Fall T.I.P.S. Training
Overview

• Fall TIPS “Super User” Training (this presentation)
  – Review the types of patient falls
  – Review the components of an evidence-based fall prevention program
    • Universal fall precautions (all patients)
    • 3-Step Fall Prevention Process
      1. Fall risk assessment
      2. Personalized fall prevention planning
      3. Strategies to ensure consistent implementation of the fall prevention plan
  – Discuss the role of the PCA in fall prevention
• Review evidence re: Fall TIPS
• Discuss roll-out of Fall TIPS
Is My Patient At Risk For Falling?

TYPES OF PATIENT FALLS
Types of Falls: Preventable

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

Types of Falls: Preventable

Anticipated physiological falls:

- Occur in those who have risk for falling
- The fall risk assessment (Morse Fall Scale) completed by the nurse every shift predicts this type of fall.
- 78% of falls

**Prevented through fall risk assessment, personalized care planning, and carrying out the planned interventions consistently**

Types of Falls: Not Preventable

Unanticipated physiological falls:

• Occur in those who have no risks for falling
• Caused by physiologic changes
  — Such as seizure
• 8% of falls

Is My Patient At Risk For Falling?

FALL PREVENTION STRATEGIES
Evidence-based Fall Prevention Strategies

• Universal Fall Precautions
• 3-Step Fall Prevention Process
Universal Fall Precautions

• Cornerstone of any hospital fall prevention program
• Apply to all patients at all times
  ✓ Clear pathways.
  ✓ Wipe up spills immediately.
  ✓ Provide access to call bell.
  ✓ Provide non-skid footwear.
3-Step Fall Prevention Process

1. Fall risk assessment (FRA)

2. Care plan tailored or personalized to each area of risk identified through FRA

3. Consistent preventative interventions (based on tailored plan)
Fall Risk Assessment at MGH

- Morse Fall Scale
- Document Morse Fall Scale every 24 hours or more often as patient condition warrants
- Used to identify each patient’s individual risk factors for falling
- Used to identify the interventions to decrease patient risk for falling
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

Recommended Interventions

History of falling (in past 3 months): Most significant indicator for falling

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

PCA: Ask the patient about previous falls. Collaborate with the nurse on implementing a plan to prevent similar falls.

Patient who have fallen in the past are likely to fall again and under similar circumstances. Plan accordingly!
Recommended Interventions, cont.

Secondary diagnosis

• Think about factors that may increase risk for falls that are related to symptoms of multiple medical problems and side effects from the medications to treat medical problems:
  — Illness/multiple medicines
  — Side effects such as dizziness, frequent urination, and unsteadiness
  — Vision problems

PCA: Ask the nurse if the patient requires frequent rounding/toileting due to symptoms of medical problems or medication side effects.
Recommended Interventions, cont.

Ambulatory aid

- 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.
- If no ambulatory aid but needs it, consider PT consult

**PCA:** Make sure patients have their ambulatory aid when walking. Remind patient about the dangers of using furniture as an aid in the hospital.
IV therapy/heparin (saline) lock

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

**PCA:** Remind the patient that the IV will cause them to urinate more frequently and to call for help with toileting. Conduct frequent rounding.
Recommended Interventions, cont.

Gait

- Help patient get out of bed.
- Assess gait when patient has ambulatory aid as baseline
- Consider PT consult.

**PCA:** Make sure patients have their ambulatory aid when walking.

**Normal gait:** Walks with head erect, arms swinging freely at the side, striding without hesitation.

**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.

**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.
Recommended Interventions, cont.

Mental status

• Use bed or chair alarm.
• Place patient in visible location.
• Encourage family presence.
• Do frequent rounding.

**PCA:** make sure bed/chair alarm are turned on when leaving the room. Do not leave patients in the bathroom unattended.

**Mental status test:** “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 limits:** Patient response is inconsistent with orders or unrealistic.
ABCS of Harm

• Patient is at high risk for injury if they fall with:
  – **Age**: 85 years old or older, frailty
  – **Bones**: osteoporosis, risk or history of fracture, etc
  – **Coagulation**: risk for bleeding, low platelet counts, or taking anticoagulation
  – **Surgery (recent)**: lower limb amputation, major abdominal or thoracic surgery
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
Findings:

Patient falls were significantly reduced on intervention units.

