The Source™

FOR JOINT COMMISSION COMPLIANCE STRATEGIES

Patient Fall Events

Patient falls are historically one of the most frequently reported sentinel events. To help focus necessary attention and resources on this issue, The Joint Commission has recently included falls in its definition of *sentinel event* (as of 2022). Specifically, a patient fall is considered a sentinel event when it results in any of the following:

- Any fracture
- Surgery, casting, or traction
- Required consult/management or comfort care for a neurological (for example, skull fracture, subdural or intracranial hemorrhage) or internal (for example, rib fracture, small liver laceration) injury
- A patient with coagulopathy who receives blood products as a result of the fall
- Death or permanent harm as a result of injuries sustained from the fall (not from physiologic events causing the fall)

Between January 1 and June 30, 2022, The Joint Commission received and reviewed 199 cases of patient falls that met the above criteria.

The Agency for Healthcare Research and Quality (AHRQ) estimates that between 700,000 and 1 million hospitalized patients and approximately half of patients in long-term care facilities experience a fall annually. Ambulatory care organizations may also have increased patient fall risks due to the use of anesthesia

or sedation. Older patients typically have a greater fall risk than younger ones, though age is not the only risk factor. Medications, vision impairment, procedures that involve the legs or arms, tethering to IV poles or other equipment, mobility assistive devices, and novel physical environments can all contribute to a patient's fall risk.

Falls most often occur when the patient is ambulating or toileting or when the patient falls from bed. Resulting injuries vary, but the most common are head trauma and/or bleeding and fractures, most frequently to the hip or leg. All patient falls should be taken seriously, even if no physical injury occurs. Any fall can cause distress and anxiety, not only for the patient but also for their family members and for health care staff providing care. This may, in turn, cause the patient's movement and activity to be restricted, which can negatively affect the patient's physical and mental health.

According to The Joint Commission's Sentinel Event Database, inadequate communication is a leading cause of patient falls. Sometimes, health care providers do not fully communicate a patient's fall risk during transitions of care such as handoffs. Other times, communication does not include critical elements that could indicate a fall risk, such as medications the patient is taking or the patient's use of an assistive device. Inadequate patient education is also a factor in many falls; patients either do not receive or do not understand information on fall risks. Finally, many falls are caused by the organization failing to follow a strong policy on fall prevention.

Strategies for Managing Fall Risks

Certain Joint Commission–accredited organizations are required to assess the fall risk of patients/residents/individuals served and take appropriate actions to prevent falls. This requirement is explicitly outlined in the standards (*see* box at right) for the following settings:

Joint Commission Standards Related to Fall Risk Assessment

CTS.02.03.11, Element of Performance (EP) 5 For organizations that provide 24-hour eating disorders care, treatment, or services: The organization assesses the risk for falls for each individual served. [BHC]

NPSG.09.02.01 Reduce the risk of falls. [ALC, NCC, OME]

EP 1 Assess the [patient's] risk for falls.

EP 2 Implement interventions to reduce falls based on the [patient's] assessed risk.

EP 3 Educate staff on the fall reduction program in time frames determined by the organization.

EP 4 Educate the [patient] and, as needed, the family on any individualized fall reduction strategies.

EP 5 Evaluate the effectiveness of all fall reduction activities, including assessment, interventions, and education.
Note: Examples of outcome indicators to use in the evaluation include decreased number of falls and decreased number of falls with injury.

PC.01.02.08 The [hospital] assesses and manages the patient's risks for falls. [CAH and HAP]

Key: *ALC, assisted living community; BHC, behavioral health care and human services; CAH, critical access hospital; HAP, hospital; NCC, nursing care center; OME, home care.*

- Hospitals and critical access hospitals
- Assisted living communities
- Behavioral health care and human services organizations that provide 24-hour eating disorders care, treatment, or services
- Home care organizations
- Nursing care centers

Fall risk management strategies will vary from one organization to the next, based on the specific risk factors, patient populations, and services provided. There is no "one size fits all" solution. The following evidence-based strategies can guide an organization through the process of identifying the interventions that will best address its unique situation:

- **Develop and implement a strong fall risk management policy.** This document serves several purposes. First, it frames fall prevention as a critical patient safety issue at the organization. It also sets expectations for accountability, implementation, performance measurement, and more. Finally, it standardizes the organization's approach to fall risk management, providing a framework that can be applied to every patient, every time, in every part of the organization. Be sure staff members are familiar with the policy and know the roles they play in implementing it.
- **Assess fall risks organizationwide**. Conduct a risk assessment that considers the organization's processes, physical environments, services provided, and patient populations to identify where and when falls are most likely to occur. These areas can then be prioritized and targeted with appropriate interventions.
- **Assess fall risks for each patient.** Fall risk assessment should be integrated into the organization's regular patient assessment procedures. This is another area where standardization is key. Select a validated tool (such as the Morse Fall Scale or Hendrich II Fall Risk Model) that will be used to assess every patient. This supports consistency and reliability. *See* page 7 for a sample fall risk assessment.
- **Develop individualized interventions.** Use the data collected during the patient assessment to identify patient-specific actions to mitigate fall risk. These might include, but are not limited to, providing nonslip socks, using bed rails, providing assistance with toileting, and lowering the patient's bed. Be sure patients understand what interventions are being used and why, and encourage them to ask questions, seek assistance, communicate concerns, and otherwise engage in their own fall prevention.

- **Reassess fall risks.** A patient's risk of falling will likely change during their health care experience. It is important to periodically reassess fall risks to determine whether interventions should be added, removed, or changed to maintain safety while minimizing restrictions that could have a negative impact on the patient's health and well-being.
- **Standardize communication.** Establish a process for communicating fall risks and relevant interventions during handoffs, shift changes, transfer to another department or area, and other times when there is a change in responsibility for a patient's care. Examples might include using whiteboards to share fall risks with all staff, incorporating alerts or prompts into the electronic medical record, or performing a bedside report during each shift.
- **Collect data on falls.** A post-fall huddle can be an excellent source of data. Talk to staff at all levels as well as the patient, when possible. What happened? What conditions contributed to the fall? What interventions were in place? Should the plan of care change and, if so, how? What can be done to avoid similar incidents and outcomes? Use a standardized script or form to ensure that all factors are considered for each huddle.
- **Use data for improvement.** Analyze fall data from post-fall huddle reports and other sources to identify contributing factors that recur. These factors should then be prioritized for performance improvement. Continue to collect and analyze fall data to evaluate the effectiveness of interventions and sustainability of improvements. TS

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