Changes in falls prevention policies in hospital in England and Wales

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Abstract

Background: in 2007, the National Patient Safety Agency (NPSA) published ‘Slips trips and falls in hospital’ and ‘Using bedrails safely and effectively’.

Objectives: this observational study aimed to identify changes in local policies in hospitals in England and Wales following these publications.

Method: policies in place during 2006 and 2009 were requested from 50 randomly selected acute hospital trusts and their content was categorised by a single reviewer using defined criteria.

Results: thirty-seven trusts responded. Trusts with an inpatient falls prevention policy increased from 65 to 100%, the use of unreferenced numerical falls risk assessments reduced from 50 to 19%, and trusts with a bedrail policy increased from 49 to 89%. It was concerning to find that by 2009 advice on clinical checks after a fall was available in only 51% of trusts, and only 46% of trust policies included specific guidance on avoiding bedrail entrapment gaps.

Conclusions: the observed changes in policy content were likely to have been influenced not only by the NPSA publications but also by contemporaneous publications from the Royal College of Physicians’ National Audit of Falls and Bone Health, and the Medicines and Healthcare products Regulatory Agency. Most areas of local policy indicated substantial improvement, but further improvements are required.

Keywords: accidental injury, older people, restraint, elderly

Introduction

In 2007, the National Patient Safety Agency (NPSA) published ‘Slips trips and falls in hospital’ [1] and a Safer Practice Notice ‘Using bedrails safely and effectively’ [2]. These reports presented a detailed analysis of over 200 000 falls in hospital reported to the NPSA’s National Reporting and Learning System [3], together with advice on improving the quality of reporting and learning from falls, a summary of the evidence related to hospital falls prevention (based on subsequently published literature reviews [4, 5]) and commentaries from experts and from frontline staff from
hospitals where this evidence had been put into clinical practice. The Safer Practice Notice required NHS organisations to update their policy and training and to audit its implementation. It provided supporting resources, including a model policy, audit tool, bedside decision-making aids, posters and educational materials. The publications aimed to ‘improve understanding of the scale and impact of falls within the NHS, and should energise staff, from the frontline to NHS chief executives, to renew efforts to prevent falls by directing them to some of the excellent resources on falls prevention which are available’ [1, p. 3].

Whilst recognising there are many other factors in addition to national reports that influence local policy and practice, this study aimed to identify if there had been changes in individual hospital policy before and after their publication.

Methods

Study population

Fifty acute hospital trusts were selected by random number table from a list of all NHS organisations providing acute hospital services in England and Wales.

Data collection

Requests were made trusts for any falls prevention and/or bedrail policies, protocols, guidelines or procedures (hereafter referred to as policies) in place during October 2006 and October 2009. Because trusts are required to include the date of approval on all policies and to routinely archive older versions of policies in case of retrospective legal action [6] policies active in 2006 were expected to be available on request. Requests were made during October 2009 and responses collated up to the end of December 2009.

Data review

Key aspects of each policy were categorised by a single reviewer (Supplementary data available in Age and Ageing online, Appendix 1 in the supplementary data on the journal website http://www.ageing.oxfordjournals.org/) to assess:

- if the falls policy included content specific to inpatients (i.e. was not solely focused on general environmental falls risk for staff, visitors and patients);
- the type of falls screening and/or falls assessment required by the falls policy, if any;
- if the falls policy included advice on clinical care after a fall;
- if advice on bedrail use was provided (either as part of the falls policy or through a separate bedrail policy);
- if advice on consent and capacity in relation to bedrails was given and, if so, did it include any inaccurate content (e.g. a policy which stated relatives could routinely make decisions on behalf of adult patients would be considered inaccurate);
- if it contained specific advice on avoiding bedrail entrapment;
- if it contained any indications (rather than solely contraindications) for bedrail use.

Additionally policies current in 2009 were checked for references to the NPSA publications [1,2].

Data analysis

As a retrospective observational study, simple descriptive data as rounded percentages without analysis of statistical significance were considered appropriate [7].

Results

By the cut-off date of 31 December 2009, 37 (74%) of the 50 randomly selected trusts had responded. The content of the policies they provided is summarised in Table 1, with key content changes illustrated in Figure 1.

