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Fall Prevention Quality Initiative: Implementation of a Unit Safety Champion (USC)

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Walden University

College of Health Sciences

This is to certify that the doctoral study by

Susan Rednak

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Walden University
2015

Abstract

Fall Prevention Quality Initiative: Implementation of a Unit Safety Champion (USC)

by

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MSN-Ed, South University, 2010

BSN, California University of Pennsylvania, 2008

Project Submitted in Partial Fulfillment

Of the Requirements for the Degree of

Doctor of Nursing Practice

Walden University

September 2015

Abstract

The literature supports that a Unit Safety Champion (USC) may reduce falls among hospitalized patients. The purpose of this project was to determine if the implementation of a USC would assist in reducing falls on an acute unit in an urban hospital environment. The frequency of patient falls on the unit was collected from the hospital's quality department 3 months before and 3 months after the implementation of the USC. The average number of falls for 3 months before implementation was 5.0 per month ($SD = 2.65$) and involved a total of 15 individual patients. The average number of falls for 3 months after implementation was 5.33 ($SD = 1.53$) and involved a total of 16 individual patients. Although the average number of falls increased, there was no statistically significant difference in the average number of falls between these time periods. Upon further investigation, it was discovered that the unit experienced an increase in nursing turnover while implementing the USC. Although this confounding variable was not examined as part of this project, the results demonstrate the importance of nursing turnover on adverse patient events. The literature suggests that front-line workers may contribute to a quality change in the acute environment. Using Lewin's change model as a foundation, an action plan was submitted to the fall committee emphasizing the relational importance of nurse staffing management and adverse events. It is recommended that a longitudinal project be conducted to fully understand the contribution of the USC to the unit.

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Dedication

I am dedicating this project to my one and only love, Lou Rednak...the one and only person I can always count on to help guide and keep me grounded...thank you for the unconditional love and passion in believing in me. I greatly appreciate you both as a person and as my best friend. The world is so lucky to have you in it!

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Section I: Overview of the Evidence-Based Project

Introduction

Patient falls among hospital inpatients are adverse events ranging from two to seven falls per 1000 patient-days (Rubinstein, 2006). The Centers for Disease Control and Prevention (2013) stated one in three older adults fall yearly. According to the Institute for Healthcare Improvement (IHI; 2014), falls are a leading cause of death in people 65 years of age or older. Falls account for greater than 10% of fatalities in the elderly population in hospitals. Falls cost the United States (US) health care system \$30 billion annually (CDC, 2013). Costs to treat fall injuries are likely to increase while reimbursements for hospital-acquired injuries will continue to decrease (Miller, Eng, Kandilov, Cromwell, & McCall, 2012).

While Joint Commission (JC) (2014) did not advise what a fall program must include, they targeted solutions for fall prevention. A fall prevention program often includes but is not limited to a hospital-wide or department specific fall prevention policy and support from experts. An 18-month project called the Robust Process Improvement (RPI) was spearheaded by TJC involving several health care organizations across the states. Results identified two important tactics that helped decrease falls by 65% in numerous cases started by holding staff accountable for knowing proper safety measures and rounding on their patient (Ferenc, 2014). Resources that endorsed the study included Lean and Six Sigma. Generally speaking, preventing falls is a cause for concern for all providers.

Background

Though the hospital in question consistently updates quality improvement measures for fall reductions, the amount of both observed and unobserved falls still remain a problem. In a 7 month time period there was a greater than 28% fall increase hospital-wide. Past data showed fall

rates both observed and unobserved in 2014 were greater 300 events. Other vital fall rates showed the pilot unit, a 38-bed Medical-Surgical/Neuro (M/S) had greater than 49 fall events from January 2014 thru June 2014. A majority of the falls occurred in the patient's room and/or bathroom area. At one point in the past a staff-effective fall prevention team did exist on these particular nursing units. It is unclear why this process was no longer implemented since it acts as a culture of patient safety initiative.

Current clinical practice guidelines for this hospital include: Hospital policy and periodic review for fall precautions and initial fall screenings with use of a nurse-driven initiative called the MORSE Falls Scale (MFS; 1997). The MFS is assessed on every new patient admitted to the hospital, updated during the stay and on an as needed basis regardless of age. MFS is validated for this type of health care setting since it meets practice standards' for clinical reliability. Other safety precautions used in this hospitals fall program include: hourly rounding, ZONE nursing, fall risk identifiers (i.e. yellow wrist band, yellow fall risk cling applied to the patient in-room white board, bed alarms, and gait belts for transfers).

Context

The National Database of Nursing Quality Indicators (NDNQI) is a record of comparable data that are collected to evaluate unit-specific nurse-sensitive statistics in the acute care setting. These measures were developed by the American Nurses Association (ANA). According to the ANA (2014), health care executives are aware of the quality indicators that need to be tracked and reported. NDNQI are accurate enough to measure patient falls since falls present one of the greatest quality challenges. In 2012-2013, the pilot hospital instituted a new QI fall prevention program concluding after overall fall rates of 517 incidents from mid-2012 to mid-2013, were

hospital-wide. Greater than 58% of fall incidents were on nine particular nursing units including the M/S division.

JC National Patient Safety Goal-9 'Fall Reduction Program' (2014) stated every health care organization's fall prevention program is expected to include all patient care settings and populations. Although not a focus for this study, the pilot unit had a high staff turnover rate during the timeframe of increased falls which led to higher need for support and education on fall prevention. The purpose of this project was to investigate if the implementation of a Unit Safety Champion (USC) on an acute care nursing unit would decrease patient falls.

Problem Statement

Despite the pilot hospital's attempt to implement best practice method for fall prevention, falls have increased across the hospital. According to Zimlichman et al (2009), approximately 17% of all hospitalized patients will experience an adverse event such as falls during their hospital stay. Quigley and White (2013) posited that falls and fall injuries in hospitals are the most frequently reported adverse events among adults in the in-patient setting. Quigley and White also discussed that falls are a nurse-sensitive measure, and how nurses play a key role in this component of patient care. TJC (2013) has identified a need for safer quality of care benchmarks for falls as well as how healthcare facilities can meet those targets. This information was based the national patient safety goals with preventing falls as one of those aims. The Centers for Medicare and Medicaid Services (CMS; 2012) instituted a rule for discharges occurring on or after October 1, 2008. The rule read: Hospitals will not receive additional payment for medical cases in which specific conditions such as falls were not present upon admission.

Purpose Statement

Ultimately the main goal in a fall prevention program is to promote a safe hospital stay for the patient. The initiation of preventative measures for falls by this organization may not have the ability to prevent all falls however it shows the organization is taking the initiative to institute a preventive measure. USC's are nurses already established as a front line safety leader. They are often referred to as "super users" and are supported by the Clinical Education Specialist and leadership level. USC's are motivated, dynamic, interested in quality outcomes with strong problem solving skills and possess leadership qualities (Aging Services of Minnesota, 2010). Tanafranca (2009) suggested safety champions engage and empower front line staff, promote system-level learning, share successes and challenges and provide peer support. TJC (2012) concludes implementation of a fall prevention education in the hospital setting not only decreases mortality rates, but also length of hospital stay especially in the aging population. As a result, the purpose of this project was to evaluate the outcomes of falls after implementation of a USC on an acute care nursing unit.

Project Objectives

A proposed Quality Initiative (QI) project for falls was used in conjunction with the pilot hospital's current fall prevention program. The researcher identified and explored ways to reduce extrinsic and internal risk factors contributing to patient falls, including perspectives of the problem from nurses that provide front line patient care. From 2013 compared to 2014, there was a greater than 28% increase in falls in this hospital.

In order to decrease the incidence of falls and improve reimbursable care, a goal of this QI project was to develop an updated protocol for utilization of a USC in the patient care area. An anticipated outcome for this project included a decrease in patient falls on the pilot unit and

throughout the hospital once implemented. The USC provided expert teaching support and methods for improvement to the healthcare provider(s) and patient in the acute care setting.

Project Question

Does the implementation of a Unit Safety Champion (USC) on an acute care nursing unit decrease patient falls?

