



Guidelines for Data Collection on the American Nurses Association's National Quality Forum Endorsed Measures:

**Nursing Care Hours per Patient Day
Skill Mix
Falls
Falls with Injury**

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The National Database of Nursing Quality Indicators® (NDNQI®) is a program of the American Nurses Association's National Center for Nursing Quality. The program is being administered on ANA's behalf by The University of Kansas School of Nursing. Questions or requests for information should be addressed to:

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INTRODUCTION

- NDNQI®
Background** The National Database of Nursing Quality Indicators® (NDNQI) was established in 1998 by the American Nurses Association in response to ANA’s Safety and Quality Initiative. This program was based on the successful implementation of a series of pilot studies conducted by ANA in seven states.
- Nursing-Sensitive Measures** Nursing-sensitive measures reflect the structure, process and outcome of nursing care. **Structure** is indicated by the supply, skill level and education of nursing staff. **Process** measures aspects of nursing care such as assessment, intervention, and RN job satisfaction. Patient **outcomes** are those that improve if there is a greater quantity or quality of nursing care (e.g., pressure ulcers, falls, and IV infiltrations).
- “Measures and indicators that reflect the impact of nursing actions on outcomes.”
American Nurses Association (ANA). (2004). *Nursing Administration Scope and Standards of Practices*, 2nd Ed., Washington, DC, page 25.
- Current NDNQI Measures**
- Nursing Staff Skill Mix*
 - Nursing Hours per Patient Day*
 - Assault/Injury Assault Rates
 - Catheter-Associated Urinary Tract Infection Rate*
 - Central Line-Associated Blood Stream Infection Rate*
 - Fall/Injury Fall Rates*
 - Hospital/Unit Acquired Pressure Ulcer Rates*
 - Nurse Turnover Rate*
 - Pain Assessment/Intervention/Reassessment Cycles Completed
 - Peripheral IV Infiltration Rate
 - Physical Restraint Prevalence
 - RN Education/Certification
 - RN Survey
 - Practice Environment Scale*
 - Job Satisfaction
 - Ventilator-Associated Pneumonia Rate*
- The measures contained in this document (NHPPD, Skill Mix, Falls, Falls with Injury) were submitted by ANA to the National Quality Forum (NQF) and are part of the NQF endorsed nursing-sensitive care measure set*. ANA is the measure steward for these 4 measures and this guideline provides the microspecifications for those measures. The ANA measures were re-endorsed by the NQF in August 2009.

NDNQI UNIT STRUCTURE

NDNQI Unit Structure

Unit level data are a foundational element of NDNQI measures. Measure data are collected and reported for specific unit types, as determined by the NDNQI Unit Structure, which classifies units by patient population and unit type. Examples of units are adult in-patient critical care and adult rehab. A unit is eligible for enrollment in the NDNQI database if the unit is staffed with RNs who spend at least 50% of their time in direct patient care.

Patient Population

The NDNQI Unit Structure identifies the following patient populations:

- **Adult In-patient Units**
Limited to units generally caring for patients over 16 years old
- **Rehabilitation In-patient Units**
Limited to distinct acute rehabilitation units providing intensive therapy 5 days/week
- **Pediatric In-patient Units**
Limited to units generally caring for patients under 18 years old
- **Neonate In-patient Units**
Limited to units caring for newborn infants
- **Psychiatric Units**
Limited to units caring for patients with psychiatric disorders
- **Other**
Limited to units which do not fit within the definitions of above patient populations

Decision Guides:

If a unit routinely cares for two different patient populations, assign the patient population of the majority of patient care beds. Exclude overflow patients when choosing the unit patient population.

Adult In-patient Unit Types

- **Critical Care**
Highest level of care, includes all types of intensive care units. In addition, apply a specialty designation if 80% of the patients are: Burn, Cardiothoracic, Coronary Care, Medical, Neurology, Pulmonary, Surgical or Trauma.
- **Step-Down**
Limited to units that provide care for patients requiring a lower level of care than critical care units and higher level of care than provided on medical/surgical units. Examples include progressive care or intermediate care units. Telemetry is not an indicator of acuity level. In addition, apply a specialty designation if 80% of the patients are: Medical, Surgical or Med-Surg.
- **Medical**
Units that care for patients admitted to medical services, such as internal medicine, family practice, or cardiology. In addition, apply a specialty designation if 80% of the patients are: BMT, Cardiac, GI, Infectious Disease, Neurology, Oncology, Renal or Respiratory.
- **Surgical**
Units that care for patients admitted to surgical services, such as general surgery, neurosurgery, or orthopedics. In addition, apply a specialty designation if 80%

of the patients are: Bariatric, Cardiothoracic, Gynecology, Neurosurgery, Orthopedic, Plastic Surgery, Transplant or Trauma.

