Rapid Fire Workshop:
Partnership for Patients Hot Topics

Moderated by Maulik Joshi,
President, HRET

Tuesday, December 11
1:30 PM – 2:45 PM

Session Agenda

<table>
<thead>
<tr>
<th>Time</th>
<th>Topic</th>
<th>Presenter</th>
</tr>
</thead>
<tbody>
<tr>
<td>1:30 PM – 1:40 PM</td>
<td>Introduction by Maulik Joshi</td>
<td></td>
</tr>
<tr>
<td>1:41 PM – 1:51 PM</td>
<td>Preventing Perinatal Harm</td>
<td>Sue Gullo, IHI</td>
</tr>
<tr>
<td>1:52 PM – 2:02 PM</td>
<td>Reducing Adverse Drug Events</td>
<td>Frank Federico, IHI</td>
</tr>
<tr>
<td>2:03 PM – 2:13 PM</td>
<td>Pressure Ulcer Prevention</td>
<td>Kathy Duncan, IHI</td>
</tr>
<tr>
<td>2:14 PM – 2:24 PM</td>
<td>Reducing Injury from Falls</td>
<td>Suzanne Rita, Iowa Health System</td>
</tr>
<tr>
<td>2:25 PM – 2:35 PM</td>
<td>Reducing Readmissions</td>
<td>Saranya Loehrer, IHI</td>
</tr>
<tr>
<td>2:36 PM – 2:45 PM</td>
<td>Wrap Up and Questions</td>
<td></td>
</tr>
</tbody>
</table>
Presentation 1: Preventing Perinatal Harm

Sue Gullo, RN, BSN, MS, Director, IHI

Hospital Acquired Conditions and Patient Safety in Hospitals

- Care Transitions
- Adverse Drug Events (ADE)
- Catheter-Associated Urinary Tract Infections (CAUTI)
- Central Line Associated Blood Stream Infections
- Injuries from Falls and Immobility
- Obstetrical Adverse Events
- Pressure Ulcers
- Surgical Site Infections (SSI)
- Ventilator-Associated Pneumonia (VAP)
- Venous Thromboembolism (VTE)
National Statistics

• 4.3 million births per year in the United States
• Care of childbearing women and their newborns was by far the most common reason for hospitalization ($98 billion)
• Six of the ten most common hospital procedures in 2008 were maternity-related
• In 2008, 41% of all maternal childbirth-related hospital stays were billed to Medicaid

http://www.childbirthconnection.org/article.asp?ck=10621
Induction of labor and cesarean delivery rates among late preterm births: United States, 1990-2006

Maternal Mortality In US, 2005-2007
Promoting Healthy Mothers and Healthy Babies

OPERATIONAL GOALS
1. Reduce elective deliveries prior to 39 weeks gestation to 5 percent or less
2. Reduce cesarean births among low-risk women to 15 percent or less

How-to Guide: Prevent Obstetrical Adverse Events

Prevent obstetrical adverse events by implementing the components of care recommended in this guide.

Copyright © 2012 Institute for Healthcare Improvement

http://www.ihi.org/knowledge/Pages/Tools/HowtoGuidePreventObstetricalAdverseEvents.aspx
Reliable Response to Fetal Heart Rate Interpretation

IHI Perinatal Improvement Community Bundle Sequencing

<table>
<thead>
<tr>
<th>Advanced Elective Induction Bundle</th>
<th>Advanced Indicated Induction Bundle</th>
<th>Advanced Augmentation Bundle</th>
<th>IHI Advanced Bundles (2010)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Defined: Patient without a medical indication for delivery between 39 and 40 weeks gestational age</td>
<td>Defined: Patient with a medical indication for induction</td>
<td>Defined: EPW documented</td>
<td>• Accept 39 weeks as minimal GA for elective delivery</td>
</tr>
<tr>
<td>GA ≥39 weeks</td>
<td>Acceptable medical indication for labor induction documented (locally defined)</td>
<td>Pelvic assessment</td>
<td>• Focus moves to pharmacologic or mechanical induction of labor — no longer focused on iud amnioncysis</td>
</tr>
<tr>
<td>Pelvic assessment: Favorable Bishop Score³ (locally defined)</td>
<td>Recognition and management of complications of induction method (including tachysystole)</td>
<td>Recognition and management of FHR status (Exclusion of NCHD Category III)</td>
<td>• Evidence-based gestational dating is core²</td>
</tr>
<tr>
<td>Recognition and management of complications of induction method (including tachysystole)</td>
<td>Recognition and management of FHR status (Exclusion of NCHD Category III)</td>
<td>(May include amniotomy, nipple stimulation, acupuncture, and capsaicin)</td>
<td>• Vaginal Bundle (2009)</td>
</tr>
</tbody>
</table>

