HQIC Patient Safety: Pressure Injury Session 2

Welcome!

• All lines are muted, so please ask your questions in the chat panel.
• For technical issues, chat to ‘All Panelists.’
• Please actively participate in polling questions that will pop up on the right-hand side of your screen.

We will get started shortly!
HQIC Pressure Injury: Tools for Prevention

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Making Health Care Better Together

Hospital Quality Improvement

Welcome from all of us!

COLLABORATORS:
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Pressure Injury Prevention
Patient Safety Network Objectives

Participants will be able to:

• Perform a head-to-toe skin assessment.
• Understand the importance of skin assessments to prevent pressure and skin integrity injuries during an inpatient stay.
• Understand the importance of documentation.
• Engage colleagues to perform “Four Eyes” skin assessment.
• Identify problem zones for pressure injuries.
Today's Learning Objectives

• Learn Today:
  • Understand the importance initial and continuous skin assessments.
  • Identify the problem areas where pressure injuries are more likely to start.

• Use Tomorrow:
  • Engage all staff to monitor skin integrity at all levels of the organization.
  • Apply AHRQ Pressure Ulcer Toolkit for pressure ulcer reduction.
Pressure Ulcer Prevention Pathway

1. **Head-to-toe skin assessment**
   - Document all skin issues, including:
     - Skin color
     - Skin temperature
     - Skin turgor
     - Skin moisture status
     - Skin integrity
     - Pressure ulcer
     - Healed pressure ulcer

2. **Patient is admitted or readmitted**
   - Complete head-to-toe skin and PU risk assessment

3. **Pressure ulcer risk assessment**
   - At Risk
     - **CURRENT or HEALED pressure ulcer**
       - **YES**
         - Document pressure ulcer:
           - Location
           - Length
           - Depth
           - Stage
         - Refer to wound specialist/shoulder, ostomy, continence nurse
         - Obtain order for treatment from health care provider and obtain consultations as needed
       - **NO**
         - Reassess skin daily
         - Go to pressure ulcer risk assessment

   - **NEW**
     - **YES**
       - Care plan for actual or potential skin problem
       - Complete care plan and problem statement; potential for impaired skin integrity as evidenced by [ ] risk assessment indicates that the patient/client/resident is at risk for skin breakdown (relation to identified risk factors)
     - **NO**
       - Review immediately if condition changes or per facility policy

4. **DEFICIENCIES?**
   - **Bed**
     - Turn/reposition schedule
     - Pressure redistribution device (PVJR)ghan
   - **Mobility, activity, or sensory perception**
     - Interventions
     - Head of bed in lowest possible position unless contraindicated by medical condition
     - Protection of vulnerable areas
     - Prevent taking off skin contact (use padding, dressing, skin barriers, and sealant products, padding)
   - **Friction and shear**
     - Incontinence
     - Clean as soon as possible after episodes
     - Use skin protective products: protectants, barriers, creams, films, etc.
   - **Moisture**
     - Nutrition, fluids, and body weight
     - Weekly weight: monitor % change
     - Baseline height
     - Consults with dietitian and speech therapist for nutrition, chewing and swallowing problems
   - **Nutrition**
     - Other patient-specific risk factors
     - Develop interventions related to any other identified specific risk factors (e.g., comorbidities, dry skin)
Today’s Focus - Assessments

- Head-to-Toe Skin Assessment: INSPECT and PALPATE
  - Document All skin issues, including:
    - Skin Color
    - Skin Temperature
    - Skin turgor
    - Skin Moisture Status
    - Skin Integrity
    - Pressure Ulcers
    - Healed Pressure Ulcers

- Patient is Admitted or Readmitted: Do Both
  - Complete Head-to-toe Skin and PU Risk
  - CURRENT or HEALED pressure ulcer
    - YES: Document pressure ulcer:
      - Location
      - Length
      - Width
      - Depth
      - Stage
    - Refer to wound specialist/wound ostomy, continence nurse

- Skin Issues:
  - YES: Report any abnormal findings to health care provider and notify and educate patient and family on findings
    - Reassess skin daily
    - Obtain order for treatment from health care provider and obtain consultations as needed
  - NO
    - Go to pressure ulcer risk assessment
Bundle of Best Practices

• Pressure injury prevention practices checklist:
  ❑ Comprehensive skin assessment
  ❑ Standardized pressure injury risk assessment
  ❑ Care planning and implementation to address areas of risk
Practice Insight
Skin Assessment Frequency

• Not a one-time event
• Repeated on a regular basis
• Optimally done daily in a systematic manner by a single individual at a dedicated time
• May be integrated into routine care—any time the patient is cleaned or turned
Elements of a Comprehensive Skin Assessment

- Skin Temperature
- Skin Color
- Skin Moisture
- Skin Turgor
- Skin Integrity
Skin Temperature

Most clinicians use the back rather than the palm of their hand to assess the temperature of a patient’s skin.

