KHC Hospital Improvement Innovation Network

March 28, 2018
10 to 11 a.m.

HIIN Goals:
By September 2018, hospitals in the KHC HIIN will achieve 20% reduction in all-cause harm and 12% reduction in readmissions.

Kansas Healthcare Collaborative

623 SW 10th Ave. • Topeka, KS 66612 • (785) 235-0763 • www.khconline.org

KHC HIIN

Agenda

- Introductions and Announcements
- KHC HIIN Data Update
- **Post Fall Management**:
  Getting to Types of Falls, Repeat Falls, and Determining Preventability
- Upcoming Events

Special Guests

Patricia Quigley
PhD, ARNP, CRRN, FAAN, FAANP
Nurse Consultant

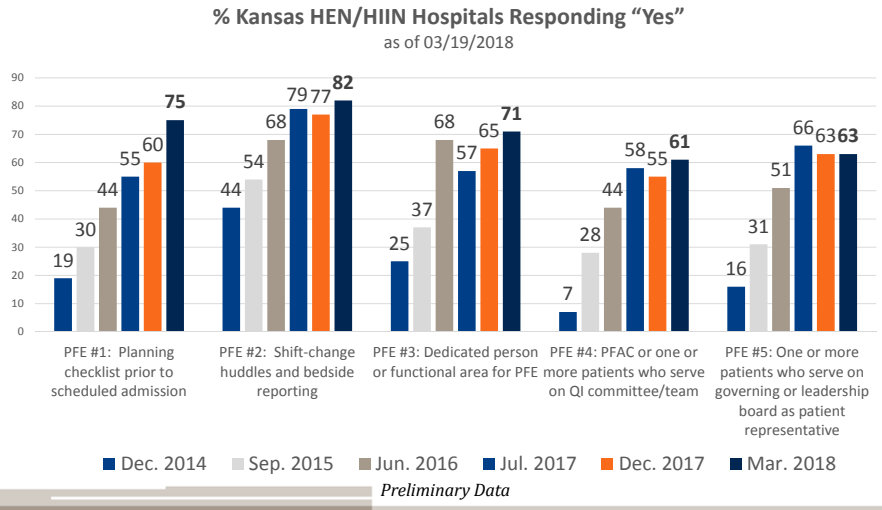
Betsy Lee
MSPH, BSN, RN
Cynosure Health

KHC Staff

Michele Clark
Program Director
mclark@khconline.org

Rob Rutherford
Senior Health Care Data Analyst
rrutherford@khconline.org

Patient and Family Engagement Metrics / Strategies



Preliminary Data

KHC HIIN WORKSHOPS
KANSAS PFA/PFAC COLLABORATIVE

COHORT 4

Regional workshops held
March 15 in Topeka
and
March 16 in Great Bend

38 Kansas hospitals participating in Cohort 4

TRACK 1

Allen County Hospital
Ashland Health Center
Atchison Hospital
Clara Barton Hospital
Ellinwood District Hospital
Goodland Regional Medical Center
Grisell Memorial Hospital
Kearny County Hospital
Kingman Community Hospital
Rawlins County Health Center
Sumner County Hospital District No. 1
Western Plains Medical Complex

TRACK 2

Anderson County Hospital
Citizens Medical Center, Inc.
Comanche County Hospital
Edwards County Hospital and Healthcare Center
Ellsworth County Medical Center
Gove County Medical Center
Greenwood County Hospital
Hays Medical Center
Hiawatha Community Hospital
Holton Community Hospital
Hospital District No. 1 of Rice County
Hutchinson Regional Medical Center
Labette Health
Lawrence Memorial Hospital
Lindsborg Community Hospital
Logan County Hospital
Meade District Hospital/Artesian Valley Health System
Memorial Health System
Mercy Hospital Fort Scott
Neosho Memorial Regional Medical Center
Newton Medical Center
Pawnee Valley Community Hospital
Ransom Memorial Hospital
Rush County Memorial Hospital
South Central Kansas Medical Center
Trego Co. Lemke Memorial Hospital

Measures & Data Update

- Milestone 6
- Overall HIIN Progress
- Focus Areas/Sprint

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KHC HIIN

KHC HIIN Data Report Updates

The final KHC HIIN data analytic report package for March will be emailed to each hospital today.

It contains:

- Data submission monitoring report,
- Data analytic report, and
- side-by-side report showing overall progress by topic toward HIIN 20/12 goals

The HIIN Improvement Calculator is distributed quarterly to KHC HIIN primary and secondary contacts. Your hospital's updated calculator was emailed to contacts yesterday (3/27).

KHC HIIN

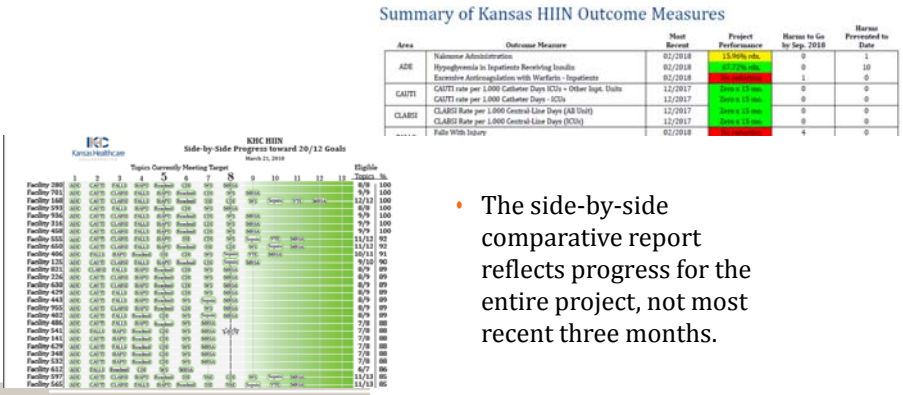
Data Analytic Report Changes

- Addition of a 3-month progress summary in the detail slides.
- Addition of Harms Prevented and Harms to Go

Progress Summary	
Overall Project	**Most recent 3 Mos.**
No reduction	9.64% rdx.
During the course of the HIIN project, your facility's overall rate for this measure has not improved since baseline.	Your facility's most recent three months of data reflects improvement compared to baseline for this measure.
Harms Prevented: 3 Harms to Go: 19	

Data Analytic Report Changes

Special notes:
The summary table on page 3 of your Data Analytic Report continues to reflect progress for the overall project.



- The side-by-side comparative report reflects progress for the entire project, not most recent three months.

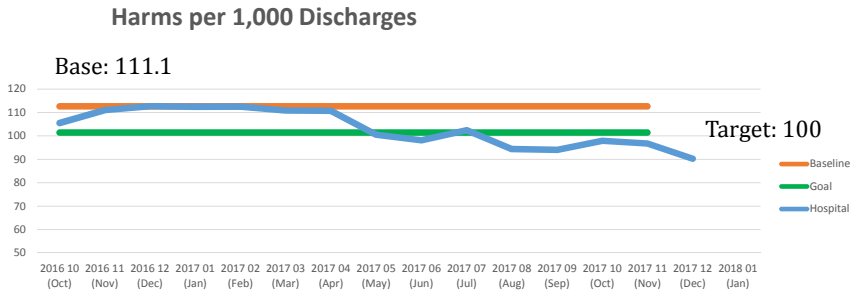
Kansas HIIN 2016-2018 Data Submission Schedule

Outcome & Process Measures for HACs occurring in:	Readmissions for index discharges in, and SSI for procedures performed in:	Submission Due
September, 2017	August, 2017	October 31, 2017
October, 2017	September, 2017	November 30, 2017
November, 2017	October, 2017	December 31, 2017
December, 2017	November, 2017	January 31, 2018
January, 2018	December, 2017	February 28, 2018
February, 2018	January, 2018	**March 31, 2018**
March, 2018	February, 2018	April 30, 2018
April, 2018	March, 2018	May 31, 2018
May, 2018	April, 2018	June 30, 2018
June, 2018	May, 2018	July 31, 2018

Preliminary Results HIIN Progress to date

Current Progress (as of Mar. 19)

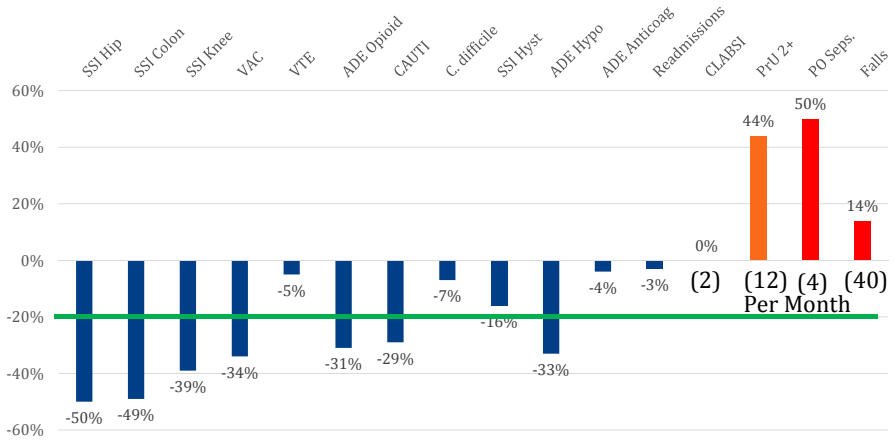
- Overall 10% Reduction in Harm!
- Saved 139 lives and $12,00,000!



