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Evidence Based Practices to Reduce Fall Events

September 19, 2024

The Joint Commission

Objectives

- Give original examples of **leveraging data** to drive fall prevention
- Recognize **fall prevention strategies**
- Summarize the **effectiveness of Root Cause Analysis** of Falls and **Action Plans**

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Sentinel Event

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Sentinel Event Definition:

- Sentinel events are a subcategory of adverse events.
- A sentinel event is a **patient safety event** (not primarily related to the natural course of a patient's illness or underlying condition) that reaches a patient and results in **death**, **severe harm** (regardless of duration of harm), or **permanent harm** (regardless of severity of harm).

https://www.jointcommission.org/resources/sentinel-event/sentinel-event-policy-and-procedures/

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Sentinel Event Reporting:

- Each health care organization is **strongly encouraged**, but **not required**, **to report** to The Joint Commission any patient safety event that meets the Joint Commission definition of **sentinel event**
- **Sentinel events** reported to The Joint Commission are **self-reported** by health care organizations that **recognize the value** of **working with the Office of Quality and Patient Safety** (OQPS) staff

https://www.jointcommission.org/resources/sentinel-event/sentinel-event-policy-and-procedures/

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Sentinel Event Data Trends

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Sentinel Event Data Trends

Data date range 1/1/2013 through 7/2/2024

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Sentinel Event Category: Falls

- **Fall** in a staffed-around-the-clock care setting or fall in a care setting not staffed around the clock during a time when staff are present resulting 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)

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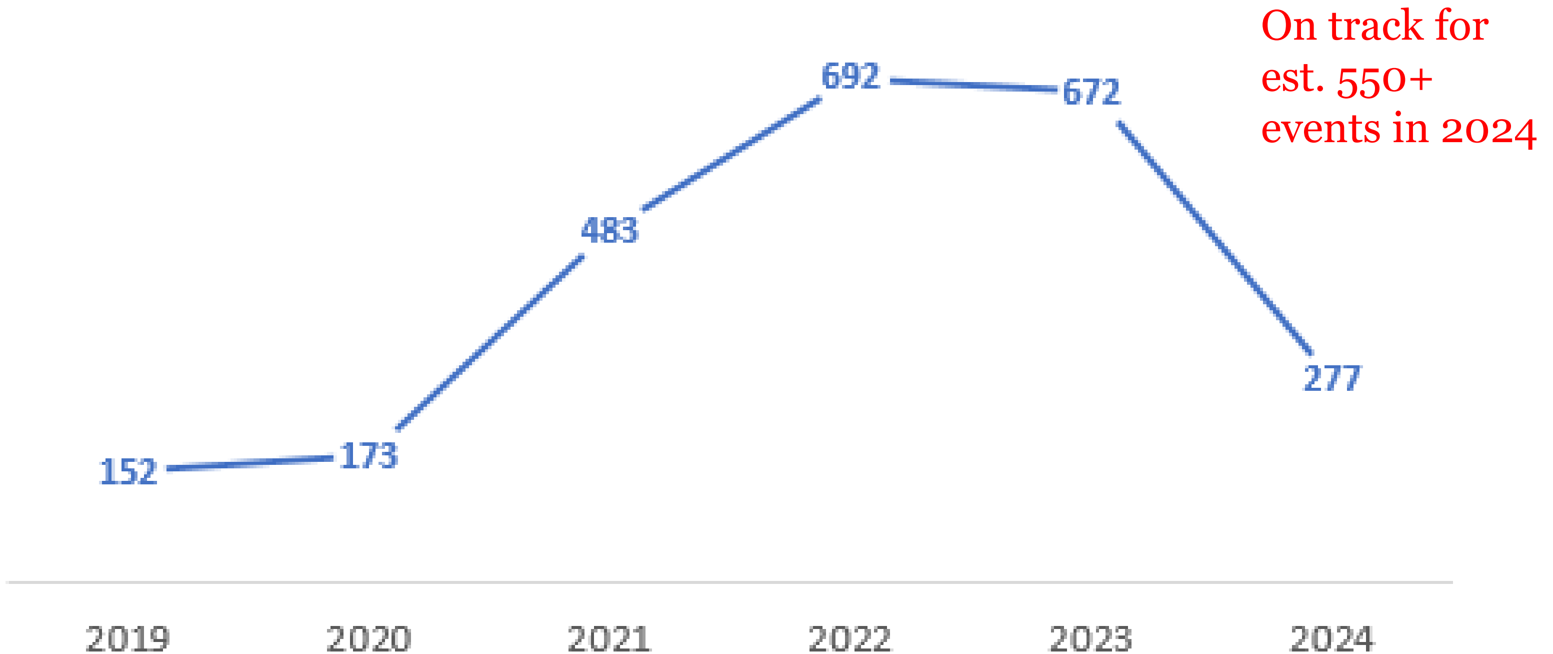
Sentinel Event Fall Data Trends



