

# Fall TIPS Champion Training Program New Champion

September, 2020



# *Role of Fall T.I.P.S champion*

Fall TIPS champions are a:

- Resource to “preceptors” during “onboarding” of new unit staff
  - New unit staff complete Health Stream
  - Fall TIPS enhanced by real time daily workflow
- Resource to unit leadership:
  - sustain the unit-based fall prevention program by monitoring performance
  - assist in developing performance and a “QAPI” plan (quality assurance performance improvement).



As the unit-based resource, “*champions*” review unit practice of:

- Universal Precautions
- Hourly Safety rounding
- Fall TIPS patient engagement
- Fall Prevention Equipment

# UNIVERSAL PRECAUTIONS



- Orient patient to to surroundings
- Place call light in reach
- Encourage patient to call for assistance
- Keep eyeglasses accessible
- Using non-skid footwear
- Keep floors clutter free
- Remove excess equipment
- Secure excess electrical/phone wires
- Clean up all spills
- Keep bed in low position
- Secure locks on beds
- Provide adequate lighting
- Educate patient/family on Fall TIPS

# Hourly Safety Rounds

Routine nursing rounds are an evidence based practice

Sometimes referred to as the 4 Ps

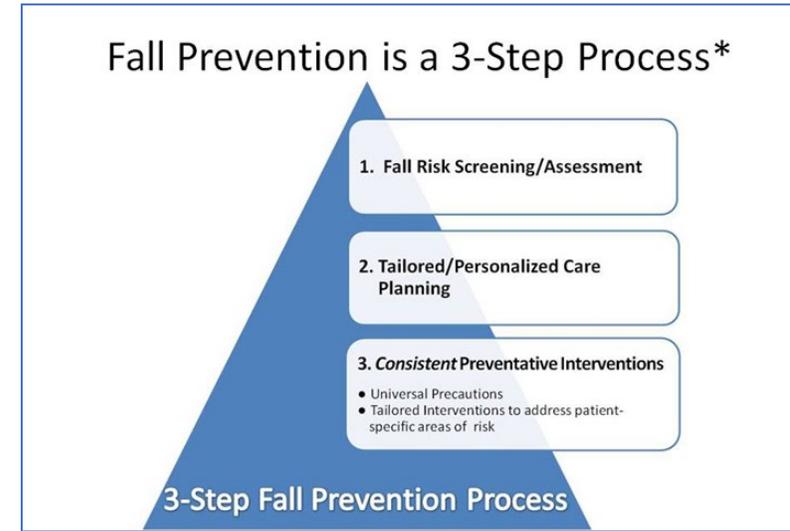
Units may implement somewhat differently

# Fall TIPS



- Assess risk for falls with the Morse Falls Scale (MFS)
- Creates a customized/tailored plan based on area of risk and matching interventions with patients
- Leverage patient and family engagement in the plan
- Complete Fall TIPS poster to communicate areas of risk to all members of the team
- Consistently implement interventions

## Fall Prevention is a 3-Step Process\*



Safe Environment	Yes	Yes	Yes	Yes	Yes	Yes
Call Light Within Reach	Yes	Yes	Yes	Yes	Yes	Yes
Overbed Table Within Reach	Yes	Yes	Yes	Yes	Yes	Yes
Bed in Lowest Position	Yes	Yes	Yes	Yes	Yes	Yes
Bed Wheels Locked	Yes	Yes	Yes	Yes	Yes	Yes
Side Rails/Bed Safety	2/4	2/4	2/4	2/4	2/4	2/4
NonSkid Footwear	On	On	On	On	On	On
Additional Safety Measures	Heightened sur.					
Patient observation type						

Morse Fall Risk	25	25	25	25	25
History of Falling	Communicate	Communicate	Communicate	Communicate	Communicate
Secondary Diagnosis	15	15	15	15	15
Secondary Diagnosis Fall Interventions	Review medica.				
IV/Equipment Taking Fall Interventions	Frequent toilet.				
Ambulatory Aids	0	0	0	0	0
Intravenous Therapy/Heparin/Saline Lock	20	20	20	20	20
IV/Equipment Fall Interventions	Check safety p.				
IV/Equipment Taking Fall Interventions	Frequent toilet.				
Gas/Transferring	10	10	10	10	10
Gas/Transferring Fall Interventions	Assistance out.				
Mental Status	0	15	0	15	0
Mental Status Fall Interventions	Bed alarm on.				
Morse Fall Risk Score	70	85	70	85	70
Unable to Assess Fall Risk					
ADCS of Harm					
At Risk for Injury					



