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PROMOTING SAFETY THROUGH ADVOCACY AND PRACTICE: NURSE INPUT AND BELIEFS REGARDING HOSPITAL FALL PREVENTION POLICIES IN THE INPATIENT SETTING

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PROMOTING SAFETY THROUGH ADVOCACY AND PRACTICE: NURSE INPUT AND BELIEFS REGARDING HOSPITAL FALL PREVENTION POLICIES IN THE INPATIENT SETTING

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PROMOTING SAFETY THROUGH ADVOCACY AND PRACTICE: NURSE INPUT AND BELIEFS REGARDING HOSPITAL FALL PREVENTION POLICIES IN THE INPATIENT SETTING

An Abstract of the Scholarly Project by
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Throughout the evolving healthcare system, many issues in the hospital setting pose significant risk to patient safety and outcomes. Falls occur at detrimental rates that inevitably impact both the patient and the nurse. Of the several reasons one would choose to join the profession, nurses often seek the satisfaction of knowing the care they have provided impacted a patient, physically and spiritually. The healthcare system has allotted for variables in patient safety to promote safe outcomes and the reduction of fall risk, such as evidence-based practices and tools like cameras and assessments. However, the lack of nursing involvement in these processes often leaves them a step behind the pattern they wish to follow. Collecting baseline data regarding nursing staff knowledge of policies and procedures allows both the researcher and nursing leadership team to drive change in many areas of practice beyond fall prevention and risk reduction alone. The purpose of the study is to highlight current nursing staff understanding regarding hospital fall prevention policies, implement an increased frequency of current assessments, and review whether these changes made an impact on staff's beliefs about their involvement in practice. Recreating this in other areas of patient safety concerns may potentially impact nursing practice at the organizational level and lead to better patient outcomes.

Keywords: competency, falls, hospital, nursing, policy, practice, procedure

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Chapter I

Introduction

Throughout the country and world, many citizens and patients turn to nurses for guidance through medical treatment and the beacon of light they shine on compassion. As one of the most sought-out, trusted professions known, nurses hold a large responsibility to the public, ensuring that physiological and sociological standards are upheld to maintain the duties of care sworn upon them in the dawn of assuming such roles. With the presumption that one will do no wrong in practice, some could concur that a large function of nursing includes the maintenance of patient safety throughout every care setting.

Description of the Clinical Problem

As most nursing professionals chose to practice exclusively to the hospital, there are many obstacles and challenges that must be faced in order to properly provide safe patient care in a day-to-day workflow. Many of the negative events that occur in the hospital have the capacity to place the patient in harm's way, resulting in untimely adverse events, prolonged hospitalizations, or even death (Myers, 2011, p. 6). One of these tragic events that remains of high prevalence despite long-term remediation is the occurrence of mechanical patient falls. Patient falls in the in-patient setting remain one of the most reported sentinel events to date, accounting for the increase in rates of patient

injury while admitted while also contributing to the development of secondary complications (Chu, 2017).

Consequences of hospital falls are not exclusive to the patient alone. Health system organizations reap the burden of these events as falls are non-reimbursed through the Center for Medicare and Medicaid Services, a federal entity known to provide financial resource to public-access hospitals in the United States (Fehlberg et al., 2018). With annual costs exceeding $30 billion (Fehlberg et al., 2018), the strain hospital administrators face when losing these funds only further exemplifies the negative outlook caused by falls in the hospital. Additionally, nurses must also face the burden of fall occurrence in the hospital. Emotional constructs often found and grow throughout a nurse's career, and breaches in patient safety and care can cause feelings of guilt and shame to the dedicated nursing professional. With this in focus, nurses also hold a large responsibility to preventing such happenings from ever existing.

Significance to Nursing Practice

Though the interdisciplinary team consists of many key individuals that promote the well-being of patient care in the hospital, nursing staff members stand at the forefront in ensuring care tasks are conducted effectively (Tracy et al., 2019, p. 290). Often known as "bedside nursing", nursing staff members in charge of performing care tasks in the in-patient units are held to a high standard within the hospital setting, requiring the use of rapid assessment and judgement skills, clinical tactics, and knowledge of evidence-based practice to deliver top-of-the-line care to patients with complex medical conditions. Applying ethical standards in addition to these care requirements signifies the diversity nurses hold to national and global health systems.

Often a subsidy of the formal nursing process, those practicing in the hospital are constantly working to monitor the care environment, intervening when appropriate to ensure the patient remains in a hazard-free setting. Determining the patient's risk and probability of falling in the hospital becomes astronomical in this process, as the nurse provides daily care tasks like activities of daily living (ADL's) or walking through the room or halls (American Nurses Association, n.d.). With developed assessment skills, nurses work to scan fine characteristics of the patient and create useful interventions that will deter or eliminate the risk of fall occurrence. Being the "eyes" of the care team, nurses hold a special value in the prevention of falls.

As patient safety and healing remain top priorities to the nursing professional, many other functions also coexist in a similar realm. The overall improvements and enhancements made to modern nursing practice have been led through the leadership and education of pioneers known to nurses and health care workers alike. Evolving forward, nursing professionals have the capacity to shape the course of hospital operations by the utilization of health policy and advocacy (Grossman et al., 2017, p. 184). Holding strong positions in the creative execution of patient care, nurses stand equally when measured against physicians, therapists, support care and ancillary staff members. Being that nurses are the first line worker when falls occur, the experiences and testimonies matched with clinical knowledge and competency support the relevance needed for nursing involvement in fall prevention and care.

In great consideration to latter noted significances, perhaps the most necessary to the role nurses have to fall prevention in the hospital is education. Bundling all other responsibilities of compassion, safety and leadership, education highlights the magnitude

of power nurses hold by fusing research and competency to deliver improvements in fall prevention, and other patient safety measures. This occurs in a two-part system: 1) the education nurses receive, and 2) the education nurses provide. In the rapid acceleration of the United States health system, nursing staff must progressively strive to better their own practices and grow individually in order to meet the demands of stagnant issues, such as patient falls (American Association of Colleges of Nursing, 2019). Adherence to professional development at both the organizational and academic levels promote the nursing profession as a whole while pushing for safe patient care. The embodiment of spirit, emotion, and physicality paired with science and medicine allow nurses to think outside of the box in ways of healing and supporting patients in the hospital, and these notions facilitate the stance more so when promoting fall prevention interventions.

Specific Aims and Purpose

As previously noted, nurses hold a vital, yet special, role in the daily function of the hospital, Adversely, with great power comes great responsibility. Nursing professionals often times feel immense amounts of pressure and stress in their daily duties (Muhawish et al., 2019, p. 4). This can be attributed to a number of issues, including length of responsibility, job environment, and personal physical or psychosocial barriers that the nurse faces in their own connection with their career. Mental and emotional issues often times relate directly to one's job performance, disguising a lack-luster attitude or practice for greater happenings. Even though the individual's psyche may bleed indefinitely into their performance as a nurse, the effects could be more minimal than not (Furr et al., 2018, p. 118).

The display of poor clinical training or understanding can often times be observed in the way nursing professionals provide patient care or operate within the given spectrum of nursing fundamentals. Poor practices, paired subsequently with the stress and hardships nurses must face on a daily basis, creates the perpetual downfall of professional behaviors and attitudes (Fur et al., 2018, p. 121). Understanding how competency and psychology intertwine themselves into hospital procedures and may potentially support the implementation of evidence-based practices into modern nursing practice and culture.

In terms of fall prevention, the purpose of this study is to directly identify nursing thoughts and attitudes toward current policies and procedures utilized throughout the organization. In addition to the determination of these factors, clinical knowledge and evidence-based practices will be combined with gaps found in current nursing competencies and education to create an updated fall prevention policy to be used throughout the units. This will give participating nursing professionals the ability to alter current trends throughout the organization and promote the inclusion of nurse advocacy and policymaking.

In doing so, the proposed policy implementation will have the ability to improve several key issues within the hospital. In-patient fall rates will tentatively decline due to the improvements in patient safety and environment. This can also correlate to patient satisfaction as an indirect outcome. Making patients aware of nursing efforts to promote safety and providing education on admission can provide the affected population a sense of security, alleviating feelings of anxiety often experienced with hospitalization. Themes of education can also speak greatly to the participating nursing staff. Incorporating competency assessments and updated continued education pertaining to fall prevention

should, in turn, refresh the participant with new literature and knowledge, potentially displaying the need for continued education in unrelated areas of nursing care. Thought of as a fundamental structure to nursing architecture, advocacy for both nurses and patients remains a valuable cause to healthcare (American Nurses Association, n.d.). While these may not be the sole purpose and meaning behind the study, incorporating central concepts of education, advocacy, and competency can prove critical stability to an effort already deep-rooted in-patient safety and outcome improvements.

Theoretical Frameworks

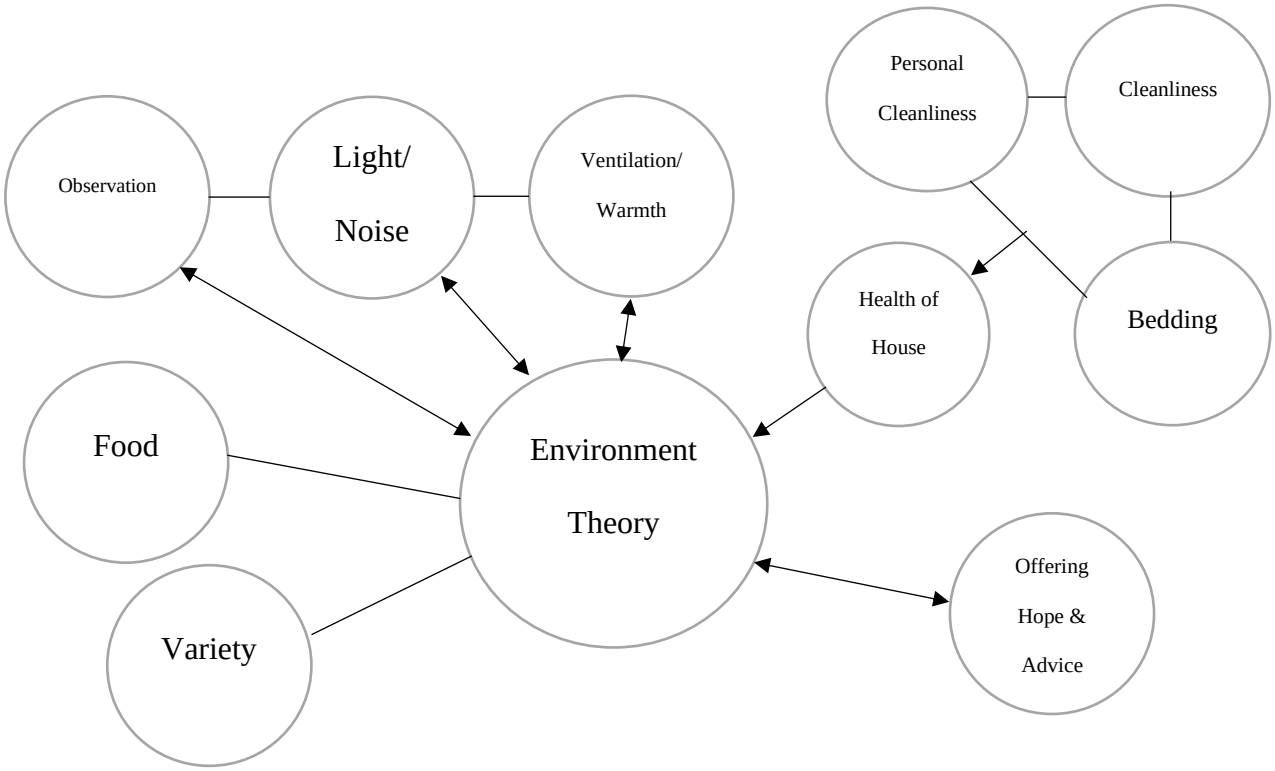
The value nursing research holds to the practices implemented throughout the world are dependent on many factors. Nursing theory details many ideologies and tactical frameworks of knowledge that become instrumental to the development of research studies. This is also true to the nature of evidence-based practice and policymaking, as theorists generalize broad ideas and thoughts and shape every aspect of nursing practice and process. Safe patient handling practices are derived from the fundamentals of nursing theory, institutionalizing the methods at which nurses deliver safe, quality care across the nation and world.

Nightingale's Environmental Theory

Applying such theories to methods of fall prevention are most important in order to combat the ever-changing obstacles nurses face in the hospital setting. Issues in environment have long been a challenge for healthcare professionals, stemming from both non-modifiable issues and factors related to the patient's current health condition. Florence Nightingale's *Environment Theory* (Nursing Theory, 2020) is a pivotal conceptual framework that targets the multitude of flaws noted in the patient care setting.

As the occurrence of falls in the hospital can be attributed to several issues in environment, it is important to analyze factors beyond nursing education and resources, focusing on methods nursing staff can implement to alter the effects of these instances.

