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**Effective Use of Your Wound Care Nurse**

**Setting Up and Implementing a Wound Care Program**

Presented by Jeri Ann Lundgren - 60-minute Webinar March 26, 2012

Welcome everyone, I’m Barb Olson with Stratis Health, the Quality Improvement Organization from Minnesota. I’d like to welcome you to this session. It is recorded and will be available on our website StratisHealth.org. We’ll have a question and answer session after we’ve completed today’s session.

Our featured guest speaker today is Jeri Ann Lundgren. Ms. Lundgren is the Director of Wound Incontinence Services at Pathway Health Services and the Director of Clinical Services at Gulf South Medical Supply. She’s a National Wound Care Consultant and is board certified by The Wound Ostomy and Continence Nurses Society (WOCN) and the American Academy of Wound Management.

For more than 10 years, Jeri has provided consultation on wound care, developed and presented staff educational programs locally and nationally, and has developed effective policies and procedures for wound care management. She has also worked both with crisis management and litigation support in the long-term care industry.

Welcome Jeri, thank you for being with us. Let me now turn the presentation over to you.

Thank you Barb and welcome everyone to the presentation. Today what we’re talking about is how to effectively implement your Wound Care Program and ensure that you’re effectively using your wound care nurse.

The nice thing about this presentation is that you can use it for an outline to decide when you’re looking at your program and say jeez, where do I start, you can refer back to this because many of the slides will walk you through and can be used like an outline to see where you need to start with your program and what areas you want to focus on.

When it comes to the wound care nurse, typically most facilities use the wound care nurse when a wound happens, so they’re triggered once the wound happens and responsible for the weekly documentation and monitoring of that wound and showing progress. They also help decide what kind of treatment strategies are going to be utilized for that wound.

What I’m here to talk to you about today is we want to think outside the box. Typically, to effectively utilize your wound nurse--think about it--if we’re utilizing their expertise after the wound happens that’s too late. We need to look at the big picture and utilizing them for prevention. If we can prevent the wounds from happening we won’t have to have those concerns.

The other areas you can utilize your wound care nurses: providing education to the other staff and getting everybody educated. It’s very important that your staff understands that preventing and treating pressure ulcers is a 24/7 thing that all staff need to be involved in, it’s not just the wound nurse’s issue and it won’t be effective if one person is trying to move things forward.

So they can help educate the staff and get them on board. It’s very important, too, that they get help with the F314 compliance and monitoring. So, instead of just using them at time of treatment maybe setting some time aside for that F314 compliance and actually helping monitor those programs, so when it does come to survey you don’t have concerns in those areas.
When it comes to wound care, especially nowadays with our unfortunate increase in litigation and being held to standards of practice, we strongly recommend that you do...you know, I always ask the wound nurses when I’m at a live presentation: How many of you got the wound nurse position by default? Many people raise their hands and say Yes, it came with the job or somebody just asked if I’d be interested in doing it.

When it comes to wound care, other than any other specialties, it’s probably one of the most complex areas, no wound is the same. If it was simple straightforward and every time somebody got a stage three we did XYZ and it would always go on to heal. That would be a different story but that is absolutely not the case when it comes to dealing with wounds. They’re very complicated.

A lot of factors come into play for healing and if you don’t give your wound nurse strong education, you won’t get the outcome you want and it can actually be somewhat dangerous if they’re picking and deciding the wrong types of treatments and things like that, so it’s strongly recommended that you do get certification.

Now the WOCN, you have to have a four-year degree, in order to get certified through the WOCN. They do have the web walk program, which is an online program and the nice thing is that they provide hands-on clinical, which is considered the gold standard.

Next is the Wound Care Education Institute for the WCC certification, which means Wound Care Certified. They also provide certification, but the nice thing about the WCC is that they will offer it to LPNs, RNs, physical therapists, etc., so you can get interdisciplinary people through the course--it’s one week course--get them certified and that will give them a strong foundation.

What’s important if you do get them certified and when you look at how much wounds cost, it will pay you to actually certify the wound nurse and be well worth the money spent. It’s important, we see a lot of times that these nurses go out and get wound certified, but again when it comes to wounds it takes experience and just because they have the clinical foundation now to treat the wounds, doesn’t mean they know how to set up a program, how to get together a team or how to write policies and procedures, so again making sure they have support in all those areas.

From there we recommend you’re training your nurses on how to prevent wounds, the ideology of wounds, how to assess and document on them and how to treat them. The other piece you need to get them trained in on is F314. It’s amazing to see how many wound nurses that I work with in facilities that have never read F314 and they don’t truly understand what’s considered the standard practice that they’re being held accountable for.

I always see that they have insomnia. It’s great reading to try and put you to sleep so every night before you go to bed you might want to read it. I recommend that you read F314, not only the regulatory guidance but the guidance to the surveyors, because they’ll also help you get an understanding of how they’re looking at your systems and making sure you’re compliant with F314. They really do need to be the experts, that way if they’re in that survey situation they have a strong understanding of F314. It’s much easier to work with the surveyors at that point.

