Wound Care Competencies for 2015: Implications for Nurse Managers

Participants will:

1. Discuss gaps in nursing knowledge based on the 2014 wound care survey.
2. Review essential nursing competencies for specific skin conditions and wounds.

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• Competence
  – Ability of an individual to do something (a job) properly

• Competency
  – Set of defined behaviors that provide a structured guide enabling the identification, evaluation and development of the behaviors of the individual
NURSING 2014 Survey Results

• I received sufficient education on chronic wounds in my basic nursing education program.

<table>
<thead>
<tr>
<th></th>
<th>2012</th>
<th>2005</th>
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</thead>
<tbody>
<tr>
<td>Yes</td>
<td>31.5%</td>
<td>30%</td>
</tr>
<tr>
<td>No</td>
<td>68.5%</td>
<td>70%</td>
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</table>


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NURSING 2014 Survey Results

• Did the number of years of nursing experience influence a yes response to the above question?

<table>
<thead>
<tr>
<th>YEARS</th>
<th>Percent</th>
</tr>
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<tbody>
<tr>
<td>2-3</td>
<td>47%</td>
</tr>
<tr>
<td>4-5</td>
<td>42.3%</td>
</tr>
<tr>
<td>6-10</td>
<td>42.6%</td>
</tr>
<tr>
<td>16-10</td>
<td>32.4%</td>
</tr>
<tr>
<td>Over 20</td>
<td>22.7%</td>
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</table>

<table>
<thead>
<tr>
<th>Work Setting</th>
<th>Percent</th>
<th>Role</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home HC/Community</td>
<td>43.0%</td>
<td>Staff nurse</td>
<td>39.4%</td>
</tr>
<tr>
<td>LTC</td>
<td>32.8%</td>
<td>Charge/Assist Manager</td>
<td>36.0%</td>
</tr>
<tr>
<td>Hospitals</td>
<td>28.9%</td>
<td>Manager/supervisor</td>
<td>21.7%</td>
</tr>
<tr>
<td>Hospice</td>
<td>28.6%</td>
<td>Advance Practice</td>
<td>5.4%</td>
</tr>
</tbody>
</table>


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Life Long Learning

- Performance Assessment
- Integration of Learning into Practice
- Reflective Practice

Basic Professional Education (minimum safe practice)

Safe practice = Ongoing Competence Competency (knowledge & skills up to date)

Years in practice

Still got it

Got it

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Wound Care Competencies Checklist:
- Direct Care Providers
- Nursing Managers

✔ Pressure Ulcers
✔ Venous Leg Ulcers
✔ Moisture Associated Skin Damage (MASD)
✔ Diabetic Foot Ulcers (DFU)
✔ Skin Tears

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Pressure Ulcer Incidence

Do you know your **facility’s** PrU incidence rate?

<table>
<thead>
<tr>
<th>2012</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>36%</td>
<td>64%</td>
<td></td>
</tr>
</tbody>
</table>

Do you know your **unit’s** PrU incidence rate?

<table>
<thead>
<tr>
<th>2012</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>38%</td>
<td>62%</td>
<td></td>
</tr>
</tbody>
</table>


© Ayello 2014

Sometimes you need to look at things differently

“the problem of pressure ulcers belongs to no one group of healthcare professionals: all on the healthcare team must work together to diminish the incidence and severity of pressure ulcers.”

Roberta Abruzzese, 1988 Editorial. Decubitus 1(1) P. 7

NJHA Collaborative Goals

- Close the gap between what is known and what is practiced
- Reduce pressure ulcer incidence by **25 %**
- Achieve 95% compliance with the PU Prevention Bundle
  - Skin assessment on admission
  - Risk assessment on admission
  - Reassessment of skin and PU risk
  - Prevention strategies implemented within 24 hrs
- Improved communication across care settings

