

After Hours Clinical Nurse Consultant Project

Rebecca Stone

Bankstown-Lidcombe Hospital

BACKGROUND

Patient safety in hospitals during nights and weekends has increasingly been recognized as a significant problem'.

(Shulkin 2009)

There is a relative large body of evidence to support the notion that:

- Pts are at risk afterhours.
- Discharges from ICU afterhours increase the risk for pts.
- Clinical support after hours is reduced.
- Staff fear contacting senior medical staff for appropriate support.
- Pt outcomes can vary dependant on staff skills and availability.

Systemic Problems

NSW Deputy Coroner Carl Milovanovich noted that:

‘There is little doubt that the NSW health system, while certainly staffed by dedicated professionals, is labouring under increased demand and expectations from the general public. Unfortunately, the same issues are invariably identified: not enough doctors, not enough nurses, inexperienced staff, poor communication, poor record keeping and poor management. These are systemic problems that have existed for a number of years’

(cited in Van Der Weyden 2009).

Local Circumstances

- At Bankstown Hospital a 'gap' in afterhours patient management and care was identified by management and staff.
- It was highlighted that patients were not receiving the appropriate clinical management for optimum outcomes.

‘With a more complicated patient group that are presenting to hospital and limited monitored beds, a greater number of high acuity patients are being placed in the general medical-surgical areas. These patients are at risk of deterioration and greater risk for increased mortality’.

(Bader, Neal, Johnson, Pyle, Brewer, Luna, Stalcup, Whittaker & Ritter 2009)

Between the Flags (BTF)

- With the introduction of the Sydney South West Area Health Service (SSWAHS) directive of the Between the Flags (BTF) system it was intended this gap of patient management would be closed.



Trial & Error

A second after hours nurse management position was created in an attempt to cover the needs of after hours staff and patients. During its trial period it was found to not support the areas of need that were highlighted which was clinical support and assessment. This position was terminated after an 8 week trial.

Solutions

- The AHCNC role was created by management to cover the hours of 1600-0030hrs.
- A project was established to manage the implementation of the role and associated monitoring and evaluation.

Support & Authority

- A Steering Committee was formed which meets once a month to evaluate the data and ensure the project remains on target.
- This has provided governance, good communication and senior management support/involvement.

THE ROLE

Pilot Phase

- Was 6 months (July to December 2010).
- Funding was sourced from the Medical Assessment unit (MAU), CNC position.
- 1962 referrals seen.
- MET call referrals' remained steady at 9-15%.
- RN referral increased from 11%- 22%
- The wards that utilise the role the most are the surgical wards (Orthopaedic, Gastro, Urology & Vascular).

Phase 1: Preparation

STEP 1: Secure agreement for AHCNC Project with Management

Completed by: December 2010

STEP 2: Initial meeting of the Steering Committee

Date: March 2011

STEP 3: Conduct initial education surrounding role with staff in Bankstown Hospital

Completed by: Pilot period end December 2010

Ongoing: Through Hospital Orientation

STEP 4: Roll out of AHCNC

Date: Jan/Feb 2011

Phase 2: Evaluation & Establishment

STEP 5: Evaluate data, use of after hours service and need for change in role

Ongoing: **Monthly with steering committee**

STEP 6: Evaluate in stages the need and feasibility of implementation of role to cover increase to hours.

Stage 1: Weekends AM shift

Stage 2: Weekdays to include ND

Completed by: **Stage 1: May 2011**

STEP 7: Evaluate need and feasibility of implementation of role to cover all hours classified as 'After Hours' (1600-0700hrs)

Completed by: **June 2011**

STEP 8: Completion of project with establishment of extended hours of service for the AHCNC position 1600-0700 hours with validation of the role through data collection at Bankstown Hospital.

Completed by: **December 2011**

Current Status

- Role Is a 7 day a week service with coverage from 1600-0030hrs.
- Is a permanent position in the Hospital.
- Has been established for 5 months.
- The project now is looking to establish enough evidence for an increase to service hours.

Job Role

- Follow up of all ICU discharges to ward environments (outreach service).
- MET call attendance during service hours.
- Follow up of earlier MET call patients left in the wards.
- BTF Yellow Zone call attendance to support nursing and junior Medical officers in patient assessment and treatment.
- Education: informal and formal sessions.
- Clinical supervision and guidance of all after hours staff.

