Raise Your Game: The UP Campaign

Include Speakers Names Here:
Questions to Run On

• How can we better engage front-line caregivers without creating additional burdens?

• What could introducing a simple, cross-cutting set of practices accomplish with your hospitals?

• How could you deploy a program like the UP Campaign with your hospitals and strengthen front-line engagement?
# 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

## Before skin incision

**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 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**

---

This checklist is not intended to be comprehensive. Additions and modifications to fit local practice are encouraged.
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, semi-permeable 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:

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Immuno-Compromised</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Age &lt; 5 or &gt; 65</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. &gt; Girth</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Type 2 Diabetes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Renal Dx</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Asthma Dx</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Burn or Trauma Dx</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Symptoms:

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Orientation Change</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Temp. &lt; 36C or &gt; 38C</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Chills/Shaking</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Warm Skin or Rash</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Tachypnea &gt; 20 bpm</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Tachycardia &gt; 100 bpm</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Hypotension &lt; 90/60</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Decreased Urine Output</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Labs:

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Decrease % of Lymphocytes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. High or Low WBC Count</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. High or Low Platelet Count</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Elevated Liver Enzymes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Elevated CRP</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Elevated Procalcitonin</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Elevated Lactic Acid &gt;36 mg/dL</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Hypophosphatemia</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. Coagulation Deficiencies</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. Acidosis - pH &lt; 7.35</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Notes: ________________________________

*For best results use only Checklist Board™ markers, other markers may stain the surface. Use a clean dry cloth to wipe clean after every use, do not use harsh chemicals. Order markers and Checklist Boards tel at 888-586-9142 or checklistboards.com.*
## Transition Intervention Activities

**Name:**  
**MR#**  
**Date of Contact:** __/__/__

**Location:**  
- Home  
- Telephone  
- Other (specify: ____________)

### Medication Management
- Compare pre-hospital medications with medications on hospital discharge list
- Identify medications that were prescribed but not obtained
- Identify medication discrepancies
- Develop a plan to resolve discrepancies
- Answer questions about medications
- Alert patient to potential adverse drug reaction(s)
- Assess patient’s ability to manage meds and implement meds mgt plan if needed
- Identify medications needing refills and/or barriers to refill
  - Other

### Discharge Planning
- Review discharge instructions
- Make plan for patient to set up follow-up appt
- Identify problems that require immediate PCP or specialist visit
- Clarify whether patient will need to obtain follow-up tests and/or results
- Provide teaching for how to obtain follow-up tests and results
  - Other

### Psychosocial Assessment
- Palliative Care:
  - Y N
  - If yes, did patient agree?
    - Y N
- Hospice Care
  - Y N
  - If yes, did patient agree?
    - Y N
- Advanced care plan?
  - Y N
- Depression:
  - Y N
- Home Safety:
  - Y N

### Patient Training
- Assess patient ability to self manage condition
- Discuss & teach self management of condition(s) as needed
- Discuss target symptoms/side effects to monitor & what to do if they arise
- Discuss when PCP should be called
- Discuss pain mgt
- Discuss constipation
  - Other

### Follow-Up
- Assess adequacy of support system and need for ongoing case management
- Connect patient to necessary community resources
- Connect patient with KP services (specify: ____________)

**Case Referred to:**
- SCM
- TCM
- HH
- HO/PC
- PCP
- Other
<table>
<thead>
<tr>
<th>Patient label</th>
<th>Date (dd/mm/yyyy)</th>
<th>Time of start transport (hh/mm)</th>
<th>Time of arrival in ICU (hh/mm)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Procedure</td>
<td>□ CT-Scan □ MRI □ Angiography</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>□ Other</td>
<td>________________________________</td>
<td></td>
</tr>
<tr>
<td>Purpose of transport</td>
<td>□ Diagnostic □ Intervention □ Diagnostic and intervention</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### 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>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>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;: 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>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>
<tr>
<td>ET/TT depth (cm)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<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>
### Pre-Procedure Verification