© Ayello, 2008
The **ABCDE** of Pressure Ulcer Incidence Reduction Initiatives

- **A**dministrative support backed by support at the patient care level is vital
- **B**undling care practices and having an identifiable theme
- **C**reating a culture of change, commitment, and communication
- **D**ocumentation of pressure ulcer prevention practices must be visible
- **E**ducation is essential

**Need for system-wide change including a culture change**

**Key Concepts**

- No more “Blame”
- “Process”
- “Catch” – build redundancy into the system

**ORGANIZATION OF TOOLKIT**

- **Six chapters** each addressing a key question:
  1. Are we **ready** for this change?
  2. How will we **manage** change?
  3. What are the **best practices** in pressure ulcer prevention that we want to use?
  4. How should those practices be **organized** in our hospital?
  5. How do we **measure** our pressure ulcer rates and practices?
  6. How do we **sustain** the redesigned prevention practices?

- **Appendices with tools and resources**
  - [http://www.ahrq.gov/research/ltc/pressureulcertoolkit/](http://www.ahrq.gov/research/ltc/pressureulcertoolkit/)
Importance of ICU clinical rounding with WOC nurses

Universal PU Prevention Bundle (UPUPB)
- Skin emollients
- Assessment of skin head-to-toe
- Floating heels off the bed
- Early identification of sources of pressure, using pressure redistribution surfaces
- Repositioning

Results
- Incidence decreased 15.5% to 2.1%
- Increased adherence to:
  - Heel elevation
    \[ t = -3.905, df = 325, P < .001 \]
  - Repositioning
    \[ t = -2.441, df = 325, P < .015 \]


Rethink forms- how you use your CNAs for skin care

- **Documentation** and knowledge of CNA staff
- **Support collaborative clinical decision making**
  - multidisciplinary team using clinical decision support tools
- **Establish practices**
  - identification and early intervention to prevent pressure ulcers (PrUs)
  - part of frontline caregivers’ daily work


© Ayello, 2011

FREE DOWNLOAD
www.woundcarejournal.com

NURSING 2014 Survey Results

- **The Braden Scale is use to assess a patient’s potential to develop a vascular ulcer.**

<table>
<thead>
<tr>
<th></th>
<th>2012</th>
<th>2005</th>
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</thead>
<tbody>
<tr>
<td>True</td>
<td>38%</td>
<td>44%</td>
</tr>
<tr>
<td>False</td>
<td>62%</td>
<td>56%</td>
</tr>
</tbody>
</table>


© Ayello, 2015
Braden Scale

Levels of Pressure Ulcer Risk

- **19 to 23 = not at risk**
- **15 to 18 = at risk**
- **13-14 = moderate risk**
- **12 to 10 = high risk**
- **9 or below = very high**

Must address low subscale scores also

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Rethink

Pressure Ulcer Risk Assessment

Because some clinicians:

- Believe its just a task
- Complete scale incorrectly
- “Copy forward” rather than assess
- Have lost the critical thinking piece

© Ayello, 2008

A comprehensive pressure ulcer risk assessment also includes:

<table>
<thead>
<tr>
<th>Nutrition Assessment</th>
<th>History and Co-morbidities</th>
</tr>
</thead>
<tbody>
<tr>
<td>History</td>
<td>Assess co-morbidities, medications</td>
</tr>
<tr>
<td>Look at the skin</td>
<td>Touch the skin</td>
</tr>
</tbody>
</table>

© Ayello 2012
4 Risk factors associated with heel pressure ulcers in hospitalized patients

Main analysis results showing significant and independent predictors of HPUs in the final logistic regression model (N=337)