HRET HIIN Improvement Calculator v4.3 on 03/19/2018

Preliminary Results KHC HIIN Progress to date

Percent Improvement Year-to-Date



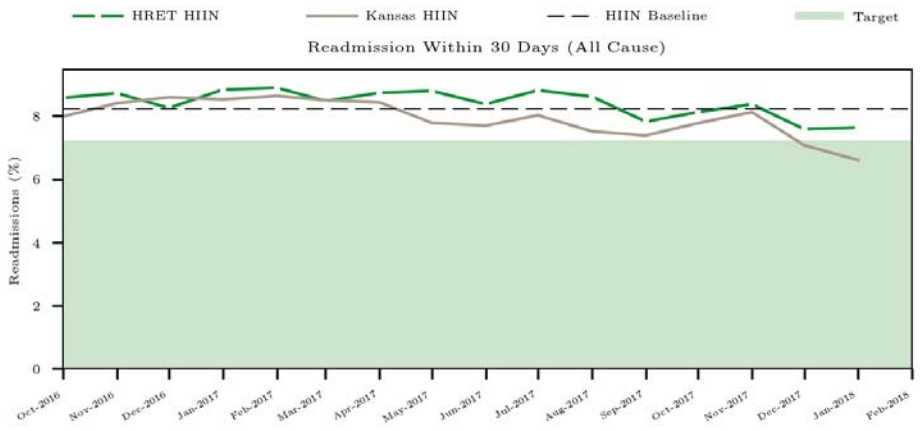
HRET HIIN Improvement Calculator v4.3 on 03/19/2018

KHC HIIN Focus Areas

KHC HIIN Currently…

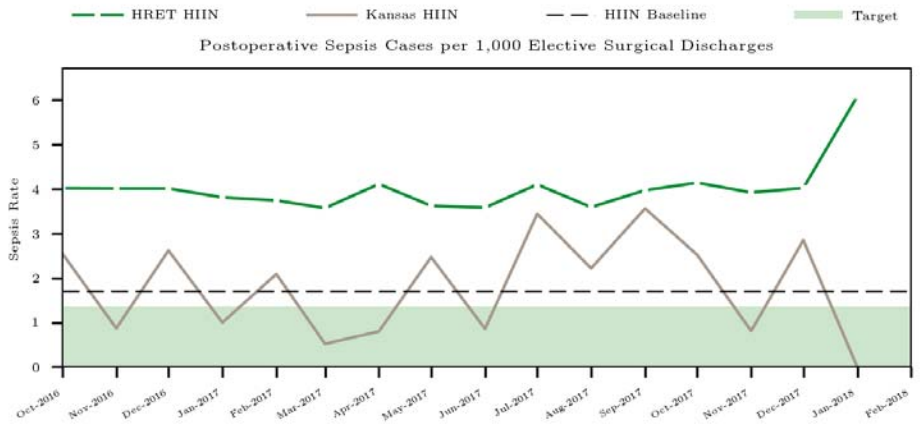
- **Readmissions** (Prevent 285/Mo.)
- **Post-Op Sepsis** (Prevent 4/Mo.)
- **CDI** (Prevent 14/Mo.)
- **Falls w/Injury** (Prevent 53/Mo.)

All-Cause Readmissions (Prevent 285/Mo.)



Preliminary Results KHC HIIN Progress to date

Post-Op Sepsis (Prevent 2/Mo.)



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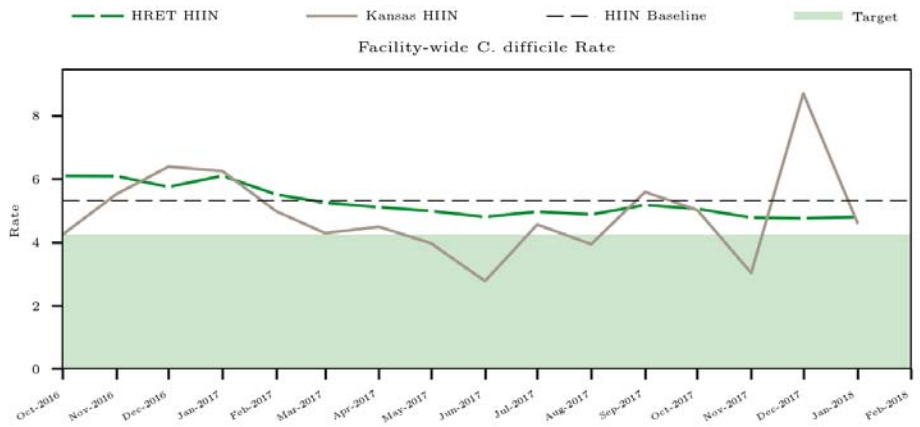
Preliminary Results KHC HIIN Progress to date

Hospital Onset *C. difficile* (Prevent 16/Mo.)



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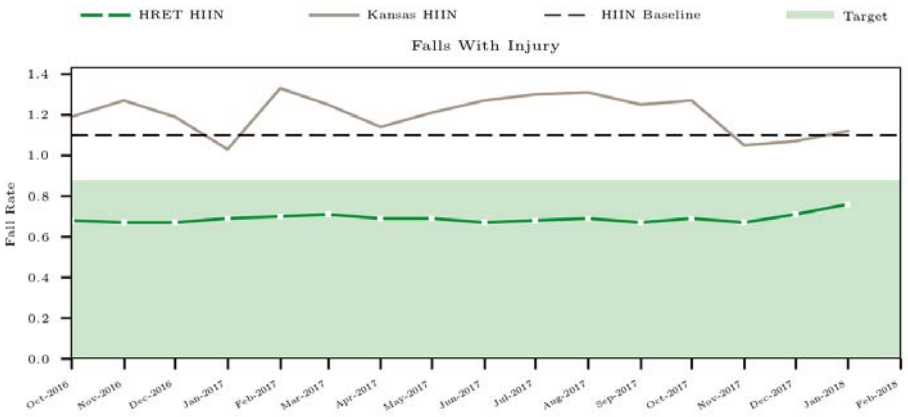
Falls with Injury (Prevent 53/Mo.)



Post Fall Management: Getting to Types of Falls, Repeat Falls, and Determining Preventability

Pat Quigley,PhD,MPH,ARNP,CRRN,FAAN,FAANP
Nurse Consultant
Retired Associate Director, VISN 8 Patient Safety Center
Retired Associate Chief for Nursing Service/Research

E-Mail: pquigley1@tampabay.rr.com

Objectives

- Examine post fall practices as key intervention to reduce repeat falls
- Differentiate:
  - Post Fall Huddles
  - Post Fall Management
  - Post Fall Documentation
  - Incident Report

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Let's Share!

- How do you know your fall prevention program is working?
- Can you affirm that patients who fall more than once are not falling for the same reason?
- How is your post fall program working?
- How do you measure success?

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Post Fall Practices

- Post Fall Huddle
- Post Fall Assessment
- Patient/Resident/Family Education
- Staff Education

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Huddles

How Many Huddles Are You Doing?

