Labrador-Grenfell Health

Patient Safety Initiatives

Nursing Responsibilities
Policies and Procedures

Objectives

- To provide overview of ***Safer Healthcare Now !***
- Ensure staff **have** an understanding of new policies
- Provide an opportunity to address questions
- A Patient Safety and Quality Department initiative

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Falls Prevention Policy

Policy covering acute care, rehabilitation, diagnostic imaging, long term care and homecare

- Strategy Document PDF Final.pdf
- CL-7-060_Falls Prevention Policy.pdf
- http://lghealth/documents/files/Falls%20Prevention%20PowerPoint%20final%20draft%20%5BCompatibility%20Mode%5D.pdf

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Did You Know…

In Canada:

- Falls are the **6th** leading cause of death among older adults.
- About **40%** of older adults who are hospitalized after a fall have suffered hip fractures, and approximately **7%** of these result in death.
- Falls are the primary cause of injury admissions, accounting for **54.4%** of all injury hospitalizations and **75.7%** of all in-hospital deaths for clients admitted for injuries.

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Falls Prevention

Uses the **MORSE FALL RISK ASSESSMENT** tool and interventions

- Risk assessment,
- Interventions and customizations,
- Post-falls reporting,
- Environmental audits,
- Communication and education,
- Auditing and evaluations.

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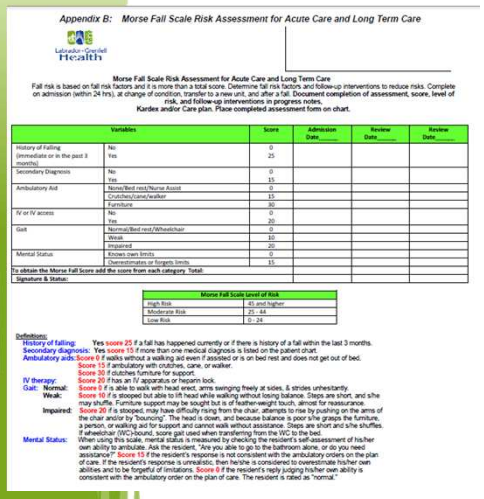
Morse Scale Risk Assessment



Appendix B: Morse Fall Scale Risk Assessment for Acute Care and Long Term Care

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Morse Fall Scale Risk Assessment for Acute Care and Long Term Care

Fall risk is based on fall risk factors and it is more than a total score. Determine fall risk factors and follow-up interventions to reduce risks. Complete on admission (within 24 hrs), at change of condition, transfer to a new unit, and after a fall. Document completion of assessment, score, level of risk, and follow-up interventions in progress notes, Kardex and/or Care plan. Place completed assessment form on chart.

Variables		Score	Admission Date_____	Review Date_____	Review Date_____
History of Falling (immediate or in the past 3 months)	No	0			
	Yes	25			
Secondary Diagnosis	No	0			
	Yes	15			
Ambulatory Aid	None/Bed rest/Nurse Assist	0			
	Crutches/cane/walker	15			
	Furniture	30			
IV or IV access	No	0			
	Yes	20			
Gait	Normal/Bed rest/Wheelchair	0			
	Weak	10			
	Impaired	20			
Mental Status	Knows own limits	0			
	Overestimates or forgets limits	15			
To obtain the Morse Fall Score add the score from each category. Total:					
Signature & Status:					

Morse Fall Scale Level of Risk	
High Risk	45 and higher
Moderate Risk	25 - 44
Low Risk	0 - 24

Definitions:

History of falling: Yes score 25 if a fall has happened currently or if there is history of a fall within the last 3 months.

Secondary diagnosis: Yes score 15 if more than one medical diagnosis is listed on the patient chart.

Ambulatory aids: Score 0 if walks without a walking aid even if assisted or is on bed rest and does not get out of bed. Score 15 if ambulatory with crutches, cane, or walker. Score 30 if clutches furniture for support.

