FALLS WITH INJURY CHANGE PACKAGE

Preventing Harm from Falls

2014 UPDATE
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The AHA/HRET HEN would like to acknowledge our partner, Cynosure Health, for their work in developing the Falls with Injury Change Package.
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WHAT’S NEW IN THIS EDITION?
• New Primary Driver Added – Prevent the Hazards of Immobility, focusing on rehabilitation assessments, progressive activity, and regularly scheduled ambulation.
• Expanded definitions of the types of falls, and which types are preventable.
• Increased focus on hourly rounding as a fall-prevention strategy, with sample tools for evaluating competency and documenting rounds.
• Increased emphasis on the role of the Pharmacy in evaluating “culprit” medications and participating in post-fall huddles. A sample Fall Medication Review Tool is included.
• Sample Post-Fall Huddle Tools.
• Sample Post-Partum Fall Risk Assessment Tool.

OVERVIEW
Background
• Among older adults, ages 65 or better, falls are the leading cause of injury-related death (CDC). Falls are also the most common cause of non-fatal injuries and of hospital admissions for trauma.
• In acute and rehabilitation hospitals, falls resulting in injury occur in 30% to 51% of patients, and falls resulting in fracture occur in 1% to 3% of patients.
• Falls are associated with increased lengths-of-stay, increased utilization of health care resources, and poorer health outcomes.
• Soft tissue injuries or minor fractures can cause significant functional impairment, pain, and distress. Even “minor” falls can trigger a fear of falling in older persons, leading them to limit their activity and lose their strength and independence.

Suggested A1Ms
• Reduce the number of patient falls with injury, organization-wide, by 40% by December 8, 2014.
• Reduce falls with and without injury to less than 2.15 per 1,000 patient days by December 8, 2014.
• Decrease minor-to-severe injuries from falls rate to less than 0.5 per 1,000 patient days by December 8, 2014.

Potential Measures
Outcome: 1. Minor-to-severe injuries from falls (the rate per 1,000 discharges). (EOM-Falls-38)
2. The number of patient falls with and without injury to the patient, by type of unit, during the calendar month. (EOM-Falls-37)
3. Days Between Falls (Rural/CAH Data Collection Tool)

Process: 1. The percentage of fall risk assessments completed within 24 hours of admission. (EOM-Falls-34)
2. The percentage of risk-for-injury assessments completed within 24 hours of admission. (EOM-Falls-130)
### PRIMARY DRIVERS

#### Fall and Injury Risk Assessment
- Conduct a fall risk assessment upon admission using a validated instrument.
- Assess a patient’s fall risk by asking the patient and family what they do outside the hospital to prevent falls.
- High risks for injury include patients with the **ABCS** — **A**ge > 85, **B**one, **C**oagulopathies or anti-Coagulation, **S**urgical patients.
- Conduct ongoing reasse ssments, including the identification of new and/or changed medications that increase the risk of falls.
- Perform rounds every 1-2 hours to assess and address patient needs for the Ps: pain, position, potty, personal belongings, and safe pathway.

#### Communicate and Educate about Patients’ Fall and Injury Risks
- Use standardized visual cues to communicate high fall risk/injury risk to all care members.
- Use standardized hand-off communications between hospital staff members.
- Use the “Teach-back” method when providing education.
- Conduct post-fall huddles at the bedside, and include patients and/or family.
- Conduct shift huddles to communicate fall/injury risks to all staff.

#### Interventions for All Patients: Identify Modifiable Fall Risk Factors and Customize Interventions
- Use Visual/Audible cues, e.g. colorful, easy-to-view alert wristbands; bedside risk signs; non-skid footwear.
- Medication Review – Avoid unnecessary hypnotic/sedative medications.
- Create a safe environment for patients by eliminating injury hazards (e.g. sharp edges)
- Involve facility management and housekeeping staff in the process by developing and utilizing a checklist for the environment and for equipment safety.
- Use beds that are lower/closer to the floor.
- Enlist family and caregivers to help prevent falls, e.g. have them sit with the patient during vulnerable times.
- Proactively round on patients to anticipate needs, and to provide assistance.
- Educate patients about the positive benefits of interventions (enhancing independence and quality of life) rather than the negative (i.e., risk of falls).
- Promote inter-disciplinary participation, including nursing, medical staff, pharmacy, therapy staff, environmental services, and engineering/maintenance, in safety programs.

#### Individualized Interventions for Moderate/High-Risk Patients
- Increase the frequency of rounding.
- Develop a checklist for room set-up for high-risk patients.
- Implement environmental changes (e.g., move high-risk patients closer to the nursing station).
- Offer assistive devices (walking aids, transfer bars, bedside commodes, etc.) located on the exit side of the bed.

#### Prevent Hazards of Immobility
- Trigger consultation with PT/OT services if appropriate based upon RN admission assessment for all patients with mobility, functional or cognitive deficits.
- Reassess bed-rest orders daily.
- Include a mobility/activity plan for each patient which includes progressive increases in activity levels and scheduled ambulation.
- Manage postural hypotension.

### Key Resources
- **Hospital Elder Life Program (HELP).** Retrieved at: [http://www.hospitalelderlifeprogram.org/](http://www.hospitalelderlifeprogram.org/)
- **IHI How to Guide Reducing Injuries from Falls.** Retrieved at: [http://www.ihi.org/knowledge/Pages/Tools](http://www.ihi.org/knowledge/Pages/Tools)
- **Transforming Care at the Bedside How-to Guide: Reducing Patient Injuries from Falls.** Retrieved at: [http://www.ihi.org/resources/Pages/Tools/TCABHowToGuideReducingPatientInjuriesfromFalls.aspx](http://www.ihi.org/resources/Pages/Tools/TCABHowToGuideReducingPatientInjuriesfromFalls.aspx)
**DRIVER DIAGRAM**

**AIM:** Reduce the number of falls, with or without injury, by 40% by 12/8/2014.

**AIM:** Reduce the number of falls with injury, minor or greater, by 40% by 12/8/2014.

**AIM:** Reduce the rate of falls with or without injury to less than 2.15 per 1,000 patient days by 12/8/2014.

**AIM:** Reduce the rate of falls with injury, minor or greater to less than 0.5 per 1,000 patient days by 12/8/2014.

<table>
<thead>
<tr>
<th>PRIMARY DRIVERS</th>
<th>SECONDARY DRIVERS</th>
<th>CHANGE IDEAS</th>
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</table>
| **Fall and Injury Risk Assessment** | • Conduct a fall risk assessment upon admission using a validated risk assessment tool.  
• Include, as part of the fall assessment, an inquiry about the patient’s level of mobility, history and circumstances of previous falls, and the fall-prevention measures utilized at home.  
• Develop mobilization protocols that trigger a referral to PT and/or OT.  
• Conduct ongoing reassessments of risk factors including new medication orders.  
• Re-assess a patient’s risk factors frequently.  
• Perform rounds every 1-2 hours to assess and address patient needs for the 3 “P’s”: positioning, pain and potty. | • The most commonly used risk assessment is the Morse Falls Score. Others include: Conley, Hendrich II, and the clinical judgment of nursing staff.  
• Use the ABCS Falls Assessment: Age, Bones, Coagulation, and Surgery to assess for risk for injury.  
• Orient patients to their surroundings.  
• Place fall risks on all hand-off communication forms and use ticklers to trigger review when giving a verbal hand-off.  
• Instruct patients about appropriate medication time/dose, side effects, and interactions with food or other medications.  
• Ask for pharmacist review of medications when a patient is at risk.  
• Designate the times of day that 3P rounds are to be conducted and provide loud-and-clear announcements as reminders.  
• Combine 3P rounds with other care related tasks, such as vital signs. |