<table>
<thead>
<tr>
<th>Item</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient's identity confirmed using two identifiers</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>Order confirmed</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>Latex allergy</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>H &amp; P reviewed for any contraindications</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>Risk/benefits discussed with patient</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>Indication for indwelling urethral catheter use</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>- Need for accurate urine output monitoring in the Hemodynamically/Physiologically unstable (i.e., vasoactive drips or unstable spine/fracture).</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Chemically paralyzed</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Multiple Stage II or greater pressure ulcers, located from the nipple line to knees, with incontinence and/or unresolved incontinence associated dermatitis.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Urinary obstruction</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Strict I &amp; O for active management of fluid status</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Catheters or vascular lines in back or groin (i.e., epidural).</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Foley catheter required for surgical procedure, medical condition, or at MD discretion.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Patient comfort for end of life care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- MD requests Foley placement for Urinary Retention</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Time Out Verification

<table>
<thead>
<tr>
<th>Item</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient's identity confirmed using two identifiers</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>Ordered verified</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>Latex allergy</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>Two staff members present (one person using sterile technique and the other person using standard precautions)</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>Appropriate size of catheter used</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>Aseptic technique used</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>Aseptic technique compromised</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>If so, PLEASE STOP and REDO!</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Foley catheter - Band tag applied</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>Documented in chart</td>
<td>YES</td>
<td>NO</td>
</tr>
</tbody>
</table>

**Safety Huddle Report?**  
Expected D/C date of Foley cath: ______________  Foley D/C Date: __________

**Early Removal Plan******  
**Goal: Decrease Foley Use and REMOVE ASAP!** — Follow Algorithm for Foley Removal

Did the patient experience symptoms of UTI (fever, suprapubic tenderness, CVA pain/tenderness, positive urinalysis or culture)? If so, please explain?

**Signature of Provider Performing Foley Catheter Insertion**  
**Date/Time Signed**

**Printed Provider Name**

**Signature and Title of Person Completing Form**  
**Data/Time Signed**

**Printed Name of Person Completing Form**
• Determine need for the checklist
• Identify the goal and audience for the checklist
• Develop content using the following:
  o Broad spectrum of peer-reviewed literature
  o Expert judgment
  o Consensus among relevant opinion leaders
  o Multidisciplinary input
  o Consideration of current practices
• Design must consider (see Table 4) [26, 30]:
  o Context for the checklist
  o Readability
  o Proper categorization of information
  o Structure of checkpoints
  o Limited use of images
  o Appropriate use of colour
  o Avoid jargon —use common terminology
  o Flow of real-time user activities
  o Clinician state of mind
• Pilot test — validation in simulated clinical environment is a must
• Review with appropriate multidisciplinary representation
• Obtain approval from appropriate regulatory authorities as required, prior to implementation in the clinical environment
• Develop an education plan to properly train users
• Frequent review of evidence-based checklist content
## Risk Assessment for Venous Thromboembolism (VTE)

### Mobility – all patients

<table>
<thead>
<tr>
<th>Tick</th>
<th>Tick</th>
<th>Tick</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical patient expected to have ongoing reduced mobility relative to normal state</td>
<td>Medical patient NOT expected to have significantly reduced mobility relative to normal state</td>
<td></td>
</tr>
</tbody>
</table>

**Assess for thrombosis and bleeding risk below**

**Risk assessment now complete**

### Thrombosis Risk

<table>
<thead>
<tr>
<th>Patient related</th>
<th>Tick</th>
<th>Admission related</th>
</tr>
</thead>
<tbody>
<tr>
<td>Active cancer or cancer treatment</td>
<td></td>
<td>Significantly reduced mobility for 3 days or more</td>
</tr>
<tr>
<td>Age &gt; 60</td>
<td></td>
<td>Hip or knee replacement</td>
</tr>
<tr>
<td>Dehydration</td>
<td></td>
<td>Hip fracture</td>
</tr>
<tr>
<td>Known thrombophilies</td>
<td></td>
<td>Total anaesthetic + surgical time &gt; 90 minutes</td>
</tr>
<tr>
<td>Obesity (BMI &gt;30 kg/m²)</td>
<td></td>
<td>Surgery involving pelvis or lower limb with a total anaesthetic + surgical time &gt; 60 minutes</td>
</tr>
<tr>
<td>One or more significant medical comorbidities (e.g., heart disease; metabolic; endocrine or respiratory pathologies; acute infectious diseases; inflammatory conditions)</td>
<td></td>
<td>Acute surgical admission with inflammatory or intra-abdominal condition</td>
</tr>
<tr>
<td>Personal history or first-degree relative with a history of VTE</td>
<td></td>
<td>Critical care admission</td>
</tr>
<tr>
<td>Use of hormone replacement therapy</td>
<td></td>
<td>Surgery with significant reduction in mobility</td>
</tr>
<tr>
<td>Use of oestrogen-containing contraceptive therapy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Varicose veins with phlebitis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pregnancy or &lt; 6 weeks post partum (see NICE guidance for specific risk factors)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Bleeding Risk

