

Dear Doc, No more wet to dry. How to maintain your patient census, increase your bottom line, and heal those wounds!

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Objectives

- Explain the purpose, method and cost-effectiveness of wet to dry wound care.
- Identify the method and benefits of topical wound care protocols.
- Describe how to implement a no more wet to dry protocol at your agency.

Why this topic matters

- 24,450+ home health/hospice agencies in the US.
- 1,343,340 SOC/ROC in a 6 month time frame.
- 92% of all SOC/ROC open wound/lesion
- 22.8 % surgical wounds
- 6.77% pressure ulcers
- 2% stasis ulcers
- Quality patient care and improvement in QOL
- \$20-25 billion annual expenditures

Wound Management & Revenue

- OASIS data
- OASIS C NRS
 - 6 revenue tiers \$14.92-\$578.27
- MO2250g moist wound healing
- Best practice /standards of care
- P4P
- Adverse events: emergent care for wound infection or deterioration
- OBQI improvement in status of surgical wounds

OASIS Answers April 2010

- “Question 37: Is it the clinician's clinical decision or the physician's that will determine the patient has no pressure ulcers with need for moist wound healing at M2250 and M2400?”
- Answer 37: ... While clinicians caring for patient with pressure ulcers may be cognizant of wound care guidelines for pressure ulcer management and understand that certain pressure ulcers are not appropriate for moist wound healing, each patient status is to be discussed with the physician who ultimately makes all treatment plan decisions.. “

OASIS Answers April 2010

- Question 35: For M2250g – “Plan of Care Synopsis and 2400f – Intervention Synopsis, Is a protective skin barrier considered a moist wound treatment for a pressure ulcer? Can you provide specific examples of moist wound healing treatments for pressure ulcers?”
- Answer 35: Moist wound healing treatment is basically any primary dressing that hydrates or delivers moisture to a wound thus promoting an optimal wound environment and includes films, alginates, hydrocolloids, hydrogels, collagen, negative pressure wound therapy, unna boots, medicated creams/ointments. CMS cannot provide you with specific products. “

Chapter 3 Section N-4

- Row g: If the physician-ordered plan of care contains orders for pressure ulcer treatments based on principles of moist wound healing (e.g., moisture retentive dressings) OR if such orders have been requested from the physician, select “Yes.” Select “NA” if the patient has no pressure ulcers needing moist wound healing treatments.

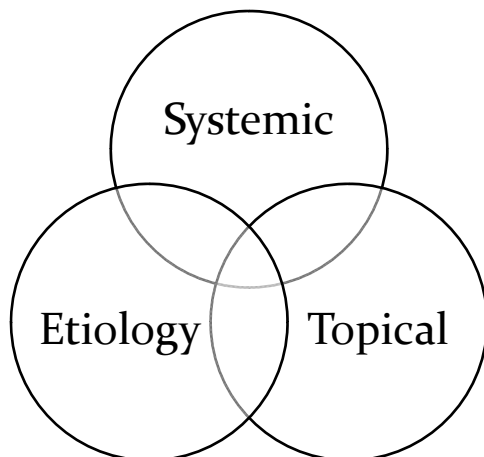
Wound Care

- Wounds have been a health concern since the Roman ages.
- Ancient physicians utilized lint, grease, and even honey to facilitate wound healing.
- Today, wound care is a \$14 billion dollar industry
- Topical products, modalities, and alternative therapies include NPWT, HBO, biologics, and advanced wound care products.

Wounds: Healing Milieu

- Based on scientific research, wounds heal faster and stronger when 3 factors are considered:
 - Etiology (correcting the cause)
 - Systemic support (Nutrition and perfusion)
 - Topical therapy (DIPAMOPI)

Wound Healing Components



Etiology

- Determine the cause
- Correct or manage the cause
 - Pressure-support surfaces, turning, etc
 - Venous stasis-compression
 - Arterial-vascular consult
 - Surgical-NA
 - Diabetic-glucose control, offloading
 - Atypical-varies, referral to dermatology (?)
 - Skin tears-improve skin integrity, pad items

Systemic Support

- Nutrition-protein 1.2-1.5kg/d & calories 30cc/kg/d
- Perfusion-decrease reducible factors
- BMI-appropriate wt/ht
- Activity-
- Glucose management
- Hydration-30cc/kg/d typical
- Immune system
- Manage comorbidities

Topical Therapy

- D Debride any non viable tissue
 - I Infection
 - P Pack dead space
 - A Absorb exudate
 - M Maintain moist environment
 - O Open closed wound edges
 - P Protect from trauma
 - I Insulate
- Addressing these components make for a happy wound.

