Spring 2019 HRET HIIN HAPI Sprint (Session #2)
May 14, 2019
11:00 a.m. – 12:00 p.m. CT
WELCOME AND INTRODUCTIONS

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Performance Improvement Coach, HRET
Maryanne Whitney, RN, CNS, MSN
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Your HRET HIIN HAPI Sprint Team

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Hello, My Name is...

- Name
- Hospital/ Allied(State Hospital) Association
- City, State
HRET HIIN HAPI Sprint Webinar Schedule

- Thursday, May 30, 2019 (11:00AM – 12:00PM CT) (register here)

- Thursday, June 13, 2019 (11:00AM – 12:00PM CT) (register here)
Hospital Submission Deadlines

- **HAPI Pre-assessment**
  - ASAP

- **HAPI Process Improvement Discovery Tool**
  - Tuesday, May 14th
  - Submit to Allied (State Hospital) Association lead

- **HAPI Scavenger Hunt**
  - Thursday, May 30th
  - Submit to Lmarc_ct@aha.org (HRET)
Allied Association Submission Deadline

- HAPI Sprint Coaching Guide & Hospital HAPI Process Improvement Discovery Tool
  - Thursday, May 30th
  - Submit to Lmarc_ct@aha.org
AGENDA

- Welcome and Introductions
- Hospital Pre-Assessment Responses
- Let’s Talk S.K.
- Questions and Answers
- What Did You Discover?
- Bring it Home
Why Are We Here?

To use quality improvement techniques to assess root causes of hospital acquired pressure injuries and engage patients and their family members in prevention.
Welcome!
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
How are YOU?
Chat in…

- What are some creative approaches you have implemented when staff are stretched?

- How is your hospital improving the accuracy of risk assessment, educational tools for Braden?
Chat in

- How have you spread success beyond your unit? Are there other care areas you plan to target?

- Question for Large Hospitals (300 + beds): What advice do you have for large hospitals engaged in HAPI improvement work? How have you spread successful practice?
Poll Question

Is your hospital using photography for documentation of pressure injury?

a) Yes
b) No
c) Unsure
Hospital Pre-Assessment Responses
Jackie Conrad, RN, BS, MBA
Improvement Advisor, Cynosure
Q8 How are you finding and reporting HAPI's? (check all that apply)

- Administrative data: 28.4%
- Occurrence reports: 71.6%
- Prevalence Studies: 53.4%
- Other (please specify): 31.8%
Q9 Is your pressure injury prevention (PIP) plan based upon the total risk score or are interventions activated based upon each sub score? (For example, nutrition, moisture, friction/shear are addressed as individual risk factors.)

- PIP Planning is based upon the total risk score: 47.7%
- PIP Planning is based upon individual risk factor sub scores: 9.1%
- PIP Planning is based upon both: 34.1%
- Not sure: 9.1%
Q10 Do your skin inspection policies and staff education explicitly include using palpation to assess for changes in skin consistency or temperature for patients with darkly pigmented skin?

- Yes: 33%
- No: 36.4%
- Not sure: 18.2%
- This is on our radar and a...: 12.5%
Q11 Do you include assessment for blanching response if tissue is reddened?

- Yes: 76.1%
- No: 10.2%
- Not sure: 10.2%
- This is on our radar and a...: 3.4%
Q12 Are nursing assistants and techs educated and activated to inspect skin for early warning signs of skin breakdown?

- Yes: 67.1%
- No: 9.1%
- Not sure: 12.5%
- This is on our radar and a...: 11.4%
Q13 Are staff re-educated on a continuous or annual basis on skin assessment, products, etc.? (check all that apply)

- We have an annual skin fair / competency fair: 39.8%
- We have hands on training with a wound specialist: 25.0%
- We use computer-based learning modules annually: 39.8%
- We include skin care and assessment in orientation: 61.4%
- Not sure: 3.4%
- This is on our radar and a...: 15.9%
Q14 Is there a policy and process in place to assure that skin and mucosa that are impacted by medical devices are inspected every shift and each time the patient is re-positioned or adjusted?
Q15 Are safe patient handling techniques used to minimize staff injury and patient friction and shear, including lifting equipment and lateral transfer devices?

- Yes: 85.2%
- No: 10.2%
- Not sure: 3.4%
- This is on our radar and a...: 1.1%
Q16 Is the application of a protective sacral foam dressing standardized (minimum in the ICU) for at-risk patients?

- Yes: 59.1%
- No: 26.1%
- Not sure: 10.2%
- This is on our radar and a...: 4.6%
Q17 Does your organization have an ER strategy in place for PIP for ICU admissions or those at risk? (For example, are patients placed on a specialty mattress or an ICU bed when available, and sacral dressing applied while in the ED?)

- Yes: 30.7%
- No: 39.8%
- Not sure: 18.2%
- This is on our radar and a...: 11.4%

Q18 Does your organization have an OR strategy in place for PIP for cases greater than 3 hours? For example, high quality mattress pad and sacral dressing applied?

