Field Guide: Falls with Injury

Definition and Harm Impact

A patient fall is an unplanned descent to the floor with or without injury to the patient. This includes 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. Clinicians have the opportunity and responsibility to use the hospitalization to address potential for falls within the hospital and afterward.\(^4\) Addressing harm from falls aligns with the high-level interventions for Age Friendly Health System 4M framework in the areas of What Matters, Medications, Mentation and Mobility.\(^5,^6\)

Engaging Patients and Families

Patients and family members are critical partners for fall prevention and falls-related injury reduction.

Education points:

- Teach falls prevention and harm reduction strategies (i.e., environment safety scan to address tripping hazards, lighting, and positioning of key items needed regularly).
- Address potential impacts of immobility—loss of muscle mass and strength, loss of independence, potential for chronic pain, and potential loss of confidence following a fall.
- Address fear of falling, which can result in decreased mobility and impaired cognition over time.\(^7\)
- Identify the effect medications may have on fall risk and activity; encourage early mobility with the support required to keep patients safe; and solicit the voice of patients and family members to partner in mitigating risks in the hospital and their homes.

Patient/Family Engagement Strategies:

- Enlist a patient story that illustrates their personal impact their fall had on mobility and other important matters.
- Keep the patient front and center, soliciting their concerns during beside reports.
- Partner with patients in toileting plans.
- Assess patient and/or family member comprehension of risk with strategies such as “Teach-Back.”
- Address health literacy and develop targeted educational materials.
- Consider use of fall prevention video for risk awareness education.\(^8\)
- Invite a patient family advisor to be a member of the fall/mobility multidisciplinary improvement team.
- Encouraging participation in community-based mobility programs after discharge.\(^9\)
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. Successful strategies in the work toward reducing falls with injury include:

- Identify patients at higher risk for falling with a standardized fall risk assessment scale
  - Identify conditions that place patients at higher risk for falling such as the ABCS model (age, bones, coagulation, surgical), or patients who present with vague symptomology instead of a specific diagnosis (abdominal pain vs. appendicitis).10
  - Consider assessment of high-risk factors specific to the emergency-department population.11
  - Assess for delirium throughout the entire hospitalization.12
- Standardize and implement interventions based on patient risk for falling13
  - Implement tools that integrate formal risk assessment and tailored interventions.14,15
  - Eliminate environmental hazards such as poor lighting or wet floors.
  - Review medications for those at increased risk for injury from falls.16
- 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 signage17
  - Incorporate reflective practice to take next step in fall prevention.18

Measurement

The Hospital Improvement Innovation Network (HIIN) goal for reduction in falls with injury is a 20 percent reduction from baseline rates (2014).

Two outcome measures are being reported: The self-reported 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. Also being measured is Number of Medicare beneficiaries with a diagnosis of a fall or fall-related injury indicated as not present on admission over the Number of Medicare beneficiaries who were admitted to a hospital with any diagnosis multiplied by 1,000.

The process measure requested is assessment of fall risk within 24 hours of admission with the denominator of all patient admissions over 18 years of age.

Resources and Guides for Hospitals


• Veterans Administration National Center for Patient Safety—Falls Toolkit. Available at: https://www.patientsafety.va.gov/professionals/onthefjob/falls.asp.

• Centers for Disease Control and Prevention (CDC)—STEADI (Stop Elderly Accidents, Deaths and Injuries) Toolkit: A Fall Prevention Resource for Health Care Providers. Available at: https://www.cdc.gov/steadi/.


9 Elliott S, Leland NE. Occupational Therapy Fall Prevention Interventions for Community-Dwelling Older Adults: A Systematic Review. The American Journal of Occupational Therapy, July/August 2018, Volume 72, Number 4.


