North Dakota Hospital Association
Innovate-ND
HRET Hospital Improvement Innovation Network

June 29, 2018

Educational Events

HRET HIIN

Physician Virtual Event | Opioid Safety and Introduction of Human Diagnosis Project
07/09/18 | 3:00-4:00 p.m. CT

HRET HIIN QI Foundations for Change Fellowship Call #10
07/11/18 | 11:00 a.m.-12:00 p.m. CT

HRET HIIN QI Accelerating Improvement Fellowship Call #10
07/11/18 | 12:30-1:30 p.m. CT

HRET HIIN Readmissions Sepsis Fishbowl Series: Part 4
7/17/18 | 11:00 a.m.–12:00 p.m. CT

HRET HIIN QI Fellowship Office Hours #8
07/25/18 | 11:00 a.m.-12:00 p.m. CT

HRET HIIN Readmissions Sepsis Fishbowl Series: Part 5
8/07/18 | 11:00 a.m.–12:00 p.m. CT

Information, registration links and recording links for **all** HRET HIIN upcoming and past virtual events can be found under the "Events" tab on www.hret-hiin.org.

Event Recordings

All event recordings are/will be available on-demand on the HRET HIIN website www.hret-hiin.org. Select the desired topic and scroll down to "Watch a Recent Data Event".

Innovate-ND Event

Important Dates to Remember

Remember to report your HIIN data in CDS every month!

Deadline	Reporting Period
06/30/18	Performance Data for May Discharges

Quality Milestones Recognition

COPPER Milestone:	COPPER, BRONZE & SILVER Milestone:
	CHI St. Alexius – Devils Lake CHI Garrison Community Hospital CHI Mercy Health – Valley City Heart of America Medical Center – Rugby Pembina County Medical Center – Cavalier Sanford Hillsboro Medical Center St. Aloisius Medical Center – Harvey
COPPER & BRONZE Milestone: Ashley Medical Center Carrington Health Center CHI Community Memorial Hospital – Turtle Lake Cooperstown Medical Center Jacobson Memorial Hospital – Elgin	**COPPER, BRONZE, SILVER & GOLD Milestone:** McKenzie County Healthcare System – Watford City Northwood Deaconess Health Center Presentation Medical Center – Rolla Sanford Mayville Medical Center

Hypoglycemia: It's More Than Low Blood Sugar
07/26/18 | 2:00-3:00 p.m. CT

No registration is necessary.
Click here to join the webinar.
Join the conference call:
1-800-251-5450
Passcode: 100-9369

Partner Educational Events

Great Plains QIN
The Art and Science of Opioid Tapering
07/11/18 | 12:00-1:00 p.m. CT
Click here to register.

Anticoagulation Forum | Summer Webinars: Acute Venous Thrombosis: Thrombus Removal With Adjunctive Catheter-Directed Thrombolysis (ATTRACT Trial)
07/11/18 | 12:00–1:00 p.m. CT
Click here to register.

US Department of Health and Human Services, Office of Civil Rights
HIPAA Training for Small Health Care Providers
7/12/18 | 8:30 a.m.-12:30 p.m. CT
Minot
7/13/18 | 8:30 a.m.– 12:30 p.m. CT
Grand Forks
Space is limited. Register Now!
Click here for more information.

Great Plains QIN
Improving End-of-Life Care: Eating the Elephant One Bite at a Time
07/19/18 | 2:00-3:30 p.m. CT
Click here to register.

Leading Together: New Paradigm for Health Care Training
July 17-18 | Denver, CO
November 7-8 | Charlotte, NC
Registration is now open for both trainings. Click here
Visit HRET HIIN Physician Page for more details.

Great Plains QIN
Community Antibiotic Stewardship Hot Topic: Antibiotic Stewardship as Part of your Quality Improvement Program
07/24/18 | 12:15-1:15 p.m. CT

Kenmare Community Hospital Linton Hospital Mountrail County Medical Center – Stanley Nelson County Health System – McVille Southwest Healthcare Services – Bowman St. Luke's Hospital – Crosby Tioga Medical Center Towner County Medical Center – Cando Unity Medical Center – Grafton	St. Andrew's Health Center – Bottineau Wishek Community Hospital
COPPER, BRONZE, SILVER, GOLD & PLATINUM Milestone: Cavalier County Memorial Hospital – Langdon First Care Health Center – Park River Sakakawea Medical Center – Hazen	

Congratulations to Denise Beaver-Eslinger, Cooperstown Medical Center for completing the HRET Quality Improvement-Foundations Fellowship!

