ARROWHEAD REGIONAL MEDICAL CENTER
Department of Ambulatory Care Services
SPECIALTY CARE POLICIES AND PROCEDURES

SECTION: **ADMINISTRATIVE**

SUB SECTION: **PLAN FOR PROVISION OF CARE**

SUBJECT: **SCOPE OF SERVICE WOUND CLINIC**

APPROVED BY: _____
Clinical Director, Ambulatory Services

POLICY

It is the policy of Arrowhead Regional Medical Center (ARMC) that Wound Care Services will be provided upon referral and authorization to the Ambulatory Services Wound Clinic. Any patient who presents with open wounds or ulcers, refractory bacterial infections, or other such conditions will be evaluated for treatment by Ambulatory Services Wound Clinic. Under the supervision of the Medical Director/clinic physicians, licensed staff will perform wound care treatments in accordance with all organizational and departmental polices and procedures.

PROCEDURES

I. Location: The Wound Clinic is located on the first floor of the ARMC Outpatient Care Center at door 1. Podiatry services are provided at door 1 and Wound care services are provided at door 9.

II. Scope: The Wound Clinic provides services to pediatric, adult and geriatric patients who may suffer from aforementioned wounds. Under the supervision of a physician a Registered Nurse, or Licensed Vocational Nurse will perform evaluations and treatment in accordance with the Wound Care Physicians orders. The practice of wound care in the Wound Clinic is multidisciplinary in scope. Physician and Ancillary services are part of Advanced Wound Care practices and may include Baromedicine, Dermatology, Diabetology, Dietary counseling, Endocrinology, Family Practice, Home Health nursing, Home Medical Equipment, Infectious Disease, Internal Medicine, Laboratory, Nuclear Medicine, Orthopedics, Orthotics and Prosthetics, Pharmacy, Physical and Occupational Therapy, Plastic and Reconstructive Surgery, Podiatry, Radiology, Vascular Surgery and others.

III. Specialized Diagnostic/Therapeutic Procedures

A. Physical Examination

B. Invasive Procedures (i.e.: wound debridement, tissue cultures, bone cultures, IV infusion, and other within the scope of practitioners' licensure.)

C. Non-invasive Diagnostic Testing Procedures (Ankle/Brachial Index, Semmes-Weinstein testing and Transcutaneous Oxygen Testing, Skin Perfusion Pressure Testing)

D. Referrals to Hyperbaric Oxygen Therapy

E. Local Wound Assessment and Treatment (wound measurement and description, dressing application)

F. Medical Photography

G. Patient education

IV. Hours of Operation: Appointments may be arranged by written referrals and authorization by the Primary Care practitioner. Clinic hours are Monday – Friday 0800 – 1630. Appointments are made through the ARMC Call Center, 855-422-8029 weekdays Monday through Friday from 0800 – 1700. After Hours Services go to the emergency room.

V. Waiting area: All Wound Clinic patients are asked to wait in the main Outpatient Care Lobby on the 1st floor until they are called for their appointment room by the staff according to appointment.

VI. Plan for Services: The Womens Health Clinic (WHC) Medical Director meets with Ambulatory Care Administration as needed to plan and collaborate on services provided, performance improvement issues, risk management, regulatory issues and any agenda item relating to care, education and services provided. Strategic plans, operational plans, budgetary considerations and commitments, and policies are developed throughout the hospital, in collaboration with the Department leadership. The Clinic Unit Manager and WHC physicians meet monthly with the Labor and Delivery unit to coordinate care.

VII. Policies: Policies are reviewed every 3 years and as needed to meet the needs of the service areas.

VIII. Meetings/Communications: Charge nurse meets with the Clinic Unit Manager is held every month and charge holds routine staff meetings as needed. Current memos and information are shared in the communication folders that come to the supervisor daily. Memos and communications are posted for all staff to read.

IX. Collaborative Relationships with Other Departments: The Wound Clinic strives to maintain productive and open communication with all departments that services our patient groups.

REFERENCES: **Title 22-70555**

DEFINITIONS: **N/A**

ATTACHMENTS: **N/A**

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	10/04/22	**Nursing Standards Committee** Applicable Administrator, Hospital or Medical Committee
	11/30/22	**Patient Safety and Quality Committee** Applicable Administrator, Hospital or Medical Committee
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SECTION: **ADMINISTRATIVE**

SUB SECTION: **PLAN FOR PROVISION OF CARE**

SUBJECT: **PATIENT REFERRAL TO WOUND CLINIC**

APPROVED BY: _____
Clinical Director, Ambulatory Services

POLICY

It is the policy of Arrowhead Regional Medical Center's (ARMC) Ambulatory Services Wound Clinic staff to assist the Patient Registration personnel in obtaining information required to register qualified patient to the Ambulatory Services Wound Clinic.

PROCEDURES

I. Patient Referrals

A. The Ambulatory Services Wound Clinic will accept patient referrals based upon any of the following:

1. A written request for consultation by a licensed physician, dentist, or other healthcare practitioner who is authorized to diagnose, treat, and prescribe within the State of California.
2. In accordance with ARMC Policy and Procedure.

II. Ambulatory Services Wound Clinic Criteria

A. The Ambulatory Services Wound Clinic will accept referrals for, either inpatients or outpatients, who present with:

1. Any chronic, refractory wound
2. Any refractory infection that results in chronic wound formation
3. Chronic disease states that result is wound formation
4. Surgical, medical or traumatic conditions that warrant the use of Hyperbaric Oxygen Therapy (HBO) in accordance with the Undersea & Hyperbaric Medical Society and/or The American College of Hyperbaric Medicine guidelines
5. Any medical, surgical, or traumatic problematic wound
6. Acute wounds of a compromised host at risk of developing into a chronic wound

III. Initial Consultation

A. During the initial assessment, and prior to the Ambulatory Services Wound Clinic physician examining the patient, the following procedures shall be performed.

1. Obtain/review baseline vital signs
2. Ambulatory Services Wound Clinic staff shall assess patient's wound, or condition for which patient is registered, and document accordingly.
3. Photograph wound per policy.

REFERENCES: **N/A**

DEFINITIONS: **N/A**

ATTACHMENTS: **N/A**

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SECTION: **ADMINISTRATIVE**

SUB SECTION: **PLAN FOR PROVISION OF CARE**

SUBJECT: **WOUND CLINIC INITIAL ASSESSMENT**

APPROVED BY: _____
Clinical Director, Ambulatory Services

POLICY

It is the policy of Arrowhead Regional Medical Center's Ambulatory Services Wound Clinic that patients referred to the Ambulatory Services Wound Clinic will be evaluated by an Ambulatory Services Wound Clinic Provider or Ambulatory Services Wound Clinic staff member. Minimum baseline lab studies may be necessary to assess wound healing potential.

PROCEDURES

I. Initial Assessment – Wound Care Clinician Evaluation

A. Initial assessment by the Ambulatory Services Wound Clinic staff shall include a brief review of the patient's medical history to determine the patient's overall medical condition and health status in order to determine the medical conditions, which may be contributing factors in the development of a problem wound. Some of the factors adversely affecting wound healing may include:

1. Aging, Anemia, Arterial Vessel Disorders
2. Cancer, Chronic obstructive pulmonary disease (COPD), (Congestive heart failure) CHF, Cytotoxic Agents (topical/systemic)
3. Depression, Diabetes, Dressings' effect
4. Infection, Ischemia (Localized or systemic)
5. Hypertension
6. Lymphedema
7. Malnourishment, Medication interaction
8. Neurological
9. Obesity, Osteomyelitis
10. Peripheral Vascular Disease, Pressure (Tissue Load)
11. Radiation therapy
12. Sickle Cell disorder, social complications
13. Tobacco use
14. Trauma
15. Non-compliance with treatment

B. Laboratory

1. Patients registered to the Ambulatory Services Wound Clinic may receive orders from the Provider for baseline lab work unless recent laboratory data can be acquired. This may include, at a minimum:

    a. Complete Blood Count with differential
    b. Panel 14 (CMP)
    c. Sedimentation Rate
    d. Glycohemoglobin (Hba1.c) for patient with a history of Diabetes

C. Diagnostic Tests

1. In order to rule out underlying diseases which may be contributing to the non-healing wound, Ambulatory Services Wound Clinic staff may request or order a number of other diagnostic tests. These may include:

    a. Glycohemoglobin (assesses diabetic control)
    b. Arterial Blood Gases (assesses cardiopulmonary effect on healing)
    c. Transferrin (assesses nutritional deficit)
    d. Pre-Albumin level (assesses nutritional deficit)
    e. Non-invasive vascular testing (assesses circulatory deficit)
    f. Venous/Arterial Doppler studies (assesses circulatory deficit)
    g. Radiological studies (confirms osteomyelitis and/or other defects)
    h. Bone/Tissue Biopsy (establishes possible infectious processes)
    i. Transcutaneous Oxygen levels (demonstrates possible hypoxemia)
    j. Angiography (demonstrates possible vascular conditions)
    k. Semmes-Weinstein Test (demonstrates peripheral neuropathy)
    l. ABI Index (may document circulatory deficit)

D. Treatments

1. Following the assessment of the patient's condition, the Ambulatory Services Wound Clinic staff shall examine the wound and make a determination as to the course of therapy and treatment to pursue. This may include cleaning, debridement, cauterization, application of dressings, wound cultures, wound biopsy and/or other treatments that the Provider deems necessary to maximize wound healing potential.
2. The Ambulatory Services Wound Clinic Provider may defer treatment to any Ambulatory Services Wound Clinic personnel who are trained to render such treatment.
3. Documentation of the patient's condition, treatment performed, and any follow-up instructions are to be documented in the patient's electronic health record (EHR) by the clinician responsible for the care of that patient, and then ultimately signed by the provider.

