

# THE Remington®

September/October 2011  
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## Health Care Reform Supply Management Systems Alignment

Supply Management Cost Savings  
**Cost Per Episode Model**

Never Events & Adverse Events  
**Payors Stop Paying For Mistakes**

**Hospice Wounds Case Studies**

Pressure Ulcer Prevention  
**Skin & Risk Assessments**

Patient Safety  
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Reference

1 The Centers for Disease Control and Prevention. Home Health Care Patients: Data from the 2000 National Home and Hospice Care Survey. Available at: [www.cdc.gov/nchs/pressroom/04facts/patients.htm](http://www.cdc.gov/nchs/pressroom/04facts/patients.htm). Accessed April 12, 2008.



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## **Achieving Real Supply Cost Savings**

**By: Larry Leahy, VP Finance; Terry Sweet, Finance, Accolade Home Health And Hospice**

A home health agency implements a cost per episode model for homecare to view supply management through a clinical and financial perspective. Imagine being able in advance to have a set rate for supply costs per episode, and if the initial agreed upon episodic rate ends up being lower, than the rate difference is split between your agency and your supply partner. Sound hard to believe? In this article, read how one of your peers discusses how it is being accomplished and, how your agency too, can find the same solution. **Page 5**

## **The Use Of Superabsorbent Containing Fluid Lock Dressing™ In Hospice Patients**

Exuding wounds present challenges in a hospice environment. Case studies of three patients with multiple wounds examine whether superabsorbent dressings can alleviate care and cost concerns in a hospice environment. **Page 7**

## **Medicaid To Stop Paying For Hospital Mistakes**

**By: Lisa Remington, Publisher, The Remington Report**

The estimated total cost of measurable medical errors in the United States was \$17.1 billion in 2008, which was 0.72 percent of the \$2.39 trillion spent on health care that year in the United States. Medicaid is following the lead of Medicare and will stop paying for about two dozen "never events" in hospitals. Read more on what the future holds. **Page 9**

## **Pressure Ulcer Prevention Program: New Online Skin & Risk Assessment Competency Program**

How can your agency reduce the incidence of pressure ulcers? Online interactive education allows your nurses to demonstrate what they learn in a virtual clinical setting. Hear more about how this works. **Page 12**

## **Product Spotlight: Patient Safety For Wound Dressings**

Learn how a new super absorbent wound product creates a new standard of gentle wound care and focuses on patient safety with educational packaging. **Page 14**



Rate reductions, ACOs, CoPays, and oh, by the way, there's a patient relying on you to deliver quality care. As a home health agency manager, you have a lot to challenge you these days. But at Medline we don't want medical supplies to be one of them.

That's why we at Medline have made it our mission to develop programs that have positive effects on your financial, operational, and clinical outcomes. For instance, in this issue you will read about how Medline and one of our customers partnered to take the guess work out of supply cost. After working with the organization to understand utilization practices and clinical requirements, Medline put together a custom formulary and order oversight controls designed to understand and control supply utilization. Once in place, a capped supply rate program was implemented. This program took the responsibility to control supply spend away from the agency and placed it squarely on the shoulders of Medline. I'll let you read the article to see the results. While you are at it, take a look at the other articles which hopefully will provide some ideas you can use to help out with the clinical and operational challenges you may be facing.

Whether you are an existing or prospective customer, I hope you will take a minute to visit our booth at NAHC or check out our website ([www.medline.com/homecare](http://www.medline.com/homecare)). When you do you will learn about an exclusive new relationship Medline has developed designed to help you save money on all of your supply needs including tel-com, hardware, office supplies, and more. You'll also see how our partnership with SHP is helping home health agencies across the country set best practices for supply utilization based on disease state. The result is better clinical and financial outcomes.

Medline's commitment is to keep developing new programs and new partnerships designed to help take the challenge out of running your business. I hope you will let me know if there is anything Medline can do for you.

Sincerely

Mike Lee  
President, Medline HomeCare  
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# Achieving Real Supply Cost Savings

## Home Health Agency Implements A Cost Per Episode Model For Homecare To View Supply Management Through A Clinical And Financial Perspective

By: Larry Leahy, VP Finance; Terry Sweet, Finance, Accolade Home Health And Hospice

Recently CMS announced proposed 2012 reductions of nearly \$640 million for reimbursements to homecare, a potential 3.35% overall rate cut. As the homecare industry accounts for over \$100 billion of the \$2.5 trillion CMS is spending and the Medicare population increases at a fierce rate through 2020, home health will continue to be a factor in reducing overall healthcare expenditures. The question will remain though: Can home health agencies continue to deliver the expected clinical outcomes at the tighter margins that the industry focuses on, and *how* can it be done.

There are many areas a home care organization can look to obtain cost savings or increased efficiencies. These include: labor, technology, coding, clinical expertise, mileage, pay structure and other incentives. However, as margins are squeezed, it becomes more critical to look outside the agency walls and find partners who can truly help you obtain these needed results. Medical Supply Price reductions are often viewed as 'low hanging fruit' when an agency looks for ways to cut overall cost. But with typical supply cost making up only 1.5 – 2% of an agency's total budget, trying to squeeze pennies off a price often provides little return for the effort.

