Partnership for Patients

ALASKA STATE HOSPITAL & NURSING HOME ASSOCIATION | Washington State Hospital Association

Washington State Hospital Association
Safety Action Bundle:
Protecting Patients from Falls and Fall-related Injuries

Rating:
- 0- Not in Place
- 1- Being discussed
- 2- In progress
- 3- Fully Implemented

CORE STRATEGIES AT ORGANIZATIONAL LEVEL:

A. Leadership	0	1	2	3
Fall Injury Prevention Program Attributes				
1. Executive leadership (i.e. hospital director, associate directors, nurse executive) "walk-arounds" with targeted questions about fall injury prevention.				
2. Management (i.e. Executive Champions, Clinical Directors, Unit Managers) and clinical representatives facilitate periodic, announced, focus groups (unit briefings) of front line practitioners to learn about perceived problems with falls and fall-related injuries.				
3. Employees are provided with timely (monthly/quarterly) feedback on falls and injury data, improvement results, significant events and close calls.				
4. Fall-Injury Prevention strategies target the organizational and unit system, along with specific patient populations.				

5. Fall-related injuries are discussed openly without fear of reprisal or blame.				
6. All fall-related injuries are discussed with patients and families regardless of injury severity.				
7. One or more specifically trained practitioners are identified to oversee the analysis of fall-related injuries, their causes and coordinate fall injury prevention activities. (Designation of Fall Experts and Unit Based Champions)				
8. Employees voluntarily report fall injury hazards.				
9. A non-blaming immediate post fall assessment (Safety Huddle) of every patient fall is conducted to identify root causes of fall and resulting injury.				
10. After immediate assessment and reporting, how the fall and injury might have been prevented is communicated to all staff.				
11. Staff participates in equipment and technology selection (i.e. surveillance and detection systems, floor mats, hip protectors).				
12. Patient Communication / Hand-off Procedures include patient's risk for an injurious fall.				
13. Fall injury prevention and intervention protocols are included in hospital and nursing new employee orientation (e.g. hip protectors, mats, low beds).				
14. Staff participates in professional and/or clinical training programs that include skills training to prevent injuries for falls (i.e. Washington State Hospital Association Educational Programs and Safe Table Webinars)				

15. Assess the current state, set aims, goals and timelines for practice changes including staffing considerations, necessary equipment, staff skill mix, etc. to reduce injuries from falls.				
16. Identify, create and support the implementation of consistent, organizational wide processes incorporating the multi-disciplinary team in a fall injury prevention program.				
B. Program Evaluation				
17. Fall Rates are analyzed and reported by Type of Fall (Accidental, Anticipated Physiological, Unanticipated Physiological).				
18. Fall-related Injury Rates are analyzed and reported by Severity of Injury.				
19. Fall injury rate is reported per unit and hospital- wide by severity level and type of fall.				
20. Analysis of Repeat Fallers (falls at the person-level) is analyzed based on post fall assessment. (Evaluate the effectiveness of post fall huddles on repeat falls by elimination of immediate cause.)				
21. Analysis of falls and injury are reported and analyzed by Age Groups (<55, 55-65, >65-75, >75).				
22. Falls with injury trend data are compared with staffing matrices.				
23. Annual Staff Education on Fall and Injury Prevention is evaluated.				

24. Measure the percent of fall and injury risk factors treated (mitigated or eliminated) as a result of individualized care planning.				
25. The entire fall prevention program is analyzed at least annually and evaluated for potential risk factors and opportunities for improvement.				
26. Trended injurious falls data are reported to the Board of Directors/Senior Leaders routinely.				
27. Falls with injury prevalence (NQF) Quarterly, Unit and Hospital is reported to team or unit.				
28. Falls with injury prevalence (NQF) Quarterly, Unit and Hospital is reported to Extranet measures.				
29. Data analysis at Organizational and Unit Levels.				
CORE STRATEGIES AT THE UNIT LEVEL:				
A. Fall Injury Risk Assessment Methodology				
30. A Fall Injury Risk Assessment is conducted on every patient on admission, transfer, change in patient status and after a fall.				
31. The history of fall injury risks (osteoporosis, anticoagulants, or other condition that might predispose to injury) is included in the patient assessment upon admission.				
32. A history of a fall-related injury, especially a fracture, is included in the patient assessment upon admission.				
33. Signage is utilized at the bedside if patient is at risk for injury.				
34. A patient-specific injury prevention plan of care is reliably implemented.				

B. Fall Assessment Methodology – Use of Valid and Reliable Instrument				
35. Assess:				
• Patient's history of falls.				
• History of Repeat Falls.				
• Altered mental status (confused, disoriented, depressed, restless).				
• Altered elimination (incontinence, diarrhea, nocturia, frequency, urgency or requirement to help to toilet).				
• Review of medications that increase risk for falls (could include meds that are triggers for injury risk, e.g. steroids, resorptive agents).				
• Altered mobility (unsteady gait, uses assistive devices, impaired balance).				
• Orthostatic hypotension.				
36. Patient-specific fall risk fall prevention plan of care is reliably implemented.				
C. Environmental Safety to Reduce Severity of Injury				
37. Hip Protectors are used for patients with history of fracture.				
38. Floor Mats are used at the bedside to reduce trauma if a fall occurs.				
39. Non-slip flooring is in place, especially in the bathroom and shower.				
40. A height-adjustable bed (in low position, except during transfers or standing) is provided for select patients.				

41. Bed-rail alternatives (body pillows, assist rails) are available and in use.				
42. Raised toilet seats and bilateral grab bars are available and in use.				
43. Any environmental sharp edges are eliminated.				
44. Patient uses the safe exit side from bed (e.g. patient transfer toward unaffected side).				
45. Alarms (bed, wheelchair) are used based on patient-specific criteria (not level of fall risk).				
46. Camera surveillance / detection systems are used appropriately.				
47. Patients have access to mobility aides (walkers, canes, bedside commode) as appropriate.				
D. Additional Fall Risk Assessment if Positive Screen: At Risk for Falls and Injury				
48. Formal tests of mobility, gait (see listed tools in comments section: 8 ft Up and Go, Berg Balance Test).				
49. Medications are reviewed for contributing causes.				
E. Post-Fall Injury Assessment Includes				
50. Conduct a neurological assessment if impact to patient's head is suspected.				
51. Assess any change in patient's Range of Motion post fall.				
52. Evaluate orthostatic vital signs if condition permits.				
53. Document any injury(ies) by severity level.				
54. Modify the patient's plan of care after the Safety Huddle to prevent a repeat fall/injury.				

F. Patient/Family Education / Discharge Education				
55. Engage patients and family in identifying the patient's fall and injury risk on admission as partners in their fall prevention program.				
56. If on anticoagulants, review the patient's anticoagulation therapy prior to discharge.				
57. If on anticoagulants, provide patient education on "*What to do if you fall and are on Anticoagulation*" (patient education brochure).				
58. If osteoporotic, review the potential need for osteoporosis therapy prior to discharge.				
59. If osteoporotic, educate the patient (and family) about osteoporosis (video, patient education brochure).				
60. If a known faller, provide patient education on "*What to do if you fall and cannot get up*" (patient education brochure).				
61. Conduct an Environmental / Home Assessment.				
TOTAL SCORE **If Score using Likert –Type Scale 0-3, Range = 0-221**				