2016 WOCN® SOCIETY & CAET JOINT CONFERENCE

S06 PREVALENCE AND INCIDENCE: IMPLICATIONS FOR CLINICAL PRACTICE

Sunday, June 5, 2016 • 11:20 AM – 1:00 PM

crossing BORDERS, breaking BOUNDARIES

June 4–8, 2016 • Montréal, Québec, Canada

Palais des congrès de Montréal Convention Center

Wound Ostomy and Continence Nurses Society®

The Canadian Association for Enterostomal Therapy

Association Canadienne des Stomothérapeutes

SUNDAY, JUNE 5, 2016 • 11:20 AM – 1:00 PM

(S06) Prevalence and Incidence: Implications for Clinical Practice

Margaret Goldberg, MSN, RN, CWOCN
Nancy Tomaselli, MSM, RM, CS, CRNP, CWOCN, LNC

Supported by an unrestricted educational grant from Hill-Rom
1.5 Contact Hours (Lecture and Discussion)

Lunch Symposium

Session Description

Inconsistency in measuring prevalence and incidence prevents facilities from benchmarking prevalence within their own facility against facilities of similar size and patient acuity.

This session will focus on the importance of benchmarking prevalence and incidence, implementation strategies related to these data in the clinical setting, and how these strategies empower the WOC Nurse.

Learning Outcome

The participant will be able to:

1. Benchmark prevalence, monitor, and guide PU prevention practices.

Accreditation Statement

The Wound Ostomy and Continence Nurses Society is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center's Commission on Accreditation.

The WOCN® Society was awarded Accreditation with Distinction, the highest recognition awarded by the American Nurses Credentialing Center's Accreditation Program.

The Wound Ostomy and Continence Nurses Society is approved by the California Board of Registered Nursing, Provider Number CEP 15115.

SPEAKER BIOS

Margaret Goldberg, MSN, RN, CWOCN

Margaret has been an active Wound Ostomy and Continence Nursing Society (WOCN) member for over 30 years, she is a past president WOCN Society. She is the immediate past president of the National Pressure Ulcer Advisory Panel; Margaret has co-authored a wound management text and two books on diversions and has authored many articles and chapters on wound and ostomy care. Her most current publications are about moisture related skin damage, unavoidable pressure ulcers, prevalence, and incidence of pressure ulcers in acute care. Margaret is currently a wound care specialist at an outpatient wound center in Delray Beach, Florida.

Nancy Tomaselli, MSN, RN, CS, CRNP, CWOCN, LNC

President and CEO of Premier Health Solutions, LLC, a professional medical services company specializing in Wound, Ostomy and Continence Care.

Nancy is nationally known for her extensive speaking and publication history having authored professional education materials as well as research articles for scientific journals. She has served the Wound, Ostomy and Continence Nurses Society (WOCN) in numerous aspects and most notably as a former Treasurer, Chair of the Wound Subcommittee, Member of the Marketing Committee, National Conference Planning Committee and OASIS Task Force among others,

Preceptor for four Wound Ostomy and Continence Nursing Education Programs, Liaison to the Agency for Health Care Research and Quality, the National Pressure Ulcer Advisory Panel, the Wound Healing Society and the National Quality Forum, Co-editor of the 2010 WOCN Guidelines for Prevention and Management of Pressure Ulcers and Wound clinician representative for the Center for Clinical Investigation Board.

SPEAKER DISCLOSURES

Margaret Goldberg, MSN, RN, CWOCN

Nothing to disclose.

Nancy Tomaselli, MSM, RM, CS, CRNP, CWOCN, LNC

Nothing to disclose.

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Prevalence and Incidence: Implications for Clinical Practice

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ANCC/AANP Conflict of Interest Disclosure

Nancy has no relevant relationships to disclose.
Margaret is an member of the
Nursing Advisory Panel for Acelity.

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AANP Unapproved or Investigational Use Disclosure

The content of our material(s)/presentation(s) in the CE activity will not include discussion of unapproved or investigational uses of products or devices.

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Learning Outcomes

The learner will participate in benchmarking prevalence and incidence and help to monitor and guide pressure ulcer prevention practices.

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Prevention pertains to all settings

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History of Pressure Ulcer Prevention (PUP)

NQF National Quality Forum

National Quality Forum (NFQ) Never Events

- Errors in medical care that are clearly identifiable, preventable, and serious in their consequences for patients
- Indicate a real problem in the ***safety*** and ***credibility*** of a health care facility

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History of PUP

NQF National Quality Forum

- 2003 NQF Never Events
  - Stage III and IV PUs
  - Hospitals are financially penalized for not reporting Stage III and IV PUs in a timely manner.

Lyder, 2012

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History of PUP

NQF National Quality Forum

- 2003 NQF Never Events
  - NFQ defines a new PU as a hospital-acquired condition that is:
    - High-cost and high-volume
    - May be preventable with implementation of evidence-based guidelines

VanGuilder, 2009

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History of PUP

- 2008 CMS enacted nonpayment policy for hospital-acquired PUs
  - Influenced facilities to change practice
    - Focus is on ***prevention*** rather than treatment after PU occurs.
    - Facilities have strived for PU prevention programs.

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History of PUP

- 2008 CMS enacted nonpayment policy for hospital-acquired PUs
  - The policy impacted facilities prioritization of adopting evidence-based practices for PU prevention.

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History of PUP

- 2008 CMS enacted nonpayment policy for hospital-acquired PUs
  - CMS goal is to use PU codes as a quality reporting measure.
  - PU data will be published on the "Hospital Report Card" as an incentive for hospitals to improve performance.