IV therapy: Score 20 if has an IV apparatus or heparin lock.

Gait: Normal: Score 0 if is able to walk with head erect, arms swinging freely at sides, & strides unhesitantly.

Weak: Score 10 if is stooped but able to lift head while walking without losing balance. Steps are short, and s/he may shuffle. Furniture support may be sought but is of feather-weight touch, almost for reassurance.

Impaired: Score 20 if is stooped, may have difficulty rising from the chair, attempts to rise by pushing on the arms of the chair and/or by "bouncing". The head is down, and because balance is poor s/he grasps the furniture, a person, or walking aid for support and cannot walk without assistance. Steps are short and s/he shuffles. If wheelchair (WC)-bound, score gait used when transferring from the WC to the bed.

Mental Status: When using this scale, mental status is measured by checking the resident's self-assessment of his/her own ability to ambulate. Ask the resident, "Are you able to go to the bathroom alone, or do you need assistance?" Score 15 if the resident's response is not consistent with the ambulatory orders on the plan of care. If the resident's response is unrealistic, then he/she is considered to overestimate his/her own abilities and to be forgetful of limitations. Score 0 if the resident's reply judging his/her own ability is consistent with the ambulatory order on the plan of care. The resident is rated as "normal."

Provides a standardized method to assess the risk for each patient

When:

- Within 24 hours of admission to acute or long term care;
- At change of status;
- Following a fall;
- Every 3 months; and
- On all home and community care clients who receive home visits.

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Interventions

Implement a plan of care based on the level of risk within 24 hours of admission and update as necessary.

High Risk: 45 or Higher

Acute Care:

- StepSafe logo stickers on the client's chart, care plan and above the client's bed;
- Apply a green armband; and
- Implement appropriate standard safety measures

Long-Term Care

- StepSafe logo stickers on the client's chart, care plan and above the client's bed;
- Apply a green armband only when the client is transferred outside of the facility
- Implement appropriate standard safety measures

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Morse Falls Scale Follow-up Interventions for Acute and Long Term Care

Morse Fall Scale Scores of:
- ☐ 0 - 24 (Low Risk) receive Standard Safety Measures
- ☐ ≥25 (Moderate and High Risk) receive Standard Safety Measures + Additional Safety Measures + Communication/Collaboration with multidisciplinary healthcare team and family is required.

Standard Safety Measures Acute and Long Term Care:

General:
- ☐ Frequent checks (q1h)
- ☐ Medication review by nurse
- ☐ Encourage regular toileting (examples may include: reducing fluid intake after dinner; assisting to toilet prior to sleep; providing bedpan/urinal/commode at bedside if appropriate)
- ☐ Provide educational materials to patient/resident and family (e.g. Please Ask Us!)

Personal:
- ☐ Wear well-fitting, non-slip footwear
- ☐ Walkers/canes/crutches are appropriately fitted and have correct tips
- ☐ Family or alternative attendant as required

Environment/Equipment:
- ☐ Call bell within reach
- ☐ If appropriate, toileting devices, personal items, phone, hand-held controls within reach
- ☐ Obstacles removed from key pathways and clutter-free bedside
- ☐ Oxygen and catheter tubing, IV pump electrical cords removed from pathway
- ☐ Use of side rails, according to clinical judgment within professional standards and scope of practice, for patients who are not bed-ridden
- ☐ Brakes on and bed in lowest position if / when patient is in bed
- ☐ Portable equipment pushed by patient/resident (i.e. IV pole) is sturdy and in good repair
- ☐ If appropriate, wheelchairs locked when stationary

Bathroom:
- ☐ Handrails in patient/resident bathroom are properly secured
- ☐ Assistive devices available as required (i.e. bath/shower chair)
- ☐ Emergency call button/cord in patient/resident bathroom present and working properly
- ☐ Non-slip surfaces provided in patient/resident shower/tub
- ☐ Door openings flush within the floor for ease of movement for patient/resident equipment

