

Wound Care ADVISOR

PRACTICAL ISSUES IN WOUND, SKIN, AND OSTOMY MANAGEMENT

Official journal of National Alliance of Wound Care
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- **Business Consult**, which is designed to help wound care specialists manage their careers and stay current in relevant healthcare issues that affect skin and wound care.

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For more information, [click here](#) to send an email to the managing editor.



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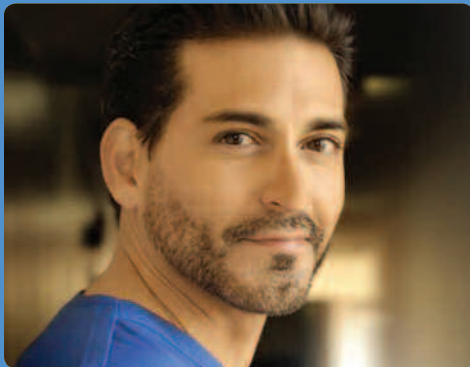
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Editorial Mission: *Wound Care Advisor* provides multidisciplinary wound care professionals with practical, evidence-based information on the clinical management of wounds. As the official journal of the National Alliance of Wound Care and Ostomy®, we are dedicated to delivering succinct insights and information that our readers can immediately apply in practice and use to advance their professional growth.

Wound Care Advisor is written by skin and wound care experts and presented in a reader-friendly electronic format. Clinical content is peer reviewed.

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A partner in wound care

One of the most important steps in achieving positive wound-healing outcomes is to choose the right wound care product. This can be tricky, challenging, and sometimes overwhelming—especially if you're new to wound care. When I first started in wound care, I had four to five “go-to” products that I knew about. Beyond that, I had to guess what would work. But I learned one thing early: I could call on my sales representatives for help.

Not only were the reps knowledgeable but they also had my back. They wanted me to succeed, because good outcomes for my patients make for a repeat customer. A good sales rep can be a valuable partner to have on your side. Besides sharing their product knowledge, reps can help with product samples and trials as well as staff education. They may share ideas and case studies of what worked for someone else. I've even had sales reps successfully convince leery, conservative, and sometimes stubborn prescribers to change their minds and try out my wound care recommendations for their patients.

When you're trying to take your career to the next level, sales reps can help get you started in wound care research. Most

wound product companies are looking for product users to assist in clinical trials of their products. Some will help you develop research ideas and publish study results. Of course, you need to ensure that the research project and subsequent publication are free of company bias.

While I sing the praises of sales reps, I must admit I've encountered a few who were just order takers. Good sales reps know about their products and are familiar with wound care lingo—pressure ulcers, not bedsores; eschar, not scabbing; drainage or exudate, not pus. They can connect the clinical

value of their products to evidence-based wound care standards. Some are so dedicated to achieving positive outcomes that they've pursued further education or even wound care certification, such as **Certified Wound Care Market Specialist** (CWCMS™) or **Certified Wound Care Associate** (CWCA®).

Here are some tips for working with product sales representatives:

- Have them schedule meetings at your convenience. To avoid frequent interruptions from patient care and job duties, set aside a specific day of the week to meet with sales reps. Inform all sales reps this is the only day they





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- can make appointments with you.
- Request research, safety, and effectiveness data before conducting product trials.
 - Ask not only about product specifics but also about value-added services, such as assistance with a cost-benefit analysis, staff education programs, and patient teaching materials.
 - Remember—honesty is a two-way street. If you don't intend, or are unable, to purchase or use a company's product, tell the sales rep up front.

If you don't know who your sales representatives are, contact the product's corporate office and request a visit from a sales rep. [Click here](#) for a detailed list of wound product companies.

Gone are the days of free ink pens and candy from sales reps. Step up and help your patients, your organization, and yourself by reaching out and partnering with companies and sales reps who are in it to make a difference.

I and the staff of *Wound Care Advisor* wish you a beautiful, magical, and prosperous New Year!



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Check the site often for new wound care clinical information, news, and insight from authoritative experts.





Diabetes carries high economic burden

According to a study published in *Diabetes Care*, the economic burden associated with diagnosed diabetes (all ages) and undiagnosed diabetes, gestational diabetes, and prediabetes (adults) exceeded \$322 billion in 2012, amounting to an economic burden exceeding \$1,000 for each American.

The authors of “**The economic burden of elevated blood glucose levels in 2012: Diagnosed and undiagnosed diabetes, gestational diabetes mellitus, and prediabetes**” note that the \$322 billion number, which comprises \$244 billion in excess medical costs and \$78 billion in decreased productivity, is 48% higher than the \$218 billion estimate for 2007.

Review article on lymphedema published

“**Recent progress in the treatment and prevention of cancer-related lymphedema**,” published in *CA: A Cancer Journal for Clinicians*, reviews recent developments in the diagnosis, treatment, and prevention of cancer-related lymphedema, including



breast cancer and other cancer types—melanoma, gynecologic, genitourinary, and head and neck.

The article also discusses the issue of insufficient insurance coverage for the diagnosis and treatment of lymphedema. The authors emphasize the importance of early identification of the condition and early referral.



Preventing breast cancer

“**Risk determination and prevention of breast cancer**,” published in *Breast Cancer Research*, estimates that half of breast cancers might be prevented in women at high and moderate risk by using chemoprevention (tamoxifen, raloxifene, exemestane, and anastrozole). For all women, lifestyle measures, including weight control, exercise, and moderating alcohol intake, could reduce breast cancer risk by about 30%.



Ostomy can hinder goal attainment in cancer patients

“**Changes in cancer patients’ personal goals in the first 6 months after diagnosis: The role of illness variables,**” in *Supportive Care in Cancer*, notes that overall, patients reported a “decrease in illness-related hindrance, higher attainability and likelihood of success, a decrease in total number of goals, goals with a shorter temporal range, and more physical and fewer social goals.”

However, patients with more advanced stages of cancer, rectal cancer, or a stoma and receiving additional chemotherapy or radiotherapy reported more difficulty attaining their goals because of their illness. Only patients with a stoma reported “lower attainability, likelihood of success, and more short-term goals.”



Device to prevent parastomal hernia studied

In “**A promising new device for the prevention of parastomal hernia,**” in *Surgical Innovations*, researchers from Switzerland

report their experience with a new stoma-plasty ring (KORING) that they invented. The ring, which has been used only once, is intended to prevent parastomal hernias.



CDC releases guideline on preventing HIV transmission from those with HIV

The Centers for Disease Control and Prevention (CDC) has released “**Recommendations for HIV prevention with adults and adolescents with HIV in the United States, 2014.**” The guideline includes recommendations about biomedical, behavioral, and structural interventions that can help reduce the risk of human immunodeficiency virus (HIV) transmission from persons with HIV by reducing their infectiousness and their risk of exposing others to HIV.



Rate of rising healthcare costs slows

The Centers for Medicare & Medicaid Services reports U.S. healthcare spending in 2013 increased 3.6% to \$2.9 trillion, or \$9,255 per person. “**National health spend-**

ing in 2013: Growth slows, remains in step with the overall economy,” published in *Health Affairs*, notes that spending slowed by an 0.05 percentage point, compared with 2012. Health care has been 17.4% of the gross national product since 2009.

The slower growth is consistent with slower growth in private health insurance and Medicare spending. Other reasons include slower growth in spending for hospital care, investments in medical structures and equipment, and spending for physician and clinical care.

Low-glycemic index diet doesn't improve cardiovascular risk factors

Overweight and obese persons who eat a



diet that has a low glycemic index of carbohydrate don't have improvements in insulin sensitivity, lipid levels, or systolic blood pressure, according to a study in *JAMA*.

“Effects of high vs low glycemic index of dietary carbohydrate on cardiovascular disease risk factors and insulin sensitivity” concludes that “using glycemic index to select specific foods may not improve cardiovascular risk factors or insulin resistance.” ■

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The Buzz Report: A wound care clinician's best friend

By Donna Sardina, RN, MHA, WCC, CWCMS, DWC, OMS

In 2014, more than 8,000 new articles related to wound healing were added to the PubMed online database and hundreds of new patents for topical wound formulations were filed. Staying up-to-date with the latest and greatest findings and products can be challenging. We all lead busy lives, and our demanding work schedules and home responsibilities can thwart our best intentions. Although we know it's our responsibility to stay abreast of changes in our field, we may feel overwhelmed trying to make that happen.

Keeping clinicians up-to-date on clinical knowledge is one of the main goals of the Wild On Wounds (WOW) conference, held each September in Las Vegas. Each year, I present the opening session of this conference, called "The Buzz Report," which focuses on the latest-breaking wound care news—what's new, what's now, and what's coming up. I discuss innovative new products, practice guidelines, resources, and tools from the last 12 months in skin, wound, and ostomy management.

This article highlights the hottest topics from my 2014 Buzz Report, with appropriate updates since the September WOW conference.

