Wound Care ADVISOR

PRACTICAL ISSUES IN WOUND, SKIN, AND OSTOMY MANAGEMENT

Official journal of National Alliance of Wound Care and Ostomy®

Palliative care and wounds, Part 2

BUZZ Report, Part 2: Trends in wound care

Finding common ground in wound care communication

Clinical trials

March/April 2015 • Volume 4 • Number 2

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Wound Care ADVISOR
Practical Issues in Wound, Skin, and Ostomy Management

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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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Consider writing an article!

Wound Care Advisor invites you to consider submitting articles for publication in the new voice for wound, skin, and ostomy management specialists.

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We are currently seeking submissions for these departments:

- ***Best Practices***, which includes case studies, clinical tips from wound care specialists, and other resources for clinical practice
- ***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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Wound Care ADVISOR

PRACTICAL ISSUES IN WOUND, SKIN, AND OSTOMY MANAGEMENT

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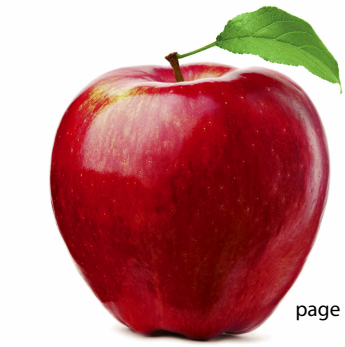

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From the EDITOR

What exactly are "the rules"?

During a recent wound care presentation, an audience member jumped up to contradict the speaker. "That is incorrect," she asserted. "The rules state…." When someone asked her what rules she was referring to, she replied, "The government's rules."

On the surface, that might seem like a straightforward answer. But when you stop to think about it, what government did she mean? Federal? State? Local?

With so many rules, regulations, and guidelines out there, you might have trouble figuring out what "the rules" really are. For wound and ostomy clinicians, they may vary from one care setting to another. However, the clinical practice guidelines (CPGs) are the same. Many different organizations have released CPGs on various skin and wound care topics. Here are some of the most quoted CPGs in our field:

- **American Diabetes Association: Comprehensive Foot Examination and Risk Assessment**
- **Association for the Advancement of Wound Care (AAWC) venous ulcer guideline**
- **Healthcare Infection Control Practices Advisory Committee**
- **National Pressure Ulcer Advisory Panel: 2014 Prevention and Treatment of Pressure Ulcers: Clinical Practice Guideline**
- **Wound, Ostomy, and Continence Nurses (WOCN) Society: Guideline for management of wounds in patients with lower-extremity neuropathic disease**
- **WOCN: Guideline for management of wounds in patients with lower-extremity venous disease**
- **WOCN: Management of the patient with a fecal ostomy: Best practice guideline for clinicians**

Other rules, regulations, and policies

Beyond CPGs, other rules, regulations, and policies affect wound and ostomy care, including those of reimbursement agencies, insurance companies, and quality organizations. See the following websites:

- **American Nurses Credentialing Center's Magnet Recognition Program®**
- **Centers for Medicare & Medicaid Services: Long-Term Care Facilities**
- **Health Insurance Portability and Accountability Act**
- **The Joint Commission**

And don't forget about rules related to safety for you and your coworkers, such as those from:

- **Occupational Safety and Health Administration**

Of course, you also need to follow your employer's policies, protocols, and rules. Finally, be sure to abide by the scope of practice and state practice acts that govern your professional licensure. Remember—basic licensure rules supersede other regulations, especially if CPGs or reimbursement or quality guidelines recommend skills and tasks to be completed that aren't within your scope of practice. Refer to the links below:

- **State boards of nursing**
- **State boards of physical therapy**
- **State medical and osteopathic boards**

Finally, if you enjoy reading guidelines or need something to do in your spare time, I can recommend a WOUNDerful website: **www.guideline.gov**. Here you'll find all the guidelines you need to keep your wound and ostomy practice safe and up to date.

Even though "the rules" can seem frustrating and overwhelming, patient safety is a theme common to all of them. ("First, do no harm.") I'm thankful for the rules because they help us keep our patients safe.

Donna Sardina

Donna Sardina, RN, MHA, WCC, CWCMS, DWC, OMS
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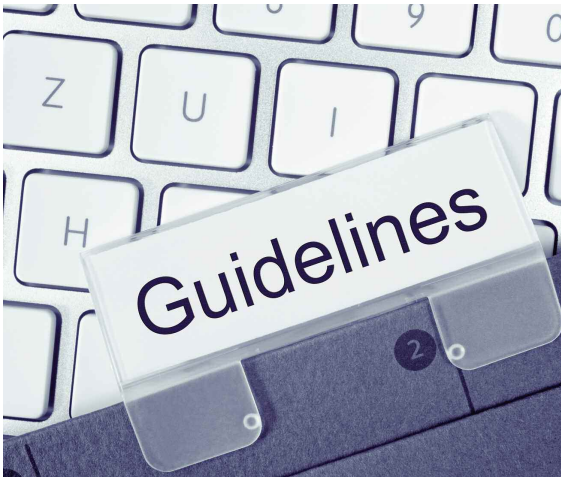
Clinical NOTES



Guidelines for optimal off-loading to prevent diabetic foot ulcers

"**The management of diabetic foot ulcers through optimal off-loading**," published in the *Journal of the American Podiatric Medical Association*, presents consensus guidelines and states the "evidence is clear" that off-loading increases healing of diabetic foot ulcers.

The article calls for increased use of off-loading and notes that "current evidence favors the use of nonremovable casts or fixed ankle walking braces as optimum off-loading modalities." The authors reviewed about 90 studies.

Updated diabetes standards released

Diabetes Care has published "**Standards of Medical Care in Diabetes—2015**" from the American Diabetes Association. The recommendations include screening, diagnostic, and therapeutic actions.

"**Standards of Medical Care in Diabetes—2015: Summary of revisions**" provides a synopsis of key changes by section. Of particular interest to wound care clinicians is that the standards emphasize that all patients with insensate feet, foot deformities, or a history of foot ulcers should have their feet examined at every visit so problems can be identified early.

Medical honey and silver dressings don't interfere with each other

A study in *Wounds* reports that medical-grade honey gel and dressings containing silver don't interfere with each other.

"**Medical honey and silver dressings do not interfere with each other's key functional attributes**" found that the in vitro antibacterial barrier activity seen with silver-containing dressings doesn't decrease with the addition of medical honey, and in some cases increases.

Fecal transplants help patients with *Clostridium difficile* infection

Medscape Gastroenterology has published

"**Fecal transplants bring hope to patients, challenge the FDA**," which states that fecal microbiota transplant (FMT) has a nearly 90% success rate in patients with recurrent *Clostridium difficile* infection.

The article discusses developments in FMT, including manufactured FMT products, stool banks, use of frozen rather than fresh stool, and biosynthetic alternatives.

Most coated stents effective in PAD 3 years after insertion

According to a study **presented** at the 2015 International Symposium on Endovascular Therapy, nearly three-quarters of patients with peripheral artery disease (PAD) who were treated with peripheral angioplasty and stents still had patent arteries 3 years after treatment.

The results are from the STROLL trial, a multicenter, nonrandomized, single-arm prospective trial studying the safety and efficacy of a nitinol self-expanding stent called the SMART Stent, manufactured by Cordis Corporation.

Ultrasound may help in healing venous leg ulcers

Adding 40 kHz noncontact, low-frequency ultrasound (NLFU) treatments three times per week for 4 weeks to standard care reduces pain and wound size, according to a study in *Ostomy Wound Management*.

"**A prospective, randomized, controlled trial comparing the effects of noncontact, low-frequency ultrasound to standard care in healing venous leg ulcers**" included 112 patients. The average wound size reduction was 62% in the group who received NLFU, compared to 45% in those who received only standard care.

Moldable skin barriers effective in preventing peristomal skin complications

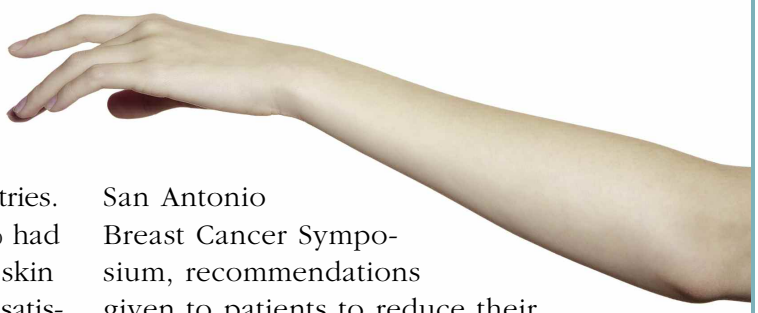
"**The effects of using a moldable skin barrier on peristomal skin condition in persons with an ostomy: Results of a prospective, observational, multinational study**" reports that this type of barrier is effective in preventing and healing peristomal skin complications and is rated as good or

excellent by most patients.

