

# Evaluation of A New Service Model with Disease-specific Nursing Quality Indicators for Fragility Hip Fracture Patients in Orthopaedic & Traumatology Department



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APN (O&T) QEH

# Our new service model

## Hardware

- An elderly friendly orthopaedic ward since 12/2016

## Software

- Fragility Hip Fracture Clinical Pathway Integrated clinical management

### G9長者友善骨科病房

#### 環境

- 充足光線
- 柔軟不反光地板
- 扶手顏色鮮艷
- 病區牆壁顏色鮮明
- 走廊暢通無阻

#### 護理指標

- 管理泌尿、排便、營養、疼痛
- 預防譫妄、壓瘡、跌倒及深靜脈栓塞

引入長者友善設計及概念

提供安全及優質的脆弱性髖關節骨折治療

醫護復康團隊無縫協作

提供家居環境  
減低治療壓力

晚晴護理  
提供舒緩治療，讓家人陪伴長者走畢人生

主動與家屬溝通

病房康復訓練

出院計劃管理

### 脆弱性髖關節骨折治療旅程

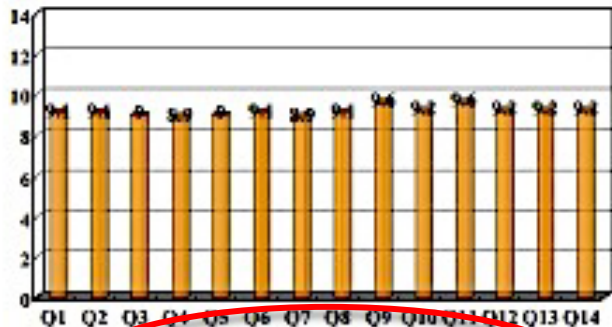


# Patients' demographic

2017		
Caseload in G9		759 patients
Age	mean ( range )	84.9 years old (67-100)
Gender	Male: Female	3: 7
<b>ALOS (G9)</b>	mean	<b>9.6 days</b>
ALOS (non G9)	mean	11.2 days

Mean ALOS in HA hospitals: 12.1 days

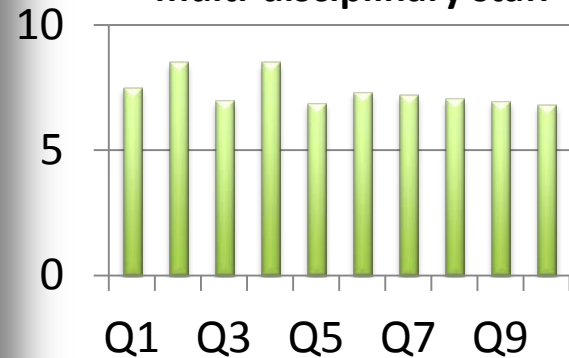
## 病人經驗及服務滿意度調查 (QEH/G9)



mean score: 9.4 /10

病人經驗及服務滿意度調查	←滿意	得分	最佳→
1. 醫院工作人員有否介紹自己、他們的角色和居住院期間的護理程序或治療措施?	0 1 2 3 4 5 6 7 8 9 10		
2. 當你在醫院期間與醫院工作人員的時候,他們的行為能表達其誠意及使你明白的答案?	0 1 2 3 4 5 6 7 8 9 10		
3. 當醫護人員討論你的病情、治療或手術程序時,有充分聽及你的說話?	0 1 2 3 4 5 6 7 8 9 10		
4. 如果你對自己的病情或治療有無建設性的時候,醫護人員有就你的情況與你討論 / 查詢嗎?	0 1 2 3 4 5 6 7 8 9 10		
5. 醫院的工作人員有討論/解釋你的病情?	0 1 2 3 4 5 6 7 8 9 10		
6. 醫生或護士有向你的家人或照顧你的人提供有關的資料去幫助你理解/照顧你?	0 1 2 3 4 5 6 7 8 9 10		
7. 醫護人員有以簡單容易方式向你講解結果?	0 1 2 3 4 5 6 7 8 9 10		
8. 假如你家人或照顧你的人與醫生交談,他們會見你機會這樣做?	0 1 2 3 4 5 6 7 8 9 10		
9. 你對醫院環境評價? (包括: 房間、地板、地毯、洗手和走廊)	0 1 2 3 4 5 6 7 8 9 10		
10. 你對病房具體設施如何評價? (物理治療區與職業治療區)	0 1 2 3 4 5 6 7 8 9 10		
11. 你對大型日曆、大時鐘和天氣報告怎樣評價?	0 1 2 3 4 5 6 7 8 9 10		
12. 有沒有持續播放我的聽生音樂(如: 心平氣安音樂)? 播放到安心。	0 1 2 3 4 5 6 7 8 9 10		
13. 無線電視的頻道有播放簡單易懂,讓我感到更好嗎?	0 1 2 3 4 5 6 7 8 9 10		
14. 如果有無線的電視設備播放我的康生節目,我會更愛使用。	0 1 2 3 4 5 6 7 8 9 10		

