Documentation on Wounds

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Objectives

* Identify the financial significance of documentation of pressure ulcers upon admission to any facility.

* Describe the common differential diagnoses of wounds on the buttocks.

* Describe the common differential diagnoses of wounds on the foot and leg.
An Old Joke Since EMR

Documentation Errors and Denial of Payment
- Principal diagnosis not clearly identified
- Lack of justification for ongoing hospitalization
  - Use the word “because”
  - Needs to stay another day because Hgb not stable and c/o dizziness
- Lack of correlation of co-morbid conditions and complications
- Hand written notes unclear, undated
- EMR notes are cut and pasted without updating and with errors

How are we doing?
- 2 year QI program in a single teaching hospital
- Reference manuals
- New documentation templates
- Staff education
- Outcomes of improved documentation
  - RN from 27% to 55%
  - MD from 12% to 36%
- After EMR
  - MD documentation fell to 0% and never improved

Dahlstrom, 2011
Why Documentation is Important

- Present on Admission Pressure Ulcers
- Documentation of stage III/IV on admission are payable to the hospital
- Stage II and DTI that progress are also POA
- Requires the MD/Midlevel provider documentation
- Coders cannot use Wound Nurse or Nurse documentation
- ICD-9 coded only stage and site
- Some financial incentives to miscode PrU stage
- ICD-10 has 150 codes for pressure ulcers
- Will try to eliminate miscoding
- As of 2012, up to 25 diagnoses are tracked

Coding Issues Being Clarified

- Coding for DTI
  - DTI does not have its own ICD-10 code
  - Code as Unstageable for now
  - Issues with differences in treatments of DTI, from debrided US and stable eschar
- Coding for midline ulcers on spinous processes
- Coding for ulcers that are deteriorating due to end of life

Common MD Documentation on Patients with Wounds

- In PE: skin often missing
- Or: Skin: warm, dry, no rashes or lesions
- Use of other’s documentation
- Be certain wound team sees patients
- Best to see wounds before validating, but if consultation services reliable, probably OK to simply “agree”
Benefits of thorough H&P

- Usual and customary medical practice
- Other professionals?
- Avoids predefining the etiology of the ulcer based only on the location
- Creates a baseline of conditions that are curable and those that are only palliative

What should be documented on a wound

- Etiology of ulcer
  - List probable risk factors such as long times in OR, ER, X-ray
- Characteristics
  - Unique characteristics such as Deep Tissue Injury
- Preventive interventions in place
  - Name bed in use, surface, chair cushion, splints
- Nutritional status
  - List diet, tube feeding, IV nutrition in place
- Treatment plans/changes and plans for follow-up
- Conversation with patient and family
  - Esp on likelihood of healing

How to determine if the wound is a pressure ulcer

- Consider the risk factors present
  - Shortness of breath, weight loss, inability to eat, orthopedic surgery (hip, knee), diabetes
- Consider if patient cannot move voluntarily
  - Bedridden, chair ridden, coma, restrained, desaturation with movement, traction, pain
- Consider the pattern of ulcer development
  - High risk?, OR acquired, trapped in one place for extended time?
  - DTI has a delayed presentation

This DTI started while the patient was flat – it now 72 hours old
Determining, cont

- Photographs, descriptions
  - Crater like ulcers common
  - Don't rely on the use of staging, many people stage wounds of any etiology

- Do not rely on the use of staging terms as evidence that a wound is a pressure ulcer

This DTI was initially called a skin tear

Consider the location of the ulcer

Incontinence Associated Dermatitis

- History of exposure to urine or stool
- Skin odor
- Skin maceration
- Quite inflamed
- Small open wounds in the skin exposed to urine or stool
- Not a single ulcer
- Pain
Intertriginous Dermatitis
- History of skin on skin
  - Obese, immobile
  - Hot bed surfaces
  - Diaphoresis
- Skin on skin irritation with inflammation and colonization
- Study found bowel bacteria, Pseudomonas, Staph, Strep

