Wound Management Program
ACE Program
Foundations of Function

WOUND OVERVIEW

Purpose:
The purpose of this program is to create an interdisciplinary approach to managing the geriatric client in a skilled nursing facility with wounds or at risk for developing wounds that will address wound prevention, healing and the related loss of function through interventions within the scope of practice for physical, occupational and speech-language pathology services.

Prevalence and Trends of Wounds:
The primary types of wounds generally found among the geriatric nursing home population are pressure, arterial, diabetic and venous. It is estimated that from 2% to 28% of nursing home residents have pressure ulcers.

Data from the National Nursing Home Survey, 2004 support the following key findings:

1. In 2004 11% of nursing home residents (159,000) had pressure ulcers.
2. Residents aged 64 years and under were more likely than older residents to have pressure ulcers (14% and 10% respectively). Stage 2 is the most prevalent.
3. Residents of nursing homes for a year or less were more likely to have pressure ulcers than those with longer stays (16% and 7% respectively).
4. One in five residents (20%) with a recent weight loss developed pressure ulcers (10% without recent weight loss).
5. Only thirty-five percent of residents with stage 2 or higher pressure ulcers received special wound care services in 2004.
6. Residents with high immobility had an 11% greater occurrence of pressure ulcers than those without high immobility (16% and 5% respectively).
7. Pressure ulcers were more prevalent by 5% among residents who had any recent bowel or bladder incontinence than among continent residents (12% and 7% respectively.
8. Polypharmacy, or taking more than 8 medications, is related to a greater prevalence of pressure ulcers (13% and 9% respectively).

Adverse Effects of Wounds:
Wound development may lead to devastating results. Individuals with wounds may experience:

- Infection
- Loss/reduction of mobility
- Loss of limb
- Pain
- Reduced quality of life

Misperceptions/Truths about wound management:

- Therapy has little to offer in regards to treatments for the healing of chronic wounds.
    - **Truth:** Therapy can help to heal wounds up to 50% faster than without therapy intervention.
- Wound care is "only for nurses."
    - **Truth:** Therapy has a vital role in both the prevention of and direct healing of wounds.
- Therapy is an expensive way to manage wounds.
    - **Truth:** Therapy can reduce the overall cost of managing wounds with improved outcomes as well.
- Longer term residents are more likely to have pressure wounds than the shorter stay residents.
    - **Truth:** Residents of Nursing Homes for a year or less are more likely to have a pressure wound than the longer term residents.

Positive outcomes associated with a rehab program for wound healing:

- Chronic wound healing may occur 30-50% faster.
- Prevention of complications which require more extensive treatments and cost
- Reduction in co-morbidity
- Improved quality indicators and survey performance
- Allows patients to re-enter the community due to a lessening of the required level of care

Risk factors for the development of wounds:

- Chronic Illness including
    - Hepatic
    - Renal
    - Cardiovascular
    - Autoimmune
    - Carcinoma
    - Diabetes
    - Systemic vascular disorders (i.e. blood supply, venous return)
- Reduced Functional Mobility resulting in
    - Development of pressure points
    - Development of edema

- Nutritional Deficiency
    - Protein
    - Calories
    - Vitamins; A & C
    - Minerals; Zinc & Copper
- Recent Weight Loss (Defined as weight loss of 5% or more in 30 days or loss of 10% or more in the past 180 days)
- Recent Bowel and/or Bladder Incontinence
- Polypharmacy

PATIENT IDENTIFICATION

Methods:

Observation: Observe the residents. Do you see residents who appear to . .

Be in bed or wheelchair more?
Have lost weight?
Be uncomfortable in their chair?
Have limb discoloration?
Struggle to feed them self?
Have wound dressings visible?
Not reposition them self?
Sit incorrectly?
Have marked extremity edema?
Have marked contractures?

Interview of Staff: Talk to facility staff and ask if they have observed any of the above behaviors or situations? Be sure to include the CNA-Med Techs and activity staff in your interviews. In addition to the above list, ask if there is a resident who is . .

