The Impact of Functional Interventions and Client Advocacy on Wound Healing

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- [Calista] The title of our course today is The Impact of Functional Interventions and Client Advocacy on Wound Healing. It is my pleasure to introduce today's presenter Neely Sullivan. Neely Sullivan has worked with diverse client populations ranging from pediatric to geriatric in a variety of clinical settings. These experiences and multiple courses on the topic have allowed her to treat and develop client care programs for clients living with lymphedema and wounds. She has served in multiple levels of regional and corporate management positions. In these positions, Neely has developed policies and work closely with the interdisciplinary teams to ensure that clients have, clients living with lymphedema and or wounds, have the opportunity to attain their highest level of function and quality of life. She is a certified lymphedema therapist and has most recently been responsible for the identification, implementation and evaluation of clinical programs in longterm care settings. Neely currently provides educational support to 13,000 plus therapists nationwide as an education specialist for select rehabilitation. Neely has lectured nationally and at the state level on the topics of lymphedema and wound care management. She has authored publications focusing on edema and lymphedema management. Welcome Neely Sullivan, we're happy to have you here today.

- [Neely] Okay, hello everyone. Thank you so much for that introduction. Before getting started today on this really important topic, I have a couple of housekeeping items aside from the housekeeping items aside from the housekeeping items that have already been said. First we have a lot of different people attending these webinars today. There's a lot of different job titles on here, a lot of different clinical backgrounds. So I've tried to be very thorough with the information that I'm giving you today. So if I cover something that's repetition for you, it's in the hope that we're gonna all have the same baseline information moving forward. Also, this is going to be an interactive webinar today. So be ready to answer some questions and work through some case scenarios with me today on this webinar. And then finally, this is the topic that I'm really

passionate about. So I hope today you're going to leave this webinar uplifted and have some great tangible ideas that you can incorporate in your practice setting. And so I do appreciate you attending today and giving me the opportunity to talk about when my very favorite topics to talk about. So thanks, and let's go ahead and get started. These are my disclosures. And it's my hope today that you will leave this course, being able to identify at least three examples of significance of the client advocacy for individuals at risk for skin breakdown, to find at least three elements of functionally-based treatment plan of cares that provide purpose and meaning for your clients. Identify at least two standardized tools available to predict the risk of skin breakdown and the need for skilled intervention. And then finally I want for you to be able to describe at least four common interventions with components of advocacy to use with the population you work with, and we're gonna go through some case examples to accomplish that learning outcome.

So let's go ahead and jump into the material. We're gonna start today with how we implement strategies for client-centered care. So first we start at the very beginning. What is advocacy? This is, we're hearing a lot about this right now, it's election season, so we hear a lot about political advocacy. And that is changing laws at the governmental level. But what does advocacy mean to us as rehab professionals when we're working with our clients each day? So simply put, as listed on the slide, advocacy is supporting or intervening on behalf of another. So for clinicians this usually means supporting our client through their daily activities and making sure that they are living up to their best quality of life. It also means promoting another's wellbeing. So perhaps if needs only using evidence interventions in your treatment sessions. Advocacy is looking out for another, standing up for someone. Making it something important known. So as an example, speaking up when our clients have cognitive deficits or when it's appropriate for a client who have other physical impairments as well. So I hope you'll see through this presentation today that advocacy is a really essential component of client centered-care. And that's something we hear about so

often today. The clients we work with need advocates. We know that we wouldn't be seeing these clients if they didn't have some type of deficit. Many of the clients we work with are no longer able to manage for themselves due to some type of illness or medical condition. So obviously a lot of clients wouldn't be coming to us to ask for help if they were able to do everything independently. A client may not notice any change in their ability to function. So sometimes the client needs a set of skilled eyes to pinpoint their deficits and help them set goals. The purpose of advocacy in the rehab setting and I noticed slides says longterm care setting, but it really does apply across all rehab settings. Is to support a client, their highest level of function.

Of course, we're trying to help that client recognize that there may be a decline, and that we're here to help reduce that decline. And also advocacy in rehab is meant to assure that all team members assist in helping all clients maintain their highest level of function. And that's what we do really every day with our clients. We have a lot of unique skills as rehab professionals. We are trained to be knowledgeable of the needs of our clients with impairment. We bring credibility to issues and are most often seen as working on behalf of others.

And there's no one else who may be advocating for the field of rehab or our particular clients and whatever setting you work in. So specifically, why are we talking about advocacy with clients with wounds today? I think this is probably a repeat for you, but do you know that chronic wounds impose a huge social and economic burden. It's estimated 6.5 million people in the United States are being treated for chronic wounds. This is an annual cost to our nation's healthcare system, about $25 billion. That's a lot of money. These numbers are expected to rise substantially in the coming years. We know that there's a growing aging population and a growing obesity and diabetes epidemic. We also know that people aren't staying in hospitals as long as they used to. So we're seeing a lot more postsurgical wounds. And then our clients are living longer and they're living longer with chronic conditions. And some of those conditions include

chronic wounds. The care and management of chronic wounds is a challenge for everyone involved. Our clients, caregivers, providers. Unfortunately, chronic wounds are not generally accepted in society. And this is the factor that leads a lot of our clients to downplay their condition or kinda hide their condition and its seriousness from others. Complications related to non-healing wounds are many.

And clients are at risk of severe pain, sepsis, hospitalization and in some cases, amputations. Wounds impose great restrictions on our client's physical mobility and day-to-day activities often leading to mental changes such as depression, anxiety and other problems. And it does end up placing a significant burden on the family and caregivers of these clients. Chronic wounds are associated with early death. So for example, the five-year mortality rate for clients living with diabetes, whose non-healing wounds result in amputation, is estimated more than 50%. That's a rate higher than that for several types of cancer. Even when our clients receive state-of-the-art treatment, a lot of times our plans that we devise for these clients are devised without really considering their living situation, their health status or their personal preferences. These plans don't consider the availability of community resources or the stress they may place on caregivers.

So as a result, clients with chronic wounds frequently feel disengaged in decision-making regarding their care. They also often believe that their concerns about their wounds are not aligned with their concerns of their healthcare providers. So I wanna give you an example of how I used to describe wounds when I first started practicing wound care, which was a really long time ago. People would ask me, "Why do you like to perform wound care?" And I would say, "Because it's very black and white. "You put something on a wound "and either works or it doesn't work. Well really the way I was describing wound care in working with clients, was not client-centered care. I was simply addressing that wound for that client. So to address this medical challenge, we have to change the way we practice. We have to put the client, not the

wound, at the center of our treatment efforts. So I have a lot of case studies today throughout this presentation. I wanted to let you know that these are all clients that I've worked with, and of course I've changed the names. But this is our first case study, this is Mrs. Howard. She's an 82-year-old who resides in a longterm care facility. And over the past three years, she's become incontinent, experienced frequent episodes of malnutrition and dehydration, and as a result, she's lost a lot of weight. She developed a stage four pressure injury in the sacral area after a recent hospitalization for exacerbation of COPD and she had a mild case of COVID-19.

She continues to experience shortness of breath, and she prefers to sit with the head of the bed above 45 degrees to help her with her breathing. She also gets agitated when she's repositioned, especially in a sideline position. So we met with the family and during the family, the son and daughter were pretty upset over their mom's agitation. And they wondered if the constant repositioning was necessary. So during this meeting, the son and daughter asked these particularly pointed questions regarding their mom's care. "If this is not something that she likes, "are we doing the right thing for her? "Is this quality of life." And these are questions I hear in communities I work with all the time. Every time I get questions like this, it immediately stops me in my tracks and I have to consider if I'm really providing client-centered care for those particular patients.

The case study I just went through brings us to question quality of life. Along with advocacy, holistic wound care should always include measures that promote comfort, dignity and relieve suffering and improve quality of life. So what does quality of life? That's one of those terms we throw it out there all the time, but if the fine by the Oxford dictionary, as a standard of health, comfort and happiness experienced by an individual or a group. What makes it challenging to measure is that although the term quality of life has meaning for nearly everyone and everyone can define it a little differently aspects of culture, values and spirituality are key domains of overall quality

of life and that adds the complexity of its measurement. So one thing I think we can all agree on is that among our clients who are living with wounds, there's very little dispute that their quality of life is diminished. This slide gives us some quality of life assessments. I tried to include assessment that were free on the internet. If you haven't used these tools in the past, I encourage you to look them up and incorporate them into your assessments of your clients living with wounds. So I wanna look at one of these tools. The quality of life ladder. This is a tool I use a lot for capturing that subjective aspect of quality of life. So to use this tool with your client, you would talk to your client, you would tell them to imagine a ladder with steps number from zero at the bottom to 10 at the top. "The top of the ladder "represents the best possible life for you, "and the bottom of the ladder "represents the worst possible life for you. "On which step of the ladder "do you feel you stand right now?"

