Health Quality Innovation Network

Pressure Injury Sprint Series – Session One: The Pre-admission and Admission Process

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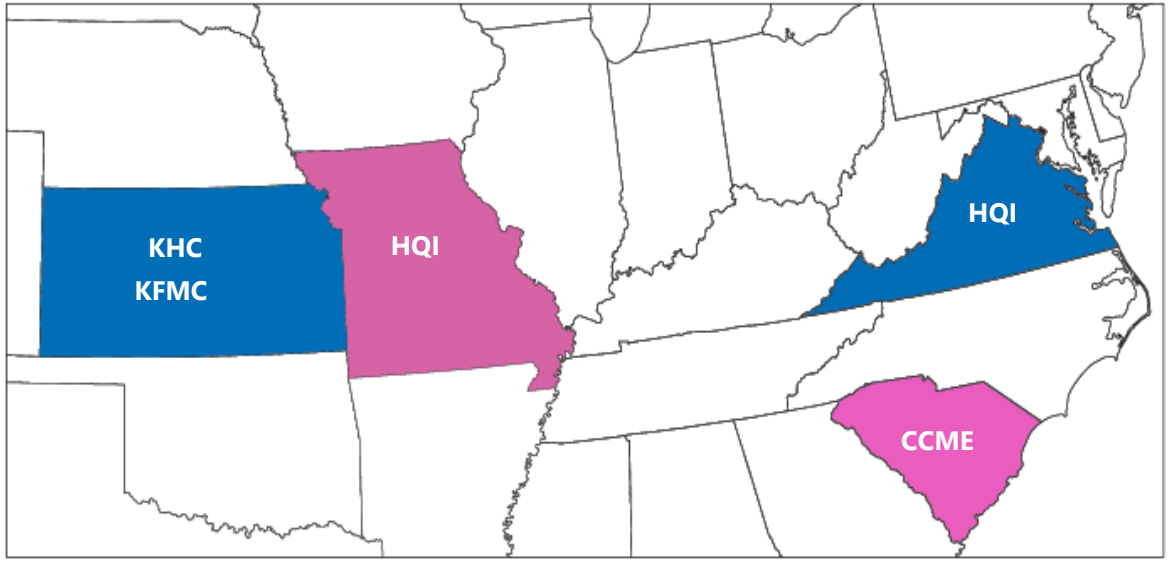

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Logistics – Zoom Webinar

To ask a question, click on the **Q&A** icon.

Raise your hand if you want to verbally ask a question.

Resources from today's session will be posted in **Chat**.

You may adjust your audio by clicking **Audio Settings**.

You have been automatically muted with video turned off.

Pressure Injury Sprint Series: Quality Improvement Principles for Pressure Injuries

This Sprint is a seven-part webinar series where each session builds upon the next. Participants can expect to:

- Apply quality improvement principles to your pressure injury program
- Engage and learn with subject matter experts
- Receive resources and tools to drive quality improvement efforts

Today's Speaker

Beth Hercher, CPHQ

Quality Specialist NH

Objectives

1. Understand Pressure Injury (PI) Definition
2. Understand regulations that impact PI prevention at the time of admission/readmission
3. Understand Facility Risk Management
4. Understand Pre-Admission and Admission Process

Pressure Injury Definition

Pressure Injury

A pressure injury is localized damage to the skin and/or underlying soft tissue usually over a bony prominence or related to a medical or other device.

The injury can present as intact skin or an open ulcer and may be painful.

The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear.

The tolerance of soft tissue for pressure and shear may also be affected by microclimate, nutrition, perfusion, co-morbidities and condition of the soft tissue.