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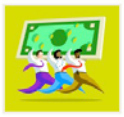
History of PUP



- Costs of failing to prevent PUs
  - 2.5 million patients per year develop PUs.
  - PUs cost $9.1 billion to $11.6 billion per year in the United States.
  - Individual patient cost ranges from $20,900 to $151,700 per PU.

AHRQ, 2016

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History of PUP

- Costs of failing to prevent PUs
  - 2007: Medicare estimated each PU added $43,180 in costs to a hospital stay.
  - There are > 17,000 lawsuits related to PUs annually!

AHRQ, 2016

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History of PUP

- Costs of failing to prevent PUs
  - PUs are the most common claim after wrongful death.
  - Approximately 60,000 patients die as a direct result of a PU each year!

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Costs of failing to prevent PU's

- Hospital-Acquired Condition (HAC) Reduction Program
  - The Affordable Care Act
    - Established the HAC Reduction Program to:
      - Incentivize hospitals to reduce HACs
      - Adjust payments to hospitals that rank in the worst-performing 25 % of all hospitals with respect to HAC quality measures

AHRQ, 2016

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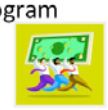
Costs of failing to prevent PU's

- Hospital-Acquired Condition (HAC) Reduction Program
  - The Affordable Care Act
    - Established the HAC Reduction Program
      - These hospitals may have their payments reduced to 99% of what would otherwise have been paid for such discharges.



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Costs of failing to prevent PU's

- Hospital-Acquired Condition (HAC) Reduction Program
  - The Affordable Care Act
    - Also requires CMS to publicly report hospitals performance information

AHRQ, 2016

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Costs of failing to prevent PU's

- Hospital-Acquired Condition (HAC) Reduction Program

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Costs of failing to prevent PU's

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Costs of failing to prevent PU's

- Hospital-Acquired Condition (HAC) Reduction Program

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Your feelings on the subject?

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You Can't Measure It Until You Define It!

- ***Prevalence***:
  - Counts PUs at a single point in time: Point Prevalence
  - Counts PUs for a prolonged period of time: Period Prevalence
  - Both include POA PUs and HAPUs
  - Reveal snapshot of PU burden but NOT quality of care

AHRQ, 2016

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You Can't Measure It Until You Define It!

- ***Incidence***:
  - Counts PUs that develop after admission
  - Provides most direct evidence of quality of care
  - Clearest indication of effectiveness of PU prevention protocol

AHRQ, 2016

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You Can't Measure It Until You Define It!

- ***Incidence***:
  - QI efforts should focus on incidence rates. (*AHRQ, 2016*)
  - Also referred to as hospital-acquired prevalence, nosocomial prevalence or agency-acquired prevalence in place of the term incidence

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You Can't Measure It Until You Define It!

Prevalence:

number of patients with a pressure ulcer divided by the total number of patients surveyed x 100

AHRQ, 2016

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You Can't Measure It Until You Define It!

Incidence:

number of patients with HAPUs divided by all the patients admitted during that time period x 100

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If You Can't Measure It, You Can't Improve It!

- Measure number of patients with pressure ulcers, ***NOT*** the number of ulcers.
- Be consistent: rates calculated by one approach cannot be compared to rates calculated by another methodology.

AHRQ, 2016

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If You Can't Measure It, You Can't Improve It!

- Prevalence versus Incidence:
  - **Prevalence** indicates how widespread the problem is.
  - **Incidence** conveys information about the risk of contracting the problem.

PREVALENCE AND INCIDENCE

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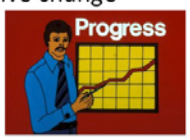
If You Can't Measure It, You Can't Improve It!

- Consistent use of PU P&I is needed to:
  - Continually monitor process improvement results
  - Sustain positive change



House et al, 2011

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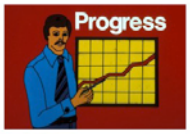
Perform P&I regularly



- Track rates of P&I
- Track effectiveness of prevention and treatment strategies
- Disseminate info to stakeholders, leadership and unit staff
- Perform root cause analysis (RCA)

AHRQ, 2016, Pittman et al, 2016

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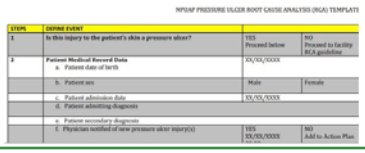
Root Cause Analysis (RCA)

- NPUAP PU RCA Template
  - Helps gain insight into the development of a PU through a review of the timeline of events



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Root Cause Analysis (RCA)

- NPUAP PU RCA Template www.NPUAP.org
  - Not for the analysis of all FAPUs
  - Use for review of the development of a Stage III, Stage IV or sDTI
  - Not intended as a punitive function
  - Learning and growth opportunity for staff

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If You Can't Measure It, You Can't Improve It!

- Quality Improvement Programs
  - Monitor PU management
  - Measure effects of PU prevention program
  - Shows effectiveness of prevention strategies
  - Several facilities reported substantial reduction of PU P&I after the implementation of QI initiatives

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If You Can't Measure It, You Can't Improve It!

- Methods to improve quality of data collected
  - Improve staff recognition and staging of pressure ulcers.
  - Track data on PUs that develop after transfer from one unit to another.

AHRQ, 2016

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If You Can't Measure It, You Can't Improve It!

- Methods to improve quality of data collected
  - Are these wounds from pressure?

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If You Can't Measure It, You Can't Improve It!

- Why measure key processes of care?
  - P&I rates do not tell you how to improve care
    - If PU rate is high, where should you focus?
    - Measure key processes of care to know where to focus improvement efforts.

AHRQ, 2016

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If You Can't Measure It, You Can't Improve It!

- Measure key processes of care
  - To assess pressure ulcer prevention (medical record reviews)
    - Performance of comprehensive skin assessment within 24 hours of admission
    - Performance of standardized risk assessment within 24 hours of admission

AHRQ, 2016

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If You Can't Measure It, You Can't Improve It!

