FALLS PREVENTION TOOLKIT:
Strategies for Streamlined Communication, Interdisciplinary Scope, and Patient and Family Engagement
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ACKNOWLEDGMENTS

The Missouri Hospital Association would like to acknowledge the following organizations for their assistance in providing valuable information required for the preparation of this summary and toolkit:

• Centers for Medicare & Medicaid Services Partnership for Patients initiative grant
• American Hospital Association/Health Research & Educational Trust Hospital Engagement Network
• Missouri HEN participants
• Missouri Center for Patient Safety, Patient Safety Organization

This Falls Prevention Toolkit was developed as part of the CMS Partnership for Patients initiative grant, under the AHA/HRET Hospital Engagement Network.
Executive Summary

The Centers for Medicare & Medicaid Services developed the Partnership for Patients initiative which was designed to improve the quality, safety and affordability of health care for all Americans. The PfP initiative has brought together over 3,700 participating hospitals since 2010 through Hospital Engagement Networks, with goals of reducing harm by 40 percent and reducing readmissions by 20 percent. Falls prevention has been a focused topic of this initiative.

While great strides have been made in preventing falls through national and local HENs over the past three years, data shows continuing opportunities for improvement in preventing falls with and without injury, and in developing an over-arching approach to creating a culture of safety that values patient and family involvement, reduces variation, and streamlines care to eliminate waste and error.

FACTS ABOUT FALLS

- Falls with injury are considered a hospital acquired condition and no reimbursement for care related to the fall will be paid.²
- Falls are the leading cause of injury-related death in adults age 65 and older, with hip fracture and head trauma accounting for the majority of reported injuries.³
- In acute and rehabilitation hospitals, falls with injury occur in 30 to 51 percent of patients, with fracture occurring in 1 to 3 percent.⁴
- Each injury from a fall adds 6.3 days to the hospital stay, with the average cost of $14,056 not being reimbursed.⁵
- All regulatory and accrediting bodies include falls reduction as a major patient safety indicator.⁶,⁷
- Fear of falling corresponds to decreases in independence and mobility, affecting quality of life.⁸
- Use of a bed or chair alarm alone does not show correlation to decreased falls.⁹
- Falls are associated with increased length of stay, increased utilization of resources and poor health outcomes.¹⁰
- Fall-related injuries account for up to 15 percent of readmissions in the first 30 days after discharge.¹¹
- Up to 50 percent of hospitalized patients are at risk for falls, and almost half of those who fall suffer an injury.¹²

Despite heightened national attention to this issue, patient fall rates across the U.S. continue to escalate, putting patients and caregivers at increased risk.

Previous fall prevention strategies have included:
- fall prevention policies
- standardized use of a falls risk assessment and set of interventions
- development of a falls committee
- patient sitter programs
- bed and/or chair alarms
- “days since last fall” transparency trackers
- collection of data and discussion of causative factors

Despite these efforts, health care facilities continue to struggle to implement necessary changes on a consistent basis. The challenge of creating environments in which patients are safe from falling remains.

WHY DO PATIENTS FALL?

A review of national data from The Joint Commission notes that top contributing factors are related to bathroom use and toileting, call light use, lack of fall prevention education, reliability of fall risk assessments, communication issues, and failure to develop a safety-focused culture.¹³ (Refer to the illustration on the following page.)
Missouri’s Center for Patient Safety, through the Patient Safety Organization, aggregates fall (and other harm events) data from more than 80 Missouri hospitals. From first quarter 2010 through third quarter 2014, participating hospitals reported the following:

- fall events remain around 20 percent of all submitted events
- 54 percent (2,325 of 4,323) of falls resulted in some level of harm
- majority of harm from falls included fractures, dislocations and lacerations
- Missouri’s top contributing factor correlates with national data for toileting-related activities

The work of the MO HEN shows promising advancements in fall prevention. From first quarter 2012 to first quarter 2014, hospitals participating in the MO HEN have reduced falls by 30 percent, preventing an estimated 2,083 falls, as compared to 2011 baseline performance.
When reviewing falls with injury, MO HEN organizations were able to prevent an estimated 123 patient harms.

As we continue improving fall prevention strategies, nationwide and through the work of the HEN, three main “Always Event®” themes have emerged as necessary pieces of the prevention approach. The following over-arching themes should be considered next steps in reducing the prevalence of falls:

- communication strategies — How do we communicate about safety every day, during every shift, with every patient?
- interdisciplinary engagement — How can we leverage expertise and utilization of time and resources?
- patient and family engagement — How can patients and families maintain safety, both in the health care facility and at home?

What is an “Always Event®”?
Those aspects of patient and family care and experience that should always occur when patients interact with health care professionals and the delivery system.
The concept of “Always Event®” was introduced by The Picker Institute, and later owned by The Institute for Healthcare Improvement, as a methodology and strategy for performance improvement.

The concept of “never events” focuses attention on what should not occur versus what should. Essentially, telling staff that something should never occur gives staff nothing actionable to do.

In contrast, use of an “Always Event®” strategy gives clinicians an actionable operational strategy to deploy to keep patients safe and prevent harm events from occurring. “Always Events®” are standardized processes designed to ensure the care is provided consistently and effectively; thereby, drastically decreasing the likelihood of errors occurring.

“Always Events®” are unique in that they incorporate the patient and family’s preferences as a way of providing standardized, yet individualized care. An “Always Event®” meets five criteria — important, evidence-based, measurable, and affordable and sustainable.

HEALTHIER POPULATIONS: EXTENDING HARM REDUCTION THROUGH PATIENT-CENTERED CARE

Although the majority of fall reduction programming has occurred within the walls of hospitals and residential care facilities, focus is being shifted to preventing falls in the home and community. In 2012, falls at home accounted for 2.4 million emergency room visits for non-fatal trauma and injury, with 722,000 of these patients being hospitalized.

The following are helpful tips on how health care providers in hospital settings can help prevent falls at home and in the community.

• improve coordination of post-acute care services
• ensure communication of needs for patients who score “high risk” for falls is passed on to future care providers
• engage the primary care provider through physician-to-physician hand-offs of care from the hospital to the clinic practice
• include fall risks and prevention as a conversation with patients during routine physician office visits, as well as a focused review of medication lists and practices that may cause side-effects or interactions; thereby, increasing fall risk
• sponsor community events promoting fall prevention education, testing and assessment, and annual eye exams
• involve community volunteer organizations to help make homes safer by adding grab bars, railings, increased lighting, and observing homes for tripping hazards to be removed
• promote community exercise classes geared towards those over age 65
• review technology opportunities to assess gait for fall risk and promote improved self-awareness

As health care adopts population health tenets, understanding linkages between a patient falling in a health care facility and the lifetime personal effects for that patient once they are discharged is imperative to success in hardwiring fall prevention interventions.

