#

Preventing Falls in Hospitals

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Quality of Care



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# Preventing Falls in Hospitals

# A Toolkit for Improving Quality of Care

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## Roadmap

|  |  |  |  |
| --- | --- | --- | --- |
| Section | Action Steps | Tool That Supports Action | Who Should Use The Tool |
| Overview | Enlist support of senior leaders | [Tool ØA, Introduction and Overview for Stakeholders](#_ØA:_Introduction_and) | Senior manager  |
| Section 1 | Are you ready for this change? |
| 1.1 | Assess the culture of safety in your hospital | [Tool 1A, Hospital Survey on Patient Safety Culture](#_1A:_Hospital_Survey) | All interdisciplinary team members |
| 1.2 | Evaluate current organizational attention to falls | [Tool 1B, Stakeholder Analysis](#_1B:_Stakeholder_Analysis) | Implementation Team leader |
| 1.3 | Assess and develop leadership support for the fall prevention program | [Tool 1C, Leadership Support Assessment](#_1C:_Leadership_Support)[Tool 1D, Business Case Form](#_1D:_Business_Case) | Implementation Team leader |
| 1.5 | Identify resources that are available and resources that are needed | [Tool 1E, Resource Needs Assessment](#_1E:_Resource_Needs) | Implementation Team leader |
| 1.7 | Assess your progress on completing readiness for change activities | [Tool 1F, Organizational Readiness Checklist](#_1F:_Organizational_Readiness) | Implementation Team leader |
| Section 2 | How will you manage change? |
| 2.1 | Identify your Implementation Team | [Tool 2A, Interdisciplinary Team](#_2A:_Interdisciplinary_Team) | Implementation Team leader |
| 2.2 | Assess the current status of fall prevention activities in your hospital | [Tool 2B, Quality Improvement Process](#_2B:_Quality_Improvement)[Tool 2C, Current Process Analysis](#_2C:_Current_Process)[Tool 2D, Assessing Current Fall Prevention Policies and Practices](#_2D:_Assessing_Current) | Implementation Team leader, individuals designated by the Implementation Team leader |
| Determine staff knowledge about fall prevention | [Tool 2E, Fall Knowledge Test](#_2E:_Fall_Knowledge) | Staff nurses and nursing assistants |
| 2.3 | Set goals for improvement based on outcomes and processes | [Tool 2F, Action Plan](#_2F:_Action_Plan) | Implementation Team leader with quality improvement/safety/risk manager |
| Section | Action Steps | Tool That Supports Action | Who should use the tool |
| 2.4 | Assess your progress on completing the managing change activities | [Tool 2G, Managing Change Checklist](#_2G:_Managing_Change) | Implementation Team leader |
| Section 3 | Which fall prevention practices do you want to use? |
| 3.1 | Identify how fall prevention care processes connect to one another | [Tool 3A, Master Clinical Pathway for Inpatient Falls](#_3A:_Master_Clinical) | Quality improvement/safety/risk manager, staff nurses, nursing assistants |
| 3.2 | Implement universal fall precautions | [Tool 3B, Scheduled Rounding Protocol](#_3B:_Scheduled_Rounding)[Tool 3C, Tool Covering Environmental Safety at the Bedside](#_3C:_Tool_Covering)[Tool 3D, Hazard Report Form](#_3D:_Hazard_Report)[Tool 3E, Clinical Pathway for Safe Patient Handling](#_3E:_Clinical_Pathway) | Unit manager, staff nurses, nursing assistants, facility engineer, hospital employee who enters patient rooms |
| 3.3 | Identify important risk factors for falls in your patients | [Tool 3F, Orthostatic Vital Sign Measurement](#_3F:_Orthostatic_Vital)[Tool 3G, STRATIFY Scale for Identifying Fall Risk Factors](#_3G:_STRATIFY_Scale)[Tool 3H, Morse Fall Scale for Identifying Fall Risk Factors](#_3H:_Morse_Fall)[Tool 3I, Medication Fall Risk Score and Evaluation Tools](#_3I:_Medication_Fall) | Staff nurses, pharmacist, nursing assistants |
| 3.4 | Use identified fall risk factors to implement fall prevention care planning | [Tool 3J, Delirium Evaluation Bundle: Digit Span, Short Portable Mental Status Questionnaire, and Confusion Assessment Method](#_3J:_Delirium_Evaluation)[Tool 3K, Algorithm for Mobilizing Patients](#_3K:_Algorithm_for)[Tool 3L, Patient and Family Education](#_3L:_Patient_and)[Tool 3M, Sample Care Plan](#_3M:_Sample_Care) | Educators, staff nurses, physicians, nurse practitioners, physician assistants, nursing assistants |
| 3.5 | Assess and manage patients after a fall | [Tool 3N, Postfall Assessment, Clinical Review](#_3N:_Postfall_Assessment,)[Tool 3O, Postfall Assessment for Root Cause Analysis](#_3O:_Postfall_Assessment) | Staff nurses and physicians |
| Section | Action Steps | Tool That Supports Action | Who should use the tool |
| 3.8 | Assess your progress on completing the best practices activities | [Tool 3P, Best Practices Checklist](#_3P:_Best_Practices) | Implementation Team Leader |
| Section 4 | How do you implement the fall prevention program in your organization? |
| 4.1 | Assign staff roles and responsibilities for tasks identified in set of best practices | [Tool 4A, Assigning Responsibilities for Using Best Practices](#_4A:_Assigning_Responsibilities)[Tool 4B, Staff Roles](#_4B:_Staff_Roles) | Implementation Team Leader, Unit manager |
| 4.3 | Assess current staff education practices and facilitate integration of new knowledge on fall prevention into existing or new practices | [Tool 4C, Assessing Staff Education and Training](#_4C:_Assessing_Staff) | Implementation Team Leader |
| 4.4 | Assess your progress on implementing best practices activities | [Tool 4D, Implementing Best Practices Checklist](#_4D:_Implementing_Best) | Implementation Team Leader |
| Section 5 | How do you measure fall rates and fall prevention practices? |
| 5.1 | Collect the right data to learn about falls, fall-related injuries, and their causes | [Tool 5A, Information To Include in Incident Reports](#_5A:_Information_tTo) | Quality improvement/risk manager, information systems staff |
| 5.2 | Measure fall prevention practices | [Tool 5B, Assessing Fall Prevention Care Processes](#_5B:_Assessing_Fall) | Unit manager and unit champions |
| 5.3 | Assess your progress on measuring progress activities | [Tool 5C, Measuring Progress Checklist](#_5C:_Measuring_Progress) | Implementation Team Leader |
| Section 6 | How do you sustain an effective fall prevention program? |
| 6.3 | Identify factors need to sustain your fall prevention efforts | [Tool 6A, Sustainability Tool](#_6A:_Sustainability_Tool) | Implementation Team Leader |

## Drawing of jigsaw puzzle with the following pieces: Assess Readiness, Manage Change, Implement Practices, Best Practices, Measure, Sustain, Tools. Tools is highlighted.7. Tools and Resources

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### ØA: Introduction and Overview for Stakeholders

**Background:** This template can serve as a letter to key players in the hospital to introduce them to the goals and purpose of a fall prevention program.

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

**How to use this tool:** Adapt this letter as needed and present it to senior leaders to enlist their support before mounting your fall prevention program. You may want to use [Tool 1B, “Stakeholder Analysis,”](#_1B:_Stakeholder_Analysis) to identify individuals and departments who may have an interest in the program.

Dear <Name>:

We would like to introduce you to our fall prevention program. We hope that you will support this exciting new endeavor.

**What is this program?** <Hospital name> is embarking on an important new initiative focused on the prevention of falls among our acute care patients.

**Why is this program important?** Falls with serious injury occurring during acute care stays represent a significant threat to patient safety, and increase the length of inpatient stays by 6.9 days and hospital charges by$13,806.[[1]](#footnote-1) In addition, falls with serious trauma have become a “never” event from the standpoint of Medicare reimbursement. Thus, falls represent both a patient safety priority and an economic priority for health care organizations. Fall rates are as high as <xxx falls per 1,000 bed days of care> on some of our units.

**How might this program affect me/my area?** In the past, fall prevention has sometimes been seen as solely a nursing unit responsibility. However, recent research makes it clear that successfully reducing fall incidence requires a coordinated interdisciplinary approach. Thus, the implementation of new prevention approaches may require, for example, the efforts of:

* Materials management: Do we have the most evidence-based products and equipment needed to prevent falls? Are new products, such as hospital beds, evaluated with this outcome in mind?
* Environmental services: Are environmental hazards in the hospital (e.g., spills, electrical cords) appropriately managed?
* Information technology: Is information about fall prevention interventions effectively integrated into the electronic health record?
* Pharmacy: Has the hospital formulary been reviewed to see if certain medicines (e.g., sleep aids) should be restricted in patients at risk for falls?
* Physicians: Are patients’ medications checked for their risk of causing falls? Is the patient’s mental status formally tested where appropriate?
* Rehabilitation services: Are protocols in place for ordering physical and occupational therapy? Are needed assistive devices (e.g., walkers, wheelchairs) available at the bedside? Are appropriate orders on file for patients’ activity levels?
* Quality improvement: Are quality improvement specialists available to assist the team working on this effort?
* Transport: Are patients who are at high risk for falls supervised when taken off the unit for diagnostic or therapeutic activities?

**What will happen?** For this program, we will use the U.S. Agency for Healthcare Research and Quality’s new toolkit. This comprehensive toolkit outlines steps in the improvement process and provides relevant tools. Using these tools, we will assess staff awareness and knowledge of fall prevention, analyze patient care processes to identify opportunities for improvement, and target interventions in those areas. Fall incidence while patients are under our care will be analyzed more closely so that progress can be assessed.

**Everyone has a role:** Most important in this effort is a shift of thinking and culture, from regarding falls as inevitable to seeing them as events that can be reduced through a comprehensive program. Your support in helping <hospital name> staff make this shift is essential to the success of this effort. Thank you.

### 1A: Hospital Survey on Patient Safety Culture

**Background:** The Hospital Survey on Patient Safety Culture is a staff survey designed to help hospitals assess the culture of safety in their institutions. Since 2004, hundreds of hospitals have implemented the survey.

There is a growing recognition that organizational change to improve patient safety, including fall prevention, requires a general culture of safety among its staff. Achieving a culture of safety requires an understanding of the values, beliefs, and norms about what is important in an organization and what patient safety attitudes and behaviors are expected and appropriate. This requires a culture that views errors as opportunities to improve the system, not the result of individual failure. For example, it may be difficult for your hospital to overcome chronic underreporting of falls if you have a culture where acknowledgment of error is not acceptable.

**Reference:** Available on the AHRQ Web site: [www.ahrq.gov/qual/patientsafetyculture/hospscanform.pdf](file:///%5C%5Cpklnfs04%5CSharedir%5COCKT%5CDPEP%5CCDOM%5CLTC%5CFall%20Prevention%5Cwww.ahrq.gov%5Cqual%5Cpatientsafetyculture%5Chospscanform.pdf)

**How to use this tool:** Consider administering a survey to assess the culture of safety in your hospital. The AHRQ Hospital Survey on Patient Safety Culture examines patient safety culture from a hospital staff perspective. The survey can be completed by all interdisciplinary team members and staff on units preparing to implement the fall prevention program but is best suited for:

* Hospital staff who have direct contact or interaction with patients;
* Hospital staff who may not have direct contact or interaction with patients but whose work directly affects patient care;
* Hospital-employed physicians who spend most of their work hours in the hospital; and
* Hospital supervisors, managers, and administrators.

A user’s guide that provides information on getting started, selecting a sample, determining data collection methods, establishing data collection procedures, conducting a Web-based survey, preparing and analyzing data, and producing reports may be found at [www.ahrq.gov/qual/patientsafetyculture/hospcult.pdf](file:///%5C%5Cpklnfs04%5CSharedir%5COCKT%5CDPEP%5CCDOM%5CLTC%5CFall%20Prevention%5Cwww.ahrq.gov%5Cqual%5Cpatientsafetyculture%5Chospcult.pdf).

The results of this survey can provide a hospital with an understanding of the safety-related perceptions and attitudes of its managers and staff. Results can be compared with those of other hospitals using the Hospital Survey on Patient Safety Culture Comparative Database available at: [www.ahrq.gov/qual/patientsafetyculture/hospsurvindex.htm](file:///%5C%5Cpklnfs04%5CSharedir%5COCKT%5CDPEP%5CCDOM%5CLTC%5CFall%20Prevention%5Cwww.ahrq.gov%5Cqual%5Cpatientsafetyculture%5Chospsurvindex.htm).

**Hospital Survey on Patient Safety**

|  |
| --- |
| **Instructions** |

**This survey asks for your opinions about patient safety issues, medical error, and event reporting in your hospital and will take about 10 to 15 minutes to complete.**

**If you do not wish to answer a question, or if a question does not apply to you, you may leave your answer blank.**

|  |
| --- |
| *An* ***“event”*** *is defined as any type of error, mistake, incident, accident, or deviation, regardless of whether or not it results in patient harm.****“Patient safety”*** *is defined as the avoidance and prevention of patient injuries or adverse events resulting from the processes of health care delivery.* |

**SECTION A: Your Work Area/Unit**

**In this survey, think of your “unit” as the work area, department, or clinical area of the hospital where you spend *most* of your work time or provide *most* of your clinical services.**

**What is your primary work area or unit in this hospital? Select ONE answer.**

|  |  |  |  |
| --- | --- | --- | --- |
| 🞏 | a. Many different hospital units/No specific unit | 🞏 | h. Psychiatry/mental health |
| 🞏 | b. Medicine (non-surgical) | 🞏 | i. Rehabilitation |
| 🞏 | c. Surgery  | 🞏 | j. Pharmacy |
| 🞏 | d. Obstetrics | 🞏 | k. Laboratory |
| 🞏 | e. Pediatrics | 🞏 | l. Radiology |
| 🞏 | f. Emergency department | 🞏 | m. Anesthesiology |
| 🞏 | g. Intensive care unit (any type) | 🞏 | n. Other, please specify: |

**Please indicate your agreement or disagreement with the following statements about your work area/unit.**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Think about your hospital work area/unit…** | **StronglyDisagree**⯆ | **Disagree**⯆ | **Neither**⯆ | **Agree**⯆ | **StronglyAgree**⯆ |
|  1. People support one another in this unit  | 🞎1 | 🞎2 | 🞏3 | 🞎4 | 🞏5 |
|  2. We have enough staff to handle the workload  | 🞎1 | 🞎2 | 🞏3 | 🞎4 | 🞏5 |
|  3. When a lot of work needs to be done quickly, we work together as a team to get the work done  | 🞎1 | 🞎2 | 🞏3 | 🞎4 | 🞏5 |
|  4. In this unit, people treat each other with respect  | 🞎1 | 🞎2 | 🞏3 | 🞎4 | 🞏5 |
|  5. Staff in this unit work longer hours than is best for patient care  | 🞎1 | 🞎2 | 🞏3 | 🞎4 | 🞏5 |

SECTION A: Your Work Area/Unit (continued)

