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Fall Prevention in Palliative Care: Improving Fall Prevention and Management at Point of

Admission

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Abstract

By nature falls begin to occur as part of the aging process and are a major source of morbidity and mortality in the elderly patients. Despite the extra blanket of care the palliative team creates for its patients, fall incidents are continuing to plague this palliative domain. During the process of this project, gaps in the delivery of care contributing to patient falls were identified. It was established that the care system's inconsistency and lack of structured assessment of the individuals' risks for falls and thus customization of patient specific fall prevention strategies at point of admission was the weakness and the greatest contributor to patient falls. It was decided that Morse Falls Risk Assessment (see Appendix B) is the best option for the organization and the patients it serves. The tool will serve as a guide for the provider to formally assess and document patient's risks for falls, educate patient and family based on the identified needs and share the findings with the interdisciplinary team so that a patient-tailored fall prevention approach can be implemented using a system approach. The project will run as a pilot from September 2017 to December 2017. The main objective of this project is to mitigate and prevent falls in the palliative patient population. The goal is to see a 30 % decrease in patient falls by the end of December 2017.

Fall Prevention in Palliative Care: Improving Fall Prevention and Management at Point of Admission

Preserving quality of life by supporting and sustaining patients' physical, emotional and psychological wellbeing, regardless of the medical condition is the primary focus of the palliative care program. Further, making every effort to assure that client safety is not compromised and is in fact strengthened through a holistic patient-centered approach falls under the same umbrella of care in the palliative domain. However, despite patient and family education aimed at safety promotion and fall prevention, fall incidents continue to occur and are the number one cause of injuries and hospitalizations among the palliative patient population.

By nature falls are a major source of morbidity and mortality in elderly patients. In palliative care patients, many of whom are elderly, the risk for falls is further increased by the patients' multiple and often complex and debilitating disease processes. Side effects of multiple medications, dementia and other mental acuity altering conditions are also major factors associated with and contribute to the falls experienced by palliative patients. Head injuries and hip fractures suffered from a fall further increase health complications, hastening of death and increased distress for the already suffering patients and their families. Furthermore, in-patient care costs associated with fall-related injuries are devastatingly high, even for the injuries not categorized as life threatening. The ultimate purpose of this project is to mitigate/prevent falls in the palliative patient population served by the care system. I hope to accomplish this by improving the fall prevention and management program at point of admission.

Clinical Leadership Theme

For the last two decades, the ongoing battle with falls and the extensive research on how to better prevent the occurrences has gained a worldwide recognition as a global health problem.

After trial and error of an abundance of interventions, it has become evident that fall prevention requires a multifaceted approach, one that is structured and addresses patient-specific needs. All members of the multidisciplinary and interdisciplinary teams should be aware and compliant with the collaborated approach, as quality patient outcomes are highly dependent on the cooperation of the entire system.

All CNL roles are equally valuable and are often intertwined when providing support and addressing the needs of both patients and the care system. This project specifically highlights the CNLs role as an educator, patient advocate and outcomes manager. The clinical leadership theme for the activity is promoting a culture of safety. The magnetism threads targeted in the process are quality improvement and quality of care. Communication is one of the key elements in quality improvement projects. Effective communication promotes a healthy environment, which supports the opportunity for growth and education for the entire organization. Delivering quality patient-centered care using an evidence based holistic approach should be the goal of every healthcare provider. This project aims to improve patient safety and the quality of care through a systematic approach. Prevent patient falls and the associated complications through risk identification and the implementation of patient centered fall prevention strategies. Improving provider knowledge and commitment.

Statement of the Problem

This specific palliative program was developed two years ago for a patient population belonging to a managed care medical group. The program was created by the stakeholders, in response to the increase in negative patient care outcomes contributing to avoidable hospitalizations and increased re-admissions affecting multiple aspects of the system (e.g. quality of care, policies and procedures, cost increase). The number one reason for hospital re-

admissions in the managed care patient population was due to fall related injuries. Since the launch of the program there has been a 40% decrease in the overall re-admission rate, however, falls are still continuing to occur despite the extra blanket of care the palliative team strives to create. The palliative program had 14 falls documented between February 2016 and January 2017 (“T” Palliative Care, 2017).

