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OASIS Process Measures: Following best practices

Roberto I. Friedman, MA, CCC-SLP, MSHA, COS-C

Moderated by:
Amy Natho, MS, CCC-SLP, CEU Administrator, SpeechPathology.com

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OASIS Process Measures:

Following best practices

Presented by:
Roberto I. Friedman, MA CCC-SLP, MSHA, COS-C
Administrator, Sentara Home Health ,Newport News, VA

CONTINUED

Learning Outcomes

After this course, participants will be able to:

- Define process measures.
- Identify five items that will be removed from the new version of OASIS (2019).
- Describe best practices relevant to process measures and related conventions.
- Describe how to differentiate between a quality episode and a payment episode.

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Disclaimer

- OASIS D is scheduled to replace OASIS C2v2 January 1st, 2019
- This presentation was created for OASIS C2; however, has been updated to reflect which items will remain and which will be replaced in 2019
- Process Measures discussed will largely still be relevant for OASIS D

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Process Measure: Defined

- "Process Measures evaluate the rate of ***home health agency use*** of specific ***evidence-based processes of care***"
- In other words, the things that ***we*** do, as an agency, to ensure the patient is taken care of
- Almost completely independent of *patients*' actions or results
- Example: did *we* educate on meds, did *we* educate on preventing pressure ulcers, etc.
- Whereas patient "outcomes" is centered around the patient's status at discharge in comparison to SOC/ROC
- Example: did the patient improve at oral meds (*M2020*)

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CONTINUED

Process Measures- treating the patient

- As home health speech therapists, we have an opportunity to step slightly outside our comfort zone
- We are in a unique position (setting) in that we're truly there to teach the whole patient, not just whatever underlying speech/swallowing related deficit they may have
- The OASIS also encourages interdisciplinary communication. Although, there is the "one clinician rule", we must collaborate with other disciplines to ensure that best practices are being followed.

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CONTINUED

Quality Episode

- In Home Health, we're all very familiar with the payment episode:
  - 60 day certification period= 1 payment episode
- A quality episode, on the other hand, is time frame between the SOC/ROC to Transfer/Discharge.
  - So, a single payment episode may have more than one quality episodes
  - While one quality episode may have several payment episodes in between
- When discussing outcomes or process measures, it's important to keep in mind that we're referring to the quality episode
- Some questions ask specifically about SOC/ROC to Transfer/Discharge
- *But, most process measures imply or suggest that certain themes are addressed across the entire quality episode*

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CONTINUED

Process Measures in the Quality Episode

- With a couple of exceptions, Process Measures let CMS know three things:

1. Did we screen the patient population in order to **Identify** an issue/problem? (*SOC/ROC*)
2. Did we **Address** issues/problems in the goal and interventions of the physician ordered Plan of Care? (*POC*)
3. Did we **Implement** the goals and interventions during the Quality Episode? (*Transfer/Discharge*)

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CONTINUED

Process Measures

- **TIOC** (M0102, M0104, M0030)
- **Medications**(M2001, M2003, M2005, M2016)
- **Physician Ordered Parameters** (M2250)
- **Diabetic Foot Care Interventions** (M1028, M2250, M2401)
- **Falls** (M1910, M2250, M2401)
- **Depression** (M1910, M2250)
- **Pain** (M1240, M2250, M2401)
- **Pressure Ulcer Risk assessment** (M1302, M2250, M2401)
- **Pressure Ulcer Treatment** (M1021, M1023, M1306, M2250, M2401)
- **Influenza Vaccine** (M1041, M1046)
- **Pneumococcal Vaccine** (M1051, M1056)
- **Heart Failure Symptoms** (M1501, M1511)

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CONTINUED

Timely Initiation of Care

Identify

- M0102- Date of Physician Ordered SOC
  - Refers to a specific date that the physician has ordered the HH agency to begin care

Address and **Implement**

- M0104 (skip pattern if M0102 is filled in)- Date of referral
  - We must admit a patient within 48 hours of receiving a "referral". An appropriate referral is considered "received" when we have enough information about a patient (name, address/contact info, and diagnosis and/or general home care needs)
- It is a *favorable* when we follow the above guidelines
  - If we're in danger of falling outside the 48 hour window, we must call the physician before the 48 hours and obtain a physician ordered start of care for the date you plan to admit

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CONTINUED

Medication Review

Identify

- *M2001*- Drug Regiment Review: Did a complete drug regimen review identify potential clinically significant medication issues?

