HRET HIIN HAPI PFE Sprint Session 4
February 20, 2019
12:30 P.M. – 1:30 P.M. CT
WELCOME AND ANNOUNCEMENTS

Jessica T. Claudio, MBA
Program Manager, AHA Center for Innovation
AGENDA

- Welcome and Announcements
- Pre-Assessment Data on Incontinence and Moisture Management
- I – Incontinence and Moisture Management: Facts and Best Practices
  - Engaging Patients and Family
- Tests of Change
- Common Themes
- Questions and Answers
Attendance Verification

- Name
- Hospital/State Hospital Association
- City, State
HRET Tools and Resources

- HRET HIIN website
  - Change packages
  - Toolkits
  - Webinars
  - Case studies
  - Infographics
  - Guideline
  - Storyboard
  - Reports
ANNOUNCEMENTS

- Thank you to all who submitted your Discovery information.

- If you haven’t done so already, please submit your completed HAPI PFE Process Improvement Discovery Tool to your State Hospital Association ASAP!
HRET HIIN HAPI PFE Sprint Webinar Schedule

- March 13, 2019 (12:30PM – 1:30PM CT) – Nutrition & Hydration (FINAL)

Please let us know if HRET needs to add any team members to the communication list.
Winter 2019 HAPI PFE SPRINT

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

Tara Bristol Rouse, MA
Patient and Family Engagement Project Consultant, AHA Center for Innovation
Winter 2019 HRET HIIN HAPI PFE Sprint Participants
Review of Pre-Assessment (Incontinence & Moisture Management)

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

Tara Bristol Rouse, MA
Patient and Family Engagement Project Consultant, AHA Center for Innovation
Q22: Do staff differentiate moisture associated skin breakdown from Stage 2 injuries?

- Yes: 65% (11/17)
- No: 23% (4/17)
- Not sure: 12% (2/17)
Q23: Are low air loss mattresses used for patients with moisture issues or incontinence?

- Yes: 65% (11/17)
- No: 17.5% (3/17)
- Not sure: 17.5% (3/17)
Q24: Can nurses order specialty mattresses?

- Yes: 76% (13/17)
- No: 18% (3/17)
- Not sure: 6% (1/17)
Chat your ideas, or raise your hand

- What ideas do you have to make conducting prevalence studies achievable in your work area?
Ideas from the last session

- Asks - Areas for more learning:
  - Perioperative pressure injury
  - Standardized HAPI prevalence measure

- Offers
  - KY has team of prevalence experts
  - Infrared technology information
  - RCA process for perioperative HAPI

- Ideas / Learnings
  - Get patients involved – they don’t want a HAPI
  - Get CNAs and Techs more involved
Perioperative Pressure Injuries

Definition: any pressure related tissue injury that presents i.e. non-blanchable erythema, purple discoloration (suspected deep tissue injury) or blistering
• 48 – 72 hours postoperatively
• Associated with the surgical position
Perioperative Pressure Injury Resource

- Chart Audit Tools
- Risk Assessment Tools
- Sample Bundles for High Risk Patients
- Educational Resources

AORN Peri Op HAPI Toolkit
Focus on the Basics

Partnering with Patients

Skin Inspection
Keep Moving
Incontinence
Nutrition
Hydration

Healthy Skin
I – Incontinence and Moisture

Jackie Conrad, RN, BS, MBA, RCC
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Patient and Family Engagement Project Consultant, AHA Center for Innovation
I – Incontinence Moisture

“In high risk individuals, shear/friction and moisture are modifiable but often underappreciated risk factors in pressure injury development.” (Brindle, 2010)
Differentiating Moisture vs. Pressure

**MASD**
- Superficial
- Top Down Injury
- Originates in superficial cutaneous layer
- Caused by prolonged exposure to moisture
- Not included in HAPU/I reporting

**HAPU/I**
- Bottom Up Injury
- Originates in underlying soft tissue
- Caused by prolonged pressure from a bony prominence or medical device
- Included in HAPU/I Reporting

