

IMPLEMENTATION OF THE FALL ROUND CHECKLIST IN HOSPITALIZED ADULT
PATIENTS

By

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Abstract

Background: One million inpatient falls occurs in U.S hospitals annually, with medical units incurring the highest fall rates. In fiscal year 2018, 325 falls occurred in patients at high risk for falls at a local academic hospital. One hundred and forty-eight or 46% were found to have gaps in fall prevention practices at the time of fall. As costs associated with falls are no longer reimbursed by the Centers for Medicare and Medicaid, the organization's goal was to improve fall prevention practices in low performing units. Clinical audits on falls have been found to directly measure fall prevention practices by assessing nursing compliance.

Methods: This Doctorate of Nursing Practice project was implemented over a 14 week period. Data was collected while conducting an electronic health record audit and direct bedside observations using the "Fall Round Checklist" by the project leader and resource nurse participants. Percentages were used to evaluate nursing compliance with each item on the checklist from data entered into Excel.

Results: Eleven medical-surgical units were audited. Two hundred and fifty- five patients were identified as high risk for falls. Consistent fall prevention interventions were observed in fall risk assessment documentation (87%). Environmental measures (call bell in sight and within reach, bed in low position, table and personal items within reach, clutter free room) averaged 96% compliance. Lack of consistency was noted with documentation of fall interventions (41%), turning the bed alarm on (46%), yellow armbands (50%), or supervision with toileting (41%).

Conclusion: Successful implementation of the "Fall Round Checklist" identified gaps in practice that will assist the organization in improving fall prevention practices in low performing units through corrective actions of care processes, thus ensuring safe and quality care.

Introduction, Background, and Significance of the Problem

Falls are unexpected and unintentional events that result in patients' descent to the floor or any other surface (Healey & Darowski, 2012; Health Research & Educational Trust, 2016; Hill & Fauerbach, 2014). Fall injuries, minor or severe, increase hospital cost, length of stay, and liability risks (Bouldin, et al., 2013; Coussement, et al., 2008). An estimated one million patient falls occur in U.S hospitals annually (Aydin, Donaldson, & Aronow, 2015; Health Research & Educational Trust, 2016). Each single fall results in an average cost of \$13,316.20 annually (Bouldin, et al., 2013; Leone & Adams, 2016). Medical units were found to incur the highest fall rates leading to serious patient safety concerns (Godlock, Christiansen, & Feider, 2016). Successful implementation of fall prevention clinical practice guidelines focused on standardizing nursing practice, promoting safe and quality care, and improving patient outcomes (Koh, Manias, Hutchinson, Donath, & Johnston, 2008). Unfortunately, fall events in inpatient settings continued to be attributed to gaps in fall prevention practices.

Audits have been used strategically to evaluate nursing practices. Clinical audits for fall prevention interventions were found to directly measure fall prevention practice by assessing nursing compliance with fall prevention measures and assisting leadership in developing corrective actions to improve fall prevention and management (Menzel & Thirumalai, 2010). In fiscal year (FY) 2018, 325 falls occurred in high fall risk patients at a large academic medical center. Of the 325 patients, 46% (148) did not have fall prevention interventions in place at time of fall. As costs associated with falls are no longer reimbursed by the Centers for Medicare and Medicaid, the organization FY 2018 goal was to improve fall prevention practices in low performing units.

Purpose Statement

Due to inconsistent fall prevention practices and to meet organizational goals for improved performance, the purpose of this Doctor in Nursing Practice (DNP) project was to implement a “Fall Round Checklist”. The “Fall Round Checklist” was designed to work in tandem with the organization published a nursing clinical practice guideline titled “*Prevention of Falls among Hospitalized Adult Patients*”. The guideline outlined key evidence-based fall prevention interventions to support nursing care and practices for the management and prevention of patient falls (Brown, 2013). The checklist was designed to evaluate nursing compliance with standard fall prevention interventions on high fall risk adult patients in medical-surgical inpatient units of a Midatlantic Tertiary Center.

Short Term and Long Term Goals

The implementation of a “Fall Round Checklist” aimed to measure the degree of nursing compliance with various aspects of fall preventions. These aspects included documentation of fall risk assessment and fall prevention interventions as well as the implementation of standard fall prevention interventions outlined in the organization clinical practice guideline. Long term goals were to audit 85% of medical-surgical units for consistent implementation of fall prevention measures by keeping counts of participating units and calculating percentage of adherence. Short term goals were established by week segments. The goal was to audit 10% of the medical-surgical units by week two, 50% by week six, and 85% by the end of the implementation period.

Theoretical Framework

The Iowa Model of Evidence-Based Practice to Promote Quality Care is a model developed by nurses to facilitate implementation of evidence-based practice (Buckwalter, et al.,

2017). The model is widely used in the organization where the DNP project was implemented, thus the reason why the theoretical framework was selected for use in this DNP project. The model allows for the evaluation and infusion of research findings into patient care (Buckwalter, et al., 2017). The Iowa model (Appendix A) is a linear format which provides strategies that are straightforward and easy to follow in the implementation of a practice change (Buckwalter, et al., 2017).

Conforming to the framework outline, falls were identified as clinical safety events thus a clinical problem for the local academic center. The organization identified falls as one of the priority topics to address in FY 2018. Overall fall rates have been steady, but gaps in fall prevention practices have been attributed to increase fall rates in low performing units. A team of key stakeholders was identified to address the issue, namely the DNP project leader, the Chair of the Fall Committee, The Director of Nursing Research, the Nursing Council Review Committee, the Chief Nursing Executive, and the members of the Fall Committee that will serve as champions and participate in the proposed DNP project. Adhering to the theoretical framework format, a literature review and synthesis of fall prevention interventions and clinical audits was performed. The effectiveness of clinical audits in assessing nursing compliance with fall prevention interventions was reported in the literature. The decision was made by key team member to implement a practice change at the organization using the “Fall Round Checklist”.

Literature Review

The effectiveness of fall prevention interventions aimed at reducing falls to ensure and maintain patient safety in hospitalized patients was examined. Successful implementation of fall prevention practices continued to face barriers such as lack of staff and patient education, and, leadership failure to provide support or pilot-testing practices that will identify factors that

affects compliance (Ayton, et al., 2017). The selection or inclusion of evidence-based fall prevention interventions designed to measure fall prevention practices or nursing compliance were explored. Stephenson et al. (2016) discussed the use of clinical audit tools as evidence-based fall prevention methods to assess current practices and improve quality care. The role of champions in enabling practice change was also considered.