| **Communicate and Educate about Patients’ Fall and Injury Risks** | • Communicate each patient’s fall risk to all staff.  
• Educate the patient and family members about fall risks. | • Use standardized visual cues to communicate fall risk to all care providers.  
• Conduct shift huddles to review patients at risk for fall or injury with all staff.  
• Use standardized hand-off communications between staff members.  
• Use the “Teach-back” method when providing education.  
• Determine who the learner(s) is/are.  
• Conduct post-fall huddles and involve the patient and/or family.  
• Provide specialized education to patients and families about risk for injury related to blood thinners. |
<table>
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<th>PRIMARY DRIVERS</th>
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<th>CHANGE IDEAS</th>
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<tr>
<td><strong>Interventions for All Patients: Identify Modifiable Fall Risk Factors and Customize Interventions</strong></td>
<td>• Implement patient-specific interventions to prevent falls.</td>
<td>• Use colorful, easy-to-view alert wristbands, bedside risk signs, non-skid footwear, and risk stickers on the chart.</td>
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<td></td>
<td>• Implement environmental interventions to prevent falls.</td>
<td>• Have family/caregivers sit with the patient during vulnerable times.</td>
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<td>• Implement intentional rounding on patients.</td>
<td>• Implement intermittent regular observation through hourly “rounding” by staff.</td>
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<td></td>
<td>• Use Visual/Audible Cues.</td>
<td>• Use “Teach-back” methods with patients and their families.</td>
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<td></td>
<td>• Staff education — Ensure staff are capable of performing a thorough fall assessment.</td>
<td>• Recruit a multi-disciplinary group of champions to address fall reduction, which includes nurses, doctors, pharmacists, PTs and OTs.</td>
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<td></td>
<td>• Medication Review — Avoid unnecessary hypnotic/sedative medications.</td>
<td>• Create a safe environment for patients by eliminating hazards.</td>
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<td></td>
<td>• Use beds that are lower/closer to the floor except when the patient is standing or during transfer.</td>
<td>• Involve facility management and housekeeping staff by developing and implementing a checklist for environmental and equipment safety.</td>
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<td></td>
<td>• Involve family and caregivers in efforts to prevent falls.</td>
<td>• Facilities/EVS — engage EVS staff as part of team to develop the checklist. The checklist should include:</td>
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<tr>
<td></td>
<td>• Patient education — emphasize the positive benefits of interventions (enhancing independence and quality of life) rather than the negative (i.e. risk of falls).</td>
<td>— All lights are working properly.</td>
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<tr>
<td></td>
<td>• Achieve multi-disciplinary buy-in, including among nurses, doctors, pharmacists, physical therapists, and support staff responsible for housekeeping and building maintenance.</td>
<td>— Area is clear of obstructions.</td>
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<td></td>
<td><strong>Individualized Interventions for Moderate/High-Risk Patients</strong></td>
<td>— Hand-rails are accessible.</td>
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<td></td>
<td>• Increase the frequency of rounding.</td>
<td>— Floors are dry.</td>
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<tr>
<td></td>
<td>• Enhance environmental improvements.</td>
<td>— Furniture is sturdy.</td>
</tr>
<tr>
<td></td>
<td>• Develop a checklist for room set-up for high-risk patients.</td>
<td>— Flooring is level and free of tripping hazards.</td>
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<td></td>
<td>• Use technology to assist.</td>
<td>— Grab-bars are in place in the toilet and shower.</td>
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<tr>
<td></td>
<td><strong>Prevent Hazards of Immobility</strong></td>
<td>— Electrical cords are secured out of the way.</td>
</tr>
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<td></td>
<td>• PT/OT services should be triggered by RN admission assessment for all patients with mobility, functional or cognitive deficits.</td>
<td>• Locate the patient as close as possible to the nursing station.</td>
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<td></td>
<td>• Include a mobility/activity plan for each patient which includes progressive increases in activity levels and scheduled ambulation.</td>
<td>• Place a non-slip/skid-padded floor mat on the exit side of the bed.</td>
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<tr>
<td></td>
<td><strong>Primary drivers</strong></td>
<td>• Locate assistive devices (walking aids, transfer bars, bedside commodes, etc.) on the exit side of the bed.</td>
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<td><strong>Secondary drivers</strong></td>
<td>• Use lighted hand-rails.</td>
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<td></td>
<td><strong>Change ideas</strong></td>
<td>• Implement an individualized toileting schedule.</td>
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<td>• Use hip protectors.</td>
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<td>• Keep audible bed and chair alarms, if available, on the “on” position.</td>
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<td></td>
<td><strong>Prevent Hazards of Immobility</strong></td>
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<td></td>
<td>• On admission, assess gait, balance, and lower extremity muscle strength.</td>
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<td>• Include the mobility plan on the patient whiteboard.</td>
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<td>• Involve the family in the ambulation plan.</td>
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<td>• Keep gait belts in patient rooms.</td>
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</table>
Prevention of Falls with Injury

Patient and family falls are among the most frequently reported incidents in hospitals and other healthcare facilities. Many inpatient falls cause little or no harm, but falls can sometimes lead to severe injuries such as hip fractures and head trauma, and are a significant cause of hospital-acquired injury.

Definitions of levels of injury from NDNQI (National Database for Nursing Quality Indicators)

- **None** – patient had no injuries (no signs or symptoms) resulting from the fall, if an x-ray, CT scan or other post fall evaluation results in a finding of no injury
- **Minor** – resulted in application of a dressing, ice, cleaning of a wound, limb elevation, topical medication, bruise or abrasion
- **Moderate** – resulted in suturing, application of steri-strips/skin glue, splinting or muscle/joint strain
- **Major** – resulted in surgery, casting, traction, required consultation for neurological (basilar skull fracture, small subdural hematoma) or internal injury (rib fracture, small liver laceration) or patients with coagulopathy who receive blood products as a result of the fall
- **Death** – the patient died as a result of injuries sustained from the fall (not from physiologic events causing the fall)

Immobility and fall risk are closely linked. Immobility is a decrease in the amount of time spent up and moving (for example, getting out of a bed or chair and walking). Immobility causes loss of muscle strength, along with changes in the cardiac response to exercise. Immobility in the hospital increases the chances of delirium, pressure ulcers, venous thromboembolism, falls, and functional decline, especially in the elderly, who account for nearly half of hospitalized patients. Unfortunately, the hospital environment is often not conducive to promoting or achieving the therapeutic goals for the elderly. (xii) The hospital environment is traditionally focused on managing illness, not on improving function. By implementing a focus on maintaining function and mobility, hospitals can mitigate the hazards of immobility that contribute to fall risk and demonstrate improved patient outcomes.

The Partnership for Patients estimates that 25% of fall injuries are preventable. Morse defines four types of falls, two of which are preventable. Preventable types of falls include accidental falls and anticipated physiological falls. Other types of falls include unanticipated physiological falls and behavioral (intentional) falls.

- **Accidental Fall**: Falls that occur due to extrinsic environmental risk factors or hazards such as spills on the floor, clutter, tubing/ cords on the floor, etc.; or errors in judgment, such as not paying attention.
- **Anticipated Physiological Falls**: Falls associated with known risks, such as those indicated on the Morse Fall Scale, that are predictive of a fall occurring, such as loss of balance, impaired gait or mobility, impaired cognition/confusion, or impaired vision. Anticipated falls that we anticipate will occur due to the patient's existing physiological status, history of falls, and decreased mobility upon assessment.
- **Unanticipated Physiological Falls**: Falls associated with unknown factors and risks that were not predicted (or could not be predicted) by a fall risk assessment, such as unexpected orthostasis, extreme hypoglycemia, stroke, heart attack, or seizure.
- **Behavioral (Intentional) Fall**: These falls occur if a patient who has behavioral issues voluntarily positions his/her body from a higher level to a lower level.


The goal toward which hospitals are aiming is to cut the number of preventable fall injuries in half by the end of 2014, while maintaining or increasing patients’ mobility. If continued for three years, successful efforts would prevent a total of 43,750 fall injuries.

Agreed-upon and evidence-based strategies to prevent falls and injuries in the hospital setting have been challenging to establish, but there is consensus to encourage safe mobility for patients. Efforts to reduce falls and fall injuries, while increasing safe patient activity, focus on risk assessment, followed by inter-disciplinary and multi-component interventions, and include:

- **Avoidance of ordering bed-rest**;
- **Institution of a toileting schedule to assure that a patient has help walking to and from the bathroom at regular intervals**;
- **Frequent walks with spotters or assistance as needed**;
- **Frequent reorientation if a patient is confused**;
- **Provision of a safe environment which includes good lighting, a bed that lowers to the floor, appropriate assistive devices, and removal of clutter**;
- **and, avoidance or reduction of medications that may cause dizziness, drowsiness, or confusion**.
Devices such as bed and chair alarms that alert staff to a patient's movement should be used only in combination with inter-disciplinary and multi-component responses to avoid the consequences of immobility.

**SUGGESTED AIM STATEMENTS**

- Reduce the number of patient falls, organization-wide, by 40% by December 8, 2014.
- Reduce the number of patient falls, to below 2.15 per 1,000 patient days by December 8, 2014 (CMS Benchmark).
- Reduce the number of preventable patient falls to zero for 6 consecutive months by December 8, 2014.
- Reduce the number of patient falls with minor-to-severe injuries, organization-wide, by 40% by December 8, 2014.
- Reduce the number of patient falls with minor to severe injuries to less than 0.5 per 1000 patient days (CMS Benchmark).
- Reduce moderate-to-severe injuries from falls to 0.01 per 1,000 patient days by December 8, 2014.

**SUGGESTED OUTCOMES MEASURES**

- EOM 37 – Falls with or without injury per 1,000 patient days
- EOM 38 – Falls with injury (minor or greater) per 1,000 patient days.
- Days since last fall
- Days since last fall with injury

**ASSESS RISK FOR FALLING AND RISK FOR SERIOUS INJURY FROM A FALL**

An accurate assessment of a patient’s risk for falling and risk for injury from a fall is a crucial first step in preventing injuries. Assessments also help focus resources towards those patients most likely to benefit from interventions. Developing a method for assessing risk is a key first step in every fall-prevention program.

**Secondary Driver: Perform a standardized fall risk assessment for all patients on admission and with every change in status.**

All patients who enter the institution must be assessed for risk of falling and risk of injury from falls. A validated, standardized assessment tool that can be used in a variety of patient settings, is simple to use, and does not take a lot of time to complete, is essential to this process. An assessment tool should identify and stratify the risk of falling for each assessed patient.

**Change Ideas: Morse Fall Scale**

- Trial a validated risk assessment tool that is already in existence, such as the Morse Fall Scale (See Appendix I), on a small number of patients. (iiiiiv)
  - Define, as an organization, when initial fall risk assessments should be done.
  - Define, as an organization, who is responsible for performing the initial fall risk assessments.
  - Define, as an organization, who is responsible for the initiation of the care plan to mitigate risk for each patient.
  - Define, as an organization, how to incorporate an interdisciplinary approach to implementing a fall risk assessment.

**Suggested Process Measure**

- Percentage of patients with a completed inter-disciplinary fall risk assessment at admission.

**Secondary Driver: Identify those patients at high risk for injury from falls.**

Prevention of falls with injuries requires special consideration and assessment of patients at risk. Patients at the highest risk for injury if they sustain a fall are those who are over age 85 or frail due to a medical condition, have a history of orthopedic conditions, are on anti-coagulation therapy, have a bleeding disorders, and/or are post-surgery or post-procedure.

The ABCS of risk for injury (Age, Bones, Coagulation, Surgery) from a fall represent an important subset of all falls. Focusing on all patients and ignoring the greater fall risks for the ABCS population is a common mistake.

