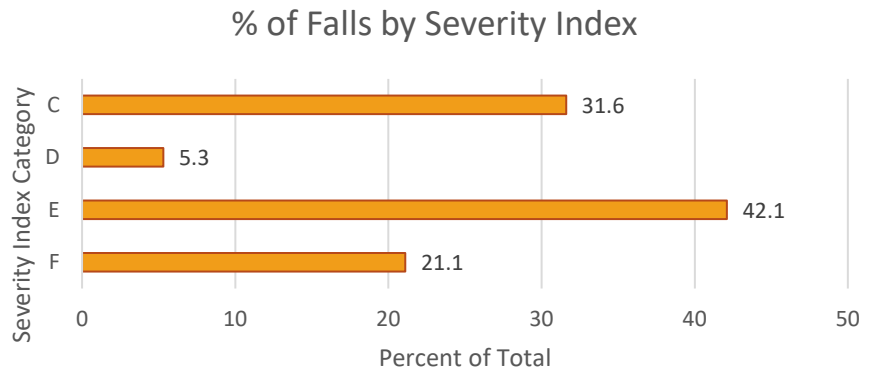
Patient Falls in Ambulatory Care Settings

Situation

Between 2018 and 2021, NCPS has received 19 reports of falls occurring in ambulatory care settings. The following graph shows the severity categories of those falls.



Severity Index Category Key:

C – Event occurred that reached the patient, but did not cause harm (includes errors of omission)

D - Event occurred that reached the patient and required monitoring to confirm that it resulted in no harm to the patient and/or required intervention to prevent harm

E – Event occurred that may have contributed to, or resulted in, temporary harm to the patient of unknown duration and required intervention

F - Event occurred that may have contributed to, or resulted in, temporary harm to the patient and required initial or prolonged hospitalization

This Safety Alert is made possible through the committed efforts of NCPS organization members in reporting patient safety events. We encourage NCPS organization members to report patient safety events to NCPS. *We improve safety when we learn together!*

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Situation

Further review of ambulatory falls reported to NCPS found that:

- Six of the falls occurred in parking lots or on sidewalks leading into the facility.
- Four happened in a lobby or reception area.
- In two of the instances occurring in outpatient departments, the hospital staff member working with the patient recognized a slip or trip hazard, verbally warned the patient of the hazard and yet the patient was unable to avoid the hazard and fell.
- Three of the instances occurred with Cardiac Rehab patients:
  - One patient was starting rehab and did not fully understanding the operation of the treadmill.
  - One patient was on maintenance and tripped coming into the building.
  - One patient fell on the front steps of the hospital when exiting the building after completing her rehab session.
- Five of the falls were experienced by persons coming into the facility for hospital sponsored senior group activities.

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Background

A fall is defined as an unplanned descent to the floor with or without injury to the patient. (AHRQ, 2013)

One-third of persons >65 years old experience a single fall each year. This equates to 36 million falls. (CDC, 2018) (Ozturk, 2021)

Falls and related injuries are major public health problems. (Johnston, 2019)

The consequences of falls among older adults include: (CDC, 2018)

- More than 95% of hip fractures are due to falls.
- Falls are the leading cause of traumatic brain injuries.
- Falls and fall injuries increase the risk of nursing home placement.
- Fall death rates increased about 30% between 2009 and 2018.

Older adult falls cost the United States $50 billion/year. (CDC, 2018)

Most falls in healthcare settings are preventable. (CDC, 2018) (Kravet, 2019) (ECRI, 2019)

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Background

- Most of the research on patient falls in healthcare settings has focused on inpatient settings; however, most healthcare in the United States is delivered in ambulatory settings. There are approximately 15 times as many primary care office visits per year as there are community hospital inpatient admissions. (Kravet, 2019)

- Screening for falls allows identification of higher-risk patients so that clinicians can take preventative steps to help avoid harmful and potentially fatal falls.
  Preventive measures may include recommendations for:
  - vitamin D supplements
  - exercise
  - physical therapy
  - medication adjustments
  - home safety evaluation

  (Huang, 2017)

- Patient and staff safety in a healthcare facility can be protected by a properly designed/built environment. Assessing safety risks and incorporating preventative measures into the facility design can minimize safety problems such as health care-associated infections, patient falls, medication errors, and security risks. (AHRQ, 2017)

Patient Falls in Ambulatory Care Settings

Assessment

A multi-pronged approach is needed to mitigate patient falls in non-inpatient care settings:

❑ **Screen ambulatory care patients for fall risk and initiate appropriate follow-up interventions**

1. **Patients should be screened at every visit, when a change in condition is noted, and after a fall.**
2. **Patients identified at risk for a fall should be referred to their primary care physician.**

See CDC's Stop Elderly Accidents, Deaths and Injuries (STEADI) program for outpatient settings (2018).