Pressure ulcer prevention and treatment

2014 was an active year in the area of pressure ulcer prevention. The latest practice guideline on pressure ulcers, released last September, was a joint collaboration of the National Pressure Ulcer Advisory Panel (NPUAP), European Pres-



sure Ulcer Advisory Panel, and Pan Pacific Pressure Injury Alliance. The intent of the guideline, titled "**Clinical Practice Guideline for Pressure Ulcer Prevention and Treatment**," was to advance international consensus on pressure ulcer prevention and management. This document is a must-read for all clinicians practicing wound care today.

Also, NPUAP updated its **Registered Nurse Competency-Based Curriculum: Pressure Ulcer Prevention**. The curriculum now includes major competencies, content objectives, content topics, suggestions for varied teaching methods, and references.

Are some pressure ulcers unavoidable? This continues to be a hot topic. At a February 2014 multidisciplinary conference hosted by NPUAP, participants reached a consensus on these key points:

- Some pressure ulcers are unavoidable.
- Patients at increased risk for developing unavoidable ulcers are those with malnutrition and multiple comorbidities, those with extensive body edema, and those who must keep the head of the bed elevated more than 30 degrees for medical reasons.

It's in every wound clinician's best in-

New products in wound care

Amnioexcel® Human Amniotic Membrane Allograft from Derma Sciences, Inc., uses the innermost layer of the placenta donated by mothers during childbirth. Applied every 2 weeks, it promotes soft-tissue repair in both chronic and acute wounds.

Have you heard that ALLEVYN Life Dressing from Smith & Nephew can help prevent wounds by redistributing pressure effectively across the coverage area, helping to reduce concentrated pressure points? The new design redistributes pressure more evenly than a traditional foam dressing and enables repositioning of the dressing without adhesion loss.

Looking for a dressing for a highly exudative wound that needs antimicrobial coverage? The Food and Drug Administra-

tion has cleared RTD® Wound Dressing from GWM Products, LLC. Its absorbent foam, containing methylene blue, gentian violet, and a silver compound, has a broad-spectrum effect that kills gram-negative and gram-positive bacteria, methicillin-resistant *Staphylococcus aureus*, vancomycin-resistant enterococci, yeast, and fungi. The dressing is compatible with compression and negative-pressure wound therapy.

Most of us know that a total contact cast (TCC) is the standard of care for treating diabetic neuropathic foot ulcers. Kinetic Casting Solutions is offering a TCC system called MaxCast Plus. This one-size-fits-all, snug-fitting, non-removable system is 25% lighter than competitive systems. Once prepared, it can be applied in

less than 5 minutes. Now we have a choice in TCC systems.

Can you think of a patient who would benefit from a device that increases venous blood flow velocity in the femoral vein by 300% and in the femoral artery by 40% in systole and 900% in diastole? Called CV2 (from GO2 Circulation Innovations), the device is a small, movable platform that patients move up and down with their feet, similar to a treadle-operated sewing machine. It offers almost no resistance, so it requires almost no effort. Also, it doesn't elevate vital signs or cause shortness of breath or fatigue. Simple to use, it could make a significant difference for patients with lower extremity conditions.

Watch for more new products in our March/April issue.

terest to stay abreast of NPUAP's position on unavoidable pressure ulcers. The **report** was published in the *Journal of Wound, Ostomy and Continence Nursing*.

Diabetes

According to the 2014 National Diabetes Statistics Report, more than 21 million people in the United States have diabetes, and an estimated 8 million of them are undiagnosed. Diabetes raises the risk of cardiovascular disease because of common concurrent conditions, such as hypertension, obesity, abnormal cholesterol and triglyceride levels, and poorly controlled glucose levels. Help your patients reduce their risk by referring them to the free "**Diabetes and Coronary Artery Disease 'Make the Link' Toolkit**" from the American Diabetes Association.

Compression therapy

Do you use compression thera-

py to treat patients with venous ulcers? I reviewed three documents on this topic. (See the selected references at the end of this article.) The most compelling was a study published in *JAMA Dermatology* titled "**Delivery of Compression Therapy for Venous Leg Ulcers**." It found more than half the nurses who applied either inelastic or elastic bandages obtained sub-bandage pressures below the 30 mm Hg required for therapeutic compression. The authors concluded that training programs focused on practical bandaging skills are needed to improve management of venous leg ulcers.

Wound care and infection

Infected wounds pose a challenge for even the most seasoned practitioners, who may have difficulty determining the recommended course of action. The Infectious Diseases Society of America published an updated guideline, "**Practice**



Guidelines for the Diagnosis and Management of Skin and Soft Tissue Infections: 2014.” It covers both diagnosis and ongoing management recommendations for a wide variety of infections, ranging from minor to life-threatening. Although practice varies, clinicians should use evidence-based interventions to identify and manage wound infections; failing to do so could lead to death.

Resources and new products

Need more resources? See Clinician Resources on page 35 for valuable links. Also, check out new products that might be useful for your patients (See *New products in wound care.*)

The world of wound care is always changing and evolving. We all need to develop a plan for staying current so we're not using outdated modalities. I'm already gathering the latest and greatest for the 2015 Buzz Report. One

thing is certain—there's never a lack of issues to review when it comes to wound care. ■

Selected references

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- b. Variable bubbling, which indicates proper functioning
- c. A steady bubbling sound, which indicates proper functioning
- d. Higher levels of suction pressure

Go to AmericanNurseToday.com/quiz-time-3/ for the answer!



Medical gauze 101

By Nancy Morgan, RN, BSN, MBA, WOC, WCC,
DWC, OMS

Each issue, *Apple Bites* brings you a tool you can apply in your daily practice.

Medical gauze, a bleached white cloth or fabric used in bandages, dressings, and surgical sponges, is the most widely used wound care dressing. Commonly known as “4×4s,” gauze is made from fibers of cotton, rayon, polyester, or a combination of these fibers. Surgical gauze must meet standards of purity, thread count, construction, and sterility according to the **United States Pharmacopeia**.



Gauze offers a variety of options—woven or nonwoven, sterile or nonsterile, plain or impregnated, and fenestrated (perforated or with slits)—and is available in various sizes, shapes, and thicknesses.

Woven or nonwoven gauze

Matching the correct type of gauze dressing to the wound is essential to successful wound healing.

Woven gauze. Woven gauze has a loose, open weave, which allows fluids from the wound to be absorbed into the fibers, wicked away, or passed through into other absorbent materials in the wound's dressing. Most woven products are a fine or coarse cotton mesh, depending on the



thread count per inch. Fine-mesh cotton gauze is often used for packing, such as in a normal saline wet-to-moist dressing, whereas coarse-mesh cotton gauze, such as a normal saline wet-to-dry dressing, is used for nonselective debriding. Woven gauze shouldn't be cut and placed in a wound because loose fibers (lint) may get lost in the wound and delay healing.

Nonwoven gauze. Nonwoven gauze consists of fibers pressed together to resemble a weave, which provides improved wicking and greater absorbent capacity. Compared to woven gauze, this type of gauze pro-

Matching the correct type of gauze dressing to the wound is essential to successful wound healing.

duces less lint and has the benefit of leaving fewer fibers behind in a wound when removed. Most nonwoven gauze dressings are made of polyester, rayon, or blends of these fibers and are stronger, bulkier, and softer than woven pads.

Types of gauze dressings

- Impregnated dressings—These gauze dressings are coated or saturated with pharmaceutical materials, such as petroleum jelly, oil or water emulsion, hydrogel, iodine, or antimicrobials.
- Wrapping gauzes—Used for securement, padding, and protection, these dressings may include cotton, elastic, or a nylon and rubber mix, and have a fluff dried with crinkle-weave pattern.
- Sponges—A sponge, often referred to as a gauze pad, is a piece of gauze folded into a square. Common sizes are 2×2 and 4×4.

Appropriate use of gauze

Gauze can be used for cleansing, packing, scrubbing, covering, and securing in a variety of wounds.

Closely woven gauze is best for extra strength or greater protection, while open or loose weave is better for absorbency or drainage.

When it comes to packing for a wound,

use a single gauze strip or roll to fill deep ulcers as opposed to multiple single gauze dressings (2×2s or 4×4s) because retained gauze in the ulcer bed can serve as a source of infection.

For many years, woven gauze was used in the wet-to-dry wound treatment. This treatment consisted of applying moistened saline gauze to the wound bed and, when the gauze was dry and embedded into the wound tissue, ripping it out to debride necrotic tissue from the wound. Many **studies** and **clinical practice guidelines** now discourage—and even condemn—the use of wet-to-dry gauze for treatment of wounds. When other forms of moisture-retentive dressings aren't available, continually moist gauze (wet to moist) is preferable to the wet-to-dry treatment.

