GET UP⇧

October 31, 2017

Indiana’s Bold Aim

To make Indiana the safest place to receive health care in the United States…
if not the world

Agenda

- Welcome and Introductions
- Get UP Campaign
- Guest Speaker Theresa Murray, RN, MSN, CCRN, Critical Care Clinical Nurse Specialist
- Resources and Support
- Get Up Webinar Series

Polling Question #1

What is your role within your organization?

- Infection Preventionist
- Nursing Professional
- Laboratory Professional
- Medical Staff
- Physical Therapy Professional
- Environmental Services/Housekeeping Professional
- Other

UP Campaign

Early Progressive Mobility

- Falls
- Pressure Ulcer and Injury
- Delirium
- Catheter-Associated Urinary Tract Infection (CAUTI)
- Ventilator-Associated Events (VAE)
- Venous Thrombo-Embolism (VTE)
- Readmissions

G E T - U P

UP Campaign

Goal: Simplify safe care and streamline cross-cutting interventions to reduce the risk for multiple patient harms

Up Campaign Schedule

- Supports Hospital Improvement Innovation Network (HIIN) harm reduction efforts
- Strategic Deployment of Three Campaigns:

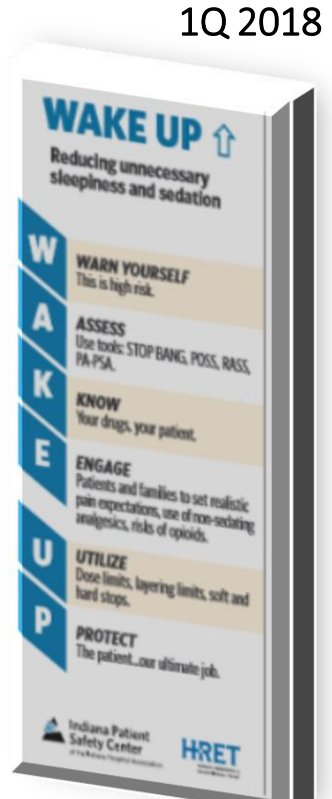
SOAP UP ⇧

GET UP ⇧

WAKE UP ⇧

4Q 2017

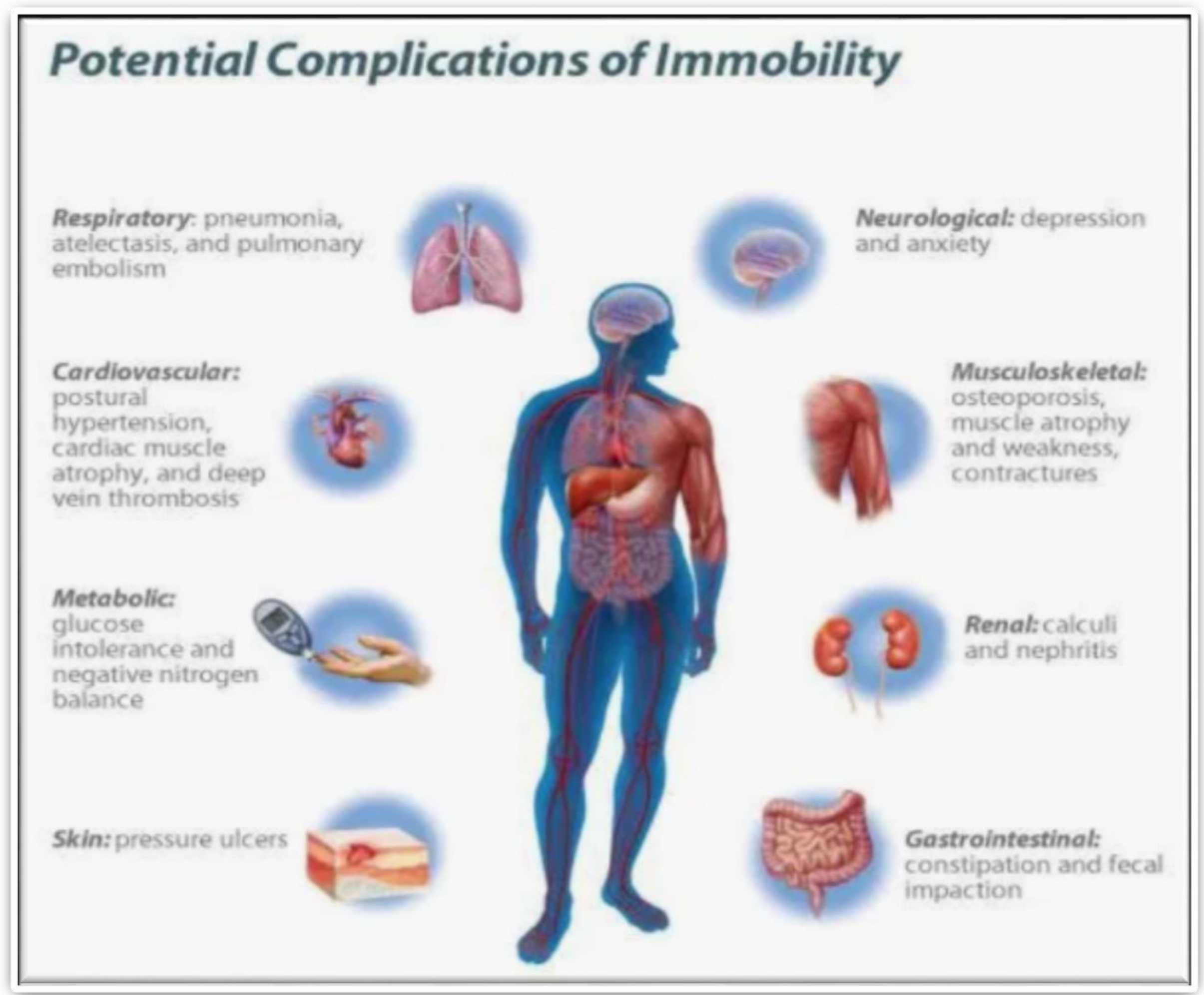
1Q 2018



3Q 2017

IHAconnect.org/Quality-Patient-Safety

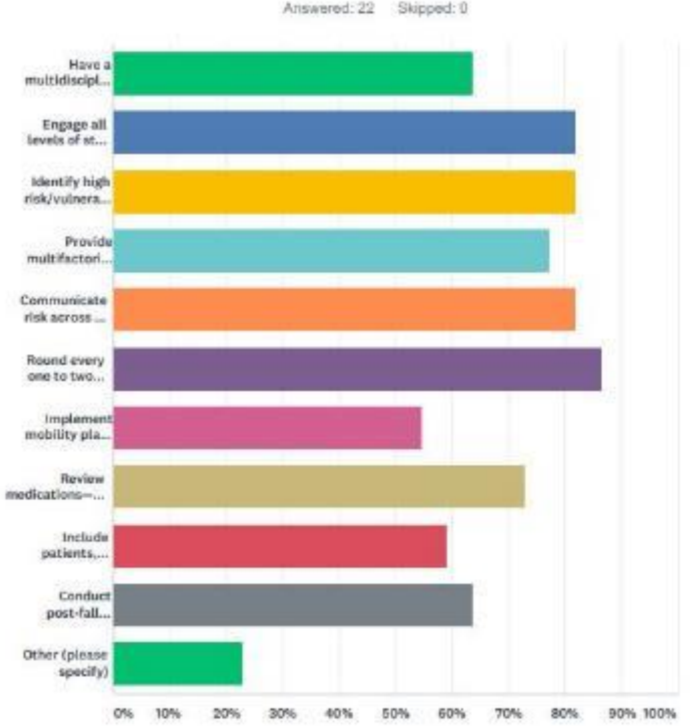
Did you know…..



Results of Falls Checklist Survey

GET UP Falls Check List

Q5 To help us better understand the Fall Prevention work in Indiana, please check all that are currently underway in your organization. Pleas include any work that doesn't fit into one of the listed categories in the "other" box.



ANSWER CHOICES		RESPONSES	
Have a multidisciplinary falls team with an executive sponsor, front-line staff from nursing and rehab, management support, physical therapy, physician and pharmacy representatives to oversee the strategic plan for the fall injury prevention program.		63.64%	14
Engage all levels of staff and disciplines in creating a safe environment that is free of tripping and slipping hazards and is responsive to patient needs, i.e., "no pass zone" and environmental rounds. Review all falls in leadership huddles to raise awareness of hazards and contributing factors.		81.82%	18
Identify high risk/vulnerable populations upon admission to receive a multifactorial falls assessment. Do not rely on a risk score alone. Examples: patients admitted with a fall, patients with a history of fall in the past six months, patients over 65, ABCS criteria, depending upon the population served.		81.82%	18
Provide multifactorial assessments and targeted interventions for high risk or vulnerable elderly patients. Assess for and address risk factors associated with gait, balance and mobility, medications, cognitive assessment, heart rate and rhythm, postural hypotension, feet and footwear and home environment hazards.		77.27%	17
Communicate risk across the team: EMR Banners, hand-offs, visual cues, huddles and whiteboards.		81.82%	18
Round every one to two hours on patients; address the five P's – pain, position, personal belongings, pathway and potty. Escalate rounding frequency to meet patient needs.		86.36%	19
Implement mobility plans for all patients to preserve function and prevent hazards of immobility: rehab referral and collaboration for a progressive activity and ambulation program.		54.55%	12
Review medications—avoid unnecessary hypnotics and sedatives and remove culprit medications from order sets. Target high-risk or vulnerable patients for pharmacist medication review.		72.73%	16
Include patients, families and caregivers in efforts to prevent falls. Provide structured education apart from admission orientation. Educate using teach-back regarding fall prevention measures and encourage family members to stay with high-risk, vulnerable patients.		59.09%	13
Conduct post-fall huddles at the bedside with patient and family immediately after the fall to analyze how and why the fall occurred, and implement change(s) to prevent future falls. Include a pharmacist and rehab staff member in the post-fall huddle or case review.		63.64%	14
Other (please specify)	Responses	22.73%	5
Total Respondents: 22			

Guest Speaker

Theresa Murray MSN,RN, CCRN,CCNS
Community Health Network
Indianapolis, IN

Theresa Murray MSN,RN, CCRN,CCNS
Community Health Network
Indianapolis, IN

Challenge, Journey, Evolution

- Everest is 29,035 ft.… 5 ½ miles
- 7,001 summits through August 2015
- 1923-1999: 1,169 summits; 170 deaths; 14.5% mortality rate
- 2000-2015: 5,832 summits; 112 deaths; 1.9% mortality rate

- Mortality rates in patients admitted to adult ICUs average 10% to 29%
- Study shows decrease in ICU length of stay, falls post ICU, and hospital length of stay
- Ultimately reduce readmissions and the mortality rate based on ICU stay

Study Purpose and Objectives

- This randomized, IRB approved study, looked at active progressive mobility with the goal to prevent deconditioning and the resultant negative outcomes (12 bed ICU)
  - falls
  - increased length of stay
  - readmission
- This progressive mobility program followed the patients throughout their hospital stay.

