Patient falls and best practices for prevention—Utah 2023

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Patient falls in hospitals and nursing homes are the number one most frequent adverse event in both the US and Utah in the past few years. This devastating event occurs despite the efforts of many healthcare facilities to create and implement fall prevention programs. There are even some misconceptions that patient falls are inevitable and unpreventable.[1]

The purpose of this report is to outline patient fall data from the US and Utah, list and detail current best practices to prevent patient falls and challenges of those practices, and talk about what other states do to prevent patient falls. A 2019 study identified that traditional single prevention strategies, such as risk assessments, alarms, nonslip socks, and patient education, do not have strong evidence of success, but, more research is needed to identify whether more than 1 type of intervention is effective.[2] Overall, this is a complex problem without a clear solution, and further development and implementation is needed.

2021–2022 Patient falls in the US

In 2021, there were 483 instances of patient falls reported to the Joint Commission. In 2022, 42% of the voluntary reports of events to The Joint Commission's Sentinel Events' Database were falls (611), a 27% increase from 2021. Of the 2022 falls in the US, 5% led to patient death and 70% led to severe patient harm. Patient falls has been the top patient safety event in the US in the past 4 years, and the number of falls has only increased over time (see figure 1).

Identified contributing factors to these falls include failure to follow policy, inadequate communication between staff during transition of care, and absence of shared mental model or understanding of plan of care.[3] The 2022 Sentinel Event Data Report also mentions that "a separate sentinel event line item on patient falls was introduced in 2021",[4] which coincides with the Joint Commission updating their Sentinel Event Policy that same year to include a detailed description of what qualifies as a fall event.[5] The current chief patient safety officer and medical director of the Joint Commission also stated that the healthcare system is still feeling the strain of the COVID-19 pandemic, identifying factors such as staff shortages, deteriorating mental health of caregivers, and patients delaying care of non-COVID conditions.[6]

These falls occur during normal everyday activity in the patient's environment (see figure 2). It's estimated that there are between 700 thousand and 1 million patient falls each year, which result in an estimated 250 thousand injuries and 11 thousand deaths.[7]

Figure 1: Patient falls reported to the Joint Commission, 2018–2022[3]

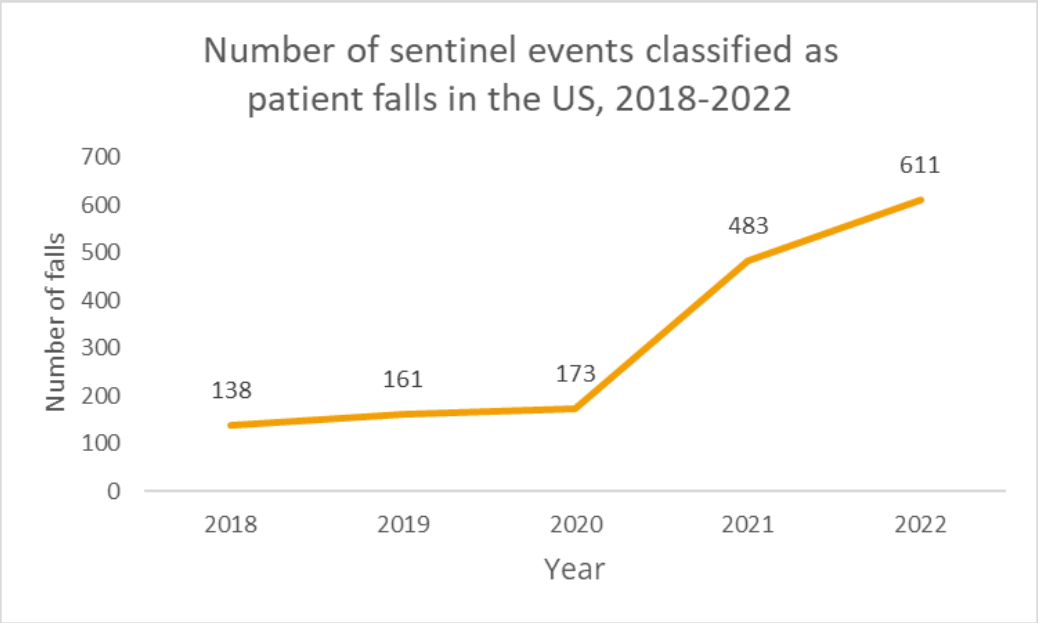
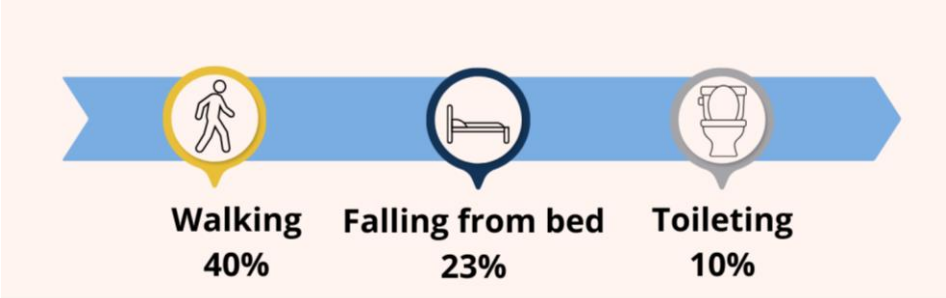


