
AOTA Position Paper

Role of Occupational Therapy in Wound Management

The American Occupational Therapy Association (AOTA) asserts that the prevention and amelioration of wounds and their impact on daily life occupations are within the scope of occupational therapy practice. Occupational therapists and occupational therapy assistants routinely work with individuals and populations who are at risk for or have sustained wounds.

In the *Healthy People 2020* initiative, the U.S. Department of Health and Human Services (DHHS; 2010) called for a 10% reduction in pressure injury–related hospitalizations in persons ages 65 years or older by 2020, identifying this area as one of significant concern for individuals and society. This position paper informs internal and external audiences, including employers and payer sources, about the role of occupational therapy related to preservation and restoration of the ability of the individual to participate in meaningful, desired, and necessary daily life occupations through prevention and amelioration of wounds.

Types, Incidence, and Prevalence of Wounds

Wounds, or impaired skin integrities, include abrasions, punctures, bites, surgical wounds, diabetic ulcers, pressure injuries, traumatic wounds, venous stasis ulcers, and arterial ulcers. Certain groups either exhibit or are at risk for wounds and related complications. These groups include people with spinal cord injuries (SCIs), cerebral palsy, hand injuries, diabetes, cancer, and burns, as well as those with sensory or mobility impairments, including older adults. For example, the Centers for Disease Control and Prevention (CDC) has reported that in 2014, 108,000 of the documented 7.2 million hospitalizations for persons with diabetes were due to lower-extremity amputations caused by nonhealing wounds (5 per 1,000 persons with diabetes; CDC, 2017).

Wounds and related conditions can negatively affect a person's ability to participate in their life roles, routines, and useful habits and can impact their performance with self-care, work, educational activities, leisure activities, social participation, and rest and sleep. Wounds affect both the physical and psychological well-being of individuals and can adversely affect quality of life. Pain, depression, social isolation, and anxiety can result from the existence of wounds, particularly those that are chronic in nature (Fearn, Heller-Murphy, Kelly, & Harbour, 2017). In addition, a person may have difficulties or require assistance with activities and contexts specifically related to the wound itself, such as

- Management of the wound site, including applying wound care treatments and products to promote healing as well as manage drainage or odor;
- Management of clothing and footwear that may no longer fit correctly or that may worsen the wound condition;
- Care, use, and application of pressure garments for scar management;
- Engaging in restful sleep due to the presence of pain;
- Functional mobility due to the wound site or associated pain;
- Engaging in physical activity necessary to prevent impairments in endurance, overall strength, cardiovascular status, pulmonary status, and cognition;

- Reduced social participation, self-efficacy, and reported quality of life due to discoloration of the skin, visible scars, contracting or hypertrophic scars, and conspicuous use of compression garments; and
- Financial stability that can be affected by the inability to work due to a significant wound.

Occupational Therapy's Role in Wound Management

The profession of occupational therapy is grounded in the principle that participation in meaningful and relevant life activities leads to life satisfaction, longevity, health, and wellness (AOTA, 2014b; Christiansen, 2011). The ability to actively pursue and participate in desired life tasks and activities can be altered temporarily or for sustained periods due to the presence of a significant or chronic wound. In addition, according to Sleight et al. (2016) and the Braden Scale wound risk assessment tool (Kring, 2007), diminished engagement in activity and mobility are considered risk factors for pressure ulcer-type wounds.

Occupational therapy practitioners¹ working in this area combine an understanding of the benefits of participation in everyday activities; the mechanism and progression of acute and chronic wound healing and management; overall impact of related body functions and structures; and contribution of mental health to well-being as they address the expressed needs of the client. Through their understanding and appreciation of the transactional relationship between client factors, including body functions and body structures, as well as performance skills and performance patterns, and occupations, an occupational therapy practitioner may focus on the wound itself as part of the overall intervention plan to prevent or reduce possible resultant occupational dysfunction (AOTA, 2014b).