Study Investigative Team

- Study Principle Investigator: Theresa Murray
- Co Investigators: Marianna Schneider, Sue Heinzman, Deb Ferguson
- Rehabilitation Study Team: Wilfredo Geronimo PT, Janet Dawes OTR, Marcia Shumaker OTR (labor team)
- Erin Gill RN, Miranda Bailey RN, Ebony Brown RN
- Physician Champion: Bassam Helou MD
- All CHE inpatient staff
- Kanitha Phalakornkule – Statistical researcher

Patient Risk Factors

- Immobility
- Number of days on mechanical ventilation/VAE's
- Length of stay in the ICU
- Heavy sedation
- Delirium*mobility

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Early ICU Mobility Therapy

- Baseline characteristics similar in both groups
- Protocol group:
  - Received as least 1 PT session vs. usual care (80% vs. 47%, $p \leq .001$)
  - Out of bed earlier (5 vs. 11 days, $p \leq .001$)
  - Reduced ICU LOS (5.5 days vs. 6.9 days, p=.025)
  - Reduced Hospital LOS (11.2 days vs. 14.5 days, p =.006)
  - No adverse outcomes;
    - Most frequent reason for ending mobility session was patient fatigue
  - Cost
    - Average cost per patient was $41,142 in the protocol group
    - Average cost per patient was $44,302 in the control group

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Morris PE, et al. Crit Care Med, 2008;36:2238-2243

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Determining Readiness

- Perform Initial mobility screen w/in 8 hours of ICU admission & Reassess mobility level at least q 24 hrs (recommended at shift change)

- $PaO_2/FiO_2 \geq 250$
- Peep <10
- O_2 Sat $\geq$ 90%
- RR 10-30
- No new onset cardiac arrhythmias or ischemia
- HR >60 <120
- MAP >55 <140
- SBP >90 <180
- No new or increasing vasopressor infusion
- RASS $\geq$ -3

No → Patient is unstable, start at Level I & progress

Yes → Patient Stable, Start at Level II & progress

Bassett RD, et al. Intensive Crit Care Nurs (2012) 2012 Apr;28(2):88-97
Needham DM, et al. *Arch Phys Med Rehabil*. 2010 Apr;91(4):536-42

The Progressive Mobility Continuum

Date:

Progressive Mobility Program

Patient Sticker

	Includes complex, intubated, hemodynamically unstable and stable intubated patients; may include non-intubated		Includes intubated, non-intubated hemodynamically stable/stabilizing, no contraindications		
Patient Assessment	**Level I**	**Level II**	**Level III**	**Level IV**	**Level V**
	RASS -5 to -3	RASS -3 & up	RASS -1 & up	RASS 0 & up	RASS 0 & up
START HERE Perform initial mobility screen within 8 hours of ICU admission. Reassess mobility level at least q24hrs. (recommended at shift change)	Goal: clinical stability; passive ROM (PT/OT consult PRN)	Goal: Upright sitting; increased strength and moves arm against gravity	Goal: Increased trunk strength, moves leg against gravity, readiness to weight bear, and perform some ADLs	Goal: Stands w/ min to mod assist, able to march in place, weight bear and transfer to chair, and perform some ADLs	Goal: Increase distance in ambulation and ability to perform some ADLs
MOBILITY SCREEN *PaO2/FiO2 ≥ 250 *PEEP <10 *O2Sat ≥ 90% *RR 10-30 *no new onset cardiac arrhythmias or ischemia *HR >60 <120 *MAP >55 <140 *SBP >90 <180 *no new or increasing vasopressor infusion *RASS ≥ -3	Maintain HOB ≥ 30° PROM 2x day performed by RN/UAP CLRT/ Pronation indicated if pt meets criteria based on institutional practice OR Q2hr turning with assist device	PT/OT consult prn Q2hr turning with assist device, *AROM/PROM 2x day, progressive bed positioning 1. HOB 45° x 15 min 2. HOB 45°, legs in dependent position x 15 min 3. HOB 65°, legs in dependent position x 15 min 4. Step (3) in full chair mode for > 30 min 3x per day OR full assist into cardiac chair 2x per day with turn assist or air transport device	PT: active resistance 1x per day, strength exercises; OT: consult PRN Q2hr turning by self or with turn assist device Sitting on edge of bed with RN, PT or RT present x15min or pivot to regular chair 2x per day with gait belt, SPD, and chair alarm	PT/OT: each daily Q2hr turning by self or with turn assist device Sitting on edge of bed with RN, PT or RT present and stand with gait belt assist 3x per day or regular chair 3x per day with gait belt, SPD, chair alarm	PT/OT: each daily Self or assisted Q2hr turning Up to regular chair min 3x per day with SPD and chair alarm Meals will be consumed while dangling on side of bed or in reg chair with SPD and chair alarm Ambulate with gait belt progressively longer distances with less assistance 3x per day with RN/PT/RT/or UAP
No: start @ level I	Progress to Level II →	Progress to level III →	Progress to Level IV →	Progress to Level V →	
Yes: start @ level II and progress	For each position/activity change allow 5-10 minutes for equilibration before determining the patient is intolerant. ***If the patient is intolerant of current mobility level activities, reassess and place in appropriate mobility level***				

Mobility is the responsibility of the RN w/assistance from the RTs, UAP, and PT/OT. PT/OT may assist the team with placement to the appropriate mobility level, always prioritizing patient and provider safety. Placement is based on clinical judgement.

Level I

RASS -5 to -3

Goal: Clinical Stability, Passive ROM, (PT/OT consult PRN

Maintain HOB $\geq 30^{0}$

*PROM 2X/d performed by RN, or UAP

CLRT/Pronation initiated if patient meets criteria based on institutional practice

OR

Q 2 hr turning with assist device

Date:

Patient Sticker

…ressive Mobility Program

Patient Assessm…

START HERE

Perform initial mobility s… within 8 hours of ICU adm…

Reassess mobility level … q24hrs. (recommended … change)

MOBILITY SCREEN *Pa… ≥ 250

*PEEP <10

*O2Sat ≥ 90%

*RR 10-30

*no new onset cardiac arrhy… or ischemia

*HR >60 <120

*MAP >55 <140

*SBP >90 <180

*no new or increasing vaso… infusion

*RASS ≥ -3

No: start @ level I

Yes: start @ level II and pr…

Includes intubated, non-intubated hemodynamically stable/stabilizing, no contraindications		
Level III	Level IV	Level V
RASS -1 & up	RASS 0 & up	RASS 0 & up
Goal: Increased trunk strength, moves leg against gravity, readiness to weight bear, and perform some ADLs	Goal: Stands w/ min to mod assist, able to march in place, weight bear and transfer to chair, and perform some ADLs	Goal: Increase distance in ambulation and ability to perform some ADLs
PT: active resistance 1x per day, strength exercises; OT: consult PRN	PT/OT: each daily	PT/OT: each daily
Q2hr turning by self or with turn assist device Sitting on edge of bed with RN, PT or RT present x15min or pivot to regular chair 2x per day with gait belt, SPD, and chair alarm	Q2hr turning by self or with turn assist device Sitting on edge of bed with RN, PT or RT present and stand with gait belt assist 3x per day or regular chair 3x per day with gait belt, SPD, chair alarm	Self or assisted Q2hr turning Up to regular chair min 3x per day with SPD and chair alarm Meals will be consumed while dangling on side of bed or in reg chair with SPD and chair alarm Ambulate with gait belt progressively longer distances with less assistance 3x per day with RN/PT/RT/or UAP
Progress to Level IV →	Progress to Level V →	

…he patient is intolerant.

…opriate mobility level***

Mobility is the responsibilit… …t to the appropriate mobility level, always prioritizing patient and provider safety. Placement is based on clinical judgement.

Level II

RASS -3 & Up

Goal: Upright sitting; increase strength & moves arm against gravity

PT/OT consult prn

ACTIVITY:

- [ ] Q 2 hr turning with assist device
- [ ] *Passive /Active ROM 3x/d

Progressive Bed Positioning

1. HOB 45º X 15 min. ☐
2. HOB 45º, Legs in dependant position X 15 min. ☐
3. HOB 65º, Legs in dependant position X 15 min. ☐
4. Step (3) & full chair mode X20 min ☐

Or

Full assist into cardiac chair with turn/assist or air transport device 2X/day ☐

Mobility is the responsibility of the RN w/assistance from the RTs, UAP, and PT/OT. PT/OT may assist the team with placement to the appropriate mobility level, always prioritizing patient and provider safety. Placement is based on clinical judgement.