Relevance to Nursing Practice

Hospital or unit-acquired falls are a nurse-sensitive performance indicator put forth by the NDNQI and the ANA. Health care providers need to be made aware of quality indicators that track and report patient falls on a consistent level since they present one of the greatest quality challenges. Since health promotion is a vital component of nursing practice, focusing on falls, how to prevent falls, and how to avoid harm to the patient should be the focus of nursing research in all healthcare institutions. Nursing led QI projects are a major patient experience concern and brings challenges to control daily in the patient environment. A QI fall program is a standard of care in nursing. The super user is the expert as a patient care giver. They are supported by a clinical expert for best practice strategies on these topic areas. Largely, fall prevention and advances in research on this topic as well as pioneering resources for decreasing falls amongst hospitalized patients continue to remain a priority for safety reasons.

Suc, Prokosch, and Ganslandt (2009) cited when change is rigid, individuals are not motivated, do not grow, and do not share their creativity with an organization. Suc et al also revealed isolating old guidelines that need updating such as physical and functional assessment changes will be based on evidenced-based practice. Extrinsic factors relevant to fall prevention in this facility include application of patient yellow wrist band, electronic under the bed monitoring and a yellow stop sign attached to the white communication wall board, and staff/patient education.

Although fall precaution methods had been updated in the past based on best practice such as use of the MFS (1997), fall data validates a need for a possible revision to current fall practice methods.

Evidenced-Based Significance

Globally, the significance of patient falls includes a lack of reimbursement monies from insurance companies and the Centers for Medicare and Medicaid Services (CMS) for conditions and/or injuries acquired in the healthcare setting. The Department of Human Health & Human Services (2010) states CMS implemented a payment policy program called the Deficit Reduction Act of 2005. Medicare will reduce payments to hospitals in the event of a patient developing a hospital-acquired condition (HACs) during their in-patient stay. While this process is in effect, CMS has incentives for institutions with reduced falls and other decreased injuries and infections.

An up-to-date physical institution design could lead to better patient harm outcomes (I.e. fewer in-patient falls in the acute setting and once the person is discharged to home). The estimated cost to an acute care facility to treat the 30% of falls resulting in serious injury is expected to reach \$54.9 billion in 2020 (CDC, 2010). Pearson and Coburn (2011) disputed because falls are among the significant adverse events experienced in hospitals, falls prevention is a critical component of any patient safety strategy. An area of focus on a daily basis in patient experience is including patient safety culture related to falls. Pearson et al also argues tactics must include communication among staff, patients, and their caretakers, or family members. As a final point, safety cultures foster the transfer of information, builds relationships, and increase continuity of care.

Implication for Social Change

A clinical goal for the Doctor of Nursing Practice level is having the ability to analyze critical practice method and related system elements. Applying this concept to staff needs and patient care will help provide a wide-range of meeting expectations for ethically sound and defensible health care delivery. Patient outcomes are a priority for obvious reasons. A design system, on an organizational level, identifies the dynamics of nursing practice on both an independent and group level. A higher level of clinical practice results in improved quality health status for the diverse populations. The DNP exhibits leadership throughout their role in practice delivery. By evaluating new practice needs, the quality approach is based on the critical appraisal and integration of nursing based on the need of the facility and/or patient and family. Benchmarks are imperative to compare the start and end of a health care change. Long-term effects of the benefits of this author's proposal for USCs will help advance nursing practice for the staff nurse as well as the safety and comprehensive well-being of the patient.

Definition of Terms

Fall: To come down quickly from a high place or position; to let yourself come or go down to a lower position (Merriam-Webster, 2015).

Education: the act or process of imparting or acquiring particular knowledge or skills, as for a profession (Dictionary.com, 2014).

Safety Champion: Front-line employees who serves as a resource for their healthcare organization for patient safety (IHI, 2015). Bonner (2006) identified a safety champion is someone that is dynamic, motivated and willing to take on the new role. The USC is typically a nursing assistant, staff nurse, staff development coordinator, or director of nursing who receives additional education and mentoring on fall prevention strategies and leadership skills (Bonner,

2006; IHI, 2014). This role similarly represents the nursing unit as a patient advocate, raising awareness to staff about the importance of fall prevention. Soo, Berta, and Baker (2009) describes a safety champion as a “leader front line clinicians” (p. 125) and can conduct a risk assessment for additional staffing needs for support and education to fall prevention measures as well as health promotion tactics.

MORSE Fall Scale: A rapid and simple method of assessing a patient’s likelihood of falling (Morse, 1997). The MFS (1997) contains six assessment items: history of falling, secondary diagnosis, ambulatory aid, intravenous therapy/heparin lock, gait, mental status. Presence of risk factor identifiers are "yes" or "no" for three of the items and descriptors (e.g., history of falling) and a score of 45-100 (MFS).

Assumptions and Limitations

The first limitation for this project could include length of study. According to the Minnesota Hospital Association (2011), a USC is identified as part of the interdisciplinary group responsible for overseeing the strategic plan for falls program planning, implementation and evaluation. A longer study could also help detect trends of learning deficits and potential bias in a fall program such as implementation of safety champions.

It was assumed that only a small percentage of patient areas and end-users would decline to participate in this initiative. As anticipated, a larger amount of people chose to commit to the change based on a need for a safety champion. Kettner, Moroney and Martin (2011) identified by promoting change through teams of stakeholders composed of leadership and end-users it will minimize negative issues to the change once implemented. USCs will monitor staff education needs for fall prevention tactics and possible learning barriers throughout the pilot timeline.

Summary

In an effort to increase patient safety and decrease overall fall costs, the global problem of falls and interventions were addressed in this chapter. Patient falls continue to be a safety event issue in this institution as evidenced by data showing a greater than 28% fall occurrence increase over a seven month period. Intrinsic and extrinsic factors will be discussed further in the proceeding chapters in addition to the expected benefits for use of USCs (Peltokorpi et al., 2008). Findings of this project may not be applicable to other patient areas such as the operating or emergency room due to the type of patient care area. It is expected findings of this study may indicate a need for a longer study time at a later date for other patient areas.

Section 2: Review of Literature and Theoretical and Conceptual Framework

Introduction

Despite increased awareness concerning falls in the hospital setting, globally a focus is on increasing health care cost burden and long-term patient outcomes. In this section of the proposal, I examined review of literature regarding falls, falls prevention, types of falls in this patient setting, recommended education for fall prevention, regulatory recommendations for a fall prevention program.

Literature Search Strategy

The search to analyze literature research included the following databases: CINAHL, EBSCO, PubMed, and Cochrane library through Walden University library. Thirty-five (35) peer-reviewed articles were identified and not older than 10-years. Key words for literature search included: *falls, falls prevention, falls literature, unit fall champion, falls prevention tools, prevention, fall safety, falls education, kit, cultural initiative, NDNQI, The Joint Commission,* and due to the volume of articles a Boolean search of “*plus*” and “*and*” were used between the other words. From the review of the articles, the following themes were identified.

Prevalence and Incidence

According to the CDC (2013), one out of three older adults age 65 or older will fall each year. In 2010, more than 662,000 of these patients were hospitalized. The prevalence of falls among the older population is most consistent with age 65 years or older. Falls tend to be the leading cause of both fatal and nonfatal injuries in this age-range. Characteristically, falls can have lasting physical and psychological complications, mostly fractures and head-injuries such as traumatic brain injury, and decreased healing times from primary illness such as stroke and even wound care. The National Center for Patient Safety (2004) estimated that the average cost

of a hip fracture in the VA is over \$33,000. The CDC (2013) claimed direct medical costs of falls in 2012 were \$29 billion compared to \$30 billion in 2013. Apart from physical injury, falling results in functional deterioration fear of falling, loss of independence, and in many cases institutionalization.

Review of Literature

Hospital-acquired falls have been identified by the CMS (2013) a preventable healthcare-acquired condition. A global effort is focusing on ways to reduce the risk of hospital falls. Traditionally, hospitals have engaged in efforts that tend to focus on creating a patient-specific fall prevention program that include safe environments, educating nursing and other staff about falls and injury prevention, and patient fall indicators. Hospitals have also relied on measurement of rates of falls to identify opportunities for improvement (DuPree, Fritz-Campiz & Musheno, 2014). Regardless of long-term efforts for fall prevention programs in the hospital setting, there are 2.3 to seven falls per 1000 patient days (DuPree et al).

