Unit Safety Coaches: The Link to Ensuring Our Patient’s and Staff’s Well Being

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Nursing Clinical System Coordinator

Our Mission
To serve through healing, education and discovery

Wisdom for Your Life.
Objectives

1. Discuss effective ways to maximize patient safety efforts through the use of Unit Safety Coaches (USC).

2. Evaluate usefulness of USC for addressing safety concerns and sharing ways to successfully decrease harm.
Background

• The Institute of Medicine landmark reports
  – *To Err is Human: Building a Safer Health System* (1999)
highlighted the need to improve patient safety and quality, as well as, the work environment for nurses.
Initial State

- Patients trust us with their safety
- Patient injury and/or death
- Staff injury and illness related to job
- Duty to ensure patient and staff safety
- Perception of safety
Future State

• Develop a Unit Safety Coach Program
  – Representative on each unit
  – Responsible for leading safety initiatives
  – Advocate for patient and staff safety
  – Collaborate with other units
Program Development

• The initial idea for Unit Safety Coaches was generated from the 2010 Magnet Conference.

• In March 2011, a Quality Council Unit Safety Coach Task Force was formed to develop the UTMC model
USC Task Force

• Direct Care Nurses
  – Medical Critical Care
  – Surgical Critical Care
  – Trauma/Neuro
  – Hemodialysis
• Nurse Manager
• Advanced Practice Nurse
• Nursing Clinical System Coordinator
Task Force Activities

- Literature review
- Proposed USC model
- Input from outside sources
- Developed training
- Input from inside sources
Internal Experts

• Patient Safety
  – Patient Safety Coordinator
  – Infection Prevention Coordinator
  – Medication Safety Coordinator

• Staff Safety
  – Director of Environmental Health & Safety
Personal Characteristics

• Quality and Safety Council member
• Admired by peers
• Strong communication skills
• Personal commitment to good outcomes
Unit Safety Coach Role

- Advocate for a culture of safety for patients and staff on unit
- Act as resource and role model on unit for safety issues
- Promote open communication and awareness of patient and staff safety policies and issues
USC Responsibilities

- Disseminate safety information
- Conduct unit safety evaluations
- Lead unit based efforts for preventing patient and staff harm
- Participate in Readiness and Environment of Care Rounds
Unit Safety Coach Training

Program Overview
• Benefits
• Goals
• USC role
• Responsibilities
• Culture of safety

Patient Safety
• Patient identification
• Critical results
• Communication
• Nurse review of orders
• Medication safety
• Infusion pump safety
• Hand hygiene
• Isolation practices
Unit Safety Coach Training

Staff Safety
- Fire safety
- Sharps safety
- Hazard reporting
- Safe patient handling
- Personal protective equipment
- Workplace violence

Communication
- Non-verbal
- Challenges
- Barriers
- Tools
- Tips for effective communication
- Advocacy
- Assertion versus aggression
Resources Used

• AHRQ TeamStepps

• Centers for Disease Control (CDC): 2002 Guidelines for Hand Hygiene in Health Care Settings

• CDC: 2007 Guideline for Isolation Precautions – Preventing Transmission of Infectious Agents in Healthcare Settings
Resources Used

- Duke Infection Control Outreach Network
- The Joint Commission Standards
- National Institute for Occupational Safety and Health (NIOSH)
October 2011
– USC model approved

December 2011
– Information about program disseminated
  – Initial USC training

January 2012
– Council name change
  – USC program implemented
Our Process

• Monthly USC projects are developed by Standards Compliance Subcommittee of Quality and Safety Council.

• Focus on a specific patient or staff safety topic each month
• Topic specific training and needed materials are provided at Quality and Safety Council meeting and by email

• Common issues and unit based solutions are shared at Quality Council

• Results of the project and any barriers identified are discussed at next meeting
January and February

Restraint Reduction
• Staff education – alternatives to restraint
• Intervention – refurbished Restraint Busy Boxes (contains diversion activities)

Fall Prevention
• Staff education – use of gait belts
• Intervention – demonstrated use of gait belts to staff
March and April

**Transfusion Safety**

- Staff education – safe blood administration
- Intervention – observed and audited blood administration on the unit

**Fire Safety**

- Staff education – what to do in case of fire on unit
- Intervention – observed for items parked in front of pull stations, fire extinguishers, electrical panels and doors propped open
May and June

