NYSHFA PRESENTS
WOUND PREVENTION AND CARE:
DOCUMENTATION THAT MEETS THE
FEDERAL GUIDELINES,
STANDARDS OF CARE AND BEST PRACTICES

Pamela Scarborough
PT, DPT, MS, CDE, CWB, CEEAA
Director of Public Relations & Education
American Medical Technologies
Irvine, CA

Notations

NPUAP  National Pressure Ulcer Advisory Panel
CMS  Centers for Medicare & Medicaid Services
SOM  State Operations Manual
MDS 3.0  Minimum Data Set, 3.0: M-Section

Clinical Pearl

Challenges??

What kind of documentation challenges do you have?
• Prevention of pressure ulcers?
• Accurate diagnosis of wound etiologies?
• Accurate patient and wound assessment?
• Consistent treatment over the different shifts?
• Up to date wound care practices?

State Operations Manual

• CMS State Operations Manual (SOM) - a guide for what you do in clinical practice
• SOM reflects current evidence based practice
• Prevention and treatment of PrUs gets lots of attention from CMS
• Taken from current wound care research and practice
• Can find and download at: http://www.cms.gov/CFCsAndCoPs/Downloads/som107ap_pp_guidelines_ltcf.pdf

Disclaimer

The information presented herein is provided for educational and informational purposes only. It is for the attendees’ general knowledge and is not a substitute for legal or medical advice. Although every effort has been made to provide accurate information herein, laws change frequently and vary from state to state. The material provided herein is not comprehensive for all legal and medical developments and may contain errors or omissions. If you need advice regarding a specific medical or legal situation, please consult a medical or legal professional. Gordian Medical, Inc. dba American Medical Technologies shall not be liable for any errors or omissions in this information.

Copyright © 2014 Gordian Medical, Inc. dba American Medical Technologies
www.amtwoundcare.com
CMS-Surveyors

- Often times surveyor sees a facility acquired pressure ulcer as a failure of your systems and care for pressure ulcer prevention
- The ONLY way to show the surveyor differently is in the quality of your documentation

Surveyor’s Directions on Records Review

- Surveyors will review the following documentation
  - Physician’s orders
  - Progress notes
  - Nurses notes
  - Pharmacy or dietary notes
  - Risk factors assessment instrument
  - Mobility
  - Associated medical conditions
  - Wound site documentation
  - Wound characteristics
  - Wound treatment interventions
  - Wound progress and complications
- In addition
  - Surveyors will interview
    - Staff at all levels including the medical director
    - Resident
    - Family

Intent of F314

- Well organized PrU prevention program reduces facility acquired PrU...only unavoidable PrU occur
- Caregivers competent
- Limited exclusively to PrUs
- Other wounds (arterial, venous, diabetic, etc.) are grouped under F309, the regulation for Quality of Care
- Critical for practitioners to accurately perform a differential diagnosis of chronic wounds

Pressure Ulcer Resources

- NPUAP/EPAP Pressure Ulcer Prevention and Treatment: Clinical Practice Guideline 2009
- NPUAP.org
  - Quick Reference Guide free
  - Fee for full version of Guideline
- AMDA Clinical Practice Guidelines for Pressure Ulcers-2011
  - www.amda.com or 800.876.2632 to order

Establish a risk assessment policy in all health care settings (Strength of Evidence = C)

Each health care setting should have a policy in place that includes clear recommendations for:
- structured approach to risk assessment relevant to that health care setting;
- clinical areas to be targeted;
- timing of risk assessment and reassessment;
- documentation of risk assessment;
- communication of that information to the wider health care team.
Risk Assessment and POC

Risk assessment

Document and address each risk in the resident’s plan of care

Braden Parameters

<table>
<thead>
<tr>
<th>Sensory Perception</th>
<th>Moisture</th>
<th>Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>4. No Limitations</td>
<td>4. Rarely Moist</td>
<td>Occasionally</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Mobility</th>
<th>Nutrition</th>
<th>Friction &amp; Shear</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Completely Immobile</td>
<td>1. Very Poor</td>
<td>1. Problem</td>
</tr>
<tr>
<td>3. Slightly Limited</td>
<td>3. Adequate</td>
<td>Problem</td>
</tr>
<tr>
<td>4. No Limitations</td>
<td>4. Excellent</td>
<td>3. No Apparent</td>
</tr>
</tbody>
</table>

Low Blood Pressure

- Systolic BP below 100 mmHg – associated with PrU development
- Hypotension may shunt blood flow away from the skin to more vital organs
- Decreasing the skin tolerance for pressure by allowing capillaries to close at lower levels of interface pressure
- Water hose

Ensure Your Braden Done Correctly!!!