Additional Safety Measures:
- ☐ Increase frequency of checks
- ☐ Placement closer to nursing station
- ☐ More frequent toileting
- ☐ Bed, chair, and personal alarm
- ☐ Occupational Therapy referral [ ] Physiotherapy referral
- ☐ Refer to Dietitian for nutritional care if score ≥45 (High Risk) or if otherwise indicated
- ☐ Medication evaluation of patient profile for poly pharmacy (>5 meds) and falls risk by physician or pharmacist (upon availability)
- ☐ Hearing, speech, vision referral if required
- ☐ Consider physician assessment

Follow up interventions completed? [ ] Yes [ ] No Date: _____
Comments: _____

FPS October 2013

See handouts

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Falls Prevention Logo

Step Safe Logo

Why

- ***Safer Healthcare Now***! Initiative and also a requirement by Accreditation Canada.
- Shown that if patients and their environments are assessed and given appropriate interventions that risk is mitigated and injuries prevented.
- Currently performing monthly audits to establish compliance with this policy.
- Future Indicators will measure the effectiveness of the assessments and interventions

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Pressure Ulcer Risk Assessment

- All nursing, acute care, home care, long term care
- Use the **Braden Scale of Risk** assessment at admission and any time the patient's health status has a significant change.
- Schedule provided to assess patients status

Pressure Ulcer Risk Assessment
Braden Risk Assessment - 2013.pdf

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Assessment Schedule

If on initial assessment the Braden Risk Score is 18 or lower, the Braden Risk Assessment is repeated and interventions reviewed as per the following schedule:

Inpatient Unit	Frequency of assessment/review of interventions
Critical Care	Daily
Medical/Surgical	Monday/Wednesday/Friday
Extended Care (e.g. rehab, palliative care, comfort care, geriatric assessment, MH-Long stay)	Weekly for one month and every three months thereafter
Medically Discharged	On admission, weekly for one month, then every three months (as per LTC environment)

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Which Interventions?

Interventions are initiated based on your professional judgment and with consideration to available resources.

The goal is to develop a plan of care that will promote, maintain and/or restore skin integrity.

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Referrals

Mild – Moderate Risk (total score 13-18)

Consider:

- a referral to appropriate clinical discipline i.e. referral to dietitian if score on nutrition component is 2 or less:
- referral to physiotherapist and/or occupational therapy if score on mobility component is 2 or less).

High Risk (total score 12 or less)

Must:

- send referral to dietitian if score on “nutrition” component is 2 or less
- a referral to physiotherapy and/or occupational therapy if score on “mobility” component is 2 or less.

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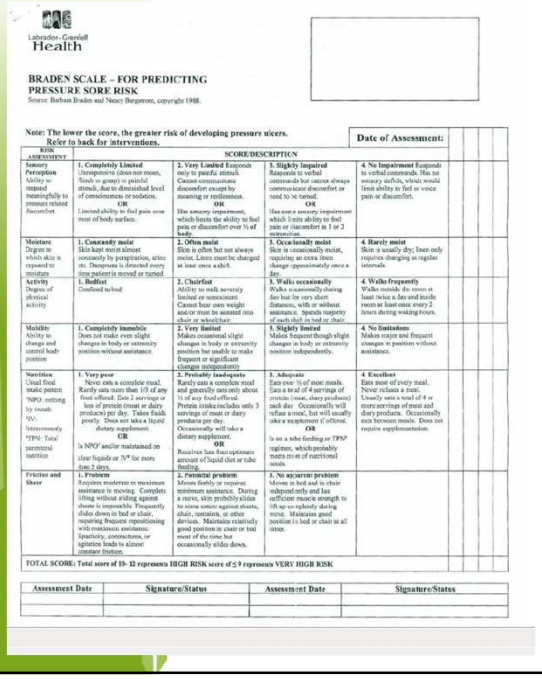
Braden Scale



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BRADEN SCALE – FOR PREDICTING PRESSURE SORE RISK

Source: Barbara Braden and Nancy Bergstrom, copyright 1988.

