MISSOURI Hospital Engagement Network

Improving Individually, Learning Collaboratively

Falls/Injuries From Falls Peer-to-Peer Learning Session

Ginger Schelp, MHA, RRT
Project Manager
Missouri Center for Patient Safety

The Missouri HEN is a Missouri Hospital Association initiative in collaboration with the Missouri Center for Patient Safety.

Overview of Session

- Welcome and overview
- MO HEN Falls data submission
- Progress Reports
- Hospital sharing
  - Samaritan Hospital – Anna Blackford, Med/Surg Supervisor, Skilled Nursing Coordinator

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MO HEN Falls data

- 68 Hospitals participating
- 85% baseline
- 90% outcome
- 71% process
- 30 hospitals entered monitoring data for July

3

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Project Title: _____ ***Date:*** _____

Hospital Name: _____ ***State:*** _____

Self Assessment Score = ___, (1=Planning; 2=Some Activity; 3=Some Improvement; 4=Significant Improvement; 5=Outstanding Results; See AHA/HRET Assessment Scale

Aim Statement

- Aim?: (Including your *How Good* and *By When* statement)
- Why is this project important?:

Changes Being Tested, Implemented

- For each listed change, indicate whether it is being Tested (T), Implemented (I) or Spread (S)

Run Charts

Make fonts large and use simple text, labels, dates and notes **prior** to shrinking graphs. Should be able to fit 6-8 readable graphs here. If no data are available for a particular measure, please create an "empty" run list that includes the name of the measure to be collected.

Lessons Learned

- Enter summary here

Recommendations and Next Steps

- Enter summary here (What do you need from Executive Project Champion, Sponsor at this time to move project?)
- Recommendations
- Next steps for testing

Team Members

- Name of Project Champion, Senior Leader Sponsor & all other names and roles

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Falls No More!

Waterbury Hospital, Waterbury , CT

Date: 7-3-2012

Self Assessment Score (1-5) = 2

Aim Statement

Long term: Reduce preventable (accidental, anticipated physiological) falls by 50% by December 2012

Short term: Reduce preventable falls by 20% by October 2012

Changes being Tested, Implemented or Spread

T – Post fall huddle revision (7/4/2012)

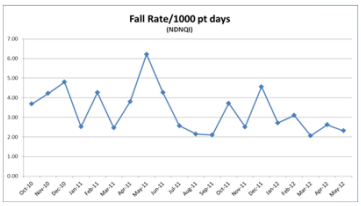
T – Data posted on all inpatient units

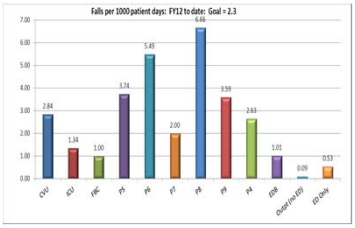
T – Pharmacy consult and review

Lessons Learned

Education for physicians regarding pharmacy review

Run Charts





Falls / 1000 pt days FY2011 = 3.61
Falls / 1000 pt days FY2012 = 3.11
Reduction of 14.1%

Recommendations and Next Steps

Assistance from IT for Pharmacy data.

Identify areas for data posting on units and who will do it.

Posting data on Intranet

Team Members

Sandi Iadarola – Exec, CNO
Cecily Byron-Iyamah – Champion, Nsg
Laura Sousa – Data Analyst, Risk Mgmt
Bea Acheampong, RN Med/Surg
Deb Burns, RN Tele
Carol Rakowski, RN ICU
Deb Margison, PT
Kristine Schmaler, RN Ortho P7
Colleen Lawlor, Education
Linda Eckman
Maura Nazario, RN ER
Marylou Oshana, Occup. Safety
Patti Szabo, RN Med/Surg
Karen Stillman, Dir, Psych
Chris Strachan, Educ, ER
Michelle Valentino, PT
Patty Volovski, Quality

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Samaritan Hospital

Samaritan Hospital

- Established in 1929
- 25 bed CAH in rural NE Missouri
- New construction of all patient care units, complete March 2012
- Final remodel of support services to be complete Fall 2012
- 155 Employees and 9 active medical staff members
- Annually: 800 discharges; 60,000 OP visits; 5,500 ED visits

