# HHS and AHRQ logos.Fall Prevention Program Implementation Guide

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## About the Fall Prevention Program Implementation Guide

### Purpose of the Guide

This Fall Prevention Program Implementation Guide is for hospital leaders and others who want to launch a structured fall prevention initiative based on quality improvement (QI) principles. It tells how to implement the Agency for Healthcare Research and Quality’s (AHRQ’s) Fall Prevention Program and the associated training curriculum*.* The Guide focuses on the tasks your hospital’s Implementation Team will perform during the initiative.

### How To Use This Guide

Throughout this Guide, you’ll find strategies for using AHRQ’s training curriculum, along with links to webinars, tools, and other helpful resources. It has the following sections:

* [Overview](#_Overview)
* [AHRQ’s Fall Prevention Program](#_AHRQ’s_Fall_Prevention)
* [Training Curriculum](#_Training_Curriculum)
* [Get Ready](#_Get_Ready)
* [Assess Your Organization’s Readiness](#_Assess_Your_Organization’s)
* [Develop a Plan To Build and Support Readiness](#_Develop_a_Plan)
* [Fall Prevention Program Phases](#_Fall_Prevention_Program)
* [Pretraining Phase](#_Pretraining_Phase)
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* [Appendix A: RACI Chart](#_Appendix_A._RACI)
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* [Appendix E: Sample Participant Agenda](#_Appendix_E._Sample)
* [Appendix F: Hospital Practice Insights—Challenges and Solutions](#_Appendix_F._Hospital)

To ensure that you understand the timeline and activities associated with AHRQ’s Fall Prevention Program, please read through the entire Guide before launching your hospital’s initiative. Revisit relevant sections as your Implementation Team carries out each phase.

## Overview

This section provides an overview of AHRQ’s Fall Prevention Program and the associated training curriculum.

### AHRQ’s Fall Prevention Program

AHRQ’s Fall Prevention Program grew out of a 3-year AHRQ-funded pilot initiative whose purpose was threefold:

* To develop training resources that provide guidance on how to use and implement into practice the tools and strategies outlined in AHRQ’s [*Preventing Falls in Hospitals: A Toolkit for Improving Quality of Care*](https://www.ahrq.gov/professionals/systems/hospital/fallpxtoolkit/index.html)
* To provide training and ongoing technical assistance—using the newly developed training curriculum—to a cohort of hospitals selected to implement the Toolkit
* To evaluate the impact of implementing AHRQ’s Toolkit, combined with training and technical assistance, on participating hospitals’ fall-related outcomes

AFYA, Inc., led the project team, with support from partners ECRI Institute and Stratis Health. During the first year of the initiative, AFYA and its partners designed and developed a focused training curriculum based on AHRQ’s Toolkit (see **Training Curriculum** below). In addition, they recruited 10 varied and geographically diverse hospitals to participate in a 2-year pilot implementation program. Quality improvement specialists (QISs) supported hospital implementation through structured training and ongoing technical assistance. The project team developed this Guide to share participating hospitals’ implementation strategies, experiences, and lessons learned with hospitals like yours.

### Training Curriculum

The training curriculum is designed to help hospitals implement [AHRQ’s Fall Prevention Toolkit](https://www.ahrq.gov/professionals/systems/hospital/fallpxtoolkit/index.html). It is composed of an in-person training and supplementary webinars.

#### In-Person Training

This 6-hour interactive working meeting provides an opportunity to discuss your hospital’s current needs, policies, and procedures. The training supports adult learning and allows participating staff to immediately apply their new knowledge to their fall reduction efforts.

Thein-person training has the following objectives:

* Educate your hospital leadership and Implementation Team on the [AHRQ Fall Prevention Toolkit](https://www.ahrq.gov/professionals/systems/hospital/fallpxtoolkit/index.html) to facilitate the change process in your hospital.
* Develop hospital-specific action plans for implementing a Fall Prevention Program using the Toolkit.
* Identify some of the specific challenges for fall prevention in your hospital.
* Use and adapt the tools and resources contained in the Toolkit to implement the Fall Prevention Program.

The in-person training is broken into five training modules that are aligned with key sections of the [AHRQ Fall Prevention Toolkit](https://www.ahrq.gov/professionals/systems/hospital/fallpxtoolkit/index.html):

* Module 1: Understanding Why Change Is Needed
* Module 2: How To Manage Change
* Module 3: Best Practices in Fall Prevention
* Module 4: How To Implement the Fall Prevention Program in Your Organization
* Module 5: How To Measure Fall Rates and Fall Prevention Practices

Each module includes participant slides. It also includes an instructor training guide with the following sections:

* Module Aim
* Module Goals
* Timing
* Learning Methodology Checklist
* Materials Checklist
* Additional Related Training Resources
* Instructor Preparation
* Script
* Supplementary Webinars
* These 12 recorded webinars (four training webinars and eight Learning Network webinars) are intended to supplement the in-person training. Training participants should view them **outside** of the in-person training.
* It is strongly recommended that participants view all four training webinars during the Training Phase (see **Fall Prevention Program Phases: Training Phase**). The Learning Network webinars are intended for use by relevant staff on an as-needed basis. **Appendix C** describes the supplementary webinars in more detail.

#### Alignment With Toolkit

The training modules and supplementary webinars were designed to align with [AHRQ’s Fall Prevention Toolkit](https://www.ahrq.gov/professionals/systems/hospital/fallpxtoolkit/index.html). **Table 1** shows how they align.

Table 1. Training Module and Webinar Alignment With Toolkit

| Toolkit Chapter Guiding Question | Training Module | Training Webinar | Learning Network Webinar |
| --- | --- | --- | --- |
| **Chapter 1**  Are you ready for this change? | [Module 1](https://www.ahrq.gov/professionals/systems/hospital/fallpxtraining/workshop/module1/mod1-trguide.html): Understanding Why Change Is Needed |  | [Sustainability](https://www.ahrq.gov/professionals/systems/hospital/fallpxtraining/trainingwebinars/index.html#Learning) |
| **Chapter 2**  How will you manage change? | [Module 2](https://www.ahrq.gov/professionals/systems/hospital/fallpxtraining/workshop/module2/mod2-trguide.html): How To Manage Change |  |  |
| **Chapter 3**  Which fall prevention practices do you want to use? | [Module 3](https://www.ahrq.gov/professionals/systems/hospital/fallpxtraining/workshop/module3/mod3-trguide.html): Best Practices in Fall Prevention | [Using Fall Risk Assessment Tools in Care Planning](https://www.ahrq.gov/professionals/systems/hospital/fallpxtraining/trainingwebinars/index.html) | [Post-Fall Huddles: Reducing Preventable Falls and Fall-Related Injuries](https://www.ahrq.gov/professionals/systems/hospital/fallpxtraining/trainingwebinars/index.html#Learning)  [Evidence for Fall Prevention Strategies](https://www.ahrq.gov/professionals/systems/hospital/fallpxtraining/trainingwebinars/index.html#Learning)  [Patient-Centered Fall Prevention Care Planning](https://www.ahrq.gov/professionals/systems/hospital/fallpxtraining/trainingwebinars/index.html#Learning) |
| **Chapter 4**  How do you implement the Fall Prevention Program in your organization? | [Module 4](https://www.ahrq.gov/professionals/systems/hospital/fallpxtraining/workshop/module4/mod4-trguide.html): How To Implement the Fall Prevention Program in Your Organization | [Staff Roles and Training for Your Fall Prevention Program](https://www.ahrq.gov/professionals/systems/hospital/fallpxtraining/trainingwebinars/index.html) | [Critical Thinking for Fall Injury Prevention](https://www.ahrq.gov/professionals/systems/hospital/fallpxtraining/trainingwebinars/index.html#Learning)  [DMAIC: A Deep Dive Into Reducing Patient Falls](https://www.ahrq.gov/professionals/systems/hospital/fallpxtraining/trainingwebinars/index.html#Learning) |
| **Chapter 5**  How do you measure fall rates and fall prevention practices? | [Module 5](https://www.ahrq.gov/professionals/systems/hospital/fallpxtraining/workshop/module5/mod5-trguide.html): How To Measure Fall Rates and Fall Prevention Practices | [Measuring Fall and Fall-Related Injury Rates and Prevention Practices](https://www.ahrq.gov/professionals/systems/hospital/fallpxtraining/trainingwebinars/index.html) | [Creating Control Charts To Interpret Fall Data](https://www.ahrq.gov/professionals/systems/hospital/fallpxtraining/trainingwebinars/index.html#Learning)  [Measurement: Using Data To Tell a Story](https://www.ahrq.gov/professionals/systems/hospital/fallpxtraining/trainingwebinars/index.html#Learning) |
| **Chapter 6**  How do you sustain an effective Fall Prevention Program? | [Module 1](https://www.ahrq.gov/professionals/systems/hospital/fallpxtraining/workshop/module1/mod1-trguide.html): Understanding Why Change Is Needed (and throughout training modules) | [Sustaining Fall Prevention Practices at Your Hospital](https://www.ahrq.gov/professionals/systems/hospital/fallpxtraining/trainingwebinars/index.html) |  |

## Get Ready

Before launching your Fall Prevention Program, make sure your hospital is ready. Assess your organization’s readiness for such a program.

### Assess Your Organization’s Readiness

To assess your organization’s readiness to launch AHRQ’s Fall Prevention Program, review Section 1 of [AHRQ’s Fall Prevention Toolkit](https://www.ahrq.gov/professionals/systems/hospital/fallpxtoolkit/index.html). Then assess your organization’s readiness for change.

One option for assessing your organization’s readiness for this initiative is to complete [Tool 1F: Organizational Readiness Checklist](https://www.ahrq.gov/professionals/systems/hospital/fallpxtoolkit/fallpxtk-tool1f.html) from the AHRQ Toolkit*.*

As an alternative, your hospital leadership and potential Implementation Team leaders may want to answer the questions in **Table 2** below. These questions were developed based on the checklist included in the Toolkit but were expanded for the AHRQ pilot initiative (see **AHRQ’s Fall Prevention Program** above), and are more specific to elements of this prevention initiative.

Table 2. Assess Your Hospital’s Readiness To Launch AHRQ’s Fall Prevention Program

| Question | Answer |
| --- | --- |
| Does your hospital have a culture that focuses on a systems approach to error reduction? |  |
| Has your hospital identified hospital-specific reasons to change how it manages the prevention of falls? |  |
| Has your hospital assessed staff attitudes about falls? |  |
| If yes, has your hospital analyzed assessment results to identify awareness-building needs? |  |
| On a scale of 1 to 5, with 5 being the highest level of support, rate the overall medical staff support for implementing AHRQ’s Fall Prevention Program at your hospital. |  |
| Has your hospital identified supporters who have a sense of urgency for addressing fall prevention? |  |
| If no, and a sense of urgency is lacking, has your hospital begun efforts to show stakeholders that falls are a significant safety concern for many reasons and that prevention efforts are needed? |  |
| Has your hospital assessed leadership support for fall prevention? |  |
| If leadership support for fall prevention is lacking, has your hospital begun efforts to generate it? |  |
| Has your hospital identified a senior leader who can serve as a champion for the fall prevention effort? |  |
| Has your hospital identified a leader for the AHRQ fall prevention effort? |  |
| Is this leader currently involved in the planning steps to participate in this program? |  |
| Has your hospital done baseline measurement of your fall rate? |  |
| If yes, have you done it by each unit? |  |
| If yes, have you identified a goal for improvement? |  |
| If no, will you be able to measure the baseline rate before beginning your efforts and have the resources to continue to measure monthly or at a minimum, quarterly, throughout your improvement efforts? |  |
| Has your hospital done baseline measurement of at least two fall process measures on your target units? (To learn more about measurement, see the supplementary training webinar *Measuring Fall and Fall-Related Injury Rates and Prevention Practices* and the Learning Network webinars *Creating Control Charts To Interpret Fall Data* and *Measurement: Using Data To Tell a Story*.) |  |
| If yes, have you identified a goal for improvement? |  |
| If yes, do you have the resources to continue to measure the processes monthly throughout your improvement efforts? |  |
| If no, will you be able to measure two process measures monthly throughout your improvement efforts? |  |
| Has your hospital developed a preliminary list of needed human (e.g., specific staff required) and material resources? |  |
| Is this leader currently involved in the planning steps to participate in this program? |  |
| Has your hospital obtained commitments or intentions from senior leadership to provide those resources? |  |

### Develop a Plan To Build and Support Readiness

Review your responses to [Tool 1F](https://www.ahrq.gov/professionals/systems/hospital/fallpxtoolkit/fallpxtk-tool1f.html) from the Toolkit (or the questions in **Table 2** above), paying particular attention to “no” responses or low ratings. Then develop a plan to address those areas before launching AHRQ’s Fall Prevention Program; failure to do so can imperil program success. Section 1 of the Toolkit suggests ways to build and support readiness. Share your results with those who will plan and facilitate the in-person training.

