

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

Welcome!

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

**We will get
started shortly!**

Collaborating to Support Your Quality Improvement Efforts



- Healthcentric Advisors ■ Qlarant
- Kentucky Hospital Association
- Q3 Health Innovation Partners
- Superior Health Quality Alliance



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Featured Speakers



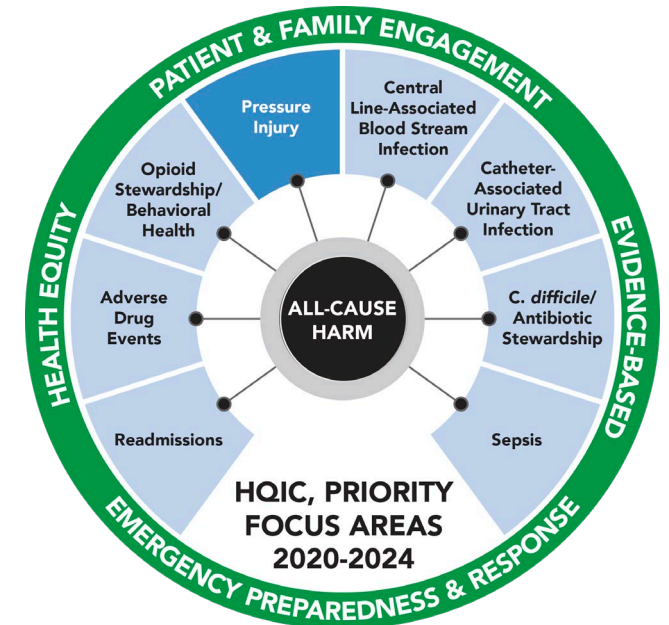
Fran Perren MSN, BSW, RN, NEA-BC, CWOCN
Unit Director WOC Services
Emory Decatur/LTAC/Hillandale
Fran.perren@emoryhealthcare.org



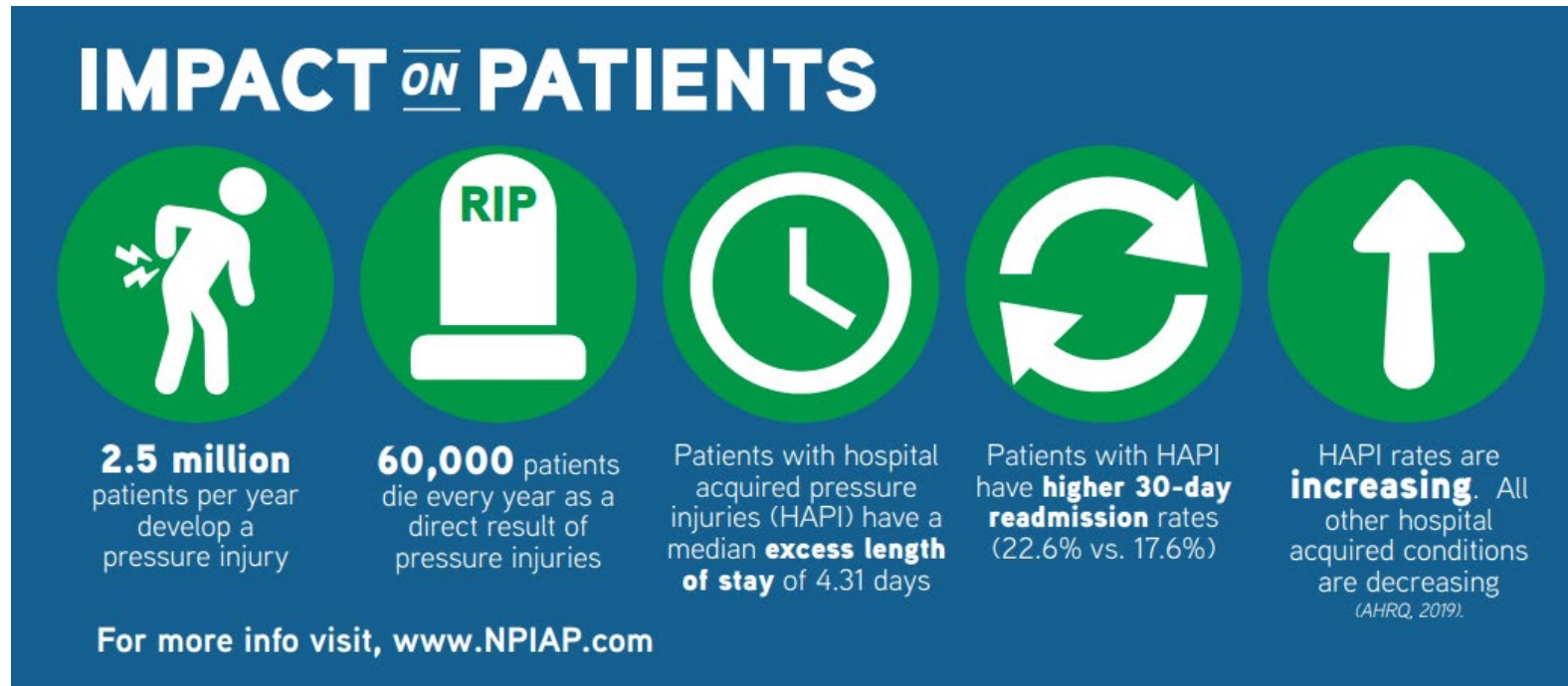
Kathy McGowan, MPH
Patient Advocate and Former Vice
President, Quality & Patient Safety
Georgia Hospital Association