Analysis of the Literature

Established as an essential component to fall prevention, clinical audit tools allow for comparison of current clinical practices against standard predetermined evidence-based practices in order to identify areas that need improvement or reinforcement (Huntley, Crock, & Shiskowsky, 2016; Stephenson, et al., 2016). The clinical audit forms had included fall risk assessment, visual cues (color-coded armband, door signs), and environmental considerations (lighting, handrails, bedrails, low beds, clutter free room) (Albornos-Muñoz, et al., 2018; Dykes, et al., 2009; Spoelstra, Given, & Given, 2012). The use of the form aids in identifying barriers to implementation of clinical practice guidelines. Common barriers experienced in hospitals regarding the implementation of fall prevention interventions include: lack of knowledge or staff education, inadequate fall risk assessment, communication failures, lack of adherence to protocols, environmental concerns, and lack of equipment or resources (Albornos-Muñoz, et al., 2018; Dykes, Carroll, Hurley, Benoit, & Middleton, 2009; Stephenson, et al., 2016). As a result, several audit tools such as the modified Scripps Mercy Hospital Rounding Tool (Rounding Tool), among several others, have provided data that can be analyzed to assess the degree of nursing compliance with fall prevention interventions (Menzel & Thirumalai, 2010). One study reported an increase in mean compliance from 50.4% to 74.5% after audit results were used to

gain staff feedback, identify barriers to compliance, and develop corrective action plan (Stephenson, et al., 2016).

The Champion Attribute

Champions are viewed as great agents in enabling and driving practice change (Ayton, et al., 2017; Dykes, et al., 2010). Fall prevention intervention programs have used fall champions to guide, support, motivate, engage, and educate staff on current fall prevention strategies to help reduce fall rates (Ayton, et al., 2017; Godlock, et al., 2016). Champions are front-line employees with additional training and education (Rednak, 2015), who promote team cohesiveness through communication (Godlock, et al., 2016), and ensure patient safety by making sure appropriate fall prevention protocols are in place (Nedved, Chaudhry, Pilipczuk, & Shah, 2012). They are individuals who are knowledgeable about care processes, often reporting outcome data, and updating staff on practice changes or modifications (RAND Corporation, Boston University School of Public Health, & ECRI Institute, 2013).

Synthesis of the Literature

Preventing falls in hospitalized adult patients have consisted of multifactorial components targeting specific patient risk factors. Successful fall prevention interventions such as the fall risk assessment, visual cues or alerts, bed/chair alarms, safety rounds, staff or patient education, and postfall huddles have been found to effectively decrease fall and fall related injuries. However, inferring which interventions are mostly effective is difficult to ascertain as studies vary widely in terms of design methodology and reporting results (Coussement, et al., 2008; Spoelstra, et al, 2012). Engaging in just usual care is not enough to completely address the challenges surrounding fall preventions. Patient intrinsic characteristics such as comorbidities, cognitive impairment or physical limitations, and a very complex healthcare environment, have been found

to increase the risk of falling (Spoelstra, Given, & Given, 2012). The one size fits all fall prevention intervention program is an almost impossible strategy to reduce falls in hospitalized patients. Unit champions are seen as the driving force and change agent in promoting a culture of safety and preventing falls (Ayton, et al., 2017; Dykes, et al., 2010; Godlock, Christiansen, & Feider, 2016), thus supporting the implementation of a “Fall Round Checklist” to determine nursing compliance with fall prevention interventions.

Implementation Plan

Methods

The implementation of the “Fall Round Checklist” (Figure 3) was a practice change for medical-surgical units at a large academic medical center. This quality improvement (QI) project took place over a 14 week period. A working collaboration was formed with the Director of Nursing Research and the Chair of the Fall Committee to support the implementation of the “Fall Round Checklist” from development to implementation, following organization standards. As stated above, the checklist outlines fall prevention interventions of the organization clinical practice guidelines such as fall risk assessment, documentation of fall interventions in the EHR, visual cues (yellow socks, yellow armband), bed alarms, environmental safety measures (call bell in sight, bed in low position, items within reach, clutter free environment), and supervision with toileting. The project leader met with the Chair of the Fall Committee and communicated by email and text messages to stay up-to-date with any organizational changes. Inclusion criteria consisted of patients with a Morse Fall Score (MFS) of 45 or greater.

There were approximately 13 medical-surgical units identified. During a quick survey and review of the MFS report of these medical-surgical units, the average number of identified patients at risk for falls per shift was approximately 11. The project leader expected to audit 15 to

20 cases per week. The estimated number of cases was adjusted to 240. The rounding observations were conducted by the project leader while partnering with the resource nurses on the units audited. The resource nurses on the units were trained to retrieve the MFS report from the electronic health record (EHR) and to complete the “Fall Round Checklist” using the lesson plan (Table 1). The lesson plan (Table 1) is a step-by-step guide created by the project leader to train volunteer nurse participants in completing the “Fall Round Checklist”. The lesson plan was also written down in a one-page instructional sheet of paper for resource nurse participants to use as a guide in the absence of the project leader. The lesson plan outlines instructions on how to access the EHR and the MFS report, how to conduct the EHR and environmental audits, and how to introduce self to patient during bedside rounding.

After selecting a unit for audit and disclosing the project to the resource nurse on duty, same day training was provided on the following tasks: Access the EHR; print the MFS report to identify high fall risk patients; de-identify high fall risk patient information on the MFS report; and conduct fall rounds/direct observations using the checklist. The total number of patients identified as fall risk were split equally between the project leader and the resource nurse when conducting the rounding observations. The resource nurse shadowed the project leader in a patient room to learn how to conduct fall rounds or direct observations. In turn, the project leader observed the resource nurse conduct the fall round or direct observation on one or two patients for validation to effectively complete the round independently. The “Fall Round Checklist” form was collected at the end of the shift.

The project leader was supportive to nurse participants throughout the project implementation period and maintained open communication. Methods of communication such as email or text messages were established for nurse participants. Project implementation updates

were provided to the Chair of the Fall Committee and the Director of Nursing Research at week two, week six, and week ten. The project leader compiled data collected into an excel spreadsheet and generated a compliance report of each item found on the “Fall Round Checklist”. The Chair was responsible to communicate compliance data to Unit Directors of audited units. Feedback on the ease of using the “Fall Round Checklist” was obtained from nurse participants.

Data Collection

The “Fall Round Checklist” was the tool used to gather data on nursing compliance with standard fall prevention interventions. No patient information was collected on the form. The MFS report, used to identify high fall risk patients, was coded using alphabetical letters. The letters were assigned next to the patient name (Table 2). The letters, not the patient name, were reported on the checklist under “room #”. Participants conducting the fall rounds using the checklist were also not identified on the form. The completed checklist was collected at the end of the audit or the shift.

