## Disease Management Guidelines

A working tool intended to assist with the development of an individualized comprehensive plan of care

## Wound Care



Goal: Optimize wound healing and minimize risk for future wound development

Ac	Action Steps:						
Ac	CM	Expon Coobt Factor Appropries (Coopt appropries					
		Pro ❖	wide referrals as required by plan, including, but not limited to: Wound Care Specialist (In-patient, Out-Patient, or In-Home):  Assess and make recommendations for wound care management Physical Therapist:				
		*	<ul> <li>Assess tissue loads and need for positioning devices</li> <li>Assess and make recommendations for appropriate support surfaces and wound care</li> <li>Assess need for mobility and safety assistive devices</li> <li>Provide CM with written report documenting assessments, recommendations, interventions, and outcomes</li> <li>Dietitian:         <ul> <li>Assess MEMBER nutritional status</li> <li>Assess MEMBER, PCA, and informal caregiver knowledge of diet requirements</li> </ul> </li> </ul>				
			Assess for nutritional impact of co-morbid conditions				

	<ul> <li>Provide nutrition guidelines including, but not limited to:</li> <li>Weight management</li> </ul>
	<ul> <li>Increased protein and carbohydrate needs</li> </ul>
	<ul> <li>Vitamin, mineral, and amino acids supplementation</li> </ul>
	<ul> <li>Oral or enteral nutritional supplementation</li> </ul>
	<ul> <li>Appetite stimulants</li> </ul>
	<ul> <li>Special needs related to co-morbid conditions</li> </ul>
	Provide nutrition education to MEMBER/caregivers
	<ul> <li>Provide CM with written reports documenting assessments,</li> </ul>
_	education, diet plan, interventions, and outcomes
	Providehome visits (frequency to be determined by MEMBER need) to:
	Monitor and evaluate MEMBER/caregiver adherence and outcomes
	to wound management plan, including, but not limited to review of:
	<ul> <li>Member/caregiver knowledge and skills</li> </ul>
	<ul> <li>Status of wound</li> </ul>
	<ul> <li>Repositioning logs</li> </ul>
	Weight
	Vital signs     Tand diam.
	Food diary  Madications
	Medications     Wound care
	<ul><li>Wound care</li><li>Lab values</li></ul>
	<ul> <li>Proper usage and maintenance of equipment</li> </ul>
	<ul> <li>Presence of adequate and appropriate supplies per guidelines</li> </ul>
	and physician orders
	Follow up on referrals
	Obtain and review reports of each visit by all providers including RN,
	Wound Care Specialist, PT, and Dietitian
	Evaluate effectiveness of plan
	Collaborate with MEMBER, caregivers, and all providers to evaluate and
	amend the plan as needed to meet changing MEMBER needs.
Ski	lled Nurse (or Wound Care Specialist) will providehome
	its (frequency to be determined by MÉMBER need) to:
	Provide initial assessment to include general health, pain,
	nutritional/hydration status and weight, comprehensive health history, wound history, vital signs, and psychosocial needs.

u		sess wound at least weekly using E-Z graph, PSST, PUSH, or other ency approved standardized tool to monitor:	
	<u>.</u>	Location	
	_	Size	
	_	Drainage	
	_	Stage	
	_	Sinus tracts	
	_	Tunneling	
	_	Eschar	
	_	Slough	
	_	Epithelialization	
		Granulation	
		Odor	
	_	Infection	
	_	Undermining	
	_	Condition of surrounding tissues	
	Ass	sess risk for pressure ulcer development using Braden or Norton scale	
	Мо	nitor and evaluate laboratory tests including, but not limited to:	
	_	Serum Albumin - 3.5-5.0	
	_	Prealbumin - >16 mg/dl	
	_	Cholesterol - > 140	
	_	Total Lymphocyte Count - > 1800/mm (note: not a good indicator of malnutrition if infection is present)	
	Provide MEMBER/caregiver education as needed regarding:		
	_	Wound healing	
	_	Nutrition	
	_	Tissue loads	
	_	Repositioning	
	_	Reducing shear	
	_	Transfers	
	_	Signs and symptoms of infection	
	_	Wound care	
	_	Skin care	
	_	Incontinence care	
	_	Standard precautions	
<b>_</b>		nitor and evaluate MEMBER and caregiver knowledge, skills, and nerence to wound care plan.	
		ovide CM with written reports of all visits documenting assessments,	
		ucation, interventions, outcomes, and recommendations	

ME	MBER/Informal Caregiver will:				
	Participate in the development, implementation, and evaluation of plan				
	Participate in plan for repositioning, nutrition, wound care, and proper use of equipment				
	Perform wound care as ordered by physician				
	Verbalize how to recognize wound healing and wound complications				
	Provide adequate nutrition including prescribed supplements				
	Maintain food diary				
	Inspect skin daily				
	Provide and record repositioning in bed every 2 hours				
	Provide and record repositioning in a chair every hour and shifting weight every 15 minutes				
	Provide incontinence care				
	Make and keep all medical appointments				
	Report concerns, changes in skin integrity, changes in wound, and problems with plan to skilled nurse, CM, or physician				
	Verbalize understanding of risks and benefits of adherence/non-adherence to plan				
PC	A will:				
	Demonstrate proper technique for transfers, repositioning, use of equipment, and shear reduction				
	Assist with keeping surfaces clean and dry				
	If providing assistance with personal care, report changes in skin condition to RN, MEMBER, and caregiver				

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## **Expected Outcomes:**

- MEMBER has access to available resources to facilitate wound healing.
- PCA, informal caregivers, and/or MEMBER can verbalize wound healing principles, wound care plan, ulcer prevention, and proper skin care.
- Wound progression is continually evaluated and plan of care amended as needed
- PCA, informal caregivers, and/or MEMBER can recognize signs and symptoms of wound progression or complications and can verbalize when to call the RN or physician.
- PCA, informal caregivers, and/or MEMBER can demonstrate proper use of equipment and supplies.
- All persons responsible for wound care can demonstrate proper wound care techniques including standard precautions.
- PCA, MEMBER, and informal caregivers have adequate information to make informed decisions, including the risks and benefits of adherence/non-adherence to plan.