Figure 2: Top mechanisms of falls reported to the Joint Commission in 2022[3]

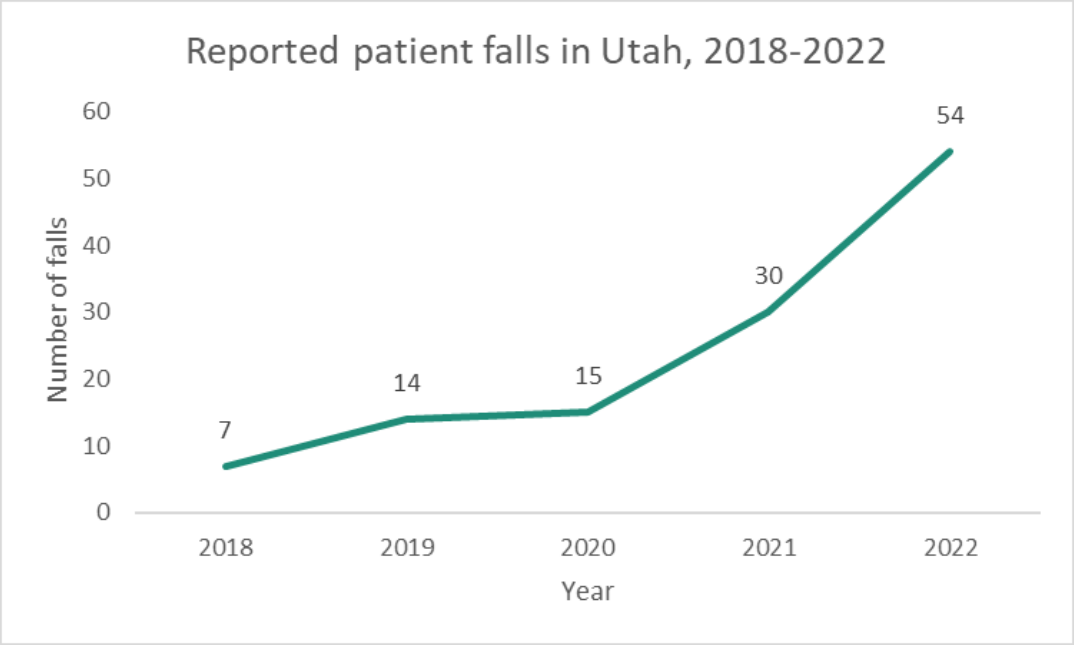


2021–2022 Patient falls in Utah

Falls accounted for 22% of all patient safety adverse events in Utah between 2021 and 2022. In Utah, there were 189 care management events reported between January 2021 and December 2022, Falls accounted for 84 or 44.7% of those events. Similar to data reported to the US Joint Commission, the number of falls

reported in Utah has been the top reported adverse event in Utah and has increased over the past 4 years (see figure 3). It is unclear exactly why the number of falls in Utah is increasing.