Level III

RASS -1 to up

Goal: Increased trunk strength, moves leg against gravity and readiness to weight bear

PT: active resistance 1x per day, strength exercises; OT: consult PRN

ACTIVITY:

Q 2 hr turning by self or with assist device

Sitting on edge of bed w/RN, PT, RT assist X 15 min.
Or
Pivot to regular chair 2X/d with gait belt, SPD and chair alarm

Level IV
RASS 0 & up

Goal: stands w/ min. to mod. assist, able to march in place, weight bear and transfer to chair

PT & OT each daily

ACTIVITY:
Q 2 hr turning by self or with assist device

Sitting on edge of Bed with RN, PT, RT present and stand with gait belt assist 3x daily
or
Regular chair 3x per day with gait belt, SPD and chair alarm

Date:

Progressive Mobility Program

	Includes complex, intubated, hemodynamically unstable and stable intubated patients; may include non-intubated		Includes intubated, non-intubate	
Patient Assessment	Level I	Level II	Level III	
	RASS -5 to -3	RASS -3 & up	RASS -1 & up	
START HERE Perform initial mobility screen within 8 hours of ICU admission. Reassess mobility level at least q24hrs. (recommended at shift change)				
	Goal: clinical stability; passive ROM (PT/OT consult PRN)	Goal: Upright sitting; increased strength and moves arm against gravity	Goal: Increased trunk strength, moves leg against gravity, readiness to weight bear, and perform some ADLs	Goal: Stan assist, abi weight be chair, and
MOBILITY SCREEN $^*PaO_2/FiO_2 \geq 250$ *PEEP <10 $^*O_2Sat \geq 90\%$ *RR 10-30 *no new onset cardiac arrhythmias or ischemia *HR >60-<120 *MAP >55-<140 *SBP >90-<180 *no new or increasing vasopressor infusion $^*RASS \geq -3$		PT/OT consult prn	PT: active resistance 1x per day, strength exercises; OT: consult PRN	PT/OT: ea
	Maintain HOB ≥ 30° PROM 2x day performed by RN/UAP CLRT/ Pronation indicated if pt meets criteria based on institutional practice OR Q2hr turning with assist device	Q2hr turning with assist device, *AROM/PROM 2x day, progressive bed positioning 1. HOB 45° x 15 min 2. HOB 45°, legs in dependent position x 15 min 3. HOB 65°, legs in dependent position x 15 min 4. Step (3) in full chair mode for > 30 min 3x per day OR full assist into cardiac chair 2x per day with turn assist or air transport device	Q2hr turning by self or with turn assist device Sitting on edge of bed with RN, PT or RT present x15min or pivot to regular chair 2x per day with gait belt, SPD, and chair alarm	Q2hr turn assist dev Sitting on RN, PT or stand wit 3x per day or regular ch with gait alarm
No: start @ level I	Progress to Level II →	Progress to level III →	Progress to Level IV →	Prog
Yes: start @ level I and progress	For each position/activity change allow 5-10 minutes for equilibration before determining the patient is intolerant.			
	If the patient is intolerant of current mobility level activities, reassess and place in appropriate mobility level			

Mobility is the responsibility of the RN w/assistance from the RTs, UAP, and PT/OT. PT/OT may assist the team with placement to the appropriate mobility level, always prioritizing pa

Level V

RASS 0 & up

Goal: Increase distance in ambulation & ability to perform some ADLs

PT & OT each daily

ACTIVITY:

Self or assisted Q 2 hr turning

Up to regular chair Min. 3X/day with SPD & chair alarm

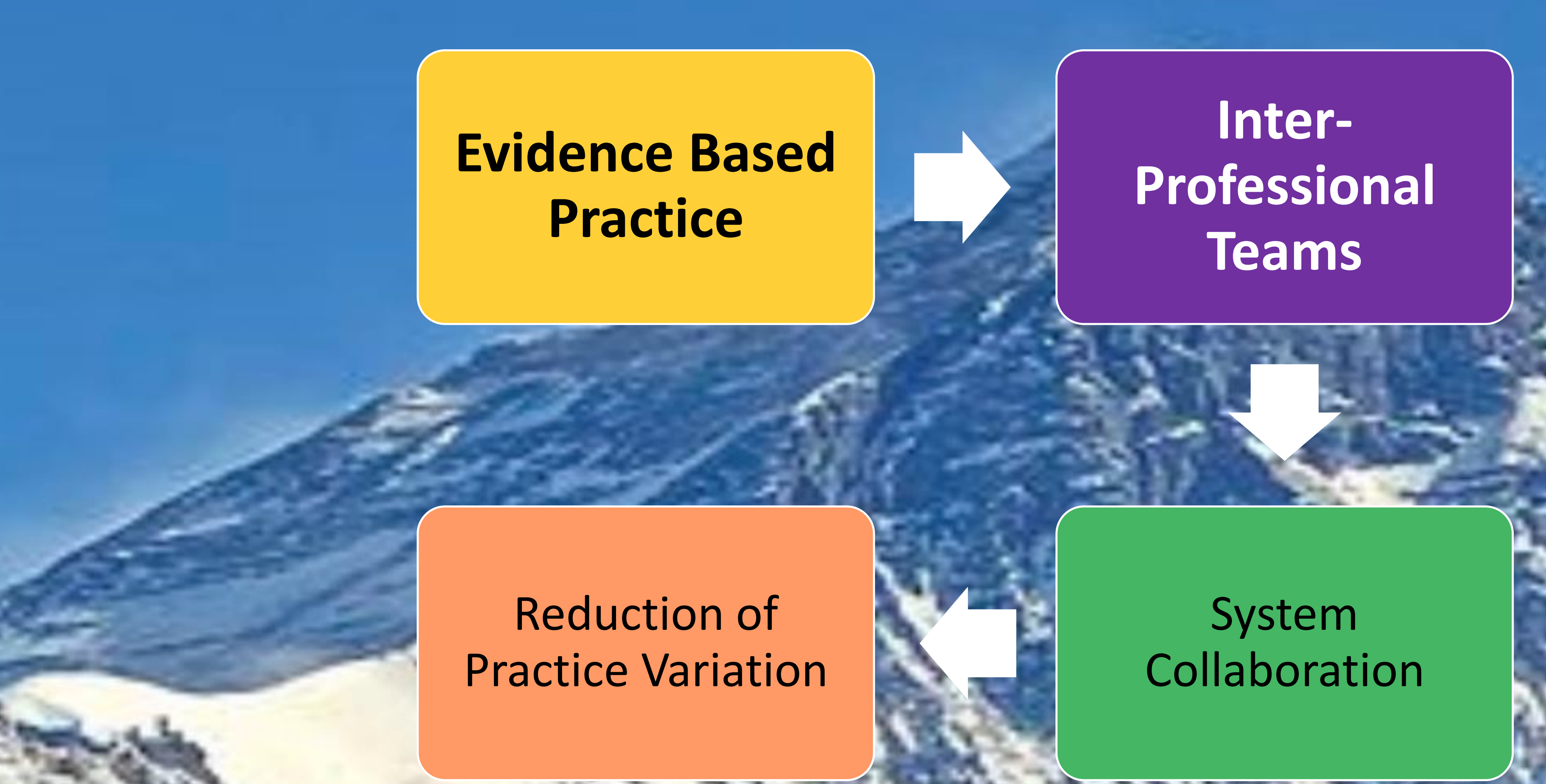
Meals will be consumed while dangling on edge of bed or in regular chair with SPD & chair alarm

Ambulate with gait belt progressively longer distances with less assistance x3/day with RN/PT/RT

Progressive Mobility: Use of Supports For In-Bed & Out of Bed Mobility

Progression to tolerating turning, upright position, sitting, SOSOB, marching, standing, walking, and out of bed chair sitting can occur quicker through the use of supports.

“Four Cornerstones for Success”



Evidence Based Practice

Inter-Professional Teams

System Collaboration

Reduction of Practice Variation

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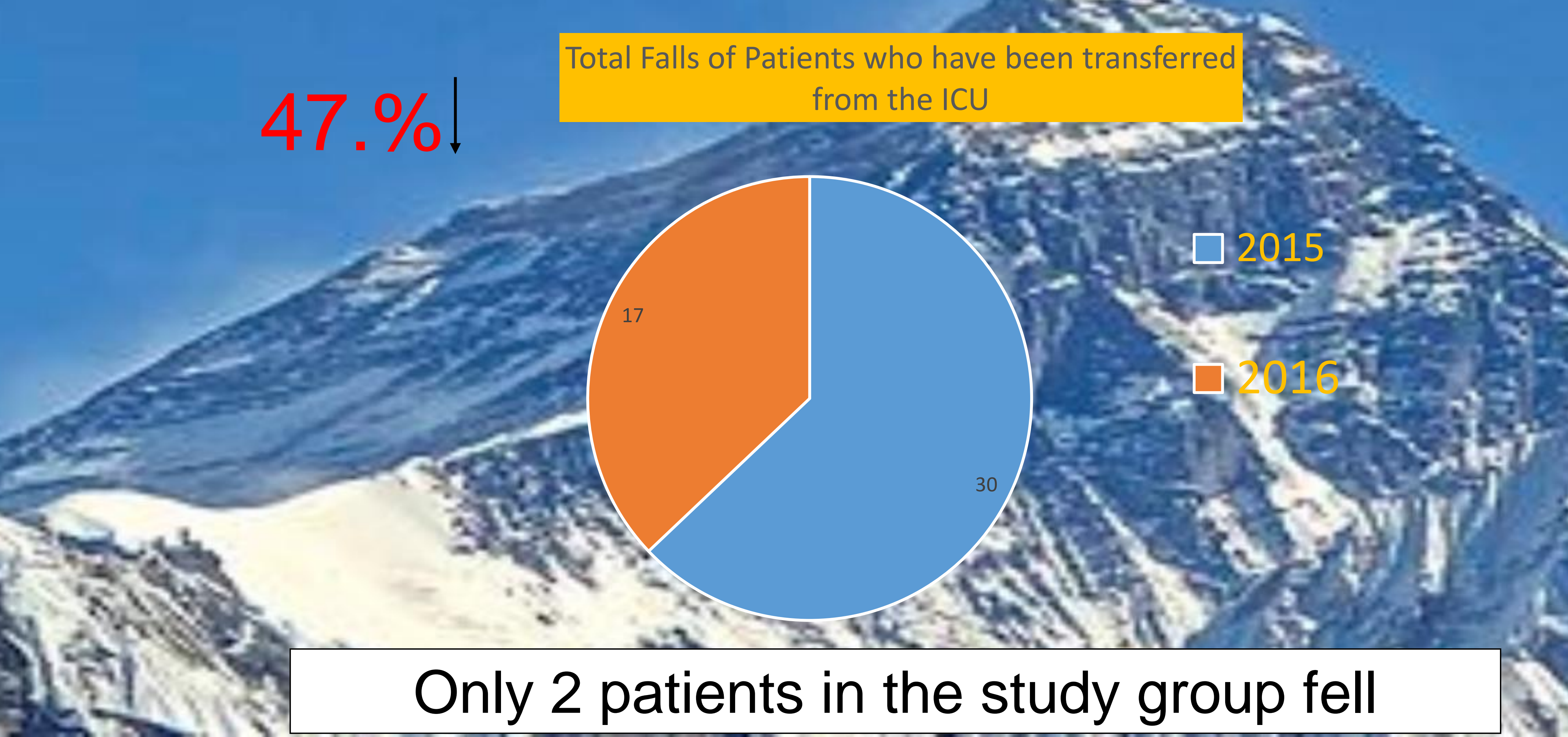
Patients in the study

