WELCOME AND INTRODUCTIONS

Lydie Marc, MPH, CHES
Performance Improvement Coach, HRET

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

- Welcome and Introductions
- Why This Matters
- Patient and Family Engagement
- Entry Point Challenges
- Measuring Our Pressure Ulcer Rates and Practices
- Questions and Answers
- Bring it Home
Learning Objectives

- Identify at least one untapped resource in your organization that can support HAPI reductions
- Describe a patient family engagement strategy for HAPI reduction that addresses at least one of the PFE operational metrics
- List opportunities for early intervention at hospital entry points: the emergency department and operating room
- Create a plan to assess the current status of supplies and equipment for HAPI prevention utilizing the HAPI Scavenger Hunt Tool
- Discuss data collection and validation challenges for PrU 1 and 2 and propose solutions
- Commit to a small test of change for HAPI reduction
Poll Question

Who is in the room?

a) Quality Leader
b) Nurse Manager
c) Skin Champion, WOCN, Clinical Specialist
d) Bedside Nurse
e) Physician
f) PFE Advisor
g) Other
Why This Matters

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

Betsy Lee, MSPH, RN
Improvement Advisor, Cynosure
Magnitude of the Problem

- About **1.2 million** cases of HAPI occurred in 2015 – 36.3 per 1000 discharges. **31.6%** of total HACs.

- Patients with a PI have **longer length of stay** (7 vs 3), **higher mortality** (9.1% vs 1.8%) and **higher costs** (Median cost $36,500 vs $17,200)

- More than **17,000** PI related lawsuits (avg cost $250,000) were filed each year. PIs are the second most common claim after wrongful death.

- As of 2008, CMS doesn’t pay for HAPI

- Up to **60,000** Americans die each year as a direct result of PI (47,600 died in 2017 from the opioid crisis)
Who is Your Greatest Resource?

Tara Bristol Rouse, MA
Patient and Family Engagement Project Consultant, HRET
Consider the Touch Points
Ensure Multi Level Patient and Family Engagement (PFE)

Integrating PFE Strategies to Reduce Hospital Acquired Pressure Injuries (HAPI)

Use the table below to identify possible change ideas to help you embed PFE strategies into your Hospital Acquired Pressure Injury (HAPI) prevention efforts. The examples below are designed to focus on specific topic areas of the HAPI prevention bundle, addressing the goals for each of the five PFE metrics while focusing on specific topic areas of the HAPI prevention bundle.

<table>
<thead>
<tr>
<th>Harm Topic</th>
<th>Metric 1</th>
<th>Metric 2</th>
<th>Metric 3</th>
<th>Metric 4</th>
<th>Metric 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sk Infection</td>
<td>As early as possible, promote the patient/family with a copy of the tool, making it clear what they can expect and when they can arrive.</td>
<td>Provide a tool or checklist that can be used to educate patients and families about the risk of infection and how to prevent it.</td>
<td>Educate patients and families about the importance of hand hygiene and the steps they can take to reduce the risk of infection.</td>
<td>Create a plan to monitor patients for signs of infection and take immediate action if detected.</td>
<td>Ensure that all patients who are at risk for infection are screened and treated promptly.</td>
</tr>
<tr>
<td>Nutritional Hydration</td>
<td>Prior to admission or as close to admission as possible, ask patients and families about their dietary preferences and any concerns they may have.</td>
<td>Obtain a nutritional history and create a personalized meal plan for each patient.</td>
<td>Establish a system to monitor and track patient progress and adjust the plan as needed.</td>
<td>Engage family members in the decision-making process to ensure that the patient’s needs are met.</td>
<td>Provide educational materials and support resources to help families understand and follow the meal plan.</td>
</tr>
<tr>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
</tbody>
</table>

**Point of Care Implementation Partners:**
- Quality and Safety Leaders, Medical Directors, Nurse Managers, Patient Engagement Professionals

**Policy & Protocol Implementation Partners:**
- Quality and Safety Leaders, Medical Directors, Nurse Managers, Patient Engagement Professionals