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Safety Huddles

- **Pre-Shift Huddles**
- **Post Fall Huddles**
- Conducted with the patient/resident where the fall occurred within 15 minutes of the fall
- Post Fall Analysis
  - What was different this time?
  - When
  - How
  - Why
  - Prevention: Protective Action Steps to Redesign the Plan of Care

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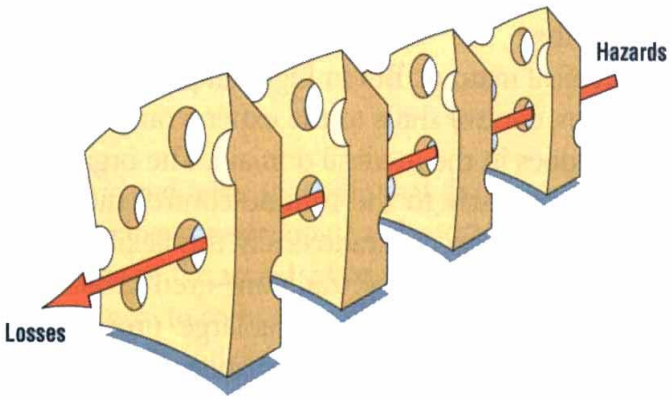
Accident Theory



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Post Fall Huddle (PFH): Essential Components

- A brief staff gathering, interdisciplinary when possible, that immediately follows a fall event.
- Convenes within 15 minutes of the fall event
- Clinician(s) responsible for patient/resident during fall event leads the PFH
- Involves the patient/resident whenever possible in the environment where the patient/resident fell
- Requires Group Think to discovery what happened.
- Utilizes discovery to determine the root cause / immediate cause of the fall: why the patient/resident fell.
- Guiding question to ask: **What was different this time you were doing this activity, compared to all the other times you performed the same activity (and did not fall), but this time you fell?**

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Steps to the Post Fall Huddle

1. TL makes announcement
2. Convene within 15 mins with the pt/resident in the environment where the patient/resident fell
3. Conduct Analysis: Determine root cause of fall, injury and Type of Fall
4. TL summarizes information gleaned from PFH and intervention(s) for prevention of repeat fall are decided by the huddle team.
5. TL completes of the Post-Fall Huddle Form and processes the form according to medical center policy and procedure.
6. Modifies the fall prevention plan of care to include interventions to prevent repeat fall
7. Communicate updated plan of care in patient/resident hand-off reports.
8. Complete EMR Post Fall Note

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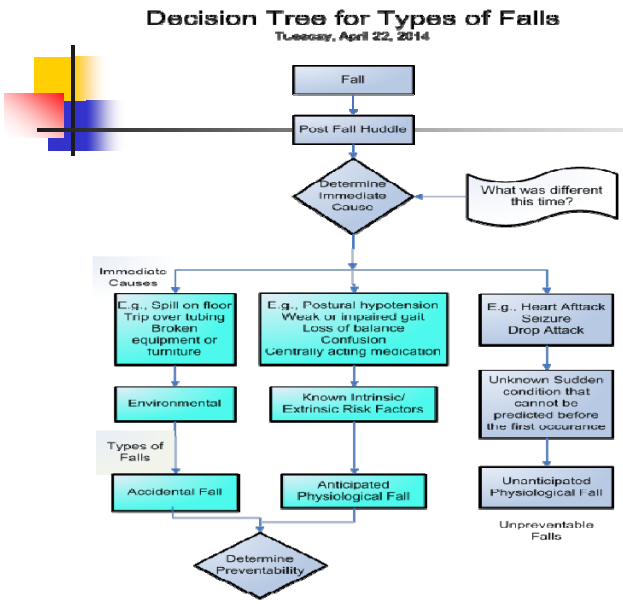

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Determine Preventability

Step 1: Conduct the Post Fall Huddle.

Step 2: Determine the Immediate Cause of the Fall.

Step 3: Determine the Type of Fall.

Step 4. If Accidental and Anticipated Physiological Falls, determine Preventability:

Could the care provider (direct care provider) have anticipated this event with the information available at the time?

- *If the Answer is **NO,** the fall is Not preventable.*
- *If the answer is **YES**, the provider must ask another question: Were appropriate precautions taken to prevent this event?*
- *Answer:*
  - *No, Clearly or likely Preventable;*
  - *Yes, Clearly or likely Unpreventable*

Levinson, D. R., (2010, Nov). Adverse events in hospitals: National incidence among Medicare beneficiaries. DHHS. OEI-06-09-00090

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Post Fall Huddle Form

- Don't Morph This Form to Be Something Else

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Outcomes of Post Fall Huddles

- Specify Root Cause (proximal cause)
- Specify Type of Fall
- Identify actions to prevent reoccurrence
- Changed Planned of Care
- Patient / Resident (family) involved in learning about the fall occurrence
- Prevent Repeat Fall
- Reduce Repeat Fall Rate

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Post Fall Huddle Resources

VA: Falls Toolkit

Post Fall Huddles

www.patientsafety.va.gov

AHRQ Falls Toolkit 2013

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Tools

- Post Fall Huddle Process
- Decision Tree
- Post Fall Huddle Form
- Determine Preventability
- Case Study Exercises

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Outcomes of Post Fall Huddles

- Specify Root Cause (proximal cause)
- Specify Root Cause of Injury
- Specify Type of Fall
- Identify actions to prevent reoccurrence
- Changed Planned of Care
- Patient/Resident (family) involved in learning about the fall occurrence
- Prevent Repeat Fall

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Formative Measures

- Structures:
  - Who attends: Nursing and others – Count them
  - Changed Plan of Care: Add actions to your run-chart: Annotated run chart; Capture interventions
- Processes:
  - Timeliness of Post Fall Huddle (number of minutes)
  - Timeliness of changing plan of care
  - Time to implemented changed plan of care

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Summative Outcome

- Prevent Repeat Fall: Same Root Cause and Same Type of Fall
- Reduce costs associated with falls and fall related injuries

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Post Fall Assessment

Different than a Huddle!

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Post Fall Assessment

- In-depth Data Gathering
- Circumstances of the Fall
- Patient/Resident Presentation
- Assessment of Patient/Resident Condition

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Comprehensive Post-Fall Assessment

Includes:

- General information about the fall
- Subjective & objective falls documentation
- Patient/Resident Assessment – vital signs; visible signs of injury (type & pain scores); glucometer (if diabetic or facility policy); Glasgow Scale (if suspected brain injury) and Morse Falls scale
- Interventions based on Fall Risk Scale/ Morse falls scale
- Facility personnel and family notification

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Post-Fall Assessment: History: Review of Systems

- Patient Symptoms to Elicit on History Linked to Risk Factors

Symptom	Fall Risk Factor
Visual disturbance (double vision, blurry vision, loss of vision)	Visual impairment?
Dizziness/lightheadedness	Orthostatic hypotension? Abnormal vital signs?
Leg weakness	Gait or balance instability?
Urinary urgency or frequency	Urinary incontinence?
Syncope/loss of consciousness	One or more chronic diseases

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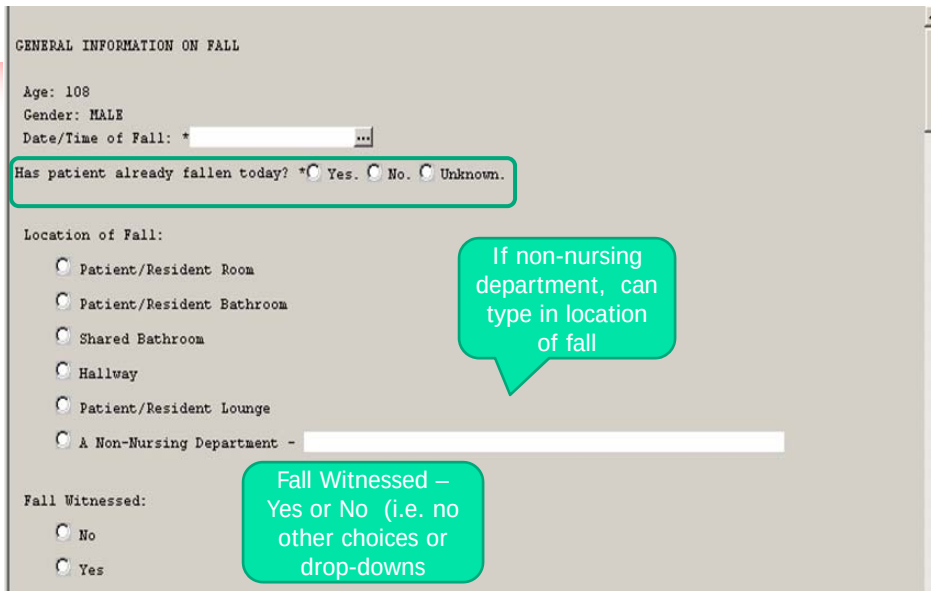
Post Fall Note (EMR)