**1 Patient Name:** \_\_\_\_\_ **1 Date:** \_\_\_\_\_

**2 Fall Risks (Check all that apply)**

- History of Falls
- Medication Side Effects
- Walking Aid
- IV and/or Equipment
- Unsteady Walk
- May Forget or Choose Not to Call

**3 Fall Interventions (Circle selection based on color)**

<b>4 Communicate Recent Falls</b>	<b>Walking Aids</b>
<input type="checkbox"/>	Crutches, Cane, Walker
<b>5 IV and/or Equipment Assistance When Walking</b>	<b>Toileting Schedule: Every _____ hours</b>
<input type="checkbox"/>	Bed Pan, Assist to Commode, Assist to Bathroom
<b>Bed Alarm On</b>	<b>Assistance Out of Bed</b>
<input type="checkbox"/>	1 person, 2 people

# Patient Engagement



## Patient-Centered Fall Prevention Toolkit Paper Fall TIPS Instruction Sheet for Nurses

### Overview

Preventing falls is a three step process: 1) identifying risk factors; 2) developing a tailored or personalized plan to decrease risk; and 3) consistently carrying out the plan. The paper Fall TIPS tool is designed to support nurses in partnering with patients and their family members in the 3-step fall prevention process.

### How To Use:

1 Patient Name:		1 Date:	
<b>2 Fall Risks</b> (Check all that apply)		<b>3 Fall Interventions</b> (Circle selection based on color)	
History of Falls <input type="checkbox"/>	<input type="checkbox"/>	<b>Communicate Recent Falls</b> 	<b>Walking Aids</b> Crutches     Cane     Walker
<b>4 Medication Side Effects</b> <input type="checkbox"/>	<input type="checkbox"/>	<b>5 IV and/or Equipment Assistance When Walking</b> 	<b>6 Toileting Schedule: Every</b> _____ <b>hours</b> Bed Pan     Assist to Commode     Assist to Bathroom
Walking Aid <input type="checkbox"/>	<input type="checkbox"/>	<b>5 IV and/or Equipment</b> <input type="checkbox"/>	<input type="checkbox"/>
Unsteady Walk <input type="checkbox"/>	<input type="checkbox"/>	<b>Bed Alarm On</b> 	<b>Assistance Out of Bed</b> 1 person     2 people
May Forget or Choose Not to Call <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

1. Write the patient's first name and last updated date. Erase all information when patient is discharged
2. Left column lists all fall risk factors from the Morse Falls Scale (MFS). Go through assessment with the patient and check off any risks that apply to patient. These risk factors should match your MFS documentation completed in the EHR and be updated at all times.
3. Right column lists all evidence-based interventions and matches them by color to the appropriate risks. Selecting the interventions that match the color associated with each risk factor will result in a plan that is most likely to prevent a fall for a patient with that particular risk profile. However, you should also use your clinical judgment to tailor the interventions to your patient. Based on individual patient differences, you may choose more interventions or you may choose not to select a recommended intervention.
4. Corresponding MFS item refers to multiple co-morbidities. Patient with multiple co-morbidities are often on many medications that can increase the risk for falls. Some of these medications may increase the need for frequent toileting.
5. If patient has a heplock and does not have equipment attached, check off the risk factor "IV and/or Equipment" without circling the corresponding intervention "IV Assistance When Walking". As always, use your clinical judgment.
6. Both the "Medication Side Effects" and the "IV and/or Equipment" risk factors have the "Toileting Schedule" as a recommended intervention. Toileting schedule should be ordered for every 1 or 2 hours based on your clinical judgment.