Learning Objectives

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



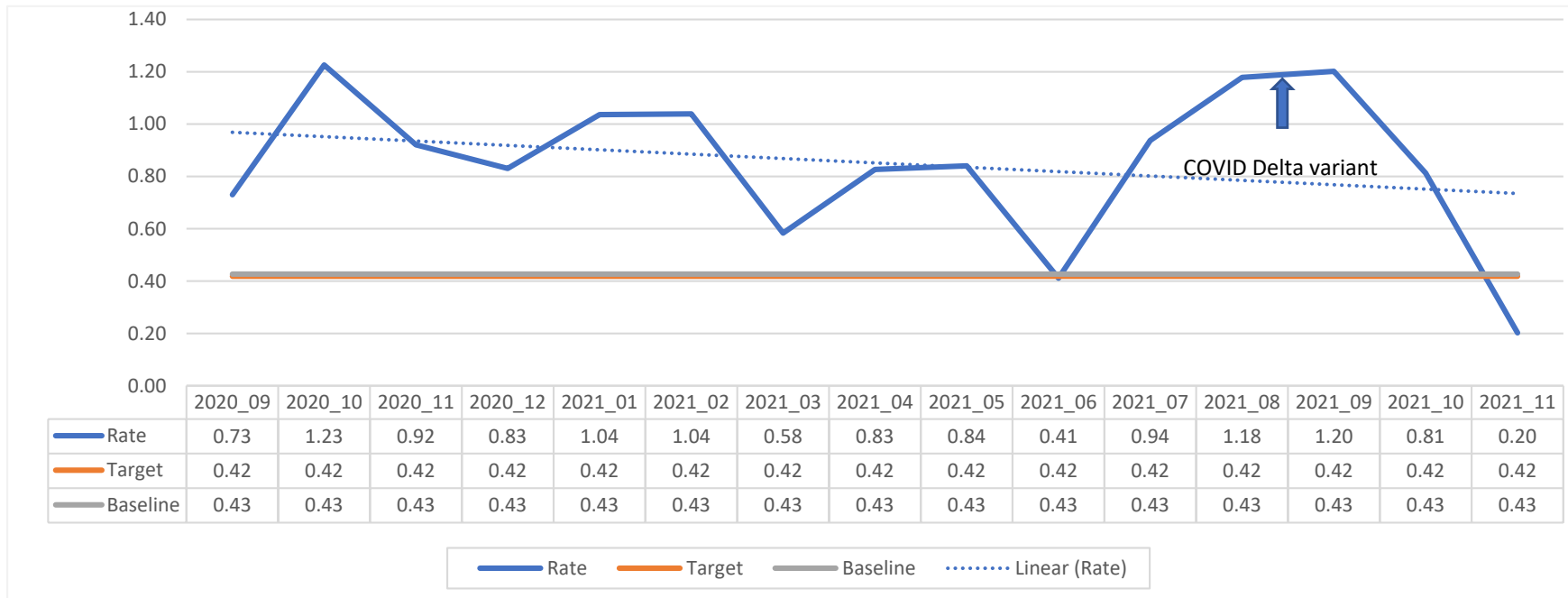
National Trends



Source: NPIAP.com

Alliant HQIC Data

Pressure Injuries per 1,000 Medical or Surgical Discharges



- Overall slight downward trend
- Below baseline and target goal for Nov 2021

Baseline: CY2019
 Target: 18 month/Mar 2002
 Source: CMS Claims
 Alliant HQIC 150 enrolled hospitals

IHC/Compass HQIC Pressure Ulcer Stage 3 Data

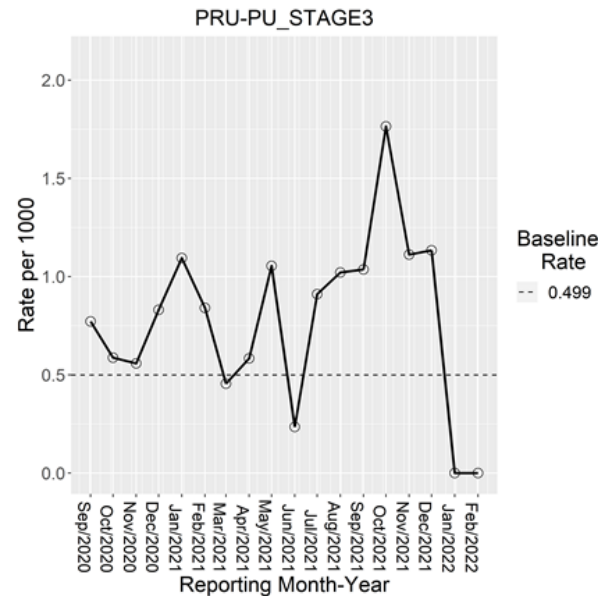


Figure 43: Pressure Ulcer Rate, Stage 3+, (AHRQ PSI-03)

Baseline: CMS Baseline Methodology

Data Source: Statewide Database

Hospitals Reporting: 275 (IA, KS, MS, SD)

Trend Direction: Decreased/Lower is better

Data Analysis: The performance rate is 0.87 per 1000 which is a negative 74.01% change from the baseline rate of 0.50 per 1000. Trend has been fluctuating above and below baseline for the past months.

