

Collaborative Wound Management with Home Health Nursing for AL Residents

PRESENTED BY **Summit Homecare & Hospice**

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1

Why this Matters

- ➡ Improve wound outcomes through **TEAMWORK**
- ➡ **COLLABORATION** between AL staff and Home Health matters to reduce hospitalizations
- ➡ Impact on resident safety, comfort, and independence
- ➡ This allows the resident to age in place

2

Who's involved in Wound Management?

AL caregivers
& Nurses

Resident's
Family

Therapy
(PT/OT/ST)

Home Health
Nurses

Providers

3

The Assisted Living Environment

- Time Constraints
- Staffing Structure
- Daily Resident Contact ➡ early detection
- AL Rules & Regulations



4

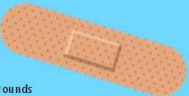
What Caregivers Can and Cannot Do

 CAN - Complete Skin Checks - Report concerns - Monitor Dressing Integrity - Complete Dressing Change	 CANNOT - Diagnose - Stage wounds - Perform Skilled Assessment
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5

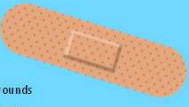
Wound Types Overview

Pressure injuries	Surgical wounds
Moisture Associated Skin Damage (MASD)	Stasis wounds
Traumatic wounds	Diabetic ulcers



6

Etiology: Why Wounds Happen



Pressure injuries Pressure to bony prominences MASD Prolonged moisture Traumatic wounds Friction/Shearing Falls	Surgical wounds Surgery Stasis wounds Poor circulation Diabetic ulcers Uncontrolled Blood sugar Neuropathy
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7

Red Flags Caregivers Must Report



- New redness
- Drainage
- Odor
- Increased pain
- Dressing saturation
- Temperature

! This is important to prevent hospitalizations, ensure proper treatment, and for patient comfort. !

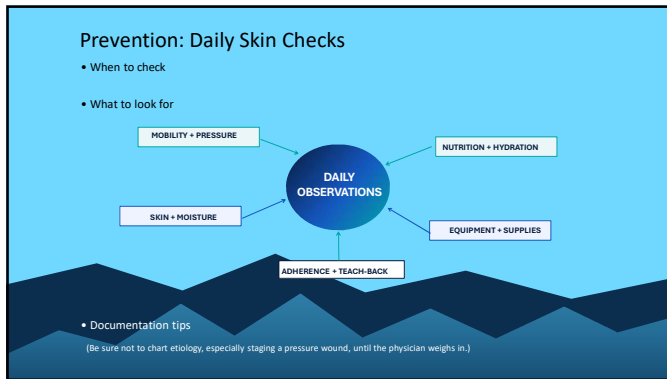
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Building a Culture of Prevention

Report early Small changes deserve attention.	Share responsibility Every team member has a role in prevention.
Communicate consistently Ask, share updates and follow through.	Protect dignity Protect comfort, safety and independence.
Recognize good care Celebrate early detection and teamwork.	Build daily habits Check skin, reposition and ask about pain.
Early ADL Intervention Report decline in mobility or functional changes	

Small, consistent actions build a culture of prevention.

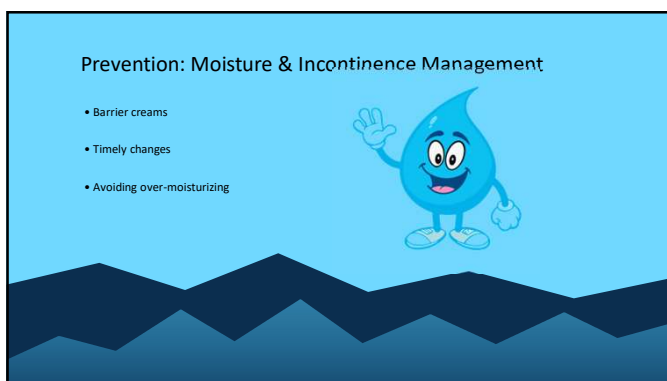
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10