Accolade Home Health and Hospice is headquartered in Denton, Texas. Our company has 21 home health and 4 hospice locations throughout 3 Southwestern states. Earlier this year, we realized our need to cut supply cost while continuing to efficiently provide the care our client based was accustomed to. We also realized there were better ways to analyze medical supply expenditures, and that the reductions we required would not be accomplished simply by lowering pricing. We needed to find a supplier partner with mutually aligned goals aimed at reducing our overall cost. We expected our supplier not only to save us money on the supply itself, but to help across clinical and operational lines to affect utilization and productivity issues as well. Based on their successful ability to implement various mechanisms designed to increase agency revenue, enhance clinical outcomes and reduce overall cost, we chose Medline as our supplier partner.



There are several questions to consider when developing a comprehensive supply management program. Together with Medline, we reviewed the following:

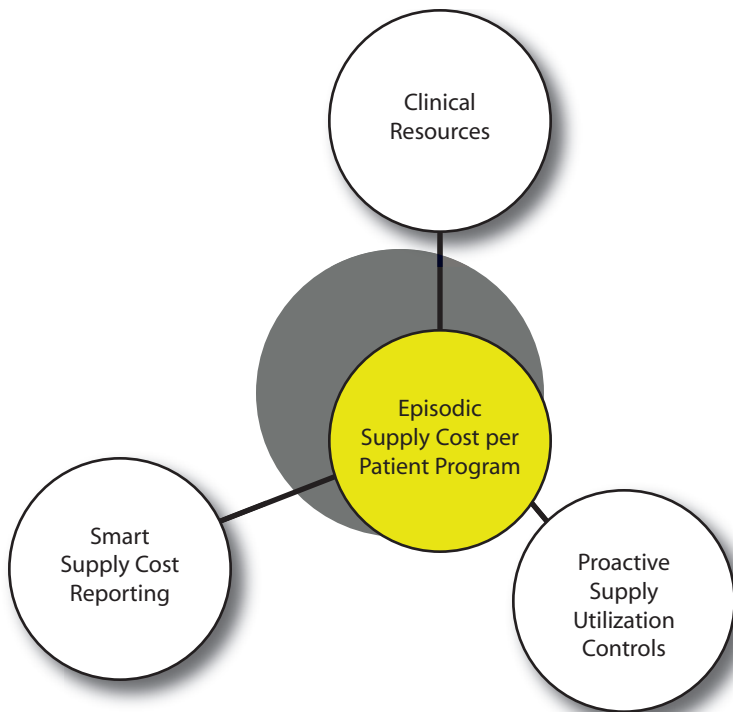
- ✓ How true is the cost, particularly if you are not using a primary sole vendor?
- ✓ Is it measured correctly?
- ✓ What is included?
- ✓ Do we understand routine and non-routine costs per patient per episode?
- ✓ Who will monitor the data?
- ✓ What will you do with the data?

### Episodic Supply Cost Per Episode Program

Perhaps the most important question is what mechanism might we have to reduce our medical supply cost per patient? From a technology standpoint, Medline possessed the tools and resources needed to monitor, track, and report on the different factors contributing to an overall cost reduction effort. Thanks to these capabilities they were able to effectively partner in the risk sharing like program which billed our homecare agency for supplies on a **capitated cost per episode basis**.

By being billed essentially for discharged episodes of care at a set specific supply rate, a significant burden was placed on Medline to utilize all of their capabilities (manufacturer direct pricing, clinical support program, and operational efficiencies) to help us control our costs in a proactive manner. Considering the episodic rate is set before "going-live," the

episodic supply cost becomes a non-variable cost, regardless of the type of diagnosis for the patient. The program is perfect from the financial perspective in that it allows our agency to know our set rate for supply costs per episode in advance. In most traditional models, this is a serious variable cost that can fluctuate. More importantly the clinical teams involved, are assured to have many resources to assist them in patient care, especially high acuity patients that may cost the agency a loss in net revenue. One example of this support is Medline's Wound and Skin Care Hotline which makes a WOCN available via a toll free number to our clinical staff out in the field. The Medline WOCN helps our staff choose the proper product based on patient need. This helps us achieve strong clinical results while keeping our cost in line.



Accolade implemented our Medical Supply Cost per Episode model in early 2011. The results of the initial phase of the program have been well received by staff, and cost savings exceeded our initial targets as indicated below:

	<b>Rate</b>
Previous 12-month Average Episodic Supply Rate .....	\$34.22
Current Cost per Episode .....	24.35
Overall savings, medical supply cost.....	28.84%

The Episodic Supply Cost per Episode Program is designed to ensure a true partnership. The reasoning behind this is based on the fact that if the initial agreed-upon episodic rate ends up being lower, then the rate difference is split. This is quite similar to a "pay for performance" type model and in this case our vendor is somewhat rewarded, as is Accolade, if we work together to achieve the lowest cost per patient episode.

