KHC Hospital Improvement Innovation Network

October 24, 2018
10 to 11 a.m. CT

HIIN Goals:
By September 2018, hospitals in the KHC HIIN will achieve 20% reduction in all-cause harm and 12% reduction in readmissions.

Kansas Healthcare Collaborative

623 SW 10th Ave. • Topeka, KS 66612 • (785) 235-0763 • www.khconline.org

KHC HIIN – October 24, 2018

Agenda

- Welcome and Announcements
- HIIN Data Update
- Introduction to New KHC HIIN Falls Prevention Sprint
- Resources
- Upcoming Events

Kansas Healthcare Collaborative 2

Introductions

Special Guest

Jackie Conrad, BSN, MBA
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Kansas Healthcare Collaborative

Michele Clark
Program Director
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Eric Cook-Wiens
Data and Measurement Director
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#UseAntibioticsWisely Week — Nov. 12-18

KDHE and KHC have developed a statewide campaign for this awareness Week.

Resources are available to engage others through social media, display of posters, outreach to media and others.

Download them all for free at:
→ KHConline.org/antibiotics

Kansas Healthcare Collaborative 4

Hospital Antimicrobial Stewardship Program

How are your action plans coming along?

Check-in Calls available soon --
Watch your email for an invitation to visit briefly on the phone with KDHE and KHC.

Kansas Department of Health and Environment
Division of Public Health
Healthcare-Associated Infections & Antimicrobial Resistance Program
Kansas Healthcare Collaborative

#FightFlu

CDC recommends everyone* 6 months and older be vaccinated by the end of October.

Encourage others to get their shots by posting pics of your team getting theirs.

Connect with KHC:
→ facebook.com/KHCqi
→ twitter.com/KHCqi

*with rare exception

Kansas Healthcare Collaborative 6

Health Research & Educational Trust

HIIN Extension!

Through March 27, 2019 (with an optional additional year through March 2020)

Yes! Cohort 4 is Continuing!
Through March 2019

New focus in tracks during the 6-month extension:

Track 1: Back-to-Basics or "Reboot"

For staff leaders needing back-to-basics instruction for working with patient and family advisors

Track 2: Mini-fellowship

For hospital teams already working with PFAs

Hospitals from earlier cohorts are welcome to rejoin us. Individuals/hospitals that have not been in the collaborative before may be interested in Track 1.

Preliminary Schedule

- ✓**Oct. 22** – Virtual Session (1 to 2 pm CT)
  Intro to Collaborative extension, next-step assignments
- ***Nov. 12*** *– "Back to Basics" Session for Track 1*
  1 to 2:30 pm CT *REGISTER HERE*
- **Dec. 4** – Virtual Session (1 to 2 pm CT)
- **Jan. 8** – Virtual Session (1 to 2 pm CT)
- **Feb. 5** – Virtual Session (1 to 2 pm CT)
- **March 5** – Virtual Session (1 to 2 pm CT)

Resources

- Action Plan
- Coaching Calls with Faculty
- Online Instructional Videos
- Virtual learning/sharing sessions
- Kansas PFAC List-serv
- PFA/PFAC Collaborative Living Toolkit
- Private KHC HIIN Web Page

Next Steps

ALL:

- ❑ Consider which track is best for you and sign up today!
  https://www.surveymonkey.com/r/KHC-HIIN-PFAC-C4-Ext-Signup

Track 1:

- ❑ Sign up for Nov. 12 webinar *REGISTER HERE*
- ❑ Sign up for coaching call
- ❑ Submit action plan. (Faculty is available to work on it with you during coaching call.)

Track 2:

- ❑ Sign up for Dec. 14 webinar
  (Link will be sent via PFAC list-serv)
- ❑ Develop action plan with your team
- ❑ Submit action plan by Nov. 21.

