GET UP ⇧

December 12, 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
- Brooke Nack, PT MHS, Inpatient Therapy Manager & Bobbi Herron-Foster MS, RN, ACNS-BC, CMSRN Franciscan Health Michigan City
- Coming Soon! Wake Up!
- Resources and Support

UP Campaign

IHAconnect.org/Quality-Patient-Safety

UP Campaign

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

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

Guest Speakers

Brook Nack, PT MHS, Inpatient Therapy Manager
&
Bobbi J. Herron-Foster MS, RN, ACNS-BC, CMSRN
Franciscan Health Michigan City

Developing our Culture of Mobility

A Journey by Franciscan Health Michigan City, Indiana

Presented by:
Bobbi Herron-Foster, Clinical Nurse Specialist, Medical Surgical
Brooke Nack, PT Inpatient Therapy/Mobility Program Manager

Property of Brooke Nack, Inpatient Therapy Manager, Franciscan Health Michigan City
Not to be copied or reproduced without permission

Mobility matters…Where do we start?

Property of Brooke Nack, PT MHS

What's the problem? Big Picture

- A healthy person loses 3% of his/her muscle strength for each day spent in bed.

  Mah et all. Resource-efficient mobilization programs in the intensive care unit: who stands to win? The American Journal of Surgery 2013;206(4):488-493

- Studies show that 83% of a hospital day is spent in bed.

  Wood et al. A mobility program for an inpatient acute care medical unit. AJN. 2014; 114(10)34-40.

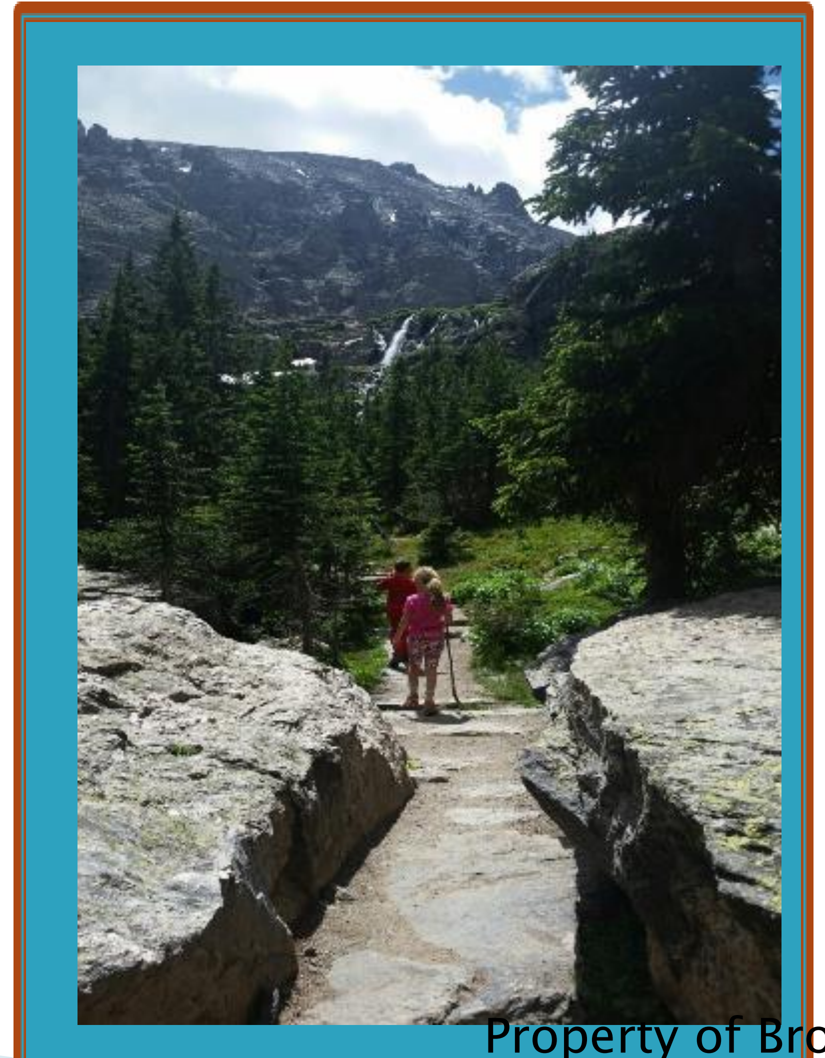
- Post-Hospital Syndrome is an acquired, transient period of vulnerability that is associated with risk for hospital readmission

  Krumholtz. Post-hospital syndrome. Patient physical functioning is associated with their risk for hospital readmission. NEJM. 2013; Jan 10;368(2):100-102.

Property of Brooke Nack, Inpatient Therapy Manager, Franciscan Health Michigan City
Not to be copied or reproduced without permission

What’s the problem: At Franciscan Health?

We have a long way to go…



Property of Brooke Nack,
PT MHS

Our mobility committee: "We have an idea…"

Getting started…
First steps on our mobility journey

<u>**Implementation Process:**</u>

1. Interdisciplinary Mobility Committee formed
2. Extensive literature review of current nursing and therapy journals
3. Agreed upon interdisciplinary Mobility Scale
4. Collected baseline data
5. Completed needs assessment
6. Calculated Return on Investment
7. Requested administrative approval to hire Mobility Team and to execute the Implementation Timeline

Property of Brooke Nack, Inpatient Therapy Manager, Franciscan Health Michigan City
Not to be copied or reproduced without permission

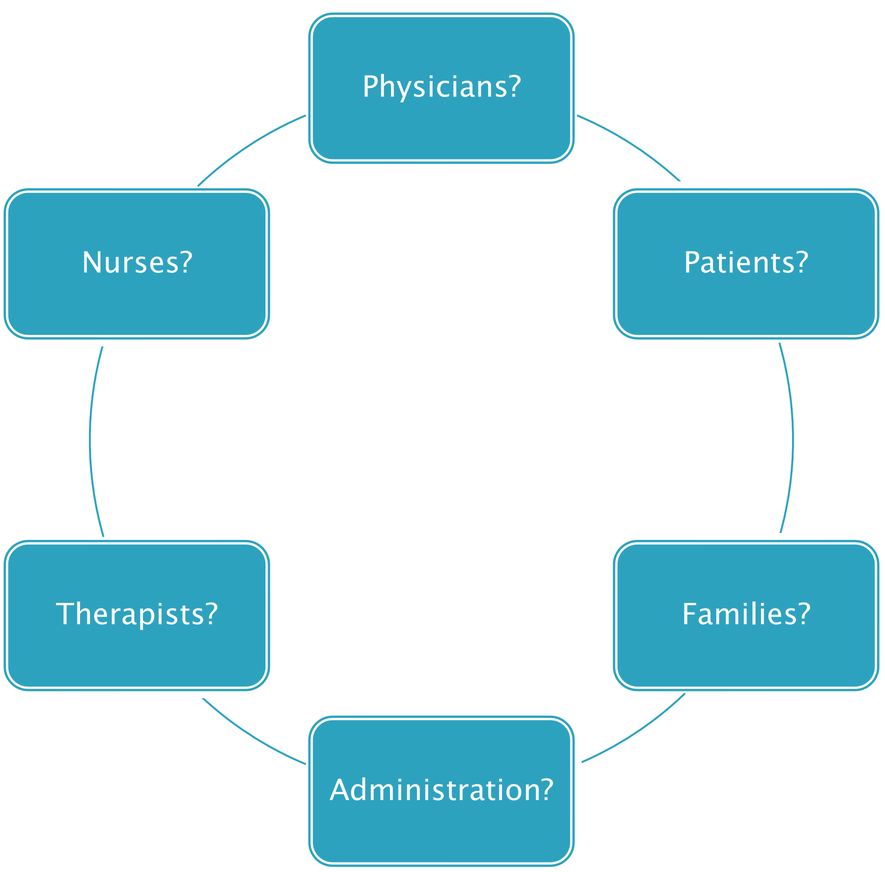
Motivation to move…our lit review

"A study of 45 elderly patients on a general medical unit , who had neither delirium or dementia and were able to walk prior to admission, found that they spent 20 out of every 24 hours in bed over the mean 5.1 days they were in the hospital."

Wood et al. A mobility program for an inpatient acute care medical unit. AJN. 2014; 114(10)34-40.

Property of Brooke Nack, Inpatient Therapy Manager, Franciscan Health Michigan City
Not to be copied or reproduced without permission

Who owns mobility?



Property of Brooke Nack, Inpatient Therapy Manager, Franciscan Health Michigan City
Not to be copied or reproduced without permission

What happens when mobility is driven by one stakeholder?

Therapy-Driven Model

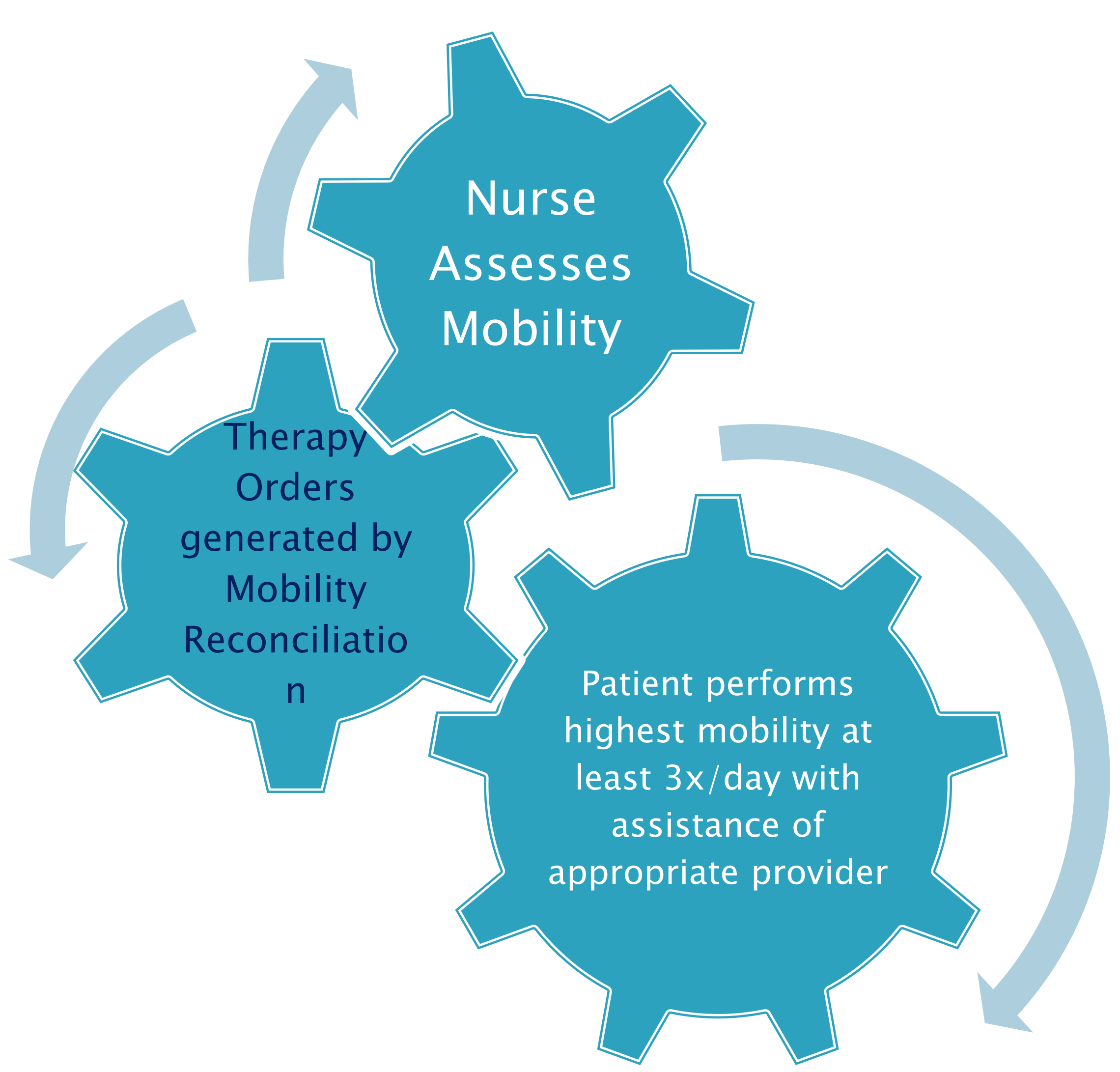
- High cost of skilled provider
- Only as robust as therapy staffing grid
- Limited carryover to other shifts and weekends
- not a 24 hour plan of care
- Insufficient episodes of mobility to support function

