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Walden University

College of Nursing

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Ramatu Dougrey Jalloh

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Walden University
2025

Executive Summary: Development of an Evidence-Based Prevention Bundle to Reduce Falls on an Inpatient Psychiatric Detoxification Unit

by

Ramatu Dougrey Jalloh

MS, Walden University, 2021

BS, Marymount University, 2016

Executive Summary Submitted in Partial Fulfillment

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Summary

Following a 16% increase in patient falls from 2023 to 2024 in an inpatient psychiatric detoxification unit, a quality improvement education project was implemented to assess the impact of an evidence-based fall prevention bundle on fall rates and nursing compliance. Nurses received education through a PowerPoint presentation to enhance understanding and implementation of the bundle, which included Edmonson reassessments after high-risk medication administration, ISHAPED bedside shift handoffs, care plan updates, and SWIFT daily safety huddles.

Posttests identified that the objective score of 80% knowledge for nurses was met. During the 10-week implementation, the goal was 100% compliance with all bundle elements and a 4% fall reduction. Nurses achieved 91% compliance with Edmonson assessments and ISHAPED handoffs, 68% with SWIFT huddles, and 66% with care plan updates. Although full compliance was not met, the intervention resulted in a 100% reduction in falls, exceeding the 4% target and demonstrating the effectiveness of structured fall prevention strategies in psychiatric detoxification settings.

The project emphasized the need for ongoing staff education and monitoring to sustain adherence to safety protocols, particularly improving SWIFT huddle participation and care plan documentation. Beyond enhancing patient safety, this staff education project fostered collaboration through structured handoffs and team huddles while ensuring equitable care by standardizing fall prevention for all patients, addressing health disparities and promoting patient-centered safety measures.

Background

Patient falls are a significant concern in healthcare, leading to increased injuries, prolonged hospital stays, and higher costs (Carpels et al., 2022; Turner et al., 2020). A 16% rise in falls within an inpatient psychiatric detoxification unit from 2023 to 2024 highlighted deficiencies in its fall prevention practices. Patients in detoxification are particularly susceptible to falls due to medication side effects, withdrawal symptoms, and altered mental status (McNamara et al., 2023). This underscored the need for a robust, evidence-based fall prevention approach.

The project evaluated whether implementing an evidence-based fall prevention bundle with staff education would reduce falls by 4% over 10 weeks in an inpatient psychiatric detoxification unit. Objectives included ensuring that registered nurses attained at least 80% knowledge of the bundle posteducation, reducing falls by 4%, and achieving 100% compliance with bundle components during the implementation period. Research indicated that standard protocols may not address the cognitive and behavioral challenges psychiatric units face when attempting to prevent falls (Carpels et al., 2022; Ocker et al., 2020; Rao et al., 2018; Storm, 2022; Turner et al., 2020). Tools like the Edmonson Psychiatric Fall Risk Assessment and SWIFT fall huddles offered targeted risk management for behavioral health patients (Matthew et al., 2020).

Studies have supported comprehensive strategies including risk assessments, care plan updates, staff education, and interdisciplinary communication to enhance patient safety in psychiatric settings (Lu et al., 2018; Varpula et al., 2010). Standardized handoff processes, such as ISHAPED, have improved communication and patient safety (Groves

et al., 2016; Patterson & Wears, 2010). Daily huddles based on the SWIFT model have enhanced team accountability and proactive safety measures (Turner et al., 2020). While much research focused on general psychiatric or acute care settings, these findings are applicable to detoxification units due to shared risk factors. Implementing evidence-based practices is essential to reduce falls and improve outcomes in this high-risk population.

Staff Education Project Development

The implementation of the evidence-based fall prevention bundle followed a structured development process, beginning with problem identification and progressing through literature review, intervention design, staff education, implementation, data collection, and evaluation. An organizational readiness assessment evaluated staff awareness and knowledge about fall prevention strategies and the proposed bundle components. A strengths, weaknesses, opportunities, and threats (SWOT) analysis identified strengths, such as leadership support and staff awareness, and weaknesses, including knowledge gaps and resource limitations. Engagement and support from a diverse group of stakeholders were deemed essential for successful implementation of the project.

A comprehensive search using databases like PubMed, The Cumulative Index to Nursing and Allied Health Literature (CINAHL), Embase, and the Cochrane Library identified best practices for fall prevention in psychiatric and detoxification settings. Search terms included “fall prevention,” “psychiatric inpatient falls,” “detoxification unit falls,” “nursing fall prevention,” “Edmonson scale,” “ISHAPED bedside handoff,” “SWIFT huddle,” and “care plan updates.” The Johns Hopkins Evidence-Based Practice

Model categorized the level of evidence of the 12 selected sources of literature: two Level I evidence (meta-analyses and systematic reviews on fall prevention strategies), two Level II evidence (randomized controlled trials examining fall prevention interventions in psychiatric units), five Level III evidence (quasi-experimental studies evaluating fall prevention bundle effectiveness), and three Level V evidence (expert opinions and clinical guidelines from organizations such as the Agency for Healthcare Research and Quality [AHRQ] and the American Psychiatric Nurses Association [APNA]). The literature review findings supported the inclusion of the Edmonson Fall Risk Assessment (Chang et al., 2023; Edmonson et al., 2011; Matthew et al., 2020), ISHAPED bedside handoff (Friesen et al., 2013; Patterson et al., 2010), SWIFT huddles, and care plan updates (Lin et al., 2022; Matthew et al., 2020; McNamara et al. 2023) as key components of the fall prevention bundle.