- Do Braden as if you haven’t seen resident before
- Do not copy others’ Braden
- Advance to next level of risk when:
  - Diastolic BP < 60
  - Systolic BP < 100
  - Advanced age, poor dietary intake of protein
  - Other complicating factors
  - Remember to do sensation on feet of people with DM
- Document ALL complicating factors

Braden Score: 
Braden Risk:
Advanced to next level of risk due other major risk factors:
☐ Yes   ☐ No  See page 2 Complicating Factors

REPOSITIONING DOCUMENTATION

- Record repositioning regimes
- Frequency & position adopted
- Evaluation of outcome of repositioning regimen
Critical Steps: PrU Prevention & Healing

- Identify individuals at risk
- Identify & evaluate risk factors
- Implement interventions to stabilize, reduce/remove risk factors
- Monitor the impact of interventions
- Identify and evaluate changes in condition
- Identify and evaluate factors removed or modified

Wound Etiologies

- Pressure Ulcers
- Peripheral Arterial Disease (PAD)
- Venous Insufficiency
- Diabetic Neuropathic Foot Ulcer
- Lymphedema

Most Common Chronic Wound Etiologies

- Pressure Ulcer
- Peripheral Arterial Disease (PAD)
- Venous Insufficiency
- Diabetic Neuropathic Foot Ulcer
- Lymphedema

Wound Dehiscence

- Surgical complication
- Wound ruptures along surgical incision site
- Common risk factors:
  - age
  - diabetes
  - obesity
  - poor closure technique
  - trauma to the wound after surgery
  - infection

Moisture Associated Skin Damage

- Urinary + Fecal Incontinence

Pressure Ulcers
NPUAP Pressure Ulcer Definition

**NPUAP: 2009**

“A pressure ulcer is localized injury to the skin and/or underlying tissue, usually over a bony prominence that results from pressure (including pressure associated with shear).”

---

**Pressure Ulcers**

- PrU formation influenced by:
  - Amount of pressure
  - Duration of pressure
  - Severity of shearing forces

- Compounding factors:
  - Nutritional deficiencies
  - Immobility
  - Decreased immunity
  - Excessive moisture

---

**Shear Forces**

- Primary effects of shear occur at deep fascial level of tissues over bony prominences
- Manifests clinically as large area of undermining which extends circumferentially
- Vascular occlusion is enhanced if shear and pressure are together

---

**CMS: Unavoidable Pressure Ulcers F314**

- Resident developed a pressure ulcer even though the facility:
  - Evaluated the resident’s clinical condition and 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
  - Revised interventions as appropriate

- The ONLY way you “prove” there is an unavoidable pressure ulcer is through your **documentation**
- The practitioner MUST validate the unavoidable PrU in their medical documentation

---

**CMS: Avoidable Pressure Ulcers F314**

- 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 resident needs, goals, and recognized standards of practice
  - Monitor and evaluate the impact of the interventions
  - Revise the interventions if appropriate

- Without adequate documentation of reasons pressure ulcer unavoidable…facility will get an F314 citation

---

**Etiology**

<table>
<thead>
<tr>
<th>Etiology</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pressure</td>
</tr>
<tr>
<td>Arterial</td>
</tr>
<tr>
<td>Surgical</td>
</tr>
<tr>
<td>Venous</td>
</tr>
<tr>
<td>Neuropathic</td>
</tr>
<tr>
<td>Other</td>
</tr>
<tr>
<td>Mixed (describe)</td>
</tr>
</tbody>
</table>

- Plan of care will be specific for etiology identified
- If etiology incorrect...treatment plan will address reason wound developed
- Outcomes poor
Depth of Tissue Destruction/Injury

**Non-PrU:**
- Partial
- Full Thickness

**PrU:**
- Stg I
- Stg II
- Stg III
- Stg IV
- sDTI

**Unstageable:** (check reason below)
- Non-removable dressing/device
- Slough/eschar; Deep tissue injury

---

Classification of Wounds by Tissue Destruction

- Cause something other than pressure
  - **Partial thickness:** limited to epidermis & upper portion of dermis
    - Heals by regeneration
    - No scar tissue
    - No slough
    - No granulation tissue
  - **Full-thickness:**
    - Extends through epidermis & dermis
    - May involve subcutaneous tissue, muscle or bone
    - May have slough/eschar
    - Granulation tissue