**Change Ideas: The ABCs of highest-risk patients**

- Assess and re-assess fall risk status for patients at the highest risk for injury from a fall at every shift.
- Conduct shift huddles to review patients 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. Trial an injury risk assessment tool on a small number of patients (See Appendix II for a sample Injury Risk Assessment).
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.

**Suggested Process Measures**
- **Percentage of patients identified at highest risk for injury from a fall** reassessed as per policy
- **Percentage of high-risk patients correctly identified** as high risk for injury during initial fall risk assessment.
- **Percentage of patients with individualized injury prevention precautions in place**, e.g. hip protectors or floor mat in place, helmet worn.

**“Hardwiring” Risk Assessment for Falling and for Serious Injury from a Fall in Improvement Plans**

Hardwiring methods include incorporating fall risk assessments in the admission process and as part of routine assessment. The fall risk assessment tool should be included in the clinical record documentation. Another hardwiring method is to create and implement an admissions checklist to ensure that all elements of fall risk assessment are completed and prevention methods are instituted when indicated.

**COMMUNICATE AND EDUCATE ABOUT PATIENT’S FALL AND INJURY RISK**

Communication among all care providers, as well as with the patient and family, is key to avoiding falls and reducing injuries related to falls. Verbal and visual communication tools at the appropriate level and in the appropriate language can be used to educate and remind others of a patient’s fall risk. For patients on anti-coagulation therapy, provide specific discharge education regarding what to do if they experience a fall as well as about their risk for internal or intra-cranial hemorrhage. (See Appendix XIV)

**Secondary Driver: Communicate to all staff a patient’s fall risk.**

Staff members who are aware of a patient’s risk for falling should implement fall precautions appropriate for the patient’s level of care. All hospital staff should be aware of signals of high risk for falls and should contribute to the monitoring of these patients’ safety.

**Change Ideas: Communicate fall risk**

- Use standardized visual cues to communicate high fall risk/injury risk to all care members.
  - 1. Place red- or yellow-colored, non-skid socks on all patients at risk for falling.
  - 2. Colored wrist bands or a colored blanket on the bed or on the patient's lap can also be used.
  - 3. Use signage in or outside the patient room to represent fall risk, being careful to maintain respect and dignity for the patient's privacy (See Appendix III).
    - Some hospitals use a picture of a leaf on the door to represent a risk for falling, with a red leaf signaling a high risk of injury from falls.
    - Other hospitals simply use colored signs or other symbols to represent fall risk.
- Use standardized hand-off communications between hospital staff members at change-of-shift or changes in departments
- Add fall risk, risk for injury, history of falls, changes in fall risk, and fall-prevention measures for each patient in the hand-off checklists that are standardized across the organization. (See Appendix IV for the sample, Hand-off Communications for Inpatient Psychiatry, which can be modified and used in other types of units).
- Conduct post-fall huddles immediately after a fall with the involved staff to analyze how and why the patient fell, and to implement changes to prevent subsequent falls. Conduct the huddle at the patient's bedside and involve the patient, focusing on “what was different or what circumstances contributed to your fall in this situation?"
  1. Involve the patient.
  2. 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 to contribute to the post-fall plan.

**Suggested Process Measures**

- **Percentage of patients identified as having a fall risk with visual cues in place**, as per hospital policy.
- **Percentage of hand-offs that include a discussion about patient’s fall risk**, as observed or documented.
- **Percentage of Post Fall Huddles Completed within timeframe** identified by hospital
**Secondary Driver: Educate the patient and family members.**

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. Healthcare providers should also assess the level of understanding patients and families have about fall risks and recommended precautionary measures.

**Change Ideas: Strategies to strengthen education**

- Determine who the learner 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.
- Include the fall prevention program on the patient’s whiteboard.
- 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, such as reminders to use the call bell.
  - After providing education, ask patients and/or family members to restate in their own words the information they heard during the education session.
  - 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**

- **Percentage of fall education sessions which include the “Teach Back” method**, as observed.
- **Percentage of bedside hand-offs** that include the patient and family in fall prevention.

**“Hardwiring” Communicate and Educate about Patients’ Fall Risks in Improvement Plans**

Integrating fall precautions into care routines will help to ensure that prevention is addressed reliably for each patient, each day.

- Implement standardized hand-off communications among hospital staff members at changes-of-shift or changes in departments.
- Include fall risk prevention as a routine part of multi-disciplinary rounds.

**INTERVENTIONS FOR ALL PATIENTS: IDENTIFY MODIFIABLE FALL RISK FACTORS AND CUSTOMIZE INTERVENTIONS**

Design interventions for patients identified as high risk for falling and injury based on a comprehensive assessment of each patient. Target the interventions to address modifiable risk factors.

**Secondary Driver: Implement environmental interventions to prevent falls.**

Create a safe environment by eliminating hazards.

**Change Ideas: Reduce environmental hazards**

- Develop an environmental safety checklist.
- Designate a time of day for routine rounds by a multi-disciplinary 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 professional “eyes” to catch hazards such as uneven flooring, poor lighting, loose grab-bars, clutter, and puddles. (See Appendix V)
- Develop a visual cue to signal the lowest possible bed position for the high-risk patient.
- Create a mechanism for regular (every 4 hour) 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. (See Appendix VI.)
- Ensure that any portable furniture is in the locked position when the patient is standing or transferring.
- Secure electrical cords off the floor and away from the patient’s walking path.

**Suggested Process Measures**

- **The percentage of environmental rounds completed within the organization.**
- **The number of issues identified and corrected** by the rounding team.

**Secondary Driver: Implement patient-specific interventions to prevent falls.**

Customize interventions based on the assessment of fall risk and the patient’s medical and physical condition.
Suggested Process Measures

• The percentage of patients identified as high risk for injury from falls receiving a medication review by pharmacist.
• The percentage of falls with medications attributed to the cause of the fall.

Secondary Driver: Implement Intentional Rounding on Patients

Perform comfort rounds on patients every 1-2 hours to proactively address their needs for pain control, positioning, and elimination. Falls frequently occur when high-risk patients attempt to get out of bed to get to the restroom without assistance. Frequent checks of high-risk patients will allow staff to provide assistance to go to the restroom and safely return to bed. (viii)

Change Ideas: Methods to standardize rounding

• Combine rounding 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 “P’s” – pain, position, personal belongings, pathway, and potty.
• Involve all hospital staff in rounding expectations.

Suggested Process Measure

• The percentage of patient rooms with documented periodic rounding as per hospital policy.
• Percentage of patients who report that toileting is offered each time staff “round” on them.

“Hardwiring” Standardize Interventions for Patients at Risk for Falling in Improvement Plans

Standardizing procedures is a method of hardwiring.
• Schedule specific activities at specific rounding times to increase the reliability that patient care needs will be met. See Appendix XI for a sample hourly rounding documentation tool that includes scheduled activities.
• Validate that staff are following hourly rounding expectations by conducting regular observations to validate performance. See Appendix X for a sample Hourly Rounding competency-review tool.
• Assign specific staff members to round in each area to ensure responsibility for the area is clear.
INDIVIDUALIZED INTERVENTIONS FOR MODERATE/ HIGH INJURY RELATED RISK PATIENTS

Patients identified as moderate to high risk for a serious injury from a fall require more intensive precautions to maintain safety. To achieve the AIM for these patients, it is necessary to implement additional precautions beyond the standardized procedures for these patients.

**Secondary Driver: Increase intensity and frequency of observation**

Patients at high risk for injury require more frequent observation than those with lower levels of risk who are assigned to standard fall precautions.

**Change Ideas: Enhancing direct patient observation**

- 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 1-2 hours.
- Develop an individualized toileting schedule for the patient.

**Suggested Process Measures**

- The percentage of high-risk patients in designated fall risk rooms.
- The percentage of patients receiving documented rounds at an increased frequency.

**Secondary Driver: Make environmental adaptations and provide personal devices to reduce risk of fall-related injury**

Environmental adaptations can provide protection from falls and reduce the risk of injury, and should be aligned with the level of assessed risk. For some patients, individualized or intensive adaptations may be needed.

**Change Ideas: Customized environmental changes**

- Place a non-slip, padded floor mat next to the patient's bed while the patient is resting.
- Place assistive devices (walking aids, transfer bars, bedside commodes) on the exit side of the bed.
- Use night lights to ensure the room is illuminated at all times.
- Use bed or chair alarms to alert staff quickly to patient movement.
- Keep the bed at its lowest possible height.
- Use gait belts when ambulating the patient.
- Create special high-risk fall rooms with environmental modifications such as furniture with round edges, and bathrooms with raised toilet seats, and upgraded grab-bars around the toilet and in the shower.

**Suggested Process Measures**

- The percentage of rooms identified on environmental rounds as meeting requirements for high-risk patients.

**Secondary Driver: Target interventions to reduce the side effects of medications**

Many medications increase the risk for falling and the risk for injury as the result of a fall. Poly-pharmacy is common, especially in the elderly, and contributes to many adverse events, including falls and falls with injury.

**Change Ideas: Safer medication management**

- Review high-risk patients' medication lists with the prescribing providers and the pharmacy to try to eliminate or replace any medications that would increase the risk for falling.
- Consider use of the Beers criteria (ix) to identify inappropriate medications for 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.
- Discourage routine use of hypnotics and sedatives by removing them from standardized order sets.

**Suggested Process Measures**

- The percentage of high-risk patients receiving a review of medications by a pharmacist.
- The percentage of falls with medications attributed to the cause of the fall.

