Injurious Fall Prevention Organizational Self-Assessment

This self-assessment is voluntary; please complete one per facility. Please do not identify any individual by name; this is confidential as to individuals.

**Hospital Name and station number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Unit Type (s) : Circle One or more (for units that you have a team for in the breakthrough series)**

**Med Surg**

**ICU/CCU/SICU**

**LTC**

**Rehab**

**Psych**

**Outpatient / Community Care**

Directions: Score the level of implementation for each component of your fall-injury prevention program, completing Section 1: Organizational-Level Assessment and Section 2: Unit-Level Assessment. Select a unit and score each item. Consider level of implementation of each component from no activity (0), discussed not implemented (1), partially implemented (2), to fully implemented (3). Circle a numeric score for each item.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Fall Injury Prevention Program Attributes | No Activity | Discussed, not Implemented | Partially Implemented | Fully Implemented |
| SECTION 1. Organizational Level  |  |
| A. Leadership  |  |
| 1. Executive “walk-arounds” with targeted question about fall injury prevention
 | 0 | 1 | 2 | 3 |
| 1. Senior management and clinical representatives facilitate periodic, announced, focus groups (unit briefings) of front line practitioners to learn about perceived problems with fall-related injuries.
 | 0 | 1 | 2 | 3 |
| 1. Employees are provided with timely and routine feedback on fall injury data, improvement results, significant events and near misses\*
 | 0 | 1 | 2 | 3 |
| 1. Fall-Injury Prevention strategies target the organizational and unit system, patient populations.\*
 | 0 | 1 | 2 | 3 |
| 1. Fall-related injuries are discussed openly without fear of reprisal or undue embarrassment.\*
 | 0 | 1 | 2 | 3 |
| 1. All fall-related injuries are discussed with patients and families regardless of injury severity.\*
 | 0 | 1 | 2 | 3 |
| 1. One or more specifically trained practitioners are identified to oversee the analysis of fall-related injuries, their causes and coordinate fall injury prevention activities.\*
 | 0 | 1 | 2 | 3 |
| 1. Employees voluntarily report fall injury hazards\*
 | 0 | 1 | 2 | 3 |
| 1. A non-blaming immediate post fall assessment (Safety Huddle) of every patient fall is conducted.\*
 | 0 | 1 | 2 | 3 |
| 1. After immediate assessment and reporting, how the fall might have been prevented is communicated to all staff\*
 | 0 | 1 | 2 | 3 |
| 1. Inter-rater reliability tests for fall risk assessment and injury risk assessment
 | 0 | 1 | 2 | 3 |
| 1. Staff Participation in Technology Selection
 | 0 | 1 | 2 | 3 |
| 1. Communication / Hand-off Procedure includes risk for injurious fall
 | 0 | 1 | 2 | 3 |
| 1. Fall injury prevention and intervention protocols are included in hospital or nursing orientation (e.g. hip protectors, mats, low beds)
 | 0 | 1 | 2 | 3 |
| 1. Staff participates in professional or clinical training programs that include skills training to prevent injuries for falls (ie VISN 8 Falls Conference)
 | 0 | 1 | 2 | 3 |
| B. Data and Injury Program Evaluation |  |
| 1. Fall Rates by Type of Fall (Accidental, Anticipated Physiological, Unanticipated Physiological)
 | 0 | 1 | 2 | 3 |
| 1. Fall-related Injury Rates by Severity of Injury
 | 0 | 1 | 2 | 3 |
| 1. Fall injury rate reported per unit and hospital- wide by severity level and type of fall
 | 0 | 1 | 2 | 3 |
| 1. Analysis of Repeat Fallers
 | 0 | 1 | 2 | 3 |
| 1. Analysis by Age Groups (<55, 55-65, >65-75, >75)
 | 0 | 1 | 2 | 3 |
| 1. Falls with injury trend data are compared with staffing
 | 0 | 1 | 2 | 3 |
| 1. Amount of Annual Staff Education on Fall Prevention?
 | 0 | 1 | 2 | 3 |
| 1. The entire fall prevention program is analyzed at least annually and evaluated for potential risk factors and opportunities for improvement