IHC/Compass HQIC Pressure Ulcer Stage 2 Data

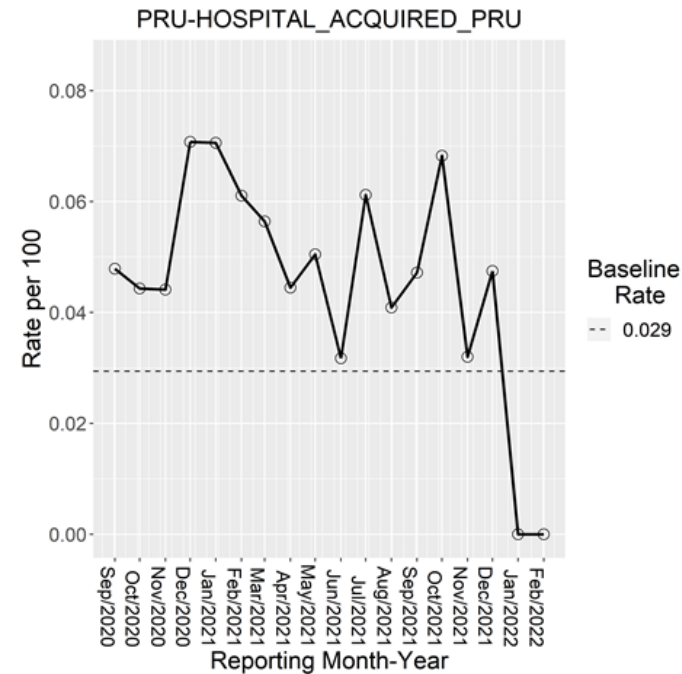


Figure 44: Acute Inpatients with a Hospital-Acquired Pressure Ulcer Stage II

Baseline: CMS Baseline Methodology
Data Source: Statewide Database
Hospitals Reporting: 275 (IA, KS, MS, SD)
Trend Direction: Decreased/Lower is better

Emory Hillandale (GA)

- Located on the eastern Atlanta perimeter
- 100 beds with a busy ER
- Family environment for staff/patients
- Personalized care
- Everyone is someone



WOCN Engagement

- History
- 2007 Medicare changes pending
- Leader empowered WOCN to own the process
- Identified individuals to support plans
- Met regularly to guide the process

Improvement Process

1. Determine at-risk population
2. Develop a Skin Prevention Bundle for at-risk patients
3. Provide simple decision trees for clinicians
4. Form a bedside team to lead the way:
 - a) Teach proper interventions
 - b) Measure compliance of interventions
 - c) Become a unit resource for Skin Management
 - d) Discuss barriers for performance improvement
 - e) Celebrate all wins

1. Determine At-Risk Population

- Braden Risk Tool performed q shift
- Using sub scales
- We decided to use 18 or less to keep it SIMPLE
- Created EMR reports for staff to be aware of at-risk patients
- Educate patient and family of risk status and expectations