“Hardwiring” Customize Interventions for Patients at Highest Risk of a Serious or Major Injury from a Fall in Improvement Plans

In order to customize prevention approaches for the highest-risk patients, assessment of risk has to be routine and reliable. If risk is unassessed then opportunities to implement precautions are missed. Assessments should be done upon admission, whenever the patient has a change of status, and at least every day (if not every shift). The findings from the completed assessments should generate customized interventions and necessary referrals.
**PREVENT HAZARDS OF IMMOBILITY**

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. By proactively incorporating activity into a patient’s treatment plan, these hazards can be minimized, while maintaining the patients’ optimal mobility and functional status.

**Secondary Driver: PT/OT Services for patients assessed to be at risk for functional or mobility decline during hospitalization.**

Initial assessments should include triggers that activate a PT/OT referral for patients with existing mobility or functional activities of daily living deficits. Criteria for PT/OT referral may include: all patients with mobility, functional and/or cognitive deficits, and patients on bed rest, patients over the age of 65, and patients who use an assistive device to ambulate.

**Change Ideas: Prevention of Hazards of Immobility**

- Incorporate assessment of gait, balance, lower extremity muscle strength, and functional abilities into initial assessments.
- Use automated triggers in the electronic medical record to notify Rehabilitation Services of the need for a PT/OT Evaluation.
- PT/OT staff should attend daily rounds with charge nurses to discuss patients needing evaluation and intervention.
- Review mobility in inter-disciplinary clinical rounds, and include Rehab Services in these rounds.

**Suggested Process Measures**

- Percent of patients evaluated by PT/OT within 24 hours of admission who meet high-risk criteria.

**Secondary Driver: Create a mobility/activity plan for each patient that includes progressive increases in activity levels and scheduled ambulation**

Early engagement in rehabilitation services and a proactive ambulation/mobility program can minimize the cascade of events caused by immobility, and can reduce the risk factors associated with anticipated physiological falls caused by weakness, orthostatic hypotension, impaired balance and gait, and confusion.

**Change ideas for initiating a mobility plan for each patient:**

- Include a mobility plan on the patient whiteboard.
- PT/OT should take responsibility for defining a mobility plan for each patient.
- Involve the family in ambulation programs.
- Manage postural hypotension.
- Encourage the use of appropriate footwear for ambulation.
- Keep gait belts in patient rooms.

**Suggested Process Measures**

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

**“Hardwiring” integration of rehab services and mobility activities to prevent the hazards of immobility**

Hardwiring can be achieved by increasing the presence of rehabilitation staff on the patient care units and by demonstrating leadership support by reallocating resources to support patient mobility.

- Schedule ambulation as a daily patient activity. Assign staff responsibility – CNA, PT Assistant
- Engage in leadership rounding to assess and observe activities promoting mobility and patient ambulation, as well as the use of whiteboards to communicate mobility plans.

**POTENTIAL BARRIERS**

Implementation of fall-prevention efforts may trigger resistance from staff due to a perceived increase in workload. To help mitigate this reaction, educate staff about how these patient safety protocols have been shown to prevent or decrease falls, and demonstrate a positive return on the time and efforts invested.

Staff may experience feelings of powerlessness and resentment when confronted with a very directive, “do this, do that,” approach. To successfully implement best practices, ask key stakeholders such as bedside nurses, physicians, nurses’ aides, and environmental services staff to serve on the improvement team to develop protocols, design work-flows, and conduct peer-to-peer education. Senior leadership may under-appreciate the impact of prevention of falls and injuries on workload. For example, units may be closed to save budget resources, resulting in the rooming of high-risk fall patients farther away from the unit staff’s line-of-sight. To support a safety program that addresses high-risk populations and their need for proactive mobility programs and rehabilitation interventions, staffing patterns may need to be re-evaluated.
Falls with moderate-to-severe injuries may also have a significant negative impact on risk-management costs. Including those ultimately responsible for organization-wide decision-making in discussions and planning efforts may help to bring appropriate attention to these issues and to the advantages of prevention programs.

Though risk assessments that weigh high-risk criteria 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 to select and implement appropriate improvement initiatives to reduce falls.

In one institution, a unit discovered that the majority of their falls occurred in patients aged 45 to 65 after surgery, when these post-procedural patients attempted to ambulate to the bathroom. This information drove action plans that led to closer observation of post-procedural patients with hourly assistance to the bathroom to prevent falls. Another organization found that falls were occurring immediately after family members visited patients, and prompted a different set of actions. A drill-down on information gathered in post-fall huddles revealed that visitors were turning bed alarms off to sit on the side of the bed, and not turning the alarms back on when they left. This prompted staff to request that visitors let the nursing staff know they are leaving so that the environment and alarms can be checked.

**Enlisting administrative leadership 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.
- Champions on clinical units are also invaluable. For example, a respected nurse champion in a specific unit may be receptive to implementing a trial of a new process until success and reliability are assured through revisions and refinements.

The champion can then assist with educating others as to the benefits of the new process and its ease of implementation. Don’t just change the practice, change the culture.

- Innovations are best launched through small tests of change, refinements and revisions, and broader dissemination after local success. The ideal outcome of these changes is the development of team-based healthcare in which each member of the team (e.g. physician, nurse, respiratory therapist, nurses’ aide, environmental services staff) contributes to the provision of high-quality patient care.

**TIPS ON USING THE MODEL FOR IMPROVEMENT**

**Assess risk for falling and risk for serious injury from falls**

- Ask one nurse to test a fall risk assessment on one patient, and then work with that nurse to improve the assessment for the next patient.
- Remember that a small test can be just that – small. Start with one patient, one physician, and one nurse. Don’t wait for approval from all departments. The results of multiple small tests-of-change will ultimately guide successful broader implementation.
- 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.
- Communicate and educate all stakeholders about patient fall risks.
- Designate an individual (e.g. charge nurse, nurses’ aide, administrator) to perform unscheduled environmental rounds to assess if visual cues are in place for patients identified as fall risks. Measure compliance with visual cues, such as a falling star sign on the door to a patient room, red socks on a patient’s feet, a red blanket across the patient’s lap, etc.
- If compliance with visual cues is not up to par, ask the relevant team members responsible for implementing the new processes to help identify the reasons for non-compliance. For example, non-compliance may not be willful or negligent, but may be due to a lack of time, resources, supplies, or effective communication. Understanding the reasons for non-compliance can drive the implementation of necessary interventions to improve performance.
Standardize interventions for patients at risk for falling

- Successful implementation of standardized rounding will require buy-in from nursing staff. The most successful hourly rounding implementations are driven by the staff through a series of small tests of change to evaluate what works best for a particular unit. Start with one nurse and one aide on one shift to test various rounding processes. These staff may then create a process that can be disseminated to one more nurse/aide team. Full implementation may be slowed by this approach, but in the long term, this methodology will require a smaller time investment because it develops staff buy-in, ownership, and engagement.

- Find a champion from among the nurses who is respected by his/her peers to help educate peers about the benefits of standardized rounding.

- Work with nurses and nurses’ aides to develop a schedule for rounding that maximizes efficiency.

- Schedule rounds around tasks, such as administering medication or taking vital signs that already require staff to be in the patient room.

- Designate an individual on the treatment team to be responsible for the rounds.

Customize interventions for high-risk patients

- Ask the pharmacist to help design a process for medication review that includes
  — how the pharmacy will be notified of a high-risk patient, and
  — how the pharmacy will communicate the results of their medication review to the treating physician and nurse.

- Test the process on one patient, and lead a debriefing after the trial to discuss how the process can be improved. Try the revised process on another patient, debrief, revise, and re-try. Gradually increase the number of patients to be reviewed, and continue to discuss “what worked well” and “what didn’t.” Learn, tweak the process, and re-test.

- Ask volunteers/participants to help improve a process, not to “approve it” (or reject it). A good question is “what do we need to do to make this work here?” instead of “can we make this work here?”

KEY RESOURCES


ECRI Falls Prevention Resources. Retrieved at: http://www.ecri.org/falls


Website: Massachusetts Hospitals. Retrieved at: http://www.patientsfirstma.org/index.cfm


Center for Disease Control and Prevention, Older Adult Falls Publications. Retrieved at: http://www.cdc.gov/HomeandRecreationalSafety/Falls/pubs.html#prevent

### Appendix I: Morse Fall Scale

#### MORSE FALL SCALE

1. **History of falling; immediate or within the past 3 months**
   - No = 0
   - Yes = 25

2. **Secondary diagnosis**
   - No = 0
   - Yes = 15

3. **Ambulatory aid**
   - None, bed rest, wheel chair, nurse = 0
   - Crutches, cane, walker = 15
   - Furniture = 30

4. **IV/Heparin lock**
   - No = 0
   - Yes = 20

5. **Gait/Transferring**
   - Normal, bed rest, immobile = 0
   - Weak = 10
   - Impaired = 20

6. **Mental status**
   - Oriented to own ability = 0
   - Forgets limitations = 15

<table>
<thead>
<tr>
<th>RISK LEVEL</th>
<th>MFS SCORE</th>
<th>ACTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>No risk</td>
<td>0 – 24</td>
<td>None</td>
</tr>
<tr>
<td>Low risk</td>
<td>25 – 44</td>
<td>See Standard Fall Prevention Interventions</td>
</tr>
<tr>
<td>High risk</td>
<td>&gt;45</td>
<td>See Moderate/High-Risk Fall Prevention Interventions</td>
</tr>
</tbody>
</table>