Figure 1. Concepts of Nightingale's Environmental Theory (Nursing Theory, 2020)



Concepts and themes constructing the *Environmental Theory* are quintessential to the function and flow of the hospital. Of importance to the foundation of a safe, therapeutic hospital setting involve the maintenance of observation, providence of warmth and ventilation, and the reduction of noise. Nursing staff have the capacity to alter the patient's environment by simply increasing their observation of both the patient and the patient's surroundings, tying deeply into processes of assessment and judgement. Cleanliness and organization of the patient's room and throughout the nursing unit not

only provide a neat and uniform appearance but also reduce further hazards amongst clutter (Medeiros et al., 2015, p. 521). Providing both education and emotional support to the patient may not directly alter the environment, but as patient education is a strong proponent of fall prevention and overall nursing care, this remains a key factor in maintaining a safe environment.

In addition of the key concepts detailed above, many assumptions characterized in Nightingale's *Environmental Theory* (Sher et al., 2018, p. 2) support the realistic duties nursing professionals have in upholding a safe environment. These assumptions include practicalities of natural laws, human capabilities, the art and science of nursing, and the separation of nursing and medicine (Sher et al., 2018, p. 2). Each of these theoretical assumptions promotes the integral responsibility nurses have in delivering safe patient care in the hospital. Furthermore, applying both concepts and assumptions of Nightingale's *Environmental Theory* to the implications of fall prevention in the hospital setting not only features nursing as a core necessity to the interdisciplinary team, using such frameworks promotes the indication that fall prevention remains solely to the nurse to guide, frame, and change in times of failed safety.

American Association of Critical-Care Nurse's Synergy Model of Patient Care

Aside from the development of a wholesome, therapeutic environment for patient care, there are also many other considerations taken into account that may affect the hospitalized patient's risk of falling. Mentioned previously, nursing education is a highly regarded entity of practice, driving the force for change and evidence seen in clinical knowledge and skills. Paired with this is the education patients have toward the care they are receiving in the hospital, as well as their own levels of competency and compliancy.

The American Association of Critical-Care Nurses (AACN) *Synergy Model of Patient Care* (n.d.) is a highly regarded patient-centered framework that envelops the understanding of the nurse-patient relationship in regard to competency, ability, and needs across both parties. Utilization of the *Synergy Model* in any care setting becomes relevant to fall prevention as "Synergy results when the needs and characteristics of a patient, clinical unit or system are matched with a nurse's competencies" (American Association of Critical-Care Nurses, n.d., p. 1).

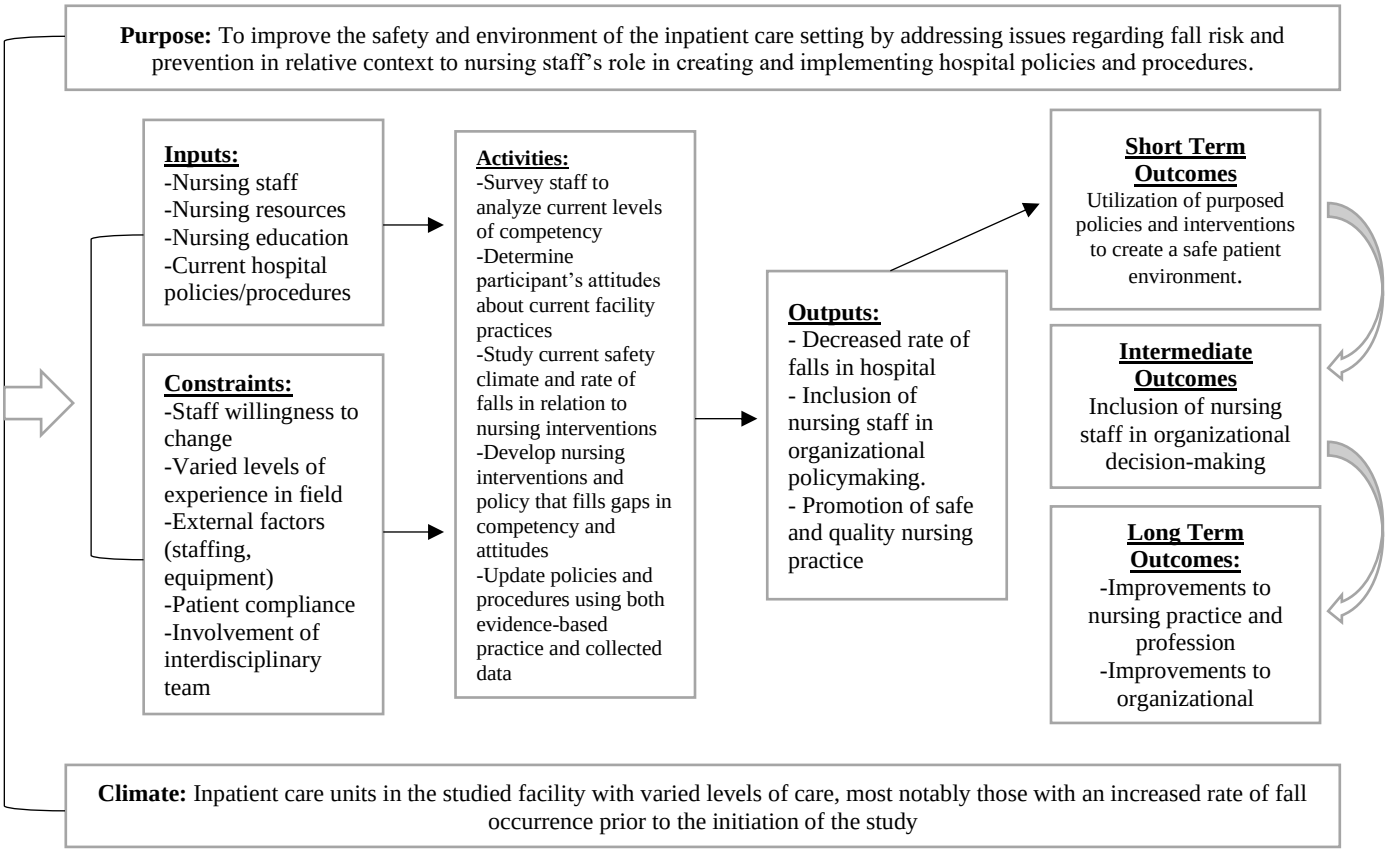
Table 1. Concepts of the Synergy Model (American Association of Critical-Care Nurses, n.d.)

Patient/Clinical Unit/System Needs	**Nurse Competencies**
Resiliency	Clinical Judgement
Vulnerability	Advocacy and Moral Agency
Stability	Caring Practices
Complexity	Collaboration
Resource Availability	Systems Thinking
Participation in Care	Response to Diversity
Participation in Decision Making	Facilitation of Learning
Predictability	Clinical Inquiry

With consideration to the concepts listed in Table 1 and facilitated information mentioned previously, the *Synergy Model* spans far past the nurse-patient relationship and applies to the practices nurses use in their respective organizations. It is with this in mind that such a framework is vital to the implementation of any hospital policy or procedure but is most crucial to policies of patient safety. Matching organizational needs with nursing abilities supports the effectiveness of the purposed practice change by highlighting gaps in clinical knowledge and providing a channel to which such gaps may be filled. The application of the *Synergy Model of Patient Care* to fall prevention interventions is multifaceted as it offers the nurse a chance to build and support their

relationship with the patient and the organization. Managing to streamline such concepts and ideas into nursing research and policymaking, again, supports nursing as a profession and as a function of patient-centered care.

Figure 2. **Logic Model of Purposed Project**



Project Questions

1. Can nursing staff's knowledge and beliefs regarding current hospital policies affect patient outcomes?

2. Will adjusting current practices to meet patient specific characteristics lead to improved outcomes?

3. Are staff nurses influential in organizational decision-making?

4. Will including nursing staff members in policymaking improve their beliefs and outlook on their role and function as nursing professionals in the organization?

Definition of Key Terms and Variables

- Assessment – the process of evaluation to determine clinical specific characteristics performed at a specific time.
- Attitude – a set of emotions, beliefs, and behaviors toward a particular object, person, thing or event resulting from experiences or upbringing and influencing behaviors (Cherry, 2020).
- Behavior – the display and action of one's perceived attitudes and thoughts, in either a positive or negative manner.
- Competency – an important skill that is needed to do a job (Cambridge, 2020).
- Environment – surrounding of setting at which an event or happening occurs.
- Fall(s) – an event which results in a person comping to rest inadvertently on the ground or floor or other lower level (World Health Organization, 2018).
- Knowledge – the fact or condition of knowing something with familiarity gained through experience or association (Merriam-Webster, 2020).
- Outcome – the result of one's actions.
- Policy – formally written document defining expected practices of staff members within an organization, helping to standardize care and reduce variations in practice (Irving, 2014).
- Prevention – the utilization of theoretical and physical applications in an effort to reduce or eliminate the probability of a particular event or situation from occurring.

- Procedure – the active use and implementation of a respective formal policy.

Summary

Hospitalized patient falls are a major event with everlasting consequences to all parties involved in the patient's care. With the presumption that nurses enter their career in an effort to provide safe and quality care, there is no doubt that issues in fall prevention must be actively addressed promptly in order to mitigate the variety of negative outcomes falls render. Many practical, ethical, and clinical considerations must fully be intertwined to such policies and procedures if the purposed practice change is considerably successful. Related to this are the

many duties nurses have to the advocacy roles they hold in their respective duties. Maintaining such status in the interdisciplinary team proves most beneficial in implementing these policies.

Finding balance in competency, psychology and practice creates a modern-day approach to nursing research and evidence-based practices. Coupling this narrative with select theoretical frameworks only adds more autonomy to a profession that is already widely known for internal change. Managing to support nurses and giving them a voice in their own practice is vital in the future of the nursing profession. Determination of gaps in current knowledge and practices in while subsequently exposing nursing staff to underlying fundamentals of advocacy and policymaking can pioneer fall prevention and any other practice changes necessary. In turn, doing such will secure nurses as a reputable representation of the hospital organization.

Chapter II

Integrated Literature Review

Curation of research in patient safety and fall prevention requires a broad assessment of the many factors typically associated with the risk of a fall (Aranda-Gallardo et al., 2014, p. 631). As the practicing nurse strives to create an environment that is conducive to quality and safe care, they must also consider the many barriers that pose potential breach in such goals. In contrast to the typical requirements of such roles, nursing professionals must exercise their duty as an advocate and policymaker by utilizing nursing research and literature in a real-world way that allows the cascade of thoughts and theories to intertwine and become reality (Gregg et al., 2018, p. 18).

The overall premise of the literature review correlates with the many concepts suggested in the objective of this project. Broad topics in patient safety and fall prevention are reviewed and compared, due primarily to the understanding that factors and risk of fall are related to several issues within the organization (Bruce et al., 2017, p. 2). While the main theoretical frameworks used for the project highlight environment and competency exclusively, the idea of fall prevention must be analyzed beyond just two distinct thoughts. Inclusion of nursing process and practice is pertinent in development of fall prevention measures and policy and must be addressed before moving forward in research. Also given the concepts of policy and practice in the basis of this project, it is

also very relevant to consider current literature regarding the nurse's role in patient care, policymaking, and other variables which benefit the promotion of safe patient outcomes.

Review of Literature and Evidence: Education, Environment, and Practice

As described, the concepts and ideas associated with fall prevention as it pertains to the purpose of the project are rather broad in nature. Though the conceptualization of fall prevention in this context is wide-spread, a review of literature and evidence-based practices (EBP) amongst important variables gives some insight to how each piece plays a role in fall prevention in the hospital. Even while some literature reviewed does not directly align with the purpose of the project, each facet holds an importance to how fall prevention and patient safety are managed as a whole.

Fall Prevention and Healthcare Education

Most important to how fall prevention measures come into practice, education across all members in the care setting serves as a driving force to the promotion of positive patient outcomes. Two parties that require the most extensive focus in this situation are the caregiver (nurse) and the patient (McNulty et al., 2012). Combining both aspects helps the nurse understand how their knowledge base inevitably affects the outcome of the patient. Regardless of specific setting, education plays a vital role in the institution of information in a manner that applies to the situation at hand.

Direct understanding of nursing education, both how it is delivered and received, is an essential part to not only the development of healthcare education (Shaw et al., 2020, p. 6), but also the contingency of functions in the healthcare organization. Utilization of education programs allow leaders to provide education opportunities for staff members while subsequently analyzing areas of needed improvement (Shaw et al.,

2020, p. 3). Events held among nursing leaders and staff aimed to broadcast updated practices and policies while strengthening staff's mind show the effectiveness of integrating EBP with the organization (Kiyoshi-Teo et al., 2017, p. 333). Development of similar efforts in other areas of patient safety concern have shown similar benefit in how staff can obtain and use information given to them (Gillespie et al., 2020). Groups of interventions known as bundles (Gillespie et al., 2020) have been shown to benefit large groups of staff nurses by grouping policies and procedures together in a singular model. Regardless of the method, the delivery of EBP and research to nursing staff in means of policy or procedure holds crucial to nursing support in an ever-changing health climate.

