Awareness of contributing factors isn't enough to protect patients from falls. It takes a team effort to prevent falls and to reduce the degree of injury should a fall occur.

Reducing falls in hospitalized patients

Patient falls remain a serious problem in healthcare. ECRI lists "ongoing challenges with preventing falls" as one of its top 10 patient safety concerns for 2024. Consistent with previous years, falls were the most common sentinel events reported to The Joint Commission in 2024, accounting for nearly half (49%) of reports. In all, 49% of falls resulted in severe harm to the patient, 21% in moderate harm, and 21% in death. Most reports to The Joint Commission are voluntary, so the incidence is likely higher.

Falls can be costly. One economic analysis from Dykes, Curtin-Bowen, and colleagues showed that non-injurious and injurious falls were associated with cost increases of $35,365 and $36,776, respectively.

More important than cost, however, is the potential harm to patients and nurses. In the CNA/NSO Nurse Professional Liability Claim Report: 5th Edition report, many of the closed claims in the patients' rights/abuse/professional conduct category involved falls that occurred because the nurse failed to follow the organization's fall-prevention policies and procedures. This failure violates the patient's right to a safe environment. In one case, a patient for whom proper fall precautions were not taken died from an intracranial hemorrhage suffered after a fall. The initial nursing assessment listed the patient as low fall risk, even though the patient met many of the organization's high-risk criteria. Of these fall-related closed claims, 38.6% resulted in death.

Fortunately, nurses can take several steps to reduce fall risk, starting with understanding contributing factors.

FALL FACTORS

Based on an analysis of several articles, Huntington and Kuhn identified four reasons why patients file Hospitalized patients are at a higher risk for falls compared with those in ambulatory settings. The CNA/NSO report notes that the locations with the highest frequency of falls include hospital-inpatient medical and surgical services, patients' home, and aging services.

ECRI and Schoberer and colleagues note several risk factors to consider, including a history of a fall in the past 6 months, age older than 70 years, male gender, certain disease states (e.g., dementia, COPD, atrial fibrillation), disease-related changes (e.g., movement restriction, vertigo, sleep disorder, cognitive impairment), and some medications (e.g., sedatives, antipsychotics). The Joint Commission notes that most sentinel event falls occur when the patient is ambulating, followed by falling from bed and toileting.

ECRI and The Joint Commission list items that can contribute

to falls with injury, including communication (e.g., inadequate staff-to-staff communication during handoffs or transitions of care, lack of shared understanding of the plan of care) and staff performance (e.g., not following preventive procedures).

Awareness of contributing factors isn't enough to protect patients from falls. It takes a team effort to prevent falls and to reduce the degree of injury should a fall occur.

PREVENTING FALLS: ORGANIZATIONS

Any fall prevention effort requires a significant organizational investment of time and money to support clinicians in their work. ECRI lists several strategies organizations can take to help reduce falls, including the following:

- Have an executive sponsor who is accountable for fall prevention for the organization. Accountability should include appropriate staffing and adoption of fall prevention technology as appropriate.
- Promote a just culture environment when reviewing safety events related to patient falls.
- Analyze culture of safety surveys to identify ways to improve communication and teamwork related to falls.
- Provide education on prevention and encourage staff to speak up and report risks that may lead to falls.
- Use tiered safety huddles to address concerns that may put patients at higher risk of falling. (Tiered huddles are multiple daily meetings that occur across multiple levels or tiers of leadership. Meetings are used to identify problems before they escalate. Because some leaders span adjacent tiers, communication is facilitated.)
- Create a multidisciplinary team to implement prevention programs that include risk assessment, data monitoring, and continuous improvement.

Organizations can promote a culture of safety, but each nurse has a role to play as well.

Fall TIPS (Tailoring Interventions for Patient Safety)

Toolkit is an example of an effective fall prevention resource. It emphasizes the need to incorporate the patient into the assessment as well as plan creation and implementation. The toolkit, which distills fall prevention into three steps, has reduced falls and saved significant money for multiple organizations.

1. Identify risk factors. This can be done by performing the Morse Fall Scale assessment.
2. Develop a prevention plan tailored to the patient-specific risk factors. Collaboration with patients and family members is an essential part of plan development. Document assessment results and plan in the electronic health record.
3. Consistently carry out the plan. This is accomplished via the Fall TIPS laminated poster, which is used to communicate the plan to other members of the care team, as well as the patient and family. The poster, which is available in multiple languages and updated daily, is color coded to match the findings of the assessment.

