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The Fall Free Zone

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Safety is the first of the six aims for improvement proposed by the Institute of Medicine. Its importance could not be minimized if every healthcare organization aims to provide high quality care for all patients every time (Institute of Medicine [IOM], 2001). As appalling as it is fact, inpatient falls are widespread preventable safety issues among hospitals. In the U.S., it is estimated that 700,000 to 1 million people fall in hospitals, and 30 to 35 percent of these falls cause either an injury or a fatality (Hospitals in Pursuit of Excellence [HPOE], 2016). Reducing falls in hospitals can contribute to improving healthcare by maintaining safety, supporting patient centeredness through individualized care plans, providing quality care by increased staff responsiveness and accuracy in assessments. Through fall initiatives, efficiency in care is promoted through effective communication and delegation of tasks involving safety throughout operations. Keeping patients safe and injury free can lower costs through shorter length of stays and avoidance of unnecessary procedures (HPOE, 2016).

Abstract

The fall prevention project is designed to decrease fall rates in the medical-surgical units by promoting accuracy in identifying fall risk patients and engaging patients in participating with their own safety. The project will follow Kotter's change model to address the urgent need for reducing fall rates (Webster & Webster, 2018). A falls taskforce committee is already in place pursuing the goal mentioned. Engaging the staff members and leaders will be accomplished through reeducation of policies and procedures, admission process and the accurate use of the SCHMID Assessment Tool. These will take place during staff meetings, huddles and roving learning cart. Unit champions will be assigned in each unit to help reinforce information and process changes. A continuous evaluation will be recorded through risk management chart

audits and environmental checks that will be done by the risk manager and unit leaders respectively. All actions will be geared towards increasing awareness of the importance of accurate documentation and collaboration of all staff members, leadership and patients towards achieving a culture of patient safety (HPOE, 2016).

Problem Description

In the year 2018, KF Hospital experienced 41 patient falls which mostly occurred in the medical/surgical units. Eight of these patients sustained minor injuries ranging from small scratches and bruising to soreness to affected areas. However, one patient fall resulted to a major injury wherein the patient sustained a fracture on his forearm requiring surgical procedure. This patient stayed additional 7 days in the hospital.

Many factors were noted to influence these falls. They can be intrinsic which are innate to the patients including patient mentation, medication side effects and gender. They can also be extrinsic factors such as environmental hazards, hesitance of patients to ask for help, low staffing, and most important is the high inaccuracy in patient fall risk identification. Among the 41 patients who fell last year, only 6 patients were accurately scored under the SCHMID Assessment Tool. These factors necessitated the need for revisiting fall prevention protocols and improve care processes where needed. The high fall rate had economic impact not only to patients who had to stay longer but to the organization as well. They also contribute to decreased staff satisfaction since some felt guilt after every patient fall. The multiple falls reflect a discord from the organization's mission of providing affordable high-quality health care and unit leaders are sensing the pressure of resolving this important patient safety matter.

Available Knowledge

Fall prevention is a well-studied healthcare issue. Multiple studies were conducted to find the best and most effective ways of preventing falls in the hospital setting. This fall prevention project aims to address how a multimodal approach compared to solely using fall assessment tools can help reduce falls among patients in the medical/surgical units.

A review of multiple studies on fall reduction and prevention, discovered that fall screening tools are quite limited and solely relying on their accuracy may not assist in lowering fall rates (Oliver, Healey, & Haines, 2010). Since multiple factors can influence fall risks among patients, it is imperative that an accurate assessment of these risks is done from admission to patient discharge to ensure patients stay injury free (Lee, Lee, & Khang, 2013). Through this consideration, patient care plans must be individualized and reviewed frequently as patient conditions may change. Additionally, an individualized care plan will not only require individualized care but a corresponding safety approach to meet patient needs to stay injury free (Oliver et al., 2010). A study conducted by Bouldin, et. al, (2013), showed that falls prevention is multifactorial and must be managed with a multimodal approach. A study also demonstrated the importance of utilizing patient information in improving safety management of every patient based on their reviewed risk factors (Dykes et al., 2010).

Rationale

This project involves reinforcement of protocols and guidelines that are already in place. However, some changes in processes may be needed to enhance patient experience and safety. These include a patient information flyer that will be placed in every room. The flyer contains information on unit routines and elements of motivation to encourage them to ask for help whenever they need to get out of bed. Toilet sensor alarms will also be piloted in one of the

units. An education board that will reinforce the fall prevention policy will be placed in each

unit as well.

All efforts in this project are formulated under Kotter's 8-step Change Model. A

committee was formed late 2018 in response to the urgency to resolve the high fall rate. The

committee is now on the communication phase wherein staff members are being informed of the

possible changes. At this phase, the committee realized how receptive staff members are for

change. Communicating the goals and planned interventions to staff members can encourage

feedback of what may or may not work in the font-liners' views (Webster & Webster, 2018).

Furthermore, while following Kotter's Change Model, consistency with a multimodal approach

is being followed through. As each planned intervention is introduced to each unit, an

educational plan for staff orientation will be an ongoing process as each patient risk is assessed

accurately and individualized accordingly (Oliver et al., 2010).

