

John Hunter Hospital



An Outcomes Driven Falls Prevention Program

Two years of progress

Alison Cowling- Clinical Nurse Educator

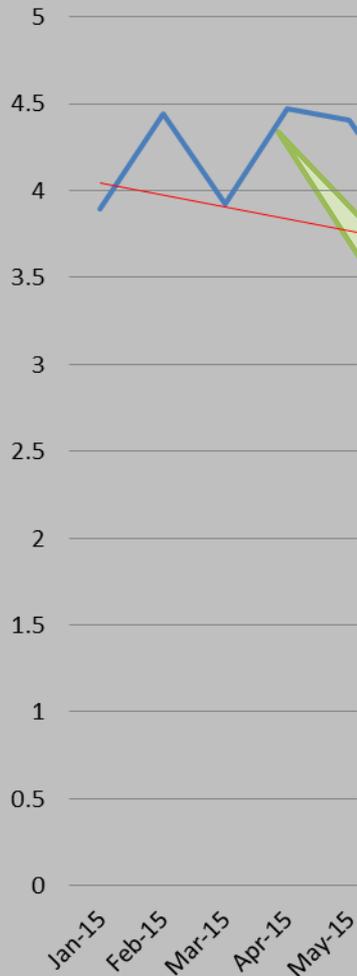
Sally Milson-Hawke- Director of Nursing/ Midwifery

John Hunter Hospital

- Tertiary referral hospital for Northern NSW
- 680 beds
- Large trauma centre/ 68 Rehabilitation beds
- 182 admissions per day
- Average length of stay 4.97 days



