MLM1 Task 1 Evidence-Based Practice and Applied Nursing Research

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A. Impact of Problem on Patient and Organization

This clinical practice problem impacts patient's safety, falls contribute to increased fractures, soft tissue injuries, lacerations, and increased incidence of preventable sentinel events. Falls adversely affect organizations as they may be financially burdened by losing reimbursement for injuries caused when falls occur.

A1. Identify PICO components

Patient/population/problem (P)

The clinical practice problem addresses patient falls in an acute inpatient hospital setting. Patient falls not only affect patient safety but financially affect the facility with the loss of reimbursement for preventable patient injuries.

Intervention (I)

Improving patient fall rates with increased patient and family education. Education on safety and fall prevention provided to the patient by facility staff is intended to decrease the rate of falls throughout the patient's hospitalization.

Comparison (C)

The clinical practice problem will examine the difference in fall rates between patients without fall risk and safety education as compared to patients that have been provided education on safety and fall prevention during treatment.

Outcome (0)

The ideal outcome for the clinical practice problem is an increased understanding from hospitalized patients on fall precautions and safety through education. This increased understanding will

decrease the rate of falls and increase patient safety. Decreased patient falls will save the organization from financial setbacks and loss of reimbursement for preventable events.

A2. Evidence-Based Practice Question

In hospitalized patients at risk for falls, will patient education on fall prevention reduce falls as compared to no patient education on fall precautions?

B. Research-based article

B1. Background/Introduction

Patient falls during hospitalization is an ongoing concern worldwide. Organizations are continually striving to introduce strategies to prevent inpatient falls to not only improve clinical outcomes but protect the organization financially This article addresses patient education as a way to increase patient understanding and engagement in fall prevention programs. “Up to 80% of falls occur when patients are not observed. Some patients initiate risky decisions about mobility based on their own judgments, without always seeking help from nurses or other health professionals”(Heng et al 2020). The article seeks to examine multiple reviews, clinical trials, and hospital interventions used to show changes based on patient education in the incidence of falls.

B2. Methodology

Arksey and O’Malley, the Joanna Briggs institute along with the Preferred Reporting Items for Systematic Reviews and Meta-analysis Extension for Scoping Reviews (PRISMA-ScR) were the protocol methods used in this research article(Heng et al 2020). A broad research question was introduced and eight databases were searched for pertinent literature to examine the subject matter. The data and articles were screened by two reviewers. Narrative revies, clinical trials, and grey literature was

systematically reviewed to achieve a summary of the highest level of evidence available in the current literature”(Heng et al, 2020).

B3. Level of Evidence

The article used as evidence for this study can be described as a level III study when referring to the Johns Hopkins Nursing Evidence-Based Practice (JHNEBP) Model. The article is a nonexperimental study. Study designs including quantitative, qualitative, and mixed-method designs were all included in the article.

B4. Data Analysis

A wide range of data was collected for this article including studies from nine different countries. Data includes a variety of systemic reviews, randomized controlled trials, quantitative studies, and quasi-experimental trials. The studies are organized and presented as a PRISMA flow chart within the article. The focus of the reviewers included several subcategories that include the content of patient falls education programs, education delivery mode, educational design principles and models, education, and fall outcomes. Fall-related outcomes, quality of falls education programs, and systematic reviews(Heng et al, 2020). The flow chart in the article provides a visual overview of the data collected in the study.

B5. Ethical Consideration

Ethical approval and consents to participate are not applicable in this case. This article is a cumulative study of research, human experimentation and testing were not implemented to achieve research results in this study.

B6. Quality Rating

The report contains transparency, diligence, verification, and insightful interpretation of collected data. A quality rating of A/B High/Good quality can be assigned based on the JHNEBP model.

B7. Analysis of the Results/Conclusions

Based on the analysis of the conducted and examined research there is ample evidence that incorporating patient education as part of a hospital's comprehensive fall prevention protocols has the potential to decrease the number of inpatient falls, The education provided to the patient needs to take into account individualized fall risk and environmental considerations. A combination of educational modes can sometimes be more effective than a single modality. Patients involved in an active learning design can be more engaged(Heng et al, 2020)

C. Non-research-based Article

C1. Background/Introduction

The project in this article examines patients at risk for falls on two medical-surgical units at the medical center. The project's purpose summarized in the article is to improve an organization's ability to understand address and identify solutions for patients at risk for falls with injury while hospitalized. Patient falls are common and often result in significant injury for patients and financial loss for institutions as injuries related to inpatient falls are not reimbursable under the Centers for Medicare and Medicaid Services(Ambutas, 2017).