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Think about your hospital work area/unit…** | **StronglyDisagree**⯆ | **Disagree**⯆ | **Neither**⯆ | **Agree**⯆ | **StronglyAgree**⯆ |
|  6. We are actively doing things to improve patient safety  | 🞎1 | 🞎2 | 🞏3 | 🞎4 | 🞏5 |
|  7. We use more agency/temporary staff than is best for patient care  | 🞎1 | 🞎2 | 🞏3 | 🞎4 | 🞏5 |
|  8. Staff feel like their mistakes are held against them  | 🞎1 | 🞎2 | 🞏3 | 🞎4 | 🞏5 |
|  9. Mistakes have led to positive changes here  | 🞎1 | 🞎2 | 🞏3 | 🞎4 | 🞏5 |
| 10. It is just by chance that more serious mistakes don’t happen around here  | 🞎1 | 🞎2 | 🞏3 | 🞎4 | 🞏5 |
| 11. When one area in this unit gets really busy, others help out  | 🞎1 | 🞎2 | 🞏3 | 🞎4 | 🞏5 |
| 12. When an event is reported, it feels like the person is being written up, not the problem  | 🞎1 | 🞎2 | 🞏3 | 🞎4 | 🞏5 |
| 13. After we make changes to improve patient safety, we evaluate their effectiveness  | 🞎1 | 🞎2 | 🞏3 | 🞎4 | 🞏5 |
| 14. We work in “crisis mode” trying to do too much, too quickly  | 🞎1 | 🞎2 | 🞏3 | 🞎4 | 🞏5 |
| 15. Patient safety is never sacrificed to get more work done  | 🞎1 | 🞎2 | 🞏3 | 🞎4 | 🞏5 |
| 16. Staff worry that mistakes they make are kept in their personnel file  | 🞎1 | 🞎2 | 🞏3 | 🞎4 | 🞏5 |
| 17. We have patient safety problems in this unit  | 🞎1 | 🞎2 | 🞏3 | 🞎4 | 🞏5 |
| 18. Our procedures and systems are good at preventing errors from happening  | 🞎1 | 🞎2 | 🞏3 | 🞎4 | 🞏5 |

**SECTION B: Your Supervisor/Manager**

**Please indicate your agreement or disagreement with the following statements about your immediate supervisor/manager or person to whom you directly report.**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **StronglyDisagree**⯆ | **Disagree**⯆ | **Neither**⯆ | **Agree**⯆ | **StronglyAgree**⯆ |
|  1. My supervisor/manager says a good word when he/she sees a job done according to established patient safety procedures  | 🞎1 | 🞎2 | 🞏3 | 🞎4 | 🞏5 |
|  2. My supervisor/manager seriously considers staff suggestions for improving patient safety  | 🞎1 | 🞎2 | 🞏3 | 🞎4 | 🞏5 |
|  3. Whenever pressure builds up, my supervisor/manager wants us to work faster, even if it means taking shortcuts  | 🞎1 | 🞎2 | 🞏3 | 🞎4 | 🞏5 |
|  4. My supervisor/manager overlooks patient safety problems that happen over and over  | 🞎1 | 🞎2 | 🞏3 | 🞎4 | 🞏5 |

**SECTION C: Communications**

**How often do the following things happen in your work area/unit?**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Think about your hospital work area/unit…** | **Never**⯆ | **Rarely**⯆ | **Some-times**⯆ | **Most of the time**⯆ | **Always**⯆ |
|  1. We are given feedback about changes put into place based on event reports  | 🞎1 | 🞎2 | 🞏3 | 🞎4 | 🞏5 |
|  2. Staff will freely speak up if they see something that may negatively affect patient care  | 🞎1 | 🞎2 | 🞏3 | 🞎4 | 🞏5 |
|  3. We are informed about errors that happen in this unit  | 🞎1 | 🞎2 | 🞏3 | 🞎4 | 🞏5 |
|  4. Staff feel free to question the decisions or actions of those with more authority  | 🞎1 | 🞎2 | 🞏3 | 🞎4 | 🞏5 |
|  5. In this unit, we discuss ways to prevent errors from happening again  | 🞎1 | 🞎2 | 🞏3 | 🞎4 | 🞏5 |
|  6. Staff are afraid to ask questions when something does not seem right  | 🞎1 | 🞎2 | 🞏3 | 🞎4 | 🞏5 |

**SECTION D: Frequency of Events Reported**

**In your hospital work area/unit, when the following mistakes happen, *how often are they reported?***

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **Never**⯆ | **Rarely**⯆ | **Some-times**⯆ | **Most of the time**⯆ | **Always**⯆ |
|  1. When a mistake is made, but is *caught and corrected before affecting the patient*, how often is this reported?  | 🞎1 | 🞎2 | 🞏3 | 🞎4 | 🞏5 |
|  2. When a mistake is made, but has *no potential to harm the patient*, how often is this reported?  | 🞎1 | 🞎2 | 🞏3 | 🞎4 | 🞏5 |
|  3. When a mistake is made that *could harm the patient*, but does not, how often is this reported?  | 🞎1 | 🞎2 | 🞏3 | 🞎4 | 🞏5 |

**SECTION E: Patient Safety Grade**

**Please give your work area/unit in this hospital an overall grade on patient safety.**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| 🞎 | 🞎 | 🞎 | 🞎 | 🞎 |
| **A**Excellent | **B**Very Good | **C**Acceptable | **D**Poor | **E**Failing |

**SECTION F: Your Hospital**

**Please indicate your agreement or disagreement with the following statements about your hospital.**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Think about your hospital…** | **StronglyDisagree**⯆ | **Disagree**⯆ | **Neither**⯆ | **Agree**⯆ | **StronglyAgree**⯆ |
|  1. Hospital management provides a work climate that promotes patient safety  | 🞎1 | 🞎2 | 🞏3 | 🞎4 | 🞏5 |
|  2. Hospital units do not coordinate well with each other  | 🞎1 | 🞎2 | 🞏3 | 🞎4 | 🞏5 |
|  3. Things “fall between the cracks” when transferring patients from one unit to another  | 🞎1 | 🞎2 | 🞏3 | 🞎4 | 🞏5 |
|  4. There is good cooperation among hospital units that need to work together  | 🞎1 | 🞎2 | 🞏3 | 🞎4 | 🞏5 |
| **SECTION F: Your Hospital (continued)** |
| **Think about your hospital…** | **StronglyDisagree**⯆ | **Disagree**⯆ | **Neither**⯆ | **Agree**⯆ | **StronglyAgree**⯆ |
|  5. Important patient care information is often lost during shift changes  | 🞎1 | 🞎2 | 🞏3 | 🞎4 | 🞏5 |
|  6. It is often unpleasant to work with staff from other hospital units  | 🞎1 | 🞎2 | 🞏3 | 🞎4 | 🞏5 |
|  7. Problems often occur in the exchange of information across hospital units  | 🞎1 | 🞎2 | 🞏3 | 🞎4 | 🞏5 |
|  8. The actions of hospital management show that patient safety is a top priority  | 🞎1 | 🞎2 | 🞏3 | 🞎4 | 🞏5 |
|  9. Hospital management seems interested in patient safety only after an adverse event happens  | 🞎1 | 🞎2 | 🞏3 | 🞎4 | 🞏5 |
| 10. Hospital units work well together to provide the best care for patients  | 🞎1 | 🞎2 | 🞏3 | 🞎4 | 🞏5 |
| 11. Shift changes are problematic for patients in this hospital  | 🞎1 | 🞎2 | 🞏3 | 🞎4 | 🞏5 |

**SECTION G: Number of Events Reported**

**In the past 12 months, how many event reports have you filled out and submitted?**

|  |  |
| --- | --- |
| 🞎 a. No event reports | 🞎 d. 6 to 10 event reports |
| 🞎 b. 1 to 2 event reports | 🞎 e. 11 to 20 event reports |
| 🞎 c. 3 to 5 event reports | 🞎 f. 21 event reports or more |

**SECTION H: Background Information**

**This information will help in the analysis of the survey results.**

**1. How long have you worked in this hospital?**

|  |  |
| --- | --- |
| 🞎 a. Less than 1 year | 🞎 d. 11 to 15 years |
| 🞎 b. 1 to 5 years | 🞎 e. 16 to 20 years |
| 🞎 c. 6 to 10 years | 🞎 f. 21 years or more |

**2. How long have you worked in your current hospital work area/unit?**

|  |  |
| --- | --- |
| 🞎 a. Less than 1 year | 🞎 d. 11 to 15 years |
| 🞎b. 1 to 5 years | 🞎 e. 16 to 20 years |
| 🞎 c. 6 to 10 years | 🞎 f. 21 years or more |

**3. Typically, how many hours per week do you work in this hospital?**

|  |  |
| --- | --- |
| 🞎a. Less than 20 hours per week | 🞎d. 60 to 79 hours per week |
| 🞎 b. 20 to 39 hours per week | 🞎 e. 80 to 99 hours per week |
| 🞎c. 40 to 59 hours per week | 🞎 f. 100 hours per week or more  |

**SECTION H: Background Information (continued)**

**4. What is your staff position in this hospital? Select ONE answer that best describes your staff position.**

|  |  |
| --- | --- |
| 🞎 a. Registered Nurse  | 🞎 j. Respiratory Therapist |
| 🞎 b. Physician Assistant/Nurse Practitioner | 🞎 k. Physical, Occupational, or Speech Therapist |
| 🞎 c. LVN/LPN | 🞎 l. Technician (e.g., EKG, Lab, Radiology) |
| 🞎 d. Patient Care Asst/Hospital Aide/Care Partner | 🞎 m. Administration/Management |
| 🞎 e. Attending/Staff Physician | 🞎 n. Other, please specify:  |
| 🞎 f. Resident Physician/Physician in Training |  |
| 🞎 g. Pharmacist |  |
| 🞎 h. Dietician |  |
| 🞎 i. Unit Assistant/Clerk/Secretary |  |

**5. In your staff position, do you typically have direct interaction or contact with patients?**

|  |
| --- |
| 🞎 a. YES, I typically have direct interaction or contact with patients. |
| 🞎 b. NO, I typically do NOT have direct interaction or contact with patients. |

**6. How long have you worked in your current specialty or profession?**

|  |  |
| --- | --- |
| 🞎a. Less than 1 year | 🞎 d. 11 to 15 years |
| 🞎 b. 1 to 5 years | 🞎 e. 16 to 20 years |
| 🞎 c. 6 to 10 years | 🞎 f. 21 years or more |

**SECTION I: Your Comments**

**Please feel free to write any comments about patient safety, error, or event reporting in your hospital.**

|  |
| --- |
|  |

***THANK YOU FOR COMPLETING THIS SURVEY.***

### 1B: Stakeholder Analysis

**Background:** The purpose of stakeholder analysis is to help program initiators identify which departments and individuals will have an interest in the program, where barriers might exist, and what actions need to be taken to obtain the buy-in and participation of those departments and individuals.

**Reference:** This tool was adapted from a template developed by Project Agency, a company focused on effective project management, and is available at: <http://projectagency.co.uk/documents/b316stakeholderform.pdf>.

**How to use this tool:** Complete the form with information regarding all the individuals you consider key stakeholders. You may need to set up a meeting with them to obtain their answers. Examples: information technology officer, director of supply/materials, housekeeping director, quality improvement (QI) department, therapy departments, diagnostic departments, emergency department. This form should be completed by the individual interested in initiating or reinvigorating a fall prevention program.

Use the completed template to identify actions needed to involve all stakeholders in the program. Ensure that all identified needs have been met before proceeding with the QI initiative. For example, the program may need process assistance from the QI department. Since this program may be competing with other QI priorities, it may be important to determine who shapes the QI agenda and how to get this program prioritized at a higher level. An example is shown in the form below. A blank form follows.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Stakeholder** | **Interest or requirement in the program** | **What the program needs from stakeholder** | **Perceived attitudes and risks** | **Actions to take** |
| Example: health information systems officer | Gatekeeper for making any changes to the electronic health record (EHR) system. Not necessarily interested in the program beyond his general mandate to keep the EHR tied to clinical documentation needs. | The program may need to add or make changes to any parts of the EHR that concern fall risk assessment, preventive measures, and postfall care. | May not want to make changes until other changes are also in process, or other changes may already be in process. | Seek information about the process for requesting/making these kinds of changes and how this person relates in the overall organizational structure to program leaders/advocates. |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Stakeholder** | **Interest or requirement in the program** | **What the program needs from stakeholder** | **Perceived attitudes and risks** | **Actions to take** |
|  |  |  |  |  |
|  |  |  |  |  |
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### 1C: Leadership Support Assessment

**Background:** This tool can be used to assess senior leadership support for implementing a fall prevention program. For more information on who is part of the senior leadership team, see the resource box in [section 1.3](#_1.3._Does_senior) of the toolkit text.

**Reference:** Developed by Falls Toolkit Research Team based on the Ontario Agency for Health Protection and Promotion’s Facility-Level Situation Assessment: [www.oahpp.ca/services/documents/jcyh/jcyh-for-hosptials/tools-for-implementation/facility-level-situation-assessment.pdf](http://www.oahpp.ca/services/documents/jcyh/jcyh-for-hosptials/tools-for-implementation/facility-level-situation-assessment.pdf).

**How to use this tool:** Complete the checklist. This assessment is best suited for hospital supervisors, managers, and administrators.

Review the responses to ascertain the level of leadership support. If the response to several of these items is “no,” it could threaten the success of your improvement process. Analyze the areas where support is not evident and take steps to inform leadership about the urgency to change.

##### Leadership Support Assessment

|  |  |  |
| --- | --- | --- |
|  | Yes | No |
| Patient safety is clearly articulated in the organization’s strategic plan. |  |  |
| Someone in senior management is in charge of patient safety. |  |  |
| The hospital’s board of trustees is committed to improving patient safety. |  |  |
| Medical staff leaders are integrated into patient safety programs. |  |  |
| There is a dedicated budget allocated for patient safety activities. |  |  |
| The budget includes funding for education and training on patient safety issues such as fall prevention. |  |  |
| Improved fall prevention is a priority within the facility. |  |  |
| The facility has implemented a fall prevention policy. |  |  |
| Current fall prevention goals are being addressed. |  |  |
| There are visible role models/champions for fall prevention. |  |  |

### 1D: Business Case Form

**Background:** This tool can be used to create a high-level overview of the case for implementing a fall prevention program. The information gathered in this tool may be presented to the senior leader who will decide whether to support your program. For more information on who is part of the senior leadership team, see the resource box in [section 1.3](#_1.3._Does_senior) of the toolkit text.

**Reference:** The form was adapted from a template developed by Project Agency to help write a business case. Available at: www.businessballs.com/project%20management%20templates.pdf.

**How to use this tool:** Complete the form with all the required information. In some cases, to complete an element of the form (e.g., section on initial estimates of cost and time), additional work will be required. This form is best suited for a hospital administrator.

Present the completed form to the senior leader who would support your program, and discuss the potential benefits of the fall prevention initiative. This leader may also find it valuable for the finance department to calculate the return on investment (ROI).

ROI = Net returns from improvement actions / Investment in improvement actions. Additional information on ROI estimation is available in a companion AHRQ toolkit for hospitals at: [www.ahrq.gov/qual/qitoolkit/f1\_returnoninvestment.pdf](http://www.ahrq.gov/qual/qitoolkit/f1_returnoninvestment.pdf).