Our Falls Prevention Journey- 2 years ago

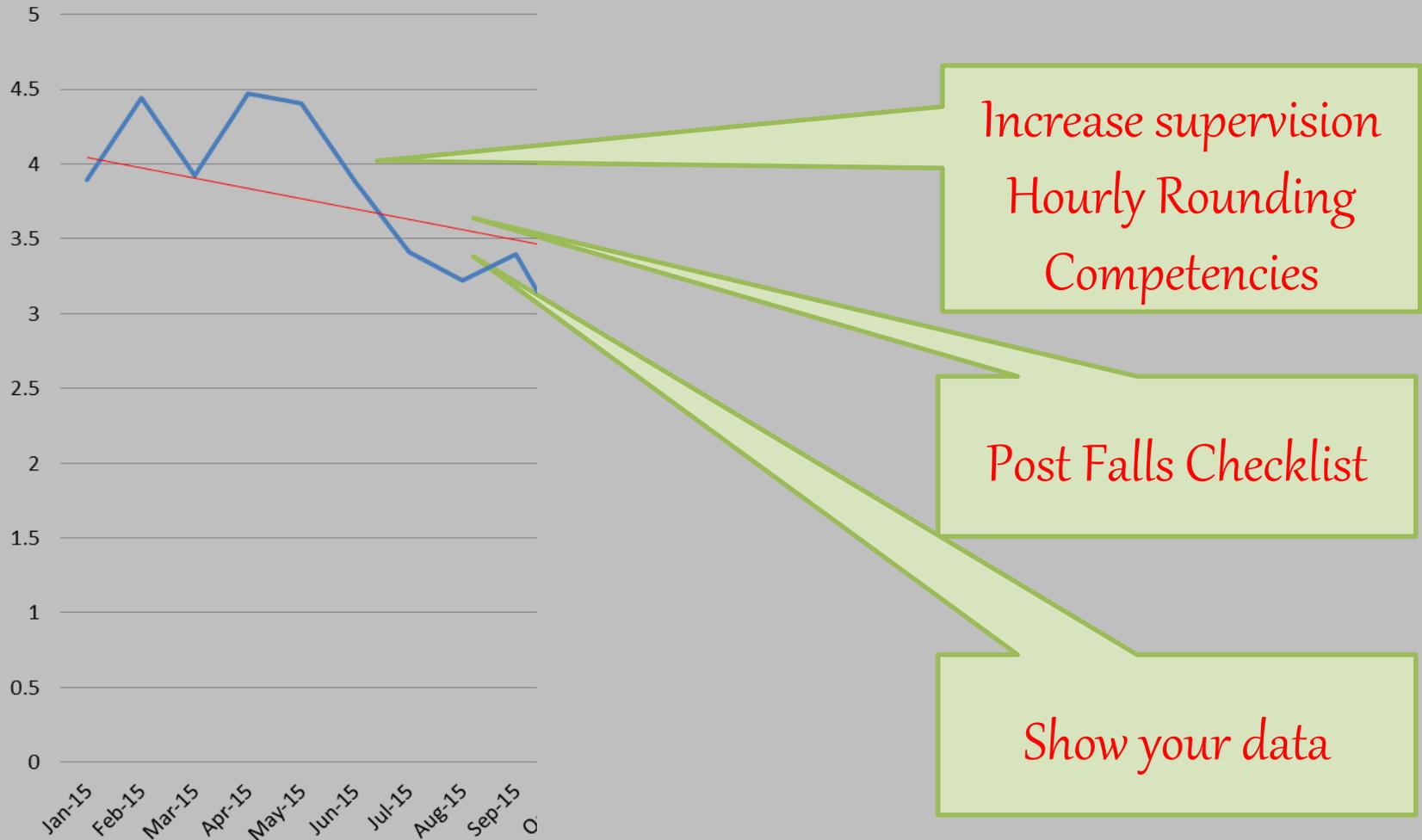


4.5 falls per
1000 occupied
bed days

6 SAC 2 FALLS



Strategy One



Post Falls Checklist

Patients name:	MRN:	
Date of fall:	Time of fall:	SAC rating:
Task	Tick or document	
Team leader notified	TL name:	
Unit manager (In hours) or After Hours Manager (after hours) notified	Name:	
Medical review requested	MO name:	
Medical review attended	/ /	
Patient reassessed for ongoing falls risk and additional strategies identified / Implemented to eliminate further falls		
Care documented on care board		
During business hours: Manager of Nursing/Midwifery Service or Service Manager notified within 1 hour of fall	Name: Time:	
After hours: After hours Manager notified within 1 hour of fall Fall documented in JHH Activity report with final SAC rating and any actions that need to be followed up.	Name: Time: JHH Activity report <input type="checkbox"/>	
IIMS commenced		
Ward daily falls chart (cross) updated with new fall		
Open Disclosure attended		
Person to contact notified		
Fall and follow up documented in patient's Health Care Record		
JHH DoNM emailed		
Service Manager in hours / Executive on-call after hours notified		
For SAC 1 or 2 Falls <ul style="list-style-type: none"> • HNE Executive Fall Report completed by the NUM or AHM within 24 hours of fall <input type="checkbox"/> • HNE Executive Fall Report emailed to Service Manager, JHH DOM/N and JHH General Manager within 24 hours of fall <input type="checkbox"/> • HNE Executive Fall Report emailed by JHH General Manager to HNE Director of Clinical Services Acute and emailed by JHH DOM/N to HNE Director of N/M <input type="checkbox"/> 		
All medical reviews / investigations completed		
Manager discussion with staff attended	<input type="checkbox"/>	

- Immediate medical follow up
- Open disclosure with patient and family
- Additional actions implemented to prevent further falls
- Escalation process NUM, Manager of Nursing Service, DON/M

Standardisation of Every Ward



The last patient fall
in our unit was on
1/10/2016
--/--/----
That means it's been