For any questions, please contact Patricia Dykes RN PhD via [pdykes@partners.org](mailto:pdykes@partners.org)

# Equipment available for consideration: (see Falls Guideline or Falls website)

## Fall Prevention Related Equipment

Name	Indications	Tips
<p>Bed Alarms</p> 	<ul style="list-style-type: none"> <li>-Patient that overestimates/may forget to call and forgets limitations.</li> <li>-Does not call appropriately for help.</li> </ul>	<ul style="list-style-type: none"> <li>-Change the sensitivity based on patient need</li> <li>-The bed needs to be zeroed first before using the alarm</li> </ul>
<p>Chair Alarm</p> 	<ul style="list-style-type: none"> <li>-Patient that overestimates/may forget to call and forgets limitations.</li> <li>-Does not call appropriately for help when in chair.</li> </ul>	<ul style="list-style-type: none"> <li>-Plugs into central call system to easily see where alarming</li> <li>-Place green nonskid sheet under sensor pad to prevent pad from slipping off chair</li> <li>-Pad: PS#408218</li> <li>-Alarm: PS#401478</li> <li>-Cable to wall: PS#401479</li> </ul>

<p>"Headstart" chair sensor</p> 	<ul style="list-style-type: none"> <li>-Patient that overestimates and forgets limitations.</li> <li>-Does not call appropriately for help when up in chair.</li> </ul>	<p><a href="#">Click Here for Video on Use</a></p> <ul style="list-style-type: none"> <li>-If patient can remove belt independently it is not considered a restraint otherwise orders are required</li> <li>- PS# 591417</li> </ul>
<p>Econo Alarm</p> 	<ul style="list-style-type: none"> <li>-Patient that overestimates and forgets limitations.</li> <li>-Does not call appropriately for help.</li> <li>-Patient that leans forward</li> <li>-clips onto patient</li> </ul>	<ul style="list-style-type: none"> <li>-Cannot be centralized but very loud</li> <li>-Make sure strap is tight enough to alarm as soon as patient stands or leans forward</li> </ul>
<p>Size wise evolution Low bed and mats</p> 	<ul style="list-style-type: none"> <li>-Patient that overestimates or forgets limitations and is at "risk for injury".</li> <li>-Does not call appropriately for help.</li> </ul>	<ul style="list-style-type: none"> <li>- Rental Equipment-See Bed Algorithm for ordering details</li> <li>-Always ask for the bed with scale and alarms</li> <li>-Order mats from materials management</li> </ul>
<p>Net enclosure bed</p> 	<ul style="list-style-type: none"> <li>-Patient with Altered mental status where lap/restraints not appropriate</li> <li>-Traumatic Brain Injury patients</li> </ul>	<ul style="list-style-type: none"> <li>-Rental Equipment-See Bed Algorithm for ordering details</li> <li>-This is considered a restraint and orders are required.</li> </ul>
<p>One to one observer</p>	<ul style="list-style-type: none"> <li>-Where the restrictive alternatives are not appropriate</li> </ul>	<ul style="list-style-type: none"> <li>-Make sure the observer is updated on the patient and reason they are there.</li> </ul>

Reaching unit adherence with Fall TIPS:

*AUDITS*



# Submit 5 audits every month

- GOAL IS TO ACHIEVE 80-100% ADHERENCE
- REVIEW FINDINGS WITH LEADERSHIP
- AND DEVELOP A PLAN TO IMPROVE AS NEEDED WITH A UNIT BASED QUALITY IMPROVEMENT PLAN (quapi)

**Fall TIPS Patient Engagement Audits** Resize

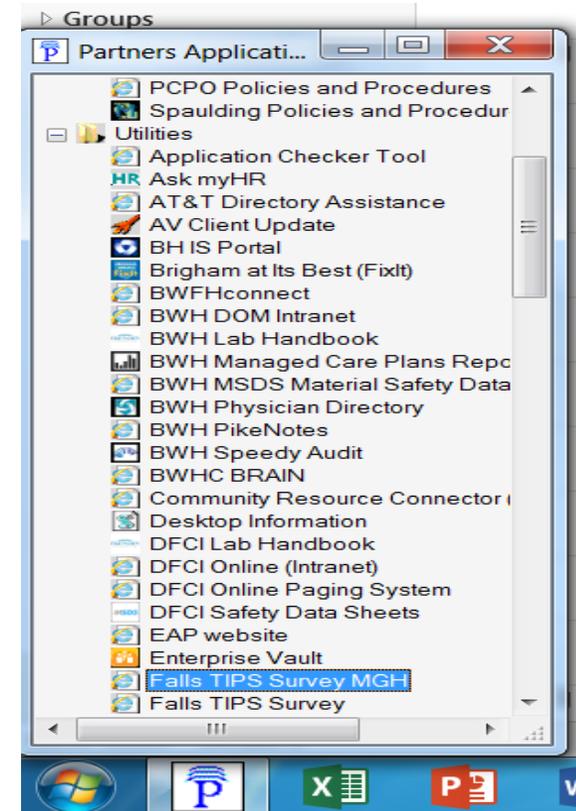
Please complete the survey below.

