Careplanning for Skin and Wound Care: Admissions and Revisions

Admissions
Develop and implement a comprehensive care plan that reflects each resident's identified needs. The process should include efforts to stabilize, reduce or remove underlying risk factors, to monitor the impact of the interventions, and to modify the interventions as appropriate. The facility should have a system/procedure to assure; assessments are timely and appropriate; interventions are implemented, monitored, and revised as appropriate; and changes are recognized, evaluated, reported to the practitioner, and addressed.

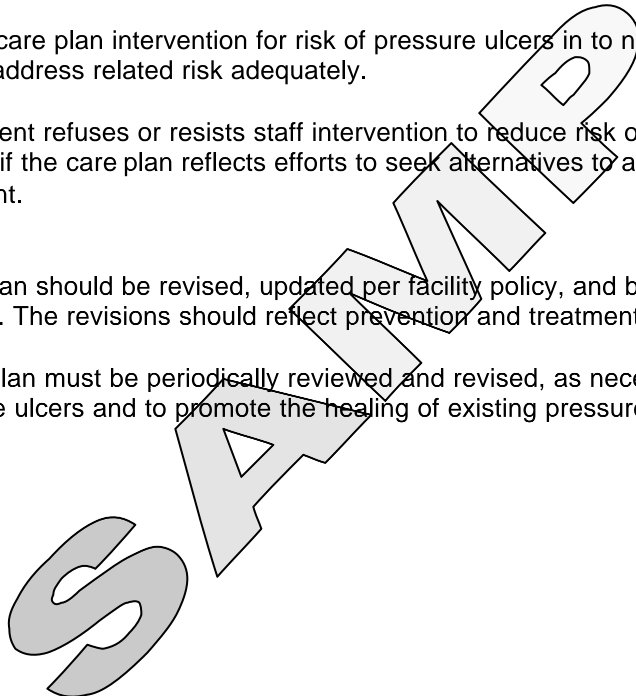
If the facility's care of a specific resident refers to a treatment protocol that contains details of the treatment regimen, the care plan should refer to that protocol. The care plan should clarify any major deviations from, or revisions to, that protocol for a specific resident.

A specific care plan intervention for risk of pressure ulcers in to needed if other components of the care plan address related risk adequately.

If the resident refuses or resists staff intervention to reduce risk or treat exiting pressure ulcers, determine if the care plan reflects efforts to seek alternatives to address the needs identified in the assessment.

Revisions
The careplan should be revised, updated per facility policy, and based on the resident's response and needs. The revisions should reflect prevention and treatment strategies specific to the resident.

The care plan must be periodically reviewed and revised, as necessary, to prevent the development of pressure ulcers and to promote the healing of existing pressure ulcers.



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Competency Validation: Wound Measurement & Documentation for the Licensed Clinician

POLICY:
- To accurately assess the clinician's skill for wound measurement and documentation.

LEVEL OF RESPONSIBILITY: RN/LPN/PT

EQUIPMENT:
1. Competency Validation: Wound Measurement and Documentation for the Licensed Clinician

PROCEDURE:
1. The Competency Validation Form specified for Wound Measurement and Documentation is initiated by an authorized "Clinical Observer*."
2. A clinical observer assesses each clinician's skills for dressing change techniques.
3. The clinical observer places a check (?) mark next to each teaching objective "MET" or "NOT MET."
4. If the teaching objective is "NOT MET," briefly explain why under the "COMMENTS" section provided on the form.
5. Upon completion of the objectives, the clinical observer reviews the teaching objectives with the clinician.
6. Both the clinical observer and clinician sign the form upon *successfully* completing all of the objectives.
7. Upon *successfully* completing all of the objectives a copy of the *completed form* is placed in the clinician's permanent file.

Suggested Documentation:
It is recommended the assessment of the clinician's skills be documented on a quarterly basis.

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To access the Competency Validation tool *Wound Management and Documentation for the Licensed Clinician*, please visit http://www.woundcarestrategies.com/shop/products.php

* "Clinical Observer" is defined as a clinician who has successfully completed the Competency Validation objectives.