In contrast to nursing education, the teaching that patients receive during their hospitalization is equally substantial to the outcome of care, often resulting in either prevention or occurrence of various scenarios or situations. Many factors contribute to the effectiveness of patient education, including matters of compliancy, literacy, and demographics (Duckworth et al., 2019, p. 2). Considerations such as these depend on the execution of nursing staff behaviors, education and teaching capabilities, giving possibility to the fact that these characteristics can affect patient outcomes. As with staff education, structure and content of patient education across many disciplines can correlate and apply to patient safety and fall prevention (Hart et al., 2020, p. 84) when altered to fit the need of discussion.

The Patient and Their Environment

Education and competency also reflect other issues within fall risk management, including environment and patient status (Kiyoshi-Teo et al., 2017, p. 333).

It is necessary for the nurse to consider the patient in relation to their environment for several reasons, but most notably is the relationship the patient's status has on the type of environment appropriate for care (Naseri et al., 2018). Whereas the patient that is oriented to their surroundings may require less attention to detail in certain environments, patients with an altered level of consciousness or impairment need special areas free of clutter or hazard. Though it is worth mentioning that all patients should be cared for or reside in a safe and low-risk environment.

Congruent with steps in the nursing process ("Nursing Process", n.d.), nursing staff need to be diligent in both their assessment findings, and how they translate such to determination and intervention. Factors that enhance fall risk should be identified at the initiation of the patient-nurse relationship (Toney-Butler et al., 2020), and continue throughout the interaction. Issues in environmental risk pose serious threat to how the patient interact with their surroundings (Nazarko, 2012, p. 111), but it is not up to the patient to determine these situations alone. Park and Lee (2016) suggest the mindset of the nurse and patient sharing the same environment. This allows the nurse into the realm of perception and realization that one's actions relate to the outcome of the patient (Park et al., 2016, p. 412). Nurses must also have general understanding of their own personality and characteristics. The influence the practicing nurse has on the care they provide is substantial and shows great relation to their own beliefs (Barradas et al., 2019, p. 3). Both variables correlate marginally to the Synergy Model (American Association of Critical-Care Nurses, n.d.) – if the nurse does not positively influence their practice, the patient cannot function as a member of the relationship.

Manifesting within their environment, the patient's physical and psychosocial status are a necessary factor of determination and inclusion for fall risk. Though the patient's risk of falling and cognition are often associated to the older adult population (Trombetti et al., 2013, p. 867), this is not always the case. Delirium provoked by hospitalization and an unknown environment can occur in any population, resulting in the inability to follow commands or adhere to fall prevention interventions (Francis, 2019). This too increases the patient's risk of falling given the decrease in musculoskeletal function and reduced psychomotor abilities.

In regard to the older adult population, patients over the age of 65 are at the highest risk of falling (Kiyoshi-Teo et al., 2017, p. 332), due their susceptibility to generalized weakness, debility, and often diagnosed comorbidities. This alone is cause for the nurse to favor increased fall prevention, as older patients typically endure longer hospitalizations and associated sequalae (Naseri et al., 2018). Having matters such as these, it is valuable for the nurse to promptly consider factors that breach environmental safety. Along with this, the nurse must understand that issues in environment span well past the physical setting the patient is seen in and include the likes of cognitive and physiological ability. Blending said variables into the nursing process enhances staff ability to identify risk to fall and act accordingly.

Tools for Process and Practice

As with the other steps in the nursing process, the systematic approach to analyzing and identifying barriers to a safe environment is of highest priority to fall prevention. Inclusion of distinct variables relevant to fall risk in this assessment assists nursing staff and leaders to include many aspects of potential hazard specific to the given

setting (“Nursing Process”, n.d.). Implementation of fall risk assessments and tools is a professional standard in this regard and adds to the policies and procedures known to many hospital nursing units. Completion of such assessments and tools assists the nurse in correlating patient status, environment, and other intrinsic factors to fall risk management within the organization (Johnston et al., 2019, p. 43).

At first glance of current literature, many fall risk tools are available that stratify pertinent data for a given organization or environment (Bruce et al., 2017; Castellini et al., 2017; Johnston et al., 2019). While the structure of the assessment process is comprehensive and applicable to almost any given patient scenario or condition, the use of one specific tool versus another is not the key representation of a fall risk assessment tool (FRAT) in practice (Shaw et al., 2020), nor is it intended to compare against one another. Rather so, general understanding of the implementation of a FRAT into the organization is necessary to integrate nursing processes, procedures, and theoretical frameworks into practice.

Coinciding with the determination of environmental risk, FRAT implementation allows the nurse to select appropriate interventions for the specific purpose of caring for a patient. Flowsheets developed within the organization detail potential threats to patient safety across many care settings and can include current policies and procedures (Johnston et al., 2019, p. 45). Moving along in the nursing process, the nurse sequentially selects appropriate interventions for the patient’s plan of care, such as increased monitoring, changes to medication therapies, or display of signage to alert staff of fall risk (Johnston et al., 2019, p. 45). While these tools focus primarily on physiologic conditions, other FRAT methods incorporate both physiologic and psychosocial

considerations to the patient's risk of falling (Popp et al., 2017, p. 2). Though both documents show great reduction in the overall rate of fall occurrence (Johnston et al., 2019, p. 48; Popp et al., 2017, p. 4), the selection of given models relates to many dependent variables and can ultimately pose difficulty in reducing fall risk. Retrospectively, combining assessment and intervention into this process can reduce lack of compliancy from nursing staff by analyzing safety hazards amongst several patient populations, which would require specialization of the patient's plan of care.

Unique to each patient, the plan of care is a singular algorithm designed to include processes spread amongst many disciplines and curate intervention and goal based on assessment and diagnoses. Just as this allows hospital staff to provide individualized care, fall TIPS (tailoring interventions for patient safety) (Duckworth et al., 2019; Fowler et al., 2021) is an extension of the FRAT in that it centers around patient assessment via organizational determinants to arrive to nursing intervention. The major feature that sets the inclusion of TIPS apart from a stand-alone FRAT is that the TIPS plan of care is altered to complement the patient's status more effectively. Doing so allows the nurse to encompass matters of the FRAT, plus barriers external to the organization, such as patient compliancy, family involvement, patient literacy, and motivation to comply with the current plan of care (Duckworth et al., 2019, p. 2). Though the exclusive use of TIPS over FRAT may not prove significant in fall risk and rate reduction alone (Johnston et al., 2019; Fowler et al., 2021), creating a plan of care involving patient attributes did enhance levels of patient satisfaction, understanding and compliancy. Determination of appropriate models for a organizational fall prevention policy will be dependent on facets of that affect the organization, namely the patient population, current practices, and staff.

Extraneous Project Concepts of Fall Prevention in Literature

Given consideration to some of the prime organizational issues of patient safety in the hospital, nurses must remain diligent in their practice to ensure the highest quality care for patients. Promotion of education for staff and patients, securement of a safe environment, and improvements to nursing processes are just three examples of the potential considerations staff, leaders, and stakeholders must face in their efforts to develop fall prevention protocols that remain consistent with evidence-based practices. However, determination for better care is not exclusive to these issues alone. As mentioned previously, the extent to which falls occur is dependent on numerous factors (Bruce et al., 2017, p. 2), which poses the question of what other precursors outside of nursing can increase these risks.

In comparison to negative consequences, many levels of professional development and management strive to better the hospital setting as well. Partnering with nursing professionals, but remaining separate in their duties, members of organizational leadership teams incorporate theoretical frameworks that deliver congruent methods and concepts to healthcare while broadening the spectrum of policy development. Including these individuals as a member of the interdisciplinary team allows nursing professionals opportunity to seek knowledge and balance in policymaking and practice. This is also the same partnership that contributes to the wide variety of issues within fall prevention and safety. Analysis of such external factors is a key part in development of research for healthcare.

Technology in Fall Prevention

The use of technology in healthcare has surpassed the ordinary thoughts of computers and gadgets, truly defining healthcare in a modern era. Implications such as video monitoring (Klymko et al., 2016, p. 329) and other equipment have added benefit and consequence (Timmons et al., 2019, p. 1109), and perceive mixed reviews among those who must follow them. Evolving the organization to include technological devices begins to alter the nursing process in both assessment and intervention functions, and since these devices are often bestowed upon nursing staff against their decision or involvement, hostility and discourse develop amongst staff populations (Timmons et al., 2019; Ozan et al., 2020, p. 904). Facilitating such measures is completely dependent on variability in staff, and it is for this reason that considerations of education, competency and knowledge are so reflective of organizational input (Ozan et al., 2020, p. 905).

However, this is not to say that technology cannot be beneficial to patient care. Collaborative with nursing assessment, these tools have shown to decrease rate or risk of fall overall among studied periods, given their different modalities. Placement of video monitoring in patient rooms has given nursing staff ability to monitor and intervene during times of potential precure to a fall occurrence (Klymko et al., 2016, p. 332; Votruba et al., 2016, p. 187), and has become somewhat of a professional norm within organizations suitable for the addition. Outside of the hospital setting, integrations of healthcare technology have reached patients in a consumer role as well. Production of smartphone applications with the ability to determine one's fall risk at home has shown to lower risk of falling to some degree (Votruba et al., 2019, p. 9). Exposure to such information could potentially carry into the hospital setting on admission in the

competent patient. Furthermore, increases in hospital use of smartphones may provide staff with similar attributes (Healthcare Leadership Review, 2017).

Interdisciplinary Approach to Fall Prevention

No secret exists that hospital functions exist within an ecosystem of many team members. Between nurses, physicians, and therapists alone, the patient quickly builds a team of trained professionals able to tend to their care and healing. This same regard holds true in fall prevention. Enabling members of this team to bind together promotes safety in the hospital by strengthening the knowledge base within the many facets of patient care (Wexler et al., 2011; Rohm et al., 2020). Management of fall prevention in this aspect becomes somewhat contrary to nursing staff, as many healthcare disciplines follow different frameworks to practice. Determining risk of fall and preventative strategies amongst the many specialties in a holistic manner ultimately promotes safe patient outcomes by addressing circumstances of potential hazard (Wexler et al., 2011, p. 132), while holding each team member accountable for their role in patient care.

Creating fall prevention policy in an interdisciplinary approach shows great benefit to patient safety. Valuing other discipline assessments and interventions within the patient's plan of care subjects wider variability in intervention criteria (Rohm et al., 2020, p. 305), but this may have some benefit. Collaboration efforts and comparison of subjective findings within the team creates larger opportunity for specific intervention for the patient, inadvertently managing the development of a care plan similar to TIPS. These team members may not even be a professional that the patient encounters during their hospitalization. As medications have shown to increase fall potential across many populations (Berry et al., 2020, p. 4), pharmacists hold a large responsibility in managing

ordered medications that both outweigh risk of harm and lower the threshold for cross-reactivity (Browne et al., 2014). Dieticians play a comparable role in fall prevention outcomes by ensuring patients follow a diet in which addresses nutritional factors to fall risk and the occurrence of injury (Ahn et al., 2018, p. 216), often a forgotten aspect of fall risk. When included in the decision-making process for patient care development and execution, all members of the interdisciplinary team show great value and responsibility in the promotion of a safe hospital environment and positive patient outcomes. Recommendations to consider these inputs within both nursing processes and research define just how important these members are to fall prevention (Wexler et al., 2011, p. 133; Browne et al., 2014, p. 974; Rohm et al., 2020, p. 306).

Policymaking in Nursing

As an abstract, distant ideology within the nursing profession, policymaking, and advocacy correlate within the realities of nursing humanitarianism ("Advocacy", n.d.). It is this function that has led evolution and validation of the profession within healthcare, and yet nurses and society often times dismiss this role. Some may consider this duty a grand feat, following suit of lawmakers and legislators. However, the role nurses play in policymaking can be as localized as within their unit or organization (Gregg et al., 2018, p. 3). Ultimately, these ethical standards allow the nurse to stand as an advocate for patient safety in many realms. Though the amount of literature surrounding the nurse's role in fall prevention policy is almost non-existent, it is imperative to acknowledge such general publications for the sake of the project at hand.

Support for nursing as a profession tends to bloom when it begins to extend passed the care setting. Though the US healthcare system has accepted nurses as a vital

asset, the drive nurses have to work within their means for change often goes unmatched. Upon review of nursing-based literature, the research supporting involvement of nurses in policymaking is dwindled. In spite of this, several nursing publications raise debate within the professional community. Dr. Beverly L. Malone, RN (1984) raised the question of nursing consideration of policymaking at a time when nursing was beginning the stages of change, accepting the role as an advocate for herself, her peers, and most importantly – her patients. Present day organizations such as *Journal of Community Nursing* (Wood, 2018) and the more recognized *American Journal of Nursing* (Nelson, 2016) discuss similar thoughts of how nurses are dismissed from the likes of physicians and other medical legislators. This has led to campaigns such as *Nursing Now* (2021), a global fight for the equalization of the professional status of nurses in the healthcare industry.