---

Pressure Ulcer Stages

- **Stage 1**
- **Stage 2**
- **Stage 3**
- **Stage 4**

---

NPUAP Staging

- **Suspected Deep Tissue Injury**
- **Unstageable**

---

Documentation of Daily Monitoring

- Pain Assessment
- Eval of Ulcer
- Eval Dressing Status
- Periwound Status
- Possible Complications

---

Not ALL Wounds are Pressure Ulcers
Wound Recognition
Is It REALLY a Pressure Ulcer?

- Critical for appropriate interventions
- Multitude of etiologies that cause ulcerations of the skin
- See Guidance to Surveyors at 42 CFR 483.25 (F309) for definition and description of ulcer types other than pressure ulcers
- MDS 3.0, M-Section recognizes and expects correct etiology to be coded

Most Common Wound Etiologies

- Pressure Ulcer
- Venous Insufficiency
- Peripheral Arterial Disease (PAD)
- Diabetic Neuropathic Foot Ulcer
- Lymphedema

Treatments Driven by Diagnosis

Venous Insufficiency Ulcers

- Wound may start due to minor trauma
- Usual location is lower leg area or medial or lateral malleolus
- Characterized by:
  - Irregular wound edges
  - Hemosiderin staining
  - Leg edema
- Pathophysiology is incompetent valves

Ankle Brachial Index (ABI) in Wound Prevention and Care

- Tells if foot & leg at higher risk for chronic wounds if wounded
- Tells if enough blood flow for wound healing
- Tells whether compression safe
- Gives information for referral for higher vascular studies

Treatment for Chronic Venous Insufficiency

- Compression
- Optimal wound bed preparation
- Appropriate dressing selection
- Optimal calf pump function
  - Ambulation/calf muscle strengthening
  - Normal ankle ROM
  - Calf pump exercise for non-ambulatory
- Diaphragmatic breathing
- Elevation
- Lifetime maintenance compression garments
- NOT TED HOSE!!
Arterial Ulcers

- Wound may start due to minor trauma.
- Usual location:
  - Toes
  - Top of foot
  - Distal to lateral malleolus

Item M1040 & M1200
Other Ulcers, Wounds and Skin Problems
Skin and Ulcer Treatments

M1040B Diabetic Foot Ulcers

B. Diabetic foot ulcer(s)

M1040D Open Lesions Other than Ulcers, Rashes, Cuts

D. Open lesion(s) other than ulcers, rashes, cuts (e.g., cancer lesion)

Is it an Atypical Wound?

- Necrotizing Fascitis
- Pyoderma Gangrenosum
- Malignant Melanoma
- Basal cell carcinoma
- Bullous Pemphigoid
- Lupus

M1040E Surgical Wounds

E. Surgical wound(s)

- Failed Flap

Other Problems
Diabetes and Wound Healing

- Diabetes interferes with all 4 phases of wound healing
- Hyperglycemia many cells from doing their job
  - Neutrophils
  - Macrophages
  - Fibroblasts
- Prevents adequate collagen synthesis
- Glucose control of paramount importance with residents who have wounds and diabetes
- Track and document blood glucose
- Correlate to what’s happening related to healing

Blood Glucose Control for Optimal Wound Healing

- < 200 mg/dl: Protein Synthesis
- < 180 mg/dl: Neutrophils

M1040F Burns

- F. Burn(s) (second or third degree)

Diabetic Neuropathic Foot Ulcers

- Do NOT include pressure ulcers that occur on residents with diabetes mellitus here.
- For example, an ulcer caused by pressure on the heel of a diabetic resident is a pressure ulcer and not a diabetic foot ulcer.
Practice Point

- There is confusion around wounds on lower extremity in patients/residents with DM
- These wounds are often mis-categorized as “diabetic wounds”
- In reality often these are wounds due to pressure related to immobility...
- PAD and DM are contributing comorbidities, causing the skin to be more susceptible to pressure injury
- Correct DX critical to initiate appropriate POC