The literature review further confirmed that structured fall prevention strategies effectively reduce falls and improve nursing compliance. Evidence supported the use of the Edmonson Psychiatric Fall Risk Assessment Tool for reassessment after high-risk medication administration (Chang et al., 2023; Edmonson et al., 2011; Matthew et al., 2020), ISHAPED Bedside Handoff to enhance communication and patient safety (Friesen et al., 2013; Patterson et al., 2010), SWIFT Daily Safety Huddles to promote teamwork and proactive fall prevention (Lin et al., 2022; McNamara et al., 2023), and care plan updates to incorporate fall risk changes into patient management (Matthew et al., 2020). The findings provided strong empirical support for implementing an evidence-based fall prevention bundle in an inpatient psychiatric detoxification unit.

Four elements comprised the fall prevention bundle: the Edmonson Fall Risk Assessment Tool, which offered an objective and reliable method to assess a patient's fall risk upon admission and throughout their stay; the SWIFT Daily Huddle, which was a daily meeting that ensured that all care team members were aligned in real time to discuss identified fall risks, immediate patient needs, and strategies for fall prevention; ISHAPED Bedside Handoff, which served as a structured framework that systematically captured key risk factors, allowing for tailored interventions during shift changes; and care plan updates, which provided regular revisions to the care plan, ensuring that all fall prevention strategies remained current, effective, and appropriately documented. Collectively, these elements worked to enhance patient safety by systematically identifying risks and implementing targeted interventions.

A 30-minute educational PowerPoint (Appendix A) was developed to educate nurses on the fall prevention bundle. The intervention included a 5-minute pretest, a 20-minute education session on key fall prevention strategies, and a 5-minute posttest to assess knowledge retention. To ensure full participation, five sessions were held for day shift nurses and four were held for night shift nurses over 2 weeks.

A total of 31 registered nurses in the detoxification unit received education on the bundle elements and their rationale. Pretest (Appendix B) and posttest (Appendix C) assessments measured nursing staff knowledge before and after the presentation. The pretest and posttest data were deidentified to protect nursing staff confidentiality. Participants were instructed to use a six-digit number on both tests that they could easily remember, ensuring that they could match their pretest with their posttest results. No

names or personal information were recorded on the tests, maintaining anonymity while still allowing for an accurate comparison of knowledge before and after the educational intervention. Over a 10-week period, 488 self-audit forms (Appendix D) were collected to track compliance with bundle components. Retrospective data on fall occurrences before implementation were compared to real-time data during the intervention. Key outcomes included comparison of posttest scores to assess educational intervention effectiveness, analysis of compliance data from audit forms to determine adherence to bundle components, and comparison of fall rates during 10-weeks.

Results

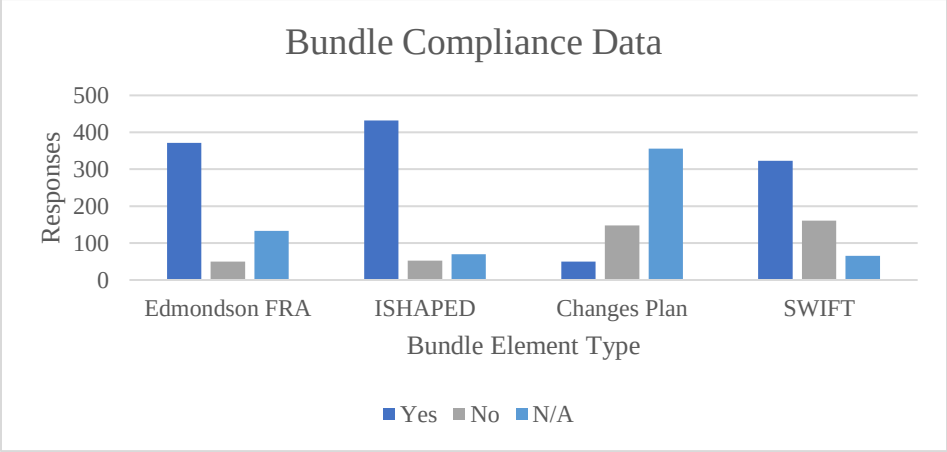
The primary objective of this quality improvement project was to achieve 100% compliance with all components of the evidence-based fall prevention bundle during the 10-week implementation period. Prior to the bundle intervention, fall rates on the unit showed variability across the 2024 quarters. There were eight falls in the first quarter (January to March), eight falls in the second quarter (April to June), 12 falls in the third quarter (July to August), and three falls in the fourth quarter (October to December). The final fall occurred in October 2024, before the project’s implementation in November.