In terms of nursing at the local and organizational level, likewise conditions follow this pattern. Whereas the large-scale discussion focuses on nurses as the primary target, the inclusion of staff when creating hospital policy is the analogical factor that purports the very meaning of nursing fundamentals. Though the influence of nursing is comparable to that of medicine (Benton et al., 2020), the open invitation for staff nurses to join the circle when building such policies goes unsent. Bringing fall prevention and patient safety to the forefront, nursing staff hold great responsibility to ensure that all previously discussed literary matters form together. It is clear that nursing leaders recommend exercising policymaking duties (“Health Policy”, n.d.), but organizational leaders must provide an open means of doing such. For this reason, and the matters of

underrepresentation of staff nurses in the hospital setting, variables of policymaking are essential to fall prevention and nursing.

Literary Value to the Project

Creating better understanding of general fall prevention concepts through nursing research and literature is a critical process in detail for the purpose of this project. Analysis of education and competency give meaning to the construction of the nurse-patient relationship, while dependent variables of environment and nursing processes assist in how that very relationship will blossom. Through the growth the nursing profession, even in recent years, it is no wonder that these matters lie so heavily on establishing a safe patient environment and reducing the risk of falling in the hospital. Momentum of such growth is catalyzed significantly by the secondary functions of the nursing role, especially policymaking and advocacy, while technology brings a steady flow of modernization into healthcare. Partnerships and collaboration with colleagues and other hospital staff solidify the role nurses sustain in their direct care of hospitalized patients. Each of these pieces justify the importance of promoting safe patient care through acts of nursing professionals with the resulting goal being optimal patient outcomes.

Chapter III

Methods and Plan

To connect to the targeted audiences of the study, it is important to structurally emphasize the importance of the topic at hand and understand why these issues necessitate improvement moving forward. Given the prior discussions of falls and their negative outcomes on both patients and nurses, events such as these require both study of prior cases and ideas on preventing the risk of future falls. Despite hospital initiatives, patient falls are a repetitive issue. With this in mind, the primary purpose of the study will focus on needed policy changes for nursing units.

Project Design

The design of the project is centered around a real-time quality improvement study, underlining the qualitative aspect of the nurse's outlook on hospital policy and safety rather than data-driven numbers. Historically, advanced nursing practice has been a gateway for quality improvement within healthcare. This has also given nursing professionals the chance to conceptualize their own practices through several frameworks of theoretical importance (Fawcett, 2017, p. 2). One of these frameworks referenced in many publications is, in fact, the Synergy Model (AACN, n.d.; Fawcett, 2017, p. 309). As the concepts for the Synergy Model focus on both patient and nurse, it is clear that this adaption of the framework is appropriate for this project, as well as quality

improvement initiatives as a whole. In utilizing this, alterations in the application of the Synergy Model's concepts are necessary to guide the study through its course of action, but it is intended to indicate the relevance of the project's concepts within its initial purpose.

Though prior data is used as a reference to the issue prior to adjustments in hospital policies and procedures, this is meant as a designation of the project's relevance to modern nursing. Data collected among nursing staff infers the true connection of quality improvement and advocacy as it relates to nursing processes. This is for the reader to understand the common themes of practice among the studied population and should not deter away from the purpose of the project or its findings.

Sample Population

With the nature of the project, the sample population necessary for the research has some degree of variation in terms of education level, experience, and possibly personal demographics such as age. The reality of the vast difference in the educational level of the bedside nursing staff, experience level, and demographics among the current working population (American Nurses Association, 2022) is a factor. Since both experience, education, and competency (skill level) all have the potential to alter practice and ultimately safety, it is of utmost importance to include this as a variable in the project.

The sample population includes nursing staff members employed in a 20-bed critical care progressive unit of a Midwest regional health system's main campus hospital. The education level and other mentioned variables were designated in the initial stage of the study via survey. Nurses staffing this unit are responsible for the care of

numerous patient populations, including those patients with cardiovascular and respiratory complications. The sample population of nursing staff members hold a responsibility and requirement per their job description to 1) uphold hospital policies and procedures and 2) promote patient safety and reduce fall risk given the implemented hospital policies and procedures. The nursing staff members also receive individual training for promotion of patient safety through system-wide required competency. Though the implemented adjustments to policies and procedures occurred throughout the unit indefinitely per hospital leadership, staff participation in the project and their input is encouraged but not required.

Patients admitted to the unit vary in age from 18 and up and often experience acute issues such as critical care delirium and psychosis. Because these patients are at a significantly higher risk of experiencing a fall (Kiyoshi-Teo et al., 2017), and variables in nursing staff allow for wider input with limited bias, this was the most appropriate unit for the project. Since the project is a quality improvement study designed around nursing as a profession, patient interaction was not necessary for the study and did not hold true relevance in this situation.

Subject Recruitment

Nursing staff recruitment for the project were based on a voluntary willingness to complete the provided surveys and questioning. They were not necessarily required to participate; however, their input is encouraged. Staff members remained completely anonymous during the entirety of the project as disclosing participant identity would neither benefit nor hinder the outcome of the study. Initial staff introduction to the project and it's proposed intention occurred via unit staff meetings. Unit employees are required

to attend these meeting per hospital job requirement. At this point, their conscious decision to partake in the project was completely individualized and consent or declination of the study was not necessary.

No patient identifiers were necessary or warranted within the data or information obtained and was not disclosed to the project committee or participants of the study. Again, the use of unit and hospital statistics is meant to signify the overall change in rate of fall occurrence within the project's timeframe and was not a direct impact on the purpose or outcome of the study. Changes made to hospital policies and procedures through nursing advocacy and their beliefs are the true drive for the quality improvement founded within the project.

Inclusion/Exclusion Criteria

Criteria for participation in the project depended mostly on the staff member's role and job title within the organization. Hallmark assets to the study content depend on the nurse's ability to assess and intervene when appropriate. This is dependent on the job description tied to individuals at both the organizational and legislative level. According to the Missouri Nurse Practice Act, "Practical nursing… [is] not limited to: (b) assessment, nursing diagnosis, nursing care, and counsel of persons who are ill, injured or experiencing alterations in normal health processes" (2019, p. 12). Ultimately, this is a definitive motion to the practicing nurse's scope of practice, underlining who can and cannot perform assessments of the hospitalized patient. In ordinance with this, the organization's *Nursing Mobility Program & Fall Risk Assessment* (Freeman Health System, 2016) dictates that it is the nurse's responsibility to conduct mobility assessments both on admission and at routine intervals per hospital policies and

procedures. It is worth noting, however, that organizational policy states "Once each shift … the Shift Mobility and Fall Assessment will be completed" (Freeman Health System, 2016). Though this assessment does relate to the patient's mobility level, it does not perform a full assessment of the patient's risk of falling as per the *Nurse Re-assessment of Mobility/Fall Risk,* which is a separate nursing assessment.

In acknowledging the nurse's scope of practice and both organizational and state-level nurse practice guidelines, the criteria for participation in the study include:

Inclusion Criteria

(a) an organizationally employed registered nurse (RN) or licensed practical nurse (LPN) licensed within the state of Missouri, where the project will be conducted;

(b) any licensed nursing staff member involved in direct patient care within the targeted unit for the study, and;

(c) any licensed nursing staff member openly willing to participate in the project's preemptive and follow-up surveys anonymously.

Exclusion Criteria

(a) any unlicensed staff member that does not possess the ability to complete patient assessments per Missouri State Board of Nursing's Nurse Practice Act (2016) [i.e., certified nurse's aides, nurse technicians, unlicensed assistive personnel, unit secretaries, or ancillary staff];

(b) any staff member that does not possess the means of implementing suggested safety interventions as outlined by the organization's hospital policies and procedures; and,

(c) any staff member that objectively declines to participate in the survey.

Since the implication of the project is to both improve patient safety while gaining understanding of nursing staff knowledge through practice, the purposed fall risk assessment "flowsheet" was completed once per shift on all patients admitted to the targeted unit. However, any survey content associated with the project was completely optional for all staff members of the unit. Staff that completed initial survey content were strongly encouraged, but not bound to, complete follow-up material at the completion of the project's trial. Inversely, it was asked that staff that did not complete initial surveying to refrain from completing follow up questioning to promote consistency throughout the study.

Since the technical participation of the study involved anonymous submissions, this was not included as exclusion criteria from the study. The integrity of both criteria was protected at two points during the project, 1) during the administration of both project surveys, and 2) as an item of each questionnaire. Lastly, while nurse technicians are outlined in Section B of *Exclusion Criteria*, activity completed by the nurse technician (i.e., nursing interventions) are met within their scope of practice and job description under full jurisdiction of the practicing nurse (RN or LPN). The utilization of the nurse technician's role within patient care was not a direct reflection of the project as the practicing staff nurse is responsible for ensuring implementation of the appropriate intervention.

Protection of Human Subjects

As any appropriate research would, the protection all human subjects is of top concern for the validity of the project, and more importantly, the validity of ethical principles. Participants of the study were to remain completely anonymous during the

entirety of the project's completion and had full capacity to withhold their participation at any time during the study. However, unit staff were expected to continue with fall risk assessment completion once a shift as part of the unit's updated standards of practice during the project's timeline. Those who chose to participate in the study are also encouraged to refrain from mention of survey content within the workplace aside from routine nursing practice in order to prevent bias among staff members. Risk and benefits of study participation will be outlined to staff during informative discussion as part of required unit staff meetings.

Risks

(a) overutilization of nursing assessments can lead to nursing fatigue (i.e., "burnout") due to repetition of patient assessment (Gesner et al., 2019, p. 1195);

(b) underutilization of nursing assessment can contribute to a lack of nursing intervention, thus compromising patient care and safety.

Benefits

(a) participation within the study allows for nursing staff input in policies and procedures that directly affect the practicing nurse's workflow;

(b) defining potential flaws within current practice can positively impact future patient outcomes;

(c) defining potential flaws within current practice can positively impact staff nursing practices;

(d) staff input can directly contribute to improved education and future competencies for nursing staff at the unit and organizational level.

Approval for the project was sought diligently in all respective parties. Initial introduction will be made to the University institutional review board (IRB) for review of project objectives, goals, and methods. Concurrent processed approval was obtained through the purposed organization by way of unit administration and leadership. Initiation of project processes did not begin until suggestive editing occurred, and final approval was made by both parties respectively.

Instruments

Three main instruments were utilized throughout the project:

Initial Survey

The use of the initial survey (see Appendix A) occurred prior to the implementation of the purposed updated nurse mobility and fall policy and procedure. This survey analyzed many of the concepts listed previously, including nursing staff's education and level of practice, their current understanding of hospital policy, and their current beliefs or thoughts toward the currently utilized policy. Items included in the initial survey were provided in a mixed Likert's survey and were administered during the initial project introduction to staff at the required unit staff meeting. Overall results from the initial survey delineated staff member's current positions on hospital policies and procedures in relation to their own practice, as well as their general understanding of the assessment.

Fall Risk Assessment

The fall risk assessment utilized in the study was the exact assessment in practice prior to the study, with the modification of frequency added to once per shift. The content contributing to the generated fall risk includes 1) Mobility and Fall Risk, 2) Other

Contributing Factors, and 3) Equipment. Data entered to the assessment via the staff nurse through the organization's electronic medical record generated a level of the patient's risk for falling: low, moderate, or high risk. Each level of risk was associated with facility guided nursing interventions as specified in the *Nursing Mobility Program and Fall Risk Assessment* (Freeman Health System, 2016). Interventions suggested following the fall risk assessment theoretically impacted the patient's risk for falling until the assessment is completed again, and also impacted the nurse's practice in either a positive or negative manner dependent on their beliefs defined in the initial survey.

Follow-Up Survey

Just as the initial survey measured the participant's baseline understanding and competency of defined objectives for the project, the follow-up survey (see Appendix B) measured the nurse's feelings and competency toward the organization's fall prevention policies and procedures after the implementation of the study's interventions. With similar questions and ideas, the follow-up survey was meant to provide graphical evidence in how using staff input in implementing safety policies can promote a positive patient and nurse experience, and ultimately improve patient outcomes. Staff had the ability to complete the follow-up survey anonymously via submission box located in a designated area of their unit.

Procedure

Following the approval of the purposed project by designated project committee members, the project was prepared for submission to the respective agencies. Project ideas were submitted to both University and organizational bodies via the institutional review board. In preparation for submission to the Pittsburg State University Institutional

Review Board, the project was submitted to the appropriate governing bodies of the organization for review and approval. This included appropriate committees and leadership teams of the study population. Documented hospital approval was used as support for the conduction of research. Once approved at the organizational level, the project was fully submitted for consideration and approval under *exempt* review (Pittsburg State University, 2022).

Project Phases

Upon completion and approval of the project, the initial step of the project began with the *introduction* phase. This was a period over one week that occurred simultaneously with the studied unit's scheduled staff meetings. At the time of meeting, staff were introduced to the project contents in a fashion similar to that of the project's committee proposal. Staff were encouraged to ask questions regarding the study and were given the option to anonymously participate or decline the study. Toward the end of the meeting, staff were provided with the initial survey, and given a submission folder to submit their survey. Data was then collected and formulated into graphical depictions representing population demographics as discussed previously. This allowed the researcher to analyze staff's current beliefs and attitudes toward current fall prevention measures before progressing into the second phase of the study, however this did not alter the intention of the study as proposed before staff introduction. Former unit data pertaining to the rate of patient falls within a given timeframe was also provided for the purpose of comparison of the rate of falls before and after the project.

