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Kristin Smith  
kesmith96@yahoo.com

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Fall Prevention Through Proactive Toileting and Patient Education

Kristin Smith

University of San Francisco

Fall 2014

## Fall Prevention Through Proactive Toileting and Patient Education

### **Abstract**

This paper will summarize the quality improvement falls prevention project conducted by a University of San Francisco Clinical Nurse Leader student. Falls in the hospital setting are an ongoing problem in our healthcare system as they have great physical and financial impacts (Salamon, Victory, & Bobay, 2012). Hospital A, an urban teaching hospital, uses the Schmid scale for determining if a patient is a fall risk which includes the assessment of need for ambulatory aids, history of falls, and impaired cognition among other criteria (Schmid,1990). Fall rates are climbing in the United States and the trend is similar on Hospital A's hematology-oncology and BMT unit hereby referred to as Unit B. Because of the impact on patient safety, a falls prevention project performance improvement project was implemented. An assessment of Unit B's needs, diagnosis of Unit B's presenting problem, and the intervention implemented will be discussed followed by an evaluation with further recommendations. The implementation process and design of this paper follow the theory of change theories of Kurt Lewin and Ronald Lippitt (see Appendix A; Mitchell, 2013).

### Assessment

According to the CDC, falls have increased by 2.8% from 2001 to 2005 (CDC, 2006). Many patients cannot ambulate independently, have cognitive impairments, and are determined a fall risk. Hospital A uses the Schmid Fall scale which assesses the above mentioned risk factors. According to policy on Unit B, if a patient is at or above a score of 3 on the Schmid scale or if their platelet count is below 50, they are deemed a fall risk (Schmid, 1990). A yellow wristband is placed on the patient and fall precautions are ordered. Fischer et al., (2005) found that patients with a diagnosis of cancer are more likely to fall and sustain injury than those patients without cancer. In this study, 42.6% of patients who fell were on the oncology unit, followed by 27.1% patients in neurology and orthopedics unit (Fischer et al., 2005).

A fall event during an inpatient stay may increase the length of stay (LOS) an average of 6.3 days (Wong et al., 2011) at an average cost of \$10,000-\$15,000 per inpatient day with possible additional days in the ICU at \$25,000 per day (Hospital A's financial statement, 2013). Furthermore, insurance companies do not reimburse for any treatment after a fall, resulting in the hospital absorbing the cost because the hospital is liable for the fall. According to Hospital A's budget statement, there was a rise in uncompensated care from \$160,045,000 in 2012 to \$205,943,000 in 2013 which is a 28.7% increase, a notable financial impact. Additionally, Currie (2006) found that nationally, falls cost between \$16 billion and \$19 billion for nonfatal, fall-related injuries and approximately \$170 million dollars for fall-related deaths based on data from 2000.

A micro system assessment of the unit was conducted utilizing observational, qualitative, and quantitative data. Nurse and patient satisfaction surveys (see Appendix B), an audit of falls occurring from June 2013 to July 2014, as well as a processes overview were evaluated (see

Appendix C) to better understand the impact of the problem. Patients were highly satisfied with their hospital care with 57% (n=14) rating their experience as excellent, 29% rated it very good, while 14% rated their stay as “good”. Not one patient reported their stay was fair or poor. With regards to the process of fall prevention and education, the processes overview revealed that 83% (n=12) viewed that the fall prevention process was a “real problem” 17% reported it to be a “small problem.” Seventy five percent also reported that patient and family education retention was limited. Additional patient and nurse fall prevention and education surveys (see Appendix D and E) were conducted to further the understanding of the intervention required.

