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# Fall Prevention: Responder 5 Bed Connectors

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Fall Prevention: Responder 5 Bed Connectors

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### Abstract

This paper explores falls, a sentinel event plaguing hospitals in the United States and internationally. Falls are a major contributor to negative patient outcomes and a source of financial strain for hospitals. One particular fall prevention intervention, Responder 5 bed alarms, was explored. A literature review on falls was conducted to study the effectiveness of bed alarms. Capezuti et al. (2009) found bed alarms to be error prone and stress the importance of patient risk factor assessment and using bed alarms as a multifactorial approach to fall prevention. Shorr et al. (2012) came to a similar conclusion after conducting a study on one unit of an urban hospital. The researchers increased the use of bed alarms but found that increased alarm usage did not result in reduced fall rates. University of San Francisco students undertook quality improvement work at a large metropolitan hospital suffering from high fall rates. Responder 5 bed alarm connectivity was studied to better understand factors contributing to falls. Forty nurses on one unit were interviewed and 83 fall risk patient's beds were assessed. Ten out of the 83 beds (12%) assessed were connected to Responder 5. The data reveals lack of knowledge and underutilization of Responder 5. An intervention of an educational material was created. Once this intervention is implemented, future root cause analysis will be conducted to continue to understand and reduce fall rates at the hospital.

### Fall Prevention: Responder 5 Bed Alarms

Hospitals are not free from problems that organizations face on a daily basis but consequently these problems can lead to negative patient outcomes. The Clinical Nurse Leader (CNL) role exists to alleviate the problems that occur and bridge the gaps between floor nurses and administrative leadership. The CNL is valuable to all healthcare settings, including inpatient, outpatient, and community health, this nurse can greatly improve the quality of care at the bedside. CNLs provide and manage care, delegate tasks, and implement actions. Through educational endeavors, CNLs have the knowledge and tools necessary for identifying problems within the microsystem and formulating solutions to those problems that are fiscally sound (Stanley, 2010, pp. 8-9).

With the creation of this role, there is an opportunity to make a difference in the delivery of care on the microsystem level by focusing on problems that directly affect both patients and nurses. By conducting a root cause analysis and reviewing literature and evidence based practice, a solution can be crafted and a plan of action implemented directly related to that microsystem problem in hopes of improving patient outcomes, patient satisfaction, improving quality of care and the environment of care, and helping to reduce nurse dissatisfaction and turnover (Stanley, 2010, pp. 9-10). This method of improving the delivery of care allows for new best practice to be spearheaded.

One such problem area that the CNL can greatly affect positively is the reduction of adverse, or sentinel events in hospitals. Sentinel events, such as suicide, retention of a foreign body, and wrong site procedures occur often in all hospitals around the United States. These unintended events which can result in injury or even death cost hospitals millions of dollars and patients and their families a great deal of suffering (The Joint Commission, 2017). Patient falls,

though not always preventable, are a common sentinel and near miss event in healthcare settings. A patient fall is defined as “an unplanned descent to the floor with or without an injury,” and include “assisted falls” where a staff member may attempt to minimize the impact of the fall (American Nurses Association, 2009). Because of its frequency, the underlying factors for preventable falls have been studied and preventative measures have been put in place to prevent such falls throughout the nation. Yet despite these efforts, fall rates continue to remain high for many hospitals putting a strain on both patient outcomes and monetary resources.

## **Problem and Background**

### **Microsystem Assessment**

One large metropolitan hospital (Hospital) catering to underserved and underrepresented populations has a high fall rate, despite measures enacted to prevent them. The Hospital serves adult and pediatric populations, providing 20% of the area’s inpatient care, and provides accommodations to approximately 100,000 people each year. Services offered include but are not limited to: inpatient, outpatient, psychiatric, diagnostic, and emergency services. The organization is committed to being a leader in medicine and its work in research has led to many advances in healthcare. Its dedication to academia allows students of health professions to learn and grow through caring for vulnerable populations suffering from acute and chronic conditions. The Hospital aims to provide quality health care and trauma services with compassion and respect.