Then they would check the respect of colored disc on the left column, and then they would, then we would ask them "On which step do you wanna stand in five years from now?" And then of course they would check on the right column where they wanna be in five years. So by using this tool, you can really gauge where your client is and then begin to set up realistic goals for improving their quality of life. This is along the similar vein that this is a self-anchoring scale to your client you would tell them to assume that this ladder is a way of picturing your life. The top of the ladder represents the best possible life for you and the bottom rung of the ladder represents the worst possible life for you.

So again, you ask your clients to indicate where they are on the ladder, where they feel personally they stand right now. And this is not, this doesn't include that five years down the road. So it might be a more streamlined tool that you can use with your clients. There's specific instruments used to evaluate health related quality of life for our clients with foot, diabetic foot ulcers. Here's several, several different tools listed on this slide. I like to use the diabetic foot ulcer scale quite often with my clients. It's pretty

quick and it's simple to use. There's the same type of assessments for clients living with leg ulcers. So what are some specific quality of life issues for our clients, not just with leg ulcers, but I'm gonna go ahead and extend this to clients living with active wounds. So this is a study Briggs and all, they reviewed findings from 12 qualitative studies. So some of the key issues impacting quality of life in our clients with wounds include physical effects and that makes sense. This is pain, odor, itch, leakage, infection. Also learning and understanding to provide care for leg ulcers. There's so much to learn about the development, treatment and prevention. We all have medical backgrounds on this call, and at times we feel overwhelmed. So you can imagine what your clients are feeling.

Another issue, the benefits and disappointment in client-professional relationship. Your clients are worried about developing a trusting with their wound care provider. They worry about the continuity of care when they're getting different clinicians each visit. If the clinician doesn't do a good job explaining what and why the client's going through this, then the client may begin to feel powerless and they result in some compliance issues. And if not client-centered care. Another issue is social, physical and financial costs of wounds. Also the psychological impact and difficult emotions. Perhaps your clients are fearful they have some anger and anxiety about living with these wounds. There's changes to body image and self-concept as well as loss of independence, and that's big one for our clients.

This is another study by Gorecki. He reviewed and summarized 31 studies that looked at quality of life in clients with pressure injuries. And these seams were quite similar to the Briggs study that I just reviewed on a previous slide but there was a couple that weren't mentioned. So first the physical restrictions resulting in lifestyle changes and then need for environmental adaptations. As an example, a individual develops a pressure injury and stops participating in daily activities like going to the store or going to church, et cetera. There's also health deterioration and the burden they place on

others. People begin to fear that they're going to be a burden, so they might start to limit their activities. And also they might even begin to downplay the seriousness, or the extent of that wound. Some other issues related to quality of life include wound dressings, treatments and interventions. All these different pieces of treatments and interventions start to add up both financially and mentally. And it starts to take a toll on the client living with the pressure injury. Also the perception of the cause. Individuals begin to worry that it's their fault. I'm particularly thing that a lot with my beriatrics clients right now that develop wounds. They start to worry that because they are heavier, that it's their fault they now have wounds. I like this framework. It was developed by a brilliant wound care clinician, Woo. And this graphic really ties it all together for us. Based on the review of literature and conceptual framework for the concept of quality of life as it relates to clients with wounds, this framework includes two concentric circles, as you can see.

And the center represents the individual coping with the chronic wound, and then that outer circle represents the social, political and healthcare systems within which quality of life is realized and actually lived. So that inner circle in case you can't see, I know it's pretty small on there, that inner circle contains six key stressors encountered by people living with chronic wounds and that's wound status and treatment, pain and other wound-related symptoms, function, status and mobility, emotions and psychological state, financial resources and cost and social relationships. And those are some of the same issues that we identified on the previous slide. So today we're really going to address functional status and mobility and social relationships as well. So how do we incorporate this framework? It's great to read that in a piece of research, it's great to go through all this research, but what does that really mean for our clients living with wounds? To improve client's quality of life, the framework we just ran through suggests that we need an environment that encourages client engagement, accompanied by consideration of the environment and the individual's access to health resources. If we do this and our wound care plans are individual, then our plan of care to are most likely

to succeed and promote the best outcome for the client with a wound. Standardized wound care plans often fail because they don't promote client adherence. Clients may be labeled as noncompliant when the real problem is that the care plan has not been properly individualized to their specific needs, taking into account their perspectives on quality of life. Even when best practices are implemented, some of our treatment options are just not feasible and they're not conducive to enhance our client's quality of life. So for example, a client with foot ulcers who can't use a total contact cast because he needs to wear protective foot wear at work. And he can't maintain his balance walking on a cast. Or a client with a venous leg ulcer who likes to take a shower everyday to maintain personal hygiene, but can't because they have to wear compression bandages.

Or another example, a client with a pressure injury who refuses an air mattress because it's too noisy, they can't sleep. While turning clients every four hours has been recommended, that repositioning can also be painful, especially among our clients with significant contractures or muscle spasticity or spasms. I continue to see this everyday. The wishes of clients continue to play a subordinate role to those of their clinicians. This situation is frequently the case when clients are being treated for wounds. Although clients and the clinicians both want treatments that will heal the wounds and prevent those wounds from coming back, clients have additional concerns. Ones that focus on quality of life.

Will the treatment impede their ability to lead an independent life? What impact, including financial, will the treatment have on their family members or other caregivers? Such questions are often not considered by clinicians when developing a treatment plan for our clients living with wounds. Most clients with wounds, I think it was 83 ish percent in one study that I just recently read, have two or more co-morbidities that interfere with wound healing. The have to do a much better job at understanding the whole client. So for clinicians, this is the outcome for what we're getting paid under our

reimbursement. The treatment goal is usually the closure of the wound. This narrow focus fails to take into account that the prescribed treatment is gonna affect other aspects of that client's life, as well as his or her work or personal life. So as an example, when clinicians prescribe offloading to a client, they may not consider the impact, the prolonged immobilization will have on the client's physical and mental health. So as a side note, a side example, a few years back, I broke my foot. And I am a pretty physical person. That's just how I live in this world. Whenever I have any kind of problem, I get up and get moving. And when that coping mechanism was taken away from me, it really impacted my quality of life and my ability to cope with difficult things in my life. Another example, we may not consider that putting a boot on a client to cure an ulcer on the bottom of the foot may cause another ulcer on the shin. In addition, clinicians who treat people with wounds may have a little specialized knowledge about the specific disease or injury that led to the wound's development. And later we're gonna talk about the importance of staff education. This is a key piece of advocacy for our clients.

As a result, treatment often tends to be center about what to put on the wound, rather than on how to improve the underlying medical problem. Clinicians also tend to approach treatment from their own medical silo, a factor that can inhibit their ability to treat the broader health issues that are faced by the client. Now admittedly when it comes to treatment guidelines, often limit what treatment can be used. So for clients with diabetic wounds, insurers will typically pay for a contact cast although a lot of our clients aren't able to wear them. Our various cushions and assistive devices, including protective cats and wheelchairs, are also used to help heal wounds, but these devices are often difficult for some clients to afford or get access to. Furthermore it's essential that a device such a wheelchair fit the client for whom it's prescribed. How often do we see our clients given a standard ill-fitting wheelchair, which may result in the development of new wounds? Also some of the technologies used to treat people with wounds do work, but there's a lot out there that don't work. There really hasn't been a

strong evidence-based approach to evaluating these treatment approaches. In addition, the technologies continue to focus only on treating the wound, not that client as a whole. Alright, this is our first poll that we're gonna take today. I want you to type into the poll, just quick, it doesn't have to be eloquent. What are some of the barriers you face in providing person-centered wound care? I'm gonna give you about 30 seconds to answer this. Okay about 10 more seconds. And I'm gonna go ahead, I will let you see what everybody is saying. Alright let's wrap it up, you have five seconds. Thank you so much to all of those that responded. I'm gonna go ahead and close this poll.

So some of the themes that I was seeing from these answers, were things such as management, productivity, a lack of coordination across that multidisciplinary team, lack of time, lack of knowledge, lack of resources, difficulty working with families. I'm gonna go ahead and end the poll. So yes, those are all things that we identified when we went through the previous study is about some of the issues facing clients with wounds. And we're gonna go through all of those barriers that you nicely just listed out for us. So this study, it's not a study, it was actually a meeting, where in 2015, 27 experts from across the country wound care experts came together and they wanted to address questions about how to best meet the needs of clients. With the desire future state defined, the moderator asked everyone, just like I asked you, to list barriers, challenges, things standing in the way of reaching a, reaching how they, how they can best meet the needs of their clients living with wounds.

