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Walden University

College of Health Sciences

This is to certify that the doctoral study by

Ramona Lancaster

has been found to be complete and satisfactory in all respects,
and that any and all revisions required by
the review committee have been made.

Review Committee

Dr. Patrick Palmieri, Committee Chairperson, Nursing Faculty

Dr. Cheryl Parker, Committee Member, Nursing Faculty

Dr. Francisca Farrar, University Reviewer, Nursing Faculty

Chief Academic Officer

Eric Riedel, Ph.D.

Walden University

2017

Abstract

Quality Improvement Project to Reduce Resident Fall Risk in a Skilled Nursing Facility

by

Ramona C. Lancaster

MSN, Walden University, 2013

ASN, Excelsior College, 2010

Project Submitted in Partial Fulfillment
of the Requirements for the Degree of
Doctor of Nursing Practice

Walden University

March 2018

Abstract

Residents who fall with injury in a skilled nursing facility (SNF) experience a significant decline in quality of life or die from their injuries. On average, 19.8% of residents fall at least once per month with an average cost per fall estimated to be \$34,000. The purpose of this quality improvement project was to use the to guide an update of a SNF fall policy based on the published evidence and resident feedback. The evidence to revise the fall policy was obtained through a scoping literature review. Resident feedback was collected through a focus group with previous fall experience. The structured group discussion provided feedback about critical gaps in communication related to the resident care plans. For example, 10 of 11 residents indicated they were never asked to participate in their care planning, 10 of 11 residents indicated the staff did not listen to them, and 11 of 11 stated they did not know they could change the care plan developed by clinical staff. The overall consensus was the residents want to be actively involved in their care; however, they are largely excluded from this process. This feedback altered the objective for the fall policy revision by focusing on practices and strategies to close the resident-clinician communication gap. The revised fall policy includes recommended clinical practices to encourage clinicians to seek resident participation in their care planning process as an essential fall reduction strategy. The policy was implemented with a revised falls oversight committee including residents, clinical staff, and management. This project contributes to positive social change by identifying resident-centered approaches and strategies in partnership with clinical staff to reduce the risk for resident falls.

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Dedication

This proposal is dedicated first and foremost to Ms. Mary Mason, my youngest son's grandmother, and to all residents of SNF who have the ability and desire to participate in the guidance of their plan of care. Through implementation of this quality improvement initiative, your voices will be heard.

Acknowledgments

The road to earning my doctorate in nursing practice (DNP) has been met with obstacles, tears, and frustration. However, today I have achieved a monumental step in my academic journey and would like to acknowledge some of the vital people that supported me. First and foremost, thank you GOD for your mercy and blessings on me to have the mindset to keep on pushing during the times when I had no thoughts to put into words nor the strength to type them.

Thank you to my Walden University faculty members, as each of you has played a role to assisting me to reach this higher step on my academic ladder. Dr. Patrick Palmieri, my DNP mentor, and Dr. Cheryl Parker, I cannot thank you two enough for all your patience, guidance, and for reviewing my work just one more time.

Thank you to my beloved children Brionna, Keyonna, Kyle, Keairra, and Armon. Mommy missed many family events and times when present, a stack of books and my lap top had my attention; thank you for your understanding and unconditional love. I do what I do and I am who I am, because for you. To my future husband, Willie Epps, thank you for your encouragement and patience.

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Section 1: Quality Improvement Initiative Project

Introduction

Residents in SNF (SNF) have a high incidence of falls resulting in increased morbidity and mortality. A SNF requires an administrative staff, registered nursing at least eight hours per day, licensed nurses 24 hours a day, medical director, licensed social worker, therapy staff, certified dietitian, and certified nursing aids on hand 24 hours a day. A SNF offers hospital services such as IV therapy, trachea care, wound care, reconditioning and therapy treatment for conditions such as stroke, heart attacks and falls.

SNFs are challenged to effectively assess and evaluate nursing interventions based on current evidence to work with fall best practices. For many residents who experience falls, the recovery process can be difficult and suffer from pain, immobility, contractures, hip or knee fractures, as well as the emotional tolls of isolation and depression. Opportunities to improve among fall programs and policies are evident in the data gathered on incidences related to falls in SNF. Evaluating falls program outcomes is an important leadership responsibility to maintain a safe resident environment. The construction of this quality improvement project included evaluation of gaps in practice, fall management programs, protocols, culture of practice setting, and the role the resident plays in his or her plan of care related to falls. Falls in SNF have implications to affect residents physically, mentally, and economically.

SNFs provide specialized services ordered and overseen by a physician such as medical exams, medication orders, diagnostic testing, and, treatment plans. Providing these services require certified technical or licensed professional health personnel such as

medical doctors, nurse practitioners, registered nurses, licensed practical (vocational) nurses, physical therapists, occupational therapists, and speech pathologists or audiologists. Additionally, services must be provided directly by or under the general supervision of skilled nursing or skilled rehabilitation personnel to assure the safety of the individual and to achieve optimal outcomes. Historically, the incidences and costs of falls have challenged health care systems and gained the attention of the Centers for Medicare and Medicaid Services (CMS), which is the regulatory body for nursing homes. The health sector is impacted by every fall, estimated to cost more than \$34,000 per incident (Lach, 2010). Emergency room treatment, hospital stays, diagnostic testing such as x-rays, cat scans, medications, and manpower all contribute to the high cost related to falls.

This was an evidence-based quality improvement project to develop a falls prevention program focused on reducing the risks for resident falls within a SNF. The project integrates resident feedback related to their knowledge and experience with falls into an intervention program. An effective and actionable falls prevention program can contribute to reducing the risk, decreasing emergency room visits, hospitalizations, and injury while encouraging resident autonomy and confidence in being active (Lach, 2010). The project design was selected to identify risks from the SNF resident's perspective. Therefore, the project included strategies for obtaining resident feedback as they are active stakeholders in this project.

Problem Statement

A reduction in resident falls in SNF would have positive implications for residents and organization, including social and economic benefits. The fall rate in the project facility was double both state and national thresholds, leading to extensive medical requirements due to injury from falls. In a 6-month review of medical records related to falls in the project facility, 124 falls were reported and 21 (16.9%) of those falls required hospital admission with 18 (14.5%) resulting in broken bones. A review of medical records and witness statements demonstrated a pattern of lack of resident feedback or suggestions into their care.

Purpose Statement

Because the project facility culture resulted in limited resident feedback into their individual plan of care, my focus was to increase resident input. Inviting residents to contribute to understanding their reasons for falling and their risk for fall was the focal point for this project. The project included soliciting resident feedback about falls and then implementing their experience into nursing practice as a method to reduce the risk for falls. This was an evidence-based process using literature with the resident voice, to reduce the risk of falls. Indirectly, the fall intervention was developed by the residents through their brief feedback. The key to the project was to intertwine resident feedback, clinical expertise, and evidence-based practice into daily nursing practice to reduce falls.

Per public data published by CMS and retrieved from project facility, falls in this skilled nursing home have continued to exceed monthly state and national benchmarks. During a 6-month review in 2015, the project facilities fall data indicated rates were

above both state and national rates at 19.8%. State average percentage during the same review time was 12.2% and the national average was 11.7%.

