls rates as a secondary consequence. There is no evidence for exercise, nor for calcium/vitamin D in hospital settings. It is important to recognize that even though some of these interventions have been shown to be effective in long-term care settings[4,23,37] it cannot simply be assumed that they will translate to the setting and patient population in hospitals.

## What about bedrails and physical restraints?

The use of overt prescribed physical restraints (e.g. leather or linen devices to tie patients' wrists to beds or chairs, or lap belts to stop people rolling from wheelchairs) is still fairly commonplace in North America but is now vanishingly rare in the United Kingdom.[21,46] This does not mean that covert restraint is not sometimes used (e.g. tucking bedclothes in too tight, putting patients on chairs that they cannot easily get out of, wedging furniture against beds, etc.).

Bedrails still come as standard attachments to most hospital beds and are still frequently applied, especially at night time. This is a controversial area. On the one hand, both in the UK and in America there are large reported series of deaths and injuries from entrapment, asphyxiation, etc. resulting from bedrails.[46,47] Bedrails also increase the height that a patient falls from and have been shown to worsen agitation delirium as well as causing a subjective feeling of entrapment/imprisonment. There have also been one or two quasi-experimental studies suggesting that when there is a deliberate programme of bedrail reduction there is no increase in the rate of falls or injuries (though these programmes are often accompanied by better use of alternative strategies). On the other hand, the majority of falls from bed, especially those that lead to serious injury or litigation, seem to occur with the bed rails in place[2,21] and the amount of empirical evidence from good quality trials is minimal[48] (unsurprisingly as it will be quite hard to randomize patients in a busy unit to who is receiving or not receiving these devices). Perhaps because of a natural belief among the public that bed rails *ought* to stop falls, there are also a significant number of claims in negligence where the failure to apply bed rails is specifically mentioned.[49] In addition to the issue of physical injury, there is much comment in the literature that the use of bed rails is degrading, infringes autonomy, etc.

There are some counters to all this however. Firstly, that bed rails are not exclusively used as a form of restraint but often as a device to help someone manoeuvre themselves in bed or even at their own request or as an aid to transferring in and out of bed. Indeed they would probably not be a very effective form of restraint for most individuals. They are also frequently used merely to stop people rolling out of bed at night. In these scenarios, the bedrails are often applied with the patient's full consent. It could also be argued that as a form of physical restraint they would be fairly useless as they are only 18 inches high. Moreover, if we look at the philosophical or legalistic definitions of autonomy, they focus on people having sufficient information and sufficient appreciation of risks and benefits to make an informed decision.[22] By this token, many confused, agitated patients for whom bed rails are applied are not fully autonomous agents and therefore acting in their interests in this way (sometimes described as weak paternalism) does not genuinely infringe their autonomy.

What *is* unacceptable is for bed rails or other forms of physical restraint to be used routinely and uncritically as a surrogate for poor levels of nursing care, poor management of confusion, or as an alternative to actually promoting somebody's autonomy and rehabilitation.[14,21] It would clearly also be unacceptable to use them in a punitive fashion for 'troublesome' patients. However, if they are used as part of a careful care plan reviewed regularly and not as a substitute for inadequate levels of nursing care, then their use is acceptable in limited circumstances.[50] After all, there is a duty of care to prevent patients from serious injury and elevating respect for autonomy above all other considerations may not always be helpful – especially when that autonomy is compromised by cognitive impairment, so that exercising a duty of care might be seen at worst as 'weak paternalism'.

In the UK, a further consideration is that the Mental Capacity Act, enacted in 2007,[51] now has specific provisions about the use of physical restraint which are useful to practitioners.[52] The case law regarding the protection of patients from themselves has tended to be very specific to mental health patients and self-harm/suicide attempts so is not especially applicable to older patients at risk of falls.[50] The Act sets out explicit tests of decision-specific capacity, and requires professionals to do everything they reasonably can to facilitate

a patient's ability to make and communicate an informed decision. The corollary is that so long as these conditions have been met, health professionals may legitimately act in the best interests of a patient who lacks capacity without occurring legal liability. Restraint is defined in Section 6 of the Act as '*the use, or threat of force where an incapacitated person resists and any restriction of liberty or movement whether or not the person resists*'. It is only permitted if the person using it reasonably believes it is necessary to *prevent harm* and if the restraint is *proportionate* to the likelihood and seriousness of harm and is that form of restraint which least infringes statutory human rights. It will be interesting to see how this law affects policies and professional behaviour around fall and injury prevention in hospital patients who lack sufficient mental capacity to appreciate their risk of falls and injuries.

## What can we learn from critical incident reporting?

Until recently, there has perhaps been a tendency for incident forms to be filled out just so that staff can 'cover' themselves and ensure that the person hasn't sustained a serious injury. With the advent of bodies such as the NPSA we now have increasingly detailed information on the patterns of falls.[2,53] This can be accessed for instance in the NPSA's own 2007 report: '*Preventing falls in hospital*'.[2] From these data we know, for instance, that:

- Most falls are unwitnessed by staff;
- Most occur from the bed or the bedside chair or somewhere in between;
- Approximately 30% result in a documented injury of some kind;
- They are more common at certain times of the day than others;
- Their frequency and patterns are different depending on the type of the institution and case-mix.