Data Analysis

The project leader reviewed completed “Fall Round Checklists” and generated a summary report of the aggregated unit data collected throughout the implementation period. Data was entered into a Microsoft Excel software and analyzed with descriptive statistics. Percentages were used to evaluate nursing compliance with each item on the checklist. Counts were used to calculate the total number of high fall risk patients as well as the total number of participants who conducted the fall rounds and completed the checklist. Compliance results were shared with the Chair of the Fall Committee who was responsible to communicate these results to Unit

Leaders in participating units. A final report of the project was provided to the Chair of the Fall Committee and the Director of Nursing Research.

Human Subjects Protection and IRB Approval Process

The proposal was submitted to the University IRB for Non-Human Subject Research and to the organization Institutional Review Board (IRB) where the DNP project was implemented. The determination finding was on Non-Human Subject Research from both organizations. The project leader received approval to implement the DNP project. Steps to protect patient's information during direct observations when using the "Fall Round Checklist" included replacing each identifier in the MFS report with letters next to the patient name, to enter the letter on the checklist to de-identify the patients, and to not report the names of nurse participants conducting the fall round audits.

Results

A total of 11 medical surgical units were audited during the implementation project. Six of the eleven units were audited twice. The first audit was performed by the project leader and the resource nurse. Subsequent audits were done independently by the resource nurse for validation in four of the six units. Two hundred and seventy-six cases were audited using the "Fall Round Checklist". Listwise deletion was performed to address missing data. The total number of cases analyzed resulted in 255 cases, exceeding the goal of 240 cases. Each fall prevention intervention outlined in the "Fall Round Checklist" was assessed for compliance. Individual percentage score by unit was calculated and a mean score was computed to assess compliance in all eleven units.

The data (Figure 1, figure 2) showed that staff nurses completed the fall risk assessment on average 87% of the time. Documentation of the fall prevention and management plan of care averaged 41% in the observed units. Visual cues such as yellow armbands (less than 50%), yellow socks (74%), and turning the bed alarm on (46%) lacked consistency. Environmental safety measures were applied more frequently, such as having the call bell in within reach (95%), bed in low position (97%), table and personal items within reach (98%), or a clutter free room (95%). Of the twelve cases assessed for chair alarms, four did not have alarms in place. Forty percent of the audited cases reported supervision with toileting.

Bed exit alarm is the only fall prevention intervention that alerts staff when a patient, who should not leave the bed without assistance, is getting out of bed (Coussement, et al., 2008). Data analysis regarding this key intervention showed that of the 37 cases audited where patients were found to be immobile, only 20 had bed alarms set in place. There was also an association between setting bed alarms on and having a urinary catheter in place. About 15 of 24 cases observed had bed alarms on at the time of the audit. Lastly, the presence of family members (two of seven cases observed had bed alarms) and sitters (five of 13 cases observed had bed alarms) at the bedside seemed to also affect turning bed alarms on for patient safety.

Discussion

The “Fall Round Checklist” was a practice change that can be adopted at this Midatlantic Tertiary Center. Its implementation consisted of using a tool to assess nursing adherence to fall risk assessment documentation and fall prevention and management interventions set by the hospital clinical practice guideline on patients at high risk for falls in medical-surgical units. The degree of nursing compliance was noted to be high, moderate, and low on various items outlined in the “Fall Round Checklist”. For instance, nurses are required to perform fall risk assessment

on admission and fall risk reassessment each shift (Albornos-Muñoz, et al., 2018; Menzel & Thirumalai, 2010). This fall prevention requirement is mandated by the Joint Commission to accredited hospitals (Cioffi, Plumadore, & Clark, 2013; Spoelstra, et al., 2012). Hospitals have increased compliance with fall risk assessment by embedding validated and standardized fall risk assessment tools in the electronic nursing documentation. Dykes et al. (2010), after implementation of a fall prevention tool kit (FPTK) which included the Morse Fall Scale, reported daily MFS completion rate of 81% in their control units and 94% in the intervention units. Although fall risk assessments were found to be documented daily on each patient, the DNP project looked at completion rate for each 12-hour shift. The fall risk assessment compliance rate was 87%, suggesting that, failure to consistently assess patients each shift could lead to preventable fall events.

The documentation of fall prevention and management interventions was found to be a low priority nursing care with a low compliance rate of 41%. As such, fall safety rounds conducted at the bedside assured that fall prevention protocols were in place to maintain patient safety (Nedved, et al., 2012). A high level of compliance (95% or greater) was noted with environmental safety measures. Menzel and Thirumalai (2010) reported similar result using the Rounding Tool in areas such as low bed/bed alarm, keeping environment free of clutter, and having a call light/bed pan/urinal/bedside commode within reach with a degree of compliance of 96.6%. Unfortunately, the DNP Project found turning on bed alarms to have a low degree of compliance (46%). Inconsistent application of bed alarms was found in patients with restricted mobility or considered bed bound, patients with urinary catheter, and patients with family members or sitters at the bedside. An implementation gap of this measure places patients at greater risk for falls because nurses do not receive the alert that a patient who is not supposed to

leave the bed without assistance, is about to do so (Coussement, et al., 2008). Also, failure to consistently apply visual cues such as yellow armbands (less than 50%), hampers vigilance against falls and communication to other staff of patients at risk for falls. Lastly, supervision with toileting showed a low compliance rate of 46%. Like turning bed alarms on, a gap in this practice creates serious safety concerns as fall events mostly occur during toileting and are likely to result in injury (Dykes, et al., 2010; Godlock, Christiansen, & Feider, 2016).

The strengths of implementing the “Fall Round Checklist” come from a multidisciplinary team approach from designing the tool to its actual use and implementation in 11 medical-surgical units. Resource nurse participants who use the checklist found it easy to read. Their feedbacks and suggestions during implementation assisted in the checklist design modifications by adding a box where terms, otherwise unknown by users/auditors, were defined. Also, the project was designed to include all patients at risk for falls with a MFS greater than 45. The average number of cases expected was 11 per unit. At times, units had 20 or more patients identified as high risk for falls. As a result, the project leader achieved a higher than expected number of cases. The “Fall Round Checklist” can be used by any nursing staff to conduct both electronic and bedside audits on all patients identified at high risk for falling. It aids in the identification of variations to nursing practices that depart from clinical standards. Leaders at the organization can therefore take corrective actions to address specific gaps in fall prevention and management practices to improve nursing care and patient safety.

Limitations

Due to the structural changes in the Fall Committee and demands of this project, the project leader faced challenges in recruiting champions from the committee as primary stakeholders and end-users of the “Fall Round Checklist”. The project leader resorted to enlist unit resource nurses as active participants in the project. The project leader was able to obtain buy-in from the resource nurses due to

long standing practice of audits at the organization. However, securing the resource nurse time and availability to learn about the audit process and complete the audit was another barrier to the project implementation. The duration of the audit could take 1 to 2 hours to educate, train, and complete the audit in just one encounter. Arriving on the unit at the beginning or early in the shift to introduce the project, hand the checklist and the tips on how to conduct a fall audit, explain expectation and duration of the audit, and exchange numbers with the resource nurse to call at the most convenient time were strategies used to mitigate this barrier. Most resource nurses responded well with these tactics. Furthermore, not all resource nurses who participated in the project had access the MFRS report. At first, a printed report by the project leader was handed to participants. However, the goal was to have participants access the report when the project leader is not present. The project leader learned to retrieve the link and provided access to the MFS Report for those who did not have the direct link.

