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Master's thesis

FALLS PREVENTION PROGRAM IN HOSPITALIZED ADULTS

Master of Science in Nursing

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Ternopil – 2022

ABSTRACT

Falls among hospitalized patients are one of the most severe sentinel events and take a lot of hospital staff's attention. Many efforts have been made to prevent falls among hospitalized patients, and much research was dedicated to the topic. Hospital falls could lead to severe complications in patients' care. According to National Database for Nursing Quality Indicators (NDNQI), all falls can be categorized into five injury levels: none, minor, moderate, major, and death. If inpatient falls result in injuries, hospitals can suffer from financial losses due to additional tests and rehabilitation needs.

Moreover, patients and families can suffer from emotional trauma due to falls and complications. Therefore, as a future prepared nurse executive, I see fall prevention as a significant part of my professional duty. Maintaining patient safety is one of the most critical nursing roles. Fall prevention feeds in this category. Therefore, this topic is very vital for my professional development as a nurse and future nursing executive. Professional literature also points out the importance of fall prevention, highlighting that according to The World Health Organization (WHO), 37.3 million hospital falls annually require medical intervention. More than half a million deaths were recorded due to hospital falls. Nursing research has been identified many risk factors for potential falls among hospitalized adults. The most common characteristics are patients with cognitive impairment and altered mental status. Additional factors related to falls among hospitalized adults reported as pharmaceutical medications affecting alertness and increased fall risk, lack of communication between patients and medical staff, and insufficient education regarding falls within hospital populations. Another fall risk population is patients suffering from mental illnesses, drug or alcohol withdrawal due to possible

delirium or disorientation. Also, patients diagnosed with vasovagal syncope episodes or incontinence could be at high risk for falling.

Research Assignments.

1. In hospitalized adults, what is the effect of the patients' safety team in comparison to no patient safety team on the number of occurrences reports in detecting fall-related injuries to be completed over six months?

Object of research. The Fall safety team will include registered nurses (RNs), Certified Nursing assistants (CNAs), identified champions, such as senior nurses or nurses in charge. In addition, patients and families would be part of post-fall huddles.

Research methods. The members of the team complete a post-fall assessment as soon as possible and facilitate a post-fall huddle. During the huddle, the reason for the fall will be discussed, and the team will suggest recommendations to improve patient safety. The post-fall checklist will address the descriptions of falls: what was the patient was doing before the fall, any change of patient condition noted post-fall, any injuries were reported? If the provider is notified, and when was the last time the fall assessment was completed? Also, the team will make their recommendation based on their observation. Before the implementation of the project, the fall safety team will go through simulation training. The simulation training will be based on factors contributing to falls, such as transferring the patient to the bedside commode or the toilet. After each task, feedback will be provided with recommendations for patient safety improvement. We will evaluate the effectiveness of the project by assessing occurrence reports related to falls biweekly.

Scientific and practical significance of the study. Consistency would be a significant key for the project's success. The patient safety team will respond to

falls, assess the situation, complete a post-fall assessment checklist, complete the huddle and make recommendations. Moreover, the team will contribute to education and training related to falls and improve multidisciplinary communication. The project will improve patient safety and implement evidence-based practice.

Conclusions:

My PICOT question was formulated as the following:

In hospitalized adults, what is the effect of the patients' safety team in comparison to no patient safety team on the number of occurrences reports in detecting fall-related injuries to be completed over six months?

P-Populations and problem-Falls among hospitalized adults

I-Intervention- An implementation of a patient safety team to prevent falls in hospital units

C-Compression- No patient safety team in place

O- Outcomes- The number of occurrence reports in detecting fall-related injuries will be decreased

T-Time frame - The results will be evaluated within six months

REFERENCES.

1. Dykes, P. C., & Hurley, A. C. (2021). Patient-centered fall prevention. *Nursing Management52*(3), 51–54. https://doi.org/10.1097/01.numa.0000733668.39637.ba

2. Godlock, G., Christiansen, M., & Feider, L. (2016). Implementation of an Evidence-Based   Patient Safety Team to Prevent Falls in Inpatient Medical Units. *Medsurg Nursing*, *25*(1), 17–23.