The other piece that you do need to get them trained in on is at least the MDS 3.0 Section M Training. Many times I see in the facilities the MDS coordinator is coding for the wound care documentation, but the wound nurse doesn’t know the MDS section M and sometimes the MDS coordinator doesn’t always know all the clinical aspects. It’s very important that they’re on the same page. You’ll see a lot of riff between the MDS Coordinator and the wound nurse, so it’s important you get them on the same page.

Your wound nurse might need to get up with your MDS Coordinator some clinical education and vice versa. Your MDS Coordinator needs to walk them through that section M because they need an understanding of why they’re interpreting certain things. Let’s say somebody staged something as a DTI. On the MDS they would code that as unstageable under DTI. There are a lot of things that can be somewhat confusing there, so it’s important they understand Section M and that will also help guide how to document on the wounds to make sure you’re covering all aspects of the MDS 3.0.
When it comes to getting started, once you have your wound nurse designated, you really do need to set up your skin care team. We highly recommend that the skin care team is interdisciplinary and has a very strong representation from your nursing assistance. When you think about prevention of wound care, all the interventions to prevent wounds such as turning, repositioning, making sure they’re cleaned after they’ve been incontinent, getting them on supplements and on the right devices, etc. are 100% implemented by your nursing assistant.

Even when a wound happens, the only thing the nurse will do is the actual topical treatment and from there all the other interventions are the nursing assistant’s. So, we help out in facilities that have strong representation from the nursing assistant’s and the nursing assistants from all shifts and a more successful wound care program. It’s very important to get it from all shifts.

It’s well documented that wounds can happen in as little as two to six hours, so all it takes is one shift one time not to continue the prevention program and a wound can develop quite rapidly. So it’s important you have representation from all shifts. Technically we do see the nurse managers involved, but another key is that they have their floor nurses involved.

Again, they’re the ones that are up and down the floors, they’re interacting directly with that resident and it’s important that they’re involved in monitoring and implementing those preventative programs. If you negate that floor nurse then the nursing assistant’s often will perceive them as their supervisor and technically and legally they are the direct supervisor.

So it’s important that you get the floor nurses involved as well as get them comfortable with both the prevention and treatment of wounds, because no wound nurse can be there 24/7. So again that means strong representation from them as well. And then again, we want that interdisciplinary team approach. There’s a lot that therapy can do as far as positioning, wheelchair positioning and some of you might have a therapy department that might actually have some topical treatment modalities they can apply.

Dietary is integral. We know that with poor nutrition wounds will not heal, so they definitely need to be part of that team. We also recommend strong representation from any physicians or nurse practitioners that would be willing to be involved and especially your medical director. They need an understanding of what your program is. They need to understand, especially if you have standing orders or protocols what those are and that they’re in agreement to that, and that they take an active role so they’re not ordering things or doing things that maybe go against what your actual program is. The more educated and involved they are the better you’re going to have.

The last one seems a little odd, housekeeping abatements, but we find them to be a very integral part of the team. There’s a lot that you can have them do to be a part of it. First of all, just being our eyes and ears. If housekeepers or maintenance are in and out of the rooms and they’re the ones who will tell you a lot of times oh, there were pills in the garbage or the supplement was in the garbage, they never did take it. I went into the room and I smelt urine and feces, things like that, or they might notice somebody has been sitting for a long period of time. So it’s very important that they know what to report and what to be watching for.

You can also have them be involved as far as your products that you have. One example is Support Services. What you can do is get them a list of who’s supposed to be on Specialty Support Services and they can make sure that they’re actually in and under the correct resident. We see that happen a lot with room changes where that support service doesn’t go with the resident.

We’ve also traced back several incidents where low air loss beds have become unplugged and we’ve traced them back to it was actually housekeeping going into the room cleaning it and unplugging it by accident and not realizing what it was. So they can be an assurance too when they leave the room checking to make sure that those are plugged in.

The other piece they can do is to make sure your standard preventative-type mattresses that you have are in good condition, that they’re on the bed correctly, things like that, even looking at wheelchairs and wheelchair cushions. So they can be a very integral part of your team.

When it comes to your team meeting you need a schedule and you need to abide by it. So many facilities I work with say we had these great team meetings that have gone so well and then we kind of backed off.
We haven’t met for six months and now we’re seeing issues again, so it really does need to be a commitment. A lot of the things you’re going to go over with the skin care team you might be able to add in other things as well, so you might be able to utilize that time as a holistic approach to really looking at your residents.

Initially, you might meet weekly or biweekly until you get things up and running and then from there we recommend at least monthly you guys meet formally as a team. Again, it just depends on the size of your facility and the amount of residents that you have with wounds. That might kind of dictate how often you actually should be meeting.

Now when it comes to the agenda it’s very important in most team meetings that go on that this is what you typically do. You review the residents currently with wounds, which is great. A lot of times I’ll hear so and so is healing okay and no one takes the time to really review okay, they’re showing progress. This is what we’re doing topically. This is the support services they’re supposed to have. This is the heel lift devices. This is the turning schedule, etc.

