



Indiana Patient Safety Center

of the Indiana Hospital Association

GET UP



November 14, 2017

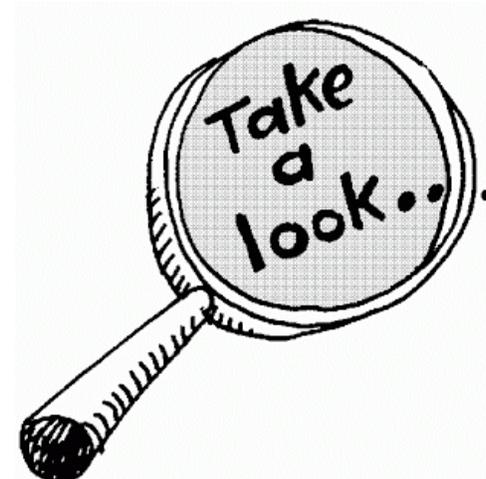
Indiana's Bold Aim



To make Indiana the safest
place to receive health care
in the United States...
if not the world

Agenda

- Welcome and Introductions
- Get UP Campaign
- Jackie Conrad, RN, BS, MBA, RCC-Cynosure Health
- Resources and Support
- Get Up Webinar Series





**Indiana Patient
Safety Center**

of the Indiana Hospital Association

UP Campaign

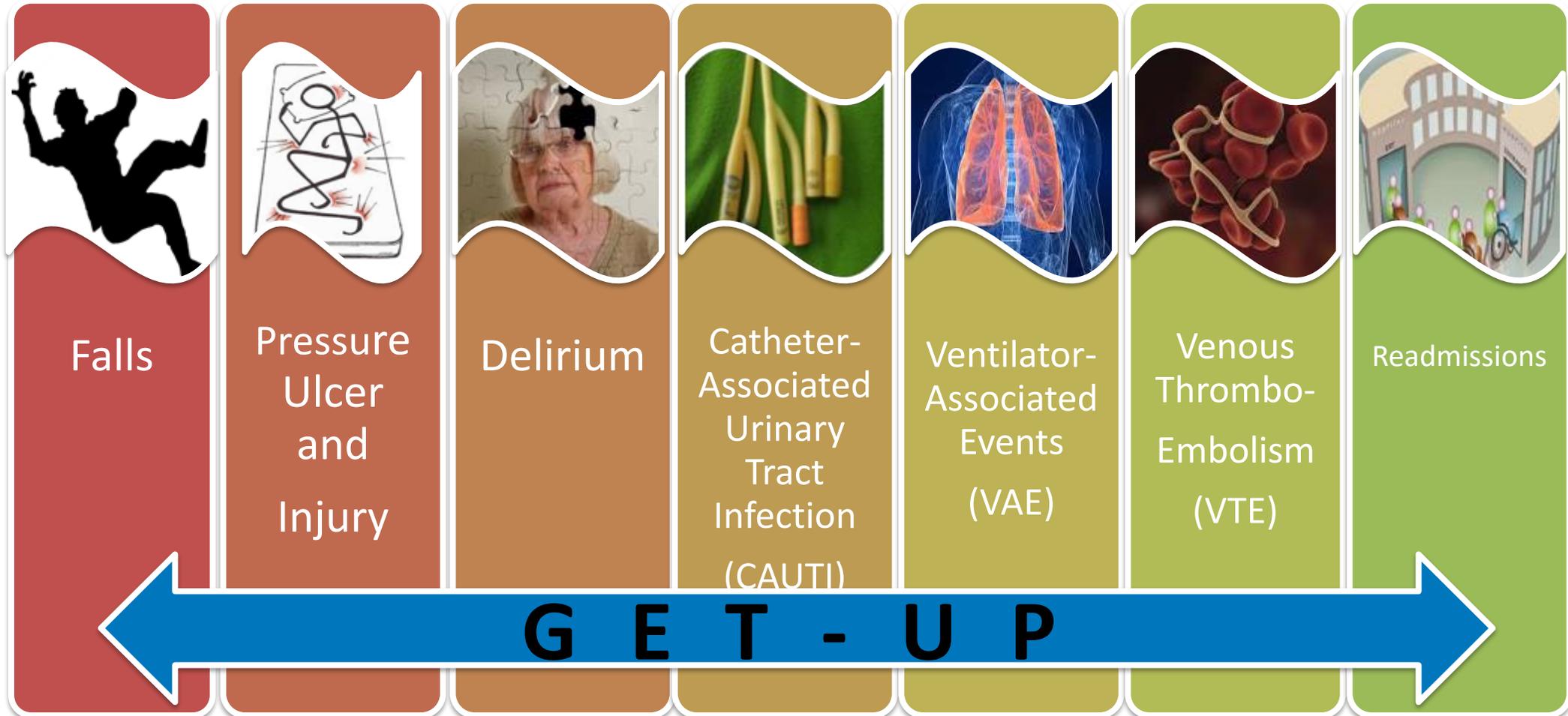
IHAconnect.org/Quality-Patient-Safety

UP Campaign

Goal: Simplify safe care and streamline cross-cutting interventions to reduce the risk for multiple patient harms



Early Progressive Mobility



2017 World Wide Pressure Injury Prevention Day

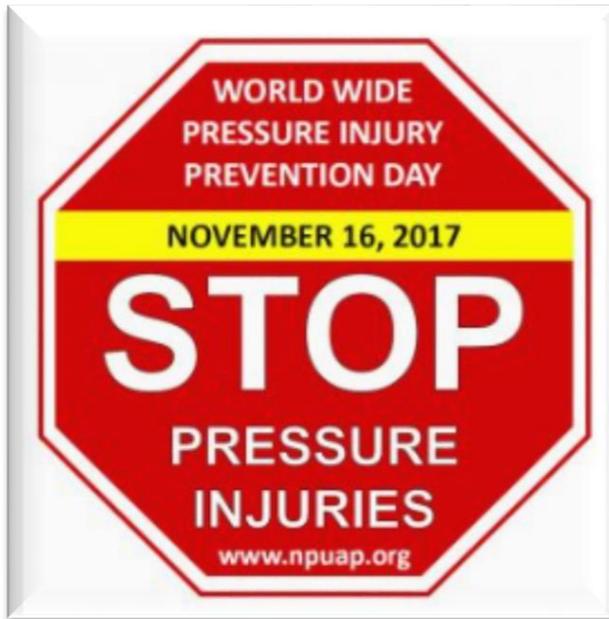
Mark your calendars for Thursday, **November 16** to raise awareness for pressure injury prevention and to educate staff on this topic.

The National Pressure Ulcer Advisory Panel (NPUAP) has promotional materials to support your efforts on their [website](#).

New tools that will help staff gain confidence in staging and documenting are available via the HRET HIIN website:

- [Full Color Pressure Injury Staging Poster](#)
- [Medical Device Related Pressure Injury Poster](#)
- [NDNQI Pressure Injuries and Staging Training Modules](#)

<http://www.hret-hiin.org/topics/pressure-ulcers.shtml>



Pressure Injury Toolkit from the National Pressure Ulcer Advisory Panel

PRESSURE INJURY AND STAGES

A pressure injury is localized damage to the skin and 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 pressure, 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-morbidity and condition of the soft tissue.

DEFINITION	SCHEMATIC DRAWING	EXAMPLE
STAGE 1 PRESSURE INJURY Non-blanchable erythema of intact skin Intact skin with a localized area of non-blanchable erythema, which may appear differently in darker pigmented skin. Presence of blanchable erythema or changes in sensation, temperature, or firmness may precede visual changes. Color changes do not include purple or maroon discoloration; these may indicate deep tissue pressure injury.		
STAGE 2 PRESSURE INJURY Partial thickness skin loss with exposed dermis Partial thickness loss of skin with exposed dermis. The wound bed is visible, pink or red, moist, and may also present as an intact or ruptured serum-filled blister. Adipose (fat) is not visible and deeper tissues are not visible. Granulation tissue, slough and eschar are not present. These injuries commonly result from adhesive incontinence and shear in the skin over the heels and shear in the heels. This stage should not be used to describe moisture associated skin damage (MASD), including incontinence associated dermatitis (IAD), intertriginous dermatitis (ITD), medical adhesive related skin injury (MARI), or traumatic wounds (skin tears, burns, abrasions).		
STAGE 3 PRESSURE INJURY Full thickness skin loss Full thickness loss of skin, in which adipose (fat) is visible in the ulcer and granulation tissue and epibial (piled wound edges) are often present. Slough and/or eschar may be visible. The depth of tissue damage varies by anatomical location; areas of significant adiposity can develop deep wounds. Undermining and tunneling may occur. Fat, muscle, tendon, ligament, cartilage or bone are not exposed. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury.		
STAGE 4 PRESSURE INJURY Full thickness loss of skin and tissue Full thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer. Slough and/or eschar may be visible. Stable (piled edges), undermining and/or tunneling often occur. Depth varies by anatomical location. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury.		

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

- ✓ **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 removable devices to assess skin at least daily
- ✓ **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

			
CT Tube	Trach Tube	Retention Sutures	NG Tube
Mucosal Membrane Pressure Injury	Unstageable	Stage 1	Unstageable
			
Oxygen Tubing	CPAP Mask	O ₂ Saturation Probe	Arterial Line Tubing
Stage 2	Unstageable	Stage 2	Stage 2

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Patient Educational Tool

Where can I find more information about pressure injuries?

Healthcare workers have formed special groups that work together to better understand pressure injuries. There is a special group called the National Pressure Ulcer Advisory Panel (NPUAP) that provides advice for health workers and the public on pressure injuries. You can find more information at

www.npuap.org



www.npuap.org



How can you help STOP pressure injuries?

When you sit in a chair or lie in bed and don't move you may have noticed that your skin feels uncomfortable or even painful. When this happens, you change your position to stop that uncomfortable feeling.

Many people are unable to take this simple step of changing position. They may be ill, be calmed (with medicine) during a surgical operation or unable to notice the uncomfortable skin feeling. Skin is fed by our blood supply. If we stay in one position too long without moving, blood can no longer get to the skin at the parts of our body where we sit or lie down. When this happens the skin can die and a wound in the skin happens. These wounds were once called bed sores (from not moving enough in bed) or decubitus ulcers. Today health workers call these pressure injuries. A pressure injury is localized damage to the skin and underlying soft tissue usually over a bony prominence or related to a medical or other device. Sadly pressure injuries are very common and many people may know of a family member or friend who has had a pressure injury.

Am I likely to get a pressure injury?

You can avoid getting a pressure injury by often changing your position when you sit in a chair or lie in bed. Anything that stops you from making these small

movements may make you at risk for a pressure injury.

Think about pressure injuries when -

- You are ill and have to stay in bed or a chair either at home or in a hospital.
- You cannot move because of your illness.
- You cannot move because of your medical condition.
- You cannot move because it is too painful.
- You are going to have long surgery that may take longer than three hours.

If these events happen to you talk to your doctor or nurse about what they will do to stop a pressure injury from developing.

Some people have to live with the risk of pressure injuries occurring. These are people that use a wheelchair to get around or have a medical condition that keeps them in bed. In these cases, health workers will give advice and assistance to help the person. The health workers may give advice to the person's family and friends, to help stop a pressure injury from occurring

www.npuap.org

STOP Pressure Injury Day

How do you stop pressure injuries?

If you are at risk to develop a pressure injury, then your doctor or nurse will help you to take steps to stop the pressure injuries from happening. They may help you change your position at regular periods of time. They may provide special beds and cushions that help to protect your skin.

They may look at other factors that may weaken your skin.

These factors can include:

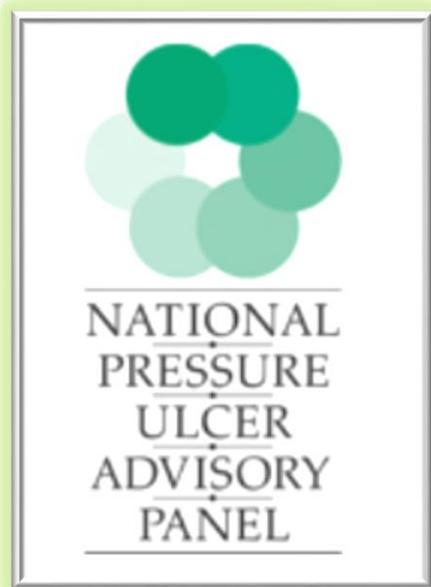
- Attention to your eating habits
- Management of your sweating
- Management of your bladder or bowels
- Management of your skin cleansing and care

What if I have a pressure injuries?

Sometimes it is not possible to prevent a pressure injury from developing. Your doctor or nurse will use actions to help the injury to heal such as special cover dressings. It is important that the steps taken to try and stop pressure injuries from developing continue to be used during the treatment of your pressure injury. Ask your doctor or nurse how they are going to treat your pressure injury.

November 16, 2017

One Page Fact Sheet



Pressure Injuries: Just the facts!

Definition of 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.

