

QUALITY HEALTH STRATEGIES

Moderator: Jackie Hairston
June 18, 2013
9:30 am CT

Operator: Ladies and gentlemen, thank you for standing by. Welcome to the Wound Etiology Part 2. During the presentation all participants will be in a listen-only mode. Afterwards we'll conduct a question-and-answer session.

At that time if you have a question please press the 1 followed by the 4 on your telephone. If at any time during the conference you need to reach an operator please press star 0. As a reminder this conference is being recorded Tuesday, June 18, 2013.

I would now like to turn the conference over to Jackie Hairston. Please go ahead, ma'am.

Jackie Hairston: Thank you, (Myra). Good morning to all of you and welcome as we start our webinar today. My name is Jackie Hairston. I am the Project Manger here at Delmarva Foundation, your QIO for Maryland and the District of Columbia.

We are pleased to be able to offer you this series on wound identification and wound documentation. This wound care series has been created in to four 30-

minute sessions to minimize the time your staff has to be off the unit. What we will be hearing today will be Part 2 of Wound Identification.

And it will be presented by our very own Pamela Kane, our wound care certified nurse here at Delmarva. This session will be repeated this afternoon at 3:30 for any of your staff who were unable to listen to this call at this time.

Part 1 and 2 recordings and PowerPoint presentations will be posted on our Delmarva Web sites ww.dcqio.org and ww.mdqio.org so you can share with your staff at your convenience. Phone lines will be muted during the call. We will have a Q&A at the end at which time the operator will instruct you on how to pose a question.

So we have with us today Pamela Kane, our very own wound care certified nurse. Pam brings 25 years of nursing practice in med-surg, intensive care, burn care, chronic and long term care. As a wound care certified nurse she's an expert in the area of assessment and treatment of chronic wounds.

She has extensive background in advanced wound care, working with interdisciplinary teams, providing wound care education and policy and procedure development in long term care since 1993.

So on that note let's begin our presentation. And, Pam, it's all yours.

Pamela Kane: Thank you so much, Jackie, and good morning, everyone. And I apologize. I am nursing a cold right now so bear with me today. Welcome to Wound Etiology Part 2.

Today just as a review for those of you who were with us last week, wound etiology is always the first thing you want to determine when you look at a

wound. And etiology is the cause of the wound. What caused that wound to occur is its etiology.

So remember all wounds are some type of tissue destruction. It could be just through the top layer of the skin in to the second layer or all the way through the skin. Partial thickness wounds is when the destruction goes only in to the epidermis, in to the dermis, but not through the dermis.

Remember that visual I gave you last week of the dermis, that scraped or skinned knee when you or one of your children scrape their knee, the dermis layer is red, bleeding, painful. There is no yellow or white structures or no yellow or white tissue in the dermis layer.

So partial thickness goes in to the dermis and when a wound goes completely through both layers of skin that's a full thickness wound. And it usually would go in to the next layer which is subcutaneous tissue in most parts of the body or it could be deeper.

These are the - several of the most common wound etiologies seen in long term care. Last week we talked about pressure ulcers and staging them correctly. Today we're going to talk about the remaining types of wounds seen in long term care and how to identify and describe them.

Our objectives today are really to again learn how to identify the wound etiology of those various types of chronic wounds that are not pressure ulcers and make sure we understand how to identify them and document them correctly.

Let's start with venous stasis ulcers. Venous stasis ulcers, just like all wounds, can be partial thickness or full thickness. And they usually happen due to

excessive edema, damage of the veins. And they happen usually on the lower leg.

Below the knee is the most common area, down by the ankle. Can happen on the top of the foot. But again in the area where a crew sock would hit your leg is the most common location for a venous stasis ulcer. Often it is the gaiter area of the leg.

Venous stasis ulcers are often and most often very irregular shaped, like little puzzle pieces. They are usually red and granular but they can have necrosis. And these are very red and granular because their - hang around for such a long time. They're very difficult to heal.

And while they can be partial or full thickness, they will most often be very superficial in appearance. In the description of our venous stasis ulcers we often see that they're usually not painful. But please remember that when they're in to the dermis layer that's where the nerve endings are, so venous stasis ulcers can cause pain.

And often the excessive edema that comes with the lower-extremity edema that causes venous stasis ulcers can be very uncomfortable as well. So if your resident is complaining of pain do not hesitate to medicate them.

Venous stasis ulcers drain a lot. These are your faucets. They are constantly draining and it's very difficult to manage that drainage.

The leg will be edematous most often. Now if it's not currently edematous check in to the history. Remember if you're getting a resident from a hospital who's been in bed for the last two weeks with their legs up, maybe the edema

has subsided. Ask the family if the legs are usually swollen when the resident is at home.