The need for improvement in this care system is the fall prevention and management program at the point of admission. The admission process is conducted by the interdisciplinary team doctor or nurse practitioner and includes an assessment of the patient as a whole (e.g. physical/mental assessment, health history, religious beliefs, health related needs and goals), which serves as a determinant for whether or not the client will benefit from the program and the resources it offers. The patient pays no out-of-pocket fees or expenses if admitted, all palliative fees and costs are covered at 100 percent by the Managed Care Group and secondary insurances (e.g. Medicare, Medicaid).

Although the initial assessment is indeed comprehensive, there is no policy, protocol or formal screening tools in place and documentation of fall risks is not a routine part of admission at our facility. According to Patrick, Slobodian, Debanne, Huang, and Wellman (2017) fall prevention measures are most effective when based on patient-specific needs resulting from identified risks. Implementing a fall risk assessment tool at the time of admission will prompt the health professional to formally identify and document the patient specific risk factors, provide patient and family with education based on the analyzed risks and use the “risk-level score” recommendations as a guide for implementing evidence based fall prevention measures that correlate with the patient’s direct needs. Furthermore, in supporting the need for a systematic approach, after the admission process is completed, the findings of the fall risk assessment and

the provider's recommendations will be communicated with the interdisciplinary team and those directly involved in the management of the patient's care. I believe the use of a fall risk assessment at time of admission can facilitate a greater awareness for the need of a patient-tailored fall prevention approach, which evidence shows to be more effective in preventing falls, and promoting safety in the delivery of care across the continuum (Patrick et al., 2017).

Project overview

It is at point of admission that either the Nurse Practitioner or the Medical Doctor creates a preliminary plan of care for how to best manage the patient and preserve/sustain his/her quality of life. The provider uses subjective patient data, medical records and his/her best judgment to create the most optimal plan of care. However, patients that are coming into the palliative program have multiple risk factors (varying from patient to patient), which contribute to the breach in their safety, hence, increasing their chances of sustaining a fall. Having said that, there is no systematic process for fall prevention in the palliative setting, patients' risks are not regularly identified and prevention measures are not sequential or strategic. It is highly important to identify risk factors using a standardized tool and then plan care to address those risk factors (AHRQ, 2013).

This project is a pilot and is aimed at improving fall prevention and management in the palliative program. The following are the project objectives; 1) staff education session (orientating the team to the project), 2) implementation of Morse Falls Risk Assessment at time of admission for all new patients, and on the next routine visit for existing patient, 3) communicate identified risks and plan of action during morning conference calls (this will initiate the facilitation of a standard process for effective communication for fall prevention, and 4) fall prevention strategies (specific to patient needs) will be executed in the initial stages of

care planning. In order to meet the objectives, an educational session will be held for all team members for one hour (see Appendix A) at which time the need will be addressed, the objectives will be discussed and the tool for assessing patients fall risks will be introduced. The learning objectives to be executed; 1) educate interdisciplinary team on the proper utilization of the risk assessment tool (at time of admission); 2) orient the team to the assessment tool's risk-level score recommendations. After the staffs' educational session, the providers will implement The Morse Falls Risk Assessment (see Appendix B) on every new patient at time of admission and on the existing patient's at his or her next routine visit. The score from the assessment tool will serve as a guide, supplementary to the provider's judgment but as a "must use" strategy to identify and document the patients' risks for falls at time of admission. The provider will use the data to customize patient-specific strategies for preventing falls and integrate them into the initial plan of care. If the patient's risk analysis elicits a score of 45 or greater at time of admission a social worker will be contacted on site to make the appropriate arrangements so that the patient's safety is not further compromised. The following morning, during the conference call (held daily by interdisciplinary team member) the patients risk assessments and the provider's plans of action for fall prevention (including report from social worker if applicable) will be discussed.

There are formal in-person meeting at the end of each week where detailed patient-care discussion takes place, care plans are re-evaluated and re-collaborated, and progress, goal achievement and any patient issues or concerns are addressed so that the needed adjustments can be made to the plan and delivery of care. The goal is to re-implement the risk assessment tool every 60 days, starting from the initial use of the tool, to monitor the progress and efficacy of the customized fall prevention plan. The data that will be collected for project effectiveness review is; 1) monitoring the staff for compliance on the implementation of the tool for all new

admissions and the existing patients, 2) tracking of any falls incidents through providers, reports of home visits and nursing courtesy calls, 3) re-assessing and re-evaluating the fall prevention strategies and interventions at follow-up visits and discussing the progress with team during weekly meetings, and 4) observing and assessing effectiveness of communication amongst staff members and between staff and patient and family (determining what works and what needs improvement in effort to continuously promote a culture of safety). Final project goals are; 1) 100 percent staff compliance in the application of the fall risk assessment tool, 2) a reduction of falls by 30 percent by December 2017, followed by a larger percentage in the following quarter, 3) a continuous decrease in costs related to falls injuries and hospitalizations.