F-655 Baseline Care Plan

1. Develop and implement a baseline care plan
2. Provide effective and person-centered care
3. Meet professional standards of quality care
4. *Within 48 hours of admission*

F-686 Comprehensive Assessment of a Resident

- Promote the prevention of pressure ulcer/ injury development;
- Promote the healing of pressure ulcers/injuries that are present (including prevention of Infection to the extent possible);
- Prevent development of additional pressure ulcer/ injury

Facility Level Risk Management

Three Key Factors of Risk Management

1. Medical record reflects adherence to standard of care

2. Medical record must document resident complications, risk factors, underlying disease if pressure injury is unavoidable

3. Must have a comprehensive program to prevent and treat pressure injury (within the parameters of resident advance directives)

Organizational Commitment

Include statement in the pressure injury/ulcer prevention and treatment policy that:

1. Confirms the resident's right to be free of pressure injury and to have timely and current treatment for any pressure injury/ulcer

2. Shows the facility's commitment to take measures to prevent pressure injury/ulcers

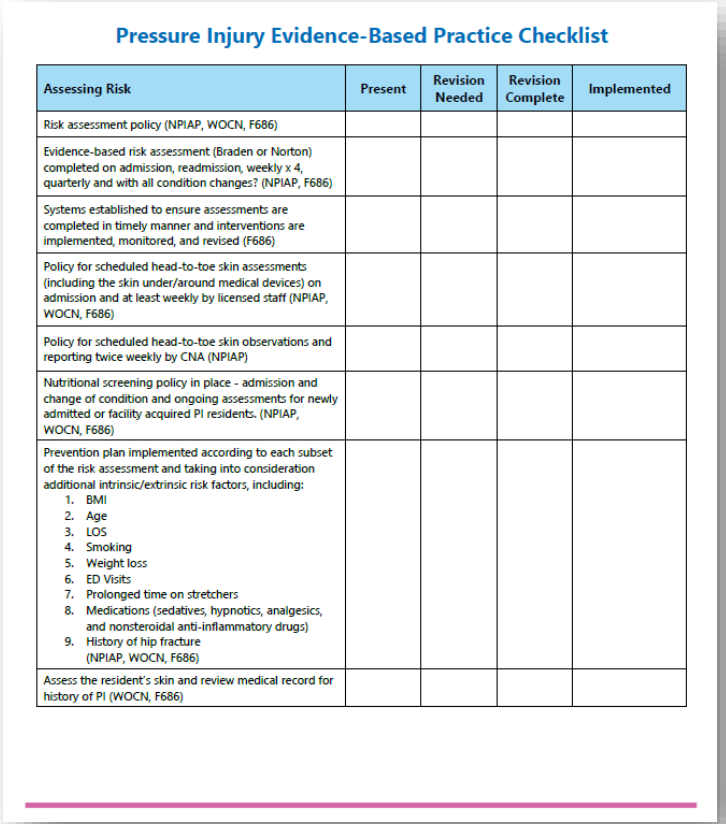
3. States staff is aware of this commitment statement

Foundational Considerations

1. Identify and train one or more nurses to become “Wound Care Certified”
2. Educate all staff on skin breakdown and pressure injuries
3. Ensure staff competencies in skin care
4. Monitor equipment used to reduce pressure injuries
5. Review all pressure injuries through a QAPI process

Evidenced Based Practice Worksheet

1. Assessing risk
2. Prevention and skin care
3. Treatment
4. Education



Pressure Injury Evidence-Based Practice Checklist

Assessing Risk	Present	Revision Needed	Revision Complete	Implemented
Risk assessment policy (NPIAP, WOCN, F686)				
Evidence-based risk assessment (Braden or Norton) completed on admission, readmission, weekly x 4, quarterly and with all condition changes? (NPIAP, F686)				
Systems established to ensure assessments are completed in timely manner and interventions are implemented, monitored, and revised (F686)				
Policy for scheduled head-to-toe skin assessments (including the skin under/around medical devices) on admission and at least weekly by licensed staff (NPIAP, WOCN, F686)				
Policy for scheduled head-to-toe skin observations and reporting twice weekly by CNA (NPIAP)				
Nutritional screening policy in place - admission and change of condition and ongoing assessments for newly admitted or facility acquired PI residents. (NPIAP, WOCN, F686)				
Prevention plan implemented according to each subset of the risk assessment and taking into consideration additional intrinsic/extrinsic risk factors, including: 1. BMI 2. Age 3. LOS 4. Smoking 5. Weight loss 6. ED Visits 7. Prolonged time on stretchers 8. Medications (sedatives, hypnotics, analgesics, and nonsteroidal anti-inflammatory drugs) 9. History of hip fracture (NPIAP, WOCN, F686)				
Assess the resident's skin and review medical record for history of PI (WOCN, F686)				

