

# WINTER IS COMING:



## HOW CAN WE LAYER PROTECTION ON PATIENTS TO PREVENT HARM?

### OVERVIEW

### LAYERS OF PROTECTION

OPIOID STEWARDSHIP

ADVERSE DRUG EVENTS (ADEs)

CENTRAL LINE ASSOCIATED BLOODSTREAM INFECTIONS (CLABSI)

READMISSIONS

SEPSIS

HOSPITAL ACQUIRED PRESSURE INJURIES (HAPI)

CATHETER ASSOCIATED URINARY TRACT INFECTION (CAUTI)

PATIENT FAMILY ENGAGEMENT PROTECTION



# HOW CAN WE LAYER PROTECTION ON PATIENTS TO PREVENT HARM?

Unprecedented surges of patient hospitalizations, staffing shortages, and limited family visitation during the recent past has had a significant effect on patient outcomes. In order to mitigate the effect of increases in hospitalization rates and staffing challenges that hospitals potentially face this winter, the Convergence HQIC has created this resource. Winter is Coming is a compilation of countless hours of discussion with subject matter experts on the frontlines of care in hospitals across America, with practical, tactical advice from peers.

**OPIOID STEWARDSHIP**

**CAUTI**

**HAPI**

**ADEs**

**KEY TO  
MEANINGFUL  
ENGAGEMENT**

**SEPSIS**

**CLABSI**

**READMISSIONS**

# LAYER WITH OPIOID STEWARDSHIP PROTECTION

## 1 REACHABLE & TEACHABLE

Hospitalization is a reachable and teachable moment for *ALL* patients and families on the risks associated with long term opioid use and treatment options.



## 2 ENGAGE PATIENTS

Engage patients in understanding their pain goals and expectations. Together weigh the pros and cons of whether and how much opioids can be used for pain management.

## 3 LESS IS MORE

Embrace less is more. Continue to prevent new opioid starts by leveraging alternatives to opioids for pain management wherever possible and through evidence based discharge prescribing guidelines.

## 4 PATH TO RECOVERY

Create a path to recovery. Connect patients to treatment and harm reduction services in your hospital and community – naloxone, inpatient recovery, etc.

## 5 WEAVE IN OPIOID SAFETY

Patients with opioid use disorder (OUD) may also have behavioral health issues and/or other chronic diseases where they are frequently re-admitted to your hospital so weave opioid safety into the work you are already doing.



IMPROVE APPROPRIATE OPIOID USE COURSE ON CLIC

OPIOID STEWARDSHIP CHANGE PACKAGE HERE!



# LAYER WITH ADVERSE DRUG EVENTS (ADE) PROTECTION

1

## WARFARIN MANAGEMENT

Collaborate with pharmacists for daily dosing. Pharmacists are really good at tracking and trending warfarin doses and can be helpful suggesting adjustments to providers to make predictive corrections rather than reactive corrections. Pharmacists can also remind us that we need an INR upon admission, even if the INR is stable.