- **Med-Surg Combined**
Units that care for patients admitted to either medical or surgical services. In addition, apply a specialty designation if 80% of the patients are: Cardiac, Neuro/Neurosurgery or Oncology.
- **Skilled Nursing**
Based on the distinction made by Medicare payment policies, which differentiate skilled nursing, acute care, and rehabilitation.
- **Obstetrics**
Units that care for pregnant patients. In addition, apply a specialty designation if 80% of the patients are: Ante-partum, Labor and Delivery, Mother-Baby combined units, and Post-partum units.
- **Critical Access Unit**
Unit located in a Critical Access Hospital that cares for a combination of patients that may include critical care, medical-surgical, skilled nursing (swing bed) and/or obstetrics.

Pediatric In-patient Unit Types

Refer to Adult unit type descriptions for corresponding unit types.

- Critical Care
- Step-Down
- Medical
- Surgical
- Medical/Surgical Combined
- Mixed Acuity

Decision Guides

NDNQI Unit Structure assigns Adult and Pediatric unit type categories based on **unit acuity**. Three sequential levels of acuity are recognized: Critical Care, Step-Down, and Medical/Surgical. A mixed acuity unit type is also an option.

Make unit type assignment decisions for Adult and Pediatric patient populations based on the following rules:

- a. Units with 2 sequential unit types
 - i. If less than 10% of beds are 2nd unit type, enroll as unit type of majority of beds.
 - ii. If greater than 10% of beds are 2nd unit type, enroll as mixed acuity.
- b. Units with 2 non-sequential unit types: enroll as mixed acuity.
- c. Units with greater than 2 unit types: enroll as mixed acuity.
- d. Universal bed units: enroll as mixed acuity. Burn units which care for patients from critical admission to discharge are an example of universal beds.
- e. Selecting a unit specialty is not required and is only appropriate if greater than 80% of patient care services are related to the specialty category.

Neonatal In-patient Unit Types

- Well Baby Nursery
- Level I Neonatal – Continuing Care
- Level II Neonatal – Intermediate Care
- Level III/IV Neonatal – Critical Care
- Mixed Acuity

Decision Guides Level I, II, and III/IV Neonatal unit types are based on the Guidelines for Perinatal Care, 5th Ed., which are used by state certification programs. Because these neonatal units generally care for infants from birth to discharge, Level I, II, and III/IV neonatal units should be enrolled based on the highest level of infant care provided. The NDNQI Neonate Patient Population includes four sequential unit type acuities: Well Baby, Level I, Level II, and Level III/IV. If a unit contains both a well baby nursery and a higher acuity care unit, the unit type is assigned Mixed Acuity.

**Rehabilitation
In-patient Unit
Types**

Medicare payment policies differentiate rehabilitation from acute care, requiring patients to be discharged from acute care and admitted to a distinct acute rehabilitation unit. Rehabilitation units provide intensive therapy 5 days/week for patients expected to improve.

- **Adult**
Limited to units generally caring for rehab patients over 16 years old. Apply a specialty designation if 80% of the patients are: Brain Injury/SCI, Cardiopulmonary, Neuro/Stroke and Orthopedic/Amputee.
- **Pediatric**
Limited to units generally caring for rehab patients under 18 years old.
- **Mixed Acuity**

Decision Guides For the rehabilitation units with both adult and pediatric patients, enroll as the unit type of the majority of beds if less than 10% of beds are adult or pediatric. Enroll as mixed acuity if the majority is less than 90% of the unit beds.