3 Days.

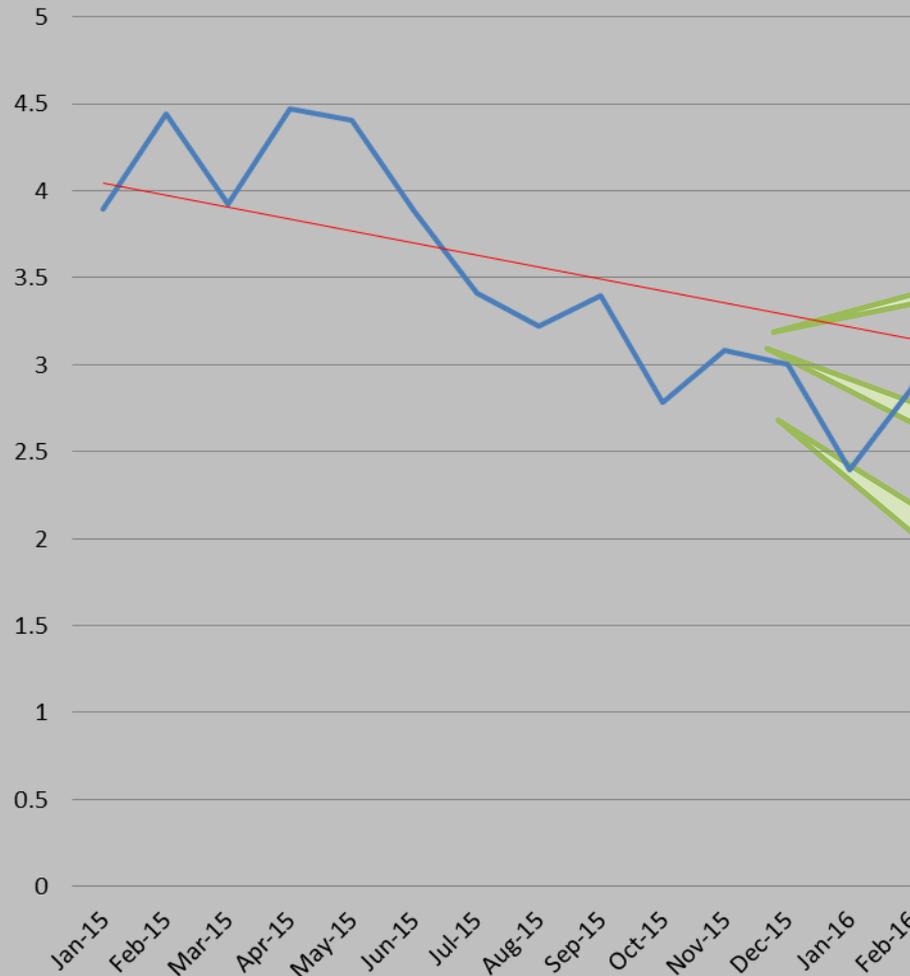
since one of our
patients had a fall
while on our ward

