# Fall Prevention Toolkit

## Module 2 ToolsPicture of puzzle with Tools piece highlighted

Tool 2A: Interdisciplinary Team

Tool 2B: Quality Improvement Process

Tool 2C: Current Process Analysis

Tool 2D: Assessing Current Fall Prevention Policies and Practices

Tool 2E: Fall Knowledge Test

Tool 2F: Action Plan

Tool 2G: Managing Change Checklist

### 2A: Interdisciplinary Team

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| --- |
| **Background:** Crucial to a fall prevention initiative is the creation of an interdisciplinary Implementation Team that will oversee the improvement effort. This tool can be used to identify people from different disciplines to take part on the Implementation Team.**Reference:** Developed by Falls Toolkit Research Team.**How to use this tool:** This tool contains three parts:1. Use the first list provided to form your Implementation Team. This tool should be filled out by the Implementation Team leader. List the names of possible team members from each department or discipline and their area of expertise.

The second list provides all the tools and resources included in the toolkit and which team roles and disciplines may be responsible for the tool. The team leader or team members can refer to this list to access the tools and ensure that appropriate people are selected for inclusion on the team.The last part, a matrix, provides the team roles and disciplines that may be included on the Implementation Team tools and the related tools and resources. Potential team members can review the tools most relevant to them to gain a better sense of their roles and responsibilities in fall prevention. The core Implementation Team should be a reasonable size (e.g., 6-12 people) in order to be effective. Additional staff may be included on an “as needed” basis. When you create a new team or invite new members to a team, make sure to set aside time for introductions at the beginning of your team meeting. |

#### Interdisciplinary Team Tool – Part 1: List of Potential Team Members

| **Position/Discipline** | **Names of Possible Implementation Team Members From Each Area** | **Area of Expertise** |
| --- | --- | --- |
| Nursing |
| Staff nurses |  |  |
| Nursing assistants |  |  |
| Rehabilitation |
| Physical therapists |  |  |
| Occupational therapists |  |  |
| Prescribing Clinicians |
| Physicians (e.g., hospitalist) |  |  |
| Other providers (e.g., nurse practitioner or physician assistant) |  |  |
| Pharmacy |
| Pharmacists |  |  |
| Facilities and Environment |
| Materials manager |  |  |
| Environmental services staff |  |  |
| Facilities engineer |  |  |
| Managers |
| Senior manager |  |  |
| Quality improvement/safety/risk manager |  |  |
| Other |
| Information systems staff |  |  |
| Administrative assistant |  |  |
| Educator |  |  |
| Registered dietitian |  |  |
| Patient representative |  |  |
| Volunteer |  |  |

#### Interdisciplinary Team Tool – Part 2: List of Tools and Roles of Individuals Who Should Use the Tool

This list provides all the tools and resources included in the toolkit and which team roles and disciplines should use the tool. The team leader or team members can refer to this list to access the tools and ensure that appropriate people are selected for inclusion on the team.

Notes: For some of the tools listed below, the Implementation Team leader may wish to designate an individual to complete the tool on the team’s behalf.

Items marked with an asterisk (\*) can be integrated into your hospital’s electronic health record with the help of information systems staff.