Where does wet to dry fit in DIPAMOPI?

- Simple answer

It doesn't.

So why do we keep doing it?

Wounds: Tradition

- Wet-to-dry gauze dressings continue to be used although consistent reputable research, RCT's, has shown their detriment to the wound base and impediment to healing.
- Evidenced based practice guidelines continue to dictate that wet-to-dry is not best practice. Wet-to dry should only be used "in mechanical debridement, and in that, with caution". (AQRH, 1992)

Moist Environment History

- In 1962, Dr GD Winter discovered the benefits of moist wound healing in an in-vivo study using an animal model.
- 1963, study replicated with same results using human models. These studies were published in the journal Nature.
- Since 1963, innumerable randomized controlled trials (RCT's) have shown that a moist wound environment is more conducive to healing.

Physician use of wet to dry

- Physicians report utilizing wet-to-dry “because it is inexpensive, relatively easy to perform, and allows for frequent assessment of the wound”.

(Podiatry Today, 2008)

Wet-to-dry: Bandaging up with the Dinosaurs

- Why physicians like wet-to-dry
 - Tradition
 - Fast
 - Cheap
 - Easy access
 - Seemingly an uncomplicated procedure
 - That’s what they taught in school “old stand by”

Wet-to-dry: Bandaging up with the Dinosaurs

- Why doctors should not like wet-to-dry
 - Fast
 - time consuming requires multiple dressing per day
 - Cheap
 - When all factors considered, costs are actually at least triple.
 - Easy access
 - True, can rip off the bandage at any time and peek at the wound. Is it any easier than other dressings?
 - Uncomplicated procedure
 - While this may seem to be an uncomplicated procedure, unless the appropriate moistening solution is used, the appropriate fiber and weave of gauze is used, and unless the appropriate removal technique is used--the goal of wet-to-dry dressings is not achieved and possibly more damage to the wound can happen.
 - Tradition
 - Research has shown this wound care impedes healing and often traumatizes the wound. New regulations are moving toward evidenced based medicine which will require healthcare providers to base their decisions on research and the best available evidence.

One Week Cost Comparison

	Wet to dry	Advanced Product
Supplies	Gauze, tape, saline \$1.87	Mepelix \$8.73
Nursing Visits	200	200
Wound Cleansing Supplies	1.09	1.09
Total supply costs (1 week)	$\$1.87 \times 14 = 14.98$	$\$8.73 \times 2 = \17.46
Total nursing costs	$\$200 \times 14 = 2800$	$\$200 \times 2 = 400$
Total cleaning supply costs	$\$1.09 \times 14 = 15.26$	$\$1.09 \times 2 = 2.18$
Total	\$2830.34	\$419.64

How to perform wet to dry

- Stated purpose of wet to dry dressings is mechanical debridement.
 - Moisten gauze
 - Apply to wound bed
 - Allow to dry
 - Remove packing
 - Do NOT moisten gauze to remove



DIPAMOPI: Why is wet to dry bad?

- **D** Debride any non viable tissue
 - Wet-to-dry does not recognize the difference in viable and non-viable
- **I** Infection
 - Wet-to-dry allows bacteria to penetrate the wound environment. It takes 64 layers of dry gauze to inhibit bacterial proliferation.
- **P** Pack dead space
 - Wet-to-dry accomplishes this
- **A** Absorb exudate
 - Wet-to-dry absorbs and often macerates
- **M** Maintain moist environment
 - Wet-to-dry allows the wound to dry and tissue to desiccate
- **O** Open closed wound edges
 - NA
- **P** Protect from trauma
 - Na
- **I** Insulate
 - Since Wet-to-dry is done several times a day this allows the wound to cool, heat up, cool heat up. The gauze also allows heat to escape and studies show that the wound responds with vasoconstriction which reduces blood flow to the area.

What effects wound healing and what does wound healing affect?