The study, published in *Ostomy Wound Management*, included 561 patients from 90 centers in three countries. In the patients with a new stoma, 90% had intact skin at baseline, 96% had intact skin after 2 months, and 98% rated overall satisfaction with the barrier as good or excellent. In patients with an existing stoma, intact skin was observed in 39.5% at baseline and 86% after 2 months, with 96.5% of patients rating overall satisfaction with the barrier as good or excellent.

Recommendations to prevent lymphedema questioned

According to data **presented** at the 2014 San Antonio Breast Cancer Symposium, recommendations given to patients to reduce their risk of lymphedema may not be effective.



Blood draws, injections, and blood pressure measurements in the at-risk arm and air travel without a compression sleeve did not increase the risk of lymphedema. The researchers did find that axial lymph node dissection and a higher preoperative body mass index were significantly associated with the development of lymphedema. ■

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

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

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.

In the January issue, I discussed some of the updates from my 2014 Buzz Report, and now I'd like to share more, with appropriate updates since the September WOW conference.

Necrotizing fasciitis

Necrotizing fasciitis, also called the "flesh-eating disease," is a progressive, rapidly spreading inflammatory infection located in deep fascia with necrosis of the subcutaneous tissues. Early diagnosis and treatment of necrotizing fasciitis are critical to saving the life of the patient.

Summarized in an article by Edlich and colleagues published in Medscape, two studies found the following:

- Of 27 patients studied, 20 died, for an overall mortality rate of 73%; 11 of the patients whose treatment was delayed for more than 12 hours died.
- The average time from admission to operation was 90 hours in nonsurvivors of necrotizing soft-tissue infections, compared to 25 hours in survivors.

To promote prompt diagnosis and treatment, the National Necrotizing Fasciitis Foundation launched a program that connects patients and their families from all over the United States and other countries with John Crew, MD, FACS, vascular surgeon and medical director for the Advanced Wound Care Center at Seton Medical Center in Daly City, California.

Crew consults with physicians (at no fee) about his groundbreaking treatment of necrotizing fasciitis, which earned him a nomination for the prestigious Lister Legacy Prize in early 2014. Crew's treatment plan includes the use of Neutro-Phase® in combination with negative pressure wound therapy. His treatment approach has saved patients' limbs—and lives.

If you have a patient with necrotizing fasciitis, contact Crew, who is available 24/7, at 908-422-7744. For more information, visit the **National Necrotizing Fasciitis Foundation**.

Bedside assessment

It's always hard to choose which published articles to focus on, but three caught my eye as being particularly useful for bedside assessment.

Burn care

Burn care is its own specialty within wound care, but some injuries don't require a specialist burn unit. The article "**Best practice guidelines: Effective skin and wound management in non-complex burns**," published in *Wounds International*, is an excellent resource for clinicians.

The article focuses on hands-on and relevant clinical information for evaluation and management of noncomplex burn injuries that are appropriate for treatment in locations outside specialist burns units, with steps for the immediate emergency management of all burns. The article also highlights the importance of correctly and expediently identifying complex wounds that indicate the patient must be transferred rapidly for specialist care, and discusses ongoing management of newly healed burn wounds as well as postdischarge rehabilitation.

Nutritional needs

Good nutrition includes not only adequate macronutrients, such as protein, carbohydrate, and fat, but also micronutrients—vitamins and minerals—for wound healing. Several micronutrient deficiencies can be identified through a simple skin assessment.

The article "**Learning the oral and cutaneous signs of micronutrient deficiencies**," published in the *Journal of Wound, Ostomy & Continence Nursing*, notes that the hallmark symptom of vitamin B deficiency is glossitis, a reddish tongue with a smooth surface. B12 deficiency is characterized by hypertrophic papillae scattered across the villous surface of the tongue, and signs of B3 deficiency include dermatitis (pellagra), which is characterized by a crepe-paper appearance with wrinkles in the skin and flat surfaces between the wrinkles.

Vitamin C deficiency can manifest as purpura, skin tears, and "plastic-wrap" skin, in which the dermis is so thin that blood vessels can easily be seen beneath a transparent epidermis.

When cutaneous symptoms of vitamin deficiency appear, serum studies should be obtained to confirm the deficiency so prompt treatment can begin.

International ostomy guidelines

The new *World Council of Enterostomal Therapists (WCET) International Ostomy Guidelines* are evidence-based practice guidelines that are internationally focused rather than country specific. The guidelines can be applied in all countries or care settings, whether resource challenged or resource abundant. The WCET guidelines include cultural, religious, and ethnic considerations for ostomy patients that are international in perspective. You can purchase the full version (64 pages) of the guidelines with the evidence tables, or **download** a free summary.

New products

Here are several new products from 2014 that you should know about.

Granulotion® Medicated Lotion. This over-the-counter lotion is designed to help support the healing of excessive granulation tissue. Granulotion was developed by a nurse practitioner, Christopher R. Speaker, APN, FNP-BC, who was frustrated with steroids and silver nitrate as the only treatment options for hypergranulation tissue. The product

is nontoxic and nonsteroidal, with ingredients that provide anti-itch benefits, antimicrobial properties, skin barrier for protection, and the ability to shrink granulation tissue that develops at gastrostomy, jejunostomy, tracheostomy, ileostomy, and colostomy sites.

SenSura® Mio ostomy appliance. This appliance fits to individual body contours and maintains a secure seal over abdomens uneven from scarring, skin folds, hernias, and other problems. SenSura Mio has a soft, elastic, hydrocolloid adhesive barrier that shapes and follows body contours when ostomates bend and stretch. The pouch is made from water-resistant textile material that gives the pouch the feel of clothing and is a neutral gray designed to stay unnoticed under all colors of clothing.

RightSpot™ pH Indicator. This small, noninvasive, in vitro diagnostic device is used to verify gastric acidity to avoid misplacement of nasogastric feeding and percutaneous endoscopic gastrostomy tubes. The RightSpot indicator strip is placed on the tube and gastric fluid is aspirated; as the aspirate saturates the strip, the strip changes color according to the level of pH in the aspirate. The color of the indicator strip is compared to a color chart on the device. A pH below 4.5 indicates gastric acidity.

Hydrofera Blue® Ready Foam. This antibacterial dressing is made of polyurethane foam, methylene blue, and gentian violet. It can be used on a variety of wounds and also under compression bandages or a total contact cast. It has broad-spectrum antibacterial activity and can be left in place for up to 7 days. This new version of Hydrofera Blue doesn't require hydration before application or a secondary dressing.

Perfect Choice Next Generation NO STING Ostomy Barrier Paste. Designed to help extend wear time, this no-sting skin barrier and filler paste has easy-on, easy-off application and removal.

NOTraum Silicone Foam Dressing. This absorbent foam dressing has a silicone border, which means no trauma for the wound and supporting skin upon removal. The dressing adheres easily and securely to dry, intact skin. It keeps the wound bed moist, but doesn't adhere to the wound bed, thereby preventing trauma.

Staytex™ tubular dressings. This tubular stretch bandage secures and maintains primary wound dressings to the affected site. The unique weave of the Staytex tube keeps the dressing in place, yet is comfortable and free of latex. It's available in precut lengths or rolls that can be cut to fit, and is washable and reusable.

Stay tuned

I'm already gathering the latest and greatest for the 2015 Buzz Report, so look for a new edition of The Buzz Report in 2016!

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

Apple BITES

Dose from WCEI

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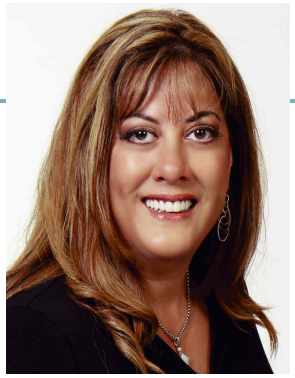


What type of wound is it?

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.

One of the most important—and most difficult—steps in wound management is to determine the etiology of the wound. Incorrect wound identification can result in delayed or no healing, can waste money, and can create problems for you if misidentification causes you to embark on incorrect care.