Figure 3: Number of reported patient falls in Utah, 2018–2022



From 2021 to 2022 in Utah, the number one mechanism of patient fall was toileting, and the top location of fall was in the patient's room. The top patient outcome was temporary harm requiring hospitalization. The most common contributing factor identified was human factor, while the most frequent action taken after falls was education (see figure 4). See appendices A and B for further descriptions of contributing factors and actions taken.

The most affected age group was those older than age 65 years (61%), and more females (55%) had falls than males. With regard to race, 64% of the patients were white, 2% were categorized as "other", and the rest were unknown. 4.6% of the patients were Hispanic, 75% were non-Hispanic, and the rest were unknown (see figure 5).

Figure 4: Characteristics of patient falls in Utah, 2021–2022: Top mechanisms of falls, location of falls, patient outcomes, contributing factors, and actions taken

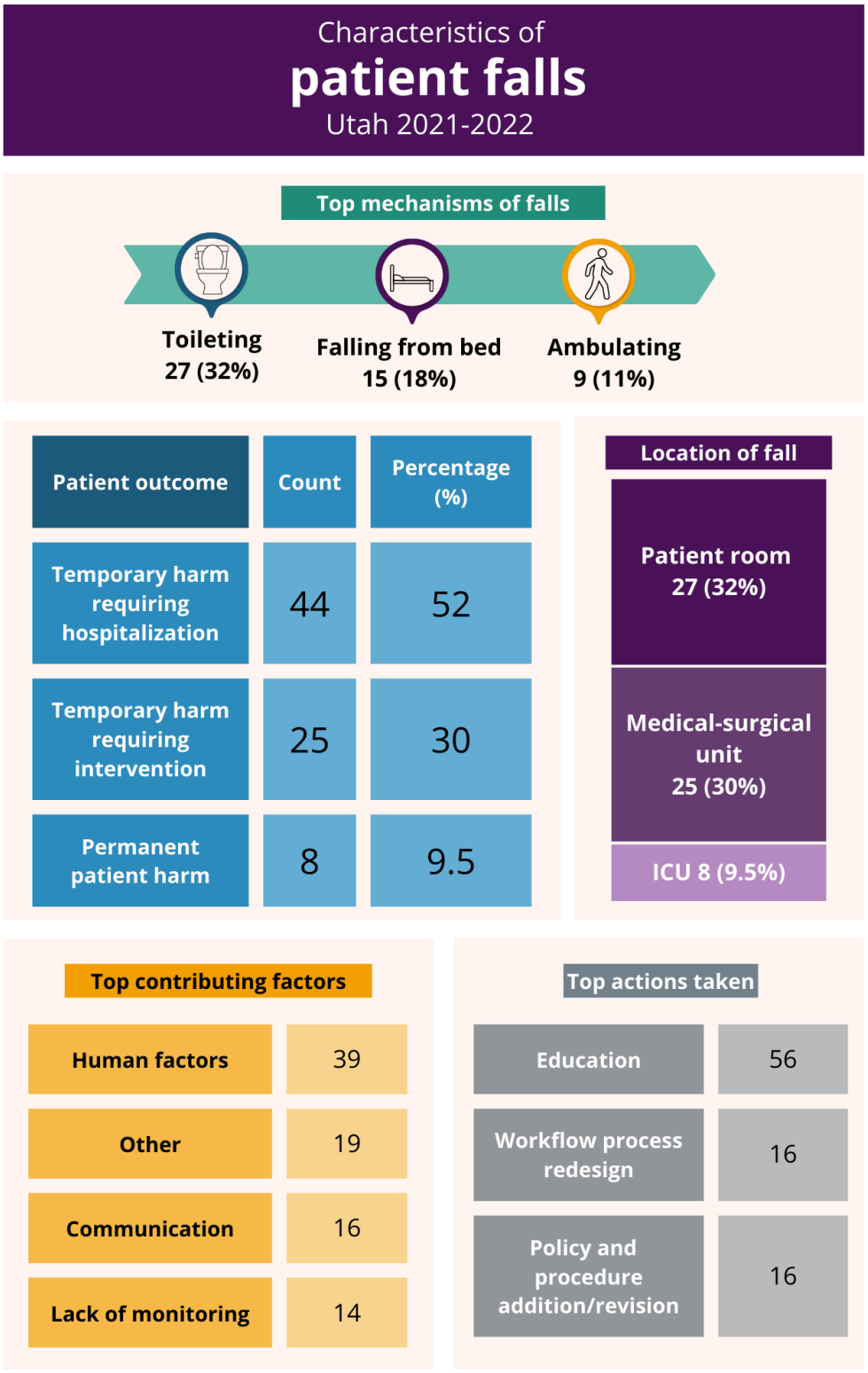


Figure 5: Demographics of patient falls in Utah, 2021–2022: age, gender, race, and ethnicity

Demographic characteristics of
patient falls
Utah 2021-2022

Variable categories	Count	Percentage (%)
Age (in years)		
<18	7	8.33
18-34	1	1.19
35-49	4	4.76
50-64	21	25
65+	61	60.71
Gender		
Female	46	54.76
Male	38	45.24
Race		
White	54	64.29
Unknown/missing	28	33.33
Other	2	2.38
Ethnicity		
Hispanic	3	4.62
Non-Hispanic	49	75.38
Unknown/missing	32	38.1

Evidence-based best practices for fall prevention

Agency for Healthcare Research and Quality - Preventing falls in hospitals toolkit[8]
(Reviewed 2023)
This extensive toolkit focuses on how to overcome the challenges associated with developing, implementing, and sustaining a fall prevention program. The content is organized by the following topics:

1. Are you ready for this change?
    a. Assess the culture of safety in your hospital
    b. Evaluate current organizational attention to falls
    c. Assess and develop leadership support for the fall prevention program
    d. Identify what resources are available and any resources that are needed
    e. Assess your progress on completing readiness for change activities
2. How will you manage change?
    a. Identify your implementation team
    b. Assess the current status of fall prevention activities in your hospital
    c. Determine staff knowledge about fall prevention
    d. Set goals for improvement based on outcomes and processes