2

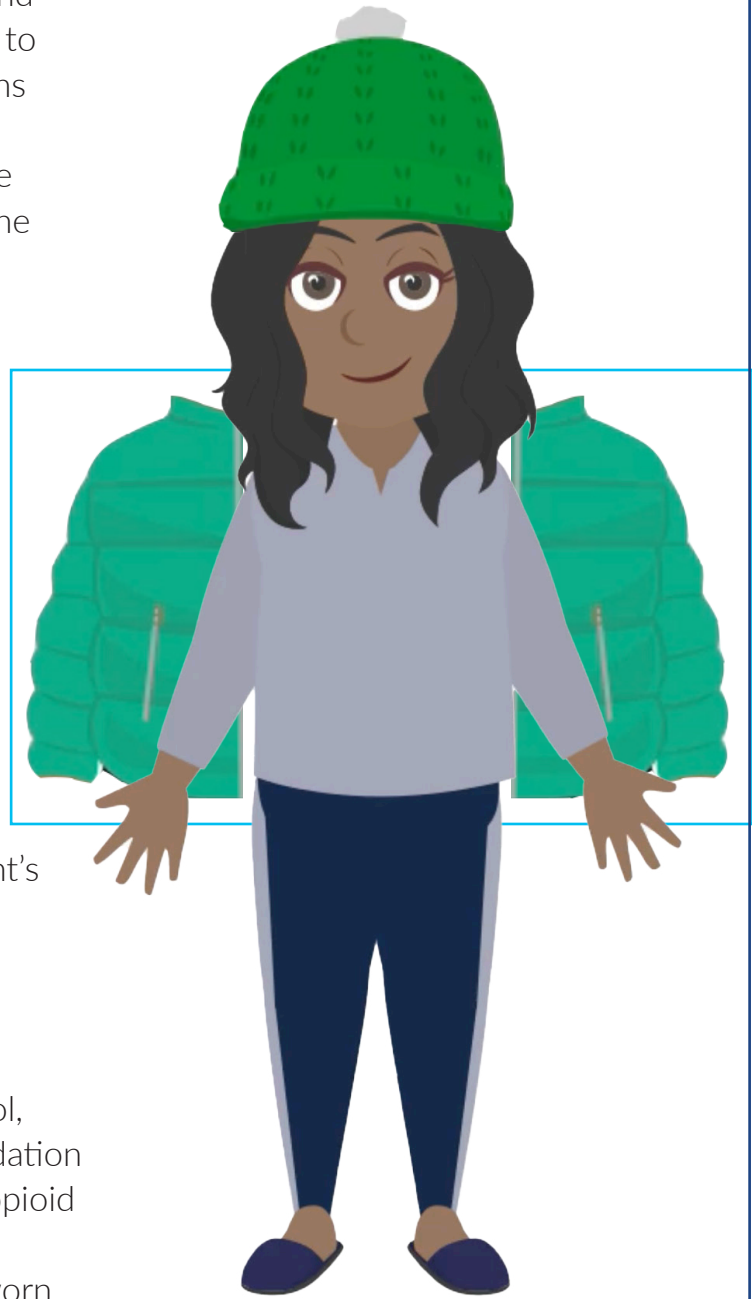
## GLYCEMIC CONTROL

Avoid sliding scale insulin. Decrease insulin dosing by 10% if glucose drops below 70 even once. Use insulin drips in obese, hard to control COVID-19 patients. Ask diabetic patients what blood glucose level makes them start to feel symptoms of hypoglycemia, and how they treat those symptoms at home. Use the whiteboard to communicate the patient's hypoglycemia plan to the care team.

3

## OPIOID SAFETY

Use an opioid sedation assessment tool, such as the Pasero Opioid Induced Sedation Scale (POSS) before every parenteral opioid dose, 15 minutes after each dose and hourly thereafter until the effect has worn off or until next dose. Then repeat POSS before next dose, 15 minutes after, and then hourly.



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# LAYER WITH CENTRAL LINE ASSOCIATED BLOODSTREAM INFECTION (CLABSI) PROTECTION

## 1 ASSESS FOR OPTIMAL INSERTION SITE

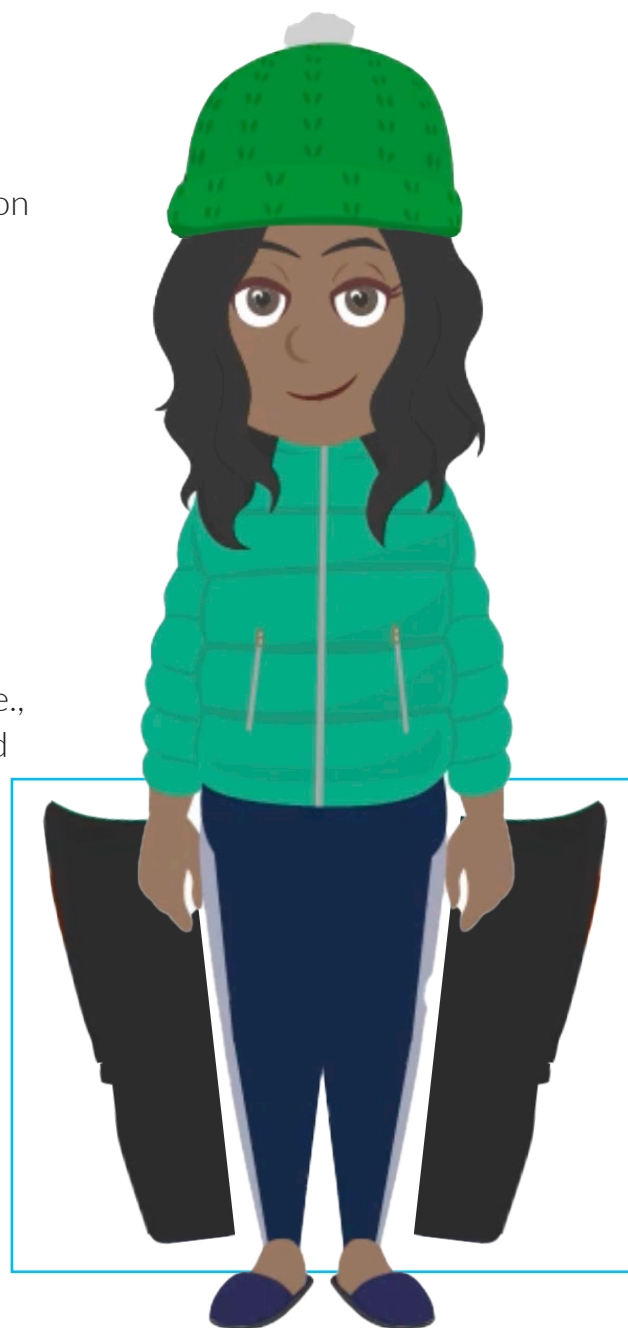
Assess for the optimal insertion site to avoid groin and sutures. Identify a physician champion who will promote optimal site selection and non-suture securement devices.