- Control Group
- 50 patients
  - 34 vents

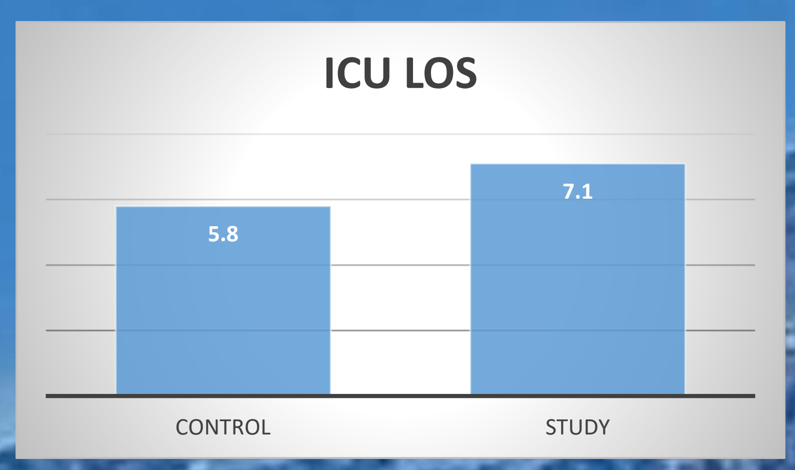
- Intervention group
- 47 patients
  - 32 vents

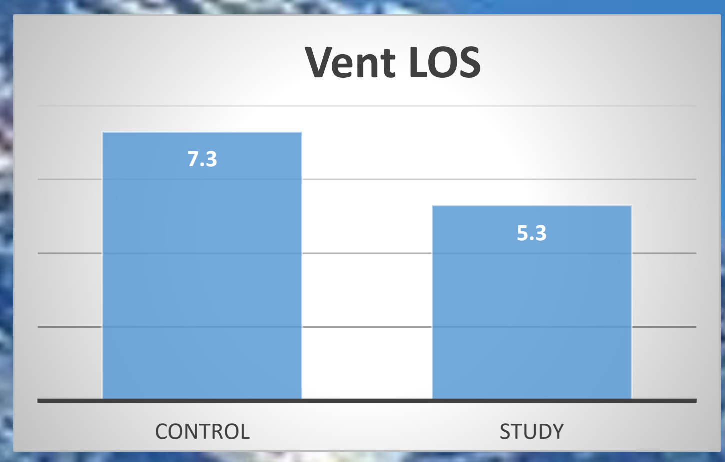
Both groups had similar age ranges, admitting diagnoses, sex

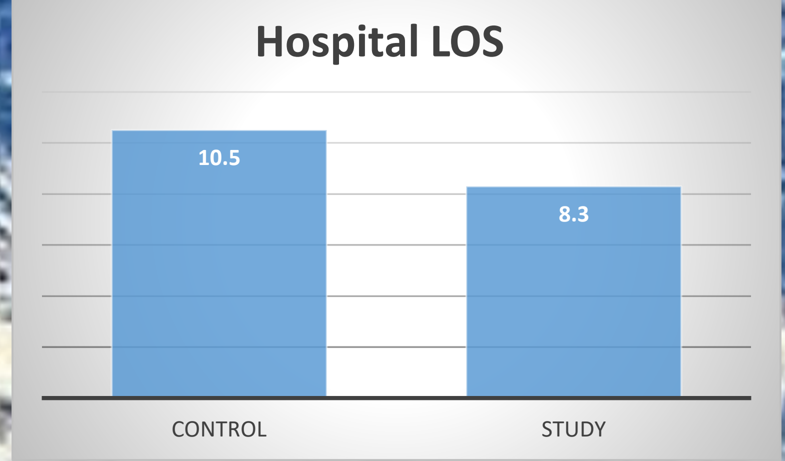
What about falls during the study?



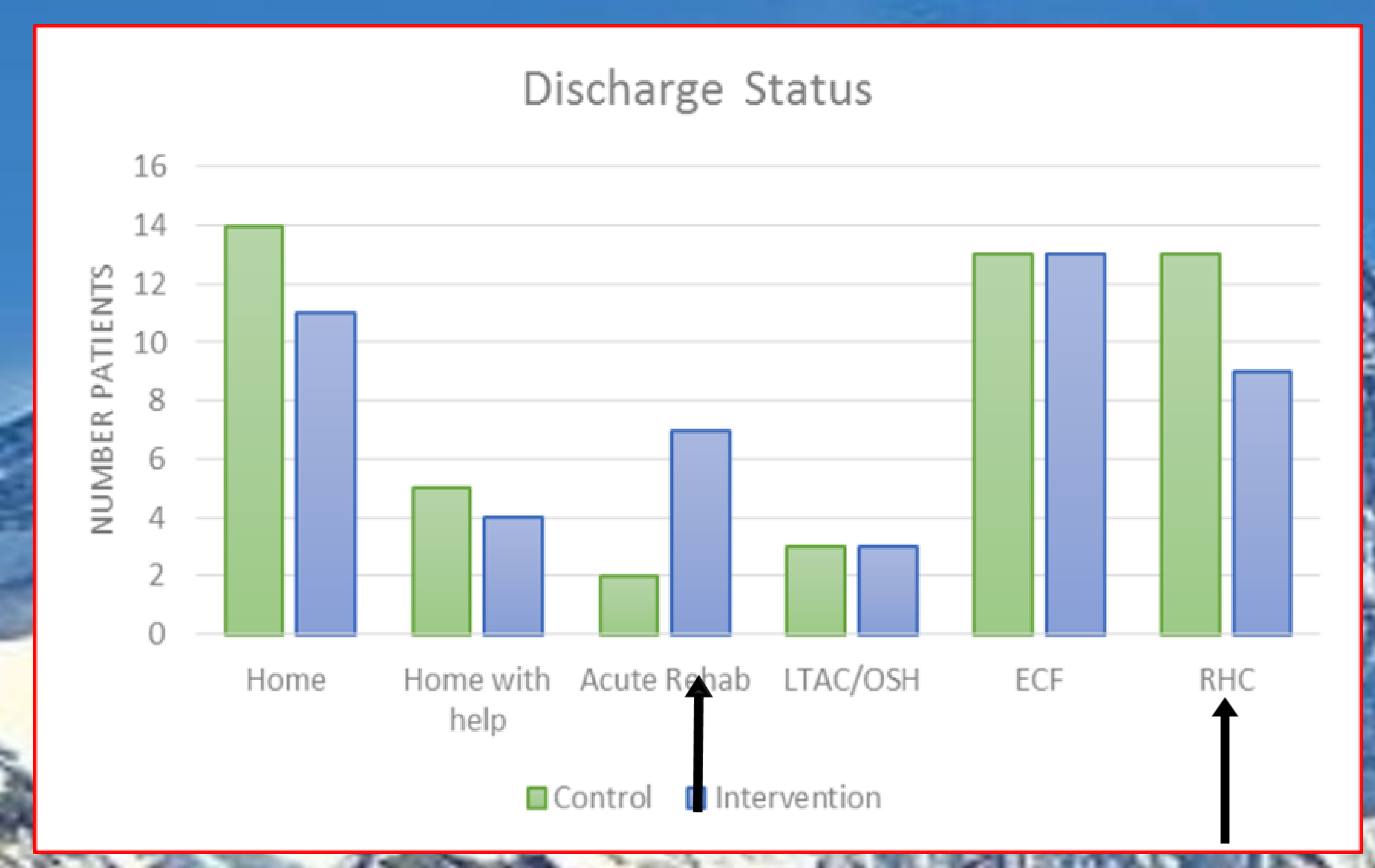
Length of Stay Aspects
Control group vs. Study group