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INTRODUCTION

Falls among hospitalized patients are one of the most severe sentinel events and take a lot of hospital staff's attention. Many efforts have been made to prevent falls among hospitalized patients, and much research was dedicated to the topic (Johnson & Magnan, 2019). Hospital falls could lead to severe complications in patients' care. According to National Database for Nursing Quality Indicators (NDNQI), all falls can be categorized into five injury levels: none, minor, moderate, major, and death. If inpatient falls result in injuries, hospitals can suffer from financial losses due to additional tests and rehabilitation needs.

Moreover, patients and families can suffer from emotional trauma due to falls and complications (Reich et al., 2017). Therefore, as a future prepared nurse executive, I see fall prevention as a significant part of my professional duty. Maintaining patient safety is one of the most critical nursing roles. Fall prevention feeds in this category. Therefore, this topic is very vital for my professional development as a nurse and future nursing executive. Professional literature also points out the importance of fall prevention, highlighting that according to The World Health Organization (WHO), 37.3 million hospital falls annually require medical intervention. More than half a million deaths were recorded due to hospital falls (Souza et al., 2019). Nursing research has been identified many risk factors for potential falls among hospitalized adults. The most common characteristics are patients with cognitive impairment and altered mental status (Grealish et al., 2019). Additional factors related to falls among hospitalized adults reported as pharmaceutical medications affecting alertness and increased fall risk, lack of communication between patients and medical staff, and insufficient education regarding falls within hospital populations (Spano-Szekely et al., 2019). Another

fall risk population is patients suffering from mental illnesses, drug or alcohol withdrawal due to possible delirium or disorientation. Also, patients diagnosed with vasovagal syncope episodes or incontinence could be at high risk for falling (Tyndall et al., 2020).

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Consistency would be a significant key for the project's success. The patient safety team will respond to falls, assess the situation, complete a post-fall assessment checklist, complete the huddle and make recommendations. Moreover, the team will contribute to education and training related to falls and improve multidisciplinary communication. The project will improve patient safety and implement evidence-based practice.

CHAPTER 1

(LITERATURE REVIEW)

Falls prevention is one of the most important and challenging goals in the nursing practice (Johnston & Magnan, 2019). Patient falls in the hospital setting can lead to different injuries and complications: from very mild injuries, like redness and swelling, to severe injuries like bone fractures, internal bleedings, and even death. Complications from falls increase hospital length of stay due to additional rehabilitation needs of the patients, full or partial loss of patient's independence, the increased financial liability of the institutions (Reich et al., 2017). This assignment will provide the literature review that describes the different approaches related to fall prevention among hospitalized adults using evidence-based practice. We will review what professional literature says about this topic, how the screening of professional literature is relevant to our project, and our importance is based on reviewed literature.

The PICOT question would be formulated as the following:

In hospitalized adults, what is the effect of the patients' safety team in comparison to no patient safety team on the number of occurrences reports in detecting fall-related injuries to be completed over six months? In this section of this assignment, we will summarize what professional literature say about falls in hospitalized adult and methods of their prevention.

I have found many professional types of research addressing the topic of falls and its preventions. Most of the studies could be categorized into two big categories. The first category named the risk factors associated with falls, and the second category dealt with different quality improvement projects to prevent falls. Johnson

and Maganan (2019) describe a quality improvement study related to the patient's hospital falls by evaluating its impact by creating a fall prevention protocol. This study helped to identify two common errors related to the institution's fall prevention protocol. Another study concentrates on decreasing patient falls with injuries by educating PCT's with clear expectations of their roles in falls preventions and expanding their knowledge regarding this topic (Reich et al., 2017). The following study describes in-hospital falls reporting and analysis of occurrence reports related to fall injuries (Souza et al., 2019). The additional research concentrates on reducing the overall fall rate by increasing the number of patients who received appropriate fall risk assessment and personalized fall prevention intervention according to the evaluation (Spano-Szekely et al., 2019). An additional study is analyzing falls prevention in public health nursing. This is a hypothetical case summary of the patient after falling and complications (Leahy-Warren et al., 2018). The common cause of those articles is that they all recognize the problem and develop different solutions for quality improvement and fall prevention. Another group of researched articles concentrates on risk factors in fall prevention. This study acknowledges the risk group of the elderly population with cognitive impairment and makes recommendations for falls preventions for this particular risk group (Grealish et al., 2019). Another article moped out factors associated with falls among hospital inpatients and classified those factors into different categories (Munsterman et al., 2018). Some reports describe cost-effectiveness analysis of a multifunctional fall prevention intervention and propose multifunctional interventions (Isaranuwatchai et al., 2017).

