Nursing excellence program provides framework for patient safety initiatives

Engaged nurses who feel their organization values their efforts and opinions have an incredibly positive effect on the quality of care patients receive. Studies have shown that organizational support for nursing leads to better quality of care, which can reduce mortality rates and improve rates for nursing-sensitive indicators, such as patient falls, pressure ulcers, and central line infections.

For the past 17 years, the American Nurses Credentialing Center’s (ANCC) Magnet Recognition Program® (MRP) has given healthcare facilities a framework around which to structure their nursing programs to achieve quality patient outcomes. Those facilities that have been designated as MRP organizations say that their hospitals have been able to take improvement in quality and patient safety to new levels. Even those facilities that have not yet been recognized but are in the application process for becoming an MRP hospital say the exercise has been a positive one.

How can one program help elevate the standard of nursing care and, thereby, patient safety nationwide?

“[The MRP program] encourages us by way of their standards—they almost mandate it—to make sure we are on our journey towards quality and that we do embark on safety, and that we not just meet the standard, that we take it to higher levels,” says Denise Occhiuzzo, MS, RNC, BC, administrative director of clinical education and nursing practice and MRP program director in the Department of Patient Care at Hackensack (NJ) University Medical Center (HUMC).

HUMC was the second facility to ever be MRP-designated and has been redesignated four times since 1995, most recently in 2008.

At its core, the MRP program requires hospitals to consider 5 Model Components: structural empowerment; exemplary professional practice; new knowledge, innovation, and improvements; transformational leadership; and empirical outcomes, the last of which really overlaps all of the other domains.

“The message I give the staff is ... you’re the one that’s taking care of the patient more than anyone else. That patient—the quality, safety, and care that’s provided to the patient—is owned by you.”

—Liz Carlton, RN, MSN, CCRN

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No small undertaking

Becoming an MRP hospital requires years of preparation and data collection, as well as a binder of materials that can be hundreds to thousands of pages long. Additionally, the cost of being designated can be substantial, depending on the size of the organization. The cost of an appraisal by the ANCC ranges from around $14,000 for hospitals with fewer than 100 beds to nearly $58,000 for hospitals with 950 beds.

However, the investment, time, and resources required are generally found to be worthwhile by organizations that go through the process, says Liz Carlton, RN, MSN, CCRN, director of quality, safety, and regulatory compliance at The University of Kansas Hospital (KUMED) in Kansas City, KS.

KUMED has been designated since 2006 and will apply for redesignation in October of this year. KUMED’s philosophy is that the patient always comes first, Carlton says. “[The MRP program] really allows us to do that, and do that in a way that helps us reach every bedside care provider,” she says. “The message I give the staff is, the bedside nurse, you’re the one that’s taking care of the patient more than anyone else. That patient—the quality, safety, and care that’s provided to the patient—is owned by you. If you empower that nurse to be able to impact their practice, put input into changing a policy or protocol … that’s all the more stronger because of it.”

The road to empowerment

Because shared governance is one of the major components of designated organizations, nurses are more simply encouraged to take part in hospital initiatives. MRP facilities give their nurses the tools and resources they need to create and lead new programs. That empowerment leads to better outcomes for patients and more satisfied staff members.

“[MRP] requires that we have a quality council and that it is staff led,” says Theresa Colarusso, RN, BSN, MPA, administrative director for performance improvement and regulatory compliance in the Department of Patient Care at HUMC. “It’s wonderful to see how bright, educated, and engaged they are. They really take this to heart, and it’s good discussion at the table.”

HUMC had success with a patient falls prevention initiative, which is led by a staff nurse. The nurse was part of a larger “champion” group, and through it she found her passion for reducing falls, says Claudia Douglas, RN, MA, CNN, APN-C, supervisor of clinical practice affairs and MRP coordinator in the Department of Patient Care at HUMC. The nurse’s program has been in place for the past four years, and many efforts around the organization can be attributed to her ability to identify a need and take hold of the resources available.

“Our organization’s philosophy from the nursing department’s point of view is to encourage nurses to be leaders,” says Douglas. “Staff nurses in particular...
are encouraged to be leaders, and the support, resources, education, and time are provided, and the nurse was able to take this to a great level.”

