

HQIC Patient Safety: Pressure Injury

Welcome!

- All lines are muted, so please ask your questions in Q&A.
- For technical issues, chat to the panelists.
- Please actively participate in polling questions that pop up on the lower right-hand side of your screen.

We will get started shortly!

HQIC Pressure Injury: Tools for Prevention



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Tracy Rutland, MBA/MHA, CLSSBB

February 23, 2022

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HEALTH SOLUTIONS

HQIC
Hospital Quality Improvement Contractors
CENTERS FOR MEDICARE & MEDICAID SERVICES
EQUALITY IMPROVEMENT & INNOVATION GROUP

Making Health Care Better *Together*

COLLABORATORS:

Alabama Hospital Association
Alliant Health Solutions
Comagine Health
Georgia Hospital Association
KFMC Health Improvement Partners
Konza

Hospital Quality Improvement

Welcome from all of us!



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Pressure Injury Prevention

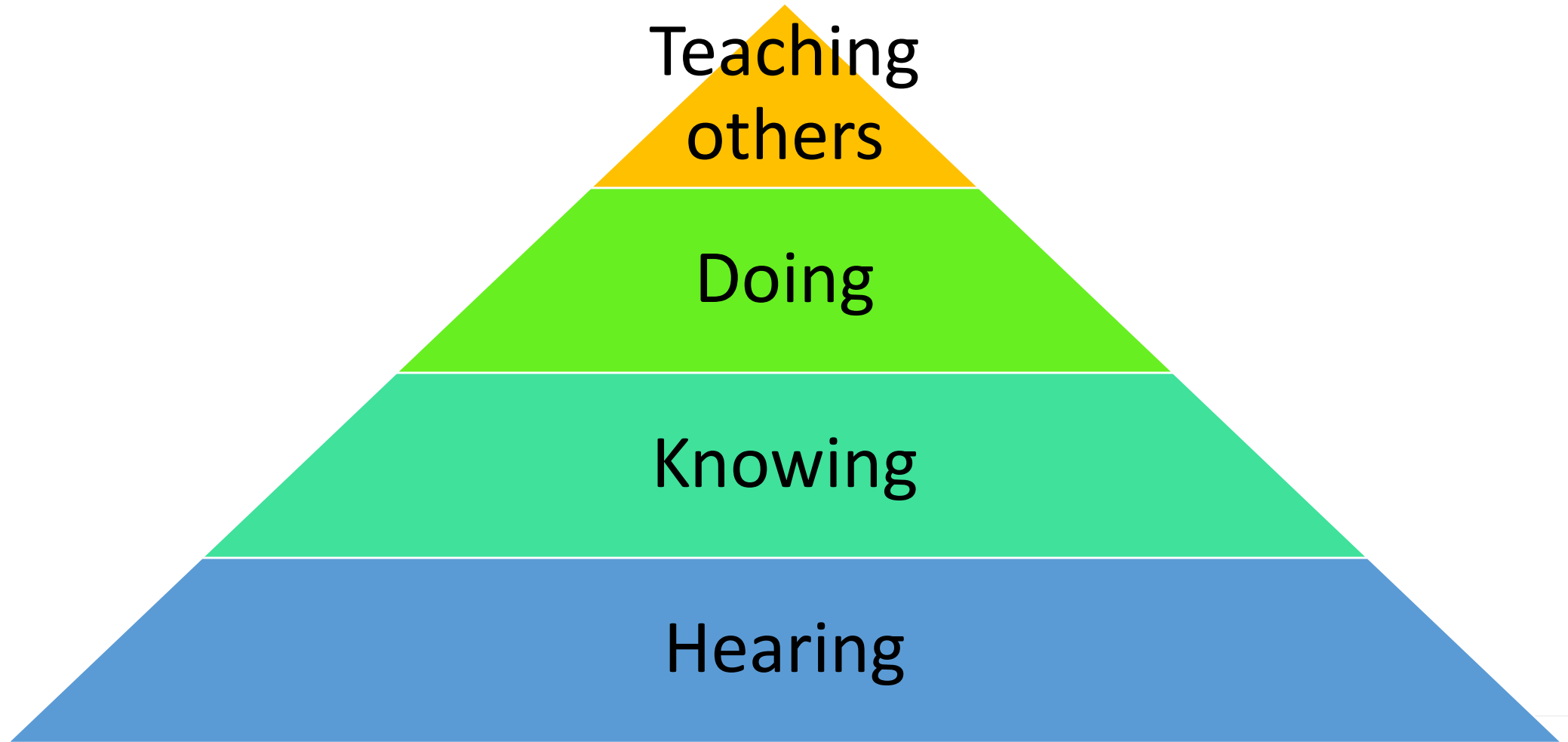
Patient Safety Network Objectives

- Participants will be able to:
 - Apply a fishbone analysis as a discovery tool to understand how to ask the right questions to discern gaps in current practices.
 - Understand the transformation of the culture from hearing about a best practice to teaching others how to apply a best practice using the learning pyramid.

Today's Learning Objectives

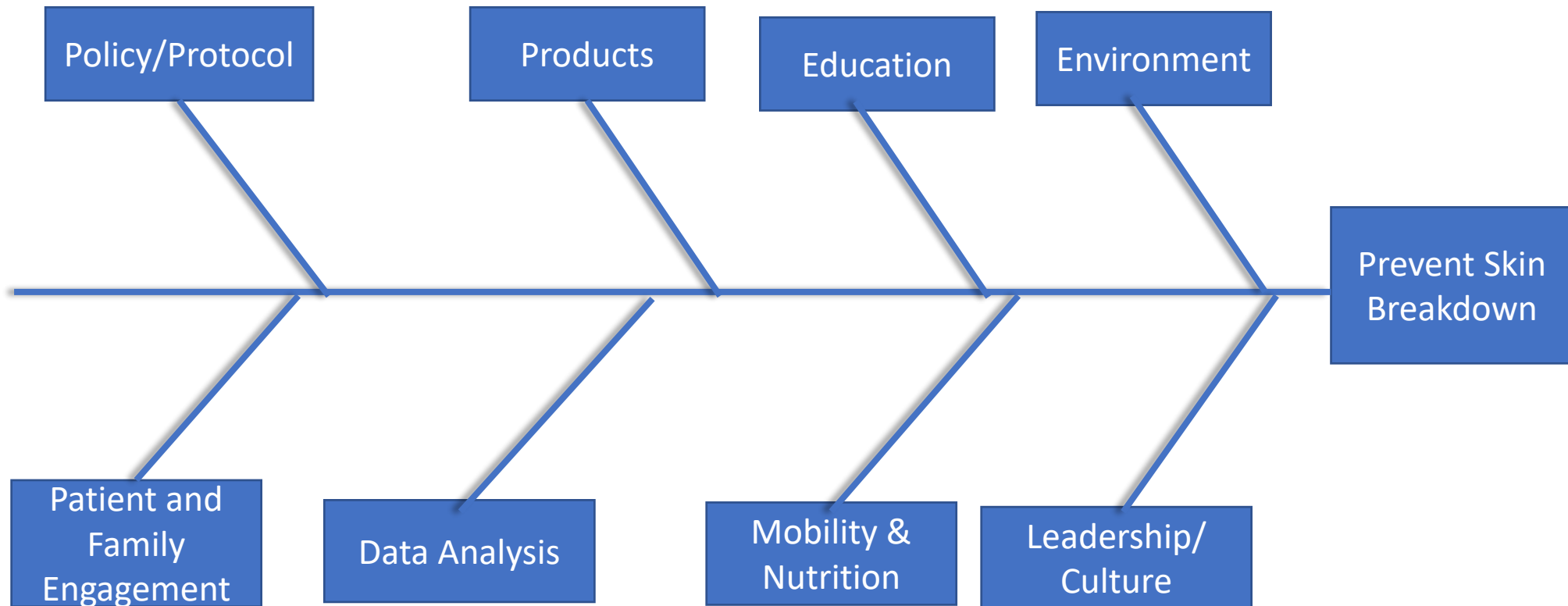
- Learn Today:
 - How to move from hearing to applying best practices.
 - Root Cause Analysis, if applied to a solution, can make the interventions stick.
 - Questions to ask as you move toward developing a high-reliability solution to HAPI prevention.
- Use Tomorrow:
 - Ask better questions regarding where your facility is on its journey to prevent pressure injuries.
 - Set priorities for interventions you can implement in the next 30 days.

