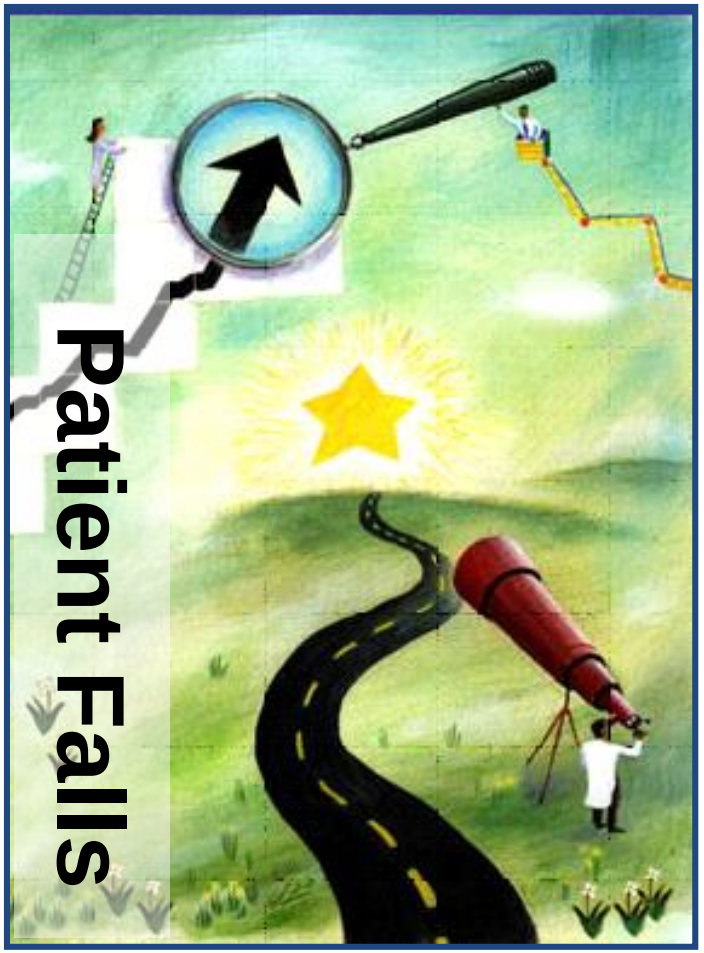
The Fall TIPS Program: Connecting Research to Evidence-Based Care

Patricia C. Dykes PhD, RN, FAAN

Overview

1. Describe the extent of the problem of patient falls
2. Discuss the components of an evidence-based fall prevention program using Fall TIPS as a model

- Discuss roll-out of Fall TIPS



The Problem of Patient Falls

- Falls are a leading cause of death and disability.
  - ~ 33% of older adults fall each year
- Hospitalization increases the risk for falls.
  - ~ 3% hospitalized patients fall
  - ~ 30% of inpatient falls result in injury
- Patient falls and injurious falls are employed as national metrics for nursing care quality.
  - The incidence of patient falls and related injuries are publicly reported by acute care hospitals.
  - As of October 2008, costs associated with fall-related injuries in hospitals are no longer reimbursable under Medicare.

Fall Prevention in Acute Care Hospitals: The Evidence Circa 2007

- Fall risk factors well established
  - Inpatient fall prevention research identified risk factors and fall risk assessment tool validation
  - Risk assessment insufficient for preventing falls
- Paper-based fall prevention guidelines recommended multifaceted, tailored interventions

Insufficient evidence to support a specific protocol that links nursing fall risk assessment to a tailored plan to prevent falls.

Example: Using the EHR for Fall Prevention Care Planning

- Fall TIPS *(Tailoring Interventions for Patient Safety)*
  - 2 year mixed methods study funded by Robert Wood Johnson Foundation:
    - Qualitative phase:
      - why hospitalized patients fall?
      - what interventions are effective and feasible in hospital settings?
    - Randomized control trial: to test an EHR-based fall prevention toolkit designed to address issues identified during qualitative phase.

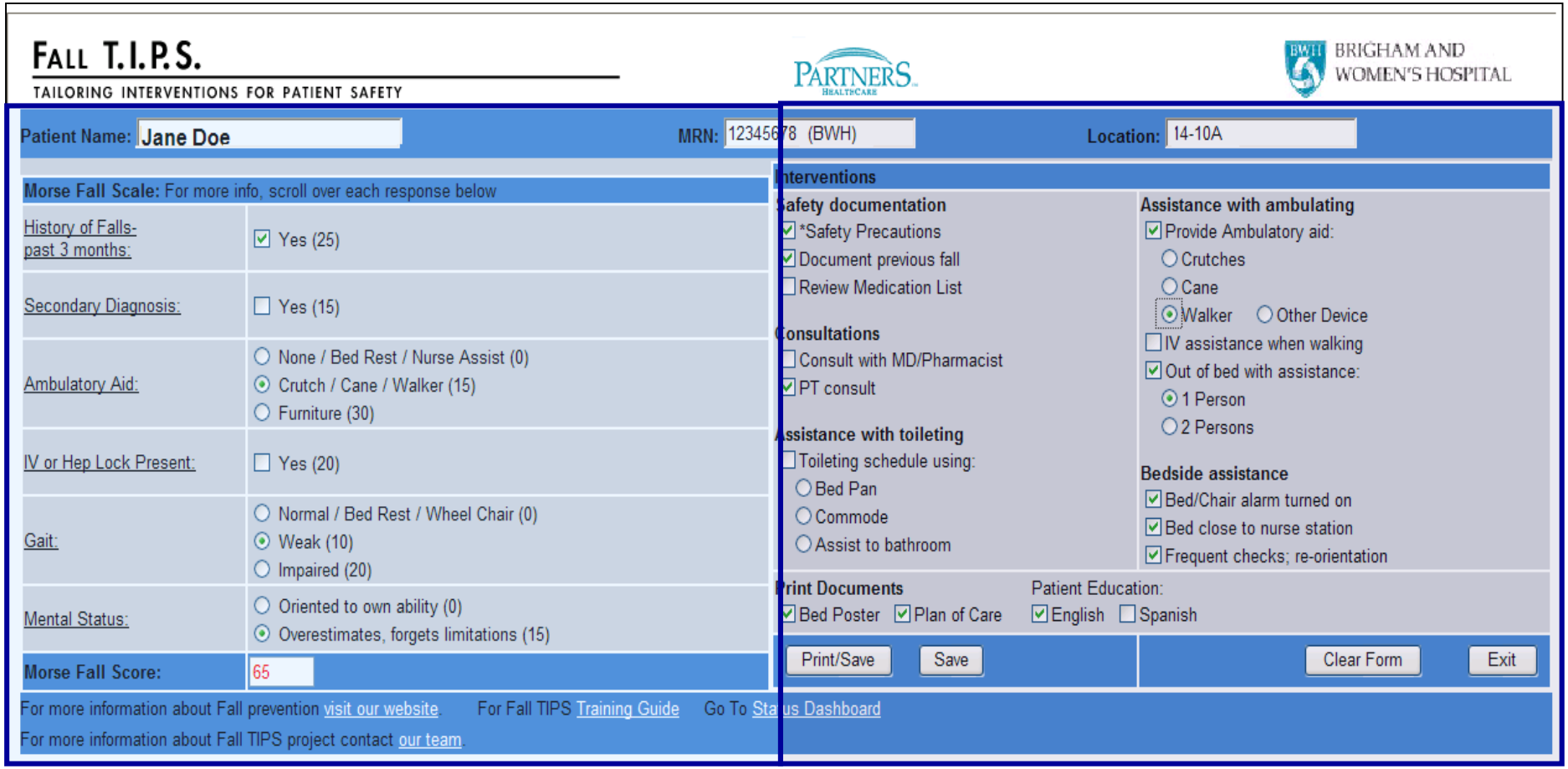
Supported by the Robert Wood Johnson Foundation, Dykes PI