On track for est. 550+ events in 2024

Data date range 1/1/2019 through 7/2/2024

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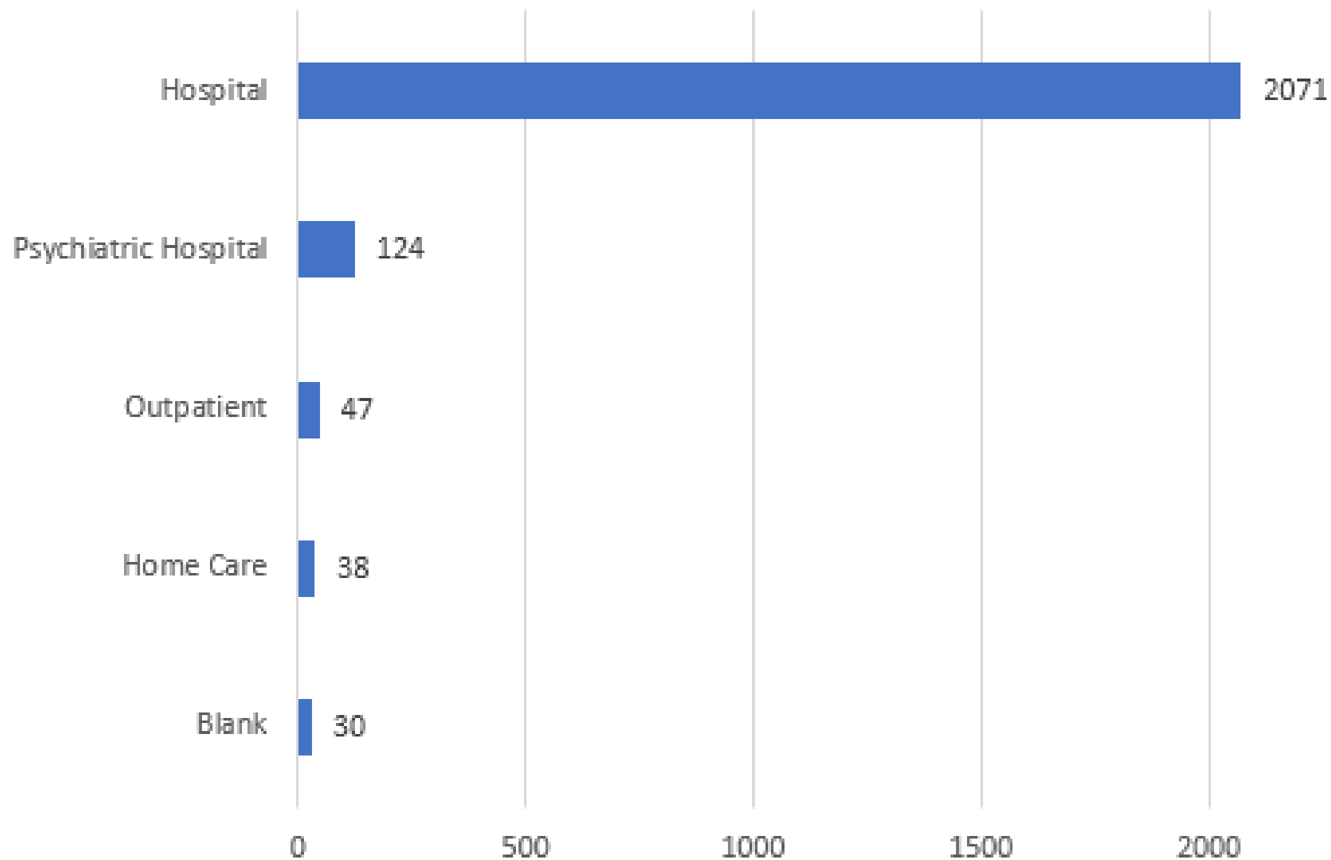
Sentinel Event Fall Data Setting Trends