**Psychiatric Unit
Types**

- **Child Psychiatric In-patient Unit**
Units caring for children, predominantly ages 2-11 years old, with acute psychiatric disorders
- **Adolescent Psychiatric In-patient Unit**
Units caring for adolescents, predominantly ages 12-18 years old, with acute psychiatric disorders
- **Child/Adolescent Psychiatric In-patient Unit**
Units caring for children and adolescents, predominantly ages 2-18 years old, with acute psychiatric disorders
- **Adult Psychiatric In-patient Unit**
Units caring for adult patients with acute psychiatric disorders
- **Geripsych In-patient Unit**
Units caring for elderly patients with acute psychiatric disorders
- **Behavioral Health In-patient Unit**
Units caring for individuals of any age with eating disorders or substance abuse diagnoses (including substance abuse rehabilitation). Substance abuse encompasses both alcohol and drugs
- **Specialty Psychiatric In-patient Unit**
Units caring for patients of any age with dual diagnoses (e.g., mental illness and mental retardation, or substance abuse and an additional mental illness)

diagnosis)

- **Multiple Psychiatric Unit Types In-patient Unit**
Units caring for patients that encompass 3 or more of the above unit types, but for which no one unit type comprises greater than 50% of the entire unit
- **Other Psychiatric In-patient or Out-patient Unit**
Units that do not fit within any of the above defined psychiatric unit types

Decision Guides

Psychiatric Unit types include the age-based groupings of Child, Adolescent, Adult, and Geri-Psych, as well as Behavioral Health, Specialty unit type, and the unit type of Multiple Unit Types.

- a. Use the unit types of Inpatient Adult, Adolescent, Child, Geripsych, Behavioral Health or Specialty if greater than 50% of patients are of that type.
- b. Use Multiple Unit Type if unit has 2 or more unit types and none are greater than 50% of patients.
- c. Use Other Psychiatric Unit type if unit is not staffed by an RN 24 hours/day, if unit is an outpatient clinic or care center, or a combination of inpatient and outpatient care.

Optional specialty designations include:

- Intensive – short stay units designated for the care of patients with acute psychosis or experiencing psychotic emergency.
- General – units with no intensive patients that are staffed with at least one RN 24 hours a day, 7 days a week.
- Mixed Acuity – units designated for the care of patients experiencing acute psychotic episodes as well as those who have achieved a level of stabilization.
- Psychiatric outpatient clinics, psychiatric residential care, and psychiatric day hospital – limited to the unit type of Other Psychiatric Units.

Other Unit Types

- **Emergency Department**
Includes general and specialty emergency departments
- **Peri-Operative**
Includes pre-op holding, operating rooms, post anesthesia care, same day and ambulatory surgery

Decision Guides

Select unit type of Emergency Department or Peri-Operative if greater than 50% of patients are of that type.

NURSING CARE HOURS (NCH) INDICATOR

Purpose

The primary purpose for collecting nursing care hours is to describe the supply of nursing hours and the skill mix on each unit. These measures of nurse staffing also are used in statistical analyses of patient outcomes, such as falls and pressure ulcers.

The following nurse staffing indicators appear in quarterly reports:

- 1) Skill mix
 - a) % of all nursing hours supplied by RNs
 - b) % of all nursing hours supplied by LPN/LVNs
 - c) % of all nursing hours supplied by unlicensed assistive personnel (aides)
- 2) Total nursing hours per patient day
- 3) RN hours per patient day
- 4) % of total nursing hours supplied by contract or agency staff

National Quality Forum (NQF) Rationale *Skill Mix*

The skill mix of the nursing staff, typically expressed as the ratio of RNs (LPNs/LVNs, and UAPs) to total nursing hours has been widely studied with respect to its effects on the quality of care. If the percentage of hours supplied by RNs is not adequate, less skilled staff may have to perform tasks for which they are not trained, thus increasing the risk of adverse patient outcomes. Examining the relationship between skill mix and processes and outcomes of care within health care organizations may identify opportunities to improve care delivery, patient outcomes, and provide an evidence base for determining the most effective mixture of staffing.¹

Nursing Hours per Patient Day (NHPPD)

Nursing care hours per patient day measures the supply of nursing relative to the patient workload. The relationship of nurse staffing to the quality of patient care and patient outcomes has been the subject of multiple research studies in recent years. The total number of nursing care hours per patient day reflects time constraints on nursing staff that can constrain quality of care, resulting in nurses being stressed, fatigued or distracted, increasing the risk for mistakes or omissions in care. Examining the relationship between nursing care hours, and processes and outcomes of care within health care organizations, may identify opportunities to improve care delivery, patient outcomes, and provide an evidence base for determining the most effective staffing levels.¹

¹http://www.jointcommission.org/PerformanceMeasurement/MeasureReserveLibrary/nqf_nursing.htm

Definitions *Nursing Care Hours (NCH)*

The number of **productive** hours worked by nursing staff assigned to the unit who have **direct patient care responsibilities** for greater than 50% of their shift.