<table>
<thead>
<tr>
<th>Patient related</th>
<th>Tick</th>
<th>Admission related</th>
</tr>
</thead>
<tbody>
<tr>
<td>Active bleeding</td>
<td></td>
<td>Neurosurgery, spinal surgery or eye surgery</td>
</tr>
<tr>
<td>Acquired bleeding disorders (such as acute liver failure)</td>
<td></td>
<td>Other procedure with high bleeding risk</td>
</tr>
<tr>
<td>Concurrent use of anticoagulants known to increase the risk of bleeding (such as warfarin with INR &gt;2)</td>
<td></td>
<td>Lumbar puncture/epidural/spinal anaesthesia expected within the next 12 hours</td>
</tr>
<tr>
<td>Acute stroke</td>
<td></td>
<td>Lumbar puncture/epidural/spinal anaesthesia within the previous 4 hours</td>
</tr>
<tr>
<td>Thrombocytopenia (platelets &lt; 75×10⁹/L)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Uncontrolled systolic hypertension (≥130/120 mmHg or higher)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Untreated inherited bleeding disorders (such as haemophilia and von Willebrand’s disease)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

© Crown copyright 2010

301292 1p:March 10
# Johns Hopkins Fall Risk Assessment Tool

If patient has any of the following conditions, check the box and apply Fall Risk interventions as indicated.

**High Fall Risk - Implement High Fall Risk interventions per protocol**
- History of more than one fall within 6 months before admission
- Patient has experienced a fall during this hospitalization
- Patient is deemed high fall-risk per protocol (e.g., seizure precautions)

**Low Fall Risk - Implement Low Fall Risk interventions per protocol**
- Complete paralysis or completely immobilized

Do not continue with Fall Risk Score Calculation if any of the above conditions are checked.

## FALL RISK SCORE CALCULATION
Select the appropriate option in each category. Add all points to calculate Fall Risk Score. (If no option is selected, score for category is 0)

<table>
<thead>
<tr>
<th>Category</th>
<th>Points</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age</strong> (single-select)</td>
<td></td>
</tr>
<tr>
<td>- 60 - 69 years (1 point)</td>
<td></td>
</tr>
<tr>
<td>- 70 - 79 years (2 points)</td>
<td></td>
</tr>
<tr>
<td>- greater than or equal to 80 years (3 points)</td>
<td></td>
</tr>
<tr>
<td><strong>Fall History</strong> (single-select)</td>
<td></td>
</tr>
<tr>
<td>- One fall within 6 months before admission (5 points)</td>
<td></td>
</tr>
<tr>
<td><strong>Elimination, Bowel and Urine</strong> (single-select)</td>
<td></td>
</tr>
<tr>
<td>- Incontinence (2 points)</td>
<td></td>
</tr>
<tr>
<td>- Urgency or frequency (2 points)</td>
<td></td>
</tr>
<tr>
<td>- Urgency/frequency and incontinence (4 points)</td>
<td></td>
</tr>
<tr>
<td><strong>Medications</strong> Includes PCA/opiates, anticonvulsants, anti-hypertensives, diuretics, hypnotics, laxatives, sedatives, and psychotropics (single-select)</td>
<td></td>
</tr>
<tr>
<td>- On 1 high fall risk drug (3 points)</td>
<td></td>
</tr>
<tr>
<td>- On 2 or more high fall risk drugs (5 points)</td>
<td></td>
</tr>
<tr>
<td>- Sedated procedure within past 24 hours (7 points)</td>
<td></td>
</tr>
<tr>
<td><strong>Patient Care Equipment</strong> Any equipment that tethers patient (e.g., IV infusion, chest tube, indwelling catheter, SCDs, etc.) (single-select)</td>
<td></td>
</tr>
<tr>
<td>- One present (1 point)</td>
<td></td>
</tr>
<tr>
<td>- Two present (2 points)</td>
<td></td>
</tr>
<tr>
<td>- 3 or more present (3 points)</td>
<td></td>
</tr>
<tr>
<td><strong>Mobility</strong> (multi-select; choose all that apply and add points together)</td>
<td></td>
</tr>
<tr>
<td>- Requires assistance or supervision for mobility, transfer, or ambulation (2 points)</td>
<td></td>
</tr>
<tr>
<td>- Unsteady gait (2 points)</td>
<td></td>
</tr>
<tr>
<td>- Visual or auditory impairment affecting mobility (2 points)</td>
<td></td>
</tr>
<tr>
<td><strong>Cognition</strong> (multi-select; choose all that apply and add points together)</td>
<td></td>
</tr>
<tr>
<td>- Altered awareness of immediate physical environment (1 point)</td>
<td></td>
</tr>
<tr>
<td>- Impulsive (2 points)</td>
<td></td>
</tr>
<tr>
<td>- Lack of understanding of one’s physical and cognitive limitations (4 points)</td>
<td></td>
</tr>
</tbody>
</table>