In addition to learning from variations at national and inter-organizational level, it is important for individual hospitals and units to learn from their own local critical incident reporting which might help them better target falls prevention interventions. It is also crucial to use each falls incident as a trigger to review that individual persons risk and look for new medical problems. It is a matter of regret that even now, however, about half of the Trusts in England and Wales are not regularly reporting their falls data to the NPSA despite falls being their most common adverse incident; the data suggests that there is still significant under-reporting of the event.

## What about legal claims in clinical negligence?

Although falls are the highest volume critical incident in terms of absolute numbers and account for nearly 50% of all reported critical incidents, and although they have major financial implications for hospitals in terms of excess bed days and costs, they appear to be an area of relatively low financial risk in the UK with regard to negligence claims. Since the NHS Litigation Authority (NHSLA) began in 1995, through to 2006 there have been a total of 648 claims where falls are the incident which triggered the claim (around 0.2% of all claims) with £7.7 million paid out (combining damages and costs). This accounts for 0.19% of all payments. This relatively modest sum might reflect the fact that falls tend to happen in frailer, older people, meaning that it is harder to establish a breach in the duty of care or to establish which consequences are directly attributable to the fall.[54] Also, because of the limited life expectancy of these individuals, the quantum is likely to be lower. A final factor is that such claims are almost universally settled out of court in the UK. These issues are explored in more detail in a forthcoming *Clinical Risk* paper designed to complement this one.[49] The patterns and circumstances of these falls tended to reflect those reported in analysis of falls incidents in general with the majority being falls from or near the patient's bed or walking unaccompanied. Perhaps because fracture of the femur is a clear result of falls and is a debilitating injury, hip and pelvic fractures accounted for over £3.5 million of payments – nearly half the total.

## So where do we go from here?

We have seen in this article that falls in hospital are the single most common risk management issue and associated with it a range of harms to individuals and problems/costs for institutions. For this reason, there is often a feeling that 'something should be done' to prevent them – as staff often feel unsure about what to do for the best. The growing weight of evidence clearly suggests that all patients admitted should have attention to the common reversible risk factors/causes for falls including confusion, faints, gait instability, medication, visual impairment, urinary frequency, etc. This is in effect simply good practice in the care of frail older people or 'Comprehensive Geriatric Assessment' which has a variety of other proven benefits beyond falls prevention.[55]

These factors should be screened for on admission with a care plan for each one and every subsequent fall that happens should result in a further reassessment of risk and further plans to minimize the chance of future falls. Use of risk assessment tools as an intervention in their own right is probably of dubious value. The use of newer flooring materials and adjustable height beds may also minimize the chance of serious fractures or head injury following falls. These individually tailored interventions should be coupled with: awareness raising, education, training and evidence-based policies on units, a concerted effort to learn from critical incident reporting and close the loop of clinical governance by using this learning to inform practice. An institution failing to learn from such incidents especially if falls rates were high could potentially be held liable. However, it would be unfair and wrong to judge the quality of care on the unit by the falls rate as the recording of falls is so subject to biases and so influenced by the case-mix of patients.

A further consideration is that the environmental safety of wards including lighting, visibility, grab rails, number of toilets and bathrooms should be made as user friendly for older people as possible as they are increasingly the core customers of hospitals. To an extent, falls rates will go down if the general care of older people in hospital is improved; both the 2001 *National Service Framework for Older People*[11,56] and its recent reiteration in the *New Ambition for Old Age*[11] have made it clear that older people in any part of the hospital should be cared for by staff with the right skills, training and experience and observational data showed that this is clearly far from the case in many places and even very common syndromes such as delirium or incontinence are under-recognized and under-managed. When older people with co-existent dementia are admitted to acute care settings, they get an especially raw deal.[11,57] Ageist attitudes still persist, with central performance targets further focusing the priorities of hospital Trusts onto

the needs of younger, fitter patients – in particular, people with dementia or acute confusion often get a raw deal in a general hospital setting. We should also not pretend when it comes to the prevention of falls that the establishment of nurses on the ward does not matter. Some gains can be achieved cost neutrally by training policies, awareness, education and governance. But there is no question that the number of staff on a shift is bound to influence the safety of patients and that resource matters.

Finally, we should always remember that older people as adults are just as entitled to experience risk as younger individuals and that if our main aim once they have recovered from their acute illness is to get them back on their feet and get them home then a certain number of falls is inevitable. We should therefore not promote an approach to the care of older people in hospital that is excessively risk averse and custodial just in order to minimize the threat of complaint or litigation and should be more proactive about explaining decisions to patients' relatives, e.g. not using cot sides or allowing people to walk to the toilet unaccompanied. The fact that a fall occurs on a ward certainly does not, by itself, mean that there has been an unacceptable breach in the duty of care

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