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Gen Info

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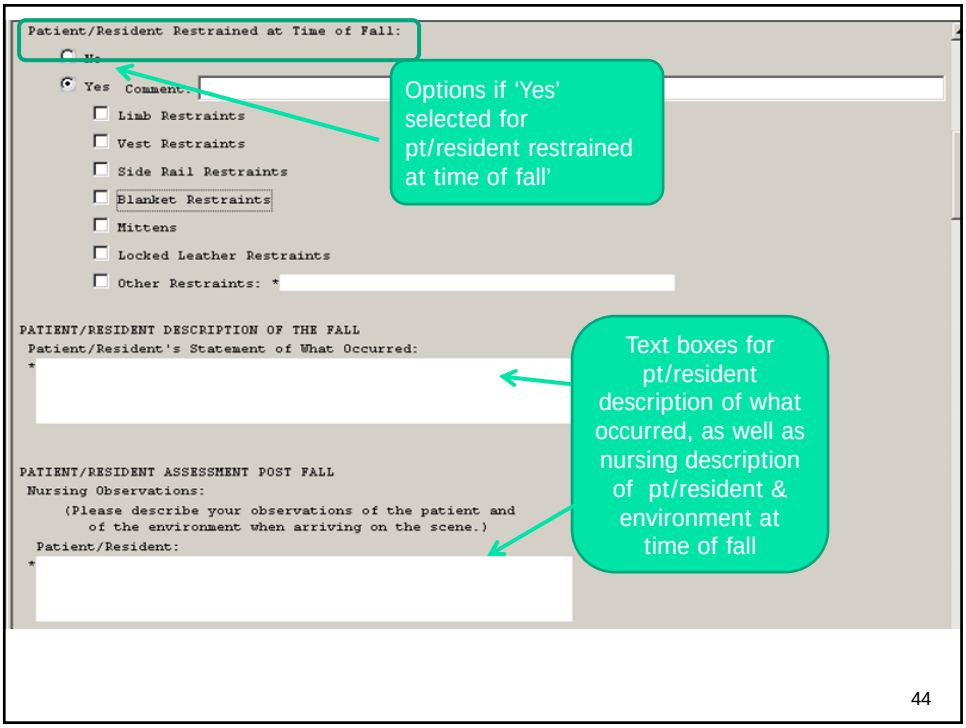

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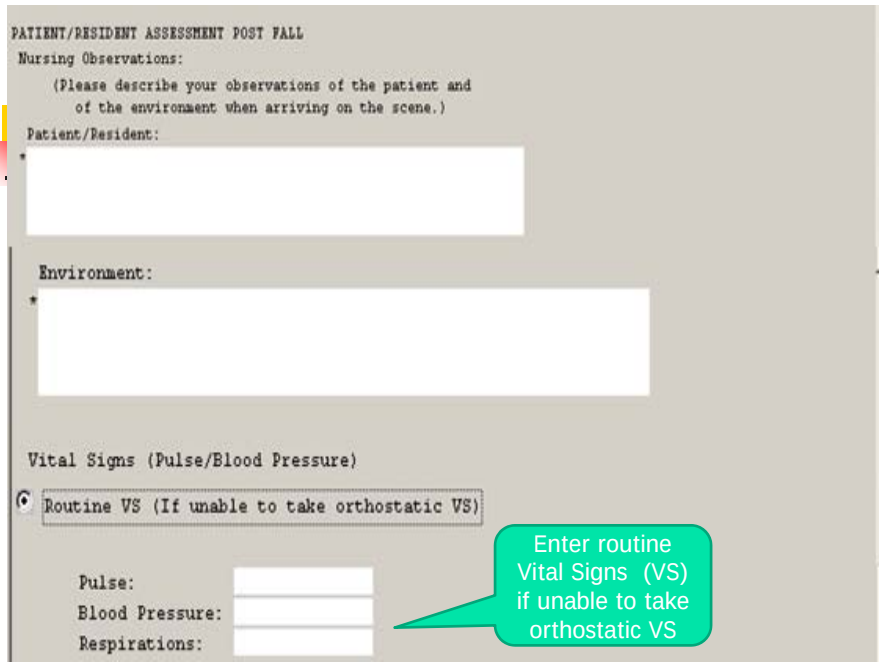
PATIENT/RESIDENT ASSESSMENT POST FALL
Nursing Observations:
(Please describe your observations of the patient and of the environment when arriving on the scene.)
Patient/Resident:
Environment:
Vital Signs (Pulse/Blood Pressure)
Routine VS (If unable to take orthostatic VS)
Pulse:
Blood Pressure:
Respirations:
Enter routine Vital Signs (VS) if unable to take orthostatic VS

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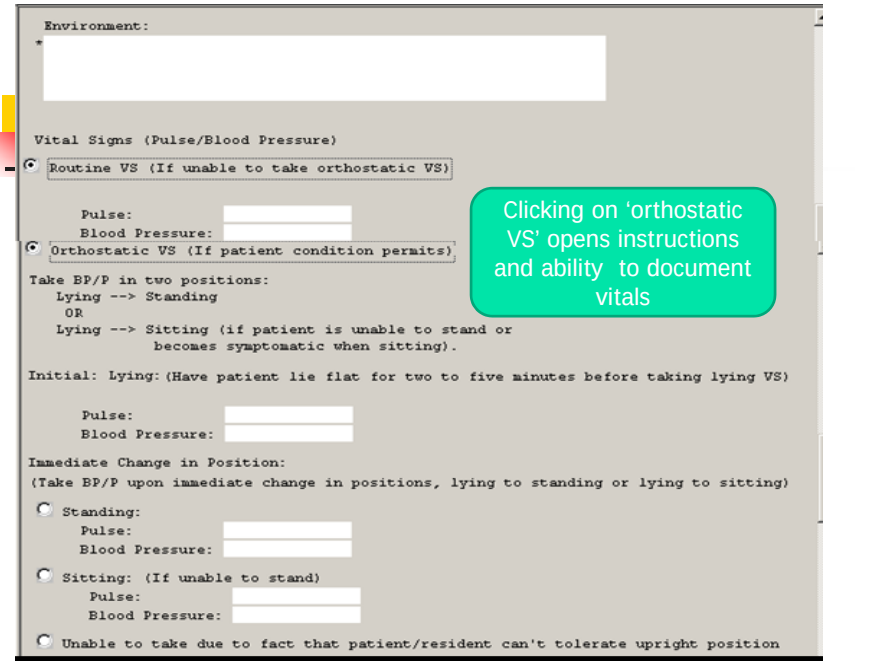
Environment:
Vital Signs (Pulse/Blood Pressure)
Routine VS (If unable to take orthostatic VS)
Pulse:
Blood Pressure:
Orthostatic VS (If patient condition permits)
Clicking on 'orthostatic VS' opens instructions and ability to document vitals
Take BP/P in two positions:
Lying --> Standing
OR
Lying --> Sitting (if patient is unable to stand or becomes symptomatic when sitting).
Initial: Lying: (Have patient lie flat for two to five minutes before taking lying VS)
Pulse:
Blood Pressure:
Immediate Change in Position:
(Take BP/P upon immediate change in positions, lying to standing or lying to sitting)
Standing:
Pulse:
Blood Pressure:
Sitting: (If unable to stand)
Pulse:
Blood Pressure:
Unable to take due to fact that patient/resident can't tolerate upright position

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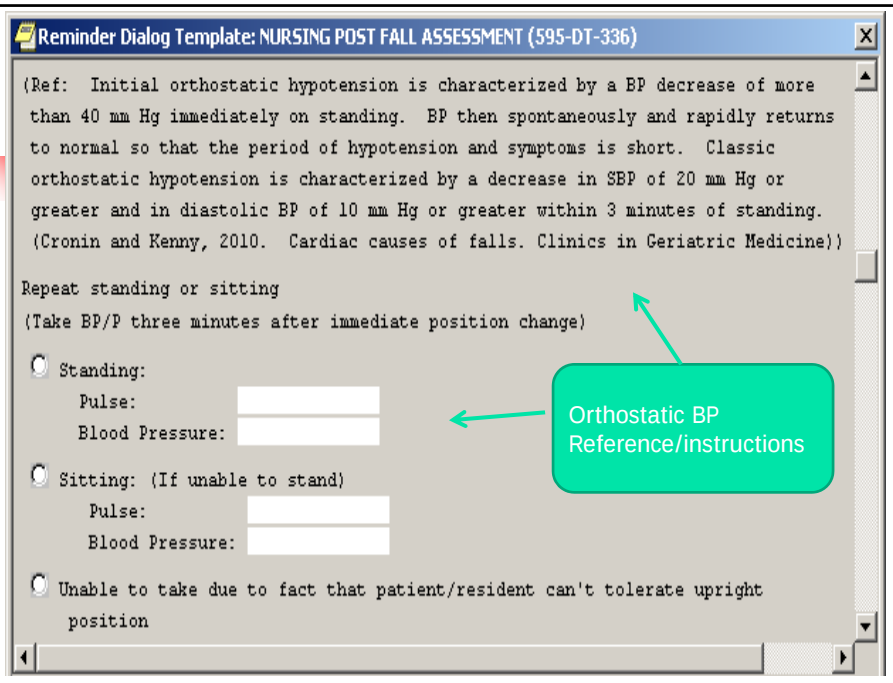
Reminder Dialog Template: NURSING POST FALL ASSESSMENT (595-DT-336)
(Ref: Initial orthostatic hypotension is characterized by a BP decrease of more than 40 mm Hg immediately on standing. BP then spontaneously and rapidly returns to normal so that the period of hypotension and symptoms is short. Classic orthostatic hypotension is characterized by a decrease in SBP of 20 mm Hg or greater and in diastolic BP of 10 mm Hg or greater within 3 minutes of standing. (Cronin and Kenny, 2010. Cardiac causes of falls. Clinics in Geriatric Medicine))
Repeat standing or sitting
(Take BP/P three minutes after immediate position change)
Standing:
Pulse:
Blood Pressure:
Sitting: (If unable to stand)
Pulse:
Blood Pressure:
Unable to take due to fact that patient/resident can't tolerate upright position
Orthostatic BP Reference/instructions