Address

"A potential clinically significant medication issue is an issue that in the care provider's clinical judgment, *requires physician/physician-designee notification by midnight the next calendar day* (at the latest)."

- 0- No- No issues found during review
- 1-Yes- Issues found during review (see *M2003*)
- 9- NA- Patient is not taking any medications

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CONTINUED

Medication Follow-up

Implement

- If *M2001* = "1-Yes"
- *M2003*- Medication follow-up: Did the agency contact a physician (or physician-designee) by midnight of the next calendar day to complete prescribed/recommended actions in response to the identified potential clinically significant medication issues?
- Select "0-No" if the agency did not contact the MD by midnight the next calendar day OR the MD did not return your call
- Select "1-Yes" IF a "two-way communication AND completion of the prescribed/recommended actions" occurred.

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CONTINUED

Drug Education

- *M2016*- Patient/Caregiver Drug Education Intervention: … was the pt/cg instructed by agency staff or other health care provider to monitor the effectiveness of drug therapy, adverse drug reactions, and significant side effects, and how and when to report problems that may occur?

Identify

- If the patient is on any medication, i.e. prescribed, OTC, supplements, etc.

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CONTINUED

Drug Education

Address

- At SOC, reconcile all medications (i.e. compare what's in the home with a med list provided from the referral)
- Provide the patient/caregiver with written material
- Use teach back
- Refer to SN if medication education needed exceeds your scope of practice

Implement

- 0- No if drug education was not provided to the patient as outlined in the item
- 1- Yes if drug education was provided by the HHA agency or another health care provider and this was documented in the clinical record
- 9- NA if the patient is not taking any drugs (at any time between SOC/ROC and Tx/DC)

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M2250- "Plan of Care Synopsis: (Check only on box in each row.) Does the physician-ordered plan of care include the following:"

Plan/Intervention	No	Yes	Not Applicable	
a. Patient-specific parameters for notifying physician of changes in vital signs or other clinical findings	0	1	NA	Physician has chosen not to establish patient-specific parameters for this patient. ***Agency will use standardized clinical guidelines accessible for all care providers to reference***.
b. Diabetic foot care including monitoring for the presence of skin lesions on the lower extremities and patient/caregiver education on proper foot care	0	1	NA	Patient is not diabetic or is missing lower legs due to congenital or acquired condition (bilateral amputee)
c. Falls prevention Interventions	0	1	NA	Falls risk assessment indicates patient has no risk for falls
d. Depression intervention(s) such as medication, referral for other treatment, oral monitoring plan for current treatment, and/or physician notified that patient screened positive for depression	0	1	NA	Patient has not diagnosis of depression AND depression screening indicates patient has: 1) no symptoms of depression: or 2) has some symptoms of depression but does not meet criteria for further evaluation of depression based on screening tool used
e. Interventions to monitor and mitigate pain	0	1	NA	Pain assessment indicates patient has no pain.
f. Intervention(s) to prevent pressure ulcers	0	1	NA	Pressure Ulcer risk assessment (clinical or formal) indicates patient is not at risk of developing pressure ulcers
g. Pressure Ulcer treatment based on principles of moist wound healing OR order for treatment based on moist wound healing has been requested from physician.	0	1	NA	Patient has no pressure ulcers OR has no pressure ulcers for which moist wound healing is indicated.

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M2401- "Intervention Synopsis: [Check only **one** box in each row.] At the time of or at any time since the most recent SOC/ROC assessment, were the following interventions BOTH included in the physician-ordered plan of care AND implemented?