## Total Fall Risk Score (Sum of all points per category)
- **SCORING:** 6-13 Total Points = Moderate Fall Risk, >13 Total Points = High Fall Risk
The 8Ps:
Assessing Your Patient’s Risk For Adverse Events After Discharge

<table>
<thead>
<tr>
<th>Risk Assessment: 8P Screening Tool</th>
<th>Risk Specific Intervention</th>
<th>Signature of individual responsible for ensuring intervention administered</th>
</tr>
</thead>
<tbody>
<tr>
<td>Problem medications</td>
<td>Medication specific education using Teach Back provided to patient and caregiver</td>
<td></td>
</tr>
<tr>
<td>(anticoagulants, insulin, oral</td>
<td>Monitoring plan developed and communicated to patient and aftercare providers, where relevant (e.g. warfarin, digoxin and insulin)</td>
<td></td>
</tr>
<tr>
<td>hypoglycemic agents,</td>
<td>Specific strategies for managing adverse drug events reviewed with patient/caregiver</td>
<td></td>
</tr>
<tr>
<td>aspirin &amp; clopidogrel dual</td>
<td>Follow-up phone call at 72 hours to assess adherence and complications</td>
<td></td>
</tr>
<tr>
<td>therapy, digoxin, narcotics)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Psychological</td>
<td>Assessment of need for psychiatric aftercare if not in place</td>
<td></td>
</tr>
<tr>
<td>(depression screen positive</td>
<td>Communication with aftercare providers, highlighting this issue if new</td>
<td></td>
</tr>
<tr>
<td>or h/o depression diagnosis)</td>
<td>Involvement/awareness of support network insured</td>
<td></td>
</tr>
<tr>
<td>Principal diagnosis</td>
<td>Review of national discharge guidelines, where available</td>
<td></td>
</tr>
<tr>
<td>(cancer, stroke, DM, COPD,</td>
<td>Disease specific education using Teach Back with patient/caregiver</td>
<td></td>
</tr>
<tr>
<td>heart failure)</td>
<td>Action plan reviewed with patient/caregivers regarding what to do and who to contact in the event of worsening or new symptoms</td>
<td></td>
</tr>
<tr>
<td>Polypharmacy</td>
<td>Discuss goals of care and chronic illness model discussed with patient/caregiver</td>
<td></td>
</tr>
<tr>
<td>(≥5 more routine meds)</td>
<td>Elimination of unnecessary medications</td>
<td></td>
</tr>
<tr>
<td>Poor health literacy</td>
<td>Simplification of medication scheduling to improve adherence</td>
<td></td>
</tr>
<tr>
<td>(inability to do Teach Back)</td>
<td>Follow-up phone call at 72 hours to assess adherence and complications</td>
<td></td>
</tr>
<tr>
<td>Patient support</td>
<td>Committed caregiver involved in planning/administration of all general and risk specific interventions</td>
<td></td>
</tr>
<tr>
<td>(absence of caregiver to assist</td>
<td>Aftercare plan education using Teach Back provided to patient and caregiver</td>
<td></td>
</tr>
<tr>
<td>with discharge and home care)</td>
<td>Link to community resources for additional patient/caregiver support</td>
<td></td>
</tr>
<tr>
<td>Prior hospitalization</td>
<td>Follow-up phone call at 72 hours to assess adherence and complications</td>
<td></td>
</tr>
<tr>
<td>(non-elective; in last 6</td>
<td>Follow-up appointment with aftercare medical provider within 7 days</td>
<td></td>
</tr>
<tr>
<td>months)</td>
<td>Involvement of home care providers of services with clear communications of discharge plan to those providers</td>
<td></td>
</tr>
<tr>
<td>Palliative care</td>
<td>Review reasons for re-hospitalization in context of prior hospitalization</td>
<td></td>
</tr>
<tr>
<td>(Would you be surprised if</td>
<td>Follow-up phone call at 72 hours to assess condition, adherence and complications</td>
<td></td>
</tr>
<tr>
<td>this patient died in the</td>
<td>Follow-up appointment with aftercare medical provider within 7 days</td>
<td></td>
</tr>
<tr>
<td>next year? Does this patient</td>
<td>Involvement of home care providers of services with clear communications of discharge plan to those providers</td>
<td></td>
</tr>
<tr>
<td>have an advanced or</td>
<td>Assess need for palliative care services</td>
<td></td>
</tr>
<tr>
<td>progressive serious illness?)</td>
<td>Identify goals of care and therapeutic options</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Communicate prognosis with patient/family/caregiver</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Assess and address bothersome symptoms</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Identify services or benefits available to patients based on advanced disease status</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Discuss with patient/family/caregiver role of palliative care services and benefits and services available</td>
<td></td>
</tr>
</tbody>
</table>
BRADEN Q SCALE: A risk assessment to be completed on admission and each 24 hours for patients with decreased level of mobility in relation to developmental age. Evidence of pressure ulcers will be defined using the classification system stage 1 to 4.