**Governance Implementation Partners:**
- Board of Directors, C-Suite

**Change Ideas:**
- Establish a skin care routine that involves daily cleansing and moisturizing, and provide education and training materials for caregivers. Set a goal for caregivers to perform skin care assessments daily and document any changes. Engage a key opinion leader to promote the importance of skin care practices. Fosters a culture of shared learning and improvement by encouraging feedback and incorporating best practices into care processes.
## Ensure Multi Level Patient and Family Engagement (PFE)

### Point of Care
- **Implementation Partners:** Point of Care Providers, Medical Directors, Nurse Managers
- **Change Ideas:**
  - **Metric 1:** At the pre-op appointment, provide the patient/family with a copy of the tool, *Staying Active in the Hospital*. Review key points regarding what to expect and the important role they have in early mobility.
  - **Metric 2:** Post the *Let’s Get Moving* chart next to the patient white board. Introduce it to the patient and family and ask them to track progress. During daily rounds, ask patient/family to report progress and any challenges they have experienced.
  - **Metric 3:** As part of his/her nursing clinical ladder program, ask a nurse to audit patient mobility charts to determine how many patients/family members are using the charts and whether their activities are aligning with agreed upon daily mobility goals.
  - **Metric 4:** Engage your PFAC to review and redesign the *Let’s Get Moving* tool so that it is personalized to your hospital and target population. Keep what they like about the tool and use their feedback to improve the areas they feel should be changed.
  - **Metric 5:** Invite family caregivers to attend a Board meeting. Ask them to discuss the role they play in early mobility and have them outline the inpatient equipment required so that they, along with the staff, can assist their loved one without causing injury to themselves or the patient.

### Governance
- **Implementation Partners:** Board of Directors, C-Suite

### Protocol & Policy
- **Implementation Partners:** Quality and Safety Leaders, Medical Directors, Nurse Managers, Patient Experience Leaders

## AHA CENTER FOR HEALTH INNOVATION

Advancing Health in America
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 massageaging your skin over bony parts of the body.
  - Use a mild skin cleanser.

✓ Eat a healthy diet
  - Take nutritional supplements as advised.
HAPI Patient and Family Engagement Resources

We will look at what you were able to do before you came into hospital to make sure we understand how best to support and encourage you to keep moving.

You should have a full assessment to help us to know how you normally get about.

We will make sure we look at any risks that may stop you from being able to get out of bed so we can support you.

Do you need glasses or hearing aid to help you communicate.
Do you know where they are?

We can support you with anything you need to help keep you moving, in or out of bed.

Do you have the right equipment to help you move about? If not we should be able to provide what you need.

If you can walk to the toilet, it keeps you moving and prepares you for home.

Sitting out of bed helps. We can help you get out of bed.

We will encourage you to 'Do It Yourself' where you can.

Eat or drink on your own if you are able.

Wash and dress yourself if you are able and wear your own clothes.

Keep changing your position even if you are in a bed or chair.

Staying Active in Hospital

Sit up... Get dressed... Keep moving...
HAPI Patient and Family Engagement Resources

Let’s Get Moving

Activity and Mobility Program

Goal: To Maintain or Increase Highest Level of Mobility (HLM) Daily

- Baseline HLM Score
- Admission HLM Score
- Discharge HLM Goal
- Mobility Aides

<table>
<thead>
<tr>
<th>HLM Score</th>
<th>Activity</th>
<th>Today’s Score</th>
<th>Yesterday’s Score</th>
<th># of Times HLM Met Today</th>
</tr>
</thead>
<tbody>
<tr>
<td>8</td>
<td>Walked 250 Feet/10 Laps</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>Walked 25 Feet</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Walked 10 Steps</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Static Standing for 1 minute</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Transferred to Chair/Commode</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Sat on Edge of Bed</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Turned Self in Bed/R.O.M.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>Lying in Bed</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Entry Point Challenges

Betsy Lee, MSPH, RN
Improvement Advisor, Cynosure

Jackie Conrad, RN, BS, MBA
Improvement Advisor, Cynosure
What we know- A few facts about HAPI