| **Tools and Resources**  | **Who Should Use the Tool** |
| --- | --- |
| ØA – Introductory Executive Summary for Stakeholders | Senior manager (e.g., Chief Executive Officer or Chief Medical/Nursing/Operating Officer) |
| 1A – Hospital Survey on Patient Safety Culture | All interdisciplinary team members and staff on units preparing to implement the fall prevention program |
| 1B – Stakeholder Analysis | Implementation Team leader (e.g., senior manager or quality improvement/safety/risk manager)  |
| 1C – Leadership Support Assessment | Implementation Team leader  |
| 1D – Business Case Form  | Implementation Team leader  |
| 1E – Resource Needs Assessment | Implementation Team leader  |
| 1F – Organizational Readiness Checklist | Implementation Team leader  |
| 2A – Interdisciplinary Team | Implementation Team leader |
| 2B – Quality Improvement Process | Implementation Team leader  |
| 2C – Current Process Analysis | Individuals designated by the Implementation Team leader |
| 2D – Assessing Current Fall Prevention Policies and Practices | Individuals designated by the Implementation Team leader |
| 2E – Falls Knowledge Test  | Staff nurses and nursing assistants |
| 2F – Action Plan | Implementation Team leader with quality improvement/safety/risk manager  |
| 2G - Managing Change Checklist | Implementation Team leader  |
| 3A – Master Clinical Pathway for Inpatient Falls | Quality improvement/safety/risk manager, staff nurses, and nursing assistants |
| 3B – Scheduled Rounding Protocol | Unit manager, staff nurses, and nursing assistants |
| 3C – Tool Covering Environmental Safety at the Bedside | Unit manager and facility engineer |
| 3D – Hazard Report Form | Any hospital employee who enters patient rooms  |
| 3E – Clinical Pathway for Safe Patient Handling | Nurse manager, staff nurses, and nursing assistants  |
| 3H – Morse Fall Scale for Identifying Fall Risk Factors\* | Staff nurses  |
| 3G – STRATIFY Scale for Identifying Fall Risk Factors\* | Staff nurses  |
| 3I – Medication Fall Risk Scale and Evaluation Tools\* | Pharmacist and staff nurses  |
| 3F – Orthostatic Vital Sign Measurement | Staff nurses and nursing assistants |
| 3J – Delirium Evaluation Bundle: Digit Span, Short Portable Mental Status Questionnaire, and Confusion Assessment Method\* | Physicians, nurse practitioners, physician assistants  |
| 3K – Algorithm for Mobilizing Patients\* | Nursing assistants |
| 3L – Patient and Family Education | Educators, staff nurses |
| 3M – Sample Care Plan\* | Staff nurses with input from other disciplines (e.g., physician, pharmacist, physical and/or occupational therapists)  |
| 3N – Postfall assessment, clinical review\* | Staff nurses and physicians |
| 3O – Postfall assessment for root cause analysis | Staff nurses |
| 3P – Best Practices Checklist | Implementation Team leader  |
| 4A – Assigning Responsibilities for Using Best Practices | Implementation Team leader |
| 4B – Staff Roles | Unit manager  |
| 4C – Assessing Staff Education and Training | Implementation Team leader  |
| 4D – Implementing Best Practices Checklist | Implementation Team leader  |
| 5A – Information To Include in Incident Reports | Quality improvement/safety/risk manager, information systems staff |
| 5B – Assessing Fall Prevention Care Processes | Unit manager and unit champions |
| 5C – Measuring Progress Checklist | Implementation Team leader  |
| 6A – Sustainability Tool | Implementation Team leader  |

#### Interdisciplinary Team Tool – Part 3: Matrix of Applicable Tools, by Role

This matrix lists the disciplines that may be included on the Implementation Team and shows tools and resources they may be responsible for. The team leader or team members can use this list to access the tools and ensure that appropriate people are selected for the team.

|  | **Tools and Resources** |
| --- | --- |
| **Position/Discipline** | **1** | **2** | **3A** | **3B** | **3C** | **3D** | **3E** | **3F** | **3G** | **3H** | **3I** | **3J** | **3K** | **3L** | **3M** | **3N** | **3O** | **3P** | **4** | **5** | **6** |
| Nursing |
| Staff nurses |  |  | X | X |  |  | X | X | X | X | X | X | X |  |  | X | X |  |  |  |  |
| Nursing assistants |  |  | X | X |  |  | X |  |  |  | X |  |  |  | X |  |  |  |  |  |  |
| Nurse manager |  |  |  |  |  |  | X |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Rehabilitation |
| Occupational therapists |  |  |  |  |  |  |  |  |  |  |  |  | X |  |  |  |  |  |  |  |  |
| Physical therapist |  |  |  |  |  |  |  |  |  |  |  |  | X |  |  |  |  |  |  |  |  |
| Prescribing Clinicians |
| Nurse practitioners |  |  |  |  |  |  |  |  |  |  |  |  |  | X |  |  |  |  |  |  |  |
| Physician |  |  |  |  |  |  |  |  |  |  |  |  | X | X |  | X |  |  |  |  |  |
| Physician assistants |  |  |  |  |  |  |  |  |  |  |  |  |  | X |  |  |  |  |  |  |  |
| Pharmacy |
| Pharmacist |  |  |  |  |  |  |  |  |  | X |  |  | X |  |  |  |  |  |  |  |  |
| Facilities and Environment |
| Facility engineer |  |  |  |  | X |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Managers |
| Quality improvement manager |  | X | X |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | X |  |
| Risk manager |  | X | X |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | X |  |
| Safety manager |  | X | X |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | X |  |
| Other |
| Educators |  |  |  |  |  |  |  |  |  |  |  | X |  |  |  |  |  |  |  |  |  |
| Hospital employees who enter patient rooms |  |  |  |  |  | X |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Unit champion |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | X |  |
| Unit manager |  |  |  | X | X |  |  |  |  |  |  |  |  |  |  |  |  |  |  | X |  |
| Implementation Team leader | X | X |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | X | X |  | X |
| Individuals designated by the Implementation Team leader | X | X |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | X | X |  | X |

