Falls Improvement Action Network

IN-PERSON WORKSHOP
MAY 17, 2018

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PARTNERS FOR PATIENTS

Illinois | Michigan | Wisconsin
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Accelerating Improvement at the Point of Care

Goals for Today

- Take another dive into clinical falls content

- Evaluate your identified process gaps to create individualized, concrete next steps to improve your approach to preventing injuries from falls and immobility.

- Learn how to use several performance improvement tools to quickly identify drivers for improvement

Agenda

- Introductions
- **Preventing Harm from Falls and Immobility**
  - *Jackie Conrad, RN, MBA; Cynosure Health*
- Break
- Improvement Workshop
  - *Developing an Aim Statement*
  - *Driver Diagrams as a Plan for Change*
- Final Thoughts

Who's here?

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Preventing Harm from Falls <u>AND</u> Immobility
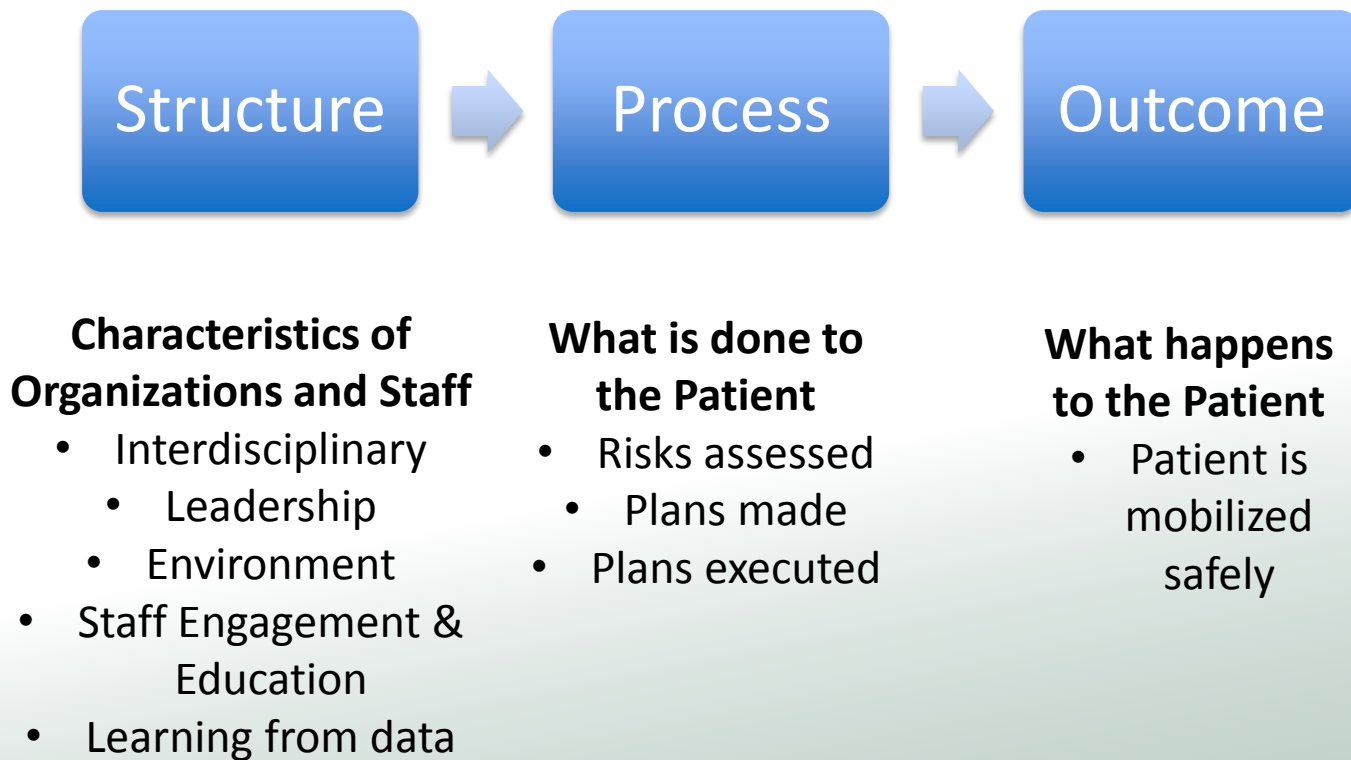
JACKIE CONRAD RN, MBA, RCC™
CYNOSURE HEALTH

Lets start where we are

Donabedian's Quality Framework

Structure → **Process** → **Outcome**

Characteristics of Organizations and Staff
- Interdisciplinary
- Leadership
- Environment
- Staff Engagement & Education
- Learning from data

What is done to the Patient
- Risks assessed
- Plans made
- Plans executed

What happens to the Patient
- Patient is mobilized safely

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Structure
Gap Analysis Results

- **Interdisciplinary Team**
  - 82% Interdisciplinary
  - 21% have MD
  - 71% Rehab
  - 44% Facilities
  - 12% Dietary
  - 21% Patient Representative

- **Learning from Data**
  - 91% Analyzing data for trends
  - 97% Sharing falls in daily safety briefings with leadership

- **Education**
  - 97% Annual fall education
  - 76% Nursing staff trained annually on safe mobility
  - 85% PT able to eval / treat high risk pts

Process
Gap Analysis Results

- **Fall risk assessed**
  - 100% On admission
  - 92% Every shift
  - 97% After fall
  - 77% Change in condition
  - 44% are capturing anti-thrombotic use as part of injury risk assessment

- **Injury Risk Assessment – ABCS**

- **Fall Risk Communicated**
  - 94% At handoff
  - 100% Visual cues
  - 94% Huddles
  - 88% Across departments
  - 91% To patient & family

Process
Gap Analysis Results

- **94% Hourly Rounding**
  - 42% can escalate to q15 min
  - 76% validate rounding

- **88% Arms length in toilet for high risk**

- **Strategies utilized**
  - 88% Keeping pts safe in bed
  - 97% Bed alarms
  - 79% sitters

This was not meant to be a trick question

Process
Gap Analysis Results

- Post fall huddles

  - 58% at bedside with patient

  - 82% Response team or leader attends huddle

- Mobility Interventions

  - 67% Gait belts in every room

  - 94% Access to equip 24/7

  - 85% PT able to treat HR pts

  - 76% Nursing staff trained annually on safe mobility

  - 91% Nurses have a standard to evaluate mobility status

Process
Gap Analysis Results

- ## Medication Risk

  – 70% Pharmacist review of HR pts meds

  – 33% Post fall review

  – 52% Ambien limited

  – 12% Post fall procedure for patients on anti-thrombotics

- ## PFE

  – 88% Bedside handoffs

  – 79% Falls prevention included

  – 61% Structured education

Let's Get Started!

- Moving beyond a score – tailoring care
- Prevent and manage delirium
- Safe mobility
- Reducing medication risks
- Engaging patients and families

- Expanding the team
- Injury Risk
- Post fall care for anti-thrombotics
- Post fall huddles at bedside
- What else?

Topic #1: What's in a score?

15

30

45

25

20

10

Item	Scale		Scoring
1. History of falling; immediate or within 3 months	No Yes	0 25	_____
2. Secondary diagnosis	No Yes	0 15	_____
3. Ambulatory aid Bed rest/nurse assist Crutches/cane/walker Furniture		0 15 30	_____
4. IV/Heparin Lock	No Yes	0 20	_____
5. Gait/Transferring Normal/bedrest/immobile Weak Impaired		0 10 20	_____
6. Mental status Oriented to own ability Forgets limitations		0 15	_____

0-24 - Low Risk   25-44 – Medium Risk   45 + - High Risk

Risk Screening Facts

- We over rely on a risk score

- It is pointless to identify fall risk factors unless interventions to reduce and manage them are planned and implemented

- A risk screening is not an intervention

- Not all screening tools perform equally well in different settings

- Isn't everyone is at risk for fall when in the hospital?

GAP ALERT:
Do you determine a fall plan based upon a
high, med or low risk score?

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Universal Bundle

Addresses Accidental Falls

- Call light and possessions in reach
- Clear Pathway
- Address tethers – remove asap
- Non-skid footwear
- Safe exit from bed, top side rails up
- Patient family education with teach back

GAP ALERT:
Do you monitor elements of your universal bundle?

Can we do better?

Identify your high risk or vulnerable populations that will receive a multifactorial assessment. For example:

- Admitted for a fall

- History of a fall

- Age based to capture elders

- Risk for injury

GAP ALERT:
Do you do anything special for a patient admitted for an injury from a fall?

A	Age > 85
B	Bones – history of fracture, bone disease, osteoporosis
C	Coagulation – on blood thinners or bleeding disorder
S	Surgery within current episode of care

GAP ALERT:
Do you screen for injury risk?

From Screening to Assessing

Risk Factor	Assessment
Mobility or Gait Disturbance	• [Get up and Go Test](#) – to assess ambulation on admission and screen for rehab eval. • [BMAT: Banner Mobility Assessment Tool for Nurses](#) - for nurse driven progressive mobility • **Rehab Evaluation**
Mental Status	• [bCAM - Brief Confusion Assessment Method](#) – for all patients over 65 or your vulnerable population
Medications: analgesics, hypnotics, antipsychotics, anticonvulsants, antidepressants, HTN or cardiac meds, diuretics	• [British Geriatric Society: Medicines and Falls in the Hospital Guidance Sheet](#) • [AHRQ Medication Fall Risk Screening Tool](#)
Postural Hypotension	• [Assess orthostatic blood pressure](#) to identify postural hypotension for elders, or your vulnerable population or patients on cardiac or HTN medications

Provide in-depth assessment based upon individual risk factors or for your "vulnerable" population.

Sample Multifactorial Risk Assessment & Care Plan

Risk factor (Tick if applicable, then link with recommended actions)	Recommended actions (Select appropriate interventions and record in care plan)

4. Medication:
☐ Is the resident taking 4 or more medications?
 	
☐ Is the resident taking any of the following?
  – Sedatives
  – Anti-depressants
  – Anti-Parkinson's
  – Diuretics (water tablets)
  – Anti-psychotics
  – Anti-coagulants
  – Anti-hypertensives
	a. Check medications have been reviewed with respect to falls risk (within the last 12 months is good practice).
	b. Report side-effects/symptoms of medication to GP.
	c. Read patient information leaflet which comes with the medication or speak to local pharmacist for information on medication side effects and interactions.
	d. Anticipate side-effects and take appropriate measures:
	  – Sedatives: toilet and prepare for bed before giving night sedation. Monitor at all times, but especially overnight and supervise in the morning.
	  – Anti-psychotics: can cause sedation, postural hypotension and impaired balance. Anticipate and compensate and report to GP.
	  – Inform GP if the resident is excessively drowsy or mobility has deteriorated.
	  – Diuretics: anticipate immediate and subsequent toileting. Ensure easy access to toilet and assist if required.

☐ Has there been a recent change in medication that may effect falls risk (eg changes involving any of the above?)	e. Write in progress notes and alert staff at handover. f. Report changes in alertness or mobility. g. Assess for postural hypotension before and one hour after morning medications, for 3 days. h. Anticipate side-effects and take appropriate measures.