Following a plan of care established by an occupational therapist and as allowed by federal and state regulations and third-party payer requirements, and within each practitioner's level of competence and scope of practice (AOTA, 2014c, 2015a), the occupational therapy practitioner can provide interventions, including the following targeted preparatory methods (AOTA, 2014b):

- Application of clean dressings using the principles of moist wound care with both exudating and non-exudating wounds;
- Application of wound closure strips;
- Removal of sutures and wound closure strips;
- Monitoring of wound status;
- Mechanical debridement using forceps, cotton-tipped applicators, wet-to-dry dressings, and pulsed lavage;
- Sharp debridement using scalpel or scissors to remove denatured tissue;
- Application of appropriate topical agents to facilitate wound healing and debridement;
- Application of silver nitrate for reduction of hypertrophic granulation tissue;
- Application of enzymatic agents (e.g., collagenase) for debridement;
- Application of negative pressure wound therapy;
- Application of physical agent modalities such as whirlpool, electrical stimulation, and ultrasound;

¹When the term *occupational therapy practitioner* is used in this document, it refers to both occupational therapists and occupational therapy assistants (AOTA, 2015b). *Occupational therapists* are responsible for all aspects of occupational therapy service delivery and are accountable for the safety and effectiveness of the occupational therapy service delivery process. *Occupational therapy assistants* deliver occupational therapy services under the supervision of and in partnership with an occupational therapist (AOTA, 2014a).

- Education of clients and caregivers in techniques for donning and doffing pressure garments to manage swelling; and
- Use of specialized techniques for the management of upper-extremity lymphedema.

This care may be offered as part of a team approach to intervention or in collaboration with the referring physician. In addition, occupational therapy practitioners may provide modifications and accommodations to the occupation, environment, and context while the wound is healing. For example, education and adaptive equipment can allow a client to assist with or perform dressing changes, basic activities of daily living (ADLs), instrumental activities of daily living (IADLs), and tasks within all other areas of occupation.

Occupational therapy practitioners also are skilled in the *prevention* of wounds for people with various acute and chronic conditions such as SCIs, burns, lymphedema, cancer, diabetes, hand injuries, and other sensory and mobility impairments. In these cases, individual attention is given to the client's health status, environment and context, patterns of activity, and lifestyle choices as part of an overall plan to maintain skin integrity. Some interventions focus on the client (persons, groups, and populations), others address the way activities are performed, and still others seek to change the context or environment that surrounds the client and influences performance. Interventions may focus on treatment of the actual wound, treatment of the resulting dysfunction, or prevention of the wound from occurring.

The following are examples of types of interventions and intervention approaches used in the delivery of occupational therapy services:

- *Restore habits and routines:* Disruptions to habits and routines by changes in client factors, performance skills and the context and environment can interfere with the quality and ease of completing daily activities. Occupational therapy practitioners can offer substitutes and adaptations for habits or can work with a client on establishing new habits to mitigate the impact of chronic or acute wounds.
- *Prevent loss of roles:* Roles define behaviors and activities in which the client expects to engage on a daily basis. Changes to client factors, skills, and the environment as a result of a wound negatively affect role execution and lead to occupational dysfunction. Occupational therapy practitioners can suggest modifications and adaptations to the activities required to continue with roles as part of an intervention plan.
- *Prevent occurrence of wounds:* Occupational therapy practitioners can position the body to alleviate points of pressure, including positioning techniques to ensure postural alignment, distribution of weight, balance, and stability. Practitioners can recommend support surfaces, such as specialized beds and customized wheelchairs, cushions, and seating systems, and can also work with clients to identify ways to incorporate recommended prevention measures into their ongoing daily routines. These measures include pressure-relief activities (techniques and frequency) and pressure redistribution equipment such as tilt-in-space wheelchairs and seat cushions.
- *Modify context and environment:* Occupational therapy practitioners work to address the physical and social environments and personal context of the client that are changed by a wound or that must change to accommodate changes in abilities. For example, a client with an SCI may not be able to use his power wheelchair in the community due to a pressure ulcer on his ischial tuberosity that requires him to stay in a prone position. An occupational therapist can make suggestions for changes to his immediate environment, including adaptive body positioning and changes to his computer setup that allow him to continue to work as a computer programmer from his home office.
- *Fabricate or provide orthotic devices:* Occupational therapy practitioners can fabricate or provide orthotic devices to help protect healing structures, prevent deformity, and secure dressings.
- *Educate about techniques:* Occupational therapy practitioners can educate clients and caregivers in skin care techniques, including moisture control and dry skin prevention; in precautions and safety techniques for all areas of occupation; and in transfer techniques to minimize risk of skin tears.