### 2B: Quality Improvement Process

**Background:** This tool will help you and your team identify the extent to which you have the resources for quality improvement (QI) in your organization. The form was developed by the Turning Point Initiative to assess if an organization has the needed systems in place to improve quality and performance.

**Reference:** Turning Point Performance Management National Excellence Collaborative. Performance Management Self-Assessment Tool. Available at: [www.turningpointprogram.org/toolkit/pdf/PM\_Self\_Assess\_Tool.pdf](http://www.turningpointprogram.org/toolkit/pdf/PM_Self_Assess_Tool.pdf).

**How to use this tool:** This tool should be filled out by the Implementation Team leader (or individual designated by the leader) in consultation with the QI department. The “you” refers to your organization as a whole. Check the box that most accurately describes your organization’s current resources. If you find that your organization has fully operationalized QI processes, connect the fall prevention initiative with these existing processes. If some processes are missing, advocate for them to be put into place in the context of the fall prevention program.

#### Quality Improvement Process

| **Assessment Question** | **No** | **Somewhat** | **Yes (fully operational)** |
| --- | --- | --- | --- |
| Do you have a process(es) to improve quality or performance? |  |  |  |
| Is an entity or person responsible for decisionmaking based on performance reports (e.g., top management team, governing or advisory board) |  |  |  |
| Is there a regular timetable for your QI process? |  |  |  |
| Are the steps in the process communicated? |  |  |  |
| Are managers and employees evaluated for their performance improvement efforts (i.e., is performance improvement in their job descriptions)? |  |  |  |
| Are performance reports used regularly for decisionmaking? |  |  |  |
| Is performance information used to do the following? (check all that apply) |
| Determine areas for more analysis or evaluation. |  |  |  |
| Set priorities and allocate/redirect resources. |  |  |  |
| Inform policymakers of the observed or potential impact of decisions under their consideration. |  |  |  |
| Do you have the capacity to take action to improve performance when needed? |
| Do you have processes to manage changes in policies, programs, or infrastructure? |  |  |  |
| Do managers have the authority to make certain changes to improve performance? |  |  |  |
| Do staff have the authority to make certain changes to improve performance? |  |  |  |
| Does the organization regularly develop performance improvement or QI plans that specify timelines, actions, and responsible parties? |  |  |  |
| Is there a process or mechanism to coordinate QI efforts among programs, divisions, or organizations that share the same performance targets?  |  |  |  |
| Is QI training available to managers and staff? |  |  |  |
| Are personnel and financial resources allocated to your QI process? |  |  |  |

### 2C: Current Process Analysis

|  |
| --- |
| **Background:** Before beginning a quality improvement initiative, you need to understand your current methods. This tool can be used to describe key processes in your organization where fall prevention activities could or should happen.**Reference:** Adapted from: Quality Partners of Rhode Island. QI Worksheet E, Current Process Analysis. Available at: http://nhqi.hsag.com/Resource\_documents/Worksheet\_E\_Current\_Process\_Analysis.pdf.How to use this tool: * Identify who will conduct the mapping and who will be on the mapping team. The mapping team should include at least two frontline staff on the Implementation Team and at least one person who has experience with process maps. Try to use the same team members if more than one process is mapped.
* Have the Implementation Team identify and define every step in the current process for fall prevention.
* Define a beginning, an end, and a methodology for all of the processes to be mapped. For example, some processes are mapped through the method of direct observation of the process taking place, while others can be mapped by knowledgeable stakeholders talking through and documenting each step in the process.
* When defining a process, think about staff roles in the process, the tools or materials staff use, and the flow of activities.
* Everything is a process, whether it is admitting a patient, serving meals, assessing pain, or managing a nursing unit. Identify key processes involving fall prevention. The goal of defining a process is to hone in on patient safety vulnerabilities and potential failures in the current process.
* Examples of processes might include initial fall risk factor assessments (e.g., when does it occur, who does it, what happens if a patient is found to have risk factors) or postfall management.