Data date range 1/1/2019 through 7/2/2024

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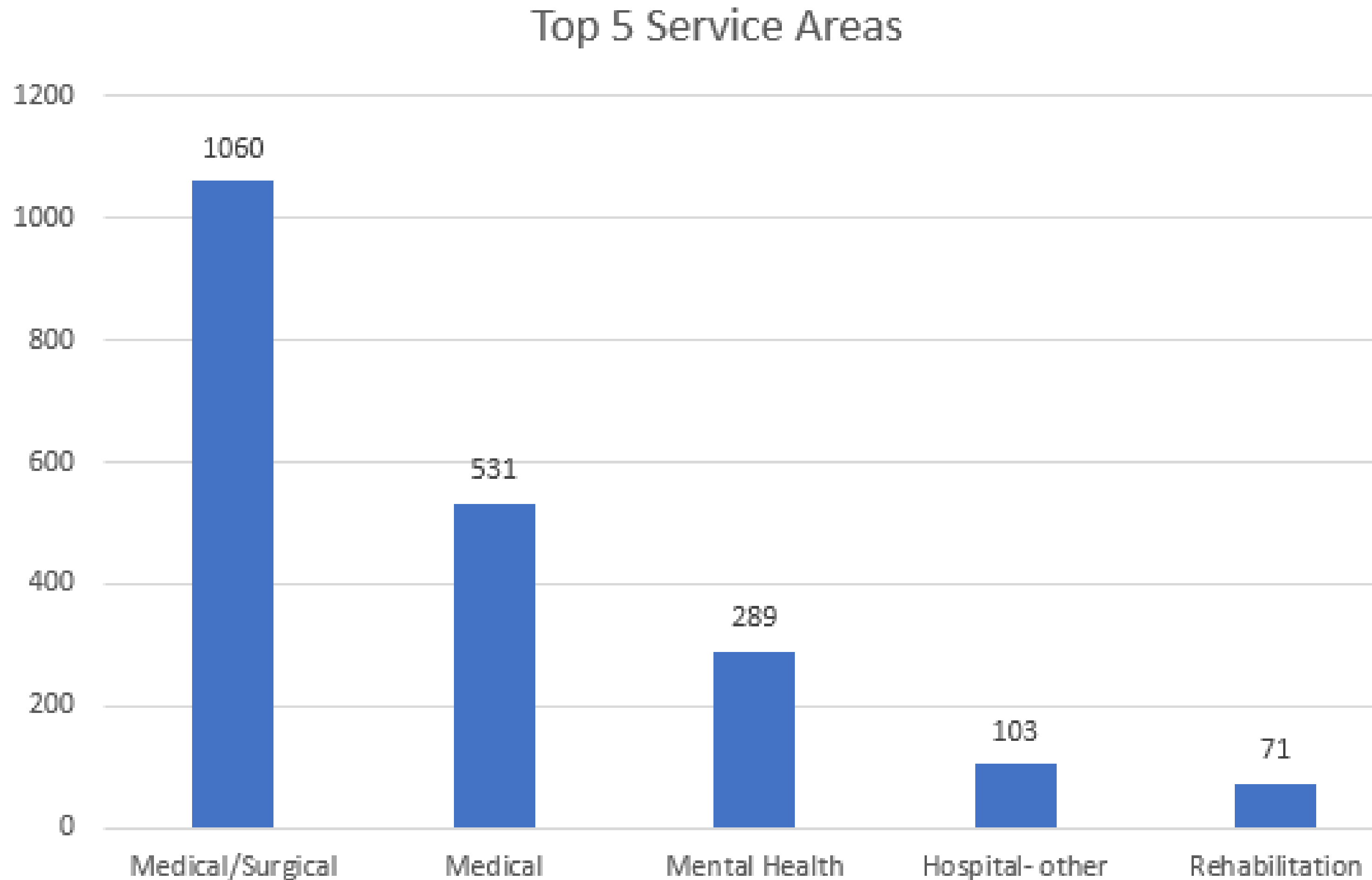
Sentinel Event Fall Data Trends by Service Area



