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Wound Care: What the Medical Director Needs to Know

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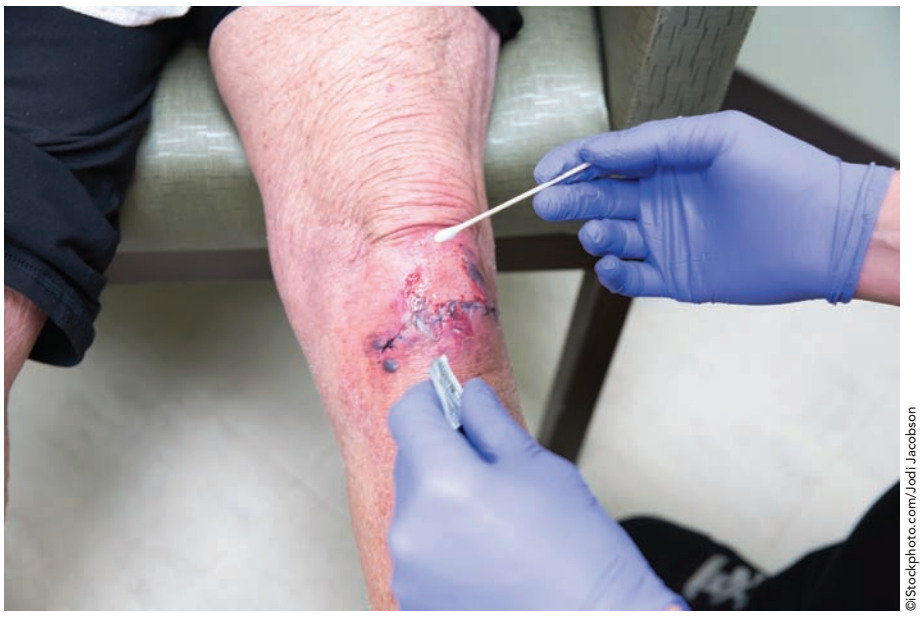
The field of wound care has expanded quickly over the last 2 decades, and progress has brought new challenges for long-term care. We now have a sicker population, multiple specialists claiming expertise in wound care, and a variety of expensive products with little evidence that one works better than the other. In this environment of health care reform, cost control, and data-driven quality measures, it is important that medical directors become knowledgeable on these issues to get the best care for their residents. This article will present a framework for components of a wound care program and discuss how medical directors can help improve patient care in their facilities.

Chronic wounds are generally defined as those that have not healed in 6 weeks, and include pressure ulcers, wounds related to arterial and venous disease, diabetic foot wounds, post-surgical dehiscence, and wounds secondary to vasculitis and malignancy. Acute wounds include skin tears, lacerations, and wounds resulting from surgical procedures. Issues related to skin care include moisture-associated dermatitis, cellulitis, yeast infection, burns, skin grafts, and other post-surgical procedures. Wound care also takes into consideration palliative wounds or those not expected to heal.

Pressure ulcers are a universally accepted quality indicator, and an effective wound care program requires a well-running set of components. However, it is a mistake to separate pressure ulcers from other types of wounds. The anatomy and physiology of skin is similar no matter the location of the pathology, and maintenance of skin



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Inadequate wound care can result in survey citations and lawsuits, and negatively affects facility reputation and the quality of patient-centered care.

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Joint European Atrial Fibrillation Guidelines Break New Ground

Bruce Jancin

ROME — The 2016 joint European guidelines on management of atrial fibrillation break new ground by declaring as a strong Class IA recommendation that the novel oral anticoagulants are now the drugs of choice — preferred over warfarin — for stroke prevention.

The joint guidelines from the European Society of Cardiology and the European Association for Cardio-Thoracic Surgery recommend that warfarin's use be reserved for the relatively small proportion of atrial fibrillation (AF) patients who are ineligible for the four commercially available novel oral anticoagulants (NOACs). That's mainly patients with mechanical heart valves, moderate to severe mitral stenosis, or severe chronic kidney disease.

