# SAFETY/QUALITY

## Patient Falls

Falls resulting in injury or harm to patients are a prevalent patient safety problem. Patients who are frail and elderly with obvious fall risk factors are not the only population of patients that are vulnerable to fall in health care settings. A patient of any age or physical ability can be a fall risk due to physiological changes with medical condition, medications, surgery, procedures, or diagnostic testing which can leave them confused or weakened.

- Every year in America, 700,000 to 1,000,000 patients fall in health care settings (Agency for Healthcare Research and Quality, 2013) and as much as 50% of those result in injury or harm to the patient (The Joint Commission on Accreditation of Health Care Organizations, 2015).
- The average cost for a fall with injury is in the range of $14,000. This is often due to an extended hospital stay which on average is approximately 6.3 additional days (The Joint Commission on Accreditation of Health Care Organizations, 2015).

### The Joint Commission Sentinel Event Database supports the most common contributing factors to be:

1. Inadequate assessment and recognition of fall risk by care providers
2. Communication or handoff failures between providers
3. Lack of adherence to protocols and safety practices around fall precautions
4. Inadequate staff orientation, supervision, skill mix or staffing levels
5. Inadequacies in physical environment
6. Lack of leadership

Research supports that one-third of falls can be prevented (Agency for Healthcare Research and Quality, 2013). Centers for Medicare and Medicaid Services (CMS) does not reimburse hospitals for certain types of traumatic injuries that occur to patients while they are in the hospital (Agency for Healthcare Research and Quality, 2013).

A large body of literature exists on fall prevention and reduction. The most successful approaches include the use of a standardized risk assessment tool, objectively evaluating the patient for injury risk factors that have not been captured in the risk assessment tool, as well as interventions designed to mitigate the identified risks (The Joint Commission on Accreditation of Health Care Organizations, 2015).

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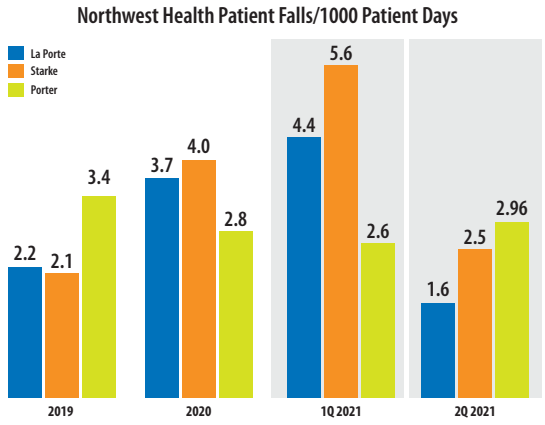


### Best practice strategies utilized at Northwest Health include the following:

- **Organizational focus goal of zero falls and zero harm**
- Universal high risk strategy: yellow gowns, socks, bracelet
- Purposeful hourly rounding for pain, potty, and position
- Fall mats for patients identified on the Morse Fall Scale as being high risk
- Fall huddles to evaluate causation
- RN bedside shift report to inspect room and co-assess that appropriate fall prevention strategies are in place
- Leader fall audits to hardwire compliance with prevention efforts

**Bibliography**

Agency for Healthcare Research and Quality. (2013, January). *Preventing Falls in Hospitals*. Retrieved June 25, 2021, from Agency for Healthcare Research and Quality: **https://www.ahrq.gov/patient-safety/settings/hospital/fall-prevention/toolkit/overview.html#Problem**

The Joint Commission on Accreditation of Health Care Organizations. (2015, September 28). Preventing falls and fall related injuries in health care facilities. *Sentinel Event Alert*, pp. 55,1-5.