E. Referrals to Hyperbaric Oxygen (HBO) Therapy

1. Referrals for treatment by hospital departments other than the Ambulatory Services Wound Clinic may be made at any time during the course of therapy. The Ambulatory Services Wound Clinic provider will write a prescription for the new treatment and include diagnosis to support the medical necessity for the additional care. Treatment with Hyperbaric Oxygen (HBO) Therapy) will be initiated following an Ambulatory Services Wound Clinic Provider order that clearly documents the medical necessity for HBO in accordance with the Undersea & Hyperbaric Medical Society guidelines. (Section 5.1)

REFERENCES: **N/A**

DEFINITIONS: **N/A**

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SECTION: **ADMINISTRATIVE**

SUB SECTION: **PLAN FOR PROVISION OF CARE**

SUBJECT: **WOUND ASSESSMENT**

APPROVED BY: _____
Clinical Director, Ambulatory Services

POLICY

It is the policy of Arrowhead Regional Medical Center's (ARMC) Ambulatory Services Wound Clinic to provide a thorough wound assessment, and to standardize wound photography, measurement orientation and scale, and the use of terminology for the purpose of clear, written communication between health care providers.

PROCEDURES

I. Documentation

A. A visual wound assessment shall be made at each scheduled clinic visit. The physical appearance of the wound will be documented, and wound measurements taken to determine healing progress or regress compared to the previous visit. Description of the physical appearance will be documented as follows:

1. Location: Anatomical site

2. Etiology of the wound: Pressure, diabetes, vascular, surgical, traumatic, other

3. Size: Measured in centimeters: Length x Width x Depth. Length is measured axially to the anatomical length of the patient's body. Width is measured perpendicular to the anatomical position. Length and Width are not a description of the longest and widest parts of a wound. Depth is measured from the deepest portion of the wound base to the approximate level of the periwound tissue. Any tunneling or undermining of the wound must be measured and documented separately. If a wound is shallow and not measurable by conventional standards, documentation as "< .5 cm" to describe the wound is acceptable.

4. Degree of Tissue Destruction: i.e., Superficial or full thickness, tissue damage with or without disruption of peri wound skin, blisters, shallow or deep crater, unable to determine tissue damage due to necrosis or eschar, supporting structure involvement.

a. 'Staging' wounds: Method of description to document tissue damage of pressure ulcers only.
b. 'Grading' wounds: Method of description to document tissue damage of diabetic ulcers only.

5. Presence of Undermining and size: Should be measured with a saline-moistened, (sterile) cotton-tipped applicator. Caution must be exercised when probing a wound to prevent trauma and pain. Undermining is assumed to be present when a tissue defect can be probed in a horizontal direction under the skin and/or fascia.

6. Presence of Tunneling and size: Should be measured with a saline moistened, (sterile) cotton-tipped applicator. Caution must be exercised when probing a wound to prevent trauma and pain.

7. Drainage: Bloody, serosanguinous, serous, purulent, foul purulent.

8. Amount: None, scant, small, moderate, and large.

9. Necrosis: Yellow slough, black tissue - eschar, and percentage covering wound bed.

10. Condition of periwound tissue: Color, edema, induration, and wound edges.

11. Condition of wound bed: The following are terms commonly used to describe the appearance of a wound.

    a. Clean - Free of foreign material or debris.
    b. Dead Space – A cavity remaining in a wound.
    c. Dehiscence – Separation of the layers of a surgical wound.
    d. Epithelialization - That stage of a wound healing in which epithelial cells migrate across the wound surface. The wound appears as deep red “ground glass”.
    e. Erythema - A redness of the periwound skin, can be blanchable or non-blanchable.
    f. Eschar - Thick, black, necrotic tissue, leather-like in appearance.
    g. Granulation tissue - Pink/red, moist tissue, highly vascular, that has filled an open wound. Often described as “beefy red” in appearance. Very fragile tissue that must be protected for continued wound healing.
    h. Macerated - Degenerative changes in the skin due to excess moistures. This can be cause by wound drainage, perspiration, incontinence, or other sources of moisture on unprotected skin. Appears blanched and soft.
    i. Necrotic tissue - Tissue that is died and has lost its usual physical properties and viability.
    j. Serum - A collection of serum/plasma in a wound. Usually a pale-yellow thin fluid.
    k. Sinus Tract - A channel or cavity underlying a wound that involves an area larger than the visible surface of the wound.
    l. Slough - Necrotic tissue in the process of separating from underlying viable tissue.

II. Pressure Ulcer Staging

A. Accurate staging of pressure ulcers is extremely important. Because it is a common terminology utilized to evaluate the extent of tissue damage. The Stage of a pressure ulcer may also determine the patient’s length of stay, home health care, availability of durable medical equipment and more. The Staging system developed by the Wound Ostomy and Continence Nurses Society (WOCN), has been adapted by the National Pressure Ulcer Advisory Panel and currently accepted by the Agency for Healthcare Research and Quality (AHRQ):

1. **Stage I:** An observable pressure-related alteration of intact skin whose indicators as compared to an adjacent or opposite area on the body may include changes in skin color

(red, blue, purple tones), skin temperature (warmth or coolness), skin stiffness (hardness, edema), and/or sensation (pain). (NPUAP 1997)

2. **Stage II:** Partial thickness skin loss involving epidermis, dermas, or both. The ulcer is superficial and presents clinically as an abrasion, blister, or shallow crater.

3. **Stage III:** Full thickness skin loss involving damage to or necrosis of subcutaneous tissue that may extend down to, but not through, underlying fascia. The ulcer presents clinically as a deep crater with or without undermining of adjacent tissue.

4. **Stage IV:** Full thickness skin loss with extensive destruction, tissue necrosis, or damage to muscle, bone, or supporting structures (e.g., tendon, joint capsule). Undermining and sinus tracts also may be associated with Stage IV pressure ulcers.

5. The following limitations are inherent in these definitions:

   a. Because the skin remains intact in Stage I pressure ulcers, these lesions are not ulcers in the usual sense. In addition, Stage I pressure ulcers are not always reliably assessed, especially in patients with darkly pigmented skin. Despite these limitations, identification of a Stage I pressure ulcer is critical for indicating the need for more vigilant assessment and preventive care.
   b. When eschar is present, a pressure ulcer cannot be accurately staged until the eschar is removed.
   c. It may be difficult to assess pressure ulcer in patients with casts, other orthopedic devises, or support stockings. Routine assessment to check for adequate circulation, movement, and sensation may fail to detect the skin under the edges of casts. Staff should: (1) Assess the skin under the edges of casts, (2) Be alert to patient complains of pressure-induced pain, (3) Determine whether casts should be altered or replaced to relieve pressure, and (4) Remove support stocking to assess the skin.
   d. Pressure ulcers, as they heal, are never staged in reverse. In other words, a Stage IV pressure ulcer that is healing, and the size and depth are greatly diminished, does not become a “Stage III”. The ulcer is described as “a healing Stage IV” or a “healed Staged IV” pressure ulcer.

III. Diabetic foot ulcer staging utilizing Wager’s Scale

A. In assessing the degree of tissue damage for patients suffering from diabetic foot ulcers, the following criteria will apply:

1. **Grade O**: Skin is intact. There are no open lesions. There may be foot deformities, Charcot Joints, or partial amputation of toes, rays, or transmetatarsal.

2. **Grade I**: Superficial ulceration without penetration of the deeper subcutaneous tissue layers.

3. **Grade II**: Penetration to the deeper tissues possibly exposing bone, tendons, ligament or joint capsules.

4. **Grade III**: Deep penetration with accompanying ositis, abscesses or osteomyelitis. May extend to mid-foot. Surgical debridement may be mandatory.

5. **Grade IV**: Gangrene of portions of the toes and/or forefoot. Gangrene may be wet or dry, infected or not infected. Surgical intervention is generally indicated.

6. **Grade V**: Gangrene of most of the entire foot. Surgical amputation at the appropriate level is usually mandatory.