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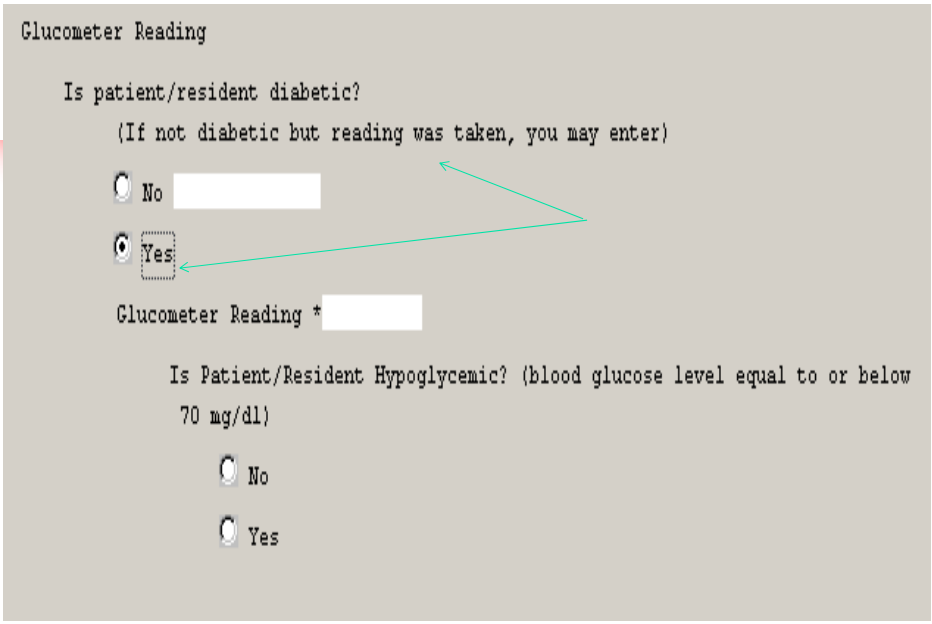
Glucometer Reading
Is patient/resident diabetic?
(If not diabetic but reading was taken, you may enter)
No
Yes
Glucometer Reading *
Is Patient/Resident Hypoglycemic? (blood glucose level equal to or below 70 mg/dl)
No
Yes

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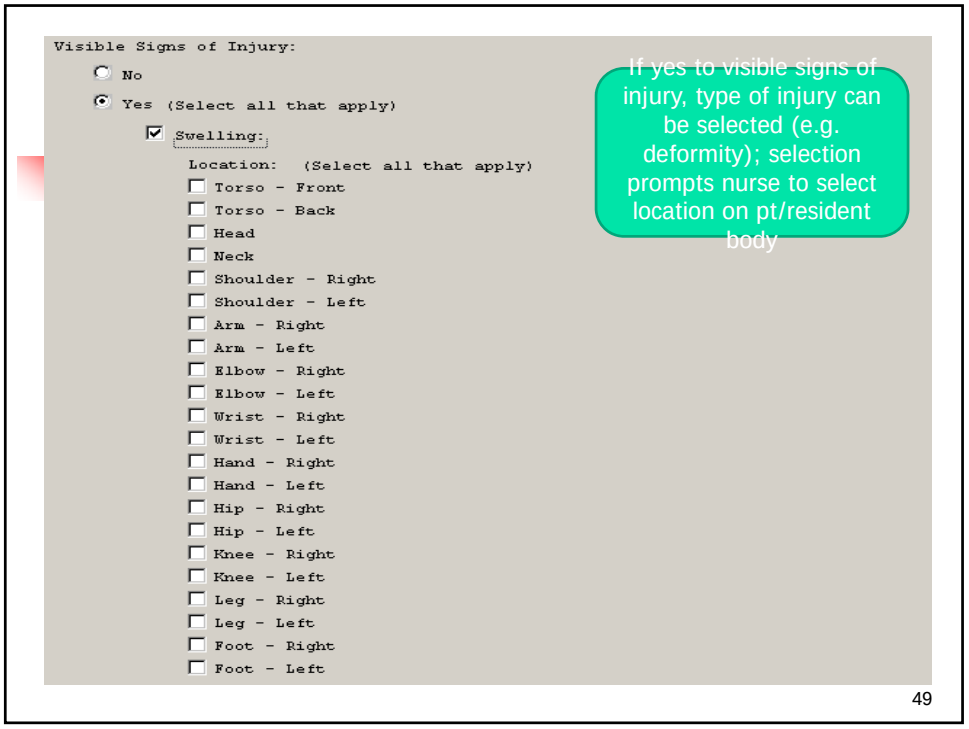
Visible Signs of Injury:
No
Yes (Select all that apply)
Swelling:
Location: (Select all that apply)
Torso - Front
Torso - Back
Head
Neck
Shoulder - Right
Shoulder - Left
Arm - Right
Arm - Left
Elbow - Right
Elbow - Left
Wrist - Right
Wrist - Left
Hand - Right
Hand - Left
Hip - Right
Hip - Left
Knee - Right
Knee - Left
Leg - Right
Leg - Left
Foot - Right
Foot - Left
If yes to visible signs of injury, type of injury can be selected (e.g. deformity); selection prompts nurse to select location on pt/resident body
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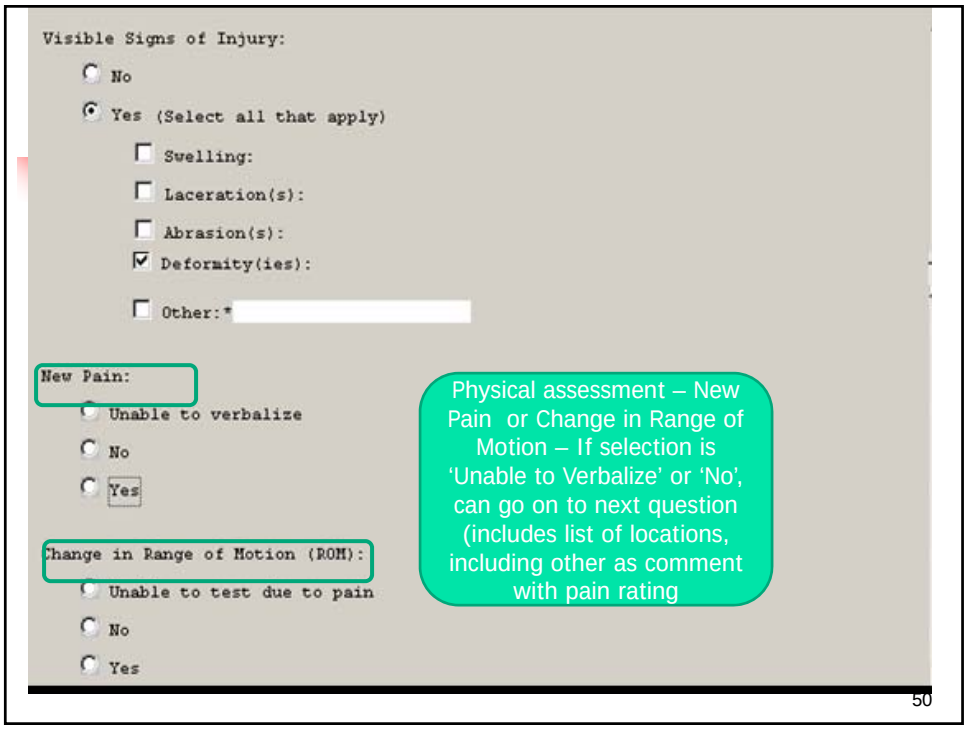
Visible Signs of Injury:
No
Yes (Select all that apply)
Swelling:
Laceration(s):
Abrasion(s):
Deformity(ies):
Other:*
New Pain:
Unable to verbalize
No
Yes
Change in Range of Motion (ROM):
Unable to test due to pain
No
Yes
Physical assessment – New Pain or Change in Range of Motion – If selection is 'Unable to Verbalize' or 'No', can go on to next question (includes list of locations, including other as comment with pain rating
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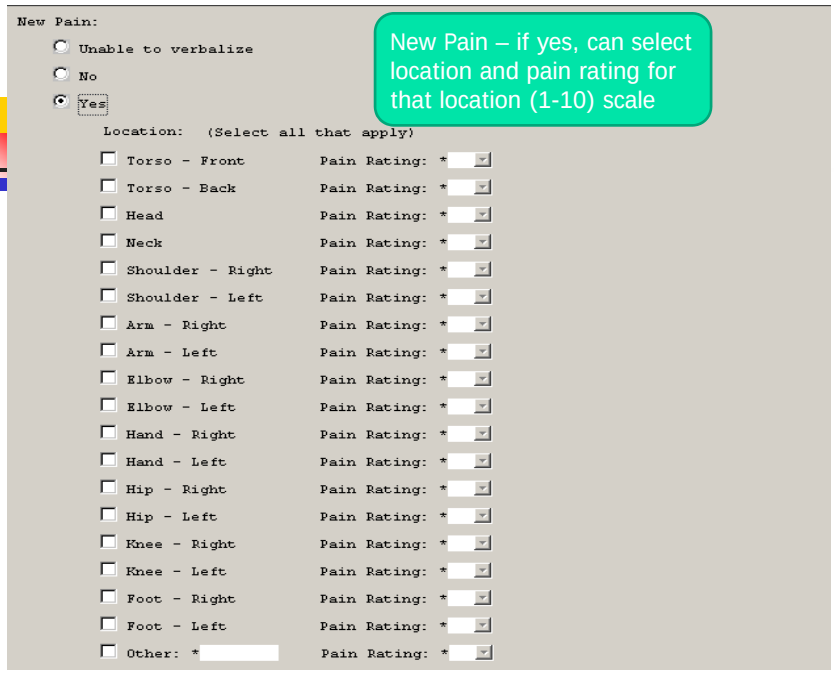
New Pain:
Unable to verbalize
No
Yes
Location: (Select all that apply)
Torso - Front Pain Rating: *
Torso - Back Pain Rating: *
Head Pain Rating: *
Neck Pain Rating: *
Shoulder - Right Pain Rating: *
Shoulder - Left Pain Rating: *
Arm - Right Pain Rating: *
Arm - Left Pain Rating: *
Elbow - Right Pain Rating: *
Elbow - Left Pain Rating: *
Hand - Right Pain Rating: *
Hand - Left Pain Rating: *
Hip - Right Pain Rating: *
Hip - Left Pain Rating: *
Knee - Right Pain Rating: *
Knee - Left Pain Rating: *
Foot - Right Pain Rating: *
Foot - Left Pain Rating: *
Other: * Pain Rating: *
New Pain – if yes, can select location and pain rating for that location (1-10) scale