Skill building in differentiating Moisture vs Pressure:
- HRET HIIN Recognizing Pressure Injury – 20 minutes
- HRET Moisture Related Skin Damage Webinar Recording – 60 min
Moisture-Associated Skin Damage

- Inflammation and erosion of the skin caused by prolonged exposure to various sources of moisture
  - Urine or stool
  - Perspiration
  - Wound exudate
  - Mucous or saliva
- Includes intertriginous skin related issues

Incontinence Irritants

- **Urine**
  - *Water*: saturates skin, reduces hardness, increases risk of friction and erosion
  - *Ammonia*: raises pH, promotes pathogenic growth, disrupts acid mantle, activates fecal enzymes
  - Damage can occur within 48 hours

- **Stool**
  - *Fecal enzymes*: damage stratum corneum, promotes erosion, worse in high volume diarrhea
  - *Gastrointestinal Bacteria*: may be pathogenic
  - Damage in 8 hours (possibly less) with high volume diarrhea

I – Incontinence Moisture

- Interventions – Best Practices
  - Low air loss mattress
  - Wicking under pads, no diapers in bed
  - Use mild soap, soft wash cloths, no HOT water
  - Barrier creams

Assessment, Selection, Use, and Evaluation of Body-Worn Absorbent Products for Adults With Incontinence

A WOCN Society Consensus Conference

Mikel Gray, Dea Kent, JoAnn Ermer-Seltun, Laurie McNichol

ABSTRACT

The Wound, Ostomy and Continence Nurses (WOCN) Society charged a task force with creating recommendations for assessment, selection, use, and evaluation of body-worn absorbent products. The 3-member task force, assisted by a moderator with knowledge of this area of care, completed a scoping literature review to identify recommendations supported by adequate research to qualify as evidence-based, and areas of care where evidence needed to guide care was lacking. Based on findings of this scoping review, the Society then convened a panel of experts to develop consensus statements guiding assessment, use, and evaluation of the effect of body-worn absorbent products for adults with urinary and/or fecal incontinence. These consensus-based statements underwent a second round of content validation using a modified Delphi technique using a different panel of clinicians with expertise in this area of care. This article reports on the scoping review and subsequent evidence-based statements, along with generation and validation of consensus-based statements that will be used to create an algorithm to aid clinical decision making.

KEY WORDS: Absorbency, Absorbent pads, Adult diapers, Body-worn absorbent products, Daytime incontinence, Fecal incontinence, Incontinence pads, Nighttime incontinence, Product selection, Urinary incontinence.
I – Incontinence Moisture

- Manage incontinence
- External catheters – male and female
- Penile wrap – holds 500cc
- Fecal collection devices for liquid stool, plus, address the cause
IT'S TOTALLY NORMAL TO FEEL THINGS BECAUSE YOU ARE NOT A ROCK.
Normalize through education...

Essentials of Skin Care for Patients with Incontinence

Incontinence is the accidental or involuntary loss of urine from the bladder (urinary incontinence) or feces from the bowel (fecal incontinence). An estimated 25 million adults in the U.S. experience this medical condition. While incontinence can occur at any age, it is most common in older adults. Urinary incontinence affects more than 30% of homebound elderly persons. Many of these individuals have symptoms and needs that demand regular home-based care.

Family members and friends play an extremely important role in caring for patients with incontinence. One of the main responsibilities of the home-based caregiver is to protect the incontinent patient’s skin—specifically the skin that is exposed to urine and fecal waste—against irritation and infection. This newsletter is intended to familiarize caregivers with treatment options and the essentials of skin care for loved ones who are incontinent.

Causes and Consequences of Incontinence

Many factors are associated with incontinence, including:
- infection and inflammation of the bladder;
- diseases of the nervous system;
- adverse effects of prescription medications;
- prostate enlargement in men; and
- the onset of menopause in women.