Lymphedema Definition

- Chronic condition
- Characterized by abnormal collection of fluid (lymph)
- Resulting in swelling (edema)
- Result of anatomical alteration in the lymphatic system
- Lymphatic system connect to every system of the body except the CNS and the cornea of the eye

Assessment Pearl

*****STEMMER SIGN*****

Stage 1
- Reversible- elevation
- Pitting edema, begins distally at foot
- Negative or borderline Stemmers
- No palpable fibrosis or secondary tissue changes

Stage 2
- Minimal pitting or nonpitting edema; not reduced by elevation
- Positive Stemmer sign
- Pronounced fibrosis
- Hyperkeratosis (thickening of skin)
- Papillomatosis (cobblestone appearance & texture)
- Frequent infections - cellulitis

Stage 3
- Lymphostatic Elephantiasis
- Accumulation of protein rich edema fluid
- Non pitting Fibrosis & sclerosis
- Severe induration
- Skin changes - papillomas, hyperkeratosis, etc.)
Venous Insufficiency & Lymphedema
AKA Phlebolymphedema

Lymphedema Interventions

- Manual lymph drainage (MLD)
- High levels compression -40-60mmHg
- Skin and nail care
- Exercise
  - Calf pump
  - Breathing
- Education

Wound Documentation

When to Document

- Initial intake
- Daily notes
- Weekly progress notes
- Weekly skin reports
- Change in treatment plan
- Signs or symptoms of infection
- Change in condition of patient/resident
The Form

- Compare your facility’s wound documentation form with documentation recommendations from current best practices, F314, MDS-M-Section and NPUAP guidelines.

- This form was created specifically for LTC taking into consideration federal mandates (F314, F309 [survey process], and MDS 3.0-M Section) and current standards of wound care and best practices.

Document Location Correctly

LOCATION: (Describe anatomically: i.e. L-trochanter)

Describe location correctly using anatomical medical terminology

<table>
<thead>
<tr>
<th>Specific Terms</th>
<th>Less Specific Terms</th>
</tr>
</thead>
<tbody>
<tr>
<td>R-ischium</td>
<td>R-buttock</td>
</tr>
<tr>
<td>R-lateral malleolus</td>
<td>R-ankle</td>
</tr>
<tr>
<td>L-trochanter</td>
<td>L-hip</td>
</tr>
</tbody>
</table>

Location

- Document in reference to head, front or back
- Commonly used terms
  - Proximal, distal
  - Superior, inferior
  - Medial, lateral
  - Anterior, posterior
  - Dorsal, plantar

  - Remember left/right

Measurement

Measurements (cm)

<table>
<thead>
<tr>
<th>L cm</th>
<th>W cm</th>
<th>D cm</th>
</tr>
</thead>
</table>

If utd, describe why:

Undermining or Tunneling (cm)

<table>
<thead>
<tr>
<th>U/T cm @ o'clock</th>
</tr>
</thead>
<tbody>
<tr>
<td>U/T cm @ o'clock</td>
</tr>
</tbody>
</table>
**Exudate**

**Exudate**

- Amount: None, Scant/Min, Mod, Heavy/Copious
- Consistency: Serous, Sanguineous/Bleeding
- Color*: None, Min; Mod, Strong/Foul

*Assess after dressing removal & cleansing

**Reasons drainage may increase:**
- Infected
- After sharp or surgical debridement
- When using collagenase

**PS: Drainage drives dressing decisions.**

---

**Wound Measurement**

**Document Wound Measurements:**

**Depth:** Distance from visible surface to deepest point in wound base not covered with necrotic tissue

**NOTE:** Do not record depth if not able to see TRUE base of wound. Use unstageable designation.

**QUANTIFYING WOUND EXUDATE**

<table>
<thead>
<tr>
<th>Status</th>
<th>Indicators: Based on a 24-hour observation period</th>
</tr>
</thead>
<tbody>
<tr>
<td>None/Dry</td>
<td>Wound bed is dry; there is no visible moisture and the primary dressing is unmarked; dressing may be adherent to wound.</td>
</tr>
<tr>
<td>Scant/Small/Minimal</td>
<td>Small amounts of fluid are visible when the dressing is removed; the primary dressing may be marked up to 25%, but strikethrough (or saturation through the dressing) is not occurring; in many cases, this is the goal of exudate management. Wound bed glistens. Routine dressing changes fully control the exudate.</td>
</tr>
<tr>
<td>Moderate</td>
<td>Routine and appropriate dressing changes show that the drainage has met the dressing’s absorptive ability without saturating or leakage; may cover 20% to 75% of the dressing.</td>
</tr>
<tr>
<td>Large/Heavy</td>
<td>Dressings are saturated with changes at routine intervals; exudate is uncontrolled and freely expressed. More than 75% of the dressing is covered by drainage.</td>
</tr>
</tbody>
</table>