Include:

- Staff who are counted in the unit's staffing matrix, **and**
- Who are replaced if they call in sick, **and**
- Work hours are charged to the unit's cost center

Exclude:

- Persons whose primary responsibility is administrative in nature
- Specialty teams, patient educators, or case managers who are not assigned to a specific unit

<i>Productive Hours</i>	Actual direct hours worked, not budgeted or scheduled hours. Excludes vacation, sick time, orientation, education leave, or committee time. Orientation time is considered non-productive. However, orientation programs vary from hospital to hospital. Once orientees reach the point where they are considered part of the staffing matrix, their work hours are charged to the unit and they would be replaced if they call in sick, then count their hours as productive.
<i>Direct Patient Care Responsibilities</i>	<p>Patient centered nursing activities by unit-based staff in the presence of the patient and activities that occur away from the patient that are patient related:</p> <ul style="list-style-type: none"> • Medication administration • Nursing treatments • Nursing rounds • Admission, transfer, discharge activities • Patient teaching • Patient communication • Coordination of patient care • Documentation time • Treatment planning
<i>Employment Status</i>	Nursing staff may be either employees or contracted (agency) staff. The hours worked by staff employed directly by the facility are to be reported separately from contract/agency staff.
<i>Employee</i>	Persons who are employed directly by the facility and are on the payroll for the purpose of providing nursing care. This would include a hospital's own internal "registry" staff. Do not include hours worked by respiratory therapists, physical therapists, occupational therapists, or social workers.
<i>Contract/ Agency Staff</i>	<p>Temporary nursing staff that are not employed by your facility but are:</p> <ul style="list-style-type: none"> • Hired on a contractual basis to fill staffing needs for a designated shift or on another short-term basis • Registry staff from outside the facility (i.e., not floating staff from within the facility) • Traveling nurse staff contracted to the facility for a designated period of time • Employed by the same hospital system (i.e., floating among several system facilities)
<i>Unlicensed Assistive Personnel (UAP)</i>	<p>Individuals trained to function in an assistive role to nurses in the provision of patient care, as delegated by and under the supervision of the registered nurse. Typical activities performed by UAPs may include (but are not limited to):</p> <ul style="list-style-type: none"> • Taking vital signs • Bathing, feeding, or dressing patients • Assisting patient with transfers, ambulation, or toileting <p>Include:</p> <ul style="list-style-type: none"> • Nursing assistants • Orderlies • Patient care technicians/assistants • Graduate nurses (not yet licensed) who have completed unit orientation

Exclude:

- Unit secretaries or clerks
- Monitor technicians
- Therapy assistants
- Student nurses who are fulfilling educational requirements
- Sitters who either are not employed by the facility or who are employed by the facility, but are not providing typical UAP activities

Note – In some states assistive nursing personnel may be licensed. For the purposes of this indicator, include these persons in the UAP category.

Eligible Unit Types

See the **Eligible Unit Type Table** in Appendix B.

Reporting Interval

Nursing care hours are reported by the *calendar month*. If your facility has bi-weekly pay periods, ask your information services staff to provide a *customized calendar monthly report*. If you are unable to receive monthly information, you should use a conversion method for pay periods that go across two months. For example, see Appendix C.

Source

Payroll or staffing records should be audited to remove non-direct care hours (education, sick leave, vacation leave etc.) and to ensure that ineligible staff are not included (e.g., unit secretary, monitor techs).

PATIENT DAYS INDICATOR

Purpose	<p>There are two purposes for collecting patient days.</p> <p><i>First</i>, it reflects the demand for nurse staffing.</p> <p><i>Second</i>, it represents the amount of time that patients have to experience adverse events.</p> <p>Patient days are used as the denominator in the:</p> <ol style="list-style-type: none"> 1) Nursing hours per patient day (nhppd) indicator 2) Patient falls indicator 3) Assault indicator
Definitions	<p>Conceptually, a patient day is 24 hours, beginning the hour of admission. The operational definitions of patient day are defined in the section labeled <i>Patient Day Reporting Methods</i>. The total number of patient days for each unit is reported for each <i>calendar</i> month in the quarter.</p>
<i>Short Stay Patients</i>	<p>Patients who are not classified as in-patients. Variously called short stay, observation, or same day surgery patients who receive care on in-patient units for all or part of a day.</p>
<i>Reporting Census</i>	<p>The adequacy of staffing levels can only be assessed when compared with an accurate measure of patient census. With the growth in the number of short stay patients on in-patient units, the midnight census may not accurately represent the demand for nursing services on many units. Although some facilities have dedicated units for short stay patients, many do not. While the midnight census may be the only measure of patient census available for some facilities, others will have additional information that can be used to produce a patient census that is adjusted to reflect the additional demand for nursing required by short stay patients. Each unit should report patient days using the method that most accurately accounts for the patient work load.</p>