All the articles I have reviewed have a direct correlation to my project. First, I have learned that many studies have been done regarding this topic. It provides me with a different understanding of how this issue is essential for the nursing practice. Moreover, I did not find many articles on patients' safety teams as fall

prevention masseurs. The only study focused on improving collaborating care by creating a patient safety team and engaging staff members in patient safety and fall precautions (Godlock, et al., 2016). However, many different studies ci=oncentrated about the issue of inpatient and outpatient falls from different perspectives, which helped me understand this issue in-depth and connect their fundings to my research. For example, most of the studies discussed various quality improvement projects related to fall prevention, like checklists and fall prevention protocols (Johnson & Magnan, 2019). Another approach specifically targeted patients with a high risk of falls via special assessment and personalized fall prevention intervention (Spano-Szekely et al., 2019). Another study described a specific assessment tool for ICU patients. By screening all those articles, I have realized that many of those tools had no significant effect on fall precautions in comprising to patient safety team. However, few studies had a direct impact on my project. One of the articles was describing and additional education to PCT's (Reich, 2017). This information could be beneficial for my project due to the direct involvement of PCTs in the patent safety team.

The following article was describing of fall incidents reports (Souza et al., 2019). I will use this information for analyzing incidents reports for my project. The following article also describes the nursing implementation for fall prevention in adults with cognitive impairment (Grealish et al., 2019), which could provide helpful information regarding the specific group of the population for high risk of falling. Another article describes the psychological impact of falling and the fear of falling from a patient perspective (Twibell et al., 2015). Kiyoshi-Teo et al. (2017) also describe the PDSA model of quality improvement for fall prevention. The following articles provide systemic case review about adult inpatient falls and suggestions for improvement. Those articles provide theoretical frameworks about fall-related factors (Munsterman et al., 2018), recommendations from the experts

on how peer-led fall presentation can be helpful for fall prevention (Khong et al., 2018), retrospective case review about inpatient falls in acute settings (Rheaume & Fruh, 2015), and patient-centered fall prevention, where discussed patient-centered care as a significant component for fall preventions (Dykes & Hurley, 2021).

Based on all information I have gathered, I believe that my project will significantly impact fall prevention in nursing practice. Although there is much information and suggestions on how to prevent falls in acute settings, there is no single guide on effectively preventing falls in high-risk populations (Grealish et al., 2019). My PICOT question is based on implementing the evidence-based practice of patient safety team implementation to prevent falls within the acute care settings population. The impact of my project could be made by raising awareness toward inpatient falls, increasing multidisciplinary collaboration, engaging leadership teams, improving communication between different health care providers, and improving the education of front-line staff members (Godlock et al., 2016).

In conclusion, we provided a literature review of 15 scholary sources discussing patient falls in this assignment. We have summarized this literature in relevance to our project and described what we have learned from different evidence-based practices regarding the same topic. Also, we told how this information related to our project and the connection of previous evidence to our project. Moreover, based on this information, we explained the importance of our project and its possible impact on fall prevention.

CHAPTER 2

METHODOLOGY

Falls among hospitalized patients are one of the most severe sentinel events and take a lot of hospital staff's attention. Many efforts have been made to prevent falls among hospitalized patients, and much research was dedicated to the topic (Johnson & Magnan, 2019). Hospital falls could lead to severe complications in patients' care. According to National Database for Nursing Quality Indicators (NDNQI), all falls can be categorized into five injury levels: none, minor, moderate, major, and death. If inpatient falls result in injuries, hospitals can suffer from financial losses due to additional tests and rehabilitation needs.

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The Fall safety team will include registered nurses (RNs), Certified Nursing assistants (CNAs), identified champions, such as senior nurses or nurses in charge. In addition, patients and families would be part of post-fall huddles (Godlock et al., 2016). The members of the team complete a post-fall assessment as soon as possible and facilitate a post-fall huddle. During the huddle, the reason for the fall will be discussed, and the team will suggest recommendations to

improve patient safety. The post-fall checklist will address the descriptions of falls: what was the patient was doing before the fall, any change of patient condition noted post-fall, any injuries were reported? If the provider is notified, and when was the last time the fall assessment was completed? Also, the team will make their recommendation based on their observation (Godlock et al., 2016). Before the implementation of the project, the fall safety team will go through simulation training. The simulation training will be based on factors contributing to falls, such as transferring the patient to the bedside commode or the toilet. After each task, feedback will be provided with recommendations for patient safety improvement (Godlock et al., 2016).   We will evaluate the effectiveness of the project by assessing occurrence reports related to falls biweekly.