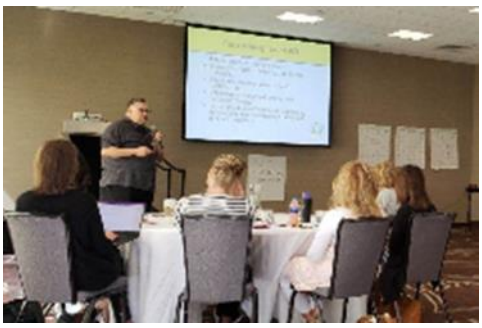
Congratulations to Marcie Schulz, Sakakawea Medical Center on completing the HRET Accelerating Quality Improvement Fellowship!

Congratulations to Sakakawea Medical Center on reaching the Platinum Milestone!

PFE Regional Convening Update

AHA HRET HIIN hosted a PFE (Patient and Family Engagement) Convening on June 7 in Denver, CO, to support a cohort of hospitals and State Hospital Associations (SHAs) in the northwest region. The purpose of this day-long meeting was to discuss and evaluate the PFE needs of hospitals and states and to design action plans for improving patient safety and quality of care through meaningful engagement of patient and family advisors. The convening included participation from 5 states–Colorado, Idaho, Nebraska, North Dakota and Wyoming–and was attended by 25 hospital and SHA representatives.

Participants from ND included Beth Hetletved, CHI St. Alexius Health-Garrison; Marcie Schulz, Sakakawea Medical Center-Hazen; CitLaly Villarreal, Unity Medical Center-Grafton; and Leslie Booth, Jacobson Memorial Hospital-Elgin.



Sessions were facilitated by the following HRET HIIN PFE Faculty: Sue Collier, Interim Vice President, Clinical Quality, HRET; Tom Workman, Principal Researcher, AIR, NCD PFE Contractor; Martha Hayward, PFE Subject Matter Expert; and Tara Bristol Rouse, PFE Project Consultant, HRET.

Click here to register.

HealthInsight QIN
Trauma-Informed Care in Nursing Homes
7/24/18 | 3:30–4:30 p.m. CT
|Registration Not Required]
To participate:

1. Click here.
2. Locate the event you wish to join, click "**Join Now**" (located to the right of the event title).
3. Enter your name and email address as prompted.
4. Enter the password: **Trauma** (The automatic system set-up should start at this point. If a dialogue box appears, click run. Please note the automatic system set-up does take a few minutes to complete.)
5. Dial into the teleconference: **1 888-896-0862**. The access code is **46703968**.

Antibiotic Stewardship National LAN Event | Reducing Inappropriate Antibiotic Prescribing in Outpatient Settings using Behavioral Interventions
08/29/18 | 1:00–2:30 p.m. CT
Click here to register.

SAVE THE DATE

Quality Health Associates of North Dakota 2018 Quality Forum
08/23/18 | Bismarck, ND
Click here for more information.

Healthcare Worker Immunizations | Return on Investment
08/30/18 | 12:00-1:00 p.m. CT

NDHA Annual Convention and Tradeshow
10/09/18-10/11/18

ND Cardiac & Stroke Conference
10/24/18-10/25/18

NATIONAL PATIENT SAFETY FOUNDATION WEBCASTS

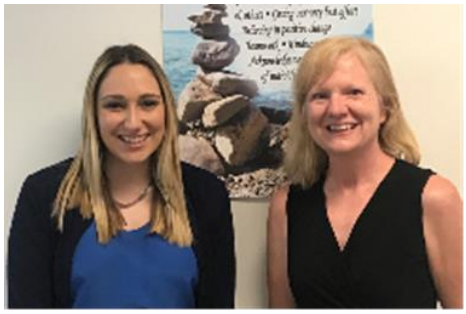
The National Patient Safety Foundation (NPSF) now offers complimentary access to past NPSF webcasts. Check back often to see what is available. Visit the NPSF

Key learnings and takeaways from the day included:

- Evaluating the specific needs of hospital and states in order to identify PFAs and/or implement a PFAC designed to improve performance in HACs and readmissions
- Designing an action plan for implementing the role of PFAs in hospitals and/or developing the structure for a PFAC
- Identifying the challenges and solutions to engaging PFAs and/or creating PFACs in quality and safety efforts
- Considering the ways to adapt the above processes for rural and critical access hospitals
- Determining how to adapt and use existing tools to sustain PFAs and/or PFACs in hospitals and states

The convening group will continue to work together in the coming months to collaborate and employ PFE strategies, as well as utilize PFE metrics to address harm and readmissions in their hospitals.

