

Back to Basics Education: Unit-Wide Patient Safety and Care Competition

Refocusing on foundational patient safety and environmental care in an acute inpatient pediatric medical subspecialty unit

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Abstract

Patient safety and harm prevention are compromised when policies, procedures, and standards of care are not considered. A 3-month unit-based competition with RNs, SNAs, and IPCs was established highlighting identified themes where safety errors had been noted. Education was provided biweekly to staff to engage in safety practices. Weekly winners and prizes were offered to increase engagement. Unit leadership established rules and oversaw the competition.

Background

- Medical-Subspecialty unit in a quaternary pediatric hospital sustained an increase in preventable safety errors.
- Without clear indication of root cause or apparent trends in data, leadership team initiated an education-based unit-wide competition to reinforce foundational nursing care.
- The identified needs are **environment of care, bedside safety checks, communication, 6 rights of medication administration, and standard of care for patient receiving high alert medications.**

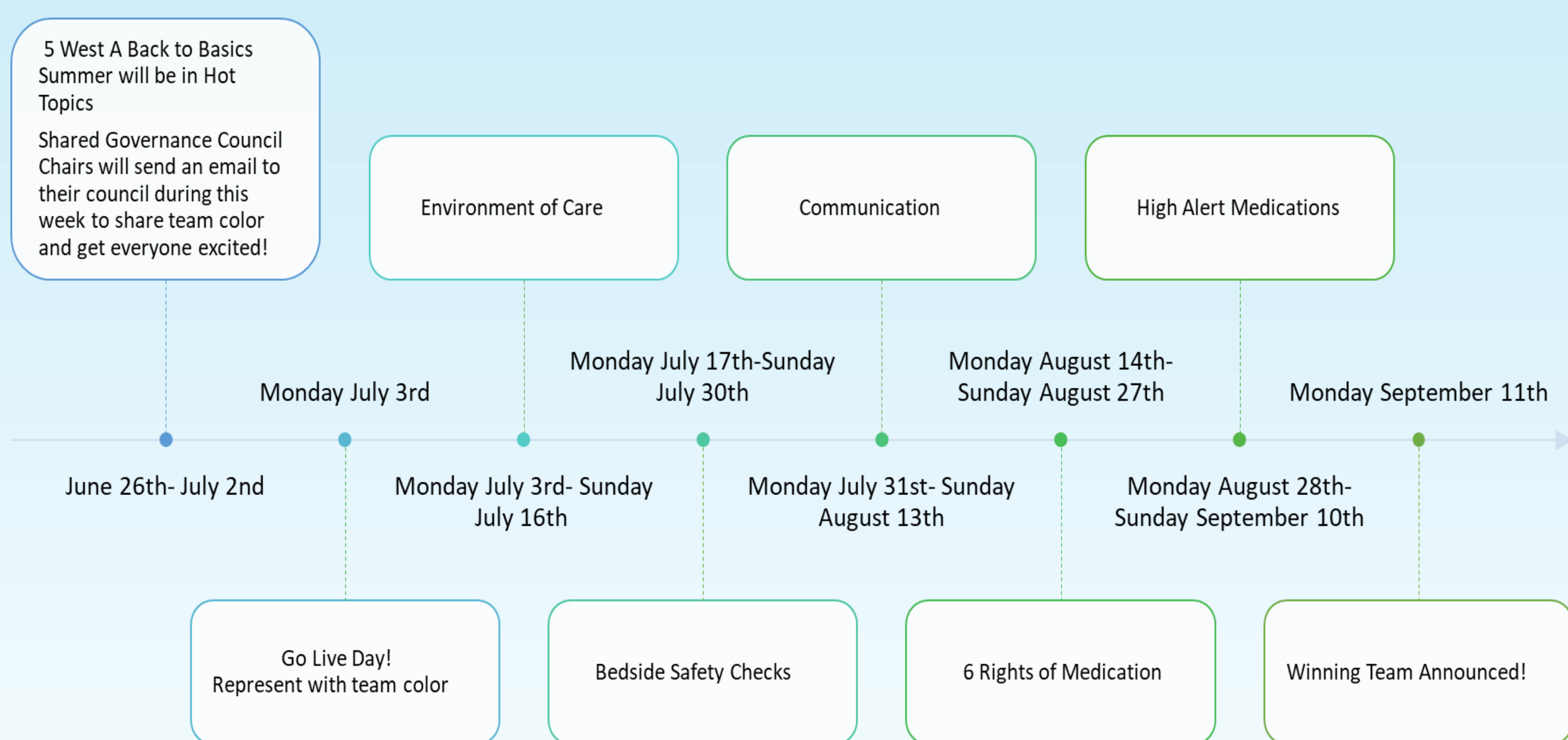


Figure 1. Timeline of Back-to-Basics Education and Competition

Aim

To reduce preventable errors and safety events using a scaffolding team education approach in a fun and competitive way.

Methodology

- **PDSA cycle approach**
 - Implementing team consisted of clinical nurse experts, safety quality specialist, unit manager, and unit supervisor.
 - Participating teams were members of preestablished nurse shared governance councils, senior nurse aids (SNA), and inpatient clerks (IPC).
 - Trends in reported and witnessed safety events were observed. Points were given to participants who delivered care as ordered, per policy.
- **Implementation**
 - Education involved all unit level staff, and each theme was presented every 2 weeks over 3 months and built upon the previous topic.
 - Themes were accompanied by a collaborative folder of supporting policies, procedures, job aids, and tip sheets available to staff.
 - Visual displays of team success, up-to-date screen savers, daily huddle announcements, and pre-shift reminders were in place.
 - Just-in-time feedback was given for observed safety behaviors.
 - Winners were announced each week, and a timeline of results was presented at the end of the 3-month period.