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According to the professional literature, Work Breakdown Structure is a decomposition of the hierarchy of the total scope of work of the project to small components allowing completing the project successfully (Mahmudah & Latief, 2021). WBS has several critical planning stages of defining management and implementation processes. Those stages include defining the scope of the project, breakdown the whole project into a list of small tasks, identifying major stakeholders, evaluating resources requirements and potential risks for the project. Moreover, WBS deals with preparing contingency plans, identifying connections

between different jobs, and critical paths of the project. Also, WBS monitoring project resources serve a role of the project control and are used as a tool for studying the project progress and its status (Mahmudah & Latief, 2021).

Another robust tool helping project development is Gantt Chart Model. Easy to build, the Gantt chart provides a general timeline helping assess the duration of the project and general progress. Gantt Chart assists the project manager by filling the gaps and analyzing different aspects of the problems regarding the timeframe and deadlinr=es of the project (Sharon & Dori, 2017).

On the following page, we will discuss the Work Breaking Structure (WBS) for implementation of patient safety team to prevent falls in inpatient medical units project (Godlock et al., 2016).

1 Patient Safety Team Project

  1.1 Formation of Fall Safety Team

    1.1.1 Identify project champions

    1.1.2 Creating the teams including RN's, CNA's, and charge nurses

    1.1.3 Making on-call monthly roster using the current work schedule

    1.1.4 Making a schedule of team monthly meetings

  1.2 Fall Safety Team Simulation Training

    1.2.1 Participations Pre-simulation Survey

    1.2.2 Creating the training program

    1.2.3 Identifying critical safety task

    1.2.4 Participations post-simulation survey

    1.2.5 Introducing post-fall checklist

  1.3 Program implementation

    1.3.1 Program kick-off party

1.3.2 Weekly evaluation of fall occurrence reports

1.3.3 Monthly team meetings

Professional literature defines Risk Management as an approach to understanding, identifying, and evaluating project risks (Widianti et al., 2018). The risk management process can be divided into different stages: problem identification, data collection, risk management planning, identification of project risk factors, risk assessment, development of risk response, stage monitoring, and control of risk response. Based on risk analysis results, risk management can provide essential data about the project team and risks considerations (Widianti et al., 2018).

One of the essential tools of risk management described in professional literature is a risk register. The effectiveness of risk management and the project's success can depend on risk register accuracy (Uzulāns, 2016). The risk register mops out all possible risk factors of the project and categorizes them in different levels, with consequences and possible interventions. Another great tool used in project management is the RACI matrix shows individuals responsible, accountable, consulted, and informed for each task of the project. The RACI matrix allows the proposed assignment to be valid and shows each involved in the project (O'Connor & Mock, 2020).

Deliverables are documents or charts describing the results and outcomes of the project. They are reflected in the plan and statistical analysis of the data during the project and summarizing the quality of the project (Fiola, 2013). In our project, deliverables would be the safety team simulation analysis. It will be done by training participants survey pre and post-simulation training. The second deliverable will be the safety team post-fall checklist. The team will complete the checklist in the unit 30 minutes post-fall and collect the fall data. The data will be

used and discussed at the weekly team meeting with a recommendation for safety improvement. Another deliverable is falling analysis per 1000 bed days in average pre and post-intervention (Godlock et al., 2019).

Critical success factors are the essential factors for project management. Professional literature describes many critical factors for different projects (Yahaya Wuni & Qiping Shen, 2020). For the implementation of the falls prevention team, CSF would be effective communication between team members and project manager, effective management of the project by project manager and sponsors, involvement of the key players during the project, effective project planning and scheduling, effective budget planning, adequate training for the team members, effective risk management considering that outcome of the project will be effecting the patient safety (Yahaya Wuni & Qiping Shen, 2020).

Professional literature points out that monitoring and control of the project are essential variables for project success (Trzeciak & Jonek-Kowalska, 2021). This process allows the project manager proper assessment and more effective implementation of the theoretical strategy. Moreover, the effective monitoring and control of the project will enable the project manager to decentralize the management, correct order of the scope of tasks, supervision of duties, and responsibilities. In large organizations with many different projects running simultaneously, monitoring and control provide more flexibility to undertake various activities and increase their efficiency and effectiveness (Trzeciak & Jonek-Kowalska, 2021).