We, the Palliative Care Team, aim to improve safety and quality of patient care by mitigating and preventing patient falls in the palliative program. The process began with the need identification through the use of structured methodology, which prompted the implementation of a fall risk assessment tool at point of admission. The process will end with the patient's and families demonstrating compliance and adherence to the patient-tailored prevention strategies set in place by the team. By working on the process, we expect a 100 percent staff compliance with the utilization of the risk assessment, demonstration of patient and family awareness in their role in preventing falls and 30% fall reduction in our palliative patient population by the end of December 2017. It is important to work on this now because 70 percent of patients' falls can be prevented through risk assessment and awareness and the right intervention (The Joint Commission, 2015).

Rationale

In the initial stages of the project, data was gathered through objective and subjective observation, assessments and structured methodology and analyzed in effort to identify the gaps

contributing to patient falls. The use of varied structured methodology in preparing for the improvement project created an illustration of concrete data and the evidence that supports it.

SWOT Analysis

The SWOT analysis of the palliative program elicited strengths, weaknesses, opportunities and threats attributed to the functionality of the microsystem (Appendix C). The data pictured in all four domains influence and affect the way patient care is delivered and the overall mechanics of the system. The strengths found are; feasibility to resource access, highly trained and highly educated staff, effective interdisciplinary collaboration and coordination and administrative and corporate support. The weaknesses are; no fall risk assessment is used as a standard in the admitting process creating a gap in fall prevention, time constraints for admission process preventing the adequate amount of time needed for a thorough risk assessment and staff resistance. The opportunities are; promote a culture of safety, improve staff and patient awareness and education, benchmarking and influence a future policy change. The threats include; patient non-compliance, lapse in patient safety, readmissions and Medicare/Medicaid sanctions.

Following the SWOT analysis, a process map was created which illustrates the flow of the current fall prevention process (Appendix D). Evidently the process does not illustrate consistency or structure aside from the routine question (i.e. Have you ever experienced a fall?). Needing to establish the origin of the problem a root cause analysis was created.

Root Cause Analysis

The summary of the root-cause analysis in which people, environment, patient factors, and communication are the main factors, concluded that a lack of a standardized process for fall

risk assessment at point of admission creates a lapse in direct communication among team members about patient-specific fall risks as well as no consistency in monitoring and re-assessment of the patients and families knowledge about fall risks and the fall prevention plan. The patients' factors, which influence the problem is the aging process, high consumption of prescription medications likely to alter mental and physical coordination, which in many patients is already compromised do to their disease processes (Appendix E).

HCAHPS

Not only do patient falls result in adverse patient health outcomes and hospitalizations, but can also lead to a decrease in patient satisfaction with care. Patient satisfaction has an impact on patient retention, clinical outcomes, and claims of medical malpractice (Prakash, 2010). Therefore, patient satisfaction is frequently used as a key metric to determine the quality of health care provided to patients, and is standardized through HCAHPS (Centers for Medicare & Medicaid Services, 2014). The results of the survey scores can give a facility an indication of the quality of care delivery, including areas in need of improvement.

There are a large number of factors that contribute to patient satisfaction in HCAHPS surveys, including communication with health care professionals, the environment, pain management, discharge information, and other factors (Centers for Medicare & Medicaid Services, 2014). Patient falls impact patient satisfaction in large part due to the factors that contribute to the falls. Many patient falls occur because the individual's risk for falls was never identified and thus, the right prevention strategy was never implemented. However, health care professionals, who have strong and frequent communication with the patient and family, should be obligated to identify patient's risks for falls and do the necessary to help prevent them.

Palliative patients account for one of healthcare's most vulnerable populations' because of their extensive health needs, which compromise the quality of their lives and often lead to premature death. Never the less majority of these patients are so grateful and are just happy to get the extra care and resources, but mostly the warmth, kindness and attention that the palliative team brings. Furthermore, despite the negative outcomes that are at times experienced by these patients, the HCAHPS surveys for the palliative care program show high ratings in patient satisfaction ("T" Palliative Care, 2017).