At KUMED, Carlton helped design a Quality Safety Investigator (QSI) program as a way to better involve bedside nurses in championing quality and patient safety. There is a designated QSI on each unit who is provided dedicated time to focus on unit-specific initiatives, as well as education in a group setting on certain topics, such as medication safety and handoffs.

“They’re responsible for taking that back to their unit, partnering with their unit leadership, and really driving those initiatives that are happening on their unit,” says Carlton. “That is a great example of the [MRP] model, empowering staff in an innovative way to share knowledge, share data, and make changes.”

There are currently 39 QSIs at KUMED. Nurses interested in becoming a QSI must go through an application process, says Carlton.

“When you get selected, you have to sign a contract that says you are going to participate and be engaged, and your manager has to sign a contract also that says they’re going to support you in being participative and engaging, so that you can’t use the excuse of ‘Well, my manager wouldn’t let me off,’ ” says Carlton.

The program has generated greater staff involvement across the organization. Peers are influenced to join the program. Additionally, part of the QSI program is a mentor opportunity for staff in the quality and performance improvement world. Mentors share advice with QSIs from various departments about gathering and presenting data.

At St. Luke’s Regional Medical Center, which is based in Idaho and has been through two designations (it recently applied for its third), nurses participated in VHA’s “Return to Care” program as one way of empowering bedside nurses and improving patient outcomes. This initiative combines the lessons of Transforming Care at the Bedside with those of relationship-based care, says Joanne Clavelle, MS, RN, NE-BC, FACHE, CNO and vice president of patient care.

“You put the patient and family at the very center of all that you do and really recommit to the whole concept of caring,” says Clavelle. “What you do is engage workforce teams in looking at the work and redesigning care delivery processes.”

The following are some of the tactics the facility employed as part of the program:

➤ Installing a Yacker Tracker, which monitors noise levels and provides visual cues when the noise reaches a certain decibel
➤ Placing whiteboards in patients’ rooms to inform patients and their families of the daily care plan
➤ Increasing nurses’ time at the bedside by relocating supplies and using bar-coded medication administration
➤ Utilizing the “take five” initiative

“Every nurse at the start of every shift, every time, takes five minutes unencumbered with any tasks, like administering medications or taking a blood pressure, to just sit down at eye level with the patient and really talk

➤ continued on p. 4

Nursing excellence designation at a glance

➤ Run by: American Nurses Credentialing Center
➤ Number of recognized facilities: 371
➤ 5 Model Components:
- Structural empowerment
- Exemplary professional practice
- New knowledge, innovation, and improvements
- Transformational leadership
- Empirical outcomes
➤ Number of quarters of data that must be gathered for application: eight
➤ Number of years that hospitals have designation before they need to apply for redesignation: four
➤ Percentage of hospitals in U.S. News & World Report’s list of America’s Best Hospitals that were designated in 2009: 71

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with them about their care plan, expectations, and what they’re going to be doing that day, and then incorporating that into their plan for the day,” says Clavelle.

This project has helped the facility improve HCAHPS scores, and specifically reduce falls with injury.

Continuous improvement

MRP facilities must track all of these programs and examples. As part of an application for redesignation, hospitals must show evidence of empirical outcomes. The initial designation is more focused on the structural framework of a solid nursing and organizational program, says Clavelle.

Because of this, it’s important to show continuous improvement. Facilities are required to show evidence at a unit level, through benchmarking, that they are above the national average in nursing-sensitive indicators, as well as two additional measures of choice.

Clavelle says organizations should demonstrate three items in their written documentation for redesignation:
➤ The structure (e.g., committees, councils)
➤ The process used to engage frontline caregivers
➤ The outcomes

“It’s not a ‘one and done,’ ” says Carlton. “You have to work at it constantly—constant dynamic. You have to show constant growth and improvement. For the hospital that’s working on [MRP], it’s a great framework for identifying where you are, where your gaps are, where you need to put action into place, and it allows you to constantly be moving forward.”

Even for those facilities that are not yet designated but are considering becoming designated in the future, simply going through the exercise of looking at what is required and taking action to be on that track is worthwhile. It will help improve the care available to patients and create a desirable work environment for staff, says Sallie Latty, RN, BSN, MA, MRP coordinator at St. Vincent Hospital in Indianapolis, which will submit its application for its first designation in October.

