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- News/Archive
- Current Issue
- About Us
- Advertise
- Industry FAQs
- Subscribe
- Classifieds
- Resources
- Glossary
- Industry Directory



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Wound Care Feature: Get it in writing

James M. Berklan, July 14 2005



Revised wound care guidelines place more emphasis on initial assessments and individualized care plans for residents. They also require new plans when progress doesn't occur.

As treatment options and regulations have expanded, so has the documentation need for care teams trying to deliver wound care. Nancy DeFranco can look back with a bit of a wry grin now, but there was nothing funny about it when it was happening.

A veteran director of nursing, DeFranco was incensed over the wound-opening rate at her facility, Little Flower Manor Diocese of Scranton, in Wilkes-Barre, PA. "We were having areas open up a few weeks after admission. I'm all over my staff, thinking their interventions are not in place, that they're not moving people properly," she recalled. "We later found that 99% of our residents coming from the hospital had fluid under the skin not visible to the naked eye. But the damage was done. If you didn't put certain measures into place, an area would open up and then you would have problems."

With pressure ulcers, all kinds of challenges are possible, of course. For residents. From family members. Surveyors. Lawyers. Insurers.

DeFranco got around some of her problems by taking a chance on a relatively new piece of technology: a portable ultrasound scanner that can detect pre-emergent wound beds and other trouble spots. She said a one-month test period eventually led to the outright purchase of a unit about three years ago.

"If you look at the cost of it up front, it will stop you," she said. "However, if you look at the potential of what it can do, I don't see why you wouldn't have the equipment in a facility."

Within a year of buying the ultrasound scanner, Little Flower recouped its investment of about \$30,000 -- on treatment-product savings alone, DeFranco said. (The scanners also can be leased for about \$600 per month.)

Such innovations may be a wave of the future, not only with regard to wound and skin care but also the all-important information gathering around it.

For example, Longport Inc.'s Episcan I-200 handheld Doppler scanner will record a history of residents' scans electronically. The soft savings in note-taking and filing alone can be substantial.

And that is what providers are looking for in this age of increased regulation. With new F-tag guidelines for wound care out and new incontinence guidelines expected at press time, documentation has become a bigger concern than ever before.

Telling the story

"Documentation is definitely going to be more critical," said Jay Heitz, the long-term care systems director for Healthpoint LTD, which produces drugs to treat wounds.

Experts have numerous recommendations on how to handle the new data loads, as well as surveyors.

Many providers simply have to make sure they fully note what they've been doing. "The good news is most of the good nursing homes are doing so much, they take it for granted and aren't articulating it in their nursing notes," said Patrick Swindell Tyson, a national accounts manager with Smith & Nephew. "Now they're going to have to show their plan is based on assessments and determinations of what intervention is needed. The documentation needs to support what they're doing. They've taken something that may have been a mystery, if you will, and are bringing it down to a science."

Nurses, including aides, will have to be able to intelligently discuss care plans. With the revised F-314 now in play, that's going to mean more individualized assessments, re-assessments and treatment plans. Further plans have to be changed if a certain treatment isn't working.

Little Flower's DeFranco has totally revised her wound-care program, based on the new guidelines. She's trying some new products and using ultrasound scans more -- up to 100 or more a day in her 133-bed facility.

Every resident is checked four times the first month after admission. Nurses also scan bruises and newly closed wounds to assess what's going on beneath the skin. The burden on admissions nurses has grown, noted Dr. Dennis Drennan, president of heel-lift maker DM Systems, Evanston, IL.



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"There's an upgrade of skin being placed on the same level as heart and lungs, as far as attention goes," he said. "And it has to be repeated for four weeks to meet the letter of the law."

For the record

Keeping track of everything is the key.

"We're really focused on the fact that documentation is a tool for you to use to communicate with other caregivers for what is going on with that person, rather than just focusing on documentation as that record that 'will keep you out of trouble,'" said Margaret Martin, MSN, RN, a corporate clinical nurse specialist with the Genesis nursing home chain.

"We have to become smarter and more streamlined with documentation. Electronic charting systems will significantly help that. You need to write pertinent info."

Martin and colleagues revised their wound care program and created a Skin Integrity Practice Council last year. Notably, the chain's facility-acquired pressure ulcers dropped from 3.2% to 2.2% over the last fiscal year.

Genesis is slowly transitioning to an electronic records system. It will be a challenge many providers will struggle with, experts agree.

"I find that computerized documentation is really lacking," said Nancy Tomaselli, who performs legal chart reviews often and is president of Premier Health Solutions. "Most computer programs don't have a form where you can write all the wound characteristics on the it.

"You have to make sure staff has the education and knows the severity of what can happen. It comes down to what's avoidable or not avoidable, and if you haven't crossed every 't' and dotted every 'i,' you can't say something was unavoidable. The guidelines are pretty strict."

Reta Underwood, president of Consultants for Long Term Care Inc., Buckner, KY, agrees: "Providers should expect more from computer software." That means "comprehensive software packages that include all system components, from the clinical outcome care plans based on MDS items to formatted documentation in the very least."

"The reason we feel so burdened with documentation is because we live in an age of technology and don't require proper software that represents the industry's current standards and practices," Underwood said, adding that some vendors may be moving in the right direction.