KHC HIIN Data Update

- Extension Period Changes
- Reports Poll
- Data submission schedule

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Extension Period (10/2018 – 03/2019)

- Encyclopedia of measures update: pending
- New Measure: PVAP
  https://www.cdc.gov/nhsn/PDFs/pscManual/10-VAE_FINAL.pdf
- Changes to Baselines
  - Falls w/ injury
    old: CY 2014, new: Oct 2015 – Sep 2016
  - *C. difficile* rate
  - SSI (colo, hyst, kpro, hpro)
  - VAE rate
    old: CY2014, new: CY2015

Quarterly Activities Survey

Watch for link in early November!

- Patient and Family Engagement (PFE)
  - No changes in the metrics.
    CMS and HRET aim for all HIIN hospitals to have implemented at least 4 of 5 metrics by March 2019
- Governance
  - Dropping from survey
- Health Disparities
  - Modified, shortened

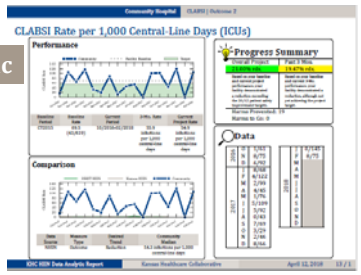
Health Disparities Metrics (Y/N)

Hospital uses a self-reporting methodology to collect demographic data from the patient and/or caregiver.
Hospital provides workforce training regarding the collection of self-reported patient demographic data.
Hospital verifies the accuracy and completeness of patient self-reported demographic data.
Hospital stratifies patient safety, quality and/or outcome measures using patient demographic data.
Hospital uses a reporting mechanism (e.g., equity dashboard) to communicate outcomes for various patient populations.
Hospital implements interventions to resolve differences in patient outcomes.
Hospital has organizational culture and infrastructure to support the delivery of care that is equitable for all patient populations.

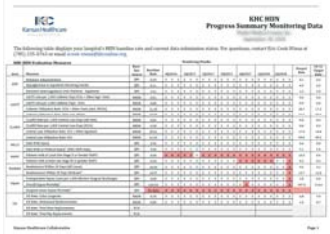
* Subject to change (10/2018)

Data Reports

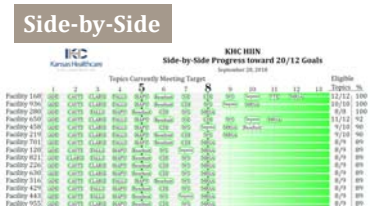
Data Analytic



Monitoring



Side-by-Side



Polling Question #1

Which HIIN data reports do you find useful?
(check all that apply)

- ❑ **Data analytic report**
  (detailed data report with run charts)
- ❑ **Side-by-Side Report**
  (peer comparison)
- ❑ **Monitoring report**
  (tracking data submission)
- ❑ All are useful
- ❑ None are useful

Polling Question #2

Which HIIN reports are used by leadership?

- ❑ **Data analytic report**
  (detailed data report with run charts)
- ❑ **Side-by-Side Report**
  (peer comparison)
- ❑ **Monitoring report**
  (tracking data submission)
- ❑ All are useful
- ❑ None are useful
- ❑ N/A

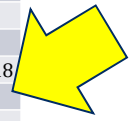
Polling Question #3

Is it important to send a preliminary AND final version of the report package each month?

- One per month is fine
- Having a preliminary before final is useful
- Do not use
- N/A

Kansas HIIN Data Submission Schedule

Outcome & Process Measures for HACs occurring in:	Readmissions for index discharges in, and SSI for procedures performed in:	Submission Due
March, 2018	February, 2018	30-Apr-18
April, 2018	March, 2018	31-May-18
May, 2018	April, 2018	30-Jun-18
June, 2018	May, 2018	31-Jul-18
July, 2018	June, 2018	31-Aug-18
August, 2018	July, 2018	September 30, 2018
September, 2018	August, 2018	**October, 2018**
October, 2018	September, 2018	November, 2018
November, 2018	October, 2018	December, 2018
December, 2018	November, 2018	January, 2019
January, 2019	December, 2018	February, 2019
February, 2019	January, 2019	March, 2019



