NPUAP Mission

The National Pressure Ulcer Advisory Panel (NPUAP) is the nation’s leading scientific expert on pressure injury prevention and treatment. Our goal is to insure improved patient health, and to advance public policy, education and research.
Reduced Price for the International Guideline!

NPUAP in collaboration with the European Pressure Ulcer Advisory Panel (EPUAP) and the Pan Pacific Pressure Injury Alliance (PPPIA) has worked to develop a pressure injury prevention and treatment the Clinical Practice Guideline and Quick Reference Guide. The price of these books have recently been reduced.

Purchase your copy today at www.npuap.org

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NEW E-Versions of the International Guideline!

The Clinical Practice Guideline and various chapters within the Guideline are now available as downloadable publications! Some of the chapters include bariatric individuals, critically ill patients and more!

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NPUAP Monograph

Released in November 2012, the 254-page, 24 chapter monograph, Pressure Ulcers: Prevalence, Incidence and Implications for the Future was authored by 27 experts from NPUAP and invited authorities and edited by NPUAP Alumna Dr. Barbara Pieper.

The monograph focuses on pressure ulcer rates from all clinical settings and populations; rates in special populations; a review of pressure ulcer prevention programs; and a discussion of the state of pressure ulcers in America over the last decade.

Purchase the monograph today at www.npuap.org
- E-version $49
- Individual Chapters $19

NEW Educational Slide Sets

- Pressure Injury Definition and Stages
- Prevention of Pressure Injury
- Treatment of Pressure Injury

Each downloadable slide set includes presentations, speaker notes and handouts

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Faculty Disclosures

Dr. Dea Kent has no disclosures.
Planning Committee Disclosures

- Mary Litchford, PhD, RD, LDN
- Joyce A. Pittman, PhD, ANP-BC, FNP-BC, CWOCN
- Tracey L. Yap, PhD, RN, WCC, CNE, FGSA, FAAN
- Colin Dworak

The planning committee members have listed no financial interest/arrangements that would be considered a conflict of interest.

Objectives

1. Define Care Coordination components that can impact smoother patient transitions in care.
2. Describe solutions/strategies that can be implemented to facilitate improved patient transitions in care.
The reason for the conversation...

The reasons for the conversation...

• Chronic wounds affects estimated 1-2% of world's population¹

7,634,078,277

• 10/29/18 at 2:48 EST=
  76,230,782-152,461,565
  people in the world
  with chronic wounds
The reasons for the conversation...

- United States 2.5 million patients develop Pressure Injury (PI) annually\textsuperscript{2}
- PI incidence rates:
  - Up to 38\% acute care
  - 2.2 \% - 23.9\% SNFs/NHs\textsuperscript{*}
  - Up to 17\% home care
  - No data for LTACHs or IRFs\textsuperscript{**3}

\textsuperscript{*}Skilled Nursing Facilities (SNFs)/Nursing Homes (NHs)
\textsuperscript{**}Long Term Acute Care Hospitals (LTACHs) or Inpatient Rehabilitation Facilities (IRFs)

The reasons for the conversation...

- NO Standard Data Sources
- Differing definitions for data
- Differing time frames for reporting/completion
The reasons for the conversation...

<table>
<thead>
<tr>
<th>Setting</th>
<th>Data Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>SNF/NH</td>
<td>Minimum Data Set (MDS) 3.0</td>
</tr>
</tbody>
</table>
| Home Health Agencies | Outcome and Assessment Information Set-C (OASIS-C)  
|                      | Coming soon: OASIS-D                     |
| Acute Care Hospitals | Inpatient Quality Reporting (IQR) Program |
| LTACHs               | LTCH Continuity Assessment Record and Evaluation (LTCH-CARE) V 4.00 |
| IRFs                 | Inpatient Rehabilitation Facility Patient Assessment Instrument (IRF-PAI) V 2.0 |
| Hospice              | Hospice Evaluation and Assessment Reporting Tool (HEART)—not implemented yet |

Some facilities do not have Electronic Medical Records (EMRs)

EMRs do not universally communicate
And
do not generally or easily interface

Reams of paper for transfers
What is Care Coordination?

“The deliberate organization of patient care activities between two or more participants (including the patient) involved in a patient's care to facilitate the appropriate delivery of health care services.”