## Fall Prevention Program Phases

Now your hospital is ready to launch AHRQ’s Fall Prevention Program. The program has five phases. Each phase is listed below with approximate timeframes for each:

* Pretraining Phase (lasts approximately 1–2 months)
* Training Phase (lasts approximately 1–5 weeks)
* Preimplementation Phase (lasts approximately 1-4 months)
* Implementation Phase (lasts approximately 8–12 months)
* Sustainment Phase (ongoing)

### Pretraining Phase

The Pretraining Phase lasts approximately 1–2 months. The purpose of this phase is to prepare your hospital for a successful Training Phase.

#### Develop a Project Charter

It’s a good idea to develop a project charter. This document helps your hospital clearly define the goals, scope, timing, milestones, team roles, and responsibilities for its Fall Prevention Program. In most cases, the Leadership Team develops the project charter and gives it to the Implementation Team.

A sample project charter template is available at [https://www.ahrq.gov/sites/default/files/  
wysiwyg/professionals/systems/hospital/qitoolkit/d2-projectcharter.pdf](https://www.ahrq.gov/sites/default/files/wysiwyg/professionals/systems/hospital/qitoolkit/d2-projectcharter.pdf). **Table 3** provides some guidelines for project charters.

Table 3. Project Charter Guidelines

| Do | Don’t |
| --- | --- |
| Give the Implementation Team guidance about what they are being asked to accomplish. | Tell the team specifically how to complete the work. |
| Make the project charter clear and concise, focusing on key elements of requested work. | Include many pages of information. |
| Keep the project charter in a location where it is available to all involved in the project so it can serve as a reference and reminder to avoid scope creep as the project progresses. | File the project charter away in a notebook or in some folder on the Team Lead’s computer. |
| Identify a consistent format for all organizational project charters to make it easier for staff to use. | Make the project charter complicated. |
| Include which leadership and other committees will receive reports from your team and how often they will receive these reports. |  |
| Provide guidance about the team’s decision-making authority. When appropriate, delineate the roles of those involved in making decisions about changes to be tested or made. Consider using a RACI chart (roles and responsibilities matrix) (see **Appendix A**). | Be unclear about the team’s decision-making authority. |
| Needlessly limit the team’s ability to plan and conduct innovative small tests of change with formal approval processes. |

#### Identify Key Program Personnel

Before your hospital embarks on the Training Phase, it’s important to identify key Fall Prevention Program personnel. These may include the Implementation Team, Implementation Leaders, and QISs (or other instructors).

***Identify the Implementation Team.***Select an Implementation Team to carry out your hospital’s Fall Prevention Program. Make sure the team is both interdisciplinary and available and that someone on the team has the requisite QI skills (e.g., expertise in analyzing and interpreting data to assess performance and support improvement initiatives). To learn more about the Implementation Team, see Chapter 2 of [AHRQ’s Fall Prevention Toolkit](https://www.ahrq.gov/professionals/systems/hospital/fallpxtoolkit/index.html) and [Tool 2A](https://www.ahrq.gov/professionals/systems/hospital/fallpxtoolkit/fallpxtk-tool2a.html).

**Note:** During the AHRQ pilot initiative (see **AHRQ’s Fall Prevention Program** above), two QISs with expertise in QI and patient safety were assigned to each hospital. The QISs delivered the in-person training, assisted the hospital Implementation Team throughout the program, and provided as-needed technical assistance. They also served as liaisons between participating hospitals and national fall prevention experts.

However, there are a variety of ways to implement AHRQ’s Fall Prevention Program. It is recommended that your hospital use QISs and make the Implementation Team accountable to them. This accountability was a critical factor in the success of the pilot initiative.

Determine what responsibilities (if any) QISs will have in your hospital’s Fall Prevention Program. If you do opt to use QISs, decide whether they will be internal staff members or consultants brought in from outside.

If you opt not to use QISs, decide who will lead the in-person training. Also decide who the Implementation Team will be accountable to and what resources will be available to the Implementation Team for any needed ongoing technical assistance.

***Identify the Implementation Team Leaders.***The Leadership Team that developed the charter (or other appropriate group within your facility) should determine who will lead the Implementation Team. Make sure the Implementation Team Leaders have expertise in training, mentoring, leading QI programs, managing projects, managing change, and facilitating meetings. Ensure the Implementation Team Leaders have support from an executive leader who will closely track the needs and progress of the team, address barriers, and provide resources as needed.

***Identify the QISs/Instructors.***[[1]](#footnote-1)Select the QISs or other instructors (e.g., Education Department personnel, Implementation Team Leaders, or other staff members) who will deliver the 6-hour in-person training (see **Training Curriculum** above) and provide ongoing technical assistance to the Implementation Team. These individuals will work to adopt and adapt the fall prevention action plan to fit the unit or hospital.

Choose the QISs/instructors with care. They should:

* Have QI training and experience.
* Be advocates of teamwork.
* Be dynamic presenters with a desire and talent to teach.
* Have strong oral communication skills.
* Hold positions that allow flexible scheduling.
* Be highly visible, accessible, and available for coaching throughout the change effort.

Fall prevention success cannot be achieved through classroom training alone. As in any change effort, the introduction of a quality improvement initiative requires champions in everyday practice to reinforce, monitor, and role-model fall prevention and QI principles.

### Prepare for the In-Person Training

To ensure a successful in-person training, hospital leadership, the Implementation Leader, QISs, and instructors should prepare for it.

***Hospital Leadership’s Responsibilities.*** Hospital leadership should prepare for the in-person training as follows:

* Provide participant handouts (e.g., hard copies of the participant agenda; participant slides; tools; and hospital processes, policies, and procedures).
* Send invitations to participants.
* Assign a person to take notes on the in-person training, including opportunities for improvement participants identify. (If there are two QISs/instructors, the one who is not presenting may fill this role.)

In addition, hospital leadership should provide the following for the in-person training:

* A room large enough to accommodate all participants
* Needed audiovisual equipment, including a laptop computer, LCD projector, and screen
* One or two flip charts with stands
* Lunch for participants (or instructions to bring a bag lunch)
* Coffee/tea/water for morning and afternoon breaks

***Implementation Team Leader’s Responsibilities.*** The Implementation Team Leader, with input from other relevant staff, should prepare for the Training Phase as follows:

* Complete the following pretraining tools[[2]](#footnote-2):
* Resource Needs Assessment, [Tool 1E](https://www.ahrq.gov/professionals/systems/hospital/fallpxtoolkit/fallpxtk-tool1e.html)
* Quality Improvement Process, [Tool 2B](https://www.ahrq.gov/professionals/systems/hospital/fallpxtoolkit/fallpxtk-tool2b.html)
* Current Process Analysis, [Tool 2C](https://www.ahrq.gov/professionals/systems/hospital/fallpxtoolkit/fallpxtk-tool2c.html)
* Assessing Current Fall Prevention Policies and Practices, [Tool 2D](https://www.ahrq.gov/professionals/systems/hospital/fallpxtoolkit/fallpxtk-tool2d.html)
* Assessing Staff Education and Training, [Tool 4C](https://www.ahrq.gov/professionals/systems/hospital/fallpxtoolkit/fallpxtk-tool4c.html)
* Obtain the following hospital policies and procedures (to be shared during the in-person training):
* Universal fall precautions
* Fall prevention care plan
* Submit the completed pre-training tools, along with the hospital policies and procedures, to the QISs/instructors **at least 2 weeks** before the in-person training.
* Be prepared to discuss the policies and procedures and the completed tools during the in-person training.

***Quality Improvement Specialists’/Instructors’ Responsibilities.*** The QISs/instructors should prepare for the Training Phase as follows:

* Review, understand, and be completely familiar with [AHRQ’s Fall Prevention Toolkit](https://www.ahrq.gov/professionals/systems/hospital/fallpxtoolkit/index.html).
* Review the training modules (see **Table 1**):
* Follow the guidelines for preparing for the in-person training. These are found at the beginning of each Instructor Training Guide.
* Customize the participant slides. Add your hospital’s name on the first slide. Insert images of the completed pre-training tools into the appropriate places within the slides (see Production Agenda to assist in determining where to include these tools).
* Watch the supplementary [Training webinars](https://www.ahrq.gov/professionals/systems/hospital/fallpxtraining/trainingwebinars/index.html) (see **Table 1** and **Appendix C**).
* Review the pretraining tools and policies and procedures submitted by the Implementation Team Leader (see above). Identify gaps and opportunities for improvement to discuss during the in-person training.
* Develop a production agenda (see an example from AHRQ’s pilot initiative in **Appendix D**). This is a detailed timeline for the in-person training.
* Develop a participant agenda (see an example from AHRQ’s pilot initiative in **Appendix E**). This is a less-detailed version of the production agenda.
* Invite/ask a senior-level hospital administrator to provide a welcome and discuss the urgency for your hospital’s Fall Prevention Program.
* Schedule the in-person training:
* The Implementation Team Leader should work with the QISs/instructors to schedule the 6-hour in-person training (see **Training Curriculum** above).Determine which staff members should participate and to what extent. Members of the Implementation Team and tentative unit champions will likely attend the entire training. Others, such as Information Technology (IT) and Education Department staff, may need to attend only the parts of the training directly relevant to their jobs.
* To prevent disruptions and scheduling problems and to maximize learning, excuse participants from all other duties during the in-person training.

During the AHRQ pilot initiative (see **AHRQ’s Fall Prevention Program** above), the in-person training took place in a single 1-day session. However, there are many alternatives to a 1-day training. Below are two examples:

* Deliver the five modules in two separate sessions:
* **Session 1** **–** Module 1: Understanding Why Change Is Needed, Module 2: How To Manage Change, and Module 3: Best Practices in Fall Prevention
* **Session 2** **–** Module 4: How To Implement the Fall Prevention Program in Your Organization and Module 5: How To Measure Fall Rates and Fall Prevention Practices
* Deliver one module per week for 5 consecutive weeks.

#### Stay in Touch

The Implementation Team and QISs/instructors should hold weekly check-in calls or meetings throughout the Pretraining Phase.

### Training Phase

The Training Phase lasts approximately 1–5 weeks. During the Training Phase, the QISs/instructors will deliver the in-person training. In addition, it is strongly recommended that participants of the in-person training view the [Training webinars](https://www.ahrq.gov/professionals/systems/hospital/fallpxtraining/trainingwebinars/index.html) during this phase (see **Training Curriculum** above).

