RIDDOR Guidance
For Patient/Service User Falls

A fall is reportable under RIDDOR when the fall has arisen out of or in connection with a work activity. This includes where equipment or the work environment (including how and where work is carried out, organised or supervised) are involved. Below are some examples of how the principle of out of or in connection with work can apply and where it is not applicable. If in doubt contact the health and safety team using the healthandsafety.service@nhslothian.scot.nhs.uk

Reportable

- A confused patient falls from a hospital window on an upper floor and is badly injured.
- A patient/service user falls in the lounge area, there is previous history of fall incidents, but reasonably practicable measures to reduce the risks have not been put in place.
- A patient/service user falls out of bed, is injured and taken to hospital. The assessment had identified the need for bedrails but they, or other preventative measures, had not been provided.
- A patient/service user trips over a loose or damaged carpet in the hallway.

Not reportable

- A patient/service user falls and breaks a leg. The individual was identified as not requiring special supervision or falls prevention equipment. There are no slips or trips obstructions or defects in the premises or environment, nor any other contributory factors.
- Patient/Service user falls out of bed and is taken to hospital. There was a detailed assessment in the care plan that identified that fall protection was not required.
- A patient/service user is found on the floor, no one has seen it happen, and/or there are no obvious work-related contributing factors. There was a detailed assessment in the care plan, which identified that fall protection was not required.

In some circumstances it may not be clear whether the accident that caused the injury arose out of, or was connected to the work activity.

Example 1: A patient/service user (who is capable of understanding and following advice) falls off the toilet having previously been advised not to get up, is injured and is taken to hospital. They have been left for dignity reasons. Their care plan identified that the individual should have assistance or supervision.

Reportable

- The member of staff left the service user out of earshot and without a call bell they could use, or had not responded promptly when they did call, as adequate supervision had not been provided.

Not reportable

- The member of staff returned to help them as soon as they called to say they have finished. Or if the service user had got up without calling for help it would not be reportable.

Example 2: An incontinent patient/service user slips on their own urine when returning back from the toilet and receives a major injury.

Reportable if:

Assessment had identified the patient/service user required assistance for toileting and it was not provided; the fall occurred in an area of the ward/nursing/care home where it was foreseeable that a patient/service user/resident may slip due to a spillage and the home had failed to assess risks from floor surfaces or act on their own assessment.

** The above guidance was extrapolated from the HSE Health and Social Care RIDDOR Health Services Information Sheet No 1 (Revision 3)*