##### Business Case

|  |
| --- |
| Program Background (keep this brief) |
| General Aims |
| Initial Risks |
| Expected Outcomes |
| Benefits of Implementing This Program |
| Initial Estimates of Cost and Time$:Time: |
| Outcome of the Business Case |
| Decision From (Program Sponsor) |
| Date |

### 1E: Resource Needs Assessment

**Background:** The purpose of this tool is to identify resources that are available for a fall prevention program.

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

**How to use this tool:** Complete this checklist to assess the resources that are available and the resources that are still needed. This assessment is best suited for hospital supervisors, managers, and administrators.

Use this tool to ensure that all resources needed for launching a fall prevention program are available.

|  |  |  |
| --- | --- | --- |
| **Resource** | **Needed:****Yes/No** | **Notes on what is needed** |
| Staff education programs |  |  |
| Quality improvement experts |  |  |
| Physical/occupational therapy consultation on work practices |  |  |
| Information technology support |  |  |
| Specific products/tools (e.g., low beds, floormats, assistive devices, safe patient handling equipment) |  |  |
| Facilities and supplies (e.g., meeting rooms) |  |  |
| Printing/copying |  |  |
| Graphics/design |  |  |
| Nonclinical time for team meetings and activities |  |  |
| Other |  |  |
| Funds |  |  |

### 1F: Organizational Readiness Checklist

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

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

**How to use this tool:** Complete the checklist. This assessment is best suited for hospital supervisors, managers, and administrators.

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

##### Organizational Readiness Checklist

| **Readiness Question** | **Assessment in Your Organization** | **Yes** | **No** |
| --- | --- | --- | --- |
| Does the organization promote a culture of safety? | Hospital culture focuses on a systems approach to error reduction. |  |  |
| Why is change needed? | Hospital-specific reasons for change have been identified. |  |  |
| Do organizational members understand why change is needed? | Staff attitudes about falls have been assessed. |  |  |
| Assessment results have been analyzed to suggest awareness-building needs. |  |  |
| Is there a sense of urgency about the change? | Supporters who have a sense of urgency have been identified. |  |  |
| Efforts are underway to generate a sense of urgency if lacking. |  |  |
| Is there leadership support for this effort? | Leadership support has been assessed. |  |  |
| If necessary, efforts are underway to generate this support. |  |  |
| Senior leader champion or sponsor has been identified. |  |  |
| Who will take ownership of this effort? | A leader has been identified for the fall prevention effort. |  |  |
| This leader is now involved in the subsequent planning steps. |  |  |
| What kinds of resources are needed? | A preliminary list of needed human and material resources has been developed. |  |  |
| Commitments to provide those resources have been obtained or are forthcoming. |  |  |

### 2A: Interdisciplinary Team

|  |
| --- |
| **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.
2. 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.
3. 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.

1. Which of the following statements is *correct*?
2. Falls have multifactorial etiology, so fall prevention programs should comprise multifaceted interventions.
3. Regular review of medication can help to prevent patient falls.
4. The risk of falling will be lessened when a patient’s toileting needs are met.
5. The use of antipsychotic medications is associated with an increased risk of falls in older adults.

2. A multifaceted intervention program should include:

1. Individually-tailored fall prevention strategies
2. Education to patient/family and health care workers
3. Environmental safety
4. Safe patient handling

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

1. Dizziness/vertigo
2. Previous fall history
3. Antibiotic usage
4. Impaired mobility from stroke disease

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

1. The cause of a fall is often an interaction between patient’s risk, the environment, and patient risk behavior.
2. Increase in hazardous environments increases the risk of falls.
3. The use of a patient identifier (e.g., identification bracelet) helps to highlight to staff those patients at risk for falls.
4. 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:

1. Confined to bed
2. Encouraged to mobilize with assistance
3. Assisted with transfers
4. 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*:

1. Moving patients away from the nursing station
2. Involving family members to sit with the patient
3. Orienting patients to the hospital environment
4. Reinforcing activity limits to patients and their families

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

1. Fall prevention efforts are solely the nurses’ responsibility.
2. A patient who is taking four or more oral medications is at risk for falling.
3. A patient who is taking psychotropic medication is at higher risk for falling.
4. 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:

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

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

1. All patients should be assessed for fall risk factors at admission, at a change in status, after a fall, and at regular intervals.
2. Medication review should be included in the assessment.
3. All patients should have their activities of daily living and mobility assessed.
4. Environmental assessment is not important in the hospital as it is all standardized.

10. Risk factors for falls include:

1. Parkinson’s disease
2. Incontinence
3. Previous history of falls
4. Delirium

11. Exercise programs for ambulatory older adults should:

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

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

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

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

1. Locking wheeled furniture when it is stationary.
2. Having nonslip flooring.
3. Placing frequently used items (including call bell, telephone, and remote control) within reach of the patient
4. 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.
 |  |  |  |
|  |  |  |
|  |  |  |
| 1. Sustain the redesigned prevention practices.
 |  |  |  |
|  |  |  |
|  |  |  |

### 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

|  |  |
| --- | --- |
| 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 |  |

### 3A: Master Clinical Pathway for Inpatient Falls

**Background:** The purpose of this tool is to provide an overview of how fall prevention care processes could occur at your hospital or hospital unit.

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

**How to use this tool:** Compare the master clinical pathway to your current activities and adapt your activities or the master clinical pathway as needed to suit your specific circumstances.

This tool can be used by the quality improvement manager, staff nurses, and nursing assistants as an aid in designing a new system, as a training tool, or as an ongoing clinical reference tool. This tool can be modified or a new one created to meet the needs of your particular setting. If you prepared a process map describing your current practices, you can compare that with desired practices outlined on the clinical pathway.

##### FallClinPathway.JPGInpatient Falls Clinical Pathway

### 3B: Scheduled Rounding Protocol

**Background:** Hourly rounds are an opportunity to ensure that universal fall precautions are implemented and that patients’ needs are being met. These rounds integrate fall prevention activities with the rest of a patient’s care.

**Reference:** Adapted from Meade CM, Bursell AL, Ketelsen L. Effects of nursing rounds: on patients’ call light use, satisfaction, and safety. Am J Nurs 2006;106(9):58-70 with permission. Items that have been modified or added are marked with an asterisk.

**How to use this tool:** Review the hourly rounding protocol and adapt it to your specific circumstances. For example, components of the fall risk factor assessment can be added, such as a brief mental status screen.

This protocol can be used by staff nurses, nursing assistants, and the unit manager to ensure that universal fall precautions are in place.

The following items should be checked and performed for each patient. Upon entering the room, tell the patient you are there to do your rounds.

|  |  |
| --- | --- |
| 1 | Assess patient pain levels using a pain-assessment scale (if staff other than RNs are doing the rounding and the patient is in pain, contact an RN immediately so the patient does not have to use the call light for pain medication). |
| 2 | Put medication as needed on RN’s scheduled list of things to do for patients and offer the dose when due. |
| 3 | Offer toileting assistance. |
| 4 | Check that patient is using correct footwear (e.g., specific shoes/slippers, nonskid socks).\* |
| 5 | Check that the bed is in locked position.\* |
| 6 | Place hospital bed in low position when patient is resting; ask if patient needs to be repositioned and is comfortable.\* |
| 7 | Make sure the call light/call bell button is within the patient’s reach and patient can demonstrate use.\* |
| 8 | Put the telephone within the patient’s reach. |
| 9 | Put the TV remote control and bed light switch within the patient’s reach. |
| 10 | Put the bedside table next to the bed or across bed.\* |
| 11 | Put the tissue box and water within the patient’s reach. |
| 12 | Put the garbage can next to the bed. |
| 13 | Prior to leaving the room, ask, “Is there anything I can do for you before I leave? I have time while I am here in the room.” |
| 14 | Tell the patient that a member of the nursing staff (use names on white board) will be back in the room in an hour to round again. |

### 3C: Tool Covering Environmental Safety at the Bedside

**Background:** Facility safety is key to preventing falls in the hospital.

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

**How to use this tool:** This tool contains an inspection checklist to be completed jointly by the unit manager and facility engineer to identify and resolve environmental safety issues in hospital rooms. The inspection is designed to be performed room by room and bed by bed within each room (if rooms are not private).

Use the results from the inspection process to determine which items require attention by the nursing staff or maintenance or replacement by the facility engineers. Additional guidance for engineers about maintenance and repairs may be found at: [www.ahrq.gov/research/ltc/fallspx/fallspxmanapd.htm](http://www.ahrq.gov/research/ltc/fallspx/fallspxmanapd.htm).

##### Inspection List

Write the unit name, date, and room numbers across the top line. Put the bed number or letter across the second line and sign it. Put an “X” under the room number and bed beside all the tasks that need to be done (leave blank if no safety issue is identified or problem can be fixed immediately). Indicate whether this task should be completed by the nursing staff or facilities staff in the Assigned column. Tasks that are typically completed by the facility engineers are denoted with an “(f).” Write notes about special problems or add details in the Notes column.

| Unit | Date: | Room Number: |  |  |  |  |  |  |  | Assigned to | Notes |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Signature:  | Bed: |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 1. Paths | Remove unused equipment (canes/walkers). |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Remove bedside commode, if unused. |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| With patient’s permission, rearrange room to clear paths. |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Put the bedside table next to the bed or across bed. |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Remove unused items from bathroom and store elsewhere. |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Make tiebacks for divider curtains. |  |  |  |  |  |  |  |  |  |  |  |  |  |  | (f) |  |
| Tie electrical cords out of path (TV, phone). |  |  |  |  |  |  |  |  |  |  |  |  |  |  | (f) |  |
| 2. Furniture | Adjust bed into locked position.  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Replace unstable bed with a stable one. |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Push bed to wall (check local and state fire codes). |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Remove all lightweight or unstable furniture. |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Clean, repair, or replace broken bed wheel locks. |  |  |  |  |  |  |  |  |  |  |  |  |  |  | (f) |  |
| Fix unstable furniture. |  |  |  |  |  |  |  |  |  |  |  |  |  |  | (f) |  |
| Secure loose bathroom handrails. |  |  |  |  |  |  |  |  |  |  |  |  |  |  | (f) |  |
| Replace missing rubber tips on bedside commode. |  |  |  |  |  |  |  |  |  |  |  |  |  |  | (f) |  |
| Replace missing rubber tips on handrails that rest on floor. |  |  |  |  |  |  |  |  |  |  |  |  |  |  | (f) |  |
| Secure raised toilet seat to commode. |  |  |  |  |  |  |  |  |  |  |  |  |  |  | (f) |  |
| 3. Easy Access | Arrange room so that items are within patient’s reach (e.g., walking aids are within safe reach). |  |  |  |  |  |  |  |  |  |  |  |  |  |  | (f) |  |
| 4. Floor | Repair or replace floor covering. |  |  |  |  |  |  |  |  |  |  |  |  |  |  | (f) |  |
| Replace high, broken, or missing thresholds. |  |  |  |  |  |  |  |  |  |  |  |  |  |  | (f) |  |
| Add grading to thresholds between room and bathroom. |  |  |  |  |  |  |  |  |  |  |  |  |  |  | (f) |  |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 5. Lighting  | Replace burned out or flickering bulbs. Use max wattage. |  |  |  |  |  |  |  |  |  |  |  |  |  |  | (f) |  |
| Repair broken room lights or call lights. |  |  |  |  |  |  |  |  |  |  |  |  |  |  | (f) |  |
| Replace broken call light cords or lengthen cords. |  |  |  |  |  |  |  |  |  |  |  |  |  |  | (f) |  |
| 6. Equipment  | Inspect wheelchair (for all wheelchairs found). |  |  |  |  |  |  |  |  |  |  |  |  |  |  | (f) |  |
| Repair cane. |  |  |  |  |  |  |  |  |  |  |  |  |  |  | (f) |  |
| Repair walker. |  |  |  |  |  |  |  |  |  |  |  |  |  |  | (f) |  |

### 3D: Hazard Report Form

**Background:** This tool contains a form for reporting environmental hazards when they are detected. Whereas the inspection checklist ([Tool 3C, “Tool Covering Environmental Safety at the Bedside”) i](#_3C:_Tool_cCovering)s for regular, systematic review for fall hazards, this form is for hazards detected incidentally during usual care.

**Reference:** Falls prevention strategies in health care settings. Plymouth Meeting, PA:ECRI Institute; 2006. Hazard Report Form 13: 248. Reprinted with permission.

**How to use this tool:** Use this form whenever an environmental hazard is detected. You may need to change the people to whom the hazard is reported based on your local organizational setup. Any hospital employee who enters patient rooms can use this form.

##### Hazard Report Form

To: Nurse Manager

Equipment or Condition Presenting Hazard:

Location of Hazard:

Date Hazard Reported:

Hazard Reported by (your name):

Corrective Action Taken (describe what you did to eliminate the hazard):

Work Order Initiated (describe what still needs to be done to eliminate the hazard):

Work Order Completed on:

Work Order Completed by:

Action Taken to Eliminate Future Occurrences:

Hazard Reported at:

Staff Meeting (date):

Shift Reports (date):

Posting on Bulletin Boards (date):

Copies of this form must be forwarded to the Risk Manager.

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### 3E: Clinical Pathway for Safe Patient Handling

**Background:** This tool is a clinical pathway that illustrates appropriate application of safe patient handling principles, which are part of universal fall precautions (described in more detail in [section 3](#_/3._Whichat_are)).

**Reference**: Developed by VA Sunshine Healthcare Network (VISN 8) Patient Safety Center of Inquiry, Tampa, Florida.

**How to use this tool:** Use this and other safe patient handling pathways available at:[www.visn8.va.gov/VISN8/PatientSafetyCenter/safePtHandling/SafePatientHandlingAssessment\_Algorithms\_031209.doc](http://www.visn8.va.gov/VISN8/PatientSafetyCenter/safePtHandling/SafePatientHandlingAssessment_Algorithms_031209.doc) as a guideline to compare against your current care processes for safe patient handling. Additional training on safe patient handling for frontline staff is available from the Centers for Disease Control and Prevention at [www.cdc.gov/niosh/docs/2009-127/default.html](http://www.cdc.gov/niosh/docs/2009-127/default.html).

This tool can be used by the nurse manager, staff nurses, and nursing assistants as an aid in designing a new system, as a training tool, or as an ongoing clinical reference tool. This tool can be modified or a new one created to meet the needs of your particular setting.



### 3F: Orthostatic Vital Sign Measurement

|  |
| --- |
| **Background:** This tool can be used to identify orthostatic hypotension, a risk factor for falls in hospitalized patients. **Reference:** Adapted from: John Dempsey Hospital Department of Nursing Clinical Manual/Nursing Practice Manual (available at: [http://nursing.uchc.edu/nursing\_standards/docs/Orthostatic%20(Postural)%20Vital%20Sign%20Measurement.pdf](http://nursing.uchc.edu/nursing_standards/docs/Orthostatic%20%28Postural%29%20Vital%20Sign%20Measurement.pdf) ) with information from MaineHealth Cardiovascular Health (available at: [www.mainehealth.org/workfiles/mh\_healthinformation/Measuring\_Orthostatic\_Vital\_Signs.pdf](http://www.mainehealth.org/workfiles/mh_healthinformation/Measuring_Orthostatic_Vital_Signs.pdf)).**How to use this tool:** Staff nurses and nursing assistants typically complete this protocol. All findings should be reported to the treating medical provider. The decision whether to use this protocol on all patients (e.g., on admission), or as needed, will depend on the specific unit. However, consider checking orthostatic vital signs:* After a fall.
* When a patient complains of a symptom that may be due to orthostasis (e.g., lightheadedness).
* As part of a routine admission assessment on units where patients frequently take medications that cause orthostasis (e.g., geriatric psychiatry).
* When a patient is on a medication that may cause orthostasis and has other risk factors for falls.