#### Prepare for the Training Phase

To ensure a successful Training Phase, hospital leadership, the Implementation Leader, and the QISs/instructors should prepare for the Training Phase (see **Pretraining Phase** above).

#### Complete a Draft Action Plan

One objective of the in-person training is to complete [Tool 2F: Action Plan](https://www.ahrq.gov/professionals/systems/hospital/fallpxtoolkit/fallpxtk-tool2f.html). This draft can be fine tuned by a core group from the Implementation Team over the following week or so and shared with the team for approval. The action plan is a living document that may change over time as it is implemented and tested.

[Tool 2F](https://www.ahrq.gov/professionals/systems/hospital/fallpxtoolkit/fallpxtk-tool2f.html) includes the following key interventions to be identified and prioritized:

* Analyze the current state of fall prevention practices in this organization.
* Identify the set of prevention practices to be used in the redesigned system.
* Assign roles and responsibilities for implementing the redesigned fall prevention practices.
* Put the redesigned care processes into practice.
* Monitor fall rates and practices.
* Sustain the redesigned prevention practices.

#### Stay in Touch

The Implementation Team and QISs/instructors should continue to hold weekly check-in calls or meetings during the Training Phase.

### Preimplementation Phase

The Preimplementation Phase lasts approximately 1–4 months. The purpose of the Preimplementation Phase is to prepare your hospital for a successful Implementation Phase.

#### Identify Opportunities for Improvement

The Implementation Team should start by identifying opportunities for improvement. (It may have identified some opportunities during the in-person training.) The team should follow your organization’s methodology or model for making improvements (e.g., Lean methodology, Model for Improvement).

#### Prioritize Opportunities for Improvement

Next, the Implementation Team should decide which of these opportunities for improvement to focus on. Try not to tackle everything at once. The team should focus on just a few key interventions.

To keep your prevention initiative moving forward, the Implementation Team should meet weekly during the 2 weeks after the in-person training for focused discussions on prioritizing opportunities for quality improvement. **Appendix B** tells how to prioritize these opportunities.

#### Refine the Action Plan

Once the Implementation Team has identified and prioritized opportunities for improvement, it can refine the draft action plan it created during the Training Phase. The goal is to develop an action plan within 2 weeks after the in-person training. The team may want to use [Tool 2F](https://www.ahrq.gov/professionals/systems/hospital/fallpxtoolkit/fallpxtk-tool2f.html) or an alternate version of the action plan to address the following items:

* How to develop unit teams and how they will work with the Implementation Team
* Roles and responsibilities of each staff member and unit champions
* Standards of care and practices to be met
* Which fall prevention practices go beyond a single unit and how they will be addressed
* How gaps in staff education and competency will be addressed
* Plans for rolling out new standards and practices and how they will be integrated into ongoing work processes
* Who is accountable for measuring and monitoring implementation
* How changes in performance will be assessed (both process and outcome measures)
* How the effort will be sustained

#### Collect Baseline Data

The Implementation Team should gather and review baseline fall data. To learn more about measurement, see the supplementary Training webinar [*Measuring Fall and Fall-Related Injury Rates and Prevention Practices*](https://www.ahrq.gov/professionals/systems/hospital/fallpxtraining/trainingwebinars/index.html) and the Learning Network webinars *[Creating Control Charts To Interpret Fall Data](https://www.ahrq.gov/professionals/systems/hospital/fallpxtraining/trainingwebinars/index.html" \l "Learning)* and *[Measurement: Using Data To Tell a Story](https://www.ahrq.gov/professionals/systems/hospital/fallpxtraining/trainingwebinars/index.html" \l "Learning)*.

#### Complete the Preimplementation Checklist

Before moving on to the Implementation Phase, the Implementation Team may want to use the checklist in **Table 4,** which was developed for the AHRQ pilot initiative (see **AHRQ’s Fall Prevention Program** above), to confirm that it has completed all the Preimplementation Phase activities.

Table 4. Preimplementation Checklist

| Tasks | Completion Date |
| --- | --- |
| Initial Post-Training Priorities | |
| Identify pilot units |  |
| Establish various teams |  |
| Multidisciplinary |  |
| Pilot unit managers on Implementation Team |  |
| Conduct process mapping |  |
| Use fall knowledge assessment |  |
| Create action plan outline |  |
| Continue to watch webinars |  |
| Primary Preimplementation Priorities | |
| Draft action plan |  |
| Prioritize list of improvement opportunities |  |
| Conduct resource needs assessment |  |
| Select improvement practices |  |
| Determine goals for improvement |  |
| Develop aim statement |  |
| Develop staff education/assessment plan |  |
| Create plans to roll out new standards/practices |  |
| Assign staff person to monitor implementation |  |
| Determine how to measure performance |  |
| Determine data collection process |  |
| Collect/assess process measure data |  |
| Collect/assess outcome measure data |  |
| Create sustainment plan |  |
| Final Preimplementation Priorities | |
| Finalize implementation action plan |  |
| Secure team buy-in |  |

#### Stay in Touch

The Implementation Team and QISs/instructors should continue to hold check-in calls or meetings. If prudent, they can decrease their meetings to every other week during the Preimplementation Phase.

### Implementation Phase

The Implementation Phase lasts approximately 8–12 months. During the Implementation Phase, the Implementation Team will implement the interventions that it prioritized in the action plan.

#### View Webinars

Team members should view any relevant supplementary [Learning Network webinars](https://www.ahrq.gov/professionals/systems/hospital/fallpxtraining/trainingwebinars/index.html#Learning) (see **Table 1** and **Appendix C**).

#### Pilot Interventions

The Implementation Team will pilot the interventions as follows:

* Choose one or two pilot units.
* Train staff on new procedures.
* Collect process and outcome measures and feedback on new procedures.
* Communicate results.

Refine practices to address any problems.

* Start to identify which practices can be spread to other hospital units or departments.
* Assign all staff roles and responsibilities to prevent falls.
* Assign specific individuals or groups to each duty identified.
* Identify any existing fall prevention experts your facility has access to, and provide staff education in collaboration with these experts.
* Determine paths of ongoing communication and reporting for fall prevention processes.
* Build fall prevention practices into ongoing work processes.
* Collect and analyze data to learn about fall rates, fall-related injuries, and causes of falls.
* Measure fall prevention practices.
* Meet regularly to assess progress.
* Create a plan to implement targeted practices to other areas in the hospital.

#### Complete the Implementation Checklist

The Implementation Team may want to complete the checklist in **Table 5** and review it with the QISs/instructors. The checklist helps assess the progress of the Team’s QI efforts. It’s a good idea to revisit the checklist every 2 months during the Implementation Phase.

Table 5. Managing Change During Implementation

|  | Yes | No | Comments/Description |
| --- | --- | --- | --- |
| Implementation Team | | | |
| Are Team Leaders and Implementation Team in place? |  |  |  |
| Does team meet biweekly to review and discuss progress? |  |  | Who attends? |
| Do Team Leaders/key staff participate in regular conference calls with QISs/instructors? |  |  | Who attends? |
| Does Unit Implementation Team meet regularly to review/discuss progress? |  |  | How often? |
| **Senior leadership** – Senior Admin Leader on Team?  Does he/she visibly promote, support, and resource the project? |  |  |  |
| **Project manager –** Does he/she have adequate support to manage the project? |  |  |  |
| Specific goals set? |  |  | List goals. |
| Action Plan | | | |
| Updated at least every 2 months? |  |  |  |
| **Challenges** to implementing the action plan prevention practices identified at organization and unit levels? |  |  |  |
| **Strategies** for building new practices into daily routine are in place? |  |  |  |
| Processes/Support in Place To Facilitate Action Plan | | | |
| **Communication** – Do you have a communication plan to keep staff and the Implementation Team up to date on rates/results and progress of prevention program? |  |  | Describe plan and progress: |
| Do you have a plan to communicate rates/progress/ resource needs to senior leadership? |  |  | Describe plan and progress: |
| Do you have a plan to keep other stakeholders up to date? |  |  | Describe plan and progress: |
| Do you have a plan for soliciting positive and negative feedback about the prevention strategies from staff? |  |  | Describe feedback/what you do with feedback: |
| Do you have a plan for soliciting feedback from patients and families? |  |  | Describe feedback/what you do with feedback: |
| Do you document your efforts on this initiative for organizational history and learning? |  |  |  |
| **Education** – Did you provide staff education to support the changes being made? List topics/mechanisms used for education: |  |  |  |
| 1. |  |  |  |
| 2. |  |  |  |
| 3. |  |  |  |
| 4. |  |  |  |
| **Education:** Do you have a patient/family prevention education plan? |  |  |  |
| Monitoring | | | |
| Is a problem-solving feedback loop in place with plans to redesign practices as needed? |  |  |  |

#### Cope With Challenges

Implementation of new processes can bring various challenges. The hospitals involved in the AHRQ pilot initiative experienced a variety of barriers and worked to overcome them. **Appendix F** (Hospital Practice Insights: Challenges and Solutions) provides some of the challenges they encountered and how they coped with these challenges.

#### Stay in Touch

The Implementation Team and QISs/instructors should continue to hold check-in calls or meetings every other week.

### Sustainment Phase

The Sustainment Phase is ongoing. During the Sustainment Phase, your organization will work to make the interventions and improved outcomes normal, integrated, and mainstream—part of your hospital’s culture. This phase includes changing thoughts and attitudes as well as processes and outcomes. Sustaining an improvement means that the progress is locked in, and staff don’t revert to the old ways of doing things. To learn more about sustainment, see the supplementary Training webinar [*Sustaining Fall Prevention Practices at Your Hospital*](https://www.ahrq.gov/professionals/systems/hospital/fallpxtraining/trainingwebinars/index.html)and the Learning Network webinar [*Sustainability*](https://www.ahrq.gov/professionals/systems/hospital/fallpxtraining/trainingwebinars/index.html#Learning).

#### Provide Leadership Support Throughout Your Fall Prevention Program

To sustain the interventions, hospital leadership must provide support from project inception through implementation and after. Hospital leadership must assess how the changes are affecting staff. Are staff making the changes as intended? If not, why not? What barriers are staff encountering, and how can management remove these barriers?

#### Communicate Clearly

Leaders and staff need to have a common vision of the change and how it will contribute to the overall goal. Make sure they understand what specific systems and processes will change (e.g., reminders or prompts in the EHR to conduct fall risk assessment within a certain time) and who will carry out these actions. Communication channels created or reinforced during the Fall Prevention Program should continue throughout the Sustainment Phase.

#### Track Performance

The Implementation Team should assess the extent to which organizational structures and routines have changes and if old behaviors are resurfacing. They should evaluate performance at both an intervention level and an outcome level at least quarterly. Senior-level staff should be responsible for sustaining gains and reviewing intervention-level performance monthly in a structured reporting format (e.g., an organizational scorecard).

To learn more about measurement, see the supplementary Training webinar [*Measuring Fall and Fall-Related Injury Rates and Prevention Practices*](https://www.ahrq.gov/professionals/systems/hospital/fallpxtraining/trainingwebinars/index.html) and the Learning Network webinars [*Creating Control Charts To Interpret Fall Data*](https://www.ahrq.gov/professionals/systems/hospital/fallpxtraining/trainingwebinars/index.html#Learning) and [*Measurement: Using Data To Tell a Story*](https://www.ahrq.gov/professionals/systems/hospital/fallpxtraining/trainingwebinars/index.html#Learning).

#### Celebrate Progress

The Implementation Team should reinforce desired behaviors. **Appendix F** (Hospital Practice Insights: Challenges & Solutions) suggests ways to celebrate progress.