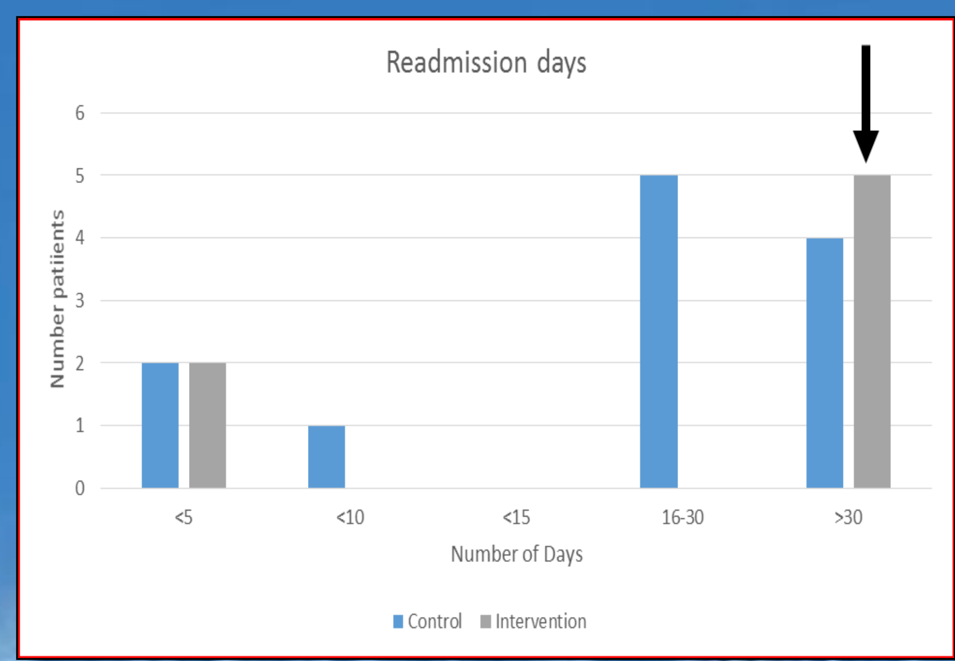


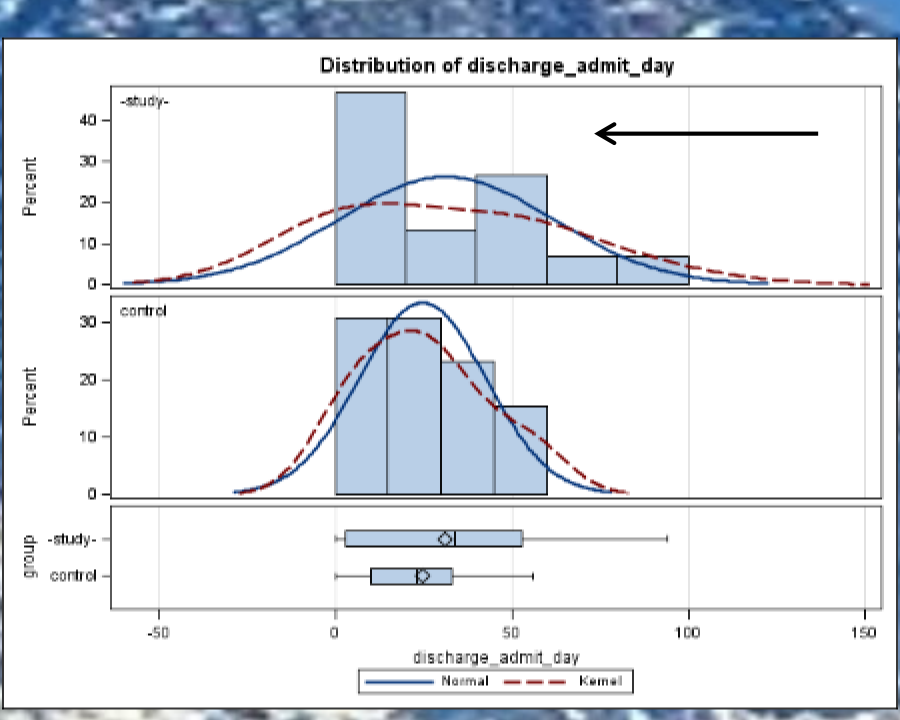


Discharge Disposition



Readmissions





Conclusions

- A progressive mobility program is possible and is found to have beneficial outcomes for all patient types; especially related to prevention of deconditioning (falls), ability to discharge to acute rehab, and less death
- Following the patient throughout the entire LOS engages all levels of caregivers to improve patient outcomes

Opportunities

- Engagement of all members of the care team is necessary
- Meeting with the group at the sharp end regularly to get their feedback on the process is essential

Thank you

Get Up Resources

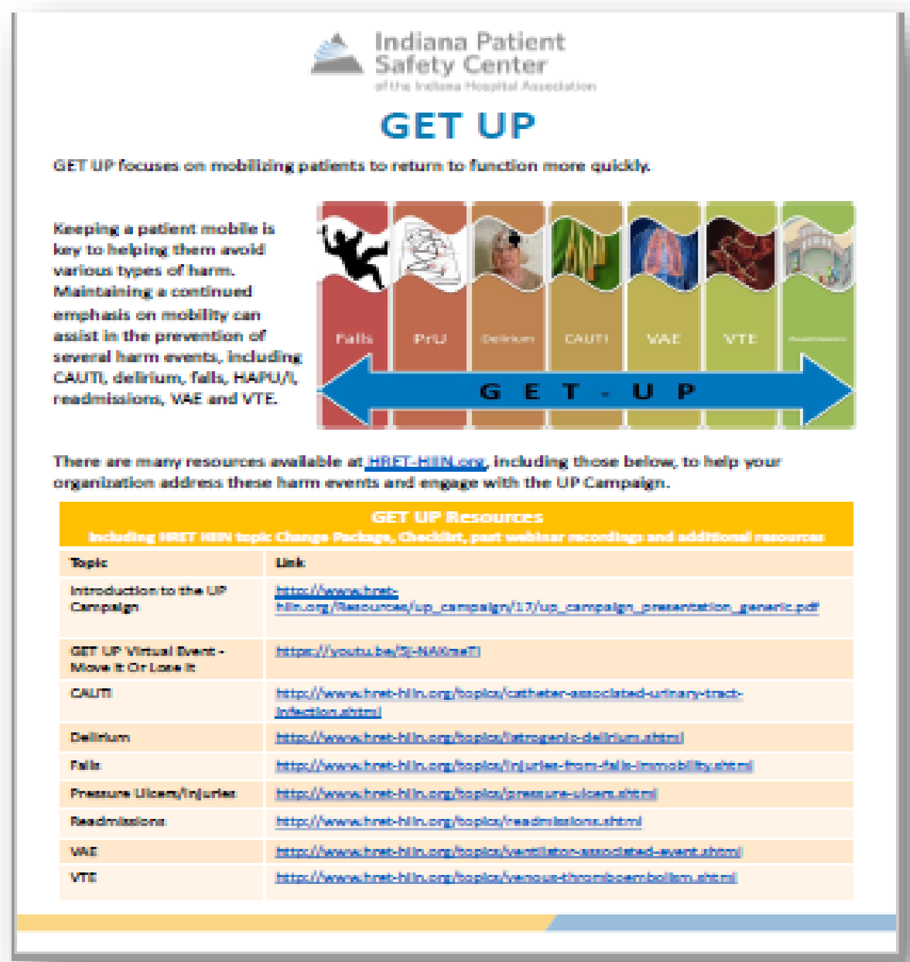
IHAconnect.org/Quality-Patient-Safety

How Can IHA Help?

- *What resources do you need to help with your improvement efforts?*

IHAconnect.org/Quality-Patient-Safety

IHA Resource Sheet



Indiana Patient Safety Center

GET UP

GET UP focuses on mobilizing patients to return to function more quickly.

Keeping a patient mobile is key to helping them avoid various types of harm. Maintaining a continued emphasis on mobility can assist in the prevention of several harm events, including CAUTI, delirium, falls, HAPU/I, readmissions, VAE and VTE.

Falls PrU Delirium CAUTI VAE VTE

G E T - U P

There are many resources available at HRET-HIIN.org, including those below, to help your organization address these harm events and engage with the UP Campaign.

GET UP Resources
Including HRET HIIN topic Change Package, Checklist, past webinar recordings and additional resources

Topic	Link
Introduction to the UP Campaign	http://www.hret-hiin.org/Resources/up_campaign/17/up_campaign_presentation_generic.pdf
GET UP Virtual Event - Move It Or Lose It	https://youtu.be/5J-NAKmeTI
CAUTI	http://www.hret-hiin.org/topics/catheter-associated-urinary-tract-infection.shtml
Delirium	http://www.hret-hiin.org/topics/iatrogenic-delirium.shtml
Falls	http://www.hret-hiin.org/topics/injuries-from-falls-immobility.shtml
Pressure Ulcers/Injuries	http://www.hret-hiin.org/topics/pressure-ulcers.shtml
Readmissions	http://www.hret-hiin.org/topics/readmissions.shtml
VAE	http://www.hret-hiin.org/topics/ventilator-associated-event.shtml
VTE	http://www.hret-hiin.org/topics/venous-thromboembolism.shtml

GET UP Resources

View the below resources for information on various harms topics and how increasing mobility can prevent these harms.

Pressure Ulcer/Injury:

- A National Pressure Ulcer Advisory Panel White Paper http://www.npuap.org/wp-content/uploads/2012/01/NPUAP-Lift-Sling-White-Paper-March-2015.pdf
- HAPU Sacral Injury Prevention Checklist http://www.hret-hiin.org/Resources/pu/17/hapu_sacral_injury_checklist.pdf

Falls:

- HRET HIIN Fall Teach-Back Tool http://www.hret-hiin.org/Resources/falls/17/falls_teach_back_tool.pdf
- Falls Test Performance Worksheet http://www.hret-hiin.org/Resources/falls/17/test_performance_measure_worksheet.pdf
- Preventing Falls in the Bathroom https://vimeo.com/201006776/d555a3d939
- Fall Mat Demonstration https://vimeo.com/210807027/2fb8fb8acb
- The Tension Between Promoting Mobility and Preventing Falls in the Hospital http://jamanetwork.com/journals/jamainternalmedicine/article-abstract/2621835

CAUTI:

- Impact of two-step urine culture ordering in the emergency department: a time series analysis http://qualitysafety.bmj.com/content/early/2017/05/03/bmjqs-2016-006250
- Culturing Practices Matter: Spotlight on Asymptomatic Bacteriuria http://www.hret-hiin.org/Resources/cauti/17/20170627_cauti_slides.pdf

VAE:

- Toolkit To Improve Safety for Mechanically Ventilated Patients https://www.ahrq.gov/professionals/quality-patient-safety/hais/tools/mvp/index.html
- Our Lady of Lourdes Regional Medical Center http://www.hret-hiin.org/Resources/vae/16/VAE-Our-Lady-Lourdes-Regional-Medical-Center-Case-Study.pdf
- St. Jude Medical Center VAE Case Study http://www.hret-hiin.org/Resources/vae/16/VAE-StJude-Medical-Center-Case-Study.pdf

