I've Got Your Back! Using Peer Feedback to Decrease Patient Falls and Pressure Ulcers

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Abstract

PICOT:
In Medical-Surgical, Pediatric and Critical Care nursing units in one academic teaching institution (P), how will implementation of structured peer feedback (I), in comparison to lack of structured peer feedback (C) effect the number of unit-acquired pressure ulcers and the number of patient falls (O) over a nine month period (T).

Background:
Nursing peer review has been present in the nursing profession for the past 27 years (American Nurses Association, 1988). Peer feedback, used as a form of peer review, can be used as a quality improvement intervention to improve patient outcomes. Peer feedback utilization is required by the American Nurses Credentialing Center *Pathway to Excellence®* (ANCC, *2012, p. 17, 22) and Magnet® (ANCC, 2013, p.28) programs.*

Problem:
A process for giving and receiving peer feedback did not exist within the organization.

Aim:
Implementation and evaluation of clinical nurse peer feedback, within a Pathway to Excellence® designated acute care organization.

Purpose:
Determine the effect of peer feedback on patient falls and pressure ulcers in (3) service lines; Medical-Surgical, Critical Care and Pediatrics.

Methods:
Nursing staff will observe and provide *peer feedback* to their randomly assigned colleagues as a mechanism to hold one another accountable for their nursing practice focused on patient falls and pressure ulcer prevention. Peer feedback sessions occur during a fifteen day timeframe, three times per year. The number of patient falls and unit-acquired pressure ulcers will be evaluated three months prior peer feedback implementation and compared to the number of patient falls and unit-acquired pressure ulcers three months post peer feedback implementation in three service lines; Medical-Surgical, Pediatrics and Critical Care.

Results:
Data analysis revealed a 7.5% cumulative reduction in patient falls and a 50% cumulative reduction in unit-acquired pressure ulcers following three quarters post peer feedback implementation in comparison to three quarters pre peer feedback implementation in Medical-Surgical, Pediatrics and Critical Care service lines. Results are clinically significant but not statistically significant related to multiple units "action planning" during the three quarters post peer feedback implementation phase.

Conclusion:
Peer feedback provides an opportunity to enhance skill development, decrease care variability, improve patient outcomes and further develop a culture of safety.

Limitations:
✓ Results are from one acute care organization
✓ Multiple action plans at the unit level prevented single source intervention reporting

Contemporary Peer Review

1. A peer is someone at the same rank
2. Peer review is practice-focused
3. Feedback is timely, routine and continuous
4. Foster a continuous culture of safety and best practice
5. Feedback is not anonymous
6. Incorporate the developmental stage of the nurse

(Haag-Heitman & George, 2011)

Peer Feedback Process And Implementation

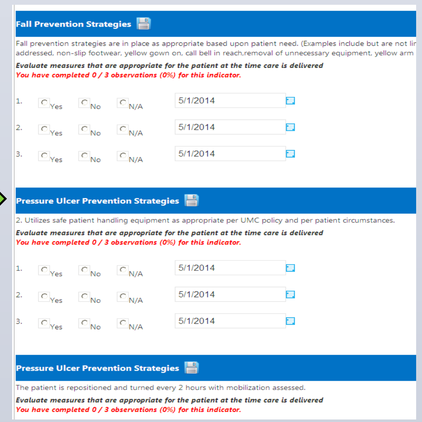
- 4th Qtr. 2013 — Peer Feedback Committee Begins
- 1st Qtr. 2014 — Tool Development, IT Build, (2) Units Pilot Test
- 2nd Qtr. 2014 — Organization Education for Nursing; Peer Feedback Begins (Session 1)
- 3rd Qtr. 2014 — Peer Feedback (Session 2)
- 4th Qtr. 2014 — Peer Feedback (Session 3)
- 1st Qtr. 2015 — Staff Survey; Unit Based Councils

Peer Feedback Process
Non-punitive
Practice and quality focused
Not anonymous
Feedback would be transparent
Each nurse would have (2) observers
(3) Feedback sessions of 15 days each per year

Nurse Director Responsibilities	Nurse Responsibilities
Step 1 Validate Schedule for Staff Available during 15 day period	**Step 1** Review Randomized Assignment before 15 day period
Step 2 Assign staff according to shift worked (7a-7p, 7p-7a, One Shift)	**Step 2** Coordinate Schedules Over 15 day period to determine when observation times are possible
Step 3 Randomize Staff / Electronically	**Step 3** Perform (3) observations (days or patients)
Step 4 Email / Post assignments to Nursing Staff	**Step 4** Electronically Document Findings / Review with Nurse
Step 5 Overview of Observation Completion / Monitor Participation	**Step 5** Review Own Findings / Electronic Sign-Off