Conclusion

Falls are serious preventable events that pose a threat to patient safety (Spoelstra, et al., 2012). Audits have been strategically employed to monitor current practices against standards of practice to assist in practice remediation and corrective action to improve staff compliance and awareness (Huntley, Crock, & Shiskowsky, 2016). The “Fall Round Checklist” enabled electronic chart audits of fall risk assessments and documentation of fall prevention and management interventions. It also facilitated documentation of observational bedside audits. The data collected during the project was analyzed to determine the degree of nursing compliance with fall prevention and management interventions. This allowed for a better understanding of current fall prevention practices in order to formulate actions for change.

The “Fall Round Checklist” was a strategic quality improvement project to meet the organization goal to improve the implementation of fall prevention interventions in low performing units. It is therefore not generalizable to other settings. The tool was implemented in

medical surgical units; however, it can be used within the Nursing Department by any leader or nurse champion looking to improve nursing practice regarding falls. Resource nurses are skilled leaders in their units that could drive practice changes. Improved nursing practice and increased compliance ensure safe and quality patient care which can be evaluated through a decrease in patient falls and an increase in hospital reimbursements from CMS for this organization. The “Fall Round Checklist” is thus sustainable within this organization. As part of a large system that incorporates other hospitals in the Mid-Atlantic area, the utilization of the “Fall Round Checklist” in the host organization can be suggested to the committee in charge of practice change for dissemination in hospitals part of this large system group.

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Figure 1. Percentage Compliance Results of All Fall Prevention Interventions of Audited Medical-Surgical Units

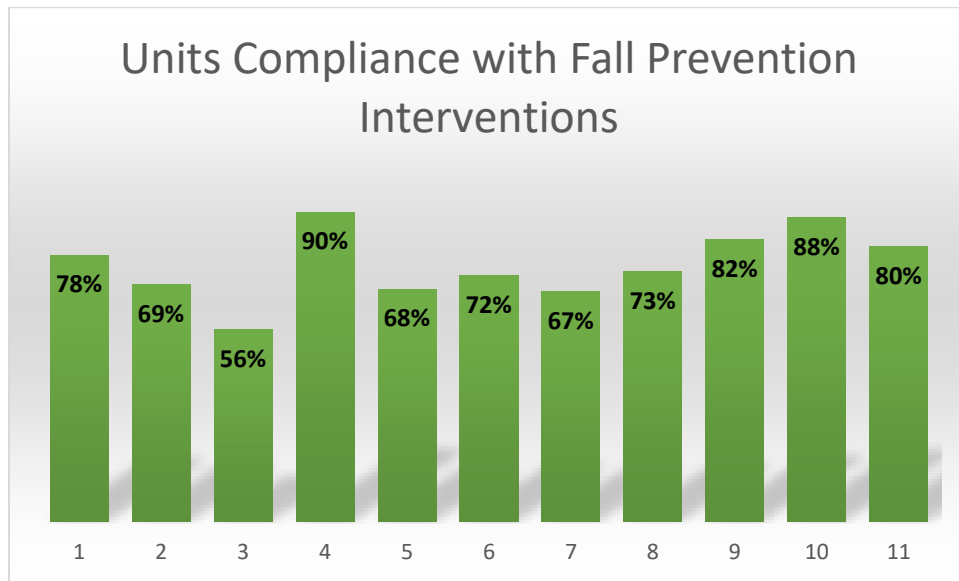
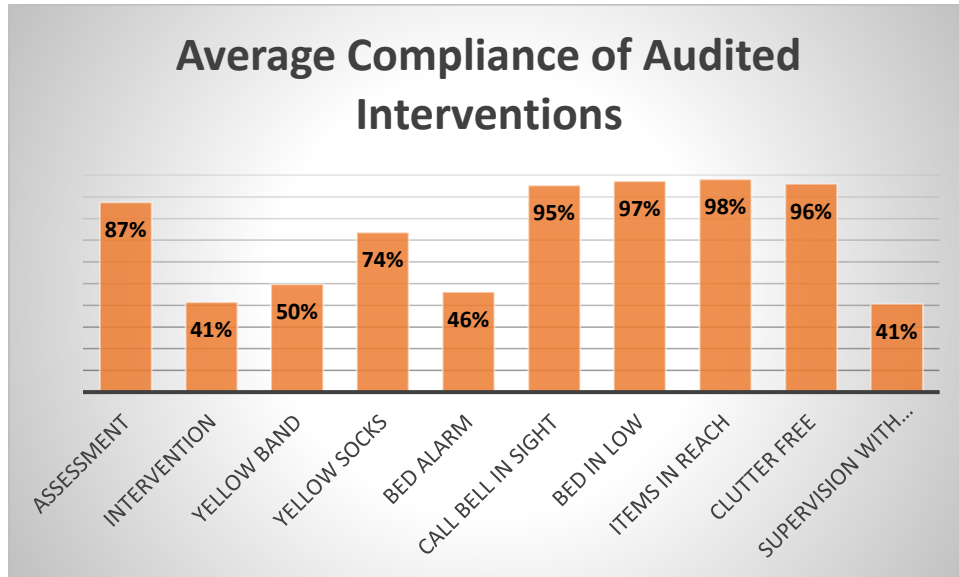
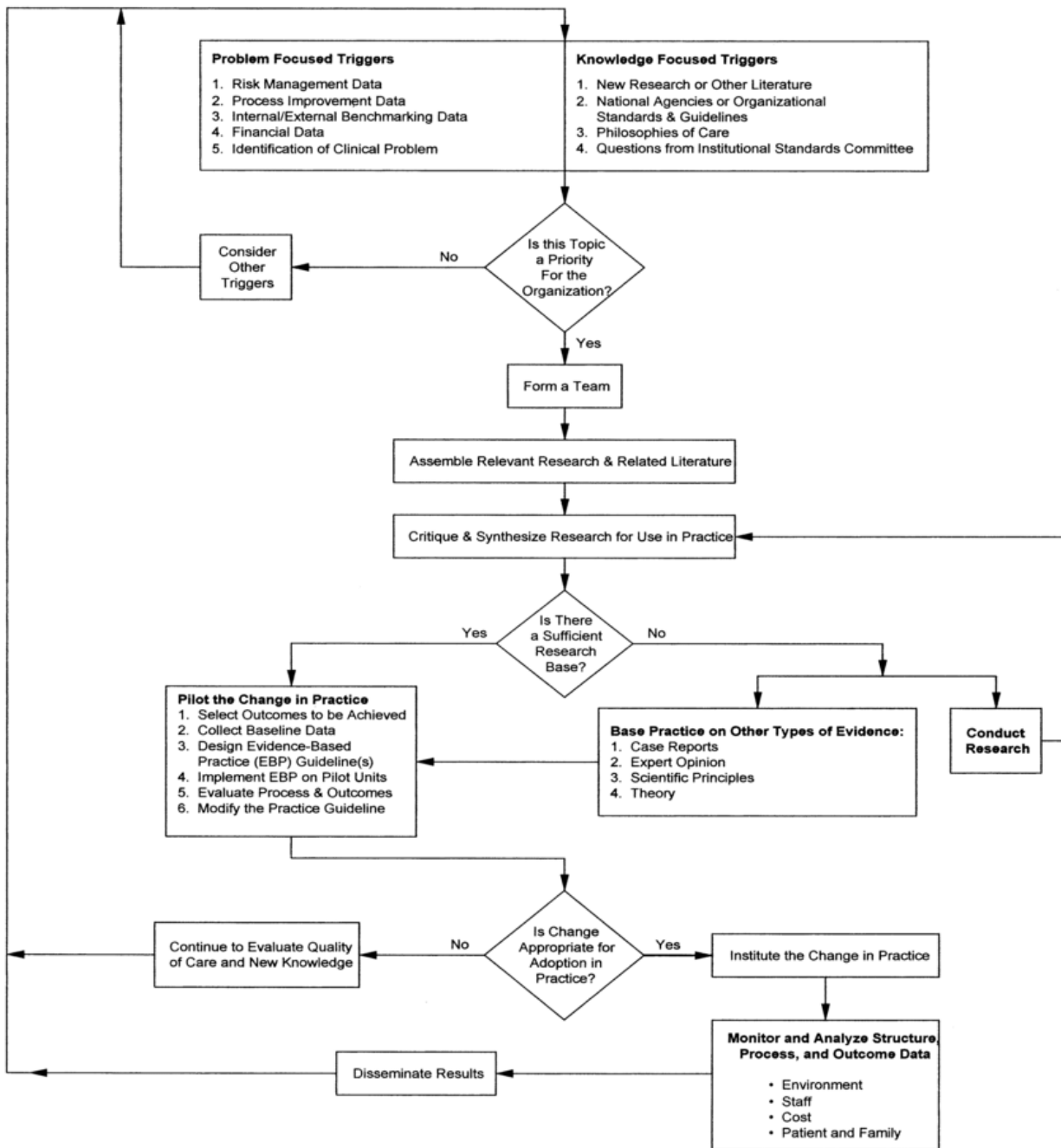