Although the project substantially improved adherence, full compliance was not achieved across all bundle components. Nurses were required to attain a minimum mean knowledge level of 80% after the educational intervention and posttest. This objective was met, with posttest scores rising from a pretest mean of 84% (min = 76; max = 100) to a posttest mean of 86% (min = 84; max = 100), surpassing the 80% target."

Nursing staff did not achieve 100% adherence to the bundle during the 10-week implementation, with compliance varying across components. A total of 488 audit forms were collected from nursing staff during the 10-week period. On each form, nurses checked "Yes" if the assessment or task was completed, "No" if it was not completed, and "N/A" if the assessment was not applicable, such as when no relevant medication or care plan was in place at the time of assessment. Adherence rates for each component were as follows: 91% compliance with Edmonson fall risk assessments, 91% compliance with ISHAPED bedside handoff, 68% compliance with SWIFT daily huddles, and 66% compliance with care plan updates (Figure 1).

Figure 1

Fall Bundle Compliance by Element



Nursing staff adherence to the fall prevention bundle was monitored using a daily self-auditing data collection tool (Appendix D). Compliance was assessed based on adherence to four key bundle components: fall risk assessment using the Edmonson scale (Appendix E) immediately after administration of a high fall risk medication, bedside

shift report using ISHAPED (Appendix F) for oncoming and off-going RNs, daily huddles using the SWIFT model (Appendix G), and care plan fall risk updates.

The final objective aimed to reduce falls by 4% in the inpatient psychiatric detoxification unit over the 10-week implementation period. The 100% reduction in falls exceeded the objective, as no falls were reported from November 2024 to February 2025. This outcome far surpassed the initial goal and demonstrated a substantial improvement compared to the 31 falls recorded in the year prior to the intervention.

The project's findings have broader implications demonstrating that structured, evidence-based interventions can be effective in similar psychiatric settings. Given the scarcity of research on fall prevention in psychiatric units, this project adds valuable insights into potentially effective strategies for this unique patient population. The outcomes from the project could promote the development of best practices for fall prevention in psychiatric care. In summary, while the project achieved its primary goal of reducing falls within the local unit, its implications extend to enhancing patient safety and informing fall prevention strategies in psychiatric settings more broadly.

Several limitations were identified during the project. First, the 10-week period may not have fully captured long-term adherence and sustainability of the intervention. Second, reliance on nurses' self-audit forms could introduce reporting bias, potentially inflating adherence rates. Lastly, lower adherence to components like SWIFT huddles and care plan updates suggests areas needing further attention. These limitations highlight the need for ongoing monitoring, extended implementation periods, and strategies to enhance compliance across all bundle components.

Conclusions

The project has had a transformative impact on the organization by enhancing patient safety, advancing nursing knowledge, and fostering a culture of evidence-based practice. Achieving zero falls during the 10-week implementation period demonstrated a substantial improvement in patient safety, addressing the 16% increase in falls seen previously. While high compliance rates were seen for Edmonson assessments and ISHAPED bedside handoffs, the objective of 100% compliance with these project components was not met. The significant gaps in SWIFT huddle and care plan update compliance did not promote achieving the 100% compliance objective and indicated areas needing targeted attention and room for improvement.

Recommendations for improvement include providing focused training and support for SWIFT huddles and care plan updates to ensure higher adherence rates. By supporting the integration of the fall prevention bundle into routine nursing workflows and policies, we can help to establish long-term improvements and maintain sustainability. Additionally, establishing ongoing audits and feedback loops post implementation will help to ensure consistent adherence to the bundle elements. The institution could benefit from testing the intervention on other units, such as general psychiatric or medical units, to evaluate its scalability and effectiveness in diverse settings.

The project reinforced the critical role of evidence-based interventions in addressing complex patient safety challenges, serving as a model for future nursing-led quality improvement initiatives. Educational interventions enhance nursing competency,

empowering staff to deliver safer, more effective care. The project underscores the importance of communication tools like ISHAPED and SWIFT huddles, which promote teamwork and shared accountability. By standardizing fall prevention practices, the intervention ensures that all patients receive consistent, high-quality care regardless of individual circumstances. The bundle's flexibility allows for adaptations that address the unique needs of diverse patient populations, particularly in behavioral health settings.

The successful implementation of the evidence-based fall prevention bundle in the psychiatric detoxification unit led to a significant reduction in falls, highlighting the importance of structured prevention strategies. Nurses play a key role in assessing fall risks and implementing interventions, though variability in adherence suggests a need for focused education. Emphasizing SWIFT huddles and care plan updates could improve compliance. Effective fall prevention requires collaboration among healthcare team members, ensuring comprehensive care plans through regular communication with physicians, therapists, and support staff.