#### Plan for Sustainment

At the end of the Implementation Phase, the Implementation Team should identify what is needed to sustain fall prevention efforts, including organizational support (e.g., new staff training, existing staff refreshers, IT support for reporting performance data). It should also decide who will be responsible for sustaining ongoing fall prevention efforts. In planning for sustainment, your Implementation Team may find it helpful to discuss the questions in **Table 6,** which were developed for the AHRQ pilot initiative (see **AHRQ’s Fall Prevention Program** above), with their QISs/instructors.

Table 6. Plan for Sustainment

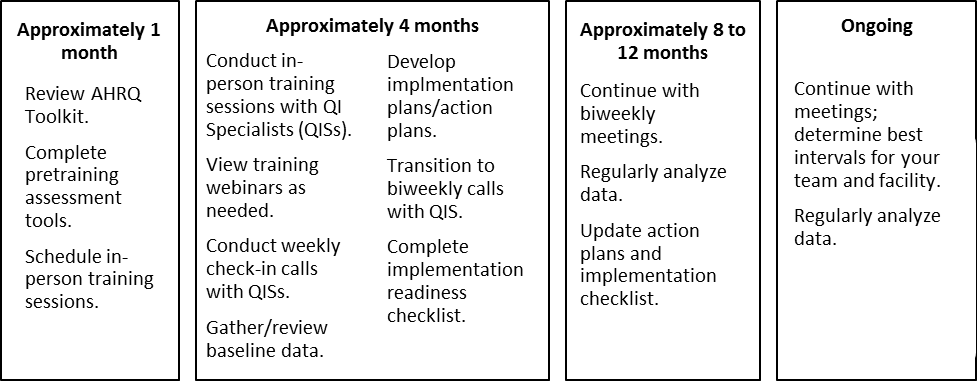
| Discussion Question | Answer |
| --- | --- |
| 1. How have you generally planned for sustaining QI project elements in the past? What areas have been problematic for sustaining prevention practices (e.g., education problems in sustainment, staff turnover, poor leadership support)? |  |
| 1. What are you planning to do now to address these historical sustainment issues? |  |
| 1. What are the critical practices from your Implementation action plan that you plan to sustain? |  |
| 1. What are your plans to sustain these critical practices? |  |
| 1. What performance measures do you plan to continue collecting that will provide information for continuous quality improvement of the identified critical practices? |  |
| 1. What is the mechanism for reporting quality program progress and outcomes to frontline staff and up through senior leadership and the board? |  |
| 1. What planned interventions will you continue to work on, or what interventions do you plan to initiate, i.e., those that are not currently at the sustainment phase? |  |
| 1. When and how do you plan to spread your QI action plan prevention practices to other hospital units or other hospitals in your system? |  |

#### Stay in Touch

The Implementation Team and QISs/instructors should continue to hold check-in calls or meetings for 6 to 12 months after implementation. In addition, the Implementation Team should keep meeting regularly.

**Figure 1** shows the phases and activities of the AHRQ pilot initiative (see **AHRQ’s Fall Prevention Program** above). It illustrates how a QI program might be organized.

Figure 1. Timeline of Fall Prevention Program Activities



## Appendixes

* Appendix A: RACI Chart
* Appendix B: Prioritize Opportunities for Improvement
* Appendix C: Training and Learning Network Webinars
* Appendix D: Sample Production Agenda
* Appendix E: Sample Participant Agenda
* Appendix F: Hospital Practice Insights—Challenges and Solutions

### Appendix A. RACI Chart

Below is a sample of a RACI Chart. A RACI Chart is a planning tool to help establish what needs to be done and who must do it. R-A-C-I stands for the different expectations of team members. A description is provided below for the role of each category—those responsible, accountable, consulted, or informed for an activity or decision.

|  |  | Description | How Many in This Role for a Decision? |
| --- | --- | --- | --- |
| **R** | Responsible | Researches options and consequences, makes recommendations | Usually one (but sometimes more) |
| **A** | Approver | Makes the decision | One |
| **C** | Consulted | Makes recommendations | Varies (0 to many) |
| **I** | Informed | Get informed of the decision after it is made | Varies (0 to many) |

### Appendix B. Prioritize Opportunities for Improvement

It’s important to prioritize high-impact prevention strategies, as outlined in the Toolkit. Follow these steps to prioritize opportunities for improvement.

* Firm up your Implementation Team Leader, Core Team, Fall Team, and fall champions for the initiative. Make sure they are all involved or represented in the prioritization process.
* Look at each idea on the brainstormed list and start to group them into categories (affinity grouping). You can use whatever categories seem to make the most sense for your group. When you review the list, categories might start to jump out at you. They might include ideas such as universal fall precautions, fall risk screening assessment, care planning, post-fall practices, education, and metrics. Alternatively, you might decide to group ideas under the major categories in the fall clinical pathway ([Tool 3A](https://www.ahrq.gov/professionals/systems/hospital/fallpxtoolkit/fallpxtk-tool3a.html)).
* Once you have the ideas grouped, work to clarify each opportunity statement as needed. If someone new to your organization read the list, would he or she understand the opportunity? Remove any duplicates from the list.
* List and review each opportunity with your team.
* Prioritize which items are most important to work on. Decide on a method to use for prioritization. Below are some examples.

#### Method 1: Multi-Voting

Figure B-. Wall Chart Displaying Votes

Multi-voting is a structured series of votes in order to narrow down your options. It involves having each person choose one-third (or other fraction) of the items.

This voting can be done in a number of ways. Think about the option that might work best for the people involved in multi-voting. In some organizations, people with more power might share their votes publicly, which could sway others’ opinions. Here are some options:

* People submit their votes privately to the person who will tally the votes.
* People share their votes publicly with the group and with the person who will tally the votes.
* People mark their choices from a list of items displayed on wall charts with an “X” or colored dot (see **Figure B-1**). This option displays results instantly. Tell people they can use all their votes for one item if that is their preference.

Once the votes are in, tally the votes.

* Eliminate items with few votes.
* If a decision is clear, stop here. Otherwise, repeat the multi-voting process with the remaining items as needed.

#### Method 2: Prioritization Matrix

Develop a prioritization matrix. List the opportunities in rows down the left side and your identified criteria across the columns.

Criteria (ideally developed by your group) might include the following:

* Resources (Are needed resources readily available?)
* Continuity (Does this support organizational goals and priorities?)
* Cost (How much cost does your organization incur each time this issue occurs or fails to occur?)
* Feasibility (Is the opportunity actionable/feasible? Are there ways to address this issue? Is there room to make meaningful improvement?)
* Integration (Is there an opportunity to build on existing work? Would this be a duplication of efforts?)
* Potential impact (Is there reason to believe that the opportunity will have a significant impact on your populations?)
* Readiness (Is there momentum to help move the issue forward? Will it be seen as important?)
* Responsiveness (Does this address a need expressed by patients, family, or staff?)
* Risk (How much of a risk does this issue pose to the well-being of patients?)
* Urgency (How soon does this issue need to be addressed?)

Decide on and define a rating scale for your criteria—typically 1 through 5 or 1 through 10. You can decide to weigh certain criteria more than others. Rate the opportunities as a group. Alternatively, have each group member rate the opportunities individually, and then discuss them as a group. The rating will be subjective and is meant to be used as a guide to stimulate discussion.

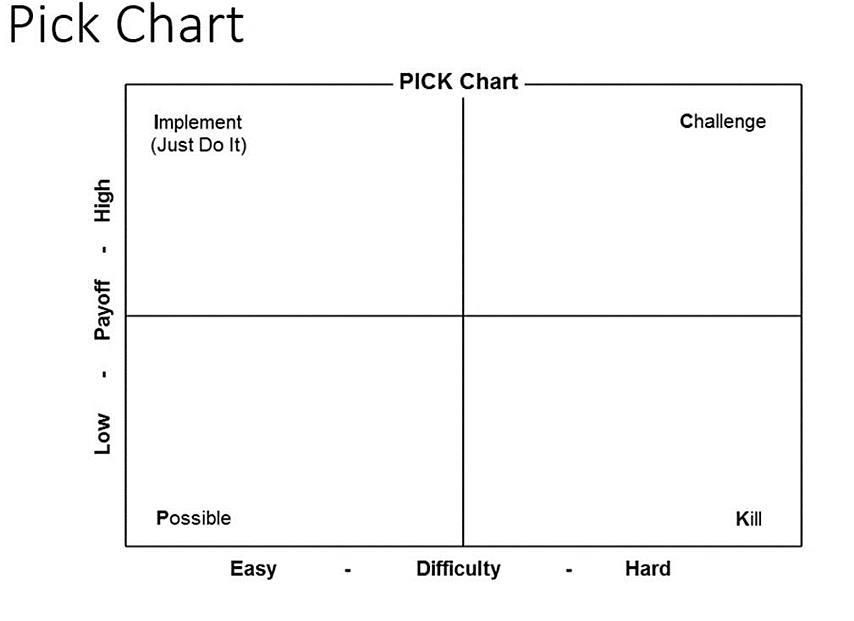
Once the matrix is completed, scores can be totaled for each opportunity. Discussion is needed to make final selections. The selections don’t need to be the items with the highest rating, although higher scores often indicate higher priority.

#### Method 3: PICK Chart

A PICK chart is a Lean Six Sigma tool used to categorize and prioritize improvement ideas. It’s sometimes called an effort/impact chart. The chart has four quadrants:

* **P**ossible idea
* **I**mplement idea
* **C**hallenge idea
* **K**ill idea

An easy way to create a PICK chart is to draw a 2 x 2 grid either on a whiteboard or a large paper flip chart. Have participants place improvement ideas (written on sticky notes) in the quadrant where they feel the idea best fits.

A PICK chart can be a helpful tool for deciding what to work on first. The ideas in the “implement” quadrant are likely a good place to start. The team can then start looking at some of the ideas in the “challenge” quadrant that are more difficult but have a high payoff. The ideas in the “possible” quadrant are not a priority to pursue, and the ideas in the “kill” quadrant should likely not be considered.

Here are some guidelines for using a PICK chart:

* Don’t let participants put their sticky notes between quadrants. They need to decide what quadrant they go in. The beauty of sticky notes is that they can always be moved as the team discusses each idea.
* Keep the PICK chart simple. Don’t subdivide each quadrant or allow participants to be strategic about the quadrant they place their sticky note in.
* If participants have trouble putting an idea in the quadrant labeled “kill,” explain that “kill” just means that the idea is hard to do and has a low payoff.

### Appendix C. Training and Learning Network Webinars

These webinars are intended to supplement the Fall Prevention Program in-person training. Participants should view these webinars **outside** of the in-person training.

#### Training Webinars

It is strongly recommended that participants view the following [Training webinars](https://www.ahrq.gov/professionals/systems/hospital/fallpxtraining/trainingwebinars/index.html) during the Training Phase.

***Staff Roles and Training for Your Fall Prevention Program***

* Presented by Cait Walsh, RN, M.S.N.
* This webinar tells how to assign staff roles and train staff for your fall prevention program.

***Using Fall Risk Assessment Tools in Care Planning***

* Presented by Patricia C. Dykes, Ph.D., RN, FAAN, FACMI
* This webinar tells how to use fall risk assessment tools in care planning.

***Measuring Fall and Fall-Related Injury Rates and Prevention Practices***

* Presented by Julia Neily, RN, M.S., M.P.H.
* This webinar tells how to measure fall and fall-related injury rates and prevention practices.

***Sustaining Fall Prevention Practices at Your Hospital***

* Presented by Pat Quigley, Ph.D., M.P.H., ARNP, CRRN, FAAN, FAA, NP
* This webinar tells how to sustain fall prevention practices at your hospital.