Click here to access examples of brands and types of gauze dressings. ■

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Communicating to caregivers: Cornerstone of care

By Jeri Lundgren, BSN, RN, PHN, CWS, CWCN

The challenge of preventing pressure ulcers is won through our frontline staff—the patient’s caregivers. Caregivers deliver most of the pressure ulcer preventive interventions, such as turning and repositioning, floating the heels, and managing incontinence. That’s why it’s imperative to communicate the patient’s plan of care directly to the caregivers.

Talking points

Preventive programs start with a risk assessment and the development of the plan of care, which is then shared with the caregiver. At a minimum, you should communicate the following:

- turning and repositioning plan
- type of support surface that’s on the bed and the need to check for proper

- inflation* before leaving the room
- type of wheelchair cushion
- how to float the heels
- positioning devices
- incontinence management
- nutritional monitoring and supplements
- notifying the nurse if a wound dressing is soiled, loose, or missing
- inspecting the skin daily and notifying the nurse if any concerns are found
- notifying the nurse if the patient has chosen not to follow one or more interventions.

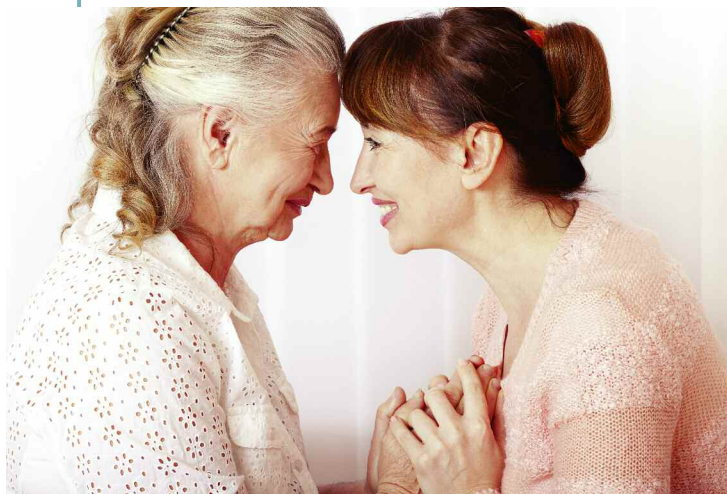
*Ensure that the bed is set at the proper setting and is plugged in and turned on if it’s a powered surface, and that the patient is not bottoming out. (The National Pressure Ulcer Advisory Panel defines bottoming out as a mattress or support surface that compresses when a hand is placed palm up under it so that the support materials feel less than an inch thick, which results in the patient’s bony prominences making contact with the underlying surface.)

Both verbal and written communication is needed, and be sure information is provided in the caregiver’s preferred language.

Communication is a two-way street: It’s also important for caregivers to contribute to the plan of care. Have them keep a notebook (either print or electronic) in which they can communicate any changes that the nurse or other clinicians should be aware of and record care tips or updates. If the patient is in the acute care setting, have the caregivers, nurses, and other interdisciplinary team members read the communication book before they start their shift and initial that they have read it.

Care for the caregivers

Keep in mind that caregivers may be coping with their own challenges as they care for their loved ones. These may include





10 tips for family caregivers

- 1 Seek support from other caregivers. You are not alone!
- 2 Take care of your own health so that you can be strong enough to take care of your loved one.
- 3 Accept offers of help and suggest specific things people can do to help you.
- 4 Learn how to communicate effectively with doctors.
- 5 Caregiving is hard work so take respite breaks often.
- 6 Watch out for signs of depression and don't delay in getting professional help when you need it.
- 7 Be open to new technologies that can help you care for your loved one.
- 8 Organize medical information so it's up-to-date and easy to find.
- 9 Make sure legal documents are in order.
- 10 Give yourself credit for doing the best you can in one of the toughest jobs there is!

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their own health problems, the challenges of running a household (sometimes while still working full time), and the need to manage finances. It may be helpful to refer caregivers to support groups or to such resources as the [Caregivers page](#) on MedlinePlus and the [Caregiver Action Network](#), which has useful tips. (See *10 tips for family caregivers.*)

Cornerstone of care

Communication is the cornerstone to ensuring effective and consistent care for our patients. Making certain that the voices of caregivers are heard and communicating with them effectively will improve their ability to provide appropriate care and help prevent pressure ulcers. ■

Jeri Lundgren is vice president of clinical consulting at Joerns in Charlotte, North Carolina. She has been specializing in wound prevention and management since 1990.

What does it mean to participate in a wound care clinical trial?

By Susan Beard, RN, BS, CWOCN

Suppose you're reading an article on a new product that states the product has been through a series of clinical trials before marketing. What does this mean? Who was involved? As a clinician, could you initiate or be involved in a clinical trial of a new product? Who are clinical trial subjects, and what's it like for them to be involved in a clinical study?

A clinical trial starts as an idea. As clinicians, we often use our critical-thinking skills to imagine a product or method of practice we think could be created or improved on to better meet our patients' needs. The idea begins to grow and a series of events begins.

An idea for a new medical product may be presented to an individual or organizational sponsor who shares an interest in the product and is willing to fund a series of clinical trials. A clinical trial is a way to study a new product for safety and effectiveness. Clinical trials are conducted in four phases, as defined by the U.S. National Library of Medicine and the National Institutes of Health. (See *Phases of a clinical trial.*)

In my experience as a research coordinator, patients may choose to participate

Phases of a clinical trial

Clinical trials for a new medical product proceed in a series of four phases.

- A *phase 1* trial is a safety study conducted with a limited number of healthy, voluntary subjects to help identify an appropriate dosage range for the new product and the presence of adverse effects.
- A *phase 2* trial involves more subjects than the phase 1 trial to further evaluate the product's safety and effectiveness.
- A *phase 3* trial has even more subjects, which allows investigators to evaluate the product's safety and effectiveness more specifically and to observe for adverse effects. This is the last phase before the Food and Drug Administration approves the product (if it does approve it) and the product is marketed.
- A *phase 4* clinical trial collects information on the product's effectiveness and adverse effects linked to long-term use in the general public.

in a research study because it may provide clinical information (through laboratory studies, X-rays, and other tests) about their medical problem at little or no cost to them. It also may give them access, at no cost, to advanced medical treatment not yet available. Patients may even be compensated for travel expenses related to study participation. (See *Online patient education resources*.)

Safety first

The safety and protection of volunteer subjects participating in clinical trials are vitally important. Once a sponsor decides to conduct a clinical trial, a master plan called a protocol is created. A protocol states the objective of the trial, outlines the study design, and details the number and types of subjects who will participate, along with additional information on how the trial will be conducted. Not all clinical trials follow the same protocol, but in a given trial, the same protocol is followed for all participants. The protocol is re-

viewed and the clinical trial is monitored by an independent committee of medical professionals and others, called an institutional review board, which makes sure the trial is conducted ethically and participants' rights are protected.

A sponsor may use a clinical research organization (CRO) to conduct the study. A CRO works with the clinician on behalf of the sponsor to carry out the details of the study protocol efficiently and ethically.

Inclusion and exclusion criteria

The type of subject needed for a particular study trial is defined by a list of inclusion and exclusion criteria, as outlined in the study protocol.

- *Inclusion* criteria may include the presence or absence of a particular medical problem, such as diabetes with an acceptable glycosylated hemoglobin level for a clinical trial on diabetic foot wounds. For such a trial, wound duration and size also may be specified.
- *Exclusion* criteria may include a particular medical problem that would affect the study negatively, such as a chronic disease or use of a specific medication.

The patient must meet all inclusion and exclusion criteria to be considered for participation in a particular clinical trial.

Introducing patients to a clinical trial

Patients who meet all qualifications for a clinical trial receive an informed consent form (ICF) to review, which includes details of the trial and how they will be asked to participate. The ICF describes the risks and potential benefits of participating in the study. Patients get ample time to review the ICF and ask questions. Then, if they desire,

they sign the form, indicating their interest in participating in the study. After the investigator conducts the informed consent discussion and reviews the consent with the participant, the research coordinator may obtain the signatures needed for the ICF. Patients are assured they can withdraw from the study at any time without risking negative consequences. (For details on what the ICF must include, visit www.hhs.gov/ohrp/policy/consentckls.html.)

Run-in period

After patients agree to participate in the study, a so-called run-in period occurs, during which they undergo laboratory tests, X-rays, and other studies as listed in the protocol and ICF. Test results are included in the final analysis of study results.







The run-in period usually lasts 2 to 3 weeks; patients receive standard-of-care treatment during this time. For instance, if your patient has agreed to be in a clinical trial, you might measure the wound and collect other specific information during the run-in period. Measurements at the beginning and end of the period will be compared to identify patients whose healing rate is acceptable with standard-of-care treatment only. These patients may be excluded from the study.

Treatment period

After the run-in period ends and the patient has been determined to qualify for the study, the treatment period begins. The patient receives the study product or possibly a placebo as outlined by the protocol and ICF. Patients are assigned randomly to receive either the study product or a placebo; neither the patients nor investigators know which patients are receiving which. Called a double-blind study, this

Online patient education resources

Direct patients seeking general information about clinical trials to the websites below.

