

PURPOSE

Purpose:

- Using a focused approach, the purpose is to improve NDNQI fall outcomes on a medical telemetry and medical / surgical telemetry nursing unit (7 North and 7 South).
- Secondary outcomes include “hardwiring” the use of huddles and the nursing care of intentional rounds, improving patient satisfaction, nursing satisfaction and culture of safety.

SIGNIFICANCE

- Fall rates were higher than comparative NDNQI data.
- Evidence-based literature supported hourly rounding, but with staffing below the 25th percentile, it was difficult to accomplish.
- On a daily basis during huddles, they intentionally looked at details about cause of falls and barriers to preventing falls.

FACILITY PROFILE & FAST FACTS

- Founded by Sisters of Mercy in 1893.
- Total Licensed Beds = 802 on 3 campuses
- NDNQI Data Comparison Group = 400-499 Beds
- Total 7 North and 7 South Beds = 78
- More than 7000 employees, 950 physicians and allied health professionals.
- Total nurses approximately 1200.
- 7 North and 7 South = 90 nurses and 30 patient care technicians
- FY12 total admissions = 36,829
- FY12 telemetry visits = 4,111
- FY12 emergency visits = 73,898
- FY12 surgical procedures = 20,569
- Areas of excellence: cancer, heart and vascular, diabetes, endocrinology, emergency medicine, medical imaging, birthing services, brain and spine services, orthopedics, rehabilitation, pediatrics, weight loss and nutrition services and various outpatient services.



STRATEGY AND IMPLEMENTATION

- Two medical / surgical / telemetry units started focusing on reducing falls in October 2011.
- The team met at least monthly to discover how to decrease falls and build a safer culture and environment for patients and staff.
- Staff began intentional rounding every two hours including the five “Ps”: 1) Proactive Potty – intentional toileting schedule on patients needing assistance; 2) Pain; 3) Position; 4) Prevent environmental hazards; and 5) Plan of care.
- The team used the Influencer Model™ to identify competency and motivation for fall prevention, individual scripting for patient education, identification of barriers, and peer accountability resources. (Figure #1)
- Performance improvement tools were used to identify barriers and implement staff suggested solutions to promote small tests of change: fishbone diagram, root cause analysis, Plan, Do, Study, Act (PDSA) Cycle and Who, What, When (WWW) Plan (Figure 1).
- Small tests of change first began in January 2012 and have continued.
- The daily focus and communication of specific fall information was shared at change of shift nursing huddles beginning in February 2012.
- The driver became a nursing quality focus on culture of safety and accountability. Audits were started.
- Nurses and patient care technicians were continually educated through huddle structure.
- Other interventions included sleep hygiene, bedside report with nurses and patients, safety checklist, revision of the activity flowsheet and utilizing patient care technicians for ambulation and “sitting”.



EVALUATION

- Evaluation includes daily audits of toileting schedule and bedside report conversations
- Change of shift huddles provide a forum for updates on patients’ toileting schedules, daily safety report of number of days since last fall, and weekly safety focus.
- Monthly review of NDNQI metrics are posted on the huddle dashboard. Overall falls improved by 0.95 falls per 1000 patient days.
- AHRQ Overall Patient Safety Culture Score was at least 10% higher on the 7th floor when compared to the rest of the hospital.

