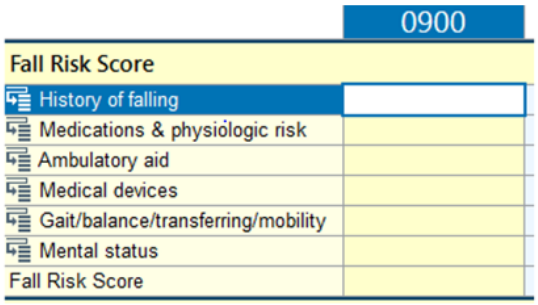
Falls /Gait Belt/ Avasure

Relevant Policies and Protocols at UCM:

- PC 149- Falls Prevention and Post-Fall Management
- Direct Observation Monitoring Pediatric and Adult Inpatients Protocol

Note: If working in a specialty area, refer to area-specific fall policy

- **Assessment**
  - All adult (ED, inpatient, Labor & Delivery, and Per-Operative) patients are assessed by the nurse upon admission, at the beginning of every shift, at transfer, post-procedure, and with any change in patient condition.
  - Fall Risk Scale Categories
    - History of Falling
    - Medications and contributing physiological factors
    - Ambulatory Aide
    - Medical Devices
    - Gait/Balance/Transferring/Mobility
    - Mental Status
- **Fall Prevention**
  - Documentation-



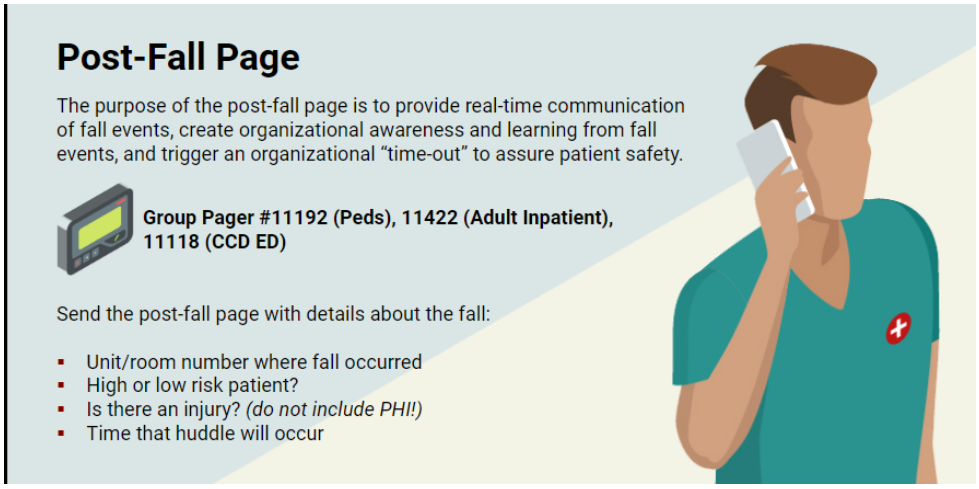
	0900
Fall Risk Score	
History of falling	
Medications & physiologic risk	
Ambulatory aid	
Medical devices	
Gait/balance/transferring/mobility	
Mental status	
Fall Risk Score	

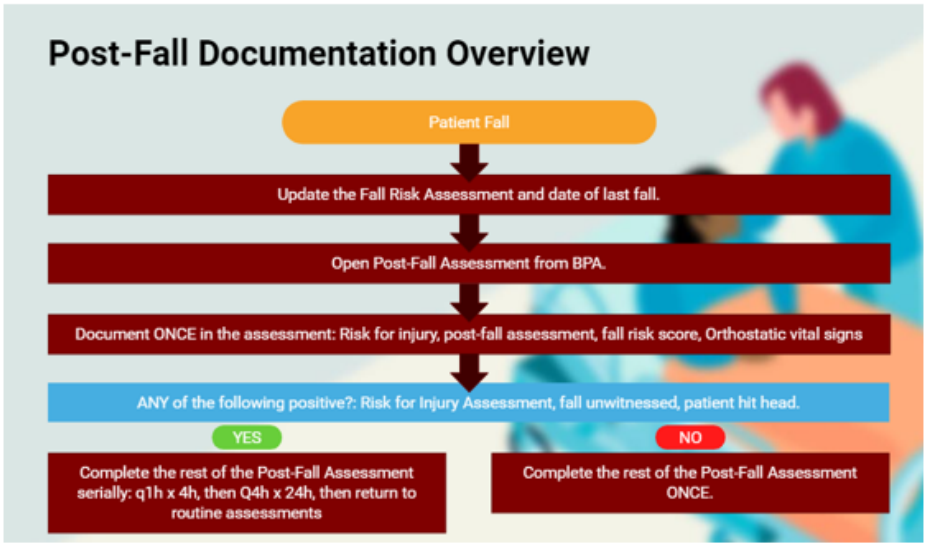
  - Universal Safety Precautions- Applied to any patient admitted to UCMC to minimize risk for falls:
    - Patient/Family education on Universal Fall Safety Interventions
    - Provide patient and family orientation to environment and routine.
    - Bed Low & Locked
    - Call light within Reach
    - Use of non-slip footwear
    - Side rails up as appropriate for patient condition
    - Remove Obstacles-Arrange furniture and objects so they are not obstacles and remove unnecessary furniture in rooms.
    - Purposeful Rounding: 5P's- Pain, Positioning, Personal Needs, Placement, and Presence

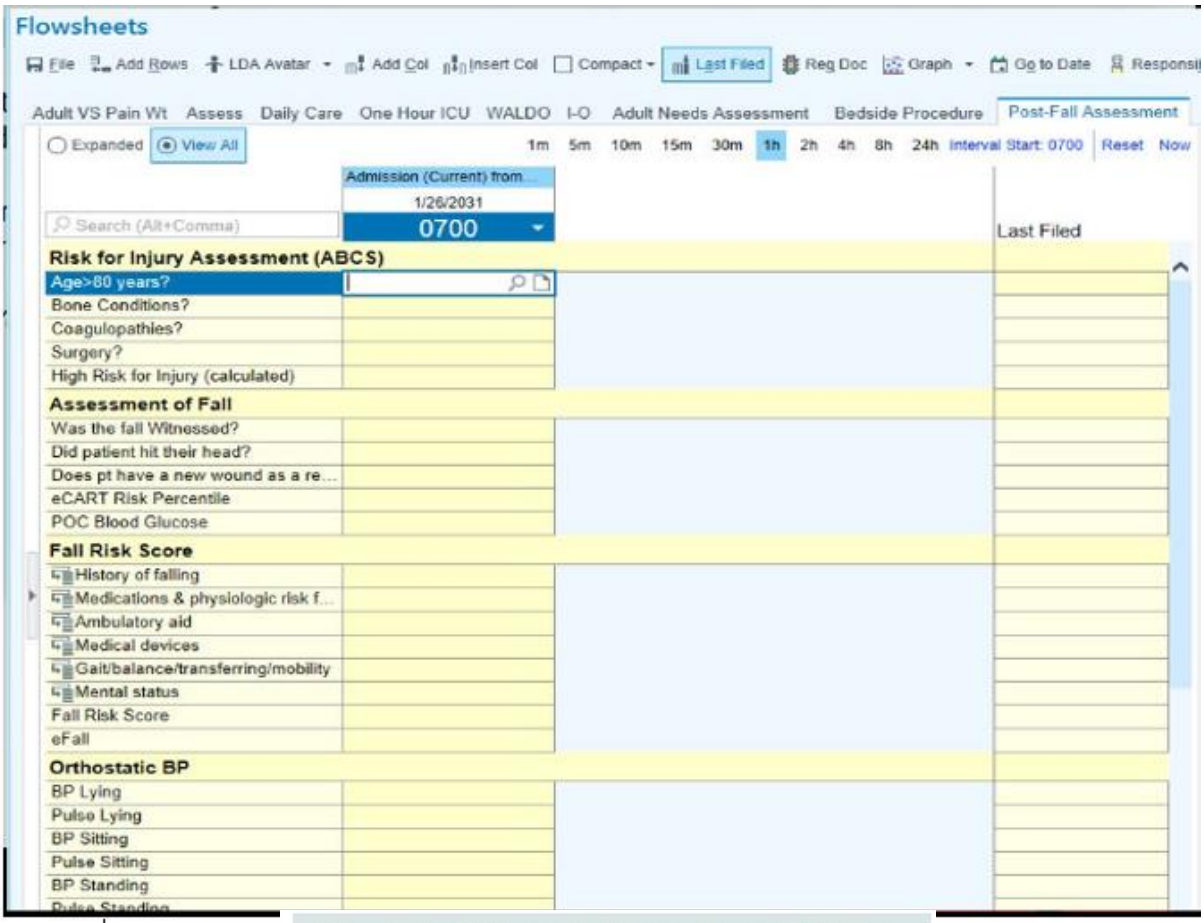
- Keep all assistive devices (glasses, walker, etc.) available to patients.

- High Risk Fall Precautions- Anyone with a score ≥45 are considered High Risk and must have:
  - Universal safety precautions implemented (listed above)
  - Yellow ID band and signage placed inside and outside of room
  - Use of Bed/Chair Alarm
  - Remain within arms' reach of patient while in bathroom/on bedside commode
  - Educate patient and family when there is a risk of falling and reinforce as much as possible to call of assistance with ambulating/toileting
  - Encourage family to stay with high-risk or confused patient, when possible
  - Door to room open, unless isolation or privacy required
  - Communicate fall risk to physicians/APP, food service staff, therapy services, patient transportation, diagnostic and procedural areas
  - Assign high risk patients to rooms near the nursing station whenever possible

- **Post Fall Process**







Post-Fall Event Report and Note

In addition to the flowsheet documentation, after a patient fall:

- Complete an Event Report.
- Write an event note in Epic.

Gail Belt

- Training Video
  https://players.brightcove.net/3906942831001/r18hsnddZ_default/index.html?videoId=6310911070112
- Criteria:
  - Gait belts should be used when mobilizing ***ALL*** patients.
  - May be used to provide support for balance during functional mobility, support standing, stepping and gait training
  - ***Should NOT be used as a lifting device.***
- Ergonomics:
  - S02-62 Ergonomic Policy (uchicagomedicine.org)
  - ***ADJUST THE BED*** to keep the work at a comfortable height to avoid excessive bending at the waist.
  - Move as close to the bed or patient as you can & give yourself a solid, ***wide base of support***.
  - Keep your ***head up and hold your shoulders upright***. If you held a yardstick along your back, it would be perfectly straight.
  - Keep your ***stomach muscles tight***, bow slightly at the hips, and then squat.
  - Ensure height and measurements are appropriate for the patient
  - ***Never twist***; always pivot or side step.
- Precautions for gait belt use
  - Grafts on trunk
  - Pacer wires
  - Chest tubes – consider the location and risk for dislodgement with use of gait belt