5
What is Care Coordination?

“Organizing care involves the marshalling of personnel and other resources needed to carry out all required patient care activities, and is often managed by the exchange of information among participants responsible for different aspects of care.”

What is Care Coordination?

“Care coordination involves deliberately organizing patient care activities and sharing information among all of the participants concerned with a patient’s care to achieve safer and more effective care. This means that the patient’s needs and preferences are known ahead of time and communicated at the right time to the right people, and that this information is used to provide safe, appropriate, and effective care to the patient.”
Care Coordination Components

• Accountability and responsibility
• Communicating/sharing knowledge
• Helping with transitions of care
• Assessing patient needs and goals
• Creating a proactive care plan

Care Coordination Components

• Monitoring and followup, including responding to changes in patients' needs
• Supporting patients' self-management goals
• Linking to community resources
• Working to align resources with patient and population needs
Who is the person responsible for care coordination?

YOU ARE
Transitions of Care (TOC)

- Defined as the movement of patients between health care providers, settings, and home as patient conditions and needs change.
- Ineffective TOCs can result in adverse events for patients, higher readmission rates and increased healthcare costs.

Transitions of Care (TOC)

- The various point where a patient moves to or returns from, for the purposes of receiving health care. This includes transitions between home, hospital, residential care settings and consultations with different providers.
- It is more than a “clinical handover.”
Ineffective TOCs: Why

- Communication breakdown
- Differing expectations between senders and receivers (and even transporters)
- Inadequate hand off time
- Lack of standardized TOC procedures and processes

Ineffective TOCs: Why

- Culture does not promote successful hand-off (lack of teamwork/respect)
- Sender has little knowledge of patient
- Timing of physical transfer and hand-off are not in sync
- Non-timely calls/callbacks
Ineffective TOCs: Why

Information received is viewed as non-important or not applicable

Sender does not regard questions as important and does not seek answers

FOCUS

Setting designations

Acute:
Urgent Care Centers
Emergency Departments
Acute Care Hospitals

Post-Acute:
Home Care  SNF
Hospice    Rehab Center
Palliative LTACH
Setting designations

The Ambulance

TOC items: Acute to Post-Acute

Demographics
Patient Specific Medical Information
Physical Findings
Cognition
Functional Status
Immunizations
Medications
Pain Assessment/Treatments
Pressure Injuries/Skin Condition
Summary of Expectations for Care
So what do we know so far?

- Communication is key
- Patient-centric information and goals are essential to preserve
- Everyone needs patient and setting specific information but no one setting is “more valuable” than another
- Collaboration is important
- Each care setting is different
So what do we know so far?

Each care setting is different

Acute care: Urgent Care
   Emergency Department
   Acute Hospital

Urgent care: Turn and Burn
Emergency Dept: Treat ‘em and Street ‘em
Acute Hospital: lots of staff and resources

So what do we know so far?

Each care setting is different

Post-Acute Care
Home Care
- Home bound—doctor appt, church ok
- May/may not have live in support
- May/may not have support
- May/may not have clean home/running water/utilities on
- Lone field nurse visits 1-7 times/week
- May have ancillary therapy in home
- Limited to no supplies available
So what do we know so far?

Each care setting is different

Post-Acute Care

Hospice Care

- Terminally ill/life expectancy 6 months
- May/may not have live in support
- May/may not have support
- May/may not have clean home/running water/utilities on
- Lone field nurse visits 1-7 times/week
- Respite option
- Can receive services in other Post Acute settings

Hospice Care (continued)

- May have ancillary therapy in home
- Limited to no supplies available
- Ability to get pressure reducing mattresses as a comfort measure
- Focus is comfort
So what do we know so far?

Each care setting is different
Post-Acute Care
Palliative Care
• Can have same conditions as home care
• Could be in another care setting (acute or post)
• May have no home services
• Not yet on hospice
• May/may not have Advanced Practice Nurse visit at home

So what do we know so far?

Each care setting is different
Post-Acute Care
Skilled Nursing Facility
• May be a building or a unit
• Nurses/Therapists/etc staff unit
• Rounding doctor often but only sees patient every 30-90 days
• Some supplies available
• Focus on “skilled” patients is discharge and therapy is an important part of the process
• Long-term patients have different focus
So what do we know so far?