KHC HIIN Falls Sprint

A targeted focus among Kansas hospitals on preventing Falls with Injury

October 2018 – March 2019

Welcome to the KHC HIIN Falls Sprint

- Our Goals
  - Create a learning community
  - Support ACTION!
    - Testing
    - Innovation
    - Sharing

Ideas for Action

- Mobility practices
  - Heels for meals
  - Mobility assessment
  - Mobilization communication tools and practices
- Strengthen PFE
  - Teach-back for Falls tools
  - Bedside Handoffs
  - Post-fall huddle at the bedside

KHC HIIN Falls Sprint

Timeline

October 1 – 31	Enrollment
October 24	Introduction and kick-off webinar Introduction to Falls Discovery Tool, Creating a Culture of Mobility
November 30	Learnings from using Falls Discovery Tool, Develop AIM, Plan PDSA
December 13	PDSA Learnings and intro to Teach-back
January 24	PDSA Learnings and intro to post-fall huddles
February 28	PDSA Learnings and next steps
March 22	Wrap up and celebration!

KHC HIIN Falls Sprint

Measuring Success

Outcome:

- HIIN Falls with Injury Measure

Processes:

- Completion of monthly PDSA cycles
  (Brief feedback via SurveyMonkey and/or KHC check-in calls
- Development of a SMART aim statement for preventing falls with injury
- Share a summary of your experience and learnings
  (Completion of brief summary template)

KHC HIIN Falls Sprint

Falls Process Improvement Discovery Tool

- 2 Methods – Chart Audit and Observations
  - Chart Audit / RCA
  - Tracer Observations
    - Observe a post fall huddle
    - Observe a bedside handoff
    - Ask staff about toileting practices, observe call light
  - Bedside Observations
    - Are delirium prevention strategies in place?
    - Are tripping hazards observed
    - Is toilet room safe?

X = process failure

KHC HIIN Falls Process Improvement Discovery Tool

Instructions: Review 5 - 10 charts over the past 12 months. Note: Do NOT spend more than 20-30 minutes per chart!
Focus on Falls with Injury as priority; use falls without injury if 5 injuries are not available in past 12 months

	Example - only fill in defects or opportunities	Chart #:	Chart #:	Chart #:	Chart #:	Chart #:
Information about the fall with injury:	**Instructions: Enter brief characteristics for each chart.**					
Nature and severity of injury	MINOR skin tear left arm					
Was the fall unassisted?	No					
Documented reason for the fall	Pt removed back brace, leaned over in chair. Balance/ impulsiveness.					
Additional remarks	Fall measures were not in place as should have been.					
Was it determined the patient and family caused the fall - non-compliant with plan?	No					
Age / Gender	64 yo male					
# day(s) of fall since admit / time of day	day 2 / 1634 (4:34pm)					
Process to evaluate in chart audit	**Instructions: Mark an X in the box where the response would be "no."** (X = Opportunity. A process failure may have occurred.)					
1. Was the patient screened for falls accurately and recently?	**X** Not re-evaluated after post-op meds admin					
2. Were the following risk factors addressed with a plan or intervention? See below	**Individualized Care Planning Processes**					
a. If applicable, was confusion, disorientation, impulsiveness addressed?						
b. Was an IV, indwelling urinary catheter or another "tether" that would limit mobility ABSENT?	**X** (SCD, IV)					
c. If applicable, was impaired urinary elimination plan addressed?						
d. If applicable, was impaired balance, gait or mobility problem addressed?						
e. If applicable, was risk for injury addressed - Age > 85, Bone Disease, Coagulation, surgery? (Examples: floor mats, toileting supervision)						
3. Factors contributing to the Fall	**Factors that may have contributed to the fall and delirium**					
a. Patient had not received medications that could contribute to delirium? Sedatives, hypnotics, benzos, anticholinergics. (See Tab 3.)	**X** - valium given 1 hr prior to fall					
b. Patient did not have uninterrupted sleep?	**X** - V.S. taken at 12a and 4a					

