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RESEARCH ARTICLE

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Reducing the cost of inpatient falls: An ERM perspective

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Abstract

Traditional fall prevention activities are not effective in preventing inpatient falls or injuries from falls. A knowledge of the five steps of Enterprise Risk Management (ERM) provides risk professionals with opportunities to apply them on an organization-wide basis to existing risks. The authors demonstrate how to apply the five steps of ERM to the common risk/patient safety issue of fall injury prevention. The authors completed a comprehensive literature review and identified predictors of injuries from falls. A comprehensive framework emerged which assists in predicting and preventing falls with injury in the inpatient setting. In combination of two or more, the following have been shown to predict injuries after falls: the use of oral anticoagulants, being born female, dementia, polypharmacy, the use of Fall Risk Increasing Drugs, urologic co-morbidities, and HIV positive status. When the ERM Process is applied to injury from falls, a Strategic Risk Response is created which assists the risk professional with application of the ERM process. Shifting focus from fall prevention to fall injury prevention, with the application of the ERM Process, creates value for the patient and the organization, and contributes to program success and sustainability.

INTRODUCTION AND OBJECTIVES

Healthcare risk management has historically centered around activities that identify, evaluate, and reduce the incidence of clinical risks and patient safety concerns, as well as identifying those events that expose the organization to claims or litigation. Today, the scope of the risk management role is still largely clinical risk and patient safety focused. However, Healthcare Risk Management has been moving toward the concept of Enterprise Risk Management (ERM) in more recent years.

In its over 40 years of evolution, American Society for Health Care Risk Management (ASHRM) has been at the forefront of elevating the work of risk management professionals with education and networking opportunities that increase the skillset of the risk management professional.[1] The risk management profession has been moving from a reactionary process to a proactive process—and from a management of purely clinical risk and patient safety issues to that of organizational risks and opportunities.

For many healthcare risk professionals, whose focus has been entirely clinical risks, the concepts of ERM and how the risk professional can influence the other domains outside of clinical and patient safety risks can be eye-opening. These risk professionals, who find themselves endeavoring to enlarge their mindset from clinical risks to that of ALL organizational risks, may benefit from this application of a clinical risk (something familiar) to the ERM process to make sense of how ERM is applied.

The objectives of this article are:

- Identify the five steps of the ERM Process.
- Understand how to apply the ERM Process to the prevention of falls with injury.
- Apply the principles of ERM to other risks identified in the organization.
- Create value for the organization and the patients who are served there. Figure 1.

WHAT IS ERM?

ERM is a method used to approach managing all risks, across all domains, that aligns with the organization's mission, vision, and values.[1] This approach allows the organization to determine which risks should be examined and what strategies should be used to treat those identified risks. Integral to this framework, ERM evaluates risks not only as potential losses, but as opportunities to create value. ERM also allows detection and response to risks both present and emerging.[1] In ERM, the risk management professional works alongside other members of the strategic team, not to be the department of "no," but the department of "how." This may sound daunting to clinical risk professionals.

Figure 1 gives an over view of the 5 steps of ERM and how they apply to the clinical risk of falls resulting in injury. These concepts will be explored in greater detail throughout this article.

ERM Step		ERM Related Action	Application to Falls Resulting in Injury
Step One	**Risk and Opportunity Assessment**	Create a Risk List	Determine if falls resulting in injury belongs on the entity's Risk List.
Step Two	**Key Performance Indicators (KPIs), Performance Measurement, Key Risk Indicators (KRIs)**	Determine KPI, KRIs, and entity risk tolerance for every item on the Risk List. Determine associated metrics and goals.	If falls resulting in injury is identified for the risk list, assign objectives and associated goals in order to measure performance.
Step Three	**Risk Evaluation and Assessment**	Place risk list items in domains. Assign a risk score for each item. Evaluate risk scores for each risk list item in the aggregate to determine where to place immediate focus.	Entity leaders should determine into which one of the 8 ERM domain falls resulting in injury belongs? Evaluate the risk score for falls resulting in injury to determine its significance when compared to other entity risks.
Step Four	**Strategic Risk Response**	Review risk scores to identify those items on the risk list that require intervention with risk tactics. These include Risk Control and Risk Financing tactics/techniques. They also can include a combination of techniques.	If falls resulting in injury have scored as a high risk, determine the entity's response. Review available Risk Control and Risk Financing Techniques to determine the best fit for the entity. Does the entity have risk predictive software that identifies those who will be injured after a fall?
Step Five	**Review, Evaluate, and Monitor**	Reflect on the current state of the ERM program. Review each item on the Risk Register. Review reflective questions from Step 5.	Review all fall related metrics. Review reflective questions on the state of the Fall/Injury Prevention Program from Step 5. Determine if adjustments need to be made.