11



12

Prevention: Nutrition & Hydration



- Ensure high protein in diet
- Hydration
- Appetite changes
- Monitor intake and if necessary, notify provider for consideration of nutritional supplement

13

Home Health's Role in Wound Care

- Assessment & staging with assistance of provider
- Coordinate with the provider on the most effective wound treatment
- Education for AL staff
- Bridge between the provider and wound care



14

Therapy's Role in Wound Care

- Offloading
- Strengthening
- Mobility training
- Wound dressing changes within scope



15

Provider Collaboration

- Provider writes orders for nursing to follow
- Follow-ups
- Medication management



16

Referral Process: When AL Should Call Home Health

To reduce delays in care:

- promptly report new wounds, worsening wounds, changes in condition, and dressing issues.
- Include all pertinent information up front when sending referrals to prevent delays.
- Referral to therapy with mobility decrease in effort to prevent skin breakdown



17

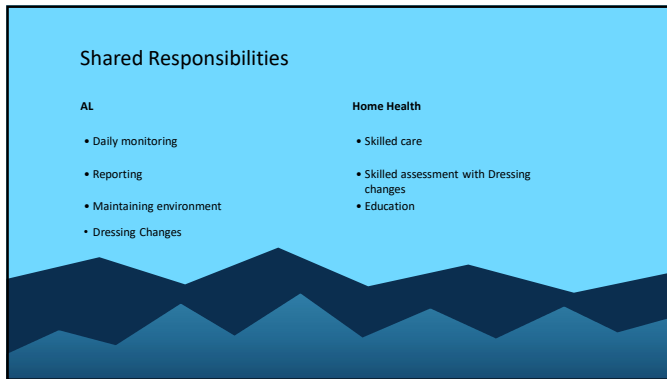
Coordinating Visits

Goal is to improve efficiency.

- Ensure access to the resident (residents may be at meals, activities, showers, or out with family).
- Ensure a private, appropriate space.
- Report dressing issues: dressings not staying in place, removal by the resident, or new wound changes. Small details could change the entire plan of care. Tell us what you have seen.
- Coordinate around facility routines, such as bingo – we all know they can't miss that!
- Communicate barriers: refusal of care, family requests, or supply shortages.



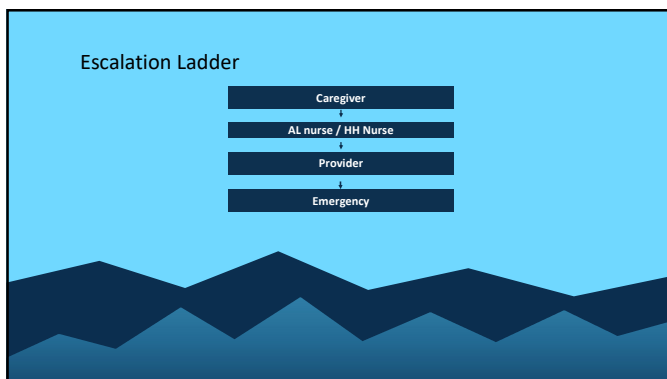
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19



20



21

Dressing Integrity: What AL Should Watch for

- Dressing saturation
- Lifting edges
- Odor
- Resident complaints

22

Supply Coordination

Home Health nurse
assesses the wound

→ Nurse contacts provider for
wound care orders

→ Nurse orders supplies

- Home Health nursing orders all supplies and communicates supply needs. Prescription items come from the pharmacy.

- Some supplies may NOT be covered by the patient's insurance plan. The resident is responsible for those items. For example, betadine is frequently not covered by certain insurances.

23

Case Study #1 – Early Detection SUCCESS

Resident background: Mrs. L is 84 years old with limited mobility, mild dementia, and occasional incontinence. She prefers sitting in a recliner for long periods, has a poor appetite, and has very thin, fragile skin.

During morning care, an AL caregiver notices a small area of redness on Mrs. L's sacrum while assisting with toileting. The caregiver remembers from training that non-blanchable redness is a red flag and immediately reports it to the AL nurse.

What should happen next?



24

Case Study #1 – Early Detection SUCCESS

You guessed it!

