NYS PARTNERSHIP FOR PATIENTS

NO HARM ACROSS THE BOARD

For internal use only

CRITICAL CARE UNIT-LEVEL GAP ANALYSIS

BEST PRACTICES	FOCUS AREAS AND PREVENTION STRATEGIES		APPLICATION OF STRATEGIES				ACTION PLAN FOR IMPROVEMENT (Who, What, Where, and by When)
			Always	Usually	Sometimes	Never	
Evidence-Based Risk-Assessments & Screening Tools	Agitation						
	Delirium						
	Falls with Injury						
	Pain						
	Pressure Ulcer (PU)/Skin Breakdown						
	Readmissions						
	Severe Sepsis and Septic Shock						
	Venous Thromboembolism (VTE)						
Protocols	Evidence-Based Care and Maintenance Protocols for:	Central Lines					
		Indwelling Urinary Catheters					
	Criteria for Review of Continued Necessity of:	Central Lines					
		Indwelling Urinary Catheters					
	Evidence-Based Infection Prevention Protocols for:	Environmental Cleaning					
		Staff/Patient Protection (e.g. PPE, Cohorting, Handwashing)					
	Evidence-Based Prevention/ Treatment Protocols for:	Adverse Drug Events (Glycemic, Anticoagulant, and Opioid Management)					
		Clostridium difficile					
		Delirium					
		Falls					
		PU					
		Severe Sepsis and Septic Shock					
		Ventilator-Associated Events					
		VTE					

BEST PRACTICES	FOCUS AREAS AND PREVENTION STRATEGIES		APPLICATION OF STRATEGIES				ACTION PLAN FOR IMPROVEMENT (Who, What, Where, and by When)
			Always	Usually	Sometimes	Never	
Discharge Planning & Readmission Prevention	Standard Hand-Off Process for Transfer from Critical Care to Another Unit or Facility, Including Documentation and Verbal Communication						
	Standard Process for Early Clinical and Care Coordination–Related Referrals (e.g., Social Work, Physical Therapy, Care Management)						
	Assessment and Referral for Palliative Care or Hospice						
	Patient and Caregiver Involvement in Care Plan Development, Are Educated about Transitions						
Quality Improvement	At the Organizational Level	There Is Executive-Level Sponsorship for Quality Improvement Initiatives					
	At the Unit Level	A Mechanism Exists for Designing, Implementing, and Evaluating Quality and Patient Safety Initiatives (e.g., a Critical Care Committee)					
		A Process Exists for Developing, Monitoring, and Communicating Patient-Specific Care Goals					
		An Interdisciplinary Team Addresses Quality, Safety, and Care Coordination					

New York State Partnership for Patients