The design of the overall program must have the following key components:

**Clinical:**

- Continuous Education in all forms (live, DVD, webinar, etc)
- WOCN consultation
- Ability to map diagnosis to supply spend and utilization
- Product in-servicing
- Wound, Continence, and Skin Care protocol design and teaching



**Financial:**

- Cost Reporting
- Electronic Proactive oversight controls for enhanced supply management
- Competitive Cost Structure
- Capability to match clinical data for targeting education, clinician needs, etc

This Cost per Episode Concept for medical supplies truly benchmarks Accolade's ability to continuously monitor and improve our costs associated with our clinical outcomes. Our planned next steps include looking specifically at wound care diagnoses and determining exactly our medical supply costs for top diagnoses. We then can compare our individual branches to one another, and then compare to our vendor's similar partners to gain the understanding how we can constantly improve.

With the initial 28.84% cost savings overall in supply spend, we anticipate we will continue to hit our targets and hopefully outpace the CMS rate cuts that lately have made a serious impact to the overall homecare industry. As pay for performance embraces various aspects of the healthcare industry and cost per patient and outcomes are front and center – it is ideal to partner with organizations that meet and exceed the goals. ■

# The Use of Superabsorbent Containing Fluid Lock Dressing\* in Hospice Patients

## INTRODUCTION

The management of exudating wounds presents challenges in the hospice environment, where the focus is on the comfort of the resident and the elevation of quality of life factors. In our practice, we have sought the use of absorbent dressings that are versatile on wound exudate, emerge at variable rates depending on the type of wound, and act as a single product across the spectrum of exudation levels. Such optimization is desirable because it allows us to focus more energy on the patient rather than on managing the choice and inventory of many different dressings for various types of wounds.

We chose patients who suffered from exudating wounds, with some wounds being more exudative than others, even within the same patient. The purpose of this limited trial was to check if a new variety of superabsorbent particle containing dressings were versatile enough on this vulnerable population, and whether the dressings had any undesirable properties such as tendency to leak, or to cause discomfort during removal. This new superabsorbent dressing consists of a contact layer that has special microchannels that allow directional fluid flow, from the wound into superabsorbent particles dispersed inside an internal core layer. Laboratory data shows that these dressings, when subjected to pressure, still allow fluid absorption. Compression on the dressings leads to minimum fluid loss. These properties are thought to be significant in managing periwound maceration. Because maceration of periwound skin is a major problem in hospice patients with exudating wounds, and all too frequent dressing changes impact cost and quality of care. This trial also examined whether the new superabsorbent dressing can alleviate care and cost concerns in a hospice environment.

## METHODOLOGY

In this safety and effectiveness study, a convenience sample of three patients with multiple wounds were chosen. In all cases, the dressings were changed as needed based on visual observation of the dressing saturation and potential exudate overloads. More frequent change was not needed during use.

## CASE DETAILS AND OBSERVATIONS

**Case 1:** DG is a 74-year-old female, admitted to our program with multiple Stage III and IV pressure ulcers. Her terminal diagnosis is AFTT. Her albumin level was 2.4. During her hospital stay just prior to her hospice admission, lab cultures revealed MRSA in her ulcers and at one point she was treated for septicemia. Initially, while in hospice care she required dressing changes as frequently as 2 times a day for several of the pressure ulcers with foam dressings. When the new superabsorbent dressing was introduced, dressing change frequently decreased considerably. The trial with the new product was started with two of her pressure ulcers. The high capacity of the dressing contributed to our patient's comfort by reducing occasions of dressing change, and proportionally reduced the caregiver's time which then impacted the cost of care.

**Case 2:** JH is a 68-year-old female who was admitted to our program with a terminal diagnosis of pancreatic cancer. She presented on admission with four ulcers, which were identified as being Pyoderma Gangrenosum in etiology. We used the superabsorbent dressing on a highly exudating wound on her right hip. The new dressing managed exudate without any maceration to periwound skin.

**Case 3:** MKL, an 84-year-old female, was admitted to our program with a terminal diagnosis of vascular dementia. She presented with two venous leg ulcers. The foam dressings in use initially were replaced with the new superabsorbent dressing. Compared to the frequency of the foam dressing change, the number of dressing changes was greatly reduced, increasing our patient's comfort and freeing up the caregiver to focus on patient comfort.