Once staff had been introduced to the project and initial data had been collected, an alteration in the nursing staff's workflow and documentation occurred, referred to as

the *alteration* phase. This indicated the timeframe at which the hospital's nursing fall risk assessment was change from the current frequency to once per nursing shift (0640 – 1910 and 1840 – 0710, respectively) for each patient admitted to the studied unit. As the function of the fall assessment is to promote patient safety, and patients were not specifically included in fall risk assessment but rather fall risk reduction. This change in the nurse's assessment was expected across all patients admitted to the unit once the study began and was encouraged by nursing leadership. Participants were encouraged to regularly address the frequency of the fall risk assessment, making changes to comply with project objectives. For the sake of the project and to account for staff participation within each participant's scheduled shifts, this occurred for a period of approximately two weeks.

Lastly, participants were re-evaluated in a process similar to the *initial* phase with changes to survey content in the *follow-up* phase. Nurses were asked recurrent demographic questions to compare participation before and after the study, followed by questions about their experience with patient safety and fall prevention during the study. Participants had approximately one week to complete the second survey and submit it to an anonymous submission folder located within the studied unit. Data was then collected in the same manner as before.

Considerations in the Alteration Phase

Several considerations were necessary during the *alteration* phase. Because the study occurred in real-time within a hospital, some changes within the nursing workflow in this phase were inevitable. Throughput of patient admission and discharge is essential to the purpose of the studied unit, and practicality of real-world nursing practice remained

superior to the purpose of the project. Patients who were transferred outside of the unit were no longer under the care of the participating nursing staff, and thus rendered changes to the care planning of that patient unnecessary. In the event the patient was transferred out of the studied unit to another inpatient hospital unit, the assessment should have been changed by the participating nurse to reflect the appropriate hospital policy and procedure for the unit receiving the patient. To contrast this, patients who were transferred from another inpatient unit to the studied unit should have had their fall risk assessment changed by the receiving participating nurse to reflect the studies objective.

Another consideration contributing to potential changes to workflow within the *alteration* phase concerns staff nurses providing care to unit patients outside of the purposed population (ex. a nurse from ICU gets "floated" to work a shift on the studied unit). In this event, they were encouraged to continue the routine fall risk assessment during the *alteration* phase's timeframe. This was to promote continuity of care across all care team members during the project. Because these nurses did not receive instruction prior to the initiation of the study nor had the opportunity to complete the initial survey, their input during the *follow-up* phase was excluded as they are not part of the studied population.

Handling Data

Due to the nature of the study with the fact that participants remained anonymous, and no patient identification or input were necessary, data did not necessarily require confidential status. With the proposed goals of the project and its intent to improve hospital policies, data was not shared or released until final project completion. Data collected during the study was stored securely via password protected file storage

capabilities. Once all data was collected and analyzed, submitted surveys during both the *initial* and *follow-up* survey were destroyed via shredder and disposed of to protect the integrity of the project and it's participants.

Project Variables

In reevaluation of the project goals and objectives, there were several variables at play. Two main concepts highlight the basis of the project: safety and advocacy. The procedure of the study aimed to determine the population's level of advocacy through competency and education, among other factors. This directly affected the level of safety promoted throughout the studied unit by determining how nurses used their knowledge base to implement hospital policy. This was also apparent in the nurse's ability to alter their practice through given policies. In promoting nursing advocacy and otherwise forward participation in practice, nursing staff could evenly distribute their practice through advocacy in a way that affected both their own future practices but also future patient outcomes.

Project Sustainability

It goes without reiteration that a central focus of the nurse's practice revolves around patient safety. As nurses hold several roles within an organization, patient safety remains a top concern for staff and leaders alike. Since the project was meant to detail patient safety through the means of nursing advocacy, considering this project as a sustainable measure of quality and safety supports staff through their journey of patient care. While not every hospital follows a similar procedure for fall risk assessment and reduction, the results of the study could possibly apply to other areas of practice within the hospital. Nurses are meant to be the forefront of patient safety, using both concepts of

advocacy and emotional support to give the best care possible. Using both concepts of safety and advocacy in other functions of the hospital would continue to drive the nursing profession through the new future of nursing.

Chapter IV

Evaluation Results

Overall, the purpose of the study exists in two separate but equal functions: determine attitudes regarding current hospital fall risk policies and procedures and stimulate the minds of staff nurses to consider the advocacy they do in their work. While patient safety is a hallmark outcome sought to achieve through the project, starting with care provided by nursing staff creates a catalyst of safe practice during the patient's hospitalization. Using the contents of the project allowed for participants the opportunity of exposure to secondary elements of the nursing profession outside of bedside care, primarily policymaking. Staff were presented with a brief presentation regarding hospital policies and procedures and fall risk assessment guidelines. These presentations occurred at three separate mandatory unit staff meetings, which allowed for the largest target audience possible accounting for day schedule and night schedule nursing staff. Staff present were not made aware of the presentation topic prior to the meetings.

Prior to beginning each staff meeting, members of the designated sample population were approached as they entered each location, and a brief explanation of the presentation and project were explained. Staff members were then provided with the Initial Survey to complete before and during the presentation. Content presented to the participants, as well as others attending the meeting, included an explanation of current

hospital fall risk assessments, nursing interventions designated by the hospital appropriate for each fall risk category, and the clinical significance of fall risk reduction and prevention. Concluding the presentation, all staff were then instructed on changes that would occur during the two-week period of the study. All nursing staff members were instructed on the alterations that would occur, and education was provided to staff on how to edit the frequency of the hospital fall risk assessment to occur once per nursing shift. Lastly, stipulations of the changes were disclosed as discussed in Chapter 3, including patients transferring in and out of the unit.

Following the presentations, the two-week *alteration phase* began starting the Sunday following the last staff meeting. During this time, staff were occasionally reminded of the assessment frequency changes by nursing leadership in passing. No intentional manipulation of patient documents or records occurred during the *alteration phase,* and patient records were not accessed in part of the project per confidentiality regulations. After two weeks from the presentation had passed, staff members were contacted at large via the unit's specified communication method. Instructions were provided to staff to complete the Follow-Up survey as presented previously. Printed copies of the survey were left in the unit lounge area with a folder to submit surveys anonymously. After one week's time, surveys were collected, and data was analyzed prospectively. Both surveys intended to provide insight and answer at least one of the project questions:

1. Will including nursing staff members in policymaking improve their beliefs and outlook on their role and function as nursing professionals in the organization?

2. Can nursing staff's knowledge and beliefs regarding current hospital policies and procedures affect patient outcomes?

3. Will adjusting current practices to meet patient specific characteristics lead to improved outcomes?

4. Are staff nurses influential in organizational decision-making?

Demographic Data of Subjects

The demographic characteristics of research subjects was aligned directly with the objectives of the nursing role, as it is designated by the Missouri State Board of Nursing's (2019) Statutes and Rules. Each study participant was a licensed registered nurse employed either full time, part time, or as needed on the Transitional Care Unit at Freeman Hospital West in Joplin, MO. Participants were presented with project information as discussed before. Though the project itself was presented to a majority of the unit nursing staff population as a whole (N = 32), this cannot be a direct reflection of demographic data reported as participation in each survey was optional and not required. Both surveys consisted of demographic data regarding current role, experience, and nursing practice, with the Initial Survey garnering more information about the participant's background. Table 1 and 2 delineate the demographic data of each survey.

Participation in each survey varied, with eighteen nurses in the Initial Survey (n_1=18) and eight for the Follow Up Survey (n_2=8). The sample was higher for the Initial Survey, which was presented to staff face-to-face at three separate events, and accounts for the majority of the staff population (n_1=56%; n_2=25%). Both group participants consisted primarily of BSN or higher level educated nursing staff (n_1=72%; n_2=75%), though no participants in the Follow-Up survey held a graduate level nursing degree. Several of the participants in both sample groups held roles in nursing leadership, with most all leaders being staff nursing who were charge nurse

trained. No members of the unit leadership team participated in the Follow Up Survey. Almost all participants had been in practice for at least one year.

Table 2.

Initial Survey Demographics

What is your current title?	**Frequency**	**Percent**
Registered Nurse	18	100%
Licensed Practical Nurse	0	--
Advanced Practice Nurse	0	--
What is your highest nursing degree you currently hold?	**Frequency**	**Percent**
Diploma	0	--
Associate degree	4	22%
Bachelor's of Science in Nursing	13	72%
Graduate Nursing Degree	1	6%
Do you have any certifications beyond your degree?	**Frequency**	**Percent**
Yes	1	6%
No	17	94%
Did you receive your nursing degree from an accredited school?	**Frequency**	**Percent**
Yes	17	94%
No	1	6%
Unsure	0	--
Do you hold a position in nursing leadership?	**Frequency**	**Percent**
Yes, Charge Nurse	5	28%
Yes, Unit Leadership	4	22%
Yes, Other	0	--
No	9	50%
Are you licensed beyond your primary state of practice?	**Frequency**	**Percent**
Yes	3	17%
No	15	83%
Unsure	0	--
How many years of nursing practice experience do you have?	**Frequency**	**Percent**
<1 year	3	17%
1-5 years	9	50%
6-10 years	2	11%
10+ years	4	22%

Table 3.

Follow-Up Survey Demographics

What is your current title?	**Frequency**	**Percent**
Registered Nurse	8	100%
Licensed Practical Nurse	0	--
Advanced Practice Nurse	0	--
What is the highest nursing degree you currently hold?	**Frequency**	**Percent**
Diploma	0	--
Associate degree	2	25%
Bachelor of Science in Nursing	6	75%
Graduate Nursing Degree	0	--
Do you currently hold a position in leadership?	**Frequency**	**Percent**
Yes, Charge Nurse	2	25%
Yes, Unit Leadership	0	--
Yes, Other	0	--
No	6	75%
How many years of nursing practice experience do you have?	**Frequency**	**Percent**
<1	1	12%
1-5	5	63%
6-10	2	25%
10+	0	--
Did you participate in the Initial Survey?	**Frequency**	**Percent**
Yes	8	100%
No	0	--

Project Variables

Three independent variables exist within the research. First, the participant's attitudes and beliefs play a large role in the study on the premise that the surveys themselves were completely voluntary. Those who chose to complete either or both surveys did so willingly through their own knowledge and decision-making skills. More importantly, the presentation provided was a novel piece of the study that presented material to the population of nursing staff. The 5-minute presentation consisted of elements of hospital policies and procedures, while touching on the nurse's role in fall risk assessment and advocacy. This was created with the intention to educate nurses

beyond their current practice, possibly considering what they could do to change hospital policy as well. Frequency adjustment also has a direct impact on the short-term goals of the study. With such a subtle change to a purposeful practice, adjusting the frequency of the fall risk assessment promotes both patient safety and nursing practice for each participant.

Nursing practice was a suggestive facet of the study throughout each phase, consisting of many concepts of practice, experience, and knowledge. Each of these work within the nurse's practice to guide clinical judgement and beliefs. At large, the dependent variable would concern the nurse as a whole, but this is too broad. More specifically, nursing practice remains the short-term variable of influence coinciding with the purpose of the project. Patient safety is a secondary dependent variable however this is a measure related to time and occurrence, both of which span far beyond the projected timeframe. Each of these variables represent the three remaining objectives of each survey: hospital policy, patient falls, and nursing practice. Questions provided under each objective relate to the research questions purposed previously and correlate to the research variables.

Analysis of Research Variables

Participants in the study were asked questions regarding their current knowledge of hospital policy, previous incidence of patient falls in the hospital, and general nursing care. Both surveys completed during the study were used as a measure of change and influence following the team presentation and alteration of current practice. While a pre-test/post-test research approach is the general basis of the study, changes to the secondary

survey items were necessary to determine influence of nursing practice. Comparisons were made and drawn from the data collected to establish a general consensus.

Research Question 1

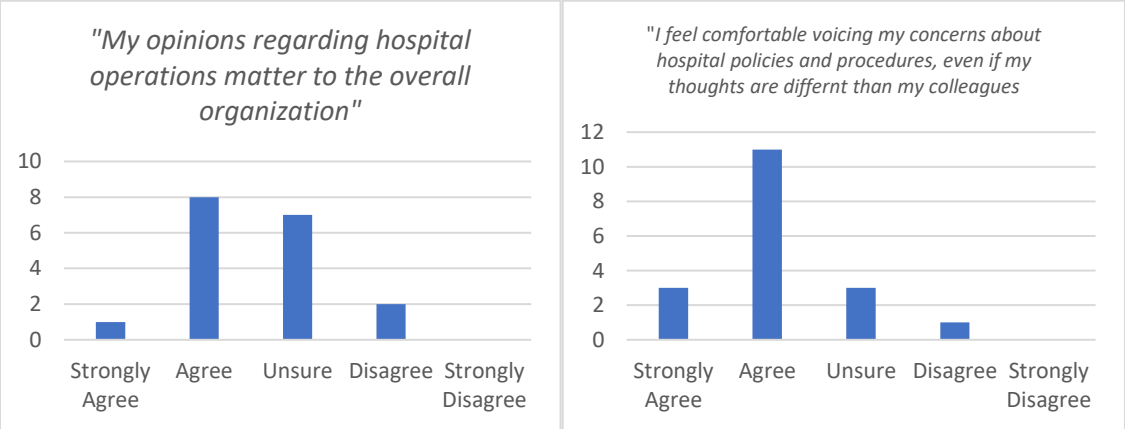
Research Question 1: Will including nursing staff members in policymaking improve their beliefs and outlook on their role and function as nursing professionals in the organization?

