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Falls Prevention as a Quality Imperative: Proven Strategies for Leading Risk Factors

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Learning Objectives: Falls and Falls Prevention

- ***What?*** Examine recent national data trends regarding patient/resident falls and fall-related injuries.
- ***Why?*** Identify why patients/residents fall across care settings, including how system-based factors and implicit bias can influence fall risk.
- ***How?*** Evaluate evidence-based strategies to prevent falls and fall-related injuries.

Feel free to use the chat!

Fall Rates: National Data

- Fall rates in acute care vary from **1 to 9 per 1000 patient days** (PDs) (injury fall rates 0.4–2.0/1000 PDs), depending on the types of units and patients' characteristics and diseases. (Heikkilä et al., 2024)

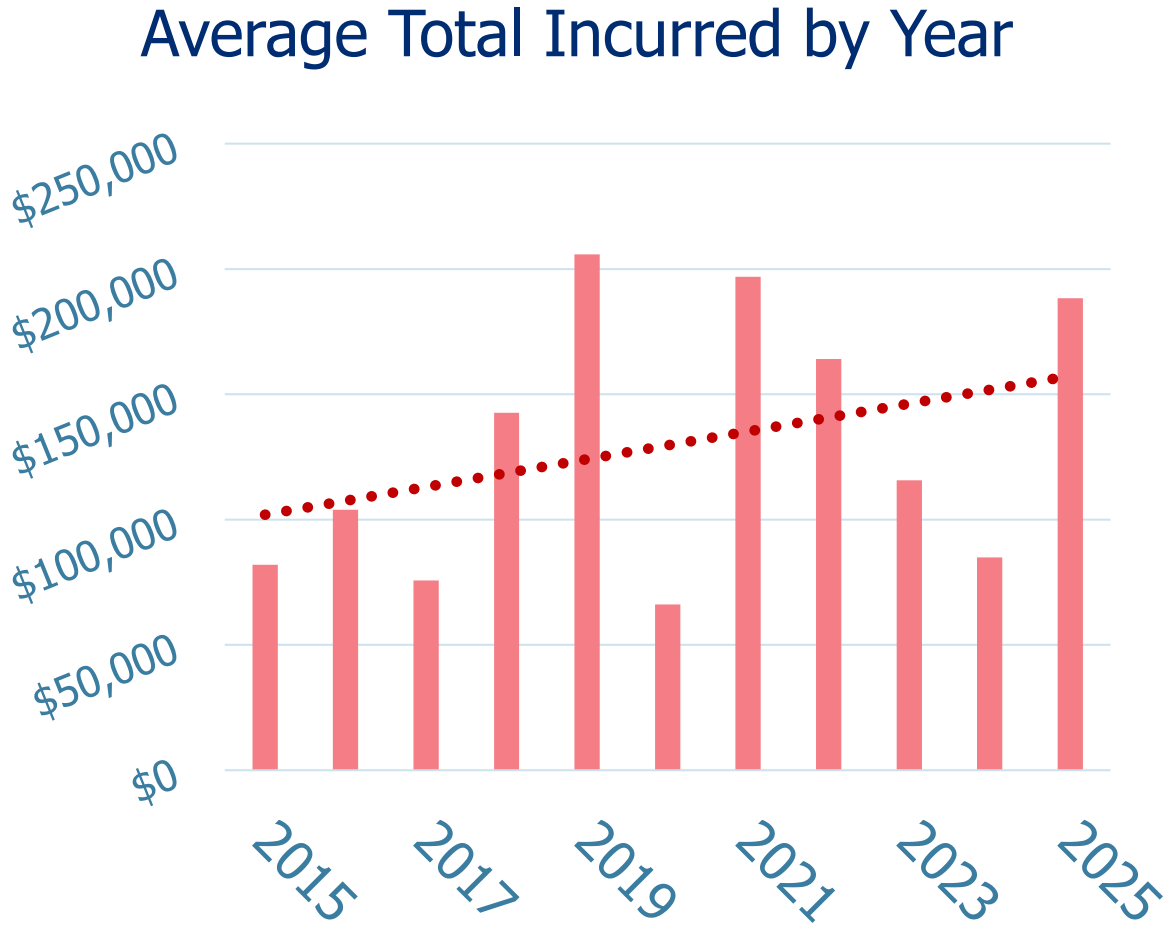
- According to CMS data published in September 2025 via Care Compare, the national average rate of long-stay nursing home residents experiencing one or more falls with major injury is **3.28%**

- Each incident can cost up to **$239,000** in medical expenses, claims, and litigation, as well as harm to patients. (Freeman, 2022)

- Recent federal report from the HHS Office of Inspector General (OIG) revealed that, despite mandatory quality reporting requirements, **nursing homes failed to report 43% of falls with major injury** that resulted in hospitalization.