- Measure key processes of care
  - To assess pressure ulcer prevention (medical record reviews)
    - Performance of care planning that addresses each deficit on standardized risk assessment

AHRQ, 2016

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CHALLENGES IN PRACTICE

Continuous Quality Improvement Initiative for Pressure Ulcer Prevention

Mary B. Hopper ▪ Sue Morgan

ABSTRACT

BACKGROUND: Hospital-acquired pressure ulcers can extend a patient's length of stay, decrease health-related quality of life, and increase the risk of mortality and cost

Process Improvement

In 2008, quarterly prevalence studies were done for the National Database of Nursing Quality Indicators.[1] In 2008, a data collection project was done to identify the hospi-

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If You Can't Measure It, You Can't Improve It!

- Continuous quality improvement
  - Huntsville Hospital: clinical culture of PU prevention
    - Reduced HAPU rate
    - Improved patient outcomes
    - Reduced costs for treatment of PUs

Hopper & Morgan, 2014

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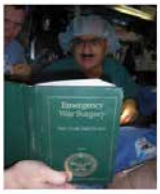
Additional P&I Parameters to Measure

- MASD
- Dry skin
- Restraints
- OR time
- SCI
- End of life



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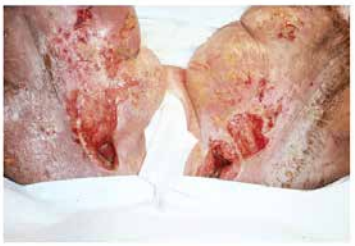
Additional P&I Parameters to Measure

- From MASD to chronic Stage IV



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Additional P&I Parameters to Measure

- Prior healed PU
- Hypoperfusion
- PVD
- Diabetes
- Smoking

AHRQ, 2016

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P&I: Other Parameters to Measure

- Year on mattresses
- Time in Emergency Department
- HOB elevation
- Physician documentation

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If You Can't Measure It, You Can't Improve It!

- AHRQ PU Toolkit www.ahrq.gov
  - Content from literature on best practices in PU prevention
  - Includes validated and newly developed tools
  - Can be tailored to your organization

AHRQ Agency for Healthcare Research and Quality
Advancing Excellence in Health Care

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If You Can't Measure It, You Can't Improve It!

- AHRQ recommends to regularly monitor
  - An outcome (incidence or prevalence rates)
  - At least one or two care processes (e.g., skin assessment)

AHRQ, 2016

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If You Can't Measure It, You Can't Improve It!

- AHRQ recommends to regularly monitor
  - Key aspects of the infrastructure to support best care practices
    - Clear lines of responsibility for overseeing accuracy of skin assessments

AHRQ, 2016

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If You Can't Measure It, You Can't Improve It!

- Institute for Healthcare Improvement (IHI)
  - Do no harm
    - It is our duty and our responsibility
    - Reliably use science-based guidelines for ***prevention***
    - Getting Started Kit: Prevent Pressure Ulcers How-to Guide

5 Million lives

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If You Can't Measure It, You Can't Improve It!

- Institute for Healthcare Improvement: 5 Million Lives Campaign *(Duncan 2007)*
  - Key elements for PU prevention program
    - Assessment on admission for all patients
    - Daily risk assessments
    - Daily skin inspection

5 Million lives

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If You Can't Measure It, You Can't Improve It!

- Institute for Healthcare Improvement: 5 Million Lives Campaign *(Duncan 2007)*
  - Key elements for PU prevention program
    - Moisture management
    - Optimize nutrition and hydration
    - Minimize pressure

5 Million lives

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- NPUAP: 5 Evidence-based interventions for HAPU prevention (*Padula et al, 2013*)
  - Risk stratification (Braden)
  - Turning and repositioning
  - Moisture, incontinence and nutrition management
  - Use of modern support surfaces
  - Ongoing clinician education

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If You Can't Measure It, You Can't Improve It!

- The Joint Commission
  - 2008 National Patient Safety Goals
  - Goal 14: Prevent health care associated PUs.
    - Assess and periodically reassess each resident's risk for developing a PU and take action to address any identified risks.

The Joint Commission

PREVALENCE AND INCIDENCE

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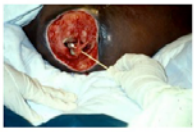
- The Joint Commission Sentinel Event:
  - Development of a pressure ulcer is a sentinel event when it results in death or permanent injury.



The Joint Commission

HELPING HEALTH CARE ORGANIZATIONS HELP PATIENTS

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If You Can't Measure It, You Can't Improve It!

- US Dept. of Health & Human Services: Healthy People 2010
  - National Goal: Reduce the prevalence of PUs

HEALTHY PEOPLE

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If You Can't Measure It, You Can't Improve It!

- Summary of Guidance to Surveyors for **LTC** Facilities
  - Effective November 12, 2004
  - F-Tag 314 : Avoidable v. Unavoidable
  - Makes recommendations to meet this criteria

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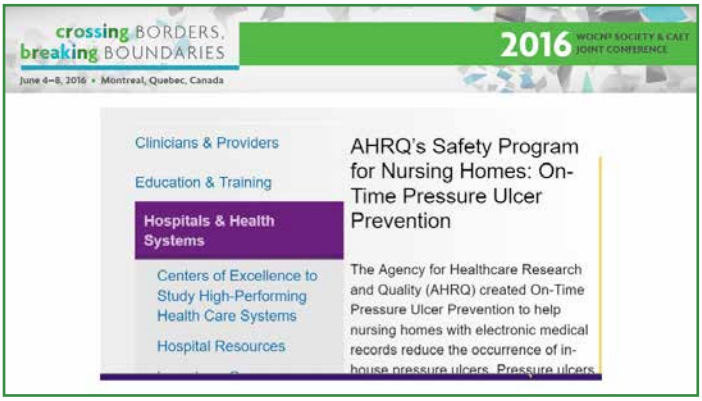
If You Can't Measure It, You Can't Improve It!

