Therapy and Wound Care

May 3, 2012

Presented by:
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Director of Rehabilitation Consulting Services

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Instructions and Handouts for:
Therapy and Wound Care

Eastern
Standard Time
12:00 PM to 1:30 PM

Central
Standard Time
11:00 AM to 12:30 PM

Mountain
Standard Time
10:00 AM to 11:30 AM

Pacific
Standard Time
9:00 AM to 10:30 AM

It is very important that you have these materials printed and ready to use prior to the start of the training.

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Dial 1-877-615-4339 at least 10 minutes prior to the start of the webinar.

1. When asked, enter **Passcode 8507011#**

2. Give your agency’s name.

3. At this time you will be entered into the call and in “listen mode.”

4. If at any time you need assistance you may press *0 for the operator.

5. There will be a Q & A period toward the end of the session. Questions will be answered in the order in which they are received. To ask a question, press *1. You will have the opportunity to ask your question and then be returned to “listen mode.” **Do not press *1 prior to this time.**

6. To view the presentation online you must click on the link sent to you from GoToWebinar.
M1306 Unhealed Pressure Ulcer Stage II or Higher

(M1306) Does this patient have at least one Unhealed Pressure Ulcer at Stage II or Higher or designated as "unstageable"?

☐ 0 - No [Go to M1305]
☐ 1 - Yes

What did the skin inspection reveal?

Skin Inspection
Wound Primer: Pressure Ulcers

- Localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear and/or friction
- 4 Stages + Suspected Deep Tissue Injury

Wound Primer: Definition Pressure Ulcers

- Partial thickness tissue loss
  - Involves epidermis and into but not through the dermis
  - Superficial; presents as shallow crater, abrasion or blister
  - Heals by epithelialization
    - Regeneration of epidermis across a wound surface
  - Includes stage I and II pressure ulcers

Wound Primer: Definition Pressure Ulcers

- Full thickness tissue loss
  - Penetrates through the fat (subcutaneous tissue) and may involve muscle, tendon, or bone
  - Deep crater; may tunnel
  - Heals by granulation, contraction and epithelialization
  - Never considered fully healed
  - Closed when fully granulated and covered with new epithelial tissue
  - Includes stage III and IV pressure ulcers
Suspected Deep Tissue Injury (SDTI)

- Purple or maroon localized area of discolored intact skin OR a blood filled blister due to damage of underlying soft tissue from pressure and/or shear

(NPUAP 2007)

OASIS Alert!

- Unstageable pressure ulcers
  - Pressure ulcer under a dressing or device that cannot be removed
  - Full thickness tissue loss in which the true wound depth is obscured by slough and/or eschar in the wound bed
  - Suspected deep tissue injury in evolution

<table>
<thead>
<tr>
<th>Stage</th>
<th>Description</th>
<th>Number of ulcers present on the day of assessment</th>
<th>Number of ulcers in Columns 1 that were also present at the most recent SOC/RDC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stage I</td>
<td>Partial thickness loss of dermis presenting as a shallow open ulcer with wet slough, if present, but without undermining and tunneling</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stage II</td>
<td>Full thickness tissue loss with visible bone, tendon, or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stage III</td>
<td>Suspected, known or likely but undiagnosed due to non-removable dressing or device</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stage IV</td>
<td>Suspected, known or likely but undiagnosed due to coverage of wound bed by slough and/or eschar</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(Time Points WOCN Guidelines NPUAP Staging)

Number of ulcers in Column 1 that were also present at the most recent SOC/RDC
Patient 1 at SOC, has no unhealed stage II pressure ulcer. There are no pressure ulcers.

<table>
<thead>
<tr>
<th>Stage description - unhealed pressure ulcers</th>
<th>Column A</th>
<th>Column B &amp; C</th>
<th>Column D</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stage II: Full thickness loss of tissue presenting as a shallow open ulcer with red, pain-sensitive base, without slough. May also present as an intact or open/ulcerated lesion.</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Other / Unspecified Necrosis or Infected Ulcer</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Unspecified Ulcer or Infected</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

Patient 1 at Follow Up has one unhealed stage II pressure ulcer.

<table>
<thead>
<tr>
<th>Stage description - unhealed pressure ulcers</th>
<th>Column A</th>
<th>Column B &amp; C</th>
<th>Column D</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stage II: Full thickness loss of tissue presenting as a shallow open ulcer with red, pain-sensitive base, without slough. May also present as an intact or open/ulcerated lesion.</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Other / Unspecified Necrosis or Infected Ulcer</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Unspecified Ulcer or Infected</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

Report that the ulcer(s) existed at SOC/ROC.