FIGURE 1 An overview of the 5 steps of ERM.

However, the risk professional already has the skills necessary to support the team through applying risk management principles across all domains in an organization.

Although this article's purpose is to demonstrate the application of the ERM process to a clinical risk, it is essential to understand that for the successful adoption of ERM as a method, the organization must also have a risk-aware culture. This culture should start at the top leadership and cascade down through the organization, reflecting the values set forth by the governing body. The structure and division of governance in the organization may vary related to the groups appointed for implementing the ERM process. However, these groups will have the responsibility of identifying the organizational risks and determining which risks will be examined further for the strategic purposes of the organization.

By integrating the ERM framework and principles into decision-making and strategy building, the benefits will be realized in several ways. The organization will see improvements in strength and governance; improved decision-making; and support for the organization's advancement of safe and trusted healthcare in the community.[1]

The ERM Process includes five steps to identify and manage risk and uncertainty. This article will navigate through the ERM Process as it applies to preventing injuries which result from patient falls.[2]

STEP ONE OF THE ERM PROCESS: RISK AND OPPORTUNITY ASSESSMENT

The first step of the ERM Process is Risk and Opportunity Assessment. For those Risk professionals who have yet to move to the ERM Model, this is usually done only in the Clinical/Patient Safety Domain. In ERM, the risk professional can identify risks across all 8 ERM domains. The 8 ERM domains will be presented later in this article.

The first step is the creation of a risk list. One way to create the risk list is to interview leaders in the organization to gather information about the specific risks in each department. Sample letters and interview tools may be found in the Healthcare ERM Playbook from ASHRM (Figure 2).

Once risks are identified across the organization, they are placed on a risk list. This is a simple line listing of identified risks without an assessment as to likelihood or impact. Figure 2 is a sample risk list representing other domains as well as Clinical/Patient Safety.

Sample Risk List
Falls resulting in injury
Negligent credentialing
Aging infrastructure
Ransomware
Poor reputation in the community
EMTALA (Emergency Medical Treatment and Active Labor Act) issues
Staffing shortage
Budgetary performance

FIGURE 2 Sample risk list.

WHY FALLS RESULTING IN INJURY MAY BELONG ON YOUR RISK LIST

In 2013, the Agency for Healthcare Research and Quality published their toolkit entitled, Preventing Falls in Hospitals: A Toolkit for Improving the Quality of Care. This publication asserted that 1/3 of all patient falls could be prevented. In 2013, between 700,000 and 1,000,000 patients (about the population of Delaware) fell while in the hospital (AHRQ, 2013). If fall prevention efforts are effective, between 230,000 and 330,000 falls should be preventable based on these statistics. However, focusing on the prevention of all falls may not be the most effective process to prevent falls.

FALLS RESULTING IN INJURIES LEAD TO CLAIMS

Patient falls make up 66%, or 2/3, of all claims in healthcare. The awards associated with a slip, trip, or fall can vary from $10,000 for a minor injury to upward of $1 million for a severe injury. Recent studies show that the elimination of ten serious reportable events per year eliminates 3.7 malpractice claims per year. Conversely, increasing serious reportable events by 10 per year increased malpractice claims by 3.7 per year.[2] When patient safety efforts fail, the patients suffer, and the risk professional is left to manage the claims that result.

CLAIMS COSTS ARE SUBSTANTIAL AND MULTI-FACETED

Claims for falls resulting in injuries may be comprised of the following:[3,4]

- Medical costs to treat the injury
- Additional medical costs and personal care
- Loss of income
- Future losses and damages
- Pain and suffering
- Permanent impairment or disability

Additional factors associated with costs of fall related injuries may include patient age and setting.[3] The cost of treating inpatient fall-related injuries is directly proportional to the patient's age. Fall related injuries that occur in the hospital setting are far more expensive than those occurring elsewhere.