PATIENT DAY REPORTING METHODS

Facilities should use all data available to them to represent a complete count of the total number of patient days per unit, including “days” of care provided to short stay patients. There are five alternative methods for reporting to NDNQI®. While Method 1 is appropriate for units without short stay patients, all other methods are suitable for units with short stay patients.

You must select and use one of these reporting methods for the entire quarter. **All values are reported in “days.”** Before entering, convert any values from hours into days as instructed below.

Method 1- Midnight Census	<p>This is adequate for units that have <i>all</i> in-patient admissions. This method is not appropriate for units that have both in-patient and short stay patients. The daily number should be summed for every day in the month.</p>
Method 2- Midnight Census + Patient Days from Actual Hours for Short Stay Patients	<p>This is an accurate method for units that have both in-patients and short stay patients. The short stay “days” should be reported separately from midnight census and will be summed by NDNQI to obtain patient days. The total daily hours for short stay patients should be summed for the month and divided by 24.</p>

Method 3-
Midnight Census + Patient Days from Average Hours for Short Stay Patients

This method is the least accurate method for collecting short stay patient hours on units that have both in-patients and short stay patients. The short stay average is to be obtained from a special study documenting the time spent by short stay patients on specific unit types. This pilot study should cover a month of data and should be repeated every year. Average short stay days are reported separately and added by NDNQI with midnight census to obtain patient days. The average daily hours should be multiplied by the number of days in the month and the product divided by 24 to produce average short stay days.

Note this method is collected by NDNQI, but it is not endorsed by NQF.

Method 4-
Patient Days from Actual Hours

This is the **most accurate** method. An increasing number of facilities have accounting systems that track the actual time spent in the facility by each patient. Sum actual hours for all patients, whether in-patient or short stay, and divide by 24.

Method 5-
Patient Days from Multiple Census Reports

Some facilities collect censuses multiple times per day (e.g., every 4 hours or each shift). This method has shown to be as accurate as Method 4. A sum of the daily average censuses can be calculated to determine patient days for the month on the unit.

IMPORTANT NOTE: , We recommend that you consistently use the same method for reporting patient days in each quarter. However, facilities using a method other than Actual Hours (Method 4) should transition to this reporting method when it becomes available. You should use the best method for each unit, according to the population served.

Eligible Unit Types See the **Eligible Unit Type Table** in Appendix B.

Source Data should come from patient census records and be reported by **calendar month**. This may require additional programming at your facility to obtain patient day data in the most accurate format for NDNQI reporting.

PATIENT FALLS INDICATOR

Purposes

The purposes of the patient falls indicator are to:

- 1) Determine the rate at which patients have a fall
- 2) Determine the frequency with which patient falls result in injury
- 3) Explore the relationship between nursing assessments performed, interventions used, and falls

Two rates are reported:

- Total Falls per 1,000 Patient Days
- Injury Falls per 1,000 Patient Days

National Quality Forum (NQF) Rationale

Patient falls occurring during hospitalization can result in serious and even potentially life threatening consequences for many patients. Efforts to reduce this adverse event have included the development of tools to assess and identify patients at risk of falling and the implementation of fall prevention protocols. More recently, research has suggested that staffing on patient care units, specifically the number of professional nurses, may impact the incidence of this patient outcome. Nurses are responsible for identifying patients who are at risk for falls and for developing a plan of care to minimize that risk. High performance measure rates may suggest the need to examine clinical and organizational processes related to the identification of, and care for, patients at risk of falling, and possibly staffing effectiveness on the unit.¹

¹http://www.jointcommission.org/PerformanceMeasurement/MeasureReserveLibrary/nqf_nursing.htm

Definitions *Fall*

A patient fall is an unplanned descent to the floor (or extension of the floor, e.g., trash can or other equipment) with or without injury to the patient, and occurs on an eligible reporting nursing unit. All types of falls are to be included whether they result from physiological reasons (fainting) or environmental reasons (slippery floor). Include assisted falls – when a staff member attempts to minimize the impact of the fall.

