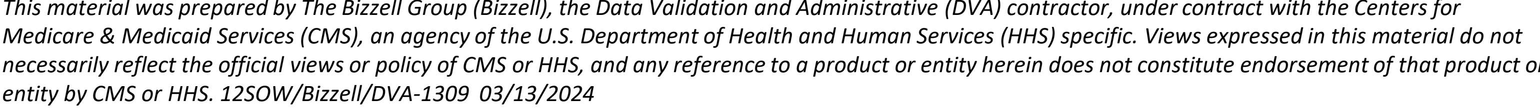
HQIC Community of Practice Call

Pressure Injury Prevention (PIP): Zero Harm

April 11, 2024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Introduction

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Welcome!

Agenda

- Introduction
- Today's topic: Pressure Injury Prevention (PIP): Zero Harm
- Presenter*:*
  - **Tamara Youngs**, WOC Nurse/Educator
- Open discussion
- Closing remarks

As You Listen, Ponder…

- What impactful actions can you take as a result of the information shared today?
- How are you able to increase engagement within your facilities to ensure a true change in patient safety?
- Based on what you heard today, what activities do you currently have underway that can leverage immediate action over the next 30, 60 or 90 days?

Meet Your Speaker

Tamara Youngs, BSN, RN, CWOCN
WOC Nurse/Educator
Community Memorial Hospital

Pressure Injury Prevention (PIP): Zero Harm

Tamara Youngs BSN, RN, CWOCN
WOC Nurse/Educator

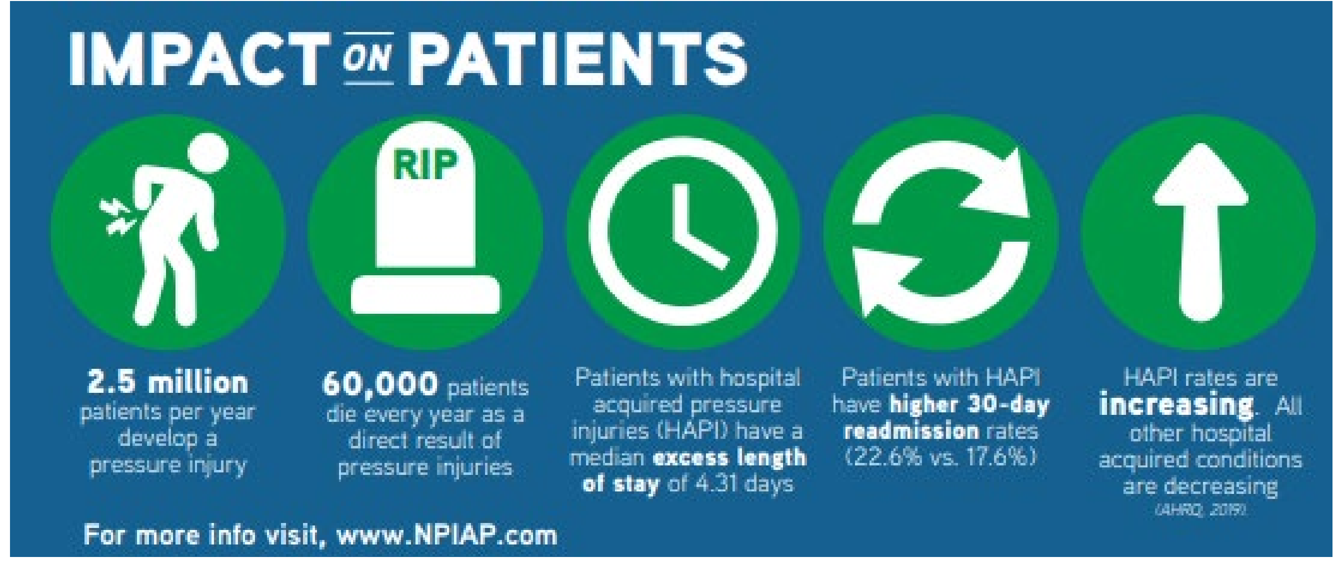
Community Memorial Hospital

Located in the town of Hamilton in Central New York
Nestled next to Colgate University

- 25-bed Critical-Access Hospital
- Serves a population of 45,000 people in 27 communities
- Cornerstone of primary care with 5 locations, urgent care, and specialty care in the region

GROUND Zero:

✓Gap analysis findings revealed an immediate need for a Comprehensive Pressure Injury Prevention Program (PIPP)



Zero IN:

- ✓People
- ✓Product
- ✓Process

Culture SHIFT

- Leadership Support
- Preventative Mindset
- Awareness
- Culture of Safety
- Wound Care Nurse
- Engage Staff
- Interdisciplinary Collaboration

Skin & Wound Care Committee

- Interdisciplinary team:
  - CNO, Director of Units, WOCN, Therapy, Nutritionist, Frontline staff
- Monthly meeting
- Developing and implementing guidelines
- Assessing risk and implementing protocols
- Monitoring and evaluating practices
- Implementing quality improvement initiatives
- Identifying education needs

Interdisciplinary Team Approach

Patient/ Caregiver

- Wound Specialist
- Physician Surgeon/ Infectious Disease
- Rehabilitation Therapy
- Dietician
- Nursing
- Case Management
- Pharmacist
- Radiology
- Leadership
- Procedures (OR,ED)
- Product Specialist

Education

- Clinical orientation
- One-on-one
- Unit huddle
- Product in-services
- Just-in-time education
- Netlearning
- Annual education

Skin Health Solutions

- Skin Champions
- Skin Matters
- Medline Specialist

Awareness & Accountability:

NO HARM ACROSS THE BOARD

Today's date: ________

# of days since last fall: (On this unit) ________

# of days since last fall: (CMH facility-wide) ________

STOP PRESSURE INJURIES!