Attempts to prevent all falls may lead to expenditures focused on those who are not at risk of injury. This may take resources, such as Patient Safety Attendants, away from those at risk of injury.

Post-fall diagnostic testing studies may also add to the cost of fall injuries. One study found that post-fall radiologic studies outnumbered the actual falls. Eighty-five percent of these studies were negative. Head CT was the most ordered test with an average cost of $663. The average cost of other fall related CT scans in the US is $3275-$6750. Imaging services account for 34% of additional medical costs in total.[5]

Other factors associated with increased cost of fall-related injuries include length of stay (LOS), which increases by more than 6 days after a fall with injury. Falls with injury also double the cost of hospitalization. This is even more impactful on those patients requiring surgery after a fall (Baris et al., 2018).

IN SUMMARY

Traditional fall prevention activities and programs are ineffective at preventing falls and falls with injury. By placing the focus on fall prevention rather than prevention of injuries from falls, important resources may be wasted. The result is harm for the patient, loss of healthcare resources and dollars, and increased claims that must be managed by the risk professional.[3, 4]

STEP TWO OF THE ERM PROCESS: KEY PERFORMANCE INDICATORS (KPIs), PERFORMANCE MEASUREMENT, KEY RISK INDICATORS (KRIs), AND TOLERANCE

When developing business objectives, it is important to be able to measure the progress, success, or failure of meeting the goals developed around those objectives. Risks identified for the risk list should have objectives and associated goals assigned to measure performance. These performance measurements are associated with specific organizational objectives and should be in line with the risk tolerance levels surrounding them. There should be one or more metrics for each objective that demonstrates the success or failure of meeting the goals. The goals associated with the objectives should be assignable to specific individuals and should be attainable within the timetables set forth in the organization's strategic plan.[1]

Traditional Risk Management, which focuses on the clinical risks, is accustomed to performance measurements such as Leapfrog scores, HCAHPS, and healthcare acquired conditions (HACs), that measure an organization's performance. There are also organizational performance measurements which lend to an ERM perspective such as staff turnover rates, observation/inpatient admission ratios, lengths of stay, and productivity. So, these concepts of measuring performance are familiar to organizations.

KPIs provide a snapshot in time of how the organization is performing against any specific objective based on defined measurements.[1] In domains other than the Clinical/Patient Safety domain, there may be KPIs around such objectives as Operating Margin (from the Finance Domain). Tolerances would be developed to determine whether the organization is performing within the accepted risk tolerance around the goal. If the performance were outside of that tolerance, some action would be triggered to bring that KPI back into a tolerable range. As an example, consider operating margin, which is the measure of profit after accounting for cost. If the operating margin began to perform outside the tolerable risk limits, actions such as halting the hiring process or monitoring productivity more closely may be implemented because, as we know, labor costs are the largest operating costs for a healthcare organization.

Key Risk Indicators or KRIs are leading indicators or precursors that can predict the occurrence of a specific risk.[1] For example, there are predictors of patients at higher risk of fall injuries, which we will examine in this article.

Most organizations have some metrics related to patient falls, such as the fall rate, whether by unit or by facility. Other metrics might be the percentage of fall risk assessments done on admission, or audits of bed alarms found to be in place and operational. However, we will assert through this article, that there are indicators for risk of injury from a fall. And that may change our KPIs if we are interested in reducing INJURIES from falls.

Since our KRIs tell us when there is a predictor of a certain risk present, if we are proactive about addressing the KRIs, we can focus our resources more sharply. This results in savings of resource allocations and assets and creates a better value for our efforts.

Healthcare has had a focus on fall prevention for decades. The traditional thought process about falls is that all falls are avoidable. But truthfully, how many times have yellow socks stopped a fall from occurring? Or even a properly applied bed alarm preventing a fall for a patient who is confused and determined to get up? What we have experienced most often is that a bed alarm tells us the patient is now up and will be on the floor before staff can respond. Truthfully, we know that all falls are not preventable.

What is now known through studies of falls, is that there are certain risk factors that have been identified for fall-related injuries. Furthermore, two or more of these factors present for any one patient are predictive of a fall-related injury.[15] Using the KRIs for fall-related injuries provides valuable information that can be used to formulate a more patient-centered approach to falls and injury prevention. These predictors of fall-related injuries, otherwise known as the KRIs for falls with injury, will be covered later in this article.