-  www.nlm.nih.gov/medlineplus/clinicaltrials.html
This Medline Health (National Institutes of Health [NIH]) website provides information on clinical trials in easy-to-understand language. The interactive tutorial is in both English and Spanish.
-  www.nih.gov/health/clinicaltrials/
-  www.clinicaltrials.gov/ct2/info/understand
-  <http://clinicalcenter.nih.gov/participate/studies.shtml>
These NIH sites provide comprehensive information, including the basics of clinical trials, benefits of being in a clinical trial, how to find a clinical trial, a list of registries, and personal stories of patients who've been in trials.
-  www.youtube.com/watch?v=9MpUwsgXLxw
This patient education video provides basic information, including informed consent and patient protections.
-  www.nlm.nih.gov/medlineplus/tutorials/clinicaltrials/htm/_no_50_no_0.htm
This interactive tutorial on clinical trials is also available in Spanish at www.nlm.nih.gov/medlineplus/spanish/tutorials/clinicaltrials/spanish/htm/index.htm.

type of study guards against bias.

If your patient is enrolled in a clinical trial studying a wound care product, for instance, you'd assess wound characteristics and measure the wound at each visit. Using a standard device provided by the sponsor, you would take a photo of the wound and send it to the sponsor or CRO. Whether they're receiving the study product or a placebo, all subjects receive the identical standard of care, as outlined by the protocol.

During each study visit, the coordinator confirms with the patient that he or she wishes to continue to participate in the study. Each step of the study visit is documented carefully on a source worksheet and entered into an electronic case report form, which is sent to the CRO for review. The CRO may generate questions about this documentation, which are submitted to

the coordinator in the form of a query. The coordinator is responsible for responding to all queries. Some queries identify errors in documentation or transcription; when appropriate, the coordinator responds that the data entered were correct.

The treatment phase of the study lasts several weeks, as long as the study protocol requires, or until the patient heals (if that occurs before the treatment phase ends).

Post-treatment phase

The post-treatment (observational) phase of the study may last 2 to 4 weeks or even longer. During this time, you would continue to monitor the patient, assess the healed wound, photograph the site at each visit, and make sure required follow-up lab tests, X-rays, and other studies are performed.

The opportunity to participate in a clinical trial is exciting and interesting for both the clinician and patient, allowing them to watch an idea grow into a clinical trial and a potential new product. Those who participate come to appreciate the many people who contribute to development of a new product. To get started participating in a clinical trial, visit <https://clinicaltrials.gov/> and search for a study that fits your clinical practice. ■



Watch: Clinical trials explained

1. Patient Education
2. Drawn to Science

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HEALTH LITERACY

Translating the language of health care

By Catherine E. Chung, PhD, RN, CNE, WCC

As a wound care clinician, you teach patients about medications, wound treatments, the plan of care, symptoms of complications, wound physiology—you teach a lot. And most patients probably smile and nod when you ask, “Do you understand?” However, health literacy research has shown that only 12% of the U.S. population is fluent in the language of health care. As health care has become increasingly complex, it has become increasingly difficult for patients to understand. Fortunately for your patient, you can translate.

Health literacy and your patient

According to the U.S. Department of Health and Human Services, health literacy is “the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions.” Health literacy has little to do with someone’s ability to read or write. Rather, health literacy is about the person’s ability to acquire, understand

the meaning, and appropriately use health information, which includes print material, verbal instructions, and online information.

Multiple factors affect health literacy, including physical status, age, culture, past experiences, emotional states, level of education, and socioeconomic status. Not every patient has the same ability to understand what you're teaching. A patient doesn't even maintain the same level of health literacy over time; for example, if a patient receives a devastating diagnosis, the associated emotional response will limit that person's health literacy. Consider a man who went to a healthcare provider because of a wound he developed, but then learns he has diabetes. The news may feel overwhelming to him, with wound care taking a back seat to concern over the diagnosis of diabetes.

Health literacy is a concept that makes sense once clinicians, as the fluent healthcare linguists, consider it. Patients at highest risk for complications, including elderly patients and those of low socioeconomic status, have the lowest levels of health literacy. These are the patients most likely to feel intimidated about asking you questions because they see you as the expert.

For clinicians, who normally speak to other clinicians in their primary language of health care, lack of health literacy presents a challenge. For example, you're treating an 82-year-old patient with diabetes and a traumatic lower leg wound that was infected and has been slowly healing. The patient asks when the wound will heal. You launch into a lengthy explanation of wound healing and the impact of blood glucose control, blood flow, the location and depth of the

wound, and the treatment of choice. The patient replies, "But when will it heal?" The patient isn't being difficult—he just didn't understand anything you said.

To translate healthcare information so your patient understands it, you must determine the patient's level of health literacy and meet the patient at his or her level of understanding. Here are some suggestions to help you start translating.

Assess the patient's health literacy status

In addition to asking your patients questions about how often they have a dressing change or how their wound originated, ask why they think their dressing change is scheduled the way it is. Or, ask if they can see any difference in the wound and what they think that difference means. Listen not only to the words the patients are saying but also to the tone of voice they use: Do they sound certain? Confused? Anxious? Remember that negative emotions will make it more difficult for your patient to understand your teaching.

If new medications are prescribed for wound care, have the patient read the



More communication tips

- Tell the patient the most important information first.
- Speak from a positive point of view.
- Explain to your patient how your message affects them.

Say, “Your wound is infected, so we have to use a different type of bandage.”

Say, “We want to use this white pad starting today.”

Say, “Your wound will heal faster if you eat more healthy foods.”

Not, “We’re changing your bandage type because the wound is infected.”

Not, “Don’t use that pink pad any more. We’re not using that one now.”

Not, “It’s important for people to eat healthier diets.”

prescription label out loud. This isn’t a test for the patient—it’s an assessment technique for you. If the patient makes excuses not to read the label, this could be a sign of limited reading or visual ability, which will affect the patient’s ability to understand and perform wound care. This exercise will help you decide if the patient is proficient in the language of health care. Then you’ll know if you can translate at an introductory level or a more advanced level.

Use plain language

The Plain Writing Act of 2010 requires federal agencies to write all regulations in a clear and easily readable style. This is a good idea for wound care clinicians as well. It allows the patient to understand the teaching in simple layperson’s language. Examples of plain language include word substitutions, such as “follow” instead of “comply with” or “stop” instead of “discontinue.”

Healthcare terminology should also be

converted to laypeople’s terms. For example, “purulent drainage” would be more meaningful to a patient as “greenish and smells bad.” Try to use words that are one or two syllables. For more tips for getting your message across, see *More communication tips*.

Limit information quantity

Just like students learning a foreign language, our patients can digest only limited amounts of healthcare language at one time. What constitutes too much information? That depends on your patients and how familiar they are with health care in general, how stressed they are about the wound and any associated diagnoses, how much support they have, and whether they’re concerned with the financial implications of the wound and associated diagnoses. So, as you can see, how much information you give your patient depends on your patient’s level of health literacy.

Try to break the information into logi-

Ask the patient, “Could you explain back to me what we talked about?”

cal steps that fit your patient’s needs. For example, you might teach the patient how to clean the wound during one appointment, how to pack the wound at the next appointment, and how to cover the wound at a third appointment if the patient seems very nervous about the process. Patients who previously have helped others with wounds or are calm about the process may be able to learn all the steps at once.

Verify information understanding

Don’t ask, “Do you understand?” It’s human nature to respond “Yes” to that question to avoid feeling inadequate. Instead, use the teach-back method. Ask the patient, “Could you explain back to me what we talked about? I want to make sure I told you everything I was supposed to today.” As the patient explains, you’ll be able to tell whether you successfully conveyed the information. You’ll also be able to determine if the patient can take in more information during the present appointment. If the patient can repeat only a small part of what you said, then you know to offer smaller chunks of information when teaching.

Your patients may not think of questions during your time together, but it’s likely they will think of them afterward. If you give patients permission to write down questions, they feel validated: The expert is saying it’s OK if they need more information later. This might seem silly, but many patients are afraid they’re wasting your time if they ask you questions about something you might not have discussed during their appointment.

Patient-centered care

As a wound care clinician, you want to practice patient-centered care. For your patients to be a partner in their care, they need to fully understand what is happening during their wound care and what to expect from the plan of care. After all, the translation your patient really wants to understand is the answer to “When will it heal?” ■

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Palliative wound care: Part 1

Although wound healing may no longer take priority, palliative wound care is far from a do-nothing approach.

By Gail Rogers Hebert, MS, RN, CWCN, WCC, DWC, OMS, LNHA

The World Health Organization defines palliative care as “an approach that improves the quality of life of patients and their families facing the problem associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual.”