Each care setting is different

Post-Acute Care

Skilled Nursing Facility

- May be a building or a unit
- Nurses/Therapists/etc staff unit
- Rounding doctor often but only sees patient every 30-90 days
- Some supplies available
- Focus on “skilled” patients is discharge and therapy is an important part of the process
- Long-term patients have different focus

Long Term Acute Care Hospital (LTACH)

- May be a building or a unit
- Nurses/Therapists/etc staff unit
- Rounding doctor daily
- Lots of supplies available
- Patients still fairly acutely ill but stable
- Many resources, but goal is stay less than 100 days
But this should be about wounds…

Unchangeable with wounds
Stage/Thickness
Dimensions
Etiology (s)
Current treatment
What happened in the care setting and what prompts the change in care setting?

But this webinar is about prevention…

When it comes to transitions in care, communication about current preventative measures, current patient state, and an informed and thorough handoff is a foundational prevention practice.
Routine prevention measures

To plan care, assemble resources and facilitate a smooth transition of care, the setting must be considered thoughtfully before any calls are made.

When planning care, account for differences in settings.

Think of the subtleties with PI prevention.

Routine prevention measures\textsuperscript{11}

- Structured Pressure Injury (PI) Risk Assessment
  - No standard risk assessment
  - Some settings have developed one
- Pay close attention to mobility issues
- Consider a stage 1 PI a heralding risk for further progression/development of other Pls
Routine prevention measures

- Consider patient's:
  - perfusion/oxygenation
  - nutrition
  - increased skin moisture
- Assess localized pain as a part of every skin assessment

Routine prevention measures

- Develop an individualized continence plan
  - Toileting plans big in SNF/IRFs
  - Indwelling urinary caths restricted
  - Consider alternates: exdwellling devices
- Do not apply heating devices on skin as a PI prevention measure
  - In home care, this is essential
- Consider use of prophylactic dressings
  - May not be paid for by insurance in some settings
Routine prevention measures

- Screen nutritional status for those at risk for PI, using a valid and reliable tool
  - Not all settings such a tool
- Assess patient’s weight/weight history to determine presence of significant weight loss (≥5% in 30 days or ≥10% in 180 days)
- Inventory food/drink intake

- Consider the condition of the individual and the pressure redistribution support surface in use
- Reposition all persons unless contraindicated
- Determine repositioning frequency
- Avoid shear/friction stress on skin with repositioning
  - Turn sheets/repositioners are available but may not be covered for home use
Routine prevention measures

- Avoid shear/friction stress on skin with repositioning
  - Turn sheets/repositioners are available but may not be covered for home use
  - Repositioning may not be possible due to caregiver availability

- Consider the condition of the individual and the pressure redistribution support surface in use
- Reposition all persons unless contraindicated
- Determine reposition frequency
Routine prevention measures\textsuperscript{11}

- Inspect heels regularly
- Offload heels to be surface free
- Use a specialty mattress/overlay
  - Home care patients may see this as a surrender they are not willing to tolerate
  - No air fluidized beds in homes
- Implement a chair cushion for sitting surfaces
- Individualize care plan
Strategies to improve TOC/CC$^{5,6,7,10,11,13}$

- Thoughtful, planned communication
- Consideration of setting change and limitations/availability of resources
- Be a resource as the sender/receiver
- Listen
- Collaborate more/seek input
- Include the patient/patient’s family
- Speak the language

Strategies to improve TOC/CC$^{5,6,7,10,11,13}$

- Go slow to go fast
- Ask for feedback during handoffs
- Ask questions when you do not know the answer
- Consider timing
- Set the TOC up for success
- Be an advocate
- Be an ally to the continuum
Strategies to improve TOC/CC\textsuperscript{5,6,7,10,11,13}

- There are no stupid questions
- Remove surprises
- Be accurate in information presented
- Consider using SBAR or another tool to assist in communication
- Wear someone else's shoes

References


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References


Thank you!

If there is any one secret of success, it lies in the ability to get the other person’s point of view and see things from that person’s angle as well as from your own.

--Henry Ford

Dr. Dea Kent
deajkent@aol.com
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