### 5B: Assessing Fall Prevention Care Processes

| **Background:** This sample protocol illustrates how to evaluate whether fall prevention care processes are occurring as they should be. **Reference:** Adapted with permission from: Royal College of Physicians *Implementing FallSafe: Care bundles to reduce patient falls.* London, UK: Royal College of Physicians; 2012. Available at: [www.rcplondon.ac.uk/resources/falls-prevention-resources](http://www.rcplondon.ac.uk/resources/falls-prevention-resources).**How to use this tool:** Use this form to observe the patient at bedside and check the notes of 20 patients on your unit every month (ideally the same date each month). To select patients:If you are a small unit, collect it from the first 20 patients who come first in handoffs.If your unit has two teams, take the first 10 patients from each team.And so on if you have three teams, etc.The assessment requires different types of information. Depending on your hospital’s record system and workflow, the information may be found in multiple locations. Make sure the people completing the form know where to find the information, which may require modifying the form to include explicit directions or cues. Observations at the bedside should occur at the time of day when most patients who are well enough would be out of bed. If your hospital uses hourly rounding logs, these can also be checked for completeness during the observations. For the chart review, check the medication administration record (MAR) and any notes easily accessible on the unit, including nursing notes, medical notes, physical therapy notes, and occupational therapy notes. The bedside observations and the chart review can be completed separately but should be done on the same day. This form should be completed by the unit manager or unit champions. This tool should be used to determine whether your hospital unit is carrying out its fall prevention care processes according to plan. It can be modified according to the needs of your specific hospital or unit by adding/deleting rows to customize the processes you want to monitor. Your hospital or unit might use this as an initial screen for assessing progress and then use the results to identify specific components for additional evaluation. |
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| Example | Sample of 20 patients (or all patients if ward has fewer than 20 patients) | **Totals** (yes out of total plus N/A) |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 |
| Use to track patient names/initials/bed number/room number if you need to | FH | AB | ST | YH | LT | YT | TY | UP | KL | MJ | NM | HK | LT | FR | GT | HY | DE | ES | FR | TT |
| All 20 patients: | If small ward with fewer than 20 patients, write total here:  |  |
| Observe: call bell in sight & reach? | Y | N | n/a | Y | Y | Y | Y | Y | n/a | Y | Y | Y | Y | N | Y | Y | n/a | N | Y | Y | 14/17 + 3 n/a |
| Observe: safe footwear on feet? | Y | Y | Y | Y | Y | Y | Y | Y | N | Y | Y | Y | Y | N | Y | Y | n/a | n/a | N | N | 14/18 +2 n/a |
| Observe: room free of clutter? | Y | Y | Y | Y | N | Y | Y | Y | Y | Y | Y | N | Y | Y | N | N | Y | Y | Y | Y | 16/20 |
|  |
| Medication administration record: given night sedation last night? | N | N | N | N | N | N | N | N | N | N | Y | N | N | N | N | N | N | N | Y | N | 2/20 |
| Chart: asked about history of falls? | Y | Y | Y | Y | Y | Y | Y | N | N | Y | Y | Y | Y | Y | Y | Y | Y | Y | Y | Y | 18/20 |
| For any of the 20 pts age 70+: | Number of patients AGE 70+: | 13 |
| Chart: cognitive screen? | Y | N | - | - | - | - | - | Y | n/a | Y | Y | Y | Y | N | Y | - | - | N | Y | Y | 9/12 + 1 n/a |
| For any of the 20 patients who are “higher risk”\*: | Number of higher risk patients:  | 8 |
| Chart: full medication review requested? | Y | Y | - | - | - | - | - | - | - | Y | Y | N | Y | Y | - | - | - | - | Y | - | 7/8 |

**\*** In some wards all patients are counted as high risk, for other wards only some. Follow your local policy.

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\*\*\* Sample of 20 patients (or all patients if ward has fewer than 20 patients). Remember “*not documented=not done*” \*\*\*

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| --- | --- | --- |
| Filled out by: | WARD: | **TOTALS** (YES out of total plus N/A) |
| DATE: | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 |
| Use to track patient names/initials/bed number/room number if you need to |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| All 20 patients: | If small ward with fewer than 20 patients, write total here: |  |
| Observe: call bell in sight & reach? |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Observe: safe footwear on feet? |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Observe: room free of clutter? |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Medication administration record: given night sedation last night? |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Chart: asked about history of falls? |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| For any of the 20 pts age 70+: | Number of patients AGE 70+: |  |
| Chart: cognitive screen? |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| For any of the 20 patients who are “higher risk”\*: | Number of higher risk patients: |  |
| Chart: full medication review requested? |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |

**\*** In some wards all patients are counted as high risk, for other wards only some. Follow your local policy.

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