Fall TIPS (2007-2009): Qualitative Results Summary

- Communication related to fall risk status and the plan to prevent falls is highly variable.
- Inconsistent communication across team members is a barrier to fall prevention collaboration and teamwork.
  - Non-nursing team members do not view fall risk assessment/plan in medical record.
  - Inadequate, incomplete, or incorrect information at the bedside (i.e., generic "high risk for falls" signs are not useful).
- All stakeholders (care team members, patients and family members) must work together to prevent patient falls.

Fall TIPS (2007-2009): Toolkit Requirements

The Fall TIPS Toolkit:
Fall Risk Assessment/Tailored Plan



Fall risk assessment

Tailored plan

BRIGHAM AND WOMEN'S HOSPITAL

FALL T.I.P.S.

TAILORING INTERVENTIONS FOR PATIENT SAFETY

Fall Prevention Plan of Care

Problem: ***Patient is at risk for falls***

Patient Name: Jane Doe **MRN:** 12345678 **Printed:** March 04, 2009

Patient has a history of falls	☐ Safety Precautions ☐ Document circumstances of previous falls	History of Falls
Patient uses ambulatory aid	☐ Place WALKER at bedside	Ambulatory Aid: Walker
Patient's gait is Weak	☐ Patient needs AssistX1	Out of Bed with Assist
Patient overestimates ability; forgets limitations	☐ Bed/Chair alarm turned on ☐ Move pt. close to nurse station ☐ Freq Checks; re-orientation; distractions	Bed/Chair Alarm On

Total Morse Fall Score: 65

Sign/Credentials *Patricia C. Dykes R.N* **Date/Time** *3/04/09*

Fall T.I.P.S. Research Study Plan of Care Documentation Form October 1, 2008 - Jur
Medical Record Copy

Plan of Care

Bed Poster

PARTNERS HEALTHCARE

BRIGHAM AND WOMEN'S HOSPITAL

USE THE CALL BUTTON

CALL DON'T FALL!

Fall Prevention Information

As part of the admission process, your nurse has assessed your risk for falling while you are in the hospital. You have been evaluated to be at risk for falling.

Jane Doe , why are you at risk for falling?

- You are in an unfamiliar environment.
- You are not feeling well.

AND:

- You have fallen before and may fall again.
- You are unsteady on your feet.
- You are weak.

How can we work together to prevent you from falling while you are in the hospital?

- We will assist you out of bed as soon as you are able.
- Wear nonskid foot wear.
- Ask to have needed items within reach.

History of Falls — Tell your nurse about recent falls.

Ambulatory Aid: Walker — Use your walker.

Out of Bed with Assist — Call for help to get out of bed.

Bed/Chair Alarm On — The bed/chair alarm is on to remind you and your nurse that you need help to get out of bed/chair.

ur nurse for more information on Fall Prevention or visit:
://www.partners.org/cird/FallsPrevention/FallsInfo.htm

Patient Education

Jane Doe

Avoid Slips, Trips and Broken Hips!

CALL DON'T FALL!

History of Falls	Ambulatory Aid: Walker
Out of Bed with Assist	Bed/Chair Alarm On

Bed Poster

Fall TIPS: Findings

Patient falls were significantly reduced on intervention units

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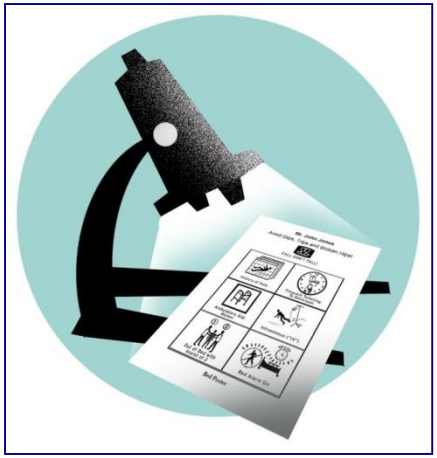
Fall Prevention in Acute Care Hospitals

A Randomized Trial

Patricia C. Dykes, RN, DNSc; Diane L. Carroll, RN, PhD, BC; Ann Hurley, RN, DNSc; Stuart Lipsitz, ScD; Angela Benoit, BComm; Frank Chang, MSE; Seth Meltzer; Ruslana Tsurikova, MSc, MA; Lyubov Zuyov, MA; Blackford Middleton, MD, MPH, MSc