Standardisation of Every Ward



Strategy Two

Implementing the HNELHD Strategies

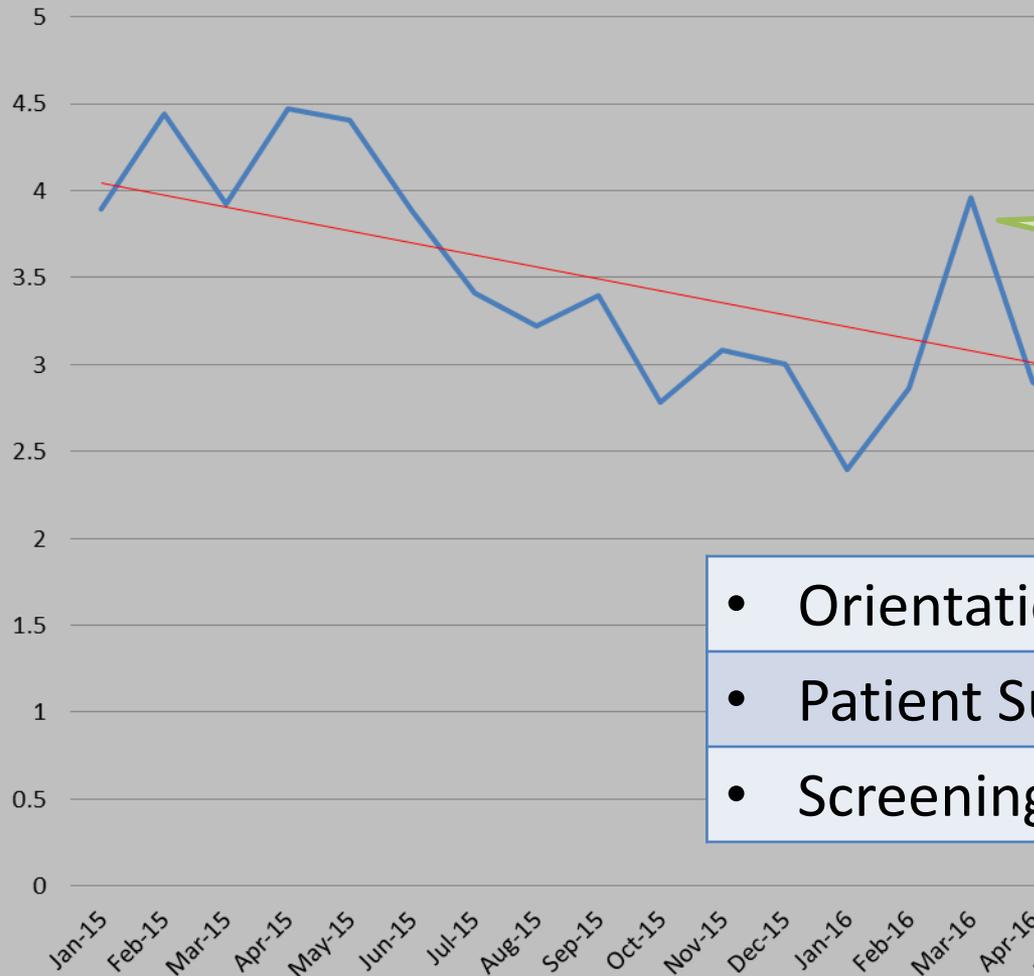


Safety Huddles

Why, Why, Why, Why
Why?

