STOP FALLS OR RISK PAYMENT DENIALS TABLES

Figure 2

FMEA Project Matrix (Part 2)

Critical Failure	Root Causes	Actions Intended to Eliminate/Reduce Failure or Mitigate Effects
All shifts and disciplines do not implement interventions consistently	Lack of training for nonnursing caregivers and transport staff	• Fall prevention training for all nonnursing caregivers and transport staff • Annual fall prevention refresher course for all nonnursing caregivers and transport staff.
Inadequate communication among disciplines	No consistent way for staff to recognize patients at high risk for falls	• Implement yellow fall prevention bracelet for every patient assessed to be at high risk for falls. • “Fall Risk” emblems to be placed on doors and patient activity boards to signify patient at high risk.
Patient not monitored as required by policy/procedure	Fall prevention monitoring not viewed by nursing staff to be a high priority task	• Importance of fall prevention monitoring reinforced by nurse manager at staff meetings • Monthly report of patient fall occurrences shared with staff, along with common factors that precipitated the falls