

Quality Initiative: Implementation of Unit Safety Champions

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Abstract

The literature supports that a Unit Safety Champion (USC) may reduce falls among hospitalized patients. The purpose of this project was to determine if the implementation of a USC would assist in reducing falls on an acute unit in an urban hospital environment. Although the average number of falls increased, there was no statistically significant difference in the average number of falls between these time periods. Upon further investigation, it was discovered that the unit experienced an increase in nursing turnover while implementing the USC. Although this confounding variable was not examined as part of this project, the results demonstrate the importance of nursing turnover on adverse patient events. The literature suggests that front-line workers may contribute to a quality change in the acute environment. Using Lewin's change model as a foundation, an action plan was submitted to the fall committee emphasizing the relational importance of nurse staffing management and adverse events.

Problem

Falls increased greater than 28% hospital-wide in a 7-month time period and greater than 300 events in 2014.

Pilot nursing unit had greater than 49 fall events from January 2014 thru June 2014 with nurse turnover and lack of support for fall precautions.

Research Question

Does the implementation of a Unit Safety Champion (USC) on an acute care nursing unit decrease patient falls?

Relevant Literature

- ❖ According to Zimlichman et al (2009), approximately 17% of all hospitalized patients will experience an adverse event such as falls during their hospital stay.
- ❖ Pearson et al, (2013) recognized better staff involvement and importance of the RN and CNA in the prevention of falls contributes to a positive safety culture in the workplace.
- ❖ Quigley and White (2013) discussed that falls are a nurse-sensitive measure, and how nurses play a key role in this component of patient care as safety support.
- ❖ TJC (2012) concluded implementation of a fall prevention education in the hospital setting not only decreases mortality rates, but also length of hospital stay especially in the aging population.
- ❖ Tanafranca (2009) suggested safety champions engage and empower front line staff, promote system-level learning, share successes and challenges and provide peer support.
- ❖ An important part of a safety, or *fall program*... (Quigley and White, 2013).
- ❖ Safety champions are staff ally's, not leadership informants or disciplinarian's (IHI, 2015).
- ❖ Champions engaged to a varying extent in a number of core activities, including education and patient advocacy (Soo et al., 2009).

Purpose

Ultimately the main goal in a fall prevention program is to promote a safe hospital stay for the patient. The initiation of preventative measures for falls by this organization may not have the ability to prevent all falls. However it shows the organization is taking the initiative to institute a preventive measure. USCs are nurses already established as a front line safety leader. They are often referred to as "super users" and are supported by the Clinical Education Specialist and leadership. USCs are motivated, dynamic, interested in quality outcomes with strong problem solving skills and possess leadership qualities (Aging Services of Minnesota, 2010). As a result, the purpose of this project was to evaluate the outcomes of falls after implementation of a USC on an acute care nursing unit.

Procedures

The frequency of patient falls on the unit was collected from the hospital's quality department 3 months before and 3 months after the implementation of the USC. The average number of falls for 3 months before implementation was 5.0 per month ($SD = 2.65$) and involved a total of 15 individual patients. The average number of falls for 3 months after implementation was 5.33 ($SD = 1.53$) and involved a total of 16 individual patients.

Data Analysis

There was not a statistical difference between the average pre implementation fall rates of 5.00 ($SD=2.65$) and the average post implementation fall rate of 5.33 ($SD=1.53$). There was not a statistical difference between the pre implementation fall rates and the post implementation fall rates ($z = -0.272, p = 0.785$).

Findings

Overall fall rate results did not determine whether a USC could help decrease patient falls as identified in Table 2 ($z = -0.272, p = 0.785$). The research had been consistent in that evidence-based practice methods such as expert support to front-line nursing staff better prepared them to think on a more proactive approach with regard to safety. A finding in this study also included why feedback to leadership can help improve nursing practice. Soo, Berta, and Baker (2009) described a safety champion as a "leader front line clinicians" (p. 125) that will initiate safety prevention measure tactics. Staff identified to the USC the need for a standardized fall risk identifier for patient doors. An action plan was submitted to the fall committee by the USC during an increase in falls for one month. The fall policy committee decided to once again include a yellow fall magnet be hung on all door frames of high fall risk patients as a standardized safety fall precaution. Other research stressed a USC is that "go-to" person for areas such as education on National Patient Safety Goals (NPSG; 2015). Largely, NPSGs tie into nursing care by aligning these guidelines to policy and procedure revisions.

Limitations

1. Length of study.
2. No comparison group such as a similar hospital and type of specialty unit with high patient fall events.

Social Change Implications

A USC could support in identifying a patients needs proactively that provides a wide-range of meeting expectations for ethically sound health care delivery. Supporting safety programs is a shared responsibility between stakeholders and the community.

Recommendations

- Conduct pre and post pilot questionnaire.
- Conduct a longitudinal project in order to understand the contribution of the USC to an organization.
- Identify core features of the clinical champion role – i.e. how clinicians become champions.