The AL nurse should perform a quick skin check to check for emergency needs, confirm the redness, and initiate a plan to prevent further skin breakdown.

What does that look like?

Repositioning schedule, moisture management plan, nutrition & hydration reminders, and protective barrier application.

Ideally, this will resolve the redness and prevent further breakdown.

25

Case Study #2: Delayed Reporting of Venous Disease Leads to Hospitalization

Resident background

Mrs. T, age 89

History: Chronic venous insufficiency, hypertension and arthritis.

Risks: Lower-leg edema, fragile skin, prolonged sitting and inconsistent elevation.

Caregivers notice mild swelling, redness and tightness. They assume it is her usual swelling and try elevation without notifying the AL nurse.

Over the next week, swelling and redness worsen. Shiny, warm skin weeps fluid. Ulcers form on both legs.

Outcome

Edema decreases within 1 week. Drainage and pain improve, and both ulcers begin closing. Wounds heal fully within 6–8 weeks. Mrs. T regains mobility confidence, and AL staff better understand venous disease warning signs.

Crisis and hospitalization

Caregivers continue elevation and non-skilled wraps without reporting worsening drainage, inflammation, pain, fatigue and mobility.

At crisis: Severe bilateral swelling, large ulcers, heavy serous drainage, redness up the calves and difficulty walking.

The AL nurse sends her to hospital for several days. Treatment addresses infection and edema with IV antibiotics, compression and pain management.

At discharge: Immediate Home Health referral.

Home Health intervention

The HH RN arrives within 48 hours and completes a full wound and vascular assessment.

Care: Venous ulcer dressings, provider-approved compression, edema management and daily elevation.

Caregiver education: Monitor drainage, maintain compression, recognize early venous changes and report any redness or swelling immediately.

Therapy: Mobility support, safe elevation techniques and strengthening to reduce sitting time.

Nutrition support helps improve healing.

Key Takeaways: Early signs were ignored, no report to AL nurse, attempted fix delayed treatment, HH referral only after hospitalization

26

Case Study # 3 – Complex Wound

Resident background

Ms. R, age 91

History: Advanced osteoarthritis, chronic venous insufficiency, CHF and limited mobility.

Risks: Edema, fragile skin, difficulty elevating her legs and long periods in a recliner.

During a morning shower, an AL caregiver notices a large, shallow open wound on her lower left leg.

Finding and referral

The wound is moist, red around the edges, weeping serous fluid, surrounded by significant edema and painful to touch.

The caregiver immediately reports it to the AL nurse.

The AL nurse performs a full skin check and documents the wound. The nurse suspects a venous stasis ulcer that could worsen rapidly without proper treatment and makes an urgent Home Health referral.

Home Health intervention

HH RN arrives within 48 hours and completes a comprehensive wound assessment.

Care plan: Absorptive, protective dressing for the venous ulcer, compression after provider approval and an edema management plan.

AL caregiver education: Elevation routines, drainage monitoring, dressing integrity and infection signs.

Provider communication: Wound orders, compression approval and medication review.

Therapy consult: Mobility training, safe leg elevation and strengthening to reduce time in the recliner.

Key Collaboration Points : Caregiver's Observation, AL Nurse's Clinical Judgement, Home Health's Skilled care, Therapy, and consistent follow through

27

Summary & Key Takeaways

Early detection matters
Report redness, drainage, odor, pain, limping or dressing problems immediately.

Everyone has a role
Caregivers monitor. AL nurses coordinate. Home Health treats and teaches. Therapy supports mobility and offloading. Providers direct medical care.

Communication is clinical care
Share timely updates across AL, Home Health and providers. Document changes to keep care connected.

Prevention protects dignity
Reposition, manage moisture and support nutrition, hydration and mobility. Use proper footwear and a safe environment.

Together: better healing, fewer ER visits and safer residents.

28

Q&A/Discussion

What wounds have you seen recently?

What were you unsure whether to report?

What dressing issues have you encountered?

No question too small – wound prevention and treatment depends on **clarity**.

29

Thank you!

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30