Plan/Intervention	No	Yes	Not Applicable	
a. Diabetic foot care including monitoring for the presence of skin lesions on the lower extremities and patient/caregiver education on proper foot care	0	1	NA	Patient is not diabetic or is missing lower legs due to congenital or acquired condition (bilateral amputee)
b. Falls prevention Interventions	0	1	NA	Every Standardized, validated multi-factor fall risk assessment conducted at or since the most recent SOC/ROC assessment indicates the patient has no risk for falls
c. Depression intervention(s) such as medication, referral for other treatment, oral monitoring plan for current treatment.	0	1	NA	Patient has not diagnosis of depression AND depression screening indicates patient has: 1) no symptoms of depression: or 2) has some symptoms of depression but does not meet criteria for further evaluation of depression based on screening tool used
d. Intervention(s) to monitor and mitigate pain	0	1	NA	Every standardized, validated pain assessment conducted at or since the most recent SOC/ROC assessment indicates the patient has no pain.
e. Intervention(s) to prevent pressure ulcers	0	1	NA	Every standardized, validated pain assessment conducted at or since the most recent SOC/ROC assessment indicates the patient is not at risk of developing pressure ulcers.
f. Pressure Ulcer treatment based on principles of moist wound healing	0	1	NA	Patient has no pressure ulcers OR has no pressure ulcers for which moist wound healing is indicated.

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Physician Ordered Patient Specific Parameters (item to be removed)

Identify, **Address,** and **Implement**

- Select Yes if
- a patient condition is discussed with physician (or representative) and you've coordinated a plan of care between the MD and the agency

AND

- orders are obtained prior to providing services (AND within assessment time frame, i.e. M0090)

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Physician Ordered Patient Specific Parameters

- Select NA if the physician has not indicated any specific parameters AND you will be using agency specific parameters
  - Please note- if you've communicated to the MD, and the MD agrees to agency parameters, then you can select "Yes"
- Select No- if the physician has not indicated any specific parameters and the agency will not use standardized physician notification parameters for the patient.

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Diabetic foot care

Identify

- Diagnosis of Diabetes in: *M1021, M1023, M1025*, and/or *M1028* OR if patient has a diagnosis of diabetes NOT in the top six diagnosis BUT included in the plan of care.
  - (OASIS includes any ICD-10 diagnosis beginning with the first three characters of E08, E09, E10, E11, E13)
- AND patient has one or both lower extremities (i.e. if the patient is a bilateral amputee, we will not be adding diabetic foot care to the POC)

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Diabetic foot care

Address (in the plan of care)

- Example interventions include:
  - Educate on daily foot inspections
  - Teach appropriate diabetic foot care
  - Inspect feet at every visit
  - Educate on appropriate foot wear

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Diabetic Foot Care

Implement

- Must inspect patient's feet AND educate on proper foot care
  - Check feet every day looking for things such as cuts, sores, red spots, swelling, fluid-filled blisters, ingrown toenails, corns, calluses, plantar warts, warm spots
  - Wash feet every day
  - Always wear socks and shoes (no tight or elastic socks, shoes need room to "breathe", etc.)
  - Protect feet from hot and cold
  - keep the blood flowing to the feet (elevate feet when sitting, keep physically active, etc.)

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Diabetic foot care

Implement (before transfer/discharge *M2401a*)

- If patient has a diagnosis of diabetes AND has one or both lower extremities AND you followed the plan of care interventions, you may click "Yes"
- If patient does not have a diagnosis of diabetes OR has a dx but is a bilateral amputee, you may click "N/A"
- If patient has diabetes AND one or both lower extremities, but you either failed to address in plan of care OR follow through on your goals and interventions, you must click "No".

