

PREVENTING HARM FROM INJURIES FROM FALLS AND IMMOBILITY



FALLS WITH INJURY *CHANGE PACKAGE*



ACKNOWLEDGEMENTS

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How to Use this Change Package

This change package is intended for hospitals participating in the Hospital Improvement Innovation Network (HIIN) project led by the Centers for Medicare & Medicaid Services (CMS) and Partnership for Patients (PFP); it is meant to be a tool to help you make patient care safer and improve care transitions. This change package is a summary of themes from the successful practices of high performing health organizations across the country. It was developed through clinical practice sharing, organization site visits and subject matter expert contributions. This change package includes a menu of strategies, change concepts and specific actionable items that any hospital can implement based on need or for purposes of improving patient quality of life and care. This change package is intended to be complementary to literature reviews and other evidence-based tools and resources.

PART 1: ADVERSE EVENT AREA (AEA) DEFINITION AND SCOPE

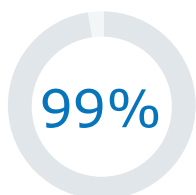
Patient falls – an unplanned descent to the floor with or without injury to the patient – affect between 700,000 and 1,000,000 patients each year¹ and rank among the most frequently reported incidents in hospitals and other health care facilities. Though many inpatient falls cause little or no harm, falls do sometimes lead to severe injuries such as hip fractures and head trauma and are a significant cause of hospital-acquired injury. In acute care and rehabilitation hospitals, anywhere from 3-20 percent of patients fall at least once during their hospitalization. Between 30 and 51 percent of those falls in hospitals result in some injury and 6-44 percent of those injuries are ones that may lead to death (e.g., fracture, subdural hematoma, excessive bleeding).² Additionally, among older adults, age 65 or greater, falls are the leading cause of injury-related death, the most common cause of non-fatal injuries and the leading cause of hospital admissions for trauma.³ Fall risk and the associated injury and cost are challenges both in health care facilities and in the community.

Magnitude of the Problem

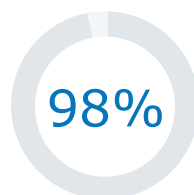
Falls that occur in hospitalized patients are a widespread and serious threat to patient safety. Falls are associated with increased length of stay, increased utilization of health care resources, poorer health outcomes and increased costs. Soft tissue injuries or minor fractures that result from falls can cause significant functional impairment, pain and distress. Additionally, even “minor” falls can trigger a fear of falling in older persons, resulting in limited activity and loss of strength and independence.⁴ One fall without serious injury costs *hospitals* an additional \$3,500 while *patients* with more than two falls without serious injury have increased costs of \$16,500. Falls with serious injury cost hospitals an additional \$27,000.⁵

> HEN 1.0 Progress

- From 2011 – 2014, the AHA/HRET Hospital Engagement Network (HEN) reduced falls with or without injury by 27 percent. This equates to 1,331 harms prevented and a cost savings of \$882,453.



of Eligible
Acute/CAH/
Children's Hospital
Reporting Data



"Chance The Information
Will Improve My
Effectiveness/Results"

of "Excellent" or
"good" Responses to
Falls Education Events

WHAT DOES THAT MEAN?



1,331

FALLS PREVENTED

\$882,453

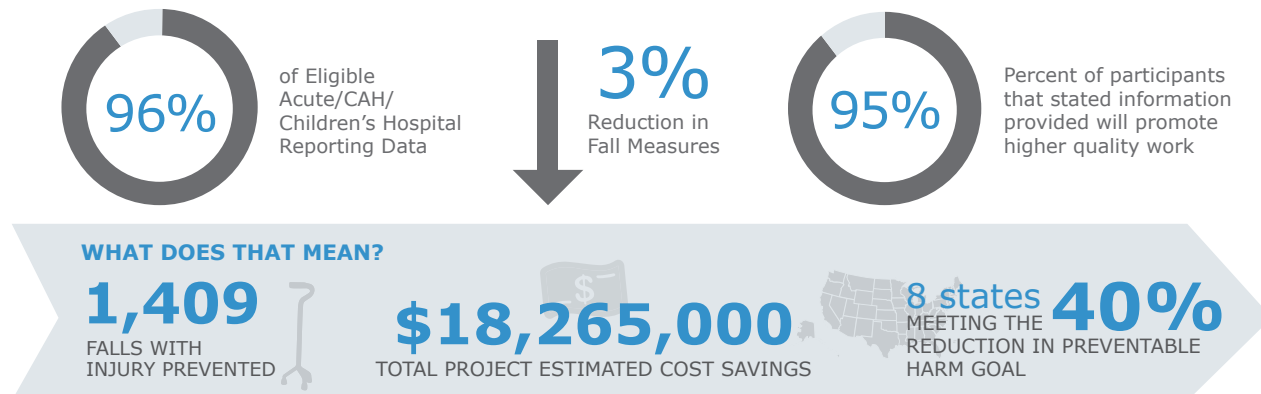
TOTAL PROJECT ESTIMATED COST SAVING



9 states
MEETING THE
REDUCTION GOAL

> HEN 2.0 Reduction Progress

- From 2015 – 2016, the AHA/HRET HEN 2.0 reduced falls with injury by three percent. This equates to 1,409 harms prevented and a cost savings of \$18,265,000



> HIIN Reduction Goals:

- Reduce the incidence of harm due to falls by 20 percent by September 27, 2018.

PART 2: MEASUREMENT

A key component to making patient care safer in your hospital is to track your progress toward improvement. This section outlines the nationally-recognized process and outcome measures that you will be collecting and submitting data on for the HRET HIIN. Collecting these monthly data points at your hospital will guide your quality improvement efforts as part of the Plan-Do-Study-Act (PDSA) process. Tracking your data in this manner will provide you with the valuable information you need to study your data across time, and determine the effect your improvement strategies are having in your hospital at reducing patient harm. Furthermore, collecting these standardized metrics will allow the HRET HIIN to aggregate, analyze and report its progress toward reaching the project's goals across all AEs.

Nationally Recognized Measures: Process and Outcome

> HIIN Process Measures

- Percentage of patients 65 years of age and older with balance or walking problems, or with a fall in the past 12 months, who were seen by a practitioner in the past 12 months who report discussing falls or problems with balance or walking with the practitioner AND report receiving a fall risk intervention from the practitioner.
- Percentage of patients 65 years of age and older who were screened at least once within 12 months, or with a history of fall who had a plan of care for falls documented and a risk assessment for falls documented within 12 months

PART 3: APPROACHING YOUR AEA

> Suggested Bundles and Toolkits for Inpatients

- AHRQ Preventing Falls in Hospitals: A Toolkit for Improving Care. Retrieved at: <https://www.ahrq.gov/professionals/systems/hospital/fallpxtoolkit/index.html>
- Department of Veteran Affairs Falls Prevention Toolkit. Retrieved at: <http://www.patientsafety.va.gov/professionals/onthejob/falls.asp>
- Hospital Elder Life Program (HELP). Delirium assessment, prevention and management tools for clinicians and patients. Retrieved at: <http://www.hospitalelderlifeprogram.org/>
- Transforming Care at the Bedside How-to Guide: Reducing Patient Injuries from Falls. Retrieved at: <http://www.ihl.org/resources/Pages/Tools/TCABHowToGuideReducingPatientInjuriesfromFalls.aspx>
- The American Geriatrics Society 2013 Clinical Practice Guidelines: Prevention of Falls in Older Adults Summary of Recommendation. Retrieved at: http://www.americangeriatrics.org/health_care_professionals/clinical_practice/clinical_guidelines_recommendations/prevention_of_falls_summary_of_recommendations
- Institute for Clinical Systems Improvement (ICSI) Prevention of Falls (Acute Care) Protocol, April 2012. Retrieved at: https://www.icsi.org/_asset/dcn15z/Falls.pdf
- Falls in older people: assessing risk and prevention. National Institute for Health and Care Excellence (NICE) (2013) UK. Retrieved at: <https://www.nice.org.uk/guidance/cg161>
- CAPTURE Falls Toolkit. Interdisciplinary teamwork tools, post fall huddles, medication and mobility assessment tools. <http://www.unmc.edu/patient-safety/capturefalls/index.html>
- VA National Center for Patient Safety Falls Toolkit. Retrieved at: <http://www.patientsafety.va.gov/professionals/onthejob/falls.asp>
- For key tools and resources related to preventing and reducing falls, visit www.hret-hiin.org

Investigate Your Problem and Implement Best Practices

DRIVER DIAGRAMS: A driver diagram visually demonstrates the causal relationship between change ideas, secondary drivers, primary drivers and your overall aim. A description of each of these components is outlined in the table below. This change package is organized by reviewing the components of the driver diagram to (1) help you and your care team identify potential change ideas to implement at your facility and (2) to show how this quality improvement tool can be used by your team to tackle new process problems.

AIM	PRIMARY DRIVER	SECONDARY DRIVER	Change Idea
	PRIMARY DRIVER	SECONDARY DRIVER	Change Idea
	PRIMARY DRIVER	SECONDARY DRIVER	Change Idea

AIM: A clearly articulated goal or objective describing the desired outcome. It should be specific, measurable and time-bound.

PRIMARY DRIVER: System components or factors that contribute directly to achieving the aim.

SECONDARY DRIVER: Action, interventions or lower-level components necessary to achieve the primary driver.

CHANGE IDEAS: Specific change ideas which will support or achieve the secondary driver.

Drivers in This Change Package

Each organization and each unit has unique variables that are associated with falls and each area could have a different driver diagram. In a study published in the Journal of Nursing Care Quality in 2014, seven hospitals analyzed falls data to determine the organization’s leading contributing factors to falls and used the information to identify targeted solutions, resulting in a 62 percent reduction in fall injury rates over an 18 month period.⁶ This study demonstrates the benefits of understanding why patients are falling before an intervention, toolkit or change idea is selected for testing or implementation.