<table>
<thead>
<tr>
<th>Predictor Variable</th>
<th>Regression Coefficient</th>
<th>SE</th>
<th>P</th>
<th>Odds Ratio</th>
<th>95% Confidence interval</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes</td>
<td>1.08</td>
<td>0.46</td>
<td>.02</td>
<td>2.9</td>
<td>1.2-7.2</td>
</tr>
<tr>
<td>Vascular Disease</td>
<td>1.35</td>
<td>0.54</td>
<td>.01</td>
<td>3.8</td>
<td>1.3-11.1</td>
</tr>
<tr>
<td>Immobility</td>
<td>1.55</td>
<td>0.51</td>
<td>.003</td>
<td>4.7</td>
<td>1.7-12.9</td>
</tr>
<tr>
<td>Admission Braden Score &lt; 18</td>
<td>3.08</td>
<td>0.64</td>
<td>&lt;.001</td>
<td>21.8</td>
<td>6.3-76.1</td>
</tr>
</tbody>
</table>


Higher rates of HAC Pressure Ulcers

- Corticosteroid use
- Congestive heart failure (CHF)
- Chronic obstructive pulmonary disease (COPD)
- Cerebrovascular disease (CVD)
- Diabetes Mellitus (DM)
- Obesity


When to Do Risk Assessment*

- On admission
  - Within 8 hours
- Reassessment frequency
  - Based on patient’s acuity
- Significant change in patient’s condition

* Based on recommendations of NPUAP/EPUAP:PPPIA 2014 PU Guideline
Risk Assessment

• Critically ill patients
  – Number of hypotensive episodes, hemodynamic instability
  – Medical devices

• Perioperative patients
  – Length of surgery
  – Number of hypotensive episodes during surgery
  – Low core temperatures during surgery
  – Amount of time immobilized before and after surgery

Pressure ulcers in surgical patients

7.3% to ___% in 3 years of HAPU's

Indications for wrist band application:
- Patients who are positioned for 4 hours or more.
- Any patient with a noted skin assessment change upon discharge from the OR.

Post Operative Interventions for all positions:
- Wash hands
- Complete Braden Scale
- Bedside HAPU staging as per NAPUs pressure staging guidelines
- Follow prescribed treatment protocol and procedures
- Follow specialty support surface protocol and procedures
- Notify MDS/NOCN

After identification of PU risk

Is the problem:
- Don’t have the prevention products
- Staff do not know now to use prevention products or reposition patients?
- Equipment not being:
  – used
  – used inconsistently
  – used timely
  – used effectively
Don’t wait to do pressure redistribution

The study data: 792 patient aged 65 years of older Evaluated on day 3 of admission

RESULTS: Only 15% had any preventive device at day 3 of admission 51% of at risk patients had a preventive device 68% of patients with pressure ulcer had documented PU in record


Evidence informed practice

Look at communication processes and identify any need for system-wide change

Automatic triggers
– One hospital improved communication across departments by building in an automatic trigger within its electronic system

Can Dressings Reduce Shear Forces and Prevent Pressure ulcers?

  \[\text{Shear force on bony prominences also decreased from 23.4 cmH2O to 5.9 cmH2O with use of dressings}\]
- Brindle, CT (2010) WOCN 30(1):11-18
  \[\text{Reduction in PrUs for inpatients (15% compared to 48% in control group); 0.2% of patients were cellulitis cases}\]
  \[\text{Reduction in PrUs for inpatients (15% compared to 42% in control group); 0.2% of patients were cellulitis cases}\]
  \[\text{Reduction in PrUs for inpatients (15% compared to 42% in control group); 0.2% of patients were cellulitis cases}\]
  \[\text{Reduction in PrUs for inpatients (15% compared to 42% in control group); 0.2% of patients were cellulitis cases}\]
  \[\text{ED patients with PrUs had lower incidence of PrUs compared to control group}\]
  \[\text{Reduction in PrUs for inpatients (15% compared to 42% in control group); 0.2% of patients were cellulitis cases}\]
- Park, KH. (2014) JWOCN 41(5): 424-429
  \[\text{Reduction in PrUs for inpatients (15% compared to 42% in control group); 0.2% of patients were cellulitis cases}\]
Wound Bed Preparation

Person with a wound

- Identify, Prevent/ Treat the Cause
- Local Wound Care
- Determine Healability: Healable, Non-healable
- Maintenance, Non-maintainable
- Debridement
- D/T
- Inflammation
- Infection
- Moisture Balance
- Edge