Fall Prevention	Pressure Ulcer Prevention
Fall prevention strategies are in place as appropriate based upon patient need. • Bed alarms on • Side rails up • Bed in low position • Bed Wheels locked • Toileting needs addressed • Non-slip footwear • Yellow gown on • Yellow arm band • Call bell in reach • Removal of unnecessary equipment • Doors open for visualization • Fall door sign present	Repositioned & turned every 2 hours and mobilization assessed. Utilizes safe patient handling equipment as appropriate per UMC policy and per patient circumstances.
Circle Each Per Observation 1. Yes No N/A 1. Yes No N/A 1. Yes No N/A Total = _____ (Example 3/3)	**Circle Each Per Observation** 1. Yes No N/A 1. Yes No N/A 1. Yes No N/A Total = _____ (Example 3/3)

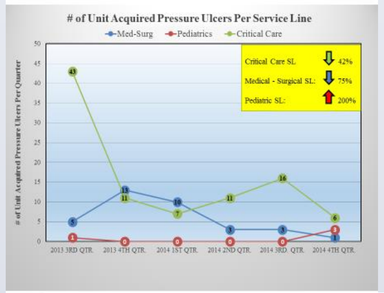
Electronic View



Results

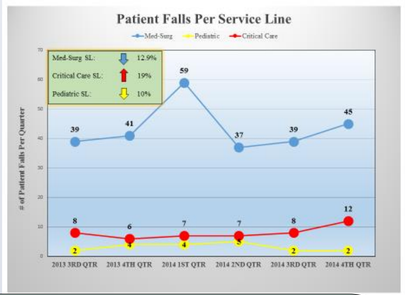
Pressure Ulcers

	2013 3rd Qtr	2013 4th Qtr	2014 1st Qtr	Totals	2014 2nd Qtr	2014 3rd Qtr	2014 4th Qtr	Totals
Medical - Surgical Service Line								
MS Unit A	2	0	2		0	0	0	
MS Unit B	0	0	1		2	1	1	
MS Unit C	0	1	0		1	1	0	
MS Unit D	0	0	0		0	0	0	
MS Unit E	2	6	2		0	0	0	
MS Unit F	1	4	4		0	1	0	
MS Unit G	0	2	1		0	0	0	
Total	5	13	10	**28**	3	3	1	**7**
Pediatric Service Line								
Pedi A	0	0	0		0	0	0	
Pedi B	1	0	0		0	0	2	
Pedi C	0	0	0		0	0	1	
Total	1	0	0	**1**	0	0	3	**3**
Critical Care Service Line								
CC Unit A	8	3	1		1	4	2	
CC Unit B	2	0	0		1	2	1	
CC Unit C	31	6	3		8	7	3	
CC Unit D	2	2	3		1	4	0	
Total	43	11	7	**61**	11	18	6	**35**
Grand Total				**90**		Red =Action Planning		**45**



Falls

	2013 3rd Qtr	2013 4th Qtr	2014 1st Qtr	Pre Total	2014 2nd Qtr	2014 3rd Qtr	2014 4th Qtr	Post Total
Medical - Surgical Service Line								
MS Unit A	6	6	10		5	6	4	
MS Unit B	4	6	5		4	4	5	
MS Unit C	9	9	15		7	9	10	
MS Unit D	1	0	1		3	1	0	
MS Unit E	5	7	7		7	5	11	
MS Unit F	9	10	12		5	9	11	
MS Unit G	5	3	9		6	5	4	
Total	39	41	59	**139**	37	39	45	**121**
Pediatric Service Line								
Pedi Unit A	1	4	3		4	1	2	
Pedi Unit B	1	0	1		1	1	0	
Pedi Unit C	0	0	0		0	0	0	
Total	2	4	4	**10**	5	2	2	**9**
Critical Care Service Line								
CC Unit A	1	1	2		0	1	3	
CC Unit B	0	1	1		1	0	4	
CC Unit C	5	0	2		3	5	3	
CC Unit D	2	4	2		3	2	2	
Total	8	6	7	**21**	7	8	12	**27**
Grand Total				**170**		Red =Action Planning		**157**



Conclusions and Future Implications

- Non-punitive peer feedback needs to be considered as an opportunity to engage nursing staff with quality measures
- Peer feedback can be used as an intervention to improve patient outcomes
- Clinical nursing staff prefer to have observations occur with the same shift as care delivery
- Clinical nursing staff prefer unit-specific quality measures
- Instructions on how to provide peer feedback need to be considered

References

American Nurses Association. Peer review guidelines. Kansas City, MO: American Nurses Association; 1988.

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