Gap in Practice Defined

After observing several months of day-to-day practice within a SNF, it was noted the project facility encompassed a culture where standard practice was not to include residents' feedback into their plan of care. Colon-Emeric et al. (2013) recounted that two decades have been dedicated to research, analyze, deconstruct, and address the multifaceted complexities of falls in SNF. Still, according to facility fall reports, my project SNF continues to be above the threshold for residents falling with injuries. Effective fall interventions in SNF need to be developed to manage the nearly 1.3 million Americans requiring these services (Carande-Kulis, Stevens, Florence, Beattie, & Arias, 2015). The demand is anticipated as the "baby boomer generation" are expected to constitute over 19% of the population, 12% of whom will be 85 years of age and older by 2025.

PICOT Process

The PICOT format is a helpful approach for summarizing research questions that explore the effect of therapy (Guyatt, Drummond, Meade, & Cook, 2008). The PICOT method was used to develop a searchable question to identify the evidence-based literature focused on improving clinical practice related to falls in the skilled nursing settings. In addition, the evidence will guide an assessment of the current facility practice and fall protocol. This project includes resident feedback with current fall data. This process was used to revise the fall policy and protocol to meet or exceed state and

national benchmarking related to nursing home falls with injury. The PICOT question is this: What impact will the integration of resident feedback into their plan of care have on reducing resident falls, and prevent those with injury? The problem for the question was developed from the PICOT elements as follows:

Problem / Population – Falls among residents, ages 65 to 100 years, in a SNF.

Intervention – New fall prevention protocol based on current evidence and resident feedback.

Comparison - Current protocol with actual benchmark for falls with injury.

Outcome –Improve protocols based on the evidence and resident feedback; and decreased falls with injury.

Type / Time - Quality improvement project to develop a protocol over 6 months.

Response to Gap in Practice

This doctoral project has the potential to address the gap in practice by demonstrating that resident feedback can indeed help to decrease individual risk for falls. Therefore, intertwining resident feedback and suggestions into their care becomes an evidence-based nursing practice to help reduce fall risk. Inclusion practice must be an ongoing practice, and the development of a fall committee can be used as a tool for reducing gaps in practice. With the accelerating growth of the aging population, lack of affordable assisted living housing, and already stressed community services, solutions for basic problems negatively impacting the expanding elderly population need to be identified and implemented (Lattanzio, 2014).

Significance of the Doctoral Project

Although gerontologists have continued to conduct studies to understand fall etiology to prevent falls with injuries (Etman et al., 2012), clinicians did face challenges to provide adequate interventions to decrease falls. This quality improvement project is significant because historically, challenges related to providing adequate fall interventions continue to be a factor for safety as evidenced by the continued gaps in fall interventions. The fact that fall rates are above state and national nursing home thresholds and the constant surmounting increase in cost associated with falls is evidence that revolutionary strategies are needed in practice. Therefore, this quality improvement initiative was designed. This doctoral project was a path to help close the gap between resident and staff communication related to falls. This doctoral project has the potential to positively benefit the quality of life for residents and patients in any health care setting.

Implications for Social and Economic Change

A reduction in resident falls in SNFs has positive implications for social change and economic change. The local benefit is substantial, as the falls rate in the project facility is doubled both state and national thresholds. Low cost intervention targeting dissemination of evidence-based best practices in nursing homes can result in the potential for fall reduction and cost savings (Teresi et al., 2013). Including resident feedback in care planning is a vital element to reduce the fall risk. The Safety Attitudes Questionnaire is also a reliable tool for measuring safety culture in nursing homes (Thomas et al., 2012). Direct medical costs nationally totaled \$19 billion for nonfatal fall injuries and \$179 million for fatal fall injuries in 2000 (Stevens, Corso, Finkelstein, &

Miller, 2006), and the costs associated are projected to reach \$43.8 billion by 2020 (Stevens, 2005).

Before industrialization, family members were cared for at home; after industrialization, nursing homes were intended to fill caregiver gaps for family members who could not care for their loved ones at home (Enderlin et al., 2015). Caregiver gaps carried a social stigma escalated by widespread physical, emotional, financial, and sexual abuse (Enderlin et al., 2015). Today, SNF are where approximately 1.3 million Americans call home (Carande-Kulis et al., 2015); therefore, the physical and emotional costs tied to residents who fall become quality of life issues such as mobility and pain. Another quality of life issue is the residents' social life, such as spending time with family and being able to attend activities that occur outside the facility (Hill & Wee, 2012).

There is a domino effect to residents who experience falls with injury. The physical, mental, financial, and social implications related to falls greatly affect resident vitality and motivation. Achieving reduced falls for residents will establish new goals for health care through setting financial and social benchmarks of acceptance and foster a culture ready to embrace ongoing evaluation of protocol and policy.

Assumptions and Limitations

Assumptions

Residents selected will have fall data to include a Briggs Fall Risk Assessment form, incident reports with at least one documented fall within the last 12 months, and have a Brief Interview for Mental Status score of at least 10. Falls documented in the last

12 months are a mandatory eligibility requirement. It is assumed that any commonalities between residents based on this selection are coincidental. Additionally, it is assumed that residents selected will give voluntary consent to participate in the survey and answer the questions truthfully. It was the assumption that the nursing staff that would secure the incident report by implementing HIPAA training and sensitivity to maintain confidentiality.

Limitations

This quality improvement project has three limitations. The first limitation is the sample will be taken from one SNF. The second limitation is the number of incident reports defines the number of potential interview participants. The interview participants might not represent the perspectives of the entire population. The third limitation is residents who have been discharged or transferred from the facility and are no longer available for interview might not be like the available participants.

Summary

Section 1 provided a brief overview of the problem statement, purpose statement, significance of the project, implications for social change, and the assumptions and limitations regarding incorporation of a new design. This section also identified why a reduction in falls would have positive implications for all stakeholders. A reduction in falls for the resident of SNF would have an optimistic implication for social and economic change by minimizing injury and decreasing cost associated with falls. The objective was to incorporate resident feedback into a quality improvement project that

helps to close the communication gap between staff and resident. Section 2 will present a review of scholarly research.

Section 2: Review of Scholarly Evidence

Introduction

SNFs are challenged to effectively assess and evaluate nursing interventions based on current evidence to work with best practices. For this literature review, I focused on evaluating falls program outcomes and the involvement of resident feedback into plan of care. The construction of this quality improvement project included evaluation of gaps in practice, fall management programs, protocols, culture of practice setting, and the role the resident plays in their plan of care related to falls. Falls in SNF have implications to affect residents physically, mentally, and economically.

Theoretical Framework

Using the self-care deficit theory (SCDT) by Doretha Orem closed the gap between clinical staff making most patient decisions and encouraged the patient to participate in their plan of care. Self-care agency is the ability of the person to engage in self-care (McEwen & Wills, 2011). For example, upon admission to the project facility, all residents are administered a cognitive exam; some residents have the cognitive ability to help direct their plan of care and are more equipped to explain preadmit practices that helped to minimize their falls at home, yet facility practices have not demonstrated the need to incorporate resident feedback. In the current practice site as well as others researched, the residents' feedback has been rarely if at all taken into consideration when placing fall interventions. By using Orem's three-step nursing process, expected outcomes or goals can be predicted. In the first step, it was vital to establish resident cognitive level of function. To achieve this step, assessment was done to determine if

there was a self-care deficit and need for nursing care, then a classification was made as to which nursing system the patient condition applies (Anna, Christensen, Hohon, Ord, & Wells, 1978). The second step occurs when care delivery plans were created and goals and expected outcomes were formulated and stated (Anna et al., 1978). Example, is the resident able to provide feedback as to why they may have experienced a fall? The third step included implementation, ongoing evaluation, and revision of the plan (Anna et al., 1978). Example, is the resident able to offer interventions to deter future fall risk?