Specific Project Aim

The goal of this project is to drop fall rates to at least meet the regional goal of 1.72 per

1000 patient days by end of 2019. However, the global aim for this project is to improve the

process of identifying fall risk patients and to eventually prevent falls. The process will begin

from accurately identifying patients who are at risk for fall and ends with safe patient discharge.

The expectations include improved accuracy in identifying patient with high fall risk, improved

documentation of fall risk assessments and increased patient awareness and participation in fall

prevention measures.

Context

After a microsystem assessment was conducted, interventions were consequently

formulated according to findings. Data obtained from the previous falls, helped identify points

of weakness and strength. Opportunities for improvement were recognized and efforts were targeted towards improvement needs. Costs of each intervention was analyzed and presented to leadership for approval. Dissemination strategies were started and evaluated for effectiveness. Communicating plans was challenging since timing is crucial in capturing as many staff members as possible. Leadership involvement was solicited through invitations to meetings and presentations to gain support during dissemination (Bourassa, 2016). Through deliberation of data, considerable elements were determined to ensure success of all efforts.

Intervention

The committee members include, a risk manager, a clinical practice consultant, a medical/surgical unit nurse manager, registered nurses and nursing assistants. On the initial meeting, the risk manager presented data to all members. Included in the presentation were accuracy in assessment, activities prior to fall, gender, patients on anticonvulsants, level of care, unit, shift and patient refusal to care (per Casie Coles, September 2, 2018). From the data presented, the following interventions were formulated including; identical education boards for each unit, roving cart for introduction of interventions and education, a reusable flyer that is intended to inform patients of their fall risks and to engage partnership with patient in regards to their safety, use of toilet alarms, development of new magnetic fall signs, improved care boards that will include information on previous falls and mobilization needs. Staff education on accurate documentation of SCHMID Assessment Tool and reorientation to the Fall Prevention Policy.

The first dissemination strategy is the roving cart with the educational materials. Leaders were requested to gather staff and show the importance of the information they are about to see and hear. Attendees were asked to sign for attestation of receiving the information. The purpose

is to promote participation through active listening and to gain feedback (King, 2016). Staff in

the piloting unit were provided an in-service on the use of toilet alarms. The sensors are per

patient use and must be changed after each patient discharge. A site visitation was proposed to

compare processes with another facility of the same size and demographics which is doing better

with fall prevention. The patient information flyer is undergoing proof reading for compliance

with organizational standards currently. The case manager and clinical practice specialist

oversee collection of data and scheduling of the teams' activities. The educational processes are

handled by the frontline staff as unit champions along with their respective unit managers. The

request for medication review to pharmacy will be emphasized as part of the fall prevention

policy that is rarely followed.

Measures

Measures that will be used to evaluate process changes and outcomes will be done by the

case manager through chart audits and post fall documentations. Audits help determine

improvement in the accuracy of assessment through SCHMID Assessment tool documentation

and adherence to individualized care planning. Post fall debriefing helps analyze factors that

influenced a fall event which can help in preventing reoccurrence of falls. The question and

answer during educational cart roving, facilitates learning and real time feedback from staff.

This can be measured through sign-up sheets which determines number of attendees and

hopefully will reflect in the accuracy checks. Effective patient education can be measured

through leadership rounding to ensure they were provided the education and unit orientation.

Medication reviews will be measured through quantity of pharmacy responses to medication

review requests. This important role of the pharmacist determines how patients respond to

specific medication side effects that can be influenced by many factors such as age,

comorbidities and underlying diagnoses.

Ethical Considerations

No ethical violations such as breach in privacy and autonomy were involved in this

project. No potential conflicts of interest were noted among members involved in this project.

Results

As the implementation stage of this project continues, the facility met target for the

month of February and more staff members are becoming aware of the importance of accurate

assessment. SCHMID scores are at a higher accuracy. However, patient participation is still an

ongoing issue. Patient resistance to calling for help is truly a challenge, especially among male

patients.

Some challenges were met during the launching of the educational roving cart. The unit

champions find it difficult to gather staff members during any shift since patient needs take

precedence of the nurses' attention. Leadership rounding is difficult since assistant nurse

managers have other duties to perform such as staffing, service recovery, project meetings and

scheduling. Printing the trifold brochure seems costly and no specific person was assigned to

print them. Reproducing the magnetic door signages was also problematic since we were relying

on volunteers to print them to cut costs. These issues were addressed on the next PDSA cycle

(Plan, Do, Study, Act; Please see Appendix I). The roving educational cart continued to be

rolled out with question and answers along with some giveaways. This caught more attention

from staff members, and they were more willing to provide feedback with some incentives.

Leaders were urged to integrate the education board with their shift huddles to ensure all that is

present will be introduced to it. The committee decided to fit laminated versions of the trifold

brochure into stationary acrylic holders in every room. The process will be the same. The

laminated brochure will be handed out to patients during admission as they are being oriented to

unit routines. Reminder signs were also placed in each room. Upper management was placing

pressure to resolve the matter of high fall rates and mandated a sister site visit to compare fall

prevention efforts. This was conducted by committee members, educators and risk managers.

Efforts at this time are mainly geared towards removing barriers to the steps being taken as more

options are being investigated.