Figure 2. Percentage Compliance of Fall Interventions Audited on the “Fall Round Checklist”



Appendix A

The Iowa Model of Evidence-Based Practice to Promote Quality Care



◇ = a decision point

(Clinical Practice Committee of the Academy of Medical Surgical-Nurses, 2013)

Figure 3. The “Fall Round Checklist”

Title: Fall Round Checklist

		Unit:			Date:			Census:			
		Room#	Room#	Room#	Room#	Room#	Room#	Room#	Room#	Room#	Room#
EHR Audits	Fall risk assessment done within 12 hours	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>
		No <input type="checkbox"/>	No <input type="checkbox"/>	No <input type="checkbox"/>	No <input type="checkbox"/>	No <input type="checkbox"/>	No <input type="checkbox"/>	No <input type="checkbox"/>	No <input type="checkbox"/>	No <input type="checkbox"/>	No <input type="checkbox"/>
	Morse score:										
	Fall interventions documented in the EHR	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>
		No <input type="checkbox"/>	No <input type="checkbox"/>	No <input type="checkbox"/>	No <input type="checkbox"/>	No <input type="checkbox"/>	No <input type="checkbox"/>	No <input type="checkbox"/>	No <input type="checkbox"/>	No <input type="checkbox"/>	No <input type="checkbox"/>
Environmental Observations	Yellow armband	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>
		No <input type="checkbox"/>	No <input type="checkbox"/>	No <input type="checkbox"/>	No <input type="checkbox"/>	No <input type="checkbox"/>	No <input type="checkbox"/>	No <input type="checkbox"/>	No <input type="checkbox"/>	No <input type="checkbox"/>	No <input type="checkbox"/>
	Yellow socks	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>
		No <input type="checkbox"/>	No <input type="checkbox"/>	No <input type="checkbox"/>	No <input type="checkbox"/>	No <input type="checkbox"/>	No <input type="checkbox"/>	No <input type="checkbox"/>	No <input type="checkbox"/>	No <input type="checkbox"/>	No <input type="checkbox"/>
	Bed alarm On	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>
		No <input type="checkbox"/>	No <input type="checkbox"/>	No <input type="checkbox"/>	No <input type="checkbox"/>	No <input type="checkbox"/>	No <input type="checkbox"/>	No <input type="checkbox"/>	No <input type="checkbox"/>	No <input type="checkbox"/>	No <input type="checkbox"/>
	Call bell in sight & reach	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>
		No <input type="checkbox"/>	No <input type="checkbox"/>	No <input type="checkbox"/>	No <input type="checkbox"/>	No <input type="checkbox"/>	No <input type="checkbox"/>	No <input type="checkbox"/>	No <input type="checkbox"/>	No <input type="checkbox"/>	No <input type="checkbox"/>
	Bed in Low Position	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>
		No <input type="checkbox"/>	No <input type="checkbox"/>	No <input type="checkbox"/>	No <input type="checkbox"/>	No <input type="checkbox"/>	No <input type="checkbox"/>	No <input type="checkbox"/>	No <input type="checkbox"/>	No <input type="checkbox"/>	No <input type="checkbox"/>
Table & personal items within reach	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	
	No <input type="checkbox"/>	No <input type="checkbox"/>	No <input type="checkbox"/>	No <input type="checkbox"/>	No <input type="checkbox"/>	No <input type="checkbox"/>	No <input type="checkbox"/>	No <input type="checkbox"/>	No <input type="checkbox"/>	No <input type="checkbox"/>	
Clutter free room	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	
	No <input type="checkbox"/>	No <input type="checkbox"/>	No <input type="checkbox"/>	No <input type="checkbox"/>	No <input type="checkbox"/>	No <input type="checkbox"/>	No <input type="checkbox"/>	No <input type="checkbox"/>	No <input type="checkbox"/>	No <input type="checkbox"/>	
Chair Alarm in Place	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	
	No <input type="checkbox"/>	No <input type="checkbox"/>	No <input type="checkbox"/>	No <input type="checkbox"/>	No <input type="checkbox"/>	No <input type="checkbox"/>	No <input type="checkbox"/>	No <input type="checkbox"/>	No <input type="checkbox"/>	No <input type="checkbox"/>	
Is the staff staying with you during toileting?	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	
	No <input type="checkbox"/>	No <input type="checkbox"/>	No <input type="checkbox"/>	No <input type="checkbox"/>	No <input type="checkbox"/>	No <input type="checkbox"/>	No <input type="checkbox"/>	No <input type="checkbox"/>	No <input type="checkbox"/>	No <input type="checkbox"/>	
Sitter in place	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	
	No <input type="checkbox"/>	No <input type="checkbox"/>	No <input type="checkbox"/>	No <input type="checkbox"/>	No <input type="checkbox"/>	No <input type="checkbox"/>	No <input type="checkbox"/>	No <input type="checkbox"/>	No <input type="checkbox"/>	No <input type="checkbox"/>	