Sources: Falls TIPS. https://www.falltips.org

PREVENTING FALLS: NURSES

Nurses can utilize several tools to prevent patient falls.

Education. In a systematic review and meta-analysis, Morris and colleagues note that educating both patients and clinicians reduces hospital fall rates. Such education can raise awareness of risk factors and strategies for prevention.

Engagement. In addition to educating patients and families, involving them in developing a prevention plan is likely to yield greater success than one unilaterally developed by the nurse. Any information provided for patients and families should be in their preferred language, at an appropriate reading level, and in a format they can absorb. For instance, printed material should be of sufficient font size for easy reading.

Communication. As noted earlier, inadequate communication during handoffs or transitions of care can result in falls. Clear signage, checklists, and verifying receipt of information can be used to promote understanding. In addition, the fall prevention plan should be communicated to all members of the healthcare team, not just nurses. Certified nursing assistants, transport staff, and other clinicians such as therapists all have a role to play in prevention. Both written and verbal communication are essential.

Guidelines. Following prevention guidelines developed by the organization not only helps patients but also reduces the nurse's risk of legal action should a patient incur an injury after a fall.

The guidelines will note that the prevention plan should be documented in the patient's electronic health record.

It's best to use multiple interventions tailored to individual patients as part of the overall prevention plan.

PREVENTING PLAN STEPS

Steps typically include assessing,

What the Nurse Should Do If a Patient Falls

Despite best efforts, patients may still fall.

- Assess the patient for injury before moving. Assessment parameters include vital signs, cognition, any signs of injury (such as cuts), and whether the patient is experiencing pain;
- After the patient has been evaluated and no injury is found, carefully return the patient to the bed and use lifting devices as needed;
- Document what happened in the patient's electronic health record. Include who was informed how the fall occurred, assessment results, and follow-up interventions (e.g., radiographs). Note any prevention interventions that were in place when the fall occurred. Thorough documentation of the situation can help protect the nurse if a legal case arises. For example, the documentation can confirm that no injuries were found on examination, and the patient denied any pain;
- File a report according to organizational guidelines. The report will typically have spaces for details similar to what is in the patient's electronic health record, such as the location of the incident. In addition, any relevant patient history (such as cognitive impairment) should be noted. Keep the information objective and fact-based. The report should not be used to cast blame, but rather to identify potential areas for quality improvement; and
- Consider what could have been done to prevent the fall. Incidences such as these can prompt new insights that can protect current and future patients.

creating, communicating, and evaluating.

Assessing. The Fall TIPS (Tailoring Interventions for Patient Safety) toolkit is a resource for reducing falls. It notes that areas to assess include fall history, medication side effects, walking aid, IV presence, unsteady gait, and whether the patient may forget or choose not to call for help.

Possible assessment tools include Morse Fall Scale, Schmid Fall Risk Assessment Tool, and STRATIFY Fall Risk Assessment Tool.

Creating. When creating the prevention plan, match interventions to assessment results. For example, if the Morris Fall Scale assessment reveals that gait is an area of risk, assist the patient out of bed and consider a physical therapy consult. Another example is the use of a toileting schedule for those with an IV or other equipment, urinary incontinence, or who may have medication side effects.

Communicating. In addition to communicating the plan to the patient, patient's family, and team and documenting it in the electronic health record, it's also important to communicate the patient's and family's response to the plan during transitions such as shift handoff.

Evaluating. In addition to sharing patient responses to the plan throughout the day, the plan should be fully evaluated daily and revised as needed. Again, patients and families should be included in the evaluation and revision process. If a patient falls, nurses should take steps to reduce injury and immediately adjust the prevention plan.

CALL TO ACTION

Fall prevention has been taught in nursing schools and written and spoken about for decades yet falls remain a significant adverse event experienced by patients. Fortunately, preventing falls can be accomplished with the proper support of organizations and clinicians. This prevention will protect patients and reduce the potential for legal action against nurses whose patients are injured as a result of a fall. It takes everyone's commitment (organizations, clinicians, patients, and families) to gain optimal outcomes.

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