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 in Acute Care Hospitals: A Randomized Trial
Fall Prevention Lessons Learned

Fall Prevention is a 3-Step Process*

1. Fall Risk Screening/Assessment
2. Tailored/Personalized Care Planning
3. Consistent Preventative Interventions
   - Universal Precautions
   - Tailored Interventions to address patient-specific areas of risk

3-Step Fall Prevention Process

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

• Fall TIPS reduced falls by 25% but >90% of falls are preventable...what happened?
  – Why did some patients with access to the Fall TIPS Toolkit fall?
    • What factors are associated with falls in younger patients?
    • What factors are associated with falls in older patients?
  – Secondary analysis of fallers (cases) n=48 and 144 matched controls exposed to the Fall TIPS toolkit*
  – Found that in all cases, planned interventions were not followed consistently by the patient (most frequently) or the nurse
    • i.e., Out of bed with assistance

How do we get patients to CONSISTENTLY follow their fall prevention plan?

## Paper Fall TIPS

### Patient Name: 

### Date: 

<table>
<thead>
<tr>
<th>Fall Risks (Check all that apply)</th>
<th>Fall Interventions (Circle selection based on color)</th>
</tr>
</thead>
<tbody>
<tr>
<td>History of Falls</td>
<td>Communicate Recent Falls</td>
</tr>
<tr>
<td>Medication</td>
<td>Crutches</td>
</tr>
<tr>
<td>Side Effects</td>
<td>Cane</td>
</tr>
<tr>
<td>Walking Aid</td>
<td>Walker</td>
</tr>
<tr>
<td>IV and/or Equipment</td>
<td>IV and/or Equipment Assistance When Walking</td>
</tr>
<tr>
<td>Unsteady Walk</td>
<td>Toileting Schedule: Every _______ hours</td>
</tr>
<tr>
<td>May Forget or Choose Not to Call</td>
<td>Bed Pan</td>
</tr>
<tr>
<td></td>
<td>Assist to Commode</td>
</tr>
<tr>
<td></td>
<td>Assist to Bathroom</td>
</tr>
<tr>
<td></td>
<td>Bed Alarm On</td>
</tr>
<tr>
<td></td>
<td>Assistance Out of Bed</td>
</tr>
<tr>
<td></td>
<td>1 person</td>
</tr>
<tr>
<td></td>
<td>2 people</td>
</tr>
</tbody>
</table>

**Note:** The table above is a guideline for identifying fall risks and selecting appropriate interventions. Ensure to fill in the appropriate checks and circle selections based on the patient's needs.

**Medical Note:** This form is a part of the patient’s medical record and should be completed by the healthcare provider or relevant staff.
<table>
<thead>
<tr>
<th>Nombre: Riesgos de Caídas (Marque todo lo que corresponda)</th>
<th>Fecha: Intervenciones Para Caídas (Circule la sección basada en el color)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Historia de Caídas previas</td>
<td>Comuníque caídas recientes</td>
</tr>
<tr>
<td>Efectos adversos a medicamentos</td>
<td>Muletas</td>
</tr>
<tr>
<td><strong>Ayudante</strong> para caminar</td>
<td>Bastón</td>
</tr>
<tr>
<td>Equipos para intravenosas (IV)</td>
<td>Caminador</td>
</tr>
<tr>
<td>Marcha inestable</td>
<td><strong>Ayudante</strong> con IV/Equipos para caminar</td>
</tr>
<tr>
<td>Olvida llamar o decide no pedir ayuda</td>
<td>Horario para ir al baño : Cada ___ horas</td>
</tr>
<tr>
<td></td>
<td>Sanitario   Asistencia con de cama la silla sanitaria llegar al baño</td>
</tr>
<tr>
<td></td>
<td>La alerta de la cama está funcionando</td>
</tr>
<tr>
<td></td>
<td>Asistencia para salir de la Cama</td>
</tr>
</tbody>
</table>

Fall risk assessment  Tailored plan based on patient’s determinants of risk
### Fall TIPS Poster Pilot Test

- January – June 2016
- Targeted units with fall/injury rates above hospital and state mean