And you will often see a very dark color to the skin over the lower leg, very hyper-pigmented. And this is called Hemosiderin staining. And this is what it looks like.

This leg looks almost of it this person went out in to the sun wearing a small sock and the top part of the leg got a tan and the lower didn't. However, this is a 90-some-year-old woman who's been living in a nursing home for the past five years and has not been out tanning at all.

The top part of the leg or the - over the shin and part of the calf area is all dark because of Hemosiderin staining.

The hemoglobin that leaks out from their diseased veins actually stains the subcutaneous tissue giving it that color. If you have a resident with these legs that look like this and you're seeing a lot of edema in those legs they probably are at risk for a venous stasis ulcer.

Here's some great pictures of venous stasis ulcers. Let's look at the one that's just above the ankle. In this picture the ankle bone is right about there. Notice that this ulcer is not located over the boney prominence as a pressure ulcer would be. It is located above it.

And then there's some more ulcers a little bit higher, very irregular shaped, again, like those puzzle pieces. Appear to be fairly shallow. They're located in the most common place. The only reason this leg does not have a lot of edema is that it was being treated with compression therapy.

And even after the wounds have been cleaned up for this great picture, they even still look very wet because venous stasis ulcers drain so much. These are classic venous stasis ulcers.

Here's another classic venous stasis ulcer. Notice the irregular shape located on the lower leg. The leg is very edematous and the wound is a - shallow in appearance. This is a classic venous stasis ulcer.

Now let's look at arterial ulcers. Now just like all wounds, arterial ulcers are - can also be partial or full thickness. But they're caused by damage to the tissue because of the lack of circulation. No oxygen or nutrition is getting to the tissues.

We have an advantage in long term care over maybe someone in a doctor's office or in a clinic who's seeing a wound for the first time. We see our residents every day and take care of them, give them baths and see their skin quite often.

We can often see the very beginning changes or the ischemia that happens with arterial disease. The white or coolness or even bluish tint to skin that can happen when it's not getting enough blood flow.

Arterial ulcers will be deep, they'll be dry, they do not drain much at all, often necrotic and very pale. They're located in a completely different area from most venous stasis ulcers.

You'll usually find arterial ulcers over the tips of the toes, between the toes, over the phalangeal heads, which is a fancy name for the knuckles of the toes, or around the ankle, especially the lateral ankle.

Your resident will have a diagnosis of peripheral vascular disease or peripheral arterial disease. And arterial ulcers are very painful. Remember they're happening because of ischemia. Not enough oxygen is getting to the tissue.

Your residents who complain of distal pain in the foot and toes, especially at night, these are also the residents that are constantly pulling their legs up and you're fighting against getting a knee contracture.

Remember when you touch something hot on a stove your automatic reaction is to pull your hand away quickly. Well they're feeling pain at the very distal end of their foot so subconsciously they're constantly pulling up that leg trying to pull away from the pain.

The leg will be shiny, tight and usually hairless. And you will not be able to palpate the dorsalis pedis or the post tibial pulse.

Here's that ischemia I was talking about. Look at the tips of the toes, even though these toes are bent over, little hammer toes they are, you can kind of see the tops of them a little bit where there - the skin looks normal, but the very distal tip of each one is starting to turn bluish purple

This is ischemia in action. If they stayed this way for long enough a dark black scab would form and we'd have an arterial ulcer. Now this is obviously a surgical emergency but I wanted you to see the ischemia.

Now here's another arterial ulcer. Now obviously the third and the fourth toes are black and another surgical emergency, but I don't want you to look at them. I want you to look at the second toe.

See the discoloration at the tip of the toe? It's kind of subtle. And also look at the knuckle of the second toe. It's white. How many times have you seen a resident that has these little white knuckles on their feet?

And then you look at the leg or the foot as you see here in this picture and the foot and leg are hairless, shiny and tight. You cannot palpate the dorsalis pedis or the post tibial.

That white knuckle on the second toe is an arterial ulcer waiting to happen. So when you see that, document it. There's not much you can do about it because you cannot improve the arterial circulation for this foot.

But later on if a scab happens to form there you'll clearly know why and not try to second guess as to whether the shoe caused it or they bumped it, is it traumatic and what's going on, you'll know the history and you'll know that it's most likely an arterial ulcer.

Here's another foot that has clearly has arterial ulcers. I just wanted you to see the top of the foot area I was talking about. It's all black in that picture. That area is where the arterial ulcer started and then the bunions started to turn dark and then the rest of the foot.

