



Complete Summary

GUIDELINE TITLE

Pressure ulcer therapy companion.

BIBLIOGRAPHIC SOURCE(S)

American Medical Directors Association. Pressure ulcer therapy companion. Columbia (MD): American Medical Directors Association; 1999. 35 p. [21 references]

COMPLETE SUMMARY CONTENT

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SCOPE

DISEASE/CONDITION(S)

Pressure ulcer

GUIDELINE CATEGORY

Diagnosis
Management
Prevention
Treatment

CLINICAL SPECIALTY

Geriatrics

INTENDED USERS

Advanced Practice Nurses
Allied Health Personnel
Nurses

Pharmacists
Physicians
Social Workers

GUIDELINE OBJECTIVE(S)

To address additional details of managing and monitoring pressure ulcers that were not covered in the original 1996 American Medical Directors Association (AMDA) clinical practice guideline.

TARGET POPULATION

Elderly individuals and/or residents of long-term care facilities.

INTERVENTIONS AND PRACTICES CONSIDERED

1. Unified care plan
2. General support, including infection treatment, hydration and nutrition, pain management, and psychosocial support
3. Turning and positioning, and use of pressure-reduction devices, such as overlay or static mattress, dynamic mattress, or low-air loss or air fluidized bed
4. Tissue culture, radiologic evaluation or biopsy, and standard infection control techniques to manage local infection
5. Wound cleansing with normal saline solution and debridement (sharp, mechanical, enzymatic or autolytic) of necrotic tissue
6. Wound dressings, such as gauze (wet or dry), impregnated gauze pads, transparent films, hydrogels, hydrocolloids, alginates, foams, wound fillers, and composite dressings
7. Manage the wound by monitoring it and the patient's progress, managing wound complications, and changing treatment, if necessary

MAJOR OUTCOMES CONSIDERED

- Quality of life

METHODOLOGY

METHODS USED TO COLLECT/SELECT EVIDENCE

Hand-searches of Published Literature (Primary Sources)
Hand-searches of Published Literature (Secondary Sources)
Searches of Electronic Databases

DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

The guideline developer relied on references identified via additional Medline searches, review of related guidelines, pertinent journal articles, and knowledge of current practice.

NUMBER OF SOURCE DOCUMENTS

Not stated

METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

Expert Consensus

RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE

Not applicable

METHODS USED TO ANALYZE THE EVIDENCE

Review

DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE

Not applicable

METHODS USED TO FORMULATE THE RECOMMENDATIONS

Expert Consensus

DESCRIPTION OF METHODS USED TO FORMULATE THE RECOMMENDATIONS

The guideline was developed by an interdisciplinary work group using a process that combined evidence- and consensus-based thinking. The groups were composed of practitioners involved in patient care in the institutional setting. Using pertinent articles and information and a draft outline, the group worked to make a simple, user-friendly guideline that focused on application in the long term care institutional setting.

RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS

Not applicable

COST ANALYSIS

A formal cost analysis was not performed and published cost analyses were not reviewed.

METHOD OF GUIDELINE VALIDATION

External Peer Review
Internal Peer Review

DESCRIPTION OF METHOD OF GUIDELINE VALIDATION

All American Medical Directors Association (AMDA) clinical practice guidelines undergo external review. The draft guideline is sent to approximately 175+ reviewers. These reviewers include AMDA physician members and independent physicians, specialists, and organizations that are knowledgeable of the guideline topic and the long-term care setting.

RECOMMENDATIONS

MAJOR RECOMMENDATIONS

The American Medical Directors Association (AMDA) prepared this companion guideline to address additional details of managing and monitoring wounds that were not covered in the original 1996 AMDA clinical practice guideline on pressure ulcers. The tool may be used by itself, but it may be more effective if used in conjunction with the 1996 Pressure Ulcer clinical practice guideline. The additional steps involved in managing and monitoring pressure ulcers among the elderly in long-term care facilities were summarized by NGC:

I. Recognition

A. Step 1

Assess the patient and the wound, and document findings

- Appropriately skilled individuals from various disciplines (nurses, nursing assistants, wound care specialists, physical and occupational therapists, physicians, dietitians, consultant pharmacists, etc.) must make and record these observations (see AMDA 1996 Pressure Ulcer and Agency for Healthcare Research and Quality [AHRQ, formerly the Agency for Health Care Policy and Research, AHCPR] Guidelines).
- Assessments also should include a review of factors and organ systems that may be affecting the onset or healing of a pressure ulcer, including the patient's general condition, hydration and nutrition status, status of active illnesses (comorbidities), presence and characteristics of any pain, and psychosocial issues.
- A physician or a mid-level practitioner such as a nurse practitioner (NP) or physician assistant (PA) should evaluate a complicated, extensive, or non-healing wound in a timely fashion.
- The physician should assess an existing pressure ulcer during each routine visit.

