HRET HIIN FALLS VIRTUAL EVENT

The Triple Crown of Safe Mobility: Engaging Nurses, Patients and Families

June 28, 2018
WELCOME AND INTRODUCTIONS
Radhika Parekh, MHA, Program Manager | HRET
Webinar Platform Quick Reference

- Mute computer audio
- Today's presentation
- Download slides/resources
- Chat with participants
- Register for upcoming events
**Agenda for Today**

<table>
<thead>
<tr>
<th>Time</th>
<th>Session</th>
<th>Speaker/Role</th>
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<tbody>
<tr>
<td>11:00 – 11:03 a.m.</td>
<td>Welcome and Introductions</td>
<td>Radhika Parekh, MHA Program Manager, HRET</td>
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<td></td>
<td>Introduction to today’s event and agenda overview.</td>
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<tr>
<td>11:03 – 11:07 a.m.</td>
<td>HRET HIIN Falls Data Update</td>
<td>Vrinda Mahishi, MPH Data Analyst, HRET</td>
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<td>Review the overall HRET HIIN falls progress to date.</td>
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<td>11:07 – 11:12 a.m.</td>
<td>Framing the Discussion</td>
<td>Jackie Conrad, RN, MBA, RCC Improvement Advisor, Cynosure</td>
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<td>Briefly discuss the three key drivers of fall injury prevention: identifying high risk, vulnerable populations; preventing delirium and functional decline through mobilization; and engaging patients and families.</td>
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<td>11:12 – 11:25 a.m.</td>
<td>Targeting the Elderly Population</td>
<td>Lisa Thompson CJCP-CPHRM-CPHQ- QMC Chief Quality Officer-Patient Safety Lea Regional Medical Center</td>
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<td>Learn about Lea Regional Medical Center’s data-driven injury reduction strategies that include a safety watch program, use of fall mats, and specific toileting supervision interventions. Acute and Transitional Care Unit successes will be shared.</td>
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<td>Time</td>
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| 11:25 – 11:37 a.m.  | Nurses Step up for Safe Mobility in Med Surgery                                | Review Catholic Medical Center’s learnings from two pilots of a nurse driven mobility program. Key elements include RN mobility assessment, mobility expectations and daily monitoring of the number of linear feet stepped by patients with nurses. Early results include reductions in falls and increased nurse and patient satisfaction. | Mercedes Fleming, RN  
Manager Nursing Systems and Support  
Catholic Medical Center                                                   |
| 11:37 – 11:50 a.m.  | Patient Safety Volunteers Rounding to Reduce Falls                            | Navicent Health implemented a pilot program with patient safety volunteers to round on high fall risk patients using teach back and to conduct environmental scans for auditing. Learn about the power of peers supporting patient activation in their safety plan. | Meryl Montgomery, RN, MSN, CLSSBB  
Coordinator Professional Nursing Practice  
Navicent Health                                                          |
| 11:50-11:55 a.m.    | Panel Discussion                                                               | Engage in active dialogue with the presenters regarding details of their approaches to reduce injurious falls.                                                                                           | All presenters and participants                                                                      |
| 11:55-12:00 p.m.    | Closing Remarks                                                                | Discus key learnings and share HRET HIIN resources                                                                                                                                                     | Radhika Parekh, MHA  
Program Manager, HRET                                                      |
Who is in the Room?

• What department do you represent?
  ○ Nursing
  ○ Rehab
  ○ Pharmacy
  ○ Medical Staff
  ○ Quality
  ○ Administration
  ○ Other
Chat your Proud Moments

• Please put in the chat what you are proud of in your improvement work in reducing injuries from falls and immobility.
Figure 5: Falls w/Injury
Results limited to hospitals reporting baseline data. HRET specified 2014 as the baseline timeframe for the measure.

<table>
<thead>
<tr>
<th>Rate</th>
<th>% reporting</th>
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<td>0.63</td>
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% reporting is calculated as: number of hospitals reporting pre-HIIN baseline data / number of hospitals expected to report (n=1640)

Results for months where data submission is below 50% should be interpreted with caution. Data are suppressed for months where submission is less than 30%.

Progress towards 20% reduction goal (shown as relative reduction in the quarterly / aggregate rates since baseline)

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<td>0.68</td>
<td>2.0%</td>
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<td>0.65</td>
<td>-2.5%</td>
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<td>0.63</td>
<td>-4.8%</td>
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<tr>
<td>0.66</td>
<td>-0.5%</td>
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Framing the Discussions

Jackie Conrad RN, MBA, RCC™
Improvement Advisor
Cynosure Health
The Triple Crown Winner – Justify!