The basis for the SCDT was to demonstrate residents' capability of providing feedback related to their care, and the goal of this initiative was to provide a path in which resident feedback and nursing practice would intertwine, thus advancing nursing practice. The proposal demonstrated how incorporating resident feedback can be used to minimize risk for falls. Included in this proposal is the Fall Intervention Resident Suggestion Tool (FIRST form; Appendix B), which nursing staff can use as a guide to collect resident feedback to help place appropriate measures for minimizing risk for future falls, thus the residents will have contributed to their self-care by directing or adding to their plan of care. Banfield (2011) suggested the SCDT can be conceptualized into three parts: (a) theory of self-care; (b) theory of self-care deficit; and (c) the theory of nursing system. Foundation principles include the following:

- People's environment determines their self-care and or dependent care behaviors,
- People must learn to promote their own health (when they can do so).

- Nursing is gaining the knowledge to act on promoting ones' health, and people must look in themselves and beyond themselves to prevent sickness and get well.

Terms

Fall: Characterized by a quick descent, by the force of gravity, to come or go down quickly from a high place or position; to come or go down suddenly from a standing position; to let yourself come or go down to a lower position (Hill & Wee, 2012).

Fall with injury: Fall with bodily harm.

Resident: A person who resides in a SNF for more than 30 days (Lach, 2010).

Gerontologist: Health care professionals who specialize in the field of aging-related dimensions of change over the lifespan. They provide their services to people in universities, hospitals, nursing homes, senior citizen centers, and the community

Baby boomer: Person born between 1942 and 1964.

Long-term care: A range of services that supports the daily needs of residents with challenges to independent living such as limited function or disability (Cho & An, 2014).

Nursing home: A place for people who don't need to be in a hospital but cannot be cared for at home. These residents require only custodial (observation and activities of daily living needs) care such as bathing, eating, and medication administration. Depending on the state, needs can be met by staff with certificates rather than licensure.

Skilled Nursing Facility (SNF): A facility that requires at minimum an administrative staff, registered nursing at least 8 hours per day, licensed nurses 24 hours a day, medical director, licensed social worker, therapy staff, certified dietitian, and certified nursing aids on hand 24 hours a day. A SNF also offers hospital services such as IV therapy, trachea care, wound care, and reconditioning status post stroke or heart attacks. The staff provides physical, speech, and occupational therapy.

Fall Intervention Resident Suggestion Tool (FIRST): The FISRT form is resource data collection tool. Staff can opt to use this resource as a guide for asking residents open-ended questions that may lead to answers to help decrease the risk for falls.

Certification and Survey Provider Enhanced Reports (CASPER): A computer view of facilities quality measure reports that is obtained by facility staff and contains collaborative information at the national, state, facility, and resident level for a single reporting period (Daly, Bay, Levy, & Carnahan, 2015).

Health Insurance Portability and Accountability Act (HIPAA): A 1996 federal law that restricts access to individuals' private medical information.

Literature Review Search Strategy

Falls in nursing care facilities and hospitals are common events that cause considerable morbidity and mortality for older people (Cameron et al., 2012). Nurse leaders are becoming more aware of their vital role needed to improve and implement evidence base practice within the SNF. This literature review focused on decreasing falls in the SNF, nursing home safety, past and current interventions, collection of peer reviewed articles, SNF literature, closing gaps, and resident feedback. Additionally,

articles related to intervention and prevention of falls in hospital setting are also included because they contained factors relevant to skilled nursing home residents. This is an overall review and is not a systematic collection of all possible fall-related articles.

The purpose of the literature review was to determine the range of resident feedback into their plan of care related to falls. The data gathered were designed to be used to close the gap between resident involvement in care and the clinical team. The review of literature involved examining current best practices and scholarly research from the experts in geriatrics, gerontology, age, and ageing, and the medical, nursing, and health care communities. The search results also include collection of peer-reviewed articles, academic journals, and scholarly books with multidisciplinary approaches to safety, policy, interventions, nursing, and health-related outcomes. Additionally, federal and state government agency websites were used to access statistical, regulatory, and legislative data.

The concentration of resource information for the project include Walden Library online databases, Google Scholar, GALILEO, PubMed, EBSCOhost, Medline, and CINAHL. Pertinent reference lists of all research selected for review were manually searched for potential additional research. The following search terms were used to gather information: *falls, fall policy, fall programs, fall assessment tools, quality improvement, incident reports, benchmarking, CASPER report, SNF, Dorothea Orem, residents and falls, safety, residents' perceptions, SCDT, benchmarking, lawsuits, and fall interventions*. Title searches included *Injury, skilled nursing, resident participation, prevention program, International Nursing Review, American Journal of Medicine, Bone,*

Journal of American Geriatrics, Archives of Gerontology and Geriatrics, Drugs & Aging, Journal of Safety Research, Rehabilitative Nursing, and Biomed Central Geriatrics.

Government agencies used were entities within the U.S. Department of Health and Human Services that primarily focus on nursing homes.

According to the Agency for Healthcare Research and Quality (AHRQ, 2008), resident falls in skilled nursing homes are the most common cause of sudden death and disability not related to a disease or disorder. Falls in nursing care facilities and hospitals are common events that cause considerable morbidity and mortality for older people (Cameron et al., 2012).

Resident Falls

Fall prevention has continued to be a challenging task for clinicians. In fact, in 2008, the CMS identified falls as a hospital-acquired condition, which is a complication or comorbidities or major complication or comorbidities that occurs because of hospitalization and is high volume and/or high cost and reasonably preventable using evidence-based guidelines (Radey & LaBresh, 2012).

The fall rate in the practicum facility was double both state and national thresholds, leading to extensive medical requirements due to injury from falls. In a 6-month review of medical records related to falls in the project facility, 124 falls were reported and 21 of those falls required hospital admission. Out of the 21 hospital admissions, 18 resulted in broken bones. A review of medical records and witness statements demonstrated a pattern of lack of resident feedback/suggestion into their care.

This section will provide foundation for the theoretical framework of SCDT literature review, search strategy, definitions, and the skilled nursing background.

Falls in skilled nursing homes are the most common cause of sudden death and disability not related to a disease or disorder (AHRQ, 2008). A reduction in falls for residents has promising implications to foster a higher level of participation in social activities, decrease heavy workloads for nursing staff, extend monetary resources within the organization, and promote long-term fiscal solvency for the health care industry (Jung, Shin, & Kim, 2014).

To date, 1.4 million people depend on SNF for safe and effective administration of comprehensive skilled care (U.S. Department of Health and Human Services, 2014). Due to the baby boomer generation, this number continues to rise. In fact, MetLife Mature Market Institute (2002) indicated almost 80% of Americans today will live past the age of 65 with life expectancy extending another 19 years for women and 15 years for men, which will require skilled nursing care. Currently, 6.4 million individuals aged 65 or older need long-term care; for this reason, the need for ongoing evaluation of fall programs and fall policy is of utmost concern to all stakeholders. Continued evaluation of fall management programs provides a safer environment for residents in SNF and is supported by evidence-based practice in nursing and safety.