All of the above observations.
Receiving wound dressings.
Less active.
Eating less or poorly.
Incontinent of bowel or bladder.
Edematous.
Showing signs of skin pressure.
Complaining of pain from sitting.
Frequently moist on their skin.

Note: If you receive a verbal comment/report from nursing, it is OK to request they complete a therapy screen and/or create nursing documentation because it will help support the need for therapy services.

Interview Family: When acceptable to the resident, appropriate and without disclosing the resident's personal/protected information, talk with a resident's family and friends about any of the above issues. Frequently a patient/resident will have confided in a family member or provide more information to them than to their caregivers.

Review of Medical Record:

1. *Nursing Notes* - Review the nursing notes to identify documentation related to wounds, the resident needing any dressing changes as well as additional assistance with ADL's or ambulation. Note any weight loss, chronic diseases and the number of medications.
    - MDS (Minimum Data Set) - When providing therapy services to long term residents of a skilled nursing facility, there are several key areas on the MDS which can be used to identify residents with or at risk for wounds.
    - Section G 1 - 9 (Physical Functioning and Structural Problems)
    - Section H 1-4 (Continence in Last 14 Days)
    - Section J 1-4 (Health Conditions – look for weight loss and soft tissue pain)
    - Section K 1-4 (Oral/Nutritional Status)
    - Section M 1- 6 (Skin Condition)
    - Section O 1 (Medications – Number of medications)

Quality Indicators Review: - Review the following quality indicators:

1. **3.1** Clinical management - use of 9 or more different medications
2. **5.1/5.3** Elimination/Incontinence
3. **7.1** Nutrition/Eating – residents who lose too much weight
4. **8.1** Pain Management – residents who have mod to severe pain
5. **9.2/9.3** Physical Functioning – Residents who spend most of their time in bed or in a chair; Residents whose ability to move in and around their room got worse.
6. **11.1/11.2** Quality of Life – Residents who were physically restrained; Prevalence of little or not activity.
7. **12.1/12.2** Skin Care – High-risk and Low-risk residents with pressure ulcers.
8. **13.2/13.3** Post-Acute Care Measures - Short-stay residents who had moderate to severe pain; Short-stay residents with pressure ulcers

Criteria for Patient Identification - The following are some criteria that may indicate therapy services are indicated either for prevention, wound care/treatment and/or management of disorders which are associated with wounds (i.e. pain, edema, decreased mobility).

- Presence of any wound
- Presence of chronic diseases
- Recent weight loss in past 30 to 180 days
- Reduced functional mobility
- Inability for resident to effectively reposition themselves
- Bowel and/or bladder incontinence
- Polypharmacy
- History of prior wounds
- Inability to communicate needs reliably (i.e. position change or toileting)

THERAPY ROLE AND INTERVENTION

Therapy Program Overview

A comprehensive therapy program for wound management is a **"3X3"** approach. Each of the three disciplines of PT, OT and SLP each according to their practice act, when appropriate, will develop an individualized plan of care for the needs of each resident considering the following three perspectives.

- Prevention - Eliminate, minimize and manage the risk factors related to wound development so as to prevent wounds from first occurring.
- Intervention - Provide treatment when a wound is already present to promote the normal wound healing phases of inflammation and proliferation to wound closure.
- Postvention - Promote the process of pressure management, tissue remodeling for proper collagen development and reduction of adhesions after wound closure so to prevent re-opening of wound.

Potential Assessments, Interventions and Plan of Care

The plan of care for each resident is individualized to their own deficits and impairments. The following are possible interventions that could be utilized when addressing wounds and wound prevention. Coordination with the nursing staff must occur to appropriately coordinate an individualized interdisciplinary wound management plan for each resident.

