



## Fall Risk Assessment – Content Review Questions

1. **What percentage of inpatient falls results in a serious injury?**
  - A. 10%
  - B. 15%
  - C. 30%
  - D. Less than 1%
  
2. **When an elderly person falls, they psychologically feel more capable of handling another fall.**
  - A. True
  - B. False
  
3. **A fall risk assessment:**
  - A. Promotes implementation of appropriate interventions based on need
  - B. Notifies all key health care staff of a patient's fall risk
  - C. Reduces potential of serious harm or even death through screening
  - D. All of the above
  - E. Only A and B
  
4. **One way to standardize an approach to fall risk identification is through the use of a falls risk screening tool or assessment.**
  - A. True
  - B. False
  
5. **What patients are at the highest risk for falling? (check all that apply)**
  - History of falls
  - Impaired cognition
  - Impaired mobility
  - Patients taking diuretics or narcotics
  - Patient in a cluttered rooms
  
6. **You only need to do a fall risk assessment once on your patient because they likely will not change status during their stay.**
  - A. True
  - B. False
  
7. **Conducting a fall risk assessment on every patient ensures each patient's fall risk level is considered when developing their individualized care plan.**
  - A. True
  - B. False



**8. Reassessment should be completed when: (check all that apply)**

- \_ There is a change in the patient's condition
- \_ There is a change in medication
- \_ Immediately after a fall
- \_ Each shift for high risk patients

**9. In order to reduce the possibility of a patient fall, the optimal time to complete the initial fall risk assessment is:**

- A. < 2 hours after admission to care unit
- B. > 4 hours after admission to care unit
- C. Within 24 hours after admission to care unit
- D. Sometime before discharge

**10. Once a fall risk assessment is completed, you should then:**

- A. Incorporate findings into the patient's individualized care plan
- B. Effectively communicate high risk patient's to the care team
- C. Follow your hospital's falls prevention policy
- D. Educate the patient and/or family regarding their fall risk
- E. All of the above
- F. Only A and D

### Fall Risk Assessment: Answer Key

1. C. 30% of patient falls result in a serious injury in the inpatient setting.
2. False. A fall increases the fear of falling.
3. D. All of the above are applicable to fall risk screening.
4. True. Standardization reduces the likelihood of variability and omitting important information.
5. All answers apply.
6. False. Patients often change their physiological and mental status during a hospital stay. Reassessment is imperative to identify fall risk status changes.
7. True. A fall risk needs to be completed on every patient to get a baseline and develop an individualized plan of care.
8. All answers apply.
9. A. Completing a fall risk assessment as soon as possible, and within 2 hours of admission decreases risk of falling through early risk identification.
10. E. All of the above are applicable once a fall risk is completed.



## Fall Prevention Interventions – Content Review Questions

1. **What are some of the interventions you may include in a patient's individualized care plan?**
  - A. Frequent/Hourly Rounding to assess needs of the patient
  - B. Communicate high risk to other care givers when handing-off
  - C. Engage the patient and family in education regarding the risk of falls and how to prevent falls
  - D. All of the above
  - E. A and B only
  
2. **Hourly rounds with purpose have been shown to reduce falls by up to 50%.**
  - A. True
  - B. False
  
3. **Staying “within arm’s reach” of a patient at risk for falls while toileting is defined as being right outside the room to give the patient privacy.**
  - A. True
  - B. False
  
4. **Having a bed alarm on will most likely prevent a patient from falling.**
  - A. True
  - B. False
  
5. **What are some of the interventions shown to assist with preventing falls? (check all that apply)**
  - Bedside Shift Report
  - Shift or Safety Huddles to review high risk patients
  - Patient Communication Boards
  - Environmental Rounds
  - Completing a falls risk assessment
  
6. **When completing frequent or hourly rounds, you only need to peek in the room to ensure the patient is not doing anything that could cause a fall.**
  - A. True
  - B. False
  
7. **Research has shown that it does not matter whether you engage the patient or family in decisions or care in prevention of falls.**
  - A. True



- B. False
8. **The “No Pass Zone” is a hospital-wide effort to reduce falls and improve patient satisfaction through improving call light response times by making it everyone’s responsibility to answer a call light.**
- A. True  
B. False
9. **In order to have a successful falls prevention program, you only need to have best practices described in your falls policy.**
- A. True  
B. False
10. **Environmental Rounding is best described as: (check all that apply)**
- A. \_\_\_ Protesting in front of the capitol for reduction of greenhouse gas emissions  
B. \_\_\_ A multi-disciplinary group completing a safety checklist on the care unit  
C. \_\_\_ Ensuring there are no physical safety hazards in the patients room  
D. \_\_\_ Inspecting the floors, ceiling and walls for leaks, stains or necessary repairs