It’s very important that you go through each one of those components, because you will be amazed that as you have that team there the team might say you know what? No, that is no change or that is not current or correct. So it’s a great time for you to look at the big picture, look at all those interventions making sure that they’re actually working and troubleshooting and then you’re trying to make sure that that care plan truly reflects what it is you’re doing for that resident. So it’s very important that you review all of those different aspects, even if the wound is healing to insure that is all in place.

The next thing is you really need to move it past just looking at people with wounds. This is your time to be preventative. We tend to wait until the resident has a wound that we realize Wow, Mr. Jones has had a decline. He used to be very mobile, pretty independent. There’s just been a slow decline and the next thing you know they’ve been sitting too long and end up with a pressure ulcer. We recommend that you bring in the treatment book or a treatment sheet for a computer system, whatever you have nowadays, and really go through all the residents and throw out to the team a couple key questions.

As we go through these people what I want you to think about is has anybody had any change in mobility, even if it’s slight that you noticed. Any subtle changes in appetite, eating habits or you notice there’s been a weight loss. We tend to wait until it’s a significant weight loss and we really shouldn’t be waiting until then. We should try to pick up those subtle changes prior, especially when we talk about the re-hospitalization. You can’t wait until they’ve had that sufficient. You really need to be looking at that. A lot of times, especially if you have a nursing assistant, they might start telling you oh, they used to take the supplements and now they don’t, but they’re definitely are eating less.

Other questions to ask them is has there been any changes in continence status. A lot of times the aides don’t even perceive that the person maybe is starting to dribble, every once in a great while having an accident. That’s something very important to report because their skin is now at risk. Also asking any change in cognition with anybody or just any overall changes and declines. So having those key questions there and going through the treatment sheets because you’ll have them right up front gets you guys talking to see if you can’t pick up any subtle change and things like that.

Depending on where things are documented, you might to have the weight right there in front of you or even their intake and just go through that because really our goal is to prevent these wounds from happening and picking up those subtle changes before they become a problem.

The other thing I recommend that you review during your team meetings is your supplies and equipment. This is a great time to talk with staff on what support services they’re using. Are they working? Any issues and things like that? Is the wheelchair cushion was it a four-inch foam that’s now a two inch. Do they need a new one? Do you have enough heel lift devices available, positioning devices?

It’s very important that the perennial cleansers and the barrier ointments and creams, talking to those nursing assistants, that they’re actually available to them. I go to so many facilities where barrier ointments aren’t utilized consistently and we find that they’re locked up in some basement and only one person has a key. You should be putting senior nursing assistants in charge of those types of products and really give them ownership with that and some responsibility. They can’t use them if they can’t get to them.
Great systems that we see used maybe on nights as they do rounds they restock the rooms. That will help, hopefully, dissipate people from hoarding things and hiding things because they're afraid they're going to run out. We always do the audits and as housekeeping is cleaning a room they can do a double check making sure one resident doesn't have 10 tubes of ointment and the next one doesn't. So if every night they're going through and making sure people have the supplies that they need for the next day, that will help eliminate a lot of those issues.

From there making sure you have topical dressings that are available, asking the nurses how are they working, any issues. You'll be surprised when you start talking and it's like you know what? We've been using such and such, but I have to change it every day. Well that's not an effective product at that point. So it's a good time to make sure you have enough products, that they're getting good product performance and not having any issues there.

Once you kind of get your team up and running and going, when it comes to actually doing the wound rounds we recommend that during the wound rounds every time that wound nurse does a wound round you have a minimum of the nurse manager, the floor nurse and the nursing assistant with you on those rounds. It's very important that you're all there seeing the wound and knowing what's going on with the progress.

It's very important that the wound nurse isn’t going in there and doing it by themselves. You really want them in there as a team so the wound nurse could do bedside teaching. Show them how they’re measuring the wound, how they're staging it, what they're going to pick for a treatment and giving them that rational.

Really, the goal is to be a team and in that way if your wound nurse is unavailable, heaven forbid they might want to go on vacation or they might get sick, if your wounds are always assessed every Wednesday you don’t have to worry about the fact that your wound nurse is not there. Your floor nurses are capable of continuing that system.

The other issue that we see a lot of times is on admission where nurses do not know how to do a proper skin assessment. It is imperative on admission that all your nurses know how to do a thorough skin assessment and when they come across a concern that they are capable of capturing what that wound looks like on admission, so they need to have the ability to know how you guys measure wound stages, describe them, etc. The more you have them involved the more confident they're going to be to do that. If possible you might meet once a month or biweekly then, depending on how large your facility is, maybe therapy, dietary and the physicians will actually round with you.

Once you kind of get your wound rounds down and your team together, one good place to start a lot of times is communication. We find that when you start trying to do a program if there isn’t good communication within the facility from shift to shift or between caregivers it’s hard to implement a program. So really asking an ongoing communication involvement with the direct caregiver, so how are we communicating to them?

It is so important on whatever you call it, whether it’s their care card, their Kardex, the nurse assistant care plan or the AV sheet, whatever you call it, you need to insure that all those interventions that they see you do to that wound and to help heal them are on there, things such as the turning schedule, the toileting schedule, what kind of product they should be using on the skin with incontinence, what kind of heel lift devices, what kind of wheelchair cushion. All of those things are very important to be directly communicated to that caregiver.