She also thinks some providers may be focusing on the wrong priorities.

"I differ from many of the industry professionals in that I don't think we're overburdened with paperwork. Rather, I see that we make ourselves overburdened by not working smart as an industry. Standardization in process is a good place to start – but where is it? Smart makes it and keeps it simple."

Documentation doesn't cause "egregious" resident conditions, but it can worsen them, she pointed out.

"Often times, it's not the treatment being provided but how well the treatment's being provided that isn't being documented," she said. "At the same time, we'll see lots and lots of documentation that says nothing."

She gave the example of a note saying "resident resting comfortably" but without a pain assessment on the record. "You'd be better off not putting anything," she says.

Underwood said she has noted a distinct culture change when it comes to wound care.

"It can be so costly and damaging, it's always a topic people will never take lightly. It's always something in the forefront because it's needed to be. As far as people ignoring this topic, I think they've come a long way in the last few years," she said.

"There was a time when people did not want to talk about wound care. Now, the understanding is you not only talk about it, but you're expected not to have wounds. With the new revisions, you have to document why they're there and was it preventable."

Many feel empowered to take closer looks at many aspects of care, some worry.

"That's the biggest change: If you do have a wound that's preventable but it happens, those will be the ones they look at," Underwood said. "In the past, they'd get really worried about Stage III or Stage IV wounds, but they'd have to get to that point before they were considered significant harm. But now it's anything. Lots of times, prevention is thought of only after it happens."

She said the revised F-tags also might assist facility operators in a not so obvious way.

"They give further justification of care and services provided, along with the documentation of the outcomes – good or bad. It also places the facility in a better position to hold attending physicians more accountable for their actions, or lack of in some cases," she explained.

Along with revising resident information forms, facilities also should revise attending physician contracts, signed with respect to the implementation of the new federal medical records rules, Underwood said. Nurse aides also should be asked to acknowledge, and be expected to follow, changes in the State Operations Manual, particularly when it comes to direct-care issues such as wound care, Underwood said.

Catching on

Wound treatment methods have advanced in many ways recently. Dressings that use silver products remain a hot topic. Now, the rush is on to find the best way to slowly release the active agent in them over a long- period of time.

"The silver products brought into the market are absolutely wonderful," says Sharon Stacy, RN, a regional wound care specialist for Genesis. "They reduce the bioburden in the wound. We've seen amazing results."

She added, however, that when it comes to note taking, many nurses need to be more detailed with their descriptions of the size, appearance and other characteristics of wounds.

Keeping wounds moist has been another point of emphasis for a number of years; now, the push is also to keep dressings in place for longer periods of time.

Ironically, while federal regulators are looking for more frequent wound-care notes from providers, clinical specialist are urging them to disturb dressings less frequently.

"It's hard to avoid the temptation, but once you get them on there, you leave it there and don't check it every shift," says Jack McMaken, president and CEO of Portland, OR-based dressings maker AcryMed.

Education, especially with a workforce experiencing such high turnover, is one of the biggest challenges when it comes to good wound care practices.

Friend or foe?

The jury will be out for a while on how much the new guidelines may affect surveyors' routines.

"These new revisions will be the best friend nursing homes have had in a long time. They're geared toward making surveyors much more objective," said Diane Johnson, a former facility admissions director and now a marketing and communications director for Smith & Nephew. "It's giving them information they haven't always had access to in the past because it hasn't been there."

She said a key element is that regulators now should be focusing on "avoidable and unavoidable wounds for the first time. Not every wound is avoidable but you have to have documentation in place," she noted.

That also means that if one method isn't working, a provider is free to, and must, make a change.

"Current standards of practice" will be emphasized, meaning more moist dressings and other cutting edge practices, she added.

The revised wound-care regulations should be seen as "a great opportunity for providers," Johnson said, along with others.

"Now, it's giving nursing home operators a chance to say, 'See, here's what we've done,'" she explained. "Documentation is always the key."

Online resources

Key Web sites for information on advanced wound and skin care topics:

Agency for Healthcare Research & Quality Care – www.ahrq.gov

American Geriatrics Society Pain Guidelines – www.healthinaging.org

American Medical Directors Association – www.amda.com

Centers for Medicare & Medicaid Services – www.cms.gov

National Pressure Ulcer Advisory Panel – www.npuap.org

Wound, Ostomy and Continence Nurses Society – www.wocn.org

Legal pressure

Wound care ranks high as a reason for lawsuits against long-term care providers.

The top types of claims (in order of prevalence) are:

1. Wrongful death
2. Pressure ulcers
3. Dehydration/weight loss
4. Emotional distress
5. Falls
6. Improper use of restraints
7. Medication errors
8. Sexual assault

Breakdown of type of defendants named in litigation brought against skilled-nursing providers:

Owners 99.4%

Administrators/executive directors/medical directors 28.2%

Nurses 19.7%

Physicians 18.8%

Nursing assistants 7.2%

Source: Leila C. Knox, RN,BSN, MA, CWOCN, 2004

Sores and more

Averages of U.S. nursing home residents with certain skin characteristics.

	2000	2004
% with pressure sores	6.90	7.40
% facility-acquired pressure sore rate	3.38	3.53
% receiving preventative skin care	61.5	70.9

Source: Cowles Research Group, 2005

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