Determine if there are any gaps and problems in your current processes, and use the results of this analysis to systematically change these processes. |

Process Analysis Procedures

* Take time to brainstorm and listen to every team member.
* Make sure the process is understood and documented.
* Make each step in the process very specific.
* Use one post-it note, index card, or scrap piece of paper for each step in the process.
* Lay out each step, move steps, and add and remove steps until the team agrees on the final process.
* If a process does not exist (for example, there is no process to assess fall risk factors upon admission and readmission), identify the related processes (for example, the process for admission and readmission).
* If the process is different for different shifts, identify each individual process.

Example: Process for Making Buttered Toast

Step Definition

1. Check to see if there is bread, butter, knife, and toaster.
2. If supplies are missing, go to the store and purchase them.
3. Check to see if the toaster is plugged in. If not, plug in the toaster.
4. Check setting on toaster. Adjust to darker or lighter as preferred.
5. Put a slice of bread in toaster.
6. Turn toaster on.
7. Wait for bread to toast.
8. When toast is ready, remove from toaster and put on plate.
9. Use knife to cut pat of butter.
10. Use knife to spread butter on toast.

#### Identify the steps of your defined process:

* Press people for details.
* At the end of the gap analysis, compile the results in a document that displays each step so that team members have the map of the current process in front of them during the team discussion (Step 2).

#### Hold team discussion.

#### Evaluate your current process as you define it:

* What policies and procedures do we have in place for this process?
* What forms do we use?
* How does our physical environment support or hinder this process?
* Which staff are involved in this process?
* Which parts of this process do not work?
* Do we duplicate any work unnecessarily? Where?
* Are there any delays in the process? Why?

#### Continue asking questions that are important in learning more about this process.

### 2D: Assessing Current Fall Prevention Policies and Practices

**Background:** The purpose of this self-assessment tool is to identify what processes of care your hospital has in place and what areas need improvement.

**Reference:** Adapted from AHRQ publication on the Falls Management Program for nursing homes. [www.ahrq.gov/research/ltc/fallspx/fallspxmanual.htm](http://www.ahrq.gov/research/ltc/fallspx/fallspxmanual.htm).

**How to use this tool:** This tool should be filled out by the Implementation Team leader. Use your hospital’s policies, procedures, and general practices to answer the questions.

The results from this self-assessment can help you identify which areas need improvement and develop a plan.

#### Current Fall Prevention Policies and Practices

| A. Culture, Organizational Commitment, and Team Skills | Yes | No | Comments |
| --- | --- | --- | --- |
| 1. Updated policies and procedures for a comprehensive fall prevention program? |  |  |  |
| 2. Appointed falls team leader and resource person for staff? |  |  |  |
| 3. Selection of staff members for interdisciplinary falls team? |  |  |  |
| 4. Monthly falls team meeting using ground rules, leader, timekeeper, and recorder? |  |  |  |
| 5. High-level managers attend team meetings periodically and monitor falls data at least quarterly? |  |  |  |
| 6. No blame/no shame environment with honest investigation and reporting by staff? |  |  |  |
| 7. Celebration of success stories and rewards for caregivers who reduce falls? |  |  |  |
| 8. Adequate staffing for team leader to spend 8 hours/week and team to meet for 60 minutes/month? |  |  |  |
| 9. Funds for adaptive equipment and environmental modifications? |  |  |  |
| 10. Employee orientation materials emphasize importance of and hospital commitment to patient safety? |  |  |  |
| B. Data Collection and Analysis | Yes | No | Comments |
| 1. Accurate completion of fall incident report form by all staff? |  |  |  |
| 2. Monthly falls analysis by: | location and time of fall |  |  |  |
| shift and day of week |  |  |  |
| type of injury |  |  |  |
| 3. Monthly falls analysis computed as falls/1,000 patient-days? |  |  |  |
| 4. Falls data reported to hospital management every quarter? |  |  |  |
| 5. Feedback about falls data given to direct care staff each month? |  |  |  |
| 6. Falls data trended over 6 months or more? |  |  |  |