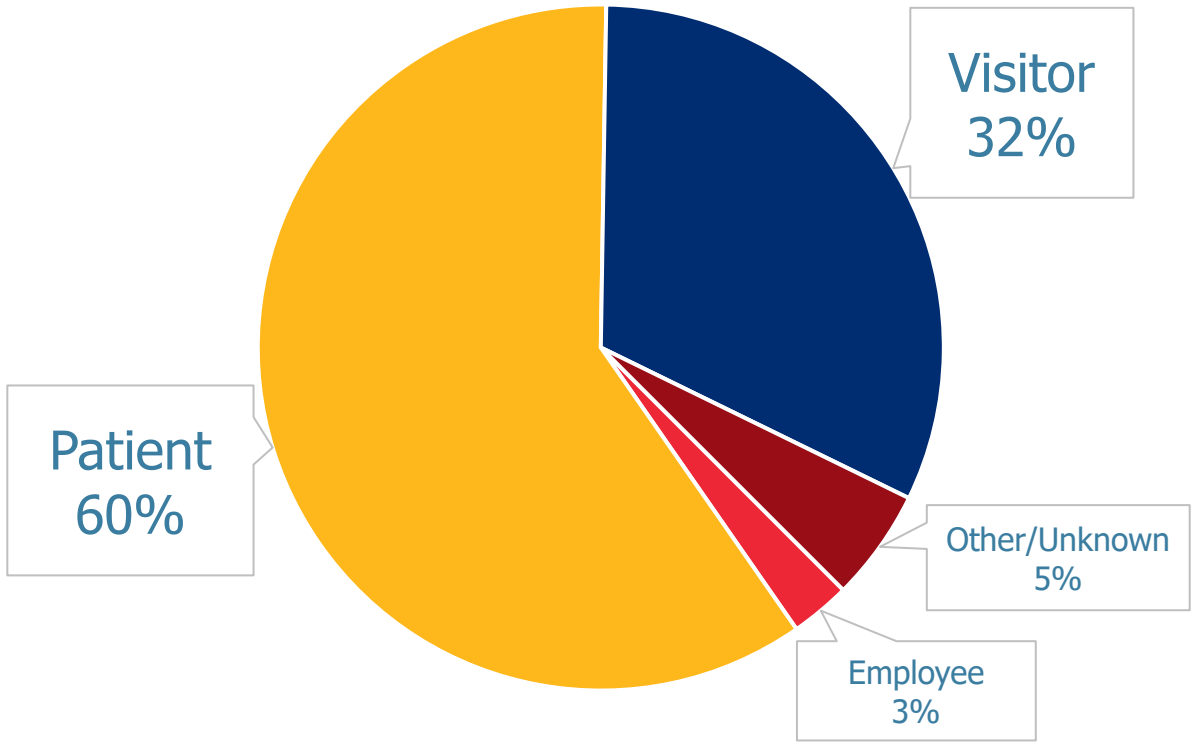
Optima Closed Claims Analysis - Falls

- Inclusion criteria:
  - Close date: 01/01/2015-11/30/2025
  - Total Incurred: >$100
- Total Number of Claims: 247
- Total Incurred, All Claims: $30,827,232
- Average Total Incurred: **$124,807**



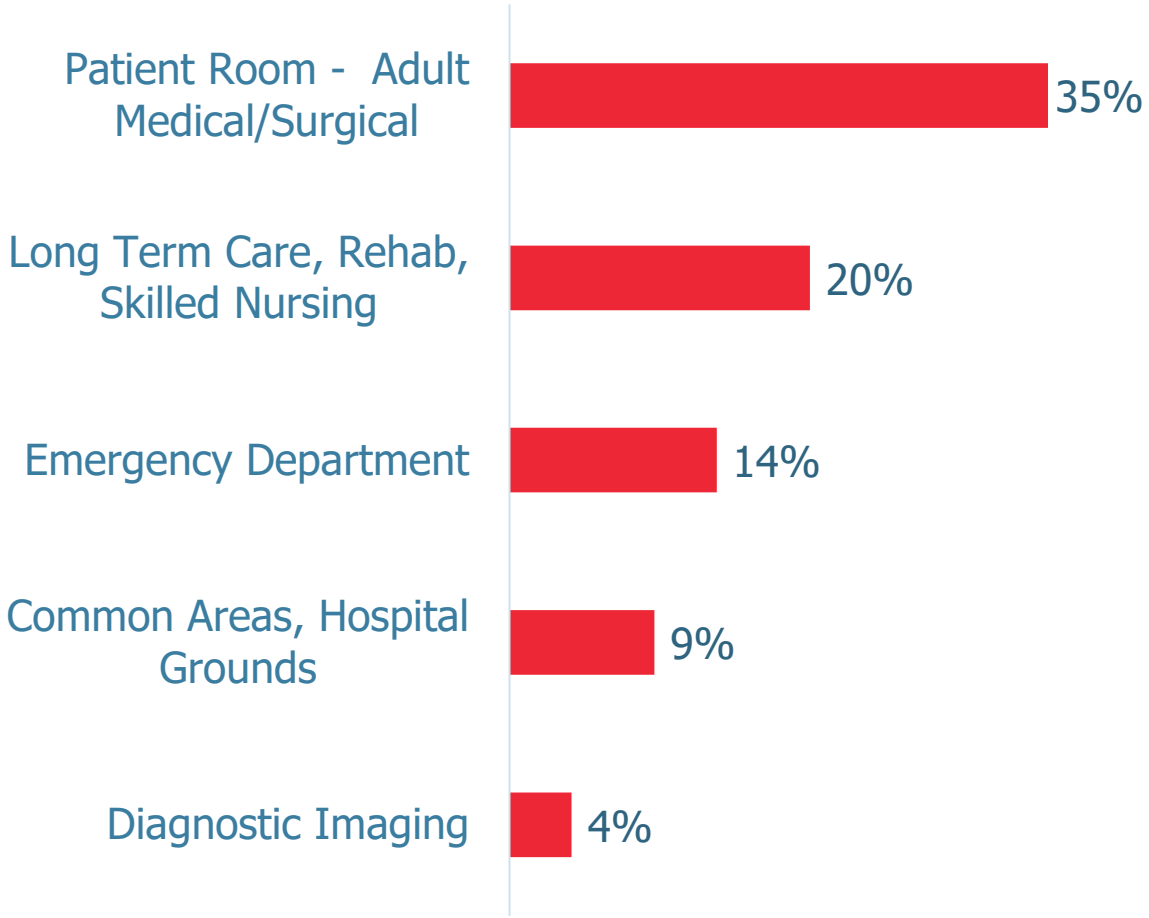
Optima Closed Claims Analysis - Falls

Fall Claims by Claimant Type



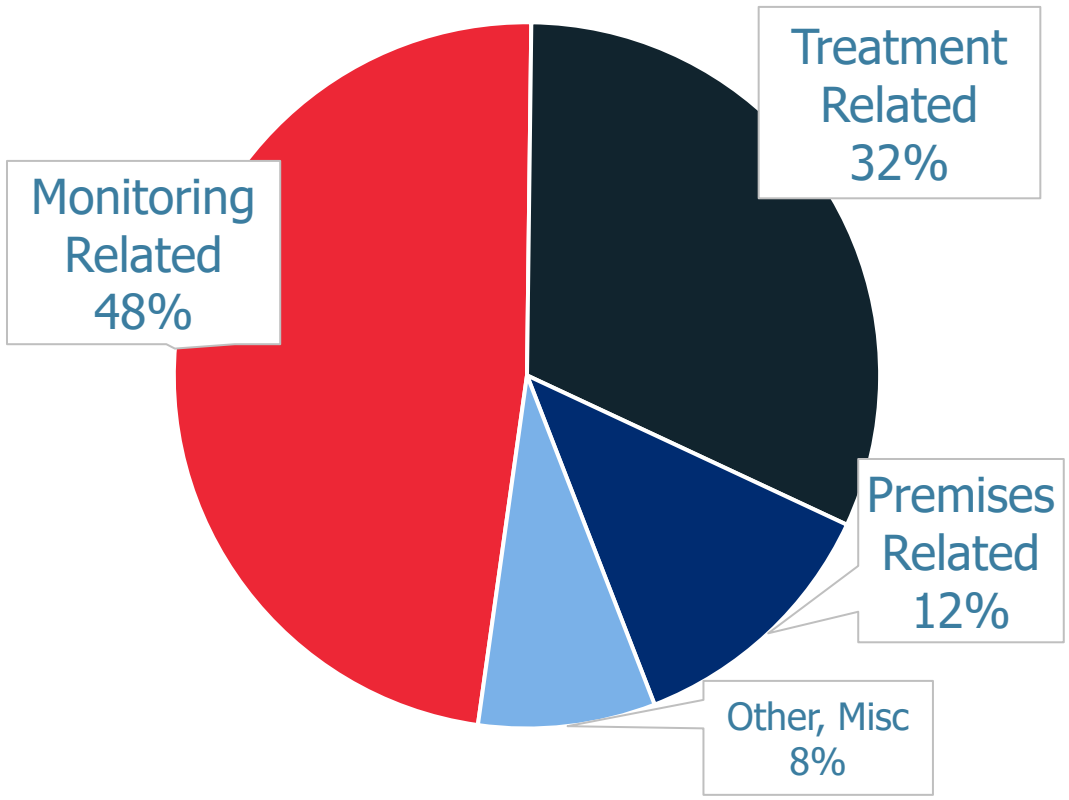
Average Total Incurred, Fall Claims Involving Patients:
$143,297 (15% higher than overall average)