There are 8 categories of risk that the items in a risk list could be assigned to in the ERM model. However, some items have more than one applicable domain, which raises the impact and complexity of that risk. Obviously falls with injury would fit right in the clinical/patient safety domain. But, in an ERM view, consideration of how falls with injury affect another domain is worth exploring. Falls with injury have ramifications for the financial domain. Reimbursements can be affected for falls with fracture, as these are considered HACs. Other effects are increased LOS or claims and litigation with large payouts. Another example could come from the strategic domain as the safety ratings can affect brand and reputation, which may also affect market share.

Risk tolerance is specific and sets limits on the latitude available for meeting performance expectations around a specific initiative or goal.[1] It specifies the minimum or maximum levels at which an organization is willing to lose. Anything outside of that pre-determined level would be unacceptable. This

Risk List Item	ERM Domain
Falls related injuries	Clinical/Patient Safety
Negligent credentialing	Operational
Aging infrastructure	Hazards
Ransomware	Technology
Poor reputation in the community/competition	Strategic
EMTALA issues	Legal/Regulatory
Staff shortages/strikes	Human Capital
Budgetary performance	Financial

FIGURE 3 Risk list and domains.

Risk List Item	Likelihood x Impact	Risk Score
Falls resulting in injury	5 x 5	25
Negligent credentialing	2 x 3	6
Aging infrastructure	3 x 2	6
Ransomware	3 x 5	15
Poor reputation in the community/competition	2 x 5	10
EMTALA issues	5 x 2	10
Staff shortages/strikes	5 x 5	25
Budgetary performance	3 x 5	15

FIGURE 4 Calculating the risk score.

is what KPIs measure–how well the performance goals are met around the initiative. In this article, falls with injury is what the KPI measures. If an organization is having an issue with falls, then some thought may need to be around what can be tolerated regarding falls with injury. Certainly, falls with injury are undesirable at any level. But risk tolerance levels would be specific to the individual organization as there is much variation in risk appetites. Some organizations might be tolerant of a minor injury like a fracture that does not require surgery, while others may want to control even minor injuries.

For this article, a fall-related injury is defined as a patient fall which occurs with deviations in fall prevention standards resulting in an injury that requires either casting, an additional procedure, increased LOS, or a transfer to a higher level of care to resolve the issue. Imaging is not considered an intervention or procedure, rather it is considered monitoring.

Risk appetite is defined as the amount of risk, on a board level, an organization is willing to accept in pursuit of value or what the organization's resources, capabilities, and strategies can support in terms of risk.[1] In an ERM model, it is crucial to understand that it is necessary to assume some risk to pursue a reward.

The national benchmark for falls is 3.44/1000 patient days in acute care settings.[21] So, a place to start with goal setting may be to evaluate how well the organization is performing compared to that benchmark. Injurious falls have been calculated to result in costs over $7000 per fall and account for about one-fourth of falls in hospitals.[21] These excess costs affect facility budgets, reimbursements, and are potential claims.

STEP THREE OF THE ERM PROCESS: RISK EVALUATION AND ASSESSMENT

Step one introduced the risk list. This is a line listing of risks across the organization or enterprise. Step two named the eight risk domains in ERM. During Risk Evaluation and Assessment, the risk list should be reviewed and any redundancies combined. The next step is to identify quick fixes which are cost-effective, easily implemented mitigation strategies.

Once these steps are completed, the risk list items are assigned to one of the eight ERM domains. See Figure 3.

In step three of the ERM process, a risk score is generated for each *significant* risk. Across the ERM literature, there are several ways to generate the score. First, a likelihood score of 1-5 is assigned with 1 being least likely to occur and 5 being most likely to occur. Then an impact score of 1-5 is assigned with 1 being least likely to occur and 5 being most likely to occur. For each item on the risk list, these numbers are then multiplied to generate the risk score.

See Figure 4 for the risk list complete with domains and a risk score.

Critical	5		Poor Reputation	Budgetary performance Ransomware	Falls resulting in injury	Staffing Shortages
	4					
Moderate	3		Negligent credentialing			
	2			Aging infrastructure		EMTALA issues
Insignificant	1					
		1	2	3	4	5
		Unlikely		Potential		Likely

FIGURE 5 Traditional heat map.