The project highlighted the importance of ongoing monitoring and evaluation, encouraging nurses to engage in quality improvement initiatives and use data to enhance patient outcomes. It also promoted positive social change by implementing standardized fall prevention measures, ensuring equitable and effective care for all patients. By tailoring interventions to diverse patient needs, the project fostered an inclusive environment that respected individual differences. Overall, it improved nursing practice by enhancing patient safety and care quality while advancing diversity, equity, and inclusion in healthcare.

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Appendix A: Staff Education PowerPoint

IMPLEMENTATION OF AN EVIDENCE-BASED PREVENTION BUNDLE TO REDUCE FALLS ON AN INPATIENT PSYCHIATRIC DETOXIFICATION UNIT

Staff Education Presentation

Ramatu Jalloh, MSN, RN, PMH-BC, PMHNP-BC

LEARNING OBJECTIVES

Upon completion of the presentation staff will be able to:

1. Identify essential components of the fall prevention bundle.
2. Effectively integrate fall risk assessments into patient care plans.
3. Validate confidence in using the ISHAPED bedside handoff tool for effective communication and continuity of care.
4. Collaborate with the project leader in implementation of the fall prevention bundle.

CURRENT HOSPITAL POLICY

- **Use of system-wide policy "Fall Prevention Program for Adult Patients"**
  - Universal fall precautions state all patients admitted to the behavioral health service line must be assessed for fall risk using the Edmonson Psychiatric Fall Assessment tool. Patients are assessed at minimum:
    - Upon arrival to the Emergency Department
    - Upon admission to the CATS unit
    - Every shift
    - With change in condition
    - Upon transfer to a different level of care

PROJECT COMPONENTS

- Edmonson Psychiatric Fall Risk Assessment Tool
- ISHAPED bedside handoff tool
- SWIFT huddle model tool
- Care plan updates

1. EDMONSON PSYCHIATRIC FALL RISK ASSESSMENT TOOL

- **Purpose:** This tool helps identify patients at risk of falling by assessing various risk factors specific to psychiatric settings.
- **Components:**
  - History of Falls: Previous falls within the last three months.
  - Medications: Use of medications that may affect balance or cognition (e.g., sedatives, antipsychotics).
  - Mobility: Assessment of the patient's gait, balance, and need for assistive devices.
  - Mental Status: Evaluation of confusion, agitation, or other psychiatric symptoms that may increase fall risk.

1. EDMONSON PSYCHIATRIC FALL RISK ASSESSMENT TOOL

Procedure:

1. Assessment: Conduct the Edmonson assessment upon patient admission and regularly thereafter, especially after any **significant changes in medication or mental status**.
2. Documentation: Record the assessment results in the patient's medical record and update the care plan based on the findings.
3. Intervention: Implement specific fall prevention strategies for high-risk patients, such as closer monitoring, environmental modifications, and assistive devices.

2. ISHAPED BEDSIDE HANDOFF TOOL

- **Purpose:** The ISHAPED tool standardizes the handoff process to ensure critical information is communicated effectively between healthcare providers.
- **Components:**
  - **I**ntroduction: Introduce yourself and your role.
  - **S**tory: Provide a brief overview of the patient's current situation and history.
  - **H**istory: Detailed medical and psychiatric history relevant to the patient's care.
  - **A**ssessment: Current assessment findings, including vital signs, symptoms, and fall risk.
  - **P**lan: The care plan, including any fall prevention strategies in place.
  - **E**rror Prevention: Highlight any potential risks and precautions to avoid errors.
  - **D**ialogue: Open the floor for questions and clarifications.

2. ISHAPED BEDSIDE HANDOFF TOOL

Procedure:

1. Preparation: Gather all necessary information before the handoff.
2. Execution: Conduct the handoff at the patient's bedside whenever possible to include the patient in the discussion. It fosters an environment of collaboration and transparency that promotes patient-centeredness.
3. Engagement: Encourage questions and ensure the receiving provider understands the patient's fall risk and prevention strategies.

3. SWIFT FALL HUDDLE TOOL

- **Purpose:** The SWIFT fall huddle tool provides a structured approach to discuss, analyze, and address patient safety events.
- **Components:**
  - S – What is the fall **situation** right now?
  - W – **Who** is a fall risk for this shift? **Why**? **What** do we need to do as a team to prevent a fall from occurring?
  - I – **Interventions** in place?
  - F – Can **family** assist?
  - T – **Team** concerns & recommendations?

3. SWIFT FALL HUDDLE TOOL

Procedure:

1. Immediate Response: After a fall, use the SWIFT tool to quickly assess and document the incident.
2. Team Huddle: Convene a team huddle to review, identify and discuss each patient's fall risk and necessary interventions and measures to promote patient safety. All staff members on duty should attend the team huddle when possible.
3. Follow-Up: Ensure that the care plan is updated, and all staff are informed of the new prevention strategies.

4. CARE PLAN UPDATES

- **Purpose:** Regularly updating care plans ensures that fall prevention strategies remain effective and responsive to the patient's current condition.
- **Components:**
  - Risk Reassessment: Reevaluate the patient's fall risk after any changes in their condition or treatment.
  - Intervention Adjustments: Modify fall prevention interventions based on reassessment findings.
  - Staff Communication: Ensure all relevant staff are aware of updates to the care plan.
  - Patient and Family Involvement: Involve patients and their families in understanding and supporting the updated care plan.