Cost Analysis

It was recorded that 15 patients experienced a fall between February 2016 and January 2017 causing them to be hospitalized ("T" Palliative, 2017). At that time this program only had a total of 112 patients. Following a chart audit, it was determined that 13 of the fall incidents were preventable. Currently, there are 200 patients in this palliative program. An average hospital stay for a single fall related injury is 6.3 days with a daily cost of care running as high as \$9100 (The Joint Commission, 2015). Based on the estimated costs and the 13 patient falls, which were considered avoidable, ($\$9100 \times 6.3 \text{ days} \times 13 \text{ patients}$), the Managed Care Group could have potentially saved approximately 745,290 dollars in unnecessary hospitalizations due to falls. Furthermore, between February 2015 and January 2016 there were a total of 14 documented patient falls that resulted in hospitalization, at which time there was a total of 102 patients in the program ("T" Palliative, 2016). Although there is no data for referencing whether or not any of the falls between the dates were avoidable, it is fair to speculate that with program population having nearly doubled in 2017, without an effective fall strategy, the number of fall incidents is likely to double as well.

After discussing project/goals with the administration, it was decided that the project

would run as a pilot project. Meaning, the only costs to the organization are the printing of the (paper assessment tool) 120 copies x \$0.08 = \$ 09.60, and the cost for the time needed for education of the interdisciplinary team members. The educational session was completed in one 1-hour session (for all of the interdisciplinary team members except the MD). The team has two RN coordinators at 52\$ per hour, two social workers at 40\$ per hour and an NP at 66\$ per hour. The MD was exempt from the education session, had she not been, her one hour education would cost the organization 125\$ for the hour. The total dollar amount to launch the project is \$257.60, this means that if the implementation of the risk assessment tool following with the patient-tailored prevention measures prevents a single patient related fall-injury resulting in hospitalization the organization will save 57,330 (Appendix F).

Methodology

The main objective of this project is to mitigate and prevent falls in the palliative patient population. The goal is to see a 30 percent decrease in patient falls by the end of December 2017. After continuous observations and a variety of methodologically guided assessments the need for improvement was identified. A formal falls risk assessment tool is to be integrated into the admission process and implemented on every patient at point of admission. The tool will guide the provider to formally assess and document patient's fall risks, educate patient and family based on the identified needs and share the findings with the interdisciplinary team so that a patient-tailored fall prevention approach can be implemented using a system approach.

Quality improvement projects are aimed at making a positive change, however, the process is seldom smooth. It would be ideal to implement a change project and not feel stressed or overwhelmed while planning, implementing, evaluating and waiting for the desired outcome. It is vital that the professional leading the project understands the concepts of the change process

and is knowledgeable in the application of a change theory, which will ultimately support and help solidify the project.

The change theory chosen to support this project is Quinn's Theory of Change (Finkleman, 2016). Based on continuous observations and evaluation of the staff's views on the proposed change, it's of essence that the change for improvement is implemented now. Not doing so the care system will experience a "slow death", which is what Quinn refers to when the organization is comfortable with the current state and is not willing to accept the need for a change (Finkleman, 2016). Furthermore, the organizational belief that there is nothing wrong becomes a status quo, driving the potential to negatively effect other processes and procedures affecting quality and safety (Finkleman, 2016). Denial is the first response in coping with the "slow death", thus the team members find a way to work around the situation, which only further compromises the organization and the patients' it serves. The CNL as an educator, advocate and team manager will take on the role of a transformational leader and implement the eight steps identified in Quinn's Change Theory to address the organizations need for a "deep change" (Finkleman, 2016).

As the primary change agent the CNL must first overcome the barriers (e.g. staff resistance) affecting a successful change process and its outcome. In doing so the leader will use education and effective communication strategies in effort to gain the support of the interdisciplinary team and create an environment acceptant of change. Forming a strategic vision, promotes clarity for the team members in understanding the objectives of the change process and how they relate to each member. The vision will be discussed during the educational session and any questions or concerns can be addressed. Evidence based data supporting the benefits of having a fall risk assessment tool as part of a multi-faceted fall prevention approach will be

provided for the team.

Once the change process is implemented, it will be essential to assess, monitor and evaluate for effective team communication, collaboration and coordination of fall prevention as well as the feasibility for creating fall prevention strategies specific to patient needs using the fall risk assessment tool. This data will help the project leader evaluate the effectiveness of the chosen intervention. The data that will be collected for review of project effectiveness is staff compliance in implementing the risk assessment on all new and existing patients, assessing patient/family knowledge and compliance with the implemented strategies in effort to determine what works and what needs improvement and the number of falls sine the implementation of the process.

