

Impact of Fall Education to Nursing Staff on Oncology Patient Fall Rates

Danni Sloane

School of Nursing, Liberty University

Author Note

Danni Sloane

I have no known conflict of interest to disclose.

Correspondence concerning this article should be addressed to Danni Sloane

Email: 

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Danielle Nina Sloane

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Dr. Rachel Joesph, PhD, MSN, BA, CCRN

Abstract

Falls and fall-related injuries impact patients' health outcomes and are the most commonly reported adverse event in hospitals for patients over 65 years of age. This scholarly project was conducted to evaluate the effect of evidence-based education to the Registered Nurses and Certified Nursing Assistance in the medical and surgical oncology inpatient on reducing the number of patients falling. Retrospective reviews of patient fall rates, were conducted two months before the fall educational sessions, and prospective reviews were conducted after implementing fall education. Patient falls also affect reimbursement rates and, on average, increase a patient's length of stay by about 6.3 days and increase undue patient harm. Therefore, fall precautions and interventions must be addressed to help decrease inpatient falls.

Implementing fall education and interventions aligns with national patient safety goals, is a cost-savings topic related to possible decreased reimbursement rates, is aligned with the organization's strategic plan, and is considered a top-priority project. This scholarly project showed a statistical significance in knowledge gained about fall prevention and fall precautions when comparing the pre- and post-knowledge test given to the nurses and nursing assistants in the medical and surgical oncology units. However, this project did not show statistical significance in the fall rates pre- and post-education.

Keywords: fall, fall prevention, acute care, surgical oncology, medical oncology, oncology patients, oncology, fall education, national patient safety goals, reimbursement rates

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Table of Contents

List of Figures..... 8

SECTION ONE: INTRODUCTION..... 9

Background 9

Problem Statement..... 10

Purpose of the Project 10

Clinical Question..... 11

PICO Question 11

SECTION TWO: LITERATURE REVIEW AND SEARCH STRATEGY 11

Critical Appraisal..... 13

Synthesis..... 14

Conceptual and Theoretical Frameworks 15

Conceptual Framework: The Iowa Model 16

Theoretical Framework: Kotter's Change Model 17

Summary..... 19

SECTION THREE: METHODOLOGY 21

Design..... 21

Measurable Outcomes 22

DNP Essentials 23

Setting..... 24

Ethical Considerations	26
Data Collection	26
Tools	27
Project Team	29
Timeline	30
Feasibility	31
SECTION FOUR: RESULTS	31
Data Analysis	31
SECTION FIVE: DISCUSSION	35
Implications for Practice	35
Limitations	36
Sustainability	37
References	40
Appendices	48
Appendix A – Evidence Table	49
Appendix B – IOWA Model Permission	143
Appendix C – Participant Consent.....	144
Appendix E – Liberty University IRB Approval	148
Appendix F – Organization IRB Approval	149
Appendix G– Organization Letter of Support	150
Appendix H – CITI Training Certificate	151

Appendix I – Post-Fall Audit Tool 152

Appendix J – IOWA Model Tool 153

Appendix K – Pre- and Post- Nursing Staff Test..... 154

Appendix L – Fall Education Evaluation..... 160

Appendix N – Poster and Flyer Advertisement 162

Appendix O – Demographic Data..... 163

Appendix P – Detailed Unit Fall Data 164

Appendix Q – Statistical Analysis of Pre- and Post- Education..... 165

Appendix R – Statistical Analysis of Pre- and Post- Falls Data..... 166

Appendix S – Education Evaluation Data 167

Appendix T – Pre- and Post- Education Unit Staffing 168

List of Figures

Figure 1 Levels of Evidence Table.....12

Figure 2 Kotter’s Change Theory.....17

SECTION ONE: INTRODUCTION

There has been an increase in patient falls on the inpatient medical and surgical oncology units at **Portland Providence Medical Center**. The unit's Quality Assurance Performance Improvement (QAPI) goal is to meet or exceed the rolling eight quarter's (quarter four of 2020 to quarter 3 of 2022) 25th percentile ranks according to the National Database of Nursing Quality Indicators (NDNQI) metrics. NDNQI's reports quarterly, and average the fall rates over eight quarters; therefore, the QAPI goal is to meet or exceed the 25th percentile's average rate by the end of 2023. Ending quarter three of 2022 the surgical oncology unit's score revealed 1.59 total patient falls per 1,000 patient days, and the medical oncology unit's score revealed 2.69 total patient falls per 1,000 patient days. The NDNQI 25th percentile rank ending quarter three of 2022 showed 1.30 total patient falls per 1,000 patient days or less for the surgical oncology unit, and 1.71 total patient falls per 1,000 patient days or less. Therefore, this unit is not meeting their QAPI goal for either unit, and an evidence-based intervention is needed to help the unit prevent more patients from falling and preventing more harm to patients. Therefore, I am going to conduct a quasi-experimental study to examine the effects of providing evidence-based fall education to Registered Nurses (RNs) and Certified Nursing Assistants (CNA), compared to pre-education fall rates.

Background

Several evidence-based fall bundles have been shown to help reduce patient falls. These bundles include fall alarms, patient rounding, fall risk scales, mobility devices, environmental factors, medication management, proactive planning, and staff education modules (Chen, Liu, & Li, 2021; Scheidenhelm, Astroth, DeLong, Starkey, & Wolfe, 2020; Stockwell-Smith, et al., 2020). The hospital where the scholarly project was implemented has many fall-risk

interventions; however, there is no standardization of interventions or education for the caregivers implementing fall prevention interventions, making it a non-standardized approach for patient fall prevention. The organization where the scholarly project was implemented already uses several fall risk interventions including the Morse Fall Scale, fall clinical practice guidelines (CPG) in the electronic health record (EHR), fall risk policies, bed and chair alarms, mobility assessments, and verbal patient education based on the nurse's patient assessment. Both units also have very active fall committee representatives who engage well in a hospital-wide fall prevention committee that meets monthly, disperses unit-wide education to nursing caregivers, performs random falls prevention audits, and helps with annual fall education at the unit's in-service education. However, caregivers are not adhering to the fall CPG and sometimes are unaware of the fall risk policy. This may be related to several new staff and the workforce turnover the hospital is experiencing; for 2022 the medical oncology unit had a total turnover rate of 14.60% and the surgical oncology unit had a turnover rate of 14.68%. Furthermore, no fall education is standardized and caregivers are not adhering to any evidence-based practices concerning fall interventions. Therefore, education regarding the fall CPGs, fall risk policy, and other evidence-based practices would be beneficial for translating evidence into practice.

Problem Statement

The increasing number of patients affected by falls on the medical and surgical oncology acute care units causes undue physical harm to patients while increasing moral distress, mental fatigue, and burnout in nurses; as well as placing financial burdens on an already stretched healthcare system.

Purpose of the Project

The purpose of this project is to evaluate the effect of tailored fall education to oncology RNs and CNAs on fall reduction on the medical and surgical oncology acute care units. The education was based on the fall CPG, fall risk policy, and other evidence-based practices to decrease the fall rate of patients. The fall rate two months of pre-education was compared to two months after implementation of the fall education.

Clinical Question

The clinical question is “What is the effect of fall prevention education to RNs and CNAs on the number of falls in the inpatient medical and surgical oncology units?” Participants included all oncology RNs and CNAs who worked on the inpatient medical and surgical oncology units who voluntarily agreed to participate in the study. The intervention was fall education based on the fall CPG, fall risk policy, and other evidence-based practices to decrease the fall rate of patients. Knowledge was assessed by using a pre-test based on the policy, fall CPG and other evidence-based practice guidelines, and the scores were compared to the post-test of the fall education to medical and surgical oncology RNs and CNAs.

PICO Question

On the medical and surgical oncology inpatient units (P), what is the impact of educating oncology RNs and CNAs on fall prevention education (I) versus no education (C) at decreasing oncology patient's' fall rates (O) over a two-month period of time (T)?

SECTION TWO: LITERATURE REVIEW AND SEARCH STRATEGY

The ability to perform a literature review and synthesize the evidence is critical. When first starting the literature review it is imperative that the researcher defines the scope of the planned research and be able to narrow down the search parameters to find evidence that is pertinent to the review. Assessing the desired outcome before the start of the literature search

will help provide clarity to the search and guide the researcher in the right direction (Murphy, Staffileo, & Foreman, 2018).

When defining the search strategy, the researcher must ensure that she learns key strategies for conducting a database search, as well as how to review the literature (Moran, Burson, & Conrad, 2020). A comprehensive literature search was performed via a database search. The database searched PubMed, ProQuest, and CINAHL. The key words used for the search included “fall education,” “fall rate,” “nurse,” “hospital” or “hospitalization,” “inpatient,” “acute care,” and “fall intervention.” It is important when defining the search strategy to use key words, as well as narrowing down the search strategy to specific types of articles, dates, and inclusion and exclusion criteria. Boolean operators were also used, including “AND,” “OR” and “NOT.” Wildcards (*) were also used, including “fall*” “edu*,” “inter*,” “hosp*,” “ and “nurs*.”

The search provided over 1,789 articles, which were then deduced to 60 articles that were reviewed, with 34 core articles that met the synthesis criteria. The date range of the articles was 2018 or newer, except for professional standards material.

A literature review appendix was organized based on the levels of evidence utilizing Melnyk’s levels of evidence (Appendix A). The subject matter of the articles and their relevance to the project were considered for both fall risk education presented via video and other alternative methods. Any article that included information on fall education for patients or RNs related to fall rates were included. Articles related to evidence-based fall precautions and interventions were also included in the literature matrix. Furthermore, articles that were older than five years were excluded unless they were of primary evidence related to the project’s topic. The articles included in the literature review were systematic reviews, literature reviews,

research articles, case-controlled studies, qualitative studies and expert opinion. The number of each level of evidence are outlined in Figure 1.

Figure 1

Levels of Evidence Table

Level of Evidence:	Number of Articles Used in Literature Review:
1	5
2	12
3	3
4	5
5	6
6	1
7	1

Note. Levels of evidence table

Critical Appraisal

Sixty articles were reviewed and a level of evidence was assigned for each. Thirty-four articles published in the last five years were included in the final synthesis. The articles within the search parameters showed a decrease in patient falls when implementing some sort of educational modality such as rounding, communication of risk factors, educational pamphlet, fall contract, multimedia education, or fall poster. There were also many articles discussing RN education to decrease falls, specifically use of fall shift huddles, staff meetings, e-modules, video education, repeat back methods, and fall prevention scales. Furthermore, there were many articles that showed a decrease in patient falls related to a nursing intervention however, the articles did not speak to the education of the RNs implementing the intervention. Of the 34 articles that were synthesized, four specifically were related to patients on an oncology acute care unit. Nine of the 34 articles specifically targeted RN education related to falls, and 11

articles targeted patient fall education. There were articles, 23, that were included in the synthesis related to fall prevention bundles, fall tools, and other modalities that were shown to decrease patient falls.

Synthesis

There were consistent findings across all studies that suggested fall education to either patients or nursing staff decrease patient falls. Multiple opportunities to share fall education with patients and nursing staff were discussed, including use of e-modules, staff meetings, huddles, video education, telehealth, games, brochures and pamphlets, and verbal education. Although, there was inconsistency in the methodology, or content of the education provided, there were multiple studies that suggested that nursing education related to fall prevention was beneficial and showed the biggest impact of decreasing patient falls (Innab, 2022; Kiegaldie, et al., 2019; Lopez, Ma, Aavik, & Cortes, 2023; Moreira Ximenes, et al., 2019, 2022; Morris, et al., 2021; Shepard, Clarke, Hemming, Martin, & Lilford, 2021; Spano-Szekely, et al., 2019; Turner, et al., 2020). Several studies showed that when a nurse uses a fall risk tool or scale to rate the patient's susceptibility to fall, that the patient was less likely to fall (Fowler & Reising, 2021; Innab, 2021; Kivoshi-Teo & Northrup-Snyder, 2022; Lopez, Ma, Aavik, & Coretes, 2023; Morris, et al., 2021; Ojo & Thiam, 2022; Shaw, Kiegaldie, & Morris, Educating health professionals to implement evidence-based fall screening in hospitals, 2021; Shaw, L., Kiegaldie, Heng, & Morris, 2023; Shaw, L.K., Kiegaldie, Jones, & Morris, 2021; Shepard, Clarke, Hemming, Martin, & Lilford, 2021; Spano-Szekely, et al., 2019). However, out of all of the studies that were reviewed, none specifically discussed the content or resource materials used to educate on the intervention.

When looking at the generalizability of the study, there were four articles that described studies conducted on medical oncology units, however, there were no studies that were conducted on a surgical oncology unit nor a medical oncology unit that cares for autologous stem cell transplant patients and research patients (Costantinou & Spencer, 2021; Harden, Wall, Galunas, Eastman, & Frederick, 2021). Therefore, the results may not be generalizable to these specific patient populations, and more research is needed. Furthermore, many of the studies were either too small or were limited to one site or hospital setting making the generalizability even smaller. There are many gaps remaining in the evidence, and there is a need for further assessment and research.

The literature synthesis and review provide compelling evidence that providing education to nursing staff related to fall prevention decreases the patient's risk of falling. However, there were no studies that were conducted with on the surgical oncology patient population nor with a medical oncology unit that cares for pharmacologic phase I research patients, and autologous stem cell transplant patients. This suggests that further research is needed in this area, and the researcher should implement these findings to see if they are in fact generalizable to this patient population. Moreover, it is important to obtain additional nursing knowledge by conducting research that would increase fall prevention education and possible fall prevention interventions to the fall bundle, helping to decrease overall fall rates and harm to patients, as well as decrease stress and burnout of nursing staff.

Conceptual and Theoretical Frameworks

It is vital for the scholarly project to be structured on sound principles and frameworks; therefore, a conceptual model and theoretical model helped support the logistical and scientific underpinnings of the project (Moran, Burson, & Conrad, 2020; Zaccagini & Pechacek, 2021). It

is important to base the scholarly project on the conceptual framework in order to withstand rigor and validity (Melnyk & Fineout-Overhold, 2019). A theoretical framework was also chosen to help with organizational change management (Melnyk & Fineout-Overhold, 2019; White, Dudley-Brown, & Terhaar, 2021).

Conceptual Framework: The Iowa Model

The conceptual framework for this evidence-based project was the Iowa model of Evidence-Based Practice to Promote Quality of Care. Permission for use in the project was approved, and is located in Appendix B. The Iowa Model is one of the most efficient, evidence-based models that help support and guide providers in research to ultimately help improve patient care outcomes (Melnyk & Fineout-Overhold, 2019; Murphy, Staffileno, & Foreman, 2018; White, Dudley-Brown, & Terhaar, 2021). The Iowa Model encourages providers to identify areas for opportunity and improvement and ask practice questions (Murphy, Staffileno, & Foreman, 2018; White, Dudley-Brown, & Terhaar, 2021; Zaccagnini & Pechacek, 2021). Within the targeted organization, a high fall rate was noted, and the organization was not meeting their benchmark for inpatient falls. Moreover, the inpatient medical and surgical oncology units noted an unusually high rate of falls in 2022, and an area of opportunity was identified. The Iowa Model is used widely for organizational, clinical, and administrative practice changes through interdisciplinary partnerships and integrating research findings; incorporating all key stakeholders and the entire interdisciplinary team (Melnyk & Fineout-Overhold, 2019; Murphy, Staffileno, 2018; Zaccagnini & Pechacek, 2021).

The Iowa Model is easy to adopt and helps guide changes through plotted questions and decision points throughout the model. The model uses a decision tree approach and guides researchers through various steps and processes (Murphy, Staffileno, & Foreman, 2018;

Zaccagnini & Pechacek, 2021). Lastly, the Iowa Model incorporates feedback loops to ensure that there is closed-loop communication and that practice gaps are mitigated by allowing the researcher to continue on a path to help fix practice discontinuities (Murphy, Staffileno, & Foreman 2018; White, Dudley-Brown, & Terhaar, 2021; Zaccagnini & Pechacek, 2021).

The Iowa Model framework helps identify stakeholders and trigger points, which is how this scholarly project was selected; the trigger point being an increase in patient falls on the medical and surgical oncology units and the units not meeting their QAPI plan. The Iowa Model also enables the researcher to evaluate the internal evidence and literature reviews and design and pilot a practice change (Melnik & Fineout-Overhold, 2019). This process, overall, helps evaluate its effectiveness and integrates sustainability in practice (Melnik & Fineout-Overhold, 2019). The Iowa Model helped support this evidence-based project because the model has the critical elements to help review the change, check the evidence-based project's effectiveness, design the practice change and help pinpoint and identify sustainability around the transformation of care related to the scholarly project (Melnik & Fineout-Overhold, 2019).

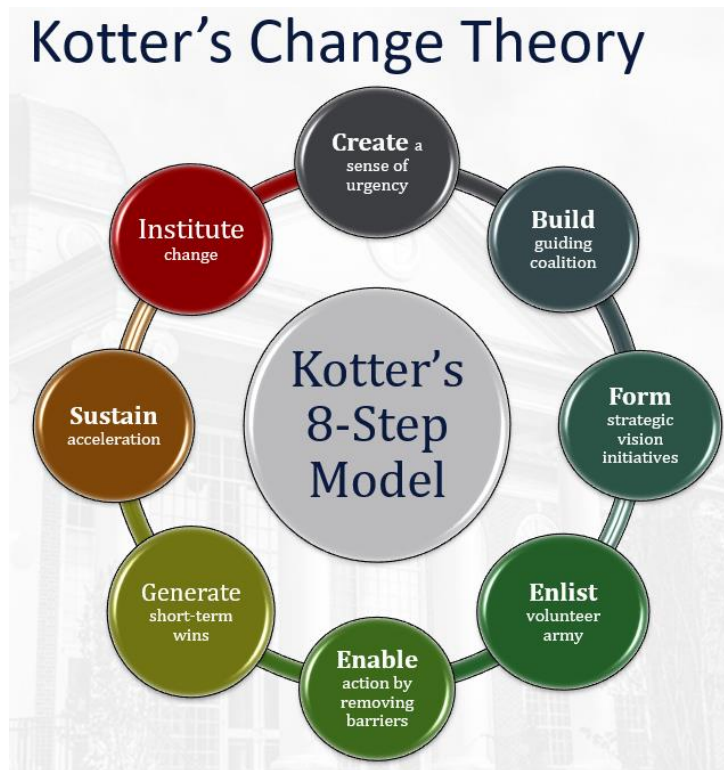
The first steps of the Iowa Model involve forming a team of key stakeholders and starting the phase of assembling, appraising, and synthesizing the body of evidence (Iowa Model Collaborative, 2017). If enough evidence supports the scholarly project, then the project is designed and piloted (Iowa Model Collaborative, 2017). If the pilot is successful and is appropriate for adopting the practice, then the project is integrated and sustained, and the results are disseminated (Iowa Model Collaborative, 2017). If the pilot is unsuccessful, alternatives are considered, and the project is redesigned for another pilot (Iowa Model Collaborative, 2017).

Theoretical Framework: Kotter's Change Model

The change theory used for the scholarly project was Kotter's change model (Kotter, 1996). This theory is an eight-step process that helps organizations lead change, (see Figure 2).

Figure 2

Kotter's Change Theory



Note. John Kotter's eight step change model (Kotter, 1996)

One of the significant benefits of this change model is its effectiveness for knowledge translation and large-scale transformational changes (Kotter, 1996). In addition, this model is easy to use through its eight-step action items and prompts to evoke new behaviors (Kotter, 1996)

The Kotter and Cohen change model is effective in practice when individuals are shown the truth that influences their feelings (Kotter, 1996). Therefore, for the scholarly project to be effective, the research must make the vision and critical points compelling and emotionally engaging (Melnyk & Fineout-Overhold, 2019). To achieve this goal, the researcher must gain

trust and rapport with the members of the project team, as well as those key stakeholders that influence the implementation of the project (Moran, Burson, & Conrad, 2020; Zaccagini & Pechacek, 2021). Furthermore, this change theory helps the researchers identify problems or possible solutions to problems and allows individuals to experience the feelings, which invokes a change in behavior (Kotter, 1996; Melnyk & Fineout-Overhold, 2019). Therefore, trust and rapport are essential for the success of the project.

Lastly, the Kotter and Cohen change model is feasible to help the organization implement change. The model supports researchers in producing large-scale changes and allows the individuals within the organization to feel like they are a part of the change. In addition, this model lays out the steps for the organization to implement successful changes, including how to build a team, guide a vision for the project, build trust and rapport within the group, empower individuals to remove barriers and act on deliverables, and create and celebrate wins within the organization (Kotter, 1996; Melnyk & Fineout-Overhold, 2019; White Dudley-Brown, & Terhaar, 2019). With these changes and translational models, the scholarly project had the best chance of success.

Summary

There were consistent findings across all studies reviewed that fall education for either patients or nursing staff decreased the incidence of patient falls. There were multiple opportunities described to share fall education with patients and nursing staff, including the implementation of e-modules, staff meetings, huddles, video education, telehealth, games, brochures and pamphlets, and verbal education. Although, there was inconsistency in both the methodology and content of the education implemented, multiple studies showed that nursing education related to falls is beneficial and exhibited the biggest impact for decreasing the

incidence of patient falls (Autissier, 2019; Innab, 2022; Kiegaldie, et al., 2019; Lopez, Ma, Aavik, & Cortes, 2023; Moreira Ximenes, et al., 2019; Moreira Ximenes, et al., 2022; Morris, et al., 2021; Shepard, Clarke, Hemming, Martin, & Lilford, 2021; Spano-Szekely, et al., 2019; Turner, et al., 2020). Moreover, there were multiple studies that showed that using a fall tool or scale greatly impacted the patient fall rate; however, none of these articles mentioned how the nursing staff was educated on the use of the tool (Autissier, 2019; Fowler & Reising, 2021; Innab, 2021; Kivoshi-Teo & Northrup-Snyder, 2022; Lopez, Ma, Aavik, & Cortes, 2023; Morris, et al., 2021; Ojo & Thiam, 2022; Shaw, Kiegaldie, & Morris, Educating health professionals to implement evidence-based fall screening in hospitals, 2021; Shaw, L., Kiegaldie, Heng, & Morris, 2023; Shaw, L.K., Kiegaldie, Jones, & Morris, 2021; Shepard, Clarke, Hemming, Martin, & Lilford, 2021; Spano-Szekely, et al., 2019; Twibell, et al., 2020).