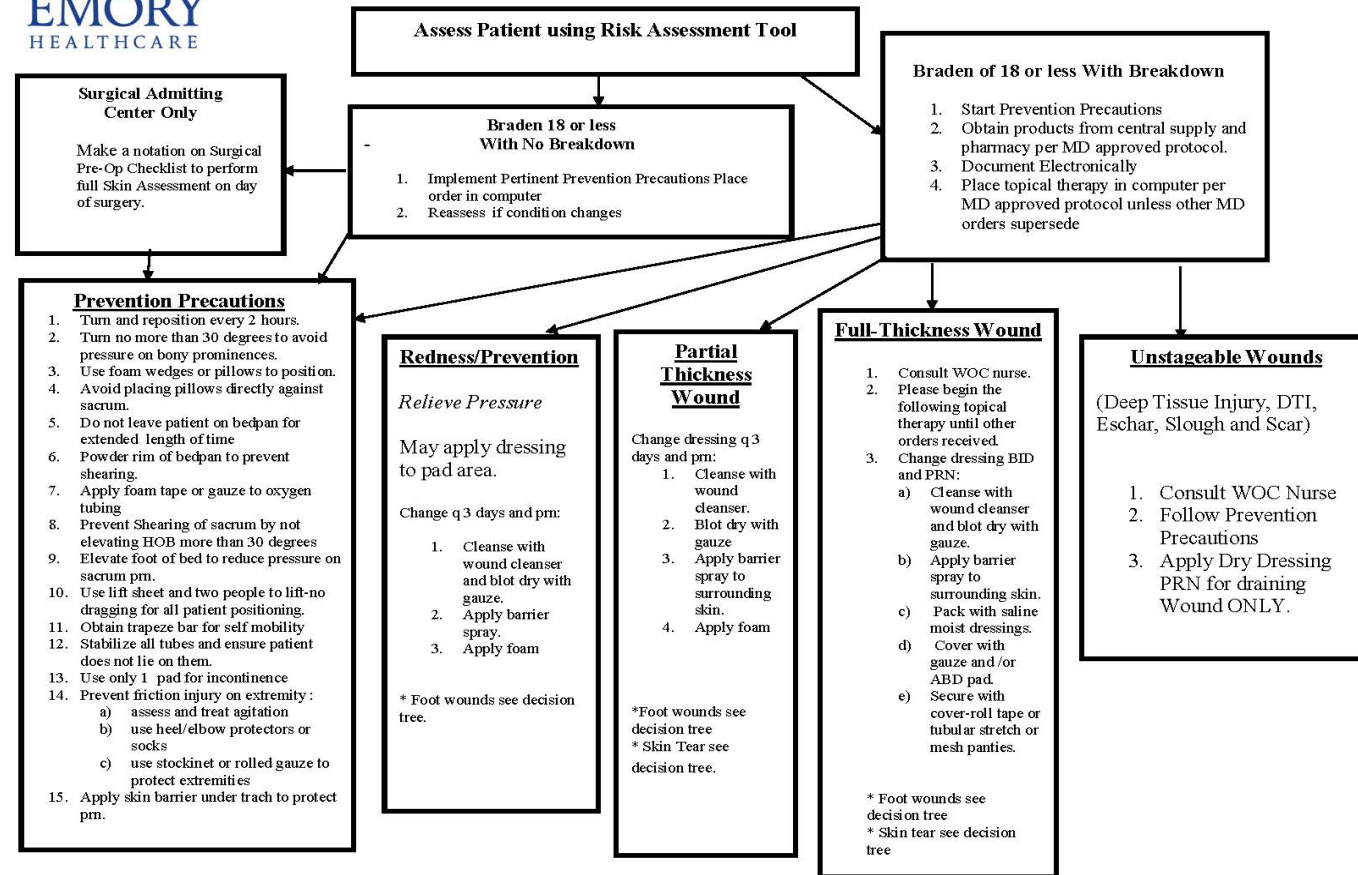
2. Develop a Skin Prevention Bundle

- Primary focus: sacrum and heels
- Repositioning at least q2hrs
- Lift sheets and wedges for positioning
- HOB at 30 degrees
- Suspension boots
- No briefs in bed (diapers)
- Incontinence management
- Medical device padding