❑ **Education of Staff**

1. **Are staff in ambulatory settings given fall prevention training?**
2. **Is it specific to their work area?**
3. **Are medications which carry a fall risk "flagged" in the electronic health record to alert the ordering clinician that the medication carries a fall risk? Does the flag appear when the drug is ordered and during medication reconciliation?**

See CDC's Stop Elderly Accidents, Deaths and Injuries (STEADI) program for providers (2018). Free CEs for physicians, nurses, pharmacists, physical therapists, and other health professionals are available. Instructions may be found on the CDC website.

❑ **Education of Patient and Families**

1. **Provide written falls prevention information to patients and their families.**
2. **Communicate to the patient their risk for falling and potentially sustaining injury.**

See CDC's Stop Elderly Accidents, Deaths and Injuries (STEADI) program for patients and caregivers (2018) and Can Fall Risk Screening and Fall Prevention Advice in Hospital Settings Motivate Older Adult Patients to Take Action to Reduce Fall Risk? (Barmentloo, 2021).

Patient Falls in Ambulatory Care Settings

Assessment	❑ **Environment of Care rounding** **1. Are environmental rounds regularly performed?** **2. Are exterior and interior spaces included on the checklist?** **3. Is corrective action promptly taken for items identified as being out of compliance?** *See AHRQ's How-To Guide: Reducing Patient Injuries from Falls (2012).* ❑ **Assess hazards related to the design of their facilities.** **If new construction or remodeling of your physical building is being planned what considerations have been given to ensuring patient and staff safety?** *See the Center for Health Care Design's Safety Risk Assessment Toolkit (2017).* ❑ **Change Management Process** **Does your organization have a standardized approach to manage changes or launch new initiatives?** *See TeamSTEPPS Change Management (2014). This process includes identifying a Falls Reduction Champion to lead this initiative. This person should have the influence needed to gain the resources and commitment to have a successful completion of the project.*

	Mitigating Risks Associated with Patient Falls in Ambulatory Care Settings	Yes	No	What action is needed?
Recommendation	Does your organization have a process to assess the fall risk for patients receiving outpatient services and/or participating in senior living activities?			
	Does the screening occur at every visit, when a change in condition is noted, and after a fall?			
	Does your organization refer patients identified as having a fall risk to a clinician for preventative steps?			
	Is training/education regarding falls prevention provided to ambulatory care staff? Is it relative and specific to their work environment?			
	Are medications which carry a fall risk "flagged" in the electronic health record to alert the ordering clinician that the medication carries a fall risk? Does the flag appear when the drug is ordered and during medication reconciliation?			
	Do you provide written fall prevention materials to patients and families?			
	Do you ensure that the patient's risk of falling and sustaining a fall-related injury is effectively communicated to the patient?			

	Mitigating Risks Associated with Patient Falls in Ambulatory Care Settings	Yes	No	What action is needed?
Recommendation	Are Environment of Care assessments completed regularly?			
	Does your organization's Environment of Care Checklist include exterior building conditions as well as interior spaces? *(e.g. Do parking lots have uneven pavement/tripping hazards? Are entrance areas free and clear? Are parking areas/entrances well lit? Are exterior stairs in good repair and do they have handrails?)*			
	Are items found to be out of compliance corrected in a timely manner?			
	If you are planning to remodel your existing facility or new construction, have you reviewed AHRQ's Health Care Facility Design Safety Risk Assessment Toolkit?			
	Does your organization have a standard change management process to utilize when new initiatives are launched?			
	Does your organization have a "Falls Reduction" Champion that has the influence to gain the resources and commitment needed for the initiative's success?			

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