HRET HIIN UP Campaign

Thursday, February 16, 2017
11:00 a.m. – 11:50 a.m. CT
Emily Koebnick, Program Manager, HRET

WELCOME AND INTRODUCTIONS
<table>
<thead>
<tr>
<th>Time</th>
<th>Session Title</th>
<th>Details</th>
<th>Presenter(s)</th>
</tr>
</thead>
</table>
| 11:00 - 11:10 a.m. | Welcome and Introductions | Virtual event objectives:  
1. To present crosscutting strategies for reducing harm across several harm topics.  
2. To challenge you to implement the UP Campaign at your facility. |
|            |                                |                                                                         | Emily Koebnick, MPH, MPA  
Program Manager, HRET |
| 11:10 - 11:40 a.m. | Next Steps to Find Your Way UP | • Review the UP Campaign crosscutting interventions and the impact on harm reduction.  
• Evaluate the “must do’s” for each UP Campaign element to help define the implementation strategy moving forward. | Maryanne Whitney, RN, CNS, MSN  
Jackie Conrad, RN, MBA  
Improvement Advisors, Cynosure |
| 11:40 - 11:45 a.m. | Q & A                          |                                                                         | All participants |
| 11:45 - 11:50 a.m. | Bring it Home                  |                                                                         | Emily Koebnick, MPH, MPA  
Program Manager, HRET |
Polling Question

Who is in the room?

• Quality
• Physician
• Nurse
• Hospital Leader
• Infection Preventionist

• State Partner
• Rehab Specialist
• Pharmacist
• Respiratory Practitioner
**Surgical Safety Checklist (First Edition)**

**Before induction of anaesthesia**

**Sign in**
- Patient has confirmed:
  - Identity
  - Site
  - Procedure
  - Consent

- Site marked/not applicable
- Anaesthesia safety check completed
- Pulse oximeter on patient and functioning

**Does patient have a:**
- Known allergy?
  - No
  - Yes

- Difficult airway/aspiration risk?
  - No
  - Yes, and equipment/assistance available

- Risk of >500ml blood loss (7ml/kg in children)?
  - No
  - Yes, and adequate intravenous access and fluids planned

**Time out**
- Confirm all team members have introduced themselves by name and role

- Surgeon, anaesthesia professional and nurse verbally confirm:
  - Patient
  - Site
  - Procedure

**Anticipated critical events**
- Surgeon reviews: what are the critical or unexpected steps, operative duration, anticipated blood loss?

- Anaesthesia team reviews: are there any patient-specific concerns?

- Nursing team reviews: has sterility (including indicator results) been confirmed? Are there equipment issues or any concerns?

- Has antibiotic prophylaxis been given within the last 60 minutes?
  - Yes
  - Not applicable

- Is essential imaging displayed?
  - Yes
  - Not applicable

**Before skin incision**

**Before patient leaves operating room**

**Sign out**
- Nurse verbally confirms with the team:
  - The name of the procedure recorded
  - That instrument, sponge and needle counts are correct (or not applicable)
  - How the specimen is labelled (including patient name)
  - Whether there are any equipment problems to be addressed

- Surgeon, anaesthesia professional and nurse review the key concerns for recovery and management of this patient

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*This checklist is not intended to be comprehensive. Additions and modifications to fit local practice are encouraged.*

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HRET
Health Research & Educational Trust
Checklist for Prevention of Central Line Associated Blood Stream Infections


For Clinicians:
Promptly remove unnecessary central lines
- Perform daily audits to assess whether each central line is still needed

Follow proper insertion practices
- Perform hand hygiene before insertion
- Adhere to aseptic technique
- Use maximal sterile barrier precautions (i.e., mask, cap, gown, sterile gloves, and sterile full-body drape)
- Perform skin antisepsis with >0.5% chlorhexidine with alcohol
- Choose the best site to minimize infections and mechanical complications
  - Avoid femoral site in adult patients
- Cover the site with sterile gauze or sterile, transparent, semipermeable dressings

Handle and maintain central lines appropriately
- Comply with hand hygiene requirements
- Scrub the access port or hub immediately prior to each use with an appropriate antiseptic (e.g., chlorhexidine, povidone iodine, an iodophor, or 70% alcohol)
- Access catheters only with sterile devices
- Replace dressings that are wet, soiled, or dislodged
- Perform dressing changes under aseptic technique using clean or sterile gloves