Use this tool in conjunction with clinical assessment and a standard assessment of fall risk factors (e.g., [Tool 3H, “Morse Fall Scale for Identifying Fall Risk Factors,](file:///%5C%5Cpklnfs04%5CSharedir%5COCKT%5CDPEP%5CCDOM%5CLTC%5CFall%20Prevention%5CFallPxToolkit_edits_dmb_103012.docx) or [Tool 3G, ‘STRATIFY Scale for Identifying Fall Risk Factors”](file:///%5C%5Cpklnfs04%5CSharedir%5COCKT%5CDPEP%5CCDOM%5CLTC%5CFall%20Prevention%5CFallPxToolkit_edits_dmb_103012.docx)) to determine a patient’s risk factors for falls, and then plan care accordingly.  |

##### Protocol for Orthostatic (Postural) Vital Sign Measurement

Policy

1. Orthostatic vital signs may be indicated to evaluate patients who are at risk for hypovolemia (vomiting, diarrhea, bleeding), have had syncope or near syncope (dizziness, fainting), or are at risk for falls. A significant change in vital signs with a change in position also signals increased risk for falls.

Orthostatic vital signs are not indicated in patients who:

1. Have supine hypotension.
2. Have a sitting blood pressure ≤90/60.
3. Have acute deep vein thrombosis.
4. Exhibit the clinical syndrome of shock.
5. Have severely altered mental status.
6. Have possible spinal injuries.
7. Have lower extremity or pelvic fractures.
8. Are not mobile enough to get out of bed.

Orthostatic vital signs (blood pressure, pulse, and symptoms) will be obtained and recorded while the patient is in the supine position as well as in the standing position. If the patient is unable to stand, orthostatics may be taken while the patient is sitting with feet dangling.

Equipment

* Noninvasive blood pressure measurement device.
* Blood pressure cuff of correct size for the patient.

Procedure

1. Instruct the patient on the process of orthostatic blood pressure measurement and its rationale.
2. Assess by verbal report and observation the patient’s ability to stand.
3. Have patient lie in bed with the head flat for a minimum of 3 minutes, and preferably 5 minutes.
4. Measure the blood pressure and the pulse while the patient is supine.
5. Instruct patient to sit for 1 minute.
6. Ask patient about dizziness, weakness, or visual changes associated with position change. Note diaphoresis or pallor.
7. Check sitting blood pressure and pulse.
8. If the patient has symptoms associated with position change or sitting blood pressure ≤90/60, put patient back to bed.
9. Instruct patient to stand.
10. Ask patient about dizziness, weakness, or visual changes associated with position change. Note diaphoresis or pallor.
11. If patient is unable to stand, sit patient upright with legs dangling over the edge of the bed.
12. The patient should be permitted to resume a supine position immediately if syncope or near syncope develops.
13. Measure the blood pressure and pulse immediately after patient has stood up, and then repeat the measurements 3 minutes after patient stands. Support the forearm at heart level when taking the blood pressures to prevent inaccurate measurement.
14. Assist patient back to bed in a position of comfort.
15. Document vital signs and other pertinent observations on the nursing flowsheet or in the medical record. Note all measurements taken and the position of the patient during each reading.

Evaluation

1. Subtract values 3 minutes after standing (or if patient cannot stand, then sitting) from lying values.

A decline of ≥20mm Hg in systolic or ≥10 mm Hg in diastolic blood pressure after 3 minutes of standing = orthostatic hypotension.

A heart rate increase of at least 30 beats per minute after 3 minutes of standing may suggest hypovolemia, independent of whether the patient meets criteria for orthostatic hypotension.

A blood pressure drop immediately after standing that resolves at 3 minutes does not indicate orthostatic hypotension. However, this finding may be useful to confirm a patient’s complaint of feeling dizzy upon standing and may lead to patient education about using caution when arising from a lying or sitting position.

Report all findings to the treating medical provider, including all sets of blood pressure and pulse results, and whether the patient experienced pallor, diaphoresis, or faintness when upright.

Sometimes it may be difficult to determine if the resident/patient has orthostatic hypotension when checking only at one point in time. If the resident/patient does not show evidence of orthostatic hypotension during the assessment but has complained of lightheadedness or dizziness, perform the measurements when the resident/patient complains or within 2 hours of the start of a meal.

### 3G: STRATIFY Scale for Identifying Fall Risk Factors

**Background:** This tool can be used to identify risk factors for falls in hospitalized patients. The total score may be used to predict future falls, but it is more important to identify risk factors using the scale and then plan care to address those risk factors.

**Reference:** Adapted from Oliver D, Britton M, Seed P, et al. Development and evaluation of evidence based risk assessment tool (STRATIFY) to predict which elderly inpatients will fall: case-control and cohort studies. BMJ 1997;315(7115):1049-53. Reprinted with permission from BMJ Group.

**How to use this tool:** Please fill out the scale as instructed below. This tool can be used by staff nurses.

Use this tool in conjunction with clinical assessment and a review of medications (see [Tool 3I](#_3IH:_Medication_fFall)) to determine if a patient is at risk for falls and plan care accordingly. Note that this scale may not capture the risk factors that are most important on your hospital ward, so consider your local circumstances.

If your hospital uses an electronic health record, consult your hospital’s information systems staff about integrating this tool into the electronic health record.

##### STRATIFY Risk Assessment Tool

Answer all five questions below and count the number of “Yes” answers.

| 1 | Did the patient present to hospital with a fall or has he or she fallen on the ward since admission (**recent history of fall**)? | Yes = 1 | No = 0 |
| --- | --- | --- | --- |
| 2 | Is the patient **agitated**? | Yes = 1 | No = 0 |
| 3 | Is the patient **visually impaired** to the extent that everyday function is affected? | Yes = 1 | No = 0 |
| 4 | Is the patient in need of especially **frequent toileting**? | Yes = 1 | No = 0 |
| 5 | Does the patient have a combined **transfer and mobility** score of 3 or 4? (calculate below) | Yes = 1 | No = 0 |
| *Transfer score*: Choose **one** of the following options which best describes the patient’s level of capability when transferring from a bed to a chair:0 = Unable1 = Needs major help2 = Needs minor help3 = Independent |
| *Mobility score*: Choose **one** of the following options which best describes the patient’s level of mobility:0 = Immobile1 = Independent with the aid of a wheelchair2 = Uses walking aid or help of one person3 = Independent |
| *Combined score* (**transfer + mobility**): \_\_\_\_\_\_\_\_\_\_\_\_  |
| Total score from questions 1-5: \_\_\_\_\_\_\_\_\_\_\_0 = Low risk 1 = Moderate risk2 or above = High risk |

### 3H: Morse Fall Scale for Identifying Fall Risk Factors

**Background:** This tool can be used to identify risk factors for falls in hospitalized patients. The total score may be used to predict future falls, but it is more important to identify risk factors using the scale and then plan care to address those risk factors.

**Reference:** Adapted from Morse JM, Morse RM, Tylko SJ. Development of a scale to identify the fall-prone patient. Can J Aging 1989;8:366-7. Reprinted with the permission of Cambridge University Press.

**How to use this tool:** A training module on proper use of the Morse Fall Scale developed by the Partners HealthCare Fall Prevention Task Force may be found at [www.brighamandwomens.org/Patients\_Visitors/pcs/nursing/nursinged/Medical/FALLS/Fall\_TIPS\_Toolkit\_MFS%20Training%20Module.pdf](http://www.brighamandwomens.org/Patients_Visitors/pcs/nursing/nursinged/Medical/FALLS/Fall_TIPS_Toolkit_MFS%20Training%20Module.pdf). In addition to completion of the module, training should include real cases where the provider conducts an assessment. Mental status and gait parameters require actual assessment of a real patient (as opposed to solely a chart review).

This tool can be used by staff nurses. Use this tool in conjunction with clinical assessment and a review of medications (see [Tool 3I](#_3IH:_Medication_fFall)) to determine if a patient is at risk for falls and plan care accordingly. Note that this scale may not capture the risk factors that are most important on your hospital ward, so consider your local circumstances.

Register through Partners HealthCare at [www.brighamandwomens.org/Patients\_Visitors/pcs/nursing/nursinged/Medical/FALLS/Permissions/PHS%20MFS%20Competency.pdf](http://www.brighamandwomens.org/Patients_Visitors/pcs/nursing/nursinged/Medical/FALLS/Permissions/PHS%20MFS%20Competency.pdf) prior to use.

If your hospital uses an electronic health record, consult your hospital’s information systems staff about integrating this tool into the electronic health record.

##### Morse Fall Scale

| **Item** | **Item Score** | **Patient Score** |
| --- | --- | --- |
| 1. History of falling (immediate or previous) | No 0Yes 25 | \_\_\_\_\_\_ |
| 2. Secondary diagnosis (≥ 2 medical diagnoses in chart) | No 0Yes 15 | \_\_\_\_\_\_ |
| 3. Ambulatory aidNone/bedrest/nurse assist Crutches/cane/walker Furniture | 01530 | \_\_\_\_\_\_ |
| 4. Intravenous therapy/heparin lock | No 0Yes 20 | \_\_\_\_\_\_ |
| 5. GaitNormal/bedrest/wheelchairWeak\*Impaired† | 01020 | \_\_\_\_\_\_ |
| 6. Mental statusOriented to own abilityOverestimates/forgets limitations | 015 | \_\_\_\_\_\_ |
| Total Score‡: Tally the patient score and record.<25: Low risk25-45: Moderate risk>45: High risk | \_\_\_\_\_\_ |

\* Weak gait: Short steps (may shuffle), stooped but able to lift head while walking, may seek support from furniture while walking, but with light touch (for reassurance).

† Impaired gait: Short steps with shuffle; may have difficulty arising from chair; head down; significantly impaired balance, requiring furniture, support person, or walking aid to walk.

‡ Suggested scoring based on Morse JM, Black C, Oberle K, et al. A prospective study to identify the fall-prone patient. Soc Sci Med 1989; 28(1):81-6. However, note that Morse herself said that the appropriate cut-points to distinguish risk should be determined by each institution based on the risk profile of its patients. For details, see Morse JM, , Morse RM, Tylko SJ. Development of a scale to identify the fall-prone patient. Can J Aging 1989;8;366-7.

### 3I: Medication Fall Risk Score and Evaluation Tools

**Background:** This tool can be used to identify medication-related risk factors for falls in hospitalized patients. A pharmacist would perform this assessment.

**Reference:** Used with permission: Beasley B, Patatanian E. Development and implementation of a pharmacy fall prevention program. Hosp Pharm 2009;44(12):1095-1102. © 2009, Thomas Land Publishers, [www.hosp-pharmacy.com](http://www.hosp-pharmacy.com).

**How to use this tool:** Evaluate medication-related fall risk on admission and at regular intervals thereafter. Add up the point value (risk level) for every medication the patient is taking. If the patient is taking more than one medication in a particular risk category, the score should be calculated by (risk level score) x (number of medications in that risk level category). For a patient at risk, a pharmacist should use the evaluation tools to determine if medications may be tapered, discontinued, or changed to a safer alternative.

Use this tool in conjunction with clinical assessment and a nursing risk scale (e.g., [Tool 3H, “Morse Fall Scale for Identifying Fall Risk Factors,”](#_3HF:_The_Morse) or [3G, “STRATIFY Scale for Identifying Fall Risk Factors”](#_3G:_STRATIFY_Scale)) to determine if a patient is at risk for falls and plan care accordingly. Note that this scale may not capture the medication risk factors that are most important on your hospital ward, so consider your local circumstances.\* A hybrid approach is to have the nurse use a scale such as the one below and alert the pharmacist if the total score is 6 or greater.

If your hospital uses an electronic health record, consult your hospital’s information systems staff about integrating this tool into the electronic health record.

\* Formularies may differ. Consult the hospital pharmacy and therapeutics committee or pharmacy department for formulary drugs within the American Hospital Formulary Service drug class identified in the table. The hospital can decide how to specify the drugs that fall within these risk classes. Also consider the dose and timing of medications (e.g., avoiding diuretic use close to bedtime).

##### Medication Fall Risk Score

| Point Value (Risk Level) | American Hospital Formulary Service Class | Comments |
| --- | --- | --- |
| 3 (High) | Analgesics,\* antipsychotics, anticonvulsants, benzodiazepines† | Sedation, dizziness, postural disturbances, altered gait and balance, impaired cognition |
| 2 (Medium) | Antihypertensives, cardiac drugs, antiarrhythmics, antidepressants | Induced orthostasis, impaired cerebral perfusion, poor health status |
| 1 (Low) | Diuretics | Increased ambulation, induced orthostasis |
| Score ≥ 6 |  | Higher risk for fall; evaluate patient |

\* Includes opiates.

† Although not included in the original scoring system, the falls toolkit team recommends that you include non-benzodiazepine sedative-hypnotic drugs (e.g., zolpidem) in this category.

##### Medication Fall Risk Evaluation Tools

Use the tools below when evaluating patients found to have high medication-related risk for falls. The comments section provides information on how to evaluate the indicators.

| Indicator | Comments |
| --- | --- |
| Medications  | Beers criteria,\* dose adjustment for renal function or disease state, overuse of medications, IV access |
| Laboratory  | Therapeutic drug levels (digoxin, phenytoin), international normalized ratio, electrolytes, hemoglobin/hematocrit |
| Disease states  | Comorbidities, hypertension, congestive heart failure, diabetes, orthopedic surgery, prior fall, dementia, other† |
| Education  | Patient’s ability/willingness to learn, patient’s mental status |

\* Beers criteria are available at: American Geriatrics Society updated Beers criteria for potentially inappropriate medication use in older adults. J Am Geriatr Soc 2012;60(4):616-31.

† Age 65 years or older.

### 3J: Delirium Evaluation Bundle: Digit Span, Short Portable Mental Status Questionnaire, and Confusion Assessment Method

Background:Patients found to have impaired mental activity as a risk factor for falls require further evaluation. The Delirium Evaluation Bundle is designed to help determine if the patient has delirium.

Reference:

Digit Span: Scoring guidelines from Montreal Cognitive Assessment are available at the Veterans Affairs (VA) Web page for the National Parkinson’s Disease Research, Education, and Clinical Center & VA PD Consortium, [www.parkinsons.va.gov/consortium/moca.asp](http://www.parkinsons.va.gov/consortium/moca.asp).

Short Portable Mental Status Questionnaire: Adapted from (1) Hospital Elder Life Program and (2) Pfeiffer E. A short portable mental status questionnaire for the assessment of organic brain deficit in elderly patients. J Am Geriatr Soc 1975;23:433-41.

Confusion Assessment Method: Adapted from Inouye SK, van Dyck CH, Alessi CA, et al. Clarifying confusion. Ann Intern Med 1990;113(12):941-8.

How to use this tool:A proper evaluation for delirium requires both standardized testing and direct observation of the patient’s behavior. Performing the Digit Span Test and the Short Portable Mental Status Questionnaire will provide information that can be used in the Confusion Assessment Method (CAM). Instructions for each test are explained below. Use the provided link to access the CAM training manual.