Appendix II: Sample Injury Risk Assessment and Population Specific Interventions

**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 to a clinical condition

<table>
<thead>
<tr>
<th>Intervention</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assistive devices within reach</td>
<td></td>
</tr>
<tr>
<td>Hip protectors (if fracture risk)</td>
<td></td>
</tr>
<tr>
<td>Floor mats (when patient is resting in bed)</td>
<td></td>
</tr>
<tr>
<td>Height adjustable beds (low when resting only, raise up bed for transfer)</td>
<td></td>
</tr>
<tr>
<td>Safe exit side</td>
<td></td>
</tr>
<tr>
<td>Medication review to reduce fall risks</td>
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</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Intervention</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hip protectors (unless DEXA scan is negative)</td>
<td></td>
</tr>
<tr>
<td>Height adjustable beds (low when resting only, raise up bed for transfer)</td>
<td></td>
</tr>
<tr>
<td>Floor mats (when patient is resting in bed)</td>
<td></td>
</tr>
<tr>
<td>Evaluation of osteoporosis</td>
<td></td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Intervention</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Evaluate use of anticoagulation: risk for DVT/embolic stroke or fall-related hemorrhage</td>
<td></td>
</tr>
<tr>
<td>Patient education: what to do if you fall now that you are on blood thinners</td>
<td></td>
</tr>
<tr>
<td>TBI and anticoagulation: helmets</td>
<td></td>
</tr>
<tr>
<td>Wheelchair users: anti-tippers</td>
<td></td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Intervention</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-op education (teach back strategies)</td>
<td></td>
</tr>
<tr>
<td>Call, don’t fall</td>
<td></td>
</tr>
<tr>
<td>Call lights</td>
<td></td>
</tr>
<tr>
<td>Post-op education</td>
<td></td>
</tr>
<tr>
<td>Pain medication: offer elimination prior to pain medication</td>
<td></td>
</tr>
<tr>
<td>Increase frequency of rounds</td>
<td></td>
</tr>
</tbody>
</table>

Appendix III: Visual Cue Fall Risk Examples

**Catch a Falling Star Program:** a falling star on door to the patient room, a yellow armband on patient, non-skid slipper socks on the patients.

**Ruby Slippers Program:** Ruby Slippers or a Red Star sign on the door to the patient room, red non-skid slipper socks on the patient’s feet, red stickers on the front of the chart/Cardex, a special ruby slipper marker on the patient’s census board.

**SAFE Program:** "Stay Alert for Falls Event": a yellow SAFE sign on the door, a yellow armband on the patient, non-skid slipper socks on the patient.

**LAMP Program:** “Look at Me Please”: a yellow lamp sign on the door, a yellow armband on the patient, non-skid slipper socks on the patient.

**IRIS Program:** “I Require Intensive Surveillance:" A sign on the patient’s door, a pink armband in place, non-skid slipper socks on the patient.

### New Admission (report to all staff taking care of patient for the first time)

- **Admitted to the hospital because of a fall**: □ No □ Yes
- **History of falls in the last three months**: □ No □ Yes
  - If yes, date of last fall: ____________________________
  - Reason for fall: ____________________________
- **History of hip fracture**: □ No □ Yes
  - If yes, report which hip protectors were prescribed: ____________________________
- **Receiving anti-coagulant/anti-platelet medications** (e.g. Coumadin, heparin, Plavix, ASA): □ No □ Yes
- **History of head injury**: □ No □ Yes
- **History of a fall while an inpatient prior to admission to psychiatry**: □ No □ Yes □ Don’t know
- **Diagnosis of osteoporosis or known risk factors**: □ No □ Yes □ Don’t know

### Shift-to-Shift Report

- **Morse Fall Scale Score**:

- **Change in risk factors**: □ No □ Yes
  - If yes, describe change: ____________________________
  - Describe changes to interventions to prevent falls: ____________________________

- **Change in medications**:
  - Medications modified: □ No □ Yes
    - If yes, describe: ____________________________
  - New medication added that can affect balance: □ No □ Yes
    - If yes, describe: ____________________________
  - Started on anti-coagulant: □ No □ Yes
    - If yes, describe: ____________________________

- **Fall event**:
  - Fall during hospitalization/admission: □ No □ Yes
    - If yes, date of last fall: ____________________________
  - Fall occurred within the last 24 hours:
    - If yes, describe: ____________________________
    - Resulting interventions: ____________________________
  - Near-fall occurred within the last 24 hours
    - If yes, describe: ____________________________
    - Resulting interventions: ____________________________

- **If history of osteoporosis or hip fractures**:
  - Check for patient wearing hip protector: □ No □ Yes
### ENVIRONMENTAL FALL RISK ASSESSMENT/SAFETY CHECKLIST

<table>
<thead>
<tr>
<th>ITEM #</th>
<th>ENVIRONMENTAL CONSIDERATION</th>
<th>YES</th>
<th>NO</th>
<th>N/A</th>
<th>ROOM #/AREA DEFICIENCIES FOUND</th>
<th>COMMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Is there adequate lighting in the patient’s room? (Bright light – no burned out bulbs?)</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>2</td>
<td>Is the nightlight on the patient’s bed functional/operating?</td>
<td></td>
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<tr>
<td>3</td>
<td>Does the patient have an unobstructed path to the bathroom?</td>
<td></td>
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<tr>
<td>4</td>
<td>Are the patient’s room furnishings safely arranged?</td>
<td></td>
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<tr>
<td>5</td>
<td>Is the bedside furniture free of sharp edges?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Is the bedside furniture sturdy?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>Are beds/stretchers kept at the lowest setting whenever possible?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>Are beds/stretchers kept in a locked position?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>Were the upper siderails in the up position so the patient could reach controls?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>Was the bedcheck system on in the patient’s room?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>Were the patient’s personal belongings/telephone call bell within reach?</td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>12</td>
<td>Are handrails provided in the patient bathroom and properly secured?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13</td>
<td>Is there an emergency call button/cord in patient care bathroom and working properly?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14</td>
<td>Are non-slip surfaces provided in patient showers?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15</td>
<td>Are the door openings into the patient bathroom wide enough for an assistive device to fit through?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>16</td>
<td>Are door openings flush with the floor for ease-of-movement for patient equipment?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>17</td>
<td>Is portable equipment pushed by patient (e.g. IV pole) sturdy and in good repair?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>18</td>
<td>Are bedside commodes available on the unit and do they have proper rubber slip tips on the legs?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>19</td>
<td>Do walkers/canes/crutches have the appropriate slip tips?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>20</td>
<td>Are wheelchairs locked when stationary?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>21</td>
<td>Is broken equipment properly tagged for non-use?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>22</td>
<td>Are floor surfaces/carpeting free of cracks and tripping hazards?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>23</td>
<td>Are hallways kept adequately clear/ clutter free to allow patient ambulation?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>24</td>
<td>Are floors properly marked when wet to avoid slipping or are spills cleaned up immediately?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>25</td>
<td>Do parking lots have uneven pavement/potholes/ tripping hazards?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>26</td>
<td>Do sidewalks have uneven pavement/ tripping hazards?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>27</td>
<td>Are entrance areas open and clear?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>28</td>
<td>Are parking areas/entrances well-lit?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>29</td>
<td>Are parking lots well marked?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**OTHER ENVIRONMENTAL CONSIDERATIONS**
Appendix V: Environmental Fall Risk Assessment/Safety Checklist Sample (continued)

ENVIRONMENTAL FALL RISK ASSESSMENT FOLLOW-UP

<table>
<thead>
<tr>
<th>ITEM#</th>
<th>CORRECTIVE ACTION</th>
<th>DATE INITIATED</th>
<th>RESPONSIBLE INDIVIDUAL(S)</th>
<th>ANTICIPATED DATE OF COMPLETION</th>
</tr>
</thead>
</table>

Appendix VI: Environmental precautions in the patient room

- Bed trapeze
- Falls prevention poster
- Bed alarm
- Non-exit side rails up for support
- Bed controls at fingertips
- Exit side head rail up for support and foot rail down at all times.
- Bedside commode placed along-side bed (replaces urinal)
- Non-slip floor mat absorbs fluid, food, & stool, and prevents slips
### Appendix VII: Sample Post-Partum Fall Risk Assessment Tool

**POST-PARTUM-FALL RISK-ASSESSMENT 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:

#### PATIENT ASSESSMENT

- Epidural anesthesia x 24 hours
- C-Section
- Prolonged labor
- Generalized weakness
- Excessive blood loss
- 1st and 2nd time out of bed after delivery
- On Ambien, diphenhydramine
- On Magnesium Sulfate
- "High risk" drugs
  - Diuretics, narcotics, sedatives (Sonata can cause sleepwalking)
  - Antidepressants, anti-arrhythmics, anti-psychotics
  - Benzodiazepines (Temazepam, Diazepam, Ativan)
  - Antihistamines: Atarax, Benadryl, Vistaril
    - Allegra, Zyrtec and Claritin are OK
- Previous falls **within last 12 months** (ask your patient!)
- Dizziness/syncope in an upright position
- ↓ Hgb (< 8), ↓ RBCs
- Gait disturbance (unsteady, shuffling, jerking, swaying)
- History of seizures
- Diabetes-potential hypoglycemia (↑ dizziness, lightheadedness)
- Incontinent/urinary frequency or urgency
- SOB on exertion or rest/respiratory difficulties
- **Potential** substance-abuse withdrawal
- Temp > 100 degrees F
- Anxiety
- Hearing- and/or visually- impaired
- Impulsiveness/Impaired memory
- Uncooperative/noncompliant/mental deficits, pt ignores limitations
- Communication barrier

#### NURSING CONSIDERATIONS

- Yellow star attached to door
- Yellow armband on
- Assist to and from bathroom and **DO NOT leave unattended**
- Patient/Significant Other education:
  - *Fall risk and why*
  - *Always* call for assistance when getting up.
  - Hold the baby in your arms only.
  - Never leave the baby on the bed even if you are in bed as well.
## Appendix VIII Sample Post-Fall Huddle Form – page 1

**PLEASE COMPLETE FOR EACH PATIENT FALL—POST-FALL HUDDLE**

This form is not part of the medical record. Used for Quality Improvement purposes.

