FINANCIAL DISCLOSURE

Michelle Ryerson, DNP,RN,NEA-BC has no relevant financial relationships with commercial interests to disclose.

David Paul, BBA has no relevant financial relationships with commercial interests to disclose.

Christine Andre, MD has no relevant financial relationships with commercial interests to disclose.
The Team

• **CSE Participants**
  - **Michelle Ryerson**, DNP, RN, NEA-BC, VP of Clinical Operations, University Health System
  - **Christine Andre**, MD, Assistant Professor, Division of Hospital Medicine
  - **David Paul**, MBA, Director Fiscal Management, University Health System

• **Our Sponsors**
  - Division of Hospital Medicine, Department of Medicine, UTHSCSA
    – Dr. Luci Leykum
  - University Health System
    – Christann Vasquez, Chief Operating Officer, University Health System
    – Tim Brierty, Chief Executive Officer, University Hospital
    – Nancy Ray, Chief Nursing Officer, University Health System
AIM STATEMENT

To decrease the overutilization of patient sitters 100% by introducing a standardized protocol and implementing alternative patient safety plans on the 9th floor General Medicine ward at University Hospital by August 31, 2011.

The goal is to accomplish this without compromising patient safety as measured by the rate of falls, falls with injury, and elopement.
Project Milestones

- Tiger Team Created: May 2011
- AIM statement created: May 2011
- Weekly Team Meetings: May-Aug 2011
- Background Data, Brainstorm Sessions, Workflow and Fishbone Analyses: June 2011
- Interventions Implemented: July 5-29, 2011
- Data Analysis: Sept 2011
- CS&E Presentation: Sept 16, 2011
Background

• Patient sitters for all indications - physician driven
  – Very little interdisciplinary collaboration

• No consideration was given to sitter alternatives
  – Patient safety plan & standard interventions were lacking

• Adverse events occurred even with sitters @ bedside

• Inadequate Nursing leadership oversight of sitter utilization

• Literature review
  – Use of the sitter not cost effective;
  – Does not reduce fall rates; does not improve patient satisfaction;

• Networking with other Magnet Hospitals
  – Common problem/concern
  – Other hospitals shared strategies/tools
Patient Sitter Costs Over-Budget

- Hospital-wide negative financial trend for patient sitters
  - Budgeted $1.5 M/FY 2011
  - Projected $2.3 M/2011 based on YTD trend
  (-$800,000)
Background Data

• The 9th floor Medicine unit was the largest consumer of patient safety sitter hours
  – On a daily basis 9-10 patients per shift on close observation

• 58 bed unit - patient sitters used for small group had negative impact on nursing skill mix for all other patients on unit

• Average Patient Sitter cost:
  – Base pay @ approximately $11/hr
  – Average cost of filling patient sitter shift increased to $16/hr
    • high volume of requests/unmet demands
    • Shifts often filled with med/surg techs (higher pay rate) working overtime

• Use of sitters became an expectation of physicians, nurses and families
Process Analysis Tools

Fishbone
Process Analysis Tools (cont.)

9th Floor General Medicine Patient Safety Assistant Work Flow
Updated: June 16, 2011

Assessment
- Mental status
- Fall Risk (scoring) - if >6 sitter recommended

Cohort Patients 2:1, 3:1, 4:1
- Problem when patient needs procedures, etc. in other area of hospital
- Gender
- Intermediate patients
- Isolation
- VRE
- MRSA
- Psychosocial

No Documentation (other than RN assessment)
- Patient baseline OBS, Psychiatric, Dementia
- Nurse documents assessment every 2 hours only for patient restraints
- Long term care patients

Patient Placed with Assistant MD order re-newed every 24 hours
- No documentation otherwise/No review of documents by unit manager

No Plan of Care Associated with Assistant

No Safe Behavior Goals for when to d/c Assistant

RN decides when to d/c Patient from Assistant Orders
- Night cross cover resident will not discontinue 1:1 because assessment is not ongoing

No documented re-assignment of Assistant
How Will We Know That a Change is an Improvement?

- Decrease in total number of PSA’s used per day
- Decrease in total hours of PSA’s used per month
- Decrease in overtime hours
- Indications for PSA’s deemed appropriate by team
- There is no increase from baseline in the volume of falls, falls with injury, and elopements
What Changes Can We Make That Will Result in an Improvement?

- Change “sitters” to “patient safety assistants (PSA)”
- Update PSA job description
- Implement decision-making algorithm for front-line teams
- Institute PSA bedside observation documentation log
- Establish nurse leader/MDs rounds on close observation patients @ least daily regarding patient safety plan
- Provide access to patient safety equipment/supplies 24/7
  - Low boy beds, bed enclosures, appropriate nurse call notification/alarms
  - Patient immobilization devices (elbow immobilizers/mittens)
- Institute lightening rounds (q 15min) when needed
**Selected Decision Making Tools**

**Algorithm for Requesting Patient Safety Assistance**

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<th>Time</th>
<th>Behavior/Activity</th>
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Hours of uninterrupted sleep: ______________________ Early awakening ______________________ Awakens feeling rested ______________________

Difficulty falling asleep: ______________________ Interrupted sleep: ______________________ Restlessness: ______________________ Sedation: ______________________

Other: ______________________

**PATIENT SAFETY ASSISTANT LOG**

(Close Observation for Patient Safety Issues)

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Intervention Plan

Pilot decision-making algorithm and observation documentation log with clinical teams to identify alternatives to Patient Safety Assistants for patient safety related issues on the 9th floor General Medicine Unit during July 2011.
Implementing the Change
Do

• Daily rounding
  – Put algorithm into practice
  – Review observation logs
  – Brainstorming/positive coaching
  – Consider alternatives to PSA’s
    • Cohorting/proximity to nurses’ station
    • Special equipment
    • Frequent checks by clinical staff (e.g. lightening rounds)

• Real-time feedback to staff on outcomes
Check Results/Impact

9th Floor General Medicine Daily PSA Utilization

Pilot Start Date
July 5th
9 Gen Medicine Fall Volume/Injury Trend 2011

Pilot Start Date
July 5th
2011 Elopements 9 General Medicine

Pilot Start Date July 5th
Indications for PSA’s

9th Floor Medicine Physician Order Indications for Patient Safety Assistants

* Generally considered indicated
2011 Patient Safety Assistant Utilization 9 General Medicine

Pilot Start Date July 5th
Expansion of Our Implementation Act

- Plan to role out to all other inpatient areas of hospital
- Nursing PSA Utilization Policy and Guideline
- Revise Patient Safety Assistant Job Description/Human Resources
  - Enhance Patient Safety Assistant Training to include Cognitive Coaching/Therapeutic Interactions
- Patient Safety Equipment Fair/training (completed)
- Enhance Communication with House Staff Regarding changes
- Modify electronic MD orders - eliminate ability to order PSA for safety indication
Project Return on Investment (ROI)

- Annual Project Costs
  - Projected labor cost: $49,002
  - Sustainment cost: $97,000
- Annual Projected Savings
  - Hard Savings: $576,000
- Projected Annual Net Savings
  - $479,000
- ROI 295%
Conclusion/What’s Next

• Intra-disciplinary communication and problem-solving are key to improving patient safety and appropriate utilization of resources
• Day to day front-line nursing leadership is key to success
• Tiger team continues to meet weekly
• Current efforts and future plans
  – Roll out to all nursing units
  – Pilot/Implement new Falls Risk Assessment tool
  – Develop and Implement Elopement Prevention Guideline
  – Improve the overall multi-disciplinary care of acute brain injured patients
Thank you!