We have found in lawsuits that that’s been one of the best ways for us to prove that we’ve put interventions in place and we communicated it to the direct caregiver who would actually implement it. So it’s very important that you look at that. Who does the care plans and how does that get brought forward to those nursing assistants.

Another great question is when a skin is concern is found how does the nursing assistant communicate those skin concerns, is it verbally or written. We really recommend you have some kind of written system. It doesn’t have to be fancy, it could be very informal, just a picture of a persons body where they stick a bunch of them in their pocket at the beginning of their shift and then they could just circle where they see that concern and get that to the nurse.
We find those facilities that have verbal communication many times if there’s a wound there’s a delay in treatment or a delay in assessment due to the fact that the nurse is so busy. A physician came, so and so fell, they got two new admin’s so they totally forgot to follow up on the wound.

So it’s very important that you do the written communication, that way it’s down in writing. Some facilities even do it in a duplicate or triplicate form, that way it can be given to that charge nurse and then from there maybe given to the wound nurse and/or or DON to make sure that everything is followed up on and that within the first 24 hours all the appropriate steps and interventions are put in place from when you found that actual skin concern.

A big question is between shift and caregivers. Many facilities do not have the luxury of having their nursing assistants overlap. They might end at 3:00 and start at 3:00 o’clock, so a lot of times your nursing assistants are giving nursing assistant to nursing assistant report. So it’s very important that you come up with some kind of system for the nursing assistants to hand off to the next shift, when was the last time they turned and repositioned them and what position was that, when they were last toileted and then maybe leaving a spot for any notes. Mrs. Jones hasn’t been feeling well today or Mrs. Jones saved her banana for later. Could you please give it to her before dinner? Things like that.

Very important that you have at a minimum and it’s a great tracking tool. If you do use a written form I recommend at the bottom you should put QA purposes only, that way they can hand off to the next shift. It’s a good monitoring tool for a nursing staff to be able to pick up the card and say okay, it’s now 4:30 and your sheet says they were last turned at 2:00 p.m. and they were on their right side. Well, it’s now 4:30, they’re two-two hour and they are still on their right side. So it’s a good Q&A for you as well with that.

We already talked about how our intervention is being communicated, also between units. We’ve actually had issues in facilities where someone is transferred from a sub-acute to the long-term care and you would have thought they got admitted to a whole new building. So how does that process work? How does that communication work to insure that there’s continuity of care and intervention from those different units. It’s very important, especially nowadays with the re-hospitalization, how your communication is between healthcare settings.

It’s interesting, especially when it comes to wounds, how basically when we admit somebody we kind of start over with what kind of interventions we’re going to do and we really need to be finding out from that prior setting what kind of bed they were on, wheelchair cushion, turning program, what treatments they’ve tried, what kind of nutritional, etc.

You need to find out what worked and what didn’t work and our goal is to continue that care and move that forward. Same with if we send them out, it’s very important that we communicate to that other care setting that they have a wound and what you have been doing for them, that way that continuity of care continues.

From there once you’ve looked at communication, the next thing you want to look at is your preventative program. We usually recommend you start with prevention because we don’t want wounds to happen in the first place. Most of you usually have a pretty good system once the wound happens as far as doing the weekly assessments, etc., so really breaking your prevention program into two areas.

First, the admission process to what happens in the first 24 hours and then from there really asking yourself what is our ongoing prevention program.

If I were to walk up to one of your caregivers and say to that nursing assistant so what is your pressure alter prevention program, could they articulate that? It’s a great question to ask because that’s really what your goal is. It’s very important with all these systems as you’re making a change that you use the quality improvement process. In our industry we tend to be more QA and we tend to be reactive, especially because of our survey system you have a short window of time to fix things.

But really try and use that quality improvement where you look at specific areas. You don’t want to tackle the world, but look at a very specific area and maybe target just a unit. Let’s try to work this out on a unit and work out all the kinks before we roll it out to the whole house.

From there you really should be reevaluating it. After several weeks how is it going, what’s working, do we need to change anything. Unfortunately, in our industry we tend to throw things out there. We throw it
whole house and we just continue it whether it’s working or not. So it’s very important that you make small changes, work out the kinks and then make sure reevaluate it to see if it’s actually working and providing the goals and outcomes that you had hoped for.

When it comes to looking at the admission process this is a great place to start, the goals are more tangible and easy. What you need to do is put a task force together of your admission and you really to ask yourself when do our admissions happen and who should we have involved with this team. Very important, because a lot of times it’s not the day shift or the wound nurse that’s actually admitting these residents.

The other thing that’s very important is that you map out reality. Not what policy is, but what is reality. So sit down with those key people that tend to get most of the admissions and when someone comes in how do we get this done? Tell them you need to be honest and you need to be open, because this is where you’re going to decide where those performance gaps are and where you need to focus.

