“From the Kitchen to the Courtroom: Wounds, and the Standard of Care”

Webinar Questions Answered by Nancy Collins, PhD, RDN, LD, NWCC, FAND

- I have been told by wound care RNs that deep tissue pressure injuries are essentially just bruises and don't require the same care as stage 1-4 injuries + unstageable pressure ulcers. What are your thoughts?

A deep tissue injury is much more than a bruise. It is a form of pressure-induced damage to underlying tissues, including muscles, bones, and subcutaneous layers, while the skin surface might remain intact. It typically results from sustained pressure or shear forces that compromise blood flow, leading to ischemia and subsequent tissue necrosis. Recognizing a suspected deep tissue injury is crucial for timely intervention to prevent progression to more severe wounds and this includes optimizing the patient’s nutritional status. Compared to superficial wounds such as abrasions or stage 1 pressure ulcers, deep tissue injuries affect more profound layers of tissue and are more challenging to detect and treat. While superficial wounds involve only the epidermis and sometimes the dermis, DTIs involve deeper subcutaneous tissues and potentially muscles and bones. Unlike other pressure ulcers that appear with open areas to the skin, deep tissue injuries may initially show no breaks in the skin, making early identification more challenging. The progression and potential complications of DTIs are also more severe than those of superficial wounds, necessitating a more aggressive and comprehensive management approach. I would use the same protein and calorie recommendations for these as I would for other pressure injuries.

- Do you have a specific practice guideline for CKD patients with acute wound care needs?

CKD in a patient with wounds is a topic that comes up very often because these are two problems with opposite plans of care. For CKD, we often restrict the amount of dietary protein in hopes of preserving renal functions while for wounds we increase the daily protein so the patient can build new tissue. Therefore, it is difficult to know exactly how much protein to recommend. This is a very complex medical predicament, so I wrote an entire article on it with information on how to approach this. You can access the full article here https://www.hmpgloballearningnetwork.com/site/wmp/nutrition-matters/wounds-versus-kidneys

- How do we go about ensuring cultural food preferences are met if our facility cannot provide other types of food? Sometimes patients will say they dislike all the food offered. Also, how do we ensure that feeding assistance is provided if nursing is supposed to provide it?

If you encounter a person with very specific cultural food preferences, I suggest you speak with the patient and family and try to come to some acceptable compromise. Perhaps the family can bring in specific meals a few times per week. In one of my facilities, we agreed to purchase a certain dish from a local restaurant twice weekly for the resident. If a patient simply dislikes all food be sure to document what you have offered, that you have provided education, and that you have done a root cause analysis to determine if there is some sort of underlying problem. I don’t think you can actually verify that every patient has been provided assistance at every meal but if short staffing is a problem and you suspect this is an issue, you should bring it up and figure out what you can do – for example, it is easier to provide assistance to multiple patients if they are in the dining room as opposed to being in their rooms. Round tables with the feeder in the center can often be a time saver, an all-hand-on-deck policy can sometimes be used, etc. The approach depends on what the issue is in your specific facility.

- Are there many lawsuits of this kind with the veteran population or the unhoused?

Someone needs to initiate the lawsuit and often it is family. So, if a veteran or an unhoused person is in a healthcare facility they can bring suit just like anyone else. I personally have never been involved in a suit involving an unhoused person but I have been with a several veterans.

- What do we look for on the label to know a product contains L-Citrulline?

Look for the word citrulline. Most products will include that on the packaging as a call out since it is likely their star ingredient.

- Any suggested brands you recommend for the prolyl-hydroxyproline or hydroxypropyl-Glycine?

These days there are plenty of products to choose from. I have used products from both Global Health Products and Medtrition.

- If a resident is under hospice care, are they held to the same standards of care regarding adding nutritional supplements for wound healing?

No, hospice patients would not get assertive nutrition care. That said, they need supportive care so that may include fluids, ice chips, favorite or comfort foods, skipping weighing them if it is painful or difficult or their wish. Hospice does not mean the discontinuation of all nutritional care but generally it does mean the end of higher-level interventions. Be sure to document weight loss may be expected and that you are supporting the patient.

- What if it's a case where the patient lost weight while being permissive underfed in the ICU per ASPEN guidelines?

If you document a clear plan with realistic goals, this is fine. ASPEN has this guideline because it serves a medic al purpose. If the purpose is well documented and makes medical sense for the entirety of the patient’s situation, there is no issue.

- Regarding documentation, sometimes the physician clearly states they want the patient to lose weight if morbidly obese, even while treating a wound. How do we address this discrepancy in care?

I am not sure this is a total discrepancy if the patient is losing at a slow steady rate and you are working to preserve their lean mass. That means adequate protein each meal and progressive resistance exercise if the patient can do it. Document that you are monitoring the wound healing progression and if you see the wound stall or even worsen, then you can assume that you are not meeting the needs for wound healing and I would then discuss those findings with the physician and determine what the next step is. Maybe at that point, you will need to concentrate on only the wound but if the weight loss is mainly adipose, then the wound might progress. This needs close monitoring and adjusting as you go along.

- Is it worth documenting if specific interventions (i.e., crackers for nausea, culturally preferred foods) are not available at the facility?

I would not document things that are unavailable. The problem with this is that it raises the question of whether this is an appropriate placement for the patient if you cannot meet his or her needs with the requested cultural foods.