ND State Hospital Psych Visit

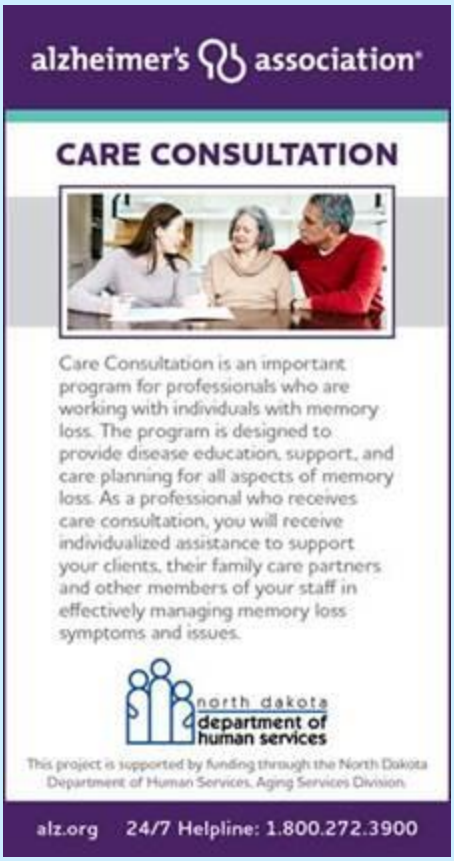


AHA HRET conducted a site visit at North Dakota State Hospital (NDSH) in Jamestown, ND, on May 31. NDSH is a freestanding inpatient psychiatric hospital that provides short-term acute inpatient psychiatric and substance abuse treatment, intermediate psycho-social rehabilitation services, forensic services, and safety net services for adults.

North Dakota State Program highlights include:

- Linking Patients to Basic Needs: NDSH partners with many non-profit and for-profit companies and organizations in the Jamestown area to provide jobs and job training to both current inpatients and patients transitioning back into the community after hospitalization. The hospital works closely with the housing authority to find safe and affordable housing for patients in their communities and works with a local estate sale company to allow patients to furnish their newly acquired housing at no cost. The hospital also partners with the local recycling company and a local construction company to employ newly discharged patients.
- Violence Reduction Training: All employees at NDSH are required to participate in Violence Reduction Training upon hire and every two years after. The training focuses on patient de-escalation techniques that keep a patient in his or her lowest state of risk, with the goal of preventing patient-to-staff and patient-to-patient violence.
- Therapeutic Options and Life Skills Training: Recognizing that many patients at NDSH have limited job and life skill experience because of the circumstances surrounding their illnesses, psychiatric rehabilitation programs at NDSH focus on helping patients build life skills that will help them integrate back into their communities after hospitalization. Patients can use their therapy time to learn to cook meals, do laundry, participate in art or music therapy, or learn vocational skills such as industrial cooking or furniture upholstery.

Webcast Archive website and follow the instructions on your screen.



Resources

LISTSERV®
Sign up and help meet our goal of approximately 1,000 subscribers per LISTSERV® topic. These platforms enable peer-sharing and are used to promote virtual events and highlight innovative topic-specific strategies to reduce harm. New subscribers are added on the first day of each week.

On the Web
The HRET HIIN website is a one-stop-shop for all HRET HIIN information and events! Check it out at www.hret-hiin.org.

Social Media
Follow the HRET HIIN on Twitter @HRETtweets! Here they'll be promoting virtual events, highlighting recruitment numbers, state partners and hospitals! Re-tweet, reply or like their posts and share your HIIN journey using #WhyImHIIN.

Featured Resources

New Resource on Social Determinants of Health

AHA has released a new presentation highlighting the importance of addressing the social determinants of health. The presentation includes an overview of the social determinants of health; the impact they have on individuals and communities; steps hospitals and health systems can take to address them; case examples from organizations who are taking action to address certain social determinants; and AHA resources. Hospital and health system leaders can use the presentation in conversations with their employees, trustees and community. Visit the AHA's social determinants of health page and the AHA's Value Initiative for more resources.

