HRET HIIN HAPI PFE Sprint Session 2

January 9, 2019
12:30 P.M. – 1:30 P.M. CT
WELCOME AND INTRODUCTIONS

Jessica T. Claudio, MBA
Program Manager, HRET
Your HRET HIIN HAPI PFE Sprint Team

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Cynosure

Tara Bristol Rouse, MA
Patient and Family Engagement
Project Consultant
HRET HIIN
AGENDA

- Welcome and Introductions
- Where are we?
- Hospital Pre-assessment Responses related to Skin Inspection
- Skin Inspection Facts and Best Practices
- Hospital Sprinters: What did you discover?
- Questions and Answers
- Bring it Home
Attendance verification

- Name
- Hospital/State Hospital Association
- City, State
Thank you
ANNOUNCEMENTS

- Complete **Hospital HAPI PFE Sprint Pre-Assessment ASAP**
  - Assessment will close on **Friday, January 18th**

- **Submit** completed HAPI PFE Process Improvement Discovery Tool to your State Hospital Association lead no later than **Friday, January 18th**
HRET HIIN HAPI PFE Sprint Webinar Schedule

- January 30, 2019 (12:30PM – 1:30PM CT) – Keep Moving (NEXT)
- February 20, 2019 (12:30PM – 1:30PM CT) – Incontinence/ Moisture
- March 13, 2019 (12:30PM – 1:30PM CT) – Nutrition & Hydration

Please let us know if HRET needs to add any team members to the communication list.
Where Are We?
Jessica T. Claudio,
Program Manager, HRET HIIN
Pressure Ulcer Prevalence, Stage 2+ overall HRET HIIN results

Data submitted to HRET as of 11/27/2018
Percent of Hospitals by Metric:
The figure below shows the percent of hospitals meeting, not meeting or not reporting each PFE metric.

Percent of Hospitals Meeting, Not Meeting, or Not Reporting PFE Metrics, by Metric (n=1,621)

* 188 Hospitals have no scheduled admissions (exempt) and are thus excluded from the PFE1 denominator
HAPI PFE Winter Sprint
Jessica T. Claudio, MBA
Program Manager, HRET
Why Are We Here?

- To use quality improvement techniques to assess root causes of hospital acquired pressure injuries (HAPI) and provide guidance on how to utilize patient and family engagement strategies to address HAPI using evidence-based practices.

- SIGN UP
- SHOW UP
- FINISH UP
- HARM DOWN!
HRET HIIN HAPI PFE Strategy

Keep it Simple

Activate Patients and Families
Partnering with Patients

Focus on the Basics

Skin Inspection
Keep Moving
Incontinence
Nutrition
Hydration

= Healthy Skin

AHA CENTER FOR HEALTH INNOVATION
American Hospital Association
Advancing Health in America
Hospital Pre-assessment Responses

Jackie Conrad, RN, BS, MBA, RCC
Improvement Advisor, Cynosure

Tara Bristol Rouse, MA
Patient and Family Engagement Project Consultant, AHA
Q11: Do you have a formal process to assure skin injuries present on admission are documented? For example, “four eyes” – 2 nurses must confirm, supervisor assesses, “measurevention” – someone checks every chart of new admissions

- Yes: 56% (9/16)
- No: 31% (5/16)
- If no, please explain: 13% (2/16)
Q12: Are skin inspections conducted every shift that include visual inspection for color changes, redness or erythema?

88% (14/16)

12% (2/16)
Q13: Are skin inspections conducted every shift that include an assessment for blanching response, assessment for heat and induration?

- Yes: 75% (12/16)
- No: 6% (1/16)
- Not sure about all shifts: 6% (1/16)
- Other (please specify): 13% (2/16)
Q14: Is a process in place to notify the care giving team, including patient and family, that a Stage 1 HAPI has developed?

- Yes: 56% (9/16)
- No: 38% (6/16)
- Other (please specify): 6% (1/16)
Q28: Are written materials available to teach and reinforce PIP with patients and families, including skin care and hygiene, repositioning, skin inspection and nutrition hydration?

- Yes: 56% (9/16)
- No: 44% (7/16)
Q29: Are patients educated and empowered to fully participate in their PIP, including skin care and hygiene, repositioning, and nutrition and hydration?
Q30: Do you have a process in place to invite patients and family members to participate in bedside care?

