Night O.W.L. program: An intervention to reduce falls during night shift in wards

Chen Qiu Yan Joyce/Wong Kok Cheong
Lau Soy Soy/A Punithavathi
Fazlina Bte Abdul Hathi/Arlene Padiernos Ramos

Changi General Hospital

Singapore Healthcare Management 2017

Introduction

The incidence of falls resulting in injury is a major concern for healthcare institutions. Patients of any age or physical ability can be at risk for a fall due to physiological changes secondary to medical condition, medications, surgery, procedures, or diagnostic testing that can leave them weakened or confused. Elderly and frail patients with fall risks are especially vulnerable to falling and getting injured easily.

Problem

It is a common challenge among healthcare institutions to reduce falls during the night shifts as hospital statistics have shown that the incidence of night falls is usually higher than the day falls. In 2010, Marques et al.[1] found that most falls (up to 63.7%) occurred at night when there are fewer manpower and patients tend not to call nurses to help them with their Activity of Daily Living (ADLs) that they consider themselves capable of, such as eliminating in the bathroom. These patients would get out of bed on their own and walk without any assistance. Those with high fall risks, particularly the elderly patients, would then lose their balance and end up falling by their bedside.

In CGH, statistics have shown that there has been several night falls which resulted in major injuries like hip fractures and head injuries. Root cause analyses of these falls have shown that closer monitoring of high fall risk patients is important. However, the challenge of night staffing to support this measure needs to be addressed.

Methodology

Hi! I'm **Olly**!
CGH's *night owl* mascot

Taking inspirations from popular US TV series '*Baywatch*' and Australian factual TV program '*Bondi Rescue*', the CGH nursing taskforce launched a new fall safety initiative called the **"Night O.W.L. program"** to address the night falls.

The **Night O**bservation by **W**atchers to **L**ower fall rate (**O.W.L.**) **Program** involves nurses who volunteer their off days as *night owl* to support ward staff in providing uninterrupted monitoring of patients with high fall risk during the night shifts.

The key guidelines for the *night owls* are as follows:

1. Prior to commencement of duty at 2200hrs, the *night owl* will receive information from the ward nurse-in-charge on patients who have been identified as potential fallers or restless.
2. *Night owl* who provides observation to this group of patients must not be a staff member performing the nursing shift duties.
3. *Night owl* must conduct continuous rounding (~90% of working hours) to ensure maximum observation of patients. To minimize the amount of time they spend behind curtains, *night owls* are only allowed to attend to simple tasks which should not take more than 3 minutes (e.g. helping to patients to drink water).
4. When the *night owl* is having a break, it is mandatory for ward nurse-in-charge to assign another ward staff to take over the watcher role temporarily until the *night owl* returns from the break.
5. *Night owl* will be identifiable by wearing grey t-shirt. He/She will be responsible for patient observation until the morning staff report for duty at 0800hrs.

The Night O.W.L. program was piloted from October 2016 in 10 identified wards which had high night fall rates. HR Department was also involved in the project to assist in the compensation of the *night owls* for their hours volunteered.

Results

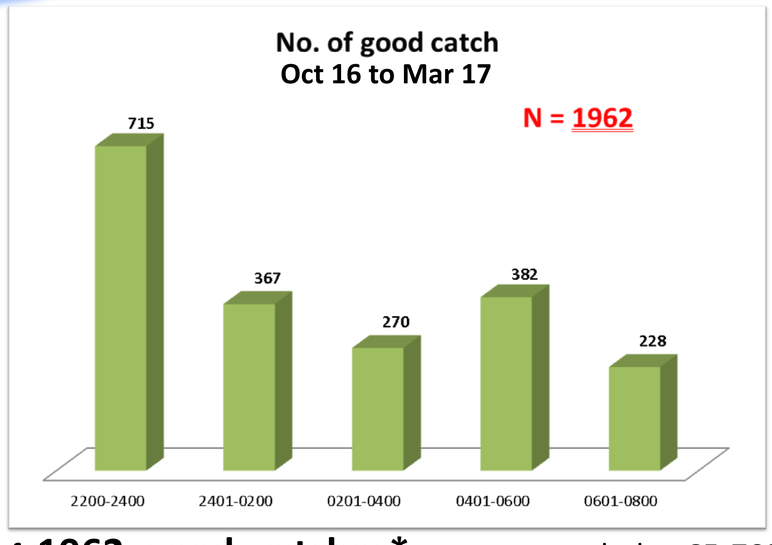

Fig. 1: A total of **1962 good catches*** were recorded. 65-70% of these patients were identified as high fall risks with cognitive impairments.
**Good catches = stopping patient from getting out of bed*

