New Research Shows Discharge Window as High-Risk Period for Patient Falls

Keywords: injurious falls, fall-related serious events, hospital discharge, fall prevention, inpatient falls, discharge planning

*Corresponding author

[1]Patient Safety Authority

Disclosure: The author declares that they have no relevant or material financial interests.

Submitted
August 20, 2025
Accepted
August 20, 2025
Published
December 31, 2025

This article was previously distributed in a September 3, 2025, newsletter of the Patient Safety Authority, available at https://patientsafety.pa.gov/newsletter/Pages/newsletter-sept-2025.aspx.

Sanchez CE, Jones R. New Research Shows Discharge Window as High-Risk Period for Patient Falls. *Patient Safety*. 2025;7(2):151865. doi:10.33940/001c.151865

By **Christine E. Sanchez**, MPH*[1] & **Rebecca Jones**, MBA, RN[1]

Inpatient falls are a persistent patient safety concern[1,2] and significant progress has been made in identifying prevention strategies to reduce their occurrence.[1-11] A recent review of reports submitted to the Pennsylvania Patient Safety Reporting System identified a previously unknown high-risk time frame for inpatient falls: the time surrounding discharge.[12] Event reports submitted between July 1, 2023, and June 30, 2024, revealed that falls that occurred during the discharge period were 2.5 times more likely to result in serious events compared to falls that happened at other times during the inpatient stay.

In many instances, falls that occurred on the day of discharge were associated with patients engaging in discharge-related activities, such as getting dressed, packing or gathering their belongings, showering or washing up, and getting into a vehicle. Unsupportive and ill-fitting footwear was also identified as a contributing factor to these falls. One event report also described a patient who, after falling, stated they believed they could ambulate independently because they were being discharged.

The transitional period surrounding discharge is a critical time to implement fall prevention strategies, such as assisting patients with dressing and packing; educating patients about proper footwear; and emphasizing to patients that although they are healthy enough to be discharged, they may still be at risk of falling. Targeting this time frame can help reduce the risk of serious injury from falls and ensure patients are discharged safely.

For full details and study findings, we recommend that facilities and providers review "The Overlooked Threat of Hospital Falls During the Discharge Period: A Statewide Retrospective Analysis of Patient Safety Event Reports" at doi.org/10.33940/001c.141403.

References

1. The Joint Commission. Sentinel Event Data 2023 Annual Review. The Joint Commission; 2024.

2. Kepner S, Jones R. Patient Safety Trends in 2024: An Analysis of 315,418 Serious Events and Incidents From the Nation's Largest Event Reporting Database. *Patient Safety*. 2025;7(2):1339876. doi:10.33940/001c.133876

3. Miake-Lye IM, Hempel S, Ganz DA, Shekelle PG. Inpatient Fall Prevention Programs as a Patient Safety Strategy: A Systematic Review. *Ann Intern Med*. 2013;158:390-7. doi:10.7326/0003-4819-158-5-201303051-00005.

4. The Joint Commission. Sentinel Event Alert Preventing Falls and Fall-Related Injuries in Health Care Facilities. The Joint Commission. 2015(55).

5. Cochran L, Foley P. Pursuing Zero Harm from Patient Falls: One Organization's Initiatives Along the Way. *J Nurs Manag*. 2022;53(11):24-33.

6. Agency for Healthcare Research and Quality. Falls 2019. PSNet: Patient Safety Network. https://psnet.ahrq.gov/primer/falls#. Reviewed June 15, 2024. Accessed August 2025.

7. Patient Safety & Quality Healthcare. Elevating Patient Safety Through Comprehensive Fall Prevention Strategies. PSQR. https://www.psqh.com/analysis/elevating-patient-safety-through-comprehensive-fall-prevention-strategies/. Published March 28, 2024. Accessed April 2025.

8. Ganz DA, Huang C, Saliba D, et al. *Preventing Falls in Hospitals: A Toolkit for Improving Quality of Care*. (Prepared by RAND Corporation, Boston University School of Public Health, and ECRI Institute under Contract No. HHSA290201000171TO#1). Agency for Healthcare Research and Quality; 2013.

9. Dykes PC, Hurley AC. Patient-Centered Fall Prevention. Nurs Manage. 2021;52(3):51-4. doi: 10.1097/01.NUMA.0000733668.39637.ba.

10. Ganz DA, Huang C, Saliba D, et al. Which Fall Prevention Strategies Do You Want To Use? In: *Preventing Falls in Hospitals: A Toolkit for Improving Quality of Care* (Prepared by RAND Corporation, Boston University School of Public Health, and ECRI Institute under Contract No HHSA290201000171TO#1). Agency for Healthcare Research and Quality; 2013.

11. Patient Safety Authority. Falls. PSA. https://patientsafety. pa.gov/pst/Pages/Falls/hm.aspx?t=tips. Accessed August 2025.

12. Sanchez CE, Jones R. The Overlooked Threat of Hospital Falls During the Discharge Period: A Statewide Retrospective Analysis of Patient Safety Event Reports. *Patient Safety*. 2025;7(2):141403. doi: 10.33940/001c.141403

About the Authors

Christine E. Sanchez (chrsanchez@pa.gov) is a research scientist on the Data Science & Research team at the Patient Safety Authority. She is responsible for utilizing patient safety data, combined with relevant literature, to develop strategies aimed at improving patient safety in Pennsylvania.

Rebecca Jones, director of Data Science & Research for the Patient Safety Authority, leads a multidisciplinary team advancing patient safety through research that informs improvements in healthcare systems and delivers insights that bridge the gap between evidence and real-world practice. A registered nurse with a Master of Business Administration in healthcare management and certifications in patient safety, human factors, and risk management, she brings clinical experience, analytical expertise, and systems thinking to complex challenges. She has authored more than 40 peer-reviewed publications and contributed to national patient safety efforts with organizations such as the Institute for Healthcare Improvement, the National Quality Forum, and the Society to Improve Diagnosis in Medicine.