There were fewer falls in intervention units than in control units

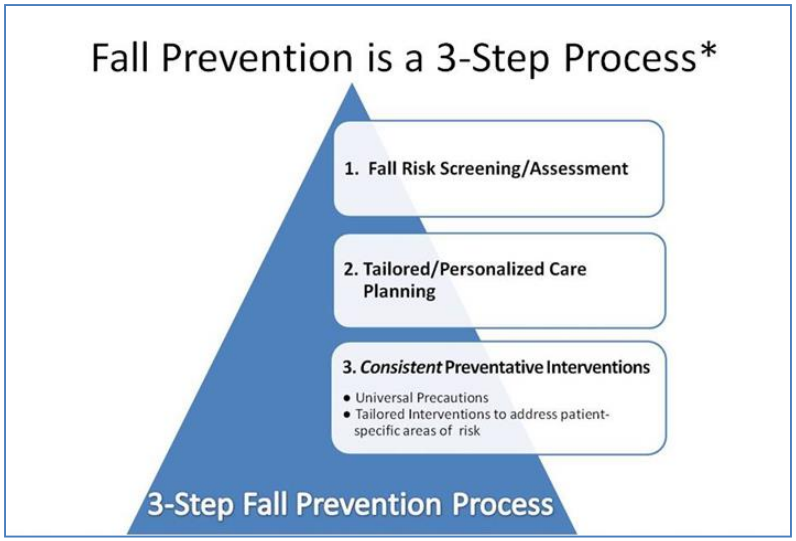
Patients aged 65 or older benefited most from the Fall TIPS toolkit



No significant effect was noted in fall related injuries

Fall Prevention Lessons Learned

- Fall prevention in hospitals is a 3-step process:
  1. Conducting fall risk assessment using a prospectively validated tool.
  2. Developing a plan of care that is tailored to patient-specific areas of risk.
  3. Implementing the plan CONSISTENTLY.
  4. Patient engagement is essential



Strategies and tools to facilitate the 3-step fall prevention process will prevent patients from falling!

Fall TIPS Next Steps

1. Identify ways to disseminate Fall TIPS outside of the electronic health record.
   - Can be used in any hospital
   - Provides clinical decision support
2. Develop tools and strategies to engage patients and families in the 3-step fall prevention process.

Laminated Paper Fall T.I.P.S.

Nombre:

Riesgos de Caídas

(Marque todo lo que corresponda)

- Historia de Caídas previas ☐
- Efectos adversos a medicamentos ☐
- ***Ayudante*** para caminar ☐
- Equipos para intravenosas (IV) ☐
- Marcha inestable ☐
- Olvida llamar o decide no pedir ayuda ☐

Fecha:

Intervenciones Para Caídas

(Circule la sección basada en el color)

Comunique caídas recientes

Ayudas para caminar

Muletas Bastón Caminador

Ayudante **con IV/Equipos para caminar**

Horario para ir al baño : Cada ____ horas

Sanitario de cama | Asistencia con la silla sanitaria | Asistencia para llegar al baño