Data date range 1/1/2019 through 7/2/2024

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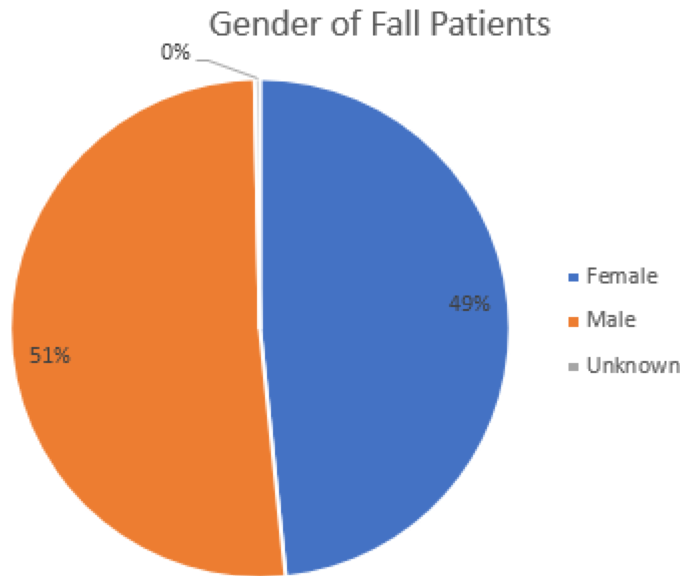
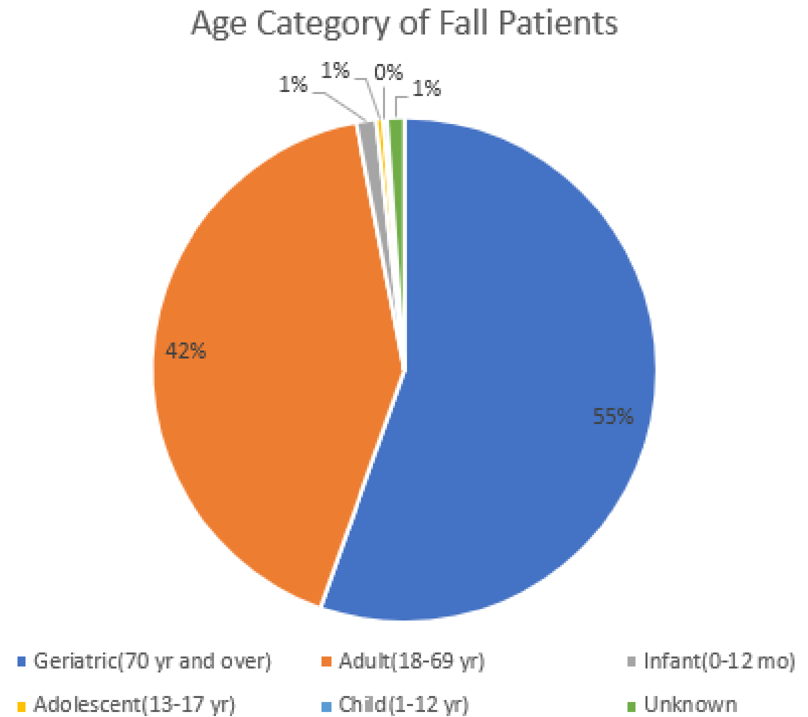
Sentinel Event Fall Data Trends by Patient Details