     The committee is currently exploring other concepts on engaging patients to participate

in their own safety while in the hospital. Moreover, the committee decided to continue present

modalities being used until further steps can be taken (Please refer to Appendix F). The sister

site visitation revealed approaches to fall prevention that may possibly work for our facility

including, color-coded gowns, larger signs, leadership rounding, toilet alarms in each room and a

more robust staff education on safety. As we continue upholding patient safety, we also urge all

stakeholders including frontline staff, leaders, patients and their families to join us in keeping

everyone safe and injury free.

Discussion

So far, the steps taken in the fall prevention project focus on staff and patient

engagement. Accurate patient risk assessment for fall is highly dependent on the frontline

nurses. Fall risk assessments drive delegation of tasks, individualization of care plans, patient

identification, education and evaluation high risk medications. In the absence of accurate fall

risk assessment patients are placed in higher safety risk. On the other hand, patient engagement

is equally important since nurses rely on patient history of falls and medication reconciliation for

sound decision making as well. If patients fail to communicate previous history of falls or

potential for fall, their SCHMID score would already be inaccurate from the very beginning.

These two issues are the main challenges that the committee is facing. Unless staff and patient

engagements are acquired, more patients are at risk of falling during hospitalization. Therefore,

for the project to be successful, a more robust education for both staff members and patients is

essential to increase awareness and adherence to fall prevention protocol.

Conclusion

Patient falls are a major issue among hospitals. A fall is harmful not only to patients but

also to the caregivers and to the organizations as well (Krupp et.al, 2016). The tools used for this

project are simple, cost-effective, user friendly and may be applied to any hospital. The success

of this project does not depend on their usefulness but to their utilization by all stakeholders

including nurses and patients. Incorporating these tools into the nursing practice that are already

in place may find success for this project. Based on the studies that were used as evidences, no

sole modality is found effective in fall prevention. It is the combination of multiple approaches

that deal with possible influencing factors that is found to be more promising (HPOE, 2016).

During the initial stages of this project, factors affecting fall risks were dissected and studied that

led to the formulation of steps taken. However, obtaining adherence from caregivers and

patients is the posing challenge. Therefore, further involvement of staff members and patients is

a must in sustaining an effective fall prevention program.

References (With Annotation)

Bouldin, E. D., Andersen, E. M., Dunton, N. E., Simon, M., Waters, T. M., Liu, M., ...

Shorr, R. I. (2013, March). Falls among adult patients hospitalized in the United

States: Prevalence and trends. *NIH Public Access*, *9*(1), 13-17.

https://doi.org/10.1097/PTS.0b013e3182699b64

This article is about a study conducted to evaluate the influence of CMS reimbursement

on costs incurred from preventable injuries. Using data obtained from the National

Database of Nursing Quality Indicators made this study reliable and valid. The study

concluded that since Medicare stopped reimbursing for these costs, there was a statistical

decline in falls among hospitalized patients.

Bourassa, D. M. (2016). Interdisciplinary communication and collaboration skills. In S. O.

Gerard & C. R. King (Eds.), *Clinical nurse leader: Certification review* (2nd ed., pp. 43-

53). New York, NY: Springer Publishing Company, LLC.

Dykes, P., Carroll, D. L., Hurley, A., Lipsitz, S., Benoit, A., Chang, F., ... Middleton, B.

(2010, November 3). Fall prevention in acute care hospitals: A randomized trial.

Journal of American Medical Association, *304*(17), 1912-1918.

https://doi.org/10.1001/jama.2010.1567

This study was conducted to determine if health information technology can be used to

aid in generating fall prevention tools to accurately identify high risk patients which

included educational materials, care plans and communication alerts to all stakeholders to

raise awareness of patient risks. This cluster randomized study was performed in 4 urban

hospital. The study was rigorous enough to conclude that use of health information

technology reduced fall rates in participating hospitals per 1000 days.

Hospitals in Pursuit of Excellence. (2016). *Preventing patient falls: A systematic approach*

from the Joint Commission Center for Transforming Healthcare project. **Retrieved**

from http://www.hpoe.org/Reports-HPOE/2016/preventing-patient-falls.pdf

This article is about a collaboration among five hospitals that pooled together data that

identified and validated root causes of falls in multiple hospital settings that led to

determining appropriate interventions that helped decrease fall rates. The process

improvement incorporated concepts from Lean Six Sigma to uncover contributing factors

to falls. The limitations to this project included age and length of stay. However, the

study was robust enough to produce positive outcomes.

Institute of Medicine. (2001). *Crossing the quality chasm: A new health system for the 21st*

century. Washington D.C.: National Academy Press.

King, C. R. (2016). Integration of the clinical nurse leader role. In C. R. King & S. O. Gerard

(Eds.), *Clinical nurse leader: Certification review* (2nd ed., pp. 61-70). New York, NY:

Springer Publishing Company, LLC.

Krupp, A., King, B., Liebzeit, D., Mahoney, J., & Pecanac, K. (2016, December 23). Impact

of fall prevention on nurses and care of fall risk patients. *The Gerontological Society*

of America, **58(2), 331-340. https://doi.org/10.1093/geront/gnw156**

This is a qualitative study conducted through interview of nurses and nursing assistant

that explored their experiences with fall prevention in their facility and its impact on how

they provide care for high fall risk patients. This study revealed that intense

administrative messaging about falls can have significant impact on nurses emotionally.

Caregivers resorted to restricting patients to meet hospital goals.