The Triple Crown of Safe Mobility

Nurses

Patients

Families
Driver Diagram

INTERDISCIPLINARY HOUSE-WIDE APPROACH
- INTERDISCIPLINARY TEAM
- SAFE ENVIRONMENT
- TEAM APPROACH

LEARNING LOOP
- BIG DATA
- POST FALL HUDDLES

IDENTIFY HIGH RISK, VULNERABLE POPULATIONS
- SCREEN FOR HISTORY OF FALLS, OR FALLS AS REASON FOR ADMIT
- CONSIDER ELDERS HIGH RISK
- SCREEN FOR RISK FOR INJURY USING THE ABCS

ASSESS AND IMPLEMENT MULTIFACTORIAL PLAN
- MULTIFACTORIAL ASSESSMENTS — COGNITIVE, MOBILITY, URINARY CONTINENCE, FRACTURE RISK
- PROGRESSIVE MOBILITY
- AVOID HYPNOTICS/SEDATIVES

PREVENT DELIRIUM AND FUNCTIONAL DECLINE
- INJURY ASSESSMENT PRIOR TO MOBILIZATION FOR UNWITNESSED FALLS
- SPECIAL PROCEDURES FOR PATIENTS ON BLOOD THINNERS
- INTENTIONAL Rounding Hourly OR EVERY TWO HOURS
- 7 ARMS LENGTH IN THE BATHROOM FOR VULNERABLE PATIENTS
- 1:1 OR VIDEO SURVEILLANCE
- 1:1 OR VIDEO SURVEILLANCE AT THE BEDSIDE — HUDDLE
- ORGANIZATIONAL DESIGN

PROVIDE OPTIMAL POST-FALL CARE
- SPECIAL PROCEDURES FOR PATIENTS ON BLOOD THINNERS
- INTENTIONAL Rounding Hourly OR EVERY TWO HOURS
- 7 ARMS LENGTH IN THE BATHROOM FOR VULNERABLE PATIENTS
- 1:1 OR VIDEO SURVEILLANCE
- 1:1 OR VIDEO SURVEILLANCE AT THE BEDSIDE — HUDDLE
- ORGANIZATIONAL DESIGN

PROVIDE APPROPRIATE LEVEL OF SURVEILLANCE/OBSERVATION
- SPECIAL PROCEDURES FOR PATIENTS ON BLOOD THINNERS
- INTENTIONAL Rounding Hourly OR EVERY TWO HOURS
- 7 ARMS LENGTH IN THE BATHROOM FOR VULNERABLE PATIENTS
- 1:1 OR VIDEO SURVEILLANCE
- 1:1 OR VIDEO SURVEILLANCE AT THE BEDSIDE — HUDDLE
- ORGANIZATIONAL DESIGN

ENGAGE PATIENTS AND FAMILIES
- SPECIAL PROCEDURES FOR PATIENTS ON BLOOD THINNERS
- INTENTIONAL Rounding Hourly OR EVERY TWO HOURS
- 7 ARMS LENGTH IN THE BATHROOM FOR VULNERABLE PATIENTS
- 1:1 OR VIDEO SURVEILLANCE
- 1:1 OR VIDEO SURVEILLANCE AT THE BEDSIDE — HUDDLE
- ORGANIZATIONAL DESIGN
Evidence Based Fall Practices

Free from Harm from Falls & Immobility

Delirium

Mobility

Engagement

Meds
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
- Non-pharmacological delirium interventions have shown to decrease the chance of falling by 62%

Non-pharmacological Delirium Interventions

• 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).

Early Progressive Mobility

Injury from Falls
HAPI/U
Delirium
CAUTI
VAE
VTE
Readmissions
Worker Safety

GET - U P
Reducing Injuries from Falls in the Hospital and Transitional Care Settings

Lisa D. Thompson, CJCP-CPHRM-CPHQ-TQMC
Chief Quality Officer/Patient Safety Officer/FCO – Risk/MSS
Lea Regional Medical Center, New Mexico
Lea Regional Medical Center

- Acute care facility in the State of New Mexico since 1974.
- 205 licensed beds
- Accreditations: Chest Pain Center, Primary Stroke Center under The Joint Commission (TJC), TJC accredited and the only facility in the State of New Mexico accredited in Heart Failure.
- Lea Regional’s Transitional Care Unit (TCU) is a separately licensed skilled nursing facility with 16 beds.
Getting Started

• Began in late 2012 with new leadership and re-implementation/re-education of the screening process to assist staff with identifying those patients who are at high risk for falls to ensure preventative measures are put in place.

