Improving Wound Outcomes with the Inter-Professional Approach

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Objectives

• To Identify the Current State and Challenges/Limitations with the Current State of Post-Acute Wound Management
• To Recognize Vital Roles of Each Team Member
• To Inspire and Transform the Post-Acute Wound Team
Challenges in Wound Management

- Survey
  - Early recognition
  - Turning and Repositioning
  - Preventative Measures
- Quality Measures
- Litigation
- Patient/Family Satisfaction
- Staff Satisfaction

- Caregiver: Risks of caring for the at-risk patient/resident
- Educational deficits from Professionals to Caregivers to family
- Perception of a ‘Pressure Injury/Ulcer’
First, ask your team...

What do you think if you hear ‘pressure ulcer’?

What do you think public perception is when they hear nursing home and pressure ulcer?

What do you think wound specialists think when they hear pressure ulcer?

What do you think when surveyors or lawyers hear pressure ulcer?
Current State of Wound Management

Triple Aim: Best Outcomes, Highest Satisfaction, Lowest Price

The shift that is NOW occurring from fee-for-service to payment for outcomes

• Rewards Innovation, Quality, and Outcomes

• Measures:
  • Quality Measures (specifically: section M for pressure ulcers, Function,
  • Claims (re-hospitalizations)

• All Post-Acute Care providers
  • IMPACT law 2014 now in effect
    • Acute Care AND who they will partner with
    • Re-hospitalizations
What are the facts...

• Up to 3 million PUs Reported per year in U.S.
• Cost > 11 BILLION annually in U.S.
• JAMA article: > 26% of hospital readmissions have PU
• > 60,000 deaths/year in U.S.
• 2\textsuperscript{nd} most common cause of litigation - Average 13 million dollars
• Pressure Ulcers impact MDS Quality Measures which impacts admissions
• F314 can and has closed centers down to admissions
• Family perception = litigation
• GHC cost to care up to $5,000/month for a stage 4 pressure ulcer
So.. How can we do better?
6 steps Providers can take to improve Wound Outcomes

1. Ensure Dx is correct
2. Question findings
3. Root Cause
4. Determine ‘wound’ prognosis
5. Collaborate with the inter-professional team
6. Communicate and lead
Ensure the wound type, or Dx, is correct

- Wounds are frequently mislabeled as ‘pressure’
  - Moisture Associated Skin Damage
  - Neuropathic Ulcers
- Question the causative findings
- Was the patient examined in sitting, side lying, supine and with their devices in place (splints, etc...)
- Was the cause pressure and related to positioning?
Root Cause: Process Symptom?

• Take a ‘deep dive’:
  • Any other in-house acquired pressure ulcers this week? This unit?
• Should a root cause analysis be done?
• Guide AWAY from ‘knee-jerk’ quick fix solutions
• Guide to sustainable process improvement that involve the team
Root Cause: Patient Symptom

- What tipped the scale of homeostasis?
- Review co-morbid conditions
- Review medications
- Discuss any changes
- Evaluate blood flow
- Detail your findings with the inter-professional team and within documentation
F314, NPUAP, AMDA = Team Approach
Provider: Determine patient wound prognosis

- Determine outcome and document rational
  - **Good for healing** (Medicare expects evidence of healing every 1-2 weeks)
  - **Anticipate a delay** (based on what findings)
  - Palliative, healing not expected, in some cases further decline may be anticipated (based on what findings)
Considerations

• Overall health of patient
• All Co-morbid conditions
• Infections
• Medications
  • Antibiotics
• Vascularity
• CBC, A1C
• Oxygen perfusion
• Osteomyelitis
• Advanced Directives
Nursing Team

• Facilitator of the Wound Team
• Experts:
  • Skin Assessments
  • Risk Assessments
  • Treatment Options (Guidelines)
  • Surface Options (Guidelines)
  • Wound Assessments
  • Wound Tracking
  • Process Improvement
  • Patient Education
Registered Dietitian Nutritionist

- Experts
  - Holistic Assessment of the patient to determine nutritional level, recognizing nutritional impairment, recommending nutritional intervention
Physical Therapists