IHI Elective Induction Bundles

<table>
<thead>
<tr>
<th>IHI Augmentation Bundle (2004)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Defined: Estimated fetal weight (EPW) documented</td>
</tr>
<tr>
<td>Pelvic assessment</td>
</tr>
<tr>
<td>Recognition and management of tachysystole</td>
</tr>
<tr>
<td>Recognition and management of FHR status (Exclusion of NCHD Category III)</td>
</tr>
</tbody>
</table>

IHI Oxytocin Bundles: Defined as patient who receives oxytocin for elective induction or augmentation. Focus on eliminating elective delivery prior to 39 weeks and reliable execution of component indicators.

Source: Elliot Hospital, Manchester, New Hampshire
Using Data for Improvement

- **PC-01 Elective Delivery**
  - Patients with elective vaginal deliveries or elective cesarean sections at >37 and <39 weeks of gestation completed

- **PC-02 Cesarean Section**
  - Nulliparous women with a term, singleton baby in a vertex position delivered by cesarean section

- **PC-03 Antenatal Steroids**
  - Patients at risk of preterm delivery at 24-32 weeks of gestation receiving antenatal steroids prior to delivering preterm newborns

- **PC-04 Healthcare-Associated Bloodstream Infections in Newborns**
  - Staphylococcal and Gram-negative septicemias or bacteremias in high-risk newborns

- **PC-05 Exclusive Breastmilk Feeding**
  - Exclusive breastmilk feeding during the newborn's entire hospitalization
  - Number of non-NICU term babies exclusively breastfed.

http://www.jointcommission.org/assets/1/6/Perinatal Care.pdf

---

Presentation 2:
Reducing Adverse Drug Events

Frank Federico, RPh, Executive Director, IHI
Principles of Medication Safety

- Prevent medication errors and harm
  - Use standardization and simplification
- Detection
  - Implement monitoring systems
- Mitigate
  - Prevent harm from the error or mitigate the harm patient experiencing

Terminology

Relationship between errors and adverse events and mortality
How-to Guide: Prevent Adverse Drug Events by Implementing Medication Reconciliation

Prevent adverse drug events (ADEs) by reliably implementing medication reconciliation at all transitions in care — admission, transfer, and discharge.

Copyright © 2011 Institute for Healthcare Improvement

All rights reserved. Individuals may photocopy these materials for educational, not-for-profit use, provided that the contents are not altered in any way and that proper attribution is given to IHI in the source of the content. These materials may not be reproduced for commercial, for-profit use in any form or by any means, or republished under any circumstances, without the written permission of the Institute for Healthcare Improvement.

How to cite this material:

How-to Guide: Prevent Harm from High-Alert Medications

Prevent harm from high-alert medications by implementing the changes in care recommended in this Guide.

Copyright © 2012 Institute for Healthcare Improvement

All rights reserved. Individuals may photocopy these materials for educational, not-for-profit use, provided that the contents are not altered in any way and that proper attribution is given to IHI in the source of the content. These materials may not be reproduced for commercial, for-profit use in any form or by any means, or republished under any circumstances, without the written permission of the Institute for Healthcare Improvement.
Minnesota Hospital Association
Road Map to a Medication Safety Program

Download the MHA “Road Map to a Medication Safety Program” and following components of the road map:
- Anticoagulation Agent Adverse Drug Event Gap Analysis
- Hypoglycemic Agent Adverse Drug Event Gap Analysis
- Call to Action – Opioid Adverse Drug Event Prevention Gap Analysis

Check back here soon for a tool kit and resources to guide you in your efforts.