P. Sue Hashley, RN, CWS, FACCWS  
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**RESULTS AND CONCLUSION**

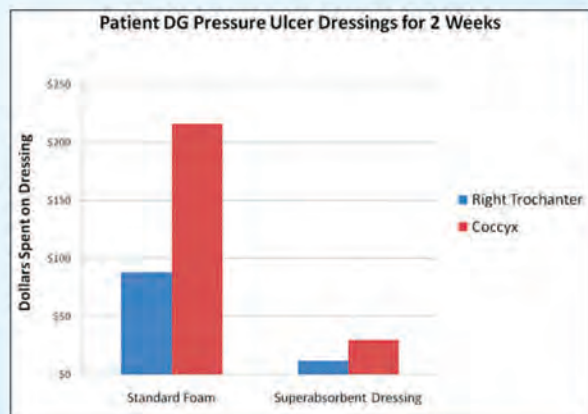
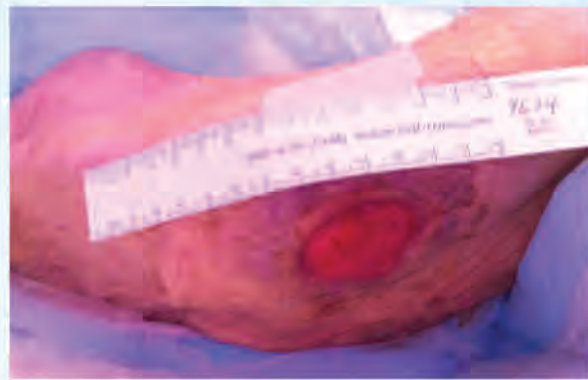
The use of a superabsorbent based dressing on our patients was a new and valuable experience for us. We found that the use of these products on wounds whose exudate level ranged from low (Case 2) to high (Cases 1 and 3) produced excellent results. Minimal or no peri-wound maceration, with no accidental strike through, and no adhesion of the dressing to the wound site was observed, even on the low exuding wound (Case 2). There was no leakage of the superabsorbent particles from the dressing into the wound during use, even when the dressing was used on the coccyx of a patient (Case 1) and the dressing was sporadically subject to the weight of the patient. Patients reported no discomfort during dressing use. Since the dressing has no observable adhesion there was also no pain reported during dressing removal. This was especially notable in the patient with Pyoderma Gangrenosum.

In our view, the availability of this affordable product to potentially replace more expensive products represents a step in the right direction both in product performance, as well as in terms of reducing cost and time for care in this hospice environment.

References

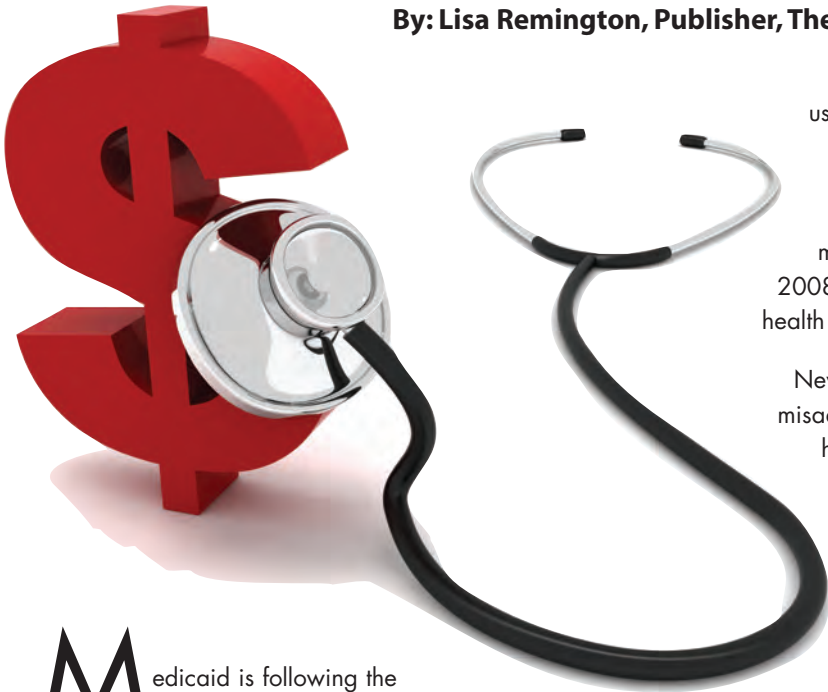
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\*OptiLock™, Medline Industries, Inc. Mundelein, IL  
 OptiLock is a trademark of Medline Industries, Inc.



# Medicaid To Stop Paying For Hospital Mistakes

By: Lisa Remington, Publisher, The Remington Report



**M**edicaid is following the lead of Medicare and will stop paying for about two dozen “never events” in hospitals, according to a final rule published in the Federal Register on June 1. The rule nationalizes a non-payment policy already implemented in 21 states, preventing funds from being

used to pay for services that “result from certain preventable health care-acquired illnesses or injuries,” Centers for Medicare & Medicaid Services (CMS) officials said. The estimated total cost of measurable medical errors in the United States was \$17.1 billion in 2008, which was 0.72 percent of the \$2.39 trillion spent on health care that year in the United States.

Never events are identified as situations where misadventures or poor outcomes befall a patient while hospitalized that could have been prevented. They include operations on the wrong body part or patient and post treatment infections. They also include blood incompatibility, serious pressure ulcers, falls, embolisms, burns, electric shocks, and comas caused by a number of means. Injuries to a patient’s spine, neck, shoulder, and elbow, and cardiovascular system while in the hospital also count.

Additional costs and mortality make these events especially troublesome, CMS says.