Post Fall Huddle
Bedside Handoff
Bedside and Unit Observation

Falls Process Improvement Discovery Tool:
Elements to be observed 3-5 times. Different staff, time of day, day of week

Instructions: Mark an X in the box where a process failure occurred. You may check more than one box per

	Observation #:	Observation #:	Observation #:	Observation #:
Process Observations				
Observe a Post fall huddle:				
Do staff engage the patient in determining "what was different this time?"				
Do staff determine cause and establish a plan?				
Observe bedside handoff:				
Do staff engage the patient in their safe mobility plan for the day?				
Do staff validate the patient understands fall and injury risks, consequences of a fall and the safe mobility plan by using teach-back?				
Toileting and call lights:				
Ask staff the practice used for patient supervison in the toilet				
Observe call light responsiveness. Is "no pass zone" honored? Do staff walk past a call light? If so, this is a process failure.				
Bedside Observations				
Call light, phone, glasses within reach				
If the patient uses a hearing aid or wears glasses, are they in place?				
During wakeful time, are shades up?				
Is the patient involved in a mentally stimulating activity?				
If not confused, can the patient teach back their fall risk factors, what could happen if they fall and how to prevent an injury? If a family member is present for a confused patient, ask the family.				

Creating a Culture of Mobility

Progressive Mobility as a Cross Cutting Strategy

Time for Change

"One crucial organizational action is to recognize that zero falls can only be achieved by unacceptable restrictions of the patient's privacy, dignity and autonomy." Oliver, Healey and Haines 2010:683

The Frances Healey Reader: Key ideas and references

Cumulative impact of immobility 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)
- Immobility contributes to delirium. The presence of delirium increase risk for LTC placement by 300%

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Where are you?

Where is your unit / organization on the mobility continuum?

0	5	10
Patients stay in bed	Some mobility Inconsistent	Patients walk 3xD in halls

Non-pharmacological Delirium Interventions

- Meta-analysis of 14 studies showed a 62% reduction in falls when multicomponent non-pharmacological delirium interventions were in place.
- Most interventions were centered around:
  - **Early mobilization (OOB for meals and ambulation);**
  - Vision and hearing interventions;
  - Orientation protocol (such as white boards);
  - Therapeutic activities (mentally stimulating ≠ entertainment!);
  - Sleep enhancement protocol (in place when delirium order sets are activated).

Sample delirium prevention activities

- Lights on
- Shades up
- Aids in – glasses, hearing aid
- **Walk three times a day**
- Stimulating activities
- AM:
  - Teeth brushed
  - Face washed
  - Up for breakfast
- Evening
  - Teeth brushed
  - Face Washed

Early Progressive Mobility

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It's Simple

If they came in walking, keep them walking.

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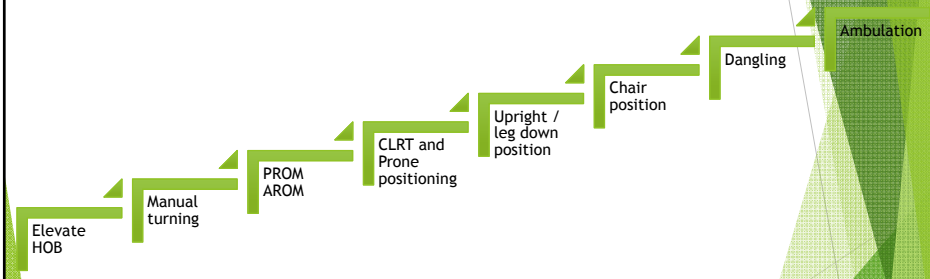
What is progressive mobility?

- 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)



Vollman, KM. Introduction to Progressive Mobility. Crit Care Nurs. 2010;30(2):53-55.

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Teaming Up to Mobilize

Med Surg

- Sitters
- Family members
- PT assistant / mobility tech
- Transporters
- Rehab

ICU

- Intensivist
- Respiratory
- Rehab
- Pharmacy

Unusual Suspects

- Materials management and Environmental Services - clutter rounds, equipment maintenance
- Facilities - for environmental factors

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MUST DO's

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GET-UP MUST DO'S!