For Facilities:
- Empower staff to stop non-emergent insertion if proper procedures are not followed
- "Bundle" supplies (e.g., in a kit) to ensure items are readily available for use
- Provide the checklist above to clinicians, to ensure all insertion practices are followed
- Ensure efficient access to hand hygiene
- Monitor and provide prompt feedback for adherence to hand hygiene
  - http://www.cdc.gov/handhygiene/Measurement.html
- Provide recurring education sessions on central line insertion, handling and maintenance

Supplemental strategies for consideration:
- 2% Chlorhexidine bathing
- Antimicrobial/Antiseptic-impregnated catheters
- Chlorhexidine-impregnated dressings
Sepsis Checklist Board

Patient Name: ____________________________ Patient ID: ______________ Date: ______________

If 2 or More Symptoms or Labs are Positive (Red), Contact Physician Immediately.

### Pre-Disposition:
1. Immuno-Compromised
2. Age < 5 or > 65
3. > Girth
4. Type 2 Diabetes
5. Renal Dx
6. Asthma Dx
7. Burn or Trauma Dx

### Symptoms:
1. Orientation Change
2. Temp. < 36°C or > 38°C
3. Chills/Shaking
4. Warm Skin or Rash
5. Tachypnea > 20 bpm
6. Tachycardia > 100 bpm
7. Hypotension < 90/60
8. Decreased Urine Output

### Labs:
1. Decrease % of Lymphocytes
2. High or Low WBC Count
3. High or Low Platelet Count
4. Elevated Liver Enzymes
5. Elevated CRP
6. Elevated Procalcitonin
7. Elevated Lactic Acid >36 mg/dL
8. Hypophosphatemia
9. Coagulation Deficiencies
10. Acidosis - pH < 7.35

Notes:

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For best results use only Checklist Board™ markers, other markers may stain the surface. Use a clean dry cloth to wipe off after every use. Do not use harsh chemicals. Order markers and Checklist Boards ten at 866-586-8152 or checklistboards.com.

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HRET Health Research Educational Trust
## Transition Intervention Activities

Name: _______________________________  MR# ___________________  Date of Contact: __/__/____

Location:  __Home  ___Telephone  ___Other (specify: ____________________)

<table>
<thead>
<tr>
<th>Medication Management</th>
<th>Discharge Planning</th>
<th>Psychosocial Assessment</th>
<th>Patient Training</th>
<th>Follow-Up</th>
</tr>
</thead>
<tbody>
<tr>
<td>___ Compare pre-hospital medications</td>
<td>___ Review discharge instructions</td>
<td>___ Palliative Care</td>
<td>___ Assess patient ability to</td>
<td>___ Assess adequacy of support</td>
</tr>
<tr>
<td>with medications on hospital</td>
<td>___ Make plan for patient to</td>
<td>___ Y __ N</td>
<td>___ Discuss &amp; teach self</td>
<td>___ Connect patient with</td>
</tr>
<tr>
<td>discharge list</td>
<td>set up follow-up appt</td>
<td>If yes, did patient agree?</td>
<td>management of condition(s)</td>
<td>KP services (specify: __________)</td>
</tr>
<tr>
<td>___ Identify medications that</td>
<td>___ Identify problems that</td>
<td>___ Y __ N</td>
<td>as needed</td>
<td></td>
</tr>
<tr>
<td>were prescribed but not</td>
<td>require immediate PCP or</td>
<td>If yes, did patient agree?</td>
<td>___ Discuss target symptoms/side</td>
<td></td>
</tr>
<tr>
<td>obtained</td>
<td>specialist visit</td>
<td>___ Y __ N</td>
<td>effects to monitor &amp; what to</td>
<td></td>
</tr>
<tr>
<td>___ Identify medication</td>
<td>___ Clarify whether patient</td>
<td>___ Y __ N</td>
<td>do if they arise</td>
<td></td>
</tr>
<tr>
<td>discrepancies</td>
<td>will need to obtain follow-up</td>
<td>___ Advanced care plan?</td>
<td>___ Discuss when PCP</td>
<td></td>
</tr>
<tr>
<td>___ Develop a plan to resolve</td>
<td>tests and/or results</td>
<td>___ Y __ N</td>
<td>should be called</td>
<td></td>
</tr>
<tr>
<td>discrepancies</td>
<td>___ Provide teaching for</td>
<td>___ Depression:</td>
<td>___ Discuss pain mgt</td>
<td></td>
</tr>
<tr>
<td>___ Answer questions about</td>
<td>how to obtain follow-up tests and</td>
<td>___ Y __ N</td>
<td>___ Discuss constipation</td>
<td></td>
</tr>
<tr>
<td>medications</td>
<td>results</td>
<td>___ Home Safety:</td>
<td>___ Other</td>
<td></td>
</tr>
<tr>
<td>___ Alert patient to potential</td>
<td>___ Other</td>
<td>___ Y __ N</td>
<td></td>
<td></td>
</tr>
<tr>
<td>adverse drug reaction(s)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>___ Assess patient’s ability to</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>manage meds and implement</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>meds mgt plan if needed</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>___ Identify medications needing</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>refills and/ or barriers to refill</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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HEALTH RESEARCH & EDUCATIONAL TRUST
## Pre-transport