Common Cause
Analysis

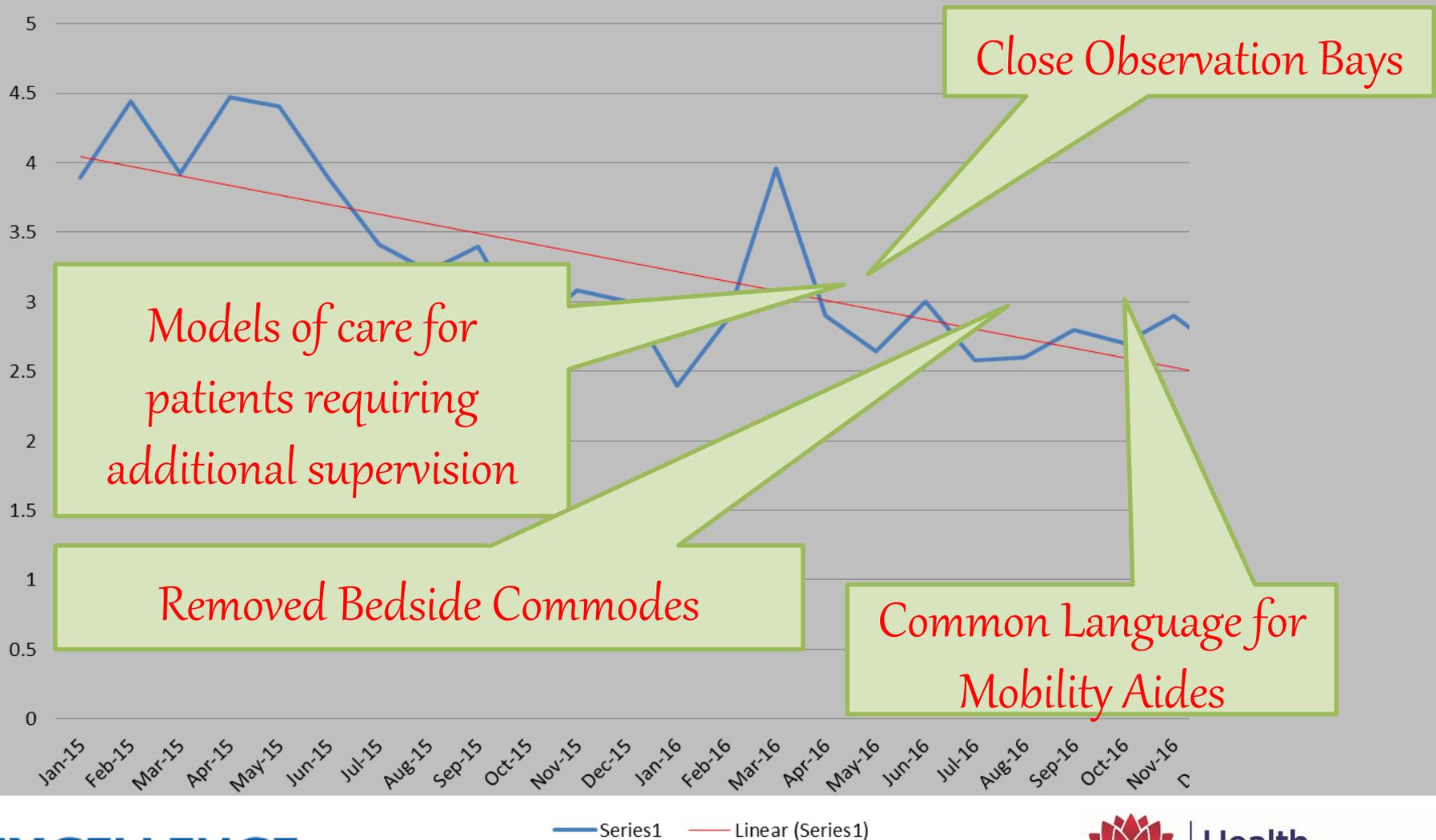
To sustain change you need to be nimble



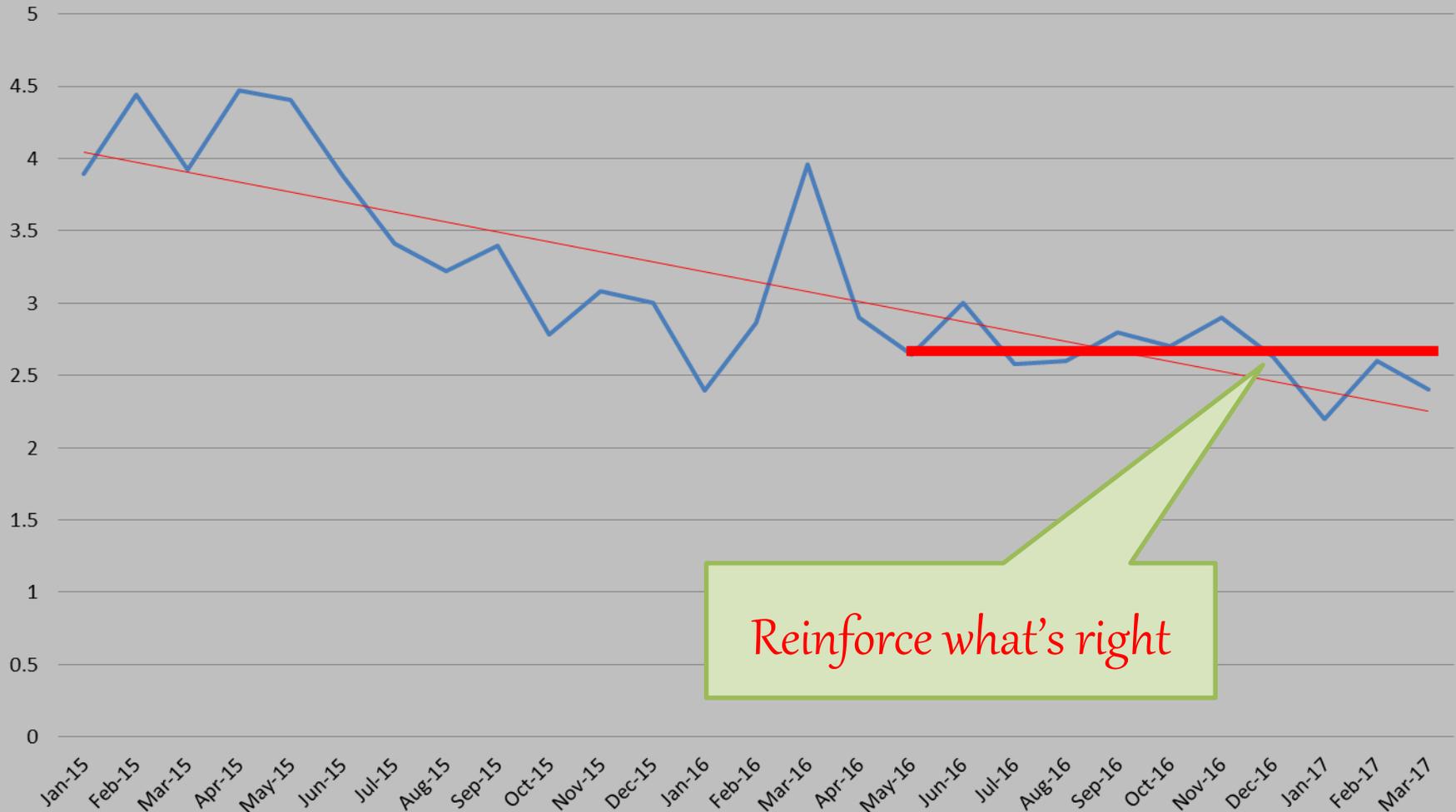
What happened???