- Best Practice
- Outcomes
- Adverse Events
- Patient satisfaction
- Physician satisfaction
- Rehospitalizations
- P4P
- Wound management protocols

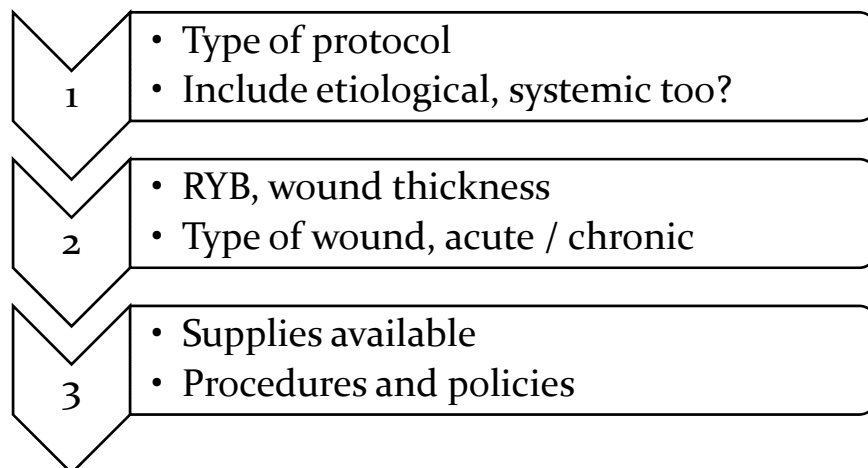
Identify the method and benefits of developing topical wound care protocols.

- What are protocols and why do I need them?
 - Protocols based on wound type or thickness.
 - Outcomes (Benefit)
- What products should be on protocols?
 - Choosing a range of supplies.
- How do I make protocols evidenced based?
 - Clinical guidelines.
 - Standards of care.
- Interactive: Let's write a protocol.
- Components of a protocol

What are protocols and why do I need them?

- Protocol- “a document with the aim of guiding decision and criteria regarding diagnosis, management, and treatment in specific areas of healthcare”.
- Benefit:
 - Continuity of care
 - Consistency through staff and caregivers
 - Evidence-based & Best Practice
 - Can be individualized
 - Decrease costs (supplies and labor)
 - Can be multidisciplinary

Getting Started: Decisions to make



How do I make protocols evidenced based?

- Guidelines
- Enlist a wound specialist
- Guidelines
- Review the literature
- Guidelines
- Ask manufacturers for studies

- **www.guideline.gov (AHRQ)**

Quality Home Health Wound Management Protocols

When to make a wound nurse referral

1. Pressure Ulcer Prevention Educational Material
 2. Protocol A- Partial thickness wounds
 3. Protocol B- Stage II
 4. Protocol C- Skin tears
 5. Protocol D- Blisters
 6. Protocol E- Full thickness wounds
 7. Necrotic or infected
 8. Protocol F- Full thickness wounds/
Non draining/minimally draining
 11. Protocol G- Full thickness wounds/
Moderately heavy draining
 12. Protocol H- Venous leg ulcers
- Page two of Protocol H

Quality Home Health Wound Management Protocols

13. Quick Assessment of Leg Ulcers
14. Compression literature
15. ABI Report Form
16. Predictors of infection
17. Wound measurement guidelines
18. Protocol I- Anodyne
19. Protocol J- Cellulitis
20. Protocol K- Diabetic ulcers
21. Diabetic Foot Assessment
22. Protocol L- Arterial ulcers
23. Support Surface Protocol
24. Seating Surface Protocol
25. Braden Interventions
26. Incontinence Protocol
27. Incontinence Education Tool
28. Protocol X-Alternative to Wet to Dry
29. WOCN OASIS Guidelines (12/09)

Interactive: Let's write a protocol.

- Components:
 - Type of wound
 - Partial thickness
 - Lets label this one Protocol B
 - Intervention
 - Documentation

Protocol B- Description/header

- Description of what this protocol is addressing.
- Partial thickness wounds.
- Describe the tissue and what the clinician will visibly see.
- Stage II pressure ulcer or other partial thickness wound/lesion.
- Loss of skin layers involving the epidermis and possibly penetrating into but not through the dermis. May present as blistering with erythema(redness) and/or induration(hardening). Wound base is usually moist and pink, painful, and free of infection. There is some epidermal loss but no slough.