And this is also obviously a surgical emergency or hospice resident. But you get the idea of arterial ulcers being related to ischemia.

Diabetic ulcers, also known as neuropathic ulcers and, again, just like all wounds they can be partial or full thickness, although these are usually a full thickness wound.

And they happen, again, in your diabetics, usually related to peripheral neuropathy. But they're located most often in a completely different area from venous stasis ulcers and arterial ulcers. They're located on the plantar surface of the foot.

That's the bottom of the foot. You'll often see them on the pads of the toes, on the metatarsal heads, that's over the ball of the foot, or on the bottom of the heel. They often have even wound margins, are usually deep and usually you can't - sometimes you cannot even see the base of these wounds.

Now when it comes to drainage and tissue type they can pretty much have any. They can be low-to-moderate. They can be granular or necrotic. So that doesn't help us much. But of course your resident will have a diagnosis of diabetes.

They will often have decreased sensation in that foot. They may even have a Charcot foot. And keep in mind that diabetic ulcers are most often associated with cellulitis or osteomyelitis.

So if you have a diabetic ulcer that looks like this. This ulcer's located on the ball of the fifth toe, excuse me, the pad of the fifth toe and it is a dry, scabbed wound. Because this resident is no longer ambulatory, it probably doesn't even need a dressing.

But it should be monitored, assessed weekly, measured and documented like any other wound in your nursing home because this little fourth toe can become infected tomorrow, two months from now or a year from now. Remember, diabetic ulcers are often associated with infection and that's how diabetic residents lose their toes.

Here's another diabetic ulcer that's been debrided. It was on the bottom of the ball of the foot over to the lateral side. It is now filling with granulation tissue but it does have some macerated edges, meaning there's too much drainage or the dressing was too wet.

Here's a classic location for a diabetic ulcer, right on the ball of the foot over the head of the first metatarsal. You can see it's all black and necrotic. And the white in the middle that you see is actually exposed tendon because the foot is completely insensate, meaning the resident cannot feel it at all, and walking on it without even knowing they had an ulcer.

Now surgical wounds you all know really well. They're created by a surgeon. But I just want to touch on them briefly because years ago when our residents would go out for surgery they usually stayed in the hospital for several days and then came back.

More often than not today though our residents come back the same day after many different surgical procedures.

Surgical dressings for the first 48 hours post-surgery need to be sterile dressings. This is a CDC requirement. Surgeons know this. They often place a surgical dressing in the OR and will write orders for the dressing not to be changed for 48 hours.

So if you have a resident coming back with a dressing leave it alone. There's a place on the MDS to document dressing cannot be changed and the dressing is intact.

If for some reason the dressing comes off, you absolutely need to change it and it is 48 hours from the time of procedure, remember it should be sterile.

That means you need to go get a sterile drape, sterile gloves, sterile supplies and do a sterile dressing.

This is a dehiscenced surgical wound. This would be full thickness because it's open. You can see some subcutaneous tissue there and some sutures.

Traumatic wounds are another type of wound that can happen in long term care. Now there's many different types of traumatic wounds. The most common ones in the long term care setting though would mean - maybe be an occasional laceration or a cut that needs to be stitched, maybe an occasional burn and then skin tears.

Now anybody who watches TV probably knows that burns have their own special classification system. However, they are fairly rare in long term care and it would completely appropriate for you to document a small blister that was caused by a burn as a partial thickness wound and not have to go in and learn the special classification system for burn.

But let's look at skin care - skin tears as they are the most common traumatic injury seen in long term care. We all know that the - basically the skin is torn by trauma.

One thing that people tend to forget though is that skin tears can be both partial thickness or full thickness and you want to document which one. And there's a great picture of a partial thickness skin tear.

You can see the dermis is exposed. It's red and clean. I often get asked whether it's better to put the flap of skin back if possible. And it is always better at the time of injury only, not the next shift or the next day.

This skin tear though is full thickness. You see the white - the pale yellow tissue that's exposed? That's subcutaneous tissue. The dermis is completely pulled away from the subcutaneous layer.

In this case the body is going to have to form granulation tissue first to fill in the damaged area and then new skin will form. This wound is going to take much longer to heal than a typical skin tear so you want to document when you see a full thickness skin tear.

Cancer wounds are also fairly rare. They're properly called fungating wounds. And this is when the cancer itself actually grows in to and through the skin. It can sometimes grow through and then crater or continue to grow and grow and cauliflower.

Dressings for fungating wounds should be non-sticky. You want them - don't want them to stick to the wound bed, absorb well and help control odor because cancer cells are not too smart.

They grow so fast they often outgrow their blood supply and then areas of necrosis form and that's what causes the odor. This is actually an ear. It has a cancerous wound growing or fungating wound.