Drivers in This Change Package

PREVENT HARM FROM FALLS	INTERDISCIPLINARY HOUSE-WIDE APPROACH	INTERDISCIPLINARY TEAM	Change Idea
		SAFE ENVIRONMENT	Change Idea
		TEAM APPROACH	Change Idea
	LEARNING LOOP	BIG DATA	Change Idea
		POST FALL HUDDLES AGENTS THAT MAY BE CAUSING OR EXACERBATING DELIRIUM	Change Idea
	IDENTIFY HIGH RISK, VULNERABLE POPULATIONS	SCREEN FOR HISTORY OF FALLS, OR FALLS AS REASON FOR ADMIT	Change Idea
		CONSIDER ELDERS HIGH RISK	Change Idea
		SCREEN FOR RISK FOR INJURY USING THE ABCS	Change Idea
	ASSESS AND IMPLEMENT MULTIFACTORAL PLAN	MULTIFACTORIAL ASESSEMENTS — COGNITIVE, MOBILITY, URINARY CONTINENCE, FRACTURE RISK	Change Idea
	PREVENT DELIRIUM AND FUNCTIONAL DECLINE	PROGRESSIVE MOBILITY	Change Idea
		AVOID HYPNOTICS/SEDATIVES	Change Idea
	PROVIDE OPTIMAL POST-FALL CARE	INJURY ASSESSMENT PRIOR TO MOBILIZATION FOR UNWITNESSED FALLS	Change Idea
		SPECIAL PROCEDURES FOR PATIENTS ON BLOOD THINNERS	Change Idea
	PROVIDE APPROPRIATE LEVEL OF SURVEILLANCE/ OBSERVATION	INTENTIONAL ROUNDING HOURLY OR EVERY TWO HOURS	Change Idea
		ARMS LENGTH IN THE BATHROOM FOR VULNERABLE PATIENTS	Change Idea
		1:1 OPERATING ROOM VIDEO SURVEILLANCE	Change Idea
	ENGAGE PATIENTS AND FAMILIES	AT THE BEDSIDE — HUDDLE	Change Idea
		ORGANIZATIONAL DESIGN	Change Idea

Primary Driver:

AN INTERDISCIPLINARY, HOSPITAL-WIDE APPROACH IS TAKEN TO ADDRESS FALLS

Best practice results have only been achieved when there is significant organizational support for falls reduction across departments and disciplines. It is clear that involving multiple levels of management and taking accountability as a team are key to maximizing effectiveness. The organization should not only implement standard interventions for fall prevention but also foster a culture to promote accountability, safety awareness and teamwork of the interdisciplinary team. This approach has been attributed to falls reduction rates.⁷

Organizational support for making falls injury prevention a highly prioritized, well-publicized organizational aim that touches all disciplines and departments is necessary for achieving best results. This includes involving and enlisting the support of medical staff of health care organizations to a much greater degree than has been done in the past. This support has been linked to falls reduction rates.^{8,9}

Transparency of falls rates by sharing between hospital units, hospitals and hospital systems or public reporting has a positive effect on falls and injury reduction.¹⁰

Secondary Driver > THE ORGANIZATION HAS AN INTERDISCIPLINARY TEAM IN PLACE TO OVERSEE THE STRATEGIC PLAN FOR THE FALL INJURY PREVENTION PROGRAM.

The team is responsible for regular review of fall events (small data) and overall hospital and unit trends (big data). The organization supports the recommendations from the falls team for universal fall precautions, screening and assessment tools, high risk interventions, policies and protocols, equipment needs and environmental safety.

The interdisciplinary falls team should be composed of clinical and non-clinical, front-line and management staff to oversee the falls prevention program. The team should include at least one clinician with a background or additional education in falls prevention.

Change Ideas

- > Assess the effectiveness of current team and change membership and/or leadership to bring in fresh ideas.
- > Reinvent the team if needed. Change focus from "Fall Prevention" to "Safe Mobility."
- > Utilize "Unit-Based Champions" approach for local accountability.
- > Populate the team with an executive sponsor, front-line staff from nursing and rehab, management support, physical therapy, physician and pharmacy representatives.

Suggested Process Measures for Your Test of Change

- The percentage of interdisciplinary team member positions filled (e.g., nursing, rehab, pharmacy, physician, executive, manager).

Secondary Driver > LEADERSHIP ENSURES THAT THE ENVIRONMENT IS SAFE

- > Engage all levels of staff and disciplines in monitoring the environment for slipping and tripping hazards. Management support is essential to ensure that hazards identified in safety rounds and in fall event reviews are addressed.



Change Ideas

- > Share falls event consequences in daily house-wide safety huddles to notify other departments of the hazard.
- > Develop an environmental safety checklist (See Appendix II).
- > Designate a time of day for routine rounds by a multidisciplinary team that includes nursing staff, administrative team members, housekeeping staff and engineering staff to review checklist items and identify potential hazards. Collaborative rounds provide an opportunity for a breadth of professionals to catch hazards such as uneven flooring, poor lighting, loose grab-bars, clutter and puddles.
- > Develop a visual cue to signal the lowest possible bed position for high-risk patients.
- > Create a mechanism for regular (e.g., every four hours) monitoring of bed position appropriateness based on visual cues. Define who is responsible for monitoring bed position and designate the intervals for monitoring.
- > Arrange the patient's room to eliminate safety risks. Move electrical cords off the floor and away from the patient's walking path.
- > Conduct "clutter rounds" with assistive personnel every shift.
- > Ensure that any portable furniture is in the locked position when the patient is standing or transferring.

Suggested Process Measures for Your Test of Change

- Percent of environmental rounds completed within the organization.
- Number of hazards discovered and corrected on environmental rounds.

Secondary Driver > AN INTERDISCIPLINARY, PATIENT-CENTERED APPROACH IS SUPPORTED.

- > There should be interdisciplinary collaboration on falls prevention at the time of admission between admitting clinicians having first contact with the patient, including admitting physicians, pharmacists and nurses.
- > Incorporate team-based success factors associated with the best reported reductions in falls and injury rates including the following:¹⁰
 - Interdisciplinary discussion of patient falls risk during daily rounding
 - Medication review for all patients at risk for injury and/or risk for falls
 - Nurse rounds to include reinforcement of education re: the patient-family's role in falls risk prevention (use of call light, assist with ambulation to bathroom, etc.)
 - Implementation of interdisciplinary post-fall huddle to discuss action plan after patient fall event



Change Ideas

- > Educate primary care physicians on the use of medications that increase fall risk and the implementation of patient self-assessment questionnaires.^{11,12}
- > Engage physical therapists and pharmacists in developing care coordination processes that will deliver optimal interdisciplinary care.
- > Engage pharmacy staff to assist with guiding medication debridement practices.

- > Create expectations that physical therapists and pharmacists discuss their recommendations with the nurse to facilitate timely implementation. Encourage frequent updates and collaboration.
- > Institute a “No Pass Zone” — no staff may pass a room with a call light ringing.
- > Leadership, pharmacy and rehab participates in post-fall huddles.
- > Chief Medical Officer or Chief Nursing Officer rounds on patients and staff post-fall.
- > Conduct weekly systems fall review to share fall circumstances and learnings across units.
- > Use CAPTURE Falls Tools to support interdisciplinary safe mobility activities.¹³
- > Incorporate TeamSTEPPS concepts of mutual support, shared mental model and other communication techniques to promote teamwork.¹⁴

Suggested Process Measures for Your Test of Change

- Percentage of patients with documentation of an interdisciplinary plan of care for fall prevention.

Hardwire the Process

To hardwire interdisciplinary teamwork and collaboration, it must be embraced by leadership. Leadership creates the infrastructure that includes collaboration in assessing, planning and implementing care. Interdisciplinary electronic documentation supports interdisciplinary care but cannot be a replacement for face-to-face collaboration at the bedside or on the unit. To hardwire interdisciplinary face-to-face collaboration, invite physical therapy, pharmacy and nutritional services to daily unit safety huddles, include falls in interdisciplinary clinical rounds and include falls in house-wide safety briefings. Include fall safety checks in leadership safety rounds. To support the work of the interdisciplinary falls team, provide data support for house-wide analysis and regular reporting of fall events and trends.

Primary Driver:

CREATE STRUCTURES FOR HOSPITAL-WIDE LEARNING LOOPS.

Organizational leadership supports systems that promote learning, ongoing evaluation and improvement of the falls prevention program including analysis of falls and injuries rates and evaluation of the effectiveness of interventions applied to those screened at risk.¹⁰



To begin an improvement, use “big data” to analyze trends and plan improvements. In a study published in the Journal of Nursing Care Quality in 2014, seven hospitals analyzed falls data to determine the organization’s leading contributing factors to falls and used the information to identify targeted solutions, resulting in a 62 percent reduction in fall injury rates over an eighteen month period.⁶ This study demonstrates the benefits of understanding why patients are falling before an improvement can be initiated.

Use post-fall event learning to guide the clinical team’s decision making to prevent a recurrent fall for the individual patient. At the organizational level, leadership and the falls team can use post-fall event learning to detect early warning of system weaknesses or new problems that require intervention or attention.

Provide support for big data analysis — times, locations and characteristics of falls by unit and organization wide. Provide leadership support to conduct post-fall huddles immediately, at the bedside.

Secondary Driver > USE BIG DATA TO INFORM THE ORGANIZATION OR UNIT’S FALL IMPROVEMENT STRATEGY.

Analyze data for trends to determine patient, environmental and other factors that are associated with falls to inform improvement activities. Drill down on circumstances surrounding unwitnessed falls to uncover system failures.

Change Ideas

- > Use trended data to dispel myths or confirm theories about who is falling, when, where and why (Appendix III).
- > Identify fall characteristics: time, location, day of week, age, sex, race/ethnicity, activities, medical condition, functional abilities to identify who is falling and what environmental and patient factors contributed. Use this information to inform changes to test.
- > Drill down on unwitnessed falls as a system failure.
- > Share trended data with leadership, staff, patients and visitors.

Suggested Process Measures for Your Test of Change

- Percent of nursing units with current falls data displayed.
- Percent of leadership meetings in which falls data is shared.



Secondary Driver > CONDUCT IMMEDIATE POST-FALL HUDDLES AT THE PATIENT'S BEDSIDE.

Post-fall huddles facilitate critical thinking about a fall event. Immediate review with the patient aims to uncover the root cause for the fall and inform the patient and the clinical team what measures to put into place to prevent a future fall. Additionally, the data that is collected from post-fall huddles can be applied to the system in general, especially as trends emerge over time.

Change Ideas

- > Use a falls resource team or administrator on call to respond to falls to support post-fall huddles.¹⁵
- > Conduct the huddle immediately at the bedside. See CAPTURE Falls Toolkit for resources on how to conduct post-fall huddles and how to involve the patient in a post-fall huddle.
- > Use Rapid Response System for unwitnessed falls to assess for injury prior to conducting the huddle (see optimal post-fall care section).
- > Track circumstances of falls to drill down on contributing factors, time of day, location, involved staff, etc., to identify opportunities for improvement.
- > Conduct weekly systems fall review to share fall circumstances and learnings across units.
- > Involve rehabilitation services and pharmacy as available. If the fall occurs after hours, have the pharmacist and rehab professional review the circumstances as soon as possible to identify contributing factors and add to the post-fall plan.