• Falls reduction and elimination of injuries related therein remains a focus to this date – adjusting focus as needed dependent upon the patient population, risk assessments, trends, etc.
Our data pointed to vulnerable populations

- Focused area/acute care = Medical/Surgical Unit
  - Patient population varies (primarily 80 years of age in 2016; in 2018 – 65 years of age or older trend/focus)

- ICU population trends = confused, detoxing patients - age range from 20-60 years of age
  - Opioid, alcohol, or methamphetamine detoxing – overdose - with critical medical issues
Focused on Injury Prevention

- **Yellow arm bands and non-skid socks** so that all staff may identify patients
- **Low beds** with bed alarms (chair alarms also)
- **Fall Risk sign** on the door of the patient’s room
- Frequent **rounding** on the 4 P’s- position, pain, potty and personal needs (glasses, water, phone, etc.)
- **Fall mats**
- Family/patient education (**signed acknowledgement/education**) with a copy to the family/patient and a copy in the chart
- **Daily Interdisciplinary Team Meeting**
- **Leadership rounding** ensuring fall precautions in place every day (audit)
- **Hospital-Wide Safety Huddle** mandatory topic
Escalating Injury Prevention Interventions

• Hourly Rounding for all patients and **Safety Watch** program for high risk for fall patients – more frequent rounding for safety
  – similar to that of **Safety Watch** for suicidal patients
  – rounding on patient **every 15 minutes** or less
  – this has proved successful for confused patients, impulsive patients, etc

• Family/caregiver **staying with the confused or non-compliant patient.** (sitter if needed) We are happy to order a meal tray for the family member staying with the patient for safety.
Toileting Interventions

• Overall trends noted related to falls – toileting (bedside commode or to the bathroom unassisted)
  – No patient to be left alone in the bathroom or bedside commode who is at risk for falling
  – Removal of the bedside commode from the patient’s room when not in use (remove patient’s inclination/belief that he/she can transfer alone because “it is just right there....I don’t want to bother nurse”)
  – Closing the bathroom door (for confused patients, they may believe they can go by themselves)
  – Prompt response to call bells for assistance (we are able to track call bells, response times, etc.)
  – Fall Mats on both side of patient’s bed, while in a chair, etc.
**Falls with Injuries – HIIN Goal Achieved**

Falls with Minor Injury or Greater REDUCED:

<table>
<thead>
<tr>
<th>Baseline Rate Per 1000 Patient Days</th>
<th>Target Rate from Baseline</th>
<th>Current Year End Data</th>
<th>Numerator</th>
<th>Denominator - Patient Days</th>
<th>Rate per 1000 Patient Days</th>
<th>Percent improvement from Baseline</th>
<th>Improvement Status (scale)</th>
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</thead>
<tbody>
<tr>
<td>0.35</td>
<td>0.28</td>
<td>2017</td>
<td>2</td>
<td>10,908</td>
<td>0.18</td>
<td>47%</td>
<td>Achieved Improvement</td>
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</table>
Balancing Safety & Mobility

• Patient ambulation and functional mobility is a primary focus on the TCU

• Mobility is promoted throughout the TCU by:
  – Engaging the patient to get out of bed and go to the dining hall for meals with fellow patients
  – Daily hygiene practices – assistance and encouraging independence – use patient’s own clothing instead of hospital gown, etc.
  – Daily PT/OT
  – Weekly Pastoral Services/Church Services in the dining hall
  – Patient kitchen availability for OT training
BARRIERS AND HOW THEY WERE RESOLVED

• For TCU in 2015/2016, a trend was identified: patient falls/falls with injuries involving patients being left unattended in the dining hall. Implemented no patient at risk for falling to be unattended in the dining hall.

• *Fall Mats - push back from staff* – staff concerned with tripping – continue to educate the importance and provide the data that patients that fall on fall mats do not/did not result in a significant injury.

• *Bedside commodes* removed from bedside unless in use and closing the bathroom door – ongoing education.

• In 2016, the TCU Medical Director and staff pushback on family staying with patient for an extensive amount of time or at night – focused on better understanding of family support impact on patient recovery and safety - coordination of care with family involvement.