Patient 2 at SOC has one unhealed stage III pressure ulcer.

<table>
<thead>
<tr>
<th>Stage description - unhealed pressure ulcers</th>
<th>Column A</th>
<th>Column B &amp; C</th>
<th>Column D</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stage II: Full thickness loss of tissue presenting as a shallow open ulcer with red, pain-sensitive base, without slough. May also present as an intact or open/ulcerated lesion.</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Other / Unspecified Necrosis or Infected Ulcer</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Unspecified Ulcer or Infected</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>
Patient 2 at Follow Up, the stage III pressure ulcer has progressed to a stage IV pressure ulcer.

<table>
<thead>
<tr>
<th>Stage description</th>
<th>Unhealed Pressure Ulcers</th>
<th>Column 1</th>
<th>Column 2</th>
<th>Column 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stage IV</td>
<td>Unhealed</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

Patient 3 at SOC has one unhealed stage II PU, one unhealed open stage III PU and one unhealed closed stage III PU.

<table>
<thead>
<tr>
<th>Stage description</th>
<th>Unhealed Pressure Ulcers</th>
<th>Column 1</th>
<th>Column 2</th>
<th>Column 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stage II</td>
<td>Unhealed</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stage III</td>
<td>Unhealed</td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stage IV</td>
<td>Unhealed</td>
<td>0</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Patient 3 at Discharge, the stage II PU that was open at SOC has healed. A different stage II PU is open in another location. The stage III PU remains open and the other stage III PU remains closed.

<table>
<thead>
<tr>
<th>Stage description</th>
<th>Unhealed Pressure Ulcers</th>
<th>Column 1</th>
<th>Column 2</th>
<th>Column 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stage II</td>
<td>Unhealed</td>
<td>1</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Stage III</td>
<td>Unhealed</td>
<td>2</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Stage IV</td>
<td>Unhealed</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
</tbody>
</table>

©2012 Time Points WOCN Guidelines NPUAP Staging
M1310, M1312, M1314 - Unhealed Stage III or IV Pressure Ulcer with Largest Surface Dimension soc/roc/dc

Definitions for M1310, M1312, and M1314: If the patient has one or more unhealed (non-epithelialized) Stage III or IV pressure ulcers, identify the Stage III or IV pressure ulcer with the largest surface dimension (length x width) and record in column 3. If no Stage III or IV pressure ulcers, go to M1320.

(M1319) Pressure Ulcer Length: Longest length ‘head to toe’  |    |    |  (cm)
(M1320) Pressure Ulcer Width: Width of the same pressure ulcer; greatest width perpendicular to the length  |    |    |  (cm)
(M1314) Pressure Ulcer Depth: Depth of the same pressure ulcer; from visible surface to the deepest area  |    |    |  (cm)

Unhealed = non-epithelialized (open) or closed stage III or IV

Also consider pressure ulcers that are unstageable D/T eschar/slush covering the wound bed M1308 row a.2

Degree/Status of Healing

Pressure Ulcer

- Wound Status
  - Not healing
  - Early/partial granulation
  - Fully granulating
  - Newly epithelialized
    - When epithelial tissue has completely covered the wound surface regardless of how long the pressure ulcer has been re-epithelialized

- www.wocn.org Wound Guidance Document

WOCN Definitions:

Degree of Healing

- Not healing
  - Wound with ≥ 25% avascular tissue (eschar and/or slough) OR
  - Signs/symptoms of infection OR
  - Clean but non-granulating wound bed OR
  - Closed/hyperkeratotic wound edges OR
  - Persistent failure to improve despite appropriate comprehensive wound management

- Early/partial granulation
  - ≥ 25% of the wound bed is covered with granulation tissue
  - < 25% of the wound bed is covered with avascular tissue (eschar and/or slough)
  - No signs or symptoms of infection
  - Wound edges open
**WOCN Definitions: Degree of Healing**

- **Fully granulating**
  - Wound bed filled with granulation tissue to the level of the surrounding skin
  - No dead space
  - No avascular tissue (eschar and/or slough)
  - No signs or symptoms of infection
  - Wound edges are open

- **Newly epithelialized**
  - Wound bed completely covered with new epithelium
  - No exudate
  - No avascular tissue (eschar and/or slough)
  - No signs or symptoms of infection

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**OASIS Alert!**

- *Stage II pressure ulcers* that close/heal/fully epithelialize are not reportable in OASIS items

- Reportable stage II pressure ulcers cannot be “newly epithelialized” for data collection

- *Stage II pressure ulcers* do not granulate - can only be “not healing” for data collection

- *Only* closed stage III and IV pressure ulcers can be “newly epithelialized”

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**M1322 Current Number of Stage I Pressure Ulcers**

- [M1322] Current Number of Stage I Pressure Ulcers: Inlet skin with non-ionizable redness of a localized area usually over a bony prominence. The area may be painful, firm, soft, warmer or cooler as compared to adjacent tissue.
  - 0
  - 1
  - 2
  - 3
  - 4 or more

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Observation of the skin reveals one pressure ulcer on the left heel that is covered with eschar. There is also one stage III pressure ulcer on the sacrum with granulation tissue present in the wound and areas of slough scattered over 10% of the wound bed.

