PREVENTING INPATIENT FALLS

Falls pose a serious safety risk for patients who may experience physical harm, emotional distress and increased length of stay. Preventing falls is challenging and requires leadership support, multidisciplinary interventions, provider collaboration and staff and patient engagement. Between FY2009 and FY2015, UCSF has achieved a 26% decline in its annual fall rate and a 59% decline in its annual fall with injury rate among inpatient units as a result of ongoing fall prevention efforts.

What happened?

Case 1: A 63 year-old non-English speaking female with a history of falls and low platelets was admitted to the hospital for chemotherapy. The morning after admission, she tripped over her IV tubing and fell while ambulating to the restroom. She subsequently developed a headache and became unresponsive. Head CT revealed acute subdural hematoma with midline shift. She was rushed to the operating room but her neurologic status remained poor and she ultimately passed away.

Case 2: A 66 year-old male presented to the emergency room for evaluation of a possible seizure and abdominal pain. Orders were placed for a CT of the head and a chest x-ray. After the head CT was completed, the patient was taken to x-ray. Unaware of the possible seizure history and fall risk, the x-ray technologist positioned the patient for a standing chest x-ray. The patient subsequently fell, sustaining a skull fracture.

What went wrong?

In the first case, the patient was identified to be at risk for injury from fall based on her frail condition and low platelets. A falls prevention plan had been activated but the patient fell during change of shift, a time that is often busy. Furthermore, communication about falls prevention with the patient was challenging and she refused the bed alarm.

In the second case, the fall risk assessment was not completed prior to the patient leaving the ED for his imaging studies. Therefore, the radiology technologist was not aware of the patient’s fall risk when positioning the patient for x-ray. A falls huddle with all relevant practitioners did not take place after the fall. This led to a delay in diagnosis because providers, uncertain as to the sequence of events, falsely assumed that the negative head CT reflected the patient’s condition after the fall when in fact, the study had preceded the patient’s fall.

Improvements: Fall Prevention

Identifying patients at risk:
- inpatients are screened for fall risk on admission, at shift change and if there is a change in condition affecting fall risk
- the Schmid Scale is used to assess risk

Nursing interventions:
- place yellow armband on patient’s wrist
- place fall risk sign outside patient’s door
- communicate fall risk at change of shift and other care transitions/handoffs
- develop a patient Fall Risk Care Plan
- educate patient and family about fall risk and safety measures

If a patient falls:
- immediately assess for injury and notify primary team
- consider patient-specific factors such as anticoagulation
- perform an interdisciplinary Post Fall Huddle
- document fall in Apex
- update Fall Risk Care Plan
- put date of fall on yellow fall risk armband
- complete incident report
- communicate fall during handoff

From the UCSF Patient Safety Committee and Office of GME. Editors: Adrienne Green MD (Professor of Medicine, CMO), Jim Stotts RN (Patient Safety Manager), Mary H. McGrath, MD (Professor of Surgery and Office of GME) and Kiran Gupta, MD, MPH (Assistant Clinical Professor of Medicine, Assistant Medical Director for Patient Safety). Please contact Kiran Gupta at Kiran.Gupta@ucsf.edu with questions. Disclaimer: Clinical details of cases have been altered to protect patient & provider confidentiality.