Date of last hospital-acquired pressure injury (HAPI): ________

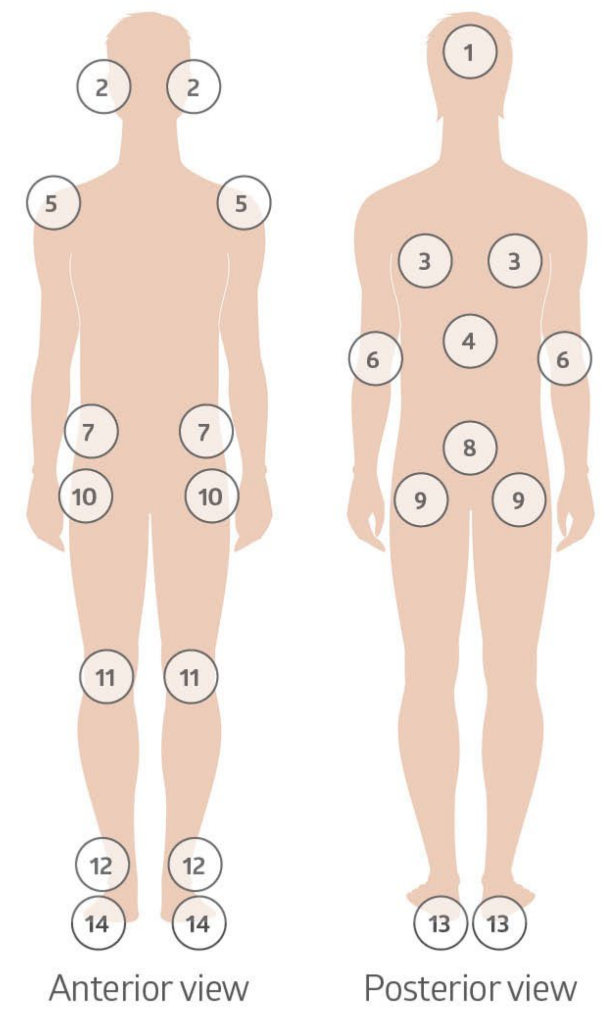
Committed to safety!

Zero OUT:

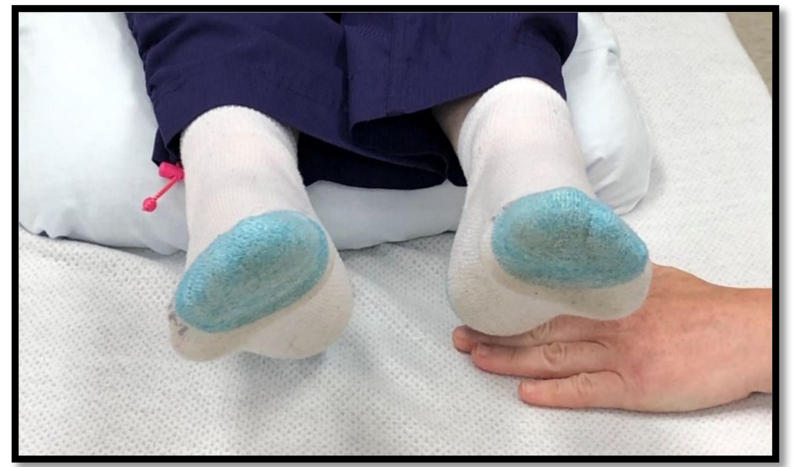
- ✓Comprehensive Skin Assessment
- ✓Braden: Risk Assessment & Implementation of Interventions
- ✓Pressure Redistribution and Offloading
- ✓Maintaining Skin Health
- ✓Nutrition & Hydration
- ✓Plan of Care & Family Education

Comprehensive Skin Assessment

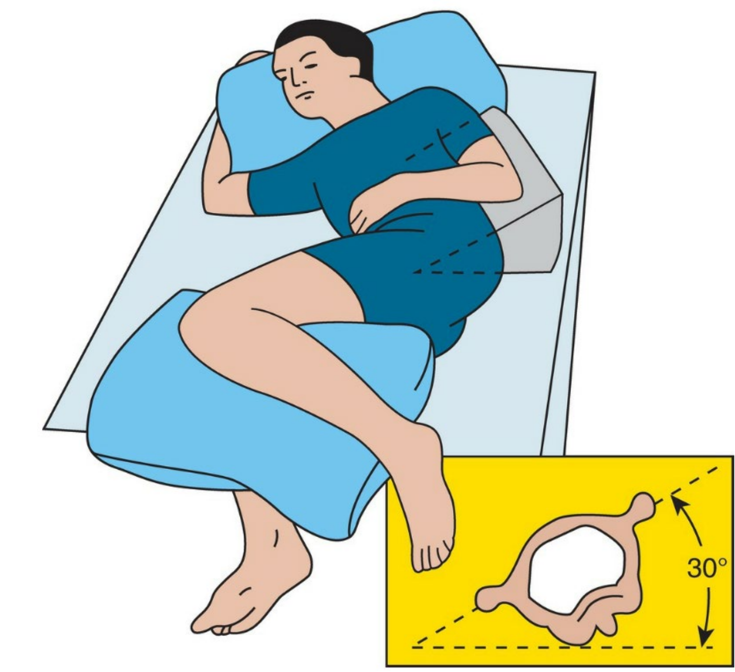
- Comprehensive skin assessment is completed:
  - On admission (<12 hours)
  - Every shift (twice daily)
  - Transfer between units
  - Change in patient condition
- Complete head-to-toe skin assessment
- Remove existing dressing
- Ensure inspection under medical devices
- Establish a baseline and effectiveness of treatment
- WOC Nurse is consulted with concerns of any pressure injuries



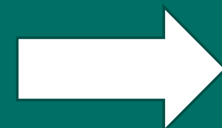
Braden Scale: Risk Assessment & Implementation of Interventions:



- Braden Scale is completed:
  - On admission (<12 hours)
  - Every shift (twice daily)
  - Transfer between units
  - Change in patient condition
- Subscale scores should be used to identify specific risk factors for the individual patient
- Early implementation of pressure injury prevention interventions
- Implement interventions prior to wound consult
- Communicate patient’s risk and interventions
  - Entire team including PCTs
  - During shift handoff report



Braden Scale Intervention Table



Guides the nurse for implementation of appropriate interventions based on the Braden risk assessment.