Top 5 Locations of Patient Fall Claims

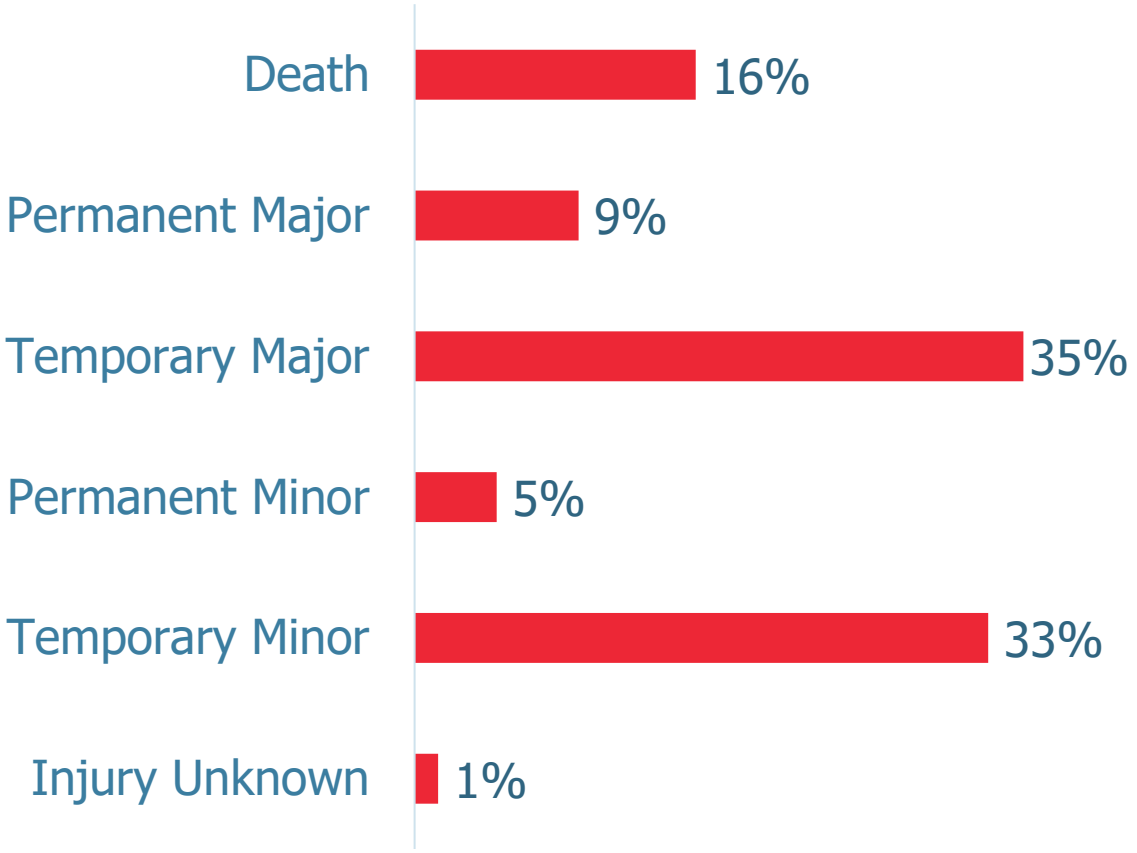


Optima Closed Claims Analysis - Falls

Contributing Factor Related to Patient Fall Claims



Injury Severity - Patient Fall Claims



Top Causes of Loss: National Professional Liability Claim Reports

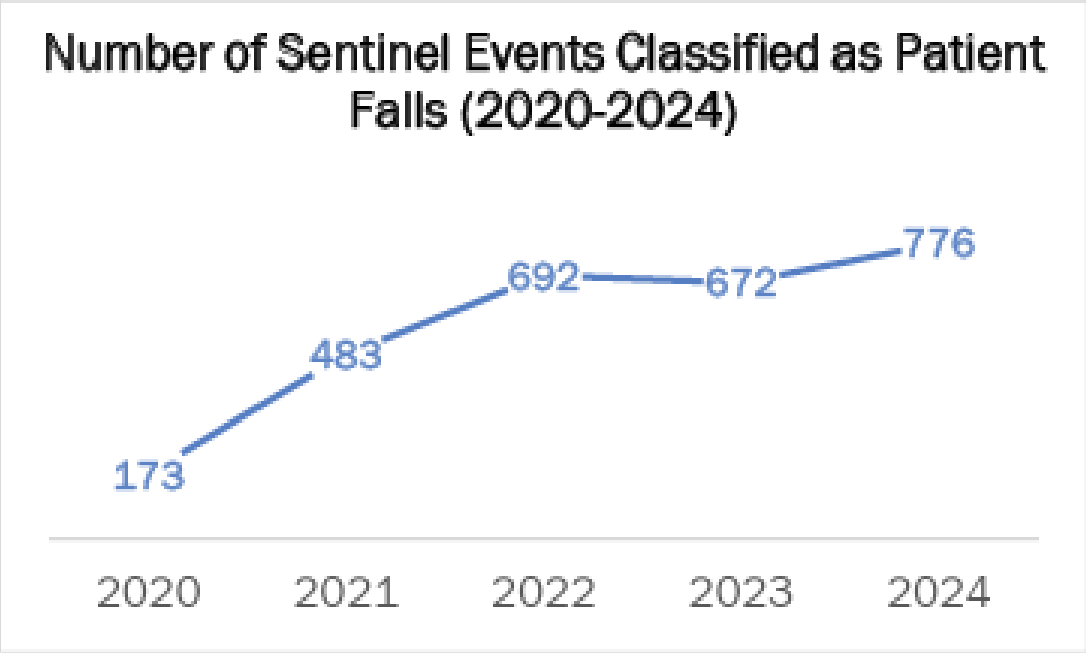
Fall-related claims account for significant exposure for healthcare providers and facilities:

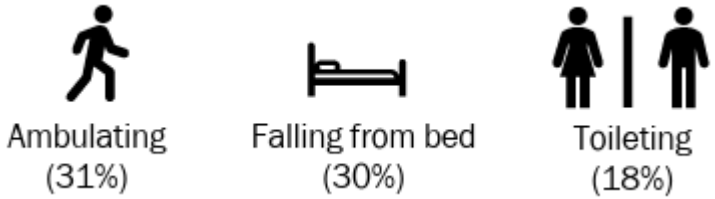
- **6.9% of all non-surgery medical professional liability claims** and cost **$124,000** on average between 2015-2024
  (ASHRM/Aon 2025-2026 Hospital and Physician Professional Liability Benchmark Report, 2025)
- **15% of nurse professional liability claims**, costing approximately **$205,000** on average between 2020-2024
  (CNA/NSO Nurse Professional Liability Claim Report: 5th Edition)

Resident falls consistently account for the greatest distribution of skilled nursing facility claims:

- **38%** of skilled nursing facility claims that closed between 2021-2023
  (CNA Aging Services Professional Liability Claim Report: 12th Edition, 2024)
- **47%** of senior living/LTC claims that closed between 2014-2023
  (Marsh McLennan General and Professional Liability Benchmark Report For Senior Living and Long-Term Care Providers, 2024)
- **31%** of LTC claims that closed from 2012–2021
  (WTW Senior Living Claims Benchmarking Study: A General and Professional Liability Analysis, 3rd Edition, 2023)

The Joint Commission: Sentinel Event Data 2024 Annual Review





Falls Leading Contributors/Opportunities (2024, n=7,774 total contributing factors identified)

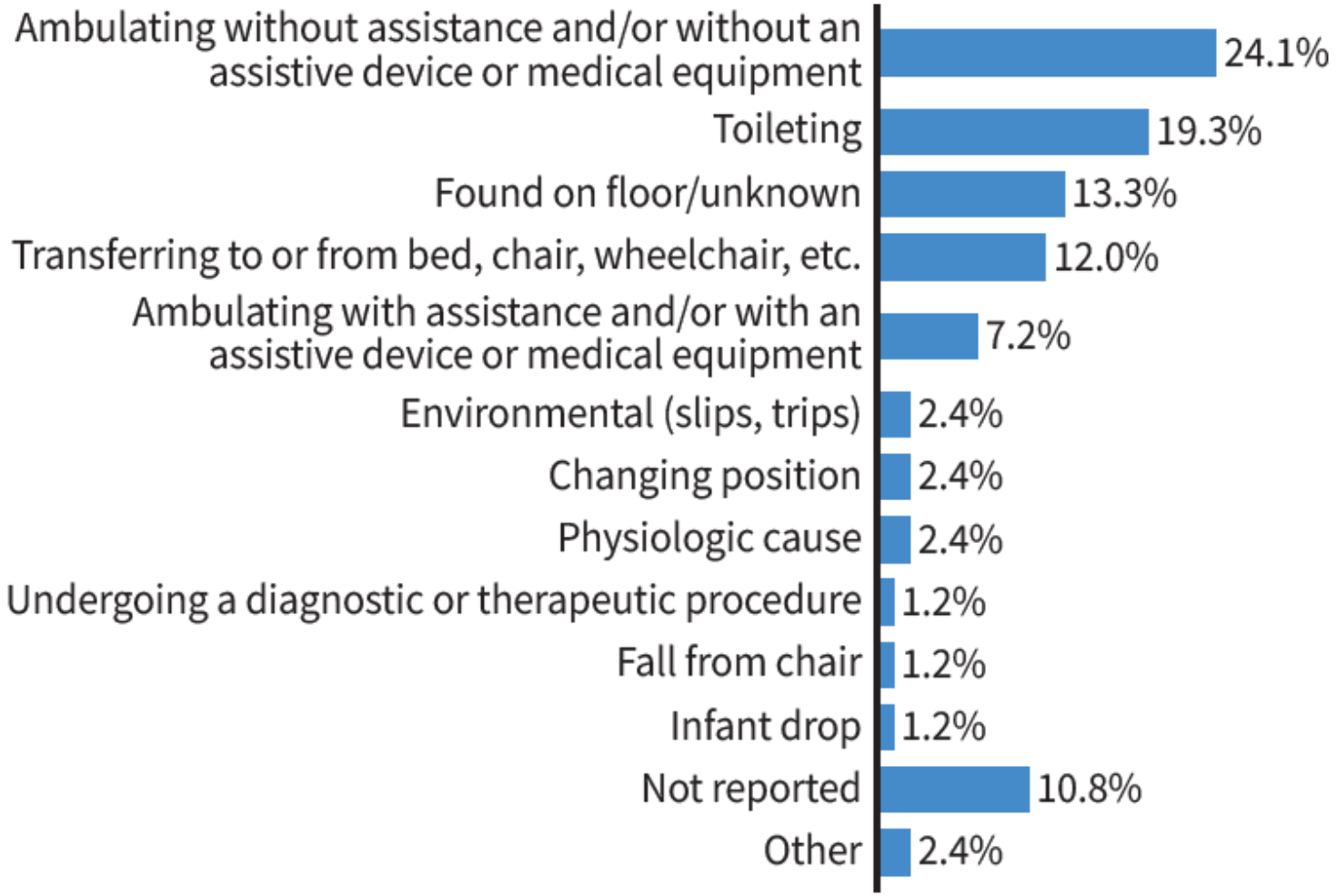
Falls risk mitigation policies and procedures were not followed or adhered to	10%
Lack of shared understanding or mental model across the care team	7%
No or inadequate patient education regarding fall risk	7%
Task fixation or preoccupation limiting situational awareness	6%
No or inadequate staff-to-staff communication during handoffs or transitions of care	6%
Insufficient provider competency to recognize abnormal clinical signs	6%
No or inadequate communication of critical information among staff	5%
Inadequate precautions in place for high fall risk patients	5%
Insufficient or incomplete staff training related to fall prevention	4%
Task saturation/multitasking increasing cognitive load	3%