4. CARE PLAN UPDATES

Procedure:

1. Regular Updates: The care plan should initially be developed when the patient is admitted, incorporating the results of the initial fall risk assessment. Update the care plan whenever there is a significant change in the patient's physical or mental status, such as immediately after a fall, a new diagnosis, or a change in medication.
2. Documentation: Record all updates in the patient's medical record. Regularly updating the care plan based on current fall risk assessments helps implement timely interventions to prevent falls and ensure patient safety.
3. Communication: Effective communication and coordinated care among healthcare teams are critical for patient safety. As a result, all healthcare members on the interdisciplinary team are involved in the updating of the patient's care plan.

ROLE OF THE RN IN IMPLEMENTING THE PROJECT

- (1) Assessment and risk identification
  - Nurses will use tools such as the Edmonson Psychiatric Fall Risk Assessment Tool to evaluate each patient's risk of falling upon admission at regular intervals thereafter, and **immediately** after the administration of high falls risk medications.
- (2) Implementation of fall prevention strategies
  - Nurses adhere to and enforce the standardized protocols and procedures included in the fall prevention bundle, such as the ISHAPED bedside handoff tool and the SWIFT fall huddle tool.

ROLE OF THE RN IN IMPLEMENTING THE PROJECT

- (3) Monitoring and reporting
  - Nurses continuously monitor patients for changes in their condition that may affect their fall risk and update care plans accordingly. In the event of a fall, nurses follow established procedures for reporting and documenting the incident.
- (4) Compliance and quality improvement
  - Nurses play a critical role in ensuring that all elements of the fall prevention bundle are consistently applied and adhered to by all staff. Nurses participate in quality improvement initiatives by providing feedback, suggesting improvements, and implementing changes based on data and outcomes.

ROLE OF PROJECT LEADER

- (1) Training and education
  - Ensures that comprehensive training sessions are conducted, equipping staff nurses with the knowledge and skills needed to implement the fall prevention bundle effectively.
- (2) Communication
  - Maintain open lines of communication, ensuring that staff nurses are informed about the project's progress, challenges, and successes.
- (3) Support and advocacy
  - Offers support to staff nurses, addressing any challenges they encounter and providing resources needed to implement the bundle.
- (4) Monitoring and evaluation
  - Monitors the implementation process, tracking compliance with the fall prevention bundle and evaluating its impact on fall rates.

SUMMARY

This project aims to decrease the incidence of falls among adult patients on the CATS unit by adopting an evidence-based fall risk prevention safety bundle as a quality improvement initiative.

Questions?

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Appendix B: Fall Prevention Bundle Pretest

Directions: This test is designed to identify your prior knowledge of fall prevention. Please answer all items by selecting the most correct answer. Circle the letter of your response for each item.

Identification Number: Please place a six-digit number on this test that you will remember as you will need to use it again following the presentation. Only place the number on the test – not your name or any other personal information.

Six Digit Identification Number:

Fall Risk Reassessment

1. **According to hospital policy, all patients admitted to the hospital will be assessed for risk of falls:**
    A. On admission and every shift, not to exceed a minimum of 12 hours
    B. Upon any change in the patient condition
    C. Upon transfer or return to the unit for a procedure
    D. All of the above
2. **What is the primary purpose of using the Edmonson Psychiatric Fall Risk Assessment Tool in behavioral health patients?**
    A. To assess the risk of medication errors
    B. To evaluate the nutritional status of patients
    C. To determine the fall risk of psychiatric patients
    D. To measure the cognitive function of patients
3. **How often should fall risk be reassessed using the Edmonson Psychiatric Fall Risk Assessment Tool after the administration of new medications?**
    A. Weekly
    B. Daily
    C. Immediately
    D. Every shift

4. **Which of the following factors is included in the Edmonson Psychiatric Fall Risk Assessment Tool?**
    A. Patient's dietary intake habits
    B. Psychotropic medication use
    C. Patient's family history
    D. Patient's financial status

Bedside Shift Handoff

5. **What is the benefit of using a standardized tool during bedside shift handoff?**
    A. It reduces the time spent on nursing shift handoff
    B. It ensures consistent communication about patient care
    C. It eliminates the need for patient and family involvement
    D. It focuses only on medication administration
6. **Which of the following should be included in the standardized bedside shift handoff tool?**
    A. Patient's financial information
    B. Updated fall risk assessment
    C. Patient's dietary preferences
    D. Patient's recreational activities
7. **Why is patient and family involvement important during bedside shift handoff?**
    A. It decreases the workload of nurses
    B. It helps in updating patient insurance details
    C. It ensures transparency and patient-centered care
    D. It allows patients to change their treatment plans

Updating Care Plans

8. **When should the care plan be updated to reflect the new fall risk assessment?**
    A. Only at the beginning of each month
    B. Whenever the patient requests an update
    C. Immediately after reassessing the fall risk
    D. At the end of each shift