Referrals

Evaluation Strategies

- Decrease in patients arresting between the hours of service.
- Improved triggering of the BTF system.
- Decrease in MET calls.
- Improved management in Yellow Zones, with patients not escalating to a MET call.
- Decrease in IIMS or critical incidents during AHCNC service hour.
- Increased referral to AHCNC by RNs for support with clinical issues.
- Improved communication of at risk patients to medical teams for management and input.
- Education of staff in relation to at risk patients.
- Staff satisfaction/retention.
- Decrease in unexpected admissions to ICU.

Positive Impacts

ICU Outreach

A study found that admission to the ICU on weekends and after hours has an effect on the mortality of the patient admitted.

(Laupland, Shahpori, Kirkpatrick and Stelfox 2008)

Unexpected admissions to ICU/HDU from MET system

- During the pilot phase 72 unexpected admissions were made.
- January to present there have been 58 unexpected admissions.

- Currently all patients discharged from the ICU environment to wards are followed up.
- Readmissions to the ICU are being examined by the AHCNC Steering Committee to evaluate the roles impact.

TEAMWORK

‘Teamwork is one of the most important components in reducing errors and improving safety’

(Kohn et al 1990 as cited by Harris 2006)

STAFF SATISFACTION

'I think having an AHCNC is proactive and forward thinking. I think this is one of the best programs implemented by the hospital. It promotes pt safety & care. Plus caring for our junior nurses/medical staff.'

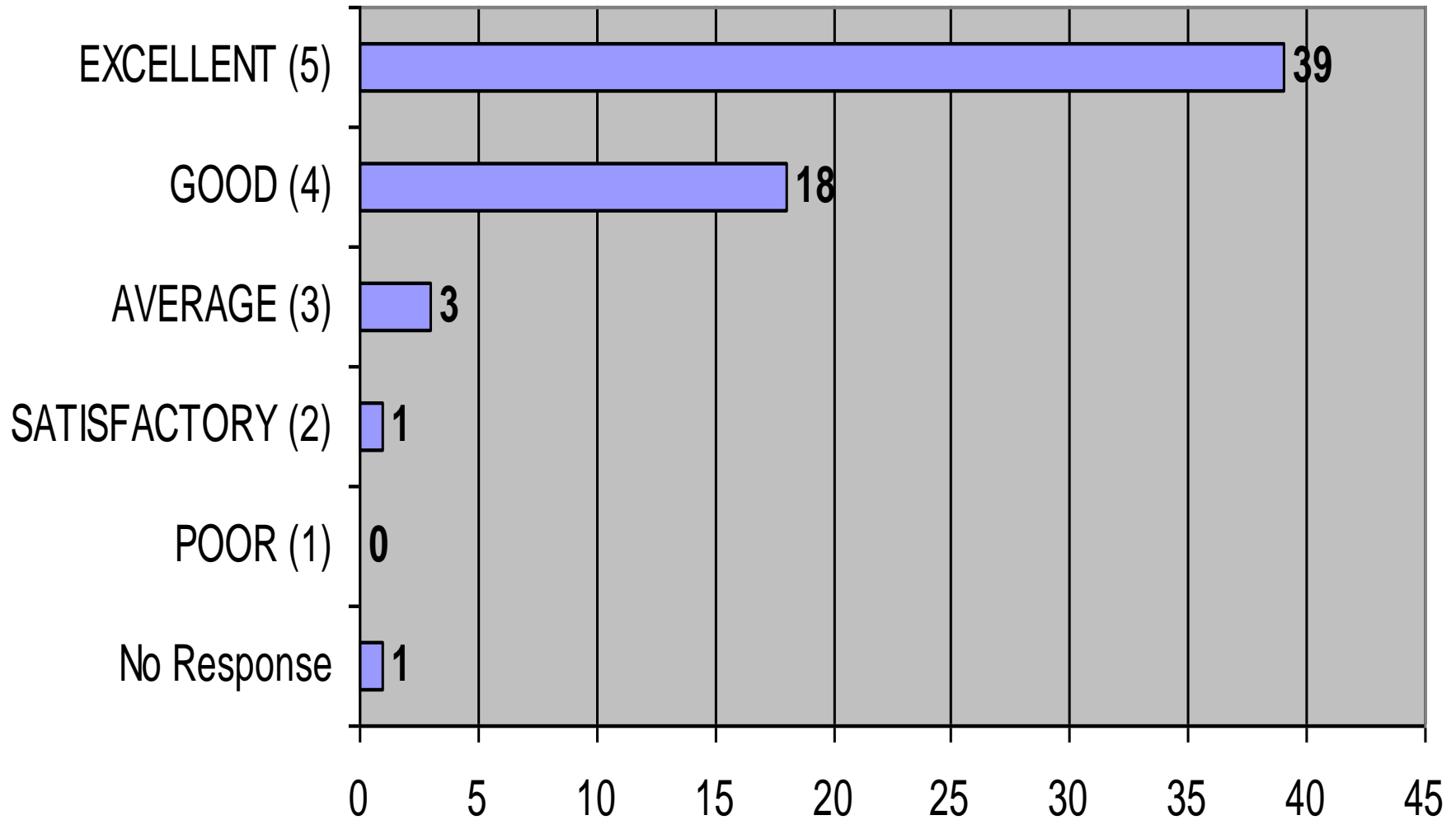
(Kylee Williams 8th year RN CCU)