    e. Assess your progress on completing the managing change activities
3. Which fall prevention practices do you want to use?
    a. Identify how fall prevention care processes connect to each other
    b. Implement universal fall precautions (*see chart on page 10)*
    c. Identify important risk factors for falls in your patients (*see STRATIFY risk assessment tool and Morse fall scale on pages 11–12*)
    d. Use identified fall risk factors to implement fall prevention care planning
    e. Assess and manage patients after a fall
    f. Assess your progress on completing the best practices activities
4. How do you implement the fall prevention program in your organization?
    a. Assign staff roles and responsibilities for tasks identified in set of best practices

    b. Assess current staff education practices and facilitate integration of new knowledge on fall prevention into existing or new practices
    c. Assess your progress on implementing best practices activities
5. How do you measure fall rates and fall prevention practices?
    a. Collect the right data to learn about falls, fall-related injuries, and their causes
    b. Measure fall prevention practices
    c. Assess your progress on measuring progress activities
6. How do you sustain an effective fall prevention program?
    a. Identify factors needed to sustain your fall prevention efforts

Universal fall precautions[9]

Universal fall precautions

These strategies apply to all patients, regardless of risk.
Each facility should adapt this list to their needs.
All staff who interact with patients should be trained on these precautions.

- Make sure the patient is familiar with the environment.
- Have the patient demonstrate call light use.
- Make sure the patient can reach the call light.
- Keep the patient's personal possessions within patient safe reach.
- Have sturdy handrails in patient bathrooms, room, and hallway.
- Place the hospital bed in a low position when a patient is resting in bed; raise bed to a comfortable height when the patient is transferring out of bed.
- Keep the hospital bed brakes locked.
- Keep the wheelchair wheel locks in a "locked" position when stationary.
- Keep nonslip, comfortable, well-fitting footwear on the patient.
- Use night lights or supplemental lighting.
- Keep floor surfaces clean and dry. Clean up all spills promptly.
- Keep patient care areas uncluttered.
- Follow safe patient handling practices.

