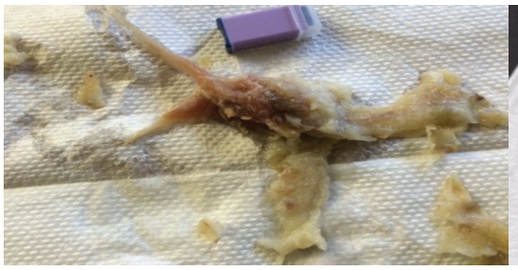
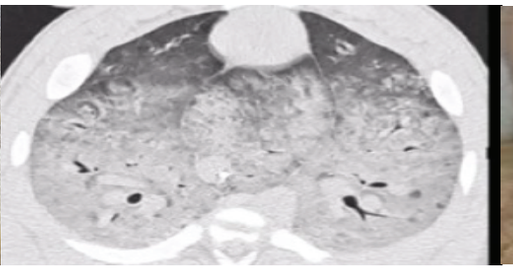
The ReddyPort® System is essential for NIV/BiPAP success

The Challenge: Reduce common causes of BiPAP/NIV failure and rate of intubation

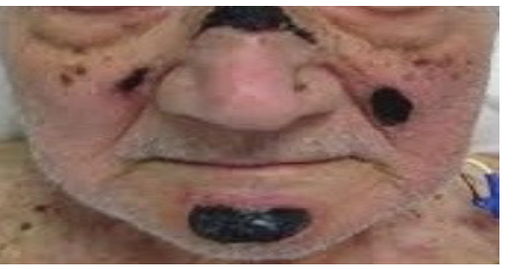
Biofilm Formation



Alveolar Collapse

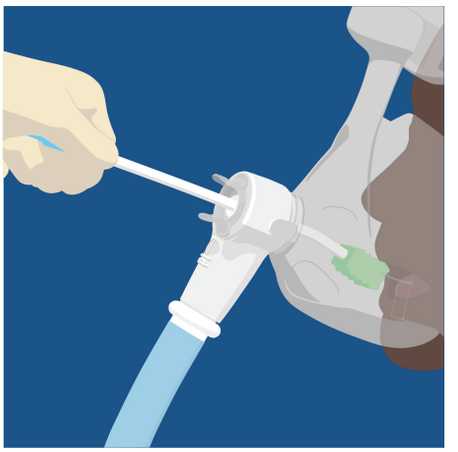


Skin Breakdown



How does the ReddyPort Solution impact biofilm?

- Uncompromised Oral Care: With ReddyPort, clinicians gain easy oral access to perform compliant 2-minute oral care and dry mouth relief on a PRN or protocoled interval (Q4) targeting biofilm formation and secretion buildup leading to NV-HAP
- The cost of NV-HAP: Length-of-stay extended by up to 15 days, Intensive Care Unit (ICU) admission required in up to 46% of non-ICU cases, increased antibiotic use, readmissions within 30 days in up to 20% of survivors at an average per patient cost of $30,000[1]



How does the ReddyPort Solution impact alveolar collapse?

- Uncompromised Oral Access: With ReddyPort's elbow and appliances, clinicians can reduce or eliminate the need for unplanned mask removal or unapproved workarounds for routine dry mouth relief, suctioning or compliant 2-minute oral care
- Avoid NIV Pressure Loss: Upon mask removal or PEEP decrease, the PO2 and the other oxygenation-related variables significantly decreased within 0:50 and remained unmodified in the following 5:50[2]

How does the ReddyPort Solution impact skin breakdown?

- Mitigate Unplanned Mask Removal: Unplanned mask removal increases the risk of improperly fitted masks and over-tightened masks are one of the primary causes of facial pressure sores[3]

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What are the Joint Commission's Quick Safety recommendations for preventing non-ventilator hospital acquired pneumonia?

1. Obtain buy-in from leadership and health care providers about the importance of NV-HAP prevention
2. Overcome beliefs that NV-HAP prevention strategies such as oral hygiene are optional tasks rather than standard-of-care interventions
3. Procure supplies necessary to implement effective interventions
4. Educate staff about the risks of NV-HAP and prevention methods such as aspiration precautions
5. Implement processes that make oral care and mobility an expectation for routine care of non-ventilated patients[4]

"We must change the mindset of nurses and other health care providers from seeing oral care as a comfort measure to recognizing oral care as a therapeutic intervention and oral care products as therapeutic devices."
– Dr. Dian Baker (Ph.D., RN, APRN-BC)

The Challenge: Overcoming NIV mask communication barrier

The ReddyPort Solution:

- The ReddyPort Microphone gives patients a voice in their care – they have the right to participate in their medical decisions, engage with family and clinicians and return dignity to the patient experience
- There is a significant association between the inability to be understood and high NIV patient anxiety leading to 4.9 times more NIV intolerance[5]

What does The Joint Commission and CHEST recommend for overcoming patient communication impairment?

- Anticipate the needs of the patient who is expected to develop communication impairments from scheduled treatment or procedures and provide augmentative and alternative communication (AAC) resources to help with treatment of patients with communication impairments[6]
- CHEST recommends the ideal AAC speech recognition device "would improve speech intelligibility while filtering background noise"[7]
- TJC Patient's Rights include the following: Participating in decisions about his/her care, including advance directives, giving or withholding consent, receiving care in a private environment that preserves dignity and promotes positive self-image, having their pain managed[6]

For more information call **801.899.3036**

References
1 Quinn B, Baker D. Comprehensive oral care helps prevent hospital-acquired nonventilator pneumonia.Am Nurse Today. 2015;10(3):18-23 2 Jaber S. Alqahtani, Mohammed D. AlAhmari Evidence based synthesis for prevention of noninvasive ventilation related facial pressure ulcers Saudi Medical Journal May 2018, 39 (5) 443-452; DOI: 10.15537/smj.2018.5.22058 3 Chiumello D, Coppola S, Froio S et al. Time to reach a new steady state after changes of positive end expiratory pressure. Intensive Care Med. 2013;39(8):1377-1385. doi:10.1007/s00134-013-2969-x 4 Quick Safety: Preventing Non-Ventilator Hospital-Acquired Pneumonia. 61st ed. The Joint Commission, Division of Healthcare Improvement; 2021:1-2. https://www.jointcommission.org/resources/news-and-multimedia/newsletters/newsletters/quick-safety/quick-safety-issue-61/#.YwOoa3ZMGUk. 5 Wong AI, Cheung PC, Happ MB, Gay PC, Collop NA. Consequences and Solutions for the Impact of Communication Impairment on Noninvasive Ventilation Therapy for Acute Respiratory Failure: A Focused Review. Crit Care Explor. 2020 Jun 15;2(6):e0121. doi: 10.1097/CCE.0000000000000121. PMID: 32695990; PMCID: PMC7314319. 6 The Joint Commission: Advancing Effective Communication, Cultural Competence, and Patient- and Family-Centered Care: A Roadmap for Hospitals. Oakbrook Terrace, IL: The Joint Commission, 2010.7 Dubin R, Ackrivo J. Giving Patients a Voice Among the Inpatient Orchestra. Chest. 2021;159(4):1324-1325. doi:10.1016/j.chest.2020.10.068

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