---

**Wound Measurement**

**Tunneling**

A single pathway that may extend in any direction

**Undermining**

Tissue destruction that occurs to the underlying intact skin adjacent to the wound margins. Formation of a "shell" of healthy, intact tissue over an area of dead space and/or necrotic tissue.

**Shelf under edge of wound**
Wound Bed

<table>
<thead>
<tr>
<th>Wound Bed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tissue Type/Color &amp; percent</td>
</tr>
<tr>
<td>Dermal Base (Pink/Red + Partial or Total)</td>
</tr>
<tr>
<td>a. Granulation: %</td>
</tr>
<tr>
<td>b. Pink, Red, Healthy</td>
</tr>
<tr>
<td>c. Pale, Pink/Red: hypergranulation tissue</td>
</tr>
<tr>
<td>d. Hydropneumocutaneous</td>
</tr>
<tr>
<td>e. Red, Fibrinous (inflamed) and/or Dusky</td>
</tr>
<tr>
<td>f. Necrotic: %</td>
</tr>
<tr>
<td>g. Slough (white/yellow/gray)</td>
</tr>
<tr>
<td>h. Eschar (intact/stable)</td>
</tr>
<tr>
<td>i. Eschar (unstable/fluctuant/muddy/boggy)</td>
</tr>
<tr>
<td>j. Other (e.g. tendon/muscle/bone)</td>
</tr>
</tbody>
</table>

All Granulation Tissue is NOT Created Equal

- Healthy granulation tissue
- Unhealthy, friable granulation tissue in infected wound
- Hypergranulation tissue

Document Necrotic Tissue
Describe Amounts and Locations in Wound Bed

Pain

<table>
<thead>
<tr>
<th>Pain</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. None</td>
</tr>
<tr>
<td>b. Yes: Intensity Rating (1-10), ________</td>
</tr>
<tr>
<td>Location:</td>
</tr>
<tr>
<td>Chronic wound pain</td>
</tr>
<tr>
<td>Cyclic acute wound pain (e.g., dressing change)</td>
</tr>
<tr>
<td>Noncyclic acute wound pain (e.g., debridement)</td>
</tr>
<tr>
<td>Frequency:</td>
</tr>
<tr>
<td>Local/systemic: Rx?</td>
</tr>
<tr>
<td>a. None</td>
</tr>
<tr>
<td>b. Yes (Describe Rx)</td>
</tr>
</tbody>
</table>

CMS and Wound Related Pain

- F314
- Pain, if present: nature and frequency (e.g., whether episodic or continuous);
**Wound Related Pain Experiences**

- **Chronic Wound Pain**
  - Absence of manipulation
  - May be continuous/intermittent

- **Cyclic Wound Pain**
  - Periodic acute wound pain
  - Regular repetitive treatments (i.e. dressing change)

- **Noncyclic Wound Pain**
  - Provoked by more sporadic procedures (i.e. sharp debridement)

**Infection/Critical Colonization**

- None or n/a
- Yes, the following noted:
  - Localized s/s:
    - Systemic s/s:
      - Non-healing
      - Exudate
      - Red/Blue
      - Debris
      - Smell/Odor
      - New onset of pain
      - Erythema/Edema
      - Pain > than expected
      - Smell/Odor
      - Culture:
      - Biopsy:

*Indicate localized or systemic Rx if 3 or more criteria noted per NERDS or STONES tax*

