EP17EO – CULTURE OF SAFETY

ADDRESSING NURSING TURBULENCE TO DECREASE FALLS

Using the required empirical outcomes presentation format, provide one example of an improved patient safety outcome associated with clinical nurse involvement in the evaluation of patient safety data at the unit level.

Problem

Demanding workloads and increasing patient acuity puts patients at greater risk for falling while hospitalized, often when left unattended. Recent studies have found that nursing turbulence, which refers to the degree to which a nurse's attention is diluted or redirected by thought diversions, resource inadequacy, communication breakdowns, or interpersonal relationships, along with increased workload, increases the risk of patient adverse events such as falls. In January 2023, the clinical nurses in the Medical Oncology (6HN-605118) [6HN] Unit at NewYork-Presbyterian/Columbia University Irving Medical Center (NYP/Columbia) expressed a perception of heightened nursing turbulence caused by supply and equipment issues, communication barriers, and increased workload. The patient falls on 6HN increased during this time.

Pre-Intervention

January 2023:

- In January 2023, the total patient falls rate on 6HN was 5.59 per 1,000 patient days.
- 6HN Unit Council members and clinical nurses Nicole Turkoglu, MSN, RN, OCN, BMTCN; Shannon Forty, MSN, BS, RN; and Nadeen Robinson, MSN, RN, OCN; evaluated falls (patient safety) data for 6HN with Archana Shenoy, DNP, RN, OCN, FNP-C, Patient Care Director (nurse manager), 6HN. By examining each fall incident, they noted an increased trend in falls related to patients reaching for

objects, getting out of bed, and toileting. Ms. Turkoglu, Ms. Forty, and Ms. Robinson along with other members of the 6HN Unit Council decided to investigate whether nursing turbulence was contributing towards the nurses' ability to promptly respond to the patients' needs thereby leading to an increase in the number of falls.

- Ms. Turkoglu, Ms. Forty, and Ms. Robinson, with the approval of Dr. Shenoy, administered a 15-item survey to the 6HN clinical nurses on nursing turbulence that included items related to thought diversion, inadequate resources, communication breakdowns, interpersonal relationships, and technology to determine the current nursing turbulence level in the unit. Next, they analyzed the survey results and found that the top four factors contributing to nursing turbulence on 6HN were distractions, interruptions, equipment/supply issues, and delayed response time related to issues with printers and Wi-Fi outages. Based on their findings, they agreed on a plan that focused on improving availability of supplies and equipment to reduce nursing turbulence and improve patient safety.

Goal Statement

To decrease the total patient falls rate per 1,000 patient days on 6HN

Participants

Name/Credentials	Discipline	Title	Department/Unit
Nicole Turkoglu, MSN, RN, OCN, BMTCN	Nursing	Clinical Nurse	6HN (at the time)
Shannon Forty, MSN, BS, RN	Nursing	Clinical Nurse	6HN
Nadeen Robinson, MSN, RN, OCN	Nursing	Clinical Nurse	6HN
Archana Shenoy, DNP, RN, OCN, FNP-C	Nursing	Patient Care Director (Nurse Manager)	6HN

Intervention

February 2023:

- Ms. Turkoglu, Ms. Forty, and Ms. Robinson began reviewing 6HN supplies and equipment inventory weekly and utilizing the 6HN unit visibility board to inform their nursing peers of broken equipment or missing supplies, resolution status, and interim plan during daily huddles.

  Impact Statement: As clinical leaders, the nurses focused on access to necessary supplies and equipment, coupled with plans to mitigate any gaps in

needs helped reduce time nurses spent searching for items. This contributed to the restoration of nurse availability, increasing the time spent with patients, and addressing patient needs in advance, ultimately reducing their risk of falling.

- Ms. Turkoglu, Ms. Forty, and Ms. Robinson added a section on the visibility board where nurses and technicians could write down room numbers of patients at a high fall risk.

  Impact Statement: Clear communication and visibility from the nursing station allowed for all team members to increase focused attention to patients at risk for fall.

March 2023:

- Ms. Turkoglu, Ms. Forty, and Ms. Robinson renovated the 6HN equipment room to allow easy access to equipment, thereby reducing nursing turbulence.

  By the end of March 2023, the RNs' interventions and heightened focus on supplies and equipment and high risk falls patients were fully implemented.

  Impact Statement: A well-organized equipment room enabled nurses to redirect their time and energy on purposeful rounding and prompt response to call bells and bed alarms, thus decreasing the patient falls rate.