Suggested Process Measures for Your Test of Change

- Percentage of falls that had a post-fall huddle completed with the patient within one hour of the fall.

Hardwire the Process

Leadership supports learning from falls through event review and post-fall huddles by allocating resources to support staff and by being actively engaged in the learning. Hardwiring occurs when the response to a fall is clearly defined with roles and responsibilities of front-line staff and resource staff. Including fall events in regular leadership safety briefings and identifying a team (rapid response, Administrator on Call or falls resource team) to attend post-fall huddles are examples of leadership interventions that can hardwire the learning loop.

Primary Driver:

IDENTIFY HIGH RISK, VULNERABLE PATIENTS AND POPULATIONS.

Discontinue use of a score on a screening tool to determine the level of fall risk.¹⁶ Rather, nurses and interdisciplinary team members must accept that essentially all patients are high risk for falls and should conduct multifactorial fall risk assessments. Spending time determining if a patient is at risk for falling or assigning a score does not add value. The United Kingdom's National Institute for Health and Care Excellence (NICE) Guidelines eliminated the use of fall risk screening tools in hospitals for older adults. Instead they classified all adults over 65 as high risk and implemented multifactorial, interdisciplinary assessments upon admission.

Evidence is strong that the most effective fall prevention programs require an individualized patient assessment and treatment plan that is multifactorial and interdisciplinary.¹⁷ Organizations should determine criteria or profile of their high risk/vulnerable populations that should have multifactorial assessments and interventions applied. Clinicians should use clinical judgment to determine what factors will put the patient at risk for falls and put interventions in place to reduce the risk.

Secondary Driver > IDENTIFY PATIENTS ADMITTED FOR A FALL OR WITH A HISTORY OF FALLS AND APPLY SPECIAL INTERVENTIONS.

History of a fall within the past 12 months has the highest predictive value for a recurrent fall.¹⁸ Fifty percent of elders who fall do not tell their provider. Patients admitted for a fall should receive a multifactorial assessment, including a gait, mobility and balance assessment by a physical therapist and a home safety evaluation by a qualified professional. In addition, older people living in the community that have a known history of recurrent falls should be referred for strength and balance training, i.e., Tai Chi.¹⁹

Change Ideas

- > Interview family to obtain fall history.
- > Record "known faller" on EMR banner.
- > Order a physical therapy evaluation for patients admitted with fall.
- > Designate specific staff to screen patients for high risk/vulnerable status.
- > Provide a home environmental safety assessment for patients being admitted for fall.
- > Refer patients to strength and balance training in the community. Use CDC STEADI Patient Referral Resources.²⁰
- > Conduct multifactorial assessment and address risk factors.

Suggested Process Measures for Your Test of Change

- Percentage of patients admitted for fall or with fall in the last six months that received the organization's special interventions.

Secondary Driver > PROVIDE MULTIFACTORIAL ASSESSMENTS FOR HIGH RISK/VULNERABLE POPULATIONS.

- > American Geriatric Society Clinical Practice Guideline: Prevention of Falls in Older Persons (AGS Guidelines) include:
 - Gait, balance and mobility assessment
 - Medication review
 - Cognitive assessment
 - Heart rate and rhythm
 - Postural hypotension
 - Feet and footwear
 - Home environmental hazards



Change Ideas

- > Evaluate the effectiveness of your current fall risk assessment tool and work flow process to create impetus to change.
- > Develop an assessment tool with interventions linked. See the NICE Multifactorial Falls Risk Assessment and Management Tool as an example of an integrated assessment and plan of care,²¹ and clearly define the responsibilities and work flow.
 - Define how initial screening for high risk/vulnerable status is determined.
 - Define who is responsible for performing each dimension of the assessments.
 - Define who is responsible for the initiation of the care plan to mitigate risk for each patient.
 - Define how the interdisciplinary collaboration will occur.

Suggested Process Measures for Your Test of Change

- Percentage of high risk or vulnerable patients who undergo a multifactorial assessment.

Secondary Driver > SCREEN FOR RISK FOR INJURY USING THE ABCS CRITERIA.

Those patients who are identified as high-risk for a fall with injury should receive targeted intervention. Patients at the highest risk for injury fall into the ABCS criteria (age, bones, coagulation and surgery). This includes those who are over 85 years old or are frail due to a medical condition, have a history of orthopedic conditions, are on anti-coagulation therapy, have a bleeding disorder and/or are post-surgery or post-procedure.

Change Ideas

- > During shift huddles, review which patients are at highest risk for injury from a fall so that all staff are aware of these highest-risk patients.
- > Use a reminder such as “ABCS” at the beginning of each shift to identify those patients at highest risk for injury from a fall (Appendix IV)
- > High-risk criteria include:
 - (A) Age or frailty
 - (B) Bones
 - (C) Coagulation
 - (S) Surgery (recent)
- > Assess for and treat osteoporosis and vitamin D deficiency by providing supplemental vitamin D.
- > Flag the electronic medical record of patients that are on anti-thrombotics to increase awareness of risk for bleeding and injury to nursing staff and other disciplines.

Suggested Process Measures for Your Test of Change

- Percent of patients with a risk for injury assessment completed within 24 hours of admission.
- Percentage of patients on anti-thrombotics that are flagged as defined by policy.



Secondary Driver > COMMUNICATE RISK ACROSS THE CARE TEAM AND ACROSS DISCIPLINES.

Communication failure is a common contributing factor to fall-related sentinel events.²² Communication of a patient's high risk/vulnerable status is important to patients, family and all members of the health care team that interact with the patient. Visual cues, such as door signs, yellow gowns and wristbands are widely used, but cannot be the sole means of communicating risk. Clinical and non-clinical team members that share risk information through face-to-face handoffs and unit safety huddles create a shared mental model that can positively impact the reliability of fall risk awareness within the team. Handoffs between departments (i.e., transfers between units and to radiology and other procedural areas) are particularly important and must include the receiving department and the individual transporting the patient. Pay special attention to communicating risk factors related to medications administered prior to transport that can increase fall risk such as sedatives, hypnotics or pain medications.

Change Ideas

- > Use standardized visual cues to communicate high fall risk and injury risk to all care team members.
 - Place red or yellow non-skid socks on all patients at risk for falling. Keep in mind that non-skid socks are not adequate footwear for ambulation.
 - Use colored wrist bands or a colored blanket on the bed or on the patient's lap.
 - Use signage inside or outside the patient room to represent fall risk, being careful to maintain respect and dignity for the patient's privacy.
- > Use standardized hand-off communication between hospital staff members at shift changes or when changing departments. Include information about fall risk, risk for injury, history of falls, fall risk increasing drugs recently administered, changes in fall risk and fall prevention measures for each patient in the hand-off checklists.
 - Use "ticket to ride" handoff tool.²³
 - Include fall risk increasing medications administered prior to handoff or transport.
- > Incorporate alerts in the electronic medical record (e.g., "known faller" in banner with patient demographics).
 - Integrate fall safety into whiteboard communication between staff and with patients and family.

Suggested Process Measures for Your Test of Change

- Percent of patients that are identified as having a fall risk that have appropriate visual cues in place, as per hospital policy.
- Percent of hand-offs that include a discussion about patient's fall risk as observed or documented.

Hardwire the Process

To hardwire the completion of multifactorial assessments for high risk/vulnerable patients, the process must be incorporated into the admission process and be user-friendly. It may require multiple tests of change to determine how to most effectively incorporate this new process into the existing workflow. Test assessment and care planning processes on paper to determine the most efficient interdisciplinary process.



Primary Driver:

IMPLEMENT MULTIFACTORIAL INTERVENTIONS TO REDUCE RISK OF FALLING OR INJURY.

High quality evidence shows that multicomponent interventions can reduce risk for in-hospital falls by as much as 30 percent.²⁴ Fall prevention interventions have been studied and results have been inconclusive to recommend an intervention or set of interventions. The consistent element in success has been the selection of interventions based upon findings in the risk assessment.²⁵

Oliver and colleagues used a systematic review to identify the most appropriate approach to fall prevention interventions. They determined that multifactorial interventions with multidisciplinary input was most appropriate.

The single interventions that were found to be most effective in this study were delirium avoidance programs, in-depth patient education and sustained exercise programs to prevent falls.²⁶

Secondary Driver > IMPLEMENT UNIVERSAL FALL PRECAUTIONS FOR ALL PATIENTS.

- > Maintain a safe environment, free of tripping and slipping hazards.
- > Orient patient to surroundings and furniture equipment on wheels.
- > Keep bed in lowest position when patient is in bed.
- > Raise bed for transfers and cares.
- > Keep top two side rails up for mobility support.
- > Place call light and frequently needed items within reach.
- > Teach patient and family fall safety precautions and use teach-back.
- > Ensure adequate lighting.
- > Provide proper fitting, non-skid footwear (slipper socks are not adequate).
- > Address any equipment that tethers the patient.

Change Ideas

- > Engage falls team, front-line staff and a patient family advisor in designing optimal universal fall precautions.
- > Integrate precautions into charting, care plans and whiteboards.
- > Develop patient teaching materials or checklist for orientation to precautions.

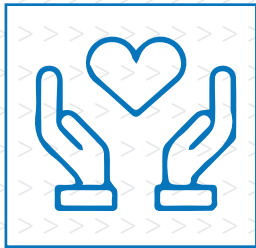
Suggested Process Measures for Your Test of Change

- Percent of patients observed to have bedside table, call bell, light switch and personal items within reach during leadership rounds.

Secondary Driver > IMPLEMENT MULTIFACTORIAL INTERVENTIONS TO REDUCE RISK OF FALL OR INJURY.