The questions that you should be asking the team is within that first 24 hours who does the head to toe skin inspection, when is it done and are they comfortable doing the head to toe skin inspection, especially if they do find concerns and making sure that it’s thorough. If it’s darker skin tones are they actually feeling those bony provinces. Are they making sure they’re actually looking at the heels and getting underneath there? I know it sounds silly, but are they actually spreading the butt cheeks apart and those skin folds. It’s very important and we find a lot of times that that is missed.

Just asking who does the skin inspection, when is it done, we always say the sooner the better. The mandate is within 24 hours, but really again F314 states it could happen in as little as two to six hours. A good time is when you’re getting them ready for bed. So as you’re getting them into their pajamas, a great time to look at the skin at that point.

The next question to ask is who does our risk assessment and when is that done. Is it done within the first 24 hours and are we gathering from all shifts to accurately fill out that risk assessment. It’s very important if we are trying to prove that a wound was unavoidable. We have to show that we did a skin inspection and that we looked and did a risk assessment immediately and from there we implemented a plan of care. We cannot wait when it comes to skin for the 21 days when the full-care plan is due.

When it comes to the skin you have to show from time of admission what you were doing to intervene with this resident. The only way we can prove unavoidability is that the risks were identified, that correlating interventions were put into place for those risk factors, that they were actually implemented and that they still broke down despite that. Unfortunately, what we see in a lot of charts is not until they actually get the wound. Now dietary gets triggered, the therapy, etc.

So it’s very important to ask who does that risk assessment for the first 24 hours and then from there who develops that temporary care plan. So who is actually putting that into place and then how do those interventions from that temporary care plan get communicated to the caregivers, because again 100% of those interventions are going to be carried out by the caregiver.

When you’re looking at a temporary care plan, this slide will give you the bullet points that at a minimum your temporary care plan should address. From there then you can get it much more tailored as you get to know the resident, but within that first 24 hours you need to be very clear on what kind of support surfaces they have in a bed and a wheelchair, and you should never wait on those, what kind of turning position schedule they have.

Of course, here in the State of Minnesota we have to do a formal tissue color observation, so showing that that was done in the first 24 hours. How are you managing the incontinence? How are getting heels up off the bed? One of the number one places for pressure ulcers now is on the heel area, so right from the get go if they’re immobile how are you getting those heels up off the bed. Did you do a referral to dietary and therapy and let them know that they’re at risk and do you have access to the topical dressings if they’re admitted with a pressure ulcer.

So on their temporary care plan if they are admitted with a pressure ulcer, you just need to put on there treatment as ordered, that you’re going to monitor for signs and systems of infection or complications and that you will notify the physician, the family and the interdisciplinary team if the wound is not showing progress.
Once you feel comfortable that you're capturing everything within the first 24 hours, the next step you might want to do is what your ongoing prevention program. A couple of things that you need to assess to maybe help you decide where you might want to start, so from there who does the ongoing risk assessment. Are they done timely and per F314? When are the ongoing skin inspections done? Is it daily with care? Is it with the nursing assistants? Are you doing it weekly, upon discharge and who is doing the ongoing care plan update?

It’s very important when it comes to the care plan that a list of interventions correlate with those potential risk factors to help develop that plan of care. Meaning, once somebody does a risk assessment how do all those risks get brought forward to the care plan and how do you determine interventions for those risks. I do recommend that you do some kind of cheat sheet for the nurses.

We find that most nurses are uncomfortable. They’ll do a brain scale and a comprehensive breast scale and they’ll do a great job with it, but then they don’t know what to do with the information. They’re like you know what? That’s sensory perception issues. I don’t know what to do for an intervention for that. So if you give them a cheat sheet with some potential suggestions of interventions to pick from they can pick what’s appropriate for them and help eliminate that issue.

It’s very important that you look at your supplies and products. So do you have pressure distribution surfaces in the facility and do you have access to higher-end beds that you might need to rent. Now is the time to really look at all the different vendors out there, have them come in and evaluate their products and their pricing. You don’t want to wait until you actually have to initiate it to be behind the ball to try and figure that out.

It’s very important to look at your wheelchairs. Do all of your wheelchairs have a wheelchair cushion? There should be no wheelchair in your facility without a cushion. They were meant to be modes of transportation, not to be left in for long periods of time. So two things to look for there, is somebody stabilizing that wheelchair sling so it’s a flat surface and then is there a wheelchair cushion and are they in good condition.

Do you have enough heel lift devices and pillows available to make sure that the heels get up and off the bed? Do you have enough barrier ointments? We already talked about the importance of making sure that they’re assessable to the nursing assistant, that they like using it and don’t have any issues with the product that you’re actually utilizing.

Another reason why a lot of them stopped using those barrier ointments is due to the fact that they might be hard to put on or take off, so really looking at those products. Do you have enough lifting and positioning devices in your facility and do you have dietary supplements as appropriate, especially ones that your residents like.

From there when it comes to prevention is looking at your monitoring programs. We recommend you get all your staff involved with your monitoring programs and that they continually be done. If you stop monitoring or spot checking I guarantee you people fall back into bad habits. So it’s very important that you’re continually monitoring your program and this is a great way to utilize your wound nurse effectively. They can help lead these monitoring programs and again then start getting other staff involved.