1. Walk in, walk during, walk out!
2. Grab and go mobility devices
3. Three laps a day keeps the nursing home away!

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MUST DO #1
Walk In, Walk During, Walk Out!

MUST DO #1
Walk In, Walk During, Walk Out!

- Determine pre-admission ambulation status
- Don't assume a frail appearance means weakness
- Use Get Up and Go or BMAT test to assess ambulation skills

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Get Up and Go Test

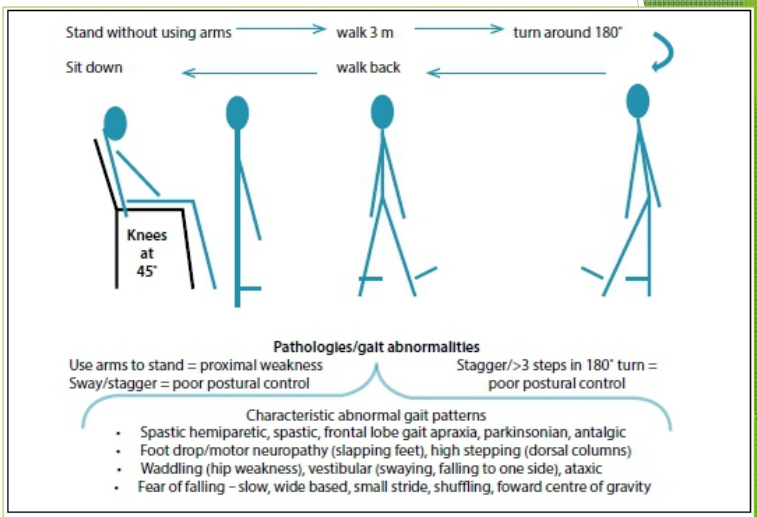

Fig. 4. The Get Up and Go test.

B.M.A.T. - Banner Mobility Assessment Tool for Nurses

Test	Task	Response	Fail = Choose Most Appropriate Equipment/Device(s)	Pass
Assessment Level 1 Assessment of: -Cognition -Trunk strength -Seated balance	**Sit and Shake**: From a semi-reclined position, ask patient to sit upright and rotate° to a seated position at the side of the bed; *may use the bedrail.* Note patient's ability to maintain bedside position. Ask patient to reach out and grab your hand and shake making sure patient reaches across his/her midline. Note: Consider your patients cognitive ability, including orientation and CAM assessment if applicable.	**Sit:** Patient is able to follow commands, has some trunk strength; caregivers may be able to try weight-bearing if patient is able to maintain seated balance greater than two minutes (without caregiver assistance). **Shake:** Patient has significant upper body strength, awareness of body in space, and grasp strength.	**MOBILITY LEVEL 1** - Use total lift with sling and/or repositioning sheet and/or straps. - Use lateral transfer devices such as roll board, friction reducing (slide sheets/tube), or air assisted device. **NOTE:** *If patient has 'strict bed rest' or bilateral 'non-weight bearing' restrictions, do not proceed with the assessment; patient is MOBILITY LEVEL 1.*	Passed Assessment Level 1 = Proceed with Assessment Level 2.
Assessment Level 2 Assessment of : -Lower extremity strength -Stability	**Stretch and Point**: With patient in seated position at the side of the bed, have patient place both feet on the floor (or stool) with knees no higher than hips. Ask patient to stretch one leg and straighten the knee, then bend the ankle/flex and point the toes. If appropriate, repeat with the other leg.	Patient exhibits lower extremity stability, strength and control. **May test only one leg and proceed accordingly (e.g., stroke patient, patient with ankle in cast).**	**MOBILITY LEVEL 2** - Use total lift for patient unable to weight-bear on at least one leg. - Use sit-to-stand lift for patient who can weight-bear on at least one leg.	Passed Assessment Level 2 = Proceed with Assessment Level 3.
Assessment Level 3 Assessment of: -Lower extremity strength for standing	**Stand**: Ask patient to elevate off the bed or chair (seated to standing) using an assistive device (cane, bedrail). Patient should be able to raise buttocks off bed and hold for a count of five. May repeat once. Note: Consider your patients cognitive ability, including orientation and CAM assessment if applicable.	Patient exhibits upper and lower extremity stability and strength. **May test with weight-bearing on only one leg and proceed accordingly (e.g., stroke patient, patient with ankle in cast).** **If any assistive device (cane, walker, crutches) is needed, patient is Mobility Level 3.**	**MOBILITY LEVEL 3** - Use non-powered raising/stand aid; *default to powered sit-to-stand lift if no stand aid available.* - Use total lift with ambulation accessories. - Use assistive device (cane, walker, crutches). NOTE: Patient passes Assessment Level 3 **but requires assistive device** to ambulate or **cognitive assessment** indicates poor safety awareness; ***patient is MOBILITY LEVEL 3.***	Passed Assessment Level 3 **AND no assistive device needed** = Proceed with Assessment Level 4. ***Consult with Physical Therapist when needed and appropriate.***
Assessment Level 4 Assessment of: -Standing balance -Gait	**Walk:** Ask patient to march in place at bedside. Then ask patient to advance step and return each foot. Patient should display stability while performing tasks. Assess for stability and safety awareness.	Patient exhibits steady gait and good balance while marching, and when stepping forwards and backwards. Patient can maneuver necessary turns for in-room mobility. Patient exhibits safety awareness.	**MOBILITY LEVEL 3** If patient shows signs of unsteady gait or ***fails* Assessment Level 4,** refer back to **MOBILITY LEVEL 3;** ***patient is MOBILITY LEVEL 3.***	**MOBILITY LEVEL 4** MODIFIED INDEPENDENCE **Passed = No assistance needed to ambulate**; use your best clinical judgment to determine need for supervision during ambulation.