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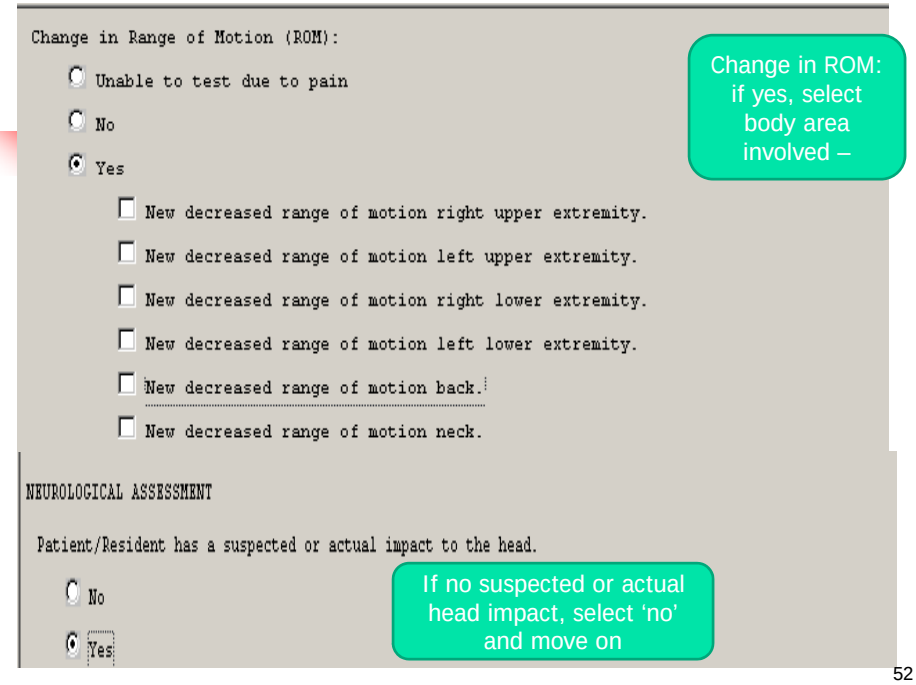
Change in Range of Motion (ROM):
Unable to test due to pain
No
Yes
New decreased range of motion right upper extremity.
New decreased range of motion left upper extremity.
New decreased range of motion right lower extremity.
New decreased range of motion left lower extremity.
New decreased range of motion back.
New decreased range of motion neck.
NEUROLOGICAL ASSESSMENT
Patient/Resident has a suspected or actual impact to the head.
No
Yes
Change in ROM: if yes, select body area involved –
If no suspected or actual head impact, select 'no' and move on