Discussion

One of the most notable changes appeared to be in the proportion of trusts with an inpatient falls prevention policy (rather than solely policies directed at environmental hazards which offered the same actions for patients, visitors and staff), which rose from 65 to 100%. There was also an increase in the external scrutiny of trusts’ falls policies during the period 2006–09, with the publication of two reports from the Royal College of Physicians’ (RCP) Falls prevention policies in England and Wales

Table 1. Comparison of content of falls prevention and bedrail policies in use in England and Wales during 2006 and 2009

<table>
<thead>
<tr>
<th></th>
<th>2006 Number</th>
<th>%</th>
<th>2009 Number</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Falls prevention policies</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Has an inpatient falls policy</td>
<td>24/37</td>
<td>65</td>
<td>37/37</td>
<td>100</td>
</tr>
<tr>
<td>References ‘Slips trips and falls in hospital’</td>
<td>N/A</td>
<td>N/A</td>
<td>18/37</td>
<td>49</td>
</tr>
<tr>
<td>Assessment tool prescribed by policy</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Direct to multifactorial checklist</td>
<td>0/24</td>
<td>0</td>
<td>3/37</td>
<td>8</td>
</tr>
<tr>
<td>NPSA ‘four questions’</td>
<td>1/24</td>
<td>4</td>
<td>6/37</td>
<td>16</td>
</tr>
<tr>
<td>Numerical validated tool (Morse)</td>
<td>4/24</td>
<td>17</td>
<td>4/37</td>
<td>11</td>
</tr>
<tr>
<td>Numerical validated tool (STRATIFY)</td>
<td>5/24</td>
<td>21</td>
<td>5/37</td>
<td>14</td>
</tr>
<tr>
<td>Referenced numerical tool</td>
<td>2/24</td>
<td>8</td>
<td>8/37</td>
<td>22</td>
</tr>
<tr>
<td>Locally devised numerical tool</td>
<td>12/24</td>
<td>50</td>
<td>7/37</td>
<td>19</td>
</tr>
<tr>
<td>Unclear what tool in use if any</td>
<td>0/24</td>
<td>0</td>
<td>4/37</td>
<td>11</td>
</tr>
<tr>
<td>Gives advice on clinical care after a fall</td>
<td>7/37</td>
<td>19</td>
<td>19/37</td>
<td>51</td>
</tr>
<tr>
<td>Bedrail policies</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Has a bedrail policy</td>
<td>18/37</td>
<td>49</td>
<td>33/37</td>
<td>89</td>
</tr>
<tr>
<td>References NPSA Bedrail materials</td>
<td>N/A</td>
<td>N/A</td>
<td>26/37</td>
<td>70</td>
</tr>
<tr>
<td>Uses the NPSA model bedrail policy</td>
<td>N/A</td>
<td>N/A</td>
<td>19/37</td>
<td>51</td>
</tr>
<tr>
<td>Gives any advice on capacity and consent</td>
<td>6/37</td>
<td>16</td>
<td>26/37</td>
<td>70</td>
</tr>
<tr>
<td>Includes incorrect advice</td>
<td>3/37</td>
<td>8</td>
<td>3/37</td>
<td>8</td>
</tr>
<tr>
<td>Gives indications for bedrail use</td>
<td>12/37</td>
<td>32</td>
<td>30/37</td>
<td>81</td>
</tr>
<tr>
<td>Advice on how to avoid bedrail entrapment</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Some (e.g. avoid gaps that could entrap neck or chest)</td>
<td>11/37</td>
<td>30</td>
<td>11/37</td>
<td>30</td>
</tr>
<tr>
<td>Specific (mm or cm)</td>
<td>2/37</td>
<td>5</td>
<td>17/37</td>
<td>46</td>
</tr>
</tbody>
</table>
National Audit of Falls and Bone Health [8, 9]. These audits specifically asked trusts to provide details of local in-patient falls prevention policies, including whether they included assessment for the use of bedrails and, latterly, if these local policies were based on ‘Slips trips and falls in hospital’. The RCP reports would also have been an influence on the observed increase in trusts with inpatient falls prevention policies, and additionally may have reinforced the influence of the NPSA publications by basing audit standards on them, but it is not possible to establish the relative influence of the NPSA and RCP publications.

The use of unreferenced apparently ‘home made’ numerical falls risk assessment tools reduced from around 50% of policies in 2006 to around 19% of policies in 2009. Influences on changes in policy are usually multiple and complex, and the recommendation within ‘Slips trips and falls in hospital’—that a numerical falls risk assessment tool was not an essential part of a falls prevention policy, but that if used it must be a validated tool—is unlikely to have been the sole influence on these changes. Further academic reviews of numerical risk assessment tools published between 2006 and 2009 [10, 11] may also have been an influence. However, debates with local policy leaders suggested this recommendation within ‘Slips trips and falls in hospital’ had ‘given them permission’ to translate the academic evidence into practice, and it was directly referenced in 49% of them, suggesting it was a key influencing factor.