Setting goals for a patient with a wound doesn't require wound healing as an endpoint. If you propose this to colleagues who aren't familiar with the palliative approach to wound care, you may get puzzled looks in return. That's because the palliative approach to wound care is a fairly new concept.

Clearing up misperceptions about palliative wound care

Certain perceptions of palliative wound care need to be clarified.

- Choosing palliative wound care *doesn't* mean you're giving up on the patient and the wound. Studies show approximately 50% of patients receiving palliative wound care achieve wound healing.
- Palliative care *isn't* the same as hospice care. Hospice care is a component of palliative care chosen by patients when their physician determines they're within 6 months of dying. This prognosis qualifies them for hospice care benefits from Medicare as well as some insurance companies and managed care organiza-



tions. Palliative care can occur simultaneously with curative therapies. In contrast, hospice care plans don't normally include curative therapies. Also, palliative care can be chosen at any time, not just the last few months of life.

- Patients who choose palliative care *aren't* indirectly hastening their deaths. In one study, researchers randomized 151 patients into two groups. The control group received standard oncologic care alone; the study group received the same care plus early palliative care. Patients in the early palliative care group had a better quality of life and longer median survival than patients in the standard care group.

Why patients may choose palliative care

As healthcare consumers become more knowledgeable about their options, more are exercising the right to make decisions based on their best interests and belief systems. Palliative wound care is well suited for patients with wounds whose underlying causes don't respond to treatment, as well as those whose treatment demands are too taxing for their diminishing endurance level.

Some wound care treatments can be painful and distressing for the patient and family to perform—or too expensive for the patient to pay for. As the underlying disease

progresses, a move to palliative wound care shifts the focus to maximizing comfort and function for the patient and family, and away from more aggressive healing therapies. It's time we begin looking at wound care from the patient's and family's perspective, and realistically incorporate the patient's prognosis into goal setting.

When to consider a palliative approach

One article suggests wound care clinicians should ask themselves: Would the patient's quality of life improve significantly if the wound healed? If the answer is no, palliative wound care should be considered. When patients are coping with serious illness and the many distressing symptoms that may accompany it, standard wound care may impair quality of life—and deserve a lower priority. When proper prioritization takes place, wound care justifiably can be optional, especially when patients are actively dying or wound care causes undue discomfort. In those cases, the need to measure wounds at least weekly can be suspended.

The National Pressure Ulcer Advisory Panel's white paper titled "Pressure Ulcers in Individuals Receiving Palliative Care" states: "Healing is seldom the goal for these individuals receiving hospice or palliative care, and therefore, there is no purpose to frequently measuring the wound size or deterioration because no plans to intervene will be derived in these measurements."

Dispelling one last myth

Learning to incorporate a palliative approach to wound care means dispelling one last myth—that palliative wound care is a "do-nothing" approach. Nothing could be further from reality. Clinicians may decide to deprioritize wound care when the patient is actively dying or experiencing pain. But this plan is a conscious decision made by the patient and

Palliative care information

A useful link for general information and resources on palliative care is [Get Palliative Care](#). It includes resources for patients and providers, such as [handouts](#) and the video "[What palliative care is and why it matters.](#)"

Direct patients to <http://getpalliativecare.org/handouts-for-patients-and-families/> for simply worded information on palliative care, which is also available as a PDF handout you can print and give to patients.

family in conjunction with clinicians. The decision begins with completing a full wound assessment to determine patient factors and identify signs and symptoms that are having the greatest negative effect on quality of life. That's where the real work begins. ■

Editor's note: "Palliative wound care: Part 2" will provide clinical tips to address the most common issues in managing palliative-care wounds—pain, odor, exudate, bleeding infection, and cosmetic appearance. Look for this article in the March/April issue of *Wound Care Advisor*.

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Healthcare reform and changes provide opportunities for wound care clinicians

By Kathleen D. Schaum, MS

Qualified healthcare professionals (QHPs), such as physicians, podiatrists, physician assistants, nurse practitioners, and clinical nurse specialists, are taught to diagnose the reasons that chronic wounds aren't healing and to create plans of care for aggressively managing the wound until it heals. Wound care professionals—nurses and therapists—are taught to implement those plans of care. All of these highly skilled wound care professionals know how to manage chronic wounds from identification through healing.

Unfortunately, many wound care professionals don't currently have the opportunity to follow patients with chronic wounds from beginning to end because the patients move from one site of care to another before their wounds heal. Suppose, for example, a patient with a chronic wound is in an acute-care hospital, then moves to a skilled nursing facility, then returns to his or her home under the care of a home health agency, and is later referred to the care of a hospital-based outpatient wound care department. The same wound care professionals rarely follow the patient through all these site changes. In addition, the plans of care and the wound care products may change because each site of service has different

staff and a different Medicare payment system. This lack of consistency leads to:

- nonspecific or inconsistent diagnoses
- duplicate tests
- inconsistent clinical practice guidelines or plans of care
- incomplete documentation or documentation not transferred to the next site of care
- wasted dressings
- inconsistent use of devices or advanced technology
- selection of services, procedures, or products based on reimbursement to the provider
- lack of wound care-related quality measures.

Nearly all, if not all, of this inconsistency can be traced to the lack of a consistent wound care QHP leader and a consistent wound care case management team that directs the wound care as the patient moves to various sites of care. However, the current unique site-of-service Medicare payment systems don't provide the incentives for wound care case management across the continuum of care.

A new way

The Centers for Medicare & Medicaid Services (CMS) and private payers also recognize the need to develop new payment systems that will provide excellent outcomes, at the lowest total cost of care and with excellent patient satisfaction. Therefore, the payers (both CMS and private payers) have released a variety of demonstration projects and risk-sharing contracts that will incentivize providers to think outside the box to manage care throughout the continuum rather than within their silos of care. This should be

great news for wound care QHPs and wound care professionals. As a wound care professional, you will finally be able to use your skills to manage wounds from the beginning through to healing.

The first step you need to take to reap the benefits of payment system changes is to recognize when networks are being developed to participate in these demonstration projects and risk-sharing contracts.

Some of the first clues that networks are forming in your community include:

- multiple QHP practices joining together
- multiple hospitals joining together
- multiple sites of care joining together into one large health system.

As soon as you notice these activities, seek out the leader of the initiative and request a meeting. During the meeting, first learn the reason for the consolidation. After listening carefully to the leader, share some ideas of how QHP case management teams can provide high-quality wound care that will result in excellent outcomes, at the lowest total cost of care, and with a high level of patient satisfaction.

Once you capture the attention of the leader, he or she will start opening doors for you to participate in the network. At that point, you will have to start thinking innovatively to develop wound care case management teams that can service this new network. Remember, the new network will usually be paid some type of bonus if it can reduce overall spending of the payer on the population group that it services, if it achieves excellent outcomes, and if it achieves a high level of patient satisfaction.

Medicare patients will have two parallel payment systems: their current Medicare volume-based payment system and the

new *value*-based system that wound care QHPs and wound care professionals will help to design. You will now be incentivized to:

- provide evidence-based patient-centered care
- coordinate care with all stakeholders
- improve efficiency
- eliminate unnecessary tests
- reduce duplication of effort
- reduce medical mistakes and postsurgical complications
- reduce hospital and emergency department readmissions
- reduce waste
- emphasize prevention
- use data to show quality of care provided.

Therefore, this is your opportunity to gain further recognition as a wound care specialist—but only if you open your eyes to what’s going on in your medical community and develop case management teams that can service the new network design by providing the right patient-centered care, for the right reason, at the right time, and for the right total cost of care. Yes, this will require you to step out of your comfort zone, but you will be stepping into your new, exciting future where you can manage wounds from start to finish. This can be your mission, if you choose to accept it.

ICD-10-CM opportunities

Wound care QHPs and wound care professionals are often frustrated because payers don’t understand the complexities involved in treating patients with chronic wounds and often deny coverage for needed treatments or advanced technology. When making coverage decisions, payers rely heavily on the diagnosis codes

and the documentation in the health record. Wound care QHPs must realize their responsibility to show what they know about each patient encounter and to paint that picture for the payer through the use of diagnosis codes and documentation. Unfortunately, these activities are typically wound care QHPs' weaknesses.

Granted, the current ICD-9-CM diagnosis codes don't offer wound care QHPs the opportunity to explain the total complexity of treating their wound care patients. Luckily, this 40-year-old system is going to be replaced with the new ICD-

When the ICD-10-CM is introduced, documentation will be more important than ever before.

10-CM coding system on October 1, 2015. (You can view the ICD-10-CM codes and specific descriptions at <http://www.cdc.gov/nchs/icd/icd10cm.htm>.)

When these new codes take effect, wound care QHPs will finally be able to describe the complexity of each patient encounter through diagnosis codes, owing to the work of QHPs who designed the new ICD-10-CM. To maximize the use of these new diagnosis codes, wound care QHPs and wound care professionals must learn the specificity that's built into the descriptions of the new diagnosis codes. You will probably not memorize the ICD-10-CM code numbers (because there are too many of them), but you can easily memorize the level of specificity about each patient encounter that must be documented in the health record.