#### Learning Network Webinars

The following [Learning Network webinars](https://www.ahrq.gov/professionals/systems/hospital/fallpxtraining/trainingwebinars/index.html#Learning) are intended for use by relevant staff on an as-needed basis.

***Post-Fall Huddles***

* Presented by Julia Neily, RN, M.S., M.P.H.
* This webinar tells how to implement post-fall huddles, use data from post-fall huddles to reduce falls and fall-related injuries, and how to apply formative and summative evaluation methods to post-fall huddle evaluation.

***Evidence for Fall Prevention Strategies***

* Presented by Pat Quigley, Ph.D., M.P.H., ARNP, CRRN, FAAN, FAA, NP
* This webinar discusses how to evaluate the level of evidence for making decisions on targeted interventions to use in a fall prevention program. The state of the science of several fall prevention strategies, such as bed alarms, surveillance strategies and rounding, protective equipment, prevention strategies for patients with mental/behavioral health disorders, and use of post fall huddle data is discussed.

***Patient-Centered Fall Prevention Care Planning***

* Presented by Patricia C. Dykes, Ph.D., RN, FAAN, FACMI
* This webinar is a review of the evidence related to fall prevention care planning. Included is a discussion of the advantages of using EHRs for fall prevention care planning, the rationale for engaging patients in the 3-step fall prevention process, and a review of some tools for engaging patients in the 3-step fall prevention process.

***Creating Control Charts To Interpret Fall Data***

* Presented by Barbara Rebold, RN, B.S.N., M.S., CPHQ; Kelly O’Neill, RN, B.S.N., M.P.A., CPHQ; and Terry Hostert, Quality Improvement Specialist (McDonough District Hospital)
* This webinar introduces the use of control charts as a data tool to support quality improvement and describes how to create and use a control chart. An example hospital shares how it uses control charts.

***Measurement: Using Data To Tell a Story***

* Presented by Pat Quigley, Ph.D., M.P.H., ARNP, CRRN, FAAN, FAA, NP
* This webinar describes core evaluation measures of fall and fall injury program components. Included is a discussion of how to use data to profile population and risk, data analysis for fall program evaluation, requirements for high reliability, and a framework for dissemination of program evaluation.

***Sustainability***

* Presented by Pat Posa, RN, B.S.N., M.S.A., FAAN
* This webinar describes key elements of sustaining a prevention program successfully over time. It describes key components of sustainable change, as well as barriers to sustainability.

***Critical Thinking for Fall Injury Prevention***

* Presented by Cait Walsh, RN, M.S.N.; and Norma McNair, RN, Ph.D., ACNS-BC
* This webinar focuses on how to incorporate critical thinking into staff education regarding falls and fall prevention. Teach-back methodology is also discussed for patient/family education about fall and fall injury risk and prevention.

***DMAIC: A Deep Dive Into Reducing Patient Falls***

* Presented by Susan Mascioli, RN, B.S.N., M.S., CPHQ, NEA-BC, LSSBB
* This webinar portrays one hospital’s experience in implementing a successful fall prevention program; and reviews lessons learned using Lean Six Sigma (LSS) methodology. Successful fall prevention strategies are identified.

#### Other Resources

* IHI Sustainability and Spread How-to-Guide, available at <http://www.ihi.org/resources/Pages/Tools/HowtoGuideSustainabilitySpread.aspx>.

### Appendix D. Sample Production Agenda for the In-Person Training

**Production Agenda: Fall Prevention Program Training**

**Hospital Name**

Date and Time for Training

| Time | Min. | Content | Speaker | Tools |
| --- | --- | --- | --- | --- |
| 8:15–8:20 | 5 | **Opening Remarks**  Thank you from leadership to attendees for participating in falls initiative | Senior Leader |  |
| 8:20–9:00 | 30 | **Module 1: Understanding Why Change Is Needed**  Welcome  Instructions to maximize participation  Logistics, breaks, cell phones, etc.  Objectives  AHRQ Toolkit approach/training | Quality Improvement Specialist (QIS)/Instructor |  |
| 10 | Resource needs | Implementation Team Leader | 1E: Resource Needs Assessment |
| 9:00–10:15 | 5 | **Module 2: How To Manage Change** | QIS/Instructor |  |
| 5 | Interdisciplinary Team | Implementation Team Leader | 2A: Interdisciplinary Team |
| 5 | Quality improvement process | Implementation Team Leader | 2B: Quality Improvement Process |
| 35 | Current process analysis  Small group exercise | QIS/Instructor  All participants | 2C: Current Process Analysis |
| 15 | Assessing current fall prevention policies and practices | Implementation Team Leader | 2D: Assessing Current Fall Prevention Policies and Practices |
| 10 | Action plan | All participants | 2F: Action Plan |
| 10:15–10:30 | 15 | **Break** |  |  |
| 10:30–12:00 | 45 | **Module 3: Best Practices in Fall Prevention**  Intro  Universal fall precautions and rounding  Fall risk assessment and case study | QIS/Instructor—facilitated group discussion  Note: Implementation Team Leader should be prepared to share on the hospital’s universal precautions, rounding practices, and fall risk assessment. | 3A: Inpatient Falls Clinical Pathway  3B: Scheduled Rounding Protocol  3C: Environmental Safety at the Bedside  3D: Environmental Safety Hazard Report  3H: Morse Fall Scale  3I: Medication Fall Risk Score  3J: Delirium Evaluation Bundle |
| 45 | Care planning  Post-fall assessment  Action plan and summary | QIS/Instructor—facilitated group discussion  Note: Implementation Team Leader should be prepared to share on the hospital’s fall prevention care plan (and compare it with a sample shown during training, looking at goal and categories, and noting potential changes) and to share on the hospital’s post-fall assessment process. | 3M: Sample Care Plan  3N: Postfall Assessment, Clinical Review  3O: Postfall Assessment for Root Cause Analysis  3P: Best Practices Checklist  2F: Action Plan |
| 12:00–12:45 | 45 | **Lunch** |  |  |

| Time | Min. | Content | Speaker | Tools |
| --- | --- | --- | --- | --- |
| 12:45–1:30 | 30 | **Module 4: How To Implement the Fall Prevention Program in Your Organization**  Implementation planning goals  Staff roles/unit team  Communication/integration  EHR  Change/monitoring/staff engagement  Staff education and training  Assessment of current staff education and training | QIS/Instructor  Individuals who can speak on IT issues | 4A: Assigning Responsibility for Using Best Practices  4B: Staff Roles  4C: Assessing Staff Education and Training |
| 10 | Develop an education plan on best practices for staff | QIS/Instructor—facilitated group discussion | Education plan for fall prevention staff education and training |
| 5 | Enhance action plan  Summary | QIS/Instructor | 2F: Action Plan  4D: Implementing Best Practice Checklist |
| 1:30–1:45 | 15 | **Break** |  |  |
| 1:45–3:00 | 20 | **Module 5: How To Measure Fall Rates and Fall Prevention Practices**  Introduction | QIS/Instructor—facilitated group discussion | 5B: Assessing Fall Prevention Care Processes |
| 20 | Measuring fall rates | QIS/Instructor—facilitated group discussion | 5A: Information to Include in Incident Reports |
| 20 | Measuring fall prevention practices | QIS/Instructor—facilitated group discussion | 5B: Assessing Fall Prevention Care Processes |
| 15 | Creating measurement action plan and enhancing overall action plan | QIS/Instructor | 2F: Action Plan |
| 3:00–3:15 | 15 | **Closing**  Evaluation  Next steps | QIS/Instructor |  |

**Note:** Remember to review supplementary webinars.

### Appendix E. Sample Participant Agenda

**Preventing Falls in Hospitals**

**Improving Quality of Care Workshop**

**Location: Insert**

**Date: Insert**

|  | **TOPIC** | **PRESENTER** |
| --- | --- | --- |
| 8:00 to 8:15 a.m. | Sign In |  |
| 8:15 to 8:20 a.m. | Opening Remarks | Senior Leader |
| 8:20 to 9:00 a.m. | Module 1: Understanding Why Change Is Needed | Quality Improvement Specialist (QIS)/Instructor  Implementation Team Leader |
| 9:00 to 10:15 a.m. | Module 2: How To Manage Change | QIS/Instructor  Implementation Team Leader |
| 10:15 to 10:30 a.m. | Break |  |
| 10:30 a.m. to 12:00 p.m. | Module 3: Best Practices in Fall Prevention | QIS/Instructor  Implementation Team Leader |
| 12:00 to 12:45 p.m. | Lunch |  |
| 12:45 to 1:30 p.m. | Module 4: How To Implement the Fall Prevention Program in Your Organization | QIS/Instructor  IT Specialist |
| 1:30 to 1:45 p.m. | Break |  |
| 1:45 to 3:00 p.m. | Module 5: How To Measure Fall Rates and Fall Prevention Practices | QIS/Instructor |
| 3:00 to 3:15 p.m. | Closing | QIS/Instructor |

### Appendix F. Hospital Practice Insights: Challenges and Solutions

#### Module 1: Understanding Why Change Is Needed

Hospital: >50–200 beds  
Pilot Units: Med/Surg, Geri/Psych

**Challenge:** Lack of leadership buy-in or support.

**Solution:** Have a physician serve on the Implementation Team.

**Description:** The Implementation Team includes a physician member. This individual leads the hospital’s annual root cause analysis (RCA), serves as the keeper of the evidence base, and holds a specialty/position relevant to fall prevention (e.g., physical medicine, rehabilitation, hospitalist). The physician is an equal member of the team but provides a physician’s perspective.

The team decided that any team that meets in a post-fall huddle should have a medical provider in the huddle; when a patient falls, he or she needs to be evaluated by a medical provider. The team speaks with physicians on a regular but informal basis to share information or get their opinion on actions under consideration. In addition, the team uses Lean quality improvement (QI) methods.

##### What You Can Do:

* Ask a physical medicine physician, rehabilitation physician, hospitalist, or other physician in your hospital to become a member of the Fall Prevention Implementation Team.

#### Module 1: Understanding Why Change Is Needed

Hospital: >400 beds  
Pilot Units: Med/Surg, Telemetry

**Challenge:** Lack of leadership buy-in or support.

**Solution:** Get the chief executive officer (CEO) involved.

**Description:** During a meeting, the hospital’s CEO told a personal story about his mother, who experienced a fall in the hospital. The chief nursing officer (CNO), chief medical officer, and chief quality officer also attended the meeting. They were all engaged as the project moved forward and challenges arose.

##### What You Can Do:

* Determine how the administration/C-suite can be involved in the project.

#### Module 1: Understanding Why Change Is Needed

Hospital: ≤50 beds  
Pilot Unit: Acute Rehab

**Challenge:** Lack of leadership buy-in or support.

**Solution:** Have a leadership sponsor.

**Description:** The Director of Quality and Risk Management served as the leadership sponsor for this initiative. She attended and participated in the in-person training. She secured the support and resources for staff to focus on this effort, including pilot testing changes sequentially over time on various units with various staff and including revisions to organizational processes and the electronic health record (EHR). She checked in frequently with the day-to-day project leaders. She worked with the project team to present the initiative to top leadership at various times, in order to secure their ongoing commitment to the changes and the resources needed for training and to ensure sustainability. These actions involved leadership in supporting the patient care teams’ goal to prevent falls for their patients.

##### What You Can Do:

* Consider approaching top-level administration, the board of trustees, and other leadership groups to ensure buy-in.
* Determine whether your facility’s EHR can be modified.
* Using gap analysis, determine whether any areas of the fall prevention process can be streamlined to make patient care easier for staff.