An optimal “bundle” for high risk patients is not established. Rather, the interventions need to be tailored to address the risks identified in the multifactorial assessment. The American Geriatric Society recommend the following interventions be activated based upon presence of risk:

- > Minimize medications
- > Provide individually tailored exercise program
- > Treat vision impairment (including cataracts)
- > Manage postural hypotension
- > Manage heart rate and rhythm abnormalities
- > Supplement vitamin D
- > Manage foot and footwear problems
- > Modify the home environment
- > Provide education and information



Change Ideas

- > Determine criteria for and process for completion of a comprehensive multifactorial assessment and plan.
 - Use Fall Resource Team or RN Champion to conduct assessments or plan.
 - Integrate assessment and care planning into admission documentation processes.
 - Develop processes for interdisciplinary collaboration for planning care for high risk/vulnerable patients.
 - Clearly define which discipline completes each dimension of the assessment and plan.
- > Develop a multifactorial fall risk assessment and care planning documentation tool to guide clinicians in decision making and facilitate documentation. Review the National Institute for Health and Care Excellence (NICE) multifactorial falls risk assessment and management tool as an example.
- > Engage physicians in collecting assessment data to determine risk factors that can be minimized. Collaborate with primary care providers about addressing fall risks prior to hospitalization utilizing STEADI resources.
 - Provider Fall Risk Checklist (Appendix V)
 - Preventing Falls in Older Patients: Provider Pocket Guide
 - Integrating Fall Prevention into Practice
- > Provide early activation of interventions for discharge planning purposes:
 - Home environmental safety assessment
 - Exercise ambulation plan to prevent functional decline
 - Referral for community strength and balance training

Suggested Process Measures for Your Test of Change

- Percent of patients 65 years of age and older with walking or balance problems or with a fall in the past 12 months who report discussing falls or problems with balance or walking with the practitioner AND report a fall reduction intervention was received (outpatient focus).
- Percent of high risk or vulnerable patients who receive targeted interventions.

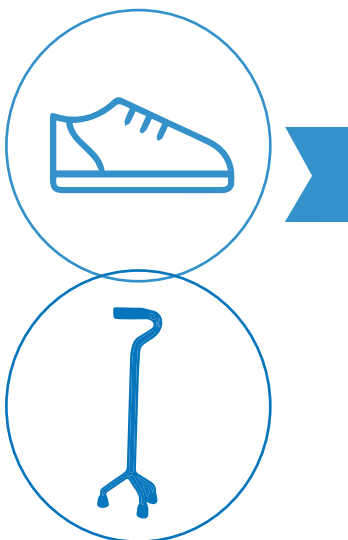
Hardwire the Process

Addressing and implementing multifactorial interventions is a team activity that must be embraced by the clinical team, including the physician, nurse, rehab service, pharmacist, home care, discharge planner and case manager. Integrate fall prevention activities into case management and discharge planning activities to hardwire preparation for home and to keep the focus on preventing functional decline. Leadership supports allocating resources to provide interprofessional collaboration and support for implementing optimal interventions.

Primary Driver:

PREVENT DELIRIUM AND FUNCTIONAL DECLINE IN VULNERABLE POPULATIONS.

Delirium avoidance programs and sustained exercise are one of the few interventions identified in the evidence as effective in reducing falls. Clinicians need to be keenly aware of an elders baseline capabilities and work with the patients and their caregivers in maintaining mobility skills to prevent hospital-induced delirium.²⁶



Secondary Driver > PROVIDE PROGRESSIVE MOBILITY.

Deconditioning and functional decline is found to occur by day two of hospitalization of elderly patients. Immobility leads to orthostatic hypotension, decreased muscle strength, increased bone loss and decreased bone density—all of which increase a patient's risk for fall and injury.²⁷ These hazards can be minimized by proactively incorporating activity into a patient's treatment. Mobility interventions include:

- > Patients should wear their shoes or non-skid footwear. Slipper socks are inadequate support to prevent falling.
- > Physical therapy and occupational therapy consults for evaluation and possible treatment.
- > Instruct the patient to rise slowly.
- > Early and regular assisted ambulation of high-risk patients.
- > Repeated education of safety measures to the patient and family members.
- > Assist high-risk patients with transfers.
- > Use of patient's regular assistive device such as a walker or cane, or equipment recommended by physical therapy or occupational therapy.
- > Regularly scheduled assistance with toileting.
- > Provide supportive chairs with armrests.
- > Apply hip protectors to patients at high risk for hip fracture.
- > Adequate daytime and nighttime lighting for ambulation and activities of daily living
- > Use of elevated toilet seats.
- > Use of a gait belt or transfer belt during mobility activities.^{28,29}

Change Ideas

- > Incorporate assessment of gait, balance, lower extremity muscle strength and functional abilities into initial assessments. Some examples of mobility tools are the Banner Mobility Tool for Nurses (Appendix VI) and the Timed Up and Go (TUG) Test.
- > Use automated triggers in the EMR to notify rehabilitation services of the need for a physical therapy/occupational therapy (PT/OT) evaluation.
- > PT/OT staff should attend daily rounds with charge nurses to discuss patients that need evaluation and intervention.
- > Review mobility in interdisciplinary clinical rounds and include rehabilitation services in these rounds.
- > PT/OT staff should recommend and assist with progressively increasing the patient's mobility status and communicate with the team in huddles and on the whiteboard. Discuss therapy progress daily with nursing staff and instruct on recommended nurse-led mobility activities.
- > Provide gait belts at the bedside of every patient requiring assistance.
- > Provide appropriate footwear. Slipper socks are not adequate for ambulation activities.

Suggested Process Measures for Your Test of Change

- Percent of patients ambulating as prescribed.
- Percent of patients with a mobility program defined on the white board.

Secondary Driver > AVOID MEDICATIONS THAT AFFECT THE CENTRAL NERVOUS SYSTEM. FOLLOW THE 2015 BEERS CRITERIA FOR SEDATIVES AND HYPNOTICS.

A subset of patients at risk include the elderly population, who are more prone to adverse effects of medications due to changes in metabolism and slowed clearance from renal and hepatic impairment. In addition, drug interactions leading to adverse effects by additive or synergistic effects may be more prevalent in elderly people as they are often on multiple medications.³⁰ Patients on four or more drugs are at greater risk of falls.¹⁰

The following medications should be avoided for the vulnerable, elderly population to prevent cognitive decline.³¹

- > Antiepileptics
- > Anticholinergics
- > Tricyclic antidepressants
- > Antipsychotics
- > Benzodiazepines
- > Opioid receptor agonist analgesics
- > "Z" hypnotics
- > Avoid drug-drug interactions of 3+ CNS impacting medications

Change Ideas

- > Include a review of patients' medications in the assessment of fall risk and risk for injury.
- > Flag vulnerable patients for a review of their medications by a pharmacist.
- > Use the Beers Criteria to determine inappropriate medications in the elderly.
- > Ask the pharmacist to recommend alternatives to medications that may increase fall risk and to place an alert in the medication system for care providers.
- > Review standing order sets for inclusion of high-risk medications such as Zolpidem Tartrate (Ambien™). Remove high risk medications from standing order sets.
- > Educate nurses and patients about medication side effects that increase fall risk (Appendix VII).
- > Create alerts in medication administration documentation when a drug that increases fall risk is administered.

Suggested Process Measures for Your Test of Change

- Percent of vulnerable patients receiving a medication review by pharmacist.
- Percent of falls with medications attributed to the cause of the fall.

Hardwire the Process

Promoting delirium prevention by implementing mobility and medication management can be optimized by using Get Up and Wake Up campaigns on <http://www.hret-hiin.org/engage/up-campaign.shtml> as a cross cutting strategy that provides common language and an interdisciplinary approach to answering one question: Is my patient awake and alert enough to get up? Shift allocation of resources from sitter hours which promote immobility for safety to allocating mobility aides to support hourly rounding and regular ambulation of patients.



Primary Driver:

PROVIDE OPTIMAL POST-FALL CARE TO MINIMIZE INJURY.

Falls can lead to serious injury. When a fall occurs, it is important that the patient is assessed for serious injury and monitored for internal bleeding or head injury so appropriate medical imaging and treatment can be provided. Of patients falling in the hospital, 28 percent have bruises or minor injuries, 11.4 percent have severe soft tissue wounds, five percent have fractures, and approximately two percent have head trauma which can turn into a subdural hematoma, long term disability or death.³²

Secondary Driver > ASSESS FOR INJURY PRIOR TO MOBILIZING THE PATIENT AFTER AN UNWITNESSED FALL.

In an unwitnessed fall, the patient should be evaluated for head injury, spinal injury and fracture before they can be safely mobilized. Staff may initially want to quickly get the patient up to minimize embarrassment and shame. However, this puts the patient at risk for further harm if an injury is present.

Change Ideas

- > Use the Rapid Response Team to respond to falls with suspected head injury, unwitnessed falls and falls where the patient is on anti-thrombotics.
- > Establish protocols for vital signs and neurochecks for patients on anti-thrombotics or with suspected head injury (Appendix VIII).
- > Communicate the patient's injury risk factors to all members of the team: age, bones, anti-thrombotics and recent surgery.
- > Escalate unassisted falls to an administrator on call, supervisor or leadership point person to assure that appropriate care and diagnostics are delivered.

Suggested Process Measures for Your Test of Change

- The percentage of patients who fell who had documented physical assessment for injury prior to mobilization.

Secondary Driver > PROVIDE SPECIALIZED POST-FALL CARE FOR PATIENTS ON ANTI-THROMBOTICS.

Change Ideas

- > Establish protocols for post-fall vital signs and neurochecks for patients on anti-thrombotics (Appendix VIII).
- > Communicate that the patient is on anti-thrombotics to the provider and rapid response team to determine treatment plan and/or diagnostics needed.

Suggested Process Measures for Your Test of Change

- Percentage of falls with patient on anti-thrombotics who had their anti-thrombotic status included in the post-fall care plan.

Hardwire the Process

Create a culture in which learning from falls and optimizing safety is clearly communicated to staff at all levels. Treat a fall as an important learning event for the patient, unit and organization. Leadership must pay attention to the follow-up to a fall and provide leadership oversight to ensure that appropriate care is delivered.

Primary Driver:

PROVIDE THE APPROPRIATE LEVEL OF SURVEILLANCE/OBSERVATION.

Nurses should use their clinical judgment to determine the level of monitoring required to maintain the patient's safety status and to monitor for changes in clinical condition. Determinations should balance respect for patients' privacy and autonomy with their safety needs.

Secondary Driver > IMPLEMENT INTENTIONAL ROUNDS ON PATIENTS.

Studies have shown that greater than 45 percent of all falls are related to toileting.³³ Some hospitals have reduced falls by 60 percent in one year by implementing hourly rounding and incorporating toileting assistance.^{34,35} Patient satisfaction and safety have been improved with this concept and hospital personnel experience less job fatigue and burnout with the decreased number of call lights experienced throughout the shift.

Change Ideas

- > Engage front-line staff in designing or redesigning an intentional rounding workflow that works for them.
- > Combine rounds with other patient care tasks such as turning, pain assessment or vital signs measurement.
- > Educate the patient that a staff member will be in the room every two hours to assist with the "5-P's" —pain, position, personal belongings, pathway and potty. Based upon the care areas' fall trends, the elements of the "5-P's" can and should be redefined.
- > Involve all hospital staff involved in the patient's care in rounds expectations.