So the thing that they identified, I'm gonna go through, over the next few slides. And I wish that there was a really fun way to present this information, but it's really a poignant way for us to see that the barriers that they identified are the same barriers that you just listed. So first inconsistent views among medical professionals about the need for interventions. A situation that leads to inconsistencies in reimbursement. ALong these same lines, I'll add that inconsistent communication among the

multidisciplinary team is always a barrier. A fee-for-service rather than a value-based model of reimbursement. And this is changing as our models of reimbursements continue to evolve. So I think that this will continue to resolve itself. Limited knowledge of diagnostics to understand the nature of a given wound and to decide which therapy would be most appropriate. A widespread ignorance of the serious medical, psychological, social and economic consequences of chronic wounds. And these are some of the factors of quality of life that we've been discussing. Also unequal client access to quality wound care due to geography, income, socioeconomic status, insurance status, other factors, of course health literacy feeds into this. Health disparities are a true barrier to access to a really sound client-centered wound care. Now clients being able to grasp and understand how to manage their wounds. This is always an issue. Therapies that are presented to clients and clinicians with limited evidence about their effectiveness.

So again, not using that evidence-based intervention. Assumptions by many clinicians that all wounds are the same. This of course is not client-centered care. The inability of some clinicians to see a client as an individual, not as a wound. We've talked about that a lot today. A reluctance by some clinicians to listen to the goals and wishes of their patients. And unfortunately I see this often. The tendency of the current healthcare delivery system to focus on sickness rather on wellness. We haven't touched on this, but we only react when there is a wound. We don't try to prevent the wound from forming in the first place.

The fragmentation of wound care, wounds are not considered a condition like cancer or diabetes, which often leads to counterproductive or ineffective treatments. Other barriers. Financial incentives to keep the client a client. The social stigma associated with chronic wounds. The medical community is focused on products as being the solution to chronic wounds. And of course this approach often overlooked the client's underlying medical conditions and his or her needs regarding treatment. We'll gonna

try to breeze through these last few barriers. A limited understanding by clinicians that wounds are not a single disease, and so not understanding or taking into account co-morbidities. Also fear. And this could be fear of clinicians to be more aggressive with therapy, of patients about treatment outcomes. And of both clinicians and patients in terms of realistic expectations regarding therapy. A limited access and funding for durable medical equipment and home services related to wound healing. How many of you see that out there and not everything is covered by insurance? That even if your client has really good insurance. And then finally the last barrier, a little understanding of the disease pathophysiology of chronic wounds. So that's a lot of barriers. How do we address these barriers? So some of the ideas on the next few slides I thought were pretty innovative. So I just want to run through them with you. Our clients with chronic wounds would have a multidisciplinary team of professionals caring for them. And that would include people like podiatrists, social workers, psychologists, nutritionists. So hopefully these are happening already in the communities you work in. The physical, emotional, social and cultural needs with client will be recognized by all members of his or her clinical team.

And this would be central in devising a treatment plan and evaluating the progress. Again, this is client-centered care 101, right? Now the client not the wound would be at the center of the care. Each client would receive the right care, at the right time by the right professional. And this is the balance that we are always trying to achieve as clinicians, correct? Clients and caregivers would be listened to, respected by clinicians. Clients won't be blamed when their wound doesn't heal. Hopefully this isn't happening in your community, but unfortunately I do see that happen often. Now the interests of clients, caregivers, clinicians, payers and society would be integrated to create a more holistic proactive care. So for example, treatment plans would offer affordable home health assistance, respite help for caregivers. Perhaps your client can't get to visit so there would be some type of transportation to the visits. Another solution would be the treatment for people with chronic wounds will be proactive rather than reactive.

Reimbursement to clinicians' hospitals would be restructured in ways that reward efforts to prevent chronic wounds from developing or we occurring rather than just closing the wounds. And I know a lot of these are very idealistic, but I just like to imagine what if, what if we could implement these in our communities? What difference would this have on our clients who are living with those chronic wounds? So this leads us into that multidisciplinary team. A lot of you in that first poll identified that this is part of the issue. The multidisciplinary team has to be part of that advocacy team, and that multiple disciplinary team is far reaching in whatever community or facility you work in. So this is probably a repeat, but who's on that team? So there first and foremost the client, their family. They're the crux of the multidisciplinary team.

But then there's people that you may not even think about. And of course it depends on what setting you're in, but people, if you're in longterm care such as dietary, or even housekeeping and maintenance, they're in the client's room, they're seeing how they actually live in their living space each day. And there's people that you of course would expect. There's your RNs, your physicians, your administrators. All these people come together for the common purpose of creating quality of life for those clients. That multidisciplinary team has to work together to ensure that the clients are able to actively participate to their maximum capability during all tasks. So the role that multidisciplinary team would be to identify appropriate candidates for skilled intervention.

So they have to have that firm understanding on the role of rehab in wound care. Again, we're gonna talk a lot about staff education in just a few minutes. They also would ensure clients are provided the opportunity to maintain their highest level of independence during activity participation, with the least amount of supervision or assistance. They will promote activities that are designed for your clients, for them to perform, not for you to perform for the clients. We need to know what activities our clients are doing and enjoying as well. The multidisciplinary should provide best

practice guidelines for documentation to support medical necessity and skilled treatment. We need some training and documentation as well to ensure that there's continue continuity on that multidisciplinary team. And then finally that feeds really nicely into that multiple disciplinary team is a really meant to ensure the continuum of care with an emphasis on the physician, staff caregiver training on how programming can be used as an adjunctive therapy. And if you aren't in longterm care, how their daily activities will be used as an adjunctive therapy by providing a means to preserve skills that they learned while they were participating in therapy. So how do we improve healing and outcomes for our clients living with wounds? Again, I know these are a bit idealistic, but I like to imagine the possibilities. What if we could create a national network of centers of excellence for wound care and direct clients to those centers when wounds fail to improve after initial appropriate care?

What if we could develop a rapid care pathway for our clients with wounds so that clients have timely access to treatment by a specialist? So think about the quick access to care that occurs when a client or when a woman discovers a breast lump. They are on a track at that point and they have a lot of care and a lot of, they go through a lot of protocols to make sure that that is addressed quickly.

What if we could develop safety and accreditation for wound care? And I know people are currently working on this, in APTA, so stay tuned. I think that this is just around the corner for us. What if we could create better metrics and tracking tools for measuring the effectiveness of various treatments? Also, what if we could redefine the desired outcome of wound care from closure wound to return of client and hopefully that's why you're on this webinar today so that we can all go out there after this webinar today, and really advocate for our clients and advocate for not just focusing on closing the wound, but helping our clients get back to what they enjoy and what's meaningful in their lives. That ties us in beautifully to functional activity-based interventions. One way that we can begin to advocate for our clients today, is through incorporating functional

activity-based interventions. I know what we just went through. They're idealistic very big picture, but this is what we can do as therapists today in our rehab settings. Now I know a lot of therapists love this opportunity. And they look forward to functional activities every treatment session. I also know a lot of therapists prefer traditional impairment-based treatment. This requires less preparation and planning, and quite honestly, we're pretty comfortable with this traditional impairment-based treatment. But we wanna ensure that our activities are skilled and not only enjoyable to the participants, but also meaningful to their daily life beyond therapy. So what their everyday looks like after therapy. So as a reminder, impairment-based treatment becomes routine for us as therapists. A lot of us, including myself, we're trained to think this way in school. So for instance, if a client comes to us with a frozen shoulder, we treat the limited range of motion, the decreased strength and pain associated with this condition. Now some of these impairment-based treatment approaches are necessary and beneficial throughout the specific points of the treatment process.

So for instance, when a client's in the acute stage of treatment, it maybe necessary to build up strength, range of motion, activity, tolerance, et cetera, but they can participate in functional activities. This stage of treatment should not last their entire plan of care. Management of wounds involves a detailed examination and discussion with your clients to adequately address their concerns. Although some traditional education interventions are necessary, they're rarely sufficient to change the behaviors of your clients and what may have contributed to the wound developing in the first place. So our interventions have to shift from simply managing the wound to focus on client engagement and self-management of the wound. As well as well as wellness and the prevention of the wound. So here's just some more examples of impairment-based treatment. So let's say a client presents with an impaired integumentary system and we treat the wound tissue with appropriate dressing. That's what we do with our clients. Or you have a client, they present with range of motion and strength, and we pull out those arcs and the weights, or a client presents with decreased activity tolerance. Then

we put them on a new step while we sit over and we do our documentation or a client presents with decreased range of motion and balance and we use those cones that I see everywhere, all over clinics, all over the United States. So we know that our clients with wound have impaired integumentary system. And yes, we will treat that with dressing them more traditional wound care, but we also know that the majority of clients with wounds experience mobility problems and their ability to perform activities of daily living is limited. Activity is often taken for granted by the general population, such as taking a shower or getting dressed or walking up the stairs, become an enormous challenge for our clients living with wounds. So this study, it consisted of 88 patients with chronic leg ulcers and 75% reported difficulty while performing basic housework. There was another study by Hyland et al and revolved at 50 clients with leg ulcers out of 50 clients with leg ulcers, 50% had problems getting on and off a bus and 30% had trouble climbing steps.