- Yes: 29.6%
- No: 25.0%
- Not sure: 36.4%
- This is on our radar and a...: 9.1%
Q22 Are written materials available to teach and reinforce PIP with patients and families, including skin care and hygiene, re-positioning, skin inspection and nutrition, hydration?
HRET HIIN HAPI PFE Strategy

Keep it Simple

Activate Patients and Families

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

Maryanne Whitney, RN, CNS, MSN
Improvement Advisor, Cynosure

Tara Bristol Rouse, MA
Patient and Family Engagement Project Consultant, HRET
Focus on the Basics

- Skin Inspection
- Keep Moving
- Incontinence
- Nutrition
- Hydration

Healthy Skin

Partnering with Patients
Skin Inspection: a very important organ

- 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 healed 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
  - Pay attention to reports of pain!

- Inspect skin for erythema or redness
  - Assess if the skin is blanchable or non-blanchable
  - Do not position a patient areas with erythema
  - Moisten darkly pigmented skin to increase visualization of color changes

- Assess the skin temperature, for edema and consistency related to surrounding tissue

- Inspect around and under medical devices at least once a day
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

Wound/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 any area that has a Wound/Pressure Ulcer. Describe any abnormalities.

- None Present
- Description

1. Bilateral
2. Axilla
3. Antecubital Fld
4. Jonhson
5. Gluteal
6. Low Back
7. Sacral Area
8. Acheen/Scapular
9. Infrarad Tarsus
10. Perimeters
11. Plantar
12. Manchick
13. Automus
14. Toe

EDRN Checklist
- Wound/Pressure Ulcer Present
- Wound/Pressure Ulcer Assessment Documented in Center
- ED Physician notified
- Wound/Pressure Ulcer Prevention Plan Documented

Reminder: Date, Time, Initial and write “W” if existing a P/U or “P” if used for prevention 
with a marker on the coloring

Admitting RN Checklist
- Wound/Pressure Ulcer Documented in Center
- MED notified for Risk for Aced Skin
- Patient assessed for correct mattress surface (all risk pts must have an inflow on mattress)
- Wound/Pressure Ulcer Prevention Plan Documented

Reminder: Date, Time, Initial and write “W” if existing a P/U or “P” if used for prevention 
with a marker on the coloring

Pressure Ulcer Prevention Practice Guidelines

Source: FCAGoMedicalCenter, Oceana/CA, 2013

Pressure Ulcer Audit ED Admissions

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
   - He 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>Reduce Pressure (for decreased sensation, activity, or mobility)</td>
<td>Place patient on Inpatient Pressure Reducing Mattress (Barflex)</td>
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<tr>
<td></td>
<td>Place patient on overlay air mattress</td>
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<tr>
<td>Moisture Control</td>
<td>Turn patient Q 2 Hours</td>
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<tr>
<td>Reduce Friction &amp; Shear</td>
<td>Check Continence Brief Q 2 Hours &amp; Provide skin &amp; continence care</td>
</tr>
<tr>
<td>Encourage Good Nutrition</td>
<td>Keep Head of bed less than or equal to 30 degrees</td>
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<tr>
<td></td>
<td>Use Glide device for transfers</td>
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<tr>
<td></td>
<td>Offer fluids Q 1 hour</td>
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<tr>
<td></td>
<td>Set up for meals</td>
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Four Eyes Assessment
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

- 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

Wounds UK, Care of the older person’s skin: Best practice statement

(Second edition)
Don’t Forget Devices

Best Practices for Prevention of Medical Device-Related Pressure Injuries

- Choose the correct size of medical device(s) to fit the individual
- Cushion and protect the skin with dressings in high risk areas (e.g., nasal bridge)
- Remove or move removable devices to assess skin at least daily
- Avoid placement of device(s) over sites of prior, or existing pressure injury
- Educate staff on correct use of devices and prevention of skin breakdown
- Be aware of edema under device(s) and potential for skin breakdown
- Confirm that devices are not placed directly under an individual who is bedridden or immobile

Bedside Tools

AHRQ Pocket Pad

Bedside HAPI PFE Tool
K – Keep Moving

Repositioning

Early Mobility
K – Keep Moving Facts

- Not all risk factors are equal (Tescher, et al 2012)
  - Braden friction score of 1 or 2 has the highest association for PU development
  - Moisture, and low sensory perception are also more predictive than other sub scores (mobility, nutrition and activity were less predictive)
K – Keep Moving Evidence

- Consider condition of the patient and the support surface when deciding on a repositioning plan.
  - No support surface provides complete relief
  - Immersion and envelopment redistribute pressure

How often?
- Q 2hr reduces pressure injury (Siddiqui, 2018)

How far over?
- 30 degrees is the ideal
- Use wedges, positioning systems to maintain position
K – Keep Moving Evidence