II. Assessment

A. Step 2

Define and interpret the factors that will impact treatment and wound healing

1. Physical Factors

- The treating health care practitioner and nursing staff should identify and document these factors at the start

of treatment. Relevant physical factors include those causing or contributing to the wound's development and those that may impact the wound's healing and the development of related complications.

2. Functional Factors
3. Psychosocial Factors

In each case, documentation of these physical conditions and functional and psychosocial factors should be included in initial and follow-up assessments and monitoring activities.

B. Step 3

Define the prognosis and identify realistic goals

- Before selecting treatments, identify the likelihood of wound healing and the benefits of pursuing a specific treatment plan.
 - Document the particular factors that may affect healing.
2. Ethical Issues
 - Review any advance directives or other care instructions that limit the scope, intensity, duration, and selection of various wound-related or adjunctive treatments.

C. Step 4

Identify priorities in managing the wound and the patient

0. Systematic factors
 - The scope of a treatment plan and the urgency with which it is implemented will depend on conclusions about the patient's condition, the prognosis, and the reversibility of the wounds.
 - Use a standardized pain assessment tool that is not specific to wound care to assess and monitor pain (for example, the 1999 AMDA guideline on chronic pain management).
1. Wound-related factors
 - It is important to describe any bacterial presence accurately, as a basis for proper management.
2. Environmental factors
 - Identify environmental factors such as excess pressure and shear, and problematic care processes such as incorrect techniques for turning and positioning.

D. Step 5

Interpret the implications of the findings for treatment selection

- Establish a realistic, unified care plan
- The attending physician should lead the effort to interpret or verify the information, define the problems, identify the priorities, and select the appropriate approaches. The nursing staff, with the participation and support of the physician and

practitioners and caregivers of other disciplines, should coordinate the care delivery.

III. Treatment

- The overall goals of treatment are to promote wound healing, to prevent complications or deterioration of an existing wound, to prevent additional skin breakdown, and to minimize the harmful effects of the wound on the patient's overall condition.
- B. Step 6

Provide general support for the patient

- Identify a management strategy for general problems such as altered level of consciousness, fever, and malaise. Wherever possible, treat specific medical conditions such as diarrhea or heart failure that may be causing or contributing to wound development or impeding wound healing.
1. Possible systemic infection
 - Document when only colonization or contamination is suspected to explain the reason for not treating.
 2. Hydration and nutrition
 - Define a patient's hydration and nutrition status as soon as possible. Encourage fluids unless they are contraindicated for some reason, especially if the patient is on an air-fluidized bed.
 - Begin to rehydrate a moderately or severely dehydrated patient promptly.
 - Nutritional deficits or risks should be addressed in a stepwise fashion, based on the presence of weight loss or undernutrition, identification of contributing factors, and overall care objectives.
 3. Pain Management
 - After assessing pain and defining its characteristics (frequency, intensity, possible aggravating factors, etc.) and causes, treat it aggressively, using appropriate pain management protocols.
 4. Psychosocial support
 - Identify and treat significant depression to maximize eating and patient participation in treatment and rehabilitative efforts.

C. Step 7

Reduce pressure as needed

- Turn and position the patient often enough to relieve pressure on the wound and try to protect uninvolved areas.
- Document (by flow sheet, Kardex, etc.) when turning and positioning occurs.
- Review proper techniques for turning and positioning with all caregivers and staff involved in patient care.
- Use positioning devices to try to position ulcerated areas off of the support surface (see AMDA and AHCPUR Pressure Ulcer Clinical Practice Guidelines).

- Document any problems caregivers encounter getting patients to understand or cooperate with treatments.
- If health care practitioners and caregivers cannot implement simple measures to try to relieve pressure on an existing ulcer or to prevent the occurrence of new ulcers, if new breakdown sites develop despite such measures, or if the patient has fewer than two intact turning surfaces, consider a Level 2 pressure reduction device such as a dynamic (e.g., alternating pressure) mattress that can be placed directly on a hospital bed frame and inflated to a height of at least five inches. For more complex wounds or to treat patients for whom Level 2 approaches are unsuccessful, a Level 3 approach (e.g., low-air loss or an air-fluidized bed) may be necessary.