• Experts in
  • Maximizing safe mobility, balance, endurance
  • Modalities to increase circulation & promote healing
    • Electrical Stimulation, Electromagnetic Therapy
    • Low Frequency Ultrasound
    • Closed Pulsed Lavage
  • Challenging positioning issues
  • Contracture management

• Many will also...
  • Sharp conservative debridement (as per Practice Act and facility policy)
  • Compression
  • Assist with Treatment Selection and Surface Selection
  • Provide treatments, if within Plan of Care
    • Must be able to justify to Medicare

NADONA/LTC National Conference
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Occupational Therapists

• Experts in
  • Adaptive Equipment
  • Activities of Daily Living
    • Improving independent continence care
    • Splinting/Contracture Management
What are your other important resources?

• Wound Specialist
• Speech Therapist
• Dentist
• Ophthalmologist
• Social Service
• Vascular
• Infectious Disease
• Dermatologist
• Risk Manager
Don’t leave out...

• Administrator
  • Surfaces for bed & chair
  • Audit schedule
  • Replacement schedule
  • Supplies

• Maintenance
  • Bed surfaces/room revisions
  • Chair adaptations (along with P.T.)

• Central Supply
  • Does your staff have the supplies they need, when they need them?

• Educator
National Guidelines

- NPUAP Revised Staging System 2016
- NPUAP 2014 Prevention & Treatment Guidelines
- AMDA Pressure Ulcer Guidelines
- WOCN
- American Board of Wound Management
Today: The ‘Silo’ approach..

- Evaluates on the ‘wound’ and not the person
- Finger pointing
- Knee jerk reactions
- Failure to recognize and change practices
- Unhappy patients, unhappy families, unhappy staff
- F314
- Litigation
- Quality Measures, Star Ratings
So what’s the Team Approach?

• Evaluates the whole patient who has a wound
• Accurate wound ‘diagnosis’ and ‘prognosis’
• Sustainable process changes that make sense
• Maximize patient outcomes
• Happy patients, happy families, happy staff
• Improved Quality Measures and Referrals
Lets review a case together...

- Patient admitted 8 weeks ago with a superficial heel ulcer.
- The ulcer is now full thickness and overall worsened.
- History: MI, COPD, Diabetes.
- Interventions: Low Air Loss surface, heel lift boot, turning, w/c cushion
- Mobility: prior to admission was independent with ambulation, now requires moderate assistance with walker. Primarily stays in bed or in w/c.
Results

• Labeled as a ‘Pressure Ulcer’ since the ulcer on heel and the patient is now immobile. MDS.

• Impacts Quality Measures for worsening short stay and at this rate, will make the 90 day as well.

• The nurse is frustrated and continuously changes treatment recommendations to get improvement (topical ointments, gels, etc..)

• Consults to the RD were made (based on ‘pressure’)

• CP goals have been set for healing (but healing was not noted)

• The patient, who was on the low air loss for the ‘pressure ulcer’ on the heel, fell out of bed while trying to sit up

• The patient and family is frustrated with the center and nurse and feel that the decline in the wound is the result of the care of the center
Big-Picture Results

- Since it was mislabeled as ‘Pressure’; it negatively impacts the short and long stay Quality Measure
- The fall out of bed contributed to more pain, more medication for pain, further decline in mobility, and a pressure ulcer on the sacrum
- Since there was fear to get patient out of bed, the patient is no longer able to ambulate; also negatively impacting the Quality Measure
- Since there was no long term plan post d/c for management of diabetes or the wound bioburden due to the diabetes, the patient was re-hospitalized for infection and subsequent amputation
- The patient/family is angry. Litigation risk.
What if? What if things were different than the way you have seen them in the past?

Rachel Naomi Remen
American
What if the approach was Inter-Professional?