<table>
<thead>
<tr>
<th>Equipment/materials</th>
<th>YES</th>
<th>NO</th>
<th>NA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Transport bag present</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Transport trolley fully charged</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Defibrillator present</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Manual resuscitation bag present</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sufficient oxygen level</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Check length of i.v. tubes</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>In case of MRI; extend length i.v. tubes</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Shut off necessary i.v. tubes</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>In case of CT-Scan with contrast</th>
<th>YES</th>
<th>NO</th>
<th>NA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intravenous cannula 18GA present</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Oral contrast administered</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>If &quot;YES&quot;:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Renal protection according to protocol</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Monitor</th>
<th>YES</th>
<th>NO</th>
<th>NA</th>
</tr>
</thead>
<tbody>
<tr>
<td>ETCO₂ monitoring present</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Check and set visual and audible alarm</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Medication</th>
<th>YES</th>
<th>NO</th>
<th>NA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sufficient intravenous medication</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Additional intravenous sedatives</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Additional intravenous inotropics</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Additional medication</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Additional infusion pump</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Additional intravenous fluids</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stop enteral nutrition</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stop enteral insulin</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Transport ventilator</th>
<th>YES</th>
<th>NO</th>
<th>NA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Turn on the oxygen</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Put HME filter between ventilator and ET/TT</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Check and set visual and audible alarms</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| ET/TT depth (cm) |     |    |    |

<table>
<thead>
<tr>
<th>Administrative</th>
<th>YES</th>
<th>NO</th>
<th>NA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Register baseline vital signs overleaf</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Switch patient in PDMS to “Transport”</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Radiology department informed</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fill in MRI safety questionnaire</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Why the UP Campaign?

• Increases impact on harm reduction
• Generates momentum in your organization
• Focuses support from leadership
• Engages front-line staff
  – Connects the dots
  – Creates a vision
• Applies throughout organization
• Simplifies patient safety implementation
• Helps patients recover faster and with fewer complications
Can we streamline and simplify to make it easier for front-line staff and still improve safety?
#2 Early Progressive Mobility

- Falls
- HAPU
- Delirium
- CAUTI
- VAE
- VTE
- Readmissions

GET UP
#3 Hand Hygiene

CDI  CAUTI  SSI  VAE  CLABSIs  Sepsis  MDRO

S O A P U P
FOUNDATIONAL QUESTIONS:

1. Is my patient awake enough to get up?
2. Have I protected my patient from infections?
Let’s hear from you!

• Have you been successful with:
  – Narcotic and sedation management?
  – Early mobility?
  – Hand hygiene?

Chat in your responses. We want to hear your successes!
# 1 Opioid & Sedation Management
Sleep vs. Sedation

Is this normal sleep or dangerous sedation?
Not Just Sedatives and Opioids

- Antihistamines/anticholinergics
- Antipsychotics
- Some antidepressants
- Antiemetics
- Muscle relaxants
Sedatives and analgesics may contribute to:

- Increased duration of mechanical ventilation
- Length of intensive care requirement
- Impede neurological examination
- May predispose to delirium

Medical/Surgical Pitfalls of Sedatives and Analgesics

- Oversedation
- Transfer to ICU
- Hypoxic encephalopathy
- Death
Must Do's
WAKE-UP Must Do’s

1. Establish expectations

2. Pair POSS & pain

3. Manage with multiple modalities
Must Do #1
Establish Expectations

Goals of Pain Management:
• Relieve suffering
• Achieve early mobilization
• Reduce hospital length of stay

THE GOAL IS NOT ZERO PAIN!
Must Do #2
Pair POSS & Pain

Overmedicated: hibernating

Undermedicated: not happy

Just right!