AT THE FOREFRONT UChicago Medicine

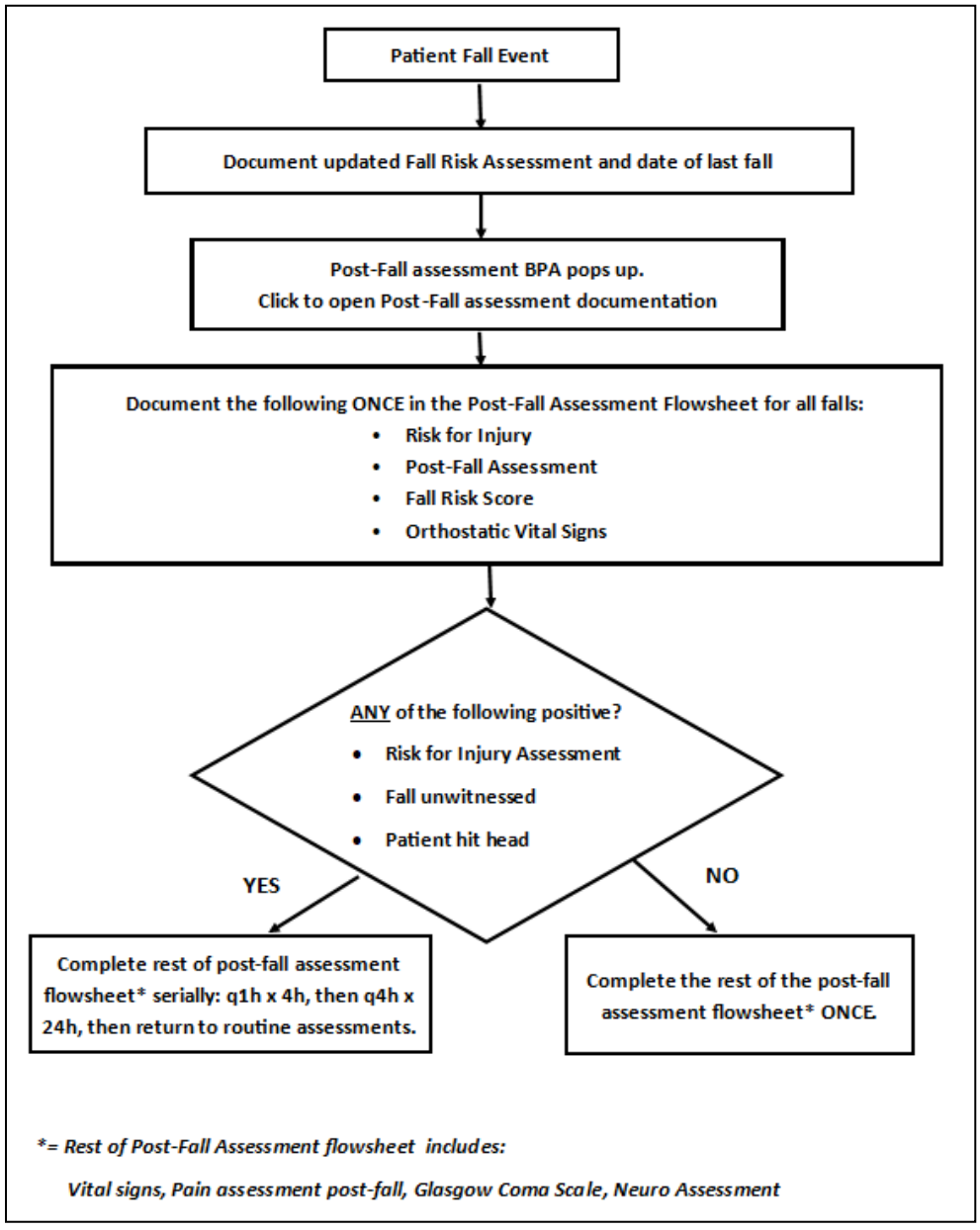
Nursing Quality and The Center for Clinical Professional Practice

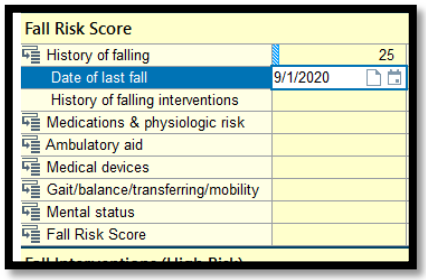
Post-Fall Assessment Process for Adult Inpatient

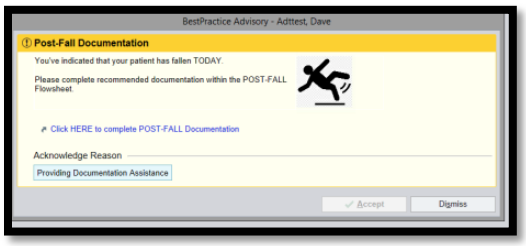
A standardized post-fall RN patient assessment workflow was designed to assess and monitor a patient's condition following a fall event. This workflow may identify changes in patient condition indicating an injury (e.g. subdural hematoma, fracture).

This tip sheet outlines the **Post-Fall Assessment** workflow.

Workflow Diagram:







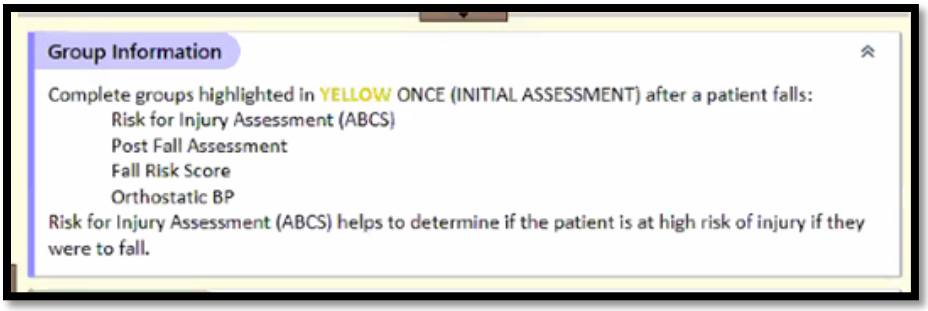
Additional assessment rows will cascade depending on which type of fall you document.

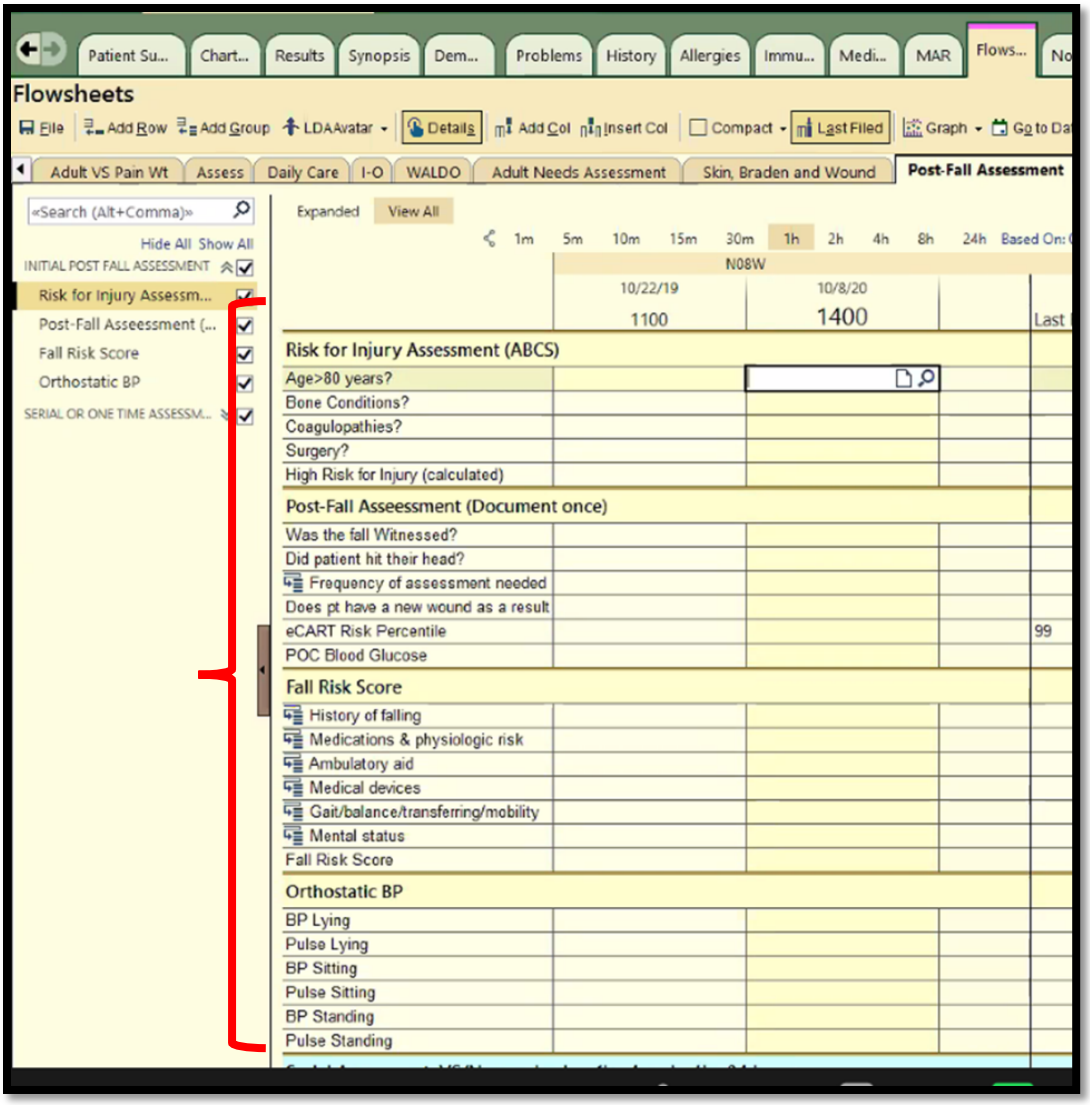
See Page 2 for detailed screenshots.

10.22.2020 Meghan Sweis/Melissa Arangoa

Document the following rows ONCE:

- Risk for Injury Assessment (ABCS), Post Fall Assessment, Fall Risk Score & Orthostatic BP
  - For all adult inpatient falls
  - Located in the Post-Fall Assessment flowsheet





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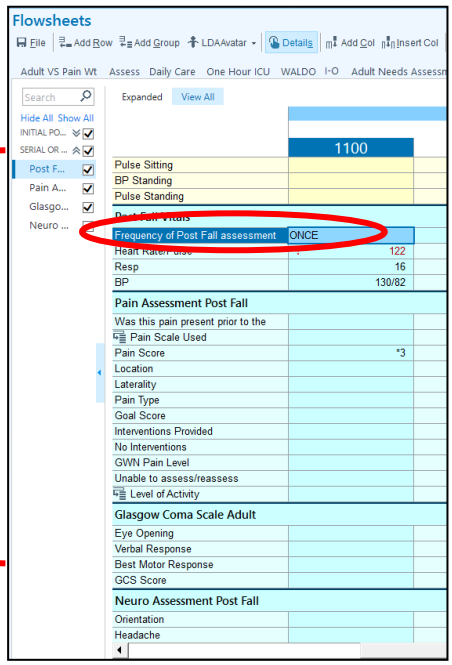
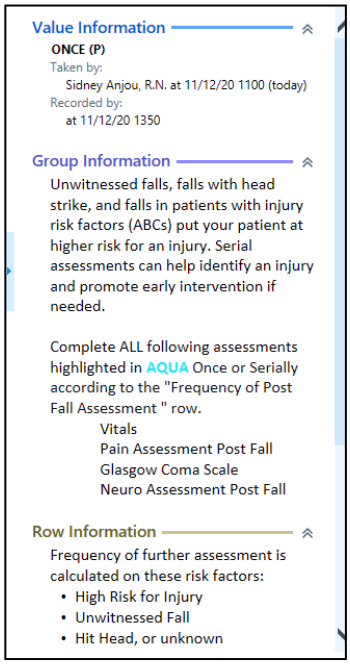
The teal rows cascade based on the initial assessment. Complete ASSESS ONCE rows if:

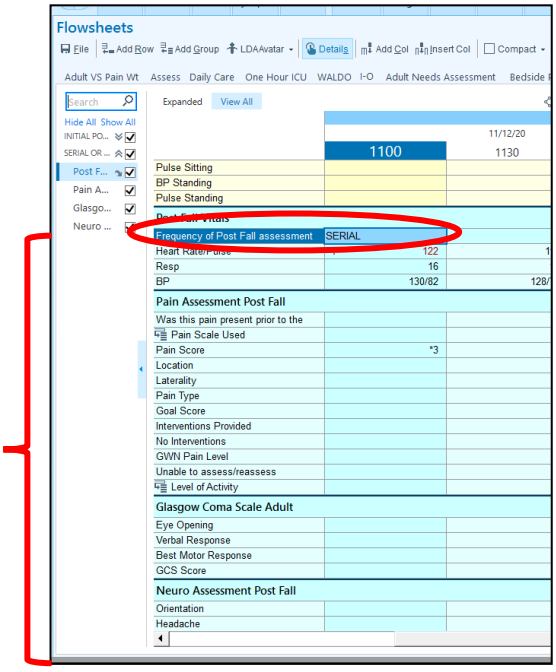
- Low risk for injury **AND** witnessed fall **AND** no head strike