BEST PRACTICE ALERT:
Conduct a multifactorial assessment on your vulnerable population or patients admitted for a fall

http://www.hret-hiin.org/resources/display/multifactorial-falls-risk-assessment-and-management-tool

Fall TIPS Risk and Care Planning Tool

BWH BRIGHAM AND WOMEN'S HOSPITAL

Patient Name: *John*

Date: *05/12/2016*

Increased Risk of Harm If You Fall ☐

Fall Risks (*Check all that apply*)

- **History of Falls** ☑
- **Medication Side Effects** ☑
- **Walking Aid** ☑
- **IV Pole or Equipment** ☑
- **Unsteady Walk** ☑
- **May Forget or Choose Not to Call** ☑

Fall Interventions (*Circle selection based on color*)

Communicate Recent Fall and/or Risk of Harm

Walking Aids
- Crutches
- Cane
- Walker

IV Assistance When Walking

Toileting Schedule: Every __1__ hours
- Bed Pan
- Assist to Commode
- Assist to Bathroom
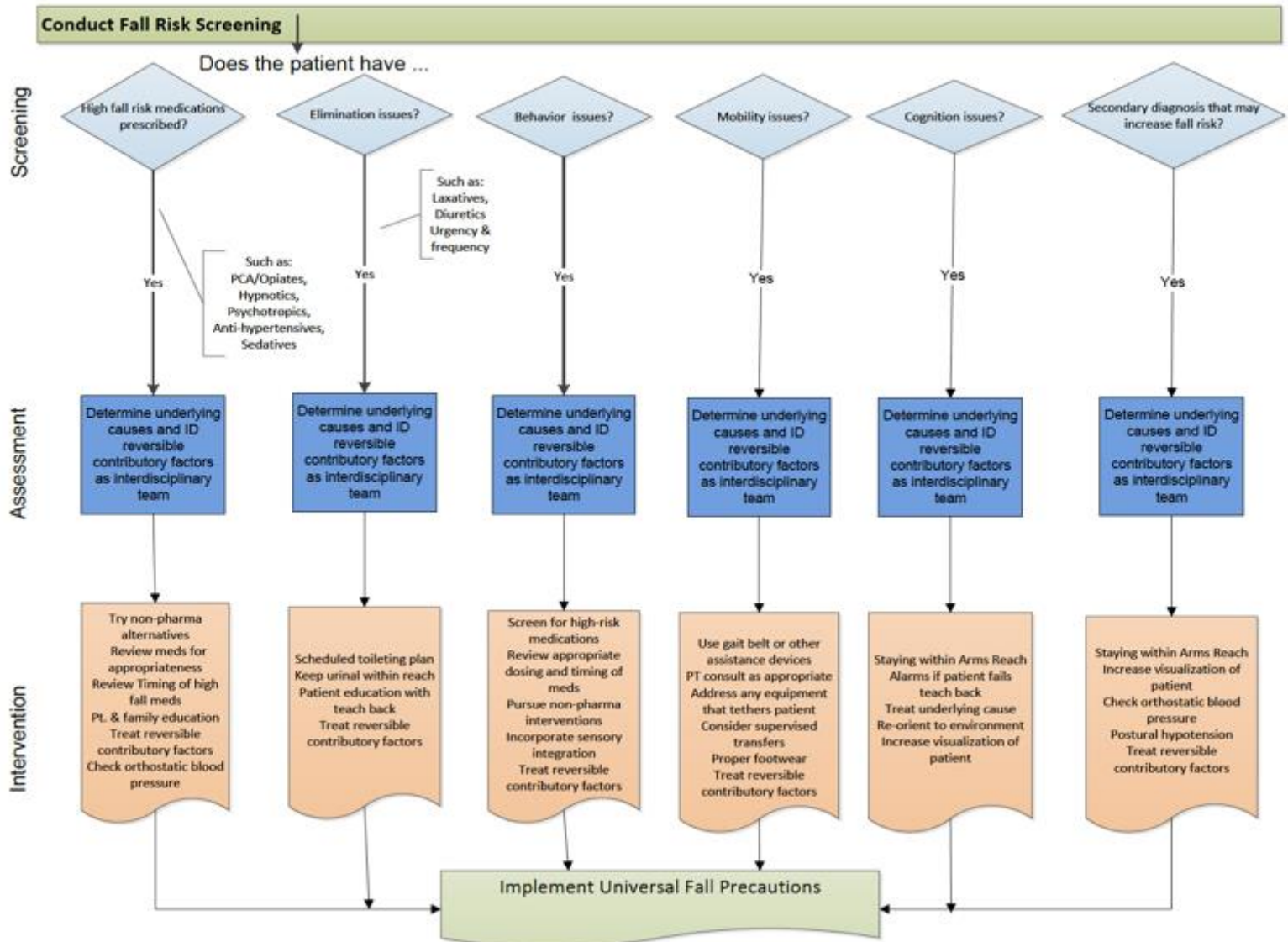
Bed Alarm On

Assistance Out of Bed
- Bed Rest
- ① 1 person
- ① ② 2 people

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Risk based interventions

Conduct Fall Risk Screening

Screening

Does the patient have …

| High fall risk medications prescribed? | Elimination issues? | Behavior issues? | Mobility issues? | Cognition issues? | Secondary diagnosis that may increase fall risk? |

Such as:
Laxatives,
Diuretics
Urgency & frequency

Such as:
PCA/Opiates,
Hypnotics,
Psychotropics,
Anti-hypertensives,
Sedatives

Yes (under each column)

Assessment

Determine underlying causes and ID reversible contributory factors as interdisciplinary team (repeated under each column)

Intervention

Try non-pharma alternatives
Review meds for appropriateness
Review Timing of high fall meds
Pt. & family education
Treat reversible contributory factors
Check orthostatic blood pressure

Scheduled toileting plan
Keep urinal within reach
Patient education with teach back
Treat reversible contributory factors

Screen for high-risk medications
Review appropriate dosing and timing of meds
Pursue non-pharma interventions
Incorporate sensory integration
Treat reversible contributory factors

Use gait belt or other assistance devices
PT consult as appropriate
Address any equipment that tethers patient
Consider supervised transfers
Proper footwear
Treat reversible contributory factors

Staying within Arms Reach
Alarms if patient fails teach back
Treat underlying cause
Re-orient to environment
Increase visualization of patient

Staying within Arms Reach
Increase visualization of patient
Check orthostatic blood pressure
Postural hypotension
Treat reversible contributory factors

Implement Universal Fall Precautions

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Injury prevention interventions

Fall Injury Reduction Protocol
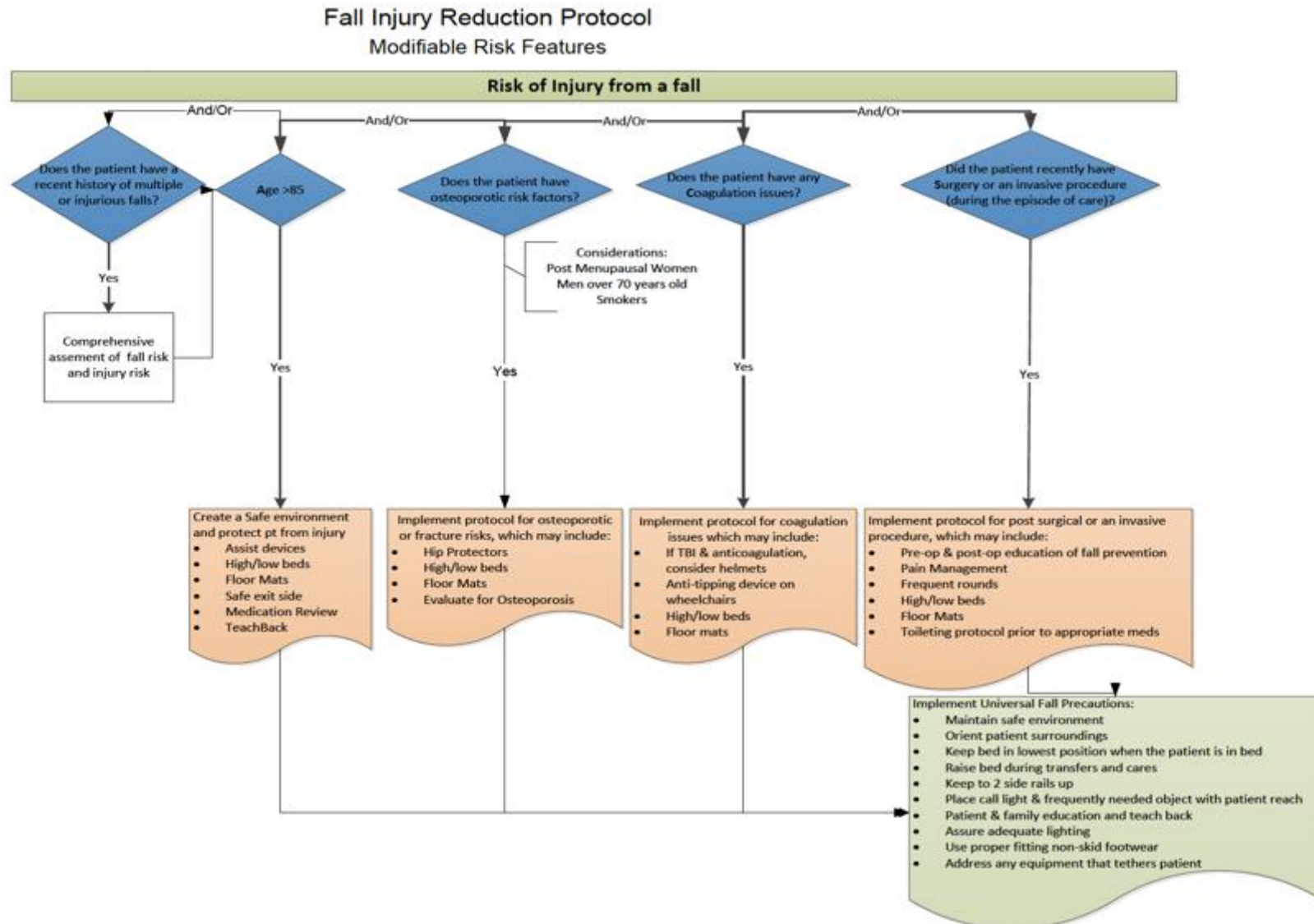Modifiable Risk Features

Table Top Discussion

What's Happening at Your Hospital?

- Have you begun screening for injury risk?
    - When, where, how often?
    - What interventions are put in place?
- What are you doing to link risk factors to interventions upon admission?
    - What disciplines are activated?
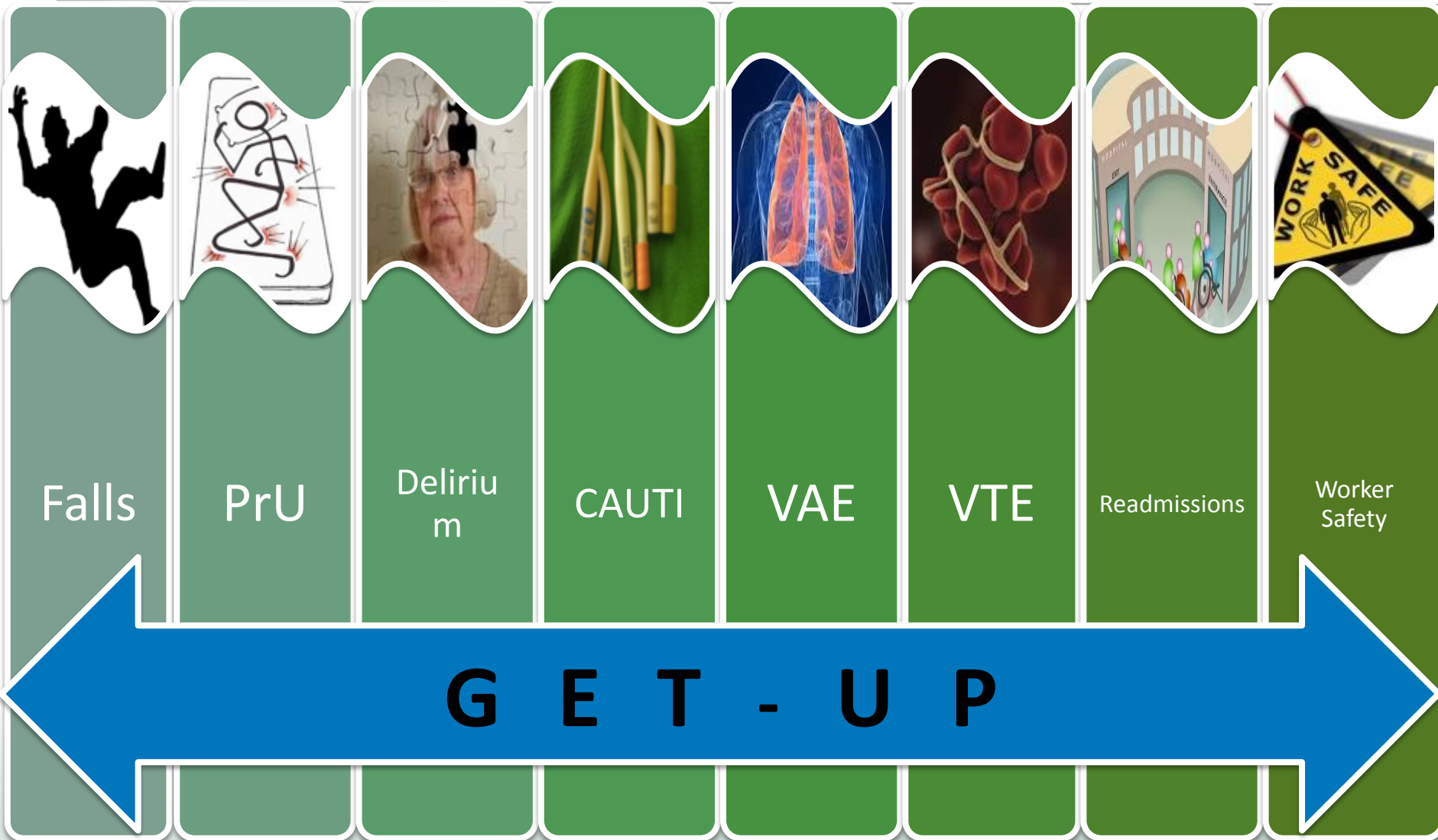   - How is plan communicated
- Report out

Hot Topic #2: Provide Safe Mobility

Stop the domino effect of forced immobility!