Thank you!

<b>Observation Date</b>	<input type="text"/> Today M-D-Y
<b>RN username</b>	<input type="text"/>
<b>MRN</b> <small>* must provide value</small>	<input type="text"/>
<b>Unit</b> <small>* must provide value</small>	<input type="text"/> ▼
<b>Is the patient's Fall TIPS poster/report updated and hanging at the bedside?</b> <small>* must provide value</small>	<input type="radio"/> Yes <input type="radio"/> No
<b>Can the patient/family verbalize the patient's fall risk factors?</b> <small>* must provide value</small>	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> N/A
<b>Can the patient/family verbalize the patient's personalized fall prevention plan?</b> <small>* must provide value</small>	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> N/A
<b>If you answered "No" to any question, did you provide peer-to-peer feedback?</b>	<input type="radio"/> Yes <input type="radio"/> No
<b>Comments</b>	<input type="text"/>

Audits are a method of evaluating unit performance.  
TIPS audit tool can be found  
via the link below or under utilizes in the partners “P” in  
Partners Utilities

<https://redcap.partners.org/redcap/surveys/?s=EYW7FFAL4H>



Monitor success  
with Fall TIPS fall  
prevention  
program

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Falls are considered a “never event”.

However, when a fall does occur, it should be reported through the RLS Safety Reporting System.

This allows for Aggregate data to

- Drive improvement
- Track and trend performance



# Hospital Falls Data

## Patient Falls Event (as of 8/31/2020)

Reporting Period: September 1, 2019 to August 31, 2020

TIPS Unit ? (All) | ACN/Director (All) | NDNQI Injury Levels (All) | NDNQI Unit Type (All) | Location (All) | SRE (Y/N)? (All)



### Monthly Volume

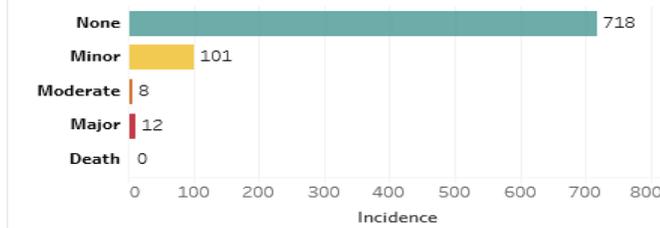
Month	Total Falls	Falls with Injury	DPH Reportable
September 2019	72	9	3
October 2019	75	10	1
November 2019	55	8	1
December 2019	75	4	1
January 2020	63	10	0
February 2020	64	12	2
March 2020	65	6	1
April 2020	59	13	3
May 2020	88	10	2
June 2020	70	6	0
July 2020	84	15	3
August 2020	69	18	3
<b>Grand Total</b>	<b>839</b>	<b>121</b>	<b>20</b>

Days Since Last Fall  
0  
8/31/2020

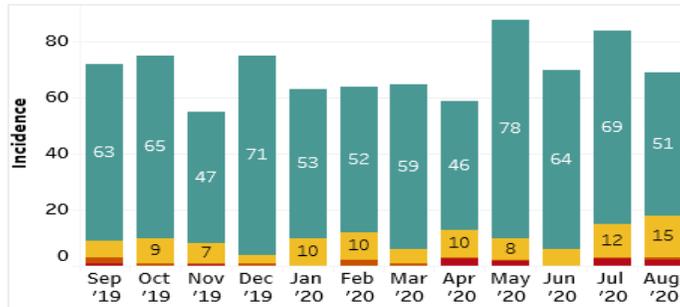
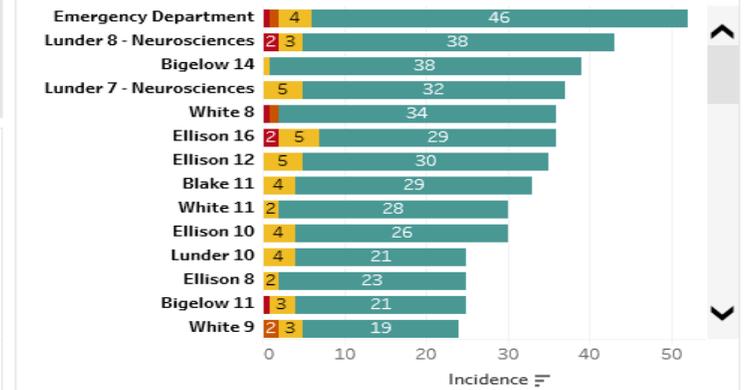
Days Since Last Injury Fall  
5  
8/26/2020