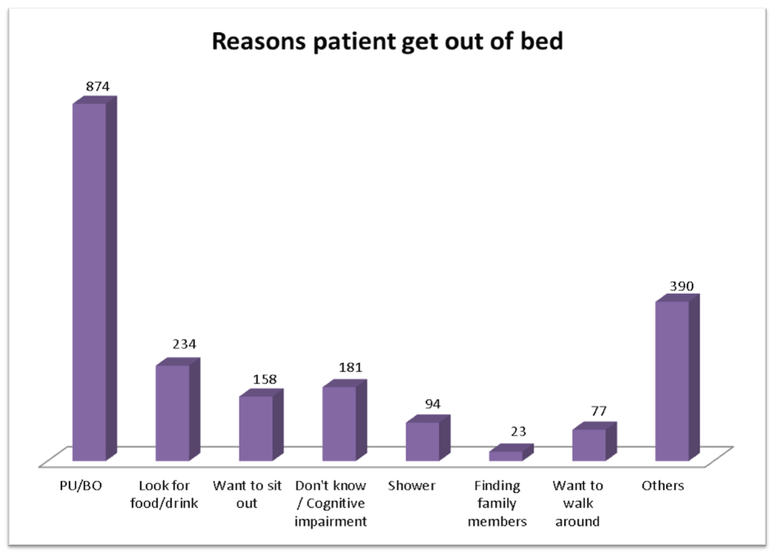

Fig. 2: **Elimination** (PU/BO) was the most common reason for patients to get out of bed.

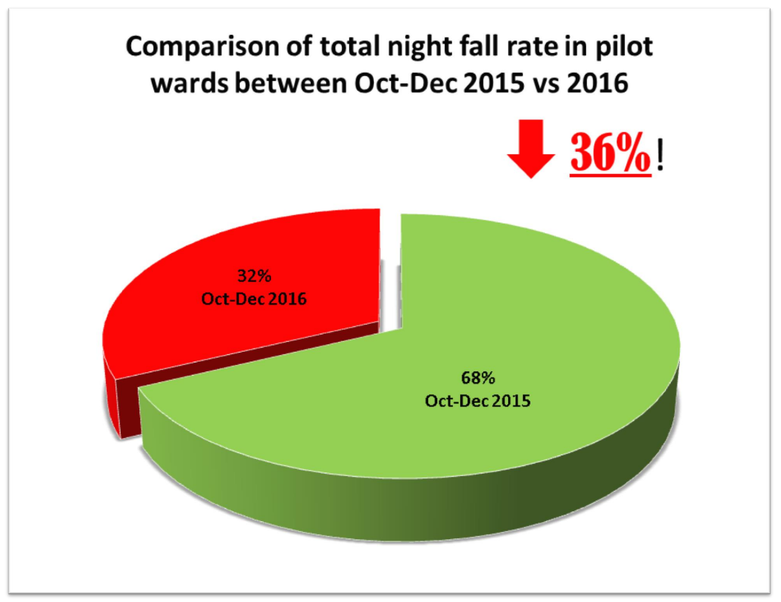

Fig. 3: There was a total **36% reduction** in the night fall rate between Oct to Dec 2016 as compared to the same period Oct to Dec 2015 in the 10 pilot wards.

Conclusion

With this Night O.W.L. program, there is now an active lookout for high fall risk patients at night and this not only helped to reduce falls among these patients by stopping them getting out of bed on their own, it also provided the ward staff a better piece of mind in performing their night duties. The *night owls* themselves were able to observe fall precaution measures in other wards and help spread the importance of fall precautions when they returned to their own units. Moving forward, the Night O.W.L. program will be expanded to recruit non-nursing staff as volunteers, so as to ensure a larger pool of *night owls* will be available to meet to the growing needs of falls monitoring when implemented hospital-wide.

1. Marques, M.C., Rupp, S.A., Berti, H.W. and Campana, A.O., 2010. Characterization of patient falls according to the notification in adverse event reports. Rev Esc Enferm USP, 44(1), 99.132-136.