- Delay in appropriate surface > 2 days highly associated with HAPI
- Not all Braden risk factors are equal. Tescher, et al 2012
  - A Braden Friction score of 1 or 2 has the highest association with HAPI, followed by moisture and low sensory perception
- Anatomical Regions for HAPI
  - Sacrum
  - Heels
- Critically ill patients have numerous intrinsic risk factors that contribute to HAPI development - ICU HAPI risk factors
  - Perfusion deficits – decreased BP, cardiac output, vasopressors
  - Oxygenation deficits – hypoxia, cellular, hypoxia, anemia
  - End of life – post resuscitation, post hypothermia
  - Medical Devices
- Surgical patients, not normally at risk are placed in HIGH risk in the OR
  - Procedures > 3 hours
Is Saving Skin a Priority?
Polling question

In your ED, when do you activate skin saving interventions such as specialty mattress?

a) After the patient is initially assessed (within 2-4 H)
b) After 8 H in the ED
c) After 12 H in the ED
d) Once the patient is placed in “ED Hold” or “boarder” status
e) Don’t know
## ED Challenges and Solutions

<table>
<thead>
<tr>
<th>Challenges</th>
<th>Solutions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Competing urgent priorities</td>
<td>PUP Team of Skin Champions in the ED</td>
</tr>
<tr>
<td>Incomplete assessments (pt not fully undressed)</td>
<td>Skin guardians rounding to assure high risk pts are fully assessed</td>
</tr>
<tr>
<td>Carts with mattresses that provide little support</td>
<td>Mattress overlays for high risk patients, hospital beds for boarders</td>
</tr>
<tr>
<td></td>
<td>Heel Protection</td>
</tr>
<tr>
<td>Long wait times</td>
<td>Activate interventions early for HR pts before boarder status:</td>
</tr>
<tr>
<td></td>
<td>S – Surface K – Keep Moving I - Incontinence N - Nutrition</td>
</tr>
<tr>
<td>Little attention to nutrition</td>
<td>Provide meals and snacks to non-NPO patients</td>
</tr>
<tr>
<td>Lack of PI prevention awareness</td>
<td>Educate ED RNs. Use ENA Code of Ethics</td>
</tr>
<tr>
<td>Friction and shear with lateral transfers</td>
<td>Provide the right equipment – glide sheets</td>
</tr>
<tr>
<td></td>
<td>Sacral dressings for high risk patients</td>
</tr>
<tr>
<td></td>
<td>Avoid HOB &gt; 30 if possible</td>
</tr>
<tr>
<td>Patient condition</td>
<td>Use a risk screen in triage to activate interventions early</td>
</tr>
</tbody>
</table>
Sample ED triage screening tool for PI

- Completed in triage
- Triggers high risk interventions
- Bundled kit
  - Sacral dressing
  - Positioning devices
  - Glide sheet
  - Mattress overlay or specialty mattress

PRESSURE ULCER SCREENING/ALERT TOOL

Does the patient have a history suggestive of pressure ulcers?

- Advanced age
- Malnutrition
- Obesity
- Dehydration
- Contractures
- Neurological impairment
- Inadequate patient immobility
- Incontinence of bowel and bladder
- Cognitive decline
- History of previous pressure ulcers
- Co-morbidities (Diabetes, Peripheral Vascular Disease)

If yes, consider the following preventative measures:

- Pressure redistribution mattress for stretcher
- Hospital bed
- Order specialized mattress (low air loss bed, fluid air bed)
- Repositioning every two hours
- Head of bed less than 30 degrees if medically feasible
- Heels off of bed

Date___________  Time ___________
Tools and Resources

- Four Eyes Assessment
- Four eyes in Four hours Case Study
- NPUAP Critical Care Guidelines
- Early prevention of pressure injury in the ED
- Support Surface Algorithm
- AHRQ Resources and RN Attitude and Knowledge Assessments
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 post operatively
• Associated with the surgical position
Let’s hear from the field

