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

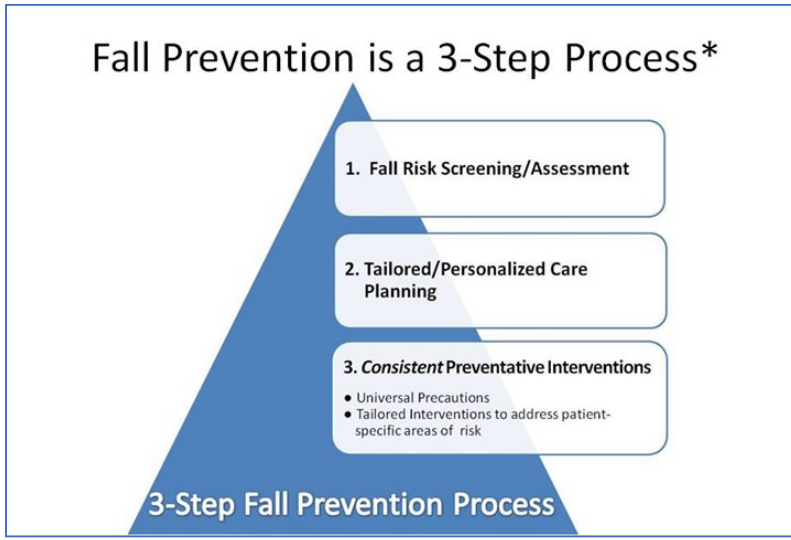
UNIVERSAL PRECAUTIONS

- 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

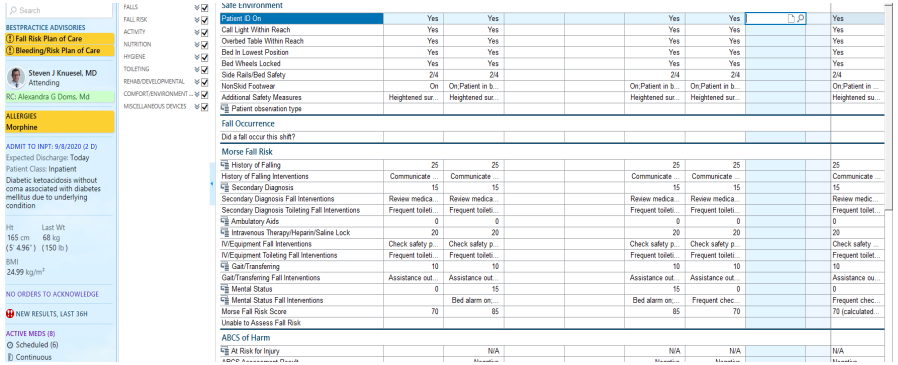
Hourly Safety Rounds

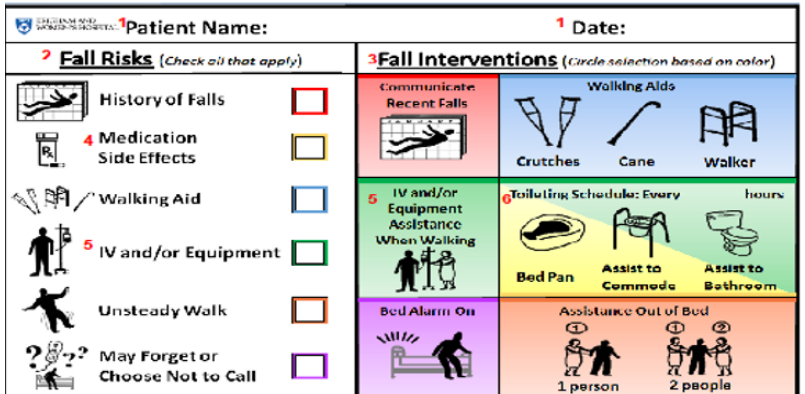
- Routine nursing rounds are an evidence based practice
- Sometimes referred to as the 4 Ps
- Units may implement somewhat differently