Application of Best Practices



Adapted from Blooms Taxonomy of Education

Root Cause Analysis To Make Improvements



Only the Best: Best Practices To Improve Your HAPI Measures

- Policy/Protocol
 - Does policy include:
 - Implementation of a multidisciplinary team?
 - Nursing, dietician, respiratory therapy and rehabilitation staff?
 - Policy/protocol defines requirements for implementation of:
 - Skin assessment
 - Identification of high-risk patients
 - Mobility assistance
 - Utilization of skin protection and support surfaces
 - Medical device injury prevention
 - Patient and family engagement
 - Development of a skin care plan

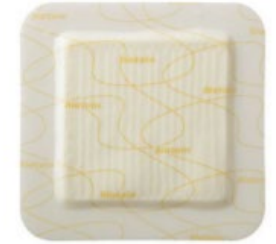
Only the Best: Best Practices To Improve Your HAPI Measures

- Environment
 - Are the rooms used for skin integrity assessments lighted appropriately for adequate skin examination?
 - If necessary, are headlamps and flashlights available for staff to use in under-lighted environments while assessing the skin?



Only the Best: Best Practices To Improve Your HAPI Measures

- Products
 - Skin care protection products:
 - Are appropriate skin protection products utilized to prevent pressure injuries?
 - Silicone foam dressing on the sacral region
 - Heel protection
 - Cushioning for medical devices, etc.
 - Are appropriate support surfaces implemented for high-risk patients?
 - Mattresses,
 - Overlays, etc.
 - Is leadership engaged in planning for purchase and replacement?



Only the Best: Best Practices To Improve Your HAPI Measures

- Education
 - Is education multidisciplinary with skills lab and case studies?
 - Are colored photos for the stage guide available to all students?
 - Is education on early detection of pressure injuries?
 - Is education on matching prevention measures to patient's risk?
 - Is education on risk assessment included in the curricula?
 - Are you building into your training the skills to speak up when they see skin breakdown?
- NDNQI Pressure Injury Staging
<http://learning2.pressganey.com/ndnqi/copyright/2021/576852/story.html>

Only the Best: Best Practices To Improve Your HAPI Measures

- Patient and Family Engagement
 - Are patients and families engaged in assessing for early signs of hospital-acquired pressure injuries?
 - Are patients and family members aware of a repositioning schedule through “whiteboard communications”?



Only the Best: Best Practices To Improve Your HAPI Measures

- Nutrition
 - Is nutritional services conducting timely nutritional assessments, implementing recommendations and following up on high-risk patients?
 - Are nutritional supplements in place if not contraindicated?
 - Is proper hydration monitored and addressed in the care plan?

Only the Best: Best Practices To Improve Your HAPI Measures

- Mobility
 - Are at-risk patients repositioned/turned every two hours (10 chart audits)?
 - Do you use lighted timers outside patient room doors to remind staff to turn patients?
 - Do you have an established mobility team (Nursing and PT) to get patients up and moving?
 - Do you have a mobility protocol and team?
 - Have you identified staff that can ambulate patients daily?
 - Do your nurses or rehabilitation/physical therapists evaluate each patient's mobility status upon admission?
 - Do you have safe patient handling and movement training for nursing and assistive staff?
 - Is mobility equipment readily available for nurses and patients to access (canes, walkers, lifting and safe patient handling devices, gait belts)?
 - Do you have a way to document and monitor daily mobility?