With this in mind, two new registered nurses in the final semester of a CNL program have embarked on a quality improvement endeavor to understand the causes for patient falls at the Hospital and how to reduce them. This work was conducted on one medical-surgical floor of the Hospital. The floor is a 36 bed unit with over a hundred registered nurses on its workflow

log. The unit provides care to geriatric and adult patients with varying acuity levels and medical-behavioral problems. It consists of a general trauma wing and a neurological trauma wing. The procedures performed on the unit consist of wound care, dressing changes, diabetic monitoring and counseling, peripherally inserted central line (PICC) and central line care, and gastrointestinal interventions such as nasogastric tubes, to name a few. Some common pathophysiologic illnesses treated include neurological, cardiac, renal, orthopedic, and oncologic illnesses. It is important to point out that these diagnoses and procedures result in patients having to take many medications, including ones for pain and sedation. Furthermore, many patients suffer from coexisting health problems, thus most of the patients are taking these medications concurrently. This combination of age, illness, and polypharmacy therefor put many at risk for falls.

### **Problem Statement**

The Hospital's high fall risk patient population has propelled a fall risk protocol that begins with a Schmid Fall Risk Assessment Tool upon admission to the unit (Alberta Health Services, 2009). This tool assesses 5 general areas: mobility, mentation, elimination, prior fall history, and current medications. Patients with a score of three or greater are considered a fall risk and fall prevention interventions are initiated. See Table 1 in Appendix A for the Schmid Fall Risk Assessment Tool in its entirety. For patients who are determined to be a fall risk, interventions must be implemented. Some interventions include but are not limited to: use of a call bell, personal items and assistive devices within reach of the patient; comfort rounds done every two to three hours to help the patient with toileting, position change, and hydration; ambulation of the patient with non-slip footwear; maintaining the bed in the lowest position;

keeping the patient's area clutter free; and activating bed alarms to alert staff when the patient tries to get out of bed (Alberta Health Services, 2009).

The Hospital utilizes two bed alarms. The first is the activation of the alarm on the bed itself through a lock/unlock keypad. The second is a Responder 5 alarm, a unit that plugs into a wall outlet and has two separate connection pieces that must be connected together. If these two types of alarms are connected and the patient attempts to get out of bed, an alarm will sound and the primary nurse and a certified nursing assistant are notified on their personal hospital phones. However, despite the Responder 5 alarm system, fall rates remain high at the Hospital. The use of Responder 5 alarms must be assessed in order to begin to understand the cause of the high fall rates at the Hospital.

### **Literature Review**

Falls are a top sentinel event reported to the Joint Commission according to their 2009 *Sentinel Event Alert*, along with medication errors, delays in treatment, post-operative complications, suicide, and wrong-site injury (Agency for Healthcare Research and Quality Improvement, AHRQ, 2016). According to the AHRQ (2013) there are approximately 700,000 to 1 million falls in hospitals every year, with elderly, frail, and long-term care patients at particularly high risk. Also at high risk are patients who are physiologically compromised, such as those who are injured, have undergone surgery or diagnostic procedures, and those on sedating and pain relief medications. Factors related to falls include but are not limited to: improper assessment of the patient, communication breakdown between care providers, lack of adherence to protocols, inherent problems with the physical environment, lack of staffing, orientation of staffing, poor patient supervision, as well as poor or absent leadership (The Joint Commission, 2015).

Falls in hospitals cause injury such as bone fractures, internal injury such as bleeding, and even death. Though research shows that a third of falls can be prevented by understanding and managing the underlying risk factors and physical environment, fall rates continue to remain high (AHRQ, 2013). Approximately 30% to 50% of falls in hospitals result in an injury of some sort, mandating more treatment, an increased length of hospital stay by 6.3 days, and an average cost of \$14,000 per patient (The Joint Commission, 2015). Sadly, an estimated 11,000 falls per year are fatal (Eliminating Alarms, 2016). Most falls in hospitals occur on neurosurgical, neurology, and medicine units, while surgical and intensive care units have far lower fall rates due to the patient population being less ambulatory (Bouldin et al., 2014).

With these statistics in mind, The Joint Commission (2015) has formulated a list of 6 suggestions for hospitals in order to prevent falls. They include: an interdisciplinary falls prevention team, utilization of a validated fall risk assessment tool, establishment of an individualized care plan, the ensuring of proper communication between staff, and staff and patients, conducting post-fall huddles to analyze the circumstances leading to a fall, raising awareness of a potential fall through ongoing staff communication, and application of equipment such as bed alarms. The use of bed alarms is a fairly new intervention for hospitals around the U.S. and the focus of much research. Through conducting a literature search, it is evident bed alarms are widely used as a means of preventing falls with the inpatient population. However, much of the research on bed alarms looks at long-term care facility patients, as they more often than not require fall prevention interventions.