All Patients	Manage Moisture
• Assess skin every shift for pressure injury development • Manage pain to allow optimal mobility • Encourage ambulation, mobility and repositioning as tolerated, involving family members as appropriate • Ensure appropriate mobility/respiratory devices are available as needed for ambulation • Apply moisturizing lotion with daily hygiene to area of dry skin • Encourage healthy food choices, involving family as appropriate • Encourage out of bed (OOB) for meals • Reassess patient repositioning schedule with changes in status and skin condition • Patient bed selection per Stryker Support Surface Selection tool	• Address cause, if possible • Offer bedpan/urinal and cup of water on a schedule • Perform incontinence care and cleanse moist skin folds • Use barrier cream or ointment for moist areas and areas subject to incontinence • Limit layers: ≤3 layers, do not double chuck • Air dry skin folds and avoid use of briefs • Moisture wicking material in skin folds as needed (Interdry AG), change q5days and PRN with soiling or saturation, or per order • Use external female or male urinary catheter
At Risk (15 to 18)	**Manage Nutrition**
All of the above and: • Encourage repositioning Q2 hours, if independent, while awake, and more frequently while in chair • Assess for red areas on bony prominences each shift • Protect heels by floating and/or using Heel Boot Protector • Use an redistribution cushion when OOB to chair/wheelchair • Suggest physical therapy(PT)/occupational therapy (OT) evaluation for limited mobility/activity • Manage nutrition, moisture, friction and shear as appropriate	• Increase protein intake • If able to take oral, consider dietary preferences • Encourage healthy snacks throughout the day • Accurate documentation of oral intake • Perform daily weights as ordered • Manage contributing factors (e.g. nausea, constipation, dentition, pain) • Assist with setup/feeding as necessary • Consider OT evaluation and use of adaptive equipment • Consult dietician to assess for and correct deficiencies and determine necessary supplementation
Moderate Risk (13 to 14)	**Manage Friction and Shear**
All of the above and: • Turn and position Q4 hours to Q2 hours, assessing bony prominences when repositioning • increase repositioning frequency in Q1 hour increments with pain, tenderness, redness of bony prominences, or degradation in overall patient status • Elevate foot of bed to 20 to 30 degrees when HOB is up to prevent sliding • Use pillows or wedges for 30 degree side position (use of hand to ensure sacrum is off bed) • Teach patient to use side rails to reposition • Use a Hovermat for transfers **and** Hoyer lift as needed	• Head of bed (HOB) up no more than 30 degrees if allowed clinically • Use trapeze when indicated • Use lift sheet to turn and reposition when assistance is necessary • Pad boney prominences (elbows, heels, ischium, etc.) when exposed to friction with multilayer silicone foam dressings • Consider use of geri-sleeves for upper/lower extremity protection
High Risk or Very High Risk (12 or lower)	**Additional Considerations**
All of the above and: • Supplement repositioning schedule with small position shifts • Alert MD if severe pain exacerbated by turning, involve Palliative Care if intractable pain • Consider fecal collection device in cases where patient is incontinent of liquid stool • OOB for meals, as tolerated, for no more than 1 hour at a time	• Do not massage reddened bony prominences • Do not use donut type devices • Maintain good hydration • Preventative Dressings: Nurse to "Peel & Peek" under dressing and document on Integumentary every shift.

Don't leave your patient in SHAMBLES

Address these concerns every time you off-load:

Pressure Injury Prevention:

S = Sacrum

- 4 Eyes Skin Assessment: 24 hours of Admission for all patients with Braden ≤18 (RN-to-RN or RN-to-WOC)
- Check for erythema and blanching & consider skin tones
- Purple discoloration consult WOC
- Sacral Foam Dressing for Braden score ≤ 14 or identified as high-risk
- Preventative Drgs: "Peel & Peek" under dressings EVERY shift (Document: Integ. Comment)
- Use an redistribution cushion such as a Rojo cushion or Gel Cushion when OOB to chair/Wheelchair

H = Heels

- 4 Eyes Skin Assessment: 24 hours of Admission for all patients with Braden ≤18 (RN-to-RN or RN-to-WOC)
- Check for erythema and blanching & consider skin tones
- Include with every reposition to ensure floating
- Consider use of Heel booties and/or Heelz-up

A = Appliances

- Check underneath every shift
- Protect with foam if concerned for breakdown (Mepilex foam/E-Z wrap Foam 02)
- Part of comprehensive skin assessment (every shift)
- Do not leave BP cuff on arm when not in use
- Remove coban over IVs or lab draw sites asap

M = Moisture

- Use EPC (Extra Protective Cream)
- Be proactive to decrease risk for pressure injury
- Use low air loss bed pump
- Consider external catheters for incontinence (Purewick)

B = Bony prominences

- High risk for breakdown
- Offload and monitor frequently
- Part of comprehensive skin assessment (every shift)
- Purple discoloration not related to trauma

L = Layers: Promote Ideal microclimate with support surface

- 3 or less layers under patient
- Do not double chuck
- Limit use of briefs

E = Edema

- Increased risk for breakdown
- Elevate extremity
- Gentle skin care to reduce skin tears
- Compression as needed, Confirm ABI/Arterial US

S = Sweep

- Check the bed for "bed trash"
- Remove wrinkles in linens
- Ensure not laying on tubing/device