Tzeng (2010) discussed identified barriers to employing fall prevention programs in acute care hospitals. From the patients prospective, a lack of a caring attitude by the staff member was less than appreciated. A major complaint by the patient revealed high expectations for a safe care environment were not always met. Staffing was short and rounding in a timely manner did not occur. Tzeng also maintained once the nurse-to-patient ratio matrix improved and staff was consistently educated with best practice methods for fall prevention, a cultivated caring attitude was evident in the work environment and HCAHPS scores moved into the green area.

Falls can increase longer hospital stays and additional treatment necessary after falls contribute to a 61% increase in patient care costs (Fitzpatrick, 2011). Approximately one-third of the 700,000 to 1 million patient falls, 19% of the population that occur annually in United States

hospitals could be prevented (Currie, 2008), and reducing falls with injuries is a persistent patient safety issue.

Fall Prevention Methods

The first step in fall prevention is identifying the patient at risk. Patients with mobility problems are high risk for injury. Variables such intrinsic characteristics associated with anticipated physiological falls included poly pharmacy, residual effects from primary illness, and confusion. The IHI (2014) indicated successful fall prevention strategies such as using the MFS (1997) to help identify those patients at highest risk for a fall helped implement fall prevention methods faster than by not using it. Sustaining serious injuries from a patient fall kept the person in the hospital longer and required further treatments that could have been avoided in the first place. Extrinsic factors for fall precaution that were not being utilized included non-use of bed alarms, lack of use of non-skid socks and placing the patient in a room far away from the nurse's station.

Impact of Patient Falls

The impact of falls can often result in patient injury and death and place an increased economic burden on the community and patient population (Currie, 2008). CMS developed 27-quality measures that include clinical process of care (24) and clinical outcome (3) measures to align with measurements for unintentional and intentional events. In addition, there are 10-patient experiences of care topics along-side indicators. The data is a comprehensive cluster of figures from nationwide comparative rates for the AHRQ Patient Safety Indicators (PSI; CMS, 2013). Indicators are benchmarked against data to incident and lack of documentation missing at time of admission. Provider rates for provider-level indicators are scaled to the rate per 1,000 persons at risk and the area-level indicators are per 100,000 (2013). CMS indicators equally

gauge provider assessment and documentation when in the hospital and out-patient level. This allows for a better picture even at the state level to for improvement in healthcare (Suchy, 2010). The outcomes in turn helps indicate a reduction in rising health care costs and better health care reality in today's economically strapped world.

Peltokorpi et al (2008) conducted a study focusing on the impact of an organizational change modeling for cost-efficiency and patient safety as a quality improvement measure in an operating room setting. Peltokorpi et al maintained the more attuned one is to the situations that may predispose patients to falls the better prepared they are to make the hospital a safer place and help prevent avoidable inpatient falls. The IHI (2014) mentioned all efforts must be made to ensure that patient safety programs are in place across settings of care. Once safety officers were implemented, Peltokorpi et al. went on to say one hospital distributed a weekly newsletter to their patients and staff members the number of days without a fall. This in turn raised not only awareness to the consumer, the patient, but also helped build a structured teamwork effort in maintaining low fall rates. Finally, both hospitals recognized better staff involvement and importance of even the CNA in the prevention of falls that contributed to the positive culture of safety (Pearson et al., 2013) in their workplace.

Fall Risk Factors

The literature identified fall risk factors based on fall classifications. An approach to fall risks included recognizing the risk before the cause of the fall. Rowe (2013) suggested that falls could be classified as accidental, unanticipated physiological or anticipated physiological falls. Miake-Lye, Hempel, Ganz, and Shekelle (2013) led a meta-analyses study including 19 in all showing multicomponent programs prevent falls among in-patient populations by as much as 30%. The purpose of this update stood to reassess the benefits and detriments of fall prevention

in the acute care setting and to identify risk factors associated with successful implementation of fall programs and reasons for falls. In this case, drivers for preventative measures was stressed and included use of front-line staff (experts on the topic of falls), execution of guidance to less experienced staff of prevention of falls, use of timely documenting fall risk in electronic health record-EHR systems, and consistent staff education and training.

MacCulloch, Gardner, and Bonner (2007) did not dispute facts the literature showed a higher number of medications such as opioids and diuretics have been associated with an increased fall risk, with some drug classes specifically shown to increase fall risk. These multiple adverse events warranted a higher level of nursing support for patient education on updated fall prevention tactics for a patient receiving this type of treatment.

Physiologic Changes

As a person ages, body system change and decline is a normal process in the absence of disease. Many of these alterations show great variability among individuals and are often impacted by genetics and long-term lifestyle factors, and involve decline in functional reserve with a reduced response to stressors. Anticipated physiological changes are types of falls (78%) that are more common than none (Quigley, Palacios, and Spehar, 2006) as well as known physiologic body changes (Haumschild, Karfonta, Haumschild, and Phillips, 2003). A person administered medications such as narcotics or diuretics that cause adverse side effects such as drowsiness and excess need for urination need to be educated of such. A history of a previous fall automatically sends a red flag when a patient is admitted to the hospital and during inpatient stay.

Impairments such as muscle strength and nerve conduction velocity stood out as two areas staff needed more education in regarding applying to general patient care. CNAs have

minimal anatomy education and expressed a desire to have occasional in-services on body mechanics and/or disease process. Moreover, both nurses and CNAs discussed a need for consistent strategic support on the latest effect physiological changes and degeneration (Youngberd, 2013) has on the human body. Schilliner (2006) suggested the Teach Back method is an effective tool for validation when educating a patient and/or family member or caregiver on a disease or illness. The Teach Back method helps isolate learning gaps of the person receiving the message as well as narrows down a need for adjustment to plan of care or teaching plan. This method can also be applied to a staff member who needs to know the basics of an issue or disorder in order to close the learning gap for safe, effective patient care (Schilliner, 2006).

With condition complications such as dehydration, this often causes orthostatic hypotension, increased heart rate, hyperthermia and weakness. The Agency for Healthcare Research and Quality (AHRQ) (2012) upholds fall prevention must be balanced with other priorities for the patient. Teaching caregiver fall education per institution protocol must be a priority for discharge. Plan ahead while in the hospital and reeducate as needed all people in the patient's care because this supports the continued plan of care and preserves continuity of care once the patient is discharged to home.

Environmental Changes

The use of bed alarms and personal alarms is widespread as one intervention in fall prevention for inpatient areas (Evans, Wood, & Lambert, 2003). Bed alarms that alert staff if a patient attempts to get out of bed without assistance (if in bed, alarm is on, if out of bed, alarm is on under them and documented correctly) has shown to decrease falls by 50 percent or greater. Nelson et al. (2004) upheld that more than 70% of adverse fall events are considered preventable. A study on the use of fall prevention technology revealed fall alarms and call bells

can enhance staff surveillance, reducing adverse events by allowing intervention before harm occurs (Nelson et al). Patients were not using the call bell reliably due to “not wanting to bother the nurse”. Easy access and the WHY of use of the call bell has to be strategically explained to confused patients and reinforced during hourly rounding and explained that the hand held tool is a safety feature and we want them to use it which will help us decrease their chance of falling.

Restraints (including bedrails) and strategies are recommended for injury prevention for acute care patients to include limiting restraint use, lowering bedrails, and using floor mats (Smith, 2005). Graham (2012) pointed out that fall risks needs continuous reassessment during the hospital visit. When caring for a patient who is prescribed multiple medications, the nurse should review the medications for individual drugs or drug-drug interactions that could increase the patient's risk for falling.

Fall prevention methods ought to include use of non-skid footwear, and gait belt for transfers. Room identifiers such as white board stickers should be of a bright color to make identifying the patient at fall risk to visitors. Use of grab bars in the patient shower and bathroom walls and good lighting should be in all walking and slippery areas. To conclude, QIs such as hourly rounding on the patient must be hard-wired with staff as well as educated to the patient why it is necessary every hour.

Education and Training for Staff

Staff education and support, from CNAs to Nurse Managers, is a critical component of a hospital falls prevention program. The scope of the practice improvement team includes everyone who comes in contact with the patient and anyone who influences the patient care environment (Bonuel, Manjos, Lockett, & Gray-Becknell, 2011; Soo et al., 2009; Kaminski, 2011). A goal is to create a culture of openness where any department can speak about their

suggestions for improvement and together, strategies to reduce patient falls can be actualized. Bonuel et al. revealed after implementing use of an interdisciplinary fall prevention team to include a unit fall champion positive outcomes were evident with practice improvement. Outcomes were compared to a national database for hospitals having a similar bed size, showed the study facility outperformed more than half of others in regard to total falls and falls with injury per 1000 days during two-quarters (Bonuel et al., 2011). Boushon et al. (2012) supported that staff communication and education regarding patient fall and injury risks were key points for preventative safety measures.

