

Chamberlain Scottsdale Hospital ED Quality Improvement Project

Student Name
Chamberlain College of
Nursing
NR631 - Nurse Executive Concluding
Graduate Experience I
Dr. Dawn Julian
February 16th

Identification of the Problem/Concern

- ▶ The project change initiative takes place at Chamberlain Hospital in Scottsdale, AZ.
- ▶ The hospital's ED had experienced operational issues.
- ▶ These negatively affected care provision and patient outcomes

Identification of the Problem/Concern

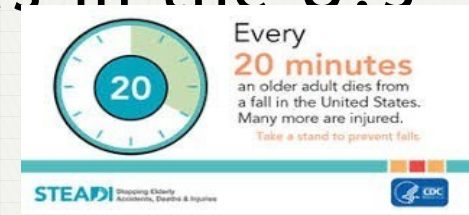
- ▶ There was low patient admission rates.
- ▶ This lapse in care delivery led to increased patient falls
- ▶ It also increased the costs of care and reduced the revenues
- ▶ The hospital's throughput was significantly affected leading to a near level closure.

Identification of the Problem/Concern

- ▶ To remedy the situation, a QI change initiative was eminent.
- ▶ Since closing it would greatly affect the health of the community.
- ▶ For they depended on Chamberlain for most of their healthcare needs.

Summary of Relevant Literature

- ▶ Available evidence supports increasing nurses as a solution to patient falls.
- ▶ Patient falls is an increasing healthcare burden increasing costs to about \$31 billion each year.
- ▶ Hospital falls for inpatients are in the range of 13% and 23% prolonging their time in hospital.
- ▶ According to the CDC, an older patient dies from a fall every 20 minutes in the U.S



Summary of Relevant Literature Continued

- ▶ 23% and 42% of these falls are injurious
- ▶ The geriatric population is at increased risk with 5% to 10% of these falls leading to major injuries
- ▶ An injury fall reduces their functionality, increases health problems and hospital costs



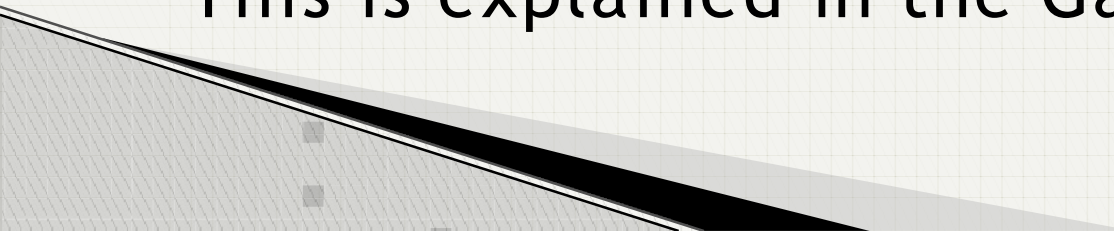
Summary of Literature Continued

- ▶ 15 scholarly articles were identified that supported the project's problem.
- ▶ They revolved around the causes of patient falls in the ED and effective interventions in reducing these falls.
- ▶ For instance, half of these article supported increasing staff nurses to enable nurse rounding.
- ▶ The move would help serve the patients better and identify those at increased risk of falling.

Summary of Literature Continued

- ▶ With enough nurses, patients would be attended to in the right manner and time.
- ▶ This move would improve the quality of care offered.
- ▶ The articles supported our study problem of patient falls caused by poor ED operations.
- ▶ They also supported increasing number of nurses as an effective intervention to reducing patient falls during care.

Project Details

- ▶ Project sponsors were ADTALEM
 - ▶ The project targeted the ED patients and the nearby community.
 - ▶ It would improve the services at the ED
 - ▶ Success of the project involved formulating an implementation strategy.
 - ▶ This is explained in the Gantt chart below
- 

The Implementation Strategy Continued

Project Measures

- ▶ **ED processes/throughput**
 - Measure efficiency by optimizing discharges, streamlining patient movements, smoothing the surgical procedures.
- ▶ **Patient health Outcomes**
 - Assessing their satisfaction levels
- **Improved Profits and Revenues**
 - To be assessed and analyzed after every six months for five years

Summary of Project: Resolution of the Problem/Concern

- ▶ Patient falls are an increasingly troubling occurrence in most Emergency Departments.
- ▶ The Chamberlain hospital in Scottsdale is one of such hospitals with a troubled ED.
- ▶ It faced increased delays in care leading to increased cases of patient falls.
- ▶ This situation also affected the general operation of the hospital.
- ▶ For instance LWBS rate was 4.6% against a national benchmark of 2%.