#### Module 1: Understanding Why Change Is Needed

Hospital: >200–400 beds  
Pilot Units: Telemetry, Geri/Psych

**Challenge:** Lack of leadership buy-in or support.

**Solution:** Get the CNO involved.

**Description:** The CNO attended fall-prevention training at the hospital. She understands the project and holds all accountable. She holds weekly meetings with the Fall Team Lead. The Team Lead also presents all results at Nursing Leadership meetings. The CNO looks at the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) results regarding responsiveness to call bells as an indicator of the success of purposeful rounding, since responsiveness should reduce call bell use.

##### What You Can Do:

* Ask the CNO or other executive leadership to commit to participation in regular meetings with the Fall Prevention Team to check on progress, identify any gaps, and serve as an advocate for the team.

#### Module 1: Understanding Why Change Is Needed

Hospital: ≤50 beds  
Pilot Unit: Acute Rehab

**Challenge:** Lack of leadership buy-in or support.

**Solution:** Communicate progress to senior leadership.

**Description:** The Fall Prevention Team gave a presentation to senior leaders to provide an update on their work over the past year and to secure their ongoing support and commitment to resources. The team discussed the following topics:

* What the team wanted from the Senior Leadership Team. It was looking for leadership support for implementation—not for content, as the team of experts that worked on this effort did a great job. This is an example of deference to expertise—letting the people closest to the work and with the most knowledge of the work do it and relying on senior leaders to remove any barriers.
* A historical perspective about this project, as well as the hospital’s processes and data.
* A brief review of strategies that have made a difference so far. These include proactive rounding and video monitoring.
* An update on the risk assessment process changes, which helped the leaders see how much easier it was going to be for the Interdisciplinary Team to share information. The team highlighted the differences between old and new processes. (They are transitioning to risk-based assessment and interventions tied to risk. In the past, they used more of a definitional risk-based assessment and interventions.)
* Plans for a rollout of the new risk-based assessment process systemwide.

##### What You Can Do:

* Share information with your board and other administrative leaders through multiple avenues (e.g., meetings, reports).
* Show them ongoing progress and improvement.

#### Module 1: Understanding Why Change Is Needed

Hospital: >200–400 beds  
Pilot Units: Telemetry, Geri/Psych

**Challenge:** Lack of leadership buy-in or support.

**Solution:** Provide data when discussing fall prevention needs.

**Description:** The team did a deep dive report for leadership that covered falls in several units for 3 months when there were a total of 50 falls. The report was presented to administration and seeing these data engaged the administration.

In response to these findings, the administration suggested some changes in the audit tools. They also identified the need to increase staff engagement, coordinate post-fall huddles with event reporting via the hospital’s software, and have the Information Technology (IT) Department assist with mobility assessment documentation. In addition, the administration directed the Falls Team to bring the results of the report to staff via the Unit Champions.

##### What You Can Do:

* Conduct surveys or compile reports of available data to underscore the importance of reducing falls in the facility and to engage leadership in understanding why change is needed.

#### Module 1: Understanding Why Change Is Needed

Hospital: >400 beds  
Pilot Units: Med/Surg, Telemetry

**Challenge:** Resource support—professional time and money.

**Solution:** Conduct a value analysis/needs assessment.

**Description:** The team conducted a value analysis/needs assessment to determine whether to purchase bedside commodes or walkers. Originally, staff thought walkers were needed. However, a review of post-fall huddle reports revealed that commodes were needed. The team presented data showing that 95 percent of falls in this unit happened when patients tried to travel to the toilet. Increased use of commodes for this unit would decrease the distance patients travel to use the toilet.

After a commode was placed in all rooms on the unit, falls decreased 27 percent. On another unit, which also received some commodes, falls decreased 19 percent. Among the interventions on these two patient care units, the purchase of commodes had the biggest impact on fall reduction. In addition, it boosted staff’s morale, since the idea came from staff on the unit.

##### What You Can Do:

* Review data to ensure that the most effective intervention is selected.
* Ask unit-level staff what they are seeing related to patient falls and involve them in the solution gathering process.

#### Module 2: How To Manage Change

Hospital: >50–200 beds  
Pilot Units: Med/Surg, Geri/Psych

**Challenge:** Delineating Implementation Team member roles.

**Solution:** Clearly define role of Unit Champion.

**Description:** The hospital had Unit Champions even before the prevention initiative started, but their roles needed to be better defined. As part of the initiative action plan, the champion role was defined, and Fall Champions were empowered to take the lead on the pilot units. The Unit Champions were provided with detailed lesson plans to use for unit staff education. Unit Champions were also responsible for data collection. The prevention initiative action plan is monitored by the Quality Department. Aggregate RCA determined a need for information to be shared. Unit Champions took on the responsibility of sharing fall prevention information and data on their units.

##### What You Can Do:

* Review job duties and expectations with all staff who will be on the Implementation Team.
* Clearly define the role of the Unit Champion and ensure that all staff understand their responsibilities related to fall prevention.
* Educate all staff on fall prevention activities and monitor to ensure that fall prevention activities are adequately implemented.

#### Module 2: How To Manage Change

Hospital: >400 beds  
Pilot Units: Rehab, Medical, Cardiac Intermediate Care Unit (IMC)

**Challenge:** Effectively involving the pharmacist in the Fall Prevention Team.

**Solution:** Clearly define the role of the team’s hospital pharmacist.

**Description:** Frontline staff nurses needed more information about regularly-prescribed medications as a risk factor for falls on each specific unit. The team pharmacist provided this education. The pharmacist attends all team meetings and acts as a resource for medications. The pharmacist makes nurses more aware of medications as a risk factor and teaches patients and families about the side effects of medications.

##### What You Can Do:

* Consider how you will tap into the expertise of your hospital pharmacist (a member on the interdisciplinary team or as an ad hoc subject matter expert to consult on specific patients as appropriate).

#### Module 2: How To Manage Change

Hospital: >400 beds   
Pilot Units: Med/Surg, Telemetry

**Challenge:** Delineating Implementation Team member roles.

**Solution:** Use patient care technicians (PCTs) more effectively in fall prevention activities.

**Description:** The Fall Prevention Team made the change from hourly rounding to purposeful rounding on the pilot units. PCTs were educated on purposeful rounding, since they are the ones who usually bring patients to the toilet. A complimentary meal (lunch or other) was included with the educational course to reinforce the PCTs’ value to the process. All leaders attended the complimentary meal.

During the educational session, the PCTs learned the following strategies: incorporating scripting during purposeful rounding, asking patients if they need to use the toilet, posting a toileting schedule in patients’ rooms, and telling patients when toileting will occur. Nurse managers monitor compliance and conduct focused rounding (including teach-back) with patients who are at high risk to ensure they have been rounded on and understand their fall risk. The educational session was found to boost PCTs’ morale.

The hospital is faced with increased patient days and several new employees. Content from the educational sessions will be incorporated into new employee orientation.

##### What You Can Do:

* Consider ways hospital leadership can communicate the importance of and support of new initiatives with PCTs and other specific team members.
* Incorporate content from the educational sessions on purposeful rounding into new employee orientation.
* Consider shadowing pilot unit staff to ensure that tasks are completed correctly and in a timely manner after initial implementation.

#### Module 2: How To Manage Change

Hospital: >50–200 beds  
Pilot Units: Med/Surg

**Challenge:** Effectively planning for Implementation Team responsibilities.

**Solution:** Expand the role of the Unit Champion to include team responsibilities.

**Description:** To streamline team tasks, the role of the Unit Champion on the pilot units was expanded to include the following quality improvement activities:

* Participating in a comprehensive review of the fall policy and procedures
* Reviewing evidence and best practices for fall prevention
* Incorporating key interventions in the policy
* Developing a fall prevention knowledge assessment tool for staff
* Conducting audits to look at adherence to processes
* Providing education for staff, both at scheduled times and during audits and other observations (including identifying barriers that staff encountered to following fall prevention processes)
* Planning the agenda for and facilitating team meetings

The Unit Champions were given regularly-scheduled paid time to work on these quality improvement activities (12 hours/month each). Through this process, the organization reinforced the use of a standardized approach that incorporates best practices in support of fall prevention.

Expanding the Unit Champion’s role to include planning, education, and data collection benefited the team in many ways. The Unit Champion is a professional who understands the culture of the hospital and the specific patient care units and has the professional expertise to understand policies and procedures and quality improvement. The Unit Champion serves as the expert on the ground who helps determine and carry out evidence-based best practices for fall prevention.

##### What You Can Do:

* Review job duties and expectations; the in-person training session may be a good point to begin this discussion. Survey staff to ensure that they understand their responsibilities related to fall prevention. Work with all staff to ensure that the fall prevention activities are adequately covered.

#### Module 2: How To Manage Change

Hospital: >50–200 beds  
Pilot Units: Medical

**Challenge:** Process analysis assessment.

**Solution:** Map the steps of fall prevention processes, and analyze problematic areas.

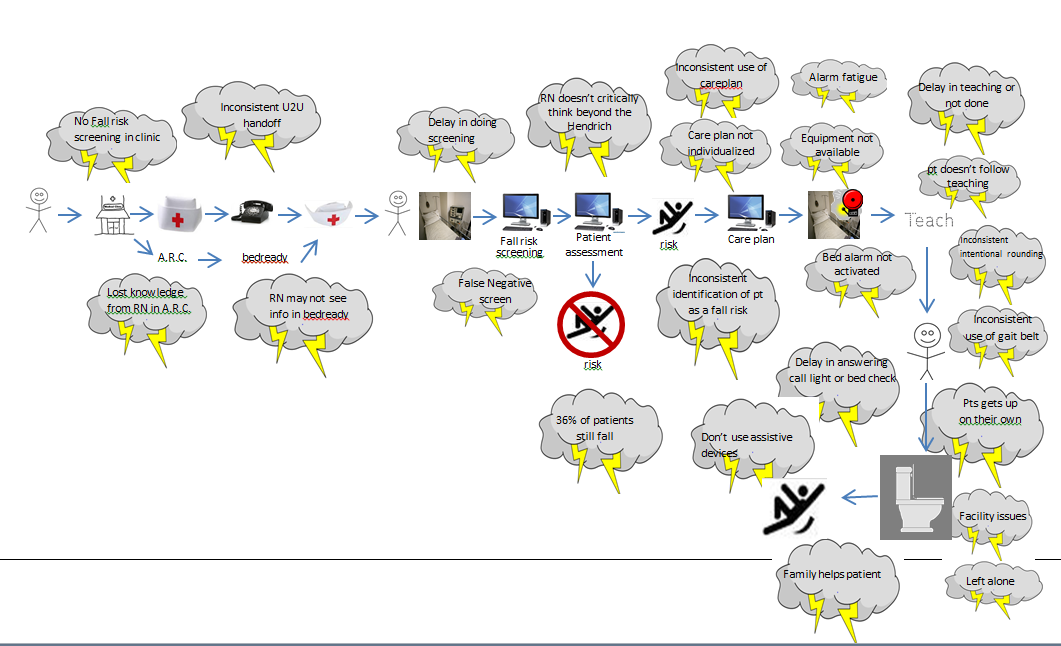
**Description:** The Fall Prevention Team used a LEAN QI transformation approach to problem solving to help uncover the opportunities to strengthen their fall prevention efforts. They developed a process map showing a high-level view of the steps in their fall prevention processes (e.g., arrival of the patient in the clinic, transfer to a hospital bed, fall risk screening, patient assessment, care planning, patient teaching, support of patient mobility in the hospital).

The team identified where breakdowns, workarounds, duplication, or variation occurred at each step and indicated those using “storm clouds” (see **Figure F-1** below). Then the team prioritized which steps and problems in the process to work on.