Stages of Pressure Injuries

<p>Stage 1 Pressure Injury: Non-blanchable erythema of intact skin over a bony prominence or over a non-blanchable erythema, which may appear differently in darkly pigmented skin. Presence of identifiable erythema or changes in sensation, temperature, or tissue may precede visual changes. Color changes do not include purple or mottled discoloration. Stage may include deep tissue pressure injury.</p>	<p>Stage 2 Pressure Injury: Partial-thickness skin loss with exposed dermis. The wound bed is shallow, pink or red, moist, and may also present as an intact or ruptured serum-filled blister. Adipose (fat) is not visible and deeper tissues are not visible. Slough, eschar, or fibrinous material are not present. These injuries commonly result from adhesive dressings and shear to the skin over the joints and often in the heel. This stage should not be used to describe medical restraints skin damage (MRSD) including adhesive restraint devices (ARD), immobilization devices (ID), medical adhesive restraint skin injury (MARS), or tourniquet-related skin tears, lacerations, or abrasions.</p>	<p>Stage 3 Pressure Injury: Full-thickness skin loss. Full-thickness loss of skin, in which adipose (fat) is visible in the ulcer and granulation tissue and yellow fibrinous material are often present. Slough and/or eschar may be visible. The depth of these injuries varies by anatomic location; areas of significant softness may develop deep wounds. Undermining and tunneling may occur. Fat, muscle, tendon, ligament, cartilage and bone are not exposed. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury.</p>	<p>Stage 4 Pressure Injury: Full-thickness skin and tissue loss with exposed or directly palpable muscle, tendon, ligament, cartilage or bone in the ulcer. Slough and/or eschar may be visible. Eschar (dried wound), undermining and tunneling often occur. Deep tissue injury by mechanical traction. A stage or depth obscures the extent of tissue loss this is an Unstageable Pressure Injury.</p>



<p>Unstageable Pressure Injury: Obliterated ulcer bed with slough and eschar. Full-thickness skin and tissue loss. The extent of tissue damage within the ulcer is not identifiable because it is obscured by slough or eschar. A stage or depth is assigned. A Stage 2 or Stage 3 pressure injury will be assigned. Slough and/or eschar, if affected, will not be staged or factored in an estimate. Risk of the wound should not be removed.</p>	<p>Deep Tissue Pressure Injury: Persistent non-blanchable deep red, purple or mottled discoloration of skin. Partial or full-thickness loss of partial or full-thickness skin and underlying tissue. Discoloration or epidermal separation resulting in skin loss over intact full-thickness skin. Pain and temperature change often precede skin loss. The discoloration may appear differently in darkly pigmented skin. This injury results from deep and/or prolonged pressure and shear forces at the same anatomic location. The wound may evolve rapidly to the extent of tissue injury, or may remain without clear loss. It is not a Stage 3 or Stage 4 pressure injury. This includes a full-thickness pressure injury (Unstageable, Stage 3 or Stage 4). Do not use DTP in describing wounds, lacerations, hemipetals, or hemorrhagic conditions.</p>

Additional Pressure Injury Definitions:

Unstaged Medication Pressure Injury: Unstaged medication pressure injury is found on mucous membranes with a history of a medical device in use at the location of the injury. Due to the sensitivity of the tissue these injuries cannot be described by terminology from the staging system. These injuries are often painful but are not full-thickness.

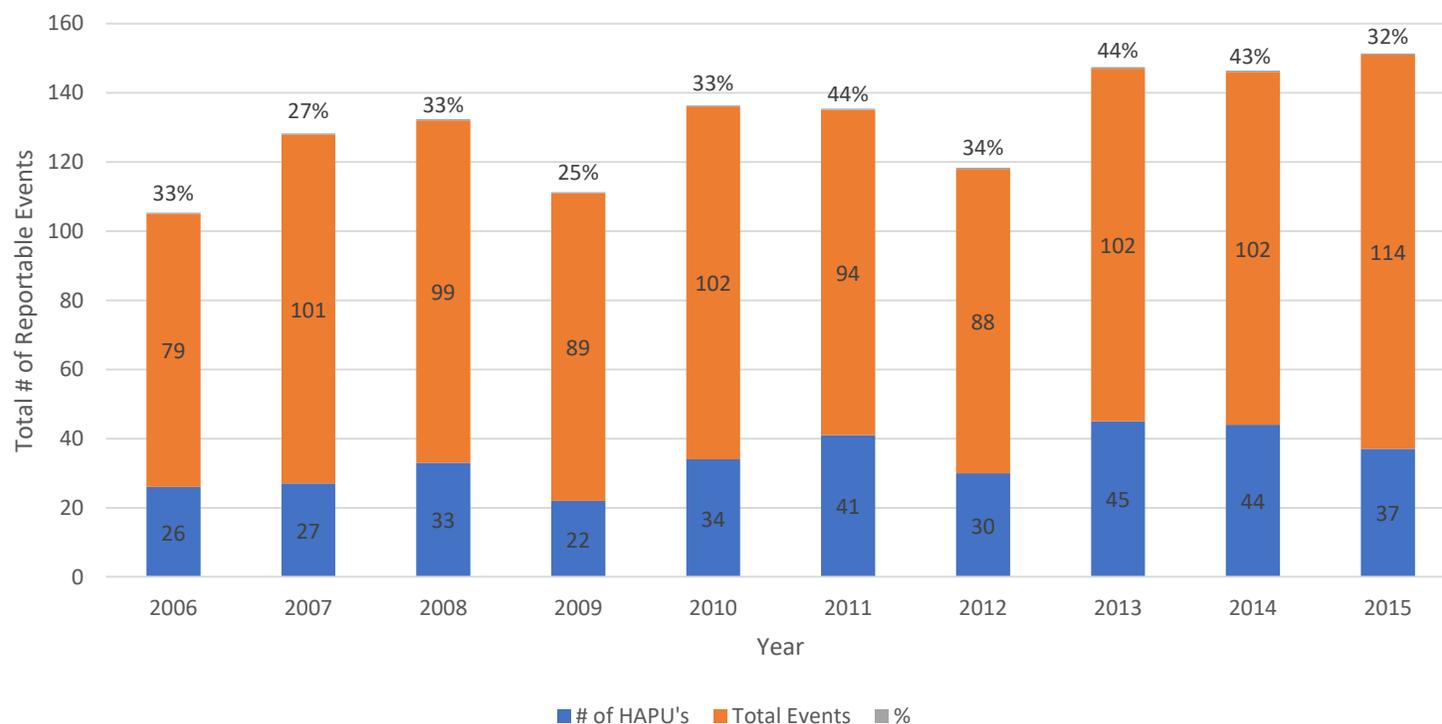
Medical Device Related Pressure Injury: This describes an etiology of the injury. Medical device related pressure injuries result from the use of devices designed and applied for diagnostic or therapeutic purposes. The medical pressure injury generally continues to the patient or stage of the device. The injury should be staged using the staging system.

www.npuap.org

<http://www.npuap.org/resources/educational-and-clinical-resources/2017-world-wide-pressure-injury-prevention-day/>

History of Hospital Acquired Pressure Ulcers-Hospitals Only

Indiana State Medical Error Report for Hospital Acquired Pressure Ulcers 2006-2015



Definition of State Reportable Harm: Stage 3 or Stage 4 pressure ulcers acquired after admission to the facility. **Excluded** is progression from State 2 or Stage 3 if the Stage 2 or Stage 3 pressure ulcer was recognized upon admission or unstageable due to the presence of eschar.

***HIIN Reporting measure *includes* unstageable ulcers.**

Source: Indiana State Department of Health (2015). *Medical Errors Reporting System*. Retrieved from <https://secure.in.gov/isdh/23433.htm>



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Guest Speaker

Jackie Conrad, RN, BS, MBA, RCC
Improvement Advisor, Cynosure Health



**Indiana Patient
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of the Indiana Hospital Association

GET UP Early to Save Skin

November 14, 2017

IHAconnect.org/Quality-Patient-Safety

Why this is important

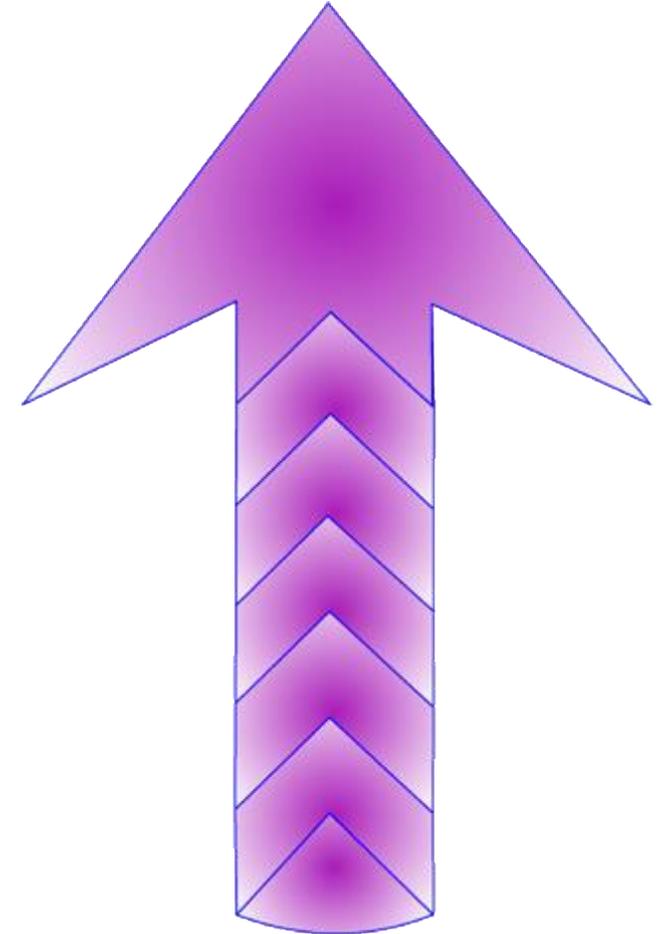


Mobility matters

- Early mobility accelerates progress
- How we mobilize can prevent injury – staff and patients

Outline / Objectives

- Integrate HAPI prevention into Get UP progressive mobility activities.
- Discuss the implications for linking HAPI, early mobility and safe patient handling to accelerate progress.



SKIN

- *Comprises 10-15% of body weight*
- *Receives approximately 1/3 of the circulating blood volume*
- *Complex organ with multiple functions, yet dependent on other organs for function*
- *Primary functions: water balance, body temperature control, immunocompetence, maintenance of vasomotor tone*