Exclude falls by:

- Visitors
- Students
- Staff members
- Falls on units not eligible for reporting
- Patients from eligible reporting units, however patient was not on unit at time of the fall (e.g., patient falls in radiology department)

Assisted Fall

A fall in which any staff member (whether a nursing service employee or not) was with the patient **and** attempted to minimize the impact of the fall by easing the patient's descent to the floor or in some manner attempting to break the patient's fall. "Assisting" the patient back into a bed or chair **after** a fall is not an assisted fall. A fall that is reported to have been assisted by a family member or visitor counts as a fall, but does not count as an assisted fall.

Risk Assessment

Fall risk assessments (screenings) may occur on admission and may be repeated periodically throughout the patient's stay. Several assessment instruments are available in the literature. The Hendrich II^{1,2}, Morse^{3,4} and Schmid⁵ Scales are

examples of validated fall risk assessment scales. Facilities can use any published instrument; or create or modify any risk assessment instrument. When a facility uses another instrument or modifies the Hendrich II, Schmid, or the Morse scales, they are using an "Other" scale. Different scales can be used within your facility, depending upon the population needs of the units. You should indicate which scale is being used on *each* reporting unit, if any are in use.

¹Hendrich, A.L., Bender, P.S. & Nyhuis, A. (2003). "Validation of the Hendrich II fall risk model: A large concurrent case/control study of hospitalized patients." *Applied Nursing Research* 16(1):9-21.

²URL: www.ahendrichinc.com

³McCollam, M. E. (1995). "Evaluation and Implementation of a research-based falls assessment innovation." *Nursing Clinics of North America* 30(3): 507-514.

⁴Morse, J. M., R. Morse, et al. (1989). "Development of a scale to identify the fall-prone patient." *Canadian Journal of Aging* (8): 366-377.

⁵Schmid, N. A. (1990). "1989 Federal Nursing Service Award Winner. Reducing patient falls: a research-based comprehensive fall prevention program." *Military Medicine* 155(5): 202-207.

Time of Assessment

Count the hours or weeks between the most recent fall risk assessment and the fall. Assign one of the following time frames to indicate how long after the last risk assessment the fall occurred. NDNQI does not recommend any particular assessment frequency as it should be based on the needs of your patient population.

- >0 to 12 hours
- >12 to 24 hours
- >24 to 48 hours
- >48 to 72 hours
- >72 hours to 1 week
- >1 week

Fall Risk

Each facility will establish which patients are at fall risk based on their particular screening process or assessment tool. For example, in the literature a cut score for the Hendrich II is ≥ 5 ; the Morse scale is ≥ 45 ; and the Schmid is ≥ 3 . However, you may select a different risk level to fit the needs of your patient population. NDNQI does not recommend any particular score to identify at risk patients. In addition, some facilities may not require calculation of a risk score on low risk patients. In this case, the scale score should be left blank for reporting purposes.

Repeat Fall

More than one fall in a given month by the same patient after admission to this unit, may be classified as a repeat fall. Patients who fall elsewhere *prior* to admission to the unit are not classified as a repeat fall. Falls occurring on a previous admission to the same unit within the same month *are* considered repeat falls. During data entry, you are able to identify repeat falls when they occur within the calendar month and on the same unit.

Injury Level

When the initial fall report is written by the nursing staff, the extent of injury may not yet be known. A method to follow up on the patient's condition at least 24 hours after the fall should be established as level of injury is a *required* data element. If the patient is discharged from the hospital within 24 hours of the fall, determine injury level at the time of discharge.

Report to NDNQI based on the following guidelines:

- **None**—patient had no injuries (no signs or symptoms) resulting from the fall, if an x-ray, CT scan or other post fall evaluation results in a finding of no injury
- **Minor**—resulted in application of a dressing, ice, cleaning of a wound, limb elevation, topical medication, bruise or abrasion
- **Moderate**—resulted in suturing, application of steri-strips/skin glue, splinting or muscle/joint strain
- **Major**—resulted in surgery, casting, traction, required consultation for neurological (basilar skull fracture, small subdural hematoma) or internal injury (rib fracture, small 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 (not from physiologic events causing the fall)

Eligible Unit Types

See the **Eligible Unit Type Table** in Appendix B.