IV. Wound Photography

A. Verify that ARMC Consent – Photography has been signed.

B. Photography of wounds shall be done to assure consistent and adequate documentation of wound conditions during the course of treatment for patients at the Ambulatory Services Wound Clinic. Photographs of wound will be taken at the discretion of the Ambulatory Services Wound Clinic staff as follows:

1. On Initial Assessment.

2. At one-month intervals.

3. During the course of treatment when there is significant changes in the wound's appearance, either positive or negative.

4. At the commencement or termination of treatment procedures. For example: Grafting, Debridement, Hyperbaric Oxygen, IV Therapy, etc.

5. On discharge from Ambulatory Services Wound Clinic.

6. Photographic Setup

a. Always attempt to take each photograph in the correct anatomical plane. If the patient is standing or sitting, the vertical plane should be used. If the patient is lying, the horizontal plane should be used. (Section 4.0 regarding anatomical plane).
b. The focal length (distance between the wound and the camera) should be approximately 25-36 inches. Focal length may be extended for larger wounds or a series of multiple wounds in an area.
c. Photographs should be able to support the narrative description of the wound(s).
d. While photographing the wound, all attempts to preserve the patient's dignity will be protected. Exposure of any portion of the patient's body, which does not contribute integrity of the photograph for descriptive purposes, should be avoided.

V. Documentation

A. In order to accurately describe the wound condition for photographic purposes, a few helpful suggestions are outlined:

1. Undermining - Gently probe the wound with a saline moistened, sterile cotton-tipped applicator to approximate the amount of undermining. A water-based marker may be used to outline the undermining along the periwound area. This will clearly demonstrate the degree of undermining in the photograph.
2. Tunneling - Place a saline moistened, sterile cotton-tipped applicator into the deepest part of the tunnel and photograph the wound with the applicator left in situ. This technique will demonstrate the length and direction of the tunneling in the photograph.
3. Communication between lesions - Pass a saline moistened, sterile cotton-tipped applicator between 2 or more lesions prior to taking the photograph. Extreme care should be taken to avoid tissue damage or causing undue pain to the patient.

B. The identification of each photograph is imperative to the identification of the patient, as well as the location of the wound. Each photograph shall be taken with a written label placed in the proximity of the wound care taken as to not contaminate the wound bed.

VI. Photograph Label will include

A. Patient's visit number

B. patient's medical record number

C. The date the photograph was taken

D. The location of the wound

E. The measurements of the wound (LxWxD)

VII. Documentation of photos

A. All photos will be stored per ARMC Policies and Procedures.

REFERENCES: **Administrative (ADM) Policy # 110.08**

DEFINITIONS: **N/A**

ATTACHMENTS: **N/A**

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SECTION: **ADMINISTRATIVE**

SUB SECTION: **PLAN FOR PROVISION OF CARE**

SUBJECT: **TOPICAL TREATMENT FOR WOUNDS**

APPROVED BY: _____
Clinical Director, Ambulatory Services

POLICY

Wound Care Products

A. Selection of wound care products is based on the anticipated clinical outcome. Every different category of wound care product produces a variety of clinical effect as noted under Policy Amplification. Thoughtful selection of the proper type of dressing, or combination of dressings is often made more difficult because of:

1. Individual patient response to various products
2. Rapidly changing body of science regarding wounds
3. Progression of the wound itself from one phase to another as the wound improves or worsens.

PROCEDURES

I. Polmeric Film

A. Examples:

1. Op-Site
2. Bioclusive
3. Tegaderm

B. Indications:

1. Superficial, partial thickness wounds
2. Wounds with necrosis and slough
3. Wounds with little or no exudate

C. Advantages:

1. May visualize the wound
2. Controls gas exchange at the wound base
3. Promotes autolytic debridement
4. Requires no secondary dressing
5. Impermeable to bacteria and other contaminants

D. Disadvantages:

1. Not suitable for draining wounds
2. Requires intact skin border for adhesion
3. Difficult to handle
4. Subject to rolling up under friction forces

E. Change Frequency: 24 to 72 hours

II. Impregnated Non-adherent gauze

A. Examples:

1. Adaptic
2. Wet Dressing
3. Xeroform
4. Gauze
5. Vaseline Gauze

B. Indication:

1. Abrasions
2. Burns
3. Graft donor sites or split thickness grafts

C. Advantages:

1. Covers, soothes and protects underlying tissues where exudate is light

D. Disadvantages:

1. Limited moisture retention
2. Limited protection from contamination
3. May damage underlying tissue if removed dry
4. Requires a secondary dressing to secure

E. Change Frequency: Every 8-12 hours unless covered and secured with a transparent film dressing

III. Polyurathane Foam

A. Examples:

1. Tegaderm Foam
2. Mepilex Foam

B. Indications:

1. Partial and full thickness wounds
2. Minimum to moderate exudate
3. Secondary dressing for wound packing, fillers
4. To absorb drainage from around tubes

C. Advantages:

1. Non-adherent, won't damage surrounding skin
2. Repels contaminants
3. Hydrophilic-absorbs a moderate amount of exudate
4. Easily applied and removed
5. May be used in conjunction with compression therapy

D. Disadvantages:

1. Not to be used on dry wounds as desiccation will increase
2. Ineffective on wounds with dry eschar
3. May macerate surrounding tissues of unprotected skin

E. Changes Frequency: Every 1-4 days or when exudate "strike through" becomes visible.

IV. Hydrogels (water-based sheets or amorphous gel)

A. Examples:

1. Woun'Dress
2. Saf-Gel

B. Indications:

1. Partial and full thickness wounds
2. Re-hydrates dry wounds (hydrophobic)
3. Fills deep crevasses/cavity (amorphous gel)
4. Burns or radiation necrosis or injuries

C. Advantages:

1. Pain reduction, soothes
2. Re-hydrates desiccated wounds
3. Promotes autolysis
4. Fill dead space in wounds
5. Promotes epithelial cell migration in a fully granulated wound bed

D. Disadvantages:

1. May require secondary dressings
2. Little or no ability to absorb exudate
3. May macerate unprotected periwound tissue

E. Change Frequency: Every 1 to 5 days dependent on exudate.

V. Hydrocolloids (wafers, paste or powders)

A. Examples:

1. Duoderm

B. Indications:

1. Superficial, partial thickness wounds
2. Shallow, full thickness wounds
3. Wounds exhibiting eschar or slough
4. Wounds with small to moderate amounts of exudate

C. Advantages:

1. Promotes autolysis of necrotic tissues
2. Partially self adherent to skin, stays put
3. Protects wound from contamination
4. Bacterial barrier
5. Limited to moderate exudate absorption
6. Minimizes trauma during dressing changes
7. May be used with compression therapy

D. Disadvantages:

1. Not recommended for infected wounds
2. Minimal to moderate absorption of exudate
3. Will not be able to visualize wound
4. Occlusive dressings minimize gas exchange
5. May damage fragile, surrounding tissues
6. May promote periwound maceration to unless skin is protected
7. All forms require secondary dressings

E. Change Frequency: 1 to 7 days dependent on exudate amount

VI. Calcium alginate (sheets or rope constructions)

A. Examples:

1. Sorbsan
2. Kaltostat

B. Indications:

1. Partial and full thickness wounds
2. Wounds with moderate to heavy exudate
3. Wound with undermining or tunneling
4. Wounds with necrotic tissue
5. Infected wounds

C. Advantages:

1. Easily applied or removed
2. Fills dead spaces and undermining
3. Absorbs large amounts of exudate
4. Promotes autolysis
5. Forms a gel interacting with exudate

D. Disadvantages:

1. Not recommended for wounds with light exudate
2. Always requires a secondary dressing

E. Change Frequency: 1 to 4 days dependent on exudate amount

VII. Exudate absorbers (pastes, beads or powders)

A. Examples:

1. Bard Absorbent Dressing
2. Chronicure
3. Debrisan
4. Hydrogen
5. Triad Wound Paste

B. Indications:

1. Partial or full thickness wounds
2. Wounds with heavy exudate
3. Wounds with necrotic tissue
4. Promotes autolysis

C. Advantages:

1. Absorbs large amounts of exudate
2. Fills, occupies dead space
3. Easily applied and removed
4. Promotes debridement

D. Disadvantages:

1. Not recommended for wounds with light exudate
2. Always requires a secondary dressing

E. Change Frequency: Daily or more frequently dependent on exudate

VIII. Composite Dressings

A. Examples:

1. Versiva

B. Indications:

1. Partial and full thickness wounds
2. Wounds with necrosis and slough

C. Advantages:

1. Promotes autolysis
2. Self adherent
3. Allows moisture vapor transmission easily applied and removed without trauma

D. Disadvantage:

1. Not recommended for wounds with light exudate
2. Requires a border of intact skin to adhere

E. Change Frequency: Every 1-4 days or as “strike through” of exudate becomes visible.

REFERENCES: **N/A**

DEFINITIONS: **N/A**

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SECTION: **ADMINISTRATIVE**

SUB SECTION: **PLAN FOR PROVISION OF CARE**

SUBJECT: **SECONDARY DRESSINGS**

APPROVED BY: _____
Clinical Director, Ambulatory Services

POLICY

Many advanced wound care products require a secondary dressing to retain the product in place. Acceptable measures for secondary dressing are listed below.