- Please chat…… How do you connect the dots?
- How do you bring pressure injuries that occur 48-72 hours post operatively into the OR’s spotlight?
  - What is your process to review HAPI’s for OR etiology?
  - How do you involve the OR staff in the RCA?
## Operating Room Challenges and Solutions

<table>
<thead>
<tr>
<th>Challenges</th>
<th>Solutions</th>
</tr>
</thead>
<tbody>
<tr>
<td>OR tables provide insufficient support</td>
<td>Hi specification, reactive or alternating pressure mattresses for high risk patients or procedures &gt; 3H. Use preoperatively and post operatively. Heel Protection</td>
</tr>
<tr>
<td>Inability to assess some areas during surgery</td>
<td>Follow AORN positioning guidelines. Frequent checks of positioning, padding, and support surfaces during the procedure. “Out of sight is not out of mind”</td>
</tr>
<tr>
<td>Failure to understand that an injury discovered after surgery originated</td>
<td>Loop back to surgical staff when an injury appears 48 to 72 hrs post operatively. Involve surgical staff in investigation. Document positioning during procedure.</td>
</tr>
<tr>
<td>during the procedure.</td>
<td></td>
</tr>
<tr>
<td>Lack of awareness of PI risks</td>
<td>Educate surgical teams. Screen for risk prior to surgery and assemble required equipment to minimize pressure and optimize perfusion pre-intra-postoperatively.</td>
</tr>
<tr>
<td>Friction and shear with lateral transfers</td>
<td>Provide the right equipment – glide sheets, lifts Sacral dressings for high risk patients</td>
</tr>
<tr>
<td>Patient condition</td>
<td>Use a risk screen prior to surgery interventions early (Scott or Munro)</td>
</tr>
</tbody>
</table>
## OR Risk Screening Tools

### Muñoz Pressure Ulcer Risk Assessment Scale for Perioperative Patients - Adult®

**Preoperative Risk Assessment** evaluates six risk factor categories to determine a score of 1, 2 or 3. The sum of the risk factors results in the Preoperative Muñoz Score Total to determine the Level of Risk.

<table>
<thead>
<tr>
<th>Preoperative Risk Factor Score</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mobility</td>
<td></td>
</tr>
<tr>
<td>Not limited, or slightly limited, moves independently</td>
<td>1</td>
</tr>
<tr>
<td>Very limited, requires transfer assistance</td>
<td>2</td>
</tr>
<tr>
<td>Completely immobile, requires full assistance</td>
<td>3</td>
</tr>
<tr>
<td>Nutritional State</td>
<td></td>
</tr>
<tr>
<td>12% or less</td>
<td>1</td>
</tr>
<tr>
<td>&gt; 12% but &lt; 24%</td>
<td>2</td>
</tr>
<tr>
<td>&gt; 24%</td>
<td>3</td>
</tr>
<tr>
<td>Length of NPO status</td>
<td></td>
</tr>
<tr>
<td>BMI</td>
<td></td>
</tr>
<tr>
<td>&lt; 30kg/m²</td>
<td>1</td>
</tr>
<tr>
<td>30kg/m² - 35kg/m²</td>
<td>2</td>
</tr>
<tr>
<td>&gt; 35kg/m²</td>
<td>3</td>
</tr>
<tr>
<td>Weight Loss</td>
<td></td>
</tr>
<tr>
<td>Weight loss in 30-180 days</td>
<td></td>
</tr>
<tr>
<td>Co-morbidity</td>
<td></td>
</tr>
<tr>
<td>Age</td>
<td></td>
</tr>
<tr>
<td>Years</td>
<td></td>
</tr>
<tr>
<td>Smoking (current)</td>
<td></td>
</tr>
<tr>
<td>Prehypertension or high BP levels (BP &gt; 120/80)</td>
<td>1</td>
</tr>
<tr>
<td>Vascular/Renal/Cardio-vascular/Peripheral-vascular Disease</td>
<td>2</td>
</tr>
<tr>
<td>Asthma/Pulmonary/Respiratory Disease</td>
<td>3</td>
</tr>
<tr>
<td>Prior History of Pressure Ulcer/Existing Pressure Ulcer</td>
<td>4</td>
</tr>
<tr>
<td>Diabetes/IDDM</td>
<td></td>
</tr>
<tr>
<td>Preoperative Muñoz Score Total</td>
<td>6</td>
</tr>
</tbody>
</table>

