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Insight and Perspectives

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We are pleased to offer our latest installment of *Insight and Perspectives*. This newsletter is dedicated to sharing healthcare news, trends and developments impacting our broker and insured customers.

In this particular installment you will find Sedgwick's Senior HCRM Consultant, Kathleen Shostek's article discussing *Falls: An Often Ovlerooked Risk in Radiology.*

As always, we appreciate your continued support and thank you for allowing Endurance to be a part of your risk and insurance programs.

About Us

Our U.S. and Bermuda teams provide healthcare professional liability coverage to non-profit and for-profit hospitals and other healthcare organizations.

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Falls: An Often Overlooked Risk in Radiology

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Injury from patient and visitor falls continues to be a source of professional and general liability claim activity that challenges and frustrates healthcare organizations across the continuum of care. In a recent claims study conducted by Sedgwick, 17% of all U.S. healthcare liability claims and suits were attributed to injuries from falls and the indemnity and ALAE paid for fall injuries was cited as one of the top five causes for severity overall.[1]

Radiology, an area that is often overlooked when assessing risk related to falls, deserves particular attention for fall prevention efforts. Falls in radiology present a risk of loss in several areas, including liability losses from claims and suits alleging failure to ensure safety. Allegations of failure to ensure safety accounted for 6% of all U.S. radiology claims identified, with the driver of these claims identified as falls.[2]

In addition to the loss from claims and suits, hospitals may not be reimbursed for the cost to care for patients sustaining iatrogenic injuries, with the shift to value-based payments. Other, less calculable losses include loss of reputation stemming from a well-publicized, serious injury or death from a fall event, losses associated with patient harm and stress on the staff involved in the care of the patient.

Addressing the Contributors to Falls in Radiology

The Pennsylvania Patient Safety Authority reported that in 2009, serious events involving falls made up 8% of all events reported in radiology departments[3]. Contributing factors for these events included syncope, slips/trips, loss of balance, falls from tables or stretchers, and medication-related effects. Injuries included fractures, lacerations, and head trauma.

The lack of risk screening, failure to implement appropriate safety measures, inadequate fall prevention training, and inattention to environmental safety all contribute to falls in radiology. Patients with a history of falls, a fear of falling, and/or who depend on an assistive device due to impaired mobility are at higher risk of falls.

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While inpatients having imaging studies generally have undergone a risk assessment for falls resulting in a 'risk for fall' alert being visibly displayed (bracelet, colored slippers, warning on chart or order, etc.), these indicators are not always verbally communicated to radiology staff when the patient is handed off for the imaging study. Outpatients, including emergency patients and patients in transition, often have not been assessed prior to arriving at the radiology department and therefore don't display any type of alert, leaving them more vulnerable to situations leading to falls.

Implementing a fall risk screening process for radiology outpatients that begins in the scheduling department can help address this gap. Schedulers can ask three simple questions, which are indicators for increased fall risk[4]:

a. Have you fallen in the past year?

b. Are you afraid of falling?

c. Do you walk with an assistive device such as a walker or cane?

Positive responses should be communicated to the radiology staff to indicate a need for further assessment and additional precautions. Taking it a step further, indication of patient fall risk factors can be added to imaging order forms and systems to indicate a need for further assessment and additional precautions.

Safety Measures, Fall Prevention Training and Communication Go Hand-in-Hand

All staff who interact with patients having imaging studies should undergo specific education and training in fall prevention, including identifying patients at risk and not leaving them unattended, using safe patient transfer procedures such as locking gurney brakes and applying safety straps, and ensuring that physical slip/trip hazards are minimized in the department. Staff should also be taught to routinely use safe patient handling techniques when moving, positioning, and transferring patients, particularly when turning a patient from side to side on a gurney, to prevent the patient from falling off.

When a patient at risk for falls is identified, the factors placing them at risk (medication, impaired mobility, history of falls, etc.) should be communicated across all departments interacting with the patient. This can include scheduling and registration, transporters, clerical and technical staff, radiology technicians, nurses and radiologists, as well as staff and caregivers in emergency services, nursing units, and laboratories. In some healthcare organizations, radiology and imaging departments use standard handoff communication tools, such as a "Ticket to Ride", that facilitates sharing fall risk information and prevention measures between sending and receiving personnel. These tools can also serve as reminders about fall risk and check lists for prevention techniques for busy technologists and staff.

When a fall or a "near miss" occurs, it is important that radiology staff communicate and report the event so that contributing factors can be identified and shared across departments and appropriate preventive actions taken. Trending of the contributing factors to fall events may identify common situations, procedures, or equipment gaps that can be rectified.

In short, by focusing staff on the contributing factors for falls and implementing proper training and consistent communication to reinforce the use of prevention techniques, healthcare organizations can mitigate the losses from falls in radiology departments. ◄

1. Gaffey A., Sedgwick claim study reveals injuries from falls as a top claim cause and loss leader. Sedgwick PL Risk Resource. 2013 3rd edition. Available online: http://www.sedgwick.com/news/Risk%20Resources/Sedgwick_PL_Newsletter-final(2013-3rdEd).pdf

2. Shostek K. Diagnostic Imaging and Radiation Liability: Preparing to Defend Claims from New Exposures. Presentation at DRI Medical Liability and Healthcare Law Symposium, March 2012. New Orleans.

3. Falls in Radiology: Establishing a Unit-Specific Prevention Program. Patient Safety Advisory 2011 Mar;8(1). Available online: http://patientsafetyauthority.org/ADVISORIES/AdvisoryLibrary/2011/mar8(1)/Pages/12.aspx

4. UTMB Outpatient Fall Risk Prevention Screening Tool: http://www.utmb.edu/rehab/sports/fall%20screening%20form.pdf

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