Fall Prevention Knowledge Test – Answer Key

Item	T	F
1. Bedside nurses know their patients and are better than a standardized screening scale at identifying patients likely to fall.		X
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.		X
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.		X
4. A common reason why hospitalized patients fall is that their fall prevention plan is not followed.	X	
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.		X
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.		X
7. All hospitals are different; therefore they should develop their own fall risk assessment forms.		X
8. A fall risk screening scale identifies those patients who are likely to fall because they have one or more physiological problems.	X	
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.	X	
10. Patients at low risk for falls do not require a fall prevention plan.		X
11. Bed and chair alarms should be activated for all patients who screen positive for being at a high risk of falling.		X