Pressure Ulcers Due to Devices
- Any item can lead to pressure on the skin
  - CPAP masks
  - ET/trach straps
  - Stockings
  - Braces, boots
  - Wheel chair arms
  - Oxygen tubing

Ulcers in a Neuropathic Foot
- Found in ambulatory patients on walking surfaces of foot
- Callous formation present
- Ulcers usually from misfitted footwear

Pressure ulcer on the heel of a DM, looks the same
Arterial disease ulcers
- Necrotic wounds in distal tissue in limbs with poor perfusion
  - Painful
  - Punched-out
- Pressure ulcers can develop quickly in ischemic limbs
  - Heal slowly, if at all

Terminal ulcers
- Rapidly developing ulcer appearing about 48 hours prior to death
  - Several names
    - Kennedy terminal ulcer
    - Skin failure
    - Terminal tissue injury
    - Skin changes at life's end
- Etiology unknown
  - Low perfusion during which the skin cannot recover from usual pressures?
  - Skin infarction?
  - Variant of DTII

Deep Tissue Injury Definition
- Purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear.
Deep Tissue Injury Description

- The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue.
- Deep tissue injury may be difficult to detect in individuals with dark skin tones.
- Evolution may include a thin blister over a dark wound bed. The wound may further evolve and become covered by thin eschar.
- Evolution may be rapid exposing additional layers of tissue even with optimal treatment.

Copyright 2007: NPUAP

Pathogenesis

- Ischemia of tissue leads to ulceration
  - Our original premise
  - Cellular deformation until the cell membrane ruptures (Gefen)
    › Repeated loading and unloading can lead to ulceration over time (Oomens)
    › Repeated shearing extends ulcer (Takahashi)
  - This differs from superficial ulcers which are due to moisture and friction (Bader)
  - Combination of cellular deformation and ischemia creates full thickness ulcers faster

So depending on the duration and intensity of pressure...

- Pure ischemia
- Ischemia plus tissue destruction
- Tissue deformation
Early presentation of purple-maroon tissue at 48 hrs

Blister phase at 72-96 hours

Necrotic phase at 7 days

Differential Diagnosis

- Traumatic events
  - History of trauma in the body area now purple
  - Skin injury in pelvis
  - Hematoma with loss of overlying skin (Morel-Lavalee Lesion)

- Ischemic events
  - Arterial or venous
  - Vasoactive drug induced
  - End of life
  - Little known, may be a shallower eschar

Differential Diagnosis

- Ischemic events
  - Arterial or venous
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  - Little known, may be a shallower eschar
Differential Diagnosis

- Skin diseases with purple hues or rapid eschar formation
  - Pyoderma
  - Calciphylaxis
  - Lymphedema
  - Coumadin necrosis

Tracking Outcomes

There are many reasons to track outcomes especially if they can be risk stratified.

Why track outcomes?

- Comparison to usual/published healing trajectories
- Provide patients an expected outcome
  - “In this facility, wounds like yours usually heal in 2 months as long as you stay off of it and do the wound care we prescribe”
- Compete for patients when 3rd party payers use outcome data for costing/preference
- Budget for operational monies for wound center, HBOT
- Stave off 3rd party wound healing groups
  - If your outcomes are comparable or better and cost is comparable or less, what would be the motive to change?
What outcomes?

* Wound size over time by type of wound
* Area is most common
* Volume is more sensitive
  * Use Kundin’s model to normalize “cubed volume” to “cone” by multiplying volume by .7
* Risk stratification crucial
  * Age
  * Socio economic status (use payer as proxy)
  * Compliance
  * Level or severity of disease

Risk Stratification for PrU

* Immobility
* Loss of protective sensation
* Poor nutritional status
* Less than 40% reduction in size at 2 weeks
* Full thickness ulcer

This noncompliant paraplegic is not likely to ever heal these ulcers

Risk Stratification for DFU

* Male gender
* Renal disease
* Loss of protective sensation
* Local infection
* Wound probes to bone
* Wound not 50% smaller in 4 wks
* Initial size over 2 x 2 cm