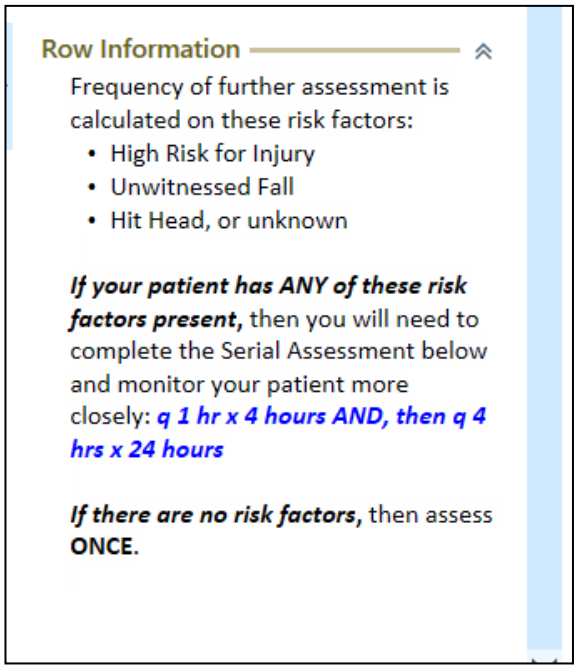




Complete remaining SERIAL ASSESSMENT rows if:

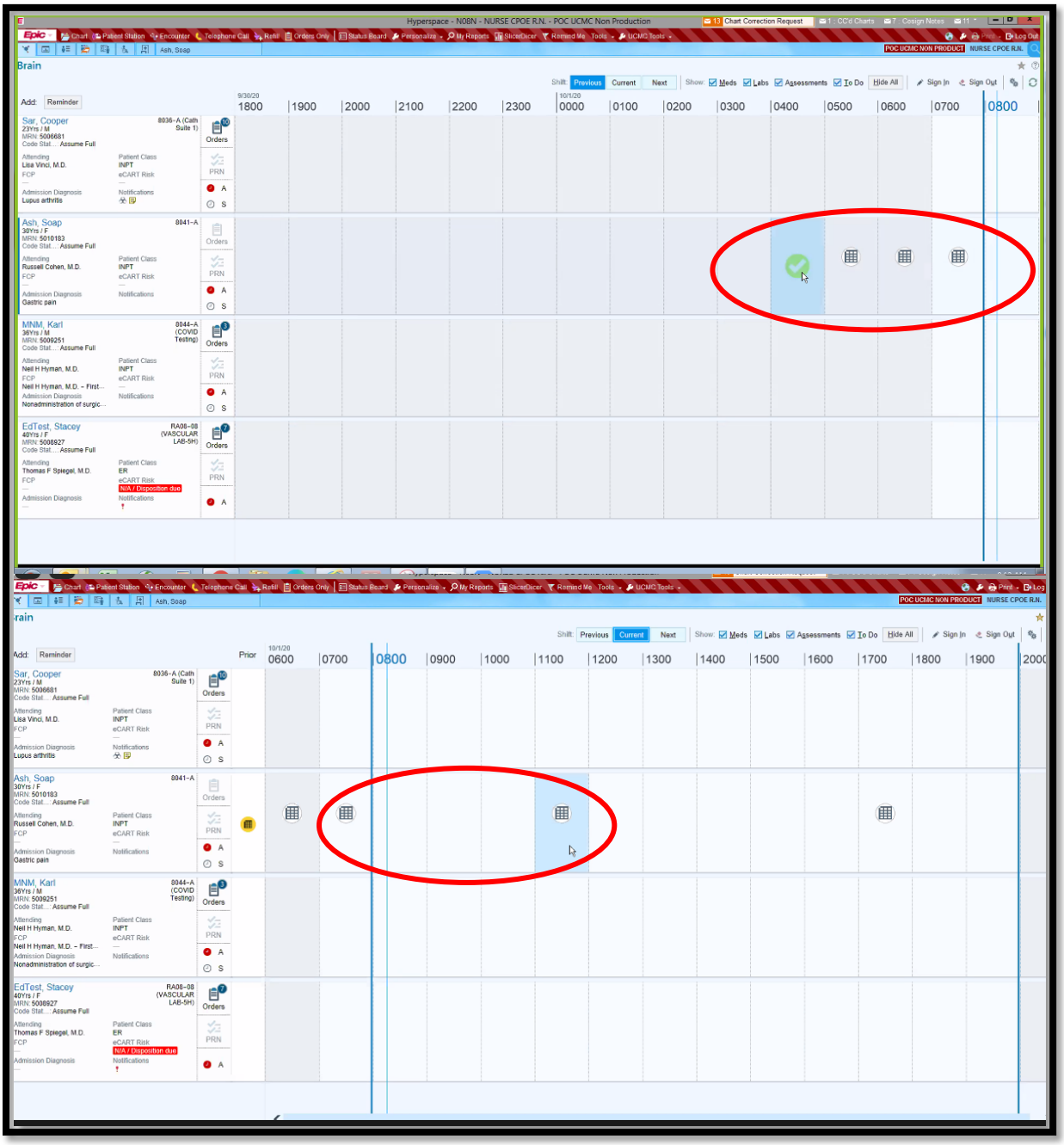
- High risk for injury **OR** unwitnessed fall **OR** head strike
- Document q1hX4 **then** q4x24 **then** return to normal assessment cadence





Remember to check the Brain!

- For serial assessments, task reminders will appear on the Brain q1 **then** q4



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Falls Committee – May 2023

Post-Fall Assessment and Documentation: Part 2 of 2

After completing a post-fall assessment (for inpatients, refer to January 2023 Huddle Card, Post Fall Assessment and Documentation Inpatient Part 1 of 2), it is important for the nurse to also document a fall note in Epic. Below are steps on what the fall note looks like and how to find this in Epic.

Inpatient Fall Note

As an "Event Note" in Epic, type the Smartphrase **.fall** to find the post-fall note. Below is how this note will look in Epic. Anything with *** means you need to type in a description. You can see available selections after hitting the **F2** button on your keyboard.

Post Fall Note

Date and time of fall: *** @ ***

Location of fall:

Environmental conditions at time of fall:

Type of fall:

Patient or witness description of fall: ***

Include what the patient said happened, what did you find/see when you found the patient, etc. Be descriptive.

Fall injury:

Name of provider notified: ***

Post fall interventions:

Follow-up & monitoring:

Additional comments:

Location of fall:
{IP Fall Location:9700}
By the bed
By bedside commode
In the bathroom
In shower
In room, away from bed
In hallway
Other (specify) ***

Yellow boxes: single select options

Blue boxes: multi-select options

Environmental conditions at time of fall:
{Environmental Conditions:9701}
Patient wearing non-slip, well fitted socks/footwear
Floor dry and free of slip or trip hazards
Clear path from bed/chair to bedside commode
Clear path from bed/chair to bathroom
Bed in low position
Head of bed, upper side rails raised
Bed alarm activated
Bed brake activated
Call light within reach
Visitor present

Type of fall:
{Fall Type:9703}
Witnessed by {IP Fall Witness:9702}.
Unwitnessed.
Assisted by {IP Fall Witness:9702}.
Unassisted.

Fall injury:
{Fall Injury:9704}
No signs or symptoms of injury
Pain (state location): ***
Bruise (state location): ***
Abrasion (state location): ***
Other (specify): ***

Post fall interventions:
{Post Fall Interventions:9705}
RRT/PET called
Updated fall risk score
Initiated high fall risk plan & interventions
Reinforced use of call light
Re-educated patient and family on fall risk
Bed alarm turned on
Other (specify)***

Follow-up & monitoring:
{Fall Followup and Interventions:9706}
See new orders
X-ray/imaging
Transferred to ***
Other (specify) ***

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Falls Committee – May 2023

Ambulatory Fall Note

As an "Event Note" in Epic, type the Smartphrase **.ambpostfall** to find the post-fall note. Below is how this note will look in Epic. Anything with *** means you need to type in a description. You can see available selections after hitting the **F2** button on your keyboard.

Patient or witness description of fall: ***

Include what the patient said happened, what did you find/see when you found the patient, etc. Be descriptive.

Yellow boxes: single select options

Blue boxes: multi-select options

AMB Post Fall Note
Date *** and Time *** (free text)

Documentation Elements	Choices
Location of Fall	{Location of Fall:3911}
Environmental Conditions At the Time of Fall	{Environmental Conditions At the Time of Fall:3912}
Type of Fall	{Type of Fall:3913}
Patient or witness description of fall	***
Fall Injury	{Fall Injury:3916}
Name of Provider (MD, APN, PA) notified	***
Post Fall Intervention	{Post Fall Intervention:3917}
Follow-up and Monitoring	{Follow-up and Monitoring:3918}
Additional comments:	***

{Location of Fall:3911}
- In the triage room
- In the exam room
- In the waiting area
- In the clinic hallway
- In the clinic bathroom
- In the DCAM lobby hallway
- In the DCAM lobby bathroom
- Other ***

{Environmental Conditions At the Time of Fall:3912}
- Patient wearing non-slip well fitted footwear
- Floor dry and free of slip or trip hazards
- Clear path from bed/ wheelchair to bathroom
- Wheelchair/stretcher brake activated
- Call light (if present) is within reach
- Visitor/s Present

{Type of Fall:3913}
- Witnessed by {Witnessed by:3914}
- Unwitnessed
- Assisted by {Assisted by:3915}
- Unassisted

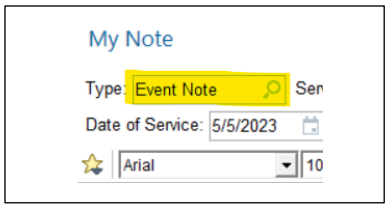
{Fall Injury:3916}
- No signs or symptoms of injury
- Pain on ***
- Bruise on ***
- Abrasions on ***

{Post Fall Intervention:3917}
- RRT/PET called
- Updated Fall Risk Score
- Initiated High Risk plan and Interventions
- Gave patient a yellow band
- Communicated the fall risk to caregiver
- Reinforced use of call light
- Re-educated Patient and Family on fall risk and interventions
- Others ***

{Follow-up and Monitoring:3918}
- See new orders
- Xray done
- Transferred to ***

Example of Event Note Selection

Instead of nursing note, select "Event Note"



Additional Follow-up

- Make sure to complete post-fall assessment flowsheets (inpatient) and update your fall risk assessment (all locations)
- Send a page to the fall huddle (inpatient/ED) or notify your direct leadership team (ambulatory)
  - **Group Pagers:** #11192 (Peds) 11422 (Inpatient Adult) 11118 (CCD ED)
  - **Include in page:** unit/room where fall occurred, high or low risk patient, is there an injury, time for huddle to occur. Do not include patient identifiers (e.g., MRN, name)
- Complete an Event Report

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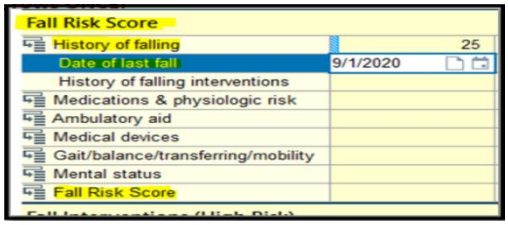
Post-Fall Assessment and Documentation for Inpatients: Part 1 of 2

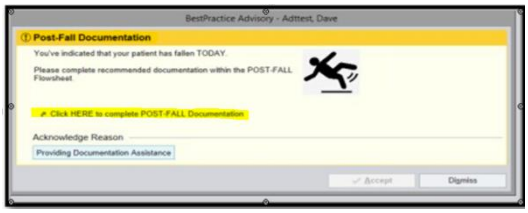
A standardized post-fall assessment and documentation for inpatients was designed to pro-actively assess and monitor risks and patient's condition following a fall and to identify changes early that may signify a related injury (e.g. subdural hematoma, fracture).