Note: The lower the score, the greater risk of developing pressure ulcers. Refer to back for interventions.

Date of Assessment:

RISK ASSESSMENT	SCORE/DESCRIPTION							
Sensory Perception Ability to respond meaningfully to pressure related discomfort.	1. Completely Limited Unresponsive (does not moan, flinch or grasp) to painful stimuli, due to diminished level of consciousness or sedation. OR Limited ability to feel pain over most of body surface.	2. Very Limited Responds only to painful stimuli. Cannot communicate discomfort except by moaning or restlessness. OR Has sensory impairment, which limits the ability to feel pain or discomfort over ½ of body.	3. Slightly Impaired Responds to verbal commands but cannot always communicate discomfort or need to be turned. OR Has some sensory impairment which limits ability to feel pain or discomfort in 1 or 2 extremities.	4. No Impairment Responds to verbal commands. Has no sensory deficit, which would limit ability to feel or voice pain or discomfort.				
Moisture Degree to which skin is exposed to moisture	1. Constantly moist Skin kept moist almost constantly by perspiration, urine etc. Dampness is detected every time patient is moved or turned	2. Often moist Skin is often but not always moist. Linen must be changed at least once a shift.	3. Occasionally moist Skin is occasionally moist, requiring an extra linen change approximately once a day.	4. Rarely moist Skin is usually dry; linen only requires changing at routine intervals.				
Activity Degree of physical activity	1. Bedfast Confined to bed	2. Chairfast Ability to walk severely limited or nonexistent. Cannot bear own weight and/or must be assisted into chair or wheelchair.	3. Walks occasionally Walks occasionally during day but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	4. Walks frequently Walks outside the room at least twice a day and inside room at least once every 2 hours during waking hours.				
Mobility Ability to change and control body position	1. Completely immobile Does not make even slight changes in body or extremity position without assistance.	2. Very limited Makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently.	3. Slightly limited Makes frequent though slight changes in body or extremity position independently.	4. No limitations Makes major and frequent changes in position without assistance.				
Nutrition Usual food intake pattern NPO= nothing by mouth IV= Intravenously TPN= Total parenteral nutrition	1. Very poor Never eats a complete meal. Rarely eats more than 1/3 of any food offered. Eats 2 servings or less of protein (meat or dairy products) per day. Takes fluids poorly. Does not take a liquid dietary supplement. OR Is NPO and/or maintained on clear liquids or IV* for more than 5 days.	2. Probably Inadequate Rarely eats a complete meal and generally eats only about ½ of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement. OR Receives less than optimum amount of liquid diet or tube feeding.	3. Adequate Eats over ½ of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered. OR Is on a tube feeding or TPN* regimen, which probably meets most of nutritional needs.	4. Excellent Eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation.				
Friction and Shear	1. Problem Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance. Spasticity, contractures, or agitation leads to almost constant friction.	2. Potential problem Moves feebly or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relatively good position in chair or bed most of the time but occasionally slides down.	3. No apparent problem Moves in bed and in chair independently and has sufficient muscle strength to lift up completely during move. Maintains good position in bed or chair at all times.					
TOTAL SCORE: Total score of 10- 12 represents HIGH RISK score of ≤ 9 represents VERY HIGH RISK								

Assessment Date	Signature/Status	Assessment Date	Signature/Status

CL-7-450_Medication Reconciliation on AdmissionFINAL.pdf

Best Possible Medication History (BPMH)

Reduces potential for medication discrepancies such as omission, duplications, and dosing errors.

- outlines the requirements for **medication reconciliation** at admission and how to resolve omissions, conflicts.
- Requires at least **2** identified sources of medication information.
- **Reliable intake information** becomes the basis for future treatments and prescriptions.
- Must be verified and signed.

