Improving Patient Outcomes and Staff Accountability While Embracing a High Reliability Organizational Culture

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Background/Problem

Sentara Healthcare has a policy for tracking falls in accordance with National Database for Nursing Quality Indicators (NDNQI) which defines fall as a "sudden, unintentional descent, with or without injury to the patient, that results in the patient coming to rest on the floor, on or against some other surface (e.g., a counter), on another person, or on an object (e.g., a trash can)". In 2018 Sentara updated the fall with injury definition to include any report of pain following the fall. 4 Heart Hospital is a 24 bed Intermediate Care Unit whose patient population is post cardiac surgery patients. Throughout 2016, 4HH, experienced an increase in patient falls. The unit had **41** total falls with **7** falls with injury in 2016.

Goals

The goals of this quality improvement project are:

- Reduce the rate of total falls by 60%
- Reduce the rate of falls with injury by 50%
- Maintain a culture of safety despite staff turnover

Literature Review

Inpatient falls continue to be one of the top adverse safety events in the hospital setting (Coyle & Mazaleski, 2016; Hoke & Guarracino, 2016). Falls have a major impact on health care costs specifically impacting length of stay, morbidity, and mortality. Adverse events are considered to be unfavorable outcomes as a result of medical care rather than a disease process and when associated with falls may include broken limb, surgical procedure, or death. The Joint Commission estimates that **the average cost of a fall with injury is $14,500** (Coyle & Mazaleski, 2016).

Fall reduction is essential to improving patient outcomes and reducing cost incurred by health care institutions.

References

Coyle, R., & Mazaleski, A. (2016). Initiating and sustaining a fall prevention program. *Nursing*, *46*(5), 16-21. doi:10.1097/01.nurse.0000482277.72036.50

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Huang S.C.C., Forster A.J. (2016) Adverse Events and Falls. In: Huang A., Mallet L. (eds) Medication-Related Falls in Older People. Adis, Cham. doi:10.1007/978-3-319-32304-6_7

Project Implementation

The number of falls that occurred on 4HH in 2016 resulted in the unit being a "unit of focus". The unit leaders were responsible for initiating an action plan to improve patient outcomes related to falls based on identified causative factors including: • Increase in number of new staff • Increase in number of new nurses • Inconsistent application of fall prevention interventions-accountability.	**2016**
Trend data for similarities for fall events in 2016 to include staff non compliance with interventions, improper patient handling, and failure to educate patient on fall plan.	**2017**
Action plan required to improve overall rate of falls	**2017**
Implementation of mandatory fall education and accountability contract for all staff See figure 1. for example of contract.	**2017**
Revised accountability contract to include new unit specific standards and practices	**2018**
Maintain accountability contract for all staff	**2018**
Mandatory fall education for new staff only	**2018**
Implementation of post fall presentation to identify lessons learned at monthly staff meeting	**2018**

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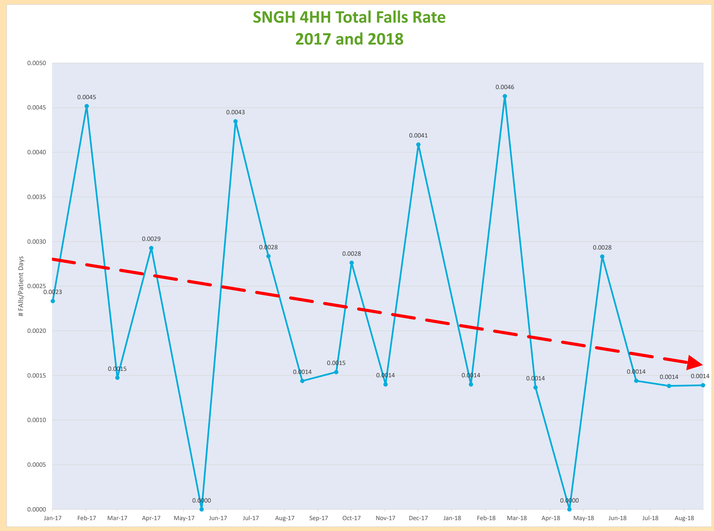
Outcomes



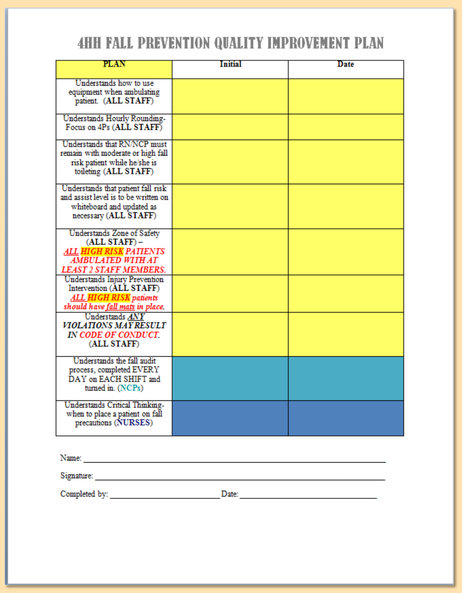
Implications for Practice

Nurses

- Internal dissemination to staff increases prompt awareness and sensitivity to operations.
- Non punitive remediation after a fall event via self reflective presentation improves nurse resiliency and confidence to competently perform as member of the team.
- Increased preoccupation with failure

Patients

- Sustained 90th percentile in customer and patient satisfaction.



4HH FALL PREVENTION QUALITY IMPROVEMENT PLAN

PLAN	Initial	Date
Understands how to use equipment when ambulating patient. (ALL STAFF)		
Understands Hourly Rounding- Focus on 4Ps (ALL STAFF)		
Understands that RN/NCP must remain with moderate or high fall risk patient while he/she is toileting (ALL STAFF)		
Understands that patient fall risk and assist level is to be written on whiteboard and updated as necessary (ALL STAFF)		
Understands Zone of Safety (ALL STAFF) ALL HIGH RISK PATIENTS AMBULATED WITH AT LEAST 3 STAFF MEMBERS.		
Understands Injury Prevention Intervention (ALL STAFF) ALL HIGH RISK patients should have fall mats in place.		
Understands ANY VIOLATIONS MAY RESULT IN CODE OF CONDUCT. (ALL STAFF)		
Understands the fall audit process, completed EVERY DAY on EACH SHIFT and turned in. (NCPs)		
Understands Critical Thinking- when to place a patient on fall precautions (NURSES)		

Name: _____

Signature: _____

Completed by: _____ Date: _____

Figure 1. Accountability contract for 4HH staff