The fall prevention and education patient and nurse surveys highlighted the disconnect between what the nurses were teaching and what patients were retaining. A difference in nurses’ beliefs and patients’ beliefs of effective interventions were surfaced in the survey. For example, 50% (n=26) of patients reported that the use of the bed alarm would not make them more likely to call for assistance with needs. This is in contrast to the 86% (n=29) of nurses who thought that the use of the bed alarm would make the patient either somewhat or definitely more likely to call for assistance. In addition, according to the fall audits of 2013, 32% of patients fell on their way to and from or while using the bathroom/commode. This emphasizes the importance for adequate toileting. On Unit B, nearly all patients have continuous IV fluids infusing, typically three or more solutions at a time. This increases the need for urinary frequency and urgency, yet 29% (n=34) of patients who fell were not adequately prompted for toileting. However, this number may be skewed because many nurses often perform tasks and forget to chart them due to lack of time. Yet, nearly 45% (n=29) of nurses reported that they had an inadequate amount of time during their shift to complete all daily tasks including initiating fall precautions on patients who are identified as fall risks.

Lack of staffing and time became a noticeable trend in the nurse survey. In reviewing the open ended questions for nurses as to what they thought would be most helpful in preventing future falls, 59% indicated the need for additional staffing in the form of either a patient care assistant (PCA), a PCA solely for toileting, or another break nurse as well as a PCA. Other fall prevention programs have been studied with variable success. Stern & Jayasekara (2009) conducted systematic review of randomized control trials. The interventions studied include patient education, target risk factor reduction, and targeted multifactorial interventions. Of these, patient education was shown to significantly reduce falls by 50%. Patient education, targeted risk factor reduction plan and two multidisciplinary multifactorial programs were effective. As discussed previously, a significant risk factor on Unit B is ambulation to and from the bathroom without assistance which could be targeted.

Another study was conducted in a similar setting to Unit B by Bakarich, McMillan, & Prosser in 1997. Although this study is over 16 years old, the significance was most relevant and the design could be easily replicated. In a 450 bed metropolitan teaching hospital, a nurse proactively toileted patients who were identified as a fall risk every two hours. There was a decrease of 53% of falls during shifts which the risk assessment (falls risk) and intervention took place. In a more recent study conducted by Wong et al., (2013) increased urinary frequency and mobility difficulties were established as increased risk factors for falls. The majority of falls that occurred were related to toileting and not requesting assistance. The intervention used a gait assessment, patient education, and more frequent proactive toileting. Falls decreased by 22% and falls with injury decreased by 37%.

### **Planning**

Because the significant risk factor of ambulation to and from the bathroom has been identified and previous studies show that proactive toileting decreases patient falls, a proactive toileting regimen conducted by a PCA would be studied. The literature review and patient surveys also indicate the need for patient education so a patient education portion describing risk factors and consequences of falls would be woven into the toileting regimen. Lewin (1951) stated that driving and restraining forces need to be identified and addressed in order to make and sustain change in a group setting. The driving forces toward this change include the desire for change from nurses, the support from management and the falls team on Unit B, and the perseverance of the author. The restraining forces associated with the performance improvement project are cost and time. However, extensive time was easily made available by the author due to her passion for increasing patient safety. Therefore, only the costs must be addressed before implementing the change.

### **Cost Analysis**

In a cost benefit analysis, the annual cost of one PCA is \$ 58,176. Four PCAs would need to be hired to staff the unit on each day and evening shift. This total cost would be \$232,702. Although the benefits of the decrease in falls would be immeasurable as life is invaluable, simply using the cost of the previous 11 falls will suffice. Eleven patients have fallen which according to Wong et al., (2011) would increase the length of stay an average of 6.3 days. At an average cost of \$12,500 per day (average of \$10,000-\$15,000), the previous falls have cost Unit B \$866,250. The cost savings would be at least \$633,540 annually. This is a modest but fair estimate using data already recorded. This cost benefit analysis does not take into account the counsel cost of malpractice lawsuits that may result from patient falls.