3. Provide Decision Trees for Clinicians

DECISION TREE FOR SKIN BREAKDOWN PREVENTION AND TREATMENT GUIDELINES

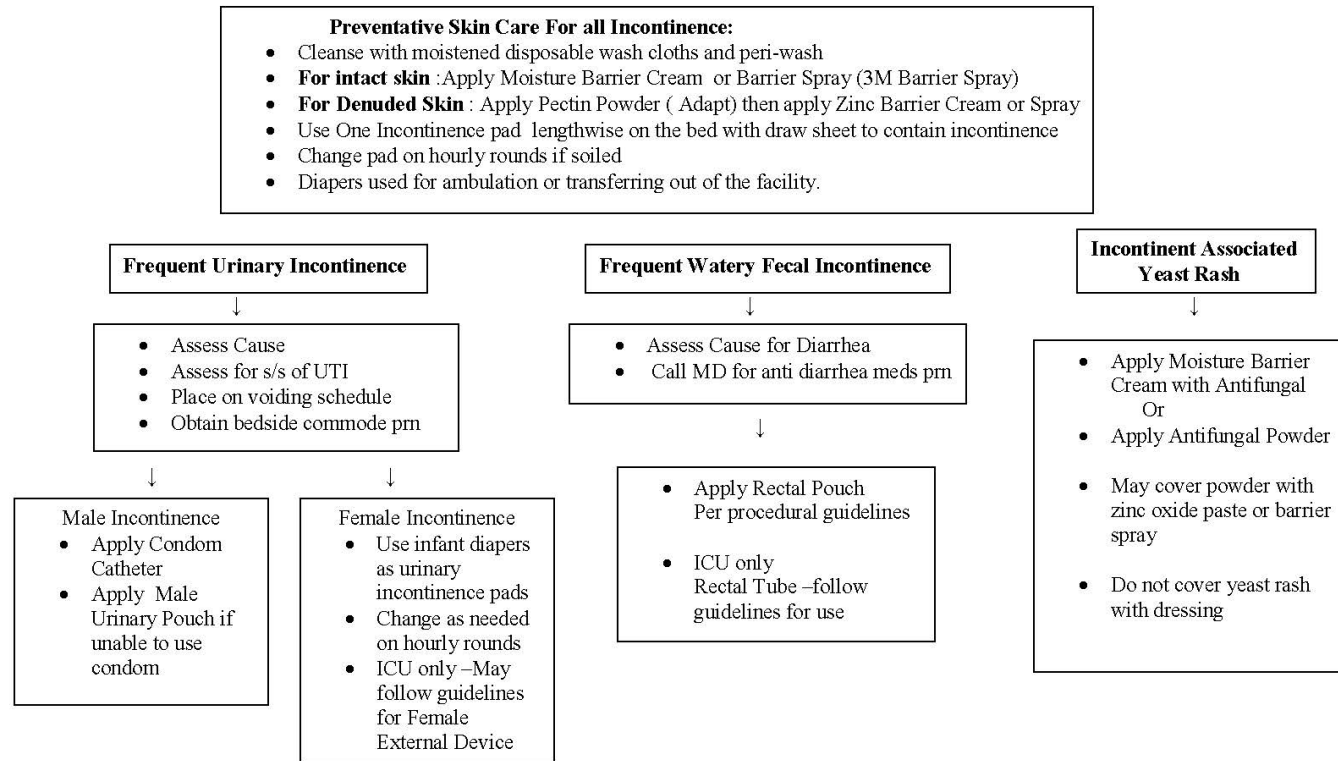
EMORY
HEALTHCARE



Incontinence Decision Tree



DECISION TREE FOR INCONTINENCE CARE



4. Form a Team: “SMART TEAM”

- Receives Train-the-Trainer team education
- Team instructs at quarterly Skin Competency Skills Fair for all Medical Surgical, ER, Surgery and Critical Care bedside nurses and techs
- Conducts monthly prevalence audits
- Attends monthly meetings prior to audits
- Serves as a unit resource for staff guidance
- Identifies opportunities and participates with performance improvement initiatives



Challenges and Solutions

Challenges	Solutions
We have no staff!	Teamwork and teach to work smarter
Why do we do this, other places don't do this!	Better patient care outcomes
We can't afford to do this!	Can we afford not to? Build the business case to support
Staff turnover	Continuous education and recruitment
Leadership changes	Continuous relationship building and explanation of program with results
Non-compliant patients	Patient education and family engagement

Keys to Success

- Leadership support at all levels
 - Financial for staff and products
 - Allowing team time to participate