(M1324) Stage of Most Problematic Unhealed (Observable) Pressure Ulcer:
- 1 - Stage I
- 2 - Stage II
- 3 - Stage III
- 4 - Stage IV
- NA - No observable pressure ulcer or unhealed pressure ulcer

M1330 Does this patient have a Stasis Ulcer?

(M1330) Does this patient have a Stasis Ulcer?
- 0 - No [Go to M1305]
- 1 - Yes, patient has both observable and unobservable stasis ulcers
- 2 - Yes, patient has observable stasis ulcers ONLY
- 3 - Yes, patient has unobservable stasis ulcers ONLY (Know but not observable due to non-removable dressing) [Go to M1305]

Report the presence of ulcers caused by inadequate venous circulation.

Upon skin inspection, the patient has one stasis ulcer under an Unna Boot by physician, and patient report with physician orders says not to change the dressing for four days. The other leg has a stasis ulcer with beefy red granulation tissue filling 75% of the wound bed.

(M1332) Current Number of (Observable) Stasis Ulcer(s):
- 1 - One
- 2 - Two
- 3 - Three
- 4 - Four or more
OASIS Alert!

- *Stasis ulcers* that close/heal/fully epithelialize are not reportable in OASIS items.

- Reportable stasis ulcers cannot be “newly epithelialized” for data collection.

Upon skin inspection, the clinician observes one stasis ulcer with beefy red granulation tissue filling 75% of the wound bed.

(M1334) Status of Most Problematic (Observable) Stasis Ulcer:

- 0 - Newly epithelialized
- 1 - Fully granulating
- 2 - Early partial granulation
- 3 - Not healing

Surgical Wound

**Scar:** Surgical wound that has been re-epithelialized (epidermal wound surfacing across the entire wound surface) for approximately 30 days or more without dehiscence or signs of infection

How will you know when 30 days begins?

OASIS Alert! A scar is not reported in OASIS data items.
M1340 Have a Surgical Wound?

(M1340) Does this patient have a Surgical Wound?

0 - No [Go to M1350]
1 - Yes, patient has at least one (observable) surgical wound [Go to M1350]
2 - Surgical wound known but not observable due to non-removable dressing [Go to M1350]

- Unhealed wound resulting from a surgical procedure
- Includes:
  - Stapled or sutured incisions
  - Wounds/I&D with drain placement except "ostomy"
  - Orthopedic pin sites
  - Muscle flap, skin advancement flap, or rotational flap to surgically replace a pressure ulcer
  - Excisions

M1340 Have a Surgical Wound?

(M1340) Does this patient have a Surgical Wound?

0 - No [Go to M1350]
1 - Yes, patient has at least one (observable) surgical wound
2 - Surgical wound known but not observable due to non-removable dressing [Go to M1350]

- Include:
  - A "take-down" of a previous "ostomy"
  - Central line sites
  - Medi-port and port-a-cath sites and other implanted infusion devices (e.g., On-Q pump/Q-ball, etc.) and venous access devices regardless of functionality (AV shunt, peritoneal dialysis catheter)
  - Shave, punch or excisional biopsy
  - Arthrocentesis
  - Left Ventricular Assist Device/HeartMate

M1340 Have a Surgical Wound?

(M1340) Does this patient have a Surgical Wound?

0 - No [Go to M1350]
1 - Yes, patient has at least one (observable) surgical wound
2 - Surgical wound known but not observable due to non-removable dressing [Go to M1350]

- Exclude:
  - PICC line peripherally inserted and Peripheral IV
  - Pressure ulcer treated with surgical debridement
  - An existing wound treated by debridement or skin graft
  - Old surgical wound with scar or keloid formation
  - Ostomies even with drains (e.g., thoracostomy/chest tube, etc.)
  - Cardiac catheterization and/or vent placement via a puncture with a needle
  - Needle aspiration without drain Placement
  - External device infusing medication via SQ needle
  - Staple site, excision or removal of tattoo
  - External device infusing medication via SQ needle
**Surgical Wounds**

- Frequently heal by Primary Intention
  - Wound edges are directly next to one another
  - Little tissue loss, no granulation occurs
  - Wound closure is performed with sutures, staples, or adhesive, etc.

