Falls Prevention Audit Tool for Acute, Long-Term, and Home Care, Supportive Living and Rehab

Instructions and Legend for Completing the Falls Prevention Audit Form

Purpose of the Audit Tool

The tool is designed for use in **Acute, Long-Term, and Home Care, Supportive Living and Rehab** and was developed to allow organizations to assess the quality of their falls prevention and injury reduction practices and determine the areas requiring quality improvement(s).

Data Collection Methodology

- Retrospective chart review to collect data for the previous month e.g. Audit conducted in April will collect March data.
- Collect information monthly or quarterly on all patients/residents/clients or a subset as recommended by your organization.

Pt./Res/Clt #

- Each row represents an individual patient/resident/client that is included in the audit.

Question by Question explanation

A. Type of Falls Risk Assessment performed on Admission (select the most detailed) (Falls-Acute/HC/LTC 3)

- **Screen**: (score as 1) Also known as a "quick screening". A brief screening to identify and sort individuals into high or low fall-risk categories. The categories may be numerical with a cut-off score, or rank as low, medium, and high risk. The result of the screen is to determine which individuals require a thorough falls risk assessment.
- **Full** (Assessment): (score as 1) Also known as a Comprehensive assessment used to identify specific risk profiles of individuals in order to create individualized targeted fall prevention/injury reduction plans of care based on identified risks. It is a more detailed and systematic process than screening. It is used to identify modifiable and non modifiable factors that contribute to a person's increased risk of falling and to develop an individualized plan where interventions are targeted at the identified risk factors.
- **None**: (score as 0) no Fall Risk Screening or Assessment was performed or documented on admission
- **Note**: Timing of assessment should be performed according to organizational policy
- **Note**: SHN Falls Getting Started Kit recommends using a multifactorial e.g. comprehensive Falls Risk Assessment Tool

B. Was patient/resident/client designated "at risk" for Fall and was risk status communicated (Falls-Acute/HC/LTC 10)

- Based on results of Screening/Assessment
- Respond '**Yes**' (score as 1) if patient/resident/client was designated 'at risk' and the status was communicated to the staff
- Respond '**No**' (score as 0) if patient/resident/client was designated 'at risk' and the status was **not** communicated to the staff
- Respond '**No Risk**' (score as 1) if patient/resident/client was not designated as 'at risk'

C. Medication review completed? (Falls-Acute/HC/LTC 11)

- Select **Yes** (score as 1) or **No** (score as 0) or **Not Recorded** (score as 0)
- A comprehensive medication review by a physician, nurse practitioner, or pharmacist should be conducted on all older adults to determine risk for fall/fall injury [Getting Started Kit (GSK), p. 51]. Medication reviews should include a review of the client's medical conditions/diagnoses/health problems and medications prescribed. Further description on GSK, pg 52).
- A medication review is not the same as medication reconciliation.
- If the medication review was not documented in the patient/resident/client chart you must select 'Not Recorded'.

D. Pt. Has documented Falls Prevention/Injury Reduction Plan (Falls-Acute/HC/LTC 5)

- Select **Yes** (score as 1), **No** (score as 0) or **No Risk** (score as 1)
- A Falls Prevention Plan is an individualized documented plan outlining strategies addressing identified falls-associated risks is in the health record (GSK p. 192).
- An Injury Reduction Plan aims to reduce the incidence of or severity of injury. This would include interventions such as hip protectors, floor mats, helmets, etc.
- If neither was documented in the patient/resident/client chart and the patient has been designated 'at risk' select '**No**' (score as 0).
- If neither was documented in the patient/resident/client chart and the patient has **not** been designated 'at risk' select '**No Risk**' (score as 1).

E. Completed Falls Risk Assessment following a significant change in medical status (Falls-Acute/HC/LTC 12)

- Select **Yes** (score as 1), **No** (score as 0) or **NA** (score as 1)
- Significant change in medical status: A change in medical status is considered "significant" if it requires a change in treatment or care plan (GSK- pg 190) and can be an improvement or worsening.
- If there has been a significant change in medical status as defined above but an Assessment was not documented in the patient/resident/client chart you must select '**No**' (score as 0).
- If there is **no evidence** of a significant change in medical status as defined above select '**NA**' (not applicable) (score as 1)
- **Note**: SHN Falls Getting Started Kit recommends using a multifactoral e.g. comprehensive Falls Risk Assessment Tool