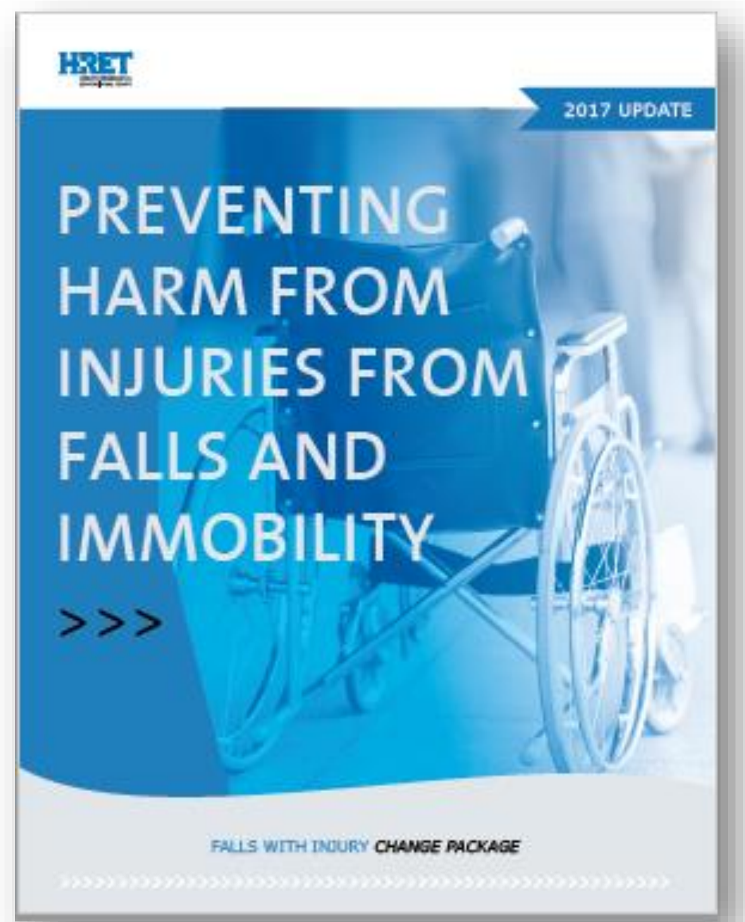
Early Progressive Mobility:

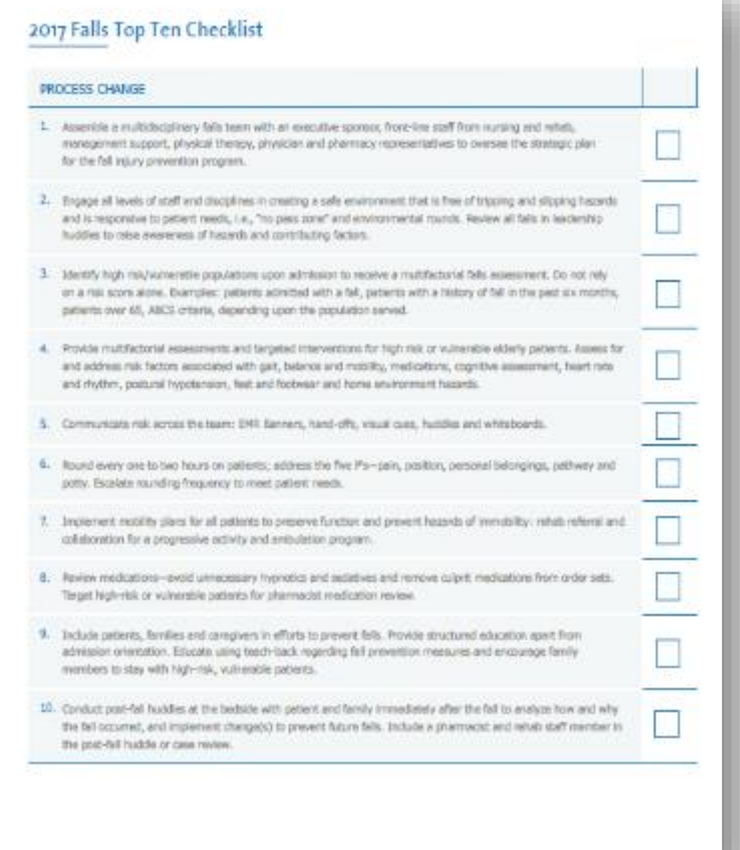
- Introduction to Progressive Mobility http://ccn.aacnjournals.org/content/30/2/53
- Implementation of Early Exercise and Progressive Mobility: Steps to Success http://ccn.aacnjournals.org/content/35/1/82.full
- Get your patients moving— now! https://www.americannursetoday.com/get-patients-moving-now/
- Advancing the Science and Technology of Progressive Mobility http://nursingworld.org/MainMenuCategories/WorkplaceSafety/Healthy-Work-Environment/SafePatient/Advancing-the-Science-and-Technology-of-Progressive-Mobility.PDF

https://www.ihaconnect.org/patientsafety/Pages/default.aspx

IHAconnect.org/Quality-Patient-Safety

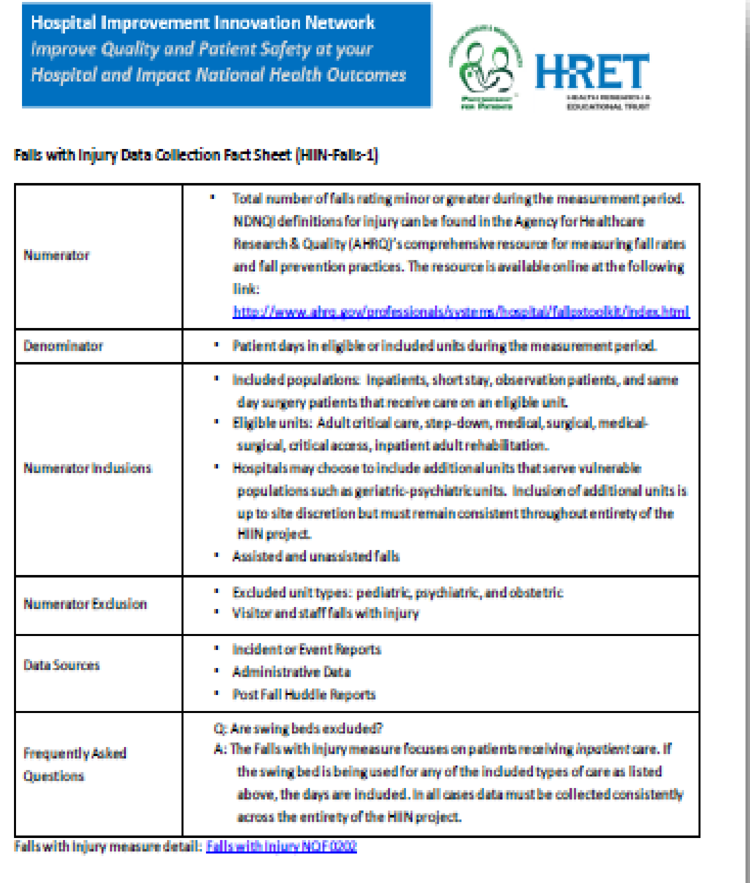
HRET Change Package/Fact Sheet- Falls and Immobility





2017 Falls Top Ten Checklist

PROCESS CHANGE	
1. Assemble a multidisciplinary falls team with an executive sponsor, front-line staff from nursing and rehab, management support, physical therapy, physician and pharmacy representatives to oversee the strategic plan for the fall injury prevention program.	☐
2. Engage all levels of staff and disciplines in creating a safe environment that is free of tripping and slipping hazards and is responsive to patient needs, i.e., "no pass zone" and environmental rounds. Review all falls in leadership huddles to raise awareness of hazards and contributing factors.	☐
3. Identify high risk/vulnerable populations upon admission to receive a multifactorial falls assessment. Do not rely on a risk score alone. Examples: patients admitted with a fall, patients with a history of fall in the past six months, patients over 65, ABCS criteria, depending upon the population served.	☐
4. Provide multifactorial assessments and targeted interventions for high risk or vulnerable elderly patients. Assess for and address risk factors associated with gait, balance and mobility, medications, cognitive assessment, heart rate and rhythm, postural hypotension, feet and footwear and home environment hazards.	☐
5. Communicate risk across the team: EMR Banners, hand-offs, visual cues, huddles and whiteboards.	☐
6. Round every one to two hours on patients; address the five P's—pain, position, personal belongings, pathway and potty. Escalate rounding frequency to meet patient needs.	☐
7. Implement mobility plans for all patients to preserve function and prevent hazards of immobility: rehab referral and collaboration for a progressive activity and ambulation program.	☐
8. Review medications—avoid unnecessary hypnotics and sedatives and remove culprit medications from order sets. Target high-risk or vulnerable patients for pharmacist medication review.	☐
9. Include patients, families and caregivers in efforts to prevent falls. Provide structured education apart from admission orientation. Educate using teach-back regarding fall prevention measures and encourage family members to stay with high-risk, vulnerable patients.	☐
10. Conduct post-fall huddles at the bedside with patient and family immediately after the fall to analyze how and why the fall occurred, and implement change(s) to prevent future falls. Include a pharmacist and rehab staff member in the post-fall huddle or case review.	☐



Hospital Improvement Innovation Network
Improve Quality and Patient Safety at your Hospital and Impact National Health Outcomes

HRET

Falls with Injury Data Collection Fact Sheet (HIIN-Falls-1)