Determining wound etiology requires a

Characteristics of wound types

	Pressure	Incontinence-associated dermatitis	Intertriginous dermatitis	Arterial	Venous	Neuropathic (diabetic)
Location	• At any site • Over bony prominences	• Fatty tissue of buttocks • Perineum • Inner thigh • Groin • Possibly over bony prominence	• Intergluteal cleft • Skin folds • Beneath pannus • Beneath breasts • Groin crease	• Tips of toes • Between toes • Over phalangeal heads • Around lateral malleolus • Pressure points from foot wear	• Medial lower leg and ankle • Malleolar area • Seldom on foot or above knee	• Plantar aspect of foot • Over metatarsal heads • Beneath heel • Toes • Areas of foot exposed to repetitive trauma
Distribution	• Isolated individual ulcers	• Consolidated *or* • Patchy	• Mirror image on each side of skin fold	• Isolated individual lesions	• Isolated lesions	• Isolated individual lesions
Shape	• Rounded, craterlike shape • Shape of object that caused pressure	• Diffuse • Kissing ulcer (copy on both sides) • Anal cleft between buttocks; linear shape	• Linear	• Round • Even wound margins • Punched-out appearance	• Irregular • Poorly defined	• Well defined • Round or oblong

continued...

comprehensive and holistic wound assessment with a full review of clinical characteristics and the systemic, psychosocial, and local factors that affect wound healing. The above chart shows some of the most common findings according to the type of wound. ■

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.

Characteristics of wound types *(continued)*

	Pressure	Incontinence-associated dermatitis	Intertriginous dermatitis	Arterial	Venous	Neuropathic (diabetic)
Depth	• Partial or • Full thickness	• Partial thickness	• Partial thickness	• Shallow to deep	• Superficial • Deep, with associated complications	• Deep
Wound bed	• Erythema • Slough • Eschar • Granulation • Epithelial • Bone • Ligaments • Tendons	• Nonuniform redness • Pink/white • Perianal redness • No necrosis	• Mild erythema • Inflammation with erosion • Oozing • Exudation • Maceration • Crusting	• Pale • Slough • Eschar • Epithelial • Nongranular • Minimal exudate	• Red, ruddy, granular • Possible slough or eschar • Moderate to heavy exudate	• Varies • Granular • Necrotic • Pale if coexisting arterial disease
Surrounding skin	• Varies • Nonblanchable erythema	• Varies	• Maceration • Secondary bacterial or fungal infections	• Pale • Hairless • Cyanosis • Cool to touch • Skin thin and shiny	• Dry or wet thin, scaly skin • Lipodermato-sclerosis • Hemosiderin • Firm edema • Evidence of healed ulcers	• Callused
Associated findings	• Pressure or shear must be present.	• Moisture must be present. • If necrosis occurs, reassess for pressure.	• Pain, itching, burning, and odor • Perspiration with or without friction	• Absent or diminished pulses • ABI* ≤ 0.9 • Intermittent claudication • Resting pain	• Perfusion diminished with coexisting arterial disease • Dilated superficial veins • Dry, thin skin	• Diminished or absent sensation in foot • Foot deformities • Palpable pulses • Warm foot

If pressure ulcers were apples: A fun inservice program

By Karen Culp, RN, WCC

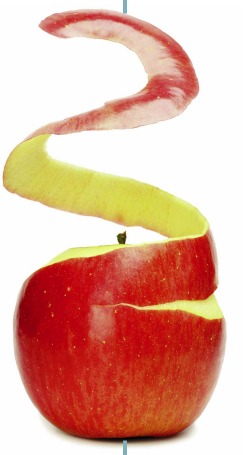
I'm one of the nurses responsible for the pressure ulcer prevention education program at the 150-bed skilled nursing facility where I work. We try to keep education sessions simple, fun, and interactive. One day, our administrator asked us to develop a crossword puzzle and "minute to win it" education game that would be appropriate for all staff—registered nurses, licensed practical nurses, certified nursing assistants, and staff from administration, the business office, scheduling, maintenance, dietary, and housekeeping.

We found a wonderful article by Patricia Turner, "**Apples to ulcers: Tips for staging pressure ulcers**," that prompted us to develop "If pressure ulcers were apples," a three-part program consisting of information about pressure ulcers, the "minute to win it" game, and a crossword puzzle. Here are the three parts of the program so you can replicate it in your organization.

Part 1: About pressure ulcers

We first provide an overview of pressure ulcers and their staging. We build on information from Turner's article, which explains that the stages of pressure ulcers can be compared to apples in various conditions. As Turner writes, "The old saying is 'An apple a day keeps the doctor away.' Well, how about, 'An apple a day can help take pressure ulcer staging confusion away.'"

You can access all the descriptions in Turner's article, but here is an example to give you a "flavor" of the comparisons.

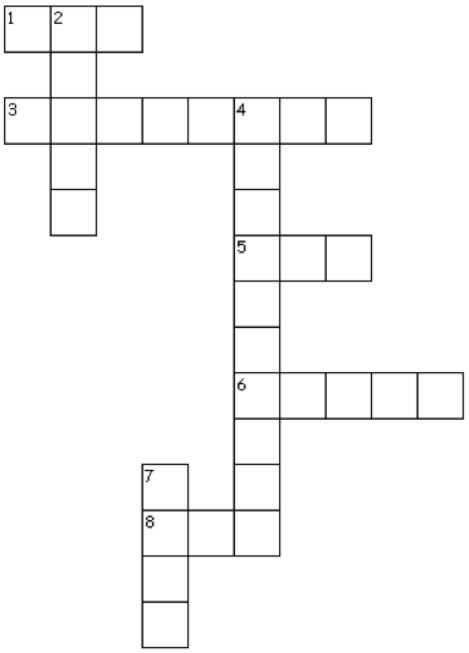


Stage II

These pressure ulcers are defined as partial thickness loss of the dermis indicated by a shallow, open ulcer. The key here is that there isn't a lot of depth to these wounds and the wound is right at the layer of the dermis, the innermost layer of skin. Think of an apple being peeled. Just the layer of outside "skin" is being removed when we carefully peel an apple. The same superficial layer has been removed or compromised in a Stage II pressure ulcer. These wounds will not have slough, and they will be superficial in nature.

Part 2: "If pressure ulcers were apples" crossword puzzle

Below is the crossword puzzle I developed and that we give participants to complete.



Across

1. What stage of pressure ulcer would you expect if your apple had a soft dark spot?
3. What type of ulcer is a localized injury to the skin or underlying tissue, usually over a bony prominence?
5. What stage of pressure ulcer would you expect if the apple were peeled carefully so just the outside layer was missing?
6. What a day keeps the doctor away?
8. What stage of pressure ulcer would you expect if you have a normal red apple and you're unable to change the red color by touching the apple?

Down

2. What stage of pressure ulcer would you expect if you took a bite out of the apple and you're into the juicy meat of the apple?
4. What stage of pressure ulcer would you expect if you had an apple completely covered with caramel so you really don't know the state of the apple underneath?
7. What stage of pressure ulcer would you expect if you were to bite into the apple and you would get to the core?

Answers

Across: 1, DTI; 3, pressure; 5, two; 6, apple; 8, one.

Down: 2, three; 4, unstageable; 7, four.

Part 3: "Minute to win it" game

Here is how to run this fun, interactive game, which reinforces the didactic material.

Supplies

- 6 apples to represent each stage of pressure: Stage I, red apple; Stage II, spot with apple peeled; Stage III, apple with chunk out of it; Stage IV, apple with core visible; Unstageable, caramel apple; DTI (deep tissue injury), apple with bruise.
- 6 place cards (8.5" wide by 5" long) to represent each stage of pressure. Laminate the cards and include information discussed in the presentation.
- 6 bowls
- 2 oven mitts
- 1 set of tongs
- 1 minute timer
- 1 tray
- 1 1ong table

Setup

- Place apples on the tray in no particular order.
- Place oven mitts and tongs next to the tray with apples.
- Put the place cards in order (Stage I, Stage II, and so on) along the edge of the table.

Game rules

Tell participants:

1. You will have 1 minute to place all six apples of different stages on place cards.
2. Pick up the apples one at a time using tongs and wearing oven mitts.
3. Carry the apples to the place card that correctly matches the stage of the apple.
4. If you drop the apple or put the apple on the wrong place card, you will have to start over with that apple.

Putting it all together

The information section and the crossword puzzle are put in the staff's break room so they can work on it at their convenience during the day. Completed puzzles are entered into a drawing for prizes. The "minute to win it" game is set up for 2

hours so that staff could participate either when coming on or leaving their shift. The game itself lasts 1 minute for each player.

