Frequently Asked Questions regarding TIPS audits:

1. How should I choose which patients to audit?

We recommend that you choose patients who have been in the hospital for at least one day and are alert and oriented. If the patient is not alert and oriented but the patient has family members present, you can also audit them.

2. How do I audit a patient who is unable to be engaged in their fall prevention plan (not alert and oriented)?

Only select patients who are alert and oriented for the audit, unless there are family members present that could be engaged in the patient's care.

3. Can I audit patients that have no fall risk factors?

Yes, because the patient should still have a plan with their name on it. If using the laminated paper poster tool, the plan should have the correct patient name and date and no risks/interventions circled. The patient should still be able to verbalize that they have talked with their nurse about fall prevention.

4. If a patient only knows one of their risks or interventions, should I record "yes" or "no" for that audit?

Record "yes." This response indicates the patient has been engaged in the three-step fall prevention process because they referenced one of their risks or interventions.

5. If the Fall TIPS poster is not updated (i.e. incorrect patient name) what do I record for the first audit question?

Record "no," as the Fall TIPS poster is not correct. Provide feedback to the patient's nurse with a reminder to make sure the Fall TIPS poster is updated between patients and discussed with the patient.

6. Do I have to use the exact same, formal wording when asking the audit questions?

The wording of the audit questions is flexible. You can change the wording to make the audit more of a conversation with the patient. For example, instead of asking: "Are you able to verbalize your fall prevention plan?" you could say: "Has anyone besides me talked to you about what you can do to avoid a fall here at the hospital?"