畤#@xx!!
POSS AKA “GOLDILOCKS SCALE”

- S- sleep, easy to arouse
- 1- awake and alert
- 2- slightly drowsy
- 3- frequently drowsy, drifts off to sleep during conversation
- 4- somnolent, minimal or no response to stimulation
Pasero Opioid-Induced Sedation Scale (POSS) With Interventions*

S = Sleep, easy to arouse
   Acceptable; no action necessary; may increase opioid dose if needed

1 = Awake and alert
   Acceptable; no action necessary; may increase opioid dose if needed

2 = Slightly drowsy, easily aroused
   Acceptable; no action necessary; may increase opioid dose if needed

3 = Frequently drowsy, arousable, drifts off to sleep during conversation
   Unacceptable; monitor respiratory status and sedation level closely until sedation level is stable at less than 3 and respiratory status is satisfactory; decrease opioid dose 25% to 50%1 or notify primary2 or anesthesia provider for orders; consider administering a non-sedating, opioid-sparing nonopioid, such as acetaminophen or a NSAID, if not contraindicated; ask patient to take deep breaths every 15-30 minutes.

4 = Somnolent, minimal or no response to verbal and physical stimulation
   Unacceptable; stop opioid; consider administering naloxone3,4; stay with patient, stimulate, and support respiration as indicated by patient status; call Rapid Response Team (Code Blue) if indicated; notify primary2 or anesthesia provider; monitor respiratory status and sedation level closely until sedation level is stable at less than 3 and respiratory status is satisfactory.

*Appropriate action is given in italics at each level of sedation.

1 If opioid analgesic orders or hospital protocol do not include the expectation that the opioid dose will be decreased if a patient is excessively sedated, such orders should be promptly obtained.
2 For example, the physician, nurse practitioner, advanced practice nurse, or physician assistant responsible for the pain management prescription.
3 For adults experiencing respiratory depression give intravenous naloxone very slowly while observing patient response ("titrate to effect"). If sedation and respiratory depression occurs during administration of transdermal fentanyl, remove the patch; if naloxone is necessary, treatment will be needed for a prolonged period, and the typical approach involves a naloxone infusion. Patient must be monitored closely for at least 24 hours after discontinuation of the transdermal fentanyl.
4 Hospital protocols should include the expectation that a nurse will administer naloxone to any patient suspected of having life-threatening opioid-induced sedation and respiratory depression.

Two Scales are Better than One
for Narcotic and Sedation Administration

PAIN ALONE
- Risk factors may be absent
- Objective?
- Dosage based on number or range
- Patients and families understand the numeric dosing

PAIN & POSS
- Two scales allow for safer dosing
- High pain scale with high POSS scale-no narcotics
- High pain scale low medical dose
Pharmacological and non-pharmacological
Multimodal Pain Management

• Combination of opioid and one or more other drugs
  • acetaminophen
  • ibuprofen
  • celecoxib
  • ketamine
  • gabapentin
  • non-pharmacological interventions

www.mayoclinic.org/pain-medications/art-20046452
Can We Manage Pain With Non-pharmacologic Methods?

What do we do at home?

**Comfort measures:**

- Pet therapy
- Warm compresses; blankets
- Ice packs
- Extra pillows
- Aromatherapy
- Massage
- Herbal tea
- Stress ball
- Music
Do Comfort Items Help?

- These modalities can:
  - Reduce anxiety
  - Reduce pain
- Reducing anxiety can reduce pain
- Non-pharmacologic pain reduction methods reduce the need for pain medications
Do Hospitals Offer These?

https://www.pvmc.org/patients-visitors/pain-comfort-menu

http://www.hopkinsmedicine.org/the_johns_hopkins_hospital/services_amenities/services/pain-control-comfort-menu.html
Positive Results

- Pain scores
- Nausea scores
- Anxiety scores all decreased by more than 50 percent

NEXT: looking to see if opioid usage and opioid ADEs both decrease
Emma, age 13, had her third surgery for a congenital foot deformity. Pain management was problematic, so both gabapentin and pet therapy were added to lower opioid doses with excellent results, allowing discharge to home 36 hours later.
Polling Question

Which strategy presented from WAKE UP will you be most likely to adopt first?