“Even if we by chance didn’t get the designation, we’ve become better because of the journey,” Latty says. “That’s hands down the best part about it. The other thing I think lends credibility to the [MRP] program in general is that you can’t get the designation and sit on your laurels; you really have to improve [on an ongoing basis] and show evidence of that improvement.”

Source
Briefings on Patient Safety, June 2010, HCPro, Inc.
Infection control

SUD reprocessing: Balancing cost savings, patient safety

Although some have IC concerns, reprocessing saves money and cuts down on waste

At a time when hospitals are continually searching for ways to reduce costs while maintaining or even increasing their focus on patient safety and infection control (IC), reprocessing single-use devices (SUD) may be a viable option that is cost-effective and environmentally friendly.

The idea of reprocessing SUDs may seem inherently incorrect to some, but doing so with appropriate devices through an FDA-regulated third-party vendor can significantly reduce waste and save your facility thousands of dollars in purchasing costs while maintaining quality care.

Reprocessed SUDs range from low-risk devices such as blood pressure cuffs or compression sleeves to high-risk devices such as balloon angioplasty catheters or implanted infusion pumps. But because these devices are labeled for single use, some healthcare providers worry that the risk to patient safety is greater than the need to save money or reduce waste.

However, according to a 2008 report from the Government Accountability Office, FDA oversight on reprocessing SUDs has increased, and data, although limited, did not indicate an elevated health risk to patients. A survey conducted by the FDA in December 2001 to February 2002 found 24.2% of all U.S. hospitals reused SUDs. Now as many as 68% of the Practice Greenhealth “Partners for Change” award applicants have implemented SUD reprocessing, according to Janet Brown, director of facility engagement at Practice Greenhealth.

In a recent commentary published in Academic Medicine, lead author Martin A. Makary, MD, MPH, the Mark Ravitch Chair of Gastrointestinal Surgery and director at the Johns Hopkins Center for Green Health in Baltimore, argued that reprocessing is a green practice that is gaining traction in the healthcare community because of the cost savings and the reduced burden of waste on the environment.

“We have found it to be a common-sense strategy that uses detailed quality-control standards to recalibrate, clean, sterilize, and remanufacture medical equipment,” the authors wrote. “The result has been a significant waste reduction and cost savings. However, uptake of such green practices by hospitals has continued to be slow because of a misunderstanding of the process and concerns about patient safety.”

What is reprocessing?

Essentially, reprocessing involves sterilizing equipment that has been used or opened so it can be safely and effectively used again. Reprocessed devices are typically given to third-party vendors rather than being handled in-house. These vendors are regulated by the FDA.

Each device is subject to premarket notification requirements set forth by the FDA. Manufacturers are required to submit 510(k)s to the FDA for that device to be approved for reprocessing.

Healthcare facilities can collect approved devices, send them to their third-party vendor, then buy the reprocessed devices back at nearly half the cost of purchasing new ones.

Reprocessed SUDs are divided into three groups: critical, semicritical, and noncritical. Healthcare facilities will often start small by simply reprocessing noncritical devices rather than focus on every device in their facility. “I don’t think I’ve met a hospital that is reprocessing

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everything the FDA says they can,” Brown says. “But I think they are working in that direction.”

Getting started

Although you may face resistance from physicians or patient safety advocates initially, the best way to begin reprocessing SUDs is by starting with less-critical items, such as compression sleeves. This will net a cost savings and reduce waste within your facility while easing employees into the process and proving its effectiveness.

Michele De Meo, sterile processing manager at Memorial Hospital in York, PA, says her facility has reprocessed external compression sleeves for the past three years. Starting with low-risk devices also allows your facility to test out a vendor to ensure that you are satisfied with the quality and the relationship. “I believe that if a company has gone through the process required to get their 510(k) and the devices are deemed safe, and the company doesn’t have any quality issues that have been noted, I think for cost savings and for the environment it’s prudent for us to explore those options as long as the quality is the same as a new device,” De Meo says.

Even today there is much more willingness to reprocess SUDs than there was 15–20 years ago, she says. At that time, physicians and health experts were concerned with reprocessing even low-risk devices such as compression sleeves. However, as more data emerge regarding the safety of this process, the more hospitals open up to the idea, and the more common it becomes.