- F-Tag 314 : Avoidable v. Unavoidable
  - Evaluate clinical condition and PU risk factors.
  - Define and implement interventions that are consistent with needs, goals and recognized standards of practice.
  - Monitor and evaluate the impact of the interventions or revise the interventions as appropriate.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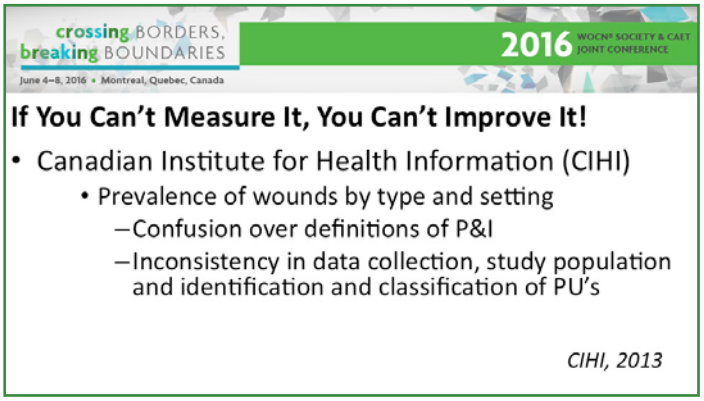
Clinicians & Providers
Education & Training
Hospitals & Health Systems
Centers of Excellence to Study High-Performing Health Care Systems
Hospital Resources
AHRQ's Safety Program for Nursing Homes: On-Time Pressure Ulcer Prevention
The Agency for Healthcare Research and Quality (AHRQ) created On-Time Pressure Ulcer Prevention to help nursing homes with electronic medical records reduce the occurrence of in-house pressure ulcers. Pressure ulcers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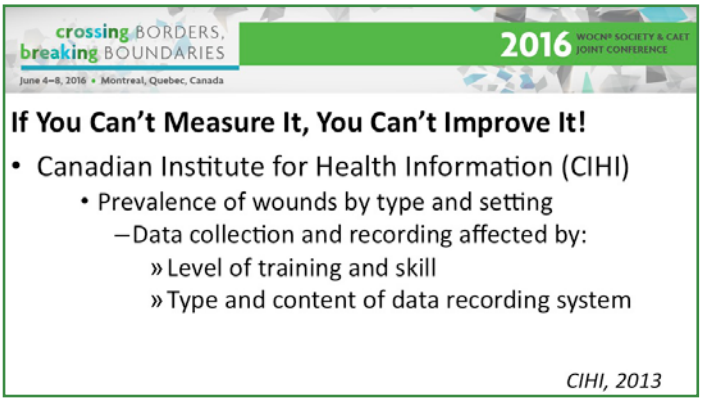
If You Can't Measure It, You Can't Improve It!
• Canadian Institute for Health Information (CIHI)
• Prevalence of wounds by type and setting
– Confusion over definitions of P&I
– Inconsistency in data collection, study population and identification and classification of PU's
CIHI, 2013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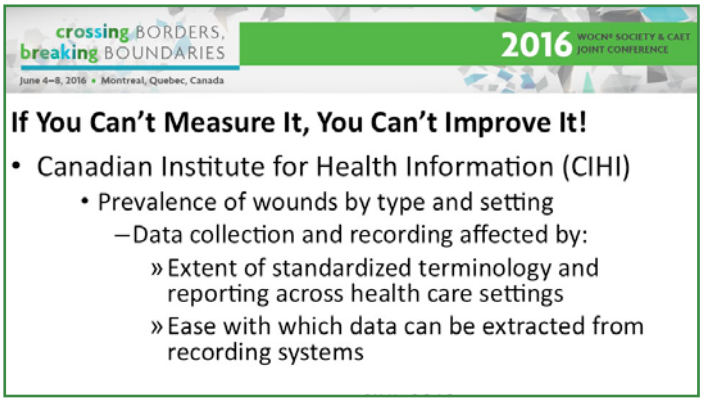
If You Can't Measure It, You Can't Improve It!
• Canadian Institute for Health Information (CIHI)
• Prevalence of wounds by type and setting
– Data collection and recording affected by:
» Level of training and skill
» Type and content of data recording system
CIHI, 2013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If You Can't Measure It, You Can't Improve It!
• Canadian Institute for Health Information (CIHI)
• Prevalence of wounds by type and setting
– Data collection and recording affected by:
» Extent of standardized terminology and reporting across health care settings
» Ease with which data can be extracted from recording systems

PREVALENCE AND INCIDENCE

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If You Can't Measure It, You Can't Improve It!

- Canadian Institute for Health Information (CIHI)
  - Prevention strategies for PUs
    - –Risk assessment policy and practice
    - –Routine skin assessment
    - –Appropriate skin care

CIHI, 2013

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If You Can't Measure It, You Can't Improve It!

- Canadian Institute for Health Information (CIHI)
  - Prevention strategies for PUs
    - –Nutrition screen/appropriate nutrition
    - –Appropriate, documented repositioning
    - –Management of pressure, friction and shear on all surfaces over a 24-hour period

CIHI, 2013

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If You Can't Measure It, You Can't Improve It!

- Evidence-based prevention plans
  - – Internal Factors
    - Hospital prevention campaigns
    - Availability of nurse specialists
    - Level of preventive knowledge of hospital staff

Padula et al, 2015

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If You Can't Measure It, You Can't Improve It!