Pressure Injury Factors

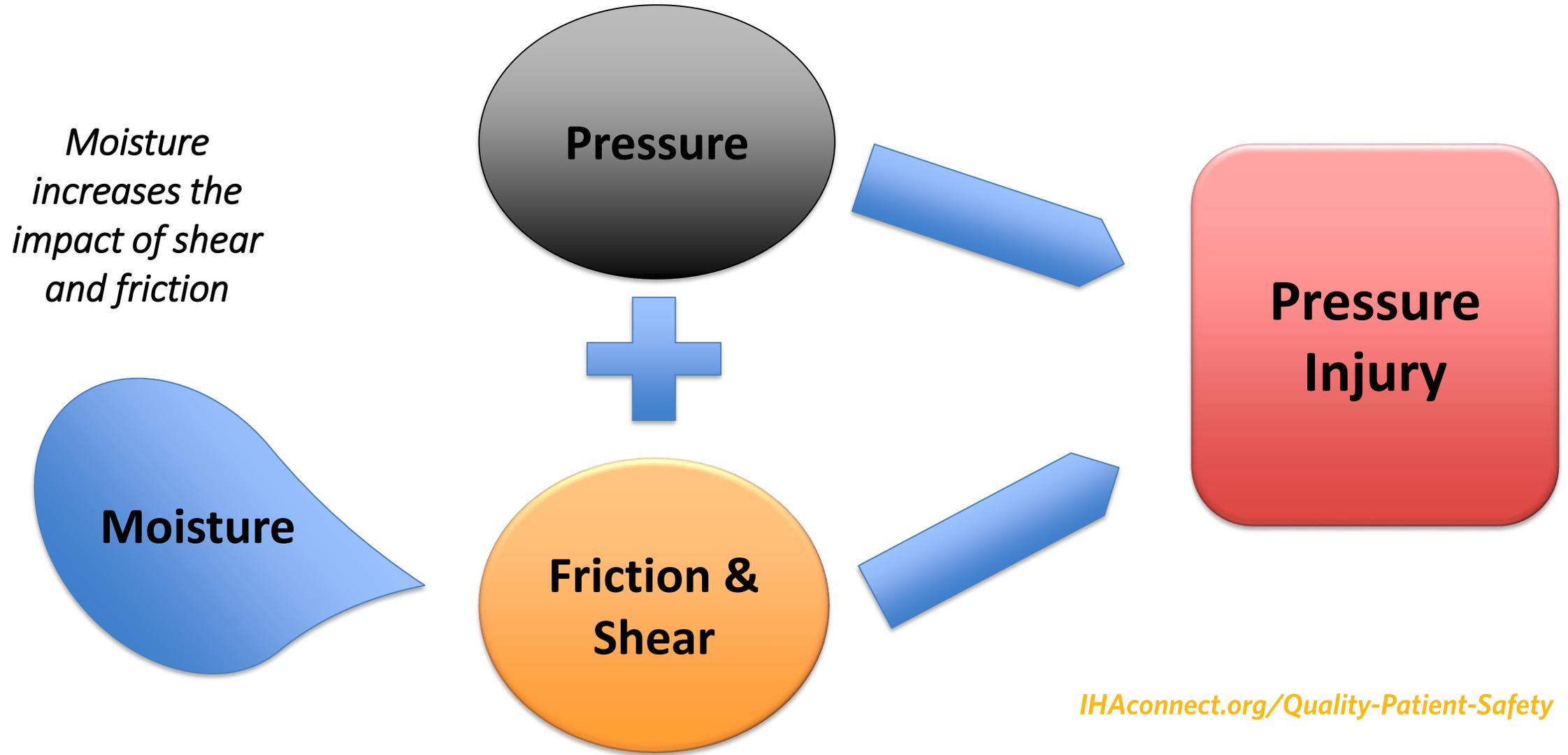
Intrinsic factors

- *Vascular health*
- *Nutrition*
- *Muscle tone*
- *Age*

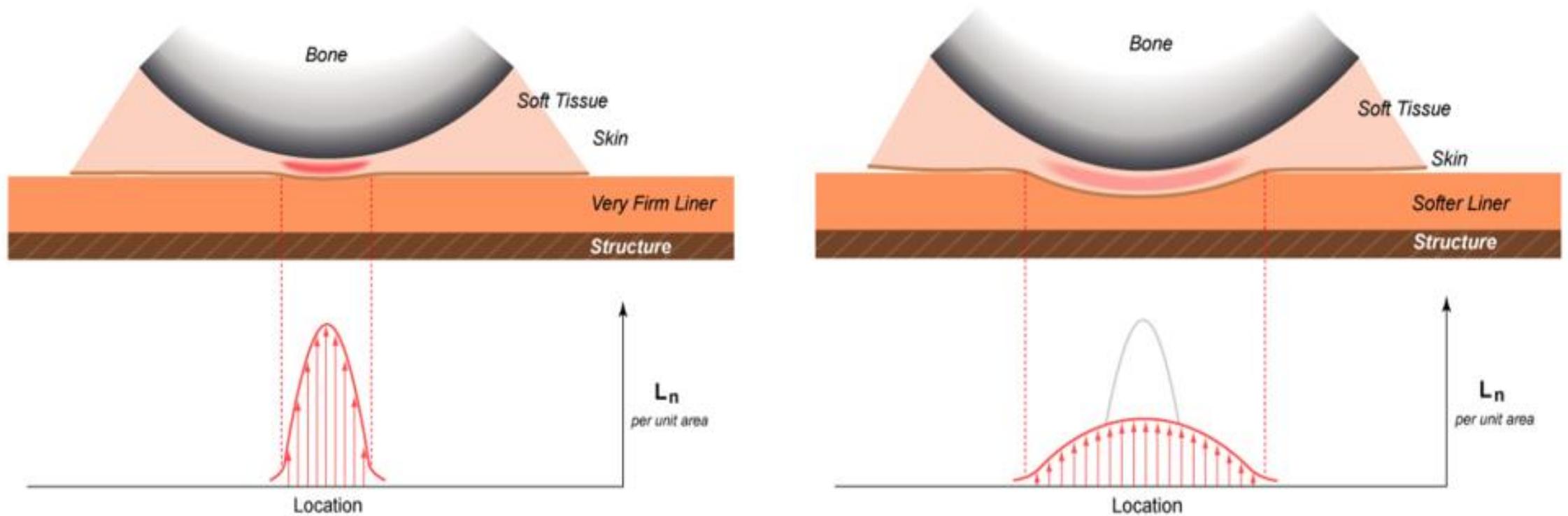
Extrinsic factors

- *Pressure*
- *Microclimate*
 - Temperature
 - Moisture
- *Shear from friction*

Pressure Injury Etiology



Pressure



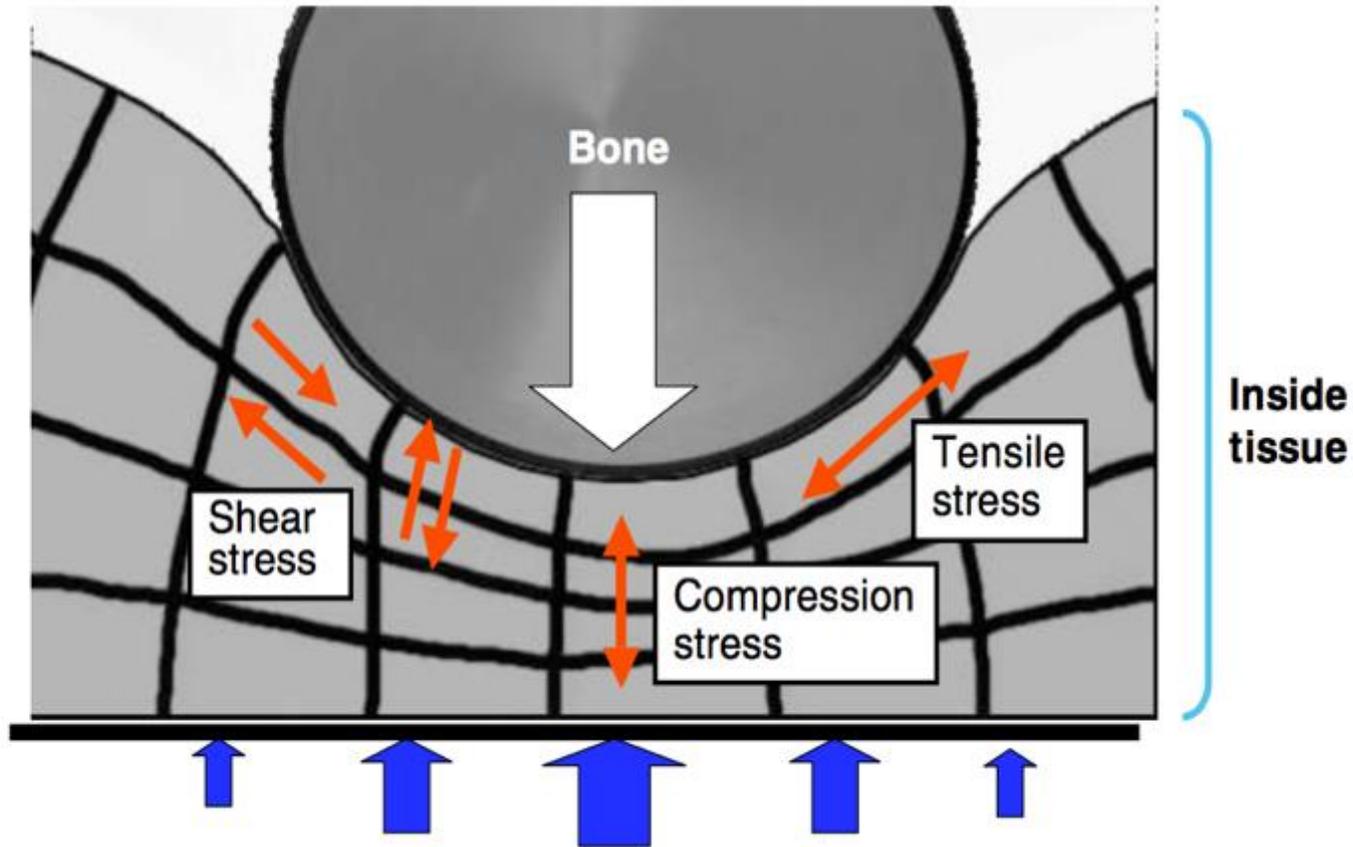
Friction

- *Static friction*
 - resistance at rest
 - keeps the object in place
 - friction load peaks before movement occurs
- *Dynamic friction*
 - resistance during movement



How does moisture impact friction?

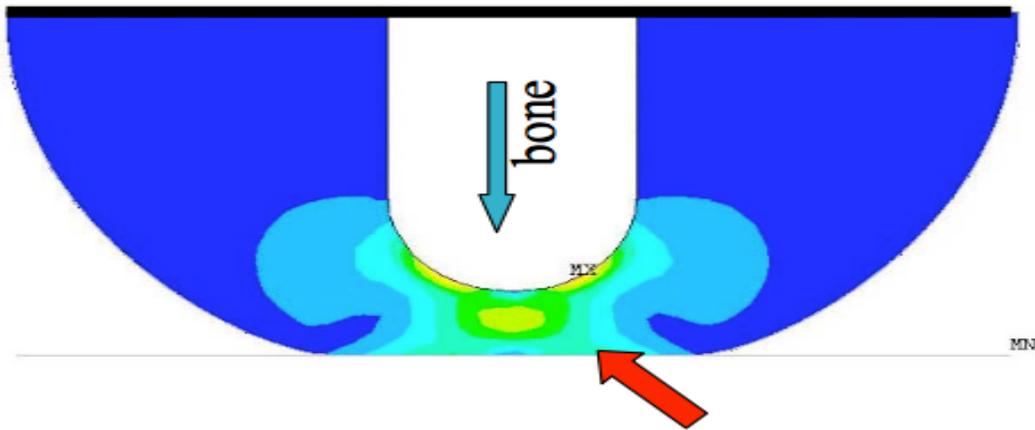
Shear



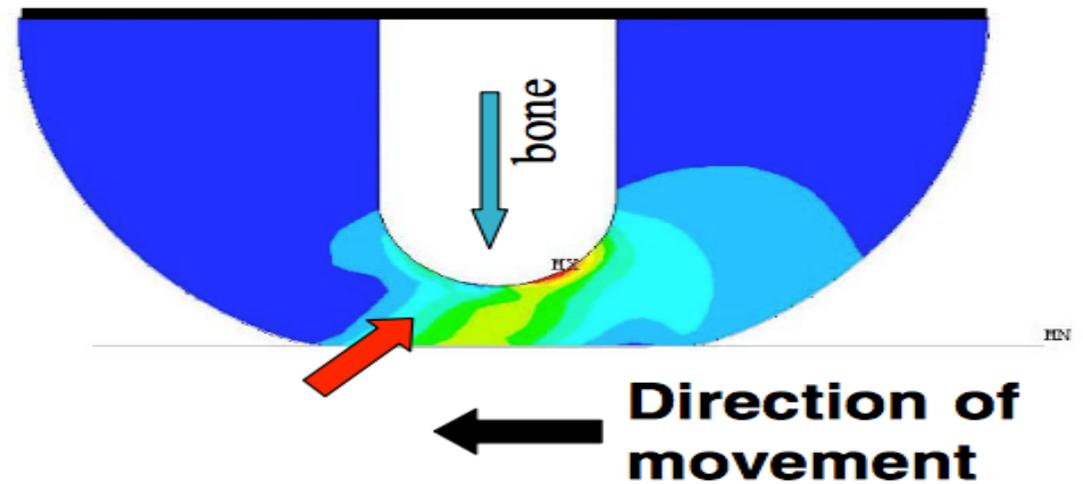
- *Distortion or deformation of tissue by two oppositely directed parallel forces. Pressure and friction are the forces.*
 - Shear stress augments the ischemic effect of pressure
 - Shear strains fracture fine biological structures

Movement influences shear forces

Pressure: 8mmHg
Lateral movement: None



Pressure: 8mmHg
Lateral movement: Only 5mm!



Movement increases strain in deep tissues



Impact of Critical Illness on Skin

- *Hemodynamic changes*
 - Hypo-perfusion
 - Mean arterial pressure – 70 for perfusion
- *Impaired thermoregulatory control*
 - Microclimate – heat and moisture

Hemodynamic Changes

- *Fluid shifts*
- *Orthostatic intolerance*
- *Hypo-perfusion of skin*

Gravitational Equilibrium

- *Orthostatic tolerance decreases w/in 8 hours*
- *Inhibits the body's ability to adapt to position changes*
- *Normal vestibular adjustment may be mislabeled as hemodynamic instability*

Vollman KM. *Crit Care Nurse*. 2012;32:70-75.

Vollman KM. *Crit Care Nurs Q*. 2013; 36:17-27.

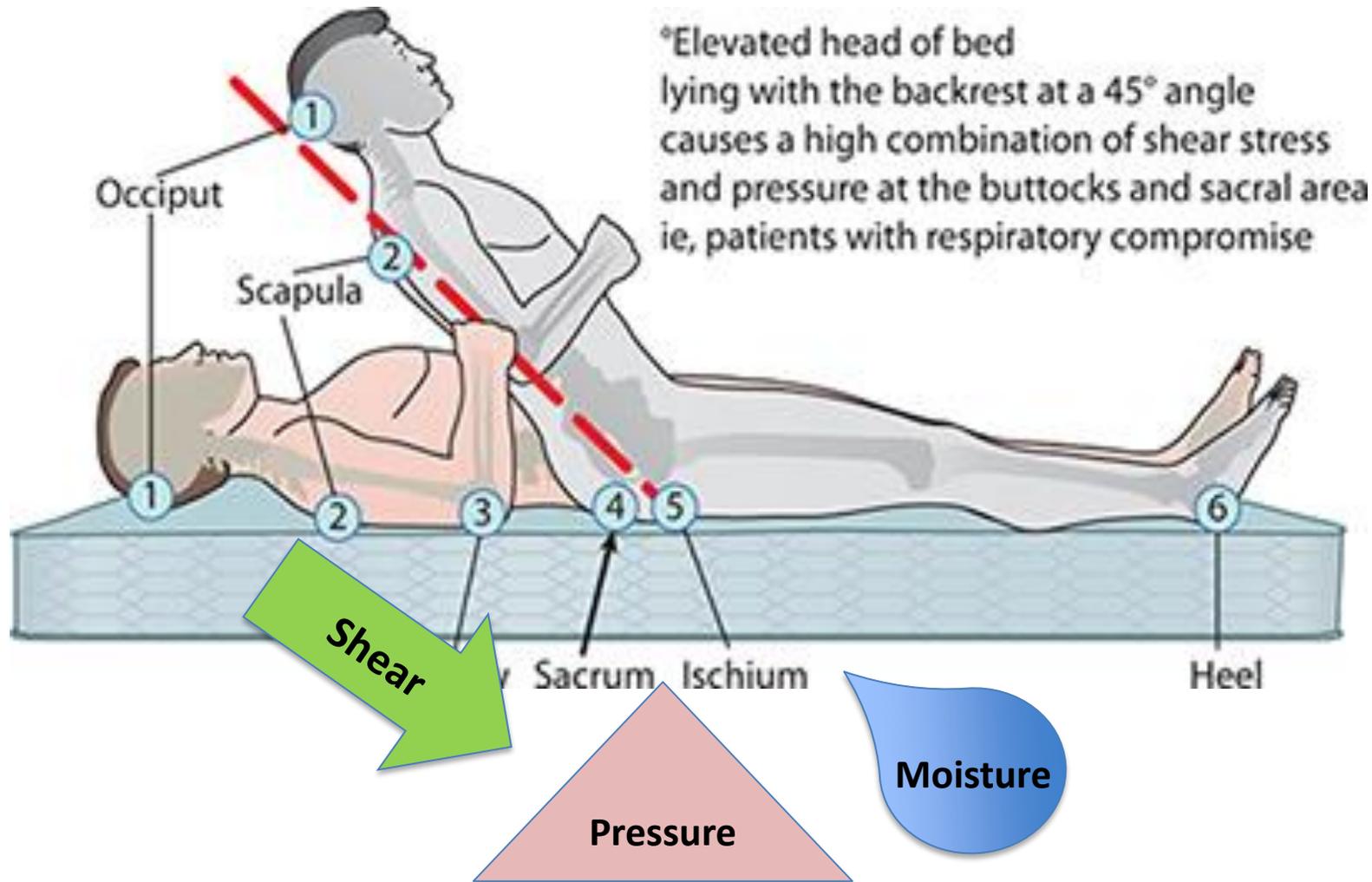
Microclimate - heat

- *Temperature affects metabolic rate*
 - Increases need for nutrients and oxygen
 - Produces higher volume of toxins that expedite ischemic conditions
 - Local tissue temperatures are affected by the heat transfer and insulation properties support surface
 - Reduces natural healing to slight amounts of tissue trauma