- Orientation
- Patient Supervision
- Screening & Care Plans

Strategy Three



Strategy Four



Series1 Linear (Series1)

Excellence Coach for John Hunter Hospital

Coaching Role	Coaching Strategies
Outcomes Driven Falls Prevention Program Phase 4	Regular meetings with Executives
	Rounding, and action planning sessions with NUMs/MUMs
	Staff rounding, inservicing and education sessions
	Presence 'on the floor'; coaching Safety Huddles and assisting with falls prevention strategies

Coaching strategies, tools and focus...

- Common Cause Analysis
- Supervision
- Communication
- Proactive Care
- Sustainability

Common Cause Analysis



Collate falls data

Visually identify trends
(common causes)

Establish priority areas for
change

Incorporate priorities into
facility-wide operating plan

Common Cause Analysis

Trimbey Healthcare

Age of patient				"Ontario Modified Stratify Falls Risk Screen" completed on admission		If indicated was "Falls Risk Assessment and Management Plan" completed following Ontario		Time of fall				Location of fall			Activity at time of fall				Cognitive state		Medication associated with high falls risk given (Anaesthetic, antipsychotic, antidepressant, sedative, hypnotic, opioid)			Time since last hourly rounding			Witnessed fall								
< 60	61 - 69	70 - 79	> 80	Y	N	Y	N	2400 - 0400	0400 - 0800	0800 - 1200	1200 - 1600	1600 - 2000	2000 - 2400	Bathroom	Outside room	Inside room	Other	Toileting	Showering	Mobilising	Transferring	Other OR Unknown	Alert	Confused	< 4 hours	> 4 hours	None given	< 15min	15 - 30min	30 - 60min	> 60min OR unknown	Y	N		

Common Cause Theme inspired changes...

Theme	Strategy
Communication	Documentation Bedside Clinical Handover Patient Care Boards Safety Huddles
Supervision	Close Observation Bay Safe Bedside Toileting
Proactive Care	Hourly Patient Rounding

Communication

Safety Huddles

Safety
Staffing
Patient Flow
Equipment/Environment
Business Continuity

A Assessment issues
C Cognition issues
T Treatment/ Care tactics

I Introduction
S Situation
B Background
A Assessment/ Actions
R Recommendations

Look Back **Look Forward** **Follow Up**

Safety Huddles

- Identify high risk patients
- Identify safety risks
- Communicate risk reduction strategies
- Increase focus on safety
- Improve communication
- Increase staff morale

Communication

Safety Huddles

Stand up meeting at the Electronic Patient Journey Board

Brief = No longer than 5-15 minutes

Led by NUM/MUM or Team Leader

Follow a structured format

Attended at changeover of each shift

Attended whenever a staff member needs to communicate an identified risk

Attended following an incident to review the incident and communicate change

Supervision

Close Observation Bays (COB)

A four bedded cubicle where patients with confusion and/or at high risk of falling are grouped together and staff are allocated to remain within the COB and within visual site of the patients at all times.