Other researches revealed staff being kept informed of up-to-date institution changes such as policy revision and regulatory standards (Boushon, 2012; IHI, 2014). This fact included changes in risk for injury from a fall that should also be communicated to the entire healthcare team. The team needs encouragement and commitment from senior leadership. The IHI (2014) recommended an administrative representative on the team is powerful in keeping the team focused and removing barriers. Identifying a champion will increase a health care team's motivation to own their nursing unit and work place.

Theoretical Framework

Lewin's Field Theory Change Model (Figure: 2) was applied to the study for this reason: By placing focus on the individual's need is evident for buy-in change in a work environment (Kaminski, 2011). The three concepts identified in Lewin's Change Theory are driving forces, restraining forces, and equilibrium (Kaminski, 2011). In the first stage, identifying a change is needed is important for "letting go of old habits", or *unfreezing them* (Kaminski, 2011). One concentration in the first stage includes identifying when re-education may be necessary for the patient. Kaminski (2011) also discussed the next stage involves the process of change of thought

and behavior that targets to teach groups of people that new way is better than the old way. The last and final stage helps establish the change as a new habit or process, so that it now becomes the “standard operating procedure” or status quo (Kaminski, 2011). Essentially, employees identify a problem (increased falls, what can be done to decrease falls, identify a need for expert support on fall prevention), collaborates as a team to “change” the problem (embraces policy review and revision based on best practice, drives patient education), and makes the change permanent (continues new habits, takes accountability for actions). Kaminski (2011) also explains expert support and champion leadership continues to be important through the final stage which is fundamentally ongoing until the next major change is needed.

A USC is considered a safety-driven design. At the present time, the Medical-Surgical division is in the early stages of implementing a shared-governance model. USCs can assist with initiation of environmental support being that expert helping develop the staff member’s knowledge-base with the latest up-to-date fall information based on regulatory and standard methods. This idea can allow staff to feel empowered by performing at a safe, autonomous level knowing they have high-level support for safe delivery of care while fostering independence and maintaining a better care environment.

Soo, Berta, and Baker (2009) expanded on peer coaching. Experts enhance positive teamwork and develop supportive working relationships that are strongly influenced by the circumstances surrounding the individual or team. The way a person practices can enhance patient safety or hurt it. Learning change can be a way of promoting buy-in for an EBP change for all staff members if everyone is on the same page, so to speak. If staff members are included in the planning and implementation phase of a major change supported by stakeholders/leadership, this can lead to a greater buy-in for future practice improvements.

Summary

A goal of this project was to determine whether implementation of a USC in the acute care setting was a viable option to add as a pre-emptive intervention in a fall prevention program to help decrease falls. Lewin's Field Theory Change Model (Figure: B) described changes in practice must have drivers that first identify the problem, retrain and embrace stability. As early as 2008 and as it stands today, CMS (2012) started limiting revenue reimbursement to hospitals secondary to hospital fall events. Stricter legislative guidelines make this a necessary priority for healthcare institutions to put emphasis on preventative measures such as consistent fall education, taking a proactive approach to patient safety and maintaining continuity of care. Boushon, Nielsen, Quigley, Rutherford, Taylor, and Rita (2012) contended that standardize interventions for patients at risk for falling should include both hospital-wide and patient-level improvement case by case to reduce severity of injury. Finally, agreeing with the IHI (2014), USCs could offer support to fellow staff members by updating on best research and regulations to policy change and procedure tactics by closing the gap of lack of knowledge-base to fall prevention methods (IHI, 2014). Results ought to show staff will tend to be more engaged with tactics for patient safety based on feedback from USCs. The next section of this study will address how the developmental stages will be undertaken.

Section 3: Methodology

Introduction

The purpose of this project was to investigate if implementation of a USC on an acute care nursing unit will assist in decreasing patient falls. This section outline's project design and methodology, data collection and analysis as well as how the project undertook these developing activities, using the following steps:

1. Identified project design and methodology;
2. Identified data collection and analysis method;
3. Assembled an interdisciplinary project team of engaged stakeholders;
4. Reviewed relevant literature and evidence;
5. Developed policy documentation and practice guidelines for piloting the use of a USC in the acute care patient area;
6. Developed an implementation plan; and
7. Developed an evaluation plan.

Project Design and Methods

A retrospect, exploratory design was used for this QI project and piloted on a 40-bed M/S nursing unit. Per Burns and Grove (2009), a retrospect study measure's and includes a time element to data that can be used to identify factors contributing to an observed change. This particular nursing unit in the pilot had consistent high fall rates and high nurse turnover rates. Urquhart (2013) conducted a retrospect study to evaluate the "effectiveness of utilizing a fall prevention /management program to minimize falls" (p.24). Data collection in Urquhart's study focused on fall rate occurrences from previously recorded instruments such as electronic post fall huddle forms. This project's data collection consisted of using a run chart to track fall rate data three months prior to, and post implementation of a USC.

The two full-time RN participants in the project worked different shifts, 1-day and 1-night, on the chosen pilot unit. Champion identification was chosen by the management team. USC partakers were informed that they may withdraw from actively participating in this project at any time. A role of the USC was to provide education support to front-line nursing staff (e.g. RNs and NTs) in an acute patient area. Education support by the USC included: fall prevention method and use of technology for fall charting. Timeline for pilot implementation of the USC project was three consecutive months following approval of IRB from both Walden University and the pilot institution committee.

Data Collection Instrument

Data collection consisted of comparing fall rates three months pre and three months post implementation of a USC on the pilot unit. Fall data was collected through the risk and quality department that maintains this information monthly (Appendix B). A run chart (Figure 3) was used to track fall rate data every month during the pilot timeline which in turn helped track trends in falls or potential gaps and a Wilcoxon signed-rank test (Table 2) was used to estimate the data given the sample size of 3 months of fall rates.

Data Analysis

Following completion of the session, the data were entered into an Excel spreadsheet and then downloaded into SPSS v.21 for analysis. The data were cleaned and assessed for missing data, normality, and outliers (Pallant, 2013). Based on the normality and linearity of the data, a Wilcoxon signed-rank test was used to estimate the data given the sample size of 3 months (Pallant, 2013). The Wilcoxon signed rank-test is a nonparametric test used when comparing two related samples to assess where the mean ranks differ. It can be used as an alternative to the paired *t*-test when the population cannot be assumed to be normally distributed. The data did not

demonstrate normality of distribution, however the assumptions of the Wilcoxon signed-rank test provided a stronger goodness of fit (data are paired; pairs are chosen randomly and independently; data are measured at least on an ordinal scale (Pallant, 2013)).

Interdisciplinary Project Team

Key project members were chosen based on both knowledge and expertise level. In addition, team members must have had some type of vested interest on the topic of this QI initiative. Jeffs et al. (2013) conducted a qualitative study design that triangulated data from interviews with six steering committee members and five members of a QI project team who participated in a safety project within a large teaching hospital in Canada. Results revealed that healthcare professionals and support staff acquired to leaders to provide opportunities for healthcare team engagement and patient safety projects to improve quality of patient care. Each member was required to bring different talents to the team that helped identify current best practice methods for fall prevention. Recognizing solutions, evaluation of the process and success of the current QI proposal were also be required by each member.

The participants of the USC QI project consisted of:

1. Clinical Specialist and author of this project: The job role functioned as the facilitator of the team.
2. Director of Professional Development & Education: This job role functioned as a resource for staff education tactics based on best practice research.
3. Director of Quality and Director of Risk Management: This job oversaw quality assessment, assurance and performance improvement systems during this QI project and policy change if applicable.

4. Medical-Surgical Registered Nurse(s): This job role oversaw and implemented fall prevention education to staff including NT on the M/S nursing pilot unit. Provision of education needs was supported by the clinical specialist.
5. Nurse Manager (NM) of pilot M/S Nursing Unit: This job role acted as Nurse Manager of the pilot unit for this QI project.
6. Assistant Vice President (AVP) of Medical-Surgical Division: This job role acted as hospital Fall Committee Chair. The author periodically met with the AVP to discuss progress of QI fall project once implemented which included: overall progress of project and data findings.