High-Alert Medications

- Anticoagulants
  - Heparin, Warfarin
  - Newer anticoagulants- pose new safety risks
- Insulins
- Narcotics
Other Websites

- http://www.ahrq.gov/
- ASHP.org
The Partnership for Patients

- Nearly 3,000 hospitals committed to reducing medication harms from anticoagulation, hypoglycemic, and opioid agents
- Measures include:
  - Total number of INRs over 5.0 divided by number of patients on warfarin, or divided by 1,000 patient days;
  - Number of patients with BG's < 40 mg/dl divided by 1,000 patient days or divided by total number of BG readings; and
  - Total number of narcotic antagonists administered divided by total number of patients on opioids

Federal Interagency Task Group on ADEs

- Similar federal “work plan blueprint” as that used from 2008-2011 to reduce hospital acquired infections in US
- Charged with proposing ways to reduce unnecessary hospitalizations, such as easier-to-understand patient medication guides, care transition that helps patients understand and take their medications, coordination of electronic health records and e-prescribing.
- NIH, FDA, CMS, HRSA, VA, CDC and others
Presentation 3: Pressure Ulcer Prevention: The Goal is Zero
Kathy D. Duncan, RN, Clinical Faculty, IHI

Reducing Pressure Ulcers

For All Patients:
- Conduct a pressure ulcer admission assessment for all patients
- Reassess risk for all patients daily

   For High Risk Patients:
   - Inspect skin daily
   - Manage moisture – keep the patient dry and moisturize skin
   - Optimize nutrition and hydration
   - Minimize pressure
Conduct a Pressure Ulcer Admission Risk Assessment; Reassess Daily

- Use visual cues in admission documentation for completion of skin and risk assessment.
- Standardize risk assessment tool/checklist across the institution.
  - Incorporate action steps linked to risk.
- Use multiple methods to visually identify patients at risk.
  - Place stickers on chart, use visual cues on door and bed.
- Post compliance rates to motivate staff.
- Improve processes to ensure risk assessment is conducted within four hours of admission and reassess daily.
- Assess surgical patients.

Design for Reliability: Risk Assessment and Skin Assessment

- Independent Redundancies:
  - Admission queue on IT system if assessments not completed within 4 hours
  - Shift check for each admitted patient
  - IT system will not proceed without complete assessment
Inspect Skin Daily

- Daily skin inspection is required for high-risk patients.
- Skin integrity can deteriorate in a matter of hours.
  - Always look at sacrum, back, buttocks, heels, and elbows every time the patient is assessed.

Design for Reliability: Inspect Skin Daily

- Design Work, routine to include skin inspection
- Design documentation to include detailed skin inspection
- Make it hard NOT to complete skin inspection
- IT documentation, Cannot complete documentation without completed detailed
- Shift checks – walking report, multi-disciplinary rounds scripts
- Engage Families
Manage Moisture

- Cleanse skin at time of soiling and at routine intervals.
  - Watch for excessive moisture due to perspiration and wounds.
  - Use gentle cleansing agent.
- Use moisturizers for dry, fragile skin.
- Provide under-pads that wick moisture away from skin.
- Keep kit of needed supplies at bedside for at-risk incontinent patients.

Design for Reliability: Manage Moisture

- Design kit to be at the bedside of each at risk patient
  - To include supplies to clean patients quickly
  - Develop process for assuring kit is complete
- Develop Process for Hourly rounds
  - Utilize IT to remind staff of rounds, documentation
  - Use Audio or visual queues to remind staff of rounds.
- Everyone who enters the room can check the patient and assist the patient
- Engage Families
Optimize Nutrition/Hydration

- Respect patient’s dietary preferences.
- Involve dietician, use supplements as needed.
- Monitor hydration.
  - Offer water (when appropriate) whenever patient is turned.

Design for Reliability: Optimize Nutrition and Hydration

- Automatic Clinical Dietary Consult
- Strategy on care plan
- Develop Hourly Rounds
  - Offer water
- Measure I and O for each patient at risk
- Shift checks – walking report, multi-disciplinary rounds scripts,
- Consider visual clue for encouraging fluids
- Engage Families –
Minimize Pressure

- Turn/reposition patient at least every two hours.
  - Use alerts and cues to remind staff to turn patient.
  - Protect skin when turning patient (use lift devices or “drawsheets,” heel and elbow protectors, sleeves and stockings; do not “drag”).
- Use pillows and cushions strategically.
- Use static and/or dynamic pressure-relieving support surfaces.
  - Static surfaces include well-designed mattresses, mattress overlays filled with water, air, gel, foam, or a combination of these.
  - Dynamic surfaces include devices that vary pressure beneath the patient, reducing duration of pressure at any given skin site.