**Below is list of preventable conditions that Medicaid will no longer pay for:**

- Foreign Object Retained After Surgery
- Air Embolism
- Blood Incompatibility
- Stage III and IV Pressure Ulcers
- Falls and Trauma
- Fractures
- Dislocations
- Intracranial Injuries
- Crushing Injuries
- Burns
- Electric Shock
- Catheter-Associated Urinary Tract Infection (UTI)
- Vascular Catheter-Associated Infection
- Manifestations of Poor Glycemic Control
- Diabetic Ketoacidosis
- Nonketotic Hyperosmolar Coma
- Hypoglycemic Coma
- Secondary Diabetes with Ketoacidosis
- Secondary Diabetes with Hyperosmolarity
- Surgical Site Infection Following:
- Coronary Artery Bypass Graft (CABG) – Mediastinitis
- Bariatric Surgery
- Laparoscopic Gastric Bypass
- Gastroenterostomy
- Laparoscopic Gastric Restrictive Surgery
- Orthopedic Procedures
- Spine
- Neck
- Shoulder
- Elbow
- Deep Vein Thrombosis (DVT)/ Pulmonary Embolism (PE) Following Total Knee Replacement or Hip Replacement – with pediatric and obstetric exceptions
- Surgery on the wrong patient, wrong surgery on a patient, and wrong site Surgery

**Source:** CMS

**Exhibit 1**

**Error And Adverse Events: 10 Most Frequent Medical Errors, 2008**

Error	Probability of Error	Number of Medical Injuries	Number of Medical Errors
Pressure Ulcer	91% or more	394,699	374,964
Postoperative Infections	91% or more	265,995	52,695
Postlaminectomy Syndrome	10-35%	505,881	113,823
Hemorrhage Complicating a "Procedure"	36-65%	156,433	78,216
Accidental Puncture or Laceration During a Procedure	91% or more	66,714	63,378
Mechanical Complication of Noncardiac Device, Implant, or Graft	10-35%	268,353	60,380
Ventral (Abdominal) Hernia Without Mention of Obstruction or Gangrene	10-35%	239,156	53,810
Hematoma Complicating a Procedure	36-65%	101,259	50,630
Unspecified Adverse Effect of Drug or Medicinal or Biological Substance Not Classified Elsewhere	Less than 10%	778,675	38,934
Mechanical Complication of Cardiac Device, Implant, or Graft	10-35%	137,659	30,973

**Source:** Shreve J, Van Den Bos J, Gray T, Halford M, Rustagi K, Ziemkiewicz E. The economic measurement of medical errors [Internet]. Denver (CO): Society of Actuaries; 2010 Jun [cited 2011 Mar 2]. From: <http://www.soa.org/files/pdf/research-econ-measurement.pdf>.

**Note:** Pressure ulcer is a Medicare "never event," explained in the text. Postlaminectomy syndrome is pain following back surgery. A Hemorrhage complicating a procedure could be hemorrhage that occurs during (intraoperative) the surgical procedure due to inadvertent laceration of an organ or vessel or bleeding that occurs or becomes evident after the surgical procedure is completed (postoperative). The latter (postoperative) may be due to inadequate hemostatis during surgery (intraoperative) as the result of overlooked bleeding vessels or failure to appropriately suture or cauterize bleeding vessels.

**Exhibit 2.**

**Frequency And Costs Of Medicare "Never Events," 2008**

Error	Number of Medical Injuries	Number of Medical Errors	Medical Cost Per Error	Total Cost of Medical Errors (\$ Millions)
Pressure Ulcer	394,699	374,964	8,730	3,273
Catheter-associated Urinary Tract Infection	13,515	12,839	24,901	320
Blood Type Incompatibility	6,685	6,350	5,911	38
Object Left in Body	12,305	11,690	8,031	94
Air Embolism	335	318	26,100	8
Surgery on the Wrong Site or Person	—*	—*	0	0
Total Cost of medical	427,539	406,162	—*	3,733

**Source:** Shreve J, Van Den Bos J, Gray T, Halford M, Rustagi K, Ziemkiewicz E. The economic measurement of medical errors [Internet] (Denver CO): Society of Actuaries; 2010 Jun [cited 2011 Mar 2]. From: <http://www.soa.org/files/pdf/research-econ-measurement.pdf>.

**Note:** Only measurable Medicare "never events" are listed; environmental conditions such as falls and traumas that occurred while under medical care are excluded. No statistically significant results were found. \*Not applicable.

*“Medicaid is following the lead of Medicare and will stop paying for about two dozen “never events” in hospitals, according to a final rule published in the Federal Register on June 1.”*

### Medial Errors And Adverse Events

More than 400,000 Medicare “never events” occurred in the United States in 2008, with an estimated total cost of \$3.7 billion. The cost of these events constitutes 22 percent of the total cost for medical errors.

Pressure ulcers were the most common medical error, followed by postoperative infections and post-laminectomy syndrome. Pressure ulcers were the only Medicare “never event” to appear among the ten most frequent errors (**Exhibit 1**).

Among these ten errors, the only item in the group with the lowest probability of error was unspecified adverse effects of a drug. Although adverse drug effects occur frequently, most are assumed not to result from medical error.

### New Medicaid Rules

Under the rule, Medicaid funds can't be used to pay doctors and hospitals for services that “result from certain preventable health care-acquired illnesses or injuries,” the officials said. A similar regulation has been in place for Medicare, the federal health program for the elderly, since 2008. “These steps will encourage health professionals and hospitals to reduce preventable infections, and eliminate serious medical errors,” said Donald Berwick, administrator of the Centers for Medicare and Medicaid Services. “As we reduce the frequency of these conditions, we will improve care for patients and bring down costs at the same time.”