This was a web-based survey and it acknowledged that mental health issues are common in our clients with wounds. Over 60% of the survey respondents indicated that between 20 and 50% of people with wounds experienced mental disorders and among the symptoms, anxiety was rated the most common. And if you do work with clients with wounds, you see this all the time. Your clients show up and they have a tremendous amount of anxiety about their health and the wound and how they're gonna live their life with this wound.

So again, are we considering the whole client when we're determining the plan of care for our clients living with wounds? Functional deficits for those living with wounds are listed on this slide. And if it's what we just said in the research that we went through. Requesting or receiving assistance could be a hustle and an embarrassment, especially if the client lives alone and needs regular help. Easy access to transportation and changes to living arrangements such as widening doors for wheelchair. This will enhance an individual's ability to function independently, but the effort to organize and

execute the plan could be daunting. I mean, think about your clients that you work with. If you told them they had to widen the door for a wheelchair, I know the clients I work with, a lot of them wouldn't even know where to start, how to accomplish that. Feeling embarrassed about the smell and fluid leakage from wounds in their body. People with wounds may intentionally start to avoid social context and activities. Beyond occupational stressors, client's office start to incur a lot of expense. Expenses for transportation, for parking, telephone bills, home health aid services, drafting supplies that aren't covered by insurance or drug costs that they have no prescription plan. Those that have no insurance but, I'm sorry, those that have, they have insurance but they don't have great coverage and they don't qualify for public assistance. These clients may be forced to tap into their savings or even refinance their homes.

The problem with impairment-based therapy is that it doesn't fully prepare the client for the functional demands of the environment that she or he will face following discharge from skilled therapy. So with this approach, the therapist commonly discharges the client from skilled therapy once the wound has closed and no further progress is being made. This is usually before that client is functionally ready. So how do we know our clients are ready for discharge unless we test them and treat them in the environment in which they operate daily, including all the obstacles they're gonna be facing in their everyday life? This is where that functionally-based treatment approach comes in. A functionally-based treatment approach prepares the client and test the client for specific activities and skill sets they need to both successfully transition and then remain in their discharge environment. So who cares if a client can do 30 long arc quads with five pound weights if they can't ascent and descent a set of stairs safely using their assistive device? So again I know not everyone on this webinar today is in a longterm care setting, but I just wanted to quickly go through the longterm care survey guidelines Tag F248 that mandate that a facility must provide a person appropriate program of activities "That should match that client's skills, their preferences, "as well as the demand of the activity "and the characteristic "of the physical, social and

cultural environment." So it's really important for those clients to have choices to participate in preferred activities. Then we have to create an environment that's respectful of the right of each client to exercise their autonomy regarding what they consider important aspects of their life. And this includes actively seeking information from the resident regarding significant interest in order to provide assistance to help our clients fulfill choices over aspects of their lives if they are in that longterm care community. And if they're not in a longterm care out in the community, then of course we want to ensure also that we are finding out what their preferences are and that we are helping them get back to those activities that are most meaningful to them. So where do we start with helping our clients make these choices?

This slide shows us some questions that we can ask with our clients and consider especially when we're developing that plan of care and setting our goals. So some questions you can ask, do they enjoy current activities that they are participating in? Are there activities missing that they want to participate in? What do they like to do for fun, relaxation and leisure, and what's their idea of a perfect day? Would they like to participate in different activities or try something new? Are they upset that they can't complete activities like they used to? And what activities did they used to complete that they can no longer complete?

What do they wanna be able to do for themselves? How much time do they now spend, if they're not in longterm care, how much time do they spend withdrawing from activity or staying at their house or staying in their room staying in their apartment. And then you can also compare notes with family members, caregiving staff, activity staff and this one as well. We should all be using standardized tests and measures when we're assessing our clients. And there's a lot of leisure skills assessments out there to help determine what level each client's at, and what the goal each functionally-based treatment session should be. This slide gives us some of those tools. I just wanna run through an example of one of these tools, the PELI which is the Preferences for

Everyday Living tool. This tool is very comprehensive. I like it, I use it a lot. It uses a combination Likert scale and open-ended questions about routines, habits and preferences. And then it goes forward to ask if those activities are important and what their preferences are and then what the value they associate with those activities. So let me give you an example. So you can see up at the top, this is question 45 and it asks, how important is it to you to be a member of a club? And this slide might look familiar to you because the section of the MDS, if you're in longterm care, that deals with activity is actually drawn directly from the PELI. So it asks you how important is it for you to be a member of a club, and then you can rank on the left-hand side the importance. And then if you say it is important, you would rank on the right-hand side, all of the things that apply. Do they participate in a book club, do they participate in religious clubs, political clubs, and then what kind of clubs do they enjoy the most? Here's another tool that you can use, it's called the Modified Interest Checklist and it's available in the public domain.

And it gathers information on the client's strength of interest and engagement in 68 different activities that they may have done in the past, currently or in the future. And the main focus on leisure interests that influence activity choice. So this slide just gives an excerpt of the checklist. What I like about this tool is that it lists a whole bunch of activities that perhaps on an open-ended question the client may not report that they had interest in. But when you give them an activity, it jogs their memory. So for instance, and this of course with pre-COVID, but I do know of one particular client who used this tool and found that a number of clients in their community enjoyed football. And while of course the clients could no longer participate in football, what they did decide to do a pre-COVID was get together and create their own modified fantasy football league. And they had a small football pool, they brought everyone together to watch football on Sundays. And then they were even doing trivia games. And the clients that were participating in this really enjoyed this activity. And felt like they connected to their, activities that they loved. So where do you start with implementing

these functionally-based treatments? To begin with, you should ask yourself and your rehab team, if that's appropriate, these questions. Are you stuck in tired treatment approaches? When is the last time you tried out a new evidence-based treatment approach? Are clients engaged during treatment sessions, or are they distracted, they're unmotivated? Do you write impairment versus functionally-oriented goals? So for example, an impairment-oriented goal would be the client will perform forward flection of the right-upper extremity to increase range of motion. Versus a functionally-oriented goal, which will be client will perform forward flection of right shoulder to 180 degrees to perform grooming activities. with fan biases.

Our last question, do you think functional focus to the rehab interventions provided? Why are you performing those long arc quads? And why is your client on that respirator? How does this translate into function? Actually, there's a few more questions. Do you collect assessment data, but struggle with establishing functional goals? So ask yourself, so what? Why does your client need to accomplish that goal? Another thing to ask are you prepare your clients for the skills required of them in the discharge environment? How will the activities you're performing in the rehab gym translate to the activity they perform in their everyday life? And then the last one's a little cheesy I admit, but has the FUN been loft from functional?

Why are your clients going to be compliant with their plan of care if it's simply not fun for them? So what does functionally based treatment look like? It uses everyday materials in situations that provide the clients opportunities to put therapy techniques into practice and fun and functional ways. Depending on your setting, it can really be used anywhere. It can be used in the therapy department, it can be used in a client's apartment. It can be used in an activities room if you're in longterm care. And again, of course, this is all pre-COVID. But functionally-based intervention can be made for just about any functional life activity. So I wanna give you an example of a company I used to work with. They had, they did great when it came to functional activities They put

together these things called functional kit cookbooks. And essentially, if you performed a functional activity with your client, you would write up the activity and then you would put them in a notebook, and then next time you were struggling with a functional activity, that you could go to that notebook and just grab one of these activities. And there was activities like gardening or pre-COVID planning grocery shopping trips, or preparing a meal, or even one of my favorites was planning and executing a gathering with friends. The therapist does have to make sure that their clients understand the purpose of the functional activities. So it's important to let our clients know upfront what they will be expected to observe the activities and analyze what they're accomplishing. Of course, all of these have to relate back to the goals and the skill that we're providing for our clients. After the conclusion of the functional activity, the therapist needs to ask all participants, what did we accomplish in therapy today?

And how could you use these skills after discharge? The therapist should take the activity and make it meaningful to the participants everyday activities, both as they function in the facility and as they function at home. We don't want our clients telling their doctors or their families that they just played balloon volleyball in therapy today. Simply implementing an activity like bingo or a balloon volleyball or making crafts in a functional setting, that's not skilled therapy. Components of functional skilled service include that we're addressing those goals during that functional activity, and again we're telling our participants what they're working on while we expect them to accomplish during the activity. Skill therapy means that modify or implement the session to restore, compensate, or adapt for functional deficit. And that we are giving skilled instruction as part of our therapy service delivery. You have to adapt your activities depending on your client. You might wanna consider adapting things listed on the slide. So some of these have to do with our clients, particularly with dementia, but you can of course expand it to other clients who don't have cognitive deficits. But you might wanna adapt the attention span. For instance, if you look at individuals in early stages of dementia, they can only attend for about 20 minutes. And then clients in the

middle stage about five to 10 minutes. In late stage, the client requires constant cues. So you might have to adapt how long your activities are, what kind of cues you're giving them, the environmental scanning. Middle-stage dementia can only see 14 inches in front of them. So when you enter the room of someone living with late-stage dementia, they can't see you at the door when you try to engage with them or ask them to come to an activity. YOu might adapt the purpose or goal of the activity. Communication. So the resident may only be able to speak with short phrases or few words. Physical attributes. What is their fine motor coordination or their gross motor coordination look like when may have to change the activity according to what those skills are? Other problem-solving abilities. Also we might wanna take into account social factors. Some people hate being around large groups of people, and some people love, being the Belle of the ball and around a lot of people doing activities together. We wanna consider adapting, considering the client's ability to initiate tasks, their ability to choose if they can follow directions and what kind of directions can they follow? Is it just simple directions, multi-step directions, et cetera. Response time. So how long does it take the client to respond?