Patient centered concerns

Differentiate wounds

- Pressure Ulcers
  - Venous
  - Arterial
- Vascular ulcers
- Neuropathic/DM ulcers
- Other skin problems

Free download
www.woundcarejournal.com

Differentiating Moisture Damage from Pressure

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>M ASD</th>
<th>Pressure Ulcer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Location</td>
<td>Larger skin area in contact with moisture</td>
<td>Usually localized over bony prominence</td>
</tr>
<tr>
<td>Edges</td>
<td>Irregular</td>
<td>Distinct</td>
</tr>
<tr>
<td>Color</td>
<td>Red, usually blanchable erythema</td>
<td>Varies, Non blanchable erythema</td>
</tr>
<tr>
<td>Depth</td>
<td>Superficial</td>
<td>Superficial to full thickness</td>
</tr>
<tr>
<td>Necrosis</td>
<td>None</td>
<td>Yes, Unstageable</td>
</tr>
</tbody>
</table>

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© Ayello, 2013

© Ayello & Sibbald

© Ayello

© Sibbald

© Ayello

© Sibbald
NURSING 2014 Survey Results

- Nurses are licensed in my state or province to do minor surgical debridement.

<table>
<thead>
<tr>
<th>Year</th>
<th>Yes</th>
<th>No</th>
<th>I don't know</th>
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<tr>
<td>2012</td>
<td>12%</td>
<td>58%</td>
<td>30%</td>
</tr>
<tr>
<td>2005</td>
<td>18%</td>
<td>53%</td>
<td>29%</td>
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© Ayello, 2015
NURSING 2014 Survey Results

- Topical enzymes are effective or removing necrotic tissue in chronic wounds.

<table>
<thead>
<tr>
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<th>Yes</th>
<th>No</th>
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<tbody>
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<td>2012</td>
<td>78%</td>
<td>22%</td>
</tr>
<tr>
<td>2005</td>
<td>89%</td>
<td>11%</td>
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</table>

© Ayello, 2015

Wound Bed Preparation

- Identify, Prevent/Treat the cause
- Local Wound Care Determine Healability: Healable, Maintenance, Non-Healable
- Patient centered concerns
- D/T Debridement
- I Inflammation
- M Moisture Balance
- E Edge


Wound INFLAMMATION/ INFECTION

- NERDS Superficial: Treat topically
- STONEES Deep: Treat Systemically

- Non-healing
  - Exudate
  - Red + Bleeding
  - Debris
  - Smell
- Size is bigger
  - Temperature ↑
  - Os (probes, exposed)
  - New breakdown
  - Exudate,
  - Erythema, Edema
  - Smell

Sibbald, Woo, Ayello 06
Woo, Sibbald 09
© 2013 IIWCC
Wound Bed Preparation

Person with a wound

Identify, Prevent/ Treat the Cause

Local Wound Care
Determine Healability: Healable, Maintenance, Non-Healable

Patient centered concerns

D/T Debridement

Inflammation

Infection

Moisture

Balance

NURSING 2014 Survey Results

• Wet-to-dry dressings are best to treat clean granulating chronic wounds.

2012 2005

– True 44% 38%

– False 56% 63%

Dressing Categories & Moisture

Increasing Absorbency

<table>
<thead>
<tr>
<th>Hydrogel</th>
<th>Transparent Films</th>
<th>Hydrocolloid</th>
<th>Hydrofibers/Alginates</th>
<th>Foams</th>
<th>Super-Absorbsents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Donates moisture</td>
<td>Neither donates or absorbs moisture</td>
<td>Donates and absorbs a small to moderate amount of moisture</td>
<td>Fluid lock</td>
<td>Absorbs moderate moisture—bioreversible</td>
<td>Absorbs large amt. moisture + fluid lock (diaper technology)</td>
</tr>
</tbody>
</table>