Always default to the safest lifting/transfer method (e.g., total lift) if there is any doubt in the patient's ability to perform the task.

Originated: 2011; revised: 2/27/12, 3/02/12, 3/07/12, 3/19/12, 4/19/12, 5/01/12, 5/03/12, 05/20/2013

Banner Mobility Assessment Tool for Nurses (BMAT) video and tool

Mobility begins on admission

Tier Level	Defining Characteristics	Intervention[a]
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

[a] 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. http://www.nursingcenter.com/pdfjournal?AID=2591440&an=00000446-201410000-00023&Journal_ID=54030&Issue_ID=2591321

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MUST DO #2
Grab and Go Mobility Devices!

- Gait belts in every room*
- Patients and staff have access to mobility devices
- Safe mobilization and patient handling training for staff

Gait belts are used to help control the patient's center of balance.

*with the exception of rooms for behavioral health patients

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Safe Patient Handling & Mobility Training

Safe Patient Handling

- Use of equipment – lifts, lateral devices
- Assisting bed activities
- Lifting limits – not > 35 lbs
- Use SPH coaches when lifts used
- How to avoid friction / shear

Mobility Training

- Assessing ambulation skills
- Use of gait belts
- Control of a fall
- Assisting with ambulation
- Screening for correct fit of mobility aid
- Special populations:
  - Hip precautions
  - Hemiplegia
  - Parkinson's

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MUST DO #3

3 Laps a Day, Keeps the Nursing Home Away!

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Make it visible

- Get the Docs involved!
- Engage patients and families

Bedside Sign

Get Up...Get Moving....Get Better!