Table 4.

Initial Survey – Hospital Policy

Have you previously been involved in any form of hospital nursing advocacy or support groups?	**Frequency**	**Percent**
Yes	7	39%
No	11	61%
In the last 6-12 months, have you wished you had the capability to change or improve the organization's current policies or procedures regarding patient safety?	**Frequency**	**Percent**
Yes	12	67%
No	4	22%
I have been in practice < 6 months	0	--
Unsure	2	11%

Figure 3. *Initial Survey – Hospital Policy Responses*



The initial sample group reported little to no involvement previously with hospital policymaking (n_1=61%). While most felt comfortable voicing their opinion of hospital

policy, half of the participants were unsure or disagreed that their opinion was influential to the organization.

Table 5.

Follow-Up Survey – Hospital Policy

Did you gain interest in any form of hospital nursing advocacy?	**Frequency**	**Percent**
Yes	6	75%
No	2	25%
I'd prefer not to say	0	--
Did you gain interest in the capability to change policies regarding safety?	**Frequency**	**Percent**
Yes	7	86%
No	1	14%
I'd prefer not to say	0	--

Table 6.

Follow-Up Survey – Voicing Opinions

Did you become comfortable voicing your concerns about hospital policies/procedures?	**Frequency**	**Percent**
Yes	8	100%
No	0	--
I'd prefer not to say	0	--

Though a smaller proportion of individuals compared to the total population (N = 32; n_2 = 8), those who chose to participate in the Follow-Up Survey stated that their interest in hospital policymaking had increased since before the study. Additionally, the entire sample group stated they had since become comfortable with voicing their concerns about policies and procedures.

Research Question 2

Research Question 2: Can nursing staff's knowledge and beliefs regarding current hospital policies and procedures affect patient outcomes?

Table 7.

Patient Fall Data

Initial Survey

Have you ever had a patient fall that was directly in your primary care?	**Frequency**	**Percent**
Yes	16	89%
No	2	11%
Were all of the appropriate interventions in place per hospital policies and procedures prior to the fall?	**Frequency**	**Percent**
Yes	9	50%
No	7	39%
I have not had a patient fall	2	11%
Were you offered a chance to debrief regarding the situation?	**Frequency**	**Percent**
Yes	9	50%
No	7	39%
I have not had a patient fall	2	11%
This event changed my perspective of hospital policies and procedures regarding fall prevention	**Frequency**	**Percent**
Strongly Agree	5	28%
Agree	4	22%
Unsure	9	50%
Disagree	0	--
Strongly Disagree	0	--
This event changed my perspective of my own nursing practice	**Frequency**	**Percent**
Strongly Agree	4	22%
Agree	10	56%
Unsure	4	22%
Disagree	0	--
Strongly Disagree	0	--

Follow-Up Survey

Did you have a patient fall?	**Frequency**	**Percent**
Yes	2	25%
No	6	75%
Were all of the appropriate interventions in place per policy?	**Frequency**	**Percent**
Yes	2	25%
No	0	--
I did not have a patient fall	6	75%
Were you offered a chance to debrief?	**Frequency**	**Percent**
Yes	2	25%
No	0	--
I did not have a patient fall	6	75%
Did this event change your perspective of hospital policy?	**Frequency**	**Percent**
Yes	2	25%
No	0	--
I did not have a patient fall	6	75%
Did this event change your perspective of your practice?	**Frequency**	**Percent**
Yes	1	12.5%
No	1	12.5%
I did not have a patient fall	6	75%

In comparison of data collected before and after the study, almost all of the participants in the initial sample group had experienced a patient fall while in their direct care at least once in their nursing career (n_1 = 89%). While 39% of reported patient falls did not have all of the appropriate nursing interventions in place per policies and procedures, the two cases reported after the study did. Regardless of the circumstance, most participants in both sample groups stated that the fall(s) that occurred in the given time frames had impacted both their outlook on hospital policies and procedures, and their nursing practice. Considering the data expressed in Tables 3-5, there does appear to be a similar trend of knowledge in comparison to outcomes.

Research Question 3

Research Question 3: Will adjusting current practices to meet patient specific characteristics lead to improved outcomes?

Table 8.

Initial Survey Data

	"I feel our interventions are appropriate in reducing the patient's risk of falling"	*"Access to resources in reducing the patient's risk of falling is adequate"*	*"The current policy for fall prevention is easily implemented into your workflow"*	*"There has been a time in your employment that you felt the patient's risk for falling should be assessed but was not"*	*"I feel the current policy regarding fall prevention is adequate"*
Strongly Agree	*0 (--)*	*0 (--)*	*0 (--)*	*6 (33%)*	*1 (6%)*
Agree	*7 (39%)*	*6 (33%)*	*14 (78%)*	*7 (39%)*	*2 (11%)*
Unsure	*3 (17%)*	*4 (22%)*	*2 (11%)*	*5 (28%)*	*4 (22%)*
Disagree	*8 (44%)*	*8 (~45%)*	*2 (11%)*	*0 (--)*	*9 (50%)*
Strongly Disagree	*0 (--)*	*0 (--)*	*0 (--)*	*0 (--)*	*2 (11%)*

Table 9.

Follow-Up Survey Data

Did you become familiar with the current policy regarding fall/mobility?	**Frequency**	**Percent**
Yes	8	100%
No	0	--
Did you feel the adjusted frequency contributed to safer outcomes?	**Frequency**	**Percent**
Yes	8	100%
No	0	--
Did you become familiar with nursing interventions for each fall risk tier?	**Frequency**	**Percent**
Yes	8	100%
No	0	--
Do you feel the current fall risk assessment is adequate?	**Frequency**	**Percent**
Yes	3	38%
No	5	62%
Do you feel the adjusted frequency was easily integrated?	**Frequency**	**Percent**
Yes	8	100%
No	0	--
Do you feel the previous frequency was more beneficial?	**Frequency**	**Percent**
Yes	2	25%
No	6	75%
Do you feel the previous frequency was more easily integrated?	**Frequency**	**Percent**
Yes	2	25%
No	6	75%

Adjustments made to the frequency of fall risk assessment were shown to be easily integrated into the participant's workflow (n_2 = 100%). Participants also felt that the adjustments made were more beneficial compared to the current hospital policy. Initial data suggested that participants generally did not find current interventions appropriate (n_1 = 64%), and that resources were limited in reducing fall risk (n_1 = ~67%). Those who chose to participate in the secondary survey stated they became familiar with the hospital's recommended nursing interventions per current policies and procedures.

Research Question 4

Research Question 4: Are staff nurses influential in organizational decision-making?

Table 10.

Initial Survey – Nursing Practice

	Mean	Standard Deviation
"I consider myself a valuable member of my unit and team"	4.06	0.87
"I feel that my practice as a licensed professional has the potential to positively influence patient outcomes"	4.56	0.62
"My practice has been influenced or changed by this organization's policies or procedures […]"	3.78	1.00
"I feel that nursing theory has positively impacted my career and practice"	4.00	0.59

Key: *Strongly Agree* = 5; *Agree* = 4; *Unsure* = 3; *Disagree* = 2; *Strongly Disagree* = 1

Table 11.

Follow-Up Survey – Nursing Practice

"Would you be interested in participating in a committee/group?"	**Frequency**	**Percent**
Yes	7	88%
No	1	12%

Participants of the Initial Survey (n_1 = 18) agreed on average that their practice was influential in one aspect or another. Most also agreed they were a valuable member of their unit and team, and that nursing theory had impacted their practice in one way or another. While participants in the Follow-Up Survey were not asked related questions to their influence in nursing practice and the organization, 88% of responses leaned to interest in participating in a hospital committee or group.

Summary

The purpose of the study was to determine staff inputs and beliefs regarding current hospital policies and procedures for fall risk reduction, as well as encourage nursing staff to consider their own practice within the organization. Given the consideration of long-term goals for reducing patient mortality, it is wise to first invest on the very minds of those who will be responsible for patient care in these areas. Both surveys completed revealed noteworthy information about nursing staff demographics, previous experience with hospital policies and patient falls, and insight to general nursing practice. Nursing staff were largely well educated, aware of hospital policies and procedures, and considerate of actions and limitations pertaining to reducing a patient's risk for falling in the hospital setting. Increased surveillance of just one patient risk assessment during the study period offered staggering evidence supporting frequent patient fall risk assessment. Through data collection and analysis, it was concluded that nursing staff do have an influence on both patient safety and organizational function. Offering nurses the voice and channel to speak, listen, and grow together can positively impact a large health organization as much as it can individual nursing practices.

Chapter V

Discussion

The focus of the study was to determine nursing staff's beliefs, knowledge, and attitudes toward hospital policy specific to fall risk reduction. Subsequently, the presentation and surveys presented in the study were used in a way to stimulate the nurse to consider their current practice and promote professional and patient advocacy. Background demographics were measured in both sample populations to establish past and current trends of organizational involvement while defining staff's education and training. Once the appropriate means of research approval were obtained, participants were presented with information regarding the organization's current fall risk assessment policy, suggesting a two-week period of increased fall risk assessment and surveillance. The total population was then given the voluntary option of participating anonymously in the Initial Survey and Follow-Up survey at their respected time intervals.

Relationships of Project Questions to Research

At a broad level, the premise of the study revolved around nursing advocacy and patient safety. With respect to patient safety, the incidence of patient falls was used as an example due to the devastating effects these events can have on patient outcomes and the organization. As falls account for a significant amount of injury in the in-patient setting (LeLaurin & Shorr, 2019, p. 273), it is very relevant to consider this a cause for concern

to nursing practice. Given the purpose of the study and the succeeding data that followed, it can be concluded that the objective was met. Staff nurses proved to be an influential force in policymaking, patient safety, and professional practice. While not all participants of the study showed similar interest in extracurricular involvement in organizational committees, the positive trend seen in the data is sufficient in suggesting such issues can be affected by nurses.

Four specific questions were purposed at the beginning of the study. Each question objectified a similar context pertaining to the purpose and aim of the project and study. The produced project questions were associated in some form to previous nursing research. While not every question related to the direct action of policymaking within the hospital setting, the true intention was to captivate a general message to the participant. The goal was to address one of the following:

1. Will including nursing staff members in policymaking improve their beliefs and outlook on their role and function as nursing professionals in the organization?
2. Can nursing staff's knowledge and beliefs regarding current hospital policies and procedures affect patient outcomes?
3. Will adjusting current practices to meet patient specific characteristics lead to improved outcomes?
4. Are staff nurses influential in organizational decision-making?

Nursing Policymaking and Improved Beliefs Regarding Role

Through the review of previous research studies, it is unclear whether nursing staff member's beliefs and attitudes toward hospital policy directly impact their role in an

organization. While others have attempted to address this matter through other nursing practice issues like technology (Benton et al., 2020; Sinha & Joy, 2022), hospital policy has not been a direct body of observation in previous literature. These studies also formulate definitive results based on single surveys or data review, disregarding any notion of change or influence based on education and knowledge. Other published literature and research do discuss nursing involvement in policymaking (Cao et al., 2018, Davis, 2020), however these talks are attributed more or less to the implications nurses hold on the policies, not their specific beliefs or thoughts toward the topic. Though technical differences exist in previous research to the project, generalized conclusions would suggest similar findings at a broad level.

The modified pretest/posttest model for the project allowed for a measurability of change and comparison, given the structure of possible sample variation between the two surveys. Initial data from the first sample population implied a limited number of nursing staff members had any previous involvement in policymaking to begin with. Several members from the initial sample also stated they wished they had an outlet to change hospital policy. This is matched with further data that suggest a mostly positive culture among the staff's unit. Most initial sample participants (78%) stated they felt comfortable voicing their opinions regardless of difference from colleagues. The data obtained from the Follow-Up survey described a positive trend in staff's interest in policymaking following the *alteration* period, with 86% of second sample participants having some interest in hospital advocacy and policymaking.

Data collected from both surveys did suggest a likeable change in the attitudes and beliefs of participant's practice following the study. Unfortunately, the difference

from 18 participants in the Initial Survey to 8 in the Follow-Up Survey contributes to concentrated responses seen as a general theme throughout the discussion of data. It is assumed that those who completed the second survey had completed the first as well per the definitive guidelines in the Follow-Up Survey (Appendix B). Since both surveys were an optional task and completed anonymously, those who participated in the second sample population are a solid representation of the changes that occurred following the study.