C2. Type of evidence

This article contains an overview of a quality improvement project. The quality improvement committee identified two medical-surgical units with fall rates exceeding rates from the National Database for Nursing Quality Indicators (NDNQI). The project examined an analysis of past falls on the units to identify trends. The project also examined past practices and incorporated new practices that included an interprofessional fall team, low beds, floor mats, teach-back for at-risk patients and their families, and documentation of mobility on the communication board. Project objectives include

implementation of a fall reduction tool kit, reducing falls to less than 0.3 per 1,000 patient days on the units being studied, and reduction of fall with injury to less than 3.4 per 1,000 patient days on participating units(Ambutas, 2017).

C3. Level of evidence

This journal article is level V using the JHNEBP model as it is based on experimental non-research evidence and includes a quality improvement project.

C4. Quality Rating

The journal article is high quality and rates A using the JHNEBP model. The article exhibits a clear focus and objectives regarding fall reduction in multiple settings that references measurable scientific evidence.

C5. Author's Recommendations

Implementation of the quality improvement program was successful in the reduction of falls with injury in this setting. Implementation of new practices that included but were not limited to increased staff education and teach-back on fall precautions to patients and their families played a significant role in the project's success. Patient fall education was not the only strategy used in the falls toolkit, promotions such as the use of signs inpatient rooms reading "Call Don't Fall" were also key elements in the program's success. The authors attribute the success of the project to a shift of accountability to the fall team members and unit leaders(Ambutas, 2017). The success of the project supports the clinical practice problem by showing positive results in the reduction of falls with the incorporation of fall education for patients.

D. Recommended Practice Change Based on Evidence-Based Practice Question

Based on a review of both articles discussed and the positive evidence documented I would recommend a practice change that includes increased education of patients and families on fall precautions to reduce the risk of falls during inpatient hospitalizations. The practice change would include the teach-back method utilized by nursing staff to educate patients and families and promotional materials to serve as reinforcement of teaching, such as signs posted as reminders for patients in visible areas in the patient's room.

D1. Key Stakeholders

Key stakeholders involved in this practice change will include nursing supervisors and unit managers, nurses and support staff, and nurse educators. I would start the process of practice change by forming a committee that includes representatives from the three groups of stakeholders. It is important to look at the proposal from each angle to ascertain barriers that may impede the success of the change. Nursing supervisors and unit managers have a good understanding of the workflow and the running of the unit they can assist the nurse educator to provide staff education promptly to facilitate the change. Nursing and support staff can provide valuable feedback acknowledging practical barriers that may come up during the implementation process, they may also have helpful ideas to make the process of educating the patients easier. The nursing educator will need to have a good understanding of the data and present the information in a way to encourage staff accountability and engagement which is crucial to the success of the practice change.

D2. Barrier to Implementation

A change in practice is often met with resistance from staff. Key stakeholders may not understand the positive implications of the practice change and may view it as an additional burden that will impede the workflow that they are used to.

D3. Strategy to Overcome the Implementation Barrier

Quality education of staff that includes evidence-based research and clear expectations of what the change will entail along with the responsibilities of each staff member. Staff members must be valued and allowed to ask questions in a supportive environment.

D4. Indicator to Measure the Outcome

The outcome measure will be a comparison between six months before the practice change, and six months after the implementation of the proposed practice change. The desired outcome from my EBP question will be to show over six months of implementing the new practice change a significant reduction of inpatient falls due to increased patient education on fall precautions.

References

Ambutas, S., Lamb, K.V., Quigley, P. (2017). *Fall Reduction and Injury Prevention Toolkit: Implementation on Two Medical-Surgical Unit*. MedSurg Nursing. May-June 2017. Vol. 26/No. 3

Heng, H., Jazayeri, D., Shaw, L., Kiegaldie, D., Hill, A., Morris, M. (2020). *Hospital falls prevention with patient education: a scoping review*. BMC Geriatrics. https://doi.org/10.1186/s12877-020-015-w