## Level of satisfaction among multi-disciplinary staff



mean score: 7.7/10

# Nursing Quality Indicators

Period of data collection 03/2017 - 12/2017 (10 months)

**Delirium (%)** 11.9%

Fall incidence (per 1000 bed days) 0.6%

No. of Pressure Injury (per 1000 bed days) 1.4%

Fecal Impaction (%) 1.8%

Success in TWOC (%) 67.7%

Dietitian consulted (%) 24.5%

Pain decreased by 50% 67%

Prevalence of delirium: 4%-53%

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affect  
patients'  
journey

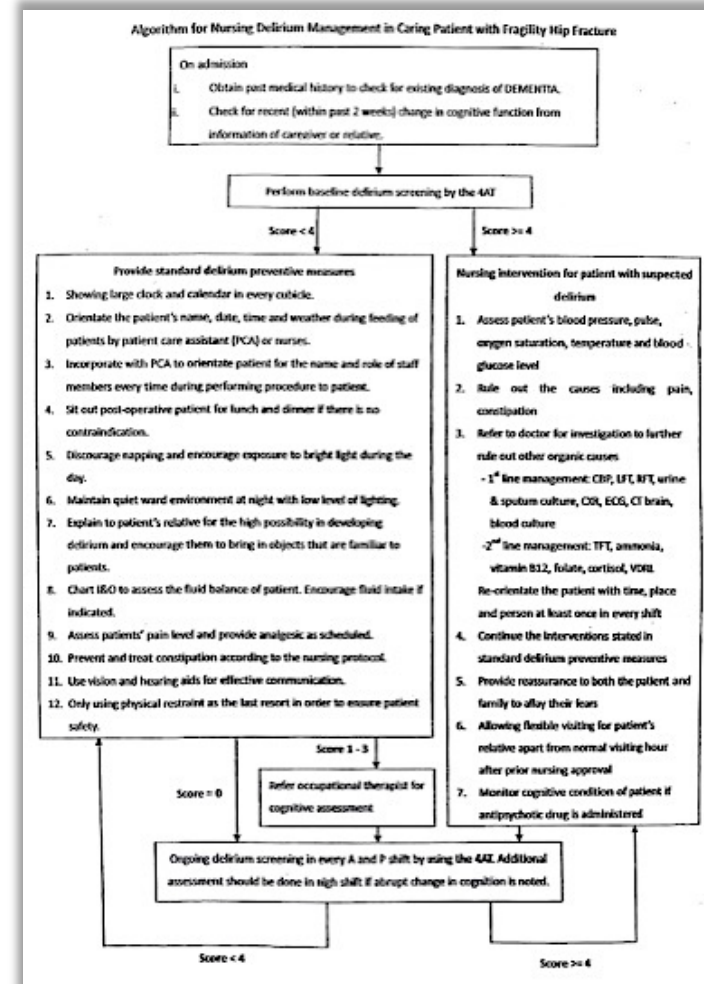
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# Proactive management of FHF patients with Delirium

Hospital Authority Queen Elizabeth Hospital		Please Use Block Letters or All-Caps Label	
Department of Orthopaedic & Traumatology		OPD / Hospital No.:	
4AT Assessment Test for Delirium and Cognitive Impairment		Name:	
		I.O. No.:	Sex:      Age:
		Dept.:	Team:      Ward/Bed:
Date			
Time			
4AT	Score		
<b>[1] ALERTNESS</b> This includes patients who may be markedly drowsy (i.e. difficult to rouse and/or obviously sleepy during assessment) or agitated/hyperactive. Observe the patient. If awake, attempt to wake with speech or gentle touch on shoulder. Ask the patient to state their name and address to assist rasing.	Normal (fully alert, but not agitated throughout assessment)      0 Mild sleepiness for <10 seconds after waking; then normal      0 Clearly abnormal      4		
<b>[2] AMT4</b> Age, date of birth, place (name of the hospital or building), current year.	No mistakes      0 1 mistake      1 2 or more mistakes/unfalsifiable      2		
<b>[3] ATTENTION</b> Ask the patient, "Please tell me the months of the year in backwards order, starting at December." To assist initial understanding the prompt of "what is the month before December?" is permitted.	Achieves 7 months or more correctly      0 Starts but scores <7 months / refuses to start      1 Unfalsifiable (cannot start because slowed, drowsy, inattentive)      2		
<b>[4] ACUTE CHANGE OR FLUCTUATING COURSE</b> Evidence of significant change or fluctuation in alertness, cognition, other mental function (e.g. paranoia, hallucinations) arising over the last 2 weeks and still evident in last 24hrs 4 or above: possible delirium +/ cognitive impairment 1-3: possible cognitive impairment 0: delirium or severe cognitive impairment unlikely but delirium still possible if [4] information incomplete)	No      0 Yes      4		
<b>4AT score</b>			

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- Nurses use a rapid clinical test (4AT) to screen FHF patients for possible delirium



- Nurses, MO & Occupational therapists built an algorithm together to prevent & manage patients with delirium