When the ICD-10-CM is introduced, documentation will be more important than ever before. Wound care QHPs and wound care professionals should take advantage of the period before the implementation of ICD-10-CM by identifying the top 20 current ICD-9-CM diagnoses that define their patients' conditions and then identifying the level of specificity that will be required in the new ICD-10-CM codes that define those same conditions. Wound care QHPs and wound care professionals should then work on improving their documentation for one major condition every 3 weeks. Once the documentation for that condition becomes a new habit, they can move on to improving their documentation for the next condition on their list.

Prepare for the future

The beauty of improving your documentation is that it will help you communicate your patients' conditions to payers today while preparing you for the documentation that will be required to prove medical necessity for your work when ICD-10-CM takes effect on October 1, 2015. Wound care QHPs and wound care professionals should take this opportunity to prepare for their future wound care case management roles by improving their clinical documentation, which will help them justify aggressive wound management and demonstrate their patient outcomes and the quality of their work. You have 10 months to improve your clinical documentation so that you can easily slide into ICD-10-CM. Prepare now; don't procrastinate! ■

Kathleen D. Schaum is president and founder of Kathleen D. Schaum & Associates, Inc., Lake Worth, Florida. Contact her with questions or consultation requests at 561-964-2470 or kathleendschaum@bellsouth.net.

Helping the Sandwich Generation find work-life balance

Learn about the support and resources available for clinicians caring for both grown children and aging parents.

By Kari Olson Finnegan, BSN, and Liz Ferron, MSW, LICSW

If you have at least one parent age 65 or older and are raising children or financially supporting a child age 18 or older, you're part of the Sandwich Generation. Coined in 1981 by social worker Dorothy Miller, the term originally referred to women, generally in their 30s and 40s, who were "sandwiched" between young kids, spouses, employers,

and aging parents. While the underlying concept remains the same, over time the definition has expanded to include men and to encompass a larger age range, reflecting the trends of delayed childbearing, grown children moving back home, and elderly parents living longer. The societal phenomenon of the Sandwich Generation increasingly is linked to higher levels of stress and financial uncertainty, as well as such downstream effects as depression and greater health impacts in caregivers.

If you're a clinician and make your living as a caregiver, the Sandwich Generation may feel like a club you don't really want to belong to. Perhaps you've fantasized about quitting your job, leaving your family behind, and decamping to an exotic South Seas island. Of course, you know you're unlikely to do that. But you also need to avoid the opposite extreme: trying to avoid thinking about your multiple caregiving roles and just soldiering on, typical of many clinicians. The impact of caregiving is real and tangible. It must be taken seriously and approached in a



way that protects the caregiver's physical, mental, and financial well-being.

Physical and mental health effects

In a 2007 "Stress in America" report, the American Psychological Association found that Sandwich Generation mothers ages 35 to 54 felt more stress than any other group as they tried to balance giving care to both growing children and aging parents. Nearly 40% reported extreme levels of stress (compared to 29% of 18- to 34-year-olds and 25% of those older than 55). Women reported higher levels of extreme stress than men and felt they were managing their stress less effectively. This affect-

Stress, anxiety, and depression can result from juggling too many home and work demands.

ed their personal relationships; 83% reported that relationships with their spouse, children, and other family members were the leading source of stress. Stress also took a toll on their own well-being as they struggled to take better care of themselves.

Another study focusing exclusively on health-related issues found employed family caregivers had significantly higher rates of diabetes, high cholesterol, hypertension, chronic obstructive pulmonary disease, and cardiovascular disease across all ages and both genders. Depression was one-third more prevalent in family caregivers than non-caregivers, and stress in general and at home was higher across all age and gender cohorts. (See *A perfect storm for the Sandwich Generation*.)

Reaching out for help

No doubt, some of you reading this article are living the Sandwich Generation experience. As a clinician, you may find it hard to reach out for help and support. But that's the most important first step—acknowledging that not only is it okay to ask for help, but it's critically important. Asking for help may reduce the stress associated with fulfilling your responsibilities at home and at work. Clinicians talk a lot about the importance of a work-life balance; such a balance is essential to coping effectively with the many demands faced by clinicians, especially those of the Sandwich Generation.

What does it really mean to balance work and life? In our practice, we see clinicians come to us for help when they feel overwhelmed; many have multiple presenting issues. As we work with them, we learn these issues sometimes are linked. For instance, financial stress can lead to family or relationship strains. Stress, anxiety, and depression can result from juggling too many home and work demands. Being responsible for dependent children or supporting an out-of-work spouse or partner can be daunting. The additional support that grown children and aging parents require can push even the most resilient clinicians past their tipping point.

For some of you, employers may have resources and programs that can help. Providing more flexible scheduling can help employees better handle family responsibilities. Speak to your supervisor to see if together you can devise a plan that allows you to take time off for such things as school events or doctor's appointments while still meeting your organization's staffing needs. Some employers offer el-

dercare benefits, which can help with planning and identifying resources.

It's also helpful to learn from others. Speak to your human resources department about forming and promoting a lunchtime or after-work support group for "sandwiched" employees to share experiences and resources—and providing the space where the group can meet. Most larger healthcare organizations offer an employee assistance program (EAP), which can provide valuable counseling and support for:

- coping skills and resilience-building
- prioritizing and time management
- setting and maintaining appropriate boundaries
- finding resources to assist with caregiving
- eldercare-related education and resources on financial and life planning for parents
- financial and budget planning to manage your money wisely while planning for your retirement, your children's college expenses, and other needs.

Some EAPS provide RN peer coaches and master's-prepared counselors to help employees deal with stressors both inside and outside of work.

Self-care

The following guidelines can help Sandwich Generation clinicians (or anyone, really) take care of themselves.

- **Watch for depression.** Studies show family caregivers are at higher risk for depression, which may creep up on you. If you or your spouse or partner has access to an EAP, ask those counselors for help with this. Otherwise, if you're experiencing signs or symptoms of depression, speak to your primary care

A perfect storm for the Sandwich Generation

The Pew Foundation's 2013 report, "The Sandwich Generation: Rising Financial Burdens for Middle-Aged Americans" describes a "perfect storm" of issues that can appear overwhelming for those caught in it. Based on a 2012 survey, the report addresses pressures facing adults ages 40 to 59 who are providing financial support for both grown children and aging parents. It found that:

- 48% of adults ages 40 to 59 had provided some financial support to at least one grown child (age 18 or older) in the past year and 27% had provided primary support
- 21% had provided some financial support to a parent age 65 or older in the past year
- 38% said both their grown children and parents rely on them for support
- 28% of those providing financial support for both a parent and a child of any age said they were living comfortably, compared to 41% who weren't financially supporting an aging parent
- about one-third were providing assistance with daily living to aging parents.

Caregiving and employment

A 2010 study published by Healthways Center for Health Research explored the effects of informal caregiving, employment, and the combination of family caregiving and work responsibilities on the overall well-being of more than 240,000 Americans. It found lower levels of well-being in family caregivers than noncaregivers of the same employment status. Among family caregivers, employment is linked to greater well-being, which has benefits (such as financial security and social support) that may ease the caregiving burden.

physician for a more complete screening and assistance or a referral to a therapist or psychologist.

- **Put yourself in the "balance" equation.** Be intentional about setting aside time for yourself. If you wait until you have free time, you may well be waiting until retirement, leaving you susceptible to

burnout. Set aside regular time for self-care, such as by taking a yoga or exercise class or scheduling time to jog with a friend.

- **Set boundaries.** This ensures you have time to take care of yourself as well as other important things. Be honest about what's absolutely necessary—and where there's room for compromise or saying no. Being at your child's school play? Not negotiable. Baking cookies for the party afterward? No one is likely to remember 15 minutes after the party ends.
- **Ask for help.** People ask you for help all the time; ask them to return the favor. They can always say no, but most won't—and may be delighted to lend a hand.
- **Hold family meetings.** This is important—to set expectations and boundaries, get help, and enlist others to share some of the responsibilities. Even young children and frail elders can be part of the solution, but you have to let them understand the needs and give them a chance to meet them.
- **Find and use a financial planner.** You can relieve a lot of stress not only by helping yourself and your parents protect your future and manage the present but also by setting reasonable boundaries and conditions around financial support for grown children and elders.

For tips on caring for yourself and to learn how to switch on and off to transition from home to work, download and use the **Helper Pocket Card**.

Eldercare can be especially challenging—but many sources of help are available. A good place to start is with the **Elder-**

care Locator, a federally funded service that connects caregivers with local resources (available online at www.eldercare.gov/Eldercare.NET/Public/Index.aspx or by phone: 1-800-677-1116). Every county or multicounty area in the United States has an Area Agency on Aging that receives federal funding to provide information and referral to family caregivers on aging and caregiving services, such as adult day care, respite care, home repair and modification, personal care, and more. ■

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Special edition: Resources from the Buzz Report



This issue, we highlight some resources from “The Buzz Report,” the popular presentation given by editor-in-chief Donna Sardina, RN, MHA, WCC, CWCMS, DWC, OMS, at the Wild On Wounds (WOW) conference, held each September in Las Vegas.