Results

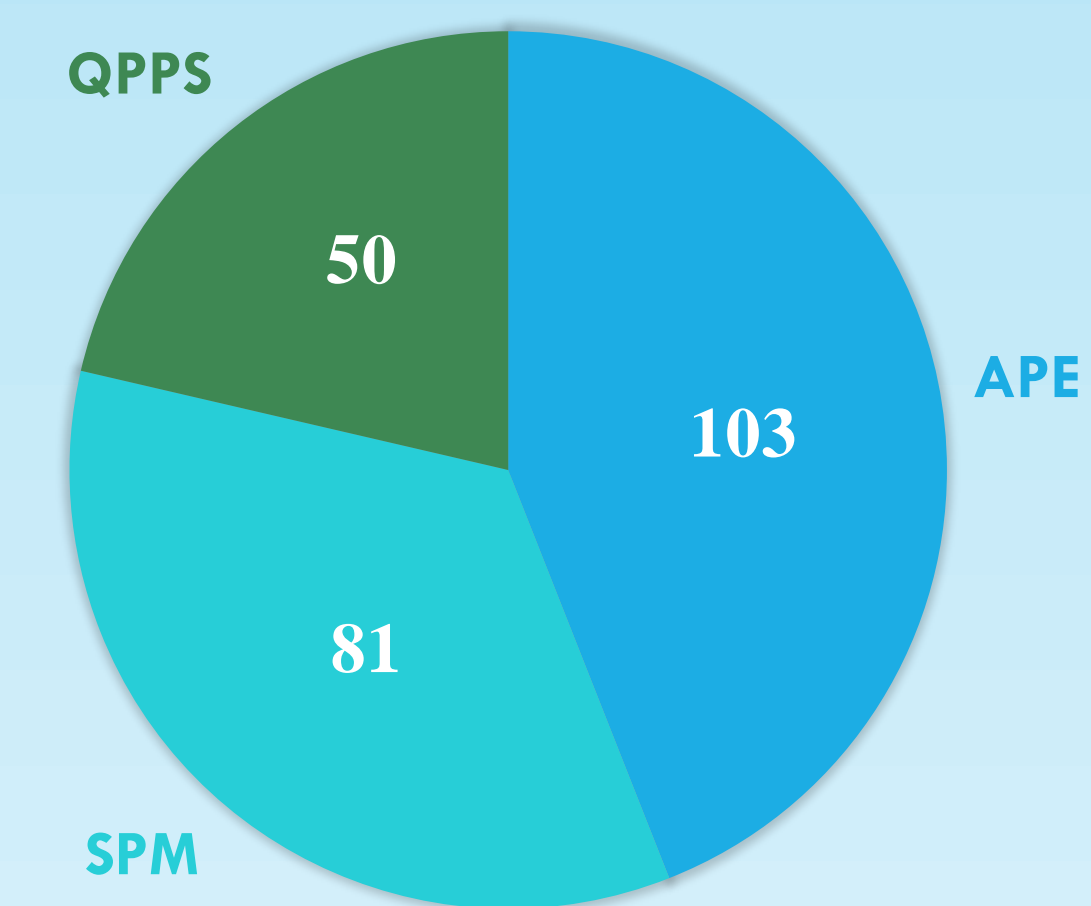


Figure 2. Total wins for each team over the 3-month education program

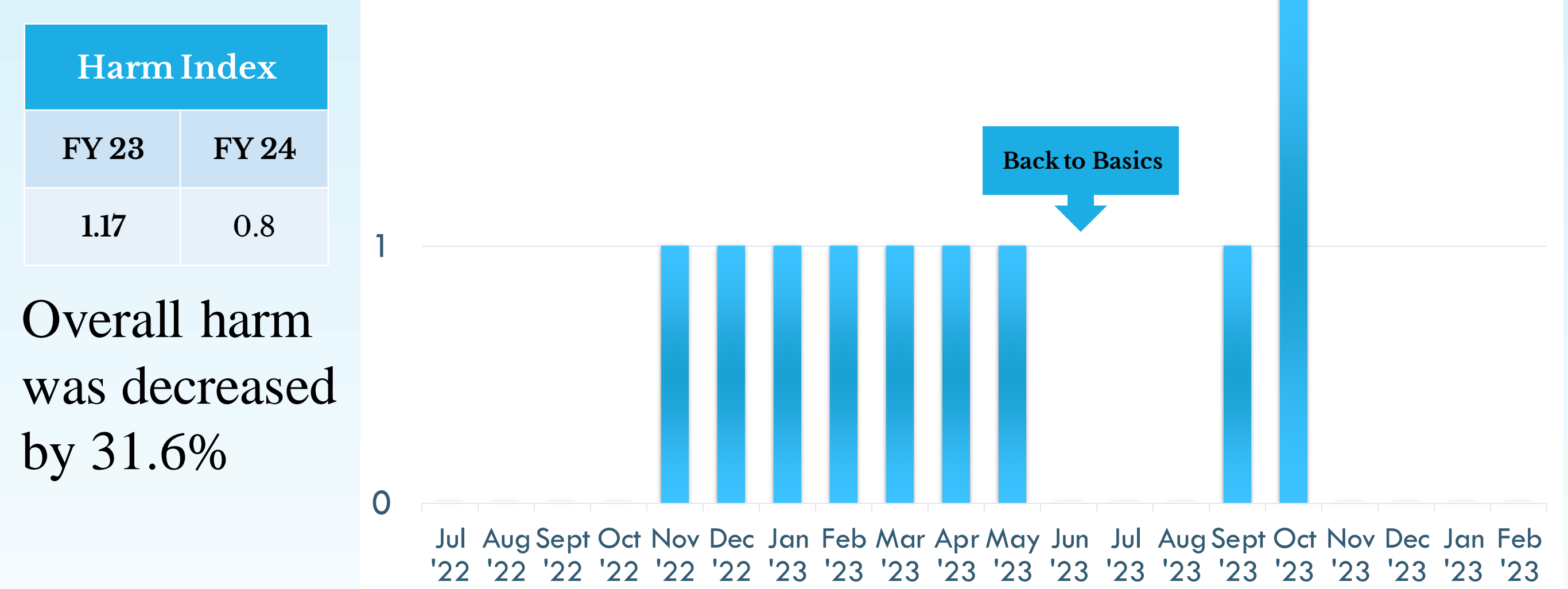


Figure 3. Preventable harm events and harm index for FY 23 and FY 24

Conclusion

After implementation of education processes, harm prevention strategies, and development of tip sheets, **staff were observed to be more engaged in foundational patient safety and care.** Nurses and support staff were reinvigorated to participate in harm prevention and all staff became more comfortable with reporting and giving feedback.



Congratulations to the winning team, APE, with 103 points!

Acknowledgments

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