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





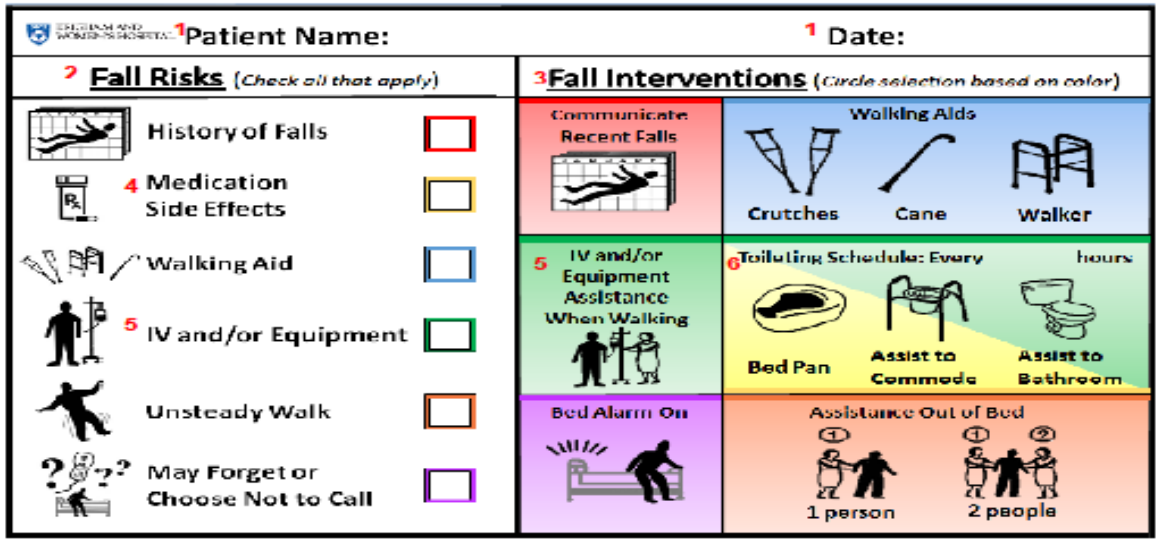
Patient Engagement

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:

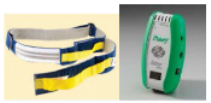


1. **Write the patient's first name and last updated date.** Erase all information when patient is discharged
2. **Left column lists all fall risk factors** from the Morse Falls Scale (MFS). Go through assessment with the patient and check off any risks that apply to patient. These risk factors should 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