Early Progressive Mobility

Falls | PrU | Delirium | CAUTI | VAE | VTE | Readmissions | Worker Safety

G E T - U P

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Forced immobility is causing harm

- "New Walking Dependence" occurs in 16-59% in older hospitalized patients (Hirsh 1990, Lazarus 1991, Mahoney 1998)

- 65% of patients had a significant functional mobility decline by day 2 (Hirsh 1990)

- 27% still dependent in walking 3 months post discharge (Mahoney 1998)

Mobilization vs Bed Alarms

Benefits of Mobility Programs

- Prevents Delirium
- Preserves functional ability
- Reduces LOS
- Prevents Readmissions
- Prevents Fall Injuries, HAPU, CAUTI, VAE, VTE
- Reduces worker injuries
- Increases patient satisfaction

Hazard of Bed Alarms

- Alarm Fatigue
- Functional decline from forced immobility
- Patient dissatisfaction

GAP ALERT:
Are Bed Alarms in your Bundle and Applied Automatically?

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Immobility, Delirium and Falls

- Immobility, illness and medications contribute to delirium

- 10-31% of fallers are delirious at the time of their fall

- A patient with delirium is 4.55 times more likely to fall (confidence interval: 1.47-14.05)

- Meta-analysis of delirium interventions and falls have shown the chance of falling decreases by 62% (odds ratio 0.38, CI: 0.25-0.6)

Pendlebury et. al. BMJ Open 2015, Nov 16, 5(11):e007808.
Corsinovi et. al. Arch Gerontol Geriatr 2009, Jul-Aug 49(1):142-5.
Hshieh et. al. JAMA Int Med 2015, Apr 175(4):512-20.

What happened to mobility?

"There is an inherent tension between preventing falls and promoting mobility"
Growdon, Shorr, Inouye 2017

It's Simple

- If they came in walking, keep them walking

Use mobility to accelerate progress

"When am I going to walk? I walked yesterday. It's better than just being in the chair. I feel better when I am walking."

What is progressive mobility?

Progressive mobility is defined as a series of planned movements in a sequential matter beginning at a patient's current mobility status with goal of returning to his/her baseline

(Vollman 2010)

Ambulation

Dangling

Chair position

Upright / leg down position

CLRT and Prone positioning

PROM AROM

Manual turning

Elevate HOB
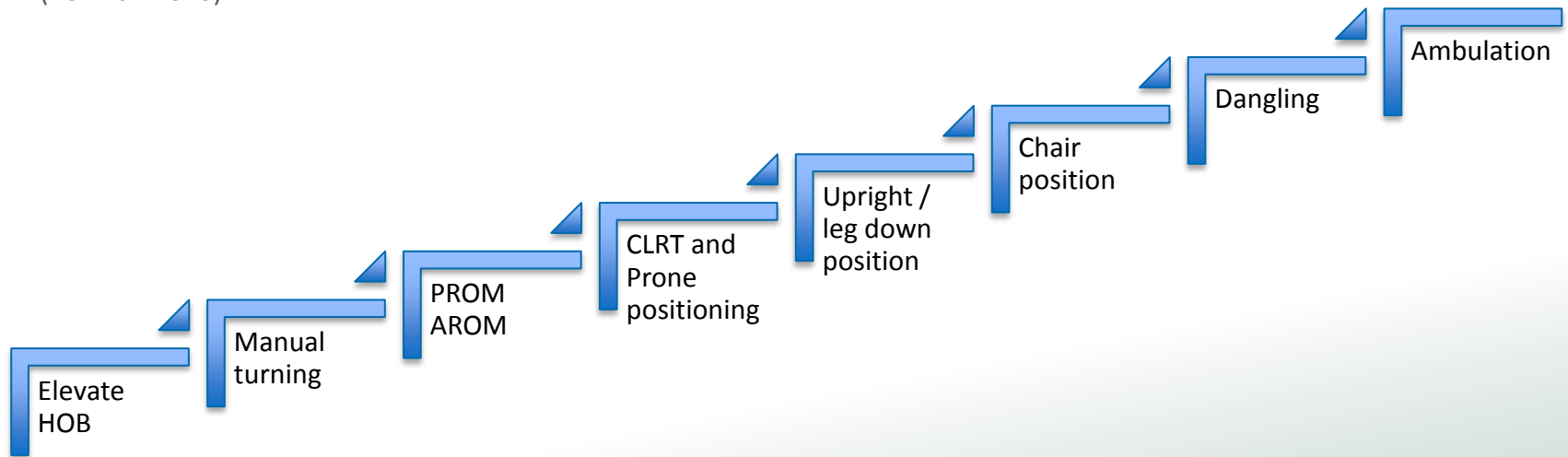
Vollman, KM. Introduction to Progressive Mobility. Crit Care Nurs. 2010;30(2):53-55.

Teaming Up to Mobilize
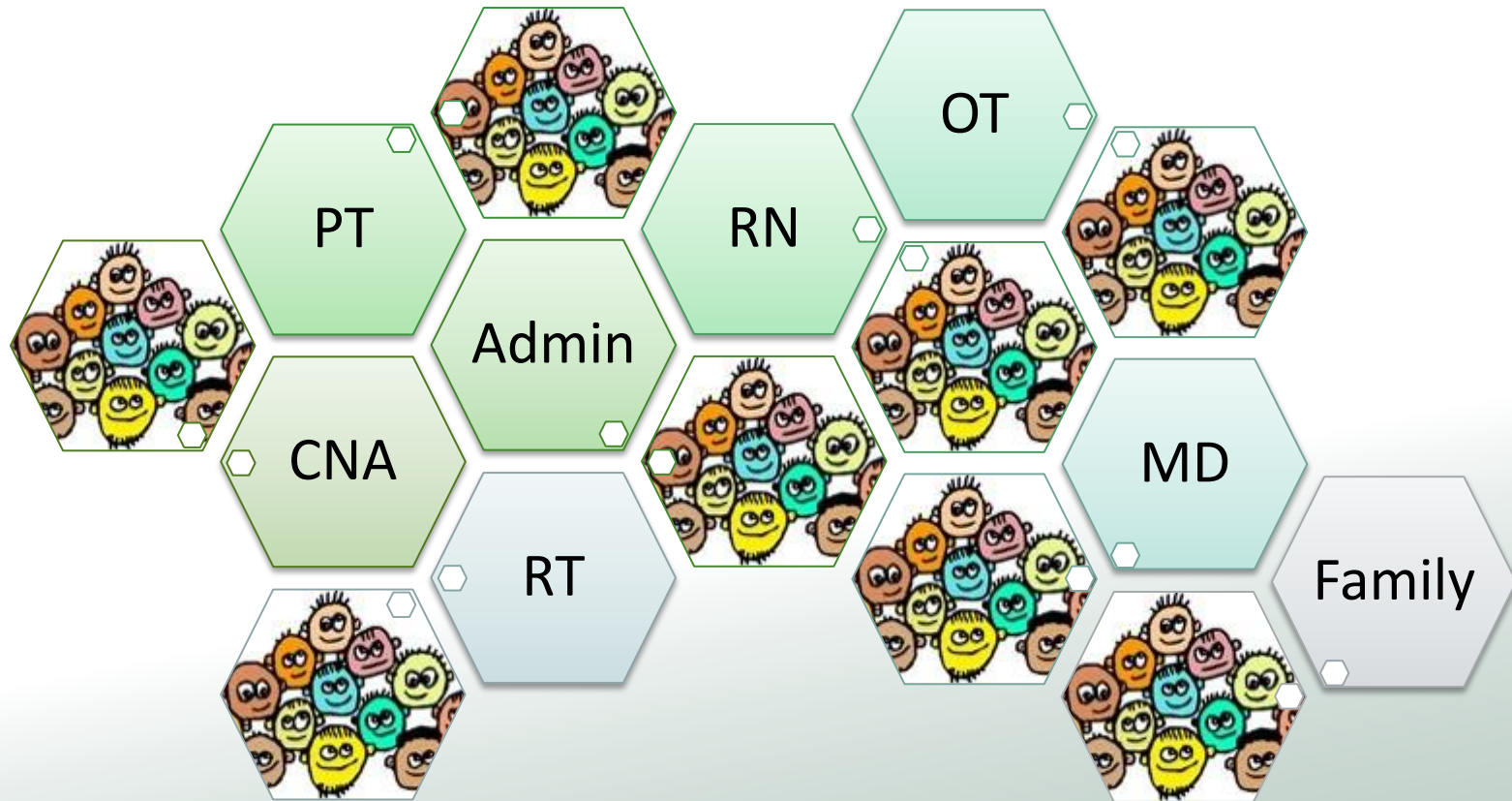
MUST DO's

GET-UP MUST DO'S!

1. Walk in, walk during, walk out!
2. Grab and go mobility devices
3. Three laps a day keeps the nursing home away!

MUST DO #1
Walk In, Walk During, Walk Out!

MUST DO #1
Walk In, Walk During, Walk Out!

- Determine pre admission ambulation status
- Don't assume a frail appearance means weakness
- Use Get Up and Go test to assess ambulation skills

Get Up and Go Test

Fig. 4. The Get Up and Go test.
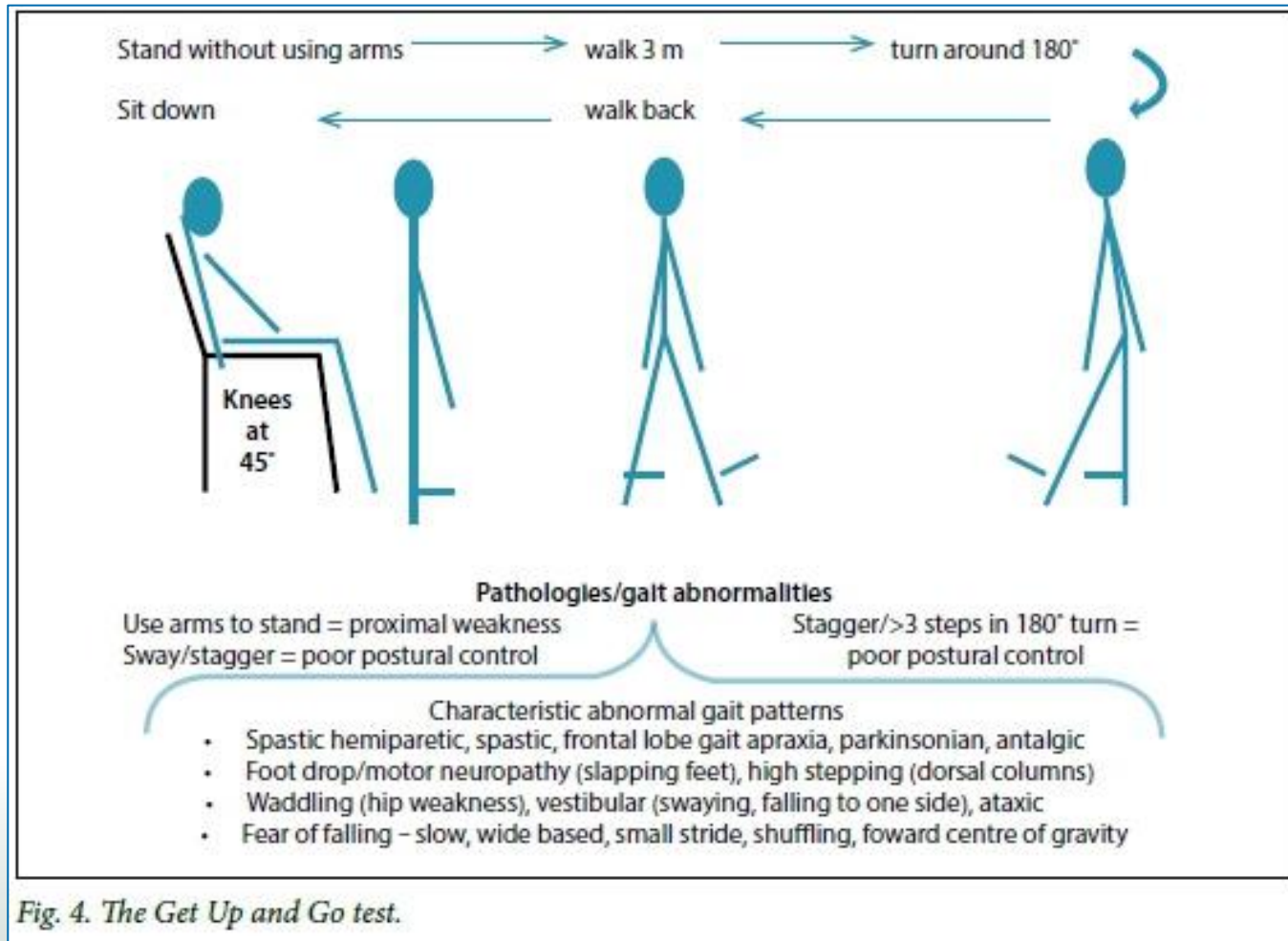
B.M.A.T. - Banner Mobility Assessment Tool for Nurses