| C. Staff Training and Information for Patients and Families | Yes | No | Comments |
| --- | --- | --- | --- |
| 1. Education on fall prevention during new employee orientation and training? |  |  |  |
| 2. Annual inservice training on fall prevention for all staff? |  |  |  |
| 3. Staff education materials, including: Hospital policies and proceduresFall risk factors and consequences of fallsHigh-risk medications, sleep hygiene measures for management of anxietyLow blood pressure precautionsLow vision precautionsSafety during transfer, ambulation, and wheelchair useUnsafe behaviors, monitoring devices, and management strategiesEnvironment and equipment safety hazards and methods for improvementFoot care and footwear |  |  |  |
| 4. All nurses trained in a fall response system that includes: Immediate evaluation and increased monitoring of patientInvestigation of fall circumstancesDocumentation of fallImmediate intervention within first 8 hours |  |  |  |
| 5. Information for families and patients on fall risk reduction? |  |  |  |
| 6. Medical staff given information about the program and their role? |  |  |  |
| D. Environment and Equipment Safety | Yes | No | Comments |
| 1. Regular inspection of all resident rooms and bathrooms for safety problems, including: ClutterPoor or insufficient lightingUnstable furnitureHard-to-reach personal itemsUnsafe flooringFoot care and footwear |  |  |  |
| 2. All staff trained to inspect and report environmental and equipment safety problems? |  |  |  |
| 3. Repair of reported safety problems in a timely manner by maintenance staff? |  |  |  |
| 4. Inspection and repair of all wheelchairs, canes, and walkers every 6 months? |  |  |  |
| 5. Communications and inspections documented for ongoing monitoring and accountability? |  |  |  |

### 2E: Fall Knowledge Test

**Background:** The purpose of this tool is to assess general staff knowledge on fall prevention.

**Reference:** Adapted from Singapore Ministry of Health Nursing Clinical Practice Guidelines on Prevention of Falls in Hospitals and Long Term Care Institutions and subsequent version by Dr. Serena Koh. Previously used in Koh SLS. Singapore Med J 2009;50(4):425. Original may be found at [www.moh.gov.sg/content/dam/moh\_web/HPP/Nurses/cpg\_nursing/2005/prevention\_of\_falls\_in\_hosp\_ltc\_institutiions.pdf](http://www.moh.gov.sg/content/dam/moh_web/HPP/Nurses/cpg_nursing/2005/prevention_of_falls_in_hosp_ltc_institutiions.pdf).

**How to use this tool:** Administer the questionnaire to staff nurses and nursing assistants. The survey may need to be modified if certain questions are not consistent with your policies and procedures, or for the needs of specific hospital units.

Use the findings to assess gaps in knowledge. Work with your education department to tailor specific education programs to the needs of your staff.

## Fall Knowledge Test

Each question may have more than one option as the correct answer.

Please circle the letters that correspond to the correct answers.

Which of the following statements is *correct*?

Falls have multifactorial etiology, so fall prevention programs should comprise multifaceted interventions.

1. Regular review of medication can help to prevent patient falls.
2. The risk of falling will be lessened when a patient’s toileting needs are met.
3. The use of antipsychotic medications is associated with an increased risk of falls in older adults.

2. A multifaceted intervention program should include:

Individually-tailored fall prevention strategies

1. Education to patient/family and health care workers
2. Environmental safety
3. Safe patient handling

3. Risk factors for falls in the acute hospital include all of the following *except*:

Dizziness/vertigo

1. Previous fall history
2. Antibiotic usage
3. Impaired mobility from stroke disease

4. Which of the following statements is *true*?

The cause of a fall is often an interaction between patient’s risk, the environment, and patient risk behavior.