- Evidence-based prevention plans
  - – External Factors
    - Financial concerns
    - Application for Magnet
    - Data sharing among peer institutions
    - Regulatory issues

Padula et al, 2015

If You Can't Measure It, You Can't Improve It!

- Evidence-based prevention plans
  - Internal and external factors
    - Not formerly recognized
    - Consider including them in PU prevention programs

Padula et al, 2015

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If You Can't Measure It, You Can't Improve It!

- WOCN evidence-based Algorithm for Support Surface Selection *(McNichol et al, 2015)*
  - Support surfaces are one of a bundle of interventions for PU prevention and treatment.
  - Algorithm and consensus statements were developed in response to a critical need for use in clinical practice.

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J Wound Ostomy Continence Nurs. 2015;42(1):19-27.
Published by Lippincott Williams & Wilkins

WOUND CARE

Identifying the Right Surface for the Right Patient at the Right Time: Generation and Content Validation of an Algorithm for Support Surface Selection

Laurie McNichol ■ Carolyn Watts ■ Dianne Mackey ■ Janice M. Beitz ■ Mikel Gray

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If You Can't Measure It, You Can't Improve It!

- WOCN evidence-based Algorithm for Support Surface Selection *(McNichol et al, 2015)*
  - Support surface selection is largely driven by Braden mobility and moisture subscale scores.
  - Provides guidance for selection of support surfaces based on individual patient needs

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If You Can't Measure It, You Can't Improve It!

- WOCN evidence-based Algorithm for Support Surface Selection *(McNichol et al, 2015)*
  - Provides guidance for selection of support surfaces based on individual patient needs
  - First evidence and consensus based algorithm for support surface selection that has undergone content validation

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If You Can't Measure It, You Can't Improve It!

- WOCN evidence-based Algorithm for Support Surface Selection *(McNichol et al, 2015)*
  - Tailor for own use: download to device
    - Include specific products used at your facility.
    - Incorporate appropriate staff education for optimal implementation.

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If You Can't Measure It, You Can't Improve It!

- Evidence-based literature

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If You Can't Measure It, You Can't Improve It!

- Evidence-based literature
  - Agency for Health Care Policy and Research (AHCPR)
    - PU prevention guidelines (1992)
    - PU treatment guidelines (1994)

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If You Can't Measure It, You Can't Improve It!

- Evidence-based literature
  - National Guidelines for Prevention and Treatment of PUs (WOCN, NICE, RNAO)
  - International Guidelines for Prevention and Treatment of PUs (NPUAP/EPUAP)

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If You Can't Measure It, You Can't Improve It!

- Evidence-based literature
  - NPUAP: Prevalence, Incidence and Implications for the Future
  - WOCN: P&I: Toolkit for Clinicians
  - Free webinars

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If You Can't Measure It, You Can't Improve It!

- Evidence-based literature
  - Registered Nurses Association of Ontario (RNAO)
    - Best Practice Guidelines:
      - Assessment and Management of Stage I to IV PUs
      - Risk Assessment and Prevention of PUs
      - Taking the Pressure Off - Preventing PUs

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If You Can't Measure It, You Can't Improve It!

- Evidence-based literature
  - AHRQ: PU Toolkit *(AHRQ, 2016)*
  - Studies describing the effects of PU prevention programs on incidence and/or prevalence in acute care facilities *(Goldberg, 2012)*
    - Show reduced P&I rates

PREVALENCE AND INCIDENCE

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If You Can't Measure It, You Can't Improve It!

- Evidence-based literature in home care
  - Evidence is lacking
  - Study findings
    - PU prevention is more complex
    - Requires significant skills in communication

Bergquist-Beringer & Daley, 2011

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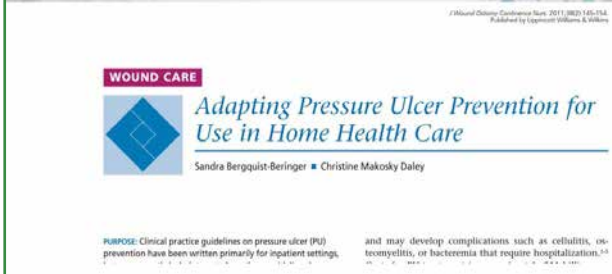
WOUND CARE

Adapting Pressure Ulcer Prevention for Use in Home Health Care

Sandra Bergquist-Beringer ■ Christine Makosky Daley

PURPOSE: Clinical practice guidelines on pressure ulcer (PU) prevention have been written primarily for inpatient settings,

and may develop complications such as cellulitis, osteomyelitis, or bacteremia that require hospitalization.[1-3]

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Benchmarking P&I

- Compare process improvements within your own facility and against other facilities of similar size and patient acuity.

VanGuilder et al, 2008

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Benchmarking P&I

- Identifies practice deficits and implementation of enhanced wound care protocols
- Benchmarking is most beneficial when used in conjunction with QI initiatives.