This diabetic foot ulcer is capable of healing with proper offloading and wound care
Risk Stratification for VLU

- Ulcer present over 6 months
- Ulcer is full thickness
- Ulcer with slough
- Less than 40% reduction in size in 4 weeks
- Ulcer size over 5 cm²

This ulcer will likely heal if compression is used along with topical wound care.
Pressure ulcer prevention

- Reduce the intensity of the pressure
- Support surfaces
- Dressing the skin to reduce the pressure
- Reduce the duration of the pressure
- Turning and repositioning
- Reduce the effect of shear
- Keeping the head of the bed low
- Dressing the skin to provide a barrier
- Improve the health of the skin
- Giving nutrition and hydration
- Keeping the skin clean and dry
- Protecting damaged skin

Common Issues Today

- How frequently should a patient be turned?
  - TURN study by Bergstrom (2013, JAGS)
  - Residents placed on a viscoelastic mattress and randomly assigned to Q2, 3 or 4 hours
  - PrU rates the same and low in all groups
- When is an upscaled mattress needed?
  - When resident/patient cannot turn himself
- How should heels be elevated from the bed?
  - Pillows or boots work
  - Use fleece boots for patients with PVD
- What to do about nonadherent patients/residents?
  - Confirm that they have mental acuity to understand significance of their decisions
  - Upscale prevention practices (mattress)
  - Speak with family

Mobilization and the chair

- Early mobility programs call for extended sitting
  - Many patients are too weak to self position
  - Most bedside chairs have no padding
  - Hospital practice often does not include repositioning in a chair or chair cushions
- NPUAP-EPUAP Guideline:
  - Position patient for stability and ability to perform usual activities (SoE= C; SoR = 4–6)
  - Tilt the seat back to prevent sliding
  - Place feet on foot rest or foot stool

This patient is not safe in this chair, nor is he sitting on the chair cushion
Was the pressure ulcer avoidable?

- Components identified by Medicare and NPUAP
  - Intact skin on admission
  - Risk assessment accurate
  - Interventions to reduce risk in place
  - Documentation of care provided
- Situations of unmitigated risk
  - Hemodynamic instability
  - Be certain high spec bed in use
  - Unrepaired Spinal instability
  - Uncorrectable malnutrition
  - Noncompliance in a mentally intact person
- Examine events at the time the ulcer developed to determine if preventive care was possible
  - DTI: 48 hours prior to purple skin
  - Patient may not have been hospitalized 48 hours prior
  - Stage 3, 4, and US; 72 hours prior
- Issues today
  - Ulcers starting in OR, ER, IR
  - Combine this assessment with location to determine events at the time pressure was applied

References

- Black, J, Brindle, CT, Honaker, J (2015, e pub). Diagnosis of deep tissue injury. International Wound Journal. Available from Joyce Black upon request. jblack@unmc.edu
Thank You

Questions?

Archived Webinar

Pressure Ulcer Prevention and Management

Originally presented on September 2, 2015

Presenter: Abbece Garcia, MD, CWON, FAACNS
Associate Professor, Department of Medicine, Geriatrics Section
Director: Brian Luneburg, Coordinator, Wound Care, Baylor College of Medicine
Director, Wound Care and Consult Service, Michael E. DeBakey VA Medical Center

This webinar will focus on the prevention and treatment of pressure ulcers for physicians and other health professionals. There will be discussion of the regulatory changes that have been made and how these will impact healthcare facilities. There will also be discussion on proper development and documentation of the wound in a pressure ulcer versus another type of wound.

After viewing this webinar participants will be able to:
- Identify the "at risk" patient
- Identify accurate pressure ulcer terminology
- Describe the pressure ulcer stages
- Document appropriate pressure ulcer findings
- Provide appropriate orders for pressure ulcer prevention and management

Useful Links:
- Watch Now
- Resources
- Endorsements, Patient & Caregiver
- Gold Standard Home Care

Upcoming Webinar

Pressure Ulcer Treatment
Dr. Amir Qaseem

December 8 (12-1)