A systematic review of fall prevention methods reveals that U.S. acute care hospitals do in fact approach fall prevention with multiple components, as recommended by The Joint Commission (Hempel et al., 2013). These interventions include: patient education, rounding by



healthcare providers, visual alerts for staff of fall risk patients, and bed-exit alarms (p. 486). However, there is not enough consistent data to “evaluate the effectiveness” of the interventions (p.492). The hospitals studied enacted interventions based on their own specific risk assessments and assessment tools making evaluation of each intervention difficult. Alternately, the study does bring to light the significance of human error and the importance of adherence by all staff since all hospitals “experienced barriers in clinical practice” such as “forgetting to remove identification signs next to call lights after high-risk patients were discharged and failing to educate new staff about fall prevention programs” (p.493).

Though this technological intervention is endorsed and used by the healthcare community and The Joint Commission, it seems there is not enough evidence to back its effectiveness for fall prevention as of yet. Capezuti et al. (2009) looked at two types of bed alarms: pressure-sensitive and a pressure-sensitive combined with infrared (IR) beam detectors (dual sensor system) in order to uncover bed alarm effectivity and effectivity based on bed alarm type. The research was conducted on nursing home residents and tracked their bed exiting movements, false alarms, and prevention of falls. The study revealed the dual sensor alarm system was more effective in preventing falls with less false alarms, but neither eliminated completely. Furthermore, the researchers point out that no one alarm is ideal for all residents and that individual risk factors must be taken into consideration when choosing which alarm type to employ. They also stress the importance of adequate staffing in the prevention of falls, indicating once again the necessity of a multifactorial approach (Capezuti et al., 2009).

Other studies too have been conducted to analyze the effectiveness of bed alarms on inpatient fall rates. A study conducted on one unit of an urban hospital aimed to uncover the connection between fall rates and alarm use. The use of bed alarms was increased through: staff

education, training, and technical support. Despite this, the researchers found that increased alarm usage did not result in reduced fall rates and concluded them to likely be useful in fall prevention programs but not an easy fix solution (Shorr et al., 2012).

Lopez et al. (2010) also speak to this finding. The researchers found four constraints that inhibit nurses from preventing falls. One of the constraints, nurse workload, forces nurses to be occupied with indirect patient care and medication administration the majority of the nursing shift, removing the nurse from the bedside and placing them closer to the nursing station. This heavy workload forces nurses to rely on technology such as bed alarms for patient monitoring. The researchers however found that the bed alarms were either too sensitive or too insensitive. The alarms were also difficult to hear in the presence of other noise and the alarms were forgotten about and not reset by other people interacting with the patient, such as a therapist or family, thus rendering the alarms ineffective. For these reasons, the researchers suggest the relevance of bed alarms but only in conjunction with adequate staffing who respond to the alarms, such as sitters (Lopez et al., 2010).

The issue of background noise and improper education on technology use is an issue not only in the United States, but around the world. A study by Bridi et al. (2014) conducted in an intensive coronary care unit found that the amount of noise from technological equipment was resulting in alarm fatigue, increased distraction, and workflow interruption. This fatigue was causing alarm desensitization. Staff either silenced or ignored the alarm, and even lowered the volume on the alarm. Other factors making the alarms useless include lack of training on how to manage the equipment and lack of adherence by staff to turn the alarm on (Bridi et al., 2014). These findings illustrate that alarms can be employed on all units in all hospitals, but if staff is not responding to them, they are bound to become extraneous. Alarms have the potential to be

effective but only if there is proper education, adequate staffing, and a minimum of competing noises on the unit, once again substantiating The Joint Commission's multifactorial approach to fall prevention.

The use of bed alarms altogether is also in question because human error is an important consideration when analyzing bed alarm effectiveness. An article published in *Healthcare Risk Management* argues that bed alarms can potentially result in increased falls rather than reduced. Factors contributing to this phenomenon include: staff forgetting to turn the alarm on, patient family members turning the alarms off, staff not responding to the alarms at all because they have learned to tune them out due to alarm fatigue, and staff conducting less rounding because the availability of the alarm has provided them with a false sense of security (Eliminating Alarms, 2016). Thus bed alarms, created to prevent falls among the inpatient population, may actually contribute to increased fall rates if they are accessible to non-staff members who are not educated on the system, such as family members, and if not utilized correctly by all staff in contact with the patient.