Floor nurses are a great way to monitor. They’re up and down the hall doing medications, doing treatments, so they can make notation of what position the resident is in, are all their devices in there right then and there and then they can really monitor that resident if you determine reposition for their plan of care.

One little trick to monitor turning and repositioning you could do one of two things. You could do sticky notes. You need to let the resident know that I’m going to put this little note here. I would put return to Jerry when found and if they get it back to you on a timely basis then you can give them positive reinforcement. You might want to have a goodie jar or whatever the case may be, but give them that positive reinforcement.

From there if they don’t get it to you timely, we recommend you go back to the floor and not only pull the nursing assistant but also the floor nurse as well and talk about okay, this person isn’t timely for their plan of care. What’s going on? It might be a great way to look at your nursing assistant assignment sheets and
also get your nursing assistants involved with what the turning program needs to be and how they need to effectively manage it. You can do the same with toileting schedules.

The other option you could do if you don’t want to do sticky notes is as that nurse or as you go up and down the hall you can just use a piece of paper and make a note of the time and then check them again at the time intervals. Let’s say you go back in two hours and you notice yep, they were actually turned and repositioned, you can give them positive reinforcement at that point. It’s also, like I said, a very good time to assess and confirm that equipment is in place and is functioning properly.

We really recommend that the wound nurse once a month look at the support surfaces, both the bed and the wheelchair. Especially if you have robo-type wheelchairs, so any air-type wheelchair cushion, they really should be checked at least monthly for proper inflation because they do lose air over time. So it’s very important that you actually monitor for that. From there looking at your interdisciplinary team, are you being proactive? So are those notes actually happening during that wound team that you’re looking at prevention.

Another very important piece is maybe using your wound nurse to spot check the nursing assistants doing daily cares. So are they doing peri care appropriately or catheter care. Are they passing the supplements at appropriate times? Things like that. Are the weight, size, all those kinds of things being adequately tracked?

It’s a great time for your wound nurses to kind of go through those things and really get comfortable watching those nursing assistants do the cares. Seen a huge increase in the F441-type patient for infection control and the number one reason is the hand washing. There are two key areas that we see citations on, either doing dressing changes or the nurse assistant doing the daily cares isn’t properly washing hands and/or gloving appropriately.

From there maybe once a month setting some time aside for your wound nurse to actually monitor your charts and your documentation to make sure it’s compliant with other report teams. So pulling charts not just for the residents who have wounds, typically those charts are up to date, but pull from your high-risk residents then make a flat check. Was the risk assessment done timely? Are the weekly skin observations being done timely and at appropriate intervals? Is the care plan truly right?

Typically, I’ll pull out the care plan, go look at the resident and look at the kind of cares. I’ll interview the staff what kind of things you do for the resident and see if what I’ve seen and what they’re saying matches the care plan. I can tell you about 99% of the time you guys are doing more interventions than you would take credit for in that plan of care.

The next thing I do is then look at the risk assessments to make sure that everything from the risk assessment was pulled forward to that plan of care. I look at section M on the MDS to make sure it also matches. Make each of those causes actually match what is on that care plan and then double checking those physician orders and the caregiver assignment sheets.

It’s amazing to me how many times we will find odd orders on the physician order sheet, so making sure that they actually match and then again looking at the caregiver assignment sheet so that everything gets communicated to them.

When it comes to your treatment programs once you’ve to looked at all those things preventative-wise and feel like you have everything in place. That your skin assessments are being done timely, that the risk assessments are being done and care plans are being implemented.

Next you want look at that overall treatment program. So breaking that down, you might want to look at what happens when a wound is first identified. This is a little check sheet here of within the first 24 hours when a wound is identified all of these things need to happen and this is very important.

We see a lot of facilities have difficulties looking at that comprehensive picture, because the nurses get so obsessed on how to treat the wound, oh, my goodness, I’ve got a wound, I’ve got to call the physician, what do I treat it with, that they forget to look at the big picture. Why did this wound happen? What is going on?
Your topical treatment is only piece of the puzzle, especially on pressure ulcers. Pressure ulcers are a caution to cutting off a blood supply and if they don’t get adequate blood supply I don’t care what you do it topically, so it’s very important that you look at this.

Even if you guys have standing orders so that you can implement your treatment, a lot of nurses don’t realize that you still have to call and notify the physician of the area. It’s very important that you involve them. We’ve had many physicians say nobody told me about the wound, they just implemented the orders. So it’s very important regardless of stage. Especially if it’s stage one, we need to catch it then. We need to notify everybody hey, we caught it at a stage one and this is what we’re doing. You don’t want to wait until it’s a three or four.

So right away upon the discovery an area, you should notify the physician or NP, the family and designee and then your interdisciplinary team. You need to make sure whoever discovers that actually documents that wound and captures what they’re seeing. You need to do a new risk assessment at this point, a very pivotal, a very important time to do that risk assessment to see what changed with the resident and now do we need to do different types of interventions.