D. Step 8

Manage local infection

- Obtain an appropriate tissue culture if needed to help with diagnosis or treatment when evidence (erythema, edema, malodorous drainage, fluctuance, or induration) of a soft tissue infection (cellulitis, abscess, osteomyelitis, etc.) is present.
- Confirm suspected bone or joint infections via radiographic evaluation or biopsy.
- Swab cultures of the wound surface are not recommended because they cannot differentiate infection from contamination or colonization.
- Use standard infection control techniques to manage and debride wounds (see AMDA and AHCPH Pressure Ulcer Clinical Practice Guidelines). Cover the wound at all times except during treatments, and follow other recommended procedures. These should include 1) standard (also called "universal") precautions for all patients, with or without wounds, and 2) contact precautions based on the presence of infection, the number and size of wounds, the amount of drainage, and the ease of containing potentially infectious materials.

E. Step 9

Cleanse and remove dead tissue from the wound

- Cleanse wounds that have debris and dead tissue using normal saline solution (NSS), initially and at the beginning of each dressing change.
- Make sure that the saline supply is used and discarded according to facility policy to prevent bacterial proliferation after opening.

2. Debridement

- Remove damaged tissue by one of several available means, each of which has various advantages and drawbacks (see Table 4 in the original guideline). Choose a debridement method based on wound size, amount of slough and exudate, the presence and severity of pain associated with the wound or with

various forms of debridement, the feasibility of obtaining support for sharp or surgical debridement, and the risks or possible problems of transporting the individual for sharp debridement outside of the facility.

F. Step 10

Cover and protect the wound and surrounding skin

- The goals of dressing a wound are to keep the ulcer bed moist and the surrounding skin dry and to protect the wound from contamination. Choose dressings based on wound characteristics including location near contamination sources, presence and amount of exudate, wound depth, and the condition of the surrounding skin.

IV. Monitoring

. Step 11

Monitor progress of the wound and the patient

- In addition to nursing assistants and direct care nurses, physicians and other practitioners must periodically monitor the progress of wound healing and the patient's overall condition. Some reassessment should be done at least weekly, or more often if the wound worsens or complications develop. A nurse should complete a thorough assessment of the patient and the wound as a basis for communicating with the attending physician. The physician should be kept aware of the progress of all wounds. He or she should examine complicated or non-healing ulcers periodically.

A. Step 12

Recognize and manage wound complications

- The nursing staff, physician, and others should monitor the patient for possible complications, such as increasing necrosis of the ulcer base, necrosis of the wound edges, cellulitis or contact dermatitis of the surrounding skin, and increasing amount of odor and exudate from the wound. The physician or nurses should document pertinent positives (the presence of such complications) and pertinent negatives (absence of complications).

B. Step 13

Decide whether to change approaches to managing the wound

- Reassess current treatment measures to ensure that they are being done properly and that they are still needed.
- Use a step-wise approach to deciding whether and how to change treatments.
- Next, review the patient's nutrition and hydration status to ensure it is still adequate, i.e., the patient is getting enough calories to at least stabilize weight, at least 1.2-1.5gm/kg/day

of protein, and there are no significant fluid and electrolyte imbalances.

3. Adjuvant therapies

- Electrical stimulation has been shown to be marginally effective, although it may not be covered by insurance. Regenerative growth factors have been helpful for some chronic non-healing wounds, although approval by the FDA for treating pressure ulcers is pending. Other adjunctive measures have no proven benefit or advantage over more standard approaches.
- The physician may consider a surgical intervention (e.g., graft or flap) when a clean, uncomplicated Stage 3 or 4 wound does not respond to standard treatments. Base the decision to offer surgery on such factors as the patient's overall burden of illness and prognosis, care goals, and the expected functional outcomes.

V. Other Considerations

. Cost considerations in choosing wound care products

0. Facility process improvement for wound care

- To help ensure consistent, state-of-the-art wound management, it is important to design, develop, and implement education and training related to wound care.
- Ensure that all practitioners and caregivers learn and refine the skills relevant to their assigned functions and tasks, such as assessing and documenting ulcer characteristics, turning and positioning, and rendering treatments.
- Collect data about the incidence, prevalence, and healing of wounds in the facility. Review and analyze the statistics regularly in an appropriate forum and ensure that the results are addressed.

1. Use of a wound care team

- A wound care team should help ensure a consistent, correct process based on objective protocols, regardless of who is doing it. It should include practitioners and caregivers with actual experience and demonstrated skills in assessing and managing wounds. The team also should involve a physician in all key care decisions.

2. Liability issues related to pressure ulcer care

- Appropriate wound care requires a consistent, correct process but does not require exhausting all possible approaches. Nor does it necessarily ensure that a wound will heal. The failure of a wound to heal as predicted should not necessarily imply that a facility should have chosen other approaches initially. The occasional deviation from a wound care plan should not be constructed as process failure or deviation from the standard of care. However, the rationale for significant deviations from protocol should be documented in the patient's medical record.

CLINICAL ALGORITHM(S)

A clinical algorithm is provided that summarizes the steps involved in preventing and treating pressure ulcer in long-term care patients.