Literature Review

The following PICO statement was used to search the literature that best supports the quality improvement project. (Will the implementation of a fall risk assessment tool help decrease falls in the palliative patients?) The search was conducted using OVID and CINAHL database, and the following supporting articles were chosen for the literature review.

Coppedge, Conner, and Se (2016) performed a fall prevention pilot study on a 24-bed medical-renal unit. The method tested was a use of a fall risk assessment tool in effort to decrease the number of patient falls on the unit. A gap analysis performed by the hospital's fall committee identified a lack of communication with other healthcare team members (e.g. physical therapists, transportation staff, and dietary staff) involved in patients care, regarding patient fall risks and individualized plans of care as being a top contributor of falls. The committee developed a fall prevention communication tool in the form of a bright yellow poster hung above patients' beds. The tool served as a facilitator of patient's fall risks, alerting all staff involved in

the patient's care of the patient-specific fall prevention needs. The integration of the tool enhanced a fall prevention culture for safety on the unit. The fall rate (falls per 1,000 patient days) decreased from 3.38 to 2.21 at the end of 2014 (Coppedge et al.).

Dykes, Duckworth, Cunningham, Dubois, Driscoll, Ferrazzi, and Scanlan, (2017) describe a qualitative study in which a New York Hospital turned to the Institute of Healthcare Improvement Framework for Spread after rigorous efforts to help prevent the escalating number of patient falls within their organization. So that the right recommendations can be made, the quality improvement team conducted surveys on patient's who experienced falls at the hospital and the medical health professionals. By doing this, it was established that patient falls are a communication problem and that fall prevention should be a three-step process: (1) conducting fall risk assessments, (2) developing a tailored or personalized fall prevention plan, and (3) implementing the tailored fall prevention plan consistently, along with universal precautions (Dykes et al., 2017).

Silva and Hain (2017) address the need for a fall prevention improvement at a 408-bed Medical Surgical Rehabilitation Hospital (associated with extremely high fall rates), through chart audits and extensive data collection it was concluded that all though the hospital had validated screening tools and other strategies, such as purposeful hourly rounding and a fall prevention bundle (yellow bracelet, yellow socks, own shoes, signs, bed/chair alarm, self-releasing belt, 1:1 observation, fall video in several language) there was no single risk assessment tool which identified patient-specific risks (Silva and Haun, 2017). Thus the actual needs for prevention were never addressed. Rather, the hospital adopted a variety of prevention measures and based on general evaluation implemented the measures into the care plan. In conclusion, it was identified that the key to effective fall prevention is accurately identifying the

risk factors on individual bases, and integrating an appropriate plan of action to address each factor (Silva and Hain).

Ambutas, Lamb, and Quigley, (2017) write that after reviewing a quality improvement fall prevention project carried for six months on two 32-bed units, which implemented a toolkit as a fall prevention strategy, to decrease patient falls, it is evident that no matter what approach is taken after a fall risk analysis, communication among care members, leader support and patient/family education using the “teach back method” are the key elements for goal achievement (Ambutas et al., 2017).

Sardo, Simões, Alvarelhão, and Simões, (2016) examine the effectiveness of the Morse Falls Risk Assessment when translated into the Portuguese language. The feasibility of the tool is related to the straightforward questions and the easily comprehensible recommendations. The tool was implemented in a Portuguese hospital with positive feedback from the health professionals, specifically reporting the tool to have good reliability and validity (Sardo et al., 2016).

In their effort to identify the best fall prevention measures suited for the palliative patient population, Morgan, Cerdor, Brown, and Currow, (2015) bring up a study done on 100 palliative patients, out of which 32% had at least one recorded fall incident, however, only 4% of the study patients had falls risks identified in their routine risk assessment. The authors proceed to ask why only 4% had an identified falls risks, yet 32% experienced falls, why where these risks not detected in the other patients? In conclusion the authors say that the most effective falls intervention strategies include a combination of systematic risk screening tools regardless of the population base. The screening tools should include medication reviews, and follow-up on identified risks (Morgan et al., 2015).