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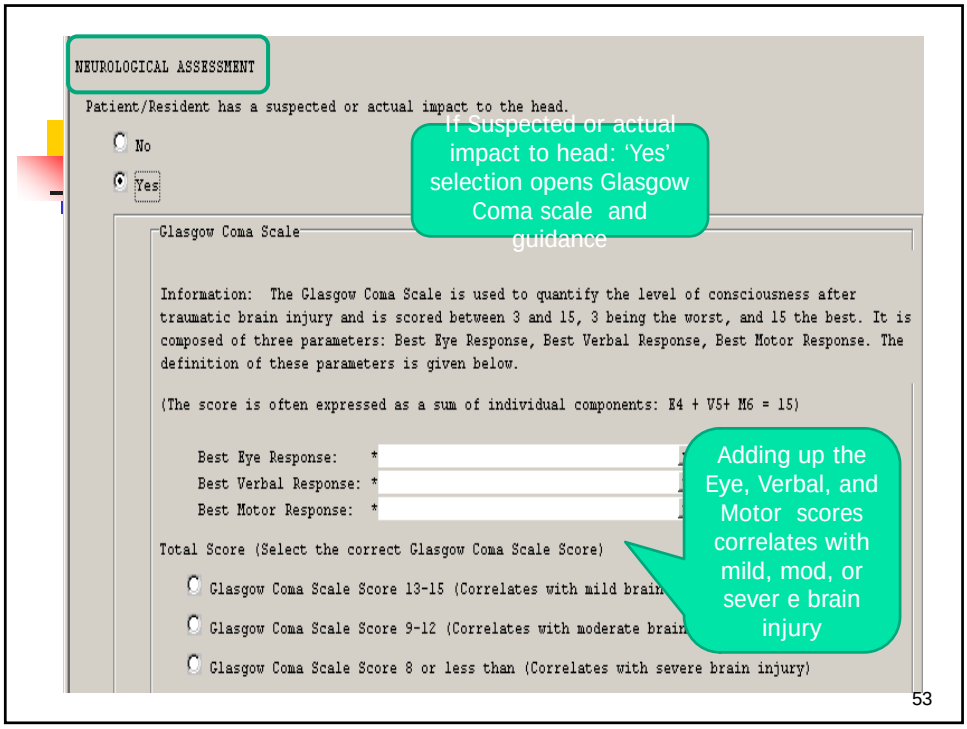
NEUROLOGICAL ASSESSMENT
Patient/Resident has a suspected or actual impact to the head.
No
Yes
If Suspected or actual impact to head: 'Yes' selection opens Glasgow Coma scale and guidance
Glasgow Coma Scale
Information: The Glasgow Coma Scale is used to quantify the level of consciousness after traumatic brain injury and is scored between 3 and 15, 3 being the worst, and 15 the best. It is composed of three parameters: Best Eye Response, Best Verbal Response, Best Motor Response. The definition of these parameters is given below.
(The score is often expressed as a sum of individual components: E4 + V5+ M6 = 15)
Best Eye Response: *
Best Verbal Response: *
Best Motor Response: *
Total Score (Select the correct Glasgow Coma Scale Score)
Glasgow Coma Scale Score 13-15 (Correlates with mild brain
Glasgow Coma Scale Score 9-12 (Correlates with moderate brain
Glasgow Coma Scale Score 8 or less than (Correlates with severe brain injury)
Adding up the Eye, Verbal, and Motor scores correlates with mild, mod, or sever e brain injury
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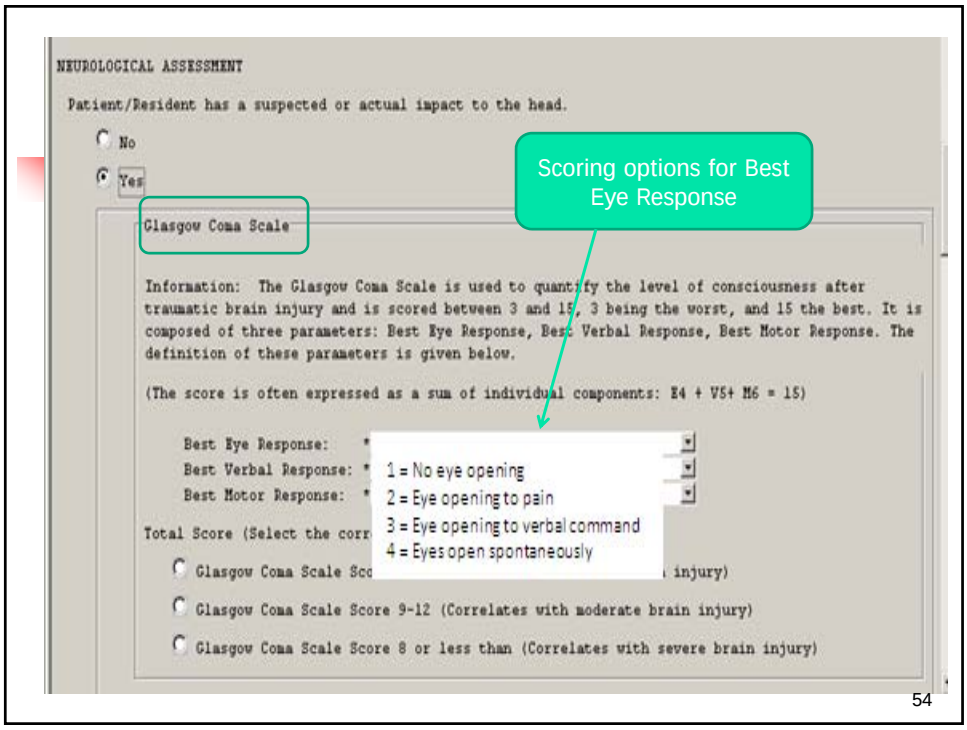
NEUROLOGICAL ASSESSMENT
Patient/Resident has a suspected or actual impact to the head.
No
Yes
Glasgow Coma Scale
Scoring options for Best Eye Response
Information: The Glasgow Coma Scale is used to quantify the level of consciousness after traumatic brain injury and is scored between 3 and 15, 3 being the worst, and 15 the best. It is composed of three parameters: Best Eye Response, Best Verbal Response, Best Motor Response. The definition of these parameters is given below.
(The score is often expressed as a sum of individual components: E4 + V5+ M6 = 15)
Best Eye Response: *
Best Verbal Response: *
Best Motor Response: *
1 = No eye opening
2 = Eye opening to pain
3 = Eye opening to verbal command
4 = Eyes open spontaneously
Total Score (Select the corr
Glasgow Coma Scale Sc injury)
Glasgow Coma Scale Score 9-12 (Correlates with moderate brain injury)
Glasgow Coma Scale Score 8 or less than (Correlates with severe brain injury)
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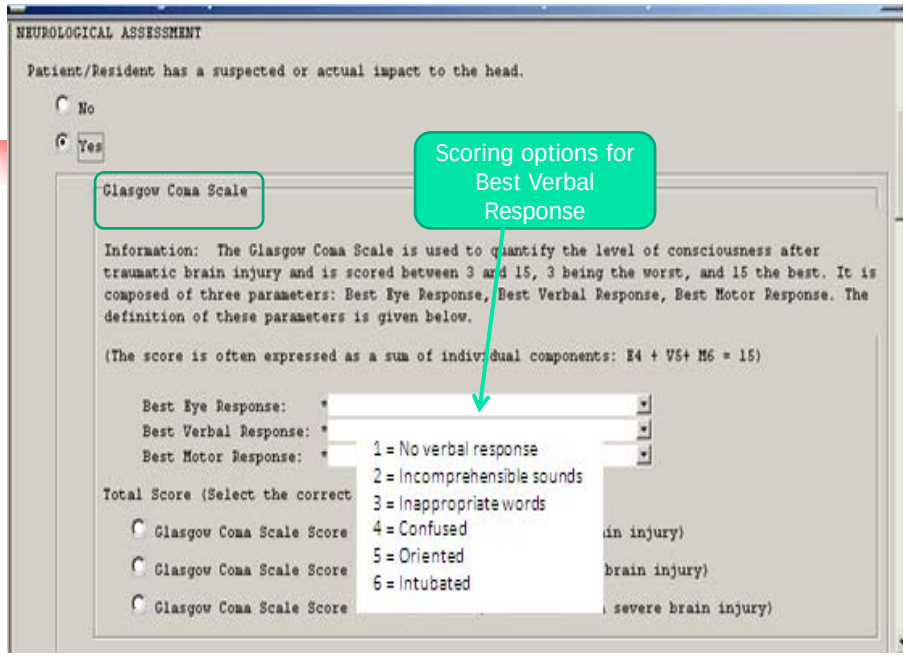
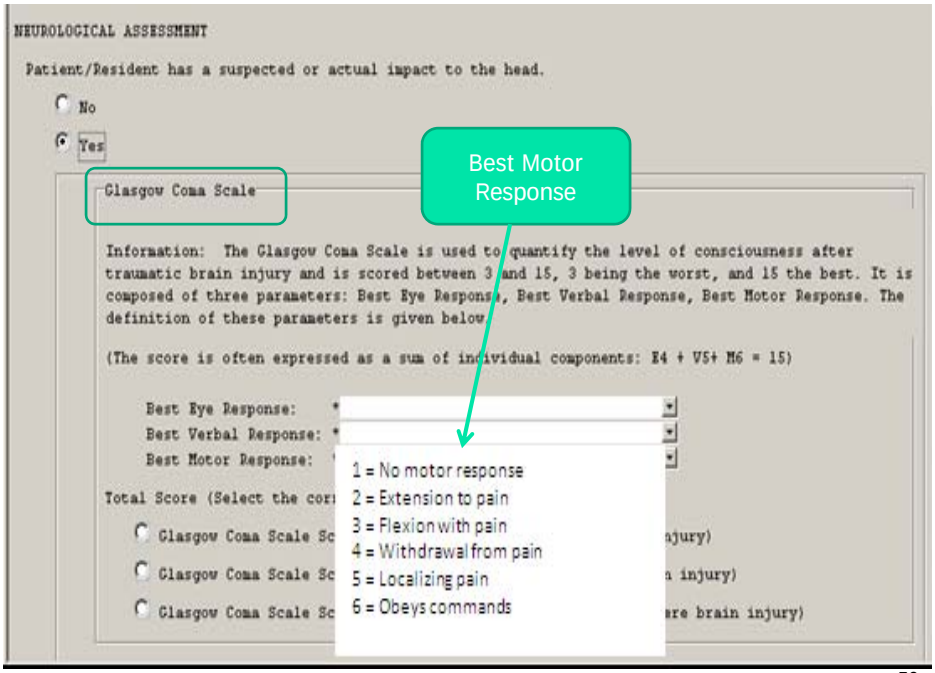
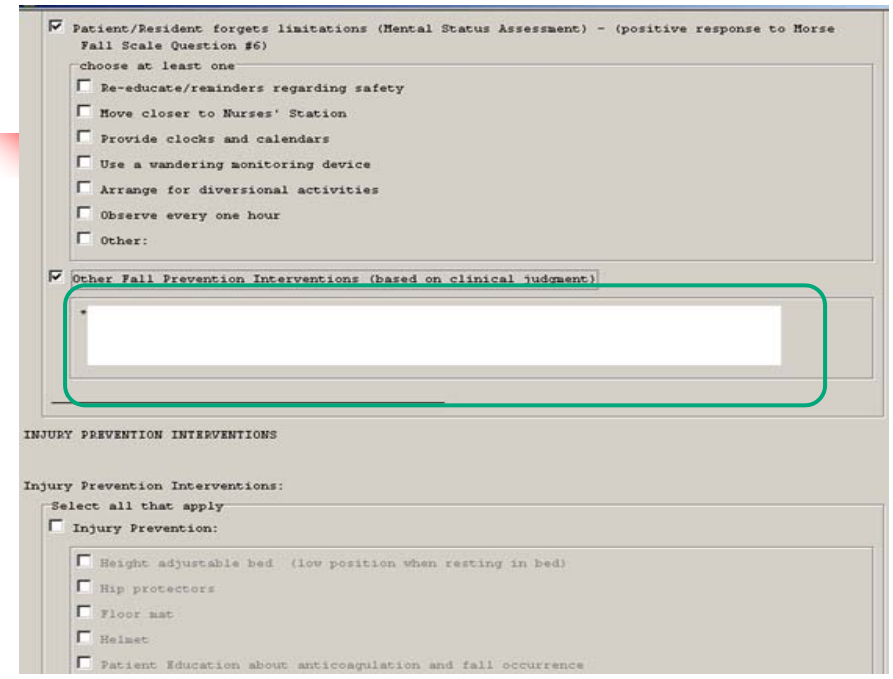