Disclosure: A DNP project under the umbrella of the Fall Committee

Table 1: Lessons’ Plan

Learning Objectives	Content Outline	Method of Instruction	Time Spent	Method of Evaluation
How to access and print the MFS report	<ul style="list-style-type: none"> - Log into the Cerner computer system with authorized credentials to access the EHR of patients’ charts. - Click in the “Explorer Menu” tab or icon - Select the Morse Fall Score report with one click on the main menu on your left - Select your unit in the window that appears to your right. - Click on “report”, then click on “execute” 	<p>Verbal teaching</p> <p>Demonstration on the computer</p> <p>Provide cheat sheet card</p>	10 minutes	Return demonstration
How to audit documentation of fall prevention interventions in the EHR	<ul style="list-style-type: none"> - Click on the “Quality/Core Measures” icon in the EHR <ul style="list-style-type: none"> - A window opens and display quality measures such as fall, pain stroke, CRI, and VTE. - Click on the + sigh to expand the “fall” quality measure. - Three sub headings will appear: assessment, interventions and falls - Only audit the patients from the MFRS report <ul style="list-style-type: none"> - A white bubble means that no interventions are in place. Patient has been found at risk for falls and no plan or order set was initiated. - A shaded blue bubble means that high fall risk management interventions are in place or initiated. 	<p>Verbal teaching</p> <p>Demonstration on the computer</p> <p>Provide cheat sheet card</p>	10 minutes	Return demonstration
How to complete the “Fall Round Checklist”	<ul style="list-style-type: none"> - Assign alphabetical letters next to the patients on the MFRS report. Record the letter as room number in the checklist <ul style="list-style-type: none"> - Directly observe the fall prevention interventions - Check “yes” if interventions are in place or “no” if lacking. - Check barriers to implementations that apply after a brief interview with the nurse assigned to the patient. 	<p>Verbal teaching</p> <p>Demonstration</p>	5 minutes	Direct observation and demonstration
Introductory statement	<ul style="list-style-type: none"> - When interacting with patient at the bedside, introduce yourself and state the purpose of 	Verbal teaching	2 minutes	Verbalization

	<p>your presence: “Hi, my name is “RN”. I am here to round on you and make sure fall prevention measures are in place for your safety. Is the staff assisting and staying with you during toileting?</p>	<p>Provide cheat sheet card</p>	<p>Direct observation</p>
<p>Disclosure statement</p>	<p>The DNP leader will say to the resource nurse when soliciting participation: “I am conducting a DNP project with the approval of the fall committee to assess nursing compliance with standard fall prevention interventions</p>	<p>Verbal teaching</p>	<p>1 minute Verbalization</p>

Table 2: Template/Example of the Morse Fall Risk Score as Generated from EHR

Unit Name	Room	Bed	Patient name	Morse Fall Risk Score	Coding with letters (by project leader/participants)
HC 4H	4H01	P (private)	NC	55	A
	4H02	A (semi private room)	KW	70	B
	4H02	B (semi private room)	RB	45	C
Total Patients	3				

Appendix B

Evidence Review Table

Author, year	Study objective/intervention or exposures compared	Design	Sample (N)	Outcomes studied (how measured)	Results	Level and Quality Rating
Albornos-Mun˜oz et al., 20018	To improve fall prevention and management through clinical audits and the implementation of a quality-improvement cycle at the local level.	Pre-post clinical audit	Two medical wards (10–19 and 40–49 beds) and a surgical ward (20–29 beds)	Compliance with Fall risk assessment, with reassessment after a fall, with targeted fall interventions	Barriers were identified in relation to fall assessment and management. Improvement in fall risk assessment criteria noted after implemented strategies. Increased awareness of the assessment and management of fall risks noted among professionals and patients on all three study wards.	4B
Aydin et al., 2015	To examine the impact of the nursing unit microclimate (unit/patient characteristics, number of nurses, mix of staff types, and use of risk assessment and prevention protocols) on the incidence of falls and moderate- or greater-injury falls, and prevalence of restraint use as a risk mitigation intervention.	Review of self-reported data from 215 hospitals	Convenience sample of 789 medical-surgical (MS) units from 215 hospitals in California, Oregon, and Washington who submitted data during 2009.	Falls and injury falls evaluated from hospitals’ adverse event reporting systems and the prevalence of restraint (limb and vest) assessed from quarterly prevalence studies.	Falls and injury falls were primarily predicted by patient characteristics and clinical processes Fewer falls/injury falls were predicted by populations with fewer frail and at-risk patients, more unlicensed care hours, and prevention protocol implementation, but not staffing per se, restraint use, or RN expertise. Lower restraint use was predicted by fewer frail patients, shorter length of stay, more RN hours, more certified RNs, and	6B

					implementation of fall prevention protocols.	
Ayton et al., 2016	To discuss perceived barriers and enablers of a 6-PACK fall prevention program.	Multi-center mixed methods randomized controlled study	24 acute wards (16 medical and 8 surgical) from 6 Australian hospitals.	Participants' perspective on their capability, the available opportunity, and the motivation in implementing fall prevention programs assessed through surveys and interviews.	A number of enablers (education, training, leadership participation, reminders, audits, and feedbacks) and barriers (belief fall could not be prevented, limited knowledge on fall preventions, lack of resources or ownership in fall prevention efforts) have been identified.	2B
Bouldin et al., 2013	To provide normative data on fall prevalence in U.S. hospitals by unit type and to determine the 27-month secular trend in falls before the implementation of the Centers for Medicare and Medicaid Service (CMS) rule.	Review of self-reported data from the National Database of Nursing Quality Indicators (NDNQI) collected between July 1, 2006, and September 30, 2008.	Convenience sample of hospitals that self-identified as nonfederal, short-term general hospitals. A total of 6100 nursing units (1949 medical; 1530 surgical; 2621 medical-surgical) contributed data during the study period. These units represented 1263 distinct hospitals.	The number of falls and fall related injuries reported using the rate calculation per 1000 patient days (pd).	A total of 315,817 falls occurred (rate = 3.56 falls/1000 pd) during the study period, of which, 82,332 (26.1%) resulted in an injury (rate = 0.93/1000 pd). Both total fall and injurious fall rates were highest in medical units (fall rate = 4.03/1000 pd; injurious fall rate = 1.08/1000 pd) and lowest in surgery units (fall rate = 2.76/1000 pd; injurious fall rate = 0.67/1000 pd). Falls and injurious both decreased over the 27-month study.	6B
Brown, 2013	To assist nurses to evaluate the evidence that supports fall risk assessment and to implement	Clinical Practice Guideline	N/A	Number of falls per 1,000 patient days and number of falls	N/A	7C