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When

Medication Reconciliation is completed within 24 hours for all clients admitted to an Acute or Long Term Care Facility

- If it is not possible to interview the client/family/caregiver, at least **two reliable sources** of information must be obtained to complete a BPMH.
- The reason an interview was not possible must be **documented** on the Regional Medication History & Reconciliation Form

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What to Do

MedRec is a three-step process:

- COLLECT the Best Possible Medication History
- COMPARE what the client is actually taking with what is prescribed to identify discrepancies
- CORRECT any medication discrepancies

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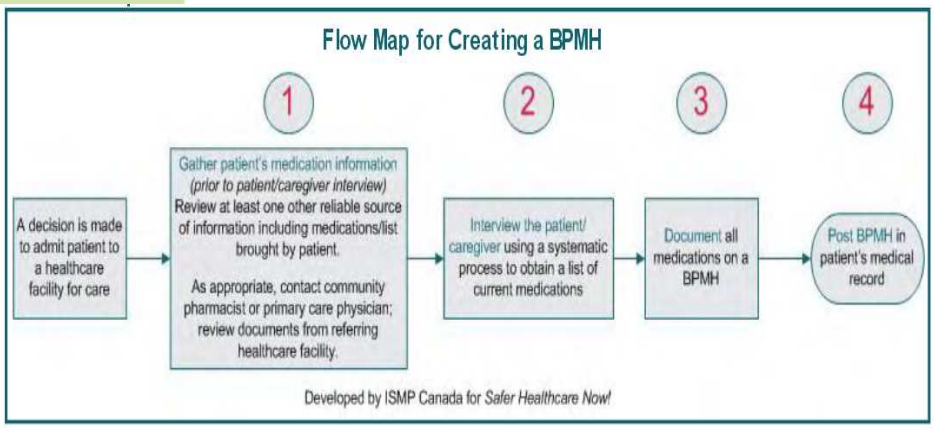
BPMH



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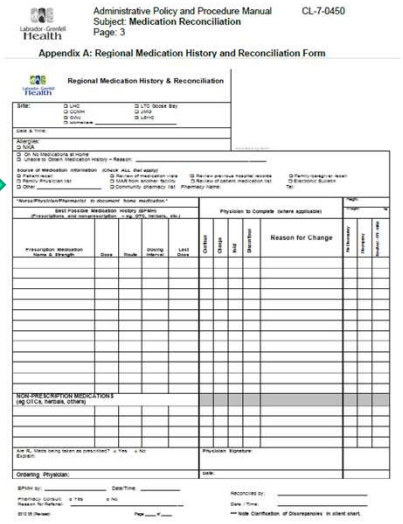
BPMH

- Check your sources: Must be 2
- Reconcile with current prescriptions
- Include OTC herbals, meds etc.



Administrative Policy and Procedure Manual CL-7-0450
Subject: Medication Reconciliation
Page: 3

Appendix A: Regional Medication History and Reconciliation Form

Regional Medication History & Reconciliation

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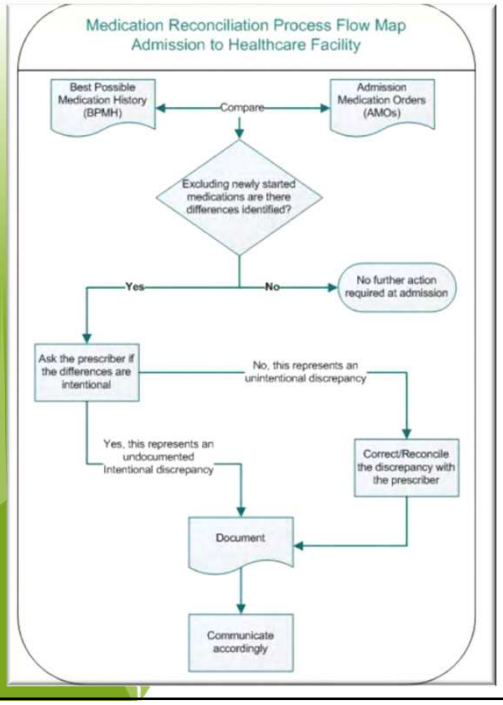
The Reconciliation Process



Investigate with the prescriber and document changes

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Venous Thromboembolism Policy (VTE)

Every hospitalized client (with exception of excluded groups) is to be assessed for VTE risk at the following times:

- Upon admission to hospital
- Changes in client's clinical condition
- Postoperatively
- At transitions of care and time of discharge

All hospitalized clients at risk for VTE will receive venous thromboprophylaxis.