Developing a culture of safety, with falls prevention as one piece of the puzzle, takes time and a concerted, collaborative effort by the entire health care organization. As John Jorgenson, MPA, R.N., wrote in his article, Reducing Patient Falls: A Call to Action, “A culture of safety doesn’t just encourage nurses to work toward change. It requires them to take action when they see something amiss. This culture has no place for those who would say, ‘Safety isn’t my responsibility. All I need to do is file a report and someone else will take care of it.’”

Health care organizations can reduce patient falls if a commitment to change and spirit of open communication exists. Staff must be encouraged and enabled to not only share safety concerns.

“Extensive research has shown that no matter how knowledgeable a clinician might be, if he or she is not able to open good communication with the patient, he or she may be of no help.”

— M.R. Asnani
A culture of safety takes time to develop; however, with the help of leadership engagement, role modeling safety conscious behaviors and involving the entire organization in a safety culture mentality, great improvements and a sense of trust can be achieved. The key is keeping the patient and their family involved.

Perform an objective review of your falls data, causative factors and current tactics as part of this future work and conduct the Plan-Do-Check-Act model of improvement. A gap analysis tool is included in the resource section to help your team work through progress and next steps.

**CONSIDER:**
- Was the strategy fully deployed? Why or why not?
- What percentage of staff can speak to fall prevention strategies?
- What percentage of staff can identify patients at high risk for falling?
- Are interventions in place consistently, 100 percent of the time? Why or why not?
- Are the strategies hard-wired? Why or why not?

MHA and the Center for Patient Safety have experts and additional resources available to assist health care organizations in their journey towards zero patient harm. Collaboration, engagement and sharing of best practices are the keys to success and improved health of our communities. MHA recommends that all health care providers review their current performance and implement strategies to ensure they are leaner, simplified, and patient-centered to decrease the prevalence of falls in our communities.
Falls risk assessments have been widely deployed as a first-line measure for predicting risk, but they are not without fault. A variety of risk tools exist (see Resource Links), each assessing similar, yet different criteria to be predictive of fall risk. Each tool is scored differently. Because of these multiple tools and the issue of inter- and intra-relator reliability, several studies have compared multiple falls risk-assessment tools and the use of clinical judgment as a greater predictor of risk. The current limitations associated with falls risk-assessment tools stimulate the need to rethink how they can contribute to managing falls risk.

Risk assessment tools continue to be supported as a first-line strategy in the literature; however, the issue of variation is apparent. In order to provide an approach to standardization and reduce variation across tools, adoption of a two-level approach is recommended.

The first approach involves understanding that all patients have an inherent risk of falling by being in the facility. Patients sick enough to be in the hospital have an underlying disease, are receiving physiologically altering medications and treatments, and are likely experiencing pain, fatigue, anxiety, sleep disturbance and other symptoms that interfere with cognitive and physical functioning. To that extent, a protocol of fall prevention for all patients and promoting education of this approach to all staff is endorsed.

1. **Always Event® for all patients**
   - Define a standardized falls prevention strategy for all patients.
     - For example, upon admission, shouldn’t every patient receive non-skid socks, room orientation and a review of fall risks? Shouldn’t every patient have an ambulation plan to maintain strength and mobility? Shouldn’t every patient have their room scanned during hourly rounds for trip hazards, inability to reach items, etc.?

2. **Always Event® for high-risk patients**
   - Consider the falls risk assessment outcome to indicate high-risk patients only. The use of the terms “low” and “moderate” can lead to confusion and possibly missing interventions to prevent falls. Having multiple levels of risk assessment and differing levels of interventions leads to a lack of standardization.
     - The following leads to an Always Event® for high risk falls patients.
       - Define how to identify these patients. Studies show that visual cues can be effective. Use of red or yellow socks, gowns, blankets, bracelets, falling stars and falling leaves have all been utilized as visual cues.
       - Define what interventions are required, utilizing the least-restrictive methods. This is where clinical judgment and individualization of the patients’ needs must be considered. Examples include moving a patient closer to nurses’ station, patient sitter, family presence, distraction boxes, and bed/chair alarms. Note: use of bed/ chair alarms should be a last resort as they severely limit mobility and can cause further functional decline.

Inter-relator reliability by frontline care providers, based on the falls risk assessment tool utilized, has been assessed through several studies and found to differ greatly depending on the tool used, clinician knowledge and skill, and patient factors. Further, there are gaps regarding use of this information once the initial or shift assessment is complete and the ability to put this information into meaningful, daily application. Too often, patient assessment and assignment of a score become required tasks, and resulting data do not drive interventions. If this level of stratification is currently used, consider standardizing protocol, educating staff on the levels and assigning interventions to each level. Use visuals to compare the risk levels and tie in interventions that are Always Event® for each level.
Although Figure 4 categories are not all inclusive of fall prevention interventions, they serve as a visual reminder for staff, patients and family members about the level of risk and interventions that should be in place. If simplifying to low- and high-risk categories only, the moderate-risk interventions in Figure 4 should be first-line interventions for the high-risk category. Placing the yellow star or falling leaf on the appropriate risk category can serve as a reminder about the importance of interventions and risk. Use of visuals in the patient’s room may also prompt questions from the patient and family that may lead to better care both in- and outside of the hospital.

Risk assessment should be a piece of the fall prevention strategy; however, more emphasis is needed on the standardization of interventions and the actual implementation of these interventions by front-line staff at the bedside. Fall prevention teams need to move beyond setting up falls programs, to improving and sustaining them. An emphasis on injury prevention through modifiable risk adjustments is the goal.

### ALWAYS EVENT® – STAFF HUDDLES

Use of huddles as a communication tool is widely supported in health care literature. Huddles can incorporate unit-level staff and leadership only, or may be more multidisciplinary in approach. The key to success is daily commitment, engagement of staff, and ensuring value to front-line staff. Huddles should be no longer than 10 to 15 minutes and should have a standardized structure. Instead of management leading the huddles, consider engaging the shift charge nurse to facilitate the huddle after receiving coaching on the process. Staff involvement has been shown to lead to greater success and satisfaction when deploying new strategies and greater overall organizational achievement.²⁶

Consider the following information from an Institute for Healthcare Communication report on the “Impact of Communication in Healthcare.”²⁷

- Communication among healthcare team members influences the quality of working relationships, job satisfaction and profoundly impacts patient safety.
- When communication about tasks and responsibilities is done well, research shows a significant reduction in nurse turnover and improved job satisfaction because it facilitates a culture of mutual support.
- There is a direct relationship between clinicians’ level of satisfaction and their ability to build rapport and express care and warmth with patients.