Nursing Driven Model

- Only as robust as the nursing staffing grid
- Difficulty balance mobility among other medical priorities
- High cost provider
- Not considered "the mobility expert"

Property of Brooke Nack, Inpatient Therapy Manager, Franciscan Health Michigan City
Not to be copied or reproduced without permission

A team approach to mobility



Property of Brooke Nack, Inpatient Therapy Manager, Franciscan Health Michigan City
Not to be copied or reproduced without permission

Team-Driven Model

- Match right skill to right need using lower cost provider to assist mobility when appropriate
- Carryover of routine across shifts/days
- Potential to achieve more frequent episodes of mobility
- Knowledge sharing, support, and engagement

Property of Brooke Nack, Inpatient Therapy Manager, Franciscan Health Michigan City
Not to be copied or reproduced without permission

What does a culture of mobility look like?

The Provider Approach

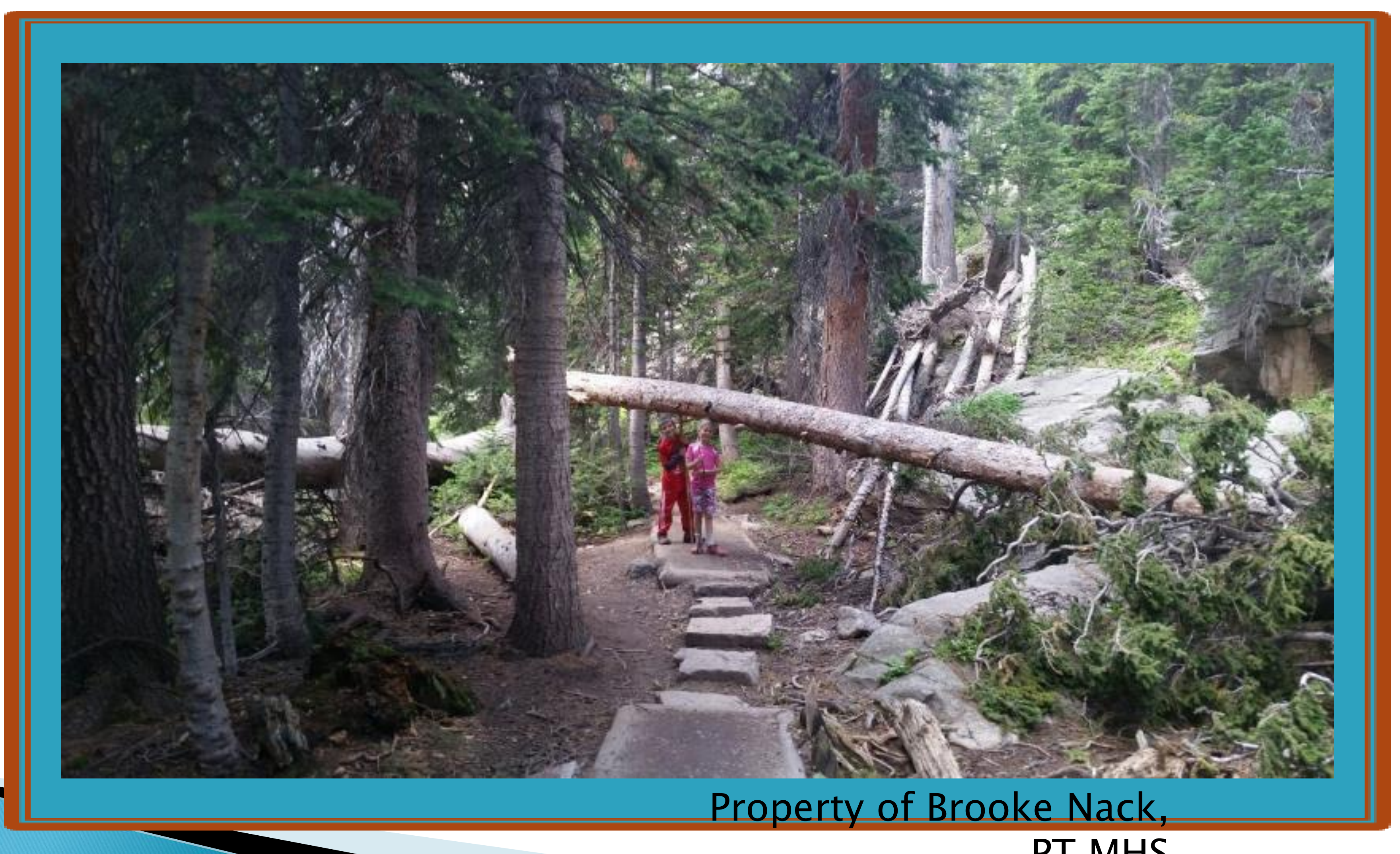
- All providers set patient/family expectations to MOVE
- Barriers to mobility are recognized and removed
- Providers hold each other accountable to achieve highest level of mobility
- Providers help each other mobilize patients
- All providers advocate for patient mobility
- Systematic use of mobility data and language
- Direct care providers know pre-admission and current mobility levels
- Medical and pharmacological management supports mobility

The Patient Experience

- Patients eat all meals in a chair unless they can't
- Mobile patients walk out of their room every day, including day of admission
- Necessary mobility equipment is at every bedside
- Families participate in patient mobility
- Mobility status, precautions, and projected discharge date is visible at bedside

Property of Brooke Nack, Inpatient Therapy Manager, Franciscan Health Michigan City
Not to be copied or reproduced without permission

You are doing a good job navigating through the wilderness!



Property of Brooke Nack, PT MHS

Rate your patient's mobility level

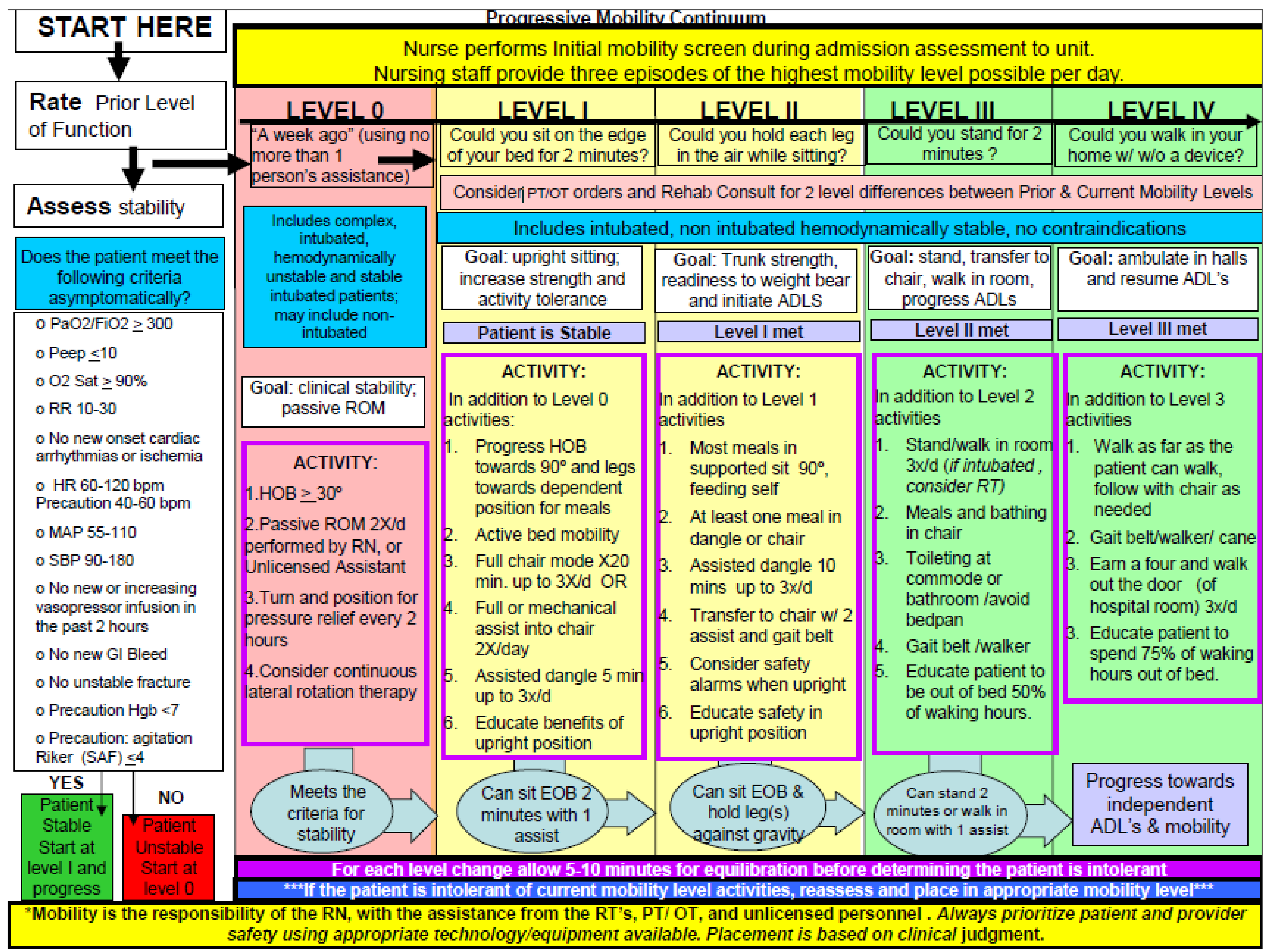
Level Zero (0):
Vital signs unstable, patient may not be conscious

Level One (1):
Needs two assist to sit patient on edge of bed

Level Two (2):
Dangles on edge of the bed with assist x 1; holds at least one leg up, indicating strength to stand

Level Three (3):
Stands with assist or device for 2 minutes *OR* walks in room with assist or device

Level Four (4):
Walks in the hallway (*"out the door"*) with or without assistance or a device