## **Design**

The author met with the falls committee and subsequently the unit manager to discuss the pilot project. The nurses were informed by the unit manager via email of the pilot study. To reinforce proper planning and implementation, the unit clerk and the charge nurse who were scheduled were contacted the day before the pilot. The purpose, design, and limitations of the proactive toileting pilot were discussed. For example, it was made clear that the priority for this role was to proactively toilet. The author would not be able to assist with any other duties unless all patients had been prompted to toilet that hour. Only at that time would assistance in short-term activities be available. For example, retrieving food trays, refilling water and assistance changing linens would be offered but no tasks that would deter from the priority would be considered. Longer tasks, such as a full bed bath, would not be done by the author during the pilot because this process may take more than ten minutes and would interfere with proactive toileting. No long-term tasks would be started unless completion could be almost certain in less than 5 minutes.

In order to conduct the one-day pilot study, a tool was created to record data in real time (See Appendix F). Additionally, a patient education script was created to highlight the risk factors of falls specific to oncology patients as well as unique consequences for patients on Unit B. Due to the numerous groups of people involved in the already existing falls prevention program and complexity of the project, a timeline was created to ensure completion and time allotted for project outcomes evaluation (see Appendix G).

## **Implementation**

The purpose of the pilot study was to see if it was feasible for one staff, a PCA, to proactively toilet each patient on the unit every two hours. During the course of the one day



pilot study, emphasis was placed on patient safety and satisfaction with educational delivery. Utilizing the proactive toileting tool, the author received the names of patients who required toileting every hour from the charge nurse. These patients were recorded on the top of the tool and bolded to ensure hourly toileting. The rest of the patients were recorded on the tool below the bolded patient names to implicate toilet prompting was only required every two hours. The patients requiring hourly toileting were immediately prompted to toilet after all other names were recorded.

The author explained the purpose of the proactive toileting process to patients as a means to increase patient safety citing an increase in incidence of patient falls on Unit B. The use of the yellow wristband and emphasis on using the call light was explained as an added safety measure. The author used the phrase “I’m here to assist you to the toilet. Let’s try.” Patients were not asked if they needed assistance to the toilet because this is a close ended question and eliminates a period available for discussion. If the patient refused, an “R” was recorded along with the time. If the patient was assisted to the bathroom but did not void, an “A” was marked on the tool along with the time to indicate “assisted.” If the patient voided, the output was recorded in milliliters in the electronic charting as well as on the tool next to the time.

For the patient education piece, an assessment of the patients education needs was conducted. If the patient needed education or reinforcement of previous education, an explanation of risk factors for oncology patients was given. Additionally, statistics of falls and related fall injuries was explained. The author described the purpose of looking at the white board which displays the patient’s daily blood counts in the patient rooms. The importance of platelets and white blood cells were discussed and each patient’s values were compared to

normal values. If the patient had a platelet count below 150, the risk for bleeding was addressed emphasizing the serious complications associated with a fall including seizure, stroke, or death.

### **Evaluation**

Because the long term effects of a decrease in patient falls would only be readily assessed after a period of several months, data was collected during the pilot study to determine if the intervention was feasible. From 0700 to 1000, the hourly patients were prompted hourly and others were prompted every two hours. After 1000, each patient was able to be prompted for toileting at least every hour. In addition to toileting, call lights and bed alarms were occasionally answered as time allowed.

Other data collected were informal interviews of nurses and patients. Nurses reported that the acuity of the unit on that day was particularly high which usually corresponds to more patient call lights. However, nurses reported a decrease in patient call lights. Nurses felt that the needs of their patients were met in a timelier manner than on days without a staffed PCA. Additionally, nurses stated that they felt their patients were safer as the patients had more direct supervision throughout the day.

Patient response to the intervention was overwhelmingly positive. Many patients thanked the author for clarification regarding the use of the yellow wristband. Patients were able to verbalize understanding as to why increased safety measures were taken due to the explanation of risk factors. Patients were receptive to the education regarding platelets and the risk for bleeding. Most patients were receptive to using the call light for assistance and many thought the proactively toileting was a good intervention. There were some outliers who did not appreciate the assistance offered. These patients made statements depicting their lack of

understanding of their risk factors. These were notable barriers to patient education that will be discussed in the recommendation section.