Some physician groups have concerns about the new policy. “Simply not paying for complications or conditions, that, while extremely regrettable, are not entirely preventable, is a blunt approach that is not effective or wise for patients or the Medicare or Medicaid program,” Dr. Michael Maves, CEO of the American Medical Association, said in written comments to CMS. He said the medical association has “grave concerns” about states extending the non-payment policy beyond the conditions considered by Medicare. The American Hospital Association expressed similar reservations.

Cindy Mann, deputy director of CMS and director of Medicaid, said the rule gives states the option to expand the nonpayment policy to health care settings besides hospitals and to add other types of “never events.” She said the policy would help improve patient care and drive down costs in the \$364 billion program. “All (health care) payers are looking to gain better value for the dollars they spend and Medicaid is no different,” she said. But the costs savings from the change is relatively modest. According to the proposed rule, Medicaid would save about \$35 million over the next five years from stopping pay for such medical mistakes. Medicare has saved about \$20 million a year under its policy. “It’s a welcome first step into the national debate on quality,” said Matt Salo, executive director of the National Association of Medicaid Directors. “Clearly many states have already moved ahead, although that should never be taken as rationale for forcing the rest of them to do ... well, anything. But improving quality in a coordinated fashion between Medicare and Medicaid is important.”

**Note:** The costs shown in all the exhibit represent average annual costs over a period of five years for inpatient errors and one year for outpatient errors. **References:** Health Affairs – April 2011 ■

# Announcing New Online Skin & Risk Assessment Competency

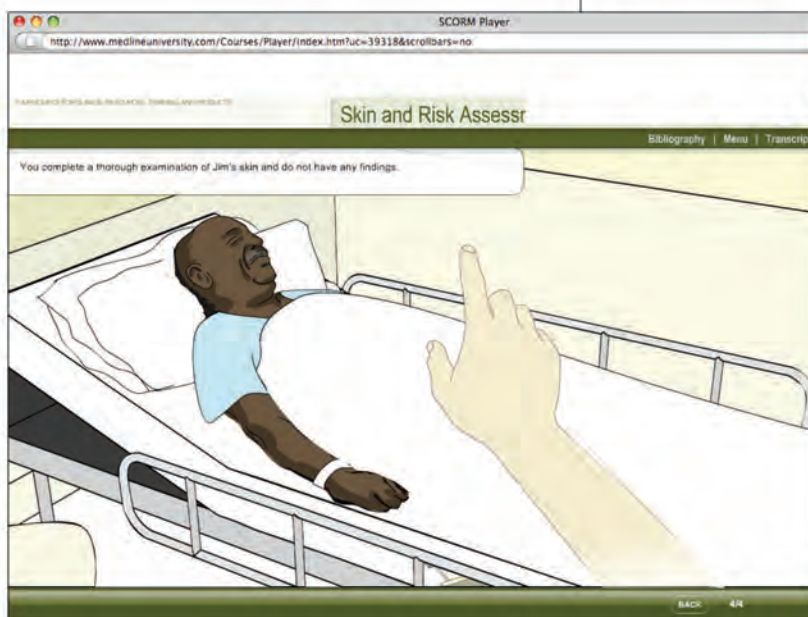
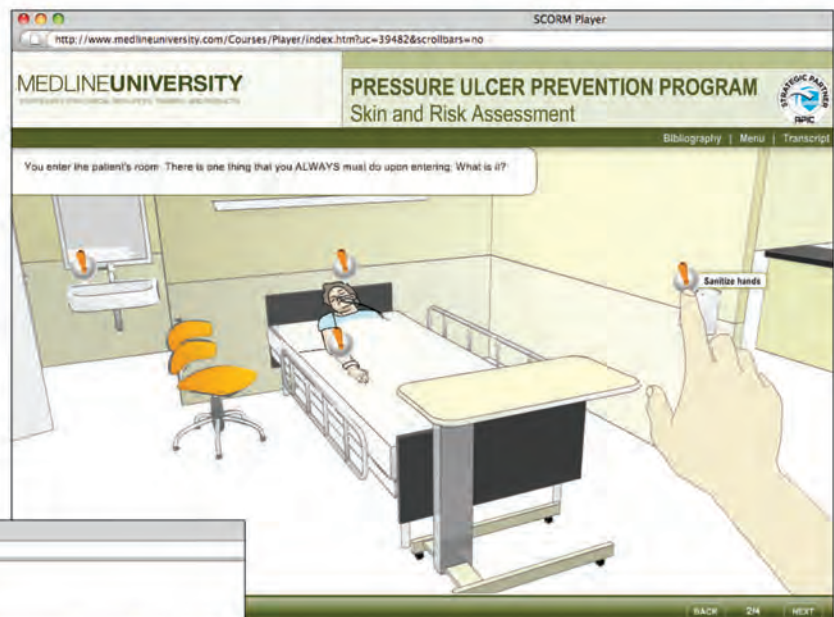
## The Latest Addition to Medline's Pressure Ulcer Prevention Program

Medline's Pressure Ulcer Prevention Program – an educational initiative aimed at reducing the incidence of pressure ulcers – has added an interactive online competency to allow nurses to demonstrate what they've learned in a virtual clinical setting. This approach provides consistency, as each learner performs the same assessments.

