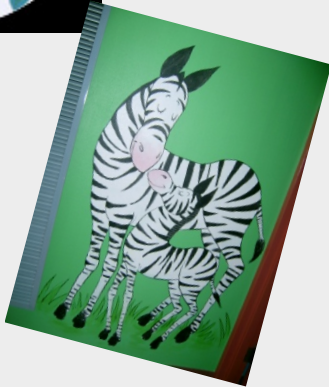




OwLy ROuNding



Cain Byrnes
Patient Safety & Clinical Quality



Health
Western Sydney
Local Health District



What about us?



Falls prevention programs are traditionally structured around the needs of the elderly, or less mobile adult patient. **Paeds are no less deserving of protection.**



A problem identified

Trending the wards incidents from 2011, 2012 and 2013 revealed that falls represented the highest (equal) proportion of incident types logged.

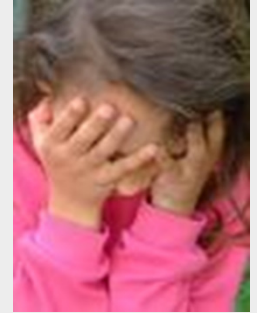
The solution

- Posters around the ward
- Add information to the admission pack
- Staff to take full responsibility for their patient's safety



It's not us... don't you get it?

Further analysis and discussions demonstrated that the most frequent common denominator present with the falls were:



1. Parents/Carers
2. Equipment: cots, beds, couches, and *strollers*



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Solutions revisited



May 2014

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Please show an interest in your ward when a caregiver is on board during rounding and please complete below:

Ward	Ward Manager	Ward Nurse	Ward Physio	Ward OT	Ward Diet	Ward Pharm	Ward Social	Ward Psych	Ward Speech	Ward Music	Ward Art	Ward Games	Ward Reading	Ward TV	Ward Radio	Ward Music	Ward Art	Ward Games	Ward Reading	Ward TV	Ward Radio
...

Dr. [Name], [Date]

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Watch out... Falls Monitor about

WHAT CAN GO WRONG?

- Go on how you think a child may be at risk of falling, slipping or tripping.
- Listen to the requests of our staff.
- Ask are not to sleep anywhere other than their bed or cot.
- When holding a child you should be doing nothing but hand! No phones, no food, no games.

WHY are we doing it?

- Hospitals are busy places with a lot going on.
- We need to team up with you to keep our kids safe.
- When kids are unwell they are at greater risk of falling, slipping and tripping.

HOW are we going about it?

- Every hour a designated falls monitor will be around to check that all is safe!
- Thanks to our volunteers we have new safer cots.
- We will be talking to each other about how well we are doing and what we need to do better.



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The unexpected...aka that 'What the's ???'



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Results

- Target: 50% reduction of paediatric falls in the ward
- Result: actual reduction rate of 78%. Only 1 fall within the ward occurred during this period, an unwitnessed slip- no resultant injury.

To achieve this result: staff completed a total of **2668 rounds**, a compliance rate of **70%** over six months.

During the 2668 rounds the FMs identified and addressed a total of **116 hazards/risks**

3 key points

- Involve staff, patients and their families from the outset.
- Don't over intellectualise or complicate.
- Know your champions.