According to the TeamSTEPPS²⁸ model, huddles provide the following value to health care providers.

- establishes situational awareness, reinforces plans already in place, and assesses for any additional needs or adjustments to the plan
- gathers team members to review patient data and decide on a course of action for the shift
- can be requested at any time by any team member
A shift huddle reinforces teamwork and allows everyone to hear important safety information so staff can help with all patients, even if they were not included on the staff member’s original assignment.

**CHANGE OF SHIFT HUDDLES**

Today’s health care environment requires creative, strategic staffing and a culture of teamwork and patient-centeredness to prevent harm and improve patient outcomes. Huddles are one way to increase the effectiveness of teamwork and communication at the unit level. The staff huddle should include relevant safety and harm indicators, and information for that unit. Falls prevention is one harm area that affects all areas of health care as they can occur anytime, anywhere.

Consider including representatives from other departments in daily safety huddles. This participation may be on-going or on a rotation. For example, pharmacy could make daily rotations through unit huddles during the course of a week to educate staff on a new medication. These huddles should have a strategic agenda. The following are suggested items to review daily.

- days since last fall
- days since last serious/sentinel event
- patient stats:
  - Number of patients at high risk for falls
  - How are high-risk patients identified?
  - visual cues — these identifiers can be as simple as writing the patient’s pneumonic in red on the assignment board or as technical as color-coding bed tracker software
  - What interventions are in place? Are more interventions needed? Who will ensure they are in place?
  - Number of patients at high risk for other safety issues (dependent on type of unit)
  - Equipment issues/shortages
- staffing priority: where should additional resources go first?
  - Review who has responsibility for rounding on high-risk patients, assisting with ambulation and mobility work, and what times these activities should occur.
  - Consider dividing high-risk patients equitably across patient care techs and nurses. It is simply not realistic to think one patient care tech can work in a silo and have four high-risk falls patients on his/her workload. Falls will continue to occur with this staffing model.

**WHEN TO HUDDLE**

- shift change
- when staffing changes are needed
- following procedures
- following potential safety/harm events
- following emergent situations
- to provide real-time education
- to provide real-time changes in patient information

*Source: Agency for Healthcare Research and Quality*
– Encourage teamwork and shared accountability for patient safety. Departments have utilized mottos such as, “not on my shift” and “every patient, every time” to encourage this teamwork.

• focused clinical topic: “top of mind” issues
• knowledge sharing: recent events, lessons learned (share positive and negative outcomes)
• take-away’s: what everyone should know before moving on with their day

As part of the huddle, use of quality metric dashboards is highly recommended. Simply put, if leaders do not share results with front-line staff, they are less likely to achieve success. The improvement effort becomes just the next “flavor of the day,” and the intensity is lost. Instead, when front-line staff are engaged not only in training and implementation, but also in the frequent review of results from those interventions, evidence-based improvement in patient care safety, outcomes, and excellence is expedited.

Consider huddles as a safety tool. Move beyond the change of shift huddle to utilizing the power of this communication technique in other situations.

ALWAYS EVENT – ROUNDING FOR OUTCOMES

Although “rounding for outcomes” or “rounding to influence” have been used extensively as part of employee engagement strategies, they may have an even greater prospect for improving safety culture and enhancing process improvement work. Rounding has traditionally been completed by those in leadership roles; however, monitoring for safety is a responsibility of the entire staff within the facility. Staff accountability begins with engaging all staff in understanding why all patients are at risk for falling. It continues with giving staff the knowledge and ability to articulate this risk with patients and families. Also, staff receives support when they experience challenging situations (for example, when a patient refuses to adhere to safety interventions). Creative staffing calls for creative use of all hospital employees. Housekeeping staff can be trained to ensure room items are returned to a certain place after cleaning and should understand the vital role they play in preventing patient safety events. Ancillary and quality/risk management staff can, and should, play a greater role in concurrent chart review and patient surveillance as part of daily work.

While the concept of “all-team” rounding for outcomes can be applied across the board for safety measures and other process and outcome measures, it is especially relevant in fall prevention. The

| TABLE 1: EXAMPLE OF ROLES VARIOUS DEPARTMENTS CAN PLAY IN ENSURING PATIENT SAFETY AND PROMOTING FALL PREVENTION |
|-------------------------------------------------------|--------------------------------------------------|-------------------------------------------------|--------------------------------------------------|-------------------------------------------------|
| **ANCILLARY DEPARTMENTS** | **HOUSEKEEPING** | **ENGINEERING/BIOMED** | **QUALITY/RISK MANAGEMENT** | **DIETARY** |
| Room scan | ✓ | ✓ | ✓ | ✓ | ✓ |
| Answer lights | ✓ | ✓ | ✓ | ✓ | ✓ |
| Patient safety scan | ✓ | ✓ | ✓ | ✓ | ✓ |
| Hydration | ✓ | ✓ | ✓ | ✓ | ✓ |
| Comfort needs | ✓ | ✓ | ✓ | ✓ | ✓ |
| Real-time chart review | ✓ | | ✓ | | ✓ |
| Patient/family education | ✓ | ✓ | ✓ | ✓ | ✓ |

Source: Missouri Hospital Association
more staff involved in patient surveillance the better chance of proactively managing patient needs to prevent falls.

**ALWAYS EVENT® — POST-FALL HUDDLES**

A strategic, standardized post-fall huddle can provide key insight to both immediately fix the situation and learn for future prevention. The key to post-fall huddles is accountability. A leader needs to be established as a general expectation in the post-fall protocol to ensure it is completed. Suggestions include leadership, charge nurse, quality improvement staff and house supervisors. Ensure a standardized, brief review tool is utilized. This creates ease of use for staff and helps with data collection and analysis regarding causation factors. These reports should be utilized to assess for immediate corrective actions, as well as retrospective reporting.

An often overlooked issue is how standardized processes are carried out after “normal business” hours. Processes should be standardized across all staff, all days of the week, and all hours. This can be a challenge and calls for more creative strategies. Assigning responsibility to unit and house supervisors to facilitate huddles is one possible solution, with leadership review during normal business hours.