Prevention

- Pressure Management – Assess for and treat abnormalities in wheelchair positioning, bed positioning, contractures, pressure causing garments (i.e. socks or elastic cuffs etc.) and shoes.
- Edema Reduction – Assess and treat extremity edema as it relates to reduced mobility, limited activity and wound development**. *****
- Circulation Promotion/Management – Assess and treat as indicated to increase peripheral circulation as it relates to pain and compromised mobility, ADL's and wound development. *****
- Incontinence Management – Assess for and treat issues of incontinence in order to protect the skin from irritation and breakdown.
- Communication management – Provide assessment and treatment as needed to maximize the resident's ability to follow positioning recommendations and effectively communicate their need for position change, toileting and dietary preferences etc.
- Swallowing management – Provide assessment and treatment as needed to maximize the resident's ability to consume adequate nutrition.
- Mobility – Provide assessment and treatment as needed for the resident to function at the highest functional level possible including feeding, toileting and other ADL's as well as ambulation, transfers and balance. The resident's ability to re-position them self in the wheelchair and bed should also be assessed and treated to help in the prevention of excessive sustained pressures and patient comfort.

(***** See section following for considerations of modality use.)

Intervention

- All the above preventative interventions apply
- Pain Management – Assess and treat as needed for pain to allow for optimal mobility and ADL performance as well as wound dressing changes etc.
- Wound Healing Promotion – Utilize all appropriate electrical, sound and electro-magnetic modalities to promote proper wound healing and eliminate the factors which inhibit wound healing (i.e. edema, chronic inflammation, insufficient inflammation etc.). Use as appropriate. .
    - Nerve block – Allows for less painful dressing changes etc.
    - Electrotherapy Muscle Pump – Reduces extremity edema.
    - Electrotherapy HVPC – Increases circulation directly to the wound.
    - Electromagnetic Therapy – Increases blood flow/circulation and reduces edema.
    - Ultrasound – Increase circulation.

Postvention

- All the above preventative interventions apply
- Tissue Remodeling
    - Motion and Controlled Stress – Assess and treat as needed for tissue mobility, joint mobility/ROM and body mobility which impacts the healed wound region to promote proper tissue remodeling and maximize patient mobility as well as the prevention of wound re-opening.
    - Sub-Thermal Ultrasound to promote healthy tissue remodeling.

Medicare Coverage Guidelines

1. Medicare A – Currently there are no restrictions regarding therapy and treatment of wounds other than the general Medicare guidelines for therapy such as the need of the skill of the therapist, progress etc.
2. Medicare B
    a. E-stim or electromagnetic therapy (diathermy) may be applied for direct treatment of any wound as adjunctive therapy 30 days following occurrence. If the wound is a pressure wound, it must also be at least Stage III or worse.
    b. Treatment may continue until the wound is closed assuming that the modalities have stimulated a positive outcome based on goal progress or achievement.
    c. A re-evaluation of progress is required every 30 days.

Documentation and Coding

1. *Common Codes to Bill related to wounds (other codes may apply)*
    - 97003 OT Evaluation
    - 97001 PT Evaluation
    - 92506 Evaluation of speech, language voice
    - 92507 Treatment of speech language voice
    - 97035 Ultrasound
    - G0281 E-stim for wounds: PT; supervised (Note distinction from G0283 which is non-wound related E-stim)
    - G0329 Electromagnetic Therapy (SWD), supervised – wound healing (Note distinction from 97024 which is diathermy not for wound healing)
    - 97597 Selective debridement etc. wound $\leq$ 20 square centimeters
    - 97598 Selective debridement etc. wound > 20 square centimeters
    - 97602 Non-selective debridement

2. *Documentation Pointers*
    - Associate the patient's wound to loss of function and activity.
    - Establish goals which are function related.
    - Wound assessment and measurement should be conducted in careful collaboration with nursing so as not to create conflicting documentation.
    - Progress in wound healing must be shown minimally every 30 days.
    - Document progress and establish goals based on consistent performance or the task as measured by multiple trials.
    - Remember, progress in wound healing may be demonstrated not only in terms of wound size, but also in regards to wound bed appearance, drainage, edema, surrounding skin margins etc.
    - Tie your skilled interventions to the goal. For example, if you are using diathermy to increase circulation or reduce edema, be sure to document appropriate wound or limb objective changes.