#1 Update Fall Risk Assessment Score and Date of Fall

1. Update Fall Risk Assessment Score following a fall
2. Document patient's mobility assessment post-fall

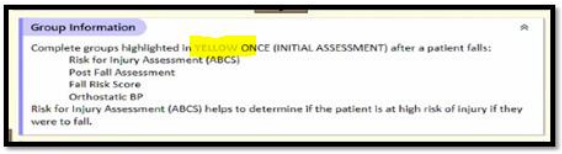


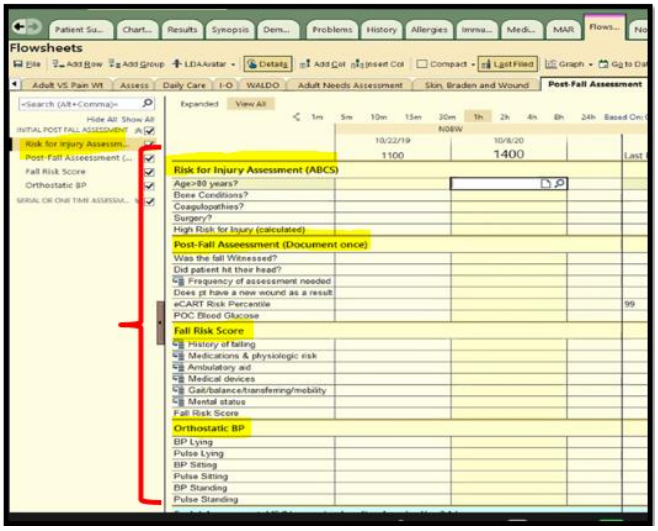
#2 Post-fall Assessment BPA pops- up:



#3 Document the following rows ONCE:

- Risk for Injury Assessment (ABCS), Post Fall Assessment, Fall Risk Score & Orthostatic BP
  - For all adult inpatient falls
  - Located in the Post-Fall Assessment flowsheet
  - **Low risk for injury & witnessed fall, NO head strike → Document post-fall assessment ONCE**





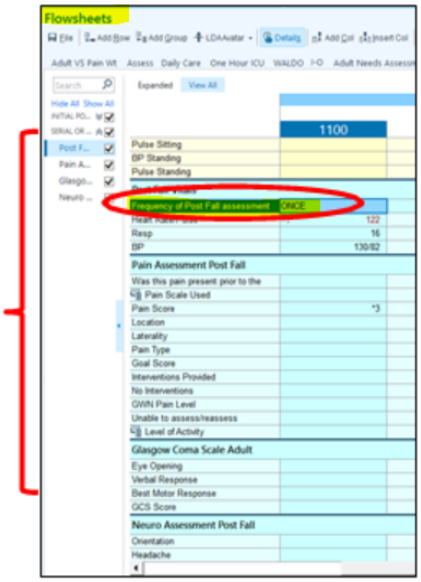
Note: If a patient is high risk for injury, even if fall was witnessed **without** a head strike, you will need to complete the **SERIAL ASSESSMENT** (Q1hr x 4 hrs. then Q 4 hrs. x 24 hrs.) – *see page 2*

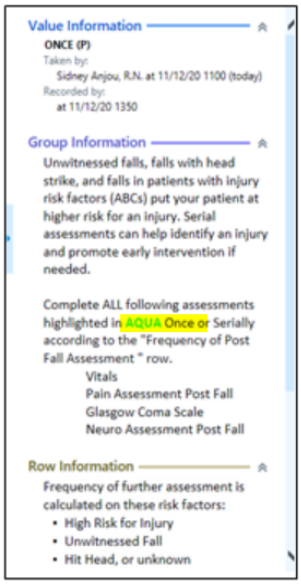
- ***Greater than 80 yrs.***
- ***Bone Conditions***
- ***Coagulopathy (e.g., low platelets, on blood thinners)***
- ***Post-surgery***

1.11.23/M.ArangoaMiller/LPalmones-Obena/UCM Falls Champions Committee

HUDDLE CARD
Falls Committee – January 2023

View of Flowsheet for patients that require post-fall assessment ONCE:



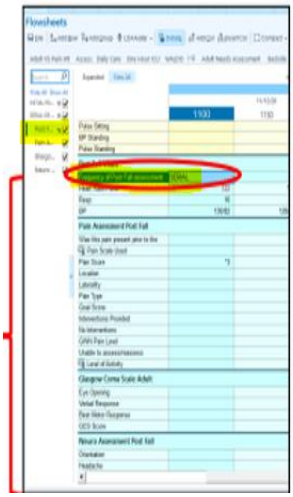


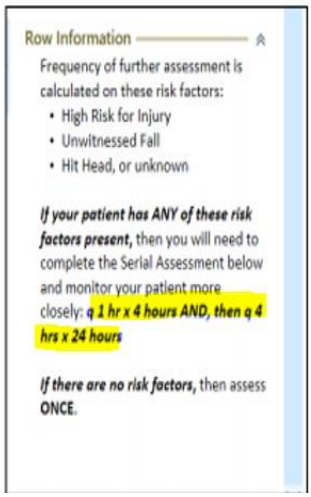
#4 Serial Assessment Documentation

Complete the remaining SERIAL ASSESSMENT rows if:

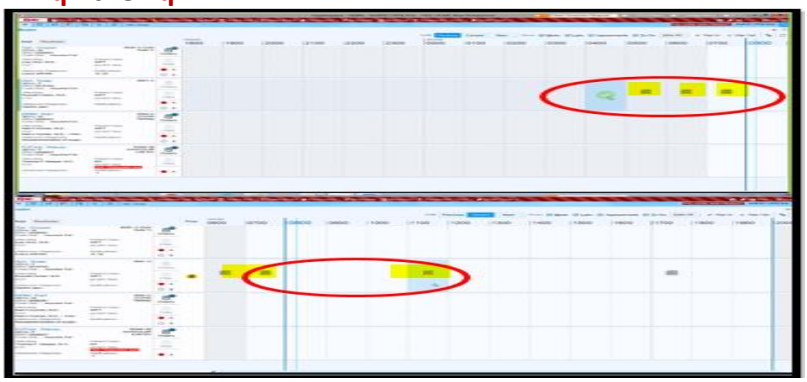
- High risk for injury **OR** unwitnessed fall **OR** head strike
- **Document q1hx4 then q4x24 then return to normal assessment cadence**

View of flowsheet for patients that need SERIAL assesment:





❖ **Remember to check the Brain! For serial assessments, task reminders will appear on the Brain q1 then q4**



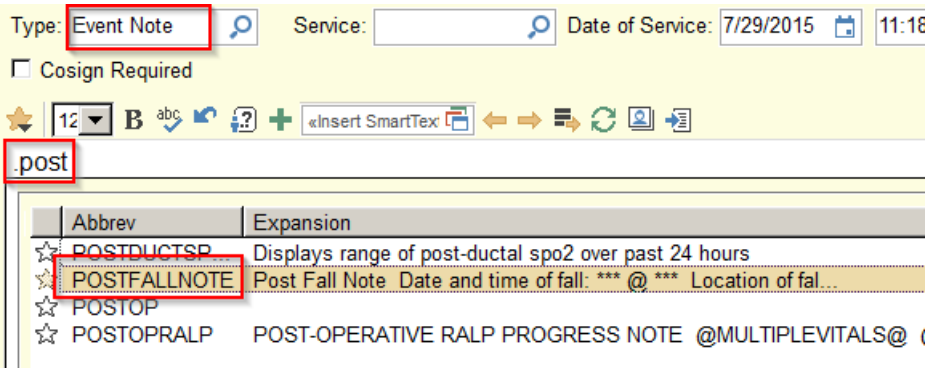
Post Fall Note

Summary

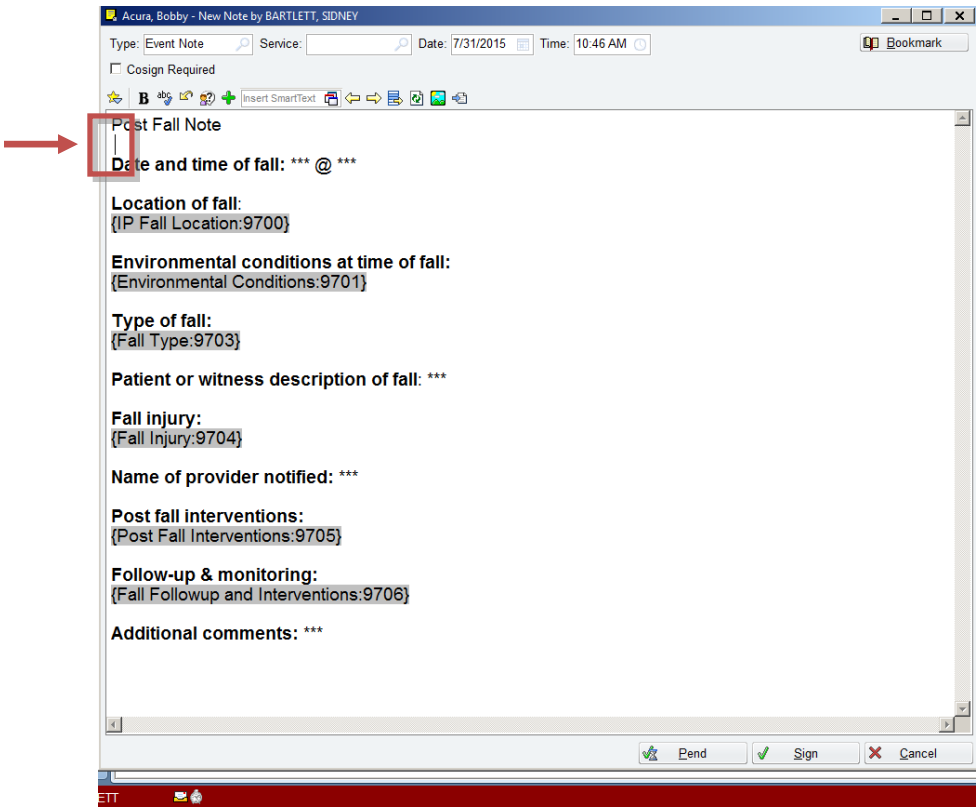
A Post Fall Smart Phrase has been created to guide documentation of a patient fall note.

Step-by-Step

1. Open a New Note and add **Event Note** in type field.
2. In the note field enter **.postfall (Note the dot before postfall)**. Select the POSTFALLNOTE from the list.



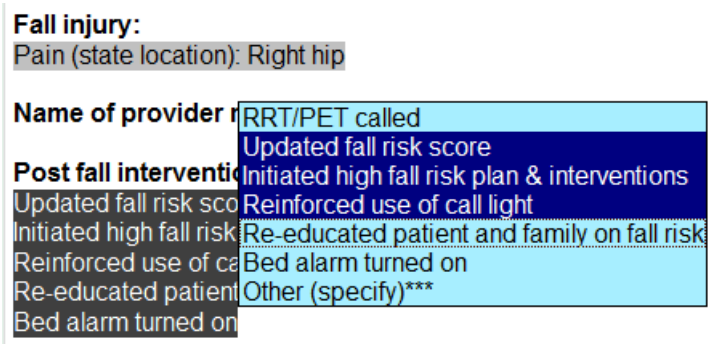
3. When the template opens the cursor will default to the bottom of the note. Start by moving the cursor to the top of the note.



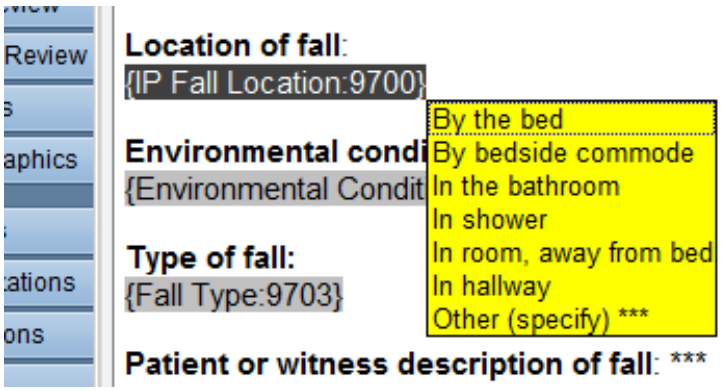
4. Select F2. This will highlight the first wild card that needs to be addressed.

> **Note:** F2 will move the cursor through the required fields. Required fields are either wild cards or an area indicated by brackets. (*** are wild cards. Consider them as blanks and enter a free text response.) The other fields have a list to select a response. **Left click to select your answers and right click to accept your answer.** The cursor will then move to the next field. You cannot sign the note until all fields are filled in.

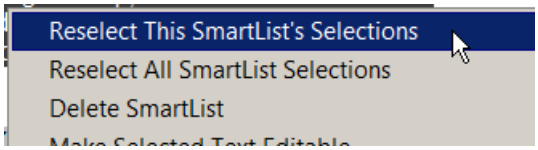
The light blue background is an indication that you may select multiple items.



5. A yellow background is a single select.



> **Note:** If you make a mistake and need to change your answers, place your cursor over the response and right click. Then select **Reselect this SmartList's Selections**.



6. When all fields are filled in click **Sign**.

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DIRECT OBSERVATION PROTOCOL UPDATES

The protocol, "Direct Observation Monitoring Pediatric and Adult Patients" is now a nurse driven protocol. Reviewing inclusion and exclusion criteria can help you determine which observation type is most appropriate for your patient. Allowing nurses to place direct observation orders removes barriers to contact a provider first, decreases time to implement direct observation for patient safety and can help decrease patient falls.

