Falls Prevention

Patient falls in hospitals are among the most frequently reported incidents, and may result in fractures, soft-tissue injuries, lacerations or internal bleeding. These events can prolong hospitalization, require rehabilitation, increase health care costs and severely affect a patient's quality of life.[i]

Despite great effort, patient fall rates across the U.S. continue to escalate, putting patients and caregivers at increased risk. The challenge remains for creating an environment in which patients are safe from falling.

Impact of Patient Falls

- Up to 50 percent of hospitalized patients are at risk for falls.
- Almost half of those who fall, suffer an injury.
- Patients who fall experience an increased hospital stay of 12.3 days on average.
- Injuries from falls lead to a 61 percent increase in patient-care costs.[i]

Defining and Measuring Falls

Successful performance improvement projects follow the basic principle, "If you cannot measure it, you cannot improve it." The Health Research & Educational Trust defines a patient fall as *an unplanned descent to the floor that results with or without injury to the patient.*

For the HIIN project falls measure description, please refer to the Encyclopedia of Measures

In an effort to increase consistency of reporting within hospitals, and as a Hospital Improvement Innovation Network cohort, the National Quality Forum Fall Injury Level Guidelines and HIIN Falls with Injury Measure are listed below.

None	Minor	Moderate	Major	Death
patient had no injuries (no signs or symptoms) resulting from the fall; if an x-ray, CT scan or other post fall evaluation results in a finding of no injury	fall resulting in application of a dressing, ice, cleaning of a wound, limb elevation, topical medication, pain, bruise or abrasion	fall resulting in suturing, application of steri-strips/skin glue, splinting or muscle/joint strain	fall resulting in surgery, casting, traction, required consultaion for neurological (basilar skull fracture, small subdural hematoma) or internal injury (rib fracture, small liver laceration) or patients with coagulopathy who receive blood products as a result of a fall	the patient died as a result of injuries sustained from the fall (not from physiologic events causing the fall)

Source: NQF Injury Guidelines (National Quality Forum, 2015)

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Key Strategies to Falls Prevention[iii,iv]

In developing a falls prevention program, it is helpful to remember that some interventions should be highly standardized and made routine, yet other aspects must be individualized to each patient.[iii] Key strategies to include in a falls prevention program are:

Communication strategies: How do we communicate about safety every day, during every shift, with every patient?

- use one-on-one "teach-back" for the patient and family
- purposeful, hourly rounding to assess and address patient needs for pain relief, toileting and positioning
- implement shift huddles to communicate and identify patients at high risk of falling

Interdisciplinary engagement: How can we leverage expertise and utilization of time and resources?

- develop individualized plans of care
- conduct post-fall management analysis — involve staff from all levels and, if possible, the patient and family
- develop multidisciplinary patient mobility programs

Patient and family engagement: How can patients and families maintain safety, both in the health care facility and at home?

- ensure patients and families understand the patients fall risk, and the care plan to reduce risk of falls
- identify aspects of the care plan that the patient and family can help implement
- provide the patient and family written instructions/information on falls prevention to help augment verbal instructions

Why do patients fall?
The Joint Commission identifies the following factors as contributors to patient falls.[iii]

- Inadequate assessment
- Communication failures
- Lack of adherence to protocols and safety practices
- Inadequate staff orientation, supervision and staffing levels physical environment deficiencies

Hot Off the Press!

HRET HIIN recently hosted a Falls virtual event, "Goodbye Bundle, Hello Care Plan." Megan Duckworth, from Brigham and Women's Hospital, shared a Fall TIPS© (Tailoring Interventions for Patient Safety) tool which combines risk assessment and falls care planning, and is used at patient bedside. Using the tool, the organization has reported a 46 percent decrease in injurious falls. The webinar will be available on the HRET HIIN website by the end of this month. In the meantime, feel free to review and use the TIPS toolkit, research article and TIPS tool shared on the webinar.

HRET HIIN Resources:

- Falls with Injury change package
- Teach-Back Tool for Falls Prevention
- Teach-Back for Falls Safety webinar
- Falls with Injury top-10 checklist
- Training resource webinar
- Preventing Falls in the Bathroom
- Bedside Commode Fall Safety

Additional Resources:
TJC's Sentinel Event Alert — *Preventing Falls and Fall-Related Injuries in Health Care Facilities*
TJC Speak Up: Reduce Your Risk of Falling
University of Nebraska Medical Center — CAPTURE Falls
Agency for Healthcare Research and Quality — Preventing Falls in Hospitals: A Toolkit for Improving Quality of Care
St. Luke's Health System: "Call Don't Fall"
Bed Alarm Algorithm

References

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[iii]Williams, A. & Downing, D. (2014). *Falls prevention toolkit: Strategies for streamlined communication, interdisciplinary scope, and patient and family engagement.* Missouri Hospital Association. Retrieved from http://web.mhanet.com/Falls_Resource_Toolkit_0215_1.pdf

[iv]Ganz, D., Huang, C., Saliba, D., et al. (2013, January). *Preventing falls in hospitals: A toolkit for improving quality of care.* Rockville, MD: Agency for Healthcare Research and Quality. Retrieved from https://www.ahrq.gov/sites/default/files/publications/files/fallpxtoolkit.pdf