All articles listed in the above literature review provide the reader with information about effective fall prevention strategies tested in pilot studies and quality improvement projects. One international article describes the accuracy and feasibility of a fall risk assessment tool that was translated to the authors' native language. The reason these specific articles were chosen for the review is that although they all provide different mechanisms for addressing fall prevention they all share the same analogy, which concretely support this project. All the articles report the need for assessing patients for the specific risks that ultimately put them in danger of sustaining a fall. The findings provided in the conclusions of the articles, highlight patient-tailored evidence based fall prevention measures as being the most effective strategies in preventing falls.

Timeline

The idea for this project came from the microsystem assessment performed in Spring of 2017. Falls data going back almost two years was collected and reviewed between the months of June and July 2017. Incident reports were analyzed to better understand the reasons for the fall prevalence (other than the obvious) in a population that was so closely monitored and where so much is implemented in effort to prevent falls. It wasn't until the application of the methodological assessments (e.g. root cause analysis, SWOT, and Process Mapping) in early September 2017, that it became clear what was the actual root of the problem. It was at that time that the need for a change was clearly identified. After that things moved quickly. The Nurse Practitioner who is the interdisciplinary team manager, and to the program administrative project manager were contacted and briefed on the findings and the proposed improvement project. The two professionals approved the project and the prompt implementation of the process. After an evaluation of three fall risk assessment tools it was decided that the Morse Falls Risk Assessment (see Appendix B) was the one that best fit the palliative patient population. In effort to outline

the project objectives and acclimate the staff to the process a teaching tool was created (see Appendix A) addressing the identified problem, goals and the Morse Falls Risk Assessment tool and its proper use.

Staff education and orientation session was positive and effective and the Risk Assessment Tool was implemented the second week of September 2017. It is planned for the pilot to run from September to December of this year before the summary data is analyzed for project effectiveness.

Expected Results

When this pilot project runs its course it is definitely expected that the goals that were set will be achieved. It is further believed that a 30 % reduction in falls will be seen in December, and a 50% the following quarter if the change is accepted and made a part of the admission process. If the tool is formally adopted it will be a while before it officially becomes a policy at the facility, however this is believed to be very realistic and achievable. This is assumed because this palliative organization is comprised of highly intelligent stakeholders and healthcare professionals dedicated to bringing optimal outcomes to their patients. Further the organization recognizes this quality improvement project as an evidence based change that will promote a culture of safety and improve the quality of care. It is important to point this out because, accepting change can be difficult especially for professionals that have adopted their own way of practice through the years, thus making change an unfavorable process.

Nursing Relevance

Nurses caring for patients who are mentally and physically debilitated, see the true meaning in quality vs. quantity. A vast majority of these patients will soon succumb to their illness, and nothing can lift your and their morale more than being able to allow them to do what

they want, whatever makes them happy even if it's not the healthiest choice for them. However, patient safety should always be the nurse's top priority, regardless of the patient population or individual situation. Through education and awareness Palliative nurses can promote a culture of safety and quality of life for their vulnerable patients.

Summary Report

The project was approved by the administration in the beginning of September 2017 to run as a pilot through the end of December 2017. After an immediate staff education session, during which the providers were briefed on the essentials of the project; objectives, timeline, goals and methods for evaluation. During the session the team was also orientated to the Morse Fall Risk Assessment and its use as well as the benefits evidence based practice elicits regarding having a structured fall risk assessment as part of the organizational fall prevention approach. Hard copies of the tool were handed to all interdisciplinary team members after the teaching session with the instructions from the team manager that the tool be implemented as early as the next patient visit. Since the integration of the risk assessment tool and the present there have been 11 new admits into the program. All of the 11 patients were screened at time of admission for individual fall risks using the assessment tool. Their cases have been discussed per policy and procedure during morning conference calls and the fall risk assessment findings were addressed as one of the project's objectives, at which time a patient specific plan was also collaborated among the team members and integrated into the care plan, which as well is an priority objective and a detrimental factor in attaining the project goal. Out of the 200 patients that were already in the program when the pilot started, 56 out of which 19 have experienced a fall in the past have been re-assessed during a follow-up visit for specific fall risks using the Morse Risk Assessment and too have had adjustments made to their plan of care in effort to better prevent them from

sustain a fall and increase the quality of their care. There has been two documented falls reported from existing patients after the launch of the project, however, neither of them were evaluated or assessed for specific fall risks using the tool. The goal is too continue implementing the risk assessment and customizing fall prevention measures for every new and existing patient until all patients in the program have been screened and are protected against falls to the best of the organizational ability.