## 2 BLOOD CULTURE STEWARDSHIP

Avoid central line draws. Assess current blood culture practices to minimize contamination and discourage blood cultures at end of life (i.e., when it is unlikely that the results will be acted upon).

## 3 CARE & MAINTENANCE

Preserve / protect insertion site and remove when no longer clinically indicated and document site inspection. Consider Chlorhexidine Gluconate (CHG) treatments. Actively assess continued need/track device days on white board.



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CLABSI CHANGE PACKAGE HERE!



# LAYER WITH READMISSIONS PROTECTION

## 1 USE YOUR DATA

Use your data as your guide – which patient population is readmitted most often, from where, with what diagnosis?

## 2 SMALL ACTS OF CHANGE

For example, if your hospital's data tells you that patients with COPD over the age of 75 that are discharged to home are most commonly readmitted, what small step can be taken to assist just that patient population?

## 3 READMITTED PATIENTS

Interview readmitted patients in real time to better understand the real reasons for readmission and patients' needs following care transitions.

## 4 EDUCATE PATIENTS

Consider low resource, high value interventions that help patients and caregivers to better understand how to care for themselves following discharge – low fidelity simulation rooms, additional post-discharge phone calls, subscription to a text service with patient level information on a regular basis.

## 5 HIGH UTILIZER PATIENTS

Consider low resource, high value interventions to meet the medical and social needs of high utilizer patients – weekly or monthly virtual touchpoints, physician, nurse, pharmacist, or physical therapist.



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READMISSIONS CHANGE PACKAGE HERE!



# LAYER WITH SEPSIS IDENTIFICATION & TREATMENT PROTECTION

## 1 EARLY WARNING SIGNS

Use the electronic medical record or other automated process for early warning signs of sepsis. While an automated processes may result in an increase in sepsis alerts, it means a decrease in missed opportunities for the early identification of sepsis.

## 2 RELIABLE IMPLEMENTATION OF HOUR 1 BUNDLE

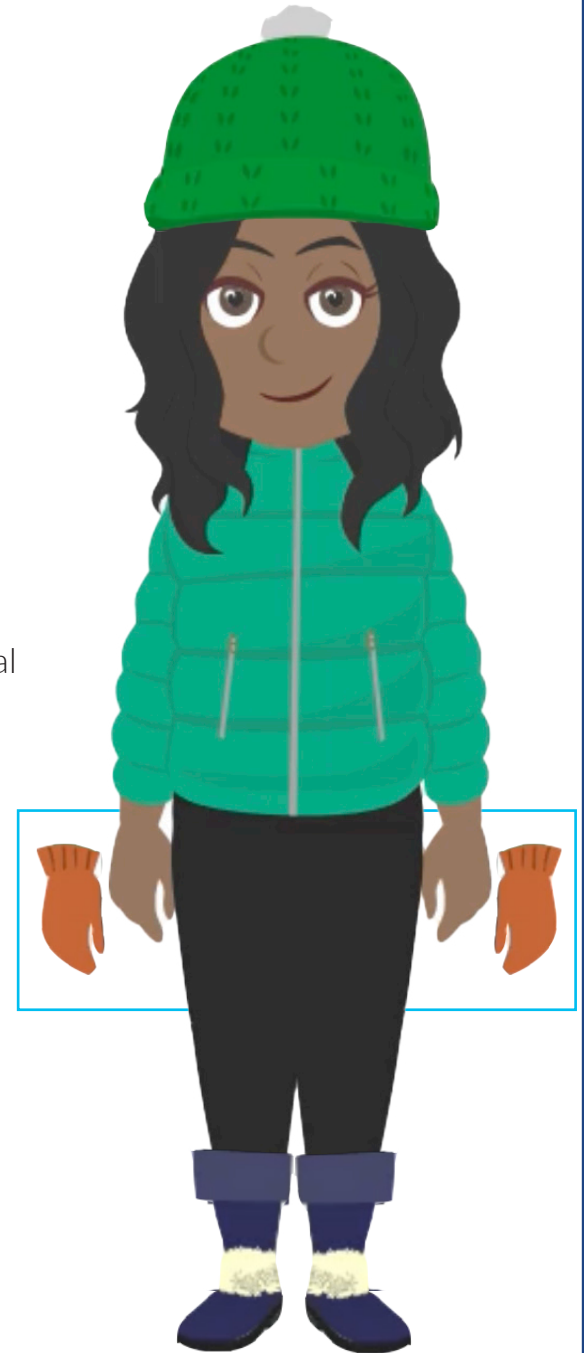
Focus on the reliable implementation of the Hour 1 Bundle for those patients in which a positive sepsis screen has occurred. Are automated alerts managed as reliably in Medical / Surgical / General units as the Emergency Department or ICU?