##### What You Can Do:

* As suggested in the pretraining phase, use [Tool 2C: Current Process Analysis](https://www.ahrq.gov/professionals/systems/hospital/fallpxtoolkit/fallpxtk-tool2c.html) from [AHRQ’s Fall Prevention Toolkit](https://www.ahrq.gov/professionals/systems/hospital/fallpxtoolkit/index.html) to map your current fall prevention processes and evaluate areas of opportunity within your processes. Address these problems using quality improvement methods, such as PDSA and Lean QI methods.

Figure F-1. Illustration of Process Problems Using Storm Clouds



#### Module 3: Best Practices in Fall Prevention

Hospital: >400 beds  
Pilot Units: Ortho/Trauma, Medical/Telemetry

**Challenge:** Conducting risk/post-fall assessments.

**Solution:** Hardwire the post-fall assessment process in an ongoing system.

**Description:** The Fall Prevention Team redesigned their post-fall assessment form based on AHRQ Toolkit [Tool 3O:Postfall Assessment for Root Cause Analysis](https://www.ahrq.gov/professionals/systems/hospital/fallpxtoolkit/fallpxtk-tool3o.html). This standard form (see **Figure F-2** below) is key to maintaining the patient’s safety and to organizational learning about how to prevent future falls.

After noticing low compliance with the paper form, the team embedded the form in their safety event reporting system, where completion is mandatory. This change has helped hospital staff track and trend falls. The nurse manager reviews the information and communicates findings during safety huddles.

##### What You Can Do:

* Use a standardized approach to post-fall evaluation.
* Link risk management with post-fall huddles, in an effort to prevent future falls in this patient and in other patients.
* Post-Fall Huddle Report FormEmbed the post-fall assessment form in the event reporting system for seamless tracking and trending.

Figure F-2. Post-Fall Huddle Report Form

#### Module 3: Best Practices in Fall Prevention

Hospital: ≤50 beds

Pilot Unit: Acute Rehab

**Challenge:** Adequately monitoring patients at high risk of falling.

**Solution:** Institute video monitoring.

**Description:** The Implementation Team contributed to policy development, training for nurses and therapists, and monitoring of falls that occurred under video monitoring. Video monitoring equipment was purchased, including four stationary units and 15 mobile units. The team developed inclusion/exclusion criteria to assist in determining which patients may benefit from the use of video monitoring, as shown in **Table F-1** below.

Table F-1. Video Monitoring Inclusion and Exclusion Criteria

| Inclusion Criteria | Exclusion Criteria |
| --- | --- |
| Meets criteria for 1:1 sitter and does not meet any exclusion criteria  Alcohol withdrawal  Delirium/restlessness  Identified as a significant risk for falls  Restraints  Elopement risk  Potentially aggressive/violent patients  Safety issues identified by members of the Interdisciplinary Team  Patients at risk of pulling out IVs, gastrostomy tubes, trachs, etc. | Newly assessed suicidal ideation and has not yet undergone evaluation by a psychologist or psychiatrist who can assess risk level  Moderate to high risk for suicide  Gravely disabled or cognitively impaired with the capacity for elopement or wandering  Risk of harm to others  Special exceptions (e.g., language barriers)  Significant hearing impairment |

The video monitoring system can speak to the patient using preprogrammed phrases available in different languages. Preprogrammed phases include “Wait for your nurse” and “Stop! Don’t get up.” The monitor tech can also use the monitoring system to talk to the patient directly, individualizing intervention messages as appropriate. (Usage reports indicate that individualized intervention messages are used more frequently than the preprogramed responses.) A runner is available for emergencies. If needed, the runner can push an alarm to alert nearby staff.

Education included special training for monitor techs and runners. Frontline clinicians received training on using the video monitor, using the alarm, communicating through the monitors, and indicating when privacy was needed or the patient was out of the room (e.g., for therapy). Basic education was provided for all clinicians. A monitoring room was set up with large viewing monitors. Documentation forms were created for video monitoring staff to track behaviors, trends, interventions, and need for ongoing video monitoring.

Video monitoring has helped reduce falls and falls with injury. It also supplements one-on-one monitoring, which has increased the hospital’s capacity to accept patients who are at high risk of falling.

##### What You Can Do:

* Various processes can be implemented to help ensure that falls are prevented; consider technology-related innovations as appropriate.

#### Module 3: Best Practices in Fall Prevention

Hospital: >400 beds  
Pilot Units: Med/Surg, Telemetry

**Challenge:** Ensuring staff conduct rounds as intended.

**Solution:** Script purposeful rounding.

**Description:** The hospital found that most hospitalwide falls happen when patients go to the bathroom. The Fall Prevention Team created a more bathroom-driven rounding schedule. During the daytime and evening shifts, staff ask patients every 2 hours if they need to use the bathroom. During the night, staff wake patients up twice to ask if they need to use the bathroom, but they honor patient preferences.

A script was developed in collaboration with the Director of Service Excellence, and education on scripting was provided for all shifts. To implement this program, hospital staff held planning meetings. The Core Team met weekly, the Fall Reduction Team met biweekly, and the unit met monthly. The hospital provided housewide education and specific education for patient care technicians (PCTs). It also conducted biweekly audits.

The Fall Prevention Team created scripts to help staff talk to patients about toileting (see **Figure F-3** below). The scripts explain the rounding schedule and ask patients about their nighttime bathroom routine. They state that the hospital’s goal is patient safety and urge patients to ask whenever they need help getting to the bathroom.

Staff meetings were held to educate staff on the scripting. Nurses and PCTs were encouraged to make the scripting their own so their words would flow more naturally. Scripting was rolled out to evening and night shifts, since most falls occurred during those times.

The rounding schedule requires nurses to round on odd hours and techs to round on even hours. The nighttime routine includes communication with each high-risk patient ahead of time to determine their usual toilet schedule and rounding request if they are awake and alert. If they are not awake and alert, they will be rounded on at the usual hours of midnight, 3 a.m., and 5 a.m.

The rounding focused on high fall risk patients. Meaningful rounding was implemented using the Henry Ford model to include modified scripting and rounding on a clock heavily influenced by patient communication.

##### What You Can Do:

* Consider using a script to maximize effectiveness of purposeful rounding.
* Compile data on underlying reasons for patient falls in your facility.
* Use available resources to address the problem.

Figure F-3. Sample Rounding Script

**Fall Prevention**

**RN and PCT Memorable Rounding Scripting**

RNs will round on patients during odd hours, and PCTs will round on even hours.

**During the morning rounds, the RNs and PCTs will say:**

“Good morning. My name is \_\_\_\_, and I want to make sure we are fulfilling your needs. Our goal is to provide you with an excellent patient experience and prevent you from falling, so you will have a member of our team coming in every hour to assist your needs. During the daytime, we will come in at 8, 10, 12, 2, 4, and 6 [or 9, 11, 1, 3, and 5] to take you to the bathroom. If you need to change positions or go to the bathroom sooner, please press the red nurse button and ask for assistance. Do you need to go to the bathroom now?”

**During the afternoon rounds, the RNs and PCTs will say:**

“Good morning. My name is \_\_\_\_, and I want to make sure we are fulfilling your needs. Our goal is to provide you with an excellent patient experience and prevent you from falling, so you will have a member of our team coming in every hour to assist your needs. We will come in at 2, 4, 6, and 8 [or 1, 3, 5, and 7] to take you to the bathroom. If you need to change positions or go to the bathroom sooner, please press the red nurse button and ask for assistance. Do you need to go to the bathroom now?”

**During the evening medication pass, the RNs will say:**

“Hello, Mr./Mrs. \_\_\_\_. Around midnight and 5:00 a.m., we will be entering your room to take you to the bathroom. How often do you normally get up to go to the bathroom at home? We will honor your normal routine. Our goal is maintaining your safety throughout the night, and we do not want you to fall. Do you need to go to the bathroom now?”

**During the evening and early morning bathroom rounds, the RNs and PCTs will say:**

“Hello, Mr./Mrs. \_\_\_\_. I am sorry to wake you, but I need to get you up and assist you to the bathroom at this time.”

**After placing the patient back in bed, the RNs and PCTs will say:**

“Again, I am sorry to have woken you at this time, but our goal is to maintain your safety through the evening. Is there anything I can do for you at this time?”

#### Module 3: Best Practices in Fall Prevention

Hospital: >400 beds  
Pilot Units: Ortho/Trauma, Medical/Telemetry

Individualized Fall Education Plan Based on Fall Risk Assessment
**Challenge:** Improving care planning, standardizing care, and using shared decision making.

Figure F-4. Individualized Fall Education Plan

Based on Fall Risk Assessment

**Solution:** Link risk assessment factors to care planning and patient education.

**Description:** The Fall Prevention Team developed a tool (see **Figure F-4**) that links the findings from the fall risk assessment to the care plan and serves as an educational tool for the patient and family. The tool provides visual cues for individualized fall prevention awareness and encourages shared decision making with the patient and family.

The tool was piloted on both pilot units, was audited, and had good results. The team believes the tool may improve interrater reliability of fall risk. Staff are expected to use the tool with patients within their first 2 hours on shift. The team is working with their electronic medical record vendor to ensure purchase of needed modules to incorporate clinical practice guidelines and enhance shift handoff communication.

##### What You Can Do:

* Ensure that once risk assessment has identified patient risk factors, care planning matches the identified risks.
* Make sure that patients and their families understand the patient’s fall risk and how the proposed care plan addresses these risks.
* Identify specific aspects of the care plan that patients and families can help to implement.

#### Module 3: Best Practices in Fall Prevention

Hospital: >400 beds  
Pilot Units: Rehab, Medical, Cardiac IMC

**Challenge:** Improving care planning and standardizing care.

**Solution:** Enhance EHR documentation.

**Description:** IT changed EHR documentation from a check box system to a free text system. While more time consuming, the new system improved nurses’ use of critical thinking when assessing fall risk and individualizing care plans. Clinical directors on the units now perform twice-daily chart audits and provide staff education in real time as issues are found. This procedure has improved accountability and sustainability.

##### What You Can Do:

* Consider including a representative from IT on your interdisciplinary team, or establish a point of contact who can support the team on an ad hoc basis.
* Determine whether your facility’s EHR can be modified.
* Determine the best ways to integrate risk assessment with care planning.

#### Module 3: Best Practices in Fall Prevention

Hospital: >400 beds  
Pilot Units: Med/Surg, Telemetry

**Challenge:** Improving care planning and standardizing care

**Solution:** Use the facility’s EHR features for maximum productivity.

**Description:** The Fall Prevention Team worked with their EHR vendor to reeducate staff specifically on features in the system that should be used to link the care plan to the risk assessment.

##### What You Can Do:

* Consider including a representative from IT on your interdisciplinary team, or establish a point of contact who can support the team on an ad hoc basis.
* Determine the most efficient ways to use your facility’s EHR.
* Determine the best ways to integrate risk assessment with care planning.

#### Module 3: Best Practices in Fall Prevention

Hospital: >50–200 beds  
Pilot Units: Med/Surg

**Challenge:** Lack of time for staff to do hourly rounding.

**Solution:** Use dedicated CNAs for purposeful hourly rounding.

**Description:** Dedicated CNAs conduct purposeful hourly rounding. One CNA does all the rounding on day shifts, and another CNA does all the rounding on evening shifts. Staff and patients like this practice, and it has improved the hospital’s patient experience survey scores. Patients report feeling that staff are in the room to help them more often.

For some nonurgent needs, patients decide to wait until the rounder comes back to help them. Staff report that this approach lessens noise on the unit, reduces call light usage, and prevents some staff interruptions.

##### What You Can Do:

* Consider ways to make purposeful hourly rounding more efficient, including by dedicating staff to this task.
* Share the purposeful hourly scheduling information with patients and their families to lessen the number of nonurgent calls between rounds.