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Dressings: Contact Layers, Selection and Use of

ACTION: Contact layer dressings provide an interface between the wound and the dressing; protecting the fragile healing tissue. This layer also acts as a liner for deep wounds that need to be packed, allowing for easy removal of the packing material.

INDICATIONS: Contact layer dressings are indicated to protect burns, graft sites, donor sites and granulating wounds.

CONTRAINDICATIONS: Contact layer dressings are contraindicated as debriding dressings. This dressing type will not clean or debride wounds because it is non-adherent.

INFORMATION: Contact layer dressings are indicated for partial and full thickness wounds, stage 2, stage 3 and stage 4 pressure ulcers. Contact layer dressings are generally the first layer of the dressing, which is placed directly over the wound or after the application of a topical medication. The contact layer usually consists of a non-adherent dressing material such as an ointment-impregnated or fine mesh gauze. This non-adherent layer prevents new epithelium from sticking to the dressing and from being inadvertently removed when the dressing is changed. This dressing also wicks or draws exudate or drainage away form the wound.

DETERMINATION OF PRODUCT SIZE: Dependent on size of wound.

PRODUCT/SUPPLIES:

1. Contact layer
2. Secondary dressing
3. Wound care procedure tray or cleansing policy and procedure

PROCEDURE:

1. Cleanse the wound per policy and procedure.
2. Apply the appropriate size contact layer to fragile healing tissue (before or after application of topical medications).
3. Cover with an appropriate absorbent dressing to absorb drainage.

SUGGESTED CLINICAL GUIDELINES FOR FREQUENCY OF DRESSING CHANGE:
Refer to respective manufacturer's guidelines.

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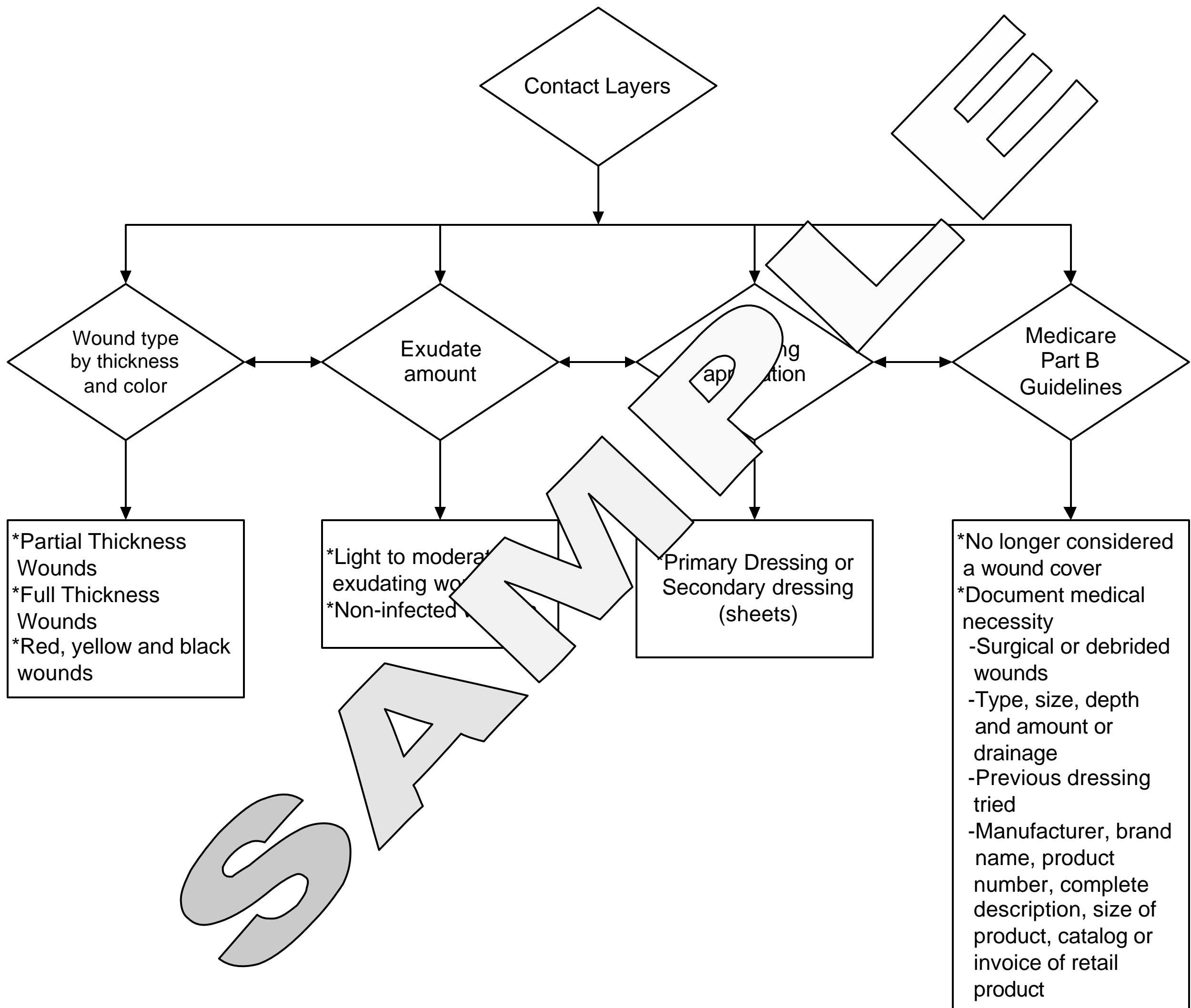
Dressings: Contact Layers Pathway