The ESC/EACTS guidelines, taken together with the American College of Chest Physicians guidelines on antithrombotic therapy for venous thromboembolic disease released earlier in the year, suggest that the old war horse warfarin is being eased out to pasture. The ACCP guidelines recommend any of the four NOACS — apixaban, dabigatran, edoxaban, or rivaroxaban — be used preferentially over warfarin in the treatment of venous thromboembolism

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integrity is dependent on oxygen, blood supply, and nutrition. The knowledge required for treatment, for recognition of infection and wound deterioration, and in our choice of products is applicable not just to pressure ulcers but to other types of wounds. Therefore, all wounds regardless of etiology could potentially fall within the reach of the facility's wound program.

Who Practices Wound Care?

The practice of wound care involves the diagnosis and treatment of wounds. Practitioners should be knowledgeable about products and trained in selective and nonselective debridement. Sharp debridement is defined as using a forceps or scalpel, scissors, or curette to remove necrotic or nonviable tissue. Minor debridement can be performed at the bedside or as an outpatient procedure, but major debridement requires an operative suite. Other surgical procedures related to wound care can include abscess drainage, colostomy, endovascular procedure, amputation, or preparation for flap rotation.

Jeffrey Levine

The growth of the wound care field has engendered a variety of practitioners and certifications. Nurses with a variety of certifications perform wound care. Many states allow registered nurses to perform sharp debridement if they have taken a course and have had supervised clinical practice, as approved by facility policy. Some nurses have additional training and certification, including wound ostomy and continence certification; others are certified wound care nurses or certified enterostomal therapy nurses. Other nurses have completed advanced training and earned their doctorate in wound care.

Many states allow registered nurses to perform sharp debridement if they have taken a course and have had supervised clinical practice, as approved by facility policy.

Many independent certified nurse practitioners, advanced practice registered nurses, and advanced practice nurses provide wound care. They are registered nurses with additional knowledge and clinical skills for expanded practice beyond that of an RN. A nurse practitioner's scope of practice can include diagnosing medical problems, ordering treatments, and prescribing medications, and in some states they are allowed to perform sharp debridement. Because the nursing profession is state regulated, the care provided by nurse practitioners can vary. Some states allow independent, unsupervised practice, whereas others require a collaborative agreement and some level of supervision by a physician.

Physician assistants are frequently involved in wound care, and sometimes they are trained in performing sharp debridement. PAs are educated in the medical model and work as members of physician-directed teams. Their scope of practice is determined by education, experience, facility policy, state law, and physician delegation. Some states allow occupational therapists and physical therapists to perform wound care and sharp debridement within their scope of practice.

A variety of medical doctors practice wound care, including general surgeons, plastic surgeons, vascular surgeons, emergency department physicians, internists, dermatologists, and family physicians. The American Geriatrics Society has embraced pressure ulcers as a "geriatric syndrome," and some geriatricians have additional expertise in wound care. Many podiatrists perform wound care,

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and their scope of practice varies from state to state. Most states allow podiatrists to perform surgery from the ankle downward, but some allow surgery of the leg.

Outsourced Wound Care

Companies that provide outsourced wound services to LTC facilities often provide their own training to physician employees and subcontractors. Outsourced wound care refers to a practitioner, organization, or group that specializes in the care of wounds and provides regular ongoing consultation on patients in your facility. These services are generally of two types: free-standing wound centers in the community, or providers that come to the facility to provide onsite care. Outsourcing wound care can indeed be helpful in bringing expertise to the table, but the facility medical director needs to understand what these services offer and how they can best be integrated into the overall care of residents.

Wound care practices, whether community-based or onsite, bring certain advantages. For example, they have documentation standards that may include photographs, and expertise in product choice and debridement. Wound care practices may offer advanced treatments such as split-thickness grafts, bioengineered skin substitutes, negative pressure therapy, and hyperbaric chambers. Disadvantages may include lack of direct interaction with the primary care attending physician, nutritionist, social worker, and family, which can be a barrier to the exchange of crucial information. Wound care practitioners may not have had training in geriatrics or palliative care, and they may not be knowledgeable about issues involving decision making in light of advance directives and individual goals of care.

Caregivers need to know that sharp debridement is painful and can have limited benefit in individuals who are malnourished, have advanced dementia, or are otherwise at the end of life.