Prophylactic Dressings

- Applied over intact skin at pressure injury points
- "Peel & Peek" Method
  - Nurse to peel back dressing every shift for inspection
- Reduces friction, shear, moisture, and pressure on at-risk areas
- Braden ≤14 have Mepilex-bordered foam applied to high-risk areas
- Applied under medical devices at risk
- Used in conjunction with pressure injury prevention interventions

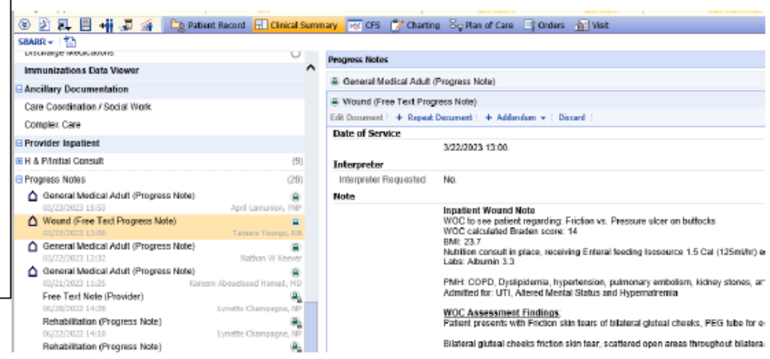
W.I.N.K.

What.I.Need.to Know.

Finding a WOC Note in CERNER

Finding a WOC Note: Clinical Summary: Progress Notes

WOC will complete:
Braden Weekly
Integumentary Progress Note
Update POC
Review/Update Orders



WHEN IN DOUBT, WOC IT OUT!

Wound/Ostomy Nurse Will:
Head-to-toe Assessment
Wound Assessment Weekly and/or wound deteriorating
Wound measurement
Diagnosis of Ulcer/wound etiology with coordination with Hospitalist and General Surgery
Offloading
Wound culture/Wound Debridement
Dressing Selection
Wound VAC Changes
Devices: mattresses, cushions, heel protectors.
Educating staff to improve quality, effectiveness, and safety of care.
Case analysis for HAPI (Hospital Acquired Pressure Injuries)
Follow up/Discharge Coordination: Wound care
Resource for Wound, Ostomy and Continence

Helpful Tip: Look at my Integumentary to see wound etiology!

Consult for concerns with:
Pressure Injuries/HAPI's
DTI's
Severe MASD
Complicated Skin Tears
Full-thickness wounds
Venous Stasis Ulcers
Diabetic Ulcers
Fistulas
Unknown Wound Etiology
Ostomy
Internal Reservoirs
Incontinence
Drains
Wound Vac Issues
PEG Tube
Percutaneous Tubes

Wound and Ostomy Department 2023: Tamara Youngs, RN, BSN, CWOCN Ext: 7049

SKIN W.I.N.K.

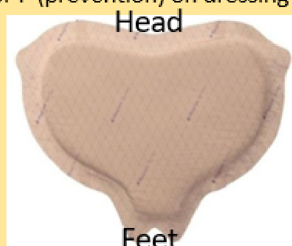
What.I.Need.to Know.

Sacral Pressure Injury Prevention Dressing

Prevention starts with you

Preventing pressure injuries is preventing harm

- The sacrum and coccyx are one of the most common areas for developing a hospital acquired pressure injury
- All patients with a Braden Score of 14 or less should have a sacral Mepilex dressing applied
- Sacral Mepilex are to be changed every 3 days and PRN if they are rolled or soiled
- Date & Initial, T (treatment) or P (prevention) on dressing



- Proven to prevent pressure injuries – by up to 88% – when used as part of a comprehensive pressure injury prevention protocol
- Mepilex Border dressings Proprietary Deep Defense Technology* addresses the key factor responsible for pressure injuries, protecting against the extrinsic forces of pressure, shear and friction and managing microclimate
- Safetac technology reduces the risk of maceration and minimizes pain during dressing changes
- Excellent fluid-handling capacity and Retention

*****No EPC underneath the dressing*****

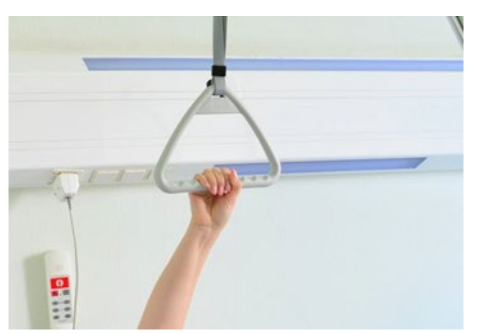
- It is ok to apply EPC (extra protective cream) around the dressing after it is placed
- Ensure the dressing makes contact with the coccyx during application

"Peel & Peek" under dressings Q shift!

Wound and Ostomy Department 2023: Tamara Youngs, RN, BSN, CWOCN Ext: 7049

Equipment for Pressure Redistribution

- Heel Booties
- Rojo cushion/Gel cushion
- Mepilex Foam Dressing
- Stryker on Low Air Loss Pump
- Stryker Bed
- Safe Patient Handling
- Hovermatt
- Trapeze



IsoFlex LAL™ Support Surface selection tool

stryker

Note: This tool does not replace clinical judgment. IsoTour is used to assist in the prevention and treatment of all categories/stages of pressure injuries **(stages 1, 2, 3, 4, unstageable, and deep tissue pressure injury)** and is recommended to be implemented in combination with clinical evaluation of risk factors and skin assessments made by a health care professional as part of a complete plan of care. Support surfaces do not eliminate the need for turning and repositioning.