La alerta de la cama está funcionando

Asistencia para salir de la Cama

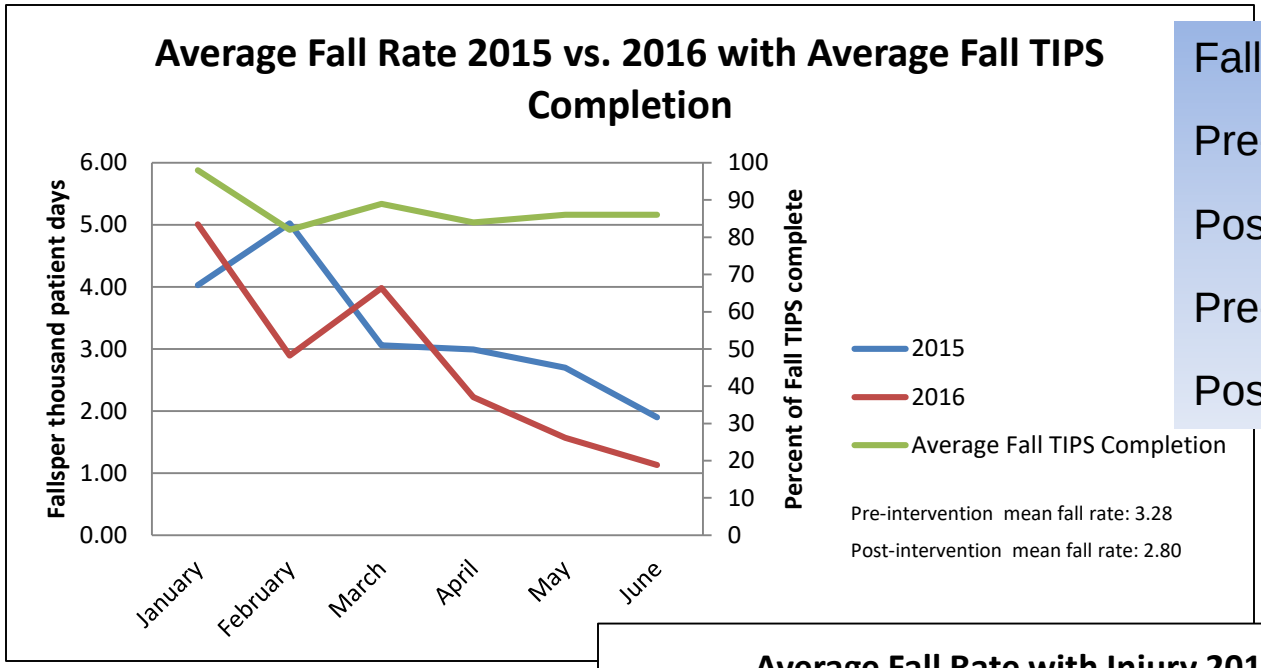
① Una persona

① ② Dos personas

Fall risk assessment

Tailored plan based on patient's determinants of risk

Fall TIPS Pilot Test Results: BWH



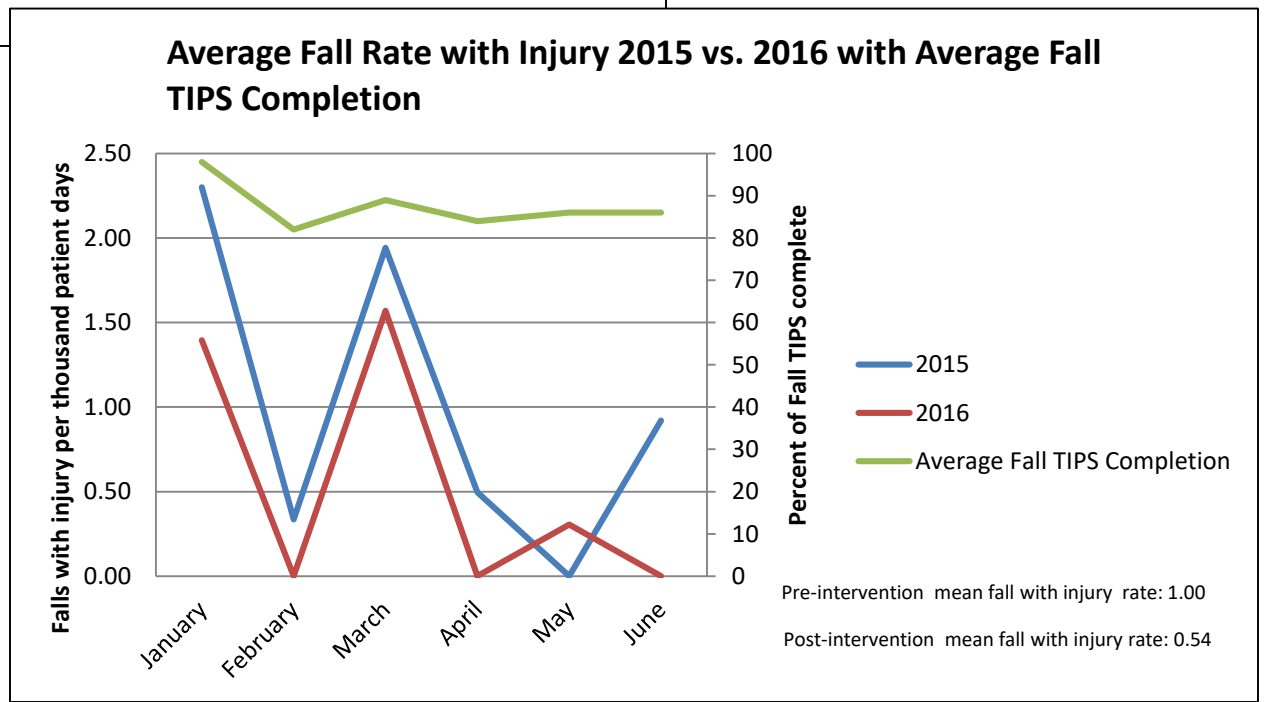
Fall TIPS Adherence: 82%

Pre-Fall TIPS Fall Rate: 3.28

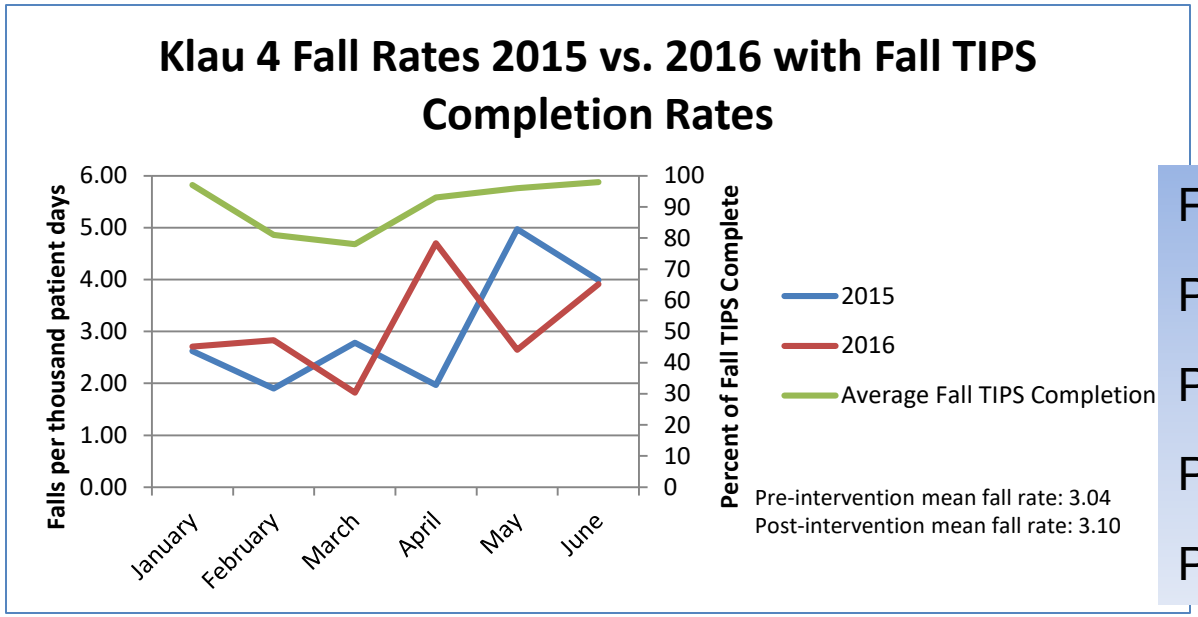
Post Fall TIPS Fall Rate: 2.80

Pre-Fall TIPS Injury Rate: 1.00

Post Fall TIPS Injury Rate: .54



Fall TIPS Pilot Test Results: MMC



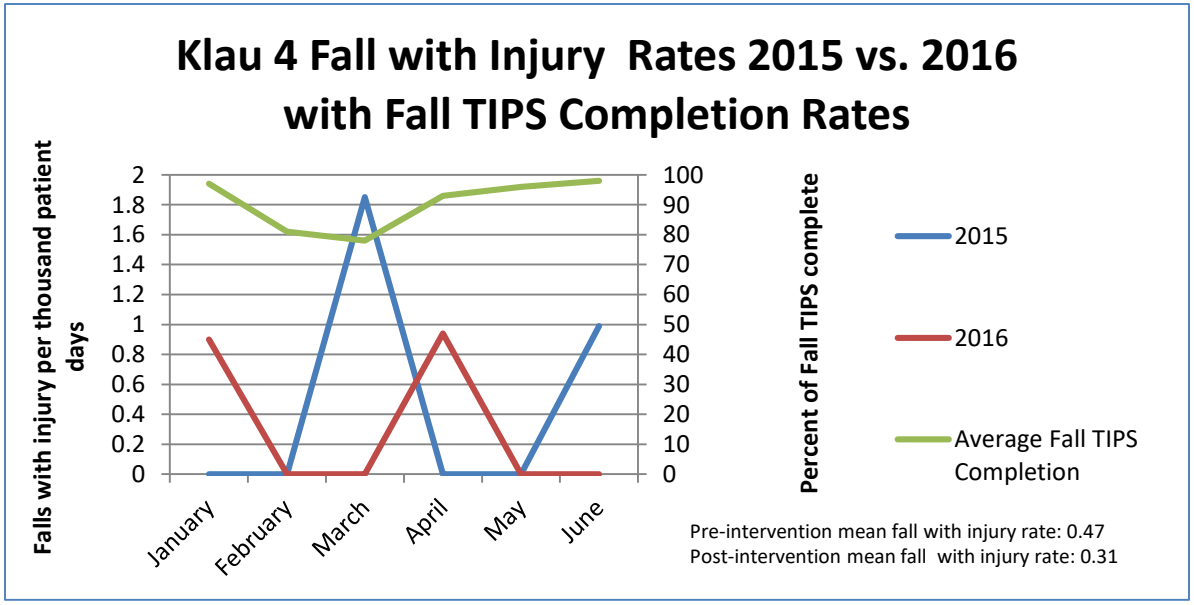
Fall TIPS Adherence: 91%

Pre-Fall TIPS Fall Rate: 3.04

Post Fall TIPS Fall Rate: 3.10

Pre-Fall TIPS Injury Rate: .47

Post Fall TIPS Injury Rate: .31



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Methods, Tools, and Strategies