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2nd Floor—Med/Surg-Swingbed

2nd Floor—Med/Surg-Swingbed

- 2012 average monthly acute admits: 44
- 2012 average monthly swingbed admits:15
  - 29% are unique visits to facility (referrals from outside source)
- Average daily census: 12
- Licensed staff to patient ratio: Less than 1:6, all shifts; Generally no more than 1:4
- Support staff: UAP 1-2 per day shift, 1 per evening shift;1 WC each day and evening

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Facts on Falls

- Leading cause of fatal and nonfatal injuries to older people in the US
  - Each year, more than 11 million people age 65+ fall
    - One in three senior citizens
  - Approx 3 to 20 percent of hospital inpatients fall at least once during their stay
    - These falls are considered "preventable" by the CMS
    - Healthcare facilities are held accountable for the costs of treating any resulting injuries.

American Academy of Orthopedic Surgeons (AAOS, 2011)

What do we do to prevent falls?

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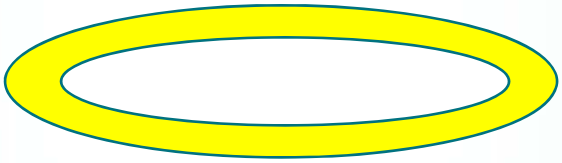
Fall Prevention—The early days

The “falling star” © 2004...we fell a little short

Fall Prevention—The early days

"Banding Together for Patient Safety"

MOCPS © 2007



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New Design with Safety in Mind

- Spring 2010—New facility planning
  - Racetrack patient room layout
  - More patient rooms closer to the centralized nurses' station
  - Rooms across from nurses' station have windows placed in corridor wall for patient viewing

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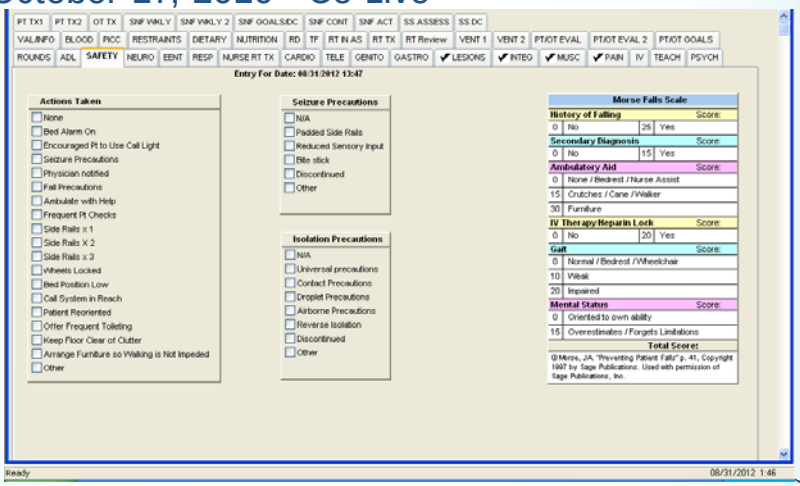
Fall Prevention Documentation

October 17, 2010—Go Live



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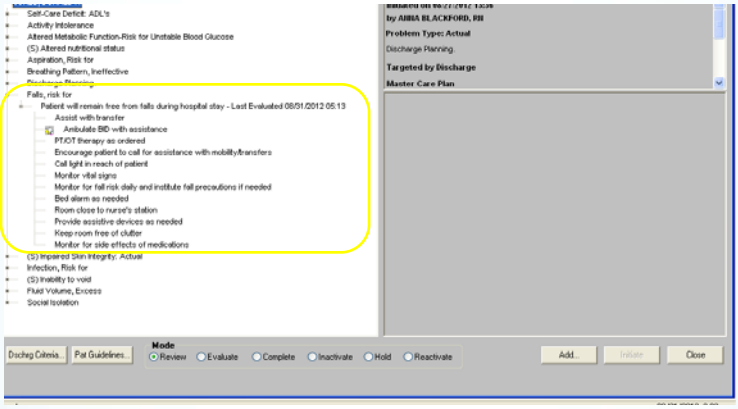
Fall prevention Documentation

- Fall Risk Assessment complete on 100% of all admissions within 24 hours of admission to floor
  - Morse Falls Scale
    - Score 0-24: Low Risk
    - Score 25-50: Moderate Risk
    - Score 51 + : High Risk
  - Based on risk score, a care plan is generated electronically

Fall Prevention Interventions

cont'd



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More "Small Tests of Change"