“So it’s been a slow evolution to gain acceptance even with using reprocessed sleeves, and I think the same will occur with other devices; it’s just a slow process,” De Meo says. “But yes, years ago getting a team on board just to do sleeves was nearly impossible.”

Brown says some hospitals simply collect devices for reprocessing but stop there, choosing not to buy back the reprocessed devices while still saving money and reducing waste at their facilities.

Brown suggests forming a “green team” within the hospital that includes IC, patient safety, nurse educators, and any staff members who want to get involved with environmentally conscious options. A team approach spreads the initiative across a number of people to collect evidence and present the case to your facility’s management or executive team.

“We want to make evidence-based decisions,” Brown says. “We don’t want to just do something because it makes less garbage; we need to balance that with safety and risk management and infection control. I think those are valid concerns. So you need to gather the information, find the research, and then once that is all

FDA classifications

Reprocessed single-use devices (SUD) are divided into three distinct categories:

➤ Class I: A noncritical reprocessed SUD is intended to make topical contact and not penetrate intact skin.
  – Examples include elastic bandages, pressure infuser bags, tourniquet cuffs, and general-use surgical scissors

➤ Class II: A semicritical reprocessed SUD is intended to contact intact mucous membranes and not penetrate normally sterile areas of the body. These devices require FDA approval for safety, effectiveness, and intended use equivalent to new devices.
  – Examples include pulse oximeter sensors, ultrasound catheters, drills, compression sleeves, and most laparoscopic equipment

➤ Class III: A critical reprocessed SUD is intended to contact normally sterile tissue or body spaces during use. To be FDA-approved, devices require scientific data proving effectiveness along with an inspection of the reprocessing facility.
  – Examples include balloon angioplasty catheters, percutaneous tissue ablation electrodes, and implanted infusion pumps

According to a commentary published in Academic Medicine, approximately 65%–75% of reprocessed SUDs fall into Class II.
gathered, you realize this is something that really can be done in balance with quality care."

Training employees

Just like any program, getting employees to comply with a new initiative is half the battle. In this case, reminding them not to throw away an SUD that your facility has decided to reprocess is usually the primary hurdle. Simply putting out a bin and telling employees to segregate a particular device will not be enough, Brown says. It requires constant reminders, observation, and hand-holding in a way that is encouraging rather than disciplinary or punitive.

Monitor employees and gently remind them if you see noncompliance with the new policy. It also helps to have a leader in the operating room (OR) suite to train employees and monitor segregation. Getting physicians involved also helps bring awareness to the movement and knowledge and perspective on the issue.

“The physician’s interest or lack of in the OR can really make or break a program, so it’s really important that they are part of it,” Brown says.

She also recommends training housekeepers to keep an eye out for devices that have been thrown away inappropriately. “[Housekeepers] are the last line of defense,” she says. “They are never put into a position to reach into a bag and fix things, but they can have the visual—an opportunity to visually inspect bags—so that if they notice an issue, they can reach out to their supervisor and address it.”

Convincing the skeptics

Undoubtedly, some employees will remain skeptical of reprocessing. The best way to convince them otherwise is to prove that SUD reprocessing is not only cost-effective, but that it also adheres to patient safety best practices.

The first step may be as simple as pointing to other hospitals that have successfully implemented a reprocessing program. As with many green practices, people within the facility don’t want to be the first to take that step for fear of failure, Brown says. For example, many facilities on the East and West coasts have begun using reusable sharps containers that are disinfected by a third-party vendor and then shipped back to the facility instead of being discarded. Brown consulted a number of hospitals in the Midwest and faced a lot of resistance to this idea. However, once she explained that many hospitals were actually reusing devices successfully, staff members were more open to trying it.

“I think a lot of times when there is something new or different, hospitals are sometimes scared to take that first step, and once a few try it and it catches on, then you see that groundswell,” Brown says.

You can also point to the regulations and some of the evidence available that proves SUD reprocessing does not affect the health of patients, De Meo says. Show them how the FDA regulates third-party vendors and that it only allows certain devices to be reprocessed. Also, make sure to tell them that reprocessing has been backed by a number of major organizations, including APIC.

“I think that usually wins a person over,” De Meo says. “If that doesn’t win a person over, it doesn’t matter how much cost savings you can indicate.”