In addition, occupations and activities are designed and provided to engage the client in tasks that are meaningful and relevant and that support the mind, body, and spirit. Skilled selection of appropriate activities will minimize the detrimental effects of physical inactivity; loss of habits, roles, and routines; and social isolation that may result from the presence of wounds (AOTA, 2014b). Activities selected should always hold meaning and have purpose to the client and can include things such as community outings, shopping, socializing, homemaking, care of others, and pet care.

Occupational therapy practitioners recognize that, in addition to neuromusculoskeletal concerns, clients experiencing wounds also may exhibit diminished sense of self and self-efficacy, anxiety, and depression that interfere with their ability to manage currently existing wounds or participate in relevant daily occupations. Individuals who currently do not present with a wound may be at risk due to various lifestyle choices or environmental situations. Practitioners engage the qualities of their personality; verbal and non-verbal communication; listening skills; and empathy to encourage, facilitate, and motivate clients as they seek and achieve personal health, wellness, and occupational participation (AOTA, 2014b). Practitioners consider the contextual issues that affect availability and choice with regard to wound care methods and access to tools. Advocacy efforts are initiated by practitioners as appropriate to prevent and treat wounds when individuals are faced with these concerns.

Cultural issues are also considered in the course of occupational therapy intervention. The impact of beliefs and choices is considered and integrated as part of the holistic approach to treatment. For example, parents may prefer that only organic debridement agents be used on their child's wound. An occupational therapy practitioner who is aware of this decision may advocate for the family through a team conference in which a discussion about the use of autolytic debrident versus pharmaceutical agents can take place. In another example, a male family member can be instructed in techniques for changing a dressing for an older man who is uncomfortable with several different home health care providers caring for the wound on his sacrum.

Education

Occupational therapy practitioners are knowledgeable in the areas of human biology and physiology and treatment methods and interventions used as part of wound management. According to the Accreditation Council on Occupational Therapy Education's *Standards* (ACOTE, 2012), occupational therapists and occupational therapy assistants must demonstrate knowledge and understanding of the structure and function of the human body to include the biological and physical sciences. They select and provide interventions and procedures to enhance safety, health and wellness, and performance in all areas of occupation (i.e., ADLs, IADLs, work, play, leisure, social participation, education, rest, and sleep). In addition, occupational therapy practitioners provide development, remediation, and compensation for physical, mental, cognitive, perceptual, sensory function, neuromuscular, and behavioral skills and are able to design, fabricate, apply, fit, and train in assistive technologies and devices (e.g., electronic aids to daily living, seating and positioning systems) used to enhance occupational performance and foster participation. Occupational therapy practitioners are able to demonstrate safe and effective application of superficial thermal and mechanical modalities as a preparatory measure to manage pain and improve occupational performance.

Occupational therapy practitioners who are interested in working with individuals with chronic or acute wounds are able to participate in continuing professional development activities that specifically target the properties or causes of wounds and wound care techniques. Educational programs targeting health care professionals are available through various companies and organizations.

Ethical Considerations

The *Occupational Therapy Code of Ethics (2015)* (AOTA, 2015a) provides principles that guide safe and competent professional practice in all areas, including wound management. It is the professional and ethical responsibility of occupational therapy practitioners to provide services only within each practitioner's level of competence and scope of practice. The Code of Ethics establishes principles that guide safe and competent professional practice and that must be applied when providing care to clients with wounds. Practitioners should refer to the relevant principles from the most current Code and comply with state and federal regulatory requirements.