9. **What is the importance of updating the care plan according to the fall risk assessment?**
    A. To meet administrative requirements
    B. To ensure patient safety and tailor interventions
    C. To reduce the workload of healthcare providers
    D. To update insurance information
10. **Which team members should be involved in updating the patient's care plan?**
    A. Only the primary nurse
    B. All healthcare team members
    C. Only the patient and their family
    D. Administrative staff

Daily Huddles

11. **What is the purpose of daily huddles in identifying patient safety needs?**
    A. To socialize with interprofessional colleagues
    B. To discuss patient safety and plan interventions
    C. To update organizational financial records
    D. To organize staff monthly schedules

12. **Who should participate in the daily huddles to address patient safety needs?**
    A. Only the senior nurses
    B. All staff members on duty
    C. Patients and their families
    D. Only administrative staff
13. **How can daily huddles contribute to fall prevention?**
    A. By reviewing and discussing each patient's fall risk and necessary interventions
    B. By focusing on administrative tasks for each patient
    C. By assigning fall prevention tasks to patients that allow nursing staff to focus on other activities
    D. By reducing the need for shift handoffs for all nurses

Appendix C: Fall Prevention Bundle Pretest

Directions: This test is designed to identify your knowledge of fall prevention after the presentation. Please answer all items by selecting the most correct answer. Circle the letter of your response for each item.

Identification Number: Please place the exact same six-digit number on this test that you used for the pre-test. Only place the number on the test – not your name or any other personal information.

Six Digit Identification Number:

Fall Risk Reassessment

1. **According to hospital policy, all patients admitted to the hospital will be assessed for risk of falls:**
    A. On admission and every shift, not to exceed a minimum of 12 hours
    B. Upon any change in the patient condition
    C. Upon transfer or return to the unit for a procedure
    D. All of the above
2. **What is the primary purpose of using the Edmonson Psychiatric Fall Risk Assessment Tool in behavioral health patients?**
    A. To assess the risk of medication errors
    B. To evaluate the nutritional status of patients
    C. To determine the fall risk of psychiatric patients
    D. To measure the cognitive function of patients
3. **How often should fall risk be reassessed using the Edmonson Psychiatric Fall Risk Assessment Tool after the administration of new medications?**
    A. Weekly
    B. Daily
    C. Immediately
    D. Every shift

4. **Which of the following factors is included in the Edmonson Psychiatric Fall Risk Assessment Tool?**
    A. Patient's dietary intake habits
    B. Psychotropic medication use
    C. Patient's family history
    D. Patient's financial status

Bedside Shift Handoff

5. **What is the benefit of using a standardized tool during bedside shift handoff?**
    A. It reduces the time spent on nursing shift handoff
    B. It ensures consistent communication about patient care
    C. It eliminates the need for patient and family involvement
    D. It focuses only on medication administration
6. **Which of the following should be included in the standardized bedside shift handoff tool?**
    A. Patient's financial information
    B. Updated fall risk assessment
    C. Patient's dietary preferences
    D. Patient's recreational activities
7. **Why is patient and family involvement important during bedside shift handoff?**
    A. It decreases the workload of nurses
    B. It helps in updating patient insurance details
    C. It ensures transparency and patient-centered care
    D. It allows patients to change their treatment plans

Updating Care Plans

8. **When should the care plan be updated to reflect the new fall risk assessment?**
    A. Only at the beginning of each month
    B. Whenever the patient requests an update
    C. Immediately after reassessing the fall risk
    D. At the end of each shift
9. **What is the importance of updating the care plan according to the fall risk assessment?**
    A. To meet administrative requirements
    B. To ensure patient safety and tailor interventions
    C. To reduce the workload of healthcare providers
    D. To update insurance information
10. **Which team members should be involved in updating the patient's care plan?**
    A. Only the primary nurse
    B. All healthcare team members
    C. Only the patient and their family
    D. Administrative staff

Daily Huddles

11. **What is the purpose of daily huddles in identifying patient safety needs?**
    A. To socialize with interprofessional colleagues
    B. To discuss patient safety and plan interventions
    C. To update organizational financial records
    D. To organize staff monthly schedules

12. **Who should participate in the daily huddles to address patient safety needs?**
    A. Only the senior nurses
    B. All staff members on duty
    C. Patients and their families
    D. Only administrative staff
13. **How can daily huddles contribute to fall prevention?**
    A. By reviewing and discussing each patient's fall risk and necessary interventions
    B. By focusing on administrative tasks for each patient
    C. By assigning fall prevention tasks to patients that allow nursing staff to focus on other activities
    D. By reducing the need for shift handoffs for all nurses

Thank you for your participation in this project.

