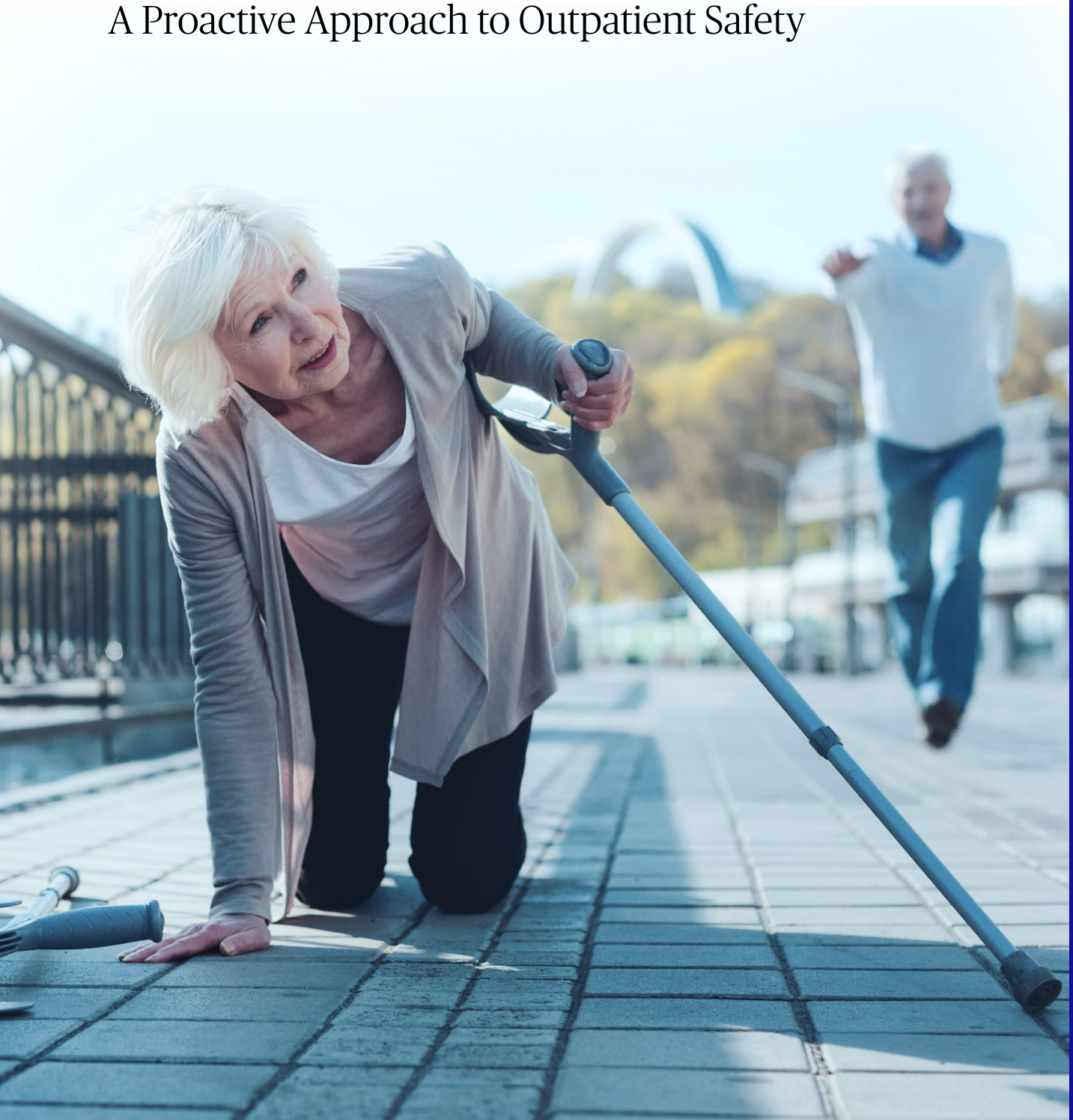
CHUBB

Slip and Fall Mitigation:

A Proactive Approach to Outpatient Safety



With the sporadic nature of ambulatory care, there is often little time to fully evaluate and observe a patient for inherent motor and sensory deficits that may contribute to falls. As a result, slips, trips, and falls pose a significant liability exposure for outpatient facilities, including: medical offices, urgent care centers, ambulatory clinics, and rehabilitation, imaging and dialysis centers, among other settings.