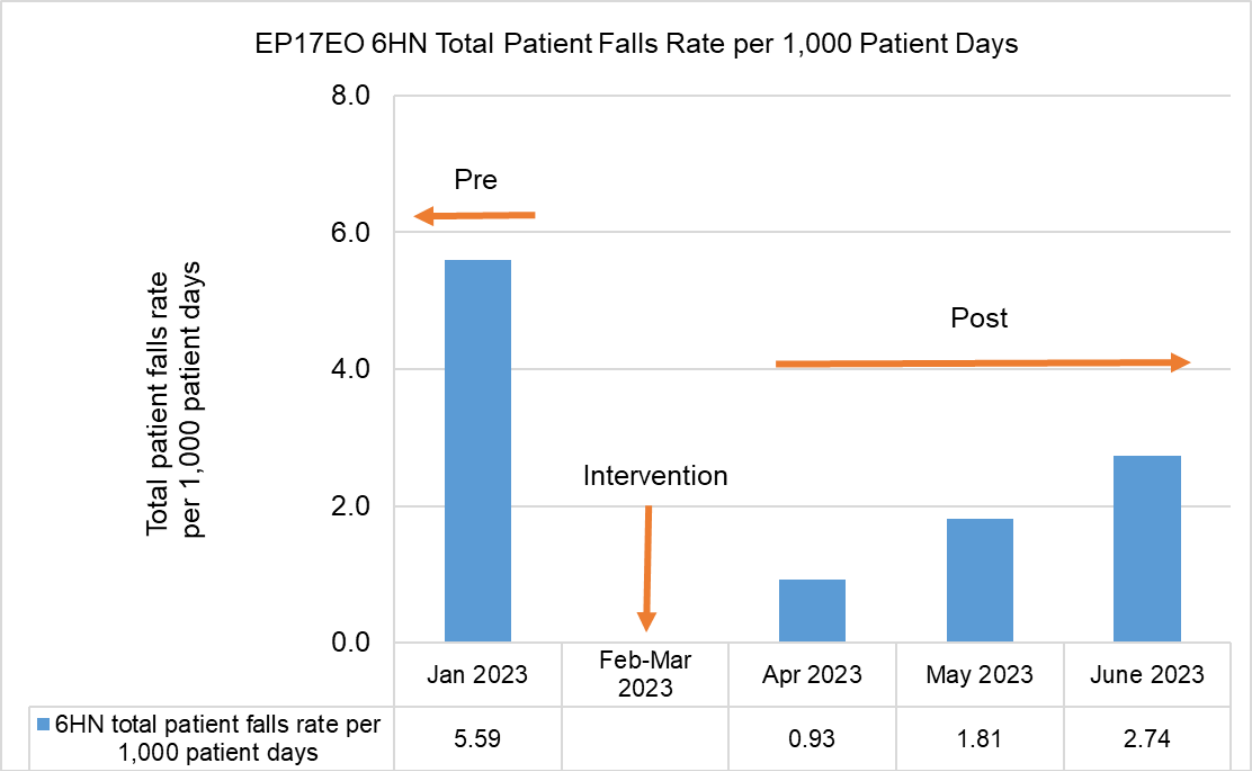
- **Key references:**

Browne, J., & Braden, C. J. (2020). Nursing turbulence in critical care: relationships with nursing workload and patient safety. *American Journal of Critical Care*, An official publication, American Association of Critical-Care Nurses, 29(3), 182–191. https://doi.org/10.4037/ajcc2020180.

Lee, A., Cheung, Y. S. L., Joynt, G. M., Leung, C. C. H., Wong, W. T., & Gomersall, C. D. (2017). Are high nurse workload/staffing ratios associated with decreased survival in critically ill patients? A cohort study. *Annals of Intensive Care*, 7(1), 46. https://doi.org/10.1186/s13613-017-0269-2.

Wynendaele, H., Willems, R., & Trybou, J. (2019). Systematic review: Association between the patient-nurse ratio and nurse outcomes in acute care hospitals. *Journal of Nursing Management*, 27(5), 896–917. https://doi.org/10.1111/jonm.12764.

Outcome


EP17EO 6HN Total Patient Falls Rate per 1,000 Patient Days
Total patient falls rate per 1,000 patient days
8.0
6.0
4.0
2.0
0.0
Pre
Intervention
Post
Jan 2023
Feb-Mar 2023
Apr 2023
May 2023
June 2023
6HN total patient falls rate per 1,000 patient days
5.59
0.93
1.81
2.74