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

Fall Prevention Related Equipment

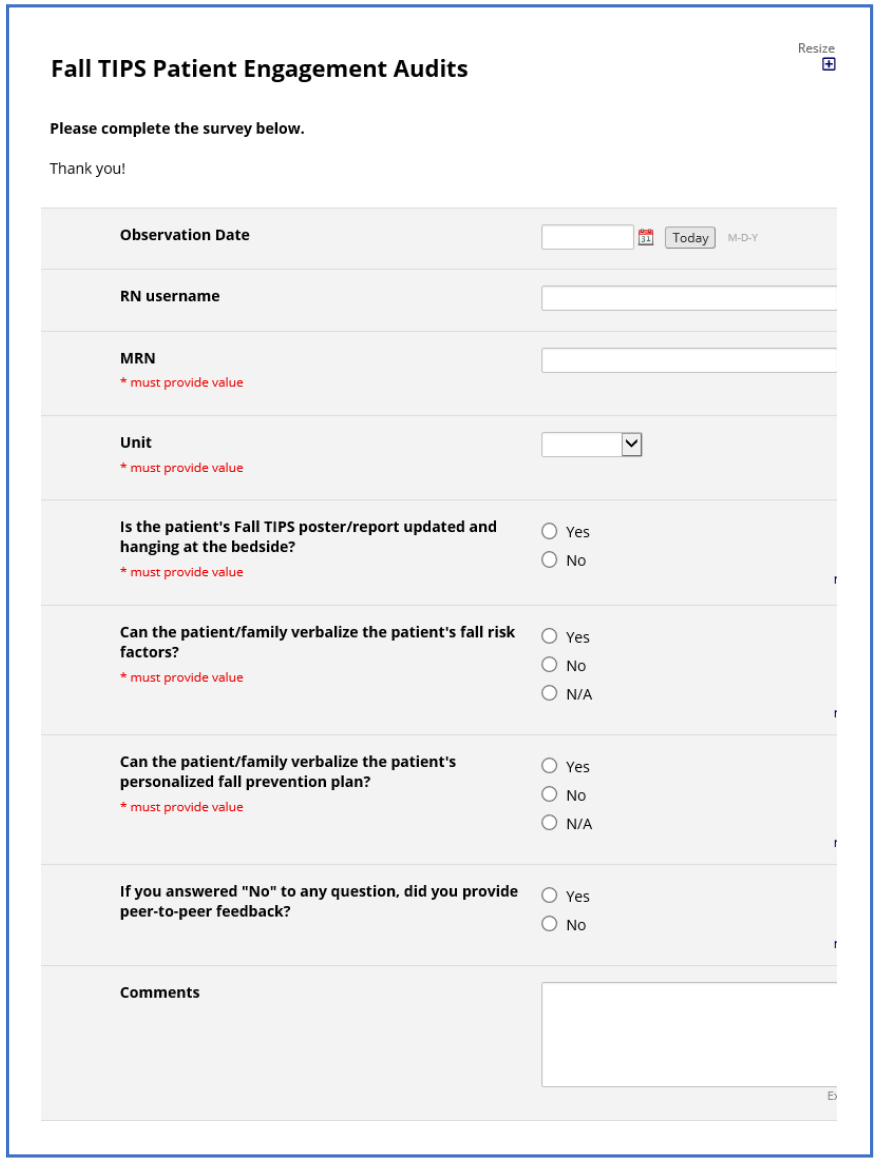
Name	Indications	Tips
Bed Alarms 	-Patient that overestimates/may forget to call and forgets limitations. -Does not call appropriately for help.	-Change the sensitivity based on patient need -The bed needs to be zeroed first before using the alarm
Chair Alarm 	-Patient that overestimates/may forget to call and forgets limitations. -Does not call appropriately for help when in chair.	-Plugs into central call system to easily see where alarming -Place green nonskid sheet under sensor pad to prevent pad from slipping off chair -Pad:PS#408218 -Alarm: PS#401478 -Cable to wall: PS#401479
"Headstart" chair sensor 	-Patient that overestimates and forgets limitations. -Does not call appropriately for help when up in chair.	Click Here for Video on Use -If patient can remove belt independently it is not considered a restraint otherwise orders are required - PS# 591417
Econo Alarm 	-Patient that overestimates and forgets limitations. -Does not call appropriately for help. -Patient that leans forward -clips onto patient	-Cannot be centralized but very loud -Make sure strap is tight enough to alarm as soon as patient stands or leans forward
Size wise evolution Low bed and mats 	-Patient that overestimates or forgets limitations and is at "risk for injury". -Does not call appropriately for help.	- Rental Equipment-See Bed Algorithm for ordering details -Always ask for the bed with scale and alarms -Order mats from materials management
Net enclosure bed 	-Patient with Altered mental status where lap/restraints not appropriate -Traumatic Brain Injury patients	-Rental Equipment-See Bed Algorithm for ordering details -This is considered a restraint and orders are required.
One to one observer	-Where the restrictive alternatives are not appropriate	-Make sure the observer is updated on the patient and reason they are there.

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!

Observation Date — Today M-D-Y

RN username

MRN
* must provide value

Unit
* must provide value

Is the patient's Fall TIPS poster/report updated and hanging at the bedside?
* must provide value
- Yes
- No

Can the patient/family verbalize the patient's fall risk factors?
* must provide value
- Yes
- No
- N/A

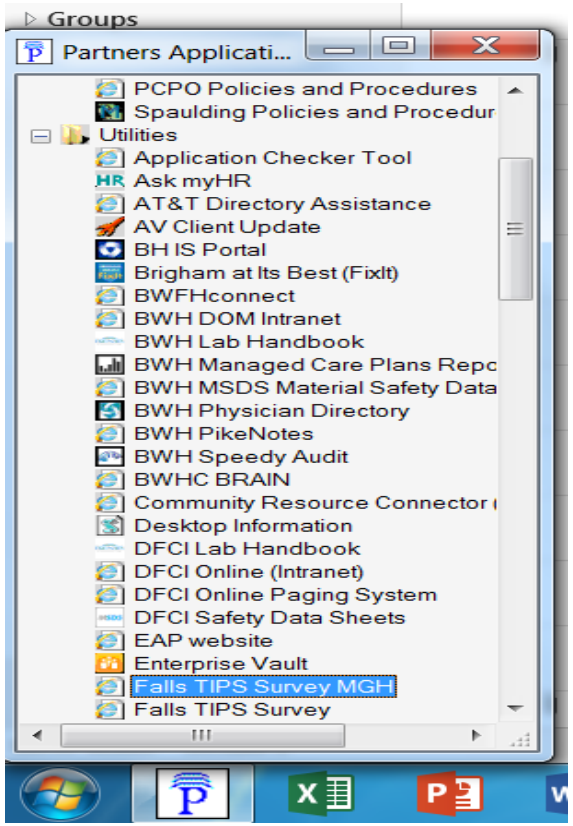
Can the patient/family verbalize the patient's personalized fall prevention plan?
* must provide value
- Yes
- No
- N/A