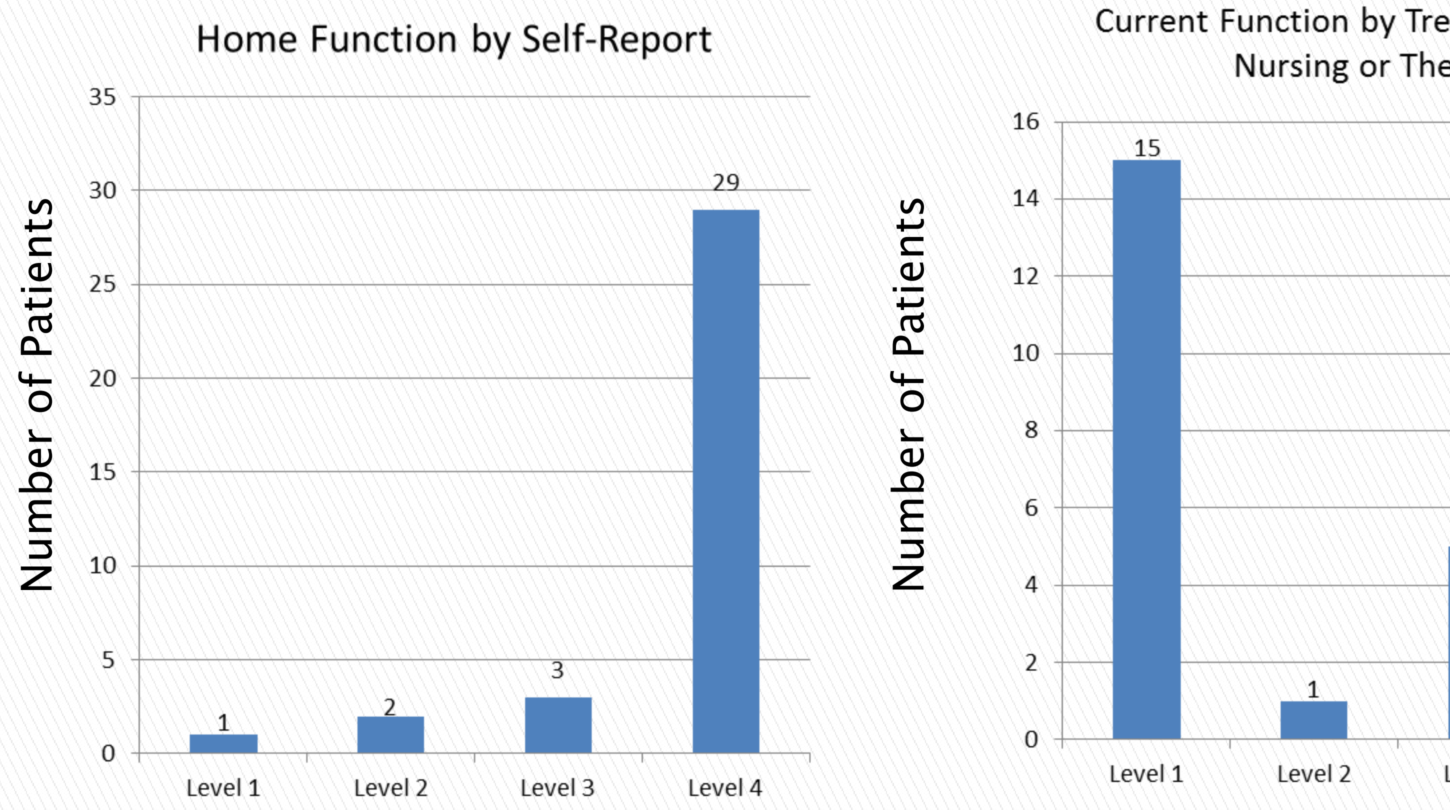


Property of Brooke Nack, Inpatient Therapy Manager, Franciscan Health Michigan City
Not to be copied or reproduced without permission

Mobility baseline data

Activity Level at Home

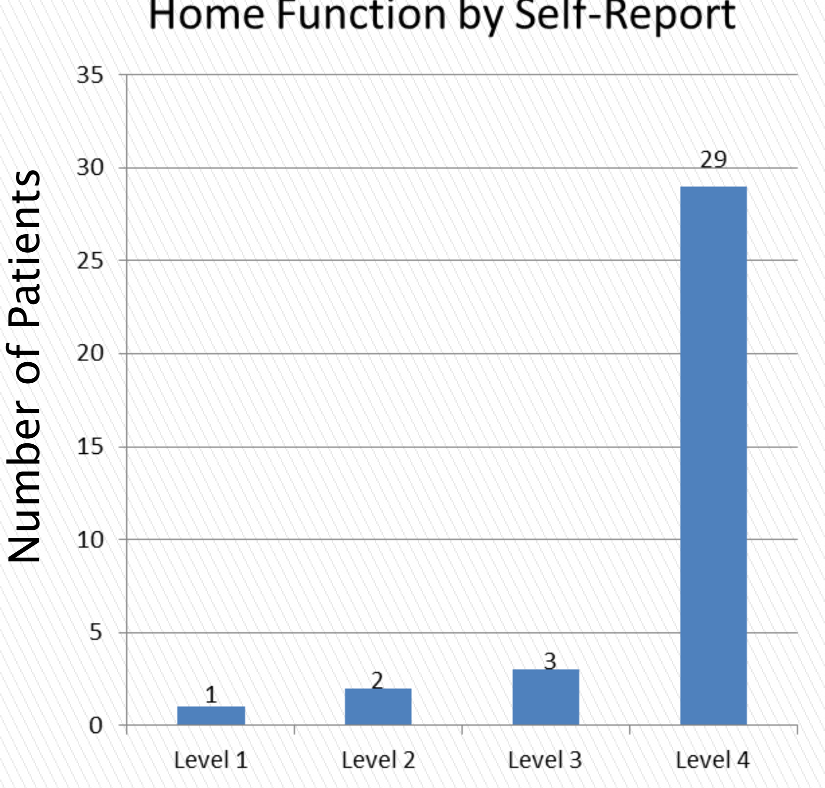
Activity Level by Unit Staff

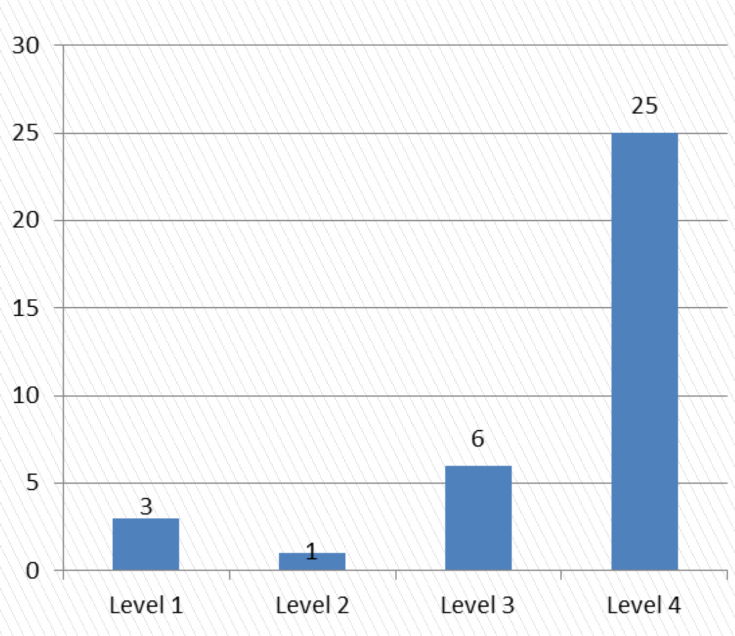


Property of Brooke Nack, Inpatient Therapy Manager, Franciscan Health Michigan City
Not to be copied or reproduced without permission

Mobility scale trial data

Activity Level using Mobility Scale





Property of Brooke Nack, Inpatient Therapy Manager, Franciscan Health Michigan City
Not to be copied or reproduced without permission

What facilities can we model?

Cleveland Clinic and its 8 regional hospitals

- Instituted an interdisciplinary mobility program across all sites utilizing AMPAC 6 clicks to communicate mobility status and collect outcome data, emphasizes mobility reconciliation, uses 6 clicks data to drive therapy consultation matching provider and needed skill to the functional level.

Johns Hopkins Hospital (994 acute care beds)

- Instituted a facility wide multidisciplinary mobility program, established an administrative policy, utilized consistent mobility language across providers, provides care map based on mobility status changes emphasis on daily reporting of the highest level of mobility, establishing interdisciplinary EPIC mobility goals, required mobility screening as rationale for EPIC therapy order, emphasizes mobility reconciliation, uses functional status to drive therapy consultation, therapists provide initial and ongoing mobility training to nursing staff.

Friedman M, Stilphen M. Establishing a Culture of Mobility in the Hospital Setting. Presented at APTA Combined Sections Meeting Indianapolis, IN. 2015 Feb 4-7.

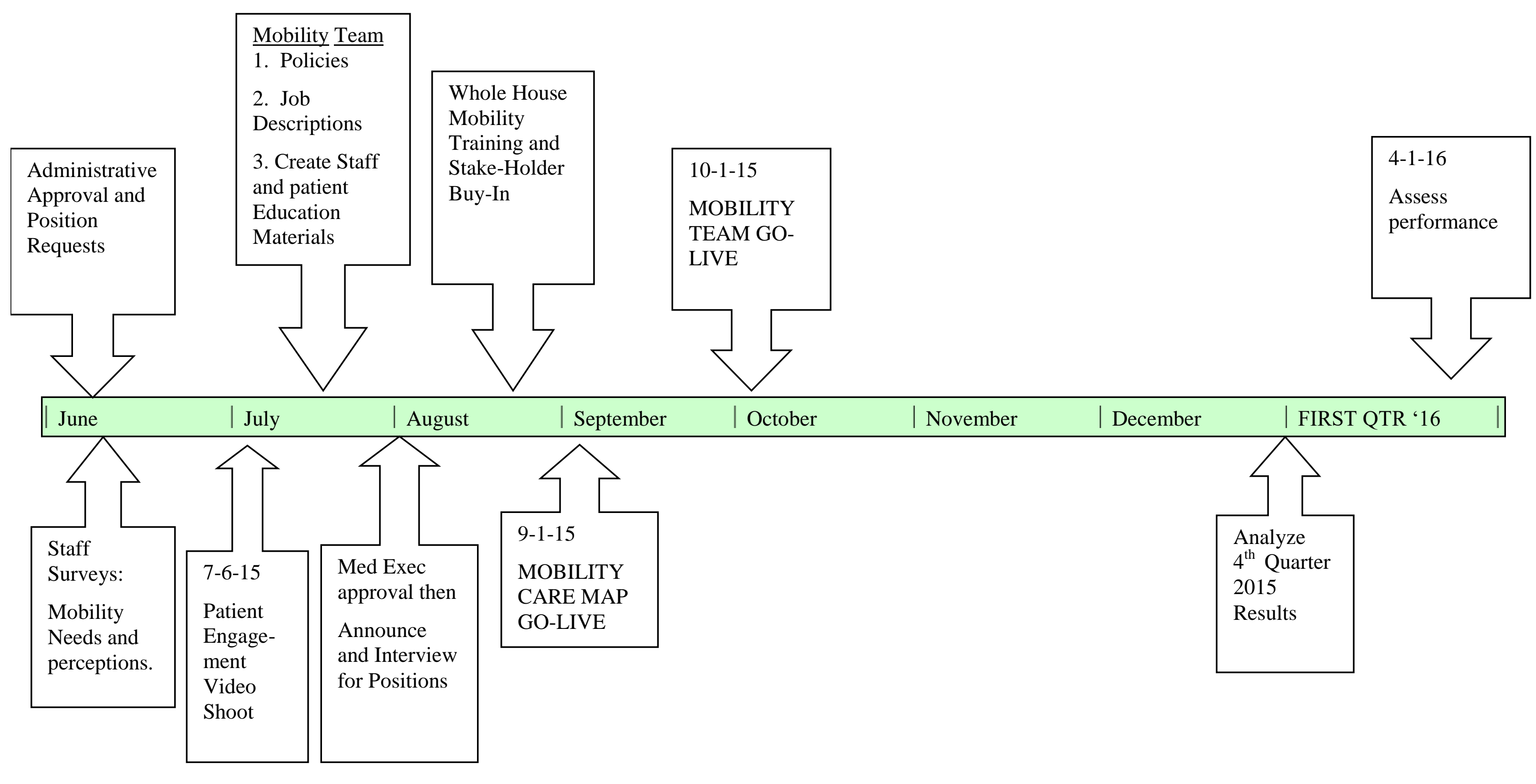
Advocate Lutheran General Hospital (638 licensed beds)

- Instituted a quality improvement program to reduce fall rate and demonstrated that a Mobility Team "is another fall reduction tool resulting in decreased patient falls…increased cost savings, and patient satisfaction."(Jezierski). Systematized mobility team consultation and provided 3 weeks

Jezierski et at. A mobility team: Making a move to reduce hospital falls. Accessed 2/5/15. Available at: http://nicheconference2012.s3.amazonaws.com/uploads/File/%202012%20Conf%20Poster%20-%20Advocate%20Lutheran%20updated.pdf.