According to the Centers for Disease Control and Prevention, falls are more common among patients over 65 years of age. A quick look at recent statistics underscores the impact that falls have on this age group:

14M falls

occur each year, accounting for 25% of the older population

1 in 10 falls

results in an injury that restricts activity

3M fall-related

emergency department visits occur annually

1M falls

require hospitalization for broken bones and head trauma

Sources: Center for Disease Control and Prevention
Older Adult Falls Data | Older Adult Fall Prevention | CDC;
Facts About Falls | Older Adult Fall Prevention | CDC

In terms of the severity of falls, there are stark differences between older and younger patients:

65 yrs and older

- incur a falls death rate of **70.8 per 100,000 persons**
- sustain annual fall-related **fatalities of 40,919**

Under 65 yrs

- incur a falls death rate of **2.1 per 100,000 persons**
- sustain annual fall-related **fatalities of 5,709**

Source: National Safety Council Older Adult Falls — Injury Facts (nsc.org)

In fact, 50% of all elderly adults (over the age of 65) who require hospitalization for fall-related hip fractures, cannot return home or live independently after the fracture.

Source: National Floor Safety Institute Slip and Fall Quick Facts | NFSI

It comes as no surprise that the financial consequences of falls and fall-related deaths are significant, extending across the care continuum and accounting for nearly $50 billion in direct medical costs each year:

Private Pay $12B + **Medicare** $29B + **Medicaid** $9B = **Annual expenditures** $50B

Source: Falls in Senior Adults: Demographics, Cost, Risk Stratification, and Evaluation - PMC (nih.gov)

The good news is that while falls are relatively common among a certain patient demographic, they are largely preventable through clinical, operational, and environmental precautions.

Commit to a Falls Reduction Program

While fall prevention programs are well established in most inpatient care settings, their presence in outpatient facilities is less ubiquitous as mitigation strategies typically used in hospitals are often impractical for ambulatory settings. To sufficiently protect outpatients from slip and fall related injuries, facilities need to demonstrate a setting-wide commitment to the safety initiative and undertake the following five basic requirements, at a minimum:

1 Appoint a program champion.

Program champions help reinforce the dividends of fall prevention activities. In some settings, champions may appoint a fall mitigation team comprised of leadership, clinicians, therapists, social workers, and IT specialists to identify barriers to fall prevention initiatives and bring about rapid change in fall prevention practices.

2 Evaluate current fall reduction activities.

Focus initially upon patient screening efforts, the identification of environmental hazards, fall safeguards, and data collection practices.

3 Engage stakeholders.

Administrators, providers, and staff should collectively discuss their experiences with falls while caring for the patient population and together brainstorm how these events may have been prevented.

4 Communicate statistics.

Reiterate to all stakeholders that falls are both common and costly from a reimbursement and professional liability perspective.

5 Articulate priorities.

Successful fall prevention programs must be incorporated into existing clinical workflows such as, routine screening of older adults during annual wellness and prevention visits; educating patients about the heightened risk of falls during routine visits; implementing universal post-fall assessment parameters to capture contributing fall-related risk factors; and repeating patient screens after hospital stays because of recent illness on mobility.