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CONTINUED

Fall Prevention

Identify

- *M1910*-Has this patient had a multi-factor Falls Risk Assessment using a standardized, validated assessment tool?
- 0- No.
- 1- Yes, and it does not indicate a risk for falls.
- 2- Yes, and it does indicate a risk for falls (see next slide)
- Multi-factor refers to taking into consideration more than just one factor, i.e. not just mobility, but also poly-pharmacy, co-morbidities, etc. You can incorporate certain M questions from the OASIS (i.e. "factors") in order to assess fall risk. M1860, M1850, M1021, M1023, …

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CONTINUED

Fall Prevention

Address

- Goals and Interventions for fall prevention should be included in the POC
- These *should be specific* to the patient.
- Examples:
  - Educate patients on clearing pathways (if patient has a cluttered home)
  - Educate on medications that affect mobility (antidepressants, sedatives, diuretics, etc.)
  - Assess environment for safety
  - Refer to physical therapy or occupational therapy (especially if you notice patient has an increased risk of falls in the bathroom).

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CONTINUED

Fall Prevention

Implement (before transfer/discharge *M2401b*)

- If *M1910* =2 (at risk) AND you've included fall prevention in the POC AND it was followed, then you can check "yes"
- If *M1910* =1 you can check "NA"
- If *M1910* =2 (at risk) BUT you've not included fall prevention in the POC OR you've not followed the POC you must check "No" on

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CONTINUED

Depression

Identify

- Does the patient have a Dx of depression in M1021, M1023?
- *M1730*- Has the patient been screened for depression, using a standardized, validated depression screening tool?
- 0- No
- 1- Yes, patient was screened using the PHQ-2(copyright) scale
- 2- Yes, patient was screened with a different standardized, validated assessment and the patient meets criteria for further evaluation for depression.
- 3-Yes, patient was screened with a different standardized, validated assessment and the patient does not meet criteria for further evaluation for depression.

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Depression Screening (PHQ2)

Instructions for this two-question tool: Ask patient: "Over the last two weeks, how often have you been bothered by any of the following problems?"

PHQ-2©*	Not at all 0 - 1 day	Several days 2 - 6 days	More than half of the days 7 – 11 days	Nearly every day 12 – 14 days	NA Unable to respond
a) Little interest or pleasure in doing things	☐0	☐1	☐2	☐3	☐NA
b) Feeling down, depressed, or hopeless?	☐0	☐1	☐2	☐3	☐NA

- Instructions indicate that a *patient* is interviewed, *not* family or others
- Used only for patients that appear to be cognitively and physically able to answer the two included questions
- NA- Unable to Respond- example when a patient may not be able to quantify how many days they have experienced the problems
  - If a patient refuses to respond or is not able to respond based on cognition, a different tool must be administered

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Depression

Address

- If patient scored higher than a 3 on PHQ2 OR screened positive with any other screening tool OR has some kind of depression diagnosis in M1021 or M1023, depression must be addressed in the POC:
- Examples of Interventions include:
  - Alert the physician if patient flags at risk for depression
  - Assess effectiveness of depression medications (may need RN)
  - Assess patient's compliance with depression medications at each visit.
  - Implement a red light, yellow light, green light protocol

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Depression

Implement (before transfer/discharge *M2401c*)

- If patient screened positive for depression OR depression is included in M1021 or M1023 AND interventions were included in the POC AND the POC was followed then you can click "Yes"
- If depression was not a factor in the quality episode, click "NA"
- If depression was identified BUT interventions were not in POC OR the interventions were not implemented then you must click "No"

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Pain

Identify

- *M1240*- Has this patient had a formal Pain Assessment using a standardized, validated pain assessment tool (appropriate to the patient's ability to communicate the severity of pain)? (Item to be removed)
- 0- No standardized, validated assessment conducted
- 1- Yes, and it does not indicate severe pain
- 2- Yes, and it indicates severe pain
- Be alert- the removal of this item from the OASIS does not relieve us from our obligation to address pain. This simply removes 1 assessment item measuring our compliance with best practices.