Test	Task	Response	Fail = Choose Most Appropriate Equipment/Device(s)	Pass
Assessment Level 1 Assessment of: -Cognition -Trunk strength -Seated balance	**Sit and Shake**: From a semi-reclined position, ask patient to sit upright and rotate* to a seated position at the side of the bed; may use the bedrail. Note patient's ability to maintain bedside position. Ask patient to reach out and grab your hand and shake making sure patient reaches across his/her midline. Note: Consider your patients cognitive ability, including orientation and CAM assessment if applicable.	**Sit**: Patient is able to follow commands, has some trunk strength; caregivers may be able to try weight-bearing if patient is able to maintain seated balance greater than two minutes (without caregiver assistance). **Shake**: Patient has significant upper body strength, awareness of body in space, and grasp strength.	**MOBILITY LEVEL 1** - Use total lift with sling and/or repositioning sheet and/or straps. - Use lateral transfer devices such as roll board, friction reducing (slide sheets/tube), or air assisted device. **NOTE**: *If patient has 'strict bed rest' or bilateral 'non-weight bearing' restrictions, do not proceed with the assessment; patient is MOBILITY LEVEL 1.*	Passed Assessment Level 1 = Proceed with Assessment Level 2.
Assessment Level 2 Assessment of : -Lower extremity strength -Stability	**Stretch and Point**: With patient in seated position at the side of the bed, have patient place both feet on the floor (or stool) with knees no higher than hips. Ask patient to stretch one leg and straighten the knee, then bend the ankle/flex and point the toes. If appropriate, repeat with the other leg.	Patient exhibits lower extremity stability, strength and control. May test only one leg and proceed accordingly (e.g., stroke patient, patient with ankle in cast).	**MOBILITY LEVEL 2** - Use total lift for patient unable to weight-bear on at least one leg. - Use sit-to-stand lift for patient who can weight-bear on at least one leg.	Passed Assessment Level 2 = Proceed with Assessment Level 3.
Assessment Level 3 Assessment of: -Lower extremity strength for standing	**Stand**: Ask patient to elevate off the bed or chair (seated to standing) using an assistive device (cane, bedrail). Patient should be able to raise buttocks off bed and hold for a count of five. May repeat once. Note: Consider your patients cognitive ability, including orientation and CAM assessment if applicable.	Patient exhibits upper and lower extremity stability and strength. May test with weight-bearing on only one leg and proceed accordingly (e.g., stroke patient, patient with ankle in cast). If any assistive device (cane, walker, crutches) is needed, patient is Mobility Level 3.	**MOBILITY LEVEL 3** - Use non-powered raising/stand aid; *default to powered sit-to-stand lift if no stand aid available.* - Use total lift with ambulation accessories. - Use assistive device (cane, walker, crutches). NOTE: Patient passes Assessment Level 3 but requires assistive device to ambulate or cognitive assessment indicates poor safety awareness; *patient is MOBILITY LEVEL 3.*	Passed Assessment Level 3 **AND no assistive device needed** = Proceed with Assessment Level 4. *Consult with Physical Therapist when needed and appropriate.*
Assessment Level 4 Assessment of: -Standing balance -Gait	**Walk**: Ask patient to march in place at bedside. Then ask patient to advance step and return each foot. Patient should display stability while performing tasks. Assess for stability and safety awareness.	Patient exhibits steady gait and good balance while marching, and when stepping forwards and backwards. Patient can maneuver necessary turns for in-room mobility. Patient exhibits safety awareness.	**MOBILITY LEVEL 3** If patient shows signs of unsteady gait or *fails* Assessment Level 4, refer back to MOBILITY LEVEL 3; *patient is MOBILITY LEVEL 3.*	**MOBILITY LEVEL 4** MODIFIED INDEPENDENCE **Passed = No assistance needed to ambulate**; use your best clinical judgment to determine need for supervision during ambulation.

Always default to the safest lifting/transfer method (e.g., total lift) if there is any doubt in the patient's ability to perform the task.

Originated: 2011; revised: 2/27/12, 3/02/12, 3/07/12, 3/19/12, 4/19/12, 5/01/12, 5/03/12, 05/20/2013

[Banner Mobility Assessment Tool for Nurses (BMAT) video and Tool](#)

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Common Language

Reference Key for Therapy Lingo

Term	Abbreviation	Definition	Effort Staff Provides	Effort Patient Provides
Independent	I	Patient requires no assistance or supervision from person or device and is safe to ambulate and/or complete said task freely ad lib	0%	100%
Modified Independent	Mod I	Patient completes task using device (e.g., walker, cane, grab bar, BSC, etc.) and/or requires extra time to complete task.	0%	100%
Supervision Standby Assist	S SBA	No physical contact from single staff member to patient is required, however d/t fall risk, staff should be close to patient to maximize safety.	0%	100%
Contact-Guard Assistance	CGA	Patient requires light physical contact from staff; but no actual assistance (e.g., hand placed lightly on back to steady patient without actual support).	<5%	>95%
Minimal Assistance	Min A	Patient requires 25% or less assistance or support to safely complete task/transfer/ambulation.	25%	75%
Moderate Assistance	Mod A	Patient requires 50% assistance from staff member to safely complete task or transfer/ambulation.	50%	50%
Maximal Assistance	Max A	Patient requires 75% assistance or support from staff member to safely complete task or transfer/ambulation.	75%	25%
Dependent Total Assistance	D Total A	Patient requires 100% assistance or support from staff member to complete task or transfer/ambulation.	100%	0%

NOTES:
- ✓ Green-shaded boxes indicate assistance options that do not involve physical touch from staff member.
- ✓ Multiple person transfers would be signified by "x2+" (e.g., max A x3).
- ✓ ALL patients designated as high fall risk (aka, yellow gown) MUST use gait belt at all times when out of bed. This includes "quick" BSC transfers, standing to pull up pants, etc.

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Levels of Assistance

Mobility begins on admission

Tier Level	Defining Characteristics	Intervention[a]
Tier 1: Nonambulatory	Patients who • require more than a one-person assist for ambulation/transfers • are unable to maintain weight on their lower extremities • require any form of lift equipment	Active range-of-motion exercises: • ankle pumps • heel slides • hip abduction • quad sets • shoulder flexion Passive range-of-motion exercises: • ankle dorsiflexion • hip flexion • hip abduction • shoulder flexion Sit on side of bed Get out of bed and into a chair with appropriate equipment
Tier 2: Ambulatory	Patients who • are able to ambulate independently • require a one-person assist with ambulation	Ambulate with or without assistance in the hallway as tolerated Get out of bed and into a chair for all meals

[a] To be performed three times a day (in accordance with a patient's ability).

Wood W, et al.(2014) A Mobility Program for an Inpatient Acute Care Medical Unit.
http://www.nursingcenter.com/pdfjournal?AID=2591440&an=00000446-201410000-00023&Journal_ID=54030&Issue_ID=2591321

MUST DO #2
Grab and Go Mobility Devices!

- Gait Belts in every room*

- Patients and staff have access to mobility devices

- Safe mobilization and patient handling training for staff

Gait belts are used to help control the patient's center of balance.

*with the exception of rooms for behavioral health patients

Integrating Safe Patient Handling

TOP DOWN

Make it Important

BOTTOM UP

Make it Easy
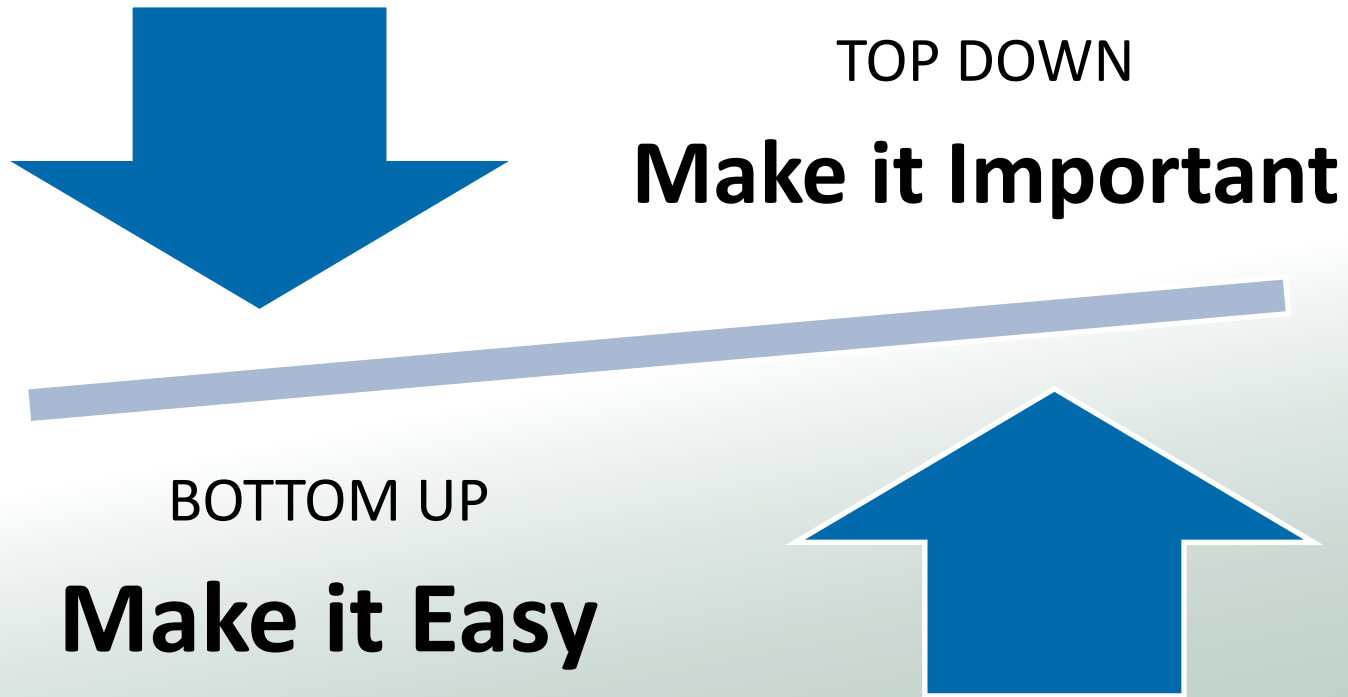
Safe Patient Handling & Mobility Training

Safe Patient Handling

- Use of equipment – lifts, lateral devices

- Assisting bed activities

- Lifting limits – not > 35 lbs

- Use SPH coaches when lifts used

- How to avoid friction / shear

Mobility Training

- Assessing ambulation skills

- Use of gait belts

- Control of a fall

- Assisting with ambulation

- Screening for correct fit of mobility aid

- Special populations:

  - Hip precautions

  - Hemiplegia

  - Parkinson's

MUST DO #3
3 Laps a Day, Keeps the Nursing Home Away!

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Facing the Facts about Mobility

Mobility interventions are regularly missed

- Nursing perceptions
  - Lack of time
  - Ease of omission
  - Belief it is PTs responsibility
- Survey results
  - Concern for patients level of weakness, pain and fatigue
  - Presence of devices – IVs and Urinary Catheters
  - Lack of staff to assist

Doherty-King, B Bowers, B. How nurses decide to ambulate hospitalized older adults: development of a conceptual model. Gerontologist. 2011 Dec:51(6): 786-97

Tips for Promoting Mobility

- Re-purpose the Falls Team to become a Safe Mobility Team

- Engage a MD champion

- Think PT Stewardship

- Start Small

  - Target a small population

    - By age, diagnosis, service line

Make it visible

- Get the Docs involved!
- Engage patients and families

Bedside Sign

Get Up...Get Moving....Get Better!

