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Long-Term Care Survey Alert

WOUND CARE: Close Your Wound Care Protocol Vulnerabilities With 5 Strategies

One clue will help you avoid an initial big mistake.

In the wound care arena, your skin ulcer assessment and treatment protocols stand between your facility and surveyors and litigators looking to blameyou for non-healing decubiti. And to help ensure your wound care efforts promote optimal outcomes, experts recommend these key tactics.

1. Use an interdisciplinary approach to develop a wound care protocol, suggests **Mardy Chizek, MBA, BSN, RN, FNP, AAS, CLNC**, a risk-management consultant in New York City. For example, the director of nursing and medical director can collaborate with wound care experts, she suggests. In her view, the protocol should list classifications of treatment modalities rather than name trademark products. (For a sample wound-care protocol, see page 22.)

2. Obtain an accurate wound diagnosis to guide treatment. "The first big mistake" providers make is failing to note and address the wound's underlying etiology, cautions **Jenny Hurlow, GNP, CWOCN,** a geriatric nurse practitioner and wound care specialist in Memphis, Tenn. "If the ulcer is a pressure ulcer, then the first, most important treatment is to remove the pressure," says Hurlow.

"The No. 1 clue that are you not dealing with a pressure ulcer is that the ulcer isn't in a pressure area," says **Debra Bakerjian PhD, RN, FNP,** president of geriHEALTHsolutions in Sacramento, Calif. And even if it is, "consider whether that person has actually experienced excessive pressure prior to getting the ulceration." Also look at the person's diagnoses.

"If the person has cardiovascular disease, a leg ulcer could be arterial."

A diagnosis of venous disease points in the direction of venous ulcers. "Venous stasis ulcers are more obvious because they appear on the lower leg and have a more distinctive look," says Bakerjian, who has seen nurses categorize them as pressure ulcers. The ulcer has an irregular border and shape and is generally superficial (at or above the level of the subcutaneous layer), according to a wound assessment protocol developed by Hurlow.

3. Weigh carefully the choice of wound dressing. To select the right dressing, follow the principles for wound care, which include keeping the wound bed moist and clean and the surrounding tissue dry, advises Bakerjian. "Debride any eschar -- and fill excessive space," she adds. "If the wound bed is dry, you want a moist wound bed to promote healing," says Bakerjian. In that case, you can use some type of hydrogel and put a cover on it.

"If the wound is draining, then foam or calcium alginate works well. It depends also on the depth of the wound. If you have a deep wound and are also trying to provide something to take up the space, then calcium alginate is a good choice. You can put a foam or dry dressing on top of it or even a hydrocolloid." says Bakerjian. Also keep in mind that a "a more expensive dressing may actually save wound care cost down the road," says Hurlow.

One "positive rationale" for selecting advanced wound products is that you have to change them less frequently, notes **Arja Polley, BSN, RN, ET, CWON,** a wound-care expert in Lubbock, Texas. "Every time you uncover a wound, the wound temperature drops. And it takes several hours for the wound to go back to the temperature required for healing to occur," she points out.

"An alginate filler and foam cover dressing is definitely more costly than gauze filler with a gauze/tape cover," says **Dorothy Doughty, MN, RN, CWOCN, FAAN,** director of the Emory University WOC Nursing Education Center. But the alginate and foam dressing only has to be changed every two days as opposed to twice daily and PRN -- and "it provides

a waterproof cover/bacterial barrier that is critical when managing trunk wounds in incontinent patients."

Tip: Make sure to have the product literature for wound care products available and that caregivers follow the directions for different types of wounds and pressure ulcers, advises **Nancy Augustine, MSN, RN,** a consultant with PointRight Inc. inLexington, Mass.

4. Don't miss seeing the patient for the wound. Hurlow sometimes sees providers focus so much on thewound that they miss the "bigger picture." You have to consider the person's nutritional status, comorbidities, and mobility, as examples, she stresses.

Dish up the protein and calories:

"The ideal intake for patients with wounds includes 1.25 to 1.5 grams of protein/kg/day and 30 to35 calories/kg/day in order for wounds to heal," says Polley. Inadequate pain assessment and treatment can also increase physiological stress and make a person resistant to repositioning and wound care, say experts.

5. Know when to change gears.

The Centers for Medicare and Medicaid Services' interpretive guidance for F314 says to re-evaluate the wound care plan's effectiveness every two to four weeks and change it, if appropriate, says Hurlow. "Clearly, signs and symptoms of acute wound infection and/or an acute change in patient status may also be a very valid reason to reevaluate" the wound care plan.