PROCEDURES

I. The method of securing a dressing in place should be selected based upon patient comfort, safety and the area of the body that is being dressed. For the most part, these secondary dressings are one of the following types:

   A. gauze wraps, either rolled or tubular

   B. adhesive tapes

   C. straps

II. General Products

   A. Gauze wraps (rolled guaze)

      1. Examples:

         a. Kerlix
         b. Stretch gauze

      2. Indications:

         a. Wrapping extremities such as hands, arms, ankle, wrist, lower legs

      3. Advantages:

         a. Will not adhere to surrounding tissues
         b. Protects tissues from friction and shear
         c. Inexpensive

      4. Disadvantages:

a. May be wrapped either too tight or loosely.
b. Must be applied from the most distal area of dressing site up to the most proximal in a figure”8” fashion in order to prevent a tourniquet-like effect from developing. As exudate dries, will stick to the wound surface and may become dislodged. Certain types of gauze lack flexibility.

B. Gauze wraps: (tubular gauze)

1. Examples:

a. Chieftain tubular gauze
b. Baxter Tube gauze

2. Indications:

a. Bandaging fingers/toes for adult patients
b. Bandaging infant or child hands, arms, feet

3. Advantages:

a. Quickly and easily applied and removed
b. Number of layers can be modified to accommodate differing amounts of exudate

4. Disadvantages:

a. Must stock several different sizes to accommodate differing needs.

C. Tapes:

1. Various types of adhesive tapes are available to the clinician in an effort to secure dressings in place and improve patient care. However, many problems still develop as patients often claim to be “allergic” to tape, or we see common evidence of “tape burns” and skin tears resulting from the use of adhesive tapes to secure wound dressings. Researchers have discovered that the most common problems associated with adhesive tapes are related to the fact that most types of adhesive tapes are not designed to flex and stretch as the patient moves. The result is severe, underlying shear forces that frequently rip and tear the skin as the patient moves. Additionally, most types of adhesive tapes do not have the properties that allow the tape to “breath” and let excess perspiration, drainage or other fluids evaporate from the skin surface, resulting in weakening the fragile dermis all the more.
2. It is recommended that tapes made from plastics, paper, rubber, or latex not be applied directly to the skin surface at any time. It is also recommended that only woven cloth tapes that display a bias stretch capability be applied directly to the patient’s skin surface in order to secure dressings in place. Manufacturers have developed woven, cloth tapes that have the ability to flex and stretch with patient movement in order to prevent shear forces and skin damage. These tapes also allow for fluids to evaporate off the patient’s skin surface. Other properties of cloth tapes allow for very easy removal, thereby not damaging the skin surface during dressing changes.
3. Woven, cloth tapes are available in several widths ranging from 1 inch to 8 inches. Some manufacturers have developed precut tapes that require no scissors to size.

a. Examples:

1) Hypafix Tape
2) Medipore Tape

b. Indications:

1) To secure dressings in areas of the trunk or on the limbs where gauze wrappings are not appropriate.

c. Advantages:

1) Flexes and stretches as the patient moves
2) Allows fluids to evaporate through the tape pores
3) Available in many different widths
4) Does not become excessively adherent when applied to areas of the body that are not weight bearing
5) Will remain in place for prolonged periods of time

d. Disadvantages:

1) Difficult to handle in larger sizes
2) Relatively expensive

REFERENCES: **N/A**

DEFINITIONS: **N/A**

ATTACHMENTS: **N/A**

APPROVAL DATE:	**N/A**	**Policy, Procedure and Standards Committee**
	10/04/22	**Nursing Standards Committee** Applicable Administrator, Hospital or Medical Committee
	11/30/22	**Patient Safety and Quality Committee** Applicable Administrator, Hospital or Medical Committee
	05/26/23	**Infection Control Committee** Applicable Administrator, Hospital or Medical Committee
	06/01/23	**Quality Management Committee** Applicable Administrator, Hospital or Medical Committee
	06/22/23	**Medical Executive Committee** Applicable Administrator, Hospital or Medical Committee
		Board of Supervisors Approved by the Governing Body

REPLACES: **N/A**

EFFECTIVE: **06/22/23**

REVISED: **N/A**

REVIEWED: **N/A**

SECTION: **ADMINISTRATIVE**

SUB SECTION: **PLAN FOR PROVISION OF CARE**

SUBJECT: **WET TO DRY DRESSINGS**

APPROVED BY: _____
Clinical Director, Ambulatory Services

POLICY

Establish Wet-to-Dry dressing procedure to be utilized by the Ambulatory Services Wound Clinic when appropriate.

PROCEDURES

I. The intended outcome of the application of wet-to-dry dressings to a wound is the removal of de-vitalized tissue/wound debris. This process is called mechanical debridement. Mechanical debridement occurs because loose necrotic tissue and debris adhere to the dressing as it dries and is removed with the dressings during the dressing change. The process of mechanical debridement is non-selective, meaning that both viable and non-viable tissues are simultaneously stripped away during dressing changes. As a result, wound repair may be dramatically retarded.

II. Following a course of wet-to-dry dressing applications, the base of the wound should become free of necrotic tissue and other loose debris. It is advisable that once a wound has been cleaned by debridement, the dressing type is changed to a physiologic dressing to allow for tissue growth and repair. In addition to enhanced healing of a wound, as well as patient comfort, physiologic dressing is less costly than the supplies needed for wet-to-dry dressings.

III. The application of a wet-to-dry dressing is as follows: coarsely woven cotton dressings, such as Kerlex fluffs (pads or rolled) or gauze, are saturated with Normal Saline. After donning sterile gloves, the practitioner milks the dressing to allow most of the Saline to drain, thereby leaving the dressing barely moist. The dressing is then packed lightly into the wound in single layers, ensuring that all surfaces of the wound are covered. Over the period of several hours, the formerly moistened dressings become dried and adherent to necrotic tissue and loose debris. At each dressing change, the dressings are carefully removed, taking the debris with it. **NOTE: This process may cause undue discomfort or pain to the patient.** The wound is then cleansed, and a new dressing applied. This process of changing dressings continues around the clock until the wound is clean and free on debris and necrotic tissue.

IV. Indications: Wounds with necrotic tissue and /or loose debris

A. Examples:

1. Coarsely woven cotton gauzes of either pad or rolled construction.

B. Advantages:

1. Removes necrotic, de-vitalized tissue
2. Removes loose debris
3. Removes wound base toxins

C. Disadvantages:

1. Non-selective removal of viable and non-viable tissue
2. May be painful to apply and remove
3. Exposes the wound to bacteria and other contaminants
4. Requires frequent dressing changes
5. Costly in terms of both supply and labor hours

D. Change Frequency:

1. Every 4-6 hours

REFERENCES: **N/A**

DEFINITIONS: **N/A**

ATTACHMENTS: **N/A**

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SECTION: **ADMINISTRATIVE**

SUB SECTION: **PLAN FOR PROVISION OF CARE**

SUBJECT: **ADVANCED WOUND CARE PROCEDURES**

APPROVED BY: _____
Clinical Director, Ambulatory Services

POLICY

Under the indirect supervision of the Ambulatory Services Wound Clinic medical director, wound care personal may perform the following procedures Pulsatile lavage, Wound Culture Collection, Ankle-Brachial Index, silver nitrate application, Compression Bandages, Diabetic Neurological Screen, sharps debridement and other unspecified procedures.

PROCEDURES

I. Pulsatile lavage with suction

A. Purpose: To promote continuity between staff when performing pulsatile lavage modality.

B. Indications: Cleanses wound, promotes debridement, induces localized circulation to wound area, reduces bacterial count.

C. Contraindications/Precautions: Fistula, active bleeding, exposed vessel, nerve tendon or bone.

D. Policy: Staff will perform pulsatile lavage using the procedure below.

E. Procedure:

1. Patient is positioned appropriately to maintain modesty, expose wound and promote proper body mechanics for patient and therapist or nurse.
2. Any IV access sites, catheters, etc. are draped.
3. Pulsatile lavage is set up using 500- or 1000-ml bag of saline, pulsatile lavage gun assigned to patient, and a new diverter tip each treatment. Diverter tip is connected to suction. More saline and additional tips may be used as indicated per wound(s).
4. Therapist or nurse performing procedure will wear protective clothing including a waterproof gown, mask with shield, and gloves.
5. Patient is educated regarding treatment procedure.
6. Wound is irrigated using pulsatile lavage to patient tolerance.
7. Wound is dried appropriately.
8. Diverter tip is disposed of properly.
9. Pulsatile lavage gun is packed in case and ready for next visit making sure excess saline is out of tubing.