This tool should be used in any patient whose mental status is unclear on admission or transfer to a unit, or whose mental status has acutely declined. The tool will allow you to determine if a patient is delirious and therefore requires further medical evaluation for delirium. Physicians, nurse practitioners, and physician assistants can carry out this assessment, but training is required (use links provided below to access material). The training is particularly important to distinguish delirium from behavioral symptoms of dementia.

Consider having clinical champions for delirium assessment who can be called in to evaluate a patient if needed. If your hospital uses an electronic health record, consult your hospital’s information systems staff about integrating this tool into the electronic health record.

##### Digit Span

Now I am going to say some numbers. Please repeat them back to me.

[SAY DIGITS AT RATE OF ONE PER SECOND]

| DIGITS FORWARD (DF) | Response |
| --- | --- |
| 2 - 9 - 1 | \_\_\_\_ - \_\_\_\_ - \_\_\_\_ |
| 3 - 5 - 7 - 4 | \_\_\_\_ - \_\_\_\_ - \_\_\_\_ - \_\_\_\_ |
| 6 - 1 - 9 - 2 - 7 | \_\_\_\_ - \_\_\_\_ - \_\_\_\_ - \_\_\_\_ - \_\_\_\_ |

Now I am going to read some more numbers, but I want you to repeat them in backward order from the way I read them to you. So, for example, if I said 6-4, you would say 4-6.

[SAY DIGITS AT RATE OF ONE PER SECOND]

| DIGITS BACKWARD (DB) | Response |
| --- | --- |
| 7 - 4 – 2 | \_\_\_\_ - \_\_\_\_ - \_\_\_\_ |
| 5 - 3 - 8 - 4 | \_\_\_\_ - \_\_\_\_ - \_\_\_\_ - \_\_\_\_ |

SCORING: Patients should be able to repeat 5 digits forward and 3 digits backward under normal conditions. Inability to do so represents an abnormal test result.

##### Short Portable Mental Status Questionnaire

| **Question** | **Response** | **Error?** |
| --- | --- | --- |
| What are the date, month, and year?\* | Date | Month | Year |  |
| What is the day of the week? |  |  |
| What is the name of this place? |  |  |
| What is your phone number? |  |  |
| How old are you? |  |  |
| When were you born? |  |  |
| Who is the current president? |  |  |
| Who was the president before him? |  |  |
| What was your mother’s maiden name? |  |  |
| Can you count backward from 20 by 3s? |  |  |

\*A mistake on ANY part of this question should be scored as an error.

Total Errors: \_\_\_\_\_\_\_

SCORING\*:

0-2 errors: normal mental functioning

3-4 errors: mild cognitive impairment

5-7 errors: moderate cognitive impairment

8 or more errors: severe cognitive impairment

\*One more error is allowed in the scoring if a patient has had a grade school education or less. One less error is allowed if the patient has had education beyond the high school level.

The Short Portable Mental Status Questionnaire was originally published as Pfeiffer E. A short portable mental status questionnaire for the assessment of organic brain deficit in elderly patients. J Am Geriatr Soc 1975;23:433-41. The version shown here is adapted from the Hospital Elder Life Program ([www.hospitalelderlifeprogram.org](http://www.hospitalelderlifeprogram.org/) ). Used with permission. © E. Pfeiffer, 1994.

##### Confusion Assessment Method

After checking the patient’s orientation and performing the Digit Span Test and Short Portable Mental Status Questionnaire, rate the patient using the Confusion Assessment Method. This is best done after going through a training process, available at [www.hospitalelderlifeprogram.org](http://www.hospitalelderlifeprogram.org/). After agreement to conditions of use, download the Confusion Assessment Method Training Manual at [www.hospitalelderlifeprogram.org/pdf/TheConfusionAssessmentMethodTrainingManual.pdf](http://www.hospitalelderlifeprogram.org/pdf/TheConfusionAssessmentMethodTrainingManual.pdf).

A brief summary of the Confusion Assessment Method for nurses is also available through the Hartford Institute for Geriatric Nursing at: <http://consultgerirn.org/uploads/File/trythis/try_this_13.pdf>.

A 50-minute training video for nurses is available through the Hartford Institute for Geriatric Nursing at: <http://consultgerirn.org/resources/media/?vid_id=4361983#player_container>.

To rate the patient with the Confusion Assessment Method, use the worksheet on the next page.

Confusion Assessment Method Shortened Version Worksheet

| EVALUATOR: | DATE: |
| --- | --- |
| I. ACUTE ONSET AND FLUCTUATING COURSE  |  | BOX 1 |
| a. Is there evidence of an acute change in mental status from the patient’s baseline? | No  | Yes  |
| b. Did the (abnormal) behavior fluctuate during the day, that is, tend to come and go or increase and decrease in severity? | No  | Yes  |
| II. INATTENTION |  |  |
| Did the patient have difficulty focusing attention, for example, being easily distractible or having difficulty keeping track of what was being said? | No  | Yes  |
| III. DISORGANIZED THINKING |  |  |
| Was the patient’s thinking disorganized or incoherent, such as rambling or irrelevant conversation, unclear or illogical flow of ideas, or unpredictable switching from subject to subject? |  | BOX 2 |
| No  | Yes  |
| IV. ALTERED LEVEL OF CONSCIOUSNESS |  |  |
| Overall, how would you rate the patient’s level of consciousness? |  |  |
|  Alert (normal) |  |  |
|  |  Vigilant (hyperalert) Lethargic (drowsy, easily aroused) Stupor (difficult to arouse) Coma (unarousable) |  |  |  |
| Do any checks appear in this box? | No  | Yes  |

If all items in Box 1 are checked and at least one item in Box 2 is checked, a diagnosis of delirium is suggested.

© 2003, Hospital Elder Life Program. Adapted from Inouye SK, van Dyck CH, Alessi CA, et al, Clarifying confusion: the confusion assessment method. A new method for detection of delirium. Ann Intern Med 1990;113(12):941-8.

### 3K: Algorithm for Mobilizing Patients

**Background:** The purpose of this tool is to provide a sample algorithm for mobilization of patients. The mobility algorithm is meant for patients who have experienced deconditioning or are at risk for deconditioning. The algorithm is NOT intended for patients whose primary reason for admission is mobility related; such patients should be offered physical and occupational therapy, as appropriate.

**Reference:** Adapted from tools created by Central DuPage Hospital in Winfield, Illinois, and subsequently published in Drolet A. Dejuilio P, Harkless S, et al. [Move to Improve: the feasibility of using an early mobility protocol to increase ambulation in the intensive and intermediate care settings.](http://www.ncbi.nlm.nih.gov/pubmed/22976447) Phys Ther 2012 Sep 13. [Epub ahead of print]. Tool adapted with permission of the American Physical Therapy Association. This material is copyrighted, and any further reproduction or distribution requires written permission from APTA. This is not the final edited version that appeared in the journal article.

**How to use this tool:** Nursing assistants or other appropriate hospital staff can follow the mobility algorithm to initiate mobilization after the treating medical provider orders mobilization and the patient’s nurse determines that the patient meets all inclusion criteria and does not have any exclusion criteria (see below).

This tool can be usedin designing a new system, as a training tool for staff, and as an ongoing reference tool on hospital units. This tool can be modified or a new one created to meet the needs of your particular setting. If your hospital uses an electronic health record, consult your hospital’s information systems staff about integrating this tool into the electronic health record.

##### mobilityalg.JPGMobility Algorithm

Adapted from tools created by Central DuPage Hospital in Winfield, Illinois, and published in Drolet A, et al. Phys Ther 2012 Sep 13. [Epub ahead of print]. Tool adapted with permission of the American Physical Therapy Association. This material is copyrighted, and any further reproduction or distribution requires written permission from APTA. This is not the final edited version that appeared in the journal article.

### 3L: Patient and Family Education

**Background:** Below are examples of key educational points about fall prevention that can be handed out to patients and their families.

**Reference:** Available as a patient education brochure at the Minnesota Hospital Association Web site: [www.mnhospitals.org/Portals/0/Documents/ptsafety/falls/English\_Patient\_Education\_Brochure.pdf](http://www.mnhospitals.org/Portals/0/Documents/ptsafety/falls/English_Patient_Education_Brochure.pdf).

**How to use this tool:** The information below can be customized for use within your hospital. When printing your educational brochure, make sure that text is at least 14 points, and make it 16 points if possible; use Times New Roman font or another font that has serifs. We recommend against printing text over photographs or colors in the background (e.g., black text on a dark green background) and suggest using sharper contrasting colors to make the text easier to read. The language should be at no more than a 6th grade reading level to ensure that all patients can understand the message.

Educators and staff nurses can distribute educational information to patients, but verbal counseling on fall risk should be performed by someone trained for this task. Consider handing out educational information to patients and their families when the patient is admitted to your unit.

Preventing Falls in the Hospital

Know when to ask for help

You will do more and more walking as your health improves. To avoid falling and hurting yourself, please follow these guidelines.

* Wear shoes or nonskid slippers every time you get out of bed.
* Call your nurse if you feel dizzy, weak, or lightheaded. Don’t get up by yourself.
* Ask for help to go to the bathroom. Make sure the path to the bathroom is clear.
* Use only unmoving objects to help steady yourself. Don’t use your IV pole, tray table, wheelchair, or other objects that can move.
* Use the handrails in the bathroom and hallway.
* If you wear glasses or hearing aids, use them.
* Keep important items within reach. This includes your call button or call bell.

**Source:** Minnesota Hospital Association.

### 3M: Sample Care Plan

**Background:** Developing a care plan specific to the needs of each individual patient is critical. This tool is a sample care plan that gives specific examples of actions that should be performed to address a patient’s needs.

**Reference:** Adapted from National Health Service document Slips, trips, and falls in the hospital, available at [www.nrls.npsa.nhs.uk/resources/?EntryId45=59821](http://www.nrls.npsa.nhs.uk/resources/?EntryId45=59821). This report is based on Healey F, Monro A, Cockram A, et al. [Using targeted risk factor reduction to prevent falls in older in-patients: a randomised controlled trial.](http://www.ncbi.nlm.nih.gov/pubmed/15151914) Age Ageing 2004;33(4):390-5.

**How to use this tool:** This tool includes examples of interventions that may be considered for specific fall risk factors. These should be tailored to meet the needs of your patient. The original care plan was completed for patients with any of the following:

* Fall since admission.
* Attempt to walk alone unsteady/unsafe.
* Patient or relatives anxious about falls.

Your hospital unit may use these factors alone or in combination with additional factors to trigger use of the care plan. This tool should be used collaboratively by staff nurses with input from other disciplines (e.g., physician, pharmacist, physical or occupational therapists). If your hospital uses an electronic health record, consult your hospital’s information systems staff about integrating this tool into the electronic health record.

Individualize the care plan to address the needs of at-risk patients.

##### Care Plan

| GOAL: To reduce likelihood of falls while maintaining dignity and independence | State action taken below (sample provided): |
| --- | --- |
| **Call.** Ensure call bell explained and in reach. Consider alternatives for patients unable to recall use of call bell, e.g., use brass bell, move bed in sight of nurses’ station. | Call bell in reach but may forget, will probably call her daughter’s name instead; moved within earshot of nurses’ station. |
| **Eyesight.** Ensure eyesight is checked and patient is wearing glasses if needed. Can the patient identify pen/key from bed length away? If eyesight is too poor to identify objects, ask the treating medical provider to review. Ensure glasses/hearing aid are worn or within reach. | Glasses broken in fall at home; family has ordered replacement and hopes to provide it tomorrow. Has fair distance vision without them. Have suggested that the family order a spare pair too. |
| **Bed and bedrails.** Assess the need for bedrails (refer to policy). If patient is likely to fall from bed, ensure bed is at the lowest possible height unless this would reduce mobility or independence. Consider use of special low bed. | Bedrails not appropriate as this patient can mobilize on her own, even though unsteady, and might be confused enough to climb over. Bed set at right height for safe move from sitting to standing. |
| **Medication.** Check for medication associated with fall risk, such as antidepressants, sleeping tablets, sedatives, and antipsychotics. Ask the pharmacist to review and make recommendations to treating medical provider (do not stop abruptly). | On temazepam 15 mg qhs for some years; will discuss with pharmacist. |
| **Mobility.** Determine the patient’s level of mobility and whether actions should be taken to improve or maintain mobility. | Participating in supervised mobility protocol with nursing assistant. Currently able to ambulate 50 feet with front wheeled walker daily. |
| **Interdisciplinary team.** Ensure medical staff, physical therapist, occupational therapist, social worker, and others on the team are aware of the patient’s risk, frequency, nature, and seriousness of falls (local protocol or pathway would cover expected actions by team members, e.g., cognitive evaluation, osteoporosis check, mobility aid review). | Treating physician aware of patient’s fall risk. Physical and occupational therapy referral sent on 11/14/11. Fall risk noted on discharge plan. |
| **Footwear.** Check footwear for secure fit, nonslip sole, no trailing laces. Ask relatives to supply safer replacement or supply new slippers from ward stock. Consider slipper socks in bed for patients at risk of falling at night. | Patient does not have footwear. Provided with new slippers from ward stock. |
| **Place.** Place patient in most appropriate place on the ward for his or her needs, e.g., close to nurses’ station, close to toilet, in quietest area (considering other patients’ needs as well). | Located nearest toilet and within earshot of nurses’ station. |
| **Lighting.** Consider lighting best for patient, e.g., bedside lamp left on overnight, night light in bathroom. | Will have overhead lamp on low overnight. |
| **Toilet.** Does the risk of falls appear to be associated with patient’s need to use toilet? If so, a routine of frequent toilet visits may help prevent falls. | Currently the patient has frequency/urgency; being treated for urinary tract infection. Will offer toilet every hour while patient is awake. |
| **Inform.** Provide falls education brochure to patient/family, engage them in care plan, find out contact wishes in event of fall. | Patient and daughter have falls education brochure, and care plan has been explained. Contact wishes entered into chart. |

### 3N: Postfall Assessment, Clinical Review

**Background:** This protocol explains how to assess and follow injury risk in a patient who has fallen.

**Reference:** Adapted from the South Australia Health Fall Prevention Toolkit. Available at: [www.sahealth.sa.gov.au/wps/wcm/connect/5a7adb80464f6640a604fe2e504170d4/Post+fall+management+protocol-SaQ-20110330.pdf?MOD=AJPERES&CACHEID=5a7adb80464f6640a604fe2e504170d4](http://www.sahealth.sa.gov.au/wps/wcm/connect/5a7adb80464f6640a604fe2e504170d4/Post%2Bfall%2Bmanagement%2Bprotocol-SaQ-20110330.pdf?MOD=AJPERES&CACHEID=5a7adb80464f6640a604fe2e504170d4)

**How to use this tool:** Staff nurses and physicians should follow this protocol, in combination with clinical judgment, with patients who have just fallen. Training on the Glasgow Coma Scale is available at: [www.nursingtimes.net/Binaries/0-4-1/4-1735373.pdf](http://www.nursingtimes.net/Binaries/0-4-1/4-1735373.pdf). (Full citation: Jevon P. Neurological assessment part 4 - Glasgow Coma Scale 2. Nurs Times 2008;104(30):24-5.) This training includes graphics demonstrating various aspects of the scale.