Admission Best Practices

Pre-Admission Practices

1. Identify the status of the resident's skin and risk for skin breakdown
2. Review all current treatments the resident is receiving to identify possible skin integrity issues not known by transferring organization
3. If the resident has skin integrity issues or pressure injuries, determine needs for:
   a. Pressure redistribution in the bed
   b. Pressure redistribution in the chair
   c. Heel lift and Turning/Repositioning programs
   d. Incontinence management
   e. Nutritional support or supplementation

Admission Practices

1. Perform skin inspection on admission
2. Conduct comprehensive skin risk assessment
3. Develop an individualized skin integrity care plan
4. Document all skin integrity interventions on nursing assistant's assignment sheets
5. Discuss skin integrity risks, and review plan of care with resident and family

Admission Comprehensive
-Assessment and Reassessment

1. Comprehensive skin inspection within 2-6 hours of admission or readmission

2. Comprehensive skin risk assessment utilizing validated tool (Braden or Norton)*

*Best Practice

Day 7, 14, 21, 28 (post-admission)

Ongoing Care Practices and Monitoring

1. Conduct daily skin inspection
2. Conduct weekly skin inspection
3. Conduct weekly rounds by the DON, Medical Director/Physician and Wound Nurse
4. Complete skin risk assessment weekly first four weeks after admission, then monthly and with a change of resident condition
5. Communicate risk assessment results, skin checks, and interventions

Prevention Interventions

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Prevention Interventions

A system is in place for assigning accountability for monitoring that risk assessments have been completed and interventions have been implemented

1. Identify a person(s) team responsible for monitoring pressure injury policies are in place and being implemented

2. Implement standard practice for pressure injury/ulcer prevention by:
    a. Using checklists
    b. Analyze current assessment tools
    c. Make changes to current practice to meet guidelines

Prevention Interventions

- Appropriate lifting techniques and devices
- Provides high-risk residents physical and/or occupational therapy
- Nutrition and hydration
- Individualized turning and repositioning schedules
- Appropriate support surfaces

Case Study


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Mr. Jones

He is a 71-year-old who was admitted after 5:30 p.m. on a Friday evening for short-term rehabilitation following a Motor Vehicle Accident resulting in a left hip fracture. On report from the hospital there was no mention of a PI.

The facility sustained a 25% decrease in staffing that weekend with 2 nurses and 3 assistants not reporting, staff were pulled to cover extra care needs.

The resident verbalized that he did not see anyone until 2 a.m. He reported that he stayed in bed on his back for most of the weekend and he had several accidents because no one responded to his call bell.

During the stand-up meeting on Monday, it was discovered that the baseline care plan was not completed including a full skin assessment. The nurse was instructed to complete a full skin assessment; upon review it was noted that the resident had a stage 2 PI.

Poll 1

What contributed to the discovery of stage 2 PI 48 hours post-admission?

a) The nursing home was short staffed over the weekend
b) Baseline care plan not completed with a skin assessment
c) Mr. Jones was not repositioned and incontinent
d) Mr. Jones had a lot of pain and therefore repositioning was not appropriate
e) a, b & c
f) All of the above

Poll 2

What interventions could the facility have implemented to avoid an untimely baseline care plan?

a. Shift-to-Shift Handoff process to ensure transfer of information

b. Admission Checklist located at nurses' station

c. Care Team Huddles

d. All of the above

Resources


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Evidenced Based Practice Worksheet