Pilot Testing Fall TIPS (Tailoring Interventions for Patient Safety): a Patient-Centered Fall Prevention Toolkit

Patricia C. Dykes PhD, RN, Megan Duckworth BA, Stephanie Cunningham RN, Sasha Dubois RN, Melissa Driscoll RN, Zinnia Feliciano RN, Michael Ferrazzi RN, Farah E. Fevrin RN, Stephanie Lyons RN, Mary Ellen Lindros EdD, RN, Allison Monahan RN, Matthew M. Paley RN, Saby Jean-Pierre RN, Maureen Scanlan RN, MSN, NEA-BC

Show more

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Background

Patient falls during an acute hospitalization cause injury, reduced mobility, and increased costs. The laminated paper Fall TIPS Toolkit (Fall TIPS) provides clinical decision support at the bedside by linking each patient's fall risk assessment with evidence-based interventions. Strategies were needed to integrate this evidence into clinical practice.

Methods

The Institute for Healthcare Improvement's Framework for Spread is the conceptual model for pilot implementation of Fall TIPS at Brigham and Women's Hospital (BWH; Boston) and Montefiore Medical Center (MMC; Bronx, New York). The key to translating the evidence into practice was engaging stakeholders by leveraging existing shared governance structures, identifying unit champions, holding training sessions for all staff, and implementing auditing to assess and provide feedback on protocol adherence and patient outcomes.

Fall Prevention in Acute Care Hospitals: The Evidence Circa 2018

- Patient falls are a common problem and can be prevented using the 3-step fall prevention process.
- EHR clinical decision support can link patient-specific risk factors to interventions most likely to prevent a fall.
- Tools are available for use in clinical care to integrate the 3-step fall prevention process into the workflow.
- Engaging patients and family in the 3-step fall prevention process ensures that they understand their risk factors and can play a role in ensuring that the fall prevention plan is implemented consistently.

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Brigham and Women's Hospital

David Bates
Alex Businger
Sarah Collins
Brittany Couture
Anuj Dalal
Patricia Dykes
Sarah Khorasani
Lisa Lehmann
Emily Leung
Stuart Lipsitz
Eli Mlaver
Ronen Rozenblum
Jeffrey Schnipper
Kumiko Schnock

Partners HealthCare

Frank Chang
Ramesh Bapanapalli
Mohan Babu Ganasekaran
Gennady Gorbovitsky

Patient-centered Fall Prevention

Patricia Dykes
Megan Duckworth
Srijesa Khasnabish
Emily Leung
Awatef Ergai
Jillian Hines
Zachary Katsulis
Ramesh Bapanapalli
Mohan Babu Ganasekaran
Jason Adelman
Maureen Scanlan

Northeastern Institute of Healthcare Systems Engineering

James Benneyan
Corey Balint
Jennifer Coppola
Nicholas Fasano
Zachary Katsulis
Meredith Clemmens
Lindsey Baldo
Awatef Ergai
Dominic Breuer
Jillian Hines
Jessica Cleveland

Components of an Evidence-based Fall Prevention Program

Components of an Evidence-based Fall Prevention Program

- Universal fall precautions
- 3-Step Fall Prevention Process:
    1. Fall risk assessment
    2. Tailored fall prevention care planning
    3. Consistent implementation of the tailored care plan
- Post fall management strategy
- Implementation strategies
  - Unit-based champions
  - Competency
  - Continuous quality improvement strategies
    - Peer coaching

Evidence-based Fall Prevention

TYPES OF FALLS

Types of Falls and How to Prevent Them

Accidental falls:

- Occur in those who have no risks for falling
- Usually caused by environmental hazard/error in judgment
- 14% of falls

Prevented through universal fall precautions

Source: Morse, J.M. *Preventing Patient Falls.* (2nd ed). New York: Springer, 2008.

Types of Falls, cont.

Anticipated physiological falls:

- Occur in those who have risk for falling
- MFS includes 6 items that can predict this type of fall.
- 78% of falls

Prevented through fall risk assessment using validated tool and tailored care planning/ interventions

Source: Morse, J.M. *Preventing Patient Falls.* (2nd ed). New York: Springer, 2008.

Types of Falls, cont.

Unanticipated physiological falls:

- Occur in those who have no risks for falling
- Caused by physiologic changes

  —Such as seizure
- 8% of falls

Most difficult to prevent. Some may not be preventable.

Source: Morse, J.M. *Preventing Patient Falls.* (2nd ed). New York: Springer, 2008.

Evidence-based Fall Prevention Strategies

- Universal Fall Precautions
- 3-Step Fall Prevention Process
    1. Fall risk assessment (FRA)
    2. Tailored fall prevention care planning
    3. Consistent implementation of the tailored care plan
- Post fall management

Universal Fall Precautions

- Cornerstone of any hospital fall prevention program
- Train **all** hospital staff who interact with patients.
- Apply to all patients at all times
  - Clear pathways.
  - Wipe up spills immediately.
  - Provide access to call bell.
  - Provide non-skid footwear.

Creates hospital culture that values fall prevention

3-Step Fall Prevention Process

1. **Conducting fall risk assessment**
2. Completing tailored fall prevention care planning
3. Consistently implementing the plan

Step 1

Step 1- Fall Risk Assessment

- Identifies patients at risk for falling
- Provides baseline measure of patient-specific areas of risk
- Aids in clinical decision making
- Informs tailored or personalized preventative measures, care plans, and communication strategies

Standardized fall risk assessment is prerequisite to implementing evidence-based fall prevention intervention protocol.