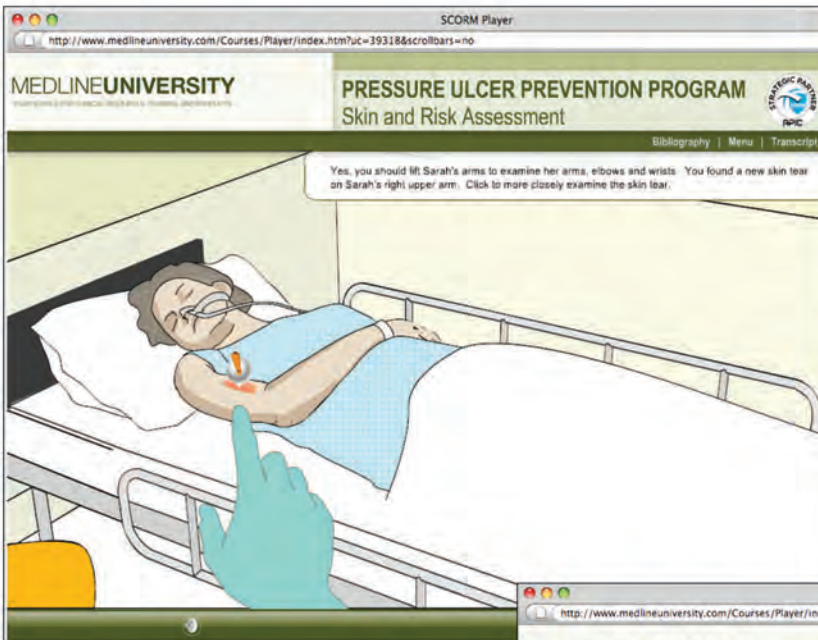


The learner proceeds through the competency using the computer mouse to complete each step – from dispensing hand sanitizer at the wall unit to pulling back the bed linens and patient gown, performing assessments on three separate patients.

An illustrated hand replaces the usual mouse arrow on the screen.

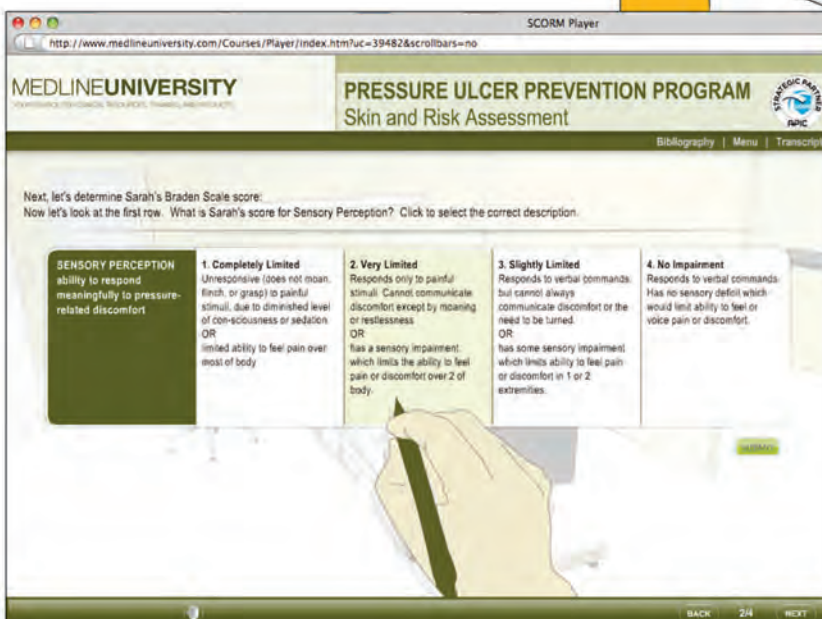


James is a 44-year-old male who is recovering from a heart attack.



Sarah is in a coma with a naso-gastric feeding tube. She has a visible wound on her right arm.

When the learner clicks on Sarah's arm, a close-up photograph of her wound and a related multiple choice question appear on the screen.



At the end of each skin assessment, the learner completes the Braden Scale to determine the patient's level of risk for pressure ulcers.

**The only way to access the Skin and Risk Assessment Competency is by joining the Pressure Ulcer Prevention Program. Visit [www.medline.com/PUPP-webinar](http://www.medline.com/PUPP-webinar) to sign up for an informational webinar to learn more. (See back cover for webinar dates.)**





# product spotlight

## OPTILOCK NON-ADHESIVE, SUPER ABSORBENT WOUND DRESSING

A new  
standard  
for gentle  
wound care

### **Absorbs**

The super absorbent polymer core efficiently absorbs high volumes of exudate. Gently absorbs exudate, even for the most heavily draining wounds.