**Describe Wound Edges / Periwound**

<table>
<thead>
<tr>
<th>Wound Edges/Margins</th>
<th>Periwound Tissues</th>
</tr>
</thead>
<tbody>
<tr>
<td>Edge epithelializing</td>
<td>Intact/Uninvolved tissues</td>
</tr>
<tr>
<td>Flash w/wound base</td>
<td>Macerated</td>
</tr>
<tr>
<td>Edge attached to base</td>
<td>Inflamed/Erythematic</td>
</tr>
<tr>
<td>Edge not attached to base</td>
<td>Indurated/Firm</td>
</tr>
<tr>
<td>Well defined wound edges</td>
<td>Necrosis/Boggy Issue</td>
</tr>
<tr>
<td>Irregular wound edges</td>
<td>Excoriation/Debridement</td>
</tr>
<tr>
<td>Epiboly/Rolled</td>
<td>Deep red/purple hue (SOTI)</td>
</tr>
<tr>
<td>Hyperkeratotic (callous)</td>
<td>Sclerotic tissue</td>
</tr>
<tr>
<td>Fibrotic, scarred</td>
<td>Other-eg weeping, dry, rash, blister</td>
</tr>
</tbody>
</table>

**Mandated Weekly or Dressing Change Monitoring**

- Classification/etiology
- Anatomic location
- Size
- Appearance of wound bed/base
- Wound Edges
- Periwound
- Drainage/Odor
- Pain, tenderness, itching
Perform and Document Wound Care Interventions that are Current Evidence-Based or Best Practices!!!

Copyright © 2014 Gordian Medical, Inc. dba American Medical Technologies. www.amtwoundcare.com 18

F314 – Documentation Assessment & Treatment of PrU(s)
See Page 2 of Wound Assessment Form
• Each existing pressure ulcer be identified
  • Whether present on admission or developed after admission
• Document factors that influenced the PrU development
• Potential for development of additional ulcers
• Factors causing deterioration of the pressure ulcer(s) be assessed and addressed
• New pressure ulcer suggests a need to reevaluate the adequacy of the plan for preventing pressure ulcers

Copyright © 2014 Gordian Medical, Inc. dba American Medical Technologies. www.amtwoundcare.com 19

Complicating Factors

Copyright © 2014 Gordian Medical, Inc. dba American Medical Technologies. www.amtwoundcare.com 20

Other Clinically Complicating Factors / Other Comments

Copyright © 2014 Gordian Medical, Inc. dba American Medical Technologies. www.amtwoundcare.com 21
M1200 Skin and Ulcer Treatments

Wound Care Interventions

Debridement
Manage Bioburden Inflammation
Dressings

Topical or Systemic Treatments
Cellular Biology
Bioengineered Tissue
PDGF

Pressure Redistribution
Negative Pressure Electrical Stimulation
Hyperbaric Oxygen
Other Biophysical Agents

Other Interventions:
• NPWT
• Other modalities/interventions:

Documenting Interventions
• Document your interventions so someone can follow your treatment even if they have never seen the resident/patient before

The MDS 3.0, M-Section
• The MDS does NOT take the place of clinical documentation from a:
  • Resident/patient assessment
  • Wound assessment
  • Treatment interventions
• It is a reporting document

Therapeutic Goals Example

Therapeutic Goals/Clinical Rationale
1. Decreased wound size by _____ cm 2/weeks
2. Decreased necrotic tissue to 50% in 2/weeks
3. Increased granulation tissue to 50% in 2/weeks
4. Decrease odor to none
5. Decrease pain from 7 to 3 during dressing changes
Short Term Goal Suggestions

- Decrease wound size by ________ cm
- Increase granulation tissue to ________%
- Decrease necrotic tissue to ________%
- Decrease edema ________ grade (pitting)
- Decrease drainage to ________ (small, moderate)
- Decrease odor ________ (min, mod)
- Decrease undermining or tunneling ________
- Educate patient/staff/family regarding ________
- Assess efficacy of pressure redistribution devices, off-loading of heels, positioning, etc

Long Term Goals Suggestions

- Wound closure in 6 wks
- Functional nutrition/hydration status maintained for wound prevention and healing
- Staff/family/resident safe and competent in protecting and preventing reoccurrence

Dressing Change Protocol Example

**Dressing Change Protocol:**

1. Cleanse wound with normal saline/wound cleanser
2. Rinse wound base with calcium alginate
3. Cover alginate with bordered foam
4. Change dressing 3X/wk

Reference Recommendations:

- Vascular consult
- Nutrition consult
- Infectious disease
- Psych/counseling-resident/family
- PT, OT, SL: Other ________

Wound documentation should be:

- Objective
- Descriptive

- Some one else should be able to visualize the wound based upon your description
- Federal mandates for prevention & treatment of pressure ulcers help drive documentation and reporting

References

- RA/MDS 3.0, M-Section
THANK YOU!!!