These should be addressed during hourly rounds.
Staff can use the "5 Ps" to help remember what to ask.

1. **Pain:** assess the patient's pain level. Provide pain medicine if needed.
2. **Personal needs:** offer help using the toilet; offer hydration, offer nutrition, empty commodes/urinals.
3. **Position:** help the patient get into a comfortable position or turn immobile patients to maintain skin integrity.
4. **Placement:** make sure the patient's essential needs (call light, phone, reading material, and toileting equipment) are within easy reach.
5. **Prevent falls:** ask the patient/family to turn on the call light if the patient needs to get out of bed.

Complete a falls risk assessment: identify fall risk factors that can be addressed by individualized fall prevention plans. This is the most important application of an assessment tool. The following tools can be used, but don’t focus on the score to help a hospital's culture move away from relying solely on a summary score. For example, if it is identified that the patient is significantly visually impaired, interventions to address that factor should be addressed, such as increased lighting, use of magnification, and room layout education.

Stratify risk assessment tool[10]

Stratify risk assessment tool

Answer all five questions below and count the number of "yes" answers.

#	Question	Yes =1	No =0
1	Did the patient present to the hospital with a fall or has he or she fallen since admission (**recent history of fall**)?	Yes	No
2	Is the patient **agitated**?	Yes	No
3	Is the patient **visually impaired** to the extent that everyday function is affected?	Yes	No
4	Is the patient in need of especially **frequent toileting**?	Yes	No
5	Does the patient have a combined **transfer and mobility** score of 3 or 4? (calculate below)	Yes	No
	Transfer score: Choose **one** of the following options which best describes the patient's level of capability when transferring from a bed to a chair: 0 = Unable 1 = Needs major help 2 = Needs minor help 3 = Independent		
	Mobility score: Choose **one** of the following options which best describes the patient's level of mobility: 0 = Immobile 1 = Independent with the aid of a wheelchair 2 = Uses walking aid or help of one person 3 = Independent		
	Combined score (**transfer + mobility**): _____		

Total score from questions 1-5: _____
0 = Low risk
1 = Moderate risk
2 or above = High risk

Morse fall scale[11]

Morse fall scale

Answer all six questions below and tally the total patient score.

#	Question	Item score	Patient score
1	History of falling (immediate or previous)	No = 0 Yes = 25	_____
2	Secondary diagnosis (≥ 2 medical diagnoses in chart)	No = 0 Yes = 15	_____
3	Ambulatory aid	None/bedrest/nurse assist = 0 Crutches/cane/walker = 15 Furniture = 30	_____
4	Intravenous therapy/ heparin lock	No = 0 Yes = 20	_____
5	Gait Weak gait: Short steps (may shuffle), stooped but able to lift head while walking, may seek support from furniture while walking, but with light touch (for reassurance) Impaired gait: Short steps with shuffle; may have difficulty arising from chair; head down; significantly impaired balance, requiring furniture, support person, or walking aid to walk.	Normal/bedrest/wheelchair = 0 Weak = 10 Impaired = 20	_____
6	Mental status	Oriented to own ability = 0 Overestimates/forgets limitations = 15	_____

Total score: Tally the patient score and record.

0: No risk for falls
<25: Low risk
25-45: Moderate risk
>45: High risk

[Patient safety movement: falls and fall prevention in adults](#)[12](2022)

This actionable evidence-based practice blueprint provides a checklist for clinicians to create an action plan to prevent falls in adult patients and make sure patients receive the best care. This document is revised as needed to incorporate the latest best practices and gold standards of care. The e-book is available free of charge.

Upon admission

- Conduct a comprehensive falls risk assessment, including, but not limited to, the following:
  - Visual assessment
  - Hearing and vertigo assessment
  - Mobility assessment
  - Medical history review
  - Medications review
- Clearly communicate patient fall risk to other team members.