The goal of this project is to decrease patient fall rate by 30% at the end of December 2017 and ultimately continue to see the decrease into the next quarter averaging a 50% reduction. Making this possible will help sustain and likely increase the quality of the palliative patients' lives. Since the start of the project there has been a lot of positive patient feedback. Patients and family report feeling the commitment and dedication the team portrays as it aims to close the gaps between primary providers and patients which too often increase the lapses in care leading too poor disease management and less then quality care outcomes. This project has promoted a culture of effective communication between providers, which is crucial in every patient care domain especially in the continuum of care where it is very easy for providers to lose track of patients and their needs. This pilot project aims to increase patient centered, safe and effective quality care. At the end of the pilot, the process will be evaluated and the needed modifications and changes can be applied in effort to create a possible proposal for an integration of a new policy.

Conclusion

Healthcare is changing and evolving everyday, it is the nurses legal and ethical responsibility to practice to the best of his/her ability, which means being a life learner and staying on top of the best evidence based practices (EBP) especially those that pertain to his/her

scope of practice. Finding new and improved ways to prevent falls has proven to be impossible.

What is possible is staying ahead of the falls, which means assess your patients for their individual risks and never be afraid to use prophylactic measures if you feel they are needed. Not enough nurses use their gut feeling, experience and EBP all at the same time, doing so can possibly promote clarity and better understanding of a complex situation and in turn promote better decision-making and optimal care outcomes.

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Appendix A

Educational Module

Rationale	Objectives	Material	Methods
<ul style="list-style-type: none"> - Patient Falls continuing to emerge - Preventing negative outcome - Promoting a culture of safety 	<ul style="list-style-type: none"> - Increase interdisciplinary teams awareness about the need for fall prevention improvement/patient fall risk assessment Increase knowledge regarding safety - Address preconceptions - Introduce The Morse Falls Risk Assessment Tool 	<ul style="list-style-type: none"> Conference room Handout of 1)Risk Assessment / 2)scoring recommendations 	<ul style="list-style-type: none"> - Discussion

Appendix B

Morse Fall Risk Assessment

Item	Item Score	Patient Score
1. History of falling (immediate or previous)	No 0 Yes 25	
2. Secondary diagnosis (≥ 2 medical diagnoses in chart)	No 0 Yes 15	
3. Ambulatory aid		
None/bed rest/nurse assist	00	
Crutches/cane/walker	15	
Furniture	30	
4. Intravenous therapy/heparin lock	No 0 Yes 20	
5. Gait		
Normal/bed rest/wheelchair	00	
Weak*	100	
Impaired†	200	
6. Mental status		
Oriented to own ability	0 0	
Overestimates/forgets limitations	1515	
Total Score‡: Tally the patient score and record. 0: No risk for falls <25: Low risk 25-45: Moderate risk >45: High risk		

* Weak gait: Short steps (may shuffle), stooped but able to lift head while walking, may seek support from furniture while walking, but with light touch (for reassurance).

† Impaired gait: Short steps with shuffle; may have difficulty arising from chair;

head down; significantly impaired balance, requiring furniture, support person, or walking aid to walk.

***Note: Tool adapted from Agency for Healthcare Research and Quality, Rockville, MD.
<http://www.ahrq.gov/professionals/systems/hospital/fallpxtoolkit/fallpxtk-tool3h.html>**