Table 1 presents case examples of occupational therapy's role in wound management.

Table 1. Case Examples of Occupational Therapy's Role in Wound Management

Geneva	
Client and Background	<p>Geneva, age 68, was referred to an OT specializing in hand rehabilitation following an extensive palmar fasciotomy resulting from progressive Dupuytren's contracture. A full-thickness skin graft harvested from her volar wrist/forearm was used to close a full thickness wound on the volar surface of the small finger proximal phalanx and palm that sustained extensive loss of tissue due to long-standing MP and PIP contracture. At the time of the initial occupational therapy evaluation, about 4 days post surgery, it was noted that the donor site (about 2 cm by 5 cm) was left to heal by secondary intention. Physician orders called for the initiation of a moist wound care regimen following removal of the postsurgical dressing.</p>
Evaluation and Findings	<p>Evaluation included the gathering of information for the occupational profile (AOTA, 2017) and the use of assessment tools to determine the status of various client factors and performance skills as part of the analysis of occupational performance (AOTA, 2014b). A thorough assessment of the wound was also completed. Following a saline rinse, the OT visually inspected the wound site and measured it using a disposable tape measure. Possible undermining and tunneling were assessed using a sterile cotton swab; no undermining or tunneling was found. The depth of the wound (2 mm) was measured with a tongue depressor and tape measure overlay. Observation of wound color and exudate indicated a clean red wound with early granulation tissue. Exudate was minimal/moderate and clear, as would be expected for this type of donor site. No signs of infection were present. Circumferential measurements were taken of the arm just distal and proximal to the wound; when compared with the noninvolved side, no significant differences were noted. The measurements served as a baseline for levels of edema. An analog pain scale revealed that Geneva had very minimal pain, with a score of 2 on a scale of 1–10.</p> <p>The COPM was used as an outcome measure and assisted the OT, with input from the client, to determine 4 goals for treatment:</p> <ol style="list-style-type: none"> 1. Return to volunteer activity of delivering meals on wheels within 1 week. 2. Ability to feed and walk family dog within 2 weeks. 3. Ability to complete all self-care activities within 1 week. 4. Return to gardening activities within 3 weeks.
Interventions	<p>The OT initiated moist wound care using hydrogel to maintain an appropriately moist environment for granulation tissue growth. She covered the wound and hydrogel with semipermeable film dressing to ensure adequate oxygenation and minimize the potential for anaerobic bacterial proliferation. A secondary dry gauze dressing was applied to protect the film dressing during splint wear and functional tasks. Geneva was instructed to keep the dressing in place until her next occupational therapy visit, at which time the wound was reassessed and redressed as appropriate. This wound care regimen was administered by the OT and OTA for 2 weeks until granulation tissue bed was established. Geneva was then instructed to continue with the program at home.</p> <p>To return to her volunteer duties as a Meals on Wheels delivery person, the OT strategized with Geneva with regard to options for driving 1 week post surgery. It was determined that Geneva's husband could drive her to the Meals on Wheels kitchen to pick up her meals and consumer list each day but that she would be able to carry meals to the homes for delivery. Once her wound was fully epithelized and she was no longer taking any medications for pain, her doctor would release her to drive and she could return to independent volunteer activities. The OT and Geneva also worked on strategies for pet care and determined that she would be independent in feeding her small dog if the dog food container was placed in a more convenient location and that she use a smaller scoop to transfer dry kibble from the container to the dog dish. Since her dog was also fed one container of moist food per day, it was decided that she would use a butter knife to pierce the foil covering vs. attempting to pinch and pull with her affected hand. It was recommended to Geneva that she use a large latex glove to cover her hand during all self-care activities to keep her dressing in place and clean. She was instructed in an adaptive bra-donning technique to reduce twisting of her forearm during donor site healing. About 2 weeks later, moist wound care was discontinued, as the wound had epithelialized fully. All initially established occupational therapy intervention goals had been achieved.</p>

(Continued)

Table 1. Case Examples of Occupational Therapy's Role in Wound Management (cont.)