3. *Goal Suggestions*

GOOD GOALS:

- Relief of pressure on bony prominences as evidenced by no new areas of pressure (redness, change in tissue consistency and/or sensation and pain) while the resident is up in chair, able to perform their normal routine of daily activity
- Decrease necrotic tissue of wound to 50% coverage from current 100% in 30 days
- Increase percentage of granulation coverage of wound from 25% to 50% in 30 days
- Decrease wound size from 10cm X 5 cm to 8 x 3 cm. in 30 days

POOR GOALS:

- Promote wound healing
- Decrease edema

In-service Outline
Wound Management Program
"The Worry about Wounds"

What is the Worry about Wounds?

- Prevalence – In 2004 as many as 11% of nursing home residents had pressure wounds. This is approximately 159,000 people.
- Consequences of Wounds
    - Pain
    - Reduced mobility and activity
    - Reduced quality of life
    - Reduced abilities to participate in the resident's activities of choice
    - Infection
    - Loss of limb

Why might residents not report the onset or presence of a wound?

- They may not have the sensation or feeling to be aware of the wound.
- They may not have the cognitive abilities to remember or be aware of the wound.
- A new resident may assume that we already know about the wound from their transfer paperwork.
- A new resident with a chronic wound may not think to notify us of their wound because they are so used to having it.
- They may not mention their wound because no one has been able to help before.

What are risk factors for wound development in a resident?

- Chronic Illness including
    - Hepatic
    - Renal
    - Cardiovascular
    - Autoimmune
    - Carcinoma
    - Diabetes
    - Systemic vascular disorders (i.e. blood supply, venous return)
- Reduced Functional Mobility through
    - Development of pressure points
    - Development of edema
- Nutritional Deficiency
    - Protein
    - Calories
    - Vitamins; A & C
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- Recent Weight Loss (Defined as weight loss of 5% or more in 30 days or loss of 10% or more in the past 180 days)
- Recent Bowel and/or Bladder Incontinence
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What should you do to help prevent wounds in our residents?

- Follow all your nursing department procedures and protocols related to skin inspection, repositioning, nurse notification, etc.
- Tell the nurse the problems you observed and ask them to document it in medical record. **Note:** The nurse needs to be your primary starting point to insure immediate action when needed in wound prevention.
- Tell the nurse and/or a member of the therapy team or leave a note (screen) in their mailbox regarding any evidence of skin pressure from devices (i.e. wc seat, leg rests etc.), pain from decreased circulation or other causes, un-controlled or un-managed edema, a change in ability to feed themselves or swallow, reduced nutrition, incontinence or recent weight loss.
- Write what you saw on the 24 hour report
- Bring it up for discussion at morning report or other patient related meeting

What can therapy do to help these residents?

- Wound modalities can reduce the wound healing time by as much as 30-50%.
- Comprehensively evaluate the resident to determine what their therapy needs are looking at prevention, healing and post healing wound remodeling for prevention of wound recurrence
- Provide treatment to reduce their pain and increase their mobility to help them be as independent and comfortable as possible
- Provide appropriate seating and recommendation for bed positioning to reduce pressure on bony prominences
- Provide treatments related to edema reduction, circulation promotion and wound healing
- Assist with the residents ability to communicate and be understood in regards to their nutritional preferences and needs for reposition etc
- Provide therapy to promote good nutrition through swallowing interventions.
- Design a strengthening, coordination and mobility program to increase the resident’s activity level

Questions?

Foundations of Function
Wound Management Program Quiz

1. Which of the following may indicate that someone is at risk for wound development?
    a. Compromised nutritional status
    b. Improper sitting or bed posture
    c. Chronic disease
    d. Recent weight loss
    e. All of the above

2. True or False – Bowel or urinary incontinence is a risk factor for wound development.

3. True of False – Older residents are at greater risk to develop wounds than younger. (Hint: It is not what you would think)

4. What should you do when you suspect that a resident is at risk for developing a wound?
    a. Wait until the wound develops
    b. Let the next shift take care of it
    c. Complain about another CNA's care
    d. Take immediate action and notify the unit nurse as well as therapy.
    e. Not A, B, or C
    f. D only
    g. Both E and F

Name:_____ Shift:_____