None of the studies reviewed were conducted on an inpatient surgical oncology unit; therefore, the results may not be generalizable to the surgical oncology unit; however, four studies were conducted on a generalized oncology unit (Autissier, 2019; Costantinou & Spencer, 2021; Harden, Wall, Galunas, Eastman, & Frederick, 2021; Twibell, et al., 2020). Furthermore, many of the studies were either too small, or were limited to one site or hospital setting making the generalizability even smaller. Therefore, there are many gaps remaining in the evidence, and thus a need for further assessment and research.

The literature synthesis and review provide compelling evidence that nursing staff education decreases the patient's risk of falling; however, research has been conducted on the surgical oncology patient population, and there were only four research studies on a medical oncology unit. It is imperative that we decrease the risk of falling in the oncology patient population through nursing education, not only to help the unit prevent more patients from

falling but to prevent undue harm to patients. Oncology patients are 16-17% more at risk for falling compared with non-oncology patients, with 25% of total oncology patients having a fall episode while admitted to the hospital (Autissier, 2019; Twibell, et al., 2020). Therefore, it is important to add additional educational interventions to the fall bundle to help decrease overall fall rates and harm to patients, as well as decrease stress and burnout of nursing staff who are at risk of moral distress when a patient experiences a fall.

SECTION THREE: METHODOLOGY

The methodology section first explains the framework and design of the study. It is important that the researcher chooses a specific framework and design for the study. Choosing the correct design is essential to obtain accurate results (Moran, Burson, & Conrad, 2020). The methodology section also describes the setting, the sample population, and ethical considerations (Moran, Burson, & Conrad, 2020). Lastly, the methodology section describes the data collection methods, the tools used during the study, as well as the intervention itself, and the expected timeline of the study (Moran, Burson, & Conrad, 2020; Roush, 2019).

Design

The design of this evidence-based practice project utilizes the Iowa Model for Evidence-Based Practice. The Iowa Model is one of the most efficient, evidence-based models that help support and guide providers in research to ultimately help improve patient care outcomes (Melnik & Fineout-Overhold, 2019; Murphy, Staffileno, & Foreman, 2018; White, Dudley-Brown, & Terhaar, 2021). The Iowa Model encourages providers to identify opportunities for improvement and ask practice questions (Iowa Model Collaborative, 2017; Murphy, Staffileno, & Foreman, 2018; White, Dudley-Brown, & Terhaar, 2021; Zaccagnini & Pechacek, 2021). The Iowa Model helped support this scholarly project by allowing the researcher to identify a

problem of interest and apply evidence-based interventions from systematic reviews to research the project's overall effectiveness. According to the Iowa Model, a practice change is evaluated with a pilot study (Iowa Model Collaborative, 2017). Using the Iowa Model for this evidence-based project guided the steps of the project. The purpose of the scholarly project was to raise awareness for the need of nursing staff education related to falls to decrease the risk of oncology patient falls.

This project used a quasi-experimental design with a pre- and post-test evaluating the oncology nursing staff's knowledge before and after fall education. The comparison of the pre- and post-test scores used a paired *t*-test. The patient fall rate data for two months pre- and two months post- intervention was also used to determine if the nursing education impacted oncology patient fall rates. In this project, the independent variable was the nursing fall education and the dependent variable was the fall data. The education was provided via multimodality education session, including in-person and virtual sessions. The fall education was based on the organization's fall CPG available through the patient's EHR, the organization's fall risk policy, and any supplemental information gathered that was evidence-based practice found during the literature review.

Measurable Outcomes

This scholarly project aimed to decrease oncology inpatient falls by implementing fall education to the nursing staff of the inpatient medical and surgical units. The first outcome was a change in the knowledge of the RNs and CNAs. This was determined by administering a pre- and post-test to the participants prior to and after their educational session. The second measurable outcome was the number of falls recorded on the medical and surgical oncology units two months post-implementation compared with the number of falls two months pre-

implementation of the project. The unit's fall rates were measured for the short-term effect on the outcome- patient fall. The long-term outcomes will be measured using the National Database of Nursing Quality Indicators (NDNQI) fall rates; however, the scope of this project will not include this data.

DNP Essentials

This scholarly project incorporates the 'Scientific Underpinnings for Practice' essentials because it synthesizes evidence and implements EBP to care at the bedside. Organizational and system leadership are essential for DNP. The DNP Essential II, Organizational and Systems Leadership for Quality Improvement and Systems Thinking, is designed to help improve patient healthcare outcomes. This project is in alignment with this Essential because it is decreasing undue harm by decreasing patient fall rates. DNP Essential III, Clinical Scholarship and Analytical Methods for Evidence-Based Practice, translates the application of research into practice, studies the implementation and then helps widen nursing research by disseminating the results with applications to practice and finding further areas to study based on this scholarly project. DNP Essential IV, Information Systems/Technology and Patient Care Technology for the Improvement and Transformation of Health Care, and Essential V, Health Care Policy for Advocacy in Health Care, both incorporate technology by using the electronic health record's CPG, as well as the discovery of fall rates using national databases and local organization technology (i.e., through use of SharePoint and data that is populated into SharePoint from event reports). DNP Essential VI, Interprofessional Collaboration for Improving Patient and Population Health Outcomes, affects this project because the evidence would positively affect the outcome of patient falls, which would be a good policy to implement and advocate for resources to educate nursing staff on fall prevention and education. The finding of this project have the

potential for influencing policy and are cross disciplinary. This project also needed to implement effective communication and collaboration skills for a successful deployment; thus it incorporated DNP Essential VII Clinical Prevention and Population Health for Improving the Nation's Health. Lastly, this project's findings have the potential to increase the knowledge of the DNP nurse. This project prepared the DNP graduate student to conduct a comprehensive assessment, review EBP literature, and develop, implement, and evaluate a research plan, which incorporated DNP Essential VIII Advanced Nursing Practice.

Setting

The setting for this scholarly project was an urban hospital located in the Pacific Northwest of the United States. The medical oncology unit is a 22-bed acute area unit that cares primarily for medical oncology patients, with primary cancer diagnosis, autologous stem cell transplants, interleukin-2 treatments, phase I clinical trials, and other high-dose chemotherapy regimens. The surgical oncology unit is a 24-bed acute care unit that cares primarily for post-surgical oncology patients, with the primary surgeries being colorectal, hepatobiliary, head and neck, and gynecological. There are about 116 employed oncology Registered Nurses (RN) and 22 oncology Certified Nursing Assistants (either CNA1 or CNA2; both referred to as CNAs) on the two units combined; all of whom are employed full-time, part-time, or per diem.

This pilot study aligns with the organization's mission and values, strategic plan, and annual organizational goals. The organization's mission is "As expressions of God's healing love, witnessed through the ministry of Jesus, we are steadfast in serving all, especially those who are poor and vulnerable" (Providence Health & Services, 2023). Therefore, this scholarly project aligns with the organization's mission because those at risk of falling are vulnerable and looking for the care they need without placing them in undue harm. One of the organization's

values is excellence, stating that they provide care through innovative and transformational care, committed to safe and reliable patient care (Providence Health & Services, 2023). Therefore, this project aligns with their value of excellence by implementing evidence-based practice and ensuring that the best outcomes are possibly implementing the most up-to-date practices and highest standards. Lastly, the organization's strategic plan includes "strengthening the core" which includes providing effective safe, person-centered care with world-class outcomes. This scholarly project is person-centered focusing on the patient's specific fall risk diagnosis and educating the patient in an innovative way that is evidence-based.

Population

This scholarly project included a convenience sample of oncology RNs and CNAs employed on the inpatient medical or surgical oncology units, and worked either full-time, part-time, or per diem. Those who wish to participate needed to agree to participate in the educational activities. This process was voluntary, and the participants signed an informed consent form (see Appendix C). The Nurse Managers on both units agreed that the fall rates were alarming; however, wanted these initial education sessions to be voluntary. If the findings showed a positive correlation on patient fall rates the recommendation moving forward would be to make the education sessions mandatory on an annual basis. The researcher's goal for this project was to have 90% of the staff complete the education sessions. Other inclusion criteria included all participants must be over the age of 18, and able to speak, read, and understand English. The exclusion criteria included all oncology nursing staff who did not agree to participate, any student nurse or CNA, or those that are not primarily employed and floating to the oncology units. For general participant recruitment, multiple drop-in education sessions were held on different days of the week and weekends and at different times, day shifts/night shifts. Lastly,

virtual education sessions were held for those who were not able to or did not wish to participate in person, as the organization was still promoting virtual in-services related to COVID at the time of the study. The demographic data of the participants was collected (Appendix D).

Ethical Considerations

Ethical considerations for research on human subjects were strictly followed. Approval from the Institutional Review Board (IRB) from Liberty University and the healthcare organization was obtained (Appendix E and F). A letter of support for this scholarly project was obtained from the organization (Appendix G). Patient privacy was maintained as outlined by the Health Insurance Portability and Accountability Act (HIPAA). In addition, the researcher maintained Collaborative Institutional Training Initiative (CITI) certification while conducting this project (Appendix H). All data collected (pre- and post-tests) were identified with the participant's employee number and did not include the participant's name or any other identifying factors. Education sessions were held at pre-scheduled dates, times, and locations, and there was a sign-in sheet when attending that only included the nursing staff's employee number. The list of participants was maintained by the unit's Nurse Managers and fall committee representatives (for training and education purposes). All correspondence between the organization and this author was sent by encrypted email and the computer was password protected. Confidentiality was maintained. Patient fall data were only reported in aggregate numbers, including the date of the fall, the type of fall, if there was any sustained injury, what fall preventions were in place at the time of the fall, what fall interventions were added after the fall, and what unit the fall occurred on. No patient or staff identifiers were kept.

Data Collection

Fall rate data was collected via the organization's fall committee internal SharePoint site that tracks all patient falls throughout the hospital. This information was used for the pre- and post- data (Appendix I). This internal site was used to review the short-term effects of the education. For long-term reports, it was advised for the organization to check at the NDNQI database for the effects of the intervention.

Tools

The Iowa Model flowchart was used to establish priorities and structure for the data collected during the pilot study (Appendix J; (Iowa Model Collaborative, 2017). A tool was developed by the researcher to measure nursing knowledge related to fall education (Appendix K). This tool was given to the nursing staff pre- and post-education intervention (with only the staff's employee number as an identifying factor). This tool was based on the organization's fall risk policy, fall CPG in the EHR, and any other evidence-based fall precautions that were not included in these tools based on other the researcher's findings (Innab, 2022; Morris et al., 2021; Ojo & Thiam, 2022; Shaw L., Kiegaldie, Heng, & Morris, 2023; Shaw, Kiegaldie, & Morris, 2021; Shepard, Clarke, Hemming, Martin, & Lilford, 2021). The results were used to facilitate communication opportunities to help further educate the nursing staff. There was also a fall education participant evaluation to provide input on the education session and suggest areas for future education topics about fall prevention (Appendix L).

Each question on the pre- and post-education tests included had a multiple-choice answer corresponding to the fall education findings. In addition, the pre-test also included demographic questions, such as age, gender, job title, years of experience in that role, years of experience on the unit, primary language spoken, ethnicity, and highest education completed. The test took approximately 10 minutes or less and was proctored by the researcher. The pre-test was given

after participants agreed to participate in the study. For education delivered in person, the pre- and post-tests were administered via paper and pencil, with an online option if the participant preferred (via QR code). The researcher scored the pre-and post-test after completing the education session. For participants participating via the virtual sessions the pre-and post-test were administered online using Microsoft Form with a QR code. The researcher scored the pre- and post-test after completing the education session.

Intervention

The project utilized Kotter's change theory, which is an eight-step process that helps organizations lead change (Kotter, 1996; Melnyk & Fineout-Overhold, 2019; White, Dudley-Brown, & Terhaar, 2021). One of the significant benefits of this change model is its effectiveness for knowledge translation and large-scale transformational changes (White, Dudley-Brown, & Terhaar, 2021). In addition, this model is easy to use through the eight-step action items and prompts to evoke new behaviors (Melnyk & Fineout-Overhold, 2019).

The Kotter change model is effective in practice when individuals are shown the truth that influences their feelings (Melnyk & Fineout-Overhold, 2019). Therefore, for the scholarly project to be effective, the research must make the vision and critical points compelling and emotionally engaging (Melnyk & Fineout-Overhold, 2019). Furthermore, this change theory helps the researchers identify problems or possible solutions to problems and allows individuals to experience the feelings, which invokes a change in behavior (Melnyk & Fineout-Overhold, 2019).

Lastly, the Kotter change model is feasible to help the organization implement change because it supports producing large-scale changes and allows the individuals within the organization to feel like they are a part of the change. In addition, this model lays out the steps

for the organization to implement successful changes, including how to build a team, guide a vision for the project, build trust and rapport within the group, empower individuals to remove barriers and act on deliverables, and create and celebrate wins within the organization (Melnyk & Fineout-Overhold, 2019; White Dudley-Brown, & Terhaar, 2019). With these changes and translational models, the scholarly project had the best chance of success.

Project Team

For the project to be fully implemented, a team was developed to help with implementing the project, educating those implementing the education sessions, and building trust and rapport with the unit's team members. Vital members of the team included the unit's fall committee representatives, the unit managers, the unit's charge nurses, and a statistician. The researcher also gained the organization's support, obtained a letter of support from the organization, and filed for IRB approval through the organization and Liberty University.

For the researcher to gain full participation from the unit's nursing staff, she sought the help of the unit's managers, charge nurses, and the fall committee representatives. They also helped prioritize the education sessions and ensured that implementation of the training occurred. This included securing conference rooms, validating dates and times that worked for the unit, helping to communicate by means of emails (Appendix M), and advertising the education sessions via posters, flyers (Appendix N), and other methods. They also helped relieve nurses, and care for their patients so the nursing staff could complete the training during their shifts, and the fall committee representatives validated and added any other evidence-based interventions, following up with answering questions that arose when the researcher was not on site. Training of nursing staff was conducted through staff meetings, unit-based council meetings, staff huddles, and multimedia meetings via a TEAMS platform. The education sessions were delivered

within a one-and-a-half-week timeframe. A schedule of the education sessions was developed and advertised throughout the departments via multiple modalities. Those that wished to participate needed to agree to voluntarily participate in all education sessions, sign a consent form, and meet the inclusion criteria. During the education sessions, the RNs and CNAs were taught aspects of fall interventions based on the organization’s fall risk policy, the patient’s EHR, and other evidence-based interventions found through the literature review.

Timeline

Planning	Pre-Implementation	Implementation	Evaluation	Completion Date
Team development				3/3/23
Proposal defense				4/14/23
	Obtain Liberty University IRB approval			4/22/23
	Obtain organization IRB approval (if needed)			5/1/23
	<u>Data collection:</u> Pre-Education Fall Rates and Fall Learnings			3/19/23 to 5/19/23
		Education teaching sessions		5/13/23 to 5/19/23
			<u>Data collection:</u> Pre- and Post-Test Scores, Demographic Survey, Education Evaluation Survey	5/20/23
			<u>Data collection:</u> Post- Education Fall Rates and Fall Learnings	5/20/23 to 7/20/23
			Final defense	8/3/23

Feasibility

The feasibility of the scholarly project should be determined to see if a larger scale of the project would be practical or reasonable (Moran, Burson, & Conrad, 2020). The feasibility of the project relied on a convenience sample of RNs and CNAs on the medical and surgical oncology units; therefore, access to staff members was essential. The scholarly project was completed during work hours; however, the Nurse Managers agreed to pay education time for those participants who wished to complete the education sessions during their off hours. The researcher secured the medical oncology or surgical oncology education conference room for the sessions. The technology for the education session, including a computer and projector, was also secured. Lastly, the support of a statistician was essential for the validity of the data analysis.

SECTION FOUR: RESULTS**Data Analysis**

The data analysis compared the different data sets of the scholarly project. The first measurable outcome measured the nursing staff's knowledge about fall prevention by analyzing and comparing the pre-test and post-test scores of the nursing staff, which will analyze the short-term effects of nursing education and correlate them with fall rates.

There were 27 participants in the project; 65% of participants were female and 35% were male (see Appendix O). There were 21 Registered Nurses, four Certified Nursing Assistants (1 or 2), and one Nurse Manager who participated (see Appendix O). The experience of the participants in their current role varied, with two having more than 20 years of experience, five having between 10-20 years of experience, three having six to ten years, seven having three to five years, seven having one to two years, and two having less than one year of experience in their current role (see Appendix O). The experience of the participants working on the medical

or surgical unit also varied, with one having more than 20 years of experience, six having between 10-20 years of experience, five having six to ten years, four having three to five years, eight having one to two years, and two having less than one year of experience in their current role (see Appendix O). Lastly, the age of the participants included a wide range, with 8% being ages 8-25 years old, 19% 26-30 years old, 27% 31-40 years old, 38% 41-50 years old, and 8% over the age of 61 years old (see Appendix O).

The pre-test scores ranged from participants answering 19 to 29 questions correctly out of the 33 questions asked. The average pre-test score was 25.1 out of 33 questions. The post-test scores ranged from 25 to 32 correct questions out of the 33 questions asked. The average post-test score was 29.3 out of 33 (see Appendix O).

The second measurable outcome was measured by the number of falls on the medical and surgical oncology unit, two months pre-education and two months post-education. The pre-education data time period was 3/19/23 to 5/19/23 and there was a total of five falls, three on the medical oncology unit and two on the surgical oncology unit (see Appendix P). Of the three falls on the medical oncology unit, none were in the first month (3/19/23 to 4/19/23), and three were in the second month (4/20/23 to 5/19/23; see Appendix P). The three falls were anticipated falls, meaning that they met the fall risk criteria and fall interventions were recommended (see Appendix P). Of the three patients who falls, one sustained minor injury (a scrape) (see Appendix P). Lastly, of the three falls, three had fall education done prior to the fall, and two of the three had reinforced fall education after the fall (see Appendix P). Furthermore, the fall CPG was used pre-fall for all three patients, and two of the three patients had the CPG continued post-fall (see Appendix P).

For the surgical oncology there were no falls in the first month of data collection pre-education (3/19/23 to 4/19/23), and there were two falls in the second month prior to fall education (4/20/23 to 5/19/23; see Appendix P). The two falls were anticipated falls, meaning that they met the fall risk criteria and fall interventions were recommended (see Appendix P). Of the two patient falls neither sustained any injury (see Appendix P). One of the two patients who fell received fall education prior to falling, and both patients received fall education post-fall (see Appendix P). Both patients had the fall CPG in place prior to falling, and post-fall (see Appendix P).

The post-education data fall period took place from 5/20/23 to 7/20/23 and there was a total of four falls on the medical oncology unit and three falls on the surgical oncology unit. Of the four medical oncology unit falls two were on days and two were on nights, three were in the bathroom and one was in the patient room doorway. Three of the four falls had minor injuries including bruises and a skin tear. Of the four patients who fell, none had preventative fall education pre-fall and only 50% of the patients received fall education after their fall; per policy, fall education is required for a fall risk patient and after a patient has a fall. Pre- and post-fall only 50% of the patients who fell had a fall CPG in their electronic medical record.

For the medical oncology unit the post-fall period totaled three patient falls, with two being on the night shift and one on day shift. Two patient falls were in the bathroom and one was from the bed, resulting in a total of one patient having a skin tear, and the other with no injuries. Only one patient had fall education pre-fall, and all three patients did not receive fall education post-fall; per policy, fall education is required for a fall risk patient and after a patient has a fall. However, all three patients had their fall CPG charted on pre- and post-fall.

The long-term effects, the researcher will advise the organization to track the national NDNQI benchmarks and the national percentile of which the organization falls under pre- and post-implementation to determine long-term effects of education on fall rates. For both the pre- and post-test, and the number of falls pre- and post-education, a two-group paired *t*-test was analyzed. The researcher determined the hypothesis to be that the post-test mean scores would be different than the pre-test mean education scores. The null hypothesis is that there is no difference in the pre- and post-test mean education scores. The degrees of freedom, standard deviation, standard error, *p*-value, 95% confidence interval, and *p*-value were also be determined (see Appendix Q). Our test determined that the *p*-value of <0.001 was less than the significance level of 0.05, meaning that there was a statistically significant change in the post-test versus the pre-test scores, suggesting that the intervention was impactful on nursing staff's fall knowledge.

The number of patient falls (falls per 1000 patient days) that occur in the pre-and post-implementation phase were also compared using a paired *t*-test. The researcher determined the hypothesis to be that the pre-education fall rates would be different than the pre-education mean fall rates. The null hypothesis is that there is no difference in the pre- and post-education fall rates. The degrees of freedom, standard deviation, standard error, *p*-value, 95% confidence interval, and *p*-value were also determined (see Appendix R). The confidence level was set at 0.05 and the test determined the *p*-value was low ($p=0.2048$), meaning that there was not a statistically significant change in the post-education fall rates versus the pre-education fall rates, suggesting that the intervention for the fall rates was not impactful. The researcher consulted a statistician during the data analysis period.

An education evaluation was given to each participant. The survey had seven questions that were rated on a Likert Scale (yes-excellent, yes-very good, neutral, no-bad, no-very bad),

and two open ended questions that participants could free text. The education evaluation survey results (see Appendix S) showed that most participants felt that the education session was a good use of their time; had a better understanding of what fall risk scale to use; had a better understanding of fall risk factors; had a better understanding of fall prevention and fall interventions; and had a better understanding of the fall CPG, fall policy, and Lippincott's fall protocol. The participants also thought that the researcher had accurate knowledge of the subject matter and presented the education in a way that they could understand. The two open-ended questions asked for feedback about the researcher and the education sessions, as well as suggestions regarding future fall education presentations. The two qualitative questions suggested that the participants thought the presentation was informative and that they "learned a lot." There was one negative comment stating that some of the multiple-choice questions had some repetitive answers. Some of the feedback regarding future fall education topics was that participants would like to see more unit-specific data and metrics, information on the Johns Hopkins fall risk tool, would like my presentation to be shared at a staff meeting, would like to see data to support the effectiveness of strip alarms, and would like more information on fall prevention while patients are attached to intravenous fluid tubing.