Learning can be fun

Staff responded enthusiastically to the program, giving us much positive feedback. Some participation came from unexpected sources. During the inservice, one of the kitchen staff said she wouldn't be able to play because she was not a nurse or certified nursing assistant. I encouraged her to read the information and try the game. She was able to put all the apples in the correct order and had a fun learning experience.

An apple a day can help take pressure ulcer staging confusion away.

We plan to offer the inservice again, perhaps as an annual event. ■

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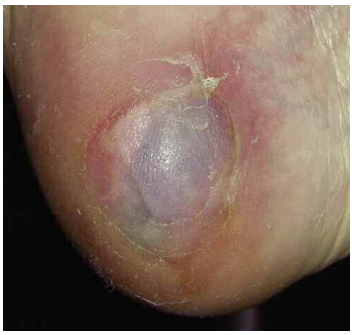
Evolution of a deep tissue injury or a declining pressure ulcer?

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

A declining pressure ulcer decreases the quality of life for patients and places providers at risk for regulatory citations and litigation. But it's important for clinicians to determine whether the first appearance of skin injury is truly a stage I or II pressure ulcer or if it's a deep tissue injury (DTI), a unique staging category for a pressure ulcer. Otherwise, a clinician might think a pressure ulcer is getting worse instead of the change being the normal progression of a pressure ulcer that is presenting as a DTI.

DTI and pressure ulcer comparisons

An increasing body of evidence demonstrates that the epidermis and dermis are more resilient to the effects of pressure than muscle tissue, so many pressure ulcers start in the muscle tissue. Pressure ulcers can present within 24 hours of insult



Deep tissue injury

or can take as long as 5 days to appear. Therefore, if a patient has experienced damage to the muscle tissue, it may take days before there is any indication on the surface of the skin that a pressure ulcer has developed. Once the deep tissue damage presents itself, it's important that the clinician accurately stages it as a DTI.

Understanding the characteristics of a DTI helps clinicians determine if the pressure ulcer is a DTI or a superficial pressure ulcer. Initially, a DTI presents as a localized area of intact skin with dark discoloration, such as purple, maroon, or a bruiselike appearance, or a blood-filled blister. The tissue in the DTI area may be preceded by tissue that's painful, firm, mushy, boggy, or warmer or cooler than adjacent tissue.

On the other hand, a stage I pressure ulcer will have light discoloration, such as light pink or light red, of intact skin. If the pressure ulcer initially presents with a fluid-filled blister versus a blood-filled blister, it would be considered a stage II pressure ulcer.

Evolution of a DTI

As a DTI evolves, clinicians may see a thin blister over a dark wound bed on the skin. The skin may open up superficially, which causes many clinicians to erroneously stage the DTI as a stage II pressure ulcer. Clinicians should continue to stage the wound as a DTI, but should describe the characteristics of how the skin is blistering or has superficial open areas. The DTI may further evolve and become covered by thin eschar, and further evolution may be rapid, exposing additional layers of tissue, even with optimal treatment. Once the DTI has fully opened, exposing the level of tissue damage, it can then be accurately staged as III or IV pressure ulcer.

Use staging only for pressure ulcers

The staging classification system should be used for pressure ulcers only to describe the level and type of tissue involvement. Accuracy of the stage is important not only to assess the progress of the wound but also to determine appropriate interventions. For more information about staging pressure ulcers, review the **National Pressure Ulcer Advisory Panel Pressure Ulcer Stages/Categories**.

> Epidermis and dermis are more resilient to the effects of pressure than muscle tissue.

Keep in mind that by accurately staging a pressure ulcer you can help your patients receive appropriate treatment so they can achieve the best possible outcomes. ■

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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.

Finding common ground: Surviving wound care communication

The author describes how to overcome challenges to effective communication in the healthcare setting.

By Jennifer Oakley, BS, RN, WCC, DWC, OMS

Accurate communication among healthcare professionals can spell the difference between patient safety and patient harm. Communication can be a challenge, especially when done electronically. With an e-mail or a text, you can't hear the other person's voice or see the body language, so it's easy to misinterpret the words.

Are you sure your colleagues accurately understand the messages you're conveying? When you communicate effectively with the people you work with, life gets easier. This article suggests ways to overcome communication challenges in the wound care workplace, whether you're communicating with prescribing authorities or wound care colleagues.

Communication can be verbal or nonverbal. (See *Verbal and nonverbal communication.*) Regardless of the type or means of communication, sender and receiver need to have a shared understanding of the communication between them. The information you convey needs to be complete, concise, concrete, clear, and accurate.

Courtesy counts

In a busy healthcare setting, we may overlook the need for—and value of—courtesy. Learn how to listen. Too often, instead of fully listening to the other person, we're busy formulating our reply. Try this: Listen as someone speaks to you; then reiterate their words back to that person to show you heard and understand. Then offer your reply.

Try smiling, too, even when you're on the telephone. Chances are, the person on the other end will hear the smile in your voice.

Types of communicators

People communicate in different styles. Identifying the communication style of your colleagues and understanding how they want information to be conveyed to them can create a better workplace. (See *Classifying communicators.*)

Communication barriers

Multiple barriers to effective communication exist. Everyday distractions are high on the list. These include ringing tele-

phones, beeping alarms, patient call bells, multiple job responsibilities, documentation tasks, and the general hustle-bustle of the healthcare workplace. When using a mobile device, interference and bad connections may pose a barrier. Even understanding a colleague's accent can be a struggle, as can background noises that threaten to drown out phone or face-to-face conversation.

Gender, social, and cultural differences also can pose communication barriers. Studies show males communicate differently than females. Males prefer quick, fact-based communication; females prefer more in-depth discussion.

One of the biggest barriers we encounter is between the physician or prescribing authority and the nurse or wound care clinician. In some cases, the physician doesn't understand the true scope of the nurse's or wound care clinician's practice. The Joint Commission reports 60% of medical errors result from direct communication breakdown between the physician and nurse. The physician-nurse (or prescribing authority–wound care clinician) divide can make clinicians feel uncomfortable about speaking up to those with more education or a higher supervisory status.

What's more, different healthcare specialties seem to have their own special language. Even within the wound care world, medical jargon can differ. Not all wound care clinicians are familiar with our own terminology, and this can be a barrier to a covering or on-call provider.

Overcoming barriers

To move beyond these barriers, we can start by managing our personal stressors and workloads. Know the type of communicator you're dealing with, as well as the how, what, when, and why of the information they want to be notified about. For example, do they want you to notify them for emergencies only, or if the wound enlarges and treatment orders need to be changed?

Also, make sure the receiver of your communication knows who you are. Introduce yourself and include your credentials to let them know you're an expert in wound care.

Be respectful and try to manage conflict wisely. We all strive for leadership on our team, and it doesn't necessarily come from the prescribing authority. Remain confident in the power of your expertise and the meaningful contributions you make to the team. At the same time, always follow the chain of command; don't go over other clinicians' heads to get faster action.

On the healthcare team, everyone must have the freedom to disagree and voice their opinion. When people express their opinions, creative problem solving can occur if conflicting opinions are managed properly. This keeps us on our toes and helps us come up with multiple solutions—as long as we're communicating effectively.

How to handle difficult communications

Not all communications are easy or planned in health care. You don't always

Verbal and nonverbal communication

- Verbal communication occurs face to face, by telephone, or in a video chat.
- Nonverbal communication occurs through written means—e-mail, texting, documentation in the medical record, and social media (such as a Facebook page or a Tweet)—and through body language (gestures and mannerisms), tone of voice, touch, eye contact, and use of the personal space between us.

We all need to be aware of the nonverbal messages we convey. Think about your body language: Is it open or closed? And remember—you have just a few seconds after meeting someone to make a first impression.

Classifying communicators

According to author Louie Mace in the book *Communication Strategies*, people fall into four basic categories of communicators. You can use this knowledge to communicate more effectively.

Analyzers. These detail-oriented people like to hear the details of the topic at hand. Make sure you present those details in a well-organized way. Give them the particulars about the patient and product studies, as appropriate, and make sure to comply with your facility's protocols.

Controllers. Controllers can come across as rude as they try to take control of the situation and "lead" through force. You need to earn respect from these highly goal-oriented people. When communicating with them, have your facts straight and at the ready. Present them in a confident, matter-of-fact way. Otherwise, Controllers will sense your uncertainty and may tear you apart. When closing the conversation, thank them for their time. Controllers like to feel they're important; it never hurts to stroke their ego a little when it's deserved.