Identify Contributing Factors

Staff training programs should prioritize the identification of patients who are at highest risk for falls. Several factors have been associated with the risk of falls and fall-related injuries, including the following:

INTRINSIC

- History of prior falls
- Vision impairment
- Loss of strength from muscle atrophy
- Confusion and disorientation
- Bowel and bladder dysfunction
- Imbalance due to dizziness
- Decreased range of motion and pain upon movement
- Reluctance to use supportive devices and aids, e.g., canes, walkers, wheelchairs
- Medication-related effects on the central nervous and/or cardio-vascular system
- Sleep deprivation

EXTRINSIC

- Unsafe footwear
- Cluttered, slippery or uneven ground surfaces
- Improper use of floor mats
- Inadequate lighting for the time of day or the location
- Lack of support structures, e.g., wall railings or stationary furniture in waiting rooms and exam areas
- Inclement weather, leading to slippery and hazardous walkways

In addition to the identification of underlying factors that may give rise to falls, providers and staff should remain vigilant to these clinical precursors commonly associated with falls in outpatient care settings:

Common Fall Precursors

Transferring patients to and from wheelchairs

Failure to monitor patients following venipuncture

Patients left unattended on exam tables

Lack of physical safeguard use in medicated patients

Poor lighting

Loose floor coverings

Lack of handrails

Screen Patients

Most ambulatory care facilities utilize a standard questionnaire by which patients are initially screened for the identification of any of the above noted risk factors, along with pertinent observations, such as current medications and potential side effects, as well as acute and chronic disease states, e.g., seizures, hypertension, strokes, arthritis, diabetes, and dementia. A sample questionnaire appears below:

1. Have you slipped, tripped, or fallen in the last 3 months? Y/N
2. Do you utilize any of the following mobility aids? Y/N
   - ___ Cane
   - ___ Walker
   - ___ Wheelchair
   - ___ Crutches
3. Do you require the assistance of another person to safely ambulate? Y/N
4. Do you have a fear of falling? Y/N
5. How are you feeling now? Y/N
   - ___ Lightheaded
   - ___ Weak
   - ___ Dizzy
   - ___ Normal
6. What medications have you taken today? _____

For a more detailed screening tool, see the Centers for Disease Control and Prevention ***Stay Independent*** questionnaire.
It should be noted, however, that despite diligent screening efforts by staff, there is no definitive predictor of falls risk. Providers and staff should therefore remain vigilant when observing the following tendencies in higher-risk patients:

OUTPATIENT RISK FACTOR PROFILE

- Is more likely to be female
- Self-reports a history of falls
- Is reluctant to use supportive devices or aids, e.g., cane, walker, wheelchair
- May take cardiovascular drugs that induce dizziness, or medications that affect the central nervous system
- Has exhibited a decline in visual acuity, altered sensory or depth perception, and/or an unstable gait

Document Assessment Findings

For patients who screen positive for fall-risk factors, staff should conduct a falls history and fully document details in the patient care record of where, when and how previous falls occurred (e.g., at home or outside, day vs. night, activity at the time of fall). In the event of litigation, patient care records are critical to defense efforts, so it is also essential to document the findings of additional patient assessments based upon identified risk factors.

Records of at-risk patients should reflect, at a minimum, that providers and staff:

- Identified medical comorbidities, such as cognitive impairment, Parkinson's disease, depression, and incontinence
- Measured orthostatic blood pressure
- Checked visual acuity
- Performed gait, strength, and balance testing
- Identified medications with potential fall-related side effects
- Assessed vitamin D intake
- Observed the patient's feet and footwear
- Inquired of home hazards

A variety of professional resources are available to assist providers and staff in performing various assessments, including those listed below:

ASSESSMENT TESTS AND TOOLS

Gait and Balance

- Timed Up and Go (TUG) Test
- 30-Second Chair Stand
- 4-Stage Balance Test

Comorbidities

- Mini-COG
- Montreal Cognitive Assessment (MoCA)

Home Hazards

- Check for Safety : A Home Fall Prevention Checklist for Older Adults

Medications

- SAFE Medication Review Framework
- American Geriatrics Society Updated Beers Criteria

Establish Mutual Expectations

Fall-related ambulatory care claims are often the result of a failure to effectively manage fall risk and patient safety expectations. Providers and staff should inform patients of fall prevention measures, both verbally and in writing, emphasizing that falls management in clinical settings is a shared responsibility.

