Fall Prevention Knowledge Pre-Test

We are asking you to take this test twice, before and after learning about Fall TIPS. While preserving your anonymity we would like to link your forms with each other. In the space below, please write your "linking" number.

Linking number: _____. Please pick a 4 digit number you will remember and write it on the line. The numbers can be the last 4 of your cell phone or any numbers you will remember (not 2017) so you can also write it on the next form.

Please mark whether you believe the statements below to be true (T) or false (F).

Item	T	F
1. Bedside nurses know their patients and are better than a standardized screening scale at identifying patients likely to fall.		
2. The 3-step fall prevention process is comprised of 1) screening for fall risks, 2) developing a tailored fall prevention plan, 3) completing fall prevention documentation.		
3. A 75 year old male with history of recent falls and osteoporosis is admitted for severe abdominal pain. He is at increased risk for injury if he falls due to his age.		
4. A common reason why hospitalized patients fall is that their fall prevention plan is not followed.		
5. Falls can be prevented in patients who are susceptible to falling because of physiological problems by providing a safe environment; e.g. clear path to bathroom, room free of clutter, good footwear.		
6. Patient engagement in fall prevention means that the nurse completes the fall risk assessment and prevention plan, and then teaches the patient about their personal fall risk factors and prevention plan.		
7. All hospitals are different; therefore they should develop their own fall risk assessment forms.		
8. A fall risk screening scale identifies those patients who are likely to fall because they have one or more physiological problems.		
9. When nurses communicate with patients about their increased risk for injury if they fall, this improves the likelihood that patients will follow their personalized fall prevention plan.		
10. Patients at low risk for falls do not require a fall prevention plan.		
11. Bed and chair alarms should be activated for all patients who screen positive for being at a high risk of falling.		

Overall, how confident are you with your current ability, either in a direct care capacity or teaching others or in a leadership/management position, to prevent hospitalized patients from falling? Please use a 10-point scale (0=not at all <--> 10=very much so) _____.

Compared to your nursing peers in positions similar to yours, how do you rate your ability to prevent hospitalized patients from falling? above average average below average

Demographic Information:

Please provide the following information by filling in or circling your response.

1. Gender ____
2. Age _____
3. Ethnic group: Hispanic Non-Hispanic Not reporting
4. Race: American Indian/Alaska Native Asian Native Hawaiian or Pacific Islander Black or African American White More than one race Nor reporting
5. Highest nursing degree: Diploma AS/AD BS/BSN MS/MSN DNP/PhD/DNSc
6. Working on degree: BS/BSN MS/MSN DNP/PhD/DNSc non-nursing
7. Number of years employed as a nurse ___
8. Number of years employed at current hospital _____
9. Number of hours worked in a typical week _____
10. Typical shift rotation schedule: all shifts evenings nights rotate D/E rotate D/N all days 7A-7P 7P-7A
11. Typical weekly schedule: mostly weekend/holiday mostly Monday-Friday rotate weekdays/weekends/holidays
12. Current position: direct patient care leadership/management education other _____
13. Type unit: medical surgical oncology neurology orthopedic other _____