• **Determined on Admission:**
  - Interview with patient and family: ulcer started prior to admit to center and hospital; started at home on the plantar heel
  - Patient has tri-neuropathy: sensory/motor/autonomic
  - At the time of ulceration, the patient was **not** immobile and the wound was not the result of sustained pressure
  - The determined to use a firmer bed to promote increase mobility and a device to prevent any injury/pressure to the heel area

• The wound was accurately reclassified as ‘**Diabetic/Neuropathic**’; the Provider documented rational to support the wound diagnosis

• A1C: 8%

• ABI: 0.7 DP/PT
Inter-professional Approach

• **The Center Leadership**, Administrator, Director, Management all support the inter-professional approach and provide the framework and mentoring for communication, documentation, and access to tests and supplies

• **Provider:**
  • Established Dx
  • determined that the ‘Prognosis’ as ‘Anticipate a delay in healing’
    • due to chronically elevated blood sugar and poor circulation.
  • Reviewing meds to improve management of blood sugars
  • Provides education to the family regarding wound healing and the challenges/risks associated with diabetes and vascularity
  • Considering a Vascular Consultation if no improvement noted in 2-4 weeks
Inter-professional Approach

• Nursing:
  • understanding that bioburden will be an issue due to A1c and ABI; recommends a treatment to better manage bioburden (Antimicrobial wound wash and antimicrobial topical).
  • Updates Care Plan, documents the inter-professional evaluation and plan
  • Informs and educates the patient and the family, documents their verbalized understanding and agreement of plan of care
  • Continuously provides education regarding treatments and care to prepare for discharge
  • Discusses with P.T. and family: the bed surface and seating surface to ensure that skin, safety, mobility, and patient preference are all considerations. Documents selection and rational. Documents patient/family understanding.
Inter-professional Approach

• Physical Therapy:
  • Collaborates with nursing and patient/family in selection of appropriate bed surface/seating surface to maximize skin & mobility
  • recognizing the impaired circulation, obtains orders to begin electrical stimulation to increase circulation to promote healing, 7x/week x 30 days
  • Recognizing the issue with bioburden, obtains orders to begin low frequency ultrasound to decrease bioburden and promote healing, 3x/week with dressing changes x 30 days
  • Evaluates for off-loading diabetic healing shoes (ex: Darco), gait training, balance training
  • Provides education regarding neuropathy and wounds to help patient/family understand, documents education
Inter-professional Approach

• **Registered Dietitian**: Evaluates holistically to determine nutritional needs, determines whether a strict diet or liberal diet would be most beneficial for the patient and works with the provider and nursing team.

• **Social Service**
  • Prepares for discharge home by coordinating either visiting wound specialist or out-patient wound care upon discharge
  • Ensures patient/family have dressing supplies upon discharge
  • Provides information for on-going support with diabetes education
Inter-Professional Approach

• Care-givers/Nursing Assistants:
  • They know WHO TO GET when the family asks about the wound condition
  • They know how to safely ambulate with patient with the Darco shoe and do so routinely to improve function for safe discharge home
  • They understand and therefore support the nutritional plan of care
  • They understand what to do/who to get/how fast to get if the dressing is soiled or dislodged
  • They feel they are heard, and respected, when they have a concern
  • They attend wound rounds and give feedback on how the plan of care is working
The **RESULTS**...

- The patient/family received accurate wound dx and prognosis
- The patient/family were educated of causative factors of the wound as well as the challenges now for healing. The patient was an integral part of goal setting.
- The inter-professional team coordinated care to establish a holistic approach that included the patient/family in the plan of care.
- The patient was discharged to home with a slowly healing DM ulcer, with appropriate shoes/gait training to ambulate, knowledge for skin checks and signs of infection, improved managed of A1c, increased circulation for healing, and home care to continue with care and prevent re-hospitalization
- The patient/family were satisfied with care. (Quality Measure)
- The inter-professional team feel respected by Center Leadership, respect each other and feel proud of their approach. (Staff retention!)
- The Ulcer did not negatively impact Quality Measures for pressure and in-fact, the improved function may improve the new Quality Measure for function.
- No Re-hospitalization.
If you want a drastically different outcome, you must do things drastically different.
Question and Answer

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Resources

1. NPUAP Pressure Injury Revision April 2016
2. ‘Common Questions section M of MDS Pressure Ulcers and Wounds’; presented by Jeanine Maguire and Pamela Scarborough to GHC 2015
3. CMS’s RAI Version 3.0 Manual, Section-M
References