1. Establish expectations
2. Pair POSS and pain
3. Manage with multiple multimodalities

Chat in why you selected that strategy.
Thoughts about WAKE UP
#2 Early Progressive Mobility

- Falls
- PrU
- Delirium
- CAUTI
- VAE
- VTE
- Readmissions

GET UP
Pathophysiologial Changes Within 24 Hours of Bed Rest

Onset of complications—Pathophysiological changes within 24 hours of bed rest:

**Psychological**
- Anxiety
- Depression
- Sensory deprivation
- Learned helplessness
- Delirium

**Respiratory System**
- Decreased lung volume
- Pooling of mucous
- Cilia less effective
- Decreased oxygen saturation
- Aspiration atelectasis

**Gastrointestinal System**
- Increased risk of aspiration
- Loss of appetite
- Decreased peristalsis
- Constipation

**Circulatory System**
- Loss of plasma volume
- Loss of orthostatic compensation
- Increased heart rate
- Development of DVT

**Musculoskeletal System**
- Weakness
- Muscle atrophy
- Loss of muscle strength by 3-5%
- Calcium loss from bones
- Increased risk of falls due to weakness

**Genitourinary System**
- Incomplete bladder emptying
- Formation of calculi in kidneys and infection
Cumulative Impact on Quality of Life

• “New Walking Dependence” occurs in 16-59 percent in older hospitalized patients (Hirsh 1990, Lazarus 1991, Mahoney 1998)

• 65 percent of patients had a significant functional mobility decline by day two (Hirsh 1990)

• 27 percent still dependent in walking three months post discharge (Mahoney 1998)
It’s Simple

If they came in walking, keep them walking.
Avoid Ageism

Do not assume all elders need a bed alarm, even if they appear frail.
“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.”
Progressive mobility is defined as a series of planned movements in a sequential matter, beginning at a patient's current mobility status, with a goal of returning to his or her baseline mobility.

(Vollman 2010)
Teaming Up To Mobilize
Get Up Must Do’s

1. Walk in, walk during, walk out!
2. Belt and bolt!
3. Three laps a day keeps the nursing home at bay!
Must Do #1
Walk In, Walk During, Walk Out!
Must Do #2
Belt & Go!

• Gait belts in every room
• Safe mobilization and patient handling training for nursing staff

See CAPTURE Falls Project Website for guidance: http://www.unmc.edu/patient-safety/capturefalls/learningmodules/index.html

Gait belts are used to help control the patient’s center of balance. Gait belts are not intended to hold a patient up.
Must Do #3
Three Laps a Day, Keeps the Nursing Home Away!
### Mobility Begins on Admission

<table>
<thead>
<tr>
<th>Tier Level</th>
<th>Defining Characteristics</th>
<th>Intervention&lt;sup&gt;a&lt;/sup&gt;</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tier 1: Nonambulatory</td>
<td>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</td>
<td>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</td>
</tr>
<tr>
<td>Tier 2: Ambulatory</td>
<td>Patients who - are able to ambulate independently - require a one-person assist with ambulation</td>
<td>Ambulate with or without assistance in the hallway as tolerated Get out of bed and into a chair for all meals</td>
</tr>
</tbody>
</table>

<sup>a</sup> To be performed three times a day (in accordance with a patient’s ability).

Tips for Promoting Mobility

• Order modifications
  – Delete orders for
    • Bedrest
    • Ad lib
  – Replace with specific orders
    • Times, activities, distance

• Promote team mobility management
  – Delegation of patient mobility
    • Replace sitters with a mobility aide
  – Rehab and nursing face-to-face bedside handoffs
    • Document plans and progress on white boards
Polling Question

Who in your organization will be a partner in implementing the GET UP strategies?

1. Rehab specialists
2. Nursing
3. Physicians
4. Patient care technicians
5. Respiratory practitioners
6. Transporters
7. Environmental service personnel
8. Volunteers
Ideas for GET UP

First Steps... Next Steps.....
#3 Hand Hygiene

- CDI
- CAUTI
- SSI
- VAE
- CLABSI
- Sepsis
- MDRO

S O A P U P
Handwashing an OLD Intervention

• Since 1847 we have understood that hand hygiene (HH) makes a difference in the spread of infections
  – Dr. Ignaz Semmelweis in Vienna – Childbed fever
  – Dr. Lister – OR
  – 1980’s concepts of hand hygiene in health care emerged
  – 2002 alcohol based hand rub adopted
  – 2007-2008 WHO Global Clean Hands initiative

• Yet, the average HH compliance is 48 percent
What Works?