Protocol B- Intervention

- Can list preventative measures which address the etiology of the wound.
- 1. Request and place patient on an appropriate support surface.
- 2. Position patient off he wound when possible. Always float heels.
- 3. Dressing Protocol

Protocol B- Intervention cont.

- Topical care, what are you going to do the wound itself.
- May delineate into further categories.
- Write everything that may be involved in the topical care.
- Frequency of changes
- Use of accessory products
- Here is NOT the place to use abbreviations.
- Non-draining-apply transparent film or border gauze after cleansing with saline(wound wash or 30cc saline bullet) and patting surrounding skin dry. May apply skin barrier prep wipe if indicated to surrounding tissue before applying adhesive. If periwound is denuded, may use 3M No-Sting wipes. Change one time weekly and prn dislodgement.

Protocol B- Intervention cont.

- You never want to put only ONE product or method of doing any topical wound care for protocols. Since they are a guide and no two patients are alike, there must be room to individualize the care.
- IF you have two sections on one sheet, include all the measures for total topical care in each section. Do not assume that your staff will review the entire page.
- Draining- Apply Mepilex, Tielle, hydrocolloid, or polymem secured with tegaderm or border gauze after cleansing with saline (wound wash or 30cc bullet) and patting surrounding skin dry. May apply skin barrier prep wipe if indicated to surrounding tissue before applying adhesive(If periwound is denuded may use 3M No sting wipes). Change one to two times weekly depending on drainage.

Protocol B-Documentation

- The last section encompasses what the staff member is expected to include in their documentation.
- This is also a great place to add reminders such as support surface, or diabetic shoes if this were the diabetic protocol.
- Many of the items in the documentation section will be on every protocol you make.
- 1. Chart size and description, including type and amount of drainage, of wound at least weekly on wound assessment sheet.
- 2. Document each dressing change within the visit note.
- 3. If on a seating or support surface, document the type of support surface product used within the visit note.
- 4. Document pt/caregiver compliance with prevention methods weekly, if applicable.
- 5. Photograph wounds on admission, onset of new wound, and monthly thereafter.

What you need when you go home

- List of your supplies
- Policies and procedures already in place
- Guidelines
- Knowledge of what makes wound happy.
- Happy wounds are healing wounds!



Tips

- Decide what type
- Get your supply sheets
- Enlist a staff nurse to assist
- Make sure your protocols match any procedure or policy regarding application of products.
- The broader the protocol the more products you are going to have to list
- The narrower the protocol the more protocols you end up with.
- Find a happy medium.

Describe how to implement a “no more wet to dry” protocol at their facility.

- Know your stuff. References to use and have on hand.
 - Regulatory issues
 - Peer reviewed articles
 - Clinical guidelines
- Policy development or protocol revision.
 - Choosing
- Administration, staff, and marketing buy in.
- Adjusting to the changing census.
 - Losing patients' and referral sources.
 - New influx and rising census.

Know your stuff

- References to use and have on hand
- AHRQ Guidelines
- Peer reviewed journal articles
- “Hanging wet-to-dry out to dry”
- **AGAIN: Clinical guidelines**

Regulatory Issues

- New OASIS ? Re: moist healing
- Best Practice---if you are not following best practice or standard of care, how high is your liability?
- Wet to dry is NOT moist wound care
- Future of wound care and healthcare in general is evidence- based practice!
- Future of healthcare: reimbursement will be based on outcomes.

Policy or Protocol

- Do I develop new policies or do I revise the protocols?
- How do I choose?
- Policy changes make it a “rule” that you must always follow
- Protocol revision is just guidance....you are NOT cited if the protocol is not followed.

Buy-In

- How do I get administrative buy in?
 - How do I get physician buy in?
 - How do I get staff buy in?

Census Changes

- Am I going to lose patients? YES
- Will they come back? YES
- Am I going to lose referral sources? YES
- Will they come back? YES

The light at the end of the tunnel

- Word has gotten out...
- The docs realize your advanced care protocols work.
- Wound outcomes are improved!!
- Less re-hospitalization for wound care!!
- Less adverse events this quarter!!
- Your census is back up!!
- You start getting more and more wound care patients!!

- References available upon request

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