ADEs

Nebraska Pain Management Guidance Document

Nebraska has developed a pain management guidance document that you may find useful. It was developed by the Department of Health and Human Services in collaboration with an expert advisory task force, actively practicing providers and senior state officials.

Nominate Safety Leaders for ISMP Cheers Awards

Each year the Institute for Safe Medication Practices (ISMP) celebrates individuals, institutions and groups who have demonstrated an exemplary commitment to medication safety and medication error prevention through innovative projects, programs, educational efforts, standard setting, and/or research. Winners are recognized for their positive examples and/or teamwork through their implementation of medication safety strategies. Nominations for this year's awards will be accepted through September 7, 2018. Click here to learn more.

Are You Working to Reduce Hypoglycemic Events? What Conversations Are You Having?

HRET HIIN ADE List Serv post | HRET Hypoglycemia Prevention Team| *June 25, 2018*

A few weeks ago, we noted that one key to preventing hypoglycemia in hospitalized patients is increasing awareness of the fragility of glycemic control in these patients. The target glucose should be 140-180 mg/dL. A glucose *less than 70 (even one time) is not OK and should lead to insulin regimen changes*.

A hospital in southern Georgia completed the Hypoglycemia Process Improvement Discovery Tool, found here, and realized that failure to recognize the importance of inpatient hypoglycemia and failure to subsequently modify the insulin regimen were causal in many of their

You can also join the HRET-HIIN on Facebook and LinkedIn. Follow the instructions for joining by clicking on the correlating icon on the right-hand side of the page when you log onto the HRET HIIN website (www.hret-hiin.org)

INNOVATE-ND SUPPORT TEAM

Jean Roland
jroland@qualityhealthnd.org
701/989-6227

Nikki Medalen
nmedalen@qualityhealthnd.org
701/989-6236

Jon Gardner
jgardner@qualityhealthnd.org
701/989-6237

severe hypoglycemic events. Within a few days of this discovery, it was being discussed in earnest at the Medication Safety Committee.

HEALTHCARE-ASSOCIATED INFECTIONS

Hospital-Acquired Conditions Fall 8% Over 2 Years

The Agency for Healthcare Research and Quality (AHRQ) released a data report on June 5, 2018, with results showing an 8% decline in hospital-acquired conditions between 2014 and 2016, preventing an estimated 8,000 deaths and $2.9 billion in health care costs. Hospital-acquired conditions decreased by an estimated 350,000 over the period, including a 15% decline in infections and adverse drug events. AHRQ stated that these results occurred largely through the work of the 16 Hospital Improvement Innovation Networks and estimated that if the 20 percent HAC reduction goal were achieved during 2015 through 2019, there would be 1.8 million fewer patients with hospital-acquired conditions, resulting in 53,000 fewer deaths and saving $19.1 billion in hospital costs. The Centers for Medicare & Medicaid Services Administrator Seema Verma stated, "Today's results show that this is a tremendous accomplishment by America's hospitals in delivering high-quality, affordable health care. CMS is committed to moving the health care system to one that improves quality and fosters innovation while reducing administrative burden and lowering costs. This work could not be accomplished without the concerted effort of our many hospital, patient, provider, private and federal partners–all working together to ensure the best possible care by protecting patients from harm and making care safer." AHA HRET HIIN thanks you for contributing to this incredible achievement in harm reduction and for your continued dedication and commitment to improving patient safety and quality of care. Let's continue to work together to protect patients and save lives. To view the AHRQ report, please click here.

Sepsis Coordinator Network Climbs to Over 500 Members

Sepsis Alliance is proud to report that in less than a month from its May 22 launch, the Sepsis Coordinator Network (SCN) already has over 500 members who come from 485 hospitals and facilities, and cover over 170,000 hospital beds! If you haven't joined yet, what are you waiting for? **Join now!**

Already a SCN member? Thank you for joining! You will find new tools and resources that have been added in your member menu, and remember to visit the forums to see all of the great conversations being had and to contribute your voice. The SCN is always evolving, so check back often.

Finally, we are happy to announce that Accelerate Diagnostics and La Jolla Pharmaceutical are joining Edwards Lifesciences as corporate sponsors of the SCN. Thank you to our sponsors for making the SCN possible.