Days Since Last DPH Reportable  
9  
8/22/2020

### Summary by Injury Level



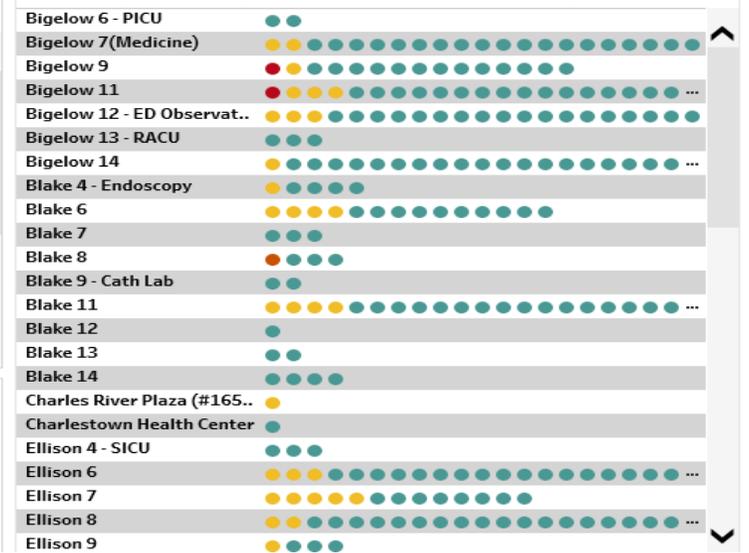
### Volume by Location



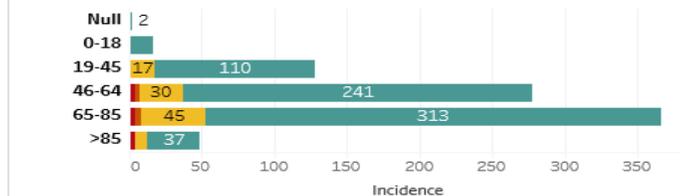
### Summary by Event Type

Specific Event Type	# of Falls	%
from bed	174	21%
assisted/lowered to floor	96	11%
unknown - found on floor	90	11%
from chair	74	9%
while standing	73	9%
from toilet/commode	69	8%
while ambulating	67	8%
while ambulating to bathroom	46	5%
while ambulating without required ..	35	4%
from recliner	30	4%
from low bed	26	3%
while ambulating with assistance	21	3%
from stretcher	19	2%

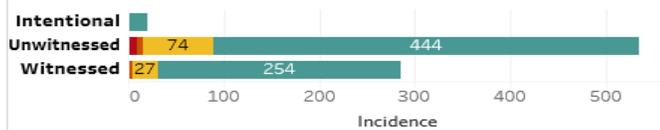
### Events by Location (hover over dots to see event details)



### Falls by Age Group



### Witnessed, Unwitnessed or Intentional?



# Remember

- Fall prevention applies to more than RN staff and the patient. It includes unit coordinators, physicians, PCAs , PT/OT and the family.  
Is your unit ready to spread?

- Resource materials can be customized to the needs/culture of each unit.  
For example: Do you need for posters in different languages?

<https://www.mghpcs.org/eed/Falls/default.shtml>

- Successful implementation is a unit-based responsibility. Target is at least 80% adherence with completion of the Fall TIPS poster.
- No one knows how to do it better than the staff who work on the unit.

# Still have more questions or ideas?

- Please reach out to [Mawalsh@partners.org](mailto:Mawalsh@partners.org) or a member of the falls team (contact us button) for more information or assistance