Promoters. These people like to be the center of attention and may take it personally if they don't get enough attention. They also like to have fun. When communicating with them, let them do most of the talking. Act like you're interested in what they're saying, and don't interrupt. You can "plant the seed" for what you want (such as a change in a patient's dressing or the overall treatment plan) by bringing it up in a casual discussion unrelated to the patient. For instance, give them ideas about products you'd like to use or advanced modalities. Later, Promoters can turn these suggestions into a "great idea" of their own. The key is they need to think the idea is theirs. If you "plant the seed" about a new dressing that absorbs a lot of exudate, the next time the Promoter sees the patient, he or she will remember what you said and think, "Wow! I know a product that would be great for this patient."

Supporters. Supporters tend to take the safe route, going along with whatever the strongest personality in the group says. They may put their patients' interests above their own; also, they may shy away from high-pressure situations. When communicating with them, don't dominate the conversation, be confrontational, or act like you know it all. Give them time to make a decision. Let them know you have the patient's best interest at heart.

have time to gather information or map out exactly what you'll say to the prescribing authority, your supervisor, or even the patient's family.

Sometimes difficult or unplanned conversations are necessary, and some may take place at inopportune times, such as the middle of the night. You may be talking to a patient on the phone when a disgruntled family member cuts in on the extension.

When something like this happens, take a deep breath and practice empathy by putting yourself in the other person's shoes. You may encounter aggression or frustration on the other end of the phone or from across the room. Listen, accept the other person's feelings, and offer polite formalities: "I understand this is hard to hear" or "I'm sorry to have to deliver this news over the phone. I can't imagine what you're going through." To remind them that you're human, too, use statements that start with "I feel." And don't take verbal attacks personally.

Abusive communication

Don't tolerate disruptive, disrespectful, or abusive behavior from colleagues. Address workplace harassment on the spot. Use such phrases as "I'm not challenging your expertise; however…" or "May I please tell you why I have additional concerns about this patient?" Stand up for yourself and call out the colleague on his or her behavior. Frequently, people don't realize they're speaking or acting inappropriately until someone calls them out on it.

If an abusive conversation escalates, walk away. Document the conversation and submit a written statement to report the abuse to the administration. The worst thing to do is to say nothing. Keep in mind that social influence can be incredibly powerful. Nobody wants to be labeled a workplace bully or be disciplined for harassment. Help shape the behavioral norms of your organization and use peer pressure to address inappropriate codes of conduct.

Specific communication challenges in wound care

Certain wound care orders can lead to communication problems.

Orders for a wet-to-dry dressing on a granulating clean wound

Many misconceptions about wet-to-dry dressings exist. The biggest misconception is that they promote moist wound healing. In fact, they don't. Remember—when gauze dries, the tissue also dries, which leads to cooling of the wound bed, in turn increasing the infection risk. Wet-to-dry dressings are labor intensive; they need to be changed every 4 to 6 hours. They're also costly. Bacteria can penetrate 64 layers of gauze.

Using wet-to-dry dressings isn't evidence-based practice. In fact, it's substandard practice for moist wound healing. The only evidence-based use for wet-to-dry dressings is mechanical debridement; this means we should use this type of dressing only on necrotic wounds. Yet how often do we see orders for wet-to-dry dressings for healthy, granulating wound beds?

As wound care clinicians, it's our responsibility to help prescribing authorities use these dressings only when appropriate. If you get an order for a wet-to-dry dressing, inform the prescribing authority of the evidence against their use; for instance, cite such articles as "**Hanging wet-to-dry dressings out to dry**," George Winter's pivotal **1962 studies** on moist wound-healing principles, and **international guidelines** that don't recommend wet-to-dry dressings for moist wound healing. At the same time, offer appropriate suggestions for your patient's treatment; prescribing authorities can't read our minds and may be unfamiliar with newer products on the market.

Orders for topical metronidazole

Suppose you have an order to crush Flagyl (metronidazole) and sprinkle it into the wound bed to help control wound odor. Flagyl is an oral medication; even though drug books say it's safe to crush this medication, they mean it's safe to crush and administer it *orally*. No studies have shown it's safe to apply Flagyl on a patient's wound bed, nor is the drug approved for use in this manner. You can't mix it with hydrogel and call it an ointment of your own making, either, because that would constitute compounding, which is out of your practice scope.

Using wet-to-dry dressings isn't evidence-based practice. In fact, it's substandard practice for moist wound healing.

In this case, suggest the prescriber change the order to MetroGel 75 (metronidazole 75%), which the Food and Drug Administration has approved for topical administration. Or if MetroGel isn't appropriate for your patient, try switching to a charcoal dressing, which helps decrease

odor. Try to find out what's causing the wound odor (bacteria or necrotic tissue, for instance) and intervene appropriately.

Other inappropriate orders for your patient's specific wound

Suppose your patient has a heavily exudative wound and the prescriber orders a transparent film. You know the film won't hold the exudate and you'll end up with a soupy mess. What should you do? Contact the prescriber to suggest a change; provide your rationale, validate your position, and cite your sources. Also, if appropriate, share your ideas for alternative treatment. Sometimes just asking for a trial period works out well. "Hi, Dr. Jones. It's Jennifer, the wound care certified nurse from the nursing home. I'm calling about Patient Smith. I see this morning you ordered a transparent film for her stage 3 pressure ulcer. I'm not sure if you're aware of the large amount of exudate the patient is having. Per the package insert, a transparent film won't accommodate that amount of drainage. Normally with such a large amount of exudate, we get good results by using a specialty absorptive product such as _____. May I suggest this product for Mrs. Smith? Could we try it for a 2-week period? Thank you for your time."

> No studies have shown it's safe to apply Flagyl on a patient's wound bed, nor is the drug approved for use in this manner.

The need to reeducate staff

Consider this scenario: When reviewing your patient's documentation on wound rounds, you note that last week the clinician documented the pressure ulcer as stage 2 with 5% slough in the wound bed. But you know there can't be slough in a partial-thickness wound.

This means it's time for staff reeducation. You can handle this in several ways. Promptly address it on a one-to-one basis with the staff member who documented the ulcer, so that person doesn't stage wounds incorrectly again. But keep in mind that if one staff member stages wounds incorrectly, other colleagues are probably doing it, too. This situation calls for facility-wide or clinic-wide reeducation.

Refer to the National Pressure Ulcer Advisory Panel's (NPUAP) pressure ulcer definitions of stages (**www.npuap.org/resources/educational-and-clinical-resources/npuap-pressure-ulcer-stagescategories/**). Print out NPUAP's illustrations of the stages in treatment books (**www.npuap.org/resources/educational-and-clinical-resources/pressure-ulcer-categorystaging-illustrations/**). Perform one-on-one evaluation of clinicians' bedside wound assessments, checking for competency. Hold facility-wide in-services for staff members performing appropriate wound and skin assessments; make such assessments a mandatory skills check-off.

Accurate tissue type identification and pressure ulcer staging are critical for documentation and proper reimbursement. Correct communication across the healthcare continuum is a must.

An ongoing challenge

Effective communication in the healthcare setting is an ongoing challenge. Know what to expect from colleagues in terms of communication—and be sure

you understand what they expect of you. Be mindful of your own and others' nonverbal communication, including body language. Keep in mind that it's easy to misinterpret the tone of an e-mail or text message. Finally, practice good listening; it's a great way to start building better communication skills. Remember, teamwork is what makes the dream work! ■

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Role of rehab in wound care

By Bill Richlen, PT, WCC, DWC, and Denise Richlen, PT, WCC, DCCT

How many times have you heard someone say, "I didn't know PTs did wound care"? Statements like this aren't uncommon. The role of physical therapists (PTs), occupational therapists, and speech therapists in wound care is commonly misunderstood by and even a mystery to many clinicians. Sometimes the therapists themselves are confused about reimbursement or what their role on the wound care team can be.

Including rehab therapists on the wound care team is vital to a successful wound care program. If there is no active therapy involvement, patients won't receive the benefits that rehab interventions can provide to help heal wounds. In addition, facilities that don't foster active therapy involvement in the treatment of wounds will lose the opportunity to increase their revenues and save money. In a world where the incidence of chronic wounds continues to rise as the population ages, the use of the skills of the rehab team in conjunction with appropriate nursing and dietary interventions will improve overall patient outcomes.

