New *Sentinel Event Alert* on Patient Falls

The Joint Commission recently published its 55th *Sentinel Event Alert* on preventing falls and fall-related injuries in health care facilities. *Sentinel Event Alert* is a free publication of The Joint Commission that addresses key patient safety and health care quality issues. Falls resulting in injury are a prevalent patient safety problem. Hundreds of thousands of patients fall in hospitals every year, with between 30% and 50% resulting in injury. The average cost of these injuries is approximately $14,000 each, as injured patients require additional treatment.[1] Falls also can prolong a patient's hospital stay.

Any patient of any age or physical ability can be at risk for a fall due to physiological changes due to a medical condition, medications, surgery, procedures, or diagnostic testing that can leave him or her weakened or confused. Falls with serious injury are consistently among the top 10 sentinel events reported to The Joint Commission's Sentinel Event Database, which has 465 reports of falls with injuries since 2009, with the majority of these falls occurring in hospitals. Approximately 63% of these falls resulted in death, while the remaining patients sustained injuries. (Note that the sentinel event data are based on self-reporting by health care organizations and are not epidemiologically valid.) The most frequently identified root causes that contribute to patient calls include the following[1]:

- Communication failures
- Lack of adherence to protocols and safety practices
- Inadequate staff orientation, supervision, staffing levels, or skill mix
- Deficiencies in the physical environment
- Lack of leadership

In the *Alert*, The Joint Commission recommends several strategies to prevent patient falls; among these are the following[1]:

- Lead an effort to raise awareness of the need to prevent falls resulting in injury.
- Establish an interdisciplinary falls injury prevention team or evaluate the membership of the team in place to ensure organizational infrastructure and capacity to reduce injury risk from falls.
- Use a standardized, validated tool to identify risk factors for falls, preferably integrated into the electronic medical record.
- Develop an individualized plan of care based on identified fall and injury risks and implement interventions specific to a patient, population, or setting.
- Standardize and apply practices and interventions demonstrated to be effective, such as a standardized patient handoff process and patient education.

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Top 5 in the News

The Joint Commission Launches Campaign on Antibiotic Stewardship The Joint Commission recently unveiled an educational campaign on the safe and appropriate use of antibiotics through its Speak Up™ program. The campaign is designed to help patients and families learn about how to use antibiotics and the risks associated with overuse. This campaign is the first in the Speak Up series to simultaneously introduce a complete package of free resources, including an infographic, podcast, and video. Visit http://www.jointcommission.org/topics/speakup_antibiotics.aspx for more information.

Study: Intensive Blood Pressure Management May Reduce Mortality More intensive management of high blood pressure, below a commonly recommended blood pressure target, significantly reduces rates of cardiovascular disease and lowers risk of death in a group of adults 50 years and older with high blood pressure. This is according to the initial results of a landmark clinical trial sponsored by the National Institutes of Health called the Systolic Blood Pressure Intervention Trial (SPRINT).

New IOM Report Shines Light on Diagnostic Errors A new report from the Institute of Medicine (IOM) focuses on reducing diagnostic errors to improve the safety and quality of health care. The report, *Improving Diagnosis in Health Care*, outlines eight strategies that all health care stakeholders can follow to prevent these widespread errors, which researchers say will affect most patients at least once in their lifetime. Visit http://iom.nationalacademies.org/Reports/2015/Improving-Diagnosis-in-Healthcare.aspx to read the report.

ISMP: Pharmacists Should Double-Check Prescription Contents Giving a correctly dispensed prescription to the wrong patient is one of the most common mistakes reported to the Institute for Safe Medication Practices (ISMP)—ISMP recently called for pharmacists to work directly with patients to catch errors. The July issue of the *ISMP Medication Safety Alert!*® Community/Ambulatory Edition describes how errors can happen and provides practical recommendations for reducing the risk, such as pharmacists and patients double-checking the contents of prescription bags before patients leave the pharmacy.

CMS Finances Second Round of Hospital Engagement Networks The US Centers for Medicare & Medicaid Services (CMS) recently awarded $110 million in Affordable Care Act funding to 17 national, regional, or state hospital associations and health system organizations to continue efforts in reducing preventable hospital-acquired conditions and readmissions. Through the Partnership for Patients initiative, a nationwide public-private collaboration that began in 2011 to reduce preventable hospital-acquired conditions by 40% and 30-day readmissions by 20%, this second round of the Hospital Engagement Networks will continue to work to improve patient care in hospital settings. Visit http://cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2015-Fact-sheets-items/2015-09-25.html for more information.

Visit **http://www.jointcommission.org/assets/1/18/SEA_55.pdf** to view the *Alert*. The Joint Commission Center for Transforming Healthcare recently completed a project on preventing patient falls with injury. Visit http://www.centerfortransforminghealthcare.org/tst_pfi.aspx for more information on that project, or see the article beginning on page 7 of the September 2015 issue of *The Source.* TS

Reference

1. The Joint Commission. Preventing falls and fall-related injuries in health care facilities. *Sentinel Event Alert* No. 55. Sep 28, 2015. Accessed Oct 8, 2015. http://www.jointcommission.org/assets/1/18/SEA_55.pdf.