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Exclusions

Not included for VTE prophylaxis:

- Pediatrics
- Obstetrics
- Mental Health
- Long Term Care
- Thromboprophylaxis is not indicated in clients who are mobile and expected to have a hospital length of stay less than 72 hours
- Contraindicated in clients who are actively bleeding or have a high risk of bleeding.

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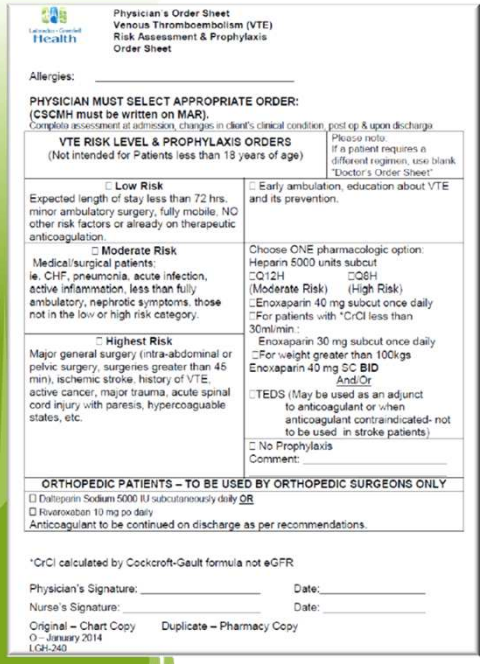

Physician's Order Sheet
Venous Thromboembolism (VTE)
Risk Assessment & Prophylaxis
Order Sheet

Allergies: _____

PHYSICIAN MUST SELECT APPROPRIATE ORDER:
(CSCMH must be written on MAR).
Complete assessment at admission, changes in client's clinical condition, post op & upon discharge

VTE RISK LEVEL & PROPHYLAXIS ORDERS (Not intended for Patients less than 18 years of age)	Please note: If a patient requires a different regimen, use blank "Doctor's Order Sheet"
☐ **Low Risk** Expected length of stay less than 72 hrs, minor ambulatory surgery, fully mobile, NO other risk factors or already on therapeutic anticoagulation.	☐ Early ambulation, education about VTE and its prevention.
☐ **Moderate Risk** Medical/surgical patients: ie. CHF, pneumonia, acute infection, active inflammation, less than fully ambulatory, nephrotic symptoms, those not in the low or high risk category.	Choose ONE pharmacologic option: Heparin 5000 units subcut ☐Q12H (Moderate Risk) ☐Q8H (High Risk) ☐Enoxaparin 40 mg subcut once daily ☐For patients with *CrCl less than 30ml/min : Enoxaparin 30 mg subcut once daily ☐For weight greater than 100kgs Enoxaparin 40 mg SC **BID** And/Or ☐TEDS (May be used as an adjunct to anticoagulant or when anticoagulant contraindicated- not to be used in stroke patients)
☐ **Highest Risk** Major general surgery (intra-abdominal or pelvic surgery, surgeries greater than 45 min), ischemic stroke, history of VTE, active cancer, major trauma, acute spinal cord injury with paresis, hypercoaguable states, etc.	☐ No Prophylaxis Comment: _____
ORTHOPEDIC PATIENTS – TO BE USED BY ORTHOPEDIC SURGEONS ONLY	
☐ Dalteparin Sodium 5000 IU subcutaneously daily OR ☐ Rivaroxaban 10 mg po daily Anticoagulant to be continued on discharge as per recommendations.	

