Healthcare reform changes

BUZZ Report: Trends in wound care

- Palliative wound care
- Communicating to caregivers
- Clinical trials

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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.

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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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**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**


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 stomaplasty 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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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 Pressure 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-
interest 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 therapy 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


Donna Sardina is editor-in-chief of Wound Care Advisor and cofounder of the Wound Care Education Institute in Plainfield, Illinois.

Quiz Time

Which of the following is an advantage of a dry-suction chest drainage system?

a. Lower levels of suction pressure
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.

Selected references


Nancy Morgan, cofounder of the Wound Care Education Institute, combines her expertise as a Certified Wound Care Nurse with an extensive background in wound care education and program development as a nurse entrepreneur.

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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
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.

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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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
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 reviewed 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 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

Online patient education resources
Direct patients seeking general information about clinical trials to the websites below.

  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
  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/clinicaltrialsspanish.htm/index.htm.
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.

Selected references


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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
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?”

Verifying 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?”

Selected references

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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-
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
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.

Selected references


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

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!

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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 affected 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-
ndercare 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 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/Elder-care.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.

**Selected references**


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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 (Randomized Evaluation of Decolonization vs. Universal Clearance to Eliminate 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)*
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.
- 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
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 Saliahi Belkadi
- Marjorie Bell
- Jenna Beltramini
- Marissa Benavente
- Donna Benedict
- Sherry Benfield
- Kejda Benz
- Melinda Berry
- Nicole Bettin
- Susan Biehler
- Bonnie Birmingham
- Sandra Bjornstad
- Viola Blankenship
- Kiley Bogart
- Emily Bonisteele
- Rebecca Bono
- Amber Boring
- Benjamin Boucher
- Sherry Brantley
- Gale Brewer
- Beth Bright
- Angela Brown
- Catherine Bruce
- Betsy Bruemmer
- Sharlyn 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
- Cheryl 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 Dellos Santos
- Amy DelPozzo
- Heather Denney
- Amy Dennis
- Cathy Dennis
- Tamara Dent-Jackson
- Lynn Devlin
- Sarah Devorss
- Oralia Diaz
Laura Dickinson
Guadalupe Dill
Andrew Ditto, MD
Anne Ditto
Glenn Dobson
Maria Dorado
Shirley Drake
Vicki Drexler
Tina Drummond
Carol Dupoux
Robert Dyer
Elizabeth Earley
Stephanie Edwards
Monia El-Sherif
Katherine Emborsky
Beth Emery
Wendy Engel
Deborah England
Kimberly Ewell
Linda Farr
Brett Ferrell
Justine Fine
Jessica Fleming
Lisa Flihr
Diane Flower
Deborah Foy
Sara Frank
Shirley Frazier
Stacy Freitag
Deborah Fritts
Sandra Fruhwirth
Katrina Fulmer
Theresa Furlong
Kelly Gabel, DO
Thomas Gagliano
Louis Gallo
Rita Garcia
Brittany Gardner
Gretchen Garrett
Lisa Garza
Tanya Gately
Donna George
Sharon George
Christine Gerhart
Richard Giguere
Gail Gill
Suzanne Gilleran
Dorit Gilman
Poloma Gonsalves
Shana Gonzales
Meredith Goodwin
Paula Gray
Shannon Greek
Kimberly Griffin
Andrew Grubbs, MD
Urszula Grzelecki
Kylene Gustafson
Russell Haas
Latina Hada
Cheryl Hadley
Mindy Hahn
Brian Halloran, MD
Kathryn Hammond
Susan Hamrick
Diane Hannon
Christine Hansen
Summer Hare
Julie Harris
Mallinda Harris
Hampton
Jeffrey Hawks
Theresa Healy
Amanda Hedge
Shauna Henson
Jennifer Herkel
Christina Hermsen
Max Herrell II
Rebecca Herter
Tasha Higgins
Kathleen Hilakos
Suginda Hill
Stacy Hinson-Austin
Joann Hoff
Lisa Hogenmiller
Potteger
Sarah Holder
Marianne Holmes
Julie Hone
Lori Honeyman
Christine Hong
Donna Hooper
Paula Horn
Rose Hornbaker
Jessica Howard
Rory Howard, MD
Michele Hudon
Lilian Huerta
Veronica Hughes
Dawn Hunt
Patricia Hunter
Hanling Huo
Anne Hussong
Michelle Jaeckels
Kalonji Jahi
Lindsey James
Robyn Janda
Venessa Jicha
Rebecca Jimenez
Cathy Johnson
Mary Johnson
Carmen Johnston
McGallis
Lisa Jones
Amanda Jones
Tiffany Jordan
Mari Joy
James Juliano
Meghan Kaping
Janet Karro
Brian Katz
Maninder Kaur
Kamaljeet Kaur
Debra Keefer
Elizabeth Kegg
LisaBeth Keith
Sarah Kelton
Melissa Khoo
Stacey Kidd
Charles King
Kellie King
Santeia Kinnon
Craig Knifley
Maureen Knights
Siew Koay
Minori Korn
Lindsay Labounty
Chasity Lade
Barbara Laman
Deborah Lambert
Kristi Laney
Bethani Lanham
Rebecca LaPorte
Mary Lariosa
Diane Lariosa
Kurt Lassig
Lissette LaRock
Stephanie LeBron
Brenda Lemmon
Jonathan Leong, MD
Edward Leu
Madele Limpahan
Amy Locke
Michele Long
Janet Long
Maria Riza Lopez
Amber Lords
Denise Lunstroth
Ariel Lusby
Disney Lusby
Nicholas Madison
Anissa Madru
Robyn Magaw
Whitney Main
Cynthia Malin
Raphael Manalo
Patricia Manchester
Patricia Mangano
Recertified certificates

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 Bohm
Yvonne Boozer
Brenda Brandl
Theresa Brooks
Linda Browne-Dicette
Kistina Busk
Cynthia Caldwell
Luigi Capobianco, MD
Jerelyn Carpenter
Larrie Castro
Jean Christopher
Jennifer Condren
Pamela Connor
Kenneth Costa
Sandi Crawford
Lynne Cunningham
Mikel Daniels, DPM
Wendy DaSalla
Sinner Dhalawi
Melanie Dominguez
Sonya Dunbar
Brandi Eckert
Holly Edwards
Rebecca Edwards
Paula Edwards
Espinos
Nancy Estep
Sherwin Estrella
Gia Falbo
Maria Faner
Cynthia Farley
Peter Ferraro
Teri Fisher
Janet Fiura
Brittany Freeman

Suzanne Gladstone
Cheryl Godding
Heidi Goes
Elena Gomez
Karen Gonzalez
Tammy Gray
Sharron Griffith
Rosemary Gyawu
Catherine Hafner
Eileen Hennie
Deborah Hillyard
Diane Hilton
Maria Hummer
Jackie Hunt Goodson
Bohdan Iwanetz, MD
Diana Jackson
Afrika Johnson
Rosita Josef
Judy Kappes
Melanie Kiel
Jessica Kipp
Victoria Kirby
Kimberly Klindera
Toni Krantz
Elenore Krause
Judith Krein
Wanda Kropuenske
Stephanie Krein
Jennifer Lombardi
Pamela Lorenz
Disney Macias
Ann Madrak
Mary Maka
Ashley Malbrough
Carrie Mancini
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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