SECTION FIVE: DISCUSSION

Implications for Practice

When considering implications for practice, it is essential to look at the organization's mission and values as to why these results are necessary for a practice change. Part of the organization's mission states, "We are steadfast in serving all, especially those who are poor and vulnerable," making the results of this study in alignment with helping those at risk for falling and making them vulnerable, possibly placing them in harm's way (Providence Health &

Services, 2023). Another value of the organization is excellence, stating that they provide innovative and transformational care, committed to safe and reliable patient care (Providence Health & Services, 2023). Therefore, if this scholarly project positively affects the patient population, it will further develop their integration of providing excellent, evidence-based practice to the patients they serve. If the results of this scholarly project positively correlate to decreasing patient falls, there will be significant implications for educational training and further dissemination of this pilot study.

The implications for practice are immense. It will be essential to ensure that the organization updates its education of new nursing staff regarding fall education to ensure that all new nursing staff are equipped with the same fall education, and the new practice does not fall by the wayside. It will also be necessary for caregivers to understand that these correlations are suitable for patients' safety and will help with hospital reimbursement rates and publicly reported scores. It is also recommended that the fall policy be revisited and written in a way that is meaningful for implementation and use. The fall policy is currently over 25 pages in length with several appendixes and attachments, making the actual length more than 35 pages. It is recommended that the fall policy be revised to be less cumbersome and practical for caregivers to read and remember. Lastly, it is recommended that the fall policy include more education regarding cancer patient fall risks, including the risk of chemotherapy-induced peripheral neuropathy being the number one reason cancer patients fall (Autissier, 2019).

Limitations

One of the biggest limitations of the project was the number of participants. The fall education was not mandatory, and as a result there were only 27 participants, out of the possible 100 caregivers employed on the medical and surgical oncology units. Therefore, it is difficult to

conclude whether the findings of the study are directly correlated with the fall education intervention. The Nurse Managers of the units did not make this education mandatory because the current environment was not conducive to adding additional mandatory in-services. Another limitation was the lack of notice regarding the in-service education sessions, The email for recruitment and the flyers were posted two days before the first in-service date, making it short notice for some to prepare and attend. Although 17 in-services were offered over a period of seven days, at various times, dates, and via in-person and on TEAMS, both units were short-staffed all seven days and there were multiple competing factors.

One of the main competing factors for the in-person in-services was the lack of shift coverage for caregivers to be fully present for the entire in-service. Many caregivers were interrupted during the education sessions via Vocera and other team members needing their assistance; therefore, it is recommended for future studies that extra staff be recruited to fully break caregivers for an uninterrupted session. There were many distractions and interruptions in the conference rooms, because of the multiple people coming and going throughout the in-service sessions.

Other possible alternative explanations for the project findings could be that the units were not as short-staffed during the post-education data collection period versus the pre-education data collection period (see Appendix T). Lastly, there was a union-authorized strike that happened from 6/19/23 to 6/24/23; consequently, both units did not have their core staff and were staffed with travelers, other clinical leaders from other hospitals within the organization, and non-clinical volunteers. Therefore, it is hard to know if there was an impact on the fall rate related to poor staffing ratios.

Sustainability

The researcher will suggest the organization continue to monitor the long-term results of patient falls via the NDNQI database. However, the researcher will establish a plan for sustainability with the Nurse Manager, charge nurses, and the unit's fall committee representatives. For short term management the leaders in the medical and surgical oncology units will need to do spot checks on falls and root cause analysis of all falls, searching for any gaps in education that may need to be mitigated. This should be completed soon after the patient fall happens, and gaps in fall interventions reported to all caregivers for further education and learning. Further fall education for new hires and transfers will need to be maintained as well. The organization's current annual education is based on the previous year's patient fall learnings. Therefore, the researcher suggests adding additional education based on the hospital policy, fall CPG, and any new evidence-based practice that is available. Lastly, the researcher suggests an interactive portion, educating on how to use the quick mobility chart and practice rating patient risk to fall and what their mobility status and interventions should be. By providing an interactive portion with hands-on scenarios this will help solidify the staff's knowledge and will allow them to practice in a safe environment.

Dissemination Plan

Dissemination of the projects results is crucial in order to expand the breadth of knowledge of nursing research. Dissemination of results also constitutes part of the DNP *Essential* III (Moran, Burson, & Conrad, 2020). It is important to disseminate the results to the organization including the Nurse Managers, the unit's nursing staff, the organization's nursing leaders, and any other key stakeholders. Whether the research results are positive or negative, it is important to disseminate them to ensure there is closed-loop communication about the project and so that others have the opportunity to further expand the research. This dissemination plan

should utilize a strategic methodology and a systematic approach to ensure all stakeholders receive communication (Moran, Burson, & Conrad, 2020). At a minimum, a presentation should be given to the unit's nursing staff, Nurse Managers, and the nursing leaders of the organization. It is important for the DNP student to keep in mind timelines, especially final deliverables for graduation (Moran, Burson, & Conrad, 2020). Many dissemination plans include a presentation to the unit and organizational staff, podium and poster presentations, and journal articles.

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Appendices

Appendix A – Levels of Evidence Matrix

Appendix B – Letter of Permission to Use The Iowa Model for Conceptual Framework

Appendix C – Participant Consent

Appendix D – Participants Demographic Data

Appendix E – Liberty University IRB approval

Appendix F – Organization IRB approval

Appendix G – Organization Letter of Support

Appendix H – CITI Training Certificate

Appendix I – Post-Fall Audit Tool

Appendix J – Iowa Model Tool

Appendix K – Pre- and Post- Nursing Staff Test

Appendix L – Fall Education Evaluation

Appendix M – Email to Participants

Appendix N – Poster and Flyer Advertisement

Appendix O – Demographic Data

Appendix P – Pre- Education Falls Data

Appendix Q – Statistical Analysis of Pre- and Post- Education

Appendix R – Statistical Analysis of Pre- and Post- Falls Data

Appendix S – Education Evaluation Results

Appendix T – Pre- and Post- Education Unit Staffing

Appendix A – Evidence Table

<p>Article Title, Author, etc. (Current APA Format)</p>	<p>Study Purpose</p>	<p>Sample (Characteristics of the Sample: Demographics, etc.)</p>	<p>Methods</p>	<p>Study Results</p>	<p>Level of Evidence (Use Melnyk Framework)</p>	<p>Study Limitations</p>	<p>Would Use as Evidence to Support a Change? (Yes or No) Provide Rationale.</p>
<p>Ang, W., Heryani, N., Lau, S., & Lau, Y. (2018). Evaluation of a fall prevention educational video on fall risk awareness, knowledge and help seeking behavior among surgical patients. <i>Singapore Nursing Journal</i>, 45(1), 27-33.</p>	<p>Evaluate effectiveness of videos on fall risk awareness and knowledge on falls</p>	<p>202 participants; 700 beds tertiary hospital in Singapore. The intervention group was carried out in a 38 beds surgical ward while the control group was in a 38 beds orthopedic ward.</p>	<p>-Quasi-experimental quantitative post-test comparison research design was used to evaluate the effectiveness of the video -The participants in the control group received education through a</p>	<p>-Independent t-test showed that the intervention group had a significant improvement (p= 0.021) in fall risk awareness. -However, Independent t-test and Mann-Whitney U test showed no significant results for knowledge on falls (p= 0.348) and help seeking</p>	<p>Level 3: Case controlled</p>	<p>-One facility/only the two units were used -Videos were only in one language -Not RCT -Control group and intervention group were separate units and not half of each unit -All patients, even control group, received a pamphlet about falls</p>	<p>This would be good supplemental evidence to support patient education via video. However, it does not analyze the impact of fall education for nurses.</p>

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			<p>fall prevention pamphlet -The participants in the intervention group viewed the fall prevention educational video from the researcher's laptop at their bedside in addition to the fall prevention pamphlet</p>	<p>behavior (p= 0.519) respectively -Video content validation index was 0397</p>			

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<p>Autissier, E. (2019). Chemotherapy-induced peripheral neuropathy. <i>Clinical Journal of Oncology Nursing</i>, 23(4), 405-410. doi:10.1188/19.CJON.405-410</p>	<p>To summarize the literature to link chemotherapy-induced peripheral neuropathy (CIPN).</p>	<p>Thirty-one studies related to CIPN.</p>	<p>Literature review was conducted to determine the risk of falling and other injuries as a consequence of CIPN, as well as assessments, treatments, and interventions.</p>	<p>Assessment and interventions related to CIPN is crucial for preventing falls and injuries from falls. Proper education of oncology nursing caregivers to assess for CIPN and management of CIPN is necessary to reduce CIPN related falls.</p>	<p>Level 1: Meta-analysis</p>	<p>There were no limitations listed in the study. However, because there were no limitations listed, makes it a limitation (because the researcher did not disclose limitations). One of the main limitations are the implications for the acute care setting. This article stated that this would apply</p>	<p>Because of the high level of evidence this would be applicable to use in regards to the scholarly project. However, this would be good supplemental evidence to support CIPN education related to fall prevention. This study also applied to cancer patients, which applies to the project as well.</p>

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						<p>to the acute care setting, however, did not go into fine details for implications (as they did in the home setting).</p>	
<p>Bateman, J., & Schmidt-Borcherding, F. (2018). The communicative effectiveness of education videos: Towards an empirically-motivated multimodal account. <i>Multimodal Technologies and Interaction</i>,</p>	<p>To find out if the theory of multimodality for the engaging in media education (both theoretical and empirical) is best practice.</p>	<p>Twenty-seven students (age: M = 24.62; SD = 3.75; 25 female) of the University of Bremen, Germany, participated in the study.</p>	<p>The experiment followed a one-factorial design applying the educational videos described in the former sections as independent variable. That is, 9</p>	<p>Multimodal communication of the kind the researchers proposed (using the framework of the theory of multimodality) will be essential for engaging with such media, both theoretically</p>	<p>Level 2: quantitative and quasi-experimental</p>	<p>The size of the study does not indicate that the results are generalizable and that it was only tested on university students.</p>	<p>This would support the framework of the theory of multimodality for the deployment of education provided via videos. However, this study would only be supplemental, as it did not call out fall education during the study, nor education for the nurses (only</p>

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<p>2(3), 59. doi:10.3390/mti2030059</p>			<p>participants watched Video 1 (the screencast), 10 participants watched Video 2 (the Prezi), and 8 participants watched Video 3 (the so-called vodcast).</p>	<p>and empirically</p>			<p>patients). Therefore, this would be supplemental to higher levels of evidence to support video education.</p>
<p>Chan, D., Sherrington, C., Naganathan, V., Hua Xu, Y., Chen, J., Ko, A., . . . Cumming, R. (2018). Innovation and translation key issues to</p>	<p>Purpose was to test if a silent video using body language would decrease fall rates for cognitively impaired inpatients and patients with a</p>	<p>-358 people on an acute ward (half were shown video, half were not) -50% of the older patients have a non-English</p>	<p>-Feasibility trial over 6 months -Silent video using universal body language.</p>	<p>50% reduction in fall events in the group who were shown the video twice a week</p>	<p>Level 3: case controlled</p>	<p>-No specific numbers for non-English speaking -One hospital and one unit -Relatively small number of subjects</p>	<p>This would support patient education via video, however, did not analyze education for nurses knowledge of video education. Showed that a simple video (shown twice a</p>

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<p>consider and innovative ideas on fall prevention in the geriatric department of a teaching hospital. <i>Australasian Journal on Aging, 37(2), 140-143.</i> doi:10.1111/ajag.12528</p>	<p>language barrier (non-English speaking).</p>	<p>speaking background -50% of the older patients admitted to the hospital are cognitively impaired</p>				<p>-Did not specify if groups were random</p>	<p>week) with one specific message could decrease falls in non-English speaking patients and patients with dementia.</p>
<p>Cho, M.-y., & Jang, S. J. (2020). Nurses' knowledge, attitude, and fall prevention practices at South Korean hospitals: A</p>	<p>This study assessed knowledge and attitudes regarding falls, and fall-prevention activities of nurses working</p>	<p>The participants' mean age was 32.49 years (SD 8.17) and 157 (96.9%) of them were female. The</p>	<p>Nurses (N = 162) from seven small- and medium-sized hospitals participated in the study.</p>	<p>The present study opens the possibility of increasing nurses' interest in fall-prevention activities in small and</p>	<p>Level 4: Cross-Sectional</p>	<p>Data was collected from only seven hospitals in a single city in South Korea; therefore, we cannot generalize the</p>	<p>This is a good study to supplement nursing education, and to use the studies findings to help support a good learning environment, and listen to barriers</p>

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<p>cross-sectional survey. <i>BMC Nursing</i>, 19(1), 108. doi:10.1186/s12912-020-00507-w</p>	<p>in small- and medium-sized hospitals</p>	<p>mean duration of participants' work experience was 8 years and 5 months. Of the total number of participants in the study, 82 (50.6%) nurses had experienced inpatient falls and 127 (78.4%) nurses had participated in educational programs on</p>	<p>Among the 190 distributed questionnaires, 4 were not returned, and 24 were blank. Therefore, the final analytic sample included 162 questionnaires (85.3% response rate).</p>	<p>medium-sized hospitals. Patient safety in small- and medium-sized hospitals can be enhanced by creating an atmosphere wherein developing fall-prevention strategies are voluntary and self-directed (for example, developing a nursing practice guideline for preventing inpatient falls), and providing appropriate</p>		<p>results to a larger population, and this study should be repeated with more nurses from different cities. Also, nurses might have understood questions differently, as attitudes and engagement in fall prevention activities were evaluated using self-reported data.</p>	<p>that may be inhibiting fall precautions and education on the unit. This was also in South Korea, so it might not be generalizable to hospitals in the United States.</p>

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		<p>fall prevention.</p>		<p>motivation and rewards</p>			
<p>Costantinou, E., & Spencer, J. (2021). Analysis of inpatient hospital falls with serious injury. <i>Clinical Nursing Research</i>, 30(4), 482-493. doi:10.1177/1054773820973406</p>	<p>The purpose of this study was to utilize an available data collection instrument to better understand patient and environmental characteristics of those who sustained a fall-related serious injury at a hospital.</p>	<p>53 medical records of patients that had fallen at a single hospital. Study done over two years.</p>	<p>Retrospective case study -Injurious Fall Data Collection Tool -Chi-square tests were performed to examine the relationship between outcomes of moderate versus major injury severity level and the nominal variables of age group,</p>	<p>-The highest percentages of falls with serious injury involved oncology patients and heart and vascular (tied at 20.8) with 4th surgery (13.2) -The highest percentages of falls with moderate injury involved oncology patients (7.5)</p>	<p>Level 5: retrospective case study</p>	<p>-Lack of reporting and inaccurate or incomplete medical record data. -Falls with serious injury that occurred in the fourth quarter of each year were not reviewed. -This study did not compare fallers with a serious injury to a control group of non-fallers or</p>	<p>This study is generalizable for the oncology patient population, and supports patient education. However, it did not analyze effects of education for the nurses on fall risks. Study showed that oncology patients and surgical patients are among the top 4 types of patient populations that could fall and to sustain moderate to serious injuries. This stresses the importance of interventions</p>

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			<p>gender, FRA category, altered mobility, and unit service line.</p>	<p>-Analysis of falls per 1000 patient days shows highest rates on 2nd oncology (0.11) and 4rd surgery (0.9) -Peak occurrence of injurious fall was between 1 and 4 days after admission.</p>		<p>fallers with mild injuries. -One site study.</p>	<p>needed on a Surgical Oncology unit. It also showed that patients were likely to fall between 1 and 4 days after admission, which is why we stress education within 24 hours of admittance or asap post anesthesia.</p>
<p>Cuttler, S., Barr-Walker, J., & Cuttler, L. (2017). Reducing medical-surgical</p>	<p>To evaluate the effectiveness of patient education videos on fall rates</p>	<p>-Four medical-surgical units in one US public acute care hospital.</p>	<p>Performance improvement study. - A 4 min video was</p>	<p>-Falls decreased 20% from 4.78 to 3.80 per 1000 PDs (IRR 0.80,</p>	<p>Level 7: performance improvement</p>	<p>-Not RCT. -Multiple things at once (made sure bed alarm was active, tried to</p>	<p>This would show that the use of patient fall education via video is effective; however, did not</p>

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<p>inpatient falls and injuries with videos, icons and alarms. <i>BMJ Open Quality</i>. 6(2), 1-9. doi:10.1136/bmj.oq-2017-000119</p>		<p>-Patients and family members were approached 1200 times to watch videos. -Patients who screened as at risk of falling (using the Schmid 9 screening tool) were identified on a computer-generated list. Videos shown at any time during their stay.</p>	<p>shown to patients and/or family.</p>	<p>95% CI 0.66 to 0.96) -Falls with any injury decreased 40% from 1.01 to 0.61 per 1000 PDs (IRR 0.60, 95% CI 0.38 to 0.94) -Falls with serious injury 85% from 0.159 to 0.023 per 1000 PDs (IRR 0.15, 95% CI 0.01 to 0.85).</p>		<p>use icons on only 10 of the patient rooms) so difficult to infer which intervention worked. -The environment of care should be considered (proximity to nurses' station, single patient room) and was not recorded and unknown if this effected anything.</p>	<p>analyze nurses knowledge on fall education. Therefore, would only be supplemental. The beds already had the alarms on them and only 10 patient rooms used the icons. The study indicated that the icons were not effective and not fully implemented. The results show using video education will decrease fall rates and injury related to the fall and for that fact alone, it can be useful.</p>

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<p>Fowler, S., & Reising, E. S. (2021). A replication study of fall TIPS (Tailoring Intervention for Patient Safety): A patient-centered fall prevention kit. <i>MedSurg Nursing, 30</i>(1), 28-34.doi: 10.1016/j.jcjq.2017.05.002</p>	<p>Replicate the study by Dykes and coauthors (2017) on a medical telemetry unit, exploring adoption of a patient-centered fall prevention tool and its impact on patient knowledge of fall risk factors and interventions, fall rates, and injury rates</p>	<p>medical telemetry unit at a 237-bed community hospital over 6 months (March-August 2018). Average daily census was approximately 30 patients during this period. Four convenience samples of 30 patients each were chosen for interviews before the</p>	<p>A pre- and post-intervention design was used to compare patients' perceived knowledge and actual fall rates before and after implementing the tool and processes. Thirty patients were interviewed before the study and at 1-, 3-, and</p>	<p>Patients were more knowledgeable about falls at months 1, 3, and 6 compared to pre-intervention (p=0.001-0.05). Fall rates fluctuated over the 6-month study, with overall reduction from 3.3% (pre-) to 1.9% (post-). Staff was 85% adherent with use of the laminated poster, with adherence</p>	<p>Level 2: Quasi-experimental</p>	<p>Findings are limited to one hospital and one medical telemetry unit. Results support the potential for a best practice change. Plans are to disseminate this new process to other patient units. overall adherence to documentation on the fall risk assessment and intervention</p>	

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		<p>intervention and at 1 month, 3 months, and 6 months during the intervention period (N=120). Patients had to be alert, oriented, and English- or Spanish-speaking to be included in the interview process</p>	<p>6-month time points during implementation (N=120). Number and rates of falls per 1,000 patient days were calculated. Audits were completed randomly to monitor adherence to the process.</p>	<p>increasing over time. RN education provided at huddles and Gemba or other communication boards provide verbal and visual opportunities for communication about falls.</p>		<p>poster in the study period was 84%, with improvement over time. Initial adherence of 45% steadily increased to 100% at the end of the study. In 183 of 259 observations, documentation on the poster was 100% completed with the five key elements of the patient's name, date</p>	

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						<p>and time, identification of risk factors, and notation.</p>	
<p>Hakvoort, L., Dikken, J., van der Wel, M., Derks, C., & Schuurmans, M. (2021). Minimizing the knowledge-to-action gap; identification of interventions to change nurses' behavior regarding fall prevention, a mixed method study. <i>BMC Nursing</i>, 20(1), 80.</p>	<p>The aim of this study is to identify intervention options to change the behavior of hospital nurses regarding fall prevention among older hospitalized patients.</p>	<p>ligible experts were medical doctors, nurse practitioners, nurse specialists and physiotherapists with further education in geriatrics. All experts worked in one of the ten tertiary Dutch teaching</p>	<p>This study used a mixed method design. The Behavior Change Wheel (BCW) was used to identify intervention functions and policy categories to change the behavior of nurses regarding fall</p>	<p>In Geriatric experts' opinions interventions targeting behavior change of nurses regarding fall prevention should aim at 'after-care', 'estimating fall risk' and 'providing information'. However, in nurses' opinions it</p>	<p>Level 5: Quantitative (Delphi rounds) and Qualitative (focus groups with interviews)</p>	<p>Low n for all study groups. Not generalizable to a larger patient population.</p>	<p>This would not be a good article to support RN education related to falls. This article was regarding RNs perception of falls, not education surrounding falls. However, this article would be good for the implementation of evidence and the RNs perception of the fall education.</p>

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<p>doi:10.1186/s12912-021-00598-z</p>		<p>hospitals affiliated with the Research, Education and Nursing regarding Elderly (RENursE) consortium.</p>	<p>prevention. This study followed the eight steps of the BCW and two methods of data collection were used: five focus groups and three Delphi rounds. The focus groups were held with hospital nurses (<i>n</i> = 26). Geriatric experts (<i>n</i> = 11), managers</p>	<p>should target; ‘providing information’, ‘fall prevention’ and ‘multifactorial fall risk assessment’. Nurses experience a diversity of limitations relating to capability, opportunity and motivation to prevent fall incidents among older patients. Based on these limitations</p>			

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			<p>(<i>n</i> = 13) and educators (<i>n</i> = 13) were included in the Delphi rounds. All data were collected within ten tertiary teaching hospitals in the Netherlands. All participants were included based on predefined in- and exclusion</p>	<p>educational experts identified three intervention functions: Incentivisation, modelling and enablement. Managers selected the following policy categories; communication /marketing, regulation and environmental/ social planning</p>			

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			<p>criteria and availability</p>				
<p>Halim, A., Mahzum, E., Yacob, M., Irwandi, I., & Halim, L. (2021). The impact of narrative feedback, e-learning modules and realistic video and the reduction of misconception. <i>Education Sciences, 11</i>(4), 158. doi:10.3390/educsci11040158</p>	<p>To determine the level of misconception percentage reduction through the use of narrative feedback, the e-learning modules, and realistic video.</p>	<p>281 students; s all first-year students in the Department of Physics, Chemistry, and Biology, Teacher Training and Education Faculty, Syiah Kuala University, who were currently taking the basic physics course.</p>	<p>The data were collected twice, namely before treatment and after treatment. The validity of the three-tier diagnostic test instrument-based e-learning, which is measured by its validity and reliability</p>	<p>The contribution of the initial baseline of the respondents to the final score (posttest) was very low in the class with narrative feedback treatment, and the highest one was in the class with e-learning modules treatment. The best feedback treatments used to reduce the</p>	<p>Level 2: quantitative and quasi-experimental</p>	<p>This study was limited to basic physics concepts, the respondents come from different fields of science, and the modules used are not directly related to the questions and answers in the pretest.</p>	<p>This study supports the use of e-modules and visual learning (realistic video). Therefore, this would help support realistic videos. However, these videos were for those in certain science classes; therefore, it is uncertain if the results are generalizable.</p>

