Academic Medical Center | Patient Safety Organization
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Patient Safety Alert:Patient Falls

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Current peer-reviewed literature has consistently demonstrated that patient falls in clinical settings are commonly reported adverse events. These observations are also reflected in data analyzed by the Academic Medical Center Patient Safety Organization (AMC PSO). Literature has shown that patient falls have also been correlated with increased length of hospital stays, transfers to higher levels of care, discharges to higher levels of skilled nursing facilities (rather than to home), and an overall increase to the cost of care. [30, 32]

In response to this ongoing safety concern, the AMC PSO convened a panel of nursing leaders to review recent trends, evaluate the current literature, and discuss novel interventions aimed at mitigating the risk for this type of adverse event.

Risks

Review and analysis of adverse event data submitted to the AMC PSO helped to offer context to this panel's deliberations. These deliberations attempted to both verify that the known contributing factors of falls are reflected in these data and to cull new and previously unidentified contributing factors of potential falls. Table 1 includes a list of the contributing factors to patient falls identified at this session:

Table 1
• Inadequate patient assessment, specifically related to medication regimens
• Patient assessments not updated following changes in clinical status, including medication regimens
• Fall-mitigation policies and protocols not available or not followed
• Failure to ensure a safe physical environment

These risks are reflected and added to by Huey-Ming Tzeng, PhD, RN in Applied Nursing research, where the contributing factors generated from the analysis of 104 patient falls resulted in the identification of the contributing factors seen in Table 2, among others.[27]

Table 2
• Patient-nurse communication breakdown
• Equipment lines or tubes misplaced
• Patients needed more staff assistance than anticipated
• Patient Fear of negative response from staff
• Bedside rails were down

Risk Mitigation Strategies

Patient falls are occasionally unpreventable, in cases of unanticipated physiological falls, especially, which make up an estimated 8% of falls.[19] However, research has demonstrated that as much as 92% of falls are preventable, with accidental falls making up 14% and anticipated physiological falls making up 78% of the portion.[ibid.] The assembled nursing leaders discussed several strategies to mitigate the risk of preventable patient falls.

STRATEGY HIGHLIGHT: FALL TIPS[6]

The Fall TIPS (Tailoring Interventions for Patient Safety), led by Patricia Dykes, PhD, RN, a senior research scientist at Brigham and Women's Hospital's Center for Patient Safety, Research, and Practice, demonstrated significant preventive potential. The study, among other aims, tested a preventative measure for patient falls. The TIPS program focused on ensuring that all stakeholders involved in the patient's care, including the patient, had open communication and access to relevant information, tailoring each patient's care to his or her specific needs, ongoing surveillance, and leveraging existing workflows, including effective utilization of HIT.

Dr. Dykes' study reported that patients in control and intervention units had similar fall risk scores at admission (49.8 and 48.6 of a possible 0-125; P=.74). There were no differences in length of stay or gender. Also of note, slightly more than half (51.3%) of patients were aged 65 years or older. Results of the study showed that there were fewer patients with falls in intervention units (n=67) than in control units (n=87). In particular, study authors found that patients aged 65 or older benefited most from the Falls Prevention Tool Kit. The authors concluded that implementation of the Falls

Prevention Tool kit "could potentially prevent 1 fall every 4 days, 7.5 falls each month, and about 90 falls each year in the study units alone."[4]

Dr. Dykes and colleagues found that "inadequate communication contributed to incomplete understanding of fall risk status[4] and the fall prevention plan consistent with results previously reported.[27] Specifically, 20% of nurse-generated solutions to prevent patient falls in hospitals relate to inadequate caregiver communication and 13% relate to inadequate assessment and reassessment of fall risk status. While fall risk screening is a common practice in hospitals the use of patient-specific screening results to tailor a prevention plan is less frequent."[2] The Falls Prevention Tool Kit created a standardized approach to communication of risk status and enabled the fall prevention plan to be available at the point of care, the patient's bedside. More detailed information and results from this study can be found here: http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2815501/.

OTHER STRATEGIES FOR REDUCING THE RISK OF PATIENT FALLS

Other peer-reviewed literature has also show that the strategies detailed in Table 3 are correlated with a reduction in patient falls.

Table 3
• Multidisciplinary approaches to fall risk assessments[10]
• Move patients at risk to rooms with best access to nursing station[12]
• Remain with patient while toileting and do not turn the lights off at night [ibid.]
• Establish elimination schedules, including beside commode use, if necessary [ibid.]
• Observe/round every hour [ibid.]

Conclusion

Clearly, patient falls within clinical settings are a persistent issue for providers within diverse clinical domains. Coordinating care, medication, and supervision are critical factors to reducing this type of adverse event. This is especially significant for nursing staff, who are the principal care givers for patients when they fall. The AMC PSO is hopeful that the strategies offered in this alert offer a solid footing on which to begin to reduce falls in your hospitals.

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