F. Documentation: Staff will document reasoning for procedure, type and amount of irrigation fluid used and patient's tolerance to procedure. Any bleeding or patient responses are documented.

G. Education: Patient is educated regarding reasoning for procedure and protective clothing, how procedure is performed and possible effects during procedure such as pain or bleeding.

II. Wound Culture Collection

A. Purpose: To promote continuity between staff when collecting a wound culture.

B. Indications: Order received for culture collection.

C. Policy: Staff will collect a wound culture using procedure below:

D. Procedure:

1. Physician or therapist/nurse receiving orders writes an order in the chart.
2. Wound is cleansed thoroughly using saline.
3. Any necrosis and exudate is removed as able.
4. Firmly swab culturette in a ten-point method, over viable tissue or from any fluid seeping from viable tissue after cleaning. Viable tissue from wound margins is preferred.
5. The culture is secured and labeled appropriately and specifically.

E. Documentation: Staff will document specific location of wound cultured and reasoning for culture if known.

F. Education: Patient is educated regarding reasoning for culture and when to expect results if known.

III. Ankle Brachial Index

A. Purpose: To provide guidelines for performing proper Ankle Brachial Index test.

B. Indications: Questionable arterial status, screen for poor arterial status prior to compression, identify need for arteriogram or further vascular studies.

C. Disadvantages: Not always reliable in patients with diabetes due to non-compressible vessels – will get false result of 1 or above.

D. Policy: Staff will perform Ankle Brachial Index test using procedure below.

E. Procedure:

1. Patient lies in supine with pillow beneath legs maintaining patient's modesty and promoting proper body mechanics for patient and therapist or nurse.
2. Blood pressure cuff is placed around lower leg just proximal to ankle.
3. Dorsal pedal pulse is located with Doppler.
4. While listening to pulse, inflate cuff until audible pulse disappears.
5. Slowly deflate cuff while listening for audible pulse to begin again. Repeat 2 times and record the number at which pulse re-appears. Remove cuff and Doppler.
6. Patient is still lying in supine and cuff is placed around upper arm just proximal to elbow.

7. Brachial artery pulse is located with Doppler.
8. While listening to pulse, inflate cuff until audible pulse disappears.
9. Slowly deflate cuff while listening for audible pulse to begin again. Repeat 2 times and record the number at which pulse re-appears.
10. Repeat procedure on both arms and record the highest number.
11. Remove cuff and Doppler.
12. Divide ankle pressure by brachial pressure to get one number.
13. Use chart below to identify arterial involvement.

    a. >1.0 Normal or Venous pathology
    b. 0.8-1.0 Some arterial involvement
    c. <0.8 Arterial involvement -Avoid compression
    d. <0.6 Secure Vascular consult
    e. <0.5 Urgent vascular referral

F. Documentation: Staff will document reasoning for procedure, patient's response and results.

G. Education: Patient is educated regarding reasoning for procedure, how procedure is performed and results of procedure.

IV. Compression Bandages

A. Purpose: To promote proper application of compression bandages between staff.

B. Indications: Edema in lower extremity.

C. Contraindications: Arterial disease with ABI < 0.6.

D. Precautions: CHF, Untreated infection or cellulitis, arterial disease with ABI < 0.8.

E. Policy: All staff will follow the below procedure and techniques when applying compression:

F. Procedure:

1. Patient is positioned comfortably and draped modestly with wound, and extremity exposed to promote proper body mechanics for patient and therapist.
2. Pulses are checked via palpation and/or Doppler at dorsalis pedis and posterior tibialis. The extremity is checked for other signs of arterial dysfunction.
3. Girth measurements are taken before compression, monthly, or if any notable changes made.
4. Legs and wound are cleaned, treated, and dressed appropriately.
5. Bony prominences are padded appropriately, and ankle area is built up appropriately to promote an even level of compression.
6. Compression bandage is performed starting at base of toes, ascending up the leg, over the calf muscle, ending just below the tibial tuberosity. Secure bandage with two revolutions at base of toes.
7. The goals of compression, patient's arterial status, and the type of bandages used determine amount of compression.
8. The specific method of wrapping should be performed as indicated by the bandage insert of the brand used in the clinic.

G. Documentation: Staff will document reasoning for procedure, girth measurements at least monthly or if significant changes, size, type and amount of bandage, amount of compression using during application, and patient response to treatment.

H. Education: Patient is educated regarding reasoning for procedure, how procedure is performed, and any instructions for care needed by patient between visits. Patient is instructed to elevate extremity as able, perform ankle pumps, and ambulation as able. Patient is instructed to notify therapist or nurse if increased shortness of breath, numbness, tingling, temperature, or discoloration in toes occurs.

V. Silver Nitrate

A. Purpose: Staff will use silver nitrate consistently following protocol.

B. Indications:

1. To stop bleeding by cauterizing after pressure has been applied and unable to cease
2. To reduce hypergranulation tissue or at wound edges for epiboly to produce an inflammation response and promote healing.

C. Policy: Staff will perform application of silver nitrate using the following procedure.

D. Procedure: To stop bleeding:

1. Patient is positioned comfortably and draped modestly with wound exposed to promote proper body mechanics for patient and therapist.
2. Wound is cleaned and treated as indicated.
3. To stop bleeding, apply constant pressure for two minutes. If this is not successful to stop bleeding then
4. Silver nitrate is applied to area of bleeding by rolling the end of stick over area then applying pressure for two more minutes. Repeat as needed until bleeding is stopped.
5. Wound is dressed appropriately.
6. Dispose of silver nitrate stick in hazardous waste bag.

E. To Reduce hypergranulation or epiboly:

1. Perform steps 1,2 and 3 above.
2. Roll the end of silver nitrate stick over all hypergranulated tissue or around edges of wound with epiboly until tissue turns gray.
3. Tissue is blotted with gauze to remove any moisture or exudate.
4. Wound is dressed appropriately.
5. Dispose of silver nitrate stick in hazardous waste bag.

Note: Excessive silver nitrate can be neutralized with 0.9% Normal Saline and wash away with water

F. Documentation: Staff will document reasoning for procedure, results of procedure and patient’s response to procedure.

G. Education: Patient is educated regarding reasoning for procedure, how procedure is performed and regarding discoloration caused to wound bed.

VI. Diabetic Neurological Screen

A. Purpose: To promote thorough and consistent screening between staff when performing neurological assessment.

B. Indications: Patient is diabetic, patient has neuropathy or history of problems with feet.

C. Policy: All staff will perform a neurological screen using procedure below:

D. Monofilament Test

1. Patient is positioned to expose feet (bilateral if applicable) maintaining patient's modesty and proper body mechanics for patient and therapist or nurse.
2. Sensory testing is performed with a 10-gram 5.07 Semmes-Weinstein monofilament.
3. Ten sites on patient's foot are checked – First, third and fifth plantar toes, first, third and fifth plantar metatarsal heads, medial and lateral plantar mid-foot, plantar heel, and dorsal foot. Bilateral feet are assessed.
4. The monofilament is applied first to patient's hand so that patient understands what to feel. Then the monofilament is used to test the sites above with pressure enough to cause monofilament to bend.
5. The patient is asked to say "yes" each time the monofilament is felt while they are not looking at feet.
6. If patient is unable to feel at any sites, the patient is documented to have a loss of protective sensation.

VII. Sharp Debridement of Non-viable Tissue in Wounds

A. Function: Using instruments, the Wound Care Personal with documented coursework and completed competency in Sharp Wound Debridement, may remove non-viable tissues from wounds.

B. Purpose: Ongoing safe and effective removal of non-viable tissue by instrument/sharp debridement for the purpose of providing a clean wound bed.

C. Circumstances: Debridement should be done when the need for the removal of necrotic tissue, particulate matter or foreign materials hinder wound assessment or healing progress.

1. Setting: Debridement may be done in the patient's room or clinic setting with appropriate resources available including adequate lighting, pain medication, appropriate instruments and competent professionals trained in debridement.
2. Patient Population: Patient of all ages with wounds requiring sharp debridement.
3. Patient Conditions: Patients with poorly healing or non-healing wounds including pressure ulcers, patients with demarcation of the ulceration. The clinician must select the most appropriate method of debridement considering not only the wound status but the physiological and emotional status of the patient. Done with Physician referral and clinical judgement.
4. Contraindications: Debride with caution and physician approval if patient has coagulation issues defined as PTT over 40 seconds, INR over 1.5. Stop debriding when: Impending exposure of viable tendon or bone, location of fascial plane, inability to indentify the underlying structure, and/or when concerned with unbearable pain expressed by the patient.
5. Supervision: May be done independently after competency validation is done by experienced medical staff.