The projected outcome of a PCA continuing this intervention is that Unit B will have 33 falls by the end of June 2015. This will be a decrease in 21 of the projected 54 falls by the end of the fiscal year, a 39% decrease. Due to the overwhelmingly positive results of the pilot study, data collected, and staff recommendations, the intervention is in the implementation phase and has been adapted on Unit B. The tool used by the student was shared with the unit manager to be distributed to the PCA conducting the role.

### **Recommendations**

Because of the barriers assessed during the implementation portion of the project, an educational tool for patients is being constructed by the author and falls team on Unit B. This tool would be interactive and allow the patient to self identify risk factors outlined by Capone et al., (2012). These include medications, abnormal gait, the use of blood products and other applicable risk factors for this population. The goal is to have the tool completed and implemented by January 1<sup>st</sup> 2015.

Additionally, in order to sustain the change, the author will continue work on the unit with the falls team until the semester is complete. During this time, the interactive tool will be distributed and explained to physicians, physical therapists, and other team members on Unit B in order to increase their awareness and gain their support. The author will continue to meet with the hospital falls committee to share information and data collected during the continued implementation phase. The interactive tool will be presented as a measure to also decrease patient falls and incorporate the patients in their own treatment plan.

### **Conclusion**

From the inception of this project and first meeting with the manager on Unit B, it was clear that there falls were a huge problem. Figuring out what changes to make and how to implement them became the challenge. Interviewing nurses and physicians was originally intimidating but once an aligned passion for patient safety was established with nurses, confidence followed. Learning to take the first step and reach out to people proved to be of vital importance for this project. The author was fortunate to have a supportive falls prevention team already assembled on Unit B to address this problem. This project incited multiple literature reviews and a realization that the process of learning never ends, even once a project is complete. There is always room for improvement, processes to fix, and patient advocacy. This author found herself being filled with an endless desire for evidence based research. This formed a solid base for the author's future role as a Clinical Nurse Leader.

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## Appendix A

## Nursing Process aligned with Lippit's and Lewin's Change Theories

Table A1

<b>Nursing Process Elements</b>	<b>Lewin's Theory</b>	<b>Lippit's Theory</b>
Assessment	Lewin's unfreezing stage (Examine status quo, increase driving forces for change)	1. Diagnose the problem 2. Assess motivation/capacity for change 3. Assess change agent's motivation and resources
Planning	Lewin's moving stage (Take action, make changes, involve people)	4. Select progressive change object 5. Choose appropriate role of the change agent
Implementation	Lewin's refreezing stage (Make changes permanent, establish new way of things, Reward desired outcomes)	6. Maintain change
Evaluation		7. Terminate the helping relationship

(Mitchell, 2013)

Appendix B  
Initial Patient Survey

Date: \_\_\_\_\_

Think about this hospital stay.

1. How often did nurses listen carefully to you?

- Always       Usually       Sometimes       Never

2. How often did doctors listen carefully to you?

- Always       Usually       Sometimes       Never

3. How often was the area around your room quiet at night?

- Always       Usually       Sometimes       Never

4. How often was your pain well controlled?

- Always       Usually       Sometimes       Never

5. Did doctors, nurses or other hospital staff talk with you about whether you would have the help needed when you left the hospital?

- Yes       No

6. How would you rate your overall hospital experience?

- Excellent       Very Good       Good       Fair       Poor

7. Would you recommend this hospital to your friends and family?

- Definitely Yes       Probably Yes       Probably No       Definitely No

8. What would make this Inpatient Unit better for you?



## Appendix C

Processes	Works Well	Small Problem	Real Problem	Totally Broken	Cannot Rate	We're Working On It	Source of Patient Complaint
Admission	12				1		
Routine Care	12						
Transfer from Inpatient	7	5					
Discharge	2	10					
Medication Administration	11	1					
Pain Management	9	3					
Monitoring Confusion	1	5	6				
At Risk for Falls		2	10			1	
At Risk for Decubitus	7	5					
Answering call Lights (phone)	8	4					
Answering call lights (phys.)	5	4	3			1	1
Communicating with Families	9	3					
Answering Phones	9	3					
Housekeeping	7	5					
Family Education (retention)	4	8					
Skid socks (keeping on)	9	3			I		
Fall Risk Assessment throughout stay	1	3	8		I	I	
Bed Alarms		4	8		I		