- February 2011: Hill-Rom Advanta-II beds purchased
  - Built in audible bed exit alarms
    - Position change
    - Sitting
    - Standing

Patient Rooms

March 12, 2012—Completion of 2nd floor unit

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Integration

- March 12, 2012
  - Hill-Rom Advanta-II beds integrate with Hill-Rom Navi-Care Nurse Call
    - Audible alarms in room
    - Audible nurse call alarm
    - Flashing zone and corridor lights
      - Alarms and lights specific to bed exit

HRET/HEN QI Data

- MO - Samaritan Memorial Hospital - Project: Falls Measure: Injuries from Falls and Trauma (MCR FFS) (CMS HAC) - Outcome (Alternate)
  - Includes all Medicare acute and skilled discharges

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Outcome

- 0.3% per 1000 patient discharges

More to come….

- Internal reporting and
  - All "near" falls (lowered to ground with assist)
  - All falls without injury
  - All falls resulting in any injury
  - All falls resulting in serious trauma
- Outpatient visits
  - Assessment and banding during registration

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Bibliography

- American Academy of Orthopedic Surgeons, 2011
  http://www6.aaos.org/news/pemr/releases/release.cfm?releasenum=1008

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Questions?

MISSOURI Hospital Engagement Network

Improving *Individually*, Learning *Collaboratively*

Prevention of Hospital Acquired Pressure Ulcers Peer-to-Peer Learning Session

12:45 p.m. Friday, September 7, 2012
Jeanne Naeger
Vice President of Quality Improvement
Missouri Hospital Association

The Missouri HEN is a Missouri Hospital Association initiative in collaboration with the Missouri Center for Patient Safety.

Overview of Session

- Welcome and overview of session activities
- Hospital sharing and peer-to-peer learning
  - Barton County Memorial Hospital – Shelly Horst, Director of Infection Control
  - Howard A. Rusk Rehabilitation Center — Shannon Keeton, Manager, Education and Wound Care
- Facilitated discussion to support participants in the planning of immediate next steps and tests of change

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Pressure Ulcer Data Submission

- 80% baseline data
- 80% outcome data
- 67% process data
- 53% outcome and process data
- Required to submit monthly data on one process and one outcome measure
- Everyone should have submitted baseline data from 2011

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Pressure Ulcer LISTSERV®

- Send an email request to: www.hret-hen.org
- Or go to http://ahals.aha.org/SCRIPTS/WA-AHALS.EXE?SUBED1=HRET-HEN-FALLS-PRESSURE-ULCERS— This screen allows you to subscribe to the pressure ulcer list serve. You can chose to receive emails as they are posted to the list serve or a once a week digest.

Project Title: _____ ***Date:*** _____
Hospital Name: _____ ***State:*** _____

Self Assessment Score = ___, (1=Planning; 2=Some Activity; 3=Some Improvement; 4=Significant Improvement; 5=Outstanding Results; See AHA/HRET Assessment Scale

Aim Statement

- Aim?: (Including your *How Good* and *By When* statement)
- Why is this project important?:

Changes Being Tested, Implemented

- For each listed change, indicate whether it is being Tested (T), Implemented (I) or Spread (S)

Run Charts

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Lessons Learned

- Enter summary here

Recommendations and Next Steps

- Enter summary here (What do you need from Executive Project Champion, Sponsor at this time to move project?)
- Recommendations
- Next steps for testing

Team Members

- Name of Project Champion, Senior Leader Sponsor & all other names and roles

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Project Title: Wipe Out Date: July
Hospital Name: Rusk Rehabilitation Center State: Missouri

Self Assessment Score = 2

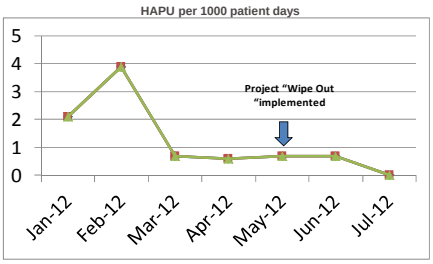
Aim Statement

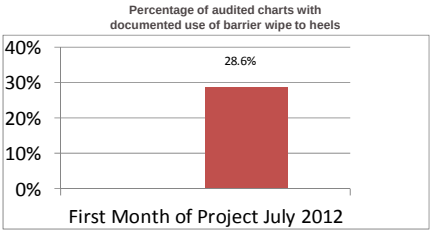
- To reduce number of Hospital Acquired Pressure Ulcers to ≤ 0.5 per 1000 patient days by January 1, 2014.
- **Why is this project important?:** Patients in the acute medical rehabilitation setting are at risk for pressure ulcers that can be painful, and cause complications as well as increase cost and burden of care.