Routine Care

- Continuously reassess fall risk, particularly alongside changes in medication, patient condition, or treatment plan.
- Leverage techniques to mitigate fall risk, including but not limited to:
  - Ambulation equipment (e.g., gait belt)
  - Visual cues (color coded gowns, wrist bands, socks, signage)
  - Maternal wraps
- Ensure the patient's bed is in the lowest position and appropriate bedrails are lifted.
- During multidisciplinary rounds, discuss the patient's balance between early mobility capability and fall risk.
- Educate patients and family members on fall risk factors and involve them in fall prevention efforts.
- Do not use restraints for fall risk prevention.
- Identify environmental hazards that could contribute to falls (e.g., wires on the floor).

Treatment after a fall • Provide lifesaving treatment if indicated (e.g., control bleeding). • Conduct a thorough evaluation of the patient after the fall. • Disclose the incident to the patient and their family members. • Debrief with the patient and family members and discuss root causes. • Communicate with the patient or a witness of the fall what had happened to cause the fall. • Ask the patient if they have experienced or are experiencing pain at any given time. • Share findings from the root cause analysis across the organization. • Provide support to the patient and family members after a patient/infant fall.
Discharge • Conduct another falls risk assessment and set realistic expectations for the patient's recovery. • Consider cultural factors that may contribute to fall risks and discuss with patients and family members how to mitigate (e.g., washing of feet before prayer). • Ensure patients and family members are aware of their personal risk factors for a fall (e.g., certain medications prescribed).

Fall TIPS (Tailoring Interventions for Patient Safety): A patient-centered fall prevention toolkit[13](2016)

A 2007 study found that posting a generic "falls risk" sign does not reduce risk. Inconsistent communication across the care team is also a significant barrier to fall prevention, and it's necessary to involve caregivers, patients, and family members to help prevent falls.

The laminated 11" by 17" TIPS poster is a low tech, low cost tool that makes it easy for clinical staff to engage patients and caregivers in the fall prevention process. The chart should be filled out with the patient and family members then placed at the patient bedside so that all care team members can implement the plan.

It has been used in more than 500 US hospitals and in a study of 8 hospitals, the TIPS program was found to save $8,500 per 1,000 patient-days by preventing 567 falls over almost 4 years.[14]

The full toolkit includes the following steps to create a facility fall prevention program:

1. Secure buy-in from hospital leadership
2. Secure buy-in from nurses
3. Train champions
4. Plan implementation
5. Communicate consistently

BRIGHAM HEALTH
BRIGHAM AND WOMEN'S
Faulkner Hospital

Patient Name: **Date:**

Increased Risk of Harm If You Fall

Fall Risks (*Check all that apply*)

History of Falls

Medication Side Effects

Walking Aid

IV Pole or Equipment

Unsteady Walk

May Forget or Choose Not to Call

Fall Interventions (*Circle selection based on color*)

Communicate Recent Fall and/or Risk of Harm

Walking Aids

Crutches Cane Walker

IV Assistance When Walking

Toileting Schedule: Every _____ hours

Bed Pan Assist to Commode Assist to Bathroom

Bed Alarm On

Assistance Out of Bed

Bed Rest 1 person 2 people

[CDC: Steps to create a hospital-based STEADI safe mobility and fall prevention program](#)[15](2021)

The purpose of this guide is to help inpatient teams integrate a fall prevention program into their existing workflow and clinical practice. The guide includes 10 practical steps informed by research findings and provider experiences to:

- Decrease patient falls during and after hospital stays
- Promote better collaboration with external providers for post-discharge care
- Improve hospital processes and records
- Identify and manage medications that increase patient fall risk

Agency for Healthcare Research and Quality—The falls management program: A quality improvement initiative for nursing facilities[16]
This expansive toolkit is designed to help nursing facilities provide individualized, person-centered care, and improve their fall care processes and outcomes through educational and quality improvement tools.