##### Postfall Assessment, Clinical Review

**Note:** There is increased risk of intracranial hemorrhage in patients with advanced age; on anticoagulant and/or antiplatelet therapy; and known coagulopathy, including those with alcoholism.In addition, there may be late manifestations of head injury after 24 hours.

|  |  |  |
| --- | --- | --- |
| **Does not hit head*** Assess immediate danger to all involved. Assess circulation, airway, and breathing according to your hospital’s protocol.
* Call for assistance. Activate appropriate emergency response team if required.
* Do not move the patient until he/she has been assessed for safety to be moved. Examine cervical spine and if there is any indication of injury do not move the patient; instead, immobilize cervical spine, and call treating medical provider.
* Identify all visible injuries and initiate first aid; for example, cover wounds.
* Assist patient to move using safe handling practices.

**Proceed to:*** Check vital signs (blood pressure, heart rate, respiratory rate, oxygen saturation, and hydration).
* Clean and dress any wounds.
* Inform treating medical provider.
* Provide analgesia if required and not contraindicated.
* Arrange further tests as indicated, such as blood sugar levels and x rays.
* Review current care plan and implement additional fall prevention strategies.
* Provide fall prevention information (Tool 3J).

**Observations:*** Continue observations at least every 4 hours for 24 hours or as required.
 |  | **Hits head or has unwitnessed fall*** Assess immediate danger to all involved. Assess circulation, airway, and breathing according to your hospital’s protocol.
* Call for assistance. Activate appropriate emergency response team if required.
* Do not move the patient until he/she has been assessed for safety to be moved. Examine cervical spine and if there is any indication of injury do not move the patient; instead, immobilize cervical spine, and call treating medical provider.
* Assess Glasgow Coma Scale (next page).
* Identify all visible injuries and initiate first aid; for example, cover wounds.
* Assist patient to move using safe handling practices.

**Proceed to:*** Record neurologic observations, including Glasgow Coma Scale. Observe for signs indicating stroke, change in consciousness, headache, amnesia, or vomiting.
* Get baseline vital signs (blood pressure, heart rate, respiratory rate, oxygen saturation, temperature, and hydration).
* Clean and dress any wounds.
* Arrange medical review.
* Provide analgesia if required and not contraindicated.
* Arrange further tests as indicated, such as blood sugar levels, x rays, ECG, and CT scan.
* Review current care plan and implement additional fall prevention strategies.
* Provide fall prevention information (Tool 3J).

**Observations:*** Record vital signs and neurologic observations at least hourly for 4 hours and then review.
* Continue observations at least every 4 hours for 24 hours, then as required.
* Notify treating medical provider immediately if any change in observations.
 |

##### Important Communications

* In the medical record, document the incident, outcome, and initial and ongoing observations, and update fall risk assessment and care plan.
* Notify the treating medical provider at the time of the incident, and schedule an interdisciplinary review of the patient’s care.
* At handover, inform all clinical team members about the incident, any changes to the care plan, and possible investigation process.
* Notify family in accordance with your hospital’s policy.

##### Glasgow Coma Scale

The Glasgow Coma Scale provides a score in the range 3-15; patients with scores of 3-8 are usually said to be in a coma. The total score is the sum of the scores in three categories. For adults, the scores follow:

**Activity Score**

|  |
| --- |
| **Eye opening** |
| None | 1 = Even to supraorbital pressure  |
| To pain | 2 = Pain from sternum/limb/supraorbital pressure  |
| To speech | 3 = Nonspecific response, not necessarily to command  |
| Spontaneous | 4 = Eyes open, not necessarily aware  |
| **Motor response** |
| None | 1 = To any pain; limbs remain flaccid  |
| Extension | 2 = Shoulder adducted and shoulder and forearm rotated internally  |
| Flexor response | 3 = Withdrawal response or assumption of hemiplegic posture |
| Withdrawal | 4 = Arm withdraws to pain, shoulder abducts  |
| Localizes pain | 5 = Arm attempts to remove supraorbital/chest pressure  |
| Obeys commands | 6 = Follows simple commands  |
| **Verbal response**  |
| None | 1 = No verbalization of any type  |
| Incomprehensible | 2 = Moans/groans, no speech  |
| Inappropriate | 3 = Intelligible, no sustained sentences  |
| Confused | 4 = Converses but confused, disoriented  |
| Oriented | 5 = Converses and oriented  |

**TOTAL (3–15): \_\_\_\_\_\_\_**

**Reference**

Teasdale G, Jennett B. Assessment of coma and impaired consciousness. A practical scale. Lancet 1974;2(7872):81-4.

### 3O: Postfall Assessment for Root Cause Analysis

**Background:** A standardized approach to postfall evaluation is key to maintaining the patient’s safety and for organizational learning about how to prevent future falls.

**Reference:** This tool is adapted from a tool developed by Ronald I. Shorr, M.D., M.S. See Shorr RI, Mion LC, Chandler AM, et al. [Improving the capture of fall events in hospitals: combining a service for evaluating inpatient falls with an incident report system.](http://www.ncbi.nlm.nih.gov/pubmed/18205761) J Am Geriatr Soc 2008;56(4):701-4.) The Confusion Assessment Method within this tool is adapted from a tool by Sharon K. Inouye, M.D., M.P.H. (See Inouye SK, van Dyck CH, Alessi CA, et al. Clarifying confusion. Ann Intern Med 1990;113(12):941-8.)

**How to use this tool:** The information below can be customized for use within your hospital. Note that the tool was originally used as part of a dedicated fall evaluation service that was called to investigate each fall. For details, see the Shorr reference. This tool can be used by staff nurses and information systems staff.

The tool may be used for the purpose of root cause analysis to prevent future falls in this patient and in future patients. This assessment should be performed in conjunction with a medical provider’s or pharmacist’s assessment of medications contributing to fall risk (see [Tool 3I, “Medication Fall Risk Scale and Evaluation Tools”](#_3IH:_Medication_fFall)) and a medical provider’s assessment of laboratory test results, if appropriate. [The Orthostatic Vital Sign Measurement tool (Tool 3F)](#_3F:_Orthostatic_Vital) and the [Delirium Evaluation Bundle (Tool 3J)](#_3JL:_Delirium_eEvaluation) may be helpful in completing this tool. A separate tool ([Tool 3N, ‘Postfall Assessment, Clinical Review](#_3N:_Post-fall_aAssessment,)) covers how to assess and follow injury risk immediately after a patient has fallen.

##### Postfall Assessment

1. **PATIENT/WITNESS DESCRIPTION OF FALL:**

##### 1.1. Can you remember anything about your fall?

\_\_Yes \_\_No The patient can’t answer reliably

##### 1.2. Did anyone witness the fall?

\_\_Yes, by:

\_\_No or don’t know (if no good quality patient or witness description, go to part 2)

##### 1.3. Where did you fall?

\_\_Bathroom \_\_Hall \_\_Room \_\_Other, describe:

##### 1.4. What were you doing at the time of the fall?

\_\_Don’t remember

\_\_ “Rolled out of bed”

\_\_Trying to reach/pick-up something

\_\_Trying to get in/out of bed to go to toilet/commode

\_\_Trying to get in/out of bed for other reason

\_\_Trying to get in/out of chair

\_\_Trying to get on/off bedside commode/toilet

\_\_Trying to use sink, shower, chair, or toilet/commode

\_\_Trying to dress/undress

\_\_Other, describe:

##### 1.5. Why do you think you fell?

\_\_Don’t know, remember

\_\_I had a recent lower extremity amputation

\_\_Slipped, tripped

\_\_Got lightheaded, dizzy, or “blacked out”

\_\_Arms or legs got weak

\_\_Tried to sit, but missed

\_\_I lost my balance

\_\_“Got tangled up” with IV, tubing, clothes, etc.

\_\_Bed or chair not locked

\_\_Other, describe:

1. **BRIEF MENTAL AND PHYSICAL ASSESSMENT**

**2.1. Short Portable Mental Status Questionnaire**

| Question | Response | Error? |
| --- | --- | --- |
| What are the date, month, and year?\* | Date | Month | Year |  |
| What is the day of the week? |  |  |
| What is the name of this place? |  |  |
| What is your phone number? |  |  |
| How old are you? |  |  |
| When were you born? |  |  |
| Who is the current president? |  |  |
| Who was the president before him? |  |  |
| What was your mother’s maiden name? |  |  |
| Can you count backward from 20 by 3s? |  |  |

\* A mistake on ANY part of this question should be scored as an error.

Total Errors: \_\_\_\_\_\_\_

##### SCORING\*:

0-2 errors: normal mental functioning

3-4 errors: mild cognitive impairment

5-7 errors: moderate cognitive impairment

8 or more errors: severe cognitive impairment

\* One more error is allowed in the scoring if a patient has had a grade school education or less. One less error is allowed if the patient has had education beyond the high school level.

Section 2.1 adapted with permission from Pfeiffer E. A short portable mental status questionnaire for the assessment of organic brain deficit in elderly patients. J Am Geriatr. Soc 1975;23(10):433-41. © E. Pfeiffer, 1994.

##### 2.2. Confusion Assessment Method

|  |  |  |
| --- | --- | --- |
| In the 24 hours prior to the fall did this patient: | Yes | No |
| CAM 1a. Have an acute change of mental status from baseline? |  |  |
| CAM 1b. Exhibit behavioral fluctuations (come and go)? |  |  |
| CAM 2. Have difficulty focusing attention or appear easily distractible (for example, have difficulty keeping track of what was said)? |  |  |
| CAM 3. Exhibit disorganized or incoherent thinking such as irrelevant conversation, unclear or illogical flow of ideas, or unpredictable switching from subject to subject? |  |  |
| CAM 4. Are any of the following abnormal levels of consciousness observed (or reported) in the 24 hours prior to the fall?* Vigilant (hyperalert)
* Lethargic (drowsy, easily aroused)
* Stupor (difficult to arouse)
* Coma (unarousable)
 |  |  |
| If yes to CAM 1a and 1b and CAM 2 AND either CAM 3 or CAM 4, then delirium is likely to be present in this patient.  |

Section 2.2 adapted from Inouye SK, van Dyck CH, Alessi CA, et al. Clarifying confusion. Ann Intern Med 1990;113(12):941-8. Used with permission, Sharon K. Inouye, M.D., M.P.H. ©2000, Hospital Elder Life Program. All rights reserved.

##### 2.3. Severity of injury (check the most severe)

\_\_None (skip to question 2.5)

\_\_Minor (complaint of pain; requires ice, dressing, cleaning of wound, elevating of limb, or medication)

\_\_Moderate (requires suturing, steri-strips, or splinting)

\_\_Major (requires surgery, casting, traction, neurologic consultation for change in level of consciousness)

\_\_*Possible,* at time of this evaluation major injury is suspected but not yet confirmed by tests

\_\_*Definite,* at time of this evaluation major injury has been confirmed

\_\_Death

##### 2.4. Describe injuries; check all that apply

|  |  |  |  |
| --- | --- | --- | --- |
| Injury | Yes | No | Site of Injury |
| Abrasion/bruise/laceration/hematoma |  |  |  |
| Bleeding |  |  |  |
| Pain/difficulty moving extremity |  |  |  |
| Other:  |  |  |  |

##### 2.5. Orthostatic blood pressure

|  |  |
| --- | --- |
| Blood Pressure (mm Hg) | Heart Rate (beats per minute) |
| Systolic blood pressure (supine) |  | Heart rate (supine) | Can’t obtain Refused |
| Diastolic blood pressure (supine) |  |
| Systolic blood pressure (standing) | Need for orthostatic | Heart rate (standing) | Can’t obtain Refused |
| Diastolic blood pressure (standing) | Need for orthostatic |
| Systolic blood pressure (sitting)\* |  | Heart rate (sitting)\* | Can’t obtain Refused |
| Diastolic blood pressure (sitting)\* |  |

\* Sitting measurements are only necessary if standing cannot be obtained.

1. **NURSE INTERVIEW (NURSE ASSIGNED TO PATIENT)**

##### 3.1. How did you find out that this patient fell?

\_\_I saw the patient fall

\_\_Alarm went off

\_\_Patient/witness called

\_\_Heard noise**/**found patient on floor

##### 3.2. What was the patient doing at time of fall?

\_\_Don’t know

\_\_“Rolled out of bed”

\_\_Trying to get in/out of chair

\_\_Trying to get in/out of bed to go to the bathroom/commode

\_\_Trying to reach/pick up something

\_\_Trying to get in/out of bed for another reason

\_\_Trying to get on/off toilet/bedside commode (BSC)

\_\_Trying to use the bedside sink, shower, toilet/BSC chair

\_\_Trying to dress/undress

\_\_Other, describe:

##### 3.3. Why do you think the patient fell/lost their balance?

\_\_Don’t know

\_\_Catastrophic event (e.g., stroke, arrhythmia NOT orthostatic hypotension)

\_\_Arms or legs got weak

\_\_Got lightheaded, dizzy, or “blacked out”

\_\_Tried to sit, but missed

\_\_Secondary gain (e.g., seeking attention)

\_\_Related to recent amputation

\_\_“Got tangled up” in equipment

\_\_Low blood sugar

\_\_Slipped or tripped

\_\_Lost balance

\_\_Medications

\_\_Bed, chair not locked

\_\_Other, describe:

##### 3.4. Prior to the patient’s fall, what was his/her activity level (ask nurse this question)?

\_\_Up ad lib

\_\_Ambulate with assistance

\_\_Bedrest

\_\_Up in chair with assistance

\_\_Other, describe:

##### 3.5. Prior to fall, identify the ancillary walking aids patient had available in room (check all that apply):

\_\_None

\_\_Cane

\_\_Walker

\_\_Wheelchair

\_\_Leg prosthesis

\_\_Other

##### 3.6. Prior to fall, were fall prevention measures in place?

|  |  |  |
| --- | --- | --- |
|  | Yes | No |
| Falls precautions  |  |  |
| Fall alert identifier (door sticker) |  |  |
| Bed alarm: if yes, check those that apply:Alarm sounded properlyAlarm did not sound properlyAlarm was disconnected |  |  |
| Call light/bell in reach |  | no n/a |
| Other: |  |  |

##### 3.7. What CONNECTED IVs/tubes were present at the time of the fall?

|  |  |  |
| --- | --- | --- |
|  | Yes | No |
| IV (central line, peripheral) |  |  |
| Bladder catheter |  |  |
| Gastrostomy or other feeding tube |  |  |
| Pneumatic compression stockings |  |  |
| Other: |  |  |

1. **OTHER IMPORTANT INFORMATION NOT COVERED ON THIS FORM**

Please record orthostatic blood pressure readings in the patient’s chart and return this form to the designated place in the staffing office.

### 3P: Best Practices Checklist

**Background:** This tool can be used to monitor your progress on identifying best practices in fall prevention for your hospital or hospital units.

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

**How to use this tool:** Complete the checklist. This tool should be filled out by the Implementation Team leader (or individual designated by the leader).