Risk Severity
4 Very High
3 High
2 Medium
1 Low

FIGURE 6 Risk severity ratings.

Once risk scores have been calculated for each item on the risk list, it is helpful to create a visual of the significance of each risk by placing these items on a heat map. Figure 5 depicts a traditional heat map.

The Risk Severity Rating is compiled from the heat map. Those risk list items which score in the red sections of the heat map carry a Risk Severity Rating of 4, or "Very High." Those risk list items in the gold sections carry a Risk Severity Rating of 3, or "High," and so on. The Risk Severity Rating is used to compile a Risk Register (Figure 6).

THE RISK REGISTER

Once the heat map has been created, the next step is to create a Risk Register. A Risk Register is a tool used in ERM that is useful to organize the risks that have been identified in an organization and the action plans associated with them (Figure 7).

The column, "Existing Risk Controls" records another score. In some literature on ERM, you will see this expressed as "Control Effectiveness Rating." These scores are added together on the Risk Register.

See Figure 8 for Existing Risk Controls/Control Effectiveness Rating.

STEP FOUR OF THE ERM PROCESS: STRATEGIC RISK RESPONSE

In the ERM process, step four considers all information collected from risk evaluation and assessment to develop a strategic response. In this step, those risks that were the highest scoring, which were those with the high impact and high likelihood of occurring, will be considered for ERM projects for the organization. If falls with injury makes it to the list of ERM projects for the organization, strategies will need to be developed that create and recognize value (ERM goals) and not just protect the organization's assets (TRM goals).

These strategic responses would fall into two main categories: Risk Control or Risk Financing Techniques.

1. Risk control techniques include risk avoidance, risk prevention, risk reduction, segregation, and non-insurance risk transfer.
2. Risk financing techniques include retain/self-insurance, transfer/insurance, and non-insurance transfer.

For addressing falls with injury, a combination of risk prevention and risk reduction strategies could be employed. Risk Prevention techniques are those measures that impact the number of times or frequency with which an event will occur. This may be in the form of evidence-based pathways/protocols, and education. Risk Reduction techniques are those measures that reduce or mitigate the loss after the event has occurred. It is helpful to examine the predictors of injury from falls to determine the tactics to use for Risk Prevention and Risk Reduction.

PREDICTORS OF INJURY FROM FALLS

Multiple studies of falls resulting in injury have led to the identification of injury predictors. By adjusting the focus of fall

Risk Register										
Identified Risk	**Category/ Domain**	**Risk Description**	**Likelihood**	**Impact**	**Severity**	**Existing Risk Controls**	**Total**	**Contin-gent Actions**	**Owner**	**Status**
Falls with injury	Clinical/ Patient Safety	Falls resulting in injuries due to a deviation in GAPS: (generally accepted performance standards) which reached the patient and caused moderate to severe harm or death.	5	4	4	2	15	Audit of Fall Prevention Tactics on Nursing Units	CNO	Open

FIGURE 7 Sample Risk Register.[6] *Source*: ASHRM Enterprise Risk Management: Implementing ERM, 2020 p. 16.

Existing Risk Control Score	Description	Definition
1	Highly Effective	Risk exposures are within established tolerance levels; controls are tested and functioning effectively; linkage between risk and return is explicitly established (performance based); comprehensive metrics and dashboard reporting in place.
2	Effective	Risk exposures are within established tolerance levels; controls are tested and functioning effectively; linkage between risk and return is implicitly established (judgment based); some metrics and dashboard reporting are in place.
3	Moderately Effective	Risk exposures are generally within established tolerance levels with few exceptions; controls are functioning at an acceptable level but not fully tested; some metrics and dashboard reporting are in place.
4	Needs Improvement	Some material exceptions to established tolerance levels; controls are established but not fully tested; minimum metrics or dashboard reporting in place.
5	Needs Significant Improvement	Significant exceptions to established tolerance levels (or tolerance levels are not established); controls are not in place or functioning effectively; minimum or no metrics or dashboard reporting

FIGURE 8 Existing Risk Controls/Control Effectiveness Rating. *Source*: Lam, *J. Risk Management*-The ERM Guide from AFP used with permission. AFP, Association for Financial Professionals.

prevention efforts from the reduction of all falls to the reduction of **injury** from falls, significant benefits can be achieved.