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			<p>values, has been tested and calculated by previous researchers.</p>	<p>misconception percentage in the concept of free-fall motion were narrative feedback and realistic video. The efforts to reduce the misconception percentage in the size and shape of free-fall objects were best employed with narrative feedback. Lastly, in efforts to reduce the percentage of misconception</p>			

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				<p>in the acceleration of falling objects, the three types of treatments could be utilized.</p>			
<p>Harden, K. L., Wall, P., Galunas, L., Eastman, D. J., & Frederick, T. S. (2021). Managing Falls. <i>Clinical Journal of Oncology Nursing</i>, 25(2), 188-193. doi:10.1188/21</p>	<p>All healthcare institutions prioritize falls as a major safety issue. Falls are of particular concern on inpatient oncology units where patients are substantially at risk for injury related to falls. Therefore, they implemented a</p>	<p>The initiative was implemented on the 32-bed inpatient acute care oncology unit at Michigan Medicine. The majority of the 64 nurses who participated in the initiative were</p>	<p>The initiative included three essential falls interventions, a standardized communication method, and a rigorous timeline for implementation for staff. The</p>	<p>With the use of the Visual Rounding Tool, there was a clinically significant decrease in the use of call lights for a period of nine weeks. During this period, average weekly call lights were reduced by 12%. In</p>	<p>Level 1: Literature Review</p>	<p>One unit therefore, not generalizable. Also, their nursing staff as the convenience sample. Despite the initial success of the results, the intervention practices were not maintained long-term.</p>	<p>This would be a good article to use to support RN fall education because the results would be generalizable to the patient population (oncology vs surgical oncology). This would also support the education of RNs related to falls, because the RNs were educated. Lastly, this was supported by a</p>

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	<p>three-prong intervention to see if it would decrease their fall rates.</p>	<p>bachelor's prepared and supported on the unit by a mix of UAPs designated as patient care technicians or nursing aides.</p>	<p>essential interventions were RN-UAP communication, proactive toileting, and hourly rounding. This initiative was guided by the quality team at the authors' institution, formally evaluated using a quality improvement process</p>	<p>addition, the set goal of a 20% decrease in falls was exceeded for the fiscal year. Following implementation, the number of total falls decreased by 31%, and the number of falls with injury decreased by 50%</p>			<p>literature review, therefore, has a higher level of evidence.</p>

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			<p>and procedure, and determined not to be human subject research. Audits were conducted to quantify observed reporting by RNs and UAPs. The outcome measures were to decrease falls and falls with harm for patients with cancer</p>				

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			<p>and to decrease the use of call lights, indicating that patient needs were being met. Staff education was intentionally created and implemented to include input from nurses and assistive personnel to refine processes, which helped to maintain</p>				

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			<p>commitment</p>				
<p>Innab, A. M. (2022). Nurses' perceptions of fall risk factors and fall prevention strategies in acute care settings in Saudi Arabia. <i>Nursing Open</i>, 8(2), 1263-1269. doi:10.1002/nop.2.1182</p>	<p>The purpose of this study was to explore nurses' perceptions of the factors associated with falls and fall prevention in acute care settings in SA. The specific aims of this study were to (1) determine the frequency and effectiveness of using preventive measures for falls in</p>	<p>At a teaching hospital. convenience sampling method to collect data from nurses working in acute care departments. Included nurses (a) were currently working in acute care units, (b) held a current Registered Nurse (RN)</p>	<p>This study adhered to the Strengthening the Reporting of Observational studies in Epidemiology (STROBE) initiative, as detailed in the Supplementary File.</p>	<p>We found that impaired balance and muscle strength, limited mobility, and an inability to follow safety instructions were reported as the top factors in falls. Multidisciplinary fall prevention strategies are effective in reducing the prevalence of falls. Nurses with higher</p>	<p>Level 4: Cross-sectional, correlational, descriptive study.</p>	<p>data were collected at a single point in time from a sample of nurses working in a single teaching hospital in SA. The researcher used a convenience sampling method, reducing the generalizability of the findings to other healthcare</p>	<p>This study does not go into fall education of the RNs. However, it does correlate certain attributes to higher fall education knowledge. This study is also not generalizable because it was conducted in a different country than the USA; therefore, may have other factors that contributed to the results. This would be good supplemental evidence to support</p>

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	<p>inpatient settings, and (2) determine the relationship between nurses' characteristics (age, gender, level of education, length of experience, position and recent fall prevention education) and their perceptions of why falls occur in acute care settings.</p>	<p>license, (c) were working as a staff or head nurse and (d) were proficient in English. Nursing students, nursing interns and nurses working in outpatient settings were excluded due to a lack of extensive work with patients at a higher risk of falls. Participants'</p>		<p>levels of education had higher perceptions towards the risk factors of falls. Formal patient safety training, including fall prevention education programs, were shown to reduce falls by making nurses more aware of fall risk factors and prevention strategies. The findings of this study can be used to inform managers</p>		<p>settings. Future researchers are recommended to use a robust design and sampling method to enhance the external validity of the study.</p>	<p>using a fall education program.</p>

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		<p>ages ranged from 26 to 56 years, with a mean age of 38.2 (± 7.9). The majority of participants (80.4%) were female. The educational level of participants ranged from college diploma to master's degree, with the majority of nurses (59.8%) holding a BSN degree.</p>		<p>about factors that may contribute to falls in acute care settings.</p>			

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<p>Kiegaldie, D., Nestel, D., Pryor, E., Williams, C., Bowles, K.-A., Maloney, S., & Haines, T. (2019). Design, delivery and evaluation of a simulation-based workshop for health professional students on falls prevention in acute care settings. <i>Nursing Open</i>. 6(3), 1150-1162. https://doi.org/10.1002/nop2.318</p>	<p>The aims of the evaluation were to measure the impact of the delivery of the SRP (Safe Recovery Program) using SBE on student's knowledge of evidence-based falls prevention strategies and their confidence and motivation to implement the SRP during their placement. A further aim</p>	<p>All students entering clinical placement on an intervention ward were trained in the SRP.</p>	<p>This study was a Pre-Post-test intervention design</p>	<p>Pre-Post-test study found that SBE improved student's knowledge and skills and provided experiential learning that was memorable and challenging. The aims of the evaluation were to measure the impact of the delivery of the SRP using SBE on student's knowledge of evidence-based</p>	<p>Level 6: Qualitative (interview questions) and Quantitative</p>	<p>This was only regarding student nurses (SN) and not RNs on a unit with the SRP; therefore, this may not be generalizable to the RN in the acute care setting. It is not possible to clearly identify whether SBE assisted in the acquisition of knowledge and skills in falls prevention as the study did not compare</p>	<p>This would not be good evidence to support RN fall education, because it is a low level of evidence and it was not generalizable to RNs (versus SN). It also does not take into account the history and experience an RN would have related to falls education. Lastly, it did not outline the fall education that was implemented.</p>

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	<p>was to explore the students' perceptions of their learning experiences</p>			<p>falls prevention strategies and their confidence and motivation to implement the SRP during their placement. A further aim was to explore the students' perceptions of their learning experiences</p>		<p>SBE with no SBE. An open-ended question seeking participant's specific views on simulation was not asked which may have disclosed negative views on the simulation experience. The study did however measure qualitative responses to further expand on student views.</p>	

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<p>Kivoshi-Teo, H., & Northrup-Snyder, K. (2022). "Adapted" motivational interviewing to engage hospital nurses in fall prevention education. <i>Online Journal of Issues in Nursing</i>, 27(2), 1-10. doi:10.3912/OJIN.Vol27No02PP T45</p>	<p>The goal of this project was to provide evidence-based training to hospital nurses to facilitate patient engagement with fall prevention measures.</p>	<p>Thirteen training sessions were conducted through September-November 2015. A total of 85 nurses participated in the training. The final sample (N=61) included those who completed both surveys (71% response rate). Participants included 40</p>	<p>An "Adapted" Motivational Interviewing (MI) for fall prevention (AMIFP) training in acute care was developed and introduced to nurses as part of a Veterans Affairs-Nursing Academic Partnership (VANAP) initiative.</p>	<p>After the single AMIFP training, nurses reported having increased knowledge about patient engagement related to fall prevention. Moreover, feelings of confidence related to using some MI skills for fall prevention increased after training. Even a brief AMIFP training for nurses can have a positive</p>	<p>Level 2: Quasi-experimental</p>	<p>Limitations include data collection at a single hospital with a small sample size. The post-training survey only measured immediate changes and not knowledge retention or attitude change over time. No sustainability over time measurement.</p>	<p>This would be a good study to use because it is in the same geographic area as the implementation hospital (Portland, OR). It is unknown if the study is generalizable, because the unit that the nurses received the education was not described. This would also help describe the confidence in the falls rating system.</p>

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		<p>RNs, 10 CNAs, and six nursing students. Five respondents did not report their roles on the unit. The sample represented both day and night shift nurses (Day: 36 and Night: 22), and two medical-surgical units (Unit A: 20, Unit B: 41). Three respondents did not report</p>	<p>Pre/post surveys were completed by 61 nurses (71% response rate) at an acute care hospital in the United States. Nurses completed the pre-survey right before the training, and the post-survey immediately after the training. Surveys</p>	<p>Impact on Improving hospital nurses' knowledge and attitudes to engage patients In fall prevention education</p>			

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		<p>the shift that they primarily work.</p>	<p>were paper-based and responses to the surveys were kept anonymous. Participants were asked to create and write a four digit code (e.g., last four digits of a phone number) so that their responses could be matched between pre- and post- survey responses.</p>				

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<p>Lopez, M., Ma, C., Aavik, L., & Cortes, T. A. (2023). Implementing a quality improvement program to reduce falls and increase patient medication satisfaction in an academic medical center. <i>Geriatric Nursing, 49</i>, 207-211. https://doi.org/10.1016/j.gerinurse.2022.09.002</p>	<p>An organizational workflow input process was launched in August 2019, which incorporates the Morse Falls Risk Scale in the electronic medical record, and a “Fall TIPS” checklist.6, 7 Implementation of these new fall prevention initiatives seek to leverage existing workflows, teamwork, and</p>	<p>quality improvement (QI) project was implemented on a medical unit in an urban academic medical center with more than three hundred beds. According to organizational internal data from</p>	<p>QI project medication fall risk factors and prevention interventions were in alignment with Evidence Based Practice (EBP) guidelines and input from clinical team experts. A patient teach-back guide was developed</p>	<p>Sixty of the 80 participants (75%) completed the post survey 1 after taking the eLearning module. Seventy-eight of the eighty participants (81%) completed the 4-week post survey 2. In the pre-survey, 89% of participants agreed that they felt confident recognizing medication fall risks in</p>	<p>Level 5: Quality Project</p>	<p>Several contextual elements interacted with the RNs completing the eLearning module and applying medication fall safety measures teach-back guide interventions. During the project period there were competing unit priorities, unanticipated electronic glitches and basic</p>	<p>The level of evidence is low, however, this article would be good supplemental evidence to support RN fall education and a decrease in falls.</p>

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	<p>tailored interventions. However, medicine RNs and team members expressed problem-focused concerns with recognizing and mitigating fall-risks associated medication use in older adult patient</p>	<p>2020, there were 28,973 patient discharges which accounted for 37% on the medical service. Of those patient discharges, 55% were patients 65 years old. The average age was seventy-seven, which ranks the</p>	<p>through the use of plain language and easy-to-understand concepts adapted from the guidelines. 13 Minimizing the risk that a patient will not understand the information provided is critical.14 Additionally, a nurse medication fall risks</p>	<p>collaboration with team experts. RNs reported 95% increase in confidence in recognizing medication fall risks in the immediate post survey 1 and 100% in 4-week post survey 2. RNs reported confidence in mitigating medication fall risk in collaboration with team members as 98.3% in the</p>		<p>nurse navigating capability with portal links to surveys. HCAHPS scores were reported in aggregate and also have limitations in providing hospitals useful information on how to improve specific patient population experience.</p>	

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		<p>highest to other specialty service.</p> <p>Most RNs identified as a female (91%) and years of professional practice experience (n=42; 53%) was less than 1 year. Seventy-four (93%) of the RNs had a Bachelor of Science in</p>	<p>facilitator guide for team rounds was also created in keeping with a health literate friendly approach (Fig. A.1). The Research Electronic Data Capture (REDCap) was used to distribute three surveys for RNs.</p>	<p>immediate post survey 1 and increased to 100% in 4-week post survey 2. In 4-week post survey 2, 97% of participants indicated that the educational intervention increased their knowledge and would recommend the module to other colleagues. Case review analysis (N=42) comparisons</p>			

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		<p>Nursing degree and 44 (55%) hold a title of staff nurse</p>	<p>A QI learning module was used to educate RNs, followed by a gap analysis and then the PDSA cycle and then assessed the impact of nurses' confidence utilizing teach-back with the patient and family "Medication fall safety measures"</p>	<p>pre-project implementation, and post project implementation showed no overall decrease in falls for all patients on this pilot unit. However, when we looked at patients 65 and older (67% of total falls), our case reviews showed prior to project implementation there was 15/28 falls</p>			

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			<p>guide.16 The RNs received mentoring by unit fall nurse champions with a Gerontological Nurse Practitioner. RNs were observed with two patients (65 years old) after viewing the eLearning module during each cycle</p>	<p>(54%) including one fall with severe injury and one fall with minor injury. Following the project implementation, the fall count decreased to 13/28 falls (46%), including two falls with minor injuries. Overall there was an 8% reduction in falls in this population. In</p>			

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				<p>this project patient population, we decreased falls even while the patients were at higher risk based on the Morse score post implementation. 6 208 M. Lopez et al. / Geriatric Nursing 49 (2023) 207211</p>			
<p>Money, A. G., Atwal, A., Boyce, E., Gaber, S., Windeatt, S., & Alexandrou, K. (2019). Falls</p>	<p>This study presents ‘Falls Sensei’ a first-person 3D exploration game that aims</p>	<p>Fifteen participants were recruited initially from adults attending an</p>	<p>A mixed methods data collection and analysis protocol was used to</p>	<p>The results support the use of serious games as an engaging tool for educating older adults</p>	<p>Mixed method (quantitative and qualitative). Level 3: observational study (questionnaire and</p>	<p>It is important to note that the findings relating to engagement have emerged from</p>	<p>This study would help support the idea of fall risk education being delivered via audiovisual program to patients.</p>

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<p>Sensei: A serious 3D exploration game. <i>BMC Medical Informatics and Decision Making</i>, 19(85), 1-16. https://doi.org/10.1186/s12911-019-0808-x</p>	<p>to educate older adults about extrinsic falls risk factors within the home environment. After presenting Falls Sensei, game usability and older adults' perceptions and attitudes towards using the game in practice are explored.</p>	<p>Active 50s gym group on a university campus. Nine identified themselves as female and six as male. The participant's age ranged between 50 and 80 years old. One participant declined to give their age. Six Participants were aged 50–60 and 60–70, seven</p>	<p>address the specific research aims of this study, details of which are presented in this section.</p>	<p>about extrinsic falls risk factors. Awareness of home hazard detection was raised by the game, and some older adults became more aware for the need to adapt their own homes after gameplay. Further research would be needed to draw comparisons with established interventions. There was</p>	<p>interviews) and Level 2: case controlled study</p>	<p>participants that were explicitly issued with the task of engaging with, and playing the game as part of the trial, and did not emerge from an audience that elected to play the Falls Sensei game because they believed it would be engaging. Further research is required to explore</p>	<p>This is not generalizable to education of nurses, because it was not tested. Therefore, this study would not support the use of the evidence alone because the study had only fifteen participants and the sample demographics were limited.</p>

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		<p>aged between 70 and 80. The inclusion criteria were age (fifty or over, basic computer knowledge and clear vision with or without correction (glasses/contact lenses) due to the game currently not being size adjustable</p>		<p>evidence that as a consequence of playing the game, some older adults became more aware for the need to adapt their own homes in the future.</p>		<p>whether the prospect of playing a falls game such as Falls Sensei is perceived as a potentially more engaging prospect than engaging with more traditional forms of falls prevention education tasks/activities</p>	
<p>Moreira Ximenes, M. A., Albuquerque Brandao, M. G., Macedo, T. S.,</p>	<p>To evaluate the effectiveness of an educational intervention</p>	<p>The study setting was the medical-surgical clinic of a</p>	<p>This is a quasi-experimental study, of before and</p>	<p>Educational intervention using the booklet was effective in</p>	<p>Level 2: Quasi-experimental</p>	<p>Exclusion of illiterate patients with cognitive deficits and</p>	<p>This research article would support</p>

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<p>Fejao da Costa, M. M., Galindo Neto, N. M., Caetano, J. A., . . . Barros, L. M. (2022). Effectiveness of educational technology for preventing falls in a hospital environment. <i>Acta Paulista de Enfermagem, 35</i>, 1-10. doi:10.37689/actape/2022AO01372</p>	<p>mediated by printed technology on knowledge about fall prevention in hospitalized patients.</p>	<p>trauma referral hospital, located in northern Brazil, Ceará State, from August to November 2019.</p> <p>The target population consisted of patients aged 18 years or older, admitted to the medical-surgical clinic of that institution during the data collection</p>	<p>after type, applied an educational intervention mediated by a booklet. The study included 86 patients hospitalized in a medical-surgical clinic. A knowledge test on fall prevention was used, containing 12 questions, which was previously validated by</p>	<p>providing guidance on the risk of falls in hospitalized adult patients.</p>		<p>mental confusion, due to the possible impediment to individual reading the booklet, as well as completing the data collection instruments. Moreover, the immediate assessment of knowledge, without longitudinal monitoring, made a medium and long-term assessment</p>	

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		<p>period. As inclusion criteria were considered: being hospitalized in the medical clinic under study; being literate and obtaining minimum scores on the Mini Mental State Examination (MMSE), the cutoff points were considered: 21 for those with education</p>	<p>professionals with expertise in patient safety. McNemar test was applied to assess, in a paired fashion, test responses before and after the educational intervention.</p>			<p>impossible, and the fact that the study was carried out only with people hospitalized in the public system, with no possibility of comparing the findings with supplementary health network users are also configured as limitations.</p>	

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		<p>between one and three years, 24 for individuals between four and seven years of formal education, and 26 for people with more than eight years of education.(12)</p>					
<p>Moreira Ximenes, M. A., Oliveira Fontenele, N. A., Bastos, I. B., Macedo, T. S., Galindo Neto, N. M., Caetano, J.</p>	<p>To build and validate an educational booklet to predict falls in the hospital.</p>	<p>After being built, the validation of the booklet was performed by nurses with expertise in</p>	<p>Methodological study developed from the construction , validation and evaluation</p>	<p>The booklet entitled "Care not to fall into this" consists of 20 pages. In the content validation, the professionals</p>	<p>Level 7: expert opinion for pamphlet research. However, the pamphlet was based on Level 5 (systematic review of literature)</p>	<p>Source size and to exchange of the type of paper used for printing. generalization of the results</p>	<p>This would support patient education via education pamphlet. However, there was nothing in the research that correlates to RN</p>

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<p>A., & Barros, L. M. (2019). Construction and validation of educational booklet content for fall prevention in hospitals. <i>Acta Paulista de Enfermagem</i>, 32(4), 1-6. doi:10.1590/1982-0194201900059</p>		<p>care in the hospital environment, patient safety or educational technologies. The sample size was defined from $n = Z_{\alpha/2} \cdot P \cdot (1 - P) / e^2$ formula. The stipulated values were Z_{α} (confidence level) = 95%, P (judges' agreement ratio) = 85%, and (accepted difference</p>	<p>of the booklet by 22 nurses and 22 patients hospitalized in a medical clinic. For the validation with judges, the objective, structure/presenting and relevancia of the material were evaluated and, in the evaluation with patients, the</p>	<p>attributed the global CVI of 1.0 to the objective, structure/presented and material relevancia. In the evaluation of patients, the overall CVI of the booklet was 0.98.</p>		<p>considering that the booklet addresses prevention of falls in the hospital context, which made it difficult to discuss the findings with studies with the same theme. Another limitation is that the material was assessed only by SUS (Brazilian Unified Health</p>	<p>education related to falls. Therefore, this would support supplemental evidence for fall education via written modality.</p>

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		<p>expected) = 15%, which resulted in 22 judges. (11)</p>	<p>Suitability Assessment of Materials (SAM) instrument was applied. The Content Validity Index (CVI) was used to analyze each stage of the validation, considering valid those equal to or greater than 0.80. Of the 33 items assessed by patients, 24 indicated 100%</p>			<p>System) users in the medical clinic sector, so that the results obtained may differ from the reality of patients assisted in the private healthcare network or hospitalized in other sectors.</p>	

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			<p>agreement (CVI equal to 1.0). Another seven had CVI of 0.95 and two CVI equal to 0.90. The booklet's overall CVI in the validation with patients was 0.98.</p>				
<p>Morris, M. E., Haines, T., Hill, A. M., Cameron, I. D., Jones, C., Jazayeri, D., . . . McPhail, S. M. (2021). Divesting from a</p>	<p>We investigated the impact of ceasing routine falls risk assessment tool (FRAT)</p>	<p>Adult inpatients admitted to participating hospitals (n = 10 hospitals, 123,176 bed days)</p>	<p>A parallel group cluster randomized controlled trial was used to compare the</p>	<p>Replacing a FRAT scoring system with clinical reasoning did not lead to inferior fall outcomes in</p>	<p>Level 2: Randomized Controlled Trial</p>	<p>It was confined to private hospitals in Australia. Although hospital-level randomization</p>	<p>This study did not address specific fall education, only how the fall risk was identified. Because this study did not see a positive or negative</p>