### Fall Prevention Interventions: Answer Key

1. D. All answers are applicable for patient care plan inclusion.
2. True. Research has shown that up to 50% of falls can be mitigated by completing hourly rounds with purpose.
3. False. Outside of the room does not meet the definition. *Staying Within Arm’s Reach* is a policy which requires a caregiver to be immediately available and within reach for patients at risk for falling.
4. False. A bed alarm is a latent indicator of a potential fall. A bed alarm is most effective when used in conjunction with other fall prevention interventions such as hourly rounds with purpose, effective hand-offs and safety huddles.
5. All answers are considered appropriate interventions for prevention of falls.
6. False. Looking in on a patient does not meet the definition of rounding with purpose. When completing hourly/frequent rounds, include assessment of pain, repositioning, toileting needs, accessibility to call light and personal items and room/environment.
7. False. Engaging patients/families is essential in prevention falls.
8. True. Answering call lights timely should be a hospital-wide priority.
9. False. Not all best practices will be described or included in the hospital’s fall policy. Interventions should be individualized to the patient based on their fall risk and functional goals.
10. B., C. & D. are all descriptions of environmental rounds in the care units.



## Post Fall Huddle and Analysis – Content Review Questions

1. **A serious injury due to a fall increases the average length of stay by approximately how many days?**
  - A. 6 days
  - B. 2 days
  - C. 1 day
  - D. Usually does not increase the length of stay
  
2. **Post Fall Huddles are really not that effective at preventing future falls.**
  - A. True
  - B. False
  
3. **Post-Fall Huddles:**
  - A. Promotes communication with caregivers and the family/patient
  - B. Assists with identifying processes improvements through the use of data
  - C. Provides key information to correlate trends
  - D. Don't really provide any value with preventing falls, only gathers data
  - E. All of the above
  - F. Only A, B and C
  
4. **A post-fall huddle provides a venue to communicate effectively and consistently for the patient care team.**
  - A. True
  - B. False
  
5. **What are some of the components of a post-fall huddle? (check all that apply)**
  - A. \_\_\_ Date, time, and location of the patient fall
  - B. \_\_\_ What was the patient attempting to do before the fall?
  - C. \_\_\_ Were there any injuries or interventions done post-fall?
  - D. \_\_\_ What fall prevention interventions were in place prior to fall?
  - E. \_\_\_ When was the last time the patient was visibly assessed?
  - F. \_\_\_ Who is bringing the cake and ice cream for the staff party?
  
6. **When a patient has a history of falls, they are more aware of their risk, so they will not likely fall again.**
  - A. True
  - B. False



- 7. Medications that a patient is administered play a very small role in whether a patient is at risk for falls.**
- A. True
  - B. False
- 8. Data collection and analysis from a post-fall huddle: (check all that apply)**
- A. \_\_\_ provides a baseline for improvement of goals
  - B. \_\_\_ trends data to identify where process improvement will be effective
  - C. \_\_\_ provides little or no value to the front-line staff on the care unit
  - D. \_\_\_ may indicate where changes in education, staffing or policy are necessary
  - E. \_\_\_ provides education to staff about why falls are happening on their unit
- 9. When defining a culture of accountability, it is best to only focus on your high risk fall patients and not worry about patients that are not assigned to you.**
- A. True
  - B. False
- 10. Falls with injury can cause lasting pain, limit activities of daily living, and increase the likelihood of skilled nursing placement.**
- A. True
  - B. False

### Post Fall Huddle & Analysis: Answer Key

- 1. A. The average additional length of stay for a fall with injury is 6.27 days.
- 2. False. A post-fall huddle prevents falls through communication, learning, data collection and trending.
- 3. F. A, B & C are all correct statements in relation to the post-fall huddle.
- 4. True. Post-fall huddles promote effective communication surrounding a safety issue.
- 5. A, B, C, D, E are all correct statements regarding the components of a post-fall huddle.
- 6. False. Research has shown that a person is more likely to fall if there is a history of a previous fall(s).
- 7. False. Medications can play a very large role in the patient's risk for falls.
- 8. A, B, D, E are all accurate statements reflecting the significance of a post-fall huddle.
- 9. False. In a culture of accountability and teamwork, all caregivers feel a sense of responsibility towards all patients.
- 10. True. False can have several long-lasting negative outcomes for a patient.