Researchers debate the importance of different areas of monitoring and control depending on the scope and nature of the project; however, most of the professional literature agrees on some key and less important areas to control and

monitor. Among the vital areas for monitoring and control are time management, cost control, scope control, risk management, resource control, and benefits provision control. Secondary important areas for monitoring and control are work control, procurement management, quality control, communication control, integrated change control, issue control (Trzeciak & Jonek-Kowalska, 2021). Different researches offer the most effective and most popular solutions for monitoring and controlling all of those areas. Among those solutions are frequent coordinating meetings, program planning, and reports. Much research points out the importance of milestones control and program planning. Another effective method of monitoring and controlling is proper documentation and follow-up with project logs, registers, and reports.

Moreover, the areas of monitoring and control depend on the stage of the project. At the start of the process, risk control and quality control play the most significant control and monitoring areas. When the project comes close to its end, the areas of more significance would be cost control and communication monitoring (Trzeciak & Jonek-Kowalska, 2021).

CHAPTER 3

DISCUSSION OF RESULTS

The project promoted patient safety by reducing the number of falls in hospitalized adults. In addition, the project improved interprofessional communication within the hospital staff. The measurable project objectives were based on the number of occurrence reports and quality evaluation of each fall according to the assessment of the checklist data. Falls among hospitalized patients is one of the most severe sentinel events and take a lot of hospital staff's attention. Many efforts have been made to prevent falls among hospitalized patients, and much research was dedicated to the topic (Johnson & Magnan, 2019). The professional literature describes many different methods to reduce hospital falls and to improve patient safety. Many of them are based on recognizing the risk factors and preventing falls by lowering them—another study providing different tools such as various assessment tools (Grealish et al., 2019). The patient safety team went through the simulation training before the project implementation. The patient safety team responded to inpatient falls, complete a post-fall checklist assessment and provide a huddle with a detailed analysis of the fall reasons and provide the recommendation for fall prevention in the future based on the current event. Professional literature shows that the patient safety team reduces the number of inpatient falls and improves the communication within the hospital staff (Godlock et al., 2016). The medical Fall Safety Team includes registered nurses (RN's), certified nursing assistants (CNA's), and team champions such as charge

nurses. Besides, the facilitation of safety huddles includes nurses in the units where falls took place, patients, and families (Godlock et al., 2016). Within six months, we saw a significant reduction of patient falls with injuries. Also, we observed improving communication and coordination among staff members. The project improved patient safety and decrease the number of falls and related injuries within hospitalized patients. Also, the project enhanced the communication within the team. Constraints factors during this project were shortage of nursing staffing and lack of cooperation from the staff members in the particular areas of the project.

This project did not demand an additional budget; however, it may increase unit overtime. The measurable project objectives were based on the number of occurrence reports and quality evaluation of each fall according to the assessment of the checklist data. The patient safety team went through the simulation training before the project implementation. The patient safety team responded to inpatient falls, complete a post-fall checklist assessment and provided a huddle with a detailed analysis of the fall reasons and provide the recommendation for fall prevention in the future based on the current event. Professional literature shows that the patient safety team reduces the number of inpatient falls and improves the communication within the hospital staff (Godlock et al., 2016). The medical Fall Safety Team includes:

Registered Nurses (RN's)- primary care providers and coordinators of care

Certified nursing assistants (CNA's)- providing direct patient care and 1:1 observation for high-risk patients.

Charge nurses- Supervision and coordination within a team

Nurses in the units where falls took place-part of the nursing team

Patients and families- Patient-centered care, involved in the decision making (Godlock et al., 2016). Comments (from each of the stakeholders listed in the Roles and Responsibilities):

RN- primary care provider, responsible for patient care and safety. Navigate the team dynamics

CAN-provides direct patient care, responsible for 1:1 and patient observation.

Charge nurse-coordinates the teamwork and Patient and family- a central care model, directly impact decision-making (Godlock et al., 2016).

CONCLUSIONS

Falls among hospitalized patients are one of the most severe sentinel events and take a lot of hospital staff's attention. Many efforts have been made to prevent falls among hospitalized patients, and much research was dedicated to the topic (Johnson & Magnan, 2019). Hospital falls could lead to severe complications in patients' care. According to National Database for Nursing Quality Indicators (NDNQI), all falls can be categorized into five injury levels: none, minor, moderate, major, and death. If inpatient falls result in injuries, hospitals can suffer from financial losses due to additional tests and rehabilitation needs.