ECRI PSO: Falls Data Analysis Snapshot

Time period
1/1/2021 to 12/31/2023

Total number of RCAs reported
83

Events by Type



Root Causes/Contributing Factors for RCAs

Communication Factors	**20.66%**
Communication breakdown between and among team, staff, and providers	43.18%
Communication during handoff, transition of care	22.73%
Availability of information	18.18%
Presentation of information	13.64%
Misinterpretation of information	2.27%
Staff Performance Factors	**20.19%**
Fatigue, inattention, distraction or workload	55.81%
Staff knowledge deficit or competency	44.19%
Management/Supervisory/Workforce Factors	**17.84%**
Appropriate rules/policies/procedure or lack thereof	50.00%
Failure to provide appropriate staffing or correct a known problem	23.68%
Staff training	21.05%
Failure to provide necessary information	5.26%
Equipment/Device/Supply Healthcare IT Factors	**10.33%**
Equipment, device, or product supplies problem or availability	36.36%
Malfunction, incorrect selection, misconnection	36.36%
EQUIP availability of information	13.64%
Health information technology issues such as display/interface issues (including display of information), system inoperability	13.64%

Task/Process Factors	**8.45%**
Lack of process redundancies, interruptions	50.00%
Workflow inefficient or complex	44.4%
Lack of decision support	5.56%
Environmental Factors	**5.16%**
Space availability, design, locations, storage	72.73%
Noise, lighting, flooring condition, etc.	27.27%
Organizational Culture/Leadership	**4.23%**
Organizational-level failure to correct known problem and/or provide resource support including staffing	66.67%
Workplace climate/institutional culture	22.22%
Leadership commitment to patient safety	11.11%
Team Factors	**2.82%**
Speaking up, disruptive behavior, lack of shared mental model	83.33%
Failure to engage patient	16.67%
Not Reported	**10.33%**

Case Study: Fall with Injury

Skilled Nursing Facility

Case Study: Fall with Injury

- An 80-year-old male resident of a skilled nursing facility (SNF) required full assistance with his activities of daily living and mechanical transfer to his wheelchair due to mobility issues. He also required anti-coagulant therapy to address co-morbid conditions.
- Several hours into an overnight shift, he used his call bell to ask for assistance transferring into his wheelchair.
- A certified nursing assistant (CNA) responded and became impatient when she could not find any other qualified team members who were available to assist her.
- The CNA proceeded to try to utilize a mechanical lift to transfer the resident to his wheelchair, despite his documented care plan with an order for a two-person transfer.

Case Study: Fall with Injury

- During the transfer from the bed to the wheelchair, the resident was improperly positioned in the mechanical lift, causing him to fall about three feet to the floor.
- The resident immediately began complaining of discomfort in both legs.
- The RN on duty that evening called the resident's primary care physician several times without response.
- Documentation in the healthcare information record confirmed that the CNA and RN had encouraged the resident to go to the emergency department following the fall, but he refused.
- As the night progressed, the resident's legs became swollen and his pain intensified.

Case Study: Fall with Injury

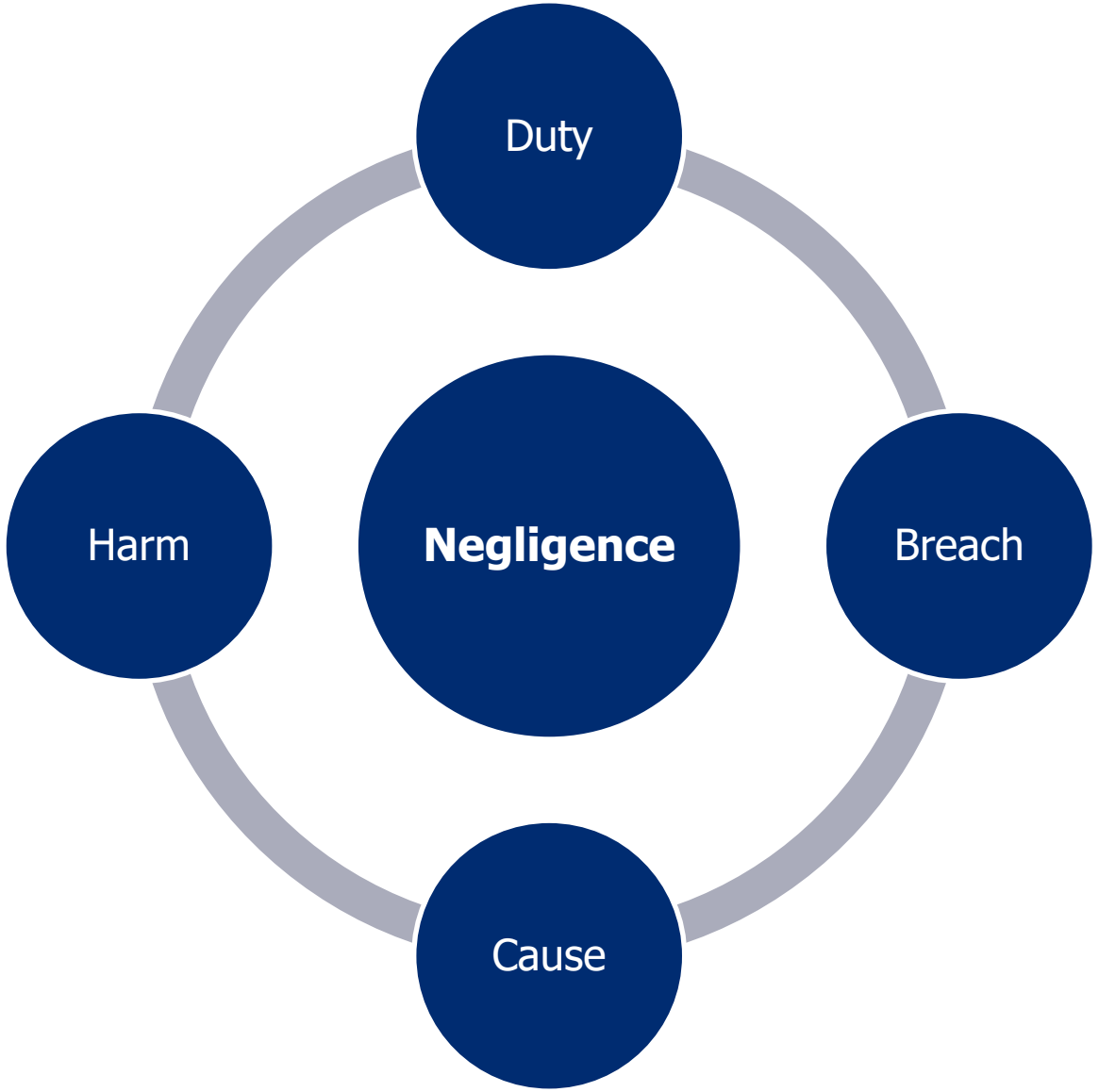
- The following morning, the SNF staff reached out to the medical director of the facility who advised that the resident should be transferred to the emergency department immediately.
- In the emergency department, x-rays revealed bilateral tibial fractures.
- During hospitalization, the resident's condition deteriorated rapidly. He experienced "coffee ground" vomiting consistent with GI bleeding, bleeding in the intercompartmental fracture areas, and the onset of renal failure.
- The resident died a few days following his admission to the hospital.