• Make sure staff are knowledgeable of the different types of bed and chair alarms and how to activate the alarms – step by step, picture education improved our staff knowledge.
TCU Results

NO FALLS WITH INJURIES IN 2 YEARS!

Reduction in falls!

![Bar chart showing reduction in patient falls over years]

- **Patient Falls**
- **>Minor Injury**
ADVICE FOR OTHERS

• Remain a focus of your QAPI/Risk monitoring
• Multi-disciplinary team approach
  – Front line team membership
• Education, education, education...(staff, patient, families...) – Skills Lab annually for nursing
• Safety Watch program works (sitters are not necessarily the solution)
• Use clinical judgement - Patients whose fall risk score is “on the fence” – between low or high fall risk – focus on the side of safety and implement fall precautions in alignment with a higher fall risk score
• Leadership validation of fall precautions in place – weekdays, weekends...holidays...
• Toileting trends
WRAP UP AND NEXT STEPS

• Preventing patient falls and eliminating patient falls requires constant attention
• Ongoing education and emphasis with new staff onboarding and experienced staff ongoing
• Focus on continued education of falls and medications that can increase fall risks
• Family Support – revamping our Patient/Family Engagement Committee – 3rd Quarter 2018
Nurse Driven Mobility to reduce Injuries from Falls

Mercedes Fleming RN
Manager Nursing Systems and Support
Catholic Medical Center, NH
Catholic Medical Center ("CMC"), a member of GraniteOne Health, is a nonprofit regional health system, with a commitment to delivering the highest quality and most advanced healthcare to patients across New Hampshire. CMC is the home of the nationally-renowned New England Heart & Vascular Institute, rated among the top cardiovascular programs in the country. Our doctors were the first in the state to perform a mechanical heart/left ventricular assist device implant and first in New England to implant the WATCHMAN™ for atrial fibrillation. CMC was also one of the first hospitals in New Hampshire to establish a joint venture with independent medical staff members when it became a partner in the freestanding Bedford Ambulatory Surgical Center and imaging center. CMC’s birthing unit, The Mom’s Place, was the first hospital in the country to have a neonatal unit based on "couplet care." Our nationally-accredited Breast Care Center was the first in the state to use contrast enhanced mammography and SAVI SCOUT® localization for breast surgery. With primary care practices that care for the very young to the young at heart and our dedication to community outreach programs, CMC is helping to foster a healthier community, everyday. CatholicMedicalCenter.org
Interprofessional Partnership Council

**Mission:** To improve the health and healthcare quality for all Catholic Medical Center patients through the collaboration, collective genius, and commitment of all stakeholder disciplines. (Aligns with Organization’s Mission)

**Process to Determine Next Project:** Brainstorming & Multivoting

**Opportunity/Problem to be Solved:** Patients who are functionally independent on admission, with or without the assistance of devices and persons, who lose the ability to ambulate during their inpatient stay necessitating discharge to a skilled nursing facility (SNF).
Solution-Seeking Steps:
- Appreciative Inquiry: Build on What Works Well Now
- Literature Review to Seek Solutions
- Development of a Culture- and Context-Customized Mobility Protocol

Aim:
Implement and maintain a safe, efficient, and evidence-based Mobility Protocol to prevent functional decline of medical patients in which 70% of protocol patients are ambulated and OOB in chair twice each day by 2019.
Understanding the Current State:

- Manual Audit of Ambulation Documentation
- Available Equipment Audit
- Observed/Listened
- Limited Documentation: “I always ambulate, I just don’t document it.”
- Limited Ambulation
- Attribution of Responsibility for Ambulation
- Reports of Inadequate Equipment, Human Resources & Time
- Dashboard Development for Real-Time Data
Two Pilots: What We Learned

First Pilot on 2 Large Inpatient Care Departments:
Partially successful on Med-Surg; Failed on Progressive Care
Primary Failure Point: Additional communication step with the medical staff on large departments

Second Pilot on a Small Med-Surg:
Keys to Success:
Partnering with department leadership
Daily monitoring of ambulation and ambulation documentation
Routine sharing of progress through dashboard postings
Monitoring for impact on falls
Providing individual and group acknowledgement of their contribution to patient health
How Does CMC’s Mobility Protocol Work Now?