1. Increase in hazardous environments increases the risk of falls.
2. The use of a patient identifier (e.g., identification bracelet) helps to highlight to staff those patients at risk for falls.
3. A fall risk assessment should include review of history of falls, mobility problems, medications, mental status, continence, and other patient risks.

5. Patients with impaired mobility should be:

Confined to bed

1. Encouraged to mobilize with assistance
2. Assisted with transfers
3. Referred for exercise program or prescription of walking aids as appropriate

6. The management of the acutely confused patient should include all of the following *except*:

Moving patients away from the nursing station

1. Involving family members to sit with the patient
2. Orienting patients to the hospital environment
3. Reinforcing activity limits to patients and their families

7. Which of the following statements is *false*?

Fall prevention efforts are solely the nurses’ responsibility.

1. A patient who is taking four or more oral medications is at risk for falling.
2. A patient who is taking psychotropic medication is at higher risk for falling.
3. Testing or treatment for osteoporosis should be considered in patients who are at high risk for falls and fractures.

8. In hospital settings, intervention programs should include:

Staff education on fall precautions

1. Provision and maintenance of mobility aids
2. Postfall analysis and problem-solving strategy
3. Bed alarms for all patients, regardless of risk

9. When assessing patients, which of the following statements is *false*?

All patients should be assessed for fall risk factors at admission, at a change in status, after a fall, and at regular intervals.

1. Medication review should be included in the assessment.
2. All patients should have their activities of daily living and mobility assessed.
3. Environmental assessment is not important in the hospital as it is all standardized.

10. Risk factors for falls include:

Parkinson’s disease

1. Incontinence
2. Previous history of falls
3. Delirium

11. Exercise programs for ambulatory older adults should:

Be very aggressive

1. Be unsupervised
2. Be ongoing
3. Include individualized strength and balance training

12. Which of the following statements on education in fall prevention is *false*?

Education programs should target primarily health care providers, patients, and caregivers.

1. Education programs for staff should include the importance of fall prevention, risk factors for falls, strategies to reduce falls, and transfer techniques.
2. Instruction on safe mobility, with emphasis on high-risk patients, should be provided to both patients and families.
3. Education should only be given at the start of the fall prevention program.

13. Which of the following is recommended to improve patient safety?

Locking wheeled furniture when it is stationary.

1. Having nonslip flooring.
2. Placing frequently used items (including call bell, telephone, and remote control) within reach of the patient
3. Rounding hourly to address patient needs

**Answer Key:**

1. A, B, C
2. A, B, C, D
3. C
4. A, B, C, D
5. B, C, D
6. A
7. A
8. A, B, C
9. D
10. A, B, C, D
11. C, D
12. D
13. A, B, C, D

### 2F: Action Plan

|  |
| --- |
| **Background:** The purpose of this tool is to provide a framework for outlining steps that will be needed to design and implement the fall prevention initiative. **Reference:** Adapted from material produced by MassPro, a participant in the Centers for Medicare & Medicaid Services Quality Improvement Organization Program.How to use this tool: This tool should be filled out by the Implementation Team leader in consultation with the quality improvement manager.1. Note the date and the objective. A sample objective is provided.
2. The form lists six key tasks. For each, list in the second column the steps that will be taken to address the task, including tools to be used.
3. In developing the plan, it is not expected that you will provide results, only that you will lay out what needs to be done.
4. In the last two columns, determine who will have lead responsibility for completing each task, and estimate an appropriate timeframe for completing the activities.
5. Use the plan as a working document that can be revised. As you begin to carry out the plan, you may need to make adjustments and add details to the later tasks.

Use the completed sheet to plan, manage, and carry out the identified tasks. The plan should guide the implementation process and can be continually amended and updated. A sample completed form is shown below, followed by a blank form. |