Advice on clinical checks after a fall was available in 19% of trusts in 2006 and this increased to 51% by 2009. Although this indicates marked progress, this would still mean around half of the trusts gave staff no guidance on how to detect and treat injury sustained in inpatient falls in 2009, a situation that may have subsequently improved after the release of the NPSA Rapid Response Report ‘Essential care after an inpatient fall’ [12] published in early 2011.

The proportion of trusts with a bedrail policy rose from 49 to 89%. More importantly, some of the key recommendations within ‘Using bedrails safely and effectively’ were reflected in policy content. These included providing advice on capacity and consent, which increased from 16% of trusts in 2006 (half of which gave incorrect advice) to 70% of trusts in 2009, although this is likely also to have been influenced by the Mental Capacity Act of 2005 [13]. Changes also occurred in the inclusion of indications (rather than solely contraindications) for bedrail use, which rose from 32 to 81%.

In 2006, only 5% of trust policies provided specific guidance on bedrail dimensions to avoid asphyxial entrapment, despite repeated alerts from the Medicines and Healthcare products Regulatory Agency (MHRA) over the previous decade. Alongside the NPSA Safer Practice Notice, further MHRA guidance on avoiding bedrail entrapment was issued in late 2006 [14] and early 2007 [15]. By 2009, 46% of trust policies included specific guidance on dimensions (e.g. ensure a gap of <6 cm or more than 25 cm between the end of the rail and the head of the bed). Fatalities from bedrail entrapment in hospitals are very rare but highly preventable events (reflected in them being identified as a ‘never event’ in England [16]) and so the remaining lack of clear and specific guidance on how to prevent this in more than half the trusts studied is very concerning.

<table>
<thead>
<tr>
<th>2006</th>
<th>2009</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trust has an inpatient falls prevention policy</td>
<td>90%</td>
</tr>
<tr>
<td>Trust uses a locally devised numerical falls risk tool</td>
<td>50%</td>
</tr>
<tr>
<td>Trust provides advice on clinical care after a fall</td>
<td>40%</td>
</tr>
<tr>
<td>Trust has a bedrail policy</td>
<td>50%</td>
</tr>
<tr>
<td>Trust gives advice on capacity and consent for bedrails</td>
<td>10%</td>
</tr>
<tr>
<td>Gives indications for bedrail use</td>
<td>30%</td>
</tr>
<tr>
<td>Gives specific advice on avoiding entrapment in bedrails (mm or cm)</td>
<td>20%</td>
</tr>
</tbody>
</table>

Figure 1. Comparison of key content of falls prevention and bedrail policies in use in England and Wales during 2006 and 2009.

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Provision of local policies for inpatient falls prevention
for falls in care setting [17] will collect data from around 50
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bedrail use in England and Wales, but more remains to be
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actually under-represent the true situation.
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the sample may not be fully representative. Complex topics
like falls may be covered by multiple policies and protocols
(for example, separate policies for environmental hazard as-
assessment or additional protocols in departments or divi-
sions) and there was no way of determining if trusts had
sent all relevant documents, so the provided policies may
actually under-represent the true situation.

The policy survey had limitations. Thirteen trusts (26%)
failed to respond within required timescales, and therefore
the sample may not be fully representative. Complex topics
like falls may be covered by multiple policies and protocols
(for example, separate policies for environmental hazard as-
assessment or additional protocols in departments or divi-
sions) and there was no way of determining if trusts had

Overall, this study indicated marked improvements in
some aspects of policies for inpatient falls prevention and
bedrail use in England and Wales, but more remains to be
done. A forthcoming pilot of a proposed new National Audit
for falls in care setting [17] will collect data from around 50
acute hospitals, community hospitals and mental health units
in the UK through methods including policy review; case note
audit and bedside observation. The results of the pilot are
expected in May 2012, and should provide a new baseline for
future priorities for improvements in local policy and practice.

Key points

• Provision of local policies for inpatient falls prevention
and bedrail use increased markedly between 2006 and
2009.
• In this period, the inclusion of key content within the pol-
ices also improved.
• Further improvement is needed, as around half of all
trusts did not provide guidance on clinical care after a fall
or on avoidance of bedrail entrapment by 2009.

Conflicts of interest

None declared.

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The lead author was employed by the NPSA at the time of
this study, which was undertaken as part of her doctoral
thesis. The NPSA played no role in the design, execution,
data analysis or writing of this study.

Supplementary data

Supplementary data mentioned in the text is available to
subscribers in Age and Ageing online.