The CMS is responsible for health and safety survey, inspection, regulatory compliance, and benchmarking rates of SNF. The spans of CMS require multiple initiatives; however, safety in SNF is a top priority because of falls. Safety management

protocols in all U.S. facilities is necessary, and to meet this necessity SNF have fall prevention programs as a component of safety measure.

Fall programs are the systematic design of nursing interventions for quality improvement initiatives related to residents' falls. As Americans demand quality of care, there is an urgent and persistent need for better outcomes in the reduction of residents' falls in SNF. Fall programs are safety protocols structured through nursing interventions to track, document, and measure the quality and progress of this health care demand (Deandrea et al., 2013).

There are many reasons that falls occur. Identifying these reasons and implementing evidence-based protocol could close the gap on ineffective fall programs. Chapman and Newhouse (2013) argued falls occur based on intrinsic and extrinsic risk factors. Intrinsic risk factors include factors with physiologic or internal origins while extrinsic risk factors are environmental or external factors. Intrinsic and extrinsic risk factors are associated with types of activities in relationship to physiologic and environmental surroundings (Chapman & Newhouse, 2013). Differentiating intrinsic and extrinsic risk factors for residents in SNF will also help to provide strategies to increase quality improvement protocols.

Both intrinsic and extrinsic risk factors are regarded as important risk factors in the nursing assessment and evaluation of fall prevention programs. Evidence-based research data are used to design and construct a qualitative initiative intervention to decrease risk factors and thereby falls of residents in SNF (Zhao & Kim, 2015). This project will incorporate resident perception as a quality improvement intervention.

Skilled Nursing

History, television, and status quo mentalities branded nursing homes as dark depressive dumping grounds for exploitive family members looking to get rid of hard to manage relatives. It is true that widespread evidence of abuse, fraud, and corruption by some skilled nursing homes, health care providers, and family members made the thought of living in a skilled nursing home less desirable (Schiamberg et al., 2011).

To help change the reputation, it will be vital for staff to be clinically progressive and have the skill set to provide education to stakeholders as well as the community related to positive outcomes. Staff should also educate on services offered, facility star ratings, quality measure results, regulatory requirements, monitoring processes, as well as survey results. Also, dissemination of ongoing research and quality improvement initiatives will help diminish the social stigma placed on skilled nursing home staff, residents, and family members.

Americans use nursing homes as alternative placement for their long-term medical and social service needs. Receiving services in SNF is more cost effective than remaining in an acute hospital setting. The cost of skilled nursing homes varies significantly between facilities across the nation and even within the same city. According to data from the project facility, the average monthly cost of a skilled nursing home stay is estimated at \$7,756.00 for a semiprivate room and up to \$21,000.00 monthly for a private room.

Skilled nursing homes that have at least 60 beds are required to have full-time staff and provide 24-hours-a-day, 7-days-a-week care for the residents. The team required

to provide all phases of care include an administrator, medical director, director of nursing, registered nurses, licensed practical/vocational nurses, certified nurse aides, social workers, a dietary manager, dietitian, activity director, therapy department, housekeeping, and environmental service staff.

Medical service provided include short- and long-term antibiotic IV therapy, wound care, diagnostic testing, medication review and administration, educational training, post stroke rehabilitation, surgical/disease wound care. For those who cannot be cared for at home, a nursing home has become a viable permanent option. SNF are also equipped with full-time therapy departments. Therapy services include nursing, physical therapy, occupational therapy, speech services, and neurological treatment plans.

Section 3: Collection and Data Analysis of Evidence

Introduction

The research method for this quality improvement project included the intervention research method. The advantages for using this method are demonstrated in its structure. The structure allows for a small sample, inclusion for intervention, low cost to conduct research, ability to measure past interventions with established intervention, and lastly the project's effectiveness can be measured. For example, falls with ineffective interventions have been identified as a significant health care issue and the gap in care, identified as the lack of resident input into their preventive care. The intervention research method was an actual way to demonstrate the effectiveness of fusing nursing intervention and resident feedback. As gaps were identified, strategies were used to effectively introduce nursing interventions using steps within the intervention research

method framework. The evidence gained from using the intervention research method was used in practice by the clinical staff to demonstrate gaps in care due to little to no resident feedback. Also, this method helped to establish effective care plans that include resident feedback and are being used to decrease practice gaps by the following:

- creating a facility culture of learning and teaching among staff and residents (inclusion);
- using resident statement/feedback in reports to create resident autonomy (inclusion and low cost);
- creating effective nursing interventions that can be measured and disseminated in other areas (measure past interventions, low cost);
- creating effective fall committees actively identifying gaps in care and researching interventions (inclusion, low cost and measurable);
- encouraging staff to accept opportunities for improvement (inclusion); and
- encouraging resident to accept accountability for following care plans they assisted in creating (inclusion).

The FIRST form has been identified as documentation that can be used as an educational tool to translate useful information that was obtained from the resident. Utilizing the FIRST form helped gather information provided directly by the resident. The On-Time Prevention design was used to explore the project question as this design provides a strategy for preventing adverse events in nursing homes. The On-Time approach involved a facilitator to help the nursing home staff with understanding how important it is to help decrease falls as well as establish buy-in for decision making to

improve care planning. For example, the On-Time facilitator readily assists staff to recognize effective interventions and those that may need to be reevaluated; a significant finding at the project site was the lack of resident feedback into their plan of care. Lastly, On-Time Prevention also provides implementation tools to help the team use the reports on a weekly basis (AHRQ, 2014).

Population and Sampling

The population for this quality improvement initiative is the residents residing in a skilled nursing center in the coastal region of Georgia. It is important to note that residents' personal identification was not required for this quality improvement initiative. The sampling or inclusion criteria included residents with a Brief Interview for Mental Status score of 10 or above and those who had scored 10 or above on the Briggs Healthcare fall risk evaluation. The exclusion criteria for the study included residents who are not cognitively appropriate, score below 10 on the BIMS assessment, or cannot participate with questions or answers related to falls; exclusion criteria also included residents who are bed bound or require total assistance with mobility.

The sampling method for this study was the convenience sampling. Grove, Burns, and Gray (2013) suggested subjects are included in this type of study because they happen to be in the right place at the right time. Residents who met the inclusion criteria and signed off on their consent forms (if needed) were included in the study. Convenience samples are usually inexpensive, accessible, and require less time to acquire samples (Grove et al., 2013); thus, this approach worked well for this quality improvement initiative.

Data Collection

All federally funded nursing home fall data are public record through the Center for Medicaid and Medicare Services (CMS) and were accessed via the Internet.

Additional data were obtained through administrative approval utilizing their medical records system. The process included hands-on collection by designated clinical staff and remote access using a specific user ID and password exclusively for this project.

Additional data were public and offered online and were accessed via online connection.

Data gathered for collection for this project included documents such as the facility's quality measures reports, quality assurance performance improvement, CASPER reports, residents' medical records, as well as data from state and national fall reports. CMS reports and other statistical data on organizations fall rates are public knowledge.

Organizations that receive reimbursement from Medicare and Medicaid are required to submit monthly reports for quality measure monitoring. The fall data rates allow the facility to be aware of their standing in comparison to similar health care settings. It helps to identify areas where improvement is needed most. Falls were established as a critical area for quality improvement.