Reporting Interval

An eligible reporting unit will report fall data by *calendar month*. In addition, each unit that reports fall data, *must also* submit patient day data for the same month (as outlined in Patient Day Indicator) in order to have fall rates calculated.

Source

Data will come from medical records and secondary risk management sources (e.g., incident reports, variance reports, event reports) that are completed by the nursing staff either on paper or electronically. Therefore any event related to a patient fall that occurs on an eligible reporting unit and generates a report should be counted. Data collection at the specific unit level captures data on patient outcomes and nurse staffing within a given unit. Therefore, for the purposes of this indicator, patient falls that occur when the patient is authorized to be off of the unit are not counted in the unit-level reporting.

APPENDIX B

Eligible Unit Type Table

NDNQI® Population & Unit Type Categories	Indicators													
	RN Survey	Nurse Turnover	NCH	Patient Days	Patient Falls	Pressure Ulcer	Restraint	RN Education	Pain AIR Cycle	PIV Infiltration	Physical Assault	CAUTI	CLABSI	VAP
Neonatal In-Patient														
Level III/IV Critical Care	X	X	X	X		X	X	X	X	X			X	X
Level II Intermediate	X	X	X	X			X	X	X	X				
Level I Continuing Care	X	X	X	X			X	X	X					
Well Baby Nursery	X													
Mixed Acuity	X													
Pediatric In-Patient														
Critical Care-Pediatric	X	X	X	X		X	X	X	X	X		X	X	X
Step Down	X	X	X	X		X	X	X	X	X				
Medical	X	X	X	X		X	X	X	X	X				
Surgical	X	X	X	X		X	X	X	X	X				
Med-Surg Combined	X	X	X	X		X	X	X	X	X				
Mixed Acuity	X													
Adult In-Patient														
Critical Care-Adult	X	X	X	X	X	X	X	X				X	X	X
Step Down	X	X	X	X	X	X	X	X						
Medical	X	X	X	X	X	X	X	X						
Surgical	X	X	X	X	X	X	X	X						
Med-Surg Combined	X	X	X	X	X	X	X	X						
Obstetrics	X	X												
Skilled Nursing Unit	X													
Mixed Acuity	X													
Critical Access Unit	X	X	X	X	X	X	X	X						

NDNQI® Population & Unit Type Categories	Indicators													
	RN Survey	Nurse Turnover	NCH	Patient Days	Patient Falls	Pressure Ulcer	Restraint	RN Education	Pain AIR Cycle	PIV Infiltration	Physical Assault	CAUTI	CLABSI	VAP
Psychiatric														
Adult	X	X	X	X			X	X			X			
Adolescent	X	X	X	X			X	X			X			
Child/Adolescent	X	X	X	X			X	X			X			
Child	X	X	X	X			X	X			X			
Geripsych	X	X	X	X		X	X	X			X			
Behavioral Health	X	X	X	X			X	X			X			
Specialty	X	X	X	X			X	X			X			
Multiple Unit Types	X	X	X	X			X	X			X			
Other Psychiatric Unit	X													
Rehab In-Patient														
Adult	X	X	X	X	X	X	X	X						
Pediatric	X					X								
Mixed Acuity	X													
Other														
Emergency Department	X	X												
Peri-operative	X	X												

APPENDIX C

Calculation of Monthly Nursing Care Hours

$$\begin{aligned}
 \text{Monthly Hours} &= \sum \text{Hours in pay period} \\
 &\times \frac{\# \text{ of days in pay period falling in current month}}{14}
 \end{aligned}$$

Suppose a bi-weekly pay period begin on Saturday 29th of the previous month. There are 11 days of this pay period in the current month. So multiply Nursing care hours in this pay period by $\frac{11}{14}$.

The next pay period is completely contained in the month.

The last pay period has 5 days in the current month.

So multiply payroll hours in this pay period by $\frac{5}{14}$.

Example:

	Nursing Care Hours	Number of Days in Current Month	Hours x $\frac{\# \text{ of days in a month}}{14}$
Pay Period 1	560	11	440
Pay Period 2	630	14	630
Pay Period 3	588	5	210
Total in this Month		30	1280

There are 1280 Nursing care hours for this month.