- May heal by Secondary Intention
  - Wound is allowed to granulate

- **OASIS Alert!** If there is any separation of the incision, then healing will be by secondary intention for data collection purposes.

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**OASIS Alert!**

- Surgical wounds healing by primary intention do not granulate and can only be “not healing” or “newly epithelialized” for data collection.

- Surgical wounds healing by secondary intention can be “not healing,” “early/partial granulation,” “fully granulating,” or “newly epithelialized.”

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**M1342 Status of Most Problematic (Observable) Surgical Wound**

(M1342) Status of Most Problematic (Observable) Surgical Wound:

- 0 - Newly epithelialized
- 1 - Fully granulating
- 2 - Early/partial granulation
- 3 - Not healing
The patient had a hip replacement four weeks ago. One week ago the therapist noted that the surgical wound completely re-epithelialized without S/S of a complication. On this DC visit, the wound is described as well as approximated, completely re-epithelialized with no scabbing or S/S of infection.

(M1342) Status of Most Problematic (Observable) Surgical Wound:
- 0 - Newly epithelialized
- 1 - Fully granulating
- 2 - Early/Partial granulation
- 3 - Not healing

M1350 Have a Skin Lesion or Open Wound Receiving Intervention

Report other wounds with interventions on the POC.

“YES” refers to:
- Other wound types (burns, diabetic ulcers, cellulitis, abscesses, wounds caused by trauma, etc.)
- Non-bowel ostomies receiving clinical intervention per the POC/485 (e.g., cleansing, dressing changes, etc.) from the home health agency

OASIS Alerts!
Status of Healing Possibilities

<table>
<thead>
<tr>
<th></th>
<th>Not healing</th>
<th>Early/Partial Granulation</th>
<th>Fully Granulating</th>
<th>Newly Epithelialized</th>
<th>Not/Healed and not reported on OASIS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stage 1 PU</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
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<tr>
<td>Stage 2 PU</td>
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<td>✓</td>
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<tr>
<td>Stage 3 PU</td>
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<tr>
<td>Stage 4 PU</td>
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<td>Closed Stage 3 or 4 PU</td>
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<td>Stasis ulcer</td>
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<td>Surgical Wound Primary Intention</td>
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<tr>
<td>Surgical Wound Secondary Intention</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
</tbody>
</table>
Can I?

Should I?

History Lesson

• Pre-PPS
• Early PPS
• Therapy Tiers
• Today?

Defining Wound Care

• “Routine Dressing Changes”
  • Could be done by a nurse
  • Competency confirmed
  • Resource management model

• Therapy Specific Interventions
  • Sharps debridement
  • Modalities
  • Specific skill requirement
Reducing Pressure Ulcer Risk

- Ambulation
- Transfers
- Shear
- ADL / IADL Tasks
- Incontinence
- Seating Surfaces

Being a Part of the Wound Team

Contact Information

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Twitter Account
FazziRehab
Please note: The certification process for therapy CEUs varies from state-to-state. In order to assist therapists with getting a session approved, we have provided the following objectives sheet that you can submit to your state licensing board to apply for a therapy CEU.

EDUCATIONAL ACTIVITY CONTENT OUTLINE

**Title of Activity:** Therapy and Wound Care  
**Date:** May 3, 2012

<table>
<thead>
<tr>
<th>OBJECTIVES</th>
<th>CONTENT (Topics)</th>
<th>TIME FRAME</th>
<th>PRESENTER</th>
<th>TEACHING METHODS</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Examine OASIS items that are tied to wound management</td>
<td>- Wound section of OASIS C and peek at OASIS C-1</td>
<td>15 mins</td>
<td>Cindy Krafft PT, MS</td>
<td>PowerPoint, Lecture</td>
</tr>
</tbody>
</table>
| 2. Define components of wound care that are in the scope of a therapist | - Routine dressing changes  
- Skilled interventions | 15 mins | Cindy Krafft PT, MS | PowerPoint, Lecture |
| 3. Explore pressure ulcer and diabetic foot management as routine parts of the therapy plan of care | - Pressure ulcer prevention  
- Managing the diabetic foot as a team | 10 mins | Cindy Krafft PT, MS | PowerPoint, Lecture |
| 4. Discuss the challenges to therapists being active participants in wound management | - Comfort level  
- Competence  
- Regulations | 10 mins | Cindy Krafft PT, MS | PowerPoint, Lecture |
| 5. Question and Answer | | 10 mins | Cindy Krafft PT, MS | Open phone lines, Question and Answer |