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LIST OF REFERENCES

3. Dykes, P. C., & Hurley, A. C. (2021). Patient-centered fall prevention. *Nursing Management52*(3), 51–54. https://doi.org/10.1097/01.numa.0000733668.39637.ba

4. Godlock, G., Christiansen, M., & Feider, L. (2016). Implementation of an Evidence-Based Patient Safety Team to Prevent Falls in Inpatient Medical Units. *Medsurg Nursing*, *25*(1), 17–23.

5. Grealish, L., Real, B., Todd, J. A., Darch, J., Soltau, D., Phelan, M., … Chaboyer, W. (2019). Implementing Evidence-Based Guidelines for Falls Prevention: Observations of Nursing Activities During the Care of Older People With Cognitive Impairment. *Worldviews on Evidence-Based Nursing*, *16*(5), 335–343. https://doi.org/10.1111/wvn.12376

6. Isaranuwatchai, W., Perdrizet, J., Markle-Reid, M., & Hoch, J. S. (2017). Cost-effectiveness analysis of a multifactorial fall prevention intervention in older home care clients at risk for falling. *BMC Geriatrics*, *17*(1). https://doi.org/10.1186/s12877-017-0599-9

7. Johnston, M., & Magnan, M. A. (2019). Using a Fall Prevention Checklist to Reduce Hospital Falls. *AJN, American Journal of Nursing*, *119*(3), 43–49. https://doi.org/10.1097/01.naj.0000554037.76120.6a

8. Kiyoshi-Teo, H., Carter, N., & Rose, A. (2017). Fall Prevention Practice Gap Analysis: aiming for Targeted Improvements. *MEDSURG Nursing*, *26*(5).

9. Khong, L. A., Berlach, R. G., Hill, K. D., & Hill, A.-M. (2018). Community peer-led falls prevention presentations: What do the experts suggest? *The Journal of Primary Prevention*, *39*(2), 81–98. https://doi.org/10.1007/s10935-017-0500-9

10. Leahy-Warren, P., Day, M. R., Philpott, L., Glavin, K., Gjevjon, E. R., Steffenak, A. K. M., … Mulcahy, H. (2018). A falls case summary: Application of the public health nursing intervention wheel. *Public Health Nursing*, *35*(4), 307–316. https://doi.org/10.1111/phn.12408

11. Munsterman, E., Hodo, A., & Newcomb, P. (2018). Factors associated with falls among hospital inpatients. *Nursing Management (Springhouse)*, *49*(11), 38–44. https://doi.org/10.1097/01.numa.0000547259.22709.82

12. Reich, J., Farrell, K., Drayton, D., & Johnson, T. (2017). Decreasing Falls With Injury Rates. Development of a support staff Falls Advocate Programm . *Journal of Nursing Care Quality*, *32*(1), 40–46. https://doi.org/10.1097/NCQ0000000000000206

13. Souza, A. B. D., Maestri, R. N., Röhsig, V., Lorenzini, E., Alves, B. M., Oliveira, D., & Gatto, D. C. (2019). In-hospital falls in a large hospital in the south of Brazil: A 6-year retrospective study. *Applied Nursing Research*, *48*, 81–87. https://doi.org/10.1016/j.apnr.2019.05.017

14. Spano-Szekely, L., Winkler, A., Waters, C., Dealmeida, S., Brandt, K., Williamson, M., … Wright, F. (2019). Individualized Fall Prevention Program in an Acute Care Setting. *Journal of Nursing Care Quality*, *34*(2), 127–132. https://doi.org/10.1097/ncq.0000000000000344

15. Tyndall, A., Bailey, R., & Elliott, R. (2020). Pragmatic development of an evidence-based intensive care unit–specific falls risk assessment tool: The Tyndall Bailey Falls Risk Assessment Tool. *Australian Critical Care*, *33*(1), 65–70. https://doi.org/10.1016/j.aucc.2019.02.003