Case Study: Fall with Injury

- The resident's family initiated a lawsuit in the months following his death, naming parties including the SNF, the SNF's medical director, the CNA who was caring for him at the time of his fall, and the RN who was on duty.
- In her deposition, the CNA explained that she operated the mechanical lift alone because the facility was short-staffed and she could not find another qualified staff member to assist her.
- Complicating the defense, the CNA's note regarding the incident in the resident's record stated that there was "no apparent injury" following the fall.
- Defendants were criticized for their delay in transferring the resident to a higher level of care and for non-compliance with the care plan requirement for a two-person transfer.

Discussion Questions

- Do you think the CNA was negligent?
- If yes, do you think the CNA's negligence caused the resident's death?
- Do you think any other parties' negligence could have also caused the resident's death?



Case Study: Fall with Injury

Outcome

- In the expert witness' evaluation of the case, the defendants were criticized for their delay in transferring the resident to a higher level of care and for non-compliance with protocols requiring two people to operate a mechanical lift.
- During deposition testimony, the CNA acknowledged she had not been trained in operating the lift.
- Due to the low likelihood of achieving a defense verdict should the case proceed to trial, the defense chose to pursue a settlement agreement with the plaintiff.
- The case eventually settled for primary policy limits.

Risk Factors Influencing Falls

Staff-Related Factors

- **Fragmentation of care and services**: Contributes to poor intra/inter-department communication and cooperation
- **High care demands:** Contributes to missed/omitted care and workarounds
- **Reduced staffing**: Unfilled job openings, lower proportion of RNs, fewer skilled/ experienced nursing professionals on staff, frequent call-outs and no-shows place greater strain on employees
- **Frequent staff turnover**: Contributes to erosion of organizational goals and policies and increases instability

Conflicts between workload and staffing can lead to no-win situations for staff, such as:

- **Staffing–workload conflicts**: The amount or type of staffing does not meet the workload
- **Workload–timing conflicts**: Time does not allow for completion of all assigned tasks
- **Task–priority conflicts**: Assigned tasks are all given equally high importance (e.g., "Never leave a patient alone when toileting" and "Answer all call bells within a specific period").

Implicit Bias

In contrast to explicit bias, implicit bias is subconscious and subliminal, and we are unaware of its influence on our cognition, behaviors, and decision-making.

Implicit biases surreptitiously influence judgment and can, without intent, contribute to discriminatory behavior

We can hold explicit egalitarian beliefs while at the same time unconsciously harbor implicit stereotypes and assumptions about others that contradict those beliefs

Ageism

Weight Bias

Socio-Economic Status

Racism

Implicit Bias

How it affects clinical decision-making and patient outcomes

Healthcare providers rely on implicit messages to 'fill the gaps' in comprehensive assessments, especially when time and effortful thought are limited

Providers do not assign equal weight to each risk factor, leading to notable discrepancies between their judgement/perception of fall risk factors and those that may be derived from fall risk assessments

Biases impact clinical decision-making, which in turn effects patients' treatment and care, and contributes to adverse events

Need to address healthcare providers' implicit and cognitive biases, as their susceptibility to such biases affect fall risk assessments and interventions