We might have to change our activity up if they don't respond immediately. The point in knowing these considerations is that as we're designing activities or interventions for our clients, we have to design based on that individual. We can't expect them to accommodate to our activity. We have to accommodate our activity to those clients. And this is client-centered care. What makes our intervention successful? Our interventions and activities are successful when we look at cognitive function, when we really try to understand the client, what do they like to do in their past habits and interests? We can use some of those tools we just talked about. And then of course we choose activities based on those interests. We adapt the activity to match physical cognitive abilities. And then we look at the intervention or the activity, and we assess whether or not it worked with our client. So if the activity went well and the client enjoyed it, then we're gonna continue on that path. If it didn't go well, we go back to

the beginning. We see how the intervention could be adapted, or we choose an intervention that might be more fun or successful for the client. The most important thing to remember is that it's really not up to us to judge whether a client will enjoy an intervention or activity. We should always give that client an opportunity to succeed in an activity and to engage in it. And then if they aren't successful, then we can adapt the activity. Now this study's from 1995, I know it's a bit old, but I think it's still relevant to the discussion here today. Back in 1995, the literature showed that residents were inactive most of the day. And this is a longterm care. The nurse-patient verbal interaction was very limited duration and largely focused on physical care needs.

They found that TV in the day room was a popular activity and while it offers stimulation to some, it fostered no engagement in the environment or social connection with other people. Now what this author focused on was the nursing staff to incorporate meaningful activity and socialization into their day-to-day activities. And the involvement vary quite a bit, depending on whether or not the nurse thought it was part of his or her role. However when they did, they discovered a, and this is from the article, quote unquote, hope fostering environment where meaningful and empathetic relationships involve active listening and affirmation of the person's dignity and self-worth despite functional limitations.

So you can imagine the effect this may have on a person living with and trying to heal a wound. So let's go back to how this relates to wound care. Now this is a study that was produced about a program called the Lindsay Leg Club model of care. In this sample they had 67 participants with venous leg ulcers referred for care to a community nursing organization in Australia. I wish we had something like this in the United States. Other participants were randomized to either the Lindsay Leg Club model of care, and this emphasize socialization and peer support or the traditional community nursing model which just consisted of individual home visits by a registered nurse. So a little bit more on the Lindsay Leg Model. By providing nursing care in a

nonmedical social environment and again pre COVID, the model had several benefits. It removed the stigma associated with leg ulcers and helped isolated older adults reintegrate into their communities, which in turn had a positive impact on healing recurrence rates. And an atmosphere of destigmatization, empathy and peer support, positive health benefit, promoted, and patients took ownership of their treatment through these clubs. So back to the study. Participants in both groups were treated by a core team of nurses using identical protocols based on a short stretch compress- I'm sorry, I can't say that. Short stretch compression bandage treatment. And then data was collected at 1224 weeks from when the study started. And they found that participants who received care under that Leg Club Model demonstrated improvement outcomes in quality of life, morale, self-esteem, healing, pain and functional ability. So let's look a little bit more into the standardized test we can use to identify our clients who are at risk for skin breakdown.

And of course if we can prevent that skin breakdown from happening in the first place, then that is advocacy for your clients, and that is client-centered care, and it can help make their treatment sessions and their time in your facility a lot more successful. So this is probably a review for most of you today. We use standardized test to look at a client's baseline, track a client's progress to determine the effectiveness of the plan of care, inform clients of their progress in a quantifiable manner, so we can actually give them numbers. We also use them to inform clients of payer progress, to enhance reimbursement, and then we provide data collected over time to improve care. So standardized tests are necessary that no matter where you practice, to record that objective data and then track it uniformly. Now in most settings, in longterm care, those nurses are responsible for the initial assessment of risk for skin breakdown, and then the assessments that follow. So the next slides are gonna show samples of some standardized risk for skin breakdown assessment. And then we're gonna talk about how rehab can use this information and these tools to develop an intervention and plan of care. I hear a therapist give reasons for not using standardized tests all the time. So

frequently I hear people say that they don't use them because it takes too long to complete them for their clients. Or it takes you time for too long for themselves as clinicians to analyze the data and complete the data. I also hear clinicians say that they had difficulty completing them with their clients. So I do sympathize with this reasoning, but these aren't acceptable reasons not to use standardized measurements in our documentation. In addition, performance-based measures relevant for clients may not be part of a repertoire easy to find. Assessments that are familiar, easy, administered, readily available in the clinic, easily scored and time efficient are reported to use more often. So I want to include some of the information on some of these tests so you can, if they're not being performed, you can use these to predict the risk of skin breakdown in your community. The skin assessment tool needs to always be part of the screening process. Standardized tests of course give us valuable information. But how we actually use these tests is equally as valuable.

So first let's look at the Braden scale. My guess is that if you work with wounds, you know about the scale. It's one of the most commonly used scales out there. It was developed to help health professionals assess a client's risk of developing pressure injuries. And it's made up of six subscales. So it's looking at sensory perception, moisture activity, mobility, friction and shear. So here's those, I'm sorry let me tie this into a case where to, to kinda bring this together for you.

So let's say you have a client Mrs. Jones, and she scored a 13 on the Braden scale. What puts her at a moderate risk for skin breakdown? Now nursing completed that Braden scale, but how does this translate to therapy? So again, the six areas that the Braden scale look at. Our sensory perception, moisture activity, nutrition, friction and shear. Technically we can address functional issues with all six areas. But there's three that rehab can address with skilled intervention. So mobility number one, we can address this regardless of the dependence level of the client. This is something that we're really good at a therapist. We have a lot of tools in our tool belt to address

mobility. Nutrition. So dietary can have them on the best nutritional diet, but if they don't eat, they're not going to get the nutrition they need. So speech therapists are definite part of the wound care team. So if we are a PT working with Mrs. Jones, and she's not getting adequate calories and nutrition, because they had the space dysphasia or difficulty communicating their wants and needs, then we would be responsible for referring an SLP to screen with the individual. We're not gonna get very far if we don't get this client's nutrition under control. The next area is friction and shear. We can provide educational on proper transfer techniques with our caregivers as well as improved mobility. We may educate caregivers and nursing staff about how to identify key factors for pressure injuries. We can ensure that support services provide for that individual's particular needs. We can help educate, help provide a pressure redistribution, shear reduction and micro-climate control, or we can utilize positioning devices in wheelchairs or chairs reduce shearing. And of course we are educating the staff all along the way. So you can see on the slide that each category is rated on a scale of one to 10. This combines for a total of 23 points with a higher score, meaning a lower risk of developing pressure injuries and vice versa.

So why don't you give you an example of the Braden scale so you can see what it actually looks like if you're not actually using it in your facility. So this gives you all six of those those different areas that they're looking at so the sensory perception is really measuring a client's ability to detect and respond to discomfort or pain that's related to pressure on body parts. It's also the ability to sense pain. And then the level of consciousness of the client and their ability to cognitively react to pressure-related discomfort. Moisture is looking at the continuous skin moisture, which we all know can pose a risk to the integrity of the skin. And it's assessing the degree of moisture that the skin is exposed to. Or the activity of looking at the client's level of physical activity since very little or no activity can encourage atrophy and breakdown of our skin tissue. Mobility, we're looking at how the client adjusts their body independently, how they move in space, their willingness to move. Nutrition, we already talked about this. We're

looking at nutritional status. We're looking at whether or not they're eating. And then friction and shear is looking at the amount of assistance a client needs to move and the degree of flighting on beds or chairs that they experienced. So multiple studies have demonstrated the validity and reliability of the Braden scale. However, the accuracy of the risk assessment is dependent upon an understanding of the multiple risk factors contributing to pressure injuries, particularly for residents with risk for lower extremity wounds. So one of the criticisms of this tool is that the Braden scale doesn't result in identification of increased risk to heels or lower extremities as a consequence of diabetes. And we all know that we see these wounds very frequently.