Some of these benefits are:

- Fewer incidents of fall-related injuries in the inpatient setting
- Reduction in the number of claims from fall related injuries
- Reduction in HACs and the associated lack of reimbursement
- A reduction in the LOS

The following risk factors for injury become predictive of injury in combination of 2 or more:

- **The use of oral anticoagulants (OACs):** OACs are a predictor for cranial hemorrhage resulting from falls.[19] OAC use is a predictor of 30-day mortality after a fall.[16] Both aspirin and warfarin are associated with increased mortality from even a ground level fall.[18]
- **Being born female**: 75% of all people who fall and sustain a hip fracture were born female. 95% of all hip fractures are due to falls. Osteoporosis and associated risk factors are more common in females which increases the risk of injury from a fall.[7].
- **Dementia**: The usual fall prevention tactics in use in hospitals today have limited success in older (defined as age $\geq$ 65) patients with cognitive impairment.[15] This, in combination with other risk factors, translates to an increased risk of fall with injury for dementia patients.
  Factors adding to risk of injury for dementia patients are:
  - Polypharmacy (common in patients with dementia)
  - Fall risk increasing drugs (FRIDs)
  - Limitations in postural responses to perturbations
    - Perturbations refer to the decreased ability of a person with dementia to respond to changes in their regular state or path due to outside influences.
  - Drug induced orthostatic hypotension
    - This is the #1 cause of hospitalization for older adults with dementia.[8]
  - Neurologic Side effects of NMDA receptor antagonists:
    - Abnormal gait
    - Cerebral infarction
    - Cerebrovascular accident
    - Intracranial hemorrhage
    - Seizure
    - Somnolence
    - Tardive dyskinesia
- **Polypharmacy and FRIDs**: Studies prove that persistent polypharmacy is associated with a 48% increase in fall related injuries, both fracture and non-fracture injuries. Most of those who were injured from a fall during a time of persistent polypharmacy were older, white, and female. The use of FRIDs caused an increase in injury over polypharmacy of non FRIDs.
  Antihypertensives are the most prescribed FRID. The risk is increased when multiple FRDs are prescribed.[9]
  The following is a list of some of the drugs which are known to increase the risk of falls:[10]
  - Antihypertensives
  - Antidepressants
  - Opioids
  - Benzodiazepines
  - Anticonvulsants
  - Antihistamines
  - Tricyclic antidepressants
  - Sedative hypnotics
  - Antipsychotics
  - Antispasmodics
    FRID incidence and prevalence
  - 7.8 billion prescriptions for various FRIDs were written over an 18-year period.
  - As prevalence of FRID prescriptions increased, so did falls with mortality.
  - Nursing home or community-dwelling residents were among the highest at risk for falling with significant injury and FRID use.
- **Urologic co-morbidities:** Urgency, incontinence, benign prostatic hypertrophy, over-active bladder, and other urologic conditions can lead to nocturia which is a prevailing factor in nighttime falls resulting in fractures. Many patients who experience falls and subsequent fractures have associated urologic co-morbidities.[11]
- **HIV positive status:** Patients who are HIV+ are at risk for falls due to polypharmacy and the impaired balance from antiretroviral therapy. Impaired balance is a known predictor of fall related injury.[12]

Predictors of Fall Related Injury	
Use of OACs	Polypharmacy/FRIDs
Being born female	Urologic co-morbidities
Dementia	HIV + status

FIGURE 9 Predictors of fall related injury.

See Figure 9 for a list of all six predictors of fall related injury.

TACTICS TO PREVENT INJURY

There are many tactics which are known to prevent injury from falls. The risk professional should not assume responsibility for the implementation of these tactics. Rather, injury prevention tactics should be presented to those organizational leaders responsible for fall prevention. These tactics, much like infection bundles, are greater than the sum of their parts and should be implemented in the aggregate.

The following injury prevention tactics are useful for injury prevention in those patients with more than one risk factor for injury. These are:

Inclusion of the pharmacist in rounds: Including the pharmacist who is already participating in interdisciplinary rounds is useful for the review of all medications, identification of FRIDs, and recommendation of safer alternatives.

- The clinical pharmacist is one of the most overlooked resources for fall injury prevention.