Day:_____

GOAL: 3 Walks

☐ ☐ ☐

Goal: Up to Chair 3x

☐ ☐ ☐

5A Walk of Fame Board

Tips for Promoting Mobility

- Order Modifications
- Delete orders for
  - Bedrest
  - Ad lib
- Replace with specific orders
  - Times, activities, distance
- Build documentation fields
  - All activity documented in one location

Tips for Promoting Mobility

- Delegation of patient mobility

  – Replace sitters with a mobility aide

  – Train sitters to ambulate patients

  – Create mobility tech role – reallocate transporters, safe patient handling coaches

- Rehab and Nursing face-to-face bedside handoffs or safety huddles

  – Document plans and progress on white boards

  – Collect data

Progressive mobility can reduce patient harm, employee injuries and LOS

Case Study: St Francis, Michigan City, IN

- 3 mobility trained nursing assistants
  - 70% reduction in HAPI
  - 40% reduction in worker back injuries
  - -45% reduction in RN turnover
  - 43% reduction in readmission
  - 39% reduction in d/c to SNF

Case Study: John Hopkins MICU

- ICU rehab program
  - 10% reduction in mortality
  - 30% (2.1 day) reduction in MICU LOS
  - 18% (3.1 day) reduction in hospital LOS

Tips for General Wards

- What works in Surgery?

- Everyone up for meals "*Heels for Meals*"

- Promote ambulation in hallways – "*earn a four and you're out the door*"

- Provide activities, mental stimulation – cross word puzzles, card games

- Work with families as partners in mobility. Bring adequate shoes to the hospital.

Tips for the ICU

- Start with micro-turns to prevent gravitational disequilibrium

- Use a safe mobility screening tool or protocol

- Use beach chair positioning

- Engage rehab, respiratory, physicians

Beach Chair Position

Share your Strides towards Mobility

What does your program look like?

- – Mobility expectations

- – Who assess mobility status?

- – Who mobilizes?

- – How is it documented?

- – How is progress measured?

Hot Topic # 3 - Delirium and Falls

- Delirium is the leading contributor to hospital falls

- 10-31% of fallers are delirious at the time of their fall

- A patient with delirium is 4.55 times more likely to fall (confidence interval: 1.47-14.05)

- Meta-analysis of delirium interventions and falls have shown the chance of falling decreases by 62% (odds ratio 0.38, CI: 0.25-0.6)

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Prevent, Detect, Manage Delirium

- Meta-analysis of 14 studies showed a 62% reduction in falls when multicomponent non-pharmacological delirium interventions were in place.

- Most interventions were centered around:

  - Early mobilization (OOB for meals and ambulation);

  - Vision and hearing interventions;

  - Orientation protocol (such as white boards);

  - Therapeutic activities (mentally stimulating ≠ entertainment!);

  - Sleep enhancement protocol (in place when delirium order sets are activated).

Prevent, Detect, Manage Delirium

- Assess for delirium
  - B-Cam or CAM
- Discontinue tethers
  - urinary catheters, IVs
- Mobilize at highest level
  - 3 x per day or more
- Minimize CNS affecting meds and anticholinergics

I can prevent DELIRIUM

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Sample delirium prevention activities

- Lights on
- Shades up
- Aids in – glasses, hearing aid
- Walk three times a day
- Stimulating activities
- AM:
  - Teeth brushed
  - Face washed
  - Up for breakfast
- Evening
  - Teeth brushed
  - Face Washed

Medications, delirium & falls

- Medications have both therapeutic effects and side-effects, which are sometimes harmful

- Medications which affect blood pressure and/or have CNS effects can be associated with increased fall risk (fall risk increasing drugs – FRIDs)

- Medications with strong anti-cholinergic effects can lead to delirium

Hot Topic # 4 – Meds – why not?

Non- Modifiable Risk Factors

- *advanced age*

- *previous falls*

Modifiable Risk Factors

- *medications*

- *muscle weakness*

- *gait and balance issues*

- *postural hypotension*

- *chronic conditions*

  - *Incontinence*

  - *Cognitive Issues*

GAP ALERT:
Do you review medications on high risk
or vulnerable populations?

The Big 3

- Medications that affect the **brain**
    - Benzodiazepines, sleep aids (the "z" drugs), antipsychotics, anticonvulsants, antidepressants, opioids, anticholinergics
    - 3 + CNS medications to be avoided – associated with increased falls
- Medications that affect **blood pressure**
    - Anti-hypertensives, alpha-blockers
    - BP of less than 110 is associated with fall risk
- Medications that **lower blood glucose**

Fall Risk Increasing Drugs

Anticholinergics	Antipsychotics Antidepressants	Anticonvulsants	Sleep Aids	Benzodiazepines	Opiates	Cardiac drugs, Diuretics w/ Hypotension
Delirium	Hypotension, sedation, slow reflexes, loss of balance	Ataxia Unsteadiness	Drowsiness, Impairs balance, Slow reactions	Drowsiness, Impairs balance, Slow reactions	Sedation, slow reactions, impairs balance, delirium	Orthostatic hypotension, Hypotension, bradycardia
Examples: Atropine® Actifed® Benadryl® Cogentin® Compazine® Dramamine® Ditropan® Detrol® Flexeril® Norpramin® Phenergan® Stelazine® Tofranil® Vistaril®	**Examples:** Elavil® Effexor® Haldol® Geodon® Symbalta® Trazadone®	**Examples:** Dilantin® Phenobarbital® Tegretol®	**Examples:** Ambien® Luminal® Dalmane® Nembutal®	**Examples:** Ativan® Valium® Xanax® Librium® Klonopin®	**Examples:** Codeine Morphine Fentanyl Duragesic® Oxycontin®	**Examples**: Aprinex® Altase® Captopril® Catapress® Chlorthalidone Tenormin® Inderal XL® Lopressor® Mavik® Nitroglycerine Monopril® Isorbide® Vasotec® Zestril®

> **This list is not exhaustive of all medication trade names. Generic names can be found at the source**

Adapted from: British Geriatric Society Medication Guidance Sheet

GREAT LAKES PARTNERS FOR PATIENTS

Drugs Increasing Fracture Risk

Tricyclic Antidepressants	Serotonin Reuptake Inhibitors	First Generation Antipsychotics	Benzodiazepines
Depression is associated with falling, bone mineral loss, fractures	Depression is associated with falling, bone mineral loss, fractures	Bone loss – drug induced hyperprolactinemia	Sedative effects, impairs cognition, psychomotor alterations
Examples: Elavil® Sinequan® Tofranil® Pamelor® Norpramin®	Examples: Paxil® Zoloft® Prozac® Celexa® Lexapro® Cymbalta® Fetzim® Efffexor XR®	Examples: Haldol® Chlorpromazine Fluphenazine	Example: Valium®

This list is not exhaustive of all medication trade names. Generic names can be found at the source

Did you know 3 or more doses of diazepam can increase risk of hip fracture by 50% in the elderly?

- Risk increases to 60% increase after 2 weeks
- Risk increases to 80% after 1 month

Wang PS. Bohn RL. Glynn RJ. Mogun H. Avorn J. Hazardous benzodiazepine regimens in the elderly: effects of half-lifedosage, and duration on risk of hip fracture. Am J psych. 2001;158(6):892-8.

Sample Medication Review Tools

British Geriatrics Society Medication and Falls Guidance Sheet

DRUGS ACTING ON THE BRAIN (PSYCHOTROPIC DRUGS)

There is good evidence that stopping these drugs can reduce falls (1).

Taking such a medicine roughly doubles the risk of falling. There is no data on the effect of taking two or more such tablets at the same time (2).

Sedatives, antipsychotics and sedating antidepressants cause drowsiness and slow reaction times. Some antidepressants and antipsychotics also cause orthostatic hypotension.

MEDICATION GROUP		COMMONLY USED MEDICATIONS WITHIN THE GROUP	EFFECTS ON FALLS RISK
Sedatives: Benzodiazepines		Temazepam, Nitrazepam Diazepam, Lortemazepam Chlordiazepoxide, Flurazepam, Lorazepam, Oxazepam, Clonazepam	Drowsiness, slow reactions, impaired balance. Caution in patients who have been taking them long term.
Sedatives: "Zs"		Zopiclone, Zolpidem	Drowsiness, slow reactions, impaired balance.
Sedating antidepressants (tricyclics and related drugs)		Amitriptyline, Dosulepin Imipramine, Doxepin Clomipramine, Lofepramine, Nortriptyline, Trimipramine	All have some alpha blocking activity and can cause orthostatic hypotension. All are antihistamines and cause drowsiness, impaired balance and slow reaction times.
		Mirtazapine, Mianserin Trazodone	Double the rate of falling.
Monoamine oxidase inhibitors (MAOIs)		Phenelzine, Isocarboxazid, Tranylcypromine	MAOIs are little now used; all (except moclobemide) cause severe orthostatic hypotension.
Drugs for psychosis and agitation		Chlorpromazine, Haloperidol, Fluphenazine, Risperidone Quetiapine, Olanzapine	All have some alpha receptor blocking activity and can cause orthostatic hypotension. Sedation, slow reflexes, loss of balance.

KEY:
High risk
Medium risk
Possible cause
NICE guidelines

AHRQ Medication Fall Risk Score – Screening tool

Medication Fall Risk Score

Point Value (Risk Level)	American Hospital Formulary Service Class	Comments
3 (High)	Analgesics,* antipsychotics, anticonvulsants, benzodiazepines†	Sedation, dizziness, postural disturbances, alter and balance, impaired cognition
2 (Medium)	Antihypertensives, cardiac drugs, antiarrhythmics, antidepressants	Induced orthostasis, impaired cerebral perfusio health status
1 (Low)	Diuretics	Increased ambulation, induced orthostasis
Score ≥ 6		Higher risk for fall; evaluate patient

* Includes opiates.

† Although not included in the original scoring system, the falls toolkit team recommends that you include non-benzodiazepine sedative-hypnotic drugs (e.g., zolpidem) in this category.

[AHRQ Medication Fall Risk Score](#)

[British Geriatric Society Medication Guidance](#)

GREAT LAKES
PARTNERS FOR PATIENTS

Ideas

- Pharmacist and physician or nurse review one patient's medications per week to build awareness.

- Flag FRIDS or your targeted meds in the medication record, indicating how they can contribute to falls. "may cause orthostatic hypotension" or "may contribute to delirium

- Run a pharmacy report on FRIDS on a targeted drug class – benzos, antidepressants, antipsychotics,

Thinking Small

- How can we target a small patient population or a drug type for targeted interventions?
  - Patients or residents
    - At risk for injury
    - Pts 65 or greater with > 5 medication
    - Pts 85 or older
    - Those who have fallen
  - Drug class
    - Benzo's and sleep aids?
    - Antidepressants or Antipsychotics?

Table Talk & Bright Spots

- What strategies are you using to optimize medications and prevent delirium?

- How are you segmenting the population?
  - By patient type?
  - By medication?

- What can nurse, physicians and pharmacists do to work together to minimize FRIDs?

- Do you have delirium interventions in place that you can share?

Hot Topic # 5 The Patient and Family

Untapped Resource

Anatomy of a Fall in the Hospital

1. Patient choice
   a. Use the call light and wait
   b. Use the call bell, wait, wait, wait get up and go
   c. Don't use the call light and get up and go
2. Medications on board
3. Unfamiliar environment
4. Mobilization, toileting need
5. Hard surfaces

More than *"Call Don't Fall"*

6E ULCA RRH: Bone Marrow Transplant Patient

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

Why is it so tricky?