<table>
<thead>
<tr>
<th>Date of Fall:</th>
<th>Time of Fall:</th>
<th>Time of Huddle:</th>
<th>Location of Fall: Unit/Room</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>IP-Admission Date:</th>
<th>IP-Admit Diagnosis:</th>
<th>OP-Reason for Visit:</th>
</tr>
</thead>
</table>

**Fall Occurred While:**
- [ ] Assisted by Staff
- [ ] Not Assisted by Staff

**What position was the patient found:**
- [ ] Prone
- [ ] Supine
- [ ] Side
- [ ] Sitting
- [ ] Other: ________________

**Fall type** (see definitions on back)
- [ ] Anticipated Physiologic
- [ ] Accidental
- [ ] Unanticipated Physiologic
- [ ] Intentional

**Injury Risk Screening identified pre-fall**
- [ ] A-Age 85 or greater
- [ ] B-Bone fractures, osteoporosis, bone disease
- [ ] C-Coagulation disorders, anticoagulation, platelets low
- [ ] S-Surgery, abdominal and/or lower extremity
- [ ] Other: (describe)

**Injury Risk Screening identified post-fall**
- [ ] A-Age 85 or greater
- [ ] B-Bone fractures, osteoporosis, bone disease
- [ ] C-Coagulation disorders, anticoagulation, platelets low
- [ ] S-Surgery, abdominal and/or lower extremity
- [ ] Other: (describe)

**Fall Risk Screening:** (remember to re-screen after each fall)

**Risk Factors identified on pre-fall**
- [ ] Age
- [ ] Fall Hx
- [ ] Elimination
- [ ] Medications
- [ ] Equipment
- [ ] Mobility
- [ ] Cognition
- [ ] Other:

**Risk Factors identified post-fall**
- [ ] Age
- [ ] Fall Hx
- [ ] Elimination
- [ ] Medications
- [ ] Equipment
- [ ] Mobility
- [ ] Cognition
- [ ] Other:

**Did patient have an alarm in use at time of fall?**
- [ ] Bed
- [ ] Zone: ______
- [ ] Chair
- [ ] Toilet

**Was any injury sustained?**
- [ ] No
- [ ] Yes

(Assess for abrasions, contusions, lacerations, fractures, head injury, etc.)

If Yes, describe injury and action taken:

**Clinical Information**

- Was patient confused, agitated or impulsive pre-fall? [ ] No [ ] Yes
- [ ] Yes-Describe:

- Was there a change in medications in last 24 hours? [ ] No [ ] Yes
- [ ] Yes-Describe:

- Time of last hourly rounds prior to fall:

- Vital Signs (post fall): B/P: _______ Pulse: _______ RR: _______ Temp: _______

**Assistive Device/Appliance:**
- [ ] Walker
- [ ] Cane
- [ ] Wheelchair
- [ ] Other: ________________

- [ ] Did the patient use assistive device/appliance at time of fall? [ ] Yes [ ] No

- [ ] Was patient on a specialty bed at time of fall? [ ] Yes: type ________________ [ ] No

- [ ] Gait Belt used? [ ] Yes [ ] No: Why____________________________

**Environmental:**

- [ ] Were personal items within reach? [ ] Yes [ ] No
- [ ] Was appropriate footwear on? [ ] Yes [ ] No

- [ ] Was patient’s family or other visitors assisting the patient at the time of the fall? [ ] Yes [ ] No

- [ ] Was the safety plan written on Communication Board? [ ] Yes [ ] No

- [ ] Contributing factors:
  - [ ] Trip Hazard (clothing, tubing, cords, obstructed path to bathroom)
  - [ ] Inadequate lighting
  - [ ] Wet Floor
  - [ ] Bed (chair) alarm not working/not on
  - [ ] Call light out of reach
  - [ ] Unlocked equipment
### Appendix VIII Sample Post-Fall Huddle Form – page 2

**Patient’s account of the fall:**

- [ ] Unable to communicate what happened

**Staff member’s account of the fall:**

**Did the patient initiate the call light prior to falling?**

- [ ] No
- [ ] Yes

If yes, how much time elapsed between the call light being turned on and the arrival of assistance in the room? _____ min.

**Fall/Injury-Prevention Interventions in place at the time of the fall:**

- [ ] Rounding
- [ ] Toileting schedule
- [ ] Bed/Chair Alarm-Zone: _____
- [ ] Bed in lowest position
- [ ] Room close to nursing station
- [ ] Within arm’s reach while toileting
- [ ] Door sign with fall risk posted
- [ ] Door open
- [ ] Non-slip footwear
- [ ] Enclosure bed
- [ ] Patient/family education
- [ ] Side rails up X2 or 3
- [ ] Sitter at bedside
- [ ] Other:

**Changes to the Plan of Care**

- [ ] Yes
- [ ] No, because:

**Staff assigned to care for patient at time of fall:**

- RN: ____________________________
- HCA: __________________________

**Huddle was led by:** ____________________________

**Huddle Attendee Names (first, last, and credential):**

**Huddle Participants: Suggestions for what can be done differently to prevent similar falls?**

---

**Original:** Associate Administrator File

**Copies to:**

- [ ] Unit Fall Champion: ____________________________
- [ ] Unit Manager: ____________________________
- [ ] Nursing Quality: ____________________________
- [ ] Unit CNS: ____________________________

- AA/CNS leads Huddle & submits event report
- Unit Nurse documents in Significant Events and makes appropriate notifications

---

**FALL DEFINITIONS**

- **Anticipated Physiologic** – factors associated with known fall risks such as those identified on the scale. Predictive of a fall occurring. Preventable.

- **Accidental** – occurs due to environmental risk factors or hazards, such as spills, clutter, or not using mobility aides properly. Preventable.

- **Unanticipated Physiologic** – factors associated with unknown fall risks, those that are not predicted on the fall scale. Such as unexpected, hypoglycemia, stroke, heart attack, seizure.

- **Intentional** – patient who has behavioral issues and voluntarily positions his/her body on floor.
Appendix IX: Sample Post-Fall Huddle – After Action Review

POST-FALL HUDDLE/AFTER-ACTION REVIEW (AAR)

<table>
<thead>
<tr>
<th>NURSE REVIEWER</th>
<th>DATE</th>
<th>PATIENT NAME/ID</th>
</tr>
</thead>
</table>

Instructions:
1. Hold an AAR as soon as possible after the patient fall has occurred.
2. Keep the AAR meetings brief; 15 minutes, if possible.
3. Involve the patient, if possible.
4. Forward the completed review to the Nurse Manager, and then to Patient Safety Manager. (11E)

<table>
<thead>
<tr>
<th>QUESTIONS</th>
<th>LESSONS LEARNED</th>
</tr>
</thead>
<tbody>
<tr>
<td>Why did this patient fall? (Ask 3 times)</td>
<td></td>
</tr>
<tr>
<td>Was the patient at correct fall/injury risk level? Were the appropriate interventions in place?</td>
<td></td>
</tr>
<tr>
<td>What accounted for the difference?</td>
<td></td>
</tr>
<tr>
<td>How could the same outcome be avoided the next time?</td>
<td></td>
</tr>
<tr>
<td>What is the follow-up plan?</td>
<td></td>
</tr>
<tr>
<td>Patient’s account (if he/she is able to share)?</td>
<td></td>
</tr>
<tr>
<td>Agreement with the patient for safety? (Promise to use the call bell; review demo on how to use the call bell)</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>TYPE OF FALL</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>NURSE MANAGER REVIEW</th>
<th>SIGNATURE</th>
<th>DATE</th>
</tr>
</thead>
</table>

“These documents or records, or information contained herein which resulted from QM activities, are confidential and privileged under the provisions of 38 U.S.C. 5705 and its implementing regulations. This material shall not be disclosed to anyone without authorization as provided for by that law or its regulations. The statute provides for fines up to $20,000 for unauthorized disclosures.”
Partnering with Patients for Safety and Optimal Outcomes - 2012

Employee name: ___________________________ Department: ____________

Competency Statement: The nurse will successfully demonstrate Hourly Rounding, Bedside Report, and AIDET.

<table>
<thead>
<tr>
<th>Method: Direct Observation by VP of Nursing, Nursing Director, and Nurse Manager.</th>
<th>Yes</th>
<th>No</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hourly Rounding: follow AIDET (acknowledge, introduce, duration, explanation, and thank the patient).</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Mr./Mrs./Ms./Miss ____________, I am here for our hourly rounding. (Four P’s)</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>• Pain: Assess pain rating, goal, next time for pain medicine, or other nursing interventions. (Additional pillows, ice pack, heating pack, warm blanket, etc.)</td>
<td></td>
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</tr>
<tr>
<td>• Potty/Bathroom needs: Can I assist you to the BR? Empty urinal, BSC, specimen hats in the BR.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Positioning: ask patient if they are comfortable, assist with repositioning, or turn patient as needed.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Possessions/Personal Items: phone, call light, urinal, tissues, &amp; bedside table with in reach</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Safety scan for fall risk hazards: check for threats to safety (bed in low position, cords secured, clutter cleaned up, trash needs emptied, temperature, BSC, urinal need emptied, etc.)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mark off time of visit on the white boards for your visit.</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Ask if there is anything else you can do for them. Inform the patient that visitors will be asked to leave the room during bedside report unless directed by the patient that it is ok for them to participate.</td>
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<td></td>
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</tr>
<tr>
<td>Remind the patient that a staff member will be back in about an hour to round on them again</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bedside Report: follow AIDET</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Nurse leaving and nursing coming on have PCP, are ready for report and go to the patient room.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Hand hygiene</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Inform patient doing bedside report. (Manage up the oncoming nurse, refer to the white board for pain goals, next available medication, and oncoming informs patient of rounds and team members providing the hourly rounding for the day.)</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>4. Ask the patient to share why they were admitted to the hospital. Have patient share his or her understanding of the diagnosis.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Involve the patient (ADL’s, Fall Risk, Diet, Tests, challenges during the shift, education needs, core measures, test results, surgery time.)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Method: Direct Observation by VP of Nursing, Nursing Director, and Nurse Manager.