### Intensity and Duration of Pressure

<table>
<thead>
<tr>
<th>Intensity and Duration of Pressure</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Mobility</strong> - Ability to change &amp; control body position</td>
<td><strong>No Limitation</strong>&lt;br&gt;Makes major and frequent changes in position without assistance</td>
</tr>
<tr>
<td><strong>Activity</strong> - The degree of physical activity</td>
<td><strong>All patients too young to ambulate OR walks frequently</strong>&lt;br&gt;Walks outside the room at least twice daily and inside room at least once every 2 hours during waking hours</td>
</tr>
<tr>
<td><strong>Sensory Perception</strong> - The ability to respond in a developmentally appropriate way to pressure related discomfort</td>
<td><strong>No Impairment</strong>&lt;br&gt;Responds to verbal commands but cannot always communicate discomfort or need to be turned OR has sensory impairment which limits the ability to feel pain or discomfort in 1 or 2 extremities</td>
</tr>
</tbody>
</table>

### Tolerance of the Skin and Supporting Structure

<table>
<thead>
<tr>
<th>Tolerance of the Skin and Supporting Structure</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Moisture</strong> - Degree to which skin is exposed to moisture</td>
<td><strong>Rarely Moist</strong>&lt;br&gt;Skin is usually dry, routine nappy changes, linen only requires changing every 24 hours.</td>
</tr>
<tr>
<td><strong>Friction</strong> - Shear Friction - occurs when skin moves against support surfaces. Shear - occurs when skin and adjacent bony surface slide across one another</td>
<td><strong>No Apparent Problem</strong>&lt;br&gt;Able to completely lift patient during a position change. Moves in bed and chair independently and has sufficient muscle strength to lift up completely during move. Maintains good position in bed or chair at all times.</td>
</tr>
<tr>
<td><strong>Nutrition</strong> - 1. Very Poor&lt;br&gt;NBM &amp;/or maintained on clear fluids, or IV's for more than 5 days OR albumin &lt; 25mg/l</td>
<td><strong>Excellent</strong>&lt;br&gt;Is on a normal diet providing adequate calories for age. Does not require supplementation</td>
</tr>
<tr>
<td><strong>Tissue Perfusion and Oxygenation</strong></td>
<td><strong>Excellent</strong>&lt;br&gt;Tissue perfusion: Oxygen saturation &gt;95%; normal haemoglobin, &amp; capillary refill &lt; 2 seconds</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Patient 'At Risk' / Mild Risk</th>
<th>'Moderate Risk'</th>
<th>'High Risk'</th>
<th>'Very High Risk'</th>
</tr>
</thead>
<tbody>
<tr>
<td>16 - 23</td>
<td>13 - 16</td>
<td>10 - 12</td>
<td>9 or below</td>
</tr>
</tbody>
</table>
### Preliminary Risk Analysis (PRA) Worksheet