 | 0 | 1 | 2 | 3 |
| 1. Trended injurious falls data are reported to the Board of Directors/Senior Leaders
 | 0 | 1 | 2 | 3 |
| 1. Falls with injury prevalence (NQF) Quarterly, Unit and Hospital is reported to team or unit
 | 0 | 1 | 2 | 3 |
| 1. Falls with injury prevalence (NQF) Quarterly, Unit and Hospital is reported to Extranet measures
 | 0 | 1 | 2 | 3 |
| 1. Data analysis at Organizational and Unit Levels
 | 0 | 1 | 2 | 3 |
| SECTION 2. Unit Level  |  |
| A. Fall Injury Risk Assessment Methodology |  |
| 1. Fall Injury Risk Assessment is conducted on every patient on admission, transfer, and change in patient status and after a fall\*
 | 0 | 1 | 2 | 3 |
| 1. History of repeat falls\*
 | 0 | 1 | 2 | 3 |
| 1. History of fall injury risks (osteoporosis, anticoagulants, or other condition that might predispose to injury)\*
 | 0 | 1 | 2 | 3 |
| 1. History of fall-related injury, esp. fracture\*
 | 0 | 1 | 2 | 3 |
| 1. Signage if patient at risk for injury
 | 0 | 1 | 2 | 3 |
| 1. Patient specific injury prevention plan of care reliably implemented
 | 0 | 1 | 2 | 3 |
| B. Screening for Likelihood of Falling  |  |
| 1. History of Falls\*
 | 0 | 1 | 2 | 3 |
| 1. History of Repeat Falls\*
 | 0 | 1 | 2 | 3 |
| 1. Altered mental status (confused, disoriented, depressed, restless)\*
 | 0 | 1 | 2 | 3 |
| 1. Altered elimination (incontinence, diarrhea, nocturia, frequency, urgency or requirement to help toilet)\*
 | 0 | 1 | 2 | 3 |
| 1. Review of medications that increase risk for falls\* (could include meds that are triggers for injury risk, e.g. steroids, resorptive agents)
 | 0 | 1 | 2 | 3 |
| 1. Altered mobility (unsteady gait, uses assistive devices, impaired balance)\*
 | 0 | 1 | 2 | 3 |
| 1. Orthostatic hypotension\*
 | 0 | 1 | 2 | 3 |
| C. Environmental Safety to Reduce Severity of Injury  |  |
| 1. Hip Protectors
 | 0 | 1 | 2 | 3 |
| 1. Floor Mats
 | 0 | 1 | 2 | 3 |
| 1. Non-slip flooring
 | 0 | 1 | 2 | 3 |
| 1. Height-adjustable bed (in low position, except during transfers)
 | 0 | 1 | 2 | 3 |
| 1. Bed-rail alternatives (body pillows, assist rails)
 | 0 | 1 | 2 | 3 |
| 1. Raised toilet seats
 | 0 | 1 | 2 | 3 |
| 1. Elimination of sharp edges
 | 0 | 1 | 2 | 3 |
| 1. Use of safe exit side from bed (pt transfer to unaffected side)
 | 0 | 1 | 2 | 3 |
| 1. Use of alarms (bed, w/c)
 | 0 | 1 | 2 | 3 |
| 1. Pt access to mobility aides (walkers, canes) as appropriate
 | 0 | 1 | 2 | 3 |
| D. Additional Fall Risk Assessment if Positive Screen: At Risk for Falls |  |
| 1. Formal tests of mobility, gait (list tools in comment section: 8 ft Up and Go, Berg Balance Test)
 | 0 | 1 | 2 | 3 |
| 1. Medications reviewed for contributing causes
 | 0 | 1 | 2 | 3 |
| **E. Post-fall injury assessment includes:**  |  |
| 1. Neurological Assessment if impact to head suspected\*
 | 0 | 1 | 2 | 3 |
| 1. Change in Range of Motion post fall\*
 | 0 | 1 | 2 | 3 |
| 1. Orthostatic vital signs if condition permit\*
 | 0 | 1 | 2 | 3 |
| 1. Documentation of injury(ies) by severity level
 | 0 | 1 | 2 | 3 |
| 1. Changed plan of care after the Safety Huddle to prevent repeat fall/injury.
 | 0 | 1 | 2 | 3 |
| F. Discharge Patient/Family Education  |  |
| 1. If on anticoagulation, anticoagulation therapy reviewed prior to Discharge
 | 0 | 1 | 2 | 3 |
| 1. If on anticoagulation, provided patient education on What to do if you fall and are on anticoagulation (pt education brochure)
 | 0 | 1 | 2 | 3 |
| 1. If osteoporotic, need for osteoporosis therapy reviewed prior to discharge
 | 0 | 1 | 2 | 3 |
| 1. If osteoporotic, patient (and family) educated about osteoporosis (Video, Pt Education Brochure)
 | 0 | 1 | 2 | 3 |
| 1. If known faller, provided patient education on What to do if you fall and can not get up (pt education brochure)
 | 0 | 1 | 2 | 3 |
| 1. Environmental / Home Assessment
 | 0 | 1 | 2 | 3 |
| **TOTAL SCORE** ( 63 items: Score Range 0-189) |  |

Comments:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_