STAFF *SHOULD...*

- Relay the expectation that patients comply with staff instructions
- Flag patient care records of at-risk individuals in an obvious and consistent manner
- Place signage in clinical settings that indicates the potential risk for falling, with hazardous areas clearly designated
- Assess pain levels in patients and inquire if they have personal needs

PATIENTS *SHOULD...*

- Request help with ambulation during an exam, if needed
- Wait for assistance getting on and off of an exam table
- Notify staff when they feel weak or unsteady
- Comply with safety instructions when under the influence of medications that affect the cardiovascular or central nervous system

In order to promote full awareness of fall risk in the clinical setting, facility-wide educational programs should be mandatory for administrators, staff, ancillary workers, and volunteers. In addition, educational pamphlets and/or digital resources should be distributed to patients, so they are fully apprised of both the risk for falling and mitigation measures. In the event of noncompliance, it is recommended that staff confront patients directly and clearly restate safety expectations.

Maintain Safe Environments

An effective fall prevention program requires regular safety inspections of patient exam and treatment areas, as well as walkways, both interior and exterior. The assessment process should verify compliance with the following measures, among others:

- Maintain exam and procedure tables at low position when patients are unattended
- Ensure patient transport gurneys and exam and procedure tables are equipped with proper safeguards, e.g., handles, side rails, and step risers
- Install handrails and nonslip treadways on all interior walkways and in bathrooms
- Lock stationary wheelchairs to prevent accidents
- Ensure emergency call systems in clinical areas and bathrooms are functioning and readily available to patients
- Illuminate interior spaces and reduce flooring glare
- Keep floors dry by quickly removing spills and puddles from surfaces
- Post signs near entrances warning of potentially slippery surfaces
- Select flooring surfaces for their natural traction, consulting safety engineers to ensure the slip-resistance factor is sufficient
- Regularly test flooring surfaces by certified walkway specialists on a regular basis
- Apply aftermarket flooring sealants, treatments, and coatings in accordance with the flooring manufacturer's recommendations
- Remove debris and repair cracks, potholes, and worn spots from sidewalks, driveways, walkways, and parking lots
- Implement written policies for the removal of snow and ice
- Apply salt or sand to exterior walkways immediately after snow storms, and guard against "black ice" in parking lots and other paved areas after snow has been cleared

Follow Response Protocols

In the event of a fall, providers and staff should comprehensively document the following items in the patient care record:

- Details of the incident, along with immediate causes and contributing risk factors
- Names of witnesses to the event and their contact information
- Physical assessment findings, including any medical conditions, interventions, and treatment
- Physician notifications and/or transfers to acute-care facilities
- Location of sequestered equipment or devices that may have contributed to the fall
- Actions taken following a post-fall team huddle

In addition, suspicious slip and fall incidents require a formal root cause analysis (RCA) in order to identify areas of deficiency, both operationally and procedurally. All post-fall RCA findings should be incorporated into quality assurance and performance improvement programs.

Resources

Centers for Disease Control and Prevention and the STEADI (Stopping Elderly Accidents, Deaths & Injuries) Initiative

- Checklist: Fall Risk Factors, 2017.
- Clinical Discussion Tool: Helping Older Patients Reduce Their Risk of Falling, 2022
- Coordinated Care Plan to Prevent Older Adult Falls, 2021
- Evaluation Guide for Older Adult Clinical Fall Prevention Programs, 2019
- Referral Form: Fall Prevention Patient Referral, 2017
- Tele-Med Adaptation of the Coordinated Care Plan to Prevent Older Adult Falls, 2024

Outpatient Falls Mitigation Self-Assessment Tool

Consistent and periodic review of existing slip and fall prevention strategies helps ensure that ambulatory patients remain upright during clinical encounters, while minimizing the potential threat of litigation for facilities and providers. The following falls mitigation tool – to be completed by administrators or qualified care professionals — is designed to help outpatient facilities assess a range of measures to aid in the reduction of fall-related risks.

