Patient Falls Assessment and Prevention

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What is a patient fall?

A fall is an unexpected change in position that causes a person to land on an object, on the floor, or the ground. A fall can happen when other people are present or when no one is there to see it. Many healthcare professionals are under the mistaken impression that if they intervene when a patient is falling and assist the patient to the floor, that this is not a fall. This is a mistaken impression; a fall has occurred. It is classified as an “assisted fall.”

Falls are a serious healthcare issue and can cause injury and even death. However, many falls are preventable.

An international healthcare issue

The U.S. Centers for Disease Control and Prevention (CDC) has identified fall-related injuries as a serious healthcare issue for the elderly,¹ and research in other countries confirms that falls among elderly patients are the most common type of patient accident.²

Falls are linked to sentinel events. The Joint Commission states that a sentinel event is an “unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof.”³

• Serious injury specifically includes loss of limb or function.
• The phrase “or the risk thereof” includes any process variation for which a recurrence would carry a significant chance of a serious adverse outcome. This is why root cause analysis (RCA) is recommended after a fall occurs. (See Chapter 7 for more about RCA for patient falls.)

Patients harmed by falls are one of the top sentinel events reported to The Joint Commission in the United States.4

Due to the prevalence of falls in hospitals around the world, the Joint Commission International (JCI), World Health Organization (WHO), and other agencies have made fall prevention a priority in ensuring patient safety. These agencies understand that the stakes are high—a recent WHO report states that the worldwide economic and societal burden of falls are expected to increase by epidemic proportions in the next few decades.5

The JCI does not currently require hospitals to report sentinel events, but addresses patient fall prevention in an International Patient Safety Goal (IPSG). Hospitals must comply with the IPSG in order to become accredited, or stay accredited.

JCI-accredited healthcare organizations are required to use assessment and prevention techniques to reduce the risk of fall-related patient harm, according to the requirements of the IPSG. In addition, organizations are required to implement a fall-reduction program and to evaluate and document the program’s effectiveness.

The JCI’s fall prevention IPSG

Reduce the risk of patient harm resulting from falls.
Assess and periodically reassess each patient’s risk for falling, including potential risks associated with the patient’s medication regimen, and take action to decrease or eliminate any identified risks.6
Risk factors

It is important to understand that all patients are at risk for falls and to identify their level of risk. According to a 2000 Joint Commission sentinel event report, in 22 fatal patient fall cases, history of prior falls, use of sedation, and anticoagulation were frequently associated risk factors. Other risk factors included a recent environmental change and urinary urgency.

For these 22 cases, healthcare organizations identified root causes related to care processes, caregivers, environment of care and organizational culture. More than 50 percent of these organizations identified communication issues among caregivers as root causes. Among these issues were failure to communicate information during nursing report, shift changes or a transfer of care; and changes in patient condition not documented in the medical record.7

As the sentinel event report shows, each patient faces different risks. These risk factors are described in the literature as either intrinsic or extrinsic (see Figure 1.1).

![Figure 1.1: Risk factors]

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Intrinsic factors are integral to the person:

• Physiologic factors
• Psychologic factors
• Effects of medication use
• Past history of falls

Extrinsic are external to the person, such as environmental risks:

• Lighting
• Floor surface
• Amount of clutter
• Arrangement of furniture and other things in the room, etc.

It is recommended that the hospital have universal falls precautions that focus on environmental (extrinsic) factors.

The risk factors cited for sustained injuries resulting from falls include:

• Previous history of falls with fractures
• Sex
• Race
• Body mass index
• Cognitive and balance impairment
• Chronic illness

**Types of falls**

Morse classifies falls as:

• Accidental—a patient trips or some other mishap causes the patient to lose balance
• Anticipated physiologic—a patient is identified at admission to be at risk of falling, and subsequently falls
• Unanticipated physiologic—a patient falls under conditions (such as a seizure or fainting) that couldn’t be predicted
These classifications are extremely important because different factors are in play whenever a patient falls, and although accidents can be avoided, you can never put in preventive measures for falls that are caused by unanticipated physiologic events (see Figure 1.2).

**Challenges to risk assessment**
Risk assessment is challenging because there might be unique characteristics in the population that make the risks vary among different populations as well as the different settings.

A fall scale can help you identify risks that present more danger to patients and prioritize your preventive measures. Figure 1.3 shows some commonly used fall scales. Hospitals are encouraged to contact the developers of these scales to adapt the scale to suit their own patient populations.

**Don’t wait**
Go ahead and try a fall risk assessment tool. Implement interventions to reduce risk.
Below is a selection of fall assessment tools. More resources are available online and from other sources. Note: Falls scales for specific populations and settings are still under development worldwide.