Understanding Human & Organizational Science

- Each patient brings unique capabilities and limitations
- The key factor associated with falls is movement
  - **Movement is important for the patient**
  - **Movement is restricted by the organization**

The Human Side

Patients may be

- overwhelmed, distracted, unreceptive due to illness

- misunderstand and deny risk for fall

- unable to wait for assistance

Patients must mobilize to go to the toilet

Patients want

- independence

- privacy

- freedom of movement

The Organization Side

Prevent injury through risk mitigation

- Limit independence
- Limit mobilization
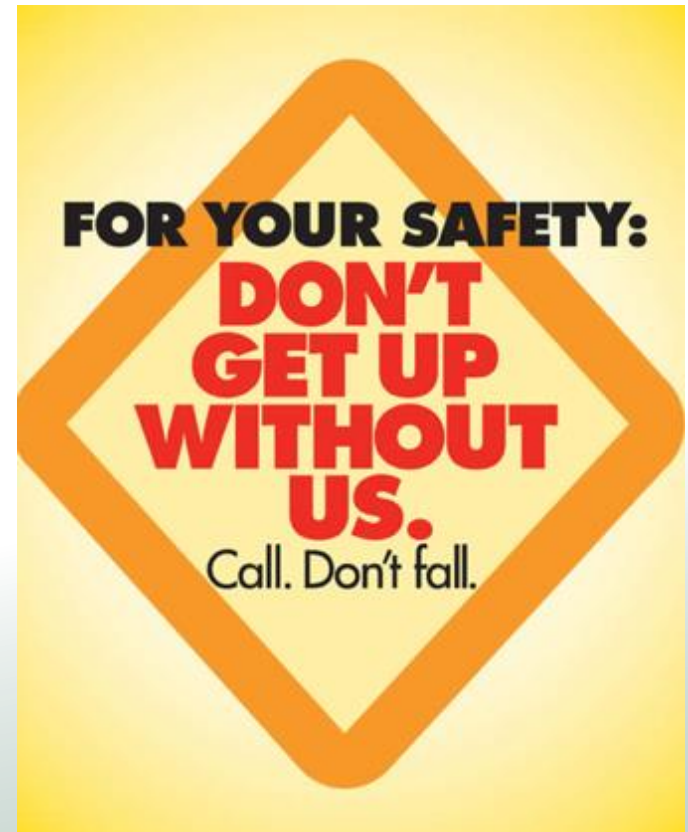
A Peek at the Evidence

- Patients understand that fall prevention is important, but 50-88% believe it does not apply to them. Twibell et al 2015, Sonnad et al 2014)

- When structured falls education is provided to cognitively intact patients, falls can be reduced significantly.

- 20 minute formal fall education with medical oncology patients led to ZERO falls with patients receiving education while those not educated continued to fall at a rate of 18% (Li-Chi Huang, 2015)
- 45 minute formal fall education with rehab patients resulted in a 45% reduction in falls in cognitively intact patients (Haines, 2011)

Changing Your Conversation with Patients

- Do you label Patients / Caregivers: Non-Compliant?

- What does Non-Compliant Mean to You?

- How do you measure your effectiveness?

- How do you evaluate effectiveness of your teaching?

The patient is non-compliant!
The patient won't listen!

Fall Education Components

- Educate about fall risks
  - Medications
  - Tripping hazards
  - Orthostatic hypotension, especially in morning
  - Footwear
  - Rolling equipment and furniture

- Educate on safe ambulation
  - Level of assistance needed
  - Promote progressive ambulation
  - Include ambulation in bedside handoffs

"Teach Back"

- "Teach Back" Testing: what are the trends in patients' difficulty to understand what is taught ?

   Ask the patient to describe or repeat <u>back</u> in his or her own words what has just been told or taught. Return demonstration is a similar technique used by diabetic educators, physical therapists, and others.

   Never ask whether patients understand; they always say "yes".

Teach Back Language

"I want to be sure I explained everything clearly. Can you please explain it back to me so I can be sure I did?"

Teach Back Question Card #1

"I want to make sure I explained this clearly. When you get back home in a few days, what will you tell your *[friend or family member]*   about *[key point just discussed]?*"

Teach Back Question Card #2

"We covered a lot today about preventing falls, and I want to make sure that I explained things clearly. So let's review what we discussed.
What are three strategies that will

Teach Back Question Card #3

"I want to be sure that I did a good job of teaching you today about risk for falls.
 Could you please tell me in your own words what you are doing to prevent falls? How you will prevent falls in the future?

Teach Back Question Card #4

Post Fall Huddles at the Bedside

Good Example of Post-Fall Huddle

Bad Example of Post-Fall Huddle

CAPTURE FALLS TOOLKIT

- Training videos and power point
- Forms
- Pocket Card
- https://www.unmc.edu/patient-safety/capturefalls/tool-inventory.html

Post-Fall Huddle Documentation

Directions: Items 1 – 3 should be completed by the huddle facilitator. Item 4 should be completed by the fall risk reduction team.

1. Date of Huddle _____   Time of Huddle _____   Huddle Facilitator Initials _____

2. Who was included in the huddle? CHECK ALL THAT APPLY

☐ Patient   ☐ Primary Nurse   ☐ COTA   ☐ Physical Therapist
☐ Family/Caregiver   ☐ CNA   ☐ Pharmacist   ☐ Physical Therapy Assistant
☐ Charge Nurse   ☐ Occupational Therapist   ☐ Pharmacy Tech   ☐ Quality Improvement Coordinator
☐ Other: _____

3. Please identify the proximal cause(s) of the fall by checking ALL appropriate boxes below and describe actions taken to prevent a reoccurrence for this patient.

FALL CAUSE	FALL TYPE PREVENTABILITY	ACTIONS TAKEN TO PREVENT REOCCURENCE FOR THIS PATIENT
☐ Environmental (Extrinsic) Risk Factors Examples: Liquid on floor; Trip over tubing, equipment, or furniture; Equipment malfunction	Accidental → Possibly could have been prevented	
☐ Known Patient-Related (Intrinsic) Risk Factors Examples: Confusion /Agitation, Lower extremity weakness, Impaired gait, Poor balance/postural control, Postural hypotension, Centrally acting medication	Anticipated Physiological → Possibly could have been prevented	
☐ Unknown, Unpredictable Sudden Condition Examples: Heart Attack, Seizure, Drop attack	Unanticipated Physiological Unpreventable	

☐ Unsure – Please describe fall cause and your assessment of preventability. _____

4. If preventable, determine error type and describe actions taken to decrease risk of reoccurrence at the system level.

ERROR TYPE	ACTIONS TAKEN TO DECREASE RISK OF REOCURRENCE AT THE SYSTEM LEVEL
☐ Task An individual did NOT ensure planned interventions were in place as intended (e.g. bed alarm not activated)	
☐ Judgement An individual made a decision about an uncertain process (e.g. patient at high risk for falls left alone while toileting in the absence of a policy not to do so)	
☐ Care Coordination Communication among multiple staff members was incomplete, inconsistent, or misunderstood (e.g. fall risk status not communicated to all parties)	
☐ System Communication and multiple elements (tasks, knowledge, equipment) combine to make the system unreliable (e.g. unreliable process for monitoring orthostatic BP across the system)	

Thank you for contributing to patient safety and quality of care.

GREAT LAKES
PARTNERS FOR PATIENTS

Bedside Signage

Get Up...Get Moving....Get Better!

Day:_____

GOAL: 3 Walks

[ ]   [ ]   [ ]

Goal: Up to Chair 3x

[ ]   [ ]   [ ]

White Board

I'm at risk for a fall because..........

I could be injured if I fall because..........

Activity orders:

How much assistance   Assistive Device

Patient and Family Engagement Tools

- Falls Teach Back Tool

- Anticoagulation Teach Back Tool

- Fall Prevention Tips for Patients and Families

- Patient Agreements

Patient Partnership Agreement

NOSCAN

"NOSCAN"

CoxHealth
Springfield, MO
All Departments

Patient Sticker

PREVENTING FALLS IN THE HOSPITAL
FALL PREVENTION PARTNERSHIP

We would like your stay at CoxHealth to be as safe as possible. We would like to partner with you to help decrease your chance of experiencing an accidental fall.

- Please do call for assistance when you need to get out of bed. Some medications may have side effects that make you feel weak or dizzy.

- Please wear the provided non-skid slippers when up.

- Please use only unmoving objects to help steady yourself. Don't use your IV pole, tray table, wheelchair, or other objects that can move. These items have wheels and could roll away from you.

- Please use the handrails in the bathroom and hallway.

- If you wear glasses or hearing aides at home, please use them while in the hospital as well.

- Please be aware of tubing, such as oxygen, catheters, etc. that may interfere with walking. By calling for assistance, staff can assist you and keep you safe.

- If you notice any spills or wet areas on the floor, please notify staff so they may be cleaned up quickly.

It is our goal to round hourly from 6am to 10pm and every two hours from 10pm to 6am to see if you need assistance to the bathroom, are in pain, are in a comfortable position and have all items you may need within your reach. It is our goal to respond to your call light timely and address any needs you may have.

By partnering together we can make your experience while in the hospital a safe one.

I will partner with my caregivers by being aware of the guidelines listed above and will notify nursing staff if my care expectations or needs are not being met.

Patient Signature _____ Date _____

Staff Signature _____ Date _____

Preventing falls while in the hospital

Your best care.

COXHEALTH

[Cox Patient Agreement](#)

GREAT LAKES
PARTNERS FOR PATIENTS

Share your bright spots!

- Describe how you overcame staff discomfort in including the patient in the post fall huddle?

- What have you learned as a result of having a patient rep on the falls team?

- Any other PFE Bright Spots?

Why Some Ideas Survive and Others Die
MADE to STICK
Chip Heath & Dan Heath
Read by Charles Kahlenberg
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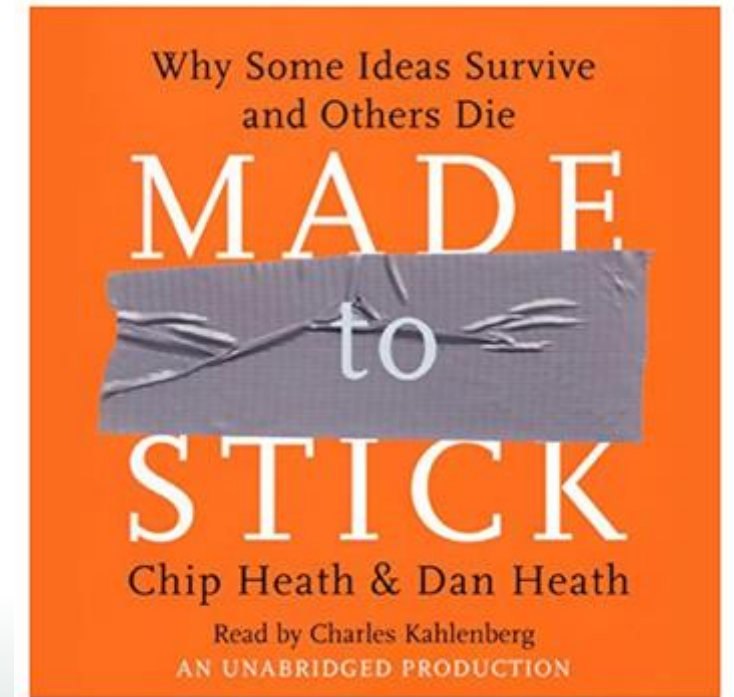
Reactions / Questions

jconrad@cynosurehealth.org

2017 Falls with Injury Change Package

[Falls with Injury Change Package](#)

[Falls Top Ten Checklist](#)

Resources

[Days Since Last Fall Sign](#)

Risk and Care Planning tools

- [NICE Multifactorial Fall Risk Assessment and Management Tool](#)

- Fall TIPS© Risk Screening and care plan tool

  - [Article](#)

  - [Fall TIPS Webinar: How to Implement on your unit](#)

Injury Risk Assessment

- [Safe From Falls Roadmap – Anticogualtion](#)

- [ABCS Injury Risk Assessment](#)

Injury Mitigation

- [Floor Mat Resource and Implementation Guide](#)

Mobility Assessments

- [Banner Mobility Assessment Tool for Nurses (BMAT) viceo and Tool](#)

- [Timed Get up and Go Test](#)

- [Get Up and Go Test](#)

Mobility Resources

- [Walk of Fame Mobility Board](#)

- [CAPTURE Falls mobility training videos, mobility tools](#)

- [Activity tracker article](#)

Delirium Assessment Resources

- [ICU LIberation - Delirium and Mobility Resourses](#)

- [Hopsital Elder Life Program (HELP) for the Prevention of Delirium](#)

Resources

Medication Review Resource

- [British Geriatric Society: Medicines and Falls in the Hospital Guidance Sheet](#)

- [AHRQ Medication Risk Tool](#)

Patient and Family Engagement Resources

- [Anticoagulation Teach Back Tool](#)

- [Teach Back Tool for Fall Prevention](#)

- [Teach Back Event Recording](#)

- [Fall Tips for Patient and Families Handout](#)

- Patient Agreements:

  - [Intermountain Health Patietn Agreement](#)

  - [Cox Health Fall Prevention Partnership](#)

Interdisciplinary Resources

- [Guide: Creating a Safe Environment to Prevent Toileting Related Injuries](#)

-

No Pass Zone Resources:

- [Sample Peer General No pass zone video](#)

- [Sample Peer Intro Video for Leadership](#)

- [Generic Non-clinical training video](#)

- All Staff video from HRET Critical Thinking Video Series: [Critical Thinking Video Series](#)