Microclimate - moisture

- *Moisture*
 - Reduces strength of outer most layer of skin
 - Causes irritation
 - Increases friction

Sacrum 37% of all injuries



Protective Dressing

*Expert consensus recommendation:
for critically ill patients, include a five
layer soft silicone bordered dressing
on the sacrum to reduce pressure,
shear and microclimate*



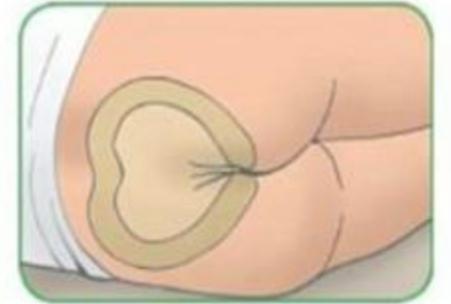
1. Remove the centre release film



2. Apply the adherent side to the
wound (do not stretch)



3. Remove the side release films



4. Smooth down each side

<http://www.hret-hiin.org/resources/display/dressings-as-an-adjunct-to-pressure-ulcer-prevention-consensus-panel-recommendations>

ICU Challenges

- *“Too unstable to turn”*
- *Off loading and repositioning is often missed*
“patients may remain in one position for extended periods of time”
Krishnagopalan 2007
- *Staff uncomfortable with mobilizing hemodynamically unstable patients*

- *How do we start mobility early to prevent gravitational equilibrium?*





Does Incremental Positioning (Weight Shifts) Reduce Pressure Injuries in Critical Care Patients?

Lee Ann Krapfl ♦ Julia Langin ♦ Caitlin A. Pike ♦ Patricia Pezzella

ABSTRACT

BACKGROUND: Incremental positioning or weight shifts are often suggested as an alternative to standard repositioning/turning in critical care patients deemed clinically unstable.

OBJECTIVE: This evidence-based report card reviews whether incremental positioning and/or weight shifts reduce hospital-acquired sacral/buttocks pressure injuries in critical care patients deemed too unstable to turn.

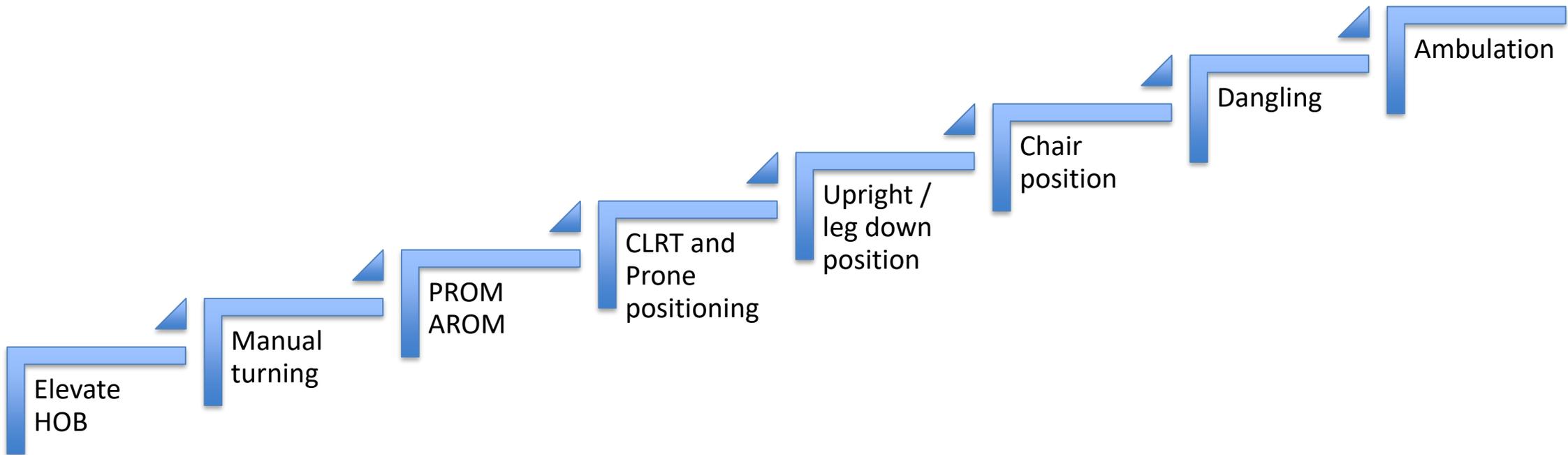
METHODS AND SEARCH STRATEGY: A scoping review of the literature was conducted for studies related to repositioning and hospital-acquired pressure injuries in high-risk, critical care patients. The databases searched were CINAHL, EMBASE, and PubMed. Key words used in the search were “intensive care,” “critical care,” “pressure ulcer(s),” “pressure injury(ies),” “pressure sore(s),” “turn(s),” “turning,” “shift(s),” “shifting,” “position(s),” OR “positioning, cardiopulmonary support.” The search yielded 183 articles. The search was then narrowed to those published within the past 10 years, yielding 35 citations. Following title and abstract review, 5 studies were identified that met inclusion criteria; an additional 13 articles were found by ancestry and hand-searching.

FINDINGS: No evidence was identified that incremental positioning and/or weight shifts reduce hospital-acquired sacral/buttocks pressure injuries in critical care patients deemed too unstable to turn. In addition, no evidence was found that incremental positioning and/or weight shifts affect interface pressure on the sacrum/buttocks. However, there was evidence that incremental positioning and/or weight shifts do impact gravitational equilibrium.

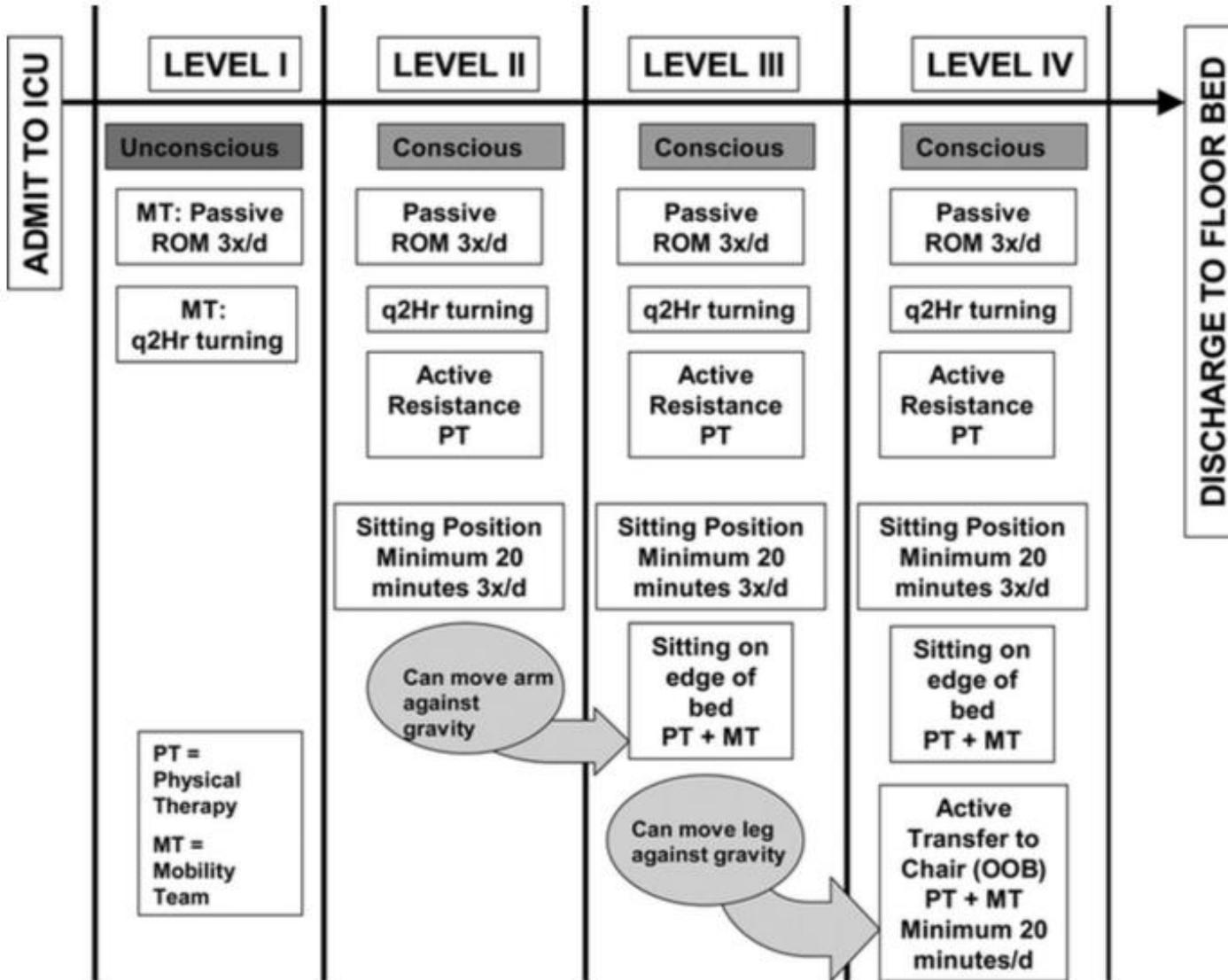
CONCLUSION: Despite the paucity of evidence, incremental positioning and/or weight shifts are recommended as an intervention in critical care patients deemed too unstable to turn. Further research is needed to examine whether incremental positioning and/or weight shifts are effective in reducing pressure injuries in critical care patients.

- *> 30 HOB elevation increases sacral pressure*
- *Evidence is lacking incremental turns directly impact HAPI development*
- *Incremental turns and weight shifts DO impact gravitational equilibrium*
- *Incremental turns should be employed to train to turn*

Progressive Mobility



Vollman, 2010



Start within 8 hours of admission

Duke Progressive Mobility Protocol

Progressive Mobility Continuum					
START HERE	Includes complex, intubated, hemodynamically unstable and stable intubated patients; may include non-intubated			Includes intubated, non intubated hemodynamically stable/stabilizing, no contraindications	
↓	LEVEL I	LEVEL II	LEVEL III	LEVEL IV	LEVEL V
<p>Perform Initial mobility screen w/in 8 hours of ICU admission</p> <p>Reassess mobility level at least every 24 hours (Recommended at shift Δ)</p> <p>Refer to the following criteria to assist in determining mobility level</p> <ul style="list-style-type: none"> o PaO₂/FiO₂ ≥ 250 o Peep <10 o O₂ Sat ≥ 90% o RR 10-30 o No new onset cardiac arrhythmias or ischemia o HR >60 <120 o MAP >55 <140 o SBP >90 <180 o No new or increasing vasopressor infusion o RASS ≥ 3 <p>NO → Start at level I*</p> <p>YES → Start at level II and progress*</p>	<p>RASS -5 to -3</p> <p>Goal: clinical stability; passive ROM</p> <p>ACTIVITY: HOB ≥ 30° *Passive ROM 2X/d performed by RN, or UAP</p> <p>CLRT/Pronation initiated if patient meets criteria based on institutional practice OR Q 2 hr turning</p> <p>Tolerates Level I Activities</p>	<p>RASS -3 & up</p> <p>Goal: upright sitting; increased strength and moves arm against gravity</p> <p>PT consultation prn OT consultation prn</p> <p>ACTIVITY: Q 2 hr turning *Passive /Active ROM 3x/d 1. HOB 45° X 15 min. 2. HOB 45°, Legs in dependant position X 15 min. 3. HOB 65°, Legs in dependant position X 15 min. 4. Step (3) & full chair mode X20 min. 3X/d Or Full assist into cardiac chair 2X/day</p> <p>Tolerates Level II Activities</p>	<p>RASS -1 & up</p> <p>Goal: Increased trunk strength, moves leg against gravity and readiness to weight bear</p> <p>PT: Active Resistance Once a day, strength exercises OT consultation prn</p> <p>ACTIVITY: Self or assisted Q 2 hr turning 1. Sitting on edge of bed w/RN, PT, RT assist X 15 min. 2. Progressive bed sitting Position Min.20 min. 3X/d Or Pivot to chair position 2X/d</p> <p>Tolerates Level III Activities</p>	<p>RASS 0 & up</p> <p>Goal: stands w/ min. to mod. assist, able to march in place, weight bear and transfer to chair</p> <p>PT x 2 daily OT consult for ADL's</p> <p>ACTIVITY: Self or assisted Q 2 hr turning 1. Bed sitting Position Min.20 min. 3X/d; 2. Sitting on edge of bed; stand w/ RN, PT, RT assist 3. Active Transfer to Chair (OOB) w/ RN/PT/RT assist Min. 3X/d</p> <p>Tolerates Level IV Activities</p>	<p>RASS 0 & up</p> <p>Goal: Increase distance in ambulation & ability to perform some ADLs</p> <p>PT x 2 daily & OT x1 daily</p> <p>ACTIVITY: Self or assisted Q 2 hr turning 1. Chair (OOB) w/ RN/PT/RT assist Min. 3X/day 2. Meals consumed while dangling on edge of bed or in chair</p> <p>Ambulate progressively longer distances with less assistance x2 or x3/day with RN/PT/RT/UAP</p>
<p>For each position/activity change allow 5-10 minutes for equilibration before determining the patient is intolerant</p> <p>***If the patient is intolerant of current mobility level activities, reassess and place in appropriate mobility level***</p>					
<p>*Mobility is the responsibility of the RN, with the assistance from the RT's Unlicensed Assistive Personnel and PT/ OT. PT and OT may assist the team with placement to the appropriate mobility level of activity, always prioritizing patient and provider safety. Placement is based on clinical judgment.</p>					

Progressive Mobility Continuum Courtesy of Teresa Murray, CNS, Community Health Network, IN

Hemodynamic Instability and Positioning

- Lateral turn results in a 3%-9% decrease in SVO_2 , which takes 5-10 minutes to return to baseline
- The act of turning may have the greatest impact on any instability seen

Winslow EH, et al. *Heart Lung*. 1990;19:557-561

Price P. *Dynamics*. 2006;17:12-19.