Local Procedure

JHH_0170: Close Observation Bay for falls



Health
Hunter New England
Local Health District

Document Number: JHH_0170

Close Observation Bays for patient observation for Falls

Sites where procedure applies:	John Hunter Hospital
Target audience:	Clinical Staff
Description:	Falls Prevention strategy – the implementation of a close observation bay
National Standard:	Standard 10

Supervision

Close Observation Bays (COB)

One RN/RM allocated each shift to provide patient care within COB, 24/7.

2nd Nurse allocated to go in and assist when patients require two person care within COB

Staff must 'tag-out/tag-in' of the COB to ensure patients are never left unsupervised

May be created at any time when two or more patients require close observation

Proactive Care- Hourly Patient Rounding

Maximises personalised, pre-emptive and proactive care offered to inpatients, minimising adverse events or lack of care relating to inpatients. Irregular and infrequent assessment of inpatients may increase the risk of not meeting patient care needs.

Hourly Patient Rounding and Documentation of Care HNELHD Pol 14_06:PCP 4

Policy
Compliance
Procedure



Health
Hunter New England
Local Health District

Hourly Patient Rounding and Documentation of Care

Proactive Care



(Purposeful) Hourly Patient Rounding

Encourages patients to utilise nursing assistance

Gives the opportunity to have needs addressed before they become a concern for the patient

Keeps patients informed about and involved in their care

Regularly evaluates the quality of essential care delivery

Improves the safety and quality of patient care

Creates trust and reduces patient anxiety by providing a known care giver and clear expectations for each interaction.

“By Your Side”

Overarching aim: Decentralise care to the bedside

Essentials of Care Project

Piloted in Ward G1

(D Armitage, M Lockyer, J Galvin, T Conway, M Kulupach, T Hamilton, L Pitt, M Cherry, D Harper)

M Lockyer, J Galvin, T Conway, M Kulupach, T Hamilton, L Pitt, M Cherry, D Harper, D Armitage

Ward G1 John Hunter Hospital

Introduction

The project arose from feedback provided by patients, visitors and staff relating to noise levels in the unit, particularly around the central desk area. The noise affected the ability of patients in rooms immediately behind the desk to rest and prevented staff from being able to hear when using the ward phones. At the same time nursing staff were concerned about the amount of time wasted looking for patient files and there was a report of a patient clinical file missing for over 12 hours.

Aim

The overarching aim of this project was to design workflow practices that would facilitate staff spending more time with patients and consequently improving safety and increasing engagement with patients, families and clinical staff.

More specific aims were:

- reduction in noise at central desk
- reduction in patient files left open at main desk, reducing the potential for confidentiality breaches
- increase in the number of members of the interdisciplinary team writing progress notes at the patient bedside
- reduction in time spent by nurses looking for patient files

Method

The project used a practice development approach of problem identification, group reflection, implementation and evaluation. The project team was multidisciplinary and included nurses, allied health and clerical staff.

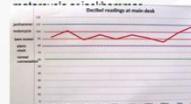
Data collection

Data was collected through:

- decibel readings
- patient surveys
- staff surveys
- observations of practice
- photographs

Issues identified

- Decibel readings were taken over a three week period. At peak times the noise level was 100-110 decibels, equivalent to a



- Observations of practice highlighted up to 17 staff at the central desk area at the s



- Potential breaches in confidentiality occurring when patient files were left open on the main desk and visible to anyone approaching the desk.

Acknowledgements

We would like to thank the John Hunter Hospital executive for their support with this project.



Evaluation – Quantitative results

Noise levels

Across the peak noise times, decibel readings at the central were reduced by over 50% with noise rarely reaching more than normal conversation level (60 decibels).



Confidentiality of files

There has been a 70% decrease in the number of files open at the main desk and the number of confidential discussions held in public areas of the ward.