Begin with engagement

To make the rehab staff part of the wound care team, the first priority is to engage them in their roles related to wound care. This may require education and guidance, as there may be a skills gap; comprehensive wound care education isn't necessarily part of the curriculum for therapists in their college programs, and therapists may not have had wound care experience during their clinical internships. This lack of training puts therapists at a disadvantage and may make them reluctant to participate in wound care. It's important to start the conversation and help therapists see where they can make a real difference in their patients' lives.

The primary question concerning rehab is this: Is the service skilled or nonskilled? Skilled therapy service is defined as one that's medically necessary and that requires the intervention of a therapist. Appropriate use of the different therapy disciplines can provide significant wound-healing benefits for the patient. Physical therapy skilled services related to wound care include such interventions as wound

debridement, modalities (for example, electrical stimulation, ultrasound, and diathermy), edema management, positioning, orthotic use, and mobility. Occupational therapy can provide edema management, wound debridement, positioning, toileting programs, self-feeding, and wheelchair management. Speech therapy can address cognitive deficits, swallowing or chewing dysfunction, and nutrition management.

Financial benefits

Financial implications of using rehab staff in wound management comprise increased revenues and cost savings. Depending on the care setting, revenues from the use of rehab staff can increase in various ways:

- Acute-care/hospital setting: Diagnosis-related group (DRG) reimbursement will improve.
- Long-term acute-care setting: DRG reimbursement will improve.
- Skilled nursing facility/long-term care setting: Resource utilization group levels with Medicare A patients and Medicare B and private insurance billing will improve; case mix index will increase.
- Home health setting: Service utilization and home health resource group scores may increase.
- Outpatient setting: Third-party reimbursement may increase.

As impressive as these possibilities sound, a clinician once commented after hearing us present on this topic that all we had done is effectively increase the bill. Therapy should be seen as a return on investment rather than a cost.

When dealing with the challenge of healing chronic wounds, one can't be a short-term thinker, especially in regard to the cost of different treatment interventions. Pinching pennies in the short term (using "cheaper" treatments to save money) generally leads to increased healing times, which ultimately lead to higher overall costs—not to mention a lower quality of life for the patient who has to endure an open wound for a longer time.

Many chronic wounds have an increased healing time because the basics of wound healing haven't been addressed, including effectively treating the cause of the wound; managing the bioburden; managing exudate; promoting appropriate moist wound therapy, efficient removal of the necrotic burden, and appropriate nutritional interventions; and ensuring good tissue perfusion.

Therapy should be seen as a return on investment rather than a cost.

The ineffective and inefficient addressing of the basics of wound healing can be attributed to a lack of education and knowledge of current wound care approaches among clinicians. A proactive rehab team can address many of these basic factors and essentially increase the speed at which wounds will heal, thereby lowering the overall costs of wound care, because the longer the healing time, the higher the cost to the facility.

Key management skills

How exactly can a rehab team decrease

healing times and lower the costs of wound care? Effectively managing necrotic tissue is an integral part of moving the wound from an inflammatory to a proliferative healing phase. Physical and occupational therapists are able to debride necrotic tissue through conservative sharp debridement, application of biological debridement, and the use of modalities at a fraction of the time required by enzymatic or autolytic debridement methods.

It's important that each discipline verifies whether its scope of practice allows its therapists to perform sharp debridement, as this parameter can vary from state to state. Physical and occupational therapy can provide modalities, such as high-voltage galvanic electrical stimulation or diathermy, that can increase circulation, decrease pain and healing times, and increase the comfort and quality of life of the patient. In addition, electrical stimulation and diathermy have bactericidal properties that can help manage the bioburden in a wound.

> Removing the cause of wounds is essential to their healing.

Removing the cause of wounds is essential to their healing. For example, physical and occupational therapists can perform ankle-brachial index/Lanarkshire oximetry index, then safely choose and apply compression bandaging systems in conjunction with massage techniques that can remove edema associated with venous insufficiency and lymphedema. Physical and occupational therapists can also assess for positioning limitations and educate patients and staff in effective positioning methods that can prevent continued pressure to the wounds and further tissue breakdown. Physical therapists can assess the feet of patients with diabetes for deformities and high-pressure points. Performing a gait analysis can contribute to the proper use of effective offloading footwear and devices to allow neuropathic ulcers to heal and prevent future ulcerations.

Effective nutritional interventions can accelerate the proliferative phase of healing. Occupational therapists can assess the patient's ability to self-feed and consume adequate amounts of protein and other nutrients needed for wound healing. Speech therapists can assess chewing dysfunction and dysphagia that impair the patient's ability to chew and swallow these nutrients, leading to dietary recommendations to improve the patient's overall nutrition. A speech therapist can also assess for cognitive deficits and educate the patient, family, and staff on how to effectively work with the patient, including ways to increase the patient's nutrition intake.

An opportunity

Rehab therapists play a wide variety of roles to assist the wound care team in the overall care of wounds. Their expertise and skilled services can exert a significant impact on the cost and reimbursement associated with managing wounds. Developing your rehab staff's understanding of wounds and their role as part of a multidisciplinary wound care team will improve outcomes and patient quality of life. ■

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Palliative wound care: Part 2

This approach brings patient-centered care to life.

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

Editor's note: This article is the second in a two-part series on palliative wound care. For the first part, **click here**.

By preventing and relieving suffering, palliative care improves the quality of life for patients facing problems associated with life-threatening illness. This care approach emphasizes early identification, impeccable assessment, and treatment of pain and other issues—physical, psychosocial, and spiritual.

When relieving distressing symptoms takes higher priority than healing the wound, the patient may choose palliative wound care after consulting with the medical team. Addressing such issues as pain, odor, exudate, bleeding, infection, and cosmetic appearance, this treatment approach couples the elements of traditional wound care with symptom management. When delivered correctly, it brings patient-centered care to life.

Addressing pain

Many wound care patients have ongoing pain. Dressing removal can be the most painful part of wound management. If pain intensifies with each dressing change, the palliative-care approach may call for use of nonadherent long-wear-time dressings to reduce dressing-change frequency. Minimizing unneeded stimuli to the wound also is important; topical lidocaine preparations help by numbing the area locally during dressing changes.

Try to schedule dressing changes for a time when patients feel their best, if possible. Before you start, offer pain medication; wait until it reaches maximal effectiveness before assessing whether the patient is ready to begin the procedure. Also consider using music, relaxation, position changes, meditation, guided imagery, and transcutaneous electrical nerve stimulation. If the patient has dis-

comfort during the dressing change, call frequent time-outs: Stop the procedure and ask if the patient would like a break. If so, don't resume activity until the patient consents.

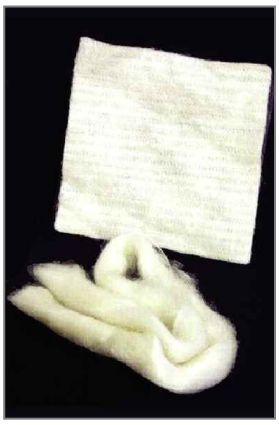
Reducing odor

When unpleasant wound odor reduces quality of life, odor management becomes a palliative-care goal. Wound odor can embarrass the patient, causing depression and self-imposed isolation. Family members may feel guilty if they can't approach the bedside owing to overpowering wound odors. Wound odor also may decrease the patient's appetite, which impedes the palliative-care goal of providing adequate nutrition.

Because odor commonly results from bacteria in necrotic tissue, consider wound debridement if it's consistent with the patient's overall plan of care. Autolytic methods commonly are used because they're gentle and easy to implement with moisture-retentive dressing products. Other aids to managing odors include systemic and topical antibiotics, silver dressings, charcoal dressings, topical honey dressings, cadexomer iodine–impregnated dressings, and properly diluted antiseptic solutions.

If wound odor permeates the patient's room, consider placing essential oils, kitty litter, or coffee beans nearby. Also consider using scented candles and having visitors place methylated preparations under their noses to mask the smell. These strategies help enable the patient to socialize with others.

Decreasing wound exudate



High exudate levels can pose challenges for both palliative wound care patients and clinicians. Consider using absorbent dressing products, such as foams, alginates, and specialty dressings. The goal is to manage exudate to keep excess moisture off surrounding skin, where it could cause further breakdown.

If exudate volume is high enough to necessitate frequent dressing changes or if odor control is needed, consider pouching the wound. Negative-pressure wound therapy (NPWT) helps contain the drainage if all other wound factors are consistent with use of this therapy. Pouching and NPWT help manage odor because these closed systems don't allow exudate to contact room air, except during equipment or dressing changes.

> A palliative-care approach may avoid moist wound healing for dry and scabbed areas.