About the Sepsis Coordinator Network:
The Sepsis Coordinator Network provides healthcare professionals with evidence-based best-practice resources and guidance to improve outcomes for patients with sepsis. The network also provides professionals with peer-to-peer forums to ask questions and get support from sepsis experts when they face challenges in their daily practice. To

learn more about SCN or register visit www.SepsisCoordinatorNetwork.org.

It's NOT Always Sepsis: A Common Sense Approach for ALS and BLS, EMS Providers

Sepsis is an emergent medical condition that kills more people annually than prostate cancer, breast cancer, and AIDS combined. For every two heart attack patients cared for by EMS, five patients are hospitalized by sepsis. EMS transports 60% of patients with severe sepsis arriving at the ED and yet EMS providers are unaware of its presence or what they should do if they find it. This presentation discussed new sepsis criteria along with expert commentary as to how they can be applied in the field. This program includes real-world, practical methods for EMS identification, assessment and field treatment of life-threatening sepsis and a look at the current state of sepsis critical care, as well as what we can anticipate in the coming months and years. Click here to view the program recording.

CAUTI Stop to Start

AHA HRET HIIN has released a new CAUTI resource aimed at Emergency Department usage of indwelling catheters. This easy to follow 3-page guide focuses on how to STOP usage of indwelling catheters in the Emergency Department and START improving through new strategies and change ideas. We encourage you to share this resource with your ED.

Do You Want to "Look Good" or "Be Good"?

Walking the line between under-identification of toxigenic *Clostridium difficile* (lack of specificity] and over-identification (lack of sensitivity) is at times a conundrum when it comes to laboratory screening for *C. difficile*. We don't want to miss any 'real' cases of *Clostridium difficile* infection (CDI) but we also don't want to go to the extremes where we end up 'over-calling' it either. The latter can result in administration of antibiotics to a patient who is really just colonized and falsely elevated hospital-onset surveillance rates that negatively impact the bottom line.

Proper lab identification and clinical diagnosis were the primary focus of the June 5th HRET HIIN CDI Sprint webinar that had just under 300 participants on the line. **Darla Silavent, RN, BSN, CIC** from **Flowers Hospital in Alabama** shared their journey and facilitated a discussion that can be heard here.

Do you want to 'look good' or 'be good'? Most of us would say 'both', however the pressure to capture 'present on admission' cases of *C. difficile* can favor the former.

Unless we have solid (pun intended) practices to assure submitted stool samples meet criteria that

- *conform to shape of the container, and*
- *are not explained by other causes (e.g., recent laxatives, stool softeners),*

then, and only then, can a stand-alone NAAT (e.g., PCR) be used without risking large numbers of false positives.

If you do not have highly reliable processes for the two processes in italics above, then you should not use a stand-alone NAAT. Instead, according to the 2017 *C. difficile* IDSA/SHEA clinical practice guidelines (here), you should use a multiple step method such as GDH plus toxin or NAAT plus toxin.

Remember, the predictive value of a test is progressively increased when each of the following are true:

1. The patient being tested has symptoms consistent with CDI (e.g., at least 3 unformed stools in the past 24 hours)
2. The patient's diarrhea is not explained by other obvious causes (e.g,. recent enema, laxative, tube feeding)
3. The laboratory exercises its right and obligation to refuse to run the test on stools that don't meet established criteria

How are you testing? Can you STAND on your NAAT only tests? Talk to your docs, to your lab. Find out what is happening In a week or two we will share more pearls from this event, and ask you to report on your initial actions.

Central Line Care: How Do We Do What's Best Even After Discharge?

Considerable attention is being focused on how we provide care to central lines in acute care settings. A recent study by Spires et al published in ICHE
(Infect Control Hosp Epidemiol 2018;39:439–444) shined the spotlight on the prevalence of central line associated complication risks in outpatient (e.g., home) settings.

The researchers discovered that approximately 1 in 5 outpatients with central venous catheters (CVCs) developed a catheter-related complication (CAC) that required medical attention (e.g., outpatient or ED visit or inpatient admission). CACs included mechanical issues (including loss of patency), thrombotic complications, and suspected CLABSI. Risk for developing a CAC increased with TPN use as well as with increasing CVC lumens (possibly markers for 'sicker' patients?).

