Chat with Pat

An expert view on issues that matter to you.

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Let's Celebrate the Other Side of the Equation and More!

Since the release of the first large scale report about incidence of patient harm in hospitals, To Err is Human (Institute of Medicine, 2000), effectiveness of patient safety efforts has and continues to be measured as rates of adverse events. Despite decades of research and resources invested in patient safety, falls continue to be the most commonly reported patient safety incident in hospitals (LeLaurin & Shorr, 2019). Falls, considered a *Never Event*, are a still a "common and devastating complication of hospital care, particularly in elderly patients" (Patient Safety Network, 2019).

For years and across bodies of research the primary outcome measure to determine the effectiveness of fall prevention programs has been the fall rate. The secondary outcome has been the fall injury rate.

Organizations strive to reach zero harm and drive down harm in very dynamic, complex healthcare systems with varying patient acuities and conditions. Still, controversy exists with the tension and stress within organizations of getting to zero acknowledging that we have much to learn about how to apply accident causation and preventability to a fall that does occur. We all agree that not all falls are preventable. Falls happen. Accidents happen. After every fall, we strive to learn the root cause of the fall through our post fall processes, so that we can prevent a repeat fall from occurring due to the same root cause.

We know intimately the complexity of fall prevention programs, the dynamic influences of organization and unit structures and processes, and the ever-changing fall risk factors of each patient. We know the compassionate, diligent, and competent care provided to keep patients safe; yet, the extent of your patient safety net is not always part of patient safety conversations. Because of the focus on reducing harm and all the focus on adverse event rates, we find ourselves focusing on the harm, alone.

I would like to shift the conversation and provide information that celebrates measures of success, different from getting to zero. Throughout my practice, I have worked to bring attention to, celebrate and expand the safety net of patient care using a variety of strategies. Nurses and interdisciplinary team members, keep patients safe from falls every day. I'd like to offer suggestions on how to get to the other side of the equation in an effort to showcase the safety net created through our care, here are some suggestions:

Celebrate all the patients per bed days of care where a fall did not occur: *This month, 97.7 patient day no fall occurred, though we had 3.2 falls per patient day.*

Celebrate all patient falls who were not injured. *This quarter, 95% of the patients who fell were not injured, 5% of patients did experience an injury.*

References

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