Nursing Improvement Group Meeting

(HRT1512)

6th & 7th August 2015, Novotel Central, Sydney

MEETING NOTES

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First session post-it note

- Separating clinical expertise nurse and patient flow
- Relook at staffing model on night duty- safety- support- efficiency
- ward staff having authority to ask the help
- increasing ability of nurses to network whilst gaining more skills and knowledge of different areas
- Four admission beds in the a.m.
- increase overnight support medical/nursing teamwork and increasing patient safety
- emergency Department authority to admit 95% correct (3)
- clinical leadership on after hours periods
- ‘no triage’ and use of flex beds
- Carps (4)
- admission beds open during the day
- hospital at night nursing team (4)
- how do they fund these changes!!
- Change to triage process leading to decreased queues
- hospital at night nursing team
- clinical carps-the ability to capture overnight data
- visibility of numbers of staff by discipline across the 24-hour period -emergency department admitting the patient- priority teams manage them-hospital night team and model-clinical carps
- nurse practitioner role at night> float> admit
- clinical carps> triage calls
- nursing team fluidity
- hospital at night team-no wait triage (4)
- Flex beds -have space to admit -24/24 discharge model-create capacity- not 100% occupied/blocked
- clinical lead and patient flow separated
- admit directly to unit
- managers/ roles discussion/ how to bring roles back into clinical focus-different team roles-clinical mentoring
- sharing nursing resources
- senior medical leadership-visibility – mentorship
- work sharing between nurses and doctors
- nursing team overnight that can be deployed to areas that require additional help and support- reviewing the traditional after hours role and removing admission to a another role
- electronic task list
- more effective utilisation of existing nursing and medical resources
- combined nursing – medical team after hours with the introduction of new roles - fantastic use of technology to promote clinical support within staff wards -the support between nursing and medical staff priorities-a great after hours clinical handover in the after- hours space
- staff ratios and how it impacts on clinical care
- roving team medical and nursing
- emergency Department authority to admit to ward without inpatient team assessment in the emergency Department
- the ability to know times where/when activity surges and allocate staff appropriately
- removal of silos at night

2nd session post-it notes –following Alex's presentation

- data not timely-didn't add value-already see a lot on this on site- too small sample size -data definitions not clear at data collection time -important to consider indicators, howeve, this session didn't hit the mark
- MET call/rapid response call data and patient outcome rather than the number of respiratory/cardiac arrest to show value or not of these teams.
- Falls with injury percentage of total -number of beds in unit data given for definition of the falls witnessed versus unwitnessed, assisted versus non-assisted -profile of each unit whose data was submitted for nursing specialists – level of staff
- is there a measure of whether care planning occurs at the bedside, involving the patient – after handover -(expectation if yes (safe) > decrease falls on the increased PACE next hour - if no (not safe)> increased falls in the next hour decreased PACE and increased ALS taken
- data add over time usage and fatigue leave – remove -shift hours
- need to compare apples with apples in relation to data collection in order to be used i.e. same size hospitals – patient groups
- weekend staffing versus weekday (? seven-day service)
- falls- noted falls not occurring overnight-focus on paediatric falling at RCH Victoria a lot of explosion of risk assessment and need to stop + during the caring
- take off workers Comp
- add –age of workforce - years of experience
- if doing agency then add agency usage –v- over time
- add patient aggression
- cardiac indicated testing data not relevant -most relevant MET calls for failure to rescue -like the mapping across the time of shifts -not focused on enough resources but are they doing the right thing
- take away Workers Comp or modify to only include injury related to patient aggression
- Interested in further analysis of sick day management
- MET critical/calls time of recognising deterioration versus actual cardiac/respiratory risk
- if turnover data then add number of new employees

3rd session after lunch

- distinguish data e.g. types of wards and number of beds
- nursing management and development program- advertise three components a) nursing executive transition to practice CNE, b) after hours education, c) nurse unit manager, after hours nurse manager and nurse manager
- leadership
- rounding
- ‘pool’ of high duties nurses

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