One striking finding was the frequency with which the CVCs were accessed each daily (over a quarter of patients required access 3 or more times a day). Because these CVCs are often handled differently than CVCs in the hospital (i.e., in the hospital nursing staff primarily handle/access the catheter vs. outpatient settings where the patient and/or his or her caregiver performs these roles), interventions to reduce such complications may be different than those used with inpatients.

Intensive patient and caregiver education (possibly including hands-on competency check off) may be necessary to ensure full implementation of infection and CAC prevention activities in the outpatient setting. Finally, infection prevention programs should expand their surveillance of healthcare-associated complications to include outpatient CVCs, given the potential volume of use and associated morbidity nicely illustrated by this study.

Complications that are associated with practices that take place after the patient is discharged are common yet not a typical focus on infection prevention programs. We recently featured an example of how to

engage patients and their families with the “One, two, three…count with me” program from UC Irvine. Has anyone done anything else to drive standardization of safe handling practices for patients who are discharged with a central line? How do we assure that patients and their families are armed with the ‘why and the how’ so they can continue to provide reliably standardized care? Please share your ideas with us all.

Pressure Ulcers

Is Saving Skin on your Radar with Sepsis?

Is saving skin on your radar as you are working with a suspected sepsis patient? HRET HIIN data is showing that sepsis is the leading diagnosis associated with pressure injuries.

Patients with sepsis experience a cascade of symptoms and pathophysiology that makes them extremely vulnerable to pressure injuries in the acute phase of illness. These contributing factors include: fever, diaphoresis, hypoperfusion, poor tissue oxygenation, inflammation, and ultimately multiple organ system failure. It is important to note that skin, as the integumentary system, can fail, too.

If this is not on your radar screen, here are two steps to take:
Step 1, take a look at your data. What are the leading discharge diagnoses for your patients with stage 3 or greater pressure injuries?
Step 2, review the HRET HIIN Sepsis HAPI Top 10 checklist to assess where your preventative practices could be strengthened.

Access the Sepsis HAPI Top 10 Checklist here under the HRET HIIN HAPI Resource Library to find ten evidence-based tips to reduce pressure injuries with sepsis.

Falls

Celebrate National Safety Month

Join the National Safety Council (NSC) and thousands of organizations nationwide in celebrating National Safety Month by focusing on reducing leading causes of injury and death at work, on the road, and in our homes and communities. The NSC will be providing downloadable resources highlighting a different safety topic for each week in June, including: Emergency Preparedness, Wellness, Falls, and Driving. To learn more about how you can participate click here.

Airway Safety

Intubations: Using a Bougie Increases Success!

The number of endotracheal intubation attempts is one way to measure harm from endotracheal intubation and improve airway safety. Success with the first pass of orotracheal intubation is associated with a smaller incidence of adverse events. As the number of attempts at intubations increased, so does the incidence of adverse events.

A recent study investigated the use of a tracheal tube introducer know as a “bougie” for intubation with all emergency department patients. he use of the bougie resulted in 98% first–attempt intubations success. This is a significant improvement when compared to a large ED intubation

registry that describes an 85% success rate for first attempt intubations. You can read the full article here.

PFE

Mobility Pearls from a Patient

Reprinted from Hospital-Wide-Topics listserv, Jackie Conrad, 6/15/18

I would like to share a story I heard the day after a Get UP workshop in New Hampshire.

A nurse who attended the Get UP workshop described a conversation that occurred while walking with one of her patients the next day. The nurse asked the patient, "What ideas do you have to encourage patients to walk in the hallways on our unit?"

The patient responded, "When you turn this corner, the wall is bare. Wouldn't it be nice to have a "search and find" picture there? Patients could take a break if needed and look at the picture and find, let's say, a heart or flower."

He went on to suggest that "for walking you could earn a ticket to play bingo. You would have to walk to get the bingo card, and if you win a prize, you will have to walk to get the prize." He also added, "I like the idea of a pedometer. Counting laps isn't as meaningful as how many steps a day."

From just **one** conversation with **one** patient, three pearls were garnished! The people closest to the care know best. Please ask your patients what matters to them. What would motivate patients to mobilize more on your unit?