- I had run into challenges where a patient continually has new problems at follow-up. For example, they don't like the taste of the food, so we change the food to fit their preferences, then they have GI issues, so we change the diet to address their GI issues and consult GI, then new problems emerge. After several unsuccessful interventions, many of these patients refuse EN. How should we document to protect our licenses?

As with any documentation, be clear and specific about your goals and plan. The goals should be realistic and in line with the patient's condition and wishes. Then you need a plan to reach these goals so document what you try and why it worked or why you felt you needed to change the plan and try a new approach. I am sure the patient is frustrated when each approach results in a new issue so you must reassure the patient and document that you provided education and understanding.

- Isn't it true that Hospice does not allow hydration through IV or tube feeding?

This is a more nuanced question than a simple true or false. First, it depends on the specific hospice company and their policies. If a patient is already getting these treatments and wants to be admitted to hospice care and continue them, often they will allow it. However, if someone is on hospice and wants to BEGIN a tube feeding, that is a different situation and most of the time, in my experience, they will not authorize that. IV fluids are a little simpler so that is done more often than initiating a tube-feeding but again, it depends on the hospice company and if they want to make exceptions.

- Can you comment on residents with wounds who don't like supplements and have a poor intake due to a mechanically altered diet that is unsafe with regular textures related to dysphagia?

My thought is that I can usually find something that they will like. Supplements come in so many flavors and forms these days that it often requires trialing many different things until we find the one thing they enjoy. I am now using high protein coffee, and it seems many of my folks will enjoy a cup of coffee. Or a bowl of soup. There are puddings, cookies, bars, ice creams, etc. Look at all the people on high protein diets now due to GLP1s. There is a whole industry catering to high protein foods and recipes these days. If I am totally stuck, I will use a liquid protein module because it is sometimes easier to get them to take one tablespoon twice daily like medication. As for being unsafe with regular foods, I would make sure your SLP is on board and has worked with the patient and see exactly what they might be able to tolerate with compensatory strategies such as proper positioning.

- What about MVI, zinc, vit C supplementation, etc?! Does documenting these recs/discussing with the provider help the case even if the patient declines or the patient may be on palliative/comfort, etc?

We only supplement these if we identify or suspect a deficiency. We do not routinely give every patient with a wound these vitamin and mineral supplements as we did years ago. Document why you believe the patient

needs these and what signs/symptoms of deficiency you are seeing. If the patient then declines them, document that as well. I am assuming the patient is cognitive enough to make his or her own medical decisions and knows what they are declining.

- What are your thoughts on using collagen dipeptides or high protein in patients with CKD and wounds?

This has been answered above.

- There is a significant amount of lack of documentation despite requests to staff and RN management. I have been documenting no intake for that shift - should I be doing that? It is very frustrating, especially for nutrition support or deciding on tube feeding. How should we proceed?

I can feel your frustration, and it sounds like this facility may have a systems problem. A lack of documentation makes it very hard to defend care and as you note, it makes it very difficult to decide on a plan of care. You are going to need to delve into this with the facility administration to figure out why this is happening and what you can do to maintain complete, timely and accurate records as required. I suspect it is lack of staffing and in almost every suit plaintiffs bring up lack of staffing as an issue.

- Our facility often makes inpatient hospice patients NPO. Do we need to document that nutrition support isn't warranted at the end of life?

Yes, you can document that the patient is at end of life and nutrition support would not be appropriate at this point and that weight loss is expected. That said, hospice does not necessarily mean NPO. Comfort foods, ice chips, etc are often used if the patient wants them.

- When you recommend zinc x 14 days, what is the time frame for re-adding the zinc x 14 days order?

You would need to use your clinical judgment and look for signs and symptoms of deficiencies and monitor the progress of the wound healing. If the wound improves with the addition of zinc, then perhaps you corrected a deficiency. If it does not, then maybe the zinc was not needed. Monitor the therapeutic response to the 2 weeks of zinc and then use your expertise to determine the next step in view of the total picture of weight, oral intake, other sources of zinc (ONS, multi vitamins) and goals.

- Do you recommend calculating calorie and protein needs for all hospitalized patients? It is hard to make sure they meet their needs when patients choose their menus as well.

This would depend on the policy at your facility. In a hospital, typical policy is that it is done only for patients at nutritional risk according to the nutritional screening. In long-term care, a complete assessment including needs is done for every admittance.

- Do you have thoughts on Juven vs Arginine?

These are two different things and not comparable. Juven is a supplement which contains 7 grams of arginine as one of its ingredients along with many other ingredients. Arginine is a single amino acid.

- What do you do for estimated needs for kcal and protein for obese patients with wounds?

I use my clinical judgement to make an adjustment to account for the metabolically inactive adipose tissue.

- What wound healing supplements would you recommend for patients who are eating poorly and have wounds with negative pressure treatment?

I always say the supplement I recommend is the one the patient will actually consume daily. A wound takes many weeks to heal so the supplement is going to have to be something the patient will stick with or even a variety of supplements. People get tired of the same thing every day long before their wound is fully healed. This is true for negative pressure treatments or not. The “eating poorly” issue is a different topic. Document a root cause analysis showing you tried to find out WSHY they are eating poorly and then have tailored the intervention to the specific issue.

- If you use citrulline, would you then not need to use a l-arginine-containing supplement? Or should you use both, assuming both are acceptable to the patient?

Citrulline produces arginine so you would not need to use both although we are seeing a new generation of products that do have both. The reason for this is that they have different metabolic pathways and the goal is a steady state of availability of arginine. It is very complex but there are many articles that look at the exact pathways if you are interested.