Suggested Process Measures for Your Test of Change

- Percent of patient rooms with documented periodic rounds as per hospital policy.
- Percent of patients who report that toileting is offered each time staff round on them.

Secondary Driver > KEEP VULNERABLE PATIENTS AT ARM'S LENGTH WHEN ON THE TOILET.

Change Ideas

- > Provide patient and family education using teach-back.
- > Listen to patient and staff concerns regarding privacy. Modify assignments as needed. For example, an elderly male patient may prefer a male caregiver assist him in the bathroom.
- > Use signage, scripting and messaging to support safety in the toilet—"Safety Trumps Privacy."

Suggested Process Measures for Your Test of Change

- Percentage of patients identified to be at arm's length observed to receive that level of supervision in toileting.

Secondary Driver > INCREASE INTENSITY AND FREQUENCY OF OBSERVATION.

Vulnerable patients at high risk for injury may require more frequent observation than those with lower levels of risk who are assigned to standard fall precautions. Available evidence suggests that sitters contribute little to falls prevention programs. Thus, while studies involving sitters suggest a questionable effect on falls rates, studies that involve increased observation and surveillance by nursing appear to have a more consistent positive effect on falls rates.¹⁰

Change Ideas

- > Encourage family members to stay with the patient whenever possible.
- > Place high risk patients in rooms that are closer to the nurses' station and more visible to hospital staff, ideally in a direct line of sight.
- > Round in the patient's room more frequently than every one-to-two hours:
 - Escalate to every 15 minutes as necessary to maintain safety.
 - Identify patients needing more frequent monitoring in pre-shift huddles.

- > Develop an individualized toileting schedule for the patient.
- > Utilize video surveillance.³⁶
- > Utilize one-on-one companions or sitters for high risk times of day for the individual patient.

Suggested Process Measures for Your Test of Change

- Percentage of close-monitoring patients that have documented observations.
- Percentage of nursing staff who report, in leadership rounds, they have the tools and resources to adequately monitor the safety of high risk patients.

Hardwire the Process

Creating a shared mental model on a patient care unit regarding how best to provide the right amount of observation and intentional rounding for each patient is crucial. There must be a level of commitment from the unit leadership and front-line staff that patient's observation and surveillance needs will be met. Leadership can support the creation of this shared mental model by discussing in pre-shift huddles which patients are a fall concern or who will need extra support and surveillance. Leadership can support intentional rounding by "inspecting what they expect" through rounding on staff and patients to identify how effectively it is working and what barriers staff are facing in executing.

Primary Driver:

ENGAGE PATIENTS AND FAMILIES IN DESIGN AND IMPLEMENTATION OF FALL INJURY PREVENTION ACTIVITIES.

Including the unique perspective of the patient in designing fall safety improvements at the organization level and the patient level is advantageous. Studies have shown that by providing structured education to cognitively intact patients, falls can be reduced.³⁷

Secondary Driver > Engage patient family advisors in designing strategies to reduce injurious falls.

Patients and family members can help prevent falls and injuries by becoming aware of the patient's risk for falling and by learning strategies for fall prevention. Health care providers should also assess the level of understanding patients and families have about fall risks and recommended precautionary measures.

Change Ideas

- > Invite two to three patient/family advisors to join the falls improvement team.
- > Ask a patient that experienced a fall to share their experience with staff as part of new hire orientation.
- > Ask patient/family advisors to preview educational materials or any documents provided to patients as tools. Review for basic understanding, readability, etc.
- > Include patient/family advisors in environmental design for fall safety.
- > Involve patient/family advisors or patients in small tests of change. Seek their input on their experience with the change being tested.



Suggested Process Measures for Your Test of Change

- Percentage of falls educational materials or handouts that have been reviewed by a patient/family advisor.

Secondary Driver > ENGAGE PATIENTS AND CAREGIVERS IN FALL SAFETY AT THE BEDSIDE.

Change Ideas

- > Determine who the learner(s) is/are. With the patient's permission, address family members who are involved in the patient's care or spend time regularly with the patient.
- > Provide structured fall safety education that includes:
 - Information about fall risks: medications, tripping hazards, orthostatic hypotension, especially in the morning, footwear, rolling equipment and furniture hazards, IV and other catheter/tubing hazards.
 - Information about safe ambulation: level of assistance needed, promote progressive ambulation, use of adaptive equipment.
- > Include the fall prevention program on the patient's whiteboard.
- > Initiate a written "patient agreement" for patients reluctant to call for help to establish patient and staff commitment to safety. The agreement outlines the patient's need to call for help, and the staff's need to respond (Appendix IX).
- > Provide "Fall Safety Tips" to each patient upon admission. Keep the document at the bedside (Appendix X).
- > During bedside hand-offs, include the fall prevention status and include the patient and family in the discussion.
 - Use the teach-back method when providing education about falls, including the reasons the patient is at risk for falling, necessary precautions to be taken and methods to keep the patient safe (Appendix XI).
 - If the patient and family member do not understand the information, provide additional teaching and follow up with another request that they teach back.

Suggested Process Measures for Your Test of Change

- Percent of patient whiteboards with fall prevention program outlined as observed during leadership rounds.
- Percent of bedside hand-offs that include the patient and family in fall prevention.

Hardwire the Process

Leaders support patient/family engagement by providing resources for structured education on fall prevention for patients and families. It does not mean extra resources, but instead realigning resources to make this evidence-based practice reliable. Assign the education to a falls champion, the nurse manager, charge nurse, educator or rehab staff depending upon your organization's resources.

PDSA in Action | Tips on How to Use the Model for Improvement

Choice of Tests and Interventions for Iatrogenic Delirium Reduction:

- > Implement an injury risk assessment process.
 - Ask one nurse to test the ABCS fall injury risk assessment tool on one patient and then work with that nurse to improve the assessment for the next patient.
 - Add patients' ABCS information to existing hand-off communication tools. Ask one nurse to help trial new protocols for communicating risk for serious injury from falls in a manner that enhances clear communication. Use visual cues, EMR prompts and other reminders to ensure effective communication.
- > Standardize hourly rounds expectations to include assessment of fall risk and interventions as appropriate.
 - Evaluate the effectiveness of hourly rounds. If necessary, work with a small group of early adopters, with each role (RN, CNA) being represented, to test different workflows that will produce the results desired from rounds. Work with one RN/CNA team until an efficient workflow is established, then spread to one additional RN/CNA team. Use the early adopters to train additional teams to spread the practice to all shifts and all days of the week.
 - Conduct daily huddles or debriefs to evaluate the effectiveness of rounds and to identify and remove barriers.
- > Customize interventions for high-risk patients.
 - Ask the pharmacist to help design a process for medication review that includes:
 - > The process for how the pharmacy will be notified of a high risk patient.
 - > The process for how the pharmacy will communicate the results of their medication review to the treating physician and nurse.

IMPLEMENT SMALL TESTS OF CHANGE

PLAN

The objective is to engage staff in designing a process to incorporate a regular toileting schedule into the hourly rounding workflow. The study will identify the role, schedule and documentation processes to achieve scheduled toileting with patients requiring the intervention.

DO

One RN and one CNA champion will test a method in which the CNA toilets the patient on the even hours and the RN rounds for safety and comfort needs on the odd hours.

STUDY

Staff found that even hours conflicted with meal times for toileting and created delays and patient dissatisfaction.

ACT

For cycle two, toileting will be performed by the CNA on odd hours and RNs will round on even hours for comfort, safety and medication administration.

Potential Barriers

- > If an organization takes a nurse-centric approach to preventing all falls, an unintended consequence can be limiting the patient's mobility and ambulation as a protective measure to prevent a fall. Restricting the patient's freedom to ambulate can lead to deconditioning and loss of functional ability and increase fall risk. In the absence of teamwork, nurses may inadvertently immobilize patients inappropriately.
- > Falls that result in moderate to severe injuries may also have a significant negative impact on risk management costs. Include those ultimately responsible for organization-wide decision making in discussions and planning efforts to bring appropriate attention to these issues and to allocate the necessary resources to prevent injurious falls.
- > Though risk assessments are valuable tools, it is important that staff avoid preconceived ideas about the types of patients who fall and the circumstances surrounding falls. For example, staff and leaders may believe that most falls happen at night and occur most often with confused, elderly patients. A review of data collected in post-fall huddles regarding the types of falls, time of day, the circumstances surrounding the falls and patient demographics in one's institution may provide evidence-based information which can help select and implement appropriate improvement initiatives to reduce falls.

Enlist administrative leadership as sponsors to help remove or mitigate barriers

- > An executive sponsor who recognizes the value of preventing falls for the organization and its patients can help brainstorm solutions, address employee concerns, provide funding and resources and minimize barriers blocking the effective implementation of safety programs. Executive sponsors can provide a “big picture” perspective on how an initiative may impact the organization as a whole and can serve as champions and advocates for safety programs on a broader level.
- > Engage decision makers in conversations about moving from immobility to mobility as a safety measure. Consider reallocating resources to provide a mobility aide to support regular ambulation of medical patients. For example, shift one-on-one coverage hours to a mobility aide to support improved outcomes.

Change not only “The Practice,” but also “The Culture”

- > Adoption of an organization-wide culture of commitment to fall safety is essential in achieving sustainable results in fall injury prevention. A comprehensive program extends beyond the nursing team to make fall prevention a priority for every employee and physician. Adopting an organizational awareness of fall safety that is communicated at every level of the organization and incorporated into the full continuum of patient care is necessary to achieve the desired results. This requires a commitment from senior leadership to be visibly involved in patient safety communication, allocate resources to support fall prevention and to role model their commitment to engaging both front-line staff and patients and families in improving care processes. Examples of strategies that promote a positive safety culture include:
 - Communication and coordination among disciplines is essential to successful implementation.
 - Daily safety huddles led by a senior leader.
 - Front-line staff champions to design, test and implement strategies.
 - Patient family engagement in designing safety practices.
 - Interdisciplinary safety rounds.
 - Reward, recognition and follow-up for staff reporting on safety risks and events.

PART 4: CONCLUSION AND ACTION PLANNING

Preventing falls and injuries from falls is a complex issue that requires a comprehensive approach. There is not one set of interventions that will work for every organization. Teamwork, data-driven decision making and effective communication are key elements to success.