The Joint Commission Sentinel Event Alert 55: Preventing falls and fall-related injuries in health care facilities[17] (2015)
Provides an analysis of most common contributing factors such as: inadequate assessment, communication failures, lack of adherence to protocols and safety practice; inadequate staff orientation, supervision, staffing levels or skill mix; deficiencies in the physical environment, and lack of leadership.

The Joint Commission Quick Safety 40: Preventing newborn falls and drops[18] (2018)
Calls for increased attention to the underrecognized issue of infant falls and includes most prevalent maternal risk factors associated with newborn falls and drops such as: cesarean birth, use of pain medication within 4 hours, second or third postpartum night (specifically around midnight to early morning hours), and drowsiness associated with breastfeeding.

Utah Commission on Aging: Utah Falls Prevention Alliance[19]
This group is composed of diverse stakeholders dedicated to reducing falls and fall injuries in Utah's older adult population. The alliance builds connections between healthcare providers, emergency medical services, and health insurers to improve coordination of care. UCOA supports coordinated efforts to help Utahns create a safe environment and take steps toward fall prevention for themselves and their loved ones to reduce the chances of falling.

Intermountain Health: Fact sheet for patients and families[20](2018)
An example of education that can be provided to include patients and families in care and fall prevention.

FACT SHEET FOR PATIENTS AND FAMILIES

Intermountain Healthcare

Prevent a Fall in the Hospital

Who's at risk to fall in the hospital?

Everyone is more likely to fall in the hospital than at home. This is true no matter your age and no matter how you feel. The stress of being in the hospital raises your fall risk because you are in an unfamiliar place with a lot of equipment and people you don't know.

In addition, you are more likely to fall while in the hospital if you:

- Have fallen before
- Take medicine that makes you sleepy, dizzy, uncoordinated, or weak
- Have an injury, illness, or condition can make you:
  - Feel dizzy, weak, or clumsy
  - Confused or disoriented
  - Have seizures or movements you can't control
  - Have an urgent need to use the bathroom
  - Have problems seeing, hearing, or feeling things
- Use equipment that makes it harder to move around, such as:
  - Crutches, a walker, or a wheelchair
  - Drains, tubes, and monitors
  - IV pumps or tubing

The more of these that apply to you, the higher your risk of falling.

Tell a care team member right away if you fall while in the hospital.

What do I need to do next?

1. Learn why you may be at risk for falling while in the hospital.
2. Tell your care team if you have fallen at any time in the past 3 months.
3. Use the "how to prevent a fall" checklist on **page 2**.
4. Share this information with friends and family who visit you.

Why are hospital falls risky?

In the hospital, even a small fall can cause serious bleeding or injury. Medicines you are taking can cause you to bleed more than normal, and injuries from falling can be more severe.

Your care team's top priority is to keep you safe and help you heal. They will:

- Assess your risk for a fall and, if needed, help you get out of bed and move around.
- Keep your walker or crutches, glasses, slippers, and other needed items within reach of your bed.
- Make sure you know how to safely use your walker or crutches.
- Keep your room well lit and free of cords or clutter you could trip over.

If you are at risk for falls, use the call button every time you need to get out of bed.

1

How to prevent a fall

Your care team will do their best to prevent a fall, but they can't do it alone. You need to help. Here are things you can do to help prevent a fall.

When in bed:

- ☐ **Make sure you know** where the nurse call light is.
- ☐ **Keep the bed rails up** if your nurse has put them up.
- ☐ **Ask for help** every time. Never hesitate to call your nurse for help getting up.

When getting up:

- ☐ **Call for your nurse the first time you get out of bed.** Even if your nurse says you can get up on your own later, ask for help the first time.
- ☐ **Don't get out of bed on your own** unless your nurse says you can.
- ☐ **Always wear non-skid socks** or other well-fitting footwear. The hospital floor can be slippery!
- ☐ **Use your glasses, cane, or walker**, if you have them. If you can't reach them without getting up, ask your nurse to bring them closer to you.
- ☐ **Stand and hold the bed rail** to steady yourself before moving.

When friends and family visit:

- ☐ **Share this fact sheet** with them.
- ☐ **Tell them to call a nurse to help you out of bed**. Friends or family members should not help an adult patient walk.
- ☐ **Remind them to not touch safety devices**, such as bed alarms or bed rails.