#### Project:

**Risk Question:** Calibration test equipment traceability

<table>
<thead>
<tr>
<th>Risk ID #</th>
<th>Hazard/Unwanted Event</th>
<th>Harm/Consequences</th>
<th>Potential Causes</th>
<th>Step 4a</th>
<th>Step 4b</th>
<th>Step 4c</th>
<th>Step 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>No traceability to test equipment</td>
<td>Inability to recall</td>
<td>Software</td>
<td>4</td>
<td>4</td>
<td>16</td>
<td>Teach dual checking b/t software systems</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Human error</td>
<td>5</td>
<td>4</td>
<td>20</td>
<td>Train employees</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Test equipment not ID’ed</td>
<td>1</td>
<td>4</td>
<td>4</td>
<td>Contract terminates</td>
</tr>
<tr>
<td>2</td>
<td>Out of calibration devices</td>
<td>Test equip. not properly calibrated</td>
<td>Test equip. not in calibration system</td>
<td>2</td>
<td>4</td>
<td>8</td>
<td>Require certificates w/ each device</td>
</tr>
<tr>
<td>3</td>
<td></td>
<td></td>
<td></td>
<td>1</td>
<td>4</td>
<td>4</td>
<td>Biomed approve and verify asset list monthly</td>
</tr>
</tbody>
</table>
Can we streamline and simplify making it easier for front-line staff and still improve safety?
# 1 Opioid & Sedation Management

ADE  
Failure to Rescue  
Delirium  
Falls  
Airway Safety  
VTE  
VAE

W A K E - U P
# 2 Early Progressive Mobility

Falls  PrU  Delirium  CAUTI  VAE  VTE  Readmissions

GET UP
# 3 Hand Hygiene

- CDI
- CAUTI
- SSI
- VAE
- CLABS I
- Sepsis
- MDRO

S O A P - U P

American Hospital Association
FOUNDATIONAL QUESTIONS:

1. Is my patient awake enough to get up?

2. Have I protected my patient from infections?
Let us know

• Who has had success with
  – Narcotic and sedation management?
  – Mobility?
  – HH?
Sleep vs Sedation

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

• Antihistamines/anticholinergics
• Antipsychotics
• Some antidepressants
• Anti-emetics
• Muscle relaxants
ICU Pitfalls of Sedatives and Analgesics

Sedatives and analgesics may contribute to:

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

• Over sedation
• 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

Over Medicated: Hibernating

Under Medicated: Not Happy

Sad 😞 $#@xx!!

Just Right!
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 least 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

<table>
<thead>
<tr>
<th>PAIN ALONE</th>
<th>PAIN &amp; POSS</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Risk factors may be absent</td>
<td>• Two scales allow for safer dosing</td>
</tr>
<tr>
<td>• Objective?</td>
<td>• High pain scale with high POSS scale – no narcotics</td>
</tr>
<tr>
<td>• Dosage based on number or range</td>
<td>• High pain scale low POSS- med dose</td>
</tr>
<tr>
<td>• Patients and families understand the numeric dosing</td>
<td></td>
</tr>
</tbody>
</table>

**Summary:**
- Two scales offer safer dosing compared to single scales.
- The combination of pain and physiological observation scales (POSS) provides a comprehensive approach to pain management.
- Understanding numeric dosing can help patients and families better manage their care.
MUST DO #3
Multi-Modal Pain Management

Pharmacological and Non-pharmacological
MULTIMODAL PAIN MANAGEMENT

• Combination of opioid and one or more other drugs
  • acetaminophen (Tylenol, others)
  • ibuprofen (Advil, Motrin IB, others)
  • celecoxib (Celebrex)
  • ketamine (Ketalar)
  • gabapentin (Gralise, Neurontin)
• 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%

