Open Book
Learning from close calls and adverse events

Lessons learnt from reviewing patient falls

Falls are one of the most common causes of injury to patients in hospital. This edition of Open Book was written in collaboration with the Health Quality & Safety Commission's Reducing Harm from Falls programme, and sets out a series of practice changes made by providers to prevent patients from being harmed by falling.

Incident 1 – Identifying patterns

Staff noted that a patient at risk of falling would immediately try and get up after a meal to wash his hands. Speaking to the family, it was found that this was a habit the patient had followed all his life.

Action taken

Nursing staff stayed close to the patient at meal times to help him reach the wash basin, because they knew he would try and get up as soon as he had finished eating. (*Practice point: Provide individualised care*.)

Incident 2 – Safe environment

A patient slipped and fell in the ward shower. The review found the shower had to be entered in order to reach the light switch, and the wet floor on which the patient slipped could not be seen in the dark.

Action taken

The incident review included a recreation of the circumstances surrounding the patient's fall. Short-term measures were taken to reduce the risk of further falls, and design changes were identified for existing and future facilities, which would help prevent similar incidents from occurring. (*Practice point: A safe environment is essential to prevent falls.)*

Incident 3 – Working with families

Staff in an aged residential care facility mapped a resident's pattern of falls. They found the majority of falls occurred between 3pm and 5pm each day.

Action taken

The pattern of falls was discussed with the family. They decided to take turns visiting the resident between 3pm and 5pm, and the frequency of falls reduced dramatically as a result. (*Practice point: Involve the family in risk assessments and care planning*.)

Incident 4 – Non-slip socks

A patient suffering from hemiplegia was walking with the assistance of staff, and wearing non-slip socks. The patient was attempting to drag his foot forward, but the non-slip socks gripped the floor, and the patient lost his balance and fell.

Action taken

The use of non-slip socks was discontinued for this patient. (*Practice point: Before fitting non-slip socks, an assessment should be performed to ascertain if non-slip socks are the safest option for the patient*.)

For more on falls prevention evidence and best practice, see:

- the 10 Topics in reducing harm from falls
- guidance on learning from falls reviews (includes a human factors framework and analysis template).

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