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<p>scored hospital fall risk assessment tool (FRAT): A cluster randomized non-inferiority trial. <i>Journal of the American Geriatrics Society</i>, 69(9), 2598-2604. doi:https://doi.org/10.1111/jgs.17125</p>	<p>completion and instead used clinical reasoning to select fall mitigation strategies.</p>		<p>effects on falls of (i) continuing to use a traditional FRAT, versus (ii) removing the risk scoring elements whilst maintaining a list of potential falls mitigation actions to support clinical decision-making</p>	<p>the short term and may even reduce fall incidence. Our findings concur with previous clinical trials reporting that assigning risk-of-fall ratings does not reduce the odds of falling or the rate of falls.</p>		<p>among hospitals from diverse geographical areas protected against the risk of between-group contamination , there was some risk of a chance finding due to between-group differences in hospital characteristics , including historical fall rates. We had initially</p>	<p>correlation with the FRAT tool and or the clinical reasoning fall risk mitigation strategies this study would not support the evidence change. However, if there was a positive relationship with the FRAT standardized tool then it would aid in supporting a standardized education tool. Furthermore, this study was related to patient fall risk education, not nursing; therefore, the education may</p>

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						<p>planned to complete hand searches for fall incident information for 20% of all medical records in the three-month period of the trial. This was reduced 10% to avoid unjustified use of resources on this time consuming task after it was observed that fall incident information</p>	<p>not be generalizable to nurses.</p>

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						<p>was widely consistent between these two sources at each site.</p>	
<p>Najafi, Z., Barghi, M., Kooshyar, H., Karimi-Mounaghi, H., & Rodi, M. (2017). A comparison of the effect of education through video versus demonstration on fear of falling in nursing home residents of Mashhad, Iran. <i>Iranian Journal of Nursing and Midwifery</i></p>	<p>Comparing the effect of education through video versus demonstration on fear of falling in nursing home residents</p>	<p>66 elderly residents, in 8 nursing homes.</p>	<p>-Quasi-experimental study -The participants were randomly divided into two groups of demonstration and video. Then, they received training. The participants' level of fear</p>	<p>Training elderly through video education showed a significant decrease in fear of falling for the elderly</p>	<p>Level 2: quasi experimental</p>	<p>-The limitation of this study was the difficulty of explaining some of the questions to the elderly. -Relatively small group of people</p>	<p>This would be supplemental evidence to support patient education via video. However, it may not be generalizable to nurses. However, it did show that video education for elderly population worked.</p>

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<p><i>Research</i>, 22(3), 195-200. doi:10.4103/1735-9066.208160</p>			<p>of falling was measured through Fall Efficacy Scale.</p>				
<p>Ojo, E. O., & Thiam, W. (2022). Effects of nurse-led fall prevention programs for older adults: A systematic review. <i>Pacific Rim International Journal of Nursing Research</i>, 26(3), 418-431. https://europepmc.org/article/MED/36051891</p>	<p>This systematic review aimed to gain insight into the effects of nurse-led fall prevention programs and identify gaps in knowledge relevant to nurse-led fall interventions for older adults.</p>	<p><u>Inclusion Criteria:</u> This review examined research studies relevant to older adults ≥ 65 years old living in the community or any</p>	<p>Systematic Review and Meta-Analysis (PRISMA</p>	<p>“Tailoring Interventions for Patient Safety” (TIPS) (3 hospitals, 1 study, 37,231 patients) and fall risks assessment education for nurses: (1 hospital, 1 study, 581 patients) resulted in reduced falls. Fall prevention videos and</p>	<p>Level 1: Systematic Review</p>	<p>generalizability limitations related to participants having a higher level of education than the general population, a small sample size (n = 30) coupled with a short period of one month of follow-up, financial limitations</p>	<p>This systematic review would be good to use to support nurse driven falls education. However, the patient population would not be generalizable to the surgical oncology patient mix, so there would need to be further research on this. The review also supported nurses educating patients, but did not</p>

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		<p>facility. The study types were any quantitative study on nurse-led fall interventions. They identified nurses as main or part of a fall prevention program provider using research</p>		<p>poster boards with promotion of measures that support independence including fall risk assessment with Morse Fall Scale (1 facility, 46, residents, 1 study) reduced fall rates. Nurses provided fall prevention education that focused on identifying fall risks, medication safety, or performance of an exercise.</p>		<p>and a drop rate in the IG doubled that of CG. The studies included in the literature review used different fall prevention program modalities that made the study outcomes very challenging synthesis. Some relevant articles may have been missed regarding literature</p>	<p>speak to the education and training that the nurses had on the education they would provide the patient.</p>

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		<p>methodologies including, but not limited to, randomized control trial (RCT), non-RCT, and quasi-experimental design.</p> <p><u>Exclusion Criteria:</u> Articles published in non-English</p>		<p>Nurses conducted and reinforced physical exercise programs. Fall incidence, fall rates, and the rate of post-falls-related complications reduced to 45% (n = 5) of the intervention group in the studies.</p>		<p>search by limiting the search to only five databases. Articles published in languages other than English were excluded from the review, which might have eliminated some crucial studies that met all other criteria except language. Eleven studies were selected from eight different</p>	

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		<p>languages, non-peer-reviewed, and qualitative articles were excluded from the study. We also excluded fall interventions led by other healthcare professionals . Conference proceedings,</p>				<p>countries. This review may have missed some nurse-led fall prevention programs outside the eleven studies selected for review from other countries of the world.</p>	

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		<p>abstracts, dissertations, book chapters, editorials, and opinion pieces were excluded from this review.</p>					
<p>Ryan, S., Ward, M., Vaughan, D., Murray, B., Moore, Z., O'Connor, T., . . . Patton, D. (2018). Do safety briefings improve patient</p>	<p>The aim of the review was to answer the research question: ‘Do safety briefings improve</p>	<p>All studies that evaluated the use of safety briefings in the acute hospital context and demonstrated</p>	<p>his systematic review employed methods informed by Cochrane guidance on conducting</p>	<p>The outcomes of the quantitative and qualitative evidence, there were notable points of contextual integration.</p>	<p>Level 1: systematic review</p>	<p>The SR was tailored to meet the needs of the hospital setting, therefore, this would not be generalizable</p>	<p>This article would support using safety briefings (rounds) to increase patient safety. Outcomes included improved risk identification, reduced falls, enhanced</p>

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<p>safety in the acute hospital setting? A systematic review. <i>Journal of Advanced Nursing</i>, 75(10), 2085-2098. doi:10.1111/jan.13984</p>	<p>patient safety in the acute hospital setting?.</p>	<p>results associated with patient safety, were included. Studies completed outside the acute hospital setting were excluded. Studies that involved the use of safety briefings but were combined with additional interventions, therefore posing difficulty in</p>	<p>reviews (Cochrane – EPPI-Centre, 2018) and was conducted as per PRISMA guidelines (Moher, Liberati, Tetzlaff, & Altman, 2009) for quantitative studies and ENTREQ guidelines for qualitative studies (Tong, Flemming,</p>	<p>The quantitative studies demonstrated how the processes of briefings led to the identification and resolution of risk, whereas the qualitative studies revealed how the structures and interactions that occurred in briefings developed a culture of safety. Outcomes</p>		<p>for a non-acute care setting. This risk of bias is somewhat mitigated through the systematic review process as it can give multi-site perspectives. When outcomes are generated from a range of settings, populations, and circumstances, systematic reviews can give robust</p>	<p>relationships, increased incident reporting, ability to voice concerns, and reduced length of stay. However, it did not correlate RN education related to falls. Therefore, would not be implicated of RN fall education. Lastly, this study is generalizable to hospitals using briefings (rounds).</p>

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		determining causative factors, were also excluded. The scope of the review also excluded the operating theatre setting as three systematic reviews on this topic have previously been conducted.	McInnes, Oliver, & Craig, 2012). A mixed method multi-level synthesis was conducted using the framework described by Thomas et al. (2004).	included improved risk identification, reduced falls, enhanced relationships, increased incident reporting, ability to voice concerns, and reduced length of stay.		and generalizable evidence. The range of studies that included general wards and whole hospital studies (86%) supports the probability that the evidence is generalizable. A lack of negative findings could be further indicative of publication bias.	
Sarkies, M. N., Maloney, S.,	This study aimed to apply	Registered nurses and	Three study groups	Providing video	Level 2: Controlled, 3-group helix	Changes in knowledge do	This study would help support the

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<p>Symmons, M., & Haines, T. P. (2019). Video strategies improved health professional knowledge across different contexts: A helix counterbalanced randomized controlled study. <i>Epidemiology</i>, <i>112</i>, 1-11. doi:10.1016/j.jcli.nepi.2019.04.003</p>	<p>a novel helix counterbalanced randomized controlled trial design to evaluate the effectiveness of video vs. written knowledge translation strategies for improving health professional knowledge of evidence provided in scientific journal articles.</p>	<p>enrolled nurses from all inpatient wards, as well as allied health professionals (physiotherapy, occupational therapy, speech pathology, dietetics, social work, psychology, podiatry, and exercise physiology) and allied health assistants at the study hospitals</p>	<p>examining the success of video and written research evidence summaries, compared with usual care control conditions were evaluated. These knowledge translation strategies aimed to align knowledge with the current research evidence for</p>	<p>knowledge translation strategies to nursing and allied health professionals increases the likelihood they will understand the main findings from scientific journal articles. Use of video abstracts may be a useful adjunct to publishing research in dissemination activities.</p>	<p>counterbalanced randomized random controlled trial</p>	<p>not necessarily lead to behavior and health outcome changes; therefore, assumptions regarding flow-on effects from improved knowledge to practice change are avoided. The majority of participants completed the study survey in sufficient time to have watched the</p>	<p>evidence that video education is better than written education and/or verbal education. However, because this study only involved healthcare professional and not patients, it is unknown if the results would be generalizable to a patient population.</p>

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		<p>were all eligible to participate in the study. Nursing staff working in aged care, outpatient, or community services, and assistant in nursing (AIN) staff working in any setting were excluded as they were not considered to be primary clinical decision-makers or delegated</p>	<p>three health contexts: (1) promoting physical activity as an adjunct to anticoagulant treatment after diagnosis of DVT, (2) written falls prevention patient education materials only without follow-up from a health professional, and (3) bedside</p>			<p>video and read the written journal article. However, out of 119 participants, 19 completed the survey in less than 3 minutes. The online survey software did not enable control of time to completion to encourage engagement with the interventions. Engagement rates reported in this trial are</p>	

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		<p>providers of interventions for the health contexts of interest in this study.</p>	<p>pressure sensor alarms to prevent falls. The knowledge translation strategies were delivered, and data were collected via an online survey.</p>			<p>similar to those reported in other implementation studies where up to 30% of participants may not engage fully with provided strategies, given these strategies must overcome considerable barriers to research implementation</p>	
<p>Shaw, L. K., Kiegaldie, D., Jones, C., &</p>	<p>Health professional education has</p>	<p>hospitals, clinical</p>	<p>At each of the hospitals,</p>	<p>The education workshop significantly</p>	<p>Level 2: quasi experimental and then post follow up</p>	<p>The study relied on self-reporting, and</p>	<p>This article would be a good supplement in</p>

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<p>Morris, M. E. (2021). Improving hospital falls screening and mitigation using a health professional education framework. <i>Nurse Education Today</i>, 98, 1-8. https://doi.org/10.1016/j.nedt.2020.104695</p>	<p>the potential to mitigate hospital falls risk, the best methods to develop, deliver and evaluate health professional education remain unclear. This study applied evidence-based approaches to education design to improve falls risk mitigation</p>	<p>leaders (n = 46)</p>	<p>clinical leaders (n = 46) received a three-hour education program. The education program on the latest evidence in hospital falls risk assessment and how to implement evidence-based falls screening and management. This was based on the</p>	<p>changed participants' views about best practice guidelines for falls screening and prevention. Participants felt more confident in assessing falls risk and judging and implementing the best mitigation strategies. They were prepared and motivated to educate others about falls prevention and satisfied with</p>	<p>telephone interview (quantitative descriptive)</p>	<p>did not directly observe health professionals' behaviors in hospital settings. The time gap from delivery of the education to the focus group and semi-structured phone interviews also resulted in some attendees having changed jobs since the</p>	<p>supporting a higher level of evidence study. Because this project was quantitative and qualitative, it would help support the education. Also the nursing population was not described, as well as the hospital, therefore it is unknown if this study would be generalizable.</p>

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			<p>“4P” education model (Presage, Planning, Process and Product). They were taught practical skills to enable them to educate other health professionals. Quantitative data were collected via three surveys: Survey 1 (S1:</p>	<p>the skills gained. Nevertheless, value was found in conducting robust program evaluations of recipients of education using both qualitative and quantitative measures. Patient education was beyond the scope of this study, even though it has been shown to reduce falls.</p>		<p>education was delivered.</p>	

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			<p>Immediately prior to the education program), Survey 2 (S2: Immediately post the education program), Survey 3 (S3: Six months post implementation of the new screening tool). Survey 3 was an online survey developed in Qualtrics.</p>				

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			<p>Qualitative data were collected via semi-structured telephone in-Interviews and a focus group interview post-implementation. Telephone interviews and the focus group were audio-recorded and transcribed to</p>				

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			<p>ensure clarity and accuracy. By using interactive teaching methodologies, such as the ones employed in this study, they may be more likely to think critically, employ clinical reasoning into their daily clinical practice and educate</p>				

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			<p>others to achieve this goal</p>				
<p>Shaw, L., Kiegaldie, D., & Morris, M. E. (2021). Educating health professionals to implement evidence-based falls screening in hospitals. <i>Nurse Education Today</i>, 101. 1-8. doi:10.1016/j.nedt.2021.104874</p>	<p>The aim of this study was to design, deliver and evaluate an interprofessional education program for healthcare professionals on how to implement a modified version of the safe recovery program to prevent falls in hospitalized patients.</p>	<p>The study took place on the medical wards of an Australian private acute hospital. All allied health professionals and nurses working on the intervention ward were eligible and invited to participate via email. On the day of the IPE intervention,</p>	<p>Thirty-four health professional participants attended a 1-h face-to-face or Zoom® interprofessional education session to learn how to deliver an evidence-based patient falls prevention education strategy, the modified</p>	<p>A 1-hour education session was insufficient to build full confidence to deliver the Safe Recovery Program. There was no statistically significant change in participant views on interprofessional collaboration. Participants recommended prior</p>	<p>Level 2: Quasi-Experimental</p>	<p>This program was not tested on patients, only on healthcare professionals.</p>	<p>Yes, this would support research of educating healthcare professionals. However, this was not correlated to the results of patient falls. Therefore, this should only be in support of educating healthcare professionals.</p>

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		<p>consenting participants completed a PICF, pre-test and post-test surveys.</p>	<p>Safe Recovery Program.</p>	<p>consultation and preparation before delivery of IPE, with additional opportunities for discussion and feedback during implementation with patients. The findings highlight the importance of interprofessional education for evidence-based interventions in hospitals. Health professionals value</p>			

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				<p>education that is timely, interactive, realistic and engaging.</p>			
<p>Shaw, L., Kiegaldie, D., Heng, H., & Morris, M. E. (2023). Interprofessional education to implement patient falls education in hospitals: Lessons learned. <i>Nursing Open</i>, 10(1), 36-47. doi:10.1002/nop.2.1276</p>	<p>The aim of this study was to design, deliver and evaluate an interprofessional education program for healthcare professionals on how to implement a modified version of the safe recovery program (SRP) to prevent falls in hospitalized patients.</p>	<p>medical wards of an Australian private acute hospital. All allied health professionals and nurses working on the intervention ward were eligible and invited to participate via email. On the day of the IPE intervention,</p>	<p>The study employed a mixed methods pre- and post questionnaire design followed by semi-structured telephone interviews, to triangulate the data from different approaches.</p>	<p>A 1-hour education session was insufficient to build full confidence to deliver the Safe Recovery Program. There was no statistically significant change in participant views on interprofessional collaboration. Participants</p>	<p>Level 5: Qualitative study mixed with quantitative descriptive</p>	<p>a single education session is not enough for lasting changes in health professional knowledge and patient falls prevention behaviors. The implementation sciences literature, coupled with these findings,</p>	<p>This would be a good supplemental evidence to support RN education on falls. However, there was not enough statistical significance to base RN education model directly using this research. Also, there was a low n therefore, more participants would likely be needed to apply significance.</p>

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		<p>consenting participants completed a PICF, pre-test and post-test surveys. Thirty-four health professionals .</p>	<p>Sequential exploratory design was used with the interview data building on the survey results. Participants received a 1-h IPE program, which was the most time available for busy clinicians to attend. The program educated participants</p>	<p>recommended prior consultation and preparation before delivery of IPE, with additional opportunities for discussion and feedback during implementation with patients. The findings highlight the importance of interprofessional education for evidence-based interventions in hospitals. Health</p>		<p>reinforce the need for co-production of falls education, involving the patient and interprofessional team. Developing and evaluating health professional education programs using the 4P model of education design, ensures all elements of the teaching context,</p>	

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			<p>on the latest evidence on patient education for falls prevention, how to implement the modified SRP and how to achieve effective interprofessional collaborative practice. A mixture of interactive teaching methods was used including small group</p>	<p>professionals value education that is timely, interactive, realistic and engaging</p>		<p>student approaches to learning and the outcomes of learning are considered. Low number of participants (n number).</p>	

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			<p>discussion on participants' current falls prevention education to patients, a small group critical thinking activity on the barriers and facilitators to delivering falls prevention education to patients, and content delivery on the latest evidence on patient</p>				

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			<p>education and its role in falls prevention in hospitals. Three pre-recorded vignettes using simulated participants demonstrated delivery of the modified SRP. Laminated scripts of the modified SRP were provided for participants to use during the</p>				

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			education intervention and instructions for implementation. Multiple copies were also available on the hospital ward throughout implementation of the intervention. The PowerPoint presentation of the education was made available for				

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			<p>those staff unable to attend training and to supplement learning for staff who attended.</p>				
<p>Shepard, D., Clarke, E., Hemming, K., Martin, J., & Lilford, R. (2021). An opportunistic evaluation of a routine service improvement project to reduce falls in hospital. <i>BMC Health Service Research</i>,</p>	<p>To describe the intervention designed to implement the RCP and NICE guidelines. b) To evaluate the intervention by analyzing routinely collected falls data by means of a step-wedge design. Implementatio</p>	<p>36 wards in a hospital in University Hospitals Coventry and Warwickshire NHS Trust. It was part of the main hospital site, which has 1100 beds</p>	<p>This implementation and evaluation covered all 36 wards in the hospital. The study was set up in such a way as to include 19 of the 36 wards in a step-wedge</p>	<p>There was an average of 6.62 falls per 1000 OBDs recorded during the control period. This decreased during the post-intervention period, to an average of 5.89 per 1000 OBDs.</p>	<p>Level 2: :RCT</p>	<p>This is a study with no contemporaneous, let alone randomized, controls. Also, because the research was rolled out fast there was no way to have a controlled group for the baseline.</p>	<p>This is a good article to use to support the TIDieR check list for fall intervention. However, this did not talk about the education process to educate RNs on fall interventions, it focused on outcome measures. This study was implemented in a hospital (36 wards),</p>

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<p>21(79), 1-11. https://doi.org/10.1186/s12913-021-06073-4</p>	<p>n of the TIDieR checklist to see if it reduced falls.</p>		<p>cluster RCT. The remaining 17 wards were deemed unsuitable for randomization. All occupied bed days and all falls between June 2015 and April 2018 contributed to the study. The intervention was rolled out between May 2017</p>				<p>however, the wards did not describe the patient population it serves making it limited for generalizability.</p>

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			<p>and August 2017. The randomized rollout of the intervention occurred in June and July 2017.</p>				
<p>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. <i>Journal of Nursing Care Quality, 34</i>(2),</p>	<p>Three primary goals were established: (1) reduce the overall fall rate (number of falls/1000 patient days), (2) eliminate all falls with injury through an evidence-based fall prevention protocol, and</p>	<p>he CPG chosen was the Institute for Clinical Systems Improvement Health Care Protocol on Prevention of Falls in Acute Care Institutions. This CPG was chosen because it</p>	<p>an interprofessional fall reduction team was commissioned by the chief nursing officer to evaluate the hospital's current fall prevention program.</p>	<p>An interprofessional team successfully reduced falls with an evidence-based fall prevention program. The fall rate decreased to 1.14, with a 72% expense reduction based on</p>	<p>Level 1: CPG (informed by systematic review)</p>	<p>Only generalizable to the med/surg patient population. The remote visual monitoring (cameras watching fall risk patients) were added later in the study.</p>	<p>This study would be generalizable to the med/surg acute care patients. This would also support implementation because it was Level 1 evidence, a CPG based on a systematic review, and then additional evidence-based guidelines added to the CPG that were not addressed. The</p>

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<p>127-132. doi:10.1097/NCQ.0000000000000344</p>	<p>(3) increase the percentage of patients who receive appropriate fall risk assessment and individualized fall prevention interventions. The PICO question was: In adult hospitalized medical-surgical patients, does an evidence-based fall prevention program that includes comprehensive assessment and</p>	<p>focused on an adult acute care setting and was appraised as high quality.⁶ The CPG identified 7 key practices for effective fall prevention:</p> <ol style="list-style-type: none"> 1. Organizational support for a fall prevention program 2. A process for 	<p>The evidence-based practice improvement (EBPI) model developed by Levin and colleagues⁴ was used as our method of using evidence-based practice (EBP) to improve patient care. Through small tests of change (STC) using</p>	<p>decreased sitter usage. With full implementation of the fall prevention program and the addition of video monitoring, we had a 54% reduction in falls from 2.51 falls per 1000 patient days for the fiscal year 2014 to 1.15 falls per 1000 patient days for the last half of 2016 and first half of 2017 on the inpatient medical-</p>		<p>However, the falls data calculation was completed before and after the camera monitoring and there was still a decrease pre-implementation of the camera monitoring.</p>	<p>education was for the RNs and interdisciplinary team as well as the patients (RNs educated patients once they were educated).</p>

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	<p>individualized interventions based on patient-specific risks decrease the fall rate?</p>	<p>evaluation of the hospitalized patient on admission for risk of falling</p> <ol style="list-style-type: none"> 3. Risk assessments to identify risk factors 4. Communication of risk factors 5. Risk factor interventions 6. Observation and 	<p>Plan, Do, Study, Act cycles,⁵ we evaluated each aspect of a proposed improvement before a large pilot or organization-wide implementation.</p>	<p>surgical units. In addition, a 72% reduction in sitter usage equating to \$84 000 in annual savings was noted (this would be higher in a larger hospital and in a hospital that did not have an existing geriatric cluster).</p>			

