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VA National Center for Patient Safety

P.O. Box 486
Ann Arbor, MI 48106-0486

Phone:.....(734) 930-5890

Fax:(734) 930-5899

E-mail: NCPS@va.gov

Web sites:

Internet.....www.patientsafety.gov
Intranet...vaww.ncps.med.va.gov

VHA Chief Patient Safety Officer
James P. Bagian, MD, PE

Editor

Joe Murphy, APR

Graphics

Deb Royal

Copy Editing

Amy Carmack
Deb Royal

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Making Falls Reduction a Full-Time Job

By Joe Murphy, NCPS public affairs officer

WHEN Mary Watson wrote her facility's analysis of fall rates for the first quarter of fiscal year 2008, she had good news: falls were down to 160 from 185 during the previous quarter and no major injuries had been reported.

A major part of the facility's success has been due to having an advance practice nurse coordinate the falls reduction program – a position she has been proud to hold for seven years.

“Having someone dedicated to this position, combined with the facility's commitment to falls reduction, has made a big difference,” she said.

Watson is a Falls Nurse Clinical Specialist at the Central Arkansas Veterans Healthcare System, Little Rock, Ark.

Because of her position's focus, Watson has been able to support clinicians by concentrating on numerous problems that otherwise might have taken much longer to solve: for instance, the challenge of keeping call lights attached to beds and off the floor.

After a patient fell out of bed when trying to reach a call light, she soon discovered a larger problem that could affect many more patients. “Over half of the call lights were missing a 45-cent clip,” she noted.

Because of supply system requirements, nurses would have had to order the clips separately. “The nurses wouldn't have had time to do a work order for something like this,” said Watson.

She acted as liaison with engineering and obtained a number of clips. She then taught other nurses how to place the clips to reduce the likelihood of them becoming damaged.

“Sometimes I put them on myself. It's the least I can do for our busy nurses!” she said.

Watson has also been able to focus on a number of larger issues that have the potential for falls reduction.

She described one of the ideas she ran across in related literature as a “fall huddle,” a gathering during which nurses were encouraged to discuss falls that had occurred in their unit.

Watson decided to promote the concept of a huddle at her facility, concentrating first on what times falls had occurred in one specific unit. “I gave them information about falls by time,” she said.

“The nurses realized a number of the falls were at meal times or in the evening.” This led to rethinking staffing levels during meals and bathing periods.

“This helped. We spread this change to other units,” Watson said, “and it has allowed nurses to feel like they have more latitude to suggest positive changes.”

In one unit, a calendar was created to track falls. It's kept in a location where all staff members can review it. “Making falls known throughout the staff helps heighten awareness,” she noted.

Large or small, fall reduction efforts are directly related to the Joint Commission's National Patient Safety Goal 9: Reduce the risk of patient harm resulting from falls.

A facility-wide effort involving ceiling lifts and additional lifting equipment has been a major factor in reducing such risks.

“We purchased 243 ceiling lifts,” Watson said, “and the purchase has been one of the best things we have done in the 19 years I have worked here.”

The facility has two types of lifts: one to help transport a patient who can stand but can't walk well; another to lift a patient who cannot stand or walk.

“The lifts are like a ‘silent employee’ helping nurses move patients in and out of bed or into a stretcher,” Watson said. “We can also use them to turn a patient in bed.”

The lifts have been a win-win for all concerned – patients are less likely to fall and nurses are less likely to be injured.

Continued on back page

VA's Strategic Nap Program

By Steven K. Howard, M.D., VA Palo Alto Health Care System; Associate Professor of Anesthesia, Stanford University School of Medicine

FATIGUE is commonplace in health care – especially at the “sharp end,” the point at which nurses and physicians provide care for patients.

Unfortunately, many of us in health care suffer from fatigue frequently.

Fatigue impacts many aspects of human performance and behavior. In particular, fatigue can result in impaired alertness and performance, which can be measured in both laboratory and field studies (*See Table 1*).

It is well known that our profession contributes to fatigue in the following basic ways:

- Long working hours.
- Working in opposition to one's circadian clock.

By the latter point, I mean when our circadian clock would rather us be asleep during nighttime work; or, awake during day recovery sleep after night work.

Our lifestyles also play a very important role in our level of daytime sleepiness.

America is a society of chronic “under-sleepers.” Population averages suggest that we get 60-90 minutes less sleep per night than we require for optimal daytime functioning.

Though we have known about the risks of sleep deprivation and fatigue for years, we have either ignored or acknowledged these risks with the question: “Yeah, we know it's a problem, but what can we do about it?”