Adam	
Client and Background	<p>Adam, age 71, was referred to home health care services following a recent fall, resulting in a pelvic fracture; increased BP; and chronic Parkinson's disease. He was discharged home from the ER with no inpatient hospitalization. On admission to home care, a Stage II ischial tuberosity ulcer was discovered. According to Adam, he preferred to stay in a recliner during the day and occasionally sleeps there at night if he doesn't "feel strong." Adam lives with his daughter and son-in-law, both of whom work during the day. Adam reported decreased appetite and that family are available to help with bathing if needed. He prefers to wear protective undergarments, as he occasionally "cannot get to the toilet in time."</p>
Evaluation and Findings	<p>During a visit to the home, the OT visually assessed the covered wound (a nurse provided documentation of measurements and granulation tissue, and occupational therapy documentation described the type of wound and dressing present). The nurse and OT collaborated to determine whether the wound dressing was appropriate for Adam to shower. A hydrocolloid dressing was recommended to the doctor to allow a moist healing environment but provide a waterproof seal to allow bathing and prevent contamination. On further visual assessment of skin integrity and evaluation of clinical factors (i.e., decreased mobility with prolonged sitting, occasional incontinence with moistness leading to potential maceration, and decreased nutrition due to poor meal planning), the OT noted 2 additional reddened areas over bony prominences on the coccyx. In addition, Adam presented with decreased pain awareness and fragile skin due to decreased weight, which contributed to pressure ulcer formation. The OT consulted with the nurse case manager to discuss a recommendation for a nutritionist consult, for which the nurse followed up and received from the doctor.</p> <p>The COPM (Law et al., 2014) was administered to Adam as part of the occupational profile (AOTA, 2017) component of the occupational therapy evaluation. It was learned that prior to his fall, Adam enjoyed spending time on his front porch and talking with the neighborhood children on their way home from school. He also enjoyed playing card games such as gin rummy. It was also learned that he has a Chihuahua that he cared for independently before his fall and that he was carrying the dog when he tripped on a throw rug in the living room. Adam and his OT determined that it would be beneficial for him to resume several of his previous activity routines in an effort to improve his mood, maintain his overall cardiovascular health, and improve his appetite.</p>
Interventions	<p>Although the home care nurse initially provided the direct application of the hydrocolloid dressing to the Stage II ulcer and monitored the wound status with photographs and diagrams, the OT was imperative in the wound care. As the wound began epithelialization, the dressing changes were reduced to every 4 days, and the nurse instructed the family in proper application, which the OT was able to reinforce during the performance of bathing. The OT instructed Adam and his caregivers on the effects of prolonged pressure, shear forces, friction, and incontinence on the development of future ulcers and prevention of healing in the current ulcer. Bathing and toileting were addressed for thoroughness of drying skin as well as techniques for self-inspection. A toileting routine was established. Pressure relief was addressed (Adam and his caregivers were instructed on changing position every hour, and a pressure redistribution device was introduced for the recliner). Adequate nutrition needs (to assist with healing) were met after meal preparation alternatives were addressed with Adam, his caregivers, and a nutritionist.</p> <p>Adam and his OT worked with his family members to bring a supportive chair to the front porch in which he could sit during the day as he did prior to his injury. A gate was also placed on the entry to the porch to ensure that his dog could not leave the porch unexpectedly. As a result, Adam was able to enjoy several hours a day in the sunshine and talk with the neighborhood children as had been his routine. A small table was also provided that fit over his lap and allowed him to play card games with his family and friends when he was outside. The OT also completed a full safety check of the areas of the home that he frequented to ensure that there were no trip or fall hazards remaining. His family agreed to remove the throw rug that caused his fall.</p> <p>The wound was considered healed after full epithelialization, and as the last health care professional involved, the OT completed proper Medicare documentation and staging of the healed wound.</p>

(Continued)

Table 1. Case Examples of Occupational Therapy's Role in Wound Management (cont.)