Questions for my care team

Pennsylvania: Patient Safety Authority[21]
This site developed by the state of Pennsylvania includes a list of tools to strengthen falls prevention programs and respond to the high-risk problem of persistent patient falls, some of which are listed below.

Hospital engagement network falls reduction and prevention collaboration self-assessment tool: A tool to evaluate the current structure and content of a hospital falls prevention program, compared with evidence-based best practice guidelines, and to identify opportunities for improvement.

Falls self-assessment tool action plan: After completing the Self Assessment Tool, the prevention team can create an action plan targeted to any best-practice elements that were identified on the SAT as missing or incompletely implemented in the facility's current falls prevention program.

Postfall investigation tool: Used to collect information after a patient fall. Information collected using the PFI Tool can be aggregated over time to help falls teams identify common intrinsic and extrinsic risk factors for falls and potential root causes.

Falls prevention process measures audit tool: Use to assess compliance with falls prevention practices most commonly included as part of hospital falls prevention plans.

Falls risk checklist: Used to determine whether a facility's falls risk assessment tool screens for certain risk factors associated with greater risk of falls and falls with injury.

Appendix A: Utah contributing factors narratives summary

Each event report includes an optional area to provide a narrative to explain contributing factors. This list is a summary of unique reasons provided in those narratives.

- Staff did not share fall protocol with provider
- Patient fell asleep with baby in the arms
- Failure to assess patient abilities prior to care and provide necessary safety measure
- Bed alarm was not reset for care
- Patient was in altered mental status
- Patient was not wearing nonslip footwear or socks
- Low staffing ratio
- Ineffective assessment of fall risk
- Patient was noncompliant
- Patient tripped on IV pole
- Night time staffing led to unwitnessed fall
- Family members were not told that a caregiver needed to know when patient left bedside
- Occupational therapist left patient in the shower
- Nursing fall score and rehab scoring tools contradict
- Failed to reset chair alarm
- Nurse failed to hear alarm
- Miscommunication among staff

Appendix B: Utah actions taken narratives summary

Each event report includes an optional area to provide a narrative to explain actions taken in response to a patient fall, as well as an area to select from a multiple choice list of actions taken. This chart is a summary of the narratives that were given when “education” was selected as an action taken. The chart divides the explanations between education for staff and education for family. “Education” was the top action taken for patient falls in Utah between 2021 and 2022.

<table>
<tr><th colspan="2">Top action taken in response to patient fall: education</th></tr>
<tr><td colspan="2">Staff education</td></tr>
<tr><td>Who</td><td>Where</td></tr>
<tr><td>● Sitters
● Falls champion
● Educators
● Falls committee
● Staff: nurses, providers, occupational therapy, and techs</td><td>● Huddles
● Staff meetings
● Visual reminder: patient whiteboards, hallways, huddle boards, signs on doors with time/date of most recent fall
● Lunch-n-learn</td></tr>
<tr><td colspan="2">What</td></tr>
<tr><td colspan="2">● Balance autonomy with safety
● Falls risk assessment and use of magnets
● Fall prevention program: bed and chair alarms
● Coaching on how to move patients to the bathroom and when to call for help (safety over privacy), especially when patient has a lot of lines
● Review resources and documentation with educator
● Simulations on how to manage uncomfortable experiences with patients and still ensure safety
● Share lessons across similar departments (gero-psych, outpatient therapy)
● Hourly rounding with 4 Ps
● Gait belt training/refresher
● Which patients are high risk for falls
● Escalate problem</td></tr>
</table>

• Treatment agreement for noncompliant patients • Educate on when a patient should have a longer inpatient stay • Share story with staff—event, documentation, post falls care • Training on when to escalate problem
Patient and family education
• Call light compliance—call, don't fall! • Sign in bathroom with call light usage instructions • Explain the why—especially about trip hazards • Prepare patients for shift changes • Boppy pillow education for breastfeeding mothers • Explain interventions to family

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