Data date range 1/1/2019 through 7/2/2024

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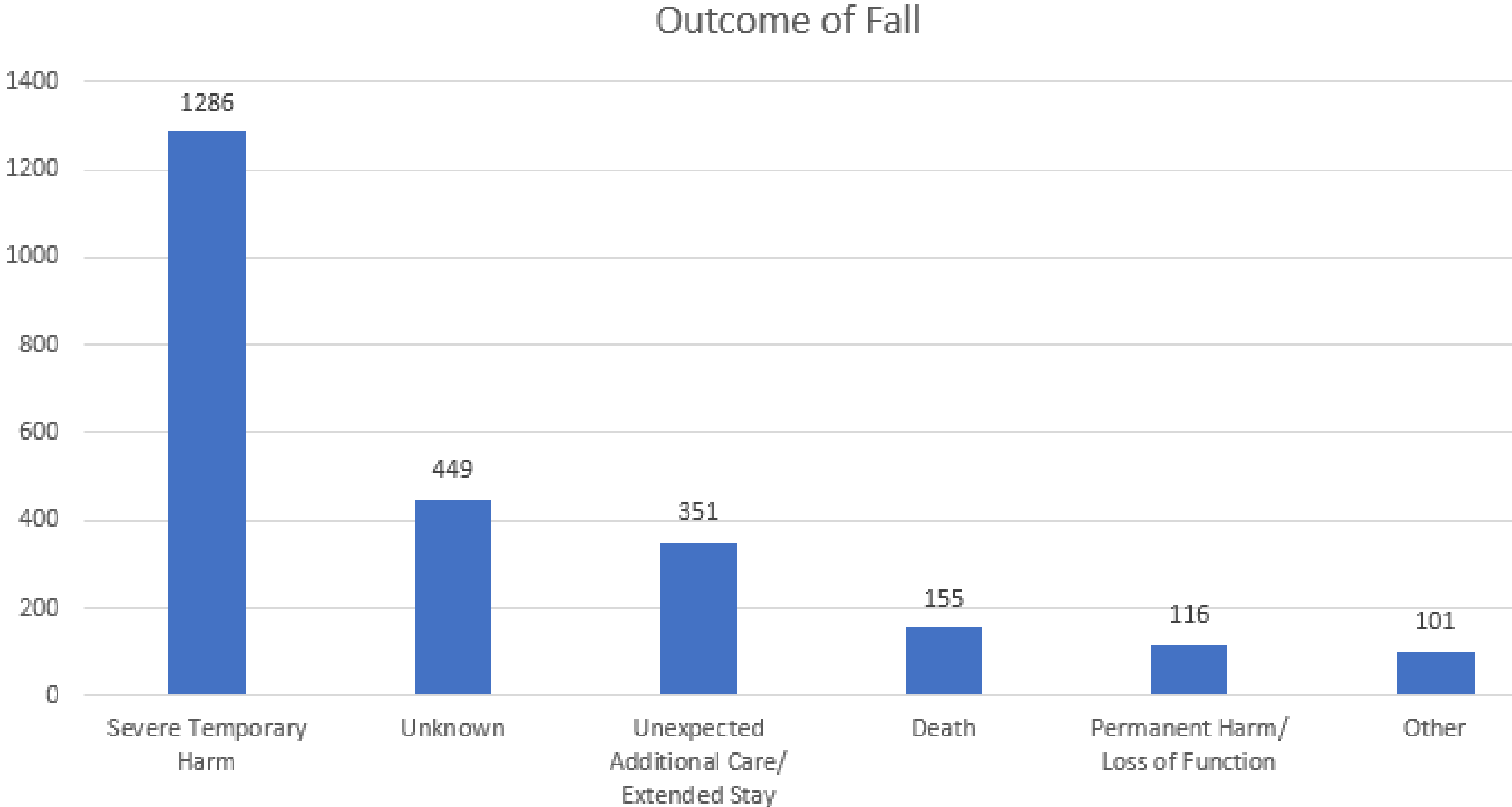
Sentinel Event Fall Data Trends by Outcomes



Data date range 1/1/2019 through 7/2/2024

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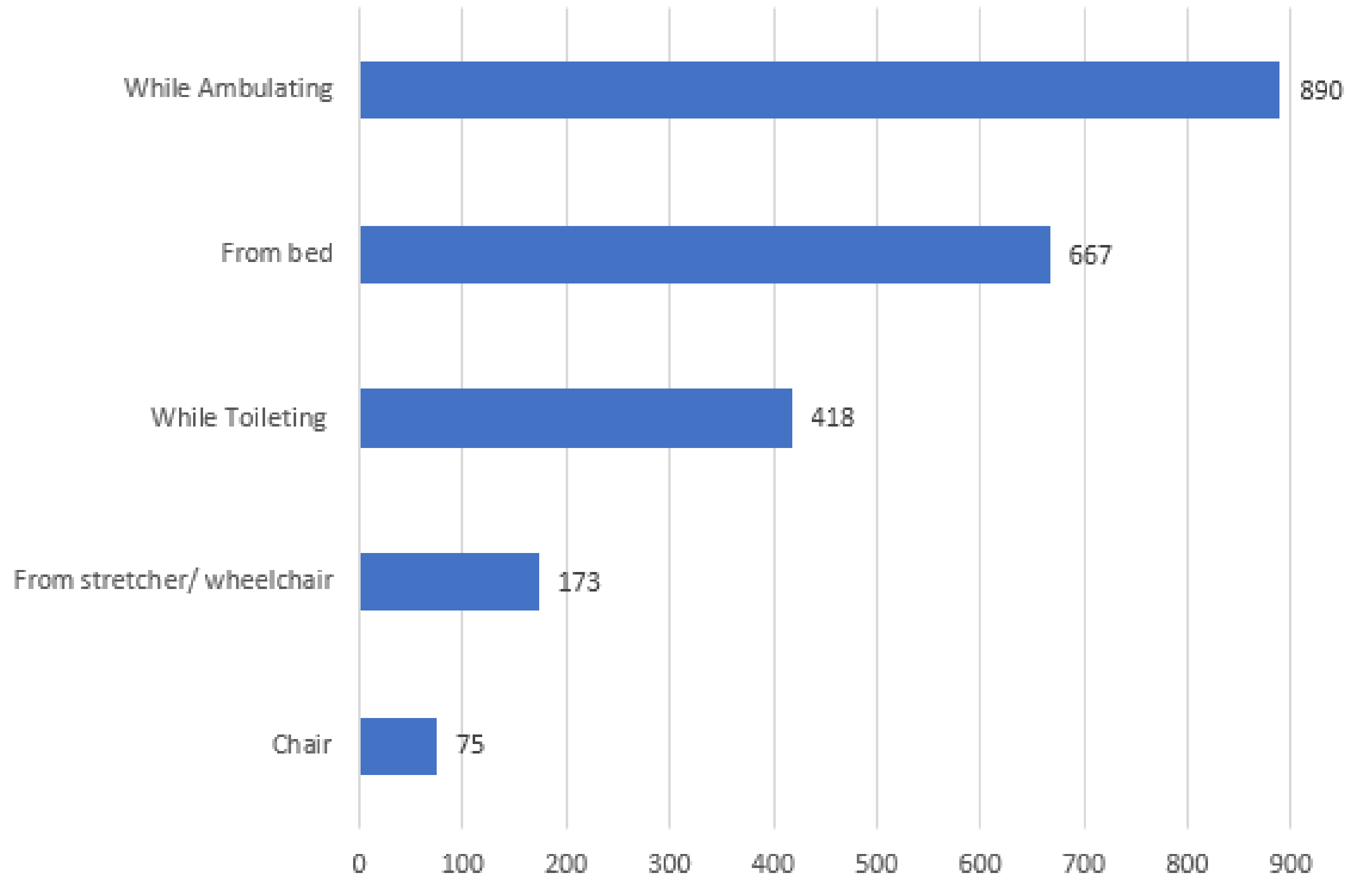
Sentinel Event Fall Data Trends by Event Details



