Mid Shift Safety Shuffle

Beth Israel Deaconess Hospital - Plymouth

Introduction/Problem

The idea of the Mid Shift Safety Shuffle was the result of a brainstorming session with Certified Nursing Assistants (CNA's) who spend the most time with the patients who were identified as the highest risk for falling. They were committed to reducing falls and participated in all of the improvement efforts to decrease falls, however, it was their solution that seemed to be most successful in reducing falls on the unit.

Nursing leadership encouraged front line staff to attend the monthly fall prevention meeting and empowered staff to create change in their practice.

Aim/Goal

- Decreased falls rate and falls with injury rate
- Increased awareness for staff about patient safety
- Improved knowledge of the standard fall prevention plan and interventions tailored to each patient's fall risk score

The Team

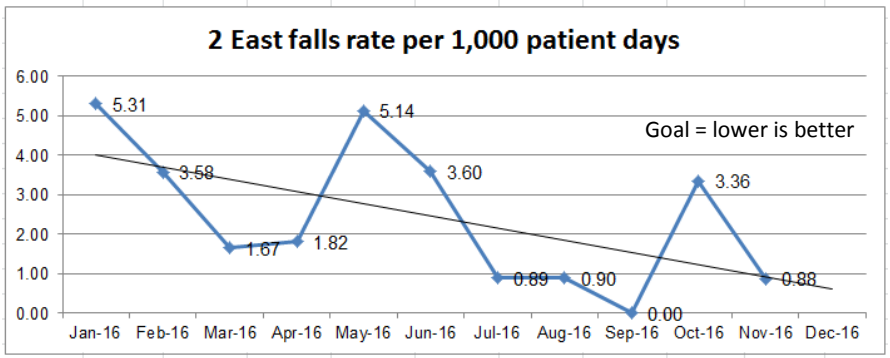
- Elizabeth Charron RN, BSN, Clinical Nurse Manager
- Jean Marie Grupillion, RN, BSN, Unit Based Educator
- 2 East CNA's

The Interventions

A time out is taken at the midpoint of the shift, i.e., 11:00, 19:30 and 04:00. Each CNA alerts their nurse that they will be leaving their assignment to participate in the Mid Shift Safety Shuffle. The CNAs each move in a clockwise fashion to the next assignment where they review a standard safety check list for the patients in that assignment. Patient safety items reviewed include:

- Level of fall risk for each patient (level is assessed and documented by RN only)
- Verify all appropriate interventions are in place for patient's level of risk
- Ensure the call light is within reach of the patient
- Conduct an environmental check to confirm that there are not wires to trip over, spills on the floor, and that there is a clear path to the bathroom
- Visually inspect that the white board in the patient room has been updated especially with hourly rounding documentation

Results/Progress to Date



The Mid Shift Safety Shuffle was implemented July 5, 2016. The data we have collected since implementation is above. In this short period of time we have demonstrated a significant improvement in our unit specific fall rates.

Lessons Learned

- Confirmed the importance of engaging frontline staff and empowering them to impact clinical outcomes.
- The importance of standardizing work flow and ensuring it is executed the same way by each employee.
- Organizing and ensuring tools for execution, i.e. grid with fall risk and specific interventions for each level of risk are understood and readily available to staff

Next Steps

- The Mid Shift Safety Shuffle is being rolled out for implementation on the other Med Surg nursing units.
- Nursing leadership will continue to monitor compliance, evaluate effectiveness, identify trends and make improvements when necessary
- Nursing leadership will continue to correlate falls data and patient satisfaction data with improvement initiatives
- Hardwire the Mid Shift Safety Shuffle process.

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