#### Module 3: Best Practices in Fall Prevention

Hospital: >400 beds  
Pilot Units: Medical, Acute Rehab

**Challenge:** Post-fall huddles were not implemented in a timely manner.

**Solution:** Standardize the post-fall huddle, and include all relevant staff.

**Description:** The hospital uses a hospitalwide paging system to announce post-fall huddles using a specific code and noting the specific unit where the fall occurred. When the code is announced, a standard tool to capture information, including risk assessment, universal fall precautions, environment, and outcomes, is used to guide the post fall huddle discussion.

Staff who participate in the discussion include the assigned nurse, CNA, nursing supervisor, charge nurse, manager or director for the department, and any staff who witnessed the fall. In addition, the Director of Risk Management and Patient Safety and the Risk Management Coordinator participate as available.

##### What You Can Do:

* Consider standardizing the post-fall process hospitalwide so that all staff understand the process after a fall has occurred.
* Consider ways to ensure that all staff needed for a post-fall huddle are informed of the fall and can get to the unit in a timely manner to complete the huddle.

#### Module 3: Best Practices in Fall Prevention

Hospital: >400 beds  
Pilot Units: Medical, Acute Rehab

**Challenge:** Staff communication about fall risk.

**Solution:** Enhance communication about fall risk during shift handoffs and huddles.

**Description:** To facilitate exchange of pertinent information among certified nursing assistants (CNAs) at shift change, CNAs round together on patients before shift change. Rounding includes discussion of information on toileting, mobility, and implementation of fall precautions and interventions. This purposeful rounding occurs in the patient’s room or wherever the patient is (i.e., not in the break room) and includes the patient. In both pilot units, the team enhanced handoff communication between nurses at shift change to include discussion of fall risk.

In addition, the team implemented daily shift huddles addressing safety issues. During shift huddles, patients at risk of falling are discussed. This discussion includes patient-specific risk factors and interventions. For example, the following information is shared:

* Patients with impulsivity who get up without calling for assistance, so a bed or chair alarm is required.
* Patients at risk for falling because of issues with new medications, elimination, activity level, or transfer assistance needs.
* Patients who have gotten up from their bed or wheelchair unsupervised.
* Patients with a change in condition.

Also during shift huddles, staff members are reminded to complete the hourly rounding sheet for patients identified at high risk of falling.

##### What You Can Do:

* Communicate patient risk factors orally during shift handoffs and shift huddles, including any change in fall risk factors during the shift.
* Review medical record documentation and patient care worksheets.
* Include the patient in handoff communications when possible.

#### Module 3: Best Practices in Fall Prevention

Hospital: >50–200 beds  
Pilot Units: Medical

**Challenge:** Maintaining Unit Team’s situational awareness of patients at highest risk for falls.

**Solution:** Use shift huddles to identify the three patients most at risk to fall on each shift.

**Description:** The Fall Prevention Team identified an opportunity to heighten collective and individual awareness of patients on the unit who were at the highest risk to fall. Many of the patients are considered high risk based on risk assessment results. However, the team sought to identify and focus on those most at risk. They examined the shift huddle process and determined that the huddle could be used to enhance communication about fall risk.

The team revised the huddle to include information on patients who had fallen, the interventions that were in place to prevent another fall, and the three patients most at risk to fall. Leaders monitored this process across shifts to assess compliance, benefits, and challenges.

Nursing staff and charge nurses appreciate the predictability of the message and knowing what to expect. They report having a heightened sense of awareness about the three patients at highest risk to fall. If they see a call light or hear an alarm for those patients, they know that it may be an opportunity to prevent that patient from falling.

##### What You Can Do:

* Communicate about high-risk fall patients during shift change to increase awareness of those needing additional preventive care.

#### Module 4: How To Implement the Fall Prevention Program in Your Organization

Hospital: >400 beds  
Pilot Units: Med/Surg, Telemetry

**Challenge:** Staff engagement.

**Solution:** Recognize staff efforts.

**Description:** The Fall Prevention Team held a breakfast for the PCTs to reinforce the importance of purposeful rounding and teamwork. They also planned a party to celebrate the PCTs and their role in the Fall Prevention Program.

##### What You Can Do:

* Recognize the important role of bedside staff in fall prevention efforts.
* Explore opportunities to generate and maintain excitement about the change process.

#### Module 4: How To Implement the Fall Prevention Program in Your Organization

Hospital: >400 beds  
Pilot Units: Ortho/Trauma, Medical/Telemetry

**Challenge:** Staff education.

**Solution:** Develop and post monthly educational fall prevention pieces.

**Description:** The Fall Prevention Team developed a monthly fall prevention staff education program. Each discipline takes a turn making an educational flier (see **Figure F-5**). The flier is then posted on all floors and discussed during safety huddles.

##### What You Can Do:

* Include all disciplines in developing fall prevention staff education.

Figure F-5. Fall Prevention Educational Fliers

#### Module 4: How To Implement the Fall Prevention Program in Your Organization

Hospital: >400 beds  
Pilot Units: Med/Surg, Telemetry

**Challenge:** Staff education.

**Solution:** Recognize and educate bedside staff.

**Description:** The Fall Prevention Team realized that success with the Fall Prevention Program required engagement of the PCTs. The team developed an educational program and planned a new 10-week PCT University. The program includes scripting for rounding, competency assessment, and auditing.

##### What You Can Do:

* Invest time and resources in educating frontline staff.
* Consider the unique needs of clinical and nonclinical staff.
* Educate all hospital staff, from top leadership to housekeeping staff.

#### Module 4: How To Implement the Fall Prevention Program in Your Organization

Hospital: >50–200 beds  
Pilot Units: Medical

**Challenge:** Staff critical thinking skills.

**Solution:** Provide just-in-time coaching.

**Description:** The Implementation Team supports staff’s critical thinking by providing just-in-time coaching. For example, unit leaders observe PCTs’ bedside handoffs. They found that some PCTs believed it was rude to have conversations in front of patients. Leaders talked to and coached staff about the purpose of bedside handoffs and how to perform them in a respectful and helpful manner that includes the patient. Leaders reinforced this practice during staff meetings and staffing huddles. Leaders continue to talk with staff about the benefits of bedside handoffs (reducing patient falls) and to provide personal coaching to support staff member growth.

##### What You Can Do:

* Use in-person coaching to improve staff’s handoff skills and critical thinking.
* Educate staff on the importance and benefits of including the patient in handoffs.

#### Module 4: How To Implement the Fall Prevention Program in Your Organization

Hospital: >400 beds  
Pilot Units: ICU, Med/Surg

**Challenge:** Staff turnover.

**Solution:** Institute a 1-year RN residency program.

**Description:** The hospital instituted a 1-year residency program for new graduate nurses in an effort to retain them. The goal is to provide specific orientation and on-the-job training to empower new nurses to learn and be confident in their skills. The program consists of:

* Three-month orientation.
* Three-week orientation to hospital.
* Nine-week preceptorship with floor nurses to build skills.
* Monthly forums to talk about their work and provide an emotionally supportive atmosphere.
* Graduation ceremony.
* Pay raise upon graduation.

The program improved retention of new graduate nurses. Its 2-year retention rate was 85 to 95 percent. Each class has 30 nurses.

##### What You Can Do:

* Determine how your facility can best retain and incorporate new nurses into its Fall Prevention Program and other patient safety efforts.
* Explore implementation of a residency program to support retention.

#### Module 4: How To Implement the Fall Prevention Program in Your Organization

Hospital: >200–400 beds  
Pilot Units: Telemetry, Geri/Psych

**Challenge:** Staff turnover.

**Solution:** Develop a new graduate education program.

**Description:** The hospital had many staffing vacancies in nurse and CNA positions. It also experienced occasional shortages when CNAs were reassigned as sitters in the ER. In addition, the hospital had a high turnover rate for nurses who came in as new graduates and, after some training and experience, left for nearby academic hospitals. In response, the hospital developed an 8- to 10-week educational program for new graduates.

##### What You Can Do:

* Determine how your facility can best retain and incorporate new nurses into its Fall Prevention Program and other patient safety efforts.
* Consider reviewing your organization’s onboarding process, identifying and acting on opportunities for improvement.

#### Module 5: How To Measure Fall Rates and Fall Prevention Practices

Hospital: >50–200 beds  
Pilot Units: Med/Surg, Geri/Psych

**Challenge:** Monitoring your Fall Prevention Program.

**Solution:** Collect process and outcome data.

**Description:** The Fall Prevention Team conducted audits of evidence-based practices. They measured the quality of the rounding and audited use of the 5 Ps. Team members conducted observational audits and 10 random chart review audits per week on the pilot unit. They also audited intentional rounding on several units and monitored all fall data.

##### What You Can Do:

* Monitor process and outcome measures to determine what processes can be improved to decrease fall rates.

#### Module 5: How To Measure Fall Rates and Fall Prevention Practices

Hospital: >400 beds  
Pilot Units: Medical, Acute Rehab

**Challenge:** Reluctance to count assisted falls as falls.

**Solution:** Collect data on all falls, but also monitor assisted falls as a subset.

**Description:** Some staff were reluctant to consider and count assisted falls as falls—particularly on rehab units where patients were being appropriately encouraged and tested to increase mobility. Leaders continued to support counting and reporting assisted falls to be transparent and consistent with National Database of Nursing Quality Indicators definitions but also began tracking the number of assisted falls for quality improvement and measurement purposes.

##### What You Can Do:

* Encourage staff to collect data on all falls.
* Consider collecting data on all types of falls (e.g., assisted falls, falls without injury, falls with injury).

#### Module 5: How To Measure Fall Rates and Fall Prevention Practices

Hospital: >200–400 beds  
Pilot Units: Telemetry, Geri/Psych

**Challenge:** Involving other disciplines in fall prevention.

**Solution:** Use data to drive quality improvement.

**Description:** At the request of hospital leadership, the Fall Implementation Team prepared a deep dive report encompassing 3 months of falls on the Med/Surg, Telemetry, and Behavioral Health Units (total of 50 falls). Forty percent of the falls occurred with staff in attendance, which may have prevented falls with injury.

Further evaluation found that with assisted falls, the staff in attendance were mainly Transport Team members. The Fall Prevention Team met with the Transport Team supervisor to discuss this finding. Together, they agreed to have transport staff attend nursing general orientation and nursing care orientation to educate transport staff on prevention strategies. The culture of this hospital is to look at its data when even the smallest trend is seen and use data to drive change and obtain buy-in from stakeholders.

##### What You Can Do:

* Use process data to explain when, where, and how falls are occurring.
* Educate all relevant disciplines.

#### Module 5: How To Measure Fall Rates and Fall Prevention Practices

Hospital: >50–200 beds  
Pilot Units: Med/Surg, Geri/Psych

**Challenge:** Lack of national benchmarks.

**Solution:** Compare fall prevention performance with previous fall rates.

**Description:** The hospital benchmarked against its earlier fall rate data, using unit-level data that goes back 3 years. It looks at data for all falls, as well as for falls with injury. The data show a drop in falls with major injury from six falls in fiscal year 2014 to four in fiscal year 2015 to one in fiscal year 2016. The data also reveal a reduction in fall rates for both the entire hospital system and for the pilot units.

##### What You Can Do:

* Focus on improvement over time within hospital units and the hospital overall, rather than focusing on your hospital’s performance compared with an external benchmark.

1. Some content in this section was adapted from TeamSTEPPS 2.0 Course Management Guide, retrieved July18, 2017, from <https://www.ahrq.gov/teamstepps/instructor/essentials/coursemgmt.html>. [↑](#footnote-ref-1)
2. Be sure to begin these assessments several weeks before the in-person training to allow enough time to complete them thoroughly. [↑](#footnote-ref-2)