Vollman KM. *Crit Care Nurs Q*. 2013;36:17-27

White, KM. *AACN Clin Issues Crit Care Nurs*. 1993 Feb;4(1):134-47

Activities That Increase O_2 Demand

• Chest X-ray	25%
• Bath	23%
• Suctioning	27%
• ↑ work of breathing	40%
• Weigh on sling scale	36%
• Position change	31%
• Linen change	22%
• Chest physiotherapy	35%
• Dressing change	10%
• Physical exam	20%
• Agitation	18%

Interventions for the Unstable Patient

- Shift weights or micro-turns
- Elevate heels from surface of bed
- Reposition arms and legs every hour, PROM
- Consider Continuous Lateral Rotation Therapy
 - Driven by a protocol
 - Begin slow and low angles
 - Stop every 2 H and reassess

Micro-turns

- *Baby steps*

**15
degrees**

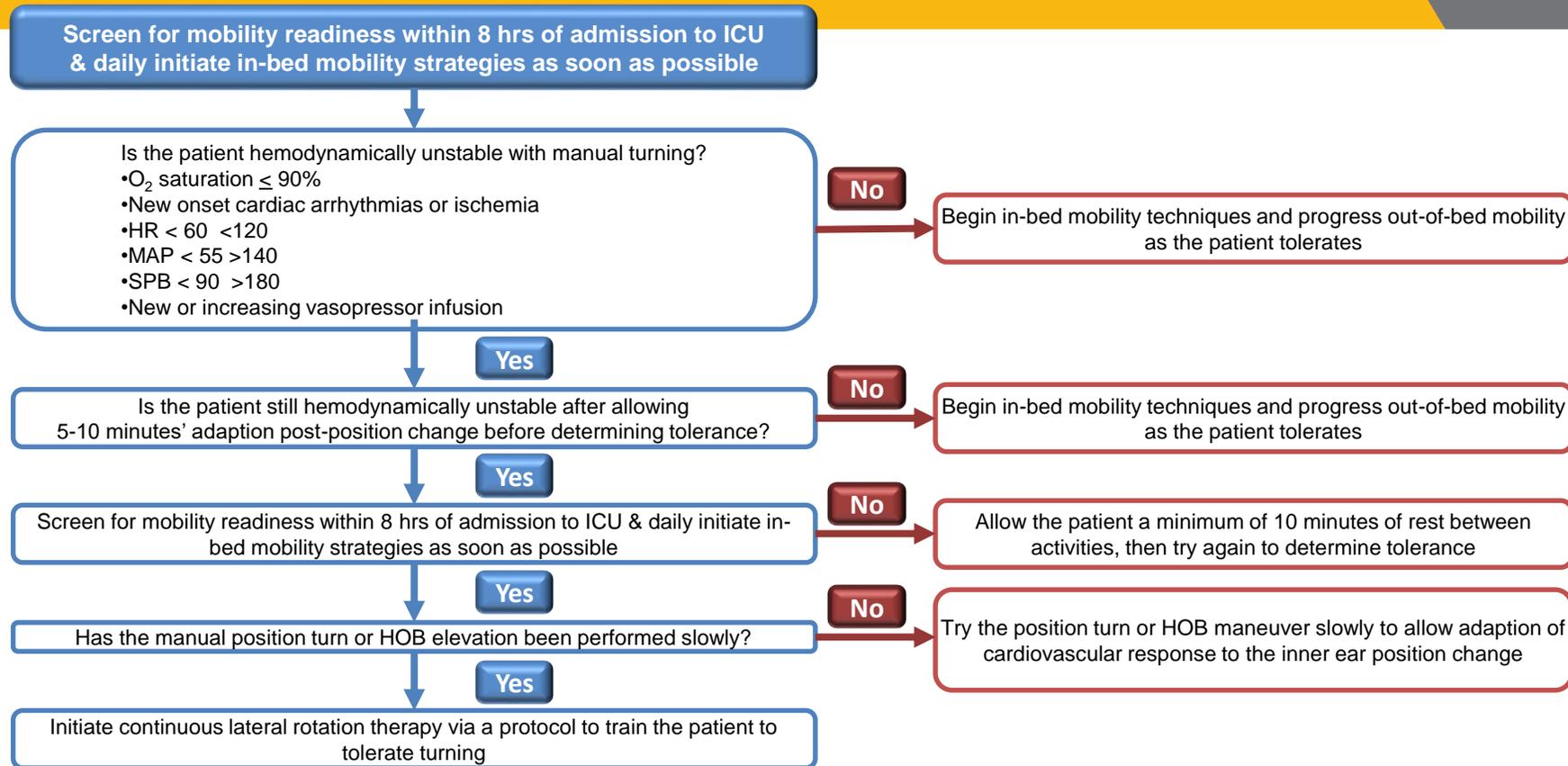
**15
seconds**



Tips for Training to Turn

- Determine the best time when the body is at rest.
- Go SLOW!!!
- Monitor for 5-10 minutes for tolerance. VS should recover within 10 min
- Start with right lateral – easier tolerated
- Return to supine w/ HOB up or right lateral up if unable to recover position change within 10 minutes

Decision-Making Tree for Patients Who Are Hemodynamically Unstable With Movement

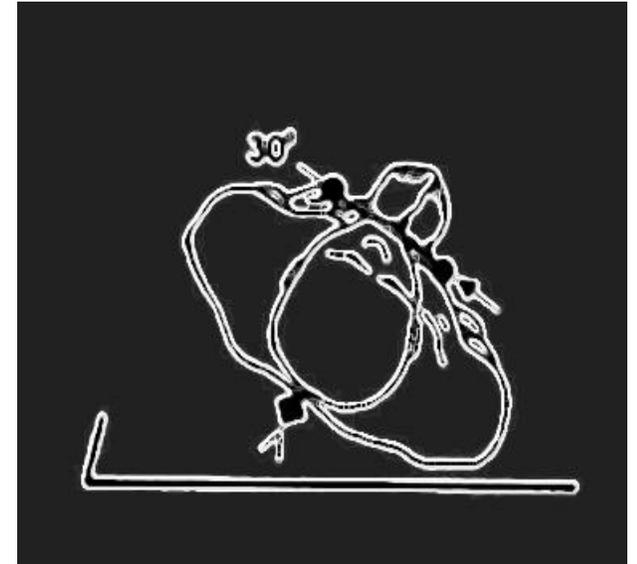


Vollman KM. *Crit Care Nurse*. 2012;32:70-75.
Vollman KM. *Crit Care Nurs Q*. 2013;36:17-27.

- *Critical to early ICU mobility success*
 - Coordinate timing of sedation and mobility to optimize wakefulness
 - Follow the ABCDEF Bundle
- *Tune in the “Wake UP” events to learn more*

EBP for off-loading & pressure reduction

- *Use 30 degree tilted side lying position as condition allows*
- *Encourage self re-positioning*
- *Assess whether offloading has occurred*
- *Use lifting devices or other aids to reposition to make it easier to turn*
- *Encourage proper seating in a chair – no slouching*



NPUAP 2014

EBP to reduce Shear and Friction

- *Loose covers and increased immersion in the support surface*
- *Protective dressing*
- *Use lifting / transfer devices*
 - Mechanical lifts
 - Transfer sheets
 - 2-4 person lifts
 - Turn and assist features on beds



Support surface with immersion reduces friction



Caring for our Caregivers



How safe are hospitals for workers?

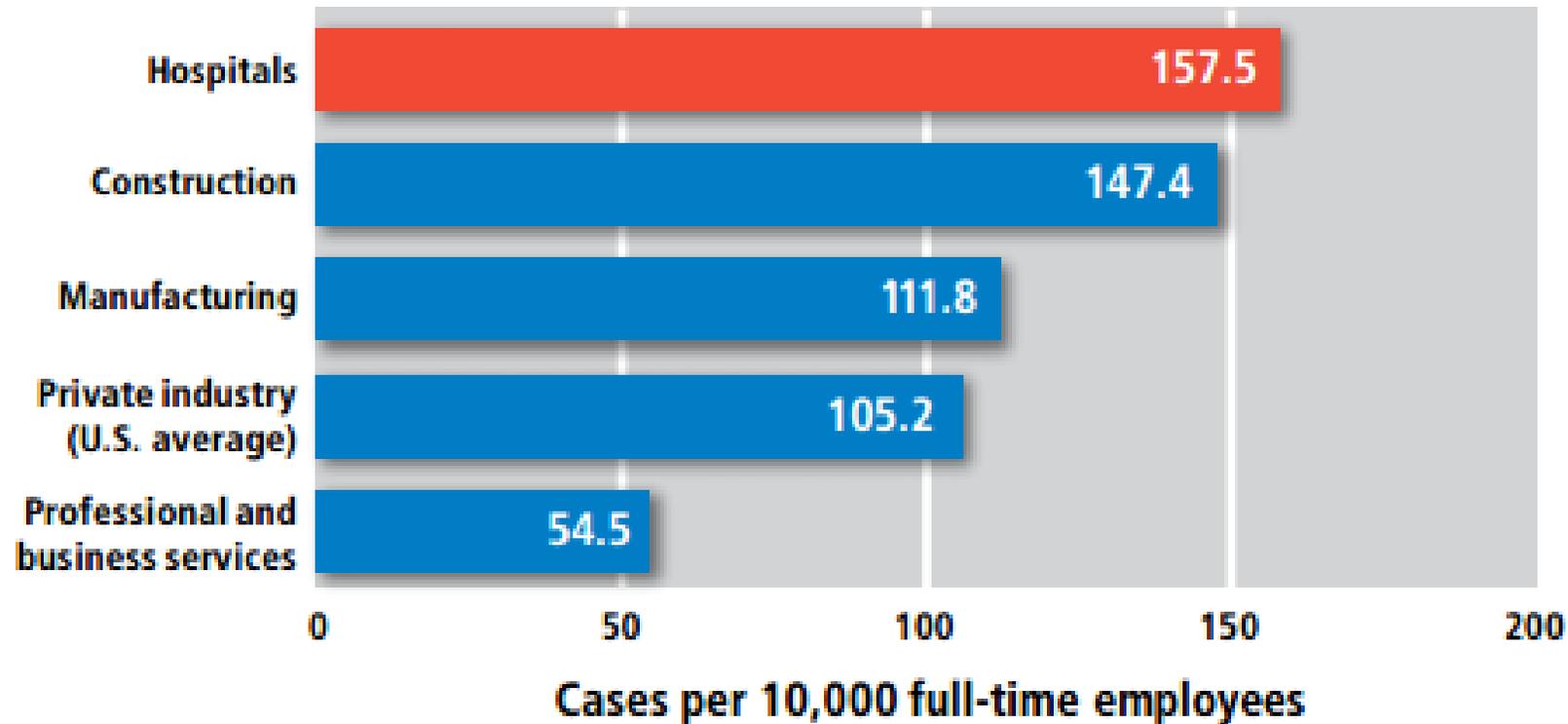
Which work setting has the highest work related injury or illness rates?