Nursing Staff's Beliefs and Patient Outcomes

Data obtained through the surveys compared the participant's previous experience with patient falls in the hospital to any possible incidence of fall during the *alteration* phase. Almost all (89%) of the first sample participants had experienced a patient fall in their care at least once in their career. Though only half of those who had patients fall previously stated all appropriate fall risk reduction interventions were in place per policy, there was a general consensus that the patient falling had impacted the nurse's beliefs on either hospital policies or their own practice. In comparison, only two participants in the Follow-Up Survey stated they had a patient fall during the *alteration* phase of the study. These participants were not questioned regarding the number of patients they had fall during the study but given the fact that the *alteration* phase was a two-week period this incidence would presumably be low. Official statistics were not collected from the organization for analysis, though this could have been beneficial to an extent.

Considering the phrasing within the questionnaire, it is uncertain whether or not the impact of the patient falls in the first sample had a positive or negative effect on the nurse. With the high incidence of patient falls resulting in injury (LeLaurin & Shorr,

2019), any ethically inclined healthcare provider would suggest that this would be a negative outcome of nursing care. Most participants reported some general understanding regarding the current fall risk reduction policy, however a quantitative depth of knowledge cannot be deduced from the given data due to survey content and timing of the project. It may not be feasible to decide the degree that beliefs have on outcomes, but with the weight of experience changing the mindset of so many nurses on top of increased surveillance of fall risk, there is a relationship in the two variables.

Adjusting Practices to Improve Outcomes

In regard to patient outcomes and the data collected, it is difficult to interpret the immediate effects of the study due to the longevity that is necessary to measure these instances in. A two-week phase may be appropriate in measuring nursing staff changes, but in order to see a reduction in fall occurrence, several weeks to months would be necessary. Because of these limitations, potential outcomes were measured through the participant's current understanding and thoughts. Seeing as each patient has a variation in their risk for potential fall, it is also appropriate to consider specific characteristics of patient scenarios when analyzing trends in outcomes.

Participants were surveyed regarding their current thoughts on hospital policies and procedures for fall prevention. Five Likert-style questions were integrated into the Initial Survey which defined staff's thoughts on the hospital's fall risk assessment tool, available resources, and the general premise of the fall prevention policy. 44% of first sample participants suggested that current interventions were not appropriate in reducing the patient's fall risk, related closely to the 50% of responses stating the current policy

was not adequate. When asked on their thoughts about the changes made to the fall risk assessment frequency, responses were generally positive.

72% of participants responded that there had been at least one occurrence where they felt that a patient's fall risk assessment should have been completed but was not. This was an interesting finding, considering the ability for the primary nurse to complete the patient's fall risk assessment on an "as-needed" basis per hospital policy.

In evaluating the effectiveness of the study on the thoughts of participants, the survey items were adjusted and paraphrased into "yes/no" questions as opposed to Likert items. This was done with the purpose of condensing survey content as to not deter the participant from completing the survey. Though it was not anticipated there would be lower participation in the Follow-Up Survey, paraphrasing these items allowed for more concise data analysis.

Second sample participants were asked about their thoughts on both previous hospital policy and changes made for the study. Overall, the alteration of fall risk assessment was well received as 100% of second sample participants stated the increased fall risk assessment interval was easily integrated into their workflow. This was of concern prior to the study as the added required assessment could have contributed to documentation fatigue and burn-out. All 100% of second sample participants also felt that this change had led to safer patient outcomes. Participants generally became more knowledgeable about the policy of discussion and the interventions that lay within it. 62% of participants did say they felt the previous policy to still be inadequate. Compared to data obtained in the first survey, these results do propose an adequate turn toward improved knowledge and patient outcomes.

Nursing Staff Influence in Organizational Decision-Making

Describing nursing influence on an organization is very complex and exhibits many layers. The degree of impact that a staff of nurses has on the central functions of an organization is a very broad concept, relying heavily on resource access and availability. If nurses do not have the means of voicing their opinions about hospital policy to organizational executives, how will they get their word across? Inversely, if nurses are not willing or capable of the initiative, there may not be much ground to stand on for advocacy. Recommendations have long encouraged nursing inclusion in the continuation of health system procedures (Benton et al., 2020; Davis, 2020; Irving, 2014), however this is not always an achieved goal. The relationship that nurses have with their organization is multifocal and dependent on the climate, culture, and politics of the system itself.

Though data analysis, it was determined that most participants themselves felt that their practice was influential within the organization, to some extent. On average, most agreed that they could positively influence patient outcomes, though it is uncertain whether the organization has had any impact on the nurses practice. A strong sense of culture and inclusivity was suggested through the data as well. Participants felt they were a valuable member to the team on their unit. Given the fact that 78% of participants in the initial sample population stated they were comfortable with voicing their opinions regarding policy and procedure, it is assumed those who would choose to do so could state their concerns freely.

The conclusive analysis as to whether nursing staff felt they had influence in the organization was generally encouraging. With respect to the population's demographic

data, a marginal percentage of the participants held a BSN or graduate level degree. Aligning with standard curriculum and scholarship associated with this training, nursing staff have some experience in nursing leadership and theory prior to their employment. In fact, most participants agreed that nursing theory had positively influenced their career and practice. Nurses who have this amount of training, knowledge, and education would be expected to use this to their advantage. Although there is no numerical value as to *how* influential nurses are, data suggests that nurses hold a valuable power within the organization. Nursing staff inclusion and integration into organizational decision-making has the potential to tremendously impact both patient and systematic outcomes.

Observations

Several observations throughout the study saw the varying topics addressed, including nursing advocacy, policymaking, and patient safety. Nurses were generally well experienced with at least one year of career experience, which contributed to the higher amount of pro-advocacy participants. The two-week *alteration* period at which the fall risk assessment tool was completed once per shift saw a limited number of patient falls, though the number of reported falls in the unit prior to the study was not reported for comparison. The change to increased assessments of fall risk was well-received across the participants of both sample groups. Since this change was limited to one singular portion of the nursing process, a more in-depth focus on the specific fall risk assessment tool may have yielded different results. Also, the use of two different surveys during the study may have proved redundant to the participants, although items and structure were created differently to account for potential change.

The implementation of fall risk measures is a large variable to the study retrospectively. Both participants that reported falls in the Follow-Up Survey claimed that appropriate fall risk interventions were in place at the time of the incident. Participants were not questioned regarding use of interventions to deter fall risk during the *alteration* phase, nor their increased utilization for those patients that did not fall. Participants did feel that access to resources for fall risk reduction was limited in the Initial Survey, which may have negatively impacted this statistic.

Negative outcomes like falls have long-lasting negative consequences on nursing professionals, as shown through data. Participants in both sample groups had very little experience in hospital leadership, committees, or policymaking before the study. Several factors impacted this, including experience in practice and education. Presumably, those who had begun their nursing career during or following the COVID-19 pandemic may have seen little involvement in hospital organization management due to the rapidly changing environment during that timeframe.

Overall, the outcomes of the survey were reassuring on many parts. Nursing professionals hold a large responsibility, personally and professionally. Having the capability to influence and adjust the policies around them contributes to a clearly outlined healthcare environment. Themes of teamwork, support, and comradery within the unit elevate the staff's professional potential, increasing the likelihood of advocacy participation. The study also showed the application of nursing evidence-based guidelines for fall risk reduction and prevention can lead to improved patient outcomes in the hospital setting.

Evaluation of Conceptual Frameworks

The context and results of the study supported both Nightingale's Environment Theory and the American Association of Critical Care Nurse's Synergy Model for Patient Care. In evaluation of the specific purpose of the study, a detailed objective was to determine characteristics and qualities of both the organization and areas where patient care occurred. Applications of both theories to the study assisted to answer at least one of the research questions.

Nightingale's Environmental Theory

Concepts of environment were a pivotal piece to the construction of the study. Florence Nightingale believed that pure, holistic nursing care could not occur if the patient was not provided care in a safe, clean environment (Wasaya et al., 2021). Interventional care provided safe and quality care during the study through the use of the nursing process and the associated tasks used to reduce the patient's risk of falling. While the interventions themselves were not studied, it is important to note that the fall risk assessment tool helped to determine which interventions would be necessary to achieve safe practices. Incorporation of the Environmental Theory to nursing practice has been shown to sustain quality patient outcomes several times over (Wasaya et al., 2021). Furthermore, understanding the environment of the organization gave nursing staff the ability to establish the inhibitions and aspects that govern their practice in the environment. This promoted an environment where nursing staff were able to involve themselves in the decision-making process and policymaking that make up the very practices they believe in. Since a safe and stable environment is a mainstay of modern

nursing practice, it seems appropriate to utilize Nightingale's concepts and thoughts in this sort of manner.

AACN Synergy Model of Patient Care

Use of the Synergy Model also yielded supportive results. The application of nursing knowledge and competency was instrumental to the use of frequent evaluation of the patient's risk of falling. This supports the ideology that nursing education is a realistic, valuable piece to the overall function of patient care. Nursing staff encouter many relationships and connections, particularly with patients, the interdisciplinary team, and the organization. Even though the Synergy Model only delves directly into the nurse-patient relationship, this is dependable in the other aspects of the nurse's role within the organization. Implementing these concepts into the policymaking role could ensure equally as impressive outcomes to the nursing profession.

Evaluation of Logic Model

Both study surveys and changes made to policies and procedures were supported through the use of the logic model detailed in Chapter 1. The logic model used for the structure of the study highlighted safety as a pertinent matter in process and outcome. Safety in terms of patient care was a relative concept given the purpose of identifying barriers to nursing policymaking. Including policies as an input to this process inevitably called for change in practice and procedure as the study progressed. Factors such as staffing ratios and equipment are often referenced in evidenced-based practice literature as a means of potential fall risk to patients. While participants were surveyed regarding their access to resources necessary for fall prevention, this was not notable as a direct result of the study. Several constraints were purposed such as experience and ability to

adapt to change. These did not prove to be as much of a barrier as concerned, given the general demographic of the sample groups.

Significant detail to the logic model used points toward the outcomes listed. While fall occurrence could easily be measured during the course of the study, it is difficult to determine whether nursing staff are/would be included in the organizational decision-making process as these decisions were not made during the study's timeline. Nurses do, however, hold the capability of making practice decisions based on critical thinking and competency. This was related to the staff's conscious decision to alter the frequency of fall risk assessment during the study period. The results of the study do suggest that nursing involvement in policymaking could potentially lead to safer patient outcomes and organizational procedures, which supports the logic model. The long-term outcomes of the model are also difficult to conclude given the timeframe of the study, however this would most like occur in a similar fashion.

Study Limitations

As important as the study is to nursing practice and patient safety, limitation to the project exist a manner that potentially limit the significance of the study. Firstly, the time period that the study occurred in was limited to two weeks. Had the project occurred over a longer time period, more participants may have had the ability to complete surveys. Studies measuring incidence is also dependent on time. A two-week period for fall rate analysis not typical, considering most studies and literature measure fall rates by month-to-month.

Participation in the study was also limited to some extent. The capability of accessing the largest number of nursing staff members was best achieved at a mandatory

meeting. However, given situations leading to absence to the meeting, it is possible that not all staff members attended the meetings the presentation and Initial Survey occurred at. Specific measurements of fall risk would have quantified evidence of improved assessment through the use of patient chart reviews. Staff members were encouraged to alter the frequency of the fall risk assessment on their own given the methods and plan for the project. Had the assessment not been updated properly for the study, it is possible that the fall risk assessment may have not been completed as requested. This could have been lessened by having the fall risk assessment frequency automatically populate for the correct interval in the organization's electronic medical record with help from the information technology department. Due to the scope and practicality of the study, this was not a feasible accomplishment.

Both surveys administered in the study were given on an anonymous, voluntary basis. This was to support the diversity and culture of nursing practice. Just as the surveys determined participation in policymaking, involvement in any entity beyond the nurse's job description of employment is generally on a voluntary basis. The items of the surveys were stated with the nurse's time in mind, especially since the Initial Survey was completed during a meeting. Each survey was given in a modified pretest/posttest format to measure change across the study. Survey questions were asked in a manner that depicted the qualitative evidence surrounding the research questions, not necessarily the data and statistics they obtain. Arrangement of survey questions in a manner that derived specific project concepts and outcomes may have generated different results. This is also true for the structure of the questions in terms of statistical analysis.

Implications for Future Research

Advancements in nursing education, leadership, and practice were central dynamics in the creation of the project. Understanding that nursing practice falls far beyond society's thoughts behind what a nurse does in their daily work generates the very foundation the nursing profession is built on. Elemental aspects of policymaking, advocacy work, and professional support are also important to consider in the longevity of the project. The study and project were formed with the initial concern for patient safety and frequent fall occurrence within an organization. As the project progressed, nursing involvement in policymaking became a true backbone for the formative processes in the research. It is also important to note that the project occurred during and following the COVID-19 pandemic, a time when nurses were both herald as heroes and criticized for their political, ethical, and moral principles.

