Safety Network to Accelerate Performance (SNAP)

HRET HIIN VTE PFE SNAP Session 3

Thursday, February 28, 2019
1:00 P.M. – 2:00 P.M. CT
WELCOME AND ANNOUNCEMENTS
Jessica T. Claudio, MBA
Program Manager, AHA Center for Health Innovation
Your HRET HIIN VTE PFE SNAP Team

Jessica T. Claudio, MBA
Program Manager, AHA Center for Health Innovation

Steve Tremain, MD, FACPE
Physician Improvement Advisor
Cynosure

Tara Bristol Rouse, MA
Patient and Family Engagement Project Consultant, AHA Center for Health Innovation

Betsy Lee, MSPH, RN
Improvement Advisor
Cynosure
Agenda

- Welcome and Announcements
- State Partner Recognition
- Hospital Pre-Assessment Responses
- Continued Discussion on Discovery
- What Have Been Your Initial Tests of Change?
  - Successes and Challenges
  - Specific Interventions as New Emerging Best Practices
- Questions and Answers
Attendance Verification

- Name
- Hospital/State Hospital Association
- City, State
Announcements

- Continue to Complete VTE PFE Discovery Tool
HRET HIIN VTE PFE SNAP Webinar Schedule

- March 18, 2019 (1:00 PM – 2:00 PM CT) - FINAL
  - Open to all HRET HIIN Hospitals
  - Register [Here!](#)

"Calendar invitations with the platform link will be sent by HRET HIIN"
State Partner Recognition
HOSPITAL PRE-ASSESSMENT RESPONSES

Steve Tremain, MD, FACPE & Betsy Lee, MSPH, RN
Improvement Advisors, Cynosure

Tara Bristol Rouse, MA
Patient Family Engagement Project Consultant,
AHA Center for Health Innovation
What Did We Learn from Pre-Assessment Surveys?

- Risk assessments are occurring in about ½ of our SNAP hospitals
- Ambulation protocols as standard work (not “up ad lib”) are not in place
- Large opportunities exist to engage nurses, patients and families in improving the understanding and acceptance of mechanical and pharmacologic prophylaxis
WHAT DID YOU DISCOVER?

Steve Tremain, MD, FACPE & Betsy Lee, MSPH, RN
Improvement Advisors, Cynosure
Tara Bristol Rouse, MA
Patient Family Engagement Project Consultant,
AHA Center for Health Innovation
### VTE PFE Mini RCA Process Improvement Discovery Tool

- Review the last 5-10 charts of patients who experienced post-op VTE
### Mini RCA VTE Process Improvement Discovery Tool (Minimum 5 charts/Maximum 10 charts)

**Note:** Do NOT spend more than 20-30 minutes per chart!

Instructions: (1) If the answer to the question is "YES", mark an X in the box. Leave the box empty if there is no documentation that this important process occurs. (2) The processes with the most blank boxes could be a priority focus.

<table>
<thead>
<tr>
<th>PROCESS</th>
<th>Chart #</th>
<th>Chart #</th>
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<th>Chart #</th>
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</thead>
<tbody>
<tr>
<td><strong>RISK SCREENING</strong></td>
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<td>A standard VTE risk screening tool was used to assess this patient’s risk.</td>
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<td>The risk screen was performed by the physician.</td>
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<td>The nurse performed the risk screen using the tool during changes in patient status or upon transfer to another unit.</td>
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<tr>
<td><strong>ORDERS</strong></td>
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<td>The physician-ordered interventions are appropriate for the determined level of patient risk for VTE and bleeding.</td>
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<td><strong>PROPHYLAXIS ADMINISTRATION</strong></td>
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<td>Unless ambulation was contraindicated, this patient was placed on an ambulation protocol that maximized his/her ambulation, and the amount/distance of ambulation was regularly documented.</td>
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<td>If sequential compression devices were ordered, there is evidence that the patient wore them at all times</td>
<td>X</td>
<td>X</td>
<td>X</td>
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<td>If anticoagulants were ordered, there is evidence that the patient received every dose in a timely manner.</td>
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<td>If the patient refused any orders, there is evidence that the patient was educated by the nurse as to the risks of refusal using Teach-Back.</td>
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VTE PFE Process Improvement Discovery Tool

What trends did you discover?

What did you learn?

What is your action plan?
Let’s hear from our First Explorers

- Eskenazi Hospital. Indianapolis, IN
- Lutheran Health, Fort Wayne, IN
- Union Hospital, Terre Haute, IN
- Methodist Hospital, Henderson, KY
Let's do this together...

- Pre-assessment
- Discovery Tool
- Initial Tests of Change
There is room for improvement!

- Start with ideas
- Test them with very very small tests
- Rapid cycle PDSA

![Diagram showing a process from complex to simple with 'I see' and 'oh...']
Ensuring Multi Level Patient and Family Engagement (PFE)

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<thead>
<tr>
<th>Point of Care</th>
<th>Change Ideas</th>
<th>Governance</th>
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<tbody>
<tr>
<td><strong>Implementation Partners:</strong></td>
<td><strong>Implementation Partners:</strong></td>
<td><strong>Implementation Partners:</strong></td>
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<tr>
<td>Point of Care Providers, Medical Directors, Nurse Managers</td>
<td>Quality and Safety Leaders, Medical Directors, Nurse Managers, Patient Experience Leaders</td>
<td>Board of Directors, C-Suite</td>
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<td>During the perioperative appointment, discuss risks and preventive practices related to VTE; share the resource Preventing Venous Thromboembolism After Surgery with the patient and family.</td>
<td>Discuss the important role mobility and the use of Sequential Compression Devices (SCDs) play in VTE prevention. Create a place for the patient/family on the whiteboard to track walking and SCD use, refer to the board during morning rounds and ask the patient/family to describe successes and challenges related to mobility and SCD use.</td>
<td>Invite members of the Board to wear SCDs during a Board Meeting to help them understand the patient experience; couple this experiential learning with a report out on the work your improvement team has conducted to prevent VTE.</td>
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<td>Select a nurse member of your VTE improvement team to spearhead an internal education campaign regarding the importance of SCD use and the role of nursing. Ask this nurse to share local patient stories or those from Stop the Clot to underscore the potential impact of blood clots on patient lives; measure the success of the campaign by conducting regular audits on SCD use in the targeted care unit.</td>
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**AHA CENTER FOR HEALTH INNOVATION**

**American Hospital Association**

Advancing Health in America
Who is capturing your data?
VTE PFE Resources

Patient Stories

Compendium of Resources

Information for Patients about Blood Clot Prevention
Other Resources

- AHRQ VTE Guide
Join HRET HIIN Hospital-Wide LISTSERV®

- HRET HIIN uses the Hospital-Wide LISTSERV® platform to encourage peer-to-peer networking, share HRET HIIN events and resources, and highlight innovative approaches to reduce harm.

Register here
Questions?
THANK YOU!