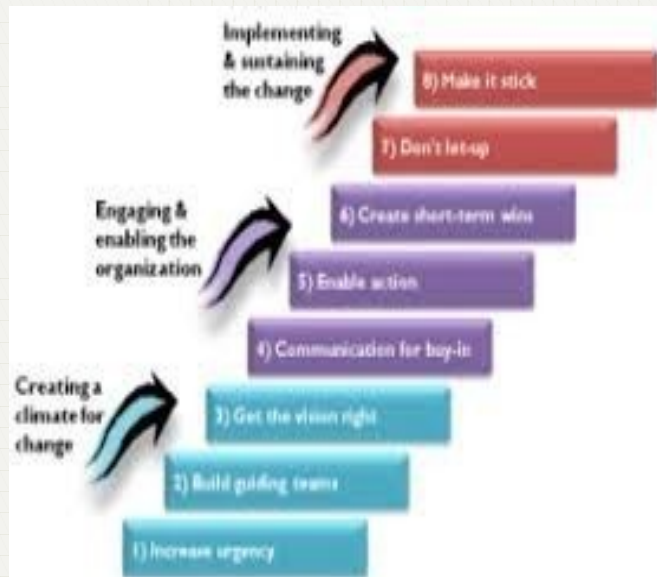
Summary of Project: Resolution of the Problem/Concern continued

- ▶ The hospital had lost 2013 patients last year due to poor services
- ▶ It had encountered an annual loss of \$1,345,791.00 in revenues.
- ▶ The hospital did not benefit from diagnostic tests
- ▶ Its current inpatient admission rate was 29% which was low
- ▶ Lost \$5,021,130.00 due to lack of admissions
- ▶ The accumulative loss was

Summary of Project: Resolution of the Problem/Concern continued

- ▶ A quality initiative project was initiated.
- ▶ A multidisciplinary team helped execute the project.
- ▶ Member roles and team work helped achieve success.
- ▶ The strategy included;
 - ☺ Slight renovations of the ED.
 - ☺ Increasing the number of staff nurses during busiest hours of the day.
 - ☺ Project assessment and evaluation
- ▶ Results so far were slight improvement in service delivery hence less -patient falls.

Summary of Project: Resolution of the Problem/Concern continued



- ▶ The Lippitt's change theory informed our change process.
- ▶ We applied transformational leadership style.
- ▶ No barriers were encountered: the PM and team were well prepared to counter any such barriers.
- ▶ No ethical issues were violated

Next Steps

- ▶ The project supports proper nurse staffing to improve ED processes and patient healthcare.
- ▶ With enough nurses, rounding can be effective.
- ▶ Through nurse rounding, patient falls can be minimized.
- ▶ **This project can help hospitals achieve;**
 - ☺ Improved ED processes
 - ☺ Increased customer base
 - ☺ Increased patient outcomes
 - ☺ Increased patient satisfaction levels
 - ☺ Increased profits and revenues.
 - ☺ Minimized additional costs to care.

Dissemination plan

- ▶ Dissemination of results to colleagues (Frontline staff) will be through;
 - ☺ Internal meetings
 - ☺ Social media platforms such as emails, WhatsApp among others
 - ☺ Poster presentations
- ▶ Dissemination to other researchers and healthcare professionals will be through quality improvement conferences such as;
 - ☺ The American Journal of Nursing
 - ☺ The journal of Aging Research
- ▶ A proposal in form of an abstract will be submitted.