**TABLE 2: POST-FALL HUDDLES**

| Who          | • staff involved  
|              | • patient/family  
|              | • unit manager  
|              | • house supervisors  
|              | • risk management  
|              | • quality leader  
|              | • physician (as available)  
| What         | complete post-fall huddle and debrief form  
| When         | as soon as possible after the event, once patient is stable and care needs are met  
| Where        | site of the fall  
| Why          | • involves patient and family  
|              | • real-time care plan corrections  
|              | • promotes active learning  
|              | • timely feedback  
|              | • optimizes event reporting  
|              | • staff involved are present to review events  

Source: Missouri Hospital Association

The value of post-fall huddles (and huddles utilized for other process improvements) is the ability to gain real-time lessons learned with the staff and patient involved. Traditional root-cause analysis efforts have been completely retrospective and often lacked front-line staff involvement due to timing issues and ability to reunite those involved. It also does not allow for the patient’s participation. Integrating the post-fall huddle report into the event reporting system would eliminate redundancy of work, promote completion, and be a staff satisfier.

**CONCLUSION**

Communication barriers continue to be the number one identified issue in all event reporting. Developing and requiring standardized communication formats for staff, patients and families provides clarity and organization, and focuses work on patient outcomes. The TeamSTEPPS model recommends four key criteria for effective communication: complete, clear, brief and timely.
Always Event®: Increase Interdisciplinary Scope

Interdisciplinary involvement is necessary for patient safety. Each discipline carries a wealth of specialized knowledge that, when combined, serves to provide a safety net for the patient. Health care providers cannot work in silos; they must bridge the care and information gaps, and develop standardized communication pathways to provide holistic, patient-centered care. Collaboration is the key!

Collaboration is defined as the act of working together with one or more people to achieve a goal. When unit teams collaborate, they have a commitment to a common mission, which they are more likely to reach as a group than as isolated individuals. While not specifically discussed in this toolkit, inclusion of “non-traditional” team members is recommended. Examples include medical records coders, financial representatives, community partners, building and plant departments, and dietary staff. These services bring a different and unique perspective to the issue of falls prevention, as well as complete the picture of the effects falls (and other harm topics) have on both patients and the health care delivery system.

The following sections review opportunities for pharmacists, therapists, nurses and other ancillary staff to support fall prevention strategies.

ALWAYS EVENT® — PHARMACY SERVICES MEDICATION REVIEW FOR HIGH-RISK PATIENTS

Medication review is an essential, but often overlooked, component of a comprehensive falls risk assessment protocol. Hospitalized patients often are prescribed new medications. They also are likely to be hospitalized related to a surgical procedure that requires anesthesia and pain medication. In addition, health care providers work with patients daily who do not have a good understanding of what their home medications are and how and when to take them correctly. Many prescription and nonprescription medications cause sedation, dizziness, postural disturbances, altered gait and balance, and/or impaired cognition. Medications most likely to increase the risk of falls include benzodiazepines, antipsychotics, diuretics (partly because they cause frequent urination), antidepressants (particularly tricyclics), neuroleptics, opioids, insulin, and oral hypoglycemics. Cardiac drugs and antihypertensives also increase the fall risk because they can cause an orthostatic blood pressure drop. Many elderly people take multiple medications, and drug interactions may contribute to falls.
Medication profile review by a pharmacist has the potential to identify opportunities to modify drug therapy and reduce the risk for medication-related falls in patients. A standardized tool and method of communicating findings to physicians and nursing staff involved in the patient’s care are essential. Ideally, this review of medications is done as close to time of admission as possible, with continuous review during multidisciplinary rounds throughout the duration of the patient’s hospitalization.

Items to review include:

- high risk medications
- new prescriptions
- inappropriate prescribing
- polypharmacy
- intake and output status
- education level
- cognition status
- disease state
- history of prior fall(s)
- indication for lab monitoring
- whether the patient had an orthopedic surgery

Of these items, the two most modifiable risk factors related to fall prevention are inappropriate prescribing and polypharmacy.34

Beer’s Criteria and the Medication Appropriateness Index are currently used most often in the inpatient setting by pharmacists conducting medication reviews. Table 3 outlines a summary of advantages and disadvantages of each tool.

**TABLE 3: BEER’S CRITERIA AND MAI ADVANTAGES AND DISADVANTAGES**

<table>
<thead>
<tr>
<th>BEER’S CRITERIA</th>
<th>MAI</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Advantages:</strong></td>
<td><strong>Advantages:</strong></td>
</tr>
<tr>
<td>Broadest use</td>
<td>Last updated in 2010</td>
</tr>
<tr>
<td>Adopted by federal quality regulators</td>
<td>Applicable to every medication</td>
</tr>
<tr>
<td>Simple</td>
<td>Comprehensive</td>
</tr>
<tr>
<td>Inexpensive</td>
<td>Focus is on the patient versus drug</td>
</tr>
<tr>
<td>Applicable to all patients</td>
<td>Inter- and intra-rater reliability</td>
</tr>
<tr>
<td>Adaptable to EHR algorithms</td>
<td>Use in inpatient and ambulatory settings</td>
</tr>
<tr>
<td>Drug indication is not required</td>
<td>Detects changes over time</td>
</tr>
<tr>
<td>Ability to apply to large patient samples</td>
<td>Reviews 10 criteria per medication</td>
</tr>
<tr>
<td><strong>Disadvantages:</strong></td>
<td><strong>Disadvantages:</strong></td>
</tr>
<tr>
<td>Has not been updated in more than a decade</td>
<td>Complex</td>
</tr>
<tr>
<td>Not designed for falls assessment</td>
<td>Not designed for falls assessment</td>
</tr>
<tr>
<td>Limited reliability IP setting</td>
<td>Requires comprehensive clinical data</td>
</tr>
<tr>
<td>Incomplete</td>
<td>Not easy to apply to large databases</td>
</tr>
<tr>
<td>Not evidence-based</td>
<td>Requires well-trained clinicians</td>
</tr>
<tr>
<td>Usage of 3 lists is confusing</td>
<td>Incomplete (causality)</td>
</tr>
<tr>
<td>Inaccurate, missing inappropriate prescribing resulting in falls</td>
<td>Time intensive</td>
</tr>
<tr>
<td>Omits dosing, duration, interactions and polypharmacy</td>
<td>Limited formal validity</td>
</tr>
</tbody>
</table>