Remote Video Monitoring

The Continuous Observation Care order for Remote Video Monitoring is to use the Avasure device.

Inclusion Criteria:

Patients who are at high risk for non-intentional self-injury which include but are not limited to the following:

- Fall Risk
- Eating disorders
- Risk for elopement
- Impaired judgment
- Impulsive behavior
- Attempting to get out of bed
- Patients on seizure precautions (excludes epilepsy monitoring patients)
- Pulling and/or manipulation of essential devices: IVs, tubes, drains, oxygen, tracheostomy, telemetry, dressings
- Other indications demonstrating additional need for continuous monitoring related to psychosocial needs (e.g., safe haven from trauma, abuse, etc.).

Exclusion Criteria:

- Patient on suicide precautions
- Patients with restraints for self-destructive or violent behavior
- Patients with intracranial electroencephalogram (EEG) leads
- Patients under forensic/security guard supervision.
- Involuntary Mental Health Admission, unless approved by Psychiatry Services
- Patients that are severely hearing impaired (e.g., deaf)

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Care Companion Roles & Responsibilities

- Use the role name “Care Companion” instead of “Sitter”
- Roles and responsibilities include but are not limited to completing ADLs, vital signs, toileting, linen changes, blood sugar monitoring, input/output, along with documentation of care rendered.
- Monitor patient related to safety needs for high fall risk needs and/or suicide risk, behavioral changes, communicating to patient and care team if additional assistance is needed.
- Care Companions are to follow UCMC policies, including but not limited to:
    - PC 149 Fall Prevention and Post-Fall Management
    - PC 104 Suicide Risk Screening & Precautions for Patients
    - PC 27 Restraints & Seclusion
    - HR 610 Electronic Communication Device and Usage

Cohort Care Companion

The Continuous Observation Care order for Cohort Care Companion includes the following care:

- High fall risk precautions implemented for all patients in cohort.
- Indication for Cohort Care Companion: Patient is oriented x1 or x2 (e.g. person, place), follows verbal commands with moderate safety risks due to confusion, delirium, dementia.
- RN implements nursing delirium screening protocol as appropriate.
- Safety checks are performed at least hourly.
    - RN/Nursing Assistant/Cohort Care Companion documents patient behaviors and interventions in medical record at least hourly.
- RN collaborates with nurse leaders and weans patient from cohort observation as aberrant behaviors resolve
- **If a care companion needs to step away from their assignment or direct observation, then they must contact the charge nurse, RN, or another NSA prior to leaving for coverage.**

1:1 Care Companion

The Continuous Observation Care order for 1:1 Care Companion contains the following criteria:

Inclusion Criteria:

- Patient on suicide precautions
- Patients with restraints for self-destructive or violent behavior
- Patients with intracranial electroencephalogram (EEG) leads
- Patients under forensic/security guard supervision.
- Involuntary Mental Health Admission as recommended by Psychiatry Services
- Patient for whom remote video monitoring or cohort care companion monitoring has been ineffective.
- Other indications demonstrating additional need for continuous monitoring related to psychosocial needs (e.g., safe haven from trauma, abuse, etc.).

Exclusion Criteria: None

HUDDLE CARD
Falls Committee – March 2023

Order Updates

- Below are updates to the Continuous Observation Care Order that will be placed in Epic.
- Comments will include inclusion and exclusion criteria for each order that is within the updated Direct Observation Order Protocol.
- Video EEG Monitoring selection needs a 1:1 Care Companion as indicated based on patient's age and device use. This will also be listed within the comments of this order.
- Sign the Epic order for "**Continuous Observation Care**" as "**Per Protocol"** when placed.

Agile MD Algorithm

An algorithm will be built in Agile MD to also help nurses determine which type of Continuous Observation Care order is best based on inclusion and exclusion criteria. Links to the order will also be available within the algorithm.

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Falls Committee – April 2023

EVENT REPORTING FOR FALLS

Although we want to prevent falls from happening, it is important to learn how to document when this happens in our Event Reporting System. Clear but concise explanations are very helpful for appropriate follow-up. The nature of this is non-punitive as explained below.

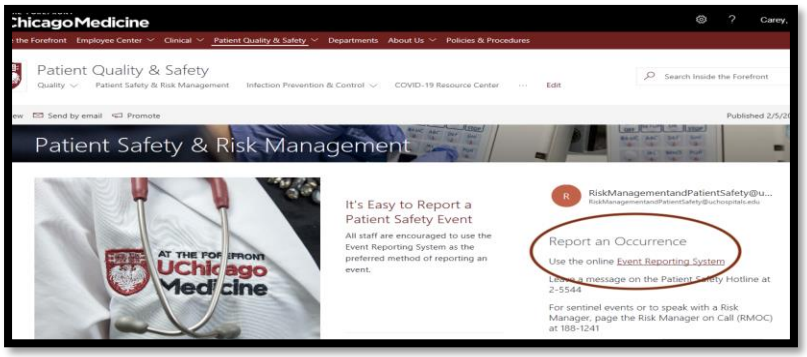
Culture of Reporting: Joint Commission

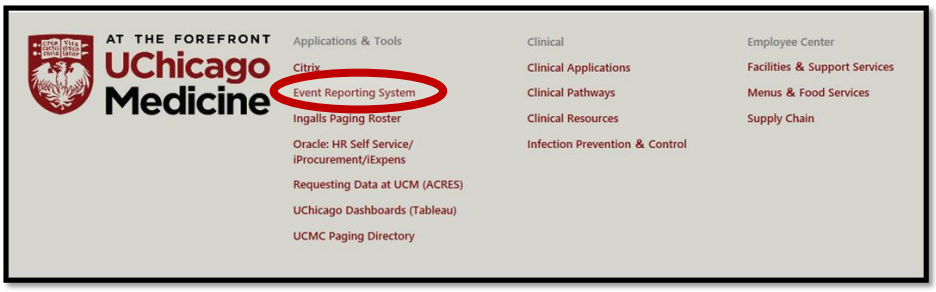
- Emphasizes value of reporting near miss & unsafe condition events (triggers improvements & learning)
- Acknowledges the necessity of anonymous reporting (fear of blame & shame)
- Demonstrates the benefit of self-identification (reporter feedback)
- Employs the **Just Culture Algorithm** during event analysis (**fair & impartial** resolution)

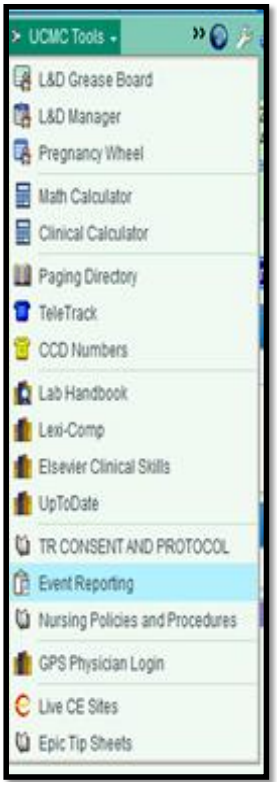
HUDDLE CARD
Falls Committee – April 2023

How to Submit the Report

- Go to "Patient Quality & Safety" page on the intranet or within UCMC Tools in Epic

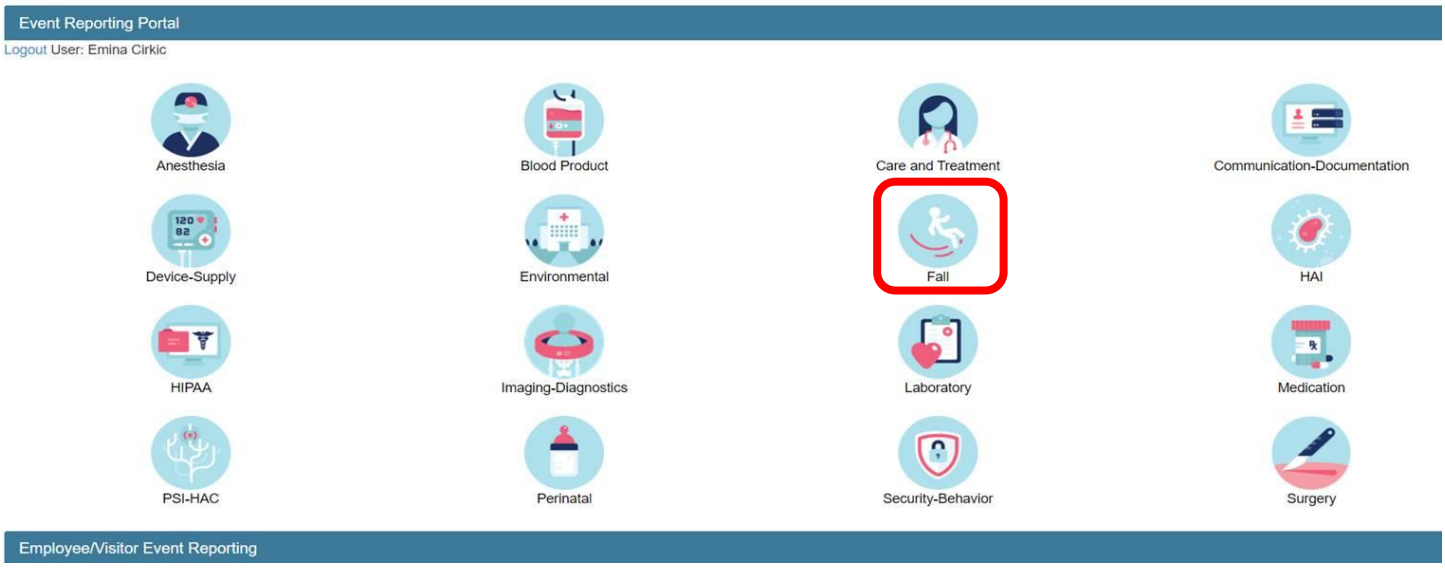






For Patient Falls, Select the "Fall" Event Report Category

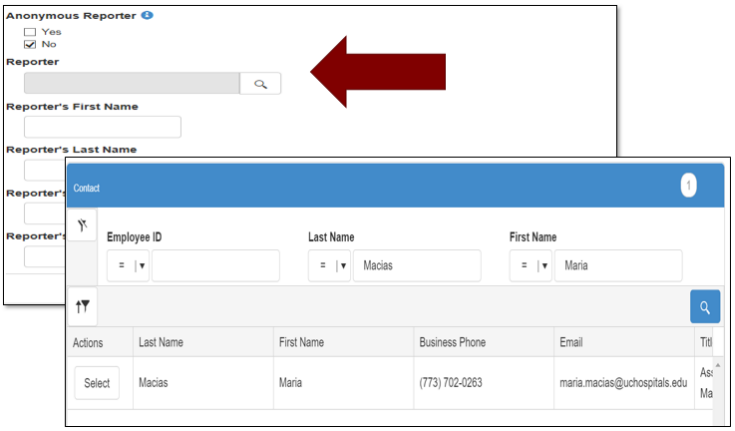
For employee or visitor falls, select "Employee/Visitor Event Reporting" instead.



HUDDLE CARD
Falls Committee – April 2023

Event Reporting Portal

The more information you list in the narrative section to describe what happened helps determine the nature of the fall. More information than "unwitnessed fall" or "patient fell" helps with the follow-up process. Include any injury-suspected, observed or reported by patient and any imaging ordered.



Tips:

- Identifying yourself allows for leaders to provide feedback or investigate further
- Don't assume someone else is submitting an event report
- You will receive an acknowledgement email confirming receipt of your report only **IF** you identify yourself using the look-up function.

- Once you click submit, the system will acknowledge the data upload and issue an event #. Use this event # to track your report.
- You will also receive an acknowledgement email confirming receipt of your report.
- The leaders of the identified departments will receive the event to review and investigate if appropriate. Leadership can provide update of event follow-up by other leaders.
- After the event review is completed and closed, you will receive another email notifying you of the review conclusion.
- Contact your leadership team if you wish to discuss outcomes of follow-up or would like to participate in the bi-weekly falls debrief where staff comes together to brainstorm on ways to prevent future falls as a team.