Literature shows nursing opinion too is split on bed alarm effectiveness. Hubbartt et al. (2011) found that nurses are not entirely sure when to use bed alarms. Some say that bed alarms are useful because knowing a patient is on the alarm reminds them to round on the patient more frequently, while others say that there are too many false alarms and subsequent alarm fatigue. Most nurses interviewed did say however that alarms seem to be most useful for patients with mobility issues and dementia. However, there is inconsistent use of bed alarms by nurses which results in "ambivalence about what really keeps a patient safe" (Hubbartt et al., 2011, p. 198). Considering these conflicting data and viewpoints more research must be dedicated to bed

alarms and their effectiveness in order for the healthcare community to construct and enforce a streamlined and consistent process for employing the alarms.

### **Plan of Action**

With conflicting data to back up the use of bed alarm, it is easy to understand why the medical community does not have a consistent protocol for its use. This lack of consistency could be a contributing factor for falls. The Hospital indeed has a high fall rate, however the reason for it is unknown. We seek to understand this cause and contributing factors of falls by conducting a root cause analysis on the Responder 5 bed alarms, a new bed alarm in use at the Hospital.

### **Root Cause Analysis**

Through meeting with the Hospital's *Fall Committee* members, it is evident that both subjective and objective data is instrumental in uncovering the root of the problem. Through discussions with the representatives and through information gathering on the Hospital's *Fall Program*, we understand the Hospital has been plagued by high patient fall rates for some time and is committed to reducing fall rates as a part of The Joint Commission's National Patient Safety Goals. An assessment of current practice reveals the Hospital utilizes the "Falling Star" system, a yellow falling star taped to a patient's door to indicate that patient is a high fall risk patient. A patient is flagged as a fall risk patient via their score on the Schmid Fall Risk Assessment Tool, as mentioned earlier. The committee member we spoke with however informed us that the falling star is not used correctly. Sometimes nurses forget to remove the star from a patient's door, and it remains there, whether or not the patient is a fall risk. We were also informed that the Responder 5 is a new implementation for the unit and there is uncertainty

around its usage. Responder 5 alarm training was provided to help us better understand what we are working with.

**Methodology.** According to this information, a plan of action was constructed that includes interviewing the nurses on one Medical-Surgical unit, during both day and night shifts. After discussions with the Fall Committee, it was decided each of us would be present at two day and two night shifts at the Hospital to interview the nurses on fall risk assessment and Responder 5 knowledge, as well as to gather data on whether or not Responder 5 alarms are connected for fall risk patients. A five question questionnaire was created in order to guide the interview process with nurses and lists of fall risk patients were obtained to assess if the alarm was connected for those patients. Refer to Table 2 of Appendix B for the Responder 5 Connectors Questionnaire. Refer to Table 3 of Appendix C for Responder 5 Connector Usage According to Fall Risk chart.

**Results.** A total of 40 nurses were interviewed with the 5 question questionnaire. Nurse knowledge on how to assess fall risk and how to use Responder 5 alarms was assessed. Question 1, part 1 asked nurses when they use bed alarms? 97.5% of nurses stated they use a bed alarm for fall risk patients, while 2.5% stated they use it for patients with altered level of consciousness and call light non-compliance. Question 1 part 2 asked nurses to indicate how they personally assess fall risk? 72.5% of respondents stated they use clinical judgment and/or report from the previous shift; 25% stated they use the Schmid Assessment Tool, and 2.5% made no indication of fall risk in their response. Question 2 asked nurses if they know how to connect Responder 5 to the bed? 82.5% of nurses stated they do know, while 17.5% said they do not. Question 3 assessed who is responsible for connecting the bed alarms. 60% reported the registered nurse (RN) (primary RN, admission RN, 1<sup>st</sup> RN in contact with the patient), 17.5% reported all staff

(everyone) is responsible, 12.5% reported the first person who brought the patient into the unit, 7.5% reported the RN or CNA (certified nursing assistant) is responsible, and 2.5% reported they do not know who is responsible for connecting the alarm. Question 4 assessed nurse knowledge of Responder 5 capabilities- connectivity to the RN's phone. 77.5% reported yes, the RN will get a call on her phone if the alarm goes off, 12.5% reported they are unsure, 7.5% reported no, the alarm is not connected to the phone, and 2.5% reported the alarm is connected to the phone sometimes, not all the time. Question 5 asked nurses who they think should be responsible for connecting Responder 5 bed alarms? 45% reported the RN, 25% reported the RN, CNA, and anyone who sets up the bed for the patient, 20% reported everyone (all staff), 5% reported the first person in the patient's room, 2.5% reported the charge nurse or primary nurse, and 2.5% reported housekeeping.