Changes Being Tested, Implemented or Spread

- Interdisciplinary Wound Team focusing on prevention.
- Project "Wipe Out" Barrier wipe to the heels of patients with Braden Scale of ≤18 BID.
- Educational video and posters
- Signs in rooms identifying patients as part of Project "Wipe Out".

Run Charts





Lessons Learned

- Staff confusion regarding where/how to document heel protection with Barrier Wipe.
- Education needs to be more concise and ongoing.
- Barrier Wipe should be easily accessible in patient care areas to increase compliance.

Recommendations and Next Steps

- Education at staff meetings.
- Chart audits to focus one on one coaching.
- Scheduling patient centered interdisciplinary wound team rounds at bedside to establish a prevention plan and provide patient education.

Team Members

- Shannon Keeton, RN, BSN, CRRN, WCC
- Anita Campbell, PT, ATP
- Lindsay Holland, PT
- Brian Garrett, OTR, ATP
- Suzanne DeChazal, OTR
- Regina Abrams, RD
- Darlene Grombka-Woodard, CCC-SLP
- Ann Stoll, CCC-SLP
- Mike Acuff, MD

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MISSOURI Hospital Engagement Network
Improving Individually, Learning Collaboratively

Shelley Horst, BSE, RN, CIC

Nurse Educator / Infection Prevention
Barton County Memorial Hospital
Lamar, Missouri

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About Us
Barton County Memorial Hospital

- Lamar, Missouri
  - Birthplace of Harry Truman
  - Population – 4,000
  - Rural, Mid-Western community
  - October 1949, hospital dedicated to 61 soldiers from Lamar who died in WWII
- December 2005
  - Twenty-five bed Critical Access Hospital (CAH)
- Population We Serve

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What Did We Test?

Evidenced –based practices ! Maintain the integrity of the skin.

- Educational modules
- Skin-risk assessment on all admissions
- Staffing levels
- Care partner program
- Hourly rounds- four Ps (pain, potty, perimeter, position)
- Administrative support
- Environmental controls
  - Beds
  - skin products

What Have We Learned So Far?

- Education
  - Yearly competencies to reinforce learned behaviors in regards to skin care.
  - Adequate orientation of new employees to skin care policies.
  - Aggressive review of new skin care products
  - Networking with colleagues
- Adequate staffing levels
  - Improve the quality of care
  - Commitment from administration

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What Have We Learned So Far?

- Skin risk assessment
  - Braden scale
  - Initial part of the admission assessment process
- Care partner Program
  - Planetree Philosophy - holistic care to patients, families, and care givers.
  - Family included in meaningful other's care.
  - Introduced in the admission process
- Physician Rapport

What Were Our Barriers?

- Attendance to educational offerings
- Administrative approval to employ additional health care workers
- Competitive salaries
- Documentation of hourly rounds

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How Did We Overcome These Barriers?

- Mandatory attendance and completion of skin care educational modules of health care personnel.
  Diverse avenues for educational presentations.
- Administrative and board approval for additional staffing of licensed nurses and CNAs.
- Salaries that conform to the regional wage
- Skin risk assessment must be completed prior to continuing with the admission assessment process.
- Scripting hourly rounds

What Can We Teach From Our Journey?

- Must have administrative buy-in
- Treating the whole patient and including the families (Planetree) ensures better patient outcomes.
- Acknowledging the health care team
- Continuing education and collaboration
- Adequate staffing with a quality skill mix

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Feel Free to Contact Us:

- Shelley Horst, RN, CIC
  shorst@bcmh.net
  417 681 5159
  Fax 417 681 5517
  Education Coordinator/ Infection Prevention