After collecting and reviewing fall assessments forms, to include the Briggs Fall Risk Assessment form, from different online and publishing companies, the conclusion demonstrated vital elements missing from these assessment tools. The current tools display limited to no space to ask for resident feedback or their input into limiting the risk for falls.

Although some residents are very capable of adding effective interventions to decrease their risk for falls, practice has displayed a lack of resident feedback. In the advancement of nursing practice, resident feedback has its place when implementing individual plan of care. This position can be implemented through understanding the goal of the FIRST form. A reduction in falls for residents in SNF would have an optimistic implication for social and economic change. The FIRST form will help staff ask the proper questions for the appropriate resident. The initial question the staff member is encouraged to ask is whether this person participate in his/her care related to fall risk reduction. Risk can be predicted using four essential questions:

- Has the patient fallen in the last year?
- Is the resident cognitively appropriate to assist with own fall program desires, suggestions and perceptions?
- Does the resident have a clinical abnormality of balance or diagnosis that will impact safety?
- Does the resident have additional risk factor for injurious fall?

Having a history of falls is one of the main indicators of future falls.

This project aim is to decrease falls by incorporating the resident's feedback into his or her individual care. Another major indicator of falls are any clinically detected abnormalities in gait or balance. Some of these domains are included in the facility risks for falls assessment on admission; however, these lacked individual resident comments or request for feedback.

FIRST is an acronym for Fall Intervention Resident Suggestion Tool. I developed the data collection tool to be used as an optional guide to assist staff with asking open-ended questions that may lead to answers for placing effective fall interventions. Specifically, the FIRST form will (a) capture specific resident comments related to falls; (b) add to nursing practice by implementing effective interventions; and (c) be cost effective to the facility as it is an optional tool to assist with including resident feedback. The clinical staff investigating the fall can choose to use the FIRST form as a resource tool to collect data from resident interviews or resident medical records. Understanding the form helps staff with thinking outside of status quo practice as it encourages open-ended questions and resident feedback.

Protection of Human Subjects

Researchers have an ethical responsibility to protect the rights of human research participants (Grove et al., 2013). Furthermore, the basic standard for researchers is to maintain the privacy, confidentiality, and physical and psychological, wellness of their research subjects. For this quality improvement project, the identification of human subjects was not required: data related to cognition and falls were required. All data, including deidentified participant health information, were maintained with a double lock. This health information was only shared with individuals directly involved in the quality improvement project. This project was approved by Walden University Institutional Review Board, Protocol # 12-05-16-0292060.

Analysis and Synthesis

Data Systems and Procedures

Facility, state, and local fall data gathered were tracked, trended, and reported by the fall committee on a weekly basis. All falls were recorded by each shift and paperwork related to the fall and the resident involvement was turned into the fall committee RN. Fall results, interventions, and resident feedback were discussed weekly. Records documentation, interdisciplinary team notes, and resident feedback paperwork were maintained in the fall binder and secured in the medication room. The results of the data analyzed served as a guide to the effectiveness and continuation of the quality improvement project. To ensure that maximal benefit was gained from the targeted population, the appropriate residents were offered a chance to participate in a focus group to assist in the development of long-term goals and objectives of this project.

Utilizing the residents' perceptions of falls considers the ability to contemplate factors beyond the individual and select appropriate targets for intervention (Hodges & Videto, 2011). The project's aim is to decrease risk for falls by including resident feedback into practice; the project facility had no fall committee or anyone dedicated to decreasing the fall quality measure percentage. A study conducted by Phillips, Roberts, and Hunsaker (2008) suggested frontline staff likely need education and have yet to be brought into the falls documentation and/or prevention process. It was essential to create an ongoing system to reduce fall risk.

The SMART criterion listed below was the procedure used for creating specific, measurable, achievable, and realistic timeframes for the program initiative. Ongoing application of the SMART criteria was used for the evaluation of the project.

S—Specific: Reduce falls within the SNF by including resident feedback in fall intervention plans.

M—Measurable: Track and trend falls weekly and monthly and compare data each month to ensure productivity

A—Achievable / Accountability: reduction of facility fall rates has been noted as evidenced by data obtained from facility reports, CMS, CASPER Reports, and so forth.

R—Realistic: reduce fall rates by 10% within SNF using enhanced evidence-based nursing interventions, data collected from the FIRST form and gained buy-in from administration.

T—Timeframe: Reduction of fall rates will be noted within 3 months from implementation of project.

The development and educational process of this quality improvement program included the usage of visual curriculum and informational charts to help stakeholders understand the progression and goals of the program.

Summary

The aim of this quality improvement initiative was to encourage the use of resident feedback as a quality improvement initiative. In addition to including resident

feedback research findings support safety of interventions that optimize function and encourage physical activity among older adults (Resnick et al., (2012).

It will be important to continue tracking and trending fall data and the involvement of resident feedback into their plan of care. The population intervention research method holds great promise for designing and testing nursing interventions and advancing nursing science (Grove et al., 2013). Continued usage of this method will ensure the inclusion of resident feedback. Ongoing testing of this initiative should be measured on a weekly basis. Another vital stance for using the intervention method framework was to help develop a path for inclusion of resident feedback, which is a step toward increasing patient autonomy.

Section 4: Findings and Recommendations

Introduction

Facility standard demonstrated status quo practice, as evidenced by the staff not being accustomed to including an interdisciplinary approach, and standard practice did not encourage resident feedback toward reducing the risk for falls. To transform status quo practice into advanced nursing practice, the suggestion of a fall committee was introduced, educated, accepted, and initiated. The goal of the fall committee is the dedicated process of decreasing risk for falls through inclusion of resident feedback into practice. The committee included a representative from each department and a clinical chairperson. The clinical chairperson is the assistant director of the nursing department, holds a BSN degree, and has a former fall reduction background. The chairperson is responsible for collecting resident fall data, setting dates for fall meetings, and tracking

and trending facility monthly falls. The chairperson educated staff and stakeholders on facility statistical reports related to state and local benchmarking percentages during all-staff meetings. The committee established a facility threshold goal of 10% for monthly falls, which is almost half of their average monthly rate of 19.8%.

Findings and Implications

The fall committee and the resident focus group supported the overall need to produce this project. The location of the focus group was chosen by the residents and held at the project facility's activity room. By resident agreement, the focus group had several observers who included an assistant to the facilitator, the clinical manager, facility administrator, and staff educator, one registered nurse, two licensed practical nurses from different shifts, activity manager and her assistant, as well as the housekeeper manager. The session was scheduled to last 1 hour with a 15-minute grace period; however, due to overwhelming resident engagement, enthusiasm, and participation, it lasted almost 2 hours, starting at 10:30 a.m. and ending at 12:10 p.m. Elements of the focus group included a welcome and thanks of participation, an overview of the project, consent forms collection, purpose of project, ground rules, presentation, discussion/engagement of residents on knowledge and thoughts of fall protocol, process and presentation, question and answer period for residents, then for staff members. Eleven of the 15 resident council members attended, and all fully participated. The following criteria had to be met to participate with the resident focus group:

- Must be a resident of the SNF

- Must understand participation is voluntary and no monetary gain will be provided
- Resident or responsible party must sign consent
- The focus group will have maximal of 15 participants/residents
- Residents will have a BIMS score of at least 10 or greater
- Residents will answer questionnaire related to falls, intervention
- Must answer questions related on FIRST form
- Must participate in discussion

An objective of the focus group was to determine if residents wanted to be involved in their individual care as it related to risk for falls. Overwhelmingly, all 11 residents in the focus group answered yes. Asked if they had been offered opportunity to provide suggestions to reduce their risk for falls, 10 answered no, and one answered that they could not remember. Another objective was to create a pathway to incorporate resident feedback into plan of care. As a pathway to gather individual feedback, the focus group was introduced and educated on the FIRST form.