Staff Survey Results

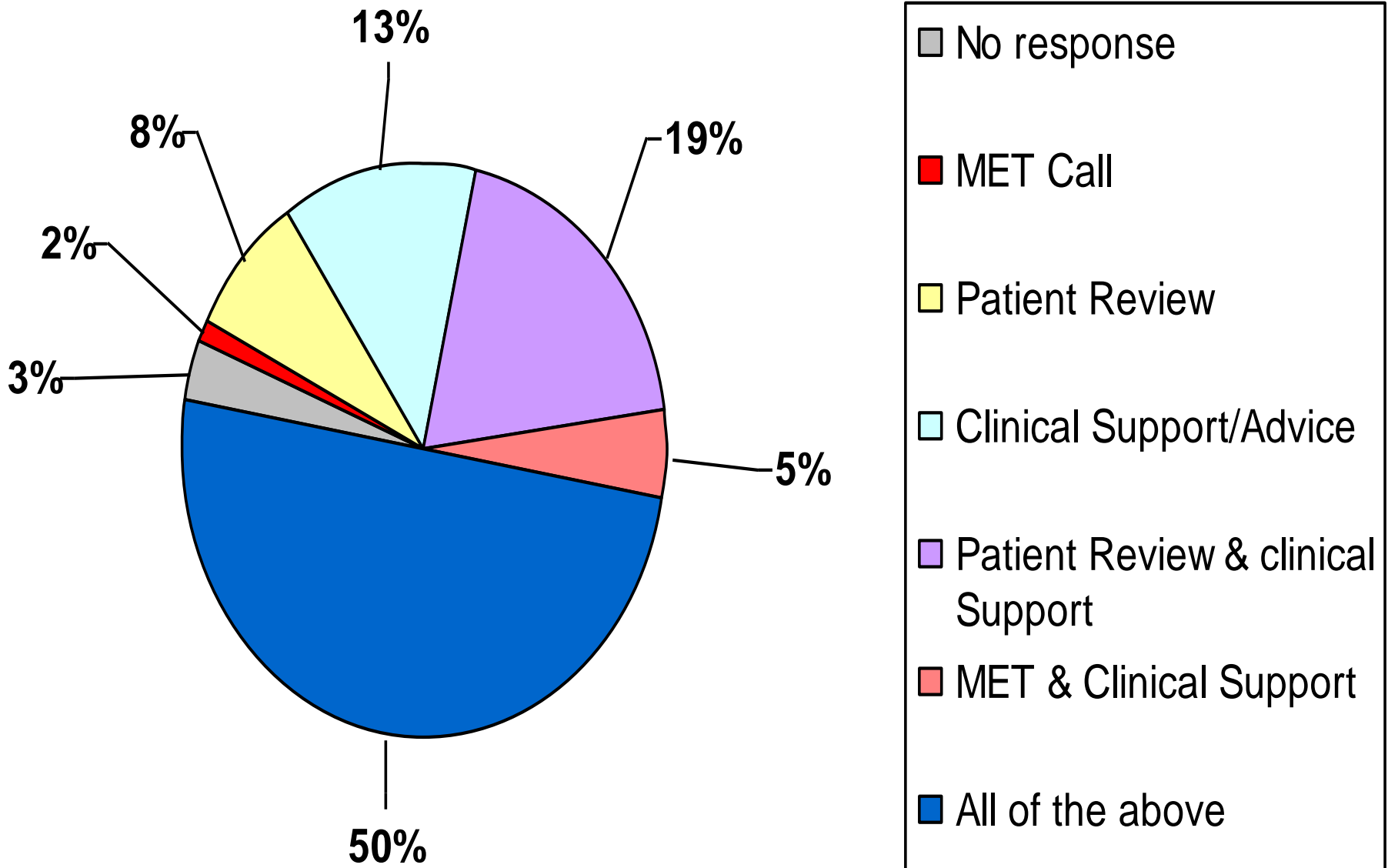
AHCNC role

- Conducted over April 2011
- 62% of surveys distributed were returned.
- 97% respondents found the role useful (3% did not answer).
- The survey will be repeated in 6 months time to gauge staff satisfaction and utilisation of the role.

Satisfaction Rating With AHCNC Role



How the AHCNC Role is Used



EDUCATION

- Majority of the education is informal at present.
- Bedside teaching with real patients and scenarios as they occur.
- Formalised education is arranged with wards and aligns with their specific needs.
- AHCNCs participate as DETECT trainers & BLS/ALS assessors.

Where to from here?

- Project completion Dec 2011.
- Increase to hours for weekends and night shift.
- Ongoing review and evaluation of the role.
- Increased staff training and satisfaction.
- Improved patient care and outcomes.
- Possible purchase of iPad for data correlation and education.

Transferability

- Role has been utilised in other hospitals. (Liverpool, Concord, Campbelltown & St George).
- The role and hours of service have been tailored for each institutions needs.
- All hospitals have reported positive outcomes from the role.
- Could your world do with an AHCNC?

‘they are leaders in patient care and within the health care system: influencing change, promoting quality and evidence based practise that improves patient outcomes and safety. (Coombs et al. 2007). A significant capacity for critical thinking and decision making were the hallmarks of their performance: reinforced by a collaborative and flexible style of practise.’