<table>
<thead>
<tr>
<th>Scale name</th>
<th>Assessment items</th>
<th>Rating</th>
<th>Scoring</th>
<th>Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Morse Fall Scale</strong></td>
<td>- History of falling</td>
<td>“yes” or “no”</td>
<td>Individuals are categorized as having “high,”</td>
<td>“Preventing Patient Falls” by Janice Morse, ©1996, Sage Publications, Inc.</td>
</tr>
<tr>
<td></td>
<td>- Secondary diagnosis</td>
<td>answers are</td>
<td>“medium,” or “low” risk of falling</td>
<td><a href="http://www.sagepub.co.uk/books">www.sagepub.co.uk/books</a>: Morse Scale and research are frequently cited worldwide in studies of falls</td>
</tr>
<tr>
<td></td>
<td>- Use of ambulatory aid</td>
<td>assigned points</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Intravenous therapy</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Gait mental status</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Hendrich II Fall Risk Model</strong></td>
<td>- Recent history of falls</td>
<td>“yes” or “no”</td>
<td>Individuals are categorized as high risk or</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Altered elimination (incontinence, nocturia, frequency)</td>
<td>answers are</td>
<td>low risk</td>
<td>AHI P.O. Box 50346 Clayton, MO USA 63105 <a href="mailto:hendj@ahincorp.com">hendj@ahincorp.com</a></td>
</tr>
<tr>
<td></td>
<td>- Confusion/disorientation</td>
<td>assigned points</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Depression</td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td>- Dizziness/vertigo</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>- Poor mobility/generalized weakness</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>- Poor judgment (if not confused)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>STRATIFY</strong></td>
<td>- History of falls</td>
<td>yes” or “no”</td>
<td>Patient fall risk is categorized on a</td>
<td>STRATIFY is frequently cited in other falls research; see <a href="http://www.bmj.com">www.bmj.com</a>, search under “STRATIFY”</td>
</tr>
<tr>
<td></td>
<td>- Mental impairment</td>
<td>answers are</td>
<td>continuum from low risk to high risk</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Visual impairment</td>
<td>assigned points</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>- Toileting</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>- Dependency in transfers and mobility</td>
<td></td>
<td></td>
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<tr>
<td><strong>HUMPTY DUMPTY</strong></td>
<td>- Age</td>
<td>yes” or “no”</td>
<td>low risk/high risk</td>
<td>Miami Children’s Hospital <a href="mailto:bing.wood@mch.com">bing.wood@mch.com</a></td>
</tr>
<tr>
<td></td>
<td>- Gender</td>
<td>answers are</td>
<td></td>
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<td></td>
<td>- Diagnosis</td>
<td>assigned points</td>
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<td></td>
<td>- Cognitive impairments</td>
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<td>- Environmental factors</td>
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<tr>
<td></td>
<td>- Response to surgeries/sedation/anesthesia</td>
<td></td>
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<td></td>
<td>- Medication usage</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>FRAT</strong></td>
<td>- Prior history of falls</td>
<td>values assigned</td>
<td>Fallers/nonfallers</td>
<td>Study information: Journal of Nursing Care Quality, April –June 2007</td>
</tr>
<tr>
<td></td>
<td>- Deconditioning</td>
<td>for muscle strength,</td>
<td></td>
<td><a href="http://www.jncqjournal.com">www.jncqjournal.com</a></td>
</tr>
<tr>
<td></td>
<td>- Impaired physical function</td>
<td>fatigue, and patient answers</td>
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<td></td>
</tr>
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<td></td>
<td>- Use of multiple medications</td>
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</tr>
<tr>
<td></td>
<td>- Age</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Sensory-neurologic deficits (eg, peripheral neuropathy)</td>
<td></td>
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</table>

* Other healthcare professionals use the FRAT (Fall Risk Assessment Tool) acronym; FRAT assessment items and other information above is specific only to the risk assessment tool cited by O’Connell, B. et al., in Risk Items Associated With Patient Falls in Oncology and Medical Settings, Journal of Nursing Care Quality, 2007(22)2, 130–137.
An effective falls program for a hospital must include the entire facility—all populations and all settings. All employees are part of this program—even the housekeepers, who can be on the alert for slippery floors and clutter in rooms.

Fall reduction interventions also require collaborative efforts between multiple types of healthcare workers, including:

- Housekeeping
- Environmental and assistant personnel
- Physicians
- Nurses

Members of the collaborative must establish guidelines with performance goals and data collection to support compliance with JCI requirements.