Data date range 1/1/2019 through 7/2/2024

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Sentinel Event Fall Data Trends: "The Story"

- **Fall** reporting **increased during 2021** potentially due to the addition of Falls line item in Sentinel event policy and **continues to remain elevated,** including 2024
- **Hospital medical surgical units** are where the majority of patients falls are occurring
- **Geriatric** patients is the most prevalent age group experiencing falls
- To reduce the risk of **severe harm, permanent harm and death,** strategies should significantly **focus** on **preventing patient falls**:
  - while **ambulating**
  - from **bed**
  - while **toileting**

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Based on Data date range 1/1/2019 through 7/2/2024

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Evidence Based Best Practices for Fall Reduction

- **Fall Risk screening** using an evidence-based Fall Risk Assessment Tool appropriate for the care setting
- Implementation of a multi-factorial **Fall Prevention** care plan tailored for the patient
- **Consistent Fall Prevention Interventions**
  - Universal Fall precautions
  - Tailored interventions to address patient-specific areas of risk

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Fall Risk Screening

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Considerations- Fall Risk Screening

- Ensure your **Fall risk tool** is **evidenced based** AND the **most appropriate for the care setting**
- **Evaluate accuracy** of Fall risk assessment/ **Interrater reliability**
- Determine if **Fall risk assessment** remains **unchanged** despite a change in clinical status or **fluctuates** despite static clinical status

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Considerations- Fall Risk Screening

- Ensure **prior history of falls is captured** AND doesn't **fall off during the patient stay**
- Evaluate that the **Fall risk level has increased after an inpatient fall** regardless of injury
- Consider risk for **injury screening** (ABCS tool for example) **as an adjunct**

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Fall Prevention care planning

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Considerations for Fall Prevention care planning while **ambulating:**

- Evaluate the patient for gait/ balance issue
- Educate the patient/ family regarding the plan for safe ambulation
- Provide appropriate level of assistance getting out of bed and with ambulation based on individual patient need
- Use of Assistive devices (cane/ walker/ crutches) for abnormal gait/ balance issues with fitting/ training for use

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Considerations for Fall Prevention care planning while **ambulating:**

- Use of gait belt during ambulation when appropriate (to reduce falls and risk from injury)
- Nonskid footwear
- Physical Therapy consultation/ treatment
- Avoid bedrest/ early mobilization (prevents loss of functional status and delirium)
- Slow position changes to prevent orthostatic hypotension

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Considerations for Fall Prevention care planning **while toileting:**

- Pro-active toileting using a rounding/ toileting schedule
- Use of urinal and/ or bedside commode for patients unable to ambulate to restroom
- Staff member remaining present with patient while toileting (*avoid patient family/ visitor in this role)
- Educate the patient/ family regarding safety vs. privacy