F. Patient/Resident/Client is restrained at any time in this reporting period (Falls-Acute/HC/LTC 6)

- There are different types of 'restraints'. For the purpose of this audit we recommend using the following 3 types (GSK p. 76). If there is documented evidence of any one of these types of restraint being used at any time during the reporting period select '**Yes**'
- **Environmental Restraint**: A barrier to free personal movement which serves to confine patients/residents/clients to specific (geographic) areas.
- **Physical Restraint**: An appliance or apparatus that inhibits general movement. Included in this definition are: Jackets and vest restraints; Geriatric chairs or wheelchairs with tabletops in place; Roller bars on wheelchairs; and lap belts if they are applied in such a fashion that the seat belt opening is placed at the back of the chair and the seat belt cannot be undone by the patient/resident/client. Devices which are not defined as restraints include: devices for positioning or limb support.
- **Chemical Restraint**: A pharmaceutical given with the specific purpose of inhibiting or controlling behaviour or movement. Differentiating between the use of a drug, a therapeutic agent or a restraint is difficult. Often a drug may be used for both purposes. When a drug is used to treat "clear

cut" psychiatric symptoms rather than socially disruptive behaviours, it should not be considered a restraint.

G. How many times did the patient/resident/client fall in this reporting period (Falls-Acute/HC/LTC 13)

- **Fall** is defined as an event that results in a person coming to rest inadvertently on the ground or floor or other lower level, with or without injury. This would include an observed fall and an unwitnessed fall, which is defined as occurring when the client is able or unable to explain the events and there is evidence to support that a fall has occurred. (GSK, p. 16)
- **Select '0'** if no falls have been documented in the patient/resident/client chart during the reporting period – **stop the audit if the patient/resident/clients has not fallen**
- **Select '1'** if only 1 fall has been documented in the patient/resident/client chart during the reporting period
- **Select '2'** if only 2 falls have been documented in the patient/resident/client chart during the reporting period
- **Select '>2'** if documentation in the patient/resident/client chart reveals that the patient/resident/client has fallen 3 or more times during the reporting period

*Apply the following questions to the **most recent fall** in this reporting period – and only for patients/residents/clients who have fallen*

H. Was patient/resident/clients assessed for harm on discovery of fall? (Falls-Acute/HC/LTC 14)

- Select **Yes** (score as 1) or **No** (score as 0)
- This assessment refers to both witnessed and unwitnessed falls and should be conducted as soon as the fall is discovered.

I. Harm from Fall? (if Death – end audit here) (Falls-Acute/HC/LTC 2)

- Select the best response that most closely aligns with the degree of harm described below resulting from the most recent fall based on available information. (Source: National Database of Nursing Quality Indicators (NDNQI) definitions)
    - **None**: post fall evaluation indicates no injuries (no signs or symptoms) resulting from the fall
    - **Minor**: Injury results in application of a dressing, ice, cleaning of a wound, limb elevation, topical medication, bruise or abrasion.
    - **Moderate**: Injury results in suturing, application of steri-strips/skin glue, splinting or muscle/joint strain.
    - **Major:** Injury results in - surgery, casting, and/ or traction (typically fractures); required consultation for neurological (e.g., basilar skull fracture, subdural hematoma) or internal injury (e.g., rib fracture, liver laceration); or, patients with coagulopathy who receive blood products as a result of the fall.
    - **Death:** the patient died as a result of injuries sustained from the fall.

J. Completed Falls Risk Assessment following fall? (Falls-Acute/HC/LTC 15)

- **The Falls Risk Assessment -** same as defined in Question A
- **Select 'Yes'** (score as 1) if there is a documented Fall Risk Assessment (FRA) in the patient/resident/client chart and completed following the fall or an existing FRA reviewed after the fall.
- **Select 'No'** (score as 0) if there is **no** documented Fall Risk Assessment (FRA) in the patient/resident/client chart that was completed following the fall or an existing FRA that was reviewed after the fall.
- **Select 'Unable to perform'** (score as 1) if the patient/resident/client was transferred to another facility <24 hours following the fall making it impossible to meet this criterion

K. Monitored for 24-48 hours after fall? (Falls-Acute/HC/LTC 16)

- Monitoring includes monitoring for potential emerging problems, e.g. slow bleed, fracture, including fall reoccurrence (GSK pg. 59)
- **Select 'Yes'** (score as 1) if there is documentation in the patient/resident/clients chart indicating the patient/resident was monitored
- **Select 'No'** (score as 0) if there is **no evidence** documented in the patient/resident/client chart that the patient/resident/client was monitored
- **Select 'Not notified'** (score as 1) if not notified of fall until greater than 48 hours post fall.
- **Select 'Not able to perform'** (score as 1) if the patient/resident/client was transferred to another facility <24 hours following the fall making it impossible to meet this criterion

