EP1EO – Professional Practice Model

EP1EO: Two examples are required (one example must be from ambulatory care setting, if applicable).

Provide two examples, with supporting evidence, of an improved outcome associated with an evidence-based change made by clinical nurses in alignment with the organization's professional practice model (PPM).

- *Outcome data must be in the form of a graph and a data table.*
- *Provide a schematic of the PPM.*

Example EP1EOa: Patient Fall Reduction in Surgical Unit Using Evidence-Based Practice (EBP) to Implement Standard Operating Procedure of Utilizing Hourly Rounding

Problem

The PPM of Nursing Affairs KFSHRC-J includes shared governance and EBP principles as the golden threads woven throughout all aspects of nursing care delivery and is used to improve patient outcomes. These are described in detail in the Nursing Practice Plan (see OO7.2) and the Shared Governance Rules and Regulations. The Nursing Quality Committee is responsible for monitoring the practice and quality of nursing care delivery within Nursing Affairs and making recommendations to the Nurse Executive Council. The Unit Councils (UC) are responsible for decision-making for nursing practice, incorporating best practice principles, and evaluating outcomes of key performance measures at the unit level.

The corporate Zero Harm initiative is part of KFSHRC General Organization's strategy to become a High Reliability Organization. Patient falls are one of the key performance indicators that Nursing Affairs is responsible for on the Zero Harm Scorecard. Thus, monitoring patient falls is a mandated clinical indicator in the nursing strategic plan for KFSHRC-J. The fall rates are reported to the Performance Improvement Council and are shared with the nursing units by the Nursing Practice and Research department.

The Surgical unit did not achieve zero patient falls in January 2021; the patient fall rate was 1.8/1000 patient days.

Goal Statement

Decrease the rate of patient falls per 1000 patient days in the Surgical unit at KFSHRC-J.

Participants

Table EP1EOa.1 below lists the participants involved with the project to reduce falls in the Surgery unit.

Table EP1EOa.1: Participants in Surgical Unit Falls Reduction Project

Name & Credentials	Job Title	Department
Maureen Koh, BSN RN, CMSRN	Staff Nurse 1 (SN1), Clinical Nurse, **UC Chair**	Surgical
Ellen Guevara, BSN RN	SN1, Clinical Nurse **Falls Sub-Group**	Surgical
Sundos Banjar, BSN RN	SN1, Clinical Nurse **Falls Sub-Group**	Surgical
Stephen Cruz, BSN RN	SN1, Clinical Nurse **Falls Sub-Group**	Surgical
Ivyn Pili, BSN RN	SN1, Clinical Nurse **Falls Sub-Group**	Surgical
Rhoda Laigo, BSN RN	SN1, Clinical Nurse **Falls Sub-Group**	Surgical
Erlinda Bacolod, BSN RN	SN1, Clinical Nurse **Falls Sub-Group**	Surgical
Joyce Jumaquio, BSN RN	SN1, Clinical Nurse **Falls Sub-Group**	Surgical
Diane Ross, MSN RN, CM	Head Nurse	Surgical
Rio Flores, BSN RN	Nurse Clinician	Surgical
Gabrielle Hutchens, MAppMgt (Nurs) RN, CPHIMS, CPHQ, CSSGB	Nursing Quality Improvement Coordinator	Nursing Practice and Research

Description of the Intervention

Using the Professional Practice Model:

UC Decision Making with Nurse Clinician and Nurse Manager as Facilitators

In February 2021, the previous 12 months of data were reviewed, and the concern of rising patient falls was discussed in the Surgical UC meeting by clinical nurse Maureen Koh, BSN, RN, CMSRN, UC Chair. The members agreed to set a goal for improvement in patient falls with a task to complete a literature review.

Using Evidence-Based Practices

The UC members completed a literature review to identify best practices in patient fall prevention. Various resources were used to collect evidence, including:

- EBP internal clinical policies
- Joint Commission International Standards for Hospitals on International Patient Safety Goals (IPSG) to reduce the risk of harm from patient falls

- Agency for Healthcare Research and Quality for preventing falls in hospitals: A Toolkit for Improving Quality of Care (https://www.ahrq.gov/)
- Two peer-reviewed articles (Daniels, 2016; Hicks, 2015) on patient rounding to reduce patient falls

The findings were presented through Microsoft Teams to the team.