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

##### Best Practices Checklist

|  |  |
| --- | --- |
| Practice | Date Completed |
| Identify a set of best practices |  |
| Create a clinical pathway |  |
| Identify key elements of a fall risk factor assessment |  |
| Choose a tool for assessing risk factors |  |
| Explore approaches to documenting and reporting results of fall risk factor assessment |  |
| Develop fall prevention care plan based on identified risk factors |  |
| Identify approaches to documenting and communicating care plan |  |
| Develop system linking changes in fall risk factors to changes in care plan |  |
| Ensure all levels of staff are aware of care plan |  |
| Develop system linking care planning to actual interventions |  |
| Choose or develop postfall assessment protocol |  |
| Customize the set of practices for specific work units |  |

### 4A: Assigning Responsibilities for Using Best Practices

**Background:** This tool can be used to determine who will be responsible for each task identified in your set of best practices for preventing falls. One way to generate interest and buy-in from the staff is to ask them to self-assign their responsibilities from a prioritized list of tasks that need to be accomplished.

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

**How to use this tool:** Complete the table by entering the different best practices and the specific individuals who will be responsible for completing each task. This tool should be filled out by the Implementation Team leader in collaboration with the other team members.

Use this tool to assign and clarify the roles and responsibilities of each staff member. Types of staff and the types of responsibilities they might take on are summarized in [Tool 4B, “Staff Roles](#_4B:_Staff_Roles).”

|  |  |
| --- | --- |
| **What practices will we use?** | **Who will be responsible?** |
| Example:Perform comprehensive fall risk assessment on admission, daily, or if condition deteriorates. | Example:RN  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |

### 4B: Staff Roles

**Background:** This table gives an example of how responsibilities may be assigned among different staff members on the Unit Team and hospital personnel whose work brings them to the unit or includes interactions with the unit.

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

**How to use this tool:** The unit manager can use this tool to help assign specific individuals or groups to each task in [Tool 4A, “Assigning Responsibilities for Using Best Practices.”](#_4A:_Assigning_Responsibilities)

| **Staff** | **Roles** |
| --- | --- |
| RN | * Conducts or supervises accurate assessment and documentation of assessment of fall risk factors on admission, daily, and if condition deteriorates (or according to facility policy).
* Documents care plan tied to identified risk:
* Mental status.
* Continence.
* Mobility level.
* Environmental risks (e.g., hooked up to IV).
* Performs or supervises performance of care plan procedures or treatments:
* Close observation of delirious patients.
* Toileting schedule.
* Use of assistive devices.
* Maintenance of clutter-free environment.
* Files incident report for new falls and carries out postfall assessment.
* Educates patient/family about fall risk factors.
 |
| LPN | * Conducts accurate assessment and documents assessment of fall risk factors on admission, daily, and if condition deteriorates (or according to facility policy).
* Documents care plan tied to identified risk:
* Mental status.
* Continence.
* Mobility level.
* Environmental risks (e.g., hooked up to IV).
* Performs or supervises performance of care plan procedures or treatments:
* Close observation of delirious patients.
* Toileting schedule.
* Use of assistive devices.
* Maintenance of clutter-free environment.
* Collaborates with other staff to ensure timely and accurate reporting of any falls and completion of postfall assessment.
 |
| CNA | * Reports any new fall risks to nurse.
* Keeps environment around bed clutter free.
* Offers assistance with toileting for patients with frequent toileting needs.
* Keeps assistive devices within easy reach of patient.
 |
| Treating medical provider (e.g., physician, nurse practitioner, physician assistant) | * Reviews needs for specific types of rehabilitation therapy and orders such therapy, if appropriate.
* Writes orders for activity level.
* Reviews medications for fall risk.
 |
| Physical and/or occupational therapist | * Assesses patient’s function and mobility levels according to scheduled protocol (e.g., after orthopedic procedures) or upon consultation.
* Determines need for assistive devices and exercise program according to scheduled protocol (e.g., in rehabilitation unit) or upon consultation.
* Educates patient and family on safety with transfers and ambulation.
 |
| Pharmacist | * Reviews medication lists of patients at high risk based on medication profile.
* Discusses medications that may increase fall risk with physician using standardized approach (e.g., note in chart, rounds with hospitalist).
 |
| Environmental services staff | * Responds to reports of fall hazards (e.g., spills).
* Keeps rooms and hallways free of clutter.
 |
| Dietitian | * Monitors patient’s weight and nutritional status to avoid unintentional weight loss and loss of muscle mass.
* Provides tube feed regimens that maximize mobility (e.g., choosing bolus rather than continuous tube feeding where appropriate).
 |
| Patient educator | * Works with nurse to provide appropriate educational materials and teaching to patients at risk for falls and their families.
 |
| Facilities engineer | * Participates in regularly scheduled environmental rounds to identify equipment in need of repair.
* Responds to repair requests submitted by unit staff.
 |
| Information technology support personnel | For units with electronic health records:* Develops or refines documentation systems for fall risk assessment and care planning.
* Develops or refines computerized order sets (e.g., mobility protocol).
* Implements computerized alerts for medications that present high risk for falls, where appropriate.
 |

### 4C: Assessing Staff Education and Training

**Background:** The purpose of this tool is to assess current staff education practices and to facilitate the integration of new knowledge on fall prevention into existing or new practices.

**Reference:** Adapted from Facility Assessment Checklist developed by Quality Partners of Rhode Island. Available at: [www.healthinsight.org/Internal/assets/Nursing%20Home/PRU%20-%20Facility%20Assessment%20Checklist.pdf](http://www.healthinsight.org/Internal/assets/Nursing%20Home/PRU%20-%20Facility%20Assessment%20Checklist.pdf).

**How to use this tool:** Complete the form by checking the response that best describes your hospital. This tool should be filled out by the Implementation Team leader or designee in collaboration with the other team members.

This tool can be used to identify areas for improvement and develop educational programs where they are missing.

##### Facility Assessment

Date:

A. Does your hospital have initial and ongoing education on fall prevention and management for both nursing and nonnursing staff?

**\_\_ No**. If no, this is an area for improvement.

\_\_ This is an area we are working on.

\_\_ **Yes**.

B. Does your facility’s education program for fall prevention and management include the following components?

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **Yes** | **No** | **Person Responsible** | **Comments** |
| Are new staff assessed for their need for education on fall prevention and management? |  |  |  |  |
| Are current staff provided with ongoing education on the principles of fall prevention and management? |  |  |  |  |
| Does education of staff provide discipline-specific education for fall prevention and management? |  |  |  |  |
| Is there a designated clinical expert available at the facility to answer questions from all staff about fall prevention and management? |  |  |  |  |
| Is the education provided at the appropriate level for the learner (e.g., CNA vs. RN?) |  |  |  |  |
| Does the education provided address risk factor assessment tools and procedures? |  |  |  |  |
| Does the education include staff training on documentation methods related to falls (e.g., circumstances of fall if applicable, risk factors for falls, how those risk factors have been addressed)? |  |  |  |  |

C. In which areas of knowledge does the assessment suggest staff need more education?

### 4D: Implementing Best Practices Checklist

**Background:** This tool can be used to monitor your progress on implementing best practices.

**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.

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

##### Implementing best practices checklist

|  |  |
| --- | --- |
| Task | Date Completed |
| Roles and Responsibilities of Staff |
| Assign specific roles and responsibilities to: |
| Members of the Unit Team |  |
| Unit Champion |  |
| Organizing the Prevention Work |
| Identify paths of ongoing communication and reporting |  |
| Develop mechanisms to address accountability |  |
| Identify strategies for building new practices into daily routine |  |
| Refine preliminary implementation plan |  |
| Ensure support from key stakeholders |  |
| Initiate plan to pilot test new practices |  |
| Establish strategy for engaging staff |  |
| Create education plans to help staff learn new practices |  |

###

### 5A: Information To Include in Incident Reports

**Background:** The purpose of this tool is to audit incident reports of falls to see if the reports provide adequate information for root cause analysis. Alternatively, the information below may be used in conjunction with [Tool 3O, “Postfall Assessment for Root Cause Analysis”](#_3O:_Post-fall_aAssessment) to develop a template to be filled out when reporting a fall.

**Reference:** Adapted from National Health Service publication Slips, Trips, and Falls in the Hospital, available at [www.nrls.npsa.nhs.uk/resources/?EntryId45=59821](http://www.nrls.npsa.nhs.uk/resources/?EntryId45=59821).

**How to use this tool:** Review your last 10 incident reports for falls and see whether the information below is captured in the report. This tool should be used by the quality improvement manager. Information systems staff may also use this tool to develop or update electronic templates for submitting incident reports.

Use this tool to identify areas for improvement and develop educational programs where there are gaps.

##### Information To Include in Incident Reports

| **Examples of Information** | **Reason To Collect This Information** |
| --- | --- |
| Reporting factors | Witnessed/not witnessed | Make a clear distinction between what was seen or heard and the patient’s account of what happened. |
| Outcome of investigations recorded | When patients are reported as having x rays or other investigations after a fall, the results of the x ray or other investigation should be included in the report. |
| Type of injury | Be specific, e.g., “fractured tibia,” not “broken leg.” |
| Environmental factors | Buzzer/bell available within reach before fall | Highlight whether there is an issue about accessing call bells. |
| If a fall from bed, whether bedrails were in use | Help assess how bedrail use is affecting falls or injury. |
| Floor wet/dry/talcum powder | Reflect on cleaning regimen and need for nonslip surfaces. |
| Footwear | If problems with missing or unsuitable footwear are highlighted, organizations could develop systems for providing alternatives. |
| Walking aid in use/in reach | It may highlight bedside storage issues or access to walking aids for patients admitted in the evenings or on the weekend. |
| Patient factors | Mental state | Identify those patients most vulnerable to falls because of sedation, dementia, or delirium. |
| First fall this admission or repeat fall | Balance resources between preventing initial falls and secondary prevention. |
| Days since admission | Ensure timescales for assessing and preventing falls are tailored to when falls are most likely to occur. |
| Medication affecting risk of falls | Sedative and psychotropic medication, or medication with drowsiness as a side effect, may contribute to falls. |

### 5B: Assessing Fall Prevention Care Processes

| **Background:** This sample protocol illustrates how to evaluate whether fall prevention care processes are occurring as they should be. **Reference:** Adapted with permission from: Royal College of Physicians *Implementing FallSafe: Care bundles to reduce patient falls.* London, UK: Royal College of Physicians; 2012. Available at: [www.rcplondon.ac.uk/resources/falls-prevention-resources](http://www.rcplondon.ac.uk/resources/falls-prevention-resources).**How to use this tool:** Use this form to observe the patient at bedside and check the notes of 20 patients on your unit every month (ideally the same date each month). To select patients:If you are a small unit, collect it from the first 20 patients who come first in handoffs.If your unit has two teams, take the first 10 patients from each team.And so on if you have three teams, etc.The assessment requires different types of information. Depending on your hospital’s record system and workflow, the information may be found in multiple locations. Make sure the people completing the form know where to find the information, which may require modifying the form to include explicit directions or cues. Observations at the bedside should occur at the time of day when most patients who are well enough would be out of bed. If your hospital uses hourly rounding logs, these can also be checked for completeness during the observations. For the chart review, check the medication administration record (MAR) and any notes easily accessible on the unit, including nursing notes, medical notes, physical therapy notes, and occupational therapy notes. The bedside observations and the chart review can be completed separately but should be done on the same day. This form should be completed by the unit manager or unit champions. This tool should be used to determine whether your hospital unit is carrying out its fall prevention care processes according to plan. It can be modified according to the needs of your specific hospital or unit by adding/deleting rows to customize the processes you want to monitor. Your hospital or unit might use this as an initial screen for assessing progress and then use the results to identify specific components for additional evaluation. |
| --- |

|  |  |  |
| --- | --- | --- |
| Example | Sample of 20 patients (or all patients if ward has fewer than 20 patients) | **Totals** (yes out of total plus N/A) |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 |
| Use to track patient names/initials/bed number/room number if you need to | FH | AB | ST | YH | LT | YT | TY | UP | KL | MJ | NM | HK | LT | FR | GT | HY | DE | ES | FR | TT |
| All 20 patients: | If small ward with fewer than 20 patients, write total here:  |  |
| Observe: call bell in sight & reach? | Y | N | n/a | Y | Y | Y | Y | Y | n/a | Y | Y | Y | Y | N | Y | Y | n/a | N | Y | Y | 14/17 + 3 n/a |
| Observe: safe footwear on feet? | Y | Y | Y | Y | Y | Y | Y | Y | N | Y | Y | Y | Y | N | Y | Y | n/a | n/a | N | N | 14/18 +2 n/a |
| Observe: room free of clutter? | Y | Y | Y | Y | N | Y | Y | Y | Y | Y | Y | N | Y | Y | N | N | Y | Y | Y | Y | 16/20 |
|  |
| Medication administration record: given night sedation last night? | N | N | N | N | N | N | N | N | N | N | Y | N | N | N | N | N | N | N | Y | N | 2/20 |
| Chart: asked about history of falls? | Y | Y | Y | Y | Y | Y | Y | N | N | Y | Y | Y | Y | Y | Y | Y | Y | Y | Y | Y | 18/20 |
| For any of the 20 pts age 70+: | Number of patients AGE 70+: | 13 |
| Chart: cognitive screen? | Y | N | - | - | - | - | - | Y | n/a | Y | Y | Y | Y | N | Y | - | - | N | Y | Y | 9/12 + 1 n/a |
| For any of the 20 patients who are “higher risk”\*: | Number of higher risk patients:  | 8 |
| Chart: full medication review requested? | Y | Y | - | - | - | - | - | - | - | Y | Y | N | Y | Y | - | - | - | - | Y | - | 7/8 |

**\*** In some wards all patients are counted as high risk, for other wards only some. Follow your local policy.

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\*\*\* Sample of 20 patients (or all patients if ward has fewer than 20 patients). Remember “*not documented=not done*” \*\*\*

|  |  |  |
| --- | --- | --- |
| Filled out by: | WARD: | **TOTALS** (YES out of total plus N/A) |
| DATE: | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 |
| Use to track patient names/initials/bed number/room number if you need to |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| All 20 patients: | If small ward with fewer than 20 patients, write total here: |  |
| Observe: call bell in sight & reach? |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Observe: safe footwear on feet? |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Observe: room free of clutter? |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Medication administration record: given night sedation last night? |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Chart: asked about history of falls? |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| For any of the 20 pts age 70+: | Number of patients AGE 70+: |  |
| Chart: cognitive screen? |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| For any of the 20 patients who are “higher risk”\*: | Number of higher risk patients: |  |
| Chart: full medication review requested? |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |

**\*** In some wards all patients are counted as high risk, for other wards only some. Follow your local policy.

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### 5C: Measuring Progress Checklist

**Background:** This tool can be used to monitor progress on your fall prevention efforts.

**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.

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

##### Measuring Progress

|  |
| --- |
| Measuring fall rates |
| Staff know definition of fall and definition of injurious fall |  |
| Management culture rewards full reporting of falls |  |
| Fall rates (e.g., falls per 1,000 occupied bed days) are calculated |  |
| Fall rates are monitored at least quarterly, preferably monthly |  |
| Information on rates is disseminated to key stakeholders and staff |  |
| Root cause analysis is conducted for each fall with at least moderate level of injury |  |
| Measuring key processes of care |
| Fall risk factor assessment is performed within 24 hours of admission |  |
| Care plan addressing every deficit on fall risk factor assessment has been developed and is being implemented |  |

### 6A: Sustainability Tool

**Background:** This tool can be used to identify sustainability issues in planning and implementing your fall prevention efforts.

