Safety Network to Accelerate Performance (SNAP)

HRET HIIN VTE PFE SNAP Session 4 – Wrap Up Summary

Monday, March 18, 2019
1:00 P.M. – 2:00 P.M. CT
WELCOME AND ANNOUNCEMENTS
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Your HRET HIIN VTE PFE SNAP Team

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Agenda

- Welcome and Announcements
- VTE PFE SNAP
- Continued Discussion on Discovery
- What Have Been Your Initial Tests of Change?
  - Successes and Challenges
  - Specific Interventions as New Emerging Best Practices
- What Did We Learn that We Can Spread to the HIIN?
- Questions and Answers
Attendance Verification

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

- We want your feedback!
- Please Complete the HRET HIIN VTE PFE SNAP Post-Assessment by Monday, April 1, 2019.
VTE PFE SNAP

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

American Hospital Association
Advancing Health in America
State Partner Recognition
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
- Review the last 5-10 charts of patients who experienced post-op VTE.
### Example

**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.

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<thead>
<tr>
<th>PROCESS</th>
<th>Chart #</th>
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<tbody>
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<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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<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>
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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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**AHA CENTER FOR HEALTH INNOVATION**
What trends did you discover?

What did you learn?

What is your action plan?
Let's do this together...

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

- Start with ideas
- Test them with very very small tests
- Rapid cycle PDSA
### Ensuring Multi Level Patient and Family Engagement (PFE)

#### Point of Care
- **Implementation Partners:** Point of Care Providers, Medical Directors, Nurse Managers
- **Change Ideas:**
  - Discuss the important role mobility and the use of Sequential Compression Devices (SCDs) play in VTE prevention.
  - Create a place on the patient whiteboard for the patient/family to track walking and SCD use.
  - Develop 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 SCDs on patient lives.

#### Policy & Protocol
- **Implementation Partners:** Quality and Safety Leaders, Medical Directors, Nurse Managers, Patient Experience Leaders
- **Change Ideas:**
  - 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.
  - Engage your PFAC to create a patient and family educational resource regarding SCDs; ask them to wear SCDs during the meeting so that they can better understand how to describe their use and benefits, as well as address potential challenges and support needs related to their use.

#### Governance
- **Implementation Partners:** Board of Directors, C-Suite
- **Change Ideas:**
  - 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.

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**VTE**

**AHA CENTER FOR HEALTH INNOVATION**

**American Hospital Association**

Advancing Health in America
Who is capturing your data?
What to Spread?
REMINDER!!!

- We want your feedback!
- Please Complete the [HRET HIIN VTE PFE SNAP Post-Assessment](#) by [Monday, April 1, 2019](#).
Other Resources

- AHRQ VTE Guide

Preventing Hospital-Associated Venous Thromboembolism
A Guide for Effective Quality Improvement
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?

Q & A
You have Questions
We have Answers
THANK YOU!