Wound practices have a financial incentive to perform sharp debridement, which may not be in accordance with the overall goals of care. For example, consider the patient with pressure ulcers who has poor oral intake and advanced malnutrition and is refusing alternative methods of feeding. Without adequate protein and calories, it is highly improbable that this patient's wounds will heal. The goals of care for this patient's pressure ulcers are palliative, as they may not benefit from serial sharp debridements, and the chances of a successful plastics procedure for closure are limited. The same applies to patients in hospice care who have advanced pressure ulceration: serial sharp debridements usually cause pain and may make the wound larger without a foreseeable benefit of cure. When wounds are palliative and healing is not expected, the goals of forestalling infection and ameliorating odor can be accomplished using nonsurgical means.

When informed consent is done correctly, it ensures that the resident and caregivers are aware of the risks and benefits involved in a particular treatment. Obtaining proper informed consent for cognitively impaired residents can be a challenge, and caregivers need to know that sharp debridement is painful and can have limited benefit in individuals who are malnourished, have advanced dementia, or are otherwise at the end of life. Medical directors should determine whether informed consent is being properly obtained by their facility's wound care practitioners if they are performing debridements.

Wound care, even when outsourced, still requires the active participation of caregivers within the facility. Outsourced wound care can increase quality and improve outcomes, but the provider must be integrated into a team approach.

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Wound Care Team

The attending physician should be engaged in wound care throughout the resident's stay, beginning with the examination and documentation of skin problems on admission. The attending physician sometimes maintains a distance from wound care by echoing the suggestions from other team members, and may defer all treatment decisions to the wound care specialist — a practice that can keep them disengaged and may even create liability exposure. Examination of the wound, working knowledge of the products and product choices, communication with families, and decisions regarding debridement and palliative care are important components of the attending physician's role.

Wound consultants are part of your team, and efforts should be made to integrate their activities into an overall and reasonable plan of care for each resident.

The registered dietician or registered dietician nutritionist is an important component of the wound care team. The RD helps determine the nutritional requirements for patients with wounds, but to do so requires an adequate onsite presence to address the complex nutritional needs of facility residents and to communicate concerns with family and caregivers. This can be a challenge when nutritional services are outsourced and the RD has limited time on the facility premises. Nutritional decision making requires communication with the resident, family, and attending physician and knowledge of what is happening to the wound. Malnourished residents with deteriorating wounds often require decisions regarding alternative methods of feeding. Although enteral feeding may be of limited help in patients with advanced dementia, there may be instances in less severely demented patients in which short-term enteral feeding can assist in healing a wound that otherwise would be unlikely to resolve.

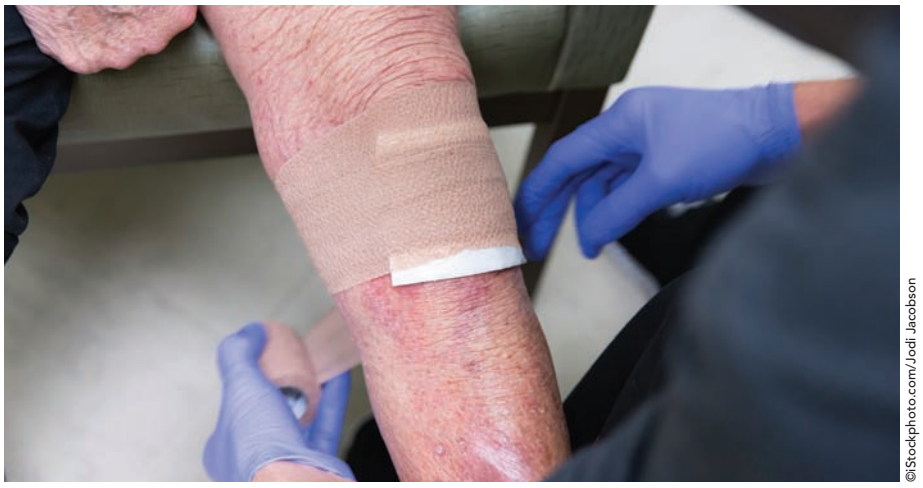
Rehabilitation specialists such as occupational therapists, physical therapists, and speech language therapists may be important members of the wound care team. OTs and PTs are involved in mobilizing the resident and helping the resident maintain independence with feeding. SLTs are critical in evaluating and caring for residents with dysphagia, weight loss, or poor oral intake. Rehabilitation therapists make observations that need to be shared with other members of the team. Some rehabilitation therapists perform wound care, including dressing changes and debridements, but this does not preclude nursing staff from involvement in assessment and documentation.