There's some type of other wounds that I'm not going to go in to that you certainly can look in to them if you take care of this type of patient. And I have them listed here and they can be seen in long term care occasionally.

Calciphylaxis is seen in - a wound that is seen in end stage renal disease residents. Hidradenitis suppurativa is a chronic inflammatory condition related to the hair follicles that you can see in the groin or the arms and on the head.

And occasionally you might get a skin abscess or what we used to call in the olden days a plain old boil. Keep in mind though that today, whether it's your nursing home, a locker room at a professional basketball team or a college dorm, a skin abscess is often today MRSA-positive.

Many doctors don't even bother to culture them. And incision and drainage, or I&D, and then packing the area is still the appropriate treatment. And often antibiotics are not even needed.

But just keep in mind this is likely MRSA-positive, especially to protect yourself and if you're taking care of other wounds. You may want to put your resident on contact isolation.

Other types of skin alterations you'll see in long term care much more common is this first one, denuded skin. The medical definition for denuded skin is listed here on your slide.

It is the loss of the epidermis caused by urine, stool, or body fluids. In other words, the dermis is exposed, that red, raw tissue. This is often - can be documented as Incontinence Associated Dermatitis or moisture associated skin damage as in the MDS 3.0 (call it that).

But what it is not is excoriated skin. The medical definition for excoriation is linear scratches of the skin and destruction of the skin by mechanical means. For some reason it's been mistakenly used to describe those red, raw diaper rashes that we see or denuded skin.

And we'll take a quick look at fungal rashes and shingles as well. Let's take a look at some denuded skin. There's a slightly darker picture - let's look at the next one.

This one's better. This is all denuded skin caused by incontinence, not pressure. It's partial thickness because we're looking at the dermis. And this needs obviously better skin care, better toileting, better moisture barrier, et cetera. None of this is the pressure ulcer.

Here's some more denuded skin that's getting better, just spotty now. And here's again the classic denuded skin. In this picture you can see the rectum is here and the coccyx is up here.

These open areas are not located over a boney prominence and all they - although they could look similar to a stage II pressure ulcer, they are not due to pressure.

They are due to the incontinence and therefore they are not a pressure ulcer. They would not be stage II. They would be partial thickness, denuded skin or Incontinence Associated Dermatitis or you could document it as moisture associated skin damage.

Excoriation, again, is linear scratching. So if you have a resident who scratches themselves often or maybe, you know, skin, you know, got rubbed against something like a rope burn would cause an excoriation. And this is a great picture of excoriated skin. See the linear lines and scratches.

Fungal rashes often happen in long term care as well. And I'm sure you all know the areas they most often happen are warm, moist areas and skin folds and that they can be very itchy for your residents.

I want you to look at the very last bullet on the slide. Is there a proper way to document a fungal rash? I often see fungal-like or nurses actually documenting a fungal rash which we are not diagnosing.

You should really document a flat red rash, often has the scalloped edges and the satellite lesions. That's the classic look of a fungal rash. And with that description and documentation I'm sure your physician will give you a proper treatment for a fungal rash.

Here's the classic look of a fungal rash. See the satellite lesions. It's in a warm, moist place. Clearly, a fungal rash. Here's another one. See the satellite lesions.

Shingles I'd just like to touch on briefly because I often see them misdiagnosed in long term care. For anyone who has seen shingles I ask you out there to be an advocate and a resource for your other nurses that have not seen it.

If you've seen it it looks very similar to chicken pox. Remember that they are very painful. The most common location is the flank, waist and abdomen. However, they can appear anywhere on the body. Anyone that has had chicken pox as child or had the vaccine can get shingles as an adult.

This is the classic picture of shingles. Well remember it doesn't always have the classic look. It sometimes can be even purplish in color. Or, the little vesicles are so close together you can't tell if it's individual vesicles or not.

I'd like to give you this advice. If you see a strange rash that is only on one side of the body, one side of the leg, one leg and not the other, one side of the back, not the other, one part of the, you know, shoulder or chest and not the

other, consider that you may be dealing with shingles and get a diagnosis so the treatment can begin because they're very painful for your residents.

So just to review, remember that venous stasis ulcers are caused by venous disease. They're usually on the lower leg. They have a lot of edema in the leg and they drain a lot. Remember that puzzle piece.

Arterial ulcers are due to poor circulation. They're dry, painful. Look for those signs of ischemia, that white cold skin, purplish skin of course and they're on the toes, tips, between the knuckles of the toes and sometimes on the ankle.