Source
Briefings on Infection Control, June 2010, HCPro, Inc.
All staff development specialists face the challenge of motivating learners who are reluctant to participate in an education program. These learners’ reactions can range from mild annoyance to outright hostility. Their attitudes affect other learners, making it difficult to establish or maintain a positive learning environment, whether the setting is a classroom or a distance learning situation. These attitudes may make you doubt yourself and can affect your enthusiasm for education.

Start by recognizing and accepting three things about resistant learners. First, there will always be some individuals who are resistant to education. This is an ongoing challenge with which all staff development specialists must deal.

Second, don’t blame yourself for somebody else’s lack of motivation. You are not responsible for others’ desire to learn. Evaluate the effectiveness of your programming and make improvements or changes as evidence dictates. But don’t assume responsibility for colleagues’ behaviors, and don’t let anybody else make you responsible for them.

Third, don’t ignore or simply accept resistant learners’ behaviors. These can impede the effectiveness of the educational activity.

What can you do to defuse resistant learners’ impact on education? Start by answering the following questions:

➤ Did you provide evidence that justifies the learning activity? In other words, was it explained to the learners why the education is mandated or important? Think about the principles of adult learning. Adults need to know why an education offering is important. They want to know how it will benefit them as an employee or help them professionally. When explaining the rationale for a program, use evidence-based terminology. What data indicated a need for the program? Explain how the education is designed to positively affect issues such as patient outcomes, job performance, and organizational effectiveness.

➤ Are the learners afraid of repercussions if knowledge is not acquired? Most organizations require demonstration of specific knowledge acquisition, such as ACLS certification for critical care personnel. If learners fail to achieve certain learning objectives, they may face termination. Or perhaps promotion depends on certain education achievements. Fear of adverse consequences can make people react negatively toward education in general and certain programs in particular.

Although you cannot alter consequences if they are employment qualifications, you can provide a supportive environment, ensure that the education is well designed and appropriately implemented, and provide tutoring to learners as needed.

➤ Is the education offered in manageable increments? If too much information is relayed at one time or too rapidly, learners may not have enough time to absorb necessary knowledge.

➤ Is the content presented/designed by a credible educator? Is the content accurate? Learners resist, and may resent, unqualified persons presenting content. Adults expect to gain accurate knowledge and skills during their learning activities.

➤ Are the learners comfortable in the learning environment? Successful learning environments must be supportive and nonthreatening. In a classroom setting, adults should not be embarrassed. They should feel they have the right and opportunity to ask questions and
acquire knowledge and skills in a setting that is conducive to learning. For distance learning, learners should have access to necessary equipment and know how to use it. If problems arise, technical help should be available.

If the answers to the preceding questions are yes, it would appear that you have done a great deal toward defusing learner resistance. However, there are still those whose resistance continues unabated, causing considerable disruption.

Consider the following scenario: Alexandra, a staff development specialist with 15 years of experience, is asked to develop education to enhance employees’ communication skills. Data from patient/visitor surveys indicate dissatisfaction with the way staff members address patient and visitor questions and concerns. In fact, risk management data show there have been some patient adverse occurrences (e.g., falls, delays in reporting symptoms) due to inadequate communication. Comments include “They act like we’re a nuisance,” “The nurses are so busy they don’t like to be bothered,” and “The people at the information desk are really rude.”

Alexandra includes representatives from all departments in the planning process. She is careful to explain why the education is necessary and how the outcomes are expected to improve patient outcomes.

The education is mandatory for all staff. So far, most staff members have been respectful and enthusiastic learners. Today, however, Kathryn is angry and resistant. She is the assistant manager for several critical care units. She arrives five minutes late for the first class. She sits in the back of the room and mutters in a low voice about being too busy to sit in a classroom.

When class members are asked for examples of how communication could be improved, Kathryn raises her hand and says, “I can tell you how to improve it. Stop wasting people’s time by making them sit in classrooms and insulting them by making them think they are causing problems!” Most of the participants look annoyed and rather distraught. A few, however, chuckle and begin to mutter that they, too, would like to leave.

Alexandra acknowledges Kathryn’s concerns and briefly explains the rationale for the education. The class resumes, and all goes well for about the next 20 minutes. As the participants split into groups to prepare for role-playing, Kathryn uses the opportunity to make negative comments about the activity. The situation is getting out of control. What should Alexandra do?