- **Yes**: 44% (7/16)
- **No**: 31% (5/16)
- **Not sure**: 25% (4/16)
Q31: Do you conduct prevalence studies?

81% (13/16) Yes
13% (2/16) No
6% (1/16) Not sure
Q32: Do you have a HAPI Champion?

63% (10/16) Yes
37% (6/16) No
Skin Inspection

- Comprises 10-15% of body weight
- Receives approximately 1/3 of the circulating blood volume
- Complex organ with multiple functions, yet dependent on other organs for function
- Primary functions: water balance, body temperature control, immunocompetence, maintenance of vasomotor tone
Skin Inspection Facts

- Facts – only 34% of patients admitted with HAPI POA had documentation present in the chart from the transferring facility.
  - Consistency of pressure injury documentation across interfacility transfers

- Pressure Injuries can be overlooked, undocumented and assumptions could be made the injury has already been reported.

- Early detection matters - Stage One injuries can be reversed by offloading pressure.
Skin Inspection Evidence Based Guidelines

- Increase frequency of inspection to with every position change for high risk or deteriorating patients
  - Assess bony prominences with each position change with special attention to sacrum, ischial tuberosities, greater trochanter and heels
- Inspect skin for erythema or redness
  - Assess if the skin is blanchable or non-blanchable
  - Do not position a patient areas with erythema
- Assess the skin temperature, for edema and consistency related to surrounding tissue
- Inspect around and under medical devices at least once a day

NPUAP 2014 Practice Guidelines
Skin Inspection Best Practices

- Frequent, ongoing education on staging and skin assessment
  - In orientation and in annual skills fairs
  - Build assessment skills beyond visualization – teach palpation and assessment of skin temperature
    - AHRQ Comprehensive Skin Assessment Video – 53 minutes
    - HRET HIIN Recognizing Pressure Injury – 20 minutes
- Engaging unlicensed assistive personnel as skin champions
- Use of photos
  - WOCN Photography in Wound Documentation Fact Sheet
- Access to an expert: “phone a friend”
Four Eyes Assessment

Pressure Ulcer Audit ED Admissions

Wounds/Pressure Ulcer Assessment: Four Eyes Audit Tool

Instructions: ED RN & Admitting RN assess the skin in the anatomical locations designated in the circles. Place your initials on the circle in the area that has a Wound/Pressure Ulcer. Describe any abnormalities.

1. Neck
2. Ear
3. Abdomen
4. Jester Process
5. Shoulder
6. Elbow
7. Rad (Front)
8. Axillaries (Subclavian)
9. Inlet Hypothenar
10. Proximeter
11. Knees
12. Metatarsals
13. Axially
14. Facial

Four Eyes Assessment

1. The following Risk Factors place patients at higher risk for Pressure Ulcers:
   - Braden Score Less than 18
   - Use of Vasopressors
   - Incontinence of Urine or Feces
   - Limited Self-mobility
   - Age 65 or greater
   - Diabetes
   - Prior Recent Hospital Stay
   - Shock/Sepsis
   - Recent Cardiac Arrest
   - History of Pressure Ulcers
   - Going to OR or Multiple Procedures Greater than 6 hours
   - Quad/Para/Hemiplegic
   - Stroke/Paralysis
   - Obese/Cachectic

2. Pressure Ulcer Prevention Intervention Guidelines

<table>
<thead>
<tr>
<th>Area of Risk</th>
<th>Interventions</th>
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<tbody>
<tr>
<td>Reduced Pressure (for decreased sensation, activity, or mobility)</td>
<td>Place patient on Inpatient Pressure Reducing Mattress (Barflex)</td>
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<tr>
<td>Moisture Control</td>
<td>Place patient on overbed air mattress</td>
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<tr>
<td>Friction &amp; Shear</td>
<td>Turn patient Q.2 Hours</td>
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<td>Encourage Good Nutrition</td>
<td>Keep Head of bed less than or equal to 30 degrees</td>
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<td></td>
<td>Use Glide device for transfers</td>
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<td></td>
<td>Offer fluids Q.1 hour</td>
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<td></td>
<td>Set up for meals</td>
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Source: FC/CityMedicalCenter.OceansideCA.2013
Skin Inspection Best Practices

- Educating patients that pain over bony prominences or under devices is an early warning sign of tissue injury
  - Preventing Pressure Ulcers: A Patient's Guide excerpt to right

- Availability of mirrors to check heels, for patients to check sacrum
Pressure Points