Patient condition[1,2]	Order status	Image	Product
Patients with: • Braden score 18-23 • At risk for skin breakdown (hx of PrI) • Slightly limited mobility to immobile • Pressure injuries stages 1-4, unstageable and DTPI	Standard		**IsoFlex standard support surface** • 500 lb. weight limit
Identify: Old Mattress or Stryker Mattress (Orange bottom) **Please consult WOCN for skin impairment**	Old Mattress: SPR plus Overlay		Sof.Care Overlay: • Add SPR plus LAL Overlay to the mattress • Add IsoFlex pump to the support surface **Consult the Wound Care Team for Pump Settings**
Patients with Moisture issues: • Patient requires linen change 2x or greater/shift related to diaphoresis • Currently has Moisture Associated Skin Damage, Friction/Shear injury • Braden Score ≤18 and/or Moisture subscale score 1-2 • Co-Morbidities/Morbid Obesity • Clinical Judgment/High Risk • Large wound exudate and/or incontinence • Pressure Injuries Stage 2, or large, multiple Stage 3 or 4 on trunk/pelvis	IsoFlex LAL (Low Air Loss)		**IsoFlex Support Surface with Stryker Air + pump** • Add IsoFlex pump to the support surface • Turn on the Stryker Air + pump by pressing the power button and select IsoFlex LAL

Maintaining Skin Health:

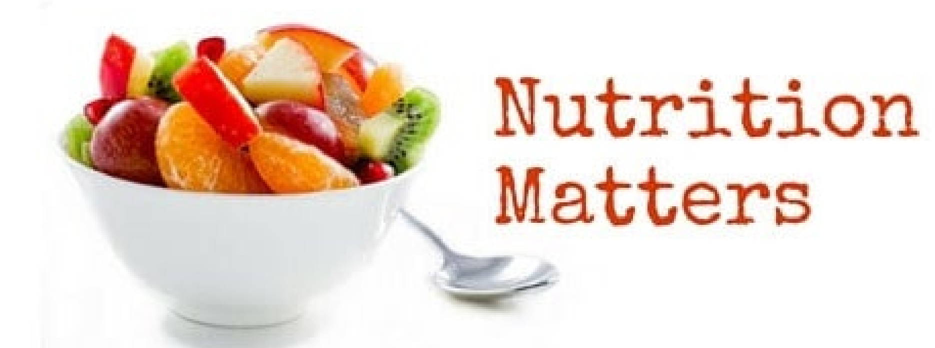
REMEDY SKIN CARE GUIDELINES

Skin Condition	Description	Cleanse	Moisturize	Prevent	Protect/Treat
Intact/Dry Skin	Skin care for patients with intact or extremely dry skin	Specialized Foaming Cleanser	Specialized Skin Cream	Be alert for any changes in skin integrity	
Intact Skin Exposed to Incontinence	Skin protection for incontinent patients with intact skin	Specialized Foaming Cleanser	Moisturization of skin is not appropriate	Specialized Silicone Cream	Be alert for any changes in skin integrity
IAD-Incontinence Associated Dermatitis	Skin protection and treatment for incontinent patients with compromised skin	Specialized Foaming Cleanser	Moisturization of skin is not appropriate		Specialized Zinc Oxide Protectant
ITD-Intertriginous Dermatitis	Skin protection and treatment for areas of skin to skin contact that is exposed to, or traps moisture	Specialized Foaming Cleanser	Moisturization of skin is not appropriate	Dri-Go HP Anti-bacterial Wicking Sheet	Clinical Antifungal Powder
Fungal Rash	Skin protection and treatment of a fungal/yeast rash	Specialized Foaming Cleansing	Moisturization of skin is not appropriate		Clinical Antifungal Ointment

BE GENTLE,
AVOID SCRUBBING

Nutrition Status:

- Nutrition screening
- Dietician consult
- Individualized diet
- Monitor nutrition and hydration status
- Monitor weight for gain/loss
- Supplemental nutrition
- Monitor nutritional lab values
- Feeding assistance and encouraging increased intake
- Wound Nurse and Dietician collaboration



Plan of Care: At Risk for Skin Integrity

- Individualize care plan
- Action plan
- Prioritize and address
- Collaboration
- Patient/Family education
- Empower