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Considerations for Fall Prevention care planning **while toileting:**

- Raised toilet seats that make it easier to sit down/ stand up
- Grab bars that assist patient with balance when standing
- Slow position changes to prevent orthostatic hypotension
- Ensure clear path to/ from restroom
- Consider equipment assistance needs (IV, oxygen, remote tele-boxes etc…)

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Considerations for Fall Prevention care planning **while patient in bed:**

- Educate the Patient/ Family to call for assistance when getting out of bed
- Rounding schedule to promote patient seeking assistance while staff is present
- Call light AND personal possessions within reach
- Bed in low position/ wheels are locked
- Target Bed Alarms for patients that are unable to use call light, may forget to use call light or choose not to call.

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Considerations for Fall Prevention care planning **while patient in bed:**

- Consider sensitivity of bed alarms with the patient activity level
- Consider visual cues to ensure bed alarm are armed/ set
- Target Observation (sitter/ tele-sitter) for patients that attempt to get out of bed AND are unable to mobilize without assistance
- Floor mats to reduce trauma from bed-related falls
- Activity schedule to avoid bedrest/ prevent delirium

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Root Cause Analysis of Falls

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Effective Root Cause Analysis of Falls

- Starts with a robust Post-Fall huddle performed with a standardized tool
- Evaluates both Fall risk factors and injury risk factors of the patient
- Evaluates the implementation of prevention measures for patient specific risk factors
- Evaluates the timeliness/ effectiveness of the patient rounding components
- Gathers facts from those involved in the event

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Effective Root Cause Analysis of Falls

- Sequester equipment as needed for investigation
- Contains a detailed event description including a timeline
- Considers all of the potential contributory factors
- Avoids Human Factors as root cause(s)- dig deeper!
- Gets to the Root Cause(s)
- Evaluates best practices to assess for gaps in Fall prevention program

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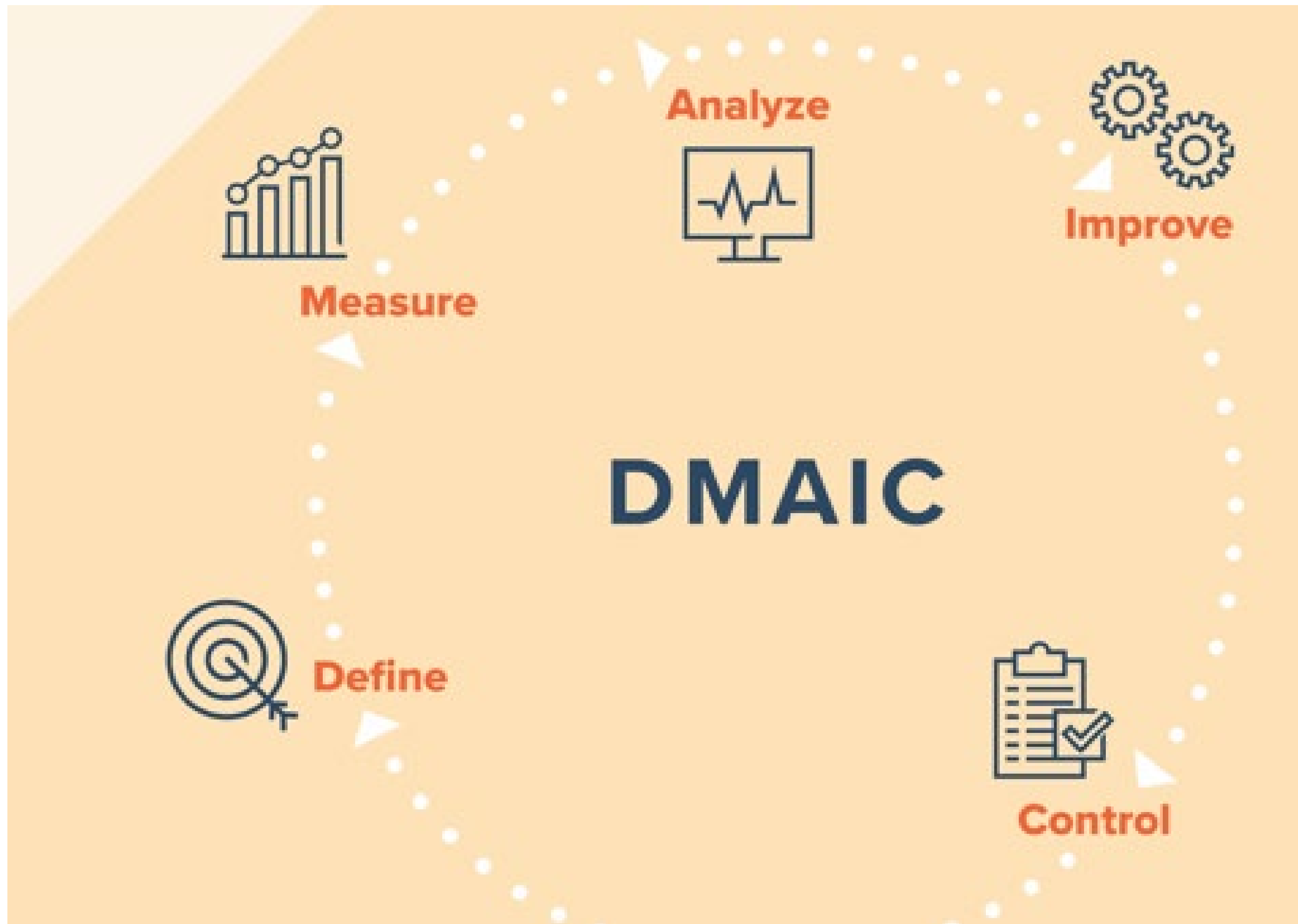
Falls Action Plans