Two ideas for your thoughts and consideration:

- In the field, staff are reporting how patients ambulating the floors lightens the atmosphere and how they are getting to know their patients better when they walk and talk. ***Can mobility help us bring joy back to work?***
- The patient's suggestion to have a mentally stimulating picture to look at on the wall could potentially help keep patients mentally sharp and free of delirium. Mobility and mental stimulation can prevent delirium. **Can this strategy reduce burden by reducing delirium on your unit?**

Please share your strategies to encourage patients to mobilize. Do you have posters, cafeteria table tents, videos, or activities? There is a ***"movement towards movement"*** in our HIIN. Let's keep spreading these great ideas!

HRET HIIN has created a patient focused Get Up Poster to support messaging that mobility is medicine.

DIVERSITY

Social Determinants of Health

HRET HIIN Health Disparities List Serv post | Health Disparities Team | June 6, 2018

How do the social determinants of health impact the communities you serve? What is the best way to close gaps in disparity?

AHA's recent Annual Member Meeting had an inaugural Equity of Care briefing which focused on the social determinants of health and the role they play in health disparities.

The briefing kicked off with a special announcement detailing a new alliance between AHA and UnidosUS to increase diversity among health care executives and improve the health of communities. The alliance builds on the AHA's work with the National Urban League. The organizations will work together to increase diversity within hospital and health system governance; promote and advise the Culture of Health grant from the Robert Wood Johnson Foundation; and collaborate on youth violence prevention and post-trauma support.

The social determinants of health and their impact on communities were discussed further in a panel discussion. Panelists shared their perspectives on how to jumpstart critical action on accelerating health equity, the importance of building relationships in the community, and the role of collecting the right data to close disparity gaps. To read more about the briefing click here.

To learn more about the work AHA is doing around the social determinants, health equity and diversity, click here.

Call for Social Determinants of Health Script

Identifying and addressing a patient's social needs is just as important as addressing their clinical needs, yet 80% of physicians do not feel confident in addressing their patient's social needs. AHA has acknowledged this gap in care and is working to develop a set of standardized screening scripts on social determinants of health for health care professionals and would appreciate your input! Please email AHA your hospital's or health system's screening scripts for identifying patients with severe social needs. From your submissions, AHA will create and share a comprehensive script on the best way to screen patients with social needs. Let's work together to reduce barriers to care for patients impacted by social determinants of health.

MISCELLANEOUS

Utilize UP to Take Down Harms

AHA HRET HIIN has released a new UP Campaign video and updated UP Campaign resources. The video explains how the UP campaign can be implemented by addressing each of its key components and highlights hospitals that are using the UP Campaign to simplify safety and streamline interventions that improve quality care. The updates to the UP Campaign resources include: a revised UP Campaign brief and audience specific resources that contain why Script UP is important and what harms are reduced by Script UP. Additionally, the performance monitoring tool has been updated to include a monitoring section for Script UP. Find the video here along with the updated UP Campaign resources.

We encourage you to share this video with your hospitals and the updated UP Campaign resources to reinforce the importance of this campaign, demonstrate its effectiveness and encourage participation.

Malnutrition Video: Facts, Case Study, 4 minutes, Go!

Reprinted from Hospital Wide Listserve, Jackie Conrad, 6/15/18

Malnutrition can significantly increase a patient's risk for harm while in the hospital. This is driving hospitals to reevaluate nutritional services in their organizations. The Vizient HIIN has produced a short, 4 minute, Malnutrition Video Clip, to get hospitals thinking about the magnitude of the problem and suggests first steps a hospital can take.

The Vizient video features HRET HIIN's Jordan Steiger and Jackie Conrad speaking about the magnitude of the problem, followed by a case study detailing the approach taken by the University of Iowa Hospitals and Clinics.

Malnutrition Facts

- Prevalence: One-third of the patients entering hospitals are malnourished and of those not malnourished, two-thirds will become malnourished while in the hospital.
- Malnourished patients are at greater risk for harm:
  - four times more likely to develop a pressure injury
  - five times more likely to develop a CAUTI
  - twice as likely to develop a surgical site infection
  - sixteen times more likely to develop an infection from an implantable device

University of Iowa Hospitals and Clinics Case Study

- The team started with a large group conversation about how to define malnutrition in their organization.
- They then piloted data collection to assess for malnutrition on two units for four months and found that 42% of the patients were malnourished. This represented a large opportunity to improve assessment and documentation workflows and begin treating this condition.
- As a result of the pilot, dietitians have become integral members of the care team, and the hospital has increased the number of full-time dietitians to address the malnutrition problem.
- It is important to note that capturing malnutrition in the clinical record is an important step in accurately documenting the acuity of your patients which will impact coding and reimbursement.