Immediate Steps from a Harm Event

- **TAKE CARE OF YOUR PATIENT**. After a harm event, first and foremost: Take care of the patient. Identify any immediate actions to mitigate the harm to the patient and prevent any further decline in the patient's condition.
    - Maintain or re-establish trust (if possible – never stop trying)
    - Determine one main point of contact from the clinical team for the patient/family
    - Stay in touch. Offer comfort and support. Avoid communicating speculations or finger pointing until after a thorough quality review is completed.
- **Be Supportive** "The worst events often happen to the best clinicians…."
    - Do not gossip, criticize, judge or place blame. The odds are – You may be in this situation at least once in your career.
    - ***Perspectives***: Individual and group counseling

HUDDLE CARD
Falls Committee – November 2022

SAFETY ALARM CONNECTIONS

Oftentimes patient bed or chair alarms become disconnected from outlets. This is unsafe because proper connection is required for alerts to the healthcare team if a bed alarm is sounding. Connected alarms can provide the opportunity for a quicker response by alerting the team through the nurse call system. Below are photos of connections. Best practice is to ensure these are in place upon rounding, bedside handoff and patient arrival or transfer.

Correct Bed Exit Alarm Connection

Please make sure the portion with the orange arrows from the cords are connected. The cord coming from the orange arrow must connect to the wall. This is in addition to the power outlets that connect to the bed.

Correct Connections for Bed Alarm Activation

Bed Connection to Cord	Cord Connection to Wall
	

Examples of Missing Cord

Missing Connection	Missing from Outlet
	

If a cord is missing, inform your leader or charge nurse. Bed should be tagged as broken then call EVS for a new bed by calling Extension 55537. This needs to be a high priority, especially if your patient is a high-fall risk and escalate to EVS leadership. If the outlet is broken and prongs do not connect, notify plant via the intranet under UCMC Facilities by clicking here. Make sure leadership and charge nurse are notified of any rooms with broken outlets for follow-up, along with ticket information.

Videos on Hillrom Beds

You can review videos on the Hillrom beds that UCM has by scanning the QR codes or clicking on links below.

Hillrom Centrella® Smart + Bed (Newer Model)	Hillrom Advanta™ 2 (Older Model)
Video: Click here or scan QR code	Video: Click here or scan QR code
Bed exit alarm is during the 3:21- 6:50 time on video	Bed exit alarm is during the 8:12-10:52 time on video

Questions? Contact your Falls Champion or Falls Committee Chairs at UCM-FallsCommiteeChairs@uchicagomedicine.org

HUDDLE CARD
Falls Committee – November 2022

Correct Chair Alarm Connection

To ensure there is timely notification if a patient gets up from a chair, the chair alarm device must connect to the wall. Scan the QR code to review other proper connections with this device.

Connection to Wall Outlet	Connection to Chair Alarm	Scan QR Code to View Chair Alarm Video
		

Missing Chair Alarm Cords

If you have missing cords that plug into wall outlets for bed or chair alarms, please contact your leader to order another cord.

Questions? Contact your Falls Champion or Falls Committee Chairs at UCM-FallsCommiteeChairs@uchicagomedicine.org

HUDDLE CARD
Falls Committee – November 2022

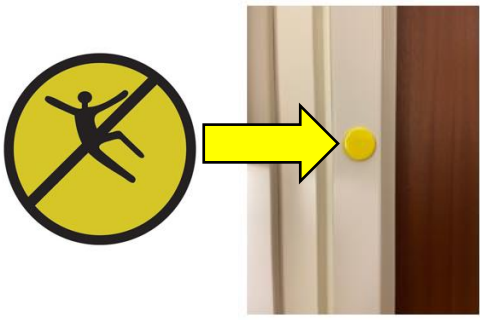
AMBULATORY FALL PREVENTION

There has been a recent increased rate of falls in ambulatory departments. Below are some tips that can help prevent falls in your locations.

Fall Risk Magnets

Place these magnets on doorframes when patients are screened positive for a fall risk. Does your department have these? If not, your leader can order them from this website under the category named "Office and Technology."

Product Catalog - UChicago Medicine [102] (agoracxmp.com)



Avoid Leaving Fall Risk Patients Unattended in Exam Rooms

Patients that are at high risk for falls should not be left unattended in exam rooms with the door closed. Please leave exam rooms slightly open when appropriate while the patient is waiting. Explain this is for the "patient's safety" to prevent falls. Allow a caregiver to accompany the patients in exam rooms when needed.

Screen for Fall Risk Early

There are some indications that immediately place a patient at risk for falls. Early prompt identification can prevent falls. Does your patient have a walker or cane? Are they limping into their visit? Place a fall risk band on early and educate the patient to get up with assistance. Inform staff before rooming the patient if they are a potential fall risk. This can help with safe assistance to the room and during their visit.

Be Safe when Weighing Patients and Other Clinic Activities

Some patients might get dizzy with standing or unsteady when stepping onto a scale. Be alert during transferring to and from chairs, sitting to standing and weighing patients. Unsteady patients may need more guidance during care that requires patient movement.

Small children and infants must be attended when on carts or tables. When caregivers are present with infants, make sure the patient is secured or held properly before leaving the room.

Questions? Contact your Falls Champion or Falls Committee Chairs at UCM-FallsCommiteeChairs@uchicagomedicine.org

HUDDLE CARD
Falls Committee – December 2022

PURPOSEFUL ROUNDING TO ENGAGE PATIENTS

Patient engagement is important for fall prevention. Here are tips on communication methods to use when performing bedside rounding and shift report. RNs can round on patients during odd hours and NSAs on even hours. Evidence shows that hourly rounding can decrease falls.

Eight Behaviors of Purposeful Rounding

We will review many of these points in this huddle card and other aspects of care related to communication, patient engagement and fall prevention for your patients.

1. Acknowledge the patient
2. Deliver scheduled interventions
3. Address the 5 Ps
4. Assess additional personal comfort needs
5. Conduct environmental safety check
6. Offer additional assistance
7. Inform the patient of return time
8. Documentation

1. Acknowledge the Patient Using AIDET Skills

Knock on door for permission to enter

- **A *cknowledge the patient***
- **I *ntroduce yourself***
- **D *uration (time)***
- **E *xplain why you are there***
- **T *hank you***

"We do hourly rounding at UCM so either myself or your NSA will routinely visit you to make sure your care needs are met. When we come in for rounding while you are sleeping at night, we will do our best to avoid disturbing you if your condition allows. ***Your safety is our highest priority.****"*

2. Toileting and Assistance

- Staff should remain at **arm's length** of the patient when on toilet or bedside commode.
- **Toileting schedule** to help create a routine and prevent falls. **Do not leave the room.**
- If patient is concerned about their privacy, respond with ***"My first priority is to keep you safe."***
- Saying to the alert & oriented patient: ***"I will keep a foot in the door to help when you are finished."***

"Let me assist you to the washroom ***now*** *so that we can go at your own pace and not rush later."*

3. Address 5 Ps

Be proactive!

- **POTTY-**Toileting assistance
- **PAIN-** 0-10 scale, comfort & notify the RN
- **POSITIONING-** Mobility
- **PATIENT/FAMILY-** Education on fall risk
- **PUMPS-** IV, Equipment in the room, items in reach

"If you do need to change positions or get up to the chair, please call your nurse. ***Our goal is to maintain your safety and we do not want you to fall****."*

HUDDLE CARD
Falls Committee – December 2022

4. Assess & Meet Additional Needs

- Comfort needs
- Blanket, pillows, phone
- Water and ice
- Other personal items

*"My name is _____ and I am your nurse. I want to fulfill your needs and **ensure your safety**. At UCM, **we want to prevent you from falling** and provide an excellent experience."*

"Let's make sure your personal items, phone and call light are within reach."

5. Environment Safety Check

- Chair, bed alarm are on and connected to nurse call system
- Room is safe & clutter-free
- Items within reach – call light, urinal, phone
- High fall risk signage, fall band on, anti-skid footwear on & fall commitment signed
- Bed low and locked with two side rails up as appropriate for patient/age

*"We like to keep a clutter-free room to **prevent you from falling**."*
*"Please call for assistance to get up so we can help and **prevent you from falling**."*

6. Offer Additional Assistance

- Communicate with family members of patients that are at risk for falls that UCM staff needs to assist the patient.
- **Inform them we do this because we care and it is for patient safety.**

*"My first priority is to keep your family member **safe**."*

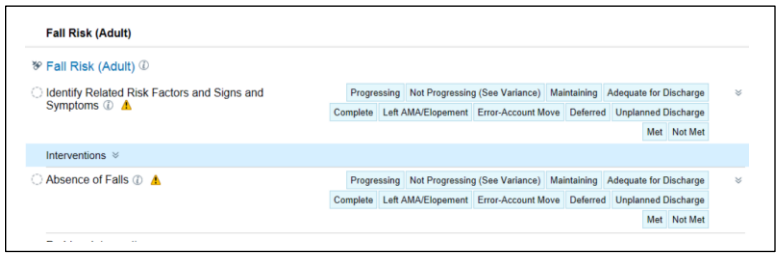
*"Either myself or the NSA will be rounding on you in about one hour. If you need anything before our return, **please use your call light**."*

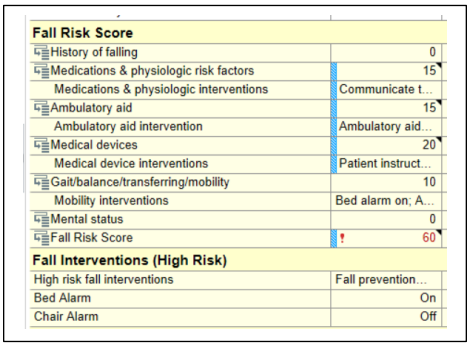
7. Staff to Staff Communication

- If a patient at high risk for falls, the RN should communicate this to the NSA **right away**.
- Reinforce high fall risk interventions upon patient arrival, shift report, and when changes occur.

8. Document

- Make sure to add the Fall Prevention Care Plan in Epic
- Document your fall risk score & appropriate interventions





University of Chicago Medical Center
Protocol Memo Letter

Date: June 23, 2020
To: Medical Executive Committee
From: Ben Laughton, Executive Director of Clinical Professional Practice and Informatics
Mary Ann Francisco, MSN, APN, AGCNS-BC, CCRN-K

In Re: Direct Observation Monitoring Pediatric and Adult Inpatients

Purpose of the Patient Care Protocol:
To ensure the safety of our patients at risk for injury or self-harm utilizing either a direct 1:1 sitter or remote visual monitoring of these patients by a trained patient safety tech/visual monitor tech.

Scope: Adult and pediatric inpatients who meet the inclusion criteria.

Additional Information:
Remote video monitoring has been used as a strategy to reduce use of 1:1 care companions for patients at risk for self-injury. Studies using remote video monitoring have demonstrated improved patient outcomes including improved patient satisfaction, decreased sitter hours, and cost savings in several organizations. [1-9]

Who does this policy impact?
Multidisciplinary: MD, APP, RN, NSA, Telehub, Remote Monitoring Technicians

Who has reviewed this protocol?
Nursing Leaders: Alecia Coe, Ben Laughton, Judy Doty
Nursing Directors: Iliana Staneva, Ursula Dolan, Ani Fredericks, Maura Brown, Tamia Walker
Nursing Managers: Travis Gesell, Yonous Turner
CNPPR staff: Mary Ann Francisco, Monica Gonzalez, Stephanie Meletis, Julie Stelzel
Patient Safety Risk Management: Phyllis Turner
Clinical Practice Informatics and Policy Committee
Interprofessional Quality and Safety Committee
Inpatient Operations Quality Committee
Physician Services: Steven Weber, Andrew Davis, Tipu
Puri Neurology Services
Falls Committee
Clinical Engineering

How will this protocol be promulgated and enforced?
RNs and NSAs have been instructed to complete the on-line education in Oracle by March 2020.
Multiple informational sessions have been held with Physician Services, Surgical and Medical Quality, case managers, social work, and other ancillary departments.

University of Chicago Medical Center
Policy & Procedure

Protocol Title: Direct Observation Monitoring Pediatric and Adult Inpatients
Issue Date: June 2020
Revised Date: Annual

PURPOSE OF PROTOCOL:
To ensure the safety of our patients at risk for injury through the use of a 1:1sitter/care companion or remote visual monitor by a trained monitor technician. Remote visual monitors are wireless and portable, with a live feed, and are non-recordable.

Scope: Adult and pediatric inpatients who meet the inclusion criteria.