Further studies have developed other medication review tools, such as the Falls Specific Inappropriate Prescribing Assessment Tool,34 the Pharmacy-Based Fall Prevention Program,35 and the Fall-Prevention Medication Review Tool.36

Falls specific inappropriate prescribing tool34 is a two-stage model utilizing a risk stratification piece to delineate low versus high risk for falls patients. In this model, the Beer’s Criteria is a first-line assessment tool used to indicate any medications with an “inappropriate” or “potentially inappropriate” use. Any patients meeting these criteria would then have a suggested modified MAI tool applied. The modified MAI tool deletes three questions from the original and also considers consolidation.
TABLE 4: MAI CRITERIA WITH FASPIP MODIFICATIONS

<table>
<thead>
<tr>
<th>QUESTIONS TO BE RATED FOR EACH MEDICATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are there significant drug-to-drug interactions?</td>
</tr>
<tr>
<td>Are there significant drug-to-disease interactions?</td>
</tr>
<tr>
<td>Is there an indication for the drug?</td>
</tr>
<tr>
<td>Is the drug effective for the indication?</td>
</tr>
<tr>
<td>Is there unnecessary duplication with other drugs?</td>
</tr>
<tr>
<td>Is the duration of therapy acceptable?</td>
</tr>
<tr>
<td>Is the dosage correct?**</td>
</tr>
<tr>
<td>Are the directions correct?**</td>
</tr>
<tr>
<td>Are the directions practical?***</td>
</tr>
<tr>
<td>Is this drug the least expensive alternative compared with others of equal utility?**</td>
</tr>
</tbody>
</table>

**The three questions to be deleted for the FASPIP. Also questions regarding drug-to-drug and drug-to-disease interactions could be consolidated.

Source: Innovations in Pharmacy

The MAI/FASPIP modifications model would have the advantage of using a screening tool, which is user friendly and time-efficient, followed by a more complex and laborious tool used only for those at a higher risk for medication issues.

PBPP was developed through a project focused on helping medication review processes become feasible for pharmacists in medium-sized, nonacademic hospitals. It utilizes nursing to perform a first-line assessment of risk by stratifying certain medication classes known to increase fall risk into three categories with a points system. This score, paired with the nursing fall risk assessment (i.e., Morse, etc.), creates a composite score. That total score indicates whether a pharmacy review is required. Using this method at Mercy Health Center in Oklahoma City, — a 351 bed, full service, tertiary care, community hospital — helped them achieve a 36 percent reduction in falls and a 44 percent reduction in falls with injury during a two year period. This translated to a savings of approximately $217,000 for the health center.

TABLE 5: PBPP MEDICATION FALL RISK SCORING SYSTEM

<table>
<thead>
<tr>
<th>AHFS PHARMACOLOGIC-THERAPEUTIC CLASSIFICATION</th>
<th>RISK FOR FALLS</th>
<th>POINTS</th>
<th>MECHANISM FOR FALLS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Analgesics, antipsychotics, anticonvulsants, benzodiazepines</td>
<td>High</td>
<td>3</td>
<td>Sedation, dizziness, postural disturbances, altered gait and balance, impaired cognition</td>
</tr>
<tr>
<td>Antihypertensives, cardiac drugs, antiarrhythmics, antidepressants</td>
<td>Intermediate</td>
<td>2</td>
<td>Orthostasis, impaired cerebral perfusion, poor health status</td>
</tr>
<tr>
<td>Diuretics</td>
<td>Low</td>
<td>1</td>
<td>Increased ambulation, orthostasis</td>
</tr>
</tbody>
</table>

American Hospital Formulary Service
A score of 6 or higher for a patient suggests an increased risk for falls and triggers evaluation of the patient (i.e., fall risk evaluation)

Source: American Society of Health-System Pharmacists
As part of the work of the HEN, HRET developed a fall toolkit that included a medication review tool adapted from St. John Medical Center, in Tulsa, Okla. (see Resource Links). The toolkit reviews classes of medications and includes other risk assessments including height, weight, kidney function, age, polypharmacy and prescribed anti-coagulant/anti-platelet medications. It also includes an indication for adding Vitamin D to the medication regimen to support muscle strength.

Patients on anti-coagulants or anti-platelet medications warrant special consideration in a falls prevention strategy. While these medications are not necessarily considered high fall-risk medications, they can have significant impacts if a patient falls. Additional interventions should include thorough patient and family education, use of protective devices, and an understanding that all falls are serious. The patient should be thoroughly assessed by a physician as soon as possible to rule out internal bleeding issues.

Once pharmacy staff completes the medication review, communication of findings is the new step in the medication review process. Ideally, this communication is standardized to avoid miscommunication or missed information. Consider the following suggestions:

- flag high risk for falls medications in the electronic medication administration record and drug dispensing device by color, font or pop-up message boxes
- pharmacy attends daily shift huddle to review medication alerts
- physician communication and recommendations — make signing-off and approval simple and standardize recommendation options
- pharmacy staff attend multidisciplinary rounds
- consider reporting quality indicators

Consider the following interventions to engage therapy services.

- Use of the “Up and Go” test can help in areas where therapy services are not as widespread to make a differentiating call for further therapy consultation. The “Up and Go” test requires a patient to stand from a chair, walk 10 feet, turn and walk back to the chair, and then sit down in less than 20 seconds. If the patient is unable to complete this exercise in 20 seconds, they should be considered at increased risk for future falls, and interventions should be deployed. There are other commonly used functional assessment measures, especially for the geriatric population, that can be utilized.

- Consider implementation of a standing order for physical and/or occupational therapy consults if the patient’s risk assessment score is high. Inclusion of this standing order in the falls protocol is recommended and avoids a missed opportunity to promote mobility and functional improvement.

- Develop an understanding and awareness of how hospitalization leads to greater weakness without intervention. Walking plans and therapeutic services offer interventions to help patients maintain strength and mobility. Use of standardized functional measurement tools can give baseline and end-of-therapy results, and could serve as a process measure of improvement.
• Standardized communication with nursing staff regarding ambulation plans, transfer needs, and progress with therapeutic interventions. Nursing staff can play a pivotal role in supporting the plan of therapy by reviewing strategies and techniques with patients, reinforcing education regarding mobility, and ambulating with patients throughout the day to supplement therapy services.

• Participation in multidisciplinary care plan meetings. Although these meetings can take various forms, the goal of having all care providers giving input on the patient’s care and discharge plan is the same.