Barton County Memorial Hospital
29 NW First Street
Lamar, MO. 64759

Resources

- Ball, J. (2011). Data collection and review in the delivery of safe care. *Nursing Management - UK*, *17*(9), 20-22.
- Kendall-Gallagher, D., Aiken, L. H., Sloane, D. M., & Cimiotti, J. P. (2011). Nurse Specialty Certification, Inpatient Mortality, and Failure to Rescue. *Journal Of Nursing Scholarship*, *43*(2), 188-194. doi:10.1111/j.1547-5069.2011.01391.x
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- To comply with new TJC standards, toss out restrictive visitation policies: Create processes that support participation of families, other partners in care. (2010). *Patient Education Management*, *17*(11), 121.
- Robinson, J. H., Callister, L. C., Berry, J. A., & Dearing, K. A. (2008). Patient-centered care and adherence: Definitions and applications to improve outcomes. *Journal Of The American Academy Of Nurse Practitioners*, *20*(12), 600-607. doi:10.1111/j.1745-7599.2008.00360.x
- Kaiser Permante. (2002). Nurse staffing and care delivery models: A review of the evidence. Retrieved from http://xnet.kp.org/ihp/publications/docs/nurse_staffing.pdf

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Improving *Individually*, Learning *Collaboratively*

"Interdisciplinary Approach To Wound Care/Prevention"

Howard A. Rusk Rehabilitation Center

A joint venture of HEALTHSOUTH and the University of Missouri-Columbia

Objective

- Discuss the benefits of an interdisciplinary approach to HAPU prevention

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What Did We Learn From This Project?

- Patient outcomes improved.
- Patient satisfaction improved.
- Collaboration among disciplines improved.
- Knowledge base/awareness improved.
- It is worth the struggle to develop and nurture an interdisciplinary wound care/prevention team.

What Were Our Barriers?

- Time, time, time!!!
- Getting members from each discipline interested.
- Educating team members and other staff.
- Buy in from administration.
- Developing documentation.
- Continuity among staff at our facility and between facilities.
- Scheduling patients for assessment.

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How Did We Overcome These Barriers?

- Short meeting times with specific agenda to stay “on track”.
- Developing a method of “rounding” at times that was most convenient to team members and patient schedules.
- Sending interested members to wound conferences, webinars, and in-services.
- Power Point Presentation at Chief Medical Officers annual meeting to introduce project.
- Annual wound fair to educate all staff.
- Invited administration to be a part of the team development.

What Can We Teach From Our Journey?

- "It Takes a Team"!
  - An Interdisciplinary approach to managing wounds and developing prevention protocols is worth the time and effort.
- Getting started is the most difficult.
  - It can take 1-2 years to fully establish the team, and then constant diligence to keep it going.
- Having a wound certified clinician is a must.
- Have the big picture in mind, but set small, achievable goals first.
- Administrative support is key, and begins with education.

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Our Accomplishments Over the Last Three Years

- Development of a Wound Care Manual.
- Development of protocols for wound treatment.
- Promoted participation in PUP program with testing for nursing staff.
- Development of Annual Wound Fair.
- Participated in Corporate initiative to streamline advance wound care products.
- Participation in Corporate review and upcoming revisions to "Wound Prevention, Care and Documentation Policy".
- Obtained equipment for prevention and wound care.

Educating Your Administration

- In our facility, average hospital acquired wounds per 1000 patient days decreased from 2.0 to 0.6
- The wound team helps to establish cost effective solutions with positive clinical outcomes. $$$
- Changes in CMS guidelines with respect to reimbursement for hospital acquired wounds. $$$
- Legal issues/ramifications. $$$

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Our Goals for the First Year

- Development of documentation guidelines.
- Development of monitoring tools.
- Updating wound protocols.
- Assessment of need for devices to assist with wound care and prevention.
- Education programs for staff, patients, and caregivers.

Our Goals for the Next Year

- Decrease our hospital acquired wound rate to ≤ 0.5 per 1000 patient days.
- Update wound team recommendations forms to increase physician ease with order writing.
- Evaluation of clinical studies.
- Project "Wipe Out" (HEN Project)
- Encouraging further development of alternative team members.

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Our Interdisciplinary Wound Care Team

Including: PT, OT, ST, RD, RN, MD, Administrator

Feel Free to Contact Us:

- Howard A. Rusk Rehabilitation Center
- 315 Business Loop 70 W.
- Columbia, MO 65203

- Shannon Keeton RN, BSN, CRRN, WCC
  - shannon.keeton@healthsouth.com
- Anita Campbell, PT, ATP
  - anita.campbell2@healthsouth.com

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Insert Rusk Video