Fall Prevention Action Plan Date: November 16, 2011

**Improvement Objective:** Implement standard fall prevention practices within 6 months.

| Key Interventions/Tasks | Steps To Complete Task and Tools To Use | Team Members Responsible for Task Completion | Target Date for Task Completion |
| --- | --- | --- | --- |
|  | Examples | Examples | Examples |
| 1. Analyze current state of fall prevention practices in this organization.
 | Identify strengths and weaknesses using process mapping and gap analysis. Tool 2C and Tool 2D. | Team leader, RNs | Within 6 weeks from initiative start |
| Assess the current state of staff knowledge about fall prevention. Tool 2E. | Education department | Within 6 weeks from initiative start |
| Set target goals for improvement. | QI department | Within 8 weeks from initiative start |
| 1. Identify the set of prevention practices to be used in redesigned system.
 | Determine how comprehensive universal fall precautions should be performed. | Implementation Team | Within 12 weeks from initiative start |
| Decide which scale or questions will be used for performing fall risk factor assessment. | Implementation Team | Within 12 weeks from initiative start |
| Decide which fall prevention activities should be in your program. | Clinical staff members | Within 12 weeks from initiative start |
| 1. Assign roles and responsibilities for implementing the redesigned fall prevention practices.
 | Determine who will complete the fall risk factor assessment on admission. Tool 4A. | Implementation Team | Within 16 weeks from initiative start |
| Identify unit champions. | Team leader | Within 16 weeks from initiative start |
| Determine how prevention work will be organized at the unit level, such as paths of communication and lines of oversight. | QI team | Within 16 weeks from initiative start |
| 1. Put the redesigned set into practice.
 | Engage staff and get them excited about the changes needed. | Team leader, unit staff | Within 12 weeks from initiative start |
| Pilot test the new practices. | QI department | Within 20 weeks from initiative start |
| 1. Monitor fall rates and practices.
 | Determine how incidence data on fall rates and fall prevention care processes will be collected. Tools 5A and 5B. | QI department | Within 6 weeks from initiative start |
| Organize quarterly reviews of data. | QI department | Within 6 weeks from initiative start, ongoing |
| 1. Sustain the redesigned prevention practices.
 | Ensure continued leadership support. | Team leader | Within 4 weeks from initiative start, ongoing |
| Ensure ongoing support from other units such as facilities management and IT. | IT, facilities management, PT, dietitians | Within 40 weeks from initiative start |
| Designate responsibility and accountability for fall prevention oversight and continuous quality improvement. | Team leader and Implementation Team | Within 40 weeks from initiative start |

Fall Prevention Action Plan Date:

Improvement Objective:

| Key Interventions/Tasks | Steps To Complete Task and Tools To Use | Team Members Responsible for Task Completion | Target Date for Task Completion |
| --- | --- | --- | --- |
| 1. Analyze current state of fall prevention practices in this organization.
 |  |  |  |
|  |  |  |
|  |  |  |
| 1. Identify the set of prevention practices to be used in redesigned system.
 |  |  |  |
|  |  |  |
|  |  |  |
| 1. Assign roles and responsibilities for implementing the redesigned fall prevention practices.
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|  |  |  |
|  |  |  |
| 1. Put the redesigned care processes into practice.
 |  |  |  |
|  |  |  |
|  |  |  |
| 1. Monitor fall rates and practices.
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| 1. Sustain the redesigned prevention practices.
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### 2G: Managing Change Checklist

**Background:** This tool can be used to monitor your progress on completing the managing change activities.

**Reference:** Developed by Falls Toolkit Research Team.

**How to use this tool:** The Implementation Team leader (or individual designated by the leader) should complete the checklist upon starting his/her role as leader and review the checklist quarterly thereafter.

Use this tool to ensure you have not skipped any essential steps in your fall prevention efforts.

#### Managing Change Checklist

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| --- | --- |
| Implementation Team composition |  |
| Team leader identified and in place |  |
| Members with necessary expertise/role identified and invited |  |
| Linkage to senior leadership defined and established |  |
| Team startup |  |
| Team agenda and charge clearly stated |  |
| Necessary training and resources in place for team to get started |  |
| Assessment |  |
| Current state of fall prevention practice and knowledge assessed |  |
| Current practice and policies systematically examined |  |
| Challenges to good practice identified at organization and unit levels |  |
| Staff knowledge assessed |  |
| Starting the work of redesign |  |
| Approaches to redesign explored and chosen |  |
| Gap analysis conducted between current practice and recommended practice |  |
| Setting goals and plans for change |  |
| Specific goals set |  |
| Plan initiated for making changes to meet those goals |  |
| Preliminary plan in place for sustaining the changes |  |