EVIDENCE SUPPORTING THE RECOMMENDATIONS

TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

The guideline was developed by an interdisciplinary work group using a process that combined evidence- and consensus-based thinking. Scientific research in the long-term care setting is scarce, and the majority of recommendations are based on the expert opinion of practitioners in the field.

BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

POTENTIAL BENEFITS

- Prevent suffering due to pressure ulcers in the long-term care setting.
- Improve quality of life for patients with pressure ulcers in the long-term care setting.

POTENTIAL HARMS

Not stated

QUALIFYING STATEMENTS

QUALIFYING STATEMENTS

This clinical practice guideline is provided for discussion and educational purposes only and should not be used or in any way relied upon without consultation with and supervision of a qualified physician based on the case history and medical condition of a particular patient. The American Medical Directors Association and the American Health Care Association, their heirs, executors, administrators, successors, and assigns hereby disclaim any and all liability for damages of whatever kind resulting from the use, negligent or otherwise, of this clinical practice guideline.

IMPLEMENTATION OF THE GUIDELINE

DESCRIPTION OF IMPLEMENTATION STRATEGY

The implementation of this clinical practice guideline (CPG) is outlined in four phases. Each phase presents a series of steps, which should be carried out in the process of implementing the practices presented in this guideline. Each phase is summarized below.

I. Recognition

- Define the area of improvement and determine if there is a CPG available for the defined area. Then evaluate the pertinence and feasibility of implementing the CPG.
- II. Assessment
- Define the functions necessary for implementation and then educate and train staff. Assess and document performance and outcome indicators and then develop a system to measure outcomes.
- III. Implementation
- Identify and document how each step of the CPG will be carried out and develop an implementation timetable.
 - Identify individual responsible for each step of the CPG.
 - Identify support systems that impact the direct care.
 - Educate and train appropriate individuals in specific CPG implementation and then implement the CPG.
- IV. Monitoring
- Evaluate performance based on relevant indicators and identify areas for improvement.
 - Evaluate the predefined performance measures and obtain and provide feedback.

INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

IOM CARE NEED

Getting Better
Living with Illness

IOM DOMAIN

Effectiveness
Patient-centeredness
Safety

IDENTIFYING INFORMATION AND AVAILABILITY

BIBLIOGRAPHIC SOURCE(S)

American Medical Directors Association. Pressure ulcer therapy companion. Columbia (MD): American Medical Directors Association; 1999. 35 p. [21 references]

ADAPTATION

Not applicable: The guideline was not adapted from another source.

DATE RELEASED

1999

GUIDELINE DEVELOPER(S)

American Medical Directors Association - Professional Association

SOURCE(S) OF FUNDING

Funding was provided by educational grants through Janssen Pharmaceutica, Knoll Pharmaceutical Company, Ortho-McNeil Pharmaceutical, Purdue Pharma, L.P., and Smith and Nephew, Inc.

GUIDELINE COMMITTEE

Steering Committee

COMPOSITION OF GROUP THAT AUTHORED THE GUIDELINE

Names of Panel Members: Jacob Dimant, MD, FACP, CMD (Chair); Joseph Gruber, RPh, FASCP, CGP (Facilitator); Dale Kathleen Adams, RN, BSN; Naval Bang, RPT; Donna Brickley, RN; Boyde Harrison, MD, CMD; Debra Horton, RNC, BSN; Virginia Reifsnnyder, LPN; Patrick Stevenson, CNA; George Taler, MD; Joyce Thompson, MD

FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST

Not stated

GUIDELINE STATUS

This is the current release of the guideline.

An update is not in progress at this time.

GUIDELINE AVAILABILITY

Electronic copies: Not available at this time.

Print copies: Available from the American Medical Directors Association, 10480 Little Patuxent Parkway, Suite 760, Columbia, MD 21044. Telephone: (800) 876-2632 or (410) 740-9743; Fax (410) 740-4572.

AVAILABILITY OF COMPANION DOCUMENTS

The following is available:

- Guideline Implementation: Clinical Practice Guideline. Columbia, MD: American Medical Directors Association and the American Health Care Association. 1998, 28 p.
- Pressure ulcers. Columbia, MD: American Medical Directors Association (AMDA); 1996. 20 p.

Electronic copies: Not available at this time.

Print copies: Available from the American Medical Directors Association, 10480 Little Patuxent Parkway, Suite 760, Columbia, MD 21044. Telephone (800) 876-2632 or (410) 740-9743; Fax (410) 740-4572.

PATIENT RESOURCES

None available

NGC STATUS

This summary was completed by ECRI on March 24, 2000. The information was verified by the guideline developer on April 10, 2000.

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