1. Hospitals
2. Construction
3. Manufacturing?

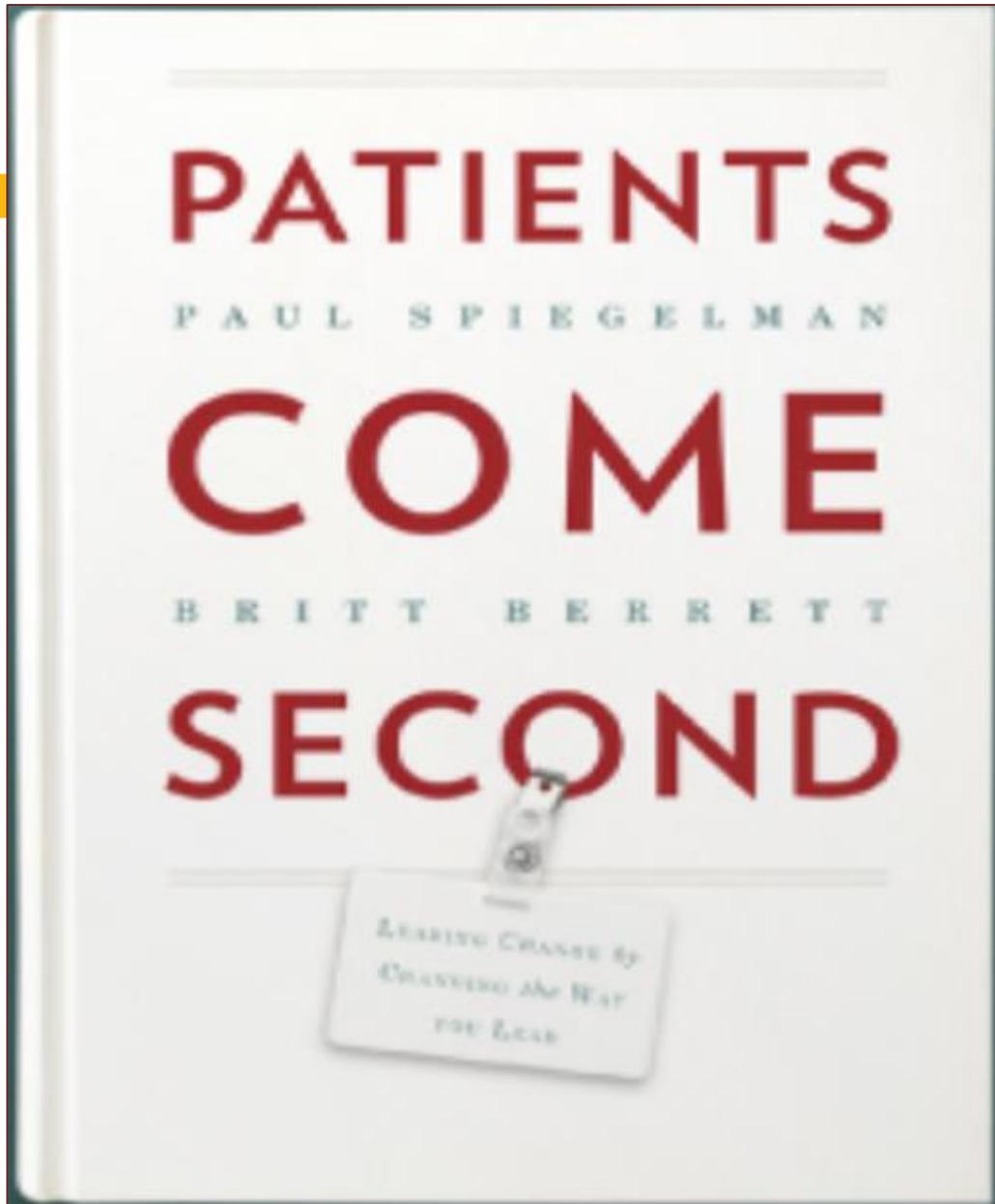


Days away from work by sector

Injuries and Illnesses Resulting in Days Away from Work, 2011

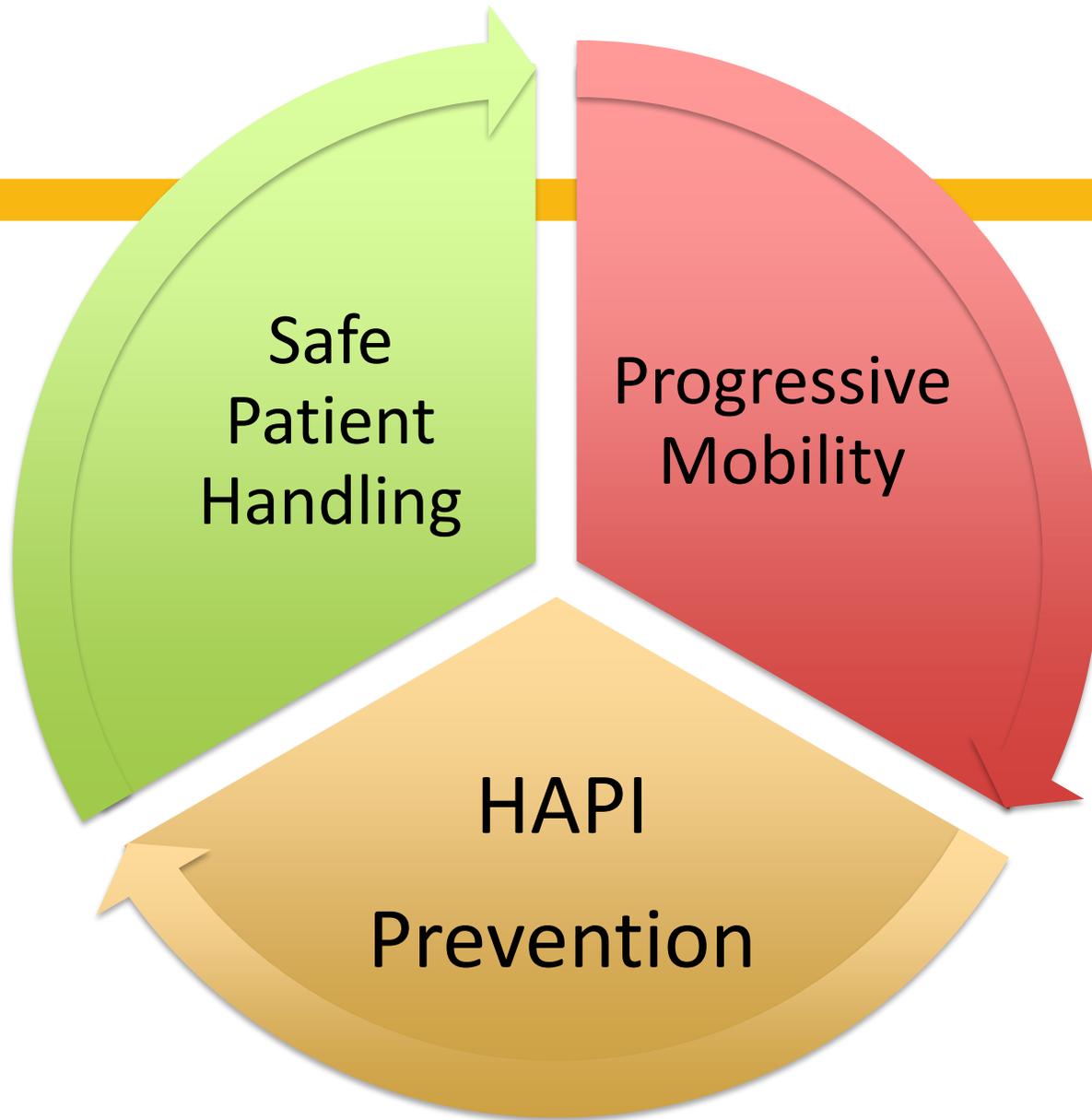


Data source: Bureau of Labor Statistics



Provide world class care to your caregiver so they can provide world class service to the patient.





*Can we integrate
SPH with Get UP
and HAPI
Prevention?*

Linking outcomes

Hurley Medical Center

Compared standard care: off loading with under pads, pillows, rolled blankets compared to use of a patient turning and positioning device and pressure relieving heel protectors

- 28% decrease in HAPI
- 58% decrease in HC worker injury
- \$432 K savings

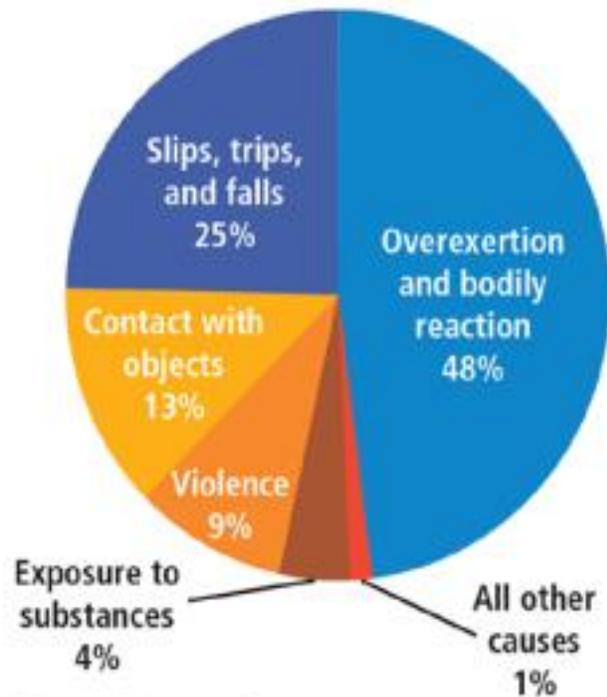
Franciscan Health, Michigan City

Implemented a mobility team staffed 7 days a week to ambulate patients. After 6 months, achieved improvements:

- 70% decrease in HAPI
- 40% reduction in HC worker back injuries
- 45% drop in readmissions

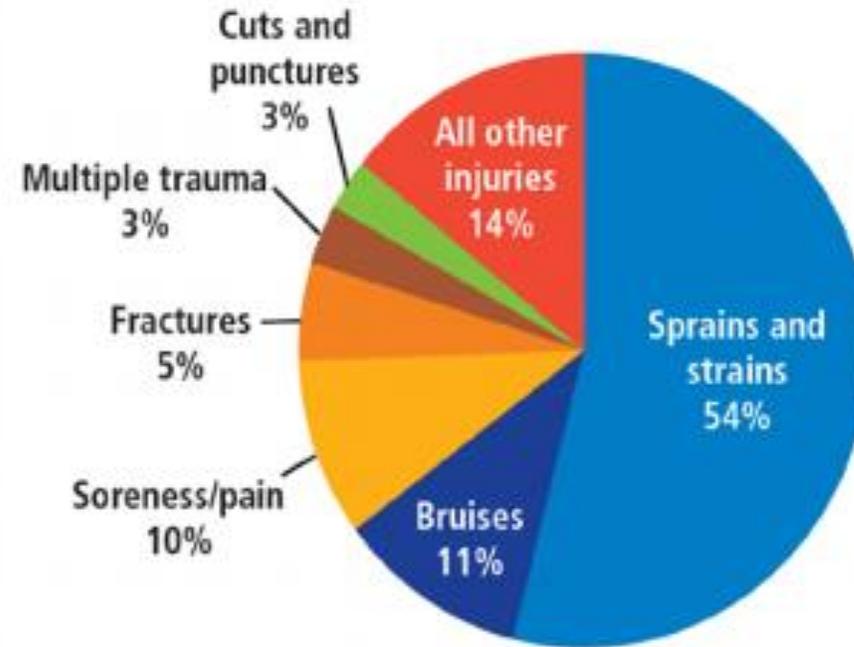
Causes & Types of Hospital Work Related Illness / Injury

Top Five Causes of Injury Among Hospital Workers



Data source: Bureau of Labor Statistics, 2011 data

Hospital Injuries Resulting in Days Away from Work, by Type

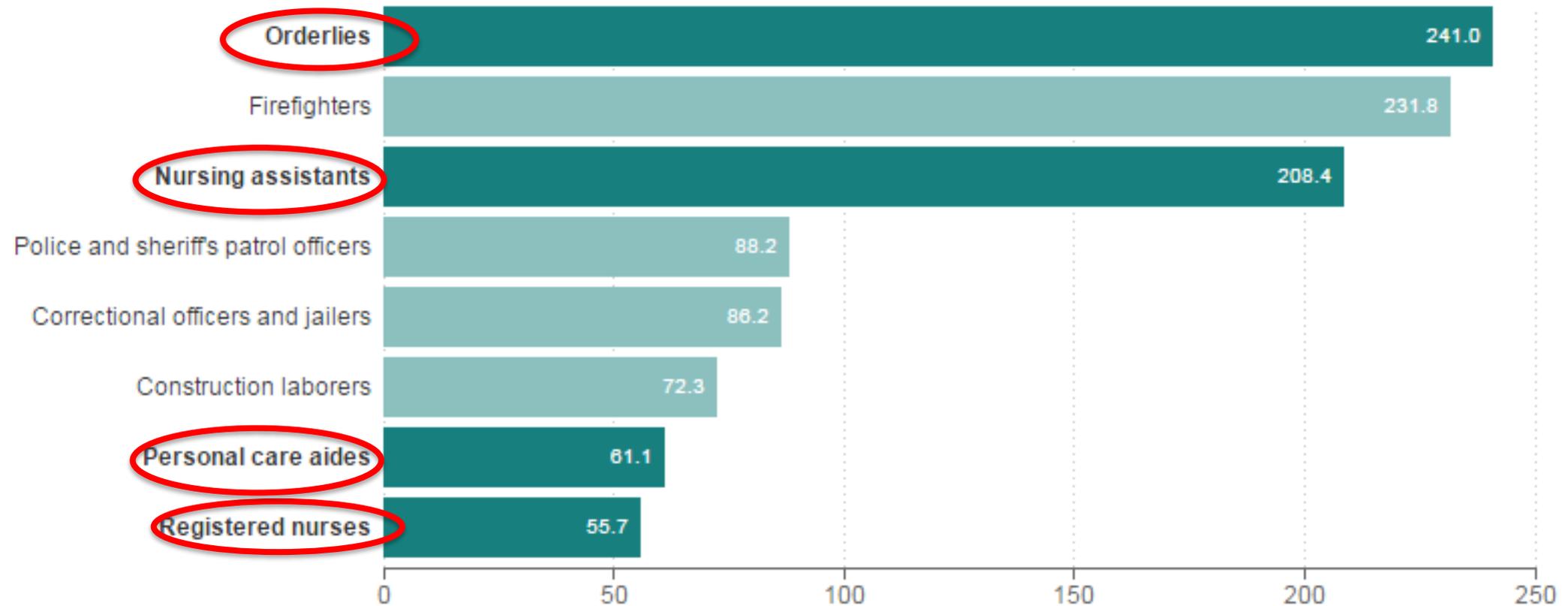


Data source: Bureau of Labor Statistics, 2011 data

Musculoskeletal injuries by role

Musculoskeletal Injury Rates For Selected Occupations In 2013

Nonfatal injuries and illnesses resulting in lost work days, per 10,000 full-time workers



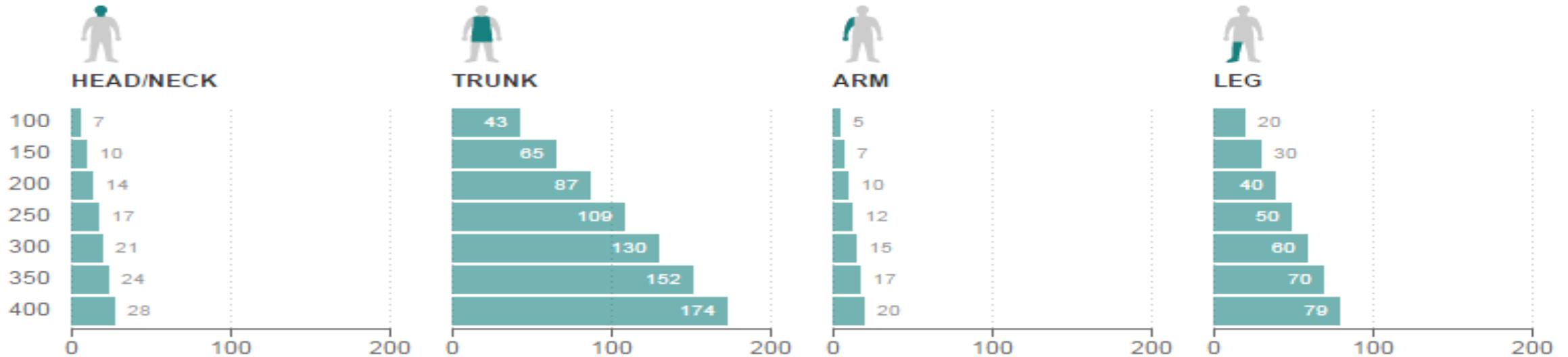
Source: Bureau of Labor Statistics

Credit: NPR

Risks are on the Rise

Heavier Patients Mean Heavier Lifts

How much each body part might weigh for a man at different body weights (in pounds)



Notes

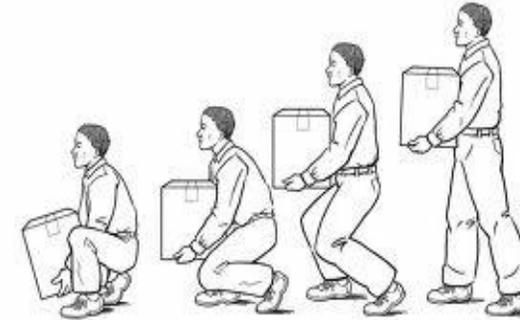
- The average weight distribution did not differ greatly between women and men.
- "Arm" includes the upper arm, forearm and hand.
- "Leg" includes the thigh, shank and foot.