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		<p>surveillance 7. Auditing, continuous learning, and improvement</p>					
<p>Turner, K., Staggs, V., Potter, C., Cramer, E., Shorr, R., & Mion, L. C. (2020). Fall prevention implementation strategies in use at 60 United States hospitals: A descriptive</p>	<p>To identify and describe the prevalence of specific hospital fall prevention implementation strategies.</p>	<p>US hospitals participating in the National Database of Nursing Quality Indicators (NDNQI) were selected for participation in this study.</p>	<p>A cross-sectional study design to identify and describe the prevalence of in-hospital, organizational-level fall prevention implementat</p>	<p>Hospitals were more likely to use leadership strategies, such as updating fall policies in the past 3 years (98%) but less likely to reward staff (40%). Hospitals commonly</p>	<p>Level 4: Cross-sectional descriptive study</p>	<p>small number (n=60) of hospitals participating in NDNQI, and the characteristics of the study sample differed from AHA hospitals, a nationally</p>	<p>This study included hospitals with low fall rates. While it did have some survey respondents state that they did RN fall education, it did not list the education that they received. It also showed that pt education, fall protocols, fall</p>

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<p>study. <i>BMJ Quality & Safety</i>, 29(12), 1000-1007. doi:10.1136/bmjqs-2019-010642</p>		<p>Eligibility included non-federal hospitals that submitted patient falls data for Q1 or Q2 2017. Press Ganey, the organization that owns the NDNQI, sent out 800 study invitations to hospitals meeting the above criteria with a goal of recruiting 80 sites. Within 24 hours, 189 hospitals</p>	<p>ion strategies in 2017 was used. The unit of analysis was the hospital. We adhered to the Strengthening the Reporting of Observational Studies in Epidemiology checklist for cross-sectional studies to report the study findings</p>	<p>used interdisciplinary falls committees (83%) but membership rarely included physicians. Hospitals lacked access to electronic health record tools, such as high-risk medication warnings (27%). Education strategies were commonly used; 100% of hospitals provided fall education at</p>		<p>representative sample. the comprehensiveness of data collection might vary across hospitals given that one individual at the hospital was tasked with collecting data from multiple sources. To minimize this risk, we relied on the NDNQI site coordinator in each hospital to assist with</p>	<p>videos, fall assessments, fall flags, etc. Therefore, this is a good study to support RN education related to falls, but not the education that was provided.</p>

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		<p>expressed interest in participating. We used this convenience sample of 1S89 volunteers to randomly select 80 hospitals to participate via stratified random sampling. We sampled to include 20 hospitals in four strata based on teaching status (yes/no) and hospital size</p>		<p>staff orientation, but only 22% educated all employees (not just nursing staff).</p>		<p>data collection. This study collected data at the hospital level and did not allow for comparisons of fall prevention implementation across units within the same hospital. Survey also did not capture risk factors for falls, such as environmental factors or hospital practices</p>	

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		<p>(<200 beds and ≥200 beds)</p>				<p>regarding bed moves. It is also unclear whether the low quality of evidence for many fall prevention interventions¹⁻¹⁴ partially explains hospital variation in fall prevention strategies.</p>	
<p>Twibell, K. R., Siela, D., Delaney, L., Avila, P., Spradlin, A., & Coers, G. (2020, July). Perspectives of</p>	<p>To understand patient’s perspectives and level of engagement related to fall prevention plans, and to</p>	<p>30 cancer patients at Indiana University Health Ball Memorial Hospital. Inclusion</p>	<p>Sample was stratified into two categories: those who had fallen or had a near-fall between</p>	<p>Primary cause of inpatient falls is no patient engagement in fall prevention plan. The other six themes</p>	<p>Level 6: Descriptive exploratory qualitative study</p>	<p>Single hospital setting that was interviewed, limited diversity of ethnicity, only</p>	<p>This study would be generalizable to the inpatient oncology patient population. This study would also supplement a descriptive aspect</p>

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<p>inpatient with cancer on engagement in fall prevention. <i>Oncology Nursing Forum</i>, 47(4), 457-468. doi:10.1188/20.ONF.457-468</p>	<p>discover new knowledge about their perspective and to improve the design of fall education. The secondary purpose was to compare perspectives of patients who have and have not fallen.</p>	<p>criteria was: inpatient on non-critical care unit; diagnosis of cancer for the present hospital encounter; ability to speak, read, and understand English; not pregnant; ability to hear adequately; medically stable; at risk for falls as scored by the fall risk assessment</p>	<p>time of hospitalization on admission and study enrollment, and those who had not fallen between time of hospitalization on admission and study enrollment. No theoretical framework was used. Qualitative descriptive exploratory approach</p>	<p>emerged: need to get out of bed, not wanting to call for help, mobilization and being able to “hold onto” things for stabilization, no education related to increased fall risk because of cancer diagnosis, not liking to wait (causing anger, shame and frustration), and the relationship with the nurse (not</p>		<p>inpatient patients, and only patients interviewed over 57 years of age.</p>	<p>of the project making sure that nurses educate the patient on the reasons why they are on a fall prevention plan.</p>

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		<p>tool; cognitively alert and oriented; not receiving hospice or end-of-life care. Exclusion criteria was: medical diagnosis of dementia, delirium, or confusion; medically unstable; or enrolled in another research study or trial.</p>	<p>was used. Interview questions were given via an interview guide at the patient’s bedside. The interviews lasted between 7 to 20 minutes. Interviews were audio recorded and transcribed by interviewer. Demographic and</p>	<p>understanding need for privacy, and being treated “child-like,” and being embarrassed). The results concluded that the nurse needs to increase therapeutic communication , focus on the nurse-patient relationship, educate the patient on the fall plan, implement scheduled toileting, and try education</p>			

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			<p>clinical data were gathered from the patient's electronic health record. The interviews stopped when the interviewers reached data saturation.</p>	<p>via video education.</p>			
<p>Wang, S.-C., Lee, D.-C., Lee, Y.-H., Chang, Y.-P., & Chu, I.-L. (2021). Effects of multimedia-based fall prevention education on the</p>	<p>The effects of a multimedia-based patient education intervention on knowledge, attitudes, and behaviors regarding fall</p>	<p>-140 participants -Seventy participants in the experimental group received multimedia-based patient</p>	<p>Quasi-experimenta l</p>	<p>-The results indicate that attitudes, knowledge, and behaviors regarding fall prevention among patients in the group who received</p>	<p>Level 2: randomized control trial</p>	<p>-The results of this study indicated that most internal medicine inpatients did not read health education leaflets. It is</p>	<p>This study showed that multimedia-based education decreased falls. Their data was also statistically significant. This showed that video education was beneficial for</p>

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<p>knowledge, attitudes, or behaviors of patients. <i>Japan Journal of Nursing Science</i>, 19(2), 1-11. doi: 10.1111/jjns.12455</p>	<p>prevention were observed.</p>	<p>education and a health education leaflet, while those in the control group received only the health education leaflet. A structured questionnaire was used for data collection at baseline, and a posttest was applied after the intervention</p>		<p>the multimedia-based patient education, and a health education leaflet were higher than those among patients who only received the health education leaflet; the differences were statistically significant. -Multimedia-based patient education influenced inpatients' knowledge,</p>		<p>possible that patients experienced discomfort after admission that may have effected their ability to read. In addition, the content of the health education leaflets was primarily text, which may have been difficult to read and led to an overload of health education information for internal</p>	<p>patients, however, it did not analyze the effects of video education on nurses. Therefore, this would only be supplemental evidence.</p>

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				<p>attitudes, and behaviors for preventing falls</p>		<p>medicine inpatients. -Patients' knowledge and behaviors regarding fall prevention differed among clinical departments (one cohort was from a pulmonology clinic while the other cohort was from a gastroenterology clinic). -This also influenced the patient's risk to fall (with</p>	

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						<p>the gastroenterology patients being more likely to fall than those in the pulmonary clinic).</p>	
<p>Wisler, H., Prado, G., & Cohn, T. (2021). Reducing unwitnessed falls on a medical-surgical unit. <i>Medsurg Nursing</i>, 35, 1-10. doi: 10.37689/actape/2022AO01372.</p>	<p>Due to this high-risk population, unpredictability of falls, and the medical-surgical unit not consistently meeting the national benchmark of zero falls, this performance improvement project was</p>	<p>medical surgical patients over age 18 who were at risk for falls based on criteria on the fall safety contract. Patients included spoke English or Spanish. Patients</p>	<p>Under the Plan-Do-Study-Act (PDSA) model, the Plan involved creating a contract between patients and staff to reduce the number of unwitnessed falls</p>	<p>This project showed implementing a fall safety contract along with fall prevention education is a viable strategy to reduce the number of falls occurring on a medical-surgical unit. Decreased</p>	<p>Level 5: Quality Project</p>	<p>If the patient did not have a signed contract they were not included in the study. RNs were also not consistent, and there was supplemental staff from the float pool. Staffing limitations with high</p>	<p>This would be good supplemental evidence for decreasing unwitnessed falls related to implementation of a fall patient contract. There were not enough details about the RN education related to falls for this to substantiate a change. Also, RN education related to</p>

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	<p>initiated. The project unit averaged 2.08 falls per 1,000 patient days before implementing the fall safety contract, slightly more than half the national average but substantially greater than zero falls per 1,000 patient days.</p>	<p>considered at risk for falls were admitted for surgery, had a seizure history, had a recent fall, were connected to hospital equipment, or took medications in defined categories (blood pressure management, sleep aids, anti-seizure, muscle relaxants, analgesics,</p>	<p>occurring in the inpatient setting by 50%. One of the authors who worked on this unit developed the contract, which then was approved by the nurse manager. The contract was based in part on the Johns Hopkins Fall Risk Assessment Tool (Johns Hopkins Medicine,</p>	<p>unwitnessed falls by 50%.</p>		<p>RN:pt ratio (1:7), high CNA:pt ration (1:20). Education and contract adherence also required patients to be alert and oriented to their specific situation. For example, the contract is not a relevant tool to prevent falls if patients cannot remember they are at risk for falls. Only 96</p>	<p>the project was only at shift huddles.</p>

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		<p>diuretics, respiratory treatments, treatment of allergies, laxatives).</p>	<p>2007). The tool included chemical risks for falls (e.g., certain classes of medications) and physical risks for falls (e.g., being tethered to an IV pole or SCDs). Most patients demonstrated physical risks because it was unlikely</p>			<p>contracts were collected August-October, suggesting about one admission or transfer to the unit daily. However, this number is unrealistic; the target number should have been closer to 300 over 3 months. The unit typically sees three to five admissions daily. Unfortunately</p>	

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			<p>they would be hospitalized without IV fluids or SCDs. The contract thus was written intentionally to capture almost all patients admitted. The agreement was translated into Spanish and verified by two hospital-certified Spanish</p>			<p>, no admission/transfer metric could be collected at the time of the project.</p>	

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			<p>interpreters. The contract was an important element in educating patients regarding their specific risk for falls because they often did not know why they were at risk for falls in the hospital when they may not have been at risk before admission.</p>				

<p>Article Title, Author, etc. (Current APA Format)</p>	<p>Study Purpose</p>	<p>Sample (Characteristics of the Sample: Demographics, etc.)</p>	<p>Methods</p>	<p>Study Results</p>	<p>Level of Evidence (Use Melnyk Framework)</p>	<p>Study Limitations</p>	<p>Would Use as Evidence to Support a Change? (Yes or No) Provide Rationale.</p>
			<p>Data were collected through hospital reports for 3 months before and after implementation, with a 1 month washout period while staff learned the new fall prevention education and fall safety contract process. Staff education regarding</p>				

<p>Article Title, Author, etc. (Current APA Format)</p>	<p>Study Purpose</p>	<p>Sample (Characteristics of the Sample: Demographics, etc.)</p>	<p>Methods</p>	<p>Study Results</p>	<p>Level of Evidence (Use Melnyk Framework)</p>	<p>Study Limitations</p>	<p>Would Use as Evidence to Support a Change? (Yes or No) Provide Rationale.</p>
			<p>the project was done daily in the morning huddle during the washout period. Reinforcement of the program then was done in the shift change huddle when patients had been admitted overnight or throughout the day. Specifically, only the</p>				

<p>Article Title, Author, etc. (Current APA Format)</p>	<p>Study Purpose</p>	<p>Sample (Characteristics of the Sample: Demographics, etc.)</p>	<p>Methods</p>	<p>Study Results</p>	<p>Level of Evidence (Use Melnyk Framework)</p>	<p>Study Limitations</p>	<p>Would Use as Evidence to Support a Change? (Yes or No) Provide Rationale.</p>
			<p>number of unwitnessed falls was recorded. Post-implementation data included documentation of patients' receipt of the evidence-based Call, Don't Fall safety contract and fall prevention education.</p>				
<p>Yang, X., Xue, X., Shi, Z., Nan, S., Lian, C., Ji,</p>	<p>Fall prevention videos are available on</p>	<p>137 YouTube videos</p>	<p>The top 300 watched videos on</p>	<p>The DISCERN instrument indicated that</p>	<p>Level 4: narrative review and expert opinion</p>	<p>All videos reviewed were in</p>	<p>This study would be a great supplement to the</p>

<p>Article Title, Author, etc. (Current APA Format)</p>	<p>Study Purpose</p>	<p>Sample (Characteristics of the Sample: Demographics, etc.)</p>	<p>Methods</p>	<p>Study Results</p>	<p>Level of Evidence (Use Melnyk Framework)</p>	<p>Study Limitations</p>	<p>Would Use as Evidence to Support a Change? (Yes or No) Provide Rationale.</p>
<p>Z., & Liu, X. (2022). The reliability, functional quality, understandability, and actionability of fall prevention content in YouTube: An observational study. <i>BMC Geriatrics</i>, 22(654). doi:10.1186/s12877-022-03330-x</p>	<p>YouTube, however, their reliability, functional quality, understandability, and actionability have not been verified. This study was to rate the videos reliability, quality, understandability, and actionability for use.</p>		<p>YouTube related to fall prevention were retrieved. After exclusion, all qualified sample videos were evaluated by three validated assessment instruments (the PEMAT scale, the HONCode scale, and the DISCERN instrument)</p>	<p>115 videos (83.94%) were of moderate to high overall quality. Medical practitioners and organizations gained the highest scores in functional quality and reliability ($P < 0.05$), while they also tended to use technical terms more often (mean = 3.15). The HONCode scale suggested a lack of traceability was common.</p>		<p>English, did not study the relationship between video comments and misleading information due to the limited time.</p>	<p>importance of health education videos. This study would also be important in making sure that the health education videos were reliable, had functional quality, understandability, and actionability. Therefore, I wouldn't use this study to base my support on, but it could be supplemental.</p>

<p>Article Title, Author, etc. (Current APA Format)</p>	<p>Study Purpose</p>	<p>Sample (Characteristics of the Sample: Demographics, etc.)</p>	<p>Methods</p>	<p>Study Results</p>	<p>Level of Evidence (Use Melnyk Framework)</p>	<p>Study Limitations</p>	<p>Would Use as Evidence to Support a Change? (Yes or No) Provide Rationale.</p>
			<p>regarding their reliability, functional quality, understandability, and actionability . Each video’s length, number of views/likes/comments, forms of expression, and the uploader’s profile were collected as well. The Wilcoxon rank sum test was</p>	<p>The most popular and actionable form of expression was workout ($n = 58$, median score = 86.90, $P < 0.05$), while monolog and keynote presentations scored the highest in understandability (no significant difference between them). The PEMAT scale suggested videos uploaded by</p>			

Article Title, Author, etc. (Current APA Format)	Study Purpose	Sample (Characteris- tics of the Sample: Demographi- cs, etc.)	Methods	Study Results	Level of Evidence (Use Melnyk Framework)	Study Limitations	Would Use as Evidence to Support a Change? (Yes or No) Provide Rationale.
			performed for further analysis from the perspective of expression forms and uploaders' identities.	medical teams were the easiest to be understood ($P = 0.011$ and $P < 0.001$, respectively), whereas they were less actionable than those made by fitness trainers ($P = 0.039$ and $P < 0.001$, respectively).			

Appendix B – IOWA Model Permission

[External] Permission to Use The Iowa Model Revised: Evidence-Based Practice to Promote Excellence in Health Care



Kimberly Jordan - University of Iowa Hospitals and Clinics <survey-bounce@survey.uiowa.edu>

To: Sloane, Danielle Nina



Tue 1/17/2023 7:55 PM

You don't often get email from survey-bounce@survey.uiowa.edu. [Learn why this is important](#)

[EXTERNAL EMAIL: Do not click any links or open attachments unless you know the sender and trust the content.]

You have permission, as requested today, to review and/or reproduce *The Iowa Model Revised: Evidence-Based Practice to Promote Excellence in Health Care*. Click the link below to open.

[Iowa Model - 2015.pdf](#)

Copyright is retained by University of Iowa Hospitals and Clinics. **Permission is not granted for placing on the internet.**

Reference: Iowa Model Collaborative. (2017). Iowa model of evidence-based practice: Revisions and validation. *Worldviews on Evidence-Based Nursing*, 14(3), 175-182. doi:10.1111/wvn.12223

In written material, please add the following statement:

Used/reprinted with permission from the University of Iowa Hospitals and Clinics, copyright 2015. For permission to use or reproduce, please contact the University of Iowa Hospitals and Clinics at 319-384-9098.

Please contact UJHCNursingResearchandEBP@uiowa.edu or 319-384-9098 with questions.

Appendix C – Participant Consent

Consent

Title of the Project: Impact of Fall Education to Nursing Staff on Oncology Patient Fall Rates
Principal Investigator: Danni Sloane, Doctoral Candidate, School of Nursing, Liberty University

Invitation to be Part of a Research Study

You are invited to participate in a research study. To participate, you must be at least 18 years or older; an RN, CNA1 or CNA2; work on the medical or surgical oncology unit. Taking part in this research project is voluntary.

Please take time to read this entire form and ask questions before deciding whether to take part in this research.

What is the study about and why is it being done?

The purpose of this study aims to evaluate the effects of fall education of RNs and CNAs on the medical and surgical oncology floor on oncology patient fall rates.

What will happen if you take part in this study?

If you agree to be in this study, I will ask you to do the following:

1. Take pre-test on fall prevention and demographic data, which will be multiple choice via paper and pencil or via Microsoft Forms link. This will take no more than 10 minutes to complete.
2. Participate in an in-person or virtual in-service that will take no more than 1 hour.
3. Take a post-test on fall prevention learnings that will be multiple choice via paper and pencil or via Microsoft Forms link. This will take no more than 10 minutes to complete.
4. Fill out the educational session evaluation. This will take no more than 5 minutes to complete.

How could you or others benefit from this study?

The direct benefits participants should expect to receive from taking part in this study include learning more about the organization's fall prevention policies and procedures, as well as new evidence-based fall prevention practices.

Benefits to society include decreasing the patient fall rate on the pilot study's units.

What risks might you experience from being in this study?

The expected risks from participating in this study are minimal, which means they are equal to the risks you would encounter in everyday life.

How will personal information be protected?

The records of this study will be kept private. Published reports will not include any information that will make it possible to identify a subject. Research records will be stored securely, and only the researcher will have access to the records.

- Participant responses will be kept confidential by replacing names with pseudonyms.
- Data collected from you may be used in future research studies and/or shared with other researchers. If data collected from you is reused or shared, any information that could identify you, if applicable, will be removed beforehand.
- Data will be stored on a password-locked computer in a locked office. After five years, all electronic records will be deleted, and all hardcopy records will be shredded.

How will you be compensated for being part of the study?

Participants will not be compensated for participating in this study. At the conclusion of the in-service, participants will be entered to win a \$20 Starbucks gift card. Any participant who chooses to withdraw from the study after beginning but before completing all study procedures will still be entered to win the gift card.

Is the researcher in a position of authority over participants, or does the researcher have a financial conflict of interest?

The researcher serves as a Director of Nursing at [REDACTED]. To limit potential or perceived conflicts, a research assistant will ensure that all data is stripped of identifiers before the researcher receives it. This disclosure is made so that you can decide if this relationship will affect your willingness to participate in this study. No action will be taken against an individual based on his or her decision to participate or not participate in this study.

Is study participation voluntary?

Participation in this study is voluntary. Your decision on whether to participate will not affect your current or future relations with Liberty University or [REDACTED]. If you decide to participate, you are free to not answer any question or withdraw at any time prior to submitting the survey without affecting those relationships.

What should you do if you decide to withdraw from the study?

If you choose to withdraw from the study, please inform the researcher that you wish to discontinue your participation and do not submit your study materials. Your responses will not be recorded or included in the study.

Whom do you contact if you have questions or concerns about the study?

The researcher conducting this study is Danni Sloane. You may ask any questions you have now. If you have questions later, **you are encouraged** to contact her at 503-869-9044 or [REDACTED]. You may also contact the researcher’s faculty sponsor, Dr. Rachel Joseph, at [REDACTED].

Whom do you contact if you have questions about your rights as a research participant?

If you have any questions or concerns regarding this study and would like to talk to someone other than the researcher, **you are encouraged** to contact the IRB. Our physical address is Institutional Review Board, 1971 University Blvd., Green Hall Ste. 2845, Lynchburg, VA, 24515; our phone number is 434-592-5530, and our email address is irb@liberty.edu.

Disclaimer: The Institutional Review Board (IRB) is tasked with ensuring that human subjects research will be conducted in an ethical manner as defined and required by federal regulations. The topics covered and viewpoints expressed or alluded to by student and faculty researchers are those of the researchers and do not necessarily reflect the official policies or positions of Liberty University.

Your Consent

By signing this document, you are agreeing to be in this study. Make sure you understand what the study is about before you sign. You will be given a copy of this document for your records. The researcher will keep a copy with the study records. If you have any questions about the study after you sign this document, you can contact the study team using the information provided above.

I have read and understood the above information. I have asked questions and have received answers. I consent to participate in the study.