Lee, A., Lee, K., & Khang, P. (2013). Preventing fall in the geriatric population. *The*

   *Permanente Journal***,** *17***(4), 37-39. https://doi.org/10.7812/TPP/12-119**

   This non-research article discussed the importance of accurate use fall screening tools

   and the required interventions following identification of high-risk patients. The authors

   recommended a multifactorial intervention program and the involvement of physicians

   and other team members in assisting with fall rate reduction in hospitals.

Oliver, D., Healey, F., & Haines, T. P. (2010). Preventing falls and fall-related injuries in

   hospitals. *Clinical Geriatric Medicine***,** *26***, 645-692.**

   https://doi.org/10.1016/j.cger.2010.06.005

   This article reiterated the importance of multifactorial fall prevention programs. The

   authors argued that there is currently no single fall prevention intervention is beneficial to

   hospitals since randomized trials and studies may involve less of the mentally challenged

   participants. They also illustrated that relying solely on predictive or screening tools is

   not enough in determining fall risk. The authors posed organizational interventions and

   clinical interventions for fall prevention as well.

Webster, V., & Webster, M. (2018). Successful change management-Kotter's 8-step change

   model. *Leadership Thoughts***. Retrieved from**

   https://www.leadershipthoughts.com/kotters-8-step-change-model/

   This article showed how Kotter's 8-step change model is used for process improvement

   initiatives and to sustain outcomes. It included examples and illustrations that are useful

   for determining which step to take next and how.

Appendix A

SWOT Analysis

S
- SCHMID tool
- Hourly rounding
- Staff acknowledgment of the problem
- Involvement of leaders
- Toilet alarms

W
- Focus on confused patients
- Inaccurate assessment
- Patient resistance
- Inaccurate rounding; inconsistent with the 3Ps

O
- Accurate documentation
- Accurate rounding; ask the 3 Ps
- Pharmacy review requests
- Patient education to ask for help

T
- Quiet at night may conflict with fall initiatives
- Staffing issues (sick calls and sitter utilization)
- Medications not required for review (diuretics and laxatives

Appendix B

Fishbone Diagram

Process		Staff

Incomplete history taking on admission

Inaccurate assessment of fall risks

Inaccurate SCHMID scoring

Lack of knowledge of fall prevention policies

Medication review by pharmacy not always done

Focus on confused patients and elderly

Inconsistent bed/toilet alarm use

High Fall Rate

Resistance to help

Staff dissatisfaction

Lack of participation

Staffing shortages/issues

Refusal of treatment

Ineffective staff education

Diagnoses and co-morbidities

Incomplete post-fall debriefing

Medication side effects

Low rounding frequency

Patient

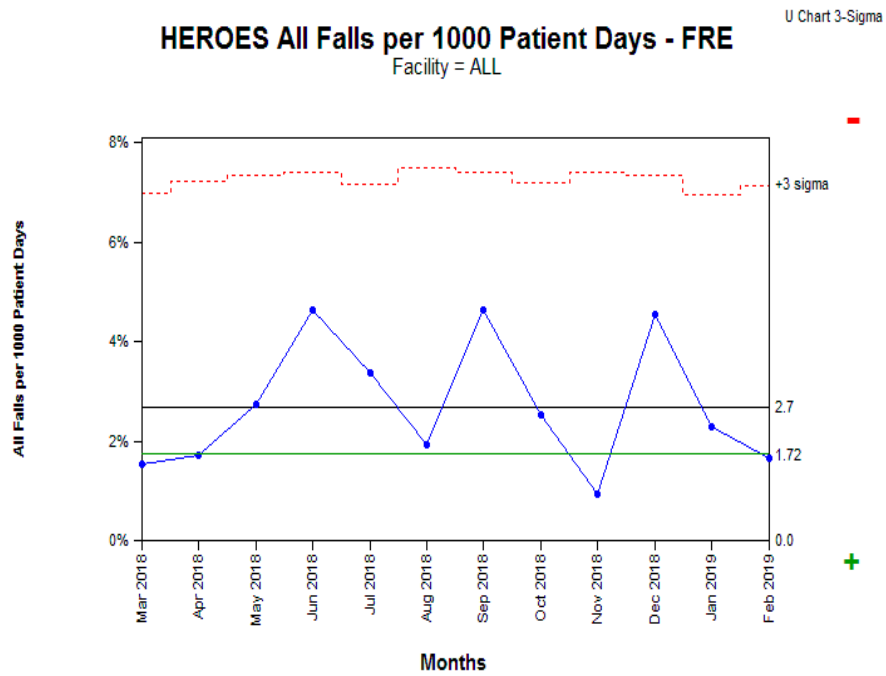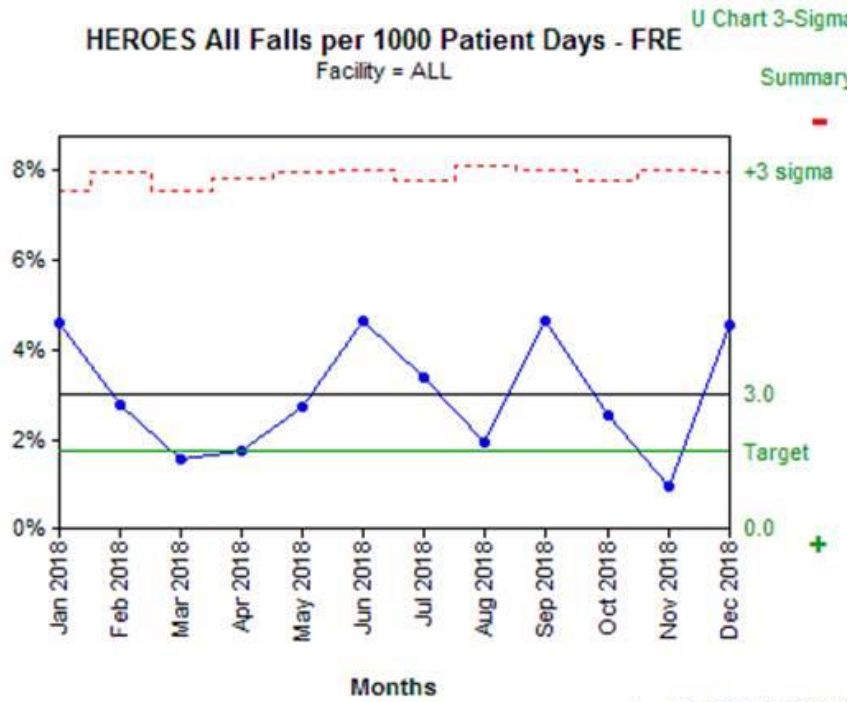**Management**