### **Locks**

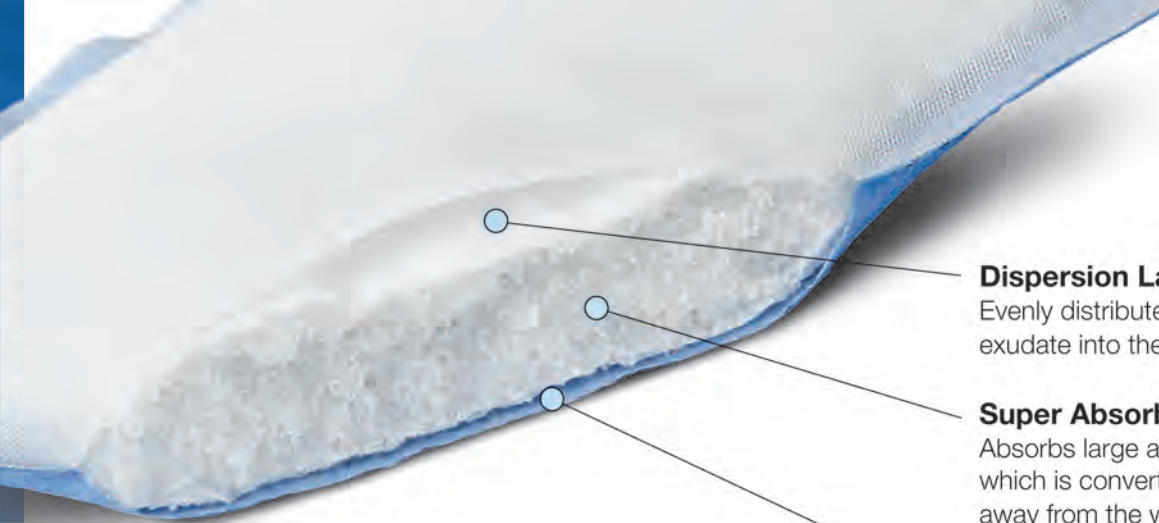
The unique reverse funnel design of the non-adherent contact layer helps direct fluid into the core. Inside the core, exudate is converted into a gel that's kept firmly away from the wound, even under compression. Gently protects against maceration, including the periwound skin.

### **Adjusts**

Continually adapts the level of absorption to the amount of wound drainage. Gently provides an optimal moist wound healing environment.

### **Protects**

Non-adherent wound contact layer prevents the dressing from sticking to the wound or periwound skin. Gently releases from the wound during dressing changes.



**Dispersion Layer**

Evenly distributes and quickly transfers exudate into the superabsorbent core.

**Super Absorbent Core**

Absorbs large amounts of exudate, which is converted to a gel and locked away from the wound.

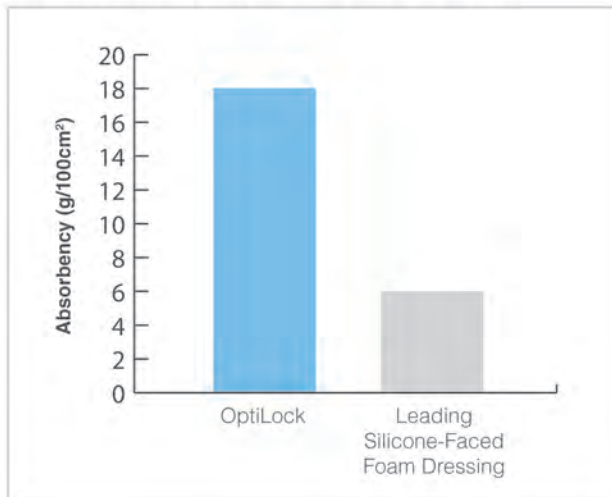
**Blue Protective Backing**

Helps protect clothing and sheets.

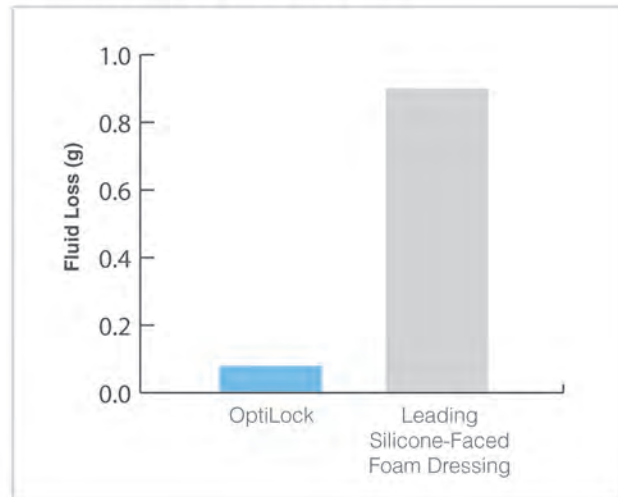
OptiLock absorbs and retains more fluid

In manufacturer's laboratory testing, Medline's OptiLock dressings outperformed a leading silicone-faced foam dressing. OptiLock's remarkable absorption and fluid retention capabilities raise the bar for gentle wound care.

Absorption Capacity Under Compression<sup>1</sup>



Fluid Loss Under Compression<sup>1</sup>



Educational Packaging

OptiLock features Medline's Educational Packaging (EP). The package focuses on patient safety and correct product application. Each package serves as a 2-Minute Course on Wound Care.™

Reference  
1. Data on file.

Recommended Uses

OptiLock is a primary dressing for use on partial thickness and full thickness wounds or a secondary dressing on full-thickness wounds, including:

- Ulcers (pressure, venous, neuropathic/diabetic)
- Postoperative wounds
- First- and second-degree burns

The dressing can remain in place up to seven days, depending on the amount of exudate.

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