Printed Subject Name

Signature & Date

Appendix D- Participants in Pre- and Post-test Demographic Data

(will put demographic data here once collected—copy of demographic questionnaire)



Employee Number: _____

Demographic Data

1. What is your age:
 - 18-25
 - 26-30
 - 31-40
 - 41-50
 - 51-60
 - >61

2. What gender are you?
 - Male
 - Female
 - Non-binary
 - Prefer not to answer

3. What is your job title?
 - Nurse Manager
 - Registered Nurse
 - CNA (1 or 2)

4. How many years of experience do you have in this role?
 - Less than 1 year
 - 1-2 years
 - 3-5 years
 - 6-10 years
 - 11-20 years
 - more than 20 years

5. How many years of experience do you have on the medical or surgical oncology unit?
 - Less than 1 year
 - 1-2 years
 - 3-5 years
 - 6-10 years
 - 11-20 years
 - more than 20 years

6. What is your primary language?
 - English
 - Spanish
 - Other: _____

7. How would you best describe yourself?
 - White or Caucasian
 - Hispanic
 - American Indian
 - Asian
 - Black or African American
 - Other: _____

8. Highest level of education completed?
 - No college
 - Some college
 - Associate degree
 - Bachelor’s degree
 - Master’s degree
 - Doctorate
 - Other: _____

Appendix E – Liberty University IRB Approval

Date: 4-30-2023

IRB #: IRB-FY22-23-1447
 Title: Impact of Fall Education to Nursing Staff on Oncology Patient Fall Rates
 Creation Date: 4-22-2023
 End Date:
 Status: **Approved**
 Principal Investigator: Danielle Sloane
 Review Board: Research Ethics Office
 Sponsor:

Study History

Submission Type	Initial	Review Type	Exempt	Decision	No Human Subjects Research
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Key Study Contacts

Member	Danielle Sloane	Role	Principal Investigator	Contact	[REDACTED]
Member	Danielle Sloane	Role	Primary Contact	Contact	[REDACTED]
Member	Rachel Joseph	Role	Co-Principal Investigator	Contact	[REDACTED]

Appendix F – Organization IRB Approval



CLINICAL INQUIRY PROJECT – NOT RESEARCH DETERMINATION

May 1, 2023

Dear Danielle Sloane:

On 5/1/2023, the Human Research Protection Program (HRPP) reviewed the following submission:


Title:	Impact of Fall Education to Nursing Staff on Oncology Patient Fall Rates
Project ID:	STUDY2023000304
Project Lead Name:	Danielle Sloane
Funding Source:	None

The HRPP determined that this project, as submitted, does not meet the definition of research as defined in the federal regulations, and does not require IRB review. This determination is based only upon the information submitted.

The project may proceed as described in the documents submitted for review and in line with requirements listed below and on the next page.

This determination does not exempt you from following hospital policies and procedures as they relate to conduct of this project.

As the project was deemed not to be research, any publication discussing the project may not refer to it as a research study, but rather refer to it as a Quality Improvement project, Evidence-Based Practice project, etc.

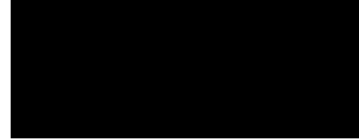
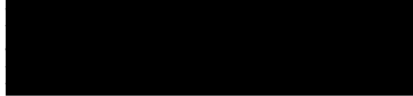
Should there be any questions, please contact the HRPP at: 

Appendix G– Organization Letter of Support



3/7/23

Jennifer McDonnell
Surgical Oncology Nurse Manager



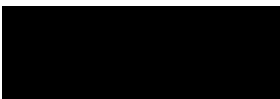
Dear Danni Sloane:

After careful review of your research proposal entitled, Impact of Fall Education to Nursing Staff on Patient Fall Rates, I have decided to grant you permission to: access our membership list and contact our staff and invite them to participate in your study, conduct your study, and receive and utilize patient falls data for your research study.

Check the following boxes, as applicable:

- I will provide our membership list to Danni Sloane, and Danni Sloane may use the list to contact our members to invite them to participate in her research study.
- I grant permission for Danni Sloane to contact Registered Nurses and Certified Nursing Assistants to invite them to participate in her research study.
- The requested data WILL NOT BE STRIPPED of identifying information before it is provided to the researcher.
- We are requesting a copy of the results upon study completion and/or publication.

Sincerely,



Jennifer McDonnell
Surgical Oncology Nurse Manger



Appendix H – CITI Training Certificate



Completion Date 27-Feb-2023
Expiration Date 27-Feb-2026
Record ID 54659506

This is to certify that:

Danielle Sloane

Has completed the following CITI Program course:

Biomedical Research - Basic/Refresher
(Curriculum Group)
Biomedical & Health Science Researchers
(Course Learner Group)
1 - Basic Course
(Stage)

Under requirements set by:

Liberty University

Not valid for renewal of
certification through CME.

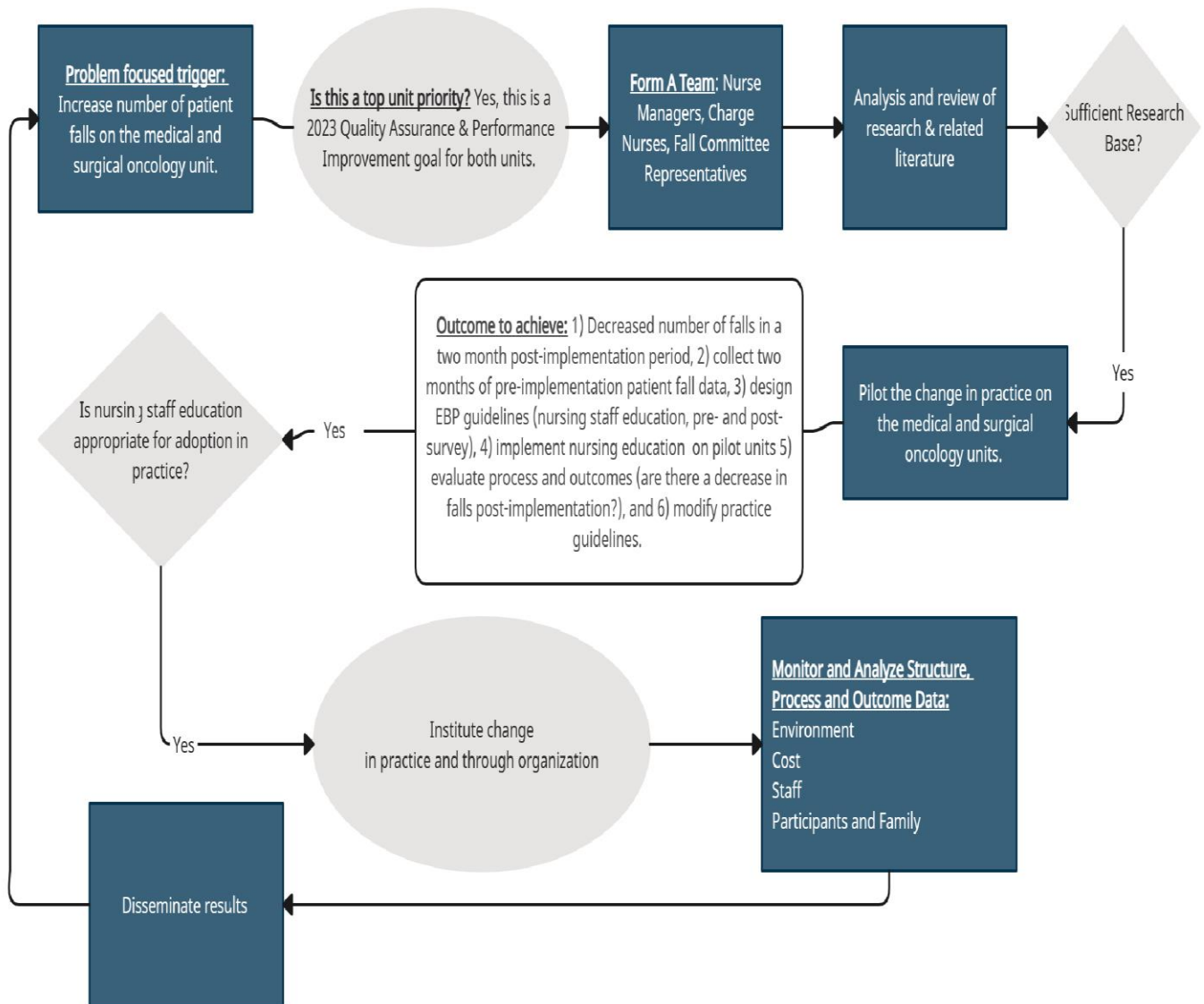


Collaborative Institutional Training Initiative

101 NE 3rd Avenue, Suite 320
Fort Lauderdale, FL 33301 US
www.citiprogram.org

Verify at www.citiprogram.org/verify/?wb341b73f-a7f2-41a3-b59f-fd827cfa7b25-54659506

Appendix J – IOWA Model Tool



Appendix K – Pre- and Post- Nursing Staff Test



Employee Number: _____

Pre-Test

1. Providence has a Fall Policy?
 - True
 - False

2. Providence has a Fall Clinical Practice Guideline (CPG)?
 - True
 - False

3. There is a fall protocol in Lippincott?
 - True
 - False

4. Fall education need to be documented every shift?
 - True
 - False

5. When a patient is first admitted, how long does the RN have to assess and document the patient’s fall risk from the time of admission?
 - Within the first hour
 - Within the first 4 hours
 - Within the first 12 hours
 - Within the first 24 hours

6. What are the fall risk and mobility tools that Providence uses? (check all that apply)
 - Quick Mobility Screen
 - Highest Level of Mobility Scale
 - MORSE Fall Risk Scale
 - Graf-Pif Fall Risk Scale
 - None of the above

7. When does the RN need to assess the patients fall risk scale? (select all that apply)
 - Upon assumption of care
 - With any new medication that may contribute to change in fall status
 - Once every 4 hours
 - Once every 12 hours
 - Once every 24 hours
 - After a procedure

8. When does the RN need to chart the fall prevention in the patient’s Plan of Care? (select all that apply)
 - On admission
 - Upon assumption of care
 - Once every 4 hours
 - Once every 12 hours
 - Once every 24 hours

9. Fall prevention care planning is an interdisciplinary process?
 - True
 - False

10. Having a cancer diagnosis increases your risk of falling?
 - True
 - False

11. Anesthesia may make patients have weaker gait than prior to surgery?
 - True
 - False

12. Purposeful/intentional rounding helps decrease patient falls in the hospital?
 - True
 - False

13. After a patient falls in the hospital, when do you need to complete a post-fall assessment?
 - You don’t need to
 - Immediately
 - Within the first hour of the fall
 - Within the first 4 hours of the fall
 - Before the end of your shift

14. After a patient falls in the hospital it is important that you fill out a fall debrief form before the end of you shift, but only if there was an injury to the patient?
 - True
 - False

15. After a patient falls in the hospital, per the policy, who do you need to communicate with? (select all that apply)

- The Nurse Manager or Manager on-call
- The hospital supervisor
- The attending LIP
- The patient's family or emergency contact
- The other team members on the unit working
- Document in the electronic health record

16. Some contributing factors that increase patient's fall risks are? (select all that apply)

- History of falls
- Age-related changes
- Fear of falling
- Impaired vision and hearing
- Medication side effects
- chemotherapy-induced peripheral Neuropathy
- Anesthesia
- Use of assistive devices
- None of the above

17. The primary cause of inpatient falls is decreased patient engagement in the fall prevention plan.

- True
- False

18. Patients who have developed a better rapport and trust with the nursing staff have decreased fall rates?

- True
- False

19. A scheduled toileting plan decreases the chance of a patient falling?

- True
- False

20. Having the patient participate in active range-of-motion exercises decreases the risk of falling because? (select all that apply)

- It improves their flexibility
- It improves their coordination
- It doesn't decrease the patient's fall risk
- It keeps their blood flowing to their lower extremities

21. These medications are associated with higher fall rates? (select all that apply)

- Diuretics ('water pills')
- Blood pressure medications
- Opioids (i.e., oxycodone, morphine, dilaudid, etc.)
- Anti-depressants
- Some chemotherapies
- Anesthesia

22. Patient falls affect reimbursement rates, increasing patients' length of stay, increasing undue patient harm, and increasing nursing staff's burnout?

- True
- False

23. A fall caused by a med side effect is?

- Unanticipated fall
- Anticipated fall

24. The Joint Commission issued a sentinel event alert about preventing falls and fall-related injuries in healthcare facilities because falls are a common safety problem in patients of any age or physical ability and can result in severe injury and death.

- True
- False

25. Hospital protocol is to start everyone with a bed alarm until they are proven not a fall risk.

- True
- False

26. Some chemotherapy medications cause peripheral neuropathy, increasing the patient's risk of falling.

- True
- False

27. What percentage of patients with a cancer diagnosis fall in the hospital?

- 10%
- 25%
- 50%
- 75%

28. Cancer patients more are 16-17% more risk for falling versus other patients?

- True
- False

29. It is important to teach patients fall risk education for their own home upon discharge?

- True
- False

30. Studies have shown that increasing staffs knowledge about falls help decrease patient fall rates?

- True
- False

31. If the patient has a history of falling it is important for you to? (select all that apply)

- Know what they were doing when they fell to better plan for fall interventions
- Predict a pattern of injury
- It is not important
- Let the Charge Nurse know

32. Fall precautions related to IV or IV access are? (select all that apply)

- Remove the line if no longer needed
- Have the patient use the IV pole
- Have the patient use a walker
- Utilize a toileting plan for patients with urinary urgency

33. One intervention that can help limit falls related to pain medications is offering toileting before administering pain medication.

- True
- False



Employee Number: _____

Post-Test

1. Providence has a Fall Policy?
 - True
 - False

2. Providence has a Fall Clinical Practice Guideline (CPG)?
 - True
 - False

3. There is a fall protocol in Lippincott?
 - True
 - False

4. Fall education need to be documented every shift?
 - True
 - False

5. When a patient is first admitted, how long does the RN have to assess and document the patient's fall risk from the time of admission?
 - Within the first hour
 - Within the first 4 hours
 - Within the first 12 hours
 - Within the first 24 hours

6. What are the fall risk and mobility tools that Providence uses? (check all that apply)
 - Quick Mobility Screen
 - Highest Level of Mobility Scale
 - MORSE Fall Risk Scale
 - Graf-Pif Fall Risk Scale
 - None of the above

7. When does the RN need to assess the patients fall risk scale? (select all that apply)
 - Upon assumption of care
 - With any new medication that may contribute to change in fall status
 - Once every 4 hours
 - Once every 12 hours
 - Once every 24 hours
 - After a procedure

8. When does the RN need to chart the fall prevention in the patient's Plan of Care? (select all that apply)
 - On admission
 - Upon assumption of care
 - Once every 4 hours
 - Once every 12 hours
 - Once every 24 hours

9. Fall prevention care planning is an interdisciplinary process?
 - True
 - False

10. Having a cancer diagnosis increases your risk of falling?
 - True
 - False

11. Anesthesia may make patients have weaker gait than prior to surgery?
 - True
 - False

12. Purposeful/intentional rounding helps decrease patient falls in the hospital?
 - True
 - False

13. After a patient falls in the hospital, when do you need to complete a post-fall assessment?
 - You don't need to
 - Immediately
 - Within the first hour of the fall
 - Within the first 4 hours of the fall
 - Before the end of your shift

14. After a patient falls in the hospital it is important that you fill out a fall debrief form before the end of you shift, but only if there was an injury to the patient?
 - True
 - False

15. After a patient falls in the hospital, per the policy, who do you need to communicate with? (select all that apply)

- The Nurse Manager or Manager on-call
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- Medication side effects
- chemotherapy-induced peripheral Neuropathy
- Anesthesia
- Use of assistive devices
- None of the above

17. The primary cause of inpatient falls is decreased patient engagement in the fall prevention plan.

- True
- False

18. Patients who have developed a better rapport and trust with the nursing staff have decreased fall rates?

- True
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19. A scheduled toileting plan decreases the chance of a patient falling?

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20. Having the patient participate in active range-of-motion exercises decreases the risk of falling because? (select all that apply)

- It improves their flexibility
- It improves their coordination
- It doesn't decrease the patient's fall risk
- It keeps their blood flowing to their lower extremities

21. These medications are associated with higher fall rates? (select all that apply)

- Diuretics ('water pills')
- Blood pressure medications
- Opioids (i.e., oxycodone, morphine, dilaudid, etc.)
- Anti-depressants
- Some chemotherapies
- Anesthesia

22. Patient falls affect reimbursement rates, increasing patients' length of stay, increasing undue patient harm, and increasing nursing staff's burnout?

- True
- False

23. A fall caused by a med side effect is?

- Unanticipated fall
- Anticipated fall

24. The Joint Commission issued a sentinel event alert about preventing falls and fall-related injuries in healthcare facilities because falls are a common safety problem in patients of any age or physical ability and can result in severe injury and death.

- True
- False

25. Hospital protocol is to start everyone with a bed alarm until they are proven not a fall risk.

- True
- False

26. Some chemotherapy medications cause peripheral neuropathy, increasing the patient's risk of falling.

- True
- False

27. What percentage of patients with a cancer diagnosis fall in the hospital?

- 10%
- 25%
- 50%
- 75%

28. Cancer patients more are 16-17% more risk for falling versus other patients?

- True
- False

29. It is important to teach patients fall risk education for their own home upon discharge?

- True
- False

30. Studies have shown that increasing staffs knowledge about falls help decrease patient fall rates?

- True
- False

31. If the patient has a history of falling it is important for you to? (select all that apply)

- Know what they were doing when they fell to better plan for fall interventions
- Predict a pattern of injury
- It is not important
- Let the Charge Nurse know

32. Fall precautions related to IV or IV access are? (select all that apply)

- Remove the line if no longer needed
- Have the patient use the IV pole
- Have the patient use a walker
- Utilize a toileting plan for patients with urinary urgency

33. One intervention that can help limit falls related to pain medications is offering toileting before administering pain medication.

- True
- False

Appendix L – Fall Education Evaluation



Employee Number: _____

Demographic Data

1. What is your age:

- 18-25
- 26-30
- 31-40
- 41-50
- 51-60
- >61

2. What gender are you?

- Male
- Female
- Non-binary
- Prefer not to answer

3. What is your job title?

- Nurse Manager
- Registered Nurse
- CNA (1 or 2)

4. How many years of experience do you have in this role?

- Less than 1 year
- 1-2 years
- 3-5 years
- 6-10 years
- 11-20 years
- more than 20 years

5. How many years of experience do you have on the medical or surgical oncology unit?

- Less than 1 year
- 1-2 years
- 3-5 years
- 6-10 years
- 11-20 years
- more than 20 years

6. What is your primary language?

- English
- Spanish
- Other: _____

7. How would you best describe yourself?

- White or Caucasian
- Hispanic
- American Indian
- Asian
- Black or African American
- Other: _____

8. Highest level of education completed?

- No college
- Some college
- Associate degree
- Bachelor's degree
- Master's degree
- Doctorate
- Other: _____

Appendix M – Email to Participants

Dear Potential Participant,

As a doctoral candidate in the School of Nursing at Liberty University, I am conducting research as part of the requirements for a Doctor of Nursing Practice (DNP) degree. The purpose of my research is to evaluate the effects of fall education of RNs and CNAs on the medical and surgical oncology floor on oncology patient fall rates, and I am writing to invite you to join my study.

Participants must be a Registered Nurse or a Certified Nursing Assistant (1 or 2), who are employed on the medical or surgical oncology unit full-time, part-time, or per diem. Participants must be over the age of 18; be able to speak, read, and understand English. Participants will be asked to complete an anonymous demographics survey and pre-test of fall prevention knowledge, taking about ten minutes to complete. The researcher will then present fall education based on the organization's fall policy, fall Clinical Practice Guideline, Lippincott's fall protocol and other evidence-based fall prevention education. The participants will then take a post-test on their fall prevention knowledge and an education evaluation form. It should take approximately one hour to complete the procedures listed. Participation will be completely anonymous, and no personal, identifying information will be collected; employee numbers will be kept by the Nurse Manager of the unit for identification of the raffle winner only.

To participate, please complete the attached survey and return to me before the start of the in-service.

By coming to the in-service the participant is voluntarily consenting to the education session. If you choose to participate.

Participants will be entered into a raffle to receive a \$20 Starbucks gift card.

Sincerely,

Danni Sloane
DNP Student



Appendix N – Poster and Flyer Advertisement

Research Participants Needed

Impact of Fall Education to Nursing Staff on Oncology Patient Fall Rates

- **Are you 18 years of age or older?**
- **Are you an Oncology RN, CNA1 or CNA2 ?**
- **Do you work on the Medical or Surgical Oncology Unit?**
- **Do you speak and understand written English?**

If you answered **yes** to each of the questions listed above, you may be eligible to participate in a research study.

The purpose of this study aims to evaluate the effects of fall education of RNs and CNAs on the medical and surgical oncology floor on oncology patient fall rates.

Participants will be asked to complete a pre-and post-knowledge test, and attend an educational in-service on the organization's fall policy, CPG, and other evidence-based fall interventions.

Benefits include increasing nursing knowledge around the organization's fall policy, CPG, and other evidence-based practice fall precautions for oncology patients; professional growth and development from participating in a research study; and adding to the research knowledge base of oncology patient falls.

Participants will be entered to win a \$20 Starbucks gift card for their participation.