© Ayello, 2015
Medical Device Pressure Ulcer Guideline recommendations

• “Inspect the skin under and around medical devices at least twice daily for signs of pressure ulcer related injury on the surrounding skin.”
(SOE=1, SOR+)

• “Conduct more frequent (greater than twice daily) skin assessments at the skin-device interface in individuals vulnerable to fluid shifts and/or exhibiting signs of localized or generalized edema.”
(SOE=1, SOR+)

• “Classify medical device related pressure ulcers using the International NPUAP/EPNAP Pressure Ulcer Classification System with the exception of mucosal pressure ulcers.”
(SOE=1, SOR+)

www.internationalguideline.com

NURSING 2014 Survey Results

• My facility has a policy for how often a wound assessment should be completed and documented.  

  2012       2005
  -- Yes     90%       88%
  -- No      5%        5%
  -- I don’t know 5%       7%

© Ayello, 2015
Minimal pressure ulcer documentation

- **Size**
- **Location and staging**
- **Exudate**
- **Edge and surrounding tissue**
- **Pain**
- **Bed- color and type of wound tissue**

Measuring Wounds

- **Length**
  - head to toe
- **Width**
  - side to side perpendicular (90° angle) to length.

NURSING 2014 Survey Results

- A pressure ulcer with full thickness tissue loss is staged/classified as:
  - Stage I 1%
  - Stage II 11%
  - Stage III or IV 88%
- I can identify the six stages of pressure ulcers in my patients

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>2012</td>
<td>55%</td>
<td>35%</td>
</tr>
<tr>
<td>2005*</td>
<td>70%</td>
<td>5%</td>
</tr>
</tbody>
</table>

© Ayello, 2007
### Pressure Ulcer Classification at a glance

<table>
<thead>
<tr>
<th>Ulcer Characteristics</th>
<th>Category / Stage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intact skin, non blanchable erythema</td>
<td>I</td>
</tr>
<tr>
<td>Open shallow ulcer with no slough</td>
<td>II</td>
</tr>
<tr>
<td>Serum, sero-sanguinesous filled or ruptured blister</td>
<td>II</td>
</tr>
<tr>
<td>Full thickness ulcer</td>
<td>II</td>
</tr>
<tr>
<td>Can have necrotic tissue, but can see wound bed</td>
<td>II</td>
</tr>
<tr>
<td>No bone, tendon, muscle visible</td>
<td>III</td>
</tr>
<tr>
<td>Full thickness ulcer</td>
<td>III</td>
</tr>
<tr>
<td>Can have necrotic tissue, but can see wound bed</td>
<td>III</td>
</tr>
<tr>
<td>Bone, tendon, muscle visible</td>
<td>IV</td>
</tr>
<tr>
<td>Presence of cartilage</td>
<td>IV</td>
</tr>
<tr>
<td>Necrotic tissue covers wound bed</td>
<td>Unstageable</td>
</tr>
<tr>
<td>Purple, maroon discoloration of intact</td>
<td>Unstageable</td>
</tr>
<tr>
<td>Blood filled blister</td>
<td>Unstageable</td>
</tr>
<tr>
<td>Blister, CMS, with signs of DTI</td>
<td>DTI</td>
</tr>
<tr>
<td>NECTIC tissue covers wound bed</td>
<td>Unstageable</td>
</tr>
</tbody>
</table>

### How should you stage this wound?

- **Stage I**
- **Stage II**
- **Stage III**
- **Stage IV**
- **sDTI**
- **Unstageable**

© Ayello, 2014
Are all pressure ulcers staged?

CMS provides guidance that

Mucosal pressure ulcers:
• Are not staged using the pressure ulcer staging system because anatomical tissue comparisons cannot be made.
• Are not reported in the pressure ulcer section.