(Santiano, Young, McDonnell , Page & Chapman 2009)

References

- Bader M. K., Neal B., Johnson L., Pyle K., Brewer J., Luna M., Stalcup C., Whittaker M. and Michael Ritter (2009). "Rescue me: Saving the Vulnerable Non-ICU Patient Population." *The Joint Commission Journal on Quality and Patient Safety* **35**(4): 199-205.
- eLearning (2007), *Project Management revised edn*, Pergamon Flexible Learning, Elsevier, Oxford.
- Harris K. T., Treanor C. M., and Salisbury M. L. (July/August 2006). "Improving Patient Safety With Team Coordination; Challenges and Strategies of Implementation." *JOGNN* **35**(4): 557-566.
- Santiano N., L. Y., McDonnell S., Page K. and Chapman A. (2009). "How do CNCs construct their after hours support role in a Major Metropolitan Hospital." *Collegian* **16**: 85-97.
- Shulkin, D. J. (2009). "Assessing Hospital Safety on Nights and Weekends: The SWAN Tool." *Journal of Patient Safety* **5**(2): 75-78.
- Tasmanian Government Project Management Guidelines, version 6 2005, accessed from http://www.egovernment.tas.gov.au/project_management_government_project_management_guidelines.
- Van Der Weyden, M. B. (19 January 2009). "In the wake of the Garling inquiry into New South Wales public hospitals: a change of cultures?" *Medical Journal of Australia* **190**(2): 51-52.
- <http://store.apple.com/au>, accessed on 22/9/2010.
- http://www.health.nsw.gov.au/policies/pd/2010/pdf/PD2010_026.pdf (PD2010_026 10th May 2010) accessed 18/8/2010.
- <http://www.industrialrelations.nsw.gov.au> accessed 22/9/2010.
- <http://www.officeworks.com.au> accessed 22/9/2010.
- <http://www.sswahs.nsw.gov.au/bankstown/> accessed 19/8/2010.