Fall Prevention

• Staff education – use of new chair alarms
• Intervention – conducted staff survey and observed chair alarm use on unit

USC Bulletin Boards

• Staff education – purpose of USC program and contact person for unit
• Intervention – created bulletin board on their unit about USC program
Our Mission
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USC Bulletin Boards
July and August

Hallway Egress

• Staff education – elimination of hallway clutter; fire alarms, O₂ shutoff valves, electrical panels
• Intervention – observed equipment storage; taped floor as visual cues if problems identified

Hand Hygiene

• Staff education – hand hygiene
• Intervention – interactive demonstration at huddles with glitter; follow-up hand hygiene rounds with glow lotion and black light
September and October

Infusion Pumps

• Staff education – use of appropriate SMART pump drug library; timely removal of pump from patient room when no longer needed
• Intervention – audited drug library use and # of unused infusion pumps in patient rooms

Consents

• Staff education – requirements for consents
• Intervention – audited required elements on consents
November and December

Meal Documentation
• Intervention – opportunity identified on tracers; USC audit of meal documentation.
• Staff education – follow-up education with individual nurses when meals not documented.

Glucometer Scanning Variances
• Staff education – scanning process
• Intervention – observe and evaluate scanning process on unit
Overall Goals of Program

- Decrease patient and staff injuries
- Improve patient outcomes for nursing sensitive indicators
- Improve the culture of safety within the organization
- Improve compliance with regulatory standards
Benefits of USC Program

- Teamwork and trust between coworkers
- Open communication
- Professional growth
- Increased patient and staff safety
Percent patients restrained is approaching NDNQI Academic Medical Centers mean

Restraint Reduction

Percent Patients with Physical Restraints

<table>
<thead>
<tr>
<th>Quarter</th>
<th>UTMC</th>
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<tbody>
<tr>
<td>3Q10</td>
<td>19.76</td>
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<tr>
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<tr>
<td>1Q11</td>
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<tr>
<td>2Q11</td>
<td>13.84</td>
</tr>
<tr>
<td>3Q11</td>
<td>9.13</td>
</tr>
<tr>
<td>4Q11</td>
<td>11.64</td>
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<td>1Q12</td>
<td>9.14</td>
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<tr>
<td>2Q12</td>
<td>6.05</td>
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Patient Falls

Patient Falls Per 1000 Patient Days

Patient fall rate has been below NDNQI Academic Medical Centers mean for last 6 quarters

<table>
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<tr>
<th>Quarter</th>
<th>3Q10</th>
<th>4Q10</th>
<th>1Q11</th>
<th>2Q11</th>
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<th>4Q11</th>
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<tbody>
<tr>
<td>UTMC</td>
<td>3.64</td>
<td>4.46</td>
<td>3.15</td>
<td>2.75</td>
<td>2.23</td>
<td>2.17</td>
<td>2.35</td>
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All variances were related to comparison of appropriate label on bag to transfusion slip
A Culture of Safety

- Establishing a culture of safety has been a priority.

- Our Unit Safety Coach Program is helping to improve our culture of safety and ensure our patient’s and staff’s well being.
Overall Patient Safety Grade = Excellent

<table>
<thead>
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<th>Year</th>
<th>UTMC</th>
<th>National</th>
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<tbody>
<tr>
<td>2011</td>
<td>29%</td>
<td>29%</td>
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<tr>
<td>2012</td>
<td>34%</td>
<td>30%</td>
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AHRQ Safety Survey

Overall Perceptions of Safety

<table>
<thead>
<tr>
<th></th>
<th>2011</th>
<th>2012</th>
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</thead>
<tbody>
<tr>
<td>UTMC</td>
<td>63%</td>
<td>67%</td>
</tr>
<tr>
<td>State</td>
<td>68%</td>
<td>67%</td>
</tr>
<tr>
<td>National</td>
<td>66%</td>
<td>66%</td>
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Improvement in Composite Scores

- 10 of 12 composites improved with 2 remaining the same

Comparison to National Average

- 2011: 4 were above; 7 were below; 1 was equal
- 2012: 11 were above; 1 was equal
Implications for Nursing

Through the efforts of the Unit Safety Coach:

• Issues can be addressed and changes made before harm occurs.

• The proactive approach provides for better outcomes.

• Patients and staff are safer.
Questions?