Decolonization protocol to reduce MRSA

The Agency for Healthcare Research and Quality has published “**Universal ICU Decolonization: An Enhanced Protocol.**” The protocol is based on materials successfully used in the REDUCE MRSA Trial (**R**andomized **E**valuation of **D**ecolonization vs. **U**niversal **C**learance to **E**liminate Methicillin-Resistant *Staphylococcus aureus*), which found that universal decolonization was the most effective intervention.

Download the protocol, which includes an overview, scientific rationale, and several appendices with valuable tools, such

as a flow chart of implementing universal decolonization, chlorhexidine bathing skills assessment, nursing protocol, and training and education materials.

Collagenase SANTYL® Ointment online dosing calculator

Use a handy **online calculator** to estimate the number of grams needed for therapy and the amount of SANTYL® Ointment to apply per application. Simply enter the width and length of the wound in centimeters, along with the planned number of treatment days. The results include not only the amount, but also the calculation.



You can also download the calculator to your computer or tablet for easy access. Of course, the estimates are simply a guide and should be adjusted based on clinical experience and individual wound characteristics.



CDC resources for long-term care facilities

The Centers for Disease Control and Prevention (CDC) has dedicated an entire

(continued on Inside Back Cover)

Note from Executive Director



By Cindy Broadus, RN, BSHA, LNHA,
CLNC, CLNI, CHCRM, WCC, DWC, OMS

With the holidays behind us and the new year here, I have to ask myself, “What happened to 2014?” It passed by so quickly, and what a year it has been! In 2014 we welcomed 1,835 additional certified clinicians to the “family.” It’s exciting to see the number of clinicians who are advancing their knowledge so that they can become the best wound care providers they can be. With this continued growth in certified clinicians, wound patients can expect to receive the best of care.

The National Alliance of Wound Care and Ostomy (NAWCO) board members have also voiced their excitement over the continued growth and interest in certification in wound care. The board works hard throughout the year to promote and establish guidelines and standards of excellence for certification and recertification in wound care.

Some of you may not know about the board or may not be familiar with its members. NAWCO is a nonprofit organization governed by a volunteer board of directors. Because the board has a vital role in NAWCO, I’d like to tell you more about what it does and discuss its goals and its members.

In this issue, I’ll explain the board’s selection process, share mission and goals, and provide the list of members.

Selection process

Below is the board selection process.

- NAWCO staff and existing board members identify prospective board members—individuals who have demonstrated leadership and commitment to values shared by NAWCO.



National Alliance of Wound Care
and Ostomy®

- The prospective member is invited to attend a board meeting.
- If the board agrees to move forward, each member interviews the candidate. If approved, the individual’s name is placed on the slate for election by the membership.
- Once elected, a member serves a term of 3 years. The member may serve up to a maximum of five consecutive terms, pending board approval for term renewal.

Mission

NAWCO is dedicated to the advancement and promotion of excellence in the delivery of wound care to the consumer through its credentialing of practitioners who have demonstrated proficiency in wound care, through its encouragement of licensed healthcare professionals to specialize in the practice of skin and wound management, and through its promotion of the recognition of skin and wound care as an essential component of the healthcare system.

Goals

Goals of the board include the following:

- promote continued education to all who are certified
- promote and support educational programs for consumers and healthcare providers
- promote excellence in wound care by working with national healthcare organizations in the promotion of wound care education and quality assurance programs.

Board members

- Debbie Dvorachek—president

- Kathryn Pieper—vice president
- Cheryl Robillard—secretary/treasurer
- Carol Krueger—board member
- Ottamissiah Moore—board member
- Rosalyn Jordan—board member
- Andrew Joiner—board member
- Clive Horrocks—board member
- Michael Richardson—board member

I have spoken at length with all the

board members and can attest to the fact that their focus is on the certified clinicians who work to better themselves not only personally but professionally, and on the patients who receive care from these credentialed clinicians.

We want you to get to know your board. Learn about each one of these talented, devoted board members in upcoming issues of *Wound Care Advisor*. ■

New certificants

Below are WCC, DWC, and OMS certificants who were certified from October to November 2014.

Verna Abacan
Sandra Marie
Abayari-Evaristo
Robyn Achmann
Roxanne Acosta
Jane Afremova
Samuel Aguado
Laura Alaniz
Heidi Albor
Tracy Alexander
Frances Alfaro
Cynthia Allen
Jeanette Allen
Jean Allen
Ann Altier
Emily Altman
Amanda Amaro
Shannon Anderson
Lee Anton
Justina Anyanwu
Zachary Aoga
Jhoanna Krista Arao
Karen Armao
Fazila Aslam, MD
Mary Baker

Kelli Ballard
Cheryl Barnes
Larisa Barskaya
Mary Bartolome
Nadia Saliha Belkadi
Marjorie Bell
Jenna Beltramini
Marissa Benavente
Donna Benedict
Sherry Benefield
Kejda Benz
Melinda Berry
Nicole Bettin
Susan Biehler
Bonnie Birmingham
Sandra Bjornstad
Viola Blankenship
Kiley Bogart
Emily Bonisteel
Rebecca Bono
Amber Boring
Benjamin Boucher
Sherry Brantley
Gale Brewer
Beth Bright

Angela Brown
Catherine Bruce
Betsy Bruemmer
Sharilyn Buckman
Frederick Buescher II
Deborah Burchfield
Suzanne Burdick
Stephanie Burres
Margaret Butler
Kerry Byrnes, MD
Deborah Carey
Jennifer Carrier-Masse
Martha Carson
Rosalia Casapa
Colleen Chamberlin
Cherryl Chambers
Naziya Charaniya
Christine Chen
Julie Chhea
Sunyoung Cho
Miranda Christen
Karen Christmas
Kristi Clark
Terri Clark
Nickol Cleary
Paula Combs
Betsy Conchar
Wenjane Conche
Megan Connell
James Corbett

Victoria Correll
Margaret Corso
Brenda Couture
Susanne Cox
Ronnel Cruz
Ian Cummins
Traci Curran
Olakunbi Dada
Ashley D'Agostino
Christine Daniels
Jennifer Daponte
Sherrell Davis
Suzanne Davis
Angela Davis
Reynaldo De La Torre
Kayce DeBakey
Brenda DeBell
Chansamone Dee
Kassi Deese
Kenneth Dehn
Cristina Delos Santos
Amy DelPozzo
Heather Denney
Amy Dennis
Cathy Dennis
Tamara Dent-Jackson
Lynn Devlin
Sarah Devorss
Oralia Diaz

Laura Dickinson	Christine Gerhart	Marianne Holmes	Kellie King
Guadalupe Dill	Richard Giguere	Julie Hone	Santeia Kinnon
Andrew Ditto, MD	Gail Gill	Lori Honeyman	Craig Knifley
Anne Dittus	Suzanne Gilleran	Christine Hong	Maureen Knights
Glenn Dobson	Dorit Gilman	Donna Hooper	Siew Koay
Maria Dorado	Poloma Gonsalves	Paula Horn	Minori Korn
Shirley Drake	Shana Gonzales	Rose Hornbaker	Tina Koss
Vicki Drexler	Meredith Goodwin	Jessica Howard	Margaret Kreiter
Tina Drummond	Paula Gray	Rory Howard, MD	Roxane Krivitski
Carol Dupoux	Shannon Greek	Michele Hudon	Victoria Kushnir
Robert Dyer	Kimberly Griffin	Lilian Huerta	Yelena Kuznetsov
Elizabeth Earley	Andrew Grubbs, MD	Veronica Hughes	Lindsay Labounty
Stephanie Edwards	Urszula Grzelecki	Dawn Hunt	Chasity Lade
Mona El-Sherif	Kylee Gustafson	Patricia Hunter	Barbara Laman
Katherine Emborsky	Russell Haas	Hanling Huo	Deborah Lambert
Beth Emery	Latina Hada	Anne Hussong	Kristi Laney
Wendy Engel	Cheryl Hadley	Michelle Jaeckels	Bethani Lanham
Deborah England	Mindy Hahn	Kalonji Jahi	Rebecca LaPorte
Kimberly Ewell	Brian Halloran, MD	Lindsey James	Mary Lariosa
Linda Farr	Kathryn Hammonds	Robyn Janda	Diane LaRock
Brett Ferrell	Susan Hamrick	Venessa Jicha	Kurt Lassig
Justine Fine	Diane Hannon	Rebecca Jimenez	Lissette LeBron
Jessica Fleming	Christine Hansen	Cathy Johnson	Stephanie Lee
Lisa Fliehr	Summer Hare	Mary Johnson	Brenda Lemmon
Diane Flower	Julie Harris	Carmen Johnston	Jonathan Leong, MD
Deborah Foy	Mallinda Harris	McGallis	Edward Leu
Sara Frank	Hampton	Lisa Jones	Madele Limpahan
Shirley Frazier	Jeffrey Hawks	Amanda Jones	Amy Locke
Stacy Freitag	Theresa Healy	Tiffany Jordan	Michele Long
Deborah Fritts	Amanda Hedge	Mari Joy	Janet Long
Sandra Fruhwirth	Shauna Henson	James Juliano	Maria Riza Lopez
Katrina Fulmer	Jennifer Herkel	Meghan Kaphing	Amber Lords
Theresa Furlong	Christina Hermsen	Janet Karro	Denise Lunstroth
Kelly Gabel, DO	Max Herrell II	Brian Katz	Ariel Lusby
Thomas Gagliano	Rebecca Herter	Maninder Kaur	Disney Macias
Louis Gallo	Tausha Higgins	Kamaljeet Kaur	Nicholas Madison
Rita Garcia	Kathleen Hilakos	Debra Keefer	Anissa Madru
Brittany Gardner	Suginda Hill	Elizabeth Kegg	Robyn Magaw
Gretchen Garrett	Stacy Hinson-Austin	Lisabeth Keith	Whitney Main
Lisa Garza	Joann Hoff	Sarah Kelton	Cynthia Malin
Tanya Gately	Lisa Hogenmiller	Melissa Khoo	Raphael Manalo
Donna George	Pottgeiser	Stacey Kidder	Patricia Manchester
Sharon George	Sarah Holder	Charles King	Patricia Mangano