Review of Evidence

Primarily a QI project aligns with the mission of the organization. An institution's mission upholds core principles that helps guide and promote health for all people a community. Similarly, an interdisciplinary team must be aware of the most updated research and best practice trends related to the topic being executed. The pilot facility is a not-for-profit 450-bed acute-care hospital located in the northern part of Tampa, Florida. The organization has five Medical-Surgical (M/S) nursing units one of which will act as the pilot unit for this QI project. The pilot M/S unit has the ability to accommodate 37 acutely ill patients, four progressive care patients and employs over 40 RNs and 18 nurse techs to care for these patients. The strategic plan this organization has announced for the year 2014 related to quality improvement is directly tied to their tactical initiatives as well as their community vision – maintaining a healthy community for everyone and elevating the hospital's mission for health and wellness for equal opportunity to healthcare.

Develop Implementation Plans

Following IRB approval by Walden University (Appendix C) and hospital approval committee (Appendix D) the QI project was undertaken in the chosen M/S nursing unit at this hospital. The succeeding was a basic tentative plan for carrying out this QI project. These items were presented to the interdisciplinary team as a starting point for further discussion in developing the full implementation plan to include with the pilot proposal for the pilot use of a USC.

- The Clinical Specialist implemented the project on the chosen nursing unit.
- All interdisciplinary members caring for M/S patients received fall prevention support from the USC who in turn received fall prevention support from the Clinical Specialist on the nursing unit.
- Fall rate data was collected with permission from the Quality Department director (Appendix B). Fall rate data was used to create a run chart (Figure 3) to track trends in fall rates 3-months prior to implementation of a USC and 3-months post implementation of a USC.
- A Wilcoxon signed-rank test (Table 2) was used to determine if there was a difference in the number of falls pre-implementation and post-implementation of USCs.
- Author evaluated project and goal achievement through data analysis and periodic meetings with USCs (i.e. number of falls, outcomes).
- Projects results will be disseminated throughout the organization at a later date.
- Results were examined regarding need for additional research time and adoption of USC in the acute care setting.

Budget

Hodges et al. (2011) contended a budget must be considered for the planning phase of the project (p.110). In addition, a well thought-out budget will help ensure success of the program and identify resources already available for use (p.110). The program budget took into consideration staffing budget, program supplies and furthermore, operational expenses. In this specific scenario, overall budgetary needs were reasonably modest since all interdisciplinary team meetings were led during normal work hours. Once the organization decided to pilot the QI project the budget for staff participation was zero dollars. The main cost for the actual pilot was for supplies and incentives for the USC participants (Table 1). Incentives include a gift card in the amount of \$25.00 for each participant. All costs for this budget were paid for in full by the main researcher.

Table 1

Program Expenses for QI Pilot Project: Unit Safety Champions (in Dollars).

Project Budget	Charge(s)	Donated By:	Total
Incentive for Participants:			
*Small key chain	\$0	Pharmacy Rep	\$0
Supplies	\$20	Paper, use of unit copier, own phone	\$20
Gift Card for participants	\$50	Donated by researcher	\$50
Total Expenses:	\$70		\$70

Meetings

The USC participants were bedside RNs-one on dayshift and one on night shift. All USC training and support was held by the clinical specialist. The clinical specialist met twice per week with the USC and at times the unit nurse manager for the first 2 weeks then weekly for the remaining of the pilot timeline. Scheduled meetings were held between the USC and/or nurse manager. All meetings were conducted on the pilot nursing unit during normal working hours. Meetings consisted of identifying needs of USC with regard to education and support for staff on the pilot unit. Education topics included fall prevention policy review, fall risk procedure and professionalism. Additional topics identified were orientation to the QI project plan and use of electronic resources for fall prevention. The clinical specialist, and USC worked closely together periodically evaluating project plans and goals were being achieved.

Project Evaluation Plan

Development of the project evaluation plan occurred with the interdisciplinary team in communication with the components of plan and team members. The following information is a tentative plan for the evaluation phase that was presented to the team as a starting point for further discussion in development of the full evaluation plan (Figure 1).

This plan included the pilot proposal of USCs. Types of evaluation for this project involved both summative and formative. Agreeing with Hodges and Videto (2011), the focus of summative evaluation is whether or not the program produced the intended effects or goals, rather than information on program improvement. This included meeting the goal of designing new or revised fall protocol or policy guidelines the organization would require in order to implement the project outcomes long term.

Formative evaluation occurred during the program planning or the implementation phase. In other words, according Hodges and Videto (2011) formative evaluation directs attention to plans, messages, and procedures of the existing program prior to execution to test for appropriateness. As a result this program had three goals with reference to the evaluation phase each one addressing both summative and formative evaluation. They included: Goal-1: At the end of the program's implementation phase, address viability for use of a USC that will help determine reduction of falls based on previous data; Next, Goal-2: Stakeholder's receive feedback on program progress from the author initially on a weekly basis times 4-weeks then on a biweekly basis until the pilot project ended 3-months after initiation. Finally, Goal-3: The organization will use the proposed guidelines and protocols to pilot the use of USC house-wide.

Confidentiality for fall data was maintained at the highest level. No fall data was used for any other purpose except for what it was intended for this project (Appendix B). There was no actual patient interaction between the author and patient. Once recorded, fall data collected was deleted from the author's electronic email and/or any printed material was shredded. Data results were only shared with team members and/or stakeholders that it was required for in this project.

Summary

The project estimation plan was built based on program goals and process objectives. Goals 1-3 needed to be specific as well as concrete because they acted as benchmarks and reflected program expectations. Outcome measurements assisted in determining if short- and long-term goals were being met. A comparison chart was used to give an overview of hospital needs and goals and objectives prior to implementing USC support on the pilot nursing unit. Key program activities were part of the work plan map. This included completing a needs assessment of a fall problem, project budget, set-up meeting with stakeholders and/or leadership for initial

input of proposal and curriculum outline of the role of the USC. Finally, confidentiality was maintained at all times by not sharing information with anyone outside of primary team members.

Section 4: Scholarly Product

Introduction

The purpose of this project was to investigate if implementation of a USC on an acute care nursing unit decreased patient falls. The project was implemented on a nursing unit with high fall rates. The literature is replete with examples that a USC can decrease fall rates as part of a focus on patient safety and/or standard of care. This section of the project examined the summary of findings, discussion of findings in the literature, practical implications in nursing, legislation, and conclusion.

Discussion of Results

A run chart tracked frequency of falls 3-months pre implementation of USC (September 2014, October 2014, November 2014) and post implementation of USC (December 2014, January 2015, February 2015) (Figure 3). The average number of falls over the three month pre USC period was 5.00 ($SD=2.65$) and the post USC period was 5.33 ($SD=1.53$). The Wilcoxon signed-ranked test was used to estimate a difference between the pre-implementation fall scores and the post-implementation fall scores (Table 2). Overall, there was not a statistical difference between the pre or post implementation fall rates ($z = -0.272, p = 0.785$).

Table 2

Comparisons of Fall Rates: Wilcoxon signed-ranked test estimated a difference between the pre implementation fall scores and the post implementation fall scores.

Month	Pre-Implementation (USC) Number of Falls	Post-Implementation (USC) Number of Fall Occurrences
September 2014	8	
October 2014	3	
November 2014	4	
December 2014		4
January 2015		7
February 2015		5
Average	Mean 5.00 (SD=2.645)	Mean 5.33 (SD=1.527)

Note. No statistical difference at ($z = -0.272, p = 0.785$); USC=Unit Safety Champion;

The USC position was supported by the clinical specialist on the pilot nursing unit. Topics included discussion of fall prevention policy and procedure and tips on how to access fall prevention resources on the nursing unit. In addition, roles in the project and project's guidelines and goals for this QI project were addressed with management by the USC. Evaluation of success of project goals was determined by feedback on falls from the USC to the author in weekly meetings on topics such as staff lack of knowledge of location of fall prevention tools. Moreover, because of USC feedback to leadership on best practice method for fall tools, a fall policy revision included a fall magnet be hung on the door frame of any high fall risk patient.