- > Teamwork — assemble a falls team or assess the current team for effectiveness. Determine if roles are clear and if the leader has the energy and time to lead a dynamic process improvement project. Assess the composition of the team and the support from key strategic partners such as the quality leader, chief medical officer, nursing director, risk manager, chief executive officer and board of directors. Define the role and expectations of each team member and strategic partner in supporting patient safety and fall injury reduction. Create strategies and/or allocate resources to engage front-line staff in designing new care processes.
- > Data-driven decision making — analyze falls data to determine the circumstances that are contributing to falls in the organization and design interventions to mitigate the risks associated with these contributing factors. Objectively assess care processes to determine efficacy through direct observation and by collecting data in leadership rounds with staff, patients and on the environment. Use this data to establish priorities in improving care processes.
- > Communication — establish channels for communication with the patient and family, within the care team and throughout the organization. Assess the clarity and consistency of communication in these three domains and apply process improvements as needed to optimize communication and organizational awareness.

PART 5: APPENDICES

Appendix I: Falls with Injury Top Ten Checklist

Appendix II: Environmental Fall Risk Assessment/Safety Checklist Sample

Appendix III: Falls Data Analysis Tally Sheet

Appendix IV: Sample Injury Risk Assessment and Population Specific Interventions (ABCS)

Appendix V: STEADI Provider Fall Risk Checklist

Appendix VI: BMAT — Banner Mobility Assessment Tool For Nurses

Appendix VII: Medication Side Effects Information Sheet

Appendix VIII: Safe from Falls Roadmap

Appendix IX: Fall Prevention Partnership Agreement

Appendix X: Fall Safety Tips for Patients and Families

Appendix XI: Teach-Back Tool for Fall Prevention

APPENDIX I: TOP TEN CHECKLIST

Associated Hospital/Organization: Health Research & Educational Trust

2017 Falls Top Ten Checklist

PROCESS CHANGE	
1. Assemble a multidisciplinary falls team with an executive sponsor, front-line staff from nursing and rehab, management support, physical therapy, physician and pharmacy representatives to oversee the strategic plan for the fall injury prevention program.	☐
2. Engage all levels of staff and disciplines in creating a safe environment that is free of tripping and slipping hazards and is responsive to patient needs, i.e., “no pass zone” and environmental rounds. Review all falls in leadership huddles to raise awareness of hazards and contributing factors.	☐
3. Identify high risk/vulnerable populations upon admission to receive a multifactorial falls assessment. Do not rely on a risk score alone. Examples: patients admitted with a fall, patients with a history of fall in the past six months, patients over 65, ABCS criteria, depending upon the population served.	☐
4. Provide multifactorial assessments and targeted interventions for high risk or vulnerable elderly patients. Assess for and address risk factors associated with gait, balance and mobility, medications, cognitive assessment, heart rate and rhythm, postural hypotension, feet and footwear and home environment hazards.	☐
5. Communicate risk across the team: EMR Banners, hand-offs, visual cues, huddles and whiteboards.	☐
6. Round every one to two hours on patients; address the five P's—pain, position, personal belongings, pathway and potty. Escalate rounding frequency to meet patient needs.	☐
7. Implement mobility plans for all patients to preserve function and prevent hazards of immobility: rehab referral and collaboration for a progressive activity and ambulation program.	☐
8. Review medications—avoid unnecessary hypnotics and sedatives and remove culprit medications from order sets. Target high-risk or vulnerable patients for pharmacist medication review.	☐
9. Include patients, families and caregivers in efforts to prevent falls. Provide structured education apart from admission orientation. Educate using teach-back regarding fall prevention measures and encourage family members to stay with high-risk, vulnerable patients.	☐
10. Conduct post-fall huddles at the bedside with patient and family immediately after the fall to analyze how and why the fall occurred, and implement change(s) to prevent future falls. Include a pharmacist and rehab staff member in the post-fall huddle or case review.	☐

APPENDIX II: ENVIRONMENTAL FALL RISK ASSESSMENT/SAFETY CHECKLIST SAMPLE

Reference: Boushon B, Nielsen G, Quigley P, Rutherford P, Taylor J, Shannon D. Transforming Care at the Bedside How-to Guide: Reducing Patient Injuries from Falls. Cambridge, MA: Institute for Healthcare Improvement; 2008. Retrieved at: <http://www.IHI.org>.

Date		Hospital				Unit	
Rooms assessed (minimum of 10 percent of rooms)							
Individual(s) surveying							
ITEM#	ENVIRONMENTAL CONSIDERATION	YES	NO	N/A	ROOM #/AREA DEFICIENCIES FOUND	COMMENTS	
1	Is there adequate lighting in the patient's room? (Bright light — no burned out bulbs?)						
2	Is the nightlight on the patient's bed functional/operating?						
3	Does the patient have an unobstructed path to the bathroom?						
4	Are the patient's room furnishings safely arranged?						
5	Is the bedside furniture free of sharp edges?						
6	Is the bedside furniture sturdy?						
7	Are beds/stretchers kept at the lowest setting whenever possible?						
8	Are beds/stretchers kept in a locked position?						
9	Were the upper siderails in the up position so the patient could reach controls?						
10	Was the bedcheck system on in the patient's room?						
11	Were the patient's personal belongings/telephone call bell within reach?						
12	Are handrails provided in the patient bathroom and properly secured?						
13	Is there an emergency call button/cord in patient care bathroom and working properly?						
14	Are non-slip surfaces provided in patient showers?						
15	Are the door openings into the patient bathroom wide enough for an assistive device to fit through?						
16	Are door openings flush with the floor for ease-of-movement for patient equipment?						
17	Is portable equipment pushed by patient (e.g. IV pole) sturdy and in good repair?						
18	Are bedside commodes available on the unit and do they have proper rubber slip tips on the legs?						
19	Do walkers/canes/crutches have the appropriate slip tips?						

APPENDIX II: ENVIRONMENTAL FALL RISK ASSESSMENT/SAFETY CHECKLIST SAMPLE (continued)

Reference: Boushon B, Nielsen G, Quigley P, Rutherford P, Taylor J, Shannon D. Transforming Care at the Bedside How-to Guide: Reducing Patient Injuries from Falls. Cambridge, MA: Institute for Healthcare Improvement; 2008. Retrieved at: <http://www.IHI.org>.

Date		Hospital				Unit	
Rooms assessed (minimum of 10 percent of rooms)							
Individual(s) surveying							
ITEM#	ENVIRONMENTAL CONSIDERATION	YES	NO	N/A	ROOM #/AREA DEFICIENCIES FOUND	COMMENTS	
20	Are wheelchairs locked when stationary?						
21	Is broken equipment properly tagged for non-use?						
Other environmental considerations							
22	Are floor surfaces/carpeting free of cracks and tripping hazards?						
23	Are hallways kept adequately clear/ clutter free to allow patient ambulation?						
24	Are floors properly marked when wet to avoid slipping or are spills cleaned up immediately?						
25	Do parking lots have uneven pavement/potholes/ tripping hazards?						
26	Do sidewalks have uneven pavement/ tripping hazards?						
27	Are entrance areas open and clear?						
28	Are parking areas/entrances well-lit?						
29	Are parking lots well marked?						
ITEM#	CORRECTIVE ACTION	DATE INITIATED			RESPONSIBLE INDIVIDUALS	ANTICIPATED DATE OF COMPLETION	

APPENDIX III: FALLS DATA ANALYSIS WORKSHEET

Purpose of Tool: Sample tools for tracking falls data to trend data

Reference: <http://www.hret-hiin.org/resources/display/falls-data-analysis-worksheet>



Falls Data Analysis

Directions: Use for recording fall circumstances to identify trends. Use one analysis sheet for each unit or patient population being studied. Analyze at least 10-30 falls to identify trends.

Total	# of Fall Occurrences Reviewed	
Time Frame	# of Months Reviewed	
		Counts or number of falls
Time of Fall	# of falls at change of shift	
	# Of falls 7a – 3p	
	# Of falls 3p – 11pm	
	# Of falls 11p – 7am	
Length of Stay	Day 1 – 0-8 hours since arrival on unit	
	Day 1 – 8-24 hours since arrival on unit	
	Day 2 – 24 – 48 hours since arrival on unit	
	More than 2 days	
Activity at time of fall	Transferring out of or back to bed	
	Unassisted ambulation	
	Reaching for personal item	
	Other	
Toileting	Was patient attempting to use toilet, commode or urinal at time of fall?	
Environmental Factors	Bed alarm issue	
	Clutter, tripping	
	Wet floor	
	Equipment issue	
	Other	
Injury Level	None	
	Minor – application of ice, bandage	
	Moderate – sutures or splints	
	Major – requires surgery, casting, neurological injury	
	Death	
Patient Profile		
Age	Less than 45	
	46 – 65	
	65-80	
	over 80	
Cognitive / Sensory	No cognitive / sensory deficit	
	Confused, memory impaired	
	Impulsive, anxious	
	Sensory deficit	
Functional	No Functional deficit	
	Incontinent	
	Altered gait, balance	
	ADL impairment	
Medical	No medical issue identified	
	Orthostatic BP	
	Sedatives / Hypnotics	
	Post procedural	

APPENDIX IV: SAMPLE INJURY RISK ASSESSMENT AND POPULATION SPECIFIC INTERVENTIONS

Associated Hospital/Organization: Veterans Healthcare Administration

Purpose of Tool: To standardize fall injury risk assessment

Reference: VA National Center for Patient Safety, Reducing Preventable Falls and Fall-Related Injuries. (2015). *Implementation Guide for Fall Injury Reduction*. Retrieved at: http://www.patientsafety.va.gov/docs/fallstoolkit14/falls_implementation_%20guide%2002_2015.pdf

ABCS Tool: The following groups of patients are most at risk for injury if they sustain a fall, providing a framework for population-based approach to fall and injury reduction:

A = Age (equal to or greater than 85) or frailty

B = Bones (fracture risk or history)

C = AntiCoagulation (bleeding disorder)

S = Recent surgery (during current episode of care)

For all patients: Education is essential using teach-back strategies. Bundled interventions for each vulnerable population follow:

> **Age:** Individuals who are greater than or equal to 85 years old or frail due to a clinical condition

- Assistive devices within reach
- Hip protectors (if fracture risk)
- Floor mats (when patient is resting in bed)
- Height adjustable beds (low when resting only, raise up bed for transfer)
- Safe exit side
- Medication review to reduce fall risks

> **Bones:** Patients with bone conditions, including osteoporosis, a previous fracture, prolonged steroid use, or metastatic bone cancer

- Hip protectors (unless DEXA scan is negative)
- Height adjustable beds (low when resting only, raise up bed for transfer)
- Floor mats (when patient is resting in bed)
- Evaluation of osteoporosis

> **AntiCoagulation:** Patients with bleeding disorders, either through use of anticoagulants or underlying clinical conditions

- Evaluate use of anticoagulation: risk for DVT/embolic stroke or fall-related hemorrhage
- Patient education: what to do if you fall now that you are on blood thinners
- Traumatic Brain Injury and anticoagulation: helmets
- Wheelchair users: anti-tippers

> **Surgery:** Post-surgical patients, especially patients who have had a recent lower limb amputation or recent, major abdominal or thoracic surgery

- Pre-op education (teach back strategies)
- Call, don't fall signage
- Post-op education to use call lights
- Pain medication: offer elimination prior to pain medication
- Increase frequency of rounds

APPENDIX V: STEADI PROVIDER FALL RISK CHECKLIST

Associated Hospital/Organization: CDC, STEADI

Purpose of Tool: Tool for providers to identify fall risk factors in older adults that can be addressed prior to hospitalization.