The Heel and Pressure Ulcers - Flexion Position of Foot is Important

- **Plantar Flexion**

- **Dorsiflexion of foot**
  - needed for ambulation
  - avoid it to prevent foot drop in immobile persons

**Devices can maintain foot in neutral (90° position**

The Heel and Pressure Ulcers - Heel rotation

- MRI evidence –
  - heel padding devices reduce internal soft tissue deformation
  - design features of heel padding devices (p=0.002)
- **Greater deformation** when foot positioned in neutral external rotation compared to 90° upright position
- Device designs (suspension boot around the foot) compared to sock-like device superior in reducing subcutaneous tissue strains

© Ayello 2015
NURSING 2014 Survey Results

- Pressure redistribution products (such as specialty beds mattresses or chair cushions) are used in my facility to prevent pressure ulcers.

   - Yes  
     2012  2005
     94%   88%

   - No  
     4%   11%

   - I don’t know  
     2%   2%

© Ayello, 2015

System and culture changes?

- How long are your patients staying in E.D. before getting to assigned unit?
- Are you assessing skin?
- Are you relieving pressure?

ED- Saving Lives, Saving Skin Starts Here!

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Support Surfaces as Part of a Comprehensive Prevention and Treatment Plan

All patients at risk for pressure ulcers should be turned and repositioned every 2 hours.

<table>
<thead>
<tr>
<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>92%</td>
</tr>
<tr>
<td>No</td>
<td>9%</td>
</tr>
</tbody>
</table>


Continue to turn and reposition the individual regardless of the support surface in use. Establish turning frequency based on the characteristics of the support surface and the individual’s response.

(SOE = C, SOR = 1 thumb up)

NPUAP/EPUAP/PPPIA Pressure Ulcer Clinical Guideline, 2014
© Ayello 2014
Building the evidence base for sDTI

Precipitating Events
- Transfers - 78.8%
- Tissue perfusion - 42.5%
- Surgery - 40.2%
- Mobility - 30.9%
- Falls - 16.9%

Meaningful physiological variables
- Anticoagulation - 61.2%
- Anemia - 67.1%
- Hemoglobin A1C <7.5 mmol/L - 74.4%

Range of days for precipitating events prior to sDTI
1 to 5 days
Average 2.41 (SD 1.04)


Since 1 out of 10 of all patients in ICU’s develop pressure ulcers, *think about this*

- Are we even *considering* skin preservation and pressure ulcer prevention among the tubes, drugs and other life saving measures?
- Should we *really* turn this patient?
- Are we *afraid* to turn this patient?
- Do we have the *resources* to turn this patient?

Universal Heel Ulcer Prevention Algorithm © For Critical Care

Step 1. Primary Stabilization of Airway, Breathing, Circulation, and Drug Infusions

Step 2. Secondary surveillance of skin and risk factors with special emphasis on heels. Complete by end of shift. If new heel found during surveillance, follow the “long term” branch of the algorithm

Step 3. Determine anticipated time of immobility
- "Short Term" Will be mobile within 6 hours
- "Unknown" Treat as "short term"
- "Long Term" Anticipate immobility for > 6 hours

Step 4. Intervene Based on Amount of Leg & Foot Movement
- No Leg or Foot Movement
  - Periods of Excessive Leg or Foot Movement
  - Use high friction dressing on heels
  - Avoid pressure on heels
  - Use heel suspension device
  - Physical Therapy Consult prn.

- Some Leg or Foot Movement (unable to keep calves on pillows)
  - Periods of Excessive Leg or Foot Movement
  - Use low friction dressing on heels
  - Avoid pressure on heels
  - Use heel suspension device
  - Physical Therapy Consult prn.

- Periods of Excessive Leg or Foot Movement
  - Use high friction dressing on heels
  - Avoid pressure on heels
  - Use heel suspension device
  - Physical Therapy Consult prn.

- Foot Drop
  - Use high friction dressing on heels
  - Avoid pressure on heels
  - Use heel suspension device
  - Physical Therapy Consult prn.