Source: Weights calculated from [body segment parameters](#) compiled by Paolo de Leva in a study published in the *Journal of Biomechanics*.

Credit: Lydia Emmanouilidou and Alyson Hurt/NPR

Why body mechanics fail

- Focus on using the legs and back



- 20-30% of a nurses time is spent bent forward with trunk twisted
- Horizontal movement
 - Arms and shoulders lifting



Equipment Types

Lifts



Sit to Stand Device



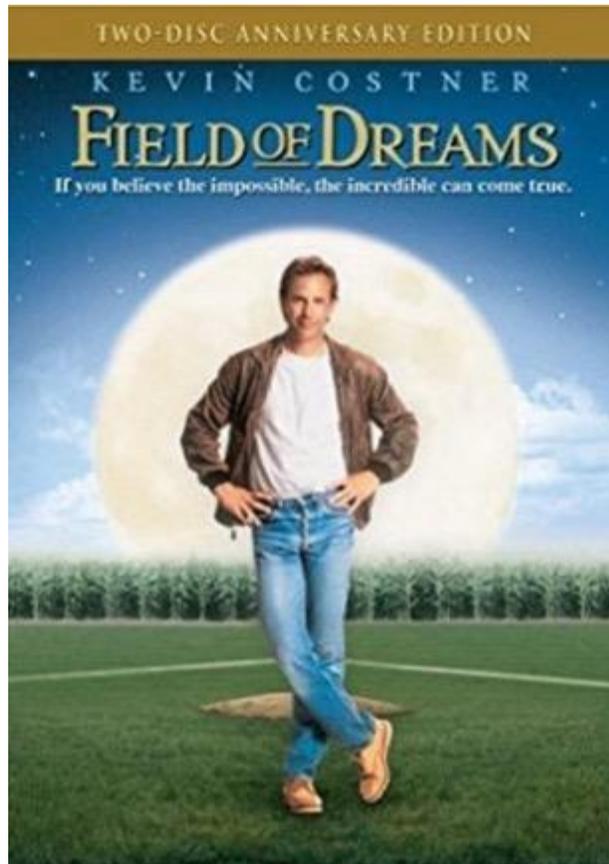
Lateral transfer aids / glide sheets



Beds and Positioning Systems



Embracing Safe Patient Handling



- *If you build it, they will come.....*

Make it important



Make it easy



First listen

- *Involve management and staff in a conversation*
 - What is the data telling you?
 - What are the barriers?
 - What special need patient population focus on?



SPH Resources

- *American Nurses Association, Nursing World. (2015) Safe Patient Handling and Mobility. Retrieved from: <http://www.nursingworld.org/MainMenuCategories/Policy-Advocacy/State/Legislative-Agenda-Reports/State-SafePatientHandling>*
- *Joint Commission. (2012) Improving Patient and Worker Safety, opportunities for Synergy, Collaboration and Innovation. Retrieved from: <http://www.jointcommission.org/assets/1/18/tjc-improvingpatientandworkersafety-monograph.pdf>*
- *Minnesota Hospital Association. Tool for MHA Safe Patient Handling Roadmap Gap Assessment. Retrieved from: <http://www.mnhospitals.org/patient-safety/current-safety-quality-initiatives/patient-handling>*
- *Occupational Safety and Health Administration (OSHA) Safe Patient Handling Resources. Retrieved from: <https://www.osha.gov/SLTC/healthcarefacilities/safepatienthandling.html>*
- *VISN 8 Patient Safety Center. (2006) Safe Patient Handling and Movement Algorithms. Retrieved from: <http://www.cbs.state.or.us/osha/grants/safe-patient-handling-health-care/resources/files-from-original-cd/va-algorithms-for-patient-handling-rev-2006.pdf>*



**Indiana Patient
Safety Center**

of the Indiana Hospital Association

Get Up Resources

IHAconnect.org/Quality-Patient-Safety

How Can IHA Help?

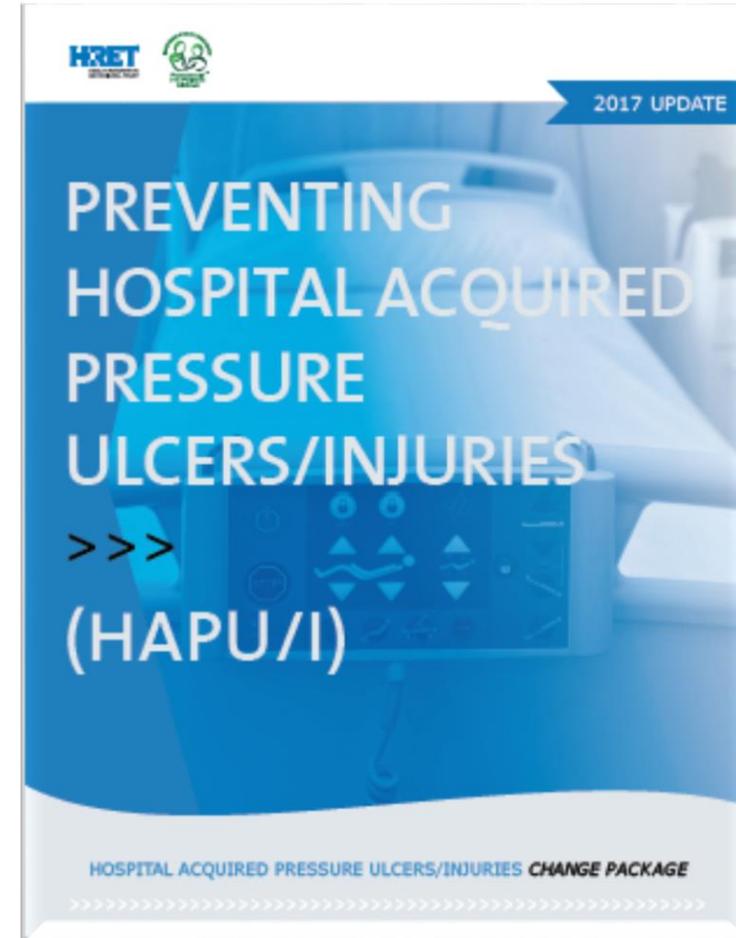
- *What resources do you need to help with your improvement efforts?*



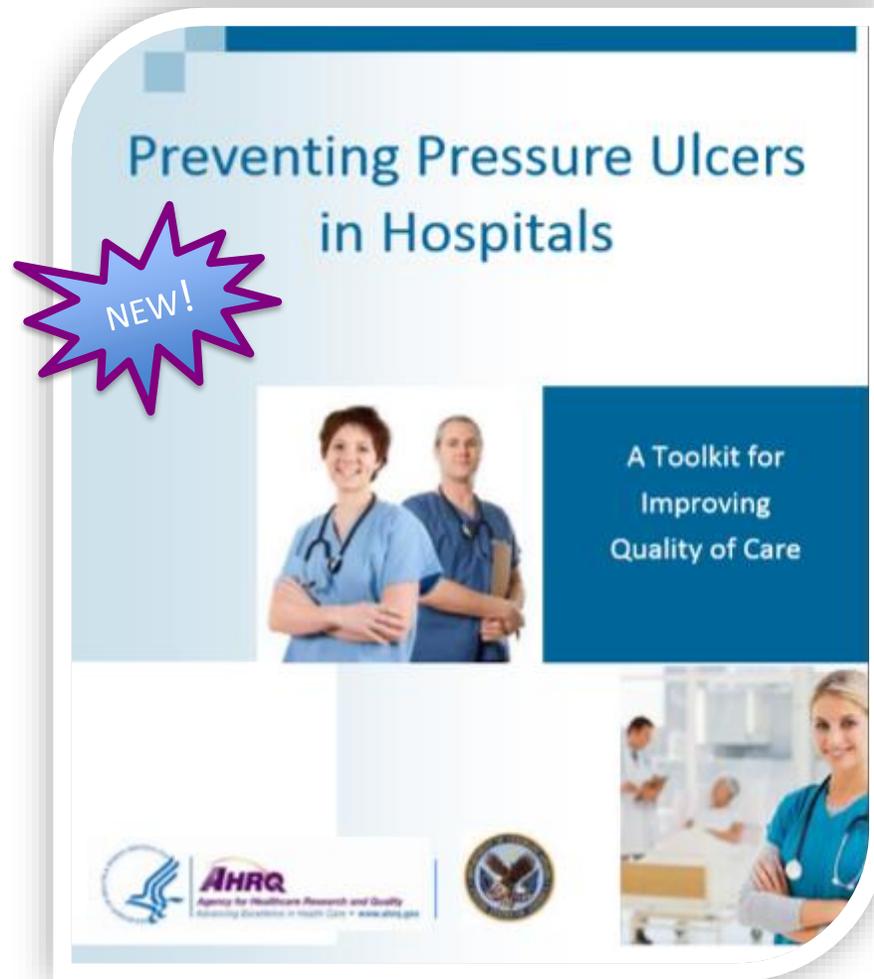
HRET Change Package-Pressure Ulcers/Injuries



<http://www.hret-hiin.org/resources/display/hospital-acquired-pressure-ulcersinjuries-change-package>

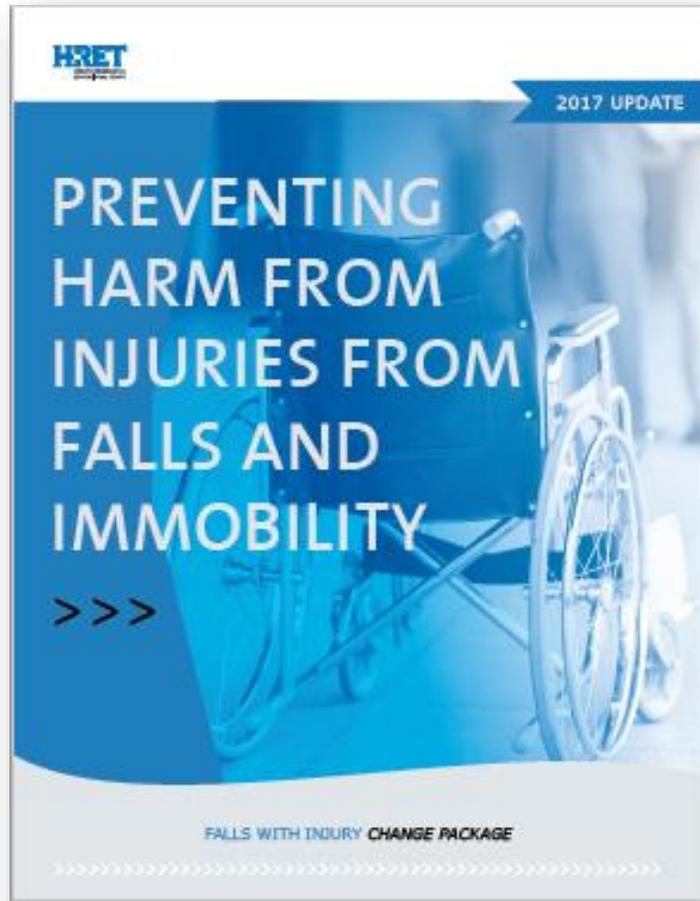


AHRQ Toolkit-Pressure Injuries



<https://www.ahrq.gov/professionals/systems/hospital/pressureulcertoolkit/index.html>