- Listening to the bedside staff for solutions
- Supporting and rewarding the team on each achievement
- Focus on one opportunity at a time

Resources

- Doughty, D., & McNichol, L. (2016). *Core curriculum wound management*. Philadelphia, Pa.: Wolters Kluwer.
- Emory University Nell Hodgson Woodruff School of Nursing Wound Ostomy and Continence Nursing Education Program; *Skin and Wound Core Content Module*, January 2017 Edition.
- Lin F., Wu Z, Song B., Coyer, F., Chaboyer, W., (2020) The effectiveness of multicomponent pressure injury prevention programs in adult intensive care patients: A systematic review. *International Journal of Nursing Studies* 102:103483
- National Pressure Injury Advisory Panel, European Pressure Ulcer Advisory Panel & Pan Pacific Pressure Injury Alliance (2019). Prevention and treatment of pressure ulcers/injuries: Clinical practice guidelines. The international guideline. Washington, D.C.: National Pressure Injury Panel.
- Saindon, K., Berlowitz, D., (2020). Update on pressure injuries: A review of the literature. *Advances in Skin & Wound Care*, 33(87), 403-409. doi: 10.1097/01.ASW.0000668552.48758.1c
- Wound, Ostomy and Continence Nurses Society Core Curriculum Wound Management 2016 Edition.