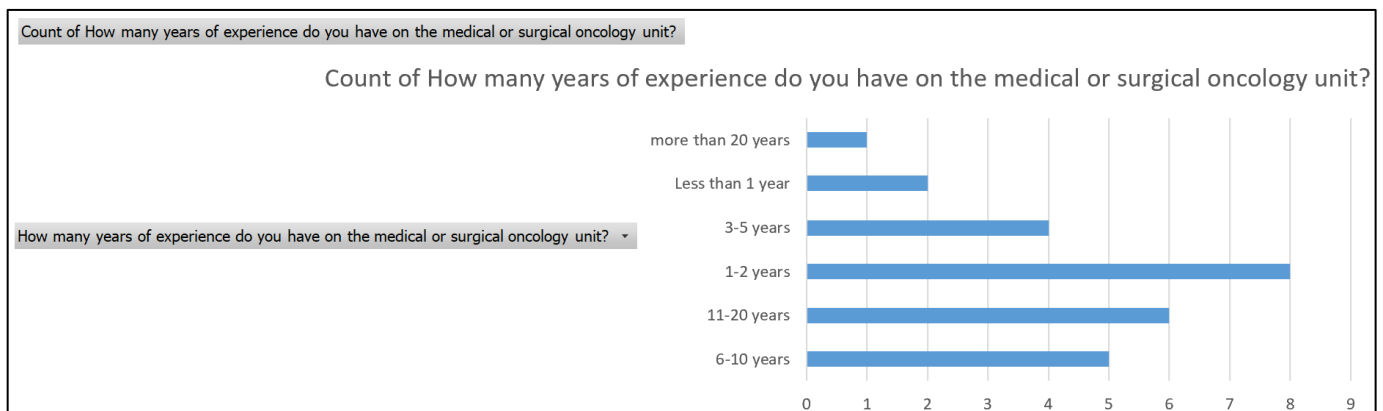
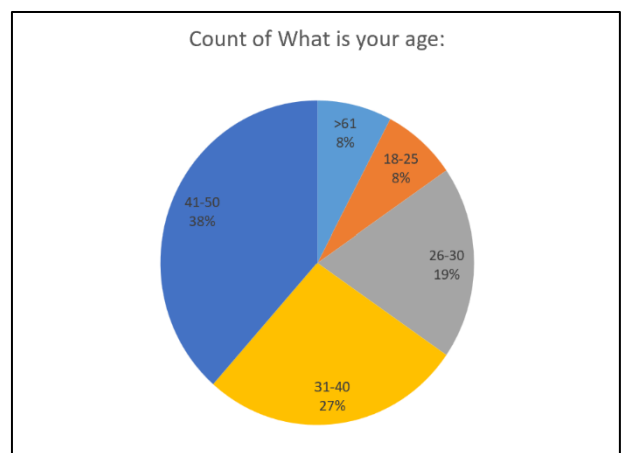
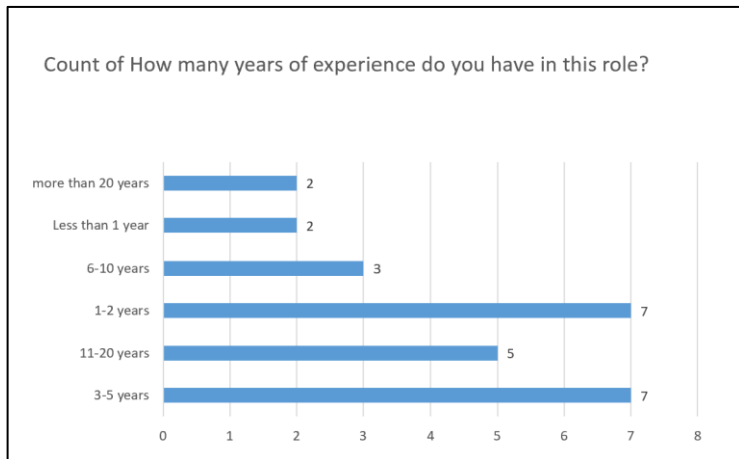
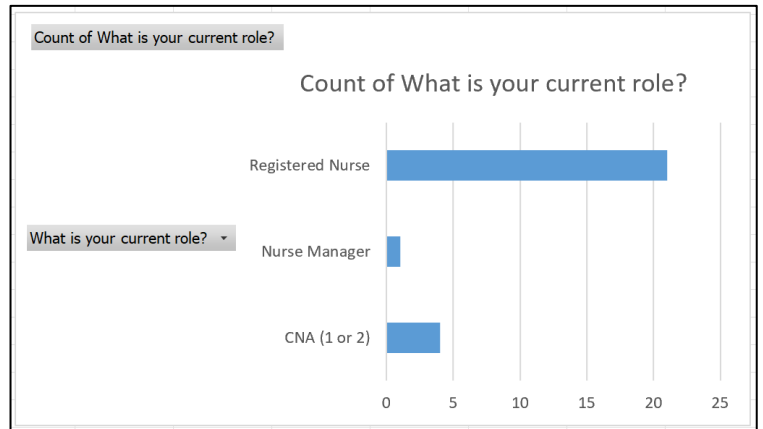
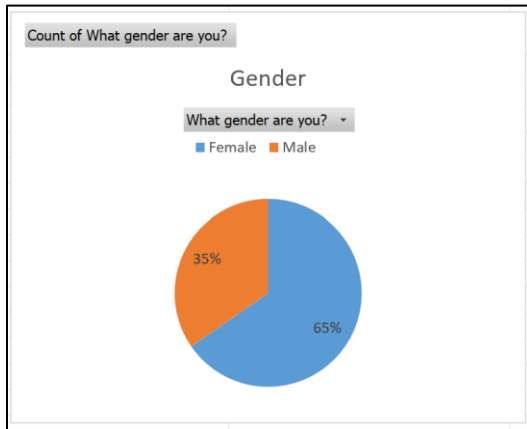
If you would like to participate, contact the researcher at the phone number or email address provided below.

A consent document will be given to you at the time of the in-service.

Danni Sloane, a doctoral candidate in the School of Nursing at Liberty University, is conducting this study.

Please contact Danni Sloane at [REDACTED] for more information.

Appendix O – Demographic Data



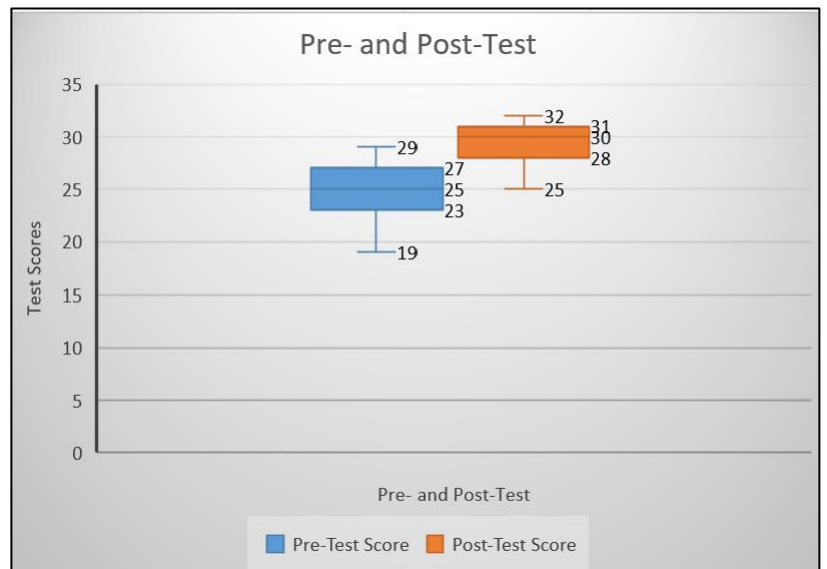
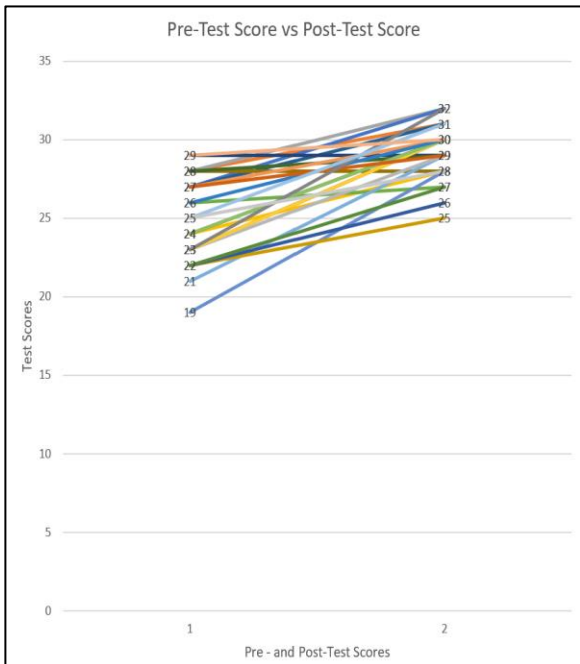
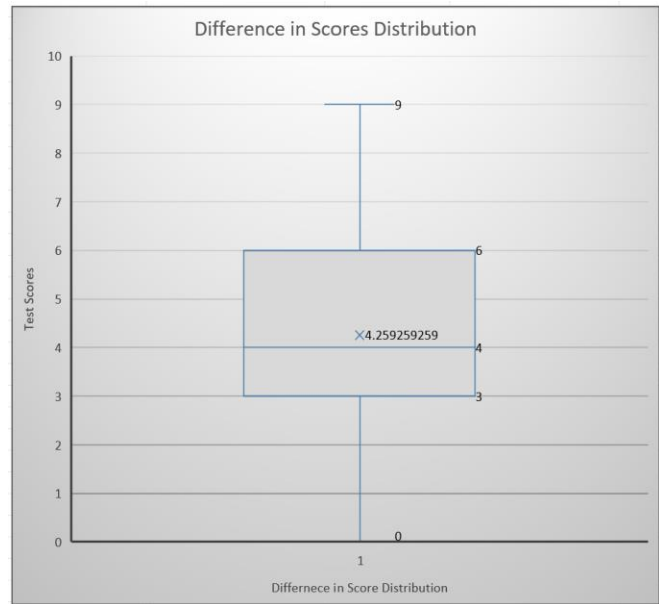
Appendix P – Detailed Unit Fall Data

Unit	Dates	Total Falls	Shift of Fall	Time of Fall	At Shift Change	Location of Fall	Anticipated or Unanticipated	Injury Sustained	Fall Education Done Pre-Fall	Fall Education Done Post-Fall	Fall CPG Used Pre-Fall	Fall CPG Used Post-Fall
7N Medical Oncology	3/19/23 - 4/18/23	0	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
	4/19/23 - 5/19/23	3	Day: 2 Night: 1	1130 2200 1830	0	Bathroom: 2 By room cabinet: 1	Anticipated: 3 Unanticipated: 0	None: 2 Scrape: 1	Yes: 3 No: 0	Yes: 2 No: 1	Yes: 3 No: 0	Yes: 2 No: 1
7S Surgical Oncology	3/19/23 - 4/18/23	0	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
	4/19/23 - 5/19/23	2	Day: 1 Night: 1	0503 2000	0	Bathroom: 2	Anticipated: 2 Unanticipated: 0	None: 2	Yes: 1 No: 1	Yes: 2 No: 0	Yes: 2 No: 0	Yes: 2 No: 0
Education Intervention Date: 5/13/23 to 5/19/23												
7N Medical Oncology	5/20/23 - 6/19/23	3	Day: 2 Night: 1	0615 1607 1715	0	Bathroom: 3	Anticipated: 2 Unanticipated: 1	None: 1 Abrasion/ Bruise: 2	Yes: 1 No: 2	Yes: 2 No: 1	Yes: 1 No: 2	Yes: 1 No: 2
	6/20/23 - 7/20/23	2	Day: 1 Night: 1	1656 2240	n/a	Doorway : 1 Bathroom: 1	Anticipated: 2 Unanticipated: 0	Skin tear: 1 None: 1	Yes: 0 No: 2	Yes: 0 No: 2	Yes: 2 No: 0	Yes: 2 No: 0
7S Surgical Oncology	5/20/23 - 6/19/23	1	Day: 0 Night: 1	1905	1	Bathroom: 1	Anticipated: 1 Unanticipated: 0	None: 1	Yes: 1 No: 0	Yes: 0 No: 1	Yes: 1 No: 0	Yes: 1 No: 0
	6/20/23 - 7/20/23	1	Day: 0 Night: 0	1945	1	Bed: 1	Anticipated: 1 Unanticipated: 0	Skin tear: 1	Yes: 0 No: 1	Yes: 0 No: 1	Yes: 1 No: 0	Yes: 1 No: 0

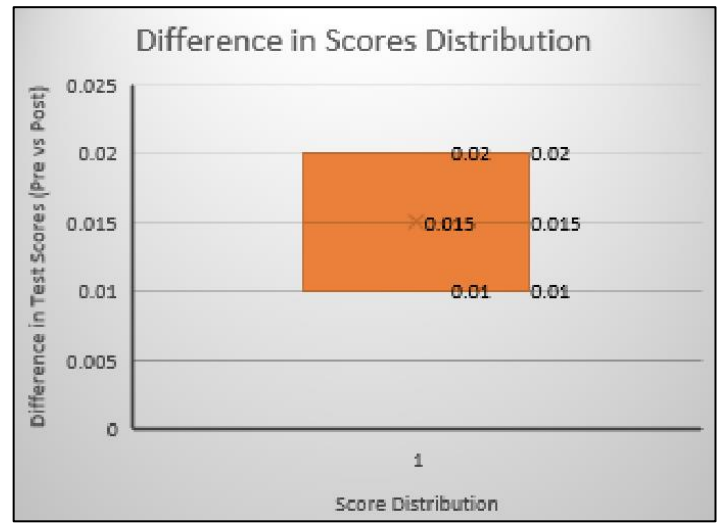
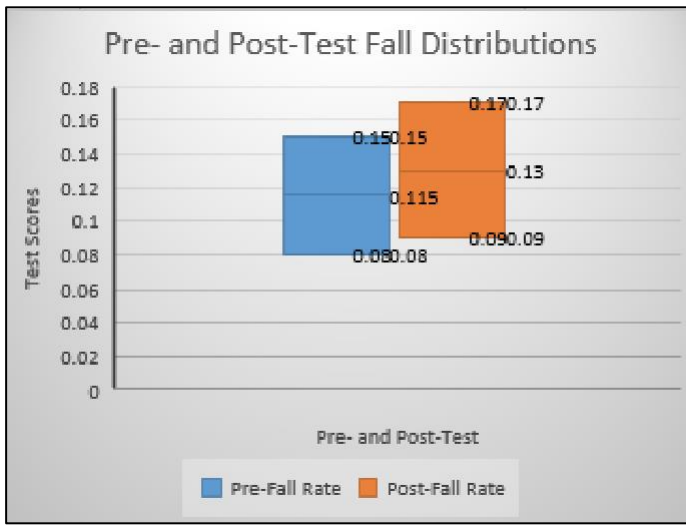
Appendix Q – Statistical Analysis of Pre- and Post- Education

Pre-Test Score	Post-Test Score	Difference in Score
27	31	4
28	31	3
28	32	4
24	28	4
27	32	5
26	27	1
27	31	4
24	30	6
23	30	7
28	28	0
29	29	0
28	29	1
21	29	8
27	30	3
23	29	6
23	30	7
19	28	9
24	30	6
26	30	4
27	29	2
23	32	9
22	25	3
22	26	4
22	27	5
25	31	6
29	30	1
25	28	3

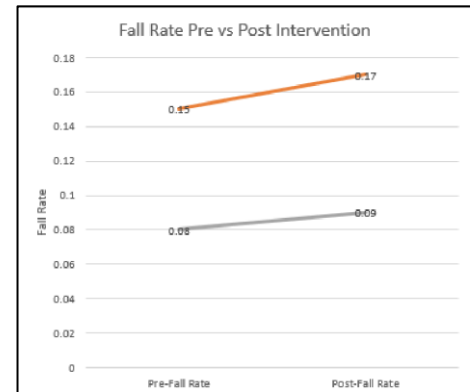
	Pre-Test Score	Post-Test Score
Mean	25.07407407	29.33333333
Variance	7.225071225	3.230769231
Observations	27	27
Pearson Correlation	0.41661127	
Hypothesized Mean Difference	0	
df	26	
t Stat	-8.727778924	
P(T<=t) one-tail	1.66373E-09	
t Critical one-tail	1.70561792	
P(T<=t) two-tail	3.33E-09	
t Critical two-tail	2.05529439	



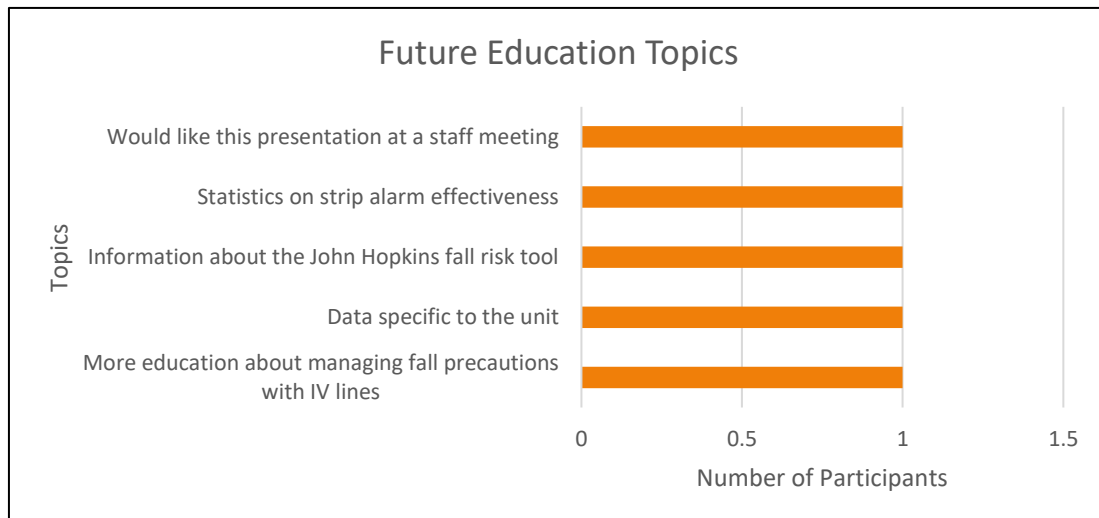
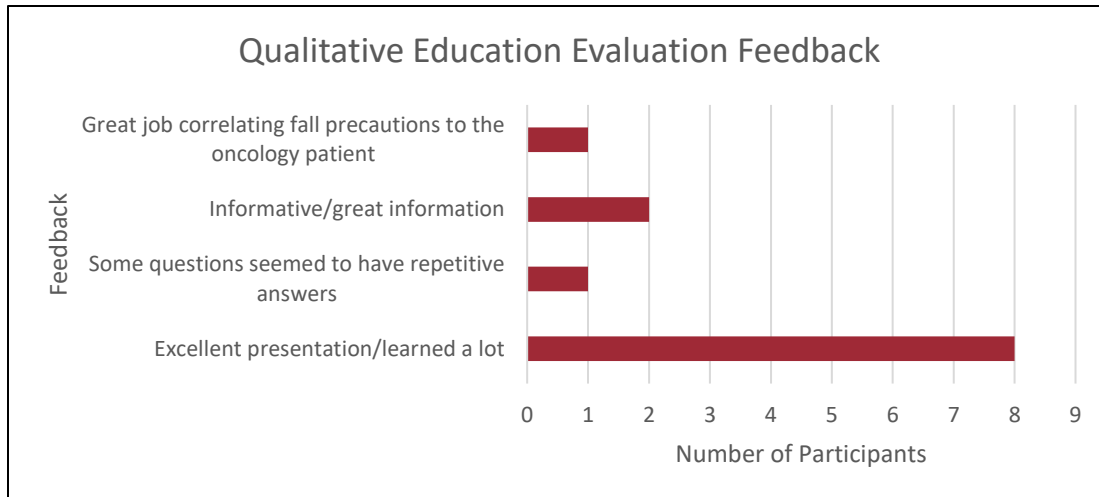
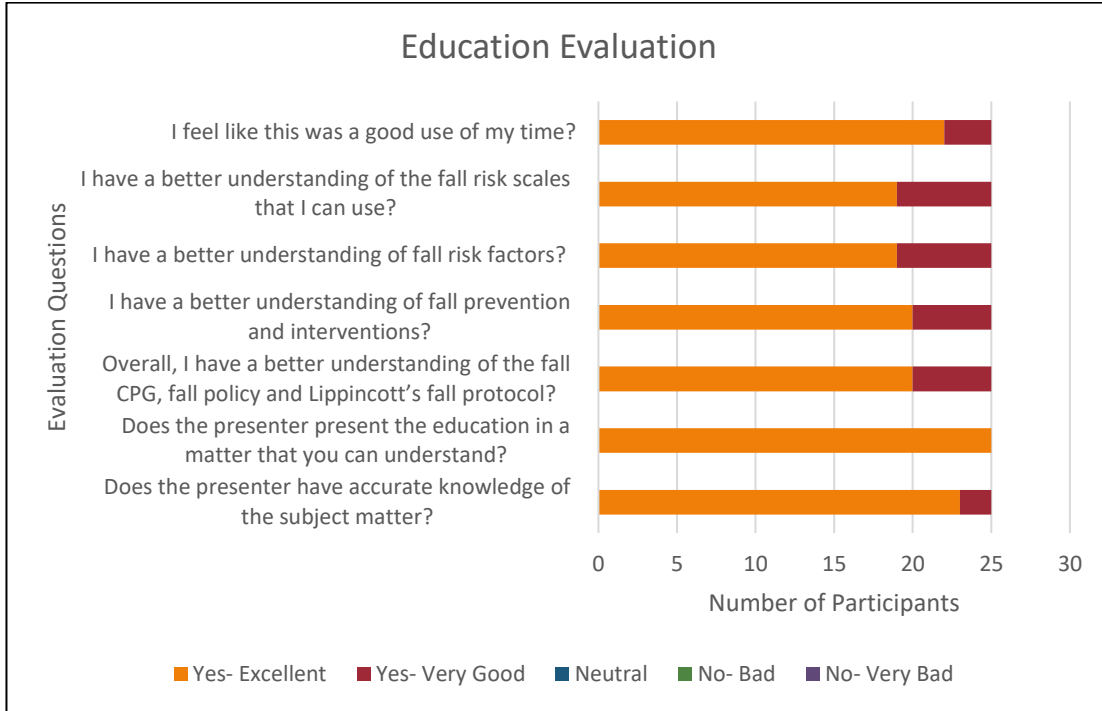
Appendix R – Statistical Analysis of Pre- and Post- Falls Data



For ALL Units			
Unit	Pre-Fall Rate	Post-Fall Rate	Difference in Score
7N	0.15	0.17	0.02
7S	0.08	0.09	0.01
Hypotheses: u = distribution mean			
H0: Null Hypothesis	u = 0	The means of before and after were the same	
H1: Alternative Hypothesis	u ≠ 0	The means of before and after were different	
TWO TAILED			
Significance:	a = 0.05		
Sample	2 Units before and after intervention		
p-value:	0.204832765		
t-Test: Paired Two Sample for Means			
	Pre-Test Score	Post-Test Score	
Mean	0.115	0.13	
Variance	0.00245	0.0032	
Observations	2	2	
Pearson Correlation	1		
Hypothesized Mean Difference	0		
df	1		
t Stat	-3		
P(T<=t) one-tail	0.102416382		
t Critical one-tail	6.313751515		
P(T<=t) two-tail	0.204832765		
t Critical two-tail	12.70620474		
High p value, above .05, we fail to reject null hypothesis			
Fail to reject the null hypothesis. We cannot determine the means are significantly different.			
Therefore there is not sufficient evidence to determine that the post test falls were different from the pre test falls.			



Appendix S – Education Evaluation Data



Appendix T – Pre- and Post- Education Unit Staffing