Date of Assessment:

Name(s) of Assessor(s):

Title & Department:

Staff Training	Yes	No	NA	Comments
Fall prevention training sessions are provided upon hire and annually thereafter, in order to reinforce the following topics:				
• The incidence rate of slips and falls in outpatient care				
• Common risk factors and unsafe conditions that give rise to falls				
• Safety device utilization, including exam table siderails, wheelchairs, transport gurneys, and handrails				
• Post-fall response reporting requirements				
• Common fall precursors in the clinical setting				

Patient Screening and Assessment	Yes	No	NA	Comments
A standard screening tool is adopted to consistently identify patients who are at greatest risk for a slip and fall incident.				
Fall-related risk factors are thoroughly assessed, including, but not limited to, the following:				
• Acute illness and chronic diseases				
• Bowel and bladder dysfunction				
• Use of sense-altering medications, e.g., psychotropics, sedatives, hypoglycemics, vasodilators, antihypertensives				
Findings of unsteady gait and poor posture are fully documented in the patient care record.				
Documenting Histories	**Yes**	**No**	**NA**	**Comments**
Patients are asked about past falls and their use of ambulation aids and/or the need for human assistance.				
All historical findings are documented in the patient care record.				
A medication profile is noted in the patient record, highlighting all drugs that affect the central nervous and cardiovascular systems.				
Inquiries into recent illnesses are noted, with emphasis on strokes, seizures, orthostatic hypotension, or febrile states.				
Promoting Patient Safety	**Yes**	**No**	**NA**	**Comments**
Facility-wide educational programs for staff, ancillary employees, and volunteers include the importance of proper equipment use and maintenance, well-lit examination areas, and the appropriate height of gurneys, as well as exam and procedural tables.				
At-risk patients are flagged in the patient care record.				
Patient intake sheets clearly identify the risk for slips and falls.				
Patients are informed of fall risks and preventive strategies, and are given online materials and/or resource pamphlets concerning fall risk and clinical safety expectations.				
Staff are assigned patient care responsibilities for the post-treatment period, in order to decrease the likelihood of patient falls and injuries due to inattentiveness.				
Patient handoff policies for patients who undergo outpatient elective procedures emphasize the need to avoid lapses in monitoring that may lead to patient falls.				

Safeguarding Clinical Environments	Yes	No	NA	Comments
An injury prevention and life safety plan includes fall mitigation measures.				
Exam and treatment areas are routinely assessed for functioning emergency call systems, sufficient lighting, and appropriately maintained patient care equipment.				
Hazardous signs are posted to indicate areas where wet spots and other slippery surfaces exist in the clinical setting.				
A comprehensive floor safety program is in writing.				
Written safety protocols address the management of seasonal hazards, such as heavy rain and snow and ice accumulation.				
Concluding Treatment/Procedures Safely	**Yes**	**No**	**NA**	**Comments**
Discharge criteria are formally established and consistently implemented, in order to determine whether a patient is deemed ready to ambulate without dizziness post-treatment or procedure.				
Staff remain cognizant of factors that can affect a patient's ability to ambulate, including anesthetic and sedative agents.				
A "responsible adult" is identified and available to assist and support the patient should symptoms of gait instability be present upon discharge.				
Patients who receive anesthetic agents or sedatives are transported out of the facility in a wheelchair and discharged to a responsible adult.				
Documenting Falls	**Yes**	**No**	**NA**	**Comments**
Fall-related injuries are comprehensively documented in the patient care record, including, but not limited to, the following items:				
• Circumstances surrounding the fall				
• Contributing factors				
• Physician notification				
• Family notification, if applicable				
• Medical actions taken, including patient transfer to an acute care facility				
• Physical and mental condition post-fall				
• Functional status before and after the fall				
A root cause analysis is conducted on all slip and fall incidents that give rise to injury, in order to determine if faulty equipment and/or contributory actions by the patient/staff factored into the incident.				
Incident reports are completed, including the names of witnesses and their account of the occurrence.				

Chubb has created this resource to help risk managers take the necessary steps to improve patient safety and reduce liability associated with slip and fall occurrences.

Connect with Us

For more information about protecting the outpatient and ambulatory services environment, visit us at www.chubb.com for healthcare risk management tools, tips and resources.

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