Throughout the interview process, we also attained lists of fall risk patients, and walked around the unit to visually observe whether or not the Responder 5 alarm was connected. Data was gathered on a total of 83 fall risk patient beds. The factors assessed: are fall risk patients, the falling star on the door, and alarms connected or not. Of the 83 beds assessed, 51.8% were not connected to Responder 5, 12% were connected, and 36.1% were unknown. This 36.1% indicates rooms we were unable to enter and alarm connectivity we were unable to visually observe. Of the 83 beds, 59% did have a falling star on the door. Of this 59% with a falling star, 46.9% were not connected to Responder 5, 10.2% were connected, and 42.9% were unknown, once again accounting for the alarms we were unable to visually observe. Of the 83 beds, 41% did not have a falling star on the door. Of the 41% without the falling star, 61.8% of them were not connected to Responder 5, 8.8% were connected, and 29.4% were unknown.

**Discussion.** There are specific data revelations that arise through data analysis. The nurse interviews reveal that nurses are not using the same objective fall risk assessment tool- the Schmid Scale, but rather are using other indicators such as judgment or shift report. This leaves room for error and creates uncertainty about who should be considered a fall risk. Furthermore, the interviews reveal an opportunity to increase knowledge in the areas of: how to connect Responder 5, whose responsibility it is to connect it, and its capabilities. Data gathered through observing the bed alarms also shows areas for improvement. The falling star is not utilized according to protocol and thus does not indicate who is actually a fall risk. Additionally, we see that the Responder 5 alarms are simply not being used. At least half of the fall risk patients (51.8%) were not connected to Responder 5, and with 36.1% unknown, there is the potential that over 80% of fall risk patients were not connected to Responder 5.

With these revelations, it is difficult to understand if the problem of falls at the Hospital are due to bed alarms being underutilized or because of the conflicting literature around bed alarm effectiveness. Considering the time constraints we are working under, there is only one direction we can move forward at the moment. Our first action is to assume that Responder 5 alarms, an initiative intended to prevent falls, is underutilized at the Hospital, rendering it inadequate for helping to prevent falls.

### **Redesign of Process and Implementation**

In order to tackle the issue of falls at the Hospital, we will begin with educating the nurses on the Responder 5 system by creating a handout on fall risk prevention and how to use the alarm. See Appendix D for the Fall Prevention handout. The handout will include: factors related to falls, suggestions from The Joint Commission on fall prevention, how to use the Responder 5 alarm, as well as the Schmid Fall Risk Assessment Tool. While lack of education

about falls and alarm use may not be the leading factors for falls, we will begin here in order to better understand what the problem is. At this moment, with such few Responder 5 alarms being used, we must assume the problem is lack of utilization.

### **Evaluation**

Once the nurses have received education on falls and bed alarms, we will go back to reassess nursing knowledge. We will administer the same 5 question questionnaire to the nurses during day and night shifts. Furthermore, we will once again collect lists on fall risk patients and walk through the unit to visually collect data on the alarms. The hope is that with this education we will see more nurses using Responder 5 for fall risk patients and that there will be cohesion amongst all staff regarding the alarm's capabilities and whose responsibility it is for connecting the alarm. Once this data is collected we will have even better knowledge of the reasons for falls at the Hospital. This data will reveal if the problem is the lack of use of alarms. If not, a new root cause analysis will be conducted to once again decipher the reason for falls.

### **Summary/Conclusion**

Falls at all hospitals are a sentinel event that affect the health of the patient and the institution. As demonstrated, falls can lead to injury and unfortunately death. They are unintended events that causes undue hardship to families and can alter the course of treatment for the worse. As they are no longer reimbursed by insurance, falls are also a major financial burden for hospitals. They deplete hospital resources and cause financial strain on the entire system. CNLs have the unique opportunity to work within these institutions, alongside other nurses, to engage in quality improvement work, such as fall prevention, to better the system.

By doing this, CNLs are able to effect change within the system. Falls at the Hospital are events that are occurring far too often. The quality improvement work described above is the



kind of work and information CNLs are privy too. Our work was conducted by constructing a plan of action and getting hospital leadership on board with the plan. After discussions and establishment of a plan of action, data was collected and analyzed, literature and evidence based practice was reviewed, and an intervention was implemented. Once this implementation has been evaluated, data collection and analysis can once again be done and a new plan of action can be implemented. As of now, lack of Responder 5 utilization and lack of Responder 5 knowledge seem to be the major contributors to falls at the Hospital. The hope is for bed alarm use to increase and fall rates to decline once the nurses have received education on fall prevention and bed alarms. If this is not so, we must refer to the literature and say that alarms on their own are not effective in preventing falls. Rather, hospital leadership will have to invest more energy into the other interventions for fall prevention outlined by The Joint Commission. Once again, a CNL will be key in undertaking this endeavor.