Appendix D: Fall Prevention Bundle Data Collection Form

Fall Prevention Bundle Data Collection Form

Date:

Patient	Shift	Patient's fall risk level	If a high falls risk medication was administered, was a fall risk reassessment conducted after administration using the Edmonson Psychiatric Fall Risk Assessment	Was bedside shift handoff conducted using the standardized tool **ISHAPED**?	Were changes made to the plan to correspond with any updated fall risk assessments?	Were huddles conducted for each shift daily utilizing the **SWIFT** model to consistently identify patient safety needs for all shifts?
1.	Day Shift	High	Yes	Yes No	Yes	Yes No
1.	Night Shift	Low	No	Yes No	No	Yes No
2.	Day Shift	High	Yes	Yes No	Yes	Yes No
2.	Night Shift	Low	No	Yes No	No	Yes No
3.	Day Shift	High	Yes	Yes No	Yes	Yes No
3.	Night Shift	Low	No	Yes No	No	Yes No
4.	Day Shift	High	Yes	Yes No	Yes	Yes No
4.	Night Shift	Low	No	Yes No	No	Yes No

Appendix E: Edmonson Falls Risk Assessment Tool

Edmonson Psychiatric Fall Risk Assessment ©

	Date & Initials						
Complete Daily & upon admission ***More than one item may be circled in each category if appropriate for the patient.**							
Age **8** Less than 50 **10** 50-79 **26** 80-over							
Mental Status **-4** Fully Alert/Oriented at all times **12** Agitation/Anxiety **13** Intermittently confused **14** Confusion/Disorientation							
Elimination **8** Independent with control of bowel/bladder **12** Catheter/Ostomy **10** Elimination with Assist **12** Altered elimination (incontinence, nocturia, frequency) **12** Incontinent but Ambulates Independently							
Medications **10** No Medications **10** Cardiac Medications **8** Psychotropic Medications (Including benzodiazepines and antidepressants) **OR** **12** Increase in these medications **and/or** PRN (psych, pain) medication received in the last 24 hours							
Diagnosis **10** Bipolar/ Schizoaffective Disorder **8** Substance abuse/Alcohol abuse **10** Major Depressive Disorder **12** Dementia/ Delirium							
Ambulation/Balance **7** Independent/Steady gait/Immobile **8** Proper Use of Assistive Devices (cane, walker, w/c) **10** Vertigo/Orthostatic Hypotension/Weakness **8** Unsteady/Requires Assist and Aware of Abilities **15** Unsteady but Forgets Limitations							
Nutrition **12** Has had very little food or fluids in the past 24 hours **0** No apparent abnormalities with appetite							
Sleep Disturbance **8** No Sleep Disturbance **12** Report of Sleep Disturbance by patient, family or staff							
History of Falls **8** No History of Falls **14** History of Falls in the last 3 months							
TOTAL *Add all nine columns*							

** **FALL RISK = SCORE OF 90 OR GREATER** **

Appendix F: ISHAPED Bedside Handoff Tool

I Introduction	**Patient Label:**	**Going to Building/Room #:**_____ **Accepting Provider:**_____ **Do Not Announce?** □ **Legal Status:** □Vol (Must sign Consent Form) □TDO (Must have TDO papers first) **Consent Signed?** □Yes □No □N/A **TDO Papers Served?** □Yes □No □N/A **TDO expiration Date** _____
S Story	**Admitting Diagnosis:** **Reason for Admission:** **Communication Issues:**	_____ _____ _____ Interpreter Needed? □ Yes □ No Language:_____
H History	**Past Medical History:** **Past Psychiatric History:** **Allergies:**	_____ _____ _____
A Assessment	**Last Vital Signs:** **Pain:** **Abnormal Labs:** **Alcohol/Drug Use:** **Urine Toxicology:** **Diabetic?** **Orientation:** **Risk Assessment:** **Mental Status:** **Sleep Hygiene:** **Musculoskeletal/Activity:** **Cardiovascular:** **Respiratory Status:** **GI:** **GU:** **Skin Integrity:** **Psychosocial/Family:**	WNL □ Time:_____ BP: _____ HR: _____ R: _____ Temp: _____ O2 Sat:_____ Compliant with VS: □ No □ Yes □ No □ Yes: Location:_____ Level/Scale:_____ Last Pain Med & Time:_____ _____ □ No □ Yes Last drink/drug use_____ History of Alcohol Withdrawal Delirium (AWD) □ No □ Yes CIWA/COWS_____ □ No □ Yes Abnormal results_____ □ No □ Yes If "Yes," Last Blood Sugar_____ Insulin Given: □ No □ Yes □N/A Alert □ No □ Yes Oriented to □ Person □ Place □ Time □ Situation Current Self Harm Plan: □ No □ Yes Current Plan to Harm Others: □ No □ Yes Who_____ Thought Content: □ Delusions □ Paranoia □ Religious Preoccupations □ Homicidal Ideation Hallucinations: □ No □ Yes If "Yes," □ Visual □ Auditory □ Other Behavior: □ Calm □ Agitated □ Aggressive □ Restless □ Manic □ Depressed □ Anxious □ Hypersexual History of violence: □ No □ Yes Number of hours slept or observed with eyes closed _____ Ambulatory: □ No □ Yes Assistive Device? □ No □ Yes Indicate type_____ □ Regular □ Irregular □ Edema □ Pacemaker Supplemental Oxygen: □ No □ Yes _____L /min □ NC □ MASK Is patient receiving RT □ No □ Yes Continent : □ No □ Yes: Nausea/Vomiting: □ No □ Yes Last bowel movement _____ Continent : □ No □ Yes Foley □ No □ Yes Cuts/Lacerations/Scars: □ No □ Yes Location(s)_____ Homeless: □ No □ Yes Family Support: □ No □ Yes
P Plan	**Tests/Procedures/Labs Pending:** **PRN meds available:** **Safety Concerns (Meds, swallows objects):** **Discharge Plan:**	_____ Compliant with labs: □ No □ Yes _____ □ No □ Yes Last Given (Time, Dose, Reason) _____ _____ _____
E **L** Error-Prevention	**Code Status:** **Isolation:** **Fall Risk:** **Elopement Risk:** **Suicide Risk:** **Potential for Aggression:** **BVC score:** **Restraints used:** **Risk for Seizures/AWD:** **Pt Preference (Gender):** **IV Access Removed:**	□ DNR □ Limited DNR □ Full Code □ No □ Yes Type: _____ □ No □ Yes □ No □ Yes □ No □ Yes **Past suicide attempt**? □ No □ Yes □ No □ Yes _____ □ No □ Yes Type: □ Behavior □ Medical □ No □ Yes _____ **Special Considerations Comments** _____ □ No □ Yes **Are Belongings transferred with Patient?** □ No □ Yes **Are sharps removed?** □ No □ Yes
D Dialogue		Explained locked unit on a psych unit if applicable/ policies rules to patient? □ Yes □ No □ N/A Patient is in disposable scrubs/gown? □ Yes □ No Other questions/comments? _____ RN Giving Report _____ Ext #_____ RN Receiving Report _____ Ext # _____