• Invite therapy staff to utilize the assignment and communication boards on each unit. Assign them a color (marker, magnet, or e-platform indicator) so they can make brief notes or comments. Possibilities include noting when initial evaluation is complete, an up or down area to indicate progress with therapeutic plan, or noting when the patient is being discharged from service.

• From an outpatient and community perspective, consider a “Fall Prevention Clinic,” like that at Johns Hopkins,\(^4^0\) to assist patients once discharged from the hospital.

**ALWAYS EVENT\(^0^0\) — NURSING STRATEGIES**

Nurses and nurse assistants are critical to falls prevention. The nurse performs the risk assessment, assigns the score, and determines the interventions to be utilized, dependent upon score and protocol. The nursing team provides 24/7 oversight of patients, their activities and care needs. The following are recommendations to include in the standards of care and fall prevention protocol.

• ALWAYS use a gait belt! Gait belts often are seen as unnecessary and inconvenient. Despite these issues, gait belts are highly recommended when transferring or ambulating patients, not only to protect and support the patient, but also the care provider.\(^4^1\) Develop a plan to maintain gait belts and monitor their usage. A zero tolerance policy is encouraged. A good plan is to issue a gait belt upon admission for every patient and include this as an Always Event\(^0^0\) for all patients in the protocol.

• Patient safety equipment, such as lifts, transfer boards and benches, should be utilized with all patients.\(^4^2\) Work with the employee health department to form a business case for purchases of additional equipment, if needed.

• As referred to in the discussion of therapy services, nurses can provide additional ambulation and mobility promotion through daily walking schedules, reinforcement of therapy education, and assistance with use of devices.\(^4\) Clear communication between nursing staff and therapy is vital.

• Since the majority of falls have been noted to occur during the act of toileting, the use of toileting schedules has

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**TABLE 6: EFFECTS OF BED REST**

<table>
<thead>
<tr>
<th>SYSTEM</th>
<th>EFFECT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cardiovascular</td>
<td>† Stroke volume, ‡ cardiac output, orthostatic hypotension</td>
</tr>
<tr>
<td>Respiratory</td>
<td>† Respiratory excursion, ‡ oxygen uptake, † potential for atelectasis</td>
</tr>
<tr>
<td>Muscles</td>
<td>‡ Muscle strength, † muscle blood flow</td>
</tr>
<tr>
<td>Bone</td>
<td>† Bone loss, ‡ bone density</td>
</tr>
<tr>
<td>Gastrointestinal</td>
<td>Malnutrition, anorexia, constipation</td>
</tr>
<tr>
<td>Genitourinary</td>
<td>Incontinence</td>
</tr>
<tr>
<td>Skin</td>
<td>Sheering force, potential for skin breakdown</td>
</tr>
<tr>
<td>Psychological</td>
<td>Social isolation, anxiety, depression, disorientation</td>
</tr>
</tbody>
</table>

*Source: Patient Safety and Quality: An Evidence-Based Handbook for Nurses\(^9^0\)*
been promoted as a proactive strategy to prevent falls. A few examples include implementing the strategy of “nobody toilets alone” and “safety trumps privacy” to encourage patients not to get up without assistance. This also sets the expectation for staff that every transfer and ambulation has staff oversight with applicable assistive devices. Most toileting schedules involve assisting all patients at prescribed times, usually after breakfast, lunch, and dinner, and before bedtime. This proactive strategy involves staff not waiting for the call light and risking not getting to the patient in time to avoid an accident or fall. It also helps them organize their shift work.

- Patient rounding strategies have been in the literature for well over a decade; however, their widespread deployment and “hard-wired” use is questionable. Use of a value-added rounding tool and specific staff assignments help to operationalize this strategy on nursing units.

- Managing workload implications is key to any type of proactive strategy. Creative ideas for staffing management of key work events throughout the shift are necessary. One strategy is to divide and conquer! Make these key tasks part of the assignment for all care providers on that shift and track them on the patient assignment boards. In addition, be a role model for staff and teach them how to accomplish rounds and toileting assistance as part of their usual tasks. For example, if a nurse assistant is in the room to take vital signs, it also is reasonable to assist with toileting, scan the room for hazards, and help with a position change. Staff huddles are helpful in these situations as all staff can see what risks are present and can work together to devise a plan to ensure key tasks, such as hourly rounds, toileting schedules and medication passes, are completed timely and efficiently.

- Patient sitter programs have become popular resources during the last few years as a way to provide one-to-one bedside oversight. These programs do not take away valuable nursing resources; particularly on a medical-surgical unit with high nurse-to-patient ratios.

- Bed/chair alarms should be used as a last resort in a fall prevention protocol. These types of audible alarms, triggered by weight changes, actually increase immobility since patients learn not to trigger the alarm with movement. Alarms are all different, with some having variable thresholds of movement before the alarm is triggered; however, they still serve the same purpose and promote immobility. In addition, the alarm is loud, can cause over-stimulation of an already agitated patient, and is a noise disturbance for the Use of volunteers and non-clinical employees is common. Training is necessary in order to meet the Health Insurance Portability and Accountability Act and regulatory standards, and to provide patient and provider safety.
entire unit, depriving patients of valuable and necessary healing sleep. It is preferable to use a patient sitter or family member presence at the bedside, exercise with the patient, and promote positive distractions if patients are cognitively impaired. These interventions promote function and mobility and offer mental stimulation that is not overwhelming.

OTHER CARE PROVIDERS

Other care and service providers such as case management, social services and physicians can play an important role in fall prevention. They have a unique position in that they are able to help continue fall prevention techniques into the patient’s home upon discharge.

- Providers should be soliciting information from the patient and/or family about the patient’s home environment, thus determining if the home is the best place for the patient to return upon discharge and possible hazards of which to be aware.

- Consideration of potential post-acute service needs is important to the patient’s ability to be successful upon discharge and to avoid readmission. Post-acute services may be as simple as having therapy evaluate the home environment for risks and level of assistance needed. Evaluation may result in the patient needing residential care. Discussing how post-acute service options can help keep the patient from falling is key to discharge planning.

- Since more than half of all falls occur in the home, it is important for physicians to discuss fall risk with patients during routine visits. Falls in the home are the leading cause of emergency room visits for injury. Physicians and their staff can help the patient and family assess the risks and determine a plan for safety.