*CrCl calculated by Cockcroft-Gault formula not eGFR

Physician's Signature: _____ Date: _____
Nurse's Signature: _____ Date: _____

Original – Chart Copy Duplicate – Pharmacy Copy
O – January 2014
LGH-240

Risk Assessment

See handout

Venous Thromboembolism Prophylaxis G-1-665 2014 final.pdf

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Dangerous Abbreviations

"DO NOT USE Abbreviations" policy

CL-7-400_Do Not Use AbbreviationsFINAL.pdf

- Certain abbreviations have been shown to be the cause of medication errors.
- These include symbols, abbreviations, trailing or leading zeros

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WHY

- **ISMP (*Institute for Safe Medication Practices)*, WHO (World Health Organization)** and other organizations worldwide recognize these as error prone and have banned their use.
- Currently auditing charts randomly for usage.

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Do Not Use

Dangerous Abbreviations, Symbols and Dose Designations

The abbreviations, symbols, and dose designations found in this table have been reported as being frequently misinterpreted and involved in harmful medication errors. They should NEVER be used when communicating medication information.

Abbreviation	Intended Meaning	Problem	Correction
U	unit	Mistaken for "0" (zero), "4" (four), or cc.	Use "unit".
IU	international unit	Mistaken for "IV" (intravenous) or "10" (ten).	Use "unit".
Abbreviations for drug names		Misinterpreted because of similar abbreviations for multiple drugs; e.g., MS, MSO_4 (morphine sulphate), $MgSO_4$ (magnesium sulphate) may be confused for one another.	Do not abbreviate drug names.
QD QOD	Every day Every other day	QD and QOD have been mistaken for each other, or as "qid". The Q has also been misinterpreted as "2" (two).	Use "daily" and "every other day".
OD	Every day	Mistaken for "right eye" (OD = oculus dexter).	Use "daily".
OS, OD, OU	Left eye, right eye, both eyes	May be confused with one another.	Use "left eye", "right eye" or "both eyes".
D/C	Discharge	Interpreted as "discontinue whatever medications follow" (typically discharge medications).	Use "discharge".
cc	cubic centimetre	Mistaken for "u" (units).	Use "mL" or "millilitre".
µg	microgram	Mistaken for "mg" (milligram) resulting in one thousand-fold overdose.	Use "mcg".

Symbol	Intended Meaning	Potential Problem	Correction
@	at	Mistaken for "2" (two) or "5" (five).	Use "at".
> <	Greater than Less than	Mistaken for "7"(seven) or the letter "L". Confused with each other.	Use "greater than"/"more than" or "less than"/"lower than".

Dose Designation	Intended Meaning	Potential Problem	Correction
Trailing zero	X.0 mg	Decimal point is overlooked resulting in 10-fold dose error.	Never use a zero by itself after a decimal point. Use "**X mg**".
Lack of leading zero	.X mg	Decimal point is overlooked resulting in 10-fold dose error.	Always use a zero before a decimal point. Use "**0.X mg**".

Adapted from ISMP's List of *Error-Prone Abbreviations, Symbols, and Dose Designations* 2008

ISMP Canada July 2008

Report actual and potential medication errors to ISMP Canada via the web at https://www.ismp-canada.org/err_report.htm or by calling 1-866-54-ISMPC. ISMP Canada guarantees confidentiality of information received and respects the reporter's wishes as to the level of detail included in publications.

ismp CANADA

Permission is granted to reproduce material for [illegible] communications with proper attribution. Download from: www.ismp-canada.org/dangerousabbreviations.htm

See Handouts

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Monthly Chart Audits

- Auditing Committees at each Hospital site monthly.
- The data is sent to the Analyst for review and charting and also sent to the Quality Improvement Coordinator for same.
- The results are shared monthly with the Site Managers: Posted on the Quality Initiative Boards
- Lessons Learned.
- Quarterly results are shared with the Regional Directors, Senior Executive and in the Board Scorecard.