Appendix G: SWIFT Daily Huddle Tool

Purpose: The SWIFT Huddle Tool is designed to facilitate quick and effective team communication about patient safety, particularly focusing on fall prevention. SWIFT stands for Situation, Who? Why? What?, Interventions, Family, and Team. It ensures that all relevant staff are aware of current patient conditions, environmental factors, and planned interventions to prevent falls.

Components of the SWIFT Huddle Tool:

S (Situation): Briefly describe the current **s**ituation regarding patient safety and fall risk.

W (Who? Why? and What?): Discuss **W**ho is a fall risk for this shift? **W**hy? **W**hat do we need to do as a team to prevent a fall from occurring?

I (Interventions): Review and confirm the **i**nterventions currently in place or needed.

F (Family): Involve and update the patient's **f**amily members if applicable.

T (Team): Ensure all **t**eam members are informed and understand their roles.

Step-by-Step Instructions:

Step 1: Gather the Team

- **Timing**: Conduct the SWIFT huddle at the beginning of each shift or when there are significant changes in patient status or environment.
- **Participants**: Include all relevant staff on duty such as nurses, clinical technicians, mental health technicians, physicians, and physical therapists.

Step 2: Situation

- **Report**: The charge nurse or unit supervisor begins by summarizing the current situation.
- **Key Points**: Highlight any recent falls, near misses, or changes in patient condition that increase fall risk.
- **Example**: "Patient X has been experiencing increased dizziness and had a near fall last night."

Step 3: Who? Why? What?

- **Who** is a fall risk for the shift? **Why**? and **What** interventions the team should take to prevent a fall from occurring?
- Discuss any environmental conditions that may affect patient safety, such as wet floors, poor lighting, or cluttered hallways.

- **Adjustments**: Identify necessary adjustments to mitigate these risks.
- **Example**: “The floors on the east side are being cleaned this morning, which may make them slippery.”

Step 4: Interventions

- **Current Interventions**: Review the interventions currently in place for fall prevention, such as bed alarms, non-slip socks, or supervision during ambulation.
- **New Interventions**: Discuss and assign any new interventions that need to be implemented.
- **Example**: “Ensure all patients in the east unit are using non-slip socks and have their call bells within reach.”

Step 5: Family

- **Family Involvement**: Update and involve family members in the patient’s care plan as appropriate.
- **Communication**: Ensure family members understand any precautions or interventions.
- **Example**: “Inform Mrs. Y’s family about the importance of keeping the room uncluttered and using the bed alarm.”

Step 6: Team

- **Roles and Responsibilities**: Confirm that all team members understand their roles and responsibilities in the fall prevention plan.
- **Questions and Feedback**: Allow team members to ask questions or provide feedback.
- **Example**: “Do we all agree on the need for increased supervision for Mr. Z during ambulation?”

Tips for Effective SWIFT Huddles:

- **Be Concise**: Keep the huddle brief but comprehensive, focusing on key points.
- **Encourage Participation**: Foster an environment where all team members feel comfortable contributing.
- **Document and Follow-Up**: Record key points discussed and follow up on any action items to ensure they are completed.