Each resident in the focus group participated with completing the form. Residents were offered the opportunity to use superheroes, actor names, or a name of their choice for additional privacy. The design of the form created opportunity to ask residents open-ended questions. For example, three residents' answers identified toileting patterns, as the residents typically need to toilet around the same time daily or after eating specific meals. Others discussed the layout of their room, by changing furnishings, maneuver through their space would work best for their individual needs. The implications noted from the

focus group concluded that resident feedback would benefit quality of care by reducing risk for falls as the intervention was established by the resident; the resident had the opportunity to maintain some level of independence related to decision making, and the cost of care related to falls would decrease as the reduction of falls decrease.

The feedback provided an opportunity for staff to anticipate toileting needs such as transfer assistance or lowering a bed. Four residents' issues or concerns were with medication. For example, a resident identified Lasix (a diuretic) being administered two times daily and the resident had no idea what the medication was needed for or that the side effects includes frequent urination. The resident feedback demonstrated that she would accept a bedside commode to reduce walking time to the bathroom. Additionally, two residents expressed concern with the layout of their rooms as there was furniture that obstructed a straight path to the closet or their bathroom. All agreed that bed and chair alarms were more agitation than useful and could cause greater harm as the resident is more mobile while attempting to stop the alarm sound.

The feedback from the focus group was captured on survey forms provided to all participants. All 11 participants circled 10 for the focus group being very beneficial to care. All participants also circled 10 to indicate full agreement that using the questions from the FIRST form will help reduce fall risk because it includes their personal preferences to care and guided staff with asking questions that the answer could reduce risk for falls. Overall the feedback included comments that this project will help to create a culture of inclusion and autonomy. All participants circled 10 stating they strongly agree that questions from the FIRST form will assist nursing staff with applying

proactive interventions. Some interventions discussed from the focus group included placing stop signs, bedside rails, rearranging room, changing medication times, and allowing the resident to move from one room to another.

Recommendations

Positive outcomes require dedicated process. During this project, it was vital to obtain organizational support for completing this quality improvement fall project. Recognizing the need for opportunity for improvement, without placing blame, was a vital key to this project. It was recommended that facility administrators approach this and other quality improvement strategies as educational and not punitive performance. It was also recommended that administration provide organizational support that makes decreasing fall risk a facility-wide priority and a well-publicized aim. It is highly recommended that the facility maintains an active fall committee. Administrators could offer incentives for staff who participate on the fall committee. Staff should have ongoing education on the differences between current practice and proposed practice related to reducing fall risk. Education should occur on a routine basis, as suggested, at least quarterly by providing staff in-services and posting updated educational reminders. It is also strongly encouraged that the new staff orientation includes understanding of assessment tools and implications of the strategies that are used to reduce risk of falls, with the most significant being inclusion of resident feedback into their personal plan of care. Ongoing placement of the fall committee is structured to keep this system on going. Furthermore, it is recommended that individualized fall assessment, care plans, and the FIRST form be internally validated on a periodical basis. Fall risks are known to be an

important factor in the strategies for falls prevention. It is recommended that staff be aware of the possibility that the risk scores might be overpredicted or be lower than expected. For this reason, any score should be investigated and reviewed for specificity and individuality. The fall committee helps to guide staff on this process as well as inclusion of resident feedback into care.

Another recommendation includes performing cognitive risk assessment to determine increase risk factors. Initial stakeholders were educated on the importance of identifying cognition levels to provide appropriate risk assessments. A part of ongoing training includes assessing cognition levels. The BIMS form is now being used to help identify residents with cognitive issues and establish alternate needs for minimizing fall risk. Cognitive dysfunction is one of the high-risk factors that have been seen in the skilled nursing center. Therefore, not all residents will be able to participate with creating their plan of care related to fall safety. Cognitive dysfunction can be thought of in two ways: patients with preexisting dementia or cognitive impairment, and patients who develop severe confusion or delirium. Those suffering from dementia are at a higher risk of getting delirium. Residents who have an acute illness or recent urinary tract infections have been noted to be more likely to fall due to experiencing cognitive changes; therefore, continued staff educational in-services are recommended to help determine other issues that may contribute to falls.

Impaired mobility is another risk factor that has been related to falling. It includes decreased mobility of the lower extremities, weakness, decreased balance and coordination, and impaired gait. The current facility utilizes a Briggs assessment upon

admission. It is recommended that the staff also uses other appropriate fall evaluation tests such as the Get Up and Go test. This test is used upon admission and reevaluations to assist with knowing resident mobility status. Included is also a physical assessment of the patient's mobility to and from bathroom to assist and identify risk patients, a task not formerly being performed prior to this project.

Most clinical nurse leaders know certain medications may produce adverse effects on resident's due to slow clearance from the renal and hepatic impairment and changes in their metabolism. Drug interactions can also lead to adverse effects and be a factor to increase risk for falls. Therefore, another recommendation is for a medication review that will need to be completed at time of admission to proactively determine fall risk as skilled nursing residents. Staff, including the medical director, MDS, and nursing team met to determine need for medication management and review and have established measures to alert fall committee chair of high risk residents.

Communicating risk factors includes using best practices for visual communication. Visual communication has been accomplished by placing visual identifiers and reminders such as signs in the resident room and bathroom, posters, chart identifiers, buttons, stickers, and so forth. All staff members and families will be educated on identifying the cues. I recommend using color-coded STOP/REMEMBER TO ASK signs as resident reminders. The family will also be informed on how to get help from the staff as well as things they can do to assist their loved one. Furthermore, it is recommended that the organization clearly communicate with the family and explain risk factors and learn information related to the resident during admission. Resident and

family education upon admission is an important part of this quality improvement fall program. Educational information related to minimizing falls as well as the FIRST form will be added into the admission package and read by resident and family members, who will have the opportunity to ask questions. Including resident feedback from the FIRST form tool will also help to significantly reduce risk for falls in residents.

It is recommended that organizational interventions in skilled nursing homes address environmental safety as resident numbers are only expected to increase (McElhone & Limb, 2005). This means that individualized interventions should be implemented for all residents. Each resident will be oriented to the room and the devices in the room. Call bells will be placed within reach for the appropriate residents. and the resident will be familiarized with the environment. Currently, the staff at the skilled nursing home center is not mandated to conduct compliance safety rounds. This project recommends incorporating facility-wide compliance rounds to ensure sturdy handrails inside the bathroom to minimize any chances of falls. The personal possessions of the resident are placed within reach. It is also suggested that the organization provide nonslip footwear for all the residents. Additional interventions include adding of adequate lighting, dedicated caregiver assignments, and adequate and good working condition equipment. I also recommend restructuring of the current restorative program to promote nutrition, strengthening, and exercise.

Impaired mobility interventions can be a result of many diagnoses including pain. Pain constitutes a constant challenge facing staff and residents of SNF. Many SNF have not adopted a uniform plan to assess and treat pain for their residents despite published

literature that demonstrated that the implementation of scales improves detection and treatment of pain (Leone, Standoli, & Hirth, 2009). Impaired mobility intervention is interdisciplinary in nature and can be helpful by reducing causes of pain.