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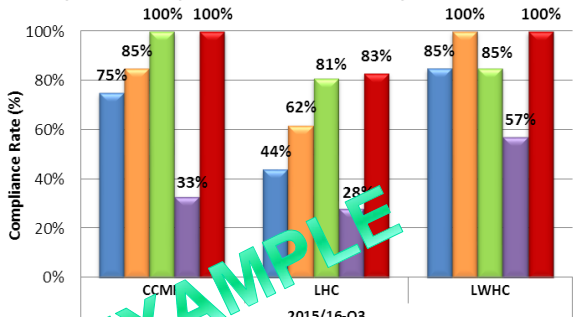
Chart Indicators

Figure 1: LGH Acute Care Chart Audit Indicators Report
Site Comparison - Q3 (October-December, 2015)



EXAMPLE

	CCMH	LHC	LWHC
VTE Risk Assessment Completed	75%	44%	85%
Falls Scale Risk Assessment Completed	85%	62%	100%
Pressure Ulcer Risk Assessment Completed	100%	81%	85%
Dangerous Abbreviations NOT Used	33%	28%	57%
Med Rec Reconciled @ Admission	100%	83%	100%

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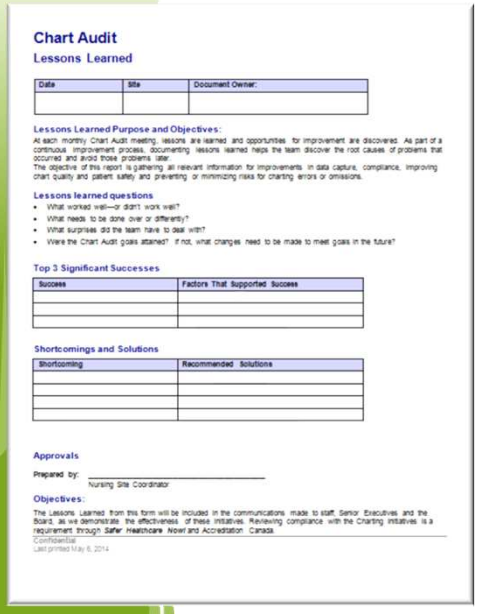

Chart Audit

Lessons Learned

Date	Site	Document Owner:

Lessons Learned Purpose and Objectives:

At each monthly Chart Audit meeting, lessons are learned and opportunities for improvement are discovered. As part of a continuous improvement process, documenting lessons learned helps the team discover the root causes of problems that occurred and avoid those problems later.
The objective of this report is gathering all relevant information for improvements in data capture, compliance, improving chart quality and patient safety and preventing or minimizing risks for charting errors or omissions.

Lessons learned questions

- What worked well—or didn't work well?
- What needs to be done over or differently?
- What surprises did the team have to deal with?
- Were the Chart Audit goals attained? If not, what changes need to be made to meet goals in the future?

Top 3 Significant Successes

Success	Factors That Supported Success

Shortcomings and Solutions

Shortcoming	Recommended Solutions

Approvals

Prepared by: _____
Nursing Site Coordinator

Objectives:

The Lessons Learned from this form will be included in the communications made to staff, Senior Executives and the Board, as we demonstrate the effectiveness of these initiatives. Reviewing compliance with the Charting Initiatives is a requirement through *Safer Healthcare Now!* and Accreditation Canada.

Confidential
Last printed May 6, 2014

Lessons Learned

What worked, what didn't and what do we want to learn for next time..

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Safer Healthcare Now!... Patient Safety Quality Initiatives

- Large impact on patient safety and quality of care.
- LG Health has committed that we will participate in these quality initiatives.
- Also a requirement by Accreditation Canada that facilities not just have these policies, but also that they demonstrate the compliance to these policies.

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No Questions?

There is a quiz!

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