Implementing the Change of Hourly Rounding in the Care Delivery System

The UC agreed to assign a sub-group facilitated by the Nurse Clinician Rio Flores, BSN, RN, with clinical nurses as members, as seen in Table EP1EOa.1 above, to pioneer changes in practice for better patient outcomes related to reduced patient falls in February and March 2021. The sub-group worked on the following:

- Implementing the "5-P's" approach during hourly rounding, i.e., Pain, Position, Potty, Periphery, and Pump
- Defining a Standard Operating Procedure (SOP) for nurses in the Surgical unit based on the outcomes of the EBP review for better implementation and compliance monitoring
- Developing patient education

When the data from the February falls rate on the Surgical unit was analyzed and the improvement demonstrated, Maureen presented the SOP to the Nursing Quality Committee in March 2021. This Committee approves changes in practice and quality for Nursing Affairs on an organization-wide basis. After the SOP was approved, it was forwarded to Gabrielle Hutchens, MAppMgt (Nurs) RN, CPHQ, Quality Improvement Coordinator, for final approval. The organization-wide SOP: NA-J-SOP-SUR-27 "Fall Prevention Utilizing Hourly Rounding" was approved on March 28, 2021.

Professional Development

Education was developed and implemented for the clinical nurses to apply the rounding practice on the Surgical unit during February-March 2021. Patients were also educated on the process of rounding.

Figure EP1EOa.1 below demonstrates how the PPM was used for achieving this goal.