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Effective Falls Action Plans

- Encourage ongoing reporting of patient safety events
- Use great catch programs to reinforce near miss reporting
- Perform aggregation and analysis of contributing factors to inform/ monitor effectiveness of improvement efforts

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Effective Falls Action Plans

- Interdisciplinary falls prevention team working on performance improvements
- Contain tangible leadership involvement to reinforce prevention measures
- Share lessons learned from RCA at all levels of the organization to create situational awareness

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Benefits of self-reporting Sentinel Events (TJC accredited organizations)

- Getting **support and expertise during the review** of a sentinel event
- Providing the health care organization an **opportunity to collaborate with a patient safety specialist** who maintains the following qualifications:
  - Masters-prepared clinician or human factors engineer
  - Certified Professional in Patient Safety (CPPS) from the Institute for Healthcare Improvement (IHI)
  - Experienced in reviewing similar events

https://www.jointcommission.org/resources/sentinel-event/sentinel-event-policy-and-procedures/

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Benefits of self-reporting Sentinel Events (TJC accredited organizations)

- **Raising the level of transparency** in the health care organization, which **promotes a culture of safety**
- Conveying the message to the health care organization's public that it is **proactively working to prevent similar patient safety events** in the future

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Goals of a Fall prevention program

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Goals of a Fall prevention program

- Continuous learning
- Ongoing performance improvement
- Promote a Culture of Safety and a Just Culture
- Strive for High Reliability behaviors

It's a journey....not a destination!

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Literature

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- Montero-Odasso, M, Kamamkar, MSc. Et. Al. Evaluation of Clinical Practice Guidelines on Fall Prevention and Management for Older Adults: A systematic review.. JAMA. 2021 Dec 1;4(12), e2138911. doi:10.1001/jamanetworkopen.2021.38911
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- Strini V, Schiavolin, R and Prendin, A. Fall Risk Assessment Scales: A Systematic Literature Review. Nurs. Rep. 2021 Jun; 11(2): 430–443. doi: 10.3390/nursrep11020041

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Resources

- AHRQ: Reducing Patient Falls with Evidence-based Tools (2022) https://www.ahrq.gov/funding/grantee-profiles/grtprofile-dykes.html
- AHRQ Preventing Falls in Hospitals: A Toolkit for Improving Quality of Care (last updated 2024) https://www.ahrq.gov/patient-safety/settings/hospital/fall-prevention/toolkit/index.html
- CDC: STEADI Clinical Resources https://www.cdc.gov/steadi/hcp/clinical-resources/index.html
- National Council on Aging: Evidence-Based Falls Prevention Programs (2023) https://www.ncoa.org/article/evidence-based-falls-prevention-programs
- StatPearls Reference: Falls and Fall Prevention in Older Adults (2023): https://www.ncbi.nlm.nih.gov/books/NBK560761/
- The Joint Commission Sentinel Event Policy (2024) https://www.jointcommission.org/resources/sentinel-event/sentinel-event-policy-and-procedures/
- USPSTF: Final Recommendation Statement Falls Prevention in Community-Dwelling Older Adults: Interventions (2024) https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/falls-prevention-community-dwelling-older-adults-interventions

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