Reference: https://www.cdc.gov/steady/pdf/fall_risk_checklist-a.pdf

Fall Risk Checklist

Patient: _____ Date: _____ Time: _____ AM/PM

Fall Risk Factor Identified	Factor Present?	Notes
Falls History		
Any falls in past year?	☐ Yes ☐ No	
Worries about falling or feels unsteady when standing or walking?	☐ Yes ☐ No	
Medical Conditions		
Problems with heart rate and/or rhythm	☐ Yes ☐ No	
Cognitive impairment	☐ Yes ☐ No	
Incontinence	☐ Yes ☐ No	
Depression	☐ Yes ☐ No	
Foot problems	☐ Yes ☐ No	
Other medical conditions (Specify)	☐ Yes ☐ No	
Medications (Prescriptions, OTCs, supplements)		
CNS or psychoactive medications	☐ Yes ☐ No	
Medications that can cause sedation or confusion	☐ Yes ☐ No	
Medications that can cause hypotension	☐ Yes ☐ No	
Gait, Strength & Balance		
Timed Up and Go (TUG) Test ≥ 12 seconds	☐ Yes ☐ No	
30-Second Chair Stand Test Below average score based on age and gender	☐ Yes ☐ No	
4-Stage Balance Test Full tandem stance <10 seconds	☐ Yes ☐ No	
Vision		
Acuity <20/40 OR no eye exam in >1 year	☐ Yes ☐ No	
Postural Hypotension		
A decrease in systolic BP ≥ 20 mm Hg or a diastolic bp of ≥ 10 mm Hg or lightheadedness or dizziness from lying to standing?	☐ Yes ☐ No	
Other Risk Factors (Specify)		
	☐ Yes ☐ No	
	☐ Yes ☐ No	



Centers for Disease
Control and Prevention
National Center for Injury
Prevention and Control

2015

STEADI Stopping Elderly
Accidents, Deaths & Injuries

CS259944J

APPENDIX VI: BANNER MOBILITY TOOL FOR NURSES (BMAT)

Associated Hospital/Organization: Banner Health System

Purpose of Tool: Standardized Mobility Assessment for Nurses

Reference: <http://www.hret-hiin.org/resources/display/bmat-banner-mobility-assessment-tool-for-nurses>

Instructional Video: <https://www.youtube.com/watch?v=vqkwI3Ucpg8>

B.M.A.T. - Banner Mobility Assessment Tool for Nurses

Test	Task	Response	Fail = Choose Most Appropriate Equipment/Device(s)	Pass
Assessment Level 1 Assessment of: -Cognition -Trunk strength -Seated balance	Sit and Shake: From a semi-reclined position, ask patient to sit upright and rotate* to a seated position at the side of the bed; <i>may use the bedrail</i> . Note patient's ability to maintain bedside position. Ask patient to reach out and grab your hand and shake making sure patient reaches across his/her midline. Note: Consider your patients cognitive ability, including orientation and CAM assessment if applicable.	Sit: Patient is able to follow commands, has some trunk strength; caregivers may be able to try weight-bearing if patient is able to maintain seated balance greater than two minutes (without caregiver assistance). Shake: Patient has significant upper body strength, awareness of body in space, and grasp strength.	MOBILITY LEVEL 1 - Use total lift with sling and/or repositioning sheet and/or straps. - Use lateral transfer devices such as roll board, friction reducing (slide sheets/tube), or air assisted device. NOTE: If patient has 'strict bed rest' or bilateral 'non-weight bearing' restrictions, do not proceed with the assessment; patient is MOBILITY LEVEL 1.	Passed Assessment Level 1 = Proceed with Assessment Level 2.
Assessment Level 2 Assessment of: -Lower extremity strength -Stability	Stretch and Point: With patient in seated position at the side of the bed, have patient place both feet on the floor (or stool) with knees no higher than hips. Ask patient to stretch one leg and straighten the knee, then bend the ankle/flex and point the toes. If appropriate, repeat with the other leg.	Patient exhibits lower extremity stability, strength and control. May test only one leg and proceed accordingly (e.g., stroke patient, patient with ankle in cast).	MOBILITY LEVEL 2 - Use total lift for patient unable to weight-bear on at least one leg. - Use sit-to-stand lift for patient who can weight-bear on at least one leg.	Passed Assessment Level 2 = Proceed with Assessment Level 3.
Assessment Level 3 Assessment of: -Lower extremity strength for standing	Stand: Ask patient to elevate off the bed or chair (seated to standing) using an assistive device (cane, bedrail). Patient should be able to raise buttocks off bed and hold for a count of five. May repeat once. Note: Consider your patients cognitive ability, including orientation and CAM assessment if applicable.	Patient exhibits upper and lower extremity stability and strength. May test with weight-bearing on only one leg and proceed accordingly (e.g., stroke patient, patient with ankle in cast). If any assistive device (cane, walker, crutches) is needed, patient is Mobility Level 3.	MOBILITY LEVEL 3 - Use non-powered raising/stand aid; <i>default to powered sit-to-stand lift if no stand aid available.</i> - Use total lift with ambulation accessories. - Use assistive device (cane, walker, crutches). NOTE: Patient passes Assessment Level 3 but requires assistive device to ambulate or cognitive assessment indicates poor safety awareness; patient is MOBILITY LEVEL 3.	Passed Assessment Level 3 AND no assistive device needed = Proceed with Assessment Level 4. Consult with Physical Therapist when needed and appropriate.
Assessment Level 4 Assessment of: -Standing balance -Gait	Walk: Ask patient to march in place at bedside. Then ask patient to advance step and return each foot. Patient should display stability while performing tasks. Assess for stability and safety awareness.	Patient exhibits steady gait and good balance while marching, and when stepping forwards and backwards. Patient can maneuver necessary turns for in-room mobility. Patient exhibits safety awareness.	MOBILITY LEVEL 3 If patient shows signs of unsteady gait or fails Assessment Level 4 , refer back to MOBILITY LEVEL 3; patient is MOBILITY LEVEL 3.	MOBILITY LEVEL 4 MODIFIED INDEPENDENCE Passed = No assistance needed to ambulate; use your best clinical judgment to determine need for supervision during ambulation.

Always default to the safest lifting/transfer method (e.g., total lift) if there is any doubt in the patient's ability to perform the task.

Originated: 2011; revised: 2/27/12, 3/02/12, 3/07/12, 3/19/12, 4/19/12, 5/01/12, 5/03/12, 05/20/2013

APPENDIX VII: MEDICATION SIDE EFFECTS INFORMATION SHEET

Associated Hospital/Organization: Memorial Hospital, Colorado Springs

Purpose of Tool: A patient teaching tool to help patients understand what medication side effects can increase their risk for falls

Reference: <http://www.hret-hiin.org/resources/display/medication-side-effects-information-sheet>



Medication Side Effects Information Sheet

This chart provides you with information about the most common side effects of medicines that are prescribed in a hospital or may be prescribed to take following a hospital stay. Please ask your nurse if you have any questions or concerns.

Reason	Names: Generic (Brand)	Most Common Side Effects
Pain Relief 	Examples: - Acetaminophen - Fentanyl - Hydrocodone/Acetaminophen (Vicodin, Lortab, Norco) - Hydromorphone (Dilaudid) - Morphine - Oxycodone (Percocet, Roxycodone) - Oxycontin - Tramadol (Ultram)	Side Effects May Cause: - Dizziness - Drowsiness - Constipation - Queasiness - Vomiting - Rash - Confusion
Queasiness/Vomiting 	Examples: - Metoclopramide (Reglan) - Ondansetron (Zofran) - Promethazine (Phenergan) - Scopolamine Patch	Side Effects May Cause: - Headache - Constipation - Fatigue/tiredness - Drowsiness
Heartburn or Reflux 	Examples: - Calcium Carbonate (Tums) - Esomeprazole (Nexium) - Lansoprazole (Prevacid) - Omeprazole (Prilosec) - Pantoprazole (Protonix)	Side Effects May Cause: - Headache - Diarrhea
Lowers cholesterol 	Examples: - Atorvastatin (Lipitor) - Pravastatin (Pravacho) - Rosuvastatin (Crestor) - Simvastatin (Zocor)	Side Effects May Cause: - Headache - Muscle pain - Upset stomach
Blood Thinner/Blood Clot Treatment 	Examples: - Aspirin - Clopidogrel (Plavix) - Apixaben (Eliquis) - Enoxaparin (Lovenox) - Fondaparinux (Arixtra) - Heparin - Rivaroxaban (Xarelto) - Warfarin (Coumadin)	Side Effects May Cause: - Risk of bleeding - Upset stomach

Chronic use may increase the risk of falls, as well as the risk of delirium in people ages 65 and older. Delirium is the sudden onset of a serious disturbance in a person's mental abilities resulting in severe confusion and a decreased awareness of one's environment.

APPENDIX VIII: SAFE FROM FALLS ROADMAP

Associated Hospital/Organization: Minnesota Hospital Association

Purpose of Tool: Provides guidance in conducting a gap analysis on Fall Injury Risk reduction for Patients on Anti-thrombotics.