D. Procedure

1. Pre-procedure

   a. Assess the following: condition of the wound, overall condition of the patient including general health status, nutritional and immunological status (potential for complications), allergies, tissue perfusion, bleeding disorders, medications (anticoagulants, corticosteroids). Need for sharp debridement versus mechanical, chemical or autolytic debridement. Patient's level of pain/comfort. History and etiology of the wound, type and amount of necrotic tissue and presence of sinus tracts, tunneling and undermining. Signs and symptoms of infection.
   b. Collaborative Consultation: Wound Care Personal should consult with surgeon if any questions arise regarding the debridement of wounds.
   c. Explain the procedure to patient/caregiver/significant other: The purpose of the debridement procedure, the advantages and disadvantages, risks, complications and alternatives, the availability of pain medications and potential bleeding.

2. Procedure Interventions:

   a. Cleanse the wound with saline/wound cleanser or betadine may be used if it is removed with saline. Using the pickup forceps, lift the non-viable tissue or eschar you are debriding and cut it with a scalpel or scissors. Cut it with care and take it down on layers to prevent removal of viable tissue. Pain and bleeding are signs of viable tissue. Remove as much necrotic tissue as possible. Cleanse the wound with saline/wound cleanser. Apply appropriate dressing for location/wound. Use antibiotics as ordered by the physician. Have materials available in the event of bleeding: gauze for pressure, silver nitrate sticks, topical gel foam agents.

3. Post Procedure:

   a. Assess and monitor the following: Amount of necrotic tissue. Presence of pus or abscess. Patient pain tolerance limit. Have materials available in the event of bleeding: gauze for pressure, silver nitrate sticks, topical gel foam agents. If bleeding is continuous and voluminous, call for help immediately and apply pressure. If there is impending exposed bone, tendon or a major vessel is encountered notify physician.
   b. Self Care Education: Instruct the patient to report bleeding and signs and symptoms of infection. Teach dressings changes and techniques where appropriate.
   c. Documentation: Complete a physician order entry and focus note on the patient progress note when initiating the standardized procedure. Include the condition of the wound, problems encountered during debridement and type of dressing applied.

E. Requirements

1. Education: Wound Care Personal will successfully complete an education program on wound debridement.
2. Experience: Ability to recognize need for sharps debridement, knowledge of skin anatomy and physiology.
3. Initial Evaluation/Skill Validation: Competence demonstration of satisfactory skill in wound assessment and a return demonstration of instrument/sharps debridement validated by a proctor annually by attending surgeon.
4. On-going evaluation/Skill Validation: Performance of the procedure will be evaluated by the selected proctor. Competency evaluation will be completed annually.

REFERENCES: **BRYANT, R. A. & NIX, D. P. (2015). ACUTE AND CHRONIC WOUNDS: CURRENT MANAGEMENT CONCEPTS (5TH ED.) ST. LOUIS: MO. ELSEVIER MOSBY.**

DEFINITIONS: **N/A**

ATTACHMENTS: **Attachment A - Wound Care Services Sharps Debridement: Skills Validation**

APPROVAL DATE:	**N/A**	**Policy, Procedure and Standards Committee**
	10/04/22	**Nursing Standards Committee** Applicable Administrator, Hospital or Medical Committee
	11/30/22	**Patient Safety and Quality Committee** Applicable Administrator, Hospital or Medical Committee
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		Board of Supervisors Approved by the Governing Body

REPLACES: **N/A**

EFFECTIVE: **06/22/23**

REVISED: **N/A**

REVIEWED: **N/A**

Arrowhead Regional Medical Center
Wound Care Services

Sharps Debridement: Skills Validation (to be validated by Attending Surgeon)

Validation Codes:
M = Meets Criteria for Validation
NP = Needs Practice/Review

***Knowledge Criteria**
****Performance Demonstration**

	Behavioral Skill	Validation	Initials
I.	**Cognitive Application:**		
*	A. Indications		
	B. Contraindications		
	C. Hazards		
	D. Procedure Sequence		
	E. Pertinent patient information considered prior to debridement		
	F. Control of possible bleeding (AgNO4 Stick, Pressure, Dressing)		
II.	**Psychomotor Skills**		
**	A. Performs 6 sharp debridement procedures		
III.	**Equipment**		
**	A. Gathers/assembles necessary equipment		
IV.	**Safety**		
*/**	A. Observes and follows standard precautions		
V.	**Policy and Procedure Competency**		
*	A. Location		
	B. Content		
	C. Verbalizes access and availability to reference documents and resource persons		
VI.	**Performance Improvement**		
**	A. Proper patient identification		
	B. Order entry		
	C. Documentation per policy		
VII.	**Interpersonal Skills**		
**	A. Patient/Family Education		
	B. Tonation instills confidence		
	C. Professional interaction		
	D. Professional demeanor		
	E. Explanation of intent/procedure		
	F. Tailored learning level/needs		
Comments:			

	1	2	3	4	5	6
MR #						
Diagnosis						

Employee Name: _____ Date: _____ Unit: _____
(Please Print)

Validator's Name: _____ Title: _____

SECTION: **ADMINISTRATIVE**

SUB SECTION: **PLAN FOR PROVISION OF CARE**

SUBJECT: **PRINCIPLES OF ADVANCE WOUND CARE**

APPROVED BY: _____
Clinical Director, Ambulatory Services

POLICY

The practice of advanced wound care requires the attempt to stabilize as many physiological systems in the wound care patient population. Common multisystem contributing factors are discussed below.

PROCEDURES

I. Chronic refractory wounds and infections may be the result of a multi-system failure. Conversely, the healing of a chronic wound or infection can be achieved more effectively when efforts to improve disease states are optimized. Several acute or chronic conditions may be present which interfere with the body's ability to heal wounds. Among a few of the most common are:

A. **Infection**: Severe bacterial, viral or yeast infections can impede healing and kill compromised tissue.

B. **Ischemia:** Promotes further necrotizing infections due to tissue hypoxia, decrease in leukocyte migration, and impede the action of chemoattractants and other cellular mediated body responses to stress (the wound).

C. **Nutrition:** Nutritionally compromised individuals are unable to complete the conversion of fibrin from fibroblasts or the synthesis of collagen to develop new tissue beds. Protein, vitamin and mineral depletion leads to complications in wound repair.

D. **Mobility:** Lack of adequate mobility leads to increased pressure, shearing and frictional forces on dependent tissue.

E. **Neuropathy:** The body's inability to sense pressure and pain will increase the likelihood of prolonged trauma to healthy tissue.

F. **Continence:** Fecal or urinary incontinence is a frequent contributing factor in chronic lesions such as pressure ulcers. Other fluids that macerate healthy tissue and cause skin breakdown include wound drainage, and perspiration.

G. **Acute or Chronic Disease States:** Many diseases which create conditions such as poor tissue perfusion, nutritional compromise etc. will cause tissue destruction or impede healing.

H. **Psycho-Social Factors:** Many non-medical problems can also contribute to the development of chronic wounds. Inadequate financial resources to eat properly or receive primary medical care, unhealthy living conditions, lack of family or caregiver support, chemical or alcohol dependency, and the lack of education or ability to learn may be contributing factors to unsuccessful wound healing.

I. **Tobacco use:** It is well documented that even in otherwise healthy individuals, the use of tobacco interferes with the body's healing capabilities.

II. Local Wound Care

A. Research has long established that "moist" wounds heal two to three times faster than "dry" wounds. Modern wound care products are interactive and promote the development and maintenance of a biologically active wound environment that enhances tissue growth and wound repair. This biologically active environment is established by first creating a moist wound base and then by managing the amount of moisture present. Wound dressings that promote an environment conducive to healing are referred to as "physiologic dressings."

B. Physiologic dressings provide a variety of advantages for the chronic wound patient and are an integral part of advanced wound care practices. They promote prolonged wear times, minimizing patient trauma and cost. Patient compliance is enhanced, as these dressing are easy to apply and require little maintenance. In addition, they are easily utilized in the outpatient setting, reducing the need for hospitalization for 'skilled dressing changes'.

C. Physiological properties of advanced wound dressings

1. Promote debridement (autolysis) of eschar and necrotic tissue.

2. Entrap the body's "wound healing" properties that allow tissue repair to occur. (Active leukocytes, platelets, enzymes, and chemical mediators.)

3. Prevent trauma to the wound's microenvironment, as a result of fewer dressing changes and subsequent manipulation of the wound bed.

4. Minimize the possibility of bacterial contamination of the wound secondary to the properties of the dressing, and fewer changes required.

5. Create a moist environment that maintains cell life, and the migration of healthy cells for tissue rebuilding.

6. Manage wound exudate, which prevents desiccation or maceration.

7. Thermal insulation helps maintain body temperature at the wound bed.

8. Allow controlled gas exchange.

9. Remove toxins from the wound bed.

10. Reduce pain during wear time and dressing changes.

11. Promote wound site homeostasis.

12. Maintain the [acidic] pH which enhances the release of oxygen from hemoglobin and the action of proteolytic enzymes within the wound.