Property of Brooke Nack, Inpatient Therapy Manager, Franciscan Health Michigan City
Not to be copied or reproduced without permission

Implementation timeline



Property of Brooke Nack, Inpatient Therapy Manager, Franciscan Health Michigan City
Not to be copied or reproduced without permission

Administrative approval process

1. Presentation to key groups:
   - Clinical Operations Group
   - Hospitalists
   - Orthopedic Surgeons

2. Corporate sponsor in Safe Patient Handling Initiative

3. Return on Investment presented to Chief Financial Officer

4. Approval to hire 4.0 FTE's into Mobility Program

Property of Brooke Nack, Inpatient Therapy Manager, Franciscan Health Michigan City
Not to be copied or reproduced without permission

Value of systematic mobility programs

Value Equation

$$\text{Value} = \frac{\text{OUTCOME}}{\text{COST}}$$

* Porter ME, Teisberg EO. Redefining health care: creating value-based competition on results. Boston: Harvard Business School Press, 2006.

**Johns Hopkins Mobility Program estimated reducing hospital costs by $800 for patients who improved highest functional level by 1 point on their scale.

Return on Investment

Quantifiable:
Financial analysis to capture savings over expenses. Initial expenses include time for program development, creation of patient and staff education tools, staff training and engagement. Annual expenses include budgeted time for annual competencies and salaries plus benefits of hiring additional staff dedicated to patient mobility.

Cultural:
Collaboration and silo breakdown, team success, morale, employee engagement and satisfaction

Friedman M & Stilphen M. Creating value by establishing a culture of mobility in the hospital setting. *APTA Learning Center Webinar*. Available at: http://www.apta.org/learningCenter. Accessed 5/14/14.

Property of Brooke Nack, Inpatient Therapy Manager, Franciscan Health Michigan City
Not to be copied or reproduced without permission

Evidence-based goals for mobility program ROI

Factor	Early Mobility in ICU	Medical-Surgical Culture of Mobility
Length of Stay	↓ ICU LOS by 22% ↓ Total LOS by 20%	↓ Total LOS by .4 days
30 Day Readmissions		↓ probability 10—20%
Hospital Mortality Rate	↓ 10%	
Sources:	Lord K, et al. ICU Early Physical Rehabilitation Programs: Financial Modeling of Cost Savings. *Critical Care Medicine* 2013;41:717-724	Friedman M & Stilphen M. Creating value by establishing a culture of mobility in the hospital setting. *APTA Learning Center Webinar*. Available at: http://www.apta.org/learningCenter. Accessed 5/14/14.

Property of Brooke Nack, Inpatient Therapy Manager, Franciscan Health Michigan City
Not to be copied or reproduced without permission

Evidence-based goals for mobility program ROI

Factor	Early Mobility in ICU	Medical-Surgical Culture of Mobility
Fall rate	Early mobility is not associated with higher risk of adverse events	Reduced fall rate from 6 falls to 1 fall every 2 months on a Gero-psych unit
Source		Kuehnlenz D & Jezierski M. A mobility team: making a move to reduce hospital falls in the older adult. *Advocate Lutheran General Hospital*. Available at: http://nicheconference2012.s3.amazonaws.com/uploads/File/%202012%20Conf%20Poster%20-%20Advocate%20Lutheran%20updated.pdf. Accessed 2/10/15.

Property of Brooke Nack, Inpatient Therapy Manager, Franciscan Health Michigan City
Not to be copied or reproduced without permission

Cost Savings Through Reduced Adverse Events

Adverse Event	Current Rate	Target (every year for 5 years)	Cost per Event	Cost Savings
Pressure Ulcers	Per 1000 patients	↓ 10%	Facility Specific	
Hospital-Acquired pneumonia	Per 1000 patients	↓ 10%	Facility Specific	
DVT	Per 1000 patients	↓ 10%	Facility Specific	
Falls	Per 1000 patients	↓ 10%	Facility Specific	

"If he has a bedsore, it's generally not the fault of the disease, but of the nursing" -Florence Nightingale, 1859

Nightingale F. Notes on nursing . Philadelphia: Lippincott; p. 1859

Property of Brooke Nack, Inpatient Therapy Manager, Franciscan Health Michigan City
Not to be copied or reproduced without permission

Cost Savings Through Employee Safety and Engagement

Metric	# of Employees	Target (every year for 5 years)	Cost per Event	Cost Savings
Workers' Compensation: Low Back Pain	Facility Count per targeted unit(s)	↓ 10%	Facility Specific stratified by event type	
Worker Retention Rate (RN/CNA/other)	Facility Count per targeted unit(s)	↑ retention by 5%	Replacement of position cost	

Property of Brooke Nack, Inpatient Therapy Manager, Franciscan Health Michigan City
Not to be copied or reproduced without permission

Is this topic feeling a little heavy yet?

Property of Brooke Nack, PT MHS

Foundational Strategies to calculate a realistic ROI

- Know your baseline state and collect real data

- Solicit information from others
  - Finance --- Human Resources
  - Quality --- Worker's compensation
  - Satisfaction --- "Sister facilities"

- Research evidence-based goals
  - From literature review
  - Contact the experts

- Establish goals that consider evidence, culture, and current outcomes

- Correlate goals to dollars
  - Cost savings through reduced adverse events
  - Cost savings through employee safety and engagement
  - Cost savings associated with higher value care
  - Income generated through changes in therapy (PT/OT) utilization

- Realistically estimate program expenses

Property of Brooke Nack, Inpatient Therapy Manager, Franciscan Health Michigan City
Not to be copied or reproduced without permission

Expenses associated with a Mobility Program

Expense	Initial Year Only	Annual Expense
Additional salaries and benefits		X
Program Planning and Stakeholder engagement	X	
Employee education and training		X
Patient engagement materials/resources	X	
Patient education materials		X
Office supplies and duplicating needs		X
Compliance and outcome tracking		X
Equipment: Minor or Capital		X

Property of Brooke Nack, Inpatient Therapy Manager, Franciscan Health Michigan City
Not to be copied or reproduced without permission

Putting it all together…

- Net revenue = Income + Cost Savings
- Subtract Expenses
- Calculate Return on Investment
- Identify Break-Even Point
- Track outcomes
- Plan on evaluating performance at 6 months and make nimble adjustments

Property of Brooke Nack, Inpatient Therapy Manager, Franciscan Health Michigan City
Not to be copied or reproduced without permission

Hang on for a bumpy ride ahead… Can we really engage our front-line staff??

Nursing opinion survey

Please rate your response about the CURRENT barriers related to patient mobility:

1. I always get enough information about how each patient moves

Strongly Disagree	1	2	4	5	Strongly Agree

2. I have had enough training in safe mobilization techniques

Strongly Disagree	1	2	4	5	Strongly Agree

3. I have enough equipment to move patients safely

Strongly Disagree	1	2	4	5	Strongly Agree

4. I believe that if I help patients get up more they are more likely to fall

Strongly Disagree	1	2	4	5	Strongly Agree

5. I believe patients are resistant to activity so a formal mobility program will decrease patient satisfaction.

Strongly Disagree	1	2	4	5	Strongly Agree

Please rate your response about the FUTURE benefits related to Mobility Master teams:

6. I believe that having Mobility Masters would improve my job satisfaction.

Strongly Disagree	1	2	4	5	Strongly Agree

7. If we were to hire "Mobility Masters" to mobilize patients 2 x daily and expect Nursing/unit PCAs to ambulate/mobilize at least one episode a day, which shift time listed below would be the most advantageous for the Mobility Masters to work?
   a) 8:00 am to 4:30 pm
   b) 11:00 to 7:30pm
   c) 10:00 to 6:30pm
   d) other (propose a new shift time: ________________________)

Property of Brooke Nack, Inpatient Therapy Manager, Franciscan Health Michigan City
Not to be copied or reproduced without permission

Nursing survey results

Question	1	2	Neg Response	4	5	Pos. Response	
I always get enough information	3	11	14	20	4	24	Inade
I have had enough training	0	10	10	18	10	28	Mobil
I have enough equipment	2	15	17	16	6	22	Gait b
I believe patients are more likely to fall	17	15	32	4	1	5	
I believe patients are resistant, so low satisfaction	17	16	33	5	1	6	
Mobility Masters = higher job satisfaction	0	3	3	15	17	32	
Schedule	**8-4:30**	**11-7:30**	**10-6:30**	**write in 9-5:30**			later
	8	20	12	1			cover
Best result of Mobility Team:	**Job satisfaction**	**Teamwork**	**Pt satisfaction**	**Healthcare Org**	**Hope**	**All of the above**	
	2	10	8	2	10	8	

Property of Brooke Nack, Inpatient Therapy Manager, Franciscan Health Michigan City
Not to be copied or reproduced without permission

Best practices of progressive mobility competence

- Use the same Progressive Mobility Scale throughout the System of Care

- Adopt the assumption that patient mobility is a fundamental nursing skill

- Formalize the role of all hands-on care providers in progressive mobility (RN, PCA, PT, OT)

- Approach mobility from the patient's perspective through the system of care

- Design formats for different disciplines to teach each other and learn from each other

Property of Brooke Nack, Inpatient Therapy Manager, Franciscan Health Michigan City
Not to be copied or reproduced without permission