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Pain

Address

- Please note, if patient has *any* pain, you must address this in the POC and implement the interventions
- Examples include:
  - Assess pain level at every visit
  - Notify physician if pain exceeds a certain pain threshold
  - Educate patient on PRN pain meds and when to appropriately take medication
  - Educate patient on alternative pain relieving methods (visualization, massage, etc.)
  - Referral to Physical Therapy for mobility

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Pain

Implement (before transfer/discharge *M2401d*)

- Select "Yes" if pain interventions were in the POC AND the POC was followed
- Select "NA" only if the patient never experienced ANY pain in this quality episode
- Select "No" if patient had *any* pain at *any* time between the SOC/ROC and Tx/DC BUT pain interventions were not in the POC or were not followed
  - Bottom line- it's good practice to always include pain in the POC even if at SOC the patient is not experiencing pain

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Pressure Ulcer Prevention

Identify

- *M1300*- Was this patient assessed for Risk of Developing Pressure Ulcer? (Item to be removed)
- 0- No assessment conducted [Go to M1306]
- 1- Yes, based on an evaluation of clinical factors (for example, mobility, incontinence, nutrition) without use of standardized tool
- 2- Yes, using a standardized, validated tool (for example, Braden Scale, Norton Scale)
- If both are done (i.e. clinical factors AND a standardized, validated tool) then select 2.
- If 1 or 2 is selected, *M1302* asks if the patient is at risk for PU.

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CONTINUED

Pressure Ulcer Prevention

Identify

- *M1302*- is the patient at risk for pressure ulcers (item to be removed)
  - 0-No
  - 1- Yes

Address

- Examples of interventions:
  - Educate patient and/or caregivers about risk factors
  - Educate patient and/or caregivers on repositioning at specific time intervals
  - Assess the need for pressure relieving support surfaces

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Pressure Ulcer Prevention

Address

Pressure Ulcer Prevention, examples

- Repeat risk assessment at regular intervals
- Address prevention based on areas of risk rather than on score, i.e. if mobility is an issue, address repositioning. If malnutrition, address nutrition
- Assess pressure points, such as the sacrum, coccyx, buttocks, heels, ischium, trochanters, elbows and beneath medical devices.
- Turn and reposition all individuals at risk for pressure injury, unless contraindicated due to medical condition or medical treatments.
- When inspecting darkly pigmented skin, look for changes in skin tone, skin temperature and tissue consistency compared to adjacent skin.
- Use skin moisturizers daily on dry skin.
- Assess the adequacy of oral, enteral and parenteral intake.

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Pressure Ulcer Prevention

Implement (before transfer/discharge *M2401e*)

- Select "Yes" if:
  - *M1302*= "1- Yes" (i.e. patient is at risk of developing pressure ulcer)
  - AND
  - Pressure ulcer prevention interventions are included in the POC and they were followed
- Select "NA" if:
  - *M1302*= "0-No"
  - OR Every standardized, validated pressure ulcer risk assessment conducted at or since the last OASIS assessment indicates the patient is not at risk of developing pressure ulcers
- Select "No" if:
  - M1302 = "1-Yes" BUT PU prevention interventions are not included in the POC or the POC was not followed OR if you can't select Yes or NA.

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CONTINUED

Pressure Ulcer Treatment

Identify

- Does patient have an active pressure ulcer *M1021*, *M1023*, *M1306*, *M1311*, etc.
- Do we have goals and interventions that follow best practices of moist wound healing?

Address

- Moist wound healing treatment is any primary dressing that hydrates or delivers moisture to a wound thus promoting an optimal wound environment and includes films, alginates, hydrocolloids, hydrogels, collagen, negative pressure wound therapy, Unna boots, medicated creams/ointments

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CONTINUED

Pressure Ulcer Treatment

Implement (before transfer/discharge M2401f)

- Select "yes" if:
  - Patient has 1 or more Pressure Ulcers AND Wound care orders are based on principles of moist wound healing OR an order is being obtained from the MD
- Select "NA" if:
  - Patient does not have a pressure ulcer
- Select "No" if:
  - Patient has a pressure ulcer BUT Wound care orders are not based on principles of moist wound healing OR orders are not being obtained

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CONTINUED

Influenza Vaccine

M1041- Data collection period: Does this episode of care (SOC/ROC to Transfer/Discharge) include any dates on or between October 1 and March 31?