Unlike traditional wound care treatment, a palliative-care approach may avoid moist wound healing for dry and scabbed areas. Although moist wound healing is widely accepted to expedite healing, when the patient's prognosis is limited and the wound can be managed without further complications, healing

takes lower priority, and scabbed areas can be left open to air with no dressing.

Managing bleeding

In malignant wounds, bleeding may result from the effects of cancer cells on blood vessels. Tissue becomes friable and more susceptible to local trauma. Bleeding also may result from overall health conditions, including abnormal platelet function.

For minor bleeding, calcium alginate dressings (typically used to absorb exudate) can help trigger the coagulation cascade. Also consider such products as absorbable gelatin powders, collagens, and vasoconstrictors. Chemical cauterization with silver nitrate may be required, as well as suturing of involved vessels and laser therapy.

Preventing and managing infection

Preventing wound infection is an important goal for all wound care patients. Use basic infection-prevention measures—good nutrition, wound cleaning, exudate management, and timely dressing changes—if these can be done in alignment with the patient's wishes. If healing is a palliative-care goal for a patient with a wound infection, traditional treatment approaches (including culturing) are appropriate. Be sure to weigh the benefits of treating the infection against the burden the treatments could place on the patient.

If wound healing isn't a goal for your patient, formal diagnosis and treatment of a wound infection isn't necessarily warranted. If treating it won't yield benefits and the patient can be maintained comfortably, the infection may not require active treatment.

However, in many cases, bacteria in the wound cause pain, odor, and high levels of exudate, which are problematic and reduce quality of life. In this case, to meet palliative-care goals you may need to take steps to reduce the bioburden. Try such traditional methods as debridement, antiseptics, antibiotics, and various antimicrobial dressings and therapies.

Improving cosmetic wound appearance

Most patients don't want others to see their wounds. If the wound is on the head, neck, or other highly visible area, this poses a challenge. Patients may be embarrassed and not want to frighten others by their appearance. A major challenge in palliative care is to dress the wound in an inconspicuous way that protects patients' dignity and supports their desire for socialization. One way to do this is to avoid bulky dressings in favor of lower-profile, more streamlined dressings.

Creating symmetry with dressings is important, too. Dressing just one side of the body immediately draws the observer's eye to that side because of the asymmetry. So when feasible, use dressings to

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Clinician RESOURCES

Below are resources you may find helpful to your practice.

AHRQ's Safety Program for Nursing Homes: On-Time Prevention

The Agency for Healthcare Research and Quality (AHRQ) has established "**AHRQ's Safety Program for Nursing Homes: On-Time Prevention**," designed to improve long-term care by turning daily documentation into useful information that enhances clinical care planning.

On-Time uses electronic medical records to develop weekly reports that identify residents at risk for common adverse events in nursing homes to help clinical staff intervene early. Facilitators help the team integrate these reports into clinical decision making to improve care planning.

For each adverse event, the website provides a description of the reports and suggested meetings and huddles where the reports may be used, the functional specifications for programming the reports, description of implementation tools, and a 2-day training curriculum for facilitators.

Sleep times guidelines

The National Sleep Foundation has issued new recommendations for appropriate sleep durations. Check below to see if your patients—and you—are getting enough sleep:

- newborns (0-3 months): 14-17 hours
- infants (4-11 months): 12-15 hours
- toddlers (1-2 years): 11-14 hours
- preschoolers (3-5 years): 10-13 hours
- school-age children (6-13 years): 9-11 hours
- teenagers (14-17 years): 8-10 hours
- younger adults (18-25 years): 7-9 hours
- adults (26-64 years): 7-9 hours
- older adults (65+ years): 7-8 hours.

Access "**National Sleep Foundation's sleep time duration recommendations: Methodology and results summary**" in *Sleep Health*.

Venous ulcer resources

The website for the Association for the Advancement of Wound Care (AAWC) has several **resources related to venous ulcers**:

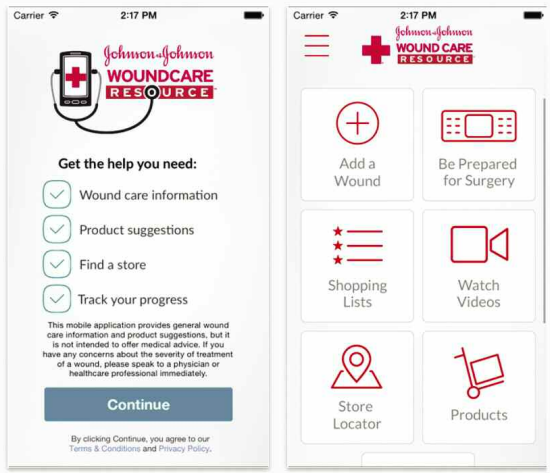
- AAWC Venous Ulcer Guideline 3.12
- AAWC Venous Ulcer Guideline Evidence 6.13
- AAWC Venous Ulcer Guideline Algorithm Presentation 8.13

- AAWC Venous Ulcer Guideline Checklist 7.13.

The resources are available at no cost.

Wound care app

The **Johnson & Johnson Wound Care Resource™ App** helps patients identify, track, and provide recommendations on wound care treatment.



The free app includes treatment videos and coupons to help patients save on wound care treatment supplies. The app is available for download on iTunes.

Note from Executive Director

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

National Alliance of Wound Care and Ostomy®

In the previous issue of *Wound Care Advisor*, I provided some insight into the election of the National Alliance of Wound Care and Ostomy (NAWCO) board members, their mission, and goals. With this issue, I'd like you to start meeting our members. Let's begin with President Debbie Dvorachek and Vice President Katie Pieper.

President of the Board of Directors of the National Alliance of Wound Care and Ostomy

Debbie Dvorachek is a licensed practical nurse and holds the Wound Care Certified (WCC) credential. She started her career providing wound care treatments to residents in a skilled nursing facility. She says her techniques for dressing changes were good, but she felt her knowledge in what was needed for optimal wound healing was lacking. Debbie decided to take the Skin and Wound Management course provided by the Wound Care Education Institute (WCEI), where she received her certification through NAWCO.

Debbie says, "Receiving the knowledge in wound care through WCEI and my WCC certification boosted my confidence in the current practice of wound healing or prevention." She adds, "I am so proud that NAWCO embraces those from a wide range of healthcare disciplines, which makes it the most diverse and inclusive wound care certification organization today. I want NAWCO to continue to be there with a multitude of resources to support all WCCs, DWCs, OMSs, and LLEs and advance their professional recognition and careers while providing a higher standard of care to their patients."

Vice President of the Board of Directors of the National Alliance of Wound Care and Ostomy

Katie Pieper has been a nurse for more than 40 years. She is retired from bedside nursing, but currently teaches nursing assistants. Katie has been wound care certified since 2003. She says, "Apparently, our class was the first to have the privilege of attending the WCEI wound class. When they said, 'Give us a week and we will change your life forever,' I was not sure how they were going to do it, but they did."

After completing the WCEI course, Katie found herself teaching anyone who would listen, and she wanted to learn as much as she could to teach others. Twelve years later, she still feels that way. "I believe that it is my duty and privilege to teach as many as I can, especially about prevention. When teaching the nursing assistant students, everything revolves around protecting and nourishing the skin," she says.

Katie wants members to know that, "As a member of the board, I want to be available to WCCs to answer questions or help them in finding answers. The Board of Directors are always available to help wherever there is a need. We are here to assist you in your career and provide help in whatever you need."

Following is the complete list of board members:

Debbie Dvorachek—president
Kathryn (Katie) Pieper—vice president
Carol Krueger—board member
Ottamissiah Moore—board member
Cheryl Robillard—board member
Rosalyn Jordan—board member
Andrew Joiner—board member
Clive Horricks—board member
Michael Richardson—board member

Watch for upcoming issues of *Wound Care Advisor* to meet other members of the board.

New certificants

Below are WCC, DWC, and OMS certificants who were certified from December 2014 to January 2015.