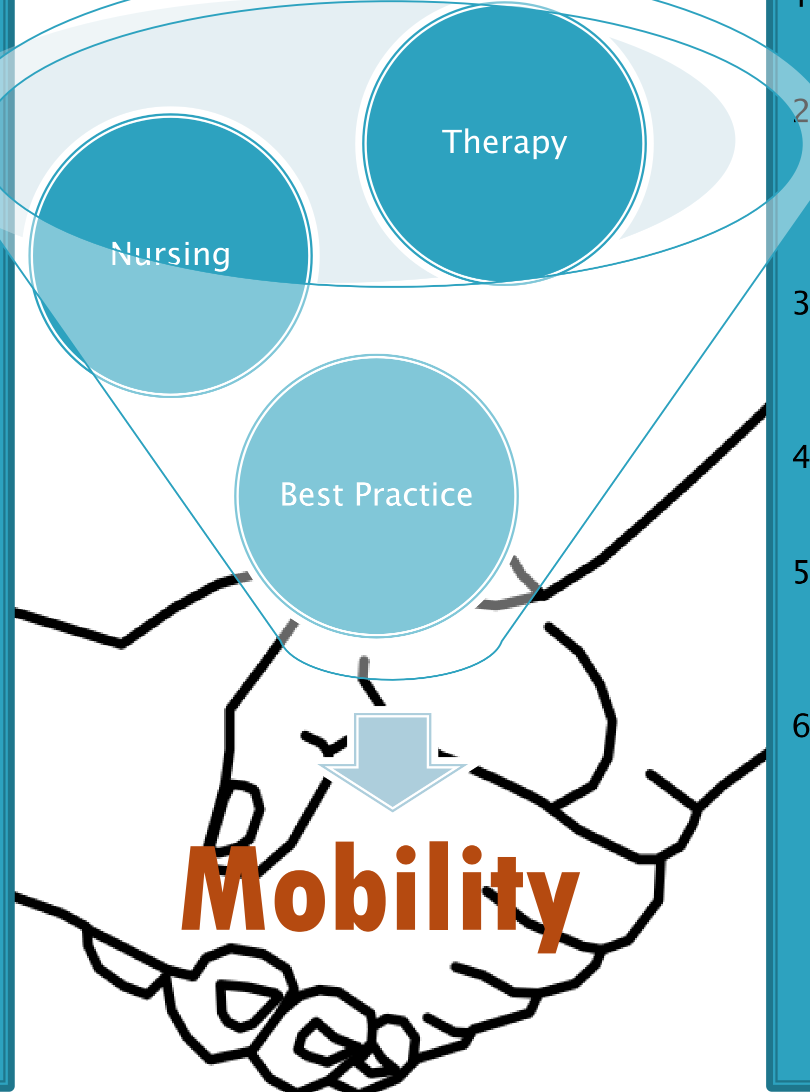
"Move Me": engaging our peers and our patients…

https://www.youtube.com/embed/e6BOqd0JPwc?rel=0

Key Messages within Mobility Competence

Nursing

1. Promote patient activity level: make it part of our nursing care
2. Only rate the patient's experience of movement
3. Inform the patient of the activity goal and current level
4. Remember: A mobile patient makes our work easier
5. Apply what we know about one patient group to another
6. Trust our clinical decisions; Use *Progressive Mobility Continuum* to assess the patient's Readiness to Move



Therapy

1. We must stop owning mobility
2. A team approach supports therapy; this is not a competition
3. Speak language that nurses can understand
4. Use our skills to equip others
5. Teach how to use Lift devices like the (SARA Stedy)
6. Provide specific examples of skilled vs nonskilled mobility services

Property of Brooke Nack, Inpatient Therapy Manager, Franciscan Health Michigan City
Not to be copied or reproduced without permission

Skills-Development for Progressive Mobility…
Have a Little Fun

Property of Brooke Nack, PT MHS

Nursing Mobility Skills Check

Method of Instruction Key: **P =** Policy/Procedure Review **C =** Classroom/Lecture **D =** Demonstration **R =** Role-Play/Simulation	**Method of Evaluation Key:** **O =** Observation (in clinical setting) **RD =** Return Demonstration **T =** Written Test **V =** Verbalized Understanding	**Employee Self-Assessment**			**Method of Instruction** (Use Instruction Key on Left)	**Validation of Competency**		
		Never Done	**Needs Review/ Practice**	**Competent**		**Able to Perform Without Cueing or Prompts**	**Evaluation Method** (Use Evaluation Key on Left)	**Referred to CNS or Educator for Remediation**
Mobility Program:		√	√	√		Date and Initials		Date notified and Initials
Provides verbal education about benefits of mobility								
Explain procedure to the patient/family								
Applies gait belt and uses it safely								
Selects medical equipment appropriate for Mobility Level								
Recognizes and complies with mobility precautions								
Utilizes safe lifting techniques for patient								
Utilizes appropriate body mechanics for staff safety								
Progresses mobility to highest level on Care Map								
Accurately rates mobility on the 1-4 Mobility Scale								
Recommends appropriate activity for Mobility Level								
Documents mobility appropriately on white board in room								
Documents mobility appropriately in medical record (EPIC)								
Sets up the patient safely upon completion of mobility								
Establishes the patients expectation for next mobility episode								
Provides a verbal report including Mobility Level and time								

	Signature	**Date**
Employee		
Preceptor/Mentor		
Nurse Manager		

Property of Brooke Nack, Inpatient Therapy Manager, Franciscan Health Michigan City
Not to be copied or reproduced without permission

From an idea to reality… introducing our mobility team

Day One Results

Expectation	Compliance
Mobility Level reported in Interdisciplinary rounds	96%
Mobility Level written on Board in Room	53%
Mobility Documentation by nursing matches reported Levels and is completed during day shift	63%

<u>Methods to Promote Compliance</u>

1. Feedback of performance provided to unit managers
2. Transparency of performance across units
3. Celebration of nurses with 100% compliance
4. Leadership presence and rounding on the units
5. Mobility Committee attends interdisciplinary rounds

Property of Brooke Nack, Inpatient Therapy Manager, Franciscan Health Michigan City
Not to be copied or reproduced without permission

MOBILITY PROGRAM RESULTS

Measure	Target	Pilot Results		
		IMCU	Med/Onc	Ortho
Length of Stay (in days)	-0.2	-0.25	-0.21	0.06
Hospital Aquired Pressure Ulcers	-10%	-70%		
Fall Rate	-10%	12.5%		
Worker Back Injuries	-10%	-40%		
Nursing Turnover Rate	-5%	-45%		
CNA Turnover Rate	-5%	-9%		
Readmission Rate	Unspecified	-42.9%		
Discharge to SNF	Unspecified	-39%		

Property of Brooke Nack, Inpatient Therapy Manager, Franciscan Health Michigan City
Not to be copied or reproduced without permission

Mobility Program Survey Results

Question	NURSING STAFF		NON-NURSING PROFESSIONALS	
	Agree/ Strongly Agree (n = 38-41)	Disagree/ Strongly Disagree (n = 1-3)	Agree/ Strongly Agree (n = 14-19)	Disagree/ Strongly Disagree
Patients receive more opportunities to move since Mobility Team	100%	0%	100%	0%
My patients are satisfied with the Mobility Team	100%	0%	100%	0%
The Mobility Team safely mobilizes patients	97%	3%	100%	0%
Parts of my job are easier because we have a Mobility Team	95%	5%	100%	0%
The Mobility Team has contributed to my job satisfaction	92%	8%	100%	0%
The Mobility Team contributes positively to DC planning	93%	7%	100%	0%

Property of Brooke Nack, Inpatient Therapy Manager, Franciscan Health Michigan City
Not to be copied or reproduced without permission

Mobility Program Survey Results April 2016

- *I see so many more patients now up in chairs and walking the halls. Great job! I think as the Mobility Team continues to work with our patients the need will increase even more. It will become the norm which is wonderful. Great program! (CNA)*

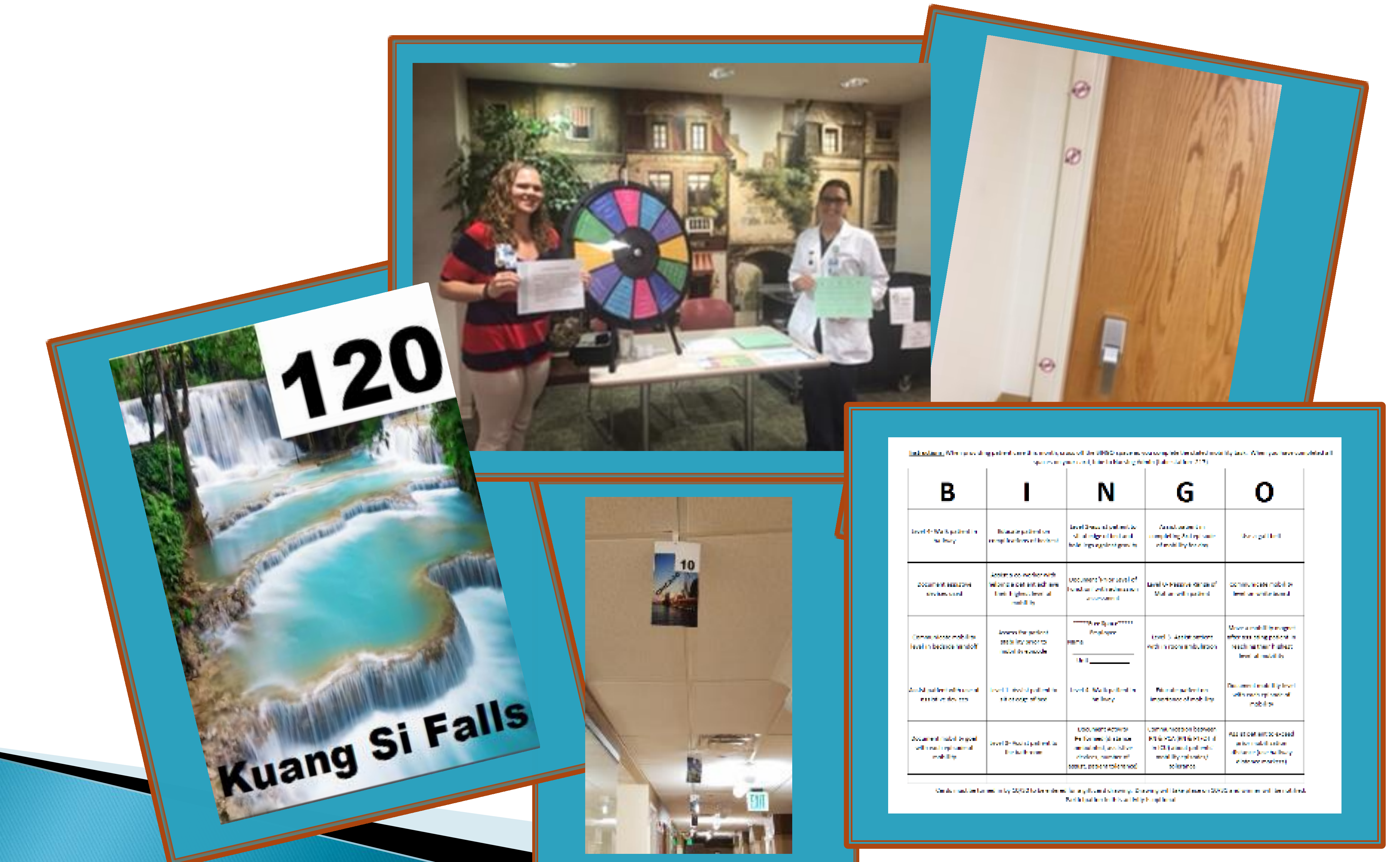
- *Early Mobilization and discharge… Patients do get better with early ambulation. (RN)*

- *Best results are decreased decubiti, decreased aspiration and overall reduced LOS. Excellent idea. Well managed and standardized. Easy to follow process. One of my favorite projects that helped my patients tremendously. (Hospitalist)*