House et al, 2011

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Benchmarking P&I: Proprietary Company

- Allows for comparison to other facilities
  - IPUP: International PU Prevention Survey
    - In 20th year with all settings included
    - > 1000 facilities survey > 100,000 patients
    - Data collection identifies trends in P&I

Van Guilder et al. 2008 & 2009 & 2016

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Benchmarking P&I: Proprietary Company

- Allows for comparison to other facilities
  - IPUP: International PU Prevention Survey
    - Allows trends to be monitored and addressed
    - Guided practice for many years
    - Attention to device-related PUs is also warranted

Van Guilder et al. 2008 & 2009 & 2016

PREVALENCE AND INCIDENCE

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Benchmarking P&I: Proprietary Company

- IPUP: Device related PUs
  - Type of device (ET/NG tube, cast/splint, nasal O2, CPAP/BIPAP, halo, SCD's, cervical collar, trach neck plate)

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NPUAP Medical Device related Posters

Best Practices for *Prevention* of *Medical Device-Related* Pressure Ulcers

- ✔ **Choose** the correct size of medical device(s) to fit the individual
- ✔ **Cushion** and protect the skin with dressings in high risk areas (e.g., nasal bridge)
- ✔ **Remove** or move the device daily to assess skin
- ✔ **Avoid** placement of device(s) over sites of prior, or existing pressure ulceration
- ✔ **Educate** staff on correct use of devices and prevention of skin breakdown
- ✔ **Be aware** of edema under device(s) and potential for skin breakdown
- ✔ **Confirm** that devices are not placed directly under an individual who is bedridden or immobile

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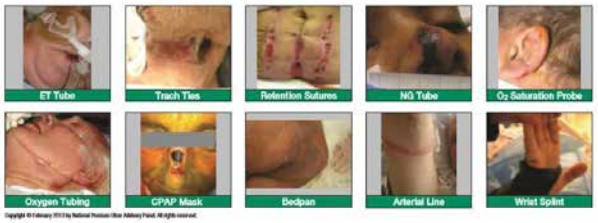
NPUAP Medical Device related Posters



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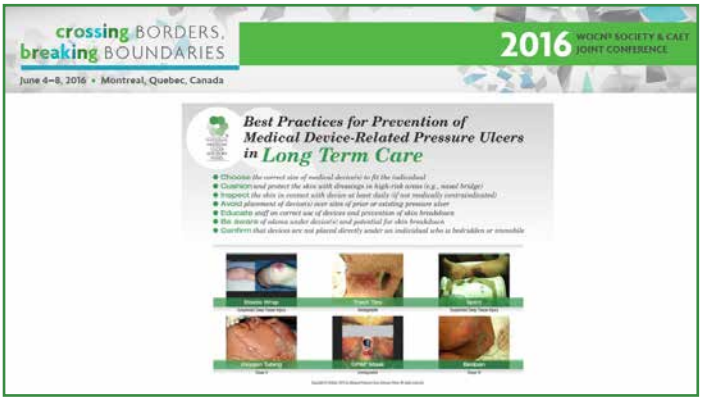
Available free at NPUAP.org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Best Practices for Prevention of Medical Device-Related Pressure Ulcers in Long Term Care


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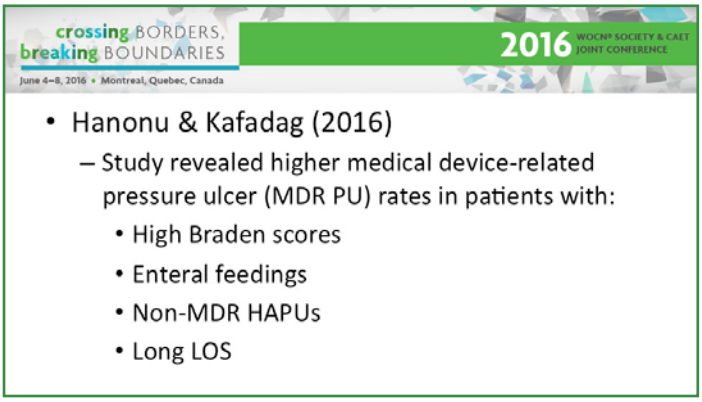
Best Practices for Prevention of Medical Device-Related Pressure Ulcers in Pediatric Populations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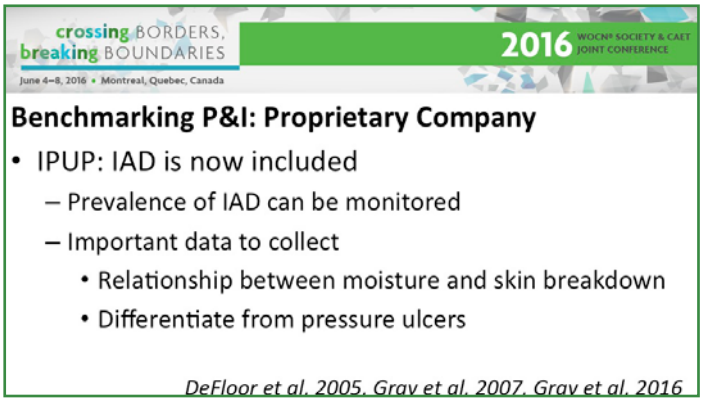
• Hanonu & Kafadag (2016)
– Study revealed higher medical device-related pressure ulcer (MDR PU) rates in patients with:
• High Braden scores
• Enteral feedings
• Non-MDR HAPUs
• Long LOS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Benchmarking P&I: Proprietary Company
• IPUP: IAD is now included
– Prevalence of IAD can be monitored
– Important data to collect
• Relationship between moisture and skin breakdown
• Differentiate from pressure ulcers
DeFloor et al. 2005, Gray et al. 2007, Gray et al. 2016

PREVALENCE AND INCIDENCE

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Benchmarking P&I

- IAD Study Revealed:
  - P&I rates of PUs and IAD in LTACs differ from acute care
    POA IAD 22.8% PU 35.1%
  - Identified factors associated with IAD and PU P&I
    - They could not be construed to identify causative factors.