Only the Best: Best Practices To Improve Your HAPI Measures

- Care Coordination
 - Are oral care bundles for respiratory patients utilized?
 - Are interventions documented, and is an intervention checklist used for patients with a Braden score < 17?

Only the Best: Best Practices To Improve Your HAPI Measures

- Data Analysis
 - Are regularly scheduled samples sets of patient records pulled and checked for proper coding of POA markers and staging?
 - Is pressure injury data collected, analyzed and reported to stakeholders for trends by unit for patient characteristics (e.g., diabetes, high risk, anatomical location and other contributing factors)?
 - Is the progression of skin breakdown recorded in the patient chart and addressed in the care plans?

Only the Best: Best Practices To Improve Your HAPI Measures

- Monitor/Assess
 - Does skin assessment documentation happen within 24 hours of admission?
 - Are skin assessments occurring every 24 hours, utilizing the “Four Eyes” method and beginning in the emergency department for emergent patients?

Only the Best: Best Practices To Improve Your HAPI Measures

- Leadership/Culture
 - Does leadership establish maintenance of skin integrity and pressure injury reduction as a priority?
 - Are multidisciplinary teams in place, including respiratory therapy, rehabilitation staff, nursing (inclusive of LPNs and CNAs), dietician and surgical services?
 - Do we utilize Strategic Breakthrough Initiative (SBI) process-Charter, FMEA and audits to develop action and implementation plans for skin integrity and pressure injury reduction as a priority?

Resources

- NDNQI Pressure Injury Training 8.0
<http://learning2.pressganey.com/ndnqi/copyright/2021/576852/story.html>
- Support surfaces for pressure ulcer prevention: A network meta-analysis
<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5825032/>
- Support surfaces for intraoperative pressure injury prevention: systematic review with meta-analysis <https://pubmed.ncbi.nlm.nih.gov/34755774/>
- AHRQ Pressure Injury Prevention Guide Appendix C. Training and Learning Webinars <https://www.ahrq.gov/patient-safety/settings/hospital/resource/pressureinjury/guide/apc.html>
- Do bedside whiteboards enhance communications in hospitals?
<https://qualitysafety.bmj.com/content/29/10/1.6>

Key Takeaways

- Learn Today:
 - How to move from hearing to applying best practices.
 - Root Cause Analysis, if applied to a solution, can make the interventions stick.
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- Use Tomorrow:
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How will this change what you do?

Getting Started


- Review the resource materials provided today.
- Develop a plan to implement best practices based on your assessment of current prevention efforts and application of other evidence-based practices.
- Share your findings within the organization.

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

Wednesday, March 23, 2022 at 12 p.m. ET



[https://bit.ly/HQIC Pressure Mar23](https://bit.ly/HQIC_Pressure_Mar23)

Hosted by: Sara Phillips

Event registration and information: [HERE](#)

quality.allianthealth.org

Learning and Action Network (LAN)

April 26, 2022 2-2:30 p.m. EST

WALK with the WOC and Step into a Brighter Future of Pressure Injury Prevention



Fran Perren MSN, BSW, RN,
NEA-BC, CWOCN
Unit Director WOC Services
Emory Healthcare (GA)

Learning Objectives:

- Gain insight into the rationale and how to support the WOC nurse to lead the nurses to decrease hospital-acquired pressure injuries (HAPI).
- Demonstrate an improvement process to reduce hospital-acquired pressure injuries, one step at a time.
- Illustrate a patient story and highlight how teach-back methodology helped a family.

Registration link:

<https://allianthealthgroup.webex.com/allianthealthgroup/onstage/g.php?MTID=e065f6bd27e7a54212931f2bb701df68f>

** See the March and April newsletters as well as Alliant website**

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Hospital Quality Improvement



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Thank you for joining us!
How did we do today?

Alliant Health Solutions



AlliantQIO



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