Patient's Story: 30 yr old male with Cerebral Palsy who used a wheelchair for mobility; limited vocabulary presenting a communication barrier



Developed a pressure injury on his lower spine from day program misuse of a Hoyer lift

Referred to wound care clinic at Emory University Hospital at Wesley Woods

Wound care physician and nurse created home rehabilitation plan

Instructions clarified to create a safe environment for the pressure ulcer to heal

Physician and nurse answered all questions as father is hard of hearing and interpreted instructions differently

Family education included "teach back" methodology

Wound care nurse available by phone to answer questions and offer support

Compliance of home rehabilitation plan for three months

Family continues to conduct weekly skin checks to prevent pressure injuries



No pressure injuries in last eight years; very positive patient experience

Key Takeaways



Learn today:

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

Use tomorrow:

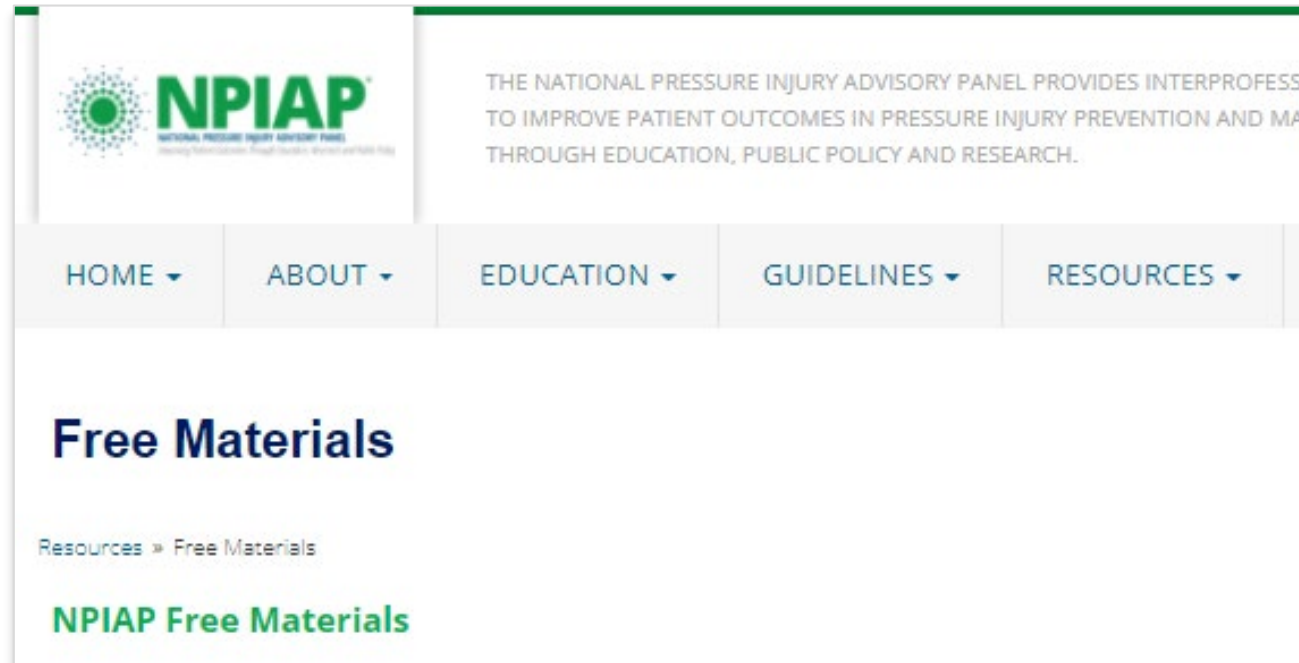
- ❖ Create a team to identify at-risk patients, implement skin management bundles and serve as a unit resource
- ❖ Use teach back methodology when communicating with patients and families

How will this change what you do? Please tell us in the poll...