In older people, common causes of incontinence are strokes, Alzheimer’s disease, and Parkinson’s disease. In addition, the muscles that control urination (smooth muscle tissue in the bladder) and defecation (the anal sphincter muscles) become weaker as we age. A potential result is accidental leaking.

Incontinence can be devastating to self-dignity and quality of life. Moreover, unmanaged incontinence is a serious health concern. The condition places individuals at great risk for painful skin irritation, ulcers (open sores that resist healing), and dangerous infections in the perineal area—the skin in front of the anus, extending to the vulva in women and to the scrotum in men.

The First Step: Seeking Treatment

Proper, continual skin care is essential for people with incontinence. However, both the patient and the caregiver should not lose sight of the fact that urinary and fecal incontinence can be effectively treated, controlled, and, in many cases, cured through behavioral and medical approaches. Your loved one’s primary care physician may recommend a specialist for developing and administering a treatment plan. You may be referred to a urologist for urinary incontinence or to a gastroenterologist, proctologist, or colorectal surgeon for fecal incontinence. Treatments for incontinence include behavioral methods, medications and, in extreme cases, surgery.

Behavioral Methods. Effective behavioral approaches to treating urinary and fecal incontinence include making regular, scheduled trips to the bathroom and performing special physical exercises that strengthen the muscles controlling urination and defecation. In addition, dietary changes may be recommended. For managing fecal incontinence caused by diarrhea, the patient’s doctor may suggest eating high-fiber foods that naturally add bulk to the feces and make them less watery. These foods include broccolis, carrots, beans, fruits, and vegetables.

Medications for Urinary Incontinence. Often used in combination with behavioral therapy, medications for urinary incontinence include:
- antispasmodic drugs, which suppress contractions of the smooth muscle lining the bladder;
- estrogen therapy, for postmenopausal women; and
- medicines that shrink the prostate, for middle-aged and older men.

One noteworthy concern about antispasmodic drugs is that they cause mental confusion in some individuals.

Medications for Fecal Incontinence. These medications include:
- anti-diarrheal drugs, which prevent watery stool and accidents;
- bowel mobility drugs, which treat incontinence by inhibiting muscle contractions in the bowel;
- mild laxatives, such as milk of magnesia, and stool softeners to restore normal bowel movements in individuals whose incontinence is associated with chronic constipation.
Normalize through MEANINGFUL education...

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Family members and friends play an important role in supporting patients with incontinence. Help your patient keep track of their urine and bowel patterns. Encourage them to eat a high-fiber diet, which can help with bladder and bowel control.

Incontinence can be devastating to self-dignity and quality of life. Moreover, unmanaged incontinence is a serious physical health concern. The condition places individuals at great risk for painful skin irritation, ulcers (open sores that

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Start With What Works

KEY POINTS
1. Incontinence is not an inevitable consequence of old age and should be treated whenever possible.
2. Skin should be kept clean dry and well hydrated.
3. Patients should be encouraged to drink regularly to maintain hydration, reduce the risk of constipation and reduce the concentration of urine.

DO'S AND DON'TS
Do
✓ Perform an assessment using appropriate tools to establish the cause of the problem
✓ Record episodes of incontinence to assess severity
✓ Establish a skin care routine with timely cleansing of soiled and wet skin
✓ Use barrier products if the skin is reddened or broken to act as a barrier to further irritation
✓ Use incontinence products and faecal management systems to help avoid contact with urine and faeces
✓ Smooth incontinence pads prior to use to prevent creases and ridges, which may cause pressure damage
✓ Inspect skin at regular intervals, eg during assistance with personal hygiene
✓ Use foam cleansers when cleansing following episodes of incontinence
✓ Encourage the patient to drink to maintain hydration, which also dilutes the urine
✓ Identify incontinent and immobile patients ‘at risk’ of pressure ulcer development. Pads should be changed during the night and regular positional changes undertaken
✓ Seek advice from the local incontinence advisor

Do not
✓ Use traditional soap and water when cleansing following episodes of incontinence
✓ Use multiple incontinence pads as they are likely to reduce the efficacy of pressure redistributing equipment
✓ Use creams and talcum powders under barrier products
✓ Assume incontinence in the older person is inevitable

GREEN
Where skin is intact and well hydrated: Inspect skin regularly, prevent prolonged exposure to moisture and manage skin temperature.

