THE CARITAS PROCESS™: DAILY HUDDLE TO DECREASE FALLS AND ONE-TO-ONE OBSERVATION IN CRITICAL CARE

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Introduction: Patient safety has risen to the forefront of healthcare and patient falls have become a major public health concern. Furthermore, patient falls are the most common adverse event reported in acute care facilities (Halm & Quigley, 2011). Despite numerous efforts, current literature indicates that hospital falls and injurious falls have not identified consistent evidence for effective preventive interventions (Halm & Quigley, 2011). Particularly, constant observations in acute care have not been found to be effective and there is no evidence to support the contention that one-to-one observation can prevent the incidence of falls in an acute care setting (Salamon & Lennon, 2003). The use of one-to-one observations initially offered an easy alternative to the use of restraints, but was found to be an inefficient use of healthcare personnel and poses an enormous financial strain to healthcare organizations (Salamon & Lennon, 2003).

Significance: The incidence of falls and the use of one-to-one observation continue to increase despite multiple efforts. Using the Caritas Processes™ (e.g., Caritas Process™ #6; Creative Use of Self and All Ways of Knowing as Part of the Caring Process; Engage in the Artistry of Caritas Nursing), Hospital administrators and staff must think creatively to solve problems related to patient safety such as reducing falls and at the same time appropriately use hospital resources such as constant observation (Watson, 2008). By allowing the expression of positive and negative feelings (Caritas Process™ #5: Being Present to, and Supportive of, the Expression of Positive and Negative Feelings) during the safety huddle, this author strongly believes that it is possible to create a caring environment while maintaining safety and reducing cost without negatively affecting patient outcomes (Watson, 2008).

Purpose: The purpose of this project is to determine the impact of the Caritas Processes™ in decreasing the incidence of falls while decreasing the use of one-to-one patient observation in a critical care setting, through the use of daily safety huddle (Cooper, 2004).

Setting and Participants: The setting of this project is Hackensack UM C Mountainside, a 365-bed community hospital located in Glen Ridge, New Jersey. This project started on June 1, 2012 in the critical care setting (MICU, SICU and step down telemetry) where this author is currently the nurse manger of the department.

Project Process: A morning huddle attended by the clinical coordinators, RNs, PSAs and unit secretaries will be conducted at the beginning of the shift to discuss issues related to safety such as risk for falls, restraints, one-to-one constant observation, pressure ulcers, prevention of infections bundle (VAPS, CLABSI, CAUTI) etc. A huddle will be conducted before the initiation of a one-to-one observation to determine its appropriate use and a daily huddle will be conducted thereafter to determine if one-to-one observation is still clinically indicated. In the case of a fall, a post-fall
A huddle will be conducted afterward to determine appropriate intervention and to provide necessary adjustment with recommendations to prevent another occurrence of fall.

**Project Projected Outcomes:** The incidence of falls in critical care is expected to drop and the use of one-to-one observation will decrease. Another expected outcome of this project is that it will foster teamwork and enhance engagement among staff with regard to patient safety. It is expected that with constant awareness on safety, staff will escalate issues, concerns, and problems that may arise without hesitation.

**Project Evaluation:** Patient safety will continue to be front and center on the list of hospital priorities. Analysis shows that the fall rates within the critical care departments continue to decline compared to the prior month before the start of the project. The number of patient watch/constant observation related to confusion, altered mental status and risk for fall continue to decline. The only appropriate reasons for a one-to-one constant observation are when patients are at risk for elopement, harming others or self (suicide).

**Future Directions:** This project is at its beginning stage. However with continued awareness and engagement of staff to creatively seek solutions through the caring process, the incidence of falls and the inappropriate use of constant observation are expected to decline. The safety huddle will serve as the forum to express ideas and suggestions to improve the care while enhancing patient safety. This author will continue to monitor the outcomes of this project. This project will undergo transformation and change as it progress. This author will continue to elicit suggestions and recommendations from staff to improve the current process. Another safety indicator that is of interest to the author will be to determine whether safety huddle actually decrease the incidence of infection bundles in the ICU.

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**References:**