Discussion of Findings in the Literature

The main purpose of this project was to analyze whether or not a USC would be beneficial in reducing patient falls. Overall fall rate results did not determine whether a USC could help decrease patient falls as identified in Table 2 ($z = -0.272$, $p = 0.785$). The research had been consistent in that evidence-based practice methods such as expert support to front-line nursing staff better prepared them to think on a more proactive approach with regard to safety. A finding in this study also included why feedback to leadership can help improve nursing practice. Soo, Berta, and Baker (2009) described a safety champion as a “leader front line clinicians” (p. 125) that initiates safety prevention measure tactics. Staff identified to the USC the need for a standardized fall risk identifier for patient doors. An action plan was submitted to the fall committee by the USC during an increase in falls one month. A fall policy revision included a yellow fall magnet be hung on all door frames of high fall risks so everyone approaches fall risk standards the same way. Other research stressed a USC is that “go-to” person for areas such as education on National Patient Safety Goals (NPSG; 2015). Largely, NPSGs tie into nursing care by aligning these guidelines to policy and procedure revisions.

Healthcare professionals and support staff require expert leaders to provide opportunities for healthcare team engagement and patient safety projects to improve quality of patient care. Suc et al. (2009) encouraged change to begin at stakeholder level deleting and revising guidelines such as physical and functional assessment modifications based on the patient population. Approximately greater than half of the research stressed the significance of support to staff from advanced clinical leaders was necessary for successful patient safety practice change (e.g., Suc et al. 2009; Soo, 2009; Evans et al. 2003). Several researchers revealed the coexistence of managerial and executive champions emerging as a team is an important key success factor to this type of initiative (Soo et al. 2009; IHI 2014; AHRQ 2012). This particular topic was discussed during bi-weekly meetings with USCs and managers on using a more team work methodology with regard to patient safety. In the long-term, it is believed benefits of this author's proposal for USCs will help advance nursing practice for the staff nurse as well as the safety and comprehensive well-being of the patient. To conclude, a longer study is recommended to help identify if falls would decrease with use of a USC.

Implications to Practice, Research and Social Change

Policy and Practice Guidelines

The projected developmental intervention planning for this QI project was use of Unit Safety Champions in order to assess whether there would be a reduction in falls in the Medical-Surgical (M/S) population. Guidelines for a structured implementation of this QI fall initiative included: education support to the USC by the clinical specialist on topics such as policy review and revision. For instance, the USC spoke to staff in daily huddles and posted a flyer of these changes brought down from the leadership level to the unit. During policy revision the MORSE fall scale low level went from a 45 to 25. This number coincides with a specific set of guidelines

the nurse is required to follow to ensure the patient has been identified as a fall risk and proper fall precautions have been applied. Over the past several months a challenge on this unit has been high nurse turnover. Roughly greater than 28% of RN staff moved to other areas in the hospital or left the hospital. Newer staff members were not completely aware of old fall policy guidelines so they were unaware of the significance of the fall occurrences.

Social Change

A goal for the DNP level is possessing ability to analyze critical practice method and related system elements. Applying this concept to staff needs and patient care helps provide a wide-range of meeting expectations for ethically sound and defensible health care delivery. Patient outcomes are always the priority in these cases. A design system, at the organizational level, identifies the dynamics of nursing practice on both an independent and group level. Furthermore, a higher level of clinical practice results in improved quality health status for diverse populations.

Patient Safety Measure Project: Federal Legislation

The National Committee for Quality Assurance (2014) concluded unsafe care harms and kills tens of thousands of Americans each year. Unforeseen falls and often preventable cost Medicare and the private sector billions of dollars each year and take a significant toll on patients and families, who suffer from prolonged illness or pain, emotional distress, and loss of productivity. As a result, the NQS (2014) has made making care safer a national priority, focusing on goals such as reducing harm from inappropriate or unnecessary care.

Project Strengths and Limitations

A strength in this study included raising awareness to management not all staff members were practicing the same procedure with regards to patient safety based on USC feedback during

weekly project meetings. Adding to that, a recommendation would be to conduct a pre and post pilot questionnaire to further strengthen outcomes when identifying potential gaps in knowledge base deficits for staff members.

Limitations involved length of study and not using a comparison group such as a similar hospital and type of specialty unit with high patient fall events. A USC is of great value when strategically planning a QI program (Minnesota Hospital Association, 2011). A lengthier study would help detect trends of learning deficits and potential bias from new and experienced staff that provide direct patient care. It is proposed that future projects have an association with other like facilities. Patient concordance with any fall-prevention intervention is crucial to a successful outcome in preventing falls. Findings from this project suggest that factors underpinning the successful implementation of fall-prevention programmes cannot be a single factor.

Analysis of Self

Scholar

Becoming a nurse was never a reality until later on in my life. As I grew as a person, so did my deep desire to help people less fortunate than me. Preceding my decision to attend school for my RN, I was “just a single mother”. The thought of my going any further than an associate’s degree in science seemed far fetch given my life situation. I was advised I would never be anything more than a Licensed Practical Nurse. Living with a reading and speech disability throughout my childhood carried over into later years. Thirteen years later I beat the odds of just settling. Deep down I knew I had the ability to succeed in this great endeavor and now this degree I was told cannot be mine is only a heartbeat away. I have two associates, a bachelor in nursing and a master’s in nursing education. My ability to teach nursing to another person is a passion and I am very good at it. If there is one attribute to nursing I can make it is just that-

being a safe nurse and teacher. Overall as a scholar, I believe I have the confidence in making a difference in many people's lives by maintaining the ability to constantly critically think at a higher improvement level.

Project Developer

As a person, I have always been fascinated with the workings of my own mind and humanity in general. As a Clinical Specialist, probably what fascinates me the most is identifying another person's need for learning. Core competencies are deemed to be essential for all practicing nurses and other staff. This project-Implementation of a QI project-Unit Safety Champions has excited my wanting to continue conducting more research. An important area I have come to appreciate on a more professional level is identifying the need of the institution. Being on the other side of research, the action plan must align with the service need. Most nurses cannot relate to the research development side of a quality and safety project. What I have learned is how to develop a plan of action based on that need and recognize the role of the person needing to help implement it.

Future plans are to submit these project results in poster format at the 2016 American Nurses Association conference. The idea is to build on the development of results by conducting a follow up review on knowledge-base for fall precaution method and fall rates on the pilot unit. This will take place in 6-months post implementation of a USC.

Summary

System issues include rising labor costs for hospitals and hospital-wide cutbacks to new programs and departments (i.e. less capital for supplies and staffing). TJC (2008) identified stricter criteria for fall precaution measures in the acute care setting based on best practice method. Similarly, Fawcett and Garity (2009) concurred EBP is necessary for application of

current best practice and decision making for safe, individualized patient care. Likewise, Suc et al. (2009) referenced when change is rigid, individuals are not motivated, do not grow and do not share their creativity with an organization. Soo et al. (2009) proposed changes in the quality of care is in the best interest of the hospital which helps maximize their chances of successful implementation of safety plans such as a fall initiative. In hindsight, the importance of how much of an investment into resources and time that some patient safety initiatives often require doesn't need to be wasted. The presence of clinical champions has been promoted as one such success factor for patient safety practice change based on EBP and regulatory standards.

Conclusion

It is anticipated an updated falls committee, stricter staff accountability for policy review and improved patient rounding may be necessary based on best practice methods to help decrease falls as described by Colón-Emeric, Schenck, Gorospe, McArdle et al (2006). Zone nursing and purposeful hourly rounding are a procedure and not policy. These initiatives have been known to have high positive impact for reducing falls in this type of setting. Based on best practice, a coordinated approach to modernized patient falls management could include a USC for nursing unit staff support that consistently tailors to meet their needs and demands for better, more efficient patient care and work environment resources.

Lewin's theory helped place importance on the individual patient's and staff's learning needs. Abraham (2011) stated that during illness, individuals are greatly in need of satisfying their physiological needs. If these needs are not met, patients leave the hospital lacking a decent experience. A USC will encourage staff "to own the unit-based initiative" which in turn allows for staff autonomy to raise the level of safe, patient care. To finish, analyses of research clearly

proved in the theory expert support to a person that doesn't know what they don't know would increase their knowledge-base and job role satisfaction.