Thought Provoking Articles

- [False Bed Alarms a Teachable Moment](#)

- [The Tension Between Promoting Mobility and Preventing Falls in the Hospital](#)

- [The Frances Healey Reader: Key ideas and references](#)

Break

10 MINUTES

GREAT LAKES
PARTNERS FOR PATIENTS

Agenda

- Introductions
- Preventing Harm from Falls and Immobility
  - *Jackie Conrad, RN, MBA; Cynosure Health*
- Break
- **Improvement Workshop**
  - ***Developing an Aim Statement***
  - ***Driver Diagrams as a Plan for Change***
- Final Thoughts
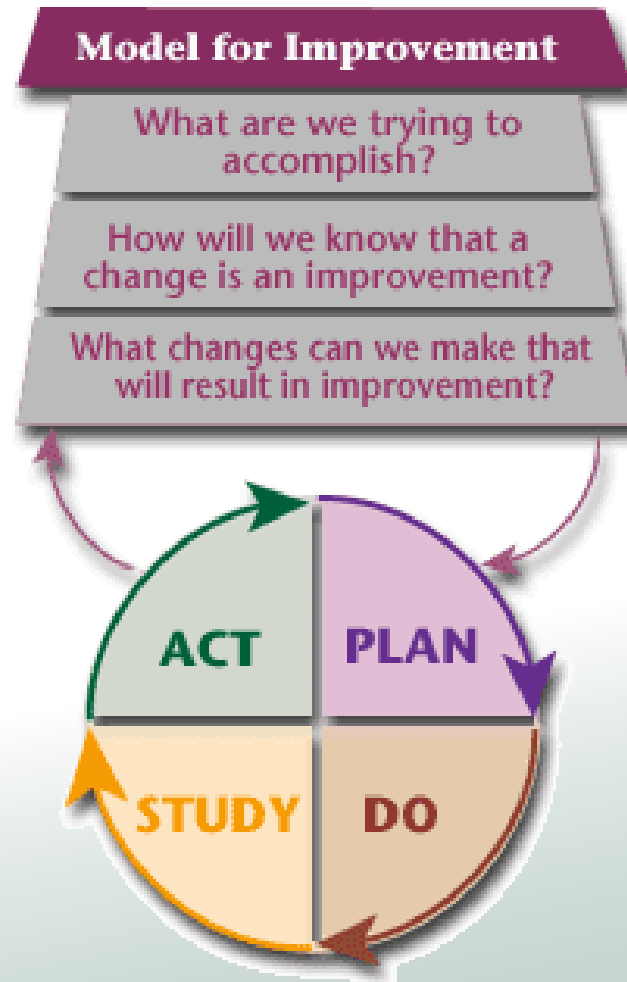
The Model for Improvement

The Model for Improvement

Model for Improvement

What are we trying to accomplish?

How will we know that a change is an improvement?

What changes can we make that will result in improvement?

ACT PLAN
STUDY DO

The Model for Improvement
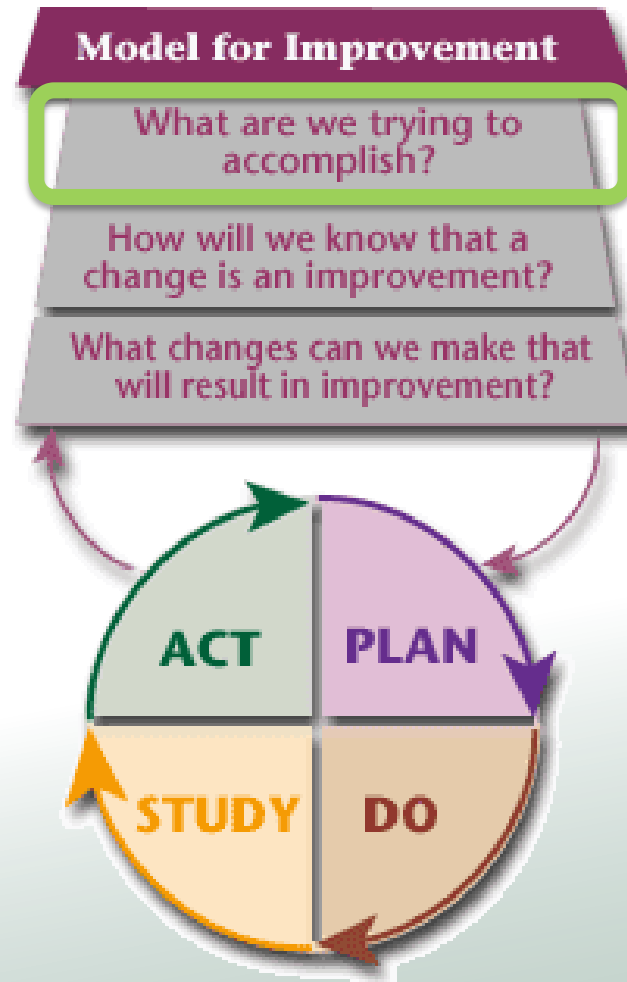
Developing an Aim Statement

- Aim
  - Verb: Point or direct at a target; have the intention of achieving.
  - Noun: A purpose or intention, a desired outcome.

- Having an aim is crucial to your success!

"A system is a network of interdependent components working together toward a common aim. Every system must have an aim. Without an aim that is clear to all, there is no system."

-W. Edwards Deming, Out of the Crisis

Developing an Aim Statement

Explicit Aim

- Open, clear, unambiguous, precise, plain

Implicit Aim

- Understood, implied, unspoken, embedded, hidden

GREAT LAKES
PARTNERS FOR PATIENTS

Developing an Aim Statement

- Essential components of an aim statement:
  - Population
  - Goal
  - Time Expectation
  - Where
  - Guidance
- Outcome measure

We will reduce our total monthly med surg falls with injury from the FY 2007 average of 6 per month to 3 per month by the end of FY2018 under the guidance of our unit managers with accountability to our CNO, Linda Lee.

GREAT LAKES
PARTNERS FOR PATIENTS

Developing an Aim Statement

- Essential components of an aim statement:
  - Population
  - Goal
  - Time Expectation
  - Where
  - Guidance

- Process Measure

We will increase our initiation of a post fall huddle at the bedside with the patient within one hour of the fall from the FY 2017 Q4 average of 30% to 60% on med surg units by FY Q4 2018, under the guidance of our unit managers and our CNO, Linda Lee.

Developing an Aim Statement

- Essential components of an aim statement:
  - **Population**
  - Goal
  - Time Expectation
  - Where
  - Guidance

*We will reduce our total monthly **adult med surg** falls with injury from the FY 2007 average of 6 per month to 3 per month by the end of FY2018 under the guidance of our unit managers with accountability to our CNO, Linda Lee.*

Developing an Aim Statement

- Essential components of an aim statement:
  - Population
  - **Goal**
  - Time Expectation
  - Where
  - Guidance

*We will reduce our total monthly med surg falls with injury from the FY 2007 average of **6 per month to 3 per month** by the end of FY2018 under the guidance of our unit managers with accountability to our CNO, Linda Lee.*

Developing an Aim Statement

- Essential components of an aim statement:
  - Population
  - Goal
  - **Time Expectation**
  - Where
  - Guidance

*We will reduce our total monthly med surg falls with injury from the FY 2007 average of 6 per month to 3 per month by the **Q4 of FY2018** under the guidance of our unit managers with accountability to our CNO, Linda Lee.*

Developing an Aim Statement

- Essential components of an aim statement:
    - Population
    - Goal
    - Time Expectation
    - **Where**
    - Guidance

*We will reduce our total monthly **med surg** falls with injury from the FY 2007 average of 6 per month to 3 per month by the end of FY2018 under the guidance of our unit managers with accountability to our CNO, Linda Lee.*

Developing an Aim Statement

- Essential components of an aim statement:
  - Population
  - Goal
  - Time Expectation
  - Where
  - **Guidance**

*We will reduce our total monthly med surg falls with injury from the FY 2007 average of 6 per month to 3 per month by the end of FY2018 under the **guidance of our unit managers with accountability to our CNO, Linda Lee.***

Developing an Aim Statement

- Essential components of an aim statement:
  - **Population**
  - **Goal**
  - **Time Expectation**
  - **Where**
  - **Guidance**

*We will reduce our total monthly **adult med surg** falls with injury from the FY 2007 average of **6 per month to 3 per month** by the end of FY2018 under the **guidance of our unit managers with accountability to our CNO, Linda Lee.***

Developing an Aim Statement

- Essential components of an aim statement:
  - **Population**
  - **Goal**
  - **Time Expectation**
  - **Where**
  - **Guidance**

Progress trumps perfection!

*We will reduce our total monthly **adult med surg** falls with injury from the FY 2007 average of **6 per month to 3 per month** by the end of FY2018 under the **guidance of our unit managers with accountability to our CNO, Linda Lee.***

GREAT LAKES
PARTNERS FOR PATIENTS

Develop your aim statement!

USE YOUR GAP ANALYSIS AS A JUMPING-OFF POINT.

The Model for Improvement

Developing Change Ideas

- "Change"?

  - First order change = do more, do less; more of the same ideas/changes that have already been implemented

  - Second order change = create a new way to do things completely; "modify the flowchart"

Developing Change Ideas

- Five methods to develop change ideas:
  - Logical thinking about current system
  - Benchmarking and learning from others
  - Creative thinking
  - Using change concepts
  - Using technology

Developing Change Ideas

Investigate Your Problem and Implement Best Practices

Driver diagrams: A driver diagram visually demonstrates the causal relationship between your change ideas, secondary drivers, primary drivers and your overall aim. A description of each of these components is outlined in the table below. This change package is organized by reviewing the components of the driver diagram to first, help you and your care team identify potential change ideas to implement at your facility and second, to show how this quality improvement tool can be used by your team to tackle new process problems.

Aim	Primary Driver	Secondary Driver	Change Idea
		Secondary Driver	Change Idea
	Primary Driver	Secondary Driver	Change Idea

AIM: A clearly articulated goal or objective describing the desired outcome. It should be specific, measurable and time-bound.

PRIMARY DRIVER: System components or factors that contribute _directly_ to achieving the aim.

SECONDARY DRIVER: Action, interventions or lower-level components necessary to achieve the primary driver.

CHANGE IDEAS: Specific change ideas which will support/achieve the secondary driver.

Outcome   *Primary Drivers*   *Secondary Drivers*   *Ideas for Process Changes*
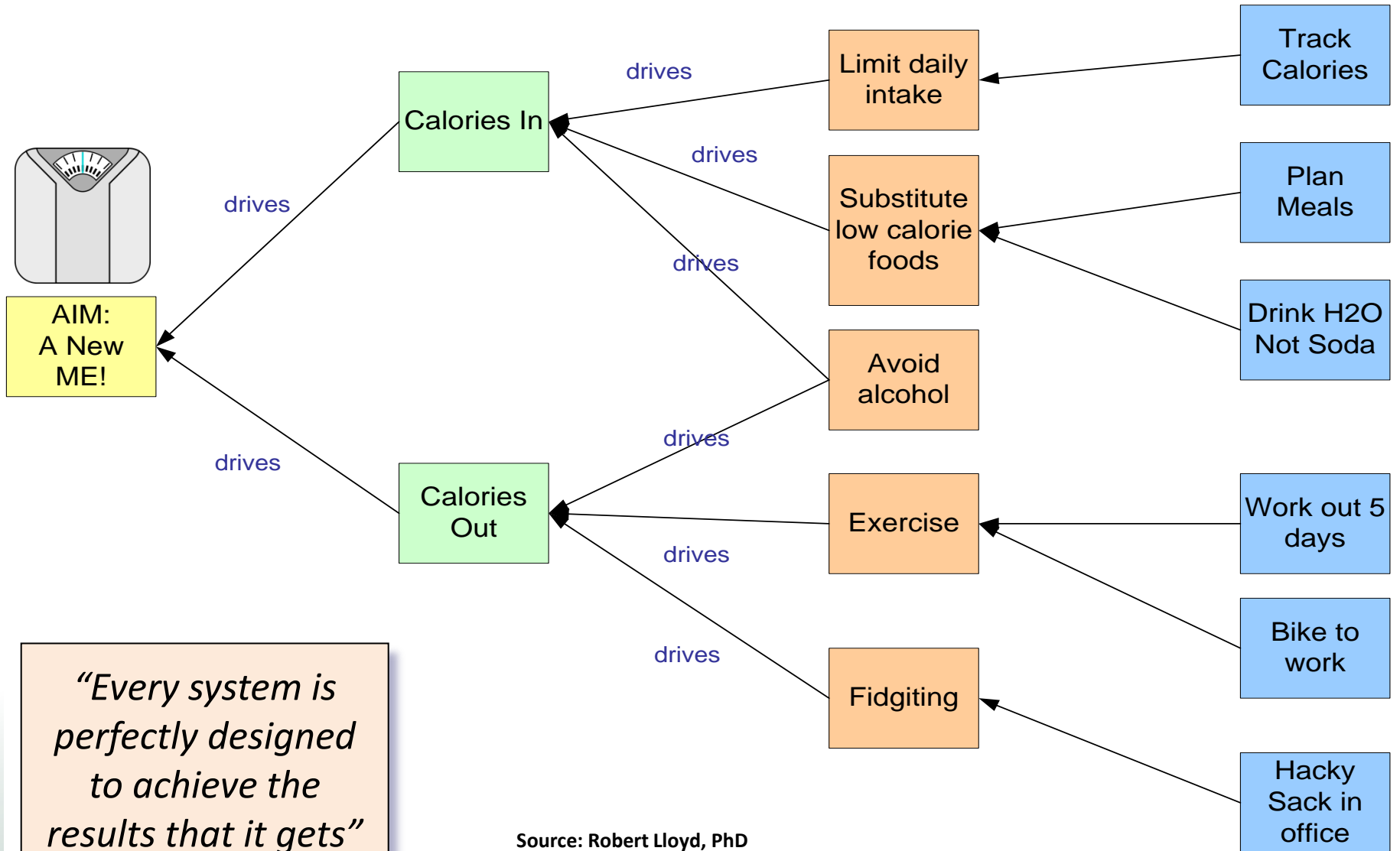
AIM: A New ME!