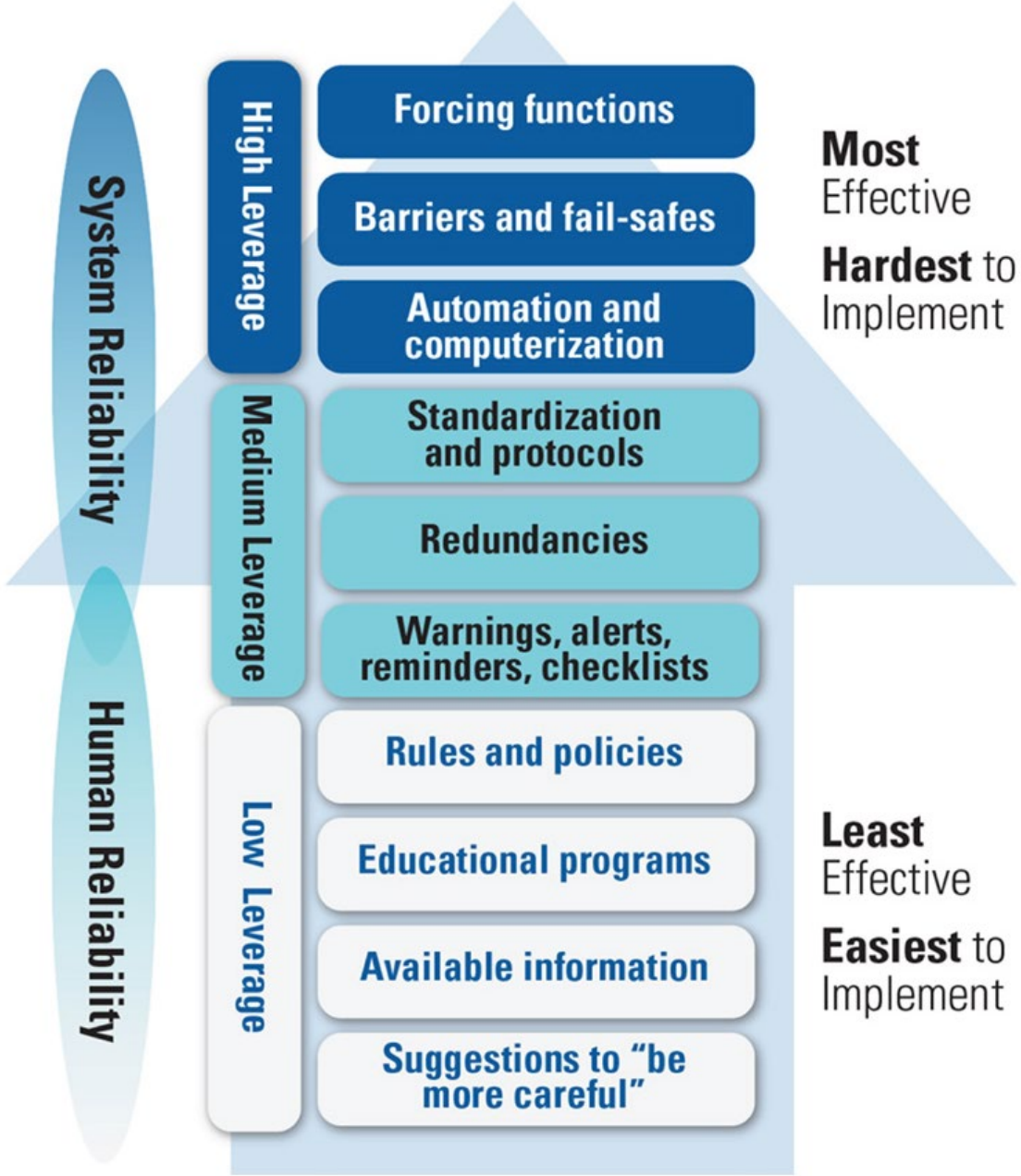
Patient-Related Fall Risk Factors

Biological	Behavioral	Medication	Environmental
• Age • Gender • Gait • Balance • Muscle mass • Vision • Chronic illness	• Cognition • Fear of falling • Emotions • Impulsivity • Activity level	• Psychotropics • Sleep aids • Narcotics • Timely administration • Med reviews	• Room design • Lighting • Furniture • Footwear • Grab bars • Clutter • Organization

System-Based Factors

- Regulatory and financial systems create incentives to maintain low fall rates
- Frontline staff behavior is shaped by leadership response and workload
- Organizational culture reinforces fear of blame
- Complacency with results causes fall prevention programs to stall or backslide
- Reporting processes may be complex or poorly designed
- Failures to correct known issues with processes, staffing, or equipment

Falls Mitigation Strategies



Action Strength	Action Type
High Leverage	Standardize equipment or processes
	Physical environment/architectural changes
	New devices (with usability testing)
	Tangible involvement by leadership
	Engineering control (forcing function)
Medium Leverage	Standardized communication tools
	Enhanced documentation, communication
	Checklists/cognitive aids
	Education using simulation-based training and observations
	Increasing staffing/decreasing workload
	Redundancy
Low Leverage	Training
	New procedure/memorandum/policy
	Warnings
	Double checks

Action Strength	Fall Prevention Action Plans - Examples
High Leverage	Establish use of a leadership rounding tool designed to improve falls risk assessment completion and implemented interventions
	Allow all members of the care team to activate the unit-based chain of command for escalation and involvement in falls prevention
	Use dome mirrors in hallways to increase patient/staff visualization
	Implement preventive maintenance program for fall prevention equipment
	Centralize process for procurement of fall prevention equipment
Medium Leverage	Require handoff reports to include fall risk status
	Implement clinical decision support that triggers fall re-assessments
	Conduct time sensitivity study for staff response to bed/chair alarms
	Implement virtual monitoring program for those at high risk of falls
	Implement and verify competencies for educational aid listing high-risk medications for falls
Low Leverage	Visualization of fall risk status via EHR

Culture of Safety

Patient safety culture is the extent to which the beliefs, values, and norms of an organization support and promote patient safety. These beliefs extend to all levels of an organization (e.g., system, department, unit) and influence the actions and behaviors of staff throughout the organization.

(*AHRQ Definition*)

Universal Precautions & Purposeful Rounding Practices

Increase patient safety communication between unit caregivers, patients, and families

Hourly rounds by RNs, LPNs/LVNs, and CNAs

- Review universal fall precautions that require checking on the patient

Help move the patient closer to their goals of care

Rounds on each shift, led by Nurse Manager

- Prompt staff to focus on various patient care and environments of care safety standards.

Provide the care team with prompts to monitor the environments of care

Environmental inspection rounds with nursing staff, facilities engineers, and senior management

Facilitate identification and mitigation of hazardous conditions

Once a check is completed, the shift leader, senior manager, or falls champion reviews findings and communicates need for action to appropriate team members.

Fall Prevention Communication Strategies

Make certain procedures universal so that staff do not have to decide which patients they apply to (such as the universal fall precautions)

Integrate communication regarding fall risk into routine points of communication, such as shift handoffs

Create visual cues or reminders in physical locations, such as logos indicating elements of the fall risk care plan (e.g., assistance with toileting) at eyesight

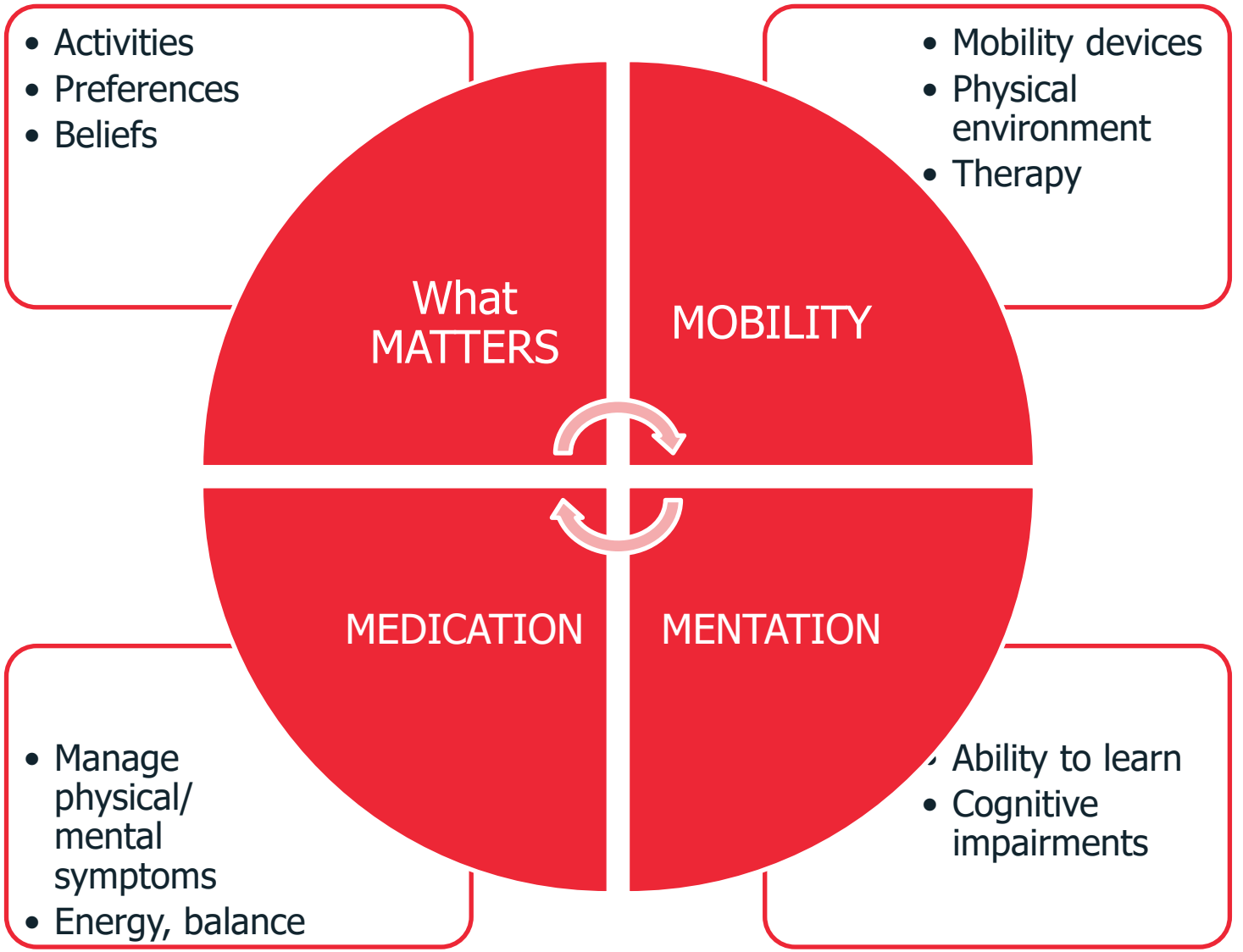
Specify in your fall prevention and management policies:

- Paths of ongoing communication and reporting
- Lines of oversight and accountability
- Documentation that is required and to whom it is submitted
- Strategies that integrate fall prevention into ongoing work processes

Managing Falls within the 4M's Framework

Age-Friendly Health Systems aim to:

- Follow an essential set of evidence-based practices;
- Cause no harm; and
- Align with What Matters to the patient and their family caregivers.



Fall Risk Assessments

Role/purpose of a fall risk assessment:

- Identifies patients at risk of falling
- Provides baseline measure of patient-specific areas of risk
- Aids in clinical decision-making
- Informs personalized preventive measures, care plans, and communication strategies
- Facilitates communication between staff
- Links strategies to counteract identified risk factors

What are your challenges to assessing fall risk?

Standardized fall risk assessment is a prerequisite to implementing an evidence-based fall prevention protocol.

Using Fall Risk Assessments

- Use valid and reliable tools
  - Ideal – 70% sensitivity and specificity
- Train staff in how to properly use risk assessment tools
- Assess patients at appropriate times
- Tailor interventions based on patient-specific areas of risk
- Patients who fall once are likely to fall again and under similar circumstances.

Note: Some assessment tools include a scoring system to predict fall risk.

- If you base a patient's individualized care plan on their fall risk score alone, their care plan will not be tailored to their risk factors.
- Instead, use assessment tools to identify fall risk factors.
- Do not rely on scores alone.

Choosing a Fall Risk Tool

- Screenings
  - Offers a fall risk score
  - Use when time is limited, lack of staff to assist, when fall risk is unknown, patient is unable to communicate or is a poor historian
  - Morse Falls Scale
  - STRATIFY
- Assessments
  - Identifies fall risk factors
  - Use when patient is good historian, time is not limited, fall risk is known, to identify specific factors for falls
  - AHRQ Falls Assessment
  - Falls Risk Assessment Tool (FRAT)
- Evaluations
  - Tests gait, balance, transfers, safety
  - Used to assess mobility, sometimes integrated with assessments, may be performed by therapy
  - Timed Up-and-Go (TUG)
  - 30-Second Chair Stand Test
  - 4-Stage Balance Test

Reapproaching Fall Incident Reporting

Draw from Systems Thinking principles:

- Staff participation
- Data integration
- Ongoing learning
- Continuous feedback

Draw from Just Culture principles:

- Non-punitive reporting policies
- Implement “good catch” reward program
- Data alignment audits
- Arrange a multidisciplinary review team

Going Beyond General Incident Reports

- **What data (fields) do you currently collect in general incident reports that can help identify fall-related patterns and cohorts?**
- General Incident Report Data
  - Person Status
  - Report Date
  - Incident (Fall) Date
  - Incident (Fall) Weekday
  - Incident Time
  - Service Line
  - Level of Care
  - Incident Type

- **What other data might you want to collect to help identify correlation of fall-related events?**
- Secondary Investigation & Data Analytics Forms
  - Staffing Factors
  - Contributing Risk Factors
    - New Admission Status
  - Workload Factors
    - Admissions
    - Discharges
  - Resident Risk Factors
    - Medications
    - Cognitive
    - Sensory
    - Mobility
    - Elimination

Falls Data

- Falls rate
  - (# of falls / resident days)*1000
- Injuries from falls (%)
  - (# of injuries/# of total falls)*100
- Frequent fallers (%)
  - (# of falls by repeat fallers/# of total falls)*100
- Population of fallers (%)
  - (# of repeat fallers/# of total fallers)*100
- Control chart
  - Identifies months with significant spike or decline in fall rates

	January	February	March
# of Falls	**4**	**2**	**7**
Patient/ Resident Days	**460**	**468**	**465**
Fall Rate	**8.7**	**4.3**	**15.0**

- Patient/Resident days ≠ census

Applying Falls Data

- Monitoring
  - Monthly, quarterly, annual trends
- Decision-making
  - Inform individual and program plans
- Benchmarks/Goals
  - SMART goals
- Data transparency
  - Share data with staff
  - Share successes and challenges
- Visuals
  - Numbers and charts are universal
- Reports
  - Document outcomes and include visuals
- Discussion at RM/safety meetings
  - Review at committee meetings

We cannot improve what we do not measure.

AHRQ Falls Management Program Framework and Tools

- Self-Assessment
- Implementation Worksheet
- Communication Worksheet
- Tracking Record for Improving Patient Safety
- Falls Assessment
- Mobility and Transfer Assessment
- Wheelchair Seating Assessment
- PCP Communication
- Fall Interventions Plan
- Equipment Inspection Form
- Staff Training Resources
- Patient Education Resources

Resources

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- Fall Prevention Guidance
- Falls management policies
- Fall Risk Assessment
- Fall response tools
- Incident reporting tools
- Falls Tracker and data tools
- Staff training tools
- Patient education templates
- Culture of safety guidance
- Falls SAQ

AHRQ

- The Falls Management Program
- LTC Falls Management Resources and Tools

Other

- Postfall Assessment Form
- FRAT (Fall Risk Assessment Tool)
- IHI: Age Friendly Health Systems

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