Most of the researchers acknowledged periodic revised fall risk assessment tools to help determine what types of patients were at a higher risk for falls. At the present time this hospital uses the MORSE fall scale. This is done upon admission, every shift with nurse handoff and with any change of condition. Consistent reinforcement of fall policy and procedure from RN to RN, RN to NT and more specifically NT to NT must be a priority for patient care of high-risk potential for injury. As described earlier in the context NT are unable to see the MORSE fall scale score for the patient in the electronic health record. This information is vital for the RN to communicate to the NT in the beginning of the shift so it doesn't act as a barrier for job routine or more importantly inhibit patient safety since NTs are required to know fall policy at this hospital.

Section V: Executive Summary

As the literature describes, falls are a leading cause of death in people 65 years of age or older, greater than 10 percent of fatal falls for the elderly occur in hospitals and high health care system cost yearly (IHI, 2014; CDC, 2013). Overall, healthcare institutions deal in patient care services for diverse populations every day. An on-site service to the community in this type of setting includes trained professionals that take responsibility to address safety needs of the patient prior to an incident happening. A proactive approach to safe patient care supports evidence based research is being implemented in the practice area. Additionally, safe patient care heightens the whole patient experience in an environment that may otherwise seem confusing for someone receiving multiple medical treatments. On the business spectrum, this type of experience also increases the exponential growth for the organizational.

Routinely RNs and NTs receive specific updates to policy and procedure related to fall prevention revisions. Moreover, these changes are typically based on the latest evidence based research and align with the mission of the hospital. During the implementation of this project USCs were supported by the educator with regard to what resources for fall precautions the institution believed in was best practice. The USC in turn supported the staff members with specific practice technique such as types of falls tools that may have been unfamiliar to them. Pre- and post-pilot survey results identified it was necessary to first meet the needs of the person actually delivering the care before they can give the care.

Globally, fall prevention improvement methods comprise of periodic review of the literature based on best practice and hospital priority when challenged with an increase in falls. This author praises after a recent focus on hospital fall initiatives in this hospital falls did

decrease in specific areas such as the pilot unit. Although a small percentage, it was a start since the staff turnover rate has been high throughout the house.

In conclusion, it is recommended that it be reiterated to stakeholders that reducing falls will continue to be an ongoing process which requires a consistent effort and focus. When updating recent hospital fall prevention policy, factors important for revision included up-to-date teamwork collaboration between staff (i.e. RN and NT) for fall prevention and nurse-patient communication. More study time may be needed to determine if a similar program evaluated over a longer period of time can suggestively help reduce falls.

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Appendix A: Figures

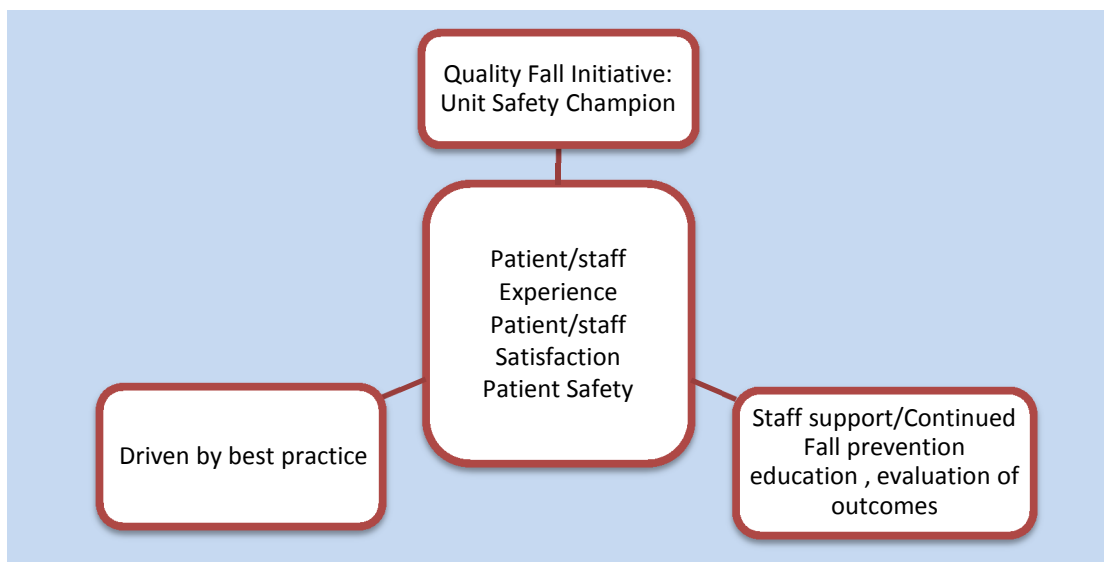


Figure 1. Guidelines for a Structured Implementation of a QI Fall Initiative.

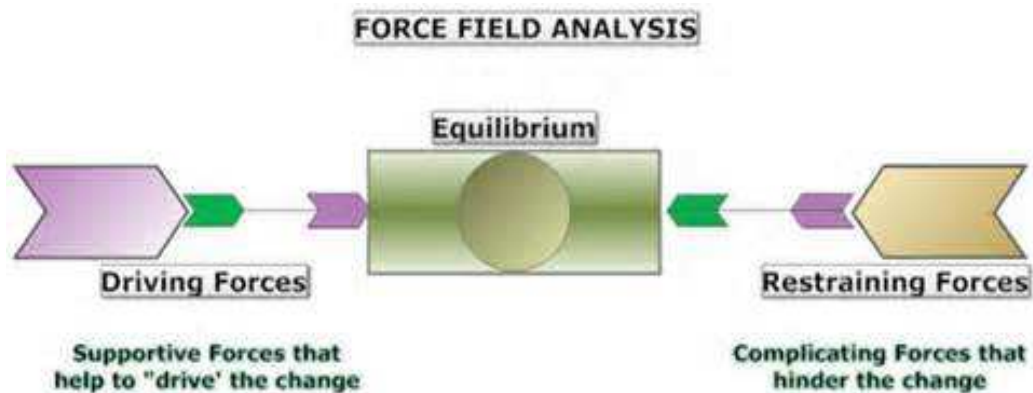


Figure 2. Description of Lewin's Change model; *Photo Source*: Kaminski, J. (2011).

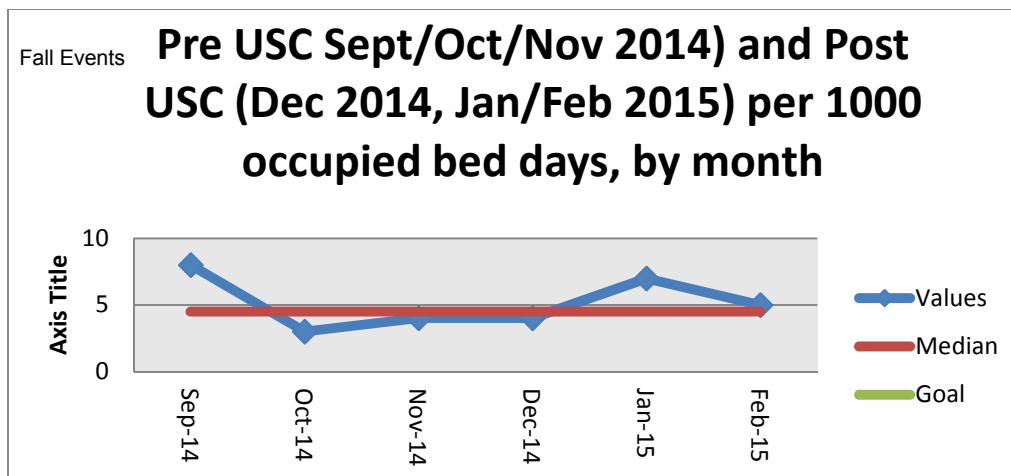


Figure 3. Run Chart Fall Occurrences Pre and Post Implementation of USC; *Data Source:* Approved for use by Quality department of pilot hospital.

Appendix B: Data Use Agreement Form.

DATA USE AGREEMENT

This Data Use Agreement (“Use of Fall Rates”), effective as of (“November 3, 2014”), is entered into by and between Susan Rednak (“Data Recipient”) and Florida Hospital-Tampa (“Data Provider”). The purpose of this Agreement is to provide Data Recipient with access to a Limited Data Set (“LDS”) for use in research **in accord with laws and regulations of the governing bodies associated with the Data Provider, Data Recipient, and Data Recipient’s educational program.** In the case of a discrepancy among laws, the agreement shall follow whichever law is more strict.

