STAND STEADI:

Fall Prevention

A Focus on Inpatient Discharge

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So readmissions are a keen area

of focus at our hospital,

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as they are at every hospital in

the United States right now.

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We spend hundreds of thousands

of dollars, millions of dollars trying

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to reduce the risk of readmission,

both in the hospital and afterwards.

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We know that patients, when

they’re admitted to the hospital,

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particularly older adults, often lose

physical function during their stay.

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So, the STEADI initiative that we’ve

been implementing, helps us find

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those patients early and plan for

that post-hospital care earlier in

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their stay so that we’re not surprised

or not aware of loss of function

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on the very last minute of the

last day of their hospital stay.

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They’re of keen importance to

patients as well because when you

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return to the hospital, obviously

something hasn’t gone well and

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you’re often not recovering as

quickly as you would like.

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And a fall is the worst

possible example of that.

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If you go home after being treated for

pneumonia, come back with a fall-related

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injury that seems particularly bad,

and it’s something we hate to see happen.

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The STEADI initiative has been

helpful in giving us a framework

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to plan for that work early.

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Our first step in the STEADI pathway

at UCSF is empowering the nurses to

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use some of the documentation

they’re doing already, in

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addition to the STEADI questions,

to automatically be able to

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consult physical therapists among

patients who are at highest risk.

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That allows the physical therapy

treatment to start earlier.

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The next step is involving physical

therapists in the care of patients

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who are at highest risk,

and those patients,

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the physical therapist sees

them daily to help improve

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their mobility and often assigns

or suggests a place of care after

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hospitalization, like a skilled

nursing facility.

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Or suggesting additional

home supports like home

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physical therapy or home nursing.

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The last step before someone leaves

the hospital, a patient leaves the hospital,

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is the physician is prompted to screen

the medication list and discontinue

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any medications that are harmful.

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At the same time, the physician’s

asked to add information to the

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discharge summary that is tailored

to the patient’s needs around

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post-acute care and access to

community supports like

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physical therapy or Thai Chi.

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That same information goes to

the patient, so they have the same

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education, and they can make

their own choices as they need to.

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This is a key step for us at UCSF.

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The goal really is to make sure

that people leave the hospital

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with better function than

when they came in.

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Our team is really representative

of the UCSF model for quality

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improvement by being really

interdisciplinary.

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Nurses, pharmacists, physical therapists,

physician assistants, nurse practitioners,

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we value all their input equally

because all of us are trying to

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provide the same type of

care to our patients.

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We may do different parts of the care,

but we’re all aiming for the same goal.

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And I think that has been a

really key part in what has made

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this program successful.

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This is about helping patients get better,

and that’s been inspiring for all of us.