5-6 = Low Risk
7 - 14 = Moderate Risk
15 or greater = High Risk

### Scott Triggers®

- **Does it meet these qualifications?**
- **If YES, please check here:**

<table>
<thead>
<tr>
<th><strong>Scott Triggers®</strong></th>
<th><strong>Does it meet these qualifications?</strong></th>
<th><strong>If YES, please check here:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>Age 62 or older</td>
<td>Age 62 or older</td>
</tr>
<tr>
<td>Estimated surgery time in hours/minutes</td>
<td>Surgery time over 3 hours or 180 minutes**</td>
<td></td>
</tr>
</tbody>
</table>

See the AORN Toolkit for Sample Bundles, Checklists, Handoff Tools.

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*Scott Triggers® is an easy-to-use screening tool designed to help perioperative and health care teams identify patients at high risk for pressure ulcers, reduce skin damage and improve patient care. Scott Triggers can be used as a preoperative risk assessment tool or as a postoperative risk assessment tool. The tool is designed to be used in conjunction with other patient assessment tools and should not be used as the sole determinant for pressure ulcer risk.

**Surgery time is calculated from the time the patient is designated as "operating room" to the time the patient is discharged from the operating room."

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*Images and graphics from American Hospital Association. Advancing Health in America.
Perioperative Pressure Injury Toolkit

Components

- Faculty Disclosure Slides (PPTX)
- Educational Slide Deck: The Basics of Patient Positioning (PPTX with User Notes)
- Sample – OR Pressure Ulcer Chart Summary Template (PDF)
- Sample – Case Studies (PDF)
- Sample Checklist – Prevent Perioperative Pressure Ulcers (PDF)
- Sample – Perioperative Pressure Ulcer Prevention Bundle/Program (PDF)
- Sample – Pressure Ulcer Worksheet (PDF)
- Scott Triggers Tool (PDF)
- Scott Triggers Gap Analysis Template (XLS)
- Instructions for the Munro Pressure Ulcer Risk Assessment Scale for Perioperative Patients for Adults (PDF)
- Munro Pressure Ulcer Risk Assessment Scale for Perioperative Patients for Adults (XLS)
- Older Adult Resources (PDF)
- Websites for Older Adult Resources and Prevention of Pressure Ulcers (PDF)
- Position Statement – AORN Position Statement on Prevention of Perioperative Pressure Ulcer Prevention in the Care of the Surgical Patient (PDF)

Webinars

Contact Hours:
You may earn 1.5 contact hours before December 31, 2017 by reviewing the 5 webinars below and completing the online evaluation.

- Positioning OR Patients to Prevent the Development of Pressure Ulcers Slide Deck (PDF)
- Pressure Ulcer Project Implementation of the Munro Scale
- Risk Assessment using the Munro Pressure Ulcer Risk Assessment Scale for Perioperative Patients Slide Deck (PDF)
- Best Practices to Improve Communication among Caregivers Related to the Prevention of Perioperative Pressure Ulcers
- Perioperative Pressure Ulcer Risk and Prevention: Scott Triggers®

Posters

- Poster 1: What is an OR-acquired Pressure Ulcer? (PDF)
- Poster 2: How to Identify an OR-acquired Pressure Ulcer (PDF)
- Poster 3: Take the Pressure Off Your Patient (PDF)
- Poster 4: Communication/Hand Off (PDF)
- Poster 5: Selecting Support Surfaces (PDF)
- Poster 6: Promote the Tool Kit (PDF)
- Poster 7: Reduce, Relieve, Reduce Tool Kit (PDF)
- Poster 8: Prevention of Perioperative Pressure Injury Tool Kit (PDF)
Resources