In terms of environmental interventions, for the safety of the residents, it is recommended that the organization implement environmental compliance rounds. Department heads should be educated on what to look for and provided an environmental hazard checklist and assigned resident halls to conduct compliance rounds. Rounds should be conducted daily to confirm environmental factors, such the hallways being brightly lit, without clutter, and have no spills that can cause people to slide and fall. The maintenance staff should be assigned the task of regular inspection of devices such as loose handles and broken walkers. The furnishings in the rooms should be placed in a manner that will minimize having to go around items to get to the bathroom or closet. Resident feedback was vital for assisting with their personal environmental set up. Adequate flooring (no sectional rugs) was encouraged throughout facility and was included in the facility quality improvement plan to help reduce falls and injury risk. Other suggested interventions, which need to be approved by administration, include purchasing updated walking devices and installing convex mirrors so that the staff can see the hallway from afar; this will help provide a view of oncoming hallway traffic.

Summary

Per public data retrieved from project facility, falls in this skilled nursing home have continued to exceed state and national benchmark. During a 6-month review in 2015, the project facility's fall data indicated rates were above both state and national

rates at 19.8%. State average percentage during the same review time was 12.2% and the national average was 11.7% (CASPER, 2015).

Quality improvement is critical in all skilled nursing settings. The staff has been provided education and tools on the process of closing the gap by incorporating resident feedback into standard practice. The focal point of this initiative includes using resident feedback in practice as a method to reduce the risk for resident falls. Incorporating resident feedback becomes an evidence-based process to reduce the risk of falls because the fall intervention is coming directly from the resident feedback and input. To achieve the focus, it was essential to intertwine resident feedback, clinical expertise, and evidence-based practice. Also, gaining staff buy-in was vital for this project initiative, as long-term benefits will be gained by ongoing implementation. Therefore, it was important to present this initiative to staff as an opportunity for improvement for their team and residents and not an opportunity to place blame.

Buy-in was achieved and included staff's ability to accept education on facility fall rates, quality measure rates, quality improvement plans, stakeholder resources, environmental interventions, and, most significantly, resident feedback. Substantial long-term practices, such as a fall committee placement, were created from this initiative and can be used to help decrease the risk for resident falls. During the project the operational process of a fall committee was explored. After staff gained understanding of the process as well as understanding of the benefits of a fall committee, ongoing usage of a fall committee was strongly recommended.

The fall committee transitioned from a passive monitoring to an active quality improvement committee. The committee included all levels of staff involvement such as certified nursing assistants and housekeeping staff, as well as members from the resident council. Effective interventions needed to include frontline staff while recognizing the constraints of staff shortages and attitudes. The committee includes members from each department. The committee met on a regular basis, functioned with an agenda, and kept meeting minutes.

Using discussion from the focus group, the committee evaluated and suggested revisions of some current fall protocol and policies that were less effective such as discontinuing the usage of bed and chair alarms. There were no significant data that proved having alarms worked; in fact, all participants of the focus group agreed the sounds from the alarms were “agitating.” The rationale was that the resident was already mobile by the time the alarm sounded and in some cases caused more agitation with its use. Ongoing process of the fall committee is to collect fall data, track and trend data, and use resident feedback to ensure that this initiative is effective and sustainable. It is the recommendation that the fall committee continue to educate stakeholders on events related to falls such as statistical data, new interventions, and forms. The committee will maintain a selected chairperson who is a registered nurse and maintains the fall log book and facility percentages.

Because of this quality improvement project, the communication gap between resident feedback and clinicians was identified. Ongoing usage of this quality improvement initiative will help bridge that gap for the residents of this SNF. It will be

pertinent for the staff to understand the policies and procedures of the facility that have been set up for prevention of falls. Therefore, it is recommended that staff be made aware of environmental indicators that can be hazardous to the safety of patients (such as clutter, powder on floors, sprays, etc.).

The project was designed to ensure that resident feedback will help to place effective nursing interventions that will help decrease risk for falls. It is recommended that questions from the FIRST form be used and data updated after each fall, as circumstances related to falls change. This process will ensure ongoing quality improvement since its design is to gather resident feedback to help reduce fall risk. I also recommend an in-depth examination of current fall policy and encourage at least yearly updates of evidence base practice to be added as needed.

Section 5: Dissemination Plan

Introduction

Nurse leaders are commissioned to take effective steps for disseminating knowledge that will advance nursing practice. To advance nursing knowledge, it is critical to be able to communicate, educate, and engage stakeholders on the latest quality improvement measures. Knowledge is power, and a vital role of the DNP is the dissemination of nursing knowledge. Dissemination of nursing knowledge is important to advance nursing practice through implementation. Knowledge about the etiology of resident falls in the skilled nursing home has significant implications for decreasing the frequency. This is an example of evidence-based nursing practice contributing to better resident quality of life.

Dissemination Products

The project facility has a serious problem with resident falls, as evidenced by the data received in the internal monthly fall reports. As such, facility stakeholders, such as the fall committee and staff educators, committed to implementing a staff resident fall meeting every other Tuesday to discuss the ongoing fall project and associated initiatives, analyze fall data, monitor and review resident involvement, track state and national data, and analyze potentially new interventions and strategies. These measures were used for this project and continue as an ongoing program to decrease risk for falls.

Knowledge dissemination from this project is appropriate for audiences and venues specific to nurses and administrators, residents and families, and professional organizations specific to skilled nursing home environments. Dissemination should be

ongoing at the local level, transmitted to staff, peers, and educators via internal communications. In addition, the dissemination can be regional and national with social media postings and symposium posters as well as publications and conference presentations. Additionally, local community health centers can benefit from resident fall knowledge. The source of communication is through the quarterly in-service educational meetings, provided to a wide range of recipients. Other venues for dissemination include corporate health provider meetings and symposiums, and presentation to the local chapter of the National Association of Directors of Nursing Administration quarterly meetings. Lastly, dissemination of this knowledge can be global via national nursing associations, health care policy makers, and medical journals such as *Journal of aging studies*, *American journal of nursing*, and *geriatric nursing*.

The dissemination plan for this project includes a presentation to the facility stakeholders. In addition, an abstract will be prepared for submission to a regional and/or national conference specific to skilled nursing homes. Finally, the project will be developed into a manuscript for submission to the *Journal of the National Association of Directors of Nursing Administration*.

Analysis of Self

As a practitioner with a risk management and legal nursing background, it was quite alarming to witness my project facility's fall data. I took for granted that all facilities were on similar practicing levels and educational levels as related to resident/patient involvement with care. Patient-centered care is a focus that must continue to be educated and encouraged among practitioners.

As a scholar, it was important to discover gaps in practice that allowed resident falls to be significantly higher than state and national thresholds. As I researched resident falls and facility practice, I noted the culture of the facility to be one that was not alarmed with the significant number of resident falls. I also noted the lack of resident participation into their plan of care related to falls. As a solution to these identified gaps in practice, my initial project plan changed from nurse patient-ratios to this quality improvement project.

As project manager, it was initially difficult to gain the buy-in from staff. I quickly realized my approach had to be one of quality improvement to make staff jobs easier rather than placing blame because of the significant fall data. Once I gained staff buy-in, my focus was on quality improvement and education. Because of this project, I have added additional education to my risk management and legal nursing clients. My passion for teaching has been reignited. Having the opportunity to witness the enthusiasm from the team about learning ways to better serve the patient as well as increase clinical knowledge has been rewarding, overwhelming, and inspiring for me.