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F-Tag 309 Quality of Care[1]

Each resident must receive, and the facility must provide, the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being in accordance with the comprehensive assessment and plan of care.

Intent
The facility must ensure that the resident obtains optimal improvement or does not deteriorate within the limits of a resident's right to refuse treatment, and within the limits of recognized pathology and the normal aging process.

Definitions
Highest practicable is defined as the highest level of functioning and well-being possible, limited only by the individual's presenting functional status and potential for improvement or reduced rate of functional decline. Highest practicable is determined through the comprehensive resident assessment by competently and thoroughly addressing the physical, mental or psychological needs of the individual.

Skin Ulcer/Wound
Skin ulcer definitions are included to clarify clinical terms related to skin ulcers. At the time of the assessment and diagnosis, the clinician is expected to document the clinical basis, which permits differentiating the ulcer type, especially if the ulcer has characteristics consistent with a pressure ulcer, but is determined not to be one.

Arterial Ulcer
This is an ulceration that occurs as the result of arterial occlusive disease when non-pressure related disruption or blockage of the arterial blood flow to an area causes tissue necrosis. Inadequate blood supply to the extremity may initially present as intermittent claudication. Arterial/Ischemic ulcers may be present in individuals with moderate to severe peripheral vascular disease, generalized arteriosclerosis, inflammatory or autoimmune disorders, or significant vascular disease elsewhere. The arterial ulcer is characteristically painful, usually occurs in the distal portion of the lower extremity and may be over the ankle or bony areas of the foot. The wound bed is frequently dry and pale with minimal or no exudates. The affected foot may exhibit: diminished or absent pedal pulse, coolness to touch, decreased pain when hanging down or increased pain when elevated, blanching upon elevation, delayed capillary fill time, hair loss on top of the foot and toes, toenail thickening.

Diabetic neuropathic ulcer:
This requires that the resident be diagnosed with diabetes mellitus and have peripheral neuropathy. The diabetic ulcer characteristically occurs on the foot, at mid-foot, at the ball of the foot over the metatarsal heads, or on top of toes with Charcot deformity.

Pressure Ulcers:
Addressed under Tag F-314.

Venous Insufficiency Ulcer:
This is an open lesion of the skin and subcutaneous tissue of the lower leg usually occurring in the pretibial area of the lower leg or above the medial ankle. Venous ulcers are reported to be the most common vascular ulceration and may be difficult to heal, may occur off and on for several years, and may occur after relatively minor trauma. The ulcer may have a moist, granulating wound bed, may be superficial, and may have minimal to copious serous drainage unless the wound is infected.

[1] Information references from The Long Term Care Survey, March 2005 Edition published by American Health Care Association.

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The resident may experience pain, which may be increased when the foot is in a dependent position, such as when the resident is seated with her or his feet on the floor. Recent literature implicates venous hypertension as a causative factor. In the past, the ulceration was believed to be due to the pooling of blood in the veins.