- It is important for any ancillary care provider to understand the patient’s fall-risk score, especially prior to transfer. Communication with nursing staff, standardized assignment board communication, and use of a hall pass are possible strategies to ensure ancillary staff are aware of the patient’s safety risks and care needs.

- Dietitians play an integral role in fall prevention. Assessment of caloric need, level of nutrition, barriers to healthy eating and current disease state can all impact a patient’s risk for falling.
Always Event©: Patient and Family Engagement

ALWAYS EVENT© — PATIENT AND FAMILY ENGAGEMENT
The Institute of Medicine defines patient-centered care as “providing care that is respectful of and responsive to individual patient preferences, needs and values, and ensuring that patient values guide all clinical decisions.” Engaging patients and families in their care is well-supported in evidenced-based practice standards. The Agency for Healthcare Research and Quality noted in 2001 that research has demonstrated that patients who are active participants in their care experience better outcomes than those who are not similarly engaged. It is important that health care workers not let patient and family engagement become the next “buzzword” in strategies to drive improvement in areas such as fall prevention. Patient and family engagement should start at the bedside upon admission and be a mutually beneficial partnership between health care workers and the patient or family.

THE FRAMEWORK FOR ENGAGING HEALTH CARE USERS
The American Hospital Association’s Framework for Healthy Individuals and Communities, shows how patients and their families can be engaged at multiple entry points during their experience with the health care system.

FIGURE 6: AMERICAN HOSPITAL ASSOCIATION’S FRAMEWORK FOR HEALTHY INDIVIDUALS AND COMMUNITIES
Learning patient preferences, habits and cultural needs is only the beginning of engagement. Health literacy should be a fundamental driver in providing communication to patients and their families, as well. Low health literacy has been linked to many of the health issues Missouri faces, including falls with injury. A 2011 literature review confirmed that adults with low health literacy tend to have poor health status, use emergency rooms and inpatient care more frequently, and have a higher risk of death.51

Missouri Health Literacy is an organization that provides assistance to hospitals and consumers regarding production of literacy-level appropriate health care education resources, including brochures, handouts and videos. The Centers for Disease Control and Prevention also has several patient education resources, including fall prevention information.3

**ALWAYS EVENT® — USE THE TEACH BACK METHOD DURING PATIENT/FAMILY EDUCATION**

Studies have shown that 40 to 80 percent of the education patients receive is forgotten immediately and nearly half of the information retained is incorrect.53 The Teach Back method has shown that patients and families often have very different interpretations of what they have been taught. Misunderstanding medication instructions, how to care for themselves at home, and when to follow-up with primary care physicians are just a few examples of the vital information patients are not correctly receiving. Anecdotal observations of bedside care providers note that a comfort level with utilizing Teach Back during patient education has not been achieved or hardwired. Strategies to implementing the Teach Back method include:

- Observe if staff utilizes Teach Back during patient education opportunities, such as fall prevention discussions with the patient. If they don’t, role model the tactic by asking the patient to repeat what they heard. Ensure the patient understands that you want to communicate instructions clearly for their safety.
- After the observation, discuss with staff the reasons for not utilizing Teach Back. It is likely just a matter of practice makes perfect!
- During a staff meeting or huddle, take a couple minutes to role play. Read a brief set of instructions and ask staff during a huddle what they heard. See how many differences there are in receipt of the message. Another option is to pair-up staff during a staff meeting and have them practice with each other.
- Ask staff to share experiences in using Teach Back. It is often eye-opening to realize a patient did not receive the message as intended.
- Teach Back is a great tool to use outside patient education to ensure clarity of all communication. Try it when closing meetings, working on projects or when teaching staff new skills to ensure everyone involved has clear understanding.

**Health literacy is defined as: the degree to which individuals have the capacity to obtain, communicate, process and understand the basic health information and services needed to make appropriate health decisions.**

–The Patient Protection and Affordable Care Act, 201052

In other words, health literacy is the ability to make good health decisions every day.

Several opportunities to utilize Teach Back in falls prevention education include the following.

- Upon admission, can the patient repeat the understanding of how to use the call light, when to use the call light, when not to get up unassisted, etc.?
- With use of a patient agreement:
  - Does the patient understand why they are at risk for falls? Do they understand the safety measures in place to help prevent falls? Note this agreement will need to be reviewed with the patient and family throughout the hospitalization as their condition changes. It is recommended to review their risk and safety plan with every shift physical assessment and as needed.
Communities as a whole have an important role to play in supporting their residents. A growing number of hospitals nationwide are beginning to include patient and family advisors on select quality improvement teams or on their board of trustees. This practice of using previous and current health care users allows the hospital staff to view the health care experience in a different manner, while gaining a better understanding about the priorities of their community. In addition, the patient and family advisor better understands the processes, constraints and “why” behind their care and treatment. Advisors can serve to bridge both sides of care — those who give it and those who receive it. Again, when patients take a more active and shared role in their health, all participants benefit.

One of the most important elements of creating a sustainable patient and family engagement culture is leadership buy-in and role modeling behaviors. In order for organizational leaders to be engaged, they must first understand what patient- and family-centered care is and why it is important to the patient’s safety and recovery. Once that message is delivered, leaders serve to support patient and family collaboration at all levels, including clinical care that promotes fall prevention, hospital policies and procedures, and long-term strategic planning.

Consider the following model when devising patient and family engagement strategies:

- **Did care support a healing, respectful relationship?**
  - linked to “Likely to Recommend” on HCAHPS

- **Did you diagnose me promptly and accurately?**
- **Did you treat me appropriately?**
  - linked to evidence-based care, Magnet quality metrics, preventing harm/infections

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**ALWAYS EVENT**

**COMMUNITY: PATIENT AND FAMILY ADVISORS**

During physician and other clinician assessments and treatments:

- Does the patient understand what they were told and why they are getting certain treatments? For example, does the patient know that the reason they are receiving physical therapy is to improve their gait?

During discharge planning:

- How does the patient function in their home environment? Do they understand their fall risks once at home?

Upon discharge:

- Does the patient have an understanding of medication changes and dosages that can increase fall risk? Do they know when to follow-up, how to care for themselves, what signs and symptoms to report?

Teach Back is not a test of the patient’s knowledge. It is a test of how well you explained the concept.