Appendix C

I. **Fall Trends**

2018 = 41 Inpatient Falls
 2S = 34%, **1S** = 32%, **2N** =27%, **Other** = 7%
8 minor injury, 1 major injury

- 93% (38/41) - Medical patients
- 66% (27/41) - Male
- 50% of females who fell were 50 or younger
- 86% (25/29) - Rounding occurred w/in 60 minutes of fall (excludes assisted falls, sitter pts, etc.)
- 46% (19/41) - Within first 24 hours on unit
- 15% (6/40) - ICU stay prior to fall
- 66% (27/41) - Related to toileting
- 96% (26/27) - Toileting falls alert & oriented pts
- 80% (33/41) - Alert & oriented at time of fall
- 83% (34/41) - Independent PTA
- 15% (6/41) - Accurate Schmid score pre-post fall
- 51% (21/41) - Apparent fall documented
- 5% (2/41) - Patient with assigned sitter
- 76% (31/41) - Day Shift
- 49% (20/41) - High risk medication w/in 8hrs
- 65% (13/20) - Anticonvulsants
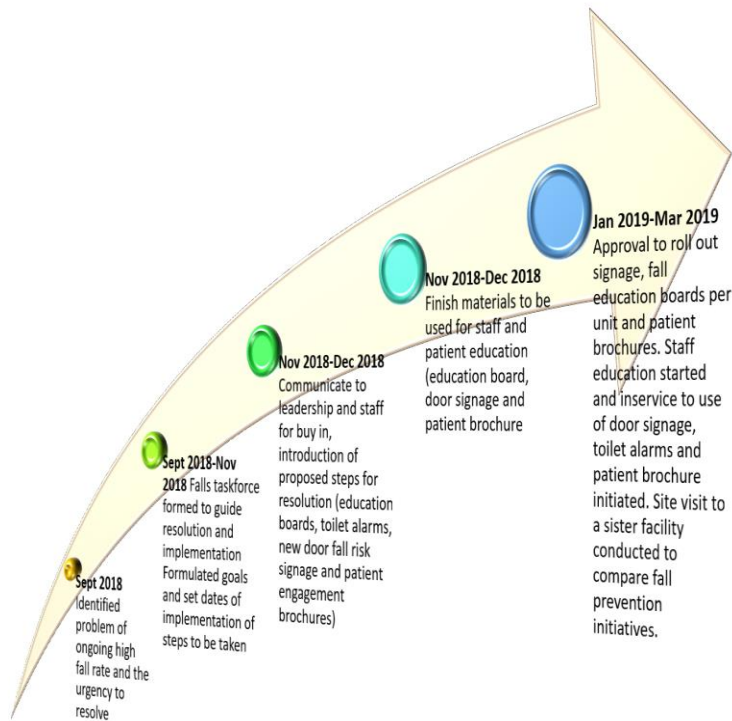- 93% (38/41) Post fall huddle conducted

II. Run Charts

HEROES All Falls per 1000 Patient Days - FRE
Facility = ALL
U Chart 3-Sigma

HEROES All Falls per 1000 Patient Days - FRE
Facility = ALL
U Chart 3-Sigma

Appendix D

Change Model/Timeline

Kotter's 8 Step Model

Source: http://www.kotterinternational.com/the-8-step-process-for-leading-change/

Sept 2018 Identified problem of ongoing high fall rate and the urgency to resolve

Sept 2018-Nov 2018 Falls taskforce formed to guide resolution and implementation Formulated goals and set dates of implementation of steps to be taken

Nov 2018-Dec 2018 Communicate to leadership and staff for buy in, introduction of proposed steps for resolution (education boards, toilet alarms, new door fall risk signage and patient engagement brochures)

Nov 2018-Dec 2018 Finish materials to be used for staff and patient education (education board, door signage and patient brochure

Jan 2019-Mar 2019 Approval to roll out signage, fall education boards per unit and patient brochures. Staff education started and inservice to use of door signage, toilet alarms and patient brochure initiated. Site visit to a sister facility conducted to compare fall prevention initiatives.