Reference: <http://www.hret-hiin.org/resources/display/safe-from-falls-3-0-roadmap>

SAFE from FALLS 3.0

Audit Questions	Yes	No
Falls screening & assessment of fall AND injury risk factors		
1a) The organization requires, and has a designated place to document, screening of all patients for fall risk factors within 8 hours of admission for inpatients.	☐	☐
1b) The organization requires, and has a designated place to document, screening of all patients for injury risk factors (i.e., ABCs – Age; Bones; Coagulation; post-Surgical) within 8 hours of admission for inpatients.	☐	☐
Anticoagulants (Increased injury risk for patients taking anti-coagulants)		
2a) Inpatients on anticoagulants are identified within 4 hours of admission during the medication reconciliation process.	☐	☐
2b) Nursing falls screening also captures anticoagulant use as part of fall injury risk screening.	☐	☐
2c) Anticoagulation usage is flagged within the electronic medical record to increase awareness across providers and nursing staff.	☐	☐
2d) The care plan is reviewed for patients on anticoagulants to include interventions specific to anti-coagulant risk: • Patient is evaluated for discontinuation of anti-platelets by the provider • Patients are encouraged to wear shoes during ambulation versus slippers • Perform environmental checks to make sure any possible environmental hazards are mitigated (e.g., no sharp corners, reduce equipment/furniture by bed that patient could hit if they do fall, obstacles between bed and bathroom) • Institute "Within Arms Reach" with toileting and ambulation for all patients on anticoagulants • Video-monitored bed (if available) if meets following criteria: on anticoagulants; impulsive or confused; risk of falling • If video-monitoring is not available, evaluate for bed/chair alarms	☐	☐
2e) Patient and family education is provided outlining increased risk for injury for patients on blood thinners along with fall and injury prevention strategies and steps to take if the patient does fall.	☐	☐
Linking interventions to specific risk factors		
3a) The organization has decision-support tools accessible (electronic or paper) that provide staff with the interventions that should be considered for each fall and injury risk factor.	☐	☐
Learning from events (Post-fall huddles)		
A post-fall policy and process is in place that includes, at minimum:		
4a) A fall with suspected injury to the head, or an unwitnessed fall, experienced by a patient taking anticoagulants is included as part of a Rapid Response Team or Rapid Response Process (if a fall was unwitnessed, it is assumed the patient hit their head).	☐	☐
4b) Vital signs and neurological checks are performed immediately post fall at the following intervals, at minimum: • q15 minutes x 2, then • q 30 minutes x2, then • q 1 hour x 4, then • q 4 hours for 24 hours • Re-evaluate the need for frequent monitoring after 24 hours.	☐	☐
4c) Changes in patient's status are reported promptly to the physician, especially if patient is on anticoagulants.	☐	☐
Safe environment (Rounding; equipment such as video monitoring and alarms; room design)		
5a) The organization has conducted an assessment of the bathroom, and pathways to the bathroom, identifying opportunities for reducing hazards.	☐	☐
5b) Environmental changes have been instituted in patient rooms and bathrooms to reduce hazards while in the bathroom or on the way to the bathroom.	☐	☐
5c) A process is in place for staff to perform fall prevention checks as part of their rounding process for every patient, which includes ensuring alarms are activated and working properly.	☐	☐

APPENDIX IX: FALL PREVENTION PARTNERSHIP AGREEMENT

Associated Hospital/Organization: Cox Health

Purpose of Tool: To engage patients in their fall prevention plan and create shared goals and strategies to keep the patient safe.

Retrieved at: <http://www.hret-hiin.org/resources/display/coxhealth-preventing-falls-in-the-hospital-fall-prevention-partnership>

NOSCAN *NOSCAN*	CoxHealth Springfield, MO All Departments	Patient Sticker
PREVENTING FALLS IN THE HOSPITAL FALL PREVENTION PARTNERSHIP		
We would like your stay at CoxHealth to be as safe as possible. We would like to partner with you to help decrease your chance of experiencing an accidental fall.		
➤ Please do call for assistance when you need to get out of bed. Some medications may have side effects that make you feel weak or dizzy. ➤ Please wear the provided non-skid slippers when up. ➤ Please use only unmoving objects to help steady yourself. Don't use your IV pole, tray table, wheelchair, or other objects that can move. These items have wheels and could roll away from you. ➤ Please use the handrails in the bathroom and hallway. ➤ If you wear glasses or hearing aides at home, please use them while in the hospital as well. ➤ Please be aware of tubing, such as oxygen, catheters, etc. that may interfere with walking. By calling for assistance, staff can assist you and keep you safe. ➤ If you notice any spills or wet areas on the floor, please notify staff so they may be cleaned up quickly.		
It is our goal to round hourly from 6am to 10pm and every two hours from 10pm to 6am to see if you need assistance to the bathroom, are in pain, are in a comfortable position and have all items you may need within your reach. It is our goal to respond to your call light timely and address any needs you may have.		
By partnering together we can make your experience while in the hospital a safe one.		
I will partner with my caregivers by being aware of the guidelines listed above and will notify nursing staff if my care expectations or needs are not being met.		
Review Date: 6/05/2012 CPS-7406.02 6-12 Rev 5-12 Not a Permanent Part of the Patient Chart Page 1 of 2		

APPENDIX X: FALL SAFETY TIPS FOR PATIENTS AND FAMILIES

Associated Hospital/Organization: HRET HIIN

Purpose of Tool: This checklist can be used as a reinforcement for verbal instruction and teach-back for patient and families.

Reference: <http://www.hret-hiin.org/resources/display/hret-fall-prevention-tips-for-hospital-patients-and-families>

AHA/HRET Fall Prevention Tips for Hospital Patients and Families



Did you know?

A fall in the hospital can lead to serious injury. You and your family can partner with your care team to reduce the risk of falling. You may be at greater risk of falling in the hospital because your room is different from your room at home and you may not get as much sleep. In addition, certain medications and staying in bed longer than usual can make you dizzy or unsteady on your feet.

How can you help prevent a fall and injury?

	Let your care team know if you have ever fallen at home or what you do at home to prevent falls.
	Always ask for help when you are getting up.
	Sit up slowly and sit on the side of the bed for a few minutes before standing.
	Wear shoes or slippers that do not slide and wear your glasses or hearing aid.
	Before you get up, look for cords, medical equipment or other items in your path so you are less likely to trip.
	Don't hold on to bedside tables or other furniture or equipment that could roll away.
	Keep your call light, phone, glasses, remote and other personal items within reach.
	Tell your care team if you are feeling dizzy, unusually tired or confused. These may be side effects from your medications.
	As encouraged by your care team, walk with your nurse, therapist or loved one and do exercises in bed to keep up your strength.
	Family members or other care partners are welcome to stay with you in the hospital. They too can help you prevent falls.
	Ask your doctor or nurse how you can stay safe and prevent falls in the hospital and at home.

Call, don't fall! Please stay safe in the hospital.



APPENDIX XI: TEACH BACK TOOL FOR FALL PREVENTION

Associated Hospital/Organization: VA National Center for Safety, Patricia Quigley

Purpose of Tool: To guide nurses in key components of teaching fall prevention to patients and families and provide teach back questions that can be used to evaluate the patient's understanding.

Reference: Quigley,P. (2016, December) Autonomy and the patient's right to choose falls prevention. American Nurse Today, 11(12). Retrieved on December 17, 2016 at:
<https://www.americanursetoday.com/autonomy-patients-right-choose-falls-prevention/>

Using Teach Back to Redesign Patient Teaching: Fall Prevention and Injury Protection

First 24 hours of Admission: Use Teach Back with patients to improve understanding of:

1. The top 3 reasons you are at risk for falling and/or injury (Based on your fall risk assessment and history of injury risk)
2. The 3 main reasons fall prevention is important
 - a. Falls for the most part are preventable
 - b. Falls can result in injury
 - c. Falls can make your hospital stay longer
3. Three actions you can take to stay safe
 - a. Learn about your fall risk factors
 - b. Call first for help (using the call light)
 - c. Wait for help before your get out of bed or up from a chair
4. Two important safety reasons why you need to ask for help when needing to go to the bathroom
 - a. The hospital bathroom is not like yours at home, and unfamiliar places can increase your risk of falling
 - b. Bathrooms are unsafe areas because they are small and it is easy to lose your balance or become dizzy.
5. The main purpose for you to use the call light
 - a. To call the nursing staff for help.
 - b. Let's find where your call light is — at your bedside and in the bathroom
 - c. Demonstrate use of the call light at both the bedside and the bathroom
6. The main reason we want you to wear your non-slip footwear?
 - a. To prevent feet from slipping on the floor, which can increase your fall risk.
7. Choosing not to call for help: What happens if you experience an accident and that accident is a fall?
 - a. You could be injured
 - b. Your length of stay could be increased
 - c. You may not be able to go home when you planned

Knowledge Test After and Return Demonstration

Checklist: Total Score: 18 points

1. What are the top 3 reasons you are at risk for falling and/or injury? (Based on your fall risk assessment and history of injury risk)
 - a. _____
 - b. _____
 - c. _____
2. What are the 3 main safety reasons fall prevention is important? Answers:
 - Falls for the most part are preventable
 - Falls can result in injury
 - Falls can make your hospital stay longer
 - a. _____
 - b. _____
 - c. _____
3. What are 3 actions can you take to stay safe? Answers:
 - Learn about your fall risk factors
 - Call first for help (using the call light)
 - Wait for help before your get out of bed or up from a chair
 - a. _____
 - b. _____
 - c. _____
4. What are 2 important safety reasons you should ask for help when going to the bathroom? Answers:
 - The hospital bathroom is not like yours at home, and unfamiliar places can increase your risk of falling.
 - Bathrooms are unsafe areas because of the small room size and it is not easy to move around. It is easy to lose your balance or become dizzy.
 - a. _____
 - b. _____

APPENDIX XI: TEACH BACK TOOL FOR FALL PREVENTION (continued)

Associated Hospital/Organization: VA National Center for Safety, Patricia Quigley

Purpose of Tool: To guide nurses in key components of teaching fall prevention to patients and families and provide teach back questions that can be used to evaluate the patient's understanding.

Reference: Quigley,P. (2016, December) Autonomy and the patient's right to choose falls prevention. American Nurse Today, 11(12). Retrieved on December 17, 2016 at:
<https://www.americanursetoday.com/autonomy-patients-right-choose-falls-prevention/>

5. What is the main purpose for you to use the call light? Answers:
- To call the nursing staff for help.
 - Let's find where your call light is – at your bedside and in the bathroom
 - Demonstrate use of the call light at both the bedside and the bathroom
- a. _____
- b. _____
- c. _____

6. What is the main reason we want you to wear your non-slip footwear? Answer:
- To prevent feet from slipping on the floor, which can increase your fall risk.
- a. _____

7. What could happen if you choose not to call for help? Answers:
- You could fall and be injured
 - Your length of stay may be increased
 - You may not get to go home when planned
- a. _____
- b. _____
- c. _____

Ask for Return Demonstration: *Points: 5 possible*

Show me:

1. Location of call light — bedside
2. Use of call light — bedside
3. Location of call light — bathroom
4. Use of call light — bathroom
5. Non-skid slippers correctly on feet
6. Others?

At least 5 action items.

Points awarded: _____ / 5 possible

Be sure to cover:

- > What is my main problem?
- > What do I need to do (for that problem)?
- > Why is that important?

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