- Studies have proven that the inclusion of the pharmacist in fall injury prevention IS highly effective in fall injury prevention, especially for patients taking FRIDs.
- Pharmacists already participating in multi-disciplinary rounds can recommend safer alternatives to FRIDs that reduce fall injury risk without compromising achievement of desired therapeutic goals.[13]

Urology Consults: Requesting a urology consult for patients suspected of urologic comorbidity may reduce nocturia and other conditions known to contribute to injury falls.

Bladder Scanning: In patients who disregard instructions to call for help before toileting, bladder scanning every 4-6 hours is useful to ensure there is no urinary retention. Urinary retention can result in overflow incontinence which gives the mistaken impression that the patient is not retaining urine.

Use of the Time Up and Go (TUG) Assessment: The TUG assessment can identify early cognitive dysfunction in those taking more than 12 seconds to complete the exercise. This is quite useful in identifying those patients who may be at risk of falling with injury due to undiagnosed cognitive decline.[17]

Use of fall mats on both sides of the bed: The use of fall mats on both sides of the bed reduces the risk of patients landing on the hard floor. In one of the facilities studies, there were 3 falls with major injury which occurred due to the patient falling on the side of the bed which did not have the fall mat.

Use of a Patient Safety Sitter/Community Watch/ Continuous Video Monitoring:

Some facilities have had success with a patient safety sitter/attendant or continuous video monitoring. In lieu of these costly interventions, others have found similar success by placing the patient closer to the nurse's desk and huddling on those patients at considerable risk of injury. During this huddle time, the patients at substantial risk of injury can be identified and emphasized so that other healthcare workers present can help maintain a watch over the patient. The phrase "Community Watch" was coined by some nurses who creatively named this alternative.

Tactics to Reduce Loss from Fall Related Injuries: Early intervention with Traditional Risk Management (TRM) tactics can decrease financial loss to the organization.

The following TRM tactics are proven to reduce loss and/or to prepare the organization to manage litigation resulting from claims:

Reporting:

- The early reporting of falls and associated injuries is vital to early intervention by the risk professional.
- Rounding by the risk professional, with emphasis on the non-punitive nature of reporting, should be a routine part of the Risk Management Program.
- Every department should set reporting goals.
- A risk professional should be available by phone for reporting of harm events 24/7.
- Leaders, including the Executive Team, should encourage and support reporting of events.

Investigation: Thorough investigation of harm events by the risk professional has the following benefits:

- Protects information and keeps it privileged and confidential.
- Preserves memory.
- Allows for accurate reporting of severity levels.
- Allows the risk professional to identify potential compensable events in a timely manner.
- Helps to preserve evidence.

Billing Interventions (and the Collateral Source Rule):

- Billing interventions are put in place due to centuries old case law called the *Collateral Source Rule*.
- This rule was upheld in Georgia, 1993:

Amalgamated Transit Union Local 1324 v. Roberts, 263 Ga. 405.

- This rule allows plaintiffs to claim the full amount of a hospital statement without being affected by contractual reductions of an insurer.
- In tort actions, "it is the position of the law that a benefit that is directed to the injured party should not be shifted so as to become a windfall for the tortfeasor.… It is the tortfeasor's responsibility to compensate for all harm that he causes, not confined to the net loss that the injured party receives."

Account Interventions v. Refunds:

- Account interventions keep a facility's bill from becoming an item of damages for the full amount.
- Patient accounts should be suspended early and prior to being submitted to the insurance carrier.
- Refunding a health insurer only allows a dollar for dollar "set off" against the eventual verdict.
- Refunds are rarely worth the effort.

Common Concerns with Billing Interventions (from an ARM/CPHRM):

- Complex billing systems may make suspending accounts difficult.
- Billing promises made during disclosures must be kept in order to maintain patient confidence.
- For this reason, it is best to defer promises and place accounts on suspension only after discussion with litigation counsel.
- If the account suspension process is not followed correctly, bills could be released without the knowledge of Risk Management.

Disclosure and Apology:

- The provider, necessary staff involved in the event, and the risk professional should be involved in the disclosure process.[14]
- Disclosure should occur even if the internal investigation is not complete.

