EQIC
EASTERN US QUALITY IMPROVEMENT COLLABORATIVE

News
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In This Issue

[EQIC events]
[Announcements]
[Tools and resources]

EQIC events

Thursday, March 30
Reducing hospital readmissions by partnering with skilled nursing facilities
1 - 3 p.m.

During this two-hour caucus, EQIC will present its newest initiative to reduce hospital readmissions by partnering with skilled nursing facilities. We will provide best practices for improving the patient and care partner experience across care transitions by implementing workflows and tools to strengthen communication between facilities. Hospitals will learn how to partner with SNFs that have frequent readmissions to their facility and reduce readmission rates through a collaborative work approach.

Announcements

EQIC conference materials now available online

Posters, materials and recordings from EQIC's virtual conference, ***Patient safety: Navigating the new norma***l, are now available online. We were fortunate to have an incredible agenda of nationally recognized speakers in hospital quality improvement who provided new methods and renewed energy for continued progressing patient safety work. EQIC thanks all of our speakers and attendees for their participation.

We encourage you to visit the website to review the materials. In addition to slides and recording for each session, you can further explore the 14 poster presentations of your peers' quality improvement projects to help facilitate your efforts. Attendees also received an email from HANYS Education & Events explaining how to apply for continuing education credits. Please contact your project manager with any questions.

Reminder: Sign up for an EQIC workgroup

EQIC hospitals can take the next step in their quality improvement journey by signing up for one or more workgroups in the following clinical focus area(s):

- adverse drug events/opioid prescribing;
- falls;
- health equity;
- infections;
- patient and family engagement;
- pressure injuries;
- readmissions; and
- sepsis.

Meet with your project manager and review your data to determine which workgroup best fits your organization's participation. Your PM can add you to the workgroup list to receive upcoming communications and event invitations. We look forward to continuing our work in improving patient safety in your organizations.

Tools and resources

As a follow-up to the Feb. 7 session, "Innovations in fall and fall injury prevention," EQIC and speaker Dr. Patricia Quigley answered questions that came up during her presentation.

Do you have a post-fall huddle template and a process/structure for performing a huddle to ensure we get all of the necessary information?
Please review the post-fall huddle form and other resources on the VHA National Center for Patient Safety Falls Toolkit website.

Have you ever heard of a successful program that uses volunteers or non-direct clinical staff on the unit to round and potentially reduce falls/unassisted OOB?
Those assisting patients who are at fall risk should be skilled and able to assess patients, determine changes in conditions and properly provide assisted mobility. Volunteers are not recommended to perform those activities unless determined to be competent. They can be used, however, to be the eyes of the staff and notify the appropriate staff of patient needs.

Can a baby monitor be used, which allows visualization and the ability to hear the patient, without getting consent?
There has to be consent. It would also have to be included in the care planning interventions for surveillance, added to policy and procedures, discussed with the patient and family and documented that they agreed to this intervention. There is no published evidence that baby monitors prevent falls, but there are three national large-scale, multi-site studies showing that available technology is so effective that falls are near zero.

We are working on a fall risk assessment for primary care, outpatient clinics and ambulatory settings. What works, what does not for those settings and how do you flag a high-risk patient from the registration level?
The Hester Davis Fall Prevention Program has a program for ambulatory care. Otherwise, the CDC has the STEADI program for fall risk screening and an assessment of position specifically designed for PCP and ambulatory care. They have training programs, patient education materials and more, specifically for older adults. You want to focus on the older adult population, not all patients in primary care or outpatient clinics. For questions about the program, contact Dr. Quigley at pquigley1@tampabay.rr.com.

What are your thoughts on the use of fall mats with a patient who is ambulatory but has confusion. Is it more of a risk to have one in place?
Fall mats are needed to protect those patients from injury if they fall. You want them in place for ambulatory patients because they will get up without help.

How do you address those patients who are unable to follow directions due to confusion, dementia or delirium, as well as those who are just simply non-compliant?
For the patients with confusion and dementia, you must anticipate their needs, i.e., have video surveillance if ambulatory, hard-wire a scheduled toileting program, etc. You can use a bed alarm, but use one that alarms with the nurse call system, not in the room. For delirium patients, use the same interventions and treat the cause of the delirium. As delirium clears, stop using the bed alarm and decrease surveillance. For non-compliant patients, I don't believe in this for adults. Adults make choices and take responsibility for their decisions—that is autonomy. The opportunity is to engage the patient to understand why the patient is choosing NOT to do something that is recommended in their care. You have to understand the NO, then provide information/education to see if you can change No to Yes. Use teach-back, AskMe3, etc. Speak from the evidence to support the intervention that is being recommended but rejected by the patient/family.

Questions

Please contact Cathleen Wright or your EQIC project manager with any questions.

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