- **Ten Top Tips: preventing pressure ulcers in the surgical patient**
- **NPUAP Preventing Perioperative PI. Clinical Guideline**
- **AORN Peri Op HAPI Toolkit** – Munro and Scott Tools
- **ScottTriggers.com**
- **Support Surface Algorithm**
- **AHRQ Resources and RN Attitude and Knowledge Assessments**
- **Complimentary NPUAP webinar recordings:**
  - FAQs about Pressure Injury Staging
  - Unavoidable Pressure Injuries, Terminal Ulcers and Skin Failure
  - **OR Positioning and Pressure Injury Prevention**
  - Considerations for Bariatric Patients in Pressure Injuries & Wound Care
  - Nutrition & Pressure Injuries
Scavenger Hunt Tool (NEW)

- Ideal person to complete the hunt?
  - Materials management
  - CFO or designee
  - Finance department
  - Administration
  - Other???

Do your staff have the best skin care supplies to prevent skin injuries?
Supply / Equipment Checklist for Materials Management / Leadership “Scavenger Hunt”

- Support Surfaces
  - Med Surg: age of surfaces: __________________________ Type of mattress: __________________________
  - ICU: age of surfaces: __________________________ Type of mattress: __________________________
  - ED: age of surfaces: __________________________ Mat thickness: __________________________
  - Type of support surfaces available in ED: __________________________
  - OR: age of surfaces: __________________________ High Density Foam Mattress or tables? Y/N
  - Bariatric Support Surfaces or equipment are delivered in a timely manner? Y/N

- Friction Management (check all that apply)
  - Glide sheets
  - Lifts and adequate slings on each unit (easily accessible)
  - Policies on safe mobilizing (no-lift or minimal lift)
  - Multi-layer soft, sacral dressing
  - Multi-layer soft, heel dressing
  - Bariatric lifting and moving equipment

- Moisture Management (check all that apply)
  - Low air loss mattresses are used for incontinent or patients with moisture
  - New female external catheters that attach to suction available
  - Male external catheters or penile pouch/wrap available
  - Non petroleum barrier cream available
  - High quality underpads are used
  - Prepared skin cleansing cloths are used (instead of soap and water)

- Assessment / Inspection Equipment (check all that apply)
  - Mirrors for patients to inspect skin and nurses to inspect heels
  - Camera and associated policies for photography

- Misc (check all that apply)
  - Heel Protectors / Boots / PNFOs
  - Patient chair at each bedside for getting out of bed
  - Low air loss chair pads are used
  - Whiteboard space for HAIP prevention plan and goals
  - Written patient education materials are available

Comments, observations: __________________________

Actions to be taken: __________________________

Signature: __________________________ Date: __________________________
Measuring Our Pressure Ulcer Rates and Practices

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

Betsy Lee, MSPH, RN
Improvement Advisor, Cynosure

Hector Sanchez III, RN
Skin, Wound, and Ostomy Liaison, Valley Baptist Medical Center, TX
Poll Question

What is the biggest challenge or barrier you face in collecting, reporting or analyzing the PrU 1 (Stage 3 or greater) measure? Please select your highest priority challenge:

a) Coding personnel rather than clinical staff collect these data
b) Reliance on administrative/billing data for this measure
c) Issues with timely documentation of Present on Admission (POA)
d) Deep tissue injuries (DTI) make up a large proportion of these HAPIs

If you have more than one barrier, or if you face additional challenges that are not listed above, please type these into the chat box.
Poll Question

What challenges or barriers do you face in collecting, reporting, and analyzing the PrU 2 (Stage 2 or greater) measure?

a) Difficulty in finding staff to help do monthly prevalence studies
b) Not enough clinical staff with expertise in skin assessment and pressure injury staging
c) Not a priority for leaders
d) All of the above
e) Other (share in chat)
How to Measure Your Pressure Ulcer Rates and Practices?