The VA Strategic Nap Program directly addresses the issue of what we can do about fatigue.

Naps have been shown to dramatically increase alertness and performance during laboratory and field studies. This is true in health care and other high-risk settings.

But the nap program is not a study – it is an *implementation* of a proven alertness strategy into the complex work environment of a hospital.

The research on the effectiveness

of a nap has clearly shown its value. The nap program extends the benefits of a nap strategy to VA health care providers.

Though the use of naps will not prevent all fatigue-related risks, it is one component of a fatigue management strategy that can be used to mitigate performance impairment.

The First Programs

The program has been successfully piloted in two ICUs at the VA Palo Alto (California) Health Care System, with the primary focus on the nursing staff.

Physician staff are not excluded from this voluntary program, but nursing staff have previously been “less allowed” to leave the bedside than their physician counterparts.

Some of the results of this pilot implementation are:

- Nurses have used personal break time to nap.
- Nurses napped at home prior to night work.
- Nurses felt subjectively more alert during their shift.

Interestingly, there were significant differences between day and night shift workers. The nap strategy was rarely used during the day, but often used at night. This finding is not surprising given the circadian differences between the two shifts (e.g., more sleep “pressure” during the night shift).

The main lesson learned from this pilot implementation involved gaining stakeholder support for the program.

During the process, our intention was to be inclusive. We had interactions with a number of key staff members, including:

- The hospital director.
- The chief of staff.
- The asst. chief of staff, nursing.
- Unit supervisors.
- The unit medical director.
- Human resources representatives.

- The union president.

Locating space for the nap has proven to be a major (and continuing) hurdle. Educating individuals who allocate space about the importance of strategic napping is an important aspect of developing and maintaining a facility's nap program.

Since naps are not commonplace in American culture, the behavior needs to be encouraged. This meant playing an active role on the unit when the program began, helping to solve some of the unit's challenges.

At Palo Alto, workers in the program are free to do whatever they want during their break; however, the nap program teaches participants about the effectiveness of a nap as an alertness strategy and encourages its use, per the program guidelines.

No additional staff members were required for the implementation, as the program allows individuals to nap during scheduled break periods.

The nap program takes into account unit workload; thus, should not be used if it could make a system less safe (e.g., critical work, short staffed).

In January 2007, we presented the nap program to stakeholders at the Portland (Oregon) VA Medical Center, hoping to implement the program at another facility.

After this presentation, a work group was formed to design a nap program based on the model created at Palo Alto. The work group consisted of members of the patient safety committee and unit “champions” from the operating room and ICU.

Portland began its program in August 2007. The implementation went well and reports are positive thus far. More than 70 individuals have participated since its inception.

Online Presentation

The nap program has multiple components (*See Table 2*), though education is the centerpiece. A slide

show about the program is available online: http://www.alertness-solutions.com/vasnp/VASNP_education.htm.

This educational slide presentation is packed with important information and is designed to be succinct and can be presented in approximately 15 minutes – an important feature for capturing busy professionals’ attention without wasting their time.

The presentation’s content includes:

- Optimal nap length and timing.
- Team communication and coordination (e.g., hand-off of care).
- Specifics about the nap room.
- Guidelines for the program.

Improving Patient Care

Implementation of the nap program changes how we care for patients: Optimal use of the program requires improved team communication and coordination.

We felt from the early stages of the development of the nap program that the number of hand-offs of care would potentially increase.

For the program to work effectively and maximize safe patient care, the issues of team communication and coordination are stressed. In fact, we feel that this might be a side benefit to program implementation.

Participation in the nap program is voluntary. If workers choose to participate, they have to attend

an educational session and sign a participant agreement.

The agreement simply states that by signing the form the provider understands and agrees to participate in the program as outlined in the program guidelines.

The thought of “sleeping at work” still makes many people shudder. But we believe that planned sleep will actually make the system of care safer.

The following points have been important when discussing the pros and cons with colleagues.

Patient safety

- Improving alertness and performance of primary caregivers (M.D./R.N.) are important.
- Adverse events increase when we are fatigued. Safety will be enhanced because of improved alertness/performance.

Provider safety

- Shift work engenders accidents at work (e.g., needle sticks) and elsewhere (e.g., driving home post-shift).
- The human cost is immeasurable – and these risks apply to all providers. Unfortunately, too often this is only appreciated in retrospect – after something catastrophic occurs.
- The nap program is proactive and directly addresses sleep loss and fatigue risks in health care.
- This program is completely voluntary – if people do not want

to participate (i.e., use the nap strategy) – they do not have to.