Are you ready to start addressing malnutrition as a cross cutting strategy?

Ask your dietitian to conduct an audit of current patients in your organization. How many are malnourished and how many have documentation that they are malnourished? Is there a gap?

Safe Patient Handling: Don't Forget Your Radiology Technologists!

HRET HIIN Hospital Wide List Serv post | HRET HIIN Radiation Safety and Culture of Safety Teams | June 21, 2018

Safe Patient Handling (SPH) programs are especially important in the radiology department due to the ergonomic challenges faced by clinicians who are often working alone without mobilization equipment.

In a 2015 article in the American Journal of Safe Patient Handling and Movement, ***Radiology and Safe Patient Handling***, the problems, challenges and solution to keeping RTs free from musculoskeletal injuries are explored.

The Challenges:

- RTs are often working alone or on call.
- Bedside imaging requires positioning and placing a cassette under the patient, often with no help.
- The radiology suite is not conducive to using standard, SPH equipment.
  - Some tables do not have an adjustable height
  - Floor-based lifts cannot be accommodated by solid based tables
  - Single-track ceiling lifts can be problematic due to the precise alignment required over a stationary exam table.
- The prevalence of overweight and obese patients is on the rise, increasing risk for staff injury, straining equipment and furniture in the department, and causing patients embarrassment when procedures must be cancelled due to their size.

The Solutions:

- Use H-track ceiling lifts which allow movement in four directions over the table.
- If ceiling lifts are not feasible, use lateral transfer/friction reducing devices, such as roll boards or air-assistive devices.
- Magnetic Resonance Imaging (MRI) units with single track ceiling lifts in the holding area with an MRI exam table that can be un-docked and wheeled into the holding area.
- Use of ceiling or floor-based lifts on the patient care units to assist with positioning for portable bedside imaging.

For more details on the challenges and solutions, please access the article here. The Occupational Safety and Health Administration (OSHA) offers a self-assessment tool for safe patient handling that can be used to assess departments and occupations most at risk in your facility.

Workplace Violence Risk Assessment

HRET HIIN Hospital Wide List Serv post | HRET HIIN Culture of Safety Team| June 21, 2018

The HRET HIIN measure of harm events related to workplace violence (WPV) refers to the Occupational Health and Safety Administration (OSHA) definition of a violent incident. OSHA defines WPV as “any act or threat of physical violence, harassment, intimidation, or other threatening disruptive behavior that occurs at the work site.” WPV ranges from threats and verbal abuse to physical assaults and even homicide.

There are numerous toolkits and checklists available to assist hospitals in identifying and addressing risks of workplace violence.

The first steps are to 1) conduct an organizational risk assessment, and 2) analyze your data to understand vulnerabilities for your facility. Threats can come from inside or outside the organization, so a comprehensive assessment of your current state of preparedness is key.

Questions to consider as you address workplace violence:

- Is your data reporting system robust enough to capture all acts and threats based on the definition above?
- Which departments or units generate the most reports?
- Do you have issues with staff-to-staff bullying and lateral violence?
- Are staff members in your emergency department and other units experiencing increased threats and acts of verbal abuse and physical violence from patients, families, and/or visitors?
- Is your organization prepared for an active threat of violence or active shooter?
- Are staff trained in identifying behavioral cues that may precede violence, as well as de-escalation techniques to address threatening behaviors?
- Do you have sufficient emotional support available for personnel threatened or harmed in a workplace violence event, including those who observed the event?
- Does your organization conduct event reviews and root cause analyses after threats or acts of workplace violence?

Access the HRET HIIN Culture of Safety Change Package here. Here is a sample of useful resources for additional help in assessing risk, preparing staff, and planning for action:

- American Hospital Association (AHA) Hospitals Against Violence (HAV):
- OSHA Preventing Workplace Violence: Road Map for Healthcare Facilities (December 2015)
- American Organization of Nurse Executives (AONE) and Emergency Nurses Association (ENA) Toolkit for Mitigating Violence in the Workplace
- Johns Hopkins Continuum of Disruptive Behaviors at Work
- Healthcare & Public Health Sector Coordinating Council Active Shooter Planning and Response in a Healthcare Setting