Leading the way to Zero

Ensure leadership is committed to a goal of zero harm

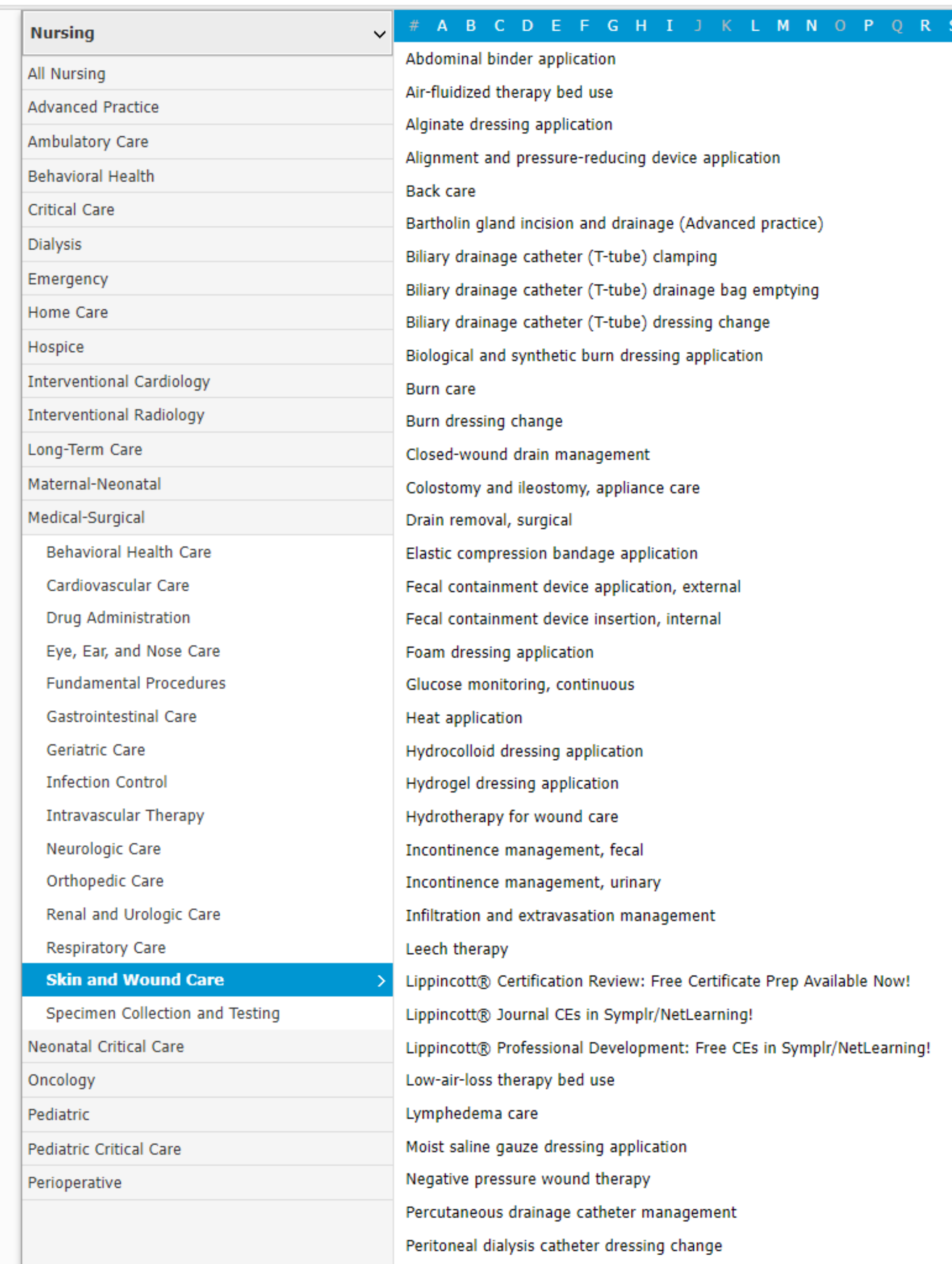
Develop and adopt a safety culture

Incorporate process improvement tools and methodologies in your work

Demonstrate how everyone is accountable for safety and quality

Skin & Wound Care Procedures

- Adopting Lippincott Procedures
- Evidence-Based Practice
- Provides Nursing guidelines for the prevention and treatment of tissue trauma and pressure injuries



Electronic Medical Records Updates

- Mandatory Braden Scale Assessment
- Braden Interventions
- Integumentary Updates
- Patient/Family Education for Pressure Injury Prevention
- Pressure Injury Report: Daily
- Wound Care Consult

Quality Chart Audits

Comprehensive Skin Assessment

Braden Scale & Implementation of Interventions

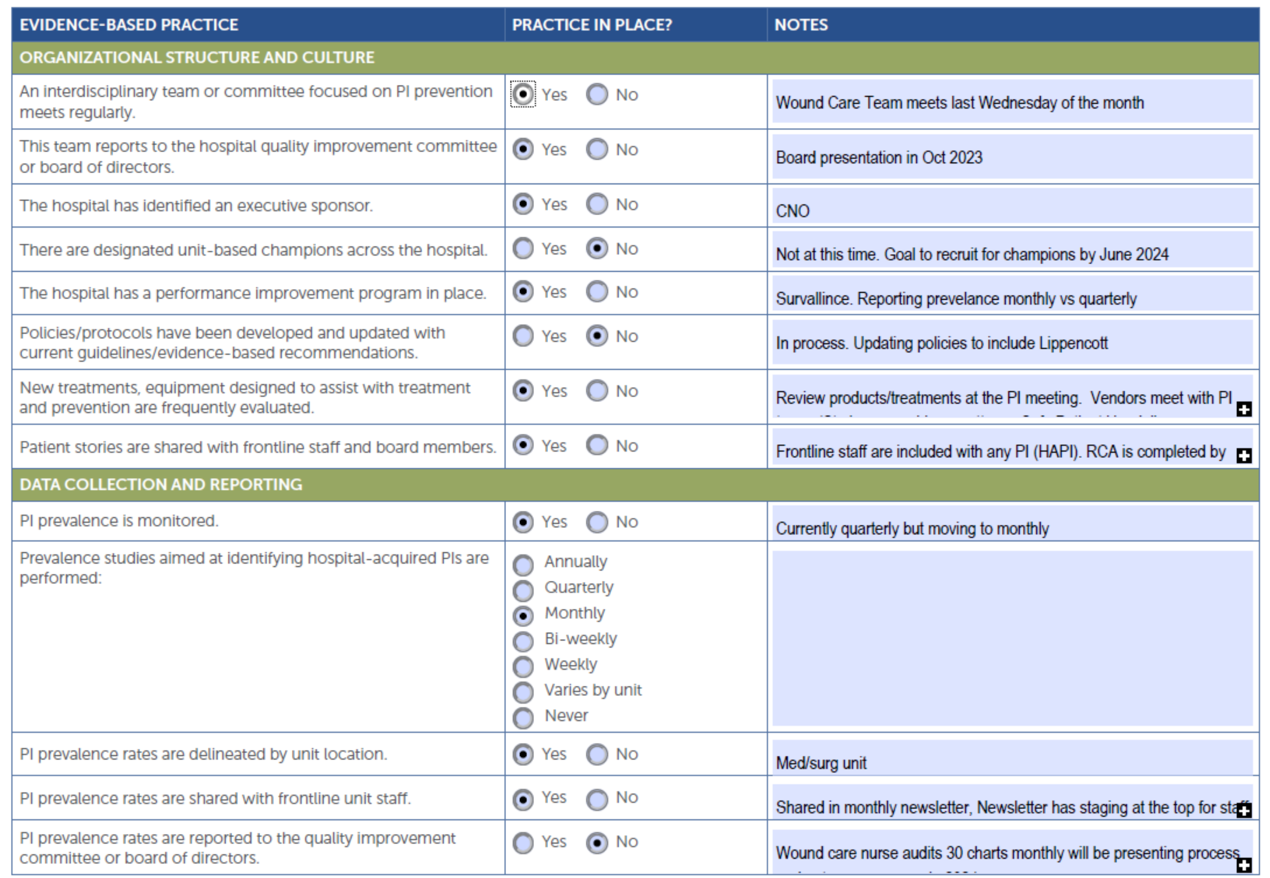
Skin Integrity Plan Of Care

Root Cause Analysis (RCA):