<table>
<thead>
<tr>
<th>Site/Number of Units</th>
<th>Service</th>
<th>Number of Beds</th>
</tr>
</thead>
<tbody>
<tr>
<td>Brigham and Women’s Hospital/3</td>
<td>Neuroscience Intermediate Care</td>
<td>43</td>
</tr>
<tr>
<td>Brigham and Women’s Hospital/2</td>
<td>Medical Intermediate Care</td>
<td>31</td>
</tr>
<tr>
<td>Montefiore Medical Center/1</td>
<td>Medical Intermediate Care</td>
<td>36</td>
</tr>
<tr>
<td>Brigham and Women’s Hospital/2</td>
<td>Oncology</td>
<td>20</td>
</tr>
</tbody>
</table>
Fall TIPS Pilot Test Results: BWH

Average Fall Rate 2015 vs. 2016 with Average Fall TIPS Completion

- Pre-intervention mean fall rate: 3.28
- Post-intervention mean fall rate: 2.80

Average Fall Rate with Injury 2015 vs. 2016 with Average Fall TIPS Completion

- Pre-intervention mean fall with injury rate: 1.00
- Post-intervention mean fall with injury rate: 0.54

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: 0.54

In Press: Joint Commission Journal of Quality and Safety
Rationale for Patient Engagement in 3-Step Fall Prevention Process

- Facilitates patient understanding of personal fall risk status and the plan to prevent a fall.
- Promotes patient understanding of their role in fall prevention.
- Facilitates patient (and family) partnership in ensuring that the plan is carried out consistently.

A common reason why patients fall is that planned interventions are not followed consistently by the patient (most frequently) or the team*

Patient Engagement Audits

• Fall TIPS Champions on each unit will conduct and submit 5 audits/month with the following data:

  1. Is the patient’s Fall TIPS poster updated and hanging at the bedside?
  2. Can the patient/family verbalize the patient’s fall risk factors?
  3. Can the patient/family verbalize the patient’s personalized fall prevention plan?
Electronic Fall TIPS

- Fall TIPS is integrated into Epic
  - HealthStream module available
- All clinical nurses will complete HealthStream module
- Unit champions’ role:
  - Complete “super user training” (this class)
  - Complete HealthStream module
  - Check off clinical nurses completing Fall TIPS at the bedside with a patient including providing patient education and posting Fall TIPS poster
  - Fall TIPS audits (5/month/unit)
Tools to Support Fall TIPS Rollout

- Fall TIPS training module (HealthStream or power point)
- eCare TIPS sheet
- Fall TIPS audit tool
- Fall TIPS RN Guide
- Fall TIPS email: PHSFallTIPS@partners.org
Fall TIPS Implementation Protocol

1. Organizational support
   - Leadership and unit director support
2. Print, laminate paper Fall TIPS
3. Meet with practice committee and unit nurses
   - Recruit champions (for peer support/training and maybe data collection)
4. Conduct fall risk assessment competency training with all staff
   - Using provided training toolkit
5. 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?
7. Provide continuous feedback
   - Via email and posters
   - In-person rounding on nurses
   - Promote patient engagement and education
EPIC Documentation:  
Two ways to access the MFS risk assessment and Fall TIPS 

1) Click: “Navigators”  
   – Click “Admission” 
   – Click “Falls Mobility” 
   – Click “Morse Fall Risk” and document assessment. 

2) Click: “Summary”  
   – Click “Flowsheets” 
   – Click “Daily Cares/Safety” 
   – Scroll to Morse Fall Risk 

**Note:** “Clear intervention” was changed to “Remove intervention” on Sept. 6th 

This documentation ensures that intervention icons that are no longer relevant (i.e. the patient does not have an IV any more and therefore does not need assistance with IV pole) are not saved in eCare and that the Laminated Fall TIPS poster will match your eCare documentation.
Evidence-based Fall Prevention

3-STEP FALL PREVENTION PROCESS CASE STUDY
Case Study

- 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 past year, most recently last month.

- As the nurse assisted John to 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 his cane, John walked with short, steady steps to bathroom.
### Patient Name: John

### Answers

#### 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

**Date**: 05/12/2016
Questions

Thank you

DCARROLL3@MGH.HARVARD.EDU

PHSFallTIPS@partners.org