Tanner	
Client and Background	Tanner, age 10 , qualifies for special education services at school due to multiple impairments (e.g., orthopedic, cognitive, visual). As a result of a disability, Tanner is not able to independently change his position to relieve pressure points created by the gravitational pull on his body in any position. Tanner is supported with a customized wheelchair for mobility, adapted stander, and adaptive seating in the school setting to facilitate his highest level of participation in instructional activities. Tanner is recovering from a medical intervention to address a pressure area.
Evaluation and Findings	Occupational therapy services evaluated Tanner's participation at school using observation, parent and teacher interviews, and the School Function Assessment (SFA) (Coster, Deeney, Haltiwanger, & Haley, 2008). From the evaluation process, it was determined that Tanner required alternative positioning options at school to facilitate his highest level of functional participation in the instructional activities presented in this setting. Additionally, the classroom personnel required training on the necessity to provide Tanner with a daily schedule for change in position to facilitate healing of the pressure area.
Interventions	The OT provided training for the classroom personnel on how to transfer and position Tanner in the various positioning options provided in the classroom and the functional performance they should expect from Tanner in each option. The OT also collaborated with the classroom teacher to develop a daily positioning schedule for Tanner while at school that not only facilitated function in the setting but also provided Tanner with continuity of his typical routines and classroom roles as well as a change in position at least every hour. The frequency of positional changes at school was determined in consultation with Tanner's orthopedic surgeon, who is medically managing the pressure area healing process.
Brian^a	
Client and Background	Brian, age 36 , had a complete SCI at the T-8 level 2 years ago as a result of motor vehicle crash. He lives alone and uses a manual wheelchair for mobility. He drives a vehicle adapted with hand controls. He has been employed as a computer programmer and has had a history of pressure injuries for the past year. Currently, he is admitted to the hospital for a UTI and a Stage 3 pressure ulcer on his left ischial tuberosity.
Evaluation and Findings	The rehabilitation team worked with the hospital urologist to determine the cause of Brian's recurrent UTIs. Brian uses intermittent catheterization and may not have always used the safest techniques. The team also reviewed Brian's pressure ulcer history. The pressure ulcer was cultured and treated according to the hospital's protocol, which may include dressings, whirlpool, vacuum-assisted closure, or surgery. Brian remains prone as much as possible while in the hospital. The OT evaluated Brian's ability to participate in bladder management and work. All equipment pertaining to seating (e.g., wheelchair, cushion) was evaluated for appropriateness, condition, and effectiveness. Pressure mapping may be necessary to find a wheelchair pressure redistribution device that helps reduce the risk of pressure injuries.
Interventions	The OT reviewed with Brian strategies for reducing infection during intermittent catheterization. She discussed strategies for continued engagement in work and leisure tasks while he is hospitalized in the prone position. If necessary, Brian's wheelchair will be modified or replaced (if finances are available). Brian will participate in group and individual pressure ulcer prevention and management education sessions and will be provided with a home program to follow. Brian will be instructed on managing the ulcer (surgical site if he had surgery) with dressings and pressure redistribution (weight shifts if he is allowed to sit) during sitting or lying in bed, on nutrition, on transfers, and on sitting tolerance. Home and work site visits are recommended to help Brian identify situations that may be contributing to his recurrent pressure injuries. He may be referred for home health services while the ulcer heals.

Note. BP = blood pressure; COPM = Canadian Occupational Performance Measure; ER = emergency room; MP = metacarpophalangeal; OT = occupational therapist; OTA = occupational therapy assistant; PIP = proximal interphalangeal; SCI = spinal cord injury; SFA = School Function Assessment; UTI = urinary tract infection.

^aThe case study on Brian was contributed by Susan L. Garber, MA, OTR, FAOTA, FACRM.

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