Remember that increased skin temperature can be a sign of fever or impending skin problems such as a Stage I pressure ulcer or a diabetic foot about to ulcerate.

• Touch the skin to evaluate if it is warm or cool.
• Compare symmetrical body parts for differences in skin temperature.
Skin Color

• Ensure that there is adequate light.
• Use an additional light source, such as a penlight, to illuminate hard-to-see skin areas such as the heels or sacrum.
• Know the person’s normal skin tone so that you can evaluate changes.
• Look for differences in color between comparable body parts, such as the left and right legs.
• Depress any discolored areas to see if they are blanchable or non-blanchable.
• Look for redness or darker skin tone, which indicate infection or increased pressure.
• Look for paleness, flushing or cyanosis.
• Remember that changes in coloration may be particularly difficult to see in darkly pigmented skin.
Skin Moisture

• Touch the skin to see if the skin is wet or dry or has the right moisture balance.

• Remember that dry skin, or xerosis, may appear scaly or lighter in color.

• Check if the skin is oily.

• Note that macerated skin from too much moisture may appear lighter or feel soft or boggy.

• Look for water droplets on the skin. Is the skin clammy?

• Determine if these changes are localized or generalized.
Skin Turgor

- To assess skin turgor, take your fingers and “pinch” the skin near the clavicle or forearm so that the skin lifts up from the underlying structure. Then let the skin go.
- If the skin quickly returns to place, this is a normal skin turgor finding.
- If the skin stays up, this is called “tenting” and is an abnormal skin turgor finding.
- Poor skin turgor is sometimes found in persons who are older, dehydrated, or edematous, or have connective tissue disease.
Skin Integrity

• Check to see if the skin is intact without cracks or openings.
• Determine if the skin is thick or thin.
• Identify signs of pruritis, such as excoriations from scratching.
• Determine if any lesions are raised or flat.
• Identify whether the skin is bruised.
• Note any disruptions in the skin.
• If a skin disruption is found, the type of skin injury will need to be identified. Since there are many different etiologies of skin wounds and ulcers, differential diagnosis of the skin problem will need to be determined. For example, is it a skin tear, a pressure ulcer or moisture-associated skin damage or injury?
Comprehensive Skin Assessment: AHRQ Preventing Pressure Ulcers in Hospitals Toolkit
Four Eyes Assessment – What Is It?

• A collaborative model utilizing two nurses (four eyes) to identify and document pressure injuries:
  • Within four hours of admission or transfer
  • When a patient has been off the floor for more than four hours
  • Both nurses should sign the assessment
  • When disagreement occurs, the skin champion or wound care nurse should be consulted early on
What Are the Benefits?

• Quick, simple and effective process for early identification of risk factors and pressure injuries
• When led by peers, provides the opportunity to educate and train nurses to create a more knowledgeable staff
• Increases ownership and responsibility for pressure injury prevention
• Ensures accuracy, reliability and drives a more cohesive approach to pressure injury prevention and treatment
• Assists in standardizing documentation of wounds and provides a baseline for treating injuries and improved monitoring
• Helps reduce hospital-acquired pressure injuries
Resources

Berlowitz, Dan. Preventing Pressure Ulcers in Hospitals. Website. October 2014


Comprehensive Skin Assessment: AHRQ Preventing Pressure Ulcers in Hospitals Toolkit. AHRQ YouTube Channel. https://youtu.be/L1OpaWDAv_A


Key Takeaways

• Learn Today:
  • Understand the importance of initial and continuous skin assessments.
  • Identify problem areas where pressure injuries are more likely to start.
  • Understand the value of implementing the “Four Eyes” assessment process.

• Use Tomorrow:
  • Engage all staff to monitor skin integrity at all levels of the organization.
  • Develop an implementation plan for the “Four Eyes” assessment process.
  • Apply AHRQ Pressure Ulcer Toolkit for pressure ulcer reduction.
Getting Started

• Review the resource materials provided today.
• Establish a team to develop assessment policies and procedures—short-term and long-term.

How will this change what you do?
Questions?

Email us at HospitalQuality@allianthealth.org or call us at 678-527-3681.
HQIC Goals

Behavioral Health Outcomes & Opioid Misuse
- Promote opioid best practices
- Decrease high dose opioid prescribing and opioid adverse events in all settings
- Increase access to behavioral health services

Patient Safety
- Reduce risky medication combinations
- Reduce adverse drug events
- Reduce C. diff in all settings

Quality of Care Transitions
- Convene community coalitions
- Identify and promote optimal care for super utilizers
- Reduce community-based adverse drug events
Upcoming Events

January 26, 2022
12 p.m. ET | 11 a.m. CT | 10 a.m. MT

Using Pressure Injury Risk Assessment Tools in Care Planning

Event registration and information: HERE
quality.allianthealth.org
Thank you for joining us!
How did we do today?