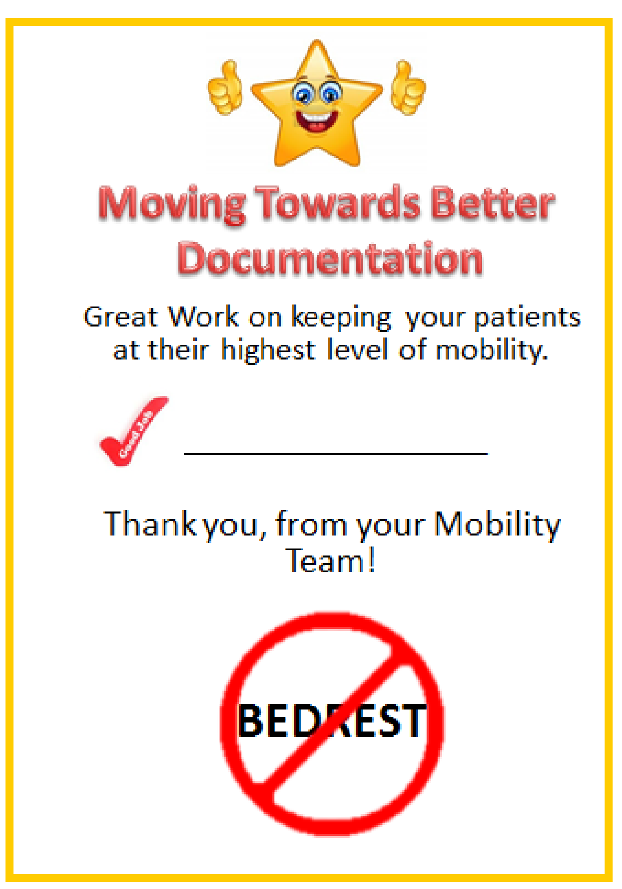
Property of Brooke Nack, Inpatient Therapy Manager, Franciscan Health Michigan City
Not to be copied or reproduced without permission

Spreading mobility throughout Franciscan Health

Spreading mobility throughout Franciscan Health



Spreading mobility throughout Franciscan Health



What's my take home?

- ✓ Optimizing patient quality of life upon discharge is an important interdisciplinary goal
- ✓ The effects of bedrest can be minimized by the attitude and the culture of our caregiving team
- ✓ Mobility *early in the hospital stay* is most predictive of a good functional outcome
- ✓ Patient mobility is everyone's priority
- ✓ A strong interdisciplinary team is absolutely necessary to achieve Early and Progressive Mobility of all patients.

Property of Brooke Nack, Inpatient Therapy Manager, Franciscan Health Michigan City
Not to be copied or reproduced without permission

The sky is the limit!

Property of Brooke Nack, PT MHS

Resources

1. Brown CJ, Redden DT, Flood KL, Allman RM. The under recognized epidemic of low mobility during hospitalization of older adults. 2009. J Am Geriatric Soc;57, p. 1660.

2. Donald et al. (2012) Eliminating waste in US Healthcare. JAMA 307(14):1513-1516.

3. Krumholtz. post-hospital syndrome. Patient physical functioning is associated with their risk for hospital readmission. NEJM. 2013; Jan 10;368(2):100-102.

4. Elliot et al. Exploring the scope of post-intensive care syndrome therapy and care: engagement of non-critical providers and survivors in a second stakeholders meeting. Critical Care Med. 2014 Jul 31.

5. Jezierski et at. A mobility team: Making a move to reduce hospital falls. Accessed 2/5/15. Available at: http://nicheconference2012.s3.amazonaws.com/uploads/File/%202012%20Conf%20Poster%20-%20Advocate%20Lutheran%20updated.pdf.

6. Friedman M, Stilphen M. Establishing a Culture of Mobility in the Hospital Setting. Presented at APTA Combined Sections Meeting Indianapolis, IN. 2015 Feb 4-7.

For further information on Franciscan's Mobility Program, contact

Bobbi Herron-Foster, CNS

Bobbi.herron@franciscanalliance.org

Brooke Nack, Inpatient Therapy Manager, Mobility Program Manager

Brooke.nack@franciscanallinace.org

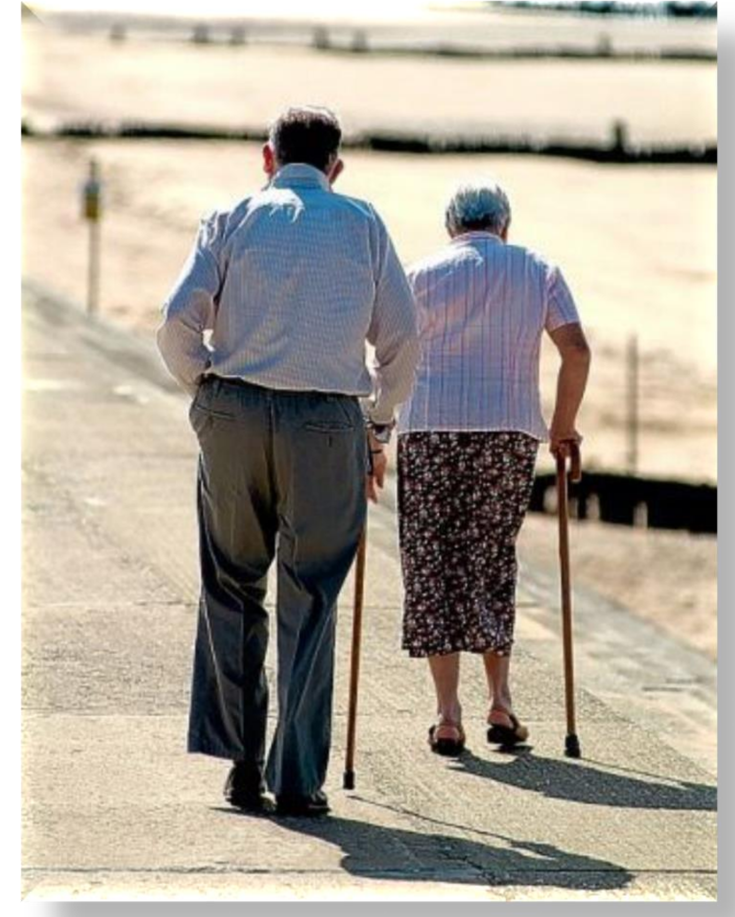
219-877-1133

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

Another Great Falls Resource

Government of Western Australia
Department of Health

Post-Fall Management Guidelines in WA Healthcare Settings

Falls Prevention Health Network

March 2015

Stay On Your Feet WA

health.wa.gov.au

Government of **Western Australia**
Department of **Health**

Guidelines on Post-Fall Management

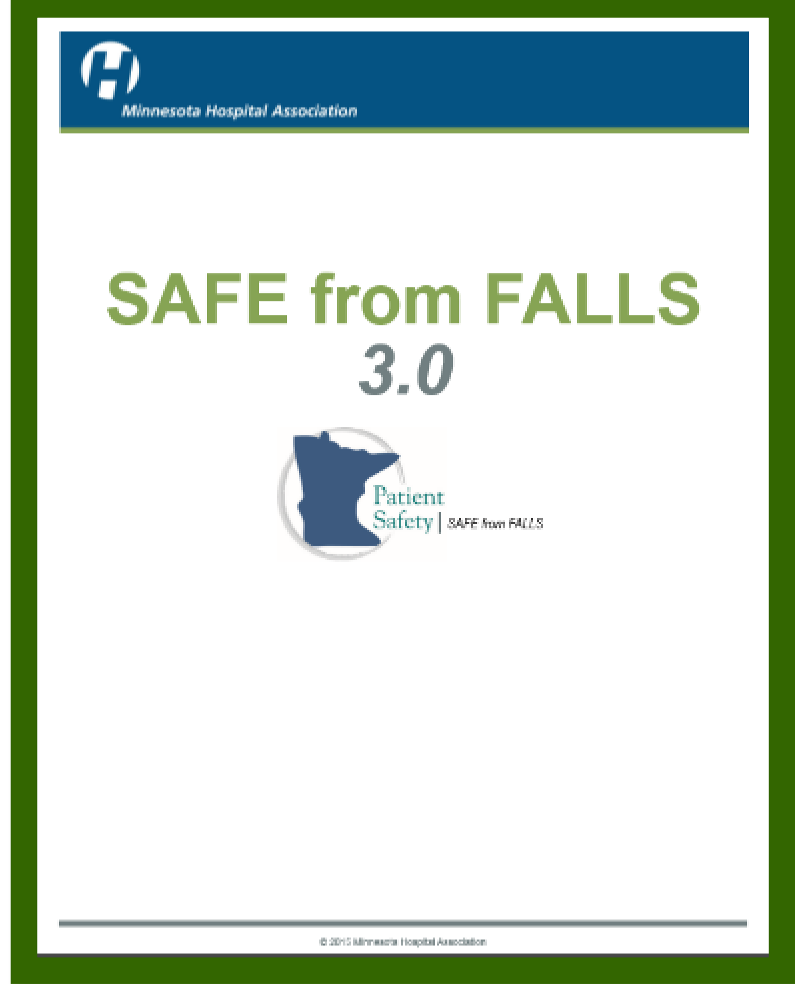
A printable version of this two page summary is available at http://www.healthnetworks.health.wa.gov.au/network/fallsprevention.cfm

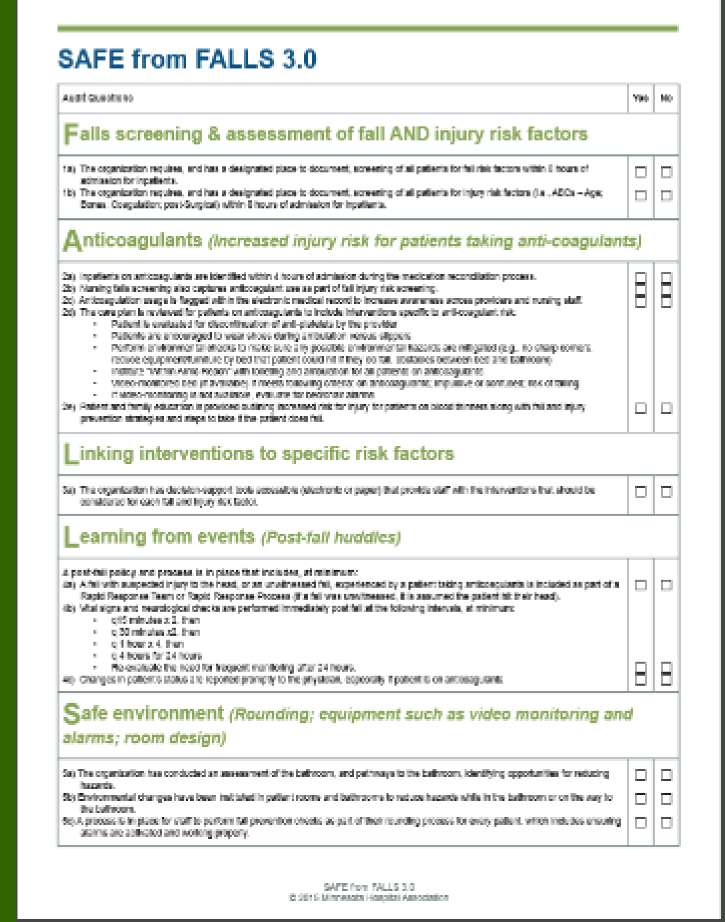
Stop and Consider

- Patients on anticoagulant, antiplatelet therapy and/ or patients with a known coagulopathy are at an increased risk of intracranial, intrathoracic, intraabdominal haemorrhage.[1, 2]
  - Anticoagulants include, but are not limited to, warfarin, heparin, enoxaparin (Clexane), dalteparin (Fragmin), rivaroxaban, dabigatran, apixaban.
  - Antiplatelet drugs include, but are not limited to, aspirin, clopidogrel, aspirin plus dipyridamole (Asasantin).
  - Alcohol dependent persons, people with liver disease and people with bleeding disorders are considered coagulopathic.
- The risk versus harm of continuing anticoagulant therapy post-fall should be considered by the treating team.
- There may be late manifestations of head injury up to 72 hours.
- Fall incidents resulting in surgical intervention or those assigned Severity Assessment Code (SAC) 1-3 are to be reviewed within 24 hours.
- Special consideration for older patients should also be given because of atypical or subtle presentations of fractures and closed head injury.