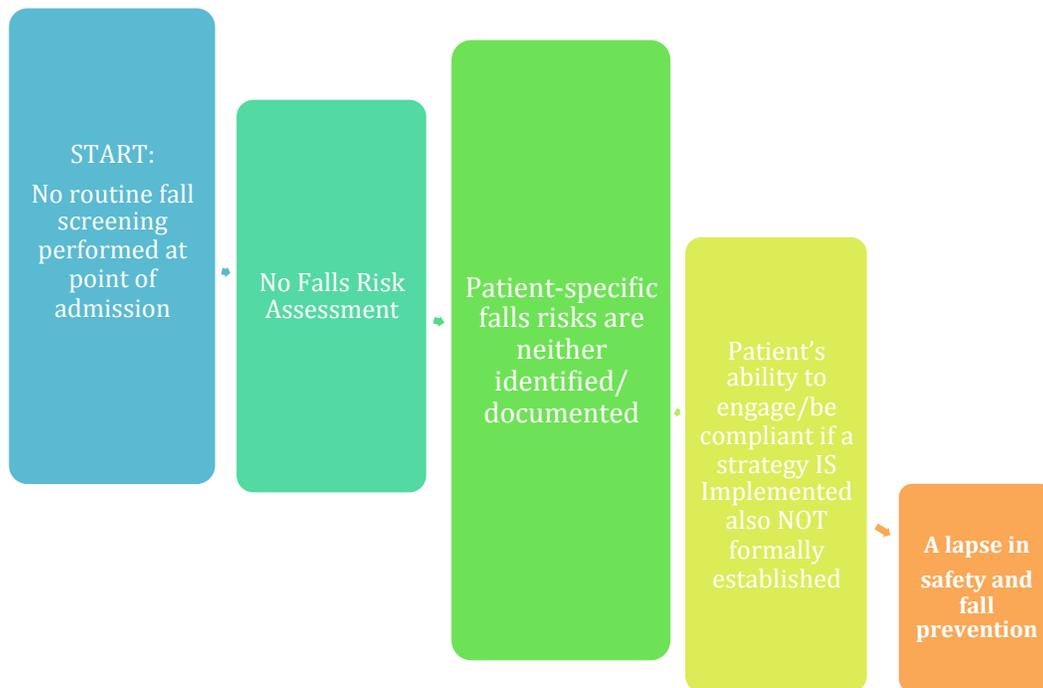
Appendix C

SWOT Analysis



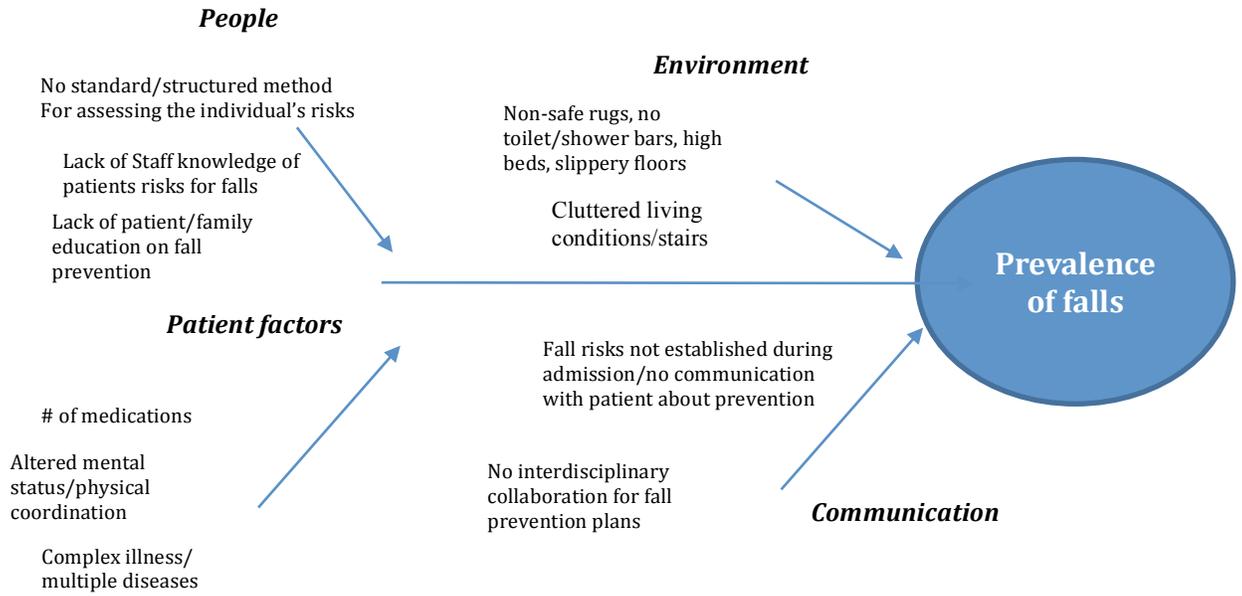
Appendix D

Process Map



Appendix E

Root Cause Analysis Fishbone Diagram



Appendix F

Cost-benefit Analysis

Estimated Cost-Benefit Analysis for One Year

(Savings from prevention of patient injuries related to falls)

ITEM	Pilot Year 1 Cost
COSTS	\$257.60
BENEFITS	57,330
CBA	
NET BENEFIT	\$57,072
BENEFIT-COST RATIO	221.5

*Savings per fall-related injury are based on the data retrieved from The Joint Commission 2015.