Step 1

Completion of the MFS

- MFS requires a chart review and **direct** observation of the patient
- MFS should be completed at least once per shift
  - Scores may fluctuate from daytime to night time
- Completion of the MFS requires training
- MFS requires competency assessment

Step 1

Risk Factors for Falls Identified by Morse Fall Scale

- History of falling
- Secondary diagnosis
  - —Associated with incontinence, vision problems, multiple medicines, orthostatic hypotension
- Ambulatory aid
- IV therapy/heparin (saline) lock
- Gait
- Mental status

Areas of Risk	Numeric Values
1. History of falling	No 0 Yes 25
2. Secondary diagnosis	No 0 Yes 15
3. Ambulatory aid None/bed rest/nurse assist Crutches/cane/walker Furniture	 0 15 30
IV or IV access	No 0 Yes 20
5. Gait Normal/bed rest/ wheelchair Weak Impaired	 0 10 20
6. Mental status Oriented to own ability Overestimates or forgets limits	 0 15

Source: Morse, JM. *Predicting Patient Falls*. CA: Sage Publications, 1997.

Step 1 + 2

Risk 1: **History of Falling**

- **Score 0** if <u>none of the following</u> are true:
  - Patient has fallen during this hospitalization.
  - Patient has immediate history of falls within the past 3 months. **This is *the most significant indicator for falling.***
- **Score 25** if <u>one or more</u> of the above are true.

History of Falls	No	0
	Yes	25

Interventions:

- Use safety precautions.
- Communicate risk status via plan of care, change of shift report, and signage.
- Document circumstances of previous fall.

Step 1 + 2

Risk 2: **Secondary Diagnosis**

- **Score 0** if only **1 active** medical diagnosis.
- **Score 15** if **more than 1** medical diagnosis is active for current admission.

Think about factors that may increase risk for falls that are related to multiple medical problems:

- Illness/multiple medications
- Side effects such as dizziness, frequent urination, and unsteadiness
- Vision problems

Secondary Diagnosis	No	0
	Yes	15

Interventions:

- Consider implementing a toileting and rounding schedule
- Review medication list

Patients with multiple medical diagnoses are often on multiple medications. Along with the physical symptoms from the secondary diagnoses, this increases their risk for falls.

Step 1 + 2

Risk 3: **Ambulatory Aid**

- **Score 0** if patient walks without a walking aid or uses a wheelchair or is on bed rest and does not get up at all.
- **Score 15** if patient uses crutches or a walker.
- **Score 30** if the patient walks clutching onto furniture for support (e.g., needs help, but does not ask or does not comply with order for bed rest or to use an ambulatory aid).

Ambulatory Aid	None/ bed rest/ nurse assist	0
	Crutches/ cane/walker	15
	Furniture	30

Interventions:

- Use ambulatory aid at bedside if needed.
- Review dangers of using furniture or hospital equipment as an ambulatory aid.
- Assess ability to use ambulatory aid.
- Consider PT consult.

Step 1 + 2

Risk 4: **Intravenous/Heparin (Saline) Lock**

- **Score 0** if the patient does not have an IV, heparin (saline) lock.
- **Score 20** if the patient has an IV, heparin (saline) lock.

IV/Heparin (Saline) Lock	No	0
	Yes	20

Interventions:

- Implement toileting/rounding schedule.
- Tell patient to call for help with toileting.
- Review side effects of IV medications.

Step 1 + 2

Risk 5: **Gait**

- **Score 0** if the patient has a normal gait.
  - Walks with head erect. Arms swinging freely at the side. Striding without hesitation.
- **Score 10** if the patient has a weak gait.
  - Stooped, but able to lift head without losing balance. If furniture required, uses as a guide (feather-weight touch). Short steps, may shuffle.
- **Score 20** if the patient has an impaired gait.
  - Difficulty rising from chair (needs to use arms; several attempts to rise). Head down; watches ground while walking. Cannot walk without assist; grabs at furniture or whatever available. Short, shuffling gait.
  - Wheelchair: score according to gait used at transfer.

Interventions:

•Help patient get out of bed.

•Consider PT consult.

Gait	Normal	0
	Weak	10
	Impaired	20

Assess your patient's gait while they are walking <u>with</u> their ambulatory aid

Step 1 + 2

Risk 6: **Mental Status**

<u>To test mental status:</u> Ask the patient, "Are you able to go to the bathroom alone or do you need assistance?"

- Normal: patient response is consistent with orders or kardex.
- Overestimates/forgets limitations: patient response is inconsistent with ambulation order or unrealistic.

- **Score 0** if the patient's mental status is normal.
- **Score 15** if the patient is considered to overestimate his/her abilities or is forgetful of limitations.

Mental Status	Normal	0
	Forgets or overestimates	15

Interventions:

- Use bed/chair alarm or virtual monitoring.
- Place patient in visible location.
- Encourage family presence.
- Do frequent rounding.

Step 1 + 2

ABCs of Harm

- Patient is at high risk for injury if they fall with:
  - **A**ge: 85 years old or older, frailty
  - **B**ones: osteoporosis, risk or history of fracture, etc
  - **C**oagulation: risk for bleeding, low platelet counts, or taking anticoagulation
  - **S**urgery (recent): lower limb amputation, major abdominal or thoracic surgery

Interventions:

•Communicate that the patient is at an increased risk for injury if they fall.

•Emphasize the importance of following their personalized fall prevention plan.

Step 2

3-Step Fall Prevention Process

1. Conducting fall risk assessment
2. **Completing tailored fall prevention care planning**
3. Consistently implementing the plan

Step 2

Step 2- Tailored Fall Prevention Care Planning

- Review areas of risk identified by Morse Fall Scale for specific patient.
- Select interventions to address each area of risk.
- Communicate tailored fall prevention plan to all staff who interact with patient. Also share it with patient and their family members.

3-Step Fall Prevention Process

1. Conducting fall risk assessment
2. Completing tailored fall prevention care planning
3. **Consistently implementing the plan**

Carry out the plan consistently to prevent falls– patient engagement can help!