HRET Change Package/Fact Sheet- Falls and Immobility



2017 Falls Top Ten Checklist

PROCESS CHANGE	
1. Assemble a multidisciplinary falls team with an executive sponsor, front-line staff from nursing and rehab, management support, physical therapy, physician and pharmacy representatives to oversee the strategic plan for the fall injury prevention program.	<input type="checkbox"/>
2. Engage all levels of staff and disciplines in creating a safe environment that is free of tripping and slipping hazards and is responsive to patient needs, i.e., "no pass zone" and environmental rounds. Review all falls in leadership huddles to raise awareness of hazards and contributing factors.	<input type="checkbox"/>
3. Identify high risk/vulnerable populations upon admission to receive a multifactorial falls assessment. Do not rely on a risk score alone. Examples: patients admitted with a fall, patients with a history of fall in the past six months, patients over 65, ABCS criteria, depending upon the population served.	<input type="checkbox"/>
4. Provide multifactorial assessments and targeted interventions for high risk or vulnerable elderly patients. Assess for and address risk factors associated with gait, balance and mobility, medications, cognitive assessment, heart rate and rhythm, postural hypotension, feet and footwear and home environment hazards.	<input type="checkbox"/>
5. Communicate risk across the team: EMR Banners, hand-offs, visual cues, huddles and whiteboards.	<input type="checkbox"/>
6. Round every one to two hours on patients; address the five P's—pain, position, personal belongings, pathway and potty. Escalate rounding frequency to meet patient needs.	<input type="checkbox"/>
7. Implement mobility plans for all patients to preserve function and prevent hazards of immobility: rehab referral and collaboration for a progressive activity and ambulation program.	<input type="checkbox"/>
8. Review medications—avoid unnecessary hypnotics and sedatives and remove outprnt medications from order sets. Target high-risk or vulnerable patients for pharmacist medication review.	<input type="checkbox"/>
9. Include patients, families and caregivers in efforts to prevent falls. Provide structured education apart from admission orientation. Educate using teach-back regarding fall prevention measures and encourage family members to stay with high-risk, vulnerable patients.	<input type="checkbox"/>
10. Conduct post-fall huddles at the bedside with patient and family immediately after the fall to analyze how and why the fall occurred, and implement change(s) to prevent future falls. Include a pharmacist and rehab staff member in the post-fall huddle or case review.	<input type="checkbox"/>

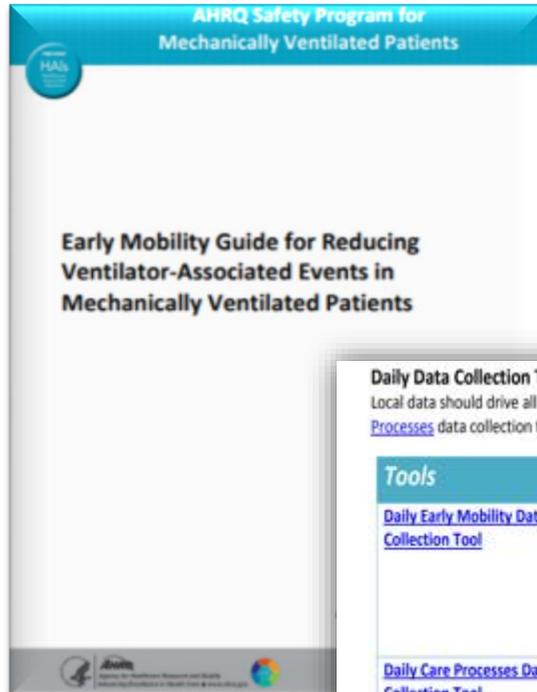
Hospital Improvement Innovation Network
Improve Quality and Patient Safety at your Hospital and Impact National Health Outcomes



Falls with Injury Data Collection Fact Sheet (HIIN-Falls-1)

Numerator	<ul style="list-style-type: none"> Total number of falls rating minor or greater during the measurement period. NDNQ definitions for injury can be found in the Agency for Healthcare Research & Quality (AHRQ)'s comprehensive resource for measuring fall rates and fall prevention practices. The resource is available online at the following link: http://www.ahrq.gov/professionals/systems/hospital/FallPrevention/index.html
Denominator	<ul style="list-style-type: none"> Patient days in eligible or included units during the measurement period.
Numerator Inclusions	<ul style="list-style-type: none"> Included populations: Inpatients, short stay, observation patients, and same day surgery patients that receive care on an eligible unit. Eligible units: Adult critical care, step-down, medical, surgical, medical-surgical, critical access, inpatient adult rehabilitation. Hospitals may choose to include additional units that serve vulnerable populations such as geriatric-psychiatric units. Inclusion of additional units is up to site discretion but must remain consistent throughout entirety of the HIIN project. Assisted and unassisted falls
Numerator Exclusion	<ul style="list-style-type: none"> Excluded unit types: pediatric, psychiatric, and obstetric Visitor and staff falls with injury
Data Sources	<ul style="list-style-type: none"> Incident or Event Reports Administrative Data Post Fall Huddle Reports

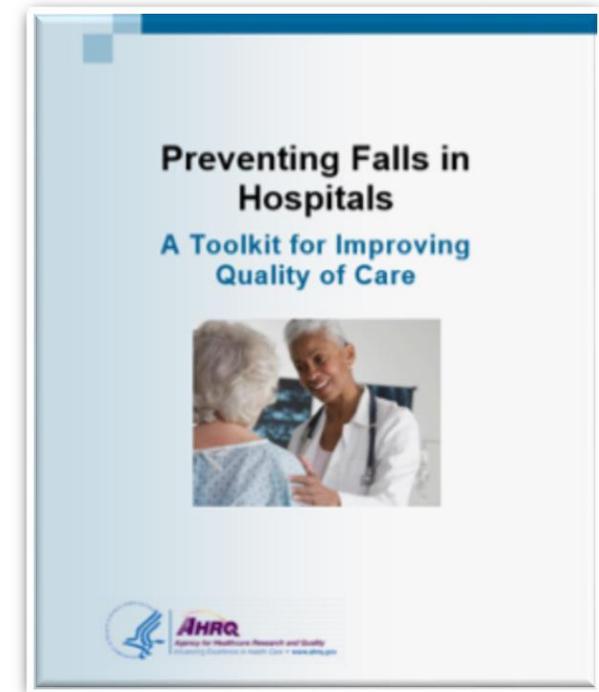
AHRQ Toolkits for Falls & Ventilator Acquired Events



<https://www.ahrq.gov/sites/default/files/wysiwyg/professionals/quality-patient-safety/hais/tools/mvp/modules/technical/early-mobility-mvpguide.pdf>

Daily Data Collection Tools
Local data should drive all quality improvement efforts. The [Daily Early Mobility](#) and [Daily Care Processes](#) data collection tools can be used for collecting data on daily patient care activities.

Tools	How To Use Them
Daily Early Mobility Data Collection Tool	This tool helps track compliance with each of the evidence-based recommendations for promoting early mobility as well as capturing perceived barriers to early mobilization, events that may occur during the mobilization process, and the level of PT and OT involvement.
Daily Care Processes Data Collection Tool	This tool helps track the compliance with each of the recommended daily care measures shown to reduce the harms associated with mechanical ventilation.



<https://wwwprofessionals/systems/h.ahrq.gov/ospital/fallpxtoolkit/index.html>

IHA Resource Sheet

 **Indiana Patient Safety Center**
of the Indiana Hospital Association

GET UP

GET UP focuses on mobilizing patients to return to function more quickly.

Keeping a patient mobile is key to helping them avoid various types of harm. Maintaining a continued emphasis on mobility can assist in the prevention of several harm events, including CAUTI, delirium, falls, HAPI/U, readmissions, VAE and VTE.



There are many resources available at HRET-HIIN.org, including those below, to help your organization address these harm events and engage with the UP Campaign.

GET UP Resources	
Including HRET HIIN topic Change Package, Checklist, past webinar recordings and additional resources	
Topic	Link
Introduction to the UP Campaign	http://www.hret-hiin.org/Resources/up_campaign/17/up_campaign_presentation_generic.pdf
GET UP Virtual Event - Move It Or Lose It	http://youtu.be/5i-NAKmeT
CAUTI	http://www.hret-hiin.org/topics/catheter-associated-urinary-track-infection.shtml
Delirium	http://www.hret-hiin.org/topics/atrogenic-delirium.shtml
Falls	http://www.hret-hiin.org/topics/injuries-from-falls-immobility.shtml
Pressure Ulcers/Injuries	http://www.hret-hiin.org/topics/pressure-ulcers.shtml
Readmissions	http://www.hret-hiin.org/topics/readmissions.shtml
VAE	http://www.hret-hiin.org/topics/ventilator-associated-event.shtml
VTE	http://www.hret-hiin.org/topics/venous-thromboembolism.shtml

 **Indiana Patient Safety Center**
of the Indiana Hospital Association

GET UP Resources

View the below resources for information on various harms topics and how increasing mobility can prevent these harms.

Pressure Ulcer/Injury:

- A National Pressure Ulcer Advisory Panel White Paper <http://www.npuap.org/wp-content/uploads/2012/01/NPUAP-ULS-White-Paper-March-2015.pdf>
- HAPI Secret Injury Prevention Checklist http://www.hret-hiin.org/resources/pu/17/hapi_secret_injury_checklist.pdf

Falls:

- HRET HIIN Fall Teach-Back Tool http://www.hret-hiin.org/Resources/Falls/17/falls_teach_back_tool.pdf
- Falls Test Performance Worksheet http://www.hret-hiin.org/Resources/Falls/17/test_performance_measure_worksheet.pdf
- Preventing Falls in the Bathroom <https://vimeo.com/201006726/d555a3d939>
- Fall Mat Demonstration <https://vimeo.com/210807027/2fb8f8a6>
- The Tension Between Promoting Mobility and Preventing Falls in the Hospital <http://jamanetwork.com/journals/jamainternalmedicine/article-abstract/2621835>

CAUTI:

- Impact of two-step urine culture ordering in the emergency department: a time series analysis <http://qualitysafety.bmj.com/content/early/2017/05/03/bmjqs-2016-006250>
- Culturing Practices Matter: Spotlight on Asymptomatic Bacteriuria http://www.hret-hiin.org/resources/cauti/17/20170627_cauti_slides.pdf

VAE:

- Toolkit To Improve Safety for Mechanically Ventilated Patients <https://www.ahrq.gov/professionals/quality-patient-safety/haps/tools/mvp/index.html>
- Our Lady of Lourdes Regional Medical Center <http://www.hret-hiin.org/Resources/vae/16/VAE-Our-Lady-Lourdes-Regional-Medical-Center-Case-Study.pdf>
- St. Jude Medical Center VAE Case Study <http://www.hret-hiin.org/Resources/vae/16/VAE-St-Jude-Medical-Center-Case-Study.pdf>

Early Progressive Mobility:

- Introduction to Progressive Mobility <http://ccn.aacnjournals.org/content/30/2/53>
- Implementation of Early Exercise and Progressive Mobility: Steps to Success <http://ccn.aacnjournals.org/content/35/1/82.full>
- Get your patients moving — now! <https://www.americannursestoday.com/get-patients-moving-now/>
- Advancing the Science and Technology of Progressive Mobility <http://trainingworld.org/MainMenuCategories/WorkplaceSafety/Healthy-Work-Environment/SafePatient/Advancing-the-Science-and-Technology-of-Progressive-Mobility.PDF>

Social Media Messaging

- IHA has created messaging for both general public, health care providers
- Messaging provided for formats:



Up Campaign Schedule

Last Webinar 12/14/17

GET UP ↑
Mobilizing patients to return to function more quickly

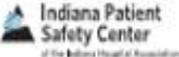
G **GO**
Determine the resources in your institution and how you will implement a mobility program.

E **EVALUATE PATIENT CAPABILITIES**
Which scale, tool or evaluation method will you use to evaluate?

T **TEAM UP FOR PROGRESSIVE MOBILITY**
Rehab, nursing and respiratory join together to implement the mobility plan.

U **UNITE**
Engage patients, families and friends in mobility progression.

P **PROMOTE PROGRESS**
Measure and report unit mobility performance.

Coming 1Q 2018!

WAKE UP ↑
Reducing unnecessary sleepiness and sedation

W **WARN YOURSELF**
This is high risk.

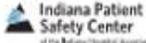
A **ASSESS**
Use tools: STOP BANG, POSS, RASS, PA-PSA.

K **KNOW**
Your drugs, your patient.

E **ENGAGE**
Patients and families to set realistic pain expectations, use of non-sedating analgesics, risks of opioids.

U **UTILIZE**
Dose limits, layering limits, soft and hard stops.

P **PROTECT**
The patient...our ultimate job.

SOAP UP ↑
Implementing appropriate hand hygiene to reduce the spread of infection

S **SCRUB**
For 20 seconds with the right product. Remember soap for CDI.

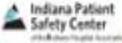
O **OWN**
Your role in preventing HAIs.

A **ADDRESS**
Immediately intervene if breach is observed.

P **PLACE**
Hand hygiene products in strategic locations.

U **UPDATE**
Hand hygiene products policies as needed to promote adherence.

P **PROTECT**
Involve patients and families in hand hygiene.

3Q 2017

Get Up Survey Open

Help IHA better understand challenges and successes your team is having regarding falls by completing a Falls Checklist survey

- Responses are anonymous
- Will take approximately two minutes
- Complete by Nov. 30

<https://www.surveymonkey.com/r/FallsChecklist>



GET UP Webinar Series

Last Webinar in the Get Up Series!

Dec. 12-Multi-disciplinary Approach to Early Progressive
Mobility

How are you incorporating GET UP within your organization?



GET UP ↑

Mobilizing patients to return to function more quickly

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 Indiana Patient Safety Center
of the Indiana Hospital Association

 HRET
HOSPITAL RECOVERY EDUCATION TRAINING



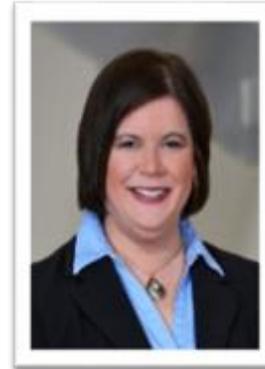
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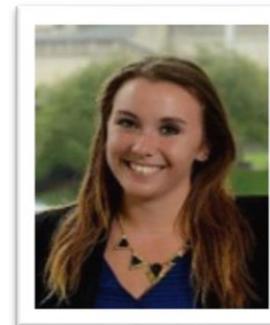
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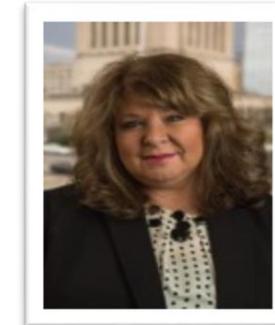
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