## 3 SEPSIS TRANSFER PROCESS

In smaller hospitals that generally transfer sepsis patients to larger receiving centers, the elements of the Hour 1 bundle should be followed prior to transfer. Does your staff have a standardized mechanism for ensuring the bundle elements are readily available, reviewed, and followed?

## 4 ESCALATE CARE

Develop a standardized process to escalate care for positive sepsis screens that includes notification of physicians, activation of rapid response teams, and/or overhead alerts.



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# LAYER WITH HOSPITAL ACQUIRED PRESSURE INJURY (HAPI) PROTECTION

## 1 CARE PARTNERS

Engage a family caregiver as a care partner to assist with early detection, nutrition intake, basic skin hygiene and repositioning. Narrate your care, use a family involvement menu to help family members at the bedside learn to assist the patient so they are prepared to help provide care at home.

## 2 PROTECTIVE DRESSINGS

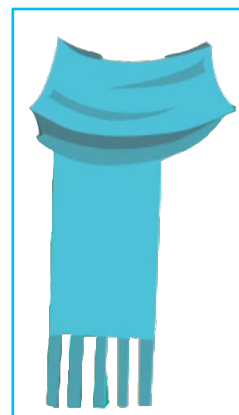
Use soft multilayered protective dressings on sacrum and heels for non-proned patients.

## 3 SKIN ASSESSMENTS

Use four eyes, ears and hands when assessing for early warning signs of skin breakdown. Conduct visual and tactile skin assessments at shift handoff and listen to your patient about where discomfort is on or around bony prominence. Do not position the patient on an area of skin discomfort, redness, or texture changes.

## 4 MEDICAL DEVICES

Inspect skin under devices and reposition devices regularly. Use protective dressings under devices before skin breakdown occurs.



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# LAYER WITH CATHETER ASSOCIATED URINARY TRACT INFECTION (CAUTI) PROTECTION

## 1 AVOID INSERTION WHEN FEASIBLE

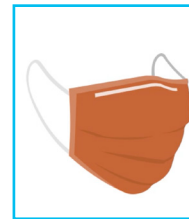
Consider external devices and/or frequent toileting opportunities. Challenge old habits, such as the use of urinary catheters for “strict I&O”.

## 2 BE CAREFUL WITH INSERTION, CARE & TIMELY REMOVAL

Find a buddy to promote ‘two-person insertion technique’ for patients that truly need a urinary catheter. Track device days on the white board, during shift report, and safety huddles.

## 3 CCULTURE ONLY WHEN IT MAKES CLINICAL SENSE

Avoid ‘pan-culturing’ unless source is unclear. Avoid culturing urine in absence of UTI symptoms. Assess current practices (e.g., specimen collection, transportation time to the lab, utilization of ‘urinalysis reflex to culture’).



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CAUTI CHANGE PACKAGE HERE!