Venous hypertension may be caused by one or a combination of factors including loss of valve function in the vein, partial or complete obstruction of the vein, and/or failure of the calf muscle to pump the blood. Venous insufficiency may result in edema and induration, dilated superficial veins, cellulites in the lower third of the leg or dermatitis. The pigmentation may appear as darkening skin, tan or purple areas in light skinned residents and dark purple, black or dark brown skinned residents.

In any instance in which there has been a lack of improvement or decline, the facility must determine if the occurrence was unavoidable or avoidable. An unavoidable determination can only be made if the following are present:

- An accurate and complete assessment;
- A care plan that is implemented consistently and based on information from the assessment; and
- Evaluation of the results of the interventions and revising the interventions as necessary.

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Support Surface: Chair Cushion and Mattress Overlay, Selection and Use of

Policy:

- **Chair Cushions**
  Uninterrupted sitting by at-risk individuals in chairs or wheelchairs should be avoided. If consistent with overall patient management goals, the individual should be repositioned, shifting the points under pressure at least every hour or be placed back in bed. Individuals who are able to move should be taught to shift weight every 15 minutes. For individuals who sit in wheelchairs or on other sitting surfaces, the use of a pressure reducing device such as those made of foam, gel, air or combination is indicated. But, do not use donut-type devices.

- **Static Air Mattress Overlay**:
  The static air mattress overly is used to prevent skin breakdown on the high risk resident and/or provide pressure relief for those resident with actual skin breakdown, in accordance with the physician's order.

- **Alternating Mattress Overlay**:
  The alternating mattress overlay is used to prevent skin breakdown on the high risk resident and/or provide pressure relief for those residents with actual skin breakdown, in accordance with the physician's order.

Level of Responsibility: Physician/RN/LPN/PT

Equipment:

1. Specialty product per facility 's protocol.

Contraindications:

2. Refer to specific manufacturer's guidelines.

Guidelines for Use:

1. The use of a chair cushion or specialty bed product does not negate the need to turn and reposition the patient at least every two hours. This will assist in maintaining the bowel, bladder and respiratory functions.
2. General maximum weight limitation for overlays is 250 lbs.
3. Refer to specific guidelines of each product for further information.

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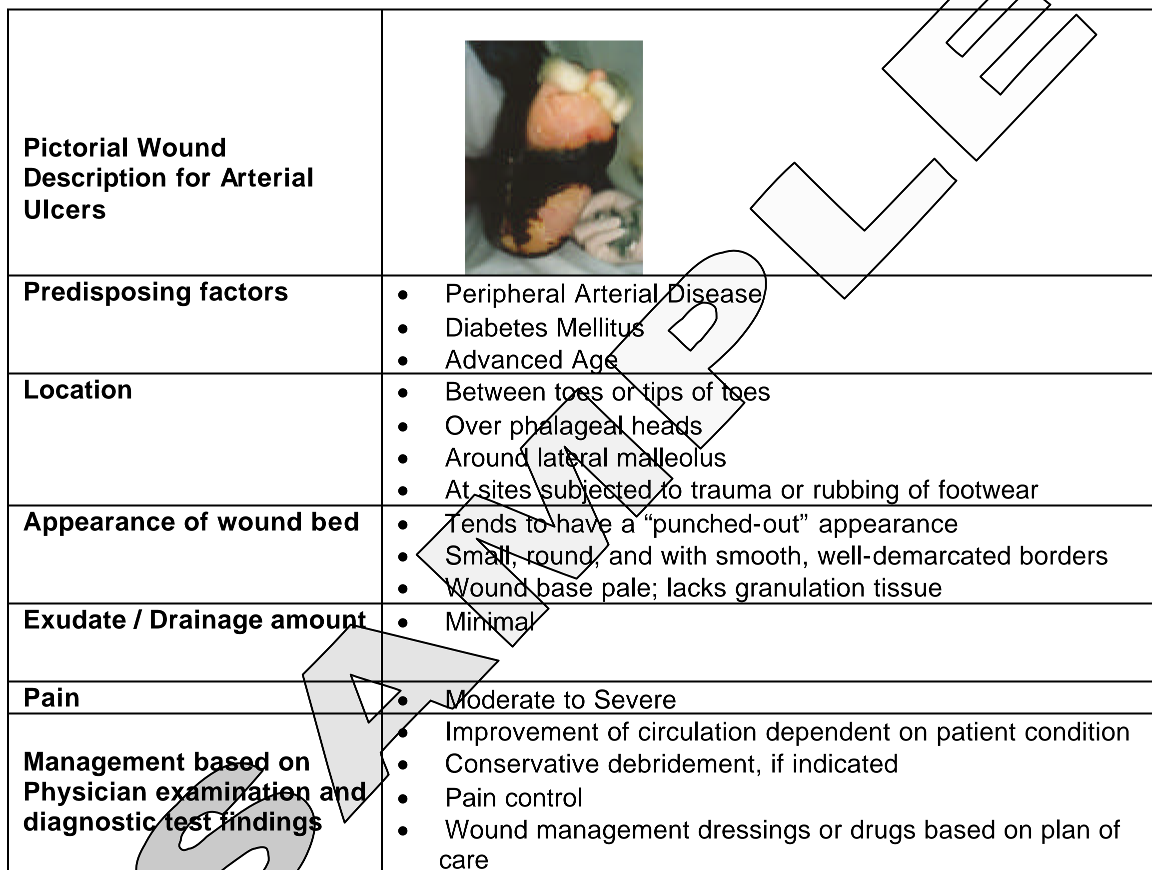
Appendix B: Arterial Ulcers