**Reference:** Adapted with permission from: Edwards JC, Feldman PH, Sangl J, et al.Sustainability of partnership projects: a conceptual framework and checklist. Jt Comm J Qual Patient Saf 2007;33(12 Suppl):37-47.

**How to use this tool:** The Implementation Team leader (or individual designated by the leader) should complete this checklist.

Use this tool to ensure you have appropriate resources and strategies in place to sustain fall prevention efforts.

| Elements of Sustainability | Notes  |
| --- | --- |
| Identity (Goals) |  |
| Is guiding vision clearly specified? |  |
| Is change goal focused (not too encompassing) and actionable? |  |
| Is “sustainability goal” clarified (i.e., what will be sustained?) and at what level is this goal?* Specific process or outcome
* General capacity to improve on more than one outcome or process
* Partnership itself
 |  |
| *Problem solving:* If vision and goals are not clearly specified, focused, and actionable, what strategies will be adopted to address this issue? |  |
| Infrastructure |  |
| Human resources |  |
| * Are the internal/external human resources in place to sustain the effort going forward (describe—e.g., team, senior leadership, champion, opinion leader)?
 |  |
| * Are external supports in place to sustain the effort going forward (describe—e.g., mentors, advisory group, professional associations, community advocates)?
 |  |
| Technical resources |  |
| * Are materials developed and accessible if sought?
 |  |
| * Are there listservs, meetings, and other mechanisms to promote ongoing communication?
 |  |
| * Are training and technical support available to develop and maintain necessary skills?
 |  |
| * Are information systems in place to support the effort going forward?
 |  |
| Financial resources |  |
| * Is funding adequate for the time period required to achieve the change goal?
 |  |
| * Is funding source stable for the time period needed to accomplish guiding vision?
 |  |
| *Problem solving:* If key elements are lacking, has a strategy been developed to address this issue? |  |
| Incentives |  |
| Is project perceived to add “value” within the organization (i.e., people can see something in it for them)? |  |
| Can value be measured quantitatively (i.e., decrease in injurious fall rate or maintenance of low injurious fall rate)? |  |
| Are other intangible values/incentives perceived (e.g., improved reputation, pride, sense of accomplishment)? Describe. |  |
| Is the project perceived as having disincentives? Describe. |  |
| *Problem solving:* If positive incentives are inadequate or disincentives are identified, have strategies been proposed to address this issue? |  |
| Incremental Opportunities for Participation |  |
| Can the project goals be best achieved with varied levels and types of participation?If **yes**, then continue to next two questions. |  |
| Are there opportunities for varied geographic participation (e.g., among units within a hospital; among hospitals within a consortium; participation in regional vs. national initiative)? |  |
| * If yes, what types of varied geographic participation opportunities are available?
 |  |
| * Is the geographic scale workable?
 |  |
| Are varied roles for participation in the project provided? If **yes**, what varied roles for participation are provided? |  |
| * Observer role
 |  |
| * Technical assistance role
 |  |
| * Data collection role (e.g., review charts or incident reports)
 |  |
| * Advisor or consultant role
 |  |
| * Implementer role
 |  |
| * Changing role throughout the project
 |  |
| * Can pick and choose among offered activities
 |  |
| * Can opt out and then opt back in later
 |  |
| * Other
 |  |
| *Problem solving:* If goals can be achieved with varied levels and types of participation but no provision has been made for participation in different ways, what strategies can be used to address this issue? |  |
| Integration |  |
| Are change goals aligned with strategic goals of participating entities (macro level)? |  |
| Are change goals integrated with other performance measures and reward systems of participating entities (macro level)? |  |
| Are change goals integrated with existing programs, policies/procedures, and information systems of participating entities (micro level)? |  |
| *Problem solving:* If change goals are not aligned and integrated with the strategic goals, performance measures, reward systems, programs, policies/ procedures, and information systems of participating entities, what strategies can be used to address this issue? |  |

## Appendix: Bibliography of Studies Implementing Fall Prevention Practices

The recommendations presented in this toolkit are based on a review of the evidence in the scientific literature, consensus recommendations, and expert input. To provide additional guidance for your fall prevention program, we have included references to programs that implemented many of the strategies presented in the toolkit within U.S. acute care hospitals.

For a full evidence review of the literature, see Hempel S, Newberry S, Wang Z, et. al. Review of the evidence on falls prevention in hospitals. RAND Working Paper WR-907-AHRQ. Santa Monica, CA: RAND Corporation; 2012. Available at: [www.rand.org/pubs/working\_papers/WR907.html](http://www.rand.org/pubs/working_papers/WR907.html).

| **Toolkit Section** | **Studies Implementing Fall Prevention Practices** |
| --- | --- |
| 1. Are you ready for this change? | * Nine programs implemented strategies to gain leadership support.[1-9](#_ENREF_1)
* One program addressed culture change.[9](#_ENREF_9)
* One program incorporated fall prevention into the organizational strategic plan.[7](#_ENREF_7)
 |
| 2.1. How can you set up the implementation team for success? | * Sixteen programs formed interdisciplinary teams.[5](#_ENREF_5),[7-21](#_ENREF_7) Two additional programs formed other implementation teams.[3](#_ENREF_3),[22](#_ENREF_22)
* One program addressed other strategies to help set up the Implementation Team for success.[18](#_ENREF_18)
 |
| 2.2. What needs to change and how do you need to redesign it? | * Seven programs followed systematic approaches to analysis and implementation such as a Continuous Quality Improvement model,[5](#_ENREF_5),[9](#_ENREF_9) Plan-Do-Program-Act,[18](#_ENREF_18),[23](#_ENREF_23) Plan-Do-Check-Act,[13](#_ENREF_13),[19](#_ENREF_19) or Rapid Improvement Event.[24](#_ENREF_24)
* One program assessed current staff knowledge of fall prevention.[25](#_ENREF_25)
 |
| 2.3. How should goals and plans for change be developed? | * One program developed an implementation plan.[13](#_ENREF_13)
 |
| 3.2. What are universal fall precautions and how should they be implemented? | * Ten programs implemented scheduled rounding to address patient needs.[7](#_ENREF_7),[10](#_ENREF_10),[25](#_ENREF_25)[-32](#_ENREF_28)
* Nine programs conducted regular environmental safety inspections or other strategies to make the environment safer.[7](#_ENREF_7),[10](#_ENREF_10),[21](#_ENREF_21),28,[33](#_ENREF_31)[-37](#_ENREF_35)
* Fourteen programs implemented other universal fall precaution strategies.[6](#_ENREF_6),[10](#_ENREF_10),[12](#_ENREF_12),[13](#_ENREF_13),[19](#_ENREF_19),[22](#_ENREF_22),[24](#_ENREF_24),[27](#_ENREF_30),[35](#_ENREF_37),[36](#_ENREF_38),38[-41](#_ENREF_40)
 |
| 3.3. What is a standardized assessment of risk factors for falls, and how should this assessment be conducted? | * Based on the evidence review, the Morse Falls Scale and STRATIFY are the most thoroughly studied fall risk assessment tools. Both scales have established reliability and validity, but research has shown that the scores from these tools may not predict falls any better than a clinician’s judgment.
* Fall risk assessments were implemented in 38 programs.[1](#_ENREF_1),[3](#_ENREF_3),[6-9](#_ENREF_6),[11-22](#_ENREF_11),[24](#_ENREF_24)[28,30](#_ENREF_28),[32](#_ENREF_33),[33](#_ENREF_35),[35-46](#_ENREF_37) Five programs used the Morse Fall Scale.[13](#_ENREF_13),[26](#_ENREF_29),28,[42](#_ENREF_44),[45](#_ENREF_47) One program used a medication fall risk assessment.[28](#_ENREF_31)
 |
| 3.4. How should identified risk factors be used for fall prevention care planning? | * Thirty-five programs implemented structured care plans for fall prevention.[1-3](#_ENREF_1),[5-15](#_ENREF_5),[20-22](#_ENREF_20),[25](#_ENREF_25),[27](#_ENREF_28),[30](#_ENREF_30),[32](#_ENREF_33),[33](#_ENREF_35),[35-42](#_ENREF_37),[46-50](#_ENREF_48)
* Five programs addressed medication review,[4](#_ENREF_4),[16](#_ENREF_16),[18](#_ENREF_18),26,[46](#_ENREF_48) four programs included physical therapy review or mobility,[4](#_ENREF_4),[10](#_ENREF_10),[16](#_ENREF_16),51 and two programs implemented strategies to address patients with altered mental status or delirium prevention.[4](#_ENREF_4),[10](#_ENREF_10)
* One program used specially configured rooms equipped with safety equipment.[34](#_ENREF_36)
* Twenty-four programs addressed patient and family education through handouts or posters in patient rooms.[6](#_ENREF_6),[7](#_ENREF_7),[9](#_ENREF_9),[12](#_ENREF_12),[14-20](#_ENREF_14),[22](#_ENREF_22),[24](#_ENREF_24),[25](#_ENREF_25),[27](#_ENREF_28),28,[31](#_ENREF_31),[32](#_ENREF_34),[35](#_ENREF_37),[37-40](#_ENREF_39),[42](#_ENREF_44)
* Programs also discussed strategies for documentation and communication of care planning. Nineteen programs addressed fall risk documentation and communication.[1](#_ENREF_1),[7](#_ENREF_7),[10](#_ENREF_10),[11](#_ENREF_11),[13-15](#_ENREF_13),[17-19](#_ENREF_17),[22](#_ENREF_22),[24](#_ENREF_24),[25](#_ENREF_25),[35](#_ENREF_37),38,39,[46-48](#_ENREF_48)
* Eight programs had care plans disseminated at change of shift reports.[3](#_ENREF_3),[11](#_ENREF_10),[19-21](#_ENREF_19),32,47 Twenty-six programs used other strategies to communicate the care plan.[1](#_ENREF_1),[5-8](#_ENREF_5),[10-12](#_ENREF_10),[14](#_ENREF_14),[15](#_ENREF_15),[17](#_ENREF_17),[20-23](#_ENREF_20),[25](#_ENREF_25),[27](#_ENREF_28),[30](#_ENREF_30),[32](#_ENREF_33),[33](#_ENREF_35),39[-42](#_ENREF_41),[47](#_ENREF_49),48
* One program implemented postfall safety huddles to improve communication between staff, patients, and families.[32](#_ENREF_28)
 |
| 3.5. How should you assess and manage patients after a fall? | * Thirteen programs conducted postfall reviews.[2](#_ENREF_2),[9](#_ENREF_9),[11](#_ENREF_11),[18-22](#_ENREF_18),[24](#_ENREF_24),[27](#_ENREF_28),[32](#_ENREF_30),[33](#_ENREF_35),[52](#_ENREF_53)
 |
| 4.1. What roles and responsibilities will staff have in preventing falls?  | * Three programs implemented strategies to optimize roles and responsibilities to provide the best care possible.[3](#_ENREF_3),[23](#_ENREF_23),[53](#_ENREF_53)
* Two programs used Unit Champions during the implementation process.[11](#_ENREF_11),[18](#_ENREF_18)
* One program discussed enhancing communication and responding to patients’ needs in a timely fashion.[53](#_ENREF_54)
* Six programs implemented strategies to integrate fall prevention into ongoing work processes.[10](#_ENREF_10),11,[13](#_ENREF_13),[36](#_ENREF_38),[48](#_ENREF_49),[54](#_ENREF_55)
* Six programs built documentation of fall risk and/or care planning into their electronic documentation systems.[10](#_ENREF_10),[18](#_ENREF_18),3[2](#_ENREF_28),[35](#_ENREF_37),[48](#_ENREF_49),[54](#_ENREF_55) Three additional programs implemented strategies to streamline documentation.[3](#_ENREF_3),[13](#_ENREF_13),[36](#_ENREF_38)
 |
| 4.3. How do you put the new practices into operation? | * Seven programs implemented strategies to promote unit-level buy-in.[7](#_ENREF_7),[11](#_ENREF_11),[13](#_ENREF_13),[18](#_ENREF_18),[22](#_ENREF_22),3[2](#_ENREF_28),[42](#_ENREF_44)
* Six programs implemented strategies for ongoing monitoring of implementation progress or assessed barriers to implementation.[7](#_ENREF_7),[13-15](#_ENREF_13),[26](#_ENREF_29),27
* Thirteen programs piloted the program, tested new strategies in select areas of the hospital, or phased in interventions.[6-8](#_ENREF_6),[12](#_ENREF_12),[15](#_ENREF_15),[17-19](#_ENREF_17),[22](#_ENREF_22),[24](#_ENREF_24),3[2](#_ENREF_28),[35](#_ENREF_37),[45](#_ENREF_47)
* One program used the development of a policy and procedures to facilitate implementation.[46](#_ENREF_48)
* Two programs implemented strategies to get staff engaged and excited about fall prevention.[11](#_ENREF_11),39
* Forty-one programs used staff education or other strategies to help staff learn new practices.[1-7](#_ENREF_1),[9-15](#_ENREF_9),[18-25](#_ENREF_18),[27](#_ENREF_27)[-32](#_ENREF_30),[35](#_ENREF_37),[37](#_ENREF_39),38,[40](#_ENREF_42),[41](#_ENREF_43),[43](#_ENREF_45),[45-49,52](#_ENREF_47),[55](#_ENREF_53)
 |
| 5.1. How do you measure fall rates? | * Thirteen programs monitored and disseminated data on falls.[2](#_ENREF_2),[5](#_ENREF_5),[7-9](#_ENREF_7),[13](#_ENREF_13),[19](#_ENREF_19),[20](#_ENREF_20),[25](#_ENREF_25),28,39,[41](#_ENREF_43),47
* One program documented falls in incident reports.[41](#_ENREF_43)
* Five programs conducted root cause analysis of falls to help identify ways to improve care.[2](#_ENREF_2),[9](#_ENREF_9),[11](#_ENREF_11),[12](#_ENREF_12),[24](#_ENREF_24)
 |
| 5.2. How do you measure fall prevention practices? | * Eighteen programs measured and monitored adherence to key processes of care.[1](#_ENREF_1),[2](#_ENREF_2),[9](#_ENREF_9),[13](#_ENREF_13),[15](#_ENREF_15),[18](#_ENREF_18),[24,25,28](#_ENREF_24),29,[31](#_ENREF_32),[38](#_ENREF_34),39,[41](#_ENREF_41),[42](#_ENREF_43),[45](#_ENREF_44),[47](#_ENREF_47),[51](#_ENREF_50)
* One program assessed care planning to ensure that it addressed each deficit on the fall risk factor assessment.[27](#_ENREF_30)
* One program conducted medical record audits to determine compliance with recommended interventions and postfall documentation.[24](#_ENREF_24)
 |
| 6. How do you sustain an effective fall prevention program? | * One program evaluated policy twice yearly to see if modifications were needed.[46](#_ENREF_48)
* Seven programs implemented ongoing awareness efforts and project updates to keep staff engaged.[8](#_ENREF_8),[9](#_ENREF_9),[14](#_ENREF_14),[25](#_ENREF_25),[30](#_ENREF_33),[37](#_ENREF_39),[41](#_ENREF_43)
* Five programs incorporated fall prevention training into staff orientation.[4](#_ENREF_4),[7](#_ENREF_7),[25](#_ENREF_25),[35](#_ENREF_37),39
 |

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