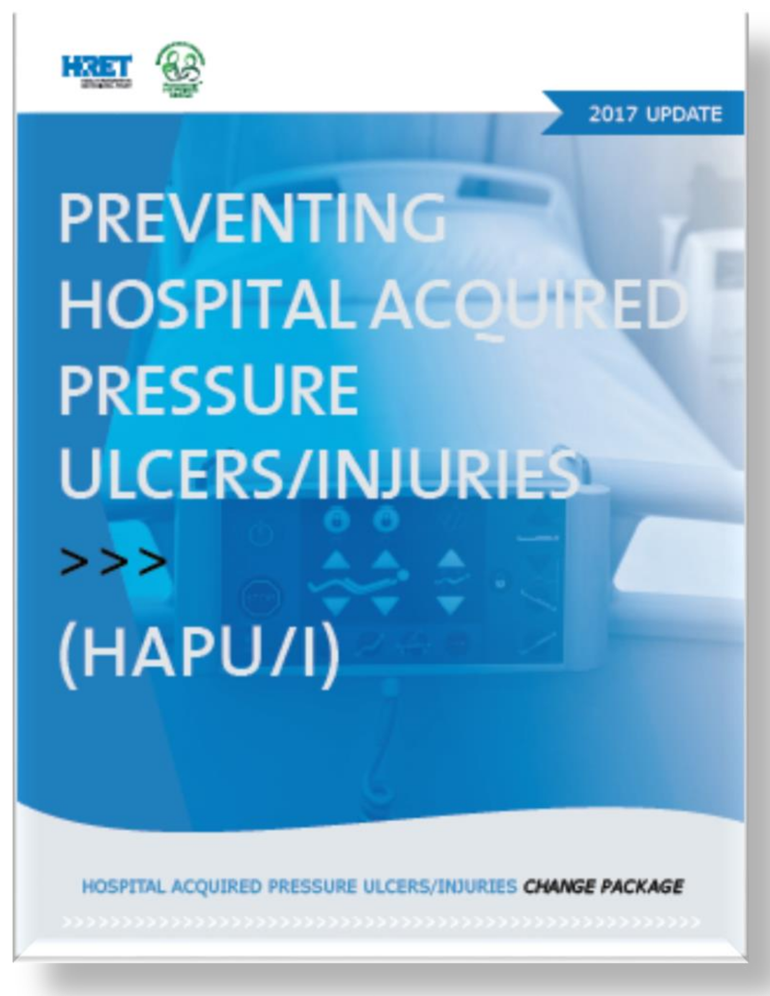
Numerator	• Total number of falls rating minor or greater during the measurement period. NDNQI definitions for injury can be found in the Agency for Healthcare Research & Quality (AHRQ)'s comprehensive resource for measuring fall rates and fall prevention practices. The resource is available online at the following link: http://www.ahrq.gov/professionals/systems/hospital/fallpxtoolkit/index.html
Denominator	• Patient days in eligible or included units during the measurement period.
Numerator Inclusions	• Included populations: Inpatients, short stay, observation patients, and same day surgery patients that receive care on an eligible unit. • Eligible units: Adult critical care, step-down, medical, surgical, medical-surgical, critical access, inpatient adult rehabilitation. • Hospitals may choose to include additional units that serve vulnerable populations such as geriatric-psychiatric units. Inclusion of additional units is up to site discretion but must remain consistent throughout entirety of the HIIN project. • Assisted and unassisted falls
Numerator Exclusion	• Excluded unit types: pediatric, psychiatric, and obstetric • Visitor and staff falls with injury
Data Sources	• Incident or Event Reports • Administrative Data • Post Fall Huddle Reports
Frequently Asked Questions	Q: Are swing beds excluded? A: The Falls with Injury measure focuses on patients receiving inpatient care. If the swing bed is being used for any of the included types of care as listed above, the days are included. In all cases data must be collected consistently across the entirety of the HIIN project.

Falls with Injury measure detail: Falls with Injury NQF 0202

http://www.hret-hiin.org/topics/injuries-from-falls-immobility.shtml

IHAconnect.org/Quality-Patient-Safety

HRET Change Package-Pressure Ulcers/Injuries



http://www.hret-hiin.org/resources/display/hospital-acquired-pressure-ulcersinjuries-change-package

Teach-Back Tool

KNOWLEDGE TEST AFTER AND RETURN DEMONSTRATION CHECKLIST:

TEACH-BACK TOOL
for Fall Prevention

HRET

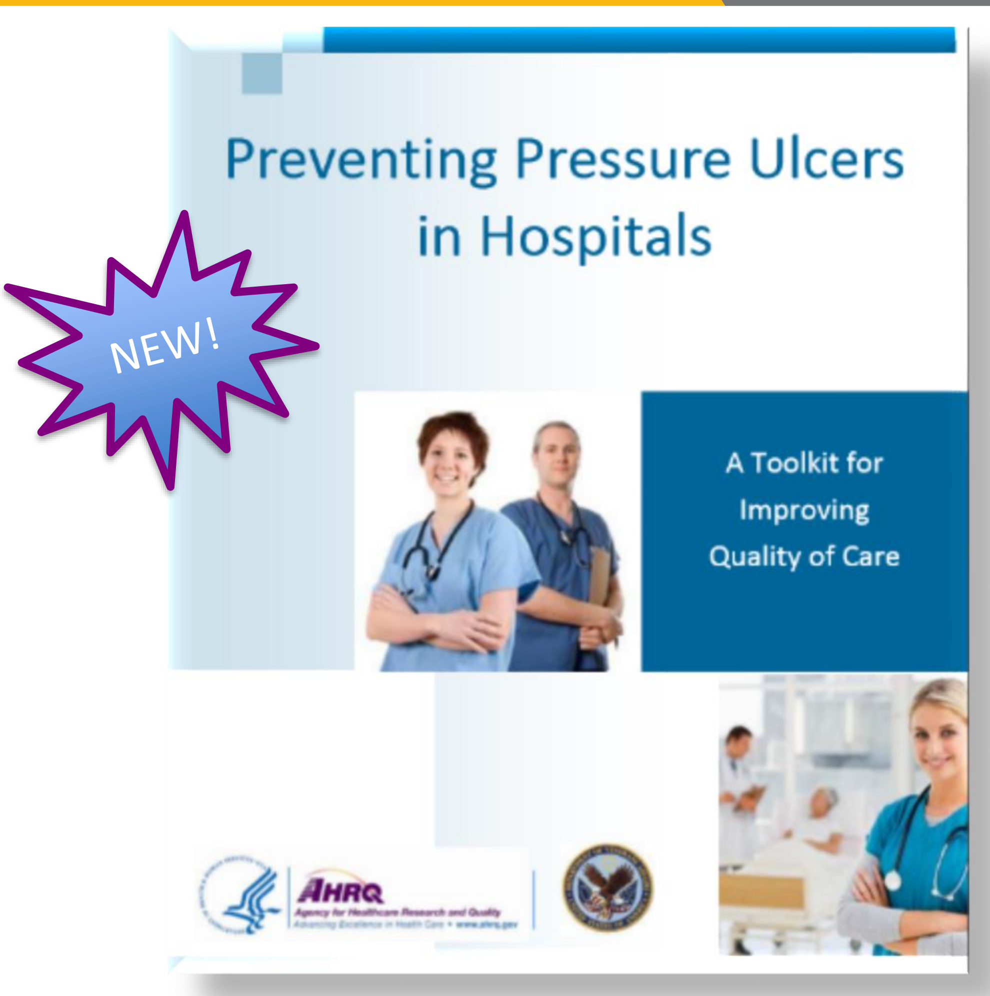
Using Teach-Back to Redesign Patient Teaching: Fall Prevention and Injury Protection

http://www.hret-hiin.org/resources/display/hret-hiin-teachback-tool-for-falls-prevention

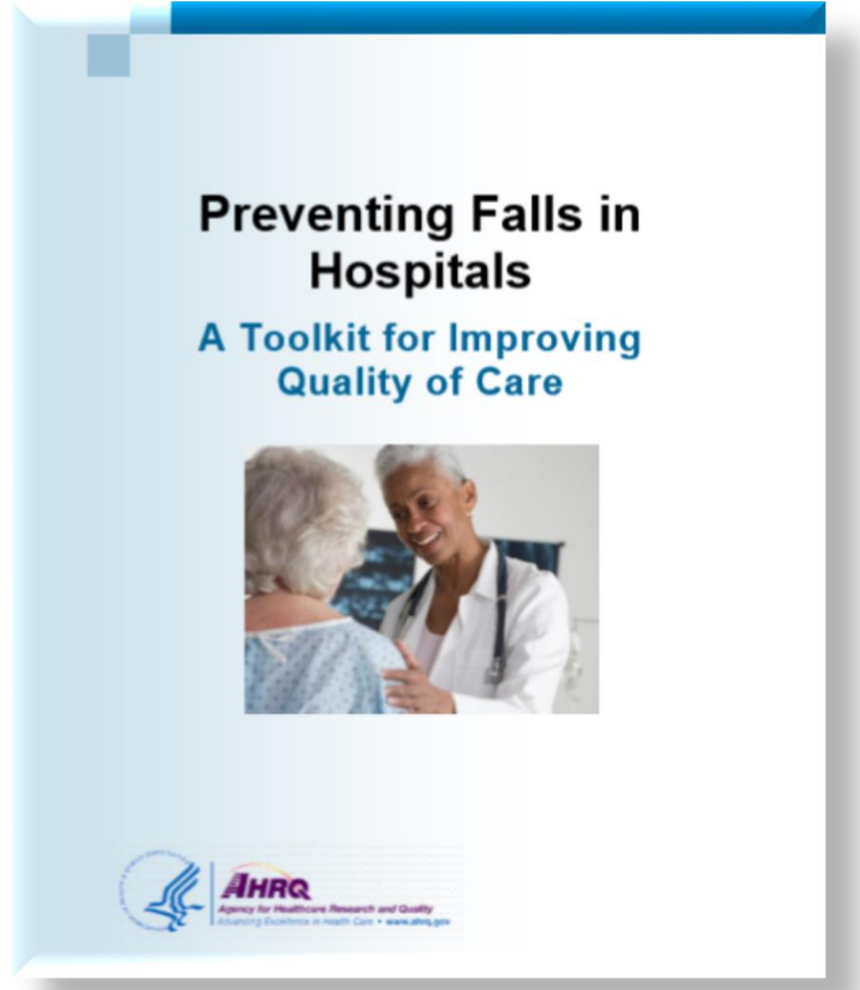
IHAconnect.org/Quality-Patient-Safety

AHRQ Toolkit-Pressure Injuries

https://www.ahrq.gov/professionals/systems/hospital/pressureulcertoolkit/index.html