• Observation and surveillance of hand hygiene is the best way to ensure appropriate compliance.
• Schedule an unscheduled observation by trained observers.
• Intervene immediately if a breach in HH is observed.
• Provide scripts for reminding peers to perform HH.
• Promote culture of safety.
We Need to Get It Right!

• Protect our patients from health care-associated infections (HAIs) by performing HH.
• Promote patient and family engagement and give them permission to “speak up for clean hands.”
• Promote patient HH for patients.

http://www.cdc.gov/handhygiene/patients/index.html
1. Prompt peer performance

2. Track quietly and trend loudly

3. Drive drift down
Must Do #1
Prompt Peer Performance

Maybe we should talk.
Must Do #2
Track Quietly and Trend Loudly

Hand hygiene
vs
Hospital Acquired Infections
Track Quietly & Trend Loudly

- SOAP UP started
- Scripting education
- New observers trained

Graph showing HH Compliance and HAI trends from January to June.
Must Do #3
Drive Drift Down
The Right Balance

Important to get the balance right; both extremes have their pitfalls.
### Shared Accountability

**Instructions:**
- Do not share with anyone that you are conducting the audit.
- Observe all staff-nurses, physicians, RT’s, housekeeping staff, etc. (see other side of form for Staff Codes).
- Observe for 30 minutes. This may be broken up in small increments of time. OR,
- Observe at least 15 staff members.

<table>
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<tr>
<th>Unit/Department</th>
<th>Date</th>
<th>Time</th>
<th>PERSON ENTERED THE ROOM FOR DIRECT CONTACT WITH THE PATIENT OR ENVIRONMENT</th>
<th>HAND HYGIENE SUPPLIES (SOAP, HAND SANITIZER, TOWELS) ARE ADEQUATE</th>
<th>DID YOU SEE HIM/HER USE SOAP OR ALCOHOL GEL WHEN ENTERING THE ROOM?</th>
<th>PERSON EXITED THE ROOM AFTER DIRECT CONTACT WITH THE PATIENT OR ENVIRONMENT</th>
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<th>DID YOU SEE HIM/HER USE SOAP OR ALCOHOL GEL AFTER REMOVING GLOVES?</th>
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**Total # of Staff Observed**

- Total
- Total
- Total
- Total
- Total
- Total
- Total
- Total

Adapted with permission from Stanford Health Care, Palo Alto, CA
Polling Question

Which of the SOAP UP “must do’s” do you feel would be easiest to implement?

1. Prompt peer performance
2. Track quietly and trend loudly
3. Drive drift down

Chat in why!
Polling question

Which UP will YOU start with?

1. WAKE UP
2. GET UP
3. SOAP UP
4. All three
Thoughts & Take Aways

• All UP interventions need:
  • Attention focused on leadership and cultural issues
  • Courage to HIINovate
  • Individual accountability

AND

1. Is my patient awake enough to get up?

2. Have I protected my patient from infections?
BRING IT HOME

Emily Koebnick, Program Manager, HRET
Up Campaign

Front-line staff are implementing multiple worthy approaches to reduce harm and improve care, which can make it difficult to prioritize and execute interventions. With ever-increasing numbers of safe practices to implement, clinicians may become overwhelmed with new tasks and responsibilities. Clinician burnout levels are increasing due to greater demands and rapid changes in workflow. Mistakes could be made simply trying to comply with new practices, demands and expectations.

The HRET HIIN UP Campaign is designed to simplify safe care and streamline interventions, reduce multiple forms of harm with simple easy-to-accomplish activities, and consolidate basic interventions that cut across several topics to decrease harm. The UP Campaign is made up of 3 components:

- **WAKE-UP** — Reducing unnecessary sleepiness and sedation.
- **GET-UP** — Mobilizing patients to return to function more quickly.
- **SOAP-UP** — Implementing appropriate hand hygiene to reduce the spread of infection.

Please join us by spreading the word on the UP Campaign using the following tools and resources:
• Join the **LISTSERV®**
  – Ask questions
  – Share best practices, tools and resources
  – Learn from subject matter experts
  – Receive follow up from this event and notice of future events
Thank You!

Find more information on our website: www.hret-hiin.org

Questions or Comments: HIIN@aha.org