Registered nurses and licensed nurses provide a critical backbone to wound care by performing risk assessments, implementing pressure-relief interventions, assessing skin condition, documenting treatments, interacting with families, and keeping the attending physician informed of changes in condition. Nursing assistants are at the front lines of hands-on care, including turning and repositioning, and their observations of skin condition and oral intake are always important. Social workers are important members of the team as well, making sure advance directives are present and carried out within the plan of care. They can counsel family members who are having difficulty coping with their loved one's deteriorating condition at life's end. Families must be engaged and informed of the patient's wound status, and they assist with decision making when difficult treatment choices arise.

The wound consultant is a potentially valuable adjunct to the team. To assemble a comprehensive patient-centered plan for wound care, their activities must be integrated into the overall plan. Their care should be reviewed and acknowledged by the attending physician or nonphysician practitioner in monthly notes of routine regulatory visits. One model for effective in-house consultation is assignment of a facility nurse to follow the consultant and write a parallel note for each visit, facilitating the transfer of information.

Wound Care Products

Wound care products present a confusing array of materials and technologies, and many physicians are unfamiliar with them, in part because most of these products are classified as "medical devices"



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While some rehabilitation therapists perform wound care, including dressing changes and debridements, nursing staff should remain involved in assessment and documentation.

by the Food and Drug Administration. Under current FDA guidelines, a product is classified as a medical device if it does not have any pharmacologic action on the body. Once classified as such, the device is exempt from controlled clinical trials to prove that it works. This is technically known as the 510(K) clearance pathway that was established by the Medical Device Amendments of 1976. Instead of showing that a product works, the manufacturer needs only to show that it is "substantially equivalent," or similar, to one already on the market. A recent Institute of Medicine report points out that the current system has created a suboptimal daisy-chain system of regulation in which new devices are approved without thorough examination as to their efficacy.

Because many wound care products are not pharmaceuticals, they historically have been exempt from the need for a physician order or prescription. This is changing, however, due to insurance requirements and facility policies. Manufacturers have been able to bypass physicians and market directly to nurses, therapists, or materials management departments to get products onto hospital or nursing home formularies because they are not pharmaceuticals. This practice has resulted in a knowledge gap, with inadequate physician education regarding wound care modalities and incorporation of expensive, unproven wound care products into institutional formularies.

Wound Care and the Medical Director

According to F-tag 501, the medical director is responsible for coordinating and evaluating the medical care within the facility, including the review and evaluation of physician care and practitioner services. The medical director is also charged with ensuring that a system exists to monitor the performance and practices of the health care practitioners. Nowhere is this responsibility more relevant or important than in the realm of wound care.

Simply assuming that outsourced wound care solves your facility's wound problems can be a mistake. Wound consultants are part of your team, and efforts should be made to integrate their activities into an overall and reasonable plan of care for each resident. I strongly recommend monitoring the activities of wound care consultants, reviewing the appropriateness of their recommendations, and gauging their interaction with facility staff and families.

The 21st century has brought wound care to a crossroads that can improve value by facilitating savings and improving outcomes, but only if we understand the tasks at hand and work cooperatively toward making our contribution. Wound care takes teamwork and communication, and weaknesses in the system can have adverse consequences in terms of survey citations, lawsuits, facility reputation, and the overall quality of patient-centered care. Medical directors are in an excellent position to facilitate an outstanding, collaborative, quality-oriented wound care program in their facilities.

Suggested Questions for the Outsourced Wound Consultant

- Is informed consent appropriately performed for debridements?
- Does the consultant documentation incorporate prevention modalities?
- Are excisional debridements appropriately charted and reasonable within the goals of care?
- Is wound pain documented, and local anesthetic administered and documented prior to sharp debridement?
- Are all wounds examined and documented on each visit, or simply the ones that require procedures?
- Does the consultant take into consideration advance directives and overall goals of care?
- Is the documentation consistent throughout the chart, and does it comply with MDS 3.0 requirements?
- Does the consultant communicate with or acknowledge nutritionist suggestions, and is nutrition incorporated into the plan of treatment?
- Does the consultant provide a value-added service such as in-service on skin assessment and prevention?

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