	strategies to prevent falls among hospitalized patients.			with injury per 1,000 patient days		
Buckwalter et al., 2017	To re-evaluate, revise, and validate the Iowa Model.	Electronic Survey	431 survey participants	Each 13 steps in the Iowa model	The revised model was evaluated by participants who They validated the model as a practical tool for the EBP process across diverse settings.	6B
Cioffi et al., 2013	To identify and analyze associations between characteristics and factors collected on the ‘Post Fall Huddle/Event Report’ form used by Nursing and Risk Management for all inpatient falls	A retrospective exploratory analysis of secondary data.	Convenience sample of 182 inpatient fall events over a six-month period between January and June 2011.	The number of inpatient falls post implementation of the form.	The average annual number of inpatient falls decreased by 50% post implementation of the “Post Fall Huddle/Event Report’ form.	6C
Clinical Practice Committee of the Academy of Medical-Surgical Nurses, 2013	N/A	N/A	N/A	N/A	N/A	N/A
Coussement et al., 2008	To determine the characteristics and the effectiveness of hospital fall prevention programs.	Systematic review	Eight identified studies: six were randomized controlled trials, one cluster randomized, and one controlled Trial.	Number of falls or fallers measured using the relative risk of a fall per occupied bed day (RRfall) and the relative risk of being a faller (RRfaller).	One unifactorial and two multifactorial studies showed a significant reduction of 30% to 49% in the intervention group. The pooled RRfall for the four multifactorial studies became nonsignificant after adjustment for clustering (RRfall50.82, 95% confidence interval (0.65-1.03).	1B

<p>Dykes et al., 2010</p>	<p>To investigate whether a fall prevention tool kit (FPTK) using health information technology (HIT) decreases patient falls in hospitals.</p>	<p>Stratified cluster randomized study</p>	<p>2 units within each of 4 hospitals involving 10 264 patients and 48 250 patient-days.</p>	<p>Patient falls Measured per 1000 patient-days. Patient falls with injury</p>	<p>There were fewer patients with falls in intervention units (n=67; range across units, 10-28) than in control units (n=87; range across units, 15-33). The FPTK was found to be particularly effective with patients aged 65 years or older.</p>	<p>2B</p>
<p>Dykes et al., 2009</p>	<p>To obtain the views of nurses and assistants as to why patients in acute care hospitals fall.</p>	<p>Content analysis</p>	<p>4 focus groups with nurses (n = 23) and 4 with assistants (n = 19).</p>	<p>Evaluate concepts such patient report, information access, signage, environment, teamwork, and involving patient/family, knowledge/communication and capability/actions in preventing falls.</p>	<p>Positive and negative components were identified.</p>	<p>5C</p>
<p>Godlock et al., 2016</p>	<p>To examine the use of a team-based strategy in enhancing teamwork and communication in the approach of fall prevention.</p>	<p>Quality Improvement Project</p>	<p>Six inpatient nursing units</p>	<p>Inpatient falls per 1,000 bed days calculated using patient safety reporting (PSR) and the Workload Management System for Nursing.</p>	<p>The study reported a decreased in fall rates after intervention from 1.90 to 0.69 falls per 1,000 bed days and an average 1.63 fall per 1,000 bed days a year after implementation.</p>	<p>6B</p>
<p>Healey & Darowski, 2012</p>	<p>To discuss the organizational culture and processes that can increase the effective delivery of evidence-based falls prevention.</p>	<p>Not defined or applicable</p>	<p>Not defined or applicable</p>	<p>Not defined or applicable</p>	<p>Effective falls prevention cannot be delivered by any single professional group working in isolation, but requires genuine multidisciplinary collaboration</p>	<p>6C</p>

					to develop local policy and practice.	
Health Research & Educational Trust, 2016	To discuss the use of the Robust Process Improvement® (RPI®) methodology to identify contributing factors and develop solutions to prevent patient falls and falls with injury on designated units in participating and pilot health care organizations.	Pilot study	Seven participating U.S. hospitals composed of included four medical-surgical units, one medical oncology unit, a cardiology unit, and a medical-surgical/stroke/telemetry unit.	Reduction of falls and fall with injury	In aggregate, these organizations demonstrated a 62 percent reduction in the falls with injury rate and a 35 percent reduction in the falls rate.	4B
Hempel et al., 2013	To systematically document the implementation, components, comparators, adherence, and effectiveness of published fall prevention interventions in U.S. acute care hospitals.	Systematic Review	59 U.S. acute care hospital studies reporting evaluations of fall prevention interventions.	Inpatient fall rate was evaluated using an incidence rate ratio (IRR) for each study.	The pooled post-intervention incidence rate ratio (IRR) was 0.77. Though an IRR less than 1 indicates a lower post intervention (or treatment group) fall rate than the pre-intervention (or control group) rate, the pooled estimates found no statistically significant intervention effect. Meta-regressions showed no systematic association between implementation intensity, intervention complexity, comparator information, or adherence levels and IRR.	1B
Hill & Fauerbach, 2014	To provide an overview of the various types of falls, fall risk factor assessment, current fall prevention strategies, and	Not defined or applicable	Not defined or applicable	Not defined or applicable	Fall risk assessments are not the sole answer to fall prevention. The use of reliability and validity fall risk assessment too	7C