Appendix E

Cost Benefit Analysis Table

	#of Staff RN	Hourly rate	# of meetings per month			Total Cost for 1 Year
Committee Meetings	4	$90	2			$8640
Supplies						
1. Education boards						$210
2. Acrylic sign holders						$380
3. Magnetic door signs						$38
Toilet Alarms 6(Pilot in 6 rooms at 2S) Alarms are free, Sensors costs $15 each 6 pts. X 2.33 sensors = approx. 14 sensors/per week=$840/mo. x 12 mos.						$10080
Laminated Prints of brochures						$57
Total Cost of Preventive Measures						**$19,405**
	# of Falls 2018	Cost incurred each day post fall (approx. 7 days)	Cost of surgery post injury from fall			
	41	$13000 x7=$91000 $91000x41= $3.73M	$14000x41= $574000			
Total Possible Cost of Falls		$3.73M	$574000			**($4,304,000)**
Total Possible Savings						**($4,284,595)**

Appendix F

Materials Used

I.   **Staff Education Board and Reminder Signs**

II. Patient Engagement Brochure

This Photo by Unknown Author is licensed under CC BY-SA-NC
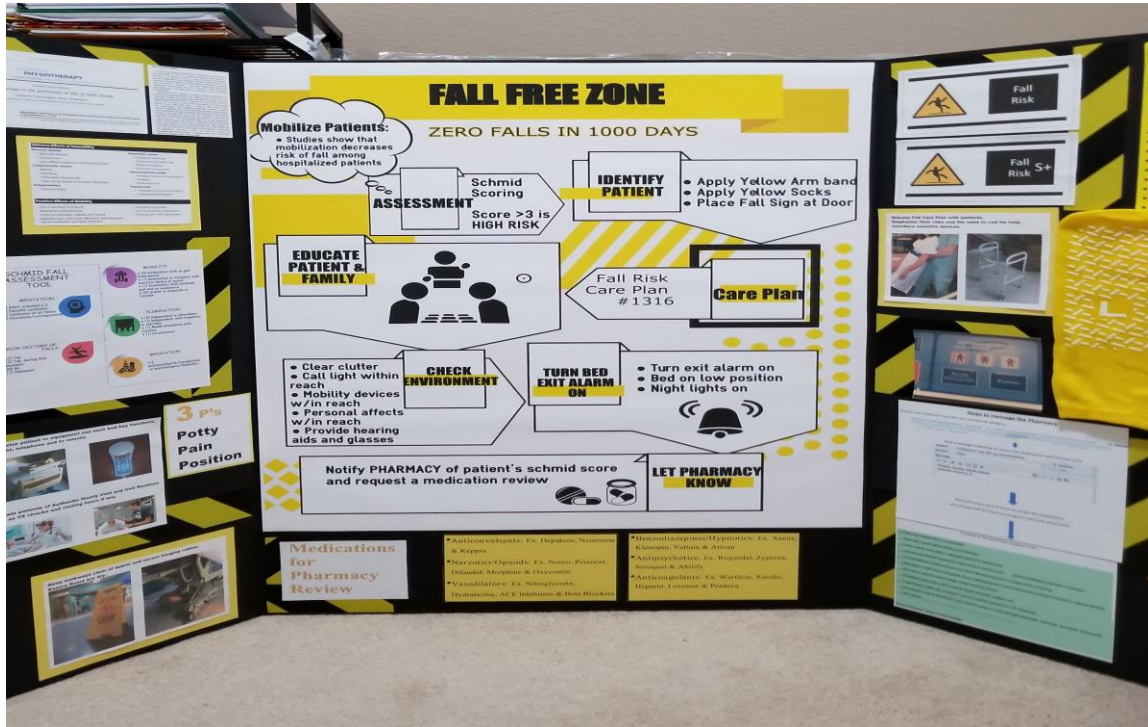
Our Goal is your SAFETY!!! Help us to keep you SAFE.

We encourage our patients to actively participate not only in their quick recovery but also in their own SAFETY.

Please let us know of previous history of falls, home medications or remedies that you are taking and other preferences to keep your environment more familiar. AND most importantly...PLEASE CALL FOR ASSISTANCE before getting out of bed.

FOR QUESTIONS ON OUR FALL PREVENTION PROGRAM PLEASE DO NOT HESITATE TO ASK YOUR NURSE, PATIENT CARE TECHNICIAN, OR ANY STAFF MEMBER.

LET US KEEP YOU SAFE

JUST CALL, DON'T FALL!!!

This Photo by Unknown Author is licensed under CC BY

DO YOU KNOW?

All patients of **ANY AGE** are at high risk for falls in hospitals. According to the Agency of Healthcare Research and Quality (AHRQ), between 700,000 and 1M people in the US fall in the hospital. Among these falls, 30-50 percent result to injury (The Joint Commission, 2015).

Patient risks may include but not limited to:

1. Unfamiliar environment
2. Medication side effects
3. Post procedure restrictions
4. Pain
5. Diagnoses (Stroke, Respiratory disease, low blood pressure and many others that may influence balance, mobility and sensory)
6. History of Falls

"Don't be shy. WE ARE HERE TO HELP YOU".