Title	Author(s)	Publisher
Healthcare Enterprise Risk Management Playbook, Second Edition	Denise Whiting Shope, Editor	ASHRM
How to Execute a Gap Analysis	Robert Izquierdo	The Ascent How to Perform a Gap Analysis: Step-By-Step (fool.com)
Guide to Gap Analysis with Examples	Joe Weller	Smartsheet Guide to Gap Analysis with Examples | Smartsheet

FIGURE 10 GAP analysis resources.

- Disclosure can reduce the number of claims filed in an adverse event.
- Disclosure should include a "sincere apology."

A Word about the Scope of the Risk Professional:

As risk professionals we are accustomed to being sources of information and support for our colleagues. In Clinical Risk Management we are often sources of vital patient safety expertise as well. This can lead us to assume responsibility for things that are not in our primary scope. The result is feelings of burnout. Often the risk professional is the first person to whom clinical staff will reach out in the aftermath of a clinical emergency. We refer to this as the "phone a friend" phenomenon. The risk professional will do well to realize the following:

- The risk professional's responsibilities do not include management of the Falls Program or other Nursing/Patient Safety Initiatives.
- The risk professional's primary responsibility is the identification, investigation, and reporting of patient harm events.
- The risk professional should involve other professionals for process review and revision.

STEP FIVE OF THE ERM PROCESS: REVIEW, EVALUATE, AND MONITOR

The last step of the ERM process is to set aside time to reflect on the current state of the ERM Program as well as each item on the Risk Register. This step allows the risk professional to make mid-course corrections and assists in preparing the annual review of the ERM Program.

The ASHRM white paper, **ENTERPRISE RISK MANAGEMENT: Implementing ERM**, contains various questions the risk professional may ask which will help pinpoint those areas. This publication may be accessed free of charge on the ASHRM website: ASHRM.org

Some of the questions are listed below:

- Is there an assigned professional responsible for the ERM program?
- Are current strategies evaluated considering emerging or previously unknown risks?
- Have significant risks to the organization been identified and addressed?
- Have you had any major, unanticipated risks occur for which you were unprepared?
- Have lessons learned been incorporated into new strategies for improvement?
- Do all employees know their role and do they all participate in the ERM program?
- Do all strategies and solutions developed to address risks have criteria built in by which their success or failure will be evaluated?

These are just a few of the questions the risk professional may find helpful. You are encouraged to make use of the various resources available through ASHRM which will strengthen your ability to operate fully within the ERM framework you have chosen.

A GAP Analysis may be particularly helpful to the risk professional and the organization so that the current state of the ERM Program may be compared to the ideal state. Since ASHRM's ERM model is based on the COSO ERM Framework, comparing your organization's ERM Program to one of these frameworks will prove quite useful in identifying where the gaps are. It will also serve to reinforce those areas in which there is a strong match between your ERM Program and one of the frameworks.

Conducting a GAP Analysis is beyond the scope of this article. However, there are multiple resources that may prove useful to the risk professional in conducting such an analysis.

Figure 10 includes some of these resources.

Using Step 5 of the ERM process as a model, evaluate your fall injury prevention program.

SUMMARY

In summary, applying the ERM process to fall injury prevention allows the risk professional the opportunity to create value for the organization. By identifying and stratifying the organizational risks, the key stakeholders can focus efforts and resources on those risks that would have the biggest impact to the organization. Value is created through the reduction of revenue loss related to treatment of injuries, reducing LOS, increasing the market share by promoting the organization as a safe place to receive care, increasing provider confidence in the care their patients receive, and reducing the risk of unplanned regulatory visits.

The application of ERM in the reduction of falls with injuries creates value for the patient as well through the reduction of pain and suffering, reduced lengths of stay, the prevention of permanent impairment or disability, and an increase in patient satisfaction.

Additionally, understanding the six risk factors for injuries from falls will help reveal those patients who are more at risk of fall related injuries-and that a combination of any two or more of those risk factors is predictive of an injury from a fall.

And finally, the application of ERM to the reduction of fall-related injuries will facilitate better management of risks internally by making fall and injury prevention more strategic, decreasing claims from falls with injury, and decreasing the amount of non-compensated care. And from an external perspective, the organization's reputation in the healthcare industry and the community is improved by reducing avoidable harm to the healthcare consumer, increasing the national care compare scores measured by CMS, increasing consumer confidence in the organization, and creating examples of healthcare safety solutions that work.

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CONFLICT OF INTEREST STATEMENT

The authors have disclosed no conflicts of interest.

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