Day:_____

GOAL: 3 Walks

Goal: Up to Chair 3x

5A Walk of Fame Booth

Facing the Facts about Mobility

Mobility interventions are regularly missed

- Nursing perceptions
  - Lack of time
  - Ease of omission
  - Belief it is PTs responsibility
- Survey results
  - Concern for patients level of weakness, pain and fatigue
  - Presence of devices – IVs and Urinary Catheters
  - Lack of staff to assist
- What Helps?
  - Rehab and Nursing face-to-face bedside handoffs or safety huddles

Doherty-King, B Bowers, B. How nurses decide to ambulate hospitalized older adults: development of a conceptual model. Gerontologist. 2011 Dec:51(6): 786-97

Tips for Promoting Mobility

- Order Modifications
  - Delete orders for
    - Bedrest
    - Ad lib
  - Replace with specific orders
    - Times, activities, distance
  - Mobility orders to flow to task list
- Build Documentation Fields - centralize
- Collect data - examples
  - Total # of feet ambulated a day documented by RNs
  - Total % of eligible pts ambulated twice by 3pm
  - Total % of eligible patients up in chair for lunch

More Tips – Building a Culture of Mobility

- Integrate mobility status and goal into clinical rounds
- Engage a Physician Champion
- Rename the Falls Team a Safe Mobility Team

Mobilizers

- Repurpose current roles
  - Replace sitters with a mobility aide
  - Train sitters to ambulate patients
  - Create mobility tech role – reallocate transporters, safe patient handling coaches, nursing assistants

Memorial Hospital, FL
Mobility / SPH Team

Franciscan Michigan City, IN
Mobility Techs

Progressive mobility can reduce patient harm, employee injuries and LOS

Case Study: Franciscan Michigan City, IN

- 3 mobility trained nursing assistants
  - 70% reduction in HAPI
  - 40% reduction in worker back injuries
  - -45% reduction in RN turnover
  - 43% reduction in readmission
  - 39% reduction in d/c to SNF

Case Study: John Hopkins MICU

- ICU rehab program
  - 10% reduction in mortality
  - 30% (2.1 day) reduction in MICU LOS
  - 18% (3.1 day) reduction in hospital LOS

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Fresh Ideas: Falls: What to STOP doing to START improving

Falls STOP to START

Resources

Tools to Test:

- HRET HIIN Falls Discovery Tool
- Progressive Mobility Tools
- Banner Mobility Assessment Tool for Nurses (BMAT) video and Tool
- Timed Get up and Go Test
- Get Up and Go Test
- Project HELP Mobility Change Package - multiple tools included
- Med Surg Mobility Protocol
- ICU Mobility Protocol

KHC HIIN Falls Sprint

Resources – future topics

Tools to Test:

- Patient Family Engagement Focused Tools
- Teach Back Tool for Fall Prevention
- Fall Tips for Patient and Families Handout

- Post-fall huddle
- CAPTURE Falls mobility training videos, mobility tools – includes Post Fall Huddle training videos and documentation tools

KHC HIIN Falls Sprint

Resources

Collaborative Tools:

- Monthly Virtual Learning Sessions
- List-serv
- Subject Matter Expert – Coach Jackie

Jackie Conrad, BSN, MBA
Improvement Advisor
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jconrad@cynosurehealth.org

KHC HIIN Falls Sprint

We hope you will join us.

Easy, online sign-up:

https://www.surveymonkey.com/r/KHC-HIIN-Falls-Sprint

Sprint Session #2 will take place Nov. 30.

KHC HIIN Falls Sprint

Your Assignments

1. Sign up for the Falls Sprint.
2. Pre-register for Session #2.
3. Briefly review 5-10 charts using the Discovery tool. (20 minutes ea.)
4. Email a copy of your completed tool to KHC by Nov. 15: info@khconline.org

KHC HIIN Falls Sprint

Session #2 – November 30
10 to 11 am CT

Hospital Learnings
from Falls Process Improvement Discovery Tool

- Hospitals share insights from using the Discovery Tool.
- Review of developing a SMART aim statement and conducting PDSA cycles.
- Review Top 10 Checklist for fall prevention.
- Select one strategy to implement using PDSA.