Bedside note writing

Survey results show that 75% of multidisciplinary team and 95% of nursing notes are written at the bedside

Time looking for files

80% decrease in the number of times per shift nurses have to search for patient files.

Time with patient

This project has returned 6 nursing hours per day to the patient bedside over morning and afternoon shifts.

Evaluation – Qualitative

Consumer engagement

Consumers report increased inclusion in discussions and decisions about their care and that there is more timely response to questions as the information is readily accessible to staff in their room.

Multidisciplinary collaboration

Medical teams report greater collaboration between medical and nursing staff and more timely implementation of care plan changes now that care is discussed at the bedside.

Correlational results

Reduction in falls

Since the implementation of By Your Side, the falls rate is the lowest in over three years, most likely due to the increased time spent by staff at the bedside providing assistance and supervision.



Conclusion

The simplest of changes can make the biggest difference. Effective and sustainable change is achieved if time is taken to understand the causes of the problem and solutions developed that address these causes.

Sustainability

By Your Side

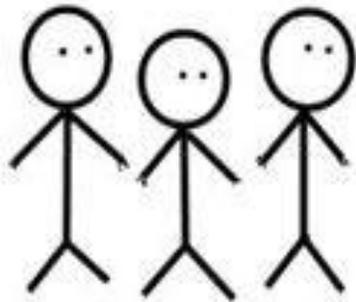
Relocate all patient files to wall holders in patient rooms

Remove chart holders from central desk area

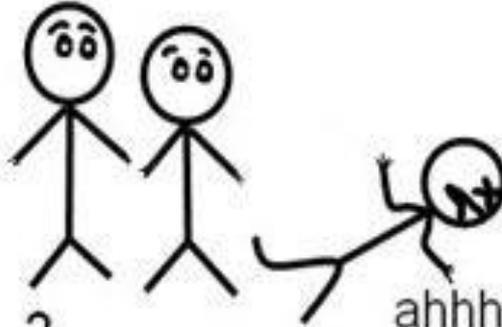
Provide writing space (desk) in patient rooms for staff

Provide additional 'Workstation on Wheels'

Reduces falls, unwitnessed falls and harm related to falls



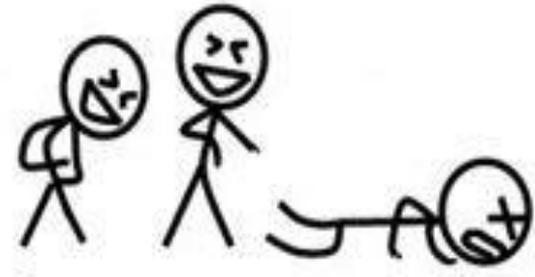
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ahhh

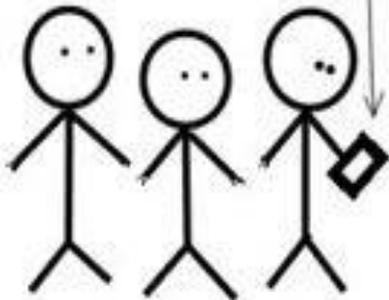
HAHAHA!!



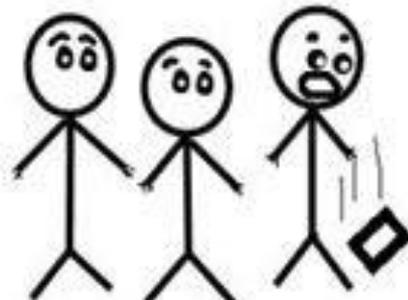
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ouch!

iPhone



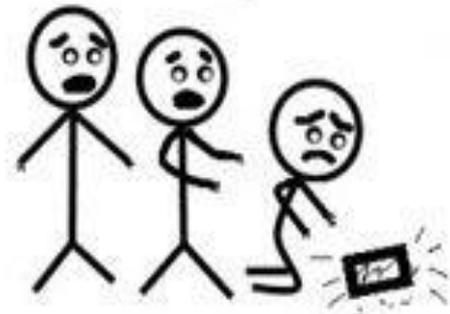
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2

ahhh

OMG,
Are you okay?



3