Note that every organization serves different types of patients, offers different specialty services, and has different staff training needs. This book provides samples of assessment and reassessment tools, monitoring techniques, and training that you may adapt to fit your hospital’s unique needs.

**How to make fall assessment and prevention work**

Designing a fall screening and prevention program with staff input is only the first step. You must also gain staff compliance and buy-in, create staff awareness, train staff, and maintain staff skills and practice. Simply adapting standard interventions (e.g., adding a fall precaution sticker to a patient’s chart) may not be enough to ensure a successful program (see Figure 1.4).

This is where leadership support is essential. The team must be interdisciplinary and there must be a strong communication and education plan.

If you’re developing a falls assessment and prevention program for the first time, study other organizations’ falls history and policies. This can provide insight into your facility’s environment, the assistance your patients require, and the diligence it takes to sustain prevention techniques over time.

Useful resources include the falls benchmark data and Falls Prevention Toolkit developed by the U.S. Department of Veterans Affairs and the National Center for Patient Safety (www.va.gov/ncps/).
As you create and fine-tune your falls policy, keep these goals in mind:

1. Create a practical, achievable policy and procedures.

2. Keep it patient-focused.

3. Above all, keep it as simple as possible. If a falls policy/procedure is too complicated, it will be more difficult to implement and sustain.

An organizational policy is not prescriptive; it is directive and global. An organizational policy must be flexible enough to accommodate more specific policies from other departments.

❑ Policy: In this section you should state that:
  • All patients are part of the fall reduction program
  • All patients will be assessed for risk of falls followed by appropriate interventions.
  • Patients have a right to be cared for within a safe environment

  Example: “It is _________ hospital’s expectation that the falls program is hospitalwide and all employees make falls reduction a priority. Patients have a right to expect a safe environment and freedom from restraints whenever possible.”

Some hospitals have two sections in their falls reduction policy: one for outpatients and one for inpatients. Interventions in outpatient areas include reducing environmental hazards and may also include assessing patients for risk of falls as part of their outpatient visit (depending on the population and setting).

❑ Purpose: The primary purpose of a falls reduction policy is to reduce the number of patient falls, with the premise that fewer falls means fewer fall injuries.

The policy should include definitions for these terms:
  • Fall
  • Repeat Fall
  • Minor Injury
  • Major Injury
Figure 1.4

Issues to consider when you develop your falls reduction policy (cont.)

❑ **Scope of the program:** You can include this in your policy statement or make a separate scope of the program statement. Either way, it must be clear that your falls program is used throughout the hospital. All areas must have a risk assessment with interventions based on the results of that assessment.

  - Admission assessment — needs to be included with your statement of how you will identify patients at risk for falls. This will be included as part of the admission assessment that nursing performs, along with expected timeframe.

  - Reassessments — in the policy, you must also specify when reassessments will occur:
    - When the patient falls
    - On transfer to another unit
    - When the patient’s status changes
    - On a regular basis to be determined by population and setting.

Some hospitals make a flow sheet for the reassessments (using the Morse scale or another scale) to streamline the documentation process. Fall reassessment sheets can be similar to pain flow sheets.

❑ **Plan of care:** JCI requires an individualized plan of care. For patients at risk for falls, there should be an interdisciplinary plan of care that targets the patient’s contributing factors for falls. This includes a medication review, when appropriate.

❑ **Patient education:** Specify what patient education you will provide to the patient/family, when the patient education will be done, and who is responsible for providing it.

Example: “On admission, the admitting nurse will provide the patient with an orientation to the room, the call lights, and orient the patient to our standard fall precautions to minimize the risk of accidental falls.”

Patients who are identified as at risk for falls will have patient education provided in alignment with the patient’s individualized plan of care for falls prevention.

❑ **Competency:** All staff will receive general education on falls prevention and staff providing direct care will receive specific education according to the identified required competencies.
Figure 1.4

Issues to consider when you develop your falls reduction policy (cont.)

Examples:

Housekeepers will receive general education and be tested after training; nurses will receive demonstration on safe transfer techniques and then must be able to demonstrate these techniques.

Nurses will receive competency testing on developing individualized care plans targeted toward the patient’s contributing factors for falls. The competency testing will consist of scenarios by case studies, followed by an evaluation of the nurses’ written care plan.

- **Fall precautions**: The policy needs to state what fall precautions are in place for the identified levels of risk. Some hospitals use a table for this to outline the various settings; other hospitals make general statements that will be applied in all areas and settings.

- **Monitoring**: Results of monitoring are shared with the leadership on a monthly basis, with the purpose of making necessary improvements and ensuring that these results are shared with front line staff.

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Endnotes


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