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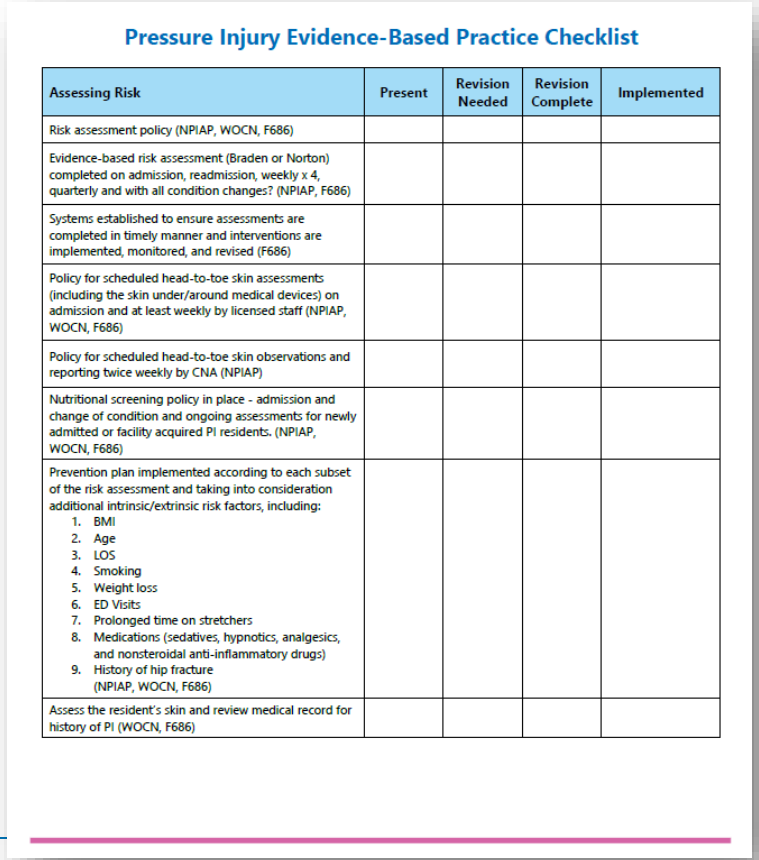

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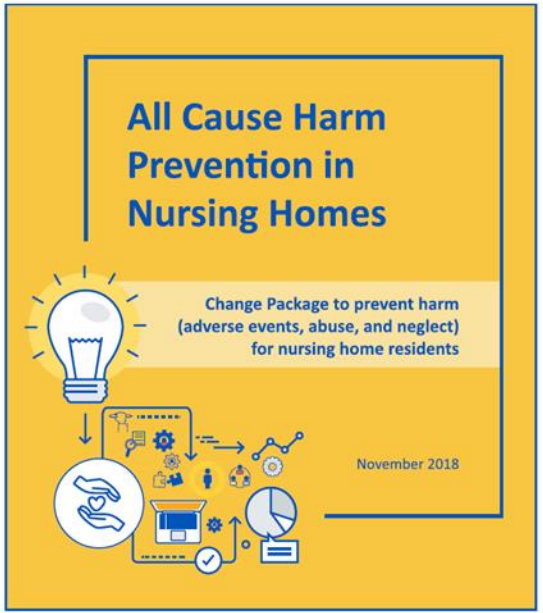
CMS All Cause Harm Prevention

- Leadership
- Committed staff, teamwork, and communication
- Resident and family engagement
- Continuous learning and quality improvement



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"Continuous Improvement implies that all employees must not let themselves become complacent about the status quo but put forth their best ideas and efforts to seek greater added-value."

From 2010 Toyota Publication

Next Session Date and Topics

- **Session 2 (June 22):** Do you know it when you see it? PI or Not
- **Session 3 (July 6):** What to do? What to do? PI Treatment Strategies
- **Session 4 (July 20):** Accurate PI MDS Coding
- **Session 5 (August 3):** The CNA Role: Identifying and Reporting
- **Session 6 (August 17):** Care Planning: Resident/Family Engagement/Education
- **Session 7 (August 31):** Ongoing Practices and Monitoring: Best Practices from High Performing Nursing Homes

FOR MORE INFORMATION

Call 877.731.4746 or visit www.hqin.org

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