Given the background and purpose for the study, it's structure and meaning are truly easily replicable in many different areas. Involving nursing staff in organizational policymaking is supported through research and practice (Benton et al., 2020). To do so, it would be imperative to first figure the demographic, beliefs, and experience of the organization's staff much like what was completed in the study. Measurements of an organization's quality indicators are necessary to consider areas of policy and procedure that may potentially benefit from improvement or nursing involvement. Topics of nursing practice regarding patient falls, central venous catheter access use and indwelling Foley catheter use have become popular discussions due to their risk for negative patient outcomes. Organizations typically institute policies for these and other patient care tasks/procedures to regulate safe nursing practice. As modern nursing progresses, these

policies will likely require adaptation to support safe, quality patient care. Application of research in a matter similar to the project could potentially benefit patients, nurses, and health organizations.

Studies with larger sample groups may potentially offer greater insight to nursing staff and their willingness to participant within the organization. Staff found in larger urban areas often including nurses with large backgrounds and levels of experience, which could offer more precise insight to nursing policy. These organizations are also known to have many committees and groups for nurses to participate in which directly influence organizational operations. Changing survey questions and formatting to better suit the intended population group would be appropriate given the purpose of future research. The addition of patient chart audits and monitoring of nursing interventions would allow an organization to evaluate fall risk assessment tool suitability while adjusting exact interventions appropriate for a given patient population or hospital.

Implications for Practice, Policy, and Education

As determined through the study and results, there is a direct relationship between nursing policymaking and safe, quality patient care. Using support from evidence-based guidelines and previous research, the project is an implicit guide to improving the nursing profession through practice, policy, and education. Incorporating nursing staff in an organization through a policymaking role can positively change patient outcomes, particularly considering those creating the policies are also the ones providing care to the patients. Nonstop education and leadership for nursing students, graduate nurses, and low experienced licensed professionals can also achieve the mindful stimulation necessary to promote the nursing role in an organizational setting.

For fall risk assessment specifically, it is imperative that nurses constantly monitor the patient for changes that increase their fall risk. Shown through the study, this is likely achieved through completing an evidence-based fall risk assessment tool at least once per nursing shift. Considering nursing education and competency as a valuable token in nursing processes, along with appropriate surveillance, has been shown to produce a safe environment for patient care. Assembling these measures across the interdisciplinary team to include nurses of all practices, physicians, and ancillary staff may also permit comparable results.

Conclusion

To conclude, the purpose of the study was to establish an understanding of nursing staff's thoughts and beliefs about hospital policies and procedures while creating improvements to fall risk prevention. Patient falls are a devastating event in the hospital setting, costing patients their safety, an organization their money, and nurses their practice. The presentation of current hospital policies and procedures to a sample nursing population gave nurses some insight to the expectations bestowed on them, while collecting information about nursing background, thoughts, and experience outlined potential for practice improvement. Following a two-week period of increased assessment of patient fall risk, nursing staff were surveyed again regarding both past experience and current experience with the policy change. Though an extra step in the already busy workflow of a hectic unit, the change in increased assessment of fall risk was met with positive review. The low incidence of fall occurrence in a two-week period was encouraging for improved patient outcomes. Subsequently, study participants became intrigued with the idea of policymaking and advocacy at the organizational level,

supporting research and evidence-based practice encouraging nursing participation in decision-making. To support the profession of nursing, nurses should work diligently to fulfil each aspect of practice in their role. Functional advocacy at the professional level provides support to fellow nurses across the world, and policymaking at an organizational level can be just as monumental as legislative measures. In doing so, nurses can work as a team with other health professionals to achieve the goal of safe patient care and outcomes while upholding the power and presence they have become known for throughout the history of healthcare.

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Appendix

Appendix A

Initial Survey

Directions: Please circle your response to each question. Participation in the survey is completely optional and *your responses and submission will remain completely anonymous.* **Participation and/or withdrawal from this survey will not result in risk for loss of employment or punishment.**

Demographics

1. What is your current title?

    Registered nurse

    Licensed practical nurse

2. What is the highest nursing degree you currently hold?

    Diploma (Practical Nursing)

    Associate Degree in Nursing (ADN)

    Bachelor of Science in Nursing (BSN)

    Graduate Nursing Degree (MSN, DNP, PhD, etc).

3. Do you have any certifications beyond your degree? (Ex. CCRN, CEN, CNE, etc)

    Yes No

4. Did you receive your nursing degree from an accredited school?

    Yes No Unsure

5. Do you current hold a position in nursing leadership? (Ex. charge nurse, director)

    Yes, Charge Nurse

    Yes, Unit Leadership

    Yes, Other

    No

6. Are you licensed in a state beyond your primary state of practice? (*Not* including the Nursing Licensure Compact [NLC])

    Yes No Unsure

7. How many years of nursing practice (practicing with a nursing license) experience do you have?

    < 1 year 1-5 years 6-10 years 10+ years

Hospital Policy

1. Have you previously been involved in any form of hospital nursing advocacy or support groups? (Unit-Based Councils, Shared Governance, etc).

Yes No

2. In the last 6-12 months, have you wished you had the capability to change or improve the organization's current policies or procedures *regarding patient safety*?

Yes No I have been in practice < 6 months Unsure

3. In the last 6 months, have you initiated any form of contact with unit leadership or hospital administration (in-person meetings, phone calls, emails) regarding concerns for current policies or procedures *regarding patient safety*?

Yes No I'd prefer not to say

4. During your hospital and/or unit orientation, did you receive information regarding accessing the organization's hospital policies and procedures catalog?

Yes No Unsure

5. In the last 30 days, have you searched the Intranet and/or hospital policies and procedures catalog for information *regarding patient safety*?

Yes No

6. My opinions regarding hospital operations matter to the overall organization *regarding hospital policy*.

Strongly Agree Agree Unsure Disagree Strongly Disagree

7. I feel comfortable voicing my concerns about hospital policies and procedures, even if my thoughts are different than my colleagues.

Strongly Agree Agree Unsure Disagree Strongly Disagree

Patient Falls

1. Have you ever had a patient fall that was directly within your primary care?

Yes No

1a. <u>If you answered Yes to #1</u>, were all of the appropriate interventions in place *per hospital policies and procedures* prior to the fall?

Yes No I have never had a patient fall

1b. If you answered Yes to #1, were you offered a chance to debrief regarding the situation?

Yes No I have never had a patient fall

1c. If you answered Yes to #1, this event changed my perspective of the hospital policies and procedures *regarding fall prevention.*

Strongly Agree Agree Unsure Disagree Strongly Disagree

1d. If you answered Yes to #1, this event changed my perspective of my own nursing practice.

Strongly Agree Agree Unsure Disagree Strongly Disagree

2. Are you familiar or aware of the organization's current hospital policy regarding nursing mobility and fall prevention?

Yes No

3. I feel that the current policy regarding fall prevention is adequate.

Strongly Agree Agree Unsure Disagree Strongly Disagree

4. Are you familiar with the nursing interventions correlating to the current policy regarding fall prevention as it pertains to each tier of fall risk (Green/Yellow/Red or "The Stoplight")?

Yes No

5. I feel that our interventions are appropriate in reducing the patient's risk of falling.

Strongly Agree Agree Unsure Disagree Strongly Disagree

6. Access to resources in reducing the patient's risk of falling is adequate.

Strongly Agree Agree Unsure Disagree Strongly Disagree

7. The current policy for fall prevention easily implemented into your workflow.

Strongly Agree Agree Unsure Disagree Strongly Disagree

8. There has been a time in your employment within the organization that you felt a patient's fall risk assessment should be performed, but it was not.

Strongly Agree Agree Unsure Disagree Strongly Disagree

9. Are you aware of the intervals at which the nursing mobility and fall risk assessment should be performed per hospital policies and procedures?

Yes No

10. Have you ever provided patients and/or families with education and materials useful in preventing their risk of falling during their hospitalization?

Yes No

Nursing Practice

1. I consider myself a valued member of my unit and team.

Strongly Agree Agree Unsure Disagree Strongly Disagree

2. I feel that my practice as a licensed professional has the potential to positively influence patient outcomes.

Strongly Agree Agree Unsure Disagree Strongly Disagree

3. My practice has been influenced or changed by *this* organization's policies or procedures since the conception of my nursing career.

Strongly Agree Agree Unsure Disagree Strongly Disagree

4. Would you be interested in participating in an organizational committee or group that influenced hospital policies and procedures if you were able to voice your opinions or concerns without repercussion?

Yes No

5. Are you aware of the concept of nursing theory?

Yes No

6. I feel that nursing theory has positively impacted my career and practice.

Strongly Agree Agree Unsure Disagree Strongly Disagree

7. In an average shift, do you feel that your documentation is adequate to support your nursing practice?

Yes No

8. I would be comfortable defending my nursing practice in a civil law case.

Strongly Agree Agree Unsure Disagree Strongly Disagree

9. Have you ever had to defend your nursing practice in a civil law case?

Yes No

Appendix B

Promoting Safety Through Advocacy and Practice

Follow-Up Survey

Directions: Please circle your response to each question. Participation in the survey is completely optional and *your responses and submission will remain completely anonymous.* **Participation and/or withdrawal from this survey will not result in risk for loss of employment or punishment.**

Demographics

1. What is your current title?

    Registered nurse

    Licensed practical nurse

2. What is the highest nursing degree you currently hold?

    Diploma (Practical Nursing)

    Associate Degree in Nursing (ADN)

    Bachelor of Science in Nursing (BSN)

    Graduate Nursing Degree (MSN, DNP, PhD, etc).

3. Do you current hold a position in nursing leadership? (Ex. charge nurse, director)

    Yes, Charge Nurse

    Yes, Unit Leadership

    Yes, Other

    No

4. How many years of nursing practice (practicing with a nursing license) experience do you have?

    < 1 year 1-5 years 6-10 years > 10 years

5. Did you participate in the Initial Survey provided at a scheduled team meeting?

    Yes No

If you answered No to #5, please do not continue with the survey.

Hospital Policy

1. Following the Initial Survey and study, did you gain interest in any form of hospital nursing advocacy or support group?

Yes No I'd rather not say

2. Following the Initial Survey and study, did you gain interest in the capability to change or improve the organization's current hospital policies and procedures *regarding patient safety?*

Yes No I'd rather not say

3. Following the Initial Survey and study, did you initiate any form of contact with unit leadership or hospital administration (in-person meetings, phone calls, emails) regarding concerns for current policies or procedures *regarding patient safety*?

Yes No I'd rather not say

4. Following the Initial Survey and study, did you search the Intranet and/or hospital policies and procedures catalog for information *regarding patient safety?*

Yes No I'd rather not say

5. Following the Initial Survey and study, did you become comfortable voicing your concerns about hospital policies and procedures, even if your thoughts are different than your colleagues?

Yes No I'd rather not say

Patient Falls

1. Following the Initial Survey and study, did you have a patient fall that was directly in your primary care?

Yes No

1a. <u>If you answered Yes to #1</u>, were all of the appropriate interventions in place *per hospital policies and procedures* prior to the fall?

Yes No I did not have a patient fall

1b. If you answered Yes to #1, were you offered a chance to debrief regarding the situation?

Yes No I did not have a patient fall

1c. If you answered Yes to #1, did this event change your perspective of the hospital policies and procedures *regarding fall prevention?*

Yes No I did not have a patient fall

1d. If you answered Yes to #1, did this event change your perspective of your own nursing practice?

Yes No I did not have a patient fall

2. Following the Initial Survey and study, did you become familiar with the current hospital policy regarding nursing mobility and fall prevention?

   Yes No

3. Following the Initial Survey and study, did you become familiar with the nursing interventions correlating to the current policy regarding fall prevention as it pertains to each tier of fall risk (Green/Yellow/Red or "The Stoplight")?

   Yes No

4. Following the Initial Survey and study, do you feel that the adjusted frequency of the nursing fall risk assessment flowsheet contributed to safer patient outcomes?

   Yes No

5. Following the Initial Survey and study, do you feel that the current nursing fall risk assessment tool is adequate in determining the patient's risk of falling?

   Yes No

6. Following the Initial Survey and study, do you feel the adjusted frequency of the nursing fall risk assessment flowsheet was easily integrated into your workflow?

   Yes No

7. Following the Initial Survey and study, did you provided patients and/or families with education and materials useful in preventing their risk of falling during their hospitalization?

   Yes No

8. Following the Initial Survey and study, do you feel that the previous frequency of the nursing fall risk assessment flowsheet was more beneficial in promoting safe patient outcomes?

   Yes No

9. Following the Initial Survey and study, do you feel that the previous frequency of the nursing fall risk assessment flowsheet was more easily integrated into your workflow?

   Yes No

Nursing Practice

1. Following the Initial Survey and study, in an average shift, do you feel that your documentation is adequate to support your nursing practice?

   Yes No

2. Following the Initial Survey and study, would you be interested in participating in an organizational committee or group that influenced hospital policies and procedures if you were able to voice your opinions or concerns without repercussion?

   Yes No