<table>
<thead>
<tr>
<th>Task Description</th>
<th>Allergies/Intolerances</th>
<th>Patient ID/Visit ID</th>
<th>Time</th>
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<tbody>
<tr>
<td><strong>Patient Care</strong></td>
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<tr>
<td><strong>TEST, INFECTION (DOB: 15-Aug-2015)</strong></td>
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<tr>
<td>Activity - Out of Bed for Meals -- 3 times a day (with meals)</td>
<td>No Known Allergies / No Intolerances</td>
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<td>Activity - Step 1: Mobility Assessment -- Daily - Sit unassisted x 3 minutes. Complete order and activate Step 2 when goal met.</td>
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<tr>
<td>Activity - Step 2: Stand with only 1 assist -- Daily - Conditional Order. Complete order and activate Step 3 when goal met. Activate when patient can sit unassisted x 3 minutes.</td>
<td>No Known Allergies / No Intolerances</td>
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<tr>
<td>Activity - Step 3: Taking steps/Amputation -- Every shift - Conditional Order. Amble every shift. Increase distance with each ambulation according to patient tolerance. Activate order when patient able to stand.</td>
<td>No Known Allergies / No Intolerances</td>
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**Medications**
Mobility is Medicine: Mobility Dashboard
Mobility is Medicine

Results to Date:

**Noteworthy Caveat:** The decrease in falls is not directly attributable to the implementation and maintenance of the Mobility Protocol.

- 16% Decrease in Falls
- 49 % Increase in the Documentation of Total Feet Ambulated
- Anecdotal evidence of patient & nursing satisfaction
Next Steps:

1. Evaluate correct management of the protocol by nursing: appropriate activation and completion of protocol order steps though observation and report interpretation.

2. Enhanced report data to include times out of bed to chair, correct management of protocol orders, and ability to compare the surgical (no order for mobility protocol) and medical patients (order for mobility protocol).

3. Survey RN and LNA staff members regarding the protocol: decision-making, barriers, roles, documentation, strategies to engage the patient, and strategies to achieve the goals of the mobility protocol despite barriers.

Next Steps (Continued):

5. Analysis of the survey results in combination with the cause-and-effect diagram will elucidate additional next steps.

6. Further streamlining of documentation planned for July 23rd.

7. Consider refinement of protocol order steps.

8. Reeducation on identified knowledge gaps and strategies for successful employment of the protocol (e.g., working with reluctant patients, etc.).

9. Extend the use of the patient engagement tool beyond one department.
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<th>Your Mobility Goal</th>
<th>Morning/ Breakfast</th>
<th>Afternoon/Lunch</th>
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<tr>
<td>Your Goal:</td>
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Eight Recommendations:

1. **Provider Order on Admission:** Early, Shared Risk, Motivates Nurses & Patients, Provides Specific Ambulation & OOB Expectations (Included in Medical Admission Order Sets)

2. **Automate:** Integrate the Mobility Protocol into the EHR (Refer to Rank Order of Error-Reduction Strategies); Order Tasks Display on Worklist to Cue Practice; Worklist Tasks Connect to Flowsheet Documentation

3. **Dashboard:** Real-Time Availability & Transparency of Data; Positive Competitive Response
Eight Recommendations (Continued):

4. **Reports:** All Characteristics of Quality Data

5. **Ongoing Monitoring & Attention to Compliance:**
   
   No Substitute

6. **Refinement:** Through Ongoing PDSA Cycles

7. **Mobility Champions:** Rounding, Sharing Successes & Challenges

8. **Involve Marketing:** Patient & Staff Engagement;
   
   Reinforce Organizational Commitment
Mobility is Medicine

Together, we can do it.

At first, Bruce thought getting out of bed after surgery was impossible, but his doctors, nurses, therapists, and LNAIs told him it was essential to healing. Nurses treated his pain and assessed him for safe ambulation. Once Bruce was safe for ambulation, the nurses initiated the mobility plan. Bruce’s nurses assessed his blood pressure, lung function, fatigue, and alertness. His LNAIs walked with him. Family members encouraged him. His doctors and nurses helped him manage pain, and checked his progress daily.

Now Bruce is moving well, and feeling confident about going home.
Mobility is Medicine

Thank you!
Patient and Family Engagement: Patient Safety Volunteer (PSV) Program

Medical Center Navicent Health

Jerry Bunnell, PSV
Mary Robertson, PSV
Meryl Montgomery, RN
We tried everything, I mean everything, then thought “PSV!”
PSV: Patient Safety Volunteers

• Role: ↓falls, patient satisfaction in a safe environment

• Orientation

• Selection- experience in hospital, strong communication and problem solving skills, knowledge of fall prevention strategies
So, how did we begin in 2016?