She can’t allow this disruptive behavior to continue. In similar situations, try to defuse the situation and address concerns, as Alexandra has done. But if that fails, you must take action. You don’t want to embarrass Kathryn or belittle her in front of others. Use the groups’ preparation time to speak to her in private. Acknowledge her concerns and ask whether there is anything you can do to help her become more comfortable with the learning activity, but tell her she cannot continue to disrupt the class.

If Kathryn refuses to cooperate, you may need to ask her to leave. This may be her goal, but if the education is mandatory and you have administrative support, she may suffer negative consequences. If she leaves the classroom, you must be proactive and seek her immediate supervisor. Explain, objectively, what happened and why you took the action that you did. Remember not to take Kathryn’s actions personally. However, you must not let one resistant learner disrupt everyone’s experience. You must also protect yourself and be ready to justify your decision to dismiss Kathryn from the activity.

What happens when a resistant learner shows indications of becoming violent? This is a rare occurrence, but you must be prepared to deal with the possibility of violence.

Suppose a nurse who has failed to achieve ACLS certification blames the instructor and approaches her in her office. She is obviously angry and her body language (e.g., clenched fists, standing close to the instructor) indicates a potential for violence. What should you do in this type of situation? The following are immediate steps you should take to defuse the situation:

➤ **Encourage the angry person to sit down.** This action often has a calming effect. Position yourself at

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**Teaching strategies** < continued from p. 9

eye level with the person. Don’t allow her to stand over you, and don’t stand over her.

➤ **Speak in a calm, measured voice.** Don’t raise your voice or let your body language betray anger or fear.

➤ **Listen actively.** Maintain eye contact. Tell the person that you are there to help her but can’t do so if she continues to shout or make threats.

➤ **Try not to take the anger personally.** You may be the target of misplaced anger. This doesn’t make it any less frightening, but it does make it easier to maintain your self-control. Becoming angry and responding in anger will only escalate this situation.

➤ **Offer the person options.** For example, if extra tutoring is an option, make sure she knows it. Emphasize that you are there to help her achieve her educational and occupational goals.

➤ **Know how to get help quickly.** Have security’s phone number handy. If you feel you are in immediate danger, don’t be afraid to call out for help, especially if you don’t have time to use the phone or if doing so will only escalate the dangerous situation. If you have a preplanned meeting with someone you suspect may become out of control, don’t meet alone. Ask another colleague to be present.

➤ **Never allow the angry person to block your exit from a room.** Never trap yourself behind a desk. Always make sure you have a quick, easy way out.

➤ **Always report this type of incident.** Never allow violence, whether threatened or actual, to go unreported. A violent or potentially violent employee is a danger to everyone who works at your organization.

Remember, you cannot make someone want to learn, you can only facilitate learning to the best of your ability. By relying on the principles of adult learning and being an enthusiastic proponent of education, you can have a significant impact on the motivation of others.

**Source**

Briefings on Evidence-Based Staff Development (formerly The Staff Educator), June 2010, HCPro, Inc.

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**Patient safety**

### Success in a fall reduction strategy

**Continuing Education | Learning Objectives**

After reading this article, you will be able to:

➤ Identify Mary Greeley Medical Center’s fall reduction strategy

➤ Define the six indicators of success in a fall reduction strategy

➤ Recognize additional fall reduction strategies

by Neal T. Loes, RN, BSN, MS, CNO at Mary Greeley Medical Center in Ames, IA

Systemic change requires visionary leadership. The board of trustees for our facility established a new three-year strategic plan based on our six indicators of success.

One such indicator is Quality & Patient Safety, and the board determined that this indicator should include a vision “to eliminate all preventable harm.”

Given this direction, we chose to focus on patient falls and began to ask ourselves whether we could eliminate all falls. The prior year baseline for our organization was 3.8 falls per 1,000 patient days. When compared to the National Database of Nursing Quality Indicators, we were within the benchmark for our medical-surgical units.

We still believed there was opportunity for improvement. To ensure organizational involvement, we added the organizational fall rate as part of the leadership merit-based performance management system. This includes all supervisors, directors, and the administrative
team. This step was crucial to remove barriers and to demonstrate support for this common goal.