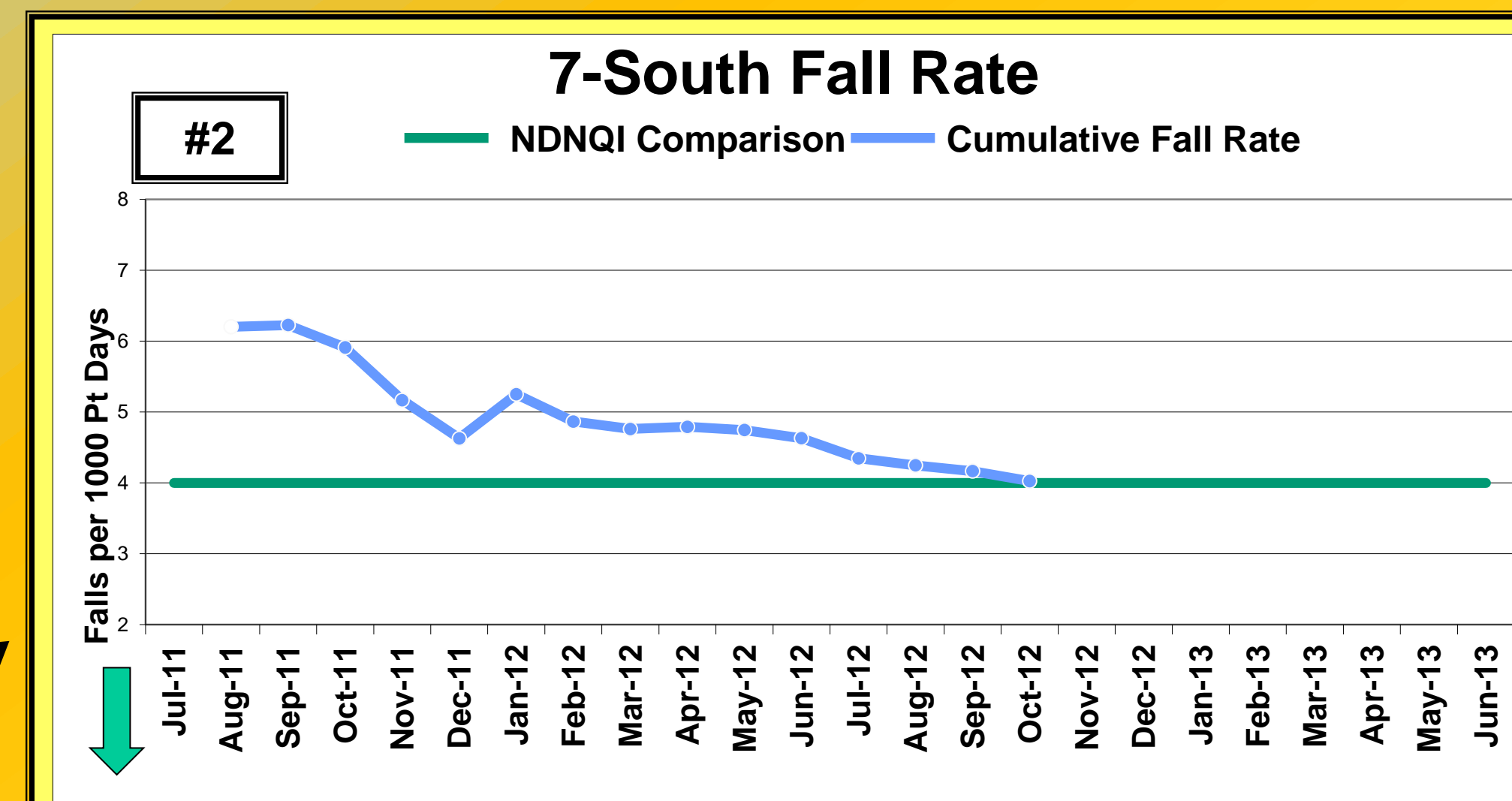
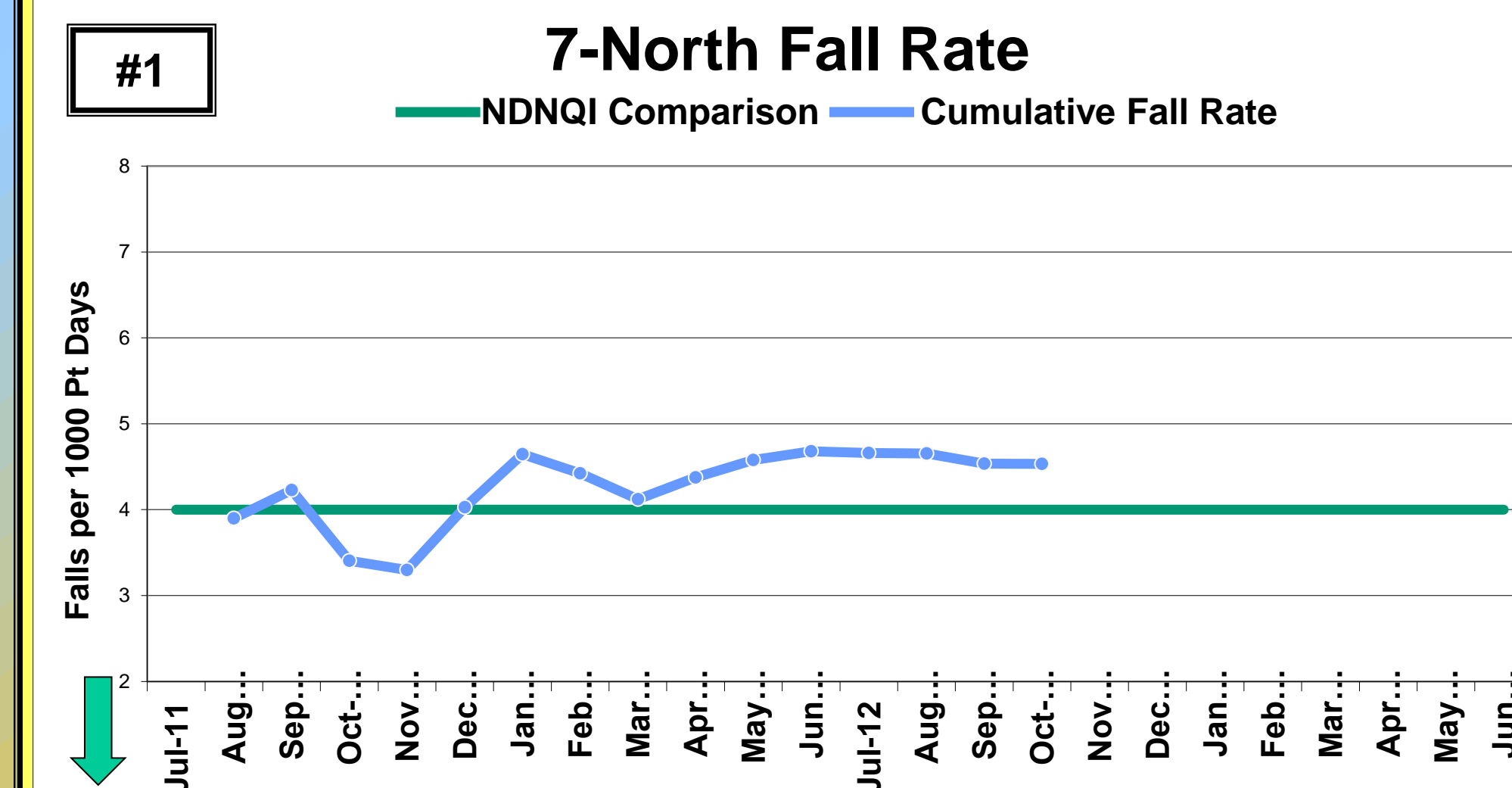
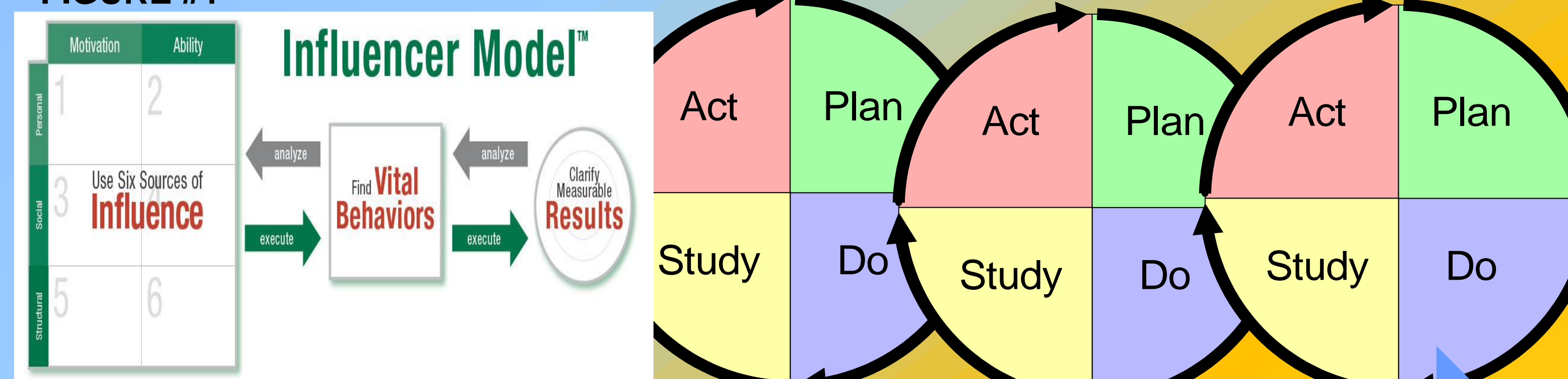


FIGURE #1



SMALL TESTS OF CHANGE WITH CULTURE SHIFT

MEET THE TEAM

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IMPLICATIONS FOR PRACTICE

- The in-depth work done on these two units demonstrate improved fall rates, culture shift, ownership and accountability by nursing.
- The continuous review of evidence-based best practice leads to the relentless pursuit of perfecting practice to reduce falls.

REFERENCES

- Kenney, C. (2011). Transforming Health Care: Virginia Mason Medical Center's Pursuit of the Perfect Patient Experience. MA: CRC Press.
- Patterson, K. Grenny, J. Maxfield, D. McMillan, R. Switzler, A. (2008). Influencer: The Power to Change Anything. NY: McGraw-Hill.