Help us KEEP YOU SAFE. Please call for assistance before:

1. Getting out of bed
2. Reaching for objects
3. Getting dressed
4. Going to the restroom or to the bedside commode

This Photo by Unknown Author is licensed under CC BY-ND

JUST CALL, DON'T FALL!!!

It is our priority **TO KEEP YOU SAFE.** Our Fall Prevention Program includes:

1. Hourly Rounding
2. Room and unit orientation during admission.
3. Call light responsiveness
4. Bed exit alarms
5. Medication Side Effects communication with patients and families
6. Early Ambulation and strengthening exercises

Appendix G

IRB Non-Research Determination Form

EVIDENCE-BASED CHANGE OF PRACTICE PROJECT

CHECKLIST *

STUDENT NAME: Brendalyn Malimban_____

DATE: February 17, 2019 _____.

SUPERVISING FACULTY: Dr. Robin Jackson _____.

Instructions: Answer YES or NO to each of the following statements:

Project Title: Preventing Falls through Change	YES	NO
The aim of the project is to improve the process or delivery of care with established/ accepted standards, or to implement evidence-based change. There is no intention of using the data for research purposes.	x	
The specific aim is to improve performance on a specific service or program and is **a part of usual care**. ALL participants will receive standard of care.	x	
The project is **NOT** designed to follow a research design, e.g., hypothesis testing or group comparison, randomization, control groups, prospective comparison groups, cross-sectional, case control). The project does **NOT** follow a protocol that overrides clinical decision-making.	x	
The project involves implementation of established and tested quality standards and/or systematic monitoring, assessment or evaluation of the organization to ensure that existing quality standards are being met. The project does **NOT** develop paradigms or untested methods or new untested standards.	x	
The project involves implementation of care practices and interventions that are consensus-based or evidence-based. The project does **NOT** seek to test an intervention that is beyond current science and experience.	x	
The project is conducted by staff where the project will take place and involves staff who are working at an agency that has an agreement with USF SONHP.	x	
The project has **NO** funding from federal agencies or research-focused organizations and is not receiving funding for implementation research.	x	
The agency or clinical practice unit agrees that this is a project that will be implemented to improve the process or delivery of care, i.e., **not** a personal research project that is dependent upon the voluntary participation of colleagues, students and/ or patients.	x	
If there is an intent to, or possibility of publishing your work, you and supervising faculty and the agency oversight committee are comfortable with the following statement in your methods section: *"This project was undertaken as an Evidence-based change of practice project at X hospital or agency and as such was not formally supervised by the Institutional Review Board."*	x	

ANSWER KEY: If the answer to **ALL** these items is yes, the project can be considered an Evidence-based activity that does NOT meet the definition of research. IRB review is not required. Keep a copy of this checklist in your files. If the answer to ANY of these questions is **NO**, you must submit for IRB approval.

Appendix H

Charter

Aim

1. The goal of the project is to reduce falls rate by accurate identification of high fall risk patients through accurate use and documentation of SCHMID scoring tool.

2. Another goal is to increase patient engagement to fall prevention initiatives for their safety through education and accurate history taking during admission.

Background

1. KF Hospital had a total of 41 falls hospital wide in the year 2018.

2. One fall event resulted to an injury with which the patient required surgery. This increased the risk of the patient for complications as well.

3. KF Hospital has the highest number of falls in comparison among 21 regional facilities in the Northern California region with a falls rate of 3.2 per 1000 patient days.

Measures

1. Continuous evaluation will be done by risk management through chart audits of SCHMID scoring.

2. Environmental checks will be conducted by assistant nurse managers to reinforce adherence to bed/toilet alarm activation.