L. Falls Prevention/Injury Reduction Plan Reviewed/Revised after Fall? (Falls-Acute/HC/LTC 17)

- See question D for the definitions of a Falls Prevention and Injury Reduction Plan
- **Select 'Yes'** (score as 1) if there is evidence in the patient/resident/client chart that a previously created Falls Prevention and/or Injury Reduction Plan was reviewed and/or revised following the fall. If the patient/resident/client did not have a Falls Prevention and/or Injury Reduction Plan select 'YES' if a Falls Prevention and/or Injury Reduction Plan was created following the fall
- **Select 'No'** (score as 0) if there is no evidence in the patient/resident/client chart that a previously created Falls Prevention and/or Injury Reduction Plan was reviewed and/or revised following the fall or created following the fall

Reference

Schwenk, M et al. Definitions and methods of measuring and reporting on injurious falls in randomised controlled fall prevention trials: a systematic review. BMC Medical Research Methodology; 2012, Vol. 12 Issue 1, p50

Best Practice Answers

Pt #	A. Type of Fall Risk Assessment Performed on Admission (Select the Most Detailed)	B. Was Patient Designated "At Risk" for Fall and was risk status communicated?	C. Medication Review Completed	D. Patient has Documented Falls Prevention / Injury Reduction Plan	E. Completed Falls Risk Assessment Following a Significant Change in Medical Status	F. Patient is Restrained at any time in the Reporting Period	G. How Many Times did Patient Fall in Reporting Period (if 0 End Audit Here)	APPLY TO THE MOST RECENT FALL IN THE REPORTING PERIOD: H. Was Patient Assessed for Harm on Discovery of Fall?	I. Harm from Fall? (If "Death" End Audit Here)	J. Completed Fall Risk Assessment Following Fall?	K. Monitored for 24-48 hours after Fall?	L. Falls Prevention / Injury Reduction Plan Reviewed Revised after Fall?
1 VOID	SCREEN FULL NONE	Y N NO RISK	Y N NOT RECORDED	Y N NO RISK	Y N N/A	Y N	0 1 2 >2	Y N	NO HARM MINOR MODERATE MAJOR DEATH	Y N NOT ABLE TO PERFORM	Y N NOT NOTIFIED NOT ABLE TO PERFORM	Y N

Green bubbles = best practice criteria
Red bubbles = undesired outcome

Fall Prevention Score (Chutes-SCD/SAD/SLD 18)

Step 1 – Calculate the **patient-level** Fall Prevention Score

The **patient-level Fall Prevention Score** is calculated by adding the best practice prevention elements on the audit form (questions A, B, C, D, and E). This corresponds to SHN measures Falls-Acute/HC/LTC 18.

You get 1 point for meeting the best practice criteria (green bubbles) for each Falls Prevention indicator (question):

- (A) Type of Falls Risk Assessment performed on Admission = **Screen** OR **Full**
- (B) Was patient designated "at risk" for Fall and was risk status communicated? = **Yes** OR **No Risk**
- (C) Medication review completed = **Yes**
- (D) Patient has documented Falls Prevention / Injury Reduction Plan = **Yes** OR **No Risk**
- (E) Completed Falls Risk Assessment following a significant change in Medical Status? = **Yes** OR **N/A**

If all five Falls Prevention indicators are met as described above, the patient's **Fall Prevention Score** = 5 (100%).

Step 2 – Calculate the **overall** Fall Prevention Score

Sum the total number of patients for whom all 5 Fall Prevention indicators were met on admission in the patient sample, and divide by the total number of patients in the patient sample (e.g . 6 of 10 patient received a perfect score of 5; Score = 6/10 = 60%)

Fall Management Score after Fall (Chutes-SCD/SAD/SLD 19)

Step 1 – Calculate the **patient-level** Fall Management Score after Fall

The **patient-level Fall Management Score after a Fall** is calculated by adding the best practice management elements on the audit form (questions H, J, K, and L). This corresponds to SHN measures Falls-Acute/HC/LTC 19.

You get 1 point for meeting the best practice criteria (green bubbles) for each Falls Management indicator (question):

- (H) Was patient assessed for harm on discovery of fall? = **Yes**
- (J) Completed Falls Risk Assessment following fall? = **Yes** OR **Not able to perform**
- (K) Appropriate monitoring in place for 24-48 hrs after fall? = **Yes** OR **Not able to perform**
- (L) Falls Prevention / Injury Reduction Plan Reviewed/Revised After fall? = **Yes**

If all four Falls Management after a Fall indicators are met as described above, the patient's **Fall Management Score after Fall** = 4 (100%)

Step 2 – Calculate the **overall** Fall Management Score after Fall

Sum the total number of patients for whom all 4 Fall Management indicators were met on admission in the patient sample, and divide by the total number of patients in the patient sample (e.g . 6 of 10 patient received a perfect score of 4; Score = 6/10 = 60%)