Field Guide: *Falls*

### Definition and Harm Impact

A patient fall is an unplanned descent to the floor with or without injury to the patient. This include falls when a patient lands on a surface where you would not expect to find a patient. Both unassisted and assisted falls are to be included when determining the number of falls, whether they result from physiological reasons (fainting) or environmental reasons (slippery floor).\(^1\) Falls are the number one reported adverse event for adults in the inpatient setting. It is estimated that more than 700,000 to 1 million individuals fall each year in the hospital, and up to one-third of these falls are preventable.\(^2\) In older adults, aged 65 or greater, falls are the leading cause of injury-related death, non-fatal injuries, and hospital admissions for trauma. Falls are associated with increased length of stay, increased healthcare utilization, poorer health outcomes, and increased costs.\(^3\) The Centers for Disease Control and Prevention (CDC) notes that about 2.8 million older adults are treated in emergency departments each year for injuries caused by falling, and more than 800,000 are hospitalized because of the injury.\(^4\)

### Measurement

The Hospital Improvement Innovation Network (HIIN) goal for reduction in falls with injury is a 20 percent reduction from baseline rates (2014). Falls with injury are measured as any unplanned descent to the ground which requires medical intervention, and can include scrapes, broken bones, and/or head injuries. Falls with injury are measured as the total number of patient falls with injury level minor or greater (whether or not assisted by staff member) over the number of patient days per 1,000 patient days.

### Known Improvement Strategies

Improvement efforts aimed at proactively addressing toileting needs, standardized approach to risk assessment, and aligning interventions have the greatest success in reducing falls with injury. The Health Research & Education Trust (HRET) created a comprehensive overview of key strategies for reducing falls with injury.\(^5\) Successful strategies in the work toward reducing falls with injury include:

- **Identify patients at higher risk for falling**
  - Use a standardized risk assessment scale, such as the Morse Scale
  - Identify other conditions that place patients at higher risk for falling such as the ABCS model (age, bones, coagulation, surgical), or patients that present with vague symptomology instead of a specific diagnosis (abdominal pain vs. appendicitis)\(^6\)

- **Standardize and implement interventions based on patient risk for falling**
  - Eliminate environmental hazards such as poor lighting or wet floors
  - Review medications for those at increased risk for injury from falls
  - Address interventions to reduce the extent of injury

- **Engage front-line staff members: unit projects, champions, and awards**
  - Hardwire safety processes, such as safety huddles, post-fall huddles, and bedside handoffs
– Enlist the leadership with focused safety huddles to include at-risk patients
– Recognize limitations of select interventions: bed alarms, sitters, and signage

Engaging Patients and Families

Patients and family members are critical partners in the journey to fall prevention. Enlist patient and family engagement through education of current conditions and falls risks, prevention strategies, and the potential impact of falling. The impact of immobility is important as it relates to possible loss of the patient’s independence, potential for chronic pain, and potential loss of confidence following a fall—particularly in elderly patients. While in the hospital, educate patients and family members on the effect medications may have on their fall risk and activity, encourage early mobility with the support required to keep patients safe, and solicit the voice of patients and family members in developing tools to help them consider potential hazards in their homes. Additional strategies to involve patients and families include:

• Engaging patients in toileting plans.
• Assessing for comprehension of risk with strategies such as “teach back.”
• Addressing health literacy and developing targeted educational materials.
• Keeping the patient front and center, soliciting their concerns during bedside reports.
• Encouraging participation in community-based mobility programs after discharge.

Resources and Guides for Hospitals

• Veterans Administration National Center for Patient Safety—Falls Toolkit. Available at: http://www.patientsafety.va.gov/professionals/onthejob/falls.asp.
• AHRQ Fall Prevention in Hospitals Training Program. Available at: https://www.ahrq.gov/professionals/systems/hospital/fallpxtraining/index.html.
• STEADI (Stop Elderly Accidents, Deaths and Injuries) Toolkit: A Fall Prevention Resource for Health Care Providers. Available at: www.cdc.gov/injury/STEADI.


8 Hoke, Linda, Guarracino, Dana. Beyond socks, signs and alarms: a reflective accountability model for fall prevention. AJNonline. Vol.116, No1, 42-47