Now the Norton scale is another tool that we use, and it predicts the likelihood of developing pressure injury as well. Clients are rated from low risk to high risk using a scale of one to four, and they are looking at five criteria. Physical condition, mental condition, activity, mobility and incontinence. Based on those five areas, there's a lot that therapists can assist with for our clients living with wounds. If a client scores lower on mental cognition portion, we can have an SLP screen and evaluate for cognitive decline. If a client scores lower on activity, PT and OT can work on their ability to complete those functional daily activities.

If mobility is an issue, of course, PT has so many tools to address mobility. If incontinence is making the client more at risk for skin breakdown, then we as PTs can also help our clients gain control over their incontinence symptoms with a variety of interventions and education that we have in our tool belt. So those five subscale scores on the Norton scale are added together, and then a lower score indicates higher levels of risk for pressure injury development, and then a score of 14 or less indicates an at risk status. So here you can see an example of the Norton's scale. One of the things that you can't see on the slide, but I really like about this tool is that it takes into account some comorbidities that might make our clients more susceptible to wounds. So it does consider things like, does your client have diabetes? Do they have

hypertension? Are they on five plus medications? And if they are, then you actually add deductions to each of their scores based on these comorbidities. The final scale I wanna introduce you to is the Waterlow scale. It gives an estimated risk for the development of pressure injuries again in your client. And it's consisting of seven items. The build-in weight, height, visual assessment of the skin, sex, age, continence, mobility and appetite, as well as special risk factors. And this is divided into tissue malnutrition, neurological deficit, whether or not that client had major surgery or trauma medication. So I'm giving you examples of all these scales because they're all so different and they take into account different details. So for instance, this tool takes into account the weight, height, sex and age, major surgery trauma. When other tools have not necessarily considered these deficits. So there's additional points and special risk categories, tissue malnutrition, neurological deficit, major surgery or trauma. And then the potential scores rating from one to 64.

One thing I like about this tool is it's actually packaged as a laminated little card and the reverse side of the Waterlow score lists examples of preventative aid and interventions based on their score. So it's pretty handy. So before moving on from that, which of these tools is best to use? The Braden scale has the best validity and reliability across many studies in settings. But both Braden and Norton scales predict pressure injury development better than a nurse's clinical judgment while the Waterlow scale is highly sensitive, but not very specific in protecting pressure injury development. So what's important to note about these scales is that they are useful tools, but they have to be used in conjunction with your clinical judgment and assessment. So pressure injury risk assessment scales are used throughout different settings. And there's a large number of empirical studies about them. However there's a lot of debate about the usefulness of these risk scales in clinical practice. These risk scales are criticized for their poor psychometric properties. In contrast to these arguments, the latest international clinical practice guidelines provided by the National Pressure Ulcer Advisory Panel and the European Pressure Ulcer Advisory Panel, which

are the leading organizations in putting forth research in ways to identify and prevent pressure injury. But they state risk assessment scales are the foundation of risk assessment practice. So your community or facility will often have their preference about these tools. My own personal opinion is that it can never hurt to have a bit more data. These tests are easy to administer. And as a therapist, you can get some more information about deficits that therapy may be able to address to help prevent skin breakdown. So as an example, let's again use Mrs. Jones. This is an actual patient that some of the clinicians in my company were examining. She is a longterm care resident. She has a qualifying hospital stay. Prior to the hospital, she was maximal assist for all aspects of care. She did not ambulate, she was wheelchair dependent.

She returned to the community and the Braden scale puts the client at a high risk for skin breakdown. Therapy does and multidisciplinary screen and determined she is at her baseline and no services are indicated. So I was called in and we talk through this case and through talking through this case, we really began to think through whether or not there was really nothing therapy could do for this client to improve her quality of life and prevent skin breakdown. What were we thinking in using clients in her care as a guiding principle when deciding the appropriateness of our client.

So when we look closer at this client, we found a lot of deficits that Mrs. Jones could address in rehab. So here's some of the things we reconsidered and eventually built into Mrs. Jones plan of care. We addressed range of motion limitations and her upper and lower extremities. We looked at her sitting balance and sitting tolerance, and we know that that plays a lot into the development of pressure injuries. We addressed transfer status currently, and we looked at the safety of how she transferred. We looked at her positioning schedule and we did some client education and staff education around that. What we looked at her actual DME. What was she sitting in when out of bed? We looked at her diet, was it appropriate? What percent of the meal was being consumed? And then we refer to SLP to do a screen. And then we also looked at the

client's goals. We talked to Mrs. Jones. What kind of activities does she like? What does she wanna get back to? what are activities that are most meaningful to her? So we're gonna move into client-centered approach to wound management. Now this scenario is probably familiar to some of you on this webinar today. If you work in longterm care, nursing has assessed the client and decided on their care plans. Rehab screen and evaluate this client and treatment planning goals have been established. The MDS complete if you're working in SNF and everyone knows their role in a multidisciplinary team. But, what are the client's goals? Is closure of the wound one of them? Is your team hyper focused on closing that wound? Have we asked the client what they would like to get other therapy? Have we achieved that closure of the wound? And if we have, are we asking ourselves as clinicians, so what? Functionally, what does that mean for the client and is it meaningful if a client's wound has closed but they still can't participate in daily activities that improve their quality of life?

Did we provide a client-centered care? In the client care population that I work with and often, across the board in different settings, therapists need to focus on small steps that can prove function versus big functional gains that at the onset of therapy are not always achievable. So I see therapists write goals all the time for really big aspirational goals. So as an example, perhaps I write a goal for my dependent client to ambulate household distances with contact guard assist Perhaps then I start getting frustrated because my client's not achieving this goal. Too often our goals are set that are not attainable. And the client is discharged due to no progress being made. Many times the goals we set are too lofty, or we're not looking at individual subcomponents of each goal and writing more manageable smaller goals. So for example, instead of ambulation goal, maybe it could be written as a standing tolerance or weight shifting goal. A better approach would be to start with the client. What's important to the client? What would improve quality of life and be meaningful to the client? Now as we've already mentioned, activities critical to reducing the chance of skin breakdown and improving mental wellbeing, is not the intensity frequency or duration of the activity

that's important but instead, it's the volume and diversity. Individuals don't typically care, whether the activity is undertaken as a part or whole, or as a sport or an exercise or a household tour or leisure activity. What individuals care about is that they are engaged in something meaningful, purposeful and useful. Let's walk through another example. This is Mrs. Smith. She's 80-years-old. She has stage four pressure injury that's been present for six months. She sees the nurse practitioner wound nurse weekly and she's making slow progress with the standard of care. She spends most of the time in her room including her meals, and she spends a lot of time in bed for pressure reduction. Often this is what we see when we first screen or access a client. We see Mrs. Smith deficits, but what's meaningful to Mrs. Smith? What are her favorite daily activities before developing the pressure injury?

So let's continue with her case. We have a PT, address, improving range of motion and nursing education for positioning. She, Mrs. Smith has met her established goal to increase range of motion by 20 degrees in bilateral hips and knees. She met this goal for nursing to demonstrate proper positioning and transfer techniques with a hundred percent consistency. So what have we improved for this client? Sure she's made progress, but how does this translate to her everyday life? How is this going to translate to her post-discharge environment? As a clinician, you dig deeper. You discover some important facts from Mrs. Smith history.

She loves music. She was active in social clubs in her community. Why is this important? Why does therapy need to know? A lot of times we think, "Isn't this more of an activity thing?" So think back to the goals, to the achieved goals and then ask yourself so what? What does that mean for the client? Does this improve range of motion to allow Mrs. Smith to participate in activity, or social club in her community, or return to being able to sit up right and play the piano? Have you improved function? Have you improved quality of life or Mrs. Smith? So an example of a functional goal for Mrs. Smith might include client will tolerate sitting in a wheelchair with good

positioning with appropriate pressure relief cushion for one hour increments to allow her to attend one daily activity in the community, including weekly entertainment. So is this functional? Yes. Is it a quality of life improvement? Yes, Mrs. Smith can go to all the activities she loves. She can go to bingo, she can participate in the community socials, et cetera. The best way to turn an impairment-based goal into a functional goal, is to ask that question that we've asked frequently on this webinar today. So what? The wound is closed, so what? Maybe now that the wound is closed, the client can eat one meal a day in the dining room, decreasing social isolation. Or maybe now that the wound is closed, Mrs. Smith would be able to sit in a wheelchair with pressure relief cushion and good positioning for one hour intervals to allow her to attend a daily church services that's meaningful to her. So some more examples. Mrs. Smith's sitting tolerance has increased to three hour increments. So, so what? Now Mrs. Smith can attend the next outing to see a play with friends that are meaningful to her. So this method can be applied to all aspects of therapy intervention to ensure improved function and overall improved quality of life.

