Falls Prevention
Establish standard approaches to adverse events from falls (a Centers for Medicare & Medicaid Services "never event").

Domain

Processes to Support Care:
Processes that are essential to support and maintain the delivery of care to all types of patients, across all units and settings in the hospital

Aims

Safe:
Delivery of care in a manner that minimizes any risk of harm to a patient

Process Attributes

Cost to Implement
The monetary resources required to implement this process

Moderate: In addition to the improvement effort, relies on additional personnel and/or technology

Time to Implement
The amount of time, from months to years, it will take on average to establish this process

1 to 2 years

Difficulty to Implement
The challenges of implementing this process

Most Challenging: Involves multiple units or disciplines AND requires a substantial shift in culture and/or operations

Level of Evidence
The degree to which the actions in this process are supported by research and experience; based on the Cochrane scale

Some Evidence: Level III — Studies published with some control included
Details

Elements

• Assess risk of falling and risk for a serious or major injury from a fall
  • Perform standardized fall risk assessment for all patients on admission and whenever patients' clinical status changes.
  • Identify at every shift the patients most at risk of moderate to serious injury from a fall.

• Communicate and educate about patients' fall risk
  • Communicate to all staff information regarding patients who are at risk of falling and at risk of sustaining a fall-related injury.
  • Educate the patient and family members about risk of injury from a fall and about what they can do to help prevent a fall.

• Standardize interventions for patients at risk for falling
  • Implement both hospital-wide and patient-level improvements to the patient care environment to prevent falls and reduce severity of injury from falls.
  • Perform hourly or two hour intentional rounding to assess and address patient's needs for pain, toilet, position, personal belongings and safe pathway. Use language aids such as cards and other devices for patients with limited English proficiency because professional interpreter services are likely to be unavailable.

• Customize interventions for patients at highest risk of a serious or major fall-related injury
  • Increase the intensity and frequency of observation.
  • Make environmental adaptations and provide personal devices to reduce risk.
  • Target interventions to reduce the side effects of medications.

Outcomes

• Mortality (HSMR): Decreased mortality (hospital standardized mortality ratio, or HSMR)
• Harm: Decreased harm to patient (e.g., Harms per 100 patient days, as measured by the IHI Global Trigger Tool)
• Patient Satisfaction: Increased patient satisfaction (e.g., HCAHPS Willingness to Recommend, HCAHPS Hospital Rating)
• Cost of Care: Decreased cost per inpatient case

Service Lines and Critical Functions

• Applies in All Patient Settings
• Nursing

Key Measures

• Incidents of Serious Patient Injury from Falls
  Incidents of serious patient injury from falls (moderate or higher) are reduced to one or less per 10,000 patient days or .1 per 1000 patient days.

Reasons and Implications

Importance for Patients and Families
In hospitals, patient falls are a leading cause of death in people ages 65 or older. Falls also cause many unintended injuries. With the right interventions and proper communication with patients and families, both can be prevented.

Requirement, Standards, Policies, and Guidelines

• Agency for Healthcare Research and Quality (AHRQ) Patient Safety Indicators Overview.
• Centers for Medicare & Medicaid Services (CMS) CMS Hospital Acquired Conditions
• National Quality Forum (NQF)
  • NQF Never Events
  • Safe Practice for Better Healthcare—2009 Update Safe Practice 33: Falls Prevention

• US Department of Health and Human Services, The Office of Minority Research National Standards on Culturally and Linguistically Appropriate Services (CLAS)
Financial Implications

- Expense reduction can occur due to decrease in cost of care for patients who have fallen and decrease in litigation expenses.  
- Expense increase can occur due to purchase of equipment.

Prerequisites

- Intentional rounding
- Purchase of equipment

Resources

Additional Resources

- The Joint Commission (TJC)
  Link to Sentinel Event Alert - Fatal Falls: Lessons for the Future

- American Hospital Association (AHA)
  Hospitals in Pursuit of Excellence – Individual Case Studies
  Empowering Nurses to Reduce Falls
  Southeastern Regional Medical Center

- American Hospital Association (AHA)
  Hospitals in Pursuit of Excellence – Individual Case Studies
  Call to Stop a Fall
  Bronson Methodist Hospital

- American Hospital Association (AHA)
  Hospitals in Pursuit of Excellence – Individual Case Studies
  Focusing on Patients to Reduce Falls Should be Falls
  Gunderson Lutheran Health System

- Agency for Healthcare Research and Quality (AHRQ)
  Chapter 26. Prevention of Falls in Hospitalized and Institutionalized Older People

- Massachusetts Hospitals
  PatientsCare Link, Patient Falls

- Centers for Medicare & Medicaid Services (CMS)
  Never Event
  Eliminating Serious, Preventable, and Costly Medical Errors

- Department of Veterans Affairs (VA)
  VA National Patient Safety Center Falls Prevention Toolkit

- ECRI Institute
  ECRI Falls Prevention Resources

- American Hospital Association (AHA)
  Hospitals in Pursuit of Excellence – Individual Case Studies
  Reducing Falls
  Mercy Health Center

- Agency for Healthcare Research and Quality (AHRQ)
  Patient Safety and Quality: An Evidence-Based Handbook for Nurses [2008]
  Chapter 10. Fall and Injury Prevention

- US Department of Health and Human Services
  Partnership for Patients

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