13. Stimulate the growth of granulation tissue.

D. As a general rule, most ointments, salves, and bactericidal solutions are considered to be wound contaminants and may have cytotoxic properties that further retard wound healing. (Kills cells.) Therefore, the use of the following products is contraindicated for wound care treatments. While Betadine is an excellent skin cleanser, it should not be used in the wound bed. In addition to its cytotoxic properties, incidence of iodine toxicity has been reported in some patients.

1. Betadine

2. Acetic Acid

3. Dakin's Solution

4. Hydrogen peroxide

5. Salves or Ointments of any kind.

E. During the healing process, it is important to remember that many wounds will appear much worse initially due to the autolysis of necrotic tissue and the accumulation of wound fluids and exudate. This is both predictable and desirable. Observe for signs and symptoms of infection and treat accordingly.

REFERENCES: **N/A**

DEFINITIONS: **N/A**

ATTACHMENTS: **N/A**

APPROVAL DATE:	**N/A**	**Policy, Procedure and Standards Committee**
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REPLACES: **N/A**

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SECTION: **ADMINISTRATIVE**

SUB SECTION: **PLAN FOR PROVISION OF CARE**

SUBJECT: **WOUND PHOTOGRAPHY**

APPROVED BY: _____
Clinical Director, Ambulatory Services

PROCEDURES

I. Photographic procedure

A. Setup

1. Always attempt to take each photograph in the correct anatomical plane. If the patient is standing or sitting, the vertical plane should be used. If the patient is lying, the horizontal plane should be used.
2. The focal length (distance between the wound and the camera) should be approximately 24-36 inches. Focal length may be extended for larger wounds or a series of multiple wounds in an area.
3. Photographs should be able to support the narrative description of the wound(s).
4. While photographing the wound, all attempts to preserve the patient's dignity will be protected. Exposure of any portion of the patient's body, which does not contribute integrity of the photograph for descriptive purposes, will be avoided.

II. Documentation

A. In order to accurately depict the wound condition for photographic purposes, a few helpful suggestions are outlined:

1. Undermining - Gently probe the wound with a saline moistened, sterile cotton-tipped applicator to approximate the amount of undermining. A water-based marker may be used to outline the undermining along the peri-wound area. This will clearly demonstrate the degree of undermining in the photograph.

2. Tunneling - Place a saline moistened, sterile cotton-tipped applicator into the deepest part of the tunnel and photograph the wound with the cotton tipped applicator in-situ. This procedure will show the depth and the direction of the tunnel.

3. Communication between lesions - Pass a saline moistened, sterile cotton-tipped applicator between 2 or more lesions prior to taking the photograph. Extreme care should be taken to avoid tissue damage or causing undue pain to the patient.

B. The identification of each photograph is imperative to the identification of the patient, as well as the location of the wound. Each photograph will be taken with a written label placed in the proximity of the wound, care taken as to not contaminate the wound bed.

III. Label the photograph with the following minimum information

A. The patient's medical record number (if appropriate)

B. The date the photograph was taken

C. The location of the wound

D. The measurements of the wound (LxWxD)

IV. Charting of Photographs.

A. Photographs will be stored on the ARMC computer server per Information Management direction. Digital images may be electronically exported to the appropriate site on the Wound Assessment Form as determined by wound location and dimensions. The Medical Record number, date, and wound location and measurements on the photograph must correspond to the documentation on the Wound Assessment Sheet.

REFERENCES: **N/A**

DEFINITIONS: **N/A**

ATTACHMENTS: **N/A**

APPROVAL DATE:	**N/A**	**Policy, Procedure and Standards Committee**
	10/04/22	**Nursing Standards Committee** Applicable Administrator, Hospital or Medical Committee
	11/30/22	**Patient Safety and Quality Committee** Applicable Administrator, Hospital or Medical Committee
	05/26/23	**Infection Control Committee** Applicable Administrator, Hospital or Medical Committee
	06/01/23	**Quality Management Committee** Applicable Administrator, Hospital or Medical Committee
	06/22/23	**Medical Executive Committee** Applicable Administrator, Hospital or Medical Committee
		Board of Supervisors Approved by the Governing Body

REPLACES: **N/A**

EFFECTIVE: **06/22/23**

REVISED: **N/A**

REVIEWED: **N/A**

SECTION: **ADMINISTRATIVE**

SUB SECTION: **PLAN FOR PROVISION OF CARE**

SUBJECT: **BODY MECHANICS**

APPROVED BY: _____
Clinical Director, Ambulatory Services

POLICY

Ambulatory Services Wound Clinic Staff will practice proper body mechanics during all activities. Good body mechanics keeps the spine balanced during any kind of movement. Poor body mechanics are the uncoordinated movement that eliminates the balance of the spine's three natural curves.

PROCEDURES

I. Stand with feet apart, in slight steppage pattern and planted firmly for increased stability.

II. Keep the center of gravity as low as possible and centered over your base of support by flexing from the hips and knees. **Maintain normal spinal curves.**

III. Prepare muscles for action – stabilize the position of the pelvis by contracting the abdominal muscles.

IV. Use the large leg muscles and joints rather than the small back muscles and joints.

V. Flex knees and keep back straight when lifting/reaching for an item off a low surface.

VI. Position the body to face the direction of the intended movement with foot pointed in the direction of the move. Move torso as one solid unit from the shoulders to the hips. **Do not twist spine when moving a load**.

VII. Keep the load close to the body, near your center of gravity.

VIII. Methods

A. How to turn the patient toward you:

1. Lower the bed rail and head of the bed. Adjust the bed height to waist or hip level.
2. Assist the patient to flex his/her knees.
3. Place one hand behind the patient's farther shoulder and the other hand behind the patient's hip.
4. Turn the patient toward you.

B. How to turn a TOTAL ASSIST patient (with 2 people):

1. Lower the bed rail and head of bed. Adjust the bed height to waist or hip level.
2. Position the patient's legs to one side of the bed. Using a draw sheet, move the patient's trunk to the side of the bed. The person on the side of the bed the patient is going from, lifts the draw sheet while the person on the side of the bed the patient is going to pulls on the draw sheet.
3. Flex the patient's knees and place one hand behind the patient's farther shoulder and hip.
4. Turn the patient toward you, with assistance, if needed.
5. Place pillows behind the patient's back to secure him/her on his/her side.
6. Adjust the patient's head, upper and lower extremities in a position of comfort and pressure release.

C. How to reposition a patient closer to the head of the bed:

1. Lower the bed rail and head of bed. Adjust the bed height to waist or hip level.
2. With an assistant, grasp the draw sheet, pointing one foot in the direction of the movement.
3. Slightly lean into the direction of the move, using your legs with one knee bent towards the direction of the movement.
4. On the count of three, lift the draw sheet and slide the patient up towards the head of the bed.
5. Instruct the patient to push with his/her feet. Give the patient an object to push against with his/her feet.

D. Putting the patient onto a bedpan:

1. Lower the bed rail and head of bed. Adjust the bed height to waist or hip level.
2. Assist the patient to roll away from you and reach for the opposite bed rail.
3. Position bedpan properly under patient and assist patient to roll as a unit onto the bedpan.

E. Reaching for high objects:

1. Do not hyperextend the arm and trunk while reaching.
2. Use a step stool or ladder to get closer to the object.

F. Correct sitting posture:

1. Lower back supported with lumbar support or rolled towel.
2. Hip and knees positioned at least 90 degrees.
3. Feet flat on the floor.
4. Maintain normal spinal curves, keep neck in good alignment. Avoid a "forward" head, slumped shoulder position.
5. Shift positions frequently.
6. The working surface should be at a level, which allows the body to be erect, and the work to be performed at elbow height.

G. Lifting an object from a low surface:

1. Bend from the knees and hips with abdominal muscles contracted.
2. Place one knee on floor for added stability and increase width of base of support.

H. Lowering a patient to the floor:

1. When a patient begins to fall, do not attempt to catch them. Once the momentum has started, it is almost impossible to stop a fall.

   a. Holding onto the gait belt, assist the patient fall to the floor with as little impact as possible.
   b. If you are near a wall, gently push the patient against it to slow the fall.
   c. If possible, move close enough to "hug" the patient.
   d. Focus on protecting the patient's head as you move to the floor.