- Foot Drop
  - Use low friction dressing on heels
  - Avoid pressure on heels
  - Use heel suspension device
  - Physical Therapy Consult prn.

- Foot Drop
  - Use high friction dressing on heels
  - Avoid pressure on heels
  - Use heel suspension device
  - Physical Therapy Consult prn.

- Foot Drop
  - Use low friction dressing on heels
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  - Avoid pressure on heels
  - Use heel suspension device
  - Physical Therapy Consult prn.

- Foot Drop
  - Use low friction dressing on heels
  - Avoid pressure on heels
  - Use heel suspension device
  - Physical Therapy Consult prn.

5. Reassess skin, foot drop and risk status at least daily.
Pressure ulcer healing
NPUAP/EPUAP/PPPIA 2014 PU Guideline

• Assess progress toward healing using a valid and reliable pressure ulcer assessment scale.
  (SOE=B, SOR= 1thumb up)

So how long does it take for PrU to heal?

N=270 patients with stage II PU
• 153 lesions healed (56.7%) after 10 weeks
• Average healing time 22.9 days (95% CL, 20.47-25.37 Days)
• Medium 18 days

SIZE mattered
• 3.1 cm shorter healing time (19.2 days) compared with PU greater than 3.1 cm 31.0 days (95% CL, 26.4-35.6 days, P=.000)


As the pressure ulcer heals...
CMS agrees with NPUAP

Do not reverse or back stage!

If the pressure ulcer has ever been classified at a higher numerical stage than what is observed now, it should continue to be classified at the higher numerical stage.

CMS LTC RAI Manual MDS 3.0 Section M page M-6
CMS LTC Quality Reporting Manual Section M page M-6
CMS IRF PAI Training Manual page IV

Wound Care Competencies for 2015: Implications for Nurse Managers

Lippincott Nursing Management Congress 2015
Wound Care Competencies for 2015: Implications for Nurse Managers

Pressure Ulcers
Venous Leg Ulcers
Moisture Associated Skin Damage (MASD)
Diabetic Foot Ulcers (DFU)
Skin Tears

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VENOUS Leg Ulcers

Pitting edema
stasis eczema
hyperpigmentation
woody fibrosis
ulceration

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NURSING 2014 Survey Results

• Compression wrap/bandaging multilayer system/dressing is the gold standard or treating venous ulcers.

   – Yes  2012  
   – No  22%

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Bandages for treatment....

Cochrane Database Syst Rev. 2012
Nov Compression for venous leg ulcers.
O’Meara S., Cullum N., Nelson EA, Dumville JC.

• Compression increases ulcer healing rates compared with no compression
• Multi-component systems are more effective than single-component systems

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NURSING 2014 Survey Results

- I know how to apply a Compression wrap/bandaging multilayer system/dressing.

<table>
<thead>
<tr>
<th></th>
<th>2012</th>
<th>2005</th>
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<tbody>
<tr>
<td>Yes</td>
<td>68%</td>
<td>71%</td>
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<tr>
<td>No</td>
<td>32%</td>
<td>29%</td>
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</table>


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Before you compress- ABI

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Bandages- Venous Ulcers

Bandages should be applied
Half way between the relaxed state & stopping distance

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Self perception of Compression Competency

Competent nurses
• more inclined to apply firmer bandages on both systems (n=6)
• obtained very high ankle pressures; nurses did not doubt their own application & their dorsi-flex values were very high. (n=2)

Self reported less competent nurses
• battled with the application of system
• could not manage to cover the heel effectively with the second layer of the bandaging system (first layer leaves the heel uncovered)
• achieved suboptimal low-pressure readings on both the ankle and calf muscle (n=8)

Lippincott Nursing Management Congress 2015

Wound Care Competencies for 2015: Implications for Nurse Managers

Participants have:
1. Discussed gaps in nursing knowledge based on the 2014 wound care survey.
2. Reviewed essential nursing competencies for specific skin conditions and wounds.

Content is true as this moment, anything could change by this evening

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Thank You