Anatomical Locations most frequently impacted by pressure injuries:

- Sacral region
  - Sacrum
  - Coccyx
  - Ischial tuberosity
  - Trochanter
- Heels
- Occiput
Bedside Tools

AHRQ Pocket Pad

Bedside HAPI PFE Tool
## Ensuring Multi Level Patient and Family Engagement (PFE)

### Change Ideas

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<tr>
<th>Metric 1</th>
<th>Metric 2</th>
<th>Metric 3</th>
<th>Metric 4</th>
<th>Metric 5</th>
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<tr>
<td><strong>Point of Care</strong>&lt;br&gt;Implementation Partners:&lt;br&gt;Point of Care Providers, Medical Directors, Nurse Managers</td>
<td><strong>Policy &amp; Protocol</strong>&lt;br&gt;Implementation Partners:&lt;br&gt;Quality and Safety Leaders, Medical Directors, Nurse Managers, Patient Experience Leaders</td>
<td><strong>Governance</strong>&lt;br&gt;Implementation Partners:&lt;br&gt;Board of Directors, C-Suite</td>
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<tr>
<td>As early in the admission as possible, share and review the resource, Preventing Pressure Ulcers: A Patient’s Guide, with the patient/family. Emphasize the important role they play in pressure injury prevention and early detection.</td>
<td>Educate patient/family on how to conduct skin inspections and ask them to record their observations using the Action Chart for Patients, Carers, and Relatives. During daily rounds, review the chart and ask if they’ve noted anything concerning.</td>
<td>Identify a team member in nursing to educate fellow nurses on how to discuss and engage the patient/family in SSkin assessments. Following education, have the team member conduct audits to ensure implementation has been successful.</td>
<td>Invite a former patient/family member who experienced a pressure injury to review your patient/family education tools and provide suggestions for making them easier to understand and use. Make changes to the tools based on their feedback.</td>
<td>Invite Board Members to tour your unit and learn how you are preventing pressure injuries through patient and family engagement. Select one or two patients/family members to share their role in skin inspections with the Board Members.</td>
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**HAPI**

- Planning, tracking for scheduled admissions (Metric 1)
- Staff emerge, number / hours reporting with patients and families (Metric 2)
- Pharmacy leader on hand in the hospital (Metric 3)
- PWCC or representative on hospital committee (Metric 4)
- Patient and family on hospital governing and leadership board (Metric 5)
What did you discover?

Jackie Conrad, RN, BS, MBA, RCC
Improvement Advisor, Cynosure

Tara Bristol Rouse, MA
Patient and Family Engagement Project Consultant, AHA
HAPI PFE Process Improvement Discovery Tool

What trends did you discover?

What did you learn?

What is your action plan?
Share your ideas to test in the chat

- Test on a small scale – one patient at a time and learn
  - ICU - Select one nurse to test completing skin inspection and palpation with each position change with a very high risk patient. Test documentation. Add a second nurse to complete the assessments on another shift.
  - Med Surg –
    - Select one high risk patient to use the picture to identify reddened skin.
    - Test a method to communicate offloading pressure until a red area subsides.
  - Test a two person skin assessment using a mirror to assess heels, inspection, palpation.
  - Select a patient to engage in participating in the skin assessment by providing input on pain. Assess current pain documentation associated with skin inspection.
Attendance verification

- Name
- Hospital/State Hospital Association
- City, State
Questions?

QUESTIONS ANSWERED HERE EVEN THE SILLY ONES
State Hospital Association Submission Deadline

- Hospital HAPI PFE Process Improvement Discovery Tool
  - Today
- Please submit to JClaudio_ct@aha.org
HRET Resources

HAPI Change Package

PREVENTING HOSPITAL ACQUIRED PRESSURE ULCERS/INJURIES (HAPU/I)

HAPI Top 10 Checklist

Top 10 Checklist

Sacral Injury Top 10 Checklist
Resources for Building Front Line Champions

- Complimentary NPUAP webinar recordings:
  - FAQs about Pressure Injury Staging
  - Unavoidable Pressure Injuries, Terminal Ulcers and Skin Failure
  - OR Positioning and Pressure Injury Prevention
  - Why is this wound not healing?
  - Considerations for Bariatric Patients in Pressure Injuries & Wound Care
  - Nutrition & Pressure Injuries
- NDNQI Pressure Ulcer Training
- AHRQ Resources and RN Attitude and Knowledge Assessments
THANK YOU!