## Appendix D

## Patient Fall Education Survey

Room number: \_\_\_\_\_

Patient Initials: \_\_\_\_\_

1. Please specify your age: \_\_\_\_\_
2. Please specify your gender: \_\_\_\_\_
3. Have you ever fallen before, either at home or in the hospital?
  - a. Yes
  - b. No
4. On admission, how often do nurses assess your history of past falls?
  - a. Always
  - b. Sometimes
  - c. Never
5. Would you consider yourself at risk for a fall?
  - a. Yes
  - b. No
6. How confident are you with your mobility?
  - a. Very confident
  - b. Somewhat confident
  - c. Not confident
  - d. My confidence varies throughout the day
7. Have you noticed any times of day that you are less confident with your mobility? (select all that apply)
  - a. Early morning (2am-6am)
  - b. Morning (7am-11am)
  - c. Afternoon (12pm-4pm)
  - d. Early evening (5pm-9pm)
  - e. Night (10pm-1am)
8. Are there any specific medications that you feel effect your mobility and balance and/or make you more like to fall? (Select all apply)
  - a. Pain medication (oxycodone, diaudid, norco, etc.)
  - b. Sedatives (Ativan, Ambien, etc.)
  - c. Diuretics (Lasix, Bumex, etc.)
  - d. Blood Pressure Medication (Amlodipine, Metropolol, Diltiazem, etc.)
  - e. Other: \_\_\_\_\_
9. What barriers prevent you from calling for assistance to get out bed? (select all that apply)
  - a. Fear of loss of independence
  - b. Not wanting to be bothersome
  - c. I feel capable that I can get up on my own
  - d. Forgetfulness
  - e. Unable to reach the call light
  - f. Having to urinate frequently/quickly

- g. No barriers, I call for assistance every time
- h. Other (please specify): \_\_\_\_\_

**10. Do you feel like “fall precautions” have a negative connotation?**

- a. Yes
- b. No
- c. If you answered yes, please elaborate: \_\_\_\_\_

**11. Please describe some fall precautions used on Unit B**

**12. Are you opposed to the use of the bed alarm?**

- a. No (please specify why): \_\_\_\_\_
- b. Yes (please specify why): \_\_\_\_\_

**13. Does the use of the bed alarm make you more likely to call for assistance to get out of bed?**

- a. Yes
- b. No

**14. What could the staff do better to promote your safety from falls?**

**15. Have you received fall education on Unit B?**

- a. Yes
- b. No

**16. If so, when was the education given**

- a. On admission
- b. At discharge
- c. Throughout inpatient stay
- d. Whenever a new nurse is taking care of me

**17. How satisfied are you with the fall education given?**

- a. Very satisfied
- b. Somewhat satisfied
- c. Not satisfied
- d. N/A –never received fall education on Unit B

**18. Would you be interested in more information about fall risks and prevention strategies?**

- a. Yes
- b. No

**19. What safety information would you like to learn more about? (select all that apply)**

- a. Your risk for injury
- b. Why you are at risk for falling
- c. Consequence of falling
- d. The statistics of how many people fall
- e. None

**20. How do you learn best?**

- a. Visually
- b. Verbally
- c. A combination of both
- d. Repeating back information

Appendix E

Nurse Fall Prevention and Education Survey

**Fall Education**

**1. When do you provide fall education to patients on Unit B? (select all that apply)**

- Upon Admission
- When they are identified as a fall risk
- At the beginning of each shift
- Throughout patient stay
- Do not usually provide education
- When there is a change in their condition

**2. What educational tools do you use to provide fall risk education? (select all that apply)**

- Educational handouts
- Care plans in Epic
- Verbal explanation
- Refer to bleeding and infection risks (Risk for Injury)
- "Your Health Matters" - Preventing Injury From Falls
- We need more educational resources on Unit B