Pictorial Wound Description for Arterial Ulcers	
Predisposing factors	• Peripheral Arterial Disease • Diabetes Mellitus • Advanced Age
Location	• Between toes or tips of toes • Over phalageal heads • Around lateral malleolus • At sites subjected to trauma or rubbing of footwear
Appearance of wound bed	• Tends to have a "punched-out" appearance • Small, round, and with smooth, well-demarcated borders • Wound base pale; lacks granulation tissue
Exudate / Drainage amount	• Minimal
Pain	• Moderate to Severe
Management based on Physician examination and diagnostic test findings	• Improvement of circulation dependent on patient condition • Conservative debridement, if indicated • Pain control • Wound management dressings or drugs based on plan of care

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Quick Reference: Interpretive Guidelines F-Tag 314

F-Tag	Description	Change as of November 12, 2004	Clinical Comments	Clinical Tips
F314 Pressure Sores	Based on the Comprehensive Assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable.	The intent of this requirement is that the resident does not develop pressure ulcers unless clinically unavoidable and that the facility provides care and services.	• **Definition of "avoidable"** means that the resident developed a pressure ulcer and the facility did not do one or more of the following: evaluate the resident's clinical condition and pressure ulcer risk factors; define and implement interventions that are consistent with the residents needs, resident goals, and recognized standards of practice; monitor and evaluate the impact of the of the interventions; or revise the interventions as appropriate. • **Definition of "unavoidable"** means that the resident developed a pressure ulcer even though the facility had evaluated the resident's clinical condition and pressure ulcer risk factors: defined and implemented interventions that are consistent with resident needs, goals, and recognized standards of practice; monitored and evaluated the impact of the interventions; and revised approaches as appropriate.	• Wound management team and guidelines to support the team's purpose. • Documentation guidelines for skin and wound care • Develop Comprehensive Care Plans which identifies risk, monitors impact of interventions and modifies interventions as appropriate (F279 and F280). • Wound/Skin Team Assessment/Reassessment Recommendations Form. • Wound and Skin Care Products Formulary Development: Dressings and Prescription Products. • Formulary Development for Off-Loading Devices and Support Surfaces. • Wound Care Protocols Formulary Exceptions: Policy and Procedure. • Educational Activities offered through contracted vendors. • Wound/Skin Team Rounds Protocol; Wound/Skin Team Members Responsibilities. • Change in Wound/Skin Status Memorandum Report • Significant Change in Status Report for Labs, Weights, Wounds, Skin Conditions. • Educational Developmental Wound and Skin Care Plan for Physicians and Clinicians. **Management Guidelines:** • Design and develop policies and procedures for implementation plan.

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