NEXT: Looking to see if opioid usage and opioid ADEs are both decreased.
# 2 Early Progressive Mobility

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

GET UP

American Hospital Association
Pathophysiological changes within 24H of bed rest

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

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

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

**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% 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)
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.”
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)
TEAMING UP TO MOBILIZE
1. Walk in, walk during, walk out!
2. Belt and bolt!
3. (3) 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

3 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>
</table>
| 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 |

<sup>a</sup> 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.  
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
Toolkits

- John Hopkins Early Mobility Toolkit: https://cdn.community360.net/app/jh/VAP/resources_e/Early_Mobility_Toolkit%206.10.14nr.docx

• Lazarus BA, Murphy JB, Coletta EM, McQuade WH, Culpepper L. The provision of physical activity to hospitalized elderly patients. Archives of Internal Medicine 1991;151:2452-2456.

• Mahoney JE, Sager MA, Jalaluddin M. New walking dependence associated with hospitalization for acute medical illness: Incidence and significance. Journals of Gerontology: Series A, Biological Sciences and Medical Sciences 1998;53A:M307-

• Vollman K.(2010) Introduction to Progressive Mobility http://ccn.aacnjournals.org/content/30/2/S3.full.pdf

• Article: Doherty-King B (2011) How nurses decide to ambulate hospitalized older adults http://gerontologist.oxfordjournals.org/content/51/6/786.long


Hand-washing 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%
• 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 HAI by performing HH.
- Promote patient and family engagement—give them permission to “speak up for clean hands.”
- Promote patient HH for patients.

http://www.cdc.gov/handhygiene/patients/index.html
MUST DO's
SOAP-UP Must Do’s

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

HH Compliance

New observers trained
Scripting education
SOAP UP Started

HAI

January
February
March
April
May
June

0
10
20
30
40
50
60
70
80
90
100

0
10
20
31
40
50
60
70
80
90
100

HH Compliance
HAI
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.

### Unit/Department

**Indicate below what activity was observed and check the one box that applies to that activity.**

<table>
<thead>
<tr>
<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>
<th>DID YOU SEE HIM/HER USE SOAP OR ALCOHOL GEL WHEN EXITING THE ROOM?</th>
<th>PERSON EXITED THE ROOM WITH GLOVES ON AFTER DIRECT CONTACT WITH THE PATIENT OR ENVIRONMENT</th>
<th>DID YOU SEE HIM/HER USE SOAP OR ALCOHOL GEL AFTER REMOVING GLOVES?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enter Staff Code</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>Enter Staff Code</td>
<td>Yes</td>
</tr>
<tr>
<td>1.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Total # of Staff Observed**

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

Adapted with permission from Stanford Health Care, Palo Alto, CA
SOAP UP

To reduce: CAUTI, CDI, CLABSI, Sepsis, SSI and VAE and MDRO

☐ Are the harms associated with inadequate hand hygiene known?
☐ Is there a strong desire to improve hand hygiene?
☐ Do you have a hand hygiene policy and procedure?
☐ Have staff been educated regarding performance expectations and the policy and procedure specifics?
☐ Do you have adequate supplies available to perform hand hygiene?
Foundational Questions:

1. Is my patient awake enough to get up?

2. Have I protected my patient from infections?
Hospital Improvement Innovation Network

Welcome to the HRET Hospital Improvement Innovation Network!

The Centers for Medicare & Medicaid Services awarded the Health Research & Educational Trust (HRET) a two-year Hospital Improvement Innovation Network (HIIN) contract (with an optional third year based on performance), to continue efforts to reduce hospital-acquired conditions (HACs) and readmissions. According to the AHRQ National Scorecard on Rates of HACs, an estimated 125,000 fewer patients died in the hospital and approximately $28 billion in health care costs were saved from 2010 to 2015 due to the reductions in HACs. This was largely due to the work of...
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:

UP Campaign Communication Resources

- UP Campaign Brief
- UP Campaign Trifold Brochure

UP Campaign Audience Specific Resources

- UP Campaign Leadership Focus
- UP Campaign Physician Focus
- UP Campaign Quality Leaders Focus
- UP Campaign Nursing Staff Focus
- UP Campaign State Leaders

UP Campaign Implementation Tools

- UP Campaign Set Up Tool
- UP Campaign Performance Monitoring Tool
Thank you!