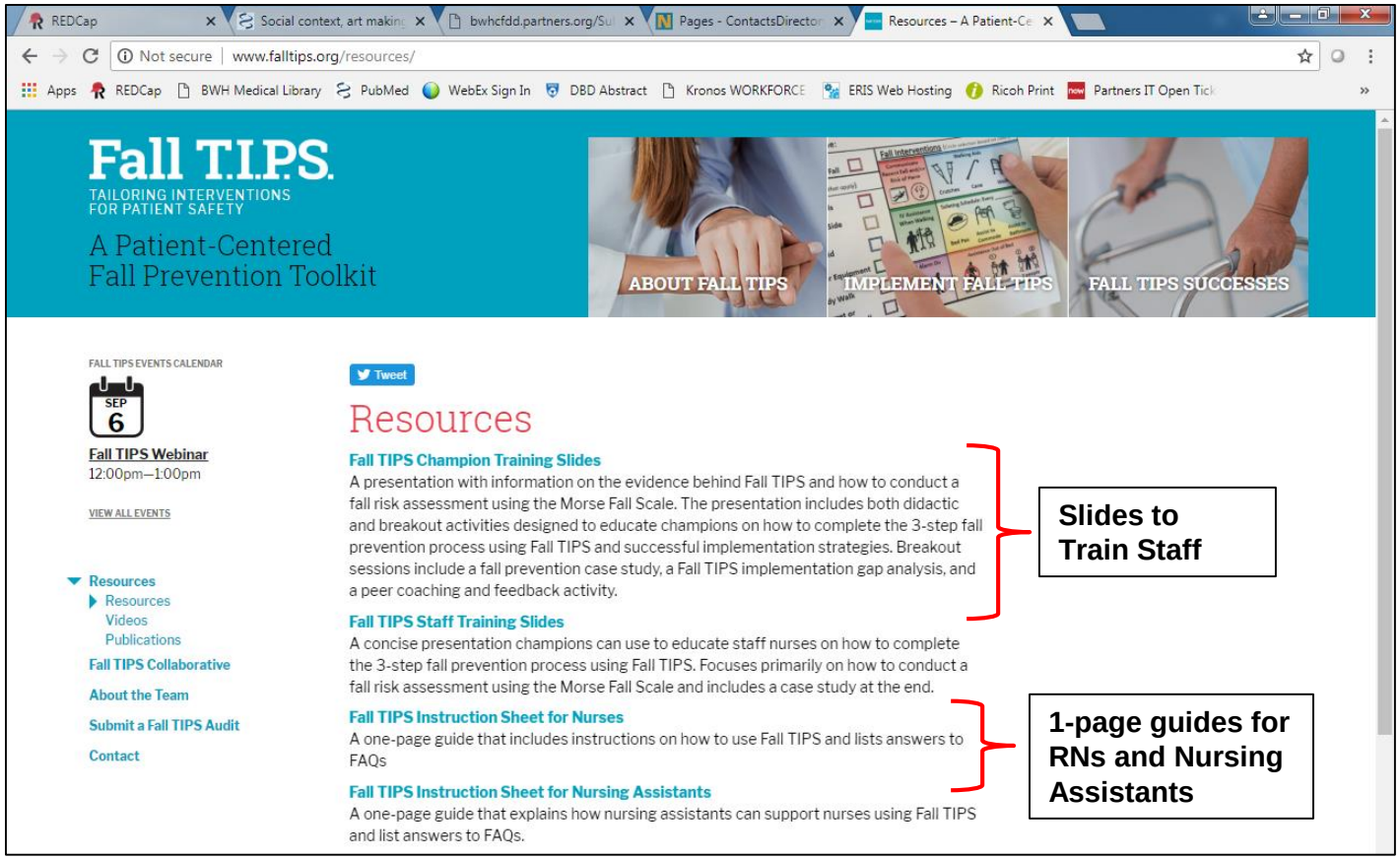
Step 3- Consistently Implementing the Plan

Patient engagement

- Engaging patients and family in the 3-step fall prevention process ensures that they understand their risk factors and can play a role in making sure that the fall prevention plan is implemented consistently.
- Conduct the fall risk assessment with the patient then develop the tailored prevention plan together based on the risk factors identified.
- Consistently educate and remind the patient how to implement the plan.

Tools to Support Fall TIPS Rollout

Available on "resources" page at www.falltips.org/resources

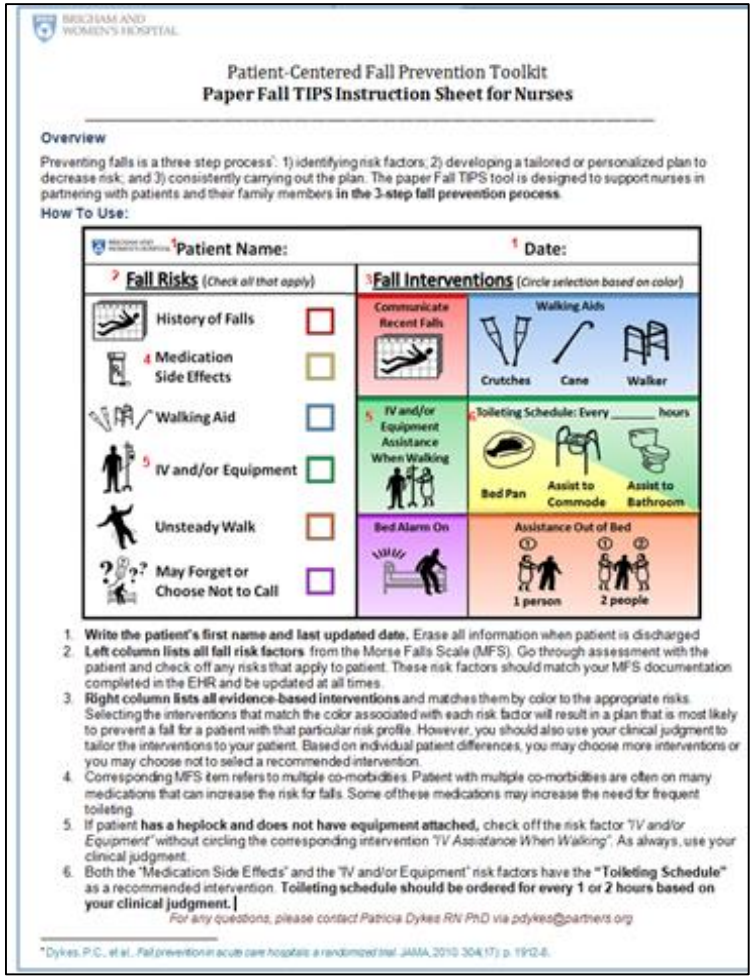


Fall TIPS email: PHSFallTIPS@partners.org

Fall TIPS Implementation Protocol

Detailed Guide available at www.falltips.org/implement-fall-tips/step-1/

1. **Secure Buy-In from Hospital Leadership**
2. **Secure Buy-In from Nurses**
   - Recruit champions (for peer support/training, data collection)
3. **Train Champions**
   - Conduct fall risk assessment competency training with all staff using provided toolkit
4. **Plan Implementation**
   - Print, laminate paper Fall TIPS
   - Use "Readiness for Implementation Checklist"
   - Select Go-Live Date
5. **Communicate Consistently**
   - Track progress weekly
     - How often is Fall TIPS tool completed? (within 24 hours of admission and updated at least once a day)
     - How accurate and up-to-date is the tool?
     - How many days since last fall?
   - Provide continuous feedback
     - Via emails and posters
     - In-person rounding on nurses
     - Promote patient engagement and education