drives

Calories In
Calories Out

drives

Limit daily intake
Substitute low calorie foods
Avoid alcohol
Exercise
Fidgiting

drives

Track Calories
Plan Meals
Drink H2O Not Soda
Work out 5 days
Bike to work
Hacky Sack in office

"Every system is perfectly designed to achieve the results that it gets"

Source: Robert Lloyd, PhD

GREAT LAKES PARTNERS FOR PATIENTS

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Developing Change Ideas

AIM	PRIMARY DRIVERS	SECONDARY DRIVERS	CHANGE IDEAS
Reduce Injuries from Falls by 20% by end of FY 2018	Address Modifiable Risk Factors	Implement a screening tool that triggers assessment, interdisciplinary input to address risks	
		Avoid hypnotics/sedatives, anticholinergics	
		Screen for Injury Risk	
	Implement a safe mobility plan	Assess mobility upon admission	
		Staff access to mobility equip 24/7	
		Maintain a safe environment and path to toilet	
		Mobilize patient at their highest level three times a day from day 1	
		Communicate mobility plan to the team and the patient	
		Document and track mobility activities	
	Engage the patient and family	Provide structed fall education using teach back	
		Conduct bedside handoffs with the patient and address mobility	
		Conduct post fall huddles at the bedside with the patient	
	Protect the patient from injury	Provide optimal post fall care – special care for blood thinners	
		Provide appropriate level of supervision in toilet room for high injury risk patients	
		Implement floor mats for high injury risk patients	

Developing Change Ideas

AIM	PRIMARY DRIVERS	SECONDARY DRIVERS	CHANGE IDEAS
Your Aim Statement Here!	1	1a	‼️
		1b	
	2	2a	‼️
		2b	
	3	3a	‼️
		3b	‼️
		3c	
	4	4a	‼️

Selecting Change Ideas

Idea	Can be accomplished in 90 days?	There's will to fix this problem?	Is within our control?	Is a sponsor for this work?
Idea 1	2	4	3	4
Idea 2	5	4	4	5
Idea X	4	2	1	3

High

IMPACT of the solution

Tips:
- Silently plot ideas
- Leave ideas on sticky notes
- … or transform ideas to #s
- Don't overthink
- Group vote after

Low ──────────────────────────→ High

EFFORT
required to implement solution
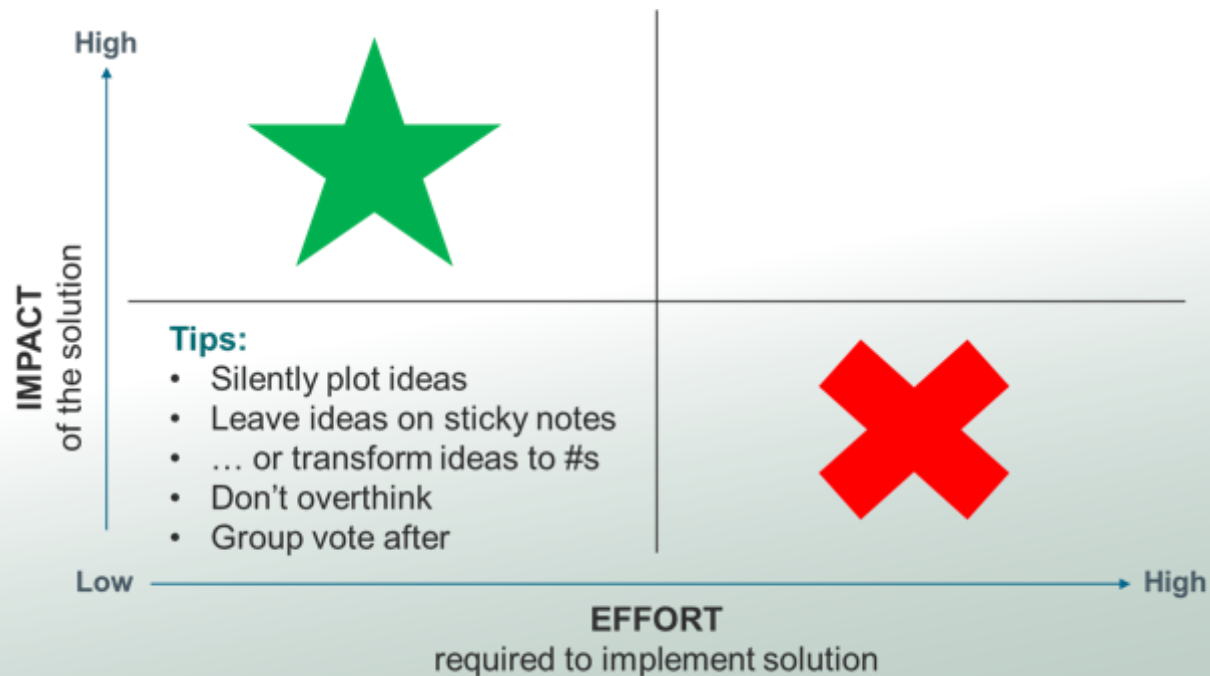
Develop your driver diagram!

USE YOUR AIM STATEMENT AS A JUMPING-OFF POINT.

Once you have your diagram...

GO TALK TO ANOTHER GROUP AND PROVIDE FEEDBACK.

GREAT LAKES
PARTNERS FOR PATIENTS

Agenda

- Introductions

- Preventing Harm from Falls and Immobility
  - *Jackie Conrad, RN, MBA; Cynosure Health*

- Break

- Improvement Workshop
  - *Developing an Aim Statement*
  - *Driver Diagrams as a Plan for Change*

- **Final Thoughts**

Wrap-Up

- Upcoming calls –
  - Wednesday, June 6 from 10-11a
  - Wednesday, June 20 from 10-11a
- Finish your gap analysis if you have not already done so to begin identifying your roadmap for change
- Continue to build your knowledge and the need for change – use your driver diagram!
- Please reach out to us for anything!
  - Adam Kohlrus (P: 217-541-1181; akohlrus@team-iha.org)
  - Brigette DeMarzo (P: 630-276-5525; bdemarzo@team-iha.org)
  - Kelly McMahon (P: 630-276-5585; kmcmahon@team-iha.org)

GREAT LAKES
PARTNERS FOR PATIENTS

Thank you!

Decision-Making Tree for Patients Who Are Hemodynamically Unstable With Movement

Screen for mobility readiness within 8 hrs of admission to ICU & daily initiate in-bed mobility strategies as soon as possible

Is the patient hemodynamically unstable with manual turning?
- O_2 saturation $\leq$ 90%
- New onset cardiac arrhythmias or ischemia
- HR < 60 <120
- MAP < 55 >140
- SPB < 90 >180
- New or increasing vasopressor infusion

No → Begin in-bed mobility techniques and progress out-of-bed mobility as the patient tolerates

Yes ↓

Is the patient still hemodynamically unstable after allowing 5-10 minutes' adaption post-position change before determining tolerance?

No → Begin in-bed mobility techniques and progress out-of-bed mobility as the patient tolerates

Yes ↓

Screen for mobility readiness within 8 hrs of admission to ICU & daily initiate in-bed mobility strategies as soon as possible

No → Allow the patient a minimum of 10 minutes of rest between activities, then try again to determine tolerance

Yes ↓

Has the manual position turn or HOB elevation been performed slowly?

No → Try the position turn or HOB maneuver slowly to allow adaption of cardiovascular response to the inner ear position change

Yes ↓

Initiate continuous lateral rotation therapy via a protocol to train the patient to tolerate turning

Vollman KM. *Crit Care Nurse*. 2012;32:70-75.
Vollman KM. *Crit Care Nurs* Q. 2013;36:17-27.

Progressive Mobility Continuum

START HERE	Includes complex, intubated, hemodynamically unstable and stable intubated patients; may include non-intubated		Includes intubated, non intubated hemodynamically stable/stabilizing, no contraindications		
↓	**LEVEL I**	**LEVEL II**	**LEVEL III**	**LEVEL IV**	**LEVEL V**

START HERE side (left column):

Perform Initial mobility screen w/in 8 hours of ICU admission
Reassess mobility level at least every 24 hours (Recommended at shift Δ)

Refer to the following criteria to assist in determining mobility level

- o PaO2/FiO2 ≥ 250
- o Peep <10
- o O2 Sat ≥ 90%
- o RR 10-30
- o No new onset cardiac arrythmias or ischemia
- o HR >60 <120
- o MAP >55 <140
- o SBP >90 <180
- o No new or increasing vasopressor infusion
- o RASS ≥ 3

NO → Start at level I*

YES → Start at level II and progress*

LEVEL I

RASS -5 to - 3

Goal: clinical stability; passive ROM

ACTIVITY:
HOB ≥ 30º
*Passive ROM 2X/d performed by RN, or UAP

CLRT/Pronation initiated if patient meets criteria based on institutional practice
OR
Q 2 hr turning

Tolerates Level I Activities →

LEVEL II

RASS -3 & up

Goal: upright sitting; increased strength and moves arm against gravity

PT consultation prn
OT consultation prn

ACTIVITY:
Q 2 hr turning
*Passive /Active ROM 3x/d
1. HOB 45º X 15 min.
2. HOB 45º,Legs in dependant position X 15 min.
3. HOB 65º,Legs in dependant position X 15 min.
4. Step (3) & full chair mode X20 min. 3X/d
Or
Full assist into cardiac chair 2X/day

Tolerates Level II Activities →

LEVEL III

RASS -1 & up

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

PT: Active Resistance Once a day, strength exercises

OT consultation prn

ACTIVITY:
Self or assisted
Q 2 hr turning
1.Sitting on edge of bed w/RN, PT, RT assist X 15 min.
2.Progressive bed sitting Position Min.20 min. 3X/d
Or
Pivot to chair position 2X/d

Tolerates Level III Activities →

LEVEL IV

RASS 0 & up

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

PT x 2 daily
OT consult for ADL's

ACTIVITY:
Self or assisted
Q 2 hr turning
1.Bed sitting Position Min.20 min. 3X/d;
2.Sitting on edge of bed; stand w/ RN, PT, RT assist
3.Active Transfer to Chair (OOB) w/ RN/PT/RT assist Min. 3X/d

Tolerates Level IV Activities →

LEVEL V

RASS 0 & up

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

PT x 2 daily & OT x1 daily

ACTIVITY:
Self or assisted
Q 2 hr turning
1.Chair (OOB) w/ RN/PT/RT assist Min. 3X/day
2.Meals consumed while dangling on edge of bed or in chair

Ambulate progressively longer distances with less assistance x2 or x3/day with RN/PT/RT/UAP

For each position/activity change allow 5-10 minutes for equilibration before determining the patient is intolerant

If the patient is intolerant of current mobility level activities, reassess and place in appropriate mobility level

*Mobility is the responsibility of the RN, with the assistance from the RT's Unlicensed Assistive Personnel and PT/ OT. PT and OT may assist the team with placement to the appropriate mobility level of activity, *always prioritizing patient and provider safety*. Placement is based on clinical judgment.