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>6. Teach-back: Involve patient in report of new medications/side effects introduced during the previous shift. Ask the patient to share the side effect of the new medication. “I see you had a new medication ordered: ___________. Can you tell me what the side effects of ___________ are? Remember to report any of the side effects while you are here to us. Thank you.”</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Pain goal: ask about current level, what is the patient’s goal, write it on the whiteboard if changed and next time pain medicine is due.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Report/Check: IV settings, PCA’s, wounds, drains, quick neuro assessment, fall level (Look under the covers!)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. Involve patient in plan of care during the next shift. Allow patient to ask questions. Discuss any discharge plans or needs.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. Safety precautions: are they in place, fall signage, call light within reach, any issues to report to be repaired</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11. Ask the patient if there is anything else the oncoming nurse would need to know to provide care to meet his/her expectations.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12. Thank the patient, manage up the oncoming nurse “You are in great hands with __________! It has been my pleasure being your nurse today.” Off going nurse: ask if there is anything else you can do for the patient. Oncoming nurse ask: “What is most important goal for us to accomplish today?”</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13. Evaluate the environment before leaving the room. De-clutter, empty urinal, BSC, hats, etc.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14. Hand hygiene as leaving the room.</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

**Contract statement:** I commit to consistently using AIDET, Hourly Rounding, and Bedside Reporting to promote safety and optimal patient outcomes.

**Rating (circle one):**  Pass  Remediation  Able to teach

Nurse Signature:

Validation Signature:
## Appendix XI: Sample Hourly Rounding Documentation Form

### PATIENT HOURLY MONITORING

<table>
<thead>
<tr>
<th>Time</th>
<th>Initials (Checked Hourly)</th>
<th>Patient Care</th>
<th>Initials (Care Provided)</th>
</tr>
</thead>
<tbody>
<tr>
<td>0600</td>
<td></td>
<td>• Given Fresh Water</td>
<td></td>
</tr>
<tr>
<td>0700</td>
<td></td>
<td>• AM Care</td>
<td></td>
</tr>
<tr>
<td>0800</td>
<td></td>
<td>• Room is Clean</td>
<td></td>
</tr>
<tr>
<td>0900</td>
<td></td>
<td>• Bathroom is Clean</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Urinal/Foley/Brief/BSC is Clean</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Patient’s Needs Met, Toileted</td>
<td></td>
</tr>
<tr>
<td>1000</td>
<td></td>
<td>• Room is Clean</td>
<td></td>
</tr>
<tr>
<td>1100</td>
<td></td>
<td>• Bathroom is Clean</td>
<td></td>
</tr>
<tr>
<td>1200</td>
<td></td>
<td>• Urinal/Foley/Brief/BSC is Clean</td>
<td></td>
</tr>
<tr>
<td>1300</td>
<td></td>
<td>• Patient’s Needs Met, Toileted</td>
<td></td>
</tr>
<tr>
<td>1400</td>
<td></td>
<td>• Given Fresh Water</td>
<td></td>
</tr>
<tr>
<td>1500</td>
<td></td>
<td>• Room is Clean</td>
<td></td>
</tr>
<tr>
<td>1600</td>
<td></td>
<td>• Bathroom is Clean</td>
<td></td>
</tr>
<tr>
<td>1700</td>
<td></td>
<td>• Urinal/Foley/Brief/BSC is Clean</td>
<td></td>
</tr>
<tr>
<td>1800</td>
<td></td>
<td>• Patient’s Needs Met, Toileted</td>
<td></td>
</tr>
<tr>
<td>1900</td>
<td></td>
<td>• Given Fresh Water</td>
<td></td>
</tr>
<tr>
<td>2000</td>
<td></td>
<td>• PM Care</td>
<td></td>
</tr>
<tr>
<td>2100</td>
<td></td>
<td>• Evening Snack</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Room is Clean</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Bathroom is Clean</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Urinal/Foley/Brief/BSC is Clean</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Patient’s Needs Met, Toileted</td>
<td></td>
</tr>
<tr>
<td>2200</td>
<td></td>
<td>• Room is Clean</td>
<td></td>
</tr>
<tr>
<td>2300</td>
<td></td>
<td>• Bathroom is Clean</td>
<td></td>
</tr>
<tr>
<td>2400</td>
<td></td>
<td>• Urinal/Foley/Brief/BSC is Clean</td>
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<tr>
<td>0100</td>
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<td>• Patient’s Needs Met, Toileted</td>
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<td>0200</td>
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<td>• Given Fresh Water</td>
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<td>0300</td>
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<td>• Room is Clean</td>
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<tr>
<td>0400</td>
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<td>• Bathroom is Clean</td>
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<tr>
<td>0500</td>
<td></td>
<td>• Urinal/Foley/Brief/BSC is Clean</td>
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<tr>
<td></td>
<td></td>
<td>• Patient’s Needs Met, Toileted</td>
<td></td>
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</tbody>
</table>

Note: Please mark N/A where applicable
FALL PREVENTION – MEDICATION REVIEW

Pharmacy - Kelsey Trail Health Region

<table>
<thead>
<tr>
<th>Height</th>
<th>Weight</th>
</tr>
</thead>
<tbody>
<tr>
<td>serum creatinine</td>
<td>Calculated creatinine clearance</td>
</tr>
</tbody>
</table>

Place Patient Addressograph Here

The patient IS NOT taking the following medication, which may DECREASE the risk of falling:

- Vitamin D (800-2000 IU for adults)

The patient IS taking the following medications, which may INCREASE the risk of falling:

PSYCHOTROPICS

- Sedative-hypnotics, including zopiclone, and especially benzodiazepines (BZDs)
- Neuroleptics (antipsychotics)
- Tricyclic antidepressants (TCAs)
- Selective serotonin reuptake inhibitors (SSRIs)

CARDIOVASCULAR MEDICATIONS

- Digoxin
- Anti-hypertensives, especially diuretics: diuretic  ACE I  ARB  CCB  β-blocker
- Class 1A anti-arrhythmics (procainamide, quinidine, and disopyramide)

OTHER MEDICATIONS

- Anti-cholinergics – including antihistamines, TCAs, and anti-psychotics
- Anticonvulsants
- Opioid Analgesics (within first 48 hrs of initiation or dosage increase)

OTHER RISK FACTORS TO CONSIDER

- Elderly patients (65 years of age or older)
- Impaired renal function
- Four or more scheduled medications
- Anti-coagulants/Anti-platelets (may increase the risk of injury from a fall)

Untreated: osteoporosis  urinary incontinence  delirium  pain
(may have an increased risk of injury from falls)

PLEASE CONSIDER THE FOLLOWING RECOMMENDATIONS TO REDUCE THE RISK OF FALLING:

Pharmacist: _____________________  Date: _____________________
VITAMIN D
- Vitamin D receptors are found in muscle. Muscle weakness is a symptom of vitamin D deficiency. Some evidence suggests that vitamin D supplementation may prevent falls by improving muscle strength.
- Vitamin D is made by sun-exposed skin, and is found in some foods. However, it is difficult to obtain enough vitamin D from food, and most people don’t get much sun exposure, especially those living in northern latitudes.
- According to a meta-analysis by Bischoff-Ferrari et al., if 15 older adults were supplemented with vitamin D, 1 fall could be prevented (NNT=15). Although confidence intervals of some individual studies cross the line of no difference, the pooled estimates favor vitamin D supplementation. Vitamin D supplements may be worth considering for elderly patients.
- Recommendations: 400 IU for infants; 600 IU for kids; 800-2000 IU for adults. Evidence suggests the higher adult dose is safe and may provide additional benefits.

PSYCHOTROPICS
- Sedative-hypnotics, including zopiclone, and especially benzodiazepines (BZDs)
  - BZDs impair balance centrally and peripherally. BZDs may also cause CNS depression leading to impaired reaction-times. Risk is greater at higher doses for both long- and short-half-life BZDs.
  - There is no clear benefit of short-acting BZDs or newer agents in reducing falls.
  - Risk of fall is greatest in the first 15 days of therapy or when increasing doses of BZDs.
  - Risk is increased with patients taking more than one BZD; therefore, combinations should be avoided.
  - Zopiclone - The recommended dosage in the elderly is 3.75 mg, possibly increased to 7.5 mg. Zopiclone causes increased body sway, which is a surrogate marker for fall risk.

- Neuroleptics (Atypical and Typical Antipsychotics)
  - May cause EPS, sedation, gait abnormalities, dizziness, blurred vision, cognitive impairment, and orthostatic hypotension.
  - Newer antipsychotics may have improved side-effect profiles, although there is no evidence relating to falls.

- Tricyclic antidepressants (TCAs)
  - Doses ≥50mg of amitriptyline are associated with an increased risk for falls.
  - Proposed mechanism of action includes orthostatic hypotension, sedation, and/or cognitive impairment due to anticholinergic effects.

- Selective serotonin reuptake inhibitors (SSRIs)
  - New use of SSRIs is associated with a greater risk for falls. Recommend starting with a low dose for the 1st week, then slowly increasing to therapeutic levels.
  - Doses ≥20mg of fluoxetine have a higher risk for falls.
  - May induce hypotension, which can lead to dizziness; recommend monitoring electrolytes.

CARDIOVASCULAR MEDICATIONS
- Digoxin
  - There is a weak association between digoxin and falls. Digoxin is renally-eliminated.