APPENDIX A

Gantt Chart

Falls Prevention Safety Team

	Start Date	End date	Duration	
Identify project champions	1/2/2022	1/5/2022	4	44558
creating the teams	1/2/2022	1/10/2022	8	44734
making team work schedule	1/2/2022	1/7/2022	5	
monthly meeting schedule	1/2/2022	1/8/2022	6	
pre-simulation survey	1/8/2022	1/12/2022	5	
training program	1/10/2022	1/15/2022	5	
identifying critical tasks	1/12/2022	1/15/2022	3	
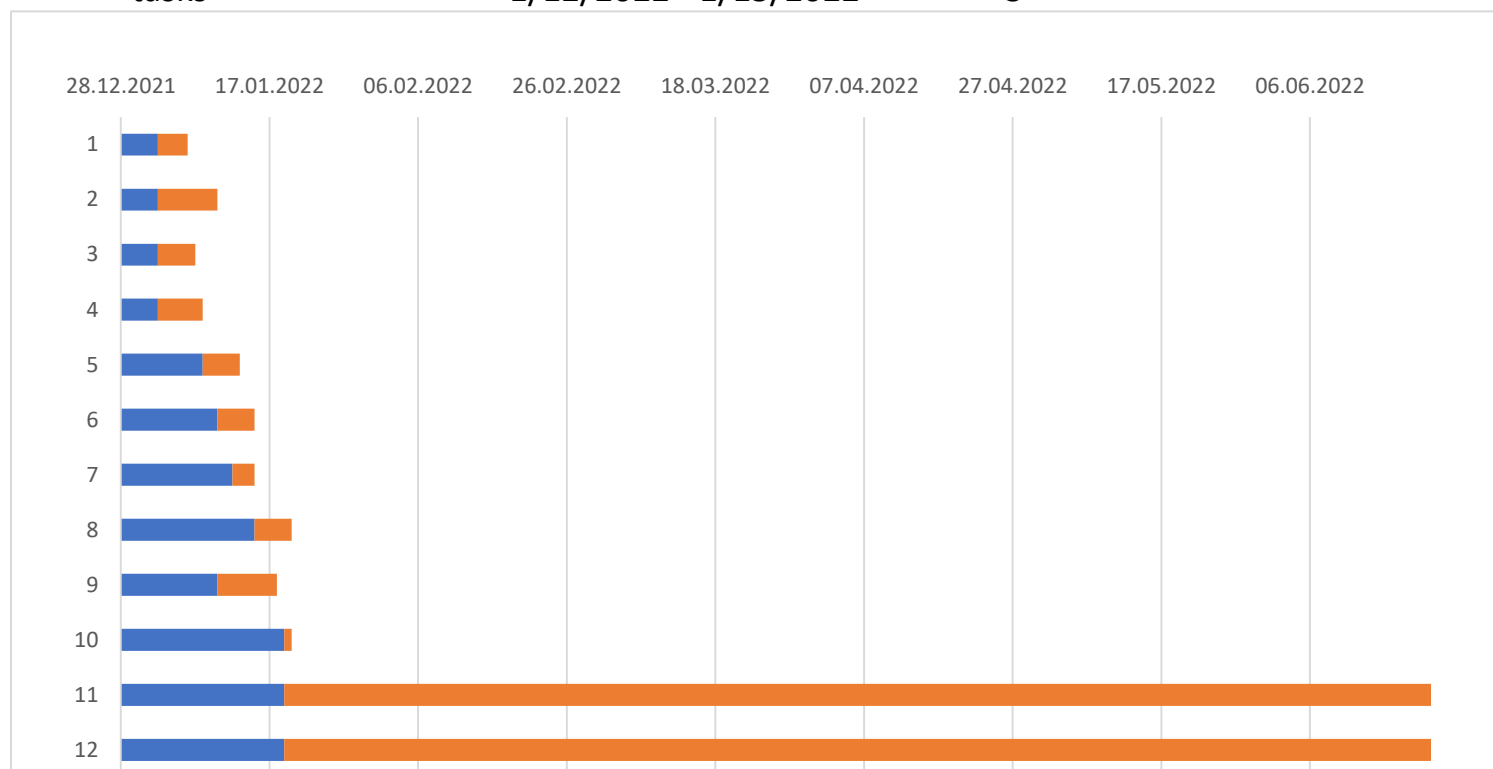
APPENDIX B

Communication Plan for Safety Team to Prevent Falls in Inpatient Medical Units

Project Team Member/Stakeholder	Communication* Preferred Format	Timing	Report Prepared by
Project Sponsor	Initial meeting in person Updates and follow up by e-mails or phone conversations	Ongoing by weekly basis	Project Manager
Fall Safety Team include Registered Nurses, Certified Nurse Assistants and Charge Nurses identified as a champion	Kick-off meeting planning and goal settings Fall Safety Team Simulation Training Meeting following The completion of training Weekly following up meetings discussing all the falls and intervention by the team	3-4 weeks before the start of the project Weekly before the start of the project The week before the project started Each Monday weekly	Project Manager Project Manager Nurses champions Project Manager Project Manager