Summary

Residents in SNF have a high incidence of falls resulting in increased morbidity and mortality. Opportunities to improve among fall programs and ongoing interventions were evident in the data gathered on incidences related to falls in the project facility. The construction of this quality improvement project included evaluation of gaps in practice, fall management programs, protocols, culture of practice setting, and the role the residents play in their plan of care related to falls. Falls in SNF have implications to

affect residents physically, mentally, and economically; thus it was vital to develop a system that would intertwine resident feedback into nursing practice to help decrease the risk for falls. One of the most significant processes in the completion of this project was the development and implementation of the fall committee. The fall committee will continue to encourage resident feedback as a measurable tool to help decrease risk for falls.

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Appendix A: Synthesized Focus Group Data

Question	Answer Rating	Comments
On a scale of 1-10, with 10 being the most interested- what is your level of participation interest	11 out of 11 answered 10	Very interested
Have you had falls in the past 12 months? If so how many 0, 1-3, 4-7, 7or more in a 12-month period	5 of 11 answered 4-7 falls 3 of 11 answered 1-3 falls 3 of 11 answered 0 falls	
What interventions were placed when fall occurred? E.g.. None, Device such as walker, alarm, cane, bedside commode, environmental aids, room change, lighting etc.	5 of 11 answered aware of none, 3 of 11 answered devices 3 of 11 hospitalized	
Did you participate with the placed intervention? Yes or no please explain answer	1 of 11 answered yes 10 of 11 answered no	Received 8 responses to include, I do my own intervention Daughter asked for walker did not want to be a bother (4 replied) did not know I could participate they won't listen anyway
Would you prefer to participate in your fall intervention? Yes or No, Why?	11 of 11 answered yes	Received 8 responses to include If I fall, I fall I am not a child (3replied) I am an adult If I was asked to I would Never thought much about it That's what they get paid for

Do you feel asking for help, limits your decision making related to fall intervention? Yes or No, why	9 of 11 answered yes 2 of 11 answered no	Received 4 responses They do what they want No limitation for me I make the decision When I tell them they don't always listen I know what I need better than nurses
Do you participate in your plan of care? Yes, No, some, not at all. Why or why not?	1 of 11 answered yes 6 of 11 answered some 2 of 11 answered no	
Please review FIRST form, questions or comments (assistant will read questions from form) Open Discussion	11 of 11 participated in discussion	Overall residents want to be heard. They do not want to be treated as "old people that can't make decisions. They want to be included in their plan of care to reduce fall risk
Do you believe adding information from the FIRST form will help with fall intervention? Yes, some or not at all, why?	11 of 11 answered yes	
Would like to be on the Fall Committee Yes or No	7 of 11 answered yes 3 of 11 answered no 1 of 11 provided comment only	I worked for 50 years I don't want to be on committee, just listen to me

Appendix B: FIRST Form

Fall Intervention Resident Suggestion Tool (FIRST) Initial Investigation Tool

Resident Name: _____ Room#: _____

Date _____

Basic Intellect Mental Score (BIMS) _____ (BIMS must be 10 or greater to proceed)

What is your usual mobility status? Circle only one of the following.

Independent (requires no assistance, proceed with assessment)

Assist X 1 person (requires assistance of 1 staff member, proceed with assessment)

Assist X 2 people (requires the assistance of 2 staff members proceed with assessment)

Maximal Assistance (no FIRST assessment needed, complete Fall Risk Assessment Only)

Please answer the following questions and provide explanations for any answers with a "YES" response.

Have you had any recent falls? If yes, when? explain and state outcome and intervention

Have you had any recent change to your mobility status? if yes explain

Have you had recent change to mental status or infections such as UTI or FLU? If yes Explain (TIA or new DX)

Do you use ambulation devices, walker, cane, rollator etc.? Document Device _____ Is Device currently available and in reach at this time?

Do you desire any adaptive equipment such as side rails, reacher, sock aid etc.? If yes provide equipment, what equipment did staff provide? _____ Orientation provided?

Do you have a schedule toileting time? If yes, what times _____ am & _____ pm

Do you have any concerns related to falling? What can staff do to help minimize concern?

Explain _____

Do you have any previous habits that you have become accustomed to help decrease risk for fall? If yes Explain _____

Have you ever experienced any episodes of dizziness or light headedness upon standing?

When _____

Why _____

Are you comfortable requesting assistance from staff?

Do you feel you would benefit from questions to remind you of safe fall prevention concerns? If yes, staff Place STOP sign.

Orientation to room completed? YES/NO _____ Call light within reach _____ Yes _____ No

POST FALL *FIRST* FORM COMPLETE SECOND PAGE of *FIRST* FORM

Describe the actual words of the resident stated facts:

In the words of the Resident; What was the resident attempting to do prior to the incident?

In the words of the resident; What could have been done to prevent this incident

What steps have been implemented to provide further incident? Name nursing interventions

If call light was not used, explain why:

<input type="checkbox"/>	Resident unable to use due to
<input type="checkbox"/>	Resident chose not to use call light due to

Safety devices currently in use:

<input type="checkbox"/>	Low Bed	<input type="checkbox"/>	Personal Alarm	<input type="checkbox"/>	Fall Mat	<input type="checkbox"/>	Hip Guards	<input type="checkbox"/>	Specialty Cushions
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Was resident wearing any of the following: Check all that apply

<input type="checkbox"/>	Glasses	<input type="checkbox"/>	Hearing Aid	<input type="checkbox"/>	Footwear	<input type="checkbox"/>	Assistive Device
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Immediate Intervention initiated to prevent future or further incident?

Notifications:

Physician notified: ___ Yes ___ No Physician: _____ Date:

____/____/____ Time: ____:____ AM/PM

Were new orders received? ___ Yes ___ No (If yes, what were the orders?)

Family/ Responsible Party Notification: Who? _____ Date:

____/____/____ Time: ____:____ AM/PM

Witness statement

--

Fall Committee
recommendation

Nurse Signature

Please ensure that this FIRST form has been turned into the fall committee chair person or designated location. Thank you

Appendix C: IRB Approval

Dear Ms. Lancaster,

This email is to notify you that the Institutional Review Board (IRB) confirms that your study entitled, "A Quality Improvement Program to Prevent Resident Falls in a SNF," meets Walden University's ethical standards. Our records indicate that you will be analyzing data provided to you by DEIDENTIFIED Skilled Nursing and Rehabilitation Center as collected under its oversight. Since this study will serve as a Walden doctoral capstone, the Walden IRB will oversee your capstone data analysis and results reporting. The IRB approval number for this study is 12-05-16-0292060.

Both the Adverse Event Reporting form and Request for Change in Procedures form can be obtained at the IRB section of the Walden website:

<http://academicguides.waldenu.edu/researchcenter/orec>

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

Both students and faculty are invited to provide feedback on this IRB experience at the link below.

Sincerely,

Libby Munson
Research Ethics Support Specialist
Office of Research Ethics and Compliance
Email: irb@waldenu.edu
Fax: 626-605-0472
Phone: 612-312-1283

Office address for Walden University:
100 Washington Avenue South, Suite 900
Minneapolis, MN 55401