• High fall risk patients
  – audit for compliance with high fall risk prevention practices
  – interview with patient regarding fall risk
    • Improve environmental safety
    • remind patients to CALL BEFORE FALL
    • correct within scope
    • provide feedback to staff
    • conversation and distraction
  – assess patient’s perception of risk/ ways to prevent fall
So, what happened?

- 6 months, 6 PSV/4 units

- PSV turnover/ no ↓ in falls
  - Inconsistent unit assignments
  - PSV: “not making a difference”
  - Barriers to recruitment
  - Lack of clear expectations for units
Program refinements early 2017

- PSV input and involvement
- Careful selection of high fall rate units
- Additional education
- Documentation tool iterations

Patient Safety Volunteer Audit by VOLUNTEERS

UNIT: HE VOLUNTEER: Mary2 DATE: 9/7/16

*Instructions: y=yes n=no or N/A. If app if applicable (bed alarm if in bed, chair alarm if in chair)

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Rapid cycle and PSV-engaged changes to the program mid 2017

- “Teach Back” methodology
- PSV included on QMS Committee
- Recognized for “Great Catches”
- Regular debriefs
- Focus on one unit for 2 months pilot of impact
- 2 PSV volunteer on M8
Additional PSV driven program improvements

- Scripting
- self-selected schedule changes
- Follow up/ communication tools
- Data feedback to PSV

- Additional supplies on stock
- Aprons to carry items
- Plastic pockets for cell phones for patients
Focus on Distraction Box

- Identified anxiety and impulsiveness in patients
- Goal: provide comfort and distraction
- Began with coloring materials/word search, stuffed animals.
  Added soft blankets, cards
- Link with Child Life; obtain grant
Communication and follow up tools
OUTCOME: >150 rounds, >1500 patients interviewed. Interventions ↑ to 100%

![Graph showing the number of falls per 1000 patient days for FY16, FY17, PSV pilot, Jul '17, and Aug '17.](chart)

<table>
<thead>
<tr>
<th></th>
<th>FY16</th>
<th>FY17</th>
<th>PSV pilot</th>
<th>Jul '17</th>
<th>Aug '17</th>
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<tbody>
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<td># falls/1000 pt days</td>
<td>3.65</td>
<td>4.77</td>
<td>2.38</td>
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Key Learnings:

• Careful selection to assure “fit”
• Narrow the focus
• Sufficient orientation and support
• Avenues for input and engagement
• Periodic feedback from PSV
• Involve current PSV in selection/ training
• Other fall measures in place in tandem
• Staff oriented to PSV program
Positive attributes for PSV

• Experience as patient/family
• Creativity/ flexibility
• Sense of humor!
• Persistence, commitment
• Communication skills
• Initiative- what do I do in THIS situation?
Going forward:

- PSV program on hiatus pending more volunteers...
  - Link to Hospital Elder Life Program (HELP)
  - Outreach efforts to recruit
  - Internal recruitment
- ↑effort at engaging patients and families in reducing hospital-acquired conditions
- Revise Marketing materials to expand participation
- Presidential Volunteer Awards
Questions & Final Comments

Lisa Thompson
Lea Regional

Mercedes Fleming
Catholic Medical Center

Jerry Brunnell
Mary Robertson
Meryl Montgomery
Medical Center Navicent
2017 Falls with Injury Change Package

- Falls Change Package
- Top 10 Checklist
Falls STOP to START Resource

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

STOP to START Improving Falls
HRET UP Campaign Page

- Posters
- Patient video
- Webinar Recordings
Safe Mobility Resources

Mobility Assessments
- Banner Mobility Assessment Tool for Nurses (BMAT) video and Tool
- Timed Get up and Go Test
- Get Up and Go Test

Mobility Resources
- Mobility Change Package
- Walk of Fame Mobility Board
- CAPTURE Falls mobility training videos, mobility tools
- Activity tracker article

Delirium Assessment Resources
- ICU Liberation - Delirium and Mobility Resources
- Hospital Elder Life Program (HELP) for the Prevention of Delirium
Patient and Family Engagement Resources

- Fall Teach Back Tool
- Anticoagulation Teach Back Tool
- Fall Prevention Tips for Patients and Families
- Cox Health Patient Partnership Agreement
Thank You!

Find more information on our website:

www.hret-hiin.org