	suggestions for the management of a patient who has fallen.				should be combined with a comprehensive set of evidence-based interventions for each area in the fall risk assessment	
Huntley et al., 2016	To describe how auditing fall interventions serve as a key piece to fall prevention	Not defined	Not defined	Compliance rate with eight fall prevention interventions. Fall rates per 1,000 patient days.	First three months of Safety Audit initiation falls decreased from 3.41 to 3.05 falls/1000 patient days. Post fall safety audit implementation the rate was 2.76 falls/1000 patient days. Two years after audit implementation, UCH had its lowest rate ever at 1.59 falls/1000 patient days.	6B
Koh et al., 2008	To assess the perceived barriers to practice change by eliciting nurses' opinions regarding barriers to, and facilitators of, implementation of a Fall Prevention clinical practice guideline in five acute care hospitals in Singapore.	A survey	Five acute care hospitals, 66 units, 1830 nursing staffs in medical-surgical and geriatric units	Perceptions of the barriers to implementation of CPGs in practice	The greatest barriers to implementation of clinical practice guidelines reported included: knowledge and motivation, availability of support staff, access to facilities, health status of patients, and, education of staff and patients.	6B
Leone & Adams, 2016	To review a quality improvement project aimed to examine how nurse leaders in an inpatient rehabilitation (IPR) unit can reduce the number of patient falls by implementing multiple fall prevention interventions and sustain their	A retrospective review study	61-bed adult inpatient rehabilitation unit who have been transferred from an acute care hospital unit for intensive therapy to restore	Total Fall Rates per 1,000 patient days obtained from the NDNQI Quarterly Reports.	The largest decrease in fall rate was noted after initial revitalization efforts of the IPR unit's culture of safety concurrently with hourly rounding.	6B

	results by promoting a strong culture of safety on the unit.		functional ability due to a medical issue such as a stroke, brain or spinal cord injury, recent orthopedic surgical procedure, or critical illness myopathy.			
Logan et al., 1999	To describe how the application of the Ottawa Model of Research Use (OMRU) guided the implementation of an evidence-based pressure ulcer project.	Not defined or applicable	Three Ottawa healthcare settings or agencies.	Multiple perspectives related to the OMRU framework.	The OMRU provided the conceptual basis to design and implement interventions promoting evidence-based nursing practice by addressing key elements in the process of research use.	6B
Manojlovich et al., 2015	To debate the merits of encompassing the two communication paradigms (communication as a transactional process responsible for information exchange and communication as a transformational process responsible for causing change) in the implementation science literature.	Literature Review	12 published literature of implementation theories	Both communication paradigms.	The use of both paradigms allows an investigation of when communication facilitates implementation, when it does not, and how to improve it so that our implementation and clinical interventions are embraced by clinicians and patients alike.	6B
Menzel & Thirumalai, 2010	To determine the level of nursing compliance in implementing Fall Prevention Protocol (FPP) in an acute care hospital in a high fall risk patient	Descriptive study	A convenience sample of 24 nurses working in a medical-surgical unit.	The degree of compliance among nursing staff was measured using the Scripps Mercy Hospital Rounding	A high level of compliance was noted on criteria such as low bed/bed alarm, keeping environment free of clutter, and having call light/bed	6B

	population and to identify the barriers in complying.			Tool (Rounding Tool)	pan/urinal/bedside commode within reach (96.6%). The level of compliance with fall signage was 51.7%, signs in the room saying “Call/do not fall” (65.5%), placing fall risk arm bands on patients (24.1%), and placing Kilroy stickers on the chart indicating fall risk to transport personnel (10.3%). An appropriate risk level was documented 100% of the time.	
Nedved et al., 2012	The study hypothesizes that an increase in staffing levels with the addition of the patient safety office would be associated with a reduction in patient falls.	Retrospective quasi-experimental study design	Two postsurgical telemetry units equivalent to 37 inpatient beds Unit A as the intervention unit and Unit B as the control unit.	The number of falls per 1000 patient-days and the percentage of days with falls	The intervention Unit experienced a decrease of patient fall from 5.9 to 2.8 falls per 1,000 patient days post implementation but saw a rise of 6.1 falls per 1,000 patient days when Patient Safety Officer was withdrawn due to budgetary concerns. The control Unit saw a rise from 4.1 to 3.3 falls per 1,000 patient days during implementation and a decrease to 3.1 post implementation without the intervention, thus attributed to other variables.	3B
RAND Corporation et al., 2013	To focus on overcoming the challenges associated with developing, implementing, and sustaining a fall prevention	A toolkit designed by expert in fall	Not defined	Fall reduction	The toolkit outlines several evidence-based fall prevention interventions and tools that can be used.	7B

	program, specifically on reducing falls during a patient's hospital stay.	prevention and organization change which draws on systematic review of literature and expert opinions.				
Rednak, 2015	To evaluate the benefit of a unit safety champion (USC) in reducing patient falls.	A retrospect, exploratory design	40-bed inpatient medical-surgical nursing unit, and 2 full time RNs as unit safety champions	Fall rates measures by using a run chart to track fall rate data three months prior to, and post implementation of a USC.	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). There was not a statistical difference between the pre or post implementation fall rates ($z = -0.272$, $p = 0.785$) making it inconclusive to determine whether a unit safety champion assisted in fall reduction.	6C
Spoelstra et al., 2012	To provide a listing of the best evidence available in the scientific literature to guide nurse administrators when developing fall prevention programs.	Integrative Review	13 articles on fall interventions in the hospital setting.	Fall reduction	Fall reduction rates were evident and ranging from 19% to 57% or 1.91 to 2.23 per 1,000 bed days. The studies that were successful at reducing hospital fall rates included some or all of the following elements: developing a culture of safety, fall-risk assessments, multifactorial interventions, post-fall follow-up and quality improvement, and	1A

					integration with electronic records. However, the study was unable to determine whether those interventions that drew on multiple strategies produced greater results.	
Stephenson et al., 2016	To assess falls prevention practices in Australian hospitals and implement interventions to promote best practice.	A multi-site audit using eight evidence-based audit criteria	Nine acute care hospitals around Australia	Percentage compliance with falls prevention audit criteria and change in compliance between baseline and follow-up audits. Fall rate data were also analyzed.	Mean overall compliance at baseline across all hospitals was 50.4% (range 30.8-76.6%). At the first follow-up, this had increased to 74.5% (range 59.4-87.4%), which was sustained at the second follow-up (74.1%, range 48.6-84.4%).	4B
The Joint Commission, 2015	To discuss recommendation of actions to help health care organizations prevent falls and fall-related injury.	Not defined or applicable	Not defined or applicable	Fall and fall-related injury reduction	The Sentinel Event Alert outlines several evidence-based fall prevention interventions and tools that can be used.	
Tremblay et al., 2010	To examine the uptake of evidence-based recommendations from best practice guidelines intended to enhance interprofessional collaborative practices within cancer teams.	An exploratory mixed methods study design	The care provider group of 24 professionals, managers, and decision-makers and the user group of 12 patients/caregivers	Evaluate adoption behaviors from the care provider and user groups performed through survey questionnaire.	Knowledge on the interventions and sources of support conducive to the uptake of evidence and building of capacity to sustain new interprofessional collaborative practice patterns, as well as information on strategies for overcoming barriers to evidence-informed interventions were found.	6B