PROTOCOL TYPE: Patient Care Protocol implemented through a Medical Order by an MD and/or APP.

DEFINITIONS:
Direct Observation Monitoring: The process by which a patient is directly observed either through a 1:1 sitter/care companion or remotely through video monitoring.

1:1 Sitter/Companion: Staff member who has completed training and demonstrated competency to provide 1:1 sitter/companion services as ordered.

Remote Visual Monitoring: The process by which a patient is observed through the use of a camera and remotely observed by a trained patient safety monitoring technician.

Patient Monitor Technician (MT): An employee educated on video monitoring process, and demonstrated competency in monitoring multiple patients simultaneously on remote video monitors.

Non-Intentional Self- Injury: Include but are not limited to the following:

- Pulling and/or manipulation of essential devices: IVs, tubes, drains, oxygen, trach, telemetry, dressings,
- Attempting to get out of bed
- Impulsive behavior
- Impaired Judgment
- Risk for Elopement Fall Risk
- Involuntary Mental Health Admission
- Eating Disorders

Self-Destructive or Violent Behavior: Patients who been identified at risk for self-inflicted bodily harm or suicide, or violent behavior as outlined in policy PC 104 Suicide Screening and Precautions

Forensic Patient: Patients in the custody of police or correctional officers as outlined in policy A02-22 Patients in Law Enforcement Custody

Fall Precautions: Patients who have been identified as "High Risk: as defined by policy PC 149 Fall Prevention.

REMOTE VISUAL MONITORING PATHWAY

Inclusion Criteria:

Patients who are at high risk for non-intentional self-injury which include but are not limited to the following:

- Pulling and/or manipulation of essential devices: IVs, tubes, drains, oxygen, tracheostomy, telemetry, dressings
- Attempting to get out of bed
- Impulsive behavior
- Impaired Judgment
- Fall Risk
- Eating Disorders

Exclusion Criteria:

- Patient on suicide precautions
- Patients with restraints for self-destructive or violent behavior
- Patients with intracranial electroencephalogram (EEG) leads
- Patients under forensic/security guard supervision.
- Risk for Elopement
- Involuntary Mental Health Admission

1:1 SITTER/CARE COMPANION PATHWAY

Inclusion Criteria:

- Patient on suicide precautions
- Patients with restraints for self-destructive or violent behavior
- Patients with intracranial electroencephalogram (EEG) leads
- Patients under forensic/security guard supervision.
- Risk for Elopement
- Involuntary Mental Health Admission

Exclusion Criteria:

None

DEPARTMENTS:

This patient care protocol is being sponsored by the Nursing Department in Collaboration with support from the Chief Medical Officer and the Executive Medical Director for Clinical Operations. Remote visual monitoring will be limited to those units with the equipment and capacity to perform this protocol.

PROCEDURE:

1. As part of daily and ongoing assessments, RN identifies need for Direct Observations Monitoring
2. RN notifies First Contact Provider patient's need for Direct Observation Monitoring
3. RN/MD/APP Places Medical Order for Direct Observation Monitoring
4. Utilizing the attached algorithm, the RN in collaboration with Nursing leadership (i.e. Patient Care

Manager/Assistant Care Manager) identifies which observation method should be utilized for the patient.

Initiation of 1:1/Care Companion Pathway

1. Nursing Leadership Notifies Staffing Office
2. RN notifies patient and family of need.
3. Staff member who has completed training and has passed the annual CBT to provide 1:1 sitter/companion services assigned.
4. Staff member documents as required.

Initiation of Remote Visual Monitoring Pathway:

1. RN Responsibilities:
    - Review algorithm for need for continuous video monitoring
    - Assess patient, attempt alternatives before obtaining approval from nurse leader for video monitoring
    - Call video monitor technician and request a video monitor for the specific patient.
    - Provide report to video monitor tech regarding patient history and indication for video monitoring.
    - Provide patient and family education regarding video monitoring equipment and process.
    - Initiate the video monitoring in the patient room, plug monitor into red outlet.
    - Provide report to charge RN regarding patient behaviors and response to video monitoring
    - Respond to VMT calls, stat alarms in patient room
    - Notify VMT of interruptions to remote video monitoring (patient privacy, patient off unit, etc)
    - Notify VMT for discontinuation of video monitoring and need to retrieve monitor
    - Re-assess need for continued remote video monitoring every shift
    - Documentation:
        1. Document assessment of patient behaviors and response to video monitoring
        2. Document use of video monitoring in care plans
        3. Document patient family education regarding video monitoring equipment and process

Continue to assess & Reassess the patient for factors that may be contributing to the observed behaviors. These may include but are not limited to the following:

- Pain/Discomfort/Hunger/Thirst
- Poor nutrition Electrolyte Imbalance
- Bowel and Bladder Issues
- Infection
- Alcohol or Drug Withdrawal
- Medication Side effects
- Sensory Impairment
- Altered fluid status
- Altered Oxygenation
- Metabolic Issues

Continue as indicated the following:

- Fall Precautions/Chair Alarm
- Provide calendar/clock
- Bundle Nursing Care
- Establish rounding schedule
- Provide patient/family education
- Distraction /diversional activities
- Move Patient Closer to Nursing Station
- Provide Reality Orientation
- Ambulate with Assistance
- Initiate sleep schedule/Nap time
- Engagement of family
- Remove any unnecessary tubes
- Assign Consistent Care Givers
- Reorient/Redirect
- Establish toiling schedule
- Reduce Stimuli
- Encourage family participation
- Camouflage/s secure tubes

2. Patient Monitor Technician is responsible for the following:

Equipment Management and Maintenance

- Enter patient data into video monitoring console and central station monitor
- Obtain video monitor from the specific storage area and sign out monitor on log
- Deliver video monitor to clinical unit
- Retrieve video monitors from clinical areas after use
- Clean and store video monitors in designated area
- Maintain log of all video monitors in use with specific patients and in storage

Clinical Care:

- Obtain phone numbers of RN, NSA and unit charge nurse
- Obtain SBAR report regarding patient and reason for video monitoring.
- Introduce self to patient/family via microphone when video monitoring is initiated
- Use voice activation (microphone) to call into patient rooms and re-direct patient to safe behaviors.
- Notify RN if patient is out of camera view
- Notify RN if patient is not responsive to voice redirection.
- Notify charge nurse/nurse leader of problems with RN/NSA response to calls
- Notify RN and NSA of technical issues with video monitor
- Initiate STAT patient assist alarm if patient is in imminent danger
- Record frequency of voice directions and calls to RN/NSA hourly on supplied log
- Record patient activities, response and events
- Provide handoff report to replacement VMT prior to breaks and shift change.

3. The NSA is responsible for the following:

- Assure video monitor is functioning in the patient room, plugged into red outlet.
- Respond to VMT calls, STAT alarms
- Document patient behaviors and response to video monitoring
- Transport video monitor with patient when transferred to another inpatient nursing unit

4. Escalation Process:

- Remote Monitor Technician calls to NSA, if no answer, calls to RN, if no answer, calls to charge nurse
- At any point, if patient is in imminent danger, Remote Monitor Technician may sound the ALARM, call RRT/Dr. Cart

5. Cleaning the Video Monitor:

- The camera and stand should be cleaned and sanitized with an antimicrobial product after each patient use following manufacturers' recommendations.
- Refer to IC 02-09 for further information.

6. Storage: All video monitors will be stored in DCAM 0013 when not in use.

7. Documentation: Nursing care plans and notes should reflect the use of video monitoring cameras for patient safety.

8. Criteria for Discontinuing Video Monitoring

- Consistently more than 3 VMT calls to RN/NSA in 30 minutes.
- Requires such close supervision from VMT, that VMT is unable to watch other patients
- Any complicating event that could harm the patient
- Absence of harmful self-injurious behaviors
- Equipment malfunction/failure

9. Downtime Procedures

A. Unplanned Downtime:

1. In the event of downtime (the inability to visually remotely monitor patients), each patient currently on a remote video monitor will be evaluated by the RN and will follow downtime procedure.
    - Video monitor staff's first line of action is to notify the RN on unit if device or software is not working correctly. Patient safety is first priority. Clinical staff is notified immediately if viewing of patient is lost.
    - Video monitor staff should then contact the patient care manager (PCM) or assistant patient care manager (APCM) (after hours, weekends, holidays) via pager to report downtime.
    - Video monitor staff will initiate basic trouble shooting as directed by AvaSure Trouble Shooting manual.
    - Video monitor staff will notify hospital IT Support or AvaSure Support if needed.
    - Video monitor staff will keep nursing units updated on progress of trouble shooting.
    - If downtime is anticipated to be longer than 15 minutes, monitor staff will notify PCM or APCM and/or AvaSure program lead to initiate contingent plan for monitoring the patients who are affected.
2. Video monitor staff will document action steps for downtime.
3. Unit RN will collaborate with unit nursing leadership to determine process to maintain patient safety.

B. Planned Downtime:

1. There may be times when downtime is planned and/or scheduled for software updates and/or hospital network updates. Hospital IT and AvaSure clinical program lead must approve any scheduled downtime.
    - At least 24 hours prior to downtime, Hospital IT and the PCM must ensure all clinical staff is aware and there is a plan in place for patient safety.
    - Video monitor staff will confirm that coverage for the patients is in place prior to system downtime.
    - Video monitor staff and patient care manager or HOA will authorize the facility and/or AvaSure to commence with downtime.
    - When downtime is complete, video monitor staff and PCM/APCM will confirm that system has been restored and all patient information is still accurate.
    - Video monitor staff and PCM/APCM will inform clinical staff that system is restored.

ATTACHMENTS

Algorithm: Direct Observation Monitoring Pediatric and Adult Inpatients

CROSS-REFERENCES:

A02-11 Photographs and Other Images

PC 104 Suicide Risk Screening
PC 149 Fall Prevention
PC 27 Restraints & Seclusion

INTERPRETATION, IMPLEMENTATION, AND REVISION:
The Nursing Department is responsible for the interpretation, implementation and revision of this protocol.

REFERENCES:
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9. Votruba, L., Graham, B., Wisinski, J., & Syed, A. (2016). Video monitoring to reduce falls and patient companion costs for adult inpatients. Nursing Economic$, 34:(4), 185-18.

Algorithm: Direct Observation Monitoring

Patient Demonstrating Behaviors Indicating Need for Direct Observation Monitoring → No → Continue Patient's Current Care Plan

↓ Yes

1. Notify PCM/ACM/CNS/Charge Nurse
2. Notify First Contact Provider
3. Direct Observation Monitoring

↓

Does Patient Require Implementation of Remote Visual Monitoring Pathway? → No → Initiate 1:1 Sitter/Care Companion Pathway

Inclusion Criteria:

Patients who are at high risk for non-intentional self-injury which include but are not limited to the following:

- Pulling and/or manipulation of essential devices: IVs, tubes, drains, oxygen, trach, telemetry, dressings
- Attempting to get out of bed
- Impulsive behavior
- Impaired Judgment
- Fall Risk
- Eating Disorders

Exclusion Criteria:

- Patient on suicide precautions
- Patients with restraints for self-destructive or violent behavior
- Patients with intracranial electroencephalogram (EEG) leads
- Patients under forensic/security guard supervision.
- Risk for Elopement
- Involuntary Mental Health Admission

↓ Yes

Initiate Remote Visual Monitoring Pathway

IMPORTANT: Continue to Assess & Reassess Patient for Behaviors Contributing to the need for Direct Observation. This may include but not limited to the following:

- Pain/Discomfort/Hunger/Thirst
- Alcohol or Drug Withdrawal
- Altered fluid status
- Poor nutrition Electrolyte Imbalance
- Medication Side effects
- Altered Oxygenation
- Bowel and Bladder Issues Sensory Impairment
- Metabolic Issues
- Infection

IMPORTANT: Continue Nursing Care as indicated

- Fall Precautions/Chair Alarm
- Move Patient Closer to Nursing Station
- Assign Consistent Care Givers
- Provide calendar/clock
- Provide Reality Orientation
- Reorient/Redirect
- Bundle Nursing Care
- Ambulate with Assistance
- If appropriate, establish toiling schedule
- Establish rounding schedule
- Assess need to remove any unnecessary tubes
- Camouflage/s secure tubes
- Initiate sleep schedule/Nap time
- Reduce Stimuli
- Engage Child Life/Volunteers to provide distraction and/or diversional activities
- Engage family& encourage family participation
- Provide patient/family education

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Clinical Professional Practice

Avasure Tip Sheet

This tip sheet will assist staff with safety in utilization of Avasure Remote Monitoring Device

Do's

- **Do** be prepared to give report when calling to admit a patient to AvaSure.
- **Do** keep all necessary safety precautions in place i.e. bed and chair alarm.
- **Do** call the AvaSure Tech (53833) to confirm visual before leaving the patient alone.
- **Do** call the AvaSure Tech (53833) if you would like privacy and let them know approximate time frame.
- **Do** call the AvaSure Tech (53833) at the beginning of your shift and as needed to provide any pertinent updates (i.e. patient is no longer NPO or patient now has restraints).
- **Do** answer any calls from the AvaSure Tech in a timely manner as this is their means of communicating with you to help prevent any adverse events from occurring.
- **Do** call if you need to move the AvaSure monitor to confirm it is still in a good location for visualization.
- **Do** respond as quickly as possible when a Stat Alarm is active – if this alarm is sounding, the patient is at high risk for having an adverse event. Staff response time should be <19 seconds.
- **Do** educate patient and visitors on what the AvaSure Monitor is.
- **Do** call and let the AvaSure tech know if the patient is ready to be discharged. Clean and bring the monitor to the nursing station as the AvaSure Techs don't go into patient rooms.