3. Staff signature for attendance to educational huddles and roving carts during less busier times of their shifts.

4. Monthly fall rate calculation by risk manager to determine if goal is reached.

Driver Diagram
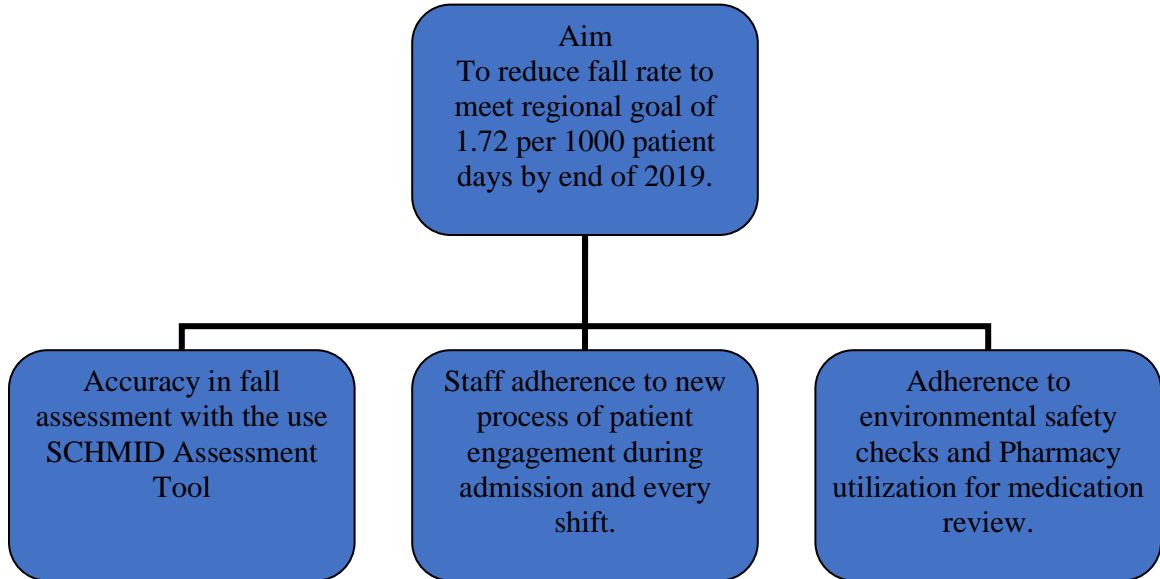
Measurement Strategy

1. Risk Manager will perform random chart audits for each unit daily.

2. Assistant nurse managers will conduct environmental checks for bed/toilet alarms, yellow bands, yellow socks and door signages daily.

Sponsors

1. HEROES Chief for KF Hospital

2. Adult Service Director
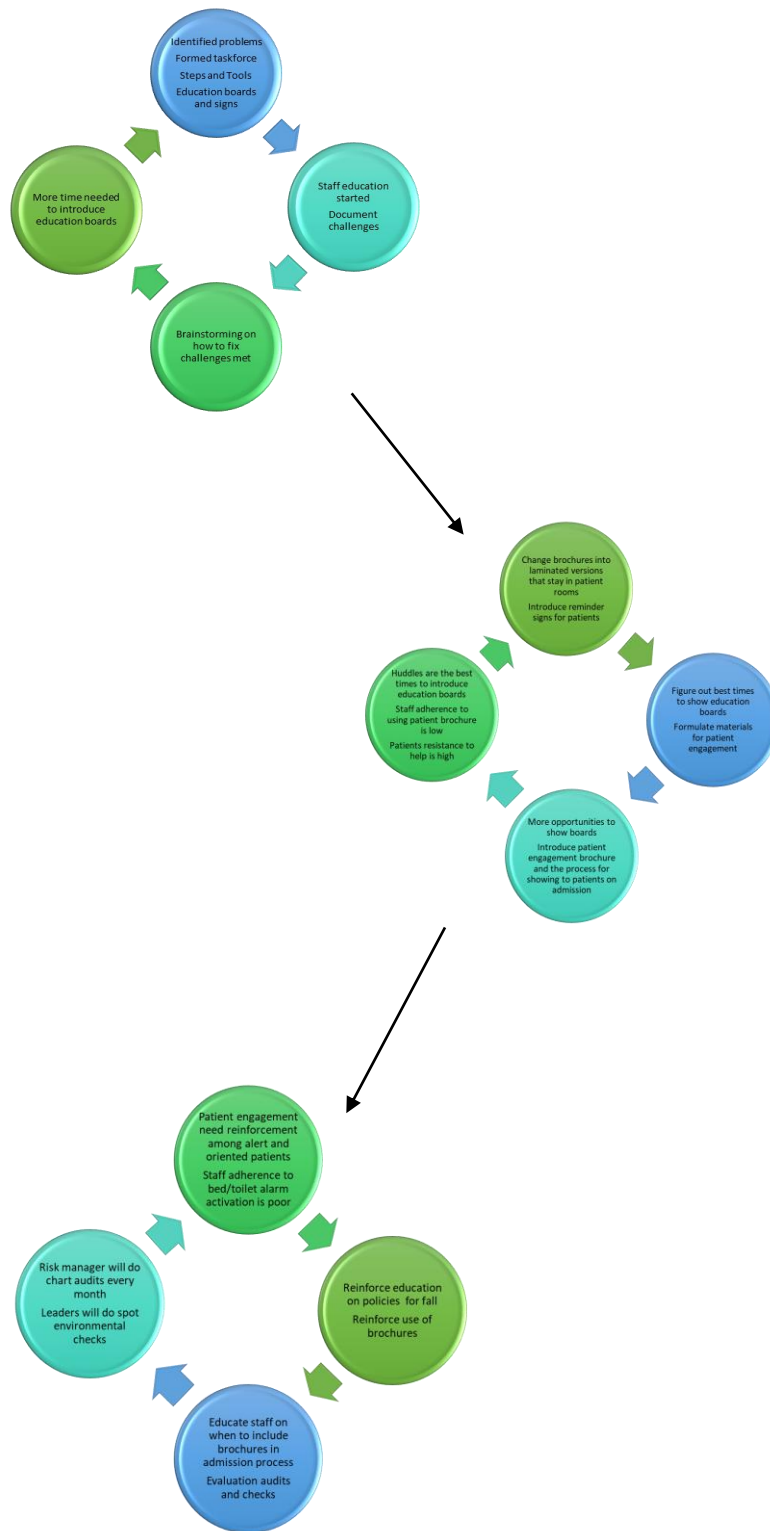
3. Clinical Practice Consultant

Team Members

1. Frontline RNs from each unit

2. Patient Care Technicians

3. Risk Manager

Timeline (Please refer to Appendix D)

Appendix I

PDSA Cycle

Appendix J

Sample questions during huddles and roving visits with education board to obtain feedback.

1.   When do you request pharmacy to review patient medications?

2.   What are the things included in the SCHMID scoring tool?

3.   What are the 3Ps of hourly rounding?

4.   When do you provide the patient engagement brochure to patients?

5.   How do we identify fall risk patients?