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PSO Monthly Brief

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Falls Happen: Here's How to Lessen the Risk

As any staff member in any hospital knows, mitigating the risk of falls is an ongoing challenge. Falls are one of the most common events reported to ECRI Institute PSO, too. Factors that increase the patient's risk of falling aren't always evident, however—so a comprehensive falls prevention program must be implemented to remove risk factors on many fronts.

Contributing factors seen by ECRI Institute PSO include:

- Patient-specific factors
- Medications
- Equipment and environmental considerations
- Staff communication

Patient-Specific Factors

Common factors seen by ECRI Institute PSO include a loss of consciousness or the patient's inability to independently stand up from a chair. One strategy to mitigate such risks is to ensure that patients and caregivers understand them; use such techniques as "teach back" with the patient or the patient's family members. Involve the family member and ensure that he or she understands the risks related to the patient's situation. Hourly rounding to assess the patient's pain level, offer toileting assistance, and reposition the patient if needed is another effective strategy. Remind the patient to "Call, don't fall."

Medication Safety

Patients may be taking medications that can cause changes in cognitive or physical function. Therefore, medications should be an item on a standardized falls risk assessment. Include the pharmacist in the patient's falls risk assessment to advise about alternative medications. Another strategy: rather than posting a list of medication categories (e.g., narcotics) that can be associated with a higher risk of falls, the organization could circulate a list of specific medications related to fall risk to increase staff awareness. Likewise, organizations can remove high-risk medications from their formulary or restrict the conditions under which they may be ordered.

Environmental Factors

Physical environment is one of the most significant risk factors for falls—do not underestimate it. Tripping hazards (e.g., power cords) should be secured, lighting should be assessed (e.g., nightlights and motion-sensor lighting), and any movable furniture should be locked into position. Involve non-clinical department representatives in discussions of environmental and equipment safety, efficacy, and quantity.

Staff Communication

Risk of a patient fall is increased when communication is inadequate. Such situations include handoffs at shift change or patient transfer, inadequate documentation in the medical record of a change in the patient's condition, and rushed communication with family caregivers. One tactic is to ensure that falls are discussed during shift change with all staff and at bedside report by standardizing handoff communications (e.g., with a checklist that includes falls risk as an item).

Falls happen—but you don't have to simply let them. Convene an interdisciplinary team to assess the organization's current falls prevention program, identify methods to increase awareness of patients' risk of falling, and implement broad but customizable strategies to reduce the risk

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How Can We Help You?

Whether you have questions about the final rule or want to learn more about ECRI Institute PSO and/or support for other PSOs, we would be happy to hear from you. Please contact ECRI Institute at pso@ecri.org or call (610) 825-6000, ext. 5558.