From there if they broke down on the current support surfaces, you need to look at are they still adequate and/or was it an issue with turning and repositioning. Things like that. So you need to re-look at that. You need to evaluate all the current interventions and them from there make sure you update that plan of care and that you update those nursing assistant assignment sheets to communicate to them.

Other communication is both intervals, so when do you communicate to the physician, the family and the interdisciplinary team. These are key intervals and really looking at the chart to see the documentation. We have found of lawsuits it’s very rare a family will sue if the facility is very actively involved and telling them every step of the way what they are trying to do with this wound. Unfortunately, a lot of the lawsuits we see it’s not until the resident is in a detrimental situation or maybe septic from the wound in the hospital and the family had no idea they have this wound or what you were doing about it.

So a key time that you would notify all these folks is upon discovery of that wound. If there’s no progress in two weeks it’s very important you re-notify everybody. Especially a physician, and the team and family, the wound is not showing progress. It has not changed. This is what we’re doing and then what you’re going to do with the plan on that. Now guidance says a pressure ulcer should show healing within two to four weeks, but it never looks good if you wait a full month.

So really looking at that progress and if you’re not seeing it in two weeks, looking at that big picture. Maybe it could be they have so many comorbidities that they are going to be slow to heal and everything does look to be in place, but very important that you show that you’re trying to intervene.

Definitely when the wound declines is a key time to communicate to everybody and then it’s also very important to take credit for the fact when the wound heals. We’ve had family members that have sued not realizing this facility has worked with this wound and they’ve actually healed it two other times and they might not know that that ever had happened.

When it comes to treatment too you need to evaluate your supplies and make sure that you do have enough. You don’t want huge stacks of dressings because (A) they’re expensive and (B) they can expire, but you want to have just enough for you to start that dressing change. So you need to make sure you have some moisture dressing available, a hydro gel, a hydro-collate and transparent film. You need to make sure you have available dressings such as foams and calcium alginate available.

You need to have access to debriding agents. Some are prescription, but medical grade honey such as your Medihoney is a great debrider. It’s much more cost effective. It’s not a prescription and its something you could have readily available in stock so that way if you needed to trigger it.

Then you want to make sure you have access to adjunctive therapy such as negative pressure wound therapy, B-stems and things like that. You don’t want to get a weight until you need it to kind of find out benders, especially when it comes to the negative pressure wound therapy, there are so many new modalities out there now that KCI has lost their patent.
So it's a great way to look at the different options that are out there so when you're in need you know exactly how to get it and get it rapidly. From there we already talked about the importance of having your high-end support surfaces readily available to you and then again that upper dietary supplementation.

When it comes to your treatment program, again a key time to use your wound nurse is to monitor all nurses doing dressing changes. Really when you do wound rounds you should have the floor nurse doing the dressing change. It's a great time to assess their technique and get them into good habits. Again, I said a 441 is being cited a lot for hand washing and a lot of the citations are because of those dressing changes.

Two key areas we see is treating multiple wounds at once, meaning taking the dressings off of all the wounds. You need to treat one wound at a time or once you take off that old dressing you need to remove your gloves at that time and you do need to wash your hands and then put on new gloves at that point. You can't just put on new gloves you need to clean your hands.

From there to monitor that physician order, the order diagnosis, that everything matches, that they're not writing things that don't match what you're saying the wound actually is and also very important to monitor those treatment sheets. A lot of times we'll see the initial physician order doesn't actually match what got transcribed to that treatment sheet, so making sure that they actually match. Make sure the interdisciplinary team is involved, and rotations from dietary, therapy, etc.

When it comes to refusal of care that you're really having those risk-benefit discussions, so are you discussing with the resident what it means to have a pressure ulcer? It's very important in that conversation that you move it on to the fact that pressure ulcers can be life threatening. That you can get an infection that can go throughout your whole body because of this wound and that could be life threatening and that people do die from pressure ulcers.

There are a lot of families that have sued and say you know what? They told me I had this pressure ulcer. I might have refused certain things because I wanted quality of life, but nobody said -- and your nurse can be the score there -- they could actually die from them. So it's very important that you say look, if you continue to refuse X, Y and Z this is what could happen.

It's very important that you do offer alternatives. A couple of key alternatives is if you have somebody that doesn't turn and reposition, so they either sit in a wheelchair all day or maybe lay in bed on a certain side, maybe a compromise is to offload them for one full minute every two hours and then put them back in the position. Plus, you might need to get more aggressive with the support surface if they're not moving around that much.

So it's very important that you list out alternatives that you've tried, had their involvement with those alternatives and then from there if they continue to refuse it really care planning to exactly what they're refusing.

We tend to DC things off of the care plan once they refuse something. So when somebody adds a care plan they wonder well why didn't you try X, Y and Z? I would definitely keep on there that they refuse and you have to be specific of what they're refusing. Refused to turn and reposition or refuses to do heel lift elevation, whatever the case may be and then put right on the intervention (A) was the alternative that you're trying, risk-benefit discussion on such and such date and where to find that notation.