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**FIGURE 7: PATIENT AND FAMILY ENGAGEMENT STRATEGIES**

![Patient and Family Engagement Strategies Diagram]

Source: Graphic modified from FY 14 Quality Planning Framework, Northwestern Medical
• Did you safely transition me to the next level of care?
  – linked to care coordination, access, readmissions, chronic disease management
• Did you improve my health?
  – linked to patient reported quality metrics, utilization of services, disparities, rates of chronic disease

CONCLUSION
Despite heightened national attention to this issue, reimbursement penalties, and implementation of best practice strategies, patient fall rates across the U.S. continue to escalate, putting patients and caregivers at increased risk. Health care facilities continue to struggle implementing necessary changes on a consistent basis. The challenge of creating environments in which patients are safe from falling remains. Use of Always Events© to strategize and standardize interventions to improve communication pathways, increase interdisciplinary scope, and engage patients and families in their care is highly recommended as a national strategy. This work is further supported through the evidenced-based work of the TeamSTEPPS® model.

THE AIM: ZERO PATIENT HARMS
Missouri Hospital Association and its partners are available to provide further resources and assistance to our member hospitals and health systems.
Citations


17. Institute for Healthcare Improvement. (2014, February). *IHI always events getting started kit*. [http://www.ihi.org/resources/Pages/Tools/AlwaysEventsGettingStartedKit.aspx](http://www.ihi.org/resources/Pages/Tools/AlwaysEventsGettingStartedKit.aspx)


STAFF HUDDLE WORKSHEET

1. The focus is the PATIENT
2. Keep it constructive 3. Keep it on task
4. Work with a regular agenda
5. Set a standard time(s)
6. Be on time

- Huddle Date
- Comments
- Follow-up
- Parking Lot
- Lessons Learned

- Changes in Census
- Who's at Risk Today? Why?
- Procedures Today?
- Reportable Events?
- Compliments and Concerns From Patients/Family?
- Clinical Focus Topic
- Knowledge Sharing/Top of Mind
- Follow-up on Prior Issues

It is recommended that the patient assignment board, whether electronic or manual, be utilized to track information. A large board works well and leaving a large blank section works for additional comments and information. This is where the opportunity to color code certain work well to use identified magnets (such as a yellow star) to place next to a patient's name to indicate high risk.

Source: Missouri Hospital Association
1. The focus is the PATIENT
2. Keep it constructive
3. Keep it on task
4. Work with a regular agenda
5. Set a standard time(s)
6. Be on time

<table>
<thead>
<tr>
<th>Huddle Date</th>
<th>Comments</th>
<th>Follow-up</th>
<th>Parking Lot</th>
<th>Lessons Learned</th>
</tr>
</thead>
<tbody>
<tr>
<td>Changes in Census</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Who’s at Risk Today? Why?</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Procedures Today?</td>
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<tr>
<td>Reportable Events?</td>
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<tr>
<td>Compliments and Concerns From Patients/Family?</td>
<td></td>
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<tr>
<td>Clinical Focus Topic</td>
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<tr>
<td>Knowledge Sharing/Top of Mind</td>
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<tr>
<td>Follow-up on Prior Issues</td>
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<td></td>
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</tr>
</tbody>
</table>

It is recommended that the patient assignment board, whether electronic or manual, be utilized to track information. A large board works well and leaving a large blank section works for additional comments and information. This is where the opportunity to color code certain patient information works well. If a patient is identified as “high risk for falls,” it is easy to use a yellow or red marker to indicate this on the board. Magnetic boards also work well to use identified magnets (such as a yellow star) to place next to a patient’s name to indicate high risk.

Source: Missouri Hospital Association
### REDUCING FALLS/INJURIES FROM FALLS CROSSWALK

<table>
<thead>
<tr>
<th>Recommended Process</th>
<th>Implemented</th>
<th>In Progress</th>
<th>Not in Place</th>
<th>Action (Leader and Due Date)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Perform a standardized risk assessment on admissions to identify patients at high risk for fall and/or an injury from a fall. Include the assessment in hourly rounds and be sure to reassess daily and with changes in patient condition.</td>
<td></td>
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</tr>
<tr>
<td>Implement patient-specific interventions, such as toileting schedules and medication review, to prevent falls and injuries.</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Include patients, families and caregivers, physical therapy, occupational therapy, nursing, physicians, pharmacy and family members staying with patients, on your care team to prevent falls.</td>
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<td></td>
</tr>
<tr>
<td>Ensure communication occurs across teams, using huddles and hand-offs.</td>
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</tr>
<tr>
<td>Perform a post-fall huddle to identify type of fall, how and why it occurred, and to implement interventions to prevent a fall from occurring again.</td>
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</tr>
<tr>
<td>Institute a “No Pass/I Stop for Light” program where staff, regardless of department, must go into rooms with the call lights on, either to assist patients or find assistance for them.</td>
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<tr>
<td>Use a white/fall board to post fall prevention successes and keep staff engaged.</td>
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<td></td>
</tr>
<tr>
<td>Engage all employees in fall prevention knowledge and strategies i.e. rounds, environmental scans, etc.</td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PFE piece</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Individualize interventions such as non-skid floor mats, hip protectors, individualized toileting schedule and adjust frequency of rounds.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Source: Missouri Hospital Association
Resource Links

FALL RISK ASSESSMENTS
Hamilton County Fall Prevention Task Force: http://www.fallpreventiontaskforce.org/tools.htm
Minnesota Falls Prevention: http://www.mnfallsprevention.org/professional/assessmenttools.html

COMMUNICATION TOOLS
American Physical Therapy Association: http://www.apta.org/
Electronic Health Record example: http://jama.jamanetwork.com/article.aspx?articleid=186836

PATIENT AND FAMILY-CENTERED CARE
Institute for Patient- and Family-Centered Care: http://www.ipfcc.org/tools/downloads-tools.html
American Hospital Association: Strategies for Leadership: Advancing the Practice of Patient- and Family-Centered Care: http://www.aha.org/content/00-10/resourceguide.pdf

GENERAL FALL RESOURCES
Pennsylvania Safety Authority: http://patientsafetyauthority.org/Pages/Default.aspx
V.A. National Center for Patient Safety: http://www.patientsafety.va.gov/professionals/onthejob/falls.asp
Johns Hopkins Medicine Falls Prevention Clinic: http://www.hopkinsmedicine.org/physical_medicine_rehabilitation/services/outpatient/falls_prevention_clinic.html
Institute for Healthcare Improvement, Always Events Getting Started Toolkit: http://www.ihi.org/resources/Pages/Tools/AlwaysEventsGettingStartedKit.aspx
Practicing Physician Education in Geriatrics Website: http://www.gericareonline.net/tools/eng/falls/index.html
Suggested Citation