Resources

- NPIAP Tip Sheet for Pressure Injury Prevention [Download Tip Sheet](#)
- National Pressure Injury Advisory Panel (NPIAP) [Click Here](#) to read "Unavoidable Pressure Injury during COVID-19 Pandemic: A Position Paper from the NPAIP"
- COVID Pressure Injury-Related Articles
 - [Medical Device–Related Pressure Injuries During the COVID-19 Pandemic](#)
 - [Pressure Injury Prevention in COVID-19 Patients With Acute Respiratory Distress Syndrome](#)
 - [The Importance of Pressure Injury Evidence During COVID-19](#)
- [AHRQ Comprehensive Skin Assessment Video](#)
- Skin and Wound Challenges in People of Color
https://www.albany.edu/sph/cphce/goldstamp_webinar_1214.shtml

NPIAP Free Materials



NPIAP Free Materials

[Deep Tissue Pressure Injury or an Imposter?](#)

[Wheelchair Seating Pocket Guide](#)

[Best Practices for Cleansing, Disinfecting, and Care of Polyurethane Support Surface Covers](#)

[Offloading Heels Effectively In Adults To Prevent Pressure Injuries](#)

[Proper Side Lying Positioning In Adults To Prevent Pressure Injuries](#)

[Proper Supine Positioning In Adults To Prevent Pressure Injuries](#)

[PROTECTING FACIAL SKIN Under PPE N95 Face Masks](#)

[Resources for Faculty on Pressure Ulcer Prevention](#)

[COVID-19 Resources](#)

[Pressure Injury Prevention During Proning](#)

[Staging Poster for Lightly and Darkly Pigmented Skin](#)

[Staging Cards for Lightly and Darkly Pigmented Skin](#)

[Quality Nutrition Poster](#)

[Quality Indicator Flyer](#)

[Best Practices for MDRPI Prevention](#)

[Critical Care MDRPI Prevention](#)

[Long-Term Care Prevention of MDRPIs](#)

[NPIAP Staging Poster](#)

[Pediatric Population MDRPI Prevention](#)

[Pressure Injury Fact Sheet](#)

Contact Us



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Alliant HQIC Team

**Karen Holtz,
MT (ASCP), MS, CPHQ**
Alliant Health Solutions
Karen.holtz@allianthealth.org

[View our Website](#)

IHC Team

Melissa Perry, MSW, LCSW
Hospital Quality Initiatives
Project Coordinator
perrym@ihconline.org

[View our Website](#)

IPRO HQIC Team

**Rebecca Van Vorst,
MSPH, CPHQ**
HQIC Project Manager
RVanVorst@ipro.org

[View our Website](#)

Telligen HQIC Team

**Meg Nugent,
MHA, RN**
HQIC Program Manager
mnugent@telligen.com

[View our Website](#)

HQIC

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Upcoming Events



May 24, 2022 2:00 p.m. EST

Infection Prevention: Words of WISDOM (What I Should Do on Monday)

Target audience: New Infection Preventionists

Presenters: IPs from Hospital Quality Improvement Contractors (HQICs):

Alliant, Compass, IPRO and Telligen

Registration link below

<https://allianthealthgroup.webex.com/allianthealthgroup/onstage/g.php?MTID=e45306de822c90f9756f455b4bc5e5258>

or

[Register here](#)



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Thank you for joining us today!

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