	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
	23	24	25	26	27	28	29
Pay Period 1	30	31	1	2	3	4	5
	6	7	8	9	10	11	12
Pay Period 2	13	14	15	16	17	18	19
	20	21	22	23	24	25	26
Pay Period 3	27	28	29	30	1	2	3
	4	5	6	7	8	9	10

APPENDIX D

NDNQI® Unit Structure

Patient Population	Unit Type	Specialty (optional)
Adult In-patient Units	Critical Care-Adult	<i>Burn Unit Cardio-thoracic ICU Coronary Intensive Unit Medical ICU Neuro ICU Pulmonary ICU Surgical ICU Trauma ICU</i>
	Step-down	<i>Med-Surg Step-down Medical Step-down Surgical Step-down</i>
	Medical	<i>BMT Cardiac Medical Unit GI Medical Unit Infectious Disease Unit Neurology Medical Unit Oncology Unit Renal Medical Unit Respiratory Medical Unit</i>
	Surgical	<i>Bariatric Unit Cardio-thoracic Surgery Unit Gynecology Unit Neurosurgery Unit Orthopedic Unit Plastic Surgery Unit Transplant Unit Trauma Surgical Unit</i>
	Med-Surg Comb.	<i>Cardiac Med-Surg Unit Neuro/Neurosurgery Unit Oncology Unit</i>
	Obstetrics	<i>Ante-Partum Labor & Delivery Mother/Baby Combined Post-Partum</i>
	Skilled Nursing Unit	
	Mixed Acuity	
	Critical Access Unit	
	Neonate In-patient Units	Level I Neonate- Continuing Care
Level II Neonate- Intermediate Care		
Level III/IV Neonate- Critical Care		
Well Baby Nursery		
Mixed Acuity		
Rehabilitation In-patient Units	Adult Rehab	<i>Brain Injury/SCI Rehab Cardiopulmonary Rehab Neuro/Stroke Rehab Orthopedic/Amputee Rehab</i>
	Pediatric Rehab	
	Mixed Acuity	

Patient Population	Unit Type	Specialty (optional)
<u>Pediatric</u> In-patient Units	Critical Care-Pediatric	<i>Burn Unit Cardio-thoracic ICU Coronary Intensive Unit Medical ICU Neuro ICU Pulmonary ICU Surgical ICU Trauma ICU</i>
	Step-down	<i>Med-Surg Step-down Medical Step-down Surgical Step-down</i>
	Medical	<i>BMT Cardiac Medical Unit GI Medical Unit Infectious Disease Unit Neurology Medical Unit Oncology Unit Renal Medical Unit Respiratory Medical Unit</i>
	Surgical	<i>Bariatric Unit Cardio-thoracic Surgery Unit Gynecology Unit Neurosurgery Unit Orthopedic Unit Plastic Surgery Unit Transplant Unit Trauma Surgical Unit</i>
	Med-Surg Comb.	<i>Cardiac Med-Surg Unit Neuro/Neurosurgery Unit Oncology Unit</i>
	Mixed Acuity	
<u>Psychiatric</u>	Adult Psychiatric In-patient Unit	<i>General Psychiatric Intensive Psychiatric Mixed Acuity Psychiatric</i>
	Adolescent Psychiatric In-patient Unit	<i>General Psychiatric Intensive Psychiatric Mixed Acuity Psychiatric</i>
	Child Psychiatric In-patient Unit	<i>General Psychiatric Intensive Psychiatric Mixed Acuity Psychiatric</i>
	Child/Adolescent Psychiatric In-patient Unit	<i>General Psychiatric Intensive Psychiatric Mixed Acuity Psychiatric</i>
	Geripsych In-patient Unit	<i>General Psychiatric Intensive Psychiatric Mixed Acuity Psychiatric</i>
	Behavioral Health In-patient Unit	<i>General Psychiatric Intensive Psychiatric Mixed Acuity Psychiatric</i>
	Specialty Psychiatric In-patient Unit	<i>General Psychiatric Intensive Psychiatric Mixed Acuity Psychiatric</i>
	Multiple Psychiatric Unit Types In-Patient Unit	<i>General Psychiatric Intensive Psychiatric Mixed Acuity Psychiatric</i>
	Other Psychiatric In-patient or Out-patient Unit	<i>Psychiatric Day Hospital Outpatient Psychiatric Clinics Psychiatric Residential (no 24/7 RN)</i>

Patient Population	Unit Type	<i>Specialty (optional)</i>
<u>Other</u>	Emergency Department	<i>General ED Obstetrics ED Pediatric ED Urgent Care ED</i>
	Peri-operative	<i>PACU Pre-Op Holding Operating Room Same Day/Ambulatory Surgery</i>