IHAconnect.org/Quality-Patient-Safety

Organizational Assessment Tool for Fall Prevention





SAFE from FALLS 3.0

Audit Questions	Yes	No
Falls screening & assessment of fall AND injury risk factors		
1a) The organization requires, and has a designated place to document, screening of all patients for fall risk factors within 8 hours of admission for inpatients.	☐	☐
1b) The organization requires, and has a designated place to document, screening of all patients for injury risk factors (i.e., ABCs – Age, Bones, Coagulation, post-Surgical) within 8 hours of admission for inpatients.	☐	☐
Anticoagulants *(Increased injury risk for patients taking anti-coagulants)*		
2a) Inpatients on anticoagulants are identified within 4 hours of admission during the medication reconciliation process.	☐	☐
2b) Nursing falls screening also captures anticoagulant use as part of fall injury risk screening.	☐	☐
2c) Anticoagulation usage is flagged within the electronic medical record to increase awareness across providers and nursing staff.	☐	☐
2d) The care plan is reviewed for patients on anticoagulants to include interventions specific to anti-coagulant risk.	☐	☐
2e) Patient and family education is provided outlining increased risk for injury for patients on blood thinners along with fall and injury prevention strategies and steps to take if the patient does fall.	☐	☐
Linking interventions to specific risk factors		
3a) The organization has decision-support tools accessible (electronic or paper) that provide staff with the interventions that should be considered for each fall and injury risk factor.	☐	☐
Learning from events *(Post-fall huddles)*		
A post-fall policy and process is in place that includes, at minimum:		
4a) A fall with suspected injury to the head, or an unwitnessed fall, experienced by a patient taking anticoagulants is included as part of a Rapid Response Team or Rapid Response Process (if a fall was unwitnessed, it is assumed the patient hit their head).	☐	☐
4b) Vital signs and neurological checks are performed immediately post fall at the following intervals, at minimum:	☐	☐
Safe environment *(Rounding; equipment such as video monitoring and alarms; room design)*		
5a) The organization has conducted an assessment of the bathroom, and pathways to the bathroom, identifying opportunities for reducing hazards.	☐	☐
5b) Environmental changes have been installed in patient rooms and bathrooms to reduce hazards while in the bathroom or on the way to the bathroom.	☐	☐
5c) A process is in place for staff to perform fall prevention checks as part of their rounding process for every patient, which includes ensuring alarms are activated and working properly.	☐	☐

SAFE from FALLS 3.0

http://www.hret-hiin.org/Resources/falls/16/safe_from_falls_3.0_roadmap.pdf

IHAconnect.org/Quality-Patient-Safety

Video Tools for Fall Prevention

http://www.hret-hiin.org/resources/display/ucla-critical-thinking-fall-prevention-case-studies

UCLA Critical Thinking Fall Prevention Case Studies

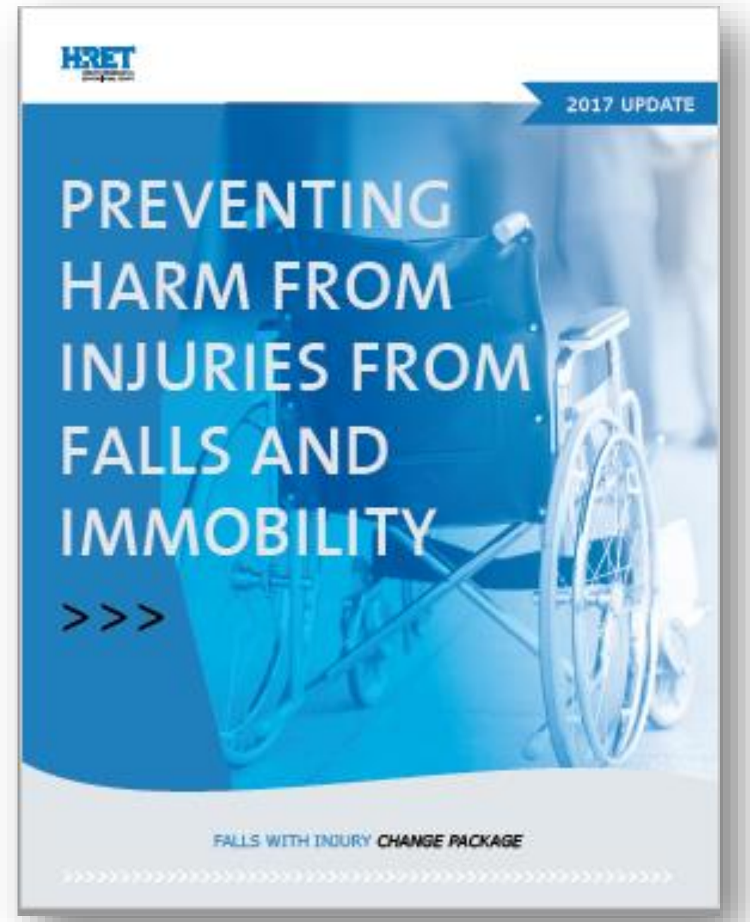
Published: October 18, 2017

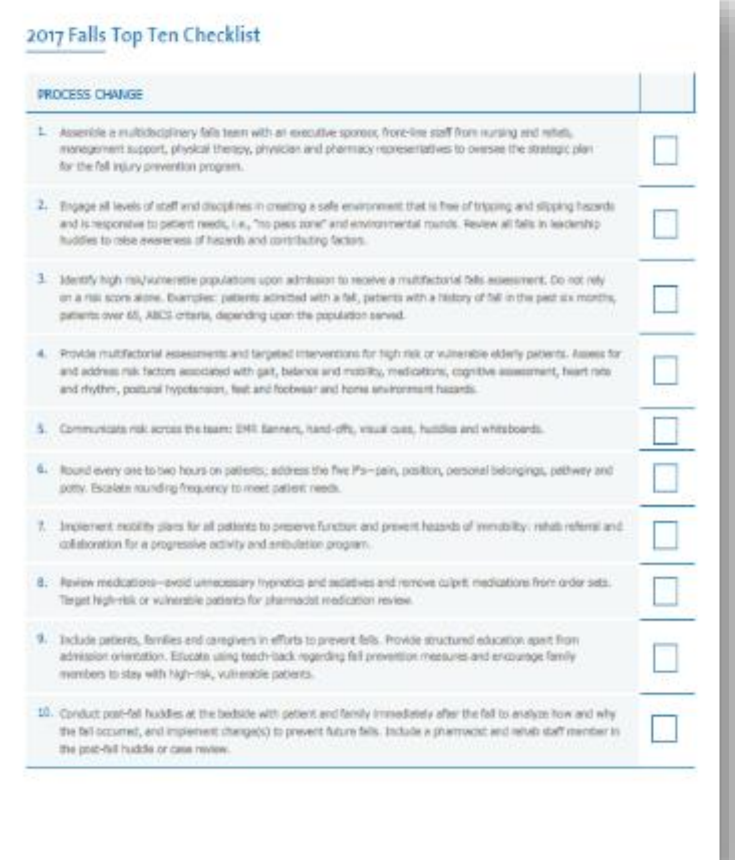
Topic: Falls, Patient and Family Engagement (PFE) | Resource type: Video

Four video case studies targeting the development of critical thinking skills with nursing staff. Can be used as self learning module or a facilitated group discussion.

1. Medicine Patient (Duration 7:31)
2. Bone Marrow Transplant Patient (Duration 09:56)
3. Liver Transplant Patient (Duration 9:55)
4. Neurology Patient (Duration 6:50)

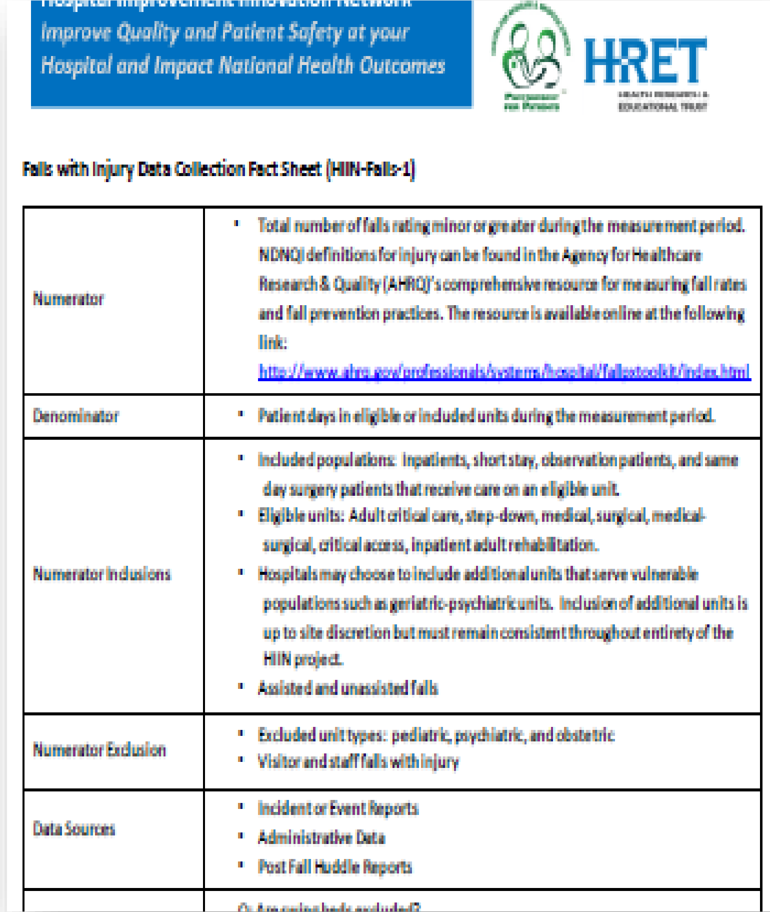
HRET Change Package/Fact Sheet- Falls and Immobility





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.	☐



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

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

IHAconnect.org/Quality-Patient-Safety

Teach-Back Tool

NOWLEDGE TEST AFTER AND RETURN
EMONSTRATION CHECKLIST:

HRET

TEACH-BACK TOOL
for Fall Prevention

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

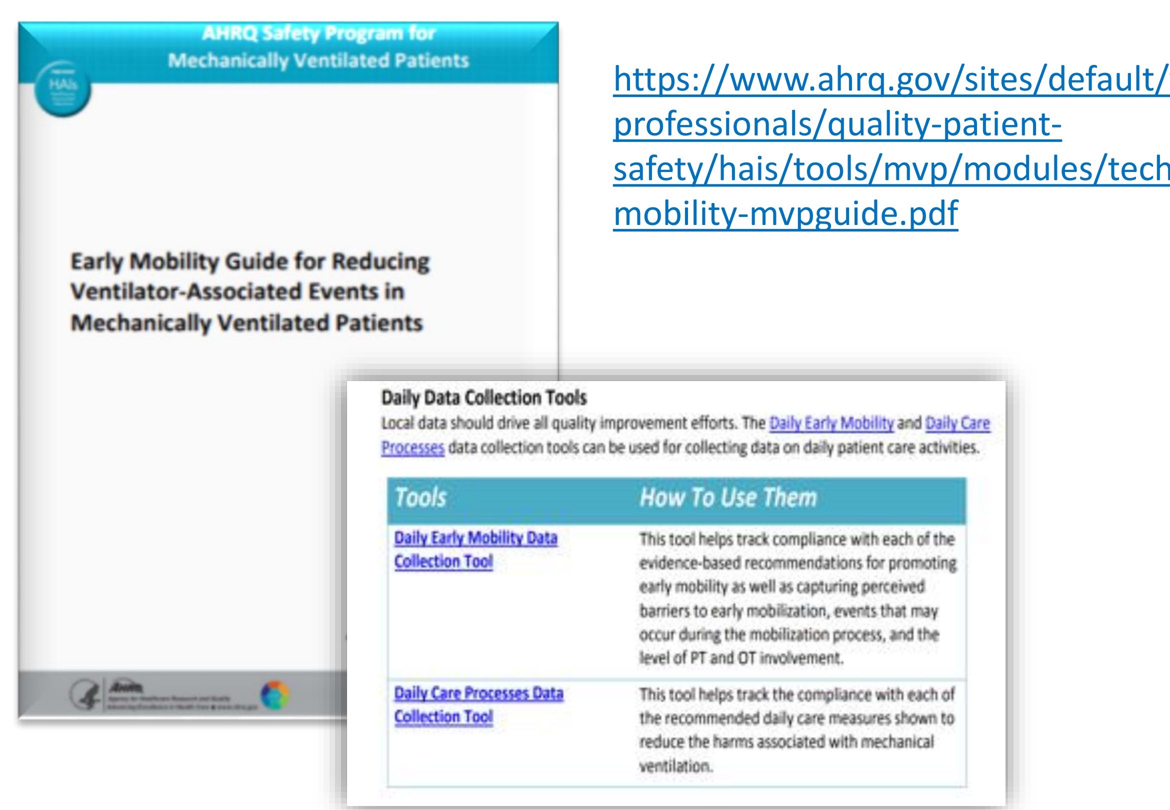
IHAconnect.org/Quality-Patient-Safety

Pressure Ulcer/Injury Prevention Tools

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

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

AHRQ Toolkits for Falls & Ventilator Acquired Events

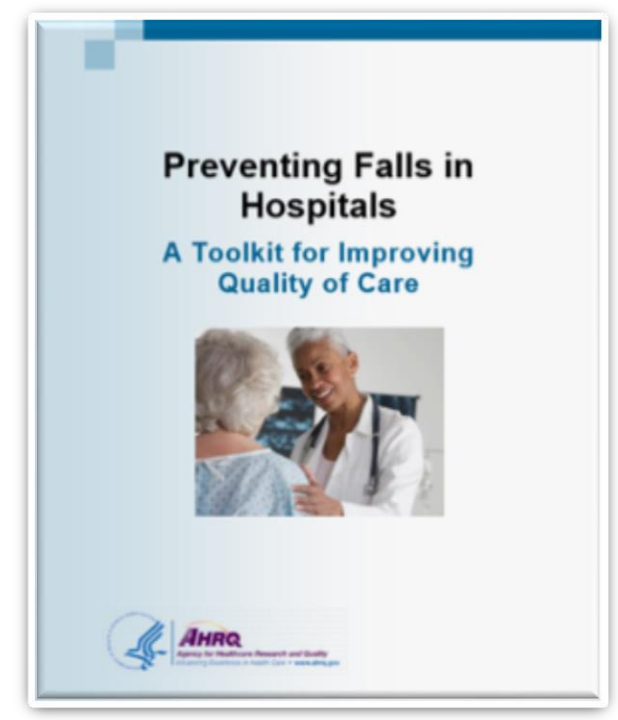


Daily Data Collection Tools

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.

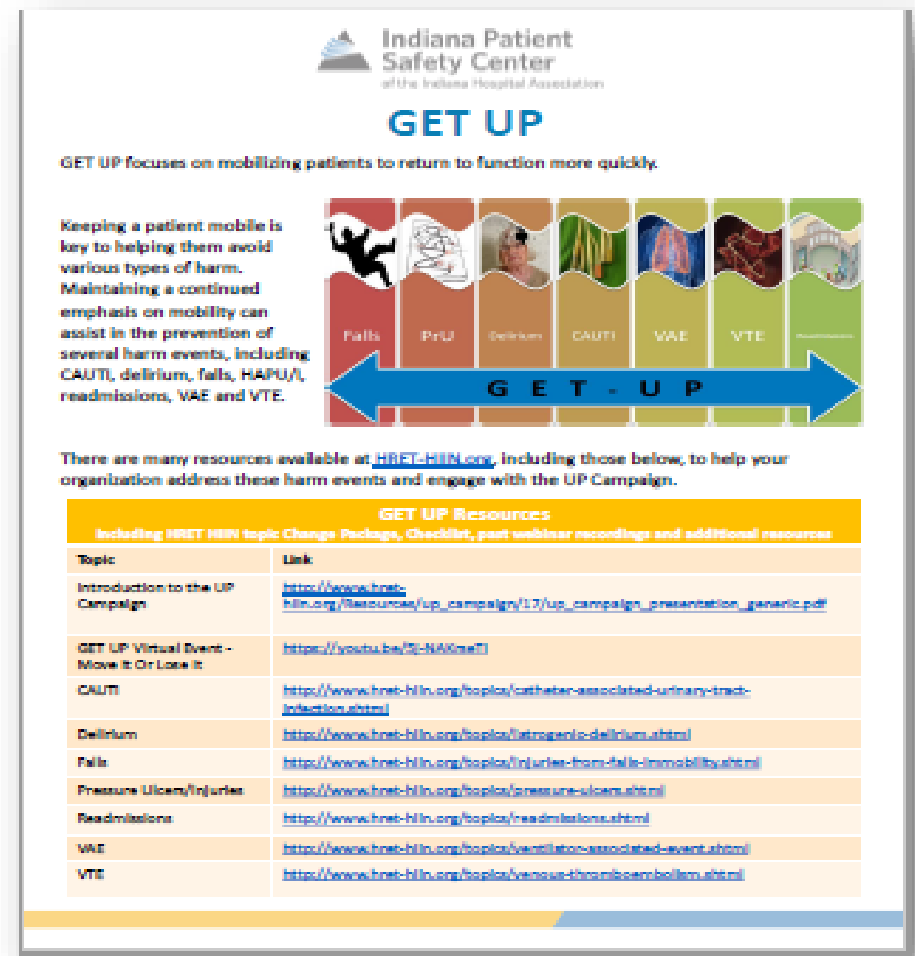
https://www.ahrq.gov/sites/default/files/wysiwyg/professionals/quality-patient-safety/hais/tools/mvp/modules/technical/early-mobility-mvpguide.pdf



https://wwwprofessionals/systems/h.ahrq.gov/ospital/fallpxtoolkit/index.html

IHAconnect.org/Quality-Patient-Safety

IHA Resource Sheet



Indiana Patient Safety Center
of the Indiana Hospital Association

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

Social Media Messaging

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

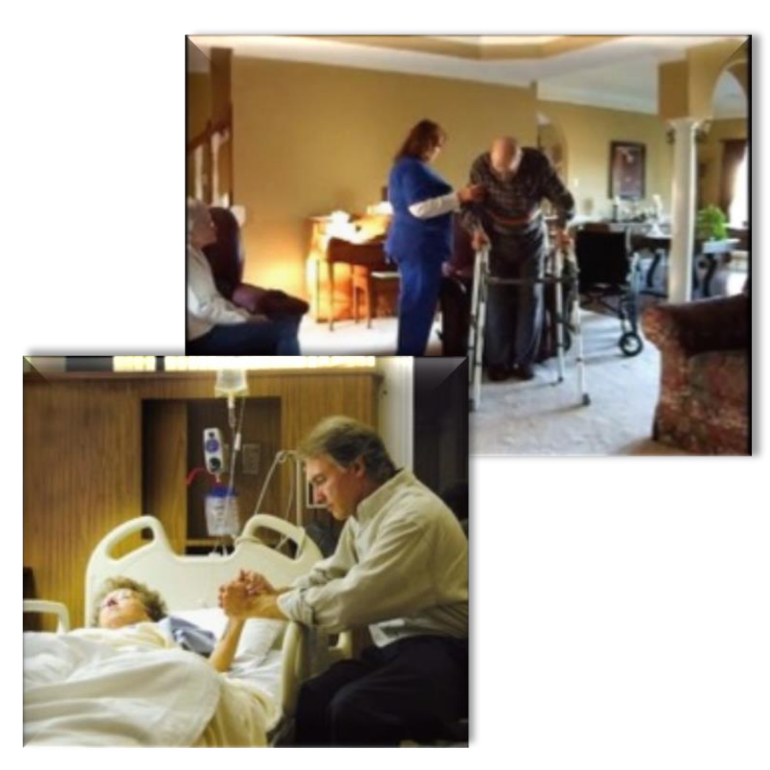
GET UP Webinar Series

Next Up!
January 23rd at 3:00 pm

Webinar Dates:

- January 23 at 3 p.m. ET: State of the State: Opioids & ED's
- February 20 at 3 p.m. ET: Sleep Apnea & Sedation Prevention
- March 6 @ 3pm. ET: To be Determined
- March 20 at 3 p.m. ET: Delirium Assessment, Prevention & Management

How are you incorporating GET UP within your organization?



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

Our IPSC Team

Becky Hancock
Patient Safety & Quality Advisor
317-423-7799
rhancock@IHAconnect.org

Annette Handy
Clinical Director
317-423-7795
ahandy@IHAconnect.org

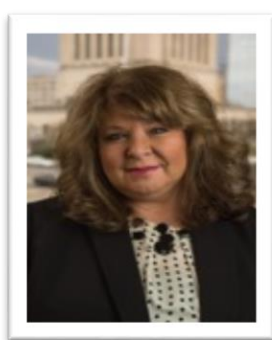
Karin Kennedy
Administrative Director
317-423-7737
kkennedy@IHAconnect.org

Patrick Nielsen
Patient Safety Data Analyst
317-423-7740
pnielsen@IHAconnect.org

Kim Radant
Special Projects
Patient Safety & Quality Advisor
317-423-7740
kradant@IHAconnect.org

Matt Relano
Patient Safety Intern
317-974-1420
mrelano@IHAconnect.org

Cynthia Roush
Patient Safety Support Specialist
317-423-7798
croush@IHAconnect.org



Madeline Wilson
Patient Safety & Quality Advisor
317-974-1407
mwilson@IHAconnect.org