BRIGHAM AND WOMEN'S HOSPITAL

Patient-Centered Fall Prevention Toolkit

Paper Fall TIPS Instruction Sheet for Nurses

Overview

Preventing falls is a three step process*: 1) identifying risk factors; 2) developing a tailored or personalized plan to decrease risk; and 3) consistently carrying out the plan. The paper Fall TIPS tool is designed to support nurses in partnering with patients and their family members **in the 3-step fall prevention process**.

How To Use:

1 Patient Name:	1 Date:
2 **Fall Risks** *(Check all that apply)*	3 **Fall Interventions** *(Circle selection based on color)*
History of Falls ☐	Communicate Recent Falls
4 Medication Side Effects ☐	Walking Aids: Crutches, Cane, Walker
Walking Aid ☐	5 IV and/or Equipment Assistance When Walking
5 IV and/or Equipment ☐	6 Toileting Schedule: Every _____ hours: Bed Pan, Assist to Commode, Assist to Bathroom
Unsteady Walk ☐	Bed Alarm On
May Forget or Choose Not to Call ☐	Assistance Out of Bed: 1 person, 2 people

1. **Write the patient's first name and last updated date.** Erase all information when patient is discharged
2. **Left column lists all fall risk factors** from the Morse Falls Scale (MFS). Go through assessment with the patient and check off any risks that apply to patient. These risk factors should match your MFS documentation completed in the EHR and be updated at all times.
3. **Right column lists all evidence-based interventions** and matches them by color to the appropriate risks. Selecting the interventions that match the color associated with each risk factor will result in a plan that is most likely to prevent a fall for a patient with that particular risk profile. However, you should also use your clinical judgment to tailor the interventions to your patient. Based on individual patient differences, you may choose more interventions or you may choose not to select a recommended intervention.
4. Corresponding MFS item refers to multiple co-morbidities. Patient with multiple co-morbidities are often on many medications that can increase the risk for falls. Some of these medications may increase the need for frequent toileting.
5. If patient **has a heplock and does not have equipment attached,** check off the risk factor *"IV and/or Equipment"* without circling the corresponding intervention *"IV Assistance When Walking"*. As always, use your clinical judgment.
6. Both the "Medication Side Effects" and the "IV and/or Equipment" risk factors have the **"Toileting Schedule"** as a recommended intervention. **Toileting schedule should be ordered for every 1 or 2 hours based on your clinical judgment.**

For any questions, please contact Patricia Dykes RN PhD via pdykes@partners.org

*Dykes, P.C., et al., Fall prevention in acute care hospitals: a randomized trial. JAMA, 2010. 304(17): p. 1912-8.

Evidence-based Fall Prevention

3-STEP FALL PREVENTION PROCESS CASE STUDY

Case 1: John

- John, an 82-year-old man with diabetes was admitted to BWH medical unit with chest pain and shortness of breath. On admission, the patient was found to be alert and oriented. He had an IV and was placed on a cardiac monitor.
- During the admission interview, John reported that with his cane, he was independent with walking and transfers. However, the nurse noted that the doctor's order was for walking with cane and assistance only.
- With further questioning, the patient reported that he had fallen at home several times over the past year, most recently last month.
- As the nurse assisted the patient to the bathroom, she noted that initially he used the bedside table and other furniture as guides and needed to be reminded to use his cane.
- Once he was given a cane, John walked with short, steady steps to the bathroom.

BRIGHAM AND WOMEN'S HOSPITAL **Patient Name:** **Date:**

Increased Risk of Harm If You Fall ☐

Fall Risks (*Check all that apply*)

History of Falls ☐

Medication Side Effects ☐

Walking Aid ☐

IV Pole or Equipment ☐

Unsteady Walk ☐

May Forget or Choose Not to Call ☐

Fall Interventions (*Circle selection based on color*)

Communicate Recent Fall and/or Risk of Harm

Walking Aids

Crutches Cane Walker

IV Assistance When Walking

Toileting Schedule: Every _____ hours

Bed Pan Assist to Commode Assist to Bathroom

Bed Alarm On

Assistance Out of Bed

Bed Rest 1 person 2 people

Answers

BRIGHAM AND WOMEN'S HOSPITAL **Patient Name:** *John* **Date:** *05/12/2016*

Increased Risk of Harm If You Fall ☐

Fall Risks (*Check all that apply*)

History of Falls ☑

Medication Side Effects ☑

Walking Aid ☑

IV Pole or Equipment ☑

Unsteady Walk ☑

May Forget or Choose Not to Call ☑

Fall Interventions (*Circle selection based on color*)

Communicate Recent Fall and/or Risk of Harm

Walking Aids

Crutches | **Cane** | Walker

IV Assistance When Walking

Toileting Schedule: Every __1__ hours

Bed Pan | Assist to Commode | Assist to Bathroom

Bed Alarm On

Assistance Out of Bed

Bed Rest | **1 person** | 2 people

Evidence-based Fall Prevention Recap

- Most patient falls are preventable
- An evidence-based fall prevention program includes the following components:
  - Standard definitions
  - Universal fall precautions
  - 3-Step Fall Prevention Process:
    - Fall risk assessment
    - Tailored fall prevention care planning
    - Consistent implementation of the tailored care plan
  - Post fall management
- Implementation requires a continuous quality improvement, interdisciplinary, team-based approach

The Fall TIPS Collaborative: A Partnership for Spread

- Benefits of Membership:
  - Ongoing access to the Fall TIPS Toolkit, Fall TIPS training webinars, and the implementation guides

Interested in joining? Sign up at www.falltips.org/fall-tips-collaborative/

Thank You!