NEUROLOGICAL ASSESSMENT
Patient/Resident has a suspected or actual impact to the head.
No
Yes
Glasgow Coma Scale
Scoring options for Best Verbal Response
Information: The Glasgow Coma Scale is used to quantify the level of consciousness after traumatic brain injury and is scored between 3 and 15, 3 being the worst, and 15 the best. It is composed of three parameters: Best Eye Response, Best Verbal Response, Best Motor Response. The definition of these parameters is given below.
(The score is often expressed as a sum of individual components: E4 + V5+ M6 = 15)
Best Eye Response:
Best Verbal Response:
Best Motor Response:
1 = No verbal response
2 = Incomprehensible sounds
3 = Inappropriate words
4 = Confused
5 = Oriented
6 = Intubated
Total Score (Select the correct
Glasgow Coma Scale Score
Glasgow Coma Scale Score
Glasgow Coma Scale Score
severe brain injury)

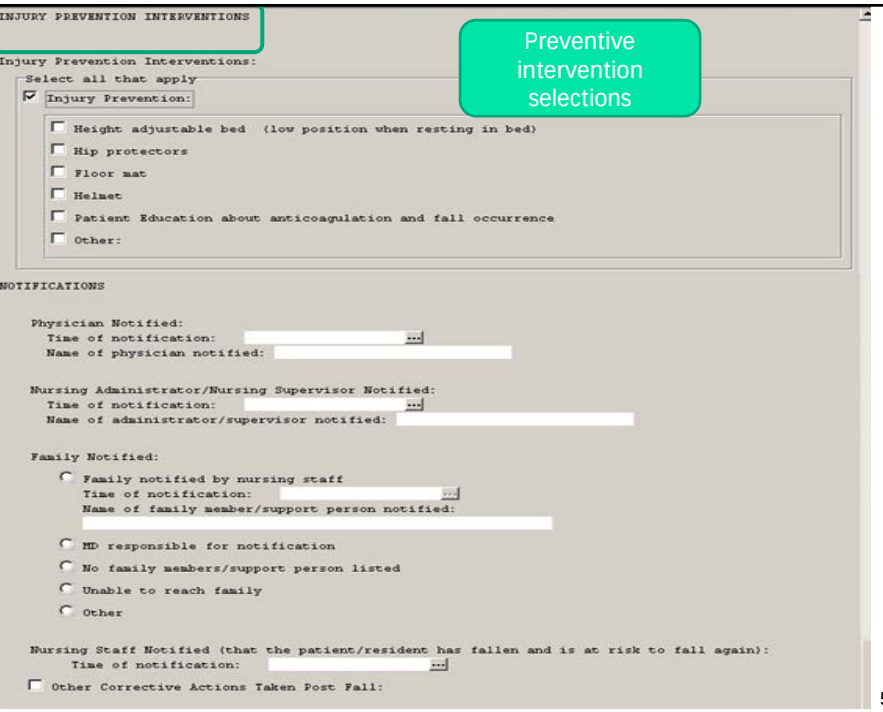
55


NEUROLOGICAL ASSESSMENT
Patient/Resident has a suspected or actual impact to the head.
No
Yes
Glasgow Coma Scale
Best Motor Response
Information: The Glasgow Coma Scale is used to quantify the level of consciousness after traumatic brain injury and is scored between 3 and 15, 3 being the worst, and 15 the best. It is composed of three parameters: Best Eye Response, Best Verbal Response, Best Motor Response. The definition of these parameters is given below.
(The score is often expressed as a sum of individual components: E4 + V5+ M6 = 15)
Best Eye Response:
Best Verbal Response:
Best Motor Response:
1 = No motor response
2 = Extension to pain
3 = Flexion with pain
4 = Withdrawal from pain
5 = Localizing pain
6 = Obeys commands
Total Score (Select the cor
Glasgow Coma Scale Sc
Glasgow Coma Scale Sc
Glasgow Coma Scale Sc
injury)
brain injury)

56


Patient/Resident forgets limitations (Mental Status Assessment) - (positive response to Morse Fall Scale Question #6)
choose at least one
Re-educate/reminders regarding safety
Move closer to Nurses' Station
Provide clocks and calendars
Use a wandering monitoring device
Arrange for diversional activities
Observe every one hour
Other:
Other Fall Prevention Interventions (based on clinical judgment)
INJURY PREVENTION INTERVENTIONS
Injury Prevention Interventions:
Select all that apply
Injury Prevention:
Height adjustable bed (low position when resting in bed)
Hip protectors
Floor mat
Helmet
Patient Education about anticoagulation and fall occurrence

57


INJURY PREVENTION INTERVENTIONS
Injury Prevention Interventions:
Select all that apply
Injury Prevention:
Height adjustable bed (low position when resting in bed)
Hip protectors
Floor mat
Helmet
Patient Education about anticoagulation and fall occurrence
Other:
Preventive intervention selections
NOTIFICATIONS
Physician Notified:
Time of notification:
Name of physician notified:
Nursing Administrator/Nursing Supervisor Notified:
Time of notification:
Name of administrator/supervisor notified:
Family Notified:
Family notified by nursing staff
Time of notification:
Name of family member/support person notified:
MD responsible for notification
No family members/support person listed
Unable to reach family
Other
Nursing Staff Notified (that the patient/resident has fallen and is at risk to fall again):
Time of notification:
Other Corrective Actions Taken Post Fall:

58

Teaching: After a Fall

- Reframe patient/resident education curricula to include "what happens after a fall".
- What can we learn from this event?
- How can we work together to prevent this again?

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Staff Education

- Universal Fall Prevention
- Individualized Fall Prevention
- Injury Reduction Strategies
- Root Cause Trends of Falls
- Interventions for Improvement
- Impact of Changes in Practices

60

You Can Always Reach Me!

- Patricia Quigley, PhD, MPH, ARNP, CRRN, FAAN, FAANP, Nurse Consultant
- pquigley1@tampabay.rr.com

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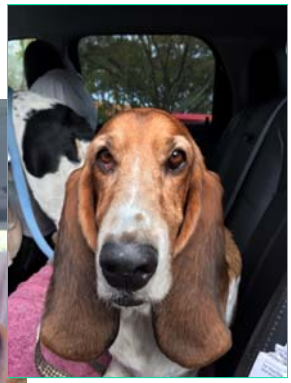
I Fall A lot! Why?

Jethro **Mr. Goober**

Oreo



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Resources & Upcoming Events

- Upcoming Events
- Wrap Up

Michele Clark
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May 15, 2018

Kansas Workshop: Hospital Antimicrobial Stewardship

Four Points by Sheraton
Manhattan, KS

A team-based, program-building workshop

- Bring your hospital ASP team
- Travel scholarships are available
- Registration is now open!

https://www.khconline.org/events/event-descriptions/326-kansas-asp-workshop

Kansas Department of Health and Environment
Healthcare-Associated Infections & Antimicrobial Resistance Program
Kansas Healthcare Collaborative

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Register Today
at www.khconline.org

10th Annual

Summit on Quality

May 4, 2018
Hyatt Regency - Wichita, KS

Kansas Healthcare Collaborative

KANSAS MEDICAL SOCIETY Established 1859 | kfmc Kansas Foundation for Medical Care, Inc. | Quality Improvement Organizations | Great Plains Quality Innovation Network

Keynote Presentations

Toward a More "Human Stewardship: The Sociology of Antimicrobial Prescribing

Julia Szymczak, PhD, assistant professor, Department of Biostatistics, Epidemiology and Informatics, Division of Infectious Diseases, Perelman School of Medicine, University of Pennsylvania

Pathways to Population and Community Health

Somova Stout, MD, MS, vice president, Institute for Healthcare Improvement; executive lead, 100 Million Healthier Lives

Upcoming HIIN Webinars

HRET HIIN: QI Improvement Fellowship Foundational Track
March 28 ● 11:00 p.m. to 12:00 p.m.
Register here

HRET HIIN: QI Improvement Fellowship Accelerating Track
March 28 ● 12:30 to 1:30 p.m.
Register here

PfP Pacing Event: Reducing Harm at Critical Access Hospitals
March 29 ● 12:00 to 1:00 p.m.
Register here

HRET HIIN: Reducing Sepsis Readmissions Fishbowl #1
April 10 ● 12:00 p.m. to 1:00 p.m.
Register here

Mark Your Calendars!

KHC HIIN Webinars
April 25, 2018
May 23, 2018

Save the Date!
KHC HIIN Sepsis Champion Workshop
June 27 (tentative)
Location TBA

Questions?

Contact your KHC Team

Please provide feedback to this webinar
Let us know your next steps.

https://www.surveymonkey.com/r/KHC-HIIN-032818

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March 28, 2018 Kansas Healthcare Collaborative 71