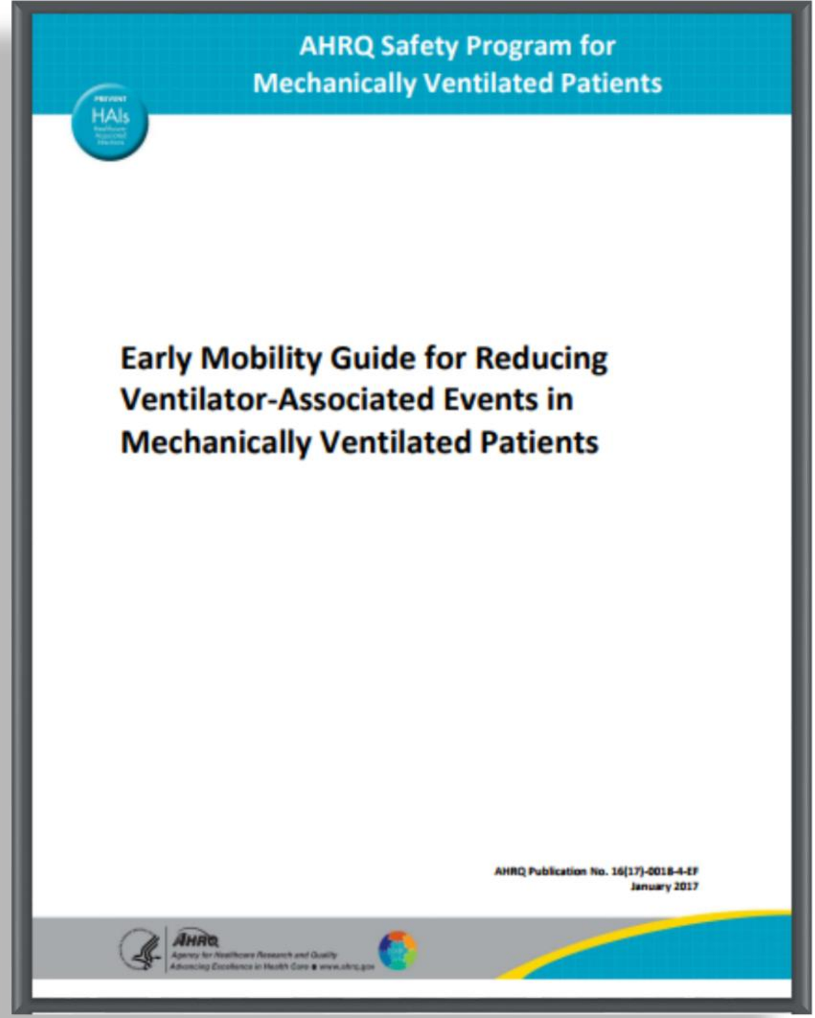


AHRQ Toolkit-Falls



https://www.ahrq.gov/professionals/systems/hospital/fallpxtoolkit/index.html

AHRQ VAE Guide



Daily Data Collection Tools

Local data should drive all quality improvement efforts. The Daily Early Mobility and Daily Care Processes data collection tools can be used for collecting data on daily patient care activities.

Tools	*How To Use Them*
Daily Early Mobility Data Collection Tool	This tool helps track compliance with each of the evidence-based recommendations for promoting early mobility as well as capturing perceived barriers to early mobilization, events that may occur during the mobilization process, and the level of PT and OT involvement.
Daily Care Processes Data Collection Tool	This tool helps track the compliance with each of the recommended daily care measures shown to reduce the harms associated with mechanical ventilation.

https://www.ahrq.gov/sites/default/files/wysiwyg/professionals/quality-patient-safety/hais/tools/mvp/modules/technical/early-mobility-mvpguide.pdf

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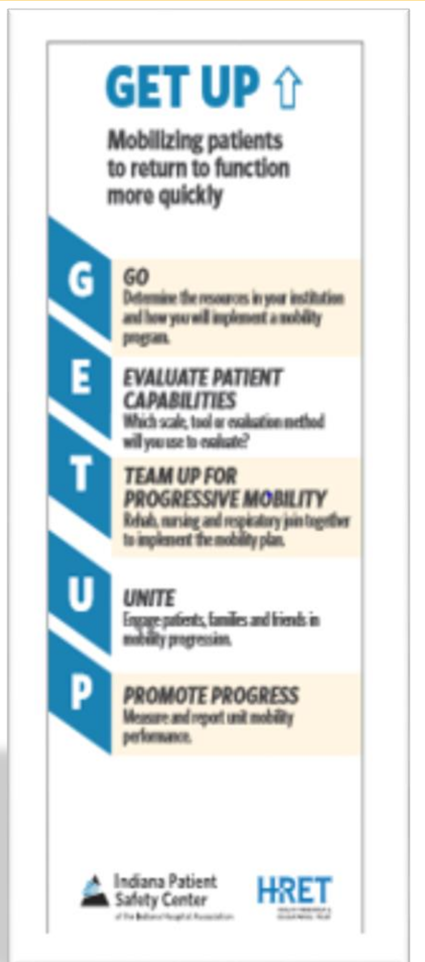
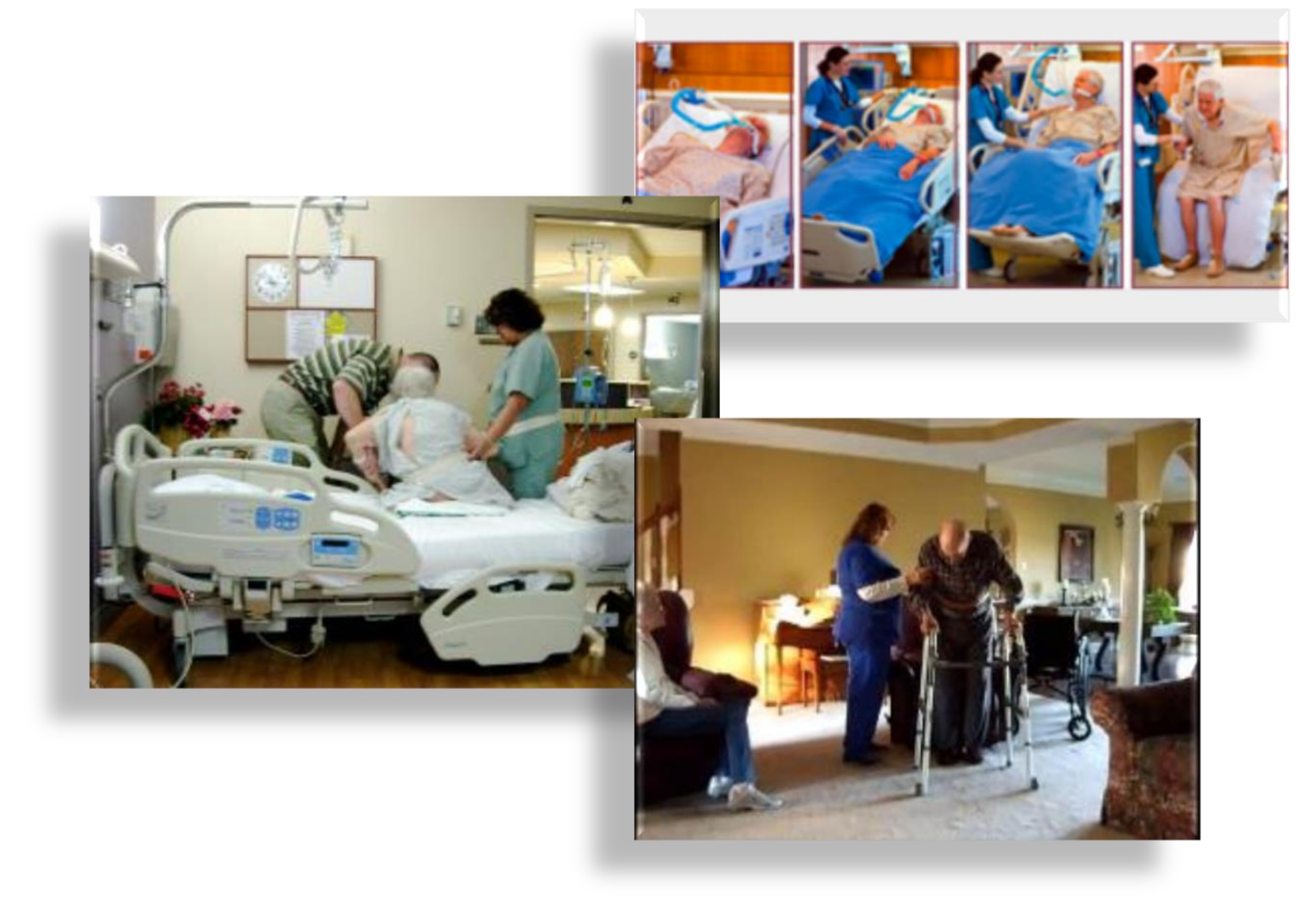
Social Media Messaging

- IHA has created messaging for both general public, health care providers
- Messaging provided for formats:

How are you incorporating GET UP within your organization?





http://www.hret-hiin.org/engage/up-campaign.shtml

GET UP Webinar Series

Nov. 14-HAPU Prevention with Early Mobility

Dec. 12-Multi-disciplinary Approach to Early Progressive Mobility

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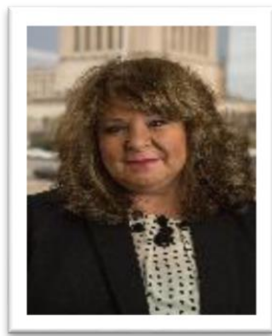

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