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Appendix A

Table 1

*Schmid Fall Risk Assessment Tool – Acute Care*

To be completed on all patients upon admission, post-fall, and/or when the patient’s status changes.

Date of INITIAL assessment: _____		Room # _____	
<b>Mobility</b> (select only ONE indicator for each category)		Score	Score
(0) Ambulates with no gait disturbance			
(1) Ambulates or transfer with assistive devices			
(1) Ambulates with unsteady gait and no assistance			
(1) Unable to ambulate or transfer			
<b>Mentation</b>		Score	Score
(0) Alert, Oriented x 3			
(1) Periodic confusion			
(1) Confusion at all times			
(1) Comatose / unresponsive			
<b>Elimination</b>		Score	Score
(0) Independent in elimination			
(1) Independent, with frequency or diarrhea			
(1) Needs assistance with toileting			
(1) Incontinence			
<b>Prior Fall History</b>		Score	Score
(0) Yes – Before admission (Home or previous inpatient care)			
(1) Yes – During this admission			
(1) No			
(1) Unknown			
<b>Current Medication</b>		Score	Score
(5) A score of 1 is given if the patient is on 1 or more of the following medications: Anti-convulsants / sedatives or psychotropics / hypnotics (consider all medication side effects and role in fall risk)			
		Score	Score
<b>Total Score</b>			
Completed by			
Date			
<b>Total Score</b> Score of 3 or more: Patient is at risk for falls and fall prevention interventions should be implemented.			

## Appendix B

Table 2

*R5 Bed Connectors Questionnaire*

Respondents	1a. When do you use bed alarms? 1b. How do you personally assess fall risk?	2. Knowledge of how to connect R5 to the bed (yes/no)	3. Who is responsible for connecting the bed alarms?	4. Do you connect the bed alarm to the phone?	5. Who do you think should connect the alarm to the bed/phone?
1					
2					
3					
4					
5					
Cont.					

## Appendix C

Table 3

*Responder 5 Connector Usage According to Fall Risk*

Bed #	Fall Risk Pt's: Falling Star on Door (Yes/No)	R5 Alarm Connected (Yes/No/Unknown)
1		
2		
3		
4		
5		
Cont.		

## Appendix D



## FALL PREVENTION

## FACTORS RELATED TO PATIENT FALLS

Assessment	Handoff Communication	Toileting	Call Light	Organizational Education	Medication
Schmid risk assessment tool is used inconsistently	Incomplete communication of patient fall risk factors between caregivers	Patient did not seek help for toileting or fell while toileting	Patient did not know, forgot, or chose not to use call light	Lack of standardization of practice and application of interventions, inconsistent patient education	Patient on one or more medications that increase the risk of falls

## SUGGESTIONS FROM THE JOINT COMMISSION (2015)

<b>Raise Awareness</b>	Communicate safety information to all clinical and non-clinical staff. Ensure resources are available, such as staffing, equipment, and preventative devices.
<b>Interdisciplinary Fall Prevention Team</b>	Include nursing, physicians, environmental services, information technology, patient advocacy, pharmacy, physical and occupational therapy, quality and risk management, and other relevant stakeholders.
<b>Standardized Risk Assessment Tool</b>	Provide training to staff on how to use the Schmid Fall Risk Assessment Tool.
<b>Individualized Plan of Care</b>	Identify individual fall and injury risks and implement interventions specific to that patient and population.
<b>Apply Practices and Interventions</b>	Standardize the hand-off communication and provide one-on-one education to each patient at the bedside.
<b>Post-Fall Management</b>	Conduct a post-fall huddle, honest and transparent reporting, trending and analysis of falls, and reassess the patient.

## PREVENTATIVE DEVICES: RESPONDER 5 ALARMS

<b>Responder 5</b>	The primary RN is responsible for making sure the alarm is connected and inserted into the outlet. If done, the alarm will be connected to the phone of the RN and the CNA.
<b>Step 1</b>	Ensure the bed alarm is activated. There should be a bright green light shining from the frame of the bed if the alarm is activated.
<b>Step 2</b>	Ensure the alarm cord is plugged into the wall outlet. The cord is gray.
<b>Step 3</b>	Ensure the 2 connectors on the cord are connected together. When connected, there should be one piece, going from the bed to the wall outlet.