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**OPIOID STEWARDSHIP**

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**KEY TO  
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**READMISSIONS**

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# LAYER WITH PATIENT FAMILY ENGAGEMENT (PFE) PROTECTION



## KEYS TO CREATING A SAFE ENVIRONMENT FOR PFE

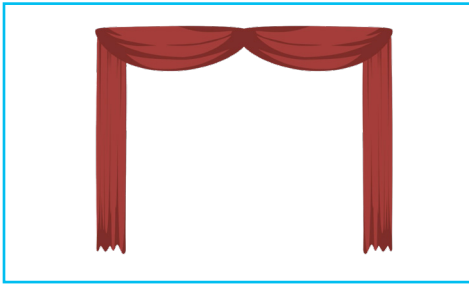
At the core of our mission are our patients and their caregivers. Care that is patient and family centered is a critical component of improved outcomes for patients, and improved environments in which care is provided. Below are some of the key components, developed directly by Patient Family Partners with lived experiences, to ensure the hospital environment is ready during the upcoming months.

- ◆ Have caregivers/patients observe and when feasible, assist with wound care, so they can watch for signs after transitioning home.
- ◆ Use simple drawings and illustrations to accompany discharge instructions to reinforce the message.
- ◆ Use plain language when explaining medical care and treatments to patients and family members.
- ◆ Ask the patient specifically “what is unique about you that I should know as your caregiver”.
- ◆ Use Teach Back and have your patient or family caregiver repeat back instructions.
- ◆ Stress the importance of adhering to {new or modified} medications.
- ◆ When risk assessments are completed for falls, readmissions, or other potential safety concerns, share the findings with patients to convey the importance of their physical safety.
- ◆ Encourage patients and/or family members to speak up – it may be the key to healing.

**\*\* Learn more on the next page. Ensure all components are added to secure protection in the room. \*\***

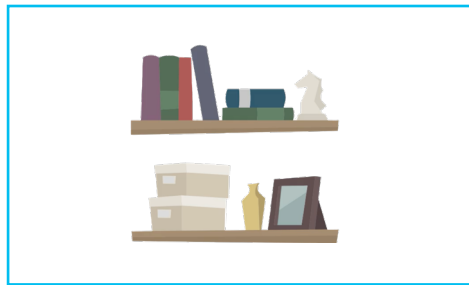


# KEYS TO CREATING AN ENVIRONMENT THAT ENCOURAGES PATIENTS & FAMILIES TO SPEAK UP



## SIGNS TO WATCH FOR

Pull back the 'curtains' – make sure patients and family are aware of the signs to watch for to avoid readmissions.



## SPEAK UP

If patients 'shelf' a concern, encourage them to speak up – reinforce with them that they are a partner in their care and their concerns matter.



## ALERT STAFF

Help patients see the 'big picture', so they can alert staff when something seems just not right with safety or care.



## PAY ATTENTION

Don't 'couch' any issue. If patients feel underserved or misunderstood or dismissed, you won't be able to flesh out these issues.



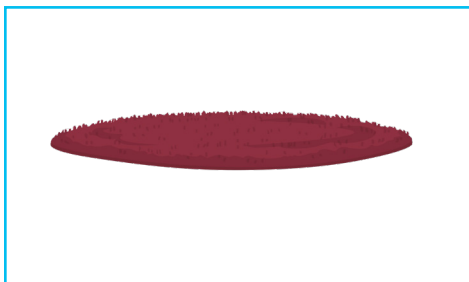
## ENGAGEMENT

'Shine a light' on a patient's willingness to engage. It can be daunting, so they need encouragement & empowerment.



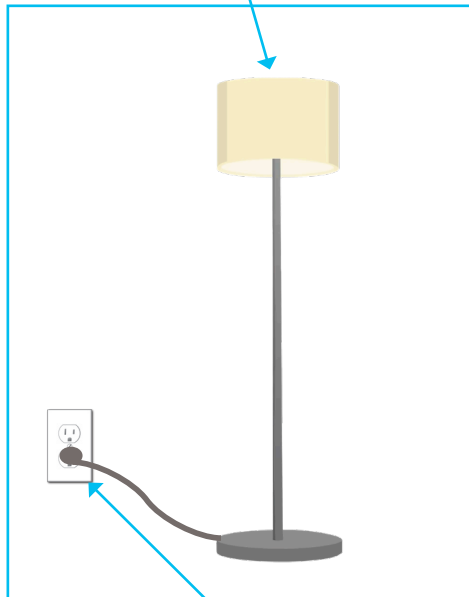
## PARTICIPATION

Make patients and family caregivers feel like a 'co-chair' in their loved ones' care.



## POST-DISCHARGE

Don't allow patients to feel like the 'rug' is pulled out from under them, once they are discharged.



## STAY CONNECTED

Stay 'connected' so patients and family caregivers gain your trust, and realize nothing is taboo.



## PATIENT INVOLVEMENT

'Fire Up' patient involvement, from the very beginning of care.