**Assessment**

**3. Please list what assessment criteria you use to evaluate a patient's risk for falls?**

**Fall Precautions**

**4. What precautions or interventions do you initiate when you identify a patient as a fall risk? (please list at least three)**

#1

#2

#3

#4

#5

**Barriers****5. What are your biggest barriers to implementing fall precautions? (select all that apply)**

- Patient resistance
- Family resistance
- Lack of time during shift
- Multiple patients on fall precautions
- Patient has a sitter
- Uncomfortable with educational tools
- Other (please specify)

**6. Do you feel the use of the bed alarms makes your patient more likely to use the call light?**

- Yes, Definitely
- Somewhat
- No

**7. What are some of the biggest barriers you encounter to placing a patient on a bed alarm? (select all that apply)**

- Patient resistance
- Lack of time to answer bed alarms during shift
- Forgetfulness
- Multiple patients on bed alarms
- Patient has family assisting with patient care
- Too many false alarms
- I don't use the bed alarms
- Other (please specify)

**Toileting Patients and Call Lights****8. On average, how often are you able to toilet your patients?**

- < Every Hour
- Every Hour
- Every 2 Hours
- Every 3 Hours

> Every 3 Hours

**9. What is your average response time to patient call lights?**

<30 secs

1 min

2 min

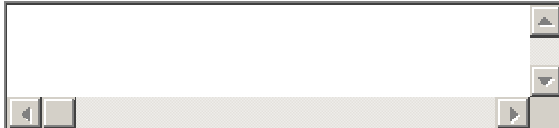
3 min

>5, I usually need help from other staff

**Recommendations**

Here is where we need your input!

**10. What could we do as a unit to reduce the incidence of falls on Unit B?**



Appendix F

Toilet Prompting Tracking Sheet

SIDE 1

Room #	Name	0700	0800	0900	1000	1100	1200	1300	1400	1500	1600	1700

*SIDE 2*

*This is a very important task. This task has been approved by management and charge nurses. The goal of this task is to help prevent falls. You must complete all toileting before assisting with any other task. If you are asked to assist with other tasks, you must prompt every patient to toilet before assisting with other tasks (bed baths, changing linens, etc.). You can show this sheet to the person asking for assistance.*

*Instructions:*

- 1. Obtain the list of patients from the charge nurse of the patients who need to be toileted EVERY HOUR.*
- 2. Write down these names and room numbers in the top boxes.*
- 3. Begin toileting these patients at 0700.*
- 4. Write down the names and room number of all other patients below the list of patients who require toileting EVERY HOUR.*
- 5. The other patients must be prompted to toilet at least every 2 hours.*
- 6. Prompt each patient by saying, "I'm here to assist you to the toilet/commode. Let's try." Do not ask "Do you need to use the restroom?"*
- 7. Record, on this sheet, if the patient did not need assistance to the toilet (R) and write down the time in the box. Example: R 1035*
- 8. If the patient required assistance to the toilet or commode, record the time and output on this sheet and in Epic. Example: 945=150ml*
- 9. If you find that the patient has a Foley catheter, you may cross them off the list. Draw a line through the patient and room number.*



Appendix G  
Falls Prevention Project Timeline

## August

- Microsystem Assessment
- Nurse Interviews
- Patient Interviews
- Unit B Falls Team meetings
- Literature Review
- Communication Board

## September

- Secondary Nurse Interviews
- Secondary Patient Interviews
- 2013-2014 Falls Audit
- Additional Literature Review (if needed)
- Wrote Project Prospectus

## October

- Met with Hospital Falls Committee
- Presented research to team and manager
- Designed Intervention
- Proactive Toileting implementation
- Gathered post intervention Data

## November

- Additions to intervention
- Literature Review
- Design of Educational Tool
- Project Summary

## December

- Final Poster Session
- Continue work on Educational Tool
- Continue Proactive toileting (as time allows)