- Not a punitive function; learning and growth opportunity
- RCA is completed with every hospital pressure injury occurrence
- Post-pressure injury huddle completed at bedside
- Review occurrence findings with entire unit staff by 3 p.m. on same day
- Review of RCA findings each shift for one week after occurrence
- Identification of education needs, action plan, facility protocol changes
- Review of Hospital-Acquired Pressure Injury (HAPI) at the Skin & Wound Care Committee meeting each month

Rapid-Cycle Improvement Process (RCIP): Pressure Injuries Assessment

- RCIP performed in December 2023 by EQIC
- Allowed for organization evaluation of current practices
- Identified areas for opportunity of improvement
- Allows for implementation of changes to improve pressure injury prevention practices
- Performance Improvement since RCIP:
  - Updated Pressure Injury Prevention Policy
  - Clinical Orientation: Wound, Ostomy, Continence
  - Facility-wide Pressure Injury Awareness



PRESSURE INJURIES ASSESSMENT (continued)

EVIDENCE-BASED PRACTICE	PRACTICE IN PLACE?	NOTES
ORGANIZATIONAL STRUCTURE AND CULTURE		
An interdisciplinary team or committee focused on PI prevention meets regularly.	◉ Yes ○ No	Wound Care Team meets last Wednesday of the month
This team reports to the hospital quality improvement committee or board of directors.	◉ Yes ○ No	Board presentation in Oct 2023
The hospital has identified an executive sponsor.	◉ Yes ○ No	CNO
There are designated unit-based champions across the hospital.	○ Yes ◉ No	Not at this time. Goal to recruit for champions by June 2024
The hospital has a performance improvement program in place.	◉ Yes ○ No	Survallince. Reporting prevelance monthly vs quarterly
Policies/protocols have been developed and updated with current guidelines/evidence-based recommendations.	○ Yes ◉ No	In process. Updating policies to include Lippencott
New treatments, equipment designed to assist with treatment and prevention are frequently evaluated.	◉ Yes ○ No	Review products/treatments at the PI meeting. Vendors meet with PI
Patient stories are shared with frontline staff and board members.	◉ Yes ○ No	Frontline staff are included with any PI (HAPI). RCA is completed by
DATA COLLECTION AND REPORTING		
PI prevalence is monitored.	◉ Yes ○ No	Currently quarterly but moving to monthly
Prevalence studies aimed at identifying hospital-acquired PIs are performed:	○ Annually ○ Quarterly ◉ Monthly ○ Bi-weekly ○ Weekly ○ Varies by unit ○ Never	
PI prevalence rates are delineated by unit location.	◉ Yes ○ No	Med/surg unit
PI prevalence rates are shared with frontline unit staff.	◉ Yes ○ No	Shared in monthly newsletter, Newsletter has staging at the top for sta
PI prevalence rates are reported to the quality improvement committee or board of directors.	○ Yes ◉ No	Wound care nurse audits 30 charts monthly will be presenting process

