Clinical Quality and Safety

Recipe for success: engaged staff, difficult patients and cheerleaders!

A small team, longing to make a difference, began a journey to improve patient care and safety. The group is composed of members from the following departments, Patient Experience, Nursing, Nursing Education, Quality and Safety.

Key Learning Objectives

As a result of attending this session, participants will be able to:

- Realize the importance of hourly nurse rounding to the reduction of falls
- Understand the importance of engagement and ownership by front line staff
- Remember to always celebrate the successes!

Our goal is the reduction of falls in the MOST challenging population on our campus through the implementation of hourly rounding. The unit that we chose as our focus is licensed as a chronic hospital, fittingly named Medical Behavioral Unit. In all other states, except Maryland, it would be known as a LTAC. This unit admits incredibly medically complex patients over the age of 55, with behaviors that acute care hospitals, assisted livings and nursing homes cannot handle. Each patient is at a high risk for falls upon admission and generally requires extensive medication adjustment which adds to the complexity of the situation. The unit had been averaging 26 falls every 30 days. The Professional Development Specialist on campus that leads the falls committee noted that Medical Behavior Unit had a pattern of patients falling within the first couple days of admission. We gathered an interdisciplinary team of front line staff and brainstormed interventions that should take place with all new admissions during the first couple days of his/her stay. The frontline staff members implemented their ideas that same day. The team started the hourly rounding project on 4/7/14, using the 3 P’s (potty, position and pain) and we are continuing to see progress and staff engagement. The team also made a safety video focusing on the 3 P’s and falls. One of the reasons for the sustained staff engagement, the team believes, is the constant feedback of successes, individual and team recognition and spreading the word about the progress made. Actually being the team cheerleaders!

Key Players

Clinical Nurse Educators, Patient Care Manager, Director of Patient Experience, Performance Improvement Coordinators and most important, the multidisciplinary front line staff members.
Steps /Processes

We began the project with brainstorming sessions on all shifts to encourage staff involvement and feedback. From a safety perspective, incidents are reviewed daily and the information is shared with front line staff on a regular basis. We include information that is helpful in planning care and maintaining patient safety, for instance one patient may have fallen at a certain time twice in the week. This allows the staff to be on high alert during that time period. We also share information about how many days we have had without a fall and how many falls we have had during the time period.

Outcomes

We were able to realize a reduction from 26 falls to 10 falls for a 30 day period and we celebrated with a pizza party.

Sustainability

We are not yet to this stage.

Role of Collaboration and Leadership

We had a small group of us that attended TeamSTEPPS Trainer classes and implemented some of the principles on the unit. The TeamSTEPPS leaders for the project are: Carolyn Bailey, Linda Goodman, Carletta Betz and Stacey Schaab

Innovation

This project is quite unique due to the population with whom staff members are working. All patients are over 55 years of age and admitted for adjustment of behavioral management medications and exhibit high fall risk behaviors. Due to their age, the patients also have a variety of medical comorbidities that can increase not only fall risk, but risk of injury from a fall.

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