AMBER
Skin at risk of breakdown: Use appropriate products to maintain skin integrity. Select suitable support surface if due to pressure damage.

RED
Skin has broken down: Document area of damage and assess wound. If the wound is caused by moisture it is more likely to be a moisture lesion. Do not confuse with a pressure ulcer. Ensure you know the difference as all pressure ulcers must be reported (use Safety Cross).
Ensuring Multi Level Patient and Family Engagement (PFE)

<table>
<thead>
<tr>
<th>Point of Care</th>
<th>Change Ideas</th>
<th>Governance Implementation Partners: Board of Directors, C-Suite</th>
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<tbody>
<tr>
<td>Implementation Partners: Point of Care Providers, Medical Directors, Nurse Managers</td>
<td>Select a member of your HAPI improvement team to conduct a focus group with patients and family caregivers who have lived experience with incontinence and HAPI; ask them what they wish they had been told about managing moisture to prevent pressure injuries. Use the provided feedback for staff education and to inform the development of patient and family caregiver education tools.</td>
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<td>Metric 1</td>
<td>Metric 2</td>
<td>Metric 3</td>
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<td>Prior to discharge home, discuss the “Do’s and Don’ts” of skin care with patients and their caregivers; provide easy-to-understand take-home instructions that walk through the types of skin care products to use, as well as when and how to use them.</td>
<td>Establish a skin care routine that engages family caregivers in the timely cleansing of wet and soiled skin, ask them to track occurrences. During nursing shift change, invite the family caregiver to share how often and when skin care was required over the previous shift.</td>
<td>Engage your PFAC to review and utilize key concepts from the HOW TO: Manage Incontinence/Moisture tool to create a patient and family caregiver educational resource.</td>
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AHA CENTER FOR HEALTH INNOVATION

American Hospital Association™
Advancing Health in America
Who is capturing your data?
What questions or comments do you have?
Updates from YOU!

- What have you done since the last sprint session?
- Who are you engaging with in this work?
- What success have you encountered?
- What barriers have you encountered
Tests of Change

Winter 2019 HAPI PFE Sprint Participants
Hospitals and State Hospital Associations
Common Themes

Jackie Conrad, RN, BS, MBA, RCC
Improvement Advisor, Cynosure
Tara Bristol Rouse, MA
Patient and Family Engagement Project Consultant, AHA Center for Innovation
HAPI PFE Process Improvement Discovery Tool

- Please submit your Process Improvement Discovery Tool to your State Hospital Association Today

- State Hospital Associations
  - Please submit the Discovery Tool to JClaudio.ct@aha.org
Preventing Pressure Ulcers

How to Prevent Pressure Ulcers

Pressure Injury Prevention

What you can do:

✓ Move, move!
  • Keep moving as often as you can. Even small movements help.
  • Change your position frequently when in bed or sitting in a chair. Talk to your healthcare professional about position changes.
  • If you are unable to move yourself, the staff will help you to change your position regularly.

✓ Look after your skin
  • Advise staff if you have any tenderness or soreness over a bony area or if you notice any redness, blisters or broken skin.
  • Keep your skin and bedding dry. Let staff know if your clothes or bedding are damp.
  • Special equipment such as air mattresses and cushions may be used to reduce the pressure in particular areas.
  • Avoid massaging your skin over bony parts of the body.
  • Use a mild skin cleanser.

✓ Eat a healthy diet
  • Take nutritional supplements as advised.

For more information, speak with your healthcare professional.

Patients, families and carers are encouraged to be involved in discussions and decisions about the prevention and management of pressure injuries.

Information for patients, families and carers.

Who is at risk: Any one! Any time! Any age!

American Hospital Association™
Advancing Health in America
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
Questions?
THANK YOU!