Don'ts

- **Don't** unplug the camera without calling the AvaSure Tech. This deletes the patient from the AvaSure system.
- **Don't** talk or wave at camera to get the AvaSure Tech attention. Please call 53833. The AvaSure Tech can only hear in 1 patient's rooms at a time and can be monitoring up to 12 patients at one time.
- **Don't** cover the camera or move behind curtains for privacy. Please call 53833 to activate the privacy mode.
- **Don't** forget to call when you want the AvaSure Tech to turn off privacy mode. This is important for patient safety. When in privacy mode, no one is watching the patient.
- **Don't** leave a Fall Risk patient unattended on the bedside commode.
- **Don't** leave the patient sitting on the side of the bed, get them up to the chair.

Thanks for helping us keep our patients safe. Please call 53833 if you have any questions!

06.03.21/Telehub Staff, Y. Turner, D. Miller, R. Perdue, J. Hernaez, I. Staneva, S. Meletis

AvaSys®
The TeleSitter® Solution

QUICK REFERENCE GUIDE

THE AVASYS TELESITTER

- Provides continuous visual monitoring of patients by trained monitor staff
- Meets HIPAA and patient privacy requirements
- Has a Privacy Mode which can be activated by monitoring staff during patient care
- Indicates monitoring is active when the LED light on the device is **ON**. Privacy Mode is enabled when the privacy light on the device is **OFF.**
- **Does not record** audio or video
- **Does not replace** the nurse call button
- **Does not replace** current safety measures

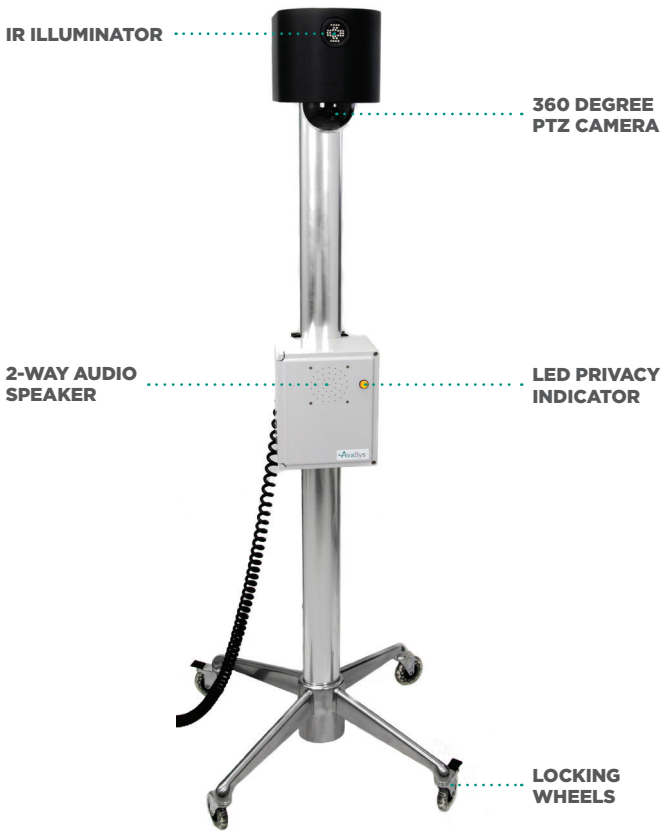
CLINICAL STAFF RESPONSIBILITIES

- Selects patient to be monitored using criteria outlined in the hospital policy and procedure
- Initiates monitoring per protocol
- Provides education to the patient and/or family
- Oversees communication between clinical staff, monitoring staff and patients
- Notifies monitor staff when patient will be out of the room
- Requests activation of Privacy Mode when appropriate
- Continuously reassesses patient monitoring needs
- Responds to patient needs as requested by monitoring staff
- Recognizes and responds to Stat Alert Alarm activation
- When appropriate, discharges patient from AvaSys monitoring per protocol

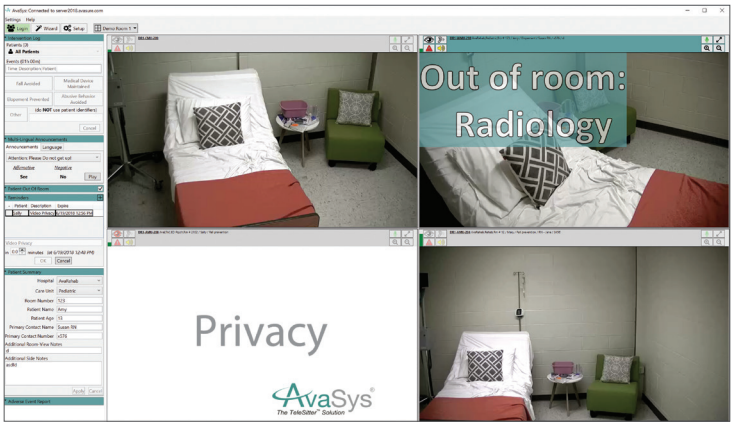
MONITOR STAFF RESPONSIBILITIES

- Provides continuous monitoring for assigned patients
- Interacts with patients per protocol using two-way audio
- Communicates observations and interventions to patient care team
- Deploys patient care team to the bedside when appropriate
- Enables Privacy Mode at request of patient care team
- Activates Stat Alert Alarm per protocol

AVASYS MOBILE UNIT (AMU)



MONITOR STATION VIEW



AvaSure

Project Walk

Collaborative effort to mobilize patients throughout the institution

RN/NSA complete Mobility AM-PAC assessment when the patient is admitted and once per shift during admission

- Score of ***19 or more*** is a Nursing Led mobility program
- Score of ***18 or less*** PT and/or OT consult requested and collaborate on mobilizing patient

This will help us guide resources for therapy to patients with lower level mobility.

AM-PAC Assessment & Scoring

Responses should reflect patient's ability to perform activity **without** aid from equipment or person

"Difficulty" Items

Select "can't do" if patient cannot perform activity

Select "a lot" if patient struggles or requires extra time/effort

Select "a little" if patient can perform but takes more effort than you think the activity should take

Select "none" if the patient has no problem

"Help from another person" Items

Total = total assist/patient dependent

A lot = Max/Mod Assist

A little = Min/Guarded/Supervision

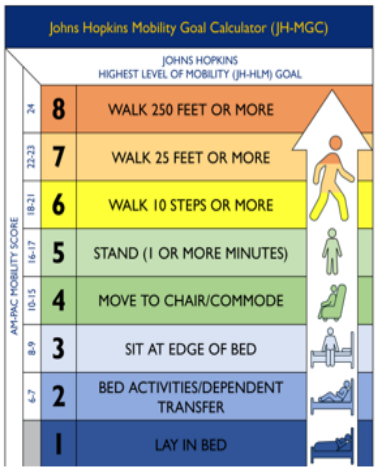
Set a Mobility Goal with Each Patient Every Day!

PATIENT GOAL

Current JH-HLM:_____

Goal JH-HLM:_____

Date:_____ AM / PM



At the start of your shift, set a goal ***with*** your patient for their mobility for the day. Using the AM-PAC score, identify the distance with your patient.

*Remember to use a gait belt to mobilize your patients!

Success "Must Haves"

- ✓ **AM–PAC Mobility Score**: Assess & Document by 11am/11pm
- ✓ **Ambulation/Mobility**: Goal TID – Every patient Every Day!
- ✓ **Distance:** Document, document, every foot counts use the **DAILY CARE FLOWSHEET** to document distance walked and **NEEDS ASSESSMENT FLOWSHEET** to document the AM-PAC mobility score
- ✓ **Mobility Goal Calculator:** Update in room every shift & PRN
- ✓ **Patient Education**: Provide Tracking Handout, engage patient
- ✓ **Airborne/Droplet Precautions**: Ambulate in room only
- ✓ **Safety**: Utilize gait belt

NSA Workflow

1. Add **Project Walk** or **AM-PAC Column** to your EPIC Brain
2. 0700/1900 Huddle with Charge RN to identify patents with ambulation needs
3. Communicate mobility plan at hand-off with RN/NSA
4. Update **Mobility Goal Calculator** in room EVERY shift & PRN
5. Document Ambulation/Distance and Activity in the **DAILY CARE FLOWSHEET**
6. **Utilize Gait Belts**

RN Workflow

1. Add **Project Walk** or **AM-PAC Column** to your EPIC Brain
2. Calculate and Document **AM-PAC score** under daily **ASSESSMENT FLOWSHEET** by 0900/2100
3. **Contact Provider** for:
    - AM-PAC score $\leq$ 18 for an order for PT evaluation
    - Bedrest Order clarification
4. **Communicate Progressive Mobilization Plan** at:
    - Hand-off: RN/NSA
    - Patient/Family
5. Update **Mobility Goal Calculator** in room EVERY shift & PRN
6. Document Ambulation/Distance and Activity in the **DAILY CARE FLOWSHEET**
7. **Utilize Gait Belts**

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Falls Committee – February 2023- Revised 6.12.23

PROJECT WALK

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- Score of ***18 or less*** contact provider and request PT and/or OT consult and collaborate on mobilizing patient

This will help us guide resources for therapy to patients with lower level mobility and reduce hospital acquired disability, need for post-acute care services, falls and VTE!

#1 Tip Complete your Mobility AMPAC score early in your shift then set a Mobility Goal with Each Patient Every Day!

AM-PAC Assessment & Scoring

Responses should reflect patient's ability to perform activity **without** aid from equipment or person

"Difficulty" Items

Select "can't do" if patient cannot perform activity

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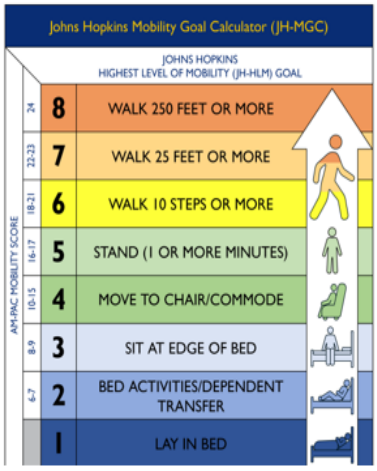
Goal JH-HLM:_____

Date:_____ AM / PM



At the start of your shift, set a goal ***with*** your patient for their mobility for the day. Using the AM-PAC score, identify the distance with your patient.

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#2 Tip Use a Gait Belt When Mobilizing your patient

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HUDDLE CARD

Falls Committee – February 2023- Revised 6.12.23

#3 Tip Document the distance ambulated in the Daily Care Flowsheet

NSA Workflow

- Add Project Walk or AM-PAC Column to your EPIC Brain
- 0700/1900 Huddle with Charge RN to identify patents with ambulation needs
- Communicate mobility plan at hand-off with RN/NSA
- Update Mobility Goal Calculator in room EVERY shift & PRN
- Document Ambulation/Distance and Activity in the DAILY CARE FLOWSHEET

RN Workflow

- Add Project Walk or AM-PAC Column to your EPIC Brain
- Calculate and Document AM-PAC score under daily ASSESSMENT FLOWSHEET by 0900/2100
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Success "Must Haves"

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