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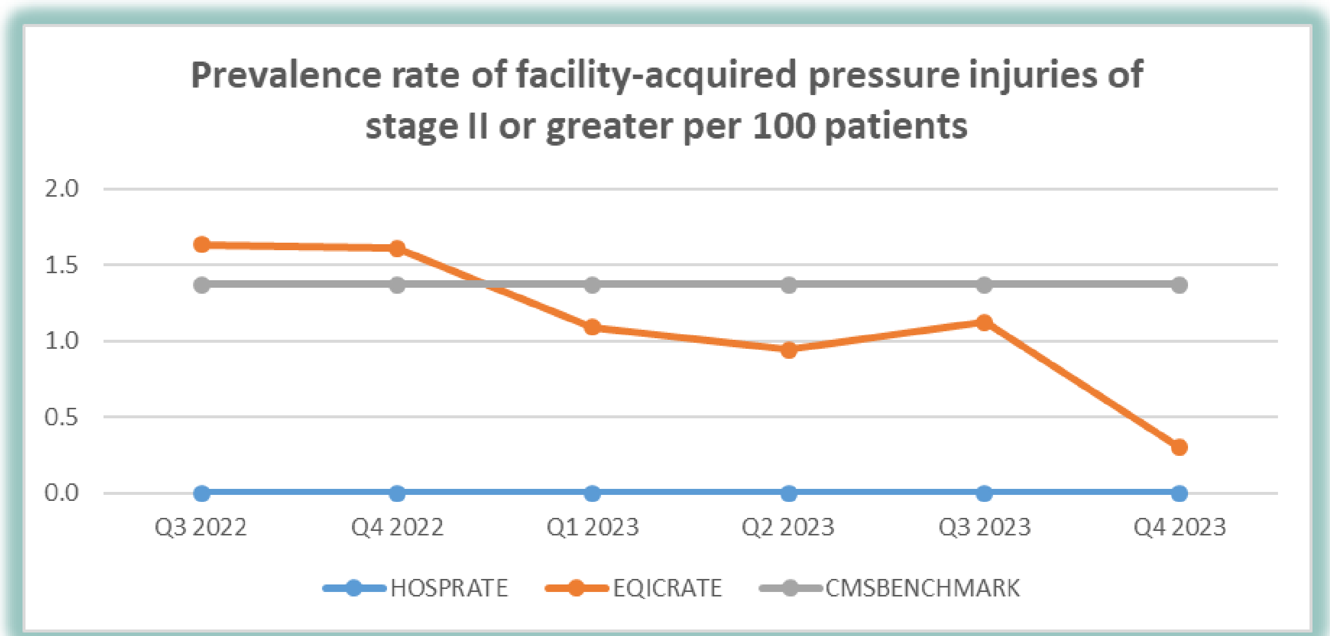
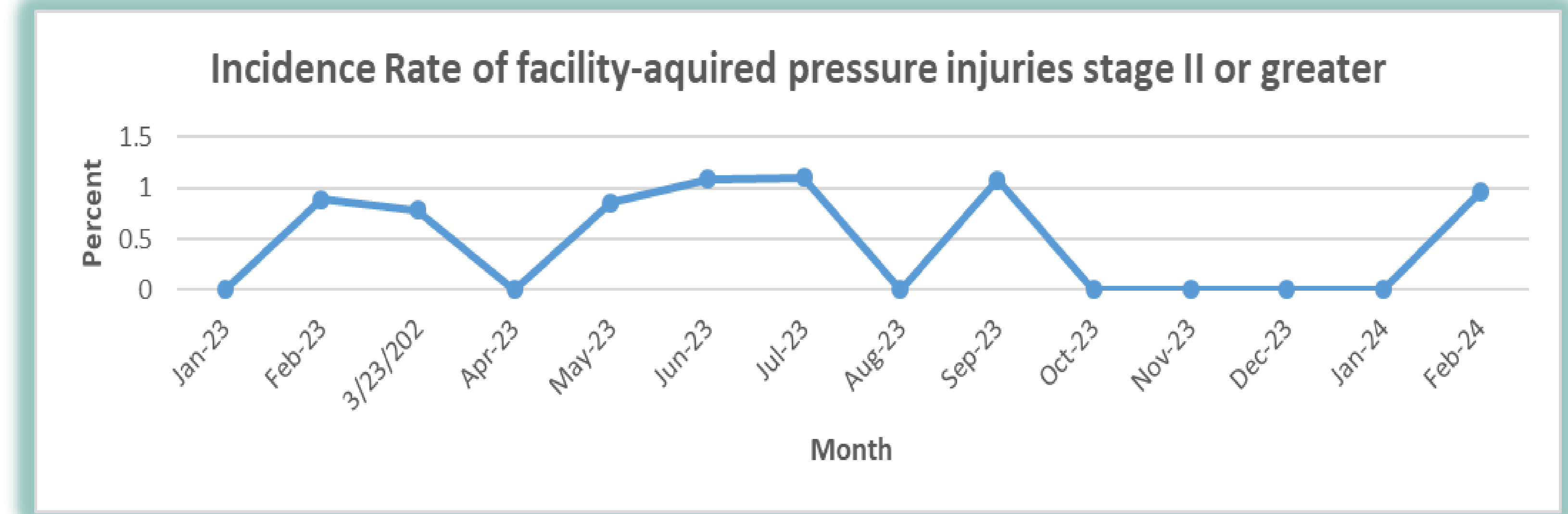
Zero to HERO!



Prevalence: **SNAP SHOT** that **100%** of patients are assessed on **ONE day** (single point in time) every **90 days** that have a facility-acquired pressure injury of **stage II or greater.**



Incidence: New pressure injuries that developed **AFTER** admission with ongoing monitoring and surveillance (cumulative) includes **stage I or greater**.

Performance Monitoring:

2024 Wound Ostomy is an official department at CMH

- First year to have a defined Scope of Practice and participate in Performance Improvement Program
- Performance Improvement 2024:
  - Outcome Measure:
    - Incidence of HAPI's (Hospital-Acquired Pressure Injuries)
  - Process Measures:
    - Braden Scale Assessment Completed on Admission (<12hrs)
    - Appropriate Braden Interventions documented/implemented based on Braden Risk Score
    - Skin Integrity Care Plan Established according to Risk Category
    - Provider Order for Treatment
- Monthly Pressure Injury Prevalence Studies
- Wound Care Department presents the quality program to the Hospital Board of Directors

“Quality is not an act,
it is a habit.”

–Aristotle

References:

Ermer-Seltun, JoAnn; Engberg, Sandy. Wound, Ostomy and Continence Nurses Society Core Curriculum: Continence Management (p. 424). Wolters Kluwer Health. Kindle Edition.

McNichol, L., Ratliff, C., & Yates, S. (2022). Wound, Ostomy and Continence Nurses Society core curriculum: Wound management (2nd Edition). Philadelphia: Lippincott, Williams & Wilkins. ISBN 9781975164591

Wound, Ostomy, and Continence Nursing: Scope and Standards of WOC Practice, 2nd Edition: An Executive Summary. Journal of Wound, Ostomy and Continence Nursing 45(4): p. 369-387, July/August 2018. | DOI: 10.1097/WON.0000000000000438

Discussion

- What impactful actions can you take as a result of the information shared today?
- How are you able to increase engagement within your facilities to ensure a true change in patient safety?
- Based on what you heard today, what activities do you currently have underway that can leverage immediate action over the next 30, 60 or 90 days?

Final Thoughts

Join Us for the Next Community of Practice Call!

Join us for the next
Community of Practice Call on May 9, 2024
from 1:00 – 2:00 p.m. ET

We invite you to register at the following link:
https://zoom.us/webinar/register/WN_ASl_l3p_TEyx_VY_YYFFeA

You will receive a confirmation email with login details.

Thank You!

Your opinion is valuable to us. Please take 4 minutes to complete the post assessment.

We will use the information you provide to improve future events.