Surgical wounds, just remember if it's a surgical wound that just came to you within 48 hours it needs a sterile dressing. Traumatic wounds often is your skin tear. And cancerous wounds happen because cancer actually grows through the skin and you want a non-adhesive, absorbent, odor-controlling dressing.

Denuded skin is that red, raw open skin. Also can be called Incontinence Associated Dermatitis or moisture associated skin damage. Excoriation is those scratches. And remember to look for those satellite lesions on your fungal rash and one-sided rashes, suspect shingles.

So I'd like to open it up for questions now so, (Myra), if you could let them - give them their instructions again? Thank you.

Operator: Thank you. Ladies and gentlemen, if you'd like to register for a question please press the 1 followed by the 4 on your telephone. You will hear a three-toned prompt to acknowledge your request.

If your question has been answered and you would like to withdraw your registration please press the 1 followed by the 3. If you are using a speakerphone please lift your handset before entering your request.

One moment please for our first question. Again, ladies and gentlemen, as a reminder if you'd like to register a question please press the 1 followed by the 4.

Our first question comes from (Annie Green). Please go ahead.

(Annie Green): Good morning. Actually it's just a comment. And I'd like to thank you so much for presenting this topic. It is a topic of interest. And it was so detailed and explanatory, so I just wanted to express my thanks to Pamela.

Pamela Kane: Thank you, (Annie).

Jackie Hairston: This is - thanks, (Annie), this is Jackie. While folks are kind of thinking about their questions, you know, we're trying to make these webinar calls as valuable to you as possible so we would value any comments that you have on is the time of day good, are there topics that you would like to hear about.

Maybe if you could include that information as you're doing your - those of you on the WebEx part, as you're doing your evaluation at the end because, you know, we're trying to make these as valuable and as useful to you as possible. So any input to help us really, you know, be able to achieve that goal.

And I know we have a few of you on the phone now. Would any of you be willing to share exactly if - of the time of day of the recordings that we're

doing are they a good time of day or not a good time of day? Is anybody willing to kind of share that with us?

Operator: Ladies and gentlemen, if you'd like to make a comment or ask a question you can press the 1 followed by the 4. And our next question or comment comes from (Frances Wyland). Please go ahead. Mr. (Wyland), your line is open. Please check your mute button or lift your handset. We're unable to hear you.

(Frances Wyland): Okay. Can you hear me now?

Operator: Yes we can. Go ahead.

Jackie Hairston: (Unintelligible).

(Frances Wyland): Okay. All right. I find this time of the day to be perfect because it's after morning meetings and, you know, before the lunch time craze starts.

Jackie Hairston: Okay.

(Frances Wyland): The unit managers that I have had sitting in on it, along with one of my aids that goes on wound rounds has found it - found the whole, you know, the last two webinars to be very informative. So, I mean, so far I know my staff has enjoyed it.

Jackie Hairston: Okay, great.

Pamela Kane: Thanks, (Frances).

Jackie Hairston: Well thank you so much for that input. Is there anyone else that would like to weigh in on any other topics that you would like to see?

Operator: And we have another question or comment from (Annie Green). Please go ahead.

(Annie Green): Thank you. I would like to say just offering it - the double times that you're offering it is just great, having it once in the morning and then again in the afternoon I am able to catch it at staff. And then of course the ability to go back online and pull it up again, so it's just wonderful.

Jackie Hairston: Okay. All right. Well we just wanted to know if we're on the right track with our thinking and our planning, so we do appreciate your comments. I don't - anyone else have any other comments or other questions?

Operator: Ladies and gentlemen, you may press the 1 followed by the 4. Ladies and gentlemen, you may press the 1 followed by the 4 to register a comment or a question.

Jackie Hairston: Okay.

Operator: I'm showing no questions or comments, thank you.

Jackie Hairston: Okay. Thank you, (Myra). Well, Pam, I just want to thank you for that wealth of information. I know our participants on the line today can go back to their facility and implement and start the spreading the knowledge that you've shared with them today.

As we close our WebEx portion of the call today do not forget to complete the brief evaluation that is now on your screen. And you do have the ability to type in any additional feedback and we do value that feedback. Part 2 of wound identification will be repeated again at 3:30.

And just a few quick reminders, you know, your May data for those of you submitting data, is due now. And also the QAPI assessment, that initial assessment, is also due to your QIC as well.

And if you're a team that is working on your goals and you need some assistance in that please don't hesitate to give your QIC a call to help you work through writing up your goals. And I just want to say thanks to all of you for joining us today. And, (Myra), this officially ends the call.

Operator: Thank you. Ladies and gentlemen, that concludes our conference call for today. We thank you for your participation and ask that you please disconnect your lines. Have a good day.

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