From there we really recommend that with each care planning interval is when you reiterate and re-go through that risk-benefit conversation with that resident. Lastly, you need to have an on-going education program. The facilities on orientation do not talk about prevention of wounds and skin care and it's imperative that you have a good orientation program for all staff. So everybody needs to be trained on the prevention of pressure ulcers and your nurses that need to have that next step up once they have a wound how to effectively treat that.

We do recommend that when you do educate that you do it in this order. First prevention, next how to assess a pressure ulcer, how to stage it, measure it, etc. and then do treatment modality. If you teach nurses treatment before how they assess a wound it's going to be difficult for them to decide what to use. They need a thorough assessment because that what determines what you're going to treat that wound with.
Once they get good at the prevention assessment and treatment of pressure ulcers then train them on the lower extremity ulcers. So what is an arterial diabetic venous and/or neuropathy-type wound, how are they different from pressure ulcers and how do we assess and manage those?

So it's very important you get all of those on orientation. We also recommend using your wound nurse for bedside follow up. So if you've done the assessment documentation class then maybe have a competency test over the next month where the nurses go to the bedside with your wound nurse and she checks them off on the assessment documentation. That's a great way you could do that follow up.

From there we recommend then you always yearly redo these training sessions. We've had issues with lawsuits where they had a great orientation program, but then the nurses involved with the suit had been there like 15 years and the last wound care training they did was four years prior.

So very easy for plaintiff lawyers to say that they weren't competent. Plus, wound care is constantly changing and being updated so we recommend not only at orientation but yearly thereafter and very important that you get attendance. If three people show up that's not going to say yes, you did your training. You need to have at least 75% or more of your staff trained in order for it to be considered effective.

Basically, when it comes to your program if you keep your resident patient's interest in mind your program is going to succeed, but it's also very important to have the mindset that just because you have a wound nurse doesn't mean the world rests on his or her shoulders. It's very important that you get the whole team involved and that you effectively use that wound nurse more as the overseer and your educator, that resource for your staff, and the one who actually helps monitor your program.

I do have some resources and if you want more information here is the WOCN's website. You can also go to this website if you're looking for that certification and some of the guidelines that are available. HRQ was supposed to come out with their updated skin care guidelines, but I have not seen that yet. American Academy of Wound Management is also another place you can get certified for interdisciplinary team.

Then the National Pressure Ulcer Advisory Panel, we strongly recommend that you constantly monitor that website and tap into the resources they have there. Both just say though that WOCN and NPUAP are considered pinnacle standards or what sets that precedence for standards of practice, so really having an understanding to their information.

Lastly, WoundService.com, a great little website if you're looking up wound care products or trying to cross reference companies and vendors. With that I'd be happy to open the lines up to any questions.

**Guest:** I work for a home health agency and I guess the lecture was based on kind of like an institution. So how do we achieve everything that she just said about the best care?

**Jeri Ann Lundgren:** The standard of practice is a little bit higher because you're not dealing with a controlled environment.

**Guest:** That's right.

**Jeri Ann Lundgren:** If you do have key wound nurses, again, working with all of those nurses going out (A) helping with competency to make sure that they're very comfortable. Maybe making cheat sheets for when they go out to the people's homes to kind of assess their environment. You know what kind of bed are they using, what are they sitting in all day, really asking questions nutrition-wise.

A lot of times what you guys can do is kind of more of cheat sheet on what the environment is like, what are they doing, compliance levels and things like that, and then really making sure they're competent.

One thing you could do if you can't necessarily go bedside with the nurses then you have some home care agencies where the wound nurse does go to visit with each nurse to check them out on competencies.
If you can’t do that, I know this is kind of an odd name, but there’s a model of a butt that actually has wounds on it. It’s called Seymour Butts and it’s by VATA. It think it’s VATA.com or VATA.org. You could also use that model to actually do the competencies with it.

Then, again, in homecare you still would be auditing those charts for OAC accuracy, that care plan that’s actually there, the physician orders, treatment orders, everything matching, etc. and then same with supplies. You know really looking at the topical treatments. In homecare about 40% of your spend is a lot of times on wound care. How are you managing those supplies?

Does that help or are there other areas in the homecare that you’re like wow, how do I do X, Y and Z?

Guest: That’s kind of helpful. We usually would send a certified nurse in wound care that we contract with who would go out and do an analysis, make a measurement and advise us. So we’re doing that, but yeah it’s kind of helpful though.

Jeri Ann Lundgren: I really recommend whomever you’re using to do that that they’re really communicating to the nurses that are caring for them so they understand what they’re recommending, what it is they saw and then maybe contact with them to come in and do some of that education competencies because those nurses in between need to know what to look for, especially with some of the treatments.

They need to know okay, this is how this is going to behave. It’s going to look worse before it gets better type thing for debriding, etc. Then you won’t have to be do dependent on that wound nurse, because it is important that your nurses know what to look for.

Guest: Thank you very much.

Jeri Ann Lundgren: You’re welcome.

Barb Olson: Jeri, thank you so much for today’s presentation. We really appreciate it.

Jeri Ann Lundgren: You’re welcome.

Barb Olson: I’d like to let everyone know that there is a small short polling evaluation on the screen. If you’d take a minute and complete that for us we’d really appreciate your feedback.

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