Design for Reliability: Minimize Pressure

- Design turn schedule
  - Design turn clock to be placed on door
  - Educate, expect all who enter to turn the patient according to the turn clock or schedule
- Develop hourly rounds:
  - Check patient
  - Offer water
  - Turn patient
  - Document
  - Utilize audio queue to remind staff of rounds (beepers, IT systems, etc)
- Engage Families
Tips for Sustaining Change

1. Set Aims and refer to them often
2. Rapid Cycle improvement cycles
3. Design Opportunities to get staff together (where the subject is the patient)
4. Expand your referral base
5. Structure framework for consistent information sharing
6. Design Independent Redundancies
7. Align Responsibilities
8. Seek Failure
9. Numbers Matter (compliance and outcome data)
10. Celebrate – Big and Often

Presentation 4:
Reducing Injuries From Falls

Suzanne Rita, RN, MSN, Iowa Health System
Reducing Injury from Falls

- Accidental – 14%
  - slips or trips
- Unanticipated – physiologic
- Anticipated – physiologic

TARGET*

Incidents of serious injuries from falls are reduced to 1 or less per 10,000 patient days.

*R IHI Transforming Care at the Bedside

**RISK OF INJURY FROM FALL**

<table>
<thead>
<tr>
<th>+ RISK FALL/- RISK INJURY</th>
<th>- RISK FALL/RISK INJURY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Traditional approach</td>
<td>Universal Fall risk precautions</td>
</tr>
<tr>
<td>Use existing protocols to prevent falls</td>
<td>Identify, communicate, and intervene when fall or injury risk changes.</td>
</tr>
</tbody>
</table>

**+ RISK FALL/+ RISK INJURY**

New area of focus

1. Use existing protocols to prevent falls
2. Add injury reduction interventions
3. Enhance communication: risk of injury

**- RISK FALL/+ RISK INJURY**

New area of focus

1. Identify, communicate, and intervene when fall risk changes
2. Implement injury reduction strategies
3. Enhance communication: risk of injury
Strategies: the Vital Few

- Screen risk for falling on admission
- Screen fall-related injury risk factors and history upon admission
- Assess multifactorial risk of anticipated physiological falling and risk for a serious or major injury from a fall
- Communicate and educate about patients’ fall and injury risks
- Standardize interventions
- Customize interventions

www.ihi.org IHI’s TCAB How to Guide: Reducing Patient Injuries from Falls
The Improvement Map – Fall Prevention

Fall Injury Assessment Tool: ABCS

- A: Age- >85
- B: Bones: History of fractures- Hip (although multiple fx could be a sign); Certain Diagnoses- (osteoporosis, bone metastasis); Treatments or medications that cause bone to be weak
- C: Coagulation: Blood Thinners(coumadin, heparin gtt); Coagulopathy
- S: Risk of surgical complications post surgery (Recent Abdominal, thoracic surgery, lower limb amputation)

Post Fall Huddles

As soon after the event as possible set up a meeting to debrief with everyone involved.

- Have a key point person to lead these at each shift
- Review within the same shift for most powerful learning
- Include patient and family whenever possible
- Ask “5 whys” to better understand the root cause of the fall

Teach-back

- Explain needed information to the patient or family caregiver
- Ask in a non-shaming way for the individual to explain in his or her own words what was understood
- Once a gap in understanding is identified, offer additional teaching or explanation followed by a second request for Teach-back
- www.teachbacktraining.com
Environmental Rounding Checklist

- Patient Bedroom
- Patient Bathroom
- Unit Corridors

Basics of Focused Rounding

- 5 Ps
  - Pain
  - Potty
  - Position
  - Personal belongings
  - Pathway – Safe exit
Quick Check in LTC

HIGH RISK TO INJURY PATIENTS
Check every 30 minutes

WHEN TO REMOVE
- The resident is no longer at risk related to a decline in mobility or increase in ability
- Acute illness or medical condition is resolved
- A change in behavior indicating an understanding of call light use and the need to call for help

Environmental Adaptation: Safe Exit

- Create a safe exit to the bathroom for the patient
- “What side of the bed do you get out of at home?"...if possible, create this as the safe exit side
- Visual cue to identify safe exit side
- Furniture placement:
  - IV pole on exit side
  - Bedside table, personal belongings on opposite side
THANK YOU