- 0- No (go to M1051)
- 1- Yes
- This refers to a quality episode, not a payment episode! For example, if in one certification period:
  - SOC March 1, Transferred March 30th = 1- Yes
  - Resumed April 2, Discharged April 20th =0- No

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Influenza Vaccine

- M1046- Did the patient receive the influenza vaccine for this year's flu season?
- 1 Yes; received from your agency during this episode of care
- 2 yes; received from your agency during prior episode of care
- 3 yes; received from another health care provider
- 4 No; patient offered and declined
- 5 No; patient assessed and determined to have medical contraindication(s)
- 6 No; not indicate-patient does not meet age/condition guidelines for influenza vaccine
- 7 No; inability to obtain vaccine due to declared shortage
- 8 No; patient did not receive the vaccine due to reasons other than those listed in responses 4-7.

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CONTINUED

Pneumococcal Vaccine

- M1051- has the patient *ever* received the pneumococcal vaccination (for example, pneumovax)?
- 0- No
- 1- Yes
- *M1056* reason not received
- 1 Offered and Declined
- 2 Assessed and determined to have medical contraindication(s)
- 3 Not indicated; patient does not meet age/condition guidelines for Pneumococcal Vaccine
- 4 None of the above

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Heart Failure

Identify (before transfer/discharge)

- *M1501*- "if patient has been diagnosed with heart failure, did the patient exhibit symptoms indicated by clinical heart failure guidelines[?]" (Item to be removed)
- Select "0-No" if:
  - The patient has a diagnosis of Heart Failure AND has not exhibited any signs and symptoms of HF in this quality episode.
- Select "1-Yes" if:
  - The patient has a diagnosis of Heart Failure AND has exhibited signs and symptoms of HF at some point in the quality episode.
- Select "2-Not assessed" if
- Patient has a diagnosis of HF AND the patient has NOT been assessed for signs and symptoms of HF.
- Select "NA" *only* if the patient does not have a diagnosis of HF

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CONTINUED

Heart Failure Symptoms

Address

- Heart Failure is a condition in which the heart is weakened and can't supply the cells with enough blood. This can result in:
  - Sudden weight gain (2-3lbs in one day, 5lbs in one week)
  - Swelling, especially of legs, feet, and ankles
  - Worsening shortness of breath with activity
  - Coughing
  - Discomfort or swelling in the abdomen
  - Trouble sleeping (is patient needing more pillows during sleep?)
  - Loss of appetite
  - New or worsening dizziness, confusion, sadness, or depression

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CONTINUED

Heart Failure

Implement

- *M1511* HF Follow-up*:* if "Yes" on *M1501* in the quality episode, then respond to what action(s) has (have) been taken (all that apply) (Item to be removed):
- 0- No Action Taken
  - Select if no action taken OR cannot select 1-5
- 1- Patient's physician (or other primary care practitioner) contacted the same day
  - Physician (or representative) responds to the agency with acknowledgment of receipt of information and/or further advice or instructions on the same day
- 2- Patient advised to get emergency treatment (for example, call 911 or go to emergency room)
  - Only if the agency instructs the patient. Not if the patient goes to the ED based on education on pre-established parameters.

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CONTINUED

Heart Failure

M1511 (continued)

- 3- Implemented physician-ordered patient-specific established parameters for treatment
  - Either the home care clinician reminds the patient to implement OR is aware that the patient is following physician-established parameters
- 4- Patient education or other clinical interventions
  - Refers to the effective sharing of pertinent heart failure-related information to increase patient knowledge, skill, and responsibility
- 5- Obtained change in care plan orders (for example, increased monitoring by agency, change in visit frequency, telehealth)

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Summary

- OASIS D coming in 2019
- Follow best practices
- Know a quality episode v a payment episode
- Understand the OASIS in order to be more effective in answering
- Be an OASIS Professional!!

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CONTINUED

Questions

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THANK YOU!

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