So one more example. In one week, this is your goal. The client will sit in a chair two hours a day, utilizing solid back insert and knee abductor wedge for extensor tone inhibition and prevention of skin breakdown in order to attend daily activities programming. I wanna go through this case study of one of the clients in our building. This client was admitted into our community in October. The client was a 54-year-old male admitted following an ex-- I cannot say this word, an exostectomy of the right foot with external fixator applied. And he has a very complicated medical history. You can see it here on the slide. I'll just give you the highlights. He is obese, he has hypertension. He has syncope and collapse, Type 2 diabetes, diabetic kidney complications, end-stage renal disease. He has acute osteomyelitis on the right foot and ankle. So he's got a lot going on, right? He has an open wound on his right foot. He has a Wegener's granulomatosis with renal involvement, muscle weakness, difficulty walking. Now, his prior level of function. He lived alone. He was independent

for all aspects of ADL's. He was independent with transfers and ambulation, including within the community without an assistive device. So part of our clinical reasoning we go through when we think about what is favorable for this client? What is gonna help this client achieve good outcomes? We know his age, he's only 54-years-old. His prior level of function, he was independent. He was living by himself, he was transferring, completing ADL's, ambulating within the community by himself. He's also motivated, and that is not necessarily captured in the objective data, but he's motivated. He wants to return home and live as independently as possible. So now on the flip side, what's working against this client? So he has a significant medical history. He's got a lot of comorbidities. Many of these are the same co-morbidities we see in our clients. He's got a wound on his right foot. He has that granulomatosis with renal involvement, muscle weakness, difficulty walking.

He has acute osteomyelitis with discussion of amputation. He is significantly deconditioned after a long hospitalization. And now he has syncope during our sessions when we're attempting to stand with the client. So let's give you a little bit more information. Currently his functional status, he has a CROW boot, and he can perform static standing balance with upper extremity support at a fair and dynamic standing balance with upper extremity support at a fair minus, His transfers contact guard assist, however upon standing he has his episodes of syncope. With gait, he's ambulating with a wheeled walker for 60 feet with contact guard assist with decreased accuracy of movement and significant compensatory movement.

So what was the focus of the intervention? The standard of care was met and the client being treated with modalities to promote wound healing. He was being seen for strengthening and bilateral lower extremity, transfer training, balance activities, gait training, safety instruction. They performed functional activities with him to simulate activities that he would be returning after discharge. And they were working on things like ambulation, descending, ascending curbs, transfers, grooming, et cetera. So in two

months, the client was discharged to home. The infection in his right foot was resolved and the wound with closed. He was able to independently transfer and ambulate without an assistive device for greater than 350 feet. His balance was much better, he was using supervision for gait on stairs. He walked out the door to return home and he was able to return to meaningful daily activities with a little support from his family and friends. So the point of this case study, what if we felt his medical condition was too complex? What if when we had one syncope episode in therapy, we discharged him until his medical condition improved? What if we discharged him from rehab until the infection in his foot and ankle was resolved? Imagine what that would have felt like to this client or his family? What toll would this have taken on his physical or mental health? He would not have accomplished all that he did in therapy. He may never have returned to his prior level or gone home relatively independently.

So Let's take that a little further. Let's consider the alternative if we had not created an appropriate plan of care that took into account while with meaningful for this client. He was at risk for depression and lack of initiative to improve. He might have demonstrated limited improvement in function, which could lead to the slowing of the wound healing in that right foot. Perhaps he saw a significant decrease in his quality of life. So does this sound familiar to some of the clients that you encounter everyday? Again, I'm in longterm care.

So unfortunately I see this happen all the time. So this ties into the importance of staff education for the client and the staff in our building. We've seen considerable development in wound healing over the last few decades. We're seeing techniques like bioengineered skin, topical negative pressure, hyperbaric oxygen, et cetera. And these interventions have advanced our treatment of wound care, but even the most cutting edge product and technique requires proper wound care and wound bed preparation in order for these tools to function optimally. Research out there demonstrates that the organization and knowledge of a team, not the sophisticated products, increases the

healing of the problem wounds. Problems arise when a technique or product used by clinicians, not specifically educated in wound care, if no treatment plan and education's performed, treatment efficacy and cost effectiveness of the intervention decrease dramatically. And we've seen a lot of research that supports that. So systematic approach to staff training can result in positive outcomes for you, your staff, your clinic and most importantly, your clients. Your staff should be knowledgeable regarding basic general care, as well as assessment treatment and documentation specific to wound management. In an ideal world, this includes all staff in your facility, not just therapists and nursing. To truly make the approach to wound care multidisciplinary, a wide variety of staff in your community should be knowledgeable about these basic topics. So a lot of research and information about proper wound care techniques, but being rich in wound care information and pouring competent staff to provide it is a bad combination. I wanted to just give you some tips on how to engage staff in the education, and this education makes us all better clinicians.

So first she wants to constantly reinforce basic of proper wound care with both new and seasoned staff. There's basic principles that we as clinicians often forget to practice. We still could use practice in educating our staff on topics like proper gloving technique, although that has improved a lot during COVID. Also give your clinicians information regarding the financial impact of wound care. Sometimes they just don't know. Other basic information you can continually share with your clinicians is information about the role of the multidisciplinary team, as well as wound documentation. We wanna make it easy for staff in your facility or building to get with your education and training. Especially now, there is so much information available online. Also our vendors are usually willing to provide education to our team. So we can encourage in-services. Right now, we do a lot of in-services virtually, that allow our staff to experience the wound care products that are gonna be using. A lot of times we would have, we would have educational sessions where they could touch and feel the products. A lot of this right now is that virtually, but it's still a valuable tool. I'm gonna

give you an example of this in just a few slides. Any time spent with staff to educate such as monthly meetings or educational handouts on payday or brief lunch and learn type programs that address a single topic during lunch breaks is well-spent. Mentoring is a invaluable method for keeping wound caregivers engaged. Nurses can be great teachers by bringing them into the fold and training them.

As an example, if you provide education to a CNA, it can be so valuable because the CNA starts to feel like they're part of the wound care team. And of course they are part of that multidisciplinary team. I encourage that multidisciplinary approach, but it's important to appoint a leader. It's important that we aren't just talking about this multidisciplinary approach, but there's really no one leading that wound care team. And it makes sure your community is using the right wound care products. You wanna avoid playing wound care product roulette. Find what really works for your client population, and then stick with those products. Our vendors play a big role in helping with our product selection. So when I am educating people or even really just having conversations in communities, I like to try to remember the principles of adult learners. This was identified by Malcolm Knowles.

And what he says is that adult learners are internally motivated and self-directed, and they bring life experiences and knowledge to learning. Adult learners are also goal and relevancy-oriented as well as practical and they like to be respected. Because our adult learners meaning the staff that we work with everyday, bring a variety of life experiences and knowledge to learning, it's beneficial when we can provide an opportunity to use that existing foundation of knowledge and then apply it to their wound care learning experiences. I'm gonna give you some examples. Education should be made fun. My approach to longterm care especially education is that it has to be engaging, it has to leave a lasting impression so that the people I'm teaching will learn. So as an example, a crossword puzzle was created by a therapist in one of my buildings. I believe this was in Missouri. And this therapist put the information section

in the crossword puzzle in the staff break room, so they could work on it at their convenience during the day. And then they completed puzzles, they completed the crossword puzzled about wound care and they entered a drawing for prizes if that crossword puzzle was complete. So that's just one idea of a fun way to engage clients in a pressure injury, crossword puzzle fun learning for wound care. So this is a game that I play often in my buildings when I am teaching clients about pressure injuries. So it was pretty easy for you to recreate this. You take six apples and you create different stages of pressure injuries. So for instance stage one would be a red apple. Stage two there would be a spot with, or on the apple peel. All the way to stage four, which is an apple with the core visible, and then you can even create an unstageable wound on this apple by covering it in caramel. And so typically you have, when I play this, you have one minute to read through the different stages of pressure injury.

And then they have to place cards, stating which stage that apple is in front of the apple. And they have, you can make it fun by, giving them oven mitts or tongs, and if they drop the apple, they have to start over, et cetera. So you can make learning fun. Another great tool that I've seen used in a couple of my buildings, is, this takes place in November, it is a Pressure Injury Prevention Day. And it focuses on prevention and treatment of pressure injuries and skin tears, along with the importance of nutrition and accurate wound documentation. So at this fair, there's different learning stations. There's a barrier cream station where you learned the indications for usage of the different types specific to that facility application of barrier creams. A documentation where you go through correct and incorrect types of documentation for your EMR's. There's a nutrition and supplementation station. I love the station is really fun. Typically a registered dietician shows it provides taste tests and nutritional supplements and indications for each of these supplements for our clients. There's a shear station where they discuss friction versus shear and it's causes the skin tear station. So this World Wide Pressure Injury Prevention Day focused on a healthy theme. And they did the same apple activity that I just went through. I believe they might've used pears instead

of apples. Skin tears were demonstrated using the fragile skin of a plum. Embrace a longterm care that's somewhat comparable to many of our older adult clients' skin. And then the multidisciplinary team was really important because they each assigned, they were each assigned a station, so they had to present to their peers and everybody had to contribute. So nurse managers contributed healthy snacks, therapists, providers, MDS nurses, everyone Attended and overall people reported that they learned a lot and they really had fun with this hands-on learning opportunity. I believe this is my last example of how we can perform staff education for our clients. In this particular building, a clinician form a team to help organize this carnival.