Long et al, 2012

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J Wound Ostomy Continence Nurs. 2012;39(3):318-327.
Published by Lippincott Williams & Wilkins

CONTINENCE CARE

Incontinence-Associated Dermatitis in a Long-term Acute Care Facility

Mary Arnold Long ■ Lu Ann Reed ■ Kari Dunning ■ Jun Ying

PURPOSE: The objectives of this study were to (1) measure the prevalence of incontinence-associated dermatitis (IAD) and pressure ulcers (PUs) on admission to a long-term acute care (LTAC) facility; (2) identify factors associated with IAD and PU on admission to an LTAC facility; and (3) measure the incidence patient length of stay, care costs, and pain and suffering[1,2]. Brem and Lyder[3] reported that a single hospital stay due to a PU often exceeds US$200,000. Annually, 6000 deaths in the United States are associated with complications of PUs. Reported PU prevalence rates in the United States vary

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Benchmarking P&I: Proprietary Company

- IPUP: Critical care patients with at least 1 FAPU
  - Hypothermia/hyperthermia
  - CVVH/CVHD/femoral lines
  - Vent
  - High/Low MAP

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Benchmarking P&I: Proprietary Company

- IPUP: Critical care patients with at least 1 FAPU
  - Vasopressor therapy
  - Steroids
  - Diabetes
  - Vascular disease
  - Sepsis

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Benchmarking P&I: Proprietary Company

- IPUP: Critical care patients with at least 1 FAPU
  - Hypothermia/hyperthermia
  - CVVH/CVHD/femoral lines
  - Vent
  - High/Low MAP

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Benchmarking P&I: Proprietary Company

- IPUP: Poster in exhibit hall
  - Acute care and Rehab overall prevalence rates and facility acquired prevalence rates have declined significantly over 10 years (2006-2015).
  - LTC and LTACs are more variable.

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Benchmarking P&I

- National Database of Nursing Quality Indicators (NDNQI)
  - Quarterly HAPU rates
  - Assist hospitals with QI efforts
  - Satisfy reporting requirements for:
    - Regulatory agencies
    - Magnet designation

NDNQI® NATIONAL DATABASE OF NURSING QUALITY INDICATORS

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Benchmarking P&I

- National Center for Nursing Quality
  - NDNQI: National Database of Nursing Quality Indicators https://www.nursingquality.org/NDNQIPressureUlcerTraining/module3/Default.aspx

NDNQI® NATIONAL DATABASE OF NURSING QUALITY INDICATORS

PREVALENCE AND INCIDENCE

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P&I Historical Statistics

- In 2001
  - Hospitals: Range from 0.4% to 38%
  - Skilled Nursing Facilities: 2.2% to 23.9%
  - Home Health Agencies 0% to 17%

NPUAP, 2001

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Variations in methodological design and rigor continue to confound analysis of prevalence and incidence studies. There is a strong need for consistency in design and reporting in order to enable more reliable international benchmarking. Particularly where the effectiveness of pressure ulcer prevention programs is being investigated, facility-acquired pressure ulcer rates should be reported.

Table 1 provides a summary of the prevalence and incidence rate ranges reported in the literature from January 2000 to December 2012.

Table 1: Ranges of pressure ulcer prevalence and incidence reported in selected peer-reviewed literature published between 2000 and 2012.

Setting or Population	Prevalence Rates	Incidence & Facility-Acquired Rates
Acute care	0%[41] to 46%[42]	0%[43] to 12%[43]
Critical care	13.1%[23] to 45.5%[24]	3.3%[25] to 53.4%[26]
Aged care	4.1%[44] to 32.2%[45]	1.9%[19] to 59%[46]
Pediatric care	0.47%[47] to 72.5%[48]	0.25%[47] to 27%[48]
Operating room setting	—	5%[28] to 53.4%[29]

An ongoing decline in pressure ulcer prevalence continues to be seen in the general acute care setting. Goldberg (2012)[1] noted a declining trend in prevalence rates over the previous decade, and this trend continued in the most recent publications. In other clinical care settings, trends are less clear because significant variations in the study designs, specific setting descriptions, and population differences confound analyses.

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Benchmarking P&I

- Other benchmark studies
  - Whittington & Briones, 2004
    - PU prevalence ranged from a low of 14% (2001 and 2002) to a high of 17% (1999).
    - Incidence ranged from a low of 7% (2001, 2003, 2004) to a high of 9% (2000).

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P&I studies: Canada

- Other Articles
  - Woodbury & Houghton 2004
    - Prevalence estimates of various Canadian health settings 15-30%
    - Overall 26 %

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15-30%

P&I: Canada

- Woodbury & Houghton 2004
  - Differences in sample sizes and patient profiles, non acute diverse populations (LTC, NH, Geriatric, complex continuing care etc.) precludes comparison with United States.

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P&I: Canada

- Other Sources
  - Ba'Pham, Teague, et al, 2013
    - Approximately 1 in 8 patients in acute care hospitals
      - 1 in 11 nursing home residents
      - 1 in 50 home care clients experience pressure ulcers

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P&I: Canada

- Ba'Pham, Teague, et al, 2013
  - Patients with HAPUs tend to stay 4 days longer in hospitals, are 7% more likely to die, and, on average, cost the health care system an additional $13,500.

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What is in it for you?

- WOC nurse is an invaluable resource in:
  - Collection of data
  - Interpretation of data
  - Leading implementation
  - Overseeing quality improvement plans

International Guidelines, 2009

PREVALENCE AND INCIDENCE

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What is in it for you?

- WOC nurse is a leader in effective prevention strategies
  - Reduction of P&I
  - Reduction in costs
  - Effective and prompt assessment, monitoring and tracking between healthcare sectors

International Guidelines, 2009

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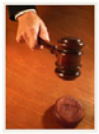
What is in it for you?

- WOC nurse is a leader in effective prevention strategies
  - Reduced risk of PU-related adverse effects on QOL
  - Reduced risk of litigation



International Guidelines, 2009

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What is in it for you?

- Effective prevention strategies

  WOC nurse can ensure:
  - Ongoing support/education of all persons involved
  - Ongoing commitment from and motivation of managers
  - Wide and sustained adoption of strategies across health settings

International Guidelines, 2009

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What is in it for you?