**AHRQ comprehensive resource for measuring pressure ulcer rates and prevention practices**

- Recommend that you regularly monitor:
  - An outcome (preferably pressure ulcer frequency or prevalence rates).
  - At least one or two care processes (e.g., patient repositioning, heels floated).
  - Key aspects of the infrastructure to support best care practices (e.g., clear lines of responsibility for overseeing accuracy of skin assessments, appropriate supplies and equipment to minimize pressure, friction, moisture).
Prevalence Studies as an Improvement Strategy
Prevalence

- **Prevalence** describes the number or percent of patients having a pressure ulcer at a single point in time.
- Best measure of the burden of care when providing for care and prevention measures.

\[ N = \text{# of patients with stage 2 or greater (POA excluded)} \]
\[ D = \text{# of patients assessed on the day of the study} \]
SWAT Team “Skin Guardians”

Hector Sanchez III RN
Skin, Wound and Ostomy Liaison
Valley Baptist Medical Center, TX

Valley Baptist's Prevalence Study Webinar
Voices from the field

Tell us the **who, what, when** of your prevalence studies.

- Who is on the prevalence teams?
- How were these staff prepared?
- How often do you conduct prevalence studies? Is it the same for every unit?
- How much time does it take to study one unit?
- How are staff scheduled?
- What are the benefits?
- What are the challenges?
Getting Started – Who?

- Assign a coordinator, skin champion
- Determine who will conduct the study
  - Team approach – 2 is ideal, can use an unlicensed staff person
    - Students, orientees
    - Exempt staff – manager, educator
  - Educate the surveyors using the NDNQI Staging and Prevalence study training modules:
    - Pressure Injury Staging Module I – basic staging with practice
    - Other Wound Types and Skin Injuries Module II – the exclusions to HAPI
    - Pressure Injury Survey Guide Module III – how to do a prevalence study
Getting Started – What?

- Time – 2.5 to 3 hours for a med surg unit
- Pick a good staffing day, schedule staff in advance, no OT
- Audit Tool
- Enjoy a team based activity that is patient- and family-centered
  - Teach patients, families and colleagues while you inspect each patient’s skin

HRET HIIN Prevalence Data Collection Tool
Getting Started - How?

- Assess each patient on the unit
  - Head to toe skin inspection focusing on bony prominences
- For injuries discovered, assess medical record to determine if the injury was present on admission (POA)
- Record all injuries discovered, indicating which are POA (POA is not included in HIIN HAPI data)
- Assess process measures
  - Was risk assessed upon admission?
  - If at risk, were interventions in place such as specialty mattress, moisture management, use of barrier cream?
- Record HAPI Prevalence
  - N = # of patients with a stage 2 or greater observed on the unit that day. Do not include patients with an injury POA when submitting HAPI dat to HIIN
  - D = # of the patients observed on the unit that day
  - Exclude patients off the unit for tests, or those that refuse
Prevalence Study Resources

- HRET Pressure Ulcer Prevalence Studies Webinar Recording
- AHRQ Pressure Ulcer Measurement Module
More Resources

- Hill-Rom International Pressure Ulcer Prevalence Study Resources
- Prevalence and Incidence: A Toolkit for Clinicians WOCN Toolkit
- Pressure Ulcer Prevention: Prevalence and Incidence in Context
  http://www.woundsinternational.com/media/issues/64/files/content_24.pdf
NDNQI Pressure Ulcer Staging Test

Question 1
Reddened area over the left heel does not blanch with tightly applied pressure.
No underlying area of purple or maroon discoloration is noted.

Correct! The answer is: Category/Stage I

Please make a selection
- Category/Stage I
- Category/Stage II
- Category/Stage III
- Category/Stage IV
- Unstageable/Unclassified
- Suspected Deep Tissue Injury

Question 2
This 78 year old patient has a pressure ulcer on the right heel.
Eschar and slough cover the wound bed.

Correct! The answer is: Unstageable/Unclassified
The Challenge Today: Go to the GEMBA

- Conduct one prevalence study on the unit that has the most opportunity to improve.
- Appoint 1-2 champion bedside nurses and 1-2 nursing assistants to partner with a leader, educator or specialist to assess skin and observe care processes and documentation.
- Interview patients and family members to gain their perspective and understanding of preventative skin care.
- Huddle after the study to share findings and discuss next steps.
Questions?
THANK YOU!