- Repositioning frequency is determined based upon the patient’s needs
  - Tissue tolerance
  - Level of activity and mobility
  - General medical condition
  - Overall treatment objectives
  - Skin condition
  - Comfort

- **Microshifting** does reduce interface pressure (Krapfl, 2017)
K – Keep Moving Evidence

- Teach the patient and family to do pressure relief lifts or other pressure relieving maneuvers
K – Keep Moving Evidence – The BASICS

- Position in a way that pressure is relieved or redistributed
- Avoid positioning over bony prominences
- Avoid pressure and shear forces – avoid HOB elevation if not contraindicated
- Avoid positioning over medical devices
- Do not leave a patient on a bed pan longer than necessary
K – Keep Moving Evidence - sitting

- Provide sitting position to allow full range of activities
- Select a seated posture that minimizes pressure and shear
  - No sliding down in the chair
  - Ensure feet are properly supported when seated
- Pay attention to chair cushions – no bed pillows!
- Reposition hourly – lifts, march in place, repositioning devices
K – Keep Moving
Best Practices

- Integrate HAPI prevention with safe patient handling
  - “Lift don’t drag”
  - 2-person boost and/or assistive devices

- Slings left in place?
  - Pressure, skin temperature and pH are not negatively impacted by a sling.
  - Benefit of the mobility enabled by the sling out-weighs the risk in most cases. Clinicians must use critical thinking.

- [NPUAP White Paper](#)
Why sacral injuries are so prevalent

Sacrum 37% of all injuries

Pressure Map – Sacrum with HOB elevated

Elevated head of bed lying with the backrest at a 45° angle causes a high combination of shear stress and pressure at the buttocks and sacral area, i.e., patients with respiratory compromise.

Shear

Pressure

Moisture

AHA CENTER FOR HEALTH INNOVATION

American Hospital Association
Advancing Health in America
Sacral Injury Prevention

- Patient and family education on repositioning
- Protect from friction and shear in mobilizing and positioning
- Protective dressing: Expert consensus recommendation: for critically ill patients, include a five-layer soft silicone bordered dressing on the sacrum to reduce pressure, shear and microclimate

http://www.hret-hiin.org/resources/display/dressings-as-an-adjunct-to-pressure-ulcer-prevention-consensus-panel-recommendations
Why Heel Injuries are so prevalent?

- Sustained high pressure over small area
- Supine position is highest risk
- Friction and shear when sliding down in bed, or if agitated, spasms
- Blood supply may be poor
- Very little padding, thin skin

Boot or Pillow or Dressing

- Soft foam protective dressing: agitated patients to reduce friction damage
- Pillows: alert patients who can maintain extremities on pillows. Avoid pressure on Achilles tendon
- Boot: decreased level of consciousness, spinal cord injury, contractures
Ensuring Multi Level Patient and Family Engagement (PFE)

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<thead>
<tr>
<th>Point of Care</th>
<th>Policy &amp; Protocol</th>
<th>Governance</th>
</tr>
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<tbody>
<tr>
<td>Implementation Partners: Point of Care Providers, Medical Directors, Nurse Managers</td>
<td>Implementation Partners: Quality and Safety Leaders, Medical Directors, Nurse Managers, Patient Experience Leaders</td>
<td>Implementation Partners: Board of Directors, C-Suite</td>
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**Metric 1**
- 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.

**Metric 2**
- 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.

**Metric 3**
- Identify a team member in nursing to educate fellow nurses on how to discuss and engage the patient/family in SSIN assessments. Following education, have the team member conduct audits to ensure implementation has been successful.

**Metric 4**
- 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.

**Metric 5**
- 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.
HAPI Patient and Family Engagement Resources

Preventing Pressure Ulcers

How to Prevent Pressure Ulcers

Information for patients, families, and carers

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 clothing or bedding are damp.
  - Special equipment such as air mattresses and cushions may be used to reduce the pressure in particular places.
  - Avoid massage your skin over bony parts of your body.
  - Use a mild skin cleanser.
- **Eat a healthy diet**
  - Take nutritional supplements as advised.

For more information, speak with your healthcare professional.

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

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.
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
Prevention and Treatment of Pressure Ulcers: Quick Reference Guide

NPUAP Evidence Based Practices

- www.NPUAP.org
**HRET Resources**

**HAPI Change Package**

**Hospital Acquired Pressure Ulcers/Injuries (HAPU/I)**

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

**HAPI Top 10 Checklist**

**Sepsis/HAPI Top 10 Checklist**

**Sacral Injury Top 10 Checklist**

**Sacral Injury Prevention Top 10 Checklist**
Questions?
What Did You Discover?

Lydie Marc, MPH, CHES
Performance Improvement Coach, HRET

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Improvement Advisor, Cynosure
What trends did your hospital discover?

How did your hospital benefit and/or what did they struggle with?

How do you plan to support your hospital moving forward?
THANK YOU!