Our strategy was simple: First, we organized a multidisciplinary team to meet monthly and began to look at the data. We found that although our falls had decreased over the past five years, there was still great variability from month to month and from unit to unit. We evaluated our fall reduction policy/program and felt it was relevant and remained current to the evidence-based literature we researched, with one exception: We implemented a national strategy promoted by the Iowa Healthcare Collaborative, which was to place a yellow wristband on all patients identified as a fall risk. We then reeducated our staff on their roles and the importance of the program.

Next, we went back to the data, which we stratified manually into day of week, time of day, level of fall prevention in place at time of fall, staffing adequacy, etc. We found through our data review that 42% of our falls occurred with bathroom activities, and there was a pattern of falls occurring at change of shift.

To address these issues, we educated our nursing staff on the data and modified our hourly rounding program so nursing staff were required to assist fall risk patients to the bathroom hourly. We also adjusted change of shift activities to free up the patient care technicians so they could make bathroom rounds prior to performing their vital signs and other duties. We use shift huddles to reinforce the fall prevention strategies and report successes, as well as issues, with falls that occur.

When a fall occurs—and yes, they do occur—we conduct an immediate root cause analysis. We evaluate whether the patient was assessed correctly and interventions were implemented, and then determine the cause variable that led to the patient's fall. Each fall is reported at the monthly meeting for further evaluation and education.

Other fall reduction strategies that we continued to utilize are as follows:

➤ **Volunteer sitter program.** We are fortunate to live in a university community and have tapped into the university to establish a sitter pool for students to volunteer once provided the competency development.

➤ **Companion program.** We have hired staff to work in our float pool to function as companions for patients needing one-to-one care. The companions function as patient care technicians for the one patient assignment, thus freeing up time for nursing staff to care for other patients.

➤ **Bed alarms.** We purchased more units and increased use of the bed alarms through our call light to the two-way communication device.

➤ **Daily fall risk assessment and falling star program.** We evaluate patients for fall risk at least once per day to see what variables have changed. In addition, if a patient has suffered a fall, we attach a falling star symbol to the outside of the patient’s room to alert staff to the greater potential of a repeat fall.

➤ **Monthly celebration.** We track the unit fall rates daily. The unit that goes the most days without a patient fall within the month receives a celebration.

➤ **Poly-pharmacy review.** We are implementing a poly-pharmacy review of all fall risk patients on 10 or more medications to identify opportunities to reduce the impact of medications on the patient’s outcome.

The results through the first six months of this fiscal year demonstrate our fall rate as 2.8/1,000. This is a 26% reduction in falls from the previous year baseline rate of 3.8/1,000, and the monthly variation in fall rate has diminished. We have not eliminated falls, nor do I know whether that is possible; however, we are well on our way to reducing the potential of this harm for our patients.

**Source**

*HCPro’s Advisor* to the ANCC Magnet Recognition Program®, June 2010, HCPro, Inc.

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**Tip of the month**

**Establishing ethical boundaries among staff**

How often do we hear leadership comment on the lack of ethics in the workplace? We think of ethical actions as those that do well and bring no harm to patients, yet at the staff level, do you see or hear of decisions people are making that raise an eyebrow?

When you start thinking, “What part of this did they think was okay?” the question of an ethical dilemma presents itself. We see a shift in values and behaviors that for some are justified, while some scenarios are unnoticed.

“The very essence of ethical drift is that it occurs before the seriousness of the dilemma takes shape or before the conflict is even perceived,” says Carol Kleinman, PhD, TN, CNA.

This “ethical drift” is affecting department morale, staff motivation, and retention. Setting ethical boundaries is an essential role of leadership. Consider these questions to help you approach the next ethical dilemma:

➤ What is the identified dilemma?
➤ What nursing value(s) does this conflict with?
➤ Is the conflicting value an organizational, professional, or other value?
➤ Do you have access to an ethics committee or representative?
➤ What outcomes are you looking for?

**Reference**


**Source**

Shelley Cohen, RN, MSN, CEN, Health Resources Unlimited, www.hru.net. Adapted with permission.

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**Website spotlight**

*The New York Times* recently blogged about studies regarding the ill effects of workplace stress. However, when reading the article, one particular statistic caught my attention:

Nurses struggling with excessive work pressure have DOUBLE the risk for a heart attack. This statistic comes from a study conducted by Danish researchers over a 15-year period.