Sprint Session #2 follow-up assignments:
o Conduct up to five bedside observations.
o *Write a SMART aim statement.*

KHC HIIN Falls Sprint

KHC HIIN Falls Sprint

Resources and Upcoming Events

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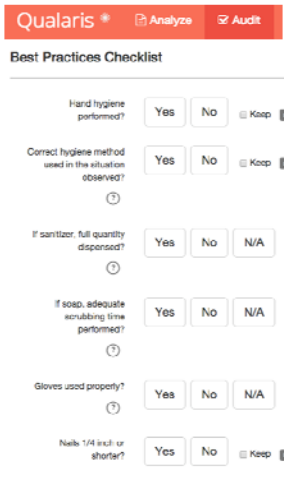
KHC HIIN Hand Hygiene Collaborative



Enrollment is still open!

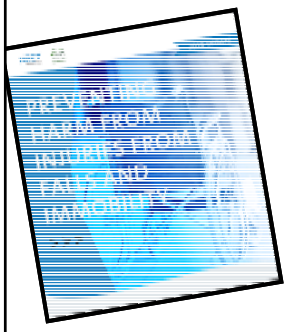
The KHC's Hand Hygiene Collaborative is offered to help hospitals track and improve hand hygiene within their facilities. Participation includes easy-to-use, mobile software provided at no cost to each hospital for observation-based measurement.

Next collaborative learning session will be held **Friday, November 9, at 11 a.m.** CT.

For more information, visit:
www.khconline.org/initiatives/hiin-initiatives/hand-hygiene-collaborative

QualarisAudit
Software for improving best practices

HRET HIIN Falls Resources



- 2018 Change Package
- Top Ten Checklist
- Teach-Back Tool
- STOP to START Improving Fall Injuries

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Resources

Use Antibiotics Wisely Week

- When: November 12 - 18, 2018
- Resources and posts to share at: UseAntibioticsWisely.org
  Or contact KHC for more info.

Upcoming Webinars

See more HRET HIIN events at
www.hret-hiin.org/events/index.dhtml

HRET and CMS: Mapping Medicare Disparities
October 25 ● 12:00 - 1:00pm
Register here:
http://hret.adobeconnect.com/health-disparities-20181025/event/registration.html

HRET HIIN: MDRO Discovery and Direction Series: Organizational Risk Assessment
November 1 ● 1:00 - 2:00pm
Register here:
http://hret.adobeconnect.com/mdro-20181101/event/registration.html

HRET HIIN: Readmissions MVP Webinar #2
November 9 ● 11:00am to 12:00pm
Register here:
http://hret.adobeconnect.com/readmissions-201811109/event/registration.html

All times listed are Central Time.

Upcoming Webinars

See more HRET HIIN events at
www.hret-hiin.org/events/index.dhtml

HRET HIIN: Culture of Safety – Workplace Violence: Up Close
November 14 ● 11:00am - 12:00pm
Register here:
http://hret.adobeconnect.com/culture-of-safety-20181114/event/registration.html

HRET HIIN: Falls Delirium Fishbowl – Session #2
November 15 ● 11:00am - 12:00pm
Register here:
http://hret.adobeconnect.com/falls-20181115/event/registration.html

All times listed are Central Time.

Upcoming KHC Webinars

KHC HIIN: Hand Hygiene Collaborative
November 9 ● 11:00am to 12:00pm
Contact Chuck Duffield (cduffield@khconline.org) for webinar registration info.

KHC HIIN: Kansas PFAC Collaborative – Back to Basics Session
November 12 ● 1:00 - 2:30pm
Track 1 Register here:
https://khconline.adobeconnect.com/pfac-track1-11-12-2018/event/registration.html

KHC HIIN: Monthly Virtual Meeting
November 28 ● 10:00 - 11:00am
https://khconline.adobeconnect.com/khc-hiin-11-28-18/event/registration.html

KHC HIIN: Falls Prevention Sprint – Session #2
November 30 ● 10:00 - 11:00am
https://khconline.adobeconnect.com/falls-sprint2-11-30-2018/event/registration.html

See more Kansas events at
https://www.khconline.org/events/full-events-list

Please provide feedback to this webinar
Let us know your next steps.

https://www.surveymonkey.com/r/KHC-HIIN-102418

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Kansas Healthcare COLLABORATIVE

Contact us anytime:
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For more information:
→ **KHConline.org**

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