Presentation 5: Reducing Readmissions

Saranya Loehrer, MD, Director, IHI
Patient and Family Engagement

Cross-Continuum Team Collaboration

Health Information Exchange and Shared Care Plans

Alternative or Supplemental Care for High-Risk Patients

The Transitional Care Model (TCM)

Comprehensive Discharge Planning
With Post-Discharge Support for Older Patients With Congestive Heart Failure

Key Design Elements

Transition from Hospital to Home or other Care Setting

Transition to Community Care Settings
The Secret Sauce: Cross-Continuum Teams

- Comprised of acute and post-acute care partnerships to co-design care transitions
- Emphasize that readmissions are not solely a hospital problem and require a community driven solution
- Have built the foundation for many care settings participating in the CCTP, ACO development and Patient Centered Medical Homes

How-to Guide: “Hospital to Home”

Perform an enhanced assessment of post-hospital needs
Provide effective teaching and facilitate enhanced learning
Ensure post-hospital care follow up
Provide real time handover communications
Diagnostic Reviews

How-to Guide: Hospital to SNF

Ensure that SNF staff are ready and capable to care for the resident

Reconcile the treatment plan and medication list

Engage the resident and their family caregivers in a partnership to create an overall plan of care
How-to Guides: Hospital to Office Practices and Home Health

### How-to Guide: Improving Transitions from the Hospital to the Clinical Office Practice to Reduce Avoidable Rehospitalizations

Support for the How-to Guide was provided by a grant from The Commonwealth Fund.

- **State Action on Avoidable Rehospitalizations**
- **How-to Guide**: Improving Transitions from the Hospital to the Clinical Office Practice to Reduce Avoidable Rehospitalizations

---

### How-to Guide: Improving Transitions from the Hospital to Home Health Care to Reduce Avoidable Rehospitalizations

Support for the How-to Guide was provided by a grant from The Commonwealth Fund.

- **State Action on Avoidable Rehospitalizations**
- **How-to Guide**: Improving Transitions from the Hospital to Home Health Care to Reduce Avoidable Rehospitalizations

---

<table>
<thead>
<tr>
<th>Observation Guide: Observing Current Processes for an Intake Assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Observe three intake assessments as they are currently done by nurses and physicians. Reflect upon what you observed to identify strengths and weaknesses and areas for improvement.</td>
</tr>
<tr>
<td>What do you predict you will observe?</td>
</tr>
<tr>
<td>Did the care team member(s)...</td>
</tr>
<tr>
<td>Did the resident and family members about their goals and concerns during their stay?</td>
</tr>
<tr>
<td>Ask the resident and family members about their goals and concerns during their stay.</td>
</tr>
<tr>
<td>Did the resident and family members about their completion of the residents’ ongoing care plan during their stay and what they go home?</td>
</tr>
<tr>
<td>Complete the medication reconciliation process?</td>
</tr>
<tr>
<td>Assess the resident’s physical and psychological status?</td>
</tr>
</tbody>
</table>

---

<table>
<thead>
<tr>
<th>Patient #1</th>
<th>Patient #2</th>
<th>Patient #3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
</tbody>
</table>

---

<table>
<thead>
<tr>
<th>Observation Guide: Observing Current Processes for an Intake Assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Observe three intake assessments as they are currently done by nurses and physicians. Reflect upon what you observed to identify strengths and weaknesses and areas for improvement.</td>
</tr>
<tr>
<td>What do you predict you will observe?</td>
</tr>
<tr>
<td>Did the care team member(s)...</td>
</tr>
<tr>
<td>Did the resident and family members about their goals and concerns during their stay?</td>
</tr>
<tr>
<td>Ask the resident and family members about their goals and concerns during their stay.</td>
</tr>
<tr>
<td>Did the resident and family members about their completion of the residents’ ongoing care plan during their stay and what they go home?</td>
</tr>
<tr>
<td>Complete the medication reconciliation process?</td>
</tr>
<tr>
<td>Assess the resident’s physical and psychological status?</td>
</tr>
</tbody>
</table>

---

<table>
<thead>
<tr>
<th>Patient #1</th>
<th>Patient #2</th>
<th>Patient #3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
</tbody>
</table>
A note about measures…

Thank You!

Please feel free to contact me:

Saranya Loehrre
sloehrre@ihi.org
617.301.4832
www.ihi.org/staar