Cecilia Mangosing	Laura Miller	Suzanne Paumen	Crystal Roque
Christopher Mannari	Joy Mitchell	Jaime Perillo	Robert Rossi
Adrienne Manzo	Amy Mitchum	Patrice Perry	Loreen Roux
Jennifer Marcellino	Megan Mobley	Karshira Peshlakai	Nicole Royston
Irene Markman	Jennifer Moody	Landon Pettit	Jennifer Ruble-Guise
Lisa Martin	Linda Moore	John Peyton Jr.	Ann Rudd
Michelle Martin	Danielle Moran-	Deborah Pferman	Annalisa Saiz
Carolyn Martin	Tanguay	Tina Phillips	Ela Salud
Meylin Martinez	Michelle Morse	Christine Piancone-	Jeliza Santos
Quinones	Sondra Moseley	Wolfe	Jennifer Sayas
Justyna Maslowski	Donald Moser	Prasad Pilli, MD	Abigail Schanney
Debra Mason	Julia Moses	Mohammad	Briana Schiller
Carrie Materniak	Kari Mracek	Pirzadah MD	Kimberly Schipper
Alice Matey	Tawna Mulcahy	Mary Ann Pitman	Rebecca Schmidt
Kelly Mattila	Doris Muriithi	Delacey Pitts	Kellee Schmitt
Myrtie Maupin	Collin Murphy	Christy Pohero	Dana Sears
Zacharias	Marla Naumchik	Brittany Pothier	Marcia Seefeldt
Mavrophilipos, MD	Shelley Neeleman	Julia Power	Heather Sevigny
Susie Mayo	Tran Nghiem	Kimberly Primiano	Melissa Shanmugam
Teresa McClain	Beverly Niebuhr	Casey Pritchard	Linda Sheley
Christopher	Katie Nolan	Matthew Quetot	Kristin Shields
McCollum	Cathryn Norman	Patricia Ragan	Vicki Shilts
Sharla McComas	April Nowland	Annie Rajan	Julie Shurtleff
Mary McDonough	Linee Nulf	Kristin Ramondetta	Barbara Simmons
Maria McElvaney	Lourdes Nunez	Angela Ramsay	Deborah Sloan
Shannon McGinn	Dianne Nunez	Rita Raymaker	Kathy Small
Jennifer Mckeown	Jennifer Nussbaum	Charlie Rencher Jr.	Kayla Smith
Josette McNeill	Olusesan Obasanya	Lisa Retallick	Megan Smith
Karla McNish, MD	Denise O'Donnell	Amber Reynolds	Michelle Snyder
Daniel Mehari	Constance O'Donnell	Danielle Rheault	Barbara Sobczyk
Jose Roberto	Christy O'Kane	Rebecca Rhodes	Cheryl Spak
Melendres	Melva Oller	Tara Richter	Amy Sparks
Carlos Mena	Dawn Olson	Wendy Ripley	Phyllis Speir
Michelle Merandi	Nanette O'Neill	Maria Rivera	Sylvia Springer-Fahie
Gloria Merideth	Harriet Onyechu	Marta Rivera, MD	Nieasha Stafford
Ma Rosario Mertola	Ashley Oubre	Lindsay Roberts	Dawna Stebbins
Monica Metri	Michael Owen	Michael Robinson,	Mary Steele
Christina Midiri	Lowanda Owens	MD	Michele Steighner
Kelly Mike	Socorro Paguirigan	Yecenia Rodriguez	Mascetta
Megaen Mikell	Kristin Parell	Gonzalez	Beth Stevenson
Blondena Miley	Linda Parker	Samantha Rollins	Pamela Stevens-Reitz
Christian Miller	Amy Paselk	Sheila Ronan	Octavia Struve
Tara Miller	Bettina Paul	Michelle Rooney	Melissa Stuparits

Dolores Suarez
Jennifer Suggs
Shawn Sumney
Jennifer Taylor
Andrea Tekip
Kim Tekut
Autumn Theoclis
Autumn Thomas
Beverly Thorpe
Kathlene Tiegs
Lalah Tolleson
Christine Tondi
Carla Tridente
John Tuitele
Janice Tuitt
Marion Tully
Elizabeth Turchi
Kelly Turner
Jennifer Ty-
DeGuzman
Stephen Tynan
Alexis Urzua
Vanessa Valdez
Michael Valerio
Kristian Van Wormer
Desiree Vasile
Elizabeth Vazquez
Renee Velez
Trina Vidrine
Benilda Villasan-
Escobar
Tobin Wagoner
Michael Waldron
Sanyu Walker
Amirah Walker
Amanda Ward
Paula Watson
Emily Webb
Elizabeth Wehnert
Anita Wells
Patricia White
Heidi White
Stacey Whitehead

Stephen Wikert
Angela Wilkins
Natalie Wilkinson
Dawne Wilkinson
Chamberlayne
Leota Wilkinson-
Burch
Nadia Williams
Anietie Williams
Linda Wines
Erin Wisian
Theresa Wood
Jeanette Workman-
Cosentino
Kendra Wright
Alicia Wyatt
Delrose Ximines
Yi Yang
Wentao Yang
Michelle Yankowski
Alice Yu
Xiaoxia Yu
Lindsey Yuen
Melissa Zaba
Carla Zahradka

Recertified certificants

Below are WCC,
DWC, and OMS
certificants who
were recertified
from October to
November 2014.

Jeanette Ackland
Donna Amato
Peter Aucoin
Amy Bala
Debra Barnhardt
Jennifer Baugh
Robert Baxt, MD

Maria Bemben-
Kalawa
Lisa Bena
Wayne Bernard
Kimberly Berry
Deborah Bezdek
Sondra Boehm
Yvonne Boozer
Brenda Brandl
Theresa Brooks
Linda Browne-
Dicette
Kisstina Bush
Cynthia Caldwell
Luigi Capobianco,
MD
Jerelyn Carpenter
Larpie Castro
Jean Christopher
Jennifer Condren
Pamela Connor
Kenneth Costa
Sandi Crawford
Lynne Cunningham
Mikel Daniels, DPM
Wendy DaSalla
Sirner Dhaliwal
Melanie Dominguez
Sonya Dunbar
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section of its website to [information for long-term care facilities](#).

Among the resources are clinical staff information, resident information, and prevention tools. You can also access [guidelines for infection prevention and control in healthcare settings](#) and information about [tracking infections in long-term care facilities](#).

Over 3 million Americans receive care in U.S. nursing homes and skilled nursing facilities each year and nearly 1 million persons reside in assisted living facilities.

[Free wound care resources](#)

Access a variety of free wound care resources from [Advanced Tissue](#). The resources include newsletters and webinars of interest to clinicians, such as [“Identifying ulcers,”](#) [“Let’s go on wound rounds! Management](#)



[of pressure ulcers,”](#) and [“Strategies for wound care treatment and debridement.”](#)

You can also sign up to receive invitations to future wound education webinars.

[Patient information on PAD](#)

[“Vascular disease patient information page: Peripheral artery disease”](#) (PAD), an article by Ratchford and Evans in *Vascular Medicine*, explains what PAD is and discusses risk factors, signs and symptoms, diagnosis, treatment, and prevention. The article includes a figure that describes ankle-brachial index measurement.

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