- Antihypertensives
  - Antihypertensives have been proposed to contribute to fall risk via postural hypotension (drop in SBP of ≥20 mmHg, in BPP of ≥10 mmHg, OR to a pressure of <90 mmHg when standing).
  - Diuretics have been significantly associated with falls (vertigo, orthostatic hypotension, frequent urination).
  - Most studies have found a non-significant relationship between other antihypertensives and falls. Inadequate treatment of a cardiovascular disease may also be a factor in increasing fall risk.

- Class 1A anti-arrhythmics (procainamide, quinidine, and disopyramide)
  - The relationship between these agents and falls may be due to the adverse effects of the medication or the disease (low blood pressure with light-headedness).

OTHER MEDICATIONS
- Anti-cholinergics
  - Anti-cholinergic properties include dizziness, sedation and blurred vision. Anti-cholinergics include atropine, benzotropine, hyoscine, scopolamine, etc.
  - Sedating antihistamines have strong anti-cholinergic properties and the half-life may be extended in elderly patients. For example, the half-life of diphenhydramine is about 13.5 hrs. in elderly patients and about 2 to 10 hrs. in younger adults.
  - Other drugs with anti-cholinergic properties include TCAs, neuroleptics, antispasmodics (oxybutynin), and some anti-emetics (prochlorperazine, metoclopramide, promethazine, trimethobenzamid, etc.).

- Anticonvulsants
  - May cause dizziness, ataxia, orthostatic hypotension, blurred vision, somnolence, and confusion, which are greatest at the beginning of therapy or after increases in dose.
FALL PREVENTION – MEDICATION REVIEW

- Opioid Analgesics
  - Opioids, in general, do not cause falls. However, they may cause sedation, dizziness, or confusion in the first 48 hours after initiation or a dose increase.
  - Patients usually develop tolerance to these side effects within 2 to 3 days of a stable dose. Therefore frequent dosage changes or use of PRNs may increase the risk of side effects.
  - Pain may increase the risk of falls. Therefore, adequate pain control is important.

OTHER RISK FACTORS TO CONSIDER
Elderly patients (≥65 years of age) have altered pharmacokinetics and may be more “sensitive” to medications.

Renal function impairment may result in medication accumulation and increased risk of adverse reactions.

Patients taking ≥4 prescription drugs, regardless of pharmacologic classification, are at an increased risk for falls.

Anti-coagulants/Anti-platelets may directly increase the risk of injury from falls due to an increased bleeding risk.

Patients with untreated osteoporosis, urinary incontinence, delirium, or pain may have an increased risk of injury from falls.
  - Delirium can occur with dementia, strokes, Parkinson’s disease, infection, abnormal blood sugars, low pulse Ox, worsening organ function (kidney failure, liver failure, heart failure, etc.)
  - Pain can affect an individual’s mobility, which in turn, can increase the risk of falls. Any changes in mobility may cause a fear of falling and anxiety, which may cause a decrease in activity levels, leading to increased muscle weakness and fall risk.
Blood Thinners: Risk Factors Associated with Falling and What to Do When You Fall

Anticoagulant Therapy

Your health care provider may have started you on a medicine known as an ANTICOAGULANT to help reduce the chance of a blood clot. Anticoagulants are sometimes called blood thinners. The most common places for blood clots to form are in your legs, your lungs, or your heart. Blood clots can travel through your blood stream to other places in your body, such as your brain or heart. A blood clot to your brain can cause a stroke, and a clot that blocks blood flow to the heart can cause a heart attack. Heparin and Warfarin (Coumadin) are common anticoagulant medicines.

Clopidogrel (Plavix) and aspirin are anti-platelet medicines, another kind of blood thinner. Platelets help your blood to clot. If the platelets are too active, this can lead to a heart attack or stroke, as described above.

When you are on blood thinners, your health care provider will monitor the time it takes your blood to clot. These tests are very important to minimize the most common side effects of bruising and bleeding that can occur from taking an anticoagulant or anti-platelet medicine.

When you were started on your blood thinners, you may remember your healthcare provider warned you about bruising if you bump yourself or bleeding gums when brushing your teeth. Our concern is about what happens when you fall.

Results of a Fall

When you fall, you may hit objects on the way down such as furniture, doorways, etc. Every part of your body that hits something when you fall may experience bleeding. Being on a blood thinner can worsen the effects of a fall, causing bleeding or even a bone fracture. Bleeding can be life-threatening, which is important to remember when you experience any fall.

When you are taking blood thinners, bleeding may be more extensive and/or last a long time. This can lead to changes in your body systems including your blood pressure, pulse and breathing. This happens because your blood will be leaking outside of the arteries and veins, and bleeding into your body tissues.

What to Do if you Fall?

Here are some tips to protect your life and health by knowing what to do if you happen to fall.

Not Bleeding
If you fall and you are not obviously bleeding, notify your primary healthcare provider. Tell your provider about the fall and the name of the anticoagulant or anti-platelet medication you are taking. You must let your provider know that you fell.
Blood Thinners: Risk Factors Associated with Falling and What to Do When You Fall

The only way that your healthcare provider can help you is for you to report your fall.

Remember, just because you don’t see any bleeding, you could be bleeding into your body tissues and you need to monitor the area of the body impacted by the fall. Mark that part of the body by putting a circle around the area. To monitor the speed of bleeding into your tissues check the sites every 3-5 minutes, and mark new circles where the bruising has expanded. If you find that your bruising continues to increase in size, either go to an emergency room or call 911 for help.

Actively Bleeding
If you fall and are actively bleeding, apply pressure directly to the site that is bleeding, and either call 911 or ask a family member to call. Do not wait to call. If you think that the bleeding is not enough to call 911, call your local emergency room, and ask the nurse what to do.

Whatever your decision, your first action is to call for medical help. Do not delay. Emergency responders can quickly get you into a healthcare system that can administer medications to control bleeding that may protect your life.

Protecting Yourself in all Situations

These simple steps may protect your life:
1. Wear a medical alert at all times that indicates you are taking anticoagulant or anti-platelet medicine.
2. Carry a list of your current medication (prescribed and over-the-counter) on your person when you are out of the house. You could keep a copy of this list in your wallet or purse. Make sure this list is the same as the one you keep in your home for emergency personnel.
3. On your medication list, include the name and phone number of your healthcare provider, in case a stranger or emergency paramedic needs to call them.
4. If you require a mobility aid (such as a cane or walker) for safe transfers and/or walking, be sure to use your mobility aids as prescribed. These devices are prescribed to help you walk safely.
5. Treat all falls as serious. Call your healthcare provider and report your fall, even if you think that you were not hurt.
6. If you are on an anticoagulant, call your health care provider before taking any drug for pain to check on possible increased effect on bleeding.

For Family Members of a Person Taking Blood Thinners who has Fallen:
1. Check for injury and bleeding. DO NOT get the person up until you are certain there is no serious injury or bleeding.
   • Are they breathing? If not, call 911 and start CPR.
   • Are they bleeding? If yes, put pressure on the site of the bleeding, call 911 and inform them that the person takes an anticoagulant or anti-platelet medicine.
   • Did they lose consciousness? Are they more confused? If yes, call 911. If the person is confused, talk to the them and orient them to the situation.
   • Where do they hurt? Ask the person if they have pain anywhere. Look for any obvious fractures. Do NOT get the person up. Call 911 for help.
2. Do NOT attempt to lift the person by yourself. Trying to lift a person can injure both of you.
3. Reassure the person. They may be confused, frightened, and embarrassed. If possible, provide a calm environment, cover them with a blanket, and stay until help arrives.
4. Ask for details about the fall, and get as much information as possible from any witnesses.
5. Ask the person how long they have been taking blood thinners, what kind, and the last time they took their medication.
6. As soon as possible notify the person’s healthcare provider about the fall. A fall can be a symptom of serious problems. Most falls can be prevented.

For more information contact:
VSM & Patient Safety Center
11605 N. Nebraska Ave.
Tampa, FL 33612-5738
813-558-3900
# Appendix XV: Falls Top Ten Checklist

## FALLS Harm Top Ten Checklist

<table>
<thead>
<tr>
<th>TOP TEN EVIDENCE BASED INTERVENTIONS</th>
<th>IN PLACE</th>
<th>NOT DONE</th>
<th>WILL ADOPT</th>
<th>NOTES (RESPONSIBLE AND BY WHEN?)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>PROCESS CHANGE</strong></td>
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<tr>
<td>Fall and Injury risk assessment on admission.</td>
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<tr>
<td>Re-assess fall and injury risk daily, and also with changes in the patient’s condition.</td>
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<tr>
<td>Implement patient specific intervention to prevent hazards of immobility: Rehab referral, progressive activity and ambulation program.</td>
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<td>Communication risk across the team: Hand-off forms, visual cues, huddles.</td>
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<tr>
<td>Rounding every 1-2 hours for high risk patients; address needs (the 3 P’s – pain, potty, position-pressure).</td>
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<tr>
<td><strong>Individualize interventions</strong></td>
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<tr>
<td>Non-skid floor mats, hip protectors, individualized toileting schedule, adjust frequency of rounds.</td>
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<tr>
<td>Pharmacist medication review – avoid unnecessary hypnotic, sedatives.</td>
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<td><strong>Multidisciplinary input to falls prevention</strong></td>
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<tr>
<td>PT, OT, MD, RN, Pharm.D.</td>
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<tr>
<td>Include patients and families and caregivers in efforts to prevent falls. Educate regarding fall prevention measures and family members staying with the patient.</td>
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<tr>
<td>Post fall huddles – occur immediately after event; analyze how and why; implement the change(s).</td>
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<td></td>
<td></td>
</tr>
</tbody>
</table>
REFERENCES

i Website: Retrieved at: http://www.patientsafety.va.gov/professionals/onthejob/falls.asp