If you answered "No" to any question, did you provide peer-to-peer feedback?
- Yes
- No

Comments

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

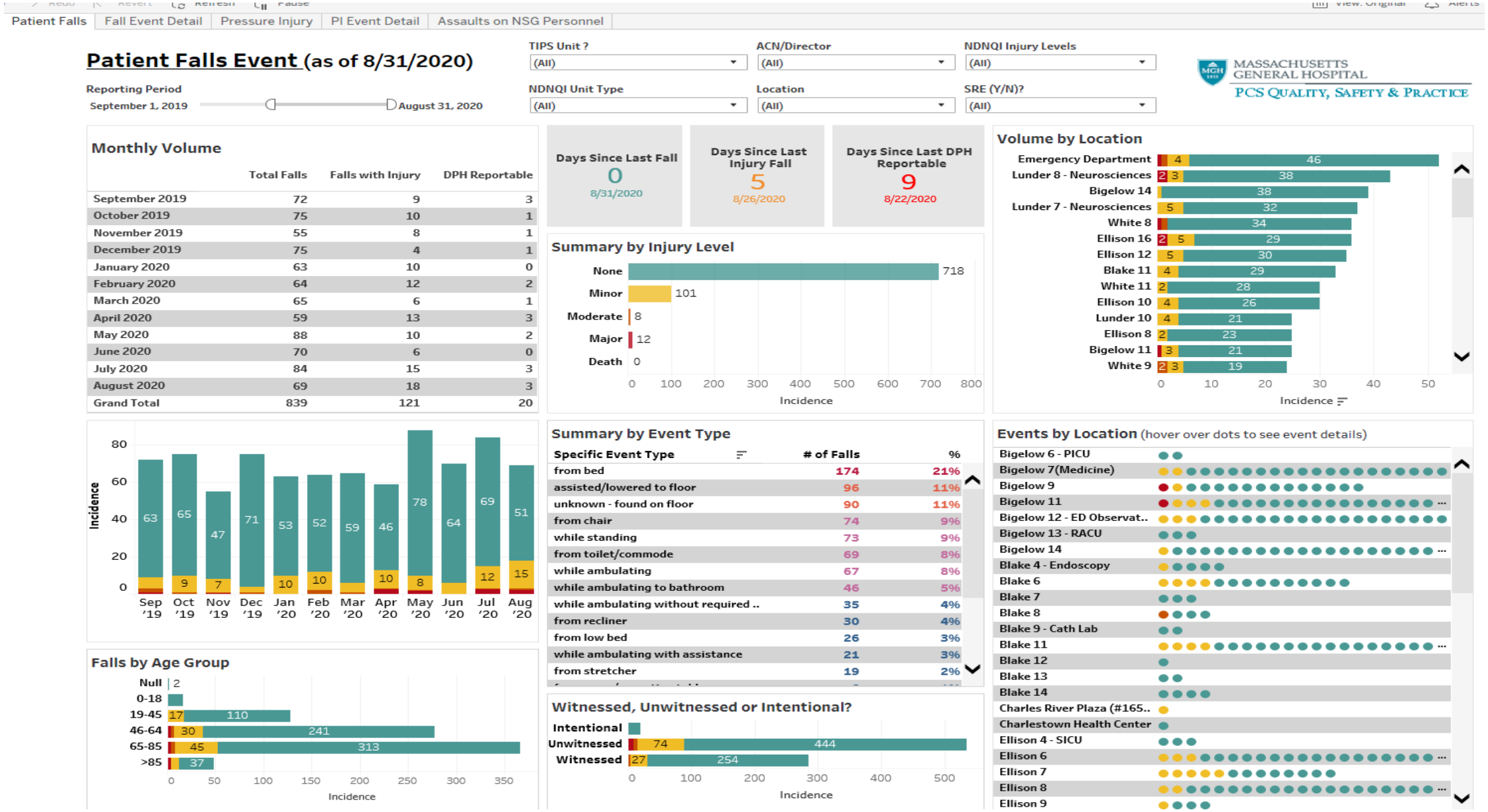


Monitor success with Fall TIPS fall prevention program

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



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 or a member of the falls team (contact us button) for more information or assistance