Project Manager and project champions	Personal meetings with Project Manager and Team champions discussing the number of the falls and interventions of the team	Each Friday weekly	Project Manager and Team champions
Nursing Quality Officer	Personal meetings to discuss overall progress of the project and its impact on patient's safety	Monthly	Project Manager

APPENDIX C

Responsible, Accountable, Consulted, Informed, (RACI) Chart

Project Tasks - Major	Team Member (RAC or I)	Team Member (RAC or I)	Team Member (RAC or I)	Team Member (RAC or I)
	Project Manager	**CNO**	**Education Department**	**Team Members**
Complete training and education	A	I	C	R
Create a budget and financial documentation	A	I	C	I
Complete project design and schedule	R	I	I	A
Report results and outcomes	A	I	I	R
Project Tasks - Subtasks				
Conduct Meetings	A	I	I	R
Complete project-related documentation	A	I	C	R

Explain terms in professional paper: R = Responsible   A = Accountable   C = Consulted   I = Informed. Add more rows as needed to include ALL team members and tasks.

Reference

O'Connor, J. T., & Mock, B. (2020). Responsibilities and accountabilities for Industrial Facility Commissioning and Startup Activities. *Construction Innovation*, *20*(4), 625–645. https://doi.org/10.1108/ci-09-2019-0094

APPENDIX D

Project Monitoring-and-Controlling Template
Project Title: Communication Plan for Safety Team to Prevent Falls in Inpatient Medical Units

Project-Management Knowledge Area	Monitoring and Controlling		Frequency*	Detailed Description of F or E Ratings**
	Process	**Outputs**		
Integration Management	Verification of dependencies between the teams	Requested changes	F	The success of the project depends on a multidisciplinary approach. Monitoring of integration of all disciplines is essential at all stages of the project
Scope Management	Earned value methods Management control Milestone control	Requested changes Requested changes Requested changes	N	
Time Management	Programm plan Gantt chart Reports	Requested corrections Requested corrections Requested corrections	F	The effectiveness of the project could be measured by time management. It is essential to stay within all deadlines
Cost Management	Multistage cost control Reports	Requested corrections Requested corrections	O	
Quality	Audit and control	Requested	E	The project promotes

Project-Management Knowledge Area	Monitoring and Controlling		Frequency*	Detailed Description of F or E Ratings**
	Process	Outputs		
Management	of the program effects. Implementation of the functional procedure of the quality process	changes Monitoring of possible changes in the project		patient safety. Constant monitoring of quality management is one of the most visual indications of the project's success.
Human-Resource Management	Human resources register Issue log	Completion of all needed documentation	N	
Communication Management	Regular coordination meetings Complete analysis of communication issues	Analysis and requested coordination	F	Communication is one of the essential parameters of project success as well. Communication control is a high priority for the project manager
Risk Management	Verification of risk influence on the project goals	Analysis and correction of all risk factor	E	Monitoring and control of the risk management allows verifying the influence of the risks on strategic goals
Procurement Management	Program procurement plan and analysis	Requested changes	O	

Frequency Key: N=Never, O = Occasional (1-4 times), F= Frequent (5-10 times), E = Excessive (>10 times)

*Record the number of times that you had to monitor and control each knowledge area during the project, using the frequency key above.

** Write a detailed description about any occurrences that happened more than 5 times or were rated frequent (F) or excessive (E).

Summary

All project-management knowledge areas are essential for the successful implementation of the project. However, we can recognize critical areas which will be monitored with more attention and frequency. Integration and coordination area provide work frame and coordination between different disciplines in the project. Time management is essential for project success. To keep the momentum going and staff enthusiasm could be achieved only within deadlines of each project stage. Quality and communication management are critical areas—both of those areas shape the quality and productivity of the project. Risk management should also be monitored excessively because it shows how the risk factors affect the project (Trzeciak & Jonek-Kowalska, 2021).

Reference

Trzeciak, M., & Jonek-Kowalska, I. (2021). Monitoring and control in program management as effectiveness drivers in Polish energy sector. diagnosis and directions of improvement. *Energies*, *14*(15), 4661. https://doi.org/10.3390/en14154661