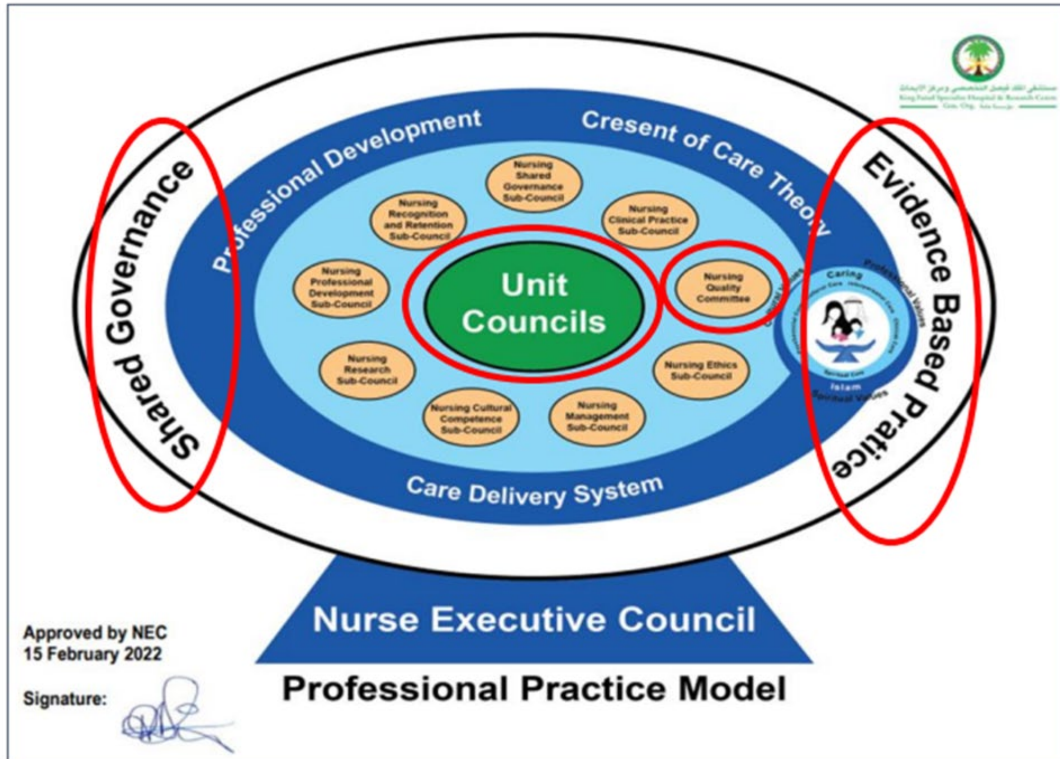
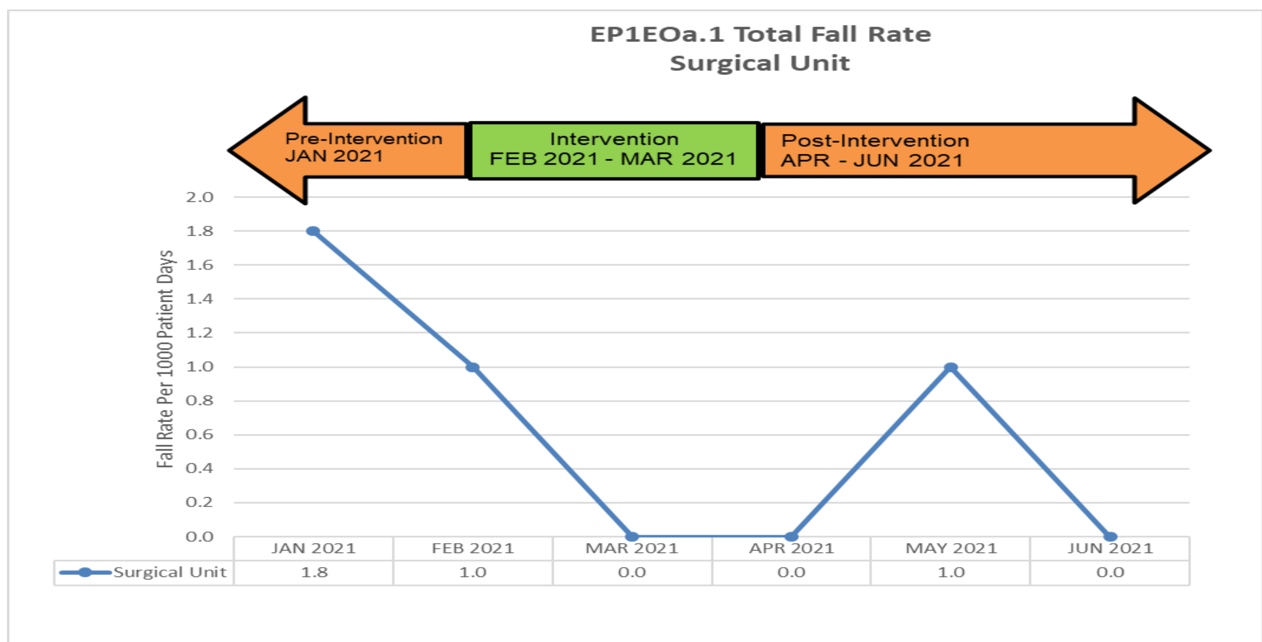


Figure EP1EOa.1: KFSHRC-J PPM, Nursing Affairs, 2022

All Interventions were completed during February and March of 2021.

<u>Outcome</u>

The rate of the Surgical unit total falls at KFSHRC-J was reduced as seen in Graph EP1EOa.1 below.



	JAN 2021	FEB 2021	MAR 2021	APR 2021	MAY 2021	JUN 2021
Surgical Unit	1.8	1.0	0.0	0.0	1.0	0.0

Graph EP1EOa.1: Surgical Unit Total Fall Rate

References

Daniels, J. F. (2016). Purposeful and timely nursing rounds: a best practice implementation project. *JBI Evidence Synthesis*, *14*(1), 248-267.

Hicks, D. (2015). Can rounding reduce patient falls in acute care? An integrative literature review. *Medsurg Nursing*, *24*(1), 51.

Joint Commission International Accreditation Standards for Hospitals, 7th Edition. (2020). https://www.jcrinc.com/

Preventing Falls in Hospitals, A Toolkit for Improving Quality of Care (2013). Agency for Healthcare Research and Quality, USA. https://www.ahrq.gov/