MUSC Health
Medical University of South Carolina
Changing What's Possible

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MUSC Health's Daily Safety Tip

January 27, 2016

It's more than the socks

Patient falls in healthcare is a daunting problem that creates significant harm to the patient and cost to the organization. Although significant emphasis has been placed on decreasing hospital acquired infections such as catheter associated urinary tract infections, falls are more prevalent and associated with higher mortality and length of stay. Many tactics have been developed to reduce falls, including bed alarms, assertive toileting and identifying patients with yellow, no-skid socks. A recent article in the *American Journal of Nursing* describes the efforts of a cardiac intermediate care unit in decreasing falls. This unit had routinely assessed patients for fall risk and implemented fall precautions; however, after an annual increase of falls by 41%, a new accountability program was started. The nurse that was caring for the patient at the time of the fall was asked by leadership to reflect on each fall and send an email to his/her colleagues describing what could have been done to prevent the fall. Falls with injury were decreased by 72% after program initiation.

Learn more about preventing falls at MUSC.

Patient Safety Resources

Patient Safety Network

NPSF

MUSC Patient Safety Webpage

Questions, comments or feedback? Email patientsafety@musc.edu

Medical University of South Carolina Medical Center

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January 7, 2016

Beware of Headless Chickens

Critically injured trauma patients are particularly complex, making their care more vulnerable to errors. Nearly 8% of trauma patient deaths are potentially preventable. A contributor to errors is poor communication during the hand-off process. A recent study examined the frequency of information discrepancies that occurred in the hand-off process in patients being transferred from the ED to ICU. Chart audits comparing information exchange between the ED and ICU showed that injuries were missed in 24% of patients. Further, 48% of patients had clinical information discrepancies. The study participants described their chaotic environments as another contributor to difficult hand-offs:

"*It's just mad chaos up here trying to stabilize somebody... It's just, you know, chickens with their headscut off running around and there's no order.*"

The authors suggest standardizing the hand-off process, including hand-offs led by a trauma team leader with training in handover communication.

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January 15, 2016

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January Safety Star

Handoffs are a critical function of patient care. While performing bedside shift report, Candice Bakoz, RN and Loree Parker, RN were assessing their patient's new colostomy. While doing a visual inspection of the stoma together, they discovered 800 ml of fresh blood that had collected over 30 minutes. This was an urgent finding. The patient was emergently taken to IR for embolization of an arterial bleed. The entire 8 East team remained calm and worked well together to make sure that the patient was optimally cared for. Kristine Harper, Nurse Manager of 8 East, recognized this extraordinary teamwork and wanted to also acknowledge Sara Goenner, Kristin Stober, Gen Med Team 3, and especially Dr. Sara Adams for their efforts. Remember to always pull back the covers during Bedside Shift Report! Way to go Candice and Loree - our January, 2016 Safety Stars!