They brought together nursing staff, nursing assistants, therapist, everybody discussed the hot topics and then they kinda divvied up who would be in charge of what booth. So we had Penny the Pear, again, it's our activity where we stage the pressure injury with a piece of fruit, we've gone through that several times. Station two was Rumple Wrinkled Skin. And in this you demonstrated friction and shear. You used the sheet of tissue paper and you would have the staff participants rub at the piece of tissue paper while leaning against the wall, pushing back and forth and the tissue paper crinkled. And then you would discuss how to prevent this from happening and introduce the appropriate use of offloading devices or positioning.

There was Gabby Grapefruit, where you can cut a grapefruit in half and you demonstrate wound measuring and application of negative pressure wound therapy if that's in your facility. There's Willy Watermelon where wound assessments can be done on a watermelon and those seeds are the necrotic tissue. And then you actually just take your finger, you dig tunnels through that watermelon and you can measure the tunnels. And section five should five with Betty Boop Barrier. They used a punch bowl and added red food coloring and then you apply a thin layer of barrier cream to the top of your hands. And you soaked your hands for two minutes, and then this shows the importance of using moisture barriers for incontinence care. A couple more examples

from this carnival. Pablo Pressure, you had staff sit on a pillow with a firm ball underneath. You told them to freeze, they couldn't change or shift their positions for 10 minutes. So they felt what that pressure felt like. And then Peter Plum, we already discussed this one. That you put tape on an over-ripe plum, and then you pull that tape off and it demonstrated how easily a skin tear can occur. Especially if you're working with older adults. Throughout this whole wound care carnival, they had fun music playing. I believe they gave out popcorn, they had games like wound care hopscotch, treasure hunt wound bingo, and they rewarded their employees with prizes. So the take home point of those previous slides is that there's several ways to make education successful. Now we are lucky because the leadership team really values education and puts a huge emphasis on the importance of prevention of wounds. But the keys to our success have been support from management, consistency so we educate our staff about wound care very frequently.

Follow-up. So anything we identify with our staff as an issue or a barrier or even something that works well, we follow up at regular intervals. We've talked about that multidisciplinary teamwork. That's really important as well as the ongoing wound education at regular intervals. Making learning about wound care fun does generate better results. The information tends to stick with you better. And we do know that in any healthcare setting across the board, the education has to be ongoing if we wanna see real impact and real change in our staff, which of course ultimately translates into better interactions with our clients and better quality of life. So let's pull it all together. The million dollar question, what does our staff need to be educated about? As always, it depends on specific wound care program in your facility or clinic, but you wanna be knowledgeable regarding basic general care, as well as the role of the multidisciplinary team. Documentation reimbursement is always a hot topic. Prevention, assessment and treatment specific to wound management. And I would take it even further, that treatment needs to be functionally-based for that individual client. Let's run through a case study. And this is Mrs. Smith. She was admitted to a skilled nursing facility in

January. She's 74-years-old and she had a fall and she also has diabetic ulcer on her right foot. She does have a medical history. She is obese, she has polyneuropathy, hypertension syncope and collapse, and she has Type 2 diabetes. When we examined Mrs. Smith, we found that she had an open wound on her right foot. She also had muscle weakness, balance deficit, difficulty walking. In her prior functional level, she lived in a private residence residence alone. She was independent for all aspects of ADL's, transfers and ambulation, including within the community and without an assistive device. She was a master gardener and she cared for foster dogs on the weekend. So remember what I just said because in just a few slides, we are going to work through the education that we would provide.

So she was admitted, we already said that, in January. She, While she was in the skilled nursing facility the standard of care with met. And she was being treated with debridement offloading with contact casting. She was also being seen for strengthening of bilateral lower extremities, transfer training using rolling Walker, balance activities, gait training and safety instructions. We were performing functional activities to stimulate activities that would be performed upon returning home. We were working on things like ambulation and activities of daily living. But we were also working on things such as gardening and walking her dog since those were activities that were meaningful to her. Alright, so this is our next poll question. We're gonna work through this together.

I want to know, quickly just type up, what of staff education would you, would you want the staff in your community to have for Mrs. Smith? And who do you think needs to receive this education? So go ahead and type in some results, oh I'm sorry, the answers to that question. I'm gonna give you about 30 more seconds to type up some answers here. Alright, 10 more seconds. I'm reading through your answers right now. Okay. So I'm summarizing these for you. So what a lot of you said some of the themes that I saw, what type of staff education should occur for Mrs. Smith? A lot of people

said documentation, and that is absolutely right. How do we assess that wound correctly? What are some of the appropriate wound products, wound precautions? What about weight bearing status? How do we prevent pressure injury because now we know Mrs. Smith's activity has decreased from where she used to be. Importance of functional activity. Nutrition, shear and friction with transfers, proper technique for transfers. These are all really important things that we would educate our staff on. And who should receive this education? Of course you all were, you all nailed this. Patients, families, caregivers, that multidisciplinary team, CNA's, nursing staff, et cetera. So yes, all of these people would be included in the staff education. Alright I'm going to end this poll. Alright, and I have one more question for you. So now this Ms. Smith, and this is her right before discharge. You can see that the wound has improved a lot. What kind of ongoing education should be occurring as Mrs. Smith continues to progress? So go ahead and type it in the chat box for me. I'm gonna give you 30 more seconds. You guys are giving me some really great answers.

Okay, alright some of the themes that I'm seeing as you give these answers, again, ongoing education for documentation. Yes, we can never have enough education on documentation, especially because it changes so frequently. Appropriate footwear for this client. Appropriate assistive devices. Functional activity training. What's appropriate in terms of functional activities? Appropriate nutrition for her to prevent this from happening. And that was another big theme, prevention in general. How do we prevent Mrs. Smith from having this wound reoccur? How do we move forward with Mrs. Smith? So you guys gave some great answers. I'm going to go ahead and close this poll. Thank you so much for your input. I feel like you guys have it. You guys have the hang of it. So that brings us to wrapping up. And I feel good because I feel like we've learned a lot today. We do know that the numbers are expected to rise substantially in the coming years due to all the things we said at the beginning of this presentation. There is growing obesity and diabetes epidemics. People are living longer, they're staying in the hospital after surgeries for a lot less time. So we're gonna

be seeing a lot of clients living with wounds. The main factors involved in optimizing wound treatment are that multidisciplinary team and how we collaborate as a team. Evidence-based treatment processes. And part of this evidence-based treatment process is it's functionally-based intervention, as well as education and training of healthcare personnel and clients. We have a lot of research and information about wound care techniques, but I've already said this. If you are rich and wound care information and poor competent staff to provide it, that's not a great combination for your client or your community. Also engaging staff in ongoing wound care education makes us all better clinicians and allows us all to provide evidence-based client-centered care for clients living with wounds.

So my takeaway for you today is this quote, "A pessimist sees the difficulty in every opportunity. "An optimist sees opportunity in every difficulty." So let's be optimist and provide our clients with the best opportunity to improve quality of life. Let's do this by being advocates for our clients, providing holistic care that takes into account our client's preferences and meaning daily experiences of our clients. If we do this and provide client-centered care, then we're going to see better outcomes with our clients and improve their quality of life. So that concludes the content of the information today. I do wanna save time for questions.

So at this time if you have a question, go ahead and type it in the Q and A box. So I had a question that said foot ulcer evaluation tools. And I did provide a slide about some potential foot ulcer evaluation tools near the beginning of the webinar. I'm trying to go to that slide for you. Here it is, the, there's diabetic foot ulcer health-related quality of life assessments. And if you go to this slide, it was my slide 16, but I think that that's not exactly the same numbers as you. But on this slide it gives you several different free diabetic foot ulcers tools that you can use. The ones that I really like to use are that diabetic foot ulcer scale. I also use the Neuro Quality of Life tool as well. Okay I see the question. I see the question, got it. So the question is the following, and

this is number seven on the posttest. The following is an instrument used to evaluate health related quality of life for clients with diabetic foot ulcers. A Neuro Quality of Life, B ABC scale, C Elderly Mobility Scale, or D all of the above. So if you look at that question and then you go to a slide entitled Health-related Quality Assessment Diabetic Foot Ulcers, the correct question is the Neuro Quality of Life. So that would be A . Any other questions? Okay, if we don't have any other questions, then that's all the information I have for you. Thank you so much for allowing me to come today and talk about one of my very favorite topics, which is Advocacy for Clients Living with Wounds. And I will conclude the webinar at this point.