Effect on the caregiver and institutional opportunities

- Anything that can make the work environment safer, more productive, more responsive to individuals, and address a known safety risk, can have innumerable positive effects in the workplace.
- Recruitment, retention, empowerment, and other metrics are all potential positive outcomes from this program.

Conclusion

Our long-term goal is to extend the nap program to all hospitals in the VA system. Clearly, the time has come to address fatigue and sleep deprivation in health care.

This program is the first of its kind – be on the lookout for it coming to a workshop near you.

We are pleased that the nap program has been supported by NCPS (*See Note 1*).

For further information on this program, please contact me: showard@stanford.edu.

NOTE 1. NCPS, in conjunction with Dr. Howard, has submitted a proposal to the American Institute of Architects’ Health Revisions Guideline Committee to include a requirement for staff strategic rest areas in the 2010 edition of the Guidelines for the Construction of Hospitals and Healthcare Facilities.

TABLE 1 – Fatigue Affects Performance

LABORATORY STUDIES

- Microsleep episodes intrude into wakefulness.
- Thinking slows.
- Performance becomes more variable.
- Non-essential activities are neglected.
- Learning of new information is impaired.

- Mood impairment increases.
- Motivation declines.
- Ethanol correlates to sleep deprivation.

FIELD STUDIES

- Sleep episodes occur during actual patient care.
- Needle sticks increase.
- Error rates increase.
- Automobile accident rates increase.

TABLE 2 – Components of the Strategic Nap Program

- Educational program.
- Program guidelines.
- Personal use tool.
- Facilities checklist (“nap room”).
- Online resources.
- Evaluation materials.

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Continued from page 1

“Next to truck drivers, nurses have the highest rate of muscular-skeletal problems, some of which are directly related to lifting or moving patients,” she said.

Her duties also include working personally with patients who are found to be fall risks, as the result of a patient profile conducted upon admission.

“For instance, we look at such things as a patient’s age, medications, and gait,” Watson said. “By reviewing these and other indicators, we can predict the likelihood a patient will suffer a fall.”

If high risk is noted in the profile, a patient is provided a “falls consult” to raise the awareness of the danger of a fall and help reduce its likelihood.

Post-fall assessments are taken just as seriously: Diabetics can suffer from falls due to low blood sugar, which is why a finger-stick blood sugar test is

included the assessment.

“We are proud we are including this,” Watson noted. “We want to check all the parameters that we can in order to reduce falls.”

In some cases, facility staff have been engaged in lively discussions about falls reduction. When it was suggested that purple arm bands no longer be used to identify patients at risk for falls, a lengthy debate ensued.

“We know the limitations of arm bands,” Watson said, “and we know compliance is not 100 percent.” But after dozens of pro and con emails, it was decided to keep the arm bands because the majority of the staff wanted to do so.

Watson’s duties as “Falls Nurse,” have been a source of great pride to her, whether it be working to provide clips for call lights or conducting one-on-one falls consults.

She participated in an NCPS hip pad study, as well as the NCPS Falls Data Project, which compared local fall and injury rates to those VA-wide.

“This position has afforded me some great opportunities,” she said. “I’ve even had a chance to speak in front of Congress during a 2002 Senate subcommittee meeting on aging and falls.”

But nothing has been as rewarding as seeing the steady improvement in major injury falls reduction at her facility.

She has even taken the time to publish a bimonthly newsletter, *Facts of Falls*. “I think it helps keep falls in front of everyone’s mind as being important,” she noted.

Watson welcomes inquires from those interested in learning more about her facility’s activities, to include providing back issues of *Facts of Falls*.

The Falls Toolkit

VA facilities are devoted to finding ways to reduce the number of falls and the severity of those that occur.

NCPS worked with the Patient Safety Center of Inquiry, Tampa, Fla., and others to create our Falls Toolkit.

It is designed to aid facilities in developing a comprehensive falls prevention program.

The Toolkit provides in-depth information on a wide range of topics, such as:

- Designing a falls prevention and management program.
- Effective interventions for high-risk fall patients.
- Implementing hip protectors for high-risk falls patients.
- Educating patients, families and staff on falls and fall-injury prevention.

Learn More

<http://www.patientsafety.gov/SafetyTopics/fallstoolkit/index.html>



Photo by Mike Hormuth, medical media, Ann Arbor Healthcare System.