REFERENCES: **N/A**

DEFINITIONS: **N/A**

ATTACHMENTS: **N/A**

APPROVAL DATE:	**N/A**	**Policy, Procedure and Standards Committee**
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	06/01/23	**Quality Management Committee** Applicable Administrator, Hospital or Medical Committee
	06/22/23	**Medical Executive Committee** Applicable Administrator, Hospital or Medical Committee
		Board of Supervisors Approved by the Governing Body

REPLACES: **N/A**

EFFECTIVE: **06/22/23**

REVISED: **N/A**

REVIEWED: **N/A**

SECTION: **PATIENT CARE**

SUB SECTION: **PROCEDURE**

SUBJECT: **OUTPATIENT CERVICAL RIPENING WITH TRANSCERVICAL FOLEY**

APPROVED BY: _____
Clinical Director, Ambulatory Services

POLICY

Cervical Ripening will be performed in the Women's Health Clinic to reduce the time to delivery when a patient is scheduled for labor induction. The procedure will be performed by a provider when the patient meets criteria.

PROCEDURES

I. Criteria:

A. The patient is 39 weeks or more of gestational age with confirmed delivery dates
B. The patient is scheduled for an inpatient induction within 24-48 hours
C. A normal ultrasound with confirmation of placenta location
D. A normal biophysical profile (BPP)
E. The patient has adequate transportation to return to hospital in less than 60 minutes
F. Vital signs are within normal limits
G. The patient signs a consent confirming understanding of instructions, risks, and benefits

II. Contraindications and exclusions:

A. BPP of 6 or less
B. Bishop score greater than 7
C. Diagnosis of Diabetes with insulin requirement
D. Fetal anomaly excluding soft markers
E. Hypertension: pregnancy induced or preexisting
F. Intrauterine Growth Restriction (IUGR) – Estimated Fetal Weight (EFW) less than 10th percentile
G. Known latex allergy
H. Macrosomia – EFW greater than 4250 grams
I. Placenta Previa, low lying placenta, vasa previa
J. Polyhydramnios

III. The clinical support staff will gather the following supplies:

A. Foley Catheter with 30ml balloon
B. Sterile gloves
C. Lubricant
D. Speculum

E. Ring Forceps
F. Tenaculum
G. Normal Saline
H. 30 or 60 ml luer lock syringe
I. Basin for drawing up normal saline
J. Catheter plug

IV. Procedure

A. The primary Obstetric provider may directly place foley during digital examination or place the patient in stirrups and guide foley into the cervix using ring forceps
B. The foley bulb will be inflated with approximately 30ml saline, or to patient comfort
C. The catheter will be taped to the patient's thigh
D. The patient will be instructed to ambulate to ensure comfort and monitored for 30 minutes to ensure no excessive bleeding or severe pain
E. The patient will be given the Cervical Ripening handout with labor precaution reviewed
F. The patient's induction appointment with Labor and Delivery department will be verified with the patient and discharged

REFERENCES: **Title 22**
Centers for Medicare and Medicaid Services
The Joint Commission Standards
American Journal of Obstetrics and Gynecology

DEFINITIONS: **N/A**

ATTACHMENTS: **N/A**

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EFFECTIVE: **06/22/23**

REVISED: **N/A**

REVIEWED: **N/A**

Attachment A
Cervical Ripening with Transcervical Foley Handout

Congratulations! It's time to have your baby. You have been selected to have an *outpatient cervix ripening with a transcervical foley catheter.* This means that you will be seen in our outpatient clinic with an obstetrics physician or physician assistant. You will have an ultrasound to check which way the baby is facing and to check the amount of amniotic fluid around the baby. If the baby is head down and the fluid is normal, the obstetrician will place a foley catheter, a soft balloon on a straw, through the cervix and inflate the balloon a little. The balloon then gently puts pressure on your cervix, causing it to open slowly.

What is an induction? An induction is when we try to help start labor.

What happens during an outpatient induction? There are several ways that we can try to encourage labor. In your situation, we are planning to ripen your cervix - to make it soft and able to stretch for labor - using a catheter called a Foley catheter.

You'll have the catheter inserted through the cervix and then the balloon will be inflated. You'll stay in the office or nearby for about 30 minutes following the insertion. This is to make sure you don't have very bad pain or heavy bleeding, which are rare side effects from using the catheter.

You will also be scheduled for an induction in the hospital within 24-48 hours of the catheter placement.

Your scheduled induction date and time is: _____ @ _____AM/PM.

Please call labor and delivery at 909-580-3400 an hour in advance of this appointment so the nurses can ensure a room is ready and available for you.

Are there risks? The risks are the same as when a woman goes into labor naturally. There is a small chance of having pain that is not tolerable, or heavy bleeding. If you have severe pain or heavy bleeding, please return immediately to the labor and delivery unit. Some spotting is normal following the catheter placement.

What will I feel at home? You may feel some cramping or contractions. You may also notice some slight blood tinged mucous discharge. Or you may feel perfectly normal! If you have any questions, call labor and delivery at (909) 580-3400.

When should I return to the hospital?

- If you have bright red vaginal bleeding, that is more than spotting, return immediately to Labor and Delivery.
- If you have mild spotting or dark brown old blood, this is usually not a concern.
- If you are having contractions lasting 60 seconds each, and they are 3-5 minutes apart for 1-2 hours and painful, return to labor and delivery.
- If you have broken your water or had a large gush of fluid, return immediately to labor and delivery. If you are not sure if your water has broken, apply a sanitary pad to your underwear and walk around for an hour. If the pad is soaked after walking, then proceed to labor and delivery. If not, it is probably cervical mucus - which is normal.
- If you have decreased fetal movement, drink at least 3-4 large glasses of water. Lay on your left side and rest, you should have at least 10 movements. If you still have decreased fetal movement after an hour of drinking, return immediately to labor and delivery.

SECTION: **PATIENT CARE**

SUB SECTION: **SCREENING**

SUBJECT: **SCREENING AND MANAGING PATIENTS WHO VERBALIZE MENTAL DISTRESS**

APPROVED BY: _____
Clinical Director, Ambulatory Services

POLICY

Arrowhead Regional Medical Center (ARMC) Ambulatory Services Specialty Care Clinics identifies patients who verbalize mental distress, such as suicidal ideation, and assures their immediate safety needs are met in the most appropriate care setting.

PROCEDURES

I. Screening

A. Screening for suicidal ideation within the specialty clinics is performed on patients who verbalize mental distress with provider and/or have a history of suicidal/homicidal ideation.

B. For any patient that has been identified at risk for suicide, the following procedure is to be followed:

1. Ensure patient safety. The patient is not to be left alone at any time.
2. Contact clinical social work.
3. If clinical social work is unavailable, and the patient agrees to receive additional services contact:

a. Contact Behavioral Health House Supervisor and escort the patient to Behavioral Health if the patient is between 18 to 64 years of age.
b. Contact the ED charge nurse and make them aware that clinic staff will be escorting a patient voluntary status to Emergency Department triage if the patient is, pregnant, under 18 years old or 65 years or older.

C. Nursing staff in Oncology/Infusion Clinic screen all patients during their second visit using the Oncology Psychosocial Distress Screening Tool.

1. If suicidal/homicidal ideation is verbalized by patient, clinical social worker will be notified. Verbal check-ins will be provided to patient upon psychosocial assessment.

D. Nursing staff in Pediatric Clinic will screen as follows:

1. Pediatric Adverse Childhood Experiences (ACE's) questionnaire on all new patients during initial visit; then on an annual basis as an established patient.

2. Standard Patient Health Questionnaire (PHQ-2/PHQ-9) questionnaire at annual physical for all patients 12 years and older. Children younger than 12 years old will be screened if they present with complaints or symptoms.
3. For children with a history of depression, screening is conducted at every visit using the PHQ-9 questionnaire.

E. Nursing staff in Women's Health Clinic will screen as follows:

1. Edinburgh Postnatal Depression Scales (EDPS) is used to screen all patients during a post-partum visit and all new patients during their initial visit.
2. All new patients are screened using the ACE questionnaire during initial visit
3. 4P's Plus Screening Tool is used in the Maternal Fetal Medicine (MFM) clinic and the Obstetrics (OB) clinic for new patients during initial visit.

F. All other Specialty Care Clinics use the PHQ-2 and/or PHQ-9 for screening upon a patient verbalizing mental distress during their visit

II. Clinical Social Work Notification

A. Clinic staff/Provider will follow the following process to contact a clinical social worker:

1. Pager or office line (see daily staffing for Social Worker covering the Outpatient Clinics)
2. If page/call is not returned within 15 minutes call the Social Work office main line at extension 01080

B. Provide the clinical social worker with the patient's identification information and the reason for consult.

C. Patient will be escorted by clinical social worker and/or security for services dependent on age.

III. Documentation

A. Document assessment and safety interventions in the patient's medical record.

B. If the patient refuses voluntary assessment, whomever was in contact with the patient last must contact local law enforcement, usually the county in which the patient resides, to request a wellness check.

1. Document the phone number of Police Department, incident number, dispatch representative name, and identification number.

REFERENCES:

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The Joint Commission Standards

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ATTACHMENTS: **N/A**

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02/07/23	**Nursing Standards Committee** **Applicable Administrator, Hospital or Medical Committee**
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	Board of Supervisors **Approved by the Governing Body**

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