- Effective prevention strategies

  WOC nurse can ensure:
  - Political awareness of success
  - Sustained decrease in PU rates

International Guidelines, 2009

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What is in it for you?

- Ineffective prevention strategies

  WOC nurse can review:

  – Education/training of healthcare professionals, patients, caregivers, managers, etc.
  – Risk assessment tools
  – Prevention and redistribution protocols

International Guidelines, 2009

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What is in it for you?

- Ineffective prevention strategies

  WOC nurse can review:

  – Resource allocation (staffing, equipment, materials)
  – Mechanisms for multidisciplinary team involvement/ communication
  – Refine/implement new strategy to reduce PU occurrence

International Guidelines, 2009

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What is in it for you?

- Some barriers to practice
  – Time for adequate skin assessment
  – Determining correct etiology of wounds
  – Documentation forms that are not consistent with components of skin
  – Staff do not feel empowered to report abnormal skin findings.

AHRQ, 2016

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What is in it for you?

- Sustainability for PUP
  – Continued leadership support and staff dedication at all levels
  – Reward changed behavior
  – Ongoing monitoring and measuring of PU rates

Gibbons, et al, 2006

PREVALENCE AND INCIDENCE

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June 4–8, 2016 • Montreal, Quebec, Canada

What is in it for you?

- Sustainability for PUP
  - Orientation of new staff
  - Ongoing refresher training to avoid old habits
  - Additional QI efforts (reducing urinary catheter time led to > MASD)

AHRQ, 2016

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What is in it for you?

- Sustainability for PUP
  - Availability of resources change (charging specialty beds to unit budgets)
  - Unannounced changes in products (device related PU due to more rigid oxygen tubing)
  - Best practices in PU care continue to evolve

AHRQ, 2016

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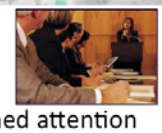
What is in it for you?



- Sustainability for PUP
  - No matter how well you are doing, sustained attention is still needed to keep improvements on track.
  - There are always additional steps to get closer to the ideal of zero incidence of avoidable pressure ulcers.

AHRQ, 2016

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The bottom line

- Epidemiologic data since 2008
  - Strongly suggest hospitals have increased efficiency in PU prevention
  - Incidence rates in the US dropped from 7% in the 2000's to 4.5% in 2012. (*Lyder, 2012, Whittington & Briones, 2004)*
  - There is still lots of room to improve!

Don't underestimate your power to change the future!

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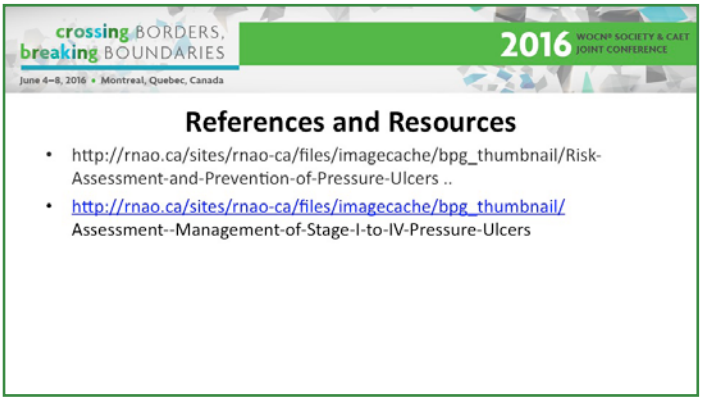
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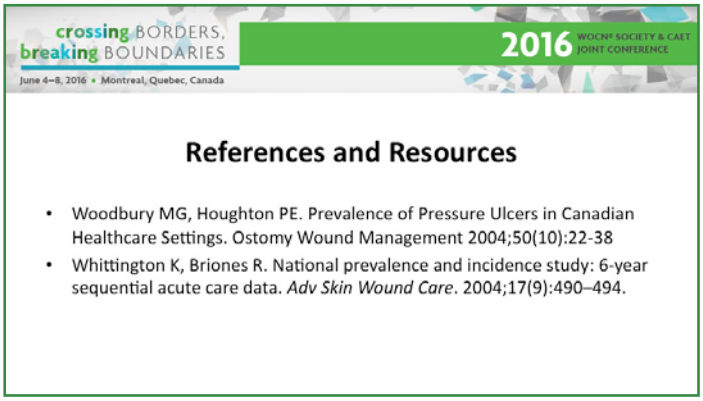
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COMPARISON OF PREVALENCE AND INCIDENCE

	Prevalence	Incidence
Definitions	Number of patients with a pressure ulcer divided by the total number of patients surveyed x 100	Number of patients with HAPU's divided by all the patients admitted during that time period x 100
Description	Measures number of people with **existing** PUs at a given point in time in a specified population	Measures number of people with **new** PU's at a given point in time in a specified population
Information provided	Indicates what proportion of the study population had a PU at a given time	Indicates the rate of PU development over a particular time period in a given population
Uses	Indicates burden of PUs Aids assessment of resource requirements and planning of health services May collect additional data to aid assessment of compliance with prevention and treatment protocols Can aid differentiation of community v facility-acquired PUs (with accurate documentation of admission skin assessment)	Increasingly used as an indicator of quality of care Study may produce data that prompts a review of factors that contribute to the development of PUs and may therefore suggest prevention strategies Tracking of comparable incidence rates over time may indicate the effectiveness of preventive measures May collect additional data to aid prevention and compliance with prevention and treatment protocols
Limitations	Does not provide as direct a measure of quality of care or efficacy of prevention protocols as does incidence	May be more time consuming and therefore more expensive than prevalence studies

Adapted from International Guidelines, Tomaselli & Goldberg.

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