Arlene Abreu, MD
Dianne Acebedo Gabriel
Sunday Adetoyese
Alvin Alexander
Emily Allred
Jocelyn Arriesgado
Jacquelyn Baker
Arielle Ball
Tammie Barnett
Mary Jean Barry
Jody Batton
Darrin Baxter
Eric Beck
Cinthia Belden
Randi Bertoni
Tatyana Bezpalaya
Kathryn Blum
Angela Boggess
Tanisha Bowen
Lori Brannin
Juan Bravo, MD
Amelia Brewer
Jackie Bringhurst
Tina Broussard
Carol Brown
Kirsten Brown
Jennifer Burke
Joanne Burt
Carmen Cama
Chelsea Cason
Ethel Castro
Kay Cavalier
Peggy Caviola
Esmeralda Chapa
Louise Cheeney
John Clayton, DO
Lisa Clements
Vanessa Copeland
Robin Cronin
Maria Antonia Cuison
Amy Dalziel
Scott Davis
Alison Delacruz
Ly Ly Delles
Wei Deng
Joanne Depoe
Delpar Diolazo
Laureen Diot
Nancy Dombek
Frederick Dressen, DO
Dawn Dugan
Belen Duygu
Wesley Ehle
Amber Ehlers
Carissa Ely
Doreen Ernest
Cynthia Eugene
Candice Fella
Janet Fisher
Jessica Fleming
Sara Foster
Lee Giampietro
Julie Gibson
Jolyne Giles
Gail Goebel
Sivakoti Guda, MD
Tracy Harding
Lavon Haskins
Laura Hayes
Patsy Hayward
Rodolfo Hebron
Jacklyn Henderson
Polly Hendrix
Lynette Henriksen
Jill Hickey
Amanda Hickey
Laura Hogan
James Hosler, MD
Anatole Hounnou, DO
Teresa Hughes
Augustina Idahor
Laura Jacobs
Kay Jesena
Yolanda Johnson
Carol Johnson McGregor
Deborah Johnston
Dana Kambe
Angela Kiefer
Angie Kilburn
Gagandeep Kingra
Fredrik Kirberg
Susan Kline
Candice Joan Lacson
Debbie LaGrange
Steven Lenthe
Lisa Lewandowski
Jeanne Lipely
Jacqueline Loosley
Julie Lovingier
Veda Luka
Tonya Madaus
Susan Manos
Valerie Martin
Tifani Maturin
Patrick Maus
Melody McDaniel
Barbara McDonald
Megan McMahon
Lisa Mittelstaedt
Kristine Moeller
Donna Morrow
Navdeep Muhar
Lawrie Murray
Kristin Myers
Melissa Nelson
Jean Nesbitt

Noelle Neudorfer
Debra O'Bryant
Gospel Ofuyah
David Okolica, MD
Megan Owens
Peggy Paino
Narinder Parhar, MD
Derek Parris
Shirley Peart-Osbourne
Angela Pennington
Elizabeth Picozzi
Annalisa Pike
Adrian Preciado
Deanna Proper
Denise Quallo
Aaron Racca
Rizalino Rafi Jr., MD
Benjamin Ramos
Maria Ramos Raymundo
Donna Randone
Debra Reese
Amber Reeves
Janice Regan
Clara Ricabal
Lisa Salvatore
Denise Scott
Cory Shaffer
Anil Shankar
Amy Smedberg
Anjeanique Smith
Rosanne Spada
Teresa Spaulding
Wendy Standifird
Patricia Staples
Donna Stauss
Vivian Sternweiler
Staci Stewart
Adrian Rico Sy
Maria Talavera
Stefanie Talbot
Jerrice Taplett
Jennifer Tesoro
Sandra Thomas
Heidi Thomas
Kelli Thornburg
Paciencia Toney-Joiner
Desiree Torassa
Jill Tucker
Connie Vedrode
Amanda Veselka
Lisa Vickrey
Joanne Watrin
William Wegesser
Amanda Wellema
Sharon Westendorf
Dixie White
Ashley Wilkins
Susan Winot
Kelli Wray
Tracie Wright
Betty Wright
Kona Yang
Lynn Zigmant

Recertified certificants

Below are WCC, DWC, and OMS certificants who were recertified from December 2014 to January 2015.

Tinuke Akinade
Rachel Aragon
Linda Avery
Valentina Ayvazova
Gifty Bandoh
Jinkee Beltran
James Beltran
Jerome Bilecki
Kathleen Blechertas
Sophie Boudreau
Brenda Brown
William Brown
Bin Mildred Bukalan
Kathleen Burciaga
Theresa Calk
Gale Cardoza
John Casey
Mona Cash
Leslie Chandler Holzman
Janice Chua
Efigenia Climaco
Ann Coles
Marguerite Collins
Rhazimar Conlu
Michele Cordivano Waters
Sharon Culp
Monette de Leon
Susan DeMere
Sharon Dircks
Audrey Dodson
Mary Famorca
Autumn Ferringer
Tiffany Ferroni
Carol Flanagan
Donna Fording
Wendi Fox
Mary Galeotalanza
Marla Garand
Kelly Gerhards
Sandra Gunter
Jenita Gutierrez
Amanda Hagwood
Jennifer Hall
Tina Hawley
Miki Hayashi
Lori Henderson
Daniela Herrera
Sid Hester
Cheryl Hilliman
Susan Hoban
Connie Holland
Clive Horrocks
Dawn Houck
Christina Hutchinson
Hailey Hwangbo
Branden Jackson
Leslie Jaros
Mary Kacmarek
Cynthia Kadziulis
Halyna Kauta
Paula Kavanaugh
Kelly Kelley
Kathryn Kelley
Susan Kim
Cynthia Kirr
Beth Kishbaugh
Christy Knorr
Judy Kuhn
Rosa Latour
Sylvia Lee
Ronald Lee
Ellen Lenihan
Kathyrn Libby
Tori Long
Geraldine Loughran-Beutler
Jessica Luebke
Sylvia Luz
Michele Lyons
Paul Marquardt
Jennifer Martin
Maricela Martinez-Kimbrell
Lori Martinson
Christy McGill
Steven McGurgan
Maureen McHale
Marlene Mellin
Angel Merchant
Rosanne Morin
Bernard Morris
Rhonda Myers

Katheryn Neuman
Michelle Nickett
Diana Ochoa
Kyleigh Odom
Rachel Pacheco
Elizabeth Panken
Medalla Paragas
Sandra Parker
Kinga Pater
Jennifer Pettis
Martha Pleitez
Lucila Puentes Stewart
David Quint
Jamie Ragland
Mary Reaves
Karen Reihl
Michael Renshaw
Michael Richardson
Leon Robinson
Sheri Ross
Vickie Rounds
Linda Salitore
Linda Schendel
Joy Severio
Tammy Sheedy
Sherry Shelton
Helen Smith
Shirley Smylie
Cathy Soto
Christy Sprague
Lorraine Steward
Cheryl Stewart
Gary Summerfield Jr.
Doneige Suprice
Sally Sytko
Marissa Szyslowski
Nina Tabachnikova
Shawnie Tallman
Melita Ticoy
Cathy Tiernan
Aletha Tippett, MD
Barbara Twombly
Natalie Van Sickle
Daniel VandenBerg, MD
Nichole Webb
Robin Wells
Staceyleigh Werner
Sabrina West
Marilyn White
Julie Wiens
Kathy Williams
Donise Wimbush
Diana Worthington
Beth Wyman
Gertrude Young
Susan Ziegler

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build up both sides of the body to restore symmetry and make the wound less noticeable. Also, dressings come in various skin tones to blend better against the skin; choose the most appropriate tone for your patient. And try to use clothing creatively to cover the wound.

Palliative wound care embodies the best of patient-centered care by focusing on what's best for the patient—even if that's not what's best for the wound. Aggressively managing the most distressing symptoms of chronic wounds helps maximize patients' quality of life.

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Gail Rogers Hebert is a clinical instructor with the Wound Care Education Institute in Plainfield, Illinois.

WHEN YOU DON'T KNOW WHAT TO SAY,

STAND UP.

When someone you love is diagnosed with cancer, you have the power to help. There are many ways you can stand up and show that you care.

THEY TALK, YOU LISTEN. One of the most helpful and important things you can do is listen—without judgment and resisting the urge to give advice.

DON'T ASK, DO TELL. Instead of waiting to be asked for help when it is needed, be specific about what you can do and when, such as: prepare a meal, babysit, pick up groceries, help with pets, or provide rides to and from appointments.

LIVE AND LEARN. Educate yourself about your loved one's diagnosis and treatment. When you understand what a cancer patient is going through, you're better able to help keep information clear, track questions, and know how you can be most useful.

STAY CONNECTED. After the initial diagnosis, people tend to drift away. Be someone to count on for the long haul. Check in, send a quick note, or drop off a book. Small gestures go a long way.

Visit ShowThatYouCare.org to learn more about how you can stand up for someone you love.

Cancer Treatment Centers of America®

STAND UP TO CANCER®

Cancer Treatment Centers of America is a proud supporter of Stand Up To Cancer, an initiative designed to accelerate groundbreaking cancer research for the benefit of the patient.

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