Quality Hour Pilot St. David's South Austin Medical Center
"The Finance of a Fall"

Tricia Casler, BSN, RN, CMSRN; Rick Claycamp, BS, ADN, RN, CMSRN; Sally Gillam, DNP, MAHS, RN, NEA-BC; Mike Lopez, BSN, MBA, RN, CEN
901 W. Ben White Boulevard Austin, Texas 78704. Phone: 512.447.2211 email: Tricia.Casler@stdavids.com

PURPOSE

The purpose of this pilot was focused on improving quality care in focused areas by utilizing a muliti-disciplinary collaboration led by the Registered Nurse for one hour at the same time everyday.

Areas of interest:

- Increase knowledge and compliance with core measures
- **Decrease patient falls**
- Decrease hospital-acquired conditions
- Improve communication between disciplines
- Improve patient discharge planning
- Improve identification of at-risk populations (ex: dementia, suicide, etc.)

INTRODUCTION

When implemented, improvements in core measure compliance, decrease in hospital-acquired conditions, and an improvement in patient safety was the aim:

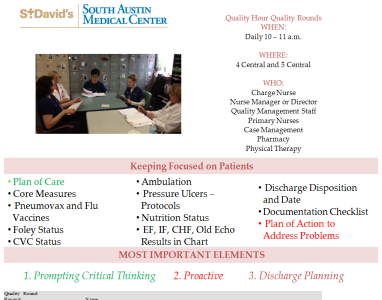
- Improve quality and convenience of patient care
- Increase patient participation in their care
- Increase practice efficiencies and cost savings
- Improve communication between disciplines
- Encourage critical thinking

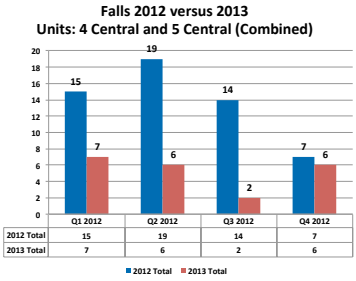
THE FINANCE OF A FALL

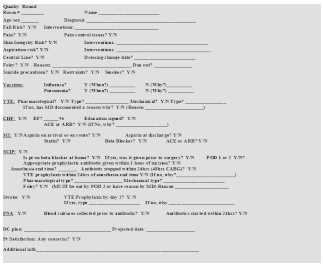
A hospital fall, defined as a sudden, unintentional change in position, coming to rest on the ground or other lower level, is among the most commonly reported adverse hospital events, with more than 1 million occurring annually in the United States.

BACKGROUND

A 304 bed acute tertiary care organization in Austin, Texas has implemented a pilot called "QUALITY HOUR". This process seems simple enough and almost something that has been a part of the past. It is not far off from the more antiquated multidisciplinary rounds. This is far from antiquated. The CNO ,Sally Gillam, and several other Nursing Leaders decided to develop a measurable pilot with a goal to reduce falls. Numerous other variables may have been selected with this pilot, however; the team wanted to actually place realistic and quantifiable avoided costs associated with it.







Communication Document:

- Tool developed to improve, consolidate, and communicate information
- Relative patient treatment data
- Core measure communication
- Intra-shift communication

Shelby Cowen RN

	2012 Falls	2013 Falls	Added LOS	Variance Cost/Day	Avoided Days	Avoided Costs	Cost/Fall
Surgical	5.5	1.3	3.5	$1,240	14.7	$18,228	$4,340
Non-Surgical	49.5	19.7	1.5	$562	44.7	$25,121	$843
Total	55	21				$43,349	$1,275

- Variable costs per day calculated by Decision Support Systems (DSS) reports for 2013 YTD through January 17
- Historical percentage of falls requiring surgical intervention are approximately 10-15%
- For this analysis a 10% rate of surgical intervention was used
- Expansion of pilot to add 2 similar units:

  Projected total cost avoidance (PTCA) = **2 x $43,349 = $86,698**

  Additional labor costs would be incurred reducing the PTCA

RESULTS

Total falls were reduced from 55 in 2012 to 21 in 2013. Avoided costs were $43,349. This is financially significant and has significant promise should we elect to expand the "Quality Hour" program to other similar units in the organization.

CONSIDERATIONS

- Expand the pilot to cover additional units
- Review benefits of additional staffing
- Evaluate the cost for additional staff to support additional units

REFERENCES

1. Anderson, D., personal communication, March 22, 2013 & April 4, 2013.
2. Caldwell, G. (2012). Clinical leadership in quality and safety at the point of care. Clinical Risk, 18(3), 84-89.
3. Hundly, P., personal communication, April 2, 2013.
4. Johnson, K., personal communication, June 1, 2013.
5. Knight, T. (2012). The patient safety movement [PowerPoint slides]. Leadership Academy Quarterly, Austin, TX.
6. Liles, B., personal communication, March 22, 2013.
7. Mion, L. (2012). Patient falls in the Hospital Setting: A Persistent Problem. Retrieved from: http://www.sizewise.net
8. Pearce, S., personal communication, April 3, 2013.
9. Richardson, A., & Storr, J. (2010). Patient safety: a literature review on the impact of nursing empowerment, leadership and collaboration [corrected] [published erratum appears in INT NURS REV 2010 Mar;57(1):158]. International Nursing Review, 57(1), 12-21. doi:10.1111/j.1466-7657.2009.00757.x
10. Zelman, W. N., McCue, M. J., & Glick, N. D. (2009). In Financial Management of Health Care Organizations (3rd ed.,). San Francisco, CA.: Jossey-Bass.