1. **Definitions.** Due to the study’s affiliation with Laureate, a USA-based company, unless otherwise specified in this Agreement, all capitalized terms used in this Agreement not otherwise defined have the meaning established for purposes of the USA “HIPAA Regulations” and/or “FERPA Regulations” codified in the United States Code of Federal Regulations, as amended from time to time.
2. **Preparation of the LDS.** Data Provider shall prepare and furnish to Data Recipient a LDS in accord with any applicable laws and regulations of the governing bodies associated with the Data Provider, Data Recipient, and Data Recipient’s educational program.
3. **Data Fields in the LDS. No direct identifiers such as names may be included in the Limited Data Set (LDS). In preparing the LDS, Data Provider shall include the data fields specified as follows, which are the minimum necessary to accomplish the research: Datapoints include No-direct identifier Monthly Fall Rates for hospital institution**
4. **Responsibilities of Data Recipient.** Data Recipient agrees to:
 - a. Use or disclose the LDS only as permitted by this Agreement or as required by law;
 - b. Use appropriate safeguards to prevent use or disclosure of the LDS other than as permitted by this Agreement or required by law;
 - c. Report to Data Provider any use or disclosure of the LDS of which it becomes aware that is not permitted by this Agreement or required by law;
 - d. Require any of its subcontractors or agents that receive or have access to the LDS to agree to the same restrictions and conditions on the use and/or disclosure of the LDS that apply to Data Recipient under this Agreement; and
 - e. Not use the information in the LDS to identify or contact the individuals who are data subjects.
5. **Permitted Uses and Disclosures of the LDS.** Data Recipient may use and/or disclose the LDS **for its Research activities only.**

- e. Headings. The headings and other captions in this Agreement are for convenience and reference only and shall not be used in interpreting, construing or enforcing any of the provisions of this Agreement.

IN WITNESS WHEREOF, each of the undersigned has caused this Agreement to be duly executed in its name and on its behalf.

DATA PROVIDER

DATA RECIPIENT

Signed: Craig Conrad

Signed: Susan Rednah

Print Name: Craig Conrad

Print Name: Susan Rednah

Print Title: Director of Quality
FH-T

Print Title: Walden University
Student

Appendix C: IRB Approval Form-Walden University.

The screenshot shows a web browser window with a Gmail email open. The browser's address bar shows the URL: <https://mail.google.com/mail/u/0/?ui=2&ik=ec2165e223&view=...>. The browser tabs include "mywalden - Yahoo Search Res...", "MyWalden University Portal", "IRB Materials Approved - Susa...", and "Walden University Mail - IR...". The Gmail interface shows the sender as "Susan Rednak <susan.rednak@waldenu.edu>". The subject of the email is "IRB Materials Approved - Susan Rednak". The email content is as follows:

IRB <IRB@waldenu.edu> Thu, Nov 20, 2014 at 4:27 PM
 To: Susan Rednak <susan.rednak@waldenu.edu>
 Cc: Marilyn Murphy <marilyn.murphy@waldenu.edu>, dnp <dnp@waldenu.edu>, IRB <IRB@waldenu.edu>

Dear Ms. Rednak,

This email is to notify you that the Institutional Review Board (IRB) confirms that your study entitled, "Fall Prevention Quality Initiative: Implementation of a Unit Safety Champion (USC)," meets Walden University's ethical standards. Our records indicate that you will be analyzing data provided to you by Florida Hospital - Tampa as collected under its oversight. Since this study will serve as a Walden doctoral capstone, the Walden IRB will oversee your capstone data analysis and results reporting. The IRB approval number for this study is 11-20-14-0346168.

This confirmation is contingent upon your adherence to the exact procedures described in the final version of the documents that have been submitted to IRB@waldenu.edu as of this date. This includes maintaining your current status with the university and the oversight relationship is only valid while you are an actively enrolled student at Walden University. If you need to take a leave of absence or are otherwise unable to remain actively enrolled, this is suspended.

If you need to make any changes to your research staff or procedures, you must obtain IRB approval by submitting the IRB Request for Change in Procedures Form. You will receive confirmation with a status update of the request within 1 week of submitting the change request form and are not permitted to implement changes prior to receiving approval. Please note that Walden University does not accept responsibility or liability for research activities conducted without the IRB's approval, and the University will not accept or grant credit for student work that fails to comply with the policies and procedures related to ethical standards in research.

When you submitted your IRB materials, you made a commitment to communicate both discrete adverse events and general problems to the IRB within 1 week of their occurrence/realization. Failure to do so may result in invalidation of data, loss of academic credit, and/or loss of legal protections otherwise available to the researcher.

Both the Adverse Event Reporting form and Request for Change in Procedures form can be obtained at the IRB section of the Walden website: <http://academicguides.waldenu.edu/researchcenter/orec>

Researchers are expected to keep detailed records of their research activities (i.e., participant log sheets, completed consent forms, etc.) for the same period of time they retain the original data. If, in the future, you require copies of the originally submitted IRB materials, you may request them from Institutional Review Board.

Please note that this letter indicates that the IRB has confirmed your study meets Walden University's ethical standards. You may not begin the doctoral study analysis phase of your doctoral study, however, until you have received the **Notification of Approval to Conduct Research** e-mail. Once you have received this notification by email, you may begin your study's data analysis.

100%

Appendix D: Determination of Research Form - Pilot Hospital



September 26, 2014

Susan Rednak, MSN-Ed, CNE, DNP-C
Florida Hospital Tampa
Nursing Administration, 1st Floor
3100 East Fletcher Avenue
Tampa, FL 33613

RE: IRB Determination: **Not Human Subjects Research (NHSR)**
IRB # 2014-021-661204-1

Project Title: "Fall Prevention Quality Initiative: Implementation of a Unit Safety Champion (USC)"

Dear Ms. Rednak,

The Florida Hospital Tampa Bay Network Institutional Review Board (IRB) acknowledges receipt of your submission entitled "Fall Prevention Quality Initiative: Implementation of a Unit Safety Champion (USC)." Based on the information provided to the IRB, it has been determined that this project does not qualify as human subjects research as defined by 45 CFR 46.102(d) & (f), and therefore is not subject to oversight by the Florida Hospital Tampa Bay Network IRB. The basis of the decision is as follows:

Determination:

The project involves utilizing Fall Reports generated by Florida Hospital, containing solely the events surrounding the fall and the month in which the fall occurred. As such, the data contains no direct patient identifiers and therefore does not fall within the definition of human subjects research.

Investigator Responsibilities:

Please note, if the activity being described in your above study protocol is modified so as to bring it within the definition of "human subjects research" you must re-submit your protocol for IRB review and approval prior to conducting such research.

Definitions:

Research

An activity designed to test a hypothesis, permit conclusions to be drawn, and thereby to develop or contribute to generalizable knowledge (expressed for example, in theories, principles, and statements of relationships).

Human Subject

Human Subject means a living individual about whom an investigator conducting research obtains: 1. Data through intervention or interaction with the individual or 2. Identifiable private information.

For additional information regarding policies and/or regulatory requirements, please refer to the Florida Hospital Tampa Bay Division Institutional Review Board Policies and Procedures Handbook, located in the IRBNet system under "Forms and Templates." You may also refer to Food and Drug Administration Code of Federal Regulations, Title 21, Part 56, or Department of Health and Human Services Federal Regulations, Title 45, Part 46, at the following websites:

Food and Drug Administration:

<http://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfcfr/cfrsearch.cfm>

Health and Human Services:

<http://www.hhs.gov/ohrp/humansubjects/guidance/45cfr46.htm>

Regulations (or 21 CFR Pt. 50, 21 CFR Pt. 56, and CFR Pt. 46 for DHHS studies).

Office for Human Subjects Research Protections (OHRP) decision chart - This chart will aid in making a determination regarding whether or not your project is research:

<http://www.hhs.gov/ohrp/policy/checklists/decisioncharts.html>

If you have any questions or concerns, please contact Brenda Wright, CIP, IRB Administrator, at (813) 615-7200, ext. 56516, or by e-mail at brenda.wright@ahss.org or Vinita Witanachchi J.D., IRB Coordinator at (813) 615-7200, ext. 50327, or by e-mail at vinita.witanachchi@ahss.org. We thank you for checking with the IRB to ensure human subjects research compliance.

Sincerely,



Charles Lambert, M.D.

Chair, Florida Hospital Tampa Bay Network IRB

IORG0001289

IRB00001715

FWA0001432

CL:bw;vw