References

- ▶ Brosey, L. A., & March, K. S. (2015). Effectiveness of structured hourly rounding on patient satisfaction and clinical outcomes. *Journal of Nursing Care Quality, 30*(2), 153-159. doi: 10.1097/NCQ.000000000000086
- ▶ de Jong, L. D., Kitchen, S., Foo, Z., & Hill, A. M. (2018). Exploring falls prevention capabilities, barriers and training needs among patient sitters in a hospital setting: A pilot survey. *Geriatric Nursing, 39*(3), 263-270. doi: 10.1016/j.gerinurse.2017.09.006
- ▶ Fabry, D. (2015). Hourly rounding: Perspectives and perceptions of the frontline nursing staff. *Journal of Nursing Management, 23*(2), 200-210. doi: 10.1111/jonm.12114
- ▶ Hicks, D. (2015). Can rounding reduce patient falls in acute care? An integrative literature review. *Medsurg Nursing, 24*(1), 51-55.
- ▶ LeLaurin, J. H., & Shorr, R. I. (2019). Preventing falls in hospitalized patients: State of the science. *Clinics in Geriatric Medicine, 35*(2), 273-283. doi: 10.1016/j.cger.2019.01.007

References

- ▶ King, B., Pecanac, K., Krupp, A., Liebzeit, D., & Mahoney, J. (2018). Impact of fall prevention on nurses and care of fall risk patients.
The Gerontologist, 58(2), 331-340. doi: 10.1093/geront/gnw156
- ▶ McCarty, C. A., Woehrle, T. A., Waring, S. C., Taran, A. M., & Kitch, L. A. (2018). Implementation of the MEDFRAT to promote quality care and decrease falls in community hospital emergency rooms. *Journal of Emergency Nursing*, 44(3), 280-284.
doi: 10.1016/j.jen.2017.10.007
- ▶ McErlean, D. R., & Hughes, J. A. (2016). Who falls in an adult emergency department and why - A retrospective review. *Quality Project Report*, 20(1), 12-16. doi: 10.1016/j.aenj.2016.11.001
- ▶ Morris, R. (2017). Prevention of falls in hospital. *Clinical Medicine*, 17(4): 360–362. doi: 10.7861/clinmedicine.17-4-360.
- ▶ Ozturk, T. C., Ak, R., Akoglu, E. U., Onur, O., Eroglu, S., & Saritemur, M. (2017). Factors associated with multiple falls among elderly patients admitted to emergency department. *International Journal of Gerontology*, 11(2), 85-89. doi: 10.1016/j.ijge.2016.05.009
- ▶ Pellerin, R., & Perrier, N. (2018). A review of methods, techniques and tools for project planning and control. *International Journal of Production Research*, <https://doi.org/10.1080/00207543.2018.1524168>.

References

- ▶ Reuben, D. B., Gazarian, P. K., Alexander, N., Araujo, K. L., Baker, D., Bean, J. F. . . McMahon, S. (2017). The STRIDE intervention: Falls risk factor assessment and management, patient engagement, and nurse co-management. *Journal of the American Geriatrics Society*, 65(12), 2733-2739. doi: 10.1111/jgs.15121
- ▶ Sanyi, C. (2018). Hourly rounding and fall prevention: A change process. *Capella University*. doi: handle.net/10755/624134
- ▶ Shankar, K. N., Lui, S. W., & Ganz, D. A. (2017). Trends and characteristics of emergency department visits for fall-related injuries in older adults, 2003–2010. *Western Journal of Emergency Medicine*, 18(5), 785–793. doi: 10.5811/westjem.2017.5.33615
- ▶ Simamora, R. H., Nurmaini, & Siregar, C. T. (2019). Knowledge of nurses about prevention of patient fall risk in inpatient room of private hospital in Medan. *Indian Journal of Public Health Research & Development*, 10(10), 759-763. doi: 10.37506/ijphrd.v10i10.5427
- ▶ Toye, C., Slatyer, S., Kitchen, S., Ingram, K., Bronson, M., Edwards, D. . . Hill, K. D. (2019). Bed moves, ward environment, staff perspectives and falls for older people with high falls risk in an acute hospital: A mixed methods study. *Clinical Interventions in Aging*, 14, 2223–2237. doi: 10.2147/CIA.S211424
- ▶ University of West Florida. (2020). *Literature Review: Conducting & Writing*. Retrieved from: <https://libguides.uwf.edu/c.php?g=215199&p=1420563>